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East Sussex
County Council

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

Foreword

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

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

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

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

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 6: Supporting those with special educational needs, disabilities and long term conditions

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Chapter 1: Introduction

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

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

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

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

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries
Booklet 5:	Enabling people to manage and maintain their mental health and wellbeing

Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

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

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 6: Supporting those with special educational needs, disabilities and long term conditions.

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 6 – Supporting those with special educational needs, disabilities and long term

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 6: Supporting those with special educational needs, dis		
Those with SEN, disabilities and long term conditions have a better quality of life and longer life expectancy	• Develop a more person-centred, coordinated approach to supporting the health and wellbeing of those with SEN, physical and learning disabilities, their parents and carers. • More children have a coordinated support plan for health, social care and education and personal budgets. • Develop an integrated 'whole system' approach to long term conditions with earlier diagnosis, care planning and joined up support for patients and carers. • Integrate mental health support into primary care and chronic disease management care pathways. • Roll out multi-disciplinary Neighbourhood Support Teams across the county.	• Earlier diagnosis and provision of personalised care in the community or at home. • More people feel supported to manage their condition better. • Better health outcomes for those with SEN, disabilities and long term conditions (all ages). • Better quality of life for those with SEN, disabilities and long term conditions (all ages). • Better physical health outcomes and quality of life for carers (all ages).

conditions

STRATEGIC OUTCOME INDICATORS

abilities and long term conditions

6.1 Improve measurable outcomes for children and young people with SEND (Special Educational Needs and Disability).
Indicator definition: The number of children and young people who have a personal budget attached to their Education, Health and Care Plan.
Baselines: This is a new measure.
Targets by 2016: 2013/14 = 60. Future targets to be set following 2013/14 outturn.
6.2 Increase the take up of health checks for people with learning disabilities.
Indicator definition: Percentage of patients on a Learning Disability register in East Sussex GP Practices who have received a health check within the financial year.
Baselines: 2012/13 at Q3 England average 65%; East Sussex average 47.8%.
Targets by 2016: to meet the England average (currently 65%). Targets to be revised upwards to match the national average if this increases.
6.3 Reduce the time that people with long term conditions spend in hospital.
Indicator definition:
6.3.1 The proportion of people with ambulatory care sensitive conditions admitted to hospital as an emergency; and
6.3.2 The number of days between admission and discharge.
Baselines:
6.3.1 (2010/11) Number of admissions: East Sussex 4,996; Eastbourne 1,064; Hastings 1,006; Lewes 846; Rother 889; Wealden 1,191.
6.3.2 (2010/11) Number of bed-days: East Sussex 6,759; Eastbourne 5,731; Hastings 5,026; Lewes 5,026; Rother 5,690; Wealden 7,203.
Targets by 2016: 20% reduction in number of admissions and 20% reduction in number of days between admission and discharge.

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

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

The reviews focused on systematic reviews and meta-analyses, but, where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 6: Supporting those with special educational needs, disabilities and long term conditions

Priority area	Sub-topic
Supporting those with special educational needs, disabilities and long term conditions	a. Interventions to support person-centred care in the community for people with special educational needs
	b.Interventions to support person-centred care in the community for people with disabilities
	c.Interventions to support person-centred care in the community for people with long term conditions
	d.Interventions to support self-management for people with long term conditions
	e. Interventions to promote better physical health outcomes and quality of life for carers (all ages)
	f. Integrated services as an intervention to avoid inappropriate attendance at A&E/admissions/bed days

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

Table 2.2: Study Quality Classification

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

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

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

2.2 Commissioning prioritisation

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

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

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

Chapter 3: Supporting those with special educational needs, disabilities and long term conditions

Focus on

3.1 Interventions to support person centred care in the community for people with special educational needs

3.2 Interventions to support person centred care in the community for people with disabilities

3.3 Interventions to support person centred care in the community for people with long term conditions

3.4 IInterventions to support self-management for people with long term conditions

3.5 Interventions to promote better physical health outcomes and quality of life for carers (all ages)

3.6 Integrated services as an intervention to avoid inappropriate attendance at A&E/admissions/bed days

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

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

3.1 Key facts and figures: people with special educational needs

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

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

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

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

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

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

3.2 Key facts and figures: people with disabilities

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

Table 3.1 shows the number of people with different disabilities in East Sussex and projections over a ten year period. It shows that an estimated 19 % of the population of the county have a disability and by 2022 this figure is predicted to rise to 20%.

Table: 3.1 Disability projections policy-based, East Sussex all people aged 10+, 2012-2022.

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

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

3.3 Key facts and figures: people with long term conditions

Long term conditions, such as high blood pressure, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease, are more prevalent in older age groups and numbers are forecast to increase. Table 3.2 shows numbers of patients on disease registers.

Table: 3.2 GP reported chronic disease registers by care plan status Clinical Commissioning Groups, 2011/12

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

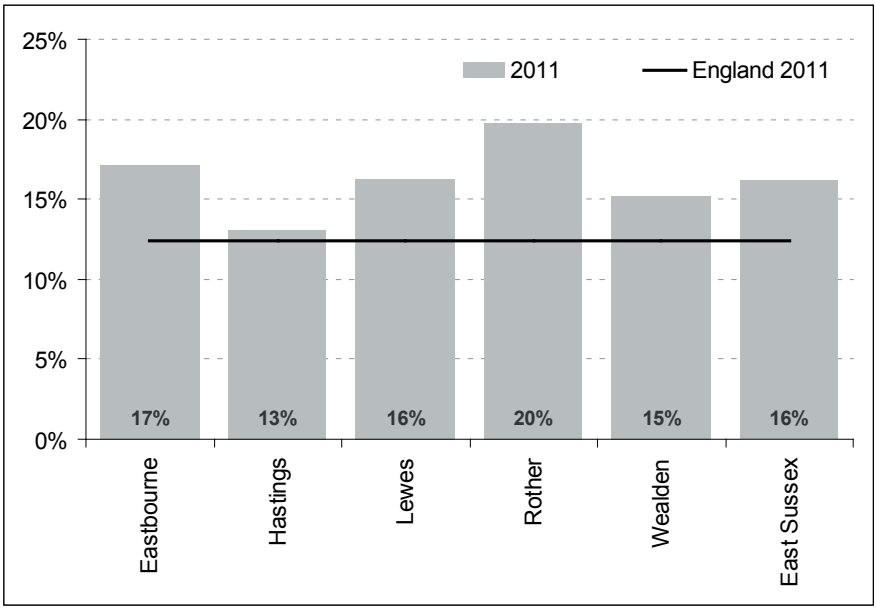
Source: Health & Social Care Information Centre

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

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

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

Figure 3.1: One person households for persons aged 65 years and over, 2011 Census



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

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

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

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

3.6 Key facts and figures: integrated services

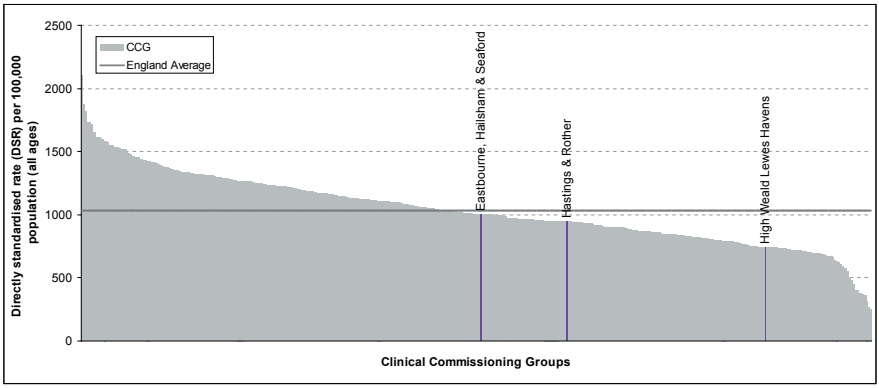
The ageing population and increased prevalence of long term conditions requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self care, more consistent standards of primary care and care that is well co-ordinated and integrated.

