Public Document Pack

SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Tuesday, 8th September, 2020
Time: 5.00 pm
Place: Virtual Meeting - MS Teams
Contact: Robert Harris
Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Minutes of the Meeting held on Wednesday 10th June 2020** (Pages 1 - 6)
Minutes attached

4 **Public Questions**

******** **Items for Decision and Discussion**

5 **Annual Public Health Report** (Pages 7 - 38)
Report of Krishna Ramkhelawon attached

6 **Teenage Pregnancy Implementation Plan** (Pages 39 - 46)
Report of Erin Brennan-Douglas attached

7 **Mid and South Essex Health and Care Partnership Diabetes Framework** (Pages 47 - 118)
Report of Patricia D'Orsi attached

8 **Flu Planning and Marketing Campaign** (Pages 119 - 132)
Report of Krishna Ramkhelawon attached

9 **Covid-19 Pandemic Updates (Health Protection Board and Local Outbreak Control Plan Oversight and Engagement Board) and EPUT: Response, actions and implications on Mental Health** (Pages 133 - 136)

A. Update report from Krishna Ramkhelawon attached

B. EPUT: Report from Sally Morris to follow

10 **Improving SEN and Disabilities Progress Update Report: Next Steps, organisational structure and HWB responsibilities** (Pages 137 - 146)
Report of Michael Marks attached

******** **Items for information**

11 **Alliance Update and Overview**
Verbal update from Patricia D'Orsi (no papers)

12 **Greater Essex LeDeR Annual Report** (Pages 147 - 164)
Report of Krishna Ramkhelawon attached

SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Wednesday, 10th June, 2020
Place: Virtual Meeting via MS Teams

3

Present: Councillor T Harp (Chair)
Councillors J Garcia-Lobera (Vice-Chair), M Davidson, D Jarvis, A Jones, I Gilbert, C Mulroney, T D'Orsi, J Gardner, Y Blucher, Mr A Khaldi, K Jackson, S Morris, A Griffin, S Dolling, K Ramkhelawon and J Broadbent

*Substitute in accordance with Council Procedure Rule 31.

In Attendance: Councillors L Salter
G Halksworth, R Harris and S Baker

Start/End Time: 5.00 - 7.08 pm

29 Chair's Opening Remarks

The Chair made an introductory speech, highlighting that this was the first public meeting of the health and Wellbeing Board to be held 'virtually' in accordance with the 2020 Regulations governing remote meetings.

30 Apologies for Absence

Apologies for absence were received from J Cripps and C Panniker.

31 Declarations of Interest

The following declarations of interest were made as indicated:

(a) Councillor Salter – Minute 33 (System Covid Response) – Non-pecuniary interest – husband is consultant surgeon at Southend Hospital; daughter is a consultant at Basildon Hospital; son-in-law is GP in the Borough; daughter and son-in-law were medical students at UCL.

(b) Councillor Harp – Minute 33 (System Covid Response) – non-pecuniary interest – wife is employee of SAVS) and future relative works for East of England Ambulance Trust;

(c) Dr Garcia-Lobero – Minute 33 (System Covid Response) – non-pecuniary interest – GP in the Borough.

32 Minutes of the Meeting held on Wednesday 22nd January 2020

Resolved:-

That the Minutes of the Meeting held on 22nd January 2020 be confirmed as a correct record and signed.

33 System Covid Response

The Board considered a report summarising Southend-on-Sea Council's, Southend University Hospital NHS Foundation Trust and Southend CCG response to the Covid-19 pandemic, covering:

- The Covid-19 Incident Timeline;
- Covid-19 Demand on Frontline Health Services;
- Covid-19 Preparation and response relevant to Southend-on-Sea and South East Essex;
- Care home support and education;
- Community resilience;
- Impact of Covid-19 on Southend-on-Sea;
- Reset and Recovering focus.

The Board asked a number of questions which were responded to by the respective health and social care representatives. The Board also made the following comments/observations:

- This was an excellent report and everyone should be thanked who have played their part;
- Wider than economic recovery – emotional and mental health wellbeing of residents, etc will be key to recovery;
- Need to reflect the work of E-Put and the commissioned services around mental health;
- Reference was made to analysis undertaken through Healthwatch which would be shared with the Board;
- Communication across the whole system with residents, etc is vital.

Resolved:

1 That the report be noted and all those involved in responding to the pandemic be thanked for their hard work and dedication.

2. That a paper from E-PUT setting out their response, actions and implications on mental health to the Covid-19 pandemic be provided to the next meeting of the Board.

34 Whole System Approach to strengthening community resilience

The Board received a PowerPoint presentation from the Director of Public Health providing an overview of the whole system approach to strengthening community resilience in light of the Covid-19 pandemic.

The Board asked a number of questions which were responded to by the Director of Public Health. The Board also made the following comments/observations:

- Essential to understand and recognise what the health and inequalities are in the Borough in order to take appropriate actions to address and reduce the gap;
- There needs to be clear and consistent communication with residents and communities and high profile;

- There are significant opportunities to build resilience, reduce health and inequalities and work differently across the system;
- The key to building community resilience is preventing the virus from spreading otherwise there is significant risk of potential further outbreaks, particularly in winter and need to be stronger at preventing the virus; Test and Trace will be key;

Resolved:

That the PowerPoint presentation, be noted.

35 Local Outbreak Control Plan

The Board considered a report from the Director of Public Health providing an update on the Local Outbreak Control Plan which is a key part of the national Test, Trace and Isolate (TTI) programme.

Resolved:

1. That a Southend Local Outbreak Control Plan be developed in partnership with Essex County Council and neighbouring authorities.

2. That a public-facing Outbreak Control Oversight Board be established, led by Council Members, as a sub-group of the Southend Health and Wellbeing Board, which will be advised by senior Council and Health officers, from which to communicate with the public.

3. That the responsibility for the production and implementation of the Local Outbreak Control Plan be delegated to the Local Health Protection Board sub-group, which will report into the Outbreak Control Oversight Board.

36 Social Capital Opportunities (Societal goodwill)

The Board received a PowerPoint presentation from the Director of Public Health providing an overview of who social capital is more important now than ever in light of the Covid-19 pandemic.

The Board made the following comments/observations:

- Southend's communities have overall behaved responsibly during the pandemic and need to build on the 'good will' of residents, etc;
- Social isolation is a key issue – people are scared to leave homes, etc;
- Need to be better prepared to minimise the trajedy caused by the pandemic and build on the opportunities, e.g. there are more volunteers than ever before the pandemic – how to build on this;
- There are significant financial challenges;
- Need to manage perceptions and use the intelligence to embed a whole system approach;
- Identified digital inequality as a key challenge;

Resolved:

That the PowerPoint presentation, be noted.

37 CCG End of Year Performance Information

The Board considered a paper from the Associate Director (Specialist Learning Disability Health Commissioning) presenting the Learning Disabilities quarter 4 performance report 2019/20.

The Board noted that the annual performance report would be presented to the Board in September.

Resolved:

That the quarter 4 learning disabilities performance report 2019/20, be noted.

38 Improving Special Educational Needs and Disabilities

The Board considered a report of the Executive Director (Children and Public Health) providing an update on progress and future plans to complete the Written Statement of Action (WSOA) as a result of the SEND area inspection in October 2018. The report also sought views on future proposals, specifically around leadership, governance and strategic oversight and asks the Board how its role can meet the statutory requirements.

The Board asked a number of questions which were responded to by the Executive Director.

Resolved:

1. That the leadership and governance workstream be engaged to review and determine the appropriate level and role of the Board in the strategic oversight and governance of SEND on an ongoing basis as laid out in the SEN Code of Practice and good practice in local area leadership.

2. That it be recognised that the SEND area partners will need to undertake a range of actions in order to ensure that the required improvements in the local offer outcomes for children and young people with SEND in Southend-on-Sea are met at pace.

3. That regular updates be provided to future meetings of the Board in relation to progress against the five areas identified in the report as part of the overarching SEND governance arrangements.

39 A Better Start Southend Progress Update

The Board received a research paper produced by the University of Essex, commissioned by A Better Start Southend, setting out the preliminary findings and evidence on the impact of the Covid-19 pandemic and ‘lockdown’ restrictions on families with babies and very young children in A Better Start Southend-on-Sea wards and how the ABSS services could respond effectively to improve the health and wellbeing being of very young children and their families during the pandemic and its aftermath.

The ABSS Chair advised that Covid-19 will alter the priorities of ABSS services and the ways in which they work with families and the research findings formed the first phase of the process. Phase two will involve interviews with parents and leaders in key organisations.

The Board made the following comments/observations:

- The research findings contains a significant amount of insight and need to think how it could be applied to all age groups;
- Emphasised the importance of working together collaboratively and facilitate Primary Care involvement and discussions with the University of Essex and ABSS;
- Patients, residents, etc must be first and foremost to have a positive impact.

Resolved:

That the University of Essex preliminary research findings, be noted and that the final report combining the findings from phase one and two be presented to a future meeting of the Board.

Chairman: _____

This page is intentionally left blank

Southend Health & Wellbeing Board

Agenda Item No.

5

Report of the Director of Public Health

To

Health & Wellbeing Board

on

8th September 2020

Report prepared by: Krishna Ramkhelawon, Director of Public Health

For information only		For discussion	X	Approval required	

Annual Public Health Report 2019

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1 To present the 2019 Annual Report of the Director of Public Health.

2. Recommendation

2.1. That HWB Board considers and notes the content and recommendations of the 2019 Annual Report of the Director of Public Health and progress made to-date in regards to the recommendations from the previous report in 2018.

3.0 Background

3.1 The Health and Social Care Act 2012 requires the Director of Public Health to prepare an annual report on the health of the local population. This is an independent report which the local authority is required to publish. The report is an opportunity to focus attention on particular issues that impact on the health and wellbeing of the local population, highlight any concerns and make recommendations for further action.

4.0 The 2019 Annual Report of the Director of Public Health

4.1 The Report this year provides an update on last year's report (2018 Annual Public Health Report) and covers the following themes:

- ✓ Health Protecting and Preventing Ill-health - Focus on the measles outbreak; MMR immunisation and with the challenge of the pandemic, we consider Flu Immunisation and building on improving Air Quality;

- ✓ Tackling Wider Inequalities – Focus on reviewing our food environment in tackling the rise of Obesity and in shaping of our Local Plan for development; we explore the challenges around parenthood and the consequences leading to adverse childhood experiences (ACES), all critical in mitigating for the negative impact on the mental health and wellbeing of children and young people, which has been further exacerbated by the 'new normal' and serious disruption to their education.

4.2 In 2018, we highlighted that we had a focus on three key themes and nine recommendations:

- Healthy Lives – Focus on cardiovascular conditions, diabetes and the implementation of the harm reduction strategy – we note some progress although most actions were delayed due to the pandemic. We are picking these up again within the SE Essex Alliance workplan.
- Community Safety – Focus on disrupting drug-associated criminal behaviours and protecting our young residents, and re-focusing our efforts on reducing teenage conceptions – we note significant progress made across these areas with the Health and Wellbeing Board poised to ratify the Teenage Pregnancy Implementation Plan in September.
- Infrastructure planning – Focus on developing a new Local Plan and maximising the health and wellbeing impact – we note some very good progress in these areas with further work in development.

  A RAG-rated summary of actions against each of the nine recommendations has been included in the report's appendix section.

4.3 The Southend 2050 Ambition and the NHS Long Term Plan collectively set out the key things we can expect to work as partners to turn the ambitions into improvements in services and build community resilience.

4.4 Working with local partners, we will ensure that the learning and actions from the Measles outbreak in the learning disability community progressed and that some of the learning will also contribute to the prevention work against communicable diseases as well as in aiding our continued management of the coronavirus pandemic.

4.5.1 We will continue to enhance our campaigning to ensure the highest level of MMR immunisation in our communities. We continue to explore new ways of communicating the benefits of this vaccine to our families as well as promoting the uptake amongst our adult population with a learning disability who may have missed this important public health intervention in their early years.

4.5.2 With the ongoing coronavirus pandemic, it is going to be essential to significantly increase our uptake of flu vaccines locally, especially as Southend has one of the lowest rates in the East of England. With the recent announcement that we will now offer this vaccine free to all those 50 years and over, we have started planning our approach in Southend much of which will need to be innovative and scalable.

4.6 There is growing evidence of the links between good spatial planning, design principles and the health impacts. The development of a new Local Plan is a real opportunity for public health, public protection and planning to work together to shape the natural and built environment. These measures will have a positive gain from reduced air pollution and how we tackle obesity in shaping our food environment.

4.7 Healthy parent involvement and intervention in the child's day-to-day life lay the foundation for better social, emotional and academic skills. In Southend, we want to support parents to ensure that children have the best start in life. We need to look at the service provision and co-produce our local approach to get the best out of our social and financial investment.

4.8 The impact of adult's poor mental health and the low levels of parenting skills on children and young people's mental health and wellbeing, coupled with them spending an innumerable amount of time on their digital devices, is stark. The rate of ill-health has been growing steadily over the years and with the additional impact of the pandemic, we will need to more than double our efforts to provide a safer growing environment for them.

4.9 The seven key recommendations for the Cabinet to note are:

4.9.1 Health Protection & Preventing Ill-health:

R1.1 Flu Immunisation – Early planning and delivery of a more innovative approach to significantly increase our uptake of flu jabs will be prioritised;
R1.2 MMR Immunisation – We will review our engagement and marketing approach and co-produce the information and advice for parents, in line with the insights gathered. We will also ensure that all our eligible residents with learning disabilities have received their MMR dosage;
R1.3 Lessons from Outbreaks – We will implement all the key actions following the measles outbreak and ensure we continue to closely collaborate in managing the coronavirus pandemic.
R1.4 Air Quality – We will explore innovative ways to monitor the level of pollution locally, and further expand our work on promoting active travel and more social media engagement to raise awareness and support the National Clean Air Day, especially in our younger populace.

4.9.2 Tackling Wider Inequalities:

R2.1 Obesity - With the increasing childhood obesity trend, we must now consider more innovative and drastic interventions. We will review our engagement with the local food environment in three ways:
(1) Improve our healthier eating campaign reach
(2) Use the Local Plan to reshape our food environment
(3) Co-produce our physical activity offer

R2.2 Parenting - We should ensure strategic alignment across the partnership to support families on their parental journey. We must also ensure we are making effective use of good practice;

R2.3 Mental Wellbeing – We must continue to take a collective approach in preventing or reducing the impact of perinatal mental ill-health, while exploring more innovative ways of supporting children and young people and in co-producing more meaningful information and guidance for them.

Director of Public Health Annual Report 2019

JUNE 2020

SOUTHEND 2050
it all starts here

Working to make lives better
www.southend.gov.uk

southend on sea
BOROUGH COUNCIL

Content

Introduction

This is my independent public health report for 2019. It reflects on some of the key achievements, some challenges and highlights where we can continue to collaborate to improve health and wellbeing in Southend-on-Sea.

I have also provided an update on the progress with last year's recommendations in the appendices, which is generally very positive and shows where we can continue to build on.

It has been a positive start for the implementation of the Southend 2050 ambition for the Council and we also welcomed the publication of the NHS's Health and Care Partnership strategy, for Mid and South Essex.

We successfully managed the measles' outbreak and our collective learning was shared and has prepared us for the arrival of the Coronavirus pandemic. We will need to improve the uptake of flu jabs and protect more of our vulnerable residents. Our MMR immunisation rates continue to improve.

Our battle against obesity remains key to improving health and wellbeing, including increasing physical activity, and taking further steps to reshape our unhealthy food environment. With a significant proportion of our population living in more disadvantaged communities, our collective approach will continue to help reduce the pronounced health inequalities, with a place-based and wider community development.

We have made some real improvement in our air quality following a number of initiatives (highlighted in this report). We must continue to build on this and on what we have learnt so far in 2020, following the impact of the pandemic on positive behaviour changes and the reduced traffic into Southend.

Preparing for parenthood is one of the most significant transition in any parent's life. This event impacts on every aspect of expectant and new parents in more ways than any other event in our lives. Many of the issues leading to adverse childhood experiences, have their foundation anchored in parenting and the support available to many parents.

The abuse and harm that children are subjected to locally has contributed to a higher rate of children in need and a significant need for statutory intervention, predisposing for a dedicated and highly effective risk assessment team. A number of other initiatives are in place to mitigate for this challenge.

Mental wellbeing is not simply the absence of mental illness but is a broader indicator of social, emotional and physical wellness. The adverse impact of perinatal mental illness affects the child's emotional, social and cognitive development, with teenage parents more prone. 1 in 5 children will suffer a mental ill-health by the time they are 12 with a new challenge looming with the consequences of the pandemic.

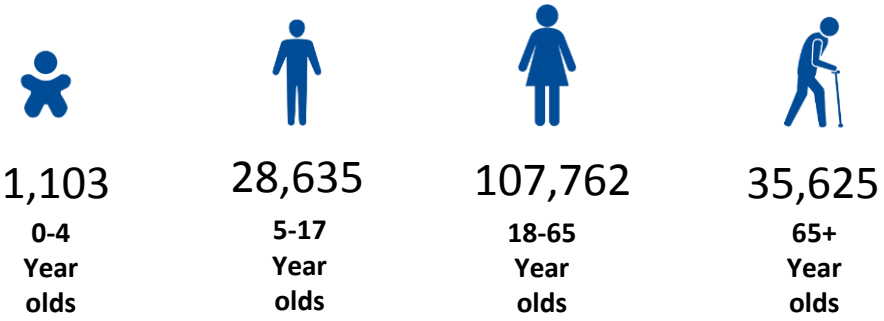
Through our many partnerships, we have a myriad of opportunities to make more positive impact on people's lives and explore how we can collectively work to improve health outcomes. Building on the social capital generated through the early stages of responding to the coronavirus pandemic, we can further galvanise our efforts with our citizens. To this end, I have narrowed our focus as we will need to continue with the manage the pandemic into 2021 which will require of significant amount of our collective resources to be diverted.

Population Size

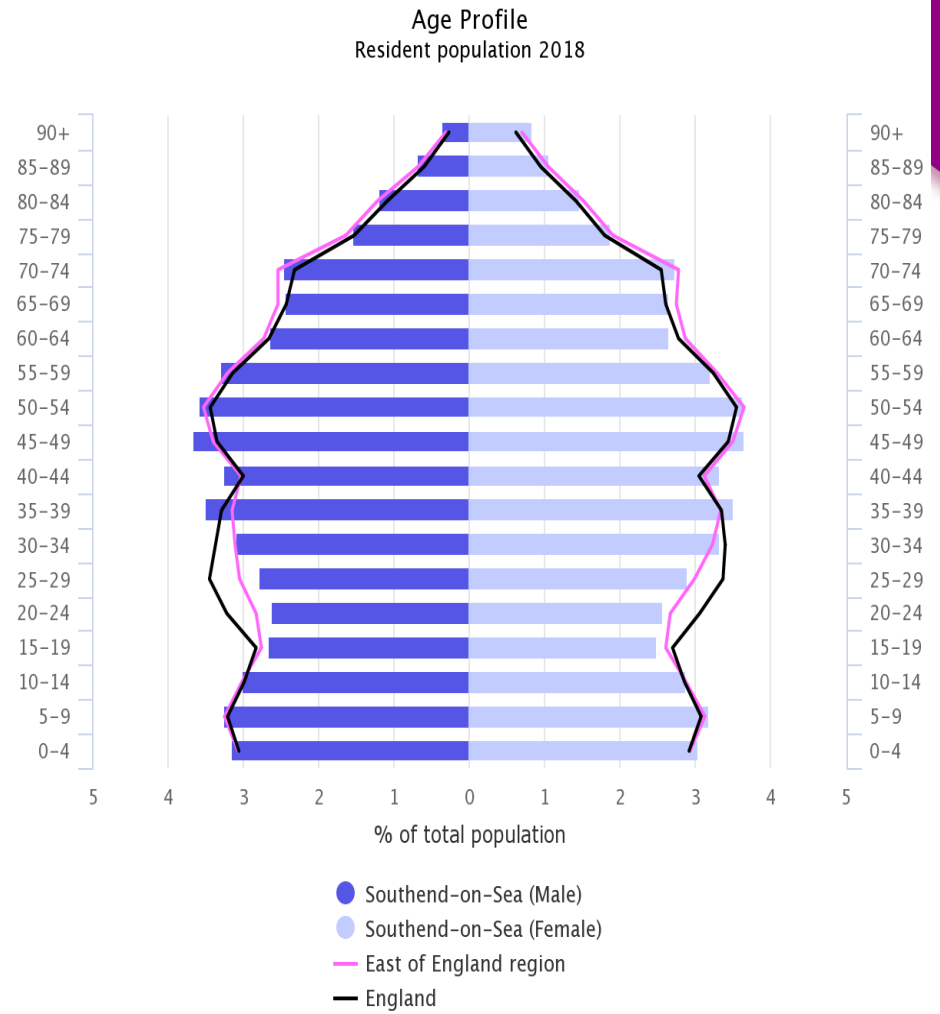
Since 2001, Southend-on-Sea's population has grown from 160,362 to **183,125, this is a growth rate of 14%,** and broadly matches the rate for England.

By 2031, the projected population for Southend-on-Sea will be 202,935. This assumes a growth rate of 12.87% which is higher than the projected growth rate for England (10.11%).

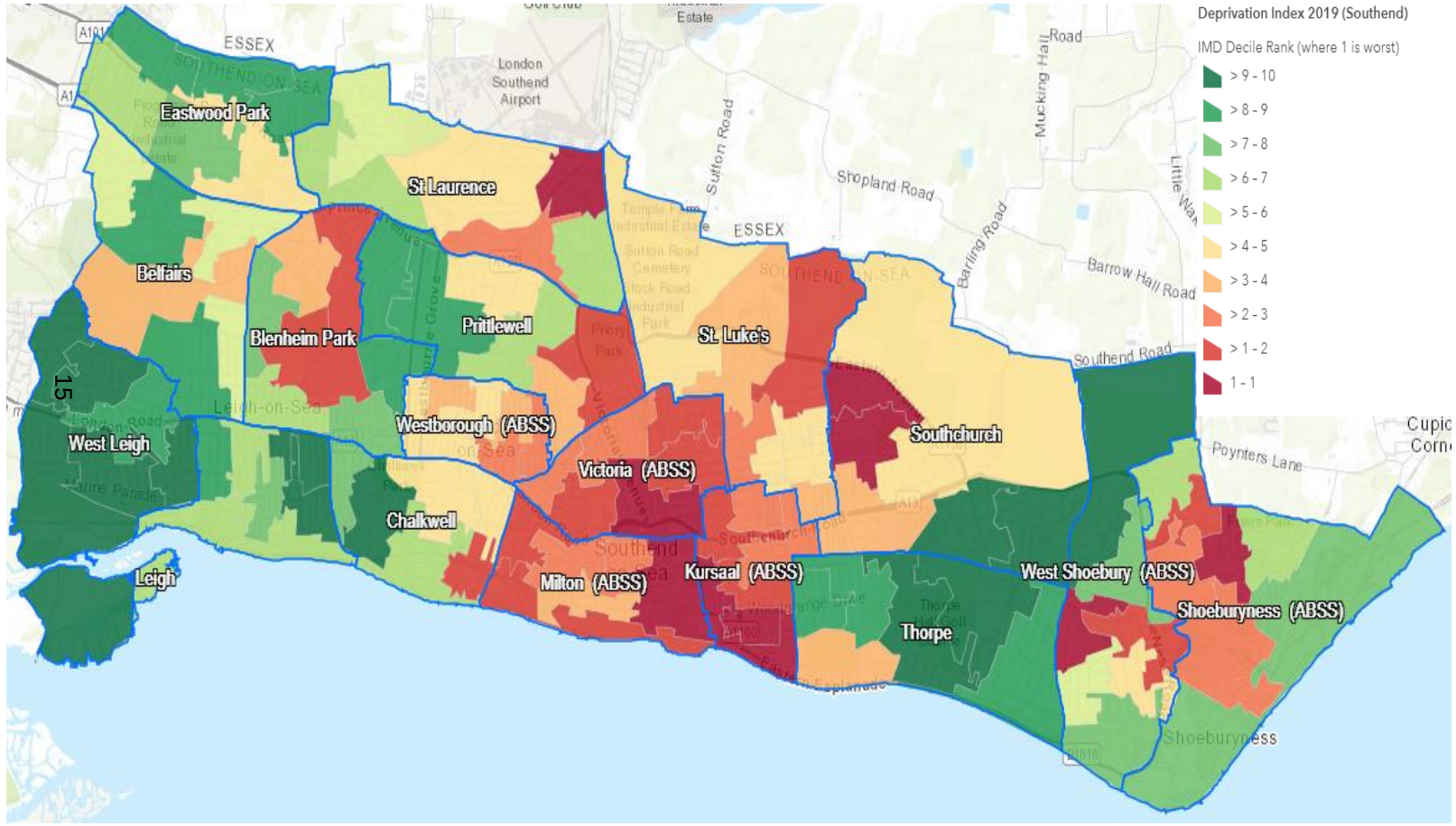
The proportion of the population who are of working age is projected to decrease by 3% by 2031 while the **over 65 population is projected to increase by 4%.**



11,103	28,635	107,762	35,625
0-4 Year olds	**5-17 Year olds**	**18-65 Year olds**	**65+ Year olds**



Deprivation Index 2019



SAFE & WELL

The Index of Multiple Deprivation (IMD) is a measure which is used to determine deprivation in every small area in England, relative to other areas in England. The map shows the deprivation deciles, areas marked in dark red are amongst the most 10% deprived small areas in England.

Many of our more disadvantaged communities are located within the Southend 'town centre' wards, Blenheim Park, the Shoebury area and across Southchurch and St Luke's wards.

Health Protection and Preventing Ill-health

SAFE & WELL

SOUTHEND 2050 it all starts here

Working to make lives better www.southend.gov.uk

southend on sea BOROUGH COUNCIL

Flu Immunisations

Flu and other adult immunisations are critical in reducing the number of preventable deaths in older people, and at risk groups. For older adults, they may not have received certain vaccinations when they were younger, or there may be new vaccinations that were not available to them as children.

It is equally important that at risk groups are offered the flu vaccination to reduce the risk of death and serious illness, and pregnant women to avoid the risk of complications with their pregnancy. This is even more important with the risk of COVID-19 as a result of the spread of coronavirus.

17 Vaccination are given to protect people from:

- Pneumococcal infections (65+)
- Shingles (70+)
- Whooping Cough (Pregnant women)
- Influenza (all groups)

Influenza Vaccinations

	Southend	Target	England
2-3 year olds	43.5%	65%	44.9%
At risk groups	40.5%	55%	48.0%
Pregnant Women	39.3%	55%	N/A
65+ years	64.3%	75%	72.0%

Childhood Immunisations

The Measles, Mumps and Rubella vaccine (MMR2) and booster coverage are used as indicators of coverage for routine childhood immunisations. Southend often achieve coverage of their childhood immunisations above the national average, however, this is still below the recommended target of 95% coverage to achieve 'herd immunity'.

Insight from Southend parents advised that there was a lack of understandable information and opportunities to discuss vaccinations with healthcare professionals before appointments. There has been some disruptions in the programme due to the pandemic and we need to renew our efforts in ensuring we continue to improve uptake.

What is 'herd immunity'? If enough people get vaccinated against a disease, it reduces the chance of the disease spreading. 95% vaccination coverage is recommended to achieve 'herd immunity'.

Focus areas for Southend

- **Increase acceptability of vaccinations across all coverage**
- **Reduce risk of outbreaks**
- **Reduce hospital admissions and attendance**
- **Focus on increase of flu, MMR and PPV**
- **Improve health literacy of communities underserved by co-producing effective communications**

	Southend	Target	England
MMR one dose(2yrs old)	91.1%	95%	90.3%
MMR one dose (5yrs old)	95.4%	95%	94.5%
MMR two dose (5yrs old)	87.2%	95%	86.4%

Measles Outbreak

- Between October and December 2019, there was an outbreak of measles amongst adults with learning disabilities in Southend, the first such large outbreak in this vulnerable group in the past decade.
- 19 suspected cases - after testing, 11 were confirmed as measles, 5 were confirmed not to be measles, and 3 remained inconclusive.
- Swift multi-agency intervention led by the Council and PHE, limited the spread of this virus and it was contained, using systematic contact tracing and maximising self-isolation where applicable. Urgent efforts to increase MMR vaccination coverage were needed to control the outbreak.
- This did lead to the disruption of support services and activities for this group of residents and their families. Southend citizens were diligent and admirable in their support to our local response to contain this outbreak.

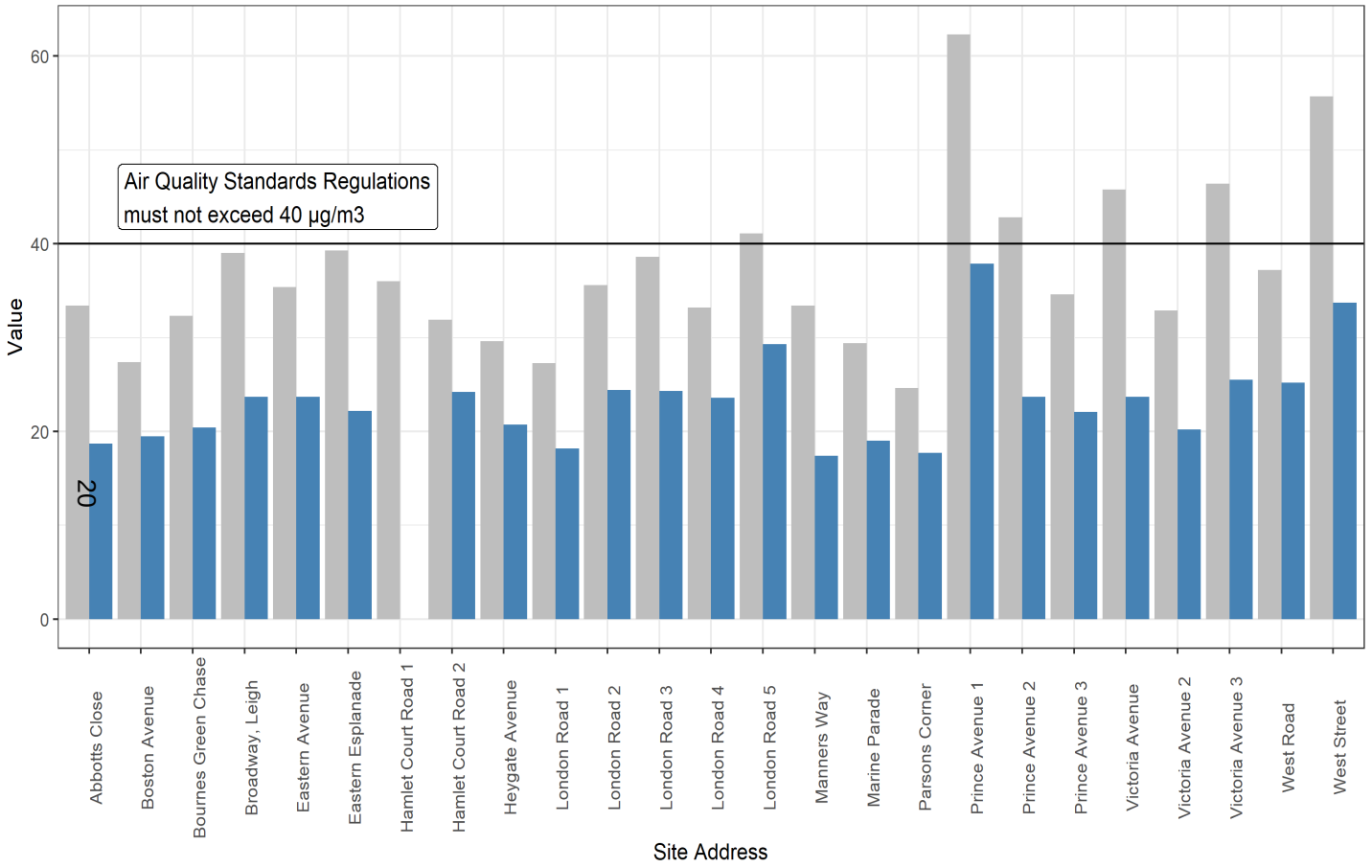
LESSONS & ACTIONS*

- We agreed to complete an MMR information and immunisation campaign for this vulnerable group.
- Active engagement with the media proved very productive for communicating the actions with the defined population and for reassurance for the wider populace.
- Planning for such emergencies must consider the need for readily accessible MMR jabs and out-of-hours clinical services.
- Defining roles and responsibilities from the outset regarding information on delegation, communication, and the management of information in order to mitigate future risk.

**A comprehensive report is available on request*

Air Quality

Year on year comparison of average Nitrogen Dioxide levels at various permanent locations throughout the borough



The year 2019 was generally considered a “good” year nationally and locally for nitrogen dioxide with average levels lower than pervious years

Of the 25 permanent monitoring sites in the borough only 1 observed values exceeding the annual mean air quality objective – A127 Bell Junction Air Quality Management Area (AQMA)

Road Traffic emissions were identified as the main source of air pollution in the borough, most notable the A13, A127 & A1159.

Air Quality

In Southend, we have taken forward a number of direct measures during 2019 in pursuit of improving local air quality. The pandemic and the impact of the national lockdown, have contributed to a further reduction in pollution and some positive change in behaviour, which we need to capitalise on for the wider benefit of our communities.

Key completed measures are:

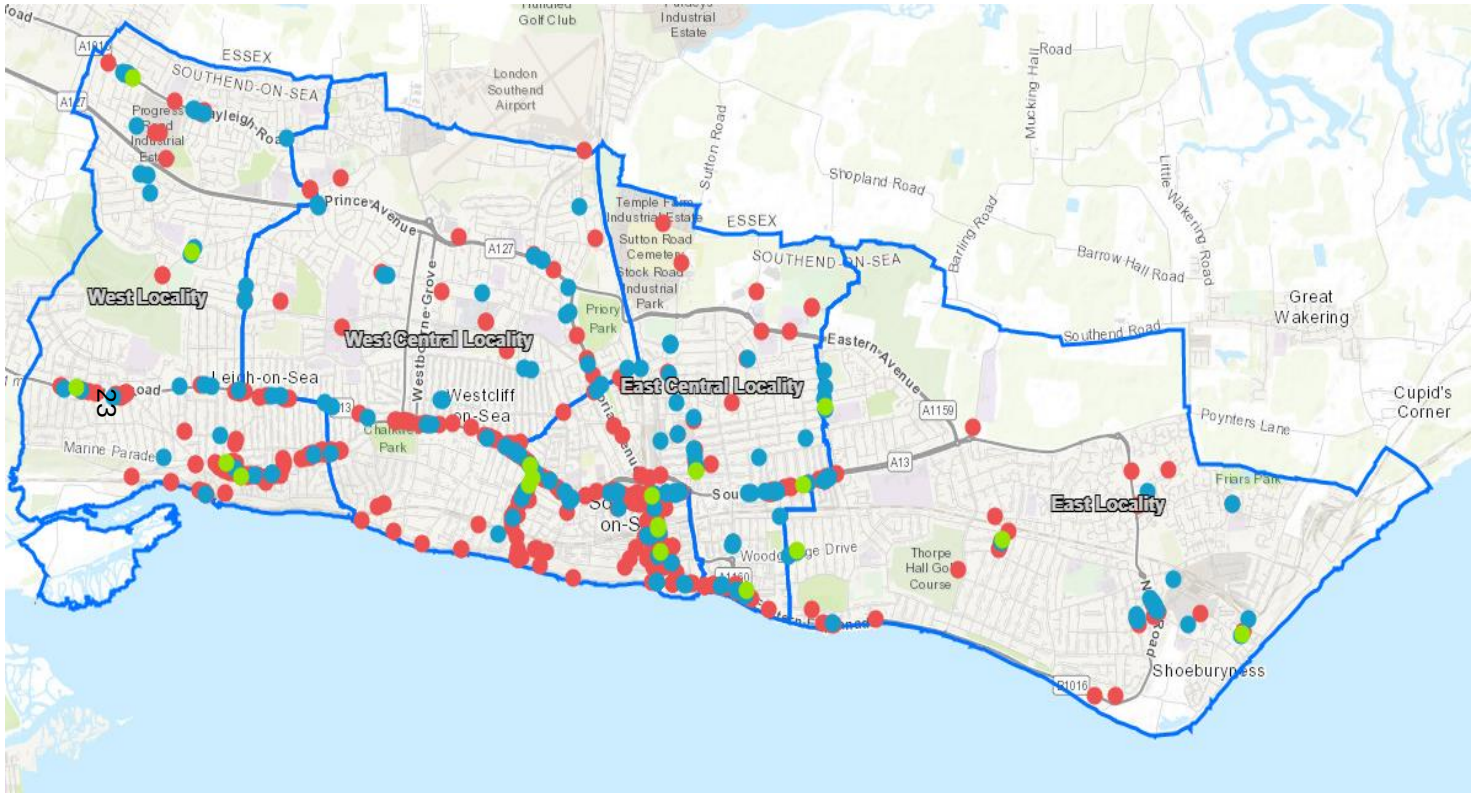
- Throughout 2019 the Air Quality Steering Group held more meetings to monitor actions.
- Feasibility Study: Review of The Bell A127 AQMA Junction Infrastructure Design. Preliminary work commenced in January 2020, and the full construction phase will commence in July 2020.
- A detailed assessment of the A127 Victoria Avenue and junctions with West Street, East Street, Priory Crescent and Fairfax Drive commenced in June 2019 and will be completed in June 2020, having decided to extend the real-time monitoring period from six to twelve months.
- The A127 Kent Elms Corner Junction alterations aimed at improving traffic flow, reducing queue length and congestion, was completed in July 2019 and monitoring continues to demonstrate a steady improvement in air quality.
- A literature review of Air Quality Sensor performance in collaboration with Essex University has been completed. This will inform future decision making with regard to the type and make of sensor, should these prove to be reliable and cost effective.
- An application to Government for £90K funding towards £120k cost of four dedicated taxi only charging points was successful.
- Social media campaign and Variable Message Signage to support National Clean Air Day 2019.

