

League of Friends of the Chalfonts and Gerrard Cross Hospital

Action to Improve the Quality of Health and Wellbeing while Reducing Demand Pressures

Summary

This note reviews evidence of the impact of steps suggested by League of Friends “Thoughts on Our Development as a Community Hub” to improve the quality of health and wellbeing while reducing demand pressures. There are no instant solutions, nor can any action guarantee the success achieved elsewhere, outcomes depend not just on what is done but how it is done and the character and response of the local community. Above all success will depend upon the commitment of our staff, GPs and Community Organisations working jointly with our health and social care providers and funders.

These suggestions are not intended as criticism of current services provided by our excellent staff primary care practices, hospitals or social care providers, nor have we identified all the actions that might be helpful or all the evidence available. We simply want to start a discussion on the steps we can take together. We welcome further suggestions for ways in which volunteers and community action can improve health and reduce demand pressures. We realise that developing community engagement will require coordination with many different organisations and groups and require time and persistence.

The need for action is emphasized by reports that over the past ten years patient GP appointments have more than doubled at national level, while A&E attendance has increased by some 50%. We are aware that concerns have been raised at local use of A&E and other services, though we have not seen any detailed evidence of the extent or nature of this. Evidence from other sites suggests that the steps proposed by our League of Friends have the potential to improve outcomes and reduce demand for Primary Care, A&E attendance and in some cases Social Care use at low cost to public services.

The broad case for steps to improve outcomes while reducing workload, from a GP point of view, is set out in the publication by the British Medical Association (2015) “Quality first: Managing workload to deliver safe patient care”. This stresses the importance of patient partnership and self-empowerment as a key strategy for all General Practices. It also lists a range of measures that can help to manage workloads, quoting sources of evidence that support the case for action.

From a broader perspective, NHS England (2013) “The NHS Belongs to the People: Call to Action” points out that our health and social care services can only be sustained by giving people more control over their health and wellbeing, while focusing primary and secondary care on those at greatest risk through personalized health and wellbeing plans. The paper points to a study that showed that in a North London area, 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.

While the following pages indicate evidence of the cost effectiveness of each proposed step towards community engagement for health, we suggest there is also likely to be a cumulative effect of greater awareness and focus on community and individual self-care.

The Impact of Social Prescribing

Social prescribing could support all forms of community engagement, helping people to use service and join in activities and support groups. This would mean that those most likely to place the heaviest demands on health and social care could be helped to develop their own personal plans for self-care and community engagement, to address their needs. The evidence of the impact of social prescribing has recently been reviewed by a team from the University of Westminster, **see annex A**. Their results show an average fall in GP attendances, by patients using social prescribing, of 28% and found that most studies show significant falls in A&E attendance and referrals to secondary care.

The Impact of Early Intervention for People with Potential Mental Health Problems

Interventions to support people with mental illness, once such conditions are diagnosed, though necessary, tend to be extremely demanding of NHS and family resources. Early intervention to support people showing signs of depression, anxiety and other mental health issues can produce both better health outcomes and reduce demand for A&E and secondary care service. The evidence for early action has been reviewed in a study published by the Department of Health, **see annex B**. The study found that early intervention in was helpful for many conditions and saved costs for the NHS and other public services, including for psychosis, alcohol dependence and prevention of conduct disorders. The role of school nurses in such cases could be particularly vital.

The Impact of a Dementia Friends Initiative

There are many reports of Dementia Friends Initiatives, some seem to suggest that, while popular, initiatives which are not followed through by concerted action may have a limited impact. A typical study is one published by Hampshire County Council, **see annex C**. This suggests that awareness raising and engagement is a long haul that may result in both better patient experience and lower use of NHS and Care services in the long term but has limited short term economic impact.

The Impact of Support for Parents of Children with Special Education and Development Needs

An analysis of the changes in policy for the support of parents of children with special educational and developments needs was undertaken to refine the policy changes recently introduced by the Department for Education, **see annex D**. This was undertaken with “a pathfinder parent group” i.e. before policy was fully implemented, so it may be too soon to draw conclusions. However, it does reinforce the need to empower parents through a social support network.

