The term ‘preventative service’ applies to the provision of services, facilities or resources that:

- prevent a need from occurring
- minimise the effect of a disability; or,
- help slow down any further deterioration for people with established health conditions, complex care and support needs, or caring responsibilities.
## Adult Prevention & Early Intervention

**Lead Service Area:** Adult Social Services  
**Date:** 2 July 2015

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<th>Cabinet Portfolio: Adult Social Services, Health &amp; Wellbeing</th>
<th>Stage: Final</th>
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<tr>
<td><strong>Author:</strong> Julie Fanning</td>
<td><strong>Version:</strong> 1</td>
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1. **Foreword**

Welcome to the Updated Joint Adult Prevention & Early Intervention Strategy which is a refresh of the previous document produced in 2011-14. The Strategy has been developed through consultation and involvement of people who use, plan, commission and provide services and from what we know about local demographics and the growing needs of the population in Redbridge.

The Strategy recognises that the health and social care system nationally and locally is under increasing pressure due to Government austerity measures, legislative change, increasing demand for services and higher expectations from the public. In order to keep pace with the transformation of public services both health and social care are already making fundamental changes to ways of working through integrated working arrangements and by increasingly focusing on prevention and early intervention approaches to improve outcomes for individuals and achieve necessary efficiencies.

The refreshed Strategy reflects a continuation of the previous strategic direction which includes a cross cutting partnership approach, acknowledging that no single agency can achieve good preventative outcomes alone.

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**Councillor Mark Santos**  
Cabinet Member for Health & Social Care  
Chair Redbridge Health & Wellbeing Board

**Dr Anil Mehta**  
Chair of Redbridge Clinical Commissioning Group  
Vice Chair Redbridge Health & Wellbeing Board

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**Tell us what you think of this Strategy**

We are very keen to hear what you think of our plans and would welcome your thoughts and ideas on what further actions you think will help us to continue to improve and achieve our Vision for the future. If you would like to comment, make a suggestion, or would just like more information you can contact us by:

1. Emailing your comments to myview@redbridge.gov.uk
2. Asking for a discussion by emailing Julie Fanning, Executive Policy Adviser to julie.fanning@redbridge.gov.uk

The formal consultation on this strategy ended on 20 September 2015; however your views are welcome at any time, as this is an ongoing process which will inform the development of the Redbridge Joint Health and Wellbeing Strategy from 2016.
2. Executive Summary

The Redbridge Prevention and Early Intervention Strategy has been refreshed for 2015-18 to reflect major changes taking place across health and social care. It builds on existing commissioning strategies and plans to improve the health and wellbeing of the local community, by putting them at the centre of their care and providing support in an integrated way. It highlights areas where shared care pathways and outcome based commissioning can improve service quality, productivity and the service user and carer experience.

The Strategy takes account of the Council’s Corporate Strategy which is an overarching document that unifies all of the Council’s activities. It sets out the shared vision for the Council, Ambitious for Redbridge, and outlines four Corporate Priorities to help achieve this vision:

- Increase **FAIRNESS** and respond to the aspirations of the Borough
- **EMPOWER** communities to help shape our Borough and the services we deliver
- **IMPROVE** quality of life and civic pride amongst our communities
- **TRANSFORM** our Council in tough times to be dynamic and responsive to the challenges of the future

In addition to the Council’s Corporate Strategy above, the NHS 5 Year Forward Plan, the Care Act 2014, the Children & Families Act 2014, the Better are Fund, the Redbridge Clinical Commissioning Group’s (RCCG) 5 year strategy Appendix 1 and the Public Health Commissioning intentions are the key drivers for this Strategy. The Redbridge Health and Wellbeing Board continues to meet regularly to consider joint plans and strategies providing a joint response to the need for the public sector to meet the projected increase in demand for health and social care services, in the context of finite resources in an integrated way.

In developing the Strategy we have also considered the priorities outlined in existing strategies and plans which aim to improve the health and wellbeing of the community and reduce inequalities, including the current Health and Well Being Strategy and the findings of the Joint Strategic Needs Assessment. This approach was agreed with our partners at a Health and Wellbeing Board Strategic Planning session and considered by the Redbridge Fairness Commission. The draft Strategy has been discussed at Council’s Service Committee and Cabinet meeting in June 2015 and Health and Wellbeing Board in July 2015.

It also takes account of recent legislation including the Children and Families Act 2014, the SEND Reforms and the Care Act 2014 which brings onto statute comprehensive changes in social care law bringing significant financial, cultural and attitudinal challenges for health and social care staff and the introduction of the Better Care Fund (BCF) which is a £3.8 billion national fund formed by bringing together existing NHS and social care funding streams. In order to access the BCF funding, all local authorities have been required to consider how they intend to meet the projected increase in demand for health and social care services in the future in an integrated way, in the context of finite resources and the changing NHS and social care landscape.

Evidence has shown that a key element of commissioning plans would be to improve preventative and early intervention services. They need to be targeted towards people with care and support needs, including carers, that would benefit most from interventions which help them live well and independently for as long as possible, empowering and supporting
them to self-care and, in doing so improve their wellbeing and prevent, reduce or delay the need for high cost care services.

This approach of providing early help to optimise health and wellbeing is seen locally as important for all age groups from expectant mothers, children and young people and adults through to older age. The Council’s Statutory duties, as set out in recent Acts, proactively promote increased integration with NHS partners and the NHS 5 Year forward view articulates the need for greater preventative approaches and for health to become a more activist agent of health related social change.

For the purpose of this Strategy, which focuses on adults, when we use the term “prevention and early intervention” we mean to ensure that people are not pushed into using long term health and social care services earlier than they need to, by helping them live active, independent lives and supporting them to manage any risks. We also aim to help people achieve as full a recovery as possible following a crisis, through the targeted use of intermediate care, reablement and community treatment services.

The Care Act 2014 describes the local authority duty in relation to prevention as follows:

\[ \text{a local authority must provide or arrange for services, facilities or resources, which would prevent, delay or reduce an individuals’ need for care and support or the need for support of carers.} \]

Preventative services would be an early intervention or activity that supports a person to retain or regain their skills or confidence; prevents a need for care and support occurring, and reduces an existing need or delays further deterioration. The activities of the local voluntary and community sector have a key role in reducing demand on health and social care services by helping people to care for themselves and each other appropriately.

The Action Plan sets out practical solutions, to improve preventative services and support for Redbridge residents. This is an evolving process and includes actions which may require resources to be identified, or a change in practice. It also highlights areas where integrated access, outcomes, commissioning and service delivery can improve quality and the service user and carer experience. Further actions will be added during and after the consultation process and will continue to be informed by consultation on other key strategies including the new Joint Health and Wellbeing Strategy for 2016-19

This Strategy also recognises that health and social care trends are not limited by borough boundaries. Some issues are common to all boroughs or concentrations of particular populations. This highlights the need and benefits of working together with the NHS, the London Boroughs of Barking and Dagenham, Havering and other London Boroughs.
3. Introduction

The demographic profile of England is changing bringing complex financial challenges to health and social care economies. Within 20 years half the adult population will be aged over 50 and currently over 65% of adults over 65 years say they have a long term condition, including dementia. Medical advancements help people with injuries and physical and learning disability to live longer and people with Downs Syndrome are at greater risk of having dementia at a younger age.

The current estimate of 15.4 million people with a long term condition will rise to 18.4 million by 2025. The Department of Health estimate that the treatment and care of people with long term conditions will account for 70% of the total health and social care spend in England. This picture of growth is reflected in Redbridge

When we use the term “prevention and early intervention” we mean ensuring that people are helped to live healthy, active, independent lives, supported to self-care and manage any risks and helped to avoid the need for long term health and social care services earlier than necessary.

This includes promoting access to sound advice and information; screening for those who would benefit most; and affordable, reliable and practical support in the home, including telecare and simple aids to daily living. We also aim to help people achieve as full a recovery as possible following a crisis, through the targeted use of intermediate care, reablement services and community based treatment teams. The Strategy identifies the areas of increased risk, where evidence has shown that earlier intervention can secure independence for longer.

To help plan for this approach, local authorities are required to identify adults with an unmet need for care and support, whether or not their needs are eligible and also carers, including those who are about to undertake a caring role, or who do not currently have a need for support. Care Act guidance sets out key areas that must, and those that should be implemented.

It is critical to the implementation of the Care Act that the care and support system works proactively to promote wellbeing and independence by identifying unmet needs, rather than waiting until people reach crisis point and meet the eligibility criteria. In order to meet these demands, new ways of working across health and social care are needed.

Appendix 2 provides some information taken from the Joint Strategic Needs Assessment and other sources about the changes taking place in the local population, the health and wellbeing priorities of the joint health and wellbeing strategy and some information about the demands on adult social care to help inform commissioning decisions.