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

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

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

Figure 3.2: Emergency admissions for acute conditions* that should not usually require hospital admission, rate per 100,000 population, 2010/11 to 2011/12



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

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

Due to the relatively high numbers of older people in East Sussex, when emergency hospital admissions are ranked by numbers of admissions, as contrasted to ranking by the rate of admissions – the ranking gets worse for clinical commissioning group areas in East Sussex. The lowest ranked CCG has the highest number of admissions. Table 3.3 shows these two sets of rankings.

Table 3.3: Emergency admissions for acute conditions that should not usually require hospital admission, rate per 100,000 population, 2010/11 to 2011/12

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

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

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

References

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

Chapter 4: Evidence based recommendations for priority area 6

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

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

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

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

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

2.2 Recommendations for interventions to support person centred care in the

This evidence review recommends:

Intervention	
Local autism strategy group	
Ensure:	
2.2.1	the group is set up, with managerial, commissioner and clinical represe parent and carer service users, and the voluntary sector.
2.2.2	a lead professional is appointed to be responsible for the local autism p
2.2.3	local autism strategy groups' aims include:
	• improving the early recognition of autism by raising awareness of th
	• supporting the smooth transition to adult services for young people
	• ensuring data collection and audit of the pathway takes place.
2.2.22	the local autism multi-agency strategy group includes representation fro mental health, learning disability, primary healthcare, social care, hous third sector. There should be meaningful representation from people wit
Autism team	
Ensure:	
2.2.4	in each area a multidisciplinary group (the autism team) is set up with th psychiatrist, speech and language therapist and clinical and/or educati
2.2.5	the autism team either includes or has regular access to the following pr
	• paediatrician or paediatric neurologist
	• child and adolescent psychiatrist
	• educational psychologist
	• clinical psychologist
	• occupational therapist.

e community for people with special educational needs

	Grade
ntation from child health and mental health services, education, social care,	A
athway for recognition, referral and diagnosis of children and young people.	A
	A
he signs and symptoms of autism through multi-agency training;	
e going through the diagnostic pathway;	
om managers, commissioners and clinicians from adult services, including ing, educational and employment services, the criminal justice system and the th autism and their families, partners and carers.	A
he following core members: paediatrician and/or child and adolescent onal psychologist.	A
rofessionals if they are not already in the team:	A

Intervention	
2.2.6	the autism team have the skills and competencies to:
	• carry out an autism diagnostic assessment
	• communicate with children and young people with suspected or kn diagnosis with them.
2.2.7	autism team members:
	• provide advice to professionals about whether to refer children and
	• decide on the assessment needs of those referred or when referral
	• carry out the autism diagnostic assessment;
	• share the outcome of the autism diagnostic assessment with paren
	• with parent or carer consent, andif appropriate, the consent of the assessment directly with relevant service;
	• offer information to children, young people and parents and carers
2.2.8	there is a single point of referral for access to the autism team.
2.2.9	the autism team have the skills (or have access to professionals that hav and young people with special circumstances including:
	• coexisting conditions such as severe visual and hearing impairmen complex language disorders or complex mental health disorders
	• looked-after children and young people.
2.2.10	that, if young people present at the time of transition to adult services, t assessment jointly with the adult autism team, regardless of the young
2.2.11	all staff working with adults with autism:
	• work in partnership with adults with autism and, where appropriat
	• take time to build a trusting, supportive, empathic and non-judgem
	• have an understanding of the nature, development and course of a
	• have an understanding of the impact on personal, social, educatio
	• have an understanding of the impact of the social and physical env

	Grade
	A
own autism, and with their parents and carers, and sensitively share the	
	A
l young people for autism diagnostic assessments;	
to another service will be needed;	
ts and carers, and with children and young people if appropriate;	
child or young person, share information from the autism diagnostic	
about appropriate services and support.	
	A
ve the skills) needed to carry out an autism diagnostic assessment, for children	A
ts, motor disorders including cerebral palsy, severe intellectual disability,	
he autism team should consider carrying out the autism diagnostic person's intellectual ability.	A
	A
e, with their families, partners and carers. Offer support and care respectfully;	
nental relationship as an essential part of care;	
utism;	
nal and occupational functioning;	
ironment.	

Intervention	
2.2.16	that in all settings the physical environment in which adults with autism factors that may trigger challenging behaviour. If necessary make adjust
	• amount of personal space given (at least an arm's length);
	• setting using visual supports (for example, use labels with words o
	• colour of walls and furnishings (avoid patterns and use low-arousa
	• lighting (reduce fluorescent lighting, use blackout curtains or advis
	• noise levels (reduce external sounds or advise use of earplugs or ea
Adults with autism	
Ensure health and social care professionals providing care and support for adults with a	
2.2.12	have a broad understanding of the:
	• nature, development and course of autism;
	• impact on personal, social, educational and occupational functio
	• impact of, and interaction with, the social and physical environm disorders and their management;
	• potential discrepancy between intellectual functioning as measu planning and performing activities of daily living including educa
2.2.13	• aim to foster the person's autonomy, promote active participatio
	• maintain continuity of individual relationships wherever possible
	• ensure that comprehensive information about the nature of, and language or format (including various visual, verbal and aural, ea
	• consider whether the person may benefit from access to a trained
2.2.14	ensure that families, partners and carers:
	• are easily identifiable (for example, by producing or wearing appr
	• clearly communicate their role and function;
	• address the person using the name and title they prefer;

	Grade
n are assessed, supported and cared for is taken into account, including any ments or adaptations to the:	A
r symbols to provide visual cues about expected behaviour);	
l colours such as cream);	
e use of dark glasses or increase natural light);	
ar defenders).	
utism:	
	A
oning;	
nent impact on, and interaction with, other coexisting mental and physical	
red by IQ and adaptive functioning as reflected, for example, by difficulties in tion or employment;	
n in decisions about care and support self-management;	A
e;	
interventions and services for, their difficulties is available in an appropriate asy-read, and different colour and font formats);	
d advocate	
	A
ropriate identification) and approachable;	