The Impact of Actions to Support Access to Arts, Sport and Other Activities for People with Disabilities

The general case for action to engage people in the arts, sport and culture is set out in a recent review of evidence, **see annex E**. The advantages demonstrated for engagement in sport and culture include: physical and mental health benefits, better social engagement, a reduction in anti-social activity and improved social capital.

There are also numerous reports that touch upon the need to improve engagement for people with disabilities, however most UK studies conclude that not enough is done and there is insufficient research in this area. Examples from other countries, including Australia and Canada are much more positive.

The Impact of Breathe Easy Groups for People with COPD

A study from the University of Kent shows the benefits of Integrated Breathe Easy Groups, **see annex F**. The groups provided mutual support for people with Chronic Obstructive Pulmonary Disease with expert advice from clinical staff at the meetings. They concluded that IBE is a cost effective programme which has positive outcomes in terms of self-efficacy, health outcomes and wellbeing for attendees, providing cost savings and wider social benefits to local communities. It has shown cost savings to the NHS in both primary and secondary care. There was a 42% reduction in unplanned GP visits and a 57% reduction in unplanned hospital admissions in IBE groups compared to the standard BE groups. With relatively modest set up, low running and sustainability costs IBE offers significant return on investment.

The Impact of Joint Pain Self-Help Support Groups

Research evidence from the USA and Canada points to the effectiveness of self-help support groups and their impact on reducing primary care and secondary care use. A review of studies study in Europe **see annex G** found only a small but consistent impact on perceptions of pain attributable to guided self-help, which might result in reduced demand for other services.

The Impact of Integrated Support for New Mothers

A recent review and analysis for Public Health England **see annex H** showed that redesign of midwifery care and steps to promote peer group support for mothers and group exercise reduce total costs and improve health outcomes by reducing post-natal depression and that other steps to promote breastfeeding and support mothers can also be cost effective.

The Impact of Steps to Extend Support for Self-Care for People with Diabetes

Care Quality Commission encourages health and social care commissioners, providers and professionals to work together to deliver an approach to diabetes care that puts people at the centre of their own care and enables them to improve their health and wellbeing and manage their diabetes effectively **see annex I**. A further report by organisations representing Diabetes patients and clinicians specializing in this areas stresses the importance of patient centred care and support in reducing hospital admissions.

The Impact of Integrated Care for Carers and Respite Services

The evidence presented in a recent literature review **see annex J** suggests that services aimed at the older person, such as the home help/care service, and services aimed at the carer, such as daycare/ institutional respite care, can be effective in improving the welfare of carers and reducing the negative psychological effects of caring. The literature also suggests that both types of service can also be effective in delaying the admission of the older person to institutional care. It is, therefore, clear that both forms of service should be available to older people with carers.

The Impact of Hospice at Home Services

The Government strategy for the improvement of the quality of end of life care **see annex k** notes that integrated hospice at home services can both improve the quality of care experienced and reduce costs.

Annex A Evidence of the Impact of Social Prescribing

Of the 94 project reports identified from the systematic search by Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., Refsum, C. (2017) "A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications" University of Westminster, 14 papers met the criteria set out in the method. Of these, only one was a randomised controlled trial (Grant et al, 2000) and two included a matched controlled group (Bertotti et al, 2015; Maughan et al, 2015).

Seven papers looked at the effect on demand for General Practice, reporting an average 28% reduction in demand for GP services following referral. Results ranged from 2% (Kimberlee et al, 2014) to 70% (Longwill, 2014).

Five studies (Kimberlee, 2016; Dayson and Bashir, 2014; Bertotti et al, 2015; Farenden et al, 2015; Kimberlee et al, 2014) looked at the effect on Accident and Emergency (A&E) attendances reporting an average 24% fall in attendance following referral. Results ranged from 8% (Kimberlee et al, 2014) to 26.8% (Farenden et al, 2015).