The Action Plan (Chapter 8) highlights our plans to explore new ways of gathering and using market intelligence about the needs and choices of individuals; stronger and more collaborative relationships to develop new delivery models; and identification of an effective system to predict an individuals’ future need for intensive social or acute health care through an electronic records system accessible to key partner agencies. The Redbridge Clinical Commissioning Group’s Plan on a page (Appendix 1) sets out their future vision for service developments.
In terms of the continued delivery of personalised, preventative services, the following areas are given priority for people who use services and their carers:

- improved co-ordination of information, advice and advocacy services;
- hospital avoidance for example through falls reduction and community based re-ablement services; integrated crisis / rapid response services to arrange and provide immediate support;
- support planning and brokerage for all service user groups and self-funders to improve access to personal budgets across health and social care and help to navigate the health and social care system;
- support for carers including young carers including the development of an integrated care pathway and memorandum of understanding across adult and children's services
- access to integrated care pathways across agencies and sectors to improve outcomes including stroke pathways, end of life care, access to equipment / adaptations / repairs, appropriate housing and first point of contact;
- targeting communities with increased risk of long term conditions for example through screening and condition management; and
- services for people with mental health problems in crisis and support for adults with autism and those with complex needs that may challenge services referred to in the Green paper ‘no voice unheard no right ignored’.

The Voluntary and Community Sector’s role in Prevention and Early Intervention in Redbridge

The activities of Voluntary and Community Sector Organisations (VCSOs) greatly reduce demands on local NHS and Social Services by helping people to care for themselves and each other appropriately. Council services, GPs and practice nurses often see people whose physical and mental health and wellbeing is affected by wider social issues such as poor housing, social isolation, exclusion, debt, unemployment and caring responsibilities. They are often unable to address these without working in partnership with other stakeholders.

VCSOs offer a wide range of services that address these social determinants as well as helping prevent illnesses or deterioration in existing conditions. A single visit to a GP, for example, costs around £451 and leads to an average prescription cost of £42. Reducing the need for such visits is of great benefit to the NHS. Supporting people to find appropriate voluntary sector services can reduce social isolation, give specific health-related advice and information from peers, and encourage healthy activities and lifestyles. This improves the health and wellbeing of the individuals concerned and, by reducing and delaying their need for services or treatment, will save the public sector time and money.

Some areas of the country are currently developing “social prescription” services, where GPs and others can make out “prescriptions” for patients to access particular voluntary agencies’ services. In Redbridge we are using the Redbridge First Response Service in a similar way.

Each year Redbridge CVS produces “Our Health in Our Hands” – a document which gives a
snapshot of the kinds of services that voluntary groups deliver though case studies of local groups’ activities. There is a wide range of voluntary and community sector organisations in Redbridge, many of which contribute greatly towards improving the health and wellbeing of their members and, in so doing, reducing local health inequalities.

VCSOs are often established in response to an unmet need. Many of these work directly in health and social care, whilst others undertake activities which help improve the wider determinants of health and wellbeing. Work may focus on a particular part of the life course or on people with particular characteristics. VCSOs often work with the most disadvantaged communities – in terms of both geographic localities and communities of interest – which public sector bodies may find hard to engage. VCSOs can play a vital role in helping the public sector to communicate with these “seldom-heard” communities, to ensure their needs and aspirations are fully understood, and that these communities in turn understand the range of services available from the public sector locally, and how to use these appropriately.

For more information on the range of voluntary and community sector in Redbridge, please contact RedbridgeCVS:

Email: ross@redbridgecvs.net

Telephone: 020 85531004

Website: www.redbridgecvs.net
4. Vision and Definition

The Vision for health and social care services, as described in the Better Care Plan is that:

“All residents of Redbridge will have the support needed to improve their health and wellbeing and to reach their full potential”

To achieve this, the aim is to ensure Redbridge residents will get more of the right care, in the right place, at the right time, enabling them to live independently and at home for as long as possible.

‘Prevention’ can refer to a range of measures, services, facilities or other resources. There is no single definition of preventative activity; it can range from wide-scale, whole population measures aimed at improving health, to more targeted, individual interventions designed to improve the skills or functioning of one person or a particular group of people. It can also include measures to lessen the impact of caring on a carer’s health and wellbeing.

“Prevention” is often broken down into three general approaches: primary, secondary and tertiary prevention which are described below.

| Primary Prevention: Measures to prevent ill health and promote wellbeing. |
|---|---|
| Primary prevention is defined as interventions, services, or resources aimed at individuals or populations who have no current particular health or social care support needs. The aim of primary prevention is to help people avoid developing needs for care and support by maintaining independence, good health and increased wellbeing. Examples include programmes to promote healthy living and programmes to build strong resilient communities. |

| Secondary Prevention: Measures to identify those at increased risk of poor health or wellbeing and intervene early. |
|---|---|
| Secondary prevention refers to interventions or services aimed at individuals who have an increased risk of developing needs, with the aim of helping to slow down further deterioration or preventing more serious ill health from developing. In order to identify those individuals most likely to benefit from such targeted services, screening or case finding is generally employed. Examples include NHS Health Checks and providing additional support to carers. |

| Tertiary Prevention: Measures that delay or minimise the impact of existing health conditions. |
|---|---|
| Tertiary prevention refers to interventions aimed at minimising the effect of disability or deterioration in people with existing health conditions, complex care and support needs or caring responsibilities including supporting people to regain skills and reduce need where possible. Local authorities must provide or arrange services, resources or facilities that maximise independence for those who already have such needs. Examples include reablement and support to people with serious mental ill health. 

The course of someone’s journey through prevention services is not necessarily a straight line with a person moving through the levels of preventative services in a successive way. For example, a person may still benefit from good quality information (primary prevention) whilst they are in or being discharged from Intermediate Care (tertiary prevention). |
5. Strategic Context

In addition to the Vision set out above, there are a number of national and local strategic drivers that influence our local planning. These include the Councils Corporate Strategy as detailed above; the Clinical Commissioning Group (CCG five year Strategy; the local response to the National Carers Strategy, (currently being refreshed locally); the Redbridge Dementia Plan; the Redbridge Autism Plan; and an End of Life Plan, currently under development. We also have in place a Redbridge Joint Health and Wellbeing Strategy; a Suicide Prevention Strategy; an Obesity Strategy; and Child Neglect and Child Sexual Exploitation Strategies, all making a contribution to the local prevention agenda.

The Barking Havering and Redbridge Care Coalition, which is a partnership across the NHS and social care involving the three boroughs, agreed their first priority is to improve services for people with complex needs, including vulnerable people and those with multiple long term conditions including dementia, through greater integration of services and preventative activities. They aim to maximize the benefits of working across borough boundaries on health and social care issues by identifying the best configuration of services to meet local need within the resources available.

The Prevention and Early Intervention Strategy provides an over-arching vision that gives focus for all the interventions that take place. It presents a strategic vision to put Redbridge residents at the heart of the prevention agenda and aligns with existing joint strategies and plans supported by health and social care partners, aiming to help people live well and independently for as long as possible, while empowering and supporting them to self-care.

In addition to the above, local authorities are responsible for delivering on their duties under the Care Act 2014, which brings about the biggest change to adult social care law in fifty years.

The Care Act (2014)

The Care Act (2014) sets out a range of additional statutory duties for local authorities, including a number related to the prevention agenda. It is critical to the vision in the Care Act that the care and support system works proactively to promote wellbeing and independence, rather than waiting until people reach crisis point. The Care Act places a duty on all local authorities to provide, or arrange for the provision, of services, facilities or resources, or take other steps, which it considers will contribute towards preventing, delaying or reducing the development of needs for care and support by adults and/or their carers in its area.

In particular, local authorities must consider how to identify “unmet need” – i.e. those people with needs which are not currently being met, whether by the local authority or anyone else - for example through activities including screening or case finding. Understanding unmet need will be crucial to developing a longer-term approach to prevention that reflects the true needs of the local population.

In order to deliver the prevention agenda, the health and social care system will need to fundamentally change so that it intervenes early to support individuals, and helps people to retain or regain their skills and confidence and prevents or delays further deterioration wherever possible.
The Care Act specifies that a local authority’s responsibilities for prevention apply to all adults including:

- Adults who do not have any current needs for care and support
- Adults with needs for care and support, whether their needs are eligible and / or met by the local authority or not; and
- Carers, including those who may be about to undertake a caring role, or who do not currently have any needs for support.

The table below sets out what the Care Act 2014 defines what local authorities ‘must do’ specifically in relation to the prevention agenda, and also suggest what they ‘should do’ to ensure Care Act compliance.

