

Havering's Health and Wellbeing Strategy 2015 – 2018

Refresh October 2016

DOCUMENT CONTROL

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EXECUTIVE SUMMARY

Our Joint Health and Wellbeing Strategy (JHWS) 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. This refresh updates the strategy to reflect changes in the local health and social care economy. The refreshed strategy focuses on four overarching themes, each with underpinning priorities for action:

Overarching Themes	Priorities
Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities. <i>Healthy</i> life expectancy can be increased by tackling (a) the common socio-economic and (b) behavioural risk factors for poor health:	<p>(a) Socio-economic risk factors</p> <ol style="list-style-type: none"> 1. Getting people into work 2. Helping people to achieve (education and skills) 3. Ensuring people have a good home 4. Providing an environment in which it is easier for our residents to make healthier choices 5. Increasing community and individual ability to take control over the own health and care to reduce demand for services <p>(b) Behavioural risk factors</p> <ol style="list-style-type: none"> 6. Promote good mental health 7. Reduce harm from tobacco 8. Reduce harm from alcohol 9. Improve nutrition and increase physical activity to promote healthy weight management 10. Improve sexual health 11. Increase uptake of immunisations 12. Increase uptake of screening programmes
Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.	<ol style="list-style-type: none"> 13. Identify vulnerable children and families and intervene earlier. 14. Provide effective support for children with health needs 15. Provide effective support for people with long term conditions (LTCs) and their carers so they can live

	<p>independently for longer.</p> <p>16. Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer.</p> <p>17. Identify those with low level mental health issues and intervene earlier.</p> <p>18. Improve secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes. •</p> <p>19. Promote earlier presentation of signs and systems of major diseases, e.g. 'be clear on cancer'.</p>
Theme 3 Provide the right health and social care/advice in the right place at the right time	<p>20. Provide improved and, where appropriate, integrated care pathways especially for the major causes of morbidity and mortality, e.g. diabetes, CVD, cancer, mental ill-health.</p> <p>21. Reduce avoidable A/E attendances, by changing 'health seeking' behaviour in our residents and providing alternatives.</p> <p>22. Reduce avoidable admissions to hospital or long term care homes</p> <p>23. Improve access to primary health care.</p> <p>24. Promote wellbeing and self care</p> <p>25. Ensure appropriate end of life care</p>
Theme 4 Quality of services and user experience	<p>26. Ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience.</p> <p>27. Reduce variations in quality and practice across primary and secondary care and social care.</p> <p>28. Reduce variations in access to services</p>

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. This strategy needs to be one of demand management, with members of the Board working together and with communities and members of the voluntary sector, to:

- keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health and wellbeing of the local population;
- support people to stay independent, and
- build community resilience and support people to manage their own conditions, by helping people and communities to look after themselves and each other wherever possible.

For those who absolutely do need to enter the health and social care system, the strategy sets out how members of the Health and Wellbeing Board will continue to work together to integrate care across the sectors, both in order to improve patient and service user experiences and outcomes and also to secure enhanced value for money.

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 the refresh of Havering's second Health and Wellbeing Strategy. This strategy has been refreshed at its mid-point to reflect the work that has been undertaken across the Barking, Havering and Redbridge health and social care economy to address an unprecedented set of challenges between now and 2021.

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 need to develop a new approach to service commissioning and delivery. Without a new service model, demand for services will increase and service user experience will deteriorate, outcomes will be poor and the funding we currently have will not be enough to meet the health and social care needs of our population into the future. We are working together to create a new accountable care system which will allow us to better integrate health and social care services and use resources more efficiently and effectively.

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.

[DN: insert photographs]

Cllr. Wendy Brice Thompson
Chair of the Havering Health and
Wellbeing Board

Dr. Atul Aggarwal
Chair of the Havering Clinical Commissioning
Group and Vice Chair of the Health and
Wellbeing Board

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 four key themes:

Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities. **Healthy** life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health:

Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.

Theme 3 Provide the right health and social care/advice in the right place at the right time.

Theme 4 Improve the quality of services and user experience

There are 28 priorities for action to deliver these themes which, in turn, rely on partnership working, joint commissioning and integrated working for successful results. Appendix 1 is the “Implementation Plan”, which signposts to the main strategies and plans through which these priority actions will be implemented

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 of the original strategy is available on the Council’s website. Individual strategies and plans and any further initiatives that are delivered to implement this strategy will also be subject to separate Equality Analyses which will likewise be published on the Council’s website, or on partner agency websites, wherever is most appropriate.

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 first Havering Health and Wellbeing Strategy which covered 2012-2014. It focuses predominantly on health and social care related factors that influence health and wellbeing. It also reflects the wider determinants of health and wellbeing including factors such as housing, education and employment.