Five studies looked at the effect on demand for other secondary care services (Palmer et al, 2017; Kimberlee, 2016; Dayson and Bashir, 2014; Farenden et al, 2015; Brandling et al, 2011). Three reported a fall in emergency hospital admissions in the months following referral (6% (Kimberlee, 2016), 7% (Dayson and Bashir, 2014) and 33.6% (Farenden et al, 2015)) and two studies measured secondary care referrals after social prescribing. One reported statistically significant drops in secondary care referrals at 12 months (55%) and 18 months (64%) (Brandling et al., 2011) and the other projected reductions in demand of 0.1 consultant psychiatrists per annum per patient and 0.2 Community Mental Health Team nurse consultations per annum per patient (Longwill, 2014). However, in contrast, one study showed that the likelihood of referral to secondary mental health care more than doubled after referral. (Grayer et al, 2008)

Eight studies calculated value for money assessments such as cost benefit analysis (Burgess, 2014; Windle et al., 2016). None of the studies used the traditional cost-effectiveness or full cost-utility analysis. Estimates varied widely from an annual Return on Investment (ROI) of 0.11 (in the first year of operations) (Dayson and Bashir, 2014) to 0.43 (Kimberlee, 2016). The randomised controlled trial reported higher cost of care per patient in the intervention group than the control, though no value for money assessments were calculated (Grant et al, 2000).

Four studies carried out broader Social Return on Investment (SROI) calculations. SROI puts an estimated monetary value on the sum of benefits accruing to all stakeholders, not just the NHS. Studies varied in the combination of stakeholders and benefits selected for inclusion in SROI calculations. Patients, Local Authorities (LAs) and the Department of Work and Pensions (DWP) were commonly cited stakeholders. Improved mental wellbeing outcomes and higher rates of employment were examples of positive externalities considered in SROI but excluded from ROI analysis. The mean SROI (Weld et al, 2015) was £2.3 per £1 invested in the first year (Kimberlee, 2016).

Annex B Evidence of Impact of Early Intervention for People with Potential Mental Health Problems

Martin Knapp, David McDaid and Michael Parsonage (editors) (2011) "Mental health promotion and mental illness prevention: The economic case" Department of Health.

Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure ^a

	NHS	Other public sector	Non-public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms ^b	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	–	–	9.69	9.69
Addressing social determinants and consequences of mental disorder				
Debt advice services	0.34	0.58	2.63	3.55
Befriending for older adults	0.44	–	–	0.44

Notes:

- a Returns on investment calculated as gross economic pay-offs divided by expenditure on the intervention. Depending on the availability of data, these returns may be calculated over different time periods for different interventions; see Section 2 and Tables 14–16 for details. Returns and expenditures discounted back to present values, expressed in 2009/10 prices.
- b For e-learning of GPs, plus CBT for all people with somatoform conditions (including sub-threshold cases as well as those with full somatoform disorders).

Annex C Evidence of the Impact of a Dementia Friends Initiative

The Dementia Friendly Communities project reported by the Institute of Public Care Oxford Brookes University (2015) “Evaluation of Hampshire Dementia Friendly Communities” Hampshire County Council. provides a good model of a dementia awareness raising initiative. In the two years of its operation, more than 3,400 people have attended awareness sessions delivered by project staff, and many more have attended sessions provided by volunteers. Eleven Dementia Friendly High Streets have been launched and 10 Dementia Action Groups established with 440 organisations signed up to the Hampshire Dementia Action Alliance. Thirty Dementia Ambassadors have been recruited and the project has helped to support the establishment of 23 new peer support groups.

Given the time needed to establish a new project covering an area the size of Hampshire, the project has done well in the range and scale of its activities. Many sections of the community, particularly the service and retail sectors, have a better awareness of dementia and how to support people with dementia and their carers.

The project team responded energetically and flexibly to demand, seizing new opportunities where they emerged and working collaboratively with a range of other organisations and individuals. This enabled the project to maximise its effectiveness in reaching as many people and groups as possible.

The timing of the project contributed to its success, coinciding as it did with growing policy interest and national campaigns around dementia. The support of leaders in local politics and social care also contributed to the impact and success of the project.

There were areas where the project was less successful – specifically around developing peer support, engaging traditionally excluded groups, and empowering people with dementia and their carers. These are areas which other dementia friendly communities projects have also found challenging. As one interviewee commented, ‘they are not called hard to reach for nothing’. It is possible that with more time at the start to develop and plan, more could have been achieved in this area, however it is not certain that the results would have been significantly different.