Intervention	
	• clearly explain any clinical language and check that the person w
	• take into account communication needs, including those arising and provide communication aids or independent interpreters (so autism) if required.
2.2.15	ensure that families, partners and carers are:
	• familiar with recognised local and national sources (organisations a
	• able to discuss and advise on how to access and engage with these
Ensure adults with autism:	
2.2.17	are encouraged to participate in self-help or support groups or have acc and engage in activities.
2.2.18	who have caring responsibilities receive support to access the full range
	• specific information, advice and support to parents about their par in the care of adults and children with autism;
	• social support, such as childcare, to enable them to attend appoint employment.
Families, partners or carers of adults with autism	
Ensure:	
2.2.19	that if a person with autism wants their family, partner or carer(s) to be i
	• negotiate between the person with autism and their family, partner basis;
	• explain how families, partners and carers can help support the per
	• make sure that no services are withdrawn because of involvement the person with autism and their family, partner or carer(s).
2.2.20	all families, partners and carer(s) (whether or not the person wants them
	• autism and its management;
	• local support groups and services specifically for families, partners
	• their right to a formal carer's assessment of their own physical and

	Grade
ith autism understands what is being said;	
from a learning disability, sight or hearing problems or language difficulties, meone who does not have a personal relationship with the person with	
	A
and websites) of information and/or support for people with autism;	
e resources.	
ess one-to-one support, and provide support so that they can attend meetings	A
of mental and physical health and social care services, including:	A
enting role, including parent training if needed, by professionals experienced	
tments, groups and therapy sessions, and to access education and	
involved, encourage this involvement and:	A
or carer(s) about confidentiality and sharing of information on an ongoing	
son with autism and help with care plans;	
of the family, partner or carer(s), unless this has been clearly agreed with both	
n to be involved in their care) have verbal and written information about:	A
and carers;	
mental health needs, and how to access this.	

Intervention	
2.2.21	that if a person with autism does not want their family, partners or carer and written information about who they can contact if they are concerne
2.2.19	that if a person with autism wants their family, partner or carer(s) to be i
2.2.24	that a specialist community-based multidisciplinary team for adults with
	• clinical psychologists
	• nurses
	• occupational therapists
	• psychiatrists
	• social workers
	• speech and language therapists
	• support staff (e.g. staff supporting access to housing, educational a skills).
2.2.25	that the specialist autism team have a key role in the delivery and coord
	• specialist diagnostic and assessment services;
	• specialist care and interventions;
	• advice and training to other health and social care professionals o not all may be in the care of a specialist team);
	• support in accessing, and maintaining contact with, housing, educa
	• support to families, partners and carers where appropriate;
	• care and interventions for adults with autism living in specialist res
	• training, support and consultation for staff who care for adults with
Interventions for adults with autism	
Ensure when discussing and deciding on interventions:	
2.2.26	that the following are considered:
	• patient's experience of, and response to, previous interventions;

	Grade
r(s) to be involved in their care, the family, partner or carer(s) is given verbal d about the person's care.	A
involved, this involvement is encouraged and	A
autism (the specialist autism team) is established with the following members:	A
and employment services, financial advice, and personal and community safety	
ination of:	A
n the diagnosis, assessment, care and interventions for adults with autism (as	
ational and employment services;	
idential accommodation;	
autism in residential and community settings.	
	A
;	

Intervention	
	• the nature and severity of autism;
	• the extent of associated functional impairment arising from the a
	• the presence of any social or personal factors that may have a rol
	• the presence, nature, severity and duration of any coexisting disc
	• the identification of predisposing and possible precipitating fact
2.2.27	that the following are taken into account:
	• the increased propensity for elevated anxiety about decision-mal
	• greater risk of altered sensitivity and unpredictable responses to
	• environment, for example whether it is suitably adapted for peop
	• presence and nature of hyper or hypo-sensory sensitivities and h
	• nature of support needed to access interventions.
2.2.28	information is provided about:
	• the nature, content and duration of any proposed intervention;
	• the acceptability and tolerability of any proposed intervention;
	• possible interactions with any current interventions and possible
2.2.29	that for any intervention used in adults with autism, there is a regular re
	• the benefits of the intervention, where feasible using a formal ra
	• any adverse events;
	• adherence to the intervention.
Promote:	
2.2.30	psychosocial interventions focused on life skills for adults with autism c consider a structured and predictable training programme based on beh
2.2.31	additional research into tele-practice as a promising service delivery app autism, Asperger's or PDD-NOS).

	Grade
autism, a learning disability or a mental or physical disorder;	
le in the development or maintenance of any identified problem(s);	
orders;	
ors that could lead to crises if not addressed.	
	A
king in people with autism;	
medication;	
ole with autism;	
ow these might impact on the delivery of the intervention;	
	A
e side effects;	
eview of:	A
ting of the target behaviour(s);	
f all ranges of intellectual ability, who need help with activities of daily living, navioural principles.	A
proach in the treatment of individuals with autism spectrum disorders (i.e.	B

Intervention	
Local care pathways	
Ensure:	
2.2.32	local care pathways are developed to promote implementation of key pr
	• negotiable, workable and understandable for adults with autism
	• accessible and acceptable to all people in need of the services
	• responsive to the needs of adults with autism their families, part
	• integrated;
	• outcome focused.
2.2.33	autism strategy groups are responsible for developing, managing and ev professional responsible for the local autism care pathway.
2.2.34	access to services for all adults with autism, including:
	• people with coexisting physical and mental disorders (including
	• women;
	• people with learning disabilities;
	• older people;
	• people from black and minority ethnic groups;
	• transgender people;
	• homeless people;
	• people from the traveller community;
	• people in the criminal justice system;
	• parents with autism.
2.2.35	information about local care pathways, given to adults with autism and
	• takes into account the person's knowledge and understanding o
	• is appropriate to the communities using the pathway.

	Grade
inciples of good care, and are:	A
, their families, partners and carers, and professionals;	
tners and carer	
valuating the local care pathways. The group should appoint a lead	A
	A
substance misuse);	
their families, partners and carers:	A
f autism and its care and management	

Intervention	
2.2.36	local care pathways promote a range of evidence-based interventions at interventions.
2.2.37	local care pathways respond promptly and effectively to the changing ne
2.2.38	an integrated programme of care across all care settings.
2.2.39	that there is a single point of referral (including self-referral) to specialis
Residential care	
Ensure residential care:	
2.2.40	is usually provided in small, local community-based units (of no more th environment should be structured to support and maintain a collaborati carer(s) for the development and maintenance of interpersonal and com
2.2.41	environments include activities that are:
	• structured and purposeful;
	• designed to promote integration with the local community and us
	• clearly timetabled with daily, weekly and sequential programmes
2.2.42	environments have:
	• designated areas for different activities that provide visual cues a
	• adaptations to the physical environment for people with hyper ar
	• inside and outside spaces where the person with autism can be
2.2.43	staff:
	• understand the principles and attitudes underpinning the effecti
	• are trained in assessing and supporting the needs of adults with
	• are consistent, predictable, yet flexible to allow change and choi
	• are committed to involving families, partners and carers.