3. CONTEXT

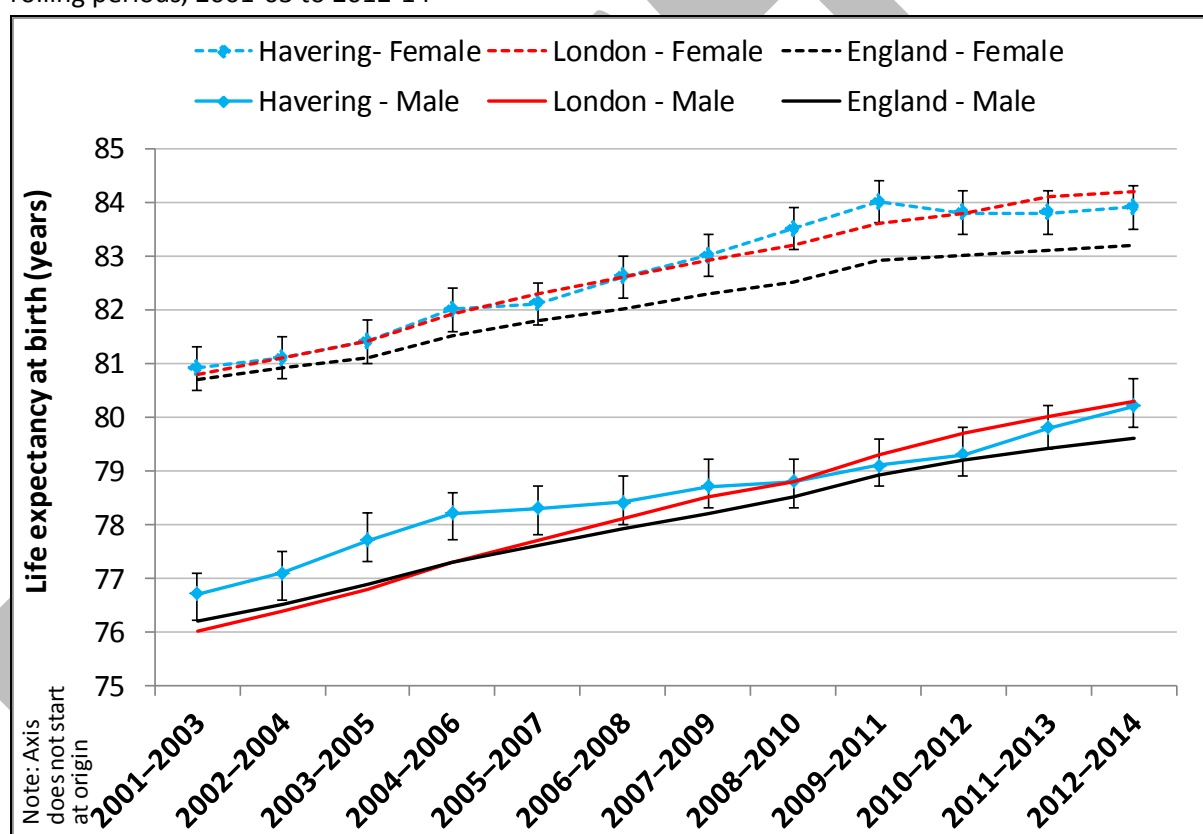
3.1 Our Population in Havering

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 about 249,085 people living in Havering¹. 262,221 people are registered with a Havering GP although 22% of these (57,474) are not resident in Havering². The population of Havering will grow from 251,618 (in 2016) by 6% (13,821 more people) and 10% (26,509 more people) in five years (2021) and ten years (2026) respectively³.

The life expectancy for people living in Havering is 80.2 years (for men) and 83.9 years (for women) from birth. Life expectancy in Havering has been mostly higher than the England average and has been on the increase over the last decade (see Figure 1).

Figure 1: Life expectancy at birth (years), by sex, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2012-14



Data source: Office of National Statistics

However, it is 7.9 years lower for men and 5.5 years lower for women in the most deprived areas of Havering than in the least deprived areas⁴. That is, life expectancy is particularly impacted by where people live and the circumstances of their upbringing.

¹Mid-year population estimates 2015; Office for National Statistics (ONS)

²Health Analytics (as of 31/06/2016)