There is no evidence that dementia friendly communities directly affect the need for more intensive support and care of people living with dementia. However, over the longer-term, by improving the quality of life of carers and people with dementia and reducing the stigma of dementia, it may be possible that it enables people with dementia to live longer and better in their communities.

The evidence for a business case is weak as there is no evidence of a direct link between dementia friendly communities activity and delayed moves into residential care. However, the project levered in large amounts of volunteer time which added value to the project, and individual cases illustrated the ways in which it contributed to the quality of life of people with dementia and their carers.

In the future, the sustainability of the project is not guaranteed until a more secure funding arrangement is established. Staff were optimistic that this would be possible. The other risk is the dependence on volunteer efforts and the risk of volunteer fatigue. The current levels of commitment and enthusiasm are very high and given this, there is also reason to be optimistic, but not complacent about the project’s long-term future.

Annex D Evaluation of Support for Parents of Children with Special Education and Development Needs

The conclusions of the report by: Graham Thom, Kathryn Lupton and Meera Craston, Susan Purdon, Caroline Bryson, Claire Lambert, Nicola James, Sarah Knibbs and Dominic Oliver, Lucy Smith and Tim Vanso (2015) "The Special Educational Needs and Disability Pathfinder Programme Evaluation Final Impact Research Report" Department for Education are as follows:

In many aspects of the assessment and support planning process, Pathfinder families reported significantly better experiences than comparison families. Positive impacts were found in parents' understanding of decisions, and how family-centred and joined up services had been. Improvements had also been made in how straightforward the process was, leading to Pathfinder parents being more satisfied overall. A number of areas for improvement were also identified. Despite feeling that the Pathfinder had improved information sharing between agencies at the assessment and planning stage, parents reported that they were still having to explain their child's needs on multiple occasions. Moreover, while understanding of decisions had improved, it was not the case for understanding of the processes per se, nor the extent to which families felt that the decisions were fair. Through the qualitative research (and the thematic research on key working), it was clear that the competency, consistency and knowledge of the key worker (or group of individuals) was critical to families' understanding of and satisfaction with the processes. Ensuring that those undertaking key working have sufficient time, knowledge of local provision, links with wider agencies, and the skills and experience to do their role effectively should be considered a priority across local areas.

Annex E Evaluation of Actions to Support Access to Arts, Sport and Culture

Peter Taylor, Larissa Davies, Peter Wells, Jan Gilbertson and William Tayleur (2015) "A review of the Social Impacts of Culture and Sport" The Culture and Sport Evidence, The Department for Culture, Media and Sport in collaboration with the Arts Council England, English Heritage, and Sport England.

Sport

Their review supports claims that access to sport provides health benefits, which prevent or reduce physical and mental health problems and save on health care costs. There are some negative health effects from sports injuries, typically for younger people, but in comparison the positive health benefits from sport are more substantial, population-wide and particularly important to older people.

There is also strong evidence that sports participation improves wellbeing and pro-social behaviour and reduces crime and anti-social behaviour, particularly for young men. In terms of the social capital impacts from sport, there is evidence that sport is a type of 'social glue', i.e. contributing 'bonding' capital by increasing social connectedness and a sense of belonging. Positive outcomes in studies include reduced social and ethnic tensions, and more collective action and community involvement through sport, particularly volunteering.

The Arts

The evidence points to positive associations between participation in arts and health, social capital, crime and education. The evidence of beneficial effects of the arts on health extends to clinical and non-clinical populations, and physical and mental health. A number of studies evidence the health benefits of music, both for the general population and for stroke victims. Studies in general testify that cultural participation can contribute to social relationships, community cohesion, and/or make communities feel safer and stronger. A majority of studies also supports positive links between arts participation and social inclusion, suggesting that cultural participation results in an improved capacity for cultural citizenship, boosting confidence and developing social skills which lead to more effective engagement with the community at large. Several studies report correlations between arts activity and a range of social impact related outcomes, such as attitudinal change, civic engagement, academic performance and professional development.

