London Borough of Redbridge

Health & Wellbeing Strategy

2024-28

Redbridge Health & Wellbeing Board

April 2024

Forward

Welcome to our new, Health & Wellbeing Strategy for Redbridge, setting out the Health & Wellbeing Boards Ambitions for working together over the next four years to support and improve our residents physical and mental health.

Redbridge remains an extremely popular Borough where many people want to live or raise family. Local people benefit from significant local assets, including great schools, leisure, and open spaces, and rapidly improving transport connectivity with the rest of London.

We are among the fastest growing parts of the country and the third most diverse London borough. Our communities are attracted by a mixture of excellent schools, relatively affordable housing compared to other parts of London, high quality open spaces and rapid transport connections into the heart of London. Our population is getting both younger and older - driving increased demand in both adults and children's services. A growing population has placed huge pressure on a housing stock built for a different era. The pace of change to meet these challenges is phenomenal.

However, we know that resources are limited and may not be keeping pace with the needs of local people. Growth in the number of people who need services, and the complexity of needs they have, means we have to look how services are best provided across the local health and care system and we know that this will be a challenge, but by continuing our excellent long-standing partnership working with health and voluntary sector partners we can contain to deliver ambitions for all of our residents.

Councillor Mark Santos

Chair of the Health & Wellbeing Board
Cabinet Member for Adult Social Care & Health

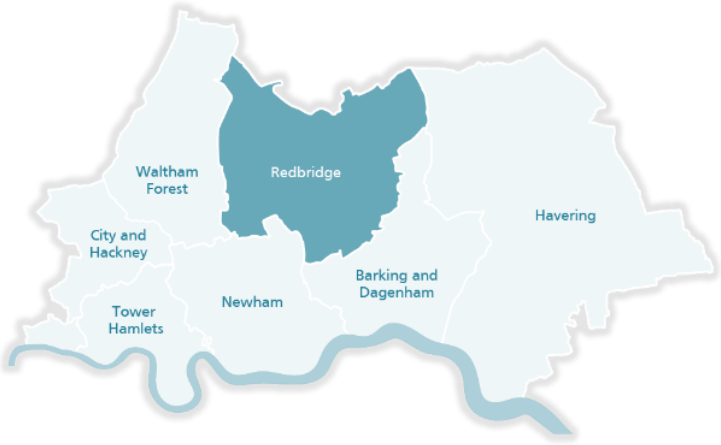
Introduction

Our new **Redbridge Health & Wellbeing Strategy 2024-28** sets out our ambitions over the next 4 years, providing an overarching strategy for the health and wellbeing of Redbridge residents.

While both national and locally there has been much change across the health and social care landscape since our last strategy, our fundamental aspiration as a health and wellbeing board remains the same - to reduce health inequalities, and enable people to live long, happy, independent lives in good health.

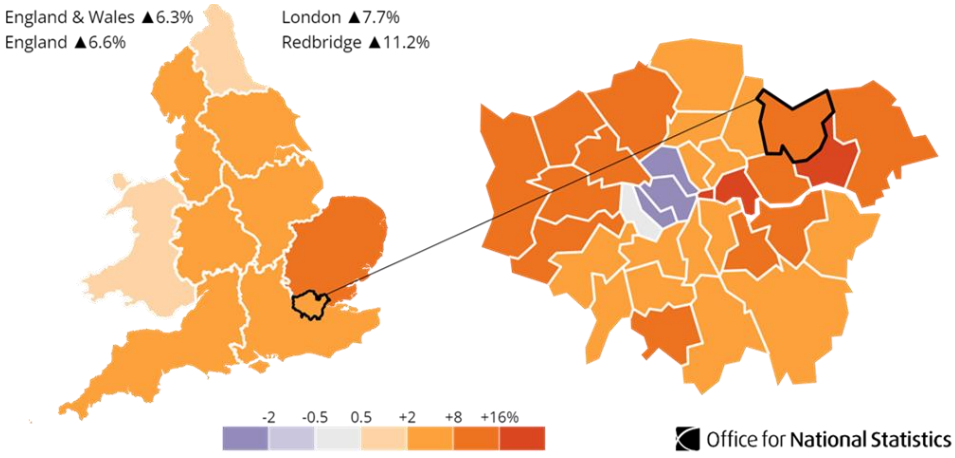
This strategy is overseen by the Redbridge Health and Wellbeing Board and seeks to improve wellbeing and reduce health inequalities in the Borough, through the range of organisations and partnerships that the Board represents.

A Picture of Redbridge



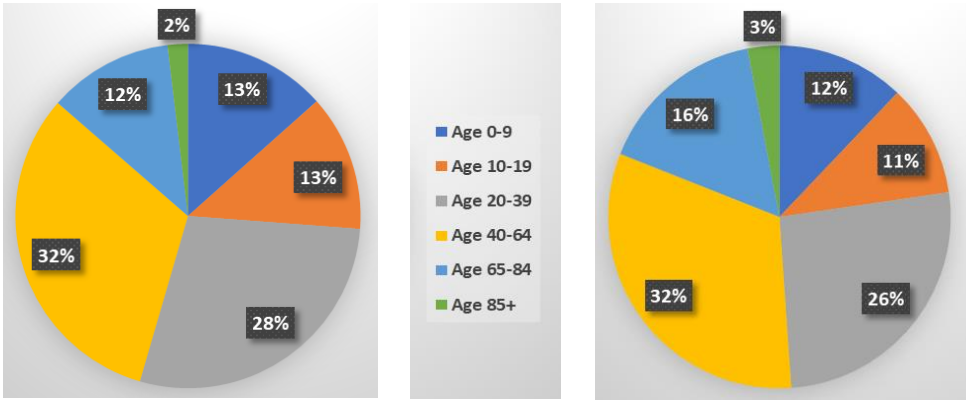
Redbridge is the 13th largest borough in London, with a rapidly growing population. Between the last two censuses (held in 2011 and 2021), the population of Redbridge increased by 11.2%, from around 279,000 in 2011 to around 310,300 in 2021. At 11.2%, Redbridge's population increase is higher than the increase for London (7.7%).

Population changes in Redbridge compared to England 2011-21



Source: ONS

Percentage of Population by Age Range in 2023 and by 2043



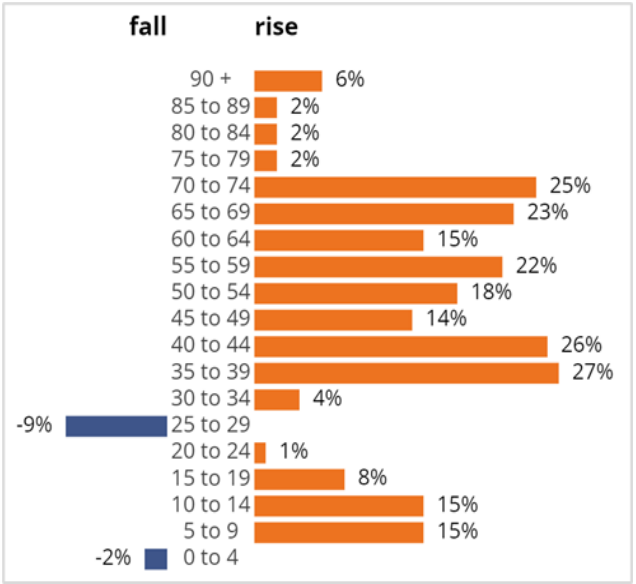
As well as the overall population growth, the age profile of the population is also projected to change with proportionally greater growth amongst older age groups (aged 65 and above), with the over 85 age group are most likely to require social care support. Looking at client data from 31 March 2023, Redbridge supports over 1,800 service users aged 65 and over on a long-term basis.

Older people disproportionally require health and social care that their younger counterparts and therefore we need to ensure that our population ages as healthily as possible in order to minimise and reduce the impact on individuals, families and local services.

There is an increasing number of older people living longer in Redbridge and as they are ageing, they are more likely to develop multiple long-term conditions which will need managing, which may include dementia. Our population is projected to age. Redbridge is expected to see one of the most significant increases in the older population in the next 20 years. Importantly there will be a proportional increase in residents aged 85+, with the most complex health and social care needs will see the greatest growth. However, alongside people living longer, is the increase in physical and mental ill-health and a dependency on health and care services.

The population here increased by a greater percentage than the overall population of London (7.7%), and by a greater percentage than the overall population of England (up 6.6% since the 2011 Census). There has been an increase of 13.5% in people aged 65 years and over, an increase of 11.5% in people aged 15 to 64 years, and an increase of 8.7% in children aged under 15 years.

