Essex Health and Wellbeing Board

14:00	**Tuesday, 14 January 2014**	**Council Chamber, Rochford District Council, Civic Suite, 2 Hockley Road, Rayleigh, SS6 8EB**,

Quorum:
One quarter of membership and will include:

- At least one Essex County Council elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council *either* Director of Adults Services, Director for Children's Services or Director for Public Health

Membership:

Councillor David Finch	Essex County Council (Chairman)
Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Jacqui Foile	Voluntary Sector
Councillor John Galley	Essex District Councils
Dr Rob Gerlis	West Essex CCG
Dr Mike Gogarty	Essex County Council
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG
Peter Tempest	Essex County Council
Co-opted Members:	
Nick Alston	Essex Police & Crime Commissioner
Simon Hart	Independent Chair ESCB & ESAB

For information about the meeting please ask for:
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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Apologies and Substitution Notices** The Committee Officer to report receipt (if any)	
2	**Minutes of meeting held on 21 November**	**7 - 20**
3	**Declarations of Interest** To note any declarations of interest to be made by Members	
4	**Questions to the Chairman from Members of the Public** The Chairman to respond to any questions relevant to the business of the Panel from members of the public, notice of which has been given in advance.	
5	**Integration Update: Better Care Fund and Integrated Plans** To receive a presentation by the Integrated Commissioning Directors/ CCG's	
6	**Essex Police Crime Commissioner and Essex Health and Wellbeing Board Strategy** To receive a presentation by Nick Alston, Co-opted Member of the Board	**21 - 30**
No.	**Break**	
7	**Essex orthodontic needs assessment 2013 - key findings and next steps** To receive a report by Linda Hillman, Anglia and Essex Public Health England Centre	**31 - 90**
8	**National Autism 2nd Self-Assessment** To receive a report by Steve Allen seeking endorsement of the local areas submissions.	**91 - 108**
9	**Annual Public Health Report 2013** To receive a report by Mike Gogarty, Essex County Council seeking endorsement.	**109 - 194**

10	**Commissioning Intentions for Children Young People and Families** To receive a report by Barbara Herts, Essex County Council seeking endorsement.	**195 - 250**
11	**Date of Next Meeting** To note that the next meeting will be held on Thursday 27 March 2014 at 2pm at Braintree District Council. Causeway House, Bocking End, Braintree, Essex CM7 9HB	
12	**Dates of Future Meetings** Tuesday 20 May 2014 at 2pm (Tendring, venue TBA) Tuesday 15 July 2014 at 2pm (Brentwood, venue TBA) Thursday 25 September 2014 at 2pm (Harlow, venue TBA) Tuesday 25 November 2014 at 2pm (Castle Point, venue TBA) Tuesday 13 January 2015 at 2pm (Maldon, venue TBA) Tuesday 31 March 2015 at 2pm (Colchester, venue TBA)	
13	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

14	**Urgent Exempt Business** To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.	

MINUTES OF A MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD HELD AT UTTLESFORD DISTRICT COUNCIL, LONDON ROAD, SAFFRON WALDEN CB11 4ER

Present:

Members

Councillor John Aldridge	Essex County Council
Dr Kamal Bishai (Vice Dr Rob Gerlis)	West Essex CCG
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Councillor David Finch	Essex County Council (Chairman)
Councillor John Galley	Essex District Councils
Dr Mike Gogarty	Essex County Council
Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
John Mitchell (Vice David Marchant)	Essex District Councils
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG (Vice-Chairman)
Peter Tempest	Essex County Council

Officers

James Bullion	Essex County Council
Ann Coldicott	Essex County Council
Clare Hardy	Essex County Council
Margaret Lee	Essex County Council
Chris Martin	Essex County Council
Clare Morris	West Essex CCG
Terry Osborne	Essex County Council

1. Apologies and Substitutions

Apologies were received from:

Mike Adams with Tom Nutt as his substitute	Healthwatch Essex
Nick Alston, Co-opted Member	Essex Police and Crime Commissioner
Jacqui Foyle	Voluntary Sector
Dr Rob Gerlis with Dr Kamal Bishai as his substitute	West Essex CCG
David Marchant with John Mitchell as his substitute	Essex District Councils

2. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 18 September 2013 were approved as a correct record and signed by the Chairman.

3. Declarations of Interest

None.

4. Questions to the Chairman from Members of the Public

Question, received in writing from Mr Kenneth Grahame Edwards BA ACIB. Mr Edwards also attended the meeting.

"As a long standing member of a Health & Well Being Group covering one of the constituent local authority councils within Essex, I can recall no occasion since its formation when the County Board has engaged with us directly by way of consultation, collaboration or other engagement. Are there any mechanisms in place for such engagement and if so can they please be outlined"

Reply.

Thank you for your question, which is a helpful reminder of the Board's need to engage with a range of stakeholders. The Health & Wellbeing Board has no formal local arrangements but engages through a number of partnership mechanisms, including Clinical Commissioning Group stakeholder forums, Healthwatch and local District Health & Wellbeing arrangements which take a different shape in each locality, depending upon local circumstances. We also maintain an extensive stakeholder database with over 350 names of partners across Essex, through which we have sought engagement on the development of the Joint Health & Wellbeing Strategy and most recently the next steps on the 'Who Will Care?' Commission. The engagement on the Strategy and the Who Will Care Commission included on-line engagement and a range of briefing seminars and workshops, including a county wide conference and 9 district workshops. Details of the activity on both the strategy and 'Who Will Care?' Commission are on the Essex Partnership website: http://www.essexpartnershipportal.org/pages/. We are keen to develop our engagement further and would welcome suggestions around efficient and effective ways to continue our engagement.

5. Who Will Care? Next Steps

The Board received a report HWB/018/13 by Dave Hill which set out the next steps on the recommendations from the "Who Will Care?" Commission report.

The Board noted the summary of all the discussions on next steps as set out in the table below:

Possible Solution	**Suggested Activity**	**Leads**
Co-ordination	Establish a HWB Advisory Group. This group would have an oversight role across the Who Will Care recommendations developing a fully costed implementation plan by end January 2014. The HWB Advisory group is considering options for co-ordinating activity under each work stream. The initial focus of the group will be on recommendation 3. It is proposed that the group is chaired by Sir Thomas Hughes-Hallett and should include Dr Gary Sweeney (deputy chair), Bob Reitemeier, Cllr John Aldridge, a District Council elected member, Joanna Killian, Dr Sunil Gupta, Andrew Gardner, Andrew Pike, James Anderson, an Essex Acute Trust representative, and Dave Hill. The group will meet monthly and report to the Business Management Group, which is chaired by Dave Hill who will report progress back to the HWB. GlaxoSmithKline have also offered support us on taking the programme forward and we are exploring with them what this approach will look like.	Sir Thomas Hughes-Hallett,
1. Understanding	Joint work is already taking place in each CCG locality on the Big Care debate, further consideration and work on this will be picked up through the integrated plans developed by the CCGs and the ECC Integrated Commissioning Directors which are due to come through the HWB in Jan/March. The Council will also work with Healthwatch to consider countywide	CCG Accountable Officers and ECC Integrated Commissioning Directors working with Healthwatch and partners in each locality.

	elements.	
2. Prevention	This work is at the heart of our integration programme and the proposals are being considered through the Integrated Plan process in each locality. The Integrated Plans are due to come through the HWB in Jan-March.	CCG Accountable Officers and ECC Integrated Commissioning Directors working with other partners in each locality.
3. Community	The HWB Advisory Group which provides the overall co-ordination will specifically focus on recommendation 3. The group will aim to strengthen the voluntary sector and harness its support and commitment to achieve the changes set out within the recommendation. The group will meet monthly and report to the HWB Business Management Group, who will report progress back to the HWB. The development of the group is linking in with the Community Budget work on Strengthening Communities and will also be able to report into the Essex Partnership Board on wider opportunities.	Sir Thomas Hughes-Hallett
4. Data & Technology	It is proposed that a Data Reform task and finish group be established to consider Essex's whole system data requirements. The group will look to identify what data we need to share, for what purpose and to whom and will work to address local barriers at both a macro and individual level. It will also use this to develop an evidence base to inform public sector data sharing enabling powers in the Government's Communications Data Bill. It is proposed that the group will be Chaired by Cllr David Finch, and will include; representatives from Essex Fire, Essex Police/ PCC, NHS England, CCGs, ECC Children's Services, ECC commissioning as	Cllr David Finch as Chair supported by Chris Martin, Integrated Commissioning Director, ECC

	well as some technical and legal input. The group will report back to the HWB, coordinated via the HWB Business Management Group. The Anglia Ruskin Health Partnership and have offered support in this area which the task and finish group will be keen to explore.	
5. Leadership	The HWB on the 18th September agreed to progress the concept of a Care Partnership but there was concern to ensure we avoid duplication with other groups. Discussions have been taking place to bring together a number of existing forums to create a new Partnership including the Anglia Ruskin Health Partnership and the NHS England Systems Group into this. Work is continuing on the most appropriate model to facilitate this and the Partnership would feed in directly to the HWB as well as the NHS England Area Team or to the Advisory Group on matters relating to the WWC recommendations.	Dave Hill and Andrew Pike

During the discussion on this item the following comments were made:

- Sir Thomas Hughes-Hallett was present at the meeting and reiterated his willingness to progress the areas outlined and that he was available to undertake the work during the coming year;
- Councillor John Aldridge advised that work had already commenced on some of the recommendations;
- Liaison with the Information Commissioner maybe required regarding information sharing;
- Tom Nutt advised that the provision of information needs to be useful to the people who need to access it and use it;
- Mention was made of an app being developed in the Tendring area regarding the availability of Mental Health Services;
- Councillor Terry Cutmore gave another example - a meeting had taken place with his local CCG regarding signposting what care is available;

- Simon Hart advised that there had been a piece of work undertaken regarding data sharing within the domestic abuse triage service. He thought the piece of work might be of use to the data sharing group;
- Sir Thomas Hughes-Hallett advised that he had visited the Prime Minister's adviser who was keen to help steer the work of the commission. The advisers view was that in order to succeed it would be important to set out what can be done rather than what cannot be done. He also advised that he would be willing to host a party at 10 Downing Street to launch the event for everyone involved; and
- Councillor David Finch asked if GlaxoSmithKline wanted anything in return for their offer to help. Sir Thomas advised that that they did not. It was a genuine offer of free high level advice, expertise, mentoring, space to facilitate discussions and that there might be a small sum of money available for a competition prize or something similar.

Resolved:

That

1. the CCG and ECC officers developing the Integrated Plans consider the recommendations around Understanding and Prevention and include appropriate activity within the Integrated Plans be agreed;

2. the establishment of a HWB Advisory Group to have oversight and co-ordination of the 'Who Will Care?' recommendations be agreed. The Group will ensure we have costed recommendations for the end of January 2014 and will focus on taking forward recommendation 3 around the community, as set out in the table above;

3. the establishment of a Data Reform task and finish group to identify data needs, address local barriers and submit evidence to support the national work on enabling data sharing as set out in section 4 of the table above be agreed; and

4. support the development of the Care Partnership concept as set out in section 5 of the table above be agreed.

6. A Vision for the West Essex Health and Care System

The Board received a report HWB/019/13 and presentation by Clare Morris, Chief Officer West Essex CCG and Chris Martin Essex County Council, which provided an overview of the key elements of the emerging vision for health and care commissioning and services in West Essex.

West Essex remains one of the most financially challenged economies in the region. The vision sets the scene for the forthcoming business planning round and for integrated commissioning discussions between the CCG and Essex County Council.

The Board was asked to consider how the plans fit with the wider Essex Health and Wellbeing Strategy.

The Board noted that West Essex CCG aimed to set a Vision that will:

- Put their patients at the centre – quality and outcomes;
- Determine and deliver the future model of the health and care system in West Essex; and
- Underpin plans that will secure both financial and clinical sustainability for this local system and a phased programme of implementation from April 2014.

Their underlying principles were:

1. Quality first - Patient safety, clinical effectiveness, improved clinical outcomes and care for people as people

2. Significantly shifting the point of care - right care is provided at the right time and in the right place

3. Integration between health and social care as a key enabler for delivery

4. Connected transition of care and support between professionals and organisations

5. Provision built around and responsive to the different needs of our communities and localities

6. Maximise productivity and efficiency where appropriate

7. Allow individuals to take responsibility for their own health and retain independence where appropriate.

The Board noted what professionals had told West Essex CCG regarding Frailty, ACSC, Children, Maternity and Mental Health. Work regarding Frailty services was more advanced than other subjects and the CCG planned to pilot the new model for Frailty Services from April 2014. They hoped to be able to replicate the model with regard to other subjects as they learn from experience.

Clare Morris confirmed that all the available money for a particular service will be given to one provider who will then channel the finances down to more minor services.

During the discussion on this item the following comments were made:

- Peter Tempest commented with regard to Learning Disability Services that in his experience from attending the Learning Disability Partnership Board, that most people with a Learning Disability did not trust their GP and therefore GP's may not always be the best person to deal with their issues;
- Kamal Bishai advised that GP's in West Essex were trying to champion Learning Disability needs and discuss how to co-ordinate services.

- Mention was made of how to give additional support to single doctor practices;
- Ian Davidson asked what work would be required to achieve a system that would work for the whole county; and
- Simon Hart raised an issue regarding safeguarding – he could see where it was implied in the vision but believed more work was required to urgently identify risk.

Clare Morris or Chris Martin responded to or noted the comments as appropriate.

The Board thanked them for their presentation.

Resolved:

That the plans and how they fit with the wider Essex Health and Wellbeing Strategy be noted.

7. Colchester Hospital University NHS Foundation Trust

The Board received an oral update from Dr Gary Sweeney regarding Colchester Hospital Trust having been put into special measures. He advised that during the Keogh review into mortality rates a whistleblower mentioned cancer waiting lists and made allegations regarding bullying. Significant evidence then came to light and a complicated investigation began. The inspectors did not want to unduly alarm the public or run the risk of further evidence being covered up or tampered with. Work is on going to make services safe whilst the review continues. Actual harm, potential harm and incidents of bullying are all being looked at together with undue delays in treatment and waiting time data relating to cancer treatment. The review will look back at 18 to 20,000 patients to properly assess the scale of who was affected.

He went on to say that the CCG are at present also undertaking an audit of GP's and that several issues were emerging there too.

Dr Gary Sweeney confirmed that as well as the hospital being in special measures it would also have a new Director and a buddy hospital for support. He advised that an internal investigation was also taking place regarding the allegations of bullying and why the initial whistleblowing claims were ignored.

Andrew Pike confirmed the following:

- that a major incident team have been set up and were being led by him and that he would remain in charge of the team until all actions have been completed;
- In order to insure public safety reviews will be completed by 27 November and the outcome will be put in the public domain by 11 December;
- Monitor are leading on the internal review and have powers to remove members of the board if they need to;

- The need to insure the safety of services today – will mean having to review 18 to 24,000 previous cases in order to assess data to see who needs further review; and
- there is a Police investigation regarding allegations of fraud and mis-conduct in public office.

Andrew Pike finished by advising that everyone involved was giving their fiull co-operation and that all agencies involved were working together.

During the discussion on this item the following comments were made:

- Dr Anil Chopra advised that some work had already been undertaken in the south of the county with Basildon Hospital regarding data manipulation which may be of use to the incident team;
- Andrew Pike advised that the CCG and hospital trust were reassuring the public about services and a helpline had been set up. He also stated that it was his belief that all work arising from the review should be put in the public domain;
- In response to a question regarding whether the special measures relate to the hospital or cancer care, Andrew Pike advised that as the special measures relate to cancer care services this has led to the hospital as a whole being placed in special measures;
- A report on lessons learned will be brought to the board in due course; and
- Councillor Anne Naylor asked if there would be any changes to the cancer care services provided. Andrew Pike confirmed that there were no plans to dismantle the specialist services provided the only plan was to make sure they are undertaken in the correct way.

The Chairman thanked Dr Gary Sweeney and Andrew Pike for their report.

8. Joint Strategic Needs Assessment (JSNA) – Countywide View 2013

1.1. The Board received a report HWB/020/13 by Dave Hill which advised them of the refreshment for 2013 of the countywide view of the Joint Strategic Needs Assessment.

In particular, the Board was asked to note the Key Issues identified in the countywide JSNA attached to the report.

During the discussion on this item the following comments were made:

- The work of Healthwatch Essex had been drawn on in the writing of the overview. Tom Nutt advised that Healthwatch were looking at making the findings more meaningful;
- Councillor Terry Cutmore advised that he was pleased that children at risk and safeguarding had been included;
- Simon Hart also stated he was pleased to see the strong safeguarding around domestic abuse issues. He went on to say he believed the analysis was a useful document but more work was required in relation to

vulnerable adults and he believed it would be useful if the JSNA went to the safeguarding boards and may prove to be a useful during any inspection; and

- Simon Hart also mentioned there was a very important piece of work being undertaken regarding teenage suicide which would be innovative and he was keen to bring to a future meeting of the Health and Wellbeing Board. Other members gave examples of how the information was being used or publicised locally.

Resolved:

That the attached countywide JSNA overview for publication be agreed.

9. Joint Health and Wellbeing Strategy (JHWBS) Refresh

The Board received a report HWB/021/13 by Dave Hill advising of:

a) the 1st annual refresh of the Joint Health and Wellbeing Strategy by taking account of changes in the Joint Strategic Needs Assessment (JSNA) and national policy since the strategy's publication in March 2013;

b) the need to set the baseline figures for the key performance indicators associated with each of the three priorities in the strategy (as agreed in the strategy's evaluation framework signed off by the HWB in May 2013); and

c) to agree on the areas for focus within each of the three priorities and five cross cutting themes during 2014/15. These will guide the development of integrated commissioning plans of the CCGs with ECC.

The Board were advised that the changes that were been made to the strategy for 2013 were:

i. incorporating the progress that has been made (and the future plans to continue at pace), with the integration of health and social care, into the whole document;
ii. the most recent data from the JSNA;
iii. a renewed evaluation framework for the strategy (as approved at the Health and Wellbeing Board in May 2013);
iv. performance "score cards" for each of the three priorities, which will act as a baseline to track progress in future years;
v. a clearer focus for each of the priorities and cross cutting themes for the year ahead (2014/15).

Resolved:

That:

1. the changes that have been made to the Joint Health and Wellbeing Strategy as identified in the 2013 Refresh document be agreed;

2. amendment of the fifth cross cutting theme so that it is extended to "Safeguarding and quality" be agreed;

3. to incorporate the recommendations from the "Who Will Care?" Commission report that have been accepted by the Board (agenda item 5), as additional areas of focus in the Strategy Refresh be agreed; and

4. the areas for focus for each of the three priorities and five cross cutting themes so that they can guide the development of integrated commissioning plans of the CCGs with ECC for 2014/15 be agreed.

10. Integration Programme Update

The Board considered a report HWB/012/13 by Dave Hill, Executive Director for People (Adults and Children), which updated members on the progress of the health and social care integration work and the Pioneer submission made by the Health and Wellbeing Board; and on the Integration Transformation Fund and the role for the Health and Wellbeing Board; and which set out the timeline for the Integration Transformation Fund and Integrated Plans.

The Board noted that on the 30th October we were informed that our submission was the most ambitious of all those received but further planning and development as to how it would be delivered was required to enable it to be a Pioneer. Although we were not accepted in this round we were encouraged to continue to work on our Integration Programme and consider resubmitting in a future round for the Pioneer programme. The HWB will need to consider its position on this at a later date.

During the discussion on this item the following comments were made:

- Dr Gary Sweeney commented that the CCGs were hoping that the five plans would not have to be homogenised. He noted that the use of the money to support social care and health was agreed however it would take time to build up to a more ambitious scope. Dave Hill confirmed that the plan was to start modest and to build up and that rules from central government were slow to arrive;
- Andrew Pike advised that the way forward was to work on the broad principles of previous years and that the five plans should use the same timescales;
- Councillor John Galley asked if responsibility stayed with the District Councils or moved with the funding. Dave Hill confirmed that the responsibility stayed with the District or which ever authority was responsible and all would need to find a way to bring everything together;
- Dave Hill advised that there were six national indicators and by February the Board will need to be satisfied that everyone has fed in to the process; and
- Tom Nutt advised that the board would have to demonstrate how they had engaged. He went on to say that full engagement should be a long term exercise not a tick box approach.

Resolved:

That the timeline for the Integration Transformation Fund and Integrated Plans including an additional HWB meeting to take place in February to sign off the Integration Transformation Fund plan be agreed.

11. Draft Voluntary Sector Strategy

The Board considered a report HWB/023/13 by Dave Hill advising of the public consultation underway to inform the development of the Essex VCS commissioning strategy and were provided with an opportunity to respond to the consultation and disseminate the message to their networks to ensure the strategy is informed by the full range of stakeholders.

The purpose of the strategy was to provide a consistent and clear approach to commissioning the VCS in Essex. It is a high-level strategic document that sits alongside the Essex, Southend and Thurrock Compacts and states some commitments and expectations of both sectors. It acknowledges the current financial challenges and resulting structural and organisational changes and articulates what a new relationship between the statutory and voluntary sector may look like. The strategy acknowledges the value of the VCS and attempts to create conditions that support the strengthening of local communities to respond to challenges themselves and to reduce the impact on public sector services at a time of increasing demographic pressures and reduced funding.

During the discussion on this item the following comments were made:

Dr Lisa Harrod-Rothwell advised that she had recently attended a voluntary sector fayre which had been lively and helpful.

Resolved:

That:

a. the Board publicise the Strategy consultation process within their organisations and wider networks be agreed; and

b. consideration be given to the approval and governance processes required for public sector partners to formally adopt the strategy following the consultation period, and that consideration be given to developing individual action plans to deliver the objectives of the strategy.

12. Date of next meeting

The Board noted that its next ordinary meeting is scheduled to take place on Tuesday 14 January at 2pm, in the Council Chamber, Rochford District Council, Civic Suite, 2 Hockley Road, Rayleigh, SS6 8EB.

Chairman
14 January 2014

Essex Police and Crime Commissioner and Essex Health and Wellbeing Board:

Achieving positive, shared outcomes to improve health, reduce crime and reduce the harm caused by crime

Essex Police Crime Plan: Priorities

- Local solutions for local problems
- Tackling Domestic abuse
- Supporting victims of crime
- Youth crime and reducing reoffending
- Reducing harm caused by alcohol and substance misuse
- Road safety
- Crime prevention
- Effectiveness and efficiency

Shared outcomes – Crime and Health

- Reducing harm caused by alcohol and substance misuse
- Improving outcomes for those with mental health problems - treatment pathways rather than punishment where possible
- Reducing levels of domestic abuse: harm caused to victims and their families
- Reducing KSIs in road collisions

Shared outcomes – Crime and Health

- Prevention: Informing YP of risks of cyber bullying and on-line exploitation; educating YP about domestic abuse and healthy relationships etc.
- Night Time Economy: Reducing levels of alcohol related admissions to A and E through better management of night time economy.

The Impact of Domestic Abuse on Health Services in Essex

THE SCALE OF THE PROBLEM IN ESSEX

Estimated 48,300 lifetime child victims, 10,800 experiencing severe domestic abuse

Radford et al (2011)

17,000 adult victims using Essex Police per year

Essex Police data

Costs the NHS in Essex a minimum of £20million per year

Walby (2009)

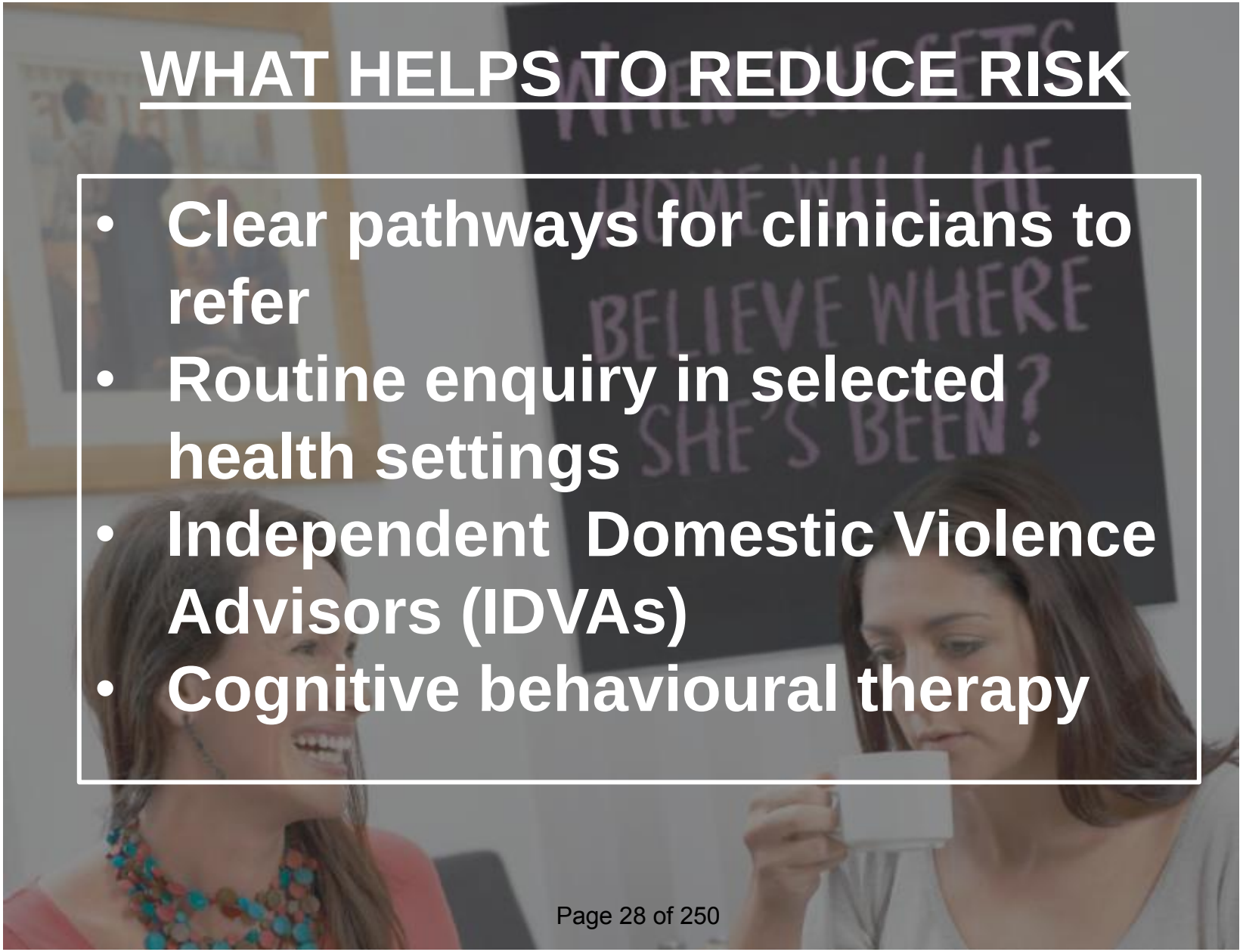
44,000 est. survivors per year

Walby (2009)

The Health Impacts of Domestic Abuse

Suicide and attempted suicide	Child behaviour problems	Irritable bowel syndrome
Sleep disruption	Post traumatic stress	Physical injury
Eating disorders	Miscarriage	Sexual infection
Unplanned pregnancy and terminations	Alcohol and substance abuse	Chronic mental illness
Depression	Anxiety	Self harm

WHAT HELPS TO REDUCE RISK



- Clear pathways for clinicians to refer
- Routine enquiry in selected health settings
- Independent Domestic Violence Advisors (IDVAs)
- Cognitive behavioural therapy

Recent Progress

- Specialist domestic abuse professionals in Maternity and Accident and Emergency services at Princess Alexandra Hospital, and working with GPs in Harlow
- Developing a proposal for engagement with professional networks for optometrists, pharmacists and dentists
- DA training for Health Visitors is now being taken forward with Public Health colleagues
- The Health Executive Forum acting as a focal point for co-ordinating the NHS response to domestic abuse

What we would like CCGs to do

- Increase awareness of issue across health professionals
- Data Sharing
- Engaging in the information sharing arrangements of the Joint Domestic Abuse Triage Team.
- Train health professionals in domestic abuse awareness and risk assessment.
- Joint commissioning of IDVAs

Report to: Health & Wellbeing Board **Report of:** Linda Hillman, Anglia and Essex Public Health England Centre	**Reference number:** **HWB/003/14** **Item 7**
Date of meeting: 14 January 2014	**County Divisions affected by the decision: All divisions**
Title of report: Essex orthodontic needs assessment 2013 – key findings and next steps	

Introduction

Orthodontics is a specialist branch of dentistry concerned with aligning the teeth and jaws, usually during a specific period of a child's development, in circumstances where the natural alignment will develop outside a functional and aesthetic range perceived as normal. An orthodontic needs assessment was undertaken for the Essex Area Team, between May and July 2013, by a consultant in dental public health from Public Health England, in collaboration with providers in the Essex local dental network, dental public health colleagues, contract managers and the NHS Business Services Authority, following a recommended framework.

Main methods and key findings

Existing data and information were collected, including the evidence base for care, local demographics and population projections, epidemiological survey reports, current contracted activity and care pathways for NHS care provision, perspectives of professionals, commissioners and the public.

It was established that there is a clear role going forward for a local orthodontic managed clinical (professional) network to support NHS Essex to set and maintain standards in orthodontic assessment and provision through the NHS, and to support service developments for efficient pathways, equitable for the entire population.

Demographic data show that absolute numbers of children in the age groups where orthodontic care is most commonly begun are unlikely to have increased in the years since a nationally co ordinated survey that included assessment of orthodontic treatment need was carried out in 2009 – 10, although numbers will again begin to rise a little by 2020. At the time of the survey, data suggested that across the county, 6055 12 year old children either needed orthodontic care or were already in treatment and it

was demonstrated that professional judgement was important to accurately identify who was eligible for care and when it should begin, and hence manage demand.

Levels of services commissioned in different parts of the county compared well with population distribution and identified need, although it was acknowledged that the calculations of both need and supply, and then their comparison, make significant assumptions. Current providers report an acute lack of capacity in the North East, not seen elsewhere. Data on wider NHS orthodontic uptake show that residents in other parts of Essex sometimes access services outside Essex and this may be why there isn't the observed pressure on local services in those areas.

Many people, particularly in some geographical areas travel a long way for orthodontic care and these populations and patients in vulnerable groups are at a greater risk that, for such long courses of treatment, that distance from specialist services is a significant barrier to access.

Management information on primary care orthodontic contracts highlights areas where improvements in service quality and productivity can be encouraged.

There are impending changes in hospital based consultant services in the North of the county, and this presents an opportunity to establish the best arrangements from the resources available. At the time when the report was prepared, hospital service data was unavailable, but the information from it is to be considered before service commissioning decisions are made.

There are gaps in our knowledge about the views of patients and the public, particularly from vulnerable groups, on local orthodontic services that are available.

Recommendations

Eleven recommendations were made in the report, which would be addressed through the following six actions that were put to NHS Essex, contributing to overarching aims to ensure service continuity and equity of provision for all population groups.

1. NHS Essex should work with the profession to address observed shortfall in capacity in North East Essex (this in part is caused by children being referred who don't need to be).

2. NHS Essex should support the establishment of an orthodontic sub-group of its existing Essex Local Dental Network. This should be consultant led and support further communications and work on all its orthodontic services. The network would also routinely monitor patient and public experience and views, especially those from people in vulnerable groups and their representatives.

3. Orthodontic consultants are well placed to support the Area Team to maintain and improve orthodontic standards across Essex in addition to their roles to undertake the most complex work, working with other specialists as required, and

to provide specialist training. Levels of investment in current hospital services and specialist training should be identified and future service models developed in liaison with the current consultant staff, the Essex orthodontic network and Health Education England.

4. Work would continue within NHS Essex to ensure consistency and excellence in management of primary care orthodontic contracts, in line with the new national performance framework, and to review the referral management system in North East Essex.

5. Management time is required to tackle areas where contract delivery falls below standards expected nationally, and staff should be supported by the local orthodontic network as outlined above (2). Further work should be begun to establish the extent of extra clinical capacity that this should release.

6. Pathways through local services should be clear and understandable for the public, and processes in place to deal with cases that might fall outside those agreed.

Health Watch and the Health and Wellbeing Boards are well placed to provide patient and public perspectives, plus those from other local organisations and professional groups. Early feedback to the Area Team would be gratefully received, along with any recommendations for more detailed or specific investigations that should be undertaken, and any ongoing support that could be offered.

Essex Orthodontic Needs Assessment 2013

A document to support commissioners in the Essex Area Team

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References

Executive summary and recommendations

To inform development of its five year commissioning strategy, NHS Essex requested an assessment of orthodontic need across the county, recognising a number of issues including an apparent greater demand than capacity in some areas, inconsistent pathways and costs of care. Contracts for specialist primary care provision were due to end in 2014 and much primary care was undertaken by dentists without specialist qualification. Changes were afoot in hospital care, with no strategic plan in place, and budgets and commissioning responsibility for these services transferring from Clinical Commissioning Groups to the NHS Essex Area Team.

Close to 1.74 million people live in Essex, which in the South, has large populations bordering onto North East London. The vast majority of orthodontic provision is for children aged 10 – 19 years.

The development of the Index of Orthodontic Treatment Need (IOTN) has given clinicians a tool to prioritise patients that stand to benefit most from treatment, and the NHS provides care usually for children who are under the age of 18 at the start of treatment, above an IOTN threshold and sufficiently motivated to comply. The index can also be used to assess need at a population level and it has been repeatedly shown that about a third of all children meet NHS criteria, but a smaller proportion both want and would benefit from care – clinical judgement is important in selecting appropriate cases. The calculation includes a factor for adults who might also access services; information on the NHS Choices website confirms the eligibility of adults for NHS care if they meet the criteria.

There is a role for an orthodontic managed clinical network to set and maintain standards in orthodontic assessment and provision across Essex, and to ensure equity in provision to the public.

Local survey data from 2008/9 showed that improvements still needed to be made in general oral health of 12 year olds in Essex; children needed to receive good dental care when required. The data indicated that 4166 12 year old children both needed and wanted orthodontic treatment in 2008/9 and a further 1897 were likely to have been already wearing an appliance at the time of the survey. Hence in total, out of about 20910 children, 6055 either needed orthodontic care or were already in treatment. The data also showed that professionals would select significantly fewer children to benefit

from orthodontic care than would the children themselves, or their parents, hence dentists have an important role in managing demand.

Population projection data show that numbers of 12 year olds in Essex were falling at the time of the 2008/9 survey and that from 2014 these numbers are starting to rise again, resulting in a small net gain by 2020. Hence in the short to medium term, where orthodontic services currently meet demand, little or no further investment would be required, particularly as existing capacity would be increased by operating pathways and services more efficiently.

The orthodontic pathway starts by appropriate referral from general dental services, to specialised or specialist services. Large orthodontic practices are often located in or near large urban centres.

We compared 'calculated need' to levels of commissioned primary care service in each of the five former primary care trust areas of Essex, assuming that on average, 22 units of orthodontic activity are required to identify and treat a case. 6055 cases were needed in 2008/9 and provision for 6881 treatments to start each year by 2013, 826 more than the need. This calculation shows

- a small *over* provision in North East, Mid and South East Essex,
- need and provision been approximately equal in West Essex,
- slightly less provision than required South West Essex.

Reports from services, however, were of not enough capacity in the North East. When looking at primary care orthodontic service uptake by Essex residents across an area wider than just Essex, it could be seen that many children were receiving services from Hertfordshire, Kent and particularly North East London; in North East Essex, there are not these options, there was a the lack of capacity experienced. Contract data shows that more than 22 units of activity are actually used to identify and treat all cases, and hence the experienced shortfall.

It is of note that the unit cost of primary care orthodontic treatment, and variations between practices is not presented in this needs assessment; NHS Essex Area Team is working to reduce the variation in price towards a national or local benchmark. The over-all cost of orthodontic treatment is high; it produces very little absolute health gain,

and is heavily demand led - this provides a strong case to support the ethical clinical leadership that an orthodontic clinical network can offer to support commissioners.

Although many people access their orthodontic care in the primary care settings of surrounding counties, on the whole, there doesn't seem to be the reciprocal number of patients coming into Essex for care. This is therefore a financial benefit for NHS Essex.

Many people, particularly in some geographical areas, travel a long way for orthodontic care. A course of orthodontic treatment may involve a visit every six weeks for up to two years, and so long travel distances are a considerable inconvenience and may preclude some from receiving the care they need, which is inequitable. There is therefore a further role for an orthodontic network to show leadership in developing models of care that provide suitable care closer to people's homes.

NHS Essex now receives regular information about its primary care contracts on delivery, assessment, treatment and outcomes. A managed orthodontic clinical network could do much to promote good outcomes from all providers, developing innovative ways to raise standards towards those of the best.

Secondary care data will soon be available to the Area Team. Per patient treated, costs are significantly higher, and so services must be used wisely, developing their leadership and teaching capacity, and ensuring that cases are treated in the secondary care environment only if there is no suitable alternative.

Recommendations

1. **An orthodontic network should be formally recognised as part of the local dental network in Essex. It should:**

    - **Support provision of good general dental services as a priority, to ensure basic, good quality preventive care for Essex residents.**
    - **Promote demand management for orthodontics.**
    - **Promote the standards that are monitored by NHS Essex, using data provided through the Dental Services Division of the NHS Business Services Authority.**

2. **Long term population projections indicate that overall orthodontic need is unlikely to change radically over the next few years; some increase in capacity is achievable through measures to ensure that current services are delivered effectively, thought collaborative planning plus quality improvement supported and promoted by the local orthodontic network.**

3. **Care should be taken to ensure that orthodontic care is accessible to eligible special needs patients and those in vulnerable groups, informed by an equity audit.**

4. **It is clear that patients in the North and East of Essex have to undertake significant travel in order to access primary care services, and they are most likely to wait for their care to commence. Their perspectives on this should be understood by commissioners.**

5. **Orthodontic consultants are ideally placed to provide clinical leadership to the orthodontic network, and the large size of the population and the differences in the communities in the South and North of Essex support the need to retain current levels of consultant presence in the major urban areas.**

6. **It is important that the resources currently invested in secondary care orthodontics are identified and transferred to the NHS Essex dental budget.**

7. **Continued evidence of long waits and the need to establish the referral management centre in the North of Essex suggest that there is currently insufficient local capacity to meet the local demand as well as the needs of those of patients who travel a long way to reach services. Some capacity will be created through effective management by clinicians and through contract, performance and quality management by Essex Area Team, supported by the managed clinical network.**

8. **Capacity in primary care in West and South Essex is bolstered through Essex patients accessing care in adjacent counties, and this supports the observation that there is an under supply in other areas of Essex (see above), where the need and capacity calculations alone do not show this. Patients in the East, North and North East do not have similar opportunities to access services out of county.**

9. **Further information is awaited on cost, outputs and outcomes of the referral management service for orthodontics.**

10. **Better information is needed, in general, on patient perspectives.**

11. The optimal configuration and contribution of secondary care orthodontic services is best decided once more data is available, and the greater skills and training of orthodontic consultants should be used to the full in order to get the best possible care to all patients who need it, as close to people's homes as possible.

Glossary

NHS	National Health Service
GDS	General Dental Services (the main type of contractual arrangement used for primary dental care in the NHS)
PDS	Personal Dental Services (an NHS primary care dental contract that can be used to commission more specialised or specific dental services)
IMD 2010	Index of Multiple Deprivation, version established in 2010.
LSOA	Lower Super Output Area – small geographic area for population counts
IOTN	Index of Orthodontic Treatment Need
DHC	Dental Health Component of the Index of Orthodontic Treatment Need
AC	Aesthetic Component of the Index of Orthodontic Treatment Need
SHA	Strategic Health Authority (part of NHS structures in England, prior to 2006)
PCT	Primary Care Trust (part of NHS structures in England, prior to 2006)
DMFT	Decayed, Missing and Filled Teeth. An index used to quantify the prevalence of dental caries in older children.
ONS	Office of National Statistics
UOA	Unit of Orthodontic Activity (contract currency used by the NHS to pay for orthodontic care)
NICE	National Institute for Clinical Excellence
CQC	Care Quality Commission; a body that oversees quality in health and social care in England
QIPP	Quality, Innovation, Productivity and Prevention
DSDBSA	Dental Services Division of the Business Standards Authority of the NHS
PAR index	Peer Assessment and Review – measurable hence comparable way to rate outcomes of orthodontic cases treated

Introduction

Since April 2013, NHS Essex has had responsibility to commission the entire NHS dental pathway for its residents within a national operating framework, to ensure quality, innovation, prevention and productivity. Prior to this, services were managed separately in five areas: North East Essex, West Essex, Mid-Essex, South East Essex and South West Essex, with secondary care services becoming the responsibility of the emerging Clinical Commissioning Groups.

Orthodontics is a specialised branch of dentistry to improve the alignment of teeth and jaws to improve function and aesthetics. It is usually most effective when treatment is overseen by a specialist and started at the right point during a child's growth and development.

NHS Orthodontic care is available on referral from a primary care dentist for patients who meet criteria, described to patients on the NHS Choices website[1]. Service distribution remains largely historical and pre-2006 general dentists could choose to offer orthodontic care themselves, usually to patients of the practice. In some parts of Essex such activity remains within current General Dental Service (GDS) primary care contracts. However, the pathway that is becoming more generally accepted is for general dentists to refer patients to specialist orthodontic practice or to hospital (consultant led) orthodontic services. The latter also provides second opinions where necessary, leadership and knowledge of standards in orthodontics and teaching and training for the next generation of specialists. Consultant care is most appropriate for cases that are harder to treat or that require multidisciplinary consultant input, usually oral surgery, with orthognathic surgery for a small minority of patients. Consultants also contribute to the routine management of patients with a cleft lip and/or palate as they grow and develop.

In the past, specialist orthodontic practices could establish themselves anywhere they considered to be viable, but in 2006, their NHS contracts were replaced by Personal Dental Services contracts (PDS contracts) that were time limited, giving an opportunity for commissioners to change arrangements in line with population needs.

Currently in Essex, there are 23 locations providing primary care NHS orthodontic services through about 40 individual contracts, of which some are GDS and others, usually those of the specialist providers, are PDS. Some of these contracts are due to expire in 2014, giving an opportunity to re-commission differently should the population's needs require this.

The contract currency for primary care orthodontic contracts is the Unit of Orthodontic Activity (UOA). The UOA value is not consistent between practices. In some GDS orthodontic contracts, there is no distinct UOA rate - the activity is recognised by a higher rate for general dental activity (Unit of Dental Activity, UDA). There may also be orthodontic care delivered through trust-based contracts for community dental services, for patients with special needs. NHS Essex is responsible for the cost of primary care services delivered in its geographical area, regardless of the place of residence of the patient.

[1] http://www.nhs.uk/Livewell/dentalhealth/Pages/braces.aspx

Hospital services are currently in Colchester, Chelmsford, Basildon and Southend; beyond Essex are services at Ipswich, Addenbrookes and Whipps Cross Hospitals. Once it is agreed that a patient should be referred to a hospital, patients can choose which hospital they wish to use, but this relies on the referring dentist knowing the system as the 'Choose and Book' system does not connect to dental surgeries. Costs to the NHS for hospital based treatment are ultimately recharged back to the commissioning body where the patient lives.

Hospital services are paid for through nationally set tariffs which are a combination of a core rate for each 'item of service', with an adjustment to take account of local factors for each hospital. There is an orthodontic tariff for each first and for each follow up outpatient appointment for each child seen under 19 years of age, and a tariff for each first and each follow up outpatient appointment for adults over the age of 19, in addition to a tariff for an orthodontic procedure.

Historically, long waiting lists for treatment had built up for some primary care specialist services in some areas; additional short term funding had been provided in recent years to deal with these, and in North Essex, referral management was commissioned, to ensure patients were not being added to more than one waiting list.

The NHS Essex primary care five year commissioning strategy will determine changes to current orthodontic services, based on the findings of this needs assessment and other evidence and will support the implementation of any future changes specified by NHS England[2]. The aim is to improve the outcomes in the following areas:

- To meet the needs of the local population with patients able to achieve timely access to services.
- To provide evidence-based treatment that complies with contemporary standards such as those of the National Institute for Clinical Excellence (NICE) and the Care Quality Commission (CQC).
- To have effective pathways across Essex to support delivery of services so that primary care specialist orthodontic services are receiving appropriate referrals and are able to liaise with other services as needed.
- To have mechanisms to recognise high quality performance and to support improvements in performance where this is required.
- To deliver best practice measured through Quality, Innovation, Prevention and Productivity (QIPP).

If proposing significant service changes, commissioners should work in consultation with commissioners of services in adjacent areas that might be affected by their proposals, and with the public. Terminating a service can be de-stabilise a whole system. Due to protracted treatment times for orthodontic care, patients may move into the area from elsewhere during a

course of treatment and mechanisms should be in place for transfer of orthodontic care to a local practitioner if required.

In Summary, the current orthodontic pathway, standards and cost to the NHS for Essex residents is not consistent across the geographical area and there is a history of long waits for specialist primary care services in some areas that have been tackled through additional short term funding.

Commissioning flexibility includes

- Over-all level of investment in orthodontic services
- PDS specialist practices with contracts due to expire.
- Local negotiation with other contract holders, eg to relinquish their UOAs if not provided by a specialist, or if their outcomes are poor, in favour of UDAs or to transfer them to a specialist, to reduce contract unit value where it is above national averages and to agree quality indicators (kpi s) and to tackle areas of practice highlighted by the Business Services Authority Quality Assurance Framework to be outside the normal range.
- Review of hospital based orthodontic care.

Process of the needs assessment

A review was undertaken by a consultant in dental public health, of

- evidence of orthodontic need at a population level and within national policy on NHS orthodontic provision in England
- orthodontic needs applied to the population of Essex
- orthodontic care and pathways.in Essex
- current contracted activity through primary care in Essex
- mechanisms for referral management across the county
- secondary care provision
- orthodontic provision in community dental services
- professional perspectives
- commissioner perspectives
- patient and public perspectives

[2] Dental Contract reform Programme. Early findings: opportunity to give feedback. Department of Health and NHS England, July 2013.

The needs assessment was requested by commissioners in May 2013, for completion of a draft report by September 2013, to inform the primary care commissioning strategy for Essex for the next five years.

To support this work, a questionnaire survey was undertaken with
a) consultant orthodontists
b) orthodontic contract holders

A meeting was held on June 25th through the developing Local Dental Network for Essex, to which all orthodontic providers across Essex were invited, specifically to discuss the needs assessment, and to identify thoughts and concerns. These were then followed up as appropriate.

Further enquiries were made to identify the volume and costs of hospital orthodontic activity, patient views and data and issues around the referral management centre.

This needs assessment excludes a review of newer orthodontic treatments or private care.

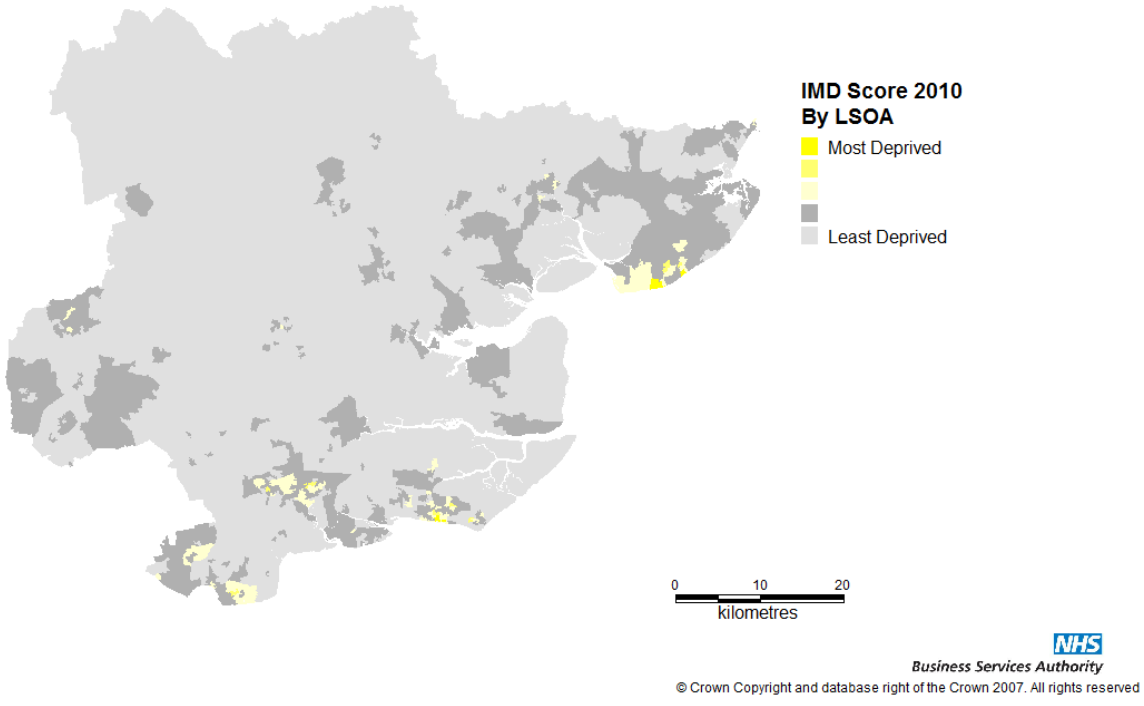
A draft report was prepared for discussion with commissioners and providers before options and recommendations were put to NHS Essex.

The population of Essex

Essex is to the North and East of London and its joint strategic needs assessment, last updated in 2012, describes a total population close to 1.74 million people across the County Council area and the two unitary authorities of Southend on Sea (population 165300) and Thurrock (population 159 600). With the exception of Tendring, there was a similar proportion of children aged 0 -15 to the England average (19%), fewer 15 – 44 year olds and more in the older age groups. Tendring had 16% of its population aged under 16 years. Colchester and Chelmsford were the largest conurbations and Harlow, Castle Point and Basildon the most densely populated areas, with Braintree, Maldon and Uttlesford the least. Areas with high population density were most likely to have pockets of high deprivation and poor housing.
173 900 residents were from black and minority ethnic groups (including Irish and 'other white'), making up 12.4% of Essex residents, less than the English average of 17.2%. Of the ethnic residents, 59 300 were from white minority groups and 114 600 from ethnic groups other than white.

Essex had some of the most affluent and deprived areas in England, with further pockets, hard to identify, for example 30% of travelling families lived on unauthorised sites and 15 430 migrants had registered to work in Greater Essex between May 2004 and December 2009, possibly experiencing poor living conditions and lack of knowledge about services..
Employment opportunity, mental health and educational achievement were recognised as being strongly associated with one another as was the need for an effective transport system to support people to have good access to services.

Figure 1: Map to show areas of deprivation in Essex



The local residents' tracker survey (2010) of public transport reported that residents from Chelmsford, Castle Point and Tendring were the most satisfied with local transport information, with Epping, Uttlesford and Maldon the least. Volume of traffic had increased by 6.25% over the previous ten years, causing congestion on many roads.

Parenting was recognised as having a huge influence on children's health and wellbeing. An estimated 2% of families experienced multiple problems, more likely to be in deprived areas. Families living in social housing, where the mother's main language was not English, lone parent families and families with a young mother all faced a higher than average risk of experiencing multiple problems. There were an estimated 1000 parents aged under 20 years in Essex.

The clinical context of orthodontics and the Index of Orthodontic Treatment Need (IOTN)

Information on clinical aspects of orthodontics relevant to this needs assessment, including the Index of Orthodontic Treatment Need used by dentists to identify patients potentially eligible for NHS treatment, is given in Appendix 1.

Of particular note, a course of orthodontic treatment requires commitment of the patient for up to three years and should not be started if the general oral health isn't good enough to prevent risk of the development of dental caries or where there is doubt about compliance with the treatment that involves regular clinic attendances over a period of months or years for reviews and adjustments. In either of these scenarios, outcomes will be unfavourable.