Wider Inequalities

Some key factors to focus our efforts

ACTIVE & INVOLVED

Food Environment



● Bakers ● Takeaways & Sandwich Shops ● Restaurants, Cafes and Canteens

Around 6 million Brits eat takeout food at least once a week

OPPORTUNITY & PROSPERITY

An unhealthy food environment can be a huge contributor to unhealthy populations, with significantly higher levels of obesity in areas where fast food outlets are most prevalent. There is robust evidence of the need to invest more effort into the 'energy in' challenge alongside promoting physical activities.

Southend has the 254th highest density of fast food outlets, out of 326 authorities across England, with 109.6 outlets per 100,000 population.

The wards with the highest rate of fast food outlets are:

- **Milton – 363.3 outlets per 100,000 population (42 outlets)**
- **Victoria – 194.5 outlets per 100,00 population (23 outlets)**
- **Kursaal - 142.0 outlets per 100,00 population (17 outlets)**

Obesity

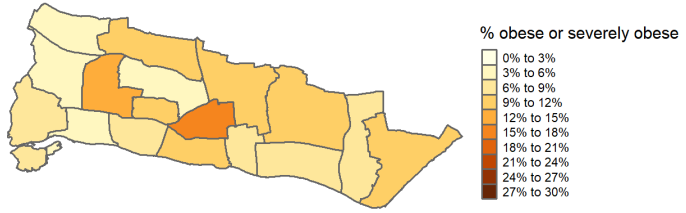
Through partnerships in Southend, families are encouraged to establish healthy nutrition and physical activity choices throughout pregnancy and childhood.

Weight loss services are not recommended for pregnant women and children under the age of 5.

ACTIVE & INVOLVED

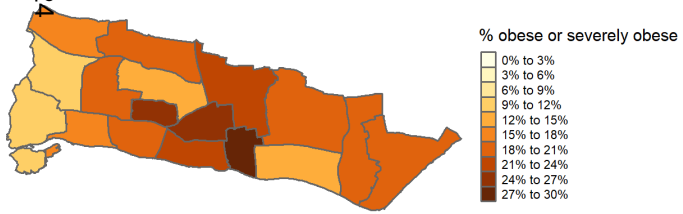
NCMP and Child Obesity – Local Landscape

NCMP 2018/19 Reception



9.1% obese or severely obese, which is similar to England (9.7%). Increased from 8.6% in 2017/18.

NCMP 2018/19 Year 6



19.5% obese or severely obese, which is similar to England (20.2%). Increased from 18.6% in 2017/18.

Children living with obesity are more likely to be obese in adulthood and thus increase the risk of obesity for their own children later in life

PHE National Child Measurement Programme (NCMP):trends in child BMI National Summary key findings academic years 2006 to 2007 and 2018 to 2019

	Reception		Year 6	
	Boys	Girls	Boys	Girls
Prevalence of obesity	↓	↑	↑	↑
Prevalence of excess weight	↓	↑	↑	↑
Prevalence of severe obesity	↔	↑	↑	↑

Increased ↑ Decreased ↓ No upward or downward trend ↔

In England 27% of women are overweight and 21% of women are obese at the start of pregnancy.

Obesity and excess weight prevalence is showing a downward trend in Reception boys. Reception girls and Year 6 boys and girls are seeing an **upward trend in** the prevalence of **obesity and excess weight**

Obesity

Breastfeeding

In Southend, we continue to promote the importance of breastfeeding for women, babies and their families. In 2018/19:

73% babies received breast milk as their first milk. This was above the national average (64.7%) and regional average (70%).

By 6-8 weeks, breastfeeding rate fell to 48.2%, but remains similar to the national average.

Adult Obesity

The Health Survey for England 2017 estimates that 28.7% of adults in England are obese and a further 35.6% are overweight. In Southend, excess weight in adults is at 58.5%.

A physically inactive lifestyle can be a major contributor to adult obesity. It is recommended that adults perform 150 minutes of physical activity each week as part of living a healthy lifestyle.

Parenting Support

Early intervention and support enables every baby, child and young person to acquire the social and emotional foundations to ensure that every child has the best start in life.

Broader context

- Parents have a critical role in their children's social and emotional well-being
- Children's secure attachment depends on their early relationship with primary carers
- Parenting behaviours have a key role to play in children's emotional and behavioural development

26

Southend context

- In Southend, the majority of children perform well in school and achieve the expected level of development
- Whilst a large proportion of children have a good standard of living, the level of child poverty within Southend is a cause for concern in some areas

Adverse Childhood Experiences

- Some events in a child's life can have a damaging effect on a child's health and wellbeing if they are repeatedly exposed to them, these are called adverse childhood experiences (ACE's)
- Children exposed to ACE's are less likely to succeed in education/employment and more likely to have poor mental health & wellbeing

SAFE & WELL

Children exposed to significant abuse or harm are subject to statutory intervention from Children's Social Care or other partners. These children will require intensive intervention to either achieve/maintain or to prevent significant harm to their health or development

Parenting Support

Some children are living in environments with a high risk of domestic abuse. These children are referred into the Multi Agency Risk Assessment Team (MARAT) to ensure that the relevant agencies are aware of the potential risk to them. In 2019/20 there were 693 referrals to MARAT

The impact of COVID-19 would have seriously affected the ability of services to support children and families at the very time that these families are facing even greater challenges.

ABSS together with partners, are making a positive impact on the most deprived children in the Borough through the National Lottery-funded program.

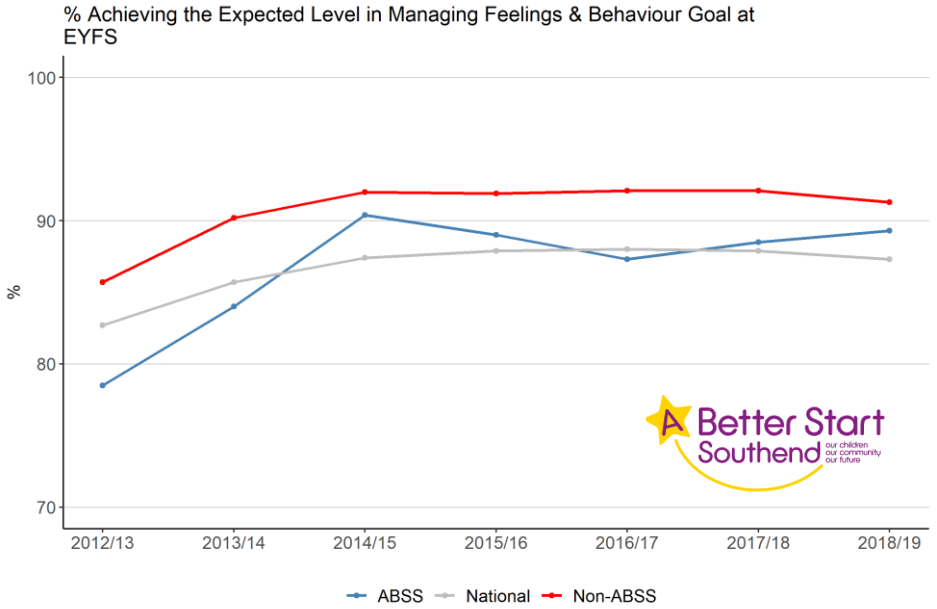
74.0% of children achieved a Good Level of Development in 2019 - **Better** than England (71.8%)

19.1% of children under 16 were in low income families in 2016 – **Worse** than England (17%)

In 2019 the 0-19 Children's Public Health Service received 3294 notifications of domestic violence where a child/young person was residing within the household

359.1 Rate of children in need per 10,000 children in 2019 – **Higher** than England (334.2)

43.2 Rate of children subject to a child protection plan per 10,000 children in 2019 – Similar to England (43.7)



Parenting Support

A range of interventions are currently delivered in Southend to support parents in their interactions with children and young people, these are delivered via group-based programmes or via home visits. We also need to re-assert our approach in reducing teenage pregnancy and continue to build on the good work in supporting teenage parents and enhance their parenting skills.

16,159 Visits made by 0-19 service to support families with children and young people (in addition to core Healthy Child Programme)

182 Families attending parenting support sessions run by Family Action at Southend Children's Centres

728 Families attending Early Help Take 3 Parenting Programme or receiving help via Family Support Team

1,665 children aged 0-3 and pregnant women benefiting from A Better Start services in the 6 target wards, reaching **34%** of the population in these areas

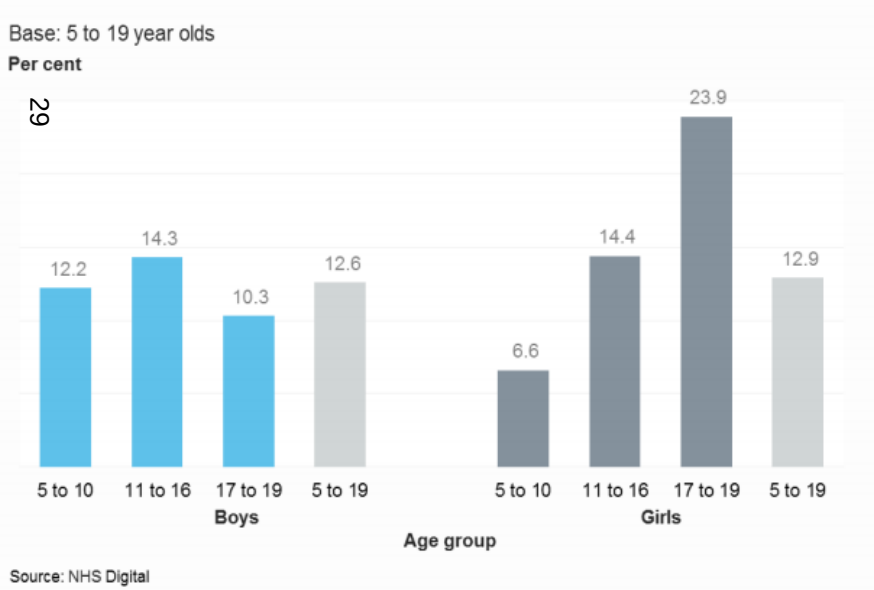
In Southend we want to support parents to ensure that children have the best start in life. Currently, a range of programmes are being used by different agencies rather than an evidence based graduated offer from which to jointly proactively drive positive parenting practices.

Building on the aspirations of Southend 2050 and the key findings and outcomes from A Better Start, the opportunity exists to achieve life-changing results for Southend's children and young people. This can be realised through better, smarter and more effective investments in a system-wide approach to early intervention & parenting support that will benefit the entire economy and community.

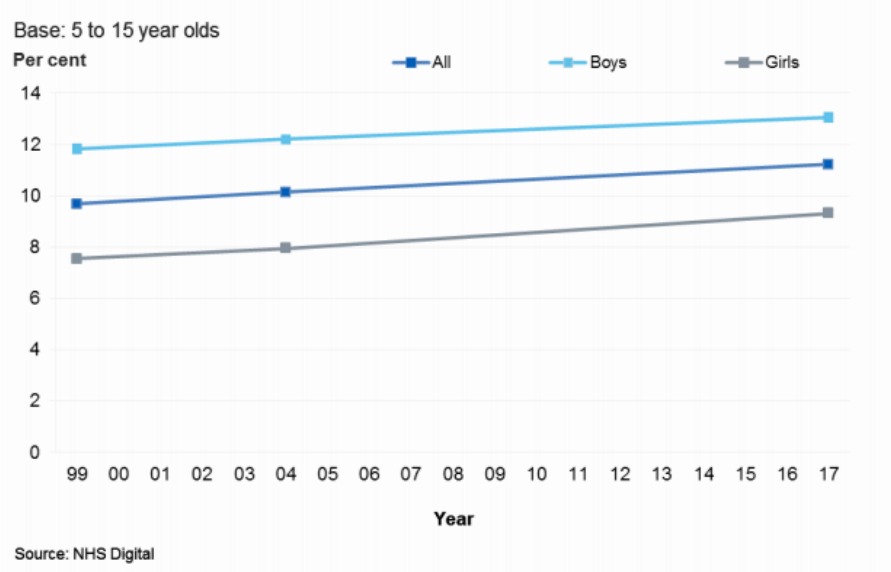
Mental Health in Children & Young People

In 2017, one in eight (12.8%) 5 to 19 year olds met the criteria for at least one mental disorder - estimate based on a sample. If all children in the population had participated, it is likely that the proportion identified with at least one disorder would have been between 11.9% and 13.7%. The school disruption during the pandemic will have some negative impact on the emotional wellbeing of our children and we will need to continue to provide additional support through our schools and the wider community as further mitigation.

Any disorder, by age and sex (2017)



Trend in any disorder by sex (1999 – 2017)



There has been a slight upward trend over time in the prevalence of any disorder among 5 to 15 year olds:

- ***9.7% in 1999***
- ***10.1% in 2004***
- ***11.2% in 2017***

Mental Health in Children & Young People

Pre-birth

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby. If untreated, these perinatal mental illnesses can have a devastating impact on the women affected and their families.

- perinatal mental illness can have an adverse impact on the interaction between a mother and her baby, affecting the child's emotional, social and cognitive development
- suicide is one of the leading causes of death for women in the UK during the perinatal period.

0-5 years

ONS report estimates the prevalence of mental disorders in children aged 2 to 4 years old. It found that 1 in 18 preschool children experienced difficulties with their mental health and that boys (1 in 15) were more likely than girls (1 in 24) to have a mental disorder.

Identifying mental disorders in children at the earliest opportunity is important as research has shown that the early years of a child's life is a foundation for lifelong emotional and physical health as well as education and economic achievement – ONS 2017

5+ years

As you may expect, rates of mental disorders were higher in older children than younger children.

In primary school aged children (5 to 10 year olds), one in ten had a mental disorder, increasing to one in seven children of secondary school age (11 to 16 year olds).

One in six young people aged 17 to 19 year olds had a disorder, with rates much higher in girls than boys.

Recommendations

SOUTHEND 2050
it all starts here

Working to make lives better
www.southend.gov.uk

southend on sea
BOROUGH COUNCIL

1. Health Protection & Preventing Ill-health

R1.1 Flu Immunisation – Early planning and delivery of a more innovative approach to significantly increase our uptake of flu jabs will be prioritised.

R1.2 MMR Immunisation – We will review our engagement and marketing approach and co-produce the information and advice for parents, in line with the insights gathered. We will also ensure that all our eligible residents with learning disabilities have received their MMR dosage.

R1.3 Lessons from Outbreaks – We will implement all the key actions following the measles outbreak and ensure we continue to closely collaborate in managing the coronavirus pandemic.

R1.4 Air Quality – We will explore innovative ways to monitor the level of pollution locally, and further expand our work on promoting active travel and more social media engagement to raise awareness and support the National Clean Air Day, especially in our younger populace.

Livewell Southend

2. Tackling Wider Inequalities

OPPORTUNITY & PROSPERITY

R2.1 Obesity - With the increasing childhood obesity trend, we must now consider more innovative and drastic interventions. We will review our engagement with the local food environment in three ways:

(1) Improve our healthier eating campaign reach

(2) Use the Local Plan to reshape our food environment

(3) Co-produce our physical activity offer

R2.2 Parenting - We should ensure strategic alignment across the partnership to support families on their parental journey. We must also ensure we are making effective use of good practice.

R2.3 Mental Wellbeing – We must continue to take a collective approach in preventing or reducing the impact of perinatal mental ill-health, while exploring more innovative ways of supporting children and young people and in co-producing more meaningful information and guidance for them.

Appendices

Glossary

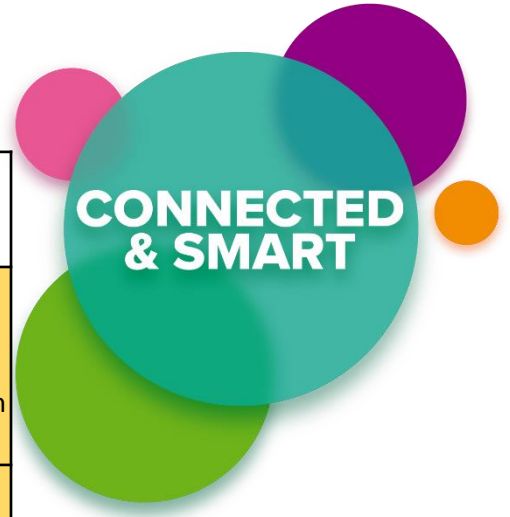
- **Southend 2050** – *The Borough's ambition for the future, developed following extensive conversations with those that live, work and visit Southend-on-Sea*
- **Health and Care Partnership Strategy** – *A publication that sets out how partners can work together to improve health and care*
- **Place-based** – *An approach that targets and entire community and aims to address issues that exist at the neighbourhood level.*
- **Deprivation** – *The English Indices of Deprivation is a measure of seven distinct domains that when combined from the Index of Multiple Deprivation*
- **Decile** – *one of ten equal groups which a population can be divided into according to the distribution of values*
- **Ward** – *Local Electoral area*
- **Pneumococcal infections** – *A number of bacterial infections that are generally minor, but can lead onto more serious infections such as Meningitis, Sepsis and Pneumonia*
- **Coverage** – *The proportion of the population that are vaccinated*
- **Co-produce** – *Jointly create a document or product with other organisations*
- **Nitrogen Dioxide** – *Forms from emission from cars and motor vehicles, and is one of the main measurements of air pollution*
- **Variable Message Signage** – *Road signage with the ability for custom messages*

- PHE – *"Public Health England"*
- AQMA – *"Air Quality Management Area"*
- NCMP – *"National Child monitoring program"*
- ABSS – *"A Better Start Southend"*
- EYFS – *"Early Years Foundation Stage"*
- WHZAN – *"WHZAN Digital Health"*
- ECC – *"Essex County Council"*
- HWB – *"Health & Wellbeing Board"*
- BMI – *"Body Mass Index"*
- ONS – *"Office of National Statistics"*
- PPV – *"Pneumococcal Polysaccharide Vaccine"*

Ethnicity

	Southend (%)	East of England Region (%)	England (%)
White	**91.60%**	**90.80%**	**85.40%**
English/Welsh/Scottish/Northern Irish/British	87.00%	85.30%	79.80%
Irish	0.90%	1.00%	1.00%
Gypsy or Irish Traveller	0.10%	0.10%	0.10%
Other White	3.60%	4.50%	4.60%
Mixed/multiple ethnic groups	**2.10%**	**1.90%**	**2.30%**
White and Black Caribbean	0.60%	0.60%	0.80%
White and Black African	0.40%	0.30%	0.30%
White and Asian	0.60%	0.60%	0.60%
Other Mixed	0.50%	0.50%	0.50%
Asian/Asian British	**3.70%**	**4.80%**	**7.80%**
Indian	1.00%	1.50%	2.60%
Pakistani	0.60%	1.10%	2.10%
Bangladeshi	0.50%	0.60%	0.80%
Chinese	0.60%	0.60%	0.70%
Other Asian	0.90%	1.00%	1.50%
Black/African/Caribbean/Black British	**2.10%**	**2.00%**	**3.50%**
African	1.60%	1.20%	1.80%
Caribbean	0.30%	0.60%	1.10%
Other Black	0.20%	0.20%	0.50%
Other ethnic group	**0.50%**	**0.50%**	**1.00%**
Arab	0.20%	0.20%	0.40%
Any other ethnic group	0.30%	0.30%	0.60%

Outcomes of last year's recommendations



R1	Reducing the impact of cardiovascular conditions and diabetes and improving related prevention work:	
R1.1	Develop an agreed locality approach to improve earlier identification of Stroke and Diabetes, ensuring reduced variability in access to primary care services	Work on the development of an enhanced quality improvement for stroke prevention and diabetes have been delayed by the pandemic and will be relaunched as part of the South East Essex Alliance work programme. The delay in reaching a consensus on the joint outcomes and collective approach have hampered our progress
R1.2	Improve the management of patients at risk of stroke and those afflicted with diabetes, including the use of digital technology as appropriate, and delivery of the Diabetes Strategy	Limited development as stated in R1.1. However, much has been achieved with the introduction of new technology – myDiabetes app is being rolled out; planning for education/self-management tool in Care homes; education is now all provided online; online clinical consultation tool (ACCURX) introduced; rolling out WHZAN's remote monitoring systems to Care homes
R1.3	Increase referral to the new Wellbeing Service to reduce and/or better manage lifestyle risk factors and implement the Harm Reduction Strategy as a key enabler.	New Wellbeing Exercise Programme for primary care launched in March 2020 although this was paused due to the pandemic lockdown; Lack of resourcing delayed implementation of the Harm Reduction Strategy – a new joint post between internal Council department will be appointed in September 2020.

Outcomes of last years recommendations

R2	Improving community safety and building resilience, with a particular focus on our children and young people:	
R2.1	Develop a programme of work that will provide for, and link into, a range diversionary activities and avenues for vocational development. This will include local apprenticeships to make young people safer, provide skill development and job opportunities and to have a healthier outlook on their lives	Pilot Cadet Scheme in development to support vulnerable young people and their skills development. Through our Economic Development and Skills team, we have undertaken 4 dedicated events (532 delegates), aimed to encourage young people to embark on apprenticeships and pursue locally available, fulfilling and healthy careers.
R2.2	Build on the work already in progress across Greater Essex and regionally, to reinvigorate the local partnerships (Community Safety and Violence and Vulnerability groups) to disrupt the local drug market and to eliminate the criminal exploitation of young people and vulnerable adults in our communities	Effective partnership with ECC in place, with all local partners engaged and the Council providing leadership, informing planning and interventions locally.
R2.3	Undertake a deep-dive on local teenage conceptions to understand local determinants and triggers, including the link with child sexual exploitation, local opportunities for young people to promote a delaying approach to parenthood.	Recommendations endorsed by HWB and implementation plan will be ready for delivery from Autumn 2020 (delayed by pandemic).

Outcomes of last years recommendations

R3	Ensuring that spatial planning incorporates health and wellbeing impacts, and delivers what residents will need to promote their health and wellbeing:	
R3.1	Adopt new evidence on spatial planning, including the adoption of the PHE/Sports England's Active Design principles, making it a requirement on developers to undertake a Health Impact Assessment where most relevant and review the barriers inhibiting local access to our physical assets	Evidence and good practice have been reviewed and now being prepared to inform subsequent stages of the Local Plan
R3.2	Our housing renewal policy must take into consideration the need for more affordable housing which espouses a mix of social housing, adaptable homes which will ensure that the adverse health effects are mitigated, promote local ownership and more affordable rent, and support the drive to increase prosperity	Leading on the development of a mixed portfolio of housing types, including the development of a regeneration approach to numerous council-owned assets (delivery of 16 units); a successful acquisitions programme (delivery of 27 units); and to ensure that new developments bring forward suitable affordable housing to meet local needs (e.g. Better Queensway estate regeneration).
R3.3	Accelerate our local undertakings in improving local transportation to further reduce the risk of pollution and traffic congestion and promote active travel.	Work through the Air Quality Steering Committee continue to support our approach in minimising air pollution. Investment in local cycling and walking infrastructure has improved facilities in and around the town centre and the A127 corridor. The South Essex Active Travel Programme has promoted and encouraged active travel including providing training and behaviour change interventions. As of March 2019 a modal shift of 8% towards sustainable modes was observed across South Essex.

Southend Health & Wellbeing Board

Agenda Item No. 6

Krishna Ramkhelawon, Director of Public Health, Southend Borough Council

to

Health & Wellbeing Board

on

September 2020

Report prepared by:
Erin Brennan-Douglas, Senior Public Health Principal, Southend Borough Council Children's & Public Health

For discussion	x	For information only		Approval required	

Teenage Pregnancy and Young Parents Implementation Plan 2020-21

Part 1 (Public Agenda Item)

1 Purpose of Report

To share the implementation plan developed as a result of the deep dive into teenage pregnancy and young parenthood in Southend.

2 Recommendations

2.1 To adopt the Teenage Pregnancy and Young Parents Implementation Plan based on the strategic approach developed by Public Health England for taking a whole system approach to teenage pregnancy prevention and support for young parents and local findings – (*please see Section 5 below*).

2.2 To establish a Teenage Pregnancy and Young Parents Working Group with senior leadership and key elected members to:

- bring together a full range of services and organisations involved in the delivery and commissioning of the teenage pregnancy and young parenthood pathways
- deliver a whole system approach to teenage pregnancy prevention and support of young parents
- adopt a clear governance framework

3 IMPACT OF EFFECTIVE TEENAGE PREGNANCY PREVENTION

3.1 The Teenage Pregnancy and Prevention Framework is informed by the most up to date international evidence on preventing early pregnancy and the learning from the Teenage Pregnancy Strategy on how to translate the evidence into a whole system approach. Applying the 10 key factors for an effective strategy has been key to reducing rates and continues to be relevant in the current commissioning landscape.

3.2 The Framework is designed to help local areas review their local programmes to see what's working well, identify any gaps, and help maximise the assets of all services and practitioners to strengthen the prevention pathway for young people. It is a companion document to the multi-agency 'Framework for supporting teenage mothers and young fathers', published by PHE and LGA in 2016 and updated in 2019.

3.3 Strategic leadership and accountability have been central to success in those areas with the highest reduction in under 18 conception rates. A successful decrease in local under 18 conception rates can result in lowering the priority to focus on prevention, and risks rates increasing. Strategic leadership and accountability is required to maintain reduced rates and provide challenge for further reductions.

4. AREAS IDENTIFIED THROUGH THE DEEP -DIVE FOR FURTHER DEVELOPMENT AND IMPROVEMENT

4.1 There was clear evidence of best practice, however the deep dive identified elements in all areas of the PHE's 10-point approach to prevention of teenage pregnancy that could be strengthened and improved.

4.2 Areas identified for further work:

- The high number of young parents with emotional wellbeing issues and significant vulnerabilities
- The high level of domestic abuse in families, domestic abuse in young parents relationships and the number of young people who identified abuse in relationship through the SHEU survey
- The number of young people who became parents, where there was issues with education i.e. a history of non-mainstream education provision, poor attendance, moved schools several times
- The high level of young parents not in education, employment or training (NEET) between ages 16-18 years
- The low number of young people reporting through SHEU survey who knew where to access sexual health or contraceptive advice/clinic and who had knowledge about STIs and contraception
- The impact of the changes made to the local Sexual Health Service offer this year, and the current challenges with access

- Lack of marketing and communications of the local sexual health offer to young people
- Reduced access to high street emergency contraception
- Lack of a condom scheme in non-health settings
- Transition issues for young parents when they moved from Children's to Adult services at 18+
- Need for greater multi-agency working and a clear lead agency for teenage parents
- Need to map the two termination of pregnancy pathways alongside the sexual health pathway to ensure timely consistent place based services

5 The 10 KEY FACTORS FOR ADDRESSING TEENAGE PREGNANCY

5.1 Public Health England has identified 10 key factors when addressing teenage pregnancy in a system based way and these have been incorporated into the implementation plan based on learning and insight gained through the deep dive for Southend:

4 IMPLEMENTATION PLAN

4.1 The implementation plan has taken into account the 10 key factors for addressing and the specific findings from the deep dive.

4.2 The plan factors in a need to benchmark and map the current position and to work collectively to identify gaps with the ultimate aim to have a clear pathway with transition points

4.3 To develop an approach to monitor outcomes and inequalities in this group at a systems level

5 FINANCIAL / RESOURCE IMPLICATIONS

5.1 None at this stage

6 LEGAL IMPLICATIONS

6.1 None at this stage

7 EQUALITY & DIVERSITY

Pregnancy and maternity are protected characteristic and fall formally under the Equality Act in addition to age. Young Parents face many adversities and there are well recognised inequalities for both young parents and children of young parents.

8 APPENDICES

Please see the attached *Teenage Pregnancy and Young Parents Implementation Plan 2020-2021*

Teenage Pregnancy and Young Parents Implementation Plan 2020-2021

Outcomes	To continue a downward trend in teenage conceptions To prevent unintended pregnancies from occurring Improve outcomes for young parents and their children
How are we going to achieve this?	Establishment of a Teenage Pregnancy & Young Parents Working Group with senior Member leadership to: ▪ Bring together a full range of services and organisations involved in the delivery and commissioning of the teenage pregnancy and young parenthood pathways ▪ Delivering a whole system approach towards teenage pregnancy prevention and support of young parents ▪ Adopting a clear governance framework for working together and monitoring outcomes at system level

	Recommendation	Activity	Timeline	Officer	RAG
Leadership	Re-establishment of a teenage pregnancy and young parent working group with a Member as chair	Provide senior level oversight at system level	October 2020	EBD	
Commissioning and Pathways	Map the service offer for those services providing teenage pregnancy prevention work and/or supporting young parents for: Clear pathways and transition arrangements Consistency of offer and age range Accessibility and visibility User feedback and co-production where appropriate to ensure young people friendly services. Gaps and opportunities Outcomes and data collection	Sexual health service offer and recommissioning of a new service	April 2021	YP	
		Termination of pregnancy services	January 2021	CM/SDF	
		Sanctuary Housing and Housing Solutions	March 2021	CM	
		Early Help Teenage Parent Surt and Connexions	November 2020	CC	
		ABBS Teenage parent pathways and • 0-19 Universal Public Health Nursing Services • Family Nurse Partnership	December 2020	WB/DP	
		Universal Services offer • 0-19 Public Health Nursing • Children's Centres	December 2020	DP/EH	
		Maternity pathway	January 2021	PH	
		A Better Start Southend – Preparation Parenthood	December 2020	WB	
		School based sexual health service	March 2021	YP/SDF	
		Condom distribution scheme	March 2021	SDF/LH	

		Pharmacy -Emergency contraception	October 2020	SDF	
Data and intelligence	Review data collection and development of a local dashboard *recognised lag time in some data	Contribution to the Joint Strategic Needs Assessment Considering what collective outcomes can be measured in relation to known inequalities for young parents ▪ Emotional wellbeing ▪ Domestic abuse ▪ Poor educational attainment and high levels of NEET ▪ Low aspirations	February 2021	SDF/TD	
Prevention	Relationship & Sexual Education	Ensure that school based relationship and sexual education in schools and colleges are a high quality	December 2020	LH /CB/AC	
		Ensure that those YP not accessing mainstream education are provided access, advice and guidance and an opportunity to explore healthy relationship	December 2020	LH/CB/AB	
		Review the targeted prevention offer for young people ▪ Young girls with risk taking behaviour ▪ Children Looked After ▪ Young people outside of mainstream education ▪ Electively home educated ▪ Poor attenders of school or not meeting expected progress age 11-14 with other risk factors (girls) ▪ Young people with special educational needs ▪ Young people who have moved schools multiple time	December 2020	LH/AB/CB/BK	
	Ensure that workforce, schools and parents are prepared to engage with children and young people and able to talk about relationships and sex education including prevention and	Develop a range of training, advice and support options for relationship and sex education for non- health professionals, education and youth services	January 2021	LH/AB/CB/GW/B	
		Develop a programme to support parents to	January 2021	LH/GW	

	access to services	discuss relationship and sexual health with their children & young people			
Communications & marketing	Develop a communications plan with partners including: young people, schools network and a range of professionals	Ensure consistent messages and service publicity to young people, parents and practitioners to ensure that services are easy to identify, access and well published in Southend through a robust marketing and communication strategy	April 2021	YP/SDF	
Support teenage parents	Clear pathways and transitions	Sexual health pathways in place for young parents for prevention of subsequent pregnancies through accessible emergency contraception and long acting reversible contraception. Develop multi-agency working arrangements, caseload analysis and information sharing framework to reduce silo working and disjointed family plans	January 2021	HO/TS/DP/Provider	

Partners

Wendy Bailey – A Better Start Southend
Cathy Braun (CB) – Head of Access & Inclusion
Erin Brennan-Douglas (EBD) – Senior Principal Public Health
Alex Bridge (AB) – Group Manager Early Help
Carol Compton- Head of Children's Services
Simon D Ford (SDF) - Health Improvement Practitioner- Advanced
Elaine Hammans- Head of Early Years
Lisa Holloway (LH) – Health Improvement Practitioner- Specialist
Binesh Kappan- Care Management 16+
Caroline McCarron (CM) – AD Commissioning
Heidi Overra (HO) – Teenage Parent Support Early Help
Deborah Payne- Clinical Lead 0-19 Public Health Nursing
Yvonne Powell (YP) – Lead Commissioner Sexual Health
Tracey Scanlon (TS)- Family Nurse Partnership Supervisor
Geri Walsh/Hannah Hayes- School Nurse Team Lead

This page is intentionally left blank

Mid and South Essex Health and Care Partnership

7

Southend Health and Wellbeing Board
8th September 2020

TITLE:	Diabetes: prevention and Mid and South Essex HCP Framework
AUTHOR:	Paris Moakes, Network Quality Improvements Manager, Mid & South Essex HCP
PRESENTED BY:	Tricia D'Orsi, Interim Deputy Accountable Officer, CP&R and Southend CCGs
FOR:	AGREEMENT

---

1. Summary

1.1 With an increased prevalence of Diabetes indicated in Mid and South Essex over the next 5 years it is expected that there will be significant impact on the health and social care system to effectively deliver to the needs of people with this long-term condition. Failure to meet these needs is not acceptable and would have a severe impact on the populations health outcomes and increase costs to the NHS and partners significantly. It is therefore required that we take a structured approach to managing and improving Diabetes care within the system.

1.2 The Mid and South Essex Diabetes Framework has been developed to encompass key evidence-based information and Diabetes statistics regarding prevalence, demographics and health care target performance for the health and care partnership to inform health service requirement for the next 5 years. The key statistics indicate the requirements of the health care service to adapt and improve to meet the care and wellbeing needs of those at risk of, or living with Diabetes.

1.3 The framework intends to provide;

- Structure to deliver new collaborative models of integrated diabetes care to meet the needs of local people with diabetes
- Intention to improve the quality and consistency of services in line with both local and national standards and funding programmes
- Methods to deliver best outcomes for people living with diabetes or at risk of developing the condition across the Mid & South Essex HCP.

1.4 The framework and model of care will assist the HCP to identify priority areas and in doing so will help to achieve the requirements set out in the NHS Long term Plan, influenced by the changing demographics of diabetes and the economic case for change; a move to more person-centred care; and move to a population-based approach to health and well-being.

1.5 The framework outlines some specific offers that are set to tackle issues in key stages of the Diabetes pathway and implement improvements that will impact patient outcomes, the key elements include;

- Prevention - Tackling obesity and social factors that lead to increased risk of Type 2 Diabetes
- Identification – Increased use of risk screening tools
- Management of Diabetes – Supporting people to pro-actively manage their condition better
- Complex Care – Fast and effective treatment and care associated with diabetes complications

1.6 Additionally, there are offers to support;

- Hard to reach groups and communities - To ensure equity of care across the system.
- Workforce - Development of the workforce including staffing levels, ensuring skilled, knowledgeable and competent workers are in place providing a high-quality service.
- Data and technology – To be data driven and embrace and implement effective new technologies where suitable and relevant.

2. Introduction

2.1 Diabetes is a common and complex multisystem condition that affects people of all ages and backgrounds. Whilst many people with Diabetes live well, others face significant challenges or develop serious long-term complications that impact on health and wellbeing and contribute to the difficulties of living with a life-long condition.

2.2 Mid and South Essex Health and Care Partnership share an ambition to work together and with the local populations to deliver new models of integrated diabetes care. The approach will be based around the needs and location of the people, rather than boundaries of organisations and will focus on prevention and supporting the strengths of communities and individuals.

2.3 In Addition, the development and subsequent maturity of Primary Care Networks (PCN’s) will build upon core primary care services and enable greater provision of proactive, personalised, coordinated and integrated health and social care providing seamless pathways for patients with long term conditions including diabetes.

2.4 The overall aim of the diabetes framework is to improve quality and consistency of services in line with both local and national standards and funding programme; to deliver best outcomes for people living with diabetes or at risk of developing the condition. Whilst also acknowledging that people, empowered through self-management, can optimise their personal health, well-being and quality of life.

2.5 The framework and model of care will assist the HCP to identify priority areas over the next 5 years and in doing so will help to achieve the requirements set out in the NHS Long term Plan; influenced by the:

- Changing demographics of diabetes and the economic case for change;
- Move to more person-centred care; and
- Move to a population-based approach to health and well-being.

2.6 Once agreed this document will be used as the foundation to enable development of local implementation plans.

3. Body of the report

3.1 Nationally there are 3.7 million people diagnosed with diabetes and an estimated further 1 million people who have diabetes but are undiagnosed and this is thought to rise to over 5 million by 2025, meaning diabetes is a significant health and resource risk (Diabetes UK 2019). The costs of diabetes to the person living with the condition, to family members and the system are significant. Complications arising from diabetes take both a personal and societal toll on those affected.

3.2 The monetary cost of Diabetes to the NHS each year is around 9% of the National Budget, and around 80% of diabetes costs are currently being spent on treating its complications, many of which are avoidable.

3.3 In Mid and South Essex, there are approximately 61,300 people living with either Type 1 or Type 2 diabetes. Around 5300 have Type 1 and 56,000 Type 2. A considerable number of people are thought to be at high risk of developing Type 2. If incidence continues at the same rate or more, there will be over 90,000 people living with diabetes in Mid and South Essex by 2025. (statistics from the Mid and South Essex Diabetes Framework 2019).

3.4 In 2017/18, the financial cost of diabetes care across the HCP economy was approximately £27.6m, split between community and acute contracts and prescribing. The latter being the largest cost to the system at £19.5m, followed by non-elective inpatients at £2.1m (based upon primary diagnosis) for which amputations and hyperglycaemia were the highest cause of admission.

3.5 At an average of 6.6%, the prevalence of diabetes in the population aged 17 years and older in Mid and South Essex HCP is broadly in keeping with the England average of 6.8%. The CCG prevalence range from 6.4% in Mid Essex and Basildon and Brentwood to 7.2% in Castle Point and Rochford.

3.6 Factors that influence the prevalence of Type 2 diabetes are:

- Obesity accounts for 80-85% of the overall risk of developing the condition
- Deprivation (obesity, physical inactivity and a diet low in fruit and vegetables, association with risk factors for poor diabetic outcomes from smoking and hypertension)

3.7 The outlook for Mid and South Essex in regards to these factors;

- Southend-on-Sea and Basildon are forecast to continue having the highest and largest increasing proportion of overweight or obese adults in the M&SE catchment area.

