Havering's Health and Wellbeing Strategy

2015 – 2018

Contents

Executive Summary

Our strategy has been developed by Havering's Health and Wellbeing Board and it is the overarching plan to improve the health and wellbeing of children and adults in our borough.

The vision of the Havering Health and Wellbeing Board remains *"For the people of Havering to live long and healthy lives, and to have access to the best possible health and care services."*

Informed by the Joint Strategic Needs Assessment and other needs analysis, we have identified the most pressing health and social care issues in the borough. By working collectively as a strategic partnership, we have prioritised the actions we need to take to deliver our vision and improve outcomes for local people. These are set out clearly in this Health and Wellbeing Strategy, which focuses on three overarching themes and eight priorities for action:

Overarching Themes	**Priorities**
Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies	Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers Priority 3: Reduce obesity Priority 4: Reduce premature deaths from cancer and cardiovascular disease.
Theme B: Better integrated support for people most at risk	Priority 5: Better integrated care for the "frail elderly" population Priority 6: Improve integrated care for children, young people and families most at risk Priority 7: Reduce avoidable hospital and long term care home admissions
Theme C: Quality of services and patient experience	Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

All member agencies of the Health and Wellbeing Board are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing.

Havering operates within a challenged health economy where historically underdeveloped community based services have led to high numbers of frail community members receiving sub-optimal care. The Health and Wellbeing Board's strategy is consequently focused, at least in the short to medium term, on improving health and social care services for this frail group but will in future turn its attention to the wider prevention agenda and strategies to assist people to understand how to age better and prevent the onset of conditions that require substantial health and social care intervention.

All of the above will need to be supported and facilitated by the continued development and delivery of integrated commissioning strategies and activities across the organisations represented on the Board.

Foreword

Welcome to Havering's second Health and Wellbeing Strategy.

Over the life of our first Health and Wellbeing Strategy, we have worked successfully together to give patients, service users and their carers better care and support. Patients now recover more quickly and are pleased to be able to benefit from home-based services that allow them to remain in or return to their own homes and communities.

This second strategy sets out how, over the next three years, we will build on the successes of our first Health and Wellbeing Strategy and how, by working in partnership with each other and the community, we will improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services.

We believe that everyone in Havering has the right to enjoy good health and wellbeing. We have a lot to be proud of in this borough. Life expectancy is high and overall the borough is quite healthy. There is a wealth of open parks and spaces, good transport links and high levels of employment. Residents feel that Havering offers a very good quality of life. However, we want to continue to do more. We want to help people to live healthier lives and we want to provide better quality of care and services.

We are in a period of great change and legislative reform that brings with it many opportunities but also many challenges. As well as the impacts arising from the Care Act, the Children and Families Act and Government austerity measures, rising demands and expectations from service users are all forcing significant changes to both the commissioning and direct provision of health and social care services.

But despite the challenging context we are working in, we believe the most vulnerable people must continue to be valued and protected. Havering has an increasing older population and we believe we can improve support for people with dementia and learning disabilities, and also help older people to remain independent for as long as possible. We understand how important carers are and we will continue to provide support for them in their crucial role. We will also continue our on-going work to improve the quality of our local hospitals and community care services.

We are clear that a "one size" approach will not fit all and that, in many cases, both the current performance data and the need to achieve more with our declining resources will mean that we will have to focus our efforts by targeting "hotspot" areas. Tackling health inequalities across the borough and improving life expectancy continue to remain priorities, particularly in the most deprived areas of Havering.

We know that it is only by working together can we create a borough where everyone can realise their potential and have the best life chances. To this end, we must ensure that everyone can access the support they need, but also empower communities to take responsibility for their own health and wellbeing and that of their families and loved ones.

Despite the challenging environment, we must be ambitious in our thinking and desire for change. Good health and wellbeing is everyone's responsibility and everyone must play their part.

By Cllr. Steven Kelly (Chair of the Havering Health and Wellbeing Board)

Dr. Atul Aggarwal (Chair of the Havering Clinical Commissioning Group)

1. Achieving our Vision

The vision of this strategy is:

"For the people of Havering to live long and healthy lives, and have access to the best possible health and care services."

To deliver this vision, we have identified the most pressing health and social care issues in the borough. Informed by the Joint Strategic Needs Assessment, we have identified the following three key themes:

Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

Theme B: Better integrated support for people most at risk

Theme C: Quality of services and patient experience

There are eight priorities for action to deliver these themes and each has a jointly agreed plan as to how improved outcomes for local people will be delivered. Partnership working, joint commissioning and integrated working are fundamental to the delivery of this strategy. Tables that set out the themes, priorities and key actions can be found at Appendix 4.

In accordance with the Council's obligations under the Public Sector Equality Duty, the strategy has been assessed for its equalities implications and the impact of the proposed actions on members of the population who possess protected characteristics. The Equality Impact Analysis is available on the Council's website. Individual schemes and initiatives arising from the Health and Wellbeing Strategy will also be subject to separate Equality Analyses which will likewise be published on the Council's website.

2. Scope and Purpose of the Strategy

The Health and Wellbeing Strategy sets out how we will work together as a strategic partnership, as well as with the local community, to improve the health and wellbeing of local people and to improve the quality of, and access to, local health and care services. It provides the overall direction for the commissioning of health and social care services across the borough.

This strategy replaces the Havering Health and Wellbeing Strategy 2012-2014.

The Strategy focuses predominantly on health and social care related factors that influence health and wellbeing. The wider determinants of health and wellbeing include factors such as housing, education and employment, and the environment. These are addressed through other key partnership strategic documents. A list of such documents can be found at Appendix 3.

3. Context

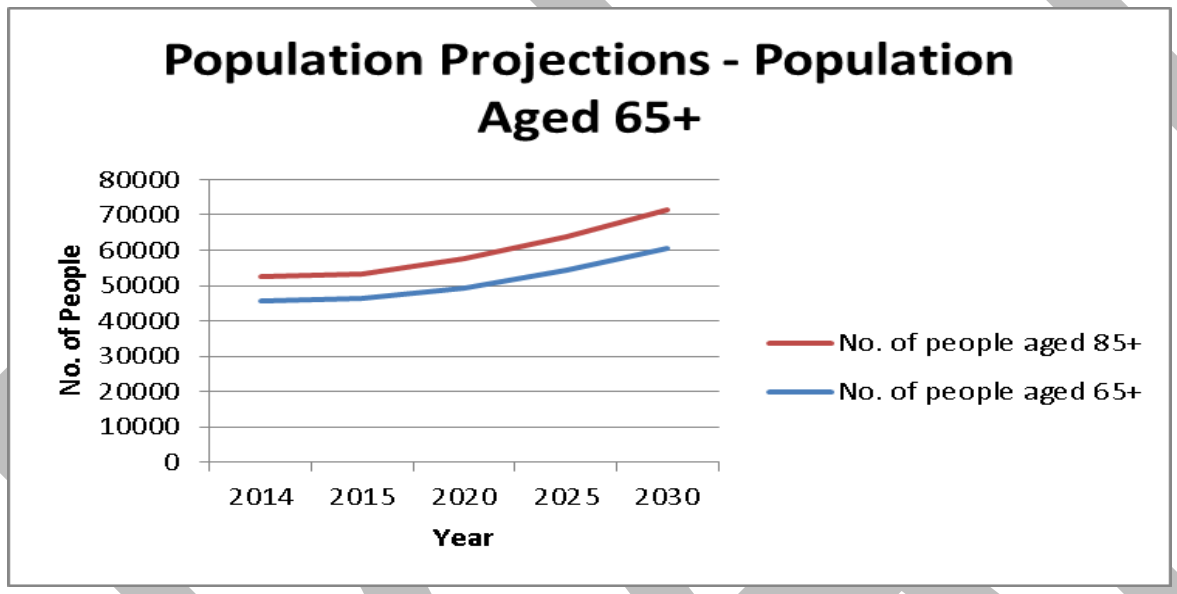
3.1 Our Population in Havering

The people of Havering are generally fairly healthy. Life expectancy is long and residents and visitors to the borough benefit from plenty of high quality parks and open spaces.

There are 237,232 people living in Havering and 256,731 people registered with a Havering GP. It is estimated that by 2016, Havering's population will have grown by 5.4% (12,699 people) and by 11.5% (27,095 people) by 2021, a faster rate of growth than the London average.

The life expectancy for people living in Havering is 78.6 years for men and 83 years for women. While life expectancy overall is above the England average, there is a 7.4 year gap in life expectancy for men and 4.6 years for women across Havering, with life expectancy particularly impacted by where people live and the circumstances of their upbringing.

Havering has one of the largest older populations in London, with more than 23% of residents (40,000) over the age of 65. Between the 2001 and 2011, growth in the 85+ age group saw the largest percentage increase (at 43%, which is higher than for both London and England), and the size of this age group is projected to continue to increase, by 20.3% by 2020.