Population orthodontic needs and national treatment policy perspectives[3]

Measures of need

The Index of Orthodontic Treatment Need (IOTN), developed in the late 1980s,[li] has provided a standardised objective assessment. Table 1 summarises studies that measured the prevalence of malocclusion using the IOTN between 1989 and 2003, in various parts of the world.

[3] The framework for this section is taken from the Cambridgeshire and Peterborough Orthondontic Needs Assessment, 2012.

Table 1: Summary of studies of prevalence of malocclusion using the IOTN

Author	Date	Country	Sample size	Age of children (years)	Percent with definite treatment need*
Brooke and Shaw[II]	1989	England	333	11-12	32.7%
Holmes[I]	1992	England	996	12	32.0%
Otuyemi et al[II]	1997	Nigeria	704	12-18 ǂ	12.6%
Breistein and Burden[III]	1998	Northern Ireland	1,584	15-16	22.6%
Wang et al[IV]	1999	China	765	12	37.0%
Chi et al[V]	2000	New Zealand	152	13	14.0%
Abdullah and Rock[VI]	2001	Malaysia	5,112	12-13	30.0%
Abu Alhaij et al[VII]	2004	Jordan	1,002	12-14	34.0%

*Definite need for treatment as defined by the IOTN Dental Health Component Grades 4 and 5 and/or Aesthetic Component Gradings 8-10

ǂ Mean age 14.8 years

The English studies found 32-33% of 11-12 year olds to have objective (ie professionally determined) need. In the other UK based study, the children were older, hence the lower percentage found might represent unmet need, rather than true objective need, as treatment usually takes place in the early teens. There are further studies that use other indices to IOTN, hence their results are not directly comparable.

The Department of Health (DH) in England recommends orthodontic treatment to be commissioned for children, aged up to 18 years and under at the time of assessment, who are classified with the Index of Orthodontic Need (IOTN) at Dental Health Component (DHC) levels of 4 and 5 or DHC level 3 where there is an Aesthetic Component (AC) of 6 or above. This is intended to focus resources on children with the greatest orthodontic need.

The British Orthodontic Society has stated that it "*believes that if treatment has to be rationed then the IOTN is an objective and reliable way for specialists to select those children who will benefit most from treatment and is a fair way to prioritise limited NHS resources.*"[viii]

Data from the decennial Children's Dental Health Surveys, that take place every 10 years, show the prevalence of objective orthodontic need in the UK to be reasonably consistent over time (although levels were lower in the 1993 sample, in both 12 and 15 year olds), as set out in Table 2.

Table 2: Time trend in prevalence of need for orthodontic treatment in the UK

	1973†‡[ix]	1983†[x]	1993[xi]	2003[xii]
12-year-olds	37%	33%	27%	35%
15-year-olds	27%	25%	15%	21%

(Source: decennial Children's Dental Health Surveys, Office of National Statistics)

* These figures exclude 8% of 12-year-olds and 14% of 15-year-olds currently undergoing treatment and is therefore likely to be an underestimation of objective need. It cannot be assumed however that all those undergoing treatment would have had an objective need as defined by the cut-off point of IOTN DHC Grade 4/5 and/or IOTN AC Grades 8-10.
† The assessment of orthodontic treatment need was not made using the IOTN until 1993. Previous to this an appropriate index was not available therefore the opinion of the examining clinician was used to determine whether or not a need for orthodontic treatment was present.
‡ The 1973 Survey examined only children in England and Wales. Surveys were broadened to cover the whole United Kingdom from 1983.

There were no statistically significant gender differences in objective orthodontic need in the 2003 survey but unmet need was greater in males (24% of 15 year old males) than females (19% of 15 year old females). This supports research findings that females have higher levels of subjective (patient opinion) need[xiii xiv xv] and are more likely to take up treatment than their male peers.[xvi xvii xviii xix].

Unlike other dental conditions such as dental decay, there is no significant difference between deprived and non- deprived areas and orthodontics does not display a social class gradient.[xx]

Subjective need

In the Children's Dental Health Survey of 2003[xxi], an assessment of subjective need (ie from the perspective of patients) for orthodontics was carried out using a postal questionnaire which collected parental views on the appearance of their children's teeth. The findings are summarised in Table 3.

Table 3: Parental assessment of dental appearance and presence of definite subjective treatment need* in the UK, 2003

Parental assessment	12 year olds	15 year olds
Child has crooked or protruding teeth	44%	28%
Child has a definite treatment need	22%	12%

(Source: decennial Children's Dental Health Surveys, Office of National Statistics)

* Definite Subjective Treatment Need is present where assessment by the Aesthetic Component of the IOTN rates the child between gradings 8 and 10

ǂThese figures refer only to children not currently under orthodontic treatment at the time of the survey

It can be seen that parents as a group, overestimated the need for orthodontic treatment, relative to the objective view of professionals. Table 4 shows levels of discrepancy between clinician and parental views on the need for orthodontic treatment.

Table 4: Discrepancies between clinician and parent views on the subjective need for orthodontic treatment*

Parent Assessment	Clinician Assessment			
	Subjective need present (AC 8-10)		Subjective need absent (AC 1-7)	
	12 yrs	15 yrs	12 yrs	15 yrs
Subjective need present	52%	45% ǂ	19%	11%
Subjective need absent	48%	55% ǂ	81%	89%

(Source: Chestnutt I; Pendry L; Harker R. The Orthodontic Condition of Children. Children's Dental Health in the United Kingdom, 2003. London: Office for National Statistics; 2004)

*****These figures refer only to children not currently under orthodontic treatment at the time of the survey

ǂ Low base number of respondent, results are indicative only

Translating normative and subjective need into commissioning need

Evidence from national surveys and literature suggest that around 33% of 12 year olds have an objective need for orthodontic treatment, so objective need is fairly stable and predictable at around one third of 12 year olds. Subjective need, on the other hand, varies between individuals - even between those with the same level of objective need, and is inconsistent and difficult to predict with accuracy. Evidence suggests that clinicians influence the desire for treatment and that provision of orthodontic services may be supply led[xxii] [xxiii].

In spite of the presence of an objective need, the variations seen in subjective need and demand mean that a number of children with objective need will decline treatment. A refined prediction method for estimating orthodontic treatment need, based upon the 12 year old child population, was developed by Stephens[xxiv]. This method involves assessing need from the dental health component (DHC) categories 4 and 5 of the index of orthodontic treatment need (IOTN).

In a typical school population, one third of the children fall into categories 4 and 5. While a number of these cases would decline to have treatment, that number would be offset by a combination of each of the following: a proportion of patients in Dental Health Component (DHC) band 3 who would also justify treatment owing to poor aesthetics, a number of children (ie under the age of 12) who would require interceptive treatment as the front teeth erupt (calculated at 9%) and some adults for whom treatment could be justified (4%).

Therefore a figure of 33.3% of the total 12 year old population was taken as the number of patients needing treatment. This proportion is comparable with the findings of previous Child Dental Health Surveys [xxv] [xxvi] where 46% of children were identified to need orthodontic treatment but only 35% had received it by 15 years. Stephens' formula can be expressed as:

$$\frac{\text{12 year old population}}{3} \times \frac{\text{100 + Interceptive factor (9\%) + adult factor (4\%)}}{100}$$

The Stephens' formula can be modified by taking out the adult factor if treatment is only to be considered in the child population. Table 7 shows the need using Stephen's

formula as compared to that estimated form the local 12 year old survey data in 2008/09.

Inequalities in access

Malocclusion is unique among oral diseases in that its incidence and prevalence are not related to socioeconomic status. There is, however, evidence that uptake of orthodontic services is higher in less deprived groups, for example, the Children's Dental Health Survey of 2003 found socioeconomic variation in access to orthodontic treatment with levels of unmet need higher in children from deprived schools. This may reflect differences in demand, differences in the availability of orthodontic services and/or variations in access to and referral patterns by GDPs. Whatever the cause, it highlights the potential of orthodontic services to increase health inequalities. Strenuous efforts should be made to ensure equitable access and distribution of resources.

Failure to complete treatment

It has been shown that failure to complete a course of treatment is related to socio-economic factors, including inconvenience and cost incurred when accessing care.

It is important, therefore, to consider distance of travel to services, inconvenience and cost when planning provision of orthodontics for patients in more deprived areas.

Predicting treatment uptake

Treatment uptake varies according to the attitude towards orthodontics and desire for treatment in the individual patient, even among children with a high level of objective need[xxvii] but subjective perceptions of need have been found to be less potent predictors of service usage than other factors.

Predictors for treatment uptake have been explored in a number of studies. Overall, objective need has been found to be the strongest predictor of treatment uptake, followed by parent's concern[xxviii], then patient's concern. Patient's gender is also significant as females are more likely to demand treatment than males[xxix xxx xxxi xxxii]

What is clear is that the clinician's assessment plays a major role in determining treatment uptake. Orthodontists therefore need to be aware of how to identify patients with the greatest need and consider those most likely to comply with treatment, so that resources can be used efficiently and clinical outcomes maximised. If clinicians accept patients on the basis of objective need alone, there is a stronger likelihood of failed

appointments and discontinued or abandoned treatments. This increases waiting lists and waiting times and disadvantages patients who could truly benefit from care.

Prioritising those with greatest need

Not all orthodontic patients benefit equally from treatment and it is important to take account of factors that influence outcomes. Services can then be targeted at those most likely to benefit. A search of the literature showed that, for example:

- Orthodontic treatment does not necessarily eliminate objective need.
- Orthodontic treatment is more effective, in the long term, for more severe cases[xxxiii]; it is difficult to achieve a 'greatly improved result' in cases with a DHC of Grade 3 or below[xxxiv].
- Treatment with full upper and lower fixed appliances is most likely to produce an improvement in objective need (and subjective need) as measured by the IOTN[xxxv xxxvi xxxvii].
- In terms of subjective need, evidence is contradictory on whether there will be a benefit from treatment[xxxviii xxxix xl xli]. In some cases, dissatisfaction with appearance is reduced by orthodontic treatment, while in others it is not[xlii xliii]. Findings of a large, 20 year cohort study[xxxviii] suggest there to be little objective evidence to suggest that orthodontic treatment produces a measurable psychological health gain. Neither did it have a positive effect on self-esteem.
- Orthodontic treatment is most likely to be effective for 12 year olds who present with an IOTN of 3.6 or above.
- As dentistry, along with the rest of healthcare, becomes more focussed on outcomes, orthodontic clinicians need to ensure they balance considerations of objective need and demand against what is known about clinical outcomes.

Recommendations:

- Develop an Essex-wide orthodontic network with a remit to have a role in local standard-setting and promoting peer review.

- That the orthodontic network promotes understanding and use, by both general dentists and by specialist orthodontic practitioners, of all aspects of the Index of Orthodontic Treatment Need in the context of managing patient demand for NHS care,

Orthodontic need in Essex

Local survey data

Local Authorities have responsibility to support survey work is carried out as needed to inform the oral health needs of the populations they serve. (Statutory instrument,[4] 3094, 2012)

The North West Public Health Observatory (NWPHO), in collaboration with the British Association for the Study of Community Dentistry (BASCD), completed an oral health survey of 12 year old children in 2008/09 and this was analysed at a local level. This survey included measurements of normative and perceived orthodontic treatment need, using a modified Index of Orthodontic Treatment Need. The remainder of this section covers the key findings relevant to Essex.

Cleanliness

Orthodontic treatment with appliances will cause dental caries if the mouth is not kept clean. The local surveys of 2008/9, showed that across England, over half (51%) of the 12-year-olds examined had clean teeth, 38% had little plaque present and 11% had substantial plaque present (Table 1). Across the Strategic Health Authorities (SHAs), the proportion of children assessed as having clean teeth ranged from 63% of the sample in South East Coast to 35% in North East. Those with substantial amounts of plaque ranged from 7% in South East Coast to 18% in London. For the East of England, 55% children were rated as having clean teeth, with 8.6% having substantial amounts of plaque.

Children with substantial levels of plaque present had the highest levels of decay severity (1.3 D_3MFT), while those with clean teeth the lowest (0.6 D_3MFT) (Figure 2). This relationship held true for all SHAs indicating a clear association between tooth cleanliness and caries.

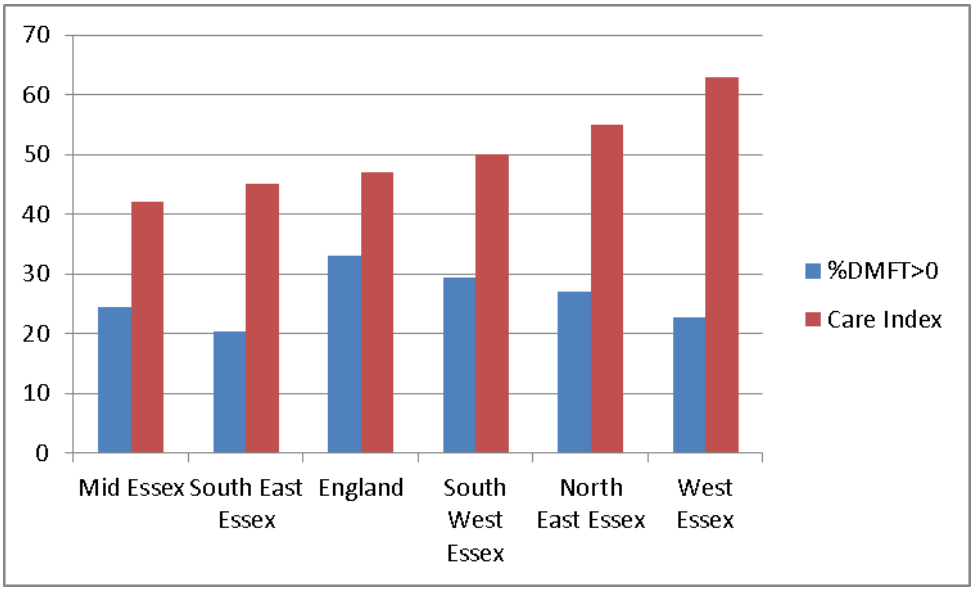
Children were asked *"In the past three months have you had toothache or sensitive teeth, bleeding or swollen gums or been aware of decay in your teeth or a broken adult tooth or ulcers or a loose baby tooth, or a problem because of tooth colour, shape, size or position?".* Response options were 'Yes', 'No', or 'Don't know'.

[4] http://www.legislation.gov.uk/uksi/2012/3094/pdfs/uksi_20123094_en.pdf

Dental decay

Access to orthodontic treatment is always via a primary care dentist, who can advise on mouth care and also identify and treat dental disease. Hence children without access to primary dental services will not benefit from the opportunity of orthodontic care if they need it and so equitable primary care access is a fundamental top priority for dental commissioners. Figure 2 shows data from the 2008/9 twelve year old survey by former Primary Care Trust area in Essex, comparing the proportions of children with any experience of dental decay (DMFT>0) with the 'care index', that measures the proportion of dental decay that is actually treated by dentists (this reflecting population levels of disease, access to dental services, professional decision-making and patient compliance). Common to all other parts of the country, a significant proportion of dental disease is untreated, indicating a great need for earlier interventions. The average across all England for the two measures is also shown.

Figure 2: Percentages of 12 year old children in Essex in 2008/9 with any dental decay experience (one or more teeth either decayed, missing or filled), alongside the percentage of teeth with decay experience that are filled rather than extracted or still decayed.



(Source: NHS Epidemiology Programme for England, Oral Health Survey of 12 year old children 2008/09).

Normative need for orthodontic care

Children in the 2008/9 survey who were not wearing a brace at the time of the study and fell into IOTN DHC 4 or 5 or those classed as IOTN Aesthetic Component (AC) 8, 9 or 10 were regarded as having a clear need for orthodontic intervention

Nationally, as the previous section showed, approximately a fifth of all 12 year olds fall into each of the five Dental Health Components (DHC) and approximately half of the 12

year old population will be classified as having an IOTN score of 3.6 or above. This is a combined score of DHC and Aesthetic Component (AC) of 3.6. 4 or 5.

Using the Modified Index of Orthodontic Need 20 – 34% of 12 year olds in different parts of Essex were identified as having a normative need and not currently wearing an appliance. Mid and West Essex had lower proportions, with South West, North East and South East having higher proportions. Data are set out in Table 5.

Table 5: Estimating the numbers of12 year old children not currently wearing an appliance 2008/09 who both met NHS criteria and who would have liked treatment

			Need- children with IOTN DHC=4 or 5 or AC=8,9,10		**Demand- Children who think their teeth need straightening and are prepared to wear a brace**		**Need and demand- Children with IOTN DHC=4or 5 or AC=8,9,10 who think their teeth need straightening and are prepared to wear a brace**		**Estimated need and demand**
Area	12 year old population (Mid 2008)	Number examined	number	% of children examined	number	% of children examined	number	% of children examined	number
England	608,460	89,442	28,269	31.6%	31,681	35.4%	17,238	19.3%	117,267
Mid Essex	4571	846	174	20.6	315	37.1	129	15.2	697
North East Essex	3661	581	188	32.4	235	40.4	137	23.6	863
South East Essex	4093	238	80	33.6	104	43.7	52	21.8	894
South West Essex	5037	684	208	30.4	278	40.6	150	21.9	1105
West Essex	3548	538	136	25.3	185	34.4	92	17.1	607
All Essex	**20 910**								**4166**

(Source: NHS Epidemiology Programme for England, Oral Health Survey of 12 year old children 2008/09. Results of Orthodontic Need and Demand in Primary Care Trusts)

Perceived need and demand for orthodontic care

As a separate exercise in the survey, volunteers were asked, through a series of closed questions in a postal questionnaire, if they thought that their teeth needed straightening. Those who replied yes were then asked if they would be prepared to have treatment and wear a brace if it were necessary. If, however, they said 'yes' to a question that asked if they were wearing a brace, or if they reported that they had one, they were classed as already being in receipt of orthodontic care and were not involved any further in the measurement of orthodontic need or demand. The findings are summarised in Table 5

As these children had not had their IOTN scores measured, it was not known if they met the criteria for normative need, and some of their appliances may have been fitted for children who would not have met the NHS Regulations.

Children already wearing an appliance

The study on normative need identified the following proportions of children in Essex who were already in treatment, wearing a brace, by the age of 12, as shown in Table 6.

Table 6: Children aged 12 years already wearing a brace 2008/09

Area	12 year old population (Mid 2008)	Examined	% Examined	Number already wearing an appliance	% of children examined	Estimated 12 year old population already wearing an appliance
England	608,460	89,442	74.1%	7,105	7.9%	48,334
Mid Essex	4571	846	65.6%	78	9.2%	421
North East Essex	3661	581	74%	38	6.5%	239
South East Essex	4093	238	73.9%	14	5.9%	241
South West Essex	5037	684	68.5%	70	10.2%	515
West Essex	3548	538	61.1%	73	13.6%	481
All Essex	**20910**					**1897**

(Source: NHS Epidemiology Programme for England, Oral Health Survey of 12 year old children 2008/09. Results of Orthodontic Need and Demand in Primary Care Trusts)

If the co-existence of objective and subjective need is taken as a proxy for the likely numbers of children who may need orthodontic treatment, amongst those who do not already have braces, then the percentages may be converted into numbers of 12 year olds potentially requiring treatment in each PCT. This is set out in Table 7.

When this is added to the number of 12 year old children estimated to be already wearing appliances we have a proxy for the number of 12 year olds each year who are likely to benefit from orthodontic treatment.

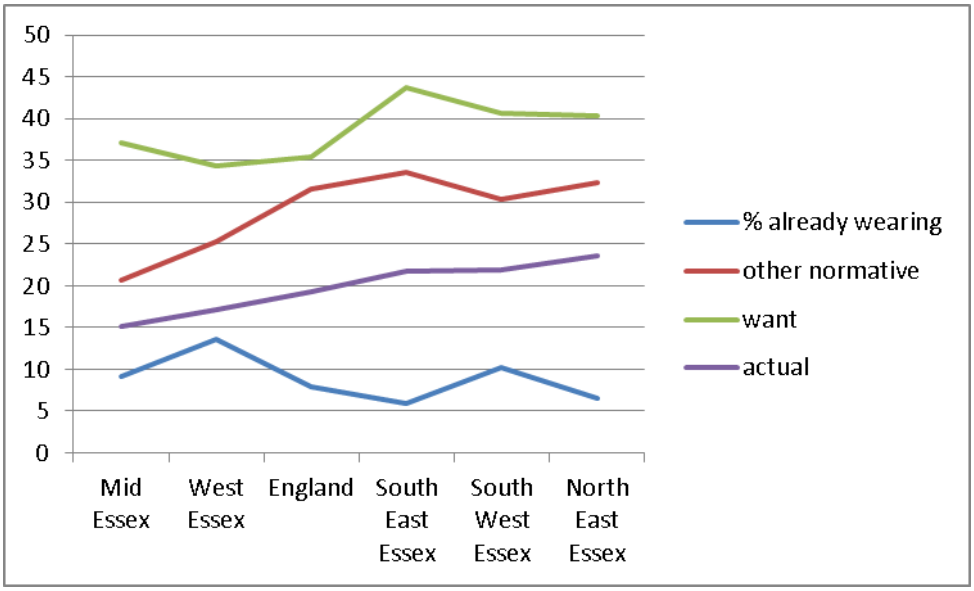
Table 7: Numbers of 12 year old children with both a normative and perceived need with those already wearing braces 2008/09

Area	12 year-old population (mid 2008)	Estimated need and demand	Estimated 12 year old population already wearing an appliance	Need and demand+ those already wearing an appliance (proxy for capacity needed)
England	608,460	117,267	48,334	165,601
E of E SHA	69,770	14,497	7,395	21,892
Mid Essex	4571	697	421	1110
North East Essex	3661	863	239	1102
South East Essex	4093	894	241	1135
South West Essex	5037	1105	515	1620
West Essex	3548	607	481	1088
All Essex	**20910**			**6055**

(Source: NHS Epidemiology Programme for England, Oral Health Survey of 12 year old children 2008/09. Results of Orthodontic Need and Demand in Primary Care Trusts)

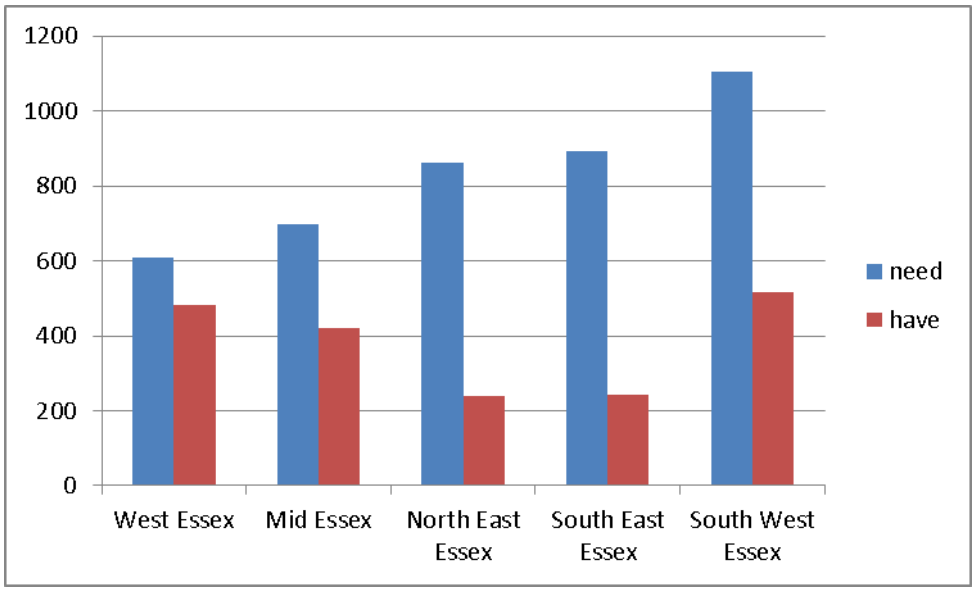
Figure 3 shows the variation between professional ('other normative') and patient ('want') perspectives of need, showing the 'actual' need (where both the patient wants it and the professional agrees it to meet NHS criteria) to be below 'want' and 'other normative'.

Figure 3: Comparison of different perspectives of orthodontic need in Essex, Essex data compared to England



(Source: Orthodontic survey 2008/9. NHS Information Centre)

Figure 4 Predicted number of children in each area that already had an orthodontic appliance and that didn't have, but would have been likely to express a need that would meet criteria for acceptance for NHS orthodontic care, if examined by a trained professional.



(Source: 2008/9 dental survey, NHS Information centre).

Numbers of 12 – 19 year olds in Essex

The distribution of the 'orthodontic population' across Essex (12 – 19 year olds), from the 2011 Census, published by the Office of National Statistics (ONS) is shown in Figure 5. The areas shaded brightest yellow have the highest numbers, and these are in parts of Billericay in South West Essex, Southend in South East Essex, Church Langley in the West, part of Braintree ford in Mid Essex and in a part of Colchester.

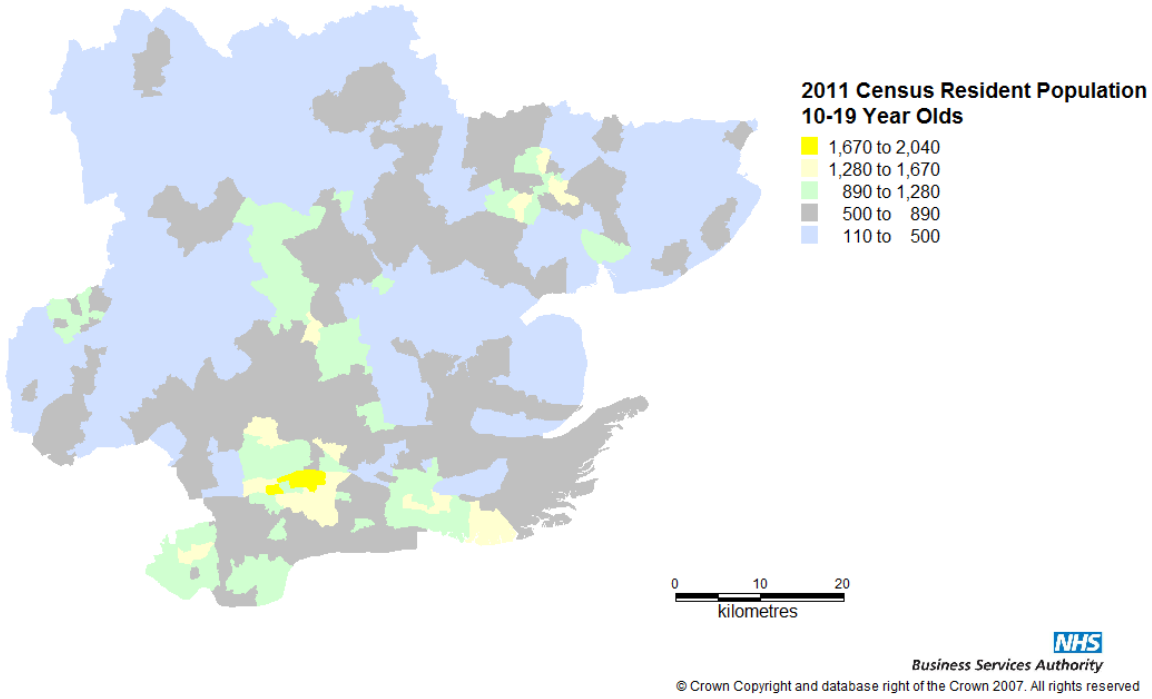
Predicting future numbers of 12 year olds

The ONS have also published interim 2011-based subnational population projections[5] to provide an indication of future trends in population over the next ten years. Assumptions for future births, deaths and migration are based on observed levels during 2006 – 2010. Data is presented by single year group, intended that aggregates of five year groups are used, rather than selection of just one, as is presented. The data nationally show that London, the East and South East are projected to grow at a faster rate to 2021 than England as a whole which is showing an overall annual growth of 0.8%. However, it is advised that the projections over-project the number of births at a national level. This particularly affects areas where the 2011 population estimates have higher numbers of women aged 16-44 than in the 2010 estimates, which is not the case in Essex as a whole. This caveat should be taken into account if using the

[5] www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/index.html Sub-national populations for England, Office Of National Statistics, Interim 2011, released September 2012.

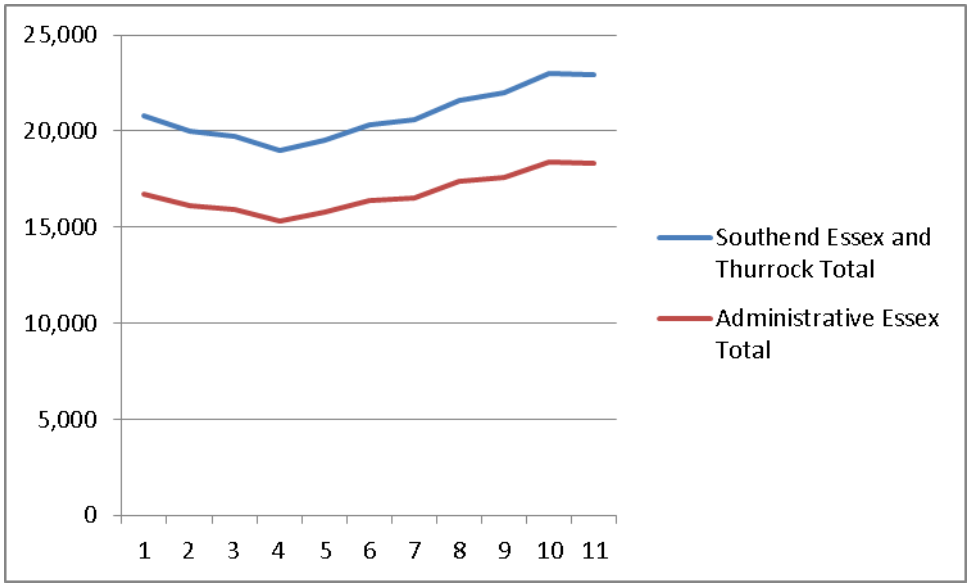
projections for planning, particularly for children under 10. It is expected that the populations will be substantially revised once the data from the most recent population Census is published.

Figure 5. 2011 Resident population of 12 – 19 year olds in Essex



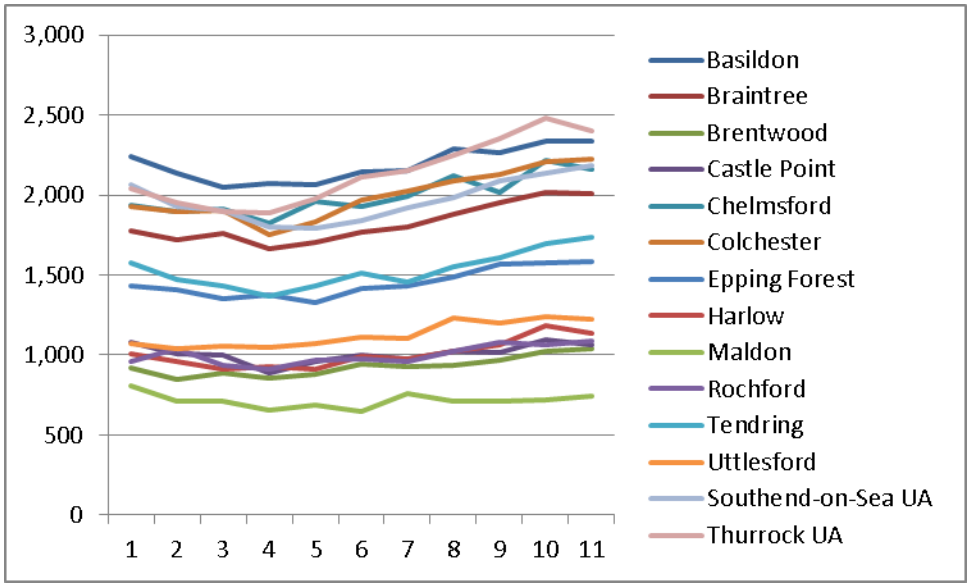
The 2011 interim data,12 year old year group projections alone for Essex County Council and the two unitary authorities of Thurrock and Southend-on-Sea together, estimated 20 827 12 year olds for 2011, rising to 22 929 by 2021, of whom 80% will be in the County Council area and 20% in the two Unitary Authorities, illustrated in Figure 6.

Figure 6: Time trend data of 12 year old population year group, Essex, 2011 – 2021 (2011 is indicated as 1 on the x axis, and 2021 as 11)



The changes within the individual districts are shown in Figure 7.

Figure 7: Estimated number of 12 year olds in different parts of Essex between 2011 and 2021.



These time trends from 2011 show a general dip in the number of 12 year olds to a lowest number in 2014, followed by a steady rise by 2021 if there are no changes to birth death or migration rates, as discussed earlier.

Summary:

The population of 12 year olds has probably dropped since the 2008/9 nationally co-ordinated, local dental survey was carried out on the age group, with lowest levels expected in 2014/15 after which it will slowly rise, if there are no changes to birth, death or migration rates.

Recommendation:

Where current services are already meeting need, capacity would not need to be increased in the short to medium term.

Orthodontic care and pathways in Essex

Orthodontics nationally has shown one of the fastest rates of growth in treatment since the late 1990s, with expenditure almost doubling over a five-year period.[xliv] Growth in population does not account for this increase, suggesting that it has been supply led.[xlv]

In Essex NHS orthodontic treatment is provided in both primary and secondary care. In primary care, there are specialist practices with expertise to serve the vast majority of patients. Orthodontics may also be provided by local community services for a very small group of patients who have 'special care needs'. Hospital services in secondary care are consultant-led and intended for more complex cases including those that may benefit from a multi-disciplinary approach.

As discussed in earlier sections, the pathway to care begins when a patient is referred from community or general dental services, ideally following assessment using the IOTN index. Patients should only be referred if they are likely to meet the criteria for need, where the dentist is unsure for example where the patient is borderline, or where the patient or parent/carer disagrees with the assessment. Figure 8 shows the distribution and size of general dental practices across Essex and figure 9, the locations of specialised services, including practices offering NHS orthodontic care.

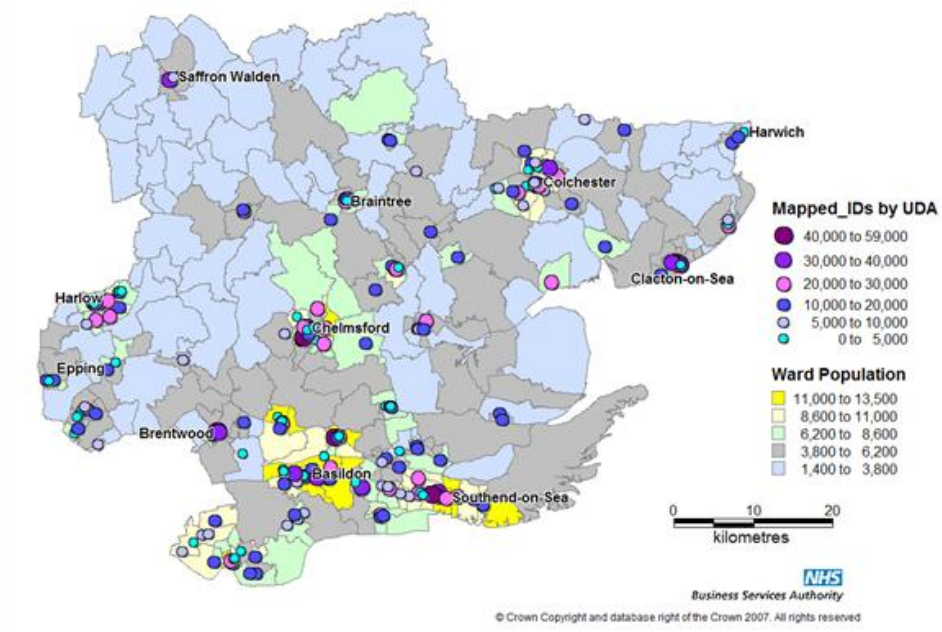


Figure 8 Map to show General Dental Practices in Essex (indicating NHS capacity and overlaid on Ward population data)

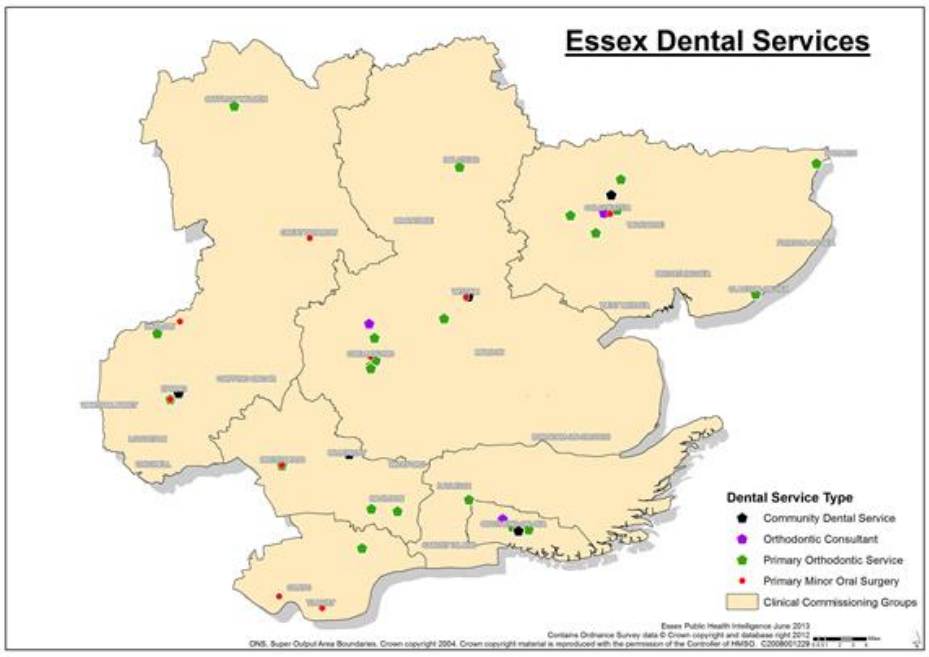


Figure 9: Map to show specialised dental services in Essex

Primary care service locations and population distribution

Figure 10 shows primary care locations along with the volume of care commissioned from them, overlaid on the map showing population density of 5 – 19 year olds.

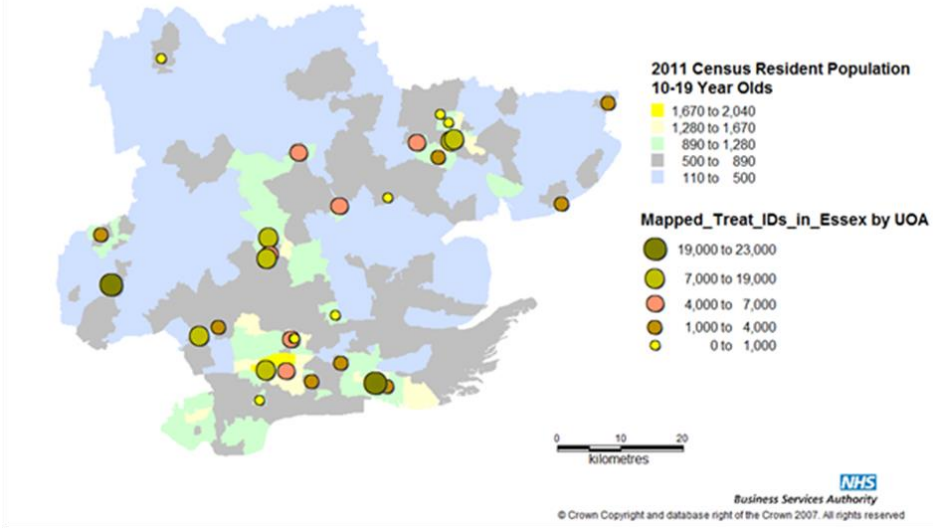


Figure 10: location and volume of primary care orthodontics, overlaid on map to population distribution of 12 – 19 year olds in Essex.

This shows that larger providers of care seem to be in places of higher population density of 10 – 19 year olds.

Primary care service locations and capacity

Figure 11 shows the number of practices within each of the former primary care trust areas of Essex that offer orthdontics. This doesn't give a true reflection of the volumes of activity available and more detail of this, along with information including the earlier estimation of need, the nature of the contracts and other local factors, is given in Table 8.

Figure 11: number of practices with contracted orthodontic activity in the former PCT areas of Essex

Table 8 aims to compare population orthodontic need data and primary care capacity data by geographic area. Although the 12 year old data and the need calculation is based on data from 2008/9, taken in conjunction with the earler graphs to show the population projections, it might reasonably enable some sort of judgement on the potential adequacy of the numbers of UOAs currently contracted, as recorded by the BSA in March 2013. They show that in every area, if (which is hypothetical) each practitioner can use every UOA efficiently such that every 22 UOAs results in a valid case undergoing a full course of treatment, and that all cases are picked up in childhood, there are more UOAs than are needed in North East and Mid and South East Essex, fewer in the West, and about the same in the South West. Dividing the currently commissioned UOA number by the population of 12 year olds illustrated, to get an approxiate number of UOAs per head, each area bar West, has between 7 and 8 UOAs, whereas West has 5.59 UOAs per head.

Table 8: Summary of data relevant to orthodontics for the former Primary Care Trust areas in Essex

Former PCT area	12 year olds*	UOAs**	UOA /22***	Capacity needed****	Comments re contract	Comments re the area
North East	3661	28790	1309	1102	13 contracts, 5 below 800 UOAs, of the other 8, 4 are PDS, 4 GDS	also have hospital service, RMS and orthodontic network, but not practicable choice outside the area
Mid	4571	35666	1621	1110	8 contracts, 1 below 100 UOAs, of the other 7, 6 are PDS	Options for patients to access services in Herts/Cambs
West	3548	19861	903	1088	5 contracts, 2 between 0 and 100 UOAs, of the other 3, 2 are PDS	Options for patients to access services in herts/North East London
South West	5037	35288	1604	1620	10 contracts, 2 between 0 and 600 UOAs, 8 over 1000 UOAs of which 5 are PDS	Options for patients to access services in North East London
South East	4093	31784	1445	1135	4 contracts all over 1000 UOAs, 1 PDS	fewer options to travel out of the area, but there is a significant hospital provision also.
All:	**20910**	**151389**	**6881**	**6055**		

(Sources: various)

*The 2008 population estimate of 12 year olds is used, sourced from the Local Survey of 2009. Population trends show that numbers may not have changed all that much

**UOAs, Units of Orthodontic Activity, were provided by the Business Standards Authority of the NHS, March 2013

***UOA/22 is an estimate of courses of treatment available assuming a ratio of two assesments for every case start

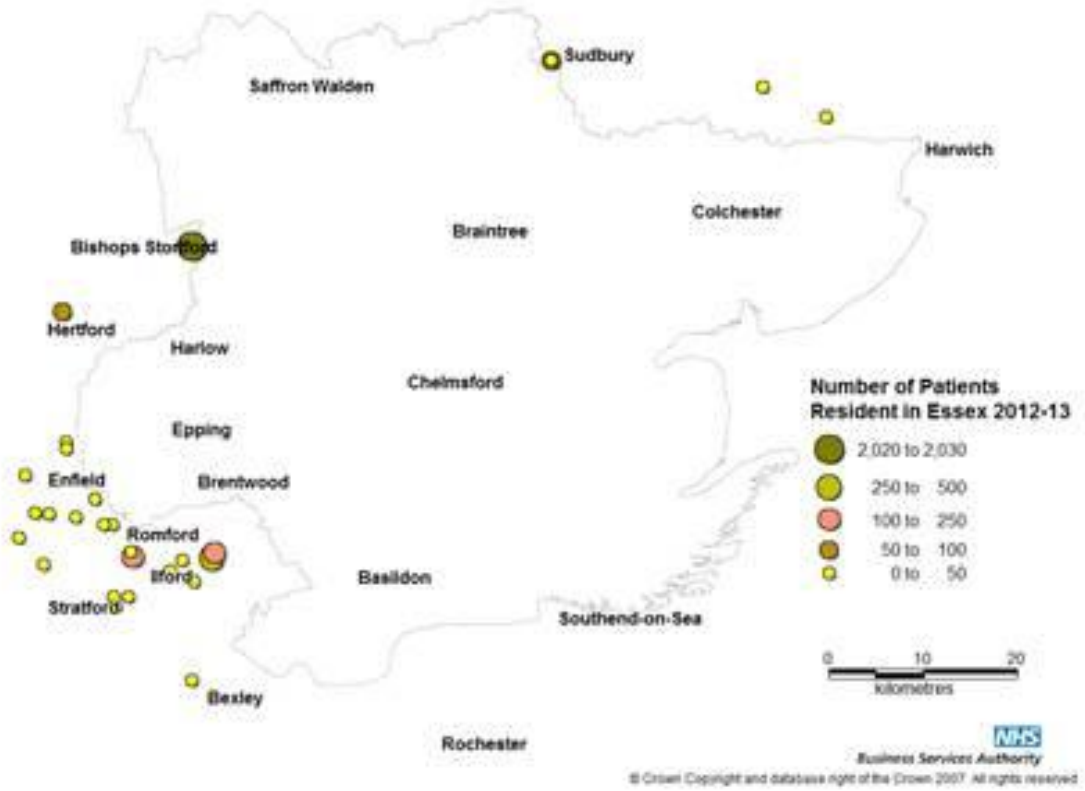
****Capacity needed is concluded from Table 5, based on survey data from the 2008/9 local survey of 12 year olds.

Evidence of insufficient capacity

Pressures are described on services in the North East and this may be due to lack of options for patients to travel outside the area, although it must be noted that there is also a secondary care facility at Colchester that serves this local population, as there is in Mid and South East Essex. This data is intended to be used only as a guide, along with other information in this needs assessment and local knowledge.

Figure 12 shows the primary care orthodontic treatment locations used by Essex patients, outside Essex. It can be seen that there is significant use of services commissioned by North East London, Hertfordshire and some in Suffolk.

Figure 12: Map to show primary care orthodontic treatment locations used by Essex patients.



In previous years there has been a local priority to reduce long waits for orthodontic care which has resulted in some further investments in primary care services. This target has now been removed, unless the wait is for a hospital consultant service, where waits should be no longer than 18 weeks from first referral to treatment commencing.

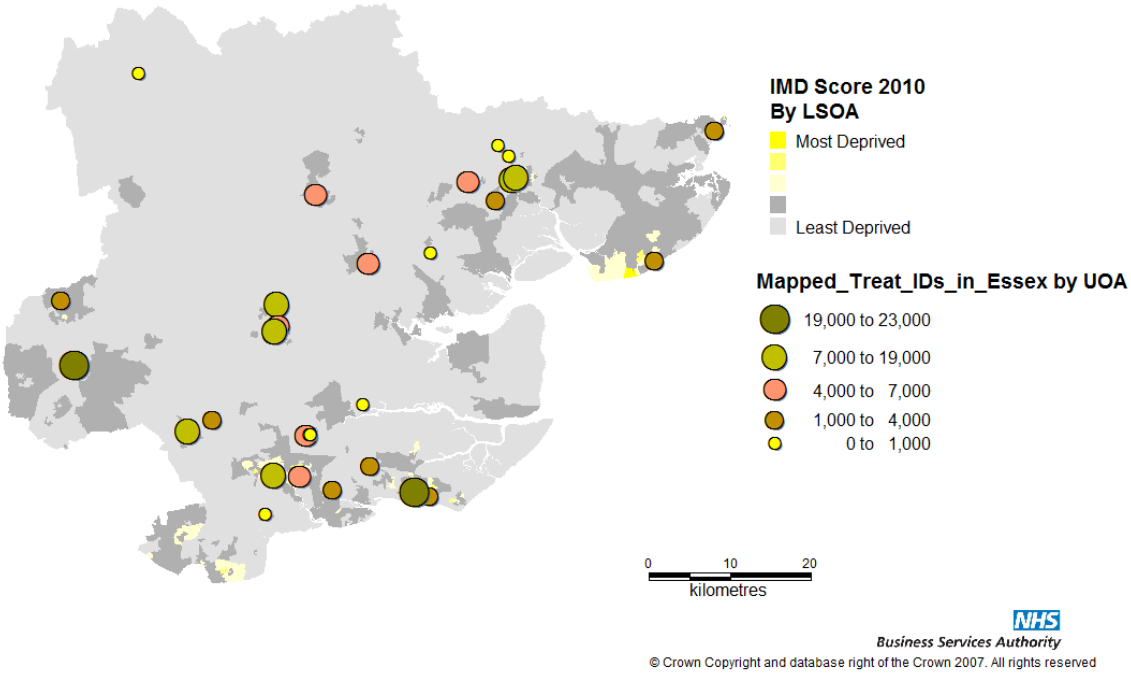
A questionnaire was circulated in May 2013, to all primary care orthodontic practitioners in Essex that asked, among other things, their perception of waiting times for their services. Most reported either no wait or a short wait of some weeks, although there are significant exceptions.

A referral management system was established in North East Essex to allocate patients to the different local providers, but at time of writing, there is no data available from this service, or its cost. The service is included in a wider referral management system that is commissioned by the local Clinical Commissioning Group. The local hospital orthodontic consultant service is not included in the referral management system, which implies that referrals are still direct to this service. If a patient is referred to a local orthodontic service that relies on the hospital for a treatment plan, one could conclude that a patient would pass through the referral management service to a practice, that would then refer to the hospital for the plan before the patient could return to that practice for the treatment to be carried out, which would cause delays to the treatment starting and have added cost.

Primary care service location and deprivation

Looking further at equity of distribution of currently commissioned primary orthodontic care, Figure 13 overlays the location of practices by volume of orthodontic treatment contracted, onto the map of deprivation, as illustrated in Figure 1. Treatment locations at an All Essex level appear to be evenly spread relative to the population density and deprivation, with the exception of the far South Western area, that borders onto London.

Figure 13: Deprivation and primary care orthodontic treatment location in Essex



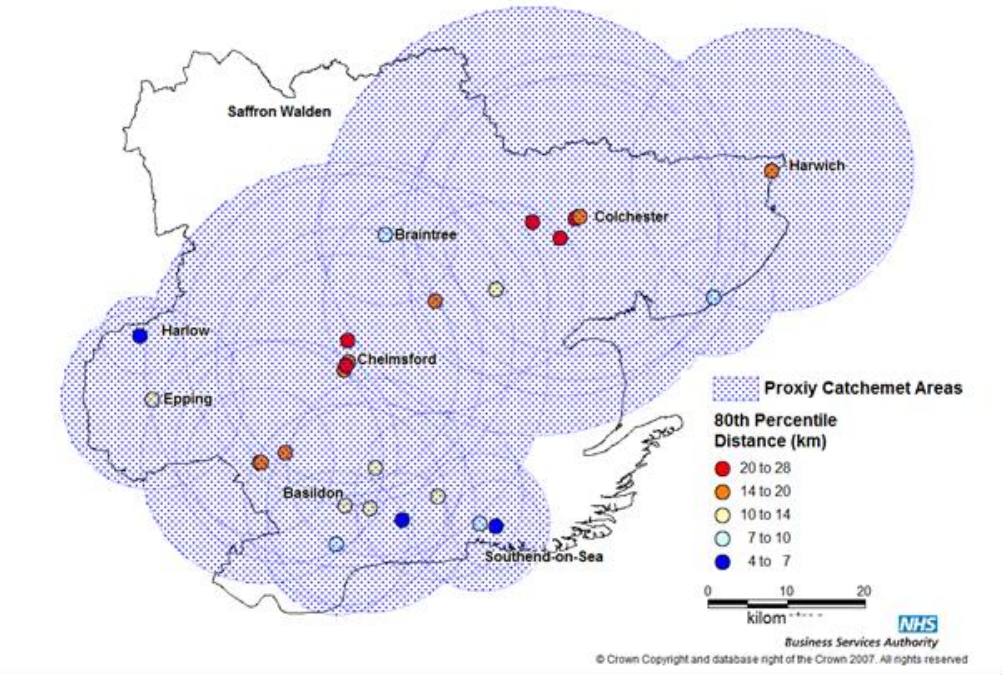
Costs in primary care

The costs of orthodontic treatment in primary care include that part of a Community Dental Contract allocated to orthodontic care of special needs patients, and the cost per UOA for each practice multiplied by the number of UOAs delivered. UOA values have not been supplied for this needs assessment, and work on establishing the costs and variations in costs across Essex is underway by the Essex Area Team. Added to this is the cost of the referral management centre.