- Basildon has the lowest proportion of adults physically active and eating healthily, and the largest decrease across the STP since 2015/16.
- Maldon and Thurrock were the only districts of the HCP with a higher proportion of overweight or obese children than England in Reception and Year 6, respectively.

3.8 Mid and South Essex faces a significant challenge in meeting the growing demand upon its Diabetes services and population health and in order to identify, frame and highlight the specific health service needs the Mid and South Essex Diabetes framework was developed.

3.9 The framework offers an evidenced based view of Diabetes population data and provides a dossier of considerations required to safely manage the health of the Diabetic Population. It sets out to improve the health and wellbeing of those at risk of developing and those living with Diabetes and strive for equity of care across the whole of the M&SE Health and Care Partnership. It specifically highlights hard to reach groups including the prevalence within these groups and challenges faced to provide a consistent approach to care delivery. The goal of the framework is to channel an approach with the collective knowledge of people to make lasting improvements that are; person-centred, equitable and outcome orientated.

3.10 There are several elements associated with key stages of the diabetes pathway, these are listed in the framework with specific intention to offer improvement;

Prevention and Identification

3.11 To prevent onset of Type 2 Diabetes by early identification of risk factors associated with Diabetes, and providing the education and support for patients to take responsibility for their own health management where possible.

3.12 The specific offers of the Health and Care partnership for prevention as listed in the framework;

- Alignment with the HCP Population Health Management and prevention strategy and self-care JSNA to embed a more proactive approach to person centered prevention and early intervention practice
- Development of professional facing information intended to inform and support professionals to deliver health improvement.
- Promotion of public -facing information intended directly for members of the public appropriate needs, age, language and culture.
- Increased use of risk screening tools within primary care with a focus on high risk groups

Management of Diabetes

3.13 Supporting people to proactively manage their condition more effectively through helping patients to understand their Diabetes, leading to better informed lifestyle choices and control.

3.14 The specific offers of the Health and Care partnership for management of Diabetes as listed in the framework;

- Enhanced and improved access to structured self-management education programmes for people with diabetes, including the newly diagnosed.
- Annual or more frequent examination, as clinically indicated, offered to all people with diabetes.
- Variation in annual care processes and treatment targets is reduced across Mid and South Essex.
- Psychological and emotional support assessed as an annual care process.
- Consistent high-quality information provided to all at appropriate times in a variety of formats.

Complex Care

3.15 Tackling long term complications of diabetes including quick identification, fast and effective treatment and care including referrals to specialist service. The most common long-term complications of diabetes being; cardiovascular disease, diabetic nephropathy, diabetic retinopathy, Diabetic neuropathy, limb amputations, erectile dysfunction, diabetic ketoacidosis and gestational diabetes.

3.16 The specific offers of the Health and Care partnership to tackle complex care in Diabetes are as listed in the framework;

- Variation in quality of care, access and treatment is reduced across Mid and South Essex.
- People at high risk of developing lower limb problems are identified and managed within a revised foot pathway to ensure they receive the right care, at the right time and at the right place.
- Access to personal insulin pumps and technologies are made available to those suitable.
- Diabetes specialist leads are available in the community to advise and help treat those with complex care needs.
- In-hospital care for people living with diabetes but admitted for other reasons is improved by enhancing the Specialist Diabetes Teams to provide care, advice and support.

Hard to Reach Groups

3.17 With population trends indicating increased diversity there may be widening gaps in the health needs of different groups leading to different challenges to healthcare providers. In these groups there may people who are at high risk of developing diabetes and/or those who are in a position where diagnosis and management of Diabetes is difficult or inadequately provided. These groups include; Children and adolescents, older people in residential settings, people with cognitive impairment, people with learning disabilities, ethnic minorities and people from hard to reach communities.

3.18 The specific offers of the Health and Care partnership to support hard to reach groups are as listed in the framework;

- Appropriate diabetes services are in place to enable people from hard to reach groups to access required services.
- Clearly defined strategies to target hard to reach groups.
- Care home staff educated around the needs of residents with diabetes.

- Individuals with a cognitive impairment diagnosed with diabetes are supported by appropriately skilled teams to achieve treatment and goals.

Workforce

3.19 Ensuring that the workforce is of high-quality with a strong person focus and multidisciplinary integration to help achieve the best possible health outcomes for patients.

3.20 The specific offers of the Health and Care partnership regarding workforce are as listed in the framework;

- Staff coming into contact with people living with diabetes will have the skills and competence to understand their needs and ensure that these needs are met in a way that is person-centred, whatever their professional background.

Data and technology

3.21 A diabetes framework and care model need to be underpinned by effective (and easy to use) technology and information management to maximize success. With new technology being created we must embrace its potential to ease and better quality of care and assess the for implementation in practice.

3.22 The specific offers of the Health and Care partnership regarding workforce are as listed in the framework;

- New intervention and technologies, where appropriate and effective, will be used to support treatment and care for people living with diabetes.
- Information management will underpin the development of diabetes services.
- Diabetes health outcomes are evaluated so we can target and assist local areas in further need of support.

3.23 Implementation of the ask needs a considered approach with governance and timelines therefore it is intended that the we will work within the existing HCP governance arrangements, ensuring system approval and sign up, to achieve the optimum level of embedded success whilst acknowledging the move towards an Integrated Care System may require an element of flexibility to delivery.

3.24 The diabetes framework and model of care has a 5-year delivery plan which compliments the HCP Long Term Plan and strategies currently in development. However, due to the impact of COVID-19 on the health systems there has been delay in delivery to many of the expected time line deliverables listed in the report. With the severe impact that the pandemic has had on those with Diabetes including; prevalence of Diabetes in up to 1/3 of patients who died from COVID-19 and; the potential impact on those who have not received essential routine health checks, the framework is ever more relevant and important.

3.25 It is requested that the board approve the framework. Once agreed with all relevant boards and stakeholders this document will be used as the foundation to enable development of local implementation plans to deliver the aforementioned offers.

4. RECOMMENDATIONS

4.1 The Health and Wellbeing Board are asked to provide approval of the Mid and South Essex Health & Care Partnership Diabetes Framework.

5. List of appendices

- 2019 MSE STP Diabetes Framework Finals
- Appendix A Diabetes Overview in MSE
- Appendix B Diabetes Framework Elements and Requirements
- Appendix C National Framework and Standards
- Appendix D Prescribing Algorithm for the Treatment of Type 2 Diabetes in Adults

This page is intentionally left blank

Mid and South Essex Health and Care Partnership

MID & SOUTH ESSEX

DIABETES FRAMEWORK

NOVEMBER 2019

CONTENTS

1. INTRODUCTION

Diabetes is a common and complex multisystem condition that affects people of all ages and backgrounds. Whilst many people with diabetes live well, others face significant challenges or develop serious long-term complications that impact on health and wellbeing and contribute to the difficulties of living with a life-long condition.

Mid and South Essex Sustainability and Transformation Partnership (STP) share an ambition to work together and with the local populations to deliver new models of integrated diabetes care. The approach will be based around the needs and locations of people, rather than boundaries of organisations and will focus on prevention and supporting the strengths of communities and individuals.

In addition, the development and subsequent maturity of Primary Care Networks (PCNs) will build upon core primary care services and enable greater provision of proactive, personalised, coordinated and integrated health and social care providing seamless pathways for patients with long term conditions including diabetes.

The overall aim of the diabetes framework is to improve the quality and consistency of services in line with both local and national standards and funding programmes; to deliver best outcomes for people living with diabetes or at risk of developing the condition. Whilst also acknowledging that people, empowered through self-management, can optimise their personal health, well-being and quality of life.

The framework and model of care will assist the STP to identify priority areas over the next 5 years and in doing so will help to achieve the requirements set out in the NHS Long term Plan; influenced by the:

- Changing demographics of diabetes and the economic case for change;
- Move to more person-centred care; and
- Move to a population-based approach to health and well-being.

This document describes the principles that the system wishes to work under, defining how it will enable new ways of working, aligning with strategies under development and already in existence, such as;

- Mid and South Essex Primary Care Strategy
- Primary Care Network (PCN) development
- Mid and South Essex STP Long Term Plan 2019
- NHS Long Term Plan 2019
- Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021
- Southend 2050
- Digital Essex 2020;
- The strategy for Acute Service reconfiguration
- Essex County Council Organisation Strategy 2017-2021
- South East Essex Locality Strategy

Once agreed this document will be used as the foundation to enable development of local implementation plans.

2. CASE FOR CHANGE

2.1. BACKGROUND

Diabetes is a lifelong condition that causes a person's blood sugar (glucose) levels to become too high (NHS Net, 2018). Although high blood glucose levels are considered the main abnormality in diabetes, diabetes is more complex than just abnormal blood glucose metabolism alone and treatment of diabetes needs to consider multiple clinical factors. People who live with diabetes must learn to self-manage their condition for the rest of their life.

While services for managing diabetes are making a difference, existing resources are being pushed to the limit as the disease is diagnosed in more people and those already with the condition live longer and develop complications from the disease.

Diabetes can be broadly classified into 4 groups or types:

Type 1 diabetes:
Where the body's immune system attacks and destroys the beta cells in the pancreas that produce insulin. Although it can occur at any age, Type 1 diabetes is the most common type of diabetes affecting children and young adults. We don't know what triggers Type 1 diabetes but some people may be genetically predisposed and environmental factors, such as viral infections, may play a role. Type 1 diabetes is not caused by lifestyle factors and is neither preventable, nor reversible with lifestyle interventions. Type 1 diabetes must be treated with insulin therapy, which is given by injection.
Type 2 diabetes:
Where the body doesn't produce enough insulin or the body's cells don't react to insulin (insulin resistance). A number of factors increase an individual's risk of developing Type 2 diabetes, including age (the risk of developing Type 2 diabetes gets higher as we get older), genetic factors (ethnicity and family history), being overweight or obese, sedentary lifestyle and low levels of physical activity, as well as high blood pressure . Type 2 diabetes can be treated in different ways, including lifestyle interventions, diet and exercise, oral medications and injectable therapies, including insulin. *Type 2 diabetes is far more common than Type 1 diabetes. In the UK, around 90% of all adults with diabetes have Type 2 diabetes but 95% of children and 10% of adults who live with diabetes have Type 1 diabetes*
Gestational diabetes (GDM):
Is diabetes that occurs only during pregnancy. Some women have such high levels of blood glucose that their body is unable to produce enough insulin to absorb it all. Gestational diabetes requires highly specialist management during pregnancy but typically resolves as soon as the baby is born. However, women who have had gestational diabetes are at risk of developing Type 2 diabetes later in life.
Specific types of diabetes:
These include different types of monogenic diabetes, cystic fibrosis related diabetes and diabetes caused by rare syndromes.

2.1.1. PRE DIABETES

Many more people have blood sugar levels above the normal range, but not high enough to be diagnosed as having diabetes. This is sometimes known as pre-diabetes and places an individual at increased risk of developing full-blown diabetes. Factors that increase your risk for developing pre-diabetes are the same as those as for Type 2 diabetes.

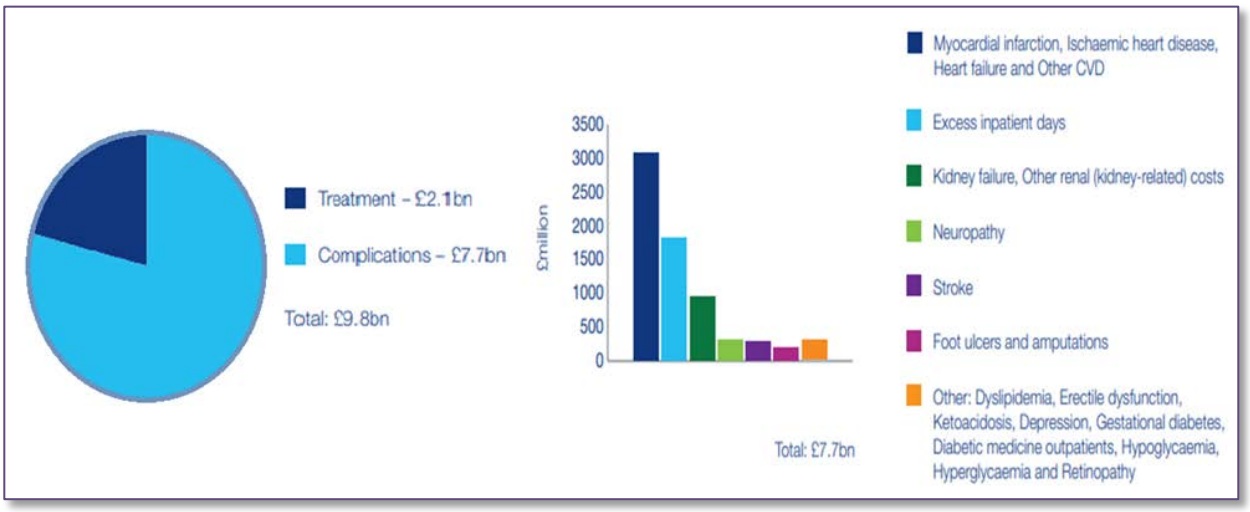
2.2. DIABETES IN MID AND SOUTH ESSEX

Nationally there are 3.7 million people diagnosed with diabetes and an estimated further 1 million people who have diabetes but are undiagnosed and this is thought to rise to over 5 million by 2025, meaning diabetes is a significant health and resource risk (Diabetes UK 2019).

The costs of diabetes to the person with the disease, to family members and the system are significant. Complications arising from diabetes take both a personal and societal toll. From visual loss to blindness, to lower limb amputation and dialysis, the complications are devastating. They affect productivity, quality of life, and personal relationships.

The cost of Diabetes to the NHS each year is £10 billion and around 80% of diabetes costs are currently being spent on treating its complications, many of which are avoidable (Diabetes UK, 2019). Whilst the figures below are cited from 2010 the position remains largely unchanged.

Figure 1: The cost of diabetes and diabetes complications to the NHS in 2010/11[1]



In Mid and South Essex, there are approximately 61,300 people living with either Type 1 or Type 2 diabetes. Around 5300 have Type 1 and 56,000 Type 2. A considerable number of people are thought to be at high risk of developing Type2. If incidence continues at the same rate or more, there will be over 90,000 people living with diabetes in Mid and South Essex by 2025.

Currently, health outcomes vary with some areas having higher than average emergency admissions and major and minor amputations. Good practice exists across the STP and there continues to be a number of initiatives that aim to improve care. However, the initiatives are not always co-ordinated and good practice is not always effectively shared or embedded across the STP.

2.2.1. STP FINANCIAL IMPLICATIONS

In 2017/18, the financial cost of diabetes care across the STP economy was approximately £27.6m, split between community and acute contracts and prescribing. The latter being the largest cost to the system at £19.5m, followed by non-elective inpatients at £2.1m (based upon primary diagnosis) for which amputations and hyperglycaemia were the highest cause of admission.

2.3. THE PREVALENCE OF TYPE 1 AND TYPE 2 DIABETES

At an average of 6.6%, the prevalence of diabetes in the population aged 17 years and older in Mid and South Essex STP is broadly in keeping with the England average of 6.8%. The CCG prevalence range from 6.4% in Mid Essex and Basildon and Brentwood to 7.2% in Castle Point and Rochford as depicted below:

Figure 2: Prevalence of diabetes within the Mid & South Essex STP (NDA 2017/18)

2017/18 Data	Number of Registered Diabetes Patients		Population Prevalence % (17+)	
	Type 1	Type 2	CCG	England
Basildon & Brentwood	1,150	12,550	6.4	6.8
Castle Point & Rochford	850	9,845	7.2	
Mid Essex	1,915	17,885	6.4	
Southend	770	8,565	6.7	
Thurrock	620	7,320	6.7	

In 2015, Public Health England produced population projections for the number of people aged 16 years or older who have diabetes (diagnosed and undiagnosed).[2] Against 2018/19 prevalence this *potentially* indicates a significant cohort, circa 20,000 individuals, who are currently living with diabetes undiagnosed and unregistered.

Although a significant proportion of diabetics are undiagnosed the National Screening Committee has been unable to find good evidence that screening of people without diabetic symptoms should be recommended.

2.4. RISK FACTORS FOR DIABETES

This section considers obesity and deprivation – two major risk factors for diabetes and poor outcomes. Comprehensive information about the full range of risk factors for all types of diabetes can be found in the NICE Clinical Knowledge Summaries.[3,4]

2.4.1. OBESITY

Obesity accounts for 80–85% of the overall risk of developing Type 2 diabetes.[4] Data indicates that at a population level an ever-growing proportion becomes overweight or obese as they age. The proportion of adults that are overweight in all but 3 local authorities (Rochford, Chelmsford, Brentwood) was higher than the across England (PH Fingertips).

This is forecast to increase across the STP:

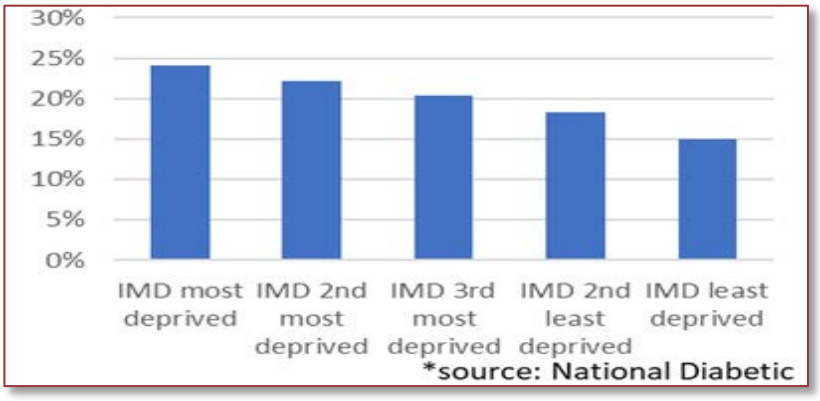
- Southend-on-Sea and Basildon are forecast to continue having the highest and largest increasing proportion of overweight or obese adults.
- Basildon has the lowest proportion of adults physically active and eating healthily, and the largest decrease across the STP since 2015/16.
- Maldon and Thurrock were the only districts of the STP with a higher proportion of overweight or obese children than England in Reception and Year 6, respectively.

2.4.2. DEPRIVATION

Deprivation is associated with risk factors for developing Type 2 diabetes - obesity, physical inactivity and a diet low in fruit and vegetables. Deprivation is also associated with risk factors for poor diabetic outcomes - smoking and hypertension.

The National Diabetes Audit data shows the social gradient in Type 2 diabetes. Those with Type 2 diabetes are more likely to come from areas of higher deprivation (figure 3). The Clinical Commissioning Group (CCG) within the STP with the highest average deprivation (Index of Multiple Deprivation, IMD) is Southend CCG. Mid Essex and Castle Point and Rochford CCGs have the lowest level of average deprivation.[5]

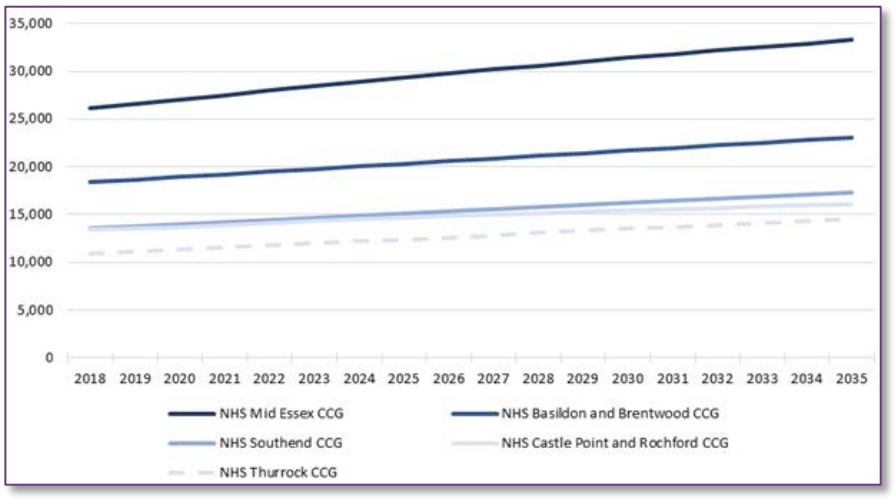
Figure 3: Proportion of type 2 diabetics by deprivation (2015)



2.5. PROJECTED TRENDS

The prevalence of diabetes over time is increasing in line with the national trend. This is driven by an ageing population and an increasing proportion that are overweight or obese. Figure 4 shows Public Health England's predictive model for diabetic prevalence in Mid and South Essex STP.[2]

Figure 4: Estimated number of people with Diabetes diagnosed and undiagnosed aged 16 and over by CCG (2015)



2.6. DIABETES: PROCESS MEASURES

2.6.1. CARE PROCESSES FOR PATIENTS WITH DIABETES AGE 12 & OVER (2017-18)

The proportion of diabetics receiving each of eight care processes recommended by the National Institute for Health and Care Excellence (NICE) are shown for Type 1 and Type 2 diabetics in figures 5 and 6.

In the latest National Diabetes Audit 92% of GP practices in the STP submitted data. This varied from 100% of practices in Mid Essex to 78% in Southend-on-Sea. Recording of the body mass index, urine albumin and foot surveillance are care processes with the most room for improvement.

The audit shows that the proportion receiving all 8 care processes across the STP ranges from 25% to 30% for Type 1 and 35% to 45% for Type 2. The England average is 40% for Type 1 and 60% for Type 2. Although the England figures are poor the STP figures are considerably lower.[6]

Figure 5: Percentage of Type 1 diabetics receiving each of the 8 care processes (National Diabetes Audit (NDA) 2017/18)

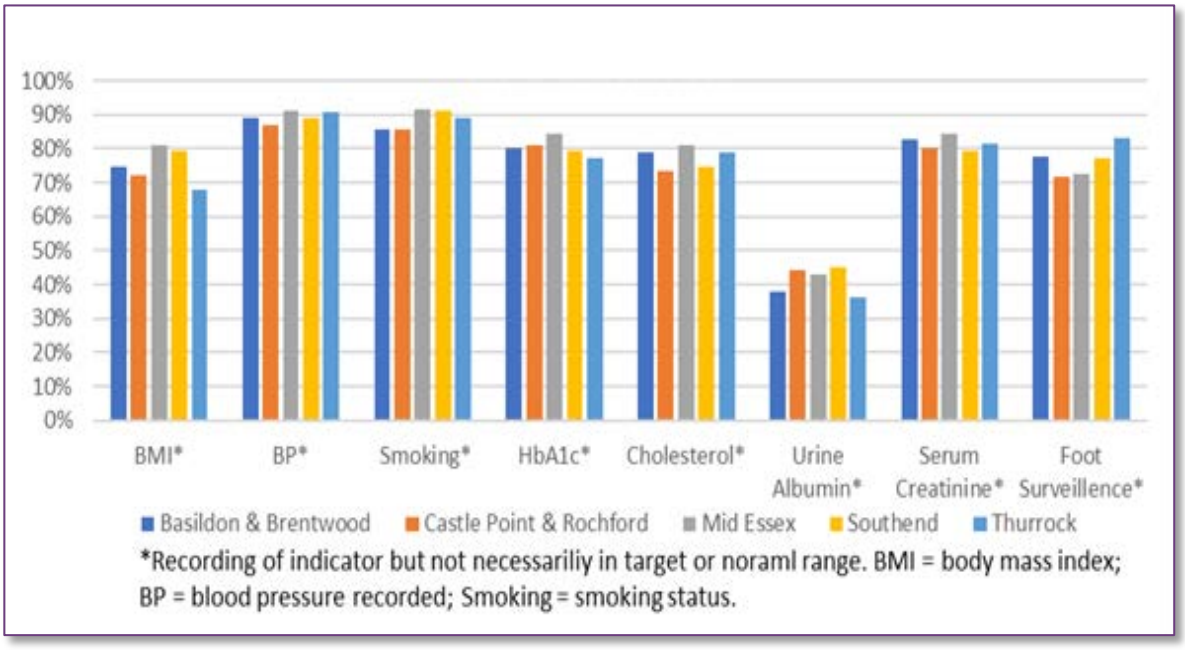
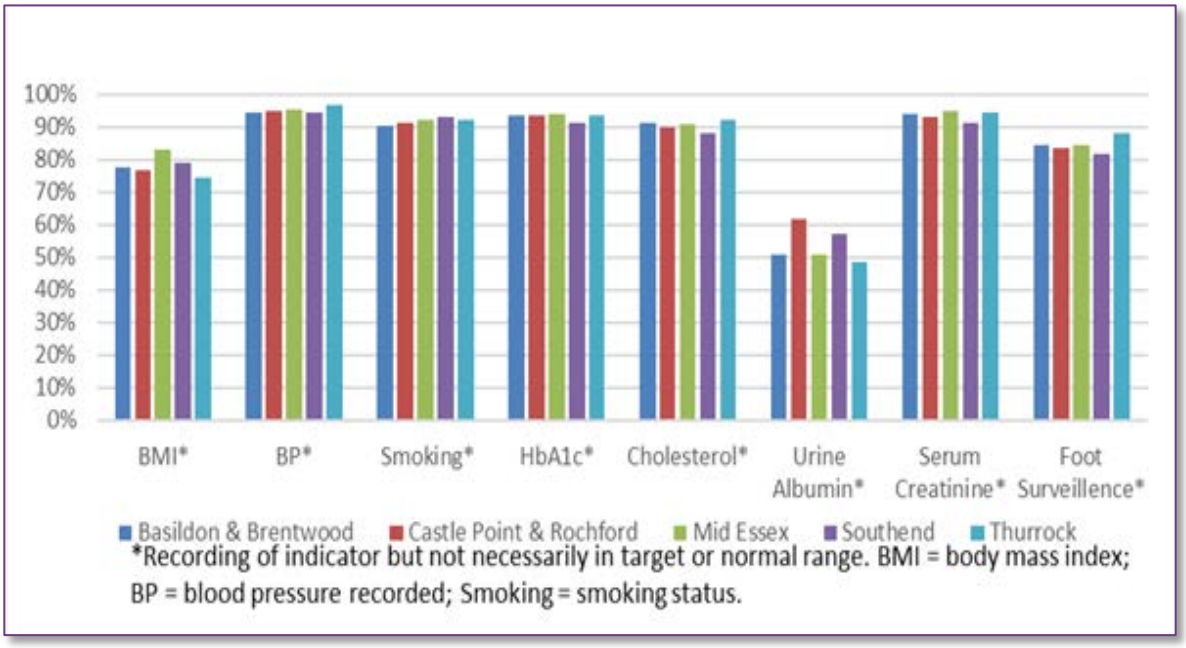


Figure 6: Percentage of Type 2 diabetics receiving each of the 8 care processes (NDA 2017/18)

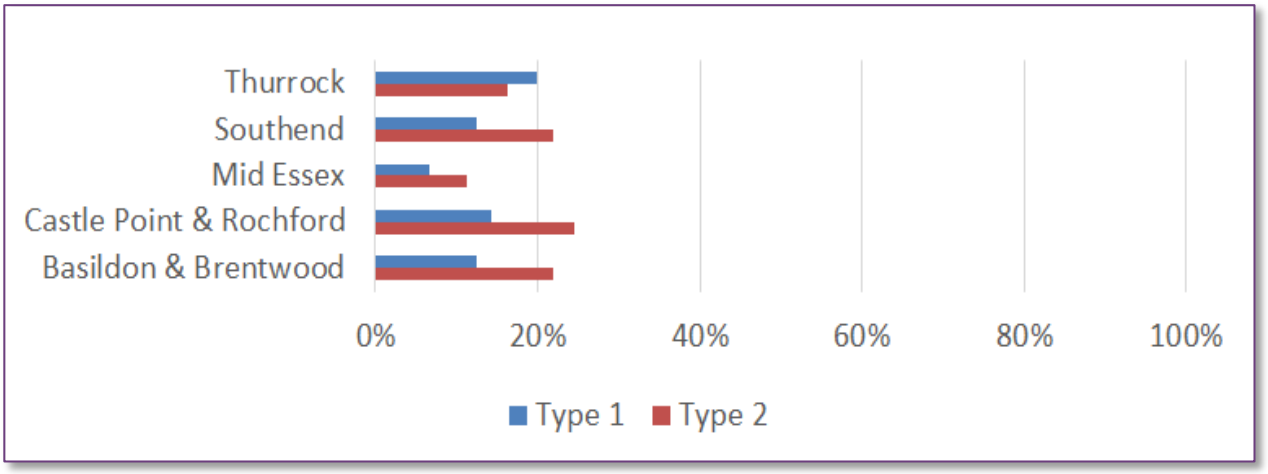


There is a ninth care process, retinal screening, commissioned and run centrally. All five CCGs are above national average (83.3%) for uptake of eye screening.

2.6.2. STRUCTURED EDUCATION 2017-18 – ALL AGES

Diabetes structured education courses deliver information, training and support on how to manage diabetes through diet, physical activity and medication. Essentially, they are providing the foundation support for diabetes self-management. Attendance at structured education sessions are captured in the National Diabetes Audit and shown in figure 7 below.

Figure 7: Percentage attending structured education within 12 months of diagnosis (NDA 2016)

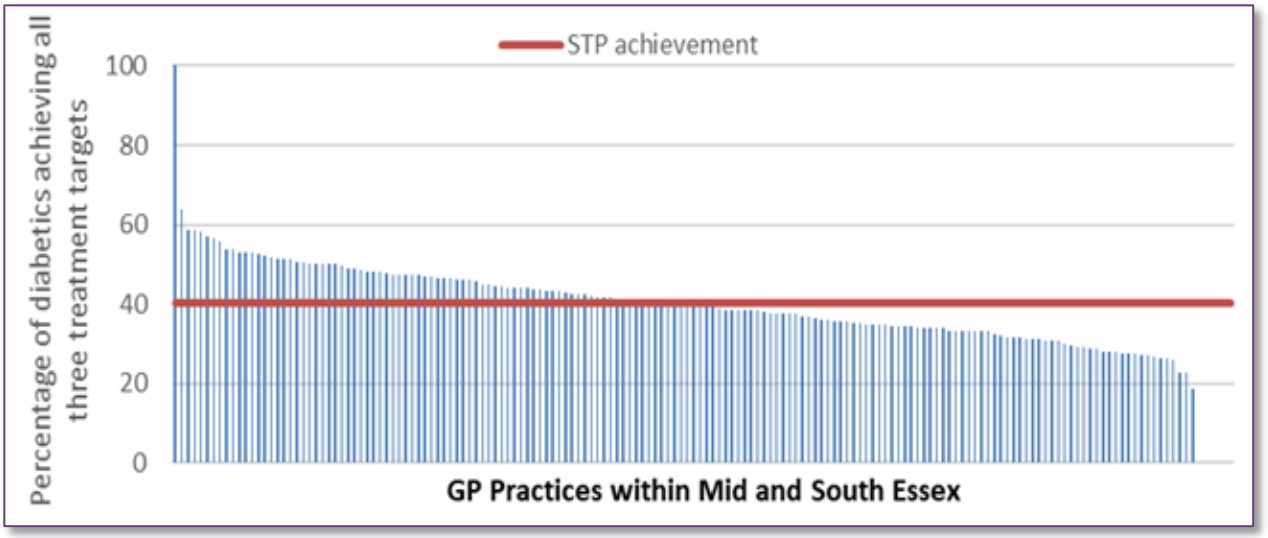


Although the numbers attending structured education is very low the STP does outperform the national averages of 5% for Type 1 and 9% for Type 2. This indicates that although there is great room for improvement this is something many areas struggle with.

2.6.3. TREATMENT TARGETS: PATIENTS AGED 12 AND OVER (2017 - 2018)

The proportion of diabetic patients achieving their treatment targets for HbA1c, blood pressure and cholesterol in 2017/18 are shown in figure 8, using data taken from the National Diabetic Audit. The performance in Mid and South Essex is similar to average in England. The wide variation across GP practices in the proportion of their Type 2 diabetics achieving all three care targets is shown in figure 8 below.

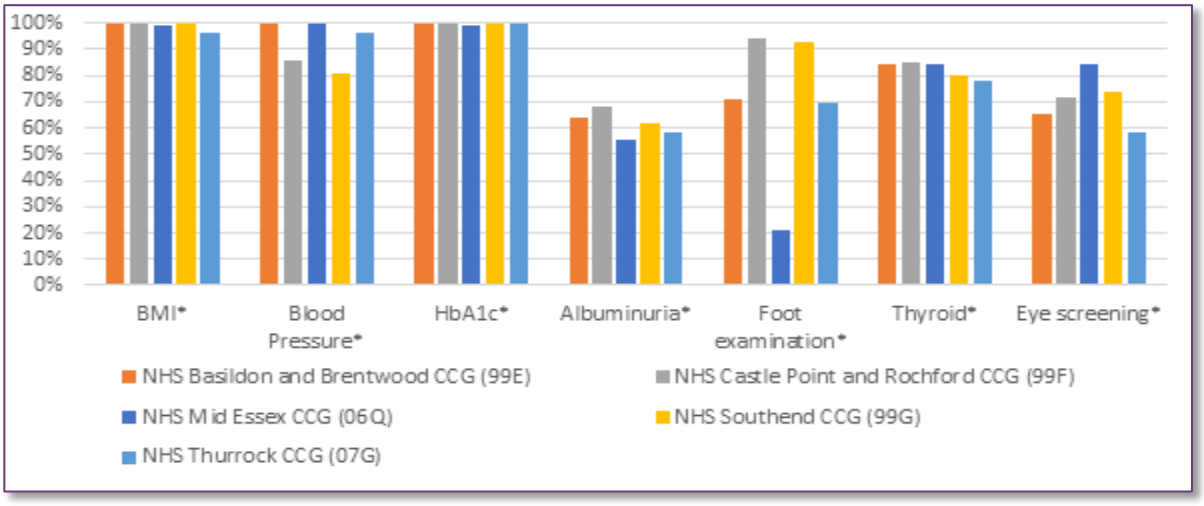
Figure 8: Variation for treatment targets for Type 2 diabetes by GP practice



2.6.4. THE NATIONAL PAEDIATRICS DIABETES AUDIT

The 2017/18 National Paediatrics Diabetic Audit captured information on all children and young people under the care of a consultant paediatrician. The data is submitted by paediatric diabetes units. The percentage of children and young people (aged 12 to 24) receiving the recommended key care processes is shown in figure 9.

Figure 9: Percentage of children and young people receiving each individual key care process, (NPDA 2017/18)



In this audit Mid Essex appears to be an outlier in the STP. In Mid Essex 21.3% of diabetes patients had foot surveillance.

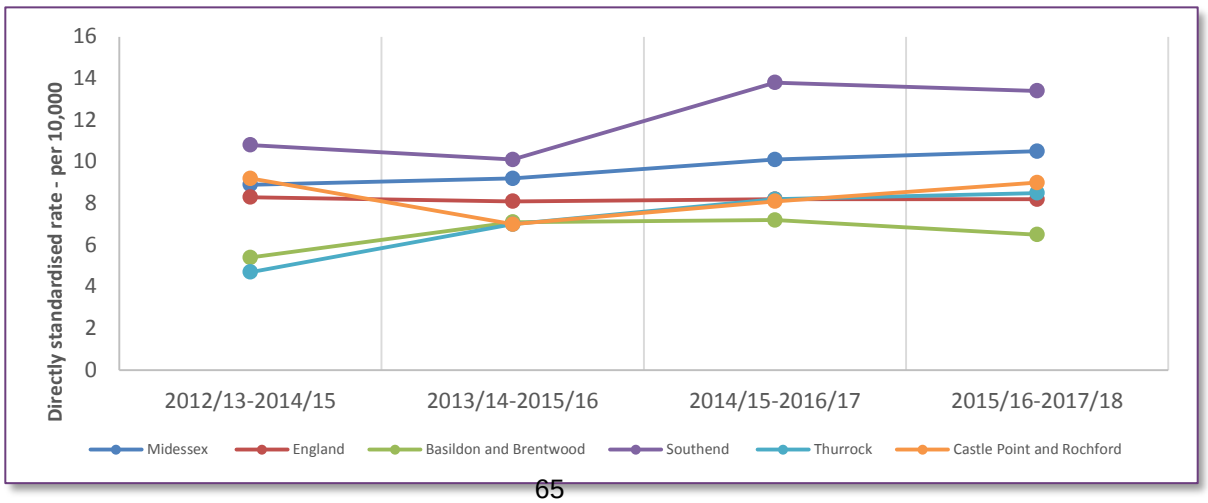
2.7. DIABETES: OUTCOMES

Data is regularly published on foot care of diabetic patients. Other health outcomes for diabetes patients, such as the excess death rate, are not published as frequently, with the most recent publication being 2015-16. For this reason, only foot care outcomes data is included.

Southend CCG is an anomaly when it comes to foot care. Whereas hospital spells for diabetic foot disease in the other CCGs of the STP are in single figures per 10,000 diabetics, Southend's figures are in the hundreds. Such a difference is most likely to be due to a data collection error, unless diabetic patients are systematically managed very differently in Southend compared to the rest of the STP.

The median length of hospital stay for diabetic foot conditions is also different in Southend CCG compared to the other CCGs in Mid and South Essex. The average stay in Southend is shorter. In 2015/16 to 2017/18 the median stay was 4 days in Southend whereas the range in other CCGs was 6 to 12 days. The need to understand how diabetic foot and leg management is managed in Southend CCG is highlighted by the very high rate of major lower limb amputation (defined as above ankle) for diabetes.

Figure 10: Comparison of Major amputations (2012 – 2018)



2.8. SUMMARY

There are a number of questions raised by our Public Health colleagues following analysis (within Appendix A) which need to be addressed collectively by the system if we are to understand the reasons for the variances across the STP. In doing so this will also provide opportunity to share good practice in high performing areas and agree uniformed approaches were appropriate.

However, it is apparent that there are several areas for improvement which require immediate focus and therefore will be prioritised in the implementation plans. They are as follows:

- Diabetes prevention and identification
- Improving quality and reducing variation in care for all people living with diabetes by:
- Improving the achievement of care processes
- Improving the achievement of treatment targets
- Improving access to structured education
- Reducing variation in adverse outcomes, with diabetic foot disease highlighted

More detail pertaining to these areas can be found in the core domain sections of this document.

3. FUTURE VISION

3.1. VISION

Our vision is to deliver the best outcomes for those across Mid and South Essex affected by diabetes or at risk of developing diabetes.