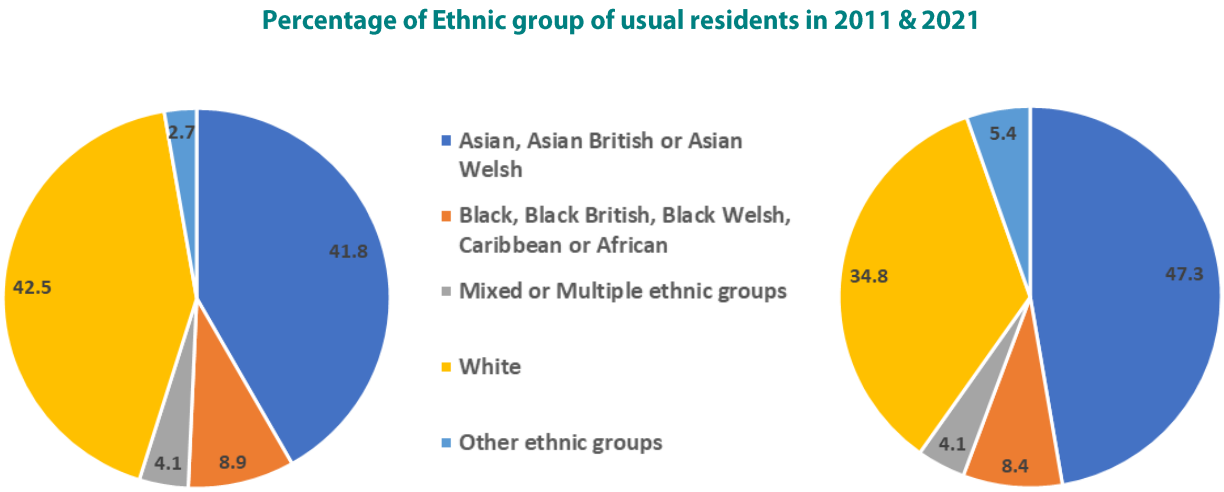
Population % change by age group 2011-21



Source: ONS

Ethnicity & Diversity

Redbridge remains more diverse in comparison to both England and London.



Source: Redbridge change in ethnic populations, 2011-2021

With over 100 languages spoken, the population is both culturally and ethnically diverse. In 2021, 47.3% of Redbridge residents identified their ethnic group within the Asian, Asian British or Asian Welsh category, up from 41.8% in 2011. This change was the largest increase among high-level ethnic groups in this area. Across London, the percentage of people from the 'Asian, Asian British or Asian Welsh' ethnic group increased from 18.5% to 20.7%, while across England the percentage increased from 7.8% to 9.6%. The largest projection increase was from Asian, Asian British or Asian Welsh communities at a 5.5% increase. The white ethnicity group decreased by 7.7% respectively.

We also need to take into consideration the needs of the Boroughs' LGBTQIA+ community (Lesbian, Gay, Bisexual, Trans, Queer, Intersex and Asexual), in relation to specific health and care needs and service provision to ensure that they will not be discriminated against, especially in multiple and mixed accommodation care settings.

Redbridge also has significant areas of deprivation and communities which experience poor health outcomes, alongside an increase in residents who have one or more long-term conditions or disabilities. In addition, the cost-of-living crisis, and those on low incomes, who spend a greater proportion of their income on food and heating, will be hit hard and pushed further into poverty. As it is, in Redbridge more than 1 in 10 residents are income deprived.

Understanding the population projection is essential for the planning of local services and is used to inform evidence-based commissioning activities. Our projections for Redbridge indicate there will be an increased demand for health and social care, housing, education, and other services and therefore we need to begin the planning and design now for what our residents will need in the future.

Population Health & Life Expectancy

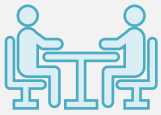
Life expectancy in Redbridge for both women and men is higher than for England as a whole and around the London average. However, within the borough both overall life expectancy and healthy life expectancy vary between different areas in the borough with the most deprived areas having poorer health and therefore may need greater health and social care services.

Population & Life Expectancy

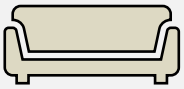
REDBRIDGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Population Growth (Census 2021 vs 2011)		**+ 11.2%**	+ 7.7%		+ 6.3%	
Health Inequalities (Gini Index Rank on Health measure commonly used to assess inequality within a given population or system).		**190**	185		157	
Female Life Expectancy		**83.3yrs**	83.5yrs		82.6yrs	
Female Healthy Life Expectancy		**64yrs**	No. of years between healthy and life expectancy is **19.3 years**			
Males Life Expectancy		**78.7yrs**	79yrs		78.7yrs	
Male Healthy Life Expectancy		**60.6yrs**	No. of years between healthy and life expectancy is **18.1 years**			
Infant mortality (per 1,000 live births)		**2.8**	3.4		3.9	

Mental Health

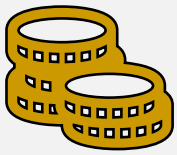
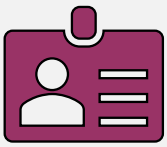
REDBRIDGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Dementia		**4.2%**	4.2%		4.0%	

REDBRIDGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Learning Disability prevalence		**0.5%**	0.43%		0.5%	
Mental Health prevalence (QOF - Quality Outcomes Framework)		**17.7%**	1.1% (QOF)		16.9%	

Obesity

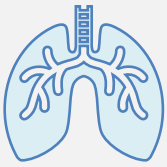
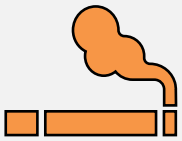
REDBRIDE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Obesity in Adults		**22.6%**	19.5%		25.3%	
Healthy eating (5-a day)		**53.2%**	55.8%		55.4%	
Physical inactivity		**31.8%**	24.3%		23.4%	

Economically Active

REDBRIDGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Child poverty		**38%**	35%		29.3%	
Employment (active)		**73.3%**	79.4%		78.4%	

REDBRIDGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
Proportion of unpaid Carers (19 hours or less)		**3.9%**	3.8%		4.4%	

Disease

REDBRDIGE AREA COMPARISONS		REDBRIDGE	LONDON		ENGLAND	
All cancers		**2.1%**	2.3%		3.3%	
Asthma prevalence		**5.0%**	4.7%		6.5%	
Coronary heart disease prevalence		**2.3%**	1.9%		3.0%	
Diabetes prevalence		**9.2%**	6.8%		7.3%	
Smoking		**13.0%**	15.5%		15.9%	

Diabetes, cardio-vascular disease and dementia are important preventable conditions locally, with direct impacts on the need for care and support and therefore prevent greater strain on health and social care services.

Demand for Services & Support

Health and Social Care Commissioners develop and arrange the provision of services, facilities and resources, that support the prevention and delay the development of needs for care and support, by planning for future need and demand. Key to this is achieving the aims of promoting wellbeing and independence and reducing dependency. We know that demand for support is increasing - for example Adult Social Care is predicted to see over **21,000 requests for support by 2027-28 – an increase of around 3,400 more requests per year** than in 2019-20.

To manage the increase in demand for health and care services, it is vital to our Ambitions that our local care and support system works to actively promote wellbeing and independence and not just wait to respond when people reach a crisis point. By continuing to understand and encourage work under the 7 areas below, we can support our residents on a path to better health and wellbeing. The challenge for health and care system partners is to intervene early to support individuals, help people retain or regain their skills and confidence, and prevent need or delays deterioration wherever possible.

Pillars for Good Health, Support & Wellbeing

1	**Prevention & Early Intervention**	• Preventing poor health and disability • Identify problems early • Access to timely treatment, care or support
2	**Tacking Causes of Poor Health**	• Poverty and low income • Maltreatment and abuse • Unhealthy homes • Poor educational attainment • Worklessness and low pay • Social isolation
3	**Supporting Good Health**	• Physically active • Healthy balanced diet • Protect mental health and wellbeing
4	**Community Benefits**	• Use of social prescribing • Use of resources in local communities - volunteering, open spaces, community centres, leisure facilities
5	**Health Protection**	• Communicable diseases • Poor air quality • Impact of extreme cold and hot weather
6	**Recovery & Self-care**	• Information and support to manage own health or disability • Use of technology and equipment Initiatives to maintain independence for as long as possible
7	**Caring Roles**	• Contribution of all Carers • Supporting Carers stay physically and mentally well to continue their caring role

Our Ambitions & Priorities

This strategy has a number of key themed **Ambitions** and **Priorities** focusing the direction of key areas of need for the people of Redbridge, over the next 4 years. These priorities have been identified through engagement with health and care partners including the North East London Integrated Care Board (NEL ICB), the Health & Wellbeing Board and Redbridge Place partnership. There are three overarching Ambition themed areas with focussed Priorities:

Ambition 1

Starting Well

Positive Beginnings for Babies, Children & Young People

Priorities

1. **Improving immunisation through increased vaccination uptake.**
2. **Better opportunities for those with special educational needs.**
3. **Reducing obesity in children and promoting healthy eating.**
4. **Supporting children and young people with mental health concerns.**

Ambition 2

Living & Feeling Well

Building Resilience for Living & Wellbeing

Priorities

1. **Partnership focus to support good mental health and wellbeing in Housing.**
2. **Promoting opportunities for using community assets to improve health and wellbeing.**
3. **Increasing employment opportunities to support poverty reduction.**
4. **Supporting unpaid carers to undertake their roles and have good physical and mental health.**

