

# A Health and Wellbeing Strategy for Redbridge 2017-21



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## Foreword from the Chair and Vice Chair, Redbridge Health and Wellbeing Board

Welcome to our new Health and Wellbeing Strategy for people in Redbridge, setting out the Board's ambitions in working together over the next four years.

Redbridge remains an extremely popular Borough where many people want to live or raise a 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. Overall, health outcomes for residents have been good, with sustained reductions in the major causes of death, disease and disability over a number of years. And as one of the most diverse communities in the country, people in Redbridge have much to celebrate and be proud of.

In shaping this strategy, the Board has considered the wider context in which it is working and the challenges this presents. 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 rethink how services are best provided across the board, but particularly health and social care service provision. We also know we can go much further in preventing poor health, and intervening earlier to keep people well and independent.

The next four years offers a challenging but exciting period of innovation and change in Redbridge and across the sub-region, with a need for sustained focus on use of resources and the quality and experience of care. The Board is also committed to maintaining its focus on improving outcomes for local people - including our six ambitions for improving child health, diabetes prevention and management, mental wellbeing, cancer survival, decent homes people can afford to live in, and care at the end of life.

We look forward to working with you.



**Cllr Mark Santos**

Chair of the Health & Wellbeing Board

Cabinet Member  
for Health & Social Care



**Dr Anil Mehta**

Vice-Chair of the Health & Wellbeing Board

Chair of the Redbridge  
Clinical Commissioning Group

# 1 Introduction



This, our second Health and Wellbeing Strategy for Redbridge covers the period 2017-21, in line with the national Five Year Forward Views for health and social care services, and local medium term financial plans. It sets out our ambitions over the next four years, providing an overarching strategy for the health and wellbeing of Redbridge residents.

While much has changed over the past four years since our first 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. The Board seeks to improve wellbeing and reduce health inequalities in the borough, through the range of organisations and partnerships that the Board represents. All partner organisations have roles and responsibilities in taking forward the shared vision and ambitions presented in this strategy (see Appendices for more information about the Redbridge Health and Wellbeing Board).

## This strategy sets out:

- our vision for the health and wellbeing of residents
- key facts about residents' health and wellbeing
- ten statements outlining our strategic approach and,
- six ambitions to be achieved over the next four years, relating to child health, diabetes, cancer, mental health, housing and end of life care.

Each of our ambitions will be achieved over the next four years through innovative partnerships, working together to plan and implement improvements. Strategies to achieve the six ambitions must be found within current resources.

An easy read version of this strategy as well as supporting documents is available to view on [www.redbridge.gov.uk](http://www.redbridge.gov.uk)

# 2 Vision

## Our vision is that:

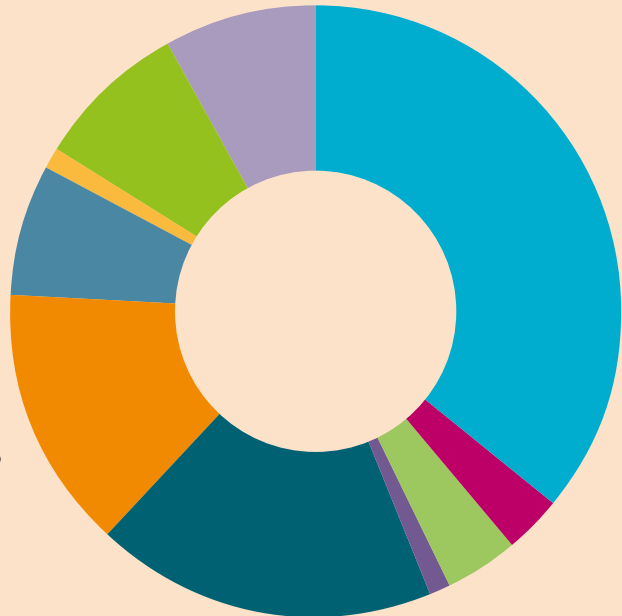
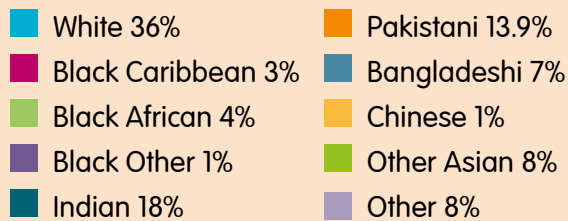
'All people in Redbridge are able to have the best possible health, quality of life and independence. We will strive to develop Redbridge economically, socially and environmentally to help people stay healthy. We will also develop an integrated health and social care system that is focused on prevention, delivered close to home, and efficiently co-ordinated to achieve great value.'

# 3 Key facts about health and wellbeing in Redbridge

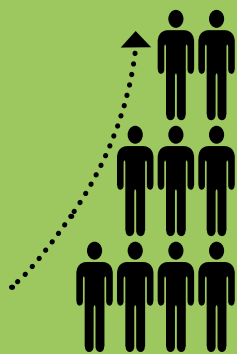
## Wider determinants of health and wellbeing

### Diversity

In 2017, **64%** of residents are from a Black or Minority Ethnic group. Indian and Pakistani minority ethnic groups are largest.



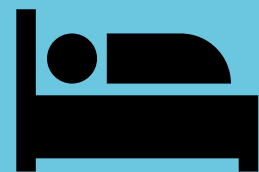
### Population growth



The number of Redbridge residents has increased by 46,360 from year 2007 and is projected to be 303,900 by 2017

### Households in temporary accommodation

In 2016/17, 21 in every 1,000 households were living in temporary accommodation in Redbridge.



### Employment

In 2015/16, **72%** of Redbridge residents were employed - lower than the London average



### Child poverty

Around 1 in 5 children aged under 16 years live in families in receipt of out of work benefits or tax credits where their reported income is <60% of the median income.