<table>
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<th>We MUST:</th>
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<tr>
<td>• Identify and understand current and future demand for preventative services</td>
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<tr>
<td>• Understand the supply of services, facilities and other resources already available</td>
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<td>that could support prevention and be part of an overall local approach, including Market position statements</td>
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<td>and asset based elements of JSNA)</td>
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<tr>
<td>• Consider how to identify “unmet” need</td>
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<tr>
<td>• Promote diversity and quality in provision so that people have a choice of provider</td>
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<tr>
<td>• Ensure the integration of prevention with health and health-related services including housing</td>
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<tr>
<td>• Establish a service providing information and advice - including preventative services.</td>
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<th>We SHOULD:</th>
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<tr>
<td>• Engage all providers to encourage innovation in supporting a preventative approach</td>
</tr>
<tr>
<td>• Consider how to align/integrate prevention approaches with local partners</td>
</tr>
<tr>
<td>• Consider the different opportunities for coming into contact with people including where the 1st contact</td>
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<td>is not the local authority.</td>
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Consultation and Engagement

The Prevention & Early Intervention (P&EI) Strategy 2015-18 is an update of the first Adult P&EI strategy produced in 2011. Prior to that date Redbridge did not have a formal plan in place. Since then, the Government has significantly raised the priority given to preventative services and support through the introduction of national strategies and plans, such as for carers, people with dementia and adults with autism and those approaching end of life.

In addition as detailed above, the Government introduced the Better Care Fund which is designed to focus existing resources towards integration and preventative services and the Care Act 2014, which brought about the most significant change to social care law in 50 years. Having a joint P&EI strategy in place with NHS and social care partners strengthened our position considerably in terms of clarifying our intentions and served as a platform for discussion about future developments.

The cross cutting nature of prevention and early intervention is both broad and complex and covers all age groups, and features in a wide range of national strategies, plans and legislation which the local authority and NHS are required to respond to locally. It creates a challenge in terms of seeking views from stakeholders from various perspectives and a risk of consultation overload which we have to manage as best we can. We therefore built on the
extensive consultation that took place for the original plan and the findings from ongoing engagement during 2013-15 to inform the development of this refreshed Strategy. This includes Adult Social Services, Public Health and CCG commissioning priorities, which were presented and discussed in detail at the Health and Wellbeing Board meetings during the municipal year.

In March 2015 discussion took place at the Health and Wellbeing Board Strategic Planning workshop to consider whether it would be useful to refresh the Prevention Strategy which had expired, or whether to wait for the renewal of the Joint Health and Wellbeing Strategy (JHWS) which expires in 2016 and also has a focus on prevention and early intervention, covering adults and children and the wider community. It was agreed to proceed with a refreshed Prevention Strategy for adults that would inform the development of the JHWS, acknowledging that consultation on both documents during 2015 may overlap and would be complementary. The intention is to include a Chapter on Prevention and Early Intervention in the new JHWS.

Examples of changes as a result of consultation have included:

- promoting access to ReFRS for GPs as they are cited as the most likely first point of contact for isolated and vulnerable people;
- aligning adult social care support including the voluntary sector with GP clusters and community based support for people with memory problems and their carers, aiming to provide a clearer more seamless circle of support.
- developing the My Life website to make it more user friendly;
- established an Approved Provider List for home care support which ensures that where people for example have complex needs, are approaching end of life, or require a greater understanding of their condition such as dementia, there are agencies with the appropriate skills to meet their needs, enabling service users to choose which agencies they use; and
- adding outcomes that needed further development to Action Plans for condition specific local Plans such as the Dementia Plan ‘Don’t you forget about me’ and the Autism Plan Refresh currently under development

Methods for consultation have included discussions at working groups such as the Redbridge Dementia Partnership, Redbridge Autism Working Group, Carers Strategy Steering Group and also Focus Groups on particular issues such as the content of the specification for the Home Care Approved Provider List with the Carers Support Service and Age Uk BHR and the Autism Self- Assessment framework. There has also been a number of wider consultation sessions such as the annual Redbridge Budget Consultation with the voluntary and community sector, the Care Act Consultation, the Green Paper ‘No voice unheard, no right ignored’, and the Fairness Commission session on ‘Getting older: keeping well’ all of which provide a source of information about the views of people currently (or potentially) using our services and their carers.

Public Health have also been fully engaged in the development of the strategy through the Joint Strategic Needs Assessment and influenced the decision to proceed with a refreshed version of the strategy for adults, to allow more time to develop the new JHWS, based on local developments in Public Health and the drivers for more integrated working across the council and NHS under consideration during 2015-16.
6. Commissioning Intentions

Commissioning for Outcomes
This chapter shows that work has been carried out to promote prevention and early intervention approaches while maximising efficiency, improving quality and customer satisfaction across the council and in partnership with the NHS.

Our continuing to drive to commission person-centred, integrated care and support services reflects the requirements of the Care Act (2014) and health service ambitions outlined nationally for the increasing personalisation of care, the NHS, Public Health and Adult Social Care Outcome Frameworks, and the NHS and Adult Social Care Commissioning for Outcome Guides. This has local resonance as a ‘Year of Care’ pilot site with the partnership working between people with long-term conditions and health professionals to develop personalised care planning.

There has been both a high level strategic approach to commissioning intentions across Barking, Havering and Redbridge (BHR) through the Integrated Care Coalition Strategic Plan aiming to achieve a series of high level outcomes through to 2019 and a local approach through the Redbridge CCG Plan (Appendix 1) and the Plan for the Redbridge Better Care Fund.

The Integrated Care Coalition Strategic Plan sets out the following outcomes

- Reduction of the number of years of life lost by 18%
- Improved health related quality of life for those with one or more long-term conditions by 4%
- Reduced avoidable time in hospital through integrated care by 13%
- Increase the percentage of older people living independently following discharge by 3%
- Reduced percentage of people reporting a poor experience of inpatient care by 12%
- Reduced percentage of people reporting a poor experience of primary care by 15%
- Reduced number of hospital avoidable deaths by reducing the expected mortality rate at BHRUT (Barking, Havering and Redbridge University Hospital Trust) by 9%

To achieve the outcomes, a number of key interventions are planned which cut across the health and social care economy and impact on adults and children’s health and social care.

Prevention and Health Promotion
Public health is about improving the health of the population, rather than treating the diseases of individual patients. It covers:

- Improving the wider determinants of health
- Health improvement and health protection
- Healthcare and preventing premature mortality

This includes the Cancer Commissioning Strategy for London priorities and the NHS England priorities of cancer screening and immunisations and finally the Barking and Dagenham, Havering and Redbridge priorities:

- Chronic disease and falls
- Alcohol
- Social determinants of health
- Mental ill health
Primary Care Transformational Programme
The Primary Care Transformational Programme aims to allow local GPs to lead a system that empowers patients to feel more supported to manage long term conditions and increase positive patient experience and reduce unplanned attendances and admissions to hospital.

BHR Integrated Care Programme
The vision and strategy for integrated care has been developed with the needs of people at its heart, aiming to help them live well, and independently, for as long as possible and empowering and supporting them to self-care.

Person centred coordinated care is being delivered across the system, designing care around patients, making sure that they receive the right care in the right place, at the right time and ensuring that different services ‘talk’ to each other, reducing inefficiencies in care.

The strategy aims to support and care for people in their homes or closer to home, shifting activity from acute to community (supporting acute reconfiguration plans), in particular locality settings.

Acute Re-configuration Programme
The Health for North East London Programme, led by clinicians, was established as a major change programme in response to the case for change. The focus is now on:

- Delivering the changes and improvements in emergency and urgent care.
- Developing and agreeing the vision for King George Hospital.
- Implementing the planned care changes.

Planned Care Programme
The Planned Care Programme aims to improve health services for local people by separating the planned surgery pathway from emergency pathways where appropriate, and improving productivity

Mental Health Services
The CCGs and the local authorities will build joint commissioning relationships over the next two years and a borough approach is likely for the development of mental health and wellbeing commissioning strategies. The key areas included in the scope of the strategic framework are likely to include:

- Adults and children
- Parity of esteem
- People diagnosed with mental illness
- Emotional health and wellbeing

Following the publication by Government of the Mental Health Crisis Care Concordat, aimed at improving outcomes for people experiencing mental health crisis, Barking & Dagenham, Havering and Redbridge CCG developed an action plan in partnership with the local authorities and physical and mental health care providers and confirmed their commitment to work with other key strategic partners, including the Metropolitan Police, London Ambulance Service and voluntary and community sector partners to implement the actions.

A Redbridge specific Mental Health Crisis Concordat Action Plan, including some issues relevant across BHR, is in place to drive and deliver local improvements to crisis care. This includes commissioning and partnership responsibilities, as well as actions to improve prevention, access, treatment and recovery provision. Some of the cross cutting issues are included in the Action Plan.
Implementation of the Redbridge Dementia Plan ‘Don’t you forget about me’, which was adopted by the Health and Wellbeing Board and the Council’s Cabinet in 2014, continues to be monitored by the multi-agency Redbridge Dementia Partnership. A review of achievements (which are considerable) has taken place and following further discussions in the 4 Work streams which focus on Community Development, Advice and Information, Personalisation and Learning & Development, new actions will be developed and built into an updated Action Plan.

**The Better Care Fund**

The Better Care Fund was formed as part of the Government’s spending review. It created a national £3.8 billion pool of NHS and local authority money to support the model of integrated health and social care by aiming to reduce NHS demand and improve joint planning for the sustainability of local health and social care economies. It builds on the success of previous transfers of funding (Section 256 monies) from NHS to Councils since 2011 and, as such, the fund consists of a number of differing existing funding streams to Clinical Commissioning Groups and Local Authorities, anticipated annual grants, as well as recurrent capital allocations. The national criteria for accessing the resource and details of local allocations were announced in November 2013.