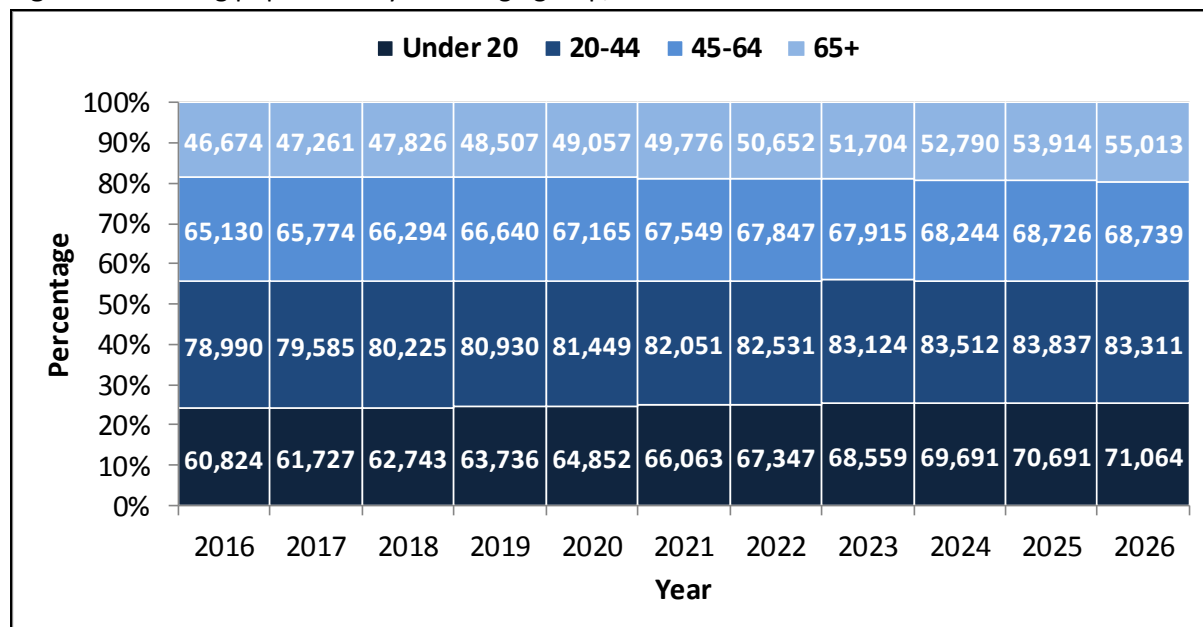
³GLA 2013 Round SHLAA-Based Capped Population Projections (March 2014)

⁴Havering Health Profile 2014 (<http://www.qpho.org.uk/resource/item.aspx?RID=142312>)

Figure 2 presents the estimated population of Havering broken down by age groups in 2016. It suggests that:

- 24% of the population are children and young people (aged under 20 years)
- 31% are younger adults (aged 20-44 years)
- 26% are middle-aged (aged 45-64 years) and
- 19% are older people (aged 65 years and above)

Figure 2: Havering population by broad age group, 2016 to 2026



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

Compared to England, London and other London boroughs, Havering has the largest number of older people (aged 65 years and above) as a proportion of the population (see In addition, the growth in the 85+ age group increased by 43.6% (higher than for both London and England) between the 2001 and 2011 censuses, and the size of this age group is projected to continue to increase. The 85+ age group in Havering will increase (from 2016) by 14% and 26% in 5 years (2021) and 10 years (2026) respectively (see Figure 4).

The 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.

Figure 3). Havering has 46,674 older people resident in 2016 and this is projected to increase by 7% and 18% in 5 years (2021) and 10 years (2026) respectively (see Figure 4).

In addition, the growth in the 85+ age group increased by 43.6% (higher than for both London and England) between the 2001 and 2011 censuses, and the size of this age group is projected to continue to increase⁵. The 85+ age group in Havering will increase (from 2016) by 14% and 26% in 5 years (2021) and 10 years (2026) respectively (see Figure 4).

⁵ This is Havering: A Demographic and Socio-economic Profile (<http://www.haveringdata.net/jsna/>)

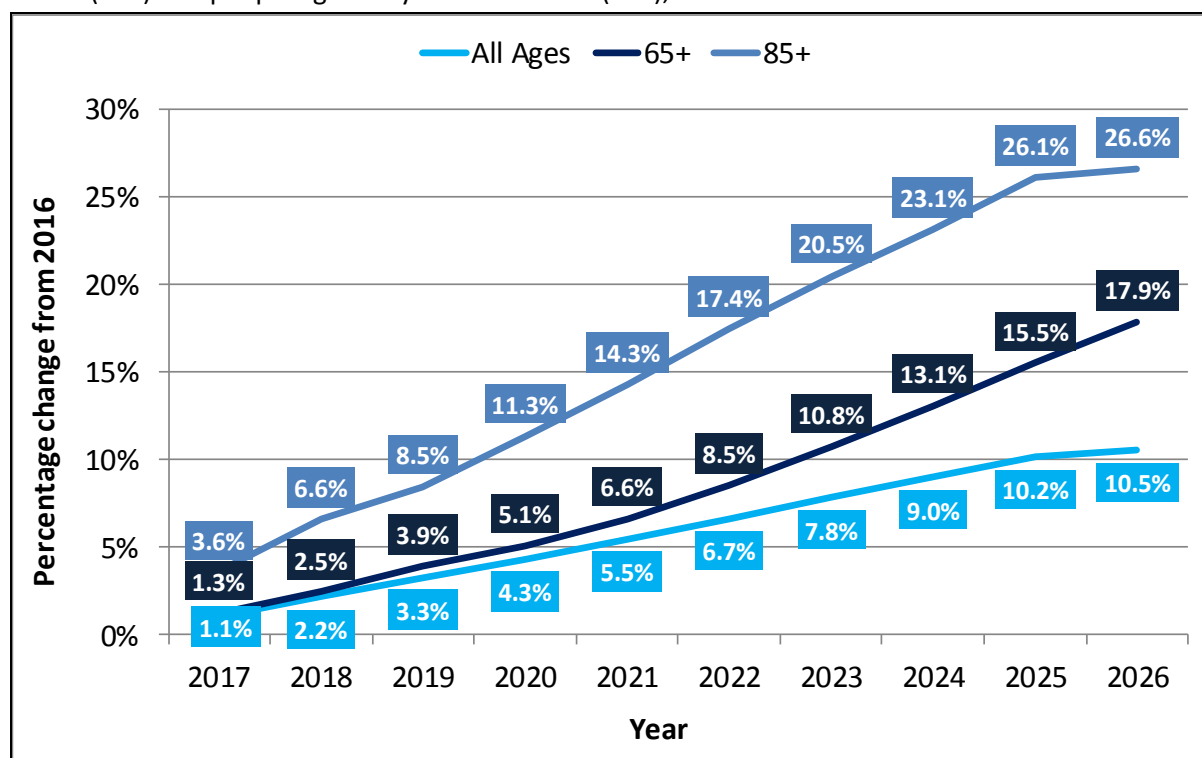
The projected increase in the older people population is likely to result in increases in numbers of residents suffering from cardiovascular disease (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis, incontinence and hearing impairments.