# Health and wellbeing

| LEGEND                    |                              |
|---------------------------|------------------------------|
| Trend                     | Compared with Benchmark      |
| Increasing/getting worse  | Better                       |
| Increasing/getting better | Worse                        |
| Decreasing/getting worse  | Similar                      |
| Decreasing/getter better  | No historical data available |
| Not significant           |                              |

| Infant mortality, 2014-16 |                            |                                     |
|---------------------------|----------------------------|-------------------------------------|
|                           | Rate per 1,000 live births | Redbridge trend / benchmark against |
| <b>Redbridge</b>          | <b>2.2</b>                 |                                     |
| London                    | 3.2                        |                                     |
| England                   | 3.9                        |                                     |

| Life expectancy at birth, 2013-15 (Female) |                          |                                     |
|--|--------------------------|-------------------------------------|
|  | Life expectancy in years | Redbridge trend / benchmark against |
| <b>Redbridge</b>                           | <b>84.2</b>              |                                     |
| London                                     | 84.1                     |                                     |
| England                                    | 83.1                     |                                     |

| Teenage conceptions, 2013-15 |                                   |                                     |
|------------------------------|-----------------------------------|-------------------------------------|
|                              | Rate per 1,000 women in age group | Redbridge trend / benchmark against |
| <b>Redbridge</b>             | <b>16.4</b>                       |                                     |
| London                       | 20.8                              |                                     |
| England                      | 22.6                              |                                     |

| Diabetes Prevalence |                |                                     |
|---------------------|----------------|-------------------------------------|
|                     | Prevalence (%) | Redbridge trend / benchmark against |
| <b>Redbridge</b>    | <b>8.1</b>     |                                     |
| London              | 6.3            |                                     |
| England             | 6.5            |                                     |

| Life expectancy at birth, 2013-15 (Male) |                          |                                     |
|--|--------------------------|-------------------------------------|
|  | Life expectancy in years | Redbridge trend / benchmark against |
| <b>Redbridge</b>                         | <b>80.5</b>              |                                     |
| London                                   | 80.2                     |                                     |
| England                                  | 79.5                     |                                     |

| Tuberculosis incidence, 2014-16 |                            |                                     |
|---------------------------------|----------------------------|-------------------------------------|
|                                 | Incidence rate per 100,000 | Redbridge trend / benchmark against |
| <b>Redbridge</b>                | <b>41.5</b>                |                                     |
| London                          | 27.1                       |                                     |
| England                         | 10.9                       |                                     |

### Smoking, 2016



Prevalence (%)

Redbridge trend / benchmark against

|                  | Prevalence (%) | Redbridge trend / benchmark against |
|------------------|----------------|-------------------------------------|
| <b>Redbridge</b> | <b>10.4</b>    | ↓                                   |
| London           | 15.2           | ■                                   |
| England          | 15.5           | ■                                   |

### Physical inactivity, 2015-16



Prevalence (%)

Redbridge trend / benchmark against

|                  | Prevalence (%) | Redbridge trend / benchmark against |
|------------------|----------------|-------------------------------------|
| <b>Redbridge</b> | <b>25.8</b>    | ▲                                   |
| London           | 27.2           | ■                                   |
| England          | 22.3           | ■                                   |

### Excess weight in adults, 2015-16



Prevalence (%)

Redbridge trend / benchmark against

|                  | Prevalence (%) | Redbridge trend / benchmark against |
|------------------|----------------|-------------------------------------|
| <b>Redbridge</b> | <b>53.4</b>    | ▲                                   |
| London           | 55.2           | ■                                   |
| England          | 61.3           | ■                                   |

### Healthy eating, 2015-16



Prevalence (%)

Redbridge trend / benchmark against

|                  | Prevalence (%) | Redbridge trend / benchmark against |
|------------------|----------------|-------------------------------------|
| <b>Redbridge</b> | <b>58.3</b>    | ▲                                   |
| London           | 56.4           | ■                                   |
| England          | 56.8           | ■                                   |

### Admission episodes for alcohol-related cardiovascular disease conditions, 2015/16



Directly standardised rate per 100,000

Redbridge trend / benchmark against

|                  | Directly standardised rate per 100,000 | Redbridge trend / benchmark against |
|------------------|--|-------------------------------------|
| <b>Redbridge</b> | <b>1,382</b>                           | ▲                                   |
| London           | 1,255                                  | ■                                   |
| England          | 1,107                                  | ■                                   |

### All cancers, 2014-16



Directly standardised rate per 100,000

Redbridge trend / benchmark against

|                  | Directly standardised rate per 100,000 | Redbridge trend / benchmark against |
|------------------|--|-------------------------------------|
| <b>Redbridge</b> | <b>109.6</b>                           | ↓                                   |
| London           | 126.8                                  | ■                                   |
| England          | 136.8                                  | ■                                   |

### Cardiovascular diseases, 2014-16



Directly standardised rate per 100,000

Redbridge trend / benchmark against

|                  | Directly standardised rate per 100,000 | Redbridge trend / benchmark against |
|------------------|--|-------------------------------------|
| <b>Redbridge</b> | <b>80.3</b>                            | ▲                                   |
| London           | 77.9                                   | ■                                   |
| England          | 73.5                                   | ■                                   |

### Respiratory disease, 2014-16



Directly standardised rate per 100,000

Redbridge trend / benchmark against

|                  | Directly standardised rate per 100,000 | Redbridge trend / benchmark against |
|------------------|--|-------------------------------------|
| <b>Redbridge</b> | <b>23.7</b>                            | →                                   |
| London           | 30.3                                   | ■                                   |
| England          | 33.8                                   | ■                                   |

# 4 Our opportunities and challenges

Health and wellbeing is a precious asset - for individuals, communities, and society. To date, people living in Redbridge have enjoyed above average life expectancy, and many residents continue to achieve above average educational attainment, access to work, and independence into old age.

Redbridge is the 13th largest borough in London, with a rapidly growing population. In 2017 it is estimated that 303,900 people live in the Borough, growing to 321,300 residents by 2021. There will continue to be significant increases in the numbers of children and young people and people aged over 65 years living in Redbridge, many of whom require support from health and social care and other services. Redbridge 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. We recognise that deprivation is an important cause of poor health and wellbeing.

The consequences of population changes, in particular ageing and deprivation, is an increase in the need for interventions to protect and improve people's health and wellbeing, as well as an increase in demand for health and social care services provided by the NHS and the Council. The health and social care system is seeking to improve health outcomes and value for money, as well as the quality and experience of care that residents receive. Many other services influence the wider determinants of health and wellbeing, and we must ensure that improving the health wellbeing and independence of residents is a common goals. The way we deliver health and social care services must continue to evolve if we are to meet the future needs of residents in a fair and sustainable way.

## Determinants of Health and Wellbeing in Redbridge

(adapted from other models for Redbridge)



Adapted from Dahlgren and Whitehead 1991, and LGA circle of social determinants



In Redbridge all local public services (within the Local Authority as well as the NHS) are under pressure due to a combination of increases in resident's needs, financial constraints, reforms to the housing and welfare system and implications of legislation such as the Care Act and Children and Families Act. Working together to develop an effective system means that we are able to ensure we get the best out of limited resources.

There is strong evidence that residents will have better health and wellbeing if we focus on preventing and providing support early before health and care problems become complex. This approach has been shown to be cost effective. Without moving our focus towards prevention and early intervention, the health and social care system faces escalating demand for services, and escalating costs to meet complex needs. The relatively good health outcomes most people enjoy in Redbridge will become more difficult to sustain.