3.2. PRINCIPLES OF A SUCCESSFUL DIABETES CARE MODEL

In line with the Mid and South Essex STP Long Term Plan, the following conditions are critical for success:

- **Collaborative working to improve system outcomes**
  - *Working in partnership across all sectors to maximise the use of resources and technology, whilst encouraging co-ordination in healthy living, prevention, early identification and control of diabetes*
- **Leadership**
  - *Strong leadership and a joint shared vision for better care*
  - *Recognising the cultural differences between organisations and focusing on the shared care aims despite differences in language and process*
- **Integration and co-ordination of diabetes care across settings, technology and sectors**
  - *Establishing a multidisciplinary approach across providers: co-ordination is essential to ensure appropriate interventions, quality and continuity of care*
- **Facilitation of person centred care, empowerment and self-management throughout life**
  - *Ensuring individuals are at the centre of their own health care and should be supported to take responsibility to self-manage to the best of their abilities and personal circumstances*
- **Reduction of Health inequalities**
  - *Acknowledging the unique needs of hard to reach populations who experience higher rates of diabetes and complications and more significant barriers to diabetes care and support*
- **Measurement of health behaviours and outcomes**
  - *Working with academic health science partners to improve planning and provision and quality of diabetes care by promoting and applying evidence based research to support as well as drive change to enable measurement of progress, relevant data will be collected and analyse*

3.3. GOALS

Our approach is about channelling the collective knowledge and energy of people towards common goals and lasting improvement whilst ensuring the following are achieved:

- **Person-centred:** empowering the individual to adopt a healthy lifestyle and to manage their own diabetes, through education and support which recognises the importance of lifestyle culture and religion.
- **Equitable:** ensuring that services are planned to meet the needs of local populations, including specific groups within the population and are appropriate to individual's needs.
- **Outcomes orientated;** narrowing the inequalities gap between those groups whose outcomes are poorest and the rest: minimising the risk of developing diabetes and its complications and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care.

4. DIABETES FRAMEWORK

4.1. PURPOSE

The purpose of the diabetes framework is to improve the health and wellbeing of people with or at risk of developing diabetes; to keep people as healthy as possible for as long as possible and so reduce the incidence and impact of their long term condition. Through this framework we will help to achieve our wider STP organisational purpose which is to reduce inequalities by:

- Supporting healthy lives - through prevention of ill health, supporting physical activity, good diet, mental health etc
- Bringing care closer to home, via four 'places' and primary care networks
- Transforming and improving our services

4.2. FRAMEWORK

The diabetes framework is an evidence-based guide designed to support system professionals delivering care and services. *Ten elements* have been identified to describe the diabetes care model. All of these elements are recognised as existing good practice; as a result of a major collaborative effort among leading professionals across America taking into account international diabetes research (including the UK).[7] The framework has been reviewed by key diabetes professionals across the local system.

The framework will underpin a care model which will promote a collaborative effort to bring together all key requirements to ensure a coordinated and integrated approach; sustaining the provision of better care in a PCN setting.

4.2.1. ELEMENTS AND SUB ELEMENTS

The *ten elements* have been grouped into core domains associated with the key stages of the diabetes pathway i.e. Identification/Prevention/ Management and Complex Care.

Within each of the elements there are *sub elements and requirements* (see Appendix B for the complete framework). Many of these are well known and some CCG areas within the STP will have established several of these requirements already or are currently working towards them. However, all the elements need to be combined to generate improvements which can be embedded and address unwarranted variation across the system.

Ensuring that all framework requirements are met, by its very nature, will improve clinical and patient outcomes, help to drive quality and improve system performance. Where appropriate, key requirements will be taken forward on an STP footprint offering a consistent approach and equity of care.

4.3. ENABLERS

Whilst the framework is to be viewed as a guide, requirements in areas such as workforce and IT, data and technology will underpin success and help to fully realise the model of care. Enablers are factors which are embedded throughout the principles and goals and influence the ability to achieve success. Where appropriate requirements linked to established STP programmes of work will be managed through existing forums working with system/place and neighbourhoods to implement.

4.4. STANDARDS

The diabetes framework forms part of a suite of documents. All diabetes services will adhere to the local and national standards highlighted in Appendix C. Delivery of services against the quality standards set will be subject to robust monitoring and review.

Figure 11: Diabetes Framework: Core Domains, Elements and Sub Elements

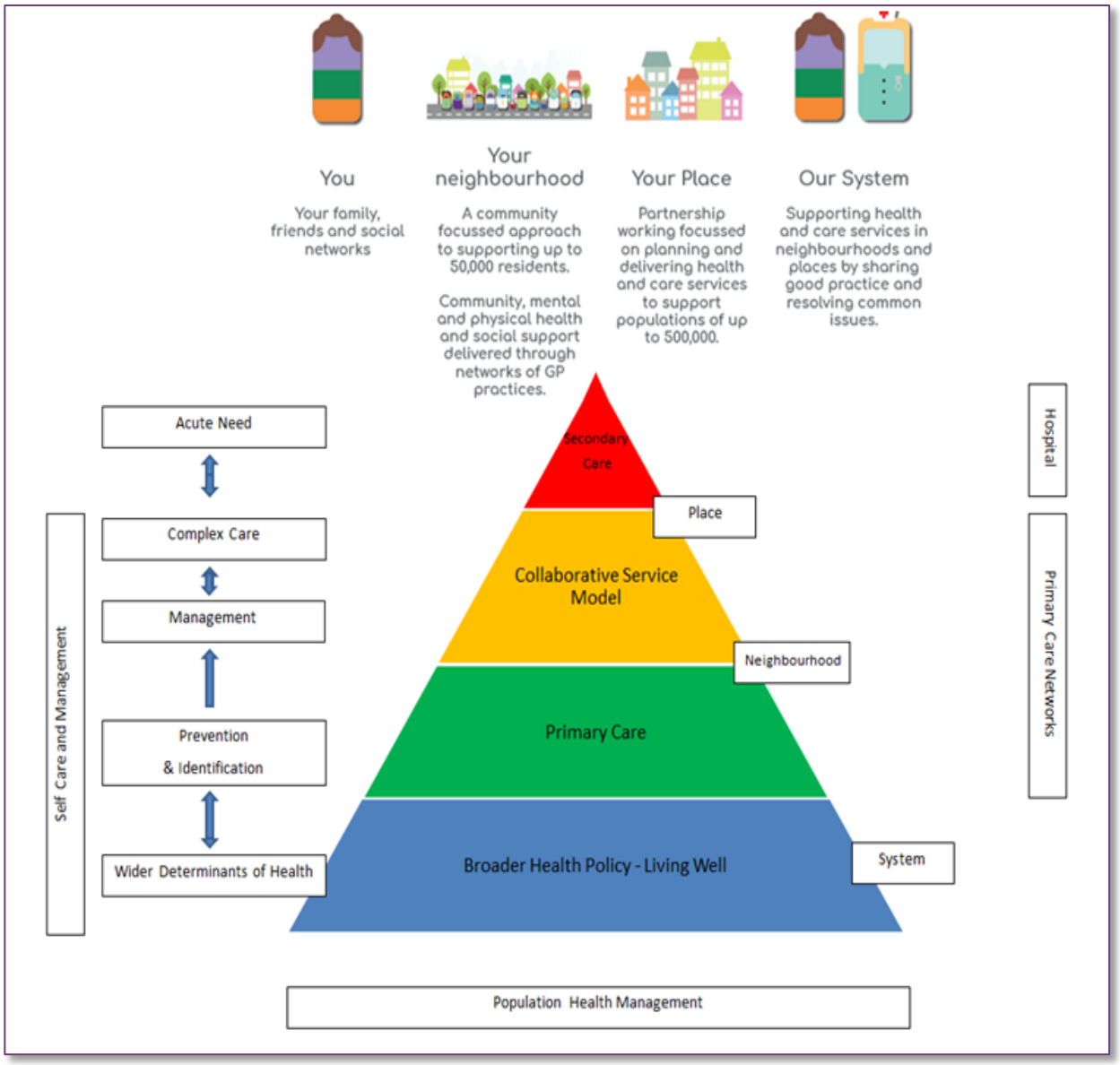
Core Domain	Element #	Element Name	Sub-Element
ELEMENTS			
IDENTIFICATION	1	Identification of People with Undiagnosed Diabetes and Prediabetes	Whom to screen for diabetes and prediabetes, and how often
			Screening tests for diabetes and prediabetes
			Screening for gestational diabetes
PREVENTION	2	Management of Prediabetes to Prevent or Delay the Onset of Type 2 Diabetes	National Diabetes Prevention Programme (NDPP)
			Weight loss and physical activity for prevention of type 2 diabetes
			Metformin for type 2 diabetes prevention
			Cardiovascular disease risk management
MANAGEMENT	3	Comprehensive, Patient-centred Diabetes Care	Consideration of health literacy and numeracy
			Consideration of patient self-management resources, including ability to afford care
			Annual comprehensive diabetes checks
			Type 1 specialist management
			Comprehensive and coordinated management of co-morbidities
	4	Ongoing Self-management Education and Support for People with Diabetes	Definition and purpose of diabetes self-management education and self-management support
			How to provide self-management education and support
			Community-based and other resources
	5	Lifestyle Modification for People with Diabetes	Provide nutrition therapy and monitoring
			Helpful eating behaviours and practices for glycaemic control
			Encourage physical activity
			Goal setting
			Appropriate precautions
	6	Overweight and Obesity in the Management of Diabetes	Assessment of overweight and obesity
			Lifestyle interventions
			Helpful behaviours and practices for weight loss
			Pharmacotherapy
			Bariatric surgery
	7	Blood Glucose Management for People with Diabetes	Benefits of blood glucose control
			Risks of blood glucose control
			Treatment goals
			Blood glucose management strategies
			Blood glucose assessment
COMPLEX CARE	8	Multifactorial Cardiovascular Disease Risk Reduction	Evidence for blood pressure control
			Evidence for lipid therapy
			Smoking cessation
			Multiple risk factor reduction and the importance of assessing medication adherence
	9	Diabetes Microvascular Complications and Treatment	Hypoglycaemia
			Diabetic ketoacidosis (DKA)
			Nephropathy
			Retinopathy
			Neuropathy
			Foot Care
HARD TO REACH GROUPS	10	The Needs of Special Populations with Diabetes	Children and Adolescents
			Women of childbearing age
			Cognitive Impairment
			Learning Disability
			Older adults
			High-risk racial and ethnic groups
ENABLERS			
WORKFORCE	11	How the health and social care workforce can meet the needs of those with Diabetes	Leadership and Management
			Skills, Competences and Roles
			Training and Development
			Collaborative working
DATA & TECHOLOGY	12	How the use of data and technology can meet the needs of those with Diabetes	Making better use of Data
			Creation of Single Shared Care Record
			Use of technology to maximise patient care and services

5. MODEL OF CARE

The diabetes framework will be delivered within a model of care based on 4 tiers: broader determinants, including prevention; primary care (neighbourhood /practice level), community care via a collaborative service (PCN/place) and hospital care. According to their individual needs, a person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future.

The collaborative service will be provided by a comprehensive diabetes skilled multidisciplinary team. Collaborative care by its definition requires all professionals involved in a person's care to work in partnership, including generalists, specialist, other health professionals and support staff, with the person living with diabetes and his/her family at the centre of their care. The workforce will be upskilled within the collaborative service to provide more specialist care in the community.

Figure 12: Diabetes Model of Care



Where appropriate the STP will agree upon a Mid and South Essex approach to elements of the model such as the wider determinants of health. All tiers will be underpinned by a population health management approach led by the system with self-care and management being a fundamental component throughout.

5.1. PRIMARY CARE NETWORKS

Primary Care Networks will form the vehicle for delivering collaborative working amongst front-line staff. Through PCNs we deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Through PCNs we move to a GP led model of care focused on improving population health and wellbeing, and supporting provider sustainability. Primary Care Networks will be the foundation stone on which local places will thrive and the key provider vehicle for delivering local services.

We see PCNs as more than just a collaboration amongst practices. At their core they will become a collaboration amongst those who positively impact on their populations health and wellbeing. This includes other significant incumbent providers of health and care, education providers, major employers, the third sector and community groups. PCNs are seen as a vehicle to bring together the wider network of primary care providers - community pharmacists, optometrists and dentists.

5.1.1. DEVELOPMENT

PCN development will be evolutionary. It is accepted that sustainable change will not be achieved through a short-term, rapid, development programme, but one that take all partners on a journey that results in embedded cultural change, new ways of collaborative working and collective ownership.

For 2019/20, the first year of a five-year development programme, the focus will be to ensure:

- Practices within the PCNs are clear on the long-term ambitions
- PCNs take 'a seat at the table' and ensure they have the required competencies
- The role of the Clinical Director is clear and there is good succession planning
- True collaborative multi-disciplinary working not "the MDT"

Whilst PCNs are in the early stages of development the STP will continue to work with the system at both place and PCN levels to support and embed change and ensure the key requirements of the framework are delivered to improve local population health.

The 5 year aim is to move towards the model of care as outlined above, the commercial vehicle to do so is yet to be determined.

5.2. STP ALIGNMENT

Significant work is underway at an STP level to support the Long Term Plan. The intention of the diabetes framework and model of care is to compliment, support and, where appropriate, provide opportunities to act as a 'test bed' for proposed approaches.

Key workstreams of note are:

5.2.1. POPULATION HEALTH MANAGEMENT (PHM)

A Population Health Management approach develops and maximises capacity and capabilities from across the STP around infrastructure, intelligence and interventions. These building blocks can support the use of linked data to provide analytics for the targeted use of evidence-based clinical and non-clinical support for the population to manage their own health, to prevent avoidable illness and improve their health and wellbeing.

The strategic aims of the STP's PHM programme are:

- **Collaboration** – a system which works as 'one' to deliver the best outcomes for the population, through the sharing of data and resources through strong leadership at all levels
- **Data** – maximising the data assets from across the system partners by linking at record level to generate valuable insight to truly understand the needs of the population
- **Integration** – evidence-based interventions, applied from person to system level which proactively address needs and are outcomes focussed

- **Empowerment** – establishing new relationships between organisations, workforce and the population where people feel in greater control of their own health and care and practitioners have the time, resources and skills to support a strength-based care model

5.2.2. STP SELF CARE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The NHS healthcare system recognises that a shift away from the' medical model' and towards one that takes into account the expertise and resources of the people with long term conditions (LTCs) and their communities is now required.

The STP Self-care JSNA will provide an evidence base for the development and improvement of care and the ways in which we support and empower patients to self-manage long term conditions (LTCs). Diabetes is one of three LTC focus areas and the recommendations from this work will be considered with partner organisations and adopted where appropriate, at either a PCN and/or Place level.

6. PREVENTION & IDENTIFICATION

STP Offer:

1. Alignment with the STP Population Health Management and Prevention strategy and Self Care JSNA to embed a more proactive approach to person centred prevention and early intervention practice.
2. Development of professional-facing information intended to inform and support professionals to deliver health improvement.
3. Promotion of public-facing information intended directly for members of the public appropriate to needs, age, language and culture.
4. Increased use of risk screening tools within primary care with a focus on high risk groups
5. Increased referral to the National Diabetes Prevention Programme for those at risk of developing Type 2 diabetes.
6. Appropriate diabetes testing for all pregnant women

Understanding the wider context in which health and well-being is shaped is crucial if we are to effectively tackle the challenges of diabetes. Factors that play a part in determining our health and well-being include income, employment status, educational attainment, and our living, working and environmental conditions, all of which impact on the level of control people have in their lives and the choices they are in a position to make. The impact of lifestyle factors is a major contributor to the increasing prevalence of Type 2 diabetes.

6.1. PREVENTION

To prevent onset of diabetes the STP ambition is to concentrate on person centred care and self-management approaches throughout a person's lifetime to ensure:

- Individuals are at the centre of their own health and healthcare
- People are supported to take responsibility for their own care

Type 1 diabetes is caused by a loss of the body's ability to produce insulin and can only be managed by replacement insulin therapy. At present, there are no interventions known to prevent or reverse Type 1 diabetes. We will continue to ensure we are kept abreast of national changes to this pattern of thinking.

The onset of Type 2 diabetes, can in many cases, be prevented or delayed. The prevalence of risk factors and expected population ageing, means it is essential that we support and encourage diabetes prevention. There are a number of risk factors for diabetes, some of which are preventable, such as weight gain around the middle (central obesity), high cholesterol/triglyceride levels and high blood pressure. Losing weight, adopting more activity into your day, stopping smoking and reducing alcohol intake can also help towards lowering the risk of developing Type 2 diabetes mellitus and improving all-round health.

Multiple strategies are needed in multiple settings if we are to slow the predicted prevalence growth. Many of the risk factors for diabetes are common to other disease areas, such as heart disease, stroke and cancer; therefore it is clearly worthwhile having cross-cutting prevention strategies, as well as targeted approaches to diabetes.

The framework and model of care promotes an integrated working with partnership organisations to reach across the entire STP population, promoting healthy living for people of all ages, as well as developing a portfolio of targeted interventions, including the National Diabetes Prevention Programme (NDPP), aimed at supporting people identified as being at high risk of developing Type 2 diabetes.

6.2. IDENTIFICATION

Raising awareness of the symptoms and signs of diabetes among the public, particularly among sub-groups of the population at increased risk of developing diabetes, and among professionals can help to ensure that people with symptoms and/or signs of diabetes are identified as early as possible.

People who have multiple risk factors for diabetes – such as family history, ethnic background, obesity, increasing age – need advice and support to reduce their risk of developing diabetes and information about the symptoms and signs of diabetes. In addition, opportunistic screening (testing for diabetes when people are in contact with health service for another reason) will identify some people within high risk groups who do not know that they have the condition.

All health professionals are in a position of identifying those at risk of diabetes. Dentists and opticians are in a good position to identify people with periodontal disease or retinal haemorrhage who may be showing risk factors for diabetes but who have not previously been identified.

Use of risk stratification tools within Primary care focuses on individuals at highest risk of diabetes, such as those with a family history of the condition or impaired glucose tolerance. This approach includes more focused interventions, such as health education and behaviour modification.

6.3. PREGNANCY

Women with pre-existing diabetes have more risks to themselves and their babies during a pregnancy. It is important that steps are taken to mitigate risk prior to pregnancy (i.e. through pre-conception care), during pregnancy and following delivery. Post-partum care may help to reduce the risk of maternal Type 2 diabetes in later life.

6.4. UNDIAGNOSED DIABETES

People with undiagnosed Type 2 diabetes are unaware of the condition and are therefore not accessing the necessary care. They may already have complications of their diabetes. A survey of Diabetes UK members diagnosed with Type 2 diabetes in a 12 month period (2009), found only 18% were diagnosed as a result of a routine test offered by the GP or practice nurse and 37% were diagnosed as a result of having a test for another condition or problem. 56% were “highly unaware” or “unaware” of the symptoms. Only 16% were diagnosed because they asked their doctor for a test or went to the GP because they had symptoms of diabetes.

By providing information, increasing awareness and early detection of Type 2 diabetes, people can be supported to make informed health-related decisions and actions, and this will improve health literacy.

7. MANAGEMENT OF DIABETES

STP Offer:

1. Enhanced and improved access to structured self-management education programmes for people with diabetes, including the newly diagnosed.
2. Annual or more frequent examination, as clinically indicated, offered to all people with diabetes.
3. Variation in annual care processes and treatment targets is reduced across Mid and South Essex.
4. Psychological and emotional support assessed as an annual care process.
5. Consistent high quality information provided to all at appropriate times in a variety of formats.

Supporting people to manage their condition is a fundamental element of good diabetes care and central to the building of relationships in which people living with diabetes can understand and take control of their condition more effectively.

Helping people to understand their diabetes and recognise its effects and how these can be managed better, can help them develop the confidence to take increasing responsibility for managing their condition. For the individual this can lead to better informed lifestyle choices and diabetes control, reduced risk of complications, fewer GP visits and hospital admissions as well as an improvement in quality of life and general well-being.

7.1. DIAGNOSIS

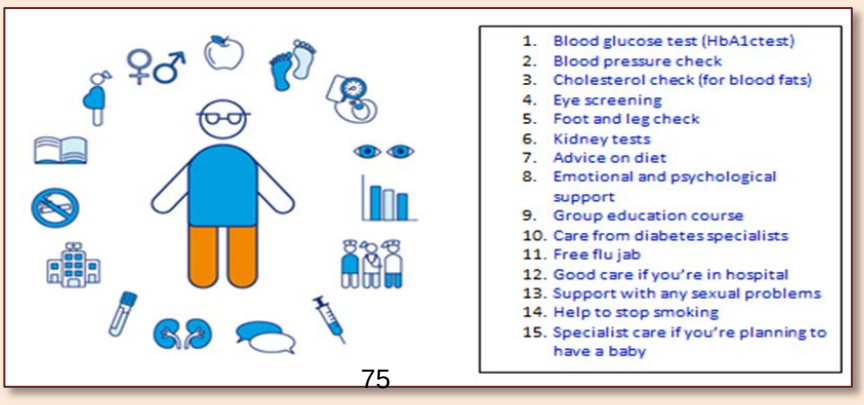
Following diagnosis, people with diabetes will be able to access high quality information, treatment and care and be supported to stay healthy and so minimise the incidence of complications. Information and education about the purpose and importance of medication should be stressed. Diabetes UK produces good quality information for people with diabetes through literature, a website and a helpline and people should be signposted to this organisation for support.

All people with diabetes will be offered advice about reducing their risk of long term complications and receive regular surveillance of risk factors. When risk factors are detected people should be supported in controlling these risks and, at an early stage, offered effective treatment to stop the progression of complications.

7.2. ANNUAL REVIEWS

Only one in five Type 1 and two in five Type 2 people are meeting their treatment targets that will reduce their risks of complications. (Diabetes UK, 2019).

Figure 12: 15 Healthcare Essentials (Diabetes UK)



People with diabetes will continue to be offered a number of annual healthcare tests as part of their ongoing care in accordance with NICE guidance. Diabetes UK, recommends the achievement of the **15 care processes** as a gold standard and have developed materials to help people with diabetes understand what they should expect of their care.

The Quality and Outcomes Framework (QOF) has been used to support improvements in care for diabetes and has resulted in improvements however, in some CCG areas, practices are achieving full QOF payments despite consistent underachievement in a number of the diabetes performance indicators (*see 2.6.1*). In Mid and South Essex, work will be done to improve the proportion of people receiving all care processes.

The Framework supports the gold standard approach, expanding traditional care processes to ensure learning and education and psychological and emotional support is considered annually as part of the care planning process. This will be reflected in an agreed and shared care plan in an appropriate format and language, where appropriate, parents and carers should be fully engaged in this process.

7.3. THREE TREATMENT TARGETS

NICE Guidelines recommend treatment targets for glucose control, blood pressure and cholesterol to help reduce the risk of future complications. If a person has prolonged periods of time with higher than normal glucose levels, high blood pressure or high cholesterol, it can eventually cause problems. Although local initiatives are underway to improve the attainment of the **3 treatment targets** we will be much more ambitious in our developmental plans and share best practice learning across the STP.

7.4. STRUCTURED EDUCATION

Structured education improves diabetes management and is likely to reduce diabetes complications. It leads to lifestyle changes conducive to good health, such as better nutrition and increased physical activity as well as improved compliance with medication and care processes. Structured education should be available to those newly diagnosed and existing people who have not previously attended.

There is provision of structured education within all CCG areas for people with Type 2 diabetes, although uptake remains suboptimal and efforts are being made to improve engagement and promote the importance of structured education as an element of routine diabetes care**.** The STP is to pilot electronic structured education via means of an app. If shown to be effective, electronic structured education *could* be offered to all those with diabetes, in addition to traditional face to face courses.

7.5. EMOTIONAL OR PSYCHOLOGICAL SUPPORT

Emotional or psychological problems are experienced by at least four in ten people with diabetes at any one time. This reduces their ability and motivation to self-manage, leading to poorer health outcomes and reduced quality of life (Diabetes UK). There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. Pilot schemes show providing such support improves health and cuts costs by 25 per cent (NHS 2016).[8]

People with diabetes experience disproportionately high rates of mental health problems such as depression, anxiety and eating disorders. A survey undertaken by Diabetes UK in 2015 found that 76 per cent of people with diabetes who needed emotional or psychological support from a specialist were not offered it.

At present, the availability of psychological support for people with diabetes differs across the STP. There is a need to raise awareness of the 'hidden problem' of depression and other psychiatric illness in diabetes and to introduce more active monitoring of psychological wellbeing.

Diabetes UK has introduced a new tool, Diabetes and Mood Information, and encourages mental health to be discussed at every appointment, referring the individual to local Improving Access to Psychological Therapies (IAPT) where appropriate.

7.6. PHARMACY AND PRESCRIBING

Due to the nature of diabetes and its management for the prevention of the development and progression of complications, there is a tendency for people with diabetes to receive polypharmacy. This may include treatment for hyperglycaemia, hypertension or hyperlipidaemia and symptom management of complications.

For many patients polypharmacy might be entirely appropriate.[9] There are many conditions in which the combined use of two, three or more drugs is beneficial and can improve outcomes especially in older people with multiple co-morbidities (for example, type 2 diabetes complicated by coronary heart disease and hypertension). However, it is important to consider whether each drug has been prescribed appropriately or inappropriately, both individually and in the context of all the drugs being prescribed.[10] See Appendix D Prescribing Algorithm.

Optimising prescribing in polypharmacy involves encouraging the use of appropriate drugs, in a way that the patient is willing and able to comply with, to treat the right diseases.

The community pharmacy is often a useful resource of advice and support for people with Type 2 diabetes. The average diabetes patient is known to visit the pharmacist between three to eight times more often than other patients. This creates various opportunities for community pharmacists to play an important role in the management of diabetes and its complication.

8. COMPLEX CARE

STP Offer:

1. Variation in quality of care, access and treatment is reduced across Mid and South Essex.
2. People at high risk of developing lower limb problems are identified and managed within a revised foot pathway to ensure they receive the right care, at the right time and at the right place.
3. Access to personal insulin pumps and technologies are made available to those suitable.
4. Diabetes specialist leads are available in the community to advise and help treat those with complex care needs.
5. In-hospital care for people living with diabetes but admitted for other reasons is improved by enhancing the Specialist Diabetes Teams to provide care, advice and support.

Diabetes is a major cause of premature mortality with over 500 premature deaths per week and doubles the risk of cardiovascular disease (heart attacks, heart failure, angina, strokes). For those people with Type 1 diabetes the risk increases four fold.

Diabetes is the most common reason for end stage kidney disease and the most common cause of blindness in people of working age. Up to 169 people per week have a limb amputated as a result of diabetes. Of those who experience a major amputation around half will die within the first two years. (Diabetes UK, 2019). In many cases amputation is avoidable.

Complications as a result of diabetes have a profound impact on those living with them, as well as their families and their carer's. The results of complications are often life changing and people require considerable support from all involved in looking after them.

Prevention of complications will be assisted by tackling inequalities. The most deprived in the UK are 2.5 times more likely to have diabetes. Deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, smoking and poor blood pressure control. These factors are inextricably linked to the risk of serious complications amongst those already diagnosed.

Evidence from landmark research studies in diabetes care, confirm that active management of the major risk factors, glycaemic (blood sugar) control, blood pressure and cholesterol, along with management of lifestyle factors such as diet, physical activity and smoking cessation, reduce the risk of long-term diabetes related complications .[11]

For those people who do develop long term complications, we must ensure they are identified quickly and they should receive effective treatment and care including referral to specialist services where appropriate.

The most common long-term complications of diabetes include:

- Cardiovascular Disease
- Diabetic nephropathy
- Diabetic retinopathy
- Diabetic neuropathy
- Limb Amputations
- Erectile Dysfunction
- Diabetic Ketoacidosis
- Gestational Diabetes

8.1. CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD) accounts for over half of all deaths in people with diabetes and those people are twice as likely to die prematurely from CVD than those without diabetes. The death rate can be halved by managing cardiovascular risk factors more effectively. This framework aims to support patients and service users to enable complications of the disease to be prevented or delayed by ensuring that those who develop Type 1 diabetes achieve treatment targets, while people with Type 2 diabetes are diagnosed early and treated effectively.

8.2. DIABETIC NEPHROPATHY

About 40% of people with diabetes will develop diabetic nephropathy. This can be reduced by good glycaemic control, blood pressure control and, for those with a diagnosis of nephropathy or micro albuminuria, treatment with ACE-I or ARB drugs. About one in eight adults have masked hypertension. This is a risk factor that is often missed. Diabetic and renal services will work together to manage people 'at risk' early with the aim of preventing progression to end stage renal disease.

8.3. DIABETIC RETINOPATHY

Diabetic retinopathy is a leading cause of blindness in the UK. People with diabetes have an increased risk of glaucoma. For the routine eye examination at an optometrist, guidance from the College of Optometrists state that risk factors for glaucoma include being over the age of 40 and the risk increases with every decade of life thereafter. Following diagnosis individuals are referred to the National Diabetic Eye Screening Programme and recalled annually thereafter. Attendance across the STP remains high.

8.4. DIABETIC NEUROPATHY

Diabetic neuropathy is a serious and common complication of Type 1 and Type 2 diabetes. It's a type of nerve damage caused by long-term high blood sugar levels. The condition usually develops slowly, sometimes over the course of several decades. Diabetes can cause neuropathy as a result of high blood glucose levels damaging the small blood vessels which supply the nerves. This prevents essential nutrients reaching the nerves.

8.5. LIMB AMPUTATIONS

Diabetic Foot disease is one of the most significant and serious adverse outcomes that can affect an individual living with diabetes. Prevention and early intervention are fundamental elements in minimising the risk, including lower extremity amputation. Ensuring that people living with diabetes receive an annual foot check, with the opportunity for education in foot self-care is one of the essential core care processes.

We will have a consistent model across the STP ensuring that our diabetes foot service includes a screening service, a foot protection service for those identified as having a higher risk of ulceration and a multidisciplinary foot service for managing active foot problems, working within agreed pathways to provide integrated seamless care.

8.6. ERECTILE DYSFUNCTION

Erectile dysfunction has an increased prevalence in men with diabetes. Even when men are affected by erectile dysfunction, they are often reluctant to mention it to the clinician. As part of undertaking the care processes, clinicians will proactively ask about erectile dysfunction.

8.7. DIABETIC KETOACIDOSIS

Diabetic ketoacidosis (DKA) is a serious problem that can occur in people with diabetes if their body starts to run out of insulin. It can be life threatening if not identified and treated quickly. DKA mainly affects people with Type 1 diabetes but can sometimes occur in people with Type 2 diabetes.

8.8. GESTATIONAL PREGNANCY

As many as 9 out of every 100 pregnant women will develop a condition known as gestational diabetes mellitus. A number of factors increase the risk of someone developing gestational diabetes e.g. certain ethnic backgrounds, being overweight, having a family member with diabetes, being aged 25 or older, having gestational diabetes in an earlier pregnancy.[12]

Some women have such high levels of blood glucose that their body is unable to produce enough insulin to absorb it all. Gestational diabetes requires highly specialist management during pregnancy but typically resolves as soon as the baby is born. However, women who have had gestational diabetes are at risk of developing type 2 diabetes later in life.

Despite considerable advances in the management of pregnancy in women living with diabetes, this remains a high-risk condition requiring particular care. Diabetes in pregnancy can result in higher rates of congenital malformations, perinatal and neonatal mortality and stillbirths than the background population. More than one third of women with diabetes in pregnancy have babies that are large for gestational age.

To improve outcomes and management of gestational diabetes we will review and improve access to structured preconception services and monitor quality standards.

8.9. DIABETIC EMERGENCIES

Some people with diabetes will encounter difficulties with their treatment which lead to diabetic emergencies. The acute complication of diabetes can lead to disability or even death. Ketoacidosis is the main cause of death and recurrent hypoglycaemia is a cause of profound morbidity and occasional mortality.

Quality of life is affected by recurrent emergencies and recurrent hypoglycaemia may cause restrictions on lifestyle. The prevalence of diabetic emergencies can be reduced through self-management and education of both people with diabetes and healthcare professionals on how to avert hypoglycaemia episodes. All hospitals should have a protocol or guideline for the management of diabetic emergencies. People presenting with diabetic ketoacidosis should be managed by a hospital team experienced in the up-to-date management of diabetes and its acute complications.

8.10. ELECTIVE CARE

People with diabetes are admitted to hospital twice as often and stay twice as long as those without diabetes. However, inpatient care for people with diabetes is too often not well managed, especially when diabetes is not the primary reason for admission. There is a need for recognition of the

particular needs of people with diabetes when they are admitted to hospital. This can be achieved through greater awareness and knowledge amongst hospital staff and teams.

9. HARD TO REACH GROUPS

STP Offer:

1. Appropriate diabetes services are in place to enable people from hard to reach groups to access required services.
2. Clearly defined strategies to target hard to reach groups.
3. Care home staff educated around the needs of residents with diabetes.
4. Individuals with a cognitive impairment diagnosed with diabetes are supported by appropriately skilled teams to achieve treatment and goals.

The management of diabetes is becoming increasingly challenging to treat and there are many pressures in primary care to achieve targets. Population trends indicate that diversity is increasing, and this may mean that there will be widening gaps in the health needs of different groups, leading to further challenges for healthcare providers. Managing diabetes in hard-to-reach groups is a significant part of this due to the different needs that exist in each.

There are several groups of people who are at a high risk of developing diabetes and/or who are in a position where diagnosis and management of diabetes is more difficult or inadequately provided.

These groups, listed below, require a targeted and specific approach:

- Children and adolescents
- Older People in Residential Settings
- People with Cognitive Impairment
- People with Learning Disabilities
- Ethnic Minorities
- People from Hard to Reach Communities

9.1. CHILDREN AND ADOLESCENTS

Most children with Type 1 diabetes are diagnosed between the age of 10 and 14 however Type 2 is on the increase but still very rare. (Diabetes UK, 2019). A key factor in reducing the impact of diabetes is good control of blood sugar levels without frequent disabling hypoglycaemic events. All healthcare professionals should understand the symptoms of Type 1 diabetes and be able to identify when a child or young person should be tested using blood capillary glucose test. Primary care staff must refer suspected cases of diabetes immediately (same day) to appropriate paediatric inpatient centres.

Transition from paediatric to adult services requires a flexible approach which meets the needs of the individual patient. The benefits of successful transition are seen in increased clinic attendance and better health outcomes in the long-term. Transition should be a clear process over a defined period of time therefore planning for the transition process needs to start around 12-14 years. Services should aim to be developmentally appropriate and person-centred, respecting the young person as an individual and involving them in their care planning.[13]

9.2. OLDER PEOPLE IN RESIDENTIAL SETTINGS

Care home residents with diabetes are particularly vulnerable, characterised by highly comorbid health state, frailty and cognitive dysfunction, high rates of hospital admission for hypoglycaemia (low blood sugar) and infection. This poses a great challenge for effective diabetes management, warranting a holistic comprehensive geriatric approach that considers all elements impacting on health and wellbeing, functional status, life-expectancy and the wishes of the individual, their family and/or carers.

Adopting a person-centred approach, individualising management plans, determining priorities for care and agreeing realistic goals based on holistic assessment, is important in supporting diabetes management. This approach reduces the risk of adverse outcomes due to poor diabetes control but avoids unnecessary overtreatment and the risks associated with hypoglycaemia and other treatment side-effects.

9.3. COGNITIVE IMPAIRMENT

Cognitive dysfunction is a broad term that includes many domains, such as memory, learning, mental flexibility, attention, and executive function. In addition, patients with cognitive dysfunction can be on a spectrum that extends from a mild cognitive impairment (defined as cognitive dysfunction without difficulty performing daily activities) to severe dysfunction (commonly referred to as dementia).

For patients with diabetes, executive functions are particularly important as they involve behaviours, such as insight into a problem, problem-solving, judgment, stopping or changing old habits, and starting new habits. All these behaviours are important when patients are asked to do complex tasks such as matching insulin dose with carbohydrate content, predicting the impact of physical activity on blood glucose, or even recognizing and treating hypoglycaemia appropriately.

9.4. LEARNING DISABILITY (LD)

Prevalence of Type 2 diabetes varies in the general population by ethnicity and social factors; however, studies have shown individuals with a learning disability are at a higher risk of developing Type 2 diabetes.[14,15]

The reasons for higher estimates being based on the following: people with learning disabilities leading a more sedentary lifestyle, undertaking low levels of exercise, consuming high fat diets and being prescribed high levels of antipsychotic medications, all of which can contribute to obesity.[16] Increasing the uptake of health checks and supporting healthy lifestyles and education is essential for individuals with learning disabilities and their carers.

9.5. ETHNIC MINORITIES

The prevalence of diabetes, Type 2 in particular, is between two to four times higher in communities of Asian and African-Caribbean origin than those of European origin. People form Asian communicates with diabetes have a two-three fold increased risk of heart disease and a four-fold increased risk of renal failure. For a variety of reasons, diabetes remains undiagnosed in large proportions of people with diabetes from ethnic minority. Consideration may be required to screening ethnic minority communities as a ‘at risk’ group to facilitate early diagnosis.

9.6. HARD TO REACH COMMUNITIES

9.6.1. PRISONERS

The prison environment it has been argued can provide the opportunity to address the health needs of a hard to reach sector of society with diabetes. For some prisoners, prison provides an opportunity to access healthcare, which, for a variety of reasons, they have not been able to access previously.[18] In addition, there are opportunities to promote health within the prison environment. However, there is also evidence of prisoners with diabetes not being able to access the services they require whilst in custody (Ombudsman -Death in custody Investigations).[17]

9.6.2. HOMELESS AND TRAVELLER COMMUNITIES

Homelessness in the UK is increasing and people experiencing homelessness face significant health inequality, including reduced life-expectancy. For people who are homeless, accessing healthcare is likely to be difficult and the individual's healthcare needs are likely to be broad ranging, requiring more support than with diabetes alone.

Romany Gypsies and Travellers are amongst the oldest established minority ethnic groups in the UK and studies have indicated a high incidence of diabetes in these populations. Research suggests that these groups have poorer diets, lower levels of exercise and an increased risk of depression. Specific barriers, such as low levels of literacy and diabetes knowledge, can prevent Gypsies and Travellers with diabetes from getting the best possible care.