Heritage

Two areas of social impact are identified in relation to heritage - social capital and multiple impacts. One study demonstrates that a historic built environment has a significant and positive relationship with social capital for adults. Another study uses a cross section survey to show that participation in Heritage Lottery Fund projects helps to maintain and deepen the skills, knowledge and social networks of volunteers and to increase their sense of belonging to their local communities.

Museums, libraries and archives

For social capital, education and wellbeing impacts, the Museums, Libraries and Archives (MLA) literature is more aspirational than evidential, with many references identifying the sector's potential for social impacts, via MLA professionals' perceptions, but few providing empirical analysis of the sector's contribution to social impacts. The most obvious way in which MLA promotes social capital is through the use of volunteers.

Annex F Evidence of the Impact of Breathe Easy Groups for People with COPD

Rowena Merritt, Tracy Pellatt-Higgins, Olena Nizalova, Ferhana Hashem, Tony Rees (2015) "Evaluation of The Benefits Of The British Lung Foundation's Integrated Breathe Easy Voluntary Group Network" University of Kent.

- For each pound invested in the IBE groups there is a return of a minimum of £5.36, i.e. £4.36 in net gain through better health outcomes of participants.
- For each pound invested in the IBE groups, there is a net gain of £22.70 in social return. This value of social return includes the £4.36 of net gain in quality of life from a conservative estimate based on highest cost and lowest (NICE recommended) cost-effectiveness threshold of £20000, NHS cost savings, and a range of social benefits.
- IBE groups are more cost effective than standard BE groups in improving wellbeing of participants.
- People living with a lung condition in converted and new IBE groups felt more confident managing their lung condition and felt more in control of their lung condition compared to standard BE groups.
- There was a 42% reduction in unplanned GP visits and a 57% reduction in unplanned hospital admissions in IBE groups compared to the standard BE groups.
- 87% of people in converted and new IBE groups felt less likely to be admitted to hospital because of their lung condition, compared to 67% in standard BE groups. Similar figures were observed for GP and nurse visits.
- There was some evidence of a decrease in carer's burden at 6 months when compared to baseline for new IBE groups that was not seen in the other groups.
- Carers in existing IBE groups felt more confident to support their partner or friend (97%), felt they had a better understanding of lung conditions (98%), and knew more about services available locally for people supporting others with lung conditions (90%).
- People living with a lung condition who attended any type of BE group had significantly greater quality of life at 6 months compared to people who did not attend a BE group. Those attending BE groups maintained quality of life throughout the study whereas quality of life decreased by more than 20% for those who did not attend a group.
- People attending standard BE groups and converted IBE groups had significantly greater levels of self-efficacy (CSES) than people who did not attend a BE group. Those attending standard BE and converted IBE groups maintained self-efficacy throughout the study whereas there was a decrease of 17% for those who did not attend a BE group.
- It was more common for people who were members of a BE group to remember their medication when travelling and take their medication regularly, even when their symptoms feel under control, when compared to people who did not attend a BE group.
- People attending converted and new IBE groups maintained wellbeing throughout the study whereas there was a decrease of 12% for those who did not attend a BE group.

Annex G Evidence of the Impact of Joint Pain Self-Help Support Groups

Liegl G, Boeckle M, Leitner A, Pieh C (2016) "A meta-analytic review of brief guided self-help education for chronic pain" *European Journal of Pain*, London