When thinking about the costs of orthodontic treatment relative to other healthcare costs, it is to be remembered that health benefit as an outcome of most orthodontic treatment is hard to demonstrate, in that the patient is not actually ill.

Figure 12 gives an indication of the extent of uptake of services outside Essex, and this is a cost that is not met by the local team, however, the costs of patients from outside the area who come into Essex for their treatment are included in their overall costs. That they are fairly low is suggested by Figure 14.

Figure 14: Catchment area of 80% patients attending Essex based primary care practices for orthodontic treatment.

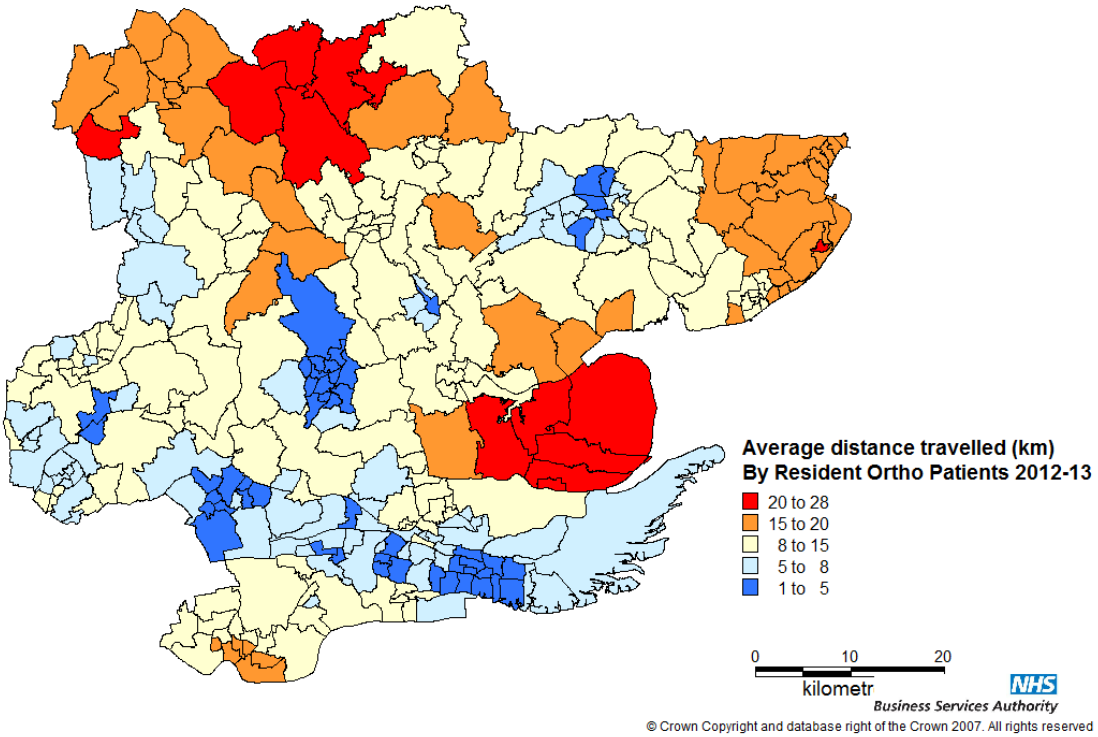


It can be seen that many people travel long distances to centres, particularly Colchester and Chelmsford and Harwich for orthodontic care, and this could contribute to the long waiting lists experienced by some practices. It would appear that travel into Essex from people outside the county is not a significant occurrence over all.

Distance of travel for patients

Figure 15 indicates how far patients are travelling to services. It can be seen that especially in North and East Essex, and the more sparsely populated areas that often have pockets of higher deprivation, patients may be travelling over 30 kilometres for orthodontic care.

Figure 15. Average distance travelled by resident orthodontic patients 2012 – 13.



Quality and Efficiency in primary care orthodontics

It has already been noted that orthodontic care has become increasingly recognised in the NHS as an area of specialist practice and that in many parts of the country, commissioners have worked with clinicians to encourage those with a low throughput of patients and those without specialist skills to replace their orthodontic activity with more general activity.

The Dental Services Division of the Business Services Authority (DSD, BSA) record a range of information collected from orthodontic contracts including some which are known as quality indicators. The format of reporting back to contract managers has been revised to deliver the single operating framework, and the first summary table for the forty contracts across NHS Essex, for the year ending 31st March 2013 is shown as table 9, where the percentages and numbers refer to the number of contracts of concern.

Table 9: summary data on delivery, assessments, treatments and outcomes from primary care orthodontic contracts, 2012/13.

Delivery		England %	AT Total	AT %
UOA Delivered	% of Contracted UOA Delivered (Year to Date)	30.4	11	27.5
Assessment		**England %**	**AT Total**	**AT %**
Assessments by category	% of assessments that are Assess and fit appliance	9.6	3	7.5
Assessments by category	% of assessments that are Assess and refuse	4.2	8	20.0
Assessments by category	% of assessments that are Assess and review	10.4	6	15.0
Age at assessment	% of reported assessments and review where patient is 9 years old or under	4.5	1	2.5
Treatment		**England %**	**AT Total**	**AT %**
Cases reported complete as a function assess and fit appliance	Ratio of reported **concluded** (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.	20.1	7	17.5
Type of appliance used	% of **concluded*** (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only. * currently only using completed	3.0	2	5.0
Outcomes		**England %**	**AT Total**	**AT %**
UOAs reported per completed case	Ratio of the number of UOAs reported per reported **completed** case (not including abandoned or discontinued cases)	12.0	5	12.5
Reported PAR Scoring: actual versus expected	% of contracts not meeting their expected reporting of PAR scores	38.3	13	32.5
Abandoned or discontinued care	% of **concluded** (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued	2.4	3	7.5

Delivery

Reflecting overall delivery on contracts, practices in NHS Essex have performed better than the English average although 27.5% of them under delivered.

Assessment

Regarding orthodontic assessments, across England as a whole, 9.6% of contracts had a low number of appliances fitted compared to the number of assessments undertaken; the percentage in Essex was a little lower, although by only a small amount. Twenty percent of contracts had above average claims for either assess and refuse or assess and review, and this is recognised as an area where the system could be more efficient, with general dentists referring the right patients and the right time, and this is an area where a strong local orthodontic network can assist in ensuring efficiency of NHS resources, through working with the dentists in the practices that refer to them. A very small proportion of orthodontic care (usually 'interceptive orthodontics') needs to take place before a patient is nine. In Essex, levels of referrals are within the expected range for England and it is important that the specialists keep an awareness of any training or information required by general dentists, such that they do not miss these cases in their efforts not to refer too early.

Treatment

Treatments are reported in terms of the ratio concluded to those started, and also the type of appliance used. Essex is recorded an outlier because two practices show up as using removable appliances only, but the number of cases treated in each of these practices was negligible.

Outcomes

Outcomes are measured through UOAs per completed case, 'Peer Assessment and Review' scores (PAR scoring), and rates of abandoned or discontinued care. Essex is an outlier nationally in the number of contracts with a high ratio, and but as with the use of removable appliances, this is affected by general under-delivery of a small number of contracts. However, improving this ratio with individual practitioners is a powerful way for the local system to increase efficiency to enable more patients to be treated within the current contract levels. The local orthodontic network may be able support contract managers with this endeavour. Essex is also flagged as an outlier in the proportion of practices with a higher than average proportion of concluded treatments that are abandoned and discontinued, but again this is due to only a small number of fairly small contracts.

The PAR score (peer assessment rating)

PAR index is accepted by the British Orthodontic Society and the Department of Health as a useful tool to assess the standard of orthodontic treatment for an individual provider. The FP17(O) has a tick box to indicate if the case has received a PAR Assessment.

It is a requirement of the NHS orthodontic contract for all orthodontists to monitor treatment outcomes for 20 cases plus 10% of the remainder of their caseload every year using PAR.

Self assessment of treatment outcomes may be subject to bias.

PAR measures the pre-treatment and the post-treatment study models of patients that have received orthodontics using a PAR ruler. The difference between the scores is the PAR improvement due to the treatment.

PAR is designed to look primarily at the results of a group of patients, rather than an individual patient, as there are always a small number of patients where the index does not really reflect the result obtained.

For a practitioner to show high standards, the proportion of cases falling in the worse or no different category should be negligible (less than 5%) and the mean reduction in PAR score should be high. An improvement of greater than 70% represents a high standard of treatment, less than 50% shows an overall poor standard of treatment.

Patient perspectives on primary care orthodontic treatment

This needs assessment currently has no data or information on patient perspectives and views, other than in the context of their likely perceptions of need for orthodontic care. Patient satisfaction with dental services as a whole has been a subject within the GP questionnaire survey, run by the NHS but there is no specific information relating to orthodontics. Possible sources are practice information systems, and NHS choices, on individual practices.

Patient complaints is another source of information on patient views; this service no longer reports directly to NHS Essex Area Team but are centrallised, Complaints are also dealt with by individual clinical commissioning groups, and there is a signposting service through Healthwatch, located within local authorities.

Recommendations

The local orthodontic networks can be a resource to support NHS managers, who now can focus attention on contracts that appear to have issues relating to performance. The outcome should be improved quality, efficiency and efficacy of existing orthodontic services.

Patient views on services in outlying areas would be a valuable contribution to ensuring equity of provision of specialist NHS dental services for this young age group.

Secondary (hospital) care services

Roles of secondary (hospital) consultant-led services

Hospital orthodontic consultants have had further training to provide leadership, teaching, mentoring and supervision for trainee specialists and consultants for the future.

An NHS consultant contract specifies that there will be a written job plan, signed off by a hospital director. This can include a variety of wider services to the NHS, and there is no reason why consultant orthodontists cannot have an explicit agreement to provide professional leadership to support orthodontists and generalists who refer and treat patients.

The focus of the current needs assessment is the pathway to the routine NHS orthodontic care, which provides largely, but not exclusively, services for children. It includes a small minority of patients whose malocclusion is so severe, that jaw surgery (orthognathic surgery) is required as part of treatment for a good outcome. The majority of hospital based clinical services provided however, are treatment planning for patients referred by generalists and orthodontic specialists, treatment of cases with complexity beyond that of a specialist and treatment for patients with special care needs, including (as part of a mulitidisciplinary treatment plan – see below) for specific aspects of care for patients with a cleft lip and/or palate. Orthodontic consultants can also provide second opinions. Many of the most severe malocclusions, IOTN 5 cases, have a protracted treatment time but this should not be the only reason they are carried out in hospital as it is likely to be less convenient for patients. Primary care clinicians may argue that there is no economic case to treat these individuals when payment is through the UOA system, but this should not be the only reason to refer to a more expensive and specialised service.

There is a group of patients with high orthodontic need due to the position in which their upper permanent canine teeth develop, such that these teeth cannot erupt, instead becoming impacted high in the top jaw. When the patient reaches an optimum point in their growth, the teeth are surgically exposed, and other teeth removed, and appliances are used to guide the long path of eruption of the tooth into the correct position. The surgical part of the treatment plan is made jointly with a consultant oral surgeon, and there is often a benefit for the case to be continued by the orthodontic consultant subsequently. As an alternative, once the surgery is over, suitable cases could be completed by the primary care specialists, but often such cases are protracted, requiring more clinical time over all, leading to the problems outlined above, regarding payment within the NHS arrangements for primary care.

Consultant orthodontists also treat severe hypodontia cases (multiple teeth congenitally missing), those with craniofacial abnormalities and can be involved with sleep apnoea clinics. Some cases fall under local policies for prior approval by commissioners before treatment can be carried out.

Sustaining the consultant workforce

An orthodontic workforce survey in 2005 identified that 38% of approximately 440 orthodontists intended to retire before 2015 leaving a potential shortfall in the capacity at the time of between 60 and 110 by 2015[92]. To prevent this, 40 new specialists a year would have needed to be trained and this would still have led to numbers per head of population below levels in the rest of Europe.

Tariffs

The majority of orthodontic care takes place in outpatient departments. The tariffs are set nationally each year. For 2013/14, a first appointment is £183.00 and each follow up, £81.00. If the patient is under the care of more than one consultant, ie jointly with an oral surgeon, then the tariffs are £251.00 for a first appointment and £115.00 for each follow up appointment.

Local service provision

Hospital based general orthodontic services in Essex are provided at Colchester/Chelmsford and Southend/Basildon. Each pair of hospitals works with an oral and maxillofacial surgery service. Trainees are overseen by the London and not the Eastern Deanery in Cambridge, and all formal teaching takes place in London, with supervised activity taking place at Colchester, Southend and Basildon.

From April, 2013, the North East London Commissioning Support Unit took charge of hospital orthodontic activity data (and other dental data). A first report on orthodontic outpatient activity is imminent and over the coming months, routine hospital data will become available again

Data previous to April 2013 is with local commissioning support units serving the local Clinical Commissioning Groups.

There is a separate specialist orthodontic service based at Broomfield Hospital in Chelmsford, for a small group of patients who have cleft lip and palate, a birth disorder which requires consistent, planned multidisciplinary care throughout childhood. This service is overseen by specialist commissioners and is not considered further here.

Southend-on-Sea/Basildon

The service at Southend-on-Sea sees patients both for assessment and treatment planning for surrounding practices and also to treat patients with severe malocclusions (IOTN grade 5). There are two consultants and three trainees that also cover a base at Basildon. Joint clinics with oral surgery, and treatment sessions, are provided for those patients that need them.

Chelmsford

The Chelmsford service runs on a part time basis. There are no specialist orthodontic training facilities at this centre.

Colchester

The service at Colchester is consultant led, serving the many surrounding practices. Training is provided, and the consultant oral surgeon from Chelmsford visits regularly for joint clinics. Oral surgery treatment sessions are held for Colchester patients at Chelmsford, after which they are returned to the Colchester clinic for continuation of their treatment as required.

Data from a local audit of patients seen in the first three months of the current financial year show that 46 new patients were seen, of whom 9 (20 %) were adults. There were 383 follow up appointments, of which 139 (36%) were adults. Within the overall case load are about 25 patients who require ongoing orthodontic support as part of their specialised treatment plan to treat cleft lip and/or palate.

Discussion and conclusions

A comprehensive orthodontic needs assessment for Essex has not been undertaken before. It has enabled the separate elements of need, demand, services available and pathways each to be considered in turn, and for clinicians to be consulted.

This needs assessment, to date, does not include data on the views of patients, other than collected through the 2008/9 survey work on oral health of 12 year old children, and no special data collection on the patient perspective has been arranged as part of the process.

Orthodontic services are specialised and expensive and the NHS must commission for quality in all aspects, with equity of access to all population groups, and to enable the professional workforce to develop as this requires. A local orthodontic network, with full engagement of hospital consultants can help to bring about the professional developments that are needed.

Public demand for orthodontic services will always outstrip available resource and the network will be instrumental in supporting the Essex Area Team to ensure that appropriate prioritisation is in place.

Further information will become available very soon on the nature, quantity and costs of orthodontic care provided through acute trusts, and this in turn, will help to inform an orthodontic strategy. The orthodontic clinical network will have a key role in the further development and implementation of this strategy.

Work is ongoing:

- with the providers in North East Essex to resolve a build up of patients awaiting assessment, including a review of the role of the referral management centre
- with secondary care providers to establish future configurations of consultant capacity
- to establish a pan-Essex orthodontic network to enable clinical engagement, to help improve outcomes and the experience for patients.

Appendix 1 - Orthodontics – the clinical background and the Index of Orthodontic Treatment Need

Source: An Orthodontic Needs Assessment and service review for Cambridgeshire and Peterborough, 19th December 2012, v 10, chapter 2.

2.1 Orthodontics and Orthodontic Treatment

Three authoritative definitions from national bodies are:
Orthodontics is the distinctive branch of dentistry which deals with the development, prevention and correction of irregularities of the teeth, bite and jaw (known as malocclusion). (*General Dental Council)*[xlvi]. Malocclusion is not a disease but the collective term given to natural variations from the "ideal" in the relationship of the teeth and jaws.

"Orthodontics is the branch of dentistry concerned with growth of the face, development of the occlusion, and the correction and prevention of occlusal abnormalities. Orthodontic treatment deals with variations in facial growth and oro-facial function, and the effects of occlusal variation on facial appearance and the health and function of the masticatory system" (*Royal College of Surgeons of England*)[xlvii].

"Orthodontic treatment" means treatment of, or treatment to prevent, malocclusion of the teeth and jaws, and irregularities of the teeth. (*National Health Service (General Dental Services Contracts) Regulations 2005*[Error! Bookmark not defined.]

2.2. The claimed benefits of Orthodontic treatment:

The *British Orthodontic Society* (BOS) is the UK specialist society for orthodontists, established to promote the study and practice of orthodontics, to maintain and improve professional standards in orthodontics, and to encourage research and education in orthodontics. They list treatment benefits[xlviii] as including:

- Removal of dental crowding (or sometimes closing gaps).
- Alignment of the upper and lower dental arches.
- Correction of the bite of the teeth so that the front teeth meet on closing and the back teeth mesh together.
- Reducing the likelihood of damage to prominent teeth.
- Enhancing facial aesthetics.
- Accommodating impacted, unerupted or displaced teeth.

- Preparation for advanced dental treatment, such as crowns, bridges or dental implants.

- Reversing the drifting of the teeth in older patients who have suffered from advanced gum disease.

2.3. Adverse consequences of orthodontic treatment

Less generally known are areas where orthodontic intervention can cause problems[xlix]. Elements of orthodontic appliances can cause localised trauma (usually mild and transient, but rarely there can be more severe consequences) or can be swallowed or inhaled. Orthodontic tooth movement has the potential to cause shortening of the tooth roots, usually minimally, but occasionally to a clinically significant degree. Fixed orthodontic appliances, in particular, make oral hygiene measures more difficult. If the teeth are not cleaned effectively when orthodontic appliances are being worn, plaque accumulation initially leads to a reversible decalcification of the teeth, which may leave permanent white patches. If trapped plaque remains beyond this initial stage, teeth become decayed. As a result of reduced access for cleaning an increase in gingival inflammation is common following the placement of fixed braces and marked loss of periodontal attachment and bony support for the teeth can occur when oral hygiene is poor[l]. Traumatic ulceration can also occur and in some circumstances death of the pulp or nerve of the tooth where the appliance is incorrectly adjusted.

Patient cooperation is essential; if not treatment may need to be discontinued part way through a course of treatment. At this point, the dental relationships may be worse than at the outset, and where extractions have been involved, the sacrifice of those (usually healthy) teeth may have produced no overall benefit.

The aim of all orthodontic treatment is to produce a stable relationship between teeth and jaws at the end of treatment phase. Teeth may relapse from the position achieved at the time the appliances are removed, and in the worst cases re-treatment may be needed.

For orthodontic treatment to be ethically acceptable, benefits of treatment must outweigh the risk of adverse consequences of treatment. In general, evidence of benefit is available for individuals with higher levels of orthodontic treatment need (see below). For those who do not fall into these categories, the risk of harm may outweigh potential benefits.

2.4. Orthodontic Treatment Need

Over the years several measures have been devised for assessing the need for, and potential benefit from orthodontic treatment. The most commonly-used and accepted measure of need in the UK, is the Index of Treatment Need (IOTN)[li]. It has two entirely separate components; the Dental Health Component (IOTN DHC) and the Aesthetic Component (IOTN AC). The IOTN DHC relates directly to tooth positions and is an attempt to measure professionally-defined need in an objective way The IOTN AC on the other hand, focuses on aesthetics and attempts to assess the subjective perception of need, from the perspective of the individual patient.

The Index of Treatment Need Dental Health Component (IOTN DHC) is assessed from a clinical examination of the teeth and jaws, or sometimes from dental models. There are five categories, ranging from one (no treatment need) to five (great need). As the categorisation involves direct measurements of the relationship between teeth, the scoring of IOTN DHC is highly robust and reproducible. There is evidence[lii] that the more severe the orthodontic problem at the onset of treatment, the greater the likelihood that treatment will effect an improvement.

Index of Treatment Need Aesthetic Component (IOTN AC) was devised as a method of recording a person's own judgement of how attractive they consider the look of their teeth to be. This is achieved by selecting the one photograph, from a series of 10 standard (reference) pictures, which they feel most closely equates to their perception of their own appearance. These 10 pictures were chosen and validated as having decreasing attractiveness, in equal steps, and are assigned scores from one (most attractive) to 10.

IOTN AC therefore represents an attempt to numerically quantify an individual's self-rating of attractiveness, but as with any subjectively-rated scale can be criticised for its lack of robustness. Child and Clinician-rated IOTN AC grades of the child's appearance may be very different[liii], as are the dentist and parent/carer ratings[liv]. Although many children who rate themselves as having a high level of unattractiveness (on the IOTN AC assessment) will also have a high-scoring clinical condition on IOTN DHC, that relationship is not a predictable one. Some individuals with a low dental health need (DH score) will have a high personally perceived need for treatment (AC score), and vice versa.

2.5 Eligibility for NHS orthodontic treatment

'High Street' dentists working under NHS General Dental Services arrangements can provide orthodontic services only if they have a specific contractual arrangement (with the local Primary Care Trust) to provide this type of care[lv]. To ensure that there are good results from treatment, it should be commissioned, to meet local needs, from appropriately trained and experienced dentists[lvi]. Such providers are limited in the overall *number* of NHS patients they can assess and treat by level of their contract with their local PCT (expressed as Units of Orthodontic Activity), and also in the *types* of orthodontic problems they can normally treat (as defined by the national Regulations). These are the *National Health Service (General Dental Services Contracts) Regulations 2005*[liii]. In summary, local General Dental Service contracts generally limit the provision of orthodontic treatment to those who:

- are under the age of 18 at the time of assessment;
- and have an IOTN DHC score of 4 or 5 , or an IOTN DHC score of 3 *together with* an IOTN AC score of 6 or above.

These Regulations do, though, offer them some clinical discretion to allow the orthodontist to provide treatment (for people under the age of 18) assessed as not having the level of treatment need assessed through IOTN (as above), "because of the exceptional circumstances of the oral and dental condition of the person concerned". The Regulations do permit PCTs to have a contract with orthodontists for assessment and treatment of people over the age of 18, but locally, such assessment and treatment

is contract exclusion. The verbatim extract of the relevant part of the *Regulations* is at Annex 1.

2.6 "Exceptional circumstances of the oral and dental condition" likely to result in adverse health impacts

There is limited evidence of major impacts on oral health or general health arising from the some of those treatment benefits stated in Section 2:

2.6.1 Prevention of tooth decay and gum disease

i. Crowded teeth, or poor alignment of teeth within the upper and lower dental arches have, in the past, been suggested as risk factors for both tooth decay and gum disease, and therefore orthodontic treatment was promoted as a means of improving oral health. Long term clinical studies do not support this view, and BOS itself states that there is little evidence that orthodontic treatment in general confers such a benefit. However they also suggest that there are individual cases where orthodontic treatment clearly has been beneficial, although give no examples.

ii. Pulpal (the living core of blood vessels and nerves) reactions may cause pain or even tooth 'death' as orthodontic treatment moves teeth. Transient or irreversible damage to pulps may occur.[lvii] [lviii] [lix]

iii. Tooth surface loss may be caused when orthodontic wires and brackets bring appliances into contact with tooth surfaces and have the potential to cause wear of the enamel surface. This can be further exacerbated if patients have a high intake of carbonated drinks or pure juices.

iv. Enamel trauma can occur during placement or removal of appliances or when parts of appliances are debonded.

v. Enamel demineralisation is a common complication of orthodontics. The extent of the problem has been assessed as ranging from 2-96%[lx]. This large variation is due to the different ways decalcification is scored. There is possibility of remineralisation of the lesions, but in some severe cases, cavitation is seen.

vi. Some degree of root resorption is inevitable with fixed appliance orthodontic treatment with, on average, 1-2 mm of the tip of the root lost. In most cases this will not be clinically significant but some teeth have higher level of risk than others and can be associated with severe resorption[lxi] [lxii]

2.6.2 Prevention of damage to prominent front teeth.

i. The number of damaged incisor teeth at age 15 has fallen in recent years; currently the incidence is about 13 teeth per thousand, the majority being fracture of the tooth enamel only[lxiii]. Looking at the child population *as a whole*, the great majority of damaged teeth are those which are not prominent. However, the sub-section of the child population who do have prominent front teeth sustain more damage, when compared with a similar number of children with teeth which are less prominent. Children with upper front teeth which protrude more than 6 mm would be eligible for NHS treatment, as they fall into the high categories of IOTN DHC.

ii. There is evidence from several studies that the risk of dental injuries increases with[lxiv lxv lxvi] an increased overjet of more than 5 mm and/or inadequate lip coverage.

2.6.3 Appearance and psychosocial benefits

i. Appearance is usually the principle factor in the motivation for seeking orthodontic treatment amongst lay people, in the belief that the cosmetic improvement resulting from orthodontic treatment will enhance the social acceptance and self esteem of the individual.

ii. A prospective UK multicentre, hospital-based, trial compared psychosocial measures in a group of children who had early orthodontic appliance treatment (at an average age of nine years old), with a control group with a similar problem, but who would have treatment at a later age. At the end of appliance therapy, the early treatment group had better 'self concept' scores for physical appearance, anxiety, popularity, and happiness and satisfaction. However, in this study there was no comparison with a group from the general population who did not undergo, or wish for orthodontic treatment. The study group actually had higher initial self concept scores than the general population of their age, confirming findings elsewhere that patients who desire orthodontic treatment tend to have a relatively high normal range of self-esteem at outset.

iii. A recent report [lxvii] of a major 20 year prospective, longitudinal cohort study found little positive impact on psychological health and quality of life in adulthood in those who had received orthodontic treatment. The observed effect of orthodontic treatment on self-esteem at outcome, was accounted for by self-esteem at baseline.

iv. Other studies have focussed on patients' perceptions of need and the difference that orthodontic intervention makes to their daily lives, using specifically oral health-related quality of life (QoL) measures. Evidence in this area is generally from weaker, cross-sectional studies, such as the recent paper by Johal et al[lxviii], cited by the BOS. This study compared 13-15 year olds with malocclusion traits with a group of 'normal' children. They found that children with malocclusion traits (prominent incisors of spaced teeth), and their carers, reported more oral health related QoL impacts on a questionnaire than did the control group. The principal limitation of this questionnaire is that it does not elicit the specific causes of the impacts recorded. Such impacts can be related to a variety of oral health conditions, and not necessarily the person's malocclusion. Also, as the research subjects were being seen in the orthodontic department of a teaching hospital it may be that they report greater oral health impact in the hope of receiving orthodontic treatment. One study reported that adolescents who had completed orthodontic treatment had a better oral health related quality of life than those who never had treatment[lxix]

2.6.4 Temporomandibular (TMJ) joint disorders

i. The TMJ is the joint between the base of the skull and the mandible (lower jaw). Disorders of these joints are related to a wide range of signs and symptoms, such as clicking, tenderness and pain on chewing or opening the mouth. All the chewing muscles may be affected by the disorder, and pain is often felt away from the joint itself. Theories of causation are complex, and include physical factors such as poor alignment of teeth, and psychosocial factors, such as stress and anxiety. There is a distinct profile of those affected, which increases with age and has a large preponderance of females.

ii. Treatment options usually begin conservatively, with reassurance and adapting behaviour, followed by a range of active treatments including physiotherapy and the use of splints worn in the mouth to change the biting surfaces of the teeth, and the biting relationship of the jaws. Research on the effect of providing one common type of splint, the Stabilisation Splint, was reviewed in 2004[lxx] and found insufficient evidence for or against its use.

iii. Orthodontic treatment seems to be neither a major preventive, nor a significant cause of, TMJ disorder. Such treatment may be offered to people with TMJ dysfunction on the hypothesis that if the teeth bite incorrectly - in the form of a malocclusion - this can then apply a restriction to the function of the TMJ (or worse, will predispose it to future pathological deterioration). Therefore by correcting the alignment and arrangement of the teeth, the TMJ

will remodel to an overriding new function, thus treating any established disease processes and allowing normal function to continue for the life of the patient.

iv. However, as there is a significant degree of controversy regarding the relationship of TMJ dysfunction and orthodontic treatment, a systematic review of the research literature has recently been commissioned by the Cochrane Collaboration[lxx lxxi]. So far, only the research protocol has been published. This does however provide a useful overview of the uncertainty in the current evidence, both of the appropriateness of orthodontic treatment for TMJ dysfunction, and conversely, the possibility of orthodontic treatment being a causative factor of TMJ dysfunction.

2.6.5 Other functional impairment; speech, mastication and swallowing

i. It is very probable that such a functional deficit will only be found in people with a high score on IOTN DHC, and so they should not be contractually excluded from receiving orthodontic treatment. Cleft lip and palate, or other less common, but severe orofacial abnormalities, require a multidisciplinary approach and therefore should be treated only within a hospital department linked to an appropriate centre.

ii. The soft tissues show remarkable adaptation to the changes that may occur during the transition between primary and secondary dentitions. In the main, speech is little affected by malocclusion and correction of an occlusal anomaly has little effect upon abnormal speech. However, if a patient cannot attain contact between the incisors anteriorly this may contribute to the production of a lisp (Mitchell)

2.6.6 Snoring and Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS)

Snoring is caused by a partial closure of the airway during sleep, allowing soft tissues in the upper throat to vibrate noisily. When the airway narrows so much that it closes, a person may stop breathing during sleep for repeated, short, periods. This not only fragments the sleep, leading to daytime drowsiness, but these repeated falls in blood oxygen levels are also linked to cardiovascular problems.

Appliances worn inside the mouth can improve these problems through altering the position of the lower jaw during sleep; Mandibular Advancement Splint (MAS) therapy. Such appliances are provided by some orthodontists in specialist

practice or within the hospital services, and by general dentists with suitable additional experience and expertise.

Treatment must follow proper physical examination and diagnosis, supported by limited sleep studies. Behavioural interventions such as obesity management are often required. Clinical Guidelines[lxxii] suggest:

- Intra oral devices (MAS) are appropriate therapy for snorers and for patients with mild OSAHS with normal daytime alertness

- Continuous Positive Airway Pressure (CPAP) is the first choice therapy for patients with moderate or severe OSAHS that is sufficiently symptomatic to require intervention, but intraoral devices (MAS) are appropriate alternative therapy such patients who are unable to tolerate CPAP.

ANNEX ONE

Extract from the National Health Service (General Dental Services Contracts) Regulations) 2005[(3)]:

SCHEDULE 1
Regulation 15

ADDITIONAL SERVICES

PART 2

ORTHODONTIC SERVICES

Patients to whom orthodontic services may be provided

4.—

(1) A contract that includes the provision of orthodontic services shall specify that orthodontic services may be provided to:

(a) only persons who are under the age of 18 at the time of the case assessment;

(b) only persons who have attained or are over the age of 18 years at the time of the case assessment; or

(c) persons falling within paragraph (a) or (b).

(2) Where a contract specifies the matters referred to in sub-paragraph (1)(b) or (1)(c), it shall in addition specify the circumstances in which orthodontic services may be provided to a person over the age of 18 years at the time of a case assessment.

(3) Subject to sub-paragraph (4), the contractor shall only provide orthodontic treatment to a person who is assessed by the contractor following a case assessment as having a treatment need in:

(a) grade 4 or 5 of the Dental Health Component of the Index of Orthodontic Treatment Need; or

(b) grade 3 of the Dental Health Component of that Index with an Aesthetic Component of 6 or above, unless the contractor is of the opinion, and has reasonable grounds for its opinion, that orthodontic treatment should be provided to a person who does not have such a treatment need by virtue of the exceptional circumstances of the dental and oral condition of the person concerned.

(4) In a case where a person does not have a treatment need but the contractor has reasonable grounds for its opinion that orthodontic treatment should be provided to that person because of the exceptional circumstances of the dental and oral condition of that person, such treatment as is referred to in sub-paragraph (3) may be provided.

ANNEX 2:

*Except from NHS Choices website[6], downloaded July 2013***.**

Around one in three British children has crooked teeth and needs orthodontic treatment to straighten them.

Braces are usually more successful in children, and four out of five orthodontics patients are children. But more adults than ever now want treatment, many having missed out when they were children. According to the British Orthodontic Society (BOS), nearly 1 million people in the UK started orthodontic treatment last year.

Are braces available on the NHS?

Orthodontic treatment is available free on the NHS for under-18s who need it. Treatment is also available on the NHS at the standard charge for complex dental treatment (just under £200) for adults who need it. However, adults who want orthodontic treatment to fix minor cosmetic problems aren't eligible for NHS treatment.

[6] http://www.nhs.uk/Livewell/dentalhealth/Pages/braces.aspx

References

[i] Holmes, (1992) *The prevalence of orthodontic need.* British Journal of Orthodontics 19 177-182

[ii] Otuyemi OD, Ugboko VI, Adekoya-Sofowora CA, Ndukwe KC. *Unmet orthodontic need in rural Nigerian adolescents*. Community Dentistry and Oral Epidemiology 1997; 25:363-366.

[iii] Breistein B, Burden DJ. *Equity and orthodontic treatment: a study among adolescents in Northern Ireland.* American Journal of Orthodontics and Dentofacial Orthopedics 1998; 113(4):408-413.

[iv] Wang G, Hagg U, Ling J. *The orthodontic treatment need and demand of Hong Kong Chinese children.* Chinese Journal of Dental Research 1999; 2(3-4):84-92.

[v] Chi J, Harkness M, Crowther P. *A longitudinal study of orthodontic treatment need in Dunedin schoolchildren. New* Zealand Dental Journal 2000; 96(423):4-9.

[vi] Abdullah MS, Rock WP. *Assessment of orthodontic treatment need in 5,112 Malaysian children using the IOTN and DAI indices.* Community Dental Health 2001; 18(4):242-248.

[vii] Abu Alhaija ES, Al-Nimri KS, Al-Khateeb SN. *Orthodontic treatment need and demand in 12-14-year-old north Jordanian school children.* European Journal of Orthodontics 2004; 26(3):261-263.

[viii] British Orthodontic Society. (2012) *What is IOTN?* Accessed at www.bos.org.uk

[ix] Todd JE. *Children's Dental Health in England and Wales 1973.* 1875. London, HMSO.

[x] Todd JE, Dodd T. *Children's Dental Health in the United Kingdom 1983.* 1985. London, HMSO.

[xi] O'Brien M. *Children's dental health in the United Kingdom 1993.* 1994. London, HMSO.

[xii] Chestnutt IG, Burden DJ, Steele JG, Pitts NB, Nuttall NM, Morris AJ. *The 2003 Children's Dental Health Survey.* Office for National Statistics. 2006. 31-07-06 http://www.statistics.gov.uk/downloads/cdh6_Orthodontic_condition.pdf

[xiii] Tuominen ML, Tuominen RJ. *Factors associated with subjective need for orthodontic treatment among Finnish university applicants.* Acta Odontologica Scandinavica 1994; 52(2):106-110.

[xiv] Tuominen ML, Tuominen RJ, Nystrom ME. *Subjective orthodontic treatment need and perceived dental appearance among young Finnish adults with and without previous orthodontic treatment.* Community Dental Health 1994; 11(1):29-33.

[xv] Shaw WC. *The influence of children's dentofacial appearance on their social attractiveness as judged by peers and lay adults*. American Journal of Orthodontics and Dentofacial Orthopedics 1981; 79(4):399-415.

[xvi] Onyeaso CO. *Demand and referral pattern for orthodontic care at University College Hospital, Ibadan, Nigeria.* International Dental Journal 2004; 54(5):250-254.

[xvii] Wheeler TT, McGorray SP, Yurkiewicz L, Keeling SD, King GJ. *Orthodontic treatment demand and need in third and fourth grade schoolchildren.* American Journal of Orthodontics and Dentofacial Orthopedics 1994; 106(1):22-33.

[xviii] Proffit WR, Phillips C, Dann C 4th. *Who seeks surgical-orthodontic treatment?* International Journal of Adult Orthodontics and Orthognathic Surgery 1990; 5(3):153-160.

[xix] Kerosuo E, Abdulkarim E, Kerosuo E. *Subjective need and orthodontic treatment experience in a Middle East country providing free orthodontic services: a questionnaire survey.* The Angle Orthodontist 2002; 72(6):565-570

[xx] National Dental Epidemiological Survey (2009/9) *Survey of 12 year old children 2008/9.* Accessed at: http://www.nwph.net/dentalhealth/

[xxi] Chestnutt I; Pendry L; Harker R. *The Orthodontic Condition of Children.* Children's Dental Health in the United Kingdom, 2003. London: Office for National Statistics; 2004

[xxii] Bergstrom K. *Orthodontic care in Sweden. Outcome in three counties*. Swedish Dental Journal 1996; 117(Supplement):1-68.

[xxiii] Kerosuo H, Kerosuo E, Niemi M, Simola H. *The need for treatment and satisfaction with dental appearance among young Finnish adults with and without a history of orthodontic treatment.* Journal of Orofacial Orthopedics 2003; 124(1):41-45.
[xxiv] Stephens et al. *Standing Dental Advisory Committee – report of an expert group.* 1992. Unpublished
[xxv] Todd J and Dodd R (1983) *Survey of Child Dental Health* (1983) HMSO, London.
[xxvi] Todd J and Dodd R (1990) *Survey of Child Dental Health* (1990) HMSO, London.
[xxvii] Tuominen ML, Tuominen RJ. *Factors associated with subjective need for orthodontic treatment among Finnish university applicants.* Acta Odontologica Scandinavica 1994; 52(2):106-110.
[xxviii] Birkeland K, Katle A, Lovgreen S, Boe OE, Wisth PJ. *Factors influencing the decision about orthodontic treatment.* A longitudinal study among 11- and 15-year-olds and their parents. Journal of Orofacial Orthopedics 1999; 60(5):292-307.
[xxix] Onyeaso CO. *Demand and referral pattern for orthodontic care at University College Hospital,* Ibadan, Nigeria. International Dental Journal 2004; 54(5):250-254.
[xxx] Wheeler TT, McGorray SP, Yurkiewicz L, Keeling SD, King GJ. *Orthodontic treatment demand and need in third and fourth grade schoolchildren.* American Journal of Orthodontics and Dentofacial Orthopedics 1994; 106(1):22-33.
[xxxi]Proffit WR, Phillips C, Dann C 4th. *Who seeks surgical-orthodontic treatment?* International Journal of Adult Orthodontics and Orthognathic Surgery 1990; 5(3):153-160.
[xxxii] Kerosuo E, Abdulkarim E, Kerosuo E*. Subjective need and orthodontic treatment experience in a Middle East country providing free orthodontic services: a questionnaire survey.* The Angle Orthodontist 2002; 72(6):565-570
[xxxiii] Shaw WC, Richmond S, Kenealy PM, Kingdon A, Worthington H. *A 20-year cohort study of health gain from orthodontic treatment: psychological outcome.* British Journal of Health Psychology. In press.
[xxxiv] Richmond S, Shaw WC, Stephens CD, Webb WG, Roberts CT, Andrews M. *Orthodontics in the general dental service of England and Wales: a critical assessment of standards.* British Dental Journal 1993; 174(9):315-329.
[xxxv] Turbill EA, Richmond S, Wright JL. *A closer look at General Dental Service orthodontics in England and Wales I: Factors influencing effectiveness.* British Dental Journal 1999; 187(4):211-216.
[xxxvi] Gray M, Anderson R. A *study of young people's perceptions of their orthodontic need and their experience of orthodontic services*. Primary Dental Care 1998; 5(3):87-93.
[xxxvii] Richmond S, Roberts CT, Andrews M. *Use of the index of Orthodontic Treatment Need (IOTN) in assessing the need for orthodontic treatment pre- and post-appliance therapy*. British Journal of Orthodontics 1994; 21(2):175-184.
[xxxviii] Shaw WC, Richmond S, Kenealy PM, Kingdon A, Worthington H. *A 20-year cohort study of health gain from orthodontic treatment: psychological outcome.* British Journal of Health Psychology. In press.
[xxxix] Bergstrom K. *Orthodontic care in Sweden*. Outcome in three counties. Swedish Dental Journal 1996; 117 (Supplement): 1-68.
[xl] Espeland L, Stenvik A. *Residual need in orthodontically untreated16-20-year-olds from areas within different treatment rates.* European Journal of Orthodontics 1999; 21 (5): 523-531
[xli] de Oliveira CM, Sheiham A. *Orthodontic treatment and its impact on oral health-related quality of life in brazilian adolescents.* Journal of Orthodontics 2004 Mar; 31(1): 20-27.
[xlii] Tuominen ML, Tuominen RJ, Nystrom ME. *Subjective orthodontic treatment need and perceived dental appearance among young Finnish adults with and without previous orthodontic treatment.* Community Dental Health 1994; 11(1):29-33.
[xliii] Albino JE, Lawrence SD, Tedesco LA. *Psychological and social effects of orthodontic treatment.* Journal of Behavioural Medicine 1994; 17(1):81-98.
[xliv] Audit Commission. Dentistry. (2002)*Primary dental care services in England and Wales.* London, Audit Commission.
[xlv] Robinson PG, Willmot DR, Parkin NA, Hall AC. (2005) *Report Of The Orthodontic Workforce Survey Of The United Kingdom February 2005.* Sheffield, Department of Oral Health and Development, University of Sheffield.
[xlvi] General Dental Council; http://www.gdc-uk.org/General+public/Look+for+a+Specialist/
[xlvii] Royal College of Surgeons of England; http://www.rcseng.ac.uk/fds/docs/special.pdf
[xlviii] British Orthodontic Society ; http://www.bos.org.uk/aboutorthodontics/thebenefits.htm
[xlix] Shaw WC et al. Quality control in orthodontics: Risk benefit considerations. 1991; *Br Dent J*: **170**: 33-37

[l] Mitchell L. *The Rationale for orthodontic treatment- An Introduction to Orthodontics*. Fourth Edition. Oxford University Press. January 2013.
[li] Brook PH & Shaw WC. The Development of an Index for Orthodontic Treatment Priority. *European Journal of Orthodontics* 1989;**11**:309-332
[lii] Richmond et al. Orthodontics in the General Dental Service of England and Wales: a Critical Assessment of Standards. Br Dent J 1993; **174**: 315-329
[liii] Mandall NA et al. The relationship between normative orthodontic treatment need and measures of consumer perception. Community Dental Health 2001; **18**: 3-6
[liv] Children's Dental Health in the United Kingdom 2003. London, Office for National Statistics 2004; http://www.statistics.gov.uk/downloads/cdh6_Orthodontic_condition.pdf
[lv] Department of Health. Commissioning for primary care dentistry. Factsheet 11 – Orthodontic new PDS agreements and new GDS contracts. Gateway 5917; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130320.pdf
[lvi] Department of Health. Strategic commissioning of orthodontic services. Gateway 7105, Sept 2006; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139176
[lvii] Takla P M, Shivapuja P K. *Pulpal response in electrothermal debonding*. Am J Orthod Dento Orthop 1995;108:623-29.
[lviii] Atack N E*. The orthodontic implications of traumatised upper anterior teeth.* Dent Update 1999;26:432-437.
[lix] Zachrisson B U. *Cause and prevention of injuries to teeth and supporting structures during orthodontic treatment*. Am J Orthod 1976;69:285-300.
[lx] Chang HS Wlash LJ Freer TJ *Enamel demineralisation during orthodontic treatment. Aetiology and prevention.* Aus Dent J 1997, 42: 322-327
[lxi] Brezniak N, Wasserstein A. *Root resorption after orthodontic treatment* Part 1 Literature review. Am J Orthod 1993;103:62-66.
[lxii] Hendrix I, Carels C, Kuijpers-Jagtman A M, Van 'T Hof M. *A radiographic study of posterior apical root resorption in orthodontic patients*. Am J Orthod Dento Orthop 1994;105:345-349.
[lxiii] Children's Dental Health in the United Kingdom 2003.London, Office for National Statistics 2004; http://www.statistics.gov.uk/CHILDREN/dentalhealth/downloads/cdh_non-carious_dental_decay.pdf
[lxiv] Soriano EP, Caldas AF Jr, Goes PS. *Risk factors related to traumatic dental injuries in Brazilian school children*. Dental Traumatology 2004 Oct; 20 (5): 246-250.
[lxv] Sgan-Cohen HD, Megnagi G, Jacobi Y. *Dental trauma and its association with anatomic, behavioural and social variables among fifth and sixth grade schoolchildren in Jerusalem.* Community Dentistry and Oral Epidemiology 2005 Jun; 33(3): 174-180.
[lxvi] Traebert J, Bittencourt DD, Peres KG, Peres MA, de Lacerda JT, Marcenes W*. Aetiology and rates of treatment of traumatic dental injuries among 12-year old school children in a town in Southern Brazil.* Dental Traumatology 2006 Aug; 22(4): 173-178
[lxvii] Kenealy PM et al. The Cardiff dental study: A 20-year critical evaluation of the psychological health gain from orthodontic treatment. *British Journal of Health Psychology* 2007; **12**: 17-49
[lxviii] Johal A, Cheung MYH, Marcenes W. The impact of two different malocclusion traits on quality of life. British Dental Journal 2007; **202**:E6
[lxix] de Oliveira CM, Sheiham A. *Orthodontic treatment and its impact on oral health-related quality of life in brazilian adolescents.* Journal of Orthodontics 2004 Mar; 31(1): 20-27.
[lxx] Al-Ani et al. Stabilisation splint therapy for temporomandibular pain dysfunction syndrome (Review). http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002778/pdf_fs.html
[lxxi] Luther F, Layton S, McDonald F. Orthodontics for treating TMJ disorders (Protocol). http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006541/pdf_fs.html
[lxxii] Scottish Intercollegiate Guidelines Network. Management of obstructive sleep apnoea/hypopnoea syndrome in adults. Guideline No 73. 2003; http://www.sign.ac.uk/guidelines/fulltext/73/index.html

Essex County Council

Item 8

Report to Health & Wellbeing Board **Report of** Cllr Aldridge	**Reference number** *HWB/004/14*
Date of meeting 14th January 2014 **Date of report** 17th December 2013	**County Divisions affected by the decision** All Divisions
Title of report : National Adult Autism 2nd Self-Assessment	
Report by Cllr Aldridge	
Enquiries to *Steven Allen 07748 623975*	

1. Purpose of report

1.1 In line with the request from Norman Lamb MP Minister of State for Care and Support dated 2nd August 2013 (see attached), all Health and Wellbeing boards are requested to endorse their local 2nd Adult Autism Self-Assessment submission as part of the evidence for local planning, health needs assessment strategy development and the supporting of local implementation work.

1.2 The purpose of this report is to provide the information submitted as the 2nd Adult Autism Self-Assessment framework for Essex in order for the Health and Wellbeing Board to endorse prior to the January 2014 deadline.

2. Recommendations

2.1 To agree to endorse the Adult Autism Self-Assessment submission, and agree the further submission from South Essex's CCGs.

3. Background and proposal

3.1 The Adult Autism Strategy *Fulfilling and Rewarding Lives* was published in 2010. It is an essential step towards realising the Government's long term vision for transforming the lives of and outcomes for adults with autism. The Department of Health is the lead policy department for the Strategy but with delivery shared

across a range of government departments and agencies, and local health and social service providers.

3.2 The Autism Strategy has five areas for action aimed at improving the lives of adults with autism:

- increasing awareness and understanding of autism;
- developing a clear, consistent pathway for diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

3.3 The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and awareness raising.

3.4 Review of the Strategy

3.4.1 The Department of Health is currently leading a formal review of progress against the Strategy. This is an opportunity for Government to assess whether the objectives of the Strategy remain fundamentally the right ones, to be assured of the progress that is being achieved by Local Authorities and the NHS, and consider what should happen to continue to make progress and what barriers could be resolved. The investigative stage of the Review will last until the end of October and the Strategy will be revised as necessary by March 2014.

3.4.2 The Department of Health launched the second self-assessment exercise for councils and CCGs on the 2nd August 2013. The exercise required Essex County Council and the CCGs to complete a self-assessment form setting out our progress against the National Autism Strategy (DH 2010). The national strategy sets out clear objectives against which our progress will be measured.

3.5 Current Position on Progress

3.5.1 The attached self-assessment response was co-produced through the formation of a task and finish group incorporating stakeholders from the Adult Autism Working Group, Voluntary and Community Sector partners, Education Service, Transition Service, and North Essex Commissioning Support Unit. Input to the framework questions was also sought from the specialist providers Hertfordshire Partnership Foundation Trust and South Essex Partnership Foundation Trust and internal county council officers.

3.5.2 The Adults Health and Wellbeing, Working Age Adults lead for Autism submitted this joint response by the deadline of Monday 30th September 2013.

3.5.3 This provided information from Essex County Council, the CCGs in the North, Mid and West areas, and the mental health provider in the South. Since then some additional information has been received from the South CCGs in relation

to their commissioning intentions which has been added to the return [in italics] for completeness.

4. Policy context

4.1. In line with the request from Norman Lamb MP Minister of State for Care and Support dated 2nd August 2013, all Health and Wellbeing boards are requested to discuss the self-assessment submission by the end of January 2014 as evidence for local planning and health needs assessment strategy development and supporting local implementation work

5. Financial Implication

5.1 While there are no direct financial implications arising from this report, paragraph 3.2 sets out the 5 areas for actions aimed at improving the lives of adults with autism**.** One of which is developing a clear, consistent pathway for the diagnosis of autism. The review of the efficacy of this pathway is part of the joint planning process between the ECC and the NHS, and will be contained within future joint planning reports to this board.

6. Legal Implications

6.1 The Autism Act 2009 placed a duty on the Secretary of State to publish an Autism Strategy by the 1st April 2010 and to keep it under review. In order to secure compliance with the strategy the Secretary of State was also under a duty to prepare statutory guidance for the exercise of social services functions by local authorities by the 31st December 2010. Local authorities are to be consulted in the preparation of such guidance and are under a duty to exercise their duties in compliance with it.

6.2 Under S. 116 of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and social Care Act 2012, the Council, in partnership with clinical commissioning groups, is under a duty to prepare and publish a joint strategic needs assessment (JSNA). In so doing they must have regard to whether the needs can best be met by a partnership arrangement under S.75 of the National Health Service Act 2006 and any guidance issued by the Secretary of State. In the subsequent exercise of their functions the Council must have regard to any statutory assessment or strategy prepared under these arrangements.

6.3 The Board are reminded that in considering this mater they are subject to the public sector equality duty set out in the Equality Act 2010. The Board must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

- Foster good relations between people who share a protected characteristic and those who do not.

Advancing equality of opportunity involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

7. Staffing and other resource implications

There are no staffing or resource implications. Progress made against the National Adult Autism Strategy has been within/ and continues as business as usual

8. Equality and Diversity implications

There are no equality and diversity implications. The self-assessment framework is the evidencing of progress made against the National Adult Autism Strategy. The DH completed the original Equality Impact Assessment (EQIA) in 2009/2010.

9. Background papers

Not applicable

From Norman Lamb MP
Minister of State for Care and Support

Department of Health

To: Directors of Adult Social Services

Copied to: Directors of Public Health
Directors of Children's Services
Clinical Commissioning Group Leads and Accountable Officers
Chairs of Health and Wellbeing Boards

Richmond House
79 Whitehall
London
SW1A 2NS

Telephone: 020 7210 3000

2 August 2013

Dear Colleague

The 2010 Adult Autism Strategy *Fulfilling and Rewarding Lives:* Evaluating Progress – the second national exercise.

This letter is to obtain your assistance in taking forward the second self-assessment exercise for the implementation of the Adult Autism Strategy. Local Authorities play a key role in implementing the recommendations of the Strategy and the statutory guidance that supports it.

The purpose of the self assessment is to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;
- see how much progress has been made since the baseline survey, as at February 2012;
- provide evidence of examples of good progress made that can be shared and of remaining challenges.

An on-line return to Public Health England via the Improving health and lives website is required **by Monday 30 September 2013**.