There is very limited published evidence that differentiates between Type 1 and Type 2 diabetes amongst Gypsy and Traveller communities. Anecdotally, however, most cases found amongst these communities are of people with Type 2 diabetes.[18,19]

Providing healthcare to the homeless and traveller community will likely require facilitation, support and partnership working between healthcare, social services and voluntary sector organisations.

10. WORKFORCE

STP Offer:

1. Staff coming into contact with people living with diabetes will have the skills and competence to understand their needs and ensure that these needs are met in a way that is person-centred, whatever their professional background.

Our workforce will be high-quality, person-focused, within integrated multidisciplinary teams spanning the health continuum, in order to support all actions and achieve the outcomes set out in this framework. We will skill diabetes champions to support individuals with established disease or at risk of developing diabetes.

10.1. NHS STRATEGIC POLICIES

The NHS Long Term Plan (2019) and interim NHS Peoples Plan (2019) sets out how we will transform models of care over the next five years to provide more co-ordinated, proactive and personalised care and better health outcomes. These changes include developing fully joined-up primary care and community services, particularly for people with long-term health and care needs, redesigning emergency hospital services, and providing digitally enabled primary and outpatient care.

Through Integrated Care Systems (ICSs), the NHS will forge much more effective partnerships with local authorities and other partners to address wider determinants of health and help enhance the health and wellbeing of local communities.

The long term plan calls for a 'fundamental shift' in the way that the NHS works alongside patients and individuals. Highlighting the need to create genuine partnerships between professionals and patients, it commits to training staff to be able to have conversations that help people make the decisions that are right for them. There is also a commitment to increasing support for people to manage their own health, beginning in areas such as diabetes prevention and management. This forms part of a broader cultural change, moving towards what we have described as shared responsibility for health.

10.2. WORKFORCE DEVELOPMENT

As part of our improving diabetes care journey, we need to identify and support current workforce capacity and competency to deliver the future model of care. Implementing a new model of care to support diabetes management will include staff training and development needs.

The skills required to support effective diabetes care include many that are generic to all long term conditions, as well as others that are specific to diabetes.

This will involve:

- Acknowledging the philosophy and principles of systematic support for self-management
- Using available evidence-based and quality-assured training

Identifying:

- Accountable leadership
- The population involved (risk stratification)
- Capacity of individuals to engage in the necessary processes and supporting them to do so
- The multidisciplinary teams involved
- The roles and responsibilities of each team member

- Robust metrics, data collection methods, analysis and feedback to drive improvement.
- Using available evidence-based and quality-assured training

10.3. GOVERNANCE

The MSE Local Workforce Board will oversee the allocation of Health Education England funding for key areas of workforce development.

This framework will be implemented through the development of a competency framework, which will identify the skills required to support individuals at differing stages of their diabetes experiences, and inform necessary investment for continuing professional development across the primary, social and secondary care interface.

11. DATA AND TECHNOLOGY

STP Offer:

1. New intervention and technologies, where appropriate and effective, will be used to support treatment and care for people living with diabetes.
2. Information management will underpin the development of diabetes services.
3. Diabetes health outcomes are evaluated so we can target and assist local areas in further need of support.

A diabetes framework and care model needs to be underpinned by effective (and easy to use) technology and information management to maximise success.

11.1. DATA

It will be impossible to monitor the impact of the framework and model of care without robust reliable data. Collecting, collating and analysing data can be achieved at system level. We will use the wealth of data we collect to maximum effect, and ensure that we are making best use of our resources, delivering efficient and effective services.

11.2. RESEARCH

Research provides the basis for understanding the causes of diabetes, its prevention and effective management, and its cure. Increasingly, pharmaceutical companies, universities and hospital research units share their expertise and costs by working together. The STP will collaborate with local research partners in order to identify the effectiveness of community based programmes to help support and drive change.

11.3. TECHNOLOGY

It is anticipated that a number of potential solutions which, taken together, could help the system close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions.

Examples include:

MANAGING DEMAND

- ***Self-care and community support.*** These tools are well developed and have a range of applications, including diabetes apps and software that support behaviour change as well as providing online support for people with a wide range of conditions including anxiety and depression
- ***Prediction and risk stratification.*** There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

CREATING CAPACITY

- ***Patient pathways and treatment.*** These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

OPERATING AT SCALE

- ***Communication across settings.*** Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

It is intended that local transformation aligns to the wider strategic intent included within the pan Essex document 'Digital Essex 2020' and the Primary Care Strategy, and that we utilise the Diabetes Framework to influence these programmes of work.

12. IMPLEMENTATION

12.1. OVERVIEW

In determining our approach to implement this framework, we have considered the best way of balancing several factors, including:

- We are not all starting from the same place – the community service offer differs across CCG areas and Primary Care Networks have differing levels of maturity
- Implementation will not be at the same pace everywhere
- The local context is critical – we know that the challenges in each CCG area are different and, as a result, the approach to implementation will differ also

As a result of these factors, we have concluded that the right approach is for each CCG to lead implementation with local system partners but within a consistent STP wide framework.

12.2. STP WORKSTREAMS

We know that in some areas it will make sense to coordinate and do things once, adopting an STP wide approach. The key areas, we have identified to date, and in which we will contribute to the development and implementation plans, are:

- Digital
- Aspects of workforce, such as work on defining consistent new roles and STP wide recruitment and training activities
- Procurement (where appropriate)

12.3. GOVERNANCE AND TIMELINE

We will work within and be guided by existing STP governance arrangements, ensuring system approval and sign up, to achieve the optimum level of embedded success; whilst acknowledging the move towards an Integrated Care System may require an element of flexibility to delivery.

The diabetes framework and model of care has a 5 year delivery plan which compliments the STP Long Term Plan and strategies currently in development. The timeline below indicates key milestones throughout the 5 years and progress against these will be monitored and reviewed on a monthly basis.

The first key milestone will be the benchmarking, within each area, against the key requirements. Once completed, the system will agree priority areas (in addition to those outlined in section 2.8) and how these will be taken forward i.e. at a local level or across the STP footprint. Detailed implementation plans will then be developed.

Key Milestone Deliverables	Timeline
STP 5 year Diabetes framework finalised and approved	Nov-19
Review and redesign STP foot pathways community through to acute	Dec-19
Governance structure established (in line with existing forums)	Jan-20
Prevention/self-care programmes identified across the wider health system	Feb-20
Benchmarking (gap analysis) against the framework completed	Feb-20
System-wide and CCG priority areas agreed and plans developed	May-20
Framework changes to service pathways implemented	Jun 20- Mar 22
MyDiabetes app distributed to 100 Type 2 diabetes patients within each CCG (initial pilot)	May-20
NDPP referrals increased in line with yearly IP allocation	Aug 20-Jul 24
Improvement in variances across practices in care processes and 3TTs	Mar-21
Diabetes workforce competencies developed based upon national guidelines	Sep-20
Workforce training needs identified	Mar-21
Collaborative working across PCN/Place - community and specialist	Apr 22-Mar 23
Care Model developed and procured (subject to PCN maturity)	Apr 23- Sep 24
Care Models implemented	Mar-25

13. REFERENCES

1. Diabetes Uk. *The Cost of Diabetes Report v2.* 2014.

2. Public Health England. Diabetes prevalence estimates for local populations; 2015. Available from: https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations

3. National Institute for Health and Care Excellence (NICE). Clinical Knowledge Summary. Risk factors for Type 1 diabetes. 2019. Available from: https://cks.nice.org.UK/diabetes-type-1#!backgroundSub:2

4. National Institute for Health and Care Excellence (NICE). Clinical Knowledge Summary. Risk factors for Type 2 diabetes. 2019. Available from: https://cks.nice.org.UK/diabetes-type-2#!backgroundSub:2

5. Ministry of Housing, Communities and Local Government. National Statistics. English Indices of Deprivation. 2015 Available from: https://www.gov.UK/government/statistics/english-indices-of-deprivation-2015

6. NHS Digital. National Diabetes Audit Report 1 Care processes and treatment targets. 2017-18. Available from: https://digital.nhs.UK/data-and-information/publications/statistical/national-diabetes-audit/report-1-care-processes-and-treatment-targets-2017-18-full-report

7. US Department of Health and Human Services, National Diabetes Education Programme, Guiding Principles for the Care of People with or at Risk for Diabetes. Published 2018

8. NHSE Five Year Forward View for Mental Health. NHSE. London. 2016. Available from: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

9. Aronson J.K. In defence of polypharmacy. Br J Clin Pharmacology. 2004; Vol.57 No.2: 119-120.

10. Aronson J.K. Polypharmacy, appropriate and inappropriate. British Journal of General Practitioners. 2006; Vol.56. No. 528: 484-485.

11. Gæde, P., Oellgaard, J., Carstensen, B. et al. Diabetologia (2016) 59: 2298. Available from: https://doi.org/10.1007/s00125-016-4065-6

12. WebMD. 2017 Gestational Diabetes: Can I Lower My Risk? [Online] WebMD. [Cited: 08.22.2017] Available from: http://www.webmd.com/diabetes/gestational-diabetes-guide/gestational-diabetes-can-i-lower-my-risk#1.

13. National Institute for Health and Care Excellence (NICE). *Transition from children's to adult's services for young people using health or social care services;* NICE guidance [NG43]. 2016. Available from: https://www.nice.org.uk/guidance/ng43

14. Walwyn, R.E.A., Russell, A.M., Bryant, L.D. *et al.* Supported self-management for adults with type 2 diabetes and a learning disability (OK-Diabetes): study protocol for a randomised controlled feasibility trial. *Trials* **16,** 342 (2015) doi:10.1186/s13063-015-0832-9

15. McVilly K, McGillivray J A, Lehmann J. Diabetes in people with an intellectual disability: a systematic review of prevalence, incidence and impact. 2014. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/dme.12494

16. Taggart L, Cousins W. *Health Promotion for people with intellectual and developmental disabilities*. Open University Press McGraw-Hill Education. 2014

17. Condon L, Gill H, Harris F. A review of prison health and its implications for primary care nursing in England and Wales: the research evidence. *Journal of Clinical Nursing.* 2007; Vol.16 (7): P.1201-9. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2702.2007.01799.x

18. Greenfield M, Lowe L. Bath and North East Somerset Gypsy, Traveller, Boater, Showman and Roma Health Survey 2012-2013 Bath and North East Somerset Health Authority. 2013

19. Greenfields M. It's a sweet life travelling: Meeting the healthcare needs of Travellers with diabetes. *Journal of Diabetes Nursing*. 2004; Vol.18 No.5: P.193–8

14. APPENDICES

Appendix A: Diabetes Overview in Mid and South Essex
Appendix B: Diabetes Framework Elements and Key Requirements
Appendix C: National Frameworks and Standards
Appendix D: Prescribing Algorithm for the Treatment of Type 2 Diabetes in Adults

Overview of Type One and Type Two Diabetes Mid and South Essex Sustainability and Transformation Partnership

Author: Essex County Council Public Health Team

1. Introduction

This report presents a short overview of Type one and Type two diabetes in Mid and South Essex Sustainability and Transformation Partnership (STP). It covers the current burden of the disease, healthcare performance and health outcomes based on available data. Its aim is to provide a starting point for discussion amongst STP partners about how to improve outcomes for type one and type two diabetes.

2. The Burden of Type one and Type two diabetes in Mid and South Essex STP

2.1. The prevalence of type one and type two diabetes

At 6.6% the prevalence of diabetes in the population aged 17 years and older in Mid and South Essex STP is similar to the England average of 6.8%. This data comes from the Quality Outcome Framework (QOF) of 2017/18.

Based on demographic data, Public Health England estimates the total (diagnosed and undiagnosed) diabetes prevalence for people aged 16 years and older to be 8.4% in 2018 in Mid and South Essex.[1] Although a significant proportion of diabetics are undiagnosed the National Screening Committee has been unable to find good evidence that screening of people without diabetic symptoms should be recommended.[2] The National Screening Committee keeps its advice under review and is expected to announce if its recommendations on diabetic screening remain the same in November of this year (2019).

2.2. Risk factors for diabetes

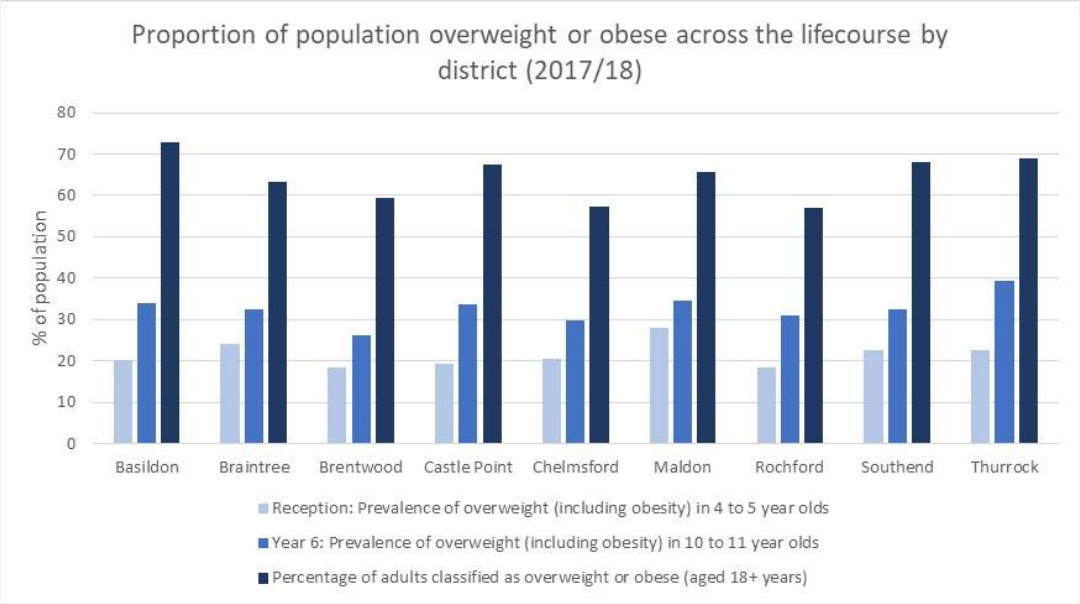
This section considers obesity and deprivation – two major risk factors for diabetes and poor outcomes. Comprehensive information about the full range of risk factors for all types of diabetes can be found in the NICE Clinical Knowledge Summaries[3,4]

[1] https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations
[2] https://legacyscreening.phe.org.uk/diabetes
[3] Risk factors for type 1 diabetes: https://cks.nice.org.uk/diabetes-type-1#!backgroundSub:2
[4] Risk factors for type 2 diabetes: https://cks.nice.org.uk/diabetes-type-2#!backgroundSub:2

2.2.1 Obesity

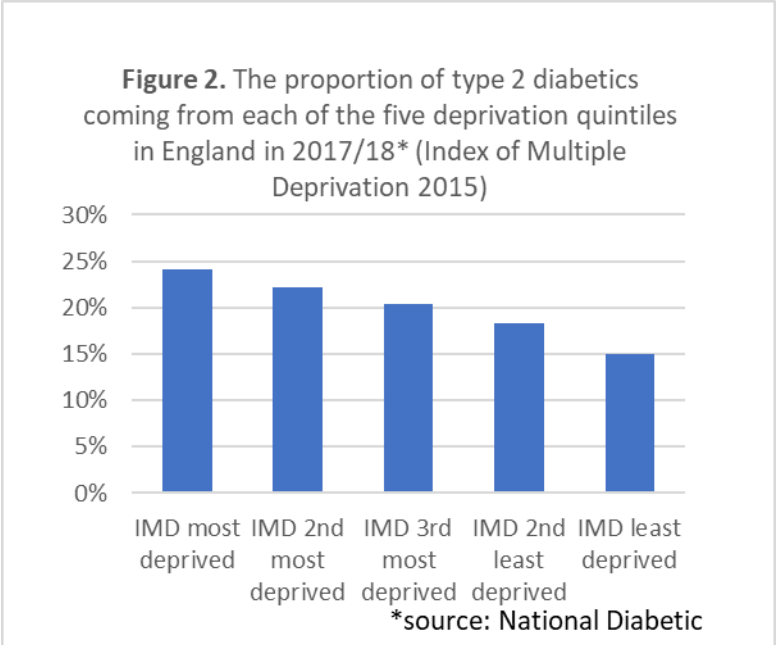
Obesity accounts for 80–85% of the overall risk of developing type 2 diabetes.5 Figure 1 shows the proportion with excess weight (overweight or obese) at different ages. It indicates that at a population level an ever-growing proportion become overweight or obese as they age.

Figure 1: Obesity



2.2.2 Deprivation

Deprivation is associated with risk factors for developing type 2 diabetes - obesity, physical inactivity and a diet low in fruit and vegetables. Deprivation is also associated with risk factors for poor diabetic outcomes - smoking and hypertension.



The National Diabetes Audit data show the social gradient in Type 2 diabetes. Those with type 2 diabetes are more likely to come from areas of higher deprivation (figure 2). The Clinical Commissioning Group (CCG) within the STP with the highest average deprivation (Index of Multiple Deprivation, IMD) is Southend CCG. Mid Essex and Castle Point and Rochford CCGs have the lowest level of average deprivation.[6]

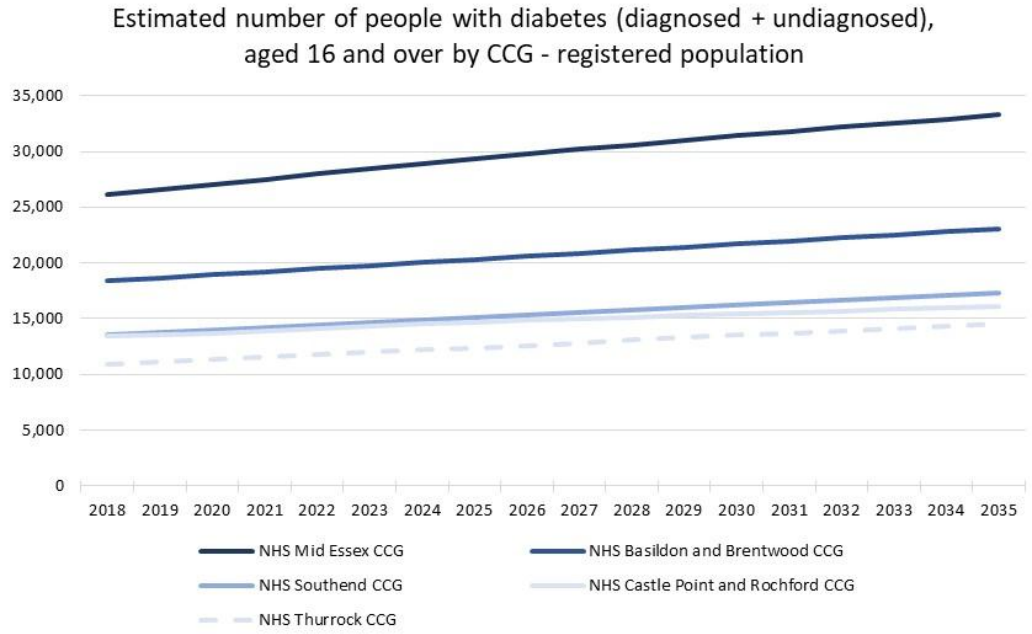
[5] https://cks.nice.org.uk/diabetes-type-2#!backgroundSub:2

[6] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015,

2.3 Projected trends

The prevalence of diabetes over time is increasing in line with the national trend. This is driven by an ageing population and an increasing proportion who are overweight or obese. Figure 3 shows Public Health England's predictive model for diabetic prevalence in Mid and South Essex STP[7].

Figure 3: Projected trends



3. Diabetes: Process measures

3.1 Care Processes for patients with diabetes aged 12 and over (2017-18)

The proportion of diabetics receiving each of eight care processes recommended by the National Institute for Health and Care Excellence (NICE) are show for type 1 and type 2 diabetics in figures 4 and 5. This data is taken from the National Diabetic Audit.[8] In the latest diabetic audit for which data is available, 2017 to 2018, 92% of GP practices in the STP submitted data. This varied from 100% of practices in Mid Essex to 78% in Southend-on-Sea. Recording of the body mass index, urine albumin and foot surveillance are care processes with the most room for improvement.

The national diabetic audit show that proportion receiving all 8 care processes across the STP ranges from 25% to 30% for type 1 and 35% to 45% for type 2. The England average is 40% for type 1 and 60% for type 2. Although the England figures are poor the STP figures are considerably lower.

[7] https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations -
[8] https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit/report-1-care-processes-and-treatment-targets-2017-18-full-report (accessed 30th September 2019)

Figure 4

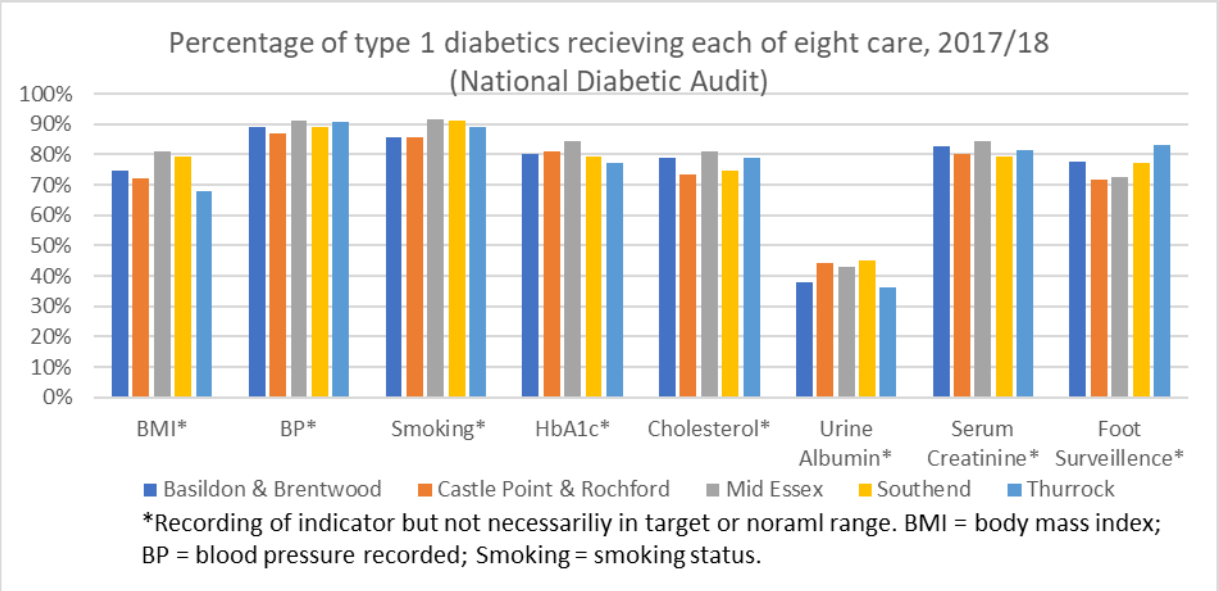
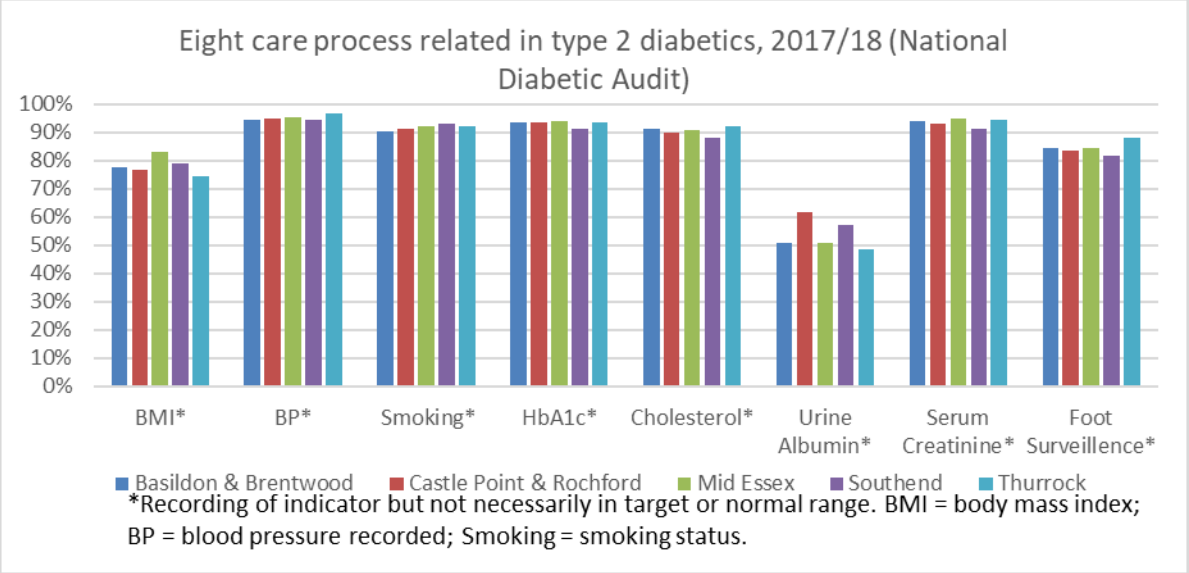


Figure 5

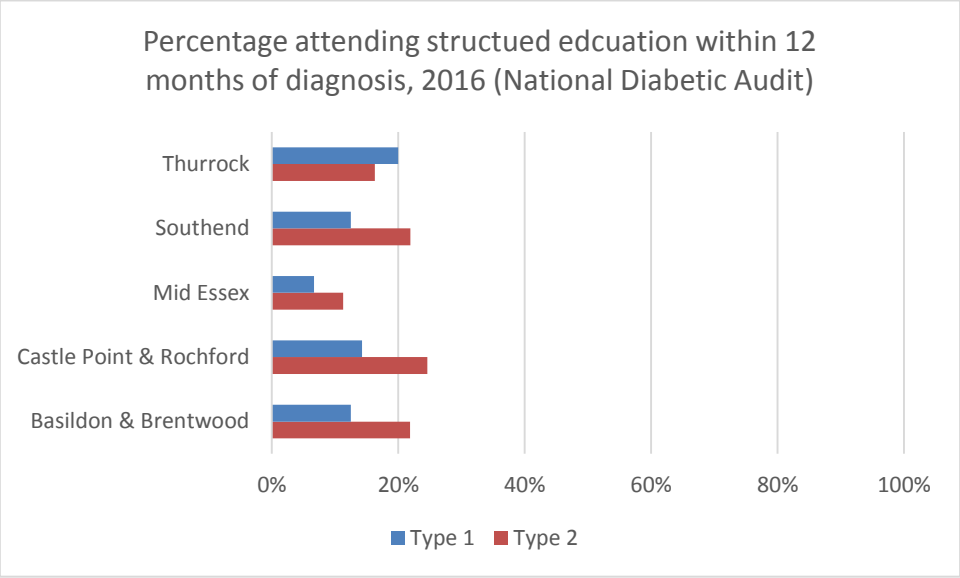


There is a ninth care process, retinal screening, commissioned and run centrally. All five CCGs are above national average (83.3%) for uptake of eye screening.

3.3 Structured Education 2017-18 – all ages

Diabetes Structured Education courses deliver information, training and support on how to manage diabetes through diet, physical activity and medication. Essentially, they are providing the foundation support for diabetes self-management. Attendance at structured education sessions are captured in the National Diabetes Audit and shown in figure 6 below.

Figure 6

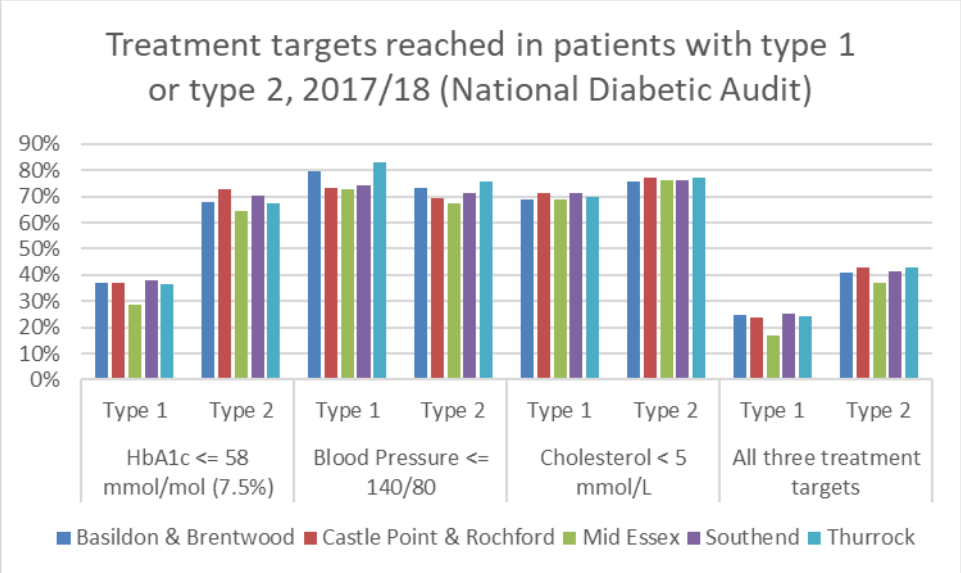


Although the numbers attending structured education is very low the STP does outperform the national averages of 5% for type 1 and 9% for type 2. This indicates that although there is great room for improvement this is something many areas struggle with.

3.4 Treatment targets for patients aged 12 and over: 2017 to 2018

The proportion of diabetic patients achieving their treatment targets for HbA1c, blood pressure and cholesterol in 2017/18 are shown in figure 7, using data taken from the national diabetic audit. The performance in Mid and South Essex is similar to average in England.

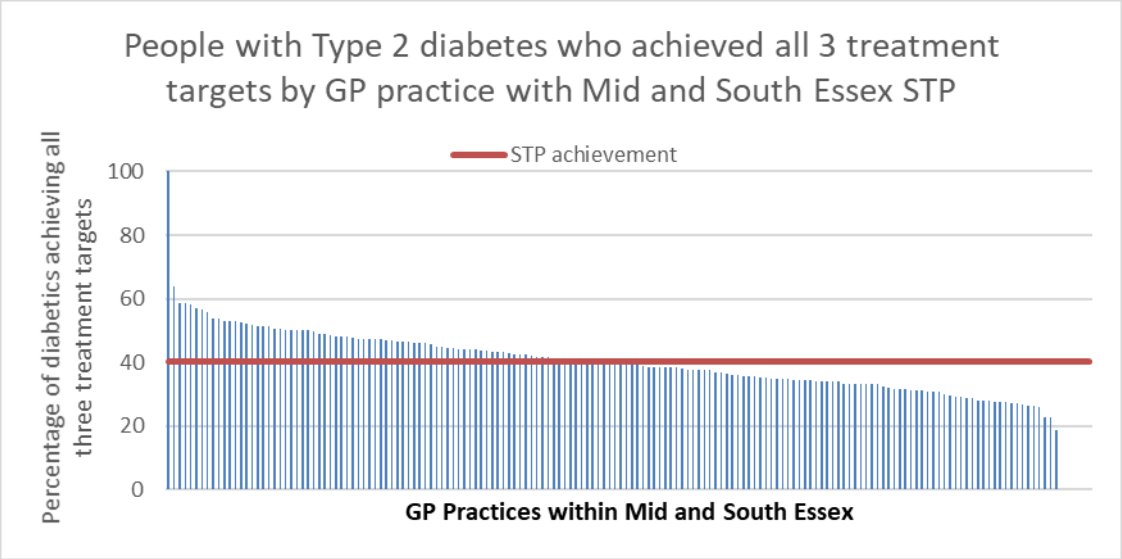
Figure 7



The wide variation amount GP practices in the proportion of their type 2 diabetics achieving all three care targets is shown in figure 8 below.

.

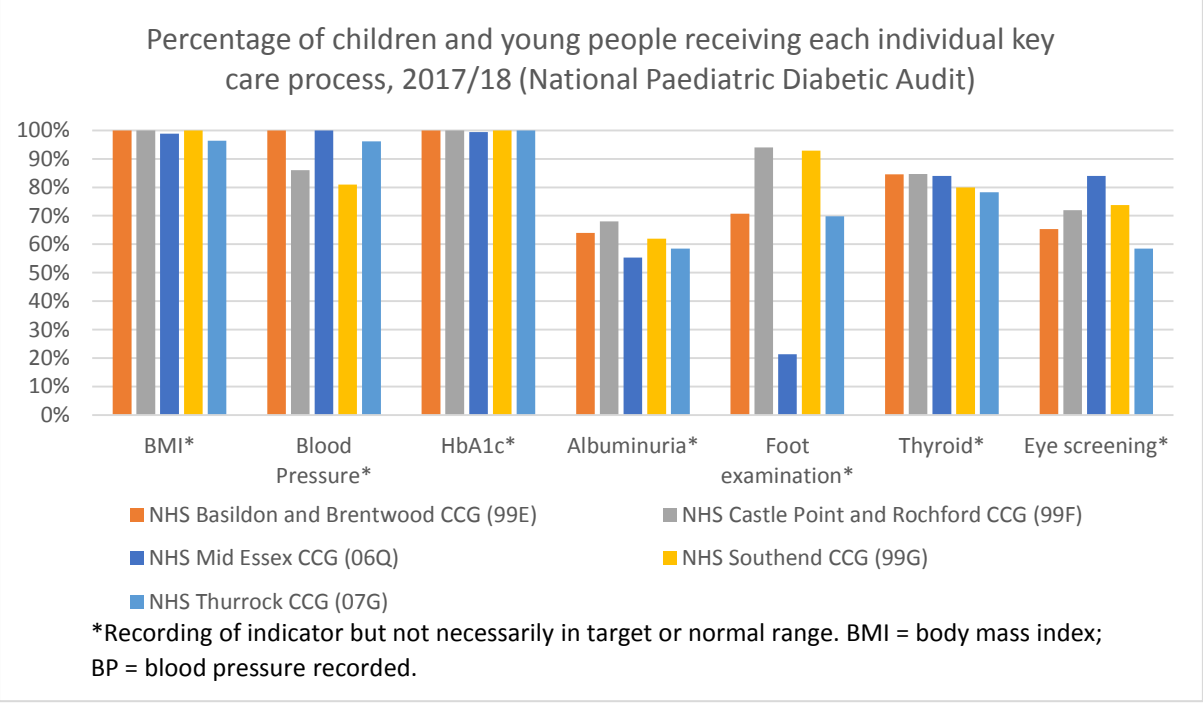
Figure 8: Variation for treatment targets for type two diabetes by GP practice



3.5 The National Paediatrics Diabetes Audit

The 2017/18 National Paediatrics Diabetic Audit captured information on all children and young people under the care of a consultant paediatrician. The data is submitted by paediatric diabetes units. The percentage of children and young people (aged 12 to 24) receiving the recommended key care processes is shown in figure 9.

Figure 9



*Recording of indicator but not necessarily in target or normal range. BMI = body mass index; BP = blood pressure recorded.

In this audit Mid Essex appears to be an outlier in the STP. In Mid Essex 21.3% of diabetes patients had foot surveillance.

3.6 Diabetes in pregnancy

The next annual report of the National Pregnancy in Diabetes Audit will be released on 10 October 2019 and will include all pregnancies from January 2017 to December 2018. It was not available at the time of writing this report.

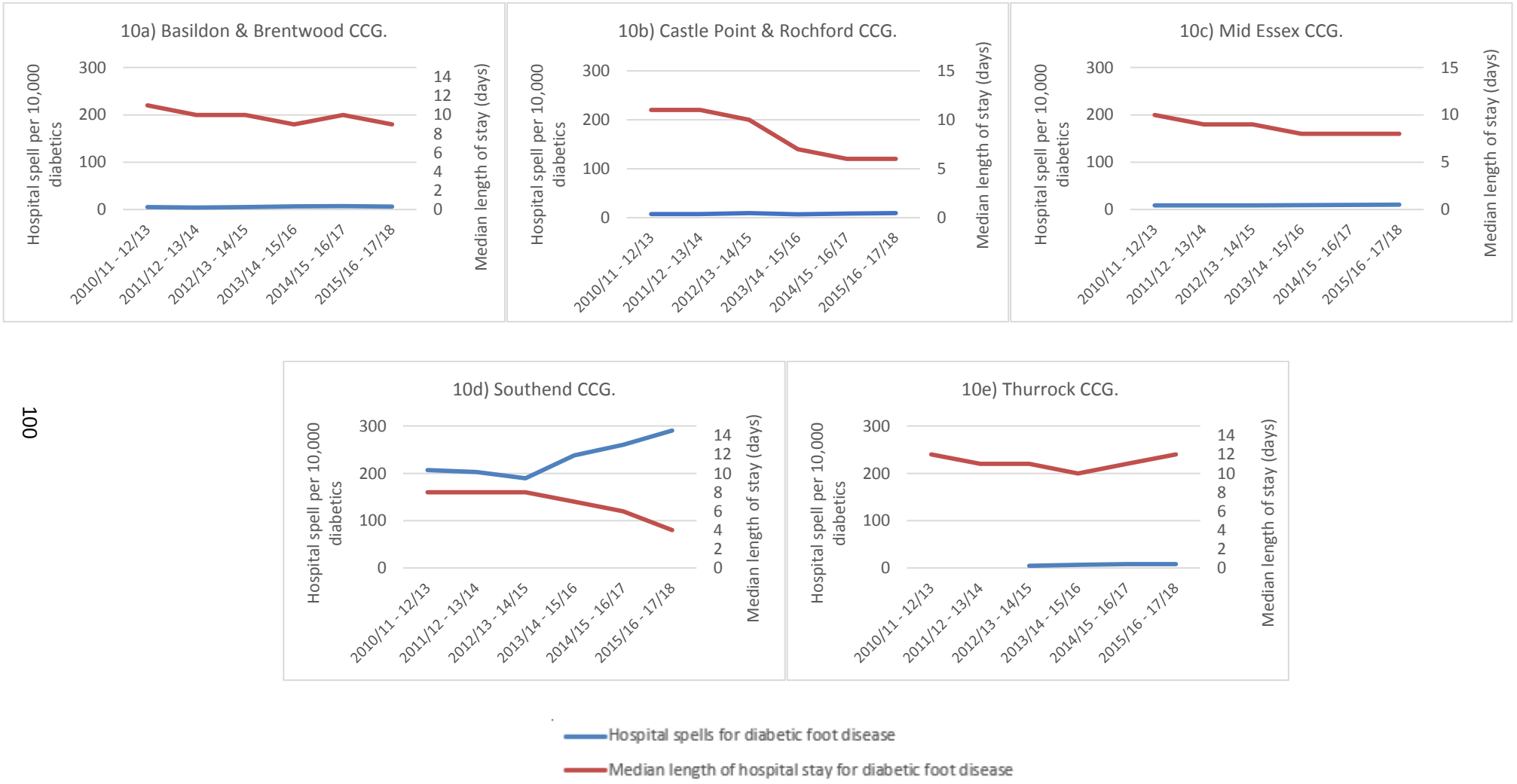
4.Diabetes: Outcomes

Data is regularly published on foot care of diabetic patients. Other health outcomes for diabetes patients, such as the excess death rate, are not published as frequently with no more recent publication than 2015-16. For this reason, only foot care outcomes data is included in this report.