Reducing the inequalities in health experienced by our most vulnerable residents, and those living in relative deprivation, is of key importance. We need to consider how local communities are empowered to enhance wellbeing, and support residents to maintain independence for longer. In Redbridge we will continue to seek to understand residents' needs, especially those groups who are under-served. We will build on the recommendations of the Fairness Commission (<https://www.redbridge.gov.uk/about-the-council/fairness-commission/>) including nurturing the assets within our local communities that promote wellbeing. We will also further develop social prescribing to ensure that the wider determinants of health and wellbeing are effectively identified in the health and care system, and addressed through appropriate information and advice, signposting or referral.

Given the pressures already identified we know that delivery of high quality services is challenging. We know that some local people struggle to access care in a timely way, and that variation exists in access to and outcomes from health and social care services. We will seek to ensure that services are responsive to residents needs and accessible to all.

Our response to the challenges of increased needs for health and social care in the context of financial constraints has been to integrate our adult health and social care services, and organise them around the places where people. In relation to services provided for adults, much progress has been made in building a more sustainable health and care system fit for the future. This works on several levels:

- At a locality level, there are four community health and social care localities in Redbridge (Fairlop, Loxford & Cranbrook, Wanstead & South Woodford and Seven Kings). We have started to develop a new service model delivered through these four health and social care localities in order to meet the needs of communities locally.
- At a Borough level - developing innovative partnerships that will culminate in a new Borough Plan.

We will also work with partners in other boroughs to explore opportunities for more collaboration with the aim of improving health and wellbeing as well as cost effectiveness. And we will be exploring what we can learn from these experiences to enhance provision for children and young people.

Redbridge residents already benefit from significant local assets within their thriving communities, or are involved in supporting their community as volunteers. Many residents provide invaluable unpaid care and support to family, friends and neighbours. We hope to continue to expand support for carers and opportunities for volunteering and social action as a part of our health and wellbeing strategy. We have an important role in working together with local communities and the local voluntary sector to ensure that our facilities and community assets are maximised to support residents to be engaged in their community, helping them to enjoy quality of life and remain healthy and independent.

We recognise that the wellbeing of residents is also influenced by the local environment and green spaces, housing, employment, transport and local infrastructure. An ambitious plan for housing, infrastructure and regeneration in Redbridge has been set out in the Local Plan that includes a particular focus on Ilford Town Centre. We aim to utilise these opportunities to further benefit the wellbeing of residents thus accommodating the needs of the health and social care system as well as resident's needs for good quality homes, schools, work, and open and green spaces.



## 5 Strategic approach to health and wellbeing over the next 4 years

The ten directional statements below outline our strategic approach to improving health and wellbeing over the term of the strategy and beyond. By working in these ways we intend to make progress across a range of health and wellbeing outcomes, including (but not limited to) our six ambitions set out in section 6.

- 1. Starting with prevention,** all strategies and plans will include a focus on action to prevent poor health and disability arising; diagnose/identify problems early, and ensure people can access timely treatment, care or support where required.
- 2. Addressing the causes of poor health including poverty,** individuals, communities and organisations will be engaged in tackling the root causes of ill health - poverty, maltreatment and abuse, unhealthy homes, low income, poor educational attainment, worklessness, poor quality jobs and social isolation.
- 3. The wider role of health and social care services,** we will ensure services address physical, mental and emotional wellbeing, and play their part in safeguarding vulnerable people. By considering health in all policies, health and social care services will maximise their contribution to the health of residents as employers and landlords/landowners, and through the goods and services they procure.
- 4. Supporting people to live in good health,** partners will support residents - to be physically active, with a healthy balanced diet and a good understanding of how to protect and sustain their mental health and general wellbeing. Targeted support will help people reduce smoking and tobacco use, drug and alcohol use, harmful sexual practices, sedentary behaviour and poor diet.
- 5. Working with communities,** people will have access to good quality information and advice to support their health, wellbeing and independence. Partners will continue to develop our local model of social prescribing, supporting isolated and vulnerable residents at high risk of poor health. Signposting or navigation towards resources in local communities will promote social action, empowering people to engage in their communities and creating positive change through volunteering, caring communities, and civic and democratic involvement.
- 6. Health protection,** activity will continue to focus on reducing the threats to health posed by communicable diseases, environmental hazards, and extreme weather - including planning for scenarios like pandemic flu, mitigation of poor air quality, and resilience plans for extreme cold and hot weather.
- 7. New models of care,** will be explored, focusing on meeting the needs of residents and patients in a sustainable way. Building on our integrated adult health and social care localities model, the specific needs of communities in each locality will be addressed, with more care delivered in the home or close to home. This will involve shared entry points into services, single or shared assessment processes, and delivery through integrated teams where appropriate. We will explore what we can learn from the integrated localities model to enhance provision for children and young people.

- 8. Recovery and self-care,** we will further develop the information and support people need to manage their own health condition(s) or disability, utilising technological advances and ensuring people maintain their independence for as long as possible. Re-ablement, rehabilitation and recovery pathways for people experiencing episodes of poor health will remain focused on helping people achieve their personal goals, independence and wellbeing, reducing long term reliance on statutory services wherever possible.
- 9. We will celebrate and support the considerable contribution of carers,** both paid and unpaid, and identify ways of helping carers stay physically and mentally well, so that they can live well alongside their caring role.
- 10. Assessing emerging challenges and opportunities** to inform **new** models of care - including supporting individuals with complex or multiple disease and disability, frailty and dementia, obesity, liver disease, and delivery of personalised medical interventions arising from genetic advances.







## 6 Ambitions for improved health and wellbeing

We have identified six ambitions for improvement over the next four years. In order to prioritise these, we considered:

- are outcomes for people in Redbridge comparable to those achieved by people living in similar areas?
- how many people are affected?
- what is the impact on quality of life, or life expectancy?
- what is the impact on use of resources?
- is there good evidence that intervention will improve health and health and wellbeing, and that this is cost-effective?
- what is the likely time frame over which the desired change can be achieved?
- is there strong local feeling about the issue?
- how will it affect health inequalities?