I am sorry that this exercise is to a broadly similar timescale as the one on Learning Disabilities. We had tried to avoid this but with the information

that is submitted being a vital part of the Review of the Adult Autism Strategy and the unavoidable timetable for the Learning Disabilities self assessment, this has not proved possible.

The Adult Autism Strategy

The Adult Autism Strategy *Fulfilling and Rewarding Lives* was published in 2010. It is an essential step towards realising the Government's long term vision for transforming the lives of and outcomes for adults with autism. The Department of Health is the lead policy department for the Strategy but with delivery shared across a range of government departments and agencies, and local health and social service providers.

The Autism Strategy has five areas for action aimed at improving the lives of adults with autism:

- increasing awareness and understanding of autism;
- developing a clear, consistent pathway for diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and awareness raising.

Review of the Strategy

The Department of Health is currently leading a formal review of progress against the Strategy. This is an opportunity for Government to assess whether the objectives of the Strategy remain fundamentally the right ones, to be assured of the progress that is being achieved by Local Authorities and the NHS, and consider what should happen to continue to make progress and what barriers could be resolved. The investigative stage of the Review will last until the end of October and the Strategy will be revised as necessary by March 2014.

The self-assessment exercise

This exercise builds on the first self assessment exercise which looked at what progress had been made since February 2012. This was based around the self-assessment framework which the Department of Health

launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010. The individual returns received and related reports from February 2012 can be found at www.improvinghealthandlives.org.uk/projects/autsaf2011.

We hope to get a national overview of local area implementation of the strategy, identify the good progress made with examples of the impact for people with autism where possible and for this to assist the review in developing next steps for the strategy. We are also keen to understand the challenges which may be impacting on progress and local solutions.

The list of questions is more focused than last time but will still enable a comparison with results from the 2012 exercise. For some questions there is a RAG rating system with scoring criteria for that question. If a question is scored Red or Amber, respondents will be asked to say what is stopping progress and for Green scores there will be the opportunity to say what actions have enabled progress. Examples of good practice and where actions have made a positive impact on individuals are also being sought.

It is important to come to a multi-agency perspective, including liaison with Clinical Commissioning Groups, to reflect the requirements of the implementation of the strategy, although the Local Authority is tasked with the consolidation of the return as the lead body locally. The returns will be analysed by the Public Health England learning disabilities observatory. The on-line questionnaire can be accessed at www.improvinghealthandlives.org.uk/projects/autism2013. Respondents should be aware that all local responses will be published in full online.

Action needed

I would be grateful if you could draw attention to and discuss this letter with the person who is responsible for adult autism within your authority, so that they lead the co-ordination of the return in your area. The timescale for completion of this part of the exercise is **Monday 30 September 2013**.

The response for your Local Authority area should be agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism. I am also asking that you are aware of the content of the return when it is submitted and that it is discussed by the local Health and Well Being Board by the end of January 2014 as

evidence for local planning and health needs assessment strategy development and supporting local implementation work.

Technical detail on how the returns are to be made can be found on the improving health and lives website.

Queries on:

- The Autism Strategy Review itself can be sent to autism@dh.gsi.gov.uk

- Questions on the self assessment exercise can be sent via the ADASS Network e-mail address Team@ADASS.org.uk for the attention of Zandrea Stewart, the ADASS National Autism Lead.

The letter has been prepared with the support of Zandrea Stewart and Sam Cramond (Head of Partnerships, NHS England). A briefing for all Directors of Social Care on the Review will also be sent via the ADASS network. The letter will be circulated to CCGs via the NHS England CCG bulletin on 8 August.

NORMAN LAMB

National Autism 2nd Self –Assessment October 2013

[with additional information from the South CCGs added December 2013]

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

5

North East
West
Mid
South East
South West

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

Yes

If yes, how are you doing this?

Both Southend Borough Council and Thurrock District Council are represented / engaged on the Adult Autism Working Group and as key stakeholders are being consulted on the co-production of the joint Essex adult autism strategy

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

Yes

Lead commissioner for Working age adult services (learning disabilities, physical and sensory impairments, behaviours which challenge and autistic spectrum disorders.
Reports to Peter Tempest - Director of Operations
Steven Allen
steven.allen@essex.gov.uk
01245 430989

4. Is Autism included in the local JSNA?

Amber

The latest draft autism chapter will be issued to the Adult Autism working group in September to consult / sign-off

5. Have you started to collect data on people with a diagnosis of autism?
Amber

Yes the two diagnostic services in Essex covering South East/West and North East do maintain intelligence data on the numbers of people diagnosed.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?
For people aged 18+ who have had a social care assessment in Essex, health details are recorded in their notes on OSCARS (internal recording system). This does include diagnoses of autism but depends on the practitioner being aware of the diagnosis and deciding to record it in the notes. These notes cannot be queried like a database so it is not possible to count who has and who has not got a recorded diagnosis of autism

If yes, what is
the total number of people?
the number who are also identified as having a learning disability?
the number who are identified as also having mental health problems?
Comment

7. Does your commissioning plan reflect local data and needs of people with autism?
Yes

The joint integrated 6th plan (Adult Social Care and North West/Mid) Section 2 details the need for a Pan Essex Autism/HF strategy.

[*Addition from South CSU December 2013:-The 2014-2016 commissioning intention gives notice to the local provider of intentions to look at the current service and review the ADHD/Autism service to ensure it meets the needs of people with autism.]*

8. What data collection sources do you use?
Amber/Green

Public Health Executive
Pansi

Poppi
Plus any other relevant data source

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?
Amber

The joint integrated 6th plan (Adult Social Care and North West/Mid) 2 section details the need for a Pan Essex Autism/HF strategy.

[*Addition from South CSU December 2013:- We have been engaging with the pan Essex autism work with current service provider SEPT on behalf of the south CCG's.]*

10. How have you and your partners engaged people with autism and their carers in planning?
Green

Adult Autism Working Group has been instrumental in supporting / advising and guiding commissioners to understand the needs of
people with ASD and support future planning. As key stakeholders they will co-produce the Essex Adult Autism Strategy 'action plan' to implement future activity / commissioning.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?
Amber

Please give an example.
JobCentrePlus
Work Choice
Right to Control

12. Do you have a Transition process in place from Children's social services to Adult social services?
Yes

Generally if a young person is in receipt of children's social care (csc) (e.g. respite/direct payments) and this needs to continue into

adulthood, there will be an automatic request. Other referrals may be received for young people not currently in receipt of csc but who are deemed by other professionals to require an adult service.
Parental requests may be made directly through Essex Social Care Direct and via General Practitioners. The Transition Pathway Service operates a central referral process for Children's Services. There is no restriction as any person may request for and be entitled to an assessment, although may not meet ASC eligibility criteria.

13. Does your planning consider the particular needs of older people with Autism?
Red

Not specifically but as people age with autism (that are known to services) their needs would be considered along the journey they take through services and would pass through into older adults services so by default the needs will be considered as we operate in a person centred approach.

Training

14. Have you got a multi-agency autism training plan?
No

15. Is autism awareness training being/been made available to all staff working in health and social care?
Green

YES - we have KWANGO E-learning which are available online or via a DVD to any staff that need it. We have also previously delivered face to face basic awareness training and intermediate level training for ECC staff within adult learning disability services.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?
Green

We have already commissioned Assessor level training for the social work staff. We have also just commissioned 2 x 1 day Advanced
level courses for Autism Champions and staff who complete assessments with people who have autism. This training includes
summarising the Autism Act and Strategy as well as communication methods.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?
No

We were originally approached by health but after offering initial advice and guidance have not been communicated to again.

18. Have local Criminal Justice services engaged in the training agenda?
No

We invited Essex Police to take part in engaging with us for Autism but they have not taken up the offer. But there is evidence and knowledge of training being implemented with Essex Police.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?
Amber

There are two commissioned diagnostic services in Essex covering South East/West (SEPFT) and North East (NEPFT). The NEPFT project does not support the diagnosis of people with severe mental health. The pilot autism pathway project in West/Mid is coming to an end, an external evaluation process will begin shortly.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?
Month (Numerical, e.g. January 01)
Year (Four figures, e.g. 2013)

Comment

NEPFT -North Essex Partnership NHS Foundation Trust started April 2011. It was agreed that the clinical psychologists in the Trust would provide a formal diagnostic assessment for referred clients, as long as they also met the Trust criteria for the severity of their co morbid mental health problems and do not have a severe LD.

SEPFT – THE service began in September 2009 and with this the diagnostic pathway for the Aspergers service only

21. How long is the average wait for referral to diagnostic services?

NEPFT - 16 Weeks

SEPFT – Currently this is up to 52 weeks but could be more or less depending on the circumstances of the referral.

22. How many people have completed the pathway in the last year?
NEPFT - It is estimated that in the last year, there have been approximately 18 ASD assessments in North East, 10 in Mid and 12 in the West areas of the Trust's Psychology Service.
However, there may be many more potential referrals that have been "rejected" at the "single gate". There may also have been clients who have been diagnosed by psychiatrists with a special interest in ASD, who have not come to the attention of the Clinical Psychology Specialists. There may also have been clients referred for help with their mental health presentation who already had an ASD diagnosis...so you see that the data is complex and therefore not likely to be 100% accurate: NB this is an estimate of numbers provided by the Trusts Psychologists only it is not based on a trawl of the Trust's formal client information system.

SEFPT – From the beginning of July 2012 to end of July 2013 of the people we have assessed 17 were given the diagnosis of an ASD.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?
Yes

NEPFT - The CSU has supported the ASD 3D QIPP which provides a diagnostic service to clients who do not have an LD or severe mental illness. These figures are being provided through Health in Mind, whom you have contracted separately, in order to avoid double counting.

SEPFT – No

24. How would you describe the local diagnostic pathway, i.e. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis
b. Specialist autism specific service

NEPFT - The Clinical Psychologists in the Trust have highly specialist training in ASD diagnostic assessment, within the context of a specialist mental health Trust that is aware of the necessary attention to co morbid mental health presentations.

SEPFT – Specialist Aspergers specific service

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?
Yes

NEPFT - all clients who receive the diagnosis are informed of their statutory right to a Social/Community Care Assessment.

SEPFT – No unfortunately not but we are working on this

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

NEPFT - On receiving a diagnosis a full care plan with appropriate adaptations to account for the ASC, would be drawn up. This includes information about and help in accessing SAFE/Autism, Anglia/Employability and Benefits advice etc. A Carers' Assessment would also be offered.

SEPFT – Where possible we try and help individuals access mainstream services but for those individuals who are aged 18-30 where this is not possible or further work is needed to achieve this we can offer support around vocational / employment aspects, accessing the community, support around anxiety / low mood, psychoeduction. We have some family therapy sessions, we do run some groups but these tend to be located in the Basildon area. A weekly running group, a monthly reading group and we also have access to a weekly sports group.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many

people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget
b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability
c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

For people aged 18+ who have had a social care assessment in Essex, health details are recorded in their notes on OSCARS (internal recording system). This does include diagnoses of autism but depends on the practitioner being aware of the diagnosis and deciding to record it in the notes. These notes cannot be queried like a database so it is not possible to count who has and who has not got a recorded diagnosis of autism.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?
No

If yes, please give details

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?
No
The pathway to access a community care assessment is generic however reasonable adjustments would be applied to the community care assessment based on individual needs.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?
Red

The advocate contract covers learning disabilities with co-morbid diagnosis. The expectation is that provider staff either access in-house awareness training or the county councils commissioned training in autism

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

Red

No -there is no specific funded advocacy service for people with a single diagnosis of autism. The commissioned service is for learning disabilities with co-morbidity

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

Yes

Floating Support (short term intervention / enablement)

33. How would you assess the level of information about local support in your area being accessible to people with autism?

Red

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

Amber

Essex is not a housing authority and needs to refer to each of the 12 districts housing strategies for a clearer perspective.
The Essex housing strategy does mention Autism.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

Red

Through linked employment there was a specific project for Aspergers into employment which has expired. Due to lack of funding this has not continued

36. Do transition processes to adult services have an employment focus?

Green

Detailed plans arise from the learning difficulty assessments and support plans we produce through a person-centred approach.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

Red

Essex County Council

Item 9

Report to Health & Wellbeing Board **Report of Director of Public Health**	**Reference number** *HWB/005/14*
Date of meeting: 14 January 2014	**County Divisions affected by the decision** *All Divisions*
Title of report: Annual Public Health Report 2013. Guidance on What delivers productivity in Integrated Care	
Report by Mike Gogarty, Director of Public Health, Essex County Council **Enquiries to** Mike Gogarty	

1. Purpose of report

1.1. There is an expectation that Directors of Public Health (DPHs) produce an annual report pertinent to the needs of the local population.

1.2. Given the JSNA suite provides detail on needs, this report focusses on the evidence base around interventions to deliver productivity for health and social care.

2. Recommendations

2.1. To accept the report and its recommendations.

3. Background and proposal

3.1 Local partners face unprecedented financial challenge

3.2 There needs to be a sound understanding of what interventions can be commissioned by partners that might deliver system productivity.

3.3 Productivity gains in this document will in the main be secured through mitigation of expected demand through effective prevention.

3.4 There is a spectrum of available evidence. In some areas there is considerable evidence of what will work, in others some pieces of the jigsaw are missing but a strong evidence case can be put forward, in others there is little evidence either way and in others a body of evidence that the intervention will not deliver productivity.

3.5 The document does not look at cost effectiveness. There are many valuable interventions that save lives and ill health and should be commissioned. We must however be clear where these will NOT yield efficiencies.

3.6 This should inform the use of system resources and inform integrated plans.

3.7 The document is "living" and as more evidence emerges is being updated. CCG linked Consultants in public health will be sighted on this.

4. Policy context

4.1 Evidence based practice is important if we are to deliver value for money.

4.2 DPH are required to produce and annual report

5. Financial Implications

5.1. The Department of Health allocates a public health ring fenced grant to local authorities to discharge their public health responsibilities. For 2014/15 Essex County Council has been allocated £50.2m. Funding allocations for 2015/16 have not been finalised but assumed to be at the same level as 2014/15.

5.2. The prudent and informed use of resources is essential if we are to meet financial challenge.

5.3. Partners need to review areas of proposed and current investment to ensure they are likely to represent a good use of resources and whether they will reduce system demand.

6. Legal Implications

6.1 The Health and Social Care Act 2012 gives responsibility for health protection to the Secretary of State and health improvement to upper tier and unitary local authorities which include the County Council. The Secretary of State also delegates some health protection functions to local authorities.

6.2 Section 12 of the Act inserts new section 2B into the NHS Act 2006 to give the County Council a new duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people of England – and it gives examples of health improvement steps that either local authorities or the Secretary of State could take, including giving information, providing services

or facilities to promote healthy living and providing incentives to live more healthily. Section 18 gives the Secretary of State the power to make regulations as to the exercise by local authorities of certain public health functions by inserting new section 6C into the NHS Act 2006. This means that the Secretary of State can require local authorities to carry out aspects of his health protection functions by taking certain prescribed steps. It also means that the Secretary of State can prescribe aspects of how local authorities carry out their health improvement function.

6.3 Accordingly the County Council is now responsible for important public health responsibilities. Section 30 then requires the Council, acting jointly with the Secretary of State, to appoint an individual who will be responsible for the local authority's public health functions. That individual will be an officer of the local authority, and known as the director of public health. .

6.4 The Government will also publish the refreshed Public Health Outcomes Framework as guidance to which local authorities must have regard. Under this same section, each director of public health is required to produce, and the relevant local authority to publish, an annual report. The Government has not further specified what the annual report might contain – this is very much a decision for individual directors of public health as to the issues they feel are important to raise.
Directors of public health are also statutory members of health and wellbeing boards (section 194(2)(d) of the Act). Schedule 5 of the Act amends the Local Government Act 1989 to add directors of public health to the list of statutory chief officers.

6.5 These duties mean that the local authority will have to take steps to ensure that it is aware of and has considered what the health needs of its local population are, and what the evidence suggests the appropriate steps would be to take to address those needs. Local authorities will have discretion as to how they choose to invest their grant to improve their population's health, although they will have to have regard to the Public Health Outcomes Framework and should consider the extant evidence regarding public health measures.

6.6 The Board are reminded that in considering this mater they are subject to the public sector equality duty set out in the Equality Act 2010. The Board must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation).
- Foster good relations between people who share a protected characteristic and those who do not.

Advancing equality of opportunity involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.

- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

7. Staffing and other resource implications

7.1. The document should inform commissioning of services and therefore will impact on the workforce required and how they will be used.

8. Equality and Diversity implications

8.1. There are no adverse impacts likely

8.2. Many of the interventions proposed focus on areas where services aimed at areas of the population are currently suboptimal. Implementation is likely to improve outcomes in these groups.

8.3. Conversely the recommendations may inform decisions to invest in particular areas rather than others. These will however be those most likely to deliver health gain (as well as productivity).

9. Background papers

9.1. Report is attached

Annual Public Health Report 2013

Guidance on what delivers productivity in Integrated Care

Foreword

Dear Colleague

It is with pleasure that I introduce you to the first Public Health Report from the Director of Public Health following the move of the function to Essex County Council.

We as a public sector organisation along with our health and district and borough colleagues are facing a time of unprecedented austerity and we need to seek new ways of working together to ensure the best use of the limited resources that are entrusted to us. It is clear we need to do things differently but what we do needs where possible to be based on strong evidence of effectiveness and cost effectiveness.

There are opportunities for social care and health partners to work together to better secure improvements in the health and wellbeing of the population we both serve. There are opportunities for us to invest scarce resources together in new ways that will be both more productive and will help people remain independent and free from the need for hospital or residential care.

This year's report then focusses on what evidence exists around effective interventions that will help keep people out of hospital and residential care and will also yield savings somewhere in the system. Partners will then be able to agree together how jointly they can ensure that the total resource entrusted to us to help people is best used across Essex for the good of all we serve.

I hope you find it a useful document

Cllr Ann Naylor
Cabinet Member

Introduction

There is strong consensus that we as health and social care commissioners need to work together to achieve agreed common aims around improving outcomes for those we serve while managing an increasingly challenging financial environment. This has been embodied nationally in the call for "pioneer" pilots around integration and the plans to identify clear resources going forward to support this agenda.

The key areas of spend we need to address include social care costs arising from residential and nursing home admissions and unscheduled admissions to hospital. There is an increasing body of published literature (of variable standard) that might inform out investment and disinvestment decisions in this area but it is not well understood. The purpose of this report then is to summarise this growing body of work to help commissioners reach a common understanding of interventions likely to secure both outcome and productivity gains locally. Best evidence is from peer reviewed comparative trials with weaker evidence from other reports and studies including some local work.

Review of published literature suggests that there is generally more published and at a higher standard (using Randomised Control Trials [RCT's] methodologies and meta-analysis) of interventions to prevent hospital admissions. There is more limited evidence on what prevents social care admissions as this is not often a measured outcome in studies based around health interventions and a number of evaluations of social care interventions do not use RCT methodologies (some do).

There are however in all areas considerable gaps in knowledge but commissioners will want to be aware of and consider carefully what evidence there is before investing, or continuing to invest in a given service or intervention.

It is recognised that some of the interventions may already be in place but what commissioners will wish to consider is whether they are comprehensively, optimally and systematically available.

Financial Outcomes of Interventions

For now focusing exclusively on the financial implications (there will be additional quality considerations), it is perhaps worth outlining possible impacts. Investment in an intervention by EITHER health or social care might result in:-

- Net saving to health care, net saving to social care
- Net saving to health care, no impact on social care
- Net saving to social care, no impact on health care
- Net saving to health, net cost to social care, net system saving
- Net saving to social care, net cost to health, net system saving

- Net saving to health, net cost to social care, net cost to system
- Net saving to social care, net cost to health, net cost to system
- Net cost to health, no impact to social care

- Net cost to social care, no impact health
- Net cost to health, net cost to social care
- Net cost to social care, net cost to health

We need to consider where any intervention sits within this grouping. Clearly those in the first three lines should be pursued. The last four should not be pursued and where identified active disinvestment should be considered. The remaining middle four need much more consideration and a potential shift from historic thinking. Those delivering net system savings should be pursued and those net system cost abandoned if we are to develop an integrated approach to commissioning.

Linked to this, there will be the need to agree together how we can ensure system "win-wins" where potentially all gains from an approach would accrue to one part with a cost to the other. This could include ensuring a fair balance of suck initiatives in favour of both health and social care partners or agreements around sharing the savings accruing to one party with the other.

It should be emphasised that the above does not consider the merit of interventions in terms of health and wellbeing gains. There are many interventions that produce gains in these areas that have a net cost but remain laudable. A full discussion of these interventions is outside the scope of this report although the likely health gains or indeed evidence against health gain is included in some sections.

It is also beyond the scope of this report to look in detail at the relative cost effectiveness of different interventions i.e. which of two possible interventions deliver the outcome for the least cost.

Dr Mike Gogarty
Director of Public Health

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Overview of what works and what does not in key areas.

This report attempts to outline areas for consideration to help deliver efficiencies based on evidence. It does not look at current service costs, shape and quality were there may be further opportunities around procurement.

Key areas where efficiencies may be possible for ECC are:-

Reablement: Evidence base is fairly poor but what there is universally suggests savings are possible and level might be considerable

Multi-disciplinary Teams (MDT): Limited evidence is available but one study suggests potential reductions in residential care admissions from the approach but there is a need to consider cost and net gain.

Depression: There is reasonably strong evidence that depression is associated with residential care admission and that it is poorly recognised and undertreated in older people. There is also evidence that it can be well treated in older people. If this treatment can reduce the risk of residential home admission, managing depression would be a very cost effective intervention across the system.

Nurse Led Units: Metanalysis suggest a benefit in preventing residential care but this is less apparent when only stronger studies are considered.

Geriatricians: There is some evidence suggesting geriatrician led teams in the community can reduce residential home admissions.

Carers: Evidence suggests that day care, home care and (often) residential respite care are cost effective in reducing residential care needs.

Mental Health: School based social and emotional learning: is cost saving to social care and particularly to educational services from the first year onwards.

Assistive Technology: There is evidence telehealth initiatives might lead to social care savings.

Falls, Continence, Stroke and Alcohol: These all produce potential savings and have already been subject to a business case

Key areas where efficiencies may be possible for CCGs are:-

Ambulance Cars: There is a limited reviewed evidence and interventions were heterogeneous but what is available appear promising.

End of Life Care: There is evidence Marie Curie nurses are very effective at preventing hospital deaths and admissions.

Mental Health: Early intervention for psychosis: optimal implementation of early intervention in psychosis with multi-disciplinary teams adopting an assertive approach produces saving to health care.

Specialist/Targeted clinics: There is evidence around heart failure and secondary prevention of CHD (coronary heart disease) that systematic evidence based practice can reduce admissions.

Support for care homes: There is evidence that investment in care home support will prevent non elective admissions.

Geriatricians: The balance of evidence suggests geriatrician led teams in hospital at the interface and in the community can reduce hospital admissions.

SOS Buses: While based on local evidence and a relatively small cost/saving, SOS buses can impact on A&E costs and yield savings.

Assistive Technology: Telecare around falls prevention may save health costs but overall cost benefit needs to be considered.

Education and Self-Management:There is some evidence around the effectiveness of this in adults with asthma including education at A&E, and in people with COPD.

GP's in A&E: This may yield a fairly modest saving.

Alcohol, Continence and Falls: These all produce potential savings and have already been subject to a business case.

The notes below consider only potential savings and not the potential quality gains for the population that may derive from the interventions.

Key high profile areas that evidence suggests are unlikely to deliver efficiencies are:

MDTs in health: There is a large body of reviews and papers looking at the impact of a variety of MDT models (including virtual wards) on non-elective admission. In every case and model there is no reduction in non-elective admissions. Some may have a small positive effect on elective activity.

Social Isolation and Social care: There is no evidence addressing social isolation impacts on social care costs and very little that it would produce savings to CCGs.

Excess Winter Mortality: There is no evidence tackling this issue impacts on need for hospital services.

Assistive Technology - Telehealth: (e.g. remote monitoring of vital signs) has been shown in a number of high quality studies to reduce mortality among

users, however similarly strong evidence suggests it is unlikely to produce savings.

Walk in centres and NHS Direct: There are no evidence that either impact on A&E attendances

Key areas where good evidence is lacking either way:-

Ambulance Cars: There is little strong evidence around cost effectiveness for these.

Depression in Health: There is limited evidence that depression is linked (independently of morbidities) to acute admissions, suggesting the possibility of reducing admission through managing depression.

Carers: No evidence was found that carer interventions impact on hospital admissions or health costs.

Reablement: There is very little evidence reablement reduces hospital admissions.

Domestic Violence: There is a lack of robust evidence but what is available appears promising although outcomes are stronger for changes in attitude etc rather than recidivism.

Management of Dementia: Neither early diagnosis of dementia nor any intervention have an evidence base that would suggest savings to the health or social care budgets.

Rapid Response teams: There is a surprising lack of good quality information but some positive case studies.

Assistive Technology - Telecare: Robust evidence of the impact of Telecare (e.g. assisted living technologies) is lacking and the impact on costs and savings is thus difficult to assess.

Step Up Beds: There is no published evidence around the effectiveness of step up beds.

1. Alcohol Misuse

Alcohol misuse is one of the major population wide public health issues facing the UK and is the third most common cause of disability in the developed world after smoking and hypertension. Approximately 15,000 deaths in England are caused by alcohol per annum.[1]

The physical harm related to alcohol has been increasing in the UK in the past three decades. Deaths from alcoholic liver disease have doubled since 1980 compared with a decrease in many other European countries.[2] Alcohol related hospital admissions increased by 85% over the past decade.

1.1 Interventions that reduce health service demand

Harmful and dependent drinkers are much more likely to be frequent accident and emergency department attendees, attending on average five times per annum. Between 20 and 30% of medical admissions, and one third of primary care attendances, are alcohol related.[3][4][5] The following interventions have strong evidence of both effectiveness and cost saving:

Improving the effectiveness and capacity of specialist treatment: Each dependent drinker costs the health and social care system on average twice as much as other drinkers. The largest and most immediate reduction in alcohol-related admissions can be delivered by intervening with this group through the provision of specialist treatment. Models of care for alcohol misusers (MocaM)[6] describes a four tier system of stepped care for alcohol misusers. The Review of the effectiveness of treatment for alcohol problems provides the evidence base for effective treatments.[7] The UK Alcohol Treatment Trial (UKATT) shows that, over a 6-month period, specialist treatment delivered savings of nearly £1138 per dependent drinker treated with nearly 40% of drinkers showing a 'much improved' outcome (reduction in problem by 2/3 or more). The DH recommends a minimum of 15% of dependent drinkers are treated.

Alcohol Nurse Liaison Services in District General Hospitals: Evaluation studies in both Nottingham Universities Hospital Trust[8] and The Royal Liverpool Hospital[9] demonstrated that nurse led services that identify and target dependent drinkers accessing acute hospitals and facilitate their entry into specialist treatment services, reduce hospital admissions/readmissions and are cost effective. The Department of Health recommends adequate provision of Alcohol Liaison Nurse Services across all acute hospitals.[10]

Intervention and Brief Advice Services (IBA) in Primary Care, Accident and Emergency Departments and Specialist Outpatient Units (e.g. fracture clinics, sexual health services): There is a very large body of research evidence supporting IBA in primary care including at least 56 controlled trials.[11] A Cochrane collaboration review[12] provides substantial evidence for the effectiveness of IBA. The Department of Health commissioned research[13] describes how intervening with men aged over 35 who regularly drink over 50
units could reduce alcohol-related admissions nationally by 13,000 over three years; this group of drinkers is shown to contribute greatly towards alcohol-
related hospital admissions. The Alcohol Learning Centre Ready Reckoner identifies the Intervention and Brief Advice approach with patients drinking at hazardous or harmful levels to be highly cost effective and to return savings within a year.[14]

1.2 Interventions that reduce social care demand

Alcohol misuse is associated with increased social care demand. Alcohol is implicated in relationship breakdown, domestic violence and poor parenting, including child neglect and abuse. It is estimated that over 1 million children are affected by parental alcohol misuse and up to 60% of child protection cases involve alcohol.[15] Alcohol also contributes to unsafe sex and unplanned pregnancy, financial problems and homelessness. Up to half of homeless people are alcohol dependent.[16] According to the Laming Review of Child Protection, *"The issues of alcohol, domestic abuse, drugs and mental health come up again and again in serious case reviews"*. Alcohol misuse is also a key causal factor in dementia. Various studies have suggested the prevalence of alcohol-related dementia to be between 10 and 24% of all cases of dementia.[17] `Heavy alcohol use' was seen as a possible contributing factor in 21–24% of cases of dementia in a review of epidemiological, neurological, cognitive and imaging data.[18]

Improving the effectiveness and capacity of specialist treatment and Alcohol Nurse Liaison Services: (as described in the previous section) will all have a positive impact on reducing demand for social care. It has been estimated that a £1 investment in alcohol treatment and care delivers a £5 saving to criminal justice, social care and health budgets.[19]

1.3 Impact on patient / client care satisfaction

There is no evidence of a difference in patient satisfaction between home and hospital outpatients as a setting for alcohol withdrawal when treating dependent drinkers, but patients are generally more fearful of inpatient facilities because of their stigmatisation.[20] A 1990 study found 40% of patients were unwilling to undergo alcohol withdrawal in a psychiatric setting and 20% were unwilling to undergo withdrawal as a district general hospital inpatient.[21]
Patient satisfaction with outpatient assisted withdrawal services has been found to be high when administered as an intensive day programme.[22]

References

[1] Jones, L., Bellis, M. A., Dedman, D., et al. Alcohol Attributable Fractions for England: Alcohol Attributable Mortality and Hospital Admissions. 2008. Liverpool: North West Public Health Observatory.
[2] Leon, D. A. & McCambridge, J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. Lancet, 2006,367, 52–56.
[3] Coulton, S., Drummond, C., James, D., et al. Opportunistic screening for alcohol use disorders in primary care: comparative study. British Medical Journal, 2006, 332, 511–517.
[4] Kouimtsidis, C., Reynolds, M., Hunt, M., et al. Substance use in the general hospital. Addictive Behaviours, 2003,28, 483–499.
[5] Royal College of Physicians Alcohol: Can the NHS Afford It? 2001, London: Royal College of Physicians.
[6] Models of care for alcohol misusers (MocaM). Department of Health 2006.
[7] National Treatment agency (2006). Review of the effectiveness of treatment for alcohol problems. london: NTa
[8] Ryder, SD, Aithal, GP, Holmes, M, Burrows, M, Wright, NR. Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. Clinical Medicine 2010 Oct. 10 (5):435-40
[9] http://www.alcohollearningcentre.org.uk/LocalInitiatives/

[10]*Department of Health. Signs for improvement – commissioning interventions to reduce alcohol related harm, 2008.*
[11]*Moyer, A., Finney, J., Swearingen, C. and Vergun, P. Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations, Addiction, 2002, 97, 279–292.*
[12]*Kaner E, Beyer F, Dickinson H, Pienaar E, campbell F, Schlesinger c, Heather N, Saunders J, Bernand B. Brief interventions for excessive drinkers in primary health care settings. Cochrane Database of Systematic Reviews, 2007, Issue 2. art No.: cD004148 DoI: 10.1002/14651858.cD004148.pub3.*
[13] *Anderson P. The scale of alcohol-related harm. (unpublished), 2007, London: Department of Health*
[14]*http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109*
[15]*Prime Minister's Strategy Unit Strategy Unit Alcohol Harm Reduction Project Interim Analytic Report.2003, London: Cabinet Office.*
[16] *Gill, B., Meltzer, H., Hinds, K., et al. Psychiatric Morbidity among Homeless People. OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 7.1996, London: Her Majesty's Stationary Office.*
[17] *Smith JS, Kiloh LG. The investigation of dementia: results in 200 consecutive admissions. Lancet 1981; 1: 824-7.CrossRefMedline*
[18] *Smith, D.M. and Atkinson, R.M. Alcoholism and dementia. International Journal of Addiction 1995, Nov-Dec, 30(13-14):1843-69.*
[19]*UKATT, Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal; 2005, 331:544*
[20]*Allen, J., Copello, A. & Orford, J. Fear during alcohol detoxification: views from the clients' perspective. Journal of Health Psychology, 2005, 10, 503–510.*
[21] *Stockwell, T., Bolt, E., Milner, I., et al. Home detoxification for problem drinkers: acceptability to clients, relatives, general practitioners and outcome after 60 days. British Journal of Addiction, 1990, 85, 61–70.*
[22]*Strobbe, S., Brower, K. and Galen, L. Gender and Outpatient Detoxification from Alcohol. Journal of Addictions Nursing, 2003, Vol. 14, No.1. 19-25*

2. Continence Care

Incontinence can have a significant effect upon the quality of life of the individual concerned, causing an increased risk of urinary tract infections (UTIs), depression and social isolation. Incontinence may cause deterioration in the relationship between the individual and their family and/or carer as well as being a major contributory factor to falls and fractures.[1] It is also cited as the second highest cause of admission to residential care.[2] Therefore, the resource implications for Health and Social Care services are great.

The National Institute for Health and Clinical Effectiveness has published numerous guidelines relating to adult continence care - CG40,[3] CG49,[4] CG97[5] - and paediatric incontinence.[6] There is plenty of guidance about, but there are clear deficits in implementation.[7] Previous studies bemoan the lack of integration across acute, primary care, care homes and community settings, resulting in disjointed care for patients and their carers.[8]

The National Audit of Continence Care (2010)[9] audit found that "*although the amount of authoritative guidance is increasing, the quality of continence care remains variable and in some respects remains poor*". Subsequently an All-Party Parliamentary Group produced guidance to support the cost-effective commissioning of continence care.[10]

2.1 Integrated Continence Service ICS

Case studies from Nottingham and Oxford, were recently mentioned by the Department of Health.[11] Oxfordshire County Council worked in partnership with the Institute of Public Care on a study of the pathways of older people who had entered a care home. The aim of the research was to identify the critical characteristics, circumstances and events which led to a care home admission in order to provide appropriate services to prevent or delay such an admission.[12] An analysis of 115 admissions of people in 2008-9 was carried out to identify common characteristics. This was followed up with interviews of people who had entered a care home, their carers and care managers, to explore more fully the circumstances and experiences prior to entering a home. The study found that certain conditions and experiences were particularly prevalent - these included incontinence, dementia, falls and depression. Most people had been receiving social care support prior to entering the care home as well as informal care. However, despite common features, individual situations were both varied and complex.

In response, Oxfordshire County Council worked with the NHS to develop a co-ordinated integrated continence service. This led to the development of a holistic, targeted, outcomes-based service which aims to support people to become more independent and reverse a potentially inevitable course towards more costly and intensive care.

This development in Oxford was influenced by the Gwent NHS Trust's undertaking to transform its fragmented continence services into a fully integrated interdisciplinary service across primary and secondary care.[13] The service provides nurse-led first-line continence care to patients across a range of settings, avoiding inappropriate referrals and reducing waiting times for medical appointments.

This was achieved by capitalising on organisational changes and adopting a process of systematic change.

2.2 Impact of Adult Social Care Services

Incontinence is a major reason for the breakdown of the relationship between the carer and the person they are caring for. This can lead to admissions into residential or nursing home care.[14][15]

Studies in the US have shown that urinary infection increased the likelihood of care home referrals two-fold and faecal incontinence almost five-fold and 50% of care home residents with faecal incontinence have overflow from constipation which is a treatable condition.

Further studies have shown that use of pads in care homes increases the risk of UTIs significantly. In a recent study of 153 residents, 118 (77%) used absorbent pads. Residents who used absorbent pads were at significantly increased risk of developing UTIs compared to residents who did not use pads (41% vs. 11%; P = 0.001) (Omli 2010). The advice is that care staff should be educated in encouraging residents to drink fluids as well as regularly reminding them of the need to use the toilet.

2.3 Incontinence in Residential Care Setting - Dementia

A large Italian study in a cohort of nursing and home residents identified that of those persons who were immobile, more than 82% were also incontinent of urine.[16] Further studies have highlighted the challenges of managing incontinence in people with dementia in residential care, as the general perception is that incontinence is managed by the use of pads and treatment is not discussed, which can have detrimental effects on the patient.

Management techniques for incontinence need to be developed to ensure that people with dementia receive the best care, as current methods such as behavioural techniques may not be appropriate for people with limited cognitive function.[17][18]

Nurses have an important role in incontinence treatment and can change this misuse of incontinence pads and ensure a holistic approach to care that will help when treating a patient with dementia.[19]

2.4 Incontinence and Risk of Falling

Falling and urinary incontinence were found to be associated with physical limitations and had an impact on quality of life. A cross-sectional postal questionnaire (5,474 people aged 70 years or more living in the community randomly selected) undertaken in the Leicestershire Medical Research Council Incontinence Study found this link to be statistically significant (P<0.0001).[1]

A systematic review and meta-analysis of observational studies (Odds ratio from 9 studies were included) investigating falls and urinary incontinence found that urge urinary incontinence, but not stress urinary incontinence, is associated with a modest increase in falls and should be an integral part of the local falls prevention program.[20]

2.5 Staff Training and Self-care

Education, or the lack of it, is highlighted as being inadequate.[7][8][9][10] Studies report that structured training in continence care occurs in less than 50% of acute hospitals and mental health care sites, with staff suggesting that there is no dedicated time to attend study days and access to fewer validated courses. A good session should include an introduction to understanding the different types of urinary incontinence, the

causes of incontinence and the strategies and good practice to enable service users to manage the condition, including elements of catheter and stoma care.
Translation of knowledge is key to change. Patient empowerment and self-reported outcomes should be the centre of building continence services as it has been shown that involvement in goal-setting, self-management and decision making will improve outcomes.

References

(1) Foley AL, et al (2012) Association between the Geriatric Giants of urinary incontinence and falls in older people using data from the Leicestershire MRC Incontinence Study. Age Ageing Jan;41(1):35-40
(2) DoH (2001) National Service Framework for Older People, Department of Health, HMSO, London.
(3) NICE (2006) Urinary incontinence in women (Clinical guideline 40). National Institute of Clinical and Healthcare Excellence, RCOG Press London.
(4) NICE (2006) Faecal incontinence (Clinical Guideline 49). National Institute of Clinical and Healthcare Excellence, RCS London.
(5) NICE (2010) Lower urinary tract symptoms: The management of lower urinary tract symptoms in men (Clinical Guideline 97). National Institute of Clinical and Healthcare Excellence, National Collaborating Centre for Acute and Chronic Conditions, Manchester.
(6) DH (2010) Paediatric Continence Service - Commissioning guide. HMSO, London.
(7) Wagg A, et al (2008). Overactive Bladder and Continence Guidelines: implementation, inaction or frustration? International J Clinical Practice 62:1588-93.
(8) McClurg D. (2010) Why are we still doing so badly in treating incontinence? Nursing Times Sept 21-27;106(37):10.
(9) Wagg A, et al (2010) National Audit of Continence Care for Older People. Royal College of Physicians, London.
(10) APPG (2011). Cost-Effective Commissioning For Continence Care. All Party Parliamentary Group For Continence Care Report, http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf
(11) DH (2011) Prevention And Early Intervention Continence Services – Health and Social Care Partnership. http://www.essexinsight.org.uk/Resource.aspx?ResourceID=721
(12) Taylor R, Cairncross L, Livadeas S (2010) Transforming Continence Services in Oxfordshire through Partnership – Case Study. Research, Policy and Planning 28(2):91-102.
(13) Logan K, Procter S (2003) Developing an interdisciplinary integrated continence service. Nursing Times 99(21): 34–37.
(14) Thom DH, et al (1997) Medically recognized urinary incontinence and risks of hospitalization, nursing home admission and mortality. Age and Ageing 26(5):367-374.
(15) Dept of Health & Ageing (2012) Incidence of Incontinence as a Factor in Admission to Aged Care Homes. National Continence Management Strategy,

Australia.
(16) Aggazzotti G, et al (2000). Prevalence of urinary incontinence among institutionalised patients: a cross sectional epidemiological study in a mid sized city in N.Italy. Urology 56:245-249.
(17) Omli R, et al (2010) Pad per day usage, urinary incontinence and urinary tract infections in nursing home residents. Age Ageing 39(5): 549-554.
(18) Hagglund D (2010) A systematic literature review of incontinence care for persons with dementia: the research evidence. J Clinical Nursing Feb;19(3-4):303-12.
(19) Price H (2011) Incontinence in patients with dementia. British Journal of Nursing Jun 24-Jul 7 ;20(12):721-5.
(20) Chiarelli PE, Mackenzie LA, Osmotherly PG (2009) Urinary incontinence is associated with an increase in falls: a systematic review. Australian J Physiotherapy 55(2):89-95.

3 Falls prevention

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK.[1] Each year, a third of the population aged over 65 has a fall, and half of these people fall at least twice.[2] Annually, over 500,000 older people attend UK Accident & Emergency departments following a fall.[3] The financial impact of falls and fractures on the NHS & Social Care is significant, incurring the use of a range of health and social care resources and interventions

3.1 Interventions that reduce health service demand

Evidence for the following statements is taken from NICE Clinical Guidance CG161.[4]

Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s and considered for their ability to benefit from interventions to improve strength and balance.

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal

3.2 Additional recommendations for older people who are admitted to hospital

The following groups of inpatients are regarded as being at risk of falling in hospital

- all patients aged 65 years or older
- patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition

Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed. Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

3.3 Interventions that cannot be recommended

There is no evidence that brisk walking reduces the risk of falling. There is no evidence that low intensity exercise interventions combined with continence promotion programmes reduce the incidence of falls in older people in extended care settings. Exercise in groups should not be discouraged as a means of health promotion, but there is little evidence that exercise interventions that were not individually prescribed for older people living in the community are effective in falls prevention.

There is no evidence that cognitive/behavioural interventions alone reduce the incidence of falls in older people living in the community who are of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions. There is no evidence that referral for correction of vision as a single intervention for older people living in the community is effective in reducing the number of people falling. Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation. There is some evidence that hip protectors are effective in older people living in extended care settings who are considered at high risk but not those living in their home or low risk in extended care settings.

3.4 Interventions that reduce social care demand

The emotional toll of falling can be as bad as the physical as it can destroy confidence and trigger a vicious circle of nervousness that stops people going out, this increases isolation and reduces independence – making both physical and mental conditions worsen. Falls can result in prematurely entering long term care. In an Essex County Council , Adult Social Care Client file audit, it was found that a 'history of falls' was given as a reason for admission into residential care by 66% of older people.[5] All of the interventions above stated to reduce health service demand will also reduce social care demand.

There is evidence that an increased prevalence of falls is related to hazards within the home with accidents happening on stairs and steps,[6] and measures to reduce accidents by reducing environmental hazards are part the Department of Health systematic approach to falls and fracture care.[7] A recent review[8] concluded that home modification in the absence of other intervention approaches may be effective for persons with a history of falling but is likely to be most effective when integrated into a multi-faceted intervention programme focussing on education, exercise and nutritional

status.

There is not conclusive evidence that addressing home hazards alone eg poorly maintained stairways, poor lighting, trip hazards and the lack of safety devises such as grab rails, will reduce falls and fractures. However, these hazards should be addressed using professionally prescribed environmental assessment and modification.[2]

3.5 Impact on patient / client care satisfaction

Healthcare professionals involved in the assessment and prevention of falls should discuss what changes a person is willing to make to prevent falls. Information should be relevant and available in languages other than English. Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling, and encourage activity change as negotiated with the participant. Further barriers and facilitators are listed in the NICE guidance.[9]

References

[1] *Age UK Stop Falling, start saving lives and money.* http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/Stop_falling_report_web.pdf?dtrk=true *[accessed 26/9/13]*

[2] *Department of Health Falls & Fractures: effective interventions in health & social care. 2009*

[3] *Royal College of Physicans, National audit of falls and bone health in older people. 2011* http://www.rcplondon.ac.uk/resources/national-audit-falls-and-bone-health-older-people

[4] *National Institute of Clinical Excellence The assessment and prevention of falls in older people CG161, June 2013* http://www.nice.org.uk/CG161 *[accessed 26/9/13]*

[5] *Essex County Council - Adult Social Care, Acute Pathway Review 2012*

[6] *Department of Health, Hospital to Home discharge pack, 2012* http://housinglin.org.uk/hospital2home_pack/ *[accessed 26/9/13]*

[7] *Age UK Breaking Through: Building Better Falls & Fracture Services in England. 2012* http://www.ageuk.org.uk/PageFiles/22486/Article/breaking_through_building_better_falls_and_fracture_services_in_england_2012.pdf?dtrk=true *[accessed 26/9/13]*

[8] *Corinne Peek-Asa & Craig Zwerling – Epidemil Rev 2003;25:77-89*

[9] *National Institute of Clinical Excellence CG161 Falls Full Guidance* http://www.nice.org.uk/nicemedia/live/14181/64166/64166.pdf *[accessed 26/9/13]*

4. Dementia

Dementia is the loss of cognitive function which can include memory loss, language difficulties and psychiatric changes. The commonest cause of dementia is Alzheimer's disease (about 50% of cases) followed by vascular dementia (about 25%), mixed dementia, Lewy body dementia (15%) and all other types (about 5%).

Prevalence increases sharply with age but recent work has shown that the risk of developing dementia has decreased in the last 20 years.[1] The increase in people living with dementia that would have been expected as a result of the aging population will be offset to a significant degree by this reduction in risk.

4.1 Interventions that reduce health service demand

There is no good evidence that any intervention for the prevention or treatment of dementia reduces the risk of admission to hospital or residential care.

With regard to prevention there is as yet no good evidence that dietary supplements such as B6, B12,[2] folate,[3] thiamine,[4] vitamin E,[5] omega 3[6] or ginkgo biloba[7] are of any benefit. There is no good evidence as yet that aspirin,[8][9] blood pressure reduction,[10] Statins[11][12] or hormone replacement therapy[13] are useful in the prevention or slow the progression of dementia.

There is some evidence that anti-cholinesterase inhibitors and memantine may delay the time to institutionalisation for patients with Alzheimer's disease.[14] This evidence has not been synthesised in a good quality systematic review. The degree of any delay in institutionalisation remains speculative.

Of the non-pharmacological interventions functional analysis,[15] cognitive stimulation,[16] reminiscence therapy[17] show promise but their effectiveness is still to be confirmed by research studies of adequate size and quality. Cognitive reframing, a cognitive approach focused on changing the carer's view of the condition, has been shown to decrease carers psychological morbidity and stress but does not improve coping or reduce the subjective burden of caring.[18] Respite care for carers has not been adequately researched to know if it improves burden of care or delays in institutionalisation[19] even though both would seem probable.

There is no strong evidence to show that special care units improve the outcomes for patients with dementia and behaviour symptoms.[20] Similarly there is insufficient evidence to recommend physical activity,[21] music therapy,[22] aromatherapy,[23] homeopathy,[24] massage[25] or acupuncture.[26]
There is insufficient evidence that early diagnosis of dementia leads to improved outcomes for either the person with dementia or their carers.[27][28] In the light of this the national and local policy of encouraging early detection is not support by evidence of effectiveness. It may be more sensible to focus on the quality of care of those diagnosed with dementia rather than early detection.

4.2 Interventions that reduce social care demand

A systematic review of case management of dementia patients found that three out of six good quality trials found a delay/reduced institutionalisation and one additional that found a significant delay in a subgroup (in one country of the three studied).[29]

4.3 Impact on patient /client care satisfaction

There is limited good quality data on which interventions provide the best outcomes for patients with dementia and their carers. The use of anti-psychotic medication in patients with dementia has been shown to result in increased mortality.[30] The avoidance of this class of medication and the use of non-pharmaceutical means of controlling distressing or potentially harmful behaviour has been advocated.[14][31]

In the absence of an adequate research evidence base it is pragmatic to follow expert opinion. This is set out in the NICE guidance. This gives guidance on:

- the care of patients with dementia (non-discrimination and valid consent)
- carers (assessment and support)
- coordination and integration of services (health and social care)
- memory services
- structural imagining services
- behavioural management
- training (of those in health, social care and voluntary sectors)
- acute hospital care

References

[1] *Matthews FE, Arthur A, Barnes LE, Bond J, Jagger C, Robinson L, Brayne C. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II The Lancet, 17 July 2013 doi:10.1016/S0140-6736(13)61570-6*

[2] *Malouf R, Grimley Evans J. Vitamin B6 for cognition. Cochrane Database of Systematic Reviews 2003 (updated 2008), Issue 4. DOI: 10.1002/14651858.CD004393*

[3] *Malouf R, Grimley Evans J. Folic acid with or without vitamin B12 for the prevention and treatment of healthy elderly and demented people. Cochrane Database of Systematic Reviews 2008, Issue 4. DOI: 10.1002/14651858.CD004514.pub2*

[4] *Rodríguez JL, Qizilbash N, López-Arrieta J. Thiamine for Alzheimer's disease. Cochrane Database of Systematic Reviews 2001, DOI: 10.1002/14651858.CD001498*

[5] *Farina N, IsaacMGEKN, Clark AR, Rusted J, Tabet N. Vitamin E for Alzheimer's dementia and mild cognitive impairment. Cochrane Database of Systematic Reviews 2012, Issue 11, DOI: 10.1002/14651858.CD002854.pub3*

[6] *Sydenham E, Dangour AD, Lim WS. Omega 3 fatty acid for the prevention of cognitive decline and dementia. Cochrane Database of Systematic Reviews 2012, Issue 6. DOI:0.1002/14651858.CD005379.pub3*

[7] *Birks J, Grimley Evans J. Ginkgo biloba for cognitive impairment and dementia. Cochrane Database of Systematic Reviews 2009, Issue 1. DOI: 10.1002/14651858.CD003120.pub3*

[8] *Jaturapatporn D, Isaac MGEKN, McCleery J, Tabet N. Aspirin, steroidal and non-steroidal anti-inflammatory drugs for the treatment of Alzheimer's disease. Cochrane Database of Systematic Reviews 2012, Issue 2. DOI: 10.1002/14651858.CD006378.pub2*

[9] *Rands G, Orrell M. Aspirin for vascular dementia. Cochrane Database of Systematic Reviews 2000, Issue 4. DOI: 10.1002/14651858.CD001296*

[10] *McGuinness B, Todd S, Passmore P, Bullock R. Blood pressure lowering in patients without prior cerebrovascular disease for prevention of cognitive impairment and dementia. Cochrane Database of Systematic Reviews 2009, Issue 4. DOI: 10.1002/14651858.CD004034.pub3*

[11] *McGuinness B, Craig D, Bullock R, Passmore P. Statins for the prevention of dementia. Cochrane Database of Systematic Reviews 2009, Issue 2. DOI: 10.1002/14651858.CD003160.pub2*

[12] McGuinness B, O'Hare J, Craig D, Bullock R, Malouf R, Passmore P. Statins for the treatment of dementia. Cochrane Database of Systematic Reviews 2010, Issue 8. DOI: 10.1002/14651858.CD007514.pub2
[13] Hogervorst E, Yaffe K, Richards M, Huppert FAH. Hormone replacement therapy to maintain cognitive function in women with dementia. Cochrane Database of Systematic Reviews 2009, Issue 1. DOI: 10.1002/14651858.CD003799.pub2
[14] NICE technology appraisal guidance 217: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease NICE 2011, http://www.nice.org.uk/nicemedia/live/13419/53619/53619.pdf
[15] Moniz Cook ED, Swift K, James I, Malouf R, De Vugt M, Verhey F. Functional analysis-based interventions for challenging behaviour in dementia. Cochrane Database of Systematic Reviews 2012, Issue 2. DOI: 10.1002/14651858.CD006929.pub2
[16] Woods B, Aguirre E, Spector AE,OrrellM. Cognitive stimulation to improve cognitive functioning in people with dementia. Cochrane Database of Systematic Reviews 2012, Issue 2. DOI: 10.1002/14651858.CD005562.pub2
[17] Woods B, Spector AE, Jones CA, OrrellM, Davies SP. Reminiscence therapy for dementia. Cochrane Database of Systematic Reviews 2005, Issue 2. DOI: 10.1002/14651858.CD001120.pub2
[18] Vernooij-Dassen M, Draskovic I, McCleery J, Downs M. Cognitive reframing for carers of people with dementia. Cochrane Database of Systematic Reviews 2011, Issue 11. DOI: 10.1002/14651858.CD005318.pub2
[19] Lee H, CameronMH. Respite care for people with dementia and their carers. Cochrane Database of Systematic Reviews 2004, Issue 1. DOI: 10.1002/14651858.CD004396.pub2
[20] Lai CKY, Yeung JHM, Mok V, Chi I. Special care units for dementia individuals with behavioural problems. Cochrane Database of Systematic Reviews 2009, Issue 4. DOI: 10.1002/14651858.CD006470.pub2
[21] Forbes D, Forbes S,Morgan DG, Markle-Reid M,Wood J, Culum I. Physical activity programs for persons with dementia. Cochrane Database of Systematic Reviews 2008, Issue 3. DOI: 10.1002/14651858.CD006489.pub2
[22] Vink AC, Bruinsma MS, Scholten RJPM. Music therapy for people with dementia. Cochrane Database of Systematic Reviews 2003, Issue 4. DOI: 10.1002/14651858.CD003477.pub2
[23] Holt FE, Birks TPH, Thorgrimsen LM, Spector AE, Wiles A, Orrell M. Aroma therapy for dementia. Cochrane Database of Systematic Reviews 2003, Issue 3. DOI: 10.1002/14651858.CD003150
[24] McCarney RW, Warner J, Fisher P, van Haselen R. Homeopathy for dementia. Cochrane Database of Systematic Reviews 2003, Issue 1. DOI: 10.1002/14651858.CD003803
[25] Hansen NV, Jørgensen T, Ørtenblad L. Massage and touch for dementia. Cochrane Database of Systematic Reviews 2006, Issue 4. DOI: 10.1002/14651858.CD004989.pub2
[26] Peng W, Wang Y, Zhang Y, Liang CM. Acupuncture for vascular dementia. Cochrane Database of Systematic Reviews 2007, Issue 2. DOI: 10.1002/14651858.CD004987.pub2
[27] Prince M, Bryce R, Ferri C. World Alzheimer report 2011: the benefits of early diagnosis and intervention. London (UK): Alzheimer's Disease International (ADI); 2011 National Guideline Clearinghouse (NGC) http://www.guideline.gov/content.aspx?f=rss&id=39435 accessed 8/31/2013
[28] There is no evidence base for proposed dementia screening BMJ 2012; 345 doi: http://dx.doi.org/10.1136/bmj.e8588 (Published 27 December 2012)
[29] [PIMOUGUET C, LAVAUD T, DARTIGUES JF, HELMER C. The Journal of Nutrition, Health & Aging (2010); 14(8):669-676]
[30] Schneider LS, Dagerman KS, Insel P. Risk of Death With Atypical Antipsychotic Drug Treatment for Dementia: Meta-analysis of Randomized Placebo-Controlled Trials JAMA. 2005;294(15):1934-1943. doi:10.1001/jama.294.15.1934
[31] Declercq T, Petrovic M, Azermai M, Vander Stichele R, De Sutter AIM, van Driel ML, Christiaens T. Withdrawal versus continuation of chronic antipsychotic drugs for behavioural and psychological symptoms in older people with dementia. Cochrane Database of Systematic Reviews 2013, Issue 3. DOI: 10.1002/14651858.CD007726.pub2

5. Excess Seasonal Mortality

There is no doubt England suffers large numbers of seasonal excess deaths each year largely amongst older people. These levels are not seen in a number of other Northern European countries and cold indoor temperatures are strongly implicated. The Health Inequalities National Support Team (HINST)[1] developed a guideline "How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level".in 2010.While the approach is laudable, the evidence base underlying the proposals is uncertain.