All local authorities and Clinical Commissioning Groups have been asked to set out in a Plan how they intend to use the Better Care Fund allocated to each area. The Redbridge BCF Plan was considered by the Redbridge Health and Wellbeing Board during its development in 2014, submitted to NHS England in September and received approval in October.

The Council entered into a Section 75 agreement with Redbridge CCG, commencing April 2015, in order to access the Better Care Fund (BCF) monies and deliver the programme of work as detailed in the Plan which set out actions to achieve the outcomes agreed for both 2014/15 and 2015/16.

Adult Social Services already had two existing Section 75 agreements with NHS partners for the provision of care services in Learning Disabilities and Mental Health. The Section 75 agreements provide a framework for pooling the financial resources between the Council and NHS partners.

The total 2015/16 revenue funding for the BCF is £16.032 million. Of this, £5.115 million will come to the local authority via the CCG to be spent on schemes as agreed in the Better Care Fund Plan. The remaining £10.917 million will be spent directly by the CCG on schemes as approved in the Better Care Fund Plan. This is not new funding and the £5.115 million to be spent by the local authority is already in the Adult Social Services revenue budget.

Of the £16.032 million, £1.2 million is dependent on performance of the local target for reducing total emergency admissions to hospitals. This funding will be at risk if the target is not achieved. This is a significant risk to the Better Care Fund as any reduction in funding will have an impact on the schemes to be delivered and could have a knock-on impact on the Adult Social Services revenue budget. The Section 75 agreement will need to contain clear guidance as to how this risk will be shared between the partners.

The portion of the fund protected for the NHS will be linked to performance against locally determined emergency admissions targets. A national target was set at a 3.5% reduction in emergency admissions. However, due to the challenged health economy across two major
acute providers in Redbridge, a target of 3% was agreed by the Health and Wellbeing Board (HWB), to avoid the risk of destabilising these organisations by aiming higher to achieve the national target.

The payment for performance will only be measured against the total number of emergency admissions metric. The level in reduction of emergency admissions during the first quarter of January - March 2015 will be compared against the performance for the same period in 2014. This will determine whether or not the performance related payment will be released.

In addition to the above national target, further outcomes to test the effectiveness of interventions have been set at local level, which are:

- Residential admissions – reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- Effectiveness of reablement - Proportion of older people (aged 65 and over) who were at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduced delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)
- Improved patient and service user experience - overall satisfaction of people who use social care services
- Local metric - reduction in injuries due to falls in people aged over 65

A series of related plans and strategies including service improvement plans, and commissioning intentions have been developed jointly to help deliver against these and other national priorities. Work has been carried out across Adult Social Services and Redbridge CCG to set a baseline for each target in the Better Care Plan to enable performance to be measured. Schemes in place to help deliver planned outcomes include Seven Day Social Care in Hospital, Discharge Management, Prevention, Early Intervention and Self-Care and End of Life Care.

Public health roles and responsibilities were transferred to the Council on 1st April 2013, as required by the Health and Social Care Act 2012. The public health budget is ring fenced for delivery of the public health responsibilities that now rest with local authorities, including the cost of public health staff that are directly employed and the various service contracts that deliver public health services and health improvement interventions.

Redbridge Public Health has since drawn up a comprehensive commissioning and procurement plan with the aim of improving the effectiveness and efficiency in all areas of work. Public Health Services cut across many areas of health and social care and as part of the commissioning priority development; it has also identified the linkages between Public Health commissioning and the inter-dependencies to other parts of the Council and partner agencies priorities which have been taken into account in setting the commissioning intentions.

In April 2013 there were roughly 32 public health contracts transferred to the Council as part of novation and a significant number of small pharmacy and GP contracts. In order to enable a manageable process for the transfer of contracted activity to the Council most of the existing public health contracts were extended for a year to allow time to review them and ensure they reflect local commissioning intentions and Joint Strategic Needs Assessment (JSNA) priorities.
Effective prevention and early intervention systems across health and social care can maintain dignity and respect, improve quality of life, maximise choice and control and increase health and wellbeing for people, whether they are living independently at home, have complex long term needs and, or live in residential or nursing home care. Increasing self-directed support through the take up of direct payments and personal budgets and promoting peer support will be a key element of ensuring that service users have more control over the choices they make about the services they use, resulting in better outcomes for people’s lives. There is a need to review and change business processes within the statutory and provider sectors and stimulate market development to create the flexibility required to support self-directed services.

Access to external support planning and brokerage is important for implementing personal budgets and direct payments for people who may not be confident or have support from carers, family and friends. The self-directed support model is designed to recognise and support a person’s informal support networks such as family and friends, neighbours and volunteers. Evidence gathered by the Social Care Institute for Excellence (SCIE) shows that people who hold personal budgets use them to increase participation and activity in their communities. Greater involvement with and access to community networks and support is being shown as having a preventative effect by reducing isolation and the idea of people with a variety of needs and abilities pooling personal budgets, including personal health budgets, to buy services they want to use should be explored in more detail.

**Public Health commissioning intentions**

Public Health has both mandatory and non-mandatory services to commission; and has a duty to promote the health of the local population (see figure 3). In Redbridge the commissioned services were major delivery areas such as sexual health, drug and alcohol services, children’s public health services, weight management, NHS health checks and smoking cessation services. A wide range of contracts are held with a variety of providers, which include Acute Trust (BHRUT), NHS Foundation Trust (NELFT), Council, GPs, pharmacists, private sector and large and small voluntary organisations. There remain some inequalities in terms of access across the Borough; due to the historical commissioning arrangements and review of some services indicated a lack of preventative services, duplication of provision and lack of pathways. This is particularly evident in Sexual Health and Substance Misuse services.

The novation of the contracts in 2013 left limited scope to drive significant change in the first year. However, Public Health have made a concerted effort to make significant improvements and are exploring and evaluating the linkages between Public Health commissioning and that conducted in other parts of the Council. There are many examples of related activity and inter-dependence, and these needs to be assessed to drive both efficiency and effectiveness. Examples include physical activity, falls prevention, work on drug and substance misuse, and both children’s health and older people’s services.

A mapping exercise of preventative services is currently underway and has already identified a good range of universal and preventative services. However there needs to be more work to develop better co-ordination and clarification of where there may be duplication, or where new technologies can free up resources, for example in the provision of universal advice and information services. There is also a need to ensure there are clear and effective care pathways to enable timely and responsive referrals to appropriate services and support, which will also benefit from better co-ordination.
There are good examples of recovery and continued support services. However, there are gaps in terms of community based options and a need to develop more support and systems to enable the implementation of personalized services. This may require less building based services and more floating or mobile support, backed up with appropriate technology, which can enhance responsiveness to rising caseloads and improve quality of care. It can also help deliver savings and boost efficiency.

Preventative interventions can enable people to take personal responsibility, by helping them to live active lives as citizens for as long as possible. They should not feel pressured into using health and social care earlier than necessary and should be supported to manage any risks.

**Adult Social Care Commissioning Intentions**

Adult Social Services have produced the list below to highlight the focus for services and support commissioned from 2015. The Commissioning for Better Outcomes Route Map, produced by University of Birmingham with a range of partners, will be used as a guide to improve commissioning practice aiming to achieve good outcomes for people using evidence, local knowledge skills and resources to best effect. As mentioned previously, it is recognised that this cannot be achieved in isolation and many of the activities described below form part of the Better Care Fund schemes and are in response to the Adult Social Care and Public Health Outcomes Frameworks, which aims to deliver person-centred, integrated care and support services as required under the Care Act 2014 and ambitions in NHS 5 year Forward View.