Achieving progress against each of the ambitions over the next four years will require a sustained focus on service quality and user experience, and will have a significant impact on the health and wellbeing of local people, the financial sustainability of the health and care system, and health inequalities. For each priority we have considered:

- how residents are enabled to improve their health and wellbeing.
- what support people need and when - so that issues are identified early, and prevented from getting worse.
- how we can work together to create a system that reduces inequality and supports all residents to achieve optimum health and wellbeing.

| OUR AMBITIONS  | OUR APPROACHES  |
|--|---|
| <b>1. Achieving the best start in life</b>                       | Children and young people are supported to achieve optimum health and wellbeing from pregnancy through to transition to adulthood.  |
| <b>2. Diabetes prevention and management</b>                     | Local people are physically active and achieve a healthy weight. People with, or at risk of developing, diabetes are identified early, and supported to prevent or manage their condition.  |
| <b>3. Mental wellbeing</b>                                       | Local people are supported to maintain good mental health and emotional wellbeing, and maximise their resilience to and recovery from adverse situations and events.  |
| <b>4. Cancer survival</b>  | Building on work to reduce cancer risk, local people increase their awareness of cancer symptoms, leading to earlier presentation. Prompt detection in primary care and an increased uptake of cancer screening programmes contributes to longer term survival from cancer as residents are able to benefit from interventions only effective in early stage disease.   |
| <b>5. Living well in a decent home you can afford to live in</b> | Local people can live in homes that meet their needs for shelter, warmth, and safety, and with sufficient space to avoid overcrowding. These homes are affordable for people on low income, leaving sufficient resources to lead a healthy life. Those at risk of homelessness are supported to retain or find a home, and rough sleepers are supported off the streets.  |
| <b>6. End of life care</b>                                       | People who are reaching the end of life are identified early, offered a comprehensive holistic assessment, and supported with their social, practical, emotional and spiritual needs. Care is coordinated across settings and services and delivered by a multidisciplinary workforce that supports people to die in accordance with their personalised care plan, for example at home, in a hospice or other appropriate location. |



# Ambition 1: Achieving the best start in life

## Why is this important for Redbridge?

Achieving the best start in life for children and young people is vital to ensuring that future residents have the best possible health and wellbeing. This is a particularly important priority for Redbridge given the large (and increasing) number of children and young people living in the borough. Whilst many children and young people grow up in safety, with good health and wellbeing, supportive families, schools and other networks which help them reach their potential, there are significant numbers who experience disability, long-term conditions including poor mental health, poverty, temporary accommodation or need social care support. In general, poverty significantly affects the health and wellbeing of children and young people at every stage of life. In Redbridge, there are many more young children resident in areas of high deprivation than in more affluent parts of the borough. Educational achievement and child development are key indicators of health and wellbeing later in life.

Supporting residents to achieve healthy pregnancy, childhood and adolescence is crucial to putting in place the best chance of healthy adulthood and older age. With evidence based early identification and early help/support, and an environment that facilitates health, it is possible to significantly enhance the wellbeing of children and families. During childhood there are key developmental stages when social and cognitive skills, health related habits, coping strategies, attitudes and values are developed that go on to influence health and wellbeing later in life. A range of partners such as maternity units, Health Visitors, School Nurses, Children's Centres, child care and early years education, schools, youth services and out of school activities have a key role to play in supporting children and families to achieve the best start. Creating an environment that supports families to live healthy lives is also critical, including the provision of safe and accessible routes for active travel to school; access to affordable and healthy food; and safe open spaces for physical activity that are attractive and welcoming.

There is reliable evidence to indicate that improving the life chances of children and young people improves long-term health and wellbeing, reduces health inequality and provides a high return on investment over the medium to long term. Ensuring that children and young people are safe is also essential to their on-going mental and physical wellbeing.

## What do we know?

- by 2026 it is projected that there will be over 118,000, 0-25 year olds living in Redbridge.
- nearly 21% of dependent children and young people under 20 years old live in households subject to relative poverty (where income is less than 60% of the median household income before housing costs).
- rates of childhood obesity in year 6 are above average for England, and unlike other parts of London increased between 2012-13 and 2014-15.
- it is recommended that children and young people participate in one hour physical activity every day (during school, after school activities and personal leisure time). Only 14% of 15 year olds attending school in Redbridge undertake the recommended level of physical activity.
- in 2016 just over 2% pupils attending Redbridge schools had a statement of Special Educational Need or Education, Health and Care Plan.

## **Our Ambition**

**Families, children and young people achieve optimum physical and mental health and wellbeing in life stages from pregnancy through to transition into adulthood.**

### **We will continue our progress to achieve our ambition by:**

- promoting early booking for antenatal care and ensuring better coverage of the healthy child programme for 0-19 year olds which maximises opportunities for health and wellbeing from pregnancy to transition to adulthood.
- promote physical activity and a healthy diet among families, children and young people.
- enabling all children and young people to make good progress in education and skills development, in preparation for work or employment.
- ensuring that health and social care services work to minimise the impact of inequality experienced by children and young people.
- working with all organisations, both voluntary and statutory, families, children and young people to ensure that children and young people in Redbridge are resilient and have the best opportunities to have good mental wellbeing.
- supporting children and families to access good quality education and childcare, including supporting families who are entitled to free early year's education and childcare.
- working with partners to continue ensuring the safety of children and young people and tackle issues such as all forms of bullying, female genital mutilation, and child sexual exploitation.

### **We will challenge ourselves to:**

- work with families, children and young people with complex mental or physical health needs or disability to improve quality of life and plan for optimum wellbeing in adulthood.
- ensure that children and young people with complex needs are identified early and supported in a timely and coordinated way by all services using an integrated approach across health, education and social care.
- work with partners to support families to access work related training and volunteering opportunities with the aim of gaining employment.
- further develop a strategic approach with all statutory and voluntary sector organisations which work with children and families with the aim of maximising the wellbeing of local children and young people by implementing opportunities for early identification and support.
- continue to engage with children, young people and families to ensure our services reflect their needs.



## How do we know we are making a difference?

Key outcome measures that we will use to monitor progress towards achieving this ambition will be:

- increased uptake of developmental antenatal checks at birth, 6 weeks, 1 year and 2 and 2½ years.
- halt the year on year increase of childhood obesity.
- children are assessed as being 'ready for school' at aged 5.

Other measures that will contribute towards our understanding of progress include:

- increase in women accessing early antenatal services.
- increase the proportion of children and young people who receive immunisations
- increase the proportion of babies who are breastfed.
- increase in physical activity among children and young people.
- decrease in tobacco use by children and young people.
- decrease in alcohol consumption among children and young people.
- increased take up of early education for 2 year old children eligible for a funded place.
- improved educational achievement - reduce the gap in achievement between children on free school meals and peers.
- improve the experience of service use among children with complex needs and their families.
- children with complex needs have timely, well planned transition to adulthood in line with legislation.



## Ambition 2: Diabetes prevention and management

### Why is this important for Redbridge?

Diabetes is one of the leading causes of disability among working age adults and the majority of type 2 cases are preventable. Being physically active, eating healthily and maintaining healthy weight can reduce the risk of diabetes.

Nationally, diabetes accounts for about 10% of the NHS budget and 80% of these costs are due to complications. People who have diabetes are at an increased risk of developing serious complications such as lower limb amputations, angina, heart attack, heart failure, stroke, kidney failure, blindness, and early death relating to complications. However, it is possible to prevent complications through appropriate management and providing recommended care and support.