There is increasing recognition that in addition to mortality there are impacts of cold temperature on a wide range of physical and indeed mental health outcomes.

The two key focused interventions directed at reducing health impacts:-

5.1 Housing Interventions to address cold

Interventions include the evaluation of "Warm Front" and similar initiatives internationally. A review by Liddell and Morris[2] looks at the recent evidence.

They concluded based on the most robust studies, effects on the physical health of adults are modest, while caregivers and children perceive positive impacts on children's respiratory health. There was a positive effect on levels of anxiety and depression in adults and the studies were not powered to look at impact on mortality. It is unlikely based on these studies that implementing "Warm Front" and similar initiatives, while entirely laudable and appropriate will have an impact on hospital admissions.

5.2 Seasonal Immunisation

Jefferson (2010)[3] reviewed evidence around the impact of seasonal influenza vaccination in people over 65 and looked at nine RCTs. He concluded that available evidence was of poor quality and provided little guidance on outcomes including unplanned hospital admissions.
A Cochrane review[4] looked at influenza vaccination in children and adults with asthma and found vaccination had no effect on hospital admissions. The same was true of studies looking at vaccination of people with COPD with no apparent impact on hospital admissions.

References

[1] Roche T., How to Reduce the Risk of Seasonal Excess Deaths Systematically in Vulnerable Older People to Impact at Population Level Health Inequalities National Support Team 2010
[2] Liddell C.,Morris C. Fuel Poverty and Health: A Review of Recent Evidence. Energy Policy 38 (2010) 2987-2997
[3] Jefferson T, Di Pietrantonj C, Al-Ansary LA et al. Vaccines for preventing influenza in the elderly. Cochrane Database Syst Rev 2010 Feb 17; (2):CD004876.
[4] Jefferson T, Rivetti A, Harnden A et al. Vaccines for preventing influenza in healthy children. Cochrane Database Syst Rev 2008 Apr 16; (2):CD004879.

6. Carers

This section draws very heavily from “The effectiveness and cost effectiveness of support and services to informal carers of older people”, A review of the literature prepared for the Audit Commission by Linda Pickard at the PSSRU and published in 2003.

This literature review has looked at the evidence for the effectiveness and cost effectiveness of the following types of support and services of potential benefit to informal carers: day care, in-home respite care, institutional respite care, carer support groups, social work and counselling, the home help/care service and multidimensional approaches. Other services of potential value to carers, including meals on-wheels and community nursing, were not included.

6.1 Effectiveness of services: Outcomes for carers

There is evidence to suggest that the following forms of support and services can be effective in reducing the negative psychological effects of caring for carers and therefore have some positive outcomes for carers:

- day care;
- home help/care;
- institutional respite care; and
- social work/counselling.

6.2 Effectiveness of services: Effects on user’s admission to institutional care.

There is evidence to suggest that the following forms of support and services can be effective in delaying admissions to institutional care:

• daycare;
• home help/care; and
• institutional respite care (though see conditions below).

Conditions: Institutional respite care can increase the probability of admissions to institutional care for some carers. This well-established relationship was also found in a community care study of England and Wales in the mid-1990s.

The ECCEP study (Davies and Fernandez 2000) found that provision of institutional respite care increased the length of time spent by the older person in the community in some cases (for example, carers of older people with behavioural problems), but decreased it in others (in particular, those with
‘bad user-carer relationships’ and more reliant older people).

6.3 Effectiveness of services: Impact on older people

There is evidence to suggest that older people may feel *ambivalent* about using the following forms of support and services:
• daycare (see conditions below); and
• institutional respite care.

Conditions: Large amounts of daycare (beyond about 2 days a week) are associated with reductions in user satisfaction with services.

Many older people do not want institutional respite care, because they do not want to go into an institution, however temporarily.

6.4 Insufficient evidence to evaluate effectiveness

There was one service, in-home respite care, about which there was insufficient evidence to evaluate effectiveness. The lack of evidence about in-home respite care was unfortunate because this is a form of service that older people and carers particularly value and for which there are expressed unmet needs.

6.5 No evidence of effectiveness

There was also one service, carer support groups, about which no evidence of effectiveness could be found. However, the literature suggests that support groups are valued by those who attend.

6.6 Cost-effectiveness

Cost- effectiveness of services -Outcomes for carers: There is evidence to suggest that the following forms of support and services can be cost-effective in reducing the negative psychological effects of caring for carers:-
- day care;
- institutional respite care; and
- social work/counselling.

Cost- effectiveness of services:- Effects on user's admission to institutional care: There is evidence to suggest that the following forms of support and services can be cost-effective in delaying admissions to institutional care:
- day care;
- home care; and
- institutional respite care.

Cost effectiveness of services – savings to health care systems: While Carers are a high risk group themselves for a range if adverse health conditions and their support is important, there was no evidence found around the impact on carer interventions on the use of hospital services for either the carer or the person they were caring for.

7. Depression

7.1 Impact on Residential Care

The audit of prevalent conditions in people in Essex residential homes in 2012 showed 25% suffered from depression. We would expect the prevalence in the general population aged over 65 to be around 9%.

Onder et al[1] in 2007 published a study assessing the effect of depression on the risk of nursing home admission in a group of older adults receiving home care across eleven European countries. They studied over 2,700 people with an average age of 82. Groups were matched for comorbidities. They found 12% of the group were depressed. They found that after a year, 14.8% of those with depression and 10.6% of those without had been admitted to residential care suggesting a 42% increased risk. The risk of nursing home admission progressively and significantly increased as the MDS Depression Rating Scale score increased (signifying more severe depression).

Similarly Ahmed et al[2] looked at people who had suffered a cardiac event in the United States and followed them to see whether their having additional depression impacted on their needing nursing home admission. These patients had a mean age of 77 years and 61% were women. Groups were matched for comorbidities. Compared with 9% non-depressed patients, 13% of depressed patients were admitted to nursing homes, again a 42% increased risk.

This suggests depression is a predisposing factor to residential care admission and opens the possibility, if appropriately managed, admissions could be avoided. A clinical review in the BMJ in 2011 by Rodda et al[3] details issues around diagnosis and management in older people. They state most depressive episodes in late life will be a recurrence rather than a first ever episode and the increased female to male ratio is in line with that in younger adults. Prevalence rates of depression are increased in brain disorders including dementia, Parkinson's disease, and stroke, and also in systemic disease, for example diabetes mellitus and cardiovascular disease. Prevalence estimates for depression in Alzheimer's disease cluster around 30% but range from 0% to 86%, reflecting the difficulty associated with definition and diagnosis of depression in dementia. Rates are also increased by a variety of social factors including isolation, being a carer, loss of social role, financial pressures and bereavement.

Mild depression will often respond to supportive treatments including exercise and 50% may improve. More severe cases respond to drug treatments. Evidence suggests a number needed to treat (NNT) of around 4 for selective serotonin reuptake inhibitors (SSRIs) and the British National Formulary (BNF) suggests average drug costs per year for older people of around £40. Clearly there will be other costs including opportunity costs in primary care and side effects from treatments but best practice in terms of identifying and managing depression in older people is likely to both improve the health of

those we serve and deliver reduced demand for social care.

If we assume as in studies above an absolute difference in admission rates between those with and without depression of 4% (14 -10%) and a NNT to manage depression of

4, the NNT to prevent a residential care admission is 100. This would mean an increased drug cost of £4000 to prevent an admission (over a year). Savings to social care would be around £20,000 for the first year rising to over £40,000 at steady state.

7.2 Impact on Hospital Admissions

Miu and Chan 4[4] looked at people attending a geriatric outpatients in Hong Kong and looked at previously unrecognised depression along with comorbidities. They found depressed subjects had an increased risk of hospital admission (odds ratio =2.67, 95%, confidence interval = 1.1, 2.12). They did not consider the benefit of intervention. Of note this smaller study found no difference in levels of residential home admission at a year.

References

[1] Onder G, Liperoti R, Soldato M, Cipriani MC, Bernabei R, Landi F. Depression and risk of nursing home admission among older adults in home care in Europe: results from the Aged in Home Care (AdHOC) study. J Clin Psychiatry. 2007 Sep;68(9):1392-8

[2] Ahmed, A Lefante C.M., Alam N. Depression and Nursing Home Admission Among Hospitalized Older Adults with Coronary Artery Disease: A Propensity Score Analysis Am J Geriatr Cardiol. 2007 Mar–Apr; 16(2): 76–83.

[3] Rodda J., Walker Z.,Carter J., Clinical Review Depression in Older Adults BMJ 2011;343:d5219

[4] Miu DK,Chan CK., Prognostic value of depressive symptoms on mortality, morbidity and nursing home admission in older people. Geriatrics & gerontology international, 04 2011, vol./is. 11/2(174-9), 1447-0594;1447-0594 (2011 Apr)

8. Social Isolation

Cattan et al[1] undertook a robust review of interventions to prevent loneliness in 2005. The results are well summarised by the DARE group in York:-
Thirty studies, with over 6,556 participants, were included in the review. Of these, 16 were randomised controlled trials (RCTs) and 10 were non-randomised controlled trials.

8.1 Effective Interventions

Group activities with an educational input: five of the nine group interventions with an educational input demonstrated a significant reduction in loneliness. Two studies demonstrated that a structured approach to physical activity decreased loneliness.

Group interventions providing social support: a social activation programme in a senior citizens' apartment building, bereavement support for recently widowed older people, therapy-type discussion groups for older people with mental health problems, and peer- and professionally-led counselling or discussion groups for adult daughters and daughters-in-law who were primary carers, all reported a significant reduction in loneliness or social isolation.
One-to-one interventions: the majority of one-to-one interventions did not show a significant effect in reducing social isolation and/or loneliness.

Home visits to provide assessment, information or provision of services: the only study in this category to demonstrate a significant reduction in social isolation and loneliness was a one-off home visit by a nurse to patients aged 75 years or more, which included a health assessment, advice, written health information and referrals if required.

Effective interventions shared several characteristics: they were group interventions with a focused educational input, or they provided targeted support activities; they targeted specific groups; they stated that the experimental sample was representative of the intended target group; they enabled some level of participant and/or facilitator control or consulted with the intended target group before the intervention; they evaluated an existing service or activity or were developed and conducted within an existing service; the participants were identified from agency lists, obituaries or mass-media solicitation; they included some form of process evaluation and their quality was judged to be high. Physical activity interventions were also effective.

8.2 In-effective Interventions

Home visits to provide assessment, information or provision of services: Three other RCTs did not show a significant effect in reducing social isolation and/or loneliness.

Home visits or telephone contact to provide directed support or problem-solving: the four studies that investigated the effectiveness of directed support
and problem-solving did not show a significant effect in reducing social isolation and/or loneliness.

Social support in one-to-one interventions: the two studies that investigated one-to-one social support did not show a significant effect in reducing social isolation and/or loneliness.

Ineffective interventions shared one characteristic, they were one-to-one activities conducted in people's own homes.

8.3 Discussion

The work at first does not seem entirely in line with the SCIE report by Windle et al[2] published in 2011. They suggest more merit in one to one approaches in addressing both loneliness and health measures including depression. Review of some of their key references suggests that the studies referenced were not exclusively looking at older people and social isolation eg Mead et al[3] paper “Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis” looks at intervention in a range of age groups and in fact the interventions were in general less successful in older people.

8.4 Cost Effectiveness

There is little evidence that there are cost savings to healthcare through these interventions and no evidence around savings to social care. Knapp et al[4] work on modelling costs “Building community capacity: making an economic case” is cited in the SCIE work and looks at time banks, befriending schemes and Community Navigator schemes. The savings proposed in the modelled approach do not in the main however apply to older people and would not accrue to the local authority (much are around impact on employment) Cohen et al[5] suggested fewer GP visits following a group based programme and Pitkala et al,[6] a marked reduction in “days in primary hospital” following a group based programme in Finland with lesser reductions in “ days in secondary hospital, and physician visits” and a slight increase in “ambulatory visits to secondary hospitals”. The savings to health at average 943 euros exceeded average costs of 881 euros but it is unlikely the saving could be translated into real savings (or demand reduction) in the CCGs.

The Pitkala study of note suggested a positive impact on mortality with 97% of the intervention versus a statistically significantly lower 90% of the control group alive at follow up.

References

[1] Cattan, M. et al. (2005) 'Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions', Ageing and Society, vol 25, no 1, pp 41−67.

[2] Windle K., Francis J. Coomber C. Preventing loneliness and social isolation: interventions and outcomes SCIE 2011, Research Briefing 39

[3] Mead, N. et al. (2010) 'Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis' British Journal of Psychiatry, vol 196, no 2, pp 96−100.

[4] Knapp, M. et al. (2010) Building community capacity: making an economic case, PSSRU Discussion Paper 2772, London: PSSRU

[5] Cohen, G.D. et al. (2006) 'The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults', The Gerontologist, vol 46, no 6, pp 726−734

[6] *Pitkala, K.H. et al. (2009) 'Effects of pyschosocial group rehabiliation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomised, controlled trial', Journal of Gerontolgy: Medical Sciences, vol 64A, no 7, pp 792−800*

9. Mental Health

Mental health conditions cover a range of disorders including depression, anxiety, schizophrenia and eating disorders. Dementia and substance misuse which are managed as mental health disorders are considered separately.

Approximately 11% of the NHS secondary care budget is spent on mental health (Department of Health data).

9.1 Interventions that reduce health service demand

In two related reviews of mental health services the King's Fund identified a number of interventions that would be expected to reduce demand of health services.[1][2] Together these reviews looked at efficiencies that could be made within the mental health services and from the integration of mental health care within chronic disease management.

9.2 Interventions recommended for integrating mental health provision with chronic disease management

Patients with mental health conditions are at increased risk of chronic physical illness and those having a chronic physical illness are at increased risk of mental health disorders. An estimated 30% of those with long term physical health conditions have mental health problems.[3]

There is evidence but it is currently too weak, to recommend improved and integrated access to psychological therapies as a way of reducing health costs and improve patient outcomes in chronic disease management.[4][5][6]

9.3 Interventions recommended for mental health services

An economic evaluation of preventive mental health initiatives and mental health promotion found that early intervention in psychosis saves over £5 within one year to the NHS for every £1 spent on the intervention.[7] This requires a multidisciplinary team that maintains contact through an assertive approach and encourages a return to normal vocational pursuits. The same evaluation found that over 2 to 5 years prevention of conduct disorder through social and emotional learning programmes delivered in schools could save the NHS over £5 and other public sector organisations over £9 for every £1 expended.

Strengthening of Crisis Resolution and Home Treatment (CRHT): These services, set up nationwide as part of the national service framework for mental health, have been shown to decrease unplanned admissions. A report from the National Audit Office in 2007 found that the quality of CRHT is variable.

Integrating acute care teams: Arranging for CRHT and other community teams to work together with inpatient staff under a common management structure has been found to reduce service costs. Where this was done in Norfolk and Waveney Mental Health Trust annual savings of approximately £1 million were achieved with increase staff motivation.[2]

Alternatives to admission: Innovative therapeutic models are being developed as an alternative to stand inpatient psychiatric hospital admissions. These include crisis homes run by health care professionals, third sector or service users themselves. These offer a reduced cost alternative but there is currently insufficient evidence of the outcomes of these models to be certain that they offer a cost-effective alternative to standard treatment.

Though more research into cost-effectiveness is needed, there is research which indicates that peer support can reduce costs and improve quality.[2] In peer support the experiences of mental health services users is shared to support recovery. This can be through mutual support groups or employing people with direct experience of mental ill health to provide services to others.

9.4 Interventions that reduce social care demand

Prevention of conduct disorder through social and emotional learning programmes delivered in schools, mentioned above is cost saving at five years to the County Council.[7]

References

[1] *King's Fund mental health and chronic conditions 2012*
[2] *King's Fund mental health the productivity challenge 2010*
[3] *Cimpean D, Drake RE (2011). 'Treating co-morbid medical conditions and anxiety/depression'. Epidemiology and Psychiatric Sciences, vol 20, no 2, pp 141–50.*
[4] *de Lusignan S, Chan T, Parry G, Dent-Brown K, Kendrick T (2011). 'Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison'. Journal of Epidemiology and Community Health [online] doi 10.1136/jech.2011.139873*
[5] *Moore RK, Groves DG, Bridson JD, Grayson AD, Wong H, Leach A, Lewin RJ, Chester MR (2007). 'A brief cognitive-behavioural intervention reduces admission in refractory angina patients'. Journal of Pain Symptom Management, vol 33, no 3, pp 310–16*
[6] *Howard C, Dupont S, Haselden B, Lynch J, Wills P. The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease Psychology, Health and Medicine(2010); 15(4):371–85*
[7] *Knapp 2011, DH, Mental health promotion and mental illness prevention: the economic case https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf*

10 Multi-disciplinary Case Management

A small proportion of patients typically account for a very large proportion of emergency hospital admissions. If these patients can be identified and offered preventive care, savings could result. In Essex, for example, 10.5% of all patients aged 16 and over who were discharged from hospital in 2010/11 were readmitted within 28 days (for patients aged 75 and over 15.0% were readmitted).

Multi-disciplinary Care Teams (MDTs) work to identify people who are at high risk of emergency hospital admission, and develop and implement an action plan to keep these patients out of hospital. This review focuses on MDT reviews of older people, although the approach has also been applied to drug and alcohol users and mental health patients.

One way that MDTs work with older people is through 'virtual wards' which use the same multidisciplinary systems and routine of a hospital ward to care for patients in their own home and prevent them from requiring hospital admissions. Croydon was the first area to establish virtual wards in England in 2004 and since then the approach has been adopted more widely, including locally in NE and SW Essex.

MDTs also work with older people through other 'case management' approaches. A clear shared definition of 'case management' is lacking but it is generally used to mean targeted, proactive and individualised care aimed at keeping people well. In the UK it is used to refer to time-limited interventions as well as ongoing care.

All case management approaches need to identify those people who are most at risk or most suitable for intervention. There are several methods of doing this:

- Clinical knowledge used to identify patients who are at high risk at present and in future. Health and social care professionals identify patients for referral to interventions based on 'clinical hunch' that these individuals would benefit. However, this approach has poor predictive accuracy; while clinicians may be able to identify patients who are currently high risk, they are less good at identifying those who will become high risk.
- Threshold modelling uses a set of criteria to identify those at high risk, for example 'over 65 with 5 or more admissions in the last 12 months'. The problems with this are selection bias (the individuals selected are outliers) and because those selected are outliers they are likely to improve over the next 12 month period without intervention (regression to the mean). Selecting these patients for case management can be inefficient.
- Predictive modelling uses a wide range of data in statistical models to calculate the risk of future admissions. Generally these models are developed through pseudonymising patient information in order to link individuals' records. Several predictive models are in use for case finding:

    - PARR (Patients at Risk of Re-hospitalisation) uses inpatient data to assign risk scores to individuals estimating their risk of readmission in the next 12 months. The 'Combined Predictive Model' or CPM combines data from GP

records with hospital data to predict emergency admissions. These models are less useful now than when first developed as they have not been updated, although a number of other bespoke tools are now available.
    - PEONY (Predicting Emergency Admissions Over the Next Year).
    - A recent (un-named) model to predict hospital admission and readmission developed by the Nuffield Trust which used a variety of GP, inpatient, outpatient, and A&E data. The Nuffield Trust have also developed a model that combines GP, hospital and social care data to predict social care use (see below).
    - PRISM (Predictive Risk Stratification Model) uses GP and hospital record data to predict risk in Welsh patients, and SPARRA (Scottish Patients At Risk of Readmission and Admission) is a system similar to PARR for Scottish patients.

While complex, identifying patients who are at increased risk of high future use of health or social care resources is just the first step. Reducing their use of services is key to financial savings for health and social care.

10.1 Interventions that reduce health service demand

Community case management: A recent King's Fund evidence review found evidence for a positive effect of 'assertive case management' in mental health, and some evidence that case management can reduce admissions in patients with heart failure. Other than this though the review found that 'case management in the community and in hospital is not effective in reducing generic admissions. A subsequent evidence review from the King's Fund (Ross et al, 2011) also found mixed evidence for case management reducing hospital use, and noted that although there is some robust evidence for the success of case management approaches from the US, differences in the systems make it difficult to transfer the successes to the UK.

A systematic review of case management post-hospital discharge looked at the risk of readmission in 15 RCTs across a number of countries, and also found mixed results. Of the 15, 6 studies found significant decreases in readmission rates, 4 found non-significant decreases and 4 found non-significant increases. However a number of these focussed on people with specific conditions such as heart failure. 9 considered the length of readmission stay, and in 7 significant reductions in length of stay were found.

Ross et al (2011) did find that various factors were associated with programs achieving successful outcomes (reduction in admissions or costs, improved care, or patient satisfaction). These factors included:

- Accurate case-finding techniques
- A single point of access and a single assessment process
- Monitored caseloads to ensure case managers can perform tasks adequately
- Continuity of care to ensure patients feel supported and reduce unplanned admissions

- Self-care to encourage and empower patients to manage their own condition rather than dependency on the case manager
- Accountability for individual patients clearly assigned to individuals or teams
- Access to diagnostic and specialist expertise in the community

Virtual ward programs use predictive models to identify the highest risk patients for intervention in a small local area, associated with one or a small number of GP practices. These patients tend to have multiple and complex problems which may include mental illness or substance abuse

In 2009 the Department of Health approved 16 pilots offering better integrated care for older people. Six pilots which took a virtual ward approach were evaluated by Roland et al (2012) through a difference-in-difference analysis comparing the HES records of patients and matched controls, and concluded that it was 'very unlikely that the sites achieved their goal of reducing emergency admissions'. In fact the patients enrolled in a virtual ward were 9% *more* likely to be admitted as emergencies than the case-matched controls (CIs 1%-16%, $p<0.05$). However, elective and outpatient admissions were each reduced by around a fifth in the six months following intervention. Overall, combined outpatient and inpatient costs were reduced by a mean of 9% (£223 per patient - CIs £54–£391, $p=0.01$) however there are additional costs of the virtual ward.

A Nuffield Trust evaluation of three virtual ward schemes across England is underway and should be reported this year, but unfortunately is not available at this time.

Locally, North East Essex ran a Virtual Ward pilot in Tendring in 2011. Patients should have been identified for the intervention using risk prediction modelling, but practical problems locally meant that most patients were referred through GPs. Patients' health care use was compared before and after their inclusion on the programme. The results showed a 19% drop in admissions for Ambulatory Care Sensitive (ACS) conditions (defined as conditions for which hospital admission should not be required where community care is adequate) and a related decrease of 40% in avoidable ACS admission bed days. However it is not clear how much of this can be ascribed to the effect of regression to the mean. GP Practices supported by Virtual Wards showed a lower rate of increase in ACS admissions among all over 65s than other Practices. There was an *increase* of 63% in A&E attendance, 30 day readmission (107%), and overall bed days (64%).

A Cochrane review of 'hospital at home' found no evidence that the service reduced admissions.

Disease management programs seek to provide better integration of care for people with certain diseases, which generally include a strong element of patient education and self-care and often include multidisciplinary team care. Evidence on their impact in terms of cost and hospital use compared to normal care is inconclusive, due partly to the variety of components included within different programs.

The Nuffield Trust evaluated (using matched controls) four MDT projects that were established as part of the POPP initiative (Partnership for Older People Project). The projects which were selected for evaluation included elements which may have had an impact on admissions;

- Support staff working alongside community matrons with people with long-term conditions
- Intermediate care supporting people discharged from hospital
- MDTs integrating health and social care staff
- Out of hours response staff as well as office hours response

However, the interventions were not associated with a reduction in acute hospital use, and similar to the evaluation of virtual wards described above, in some cases the intervention group patients had *more* admissions than the controls.

A recent Cochrane review of case management and MDT interventions for heart failure patients found that 'there is now good evidence that case management type interventions [intense monitoring of patients following hospital discharge often involving telephone follow up and home visits] led by a heart failure specialist nurse reduces CHF related readmissions after 12 months follow up, all cause readmissions and all cause mortality.' There were fewer reviewed papers looking at MDT interventions and the authors concluded "multidisciplinary interventions may be effective in reducing both CHF and all cause readmissions." While interesting, this work focused on just one condition and did not use case finding to identify high risk patients; instead research participants were those who had previously been admitted with heart failure.

Torbay Care Trust is often cited as a good example of MDT working which has effectively reduced admissions, however information on how this was reflected in cost savings was not found. The CPM is used to identify the patients at highest risk of admission and these patients are managed in a virtual ward. Torbay now has the lowest rate of emergency bed use for older people with two or more admissions. A full cost benefit analysis is being conducted at present by the Nuffield Trust.
In summary, the evidence supporting virtual wards and case management in the UK does not strongly support their use to reduce emergency admissions or to significantly reduce costs.

Interventions that focus on one particular condition may be more effective, but the highest-risk patients are likely to have multiple co-morbidities..

10.2 Interventions that reduce social care demand

Less evidence is available on the role of multidisciplinary teams / virtual wards in reducing social care demand. On balance, the evidence broadly supports a case management approach in reducing use of nursing homes but evidence is sparse
.

- Ross et al's (2011) review for the King's Fund found that case management has been associated with reduced admissions to long-term or nursing home care.
- A systematic review of case management of dementia patients found that three out of six good quality trials found a delay/reduced institutionalisation and one additional that found a significant delay in a subgroup (in one country of the three studied).
- A large European retrospective cohort study (including some UK areas) found that case management of frail older people almost halved the risk of nursing home admission compared to patients in the 'traditional care' group (Case

managed patient admission rate 6.8% vs control admission rate 13%; adjusted OR=0.56; 95% CI=0.43-0.63). The risk of admission increased progressively and significantly with the severity of depression (measured by MDS Depression Rating Scale; P=0.001). The hazard ratio for a 0 score was 1.43 (95% CI=1.11-1.90) and for a score of 5 was 2.23 (95% CI=1.24-3.99).

Elkan et al undertook a systematic review and meta-analysis into the effectiveness of home based support for older people. The interventions included.

10.3 Impact on patient / client care satisfaction

Roland et al's (2012) national evaluation of virtual ward schemes found that patients gave mixed responses about their care; while they were more likely to know who to contact, they felt less involved in decisions about their care.

Ross et al's review of the literature for the King's Fund (2011) found that studies with people on case management programmes found high levels of satisfaction. They note that it is important that the case manager encourages
patients to be independent so that the prospect of discharge from the service does not make patients anxious. The review also found evidence that case management improves patients' perceptions of their ability to cope, and their
self-reported quality of life.
The Virtual Ward pilot in NE Essex sought user feedback. 64% of patients felt confident that the scheme had reduced the chance of an admission to hospital, and 70% agreed that the scheme was joined up and working well for them.

References

(1) Lewis G. (2010) Predictive modeling in action: How 'virtual wards' help high-risk patients receive hospital care at home. New York: The Commonwealth Fund Lewis G (2010) as above

(2) Data from the NHS Health and Social Care Information Centre.

(3) Lewis G (2010) as above

(4) Curry N, Billings J, Darin B, Dixon J, Williams M, Wennberg D (2005) Predictive Risk Project; Literature Review. The Kings Fund.

(5) Allaudeen N, Schnipper JL, Orav EJ, Wachter RM, Vidyarthi AR. (2011) Inability of providers to predict unplanned readmissions. Journal of General Internal Medicine, 26 (7) 771-6

(6) Ross S, Curry N, Goodwin N. (2011) Case management; what it is and how it can best be implemented. The Kings Fund.

(7) Curry et al (2005) as above.

(8) Purdy S (2010) Avoiding hospital admissions: What does the research evidence say? The Kings Fund.

(9) Nuffield Trust (2011) Predictive risk and health care; an overview.

(10) Lewis G (2011) PARR++ is dead; long live predictive modelling. Blog post at http://www.nuffieldtrust.org.uk/blog/parr-dead-long-live-predictive-modelling

(11) East of England Evidence Adoption Centre (2011) Does targeted case-finding of frail elderly result in improved QIPP outcomes?: Review of the evidence

(12) Billings J, Georghiou T, Blunt I, Bardsley M (2013) Choosing a model to predict hospital admission: an observational study of new variants of predictive models for case finding.BMJ Open, 3 (8)(13) Bardsley et al (2011) Predicting social care costs; a feasibility study. The Nuffield Trust.

[14] *Purdy S (2010) as above*

[15] *Ross S, Curry N, Goodwin N. (2011) as above*

[16] *Chiu WK and Newcomer R (2007) Professional Case Management Vol. 12, No. 6, 330–336*

[17] *Roland M et al (2012) Case management for at-risk elderly patients in the English integrated care pilots: observational study of staff and patient experience and secondary care utilisation. International Journal of Integrated Care, 12.*

[18] *Lewis G et al (2011) Do 'virtual wards' reduce rates of unplanned hospital admissions, and at what cost? A research protocol using propensity matched controls. International Journal of Integrated Care, 11.*

[19] *Essex Public Health Team (20012) An Evaluation of the Virtual Ward Pilot in NE Essex*

[20] *Shepperd S et al (2010) Hospital at home admission avoidance. The Cochrane Collaboration.*

[21] *Curry N and Ham C (2010) Clinical and service integration; the route to improved outcomes. The King's Fund.*

[22] *Steventon A et al (2011) An evaluation of the impact of community-based interventions on hospital use. The Nuffield Trust.*

[23] *Takeda A et al (2012) Clinical service organisation for heart failure (Review). The Cochrane Collaboration.*

[24] *Lewis G et al (2011) as above*

[25] *Pimouguet C, Lavaud T, Dartigues JF, Helmer C (2010) Dementia case management effectiveness on health care costs and resource utilization: a systematic review of randomized controlled trials. Journal of Nutrition, Health & Aging, 14 (8)*

[26] *Onder G et al. (2008) Case management, preventive strategies, and caregiver attitudes among older adults in home care: results of the ADHOC study. Journal of the American Medical Directors Association 9/5(337-41), 1525-8610;1538-9375*

[27] *Ross S, Curry N, Goodwin N. (2011) as above*

11 Geriatricians and Frail Elderly Patients

A geriatrician is a general physician who specialises in the medical needs of older people. In many aspects, these may differ from those of midlife adults. Older people often have multiple medical problems. The geriatrician is trained to look at the problems as a whole and determine how they interact. The geriatrician knows about the syndromes of ageing that are not in any particular speciality, like mental confusion, urinary incontinence, instability and gait disorders, failure to thrive, depression. As such Geriatricians coordinate care that an older person may require from a number of different specialties. The job of the geriatrician is also to improve the quality of life, to keep older people functional and independent as long as possible. Sometimes with very simple advice, such as exercise, a patient can be made more functional and independent. This section considers the impact that Geriatricians can have on reducing demands on health and social care services and improving patient outcomes.

11.1 Inpatients

There is good evidence that older people who receive treatment from a geriatrician including a Comprehensive Geriatric Assessment (CGA) are less likely to be discharged to residential or nursing care and more likely to be discharged home.[1][2][3][4] A systematic review found that patients receiving CGA in an in-patient setting were more likely to be living at home during the follow up period after discharge (OR 1.25, 95% CI 1.11–1.42, p=0.0002), at six months post-discharge (OR 1.16, 95% CI 1.05–1.28, p=0.003) and at the end of follow-up (median one year). They were also less likely to be institutionalized (OR 0.79, 95% CI 0.69–0.88, p<0.00001), less likely to have deteriorated in their level of function (OR 0.76, 95% CI 0.64–0.90, p=0.001) and more likely to have improved cognitive function (OR 1.11, 95% CI 0.02–2.01, p=0.002) for up to 12 months compared to usual care.[1]

There is good evidence for integrated CGA services for orthogeriatric patients which cover acute care and supported discharge, and for the CGA approach in the management of stroke and delirium.[5]

The evidence relating to the impact of Geriatricians on readmission rates, patient length of stay, future unplanned care demand and rate of future outpatient demand is equivocal.[1] More research needed about what are the components of specific types of interventions that improve patient outcomes. However one pre-post cohort study looked at the impact of embedding CGA in A&E in an East Midlands Hospital on conversion rates of A&E attenders to hospital admissions for those aged 85+. It examined the records of 4,034 A&E attenders aged 85+ in the study period and 6,895 A&E attenders aged 85+ in the control period and found that the conversion rate of A&E attendance to hospital admission fell from 69.6 to 61.2% during the study period, and readmission rates at 90 days fell from 26% to 19.9%. These reductions were statistically significant at p<0.001. The risk ratio at 95% confidence interval for initial admission comparing the intervention to control periods for those aged 85+ was 0.88 (CI 0.81 - 0.95) and for re-admission at 90 days was 0.77 (0.63–0.93) at 90 days.[6]

There is no evidence that in-patient care from a Geriatrician results in lower mortality compared to normal care or that Geriatricians in inpatient specialised teams that

conduct Comprehensive Geriatric Assessments and advice on patient care across improve long term patient outcomes.[1][7]

An RCT based in Nottingham of 220 older patients found that those who were discharged from acute to community hospitals had a greater level of independence at six months and lower depression scores compared to those whose care was delivered entirely on a ward of the District General Hospital.[8] Independence at six months was greater in the community hospital group (adjusted mean difference 5.30 on the Nottingham extended activities of daily living scale, 95% confidence interval 0.64 to 9.96).[9]

11.2 Out-patient units.

Geriatricians in teams and as consultants had mixed results in terms of impact on function, living at home and health services use. Interventions in which geriatricians have direct patient contact are more likely to result in better outcomes than interventions where the interaction is limited to supporting other clinicians. Geriatricians as primary care providers provide more effective medication management than other clinicians.[1][2]

There is no evidence that Geriatricians impact on mortality rates over and above usual care[1] or that that CGA in outpatients or day hospitals alone is effective.

11.3 Community

There is evidence that Community Geriatricians can improve patient outcomes although this evidence is not as robust as that for in-patient settings. Evidence regarding impact of community geriatricians on urgent care demand is equivocal. and A large scale American retrospective cohort study found that for 287,000 patients with a history of cardio-vascular disease living in the community, one or more community geriatrician visits in a 6-month period were associated with 11.3% lower Emergency Department use the following month (95% confidence interval (CI) = 7.5–15.0, N = 287,259). Participants who received primary care from geriatricians were less likely to visit the Emergency Department (ED) than those who had traditional primary care. Community Geriatric care was associated with an estimated 108 fewer ED visits per 1,000 patients. Similar results were found when >66,000 notes of patients living in nursing homes were analysed. Patients who had received Community Geriatric Care in the previous six month period had 133 fewer ED visits per 1,000 nursing home residents per year. Geriatric consultative care in collaboration with primary care providers may be as effective in reducing ED use as geriatric primary care. Increased provision of collaborative care could allow the existing supply of geriatricians to reach a larger number of individuals.[10]

An Australian randomised control trial that looked at 739 patients aged >75 that had visited ED found that those that underwent a Comprehensive Geriatric Assessment by a multi-disciplinary outreach team within 28 days
had a lower rate of all admissions to the hospital during the first 30 days after the initial ED visit (16.5% vs 22.2%; *P*=.048), a lower rate of emergency admissions during the 18-month follow-up (44.4% vs 54.3%; *P*=.007), and longer time to first emergency admission (382 vs 348 days; *P*=.011).[11]

A further RCT study with a cohort of 414 found that community based Comprehensive Geriatric Assessment and subsequent interventions including medication

review/adjustment, exercise instruction, nutrition support, physical rehabilitation, social worker consultation, and speciality referral resulted in better clinical outcomes and less deterioration at six month follow up compared to controls. The study also found that the odds of being dependent on assistance in the basic activities of daily living at three years were significantly lower in the intervention group than in the control group (adjusted odds ratio, 0.4; 95% interval, 0.2 to 0.8; P = 0.02; P = 0.03 for the unadjusted odds ratio).[12] However the intervention had no significant impact on rate of admission to hospital.

A series of further studies also questioned the impact of community based geriatrics on urgent care demand. One randomised control trial actively screened community dwelling older people (irrespective of their contact with primary or secondary care) for conditions such as depression, falls, urinary incontinence, and cognitive and functional impairment (the so called geriatric giants). The researchers then intervened intensively using specialist services that included geriatric medicine and psychiatry, urology, audiology, rehabilitation, psychology, and social services. However, they found no reduction in admissions compared with the usual care group over a three year follow-up.[13]

Another trial investigated a hospital based team consisting of a geriatrician, trained nurses, and social workers that offered outreach in the community. Despite active intervention, extensive assessments, and round the clock support during follow-up, admissions were not reduced compared with usual primary care.[14]

In additional community based interventions can reduce demand on long term residential and nursing care. Two systematic reviews of home based interventions, despite being complicated by methodological variations and a lack of standardisation of interventions, show that community based patient centred care delivered comprehensively in a sustained fashion with multiple visits reduces long term institutional care.[15][16]

11.4 Interface Geriatricians

'Interface Geriatricians' work across both community and secondary health care settings to provide an interface of care between both settings. This includes Comprehensive Geriatric Assessment (CGA) on AMU after assessment by a general physician, and then following discharge a

comprehensive medical assessment, general medical review including psychiatric assessment, investigation into geriatric syndromes and medication review. Interface Geriatricians are also responsible for liaison with the GPs post discharge and follow-up home assessment where appropriate. There is strong evidence from systematic review and meta-analysis of 28 control trials considering 9961 subjects that this model of care results in a greater likelihood that patients will remain living at home. Combined odds ratio (95% confidence interval) of living at home at follow-up was 1·68 (1·17-2 41) for geriatric evaluation and management units, 1·49 (1·12-1·98) for hospital-home assessment services.[17][18]

A Geriatric care pathway of 'front door' hospital geriatric assessment and where appropriate, crisis intervention and acute geriatric admission, integrated community care with geriatrician input and outpatient and other speciality referral has been shown to

avoid unnecessary hospital admission, reducing length of inpatient stay, deliver comprehensive discharge care plans, reducing delayed discharge and reducing the risk of re-admission.[19]

References

[1] *Totten A, Carson S, Peterson K, Low A, Christensen V, Tiwari A. Evidence Brief: Effect of geriatricians on outcomes of inpatient and outpatient care, VA-ESP Project #09-199; 2012.*

[2] *Stuck AE, Siu AL, Wieland GD, Adams J, Rubenstein LZ. Comprehensive geriatric assessment:*
a meta-analysis of controlled trials. Lancet 1993;342:1032-6.

[3] *(PHRU) PHRU. Oxford: Public Health Resource Unit (PHRU), 2006.*

[4] *Ellis G, Langhorne P. Comprehensive geriatric assessment for older hospital patients. Br Med Bull 2005;71(1):45-59.*

[5] *Day P, Rasmussen P. What is the evidence for the effectiveness of specialist geriatric services in acute, post-acute and sub-acute settings? A critical appraisal of the literature. NZHTA Report, 2004.*

[6] *Conroy, S., Khawar, A., Williams, M. et. Al. A controlled evaluation of comprehensive geriatric assessment in the emergency department: The 'Emergency Frailty Unit'. Age and Ageing, 2013. Doi: 10.1093/ageing/aft087*

[7] *Parker SG, Peet SM, McPherson A, Cannaby AM, Abrams K, Baker R, et al. A systematic review of discharge arrangements for older people. Health Technology Assessment (Winchester, England) 2002;6(4):1-183*

[8] *Green, J. Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial, BMJ 2005; 331*

[9] *D'Arcy LP, Stearns SC, D?, Journal of The American Geriatric Society, 2013 Jan; 61(1):4-11.*

[10] *Caplan, G., Williams, A., Daly, R. and Abraham, K. A randomised control trial of CGA and MultiDisciplinary Intervention After Discharge of the Elderly from the Emergency Department. Journal of American Geriatric Society 52:1417–1423, 2004*

[11] *Chia-Ming Li, The effectiveness of a comprehensive geriatric assessment intervention program for frailty in community-dwelling older people: a randomized, controlled trial., Archives of Gerontology and Geriatrics ,2010, Volume: 50 Suppl 1: S39-S42*

[12] *Conroy S, Stevens A, Gladman JRF.The interface between acute hospitals and community care for older people presenting to acute medical units: a mapping review, Medical Crises in Older People. Discussion paper series ISSN 2044 4230,*

Issue 6 December 2010

[13] *Rubenstein LZ, Alessi CA, Josephson CR, Hoyl MT, Harker JO, Pietruszka FM. A randomized trial of a screening, case finding, and referral system for older veterans in primary care. J Am Geriatr Soc 2007;55:166-74.*

[14] *Boult C, Boult LB, Morishita L, Dowd B, Kane RL, Urdangarin CF. A randomized clinical trial of outpatient geriatric evaluation and management. J Am Geriatr Soc 2001:49:351-9.*

[15] *Stuck AE, Egger M, Hammer A, Minder CE, Beck JC. Home visits to prevent nursing home admission and functional decline in elderly people: systematic review and meta-regression analysis. JAMA 2002;287:1022-8.*

[16] *Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, et al. Effectiveness of home based support for older people: systematic review and meta-analysis. BMJ 2001;323:719-25.*

[17] *Conroy S, Stevens A, Gladman JRF.The interface between acute hospitals and community care for older people presenting to acute medical units: a mapping review, Medical Crises in Older People. Discussion paper series ISSN 2044 4230, Issue 6 December 2010*

[18] *Stuck AE, Siu AL, Wieland GD, Rubenstein LZ, Adams J. Comprehensive geriatric assessment: a meta-analysis of controlled trials. The Lancet 1993;342(8878):1032-36.*

(19) *Conroy, S, Stevens, A, Gladman, JFL Interface Geriatrics: a mapping review. MCOD discussion paper, University of Nottingham 2010 15-16 Issue 6.*

12. Community Beds

This section looks at published evidence around the use of intermediate care beds and then at the Essex residential reablement pilot.

12.1 Published evidence

A randomised controlled trial by *Green et al.* (2005)[1][2] addressed the question of providing community hospital care following a hospital admission to medically stable patients (n=220). The intervention consisted of patients being randomly allocated to a locality based community hospital or to remain within a District General Hospital. Patients allocated to community hospital care were assessed by a multidisciplinary team and received an individual care plan designed to maximise recovery and promote independence. The consultant visited the hospital at least twice a week and the hospital practitioner visited the hospital each weekday. Local general practitioners provided out of hours cover. The median length of stay of 15 days was the same for both the community hospital and the District General Hospital groups however independence at six months was greater in the community hospital group (the adjusted mean difference changes in scores on the Nottingham extended activities of daily living scale was 5.30, 95% confidence interval 0.64 to 9.96). No information was given by the authors relating to the clinical details of the initial hospital admission, however, the study population was described as average age 85, predominantly female, community dwelling, reduced independence before admission, and in receipt of care from social services.

This study suggests that providing an individually tailored package of care in a community hospital in older adults once they are deemed medically stable may be beneficial in promoting independence several months after the admission.

A secondary analysis of this study by Y*oung et al.* (2007)[3] into the effects of timing of post-acute transfer to intermediate care suggest that transfer for post-acute rehabilitation should be as soon as possible after medical stability has been achieved.

A systematic review (n=1896) by *Griffiths et al.*[4] of ten random or quasi-random controlled trials (high quality evidence) published in 2009 reviewed the effectiveness of intermediate care in nursing-led in-patient units (NLU) following an acute hospital admission for a physical health condition. The review aimed to determine whether NLUs are effective in preparing patients for discharge from hospital. Effectiveness of the NLU was compared to 'usual care' (inpatient care in general acute hospital wards).

Discharge to institutional care was reduced for the NLU (OR 0.44 95% 95%CI 0.22 to 0.89), however this finding was less clear when only the strongest studies were included and may in part have related to higher death rates in the NLU group. Functional status at discharge increased (0.37 (points measured on the Barthel Index), 95%CI 0.20 to 0.54) but there was a near significant increase in inpatient stay (5.13 days 95%CI -0.5 days to 10.76 days). Early readmissions were reduced (OR 0.52 95% CI 0.34 to 0.80).

The components of the care provided at the nurse led unit were not specified further in the systematic review and therefore it is not possible to determine why this model of care was successful.

In summary, published evidence specifically addressing whether clinical models of step down provision in community hospitals reduce length of stay or prevent further hospital admissions is lacking. However, the limited evidence from the UK suggests that step down beds may be beneficial for promoting independence, although may have no impact or may increase average length of inpatient stay. Whilst discharge to institutional care may be reduced, long term outcomes were not established. The evidence suggests that individually tailored care in a community hospital or a nurse led model of care is to be effective in achieving improved functional outcomes.

12.2 Review of local residential reablement pilot

There is no published evidence around the impact of residential reablement on social or health care costs.

Prior to the residential reablement pilot at Drake House in Chelmsford, provision of intermediate care in Essex was largely restricted to purchasing of beds within residential care homes. Essex County Council reported that 86% of individuals using these beds went on to permanent residential placements. Based on data from the 15 month pilot study, only 11% of recipients of residential reablement were discharged to a care home and 76% of recipients were discharged home. This is not a direct comparison in that not all individuals who were admitted to the intermediate care beds would have been appropriate to consider returning home.

In addition 75 individuals (36% of pilot participants) who received residential reablement services at Drake House were followed up at 91 days post discharge to give an indication of longer term outcome. 68% (51) individuals remained at home at 91 days of which 13 were fully self-caring.

The Essex County Council evaluation of the Drake House pilot over 15 months found that 93% of all service users demonstrated an improvement in their skills relating to activities of daily living during this time.

Post-pilot: Since the pilot has been completed, Mid Essex CCG has commissioned 10 residential reablement beds at Drake House. 145 individuals have received residential reablement at Drake House during 2012/13. The outcomes for people at the end of the six week reablement course have shown that 79% were deemed to be successfully reabled, either being self-caring (60%) or receiving domiciliary ('agency') care (19%). This outcome compares to 81% of those receiving domiciliary reablement being successfully reabled, showing the residential reablement service is able to deliver similar results.

References

(1) Green J, Young J, Forster A, Mallinder K, Bogle S, Lowson K, Small N. Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial. BMJ. 2005;331:317-22

(2) O'Reilly J,Lowson K,Green J.,Young J.,Forster A.,Post-acute care for older people in community hospitals—a cost-effectiveness analysis within a multi-centre randomised controlled trial Age and Aging.37;5;513-520

(3) Griffiths PD, Edwards ME, Forbes A, Harris RG, Ritchie G Effectiveness of intermediate care in nursing-led in-patient units, Cochrane Collaboration, 2009

13 Step Up Beds

The evidence base for Intermediate Care (IC) remains insufficiently robust to allow dogmatic conclusions but there is sufficient research evidence (systematic reviews of RCTs) to describe IC service models that are more likely to be effective or cost-effective.[1][2][3] It is anticipated that more published evidence of local schemes will become accessible in the near future.

This intervention should be an integral part of the Unscheduled/Unplanned Care programme. These are patients with complex health care needs likely to have a high level of physical dependency care and therefore they are beyond the capacity of the usual primary care team.[4]

Hospital-at-home (HaH) schemes are currently the best RCT supported IC model (22 trials reported up to 2009). A HaH service is a service that provides active treatment in the patient's home, of a condition that would otherwise require acute hospital in patient care, and is condition and function (admission avoidance, early discharge, palliative care) flexible. It is regarded as an excellent foundation service for a more comprehensive IC service such as HaH plus social service care or HaH plus community rehabilitation.[5]

References

[1] *Forster A, Young J, Langhorn P (1999). Systematic review of day hospital care for elderly people. BMJ 318: 837-41.*
[2] *Young J, Green J, et al (2007). Postacute care for older people in community hospitals: a multicenter randomized, controlled trial. J American Geriatr Assoc. 55: 1995-2002.*
[3] *Griffiths PD, et al (2004). Effectiveness of intermediate care in nursing-led in-patient units. The Cochrane Database of Systematic Reviews 2004, Issue 4.*
[4] *Scottish Govt (2007). Delivering for Remote and Rural Healthcare. The final report of the remote and rural work stream. November 2007.*
[5] *British Geriatric Soc. (2008). Intermediate Care - Guidance to Commissioners and Providers of Health and Social Care.*
http://www.bgs.org.uk/index.php?option=com_content&view=article&id=363:intermediatecare&catid=12:goodpractice&Itemid=106

14. Care Pathways

Care pathways are defined by the European Pathway Association as:" a methodology for the mutual decision making and organization of care for a well-defined group of patients during a well-defined period" Their aim is to promote effectiveness and thereby improve quality, reduce the unintended variations in care, reduce resource utilization, improve patient education and improve quality of care.