Ambition 3

Caring Well

Prevention & Care of Long-term Conditions

Priorities

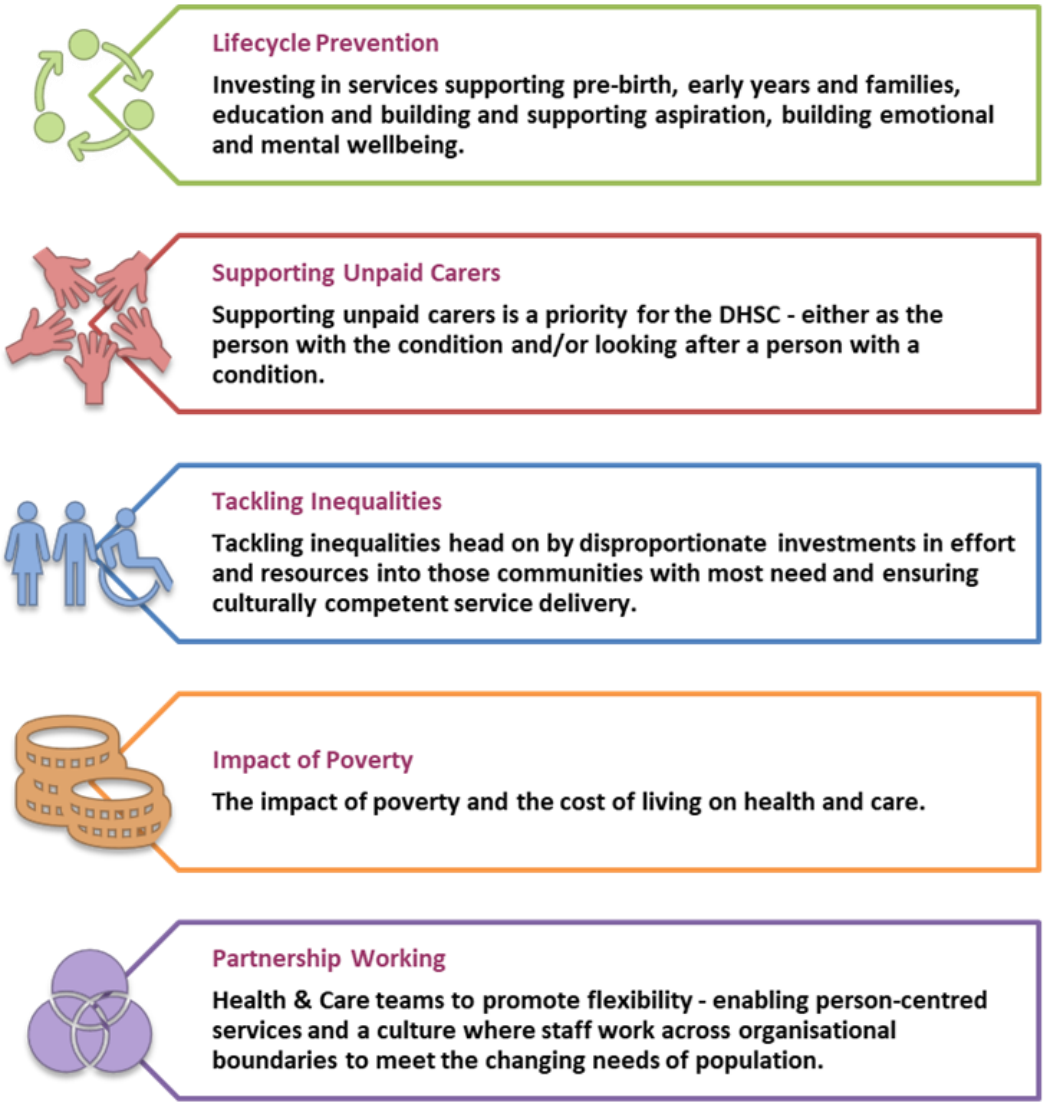
1. **Reducing the risk of long-term conditions from air pollution.**
2. **Improve identification and management of hypertension.**
3. **Reducing overweight and obesity in adults and promoting behaviour change.**
4. **Supporting early diagnosis and management of dementia.**

Working Together: Priority 'Golden Threads'

To ensure that we support those who are most vulnerable within our community, we need to ensure that early help and preventative services are targeted in order to maximise the opportunities in reducing escalation of need and improve poorer outcomes for residents of the borough. We can do this by:

- Focusing on ensuring that residents receive services that promote good mental and physical health and wellbeing.
- Helping residents live active, independent lives and supporting them to manage any risks.
- Ensuring that people are not pushed into using long term health and social care services earlier than they need to.
- Improving outcomes for people receiving health and care services within Redbridge, by planning and delivering of services in partnership across our health and care partners.

To this we have developed a number of golden threads to be embedded through each Ambition area. These are:



Working Together with our Health & Care System Partners

Over the last few years, the landscape of the health and care system in Redbridge has changed. A move to more locality placed based model of service delivery has seen the shift to ever more integrated working of health and care partners.

Redbridge Health & Wellbeing Board (HWB)

Established under the Health & Social Care Act 2012, they set the strategic direction to improve the health and wellbeing of people locally. The board operates as a partnership of key local organisations by bringing together system leaders who arrange for the provision of any health or social care services in that area to work in an integrated manner, and where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and look to reduce health inequalities. They are responsible for developing and publishing:

- A Joint Strategic Needs Assessment (JSNA) providing the evidence base for the health and wellbeing needs of the local population.
- A Joint local Health and Wellbeing Strategy (JHWS) which sets out the priorities for improving the health and wellbeing of its local population, and how needs will be addressed, including health inequalities.
- A Pharmaceutical Needs assessment (PNA).

HWBs will continue to lead action at place level to improve people's lives and remain responsible for promoting greater integration and partnership between the NHS, public health and local government. This involves working effectively with local leaders, including place-based partnerships.

Integrated Care Boards (ICBs) & Integrated Care Partnerships ICPs)

The Health and Care Act 2022 introduced new structures to the health and care system, specifically the establishment of ICPs and ICBs. The NEL ICB is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services.

The Redbridge HWB was featured in guidance from the Department of Health & Social Care (DHSC) back in November 2022 as a case study in relation to its wider board membership, which provides a holistic leadership in supporting the wider determinants of health, such as the impact of housing and crime DHSC - HWB Guidance. This sets out how ICBs, local authorities and HWBs should work together to ensure effective system and place-based working.

Redbridge Place Partnership

The partnership is responsible for planning and buying health services for the people of Redbridge and making sure these services meet the needs of local people. They ensure high quality healthcare services are in place - whether this is advice from a pharmacist or GP, a procedure in hospital, help at home through local community services, or support with your mental health.

Primary Care Networks (PCNs)

In Redbridge we have six PCN areas. These are groups of general practices working together with a range of local providers, including community, mental health, social care, pharmacy, hospital and voluntary services.

Adult Community & Health Social Care Localities

Both Adult Social Care Services and community health services, including Mental Health, Learning Disability, District Nurses are co-located together under four locality areas within Redbridge.

Our Partners include:

How will we measure success?

We will measure our success through the strategy **Action Plan** using a range of data and information sources. Some of these are national performance measures through Outcomes Frameworks, while others are through local sources such as surveys and case studies, from engagement and consultation work to really understand our residents 'Lived experiences', as set out in the document under the Priorities.

- London Datastore – Greater London Authority
- Adult Social Care Outcomes Framework (ASCOF)
- NHS Outcomes Framework (NHSOF)
- Public Health Outcomes Framework (PHOF)
- Active Lives National Survey
- National Child Measurement Programme (NCMP)
- Office for National Statistics (ONS)

We will look at our strategy at the end of each year to ensure that the Ambitions and Priorities remains flexible and relevant to support and meet the needs of our residents.

Ambition 1: Starting Well
Positive beginnings for Babies, Children & Young People



Good health across an individual's life course is significantly influenced by their risk exposures and health outcomes in early life. The social and physical environment in which a child lives and grows is vitally important as a determinant of initially dependent behaviours in early years and then later independent behaviours as the child grows into adulthood. Primary prevention disease and injury prevention measures such as vaccination, access to healthy food, and safe exercise need to be easily available and strongly encouraged for all.

Redbridge currently faces challenges with poor uptake of some childhood vaccinations against national targets, high levels of overweight and obesity at school age, and high levels of physical inactivity during childhood.

What do we know?

We know that there are multiple determinants of health for everyone, and these relate to our individual genetic make-up, our families and social circles, our personal resources, the environment and healthcare services around us, and the local, national, and international policies and situations around us. Within Redbridge, our residents and communities are facing many pressures in relation to these determinants, and this is often impacting negatively on our current and future health.

With increasing financial concerns for residents and increased pressures for public services, we need to support our communities to access primary prevention opportunities (things we can do to stop problems starting), to avoid people and services facing future costs. We want to help residents avoid preventable disease and to help maximise life opportunities through helping all children achieve their full potential in education.

Data Snapshot[1]

Birth

- Healthy life expectancy at birth is 2.5 years lower than the national average for males in Redbridge (60.6 years versus 63.1 years).
- The proportion of babies with low birth weight is significantly higher than the national average - Redbridge 4.1%, England 2.8%.

Vaccination

- Vaccination coverage for all elements of the childhood vaccination schedule are lower than the national average and the national average, for example:
  - MMR dose 1 (at age 2) - Redbridge 80.5%, England 89.3%
  - Meningitis B booster - Redbridge 7579%, England 87.6%
  - Diphtheria, Tetanus, and Whooping Cough vaccine & Polio vaccination (at age 2) - Redbridge 86.4%, England 92.6%

Obesity

- The proportion of children in Year 6 who are overweight or obese significantly higher than the national average - Redbridge 41.2%, England 36.6%.
- Only 42% of children in Redbridge are classified as physically active.