A higher proportion of Redbridge residents have diabetes than the average for London or England - with an estimated 12% of residents projected to have diabetes by 2030. This high prevalence is related to higher risk of diabetes among South Asian communities and increasing numbers of residents who are overweight or obese. We also know that some residents are unaware that they have diabetes. Without a diagnosis, people with diabetes do not have access to information or treatment and may develop serious complications.

NICE, the National Institute for Health and Clinical Excellence recommends nine care processes (tests) that all people with diabetes should receive. These tests are designed to help the management of the patient's diabetes ensuring it is well controlled and long-term complications are prevented. Across our GP Practices, implementation of the nine care processes is variable.

Improving resident's awareness of risk factors for type 2 diabetes is an important part of prevention. The NHS Health Checks programme offers a health check to all residents between the ages of 40-74 (once every 5 years) to assess their risk of developing heart disease, stroke, diabetes, kidney disease and certain types of dementia. Residents are provided with advice, supported to manage their risks or provided with appropriate treatment. Between 2013-16 figures reveal that 62% of residents offered a Health Check took this offer up. This is a greater proportion compared to London, England or neighbouring boroughs. In addition to signposting residents to services, we can help individuals to maintain a healthy weight, eat a nutritious diet and be active by creating an environment that promotes wellbeing. This includes ensuring that the environment supports residents to actively travel and enjoy active leisure time; and provides access to healthy, affordable foods.

### What do we know?

- 8% of residents have diagnosed diabetes, by 2030, it is estimated that this will increase to 12%.
- in Redbridge, risk factors such as genetic predisposition, physical inactivity, poor diet and obesity significantly contribute to the increasing proportion of residents who are affected by diabetes.
- residents who have diabetes are at higher risk of suffering a heart attack or stroke than those with diabetes nationally.



## Our Ambition

Local people are supported to maintain healthy lifestyles including being physically active and achieving a healthy weight. People with, or at risk of developing, type 2 diabetes are identified early, and supported to prevent or manage their condition.

### We will continue our progress to achieve our ambition by:

- working with local communities to ensure that residents of all ages have access to advice, care and support about how to maintain healthy lifestyles (such as healthy weight, physical activity, nutrition), and to reduce risk of developing diabetes.
- creating a local built environment that supports residents to be active.
- ensure that residents are able to eat a healthy diet.
- raise awareness of risk factors and symptoms of diabetes and ensure prompt assessment and detection in primary care.
- further promote the NHS Health Check programme to eligible residents and ensure it reaches those most at risk.

### We will challenge ourselves to:

- develop services aimed at supporting residents to adopt healthy lifestyles that are integrated into the four Redbridge health and social care localities.
- engage with local communities (of all ages) who are most at risk of developing diabetes, ensuring that there is culturally appropriate information and advice about lifestyle, early identification and support for effective management.
- work with all partners to ensure that residents diagnosed with diabetes are supported to manage their own conditions and optimise their health and wellbeing with the aim of preventing further complications, including implementation of the updated NICE care process in primary care.

### How do we know we are making a difference?

Key outcome measures that will be used to monitor progress towards achieving this ambition will be:

- halt the year on year increase in obesity levels for both children and adults.
- reduce the rate of diabetic complications by increasing numbers of residents who receive the updated NICE care processes and diabetic eye screening (Diabetic Retinopathy screening).
- increase the number of residents who currently have undiagnosed diabetes to receive a diagnosis.

Other measures that will contribute towards our understanding of progress include:

- increase in physical activity for both children and adults.
- increased uptake of NHS Health Checks.
- a reduction in emergency admissions due to diabetes.
- a reduction in lower limb amputations and hospital stays due to other complications.

## Ambition 3: Mental wellbeing

### Why is this important for Redbridge?

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 work places, early access to psychological therapies and dementia friendly facilities.

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.

Supporting children's and young people's 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.

### What do we know?

- 1 in 10 5-16 year olds have a diagnosable mental health condition (Green et al, Mental Health of Children and Young People in Great Britain, 2004).
- 1 in 4 young women between the ages of 16 and 24 years self-harm at some point, evidence shows that this is increasing (Adult Psychiatric Morbidity Survey, 2014).
- up to 20% of women who give birth will experience depression or anxiety during pregnancy or in the first year after birth (Parsonage et al, 2016). This equates to over 936 women in Redbridge potentially affecting the wellbeing of children in the long term.
- nationally at any one time, 1 in 6 adults will have a common mental health disorder such as anxiety or depression (Adult Psychiatric Morbidity Survey 2014).
- people who live alone, have other health conditions or who do not work are at greater risk of having mental health conditions (Adult Psychiatric Morbidity Survey, 2014).

## **Our Ambition**

**Local people of all ages are supported to maintain good mental health and emotional wellbeing, and maximise their resilience to and recovery from adverse situations and events.**

### **We will continue our progress to achieve our ambition by:**

- ensuring that the local environment enhances good mental wellbeing by promoting access education, good quality housing, employment, open spaces, physical activity, leisure and culture opportunities, supportive community networks and ensuring community safety.
- improving mental wellbeing and resilience among families, children and young people by working with partners to develop and implement the CAMHS Transformation Plan.
- working with partners including the voluntary sector, Early Years, 0-19 Service and Education to support families to encourage mental wellbeing among children and young people.
- working with local communities, voluntary sector and partner organisations to raise awareness about mental wellbeing and tackle stigma.
- working with partners (including the local voluntary sector) to tackle factors that make it difficult for people, especially among Redbridge's diverse communities, to maintain good mental wellbeing such as homelessness, substance misuse, domestic violence and social isolation.
- further development of Redbridge as a 'Dementia Friendly' borough. This includes a programme of awareness raising for the wider community with the purpose of supporting people living with dementia, enabling them to feel supported and maintain independence for longer.
- ensuring support for carers of residents with dementia by identifying carers early and offering practical and emotional support provided mainly within the voluntary sector.

### **We will challenge ourselves to:**

- ensure that the local health, social care and law enforcement workforce are trained in relation to mental wellbeing.
- identify mental health needs among children and young people, families and adults early and ensure timely, evidence based early support.
- support people with long term mental health needs to manage their conditions, maintain physical wellbeing, healthy lifestyles, good quality housing, social networks, education or employment.
- work with local law enforcement, GPs, voluntary sector, hospitals and other partner services to ensure effective models of early identification and support for people who have mental health and substance misuse needs.
- work with partners to identify people who have dementia early, and ensure timely evidence based treatment and care.