Purdy et al[1] review the evidence in this area as well as revisiting earlier reviews. They conclude "there is no convincing evidence to make any conclusions on the effect of pathways and guidelines on hospital admissions although it is important to point out that data are limited for most conditions".

References

[1] *Purdy S., Paranjothy S., Huntley A., Thomas R., Mann M., Huws D., Brindle P. Elwyn G., Interventions to reduce unplanned hospital admission: a series of systematic reviews Final Report June 2012*

15 Domestic Abuse

The term 'domestic abuse' is used to mean: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or are family member regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological; physical; sexual; financial; or emotional.

15.1 Interventions that reduce health and social care service demand

Although there is widespread agreement that interventions targeted at reducing and preventing domestic abuse should be funded there is limited guidance on which specific interventions provide good value for money. The National Institute of Health and Clinical Excellence (NICE) is currently consulting on its draft guidance on "Domestic violence: identification and prevention".[(1)] The review considered evidence for prevention, identification, intervention (survivors and perpetrators) and children exposed to DV.

Prevention: the review did not find sufficient evidence to make recommendations on primary prevention programmes via media or in health or community settings; there was modest evidence that prevention programmes targeting young people at risk of domestic abuse may improve knowledge, attitudes and interpersonal outcomes although perhaps limited generalisability to the UK population.

Screening: overall, there is insufficient evidence to reach a view on the effectiveness of screening programmes for intimate partner violence (IPV).Reviews conducted for the UK National Screening Committee (UKNSC) revealed that screening results in increased identification of violence on women and is acceptable to most women, yet they did not find sufficient evidence that screening resulted in improved health outcomes or a decrease in recurrence of violence, and found mixed reports from health care providers regarding acceptability. The evidence on the effectiveness of provider education interventions for improving screening practices or clinical enquiry is inconsistent. There is moderate evidence for universal screening or routine enquiry for DV in pregnancy, when supported by staff training and organizational support.

Survivor interventions: overall, evidence of effectiveness - from 3 systematic reviews of IPV interventions (advocacy, skill building, counselling) for victims - is inconclusive, although both intensive advocacy interventions and system centred interventions with ongoing staff training appear promising. Further analyse by NICE reports that there is moderate evidence for advocacy, skill development, counselling and therapeutic approaches. The NICE economic evaluation suggested that independent domestic violence advisors (IDVAs) and cognitive trauma therapy for battered women (CTT – BW) are both cost effective interventions. The NICE economic evaluation took at societal approach to its analysis taking into account costs and savings beyond that attributable to health. The savings accruing to IDVA are predominantly human & emotional costs and to the criminal justice sector with savings to health particularly reduced use of primary care. For CTT the savings (from averted consequences of post-traumatic stress disorder) predominantly related to reduced absenteeism.

Perpetrator interventions: overall the evidence of effectiveness of these intervention programmes is inconclusive – moderate evidence for individual interventions and

inconsistent evidence for group interventions. The types of individual interventions employed varied, including: case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing. Overall, interventions appeared to have a greater effect on attitudinal outcomes than recidivism/ violence outcomes (which, when measured improved in some but not all studies).

Identification schemes appear to be cost effective. No economic evaluations were identified for prevention or children witnessing DV.
NICE did not review any interventions relating to enforcement, nor use of refuges or other housing options.

15.2 Impact on patient / client care satisfaction

The primary impact of IDVA is on human and emotional benefits.

References

(1) http://guidance.nice.org.uk/PHG/44/Consultation/Latest *[accessed 23/8/2013]*

16. Reablement

Reablement can be defined as providing “Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living" (Kent et al., 2000).[1]

There are few good trials in this area over the last decade. There are even fewer that enable a sense of what savings are possible. The Social Policy Research Unit, University of York published Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) by Glendinning et al[2] in late 2010. This report forms much of the evidence within the 2011 SCIE research briefing as the report includes one year follow up data and attempts at health and social care costings. The report concludes that in the first year, in the group receiving reablement the mean combined cost of reablement and ongoing social care (for those in that group who needed it) was £1,640 for reablement plus £790 for the rest of the year social care costs. The cost in the control group was £570 for the first two months , then £2,240 for the next ten months. The difference in the first year in total social care costs between the two groups (ie sum reablement plus other social care) was a non-significant £380. The difference in social costs excluding reablement costs and after accounting for baseline differences between the two groups was a 60% reduction in costs in the reablement group.

There was a higher cost to health services in the reablement group in the first two months and then no difference over the rest of the year.

There are however many potential problems with the study. Drop out in both groups was high with one year data only in about a third of those starting the trial. The trial is NOT randomised and the reablement group and control group appear very different. 75% of the reablement group were referred from hospital and 55% of control. 15% reablement where first time community referrals versus 29% in the controls. 37% of the reablement group were felt to have “critical or substantial need” at recruitment against 77% of controls. One could conclude that the control group were more likely than the reablement group to have been referred due to social care issues per se and the reablement group due to needs precipitated through health reasons (evidenced by higher rate hospital discharge and initial higher ongoing healthcare cost). While the authors attempt to account for this in analysis, it does raise problems with interpretation. The study by McLeod and Mair[3] “Evaluation of City of Edinburgh Council Homecare Reablement service” published in 2009 has no such problems with its intervention group but only follows up for three months.

The results show that up to 62 per cent of reablement users no longer need a service after 6−12 weeks (compared with 5 per cent of the control group), and that 26 per cent had a reduced requirement for home care hours (compared with 13 per cent of the control group). Of interest is the fact that following initial assessment the control group had an INCREASING spend on social
care in those referred from the community (but a reduction in those referred from hospital). While there are reductions in need for social support in all who access reablement, gains were highest (60% reduction in care requirements) in those whose dependency required them receiving 5 -10 hours per week. The least benefit (but still 19% reduction) was in those requiring more than 15 hours per week. In this study the

cost of frontline support for the first six weeks was no different between the reablement and control group but there were some added costs from OT and management. The average cost for 6 weeks reablement in Mair study was £1050 against £850 control costs. This suggests that much can be achieved for frankly little extra investment. In this study the vast majority of referrals where seen as appropriate for reablement. Similarly benefit was considerable regardless as to whether admission was from community or hospital although in this study, gains were somewhat higher in those referred from the community.

Lewin[4] reported in 2010 initial findings from her study in Western Australia but a full peer review version was not available. Of note she used an RCT methodology looking at 750 clients and there is some information on two year follow up.. In the intention to treat analysis at 3 months and 1 year follow ups, 63.5% and 40.3% respectively for normal care and 27.5% and 17.9% for reablement were receiving an on-going personal care service In the actual services analysis, the respective figures were 68.9% and 43% for normal care and 21.3% and 14.2% for reablement. There were significant differences between the groups in terms of the total amount of personal care service used in the study year, the subsequent year and in the two years combined, with the reablement group using significantly fewer hours of care. The cost of the reablement group was less. While analysis was on-going, at the time of the report there was no impact on health admissions but the reablement group had fewer “Emergency Department” attendances.

Tinetti et al[5] compared readmissions of Medicare recipients of usual home care and a matched group of recipients of a restorative (reablement) model of home care. Among the matched pairs, 13.2% of participants who received restorative care were readmitted to an acute hospital during the episode of home care, versus 17.6% of those who received usual care. Individuals receiving the restorative model of home care were 32% less likely to be readmitted than those receiving usual care (conditional odds ratio = 0.68, 95% confidence interval= 0.43–1.08). The reader will note however that caution is called for as the results do not reach conventional levels of significance. The matching was also not ideal given the marginal result with more in the control group living alone, having depression, diabetes and heart problems and more in the intervention group having respiratory problems.

In summary, the evidence around the benefits of reablement is growing but is not of the most robust nature. There is however increasing evidence that reablement focusing on all who might benefit can be delivered at moderate cost and can markedly reduce on-going homecare costs to social care for at least two years. It is less clear how it impacts on health costs but Tinetti et al suggests some promise As Lewin suggests (2011), it should be the “gateway”

to services for the majority who might benefit.

References

[1] Kent, J., Payne, C., Stewart, M. and Unell, J. (2000) External evaluation of the home care reablement pilot project, Leicester: De Montfort University.

[2] *Glendinning, C. et al. (2010) Home care re-ablement services: investigating the longer-term impacts (prospective longitudinal study), York/Canterbury: Social Policy Research Unit (SPRU)/Personal Social Services Research Unit (PSSRU)*
[3] *McLeod, B., Mair, M. and RP&M Associates Ltd (2009) Evaluation of City of Edinburgh Council home care re-ablement service Edinburgh: Scottish Government Social Research.*
[4] *Lewin, G. (2010) Submission to inquiry into caring for older Australians, Canberra: Caring for Older Australians Productivity Commission*
[5] *Tinetti M., Charpentier P., Gottschalk M., Baker D., Effect of a Restorative Model of Posthospital Home Care on Hospital Readmissions.* ***J Am Geriatr Soc 60:1521–1526, 2012.***

17. Specialist Clinics

17.1 Impact on Health services

Purdy et al[1] in “Interventions to reduce unplanned hospital admission: a series of systematic reviews” produced in 2012 is a useful and relevant description of the evidence in this area. In this report a specialist clinic “provides advanced diagnostic or treatment services for diseases/conditions. Specialist clinics have been set up in both primary and secondary care settings, which may utilise nurses to provide specialist nurse led clinics or multidisciplinary care teams to help manage long term conditions”.

The report looks at Randomised Controlled Trials (RCTs) and specifically at heart failure, older people, and asthma where most of the evidence exists with single studies in other areas.

17.2 Heart Failure

There is evidence that a system of decreasing intensity of support (from weekly or fortnightly down to 3 monthly) for people with heart failure following hospital discharge reduces unplanned hospital admissions by a statistically significant 58% at one year. There is less evidence around other follow up regimes. In the Bruggink[2] study for example looking at patients with New York Heart Association Classification System (NYHA) 3 and 4, the patients were so ill that the NNT to prevent and admission at 12 months was 5

17.3 Older people

Of seven published studies looking at both outpatient and primary care based services only two showed a reduction in hospital admissions. Scott 2004[3] in USA used a “Co-operative health care model” that involved monthly group sessions led by the primary care clinician that were quite intensive and supported by one to one sessions as required. Follow up was for 2 years and the intervention group had 41% less admissions. There is no cost data around the intervention.

Fletcher et al (2004)[4] in the UK used a questionnaire to identify at risk patients who had a subsequent detailed assessment and specialist clinic follow up. At three years there was around 8% less admissions in the intervention group but again costing was not clear. A range of other studies with fairly similar intervention and clinic follow up did not show a benefit.

17.4 Asthma

The conclusion is that studies are of poor quality and asthma clinics seem to have no effect on unplanned admissions.

17.5 COPD

Soler 2006[5] undertook a small study in Spain of monthly visits to a specialised clinic and a short educational program versus normal care and found a very significant 73% reduction in admissions in the intervention group. Though a small study the approach shows promise.

17.6 Mental Health

Herz[6] in the US in 2000 looked at the impact of “relapse prevention” on mental health admissions in people with schizophrenia. The work showed that complex on-going community support to patient and family including helping in recognition of early signs of relapse impacted on admissions. At 18 months follow up 39% of the control and 22% of the intervention group had been admitted. In this high risk group then, the NNT for 18 months to prevent an admission is only 6. While the approach may have application locally, the intervention is quite complex and potentially costly.

17.7 CHD

Campbell 1998[7] and Murphy 2009[8] both in the UK showed the benefit of focused primary care follow up in CHD patients including addressing lifestyle factors. The studies showed an absolute reduction of between 6 and 9% in admissions.

17.8 Impact on Social Care Services

There is no strong published evidence around the impact of these interventions on social care need.

References

[1] Purdy S., Paranjothy S., Huntley A., Thomas R., Mann M., Huws D., Brindle P. Elwyn G., Interventions to reduce unplanned hospital admission: a series of systematic reviews Final Report June 2012

[2] Bruggink Andre de la Porte P. Added value of a physician-and-nurse-directed heart failure clinic: results from the Deventer-Alkmaar heart failure study. Heart. 2007;93:819-815.

[3] Scott JC, Conner DA, Venohr I et al. Effectiveness of a group outpatient visit model for chronically older health maintenance organization members: A 2 year randomised control trial of the cooperative health care clinic. J Am Geriatr Soc 2004; 52:1463-1470.

[4] Fletcher A E. Population-based multidimensional assessment of older people in UK general practice: a cluster-randomised factorial trial. Lancet 2004; 364:1667-1677.

[5] Soler JJ, Martinez-Garcia MA, Roman P et al. Effectiveness of a specific program for patients with chronic obstructive pulmonary disease and frequent exacerbations. Archivos de Bronconeumologia 2006; 42(10):501-8.

[6] Herz MI, Lamberti JS, Mintz J, Scott R, O'Dell SP, McCartan L, Nix G A program for relapse prevention in schizophrenia: a controlled study. Arch Gen Psychiatry. 2000 Mar;57(3):277-83.

[7] Campbell NC, Thain J, Deans HG et al. Secondary prevention clinics for coronary heart disease: Randomised trial of effect on health. BMJ 1998; 316(7142):1434-7.

[8] Murphy AW, Cupples ME, Smith SM et al. Effect of tailored practice and patient care plans on secondary prevention of heart disease in general practice: cluster randomised controlled trial. BMJ 2009; 339: b4220.

18.1 Assistive Technology

Assistive technology (AT) describes any technology-enabled product or service designed to facilitate independence for people with health and social care needs, such as Long Term Conditions (LTCs) or the frail elderly. It is increasingly seen by policy-makers as a key building block of service redevelopment in order to address rising service demand,[1] however there has been a lack of empirical evidence on the effectiveness of AT in addressing health and social care needs.[2] AT includes:

- Telehealth: the remote exchange of physiological and wellbeing data between a patient at home and medical staff to assist in diagnosis and monitoring (this could include support for people with lung function problems, diabetes, heart failure etc).
- Telecare: a combination of remotely monitored passive alarms, sensors, other equipment and services to help people live independently in their own homes.
- Telemedicine: the provision of consultation and other services by off-site health care professionals to those on the scene; diagnosis and treatment advice can be given at a distance through methods such as videoconferencing and/or rapid transmission of digital files and images. (Telemedicine is not covered in this review, however in general the evidence is mixed - whilst some uses have been well-studied, there are a number of applications for which high quality evidence is lacking.)[3]

Section 22 of the Chronically Sick and Disabled Persons Act 1970 requires a report to be laid before Parliament each year describing the research activity the government has funded to improve equipment for disabled and older people, known as Assistive Technology (AT). This provides a comprehensive summary of the various types of AT currently in development.[4]

18.1 Impact on Health Services

Telehealth: The literature on the impact of telehealth on health service usage is inconclusive overall. For example, a 2010 review of systematic reviews concluded that "the issue of whether [telehealth] is economically viable has not yet been adequately addressed".[5] This is due in part to the differing technologies studied, the different ways in which the technologies are used, and the generally poor quality of the research.[6] It should also be noted that much of the literature on telehealth comes from the US (and specifically the Veterans Health Association, which uses telehealth to support over 50,000 military veterans in the US),[7] and its impact in the UK health system is likely to differ.[8]

Studies of telehealth support for certain chronic health conditions have shown an impact on health services. A meta-analysis of 11 Randomised Controlled Trials (RCTs) (2,710 participants) for patients with chronic heart failure (CHF) found that telehealth reduced CHF hospital admissions by 21% (Relative Risk [RR] 0.79; 95% Confidence Interval [CI] 0.67 to 0.94; P=0.008).[9] A
systematic review of telehealth for asthma found a weaker but significant 5% reduction in hospitalisations over a 12-month period (Odds Ratio [OR] 0.21; 95% CI 0.07 to 0.61; =0.04; NB number of events was low overall), however there was also a non-significant 4% increase in emergency department visits (OR 1.16; 95% CI 0.52 to 2.58; P=0.72).[10] A systematic review by the same authors of 10 RCTs of telehealth in Chronic

Obstructive Pulmonary Disease (COPD; 1,004 participants) found a reduction in emergency department visits by telehealth users (OR 0.27; 95% CI 0.11 to 0.66; P=0.005) as well as a reduction in hospital admissions (OR 0.46; 95% CI 0.33 to 0.65; P < 0.00001).[11]

However, evidence is simply lacking for many interventions in other conditions, such as rheumatoid arthritis[12] and schizophrenia.[13] There is also some limited evidence that some interventions have no impact, such as hip protectors in care homes.[14]

The recent Whole System Demonstrator (WSD) cluster RCT of telehealth provides the most robust UK evidence on the impact of telehealth. It included 3230 UK people with a LTC (CHF, chronic obstructive pulmonary disease, or diabetes),[15] and found that 5% fewer people receiving telehealth were admitted to hospital in 12 months than in the control group (OR=0.82; 95% CI 0.70 - 0.97; P=0.017).[16] The mean number of emergency admissions per head also differed between groups (crude rates, intervention 0.54 *v* control 0.68), however this difference was not significant after adjusting for baseline characteristics. Length of hospital stay was significantly shorter by 0.64 days (mean bed days per head 4.87 v 5.68; P=0.023) for intervention patients than for controls. These differences did not translate into differences in notional costs of hospital treatment however.

The additional annual costs of telehealth per person in the WSD trial ranged from £1,500-£2,000, the QALY gain by patients using telehealth in addition to usual care was similar to that by patients receiving usual care only, and the incremental cost per QALY of telehealth when added to usual care was £92,000.[17] Despite the moderate impact on service usage, as delivered in the WSD, telehealth is thus unlikely to be cost effective (based on health and social care costs, outcomes after 12 months and the willingness to pay threshold of £30,000 per QALY recommended by NICE), with only an 11% chance of being cost effective. If equipment costs reduced by 80% and service was delivered at optimal capacity to minimise costs, the likelihood of telehealth being cost effective increases to 61%.[18]

Telecare: The number of telecare interventions and devices is vast, but many have not been well-evaluated,[19] and many studies are case reports only.[20] There is however some evidence that specific telecare interventions can have an impact on health services:

Tchalla et al. (2012) undertook a longitudinal prospective cohort study of a light path coupled with tele-assistance service for preventing unintentional falls. The study included 194 people aged 65 and over and found that after one year, 20% fewer people in the intervention group had falls, compared to the control group. There was also a greater reduction in post-fall hospitalisation among the intervention group (OR=0.30; 95% CI 0.12-0.74; p value=0.0091).[21] One before / after cohort study also found that installing call systems in care homes can reduce falls and their associated health care costs by up to 50%.[22]

18.2 Impact on Social Care Services

Telehealth: Few studies that were identified considered the impact of telehealth on social care demand per se, however the WSD RCT reported a non-significant 27% lower cost of social care in the telehealth group compared to the control group.[23]

Telecare: Limited robust evidence on the impact of telecare on social care demand was identified. A 2007 systematic review found a lack of robust evidence on the efficacy of telecare interventions such as home safety and security alert systems.[24] The British Psychological Society's 2007 guideline on Dementia[25] stated that initial findings support the use of AT in aiding people with dementia to stay in the community longer, thereby delaying moves to higher dependency care, but also found that further research is needed before any firm conclusions can be drawn.

An evaluation of telecare provision in Essex in 2009-10 reported that, across 240 randomly selected telecare users, for every £1 spent on telecare £3.82 was saved in traditional care, based on social worker report of the next best care scenario. For those users where telecare was a direct replacement for traditional care, every £1 spent on telecare saved £12.60 in traditional care.[26]

18.3 Impact on Patients, Clients and Families

The efficacy of AT interventions depends on people's willingness to use them. The WSD RCT considered why some people did not wish to use AT equipment, and found the main barriers to be: requirements for technical competence and operation of equipment; threats to identity, independence and self-care; and expectations and experiences of disruption to current services.[27] Greenhalgh *et al.* (2013) conducted an ethnographic study to look at this in more detail. A detailed picture of 40 participants' (aged 60-98) lives, illness experiences and use (or non-use) of technologies was built up. Data were analysed phenomenologically, and the authors concluded that the AT devices met few participants' needs and generally did not assist them to live with illness, except in a few cases where customised to an individual's particular needs.[28] The design and flexibility of AT devices to support autonomy and individuality are therefore crucial to their uptake and thus their effectiveness.

Telehealth: In the UK WSD RCT, telehealth did not improve quality of life or psychological outcomes for patients with LTCs over 12 months, compared to normal care.[29] Meaningful quality of life improvements were not found in a systematic review of asthma trials either (mean difference 0.08; 95% CI 0.001

to 0.16; P=0.02),[30] although a COPD systematic review did report a small but clinically significant increase in quality of life in two trials with 253 participants (mean difference -6.57 (95% CI = 13.62 to 0.48)[31]

The mortality rate in the WSD RCT was 45% lower in the telehealth group than in the control group (4.6% *v* 8.3%; unadjusted OR 0.54; 95% CI 0.39 to 0.75; P<0.001).[32] Mortality was reduced by a similar proportion in a US RCT of 781 people, which tested the efficacy of a telephonic health and social care management approach and 12 month review. The intervention group had significantly lower odds of mortality throughout the study (OR = 0.55; p = 0.005).[33] A meta-analysis of 11 RCTs for patients with chronic heart failure (CHF) also found all-cause mortality was reduced by 34% (RR 0.66; 95%CI 0.54 to 0.81; P < 0.0001)[34] but a similar review of mortality in COPD telehealth trials found no impact on mortality.[35]

Van den Berg and colleagues (2012) undertook a systematic review which included 68 papers on the outcomes for users of telehealth.[36] They found predominantly positive

results but with a clear trend towards better results for "behavioural" endpoints, e.g. adherence to medication or diet, and self-efficacy compared to results more clinical outcomes (e.g. blood pressure, or mortality), quality of life, and economic outcomes (e.g. costs or hospitalisation).

Telecare: Numerous case reports have looked at the impact of different telecare technologies on small numbers of patients, but there have been few large-scale randomised controlled trials, and insufficient high quality studies to robustly assess the impact of telecare overall on its users. For example, Lindqvist and Borrell (2012) described how a computer-based AT intervention helped four stroke survivors regain control of their everyday lives and of social contacts,[37] however the additional benefit over usual care and systemic implications of the intervention are unclear.

The British Psychological Society (2007)[38] recommends that Dementia Care Plans should include environmental modifications to aid independent functioning, including assistive technology, with advice from an occupational therapist and/or clinical psychologist. It suggests that the provision of an adaptive aid, low-level technology (such as visual prompts and signs, or structural changes to the home, such as shower installations), or memory aid should consider the person with dementia and any carer in their own environment and be chosen in collaboration with them. It also notes that combining adaptive aids with patient/carer education and environmental modifications contributed to improved outcomes in independence for people with dementia and reduced stress for their carers.

A number of publications have concluded that, in order to used effectively, introduction of AT should be

i) supported by comprehensive staff training,
ii) ii) done as part of fundamental service redesign e.g. to increase caseloads and allow the benefits of AT to be realised, and
iii) iii) for individuals, part of a wider holistic package of care and/or include some sort of wider support or education for individual patients and carers.[39]

A systematic review considering the impact of telecare on informal carers identified only 7 studies for inclusion. The authors concluded tentatively that telecare may exert a positive effect on carer stress and strain, but that there is no evidence to indicate benefits on carer burden or quality of life. The evidence is conflicting about the effect of telecare on the amount of time carers spend on their caring duties, and on relationships between the carer, cared-for person and other family members.[40]

In conclusion, the evidence around AT is conflicting. There is evidence that telehealth is effective in reducing avoidable mortality (by around 35-45%) among patients with some but by no means all LTCs, and in making moderate reductions in acute hospital usage among similar patients cohorts, however the latter is offset by the high additional cost of the intervention itself, rendering telehealth a non-cost-effective intervention overall. There is less robust evidence for a beneficial impact of telecare on individuals, families and the wider health and social care system. More high quality research in this area is indicated.

References

[1] *The King's Fund (2011) Transforming our health care system - Ten priorities for commissioners*

[2] *Martin et al. (2008) Smart home technologies for health and social care support. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD006412. DOI: 10.1002 /14651858. CD006412.pub2.*

[3] *Bahaadinbeigy et al. (2010) Gaps in the systematic reviews of the telemedicine field. Journal of Telemedicine and Telecare 16: 7: 416-8*

[4] *Department of Health (2013) Research and development work relating to assistive technology 2012-13. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211647/S22_Report_2012-13__2__FINAL.pdf*

[5] *Bahaadinbeigy et al. (2010) as above*

[6] *Martin et al. (2008) as above*

[7] *Darkins et al. (2008) Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions. Telemedicine and eHealth p1118-1126*

[8] *Vergara & Gagnon (2008) A systematic review of the key indicators for assessing telehomecare cost-effectiveness. Telemed J E Health 14: 896-904*

[9] *Inglis et al. (2010) Structured telephone support and telemonitoring in the management of patients with chronic heart failure. Cochrane Database of Systematic Reviews 2010, Issue 8. Art. No.: CD007228. DOI: 10.1002/14651858.CD007228.pub2.*

[10] *McLean et al. (2012) Telehealthcare for asthma. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD007717. DOI: 10.1002/14651858.CD007717.pub2*

[11] *McLean et al. (2011) Telehealthcare for chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2011, Issue 7. Art. No.: CD007718. DOI: 10.1002/14651858.CD007718.pub2.*

[12] *Tuntland et al. (2009) Assistive technology for rheumatoid arthritis. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD006729. DOI: 10.1002/14651858.CD006729.pub2.*

[13] *Välimäki etal. (2012) Information and communication technology in patient education and support for people with schizophrenia. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD007198. DOI: 10.1002/14651858.CD007198.pub2*

[14] *Anttila et al. (2012) Quality of evidence of assistive technology interventions for people with disability: An overview of systematic reviews. Technology and Disability 24/1(9-48), 1055-4181;1878-643X*

[15] *Cartwright et al. (2013) Effect of telehealth on quality of life and psychological outcomes over 12 months (Whole Systems Demonstrator telehealth questionnaire study): nested study of patient reported outcomes in a pragmatic, cluster randomised controlled trial. BMJ 346: f653.*

[16] *Steventon et al. (2013) Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial. BMJ 344: e3874.*

[17] *Henderson et al. (2013) Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. BMJ 346: f1035*

[18] *Ibid.*

[19] *Martin et al. (2008) as above*

[20] *Social Care Institute for Excellence (2008) Assistive Technology and Older People. Available from: http://www.scie.org.uk/publications/briefings/files/briefing28.pdf*

[21] *Tchalla et al. (2012) Efficac of simple home-based technologies combined with a monitoring assistive center in decreasing falls in a frail elderly population (results of the Esoppe study). Archives of Gerontology & Geriatrics 55/3(683-9), 0167-4943;1872-6976*

[22] *Al-Oraibi et al. (2012) Impact and economic assessment of assistive technology in care homes in Norfolk, UK. Journal of Assistive Technologies, 6(3), 192-201*

[23] *Henderson et al. (2013) as above*
[24] *Barlow et al. (2007) A systematic review of the benefits of home telecare for frail elderly people and those with long-term conditions. Journal of Telemedicine and Telecare 13/4(172-179), 1357-633X*
[25] *The British Psychological Society (2007) Dementia - A NICE–SCIE Guideline on supporting people with dementia and their carers in health and social care National Clinical Practice Guideline Number 42 and references therein. Available from: http://www.nice.org.uk/nicemedia/live/10998/30320/30320.pdf*
[26] *Department of Health (2010) Efficiencies in Telecare*
[27] *Sanders et al. (2012) Exploring barriers to participation and adoption of telehealth and telecare within the Whole System Demonstrator trial: a qualitative study. BMC health services research. 12:220*
[28] *Greenhalgh et al. (2013) What matters to older people with assisted living needs? A phenomenological analysis of the use and non-use of telehealth and telecare. Social Science and Medicine 93/(86-94), 0277-9536;1873-5347*

[29] *Cartwright et al. (2013) as above*
[30] *McLean et al. (2012) as above*

[31] *McLean et al (2011) as above*
[32] *Steventon et al. (2013) as above*
[33] *Alkema et al. (2007) Reduced mortality: The unexpected impact of a telephone-based care management intervention for older adults in managed care. Health Services Research 42/4(1632-1650), 0017-9124;1475-6773*
[34] *Inglis et al. (2010) as above*
[35] *McLean et al. (2011) as above*
[36] *Van den Berg et al. (2012) Telemedicine and telecare for older patients--a systematic review. Maturitas 73/2(94-114), 1873-4111*
[37] *Lindqvist & Borell (2012) Computer-based assistive technology and changes in daily living after stroke. Disability and Rehabilitation: Assistive Technology 7/5(364-371), 1748-3107*
[38] *The British Psychological Society (2007) as above*
[39] *The British Psychological Society (2007) as above; Social Care Institute for Excellence (2008) as above; The King's Fund (2011) Perspectives on telehealth and telecare*
[40] *Davies et al. (2013) Systematic review of the effects of telecare provided for a person with social care needs on outcomes for their informal carers. Health and Social Care in the Community. Centre for Reviews and Dissemination Database of Abstracts of Reviews of Effects 2013 Issue 3*

19. Ambulance Cars

There have been a range of initiatives looking at the role of emergency response vehicles to manage people in their homes and reduce conveyances or admissions to hospital. These initiatives typically use highly qualified paramedics and/or additional care personnel eg nurse, A&E SpR, GP, social worker, to manage a range of minor acute conditions eg falls and arrange for further interventions in the patient's home setting. The aim may be to see and treat on the scene and/ or to make arrangements for further care input rather than convey to hospital.

19.1 Interventions that reduce health and social care demand

There is limited peer reviewed evidence on the effectiveness of ambulance cars/emergency response vehicles. One study of emergency medicine registrars and paramedics reported 31% discharge at scene; whilst the study claimed this was an improvement on usual practice no comparative figures were presented].[1] Another study of emergency care practitioners found an increase in see and treat (falls and breathing difficulties) at the scene (64% compared to 24% usual practice); there was subsequent attendances and admission to hospital within 72 hours or 28 days but little comparative data was presented.[2] Gray noted that there are significant upfront costs in training staff and a return on investment may take up to 4 years. Gray also noted that many of the see and treat contacts were in the minor category and that A&E attendances rather than more costly admissions may be avoided. A study of paramedic practitioners also found a reduction in A&E attendance (62.6% compared with 87.5%) although they did find a higher rate of subsequent unplanned contact with services (21.3% compared with 17.6%)[3]

There are a number of initiatives being carried out nationally on variations of pre hospital emergency response but little detail on rigorous evaluation.[4]
Impact on patient / client care satisfaction
The study by Mason et al (2007) assessed patient satisfaction and found that 85.5% (compared with 73.8% typical practice) were very satisfied with their care.

References

[1] *Deasy C.,Ryan D.,O'Donnell C.,Cusack S. The impact of a pre-hospital medical response unit on patient care and emergency department attendances Irish medical journal, Feb 2008, vol./is. 101/2(44-46), 0332-3102 (Feb 2008)*

[2] *Gray J.T.,Walker A. Avoiding admissions from the ambulance service: A review of elderly patients with falls and patients with breathing difficulties seen by emergency care practitioners in South Yorkshire Emergency Medicine Journal, March 2008, vol./is. 25/3(168-171), 1472-0205 (March 2008)*

[3] *Mason S.,Knowles E.,Colwell B.,Dixon S.,Wardrope J.,Gorringe R.,Snooks H.,Perrin J.,Nicholl J. Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: Cluster randomised controlled trial British Medical Journal, Nov 2007, vol./is. 335/7626(919-922), 0959-8146 (03 Nov 2007)*

[4] *http://ro.ecu.edu.au/cgi/viewcontent.cgi?article=1189&context=jephc Examples of initiatives [accessed 24/9/13].*

20. Urgent Interventions at time of Crisis

This section considers interventions by health and social care when unscheduled need arises that will potentially precipitate hospital admission. It does not include mental health crises. These are addressed elsewhere.

20.1 Rapid Response Teams

Purdy in her Kings Fund[1] report stated that there is no evidence identified in relation to Rapid Response teams and their effectiveness in preventing admissions. In brief, Rapid Response teams aim to offer social support in a time of crisis in order to avoid emergency hospital admission.
Unfortunately, there have been few UK studies of Rapid Response teams. The role of rapid response teams in preventing hospital admission hence remains unclear.

Recently, Wright et al[2] reported the evaluation of "TREAT", a system of care combining early Accident and Emergency (A&E) based senior doctor review, Comprehensive Geriatric Assessment (CGA), therapist assessment and supported discharge; post-discharge supported recovery; and a rapid access geriatric 'hot-clinic'. TREAT was supported by a post-acute care enablement (PACE) team, providing short-term nursing support immediately following discharge.

The team reduced mean length of stay (LOS) by 18.16% (1.78 days, $P < 0.001$) for TREAT-matching admissions; by 11.65% (1.13 days, $P < 0.001$) for all emergency geriatric admissions; and by 1.08% (0.11 days, $P = 0.065$) for the residual population. Over the same period, the percentage of admissions resulting in same-day discharges increased from 12.26 to 16.23% (OR: 1.386, 95% CI: 1.203–1.597, $P < 0.001$) for TREAT-matching admissions, but for the residual population fell from 15.01 to 9.77% (OR: 0.613, $P < 0.001$, 95% CI: 0.737–0.509).

This scheme appears to have reduced avoidable emergency geriatric admissions, and to have shortened LOS for all emergency geriatric admissions.

Similarly the NHS QIPP (Quality, Innovation, Productivity and Prevention) Evidence[3] describes evaluation of the Bristol multi-disciplinary health and social care service to respond rapidly to a health or social care crisis. The total cost of the crisis response element of the service is £2.8m to which both the PCT and local authority contribute (approximately 70/30 ratio). The costs are made up of staff cost, accommodation, treatment and step-up, bed-based services where they are required.

The net savings to the PCT by treating people in the community are £3.6M and £0.7m for the local authority (see above and case study for further detail). These are the savings achieved in 08/09, the period that the case study refers to, but are typical of what the service has achieved since its creation. The population served is around 450k. Unfortunately this evidence is not of the

most robust kind but suggests consideration.

20.2 Social care in A&E

A Canadian study demonstrated that 5 per cent of admissions could have been avoided if seen by a social worker in A&E (Boyack and Bucknam 1991).[4] A French study found that a similar proportion of admissions was potentially preventable by a social work intervention (Monsuez *et al* 1993).[5] A study of a US emergency department demonstrated that having social workers available 24 hours a day can be economically beneficial (Gordon 2001).[6] There were greater advantages in larger departments in terms of fewer return visits, prevention of admissions for social reasons only, and savings in terms of other staff time. The applicability of this study to the UK is limited by the differences in costing health care in the two systems. Overall, there seems to be uncertainty about the effectiveness of social workers based in the emergency department in terms of reducing inappropriate admissions among older people although this may be because of a lack of supporting community resource (McLeod *et al* 2003).[7]

In conclusion, there is very limited evidence around the benefits of rapid response and crisis intervention either way although there are some examples of potential benefit. Partners may wish to consider developments in this area but to exercise caution and evaluate robustly with clear exit strategies.

References

[1] Purdy S. Avoiding Hospital Admissions. What does the evidence say?. Kings Fund 2010[2] *Wright P,Tan G.,Illiffe S.,Lee D. The impact of a new emergency admission avoidance system for older people on length of stay and same-day discharges*

[3] Rapid Response Services: intermediate tier, multi-disciplinary health and social care service Provided by: Care Services Efficiency Delivery Programme (CSED - DH) in Partnership with Bristol PCT and Bristol City Council DH 2011

[4] Boyack VJ, Bucknum AE. The Quick Response Team: a pilot project. Soc Work Health Care. 1991;16(2):55–68.

[5] Monsuez JJ, Fergelot H, Papon BJ, Le Gall JR. Early social intervention in the emergency department. Eur J Med. 1993 Oct-Nov;2(8):489–492.

[6] Gordon JA. Cost-benefit analysis of social work services in the emergency department: a conceptual model. Acad Emerg Med. 2001 Jan;8(1):54–60.

[7] McLeod E, Bywaters P, Cooke M (2003), Social work in accident and emergency departments: a better deal for older patients' health?, British Journal of Social Work, vol.33(6), pp787-802

21. Support to Care Homes

Over the past few decades there has been a large transition of older individuals moving from living alone to living in care-homes, with a majority of these individuals having multi-faceted complex medical issues.(1) Currently there are 4,541 individuals supported in registered care, with 572 individuals supported in residential care and 3,969 older individuals supported in nursing care across Essex.(2) Individuals from care homes have been found to have a higher rate of admission and re-admission to hospitals compared to other individuals of the same age and due to this, usually have a longer length of hospital stay. Several studies have identified that many of these admissions are avoidable and that care home residents would prefer to remain in the care home as opposed to being admitted to a hospital.(3)

21.1 Issues

Over-arching themes noticed among several studies indicate that these hospital admissions could be avoided with improved primary care participation and input, improved general access and support from out of hour's physicians and specialist nurses, improved access to clinical tests (blood results/ECGs) and furthermore improved communication between all care staff and improved knowledge and training surrounding end-of-life care.

21.2 Interventions

Despite the limited number of interventions currently in practice, there are promising interventions available that could help tackle these prominent issues, improving clinical and financial outcomes.

21.3 Community Management Team and Improved partnership between Geriatricians and GP's.

There is strong evidence to suggest that an integrated clinical and social care plan can improve patient outcomes, reduce hospital admissions, and reduce financial costs associated with avoidable hospital admissions.(4) The clinical and social care plan would involve a combination of individual case management and future care planning as administered by a combination of a geriatric community team working in conjunction with general practitioners. One study estimated there to be a 31% reduction in hospital admission in individuals who have an integrated clinical and social care plan in place.(4) A similar study carried out in the UK, which initially targeted three nursing homes with the highest amount of multiple admissions, reduced hospital admissions by 52%. The three initial homes combined had a total bed capacity of 165 beds, and resulted in a reduction of 57 bed days over a 3 month period. When an additional three care homes were included, not dependent on the number of previous multiple admissions, a significant reduction of 43% was seen. This study estimated that each emergency admission cost the trust £523 and that there would be cost savings if this intervention was implemented. The service provided in this study included; monthly medical advisory meetings with GP's and geriatricians, telephone advice available daily, supported end of life care plans and support from a tertiary company to provide IV fluids and antibiotics in care homes.(5) Over the initial six months there was a reduction of 250 bed days estimated at £260 per day.(5) This service has since been implemented by the North West Surrey CCG enrolling 15 care homes in total.

21.4 Local Enhanced Service (LES) from GP's.

LES's targeting residential and nursing homes have already been implemented in parts of England and have shown qualitative and quantitative improvements to clinical outcomes and financial outcomes.[1] Although the services provided vary slightly from region to region, they generally encompass new patient review and annual review for clinical status, annual medication review, and monthly MDT reviews or routine ward rounds. This approach is similar to that of a community management team however with a stronger prime emphasis on continuity of care provided by GP's. There have also been recommendations to implement a similar pharmacist-led service to ensure prompt delivery of medication.

21.5 Care Home Training and Support.

There has been promising evidence in interventions that target improving services provided by care homes. A trial intervention carried out in the United States has implemented a quality improvement set of tools and strategies targeted at care home staff to improve early identification, assessment, communication, and documentation about changes in resident status.[6] The service provided on-site education, tools to reduce acute care transfers and fortnightly teleconferences between care home staff and a geriatric nurse practitioner. It is estimated that hospital admissions would be reduced by 17%.

A study in the UK, which implemented a dedicated nursing and physiotherapy team to support 131 residents and 15 virtual beds from four residential care homes in Bath and North East Somerset, prevented hospital admission by allowing early detection of illness and subsequent early intervention.[7] 733 referrals were made during a 2 year period of time, and after full assessment, 197 hospital admissions were averted. This study estimated that the costs and savings of this intervention can vary, with a worst case scenario costing the NHS £2.70 more per resident per week. However if the intervention is implemented with the proper support, the maximum potential overall saving of £36.90 per resident per week would equate to nearly £250,000 saved per annum in a population of 131 residents.[7]

21.6 Impact on patient / client care satisfaction

All of the interventions detailed above improve patient /client care satisfaction. Patients will feel supported and will have a point of contact to answer any questions as developed, by a stronger continuity of care. This in turn will allow residents to retain a greater sense of independence as they will have input into their health care planning. Relatives will also be re-assured that everything has been done in the community prior to a hospital admission. There will also be a higher level of service efficiency in care home staff if a clear and coherent plan is in place and a stronger working relationship will be developed between the GP 's and the nursing home staff.

References

[1] *Briggs, D and Bright,L. Reducing hospital admissions from care homes: considering the role of a local enhanced service from GP's. Working with Older People: Community Care Policy & Practice,2011 Vol 15 (1) pp4-12.*

[2] *Commissioning, Commercial & Operational Intelligence. Older People Locality Profile: West. 2013.*

[3] *Gillie Evans. Factors Influencing Emergency Hospital Admissions from Nursing and Residential Homes: Positive Results from a Practice Based Audit. Journal of Evaluation in Clinical Practice 2011.Vol 17 pp1045-1049*
[4] *Bernabei, R. et al. Randomised trial of impact of model of integrated care and case management for older people living in community. The British Medical Journal. 1998, vol 316, pp 1348-1351*
[5] *R. Lisk, K. Yeong, M. Bhaskar, B. Mike, D. Zahid. Effective partnership between geriatricians and general practitioners (GPS) in nursing homes reduces emergency hospital admission. European Geriatric Medicine. 2011. 2S, S1-S23*
[6] *Ouslander JG, et al. Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project. Journal of the American Geriatrics Society. 2011 vol 59(4) pp. 745-753*
[7] *Szczepura, A., Nelson, S., and Wild, D. In-Reach Specialist Nursing Teams for Residential Care Homes: Uptake of Services, Impact on Care provision and Cost Effectiveness. BioMed Central Health Services Research. 2008. 8:269*

22. End of Life Care

The final year of life is strongly associated with hospital admissions – around 90% of people spend some of this time in hospital, and the total cost of non-elective episodes ending in death is around £750m per year.[1] However, understanding how many admissions near the end of life are avoidable is not straightforward and a review of the literature has not found clear agreement.
A retrospective study of inpatient deaths in an English hospital concluded that 20% of admissions were 'clearly avoidable' and 13% were 'probably avoidable' (assuming suitable services for care at home).[2] Work for the National Audit Office's End of Life Care report found that 40% of deaths in one month in a Sheffield hospital could have occurred at home or in another setting.[3] Gott et al (2013)[4] looked at the extent of potentially avoidable admissions of patients with palliative care needs, and found that just 7% of admissions of patients meeting criteria for palliative care were identified as avoidable. Given the lack of clarity around how many end of life admissions are avoidable, it may be difficult to significantly reduce the hospital use of patients at the end of life.

This review of the literature has looked at the evidence for reducing health and social care use at the end of life. The recent review of funding for palliative care[5] concluded that 'there is a stunning lack of good data surrounding costs for palliative care in England'; unfortunately it seems that there is also a lack of good data around many other aspects of end of life care.

Death at home is the preferred option of most people, with hospice-style care a clear second preference. Actual place of death for Essex CC residents is quite different (although similar to national place of death data); 58% die in hospital (or in a hospice unit or specialist palliative care unit within a hospital), and just 36% die at home or in a care home. Of those deaths in hospital, a very high proportion were admitted as emergencies (93%, significantly higher than the England average of 90%).[6] The estimated number of deaths per year where palliative care is needed was 12,067 across Essex (including Southend and Thurrock).[7]

22.1 Impact on Health Service

'Hospice at home services': A Cochrane review (Gomes et al, 2013)[8] looked at studies which compared the effect of home palliative care versus 'usual care' on emergency department care and intensive care use. These studies were all conducted in the United States. The reviewers found 'moderate evidence of no statistically significant effect' on these measures, and also found that the evidence was inconclusive around the cost-effectiveness of home palliative care compared to usual care. The review did find that there was clear and reliable evidence that home palliative care increased the chance of dying at home and reduced the symptom burden. The review also found that the evidence on home palliative care's impact on use of social services was inconclusive. A similar meta-analysis of 'community specialist palliative care services' (services to enable people to be cared for and to die at home) found inconclusive evidence that these services increased the rate of home death without increasing costs.[9]

A recent retrospective cross-sectional study in Western Australia (published after the Cochrane review's literature search) found that early access to community-based

palliative care reduced the chance of visiting the emergency department (OR=2.86, 95% CIs 1.91-4.30) but the report did not define 'community based palliative care'.[10]

However Chitnis et al (2012)[11] published (after the Cochrane review literature search) a UK case-control study which compared nearly 30,000 people who received Marie Curie Nursing Service care (home-based palliative care) with matched controls. Marie Curie patients were significantly more likely to die at home (77% died at home compared with 35% of the control group – adjusted OR 6.97, 95% CIs 5.94-6.38). Just 8% of Marie Curie patients died in hospital compared with 42% of controls (OR not given). Compared to controls, Marie Curie patients had around a third of the number of A&E attendances and emergency admissions (adjusted OR 0.19, 95% CIs 0.18 – 0.20), and less than half the number of elective admissions (adjusted OR 0.41, 95% CIs 0.41-0.41). The reduced likelihood of hospital admission and A&E attendance was reflected in hospital care cost savings, with an estimated average reduction of over £1,100 per Marie Curie patient compared with controls (this excludes the cost of providing Marie Curie care however). Interestingly, the cost savings for patients with cancer were smaller than for patients with other conditions (around £1,000 per cancer patient and around £1,500 for other patients).

If 75% of all deaths from cancer in Essex used health services in the same way as the Marie Curie cohort in this study, the savings to hospital care costs could be around £2.7m (excluding the costs of providing the Marie Curie care, and assuming similar services are not in place at present). The proportion of deaths from cancer at home could increase from 27% to 58% (the proportion of all deaths at home would increase from 20% to 32%).[12]

Overall, the evidence base lends some support for investment in home palliative care to reduce emergency hospital admissions but this is based on one large UK study only.

Advance care planning : Abel et al (2013) conducted a retrospective cohort study of hospice patient deaths in the South West of England, looking at the effect of advance care planning (ACP; indicated by notes on preferred place of death) on place of death and use of health services. 11% of patients whose notes indicated ACP died in hospital, compared to 26% of controls (who received hospice care but whose notes did not indicate ACP). The mean number of hospital bed days for the ACP patients was significantly lower than for controls (18.1 days vs 26.5 days, $p<0.001$) although the number of admissions, number of emergency admissions, and cost of emergency admissions were not significantly different. The limited effect of ACP should be seen as additional to the other benefits that hospice care may have in reducing hospital use by patients at the end of life (see next section).
Similar work in the US by Fonk et al (2012)[13] found that the use of 'Advance Directives' for Medicaid patients did not reduce end of life costs when controlled for patient health.

However, there is some evidence for the use of advance care planning for residents in nursing or care homes. A lack of advance care plans was one reason given for a high admission rate of end of life patients from care homes in Norfolk, and Ahearn et al (2010) also suggest that advance care planning can reduce hospital admissions in end of life patients resident in nursing homes.[14][15]

Hockely et al (2010)[16] found that the introduction of the Gold Standards Framework for Care Homes was associated with a reduction in 'clinically inappropriate' hospital bed days, hospital admissions in the last eight weeks of life, and a reduction of deaths in hospital, but this does not appear to have been tested for statistical significance.

Hospice and community hospital care for end of life patients: There is very little published work looking at the effects that inpatient hospice or community hospital care for end of life patients have on emergency admissions or other acute hospital use.

It seems intuitive to expect hospice or community hospital care to reduce the need for acute care for end of life patients, but there is not a solid evidence base to support (or refute) this assumption. However, in Essex, 559 people die in hospice each year[17] and without the availability of the hospice care it seems reasonable to assume that a large majority of these people would have died in hospital, incurring cost pressure on the acute trusts in the county.
DeVader et al (2012)[18] evaluated a hospice unit within a hospital in the USA and found that transferring end of life patients directly from the emergency department to the hospice unit reduced hospital costs, compared with transferring patients from elsewhere in the hospital (intensive care or other wards).

22.2 Impact on Social Care

The literature search did not identify any work on interventions to reduce social care use at the end of life.

References

[1] Gott M et al (2011) A narrative literature review of the evidence regarding the economic impact of avoidable hospitalizations amongst palliative care patients in the UK. Progress in Palliative Care 19 (6)
[2]Abel J, Rich A, Griffin T and Purdy S. (2009) End of life care in hospital: a descriptive study of all inpatient deaths in one year. Palliative Medicine 23.
[3] Balance of Care group in association with the National Audit Office. Identifying alternatives to hospital for people at the end of life. London: NAO; 2008.
[4] Gott M et al (2013) What is the extent of potentially avoidable admissions amongst hospital inpatients with palliative care needs? BMC Palliative Care. 12 (1)

[5] Hughes-Hallet review XX add ref
[6] National End of Life Care Intelligence Network. National End of Life Care Profiles for Primary Care Trusts – Essex. Place of death data is from ONS for 2008-10, type of admission that ends in death is from 2010/11 HES data.
[7] Palliative care need estimate deaths per year 2008-10 from Marie Curie End of Life Care Atlas (http://www.mariecurie.org.uk/en-GB/Commissioners-and-referrers/Resources/Marie-Curie-Atlas/ accessed August 2013)
[8] Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ (2013) Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers (Review). The Cochrane Collaboration. (XX check reference format)
[9] Luckett T et al (2013) Do community specialist palliative care services that provide home nursing increase rates of home death for people with life-limiting illnesses? A systematic review and meta-analysis of comparative studies. Journal of Pain and Symptom Management, 45 (2).
[10] McNamara B et al (2013) Early admission to community-based palliative care reduces use of emergency departments in the ninety days before death. Journal of Palliative Medicine, 16 (7)

[11] *Chitnis X, Georghiou T, Steventon A and Bardsley M (2012). The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life. The Nuffield Trust.*
[12] *3,655 deaths from cancer each year in Essex (2008-10 figure from the End of Life Care Profile, National End of Life Care Intelligence Network). Not all cancer patients can be safely cared for at home. 20% of deaths in Essex take place at home at present – figure from the End of Life Profile.*
[13] *Fonk, J et al (2012) The effect of advance directives on end-of-life cost experience. Journal of Health Care for the Poor & Underserved. 23 (3)*
[14] *Ong AC, Sabanathan K, Potter J, Myint PK (2011) High mortality of older patients admitted to hospital from care homes and insight into potential interventions to reduce hospital admissions from care homes: the Norfolk experience. Archives of Gerontology and Geriatrics. 53 (3)*
[15] *Ahearn DJ, Jackson TB, McIlmoyle J, Weatherburn AJ (2010) Improving end of life care for nursing home residents: an analysis of hospital mortality and readmission rates. Postgraduate Medical Journal. 86*
[16] *Hockley J, Watson J, Oxenham D, and Murray SA (2010) The integrated implementation of two end-of-life care tools in nursing care homes in the UK: an in-depth evaluation. Palliative Medicine 24 (8).*
[17] *2008-10 figure from the End of Life Care Profile, National End of Life Care Intelligence Network*
[18] *DeVader TE, DeVader SR, Jeanmonod R (2012) Reducing cost at the end of life by initiating transfer to inpatient hospice in the emergency department. Annals of Emergency Medicine, 60 (4S).*

23. SOS Bus

This section focuses on the local evaluation of the Colchester SOS bus.