Figure 3: Distribution of the population by under 65 and 65+ year age groups, Havering compared to London boroughs, London and England

	65+	Under 65
Havering	18.4%	81.6%
England	17.7%	82.3%
Bromley	17.5%	82.5%
Bexley	16.6%	83.4%
City of London	15.5%	84.5%
Sutton	15.1%	84.9%
Harrow	15.0%	85.0%
Richmond upon Thames	14.8%	85.2%
Kensington and Chelsea	14.3%	85.7%
Barnet	14.0%	86.0%
Kingston upon Thames	13.2%	86.8%
Hillingdon	13.1%	86.9%
Croydon	13.0%	87.0%
Enfield	12.8%	87.2%
Redbridge	12.2%	87.8%
Merton	12.2%	87.8%
Ealing	11.8%	88.2%
Westminster	11.7%	88.3%
Camden	11.7%	88.3%
London	11.5%	88.5%
Hounslow	11.3%	88.7%
Brent	11.3%	88.7%
Greenwich	10.4%	89.6%
Hammersmith and Fulham	10.3%	89.7%
Waltham Forest	10.3%	89.7%
Barking and Dagenham	9.7%	90.3%
Wandsworth	9.3%	90.7%
Lewisham	9.3%	90.7%
Haringey	9.3%	90.7%
Islington	8.8%	91.2%
Southwark	7.9%	92.1%
Lambeth	7.8%	92.2%
Hackney	7.2%	92.8%
Newham	7.0%	93.0%
Tower Hamlets	6.0%	94.0%

Data source: ONS Mid-year 2015 Population Estimates Analysis Tool (published 2016)

Figure 4: Projected percentage change from 2016 for Havering population, people aged 65 years and above (65+) and people aged 85 years and above (85+), 2016 to 2026



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

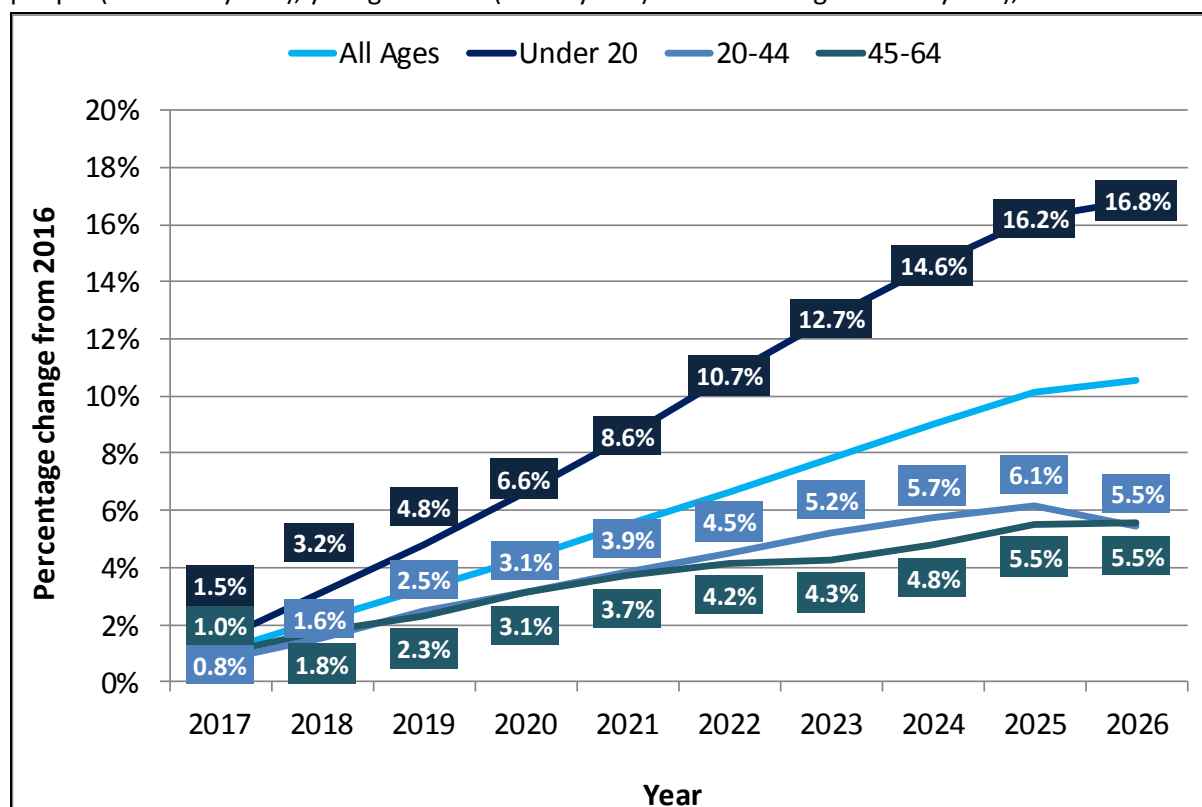
The Borough has a large younger population too. As stated earlier, around 24% (59,383) of the population in Havering are children and young people aged under 20 years (see Figure 2), which is similar to the England average of 24%. Future projections suggest that this group is estimated to grow by 8.6% by 2021 and 16.8% by 2026 (see Figure 5), **with the Borough being the biggest net importer of children in London.**