Children & Young Peoples (CYP) Mental Health

- Over half of all mental health disorders start before the age of 14, with 75% by 24 years of age.
- Up to 25% of children show signs of mental health problems more than half of which track through into adulthood.
- Evidence suggests that mental illness stigma is higher among ethnic minorities, younger people, and those with less social support.

SEN

- Between 2019 and 2022, the total number of school age pupils with an Education, Health and Care Plan (EHCP) rose by 22%.

Focused Priorities

1. **Improving immunisation through increased vaccination uptake**
2. **Better opportunities for those with special educational needs**
3. **Reducing obesity in children and promoting healthy eating**
4. **Supporting children and young people with mental health concerns**

Priority 1.
Improving immunisation through increased vaccination uptake

Like the majority of London boroughs, uptake of vaccinations within the childhood immunisation schedule is significantly lower than both the national average and the target for what is known as 'herd immunity'. Many of the diseases included in the vaccination schedule are very rarely seen in the population now, having been common experiences for people in the past. This means that as a society, and as a healthcare system, we are not used to seeing the sometimes very serious impact of these vaccine preventable diseases.

There have been increases in rarely seen diseases such as measles in recent years in London which has followed a deterioration in uptake of the MMR vaccine following highly publicised and baseless concerns over its safety at the turn of the century. In addition, the instances of diseases such as diphtheria for which there have been negligible numbers of cases in recent decades, and increases in risk for polio, following crises and stresses in the global political situation. Additionally, the impact of a pandemic of a new disease with Covid, and the continuing danger from new variants of the flu virus. For both of these diseases, there are vaccinations available for children

[1] Data on healthy life expectancy, vaccination, and obesity are taken from OHID's Fingertips website

to help keep them safe from serious illness and help prevent them pass the infection on to other older family members, and therefore childhood vaccination is a prevention measure that supports all ages.

Episodes of illness and disease cause great challenge for unpaid carers, be it their own illness or illness in the person for whom they care. Where there is illness for a child, parents may have to have time away from work which can impact the family financially.

The uptake of vaccination and experience of vaccine-preventable disease are both linked to levels of wealth and deprivation. Some residents and communities within Redbridge are at higher levels of risk than others. We know that uptake of childhood vaccination in our children who have experienced care is significantly lower than other children and similar cohorts in other boroughs. Our work is focused on tackling these inequalities. As such, there is collaborative working across all organisations to improve access to vaccination, and advocate in all communities for increased uptake.

How will we know we are making a difference?

Measure 1	Monitor the general uptake of vaccination across the schedule using the national data made available by the Office for Health Improvement and Disparities (OHID) and we will see any changes as data is refreshed annually. PHOF indicators
Measure 2	Examine changes at more detailed level (including ethnicity and geographic differences) through local data held by Primacy Care Networks (PCNs).
Measure 3	Monitor the frequency and impact of any outbreaks of communicable disease (disease than can be passed between people).

Priority 2.
Better opportunities for those with special educational needs

Redbridge has seen an increase in demand for places to specialist education provision, which has been in line with regional and national trends. Between 2019 and 2022, the total number of school age pupils with an Education, Health and Care Plan (EHCP) rose by 22%. This trend is forecast to continue due to several factors including the impact of the pandemic, greater pupil and parent engagement and better identification methodologies.

We have already taken steps to create better opportunities for special education needs by increasing specialist capacity including new Additionally Resourced Provision within mainstream schools, upgrading a number of specialist school settings, alongside an expansion of places and broadening our offer through the creation of a supported internships programme.

Our **Special Education Needs & Disability (SEND) strategy** sets out four key priorities for the future:

- Early identification: provide early identification and intervention with a specific focus on Autistic Spectrum Conditions and Speech, Communication and Language Needs.
- High quality provision: ensure that SEND provision in early years settings, schools, Pupil Referral Units (PRU), alternative provision, colleges and training providers is of high quality with timely access to Speech and Language Therapy.
- Effective co-production with the community: collaborating and involving our community in the shaping of services and ensuring that equality is a key feature with the principles of co-production at its core.
- Transition to adulthood: preparing children and young people for adulthood including life and living skills as well as employment skills.

How will we know we are making a difference?

Measure 1	A clear pathway for identification of young children with emerging special education needs.

Measure 2	A formal review of support arrangements across the early years' sector, including schools Increased capacity to support children with complex special education needs, particularly those with significant social communications needs.
Measure 3	Specialist provision developed to meet project special education needs within the borough.
Measure 4	Strong partnership arrangements with other organisations to support children with special education needs.
Measure 4	Increased participation and engagement with parents and families.
Measure 5	Children, young people and families are supported to understand their rights, make choices and contribute to decision-making about their plans and support.

Priority 3.
Reducing obesity in children and promoting healthy eating

There is very strong evidence that poor diet and obesity are significant risk factors for a wide range of diseases and a major contributor to lower healthy life expectancy. There is also strong evidence that experience of overweight and obesity in childhood is a predictor for this risk factor across the whole life course. Supporting people to get on the track of good diet and a healthy level of exercise early in life, and to maintain that through teenage years, is an important public health measure. We also know that supporting healthy weight maintenance in children can further support healthy weight management in the wider family.

There is a strong link between increased levels of overweight and obesity and increased levels of poverty. It can be harder to build a healthy lifestyle in terms of food and drink, and exercise when you have lower levels of income and time and social support. This contributes to health inequalities in our communities. The challenges around cost of living being experienced by our residents is likely to exacerbate these differences in health behaviours and to increase inequalities around health outcomes.

The National Child Measurement Programme (NCMP) is a statutory annual process, commissioned by Local Authorities. In Redbridge, school nurses lead the programme to measure the height and weight of children in the Reception and Year 6 school years. Data from this programme has shown that the proportion of children who are overweight or obese in these school years is significantly higher in our borough than the London or England average.

Health and care partners are committed to tackling the problem of overweight and obesity in early years and childhood. Together, local authority, NHS, and community and voluntary sector organisations will improve primary, secondary, and tertiary prevention initiatives and services to support a better fed and more active childhood for all communities in the borough. We have developed as a partnership our System-Wide Approach to Obesity with all key stakeholders working together regularly to review and develop our **Obesity Strategy for Adults and Children** and assure the effective implementation of its action plan.

Primary Prevention	**Working to stop problems with overweight occurring in individuals** This can be through empowering people with knowledge about risks and strategies for improving diet and exercise. It can be improving the physical environment around a child to encourage eating well and exercising.
Secondary Prevention	**Working to stop existing problems with overweight worsening and developing obesity** This can be through support from primary care or voluntary sector services, or provision of specialist weight management services for individuals where this would be beneficial.

Tertiary Prevention	**Working to stop problems with overweight and obesity causing poor health outcomes** Again, we can design specific services to support individuals in this area, upskill and support non-specialist services to understand any particular health needs for people relating to weight management, and work to reduce stigma about weight with our communities.

How will we know we are making a difference?

Measure 1	We will know from NCMP data over time whether the situation is changing for children in Redbridge, and we can monitor and assess the success of specific weight management interventions for engagement and participation in our support for healthy eating and increased physical activity. While both healthy eating and exercise are methods for helping reduce weight, they are also health positive behaviours in their own right and increased participation is a positive outcome in itself.
Measure 2	We will also continue to engage with our residents and communities to understand: a) How people feel about healthy eating and exercise and whether they feel able and helped to follow healthier behaviours. b) Identify barriers to healthy eating and exercise and develop plans to reduce these hurdles.
Measure 3	We will know we are successful when we talk to our residents and hear from them that they are confident they can get hold of healthier meals and they feel happy and confident in their ability to get around the borough actively and safely.

Priority 4.
Supporting children and young people (CYP) with mental health concerns

Supporting children and young people's mental health is a priority for Redbridge and has been added as one of the key ambitions on **Redbridge Suicide Prevention Strategy**. Evidence shows that over half of all mental health disorders start before the age of 14, with 75% by the age of 24 with up to 25% of children showing signs of mental health problems - more than half of which track through into adulthood.

A mental health survey undertaken for England showed:

- An increase in probable mental disorder among 17-19 year olds from 1 in 10 in 2017 to 1 in 4 in 2022.
- Young women were almost twice as likely to report having been bullied online.
- CYP tend to seek help or advice from friends or family, education, health and online/telephone support.
- Nearly 9 out of 10 people with mental health problems say that stigma and discrimination have a negative effect on their lives.
- By tackling mental health issues early, children and young people are more likely to grow into adults with better mental health.
- Early intervention support for children and young people can improve resilience, wellbeing and self-help techniques.
- School based-awareness programmes have shown promise in reducing suicide attempts.

Ther are a number of risk factors for CYP – they are more likely to have poor mental health if they experience some form of adversity, such as living in poverty, parental separation or financial crisis, where there is a problem with the way their family functions or whose parents already have poor mental health. Young people who identify as LGBQT are also more likely to suffer from a mental health condition, while Children who are Looked After are four times more likely to experience mental health issues than their peers. Nearly three quarters of children with a mental health condition also have a physical health condition or developmental problem and a third of people in the youth justice system are estimated to have a mental health problem.

It is also important to note that demand for mental health services across England has increased, services do not have capacity to support children and young people in need and there is limited community provision in

Redbridge and research shows CYP delay seeking support and would rather not go via their GP. Therefore, Redbridge is lobbying both the NEL ICB and central Government, in order that our CYP can have equity of access to services and outcomes as seen in other areas of the NEL ICB.