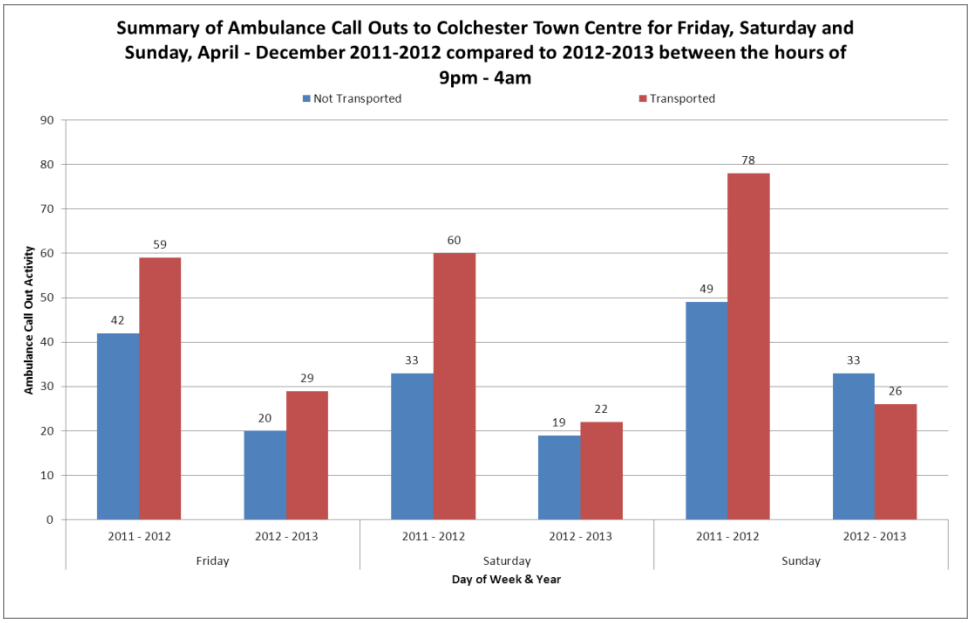
The original purpose of the bus was to support and improve the night-time economy and environment of Colchester town centre by providing a place of safety for anyone alone, ill, injured or otherwise vulnerable and to support other agencies, such as the police, working in the town at night. Run by Open Road and staffed mainly by volunteers, it operates on Friday and Saturday nights, from 9pm until 4am, and other peak nights for alcohol consumption such as New Year's Eve. Current funding comes mainly from Colchester Borough Council with a contribution from ECC Public Health and, more recently, from North Essex Clinical Commissioning Group (CCG).

23.1 Service and savings

Clinical cover, provided by a doctor or paramedic, was introduced for an initial one year pilot project from April 2012. A wider range, and more serious, injuries and illnesses could then be treated, reducing demand on other services, as demonstrated by ambulance, SOS Bus and A&E data.

23.2 Ambulance service data

Ambulance service data (see below), comparing the first nine months of the service in 2012 with the same period in 2011, shows a reduction of over 50% (from 321 to 149) in call-outs to Colchester town centre during the hours when the Bus was operational and a 60% reduction (197 to 77) in transported cases.

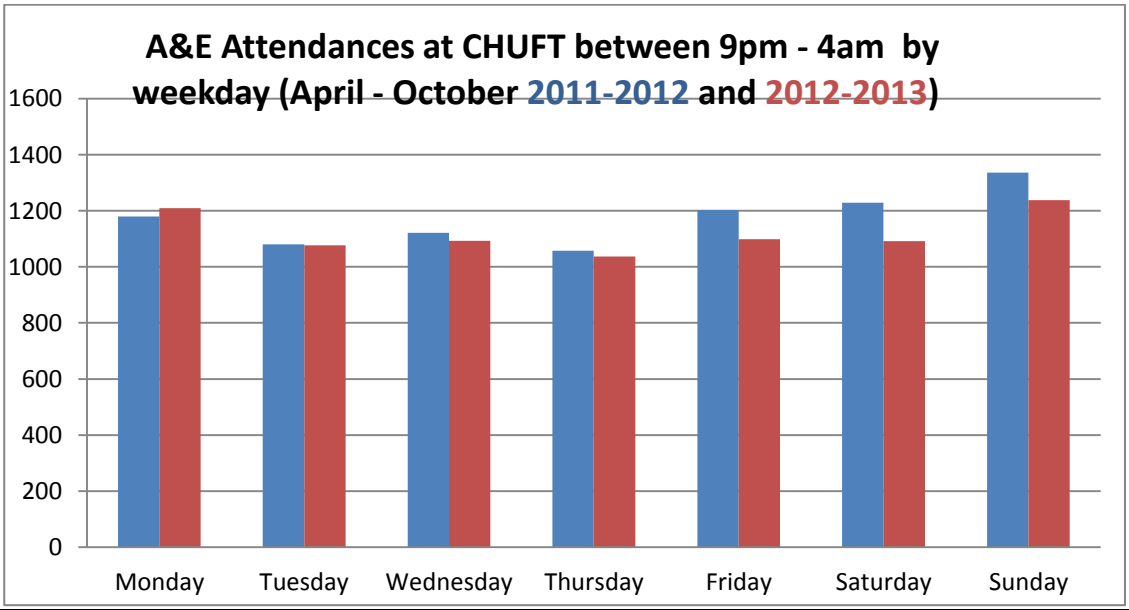


23.3 A&E data

SOS Bus data shows that in the first nine-months 155 cases were treated that would otherwise have required A&E treatment, reducing A&E walk-in costs by an estimated

£8,500. In addition data from CHUFT (Colchester Hospital University Foundation Trust) shows decreasing A&E attendances during SOS Bus operational hours (see below).

It should be noted that there is likely to be some double-counting within these data sets (i.e. the Bus treated someone who may otherwise have called an ambulance)



Left/Blue column – 2011-2012 **Right/Brown column 2012-2013**

23.4 Savings

It is estimated that in the first nine month period an investment of £40,500 may have reduced costs by over £100,000, which suggests that savings to the health economy were in the region of £60,000.

24. Inappropriate Urgent Care Usage

It has been widely reported that current demands on Accident and Emergency departments are increasing current A&E capacity, threatening the ability of services to work effectively. This section considers evidence in terms of programmes that reduce inappropriate demand on A&E

24.1 GP within A&E Schemes

Employing GPs in emergency departments has been shown to reduce rates of investigations, referrals and prescriptions.[1] A pilot in York District Hospital A&E where a GP saw 9% of all patients resulted in 73% being discharged home. Patient waiting time was significantly reduced by seeing the GP rather A&E doctors, and patient satisfaction was high. The study did warn however, that because of high patient satisfaction with the pilot, permanently basing GPs in A&E may actually encourage more patients to attend A&E to see a GP.[2]

A Cochrane review of three non-randomised studies involving a total of 11,203 patients, 16 General Practitioners (GPs), and 52 Emergency Physicians (EPs), evaluating the effects of introducing GPs to provide care for patients with non-urgent problems in A&E compared to hospital A&E doctors. The review demonstrated that GPs order less blood tests and x-rays and admit fewer patients to hospital and that EPs referred more patients and prescribed more medications than GPs. Two of the three studies showed marginal cost savings of the intervention and provided limited evidence on patients' self-reported health outcomes. The third study found no differences between the two approaches with respect to blood tests, x-rays or hospitalizations. This study involved fewer participants (1878), and used an unstructured triage system which may have led to misclassification of patients into urgent and non-urgent groups.[3]

24.2 Reducing A&E usage by high frequency users.

A number of studies have sought to describe the clinical and demographic profile of patients that use A&E multiple times a year. High frequency A&E users have found to be more likely to come from lower socio-economic groups and have lower levels of social support.[4][5][6] One large study which analysed 117,000 A&E attendances over one year in a south-east London teaching hospital concluded that patients that were high intensity users (defined as >4 visits in a year) were more likely to be older, male and have more serious health conditions. They were also more likely than other patients to attend out of hours.[7] A case control study using 457 cases accessing A&E at Basildon hospital in the late 1990s found that of 457 patients who attended A&E appropriately matched with 457 controls on age, sex, socioeconomic status, distance from A&E and registered GP practice in south Essex found that inappropriate attenders had twice as many GP appointments and ten times as many out of hours advice calls as non-attenders. Markers of anxiety and depression strongly significantly correlated with A&E attendance but was no significant difference between inappropriate attenders and non-attenders in terms of chronic morbidity, suggesting general clinical need was not a factor

Overall inappropriate attendance ratio was 16.8% of all attendances.[8]

There is evidence that implementing multi-disciplinary team care planning on discharge from A&E of high intensity users reduces future use. A study that analysed the A&E

usage of 32 patients that accounted for 858 A&E visits and 209 hospital admissions found that in the 12 months after the introduction of care plans (incorporating information from the patient's GP, social care needs, mental health needs, drug/alcohol needs, etc), A&E attendances fell to 517 with only 77 admissions. The study concluded that individual care planning can reduce attendance by 50%, although absolute numbers may be small.[9] A study examining a cohort of 57 patients with very high usage of A&E >10 times in a year found that implementing multi-disciplinary case management/care plans reduced usage by 31%. High usage patients often had complex multi-factoral health and social needs, especially social isolation, and case management was effective at addressing them. However an alternative explanation may be regression towards the mean – i.e. patients who are initial outliers in A&E use are likely to normalise use over time. Alcohol misuse was the most common problem amongst the cohort, followed by mental health problems.[10] A further study found that intervention by a multi-disciplinary team consisting of a social worker and nurse care manager improved the clinical management of patients regarding medical and psycho-social care across the healthcare continuum, improved effectiveness by linking patients with community resources and decreased the use of A&E as a primary care provider.[11]

24.3 Hospital Based Alcohol Harm Reduction/Treatment Referral Programmes.

There is a large body of evidence that a significant number of A&E attendances have alcohol as an underlying cause.[12][13][14] Introducing alcohol screening using a FAST or AUDIT tool, and providing appropriate brief intervention or referral to extended intervention is highlighted in the Department of Health Commissioning Guidance on Alcohol[15] as one of the high impact changes that can reduce A&E revolving door patients. Similarly, commissioning Alcohol Nurse Liaison Services (ALNS) within secondary care to identify dependent drinkers admitted for health problems directly attributable to alcohol misuse (e.g. liver and gastroenteritis) and developing a case management approach to address their alcohol dependency in association with drug/alcohol services has been shown to be highly cost effective.[16]
There is no evidence that:

- Out of hours walk in services reduce A&E attendance
- NHS direct reduces A&E attendances

References

[1] *Dale, J., Lang,H., Roberts, J.A. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practioners, senior house offices and registrars. British Medical Journal. 1996,* ***312****: 1340-4.*

[2] *Jones 2011*
[3] *Khangura JK, Flodgren G, Perera R, Rowe BH, Shepperd S Primary care professionals providing non-urgent care in hospital emergency departments (Review), Cochrane Library, 2012, London: Wiley*
[4] *Lee A, Hazlett CB, Chow S, Lau FL, Kam CW, Wong P, Wong TW. How to minimize inappropriate utilization of Accident and Emergency Departments: improve the validity of classifying the general practice cases amongst the A&E attendees. Health Policy. 2003, Nov;66(2):159-68.*

[5] *Murphy, A.W., Leonartd, C., and Plunkett, K.P. Characteristics of attenders and their attendances at an urban accident and emergency department over a one year period. Journal of Accident and Emergency Medicine. 1999,* ***16****:425-7*
[6] *Sun, B.C., Burstin, H.R. and Brennan,T.A. Predictors and outcomes of frequent emergency department users. Academic Emergency Medicine. 2003,* ***4****:574-80*
[7] *Moore, L., Deehan, A., Seed, P., and Jones, R. Characteristics of frequent attenders in an emergency department: analysis of 1-year attendance data. Emergency Medical Journal, 2009,* ***26****:263-267.*
[8] *Martin, A., Martin, C. Martin, P.B., Green, G. and Eldrige, S. Inappropriate attendance at accident and emergency department by adults registered in local general practices: how is it related to their use of primary care? Journal of Health Services Research Policy, 2002, 7(3): 160-165.*
[9] *Newton, A., Sarker, S,J., Parfitt, A., Henderson, K., Jaye, P. and Drake, N. Individual care plans can reduce hospital admission rate for patients who frequently attend the emergency department. Emergency Medical Journal. 2011,* ***28****:654-657.*
[10] *Skinner, J. Carter, L. and Haxton, C. Case management of patients who frequently present to a Scottish emergency department. Emergency Medical Journal. 2009,* ***26****:103-105*
[11] *Bristow, D. and Herrick, C. Emergency Department Case Management. Lippincott's Case Management, 2002,* ***7(6):****243-249*
[12] *Green, M., Setchell, J., Hames, P., Stiff, G., Touquet,R., and Priest, R. Management of alcohol abusing patients in accident and emergency departments. Journal of the Royal Society of Medicine, 1993,* ***86****:393-395*
[13] *Department of Health, Signs for Improvement- Commissioning Interventions to Reduce Alcohol Related Harm. 2007, London: Department of Health*
[14] *Thom, B., Herring, R. and Judd, A. Identifying alcohol-related harm in young drinkers: the role of Accident and Emergency departments. Alcohol and Alcoholism, 1999,* ***34****: 910-915*
[15] *Department of Health (2009) Signs for Improvement- Commissioning Interventions to Reduce Alcohol Related Harm. London: Department of Health*
[16] *Charalambous, M.P. Alcohol and the Accident and Emergency Department: A Current Review. Alcohol and Alcoholism. 2002,* ***37****(4) 307-312*

25 Education and Self-Management

Definition: According to Purdy et al.[1] review, self-management is a term applied to any formalized patient education programme aimed at teaching skills needed to carry out medical regimens specific to the disease, guide health behaviour change, and provide emotional support for patients to control their disease and live functional lives.

25.1 Asthma

There have been four and three recent Cochrane reviews in children and adults respectively looking at the impact of education and self-management interventions on hospital admissions. A Cochrane review of limited education interventions (information only) included 12 trials 12 RCTs. {Gibson 2008}[2] reported that limited asthma education did not reduce hospitalisation for asthma. The same authors (Gibson 2009)[3] found however that self-management with education and practitioner review reduced hospitalisations (relative risk 0.64, 95% CI 0.50, 0.82)

Tapp[4] in 2010 reviewed educational interventions in the accident and emergency department. There was a statistically significant reduction in subsequent hospital admission in the educational intervention groups (RR 0.50; 95% CI 0.27 to 0.91,).

Reviews of action plans[5] and self-management and educational interventions in children[6] showed no impact on hospital admissions, review of A/E interventions was equivocal.[7]

25.2 COPD

A Cochrane review of action plans[8] found no impact on hospital admissions. A review of self-management with education[9] showed, at follow up times of 3-12mths, a significant reduction in the probability of at least one hospital admission among patients receiving self-management education compared to those receiving usual care (OR 0.64; 95%CI 0.47, 0.89). This translates into a one year NNT ranging from 10 (6 to 35) for patients with a 51% risk of exacerbation, to an NNT of 24 (16 to 80) for patients with a 13% risk of exacerbation.

25.3 Heart Failure

Boyde 2011[10] a total of 2686 patients were included in 19 RCTs. Most of the included studies comprised of an initial educational intervention which was a one-on-one didactic session conducted by nurses supplemented by written materials and multimedia approaches. The RCTs used a variety of outcome measures to evaluate their effectiveness. Of the RCTs reviewed, 15 demonstrated a significant effect from their intervention in at least one of their outcome measures.

25.4 Older People

Parry 2009[11] used an RCT to test whether a self-care model for transitional care could improve outcomes in Medicare Advantage and Medicare fee-for-service populations in the US. Intervention patients were less likely to be readmitted to a hospital in general, and for the same condition that prompted their index hospitalization, at 30, 90, and 180 days versus control patients. Application to this country is uncertain.

References

[1] *Purdy S., Paranjothy S., Huntley A., Thomas R., Mann M., Huws D., Brindle P. Elwyn G., Interventions to reduce unplanned hospital admission: a series of systematic reviews Final Report June 2012*

[2] *Gibson PG, Powell H, Coughlan J et al. Limited (information only) patient education programs for adults with asthma. Cochrane Database Syst Rev 2008 ;(2):CD001005.*

[3] *Gibson PG, Coughlan J, Wilson AJ et al. Self-management education and regular practitioner review for adults with asthma. Cochrane Database Syst Rev 2009; (2):CD001117.*

[4] *Tapp S, Lasserson TJ, Rowe B. Education interventions for adults who attend the emergency room for acute asthma. Cochrane Database Syst Rev 2010 Jul 18;(3):CD003000.*

[5] *Bhogal S, Zemek R, Ducharme FM. Written action plans for asthma in children. Cochrane Database Syst Rev. 2009 ;(3):CD005306.*

[6] *Wolf F, Guevara JP, Grum CM et al. Educational interventions for asthma in children. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD000326. DOI: 10.1002/14651858.CD000326*

[7] *Boyd M, Lasserson TJ, McKean MC et al. Interventions for educating children who are at risk of asthma-related emergency department attendance. Cochrane Database of Systematic Reviews 2009 Apr 15 ;(2):CD001290*

[8] *Walters JA, Turnock AC, Walters EH et al. Action plans with limited patient education only for exacerbations of chronic obstructive pulmonary disease. Cochrane Database Syst Rev 2010a May 12;(5):CD005074*

[9] *Effing T, Monninkhof EM, van der Valk PD et al. Self-management education for patients with chronic obstructive pulmonary disease. Cochrane Database Syst Rev. 2007 Oct 17 ;(4):CD002990.*

[10] *Boyde M, Turner C, Thompson DR et al. Educational interventions for patients with heart failure: a systematic review of randomized controlled trials. J Cardiovasc Nurs. 2011 Jul-Aug; 26(4):E27-35.*

[11] *Parry C, Min SJ, Chugh A, Chalmers S et al. Further application of the care transitions intervention: results of a randomized controlled trial conducted in a fee-for-service setting. Home Health Care Serv Q. 2009; 28(2-3):84-99.*

GLOSSARY OF TERMS

A & E – Accident and Emergency
ACP – Advanced Care Planning
ACS – Ambulatory Care Sensitive
AMU – Acute Medical Unit
ANLS – Alcohol Nurse Liaison Service
AT – Assistive Technology
AUDIT – Alcohol Use Disorders Identification Test
BNF – British National Formulary
BW – Battered Women
CCG – Clinical Commissioning Group
CGA – Comprehensive Geriatric Assessment
CHF –Congestive Heart Failure
CHUFT - Colchester Hospital University Foundation Trust
CI – Confidence Interval
CPM – Combined Predictive Model
CRHT – Crisis Resolution and Home Treatment
CTT – Cognitive Trauma Therapy
DV – Domestic Violence
ECC – Essex County Council
ECCEP – Evaluating Community Care for Elderly People study
ECG – Electrocardiogram
ED – Emergency Department
EP – Emergency Physician
FAST – Fast Alcohol Screening Tool
HINST – Health Inequalities National Support Team
IBA – Intervention and Brief Advice Services
ICS - Integrated Continence Services
IDVA – Independent Domestic Violence Advisors
LES – Local Enhanced Service
LTC – Long term Condition
MDS – Minimum Data Set Depression rating scale
MDT – Multi-disciplinary Team
NAO – National Audit Office
NICE – National Institute for Health and Clinical Effectiveness
NLU - Nurse Led Unit
NNT – Number Needed to Treat
NSF – National Service Framework
NYHA – New York Heart Association (classification system)
ONS – Office for National Statistics
OR – Odds Ratio
P – p value (probability)
PACE – Post Acute Care Enablement
PARR – Patients at Risk of Re-hospitalisation
PCT – Primary Care Trust (ceased in March 2013)
PEONY – Predicting Emergency Admissions Over the Next Year
POPP – Partnership for Older People Project
PRISM – Predictive Risk Stratification Model

PSSRU – Personal Social Services Research Unit
QALY – Quality Adjusted Life Year
RCT – Randomised Controlled Trial
RRT – Rapid Response Team
SCIE – Social Care Institute for Excellence
SpR – Specialist Registrar
SSRI – Selective Serotonin Re-uptake Inhibitor
TREAT - Triage and Rapid Elderly Assessment Team
UKATT – the UK Alcohol Treatment Trial
UKNSC – UK National Screening Committee
UTI –Urinary Tract Infection

Essex County Council

Item 10

Report to Health & Wellbeing Board **Report of Dave Hill**	**Reference number**: HWB/006/14
Date of meeting 14th January 2013 **Date of report 19th January 201**	**County Divisions affected by the decision: All Divisions**
Title of report: Essex County Council, NHS England and Clinical Commissioning Groups Commissioning Intentions for Children, Young People and Families 2014-15	
Report by: Dave Hill, Executive Director People Commissioning **Enquiries to**: Barbara Herts Director for Integrated Commissioning and Vulnerable People	

1. Purpose of report

1.1. To set out the commissioning Intentions and priorities of Essex County Council and the Clinical Commissioning Groups across Essex for children young people and families. This report includes Commissioning Priorities also identified by Southend and Thurrock Unitary Councils.

1.2. To identify where there are opportunities for joint commissioning and collaborative working across key partners that support children, young people and families.

2. Recommendations

2.1. Agree and support the document as a starting point and acknowledge that it will need to develop as a result of the implementation of the Children and Families Bill.

2.2. Encourage the CCG's, working with the ECC Integrated Commissioning Directors to support the Children's Integrated Planning and Commissioning Process.

3. Background and proposal

3.1 This document has been developed over the last months by the North and South Integrated Commissioning Groups to reflect the collaborative approach developing across key ECC, CCG and NHS England partners working to support children young people and families. It has been updated recently to reflect the principles of early intervention and prevention and to include the Children and Young People's Plan as this area has become more clearly articulated by partners.

3.2 The document has been developed in consultation with each Clinical Commissioning Group and representatives from the Commissioning Support Unit and NHS England.

3.3 The document aims to provide the key information about children's commissioning across health and social care partners in Essex. These integrated commissioning intentions are intended to set out the position, vision, priorities and ambitions of all partners involved in integrated commissioning over the next two years. The re-commissioning of Children's Mental Health and Well-being remains a high priority for 2014/15.

3.4 Essex County Council, NHS England, the five Essex Clinical Commissioning Groups (CCGs) and the Commissioning Support Unit (CSU) are responsible for commissioning a range of activity to deliver the vision for Children, Young People and Families in Essex, including Public Health, Primary and Secondary Care, Social Care, Education and Early Help. The document details how the partnership has set itself up to deliver integrated, outcomes based commissioning, making real organisational changes in order to maximise the opportunities to bring together shared outcome frameworks, joint needs assessments and financial and staff resources to achieve more together.

3.5 It outlines the commissioning approach which will ensure the partnership can maximise the impact of opportunities that arise as a result of national, regional and local reforms to improve outcomes for children and young people across Essex.

3.6 It outlines the importance of adopting an early intervention approach to commissioning which delivers both early intervention and early help and clearly provides for effective support around key points of transition.

3.7 Safeguarding is highlighted as a core theme across all activity and the integrated commissioning approach will enable it to be embedded across commissioning intentions.

3.8 The document reflects how the reconfiguration and reform of the NHS and the transfer of Public Health responsibilities into the Local Authority has created a fully integrated approach to meeting the public health needs of Essex residents through joined up commissioning, making efficient use of limited resources. This

offers greater opportunity to ensure that services commissioned improve health and wellbeing and lead to sustainable, improvement in outcomes for children young people and their families.

4. Policy context

4.1 This document establishes clear intentions for integrated commissioning, contributing towards the strategic delivery of the Health and Wellbeing Strategy for Essex, in particular the delivery of *Priority 1 Starting and Developing Well – ensuring every child in Essex has the best start in life* and the delivery of the ten strategic priorities in the Children, Young People and Families Partnership Plan (CYPFP). It also supports delivery of the corporate aspirations of the Local Authority as well as those of the CCGs and NHS England. The document will be kept under review in view of the implementation of the 2014 Children and Families Bill.

5. Financial Implications

This report sets out the commissioning Intentions and priorities of Essex County Council and the Clinical Commissioning Groups across Essex for children young people and families. This report includes Commissioning Priorities also identified by Southend and Thurrock Unitary Councils.

While this paper is a starting point with further work being undertaken between January and March 2014 the intention is to:

- Align funds to create a single budget from which the integrated service will be commissioned ensuring that the impact of opportunities that arise as a result of national, regional and local reforms to improve outcomes for children and young people across Essex can be maximised.

6. Legal Implications

6.1. As integrated commissioning develops the Board will need to consider the merits and demerits of the statutory powers and arrangements that are available to the Council and partners. Work is being undertaken on these and further reports will be brought to the Board at appropriate stages.

6.2. The Board are reminded that in considering this mater they are subject to the public sector equality duty set out in the Equality Act 2010. The Board must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

- Foster good relations between people who share a protected characteristic and those who do not.

Advancing equality of opportunity involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

7. Staffing and other resource implications

7.1. Implementing the collaborative working joint commissioning approach outlined in the document with be the core business of the Directors of Integrated Commissioning and the Heads of Commissioning Vulnerable People ECC who will work closely with colleagues within the CCGs and NHS England.

7.2. The Directors for Integrated Commissioning will take forward the Commissioning Intentions with each CCG to meet all requirements of the Children and Families Bill.

8. Equality and Diversity implications

8.1. An EIA will be completed in due course

9. Background papers

9.1. The Children and Young People's Plan

Essex County Council, NHS England and Clinical Commissioning Groups - Commissioning Intentions for Children, Young People and Families

2013-2015

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Co-produced by;
Essex County Council
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Public Health
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West Essex Clinical Commissioning Group
Mid Essex Clinical Commissioning Group
Basildon and Brentwood Essex Clinical Commissioning Group
Castle Point and Rochford Clinical Commissioning Group
The Commissioning Support Unit

Subject to a regular programme of review.

8th December 2013

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1. Foreword

This document aims to provide the key information about children's commissioning across health and social care partners in Essex.

These integrated commissioning intentions are intended to set out the position, vision, priorities and ambitions of all partners involved in integrated commissioning over the next twenty four months (NHS England Commissioning Intentions included run 2014/2015).

Essex County Council, NHS England, the five Essex Clinical Commissioning Groups (CCGs) and the Commissioning Support Unit (CSU) are responsible for commissioning a range of activity to deliver the vision for Children, Young People and Families in Essex, including Public Health, Primary and Secondary Care, Social Care, Education and Early Help. This partnership is at the forefront of integrated, outcomes based commissioning making real organisational changes in order to maximise the opportunities to bring together shared outcome frameworks, joint needs assessments and financial and staff resources to achieve more together.

Our commissioning approach ensures that we can maximise the impact of opportunities that arise as a result of national, regional and local reforms to improve outcomes for children and young people across Essex. All integrated commissioning will focus on improving life outcomes, considering the needs of children and families within an all age framework. This gives significant importance to adopting an early intervention approach which delivers both early intervention and early help and clearly provides for effective support around key points of transition. Safeguarding is a core theme across all activity and the

integrated commissioning approach will enable it to be embedded across commissioning intentions.

Reconfiguration and reform of the NHS has placed emphasis on quality and joined-up patient-centred care whilst realising local efficiencies. Transfer of Public Health responsibilities into the Local Authority has created a fully integrated approach to meeting the public health needs of Essex residents through joined up commissioning. This offers greater opportunity to ensure that services commissioned improve health and wellbeing and lead to sustainable, improvement in outcomes for children young people and their families, as well as making efficient use of limited resources. Locally these changes are supported by a transformational restructure within the Local Authority that will support and drive integrated commissioning within the context of CCG and Essex County Council Commissioning plans and priorities.

Establishing clear intentions for integrated commissioning, this document contributes towards the strategic delivery of the Health and Wellbeing Strategy for Essex, in particular the delivery of *Priority 1 Starting and Developing Well – ensuring every child in Essex has the best start in life*. (See Appendix 1).

This document sets out how the integrated commissioning programme will support the delivery of the ten strategic priorities in the Children, Young People and Families Partnership Plan (CYPFP). The CYPFP articulates the broader vision and outcomes for Children and Young People and acts as a framework for the integrated commissioning intentions for the local health and social care economy.

It also supports delivery of the corporate aspirations of the Local Authority as well as those of the CCGs and NHS England.

2. The Vision 2013-2016[1]

This document sets out how we as commissioning partners will contribute to delivering the vision of the Children, Young People and Family Partnership:

Children, Young People and Families will reach their full potential

[1] Children, Young People and Families Partnership Plan 2013-2016

We will do all we can to support all children, young people and their families to reach their full potential. We have high aspirations for all children and young people – they will grow up safe, happy and healthy, able to make the best use of their skills to secure good employment opportunities and make the most of their lives.

Children and young people will be supported by strong families

Families are the foundation of strong local communities. As the key contributor to a child or young person's safety, health and wellbeing we will take a whole family approach to supporting all families to fulfil this role.

Families will be given early help to assist them in managing their difficulties

Families in difficulty will be offered help at the earliest opportunity. The help provided will promote family resilience and help prevent family problems escalating into more serious ones.

Children and young people will not be disadvantaged by being in care

If a child or young person needs to be in care we will ensure that this is in a family setting (foster care) wherever possible, of good quality and it improves the life chances of the children and young people in question.

We will protect children and young people from harm

Through early help and a joint commitment to effective child protection services we will reduce risks to children and young people and ensure they are protected from abuse and neglect. We will work with families to build on their strengths and make the changes that are needed. If this does not work and a child or young person is identified as likely to suffer significant harm, we will act quickly to protect them.

Children, young people and their families will influence what we do

We will be family focused, putting the needs and aspirations of children, young people and their families at the heart of everything we do. We will listen to the views of children, young people and families and wherever

possible act upon them. We will improve our services through consultation with children, young people and their families.

Services for children, young people and their families will be improved by us working together

We will work in partnership through all four levels of need to provide more responsive, better integrated and more effective services which are easy to access.

We recognise that the financial challenges faced by the public sector are unprecedented. Reduced funding from central government, together with the impact of inflation and increasing demands for services requires that statutory, community and voluntary sector partners work together to combine resources and share expertise, in so doing, developing genuinely integrated commissioning that can demonstrate accountability for public expenditure and deliver improved outcomes for children, young people and families.

The establishment of the Essex Health and Wellbeing Board and subsequent alignment between the Health and Wellbeing Strategy for Essex and the Children's Partnership Plan provide the strategic framework for integrated commissioning in Essex.

With emphasis on intervening early through clear and innovative commissioning intentions, the Local Authority and partners can ensure that maximum impact is achieved through the most efficient commissioning, procurement and contract management processes.

A clearly conveyed series of integrated commissioning intentions, as set out within this document, enables the wider partnership to meet their specific and shared duties, responsibilities and priorities with regard to safeguarding, promoting and protecting the welfare of children and young people, whilst maximising the opportunities for integration and efficiency.

We believe that realising the potential that integrated commissioning offers will also maximise efficiency and reduce barriers to accessibility, choice and end user costs by exploiting jointly developed commissioning strategies, joined up contract management and the pooling of expertise, experience and budgets. Across Essex partners have made a commitment to support and help to drive the development and

implementation of integrated commissioning and this document sets out in more detail how this can be delivered.

3. The influences on our commissioning intentions

3.1 Strategic Context for Commissioning

The Health and Social Care Act 2012 introduced some of the most notable reforms to the NHS in England for decades. These changes came into being on 1 April 2013 and set the mandate for Clinical Commissioning Groups to buy care on behalf of local communities and established NHS England as a body independent of the Department of Health.

The Children and Families Bill underpins the clear commitments made by the Local Authority and strategic partners to provide services that target early help and commission against outcomes that support strong, resilient children and families, addressing the needs of the most vulnerable children and young people in Essex, further strengthening the need for the Local Authority and health to commission together.

The broad reaches of the Bill seek to reform the systems for adoption, looked after children, family justice and special educational needs as well as encouraging growth in the childcare sector and ensuring children in England have a strong advocate for their rights. These national priorities mirror the Essex commissioning intentions set out in part 5.

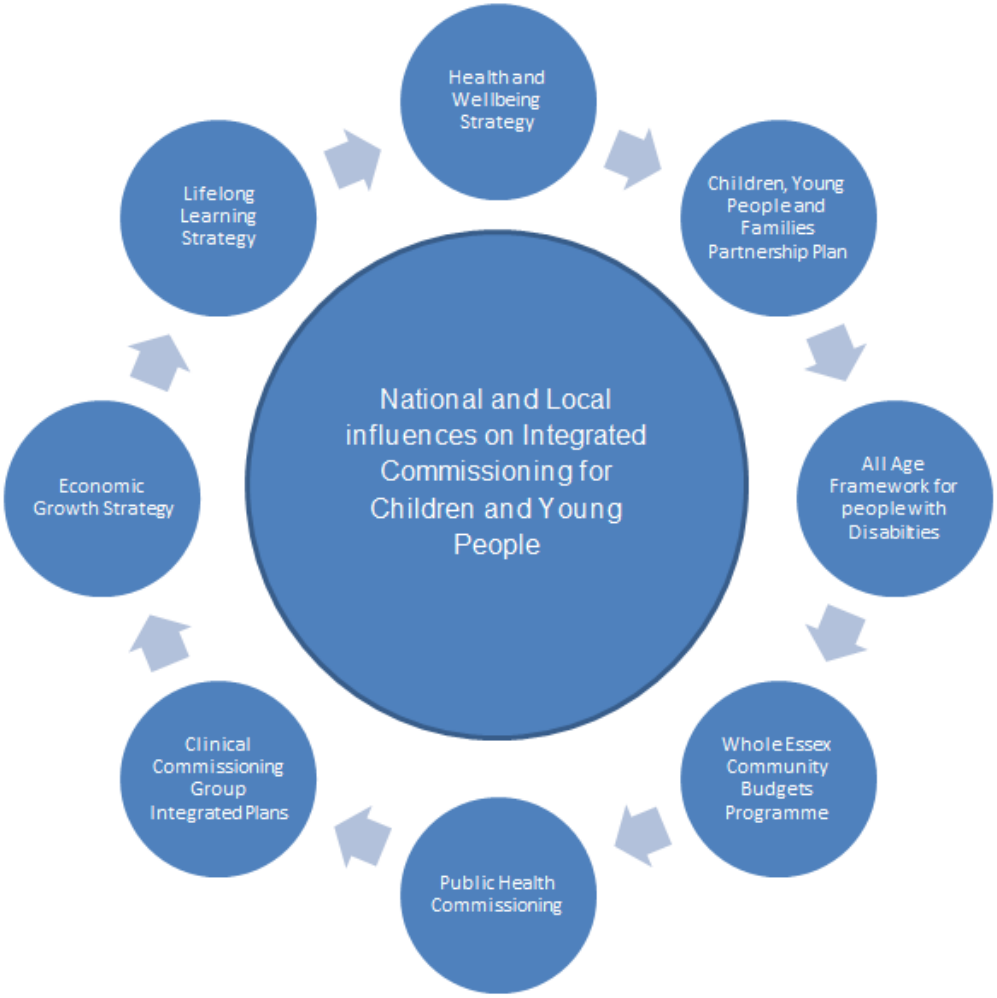
A clear direction of travel has been set out by Government, defining meaningful integration as public, voluntary and private sector partners working together with users and patients to achieve better outcomes. This co-production approach has been fully embraced locally and incorporated into the planning for integrated commissioning with the impact of sharpening focus on outcomes based commissioning and building a holistic approach to working with families at an early stage to build resilience. This is demonstrated through the Local Authorities Divisional Based Intervention Teams (D-BIT) and Multi-Systemic Therapy Social Impact Bond (MST SIB), Family Solutions and commitment to sustaining resources to deliver Children's Centres.

In line with national and local policy, partners are committed to embedding early intervention within commissioning practice to deliver improved outcomes and build resilience, capacity and independence. This approach will help to prevent problems developing and protect children and families who are most at risk. Whether through universal or targeted activity, intervening early in life (as soon as conception) or early in the development of a problem (at any age) can reduce the severity of problems and avoid the recurrence of existing issues.

As partners committed to improving outcomes for children and young people, safeguarding is a core theme of all our activity. Working across the health, education and social care economy, and across the wider partnership, partners will use integrated commissioning to improve safeguarding practice and ensure children and young people are protected from harm and neglect.

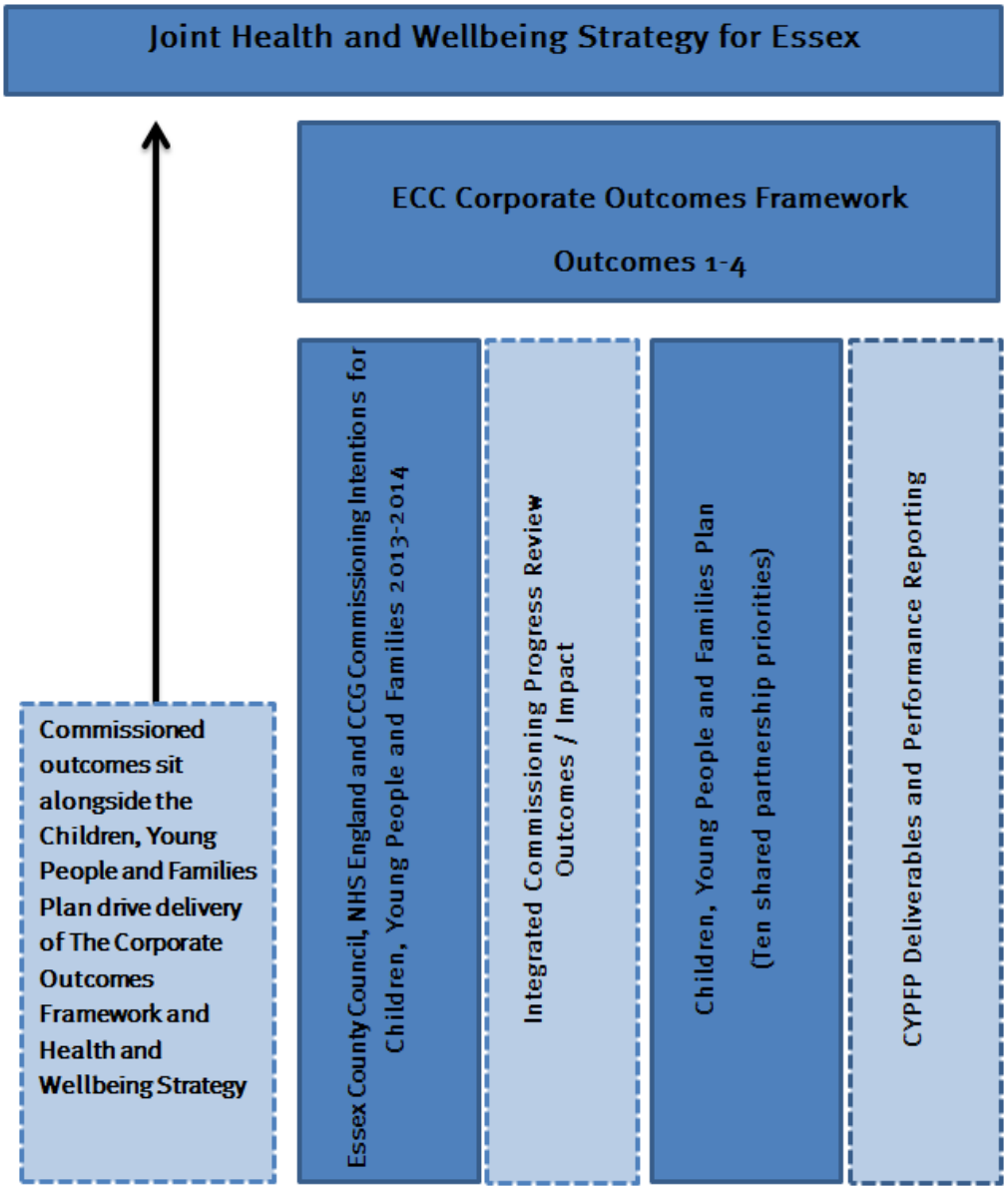
The Local Authority shares with the CCGs and NHS England a desire for innovation reflected by the investment in developing an All Age Framework and establishing one of a small number of Community Budget Pilots in pursuit of best practice, efficiency and value for money.

The following diagram sets out the primary drivers for integrated commissioning, nationally and locally. More detailed descriptions of each can be found in Appendix 2.


National and Local influences on Integrated Commissioning for Children and Young People
Health and Wellbeing Strategy
Children, Young People and Families Partnership Plan
All Age Framework for people with Disabilities
Whole Essex Community Budgets Programme
Public Health Commissioning
Clinical Commissioning Group Integrated Plans
Economic Growth Strategy
Lifelong Learning Strategy

4. Commissioning priorities and high-level outcomes

The Health and Wellbeing Strategy represents the principal, high level plan and as such provides a strategic framework for the commissioning and delivery of health and social care services across Essex. It is essential that all strategy and commissioning that sits below this makes a direct contribution towards progressing the relevant high level outcomes.



This diagram explores the linkages between this document and the Health and Wellbeing Strategy, the Local Authority Corporate Outcomes Framework and the Essex Children, Young People and Families Partnership Plan.

The Essex Children, Young People and Families Partnership Plan establishes 10 Strategic Priorities which form the partnership framework for current ambitions for children, young people and families in Essex .

Essex Children, Young People and Families Partnership Plan Priorities

1. Protect Children and Young People from harm and neglect
2. Develop resilience in families to help reduce dependency on public services by enhancing their capacity to resolve their own problems
3. Improve outcomes for Looked After Children and Care leavers as well as improving support to children and young people on the edge of care
4. Support and Challenge Schools to raise Educational achievement and aspirations at all key stages
5. Enabling children to get the best start in life
6. Work with partners to provide inclusive education that meets the needs of those with the most difficulties
7. Promote good health for Children and Young People and reduce health inequalities
8. Work with partners to maximise the number of young people who are in Employment, Education or Training
9. Promote the benefits of young people making a positive contribution to their community and decisions affecting their own lives
10. Provide opportunities for reskilling and up-skilling throughout residents' working lives

These priorities are aligned with the corporate direction of the Local Authority and Strategic Partners. The ten strategic priorities, along with the associated performance reporting that exists to demonstrate impact, reflect the Joint Strategic Needs Assessment at a County and Local level and inform the outcomes for commissioning for children, young people and their families, underpinning the commissioning intentions that follow in this document.

The Essex County Council Corporate Plan places a significant emphasis on developing Health and Wellbeing and broadening application of the Localism agenda. It sets out to provide local people with a stake in

community services, to make appropriate investment into health, education and skills and keep the most vulnerable in society safe, supported and thriving.

ECC has developed a Corporate Outcomes Framework aligned to the Health and Wellbeing Strategy Outcomes Framework 2013. Within this framework, Outcomes 1-4 (see below) align with the joint integrated commissioning intentions and the priorities within the Children, Young People and Families Partnership Plan. All commissioned activity will drive the Corporate Outcomes Framework and the Health and Wellbeing Strategy.

Corporate Outcomes 1-4[2]

1. Children in Essex get the best start in life
2. People in Essex enjoy good health and wellbeing
3. People in Essex have aspirations and achieve their ambitions through education, training and lifelong-learning
4. People in Essex live in safe communities, feel safe and are protected from harm

5. Integrated commissioning

There is a shared commitment across agencies in Essex to integrate commissioning and to work in partnership to develop more integrated pathways across health and social care. A shared understanding that no one partner can plan, commission or deliver services independently if high quality services and efficient use of reducing resources are key priorities.

At a County and a locality level a network of complex, multi-agency partnerships exist in order to develop joint strategic planning, build understanding of need, develop robust outcomes measures and address information requirements with the shared aim of driving genuinely joined up commissioning.

Not all of the partners involved in this strategic planning are specifically involved in the commissioning of health and social care services but are critical to the success of delivering the wider Health and Wellbeing agenda for Essex.

The five Essex CCGs have each developed Integrated Plans for 2013-2016 which set out their own priorities but also incorporate plans for integrated

[2] Developing the Corporate Outcomes Framework - Proposed outcomes (Nov-13)

commissioning with the Local Authority. Each of the CCGs has worked closely with the Local Authority to ensure that priorities for children's integrated commissioning are reflected in the CCG Plans.

Our Public Health vision for Essex is for the people of Essex to enjoy long, healthy, disease free lives and for this to be possible wherever they live and whoever they are. There is a clear understanding that Public Health is everybody's business and working in partnership with all commissioners, wider stakeholders and the communities of Essex is seen as the most effective way of delivering against the outcomes nationally and locally. We recognise the identified and agreed public health priorities within the communities of Essex and this document provides the platform from which we will seek to secure improvements.

Alongside integrated commissioning partners, NHS England will seek to secure service change, maintain financial balance across the local health economy and continue to drive up the quality of the services. As a key partner in the delivery of integrated commissioning the NHS England – Essex Area Team has set out clear commissioning intentions for the 2014/15 financial year '*Essex Area Team Generic Commissioning Intentions 2014/2015*'. These fall in line with the NHS England contract for services which requires six months notification of any changes of services and counting and charging proposals. With a pan Essex focus these commissioning intentions may be supplemented by National Commissioning intentions as the landscape further unfolds.

The Local Authority, the CCGs and NHS England are part of the North Essex and South Essex Maternity, Children and Young People's Integrated Commissioning Strategic Groups which aim to develop and implement integrated commissioning. These groups report to the Business Management Group of the Health and Wellbeing Board and link to the wider Essex Children's Partnership.

6. Making a difference through shared outcomes

In developing integrated commissioning as partners we are keen to move towards commissioning by outcome, across health and wellbeing provision. This is a significant development and one that changes the role of commissioning and the relationship between commissioners and providers. As well as establishing clear outcomes against which the impact of individual commissioned activity will be assessed, all commissioning will drive forward an agreed series of high level outcomes

which reflect the corporate aspirations of Essex County Council and key partners.

6.1 Our Commissioning Intentions

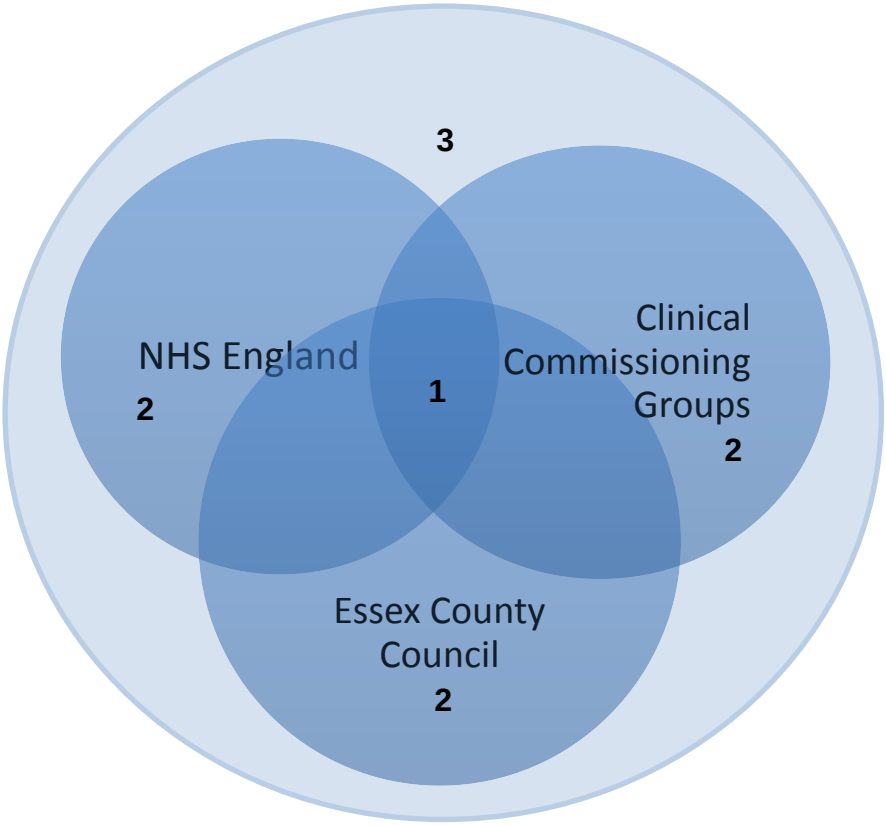
We want to ensure that appropriate interventions are provided for children and families with complex and specialist needs, children on the edge of, in or leaving care and those with a disability. However we also want to provide early help and intervention for all through universal and targeted provision. Our approach aims to support children and young people in family settings where appropriate, protected from harm or neglect and able to lead as normal a life as possible.

All agencies have a role to play at all levels of need and CCGs NHS England and the Local Authority will work together to facilitate and maximise contributions as appropriate. There is a strong commitment to ensuring integrated resourcing, commissioning and provision of interventions to improve outcomes for children, young people and families across Essex and maximise effectiveness for all agencies.

We want to ensure that children, young people and families across the County can strive to achieve common outcomes and receive a consistent offer appropriate to need. We know that there are local variations in needs, population, local context and existing provision across the County; hence we recognise that priorities, resources and how outcomes are met will vary locally and across districts and CCGs. Some of our commissioning will be undertaken County wide; some will be undertaken at CCG or even district level. We also recognise that commissioning for some Tier 4 highly specialist provision is now undertaken regionally and that we will need to work with regional agencies to ensure the needs of children, young people and families in Essex are addressed appropriately.

The opportunity for integrated local joined up working has been enhanced by the recent transformational restructure within Essex County Council that has created an integrated structure allowing for robust, coterminous relationships with CCGs.

Working in partnership with CCGs through jointly developed strategies, integrated systems for commissioning, contract management and delivery as well as a pooling of expertise and experience will not only maximise efficiency and effectiveness, but will reduce barriers to accessibility and increase choice for users.



Key:-

1 Pan Essex Integrated Commissioning Intentions
2 Individuals partner commissioning intentions[3]
3 Broader Children, Young People and Families agenda for Essex

The diagram sets out the main elements of commissioning for Children, Young People and Families. The core element (1) is the central overlap which forms the integrated commissioning intentions. These then form part of a 'long list' of commissioning intentions for each of the individual organisations within a broader context of their own statutory and organisational objectives (2).

The initial priority is to strengthen integrated commissioning across the Local Authority, CCGs and the NHS England Essex Area Team. This reflects our strong track record of joint working to date as well as the significant agenda and budget for improving children's health outcomes. There are a significant number of areas identified for integrated commissioning but

[3] *Currently not prioritised for integrated commissioning but where awareness exists for the need to communicate and share information.*

the development needs to be incremental. The aim is to start with the key priority areas of CAMHS, early years, SEND and continuing care in 2013-14 underpinned always by the themes of strong safeguarding and early intervention, increasing over time the areas where commissioning in an integrated way across the Local Authority CCGs and NHS England takes place.

6.2 Integrated Commissioning Partnership Priorities

Each agency has its own commissioning priorities which it will need to deliver in 2013/2014 and 2014/2015. Below, we identify those priorities which are shared across the partnership and which fall within the remit of the Health and Wellbeing Board and the North and South Essex Commissioning Groups. These are agreed integrated commissioning intentions focused on improving outcomes for Children, Young People and Families in Essex. The Local Authority has outlined its intentions and plans for integrated commissioning with health in a document that sits alongside the five CCG plans entitled *'Essex County Council Integrated Plans 2013-2016 and County Council Health and Wellbeing Plan'*. The following commissioning intentions have been developed within this suite of plans and the strategic framework of the CYPFP.

CAMHS	The JSNA carried out in April 2013 and regular user and partner feedback confirm that there is insufficient integration between the Tiers of provision; that there is too much batting backwards and forwards between agencies and that there are significant gaps especially when there are behaviour issues as well as mental health concerns. We will develop seamless pathways and integrated provision across the Tiers and improve access to CAMHS provision especially for the Children's Social Care population including by joint performance monitoring of contracts. We want to develop plans to re-commission an integrated CAMHS and behaviour service across Tiers 2 and 3 with good links with universal and Tier 4 provision based on joint needs assessment and shared understanding of the issues. We will work within the wider partnership to deliver a CAMHS/LD service with an integrated pathway with particular focus on integration with specialist school nurses and community nurses.
Early Years and Children's Centres	ECC, CCGs and the NHS England LAT will work together to ensure that in future specifications ensure improved links, information sharing and joint working between midwifery, health visitor/MESCH/Family Nurse Partnership services and children's centres and all other appropriate early years services. From April 2013 onwards we will review the re-commissioning of children's centres and we want to ensure that we develop plans together for an integrated early years service covering health visiting and children's centres which has clear links and pathways with midwifery, breastfeeding and immunisation services, which takes a whole family approach and links closely with Family Solutions.