The Borough is generally fairly affluent, being ranked 166th overall out of 326 local authorities for deprivation (1st being most deprived, 326th being least deprived), 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 and 8 small areas in Havering fall into the 10% most deprived areas in England⁶. When compared with other London boroughs, Havering has a relatively small proportion of children living in poverty, but this has risen in recent years (bucking the trend seen in most other London boroughs of declining levels of child poverty)⁷.

⁶ This is Havering: A Demographic and Socio-economic Profile (<http://www.haveringdata.net/jsna/>)

⁷ Children in Poverty Intelligence Update, Greater London Authority, released 2011

Figure 5: Projected percentage change from 2016 for Havering population, children and young people (under 20 years), younger adults (20-44 years) and middle-aged 45-64 years), 2016 to 2026



Data source: 2015 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections; Greater London Authority (GLA)

While the population is predominantly White British, it is becoming increasingly diverse. The ethnic minority population in Havering is 16.7% (39,617 people). This percentage is well below the London average (55.1%) and the average for England (20.2%).⁸ However, the school census reported that nearly 23% of school pupils in Havering were from non-white ethnic groups.⁹

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.

⁸ Ethnic minority is defined as all ethnicities apart from White British

⁹ *This is Havering: A Demographic and Socio-economic Profile* (<http://www.haveringdata.net/jsna/>)

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

- 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

3.3.1 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 included:

- 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 has been 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.

3.3.2 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 BCF is not new money but benefits in terms of better integrated working can be achieved from our combined budget.

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.

3.3.3 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 replaces the statementing system. These are being gradually implemented over a two to three year period from September 2014 and 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.

In addition, the Act 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.

3.3.4 NHS 5 year Forward View and local Sustainability and Transformation Plan

The NHS Five Year Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from government.

The first argument made in the Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Second, when people do need health services, patients will gain far greater control of their own care. Third, the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single disease

In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within

these geographic footprints are working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

Havering is part of the North East London STP footprint and the aims of the NELSTP plan are

- To measurably improve health and wellbeing outcomes for the people of NEL and ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.

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 implementation plan.

Recently updated terms of reference and membership of the Havering Health and Wellbeing Board is set out at Appendix . The governance structure (also attached at Appendix [DN: to be updated]) 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: <http://www.haveringdata.net/jsna/>.

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. We are facing significant budget pressures while operating in an environment where demand for higher quality services is increasing. The implementation of the Care Act 2014 and the Children and Families Act 2014 has also put further financial pressures on the Council and its partners. The Health and Wellbeing Board's strategy going forward therefore needs to be one of demand management, with partners working together with one another and with the local community to:

- keep people out of the health and social care system altogether wherever possible, by taking action to reduce the need for health care and improving the health of the local population;

- support people to stay independent, and
- build community resilience and support people to manage their own conditions by helping people and communities to look after themselves and each other wherever possible.

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

3.5 Implementation Plan

This JHWS sets out the Health and Wellbeing Board's four themes and 28 priority areas for action. The JHWS Implementation Plan accompanying the strategy is set out at **Error! Reference source not found..** This signposts to the main strategies and plans through which the priority actions will be implemented and which include 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 this Joint Health and Wellbeing Strategy. Performance against the key actions and indicators set out in this Strategy will be monitored on a quarterly basis by the Board using a performance dashboard (DN:in development based on the composite implementation plan].