<p>| Commission Supported Living services as an alternative to Residential Care to support people to remain independent in the community and enable recovery focused care to people with mental health problems | Engage the market in particular registered providers to source suitable properties and develop outcome and recovery focused services to meet the demand |
| Commission Extra Care service to complement and where appropriate provide an alternative to Residential and Nursing Care | Commission Extra Care services in conjunction with Housing service from April 15 |
| Implement the trail blazer program of issuing Direct Payments in Residential Care | Collaborate with key stakeholders including providers, service users and their families to implement the use of Direct Payments in Residential care |
| Review and where appropriate remodel day opportunities services, ensuring services working with vulnerable people operate high quality standards | Work with providers including in-house services to deliver person centred and recovery oriented day service; ensure quality and safeguarding standards are maintained whilst working with people with high support needs |
| Commission a range of Prevention and Early Intervention Services to delay and/or reduce the need for care and support | Continue to commission outcome focused reablement services; equipment services; work with CCG and Public Health to commission voluntary sector services that reduce social isolation, provides support to carers, healthy living activities, respite and specialist services |</p>
<table>
<thead>
<tr>
<th>Action/Strategy</th>
<th>Description or Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remodel intermediate care service in line with existing social care reablement service and Community Treatment Team (CTT) to enable an integrated community based reablement/rehabilitation service provision</td>
<td>Work with CCG to commission an integrated Community Service provision that incorporates health and social care elements</td>
</tr>
<tr>
<td>Enhanced falls service as part of integrated care service</td>
<td>Gap in falls service identified in relation to prevention; Review current provision with CCG.</td>
</tr>
<tr>
<td>Develop Integrated Case Management (ICM) further to widen the scope and link effectively with other community social care and health services</td>
<td>Review the full year effect of ICM and work with stakeholders to improve performance; engage new partners to address gaps and link to community services</td>
</tr>
<tr>
<td>Implement seven day working to facilitate timely and appropriate discharge and prevent unnecessary hospital stays</td>
<td>Arrangements with CCG, Acute Trusts and Providers have been put in place and the impact will be reviewed to determine longer term arrangements</td>
</tr>
<tr>
<td>Improved quality of care for nursing home residents</td>
<td>Work with CCG to support and monitor nursing care providers in meeting approved quality standards</td>
</tr>
<tr>
<td>Improved co-ordination End of Life (EOL) Care in relation to the recommendations contained in the National End of Life Strategy</td>
<td>Work with CCG, Acute Trusts and Providers to develop and implement plan to improve end of life care in all care settings</td>
</tr>
<tr>
<td>Develop a tariff for People with Long Term Conditions (LTC) through the national Year of Care Pilot</td>
<td>Identify the cohort of people with LTC and work with CCG and acute trust to model virtual year of care budgets</td>
</tr>
<tr>
<td>Streamline and consolidate Continuing Health Care arrangements across Direct Payments, home care, care homes and equipment services</td>
<td>Review the existing arrangements with CCG and develop a way forward for efficient joint commissioning arrangements, implementing Gold Standards framework</td>
</tr>
<tr>
<td>Develop joint commissioning intentions for people with learning disabilities and challenging behaviour and progress joint commissioning arrangements in line with the Winterbourne Concordat.</td>
<td>Work with the LD Partnership Board and CCG and link to relevant actions identified in the Autism Plan and the review of People with Learning Disability and Challenging Behaviour</td>
</tr>
<tr>
<td>Continue to implement the Redbridge Autism Plan review and refresh the Plan in the light of the new focus of the revised National Autism Strategy 2014</td>
<td>Work with the Adults with Autism Working Group and monitor the delivery of the plan</td>
</tr>
<tr>
<td>Dementia: Review the current service provision across health, social care and public health to assess the care pathway and identify gaps</td>
<td>Work with the Dementia Partnership to review the existing action plan to ensure a joined up care pathway across early intervention to end of life care</td>
</tr>
<tr>
<td>Develop Redbridge as a Dementia Friendly Community</td>
<td>Explore with CCG, Public Health and the wider community ways to develop a Redbridge Dementia Friendly Community Initiative engaging the local community</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Develop joint commissioning intentions for people with mental health conditions, in line with the recovery model and ensure services are joined up and complementary across social care, and health including public health</td>
<td>Work with CCG to build on existing section 75 agreement with NELFT; review joint commissioning arrangements for mental health services in the voluntary sector, continuing health care placements</td>
</tr>
<tr>
<td>Review commissioning of recovery based service contracts including mental health employment services</td>
<td>Services currently provided by providers, one jointly commissioned with CCG</td>
</tr>
<tr>
<td>Ensure care providers provide high quality recovery focused care to service users with mental health problems</td>
<td>Work in partnership with NELFT and implement an improvement program for residential care providers</td>
</tr>
<tr>
<td>Ensure care providers provide high quality care to service users with Dementia</td>
<td>Work with CCG and NELFT to support care home providers in implementing good practise models in working with people with dementia</td>
</tr>
<tr>
<td>Promote user led organisations and volunteering in Redbridge</td>
<td>Work with CIIL ® and Redbridge Volunteer Centre to promote the user voice and volunteering opportunities</td>
</tr>
<tr>
<td>Ensure effective partnerships between the Voluntary and Statutory sector</td>
<td>Manage the review and delivery of the Redbridge Compact; Review the Councils grants to voluntary and community sector scheme to enable the council to deliver the Corporate Strategy</td>
</tr>
<tr>
<td>Ensure high quality advice, information and advocacy services are in place which meet the diverse needs of the wider communities in Redbridge</td>
<td>Review and where required re-tender advice and information services to enable high quality service provision and meeting the requirements of the Care Act 2014 and the wider community</td>
</tr>
</tbody>
</table>

**Health and Social Care Integration**

Work is underway to explore the potential for greater integration across the NHS and social care, `building on the success of the jointly provided Community Mental health and Learning Disability services, through the development of an integrated health and adult social care service through a new partnership arrangement across adult social services, NHS and public health. Consideration will be given to the findings from significant work already undertaken as part of the transformation of Adult Social Care, Clinical Commissioning Group and North East London Foundation Trust.

**Partnerships with Children’s Services**

There is more work to do to smooth the transition between Adult and Children’s Services, and the development of a new Transition Team will facilitate this process. In addition, closer working across health and social care will be greatly assisted by the implementation and publication of the Joint Young Carers Protocol, which is currently being piloted with input from service users and carers. One of the key developments for children’s services in the
next five years is the development of a Children’s’ Commissioning Strategy. The aim of the Strategy will be to develop children’s services with the point of view of children in mind and increase health gain.

Recent work on the Special Educational Needs and Disability (SEND) reforms have greatly improved access to good quality information and advice, which helps people find their own solutions wherever possible.

**Screening and technology**
Screening and vaccinations for those who would benefit most and the provision of affordable reliable practical support in the home, including some tele care and simple aids to daily living, are important preventative services which are in place for people who do not meet the eligibility criteria.

There is strong evidence that shows prevention services targeted at people with specific long term conditions can have a greater impact on whether independence can be maintained. This would include services such as dental care, podiatry services, continence services, dehydration monitoring, falls prevention and stroke recovery. Health Analytics is an important tool for identifying those most at risk of losing their independence due to a number of long term conditions which, if managed effectively could avoid unplanned hospital admissions.

There is also increasing evidence of the contribution made by leisure services (Vision) to general health and wellbeing and increase independence i.e.

- People with active lifestyles have a lower risk of coronary, cardiovascular and respiratory disease than those who have inactive lifestyles;
- Participation in sport and physical activity can have a beneficial effect on mental health and bring an improved sense of wellbeing and self-esteem;
- Several rigorous, hospital-based studies involving control groups have shown that participation in arts activities can result in reduced stress levels and reduction in patients suffering depression; and,
- Dancing can bring a wide range of physical and mental benefit, stronger bones and reduced risk of osteoporosis, reduced risk of falls and reduced visits to A&E.

**Recovery and re-ablement support**
When they initially need health or social care, people should be enabled to achieve as full a recovery as possible and any crisis would be managed in a way which maximises chances of staying at home. This would include reablement services, health and social care crisis/rapid response services and more targeted use of tele care and aids to daily living. The use of the recovery model in mental health services and the provision of Improving Access to Psychological Therapies (IAPT) services also play a key role here.

When maximum recovery is achieved by an individual, if continued support is needed, personal budgets may be allocated providing the opportunity for individuals to choose how to spend the resource to meet their needs. A range of services need to be available which help them to retain or regain their independence, from effective support planning and brokerage, supported housing options, including clustered units and purpose built accommodation and day opportunities that offer access to training, volunteering and employment and the chance to make a positive contribution to the communities in which they live. There will be a need for active and integrated case management of those most at risk of greater dependency, enabling them to take as much control as possible over how
their condition is managed and to have in place effective electronic record systems to record individual needs and wishes and monitor outcomes.

**Our aim for the future is to have enabled more people to be:**
- More active and able to self-manage their health.
- Able to access appropriate support, contribute to and be part of a vibrant community.
- Supported in the community rather than in acute settings, (unless it is essential), with better clinical and social outcomes, improved safety and user experience.
- Use tele care, tele health and other assistive technology systems to give people a sense support, safety and freedom.
- Confident to use personal health and care budgets to buy and shape their support in the way they want.

**In order to achieve these we will need to:**
- Ensure all services look at people’s strengths and how to sustain them for longer.
- Pool monies between health and social care and explore possibilities of pooling resources with other council departments.
- Work with primary care services for a stronger, better networked structure based on the existing locality configuration which will be at the core of the community offer for our people.
- Develop and implement joint-commissioning mechanisms that look to commission ‘one lead provider’ with ‘outcomes’ clearly described and all agencies involved are accountable throughout the person’s journey through the health and social care system.
- Achieve financial efficiencies and the opportunities to re-invest in public health and other preventative early intervention services.
- Reflect the increasing use of the internet and smartphones to harness advanced web technologies for promoting self-care and providing advice and information to the residents of Redbridge in a faster and more creative way.