This projected increase in the older people population is likely to result in increases in numbers of residents suffering from cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis, incontinence and hearing impairments.

Simultaneously, however, the borough's large older population also offers many assets to the community. Their skills and experience can be – and are – harnessed to enrich community life. Older people are always very willing to offer their views in

response to surveys and other consultations and offer considerable resources and expertise for volunteering opportunities. Older people also offer the majority of informal care to their spouses and loved ones.

The borough has a large younger population too. It is estimated that around 23% (54,018) of the population in Havering is aged 0-19, similar to the England average of 24%. Future projections suggest that the 0-15 age group is estimated to grow by 8.2% by 2016 and 21.1% by 2026.

While the population is predominantly White British, it is becoming increasingly diverse. It is estimated that around 12% of Havering's working age population is of non-white ethnicity, however the school census reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.

The borough is generally fairly affluent, being ranked 177th overall out of 326 local authorities for deprivation, but has pockets of deprivation. Two small areas of the borough (situated in Gooshays and South Hornchurch) fall into the 10% most deprived areas in England. When compared with other London boroughs, Havering has a relatively small proportion of children living in poverty, however this has risen in recent years (bucking the trend seen in most other London boroughs of declining levels of child poverty).

The results of the 2011 *Your Council, Your Say* survey indicated that health services are the top priority for local people in making the Borough a good place to live, followed by clean streets and the level of crime.

3.2 Key Achievements to Date

While we are aware that we still face significant challenges in addressing health inequalities and improving wellbeing, we are proud of the significant improvements that have been made during the life of the first Health and Wellbeing Strategy.

As we move into the next planning period, much good work has already started, giving the Board a strong foundation on which to build. As a partnership, we are particularly proud that:

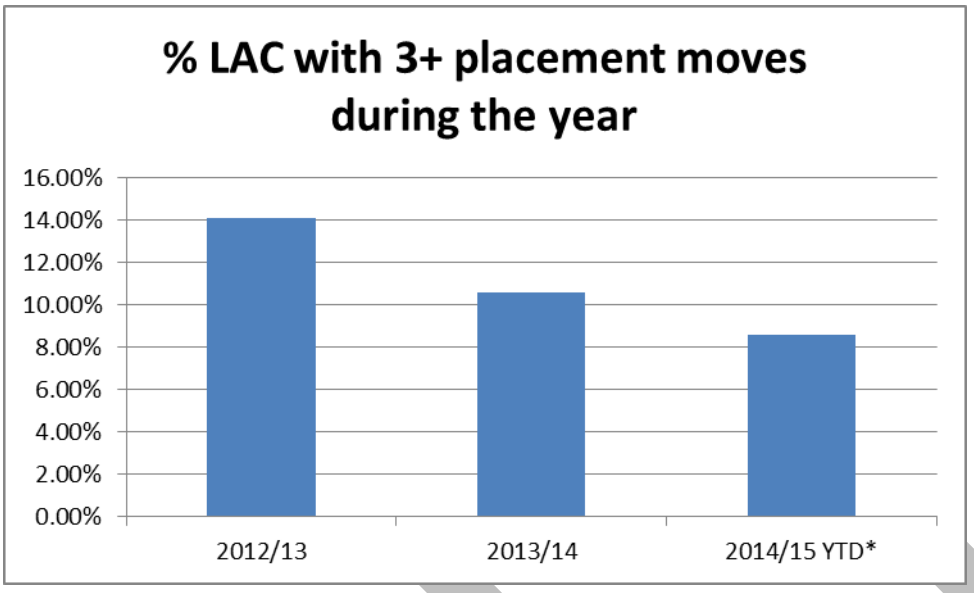
- Urgent Care Centres have been set up in the borough, with the aim of reducing A&E attendances and helping patient flow by seeing patients in the most appropriate setting. Hospital staff and local GPs can book non-urgent cases directly into these clinics.
- An Integrated Care Strategy is in place and being delivered, which is helping to shift activity away from acute settings towards community and locality settings. As part of this, Integrated Case Management across health and social care has already been introduced.
- Residents of the borough now benefit from a Joint Assessment and Discharge (JAD) team, operating seven days a week, which provides a more collaborative approach across health and social care to ensure that planning for discharge takes place closer to the point of admission. This has played a

large part in making Havering one of the best performing boroughs in London in terms of delayed transfers of care.

- In response to feedback from patients that they want to be supported closer to, or in, their own homes where possible, we have implemented Community Treatment Teams (CTTs) and the Intensive Rehabilitation at Home Service (IRS), and surveys indicate that most patients are very happy with these new models of care, with CTTs receiving a patient rating of 8.7 out of 10 and the IRS receiving a patient rating of 9 out of 10. In 2013/14, Havering's Intensive Rehabilitation Services received 159 referrals against a target of 69. During the same period, there were 1,576 referrals to the Queens Hospital hub of the new Community Treatment Team, 78% of which did not go on to be admitted to hospital. Within the community spoke of the CTT, 2,707 referrals were received during this time, 94% of whom were treated and maintained at home without the need for an acute admission. Without services such as these, many more patients would be presenting at already over-stretched A&E departments and required more help from their family and / or carers.
- A Frailty Academy was launched across Barking and Dagenham, Havering and Redbridge in February 2014, to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services. As at May 2014, 34 participants had enrolled in the Academy, representing a range of agencies including the London Ambulance Service, NELFT, BHRUT and the Havering Care Association.
- The first stage of the new Community Health and Social Care Service (CHSCS) went live on 28 April 2014, with the reconfiguration of community nursing, Integrated Case Management, therapies and mental health services into locality based teams. We are now working towards the integration of partners outside of NELFT (e.g. social care and others) into this model.
- In June 2014, Havering became the first borough in London, and one of the first in the country, to expand its Multi-Agency Safeguarding Hub (MASH) to identify adults as well as children at risk. Alongside this, the Council and its partners developed a Community Multi-Agency Risk Assessment Conference (Community MARAC), to provide a multi-agency problem solving forum in respect of adults who do not meet the threshold for statutory services but who nonetheless require a multi-agency response in order to maintain them safely in the community. An independent evaluation is now underway, but anecdotal evidence and performance data suggests that both these initiatives are adding value to the partnership's work to identify and support vulnerable people and families.
- Havering has performed particularly well in the national Troubled Families programme. As at March 2014, the borough's initial target of identifying 415 "troubled families" to work with had been exceeded, with over 500 families

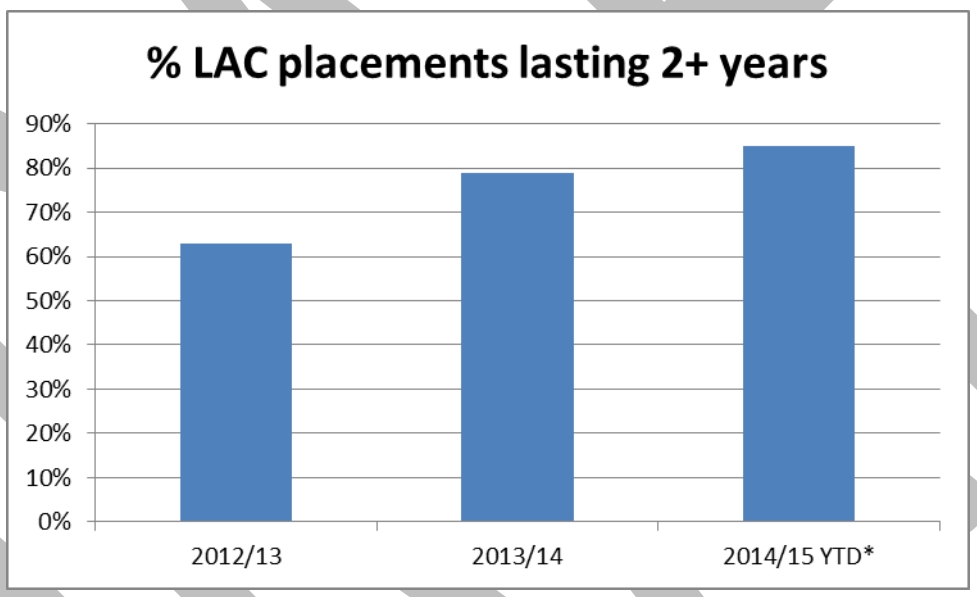
having been identified. Havering's Troubled Families team is now closely involved nationally in the development and roll out of Phase 2 of the programme.

- Havering was awarded Dementia Friendly Borough Status in 2014, making the borough only the second London borough to receive this status.
- The stability of care placements for children looked after by the local authority has improved, with the percentage of looked after children with three or more placements during the year reducing each year.



* As at end November 2014

- The percentage of LAC placements lasting two or more years has also steadily improved.