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

4.1: THEME 1: *Primary prevention to promote and protect the health of the community and reduce health inequalities. Healthy life expectancy can be increased by tackling the common socio-economic and behavioural risk factors for poor health:*

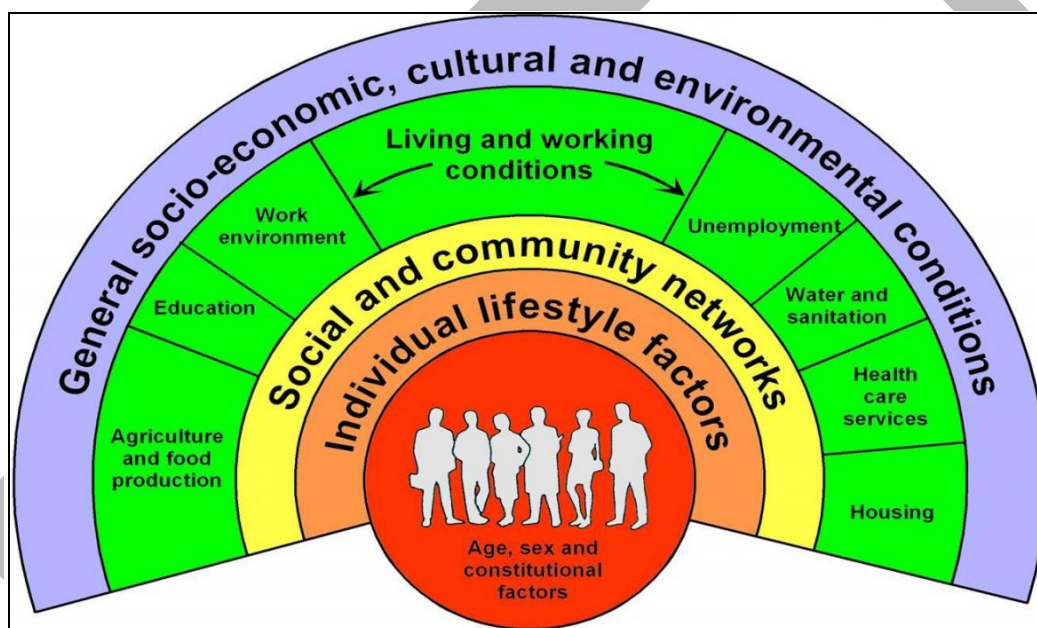
4.1.1 Background to Theme 1

The factors that determine the health of a population are, broadly speaking, divided as follows:

- Socio-economic factors e.g. employment, income, education, housing, environment, etc.
- Lifestyle choices e.g. smoking, diet, exercise, alcohol, uptake of preventive services, etc.
- Health service provision (the contribution of health services to health differs by population subgroup).
- Genetics (although a relatively small contribution, its importance is increasing).

Dahlgren and Whitehead¹⁰ have mapped the complex relationship between the factors that impact on the health of individuals and communities (see Figure 6).

Figure 6: Dahlgren and Whitehead's model of the determinants of health.



Source: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.

Individually and collectively, we can influence some of these factors in Havering and in so doing improve the quality of our lives.

4.1.1.1 What are health inequalities?

Health inequalities (sometimes called health inequities) are differences in health status between social groups. They exist in all countries – whether low, middle or high income. The lower an

¹⁰ Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.

individual's socio-economic position, the higher their risk of poor health. Such disparities in health are considered avoidable and modifiable and, therefore, unjust. There are health inequalities within Havering and between Havering and other local authorities.

Reducing health inequalities has been a longstanding national and local priority. There has been an increasing realisation (articulated in many Government documents over the past 30 years), that more effort needs to be put into preventing individuals and families from getting into situations where they require health or social care interventions. This would help to reduce health inequalities. There is also ample evidence that it is possible to prevent such situations from occurring. Therefore, there has been a strong national and local policy drive to shift more resources into prevention and early intervention and away from more expensive services that are required once problems have occurred.

This understanding informs the selection of our prevention priorities and shapes the things we can do in Havering to deliver these priorities. It allows us to engage all the resources at our collective disposal to create a more resilient economic and social environment in which individuals can make fully informed decisions about how to live their lives. It guides us to develop the circumstances in which it is easier for individuals to make healthier choices and to make best use of the services that are available to them to promote and protect their health and that of their family.

4.1.1.2 What is the current status of health in Havering?

Although health in Havering is better than a lot of other areas we have too many children who are overweight or obese because of poor diet and lack of physical activity. We also have too many adults who smoke, drink more alcohol than they should, and are overweight or obese. The JSNA sets out the health of people in Havering, and the key points to note are:

- The top 5 (underlying) causes of death in Havering (from 2012 to 2014) are: cancers, circulatory diseases, respiratory diseases, dementia and Parkinson's disease, and diseases of digestive system.
- Unspecified dementia comprises the biggest single underlying cause of death. Lung cancers comprise the largest proportion of deaths from cancer.
- About 625 (29%) deaths each year occur prematurely (deaths that occur before a person reaches the age of 75 years). Cancer, heart disease and stroke are the main causes of premature deaths.