**Delivering integrated services**
The Health 1000 pilot scheme has been set up to test out the benefits of multi-disciplinary working in a primary care setting, focusing on people with five or more long term conditions that have complex health and social care needs.

The Better Care Fund (BCF) is how we build on the work of the pilot to further reduce duplication, improve timeliness and accessibility and get the right service to the individual to address their specific needs. If we can get this right through more integrated commissioning and improving our responsiveness to service users in the design of our services, we can improve outcomes and rates of satisfaction and begin to reduce inefficiencies, gaps and duplication.

Other new developments since the publication of priorities in the last Prevention and Early Intervention Strategy include:

- The development of a holistic primary/community based reablement services, including Intermediate Care Services, Community Treatment Team, Intensive Rehabilitation at home service, to meet physical, social and psychological needs of the community.
- Development of the Redbridge First Response Service (ReFRS), which includes a common referral form and process for ensuring action is taken within an agreed
timeframe. ReFRS is used by GPs, Met Police, Fire Brigade as well as adult social care and voluntary and community sector groups.

- Integrated case management teams providing access to health and social care
- Successfully secured funding from the Prime Ministers Challenge Fund to pilot Health 1000 where people with complex health and care needs are invited to take part in a pilot scheme to meet the needs of individuals holistically, through multi-disciplinary teams.
- Appointment of an EoL Social Work Practice Manager working with commissioners, planners and front line staff across the statutory voluntary and community sectors and with service users and carers
- Appointment of a Children’s Joint Commissioner working across Children’s Services and the CCG
- Development of a pan London End of Life Charter for local implementation
- Improvements in recording of dementia diagnosis and improved waiting times at the Memory Clinic
- New diagnostic pathway to improve diagnosis of people with autism
- Launch of the Autism Alert Card to help identify and engage with people living unsupported in the community
- Secured funding to ensure continuation of a handy person scheme.
- Review of voluntary sector contracts to ensure they meet local priorities
- Alignment of living Well Community Bridge builders with GP Clusters to support people with memory problems;
- Development of support group for people with early onset dementia
- Creative Arts schedule of activities for people with dementia
- The Frailty Programme, where specific work is ongoing to best support those individuals over the age of 65 with community services to prevent hospital admission and also to assist hospital discharge.
- Winter Resilience Plans, to manage increased pressure within the health and social care system at times of greater demand.
- Care navigation training for frontline staff across BHR, funded via Health Education England, North Central and East London.
- Re-commissioning of an integrated Improved Access to Psychological Therapies (IAPT) service at level two and three, designed to meet national access and recovery targets, to embed the service in the community and reduce barriers between mental and physical health care.

Considerations for providing support for carers

In Redbridge there has been a long tradition or support for carers in recognition of the important role they have in providing care and support for their family and friends, significantly reducing the financial burden on statutory agencies. The council has a number of contracts in place with voluntary organisations that work with carers such as the Redbridge Carers Support Service. A Joint Strategy for Carers has been in place for many years and we are in the process of updating the last Strategy to take account of the new policy changes which increasingly highlight the need for an integrated approach across health and social care service provision and greater recognition of the importance of engaging carers in the development of individual health and care plans.

In addition there is a focus on meeting the needs of carers in other key Redbridge strategies and plans such as the Dementia Plan, the refresh of the Autism Plan and the End of Life Plan which is currently under development.
Primary care support for carers

Redbridge Clinical Commissioning Group (CCG) has identified a number of areas where it can work with the local authority and its GP membership in improving the support offer to carers in Redbridge. The Redbridge Better Care Fund has identified seven key schemes against which budgets and services have been assigned. These include early intervention and prevention, integration and carers’ support that reflects the implementation of the Care Act.

As part of its role in supporting primary care improvement, the CCG will review the degree to which its GP practice members are recording where patients are known to be carers and work with them to improve the numbers recorded.

This to be completed with training opportunities, including engaging with GPs during 2015 at their regular CCG meetings (individual locality committees and Protected Learning Event) to help them understand the role and expectation of primary care in relation to carers. This will be in the context of implementation of the Care Act 2014 in Redbridge and the Better Care Fund and more recent guidance form the Department of Health in Transforming Primary Care, NHSE Commitment to Carers and the NHS Five year Forward Plan.

One key aspect that the CCG would expect to emphasise to GPs is how important their role can be in identifying young carers, who perhaps do not conform to the perceived image of what a carer is and may not even know that this is a role they are carrying out. Through their GP recognising this and knowing the range of services and support available, or the local authority’s gateway to accessing these services - there is a much better opportunity for carers to get the right help at the right time.

Consideration will be given to opportunities for GPs to direct carers to the Redbridge First Response Service as an entry point to wider social care and community support and advice. Since its inception in December 2013, GPs have been the largest source of referral (across all patient categories) and the CCG recognised that for this to be sustained and, potentially expanded, extra demand was likely to require an increase in its capacity. Some initial discussions – linked to the NHS England concept of proactive care have taken place and further exploration will take place via the joint steering group working on the development of the Plan for the Redbridge Better Care Fund (First Response being one of the many services included in the Fund).

The census data released in December 2012 showed that the number of carers increased from 5.2 million to 5.8 million in England and Wales between 2001 and 2011. Almost 1.3 million (1,277,693) older people are devoting their retirement to caring for partners with health care needs or their own ageing parents. Census figures show that this is an increase of 35% in the last ten years. The greatest rise has been among those providing over 20 hours care which is the point at which caring starts to significantly impact on the health and wellbeing of the carer, and their ability to hold down paid employment alongside their caring responsibilities.

Across England and Wales there are now 2.1 million people providing over 20 hours a week, this represents a rise of almost half a million people in the last 10 years. Those providing the most number of hours of care, i.e. over 50 hours a week, very often caring round-the-clock - has increased by 272,000 and is up from 1,088,000 to 1,360,000. Further data relating to Carers can be found in Appendix 2.
7. Workforce

Development of the workforce is essential to ensure we have appropriately skilled staff to deliver Care Act compliant services which provide high quality information, advice and guidance, rehabilitative and therapeutic support that enables people to be more independent for as long as possible. Staff need to have the skills to be able to consider options available from community, social and primary care provision.

The Council has recently developed a new People Strategy which highlights the issues and challenges facing the Council, the key ambitions and short and longer term deliverables.

Supporting the Workforce through the transformation of public services forms a key element of recent national and local Strategies and Plans. They acknowledge the challenges facing staff across partner agencies, and the need for strong leadership and modern flexible processes to create organisations that are fit for the future, providing personalised care and support and better outcomes for people using services, while facilitating change and delivering efficiencies. Integrated services where the health and social care workforce work effectively together are key to this process and consideration will be given as to how this can be achieved locally in partnership with NELFT through improved access to effective advice and information on improving health and wellbeing as well as wrap around services and support.

For Adult Social Services the model of a sector led approach to improving quality is now well established. As part of this process, the council has published an annual Local Account which describes what has been achieved locally and identifies areas for improvement. A programme of peer-reviews has taken place and pan London Networks have been established to provide opportunities to share good practice and achieve continuous improvement.

Skills For Care and Skills for Health have worked with the Department of Health and national and regional Networks to develop a range of training tools and briefings to help with the implementation of the Care Act 2014 in addition they provide access to a wide range of other resources linked to specific areas for learning and development including workforce integration End of Life, Dementia, and carers.

Wherever possible, opportunities to secure external resources for training for the health and social care workforce in areas of priority are pursued. A good example of this approach includes the Gold Standard Framework Training across Barking Havering and Redbridge for GPs, residential and nursing care homes and home care providers was secured from NHSE. Subsequently agreement was given to extend the GSF sessions to include shared learning and good practice opportunities for community nursing and acute hospitals and a contribution towards a programme of accreditation.
## 8. Action Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Actions</th>
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</thead>
</table>
| Preventing reducing or delaying needs through information advice and advocacy | 1. Explore opportunities to improve links across NHS, Adult and Children’s Services by taking a whole family approach to advice and information services relating to care and support.  
2. Review information advice and guidance on mental health crisis services available on NELFT Website, leaflets and flyers to ensure they are easy to obtain and provide consistent and coherent information for referrers, self-referrers, their families and carers.  
3. Map services, facilities and resources currently available in Redbridge to form part of the local ‘prevention offer’  
4. Review Advocacy contract  |
| Promote an holistic approach to care and support to achieve wellbeing focusing on delaying and preventing care and support for adults, their carers and young people in transition | 1. Develop a single care and support plan  
2. Develop processes for health and care personal budgets, or direct payments to be pooled to enable people to direct their own care and health and achieve personal goals.  
3. Review the Redbridge First Response Service and explore capacity to increase the number of referrals taken whilst maintaining the current high quality service which already improves co-ordination and outcomes for individuals.  
4. As part of its role in supporting primary care improvement, the CCG will review the degree to which its GP practice members are recording where patients are known to be carers and work with them to improve the numbers recorded.  
5. This to be completed with training opportunities, including engaging with GPs during 2015 at their regular CCG meetings (individual locality committees and Protected Learning Event) to help them understand the role and expectation of primary care in relation to carers, including young carers.  
6. Refresh actions in the Redbridge Dementia Plan and Autism Plan and produce a new Joint Carers Strategy and Redbridge End of Life Plan for 2016-19  |
| Integration, co-operation and partnership                                  | 1. Promote greater integration with NHS and other health related services (wider determinants of health) including Housing and Leisure  
2. Stroke Pathway Transformation Project. CCG Commissioning Support Unit is working across BHR, and Waltham Forest to develop an equitable pathway;  
3. Explore the potential for developing a new integrated operating model for adult health and social care services  
4. Develop and implement a Young Carers Protocol  |
| Mental Health Crisis Care Concordat                                        | 1. Develop and implement an action plan to ensure we can deliver a high quality response when people of all ages with mental health problems urgently need help  
2. Increase the awareness and use of personal health budgets for those with long term mental health needs  |