The review of literature on this subject, notes that treatment of chronic pain causes medical and socioeconomic problems. Guided self-help (GSH) might be an effective supplementary treatment, however, the size of this effect is unclear. This meta-analysis quantifies the effect of GSH on chronic pain. A systematic literature search was conducted using PubMed, Cochrane, Psyn dex, Psycinfo and Scopus. Studies that investigated GSH in chronic pain conditions (children and adults) were included. Disability, quality of life and pain severity were defined as main outcomes. A random effects model was applied to calculate standardized mean differences (SMDs). By applying mixed models and subgroup analyses, the moderating effects of sample characteristics were examined (age; pain region), GSH format (online; face-to-face contact) and study characteristics (study quality; control condition). 16 eligible studies were identified, including 739 subjects. Between-group analyses resulted in a medium, but heterogeneous effect size for pain severity (SMD = 0.51; CI₉₅ : 0.21, 0.81). After excluding two samples suggesting small study bias, the effect on pain severity was small but homogeneous (SMD = 0.34; CI₉₅ : 0.13, 0.54). A small effect size for disability was found (SMD = 0.30; CI₉₅ : 0.10, 0.50). The pooled effect size for quality of life did not reach significance (SMD = 0.24; CI₉₅ : -0.07, 0.54). It was concluded that GSH has a small but robust effect on pain severity and disability in chronic pain patients. This applies to various GSH formats and patient populations. It seems reasonable to integrate GSH into clinical practice as a supplemental treatment option. Thus this meta-analytic review found small but robust effects of guided self-help interventions for the treatment of chronic pain.

Annex H Evidence of the Impact of Integrated Support for New Mothers

Jacque Mallender, Rory Tierney, Dimitrios Gontzes, Belinda Baah (2018) “Cost-effectiveness and Return on Investment (ROI) of interventions associated with the Best Start in Life” Public Health England:

The review examined evidence from studies of actions to support the “Best Start in Life” programme to determine their cost effectiveness as shown by applying a “return on investment” economic analysis tool. Eleven interventions were included in the tool. These are focused on breastfeeding uptake (two interventions) and preventing or treating postnatal depression (PND) (nine interventions).

The two interventions relating to breast feeding and the ICER values calculated were:

- proactive and reactive calls after hospital discharge for women from more disadvantaged areas to provide breastfeeding support (Dominant)
- enhanced staff contact for all mothers with low birthweight infants (£1,939)

Of the two breastfeeding interventions, one (enhanced staff contact for underweight new-borns) is dominant i.e. shows both reduced costs and better health outcomes compared to treatment as usual, and the other (proactive and reactive calls) is cost-effective, with a very low incremental cost effectiveness ratio (ICER) (£1,939 per quality adjusted life year (QALY)). An ICER is the difference in the change in mean costs in the population of interest divided by the difference in the change in mean outcomes in the population of interest compared to treatment as usual, a negative value indicates that the intervention is dominant. When compared to the NICE threshold for cost effectiveness of £20,000-£30,000 per QALY, an ICER value below the threshold (the lower the better) suggests, in a simplistic, yet effective way, that the intervention is a good use of resources

The nine interventions relating to PND and the ICER values calculated were:

- midwifery redesigned postnatal care (universal, i.e. for all mothers) (Dominant)
- peer support for prevention of postpartum depression² (targeted at those with, or at risk of, PND) (Dominant)
- group physical therapy exercises (universal) (Dominant)
- cognitive behavioural therapy (CBT)-based intervention (targeted) (£41,258)
- education on preparing for parenting (targeted) (£17,551)
- interpersonal psychotherapy (IPT)-based intervention (targeted) (£35,083)
- calcium prescription (universal) (£9,566)
- booklet on postnatal depression (universal) (£147)
- early contact with care provider (universal) (£7,365)

The first three PND interventions; midwifery redesigned postnatal care, peer support intervention for prevention of postpartum depression and group physical therapy exercises, were all estimated to be dominant. These would show a negative ICER i.e. delivering both cost saving and better health gains compared to treatment as usual. Other ICER values were as shown indicating that in addition to the first three interventions 4 other interventions would be regarded as a good use of resources.

However the review points out that certain costs may be overestimated and benefits may be greater than shown, thus these results can be regarded as cautious.

Annex I Evidence of The Impact of Steps to Extend Support for Self-Care for People with Diabetes

Care Quality Commission (2016) “My diabetes, my care”

This guidance document was prepared following a review of evidence and consultation with organisations representing Diabetes patients and Clinicians. Key components of the recommended approach are:

- A local plan for improved diabetes care through support to self-management.
- Commissioners and providers engaging with their whole community to increase awareness and understanding of diabetes and encourage uptake of health checks.
- Professionals engaging with people to understand their individual needs and developing a personalised care plan together.
- Emotional support embedded in care for people with diabetes.
- Development of education approaches to ensure everyone, including people from BME groups and people with a learning disability, can gain the knowledge and skills they need.
- Evaluation of the effectiveness of structured education and annual review in giving people the knowledge and ability to self-manage their diabetes.
- Making better use of available technology to support self-management through education, motivation, and self-monitoring.
- Training in diabetes for care workers to enable them to fully support and care for people with diabetes.