Long Term Conditions

- There is an increasing number of Havering residents living with long term conditions (LTCs) – this has a significant impact on daily lives including the use of urgent and emergency health and social care services.
- Havering CCG patients with five or more LTCs are 5 times more likely to attend A&E, 20 times more likely to be admitted for an emergency, and the average number of inpatient bed days will be 37 times greater compared to patients with no LTC.
- The prevalence of mental health problems in Havering (0.65%) is generally lower than both London (1.07%) and England (0.88%) but there is variation in how common it is across the wards in the borough.

- The prevalence of depression ranges from 53.6 per 1000 persons aged 17 and over in Upminster to 111.5 per 1000 persons aged 17 and over in Gooshays (i.e. more generally more common with increasing deprivation).
- In Havering, the number of people living with diabetes is on the increase. The prevalence of diabetes is lowest in Romford Town (47.5 per 1000 persons aged 17 and over) and highest in South Hornchurch (68.3 persons aged 17 and over).
- Dementia is more common in Havering than London but similar to England; and it will be an increasing problem for Havering because of its ageing population.

Disability

- Children and adults with a learning disability are at increased risk of having or developing physical and mental health problems. In addition, they are 10 times more likely to have serious sight problems.
- Havering was estimated to have 945 adults with moderate or severe learning disability in 2015, of which about 300 are estimated to be living with a parent. Additionally, about 1,850 people were estimated to have autistic spectrum disorders.
- Havering has a lower rate of people registered blind (205 per 100,000) compared to London and England.
- The number of children with special educational needs and disabilities is growing year on year, averaging increases of between 40 to 60% in all groups over the past 3 years.
- There is increasing demand for specialist help and schooling for children with autism (ASD) and for those with behavioural, emotional and social difficulties (BESD), including those with mental health issues.

4.1.2 Our priorities for action under this theme are:

Tackling socio-economic risk factors

- Getting people into work
- Helping people to achieve (education and skills)
- Ensuring people have a good home
- Providing an environment in which it is easier for our residents to make healthier choices
- Increasing community and individual ability to take control over the own health and care to reduce demand for services

Tackling behavioural risk factors

- Promote good mental health
- Reduce harm from tobacco
- Reduce harm from alcohol
- Improve nutrition and increase physical activity to promote healthy weight management
- Improve sexual health
- Increase uptake of immunisations
- Increase uptake of screening programmes

4.2: THEME 2: *Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on.*

4.2.1: Background to Theme 2

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.

Of just over 30,000 families in Havering, it is estimated that nearly 400 of them are categorised as ‘families with multiple complex needs’ and over 2,000 are ‘barely coping’. The level of poverty among children under 16 in Havering is slightly better than the England average with 20% 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 (26.5%) and England (20.6%) 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.

4.2.2: Our priorities under this theme are:

- Identify vulnerable children and families and intervene earlier.
- Provide effective support for children with health needs.
- Provide effective support for people with long term conditions (LTCs) and their carers so they can live independently for longer.
- Provide effective support for people with learning disabilities/dementia and their carers so they can live independently for longer.
- Identify those with low level mental health issues and intervene earlier.
- Improve secondary prevention for those with existing LTCs, e.g. identify those at risk of going on to develop CVD, diabetes, liver, renal failure etc. and clinically intervene to avoid worsening outcomes
- Promote earlier presentation of signs and symptoms of major diseases, e.g. ‘be clear on cancer’.

4.2.3 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.
- 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.
- 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
- 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.

4.3: THEME 3: *Provide the right health and social care/advice in the right place at the right time*

4.3.1 Background to Theme 3

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 main health conditions responsible for avoidable admissions in Havering are chronic obstructive pulmonary disease, influenza and pneumonia and dehydration and gastroenteritis. 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 25 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

4.3.2 Our priorities under this theme are

- Provide improved and, where appropriate, integrated care pathways especially for the major causes of morbidity and mortality, e.g. diabetes, CVD, cancer, mental ill-health.
- Reduce avoidable A/E attendances, by changing 'health seeking' behaviour in our residents and providing alternatives.
- Reduce avoidable admissions to hospital or long term care homes

- Improve access to primary health care.
- Promote wellbeing and self-care
- Ensure appropriate end of life care

4.3.3 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
- 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.

4.4 THEME 4: *Quality of services and user experience*

4.4.1 Background to Theme 4

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 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.

The Havering Health and Wellbeing Board remains concerned 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.

4.4.2 Our priorities under this theme are :

- Ensure that services provided/commissioned are of good quality, are effective and provide the best possible service user's experience.
- Reduce variations in quality and practice across primary and secondary care and social care.
- Reduce variations in access to services

4.4.3 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.
- Develop an integrated health and social care commissioning function
- 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
- 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.

5. SYSTEM ENABLERS

The work streams below have been identified as essential to the successful transformation of the health and social care economy across BHR and relate directly to the successful delivery of this strategy. Although they are not specific priorities for the HWB per se, the Board will need to be kept updated on how this work is progressing.