*As at end November 2014

- Going forward, the recent successful bid to the Prime Minister's Challenge Fund will facilitate further improvements to the quality of and access to primary care services across the Clinical Commissioning Group by investing in improvements to complex care and facilitating access to services between 8am and 10pm seven days a week, as well as enabling technology to facilitate better information and data sharing.

3.3 The National Context

The Care Act 2014

The Care Act is the most important and far reaching piece of legislation impacting on adult social care since the NHS Community Care Act 1990. The Care Act combines many different laws regarding care and support into one piece of legislation that creates a range of duties and responsibilities.

Key areas of change to be implemented from April 2015 include:

- Greater responsibilities on local authorities, including to promote people's wellbeing, focusing on prevention and providing information and advice (including to self-funders);
- The introduction of a consistent, national eligibility criteria;
- New rights to support for carers, on an equivalent basis to the people they care for;
- A legal right to receive a personal budget and direct payment;
- A requirement to ensure more holistic and integrated provision of services across both statutory and non-statutory organisations;
- New guarantees of continuity of care when service users move between areas;
- The extension of local authority adult social care responsibilities to include prisons, and
- New responsibilities around transitions, provider failure, supporting people who move between local authority areas and safeguarding.

Major reforms to the way that social care is funded will be effective from April 2016, including:

- A lifetime 'cap' of no more than £72,000 for individuals on reasonable care costs to meet their eligible needs, and
- An increase in the capital threshold for people in residential care who own their own home.

Better Care Fund

The Better Care Fund (BCF) supports the transformation and integration of health and social care services to ensure local people receive better care. The BCF is a pooled budget that shifts resources into social care and community services for the benefit of the NHS and local government.

The key objectives of the BCF (which will be linked to a payment by results mechanism) are to:

- Ensure more joined up and effective commissioning, including the procurement, specification and contracting of health and social care services;
- Deliver more integrated solutions for residents and service users, at the lowest and most appropriate level possible, and
- Avoid hospital and long term care home admissions by ensuring improved management of high cost resources through targeted locality interventions.

The Better Care Fund is not new money that we can invest in the local health economy, but does provide an opportunity for partners to accelerate established plans to deliver greater benefits and improved outcomes to local people by combining budgets and working in a more integrated manner. Partners represented on the Health and Wellbeing Board will work together to deliver the specific schemes highlighted in the borough's BCF Plan, which in turn contribute to the achievement of our Health and Wellbeing Strategy.

The Children and Families Act 2014

The Children and Families Act draws together the support a child or young person aged 0-25 with special educational needs (SEN) requires across education, health and social care into a single Education, Health and Care (EHC) Plan which will replace the current statementing system. These will be gradually implemented over a two to three year period from September 2014 and will require plans to be outcomes, rather than outputs, focussed as well as requiring a co-ordinated, multi-agency assessment process. The Act introduces a new legal requirement for the local authority to work with health to integrate services, as well as a requirement for joint commissioning arrangements across education, health and social care, and a mechanism to agree the levels of service required.

The Act also strengthens the rights of young carers to an assessment of needs for support. It is believed that the number of young carers in the borough is currently under identified and likely to increase. This in turn will increase the demand for assessments and services. This is recognised in the borough's BCF plan.

The Act also requires children, young people and their parents or carers to be offered personal budgets to meet their care needs. This will require increased transparency,

signposting and market development of “the Local Offer” within an increasingly competitive health and social care economy.

The Marmot Review 2010

The Marmot Review 2010, *Fair Society, Healthy Lives*, proposed evidence based strategies for reducing health inequalities including addressing the social determinants of health. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are fundamentals for improving quality of life and reducing health inequalities. We are aware that, to reduce health inequalities and improve wellbeing, we must focus our efforts on those who are experiencing poverty and deprivation and must support our communities to lead healthy lives and to make healthy choices.

3.4 The Local Context and Delivery Arrangements

3.4.1 The Havering Health and Wellbeing Board

The Health and Wellbeing Board is the forum through which key leaders from health and social care work together in partnership to improve the health and wellbeing of the people of Havering and to reduce health inequalities across the borough. The Board is committed to ensuring that health and social care services in the borough are operationally and cost effective and oversees the implementation of the wider change agenda across the local health and social care economy. The Board will hold commissioners in the borough accountable for delivering the priorities and actions outlined in this strategy and its accompanying action plan.

Membership of the Havering Health and Wellbeing Board is set out at Appendix 1.

The Governance Structure (also attached at Appendix 1) illustrates how the Health and Wellbeing Board fits into the wider health and social care system and the other local governance structures which, whilst not all directly accountable to the Health and Wellbeing Board, provide the mechanisms through which the Board can receive assurance on progress against the priorities identified within this strategy.

3.4.2 Havering’s Joint Strategic Needs Assessment (JSNA)

The JSNA identifies and assesses the health and wellbeing needs of the local population. It is carried out by analysing a range of data and intelligence from various sources, including feedback from local people. It identifies where our health and social care services perform well compared with others and where we need to improve. The JSNA is regularly updated and available to view on the Havering data intelligence hub at: www.haveringdata.net/research/jsna.htm.

3.4.3 The Financial Landscape

Both the local NHS and the Council are facing a highly challenging financial position for at least the short to medium term. The total forecast financial gap by 2018/19 for the major providers in Barking, Havering and Redbridge is £260m. The borough's acute trust (BHRUT) accounts for £150m of this – which compounds the current issues concerning service quality, performance and productivity. For the CCGs, the forecast gap is £128m, with the Havering CCG having a gap of £48m. Meanwhile there is a need for the local authority to reduce its budget by £60m over the four years from 2015/16. All of these budget reductions will be extremely challenging to achieve given the levels of population growth being experienced in the borough and the changing care needs and increasing acuity that are presenting in the local population. The implementation of the Care Act 2014 and the Children and Families Act 2014 will also put further financial pressures on the Council and its partners. All key partners are therefore facing significant budget pressures while operating in an environment where demand for higher quality services is increasing.

In such a challenging financial context, it is crucial to ensure that projects and resources are managed diligently in order to maximise the return on investment; ensure a sustainable financial position and, even more critically, to improve the health and wellbeing of local residents.

3.5 Action Plan

This Strategy sets out the Health and Wellbeing Board's eight priorities, and each has a jointly agreed action plan as to how improved outcomes for local people will be delivered. The Action Plan accompanying the Strategy is set out at Appendix 4. This includes a variety of interventions including individual, targeted and population-wide initiatives. Each intervention seeks to provide the most beneficial outcome for individuals, whilst being achievable within the constraints of health and social care budgets.

3.6 Monitoring and Review Arrangements

It is the responsibility of the Health and Wellbeing Board to oversee the delivery of the strategy. Performance against the key actions and indicators set out in this Strategy will be monitored on a quarterly basis by the Board.

The strategy will be critically reviewed and refreshed as necessary at the end of the three year period. In the meantime, plans will be continually reviewed in light of the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

4. Health and Wellbeing Themes and Priorities

Theme A: Preventing, reducing and delaying the need for care and support through effective demand management strategies

People with the most complex needs pose the greatest challenge to health and social care providers. Older people, especially those with **long-term conditions**[1], are the most intensive and costly users of health and social care services. In response to the 2011 *Your Council, Your Say* survey, more than a quarter (25.3%) of residents identified themselves as having a long standing illness or disability.

As well as treating the symptoms of these conditions, we need to address some of the lifestyle choices and factors that contribute to them. For example, one in five adults smoke and the alcohol consumption of one in five is at a harmful or increased level. By focusing on prevention and early intervention, we aim to help manage demand on services and enable more people to be healthier and to live independently and safely in their own homes for as long as possible. Our continued focus on reablement and rehabilitation services for those recovering from a period of illness, alongside support to help older and vulnerable people manage long-term conditions and to lead healthier lifestyles, will help more people to maintain independent living for longer. However, given the broad range of factors that impact on the health and wellbeing of the local community, our prevention initiatives will not simply be restricted to those provided by health and social care services. Other services that are delivered or commissioned right across the partnership, such as leisure and cultural services, will also have a key role to play in tackling root causes of ill health and health inequalities. Particularly in the current economic climate, we will also need to consider how we can get the most health gain from universal services by identifying the prevention opportunities that we may be able to build into all mainstream services rather than necessarily commissioning bespoke services to respond to each and every presenting need.

Overall, the level of mental health difficulties in Havering is comparatively low, but it remains an issue for the local population and for the Health and Wellbeing Board as there are significant inequalities in the distribution of risk factors and the prevalence of mental illnesses across the borough, with evidence showing that people who live in the most deprived wards such as Gooshays and Heaton are much more likely to suffer from a mental illness than those who live in the least deprived parts of the borough such as Upminster and Cranham. However, whilst Havering has a significantly lower prevalence of patients recorded with a diagnosis of mental illness overall, **dementia** is a particularly pertinent issue in Havering due to its large and growing older population. Dementia is a particularly distressing illness for both the sufferers themselves and their friends and family and others who care for them.