Southend CCG is an anomaly when it comes to foot care. Whereas hospital spells for diabetic foot disease in the other CCGs of the STP are in single figures per 10,000 diabetics, Southend's figures are in the hundreds (figure 10, a) to e)). Such a difference is most likely to be due to a data collection error, unless diabetic patients are systematically managed very differently in Southend compared to the rest of the STP.

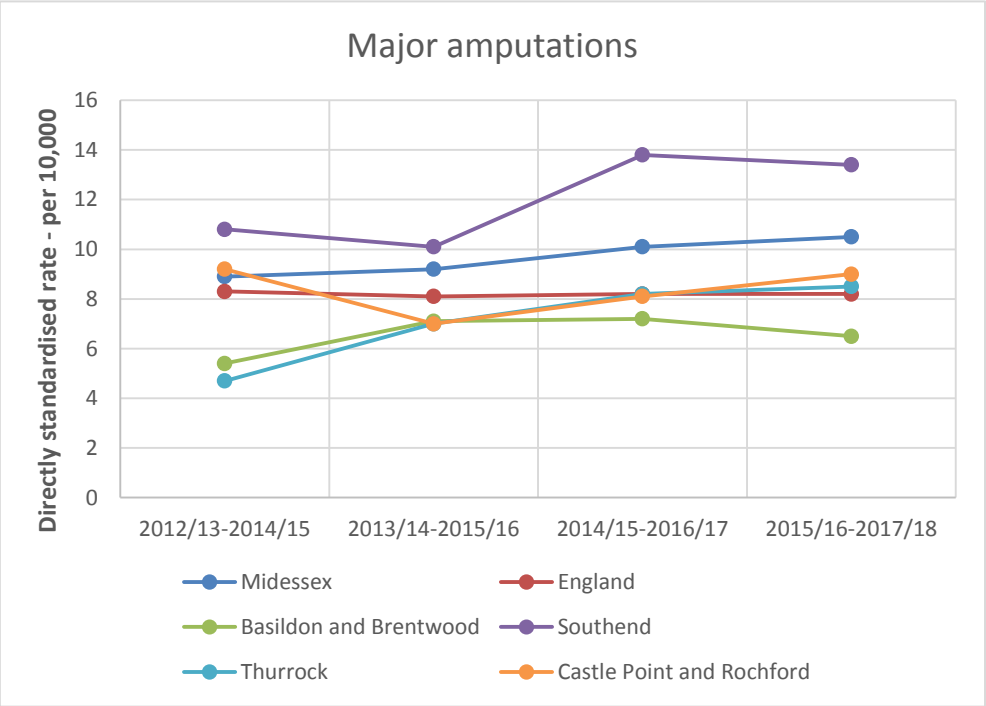
The median length of hospital stay for diabetic foot conditions is also different in Southend CCG compared to the other CCGs in Mid and South Essex. The average stay in Southend is shorter. In 2015/16 to 2017/18 the median stay was 4 days in Southend whereas the range in other CCGs was 6 to 12 days (figure 10, a) to e)). The need to understand how diabetic foot and leg management is managed in Southend CCG is highlighted by the very high rate of major lower limb amputation (defined as above ankle) for diabetes (figure 11).

Figure 10: Hospital spells for diabetic foot disease and the median length of stay for diabetic foot conditions (hospital episode statistics)



100

Figure 11: Major Lower Limp amputations



5. Areas for discussion

The above review has been written using readily available data. The insights of clinicians, patients and carers have yet to be sort. This document therefore provides an incomplete picture. The picture it provides suggests areas most likely to benefit from further exploration.

- A significant increase in diabetic prevalence is predicted. This will disproportionately affect populations in deprived areas. How is this to be managed?

- The high proportion of the population overweight or obese is a major avoidable cause of type 2 diabetes. What weight management strategies should be adopted?

- Submission of data to the National Diabetic Audit is patchy across the STP. This impairs the monitoring of the services provided.

- How can the coverage of care processes be increased? The processes that seem to have the greatest room for improvement are measurement of body mass index, urine albumin, and foot surveillance. There seems to be a particular issue with paediatric diabetic foot surveillance in Mid Essex but this might be a data collection issue.

- Only a small minority of newly diagnosed diabetics attend the structured education. How can the STP understand why this is, how access may be improved or what alternative ways of helping patients and carers take control of their condition could be tried?

- Why does Southend CCG have a rate of hospital spells for diabetic foot disease two orders of magnitude above the other CCGs in the STP?

- What is it in the pathways of care in Southend CCG that leads to the high lower limb amputation rate?

- Linking of primary care, secondary care and mortality data could be used to monitor the outcomes of diabetic care across the STP. Can this be achieved?

With the engagement of patients, carers, clinicians and health managers the population outcomes for diabetics can be improved. Not to capitalize on this potential would be an opportunity lost.

Appendix B: Diabetes Framework Elements and Requirements

Section: Identification and Prevention

Core Domain	Element #	Element Name	Evidence Statement	Sub-Element #	Sub-Element	Framework Requirements
ELEMENTS						
Identification	1	**Identification of People with Undiagnosed Diabetes and Prediabetes**	*targeted screening identifies individuals who can benefit from evidence-based interventions that can lower risk of adverse outcomes*	1.1	**Whom to screen for diabetes and prediabetes, and how often**	Prediction/ risk stratification tools used within each practice/ PCN to risk stratify patients and identify those patients that have 'rising risk'.
						Blood glucose screening as part of cardiovascular risk assessment in adults ages 40 to 75
						Blood glucose screening as part of SMI (serious mental illness) health checks for all those on register age 18+
						Screening is offered to younger adults who are overweight or obese
						Repeat screening every 1-3 years where appropriate
				1.2	**Screening tests for diabetes and prediabetes**	HbA1c and fasting BG are carried out annually for those at high risk
						Practice level registers maintained for pre-diabetic (NDH) individuals
				1.3	**Screening for gestational diabetes**	Women at high risk for type 2 diabetes are tested prior to conception or at the first prenatal visit for pre-existing diabetes
						Women with a history of GDM are screened yearly with a fasting glucose and HbA1c
Prevention	2	**Management of Prediabetes to Prevent or Delay the Onset of Type 2 Diabetes**	*Progression to type 2 diabetes among people with prediabetes is not inevitable. Modest, sustained weight loss, increased physical activity, and/or metformin therapy in these individuals can prevent or delay the onset of type 2 diabetes*	2.1	**National Diabetes Prevention Programme (NDPP)**	People at risk of diabetes are referred/or encouraged to self refer to the national programme as per the criteria
				2.2	**Weight loss and physical activity for prevention of type 2 diabetes**	People with prediabetes are provided with lifestyle interventions that include regular physical activity and dietary changes to enable sustained weight loss
						Registered dieticians, nutritionists or diabetic educators are available via referral to individuals with prediabetes
						Weight loss goals are set at a minimum of 5-10% of an individuals body weight
						Physical activity goals are set to target at least 30 minutes of moderate activity at least 5 days a week
						Weight loss to focus on evidence based dietary interventions
				2.3	**Metformin for type 2 diabetes prevention**	Metformin to be offered to relevant individuals to prevent diabetes - based upon risk and on a case by case assessmet by their HCP
				2.4	**Cardiovascular disease risk management**	CVD risk factors should be monitored and treated based on general guidelines for the prevention and management of CVD in individuals with prediabetes

Section: **Management**

Core Domain	Element #	Element Name	Evidence Statement	Sub-Element #	Sub-Element	Framework Requirements
ELEMENTS						
Management	3	**Comprehensive, Patient-centred Diabetes Care**	*The person with diabetes, often with support of family, plays the central role as self-care manager and decision maker. Team care integrates the skills of health care professionals with those of the patient and family into a comprehensive diabetes management program*	3.1	**Consideration of health literacy and numeracy**	Screening of health literacy is available to relevant patient groups
						Low health literacy materials are routinely used for relevant patient groups
				3.2	**Consideration of patient self-management resources, including ability to afford care**	Assessment of an individuals ability to afford/attend clinic visits
						Diabetes care is provided in settings that are accessible to people with limited resources
						Home glucose monitoring is offered to eligible patients and the frequency of monitoring set to achieve maximum impact
						Flash glucose monitors are offered to eligible patients with diabetes
				3.3	**Annual comprehensive diabetes checks**	People with type 1 and 2 diabetes receive 15 diabetes healthcare essentials annual review to include: HbA1c, BP, Cholesterol, Eye screening, Foot check, Kidney test, Diet advice, Emotional and Psychological support, Diabetes Education course, Diabetes specialist if needed, Flu jab, Sexual problems, Smoking Specialist care if planning pregnancy, Medication review
						People with type 1 and 2 diabetes have their shared care plan set and reviewed annually
				3.4	**Type 1 specialist management**	People with type 1 diabetes to receive an annual specialist review as a minimum
						Individuals have access to an Insulin Pump/Freestyle Libre or Continuing Glucose Monitoring wherever appropriate
				3.5	**Comprehensive and coordinated management of co-morbidities**	Health care teams regularly consider a number of clinical assessments and related interventions to address each individuals co-morbidities
						Social prescribers are available to support peple to access relevant community interventions to manage co-morbidites
						Depression screening and treatment is available to patients with diabetes
						Screening for cognitive impairment is available for older adults who are having difficulty with self-management
						People with diabetes are encouraged to undergo recommended age and sex-appropriate cancer screenings and to reduce their modifiable cancer risk factors
						People with diabetes are encouraged to receive regular dental care
						People with diabetes are asked about symptoms of sleep apnea and those with symptoms are referred for testing
	4	**Ongoing Self-management Education and Support for People with Diabetes**	*Effective self-management education and ongoing self-management support are essential to enable people with diabetes to make informed decisions and to assume responsibility for the day-to-day management of their disease and risk factors for complications.*	4.1	**Definition and purpose of diabetes self-management education and self-management support**	Objectives are set within the care plan to support informed and shared decision-making, self-management behaviours, problem solving, and active collaboration with the health care team to improve clinical outcomes, health status, and quality of life.
						Self-management support involves system professionals to help people with diabetes to implement and sustain ongoing behaviours needed to manage their diabetes.
						These activities include behavioural, educational, psychosocial, and clinical support.
				4.2	**How to provide self-management education and support**	Educational materials provided to all people diagnosed with diabetes in line with Public Health and Diabetes National Bodies
						Psychological support is available (including IAPT) to address individual barriers and readiness for change.
						Programmes are available that address health literacy, and are culturally and age appropriate
						Opportunities are available for families to be included in the process if it supports the self-management aspect
						A mixture of 1-1 and group sessions are available where appropriate
						Programmes available demonstrate that they meet the needs of patients which may involve 10 or more contact hours.
						Specialist input available to all people with Type 1 diabetes at management and education levels
				4.3	**Community-based and other resources**	Referrals to appropriate services are made for people with socioeconomic barriers to diabetes self-management

Core	Element	Element Name	Evidence Statement	Sub-Element	Sub-Element	Framework Requirements
ELEMENTS						
Management	5	**Lifestyle Modification for People with Diabetes**	*Nutrition and physical activity are the foundations of diabetes management. Individualised nutrition therapy helps people achieve blood glucose, blood pressure, blood lipid, and weight goals; address individual nutrition needs; and prioritise food choices when indicated by scientific evidence. Regular physical activity helps improve insulin sensitivity and glycaemic control, positively affects lipids and blood pressure, assists with weight maintenance, and is associated with reduced risk for cardiovascular disease (CVD)*	5.1	**Provide nutrition therapy and monitoring**	People with diabetes who meet the agreed criteria have access to a registered dietitian from the time of diagnosis.
						Dietary review involves a nutrition assessment, individualised nutrition interventions, and nutrition monitoring and evaluation with ongoing follow-up to support long-term lifestyle changes, evaluate outcomes, and modify interventions as needed
				5.2	**Helpful eating behaviours and practices for glycaemic control**	Carbohydrate intake is monitored to achieve glycaemic control
						Portion size control is recommended to achieve glycaemic control
				5.3	**Encourage physical activity**	Programmes encourage at least 150 minutes per week of moderate-intensity aerobic physical activity. Activity should be spread over at least 3 days per week, with no more than 2 consecutive days without exercise.
						Able individuals or more physically fit are encouraged to do at least 75 minutes of vigorous-intensity per week
						Programmes encourage muscle-strengthening activities two to three times per week on non-consecutive days, targeting all major muscle groups
						Programmes are available that target older adults or those with limited mobility, and encourage safe ways to be more active, such as chair exercises, exercise classes designed for seniors, or aquatic exercise
				5.4	**Goal setting**	People with or at risk for diabetes are supported to set a modest initial physical activity goal which increases gradually over time, regardless of the person's current level of physical activity
						Inactive people and those with low levels of physical activity are supported to develop self-efficacy in collaboration with social support from family, friends, and the health care team.
				5.5	**Appropriate precautions**	Individuals are evaluated for contraindications and limitations to physical activity when initially developing a programme
						Appropriate physical activity plans are developed for individuals with contraindications or limitations to activity in consultation with them
						Blood glucose monitoring advice given to people taking medications that can cause hypoglycaemia as a result of exercise.
						Advice is sought from eye care professionals for any individual being treated for proliferative retinopathy before initiating vigorous aerobic or muscle-strengthening exercises
	6	**Overweight and Obesity in the Management of Diabetes**	*Obesity and overweight play a crucial role in the development of diabetes and weight management is essential part of diabetes management.*	6.1	**Assessment of overweight and obesity**	BMI is calculated and recorded in the individuals health records at least annually
						Weight is measured at all subsequent routine patient encounters and plotted to allow assessment of the individuals trajectory of weight change
						Overweight or obese individuals are advised of the impact of high BMI on glycaemic control and other measures such as lipids and blood pressure, as well as its association with cardiovascular disease and other adverse health outcomes
				6.2	**Lifestyle interventions**	Health care professionals should provide recommendations and/or referrals for diet, physical activity, and behavioural therapy.
						Weight loss recommendations a tailored for older or more frail people at risk of nutritional deficiencies
				6.3	**Helpful behaviours and practices for weight loss**	Counselling sessions are offered to individuals
						Web based interventions are offered where appropriate
				6.4	**Pharmacotherapy**	When choosing among weight-loss medications, consideration is given to patient preferences, cost effectiveness, potential side effects, and contraindications
						Side effects and effectiveness are measured once medication is started and at regular intervals
				6.5	**Bariatric surgery**	Eligible patients offered bariatric surgery referrals
						All surgical candidates receive a preoperative evaluation, including a comprehensive medical and psychosocial assessment by a multidisciplinary team, physical examination, and appropriate laboratory testing to assess surgical risk

Core	Element	Element Name	Evidence Statement	Sub-Element	Sub-Element	Framework Requirements
ELEMENTS						
Management	7	**Blood Glucose Management for People with Diabetes**	*Hyperglycaemia is one of the cardinal characteristic of diabetes, and control of blood glucose is a central component of diabetes care. A patient-centred approach to treating diabetes includes careful consideration of patient factors and preferences that lead to individualised treatment goals and strategies that balance potential benefits against potential harms of blood glucose control*	7.1	**Benefits of blood glucose control**	Patients with diabetes and poor glucose control are offered treatment to lower HBA1C to the agreed individual target level
				7.2	**Risks of blood glucose control**	Safety mechanisms are in place for treating diabetes aggressively to near-normal HBA1C goals in people with long-standing diabetes who have CVD or multiple CVD risk factors.
						Hypoglycaemia is identified correctly (plasma glucose < 4 mmol/l) and treated appropriately
						Emergency glucagon kits, (which may require a prescription) are available to individuals with severe hypoglycaemia who is unable to ingest fast-acting carbohydrates
						People in close contact with these individuals are identified and training provided on how to use the emergency kits
						People with diabetes should understand factors, such as physical activity or missed meals, that increase their risk of hypoglycaemia and ways to prevent and treat it
				7.3	**Treatment goals**	Treatment targets are individualised based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycaemia unawareness, and patient preferences after discussion of the potential benefits and risks of specific levels of glycaemic control and treatment strategies
						Goal setting is conducted through shared decision-making, balancing the potential for relatively small incremental benefit with potential harms of medication side effects and costs.
						HBA1C targets are set appropriately and reassessed with patient preferences, and treatment strategies over time; modifying goals as appropriate.
				7.4	**Blood glucose management strategies**	Consider medication initiation early on alongside the lifestyle intervention
						Patients are supported through the use of strategies to help them take their medicines as directed
				7.5	**Blood glucose assessment**	A number of options are available to enable patients wherever appropriate to regularly self monitor their blood glucose levels

Section: **Complex Care**

Core Domain	Element #	Element Name	Evidence Statement	Sub-Element #	Sub-Element	Framework Requirements
ELEMENTS						
Complex Care	8	**Multifactorial Cardiovascular Disease Risk Reduction**	*Cardiovascular disease (CVD) is the leading cause of death for people with diabetes and is a major contributor to health care costs related to diabetes.*	8.1	**Evidence for blood pressure control**	Individuals are supported to lower their blood pressure (where appropriate) to the agreed target level
						Health care professionals develop individualised blood pressure targets with their diabetic patients in the context of shared decision-making that incorporates patient preferences.
						Blood pressure is measured at appropriate intervals
						Home blood pressure monitoring is encouraged where needed
				8.2	**Evidence for lipid therapy**	Statin therapy is offered to people as per national recommended guidelines
						Lifestyle modification to improve lipid profiles is offered to people with diabetes .
				8.3	**Smoking cessation**	Effective support and interventions are available to patients with diabetes who are smokers
				8.4	**Multiple risk factor reduction and the importance of assessing medication adherence**	Identification is made of individuals who do not meet HbA1c, blood pressure targets on multiple anti-hypertensive medications or show evidence of cholesterol lowering with statins, but are failing to take medication regularly as directed
						Strategies are developed to ensure patients with diabetes take their medication as directed
	9	**Diabetes Microvascular Complications and Treatment**	*The prevention and treatment of microvascular complications are of paramount importance to decrease the associated mortality and morbidity.*	9.1	**Hypoglycaemia**	Actively enquire about hypoglycaemia episodes during any contact with patients with diabetes
						Individuals are appropriately management to avoid reoccurrence of hypoglycaemia
						Appropriate hypoglycaemia education is made available during annual reviews
				9.2	**Diabetic ketoacidosis (DKA)**	Patients at risk of DKA to have appropriate education to avoid episodes
						Urgent review upon patient discharge from hospital to avoid reoccurrence.
				9.3	**Nephropathy**	Annual urine albumin creatinine ratio (ACR) checks offered to patients with diabetes
						ACR is assessed at diagnosis of diabetes
						Offer ACE inhibitor or an ARB medication to patients with micro/macro albuminuria
						BP control as per the national guidelines
						Education is provided to people with nephropathy about the progressive nature of kidney disease, the renal preservation benefits of optimal management of blood pressure and blood glucose, the importance of a low-sodium diet, and the potential need for renal replacement therapy.
				9.4	**Retinopathy**	Adults with T1DM referred at diagnosis and children over 12 years of age with T1DM are referred for an initial dilated and comprehensive eye examination by an eye care professional (optometrist or ophthalmologist)
						People with type 2 diabetes are referred for an initial dilated and comprehensive eye examination by the DESPat the diagnosis of diabetes.
						Eye screening to continue as per national guidelines
						Community opticians are able to identify the onset and progression of diabetic retinopathy and other ocular complications of diabetes, and should promptly communicate eye examination findings to the patient's primary care provider
				9.5	**Neuropathy**	All people with diabetes are screened for DPN and have annual screening
						People found to have peripheral neuropathy are assessed for B12 and other vitamin deficiencies, alcohol use disorder, hypothyroidism, and heavy metal or toxin exposure
						People with evidence of other microvascular or neuropathic complications are screened for signs and symptoms of cardiovascular autonomic neuropathy, such as resting tachycardia and orthostatic hypotension
				9.6	**Foot Care**	Starting at the time of diagnosis of diabetes a comprehensive foot examination is conducted annually for each diabetic patient
						General foot health education is available to all adults with diabetes, including preventative strategies such as appropriate footwear
						Podiatry Care Enhanced education is provided to patients with foot risk factors including DPN (loss of protective sensation) and Peripheral Vascular Disease about self-care of the feet
						Podiatric assessment and ongoing monitoring is provided to patients in line with Diabetic agreed foot pathways.

Section: Hard to Reach Groups

Core Domain	Element #	Element Name	Evidence Statement	Sub-Element #	Sub-Element	Framework Requirements
ELEMENTS						
Hard to Reach Groups	10	**The Needs of Special Populations with Diabetes**	*Recognising inequalities is the first step to confronting the challenge of taking effective action*	10.1	**Children and Adolescents**	Identification is made of maturity-onset diabetes of the young (MODY) in older children or young adults with atypical forms of diabetes
						Diabetes care for children and teens is provided by a team that can deal with the special medical, educational, nutritional, and behavioural issues
						Planning for transition of care from parents to self and from paediatric to adult care professionals is provided during the vulnerable time as teens transition into adulthood
						Close communication and cooperation is established between the diabetes care team, school nurses, and other school personnel for optimal management, safety, and academic opportunities for youths with diabetes
						A personal diabetes management plan and daily schedule is developed for the young person in partnership with their parents and the wider team
						Children and teens are supported to check blood glucose levels before beginning a game or a sport and learn to prevent hypoglycaemia
						Local peer groups are available for children and teens with diabetes to provide positive role models and group activities
				10.2	**Women of childbearing age**	Counselling about the importance of planning pregnancies is available to all women with diabetes who have childbearing potential
						Preconception care to achieve glucose control, and discontinuation of medications contraindicated in pregnancy is available to all women with diabetes who have childbearing potential
						Folic acid 5mgs to women who have pre-existing diabetes and are planning a pregnancy and/or that they should be aiming for an HbA1c of <48mmol/mol prior to conception
						Care from a skilled MDT experienced in the management of diabetes before and during pregnancy is available to all women with diabetes who have childbearing potential
						Support to maintain stable blood glucose values close to normal before and during pregnancy, as well as management of any existing long-term diabetic complications is available to all women with diabetes who have childbearing potential
						Women of childbearing age with a history of gestational diabetes mellitus (GDM), prediabetes, or obesity are routinely screened for type 2 diabetes prior to conception or very early in pregnancy
				10.3	**Cognitive Impairment**	Targets and care plans are individualised including education for family and carers around signs of diabetes complications
						HbA1C is monitored to assist better glycaemic control Self-administration and care in people with cognitive-impairments / dementia is closely monitored
						Regular medication reviews are undertaken to simplify regime
						Diabetes care is provided by a team that understand the complex interaction between diabetes and cognitive impairment / dementia
						MDT members have an understanding of the monitoring needs and support of individuals with cognitive impairment
						Annual dementia reviews are carried out in conjunction with diabetic reviews via integrated care plan
				10.4	**Learning Disability**	Individualised targets and care plan. Education for family and carers around signs of diabetes complications
						Regular medication reviews to simplify regime
				10.5	**Older adults**	Management goals are individualised, incorporating a consideration of health and life expectancy in older adults with diabetes
						Care home to staff to receive diabetes education
				10.6	**High-risk racial and ethnic groups**	Screening targets people who are at high risk of diabetes due to race or ethnicity
						Health care team take proactive and practical steps to understand how people view and treat diabetes within their respective cultures
						Appropriate and culturally sensitive diabetes education materials are available to relevant racial and ethnicity groups

Section: **Workforce and Data and Technology**

Core Domain	Element #	Element Name	Evidence Statement	Sub-Element #	Sub-Element	Framework Requirements
ENABLERS						
Workforce	11	**How the health and social care workforce can meet the needs of those with Diabetes**	*Where appropriate requirements linked to STP strategies will be managed through existing forums/boards working with system/place and localities to implement*	11.1	**Leadership and Management**	System leaders promoting framework requirements as best practice and ensuring key requirements are fully embedded
						Joint workforce planning in place across sectors (PCN/Place) to maximise patient impact and outcomes
						System leaders working with research partners to improve planning and provision of quality diabetes care
				11.2	**Skills, Competences and Roles**	Clear competencies developed for the diabetes workforce and other professionals involved in diabetes care based on national guidelines
						Nursing staff assessed and reviewed annually against the Integrated and Competency Framework for Diabetes Nursing
						Alternative roles identified in PCNs to support elements of diabetes care
						A mental health professional with knowledge of diabetes is part of every diabetes care team.
						Diabetes Champion identified within each PCN
				11.3	**Training and Development**	Primary care and public health workforce upskilled to support people in making healthy choices
						Workforce is appropriately skilled to support the concept of self management and person centred care
						Diabetes nurses training in dementia needs
				11.4	**Collaborative working**	High-quality, person-focused and integrated multidisciplinary teams (MDT) established, co-located or virtually, providing collaborative care planning for people with diabetes
						Specialist support (consultant) available to provide diabetes care within a reasonable time.
Data and Technology	12	**How the use of data and technology can meet the needs of those with Diabetes**	*Where appropriate requirements linked to STP strategies will be managed through existing forums/boards working with system/place and localities to implement*	12.1	**Making better use of Data**	Data is collated and analysed at system level, enabling performance to be monitored and evaluated against framework requirements
						Patient level information is available across a range of settings to assist with the management of local populations (PNC/Place)
						Collaboration with local research partners is in place to help support and drive change (eg Academic Health Scientific Network)
				12.2	**Creation of Single Shared Care Record**	Health and social care staff have access to a shared care record
				12.3	**Use of technology to maximise patient care and services**	Prediction/ risk stratification tools used within each practice/PCN to risk stratify patients and identify those patients that have 'rising risk'.
						Technology is available to support traditional assessment, education and monitoring.
						Telehealth and other technologies, such as apps, are utilised where appropriate

This page is intentionally left blank

APPENDIX C: NATIONAL FRAMEWORKS AND STANDARDS

1. REDUCING UNWARRANTED VARIATION

Variation in healthcare is often unavoidable because of its complexity and the difficulties in controlling all the variables that contribute to it. Some can be explained by the characteristics of the local population, individual patients or by differences in the capability of healthcare professionals (NHS Confed, 2004).

Often differences occur when there are local innovations benefiting smaller numbers and dissipate when the innovations become more widespread. The important thing for us to understand is whether the variation is unwarranted. The term 'unwarranted clinical variation' has been described as 'care that is not consistent with a patient's preference or related to [their] underlying illness (NHS Confed, 2004).' This can relate to substandard care around access to services and outcomes.

To limit unwarranted variation in diabetes care, we have outlined below a set of minimum standards people should expect from our services. These local and national standards and our priorities and expected outcomes are set out clearly in this framework.

The following standards and frameworks highlighted are:

- NICE Guidance & Quality Standards
- NICE Diabetes in Pregnancy Quality Standard
- NICE Quality Standard for Diabetes in Children and Young People
- Footcare Standards & Pathways
- National Diabetes Prevention Programme (NDPP)
- NHS Rightcare Diabetes Pathway
- Quality Outcome Framework (QOF)

2. NICE GUIDANCE AND QUALITY STANDARDS

NICE guidelines on prevention of Type 2 diabetes (2018) recommend that risk assessment is carried out in adults aged over 40 years (younger adults from certain minority ethnic groups) with conditions that increase their risk of Type 2 diabetes. Those eligible can also be assessed through the NHS Health Check programme. A person is considered high-risk of diabetes if they have fasting blood glucose of 5.5-6.9 mmol/l or HbA1c of 42-47 mmol/mol.

NICE recommends lifestyle-modification programmes for people at high risk. Metformin is recommended only if blood glucose control has deteriorated despite lifestyle change, or if a person is unable to participate in such programmes, particularly if their BMI is above 35kg/m2. Similarly, orlistat may be considered if BMI is above 28. No other drug therapies are recommended.

2.1.1 NICE QUALITY STANDARDS

1. People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.

2. People with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme.

3. People with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.

4. People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%) and receive an ongoing review of treatment to minimise hypoglycaemia.

5. People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidance.

6. Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

7. Women of childbearing age with diabetes are regularly informed of the benefits of preconception glycaemic control and of any risks, including medication that may harm an unborn child. Women with diabetes planning a pregnancy are offered preconception care and those not planning a pregnancy are offered advice on contraception.

8. People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.

9. People with diabetes are assessed for psychological problems, which are then managed appropriately.

10. People with diabetes at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance.

11. People with diabetes with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.

12. People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.

13. People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.

14. People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

3. NICE DIABETES IN PREGNANCY QUALITY STANDARD (QS109)

1. Women with diabetes planning a pregnancy are prescribed 5 mg/day folic acid from at least 3 months before conception.

2. Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of their pregnancy being confirmed.

3. Pregnant women with pre-existing diabetes have their HbA1c levels measured at their booking appointment.

4. Pregnant women with pre-existing diabetes are referred at their booking appointment for retinal assessment.

5. Women diagnosed with gestational diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of diagnosis.

6. Pregnant women with diabetes are supported to self-monitor their blood glucose levels.

7. Women who have had gestational diabetes have an annual HbA1c test

4. NICE QUALITY STANDARD FOR DIABETES IN CHILDREN AND YOUNG PEOPLE

1. Children and young people presenting in primary care with suspected diabetes are referred to and seen by a multidisciplinary paediatric diabetes team on the same day.

2. Children and young people with Type 1 or Type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

3. Children and young people with Type 1 diabetes are offered intensive insulin therapy and level 3 carbohydrate-counting education at diagnosis.

4. Children and young people with Type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real time continuous glucose monitoring with alarms.

5. Children and young people with Type 1 diabetes are offered blood ketone testing strips and a blood ketone meter.

6. Children and young people with Type 1 or Type 2 diabetes are offered access to mental health professionals with an understanding of diabetes

5. FOOT CARE STANDARDS & PATHWAYS

Effective care requires multidisciplinary team working between professionals in different specialties and, in some cases, in different hospitals or across primary and secondary care. The pathway should have 3 integral components, a foot screening program, a foot protection service (FPS) and a multidisciplinary foot care service (MDFS). The components of each service are described in detail in the new NICE guidance ‘Diabetic foot problems; prevention and management’ (NG19, 2015).

6. NHS DIABETES PREVENTION PROGRAMME

The NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. It is known that many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk.

7. NHS RIGHTCARE DIABETES PATHWAY

The NHS Right Care diabetes pathway shows the core components of an optimal diabetes service, evidence of the opportunity to reduce variation and improve outcomes and the key evidence-based interventions which the system should focus on for greatest improvement, supported by practice examples from across the NHS.

The diabetes pathway defines the core components of an optimal diabetes service for people with or at risk of developing Type 1 and Type 2 diabetes that delivers the better value in terms of outcomes and cost.

The diabetes pathway has been developed in collaboration with the National Clinical Director for Diabetes and Obesity, Jonathan Valabhji, Associate National Clinical Director for Diabetes, Partha Kar, the NHS Diabetes Prevention Programme, Public Health England, Diabetes UK and a range of other stakeholders.

The pathway shows the core components of an optimal diabetes service, evidence of the opportunity to reduce variation and improve outcomes and the key evidence-based interventions which the system should focus on for greatest improvement, supported by practice examples from across the NHS.

8. QUALITY OUTCOME FRAMEWORK (QOF)

We will continue to encourage the best care and management for people with diabetes through the Quality and Outcomes Framework (QOF) payment mechanism to GP practices.

An update of the QOF indicator list for 2019/20 features eight new diabetes indicators. NICE stated that the new approach, which comes following a review of the QOF in England, will improve outcomes and decrease the risk of harm from over-treatment.

Updated indicators on Type 2 diabetes include two indicators on blood glucose targets for people with and without frailty, while another sets one blood pressure target for all people without frailty. Meanwhile, three new indicators feature which have been added since the consultation draft, supporting existing NICE recommendations on cardiovascular risk assessments and statin treatment for people with Type 2 diabetes.

8.1.1 THE NEW INDICATORS

- **NM157** – The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58mmol/mol or less in the preceding 12 months.

- **NM158** – The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 12 months.

- **NM159** – The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less.

- **NM142** – The percentage of patients with Type 1 diabetes who are aged over 40 years currently treated with a statin.

- **NM160** – The percentage of patients aged 25-84 years, with a diagnosis of Type 2 diabetes, without moderate or severe frailty, not currently treated with a statin, who have had a consultation for a cardiovascular risk assessment using a risk assessment tool agreed with the NHS Commissioning Board in the last three years.

- **NM161** – The percentage of patients with a diagnosis of Type 2 diabetes and a recorded CVD risk assessment score of ≥10% (without moderate or severe frailty), who are currently treated with a statin (unless there is a contraindication or statin therapy is declined).

- **NM162** – The percentage of patients with diabetes aged 40 years and over, with no history of CVD and without moderate or severe frailty, who are currently treated with a statin (excluding patients with Type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)

- **NM163** – The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin

Appendix D: PRESCRIBING ALGORITHM FOR THE TREATMENT OF TYPE 2 DIABETES IN ADULTS

1st LINE **In ADDITION to lifestyle measures**	**SET GLYCAEMIC TARGET: HbA1c <7% (53 mmol/mol) OR INDIVIDUALISED AS AGREED**			
	USUAL APPROACH		**ALTERNATIVE APPROACH: if osmotic symptoms or intolerant of metformin**	
	METFORMIN	IF OSMOTIC SYMPTOMS (POLYURIA, POLYDIPSIA) CONSIDER **SULPHONYLUREA** FIRST. ONCE OSMOTIC SYMPTOMS RESOLVED, ADD OR REPLACE **METFORMIN**.	**SULPHONYLUREA**	IF SEVERE OSMOTIC SYMPTOMS WITH WEIGHT LOSS OR POSSIBILITY OF TYPE 1 DIABETES **(URGENT-PHONE SECONDARY CARE IMMEDIATELY, BTUH AMBULATORY CARE)** ⇩ **BASAL INSULIN***
EFFICACY	MODERATE		HIGH	
CV BENEFIT	YES		NO	
HYPOGLYCAEMIA RISK	LOW		HIGH	
WEIGHT	NEUTRAL/REDUCTION		GAIN	
MAIN ADVERSE EVENTS	GASTROINTESTINAL		HYPOGLYCAEMIA	
IN CKD STAGE 3A	MAXIMUM 2 g DAILY		CAREFUL MONITORING [1]	
2nd LINE **In ADDITION to lifestyle measures**	**IF NOT REACHING TARGET AFTER 3–6 MONTHS [2], REVIEW ADHERENCE: THEN GUIDED BY PATIENT PROFILE**			
	ADD ONE OF (CHOICE DEPENDENT ON INDIVIDUAL PATIENT CIRCUMSTANCES, ADD ONE AT A TIME):			
	SULPHONYLUREA *OR*	**DPP-4 INHIBITOR* *OR***	**SGLT2 INHIBITOR* *OR***	**PIOGLITAZONE (specialist)***
EFFICACY	HIGH	LOW/MODERATE	MODERATE	MODERATE
CV BENEFIT	NO	NO	YES (EMPAGLIFLOZIN AND CANAGLIFLOZIN)	PROBABLE (BUT FLUID RETENTION)
HYPOGLYCAEMIA RISK	HIGH	LOW	LOW	LOW
WEIGHT	GAIN	NEUTRAL	LOSS	GAIN
MAIN ADVERSE EVENTS	HYPOGLYCAEMIA	FEW	GENITAL MYCOTIC INFECTIONS	OEDEMA/FRACTURES [5]
IN CKD STAGE 3A	CAREFUL MONITORING [1]	REDUCE DOSE [3]	DO NOT INITIATE [4]	DOSE UNCHANGED
3rd LINE **In ADDITION to lifestyle measures**	**IF NOT REACHING TARGET AFTER 3–6 MONTHS, REVIEW ADHERENCE: THEN GUIDED BY PATIENT PROFILE [6]**			
	ADD *EITHER* AN ADDITIONAL ORAL AGENT FROM A DIFFERENT CLASS			
	SULPHONYLUREA *OR*	**DPP-4 INHIBITOR* *OR***	**SGLT2 INHIBITOR* *OR***	**PIOGLITAZONE* (specialist)**
	OR AN INJECTABLE AGENT			
	GLP-1 AGONIST*: *If BMI is ≥35kg/m² in people of European descent (adjust for ethnic groups) and there are specific psychological or medical problems associated with high body weight, or BMI<35kg/m² and insulin is unacceptable because of occupational implications or weight loss would benefit other co-morbidities*		**BASAL INSULIN*:** *If BMI <30kg/m²*	
EFFICACY	HIGH	• stop DPP-4 inhibitor • consider reducing sulphonylurea • continue metformin • can continue pioglitazone • can continue SGLT2 inhibitor • aim for reduction of at least 11 mmol/mol (1.0%) in HbA1c and a 3% weight loss at 6 months (or individualised target)	HIGH	• inject before bed • use NPH (isophane) insulin - or longer-acting analogues if previous history of hypoglycaemia, or if hypoglycaemia on NPH (isophane) insulin • can continue metformin, pioglitazone, DPP-4 inhibitor or SGLT2 inhibitor • can reduce or stop sulphonylurea
CV BENEFIT	YES (SEMAGLUTIDE/LIRAGLUTIDE)		NO	
HYPOGLYCAEMIA RISK	LOW		HIGHEST	
WEIGHT	LOSS		GAIN	
MAIN ADVERSE EVENTS	GASTROINTESTINAL		HYPOGLYCAEMIA	
IN CKD STAGE 3A	DOSE UNCHANGED [7]		DOSE UNCHANGED [8]	
4th LINE **In ADDITION to lifestyle measures**	**IF NOT REACHING TARGET AFTER 3–6 MONTHS, REVIEW ADHERENCE: THEN GUIDED BY PATIENT PROFILE ADD ADDITIONAL AGENT(S) FROM 3rd LINE OPTIONS (NEED SPECIALIST INPUT)**			

NOTES:
***Continue medication at each stage if EITHER individualised target achieved OR HbA1c falls more than 0.5% (5.5 mmol/mol) in 3–6 months. DISCONTINUE IF EVIDENCE OF INEFFECTIVENESS.**
Algorithm does not apply in severe renal or hepatic insufficiency. 1. Consider dose reduction. 2. Do not delay if first line options not tolerated / inappropriate. 3. See BNF: no dose reduction required for linagliptin. 4. See BNF: specific agents can be continued at reduced dose. 5. Pioglitazone is contraindicated in people with (or with a history of) heart failure or bladder cancer. 6. Do not combine dapagliflozin with pioglitazone. 7. Caution with exenatide when eGFR<50 ml/min/1.73 m^2. 8. Adjust according to response.