	Grade
each step in the pathway and support adults with autism in their choice of	A
eeds of populations served by the pathways.	A
	A
t services for adults with autism.	A
han six people and with well-supported single person accommodation). The ive approach between the person with autism and their family, partner or munity living skills.	A
	A
se of local amenities;	
s that promote choice and autonomy.	
	A
about expected behaviour;	
nd/or hypo-sensory sensitivities;	
alone.	
	A
ive delivery of residential care for adults with autism;	
autism;	
ce;	

Intervention	
Identifying health needs	
Ensure:	
2.2.45	staff are aware of the barriers people with learning disabilities face to ac facilities, rigid procedures and lack of appropriate interpersonal skills a
2.2.46	that third parties do not obstruct access to health care.
Promote:	
2.2.44	the following interventions to improve access to health care:
	• a communication aid
	• a prompt card to support general practitioners,
	• health checks programmes and walk-in clinics.
2.2.47	health checks to identify previously unrecognised health needs in peopl
Ethnicity	
2.2.49	Ensure that people with mental health problems from different ethnic ba
Staff	
2.2.50	Ensure that staff serving clients with intellectual disabilities receive trai
	• The combination of in-service with coaching-on-the-job.
	• In-service formats should use multiple techniques and verbal fee
	• Coaching-on-the-job formats, verbal feedback should be part of t program developers should carefully prepare training goals, train practice.
Living environment	
2.2.51	Support the use of dispersed housing over clustered housing for adults studied.
2.2.52	Promote deinstitutionalisation and community living for people with int

	Grade
ccess health care including: problems with communication, inadequate mong mainstream health care professionals in caring for these patients.	B
	B
	A
e with intellectual disabilities.	B
ackgrounds have access to mental health services.	B
ning to improve clinical practice in the following formats:	B
edback.	
he program, as well as praise and correction. To maximize effectiveness, ning format, and training techniques, which will yield a profit for clinical	
with intellectual disability to improve the majority of quality indicators	B
ellectual disability.	B

2.3 Recommendations for interventions to support person centred care in the

This evidence review recommends:

Intervention	
Cerebral palsy	
Ensure:	
2.3.1	adults with cerebral palsy are provided with knowledge and understan
2.3.2	psychosocial issues of concern for adults ageing with cerebral palsy ar
2.3.3	support for the following five key elements to achieve a positive transit
	• preparation
	• flexible timing
	• care coordination
	• transition clinic visits
	• interested adult-centred health care providers.
Multiple sclerosis	
Promote:	
2.3.4	multidisciplinary rehabilitation programmes to improve the experience evaluation and assessment of these persons for rehabilitation is recon
2.3.5	inpatient multidisciplinary rehabilitation to produce short-term gains a sclerosis.
2.3.6	outpatient and home-based rehabilitation programmes for patients wi disability with high intensity programmes.
2.3.7	low intensity programmes conducted over a longer period to achieve lo
Physical activity	
Promote:	
2.3.8	physical activity for youth with developmental disabilities.
2.3.9	participation in group exercise programs, treadmill training, or therape disabilities to achieve health benefits.

e community for people with disabilities

	Grade
ding to enhance the decision-making processes about their health.	B
e addressed.	B
tion to adult-centred health care for cerebral palsy and spina bifida:	B
e of people with multiple sclerosis in terms of activity and participation. Regular mmended.	B
at the levels of activity (disability) and participation for patients with multiple	A
th multiple sclerosis to achieve short-term improvements in symptoms and	B
onger-term gains in quality of life.	A
	A
eutic riding/hippo-therapy for children and adolescents with developmental	A

Intervention	
2.3.11	physical exercise therapy to gain a positive effect on mobility and phys
2.3.12	progressive resistance strength training as an effective intervention to
Ensure:	
2.3.13	therapists start with low intensity progressive resistance strength train clinical population.
2.3.14	progressive resistance strength training exercise frequency is two to th reached.
2.3.15	therapists apply one of two strategies to increase the effect of progress
2.3.16	that during progressive resistance strength training therapists monitor
Tele-counselling	
Promote:	
2.3.17	tele-counselling as an effective treatment modality for adults adjusting
Home environment	
Promote:	
2.3.18	interventions that improve home environments to enhance functional
Children and young people with special care health needs	
Ensure:	
2.3.19	that a system of services for children and youth with special health car
	• coordination of child and family services;
	• effective communication among providers and the family;
	• family partnership in care provision;
	• flexibility.
Promote:	
2.3.20	changes at the macro level of society to implement a community-based
2.3.21	changes at the micro level of society to implement a community-based

	Grade
sical functioning.	B
reduce physical disability in older adults.	B
ning and slowly progress the intensity to moderate or high to accommodate the	B
ree times a week and lasts for at least 6 weeks after the target intensity is	B
sive resistance strength training:	B
possible adverse events cautiously and adjust the programme accordingly.	B
g to a physical disability.	B
ability outcomes.	B
e needs has the following critical characteristics:	B
d system of services for children and youth with special health care needs.	B
system of services for children and youth with special health care needs.	B

Intervention	
2.3.22	early intervention for children from birth to nine years who have a phys
Musculoskeletal pain disorders	
Promote:	
2.3.23	educational strategy addressing neurophysiology and neurobiology of pain, disability, catastrophization, and physical performance.
Deafness	
Promote:	
2.3.24	unilateral cochlear implantation as safe and effective for adults and ch

2.4 Recommendations for interventions to support self-management for peop

This evidence review recommends

Intervention	
Employees on long-term sickness absence	
2.4.1	Ensure employers identify someone who is suitably trained and impartia reason for the sickness and their prognosis for returning to work and if t need for workplace adjustments) decide on the options for returning to
2.4.2	If following initial enquiries action is required, then identify:
	• whether or not a detailed assessment is needed to determine wha
	• whether or not a case worker/s is needed to coordinate a detailed plan;
	• If it is necessary for a case worker to be appointed;
	• where necessary for employers to arrange for a referral to relevant
2.4.3	Coordinate and support the delivery of any planned health, occupationa developed following initial enquiries or the detailed assessment. Peopl from more 'intensive' interventions and services; those with a good prog services.