Please note the actions included in the action plan form part of the ongoing engagement process and are therefore subject to further development and change.
Appendix 1 - Redbridge CCG Plan


## Appendix 2 - Local Data

### Health and Wellbeing of the Redbridge population

### Table 1: Census 2011

<table>
<thead>
<tr>
<th>Ward</th>
<th>No. households</th>
<th>% households</th>
<th>% older households</th>
<th>No. households</th>
<th>% households</th>
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<td>860</td>
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<td>17.6</td>
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<td>39.6</td>
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<td>21.1</td>
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Table 1 above shows the picture of older people living alone across the wards and for Redbridge for single older person households as at 2011 Census and a comparison with London. This suggests that 10.1% of all households were single older people and 29.9% of all people aged over 65 lived alone. A further 15.4% of households were single people living alone who were aged under 65.

The latest population statistics estimated that we had 35,000 people aged 65 and over living in Redbridge in June 2013. If the proportions remained the same, this would suggest that around 10,500 people aged 65 and over were living alone in 2013.
Table 2: Redbridge Projected population increase 2001-37

Sources: ONS:
2001 Census;
2006 mid-year estimates;
2011 Census;
2012-based subnational population projections.

Figure 3: Strategic priorities and outcomes for Redbridge
The Joint Strategic Needs Assessment (JSNA) sets out the evidence base from which our Health and Wellbeing Strategy was developed. These are areas in which the Health and Wellbeing Board identified would have the greatest positive impact upon health and wellbeing. Our current strategic priorities are:

- Improved life chances for children and young people to maintain optimum physical and mental wellbeing and safety.
- Healthy Communities - residents are supported to lead healthy lifestyles and manage risks to wellbeing including mental health.
- Prevention and Early Intervention - services support residents to manage long term conditions and avoid unnecessary hospital admissions.
- Maximising the health benefits for our communities by supporting children and vulnerable adults including older people and those with mental health needs to access appropriate support including good quality information, advice and advocacy.

Redbridge has a growing and mobile population. In 2013 the population was estimated to be 293,500 (ONS 2011 estimates). It is predicted that the population will grow by another 45,000 (15%) by 2021, with the greatest growth predicted in children.

By 2021 it is predicted that 28% of the population will be under 20 years. Fertility rates are high and increasing. There was a 42% increase in births between 2003 and 2012 although the rate of increase appears to be levelling off. There is projected to be a 19% increase in the numbers of people aged 85+ years by 2021, with a consequent effect on demand for services for this age group. The population of adults aged 65+years is projected to increase by 10% (3,400 people) by 2020, with the greatest increase in the age group 70-74 years (projected 23% increase). The ethnic profile of older adults is different from the wider...
population with 31% from an ethnic minority background (24% Asian, 5% black).

**Table 3: Age and Ethnicity of population**

- Ethnic variation varies by age: in children 0-14 years 77% are BME origin whilst in people 65+ years 70% are white.

- Ethnic composition also varies by ward with the largest proportion of ethnic minority groups mainly in the south.

Source: JSNA 2014-15

Redbridge ranks 134th out of 326 local authorities on the Index of Deprivation scores 2010 (1=most deprived), but there is wide variation across the borough with some wards predominantly in the lowest 2 quintiles for deprivation (Clementswood) and some in the highest 2 quintiles (Monkhams).

With increasing numbers in the population there will be increasing numbers of people who will need support with domestic tasks, self, mobility and continence support and advice, with projected increases of 6% between 2016 and 2020. Rates of dementia increase with age. It is estimated that there are 2016 people with dementia, expected to increase by 8% (215 people) by 2020. Similarly, the number of people with limiting longstanding illness is expected to increase by 9% between 2014 and 2020. It will be a challenge to enable increasing numbers of people to maintain independence into old age, therefore, we need to be able to identify people early enough to ensure that the appropriate care and support in put in place so that they are not reaching crisis point and ending up as emergency admissions.

**Projected numbers of people 65+ years unable to manage at least one mobility activity on their own**

Source: JSNA 2014-15
Take up of Adult Social Care Services

Age make up of new adult social services service users

Age of service users compared to age of local population
Faith of new service users receiving adult social care over the past two years

Faith of service users compared to Faith of the local population aged 65+
Growth in direct payments

Growth in the number of home care packages - older people
Growth in the increase in home care packages for service users aged under 65

![Graph showing growth in home care packages for different groups over time.]

Total number of people (65+) in residential and nursing care

![Graph showing total number of people aged 65+ in residential and nursing care over time.]

35
**Information about Carers**

It is important to understand that within the definition of a carer - there are three types of carers:

1. **Adult carers** - adults caring for adults over the age of 18, this includes parents caring for their adult children.
2. **Parent carers / lifelong carers** - parents caring for a child or young person under the age of 18 who has a disability.
3. **Young carers** - children or young adults under the age of 25 who are caring for either another child or young person or an adult.

It is recognised that these three types of carer are broad groups and that all carers are individuals. Some service users may have more than one carer. Health and social care professionals should ‘think family’ and identify the support from all the carers involved. It is also acknowledged that many people do not see themselves as carers because, first and foremost, they may be husbands, wives, partners, siblings and friends and are often unaware of the support they might be able to get to help them in their caring role. Access to good quality information at the right time in the right way, is therefore a very important part of that support.

The Care Act 2014 and the Children & Families Act 2014 which come into effect in 2015 both strengthen the rights of carers in the social care system and aim to make care and support for people more consistent.

The Care Act introduces new rights which entitle carers and the people they care for, to an assessment of their needs regardless of their income or their level of need and includes responsibilities in relation to young carers. The assessment will take a whole family approach and look at how caring affects the life of the carer including their wellbeing, physical, mental and emotional needs and there will be an assessment of their ability to pay if there is a charge for services provided for the carer.

Redbridge has a good record in the support it provides for local carers including contracts with community organisations that provide emotional and practical support, for example the Redbridge Carers Support Service which is the key umbrella organisation for carers and other groups such as the Alzheimers Society, Barnardos Young Carers Project and AgeUK BHR.

From age 65, the proportion of carers providing higher levels of care rises sharply. Among the oldest carers, aged 85 and over 56% care for 50 or more hours a week (Census 2011). This is compounded by an increased risk of financial hardship, isolation and social exclusion among older people generally. It is also common for older couples to care for each other as a natural part of life and to be less likely to access support.

**Young Carers and Young Adult Carers**

The Equalities Task Force of the National Carers Strategy reported that being a young carer sometimes as young as 7 or 8 years old, has a detrimental effect on young people’s life chances and opportunities. Among young adults (aged 16-24), caring reduces the likelihood of participating in further or higher education, with an impact on future earnings and their own personal development.

The Carers Trust highlights that caring can affect a young adult in terms of their education
and employment prospects due to absences, achieving lower grades; guilt over leaving the person they care for or poor relationships with their peers.

Their health and wellbeing is affected through increased risk of mental and physical health problems due to isolation, exhaustion, financial hardship, bullying and stress potentially leading to self harm and poor health.

**Information about carers in Redbridge**

Number of unpaid carers and hours spent caring:-

The 2011 Census recorded 27,291 people providing unpaid care - about 10% of the population. Redbridge ranked fifth highest of all London Boroughs for the proportion of residents who provided unpaid care - this was well above the London average (8.4%) but lower than the average for England and Wales (10.3%).

- 17,182 (63%) carers provide 1 to 19 hours unpaid care a week
- 4,405 (16%) carers provide 20 to 49 hours unpaid care a week
- 5,704 (21%) carers provide 50 or more hours unpaid care a week

**Age and sex of Carers**

- 80% of carers (21940) were of working age (under 64);
- 17% of carers (4566) were over 65. Of these 8.5% (390) were 85 and over.
- 133 were caring for 50 hours or more 2.8% of the carers (771) were below 16;
- It is estimated that there are around 3000 young carers in Redbridge
- 56% of carers were female and 44% male. Females outnumber males in all age groups except for 16-24 years and over 85s. The gender difference is narrower in younger Carers, i.e. under 16 years.
- Just under 12% (13,391) of the economically active population 16-74 were carers.
- 6712 were male carers, slightly outnumbering the 6679 female carers. Of these:
  - 10,677 provided 1-19 hours of care;
  - 1,401 provided 20 to 49 hours of care;
  - 1313 provided 50 or more hours.