[1] Defined as one or more of the following: Asthma, Cancer, Coronary Heart Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Dementia, Depression, Diabetes, Epilepsy, Hypertension, Heart Failure, Learning Disability, Stroke and those receiving end of life services

Supporting people with dementia is a high priority both nationally and locally and, whilst clinical diagnosis of dementia is predominantly a matter for the NHS, access to post-diagnostic support (for both the patient and their family and carers) is a matter for all members of the Health and Wellbeing Board.

Research carried out to inform the Joint Strategic Needs Assessment (JSNA) chapter on mental health also found that people with **learning disabilities** in the borough have significant unmet needs, and also identified links between learning disabilities and depression, anxiety and other mental disorders. In particular it was noted that clients with a LD can particularly struggle with grief following a bereavement (often of a parent).

In February and March 2014, Healthwatch Havering facilitated a series of workshops, attended by service users and carers as well as representatives from the voluntary and community sector, NHS organisations and the Council, to investigate what services were available in the borough for people with dementia or learning disabilities and what could be done to secure improvements. The findings of the resulting report are addressed in our Action Plan attached at Appendix 4.

Obesity increases the likelihood of the development of a range of health conditions, with the most important of these in terms of the burden on health services being type II diabetes, cardiovascular diseases and several types of cancer. It increases the risk of morbidity, disability and premature mortality. Being obese also restricts mobility, can lead to poor mental health and reduce life quality. Obesity in pregnancy increases the risk of complications both for the mother and the child. These effects can last throughout childhood and into adulthood, with babies born to obese women facing increased risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. Type II diabetes has increased in overweight children. Other risks associated with childhood obesity include early puberty, eating disorders, skin infections, asthma and other respiratory problems.

Obesity further costs society through the loss of disability-free life years, additional pension payments due to early retirement through ill health, increased absenteeism and / or reduced productivity at work due to ill health. There have also been links made between obesity and various emotional and psychological effects such as anxiety and depression. In children, this can have a knock-on effect on educational attainment. Once established, obesity is difficult and costly to treat, so prevention and early intervention are paramount. By promoting healthier lifestyles, increasing levels of physical activity and commissioning appropriate support services, the Havering Health and Wellbeing Board aims to help residents maintain healthy weight.

Partly linked to this, a greater proportion of people in Havering than in England and other statistically similar local authorities die prematurely from heart disease and strokes. The expected increase in the number of elderly residents in Havering is

predicted to increase still further the numbers of residents experiencing cardiovascular diseases (CVD) and cancer, as well as respiratory illnesses (e.g. bronchitis and pneumonia), osteoporosis (and fractures due to falls), incontinence and hearing impairment. This emphasises the need to reduce the prevalence of **cardiovascular disease** through primary prevention.

Meanwhile **cancer** is one of the top for priorities for outcomes improvement across London and one of the top three causes of premature mortality across the Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Group (CCG) and therefore warrants our continued attention.

What we want to see

- Earlier identification and diagnosis of dementia in order to improve treatment
- Earlier diagnosis and treatment of cancer
- Improved quality of life for those with one or more long term conditions
- Individuals feeling in control of their care, and empowered and enabled to live well.
- Reduced harm caused by modifiable risk factors
- Better co-ordination of end of life care.

Our four priorities are to…….

Priority 1: Provide effective support for people with long term conditions and their carers, so that they can live independently for longer

Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

Priority 3: Reduce obesity

Priority 4: Reduce premature deaths from cancer and cardiovascular disease

Priority 1: Provide effective support for people with long term conditions and their carers so that they can live independently for longer

What we know about Havering

- As at 19 September 2014, the number of people who were both registered with a Havering GP and resident in Havering with long-term conditions was as follows:

No. of long-term conditions	No. of people aged 18-64	No. of people aged 65-74	No. of people aged 75+	TOTAL
1	27,822	7,999	6,256	**42,077**
2	6,612	4,493	5,783	**16,888**
3	1,445	1,720	3,501	**6,666**
4+	413	773	2,424	**3,610**

- As at 19 September 2014, 32,949 Havering residents aged 65 or over have a limiting long term illness.

- 17.3% of the population of Havering say that their day to day activities are limited due to their health, compared to 14.2% for London and 17.6% for England.

- As at 31 March 2014, there were 530 people with learning disabilities and 3,615 people with physical and sensory impairments receiving social care support in Havering. A further 1,765 older people were believed to be directly purchasing and funding their own care.

- In 2013/14, there were 378 people aged 65 years or over with a physical disability who were receiving residential / nursing care; 766 receiving domiciliary care; 804 in receipt of equipment and / or assistive technology; 377 in receipt of direct payments and 121 receiving reablement services.

- There are 1,200 older people in the borough that have particularly complex health and social care needs.

- People aged 85+ have the most complex health and social care needs, with approximately 900 of them accounting for 38% of all emergency beds.

- 45.2% (2,656) of adult social care clients receive some form of self-directed support. During 2013/14, 975 adult social care clients received a personal budget, which is above both the London and England averages.

- 52% of those with a long term health condition in Havering feel they have had enough support from local services or organisations in managing their condition. This is slightly lower than the figure for the whole of England (55%) but in line with the London-wide figure (52%)

Case Study

Mr OB is a 57 year old man who suffered a brain injury six years ago. When he was discharged from hospital Mr OB went into rehabilitation. He suffered severe bouts of depression and he and his family believed that he would always need some form of residential care. When he was ready to leave rehabilitation, Mr OB and his wife made clear that he really wanted was to go home to be with his family.

A personal budget was arranged with Mr OB and his wife, so they could be confident that when he returned home on a permanent basis, the work of the rehab unit could be continued. As his wife was his main carer, this would also ensure she had some time to herself so she could continue to provide the support he needed

In Spring 2014, Mr OB left the rehab unit and moved home. He uses his personal budget to purchase support from carers who have specialist training in working alongside people who have a brain injury. They go to his home to support him providing a structured day and trips to the gym to continue the physiotherapy programme started in rehabilitation. He also spends two days a week in a physical disability specialist unit where he participates in many different activities and discussion groups. Most importantly for Mr OB and his wife, the flexible personal budget has given them the opportunity to have a quality home life together; something that neither of them had believed would be possible again.

What we plan to do

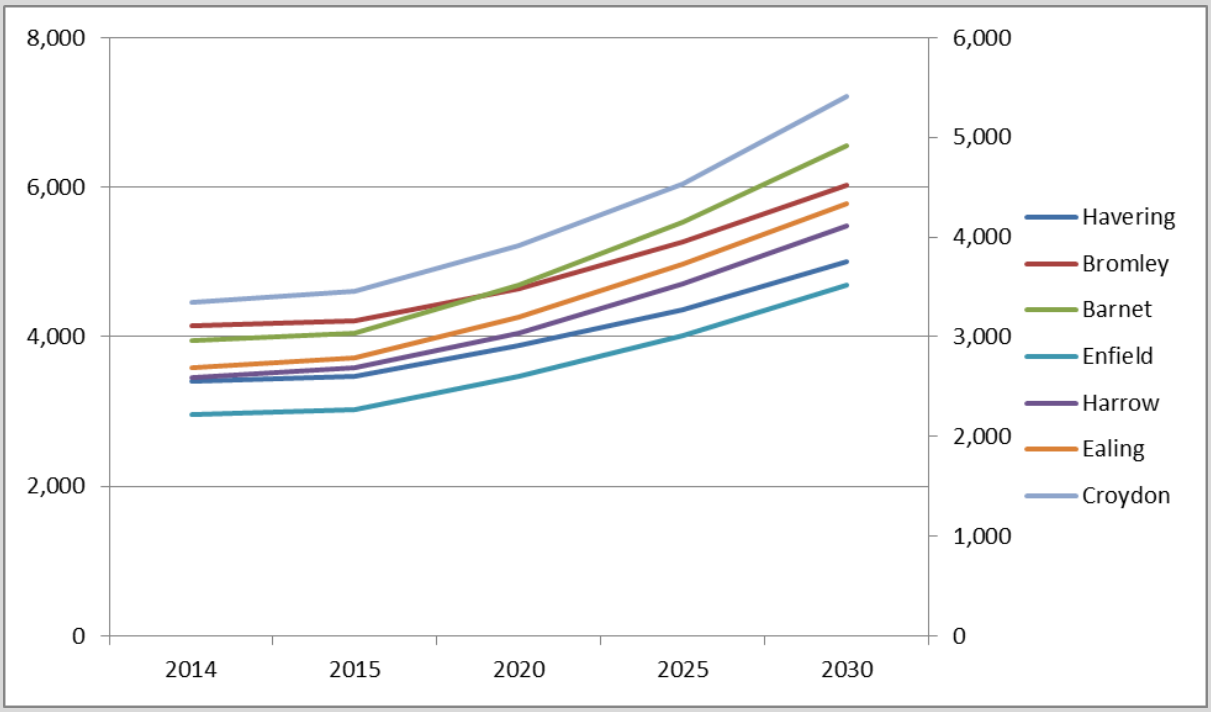
- Work as a partnership to improve residents' choice and control over the health and social care services they receive.
- Provide co-ordinated health and social care services in individuals' own homes, or as close to where they live as possible
- Work with the voluntary and community sector to support vulnerable people in the community, including providing respite care and support schemes for people who have just left hospital and their carers.
- Build community resilience and support people to manage their own conditions through initiatives such as peer support, mentoring and time-banking.
- Strengthen the co-ordination of complex care and end of life services across health and social care.