How will we know we are making a difference?

Measure 1	Continue building on current mental health programmes in schools and colleges, including include training and support for parents.
Measure 2	Embed children and young people's mental health is a core part of the planned Family Hubs Programme to improve awareness, reduce stigma, create support network for families and improve access to training.
Measure 3	Continue working with the UNICEF child friendly borough programme - to promote wellbeing and reduce inequalities.

Ambition 2: Living & Feeling Well
Better Mental Health & Wellbeing for Good Health



Mental wellbeing is a fundamental component of good health. We know that people who have poor mental health often have poorer physical health in addition to challenges such as maintaining employment, finding a sustainable home and building a social network. Locally, as well as nationally, there is evidence that mental health needs are increasing.

There are many opportunities to enhance factors that promote good mental wellbeing such as early identification of depression during pregnancy or postnatally, parenting, supportive early years and school settings, early identification of problems during adolescence, healthy workplaces, early access to psychological therapies and dementia friendly facilities.

What do we know?

Poor mental wellbeing is costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities. It has been estimated that poor mental health costs London alone £7.5bn annually - this includes costs to individuals such as days of work lost to poor health and increased health and social care costs. There is strong evidence for a range of interventions in mental health which improve mental wellbeing and are cost effective - these include prevention and early intervention, mental health care for people with physical health conditions and improved services for people with severe mental illness. Therefore, supporting the design and implementation of outreach approaches to target high-risk service users, and requiring culturally competent and sensitive approaches to tackling stigma and structural inequalities.

Supporting children and young peoples' mental wellbeing is key to improving outcomes and reducing long-term mental health needs. Young People who experience mental health problems often start to have symptoms during teenage years. Promoting adoption of best practice is fundamental to improving the mental wellbeing of residents as well as reducing the cost of mental illness.

Dementia is an important concern in relation to the health and wellbeing of residents as they age. Our recorded dementia prevalence is just over 4% of the total population and is increasing in line with the regional and national trend but is lower than England. Early identification of dementia enables treatment and care to be planned for and provided in a timely manner. Dementia accounts for more expenditure than heart disease and cancer combined, yet a significant proportion of dementia (vascular dementia) is preventable through healthier lifestyles. The NHS Health Check Programme will contribute to enabling people to reduce their risk for developing vascular dementia and identifying early signs of dementia.

Therfore, a joint partnership approach is essential to help protect those who are most vulnerable, e.g., people and families in debt, those living in poverty, people who are homeless, unemployed and those experiencing loneliness and isolation.

Data Snapshot

Mental Health

- Nationally 1 in 4 people suffer from mental ill health during their lifetime.
- Women aged between 17-22 are most likely to develop a mental health problem.
- In 2020-21, the recorded prevalence of depression on GP practice registers was 7% compared to 12.3% nationally, which could be due to stigma around mental ill-health deterring people from seeking treatment.

Housing

- Over 40% of households in temporary accommodation were housed in homes outside of the Borough.
- In 2021, there were an estimated 741 deaths of homeless people in England and Wales.
- Average mean age death of rough sleepers was 45 for men and 43 for women - lower than for the general population.
- In Sept 2022, there were 2,806 households living in temporary accommodation and a total of 4,159 children in temporary accommodation.
- During 2021-22, the number of rough sleepers in Redbridge recorded by Combined Homelessness and Information Network (CHAIN) database was 247.
- Annual rough sleeper count in November 2022 recorded a snapshot of 27 rough sleepers in Redbridge.

Employment

- Redbridge employment rate is 76.3% which is significantly below the London average of 79.8%.

Carers

- Census data shows more than one in 20 people in Redbridge were providing unpaid care as of 2021.
- In Redbridge, 10,956 people were providing more than 20 hours of unpaid care a week in 2021 - including 5,853 people doing so for more than 50 hours a week.
- 44% of working age adults who are providing unpaid care for more than 35 hours a week are in poverty.
- A significant proportion of unpaid carers who are only in receipt of Carer's Allowance - the lowest benefit of its kind at around £75 per week.

Focused Priorities

1. **Partnership focus to support good mental health and wellbeing in Housing**
2. **Promoting opportunities for using community assets to improve health and wellbeing**
3. **Increasing employment opportunities to support poverty reduction**
4. **Supporting carers to undertake their roles and have good physical and mental health**

Priority 1.
Partnership focus to support good mental health and wellbeing in Housing

Whether a vulnerable adult sleeping rough, a child living in a hostel room, or a young person sofa surfing, all experience a huge toll on their physical, mental and financial health when faced with homelessness and the lack of secure housing. People experiencing street homelessness often experience severe and multiple disadvantage and unmet health and social care needs and use more acute hospital services and emergency care than the general population.

Homelessness is not just about people living on the streets. It also includes individuals and families who have lost their home for various reasons. In 2021-22, over 891 homelessness applicants were owed a prevention or relief homelessness duty with single parent females with children; single adults females and couples with dependent children owed the highest. Of those 891, 24.8% were Asian / Asian British, 18.6% were Black / African / Caribbean / Black British and White 15.6%.

Under Housing Law, if a person or family becomes homeless and urgently needs a home, the Council may provide temporary accommodation while helping them find long-term housing. The health and wellbeing of these residents is important and as they are either applying under homelessness legislation or fall within our duty under homelessness legislation. This follows on from the great collaborative work undertaken during Covid utilising the NHS Act to prevent the spread of Covid and improve health indicators. The 'Everyone In initiative' took in over 300 people during the lockdown measures. Redbridge Council already work with partners to improve unmet health and social care needs and by prioritising this it will improve access to these services for tenants in temporary accommodation. Housing Needs services work alongside other council services including public health, benefits and Work Redbridge.

For all homeless persons and families, there are significant costs in terms of their physical and mental health. The lack of secure housing means unstable lives and the inability to plan their lives, and the increased costs of living crisis exacerbates their situation. There has also been an increase in homelessness in the borough and suicide is the third highest cause of death among homeless people in England and Wales, causing 10.8% of deaths. As well as improving access there would be the opportunity for partnership working that could integrate services and improve outcome for homeless households living in temporary accommodation and reverse inequalities that some currently experience.

Partnership Support

1. We encourage our Housing Agent partners to provide information packs.
2. For households in our out-of-borough schemes, packs are provided to support sign-up to schools, GPs and benefits.
3. Residents in hostels are invited to attend information training and advice sessions.
4. Our 'Housing Solutions Move on Assessment team' at the time of homelessness applications will talk to clients about registering with Work Redbridge, accessing benefits, and liaising with tenancy sustainment officers.

Further information about our work and priorities for Housing can be found in our **Housing Strategy**.

How will we know we are making a difference?

Measure 1	Ensure residents in Temporary Accommodation residents are given information about registering for key services - with number of tenants successfully registered with GP and Health Services particularly those in our hostels.
Measure 2	Work with partner organizations to ensure all rough sleepers in existing schemes are registered with GP services.
Measure 3	Measure indicator through ASCOF: a) The proportion of adults in contact with secondary mental health services living independently, with or without support.

Measure 4	Improve access to primary care and community services including mental health and drug and alcohol services, for those who are experiencing homelessness with the ambition of ensuring that they will no longer be discharged to the streets and can access step down accommodation that supports onward support out of homelessness.
Measure 5	Measure indicator through PHOF: a) Homelessness - Households in Temporary Accommodation.

Priority 2.
Promoting opportunities for using community assets to improve health and wellbeing

Redbridge has a significant number of community assets to support access to improve health and wellbeing for our residents. It has a larger volume of green public spaces than most other London boroughs, including two country parks and a flagship park in Ilford Valentines Park, and four leisure centres as well as two sports stadiums, a cycle centre, and two gyms co-located with Libraries with more facilities due to open in the next two years. All our leisure and cultural assets are managed by our partner Vision RCL. Access to our green spaces is free, with our leisure facilities charging lower costs than most private operators, which is vital to ensuring our residents can improve their health and wellbeing at low or no cost.

Many parks were exceptionally well used during the Covid period and were vital to supporting people's health and wellbeing, during what was a difficult period. We know that usage of our parks remains strong and that these are popular with our residents, and many of these will have had the opportunity to discover our green spaces for the first time during Covid. In addition, contained within a number of our parks are facilities such as outdoor gyms and children's play areas which have received investment in recent years and are well used.

Case study: Hainault Forest Country Park

Hainault Forest Country Park has seen investment of over £7m to buildings and landscaping with funding from National Lottery Heritage Fund, the Council and others. This includes restoring historic buildings that host a café, visitor centre and space for hire, improvements to footpaths to make them more accessible, including to those in wheelchairs, and outdoor play provision. Hainault Forest was already a popular site in summer, but the improvements will result in an offer that maintains interest for visitors even in poorer weather and out of season, which we expect to lead to improved take up over the whole year. The site provides numerous opportunities for walking and enjoying nature which we know is impactful on both physical and mental health.

Our leisure centres and wider leisure facilities have been recovering well since Covid, when there were a number of full closure periods and significant times where access was reduced. During this period half of all Leisure Centre members cancelled or paused their memberships. Vision have worked hard promote the leisure offer and take up in the last 18 months has been positive, with memberships nearly back to pre-covid levels, and take up of pay and play opportunities, pitch hire, and swimming lessons really strong. The Council has also funded a low-cost holiday programme for children called 'Megamix', with many sports activities available for just £1 a session, recognising the cost-of-living crises means that more than ever many local families need to be able to access very low-cost holiday activities - where over 1,000 children took part in sessions during the summer of 2023.