	Grade
sical disability.	B
pain for chronic musculoskeletal pain disorders, to achieve a positive effect on	B
ildren.	B

ole with long term conditions

	Grade
al to undertake initial enquiries with the relevant employees to: determine the they have any perceived (or actual) barriers to returning to work (including the work and jointly agree what, if any, action is required to prepare for this.	A
	A
t interventions and services are required and to develop a return-to-work plan;	
assessment, deliver any proposed interventions or produce a return-to-work	
specialists or services.	A
l or rehabilitation interventions or services and any return-to-work plan e who have a poor prognosis for returning to work are likely to benefit most gnosis are likely to benefit from 'light' or less intense interventions and	A

Intervention	
2.4.4	Ensure employers appoint a case worker/s to coordinate referral for, and the return-to-work plan.
2.4.5	Ensure employees are consulted and jointly agree all planned health, oc plan
2.4.6	Encourage employees to contact their GP or occupational health service
2.4.7	Ensure psychological interventions and services are evidence-based. Als
Promote:	
2.4.8	evidence-based psychological interventions to help people to develop p have to returning to work and to support them to return. Examples whic
	• women with musculoskeletal pain: CBT in small groups (involving
	• men and women with stress-related conditions: CBT and contact w
	• men and women experiencing low back pain: CBT in small groups (graded activity and liaison with the workplace to discuss a return-t
	• men and women with psychological or musculoskeletal problem: s
	• focused group sessions - men and women with whiplash injuries: p multimodal programmes.
2.4.9	multi-disciplinary back management programme to help employees
Unemployed people claiming incapacity benefit	
Promote:	
2.4.10	the commissioning of an integrated programme to help claimants enter
Patient centred care	
Promote :	
2.4.13	the key principles of patient-centred care:
	• Explore patient "cognitions" (what they think, believe and expect a
	• Explore the social supports, social and family influences and phys
	• Apply the principles of behaviour change.

	Grade
d delivery of, any required interventions and services. This includes delivery of	A
ccupational or rehabilitation interventions or services and the return-to-work	A
for further advice and support as needed.	A
so ensure they are delivered by suitably trained and experienced practitioners.	A
roblem solving and coping strategies. The aim is to overcome any barriers they h have been proven to be effective for certain groups and conditions include:	A
5– 6 people), with one-to-one telephone follow-up;	
ith the employer;	
involving 5-6 people) combined with one-to-one sessions of behavioural o-work plan;	
olution	
rogressive goal attainment programmes combined with physiotherapy or	
s with this condition return to work.	A
or return to work (paid or unpaid).	A
	B
and their confidence about their disease management).	
ical environment in which people live.	

Intervention	
	• Work with teams of healthcare providers, community agencies and
2.4.11	shared management of an illness between patient and doctor - especial
2.4.12	patient education programs integrated into patient-centred care over pr
Information technology for chronic illness care	
Promote:	
2.4.14	the following chronic illness care information technology components: C management (including reports and feedback), specialised decision sup included costs, data privacy and security concerns, and failure to consid
2.4.15	informatics strategies to improve care for chronic illness. Software to im within the context of organisational efforts to improve care.
2.4.16	Ensure that informatics to improve care for chronic illness is: patient-cen management. Ensure that outcomes are: routinely assessed, provided t management.
2.4.17	Promote implementation of interactive, sequential, disorder-specific tre treatment history, and decision support.
2.4.18	Promote interventions that contain at least 1 chronic care model (CCM) e extent, quality of life for patients with chronic illnesses.
Psychosocial interventions involving family members	
2.4.19	Promote psychosocial interventions involving family members in the tre patient and his/her family. Family involvement resulted in significantly b were not large, but they were broad, significant and stable over a long p
2.4.20	Ensure that future interventions that aim to improve chronic illness outc family support for the patient's autonomous motivation.
2.4.21	Promote family emphasis on self-reliance and personal achievement, fa outcomes.
Exercise interventions	
Promote:	
	exercise interventions to reduce depressive symptoms among patients w moderate depression and for whom exercise training improves function

	Grade
d support groups.	
lly for chronic problems such as diabetes, asthma and arthritis.	B
ograms delivered independently of primary-care professionals.	B
Connection to an electronic medical record, computerised prompts, population pport, electronic scheduling, and personal health records. Barriers identified der workflow.	B
plement these strategies should be developed, and rigorously evaluated	B
ntred, focused on improving outcomes, and provide support for illness self- o clinicians during the clinical encounter, and used for population-based care	B
eatment pathways to quickly provide clinicians with patient clinical status,	B
element to improve clinical outcomes and processes of care, and to a lesser	B
atment of chronic physical diseases to improve health outcomes for both the better health than standard treatment for all outcomes. Overall, the effects eriod of time.	B
comes emphasize increased family use of attentive coping techniques and	B
mily cohesion, and attentive responses to symptoms to achieve better patient	B
with a chronic illness. Patients with depressive symptoms indicative of mild-to- -related outcomes achieve the largest antidepressant effects.	B

Intervention	
Pharmacist-provided direct patient	
Promote:	
2.4.22	pharmacist-provided direct patient care to achieve favourable effects ac
2.4.23	the incorporation of pharmacists as health care team members.
Nurse-led interventions	
Promote:	
2.4.24	education programmes delivered by specialist nurses to improve the as
2.4.25	educational interventions and the use of protocols by specialist nurses control.
2.4.26	acute pain teams, led by nurses, to reduce pain intensity.
Integrated care	
Promote:	
2.4.27	integrated care
Outreach	
Promote:	
2.4.28	specialist multifaceted outreach intervention involving collaboration wit
Critical illness and intensive care	
Promote:	
2.4.30	multidisciplinary physical rehabilitation, initiated early and continuing
2.4.31	the following to reduce the long term complications of critical care: prev stress disorder, delirium prevention and hypoglycaemia prevention for handbook for self-guided rehabilitation for quality of life.
Dementia	
Ensure:	
2.4.32	health and social care staff aim to promote and maintain the independe address activities of daily living.

	Grade
cross various patient outcomes, health care settings, and disease states.	B
	B
sessment and documentation of acute and chronic pain.	B
to improve patients' understanding of their condition and improve pain	B
	B
	B
th primary care, education or other services.	B
throughout the intensive care unit care stay.	B
enting hypoglycaemia for depression; limit use of sedation for post-traumatic cognitive complications (including memory, attention and executive function);	B
ence, including mobility, of people with dementia. Promote care plans that	A

Intervention	
2.4.33	people with mild-to-moderate dementia of all types are given the oppor
2.4.34	consideration is given to providing access to interventions tailored to th
2.4.35	that if language or acquired language impairment is a barrier to accessi professionals provides the person with dementia and/or their carer with
2.4.36	health and social care managers coordinate and integrate working acros and their carers, including jointly agreeing written policies and procedu highlight and address problems specific to each locality.
Depression	
Ensure:	
2.4.37	that for all known and suspected presentations of depression: assessm assessment and interventions.
Promote:	
2.4.38	low-intensity psychosocial interventions, psychological interventions, m sub threshold depressive symptoms or mild to moderate depression.
2.4.39	for moderate and severe depression: medication, high-intensity psycho further assessment and interventions for persistent sub threshold depr initial interventions:
2.4.40	medication, high-intensity psychological interventions, electroconvulsiv inpatient care for severe and complex depression or people with risk to
Epilepsy	
2.4.41	Promote psychological interventions (relaxation, cognitive behaviour th
Rheumatoid arthritis	
Ensure:	
2.4.42	ongoing access to a multidisciplinary team.
2.4.43	people with RA have access to specialist physiotherapy.
2.4.44	people with RA have access to specialist occupational therapy, with peri problems with hand function.