## How do we know we are making a difference?

Key outcome measures that will be used to monitor progress towards achieving this ambition will be:

- percentage of adults in contact with secondary mental health services who are in paid employment and those who live independently with or without support.
- a reduction in the numbers of suicides of all ages.
- reduce the gap in mortality between those who have long term mental health conditions and the general population.
- reduce social isolation as measured by the percentage of adult social care users who have as much social contact as they would like.

Other measures that will contribute towards our understanding of progress include:

- increase in referrals to the memory clinic.
- monitor patient and carers experience of community mental health services.
- reduction in emergency admissions to hospital due to mental health causes for both adults and children.



## Ambition 4: Cancer survival

### Why is this important for Redbridge?

Cancer continues to be a major cause of premature deaths among our residents, despite a reduction in the number of deaths due to cancer over the last decade. Lung cancer accounts for around 18% of premature deaths from cancer, along with 10% due to colon and rectal cancers and 10% due to breast cancer. Premature deaths represent a significant impact to the individual and their family, both emotionally and economically. Importantly, the one year survival rate of Redbridge residents diagnosed with lung or breast cancer is lower than average for England. This represents avoidable premature deaths as well as a significant emotional and economic burden for residents and the health and social care system.

Premature deaths attributable to lung cancer are the largest proportion of premature deaths among all types of cancer. Eight of ten lung cancers are related to smoking, indicating a significant number are preventable.

Mortality from cancer is preventable by encouraging healthy life styles such as good nutrition, exercise and weight management, reducing smoking and harmful alcohol consumption. For nearly all types of cancer, early diagnosis results in improved survival - largely because people are able to access medication, surgery or therapy while they are still relatively well and which may not be effective in later stage cancers. National cancer screening programmes play an important role in diagnosing bowel, breast and cervical cancer early and efforts to promote uptake of these programmes is crucially important. Working with communities to raise awareness of cancer signs and symptoms, tackle the fear and stigma that surrounds cancer in some communities, and supporting people to present early to their GP for further investigation are also key to improving cancer survival. Over time, this will contribute to a reduction in the proportion of cancers diagnosed through emergency presentations and the often complex care required for late stage cancers.

### What do we know?

- among Redbridge residents premature deaths due to cancer have decreased (166 per 100,000 to 117 per 100,000) between 2001 and 2014.
- among Redbridge residents deaths due to lung cancer have reduced (from 61 per 100,000 to 45 per 100,000) between 2001 and 2014.

### Our Ambition

Local people increase their awareness of cancer symptoms, leading to earlier presentation. Prompt detection in primary care and an increased uptake of cancer screening resulting in longer survival from cancer due to early treatment.

## **We will continue our progress to achieve our ambition by:**

- support residents to maintain healthy lifestyles, especially reducing obesity and the proportion of residents who smoke or use tobacco products by redeveloping behaviour change services at a locality level.
- work with partners to ensure that residents are aware of risk factors and how to reduce the risk of developing cancer.
- work with local communities to ensure that there is good awareness of signs, symptoms, and the importance of cancer screening to enable early presentation and early detection.
- work with partners to reduce exposure to second hand smoke.
- further reducing exposure to tobacco smoke for example in children's play areas and on NHS and Council owned estate.

## **We will challenge ourselves to:**

- pilot new ways of increasing the uptake of cancer screening, especially among groups who often do not use this service.
- targeted work with communities which have a higher proportion of residents who smoke or use tobacco products with the aim of reducing smoking and use of tobacco.
- work with children and young people to reduce uptake of smoking and other tobacco products.
- ensure that local health services provide timely treatment and care for residents with suspected diagnosis of cancer in line with NICE guidance.

## **How do we know we are making a difference?**

Key outcome measures that will be used to monitor progress towards achieving this ambition will be:

- increased uptake to cancer screening.
- increased diagnosis of early cancer.
- increased survival (measured at one year and at five years) from cancers.

Other measures that will contribute towards our understanding of progress include:

- reduction in the incidences of cancer.
- reduction in the premature mortality rate for cancer.
- an increase in the numbers of residents quitting smoking and a decrease in numbers of residents using tobacco products.
- halt the year on year increase in obesity for both children and adults.
- increase in the uptake of physical activity among children and adults.



## Ambition 5: Living well in a decent home you can afford to live in

### Why is this important for Redbridge?

Redbridge remains a popular borough where lots of people want to live. Limited supply of homes is impacting on the health and wellbeing of increasing numbers of people in the Borough - through an unmet need for affordable homes, variations in the quality of homes in the private rented sector, and increasing numbers of households living in temporary accommodation.

Decent homes that people can afford to live in make a fundamental contribution to the health and wellbeing of residents, supporting people to stay well and independent and reducing demand for health and social care services. Decent home standards have been achieved in the vast majority of social housing provided by the Council and Social Landlords, but there is considerable variation in the private rented sector and the Council has limited control or influence over these homes. Housing conditions with a particular influence on health and wellbeing include affordable warmth, damp and mould, carbon monoxide emissions, over-crowding, trip and fall hazards, security of tenure and disrepair. Housing adaptations for people with disabilities and frail older people help maintain people in their home, supporting independence and wellbeing. The environment in which the home is located influences factors such as air quality, accessible outdoor space for active leisure/play, access to safe walking, cycling and public transport routes, access to affordable healthy food, and community facilities are all factors that influence wellbeing of residents.

A strategic assessment of the Redbridge housing market up to 2033 estimated a total supply deficit of nearly 47,000 homes in the borough, of which nearly a third need to be affordable. Nearly 90% of this deficit is for family sized homes, especially with three bedrooms or more. In the context of limited local housing stock, high demand for rental property in London driving up rents, and an increasing gap between Local Housing Allowance thresholds and local rents it is becoming increasingly difficult for people on low incomes or in receipt of benefits to secure and retain a decent home in the borough. The Council is also finding it increasingly difficult to secure temporary accommodation of suitable quality and cost in or around Redbridge.

Many households face multiple challenges and difficult choices in terms of prioritising housing costs over the other goods and services their families need, causing stress and impacting on health and overall wellbeing. Overcrowding can result where people decide or are forced to share accommodation. In this context, work with private sector landlords and agents to improve housing standards and affordability is a key priority in Redbridge.

As homes become less affordable, helping households to maintain their accommodation and prevent homelessness becomes an increasing priority for all services in Redbridge. Helping those with health conditions, or in crisis, to maintain their accommodation or to move in a planned way will reduce the risk of homeless, and the need for temporary accommodation that is of poor quality and increasingly hard to secure locally. Risk factors for homelessness include:

- relationship breakdown
- loss of employment
- health conditions affecting ability to work, or maintain a job
- renting in an area with rapidly increasing rental values
- households in receipt of universal credit and not in work

Homeless individuals or households may bed down in the open air (such as on streets, or in doorways, parks or bus shelters); or in buildings or other places not designed for habitation (such as sheds, car parks, cars, or stations). Rough sleepers experience a disproportionate level of health inequalities in comparison to those living in permanent or substantive accommodation. Overcoming poor physical or mental health problems is a major factor in supporting people who have been sleeping rough back into permanent accommodation, employment and recovery.