DRUG CLASS	FORMULARY CHOICE	ADDITIONAL INFORMATION
BIGUANIDES	METFORMIN	• Start low dose, with gradual dose escalation, best taken with/after a meal/evening meal. • GI side effects often improve after a few days of continued therapy, or with a small dose reduction. • Modified release: reserved for those who suffer with persistent GI side effects only after gradual titration with standard release metformin (prescribe as brand name **Sukkarto SR**).
SULPHONYLUREAS	GLICLAZIDE *(1st line)* *(consider glimepiride if compliance issues)*	• Holders of group 2 licenses (bus and lorry drivers) taking sulphonylureas must be able to provide evidence of checking blood glucose at least twice per day and at times relevant to driving. • Holders of group 1 licenses (car drivers and motorcyclists) taking sulphonylureas need not notify the DVLA provided they have experienced no more than one episode of severe hypoglycaemia in the last 12 months and, if needed, check blood glucose at times relevant to driving and are under regular review.
DPP-4 INHIBITORS	ALOGLIPTIN	• Recommended dose of alogliptin is 25mg once daily. -Dose reduction in moderate renal impairment (eGFR 30-50ml/min): 12.5 mg once daily. -Dose reduction in severe renal impairment (eGFR < 30 ml/min): 6.25 mg once daily. • *Consider linagliptin in patients with end stage/deteriorating renal function only.*
116 **SGLT2 INHIBITORS**	EMPAGLIFLOZIN or DAPAGLIFLOZIN	• In individuals with type 2 diabetes and established cardiovascular disease, SGLT2 inhibitors with proven cardiovascular benefit (currently empagliflozin and canagliflozin) should be considered *AFTER* and in addition to metformin. • Risk of diabetic ketoacidosis (DKA) and lower limb amputation. DKA may present atypically, with relatively normal glucose levels. MHRA guidance advises testing for raised ketone levels in people with symptoms of DKA, even if plasma glucose levels are near normal. • Small risk of developing a genital yeast or fungal infection (most commonly thrush in women) due to more glucose being excreted in the urine. • Continue canagliflozin if requested by secondary care (may be recommended for renoprotective effect in specific cases)
THIAZOLIDINEDIONES	PIOGLITAZONE	• For specialist use only, to be considered in insulin resistant patients, or as an alternative to injectable therapy • Contraindicated in people with (or with a history of) heart failure or bladder cancer. • The risk of fracture/osteoporosis should be considered during long-term use of pioglitazone. • Be aware of possibility of macular oedema if patients report disturbances in visual acuity
GLP-1 AGONIST	SEMAGLUTIDE (LIRAGLUTIDE-up to 1.2mg once daily, for specialist endocrine use in specific cases)	• For individuals with type 2 diabetes and established cardiovascular disease, GLP-1 receptor agonists with proven cardiovascular benefit should be considered *AFTER* and in addition to metformin. • When a GLP-1 receptor agonist is added to a sulphonylurea, a reduction in sulphonylurea dose should be considered. • People taking GLP-1 receptor agonists may hold a regular (Group 1) driving licence without restriction, but must notify the DVLA if they hold a Group 2 licence.
MEGLITINIDES	REPAGLINIDE	• Specialist recommendation. Licensed as monotherapy or in combination with metformin.
COMBINATION PRODUCTS ARE NOT ROUTINELY RECOMMENDED AND NOT SUPPORTED FOR PRESCRIBING		

Title	Prescribing algorithm for the treatment of type 2 diabetes in adults
Reference	SIGN 154: Pharmacological management of glycaemic control in people with type 2 diabetes, November 2017, https://www.sign.ac.uk/assets/sign154.pdf
Version	1
Author	Medicines Management Team
Approved by	Basildon & Brentwood CCG: Prescribing Subgroup, Patient Quality and Safety Committee, Board Thurrock CCG: Medicines Management and Safety Group, Patient Quality and Safety Committee, Transformation & Sustainability Committee, Board South Essex Medicines Management Committee
Date approved	July 2019
Review date	July 2021

This page is intentionally left blank

Southend Health & Wellbeing Board

Agenda Item No.

8

Report of the Director of Public Health

To

Health & Wellbeing Board

on

8th September 2020

Report prepared by: Claire Routh, Head of Communications and Engagement, NHS Southend CCG & NHS Castle Point and Rochford CCG

For information only		For discussion	X	Approval required	

Flu Campaign Plan 2020-21

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1 To provide an update on the flu campaign plan and implementation for 2020-21

2. Recommendation

2.1. That HWB Board notes the content and approach being taken.

3.0 Background

3.1 Flu immunisation is critical in reducing the number of preventable deaths in older people, and at risk groups. It provides a good level of immunity against the expected flu strains this year, as advised by the World Health Organisation.

It is important that at risk groups are offered the flu vaccination to reduce the risk of death and serious illness, and pregnant women to avoid the risk of complications with their pregnancy. The government has also announced that all those aged between 50 and 64 years, will also receive a free flu jab this year. For this cohort, this is likely to take place from November and depending on flu jabs availability.

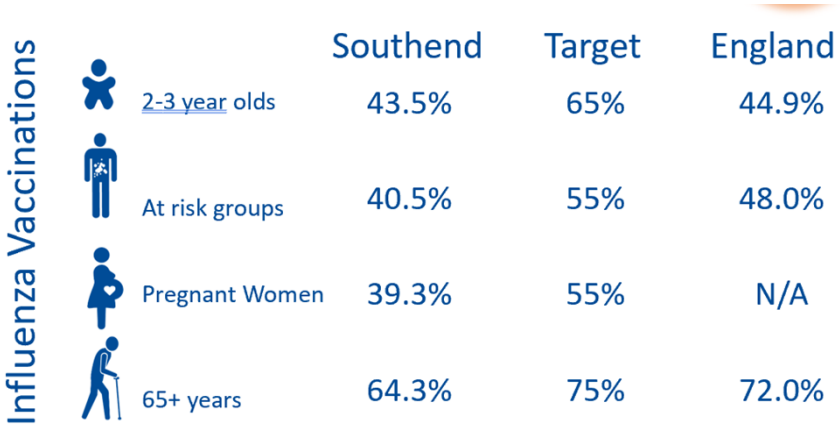
Given the unprecedented challenge of the pandemic and some unknown risks associated with COVID-19, people who are entitled to a jab should ensure they have one as soon as they are invited for this. With the anticipated risk of an

increasing spread of coronavirus and the flu virus this autumn and winter, increasing the uptake of the flu jab is critical for people's health and the added strain that resulting poor health will have on health care services as well as social care provision.

4.0 Flu Uptake in 2019-20 and Our Approach in 2020-21

4.1 It is widely viewed that many people entitled to a free flu jab are not taking this up, putting their health at risk, albeit suggestions that people are becoming complacent.

Our flu jabs uptake in Southend are amongst the lowest in the country. We have low uptake across all our key target groups



Our plan for 2020-21 is to take a more innovative approach and engage more directly with our population working more collaboratively between the NHS, the Council and SAVS. We are also looking at better engaging with local providers such as the pharmaceuticals and EPUT, to maximise the uptake of flu jabs amongst our local workforce.

The local campaign will be primarily led through three key objectives:

- **INFORM:** to raise awareness of flu vaccination across key audiences informed by data
- **EDUCATE:** tailored educational messages to help overcome barriers to accepting the offer of a vaccination
- **INSPIRE:** encouragement from staff and wider community to increase uptake

5.0 Recommendation

The HWB Board should note the approach taken and support our local drive in identifying champions to support our campaign, including people who would be willing to receive a jab and be the 'face' of our media campaign.

FLU CAMPAIGN

Key objectives

- **INFORM**: to raise **awareness** of flu vaccination across **key audiences** informed by data
- **EDUCATE**: tailored educational messages to help **overcome barriers** to accepting the offer of a vaccination
- **INSPIRE**: encouragement from staff and wider community to **increase uptake**

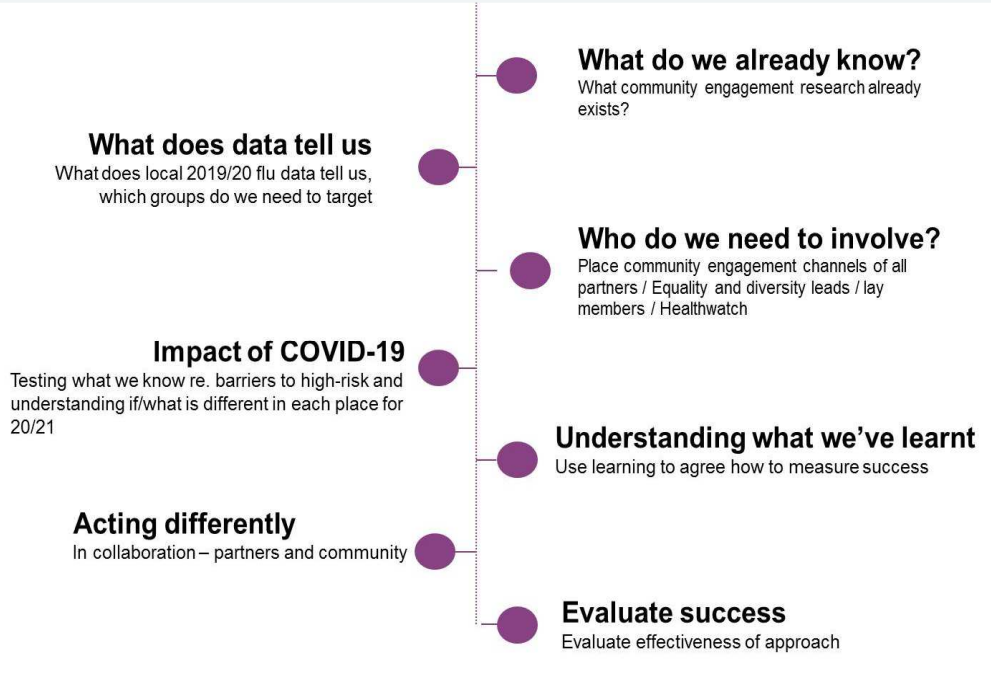
INFORM

Communications strategy is deliberately targeted and tailored to support to allow prioritisation of those in ‘at-risk’ groups first.

NOTE: The aim to further extend the vaccine programme in November and December to include the 50-64 year old age group is subject to vaccine supply.

NEED: to manage expectation

Community engagement



Southend Borough Council is working with colleagues in CCG and SAVS to undertake some research within our 'at-risk' groups to understand barriers.

Resulting insight will be used to help shape action re. local communications – working alongside community leaders to co-producing assets to help educate/inform/drive action.

Engagement and reach

Partnership working in order to be successful in reaching intended audiences.

Partnership working – with local health and social care, local authorities, councils and school networks. Strategic partnerships e.g. south east Essex includes:

CAVS, RRAVS, SAVS, Healthwatch Southend, PCNs, Schools (primary, pre-schools and children's centres), Essex County Council, Local Authorities, Community Services, Essex Child and Family Wellbeing Centres, School Nurses.

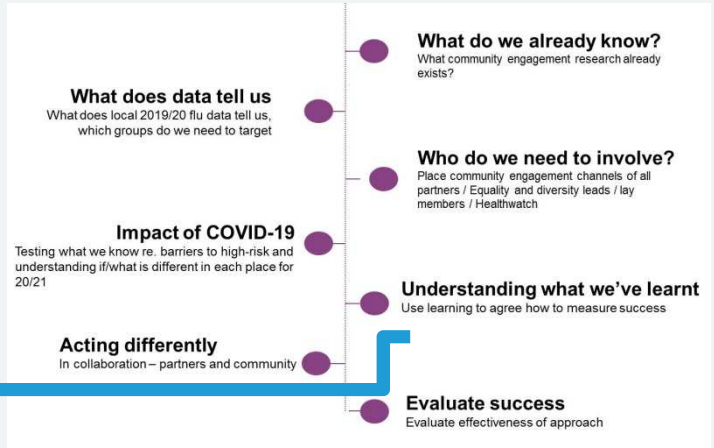
- **Southend Healthy Schools Network**
- **Southend Borough Council – Early Years Network**
- **A Better Start Southend (ABSS).**

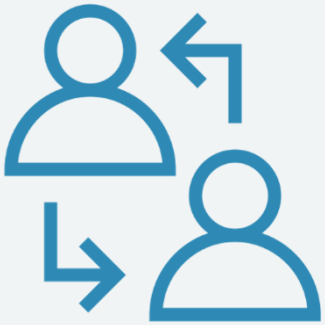
SEE Community Engagement channels

Area	Existing
Partner engagement channels - Southend	• Bang the table – SBC engagement platform • Southend Hospital Patient Council • Southend Hospital – LD/Autism/Aspergers committee meeting – chaired by Shields • SAVS – community newsletter • EPUT –MH user experience forum • Mental Health Partnership Board (Simone Longley, EPUT/Georgina Beadon MH commissioning) - all community services • LD Partnership Board • Healthwatch Southend • SBC Interfaith Group • South Essex Homes – community hubs • Southend Youth Council • SEND Local Off • A Better Start Southend – Parent Champions • Education • 'Talking Heads' community engagement platform • Southend Borough Council Livewell platform • Family Voice • YMCA Youth Board • Scope monthly meetings supporting people with a disability • Patient Participation Groups • Shoebury/Westborough Residents Associations • Project 49 • Southend Carers Newsletter • CCG Patient and Community Reference Group

EDUCATE

CENTRAL WEBPAGE/SOCIAL MEDIA : tailored educational messages to help **overcome barriers** to accepting the offer of a vaccination





STAFF ENGAGEMENT: Subject to final budget approval: promote FLU BEE GAME, explore system clinics (tbc pending IPC advice). Use HCP staff facing website with links to public facing page.

EDUCATE

Targeted text communications to at-risk groups registered at GP practices using relevant read codes (gathered as part of COVID-19 response)

160 characters – 2p per text

At-risk group	2019/20 MSE stats
Over 65's:	235,848
Pregnant women:	11,265
Parents of Children 2/3:	29,514
Total texts:	Approx: 276,627

FLU BEE

What is Flu Bee Game?

- A digital game to encourage NHS staff to get vaccinated against flu.
- Developed with James Paget University Hospitals NHS FT in 2016.
- Simple quiz-style game that busts common myths and misconceptions.
- Delivers key messages to staff on their own smart phones and tablets.
- Focus Ga

www.FluBeeGame.com
@FluBeeGame

Example of landing web page

- 2019/2020 – themed web page

www.FluBeeGame.com
@FluBeeGame

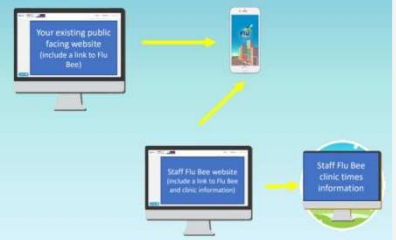
Award winning game now in its 4th Year

- Used by NHS Trusts, Care Homes, Local Authorities and Universities
- NHS England, NHS Scotland, NHS Northern Ireland.
- International versions in France and Spain
- NHS Flu Fighter Awards 2018 – NHS Frimley "most improved Flu campaign"
- Finalist Health Service Journal Awards 2020

www.FluBeeGame.com
@FluBeeGame

Public facing game

- Use of Flu Bee and promoted on a public facing website in a geographical area.
- Update questions in the game to support a public campaign
- Branding and graphics pack to support marketing (game images etc.)
- Run public and staff games together.



www.FluBeeGame.com
@FluBeeGame

INSPIRE

- **FREE masks offered to community partners, NHS volunteers & social influencers & influential/respected clinicians post-jab**

EVALUATING SUCCESS

*ultimate measure will be impact on flu vaccinations for those at risk

X

People took part in community engagement.

X

Played FLU BEE game engaging in key messages around 2020 flu myths.

1

Engagement report to inform campaign messaging

X

Masks disseminated to partners.

X

Impressions/people reached (total) across social media

X

Page views on campaign webpage.

This page is intentionally left blank

Southend Health & Wellbeing Board

Agenda Item No.

9

Report of the Director of Public Health

To

Health & Wellbeing Board

on

8th September 2020

Report prepared by: Krishna Ramkhelawon, Director of Public Health

For information only		For discussion	X	Approval required	

Coronavirus Pandemic Management
Updates from the Health Protection Board and the Oversight and Engagement Board

Part 1 (Public Agenda Item)

Purpose

This is to provide an update on the COVID-19 Local Outbreak Control Plan implementation of the national Test, Trace, Contain and Enable (**TTCE**) programme.

Background

The TTCE programme is a central part of UK government's COVID-19 recovery strategy. The primary objectives are to control the COVID-19 rate of reproduction (R), reduce the spread of infection and save lives, and in doing so help return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

Achieving these objectives will require a coordinated effort from local and national government, the NHS, General Practice, businesses and employers, voluntary organisations and other community partners, and the general public.

Local Outbreak Control Plan (LOCP)

Local planning and response will be essential. Local Government, NHS, the Local Resilience Forum (Essex Resilience Forum - **ERF**) and other relevant local organisations will be at the heart of the programme. Response may include appropriate local containment strategies, the implementation of which is expected to be achieved within the existing legal framework and by appealing to the public's sense of civic duty and working with local community leaders.

The seventh version (click this link for access to the document) of the Southend LOCP was updated on the 25th August with new guidance and will remain a dynamic document.

Resources

A dedicated £889,000 has been allocated to Southend for implementing this programme in 2020-21. The local system will build on existing health protection arrangements, including but not limited to those delivered by local authorities, to put in place measures to identify and contain outbreaks, and protect the public's health.

Actions by Local Boards

The governance structure and support arrangements are as follows:

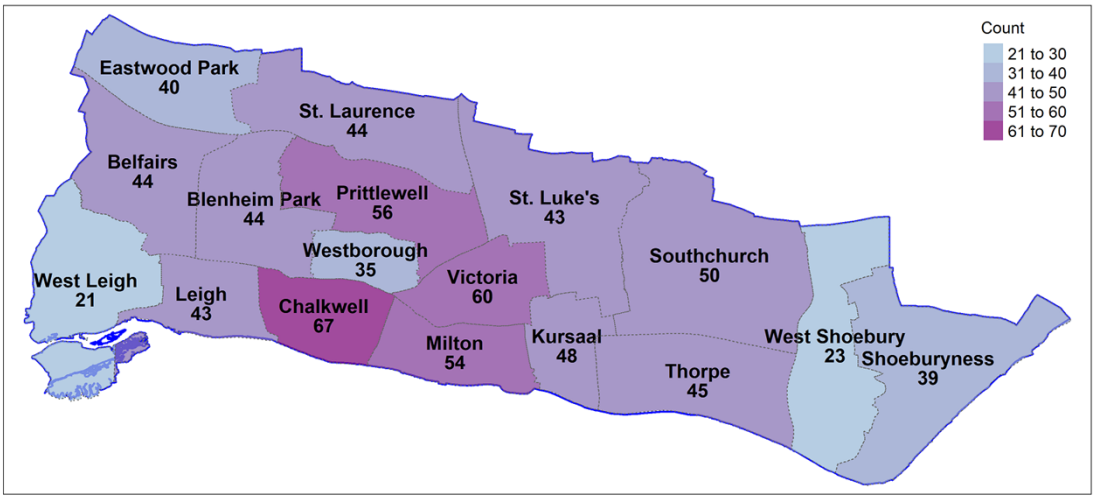
- A COVID-19 Health Protection Board (**HPB**) responsible for defining these measures and producing the plans. It will be supported by and work in collaboration with the local emergency planning forums.
- The Outbreak Control Oversight and Engagement Board (**O&E Board** – Chair, Cllr Harp) led by Council Members, with support for the NHS and Police and Crime Commissioner, to communicate with the public.

The HPB meets weekly and receives the local Surveillance Report monitoring our testing capabilities, infection rate, mortality rate, positivity rate, level of contact tracing and any report and case reviews of local outbreaks. There has been no outbreak in Southend in the past 9 weeks (@ 1st Sept 2020).

Our joint Essex and Southend Contact Tracing service is up and running and we await further alignment with the national centre, following the restructure of Public Health England (**PHE**). The NHS Test and Trace service, the Joint Biosecurity Centre and the health protection function of PHE have merged to form the National Institute for Health Protection (**NIHP**). There has been no change in how Southend engages with our regional team.

We now have three days of operation from the Mobile Testing Unit (**MTU**) at Southend Airport and NHS England is considering an additional MTU to be based either in Benfleet or on Canvey Island. The Department of Health and Social Care has also provided Southend with a Walk-through facility in central Southend (Short Street Car Park). This is operational 12 hours/day and 7 days a week. We have seen a significant increase in daily testing numbers averaging around 110/day at the beginning of August to over 450/day at the end of August. Our positivity rate remains low although we have seen a marginal increase in infection, which is expected with increasing testing.

A total of 756 positive tests have been recorded across Southend since the start of the pandemic. This is fairly evenly spread across the borough as highlighted in the map below.



Two table-top exercises took place in July (led by the ERF) and August (led by the Southend HPB) to test the robustness of our plans. Some of the learning from the second exercise will be incorporated into the next revision of our LOCP. All the 11 Cell Leads (multi-agency) were engaged in the local exercise.

The O&E Board continue to lead on a large number of communication and engagement activities, including refreshing our messaging to the public and local businesses. We continue to hold regular webinars with schools and businesses and we are actively engaged with a multi-media social marketing campaign. This will soon see the use of social influencers to target key groups, such as younger people (<30 years), in promoting our key messages of maintaining social distancing, hand hygiene and using face covering in the appropriate settings.

All our actions and local interventions are reviewed and shared with the Regional Test and Trace Support and Assurance Team.

Recommendation

1. For the HWB Board to note progress and ongoing implementation of the Local Outbreak Control Plan by the Local Health Protection Board and the Outbreak Control Oversight and Engagement Board.

This page is intentionally left blank

Report for Health and Well-Being Board

10

Subject: Children and young people with Special Educational Needs and Disabilities (SEND)

Date: 8th September 2020

From: Brin Martin, Director of Education and Early Year

1. Background and Purpose of this report

HWBB received and discussed a briefing paper about children and young people with special educational needs and disabilities (SEND) in June 2020. The briefing outlined the clear remit and responsibilities of HWBBs to lead in this area, outlined in the Special Educational Needs and Disabilities Statutory Code of Practice. It also provided an update on progress and future plans to complete the Written Statement of Action (WSOA) as a result of the SEND inspection in October 2018, and sought HWBB views on future proposals, specifically around leadership and governance, and how the role of HWBB could be strengthened to not only meet statutory requirements. It also to asked partners to ensure that there is a clear focus across the local area at the highest level on lived experiences and outcomes for these children and their families.

HWBB resolved that:

1. The leadership and governance workstream be engaged to review and determine the appropriate level and role of the Board in the strategic oversight and governance of SEND on an ongoing basis as laid out in the SEN Code of Practice and good practice in local area leadership.

2. It be recognised that the SEND area partners will need to undertake a range of actions in order to ensure that the required improvements in the local offer outcomes for children and young people with SEND in Southend-on-Sea are met at pace.

3. Regular updates be provided to future meetings of the Board in relation to progress against the (five) areas identified in the report as part of the overarching SEND governance arrangements.

This paper provides a further update of progress and evidence of how we are doing in three headings:

1) Leadership and Governance
2) Knowing ourselves: current evidence of how we are doing including self-evaluation, survey results and measuring outcomes and impact in the future
3) Generating improvements.

2. Leadership and Governance

Appendix A provides as synopsis of statutory requirements re: governance, including the role of the HWBB.

There has been progress in developing a new local governance framework for SEND sited below the HWBB, with good engagement and agreement at a joint meeting of partners (the current Strategic Board and Joint Commissioning and Accountability group) in July 2020.
(By governance, we mean an organisational structure; communication and reporting arrangements across the system; terms of reference, membership and their responsibilities, functions and activities for each group; decision making, risk and escalation arrangements through the system.)

The first outline for consultation is currently planned as follows:

1. First draft sent for consultation to current SEND strategic group members, including the HWBB learning and governance workstream, other key stakeholders and including local parents, for comment by 20th September
2. Hold first meeting of the new SEND Strategic Partnership Board in October/November to agree final governance arrangements
3. Have all new groups, membership and functions clear and operational by 30th November 2020.

We would ask HWBB to

- consider and approve the current proposed organisational structure attached in Appendix B, pending any other consultation responses as well as future work with the HWBB leadership and governance workstream.
- Identify members of HWBB to act as "SEND champions" to firstly hold the area officers to account for progress made in between meetings, but also to be able to share this progress with both members of the Board and more widely.

3. Knowing ourselves: current evidence of how we are doing including self evaluation, survey results and measuring outcomes and impact in the future

3.1 Self Evaluation and Strategy

We have arranged development sessions with relevant stakeholders to review current evidence, finalise the self evaluation and agree priorities and areas for improvement for the next period, resulting in a refresh to the current SEND strategy in December. Children and young people, parents, carers, the community and voluntary sector will be integral stakeholders in this.

3.2 Current evidence

There is progress on improving the range of evidence that is available that tells us how we are doing.

a) An updated SEND summary (Joint Strategic Needs Assessment chapter) will be available in first draft at the end of September. This has been extended to include a greater breadth of evidence from across the local area, and qualitative information including messages from research.
b) Developing an outcomes framework aligned with the Southend, Essex and Thurrock arrangements has commenced. It will provide greater access across the local area to

strategic information of how we are doing on an ongoing basis, including reports to HWBB. This work is aligned to the SEND summary and the strategy.

c) Following implementation of different ways to listen the views and experiences of children, parents and carers, the first results from the POET survey are currently being analysed, and will be shared with Board at the meeting.

4. Generating improvements

The area continues to progress the actions identified in the Written Statement of Action (WSoA) in addition to continuously developing to deliver good outcomes. Whilst the impact of the pandemic and delays in recruitment to key posts have slowed the progress that was noted earlier in the year, significant traction has been made in several significant areas.

a. The SEND Service has been running with a significant number of vacancies during the lockdown period which has added to the challenge of delivering Business As Usual and responding to the challenges brought about by Covid19. Despite this several innovative services have been introduced which have been well received by parents, young people and practitioners both locally and on a national stage, in particular that of the Educational Psychology Service.
b. The restructure of the SEND Service has been completed and all staff will be in post by September 20. The emphasis on recruiting high quality staff who fully demonstrate the Southend 2050 values and behaviours and have the necessary skills required has meant that initial recruitment on some occasions was unsuccessful resulting in re-advertising and selection.
c. The new parent designed SEND Local Offer website was launched in January 2020, and during the transition phase a Local Offer Facebook page was used to share important information with parents and young people and continues to be part of a much broader social media presence relating to SEND.
d. A new case management system, Open Objects EHC Hub has been procured, trialled and is scheduled for implementation in September. Feedback received from parents/carers and SENCOs has been very positive.
e. The DfE through their contract agency Contact took the decision not to award the contract for the Parent Carer Forum to either of the two organisations who submitted a bid. As a result the Council is working closely with Contact to establish a new PCF as soon as possible. In the meantime, we are engaging with both organisations to ensure we have authentic voice supporting co-production.
f. Of relevance to the fourth area on the WSoA, the Council set in place comprehensive systems during the lockdown to support schools in ensuring the wellbeing of vulnerable pupils who were not attending school. This provision also included the secondment of serving HMI to add additional scrutiny.

5. Recommendations to HWBB

We would ask HWBB to:

1. Note progress on leadership and governance, and support the pace required for the changes.
2. Agree the new organisational structure, pending further stakeholder consultation and liaison with the HWBB leadership and governance workstream. Decide sign off arrangements for Terms of Reference and membership at SEND Strategic Partnership Board level, given the attention needed to pace.
3. Consider their effectiveness in undertaking the statutory requirements.

Appendix A

Special Educational Needs and/or Disabilities - Legislative Framework

(v0.1 29 Jul 2020)

These are regulations from the Statutory Code of Practice and Part 3 of the Children and Families Act 2014 and associated regulations. The regulations associated with the Children and Families Act 2014 are:

- The Special Educational Needs and Disability Regulations 2014
- The Special Educational Needs (Personal Budgets) Regulations 2014
- The Special Educational Needs and Disability (Detained Persons) Regulations 2015
- The Children and Families Act 2014 (Transitional and Saving Provisions)(No 2) Order 2014

1. (1.19) Local authorities, CCGs and other partners must work together in local Health and Wellbeing Boards to assess the health needs of local people, including those with SEN or who are disabled. This assessment, the Joint Strategic Needs Assessment, informs a local Health and Wellbeing Strategy which sets priorities for those who commission services. Local authorities must keep their educational and training provision and social care provision for children and young people with SEN or disabilities under review (Section 27 of the Children and Families Act 2014). In carrying out this duty, the local authority will gather information from early years providers, schools and post-16 institutions. In most cases, those institutions must, in turn, co-operate with the local authority. The local authority must publish and keep under review its Local Offer of provision in consultation with children, their parents and young people. Guidance on these matters is given in Chapters 3 and 4.
2. (3.1) Section 25 of the Children and Families Act 2014 places a duty on local authorities that should ensure integration between educational provision and training provision, health and social care provision, where this would promote wellbeing and improve the quality of provision for disabled young people and those with SEN.
3. (3.1) The Care Act 2014 requires local authorities to ensure co-operation between children's and adults' services to promote the integration of care and support with health services, so that young adults are not left without care and support as they make the transition from children's to adult social care. Local authorities must ensure the availability of preventative services for adults, a diverse range of high quality local care and support services and information and advice on how adults can access this universal support.
4. (3.3) Local authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities (Section 26 of the Act). The term 'partners' refers to the local authority and its partner commissioning bodies across education, health and social care provision for children and young people with SEN or disabilities, including clinicians' commissioning arrangements, and NHS England for specialist health provision.

5. (3.4) Joint commissioning should be informed by a clear assessment of local needs. Health and Wellbeing Boards are required to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, to support prevention, identification, assessment and early intervention and a joined-up approach. Under section 75 of the National Health Service Act 2006, local authorities and CCGs can pool resources and delegate certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

6. (3.5) To take forward the joint commissioning arrangements for those with SEN or disabilities described in this chapter, partners could build on any existing structures established under the Children Act 2004 duties to integrate services.

7. (3.6) The NHS Mandate, which CCGs **must** follow, contains a specific objective on supporting children and young people with SEN or disabilities, including through the offer of Personal Budgets.

8. (3.7) Joint commissioning arrangements should enable partners to make best use of all the resources available in an area to improve outcomes for children and young people in the most efficient, effective, equitable and sustainable way (*Good commissioning: principles and practice, Commissioning Support Programme, (Rev) September 2010*). Partners **must** agree how they will work together. They should aim to provide personalised, integrated support that delivers positive outcomes for children and young people, bringing together support across education, health and social care from early childhood through to adult life, and improves planning for transition points such as between early years, school and college, between children's and adult social care services, or between paediatric and adult health services.

9. (3.8) Under the Public Sector Equality Duty (Equality Act 2010), public bodies (including CCGs, local authorities, maintained schools, maintained nursery schools, academies and free schools) **must** have regard to the need to eliminate discrimination, promote equality of opportunity and foster good relations between disabled and non-disabled children and young people when carrying out their functions. They **must** publish information to demonstrate their compliance with this general duty and **must** prepare and publish objectives to achieve the core aims of the general duty. Objectives **must** be specific and measurable.

10. (3.13) Local authorities must work to integrate educational provision and training provision with health and social care provision where they think that this would promote the wellbeing of children and young people with SEN or disabilities, or improve the quality of special educational provision. Local partners must co-operate with the local authority in this. The NHS Mandate, NHS Act 2006 and Health and Social Care Act 2012 make clear that NHS England, CCGs and Health and Wellbeing Boards must promote the integration of services.

11. (3.18) At a strategic level, partners must engage children and young people with SEN and disabilities and children's parents in commissioning decisions, to give useful insights into how to improve services and outcomes. Local authorities, CCGs and NHS England must develop effective ways of harnessing the views of their local communities so that commissioning decisions on services for those with SEN and disabilities are shaped by users' experiences, ambitions and expectations. To do this, local authorities and CCGs should engage with local Healthwatch

organisations, patient representative groups, Parent Carer Forums, groups representing young people with SEN and disabilities and other local voluntary organisations and community groups.

12. (3.21) Each upper tier local authority (county council or unitary authority) has a Health and Wellbeing Board. The Health and Wellbeing Board is a strategic forum which provides leadership across the health, public health and social care systems. The board's job is to improve the health and wellbeing of the local population and reduce health inequalities. Health and Wellbeing Boards have a duty to promote greater integration and partnership working, including through joint commissioning, integrated provision and pooled budgets. The membership of the board must include the Director of Children's Services, Director of Public Health, Director of Adult Social Services and a minimum of one elected member from the local authority, a CCG representative and a local Healthwatch representative. Membership from communities and wider partners is decided locally.

13. (3.43) Partners should agree how they will work together to monitor how outcomes in education, health and care are being improved as a result of the provision they make. Partners should monitor the changing needs of the local population of children and young people with SEN and disabilities closely and, crucially, establish whether or not the provision arranged for them is improving outcomes. EHC plans for individual children and young people must be similarly reviewed to see if they are enabling the child or young person to achieve their desired outcomes, so that where appropriate the commissioned provision can be changed. Feedback from children, young people and families is useful in identifying gaps in provision. Any changes in provision commissioned locally should be reflected in the Local Offer.

Local accountability

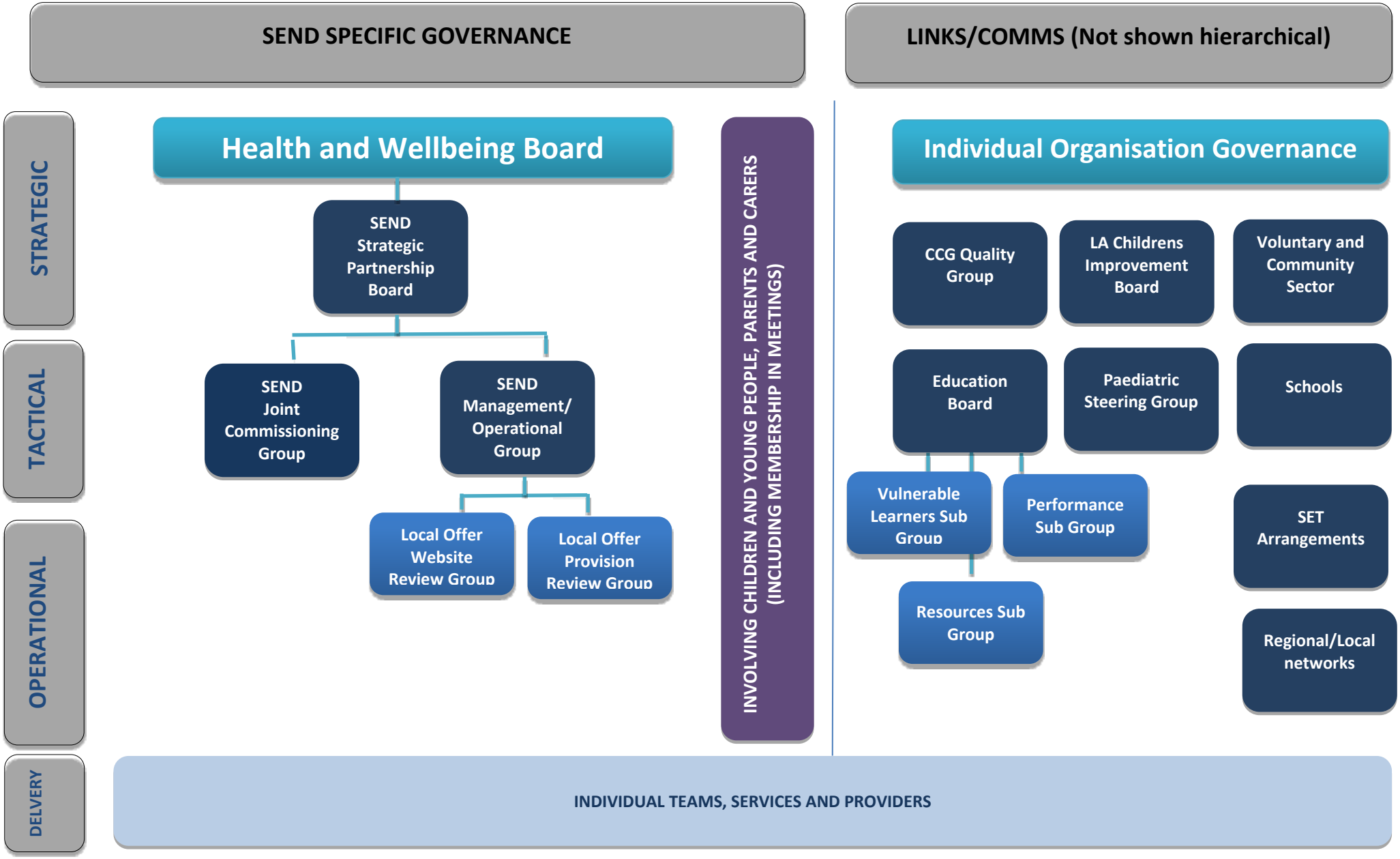
(3.70) The roles and responsibilities of bodies involved in joint commissioning arrangements are summarised below:

Agency	Key responsibilities for SEN or Disability	Accountability
Local authority	Leading integration arrangements for Children and Young People with SEN or disabilities	Lead Member for Children's Services and Director for Children's Services (DCS)
Children's and adult social care	Children's and adult social care services must co-operate with those leading the integration arrangements for children and young people with SEN or disabilities to ensure the delivery of care and support is effectively integrated in the new SEN system.	Lead Member for Children and Adult Social Care, and Director for Children's Services (DCS), Director for Adult Social Services (DASS).
Health and Wellbeing Board	The Health and Wellbeing Board must ensure a joint strategic needs assessment (JSNA) of the current and future needs of the whole local population is developed. The JSNA will form the basis of NHS and local authorities' own commissioning plans, across health, social care, public health	Membership of the Health and Wellbeing Board must include at least one local elected councillor, as well as a representative of the local Healthwatch organisation. It must also include the local DCS, DASS, and a senior CCG representative and the Director of Public Health.

	and children's services. This is likely to include specific needs of children and young people with SEN or disabilities.	In practice, most Health and Wellbeing Boards include more local councillors, and many are chaired by cabinet members.
Clinical Commissioning Group	To co-operate with the local authority in jointly commissioning services, ensuring there is sufficient capacity contracted to deliver necessary services, drawing the attention of the local authority to groups and individual children and young people with SEN or disabilities, supporting diagnosis and assessment, and delivering interventions and review.	CCGs will be held to account by NHS England. CCGs are also subject to local accountability, for example, to the Health and Wellbeing Board for how well they contribute to delivering the local Health and Wellbeing Strategy. Each CCG has a governing body and an Accountable Officer who are responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically and to improve the quality of services and the health of the local population whilst maintaining value for money.
NHS England	NHS England commissions specialist services which need to be reflected in local joint commissioning arrangements (for example augmentative and alternative communication systems, or provision for detained children and young people in relevant youth accommodation).	Secretary of State for Health
Healthwatch	Local Healthwatch organisations are a key mechanism for enabling people to share their views and concerns – to ensure that commissioners have a clear picture of local communities' needs and that this is represented in the planning and delivery of local services. This can include supporting children and young people with SEN or disabilities.	Local Healthwatch organisations represent the voice of people who use health and social care on the Health and Wellbeing Board. They are independent, but funded by local authorities.
Maintained nurseries and schools (including academies)	Mainstream schools have duties to use best endeavours to make the provision required to meet the SEN of children and young people. All schools **must** publish details of what SEN provision is available through the information report and co-operate with the local authority in drawing up and reviewing the Local Offer. Schools also have duties to make reasonable adjustments for disabled children and young people, to support medical conditions and to inform parents and young people if SEN	Accountability is through Ofsted and the annual report that schools have to provide to parents on their children's progress.

	provision is made for them. More information about the role of early years settings, schools and post-16 institutions is given in Chapters 5 to 7.	
Colleges	Mainstream colleges have duties to use best endeavours to make the provision required to meet the SEN of children and young people. Mainstream and special colleges **must** also co-operate with the local authority in drawing up and reviewing the Local Offer. All colleges have duties to make reasonable adjustments for disabled children and young people. More information about duties on the further education sector is in Chapter 7.	Accountable through Ofsted and performance tables such as destination and progress measures.