	Grade
tunity to participate in a structured group cognitive stimulation programme.	A
e person's preferences, skills and abilities.	A
ng or understanding services, treatment and care, health and social care n information in the preferred language and/or in an accessible format.	A
ss all agencies involved in the treatment and care of people with dementia res. Joint planning should include local service users and carers in order to	A
ent, support, psycho-education, active monitoring and referral for further	A
nedication and referral for further assessment and interventions for persistent	A
logical interventions, combined treatments, collaborative care and referral for essive symptoms or mild to moderate depression with inadequate response to	A
ve therapy, crisis service, combined treatments, multi-professional and life or severe self-neglect.	A
erapy, biofeedback).	A
	A
	A
iodic review if they have difficulties with any of their everyday activities, or	A

Intervention	
2.4.45	Promote psychological interventions (for example, relaxation, stress ma with their condition.
2.4.46	Ensure all people with RA and foot problems have access to a podiatrist functional insoles and therapeutic footwear is available for all people w
2.4.47	Ensure people with satisfactorily controlled established RA are offered r addition, make sure they:
	• have access to additional visits for disease flares;
	• know when and how to get rapid access to specialist care; and
	• have ongoing drug monitoring.
Occupational therapy to support self-management	
Promote:	
2.4.48	comprehensive occupational therapy for elderly people and people with improve quality of life and improve social participation.
People with multi-morbidity	
Promote:	
2.4.49	access to case management services to achieve positive impact on the p

2.5 Recommendations for interventions to support self-management for peop

This evidence review recommends:

Intervention	
Self management	
Promote:	
2.5.1	self-management support for chronic conditions that is integrated in
2.5.2	the following evidence-based principles to improve patient self-mana
	• brief targeted assessment;
	• evidence-based information to guide shared decision-making;

	Grade
nagement and cognitive coping skills) to help people with RA adjust to living	A
for assessment and periodic review of their foot health needs. Ensure that ith RA if indicated.	A
eview appointments at a frequency and location suitable to their needs. In	A
stroke or rheumatoid arthritis to promote increasing functional abilities,	B
patient, the carer and the healthcare staff, particularly the GP.	B

le with long term conditions

	Grade
to routine health care.	B
agement and/or health outcomes:	B

Intervention	
	• use of a non-judgmental approach;
	• collaborative priority and goal setting;
	• collaborative problem solving;
	• self-management support by diverse providers;
	• self-management interventions delivered by diverse formats;
	• patient self-efficacy;
	• active follow up;
	• guideline-based case management for selected patients;
	• linkages to evidence-based community programs;
	• Multifaceted interventions.
Ensure:	
2.5.3	core skills of self-management such as self-efficacy building, goal-set emphasized throughout the programs.
2.5.4	measures of managing pain and disability such as relaxation, exercis well organised and effectively delivered.
2.5.5	methods such as mailing, telephone and internet are considered to d
2.5.6	the enhancement of standard care with: reminders, disease monitori message services to help improve health outcomes and care processe
2.5.7	interactive Health Communication Applications (IHCAs) for people wit support and possibly improve behavioural and clinical outcomes com
Healthcare provider	
2.5.8	Ensure healthcare providers facilitate self-management by coordinati management processes vary in importance to patients over time, and appropriate self-management plans.
Lay led self-management	
2.5.9	Promote education programmes for people with chronic conditions to health, cognitive symptom management, and frequency of aerobic ex

	Grade
ting, action-planning, problem-solving and self-tailoring are taught and	B
e, rational use of medication, and physician– patient communication are	B
eliver self-management interventions.	B
ng and management, and education through cell phone voice and short es for both patients and providers.	B
h chronic disease, to improve user knowledge, improve users feeling of pared to non-users.	B
ng self-management activities, by recognising that different self- by having ongoing communication with patients and providers to create	B
achieve short-term improvements in participants' self-efficacy, self-rated ercise.	A

Intervention	
Self-management of pain	
2.5.10	Promote the following self-management programs for older adults wit massage therapy, Tai Chi, and music therapy.
Exercise interventions	
2.5.11	Promote exercise in the management of both chronic low back pain a
2.5.12	Ensure that exercise, supported by advice and education, is at the co osteoarthritis.
Arthritis	
Promote:	
2.5.13	both patient education and exercise for patients with knee osteoarth being.
2.5.14	exercise regimes to achieve improvements in physical health (by self-
2.5.15	self-management as a safe, community-based and effective way for p self-management are delivered using multiple approaches.
2.5.16	self-management programs for adult patients with arthritis to achieve level.
2.5.17	self-management programs for osteoarthritis to achieve small improv
Diabetes	
Promote:	
2.5.18	diabetes self-management training programs to improve patients' qu
2.5.19	individual patient education for people with type 2 diabetes mellitus
2.5.20	chronic disease self-management programmes for elderly people with
COPD	
2.5.21	Promote regular practise at pursed lip breathing as an effective self- disease (COPD) to improve their dyspnoea.
Musculoskeletal pain	
2.5.22	Promote educational programs for patients with back pain in an occu

	Grade
th chronic pain: Arthritis Foundation Self-Help Program (AFSHP), yoga,	B
nd osteoarthritis.	B
re of self-management strategies for chronic low back pain and	B
ritis to achieve a modest, yet clinically important, influence on patients' well-	B
report and direct measures) and in overall impact of osteoarthritis (OA).	B
atients with arthritis to manage pain and disability. Ensure that core skills of	B
e small to moderate effects in improving pain and disability at the long-term	B
vements in pain and function.	B
ality of life.	B
to improve glycaemic control.	B
n diabetes mellitus or hypertension to achieve clinically important benefits.	B
management strategy for individuals with chronic obstructive pulmonary	B
pational setting in combination with an exercise program.	B

Intervention	
Kidney disease	
Promote:	
2.5.23	multi-component structured educational interventions to improve pre
2.5.24	effective frameworks to develop, implement, and evaluate educationa disease.
Mental health disorders	
2.5.25	Promote the Monthly Medication Journal as a tool to promote day-to-d clinical services for individuals with mental disorders.
Anticoagulation therapy	
2.5.26	Promote self-monitoring to improve the quality of oral anticoagulation
Epilepsy	
2.5.27	Promote self-management for adults with epilepsy.
Calendar blister packaging	
2.5.28	Promote calendar blister packaging, in combination with education a

2.6 Recommendations for interventions to promote better physical health ou

This evidence review recommends:

Intervention	
Commissioners	
2.6.1	Ensure a range of information, support (including practical help and r spectrum of need. They will need to work with statutory and voluntary
Provider	
2.6.2	Nominate a lead to oversee the development and implementation of s
2.6.3	Assess and address the needs of family members and carers on an on carers have regular opportunities to discuss particular concerns.