Priority 2: Improve identification and support for people with dementia and learning disabilities and their carers

What we know about Havering

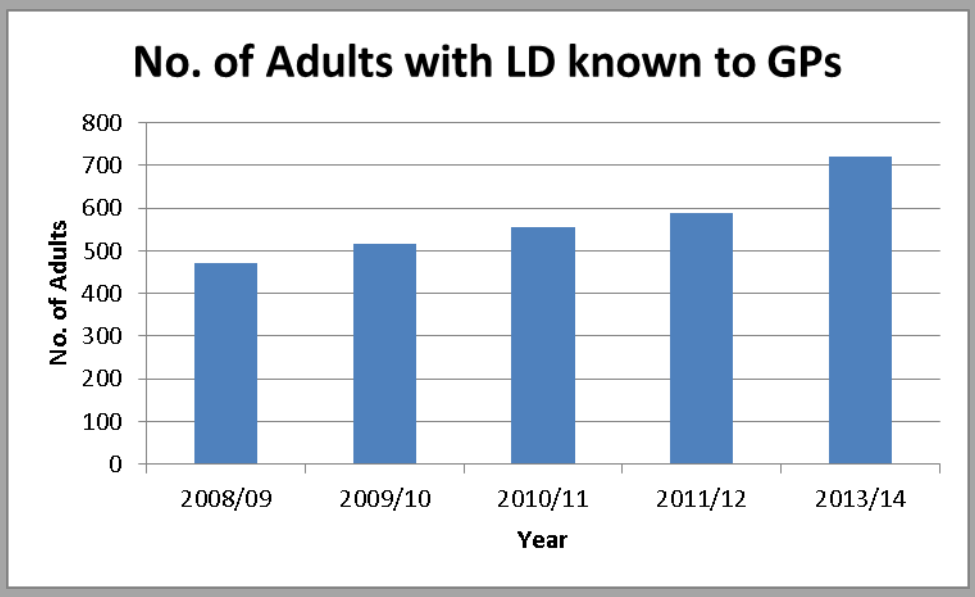
- It is estimated that, in 2014, Havering had over 3,000 people aged 65+ with dementia. This is predicted to rise to 3,794 by 2020 and to 5,005 by 2030, with Havering being home to the sixth highest number of residents with dementia in London

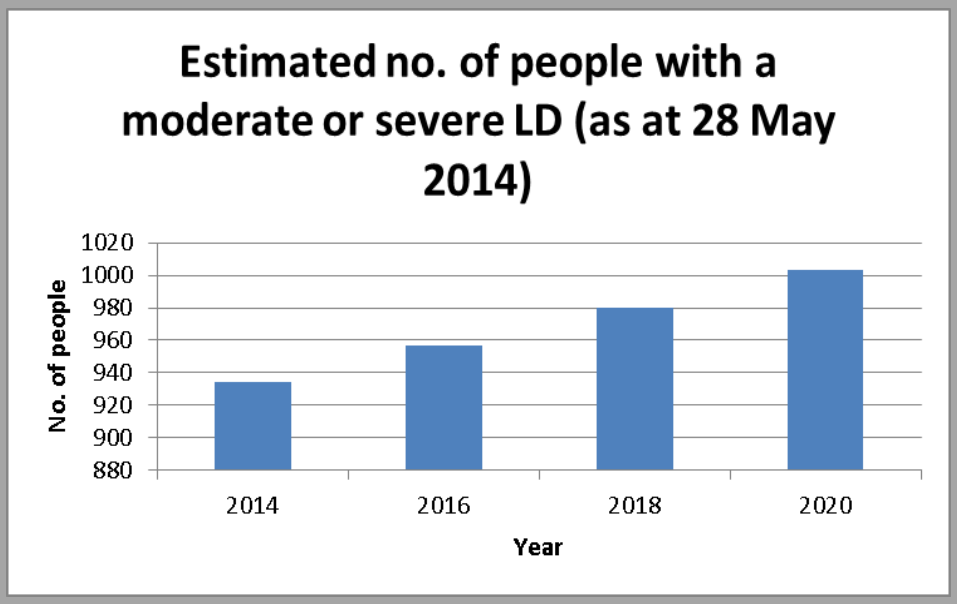
People aged 65 and over predicted to have dementia projected to 2030 in the top seven boroughs (POPPI) 2014



- As at December 2014, the dementia diagnosis rate for Havering had increased from 39% to 48.4%. However this remains considerably lower than the 55% national diagnosis rate and the 67% national target diagnosis rate. The Memory Service would need to see at least another 500 people to reach the national target.
- The recorded number of people with dementia in Havering is significantly lower than the expected number (given the borough's demographics), suggesting that more than 2,000 local people are living with undiagnosed dementia and, therefore, are not benefiting from treatments that could slow its progression and improve their wellbeing.
- Around 60 people aged 30-64 in Havering are estimated to be affected by early onset dementia

- It is estimated that around 63% of those with late onset dementia live in private homes in the community, and around 37% live in care homes
- Evidence suggests that the majority of people with dementia in Havering are white, aged 70+, and that there are considerably more female dementia cases than male.
- A large proportion of care for people suffering from dementia (particularly the undiagnosed) is provided by family and friends.
- The borough is a "net-importer" of people with learning disabilities, due to the large and growing number of supported living schemes in the borough, which mean that other borough place people in Havering. Due to ordinary residence rules, these individuals become the responsibility of the local authority and primary care services within Havering.
- As at 31 March 2014, there were 530 people with learning disabilities receiving adult social care support in Havering. Of these, around 9% are aged 65 plus. The number of new LD service users requiring assessments has increased substantially in recent years, which has also resulted in an increase in the number of carers of people with LD requiring an assessment or review.
- In Havering, we are expecting an increase of 10% in people aged over 65 with a learning disability to 2020, and an increase in 5% in the number of people aged 18 – 64 with a learning disability.
- The average age of adult social care service users with a learning disability has reduced from 29 in 2012/13 to 26 in 2013/14, whilst the average age of carers has remained consistent at approximately 60 years old.
- As at 28 October 2013, there were just 72 children registered with a Havering GP who were recorded as having a learning disability. This suggests substantial under-recording of learning disabilities.
- Comparisons of the number of adults with learning disabilities known to GPs (see below) or social care and the estimated numbers of adults with learning disabilities in Havering (also shown below) suggests that – as for dementia - a large proportion of people with learning disabilities are still being solely supported by their own families.


No. of Adults with LD known to GPs
800
700
600
500
400
300
200
100
0
No. of Adults
2008/09
2009/10
2010/11
2011/12
2013/14
Year


Estimated no. of people with a moderate or severe LD (as at 28 May 2014)
1020
1000
980
960
940
920
900
880
No. of people
2014
2016
2018
2020
Year

What we plan to do

- Aid prevention through early identification of risk factors.
- Increase referral and diagnosis rates for dementia.
- Improve the level of local detail about learning disabilities and dementia within the Joint Strategic Needs Assessment (JSNA), thus providing a better opportunity to plan and design care for the longer term.
- Ensure that people with dementia and learning disabilities and their carers are effectively supported by health and care services and the community to live as well and as independently as possible with their condition(s).

Priority 3: Reduce obesity

What we know about Havering

- In 2012, 41% of people were overweight and 22.3% were obese in Havering
- Obesity rates in reception year children appear to be increasing over time**.** Just over one in ten (10.7 %) of reception year children in Havering are obese, whilst almost one in five (19.3%) year six children are obese. For children aged 4 – 11, there are correlations in Havering's Middle Layer Super Output Areas (MSOAs) between obesity and income deprivation and between obesity.
- At 27.3%, the proportion of adults in Havering who are obese is the second highest in London and also higher than both the England average of 24.2% and the London average of 20.7%
- In Havering, the proportion of patients who are obese (with a BMI of 30 – 34.9) is significantly greater in patients with a diagnosis of depression than in those without.
- Pockets of high obesity prevalence across the Borough tend to be clustered in the less affluent wards of Gooshays, Heaton and South Hornchurch.
- Although a low number of Havering residents aged 16+ (17.5%) reported that they took part in the recommended 3x30 minutes of physical activity (which is lower than previously and below both London and England participation rates), Sport England's Active People Survey 2009/10 showed that almost 50% (54% men / 43% women) of borough residents took part in sport or active recreation at least once in the four weeks prior to the survey. In addition, the 2010/11 survey showed that 21% of the borough's residents were members of sports clubs, 13% had received sports tuition in the last 12 months and 13% had taken part in organised competition in the last 12 months. However data also suggests that 51.8% of adults in Havering do no physical activity at all.