Redbridge is currently developing its wide ranging and ambitious **Physical Activity Strategy** to drive and support an increased uptake in physical activity and exercise across all communities in the borough.

How do we know we are making a difference?

Measure 1	Vision collects information on leisure centre usage and pitch bookings (whether on leisure sites or in parks).
Measure 2	Resident report improved health and wellbeing and satisfaction of Council open spaces and leisure facilities, where uptake of the use of community assets should have a positive impact on residents' physical and mental health.

Measure 3	General parks usage is more difficult to measure, but car parking data provides a proxy for usage of parks. In places where specific investment has been made such as Hainault Country Park, we will be able to compare data with pre investment levels.

Priority 3.
Increasing employment opportunities to support poverty reduction

The Redbridge employment rate is 76.3% which is significantly below the London average of 79.8%. There is a rising disparity of unemployment amongst marginalised groups including those with disabilities, Black and Minority ethnic and women. The increasing transiency of refugee populations in Redbridge, including amongst Ukrainians.

The Redbridge Corporate Plan set out an ambition to *'genuinely reduce poverty and improve wellbeing and by 2040 to eradicate child poverty and ensure no area in Redbridge is classified as deprived'*. To mitigate the impacts of poverty the Council is an accredited London Living Wage employer and this also applies to raising pay within our supply chain. However, reducing poverty needs a place-based partnership approach and a **Tackling Poverty strategy** is being developed.

Against the backdrop of a cost-of-living crisis, many of those in marginalised groups need more intensive support to get back into appropriate, sustainable employment. The Council's Work Redbridge service has been working across service areas to support referred residents with the information, advice and guidance they need to begin a journey to employment. By continuing this work and identifying those in most need of support, we will be able to better address the challenges of poverty and inequality by building financial resilience and in turn have a positive impact on mental health and wellbeing of residents. Suicidal thoughts, attempts and self-harm are highest in economically inactive people. The second highest level is in those who are unemployed, while the lowest proportion are in those who are employed. This is relevant to Redbridge, as 66% of working age residents are in employment compared to 75% in London. There is also a gap of 66% between the employment rate of people who are in contact with secondary mental health services in Redbridge, and those who are not.

In addition, supporting those who are most vulnerable to access employment and volunteering opportunities includes Care Leavers, those with Learning Disabilities (LD) with Mental Health (MH) and/or Autism and those considered as NEETS - Not in Education, Employment or Training. A key part of our Day Opportunities services is the implementing the Progression model for people with LD and MH, which is a person-centred approach which allows people to be given a free choice and be more independent than dependent. This support interventions to help people achieve their aspirations and through independence skills, travel training, and gaining employment and skills support.

How will we know we are making a difference?

Measure 1	Seeing an increase in the employment rate across the borough will evidence work to support individuals into work has made a difference.
Measure 2	More localised data demonstrating the residents Work Redbridge has supported across marginalised groups will also evidence impact.
Measure 3	Measures through a range of ASCOF indicators: a) Proportion of adults with a learning disability in paid employment. b) Proportion of adults in contact with secondary mental health services in paid employment.
Measure 4	Measures through a range of PHOF indicator: a) Reduction on young people not in education, employment or training (NEET). b) Gap in the employment rate between those with a physical or mental long-term health condition (aged 16 to 64) and the overall employment rate. c) The percentage of the population with a physical or mental long-term health condition in employment (aged 16 to 64).

Measure 5	Supporting Redbridge Care Leavers to gain opportunities into volunteering and paid employment.

Priority 4.
Supporting unpaid carers to undertake their roles and have good physical and mental health

Every day in Redbridge adults, children and young people support ill, frail or disabled family member, friend, or partners. Carers make a tremendous contribution to their families, communities, workplace and society and it is important that we continue to recognise and value this contribution, and that we work together to support them. Census data shows more than one in 20 people in Redbridge were providing unpaid care as of 2021. This was a fall, however, from the previous census in 2011, when 11.7% of people in the area were providing unpaid care. In England and Wales, the rate also fell over the decade, from 11.4% to 9% - although the ONS warns that as the census was carried out during the pandemic, many people may have been avoiding seeing elderly or vulnerable friends and family. In Redbridge, 10,956 people were providing more than 20 hours of unpaid care a week in 2021 - including 5,853 people doing so for more than 50 hours a week and research from Carers UK and the University of Sheffield indicates unpaid carers contribute £626m to the Redbridge economy - £29,259 per head.

Early intervention, enabling carers to conduct their roles safely and effectively is of critical importance to the local authority. Preventing carers and their loved ones from suffering breakdown and admission to expensive statutory care services enables not only results in significant savings for the local authority, but also enables a supportive caring environment, keeping families and loved ones together. It is important that the statutory provision of a Carers' Assessment reflects the importance of signposting to early intervention services for unpaid carers.

Supporting young and young adult carers, and ensuring they have the ability to thrive is a key priority. For some, being a young carer can be a positive experience giving a sense of responsibility and value. The role of a young carer can also enable a young person to gain life skills and develop a greater understanding and compassion. Many young carers are happy to undertake the extra responsibilities of their caring role, and lead happy, healthy and fulfilling lives, within a supportive family unit. However, the impact of caring can affect a young person's social, emotional and educational development. Therefore, it is important to have services available, enabling young carers to thrive.

Case Study: Young Adult Carers Project

Our primary Carers Support Service have recently completed the Young Adult Carers Project, providing a safe space for carers to meet and socialise with their peers, including mental health resilience sessions, employability workshops and recreational activities. This was complemented with a training programme to professionals, helping to easily identify and support carers. Strong working relationships have been developed throughout Redbridge with social care, NHS services, the voluntary sector and educational providers to enable early intervention in recognising and providing our young carers with the services they require to thrive in their caring role whilst pursuing educational, professional and personal ambitions.

Case Study: Working for Carers Project

This provides unpaid carers aged 25 or over with tailored and personalised employment support, by enabling the pursual of employment goals and skills development whilst supporting on mental wellbeing and stress management that employment can bring. There has been an emphasis on working with local organisations such as the DWP Jobcentre Plus to better identify carers seeking employment to ensure they are signposted to relevant services available to them. The benefits of employing carers, adopting carer friendly policies, and understanding the needs of carers in the workplace have also been highlighted as a pivotal early intervention practice.

Case Study: Supporting Carers Mental Health & Wellbeing - Preventing Carer Crisis

The Council has invested in a mental health support service for unpaid carers with Redbridge Carers Support Service. It provides unpaid carers with emotional and mental wellbeing support intervention offering

assessment, information, advice and guidance, signposting, group activities and access to short-term counselling and coaching services. Its aims to:

- Reduce incidence of crisis (patient and carer) through targeted community-based activities linked into existing pathways of care and support.
- Provide evidence-based research to inform future commissioning in the areas of peer led activities and support for mental health carers.

It is open to both carers with mental health issues and a cared for person with mental health issues. It can be accessed through self-referrals, via GPs, Social Prescribing team, Social Services or Crisis and Mental Health teams.

Carers of someone with dementia and their dependents were particularly hard hit by the impact of Covid, with many finding themselves housebound as day services and respite opportunities closed. Caring responsibilities increased significantly as domiciliary support ceased for those that were concerned about transmission and infection. Despite this, emergency support was provided through the availability of a dementia support worker who gave information, advice and conducted referrals, with emotional support and social activities virtually also offered. Carers' physical health was also a key priority, and in collaboration with regional partners, postal activity packs were shared, and key partnerships continue to be established with external organisations to expand the range of services on offer to develop fun and stimulating activities for carers to join with their loved ones.

Unpaid carers are facing unprecedented financial difficulties because of the UK's current cost of living crisis, piling further stress on those caring for family and friends after an extremely challenging two years caring through the pandemic. According to the Joseph Rowntree Foundation (2022), 44% of working age adults who are providing unpaid care for more than 35 hours a week are in poverty. A significant proportion of unpaid carers who are only in receipt of Carer's Allowance – the lowest benefit of its kind at around £75 per week, missed out on key support measures introduced over the last two years.

In Redbridge, unpaid carers are supported with financial advice and help to access welfare benefits. Also, a cost-of-living toolkit has been shared to effectively communicate the Government's help for households and cost of living payments. As a local authority, we have also created a directory of cost-of-living support to make it easier for residents and their families to access any support or information they may need.

How will we know we are making a difference?

Measure 1	Measures through a range of ASCOF indicators (for those adult Carers in touch with social services only): a) Carer-reported quality of life. b) Proportion of carers who reported that they had as much social contact as they would like. c) Overall satisfaction of carers with social services. d) Proportion of carers who report that they have been included or consulted in discussion about the person they care for. e) Proportion of carers who find it easy to find information about services.
Measure 2	Implementation of the **Redbridge Carers Strategy Charter** and actions for stakeholder partners to deliver.
Measure 3	Carers feedback and case studies through monitoring of local Carers services for carers all Carers.