- Intelligence and data sharing across the system – mapping hot spots
- Workforce transformation, e.g. clinical and social care workforce
- IT – to facilitate joint data sharing and working together across boundaries
- Estates transformation
- Innovation - new models of care and pathway redesigns
- Clinical engagement

Appendix 1: Key partnership strategic documents

London Borough of Havering Early Help Strategy

Havering's Better Care Fund (BCF) submission

Havering Joint Dementia Strategy 2014 - 2017

Integrated Care Strategy

London Borough of Havering's Corporate Plan

London Borough of Havering's Corporate Parenting Strategy

London Borough of Havering's Voluntary Sector Strategy

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

London Borough of Havering Market Position Statement

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

Violence against Women and Girls Strategy

Community Safety Plan

Housing Strategy

Joint Strategic Needs Assessment (JSNA)

Education and Skills Delivery Strategy

Children Missing Education Policy

Looked After Children Education Policy

Attendance Policy (with Attendance and Behaviour Service)

Fair Access Protocol

Elective Home Education Policy

Commissioning Plan for Education Provision

Homelessness Strategy

Local Plan

Tobacco Harm Reduction Partnership Terms of Reference and Action Plan

Drug and Alcohol Harm Reduction Strategy 2016-19

Prevention of Obesity Strategy 2016-19

Havering Immunisation Action Plan

Joint Dementia Strategy

Havering Children and Young People's Mental Health Transformation Plan 2015

[DN: STP/ACO information to be included]

Appendix 2:

Havering Health and Wellbeing Board Terms of Reference

Purpose of the Health and Wellbeing Board

Health and Wellbeing Boards (HWBs) were established by the Health and Social Care Act 2012. Each top tier and unitary council (including London Boroughs), is required to have a board, established as a formal council committee. HWBs are strategic leaders and agents of change in the health, social care and wellbeing systems of their areas.

The Havering HWB is set up to

- improve the health and wellbeing of the residents of Havering and to reduce health inequalities.
- join up commissioning across the NHS, social care, public health and other health and wellbeing services in order to secure better health and wellbeing outcomes for the local population, better quality of care for patients/care users and better value for the taxpayer.
- build strong and effective partnerships

Responsibilities

The main responsibilities of the Board are to:

1. Agree the health and wellbeing priorities for Havering and oversee the development and implementation of a joint health and wellbeing strategy (JHWS).
2. Oversee the development of the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA).
3. Provide a framework within which joint commissioning plans for the NHS, social care and public health can be developed and to promote joint commissioning.
4. Consider how to best use the totality of resources available for health and wellbeing e.g. consider pooled budgets. Also oversee the quality of commissioned health and social care services.

5. Provide a key forum for public accountability of NHS, public health, social care and other health and wellbeing services, ensuring local democratic input to the commissioning of these services
6. Monitor the outcomes of the public health, NHS and social care outcomes framework.
7. Consider the wider health determinants such as housing, education, regeneration, employment.

Membership

- Four elected members (as per LBH constitution)
 - Lead member for adults and public health (Chair)
 - Lead member for Children's Services
 - Leader of the Council
 - Additional member nominated by the Leader
- Director of Public Health
- Director of Adult Social Care
- Director of Children's Services.
- LBH Chief Executive
- CCG representatives x 4
- BHRUT representative
- NELFT representative
- Local Healthwatch representative
- NHSE (London) representative

All HWB members must be cognisant of potential conflicts of interest. Board members must declare such conflicts of interest and absent themselves from discussions and decision making where such conflicts of interest exist.

In attendance

LBH Head of Policy and Performance

LBH Public Health Consultant and/or Public Health Support Officer (to support DPH in their HWB lead officer function)

Reporting and Governance Arrangements

- The Health and Wellbeing Board is a committee of the Council.
- The Board will receive regular progress updates from all groups that report to the Board according to the structure chart below.
- The Health and Wellbeing Board will be held in public unless confidential financial or other information should prevent this (as per the Local Government Act, 1972)
- The Leader of the Council will be required to nominate the Chair of the Board. Board members will nominate a vice Chair.
- All full members of the Board will have voting rights. Where a vote is tied, the Chairman will have the casting vote.
- The Board is quorate when nine members are present.
- Meetings will be held every other month. Special meetings may be requested by the Board at any time.
- Papers to be circulated at least five working days before a meeting
- The Board may co-operate with similar Boards in other locations where their interests align. This may include multi-area commissioning arrangements
- These terms of reference will be reviewed 12 months from the date of formal sign off by the Board.

Updated May 2016

Signed
(Chair of the Health and Wellbeing Board)

Date:

Governance Structure Chart

[DN to be inserted]



Appendix 1: 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 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.

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 8pm, 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

COPD – Chronic Obstructive Pulmonary Disease

CPP – Child Protection Plan

CQC- Care Quality Commission

CTT – Community Treatment Team

CVD- Cardiovascular Disease

DTOC – Delayed transfers of care

GP – General Practitioner



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