What we plan to do

- Increase physical activity levels amongst residents in the borough
- Assist residents (particularly in the most deprived areas of the borough) to maintain healthy weight
- Continue to invest in the assessment, treatment and prevention of childhood obesity, especially for under 5s
- Capitalise on opportunities presented through the National Child Measurement Programme to identify overweight and obese children, and signpost them to services

Priority 4: Reduce premature deaths from cancer and cardiovascular disease

What we know about Havering

- The premature mortality rate (all causes) for Havering is 90.5 (1,684) for people aged under 65 and 92.1(3,327) for people aged under 75, compared to the England ratio of 100.

- Levels of smoking are high in the borough. 20% of adults smoke, which is worse than the London average, and the borough also has the highest rate of smoking during pregnancy in London. The proportion of women who smoke in maternity almost doubled between 2005/06 and 2013/14. Nationally, people with mental health difficulties are more likely to smoke, and this is also reflected in the Havering population. There are around 400 smoking related deaths per annum in the borough.

- High numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the large older population. This will increase even further as the population continues to get older.

- Cancer survival rates are not improving and are worse than the national average

- Breast, bowel, and lung cancer are the most common cancers in women in Havering, while prostate, lung and bowel cancer are most common in men

- Around a third of deaths in Havering are caused by Cardiovascular Disease (CVD), a large proportion of which are deaths from Coronary Heart Disease and Strokes. However, overall, mortality from CVD in Havering is lower than the England average, but above the London average

- There are nearly twice as many male deaths from CVD in Havering as in women (which is also the case in London and England).

- Those who live in the less affluent areas of Havering are more likely to die from CVD, and those registered at GP practices in the most “deprived” areas of the borough a 55% more likely to have hypertension, 36% more likely to have congestive heart failure and 70% more likely to have coronary artery disease than those registered at GP practices in the least “deprived” areas.

What we plan to do

- Improve support and care coordination for people living with and beyond cancer.
- Maximise participation in screening programmes and health checks by identifying communities with low participation rates and taking targeted action in those communities
- Commission well-evidenced prevention programmes to tackle modifiable risk factors such as smoking, unhealthy diets and alcohol consumption

Theme B: Better integrated support for people most at risk

Havering has large and growing population of vulnerable people and older people. As our older people population continues to grow, and so does the number of **"frail elderly"** residents in the borough, we are facing increasing demands on services. By better integrating services across the health and social care sectors, as well as the voluntary and community sector, we can improve service user experiences and outcomes and also secure better value for money.

Vulnerable children, such as those in care or with disabilities, also face particularly complex challenges. Physical and psychological ill-health tends to be more prevalent amongst looked after children and care leavers compared with their peers. It is therefore essential that all looked after children receive a comprehensive and holistic health assessment and annual reviews, and that looked after children and their carers are supported to lead healthy lives.

In January 2014, the Government confirmed that the Healthy Child Programme (HCP) (Universal / Universal Plus) for 0-5 year olds, which includes the commissioning of health visiting and family nurse partnership services, will transfer from NHS England to local government on 1 October 2015. This transfer marks the final park of the overall public health transfer (which saw wider public health functions transfer to local government from Primary Care Trusts in 2013) and will join up commissioning arrangements for 0-19 year olds (and up to 25 years for young people with Special Educational Needs and Disabilities). The transfer represents a unique opportunity to transform and integrate health, education, social care and wider Council led services in pursuit of improving outcomes for children and young people. The Health and Wellbeing Board will need to maintain a strategic overview of the transfer; ensure that there are appropriate governance and communications arrangements in place, and plan how best to meet the needs of the local population. Unlike the previous public health transfer, in this case it is only the commissioning responsibility that will transfer; not the workforce. Health visitors and family nurses will continue to be employed by their provider organisations however, across the partnership, we will need to consider the workforce profile and the skills mix needed to support the programme.

Having successfully reduced the incidence of delayed transfers of care, more work now needs to be done across the whole system to **reduce the number of admissions and the average length of stay in hospital**. 60% of deaths in the borough occur in hospital, often following unplanned and prolonged hospital admissions. Hospital admissions are costly to the health service and disrupt the lives of those affected, including family and friends. Long and frequent hospital stays also reduce people's confidence to manage at home in the future. Emergency admissions account for nearly two thirds of hospital bed days in England and are costly compared to other types of care. Some of these admissions could be avoided. The Havering Health and Wellbeing Board is therefore keen to reduce unnecessary

and unplanned hospital admissions, particularly where these relate to ill health or injury that could have been avoided, and / or individuals who are admitted to hospital on a frequent basis.

The Havering Health and Wellbeing Board's vision for whole system integrated care is based on what individuals, communities of interest and local organisations have told us is most important to them. Our aim is to provide people with new ways to access primary care, and to offer other innovative services which are designed around the needs of the patient in order to reduce acute admission and A&E attendance and also to improve the patient experience.

What we want to see

- Seamless, integrated and people-centred health and social care services delivered to Havering residents.
- Greater co-commissioning across the CCG and local authority, and also across Havering, Barking and Dagenham and Redbridge where appropriate.
- Effective co-commissioning and delivery of early years services, from pre-birth
- The introduction of joint assessments of health and social care needs; interoperability between health and social care systems and the holding of single case records across the health and social care sectors
- A vibrant primary care model
- Services shifted out of secondary care and into the community and primary care
- A reduction in avoidable time spent in hospital
- A higher proportion of older people living independently following discharge
- Improved physical, social and psychological health across the looked after children population

Our three priorities are to…….

Priority 5: Better integrated care for the "frail elderly" population

Priority 6: Improve integrated care for children, young people and families most at risk

Priority 7: Reduce avoidable hospital and long term care home admissions

Priority 5: Better integrated care for the "frail elderly" population

What we know about Havering

- There are 1,200 older people in the borough that have particularly complex health and social care needs.
- Approximately 19,500 Havering residents aged 65 or older have a limiting long term illness
- 17,277 older people were estimated to be living alone in 2014 and this is predicted to rise to 20,590 by 2020.
- Havering experiences the second highest number of excess winter deaths in London. Between 2006 and 2009, there were an average of 137 winter deaths per annum involving a person aged 85+ in Havering and these deaths are expected to increase along with the age of the population.
- In 2014, 15,784 older people aged over 65 were estimated to be unable to manage at least one self care task on their own, and 19,248 were estimated to be unable to manage at least one domestic task (e.g. shopping, washing etc) on their own.

What we plan to do

- Work as a strategic partnership to design and deliver seamless, integrated and efficient care pathways for "frail elderly" people with care needs
- Maintain our collective commitment to the Frailty Academy.
- Enhance the independence and capability of individuals to manage their conditions at home
- Provide support within the community to people who have recently been discharged from hospital or who are at risk of admission / readmission.

Priority 6: Improve integrated care for children, young people and families most at risk

What we know about Havering

- Of just over 30,000 families in Havering, it is estimated that nearly 400 of them 'families with multiple complex needs' and over 2,000 are 'barely coping'.
- The level of child poverty in Havering is better than the England average with 19.1% of children in Havering living in poverty as at March 2014. However in some wards (e.g. Gooshays, at 35.2%) the percentage of children living in poverty is above both the London (28.8%) and England (18.2%) average, and the proportion of children living in poverty in the borough has bucked London-wide trends by increasing over recent years. Havering is one of only two London boroughs in which the rate of child poverty has increased. This is a concern to the Health and Wellbeing Board as children in poverty are more likely to report a range of poor health outcomes.
- Between 1 April 2013 and 31 January 2014, domestic violence was a presenting factor in 10.9% of all initial contacts to children's social care and was the second highest reason for contacts progressing to a referral to children's social care (placed only behind physical abuse). Domestic violence also featured in 19.7% of Children in Need Plans and 16.4% of Child Protection Plans.
- As at the end of November 2014, there were 180 children from Havering on Child Protection Plans. This had increased from an average of 124 per month during 2013/14.
- As at the end of November 2014, there were 164 children on a Child in Need (CIN) Plan. This had reduced from a peak of 214 at the end of July 2014.
- As at the end of November 2014, there were 216 children looked after by the local authority. The numbers of LAC have been at their highest ever levels in the borough during 2014/15.
- At primary level, speech, language and communication difficulties are the most commonly identified type of special educational need (SEN), followed by moderate learning difficulties, then behaviour, emotional and social difficulties. At secondary level, moderate learning difficulties are more prevalent, followed by behaviour, emotional and social difficulties, then speech, language and communication needs. Special schools, meanwhile, have a very different profile, with most of their pupils having severe, moderate or profound and multiple learning difficulties.
- The number of children aged 5 – 10 with an emotional disorder is expected to rise by 26 between 2014 and 2017, split roughly equally between boys and girls.