Safeguarding and Child Protection	We want to improve the links and joint working between CCGs, Healthcare Providers and ECC staff to improve safeguarding and child protection responses. We will ensure health contracts specify that appropriate and timely reports and contributions are made by health staff to Child Protection Assessment, Conference and Core Group, Planning and Review activities and that healthcare staff work with other agencies to deliver joined up interventions to children In need or on a Protection Plan. We will ensure continuing joint development and resourcing of the Essex Safeguarding Children's Board.
Children In Care and Children Leaving Care	Children In Care and Children Leaving Care have high levels of need and often achieve poorer outcomes when compared with their peers living in the community. We want to work together to: ▪ improve the access to timely and appropriate health services for Children and Young People in Care and Leaving Care and ensure Young People Leaving Care are supported to access adult services ▪ Ensure the core LAC health team (nursing and administrative) to be commissioned by CCGs. i.e. Specialist LAC Nurse provides single point of access to community health services for LAC within each provider area; consistent and timely co-ordination of healthcare for LAC wherever they are placed; fulfils Statutory functions and meets timescales. We will ensure robust quality assurance of healthcare delivery so that LAC and care leavers who do not have access to universal school nursing or 0-19 services receive targeted healthcare and support. Together we will ensure improved health outcomes for LAC through consistent partnership working with local authorities and other health and social care providers ▪ improve the consistency of the quality and the speed/priority of health and dental assessments and interventions/treatment for Children In and Leaving Care and embed this within main provider contracts ▪ improve the links and joint working opportunities between Health provider and ECC staff and embed requirements into health contracts to ensure appropriate and timely reports and contributions are made by health staff to assessment, planning and review meetings of Children In and Leaving Care ▪ develop the contracts with health providers to ensure they are responsible and accountable for the

	provision of health assessments and any subsequent advice/interventions to Adoption and Fostering Panels ▪ Review the JAP
Continuing Care	We will continue to jointly plan and fund the care packages for individual children with complex and specialist care needs agreeing resources and plans at the Joint Assessment Panel (JAP). We want to ensure funding and health service provision to all children with disabilities requiring continuing health care and develop and agree a joint protocol and criteria.
Family Solutions - Integrated Support for Families with Complex Needs	We will support the continuing development of Family Solutions and ensure that children's health providers recognise and contribute to delivering coordinated interventions which will support improved parenting skills, and work in alignment with the Family Solutions Teams to achieve this.
Children with SEN and/or a Disability	We want to develop an integrated approach in line with the All Age Disability framework and the forthcoming new government guidance due in the Children and Families Bill 2013 which will bring together adult social care, children's social care, education and health into an integrated system of commissioning, assessment and planning that takes the whole view of a disabled person's life and the support they access from family, the community, local authorities (including districts and borough councils), schools and the health service. We have produced a revised SEN Strategy. We will develop proposals for implementation of the Single Assessment/ One Plan across health, education and social care for children and young people with disabilities and special education needs. Also in response to the Bill we will develop a Local Offer by September 2014 - to enable parents and young people to see more clearly what services are available in their area for this group and how to access them. The Offer will include provision from birth to 25, across education, health and social care.

	Health, education and social care commissioners will work together to develop joint commissioning for disabled children's services, including Aiming High short/respite breaks, the speech and language therapy and occupational therapy for children with a Special Educational Need and/or disability and the social work provision for families with a child with a disability.
Children's Equipment	As part of the wider Integrated Community Equipment Service re-modelling, we will work together on a single referral and ordering gateway for children's equipment across Essex with clear inventories for retrieved and recycled equipment.
Support for Young Offenders	We want to improve joint work across ECC, CCGs, health providers, schools and the police to ensure appropriate support continues to be made available for young people on the edge of becoming offenders and who are offending.
Domestic Abuse	One in five of all crimes committed in the county is domestic abuse; hence this is a priority issue across partners. We will work to ensure effective health participation in the Domestic Abuse Strategy Group and in developing a fully integrated, multi-agency approach to responding to and reducing incidents of domestic abuse. This includes early identification through effective reporting and early intervention and prevention, for example within schools, which can reduce escalation of violence and aggression within families. This is a high priority across the wider partnership and the work entails system re-design to ensure that our ambition is achieved. All CCGs and all Local Authorities will work together in setting up of the Multi-Agency Safeguarding Hub (MASH) and Domestic Abuse Safeguarding Hub (DASH).
Homelessness Prevention	Partners are developing an integrated approach to responding to the needs of 16/17 year olds at risk of homelessness. We will work across services to develop effective responses to reduce the level of homelessness and to respond effectively to those young people in housing need.
Alcohol	The partnership is built on a shared strategic approach as set out in the Health and Wellbeing Strategy to reduce health inequalities and to support the most vulnerable in society. As identified by public health, we wish to address alcohol use and to reduce the level of hospital admissions of alcohol use.
School	Working with a wide range of stakeholders we have considered the best use of resource committed in this

Nursing (5-19 Healthy Child Programme)	area. Healthy Schools is a proven programme taking a holistic view of Health Improvement. It deploys an early intervention strategy by focussing on individual and environmental vulnerabilities plus family and society influences. Public Health priorities will be further supported by the development of an Essex Wide School Nursing Specification. The work also considers the optimal approach to safeguarding. Taking into account the recommendations of the recent needs assessment the key drivers for future commissioning of the 5-19 HCP are as follows:- • Improved matching of clinical and economic resources to prevention agenda while maintaining required safeguarding approach and links to other service provision for children and young people e.g. Family Solutions, Education Welfare, CAMHS • Improved outcomes and reduce inequalities in the health and wellbeing of children linking to Public Health Outcomes Framework, the Essex Joint Health and Wellbeing Strategy and the Essex Children and Young Peoples Plan • The drive to achieve efficiencies focussing on both improved quality and value for money ensuring that resources are focussed on evidenced need rather than historical spend • Embed evidence based prevention in service provision in order to reduce future spend on health and social care by ensuring children and families are supported to make informed decisions that will improve health and wellbeing on a sustainable basis. The Healthy Child Programme is a progressive universal programme tailored to individual child and family needs and anticipated outcomes, focussing on public health priorities. It includes a universal minimum core for all children with enhanced and additional preventative services and programmes. To make the best use of resources and improve access for children and young people the HCP requires integrated working and from a workforce perspective provides local flexibility around skill mix with SCPHN SN as lead professional. For 2014/15 commissioning intentions can be described as follows

	• Mid Essex/North East Essex – due to the Business Transfer Agreement that ECC has inherited as part of the contract transition for services provided by Provide/ACE it has been agreed that School Nursing/School Health Improvement Services will not be part of the procurement that is planned for the rest of Essex. Both provider organisations have been asked to secure 5% efficiencies across all commissioned services and we have commenced in depth work with each to introduce the new 5-19 HCP service specification with effect from 1st April 2014 • South/West Essex – both SEPT and NELFT have been formally advised that a procurement will be undertaken for the 5-19 HCP with new contracts to be in place by 1st September 2014. The current contracts will be extended until 31st August 2014 to ensure no disruption to service provision and providers have also been advised that they will be required to make 5% efficiencies against the contract from 1st April 2014.
Sexual Health	A detailed health needs assessment has been undertaken and the recommendations of this together with the guidance contained in "Commissioning Sexual Health services and interventions - Best practice guidance for local authorities" issued by the Department of Health in March 2013 have resulted in the following key principles for the commissioning of the sexual health pathway from 2014/15 onwards • The need to drive out efficiencies from existing contracts while continuing to improve service quality and equity of access and acceptability of provision • The need to work towards the introduction of an integrated sexual health service model which aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and accessible locations. • GU services to continue to be commissioned through existing providers for 2014/15 with a 5% efficiency being applied to current contract values. A National Service Specification for Sexual Health Services has been developed by Public Health England and this will be used as a framework for revised specifications to be issued to all providers using the contract negotiation process to embed these

	• In view of the Business Transfer Agreements that have been inherited as part of the contract transfer for ACE and Provide non-GU services will not be part of the planned procurement of these services. Work is already underway with both these providers to introduce revised specifications by 1st April 2014 which will include a requirement to achieve 5% efficiencies against current contract values • Procurement will be undertaken for the provision of non- GU services in South and West Essex with new contracts to be in place by 1st October 2014. Both SEPT and NELFT have been formally advised that this procurement will be going ahead and the current contracts will be extended until 30th September 2014 to ensure there is no disruption to service provision. Providers have also been advised that they will be required to make 5% efficiencies against the contract from 1st April 2014.

6.3 Individual Commissioning Intentions

For each of the partners there will remain the need to commission and procure activity individually, even where strategy development, needs assessment and planning are carried out jointly. It is likely that there will be reviews in a number of the areas described below over the coming years as a result of financial constraints, new government guidance and legislation and evolving ambitions. Over time, the aim is for integrated commissioning to become the norm. The Local Authority and partners recognise the importance of effective communication and information sharing in relation to all activity commissioned in the interests of best value. The following pages set out the individual commissioning intentions of partners.

6.4 Essex County Council

Safeguarding and Child Protection	We resource and provide safeguarding advice to schools; an Initial Response and Referral Service into Children's Social Care which also provides advice to other agencies including health professionals and an Emergency Duty Service. We resource and provide family centres and supervised contact to support families where there are concerns about the family's care for the child. We also resource and provide specialised support to young people on the edge of care (Divisional Based Intervention teams - D-Bit) and Assessment and Intervention and Family Support and Protection teams to assess and work with families where there are concerns about the care of the children. We are resourcing a Multi-Systemic Therapy Service, financed through a Social Impact Bond, aimed at diverting young people from entering care and becoming involved in the criminal justice system.
Children In Care and Children Leaving Care	We commission and provide foster care, adoption and residential placements as appropriate for children and young people who are not able to be cared for by their family. We also commission and provide support for young people on leaving care, supporting them into adulthood
Education and	We support a range of early years and before/after school settings to deliver childcare for children aged up

Childcare	to 12 years old. We also support a range of early years settings to deliver nursery education for children aged 2 to 5 years old. Schools and Colleges are funded to deliver education; we also commission a range of support services for schools including school meals and transport and services to support schools with school attendance and behaviour issues and provision for those at risk of exclusion or excluded from schools and children and young people with a Statement of Special Educational Need. Many of these services are increasingly traded.
Adult and Family Learning	We commission, facilitate and provide a wide range of adult and family learning activities and classes.
Support for Young People	The Local Authority commissions, facilitates and directly provides a range of targeted activities to support young people including youth centres, mobile provision and targeted advice and support to individual young people including Young Carers. We commission, facilitate and provide advice and training including apprenticeships for young people 16 – 18 Not In Education, Employment or Training.

6.5 Clinical Commissioning Groups (CCGs)
Children, Young People, Maternity and CAMHS Commissioning Intentions 2014/15

Proposed Action	Expected Outcomes	Providers Affected	CCG Lead
Redesign of Autistic Spectrum	Patients in South Essex are able to access diagnostic testing from a local service and repatriation of tertiary activity	SUHT NAS - Lorna Wing NELFT	Southend CCG & Castle Point & Rochford CCG

Disorder (ASD) Pathway			
Asthma	Effective utilisation of pathway. Part of the HIP work stream.	SEPT SUHT	Southend CCG & Castle Point & Rochford CCG
PAU/ HIP/Care Closer to Home	Effective utilisation of the pathway for common childhood illness and conditions where all elements of the NHS take appropriate responsibility. To deliver care closer to home. Review outpatient 1st appointments without a follow up. Extension of CCNT to cover 7 days a week reducing activity in CAU/WIC/A&E/NICU	SUHT BTUH PAH MEHT SEPT NELFT HCT CECS	All CCGs
Therapies	Review of SLT, dysphagia and video-fluoroscopy	SUHT SEPT Southend Council	Southend CCG & Castle Point & Rochford CCG
Communications Aids	Strategy for whole area	SUHT BTUH PAH MEHT SEPT NELFT CECS HCT	All CCGs
Light House Centre Redesign	Redesign and redefinition of the lighthouse	SUHT SEPT	Southend CCG & Castle Point & Rochford CCG

		Local Authorities	
CYP Phlebotomy	Review of CYP Phlebotomy services in SE Essex	SUHT SEPT	Southend CCG & Castle Point & Rochford CCG
Implementation of Personal health Budgets for CYP Continuing Healthcare	A standardised framework for the delivery of Personal Health Budgets for CYP Continuing Healthcare	Various CCC providers	All CCGs
Maternity Capacity & Choice	Providers to work with us to review capacity and redefine future service provision	SUHT BTUH PAH MEHT QUEENS WHIPPS CROSS ADDENBROOKES	All CCGs
Sickle Cell	To review and re-design a Sickle Cell Pathway to deliver 0 – 19 Service. Alignment with CYP to the South Essex Specialist Service North Essex Providers will ensure there is a robust pathway for Sickle Cell	SUHT BTUH	South Essex CCGs North Essex CCG's

Diabetes	Sub-contracting elements with the community provider – on call arrangements, psychology support and dietetic cover for the diabetes best practice pathway Delivery and implementation of Diabetes Best Practice pathway (14 elements). Establish assurance mechanisms through acute contract.	SUHT SEPT BTUH NELFT PAH MEHT HCT CECS	All CCGs
Establish urgent and non urgent telephone hotlines for advice and admission avoidance	Telephone hotline for primary care to speak directly with a paediatrician, reducing referrals to secondary care	MEHT PAH	Mid CCG West CCG
Paediatric screening and triage of non urgent referrals	Review of implementation and impact alongside refining processes for good reporting and monitoring as service progresses.	MEHT PAH	Mid CCG West CCG
Reducing paediatric admissions from A&E and inpatient length of stay	Reducing/eliminating inappropriate admissions from A&E and use of in-patient beds. Redirecting patients from A&E to community services.	MEHT PAH	Mid CCG West CCG
CECS Service Review	Reviewing service to inform redesign	CECS	Mid CCG
Tier 2	Inclusion of children over 2 years within the current tier		Mid CCG

Ophthalmology Service	2 ophthalmology service		
Medical Response Vehicle	Including children and young people in the current pilot for the MRV		Mid CCG
Safeguarding Training	Intention to increase safeguarding training KPI for all levels. 95% compliant for levels 1, 2 and 3. 100% complaint for level 4.	All Providers	All CCGS
LAC Training	Intention to increase LAC training. 95% compliant for level 3. 100% complaint for level 4.	All Providers	All CCGs
Safeguarding Training Evidence	Evidence of 100% of level 5 training for all designated professionals	All Providers	All CCGs
Trouble Tree Tier 2 CAMHS Service	Decommissioning of Trouble Tree from current provider potential re alignment to ECC Tier 2 CAMHS service	SEPT	CPR CCG
Leverton Hall **Section 75/76 expires 31/03/2014**	SEPT to inform commissioners what their intentions are for the service delivery 2014/15	SEPT	CPR and Mid Essex CCGs

6.6 NHS England – Essex Area Team[4]

HEALTHY CHILD PROGRAMME (HCP) 0-5 Yrs.	The Area Team will continue to commission increased numbers of Health Visitors in line with the implementation national "Health Visitor Implementation Plan 2011-15: A Call to Action" published in 2011. The Plan puts in place across the country a new health visiting service that all families can expect to access and agreed trajectories have been reached with providers to ensure that we achieve the national objectives by 2015. However, the local financial scenario within Essex requires commissioners to negotiate a level of restructuring and cost avoidance within these contracts to enable resources to be freed up to support the continuation of the Health Visitor expansion role out. The Area Team has agreed with providers an updated service specification and contract varied this in 2013/14. This specification will form part of the baseline service from 1 April 2014. Providers should ensure that data requirements are delivered in a robust and effective way. The Area Team will also be working with providers to understand and review current staffing structures within the HCP 0-5 years resource that were inherited from PCTs and will undertake a review of the service line breakdown in 13/14. In year contract variations will be negotiated with providers during 2014/15 to reflect the financial consequences of the recruitment to increase the numbers of Health Visitors from October 2014, in line with agreed provider specific trajectories. From April 2015 it is the intention of NHS England to transfer the commissioning of this service to Local Government; therefore, we will expect providers to work with us during 2014/15 to ensure a smooth transition.
FAMILY NURSE PARTNERSHIP (FNP)	The Family Nurse Partnership is a national initiative (2007) and is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive

[4] *(sourced from Essex Area Team – Generic Commissioning Intentions 2014/15 - 30th September 2013)*

	relationship with the family. The Area Team is required to support the expansion of FNP places to 16000 places across the country, which will mean an increase from 125 currently provided in SE Essex to 350 places for the whole of Essex. This will be as a collaborative agreement with Essex County Council, Southend Council and Thurrock Council. In order to expand the service across the Essex Area Team geography in a way that meets national expectations and needs within the population, the Area Team gave notice to the current provider in 2013/14 and will be undertaking a limited procurement process to ensure that an Essex-wide service that can deliver 350 places is in place from 1 April 2014. Providers are advised that they will be required to work with the successful organisation in 2014/15 onwards. From April 2015 it is the intention of NHS England to transfer the commissioning of this service to Local Government; therefore we will expect providers to work with us during 2014/15 to ensure a smooth transition.
CHILD HEALTH INFORMATION SYSTEM (CHIS)	Services will be commissioned in line with the revised service specification and contract varied into 2013/14 contracts. This specification will form part of the baseline service from 1 April 2014. Providers should ensure that data requirements are delivered in line with the "Gold standard", in a robust and effective way. The Area Team is likely to go to procurement in 2014/15 to move to a commissioning model with a single organisation providing services from multiple site across Essex. However, this is still subject to confirmation. It is the currently the intention of NHS England to transfer from April 2015 the commissioning of this service to Local Government however, this transfer is currently subject to review. We will therefore expect providers to work with us during 2014/15 to ensure a smooth transition.
IMMUNISATIONS	The Area Team is likely to go to procurement during 2014/15 to move to commissioning "school age" immunisation programmes across the whole of the Essex Area Team geography. We will be reviewing the service specifications for domiciliary and community based immunisation

	services, and will consider re-procuring this as part of a wider immunisation service. Providers are expected to work with the area team and provide information for this review. There are currently no new national programmes expected, although we await confirmation and clarification in the national NHS England Operating Framework, due to be published in December 2013. We will continue to roll out and extend the new immunisation programmes launched during 2013/14, including: • Men C catch up programme for University entrants; • Seasonal Flu programme for children; • MMR catch up for those not or partially vaccinated We are expecting changes minor changes to the service specifications, including uptake rates that cover pneumococcal, routine seasonal flu, pertussis for pregnant women, routine childhood immunisation. We wish to continue to support SEPT with the pilot of seasonal flu immunisation of children aged 4-10 year olds.
BREAST SCREENING	The Area Team will continue to commission the roll out of the "age extension" of the breast screening programme to ensure that services invite women aged 47-49 years and 71-73 years by 2016. We will work with SUHT and PAHT to ensure age extension and digital mammography is fully implemented within their services. We await confirmation in the NHS public health functions agreement for 2014/15 as to whether there will be changes to coverage levels and other KPIs. These will be agreed through the contractual process. We await confirmation in the national NHS England Operating Framework for advice on the "high risk screening" services due to be published in December 2013. We expect providers to work with us during 2014/15 on this.

CERVICAL SCREENING	The Area Team will commission the screening services in line with the outcome of the East of England Pathology review which has outlined the reconfiguration in services (Transforming Pathology Services (East of England). Providers will be required to implement the recommendations of the review. We expect PAHT to have aligned themselves appropriately in order to implement the recommendations within the relevant timescale. The service specification for cervical screening will include Human Papilloma Virus (HPV) testing as triage and test of cure, for women with low grade ab-normalities, as an integral component of the programme. We await confirmation in the NHS public health functions agreement for 2014/15 as to whether there will be changes to coverage levels and other KPIs. These will be agreed through the contractual process.
BOWEL CANCER SCREENING	There are no planned changes to the commissioning of this service in 2014/15, however following receipt of validated baseline indicators from Public Health England, the Area Team may negotiate new targets within contracts. We will ensure service specifications are renewed for the 2014/15 contract. We will continue to support local providers wishing to be part of the nationally funded, roll out of bowel scoping for 55 year olds.
ABDOMINAL AORTIC ANEURYSM SCREENING(AAA)	There are no planned changes to the commissioning of this service in 2014/15, however the national funding ceases at 31 March 2014 and the Area Teams will need to ensure that these resources are prioritised to continue the screening services from 1 April 2014.
DIABETIC EYE SCREENING (DES	We await confirmation in the NHS public health functions agreement for 2014/15 as to whether there will be changes to coverage levels and other KPIs. These will be agreed through the contractual process. The Area Team intends to commission an end to end service from one lead provider in all programmes, predominantly affecting the South Essex system. There will be an options appraisal during 2014/15 to ensure this service configuration is in place for 2015/16.

	It is also our intention to commission the common pathway for Diabetic Eye Screening, in line with national policy. This includes introduction of surveillance clinics and slit lamp bio-microscopy within the screening programmes.
ANTENATAL & NEW BORN HEARING SCREENING	The CCGs will continue to commission this service (as they did in 2013/14) on behalf of the Area Team, as part of the national PBR maternity tariff. We expect CCGs to ensure that all providers are producing cohort data and reporting this through established programme boards. We await confirmation in the NHS public health functions agreement for 2014/15 as to whether there will be changes to coverage levels and other KPIs. CCGs will be informed on these and the Area Team will support CCGs with agreeing these with providers through the contractual process.
SEXUAL ASSAULT RESOURCE CENTRE SARC	We await the outcome of national commissioning intentions in respect of SARC and will inform providers and partners in due course.
SECONDARY CARE DENTAL SERVICES	From April 1 2014 primary and secondary care NHS dental services have been directly commissioned by the NHS England and has given us the opportunity to bring further improvement to the commissioning of dental care across the whole pathway. By commissioning the totality of dental care, this gives the Essex Area Team the opportunity to better integrate primary and secondary services to provide better care and outcomes for patients and more rewarding careers for all clinicians. We will strive to ensure that we are "*Securing Excellence in Commissioning NHS dental services*" We will continue to work with clinicians and commissioners to develop care pathways for patients in need of an element of advanced care. We ensure that we utilise the skills of the whole dental team within a specialist led, but not necessarily delivered, service that provides high quality care regardless of setting. We will implement the emerging national dental care pathways for dental services, including minor oral surgery, maxilla-facial surgery, orthodontics, restorative dentistry and vulnerable people. It is anticipated that these will include national consistent standards in the following areas:-

	• Levels of care, complexity and procedures • Consistent competencies for each level of care (building on advanced care work) • Consistent environment/equipment standards for each level of care • Consistent clinical outcomes, quality standards and/or patient reported outcome measures (PROMS) for each level of care • Consistent approach to coding and costing measures for the care pathway across all settings • Monthly reporting to the North East London CSU on all activity • Access to services across each pathway to ensure that people with disabilities and all other "hard to reach" groups of people have equitable access to good oral health outcomes. We expect all providers to meet national 18 week targets for dental services and report monthly on performance; where performance is deteriorating, action plans to address the situation will be required and weekly performance reporting implemented, to avoid potential RTT breaches. Providers are also expected to adhere to existing service restriction criteria; a review of service restriction criteria across all providers will be undertaken to ensure a consistent approach by all providers commissioned by the Area team. A dental triage system for all dental referrals into secondary care will be commissioned across Essex in 2014/15 to ensure a consistent approach; notice will therefore be given for existing providers in line with current contract notice periods.
ORAL SURGERY PATHWAY - RIGHT PLACE RIGHT TIME	It is our intention to ensure all referrals from primary care (GDP/GPs) are managed effectively to maximise the quality of care and timely access. We will work with all providers to instigate or refine referral management/triage system for all Essex patients. This system will be in place for all secondary and specialist providers by April 01st 2014. Only referrals that are appropriate to secondary/speciality services will be managed in that sector, all other referrals will be treated in the most appropriate non-acute setting.
PRIMARY DENTAL	KPIs for existing PDS+ providers will be reviewed and aligned to support local priorities during 2014/15.

SERVICES	Following completion of the Essex orthodontic needs assessment, services delivered by existing orthodontic providers will be reviewed and benchmarked in line with NHS England Quality and Value audit framework. This process will inform whether existing contracts are extended or whether services are re-commissioned through a national procurement process
PRIMARY MEDICAL SERVICES / PMS REVIEWS	NHS England has recently undertaken a baseline review of PMS agreements across the country and a national decision on the future funding arrangements for PMS agreements is expected shortly. It is likely however that PMS contracts will need to be aligned with the emerging Essex Primary Care Strategy to achieve better outcomes for patients and deliver improved value for money. Where contracts terminate on 31 March 2014, these have been given notice separately on 30 September 2013
APMS REVIEWS	The Area Team will also be seeking in 2014/15 to ensure that APMS contracts are in line with emerging Primary Care Strategy to achieve better outcomes for patients and improved value for money. In discussion with CCGs and providers where existing Walk In Centre contracts are to be extended into 2014/15, the Area Team will wish to identify QIPP efficiencies on existing contracts and will also determine in consultation with stakeholders as to whether existing Walk In Centre APMS contracts will be re-commissioned through a procurement process from 2015/16.
TRANSLATION AND INTERPRETING SERVICES	NHS England will consider the future procurement of translation and interpretation services for primary care clinical service with the intention of identifying opportunities to achieve efficiencies through economies of scale.
OCCUPATIONAL HEALTH SERVICES	NHS England will consider the future configuration of occupational health services during 2014/15 with the intention of identifying opportunities to achieve efficiencies through economies of scale.
CLINICAL WASTE SERVICES	NHS England will be considering the future configuration of waste disposal during 2014/15 to determine whether these services can be delivered on either a regional or sub regional basis and through

	economies of scale. A number of options will be considered and discussed with a wide range of stakeholders before determining the scope of any procurement for these services.
LOCAL ENHANCED SERVICES (LES)	Any outstanding LESs carried over by NHS England through transition will cease from 31 March 2014. Responsibility for future commissioning of enhanced services will rest with CCGs to commission any on-going service needs through the NHS standard contracts
PRIMARY CARE SUPPORT (FHS) SERVICES	A national service specification for these services is being developed to ensure that these services are commissioned on a consistent basis across England and that cost efficiencies are delivered from 2014/15. Further work is on-going to determine whether these services should be subject to a national procurement exercise.

7. Integrated commissioning building blocks

The development of integrated commissioning will build on good practice already in place across the partnership. It will use a number of building blocks to assist partners to commission effectively within an evolving landscape of children's service reforms.

Statutory and policy framework

Our commissioning plans take account of and reflect the following

- Children Act 2004 and Children Act 1989
- Education Act 2002
- Childcare Act 2006
- SEN Code of Practice 2001 – being revised through the Children and Families Bill
- Health and Social Care Act 2012
- National Health Services Act 2006
- No Health without Mental Health
- Health and social care outcomes frameworks developed nationally

Safeguarding

Our duties to promote safeguard and protect the welfare of children and young people underpin all strategies and commissioning plans. The commissioning arrangements in place ensure all organisations have clear, appropriate and safe procedures that reflect the government guidance Working Together to Safeguard Children 2013 and are in line with the Southend, Essex and Thurrock safeguarding procedures – SET procedures.

User engagement

The value of effective, meaningful and consistent service user engagement is critical if we are to commission outcomes effectively and it will form an integral element of our commissioning strategy. This will enable us to ensure we understand better how service users can best access services, advice and information and to respond to what they consider will best meet their needs. Creating an open dialogue with children, young people and families will inform needs analysis, the assessment of existing provision, input into local delivery models and, in line with the Localism Act 2011 and Community Right to Challenge, opportunities for direct community delivery models.

County and Locality based Joint Needs Analysis

A Joint Strategic Needs Assessment (JSNA) is both a process and a resulting suite of documents and is a means by which CCGs, NHS England, and the Local Authority describe the future health and wellbeing needs of local populations and the strategic direction of service delivery to meet these needs. It is used to identify commissioning priorities and procure interventions that are based on need and will in turn achieve better outcomes and reduce inequalities. The needs identified therein have informed the priorities and underpin the development of these commissioning intentions.

The overarching Essex JSNA report provides a high level account of health and wellbeing issues for Essex over the next three years. Through its detailed evidence base the JSNA enables the Essex Health and Wellbeing Board to make well informed judgments about priorities for the Essex Health and Wellbeing Strategy.

Among the JSNA products there are reports for each of the five Clinical Commissioning Groups across Essex and summary reports for Localities (for which local needs assessments have been completed through the Locality Children's Partnerships), Borough and District Councils as well as reports on specific subject areas such as Mental Health. These and other JSNA products are available, on Essex Insight – www.essexinsight.org.uk.

In addition to the on-going needs analysis a Service Mapping exercise has also been undertaken against these priorities to determine gaps and identify duplication, therefore enabling us to improve resource use and highlight commissioning priorities at both County and Quadrant/CCG level. We will continue to review and update this regularly to support key commissioning decisions.

Effective Support for Children and Families in Essex

All commissioning intentions are underpinned by this guidance which describes how practitioners and agencies can work together effectively, share information and put the child and their family at the centre to provide early help and targeted and specialist support. The aim is to help children, young people and families find solutions to their problems at an early stage, at the point that needs become apparent, and to avoid specialist statutory interventions where possible.

The Essex Effective Support for Children and Families in Essex guidance offers a clear framework of intervention and provides the backdrop for effective commissioning creating a uniformly understood series of

descriptors against which services can be commissioned with clarity and a shared understanding of the target outcomes. It also sets out a framework against which the range of existing services can be mapped (see Appendix 3).

Early Intervention

Early Intervention will form a key component of integrated commissioning across Essex. This will be early in life, as early as conception, through the provision of clear and consistent information, advice and support or early in the development of a problem at any age. Underpinned by accessible early help at the point of need, we will use our collective understanding of the personal, social and emotional factors that influence children, young people and families to proactively commission universal and targeted early intervention options (Appendix 4 – Early Intervention Principles).

Effective contracting and procurement

Creating an efficient commissioning cycle may lead to the de-commissioning of existing contractual arrangements or short term extension of historical contracts in order to align and secure outcomes based commissioning activity. Given the importance of maintaining front line service provision there will be a need to establish interim and transitional arrangements that ensure business continuity whilst affording providers the opportunity to prepare for revised commissioning timelines

High quality joint procurement, when commissioners' work together to achieve common outcomes can help improve integrated provision. Integrated commissioning will need to be delivered via single or joint procurement led by the Local Authority or other public sector partners. Essex County Council has its own Procurement and Business Intelligence infrastructure and four of the five CCGs are supported by the Commissioning Support Unit (CSU). Any procurement will be joined up as much as is effective and appropriate. Shaping of important sectors of the health and care market and the development of shared market strategies presents previously unavailable opportunities to drive up standards and quality in areas such as care provision where different commissioners are often charged different rates for the same services which are delivered to different contractual standards

Contract Management

Partners to integrated commissioning contracts will work together to review whether commissioned outcomes are being met. Regular, open

and honest dialogue between partners and providers around a commonly understood series of expected outcomes will provide for effective contract management.

All contract management will seek to establish the progress made by the provider against the specification or the performance. In addition it will review any contractual risks or efficiencies identified by either party and any subsequent variations will be addressed through a formal change control process.

Ensuring outcomes based accountability, commissioners will use simple and clear language, request the collection and use of relevant data and expect evaluation to include stakeholder involvement.

Where performance management indicates that services are inefficient, ineffective or unsustainable, commissioners will either support or challenge that service to improve or decommission it and find other provision to meet the identified needs.

8. Realising our commissioning Intentions

The governance route for delivery of the integrated commissioning intentions set out in this document will be that of the North and South Essex Maternity, Children and Young People's Integrated Commissioning Strategic Groups which comprise representatives from the Local Authority, CCGs, the CSU, NHS England and representatives from Southend and Thurrock. Each group will lead the children, young people and families integrated commissioning agenda for their area to deliver effective outcomes whilst seeking to reduce demand and achieve efficiencies. They will take a strategic overview of current commissioning commitments, priorities, opportunities and resources.

These groups report into the wider Essex Children's Partnership and the Business Management Group of the Essex Health and Wellbeing Board. They will influence needs analysis work to inform commissioning priorities and will monitor progress across the key stages of the commissioning cycle having regard to contract management, service impact and re-commissioning.

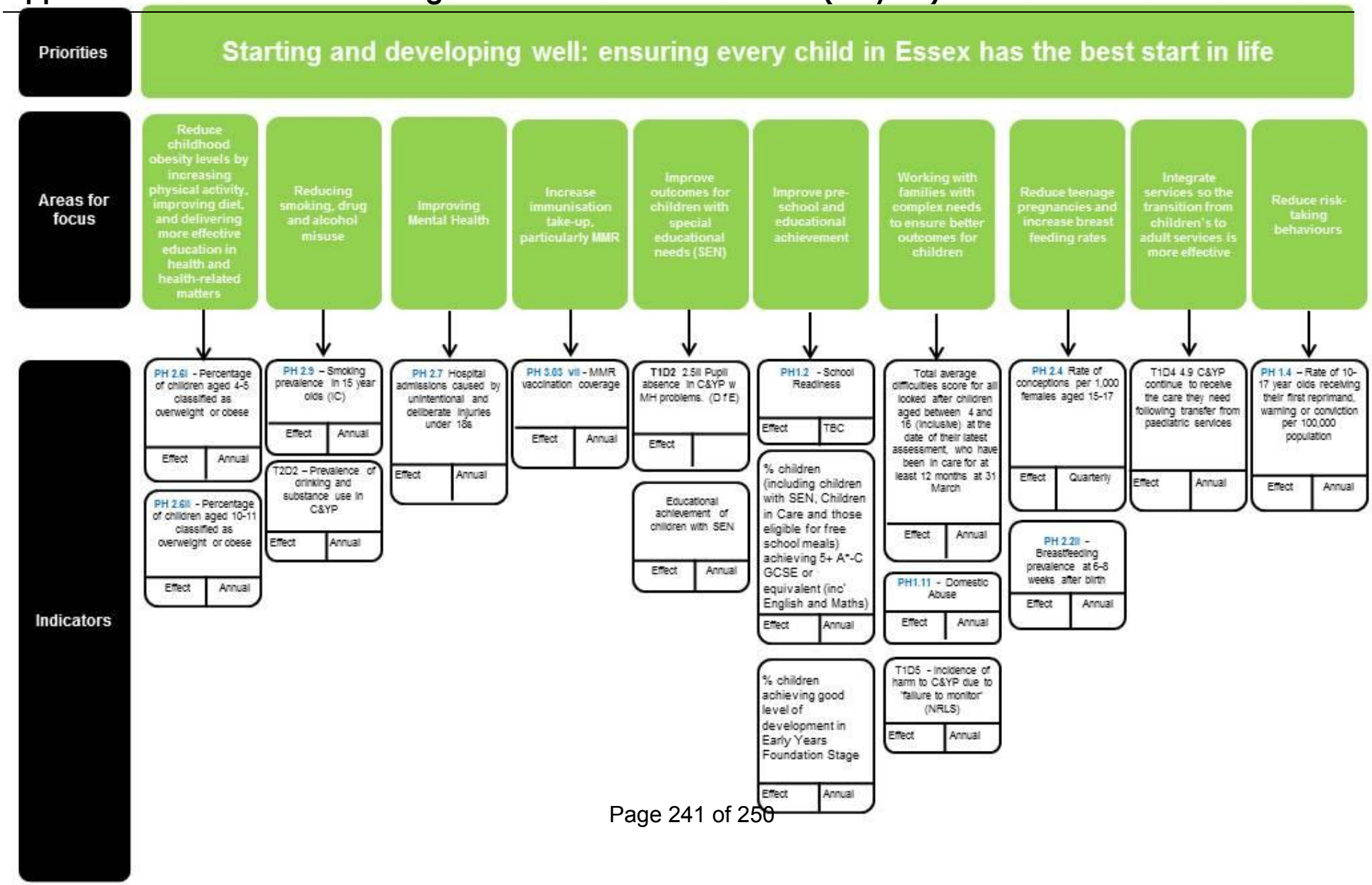
The key priorities for the Local Authority, from the wider integrated commissioning agenda in 2013-14 are:

- CAMHS
- Children's centres
- Continuing care/Children with a Disability/Special Educational Needs
- All schools to be good schools
- Improved school readiness and Early Years Foundation Stage Profile outcomes
- Education and skills provision to meet the needs of employers, communities and individuals throughout their lives

The Local Authority is now working together with the 5 CCGs across Essex, the CSU and with Southend and Thurrock where appropriate and with other commissioning organisations to develop detailed plans which will articulate the actions and timescales needed to ensure these commissioning intentions are realised.

A significant amount of the joint work in 2013/14 will be in system assurance and joining up thinking between agencies. Much planning work will be undertaken during 2013/14 to develop and agree specifications, plans, resources and commissioning processes for the various service areas we want to commission jointly from April 2014 onwards.

Appendix 1: Health and Wellbeing Board Outcomes Framework (May-13)



Appendix 2: Strategic Context for Commissioning

- **Essex Health and Wellbeing Strategy**

The Essex Health and Wellbeing (HWB) Board brings together key partners to improve health and wellbeing across Essex through the development and implementation of a Health and Wellbeing Strategy for the communities of Essex (*Health and Wellbeing Strategy for Essex 2013-2018)*. The Strategy is the principal high level plan and provides a strategic framework for the commissioning and delivery of health and social care services for a five year period for both children and adults. The vision for better health and wellbeing in Essex which can be found in the Health and Wellbeing Strategy is:

'By 2018 residents and local communities In Essex will have greater choice, control and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.'

The HWB Priorities cover pre-birth ante-natal support through to old age with an emphasis on supporting transition between services to improve the standards of care provided and are:

- Starting and developing well: ensuring every child in Essex has the best start in life
- Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life
- Ageing Well; Ensuring that older people remain as independent for as long as possible

This Commissioning Strategy outlines ECC's contribution to the 'Starting Well' priority. The outcomes for this priority are given in Appendix 2.

In addition to the three priorities there are five cross cutting themes that run through the Strategy:

- Tackling health inequalities and the wider determinants of health and wellbeing
- Transforming services: developing the health and social care system
- Empowering local communities and community assets
- Prevention and effective interventions
- Safeguarding

- **Children, Young People and Families Plan (CYPFP)**

The Children, Young People and Families Partnership is the partnership body driving an integrated and coordinated approach to children's services across Essex and in localities. Partners will ensure that integrated commissioning reinforces and is reinforced by the Partnership Children and Young People's Plan 2012-2015: *'Children, Young People and their Families Partnership: Vision, Priorities and Principles'* .

- **All Age Framework for People with Disabilities**

The 'All Age' framework is an advanced model of integrated commissioning and provision which takes a whole view of a disabled person's life and the support they access from their family, community, local authorities and health services. It is an example of emerging alignment between services for Children and Adults. The framework creates a multi-agency service pathway that considers and seeks to minimise the impact on service users of transition from childhood to adulthood, and from adulthood to older life.

The overall objective is to strive to reduce levels of need where possible through timely and coordinated interventions. The project seeks to achieve an organisational culture that enables front-line staff to work with disabled children, young people and adults through a customer pathway, to build people's resilience and independence in a sustainable way.

- **Whole Essex Community Budgets Programme**

The Whole Essex Community Budget (WECB) programme involves public sector partners working together, delivering services that improve the lives of Essex residents whilst also cutting waste and duplication. By transcending organisations, the Whole Essex Community Budget has the potential to improve radically the way we resource, commission and deliver services in the future. Taken together it is expected that the initial proposals could deliver significant net benefits, accelerate the delivery of new jobs and homes and investment in our physical and service infrastructure.

The learning from the Community Budget work is informing the wider commissioning of the County Council including for People Commissioning. The key complementary themes are:

- Strengthening communities – enhancing community resilience, redefining the relationship between citizens and the public services and reducing service demand;
- Early intervention and prevention – tackling social problems before they become intractable and costly; and
- Integration – using resources held by different partners to meet shared objectives and drive new behaviours.

All areas of focus have significant relevance to children, young people and families and are: families with complex needs, domestic abuse, reducing offending and enhancing skills. Hence, there is considerable join up between ambitions in the Strategy and WECB plans.

- **Public Health Commissioning Intentions**

ECC is committed to reducing health inequalities and supporting the most vulnerable in society will require an integrated approach to commissioning developed through close partnership working. The transition of the responsibility for commissioning Public Health interventions will enable the organisation to fulfil this aspiration. Whilst there are some centrally mandated commissioning requirements identified through the National Public Health Outcomes Framework and Department of Health Guidance, there is scope to develop local priorities through both the Joint Strategic Needs Assessment and the local evidence base that have informed the Joint Health and

Wellbeing Strategy and Children's Commissioning Priorities. The Public Health commissioning intentions have identified the following key Priority Outcomes: [5]

- Improved Development at age five
- Higher levels of Physical Activity
- Reduced hospital admissions due to alcohol misuse
- Increased breastfeeding
- Reduction in Teenage Pregnancy
- Reduced Levels of Obesity
- Reduced Drug Misuse
- Improving Mental Health
- Reduced Pressure on Carers
- Reductions in Excess Seasonal Mortality
- Reductions in Social Isolation

Public Health commissioners are in direct contractual arrangements with a range of providers, including the third sector to ensure that high quality services are being delivered to contribute to the achievement of these outcomes. It is recognised that there is some overlap between children's and public health commissioning as the responsibility for the latter has now transferred to the local authority. This offers a significant opportunity to redesign services to deliver optimal outcomes and value for money, working in partnership with CCGs, NHS England and wider stakeholders. The ECC transformation agenda will enable the organisation to align commissioning responsibilities and streamline existing provider relationships as well as seek opportunities to develop the market. The re-design priorities are:-

- Sexual Health Services
- School Health Services

[5] Achieving Better Public Health for the People of Essex – Essex County Council 2013 (Draft)

- **Clinical Commissioning Group (CCG) Integrated Plans**

Integrated commissioning plans set out the principles, vision and decisions of the Clinical Commissioning Groups (CCGs) to enable delivery of effective and sustainable healthcare. All five CCGs in Essex have expressed their commitment to integrated commissioning in their plans, and the Local Authority will work closely with them to develop and implement these.

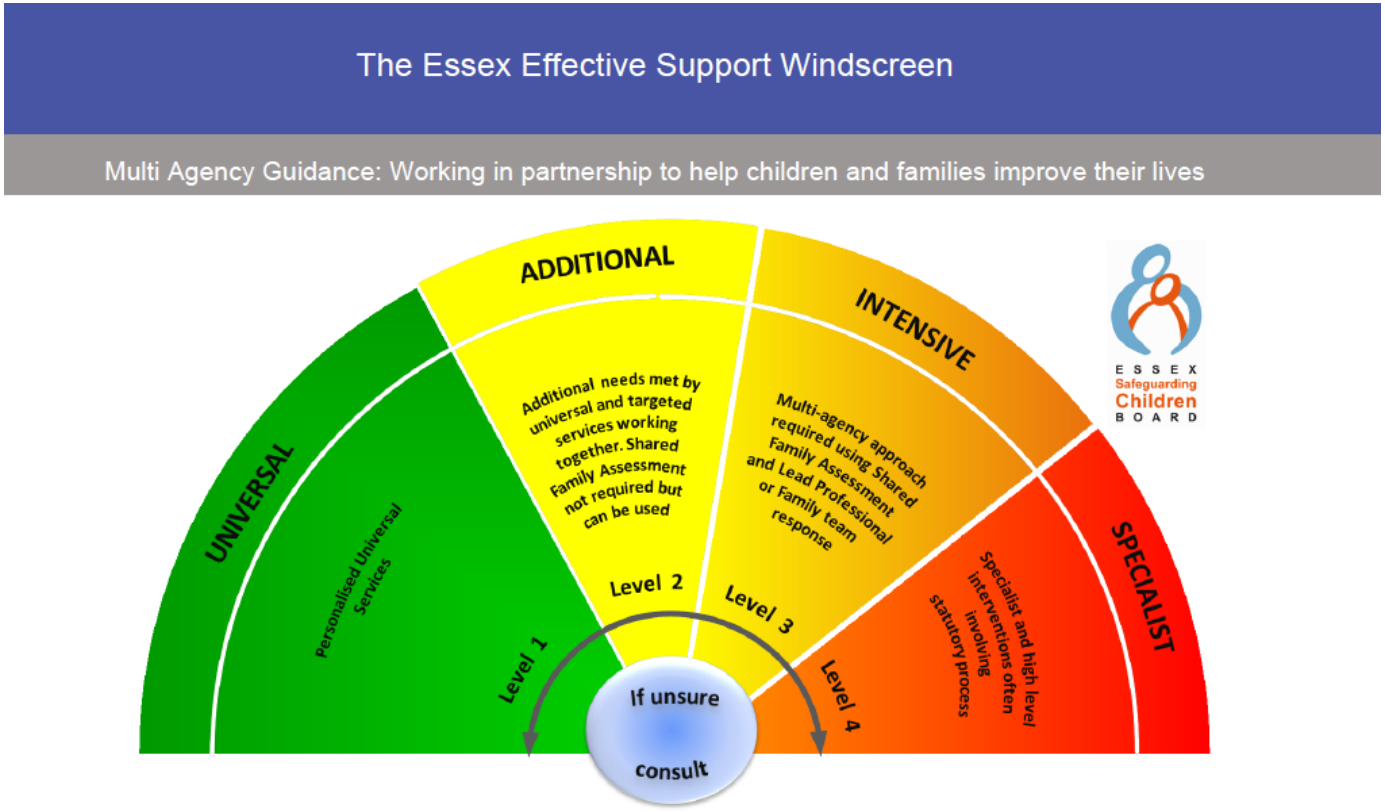
- **Lifelong Learning Strategy**

This 2013 strategy sets out the pathway for seamless access to learning opportunities through statutory and community provision. The document represents the widening out of the remit of Education services to reflect a commitment to Lifelong Learning with a focus on ensuring the residents of Essex at all stages of their lives are prepared to actively contribute to the economic development of the County.

- **Economic Growth Strategy**

Developed in 2012 this document is a blueprint for short, medium and long term financial growth and stability for Essex. The aims of this Strategy are supported by the design of an Adult Community Learning curriculum and skills offer that prioritises skills for work, employability, English and maths, vocational training and providing progression routes to higher level qualifications.

Appendix 3: Essex Effective Support Windscreen



All partners working with children, young people and their families will offer support as soon as we are aware of any additional needs. We will always seek to work together to provide support to children, young people and their families at the lowest level possible in accord with their needs

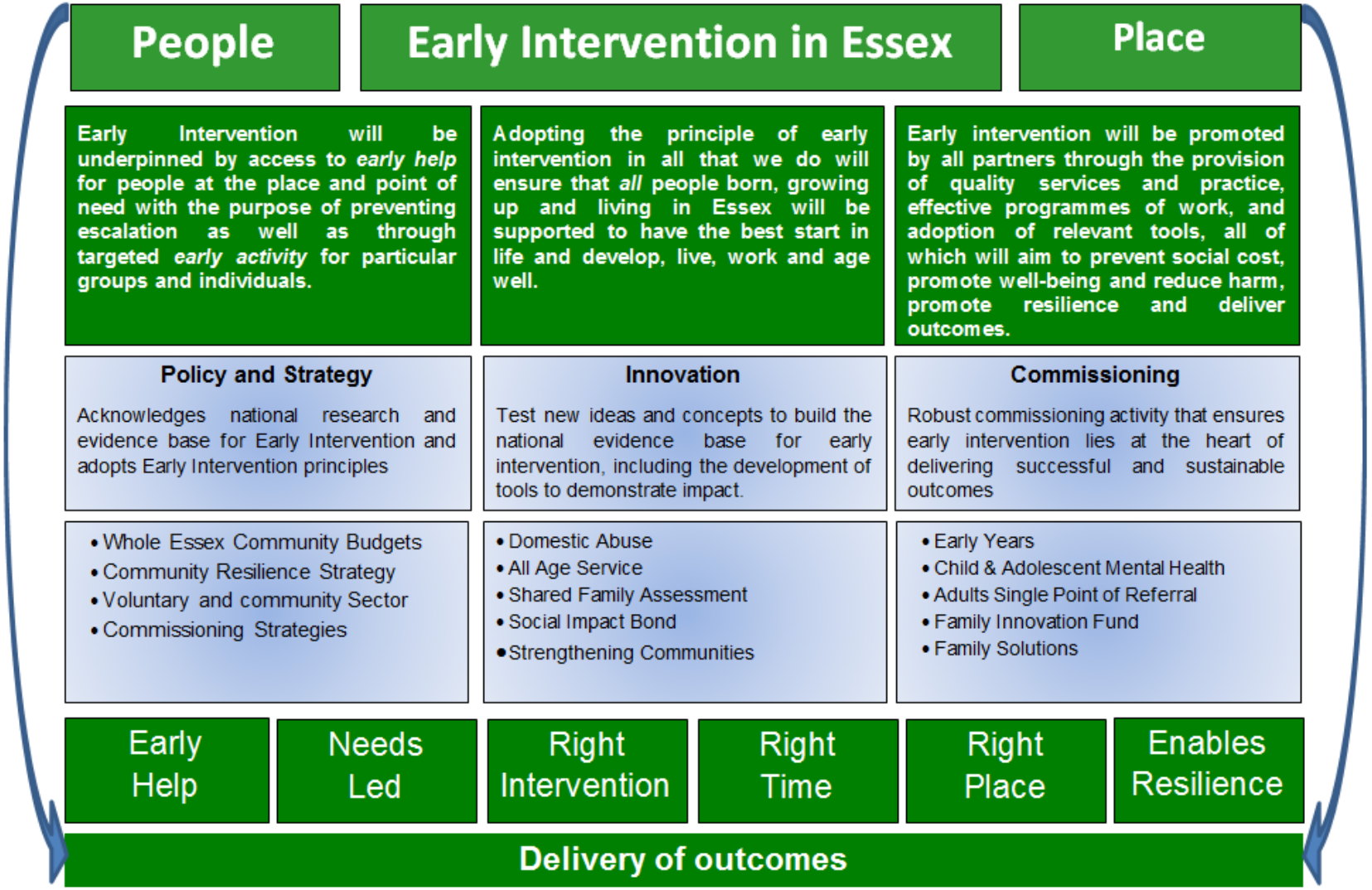
Services for children with additional needs are sometimes known as *targeted services*, such as behaviour support or additional help with learning in school, extra support to parents in early years or targeted help to involve young people through youth services. Children with ***additional*** needs are best supported by those who already work with them, such as children's centres or schools, organising additional support with local partners as needed.

For children whose needs are ***intensive***, a co-ordinated multi-disciplinary approach is usually best, involving a ***shared family assessment*** and a ***lead professional*** to work closely with

the child and family to ensure they receive all the support they require.

Specialist *services* are where the needs of the child are so great that statutory and/or specialist intervention is required to keep them safe or to ensure their continued development. Examples of specialist services are Children's Social Care, Child & Adolescent Mental health Service (CAMHS) tier 3 or Youth Offending Service. By working together effectively with children with additional needs and by providing co-ordinated multi-disciplinary support and services for those with more intensive needs, we seek to prevent more children and young people requiring specialist services.

Appendix 4: Early Intervention Principles


People
Early Intervention in Essex
Place
Early Intervention will be underpinned by access to early help for people at the place and point of need with the purpose of preventing escalation as well as through targeted early activity for particular groups and individuals.
Adopting the principle of early intervention in all that we do will ensure that all people born, growing up and living in Essex will be supported to have the best start in life and develop, live, work and age well.
Early intervention will be promoted by all partners through the provision of quality services and practice, effective programmes of work, and adoption of relevant tools, all of which will aim to prevent social cost, promote well-being and reduce harm, promote resilience and deliver outcomes.
Policy and Strategy
Acknowledges national research and evidence base for Early Intervention and adopts Early Intervention principles
Innovation
Test new ideas and concepts to build the national evidence base for early intervention, including the development of tools to demonstrate impact.
Commissioning
Robust commissioning activity that ensures early intervention lies at the heart of delivering successful and sustainable outcomes
• Whole Essex Community Budgets
• Community Resilience Strategy
• Voluntary and community Sector
• Commissioning Strategies
• Domestic Abuse
• All Age Service
• Shared Family Assessment
• Social Impact Bond
• Strengthening Communities
• Early Years
• Child & Adolescent Mental Health
• Adults Single Point of Referral
• Family Innovation Fund
• Family Solutions
Early Help
Needs Led
Right Intervention
Right Time
Right Place
Enables Resilience
Delivery of outcomes