	Grade
e-dialysis and dialysis care.	B
al interventions that target patients with early stages of chronic kidney	B
day functioning, perceptions of quality of life, severity of illness, and use of	B
n therapy.	A
	B
nd reminder strategies, to improve medication adherence.	B

tcomes and quality of life for carers (all ages)

	Grade
respite arrangements) and bereavement services are in place to meet the health and social care agencies to achieve this.	A
services that specifically focus on the needs of families and carers.	A
ngoing basis. Teams should establish a system to ensure family members and	A

Intervention	
2.6.4	Where carers are providing a substantial amount of care on a regular
	respond positively when a carer asks for one, in accordance with The
2.6.5	Ensure all family members and carers are offered information on a va
	accounts of cancer, its treatment and consequences and services avai
2.6.6	Ensure teams provide families and carers with a clear indication of th
2.6.7	Promote support groups for family members and carers, either profes
2.6.8	Ensure awareness of the needs of family members from different ethn
	culture, is necessary within a multi-cultural society.
2.6.9	Ensure teams have access to reference guides on the cultural differen
	on accessing interpreters, relevant health advocates (where available
Carer stress/anxiety/depression	
Promote:	
2.6.10	the development of standardised guidelines that address caregiver a
2.6.11	the identification of "caregiver champions" in practice settings.
2.6.12	provision of referrals to established support organisations for caregiv
2.6.14	collaboration among care-giving, professional, and cancer-related org
2.6.15	Ensure families coping with bipolar disorder benefit from family interv
	moods, even when the patient is not available for treatment.
2.6.16	Be aware that psychological morbidity, such as symptoms of depressi
	of decreased physical health.
Carers support and counselling	
Ensure:	
2.6.17	family members and carers are made aware of, and have easy access
	own needs.
2.6.18	family members and carers who are bereaved are, in the first instance
	or it is predicted that those involved are likely to experience difficult g
Promote:	

	Grade
basis, providers should ensure they are offered a separate assessment, or Carers (Recognition and Services) Act 1954.	A
riety of topics, from a simple 'who's who' of professionals to more detailed ilable locally.	A
e personnel they might contact in relation to a range of needs.	A
sionally or peer-led.	A
ic populations, including differences in language, religious practice and	A
ces surrounding a diagnosis of cancer, death and dying, and that information) and faith leaders is readily accessible.	A
ssessment, education, and resources.	B
	B
ers.	B
ganisations to advocate policy and practice changes for family caregivers.	B
ventions to support caregivers' ability to manage stress and regulate their	C
ion or anxiety, as well as caregiver strain or burden, is associated with reports	B
to, sources of local information, advice and support designed to meet their	A
e, encouraged to use existing support systems. Where these prove insufficient, grief reactions, there should be access to additional help and support.	A

Intervention	
2.6.19	provision of referrals to established support organisations for caregiv
2.6.20	counselling and support preserved self-rated health (SRH) in vulnerab
2.6.21	enhanced counselling in vulnerable caregivers. Enhanced counselling support group participation, and continuous availability of ad-hoc tel
2.6.22	enhanced caregivers' social support in vulnerable caregivers, fosterin order to yield indirect health benefits.
Carers information and advice	
2.6.23	Ensure family members and carers are made aware of, and have easy their own needs.
Respite for carers	
Promote:	
2.6.24	respite care for frail elderly people to improve carers mental or physic
Family	
2.6.25	Ensure that families coping with bipolar disorder are offered family in is not available for treatment.
2.6.26	Consider Family-Focused Treatment-Health Promoting Intervention (FF among caregivers of patients with bipolar disorder.
Joint working	
2.6.27	Providers of specialist bereavement support should work closely with members can access services when needed.
2.6.28	Promote collaboration among care-giving, professional, and cancer-re caregivers.
Training for carers-self care/problem-solving	
Promote:	
2.6.29	structured, multi-component skills training interventions in racially a caregiver's self-care behaviours.

	Grade
ers.	B
ble caregivers.	B
g and support consists of six sessions of individual and family counselling, ephone counselling.	B
g more benign appraisals of stressors, and reducing depressive symptoms in	B
access to, sources of local information, advice and support designed to meet	A
al health.	B
terventions to manage stress and regulate their moods, even when the patient	C
T-HPI) to reduce caregiver depressive symptoms and health risk behaviour	C
other care providers (both statutory and voluntary) to ensure carers and family	A
elated organisations to advocate policy and practice changes for family	B
nd ethnically diverse caregivers of people with dementia that is targeted at	B

Intervention	
2.6.30	the Resources for Enhancing Alzheimer's Caregiver Health (REACH) int health, in caregivers.
2.6.31	problem-solving training provided in the home to alleviate distress ar persons with traumatic brain injuries (TBI).
Carer gender/ age/ethnicity	
Be aware there is evidence that:	
2.6.32	female and male caregivers do not differ in the use of informal and fo
2.6.33	higher age, lower socioeconomic status, and lower levels of informal s
2.6.34	all groups of ethnic minority caregivers report worse physical health t
2.6.35	ethnic minority caregivers provided more care than white caregivers a

2.7 Recommendations for integrated services as an intervention to avoid inap

This evidence review recommends:

Intervention	
Policy makers should	
2.7.1	consider the impact of socio-economic deprivation and other socio-d
2.7.3	encourage commissioners to implement evidence-based interventior context.
2.7.4	the impact of socio-economic deprivation and other socio-demograp
2.7.5	aim to increase self-management among people with long- term con
2.7.6	consider the impact of socio-economic deprivation and other socio-d
2.7.2	Commissioners and providers should aim to increase self-manageme benefit.
Commissioners should consider:	
2.7.8	the impact of local out-of-hours primary care arrangements on avoida
2.7.9	implementing multidisciplinary interventions and telemonitoring for

	Grade
ervention, to improve self-rated health, sleep quality, physical and emotional	B
nd decrease dysfunctional problem-solving styles among family caregivers of	C
rmal support.	C
support are related to poorer caregiver health.	B
han white groups. (US study).	B
nd had stronger filial obligations beliefs than white caregivers. (US study).	B

opropriate attendance at A&E/admissions/bed days

	Grade
emographic factors when designing policy around admission rates.	B
ns for avoidable admissions, and to evaluate their impact in the local	B
hic factors when designing policy around admission rates.	B
ditions where there is evidence of benefit.	B
emographic factors when designing policy around admission rates.	B
ent among people with long-term conditions where there is evidence of	B
able admissions alongside primary care providers.	B
patients with heart failure.	B

Intervention	
2.7.10	implementing hospital at home.
2.7.11	implementing assertive case management for people with mental he
2.7.12	closer integration of primary and social care, and should evaluate th
2.7.13	closer integration of primary and secondary care and should evaluat
Commissioners need to:	
2.7.7	be clear about which admissions they consider to be avoidable, wha should be coded and measured.
2.7.14	be clear about which admissions they consider to be avoidable, wha should be coded and measured.
2.7.15	implement evidence-based interventions as follows:
	• multidisciplinary interventions and tele-monitoring for patients
	• assertive case management for patients with mental health pro
	• hospital at home;
	• closer integration of primary and secondary care;
	• conduct early senior review in A&E;
	• implement structured discharge planning (providers only);
	• continue to implement acute assessment units, but consider th
	• aim to increase self-management among people with long-term
2.7.16	disinvest in programmes where there is robust evidence that they ha
2.7.17	evaluate all new interventions, as even those that have proved benef
Service providers should consider:	
2.7.18	early senior review in A&E.
2.7.19	structured discharge planning.
2.7.20	Providers and commissioners should continue to implement acute admissions.