Groups who are disproportionately affected by housing problems include children and families, older people, people with disabilities and long-term conditions and those with mental health problems. Housing significantly impacts on the life chances of children and young people. Children who live in overcrowded homes or those in poor condition are more likely to experience respiratory problems, infections, accidents, poor mental health and lower educational outcomes. Older people living in poor quality housing are more likely to experience falls, and excess cold resulting in winter deaths and isolation.

### What do we know?

- the Strategic Housing Market Assessment for North East London 2011-33 shows a housing supply deficit of 46,900 homes in the borough. Of these 15,300 is the assessed deficit in affordable homes. 89% of deficit is for family sized homes, especially with three bedrooms or more.
- at the end of September 2016 update, this figure there were 2,265 households in temporary accommodation of which 1,947 were families with dependent children or pregnant women. 344 households were in bed and breakfast accommodation of which 193 were families with children or pregnant women.
- among Redbridge residents, 20.5 per 1,000 households live in temporary accommodation.
- 45% of those in temporary accommodation were placed outside of Redbridge as the end of September 2016.
- as at January 2017, 8,320 households were on the Redbridge Housing Register waiting for accommodation. 28% of these were waiting for studio flats or one bedroom homes and the remainder were waiting for family sized homes. Between April and December 2016, 208 council and housing association homes became available for letting of which 44% were family sized homes.
- 424 households on the housing register as at January 2017 had been awarded medical priority because their current housing did not adequately meet their medical needs.
- across England and London the numbers of rough sleepers has been increasing since 2010. In 2016 Redbridge was amongst the ten Local Authorities (across England) with the highest counts of rough sleepers.

### Our Ambition

Local people can live in homes that meet their needs for shelter, warmth, and safety, with sufficient space to avoid overcrowding. These homes are affordable for people on low income, leaving sufficient resources to lead a healthy life. Those at risk of homelessness are supported to retain or find a home, and rough sleepers are supported off the streets.

## **We will continue our progress to achieve our ambition by:**

- work with partners in the development of emerging Housing strategies in Redbridge, including homelessness and supported living.

## **We will challenge ourselves to:**

- work together to understand and mitigate the factors that are increasing homelessness in Redbridge, raising awareness amongst staff, service users and carers and developing tenancy support strategies where appropriate.
- support people (including those who have been long term unemployed, have physical or mental health problems) into sustainable work.
- work with partners to ensure that residents have access to benefits advice and are signposted to local support including voluntary sector services.
- support people who have a disability, long term condition or mental health problem to live in good quality homes, independently, and develop supported living opportunities for adults and older people in the borough.
- make best use of existing housing stock, and support people to regain mobility and maintain independence and reduce social isolation.
- support those who experience homelessness to manage within temporary accommodation, and work with them to find alternative options to better meet their needs - including those accommodated out of borough.
- support efforts to improve conditions in the private rented sector, including the private landlord registration scheme.
- ensure all households can access affordable warmth, reducing fuel poverty and preventing cold related illness and deaths.
- take opportunities to create environments surrounding homes that support residents to live healthy lives.
- work in partnership with the voluntary sector to support people who are homeless or at risk of homelessness.

## **How do we know we are making a difference?**

Key outcome measures that will be used to monitor progress towards achieving this ambition will be:

- a reduction in homelessness applications and acceptances.
- a reduction in the number of families with dependent children and pregnant women living in bed and breakfast accommodation.
- an increase in landlords sign up to the landlord register.
- an improvement in private sector housing standards - numbers of landlords licensed.

Other measures that will contribute towards our understanding of progress include:

- a reduction in fuel poverty.
- a reduction in excess winter deaths.
- an increase in social housing supply available to those in housing need through the delivery of the affordable homes programme.

## Ambition 6: End of life care

### Why is this important for Redbridge?

Redbridge has more than 36,000 people aged 65 and over. This represents over 12% of the population and projections show an increase of 8,800 by 2026. In Redbridge, just over 40% of deaths occurred in adults aged 85 and above which is higher than both the London and England average. As a greater proportion of people die during very old age and/ or with an increasing range of complex medical conditions, consideration of quality end of life care for those with complex health and social needs is crucial to ensuring the systems and services are in place to support the service users and their families and carers.

Population based studies indicate that the majority of people would prefer to be able to die at home - wherever people are, we want to enable them to live and die well, with appropriate support available for bereaved carers, family and friends. In addition early support also avoids costly and unnecessary admissions to hospital, and ensuring that residents have the advice, information and support when required to have a choice in where they die is essential.

### What do we know?

- over 60% of Redbridge residents die in hospitals compared to over 53% in London and 47% nationally - amongst the highest proportion in the Country, and seen across all age groups.
- only 20% of deaths in Redbridge occur in the persons own home. This is the lowest in London and eighth lowest nationally.
- around 15% of deaths occur in care homes, whereas across London this ranges from over 5% up to 21%.
- Redbridge residents experience the second lowest percentage of deaths in hospices and other places in London.

### Our Ambition

**People who are reaching the end of their life are identified early, and supported with their family or carers to live their end of life as well as possible.**

### We will continue our progress to achieve our ambition by:

- effectively planning care and support for people reaching the end of life by involving the individual and carers in the planning process and ensure that services and professionals work together to provide the right help at the right time.
- raising awareness and empower professionals and local communities regarding the importance of honest, informed and timely conversations about choices for end of life care.
- enabling people at the end of their lives to make choices about where they receive their care.
- building on existing work, develop a coordinated approach to end of life care by ensuring that the recognised 'building blocks' are in place, which includes an accessible 24/7 advice service and the enhanced community based care including Hospice at Home.

## We will challenge ourselves to:

- earlier identification of people (children, adults and older people) who are reaching the end of life.
- establish a coordinated approach across health, social care and the wider community including the development of shared records across health and social care.
- explore opportunities for information sharing between service providers to assure appropriate actions at times of crisis.
- explore how people with communication difficulties (such as dementia, learning disability or Autism) are supported to make their choices about end of life known.
- identify the needs of isolated older people including those caring for someone with a life limiting or long term condition.

## How do we know we are making a difference?

Key outcome measures that will be used to monitor progress towards achieving this ambition will be:

- an increase in the proportion of people who die in settings other than hospital.