Appendix B - PROPOSED SEND GOVERNANCE STRUCTURE



Southend Essex and Thurrock LeDeR Mortality Review End of Year Report 19-20

12

Executive summary

The LeDeR programme is now well established across Southend Essex and Thurrock (SET) and a local backlog of cases has been completed. The 2018 backlog of 98 cases is being managed by a CSU commissioned by NHSE.

Across SET, people with Learning Disability are still dying 20 years younger than the rest of the population and experience health inequalities because of their learning disability.

Pneumonia and respiratory issues are the leading direct cause of death, often as part of a pattern of frailty and deterioration.

There have been examples of excellent practise which show that it is possible to deliver outstanding care, but also instances where people did not get the care their required. In a few cases the poor care impacted directly on the cause of death of the individuals.

Some progress has been made against the 19-20 action plan including a review of DNACPR policy in acute hospitals, the establishment of Learning Disability Strategic Forums in CCGs, Easy Read resource pack for Annual Health Checks. However, in terms of delivering the whole action plan, complex engagement across a number of different footprints and organisations has been a challenge.

In 20-21 we are in a good position to achieve KPI compliance and will focus on 4 priority areas:

- Annual Health Checks
- Frailty
- Dynamic Support Register
- Case Management

Introduction to the LeDeR programme

The LeDeR programme aims to review all deaths of people with Learning Disability aged 4 years and upwards in order to identify health inequalities and issues which contributed to early or preventable deaths. The learning is to be used to change the system and raise the age at which people with Learning Disability are dying.

The LeDeR programme started in Southend Essex and Thurrock (SET) in September 2017 and since Jan 2019 has been managed through the Learning Disability Health Equalities Team, which works on behalf of the SET Collaborative Forum made up of 7 CCGs and 3 Local Authorities.

SET has almost a third (271/900) of the LD deaths in Eastern Region and LeDeR is therefore a resource intensive programme. SET has a relatively high population of people with LD (7134) because of
a) a history of long stay institutions such as Turner Village and South Ockenden. When these closed, people moved into the local community and supported living/residential provision clustered in those areas.
b) proximity to London and the relative low cost of housing and social care provision has meant that people with Learning Disability have moved into Essex.

More work is needed to fully understand the demographics of our Learning Disability community.

In addition to their funding of the whole LD Health Equalities Team, in the last year the Collaborative Forum funded 2.0 wte permanent reviewers, the Local Area Coordinator function and a Team Coordinator and this has made it possible for reviews to be completed and lessons learned. This made a significant impact on the year's performance and enabled us to achieve our local target. Processes are now embedded for operational running of the programme; quality assurance; governance and reporting; and liaison with other functions such as the Coroner's Office and Essex Safeguarding Board.

NHSE funding to SET for LeDeR 2019-20 was used to employ contractor reviewers to address backlog cases and to employ fixed term administrative support to request notes.

NHSE also commissioned NEC (a Clinical Support Unit in the North East of England) to clear 98 backlog cases from 2018.

Local Purpose
While much focus this year has been on establishing processes and capacity to complete reviews and bring the programme up to date, the learning from reviews has been considerable and gives a picture of both the common themes and the range of issues impacting on people's lives. The drive for the coming year has to be implementation of learning both at an organisational and CCG level and also in a more integrated system-wide approach to broader issues.

Involvement of the Local Learning Disability Community
All reviews are discussed at the Steering Group, which has representation from an Adult with Learning Disability, who is also a Health Access Champion, the Chair of Essex Family Carers Network and the Co-Chair of the HE Experts by Experience Forum.

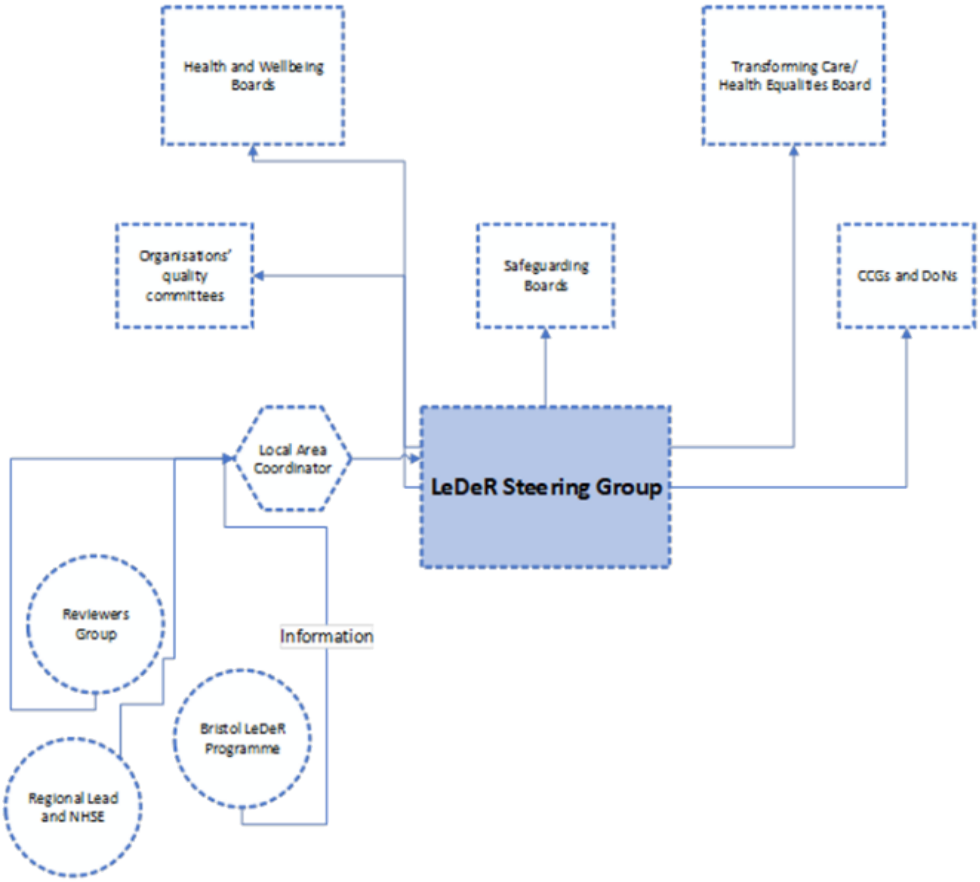
Working groups on AHC and STOMP have had intermittent representation from adults with learning disability, but recognising that this was insufficient, the LD Health Equalities Team had planned a structured approach to co-development, recruitment to a central EbyE group and involvement in key projects flowing from this. Unfortunately Corona virus halted this piece of work, but it will be re-started in 20-21.

A contract for EbyE representation in the coming year will enable representation of adults with Learning Disability and families at the Quality Panels.

Because of COVID and the inability to meet face to face, full engagement on the End of Year Report will not be possible before publication.

Governance arrangements

The LeDeR Steering Group provides oversight of the whole programme and reports to the Learning Disability Health Equalities Board and the Health and Wellbeing Boards.



Deaths in our local area[1]

Between 1st September 2017 and 31st March 2020, 272 people with Learning Disability died in the SET area. There are just under 100 deaths per year with around 10% of those children or young people. A comparison of year on year figures is available in Appendix 1.

[1] Please note local data is based on cumulative figures from September 2017. NHSE data is based on cases notified between Jan and Dec 2019.

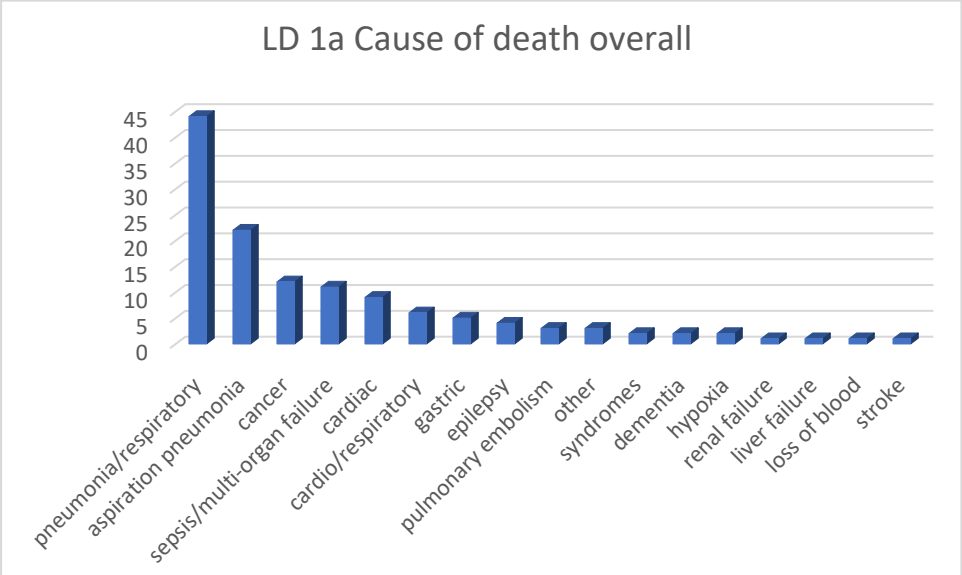
CCG	Total LD Reg	% of SET LD pop	No. deaths	% of deaths
NEE	1920	27%	85	31%
Mid	1374	19%	46	17%
Southend	1057	15%	38	14%
BBW	899	13%	25	9%
West	852	12%	35	13%
Thurrock	527	7%	21	8%
CPR	505	7%	22	8%
	7134		**272**	

North East Essex CCG continues to be the area with the highest population of people with learning disabilities, but an even higher proportion of deaths. A deep dive in mid 2019 showed no direct cause or correlation associated with this. Potentially the long stay institutions in the history of the area and the age of the local population had an impact.

i) Causes of death

With the larger number of completed reviews we can see that pneumonia (34% of all COD 1a)and aspiration pneumonia (17%) are the major clinical cause of death showing on 1a of death certificates and outweigh sepsis (9%), whereas last year, using a smaller data set, sepsis seemed a more significant issue (19%).

We still see a very common pattern of early frailty ending in increased infections and death from pneumonia or sepsis. Aspiration pneumonia sometimes fits into this pattern (for instance where swallow deteriorates toward the final presentation of dementia and is not appropriate for PEG feeding) but is also sometimes a result of textured diet guidance not being adequately followed in the community. Lack of dental treatment also impacts here.



Cancer continues to be the third largest cause of death. People with Learning Disability are sometimes dying before they are eligible for screening.

If we look at the secondary causes of death, cardiac issues are the leading underlying cause with chronic heart disease, cardiomegaly or hypertension are represented in 1b, 1c and Part 2 of the death certificates also (see appendix 1 for definitions and detail).

Worryingly terms such as “learning Disability”, “Cerebral Palsy”, “Downs Syndrome” also appear throughout all sections of the death certificates and training is needed in this regard.

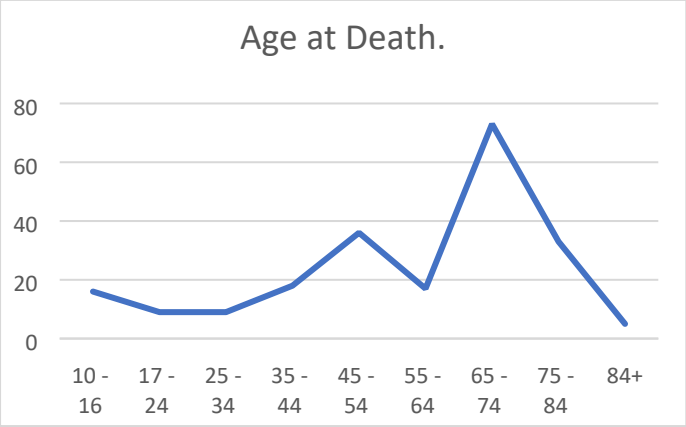
.

ii) Gender

Men with LD die at a higher rate than can be explained by gender split in the local LD population: 64% of deaths were of males whereas 58% of the LD population are male (as shown by GP Registers) and 58% of the national deaths are of males. Some CCGs show a more significant impact than others (details in Appendix 1). We need to explore further the underlying causes of our local gender difference.

iii) Age

In the UK general population, the average age of death for males is 79.3 years and for females 82.9 years (average 81.1). The average age of death for people with LD in SET is 60.4 years overall with a spike in deaths at 65 – 74 years. This continues to be well under the life expectancy in the general population but in line with the national average for people with LD (60 years). The LeDeR themes document highlights the systemic problems underlying this.



Children’s deaths are reviewed by the Child Death Review Team (CDRT) as part of their established process and more detail is available in Appendix 1.

iv) Ethnicity

People with Learning Disability across SET identify predominantly as British (87%) and this is broadly in line with the population of Essex (90% white British). Nationally

90% of people with LD identify as white British. All but one of the people who died and were registered as from a Black or Minority Ethnic background were children.

We do not currently understand the ethnic mix of people registered with LD on GP registers and have much work to do to understand the issues of race and ethnicity, particularly for children. We are seeking BAME representation on our SteeringGroup.

v) Place of Death

More people with Learning Disability in SET died in hospital (55%) than in the general population (46%). The figure is higher at the national average for people with LD (60%). LeDeR themes indicate a need for earlier and better End of Life planning so that people can be supported to die in the place of their choosing.

vi) Grading of Care

Grade of Care	No.
This was good care (it met expected good practice)	69
This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the persons wellbeing)	35
Care fell short of expected good practice but did not constribute to cause of death	17
This was excellent care (it exceeded expected good practice)	8
Care fell short of expected good practice and this significantly impacted on the persons wellbeing and/or had the potential to contribute to the cause of death	6
Care fell far short of expected good practice and this contributed to the cause of death	3
Grand Total	**138**

Care could refer to any organisation or combination of organisations which were involved in the person's life. 75% of cases reviewed showed good or satisfactory care. 6% gave examples of excellent care. 6.5% found care so poor that it either impacted directly on the death or had the potential to do so Cases where care fell short and contributed to the cause of death or had the potential to do so. This level of grading results in a Multi-Agency review and a referral to Essex Safeguarding Board for further scrutiny. We expect to see the full impact of this in the coming year.

Supporting data for i) to vi) can be found in Appendix 1.

Performance against national targets

1. Compliance with Key Performance Indicators

Of the 271 deaths at the end of March 2020 we have reviewed 51% with a further 33% in progress. This splits into two cohorts:

	Total	Unallocated	In progress	Completed
Local	173	18	23	132
NEC	98	2	91	5
	271	20	114	137

Because of the focus on backlog work to the end March 2020, we were not showing compliance with KPIs of

a) Allocation of reviews within 3 months of notification
b) Completion of reviews within 6 months of notification

However, we are now in a good position to achieve regular compliance in 20-21 now that our local backlog is complete.[2] We have more completed reviews than any other area in the Eastern Region and have sufficient capacity to manage our cases.

Allocations are made centrally by date of notification (not based on CCG area) and the availability of records. Access to GP records continues to be the major block to timely completion but as the programme has become familiar to primary care we have been able to build relationships with surgeries and use an agreed escalation route for significant problems.

	DEATHS OF PEOPLE AGED 18 AND OVER - excluding those on hold					DEATHS OF PEOPLE AGED 18 AND OVER: REVIEWS CURRENTLY 'ON HOLD'			CHILD DEATHS			
	Reviews assigned within 3 months of notification (notifications			Reviews completed within 6 months of notification		Waiting for coroner's inquest	Waiting for other investigation	Delays with family involvement	Total notifications to date:	progress	Completed	Completed
Region, steering group & CCG	No.	%	No. notified >6m	No.	%	No.	No.	No.	No.	No.	No.	%
England total	**2449**	**38%**	**5843**	**728**	**12%**	**38**	**69**	**19**	**588**	**274**	**314**	**53%**
EAST OF ENGLAND	**107**	**15%**	**675**	**28**	**4%**	**4**	**22**	**1**	**61**	**26**	**35**	**57%**
NHS BASILDON AND BRENTWOOD	6	30%	15	0	0%	0	0	0	1	1	0	0%
NHS CASTLE POINT AND ROCHFORD	5	25%	17	2	12%	0	0	0	0	0	0	0%
NHS MID ESSEX CCG	9	23%	37	1	3%	0	0	0	6	4	2	33%
NHS NORTH EAST ESSEX CCG	12	18%	67	0	0%	1	3	0	5	0	5	100%
NHS SOUTHEND CCG	9	28%	30	4	13%	0	0	0	3	1	2	67%
NHS THURROCK CCG	4	31%	12	2	17%	0	1	0	5	1	4	80%
NHS WEST ESSEX CCG	5	18%	26	0	0%	0	1	0	4	0	4	100%
	50		**204**	**9**		**1**	**5**	**0**	**24**	**7**	**17**	

A review may be put on hold if a safeguarding, coroner or police investigation is still in progress.

2&3 Representation of CCGs in LeDeR programme

All CCGs have membership of the LeDeR Steering Group and have a lead representative from Southend/CP&R. Thanks goes out all the organisations across Southend Essex and Thurrock who have consistently attended, contributed and engaged strategically to ensure improvements in the lives of people with Learning Disability.

4. Production of Annual Report

[2] After the end of year, the temporary suspension of LeDeR Reviewing during COVID pandemic caused a further local backlog, but a fresh NHSE target of KPI compliance by Dec 31st is achievable and a trajectory is under regular monitoring.

This report will be made public through presentation to Health and Wellbeing Boards in September and subsequent inclusion of minutes and supporting papers on their public facing webpages.

Recommendations made by reviewers for local actions.

The 19-20 Action Plan identified priorities as described below, but it was not possible at the time for Lead CCGs in the plan to take responsibility for wider strategic decisions outside their own areas.

Other items from the wider action plan were implemented locally and at single organisational level for instance, in Mid and South STP the acute hospital trusts reviewed their Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy and paperwork to ensure that learning disability or assumptions about the physical health or quality of life of a person with learning disability could not be used to inform DNACPR decisions. A paper on this went to NHSE as an example of good local work.

Where cross-organisational working groups were facilitated this was effective, but capacity for this was limited. For instance two working groups were held with representation across all 10 partners, resulting in:

a) an integrated pathway for STOMP “Stop Over Medication of People with LD/Autism”. The aim of this is to ensure a joined-up approach to removing or optimising medication used to control behaviour.

b) a pack of Easy Read Resources was formed to empower people with Learning Disability and their families to understand what they should expect from Annual Health Checks, get on their local GP register and prepare well for a check. A paper was submitted to NHSE as an example of good local work.

LeDeR Areas of Priority and Action 2019-2020					
Outcome	**Deliverable**	**Actions**	**Who**	**Existing Resources/Good Practise**	**Timescale**
Carers/family understand how to support and maintain the health of someone with LD	Widely available Information on healthy lifestyles, common health issues for people with LD, available services	Identify (develop if necessary) and agree resources - information leaflets, videos,	Thurrock CCG Lead	\\chesfs50\euchomedirs\rebekah.bailie\My	End Sept 19
		identify and agree key routes for sharing information (networks, organistaions, venues etc)	Thurrock CCG Lead		Oct-19
		ensure families and carers understand and request an annual health check and support adults to be well prepared for it	Mid and West CCG leading AHC oversight group	AHC working group has action plan	Dec-19
		agree as part of comms plan, budget if required	LAC and CP&R Comms Lead		Jan-19
Adults understand their own health and how to maintain it, when to ask for help.	Widely available Easy read information on healthy lifestyles, common health problems for people with LD and how to get help.	Identify (develop if necessary) and agree Easy Read resources - information leaflets, videos, local services etc	B&B CCG lead		End Sept 1
		identify and agree key routes for sharing information (networks, organistaions, venues etc)	B&B CCG lead		Oct-19
		develop and pilot adult held record including Health Action Plan	Southend to pilot	\\chesfs50\euchomedirs\rebekah.bailie\My	Mar-20
		ensure adults understand and request their annual health check and are well prepared for it.	Mid and West CCG leading AHC oversight group	AHC working group has action plan	Dec-19
		agree as part of comms plan, budget if required	LAC and CP&R Comms Lead		Jan-19
Adults/ arers/family can identify changes in health and know what to do to get the relevant help and prevent	Information on sepsis, pneumonia and their place in frailty/deterioriation.	identify and agree existing resources and develop local information as part of overarching health plan and comms plan using routes as above	NEE CCG lead	\\chesfs50\euchomedirs\rebekah.bailie\My	Sep-19
The health and social care system understands individuals health needs, identifies, intervenes early and manages risks to health collaboratively	Training for Primary Care on Sepsis, Pneumonia and their place in deterioration/frailty, how to support people with LD to access healthcare	Scoping of existing training and resources Identify where adaptations need to be made to make relevant for LD and support implementation Identify gaps and routes to commissioning/delivery of needed training and information Health and Wellbeing Strategy for LD to be established covering social prescribing, care navigation, and accessible information	LD Integrated Health Commissioning with Public Health and CP&R	ELDP offer training to GPs and capacity is detailed in LD Place Plans for each CCG Some Primary Care Engagement leads in CCGs are rolling out training on sepsis to Primary Care (West)	Oct-19
	Training on Sepsis, Pneumonia and their place in deterioration/frailty, how to keep healthy and get the right help - for social care providers	training on LD awareness to be devised/national resources used	ECC Lead	PROSPER offers training on sepsis to social care providers in ECC footprint	Jan-20
	Early intervention, extended Dynamic Risk Register to include those at risk of escalation to acute admission	ELDP to form cross-organisational working group	Inder Sawnhey Clinical Lead	ELDP contracted to deliver this in 2020.	Jan-20
	Training on LD Awareness	to be rolled out and made mandatory nationally	Integrated Commissioning	in development nationally	as advised

Local priorities and the evidence base that supports them

At the end of March 2020 we had 318 recommendations from completed reviews. These were grouped into themes and identified as:

a) Relevant to specific organisation
b) Cross-system issues

Organisations will report back to the Steering Group the progress towards their specific recommendations.

Of the cross-system issues, the following four priorities will be taken forward through commissioning of the LD specialist healthcare function and engagement with relevant STP or CCG level forums:

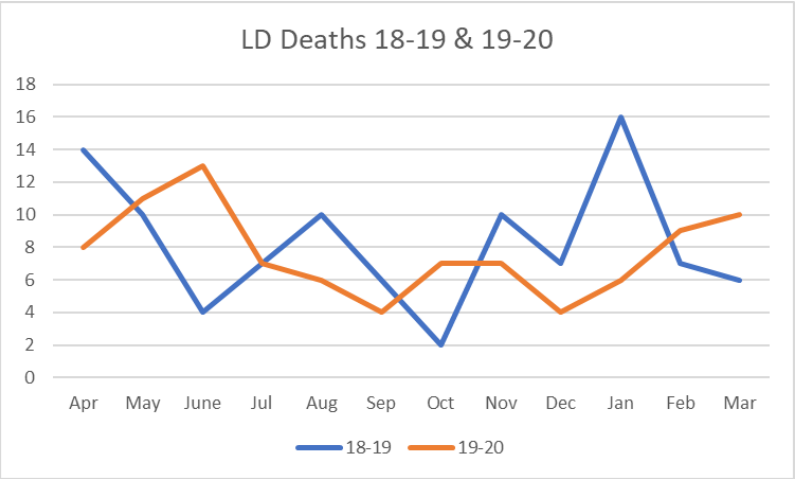
1. Delivery of effective Annual Health Checks
2. A clear understanding of early frailty in people with LD and an integrated offer to address it
3. A dynamic health support register to identify and support those at risk of acute admission
4. Case Management

The action plan and a more detailed document outlining themes accompanies this report.

Rebekah Bailie
LeDeR Local Area Coordinator
25/06/20

Appendix 1. LeDeR Supporting Data 2019-2020

LeDeR Notifications – comparison 2018 and 2019



	18-19	19-20
Apr	14	8
May	10	11
June	4	13
Jul	7	7
Aug	10	6
Sep	6	4
Oct	2	7
Nov	10	7
Dec	7	4
Jan	16	6
Feb	7	9
Mar	6	10
	99	92

With only two financial years to compare it is not possible to see any trends in notification.

Cause of Death

An official death certificate has the following sections:

I (a) Disease or condition leading directly to death
I (b) Other disease or condition, if any, leading to I(a)
I (c) Other disease or condition, if any, leading to I(b)

II Other significant conditions contributing to death but not related to the disease or condition causing it

1a must be filled in, but other sections are optional. A death certificate is not always available even on completion of report, particularly where GP records are not made available and not all sections are relevant for all certificates, so totals do not always relate to total number of deaths for the CCG.

Every death certificate is completed in the practitioner's own words (rather than a selected option) so that some grouping of causes of death has been done to make sense of the overall data. For instance "bronchopneumonia", "pneumonia" and "lower respiratory tract infection" would all be captured under "pneumonia/respiratory" but aspiration pneumonia is separate because it has a different cause.

This is not the case at the CCG level breakdown because the numbers are lower and so more easily read without significant categorisation. Codes might therefore not easily read across from the overall to the CCG data.

Cause of Death 1a, 1b, 1c and Pt II summarised for all ages Southend, Essex and Thurrock

COD1a

pneumonia/respiratory	44
aspiration pneumonia	22
cancer	12
sepsis/multi-organ failure	11
cardiac	9
cardio/respiratory	6
gastric	5
epilepsy	4
pulmonary embolism	3
other	3
syndromes	2
dementia	2
hypoxia	2
renal failure	1
liver failure	1
loss of blood	1
stroke	1

COD 1b

Heart	10
CP/LD/Downs	7
Bowel	6
pneumonia/embolism	5
COPD/respiratory LTC	4
Epilepsy	4
aspiration pneumonia	3
Frailty	3
Syndromes	3
Sepsis	2
Dementia	2
Cellulitis	2
DVT	2
Cancer	2
Stroke	2
chronic kidney	1
diabetic ketoacidosis	1
Cirrhosis	1
Immobility	1
infection in prosthesis	1
viral infection	1

COD P2	
Downs Syndrome/LD	11
cardiac	9
epilepsy	6
Cerebral palsy	5
multiple	4
syndromes	3
kidney	2
liver	2
cancer	2
diabetes	2
Autism	1
spastic paraplegia	1
gastric/bowel	1
anaemia	1
dysphagia	1
CD	1
hypotension	1
sepsis	1
UTI	1

COD 1c

Heart	4
Downs/LD/CP	3
Syndromes	3
Respiratory	3
Dementia	2
Diabetes	2
complications of surgery	2
Gastric	1
Epilepsy	1
Frailty	1
Dementia	1
Kidney	1
infected leg ulcer	1

Cause of Death – CCG Breakdown

BBW COD 1a	
Aspiration Pneumonia	1
Chest infection.	1
Pneumonia	3
Pulmonary Embolism	1
Respiratory and Cardiac Arrest	1
Septicaemia	1
	8

MID COD1a	
Bronchopneumonia	7
Cardio-respiratory failure	2
Aspiration pneumonia	2
Cancer of bowel	1
Chest Infection	1
Hypoxic Brain Injury & status epilepticus	1
Left ventricular failure	1
Congestive Cardiac Failure & COPD	1
Organ frailty	1
Right sided basal ganglia bleed. Bilateral basal ganglia lunar infarcts.	1
sepsis	1
Small Bowel Obstruction	1
	20

SOUTHEND COD1a	
Aspiration Pneumonia	3
BronchoPneumonia	3
Community acquired pneumonia	2
Cancer endometrial	1
Astrocytoma	1
Cardiomegaly	1
Dementia	1
Heart attack	1
Hospital acquired pneumonia	1
Juvenile Sandhoff Disease	1
Metastatic Hepatocellular Carcinoma	1
Peritonitis and Sepsis	1
Respiratory failure	1
	18

WEST COD 1a	
Aspiration pneumonia	6
Sepsis	2
Left lobe pneumonia with left lung collapse	1
Pneumonia	1
Respiratory Failure	1
Coalescing bronchopneumonia	1
Cerebral Palsey	1
Biventricular failure	1
Cause of death Liver disease from Alcohol ab	1
Hypothalamic Hamartoma	1
Protein Losing Enteropathy	1
Intestinal obstruction with peritonitis	1
seizure	1
	19

CPR COD 1a	
Aspiration Pneumonia	4
Bilateral Broncho Pneumonia	1
Myocardial Infarct	1
Multiple Organ Failure	1
Spontaneous retroperitoneal haemorrha	1
Vascular Dementia	1
	9

NORTH EAST COD 1a	
Bronchopneumonia	6
Cardiac Arrest	4
sepsis	3
Bronchopneumonia Pulmonary thrombo	2
Aspiration pneumonia with respiratory fa	2
Respiratory Failure	2
Community acquired pneumonia	2
Lung collapse	1
COPD	1
lower chest infection (LRTI)	1
Infective exacerbation of asthma.	1
malignant neoplasm of rectum	1
Liver cancer	1
Malignant Neoplasm of Female Breast	1
Perforated Duodenal Ulcer	1
Acute Renal Failure	1
Chronic Epilepsy	1
blood clot to the lung, causing cardiac arr	1
chest sepsis	1
Staphylococcus aureus Septicaemic. Complex Congenital Heart Disease with Eisenmenger Syndrome.	1
post operative blood loss	1
Natural causes	1
Old age	1

THURROCK COD 1a	
Multi -organ failure	1
Anaplastic astrocytoma of the brain	1
metastatic adenocarcinoma unknown pri	1
Aspiration Pneumonia	1
Bowel Cancer	1
Bronchopneumonia	1
Cardio Respiratory Arrest	1
Gastro Intestinal Bleed	1
Hypoxic Brain Injury	1
Laryngeal cancer	1
	10

Age and Gender

Average age is taken from GP registers and average age at death from LeDeR notifications.

CCG	Average Age	Av Age Death
NEE	44	58
Mid	36	65
Southend	47	62
BBW	41	64
West	40	57
Thurrock	41	65
CPR	35	52
	41	**60**

Southend and North East CCGs have significantly older populations whereas Mid and CPR are younger. The median age in the UK general population is 40 years.

In the UK general population, the average age of death is males 79.3 years and females 82.9 years (average 81.1). The average for people with LD is 60 years overall, 58 for females and 61 for males.

We know that a higher proportion of males die than females and that this is not explained by the gender split in the LD population.

There are different patterns across CCGs with Mid and West showing a more significant impact on males. In CPR the discrepancy is not so great.

CCG	Total LD Reg	Male	Male%	%male deaths	Fem	Fem%	%Fem deaths	No deaths
NEE	1920	1102	57%	64%	818	43%	36%	85
Mid	1374	820	60%	70%	554	40%	30%	46
Southend	1057	623	59%	61%	434	41%	39%	38
BBW	899	530	59%	64%	369	41%	36%	25
West	852	476	56%	66%	376	44%	34%	35
Thurrock	527	297	56%	67%	226	43%	33%	21
CPR	505	309	61%	55%	196	39%	45%	22
	7134	**4157**	**58%**	**64%**	**2973**	**42%**	**36%**	**272**

Children

24 children have died since the start of the programme across SET with age range from 5 – 16 years. The average age of death was 11 years and the median 7 years. 12 were male and 12 female. The breakdown by CCG is below:

CCG - Child Deaths	No.
MID ESSEX CCG	6
NORTH EAST ESSEX CCG	5
THURROCK CCG	5
WEST ESSEX CCG	4
SOUTHEND CCG	3
BASILDON AND BRENTWOOD CCG	1
	24

Grade of Care

The majority of care for children was good or satisfactory (83%) and 9% excellent. In 2 cases the care fell short of good practise and in one case this was contributory to the death. The CRDT board take forward all recommendations and actions.

Care Grade - Children	No.	%
This was good care (it met expected good practice)	15	65%
This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the persons wellbeing)	4	17%
This was excellent care (it exceeded expected good practice)	2	9%
Care fell far short of expected good practice and this contributed to the cause of death	1	4%
Care fell short of expected good practice but did not constribute to cause of death	1	4%
Grand Total	23	

Cause of Death

While not all children were on end of life pathways at the time of death, they tended to have more syndromes or complex health needs (than adults) which were contributory to or underlying the cause of death. All but one died in hospital or palliative care unit.

Not all reviews are complete, so cause of death is available for 18 children at time of writing.

N_COD_1a	N_COD_1b	N_COD_1c	N_COD_P2
Respiratory and Cardiac Arrest			
Pneumonia	POLG mutation mitochondrial cystopathy		
Cardio Respiratory Failure	Viral Illness	Edwards Syndrome	
Hypoxic Brain Injury	Epileptic Seizure	Gaucher Disease	
Pneumonia			
seizure	Lennox-Gastaut Syndrome	Trisomy 5p	
Cardiac Arrest	Catecholamine Polymorphic Ventricular Tachycardia		
Hypothalamic Hamartoma			
	Long QT Syndrome		Acute Colitis
Multi -organ failure	1b. Systemic inflammatory response syndrome (SIRS) septic shock		
Anaplastic astrocytoma of the brain			
Ia. Protein Losing Enteropathy	Ib. Failing Fontan with circulation failure.	Ic. Unbalanced Atrioventricular Septal defect (operated with total cava-pulmonary connection 2009).	Autism
Bronchopneumonia			Myopathy and learning difficulties
Pneumonia	Cerebral Palsy	Epilepsy	
Juvenile Sandhoff Disease			
Acute Renal Failure			Severe Global Delay, Cerebral Palsy, Epileptic Encephalophy.
I (a) Cardio-respiratory failure	I (b) Atrial and ventricular septal defects, pulmonary hypoplasia and lung abscess		II Multiple congenital abnormalities
Peritonitis and Sepsis	Gastric Fundus Necrosis and Perforation	Superior Mesenteric Artery Syndrome following corrective spinal surgery for progressive neuromuscular	

Ethnicity

The following table shows the ethnicity of all people with LD who have died in SET since Sept 17

Ethnicity	No.	%
British	237	87.13%
Any other ethic group	3	1.10%
Any other White background	3	1.10%
Irish	3	1.10%
African	2	0.74%
Pakistani	2	0.74%
Any other Black/African/Caribbean background	1	0.37%
Bangladeshi	1	0.37%
Chinese	1	0.37%
(blank)	19	6.99%
Grand Total	272	

We do not currently have data on ethnicity of our local LD population or whether it is representative of the general population in SET, but the data from deaths looks to be in line:

Ethnicity of Essex

White British	90.80%
Other white	3.60%
Asian	2.50%
Black	1.30%
Mixed	1.50%
Other	0.30%

Children and Ethnicity

Ethnicity Children	No.	%
British	16	67%
African	2	8%
Any other White background	2	8%
Bangladeshi	1	4%
Chinese	1	4%
Pakistani	1	4%
unknown	1	4%
	24	

When the figures for child deaths are split out it becomes clear that the deaths of Black and Minority Ethnic people are almost entirely those of children.

Place of Death – all age

Place of Death	No.
Hospice/palliative care unit	10
Hospital	149
Not known	9
Residential / nursing home that was not usual address	12
Usual place of residence	88
(blank)	4
Grand Total	**272**

55% of people with LD who died since Sept 17 died in hospital. This is lower than the national average for people with LD but higher than the average for the rest of the population.

Rebekah Bailie
LeDeR LAC