Ambition 3: Caring Well
Prevention & Care of Long-term Conditions



Long-term health conditions cause very significant costs for individuals, communities, and public services. The costs for individuals can be pain and discomfort, limited life opportunities, financial costs, and premature death. For communities, a high level of limiting long term conditions can create stigma and discrimination and for services, long term conditions can create very high levels of demand for care in inpatient and community-based services, and high financial costs for providers of social care.

Common long-term conditions experienced by our residents include cardiovascular disease (for example heart disease and complications from strokes), respiratory disease (for example chronic obstructive pulmonary disease and asthma), cancers, and diabetes. The most common causes of death for people in Redbridge and across the country are cardiovascular disease and cancers. These diseases contribute significantly to the local burden of disease for our residents. People in Redbridge are less likely to be physically active than the London average, less likely to attend cancer screening services, and they are exposed to high levels of air pollution across the borough. There is also a significant proportion of our resident population who have unidentified conditions and risk factors for more serious illness, such as hypertension and atrial fibrillation.

What do we know?

Long-term conditions like cancers and cardiovascular disease are the biggest killers across the life course in Redbridge. Many cases of long-term conditions are potentially preventable through changes in health behaviours, changes to the physical environment and our interaction with it, and early detection of risks. Demand for treatment of long-term conditions is hugely resource intensive within our health and social care services and that better levels of prevention can lead to less pressured and more effective services for those cases that do occur.

In Redbridge, for every 10 people in England diagnosed with high blood pressure, it's estimated that another seven remain undiagnosed (Public Health England, 2017). There are currently just over 40,000 people with diagnosed hypertension, meaning that potentially there are a further 25-30,000 people who are not aware they carry this risk factor for serious illness. In addition, around a quarter of people with diagnosed hypertension have not had their blood pressure checked in the last 12 months.

Data Snapshot

Air Pollution

- 7.2% of all deaths per year are caused by air pollution, significantly more than the proportion in England as a whole.

Healthy Eating

- 47% of adults do not eat five or more portions of fruit and vegetables per day.
- 57% of adults are overweight or obese.
- 32% of adults are classified as physically inactive.
- An estimated 21% of people with diabetes have not yet been diagnosed with the condition.

Dementia

- Alzheimer's disease is the most common cause, accounting for 60-80% of cases of dementia.
- It is estimated that around 670,000 unpaid carers look after people with dementia in the UK.

Hypertension

- There are around 40,000 people with diagnosed hypertension.
- There are also an estimated 25,000 to 30,000 more people who may have hypertension and are unaware they have it.

Focused Priorities

1. **Early diagnosis and management of Dementia**
2. **Reducing the risk of long-term conditions from air pollution**
3. **Improve identification and management of Hypertension**
4. **Reducing overweight and obesity in adults**

Priority 1.
Early diagnosis and management of Dementia

Dementia is a group of symptoms, in which there is a decline in cognitive function severe enough to interfere with daily life and function. The risk of dementia increases exponentially with age and in 2019, the prevalence of dementia among those over 65 years in Redbridge was 7.29% compared and 7.2% nationally. Locally, this equates to about 2,838 people. It is estimated that only about two thirds of those have received a diagnosis.

There are many possible causes of dementia; Alzheimer's disease is the most common cause, accounting for 60-80% of cases of dementia. Research suggests that a third of dementia cases may be preventable through addressing modifiable risk factors, such as education, exercise, maintaining social engagement, reducing smoking, and management of hypertension, hearing loss, depression, diabetes, and obesity. Between 2025-40 the number of people over 65 predicted to have dementia in Redbridge is estimated to rise from 2,841 to 4,340 - an increase of 1,499 people meaning that it is vital to support both the cared for person for and the carer.

It is also estimated that that by 2025 over 6,205 people over the age of 65 will be providing unpaid care with this projected to increase to over to 8,240 by 2040. It is essential that Carers are given their own levels of support to enable them to undertake and fulfil their role, and to access vital care and support for both themselves and the service user - including mental wellbeing and financial support.

In Redbridge, social care accounts for the largest proportion of the cost of dementia, and this is expected to grow by nearly 70% to £113 million in 2030. The value of unpaid care is expected to grow by nearly 63% from £44.3 million in 2019 to £72.1 million in 2030. Healthcare costs, which account for the smallest proportion of the cost of dementia locally, are expected to grow by 56% from £15.8 million in 2019 to £24.6 million in 2030.

Dementia is a key health and wellbeing concern for our residents as they age and is a key priority both nationally and for Redbridge. Research suggests that a third of dementia cases may be preventable through addressing modifiable risk factors. Due to an ageing population, the prevalence and number of people with dementia are expected to continue to grow locally and nationally. Dementia costs the health and social care sector in the UK more than chronic heart disease and cancer combined. Due to an ageing population, the prevalence and number of people with dementia are expected to continue to grow locally and nationally.

It is estimated that around 670,000 unpaid carers look after people with dementia in the UK, with two thirds of people with dementia living at home. This means that we also need to provide support to carers as well as those diagnosed with dementia to help prevent them falling into crisis and enable them to live well at home and in their local community. Improving the health and wellbeing of people with dementia and their carers will maximise the extent to which people can continue to remain independent and reduce pressure on long term care services. Providing an early dementia diagnosis allows time for the person and their family/carer to plan for the future.

Incorporating early intervention and prevention to support a reduction in the number of hospital admissions, improve hospital discharge arrangements and develop the capacity for more community-based support to give people and carers the skills to better manage care, through the provision of equipment, assistive technology and support at end of life. It is important to continue supporting the provision of services for both carers and those with dementia through day service activities, respite care, befriending, services, and falls prevention.

Supporting early identification and diagnosis through our 'Memory Service' which receives referrals from local GPs for an assessment of people experiencing memory problems. It can also provide outreach services at satellite buildings and in the home. Intensive work has taken place with GPs to increase the number of people being referred for a formal diagnosis and performance in this area continues to improve.

Case Study: Redbridge Memory Service

The Redbridge Memory Service offers assessment, diagnosis, treatment and therapeutic interventions to people aged 18 years and experiencing memory problems. Provided by a range of health care professionals it focuses on both mental and physical support and includes carers of individuals who have dementia, through an offer of on-going support, individually and in groups with interventions also involving community outreach visits and group work.

Case Study: Home Respite Services

Carers of people suffering with Dementia, who live in the same household (as the cared for person) and who provide extensive support, are often unable to leave the person cared for unattended, and therefore do not get a break from their caring role - finding it difficult to leave the person that they care for unattended.

The Council also provides a number of services through our voluntary and community to provide short-term respite solutions for carers and the cared for person. These include trained support workers opening up their own home to groups of cared for and providing social activities and person-centred day opportunities and a sitting service to give alternative care to the cared for person in their own home, enabling the carer to have a break from their caring role and to take breaks from their caring roles and attend to other activities or to spend the time as they wish.

How will we know we are making a difference?

Measure 1	Develop and deliver a Multi-Disciplinary Team (MDT) model for Dementia Care.
Measure 2	Undertake comprehensive dementia pathway mapping in each place to understand existing service provision and any gaps / inequities between places.
Measure 3	Deliver improvements in Dementia diagnosis rate in every borough and work to support those with early age Dementia. Measure through PHOF: Estimated Dementia diagnosis rate (aged 65 and over).
Measure 4	Number of unpaid Carers caring for someone diagnosed with Dementia offered support.

Priority 2.
Reducing the risk of long-term conditions from air pollution

Air pollution is a significant contributor to disease and ill health globally and is a major health problem for many boroughs in London, where it is estimated that up to 4,000 people die each year from the results of air pollution. Redbridge has particularly high levels of air pollution and is designated an Air Quality Action Zone.

Case Study: Public Health England

In 2022, using a tool developed by Public Health England which estimates the cases of disease and financial costs which could be avoided over a 10-year period, should air pollution exposure for everyone in Redbridge be reduced to the current lowest levels experienced within the borough, showed that:

- Cases of asthma would reduce by around 350 cases.
- Cases of diabetes would reduce by around 1,100 cases.
- Cases of lung cancer would reduce by around 10.
- Around 75 to 100 premature deaths would be avoided.
- This would equate to around £3.55 million in health and social care costs which could be avoided.

Evidence also suggests a link to air pollution with low birthweight and negative impacts on child development, causing long-term impacts across the whole life course. One of the primary producers of air pollution is road traffic and the highest concentrations of pollution in are found around busy roads and junctions, which tends to link with areas of deprivation and disease caused by air pollution and widening health inequalities. For local journeys, there are multiple benefits to active travel (walking, cycling, mixed journeys - part by bus, train, car and part by active travel), increase opportunities for physical exercise, reduce air pollution, and can save money at a time when there is a significant cost of living crisis.

Tackling air pollution is a challenge for our all our Health & Wellbeing Board partners. Primary prevention (stopping illness before it starts) involves reducing levels of local air pollution (road management, wood burning) and helping residents to avoid high levels of exposure by, wherever possible, taking routes that avoid walking along busy roads. While we also rely on wider efforts in London and across borough boundaries, there are improvements to emissions that we can make locally. Secondary prevention (stopping early signs of illness progressing) can be improving monitoring systems and alerting residents to when there are high levels of air pollution. Tertiary prevention (limiting the impact of ill health) can be supporting patients in primary care with treatment for asthma and cardiovascular disease (CVD).

How will we know we are making a difference?