Other measures that will contribute towards our understanding of progress include:

- an increase in the number of personal health budgets for people at end of life.
- the number of shared electronic health and social care records for people in the last year of life.
- identify and reduce inequalities in the number of people taking up end of life care services.



## 7 How do we know we are making a difference?

The Health and Wellbeing Board are responsible for overseeing the delivery and progress of this strategy. In recognition of the complex and changing environment we are operating in, the Board will follow an annual delivery plan and reporting cycle that demonstrates how we are progressing against our ambitions.

The Board will use key outcome measures identified under each ambition to monitor progress as well as a range of other health and wellbeing measures to understand development. Progress towards broader health and wellbeing gains will be monitored using the Adult Social Care, NHS and Public Health Outcomes Frameworks.

### Population health and wellbeing measures:

- life expectancy: at birth/at age 65 years
- healthy life expectancy
- the difference in life expectancy between areas of highest deprivation and areas of least deprivation (slope index of inequality)
- infant mortality





| Ambition                           | Key outcome measures to monitor progress   | Other measures to inform understanding   |
|------------------------------------|--|--|
| Achieving the best start in life   | <ul style="list-style-type: none"> <li>■ increased uptake of developmental antenatal checks at birth, 6 weeks, 1 year and 2 and 2½ years.</li> <li>■ halt the year on year increase of childhood obesity.</li> <li>■ children are assessed as being 'ready for school' at aged 5.</li> </ul>   | <ul style="list-style-type: none"> <li>■ increase in women accessing early antenatal services.</li> <li>■ increase the proportion of children and young people who receive immunisations</li> <li>■ increase the proportion of babies who are breastfed.</li> <li>■ increase in physical activity among children and young people.</li> <li>■ decrease in tobacco use by children and young people.</li> <li>■ decrease in alcohol consumption among children and young people.</li> <li>■ increased increase take up of early education for 2 year old children eligible for a funded place.</li> <li>■ improved educational achievement – reduce the gap in achievement between children on free school meals and peers.</li> <li>■ improve the experience of service use among children with complex needs and their families</li> <li>■ children with complex needs have timely, well planned transition to adulthood in line with legislation.</li> </ul> |
| Diabetes prevention and management | <ul style="list-style-type: none"> <li>■ halt the year on year increase in obesity levels for both children and adults.</li> <li>■ reduce the rate of diabetic complications by increasing residents who receive the updated NICE care processes and diabetic eye screening (Diabetic Retinopathy screening).</li> <li>■ increase the number of residents who currently have undiagnosed diabetes to receive a diagnosis.</li> </ul> | <ul style="list-style-type: none"> <li>■ increase in physical activity for both children and adults.</li> <li>■ increased uptake of NHS Health Checks.</li> <li>■ a reduction in emergency admissions due to diabetes.</li> </ul>  |

| Ambition   | Key outcome measures to monitor progress   | Other measures to inform understanding  |
|--|--|---|
| <b>Mental Wellbeing</b>                            | <ul style="list-style-type: none"> <li>■ percentage of adults in contact with secondary mental health services who are in paid employment and those who live independently with or without support.</li> <li>■ a reduction in the numbers of suicides of all ages.</li> <li>■ reduce the gap in mortality between those who have long term mental health conditions and the general population.</li> <li>■ reduce social isolation as measured by the percentage of adult social care users who have as much social contact as they would like.</li> </ul> | <ul style="list-style-type: none"> <li>■ increase in referrals to the memory clinic.</li> <li>■ monitor patient and carers experience of community mental health services.</li> <li>■ reduction in emergency admissions to hospital due to mental health causes for both children and adults.</li> </ul>  |
| <b>Cancer</b>                                      | <ul style="list-style-type: none"> <li>■ increased uptake to cancer screening.</li> <li>■ increased diagnosis of early cancer.</li> <li>■ increased survival (measured at one year and at five years) from cancers.</li> </ul>   | <ul style="list-style-type: none"> <li>■ reduction in the incidences of cancer.</li> <li>■ reduction in the premature mortality rate for cancer.</li> <li>■ an increase in the numbers of residents quitting smoking and a decrease in numbers of residents using tobacco products.</li> <li>■ halt the year on year increase in obesity for both children and adults.</li> <li>■ increase in the uptake of physical activity among children and adults.</li> </ul> |
| <b>Living well in a decent home you can afford</b> | <ul style="list-style-type: none"> <li>■ a reduction in homelessness applications and acceptances.</li> <li>■ a reduction in the number of families with dependent children and pregnant women living in bed and breakfast accommodation.</li> <li>■ an increase in landlords to sign up to the landlord register.</li> <li>■ an improvement in private sector housing standards - numbers of landlords licensed.</li> </ul>   | <ul style="list-style-type: none"> <li>■ a reduction in fuel poverty.</li> <li>■ a reduction in excess winter deaths.</li> <li>■ an increase in social housing supply available to those in housing need through the delivery of the affordable homes programme.</li> </ul>   |
| <b>End of life care</b>                            | <ul style="list-style-type: none"> <li>■ an increase in the proportion of people who die in settings other than hospital.</li> </ul>   | <ul style="list-style-type: none"> <li>■ an increase in the number of personal health budgets for people at end of life.</li> <li>■ the number of shared electronic health and social care records for people in the last year of life.</li> <li>■ identify and reduce inequalities in the number of people taking up end of life care services.</li> </ul>   |



# 8 Appendices

## 1. Governance

Information about the Redbridge Health and Wellbeing Board can be found [here](#).

## 2. Data Sources

All data has been sourced from the following:

- Annual Public Health Report
- Joint Strategic Needs Assessment

These can be found [here](#). All data is correct at time of publication of the document.

## 3. Performance Measures

Our performance measures are linked to the following national outcomes frameworks. Improvement on performance is based upon an increase/decrease (as stated in the performance indicator) from established baselines. Performance will also include those outcomes from the relevant specific thematic strategies.

- Adult Social Care Outcomes Framework provides robust information that enables monitoring of the success of local interventions in improving outcomes, and to identify priorities for making improvements. For further information visit [here](#).
- Public Health Outcomes Framework sets out a vision for Public Health and helps understand how well public health is being improved and protected. For further information visit [here](#).
- NHS Quality Outcomes Framework is a mechanism utilised in primary care to monitor progress towards national primary care targets relating to some of the most common chronic diseases, e.g. asthma, diabetes, major public health concerns, e.g. smoking, obesity and preventative measures, e.g. regular blood pressure checks. For further information visit [here](#).
- Adult Social Services Local Account is produced annually to give an account on the work that we do, how we are performing and what we and others believe we need to do in the future to improve our services. For further information visit [MyLife](#).
- Annual Public Health Report is an annual document which provides an update on the latest data and summary of health within the borough. For further information see link above.