What we plan to do

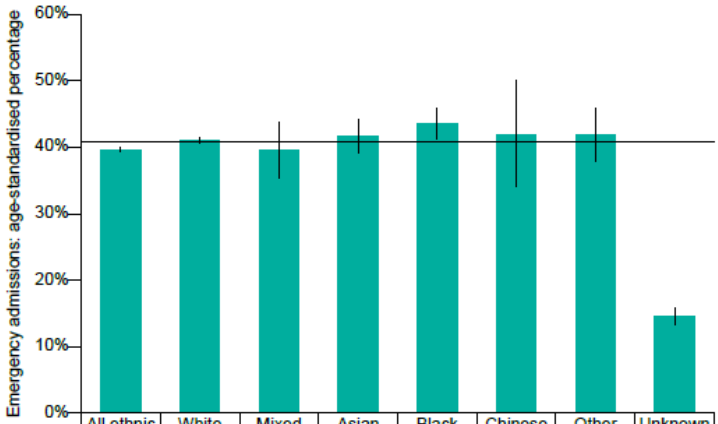
- Continue to provide intensive, bespoke support to families with multiple complex needs to avert the escalation of their difficulties.
- Reduce the numbers of children living in poverty in Havering
- Promote the physical, social and psychological health and wellbeing of children looked after by the local authority
- Work across the health and social care economy to put in place an effective Early Years Pathway from pre-birth
- Improve transitions from children's to adults' care packages for young people with disabilities.
- Improve access to high-quality therapies for children and young people.

Priority 7: Reduce avoidable hospital and long term care home admissions

What we know about Havering

- Approximately 60% of deaths in the Havering occur in hospital, often following unplanned and prolonged hospital admissions.
- Rates of emergency hospital admission in Havering are significantly lower than the average for England and London but are increasing. A&E attendance rates, meanwhile, have declined in recent years with a reduction of 12% overall between Q3 2012/13 and Q3 2013/14, due largely to the work of the Integrated Care Coalition.
- The main health conditions responsible for avoidable admissions in Havering are chronic obstructive pulmonary disease (16.5% of all avoidable admissions), influenza and pneumonia (15.1%) and dehydration and gastroenteritis (11.3%)
- There are pockets across the borough with particularly high rates of avoidable hospital admissions. There is a cluster of high rates around Brooklands and Romford Town as well as some areas within Rainham and Wennington, Heaton, South Hornchurch and Harold Wood
- There are wide variations between Havering GP practices in terms of avoidable hospital admissions, ranging from 7 per 1,000 population to 32 per 1,000 population
- Readmission rates in Havering have risen by more than 4% over the last 10 years, in line with national trends. However, when emergency readmissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are readmitted to hospital in an emergency within 28 days of discharge, compared with England

Percentage of hospital admissions that were emergencies, by ethnic group



This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Havering

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
22,082	19,779	223	625	725	57	245	428	Local number of emergency admissions
39.7	41.0	39.5	41.6	43.5	41.9	41.8	14.5	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

Havering Health Profile 2014

What we are going to do

- Continue to develop effective care pathways both in and out of hospital and primary care
- Improve access to primary care, including in community settings
- Continue to develop Intermediate Care services
- Develop an integrated health and social care commissioning function

Theme C: Quality of services and patient experience

Ensuring that patients, their families and carers receive the best quality health and social care services is crucial to achieving the best long-term outcomes for patients and for the borough's population as a whole. In Havering, we want all patients to have as positive an experience as possible from the health and social care services they receive. Services across the whole health and social care economy should be delivered efficiently, safely and sustainably.

The Havering Health and Wellbeing Board remains aware of the serious quality and patient safety concerns identified within some of the borough's providers. CQC reports identified specific concerns relating to BHRUT (the borough's major acute provider) and it was placed in special measures in December 2013. This meant that it had to make significant improvements in the way it provides patient care and operates as an organisation. The Trust now has a new leadership team in place and is working to a robust improvement plan – *Unlocking our Potential* - that members of the Health and Wellbeing Board were instrumental in developing. Patient satisfaction has improved, with the Trust's Friends and Family Test inpatient score for June 2014 reaching 69, compared with 43 in June 2013. But while improvements have been made since, there is still more that needs to be done, and the Health and Wellbeing Board continues to have a vital role in scrutinising, challenging and supporting BHRUT to continue to make progress and improvements to benefit patients and their families.

The Council commissions Healthwatch Havering to engage local people on the health issues that matter most to them and to ensure that the voices of local patients and residents are represented on the Health and Wellbeing Board, in order to inform the development and improvement of local health and social care services.

What we want to see

- Consistently high quality and safety of care in all health and social care services provided in the borough.
- CCG and social care commissioners commissioning and procuring jointly, with a focus on improving outcomes for individuals within our communities.
- Improved patient engagement
- Better communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services

Our priority is to…….

Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

Priority 8: Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

What we know about Havering

- The borough has two major service providers, these being the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) for acute hospital services and the North East London Foundation Trust (NELFT) for community services (such as district nursing and mental health services). Community and mental health services are provided in clinics and hospitals as well as in people's own homes.
- We are working in one of the eleven most challenged health economies in the country and with one of the most challenged hospital trusts in the country. While improvements have been made, there is still more needing to be done to improve quality of services.
- Havering's patient experience of primary care and out of hours services is in the bottom quartile of London CCGs, while our patient-to-GP ratio (the number of patients to every GP in the borough) is very high.
- GP practices in Havering generally see lower levels of patient satisfaction with their GP than in most other CCGs nationally, and issues of patient access persist in some practices.

What we plan to do

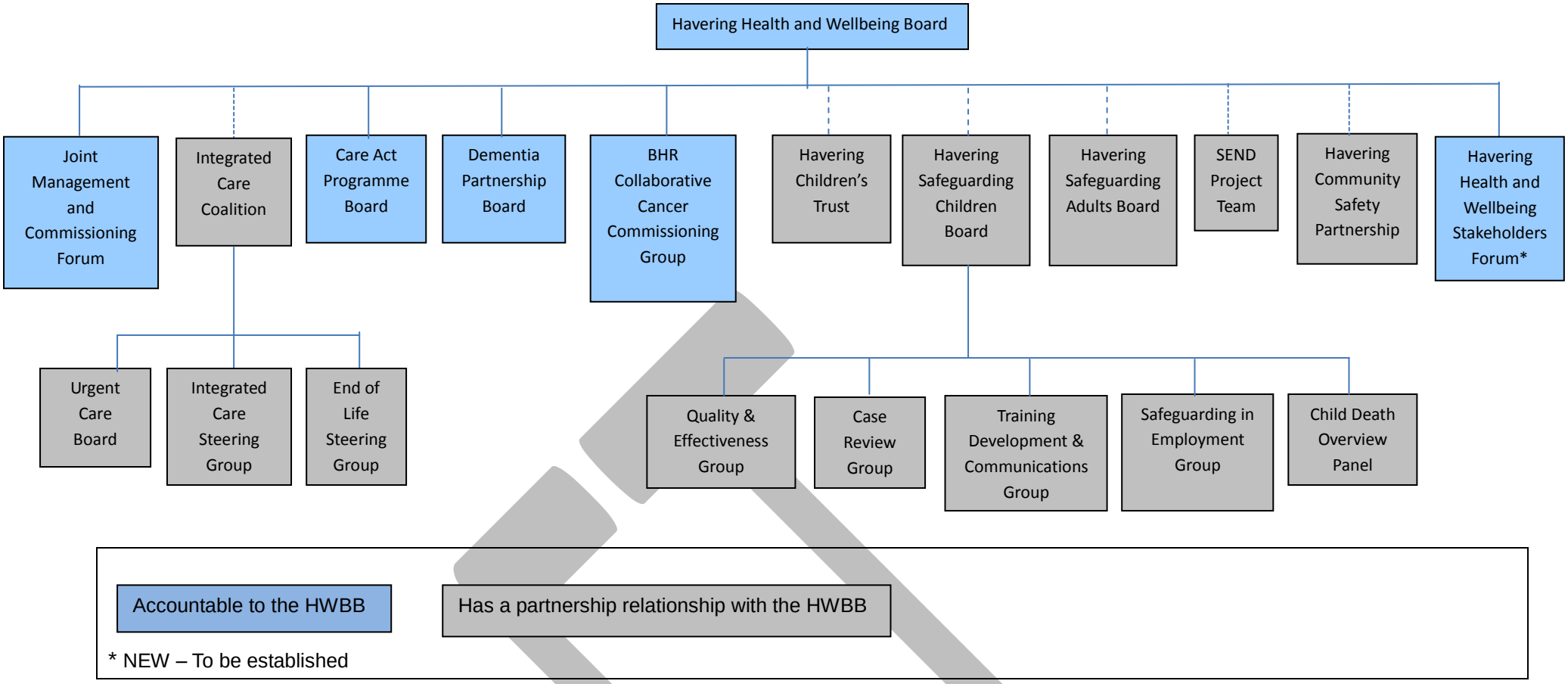
- Ensure that the CQC's findings and recommendations for improvements in the quality of care and patient safety at Queen's Hospital continue to be addressed.
- Work across the health and social care sectors to make the best use of our combined estates and assets.
- Ensure that patient and public engagement actively informs service improvement.
- Improve communication of the activities of the Health and Wellbeing Board and its impact on local health and social care services.