Measure 1	• Fraction of mortality attributable to particulate air pollution (OHID Fingertips). • Annual mean NO2 concentration at monitoring locations in Redbridge (london.gov). • Annual mean PM10 concentrations at monitoring locations in Redbridge (london.gov.) • Hospital admissions for asthma (under 19 years) (OHID Fingertips).
Measure 2	Monitor levels of air pollution at key sites through our pollution monitoring system to provide data on whether these are reducing.
Measure 3	Engage with our residents and communities to learn whether routines and behaviours are changing to reduce the risks from pollution and engage to make sure the benefits and costs of measures taken to help reduce pollution exposure are understood, owned, and agreed with our communities.
Measure 4	Monitor key health outcome measures, such as hospital admissions for asthma to assess whether air pollution reduction plans are leading to improved health outcomes.

Priority 3.
Improve identification and management of Hypertension

Hypertension, or high blood pressure, rarely has symptoms but it can significantly increase your risk of heart attack or stroke. It is estimated that around a third of adults in England have hypertension, but many of us are not aware due to the lack of symptoms. The only way to know if you have hypertension is to have your blood pressure checked. There are several reasons for why you may have hypertension and some of them are to do with our age or our genetic makeup. But there are many risk factors for hypertension that are within our control and that we can reduce through changes to our behaviours through eating a healthier diet with less salt, exercise more, sleep better, and cut out smoking and reduce alcohol consumption.

In Redbridge, there are currently around 40,000 people with diagnosed hypertension. However, we can estimate that there are between 25,000 and 30,000 more people who may have hypertension and are unaware of this. This means that potentially there is a large number of our residents who may be at increased risk of heart attack or stroke who do not have the trigger to change health behaviours that this knowledge can often bring. It is important then to ensure that effective promotion and support for health positive behaviours is there across the whole life course and that we have more effective ways of ensuring residents are aware of their potential blood pressure risks.

Hypertension is more common in communities which are experiencing higher levels of deprivation, and there is also evidence to suggest that people are more likely to engage with primary care and have access to blood pressure monitoring where they live in lower areas of deprivation. This can lead to increased incidence of heart attack and stroke and further increase health inequalities. Some ethnicity communities also see higher levels of hypertension which leads to worse health outcomes for cardiovascular disease. The effects of heart attack and stroke may also lead to requirements for increased support from unpaid carers in family members and friends which can lead to further household challenges at a time of crisis in cost of living.

How will we know we are making a difference?

Measure 1	• Hypertension: QOF prevalence (OHID Fingertips). • Various measures of last blood pressure reading being lower than recommended thresholds (OHID Fingertips). • Record of a blood pressure check in the last 12 months for patients on the mental health register (OHID Fingertips). • Under 75 mortality rate from cardiovascular disease (OHID Fingertips). • Stroke all age admission trends (OHID Fingertips).
Measure 2	Identifying residents with hypertension through the NHS Adult Health Check for people aged between 40 and 74, and through opportunistic checks for individuals at higher risk.
Measure 3	Improving support for people with hypertension to reduce their blood pressure (following national best practice on primary care led control measures and improving healthy lifestyles).
Measure 4	Monitor and assess the number of residents in Redbridge identified as having hypertension against the expected number for the borough. An increase in the number will show that efforts to reduce the gap between observed and expected numbers are showing success.
Measure 5	Monitor performance on GP practices in providing hypertension control interventions in their list of patients with diagnosed hypertension.
Measure 6	Monitor the rate of admissions for stroke and heart attacks over the mid to long term and engage with our residents and communities about how they think about risks of cardiovascular disease, and our provision of health care in this area.
Measure 7	Assess the equity and effectiveness of access to services aimed at improving health through lifestyle changes.

Priority 4.
Reducing overweight and obesity in adults

Poor diet and obesity are significant risk factors for a wide range of diseases and a major contributor to lower healthy life expectancy and contributes significantly to the burden of cardiovascular disease in England - with evidence suggesting 44% is caused by being overweight and obese. Obesity has also been shown to be a major risk factor for type 2 diabetes, high blood pressure (hypertension), high cholesterol, and some cancers.

In Redbridge, more than half of adults are either overweight or obese. In addition, the primary behavioural risk factors for overweight and obesity are common in our borough. Nearly half of adults fail to eat 5 or more portions of fruit and vegetables per day, and a third of residents are classified as physically inactive. Challenges with weight and with the health conditions linked to weight can persist across the whole life course. A system-wide approach to Obesity with all key stakeholders has been developed to work together regularly to review and develop our **Obesity Strategy for Adults and Children** and assure the effective implementation of its action plan.

There is a strong link between deprivation and an increased risk of overweight and obesity. This likely contributes to the inequalities in health outcomes we see between the most deprived and least deprived places in Redbridge. An approach to prevention that includes all who can benefit but concentrates more support on those who need it most, can help to reduce these inequalities by promoting health eating and physical activity in our health promotion work, through a Making Every Contact Count (MECC) approach, and through shaping the physical and social environment. There are also particular challenges in the borough and across the country with a cost-of-living crisis, which will be a key consideration in how we design help for residents and communities.

Case Study: Bangladeshi Healthy Eating Project

Following community engagement with the Bangladeshi community in Redbridge, a need was identified to provide culturally sensitive healthy eating advice that would be easy to follow at home, particularly amongst communities with high levels of Type 2 Diabetes.

The Bangladeshi Healthy Eating Project was developed to provide participants with the knowledge and skills required to cook healthy Bangladeshi meals. The workshops covered the basics of a balanced diet, understanding Type 2 Diabetes, and the nutritional values of Bengali foods. A key aim of the project was providing residents with examples of how small changes can improve our diet whilst continuing to eat foods we enjoy. Participants suggested recipes they would like to adapt, and a qualified dietician provided a healthier version. The group then learned the health reasons behind the changes and were able to prepare and cook each recipe within the workshop as well at home.

The participants on the programme were encouraged to post examples of the changes they had made on social media and all reported that additional family members and friends had also made the healthy changes, increasing the impact of the project beyond the workshops themselves.

How will we know we are making a difference?

Measure 1	• Proportion of the population meeting the recommended 5-a-day on a usual day (OHID Fingertips). • Percentage of adults classified as overweight or obese (OHID Fingertips). • Percentage of physically active adults (OHID Fingertips).
Measure 2	Engage with our residents and communities to: a) Understand how people feel about healthy eating and exercise and whether they feel able and helped to follow healthier behaviours and obtain healthier meals. b) Identify barriers to healthy eating and exercise and develop plans to reduce these hurdles.
Measure 3	Monitor and assess the success of specific weight management interventions through the engagement and participation in our support for healthy eating and increased physical activity (National Active Lives survey data on overweight and obesity, and physical exercise and diet).
Measure 4	Assess the equity and effectiveness of access to services aimed at improving health through lifestyle changes.

Strategic Priority Links
The Redbridge Plan and Health & Wellbeing Strategy

The **Redbridge Plan 2022-26**, sets out the key ambitions and priorities the Authority needs to deliver, including measuring progress for its residents.

Ambition Safe & Healthy

ACHIEVE	ACTIVITIES	OUTCOME MEASURES
• Reduce health inequalities and improve the health of the poorest the fastest. • Support healthy, physically active lifestyles and co-produce opportunities that encourage residents to improve their health. • Support people to live healthy, independent lives and support those than need it. • Committed to delivering cultural, leisure and sports facilities within 20 minutes of where you live.	• Deliver vaccination take-up including childhood vaccination. • Lobby for improved resources for primary care. • Run Summer and Easter programmes of culture and sports. • Support the Whipps Cross Hospital re-build. • Invest in park play equipment, refurbish tennis courts, and create more cricket pitches.	• Increased usage of leisure facilities. • Increased average life expectancy. • Increased average healthy life expectancy. • Develop and implement a cancer awareness and screening plan.

Ambition Jobs & Skills

ACHIEVE	ACTIVITIES	OUTCOME MEASURES
• Continue to improve educational attainment closing achievement gaps for children and young people from all backgrounds, support families to give children the best start in life and create a Child Friendly Borough. • Help people out of financial hardship, reduce low pay and the gender pay gap, targeting interventions to tackle poverty in priority neighbourhoods. • Support businesses and residents to improve skills, helping people into sustainable and secure jobs.	• Continue to deliver employment advice through Work Redbridge. • Reduce the number of young people not in employment, education, or training. • Deliver skills training at locations across the borough through Redbridge Institute.	• Reduced percentage and number of young people who are not in employment, education, or training. • Increased percentage of working adults earning the London Living Wage. • Increased employment and reduced unemployment levels.

Ambition Clean & Green

ACHIEVE	ACTIVITIES	OUTCOME MEASURES
• Improve air quality by working with partners to improve the infrastructure and incentives to support residents and businesses to accelerate the switch to cleaner electric vehicles. • Support, improve, and promote our open spaces, including Hainault Forest Country Park and Fairlop Waters.	• Deliver Clean Air Zones around schools. • Install air quality monitors across the borough. • Plant 20,000 trees and create up to 160,000sqm of wild spaces, create new allotment spaces and set up new pocket parks and community gardens.	• Improved air quality in the borough.

Information

For further information and to see the other strategies mentioned in this document, please visit: www.redbridge.gov.uk

or contact: healthandwellbeingboard@redbridge.gov.uk

All data and information are correct at time of publication of this document.