Joint British Diabetes Societies for Inpatient Care (JBDS – IP) (2013) “Admissions avoidance and diabetes: guidance for clinical commissioning groups and clinical teams” Association of British Clinical Diabetologists and Diabetes UK also stresses the importance of patient centred care and support in reducing hospital admissions.

Annex J Evidence of the Impact of Integrated Care for Carers and Respite Services

Linda Pickard (2004) "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" PSSRU, University of Kent

One of the issues that this literature review aimed to explore was whether it is more effective to support carers by supporting the older people that they care for or whether it is more effective to support carers by providing specific carer services.

The evidence presented in the literature reviewed suggests that both services aimed at the older person, such as the home help/care service, and services aimed at the carer, such as daycare/institutional respite care, can be effective in improving the welfare of carers and reducing the negative psychological effects of caring. The literature also suggests that both types of service can also be effective in delaying the admission of the older person to institutional care and both are consequently in the interests of older people who wish to remain in the community. It is, therefore, clear that both forms of service should be available to older people with carers.

The literature also suggests that both services aimed at the older person and carer specific services are cost-effective ways of supporting older people with carers to remain in the community for longer periods of time. Indeed, daycare, home care and institutional respite care were the three services that were most cost-effective in maximising older people's length of stay in the community (Davies and Fernandez 2000). The literature also suggests that daycare and institutional respite care are cost effective in reducing carer stress and that, although the evidence in this respect for home care is more equivocal, other services provided to the older person, like meals on-wheels, are cost-effective. Taken together, the literature suggests, again, that both services aimed at the older person and carer specific services can be cost-effective. And again, this supports the conclusion that both forms of service should be available to older people with carers.

On balance, however, services aimed at the older person may be more acceptable to both to the older person and the carer. Services provided for the older person are much less likely to raise issues of conflict between older people and their carers than are specific carer services. There is evidence that older people are often ambivalent about services such as daycare and institutional respite care. For example, daycare that is provided primarily to benefit the carer may not be what the user wants, especially when this involves frequent attendances at a day centre. Equally, many older people do not want to go into an institution, even if this is just for a short stay.

This suggests that, if anything, there should be a preference in favour of services provided to the older person. Current government policies, however, currently favour specific carer services, such as breaks from caring. In terms of current community care practice, while there is some evidence that access to respite services for carers of older people increased during the 1990s, the same does not seem to have been true of home care services. The home care service is the bedrock of community care in this country and yet it is still primarily directed at older people without carers. In the 1998 GHS, older people needing regular daily care who lived alone without informal help were nearly ten times more likely to receive home care than older people who lived with their spouses/partners. This, in turn raises more general issues about access to services.

Annex K Evidence of the Impact of Hospice at Home Services

Department of Health (2008) "End of Life Care Strategy" London

This government strategy builds on the vision and expertise of hundreds of people and organisations from all walks of life addressing the challenges of providing high quality end of life care. While it notes that it is probably impossible to quantify the cost of end of life care it identifies key elements of expenditure as:

- Hospital admissions: the total cost of non-elective final finished consultant episodes ending in death amounts to around £750m pa.
- Hospices and specialist palliative care services: these are estimated to cost around £450m pa of which over £200m is borne by the voluntary sector;
- Community nursing services: the Audit Commission estimated in 1999 that end of life care took up 40% of district nurses' time, though it only accounted for 8% of their caseload. The cost of district and community nursing in 2005/06 was around £1bn; and
- Care homes: a currently unquantified cost, some of which is met from NHS Continuing Care Funds and a significant proportion from the private purse.

The strategy document provides many examples of the importance of hospice at home provision as an important way of providing high quality end of life care for patients and their families which is also probably cost effective.