Appendix 1: Membership and Governance of the Havering Health and Wellbeing Board

Membership of the Health and Wellbeing Board

Name	Designation	Organisation
Cllr. Steven Kelly (Chair)	Elected Member	London Borough of Havering
Cllr. Meg Davis	Cabinet Member for Children and Learning	London Borough of Havering
Cllr. Wendy Brice-Thompson	Cabinet Member for Health	London Borough Of Havering
Cheryl Coppell	Chief Executive	London Borough of Havering
Joy Hollister	Group Director (Children, Adults and Housing)	London Borough of Havering
Andrew Blake-Herbert	Group Director (Communities and Resources)	London Borough of Havering
Mark Ansell	Acting Director of Public Health	London Borough of Havering
Conor Burke	Chief Officer	Barking, Havering and Redbridge Clinical Commissioning Group
Dr. Atul Aggarwal	Chair	Havering Clinical Commissioning Group
Alan Steward	Chief Operating Officer	Havering Clinical Commissioning Group
Dr. Gurdev Saini	Clinical Director (Frail Elders)	Havering Clinical Commissioning Group
Anne-Marie Dean	Chair	Healthwatch Havering
John Atherton	Head of Assurance	NHS England

The Health and Wellbeing Board's Governance Structure



Appendix 2: Glossary of Key Terms

Chronic Obstructive Pulmonary Disease (COPD) – A collection of lung diseases including chronic bronchitis, emphysema and Chronic Obstructive Airways Disease.

Community Health and Social Care Service (CHSCS) – A team developed through the reconfiguration of relevant NELFT services (community nursing, Integrated Case Management, therapies, and a mental health link worker) into locality based teams.

Community Learning Disabilities Team (CLDT) – An integrated team, historically governed through a Section 75 Agreement between the CCG, the local authority and NELFT, providing a range of care and support services. The NHS and local authority commission the CLDT, which in turn is responsible for commissioning services on behalf of the CCG and local authority to meet the needs of individuals (including services for informal carers).

Community Treatment Team (CTT) – An expanded service operating in Havering between 8am and 10pm, seven days a week. This aligns with peak attendances in A&E, in an effort to help relieve the pressure on accident and emergency units. The team provides short-term intensive care and support to individuals with a health and / or social care crisis to help support them at home rather than in hospital. The team includes both health and social care professionals, including doctors, nurses, occupational therapists, physiotherapists, social workers and support workers. The CTT aims to:

- Provide short term intensive care and support to people experiencing health and / or social care crisis, to help them to be cared for in their own home rather than in hospital;
- Support people to return home as soon as possible following an acute or community inpatient stay, where this is appropriate, and
- Provide a single point of access to intensive rehabilitation at home or in a bed in a community rehabilitation unit if necessary.

Frailty Academy – A virtual academy operating across Barking and Dagenham, Havering and Redbridge and comprising of clinicians and other staff from across health and social care as well as academics from University College London (UCL). Its aim is to ensure that the lessons of various approaches and initiatives are learned and used to inform the development of mainstream services.

Healthwatch Havering – The consumer local champion for health and social care services within the borough. It aims to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for individuals locally.

Healthy Child Programme (HCP) – A national public health programme based on best knowledge / evidence to achieve good outcomes for all children.

Integrated Care Coalition (ICC) – Brings together senior executive leaders within the Barking and Dagenham, Havering and Redbridge health and social care economy to support the

three Clinical Commissioning Groups and the three local authorities in commissioning integrated care and building a sustainable health and social care system. The ICC is responsible for developing recommendations for system wide integrated care for consideration by commissioners and the Health and Wellbeing Boards.

Integrated Care Steering Group (ICSG) – Co-ordinates (on behalf of the Integrated Care Coalition) the production of the five year strategic plan across the Barking, Havering and Redbridge health economy.

Integrated Case Management (ICM) – A model of practice which aims to ensure that patients with complex health and social care needs receive the right care, in the right place, at the right time. The ICM team in Havering includes a GP, a Community Matron, a District Nurse, a Social Care lead, a Care Liaison Officer and any other relevant staff needed in order to meet specific needs (e.g. from the mental health team).

Intensive Rehabilitation Service (IRS) – A team consisting of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants, with access to a geriatrician as required via the Community Treatment Teams (see above). It aims to offer an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates between 8am and 8om, seven days a week.

Joint Assessment and Discharge (JAD) team – Brings together the assessment and discharge teams across Barking and Dagenham, Havering and Redbridge into a single, integrated, ward based system, able to discharge to any of the three boroughs.

Multi-Agency Safeguarding Hub (MASH) – A co-located, multi-agency team working in a single, secure assessment and referral unit where protocols govern what information from each agency can be shared and how in order to ensure that the welfare of the individual is safeguarded and promoted. Information is gathered from a range of relevant agencies to inform the decision about what further action is required and which agency is best placed to lead this.

Nursing Home Scheme – A scheme designed to prevent unnecessary conveyances to hospital from nursing homes. As at May 2014, 31 nursing homes in Havering were signed up to the scheme.

Urgent Care Board (UCB) – Develops and delivers the improvement plan for urgent care

Abbreviations

A&E – Accident and Emergency Unit

BCF- Better Care Fund

BHRUT- Barking, Havering and Redbridge University Hospitals Trust

CAMHS- Child and Adolescent Mental Health Services

CCG- Clinical Commissioning Group

CHSCS – Community Health and Social Care Service

CIN – Child in Need

CLDT – Community Learning Disabilities Team

COPD – Chronic Obstructive Pulmonary Disease

CPP – Child Protection Plan

CQC- Care Quality Commission

CTT – Community Treatment Team

CVD- Cardiovascular Disease

DH – Department of Health

DTOC – Delayed transfers of care

FNP – Family Nurse Partnership

GP – General Practitioner

HCP – Healthy Child Programme

ICC – Integrated Care Coalition

ICM – Integrated Case Management

ICSG – Integrated Care Steering Group

IRS – Intensive Rehabilitation Service

JAD- Joint Assessment & Discharge Team

JCB – Joint Commissioning Board

JSNA- Joint Strategic Needs Assessment

LA – Local Authority

LAC – Looked After Child(ren)

LAS – London Ambulance Service

LBH – London Borough of Havering

LD – Learning Disability

LTC – Long Term Condition

MASH – Multi-Agency Safeguarding Hub

MARAC – Multi-Agency Risk Assessment Conference

NCMP – National Childhood Measurement Programme

NELFT- North East London Foundation Trust

NHS – National Health Service

NHSE – National Health Service England

PEF – Patient Engagement Forum

PHE – Public Health England

PPG – Practice Participation Group

SALT- Speech and language therapies

SEN – Special Education Need(s)

SEND – Special Educational Needs and Disabilities

UCB – Urgent Care Board

Appendix 3: List of key partnership strategic documents

Havering Better Care Fund (BCF) Submission

Children and Young People's Plan 2014 - 2017

Havering Joint Dementia Strategy 2014 - 2017

Integrated Care Strategy

Child Poverty Strategy

London Borough of Havering's Corporate Plan

London Borough of Havering's DRAFT Corporate Parenting Strategy

London Borough of Havering's DRAFT Looked After Children (LAC) Strategy

London Borough of Havering's DRAFT Voluntary Sector Strategy

Havering Clinical Commissioning Group's Commissioning Strategic Plan 2014/15 – 2015/16

Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Strategic Plan Final Submission (June 2014)

Unlocking our Potential (BHRUT's improvement plan)

Culture and Leisure Strategy

Arts Strategy

DRAFT Violence against Women and Girls Strategy

Community Safety Strategy

Housing Strategy

Joint Strategic Needs Assessment (JSNA)

Appendix 4: Action Plan

TO BE INSERTED