	Grade
	B
ealth illnesses.	B
e outcomes of any new interventions.	B
e the outcomes of any new intervention	B
t proportion of these admissions are avoidable, and how these admissions	B
t proportion of these admissions are avoidable, and how these admissions	B
	B
s with heart failure;	
oblems;.	
e overall impact on number of admissions;	
n conditions where there is evidence of benefit;	
ve little or no effect.	B
ficial in other settings may not be transferable to the local population.	B
	B
	B
assessment units, but should consider the overall impact on number of	B

Intervention	
Primary care should:	
2.7.21	increase continuity of care with a GP.
2.7.22	provide GP continuity of care.
2.7.23	provide diabetes clinics.
2.7.24	review the quality of local, out-of-hours primary care arrangements
2.7.25	consider closer integration of primary and social care.
2.7.26	consider closer integration of primary and secondary care.
Effective interventions to reduce admissions and re-admissions	
Promote:	
2.7.27	
	• continuity of care with a GP;
	• hospital at home as an alternative to admission;
	• assertive case management in mental health;
	• self-management;
	• early senior review in A&E;
	• multidisciplinary interventions and tele-monitoring in heart fa
	• integration of primary and secondary care;
	• structured discharge planning;
	• personalised health care programmes.
Personalised health care programmes	
Promote:	
2.7.29	integrated teams that work in the patient's home and incorporate e management and health promotion.
2.7.30	interventions that include home care components. These include pa adjustment of medication and regular communication with clinical

	Grade
	B
	B
	B
on avoidable admissions.	B
	B
	B
	B
ilure;	
elements of comprehensive geriatric assessment, care planning, disease	B
atient education on specific issues, close follow-up, home monitoring, experts.	B

Intervention	
2.7.31	interventions that incorporate geriatric management supported wit patients.
Telecare	
Promote:	
2.7.32	interventions that include automated vital signs monitoring and tel
2.7.33	Telemedicine to support patients with heart failure.
2.7.34	Telemedicine interventions for heart disease, diabetes, hypertensio
2.7.35	interventions to improve care for frail elderly people and people wit
Factors that impact on inappropriate attendance at A&E/ admissions/ bed days	
2.7.36	When planning services to reduce inappropriate admissions be awa
	• those who live in urban areas have higher rates of emergency
	• higher levels of morbidity in a population are associated with
	• admission rates are also correlated with chronic illness;
	• age is a risk factor for emergency hospital admission, with ba
	• people from lower socio-economic groups are at higher risk of
Integrated health and social care services	
Promote:	
2.7.37	integration of primary and social care.
2.7.38	integrated health and social care teams, working with people in the
Integrated case management	
Promote:	
2.7.39	assertive case management for patients with mental health proble
2.7.41	intensive case management for people with severe mental illness w
2.7.42	patient advocacy case management in frail elderly patients.

	Grade
h home care post discharge to prevent hospital readmissions in elderly	B
ephone follow-up by nurses.	B
	B
on and older people.	B
th chronic conditions.	B
are that:	B
hospital admission than those in rural areas;	
higher levels of emergency admission;	
bies or very young children and older people being at higher risk;	
avoidable emergency admissions.	
	B
eir own homes.	B
ms.	B
when hospital use is high.	B
	B

Intervention	
Hospital at home services	
Promote:	
	hospital at home services where appropriate.
Accident and emergency	
2.7.43	Promote early review by a senior clinician in the emergency departm
2.7.44	Consider promoting GPs working in the emergency department to re cost-effectiveness.
Integrated primary and secondary care services	
Promote:	
2.7.45	the integration of primary and secondary care.
Integrated dementia services	
2.7.46	Consider alternatives to an acute hospital admission for those peop
Improved out-of- hours services	
Promote:	
2.7.47	quality out-of hours services.
Integrated disease management and care pathways	
Promote:	
2.7.48	integrated use of disease management interventions for asthma an
2.7.49	integrated care pathways for disease management.
Specialist heart-failure services	
Promote:	
2.7.50	specialist clinics for heart failure patients, which include clinic appo
2.7.51	case management type interventions led by a heart failure specialis months follow up, all cause readmissions and all-cause mortality.
2.7.52	multidisciplinary interventions to reduce congestive cardiac failure

	Grade
	B
ment.	B
educe inappropriate admissions, consideration should be made regarding	B
	B
ple with dementia, e.g. respite care or home care.	B
	B
nd COPD.	B
	B
ointments and monitoring over a 12 month period.	A
st nurse to reduce congestive cardiac failure related readmissions after 12	A
and all cause readmissions.	B

Intervention	
Integrated community services	
Promote:	
2.7.53	the visiting of acutely at risk populations e.g. failure to thrive infant
Exercise and rehabilitation services	
Promote:	
2.7.54	pulmonary rehabilitation as a highly effective and safe intervention
2.7.55	exercise based cardiac rehabilitation for coronary heart disease.
Specialist outreach integrated services	
Promote:	
2.7.56	especially when delivered as part of a multifaceted intervention to i
2.7.57	to facilitate engagement between specialists and primary care prac multifaceted intervention which involves case-conferences, joint co other care enhancements.
2.7.58	as part of more complex multifaceted interventions involving collab
Supported discharge services for the management of acute stroke	
Promote:	
2.7.59	early supported discharge services to allow patients to return home familiar environment of their own home. Early supported discharge
2.7.60	early supported discharge services because patients are more likely who received conventional services.
Comprehensive geriatric assessment	
Promote:	
2.7.61	evidence that comprehensive geriatric assessment increases patien admission to hospital.
2.7.62	as routine part of inpatient care in older patients.

	Grade
ts, heart failure patients.	B
in patients who have recently suffered an exacerbation of COPD.	B
	B
mprove access, outcomes and service use.	B
titioners. Interaction is greatest when outreach is part of a complex nsultations, seminars and education sessions, other health professionals or	B
oration with primary care, education or other services.	B
e from hospital earlier than usual and receive more rehabilitation in the services are provided by teams of therapists, nurses and doctors.	A
y to be independent and living at home six months after stroke than those	A
nts' likelihood of being alive and in their own homes after an emergency	A
	A

Intervention	
2.7.63	to support all frail elderly patients admitted to hospital as an emerg providers, and the provision of geriatric services needs reviewed.

This evidence review does not recommend:

2.7.64	the following:
	• pharmacist home-based medication review;
	• intermediate care;
	• community-based case management (generic conditions);
	• early discharge to hospital at home on readmissions;
	• nurse-led interventions pre- and post-discharge for patient
2.7.65	therapy based rehabilitation targeted towards stroke patients livi

	Grade
gency. Compliance with best practice should be audited across healthcare	A
	B
s with chronic obstructive pulmonary disease.	
ng at home.	B

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