**Ethnicity**

The largest ethnic groups were 63% White British (14,965), 15% Indian (3556), 6% Pakistani (1512), 2.6% Black Caribbean (627) and 2% Black African (447);

The ethnicity of carers varied across age groups. 82% of carers (4137) above pensionable age were White British. The next largest groups were Indian 6.7% (338), Pakistani 1.6% (80) and Black Caribbean 2% (92);

From 16 years to pensionable age 58% of carers (10,655) were White British, 17% Indian (3069), 7.5% Pakistani (1363), 3% Black Caribbean (526) and 2% Black African (409);

Below 16 years old, 33% of these young carers were White British (177), 28% Indian (149), 13%, Pakistani (69) and 6% Black African (31).

**Key factors influencing wellbeing of carers**

**Equalities**

We need to consider how to provide support to carers, so their caring responsibilities do not unfairly limit their choices for wider opportunities. Carers providing 20 or more hours care a week are likely to experience disadvantage in poorer health, income, employment and/or...
education. Carers do not experience caring or the effect of caring equally. For example, the experience of caring will differ according to the circumstances of the person cared for and cultural expectations and family structures within different communities. There are some groups about which little are known, for example disabled carers and carers of people with alcohol and drug issues.

Young carers often provide emotional and practical support including physical and personal care, looking after siblings and managing family finances as well as administering medication and attending appointments with the person they care for. Very often these young people do not recognise themselves as having a caring role and may not ask for help. Following the introduction of the Care Act 2014 and the Children & families Act 2014 councils have a duty to identify young carers as part of a whole family approach and ensure they get the help and support they need. This will require closer working practices across adult and children’s services and in response to this work is underway to develop a young carer’s protocol to ensure that young carers are identified and do not fall between a gap in services.

Key responsibilities in the Care Act 2014, which apply equally to service users and carers include the principle of promoting wellbeing, which has a broad definition including ensuring personal dignity, physical and mental health, protection from abuse and neglect and control over day to day life including participation in work education and training. The Act also places a duty on local authorities from April 2015 to prevent reduce or delay the need for care and support and provide good quality advice and information about how the system works locally, how to access care and support, details of choices available and from April 2016 access to independent financial advice on care issues.

An Equalities Review which contributed to the National Carers Strategy suggests that, in order to offer carers more choice and control in balancing commitments and aspirations, and tackle inequalities, the strategy would need to tackle the barriers to achieving more equal outcomes for carers and ensure equality of access to support.

**Reaching Hidden Carers**
Research suggests that key groups likely to experience inequalities include:

- Carers providing 20+ hours of care a week
- Carers from diverse backgrounds
- Older carers providing high levels of care
- Young carers and young adult carers

In order to achieve better outreach to all carers including Black and ethnic minority communities, isolated and socially excluded populations, as well as working carers, service commissioners and providers within statutory, voluntary, community and independent sectors need to develop their own approaches to identify hidden carers.
Public Health Summary

The United Kingdom (UK) is one of the largest countries in the European Union based on population size; the characteristics of this population have gone through significant changes during the last 50 years. The arrival of the National Health Service (NHS) and overall improvements in the standards of medical care have led to an increased life expectancy; 78.7 and 82.6 years of age for men and women respectively. In Redbridge, this figure is higher than the national average - 79.6 years for males and 83.3 years for females and; however in the most deprived wards this figure is up to 5 years lower for both groups.

Between 2001 and 2011 Redbridge had the ninth highest growth rate in London; the population has increased by 17% compared to 14% in London. During this time the population between 25-44, 45-64 and 85+ has grown by 19.3%, 16.8% and 13.6% respectively. In keeping with the national trend, the population of Redbridge is projected to continue increasing in coming years- the over 85s are projected to grow by 24.5% in the next 10 years. This cohort of the population presents a new challenge to the health and social care systems, as living for longer does not necessarily equate to prolonged years of healthy living or a good quality of life. Families often need to provide some level of care for older family members whilst many older people find themselves as carers and may become isolated from society. Therefore, the demand for quality adult health and social care is greater than ever before.

The growing population and the increasing complexity of people's needs, means that it is important to maximise any opportunity for prevention and early intervention. Inequalities exist across society; these affect long-term health outcomes and there is strong evidence that what happens early on in life affects health and wellbeing in later life. In other words, inequality across society starts before birth and accumulates through a lifetime. Interventions later in life can also be beneficial, however they are less effective if early life experiences have been negative and people lack a good early foundation. Providing an early intervention is also more cost effective, as widespread inequality leads to lost years of life and economic activity as well as increased costs of health and social care. This evidence strengthens the argument for providing an early and sustainable intervention to improve overall wellbeing.

Determinants of health

In 2010 Redbridge was ranked 134th out of 326 local authorities in England using the Index of Multiple Deprivation – this measure uses different indicators to assess the extent of deprivation in a certain area. Many differences in health outcomes across Redbridge for conditions such as cardiovascular disease and liver disease are due to varying levels of deprivation. Similarly employment rates and access to employment are lower amongst people with learning disabilities, benefits claimants and people with complex health needs. These groups are also at higher risk of mental health issues as well as those living in poor housing and experiencing domestic violence. According to the recent Annual Public Health Report (2013/14), Redbridge has a higher rate of admission for mental health conditions than England but a similar figure to that of London. These following factors have been identified as social determinants of health.

- Early life experiences
  - Maternal mental health
  - Maternal physical health - drugs, alcohol, smoking, stress
  - Parental employment
  - Parental educational attainment
- Education
  - School readiness
  - Being read to daily
  - Social & emotional development
  - Communication & literacy skills
- Employment and wellbeing
Employment

Being in secure quality employment is a protective factor, especially for those with mental health problems or learning disabilities. In 2011 Redbridge was ranked fifth lowest of all London boroughs, for the percentage of working age adults in full-time employment; the London average was 39.8% whilst Redbridge was only 35.9% (Joint Strategic Needs Assessment 2014/15 - JSNA). For the period December 2014 to February 2015 the unemployment rate in Redbridge was 7.2% which is higher than the national average (5.6%) and in London (6.2%). One of the most deprived wards, Loxford has about 26% of people in full-time employment and the highest rate of unemployment. This is a recurring trend in lower socioeconomic groups as people are more likely to have fewer qualifications and a lack of opportunities for progress in work which can further increase the social gradient. Unemployment is also detrimental to physical and mental health as it is associated with increased rates of smoking, alcohol consumption and reduced levels of exercise. It can also cause anxiety due to housing issues, financial uncertainty and low self-esteem; one in seven men develops depression within six months of losing their job.

Younger adults may have complex needs if they experience one or more of the following:

- Learning difficulties
- Physical disability
- Post traumatic brain or spinals injuries
- Mental health problems
- Alcohol and substance misuse
- Poor educational attainment

Adults of working age with complex needs often find it difficult to gain and maintain regular employment; they are also more likely to be in low paid, insecure, poor quality jobs which can lead to increased deprivation. There are several barriers that this group may face including discrimination from employers because of their long term condition or finding it difficult to take time off work to attend multiple appointments. Support services need to advocate for this group to ensure that people can access services easily and have equal opportunities at work. Therefore, it is important to take an approach of life-long learning as recommended in the ‘Marmot review’; this will:

- Widen the availability of life-skills training
- Promote employment opportunities and work-based training
- Increase the possibility of ‘good employment’

People with Learning Disabilities and employment

There is no definitive record of the total number of people with a learning disability (LD); estimates suggest that 905,000 adults in England have a LD. These estimates are made based on data from government departments, numbers of people with LD using services and figures from GP records. The latest learning disability census published in January 2015 showed that there were 46,473 people in contact with learning disability services in England. In Redbridge there were an estimated 4,916 resident with an LD in 2011; this figure is projected to increase to 5,755 by 2030 (Data from the JSNA 2014/15).

Recent reports for example the Winterbourne View Review have highlighted the systematic
failings in services which have neglected the health and wellbeing of adults with learning disabilities. Nationally, the number of people living with an LD is increasing. This is likely due to advances in neonatal care which has improved survival rates into adulthood following a traumatic birth or peri-natal brain injury. In August 2013 the LD service in Redbridge identified 975 adults with LD, based solely on contact with the service. This figure is higher than the number identified from the GP LD register but roughly equates to 0.2% of the Redbridge population. This cohort is more likely to face barriers to employment and have complex needs requiring health and social care. Adults with LD often encounter inequality in their access to health care and the quality of care that they receive. Therefore, identifying individual needs early on will help address some of the inequality faced by people with LD.

Benefits
There are a range of welfare benefits available including Jobseeker’s Allowance, Employment and Support Allowance and Incapacity Benefit. People claiming benefits are more likely to be disabled, long-term unemployed or have a caring responsibility. For some benefits claimants it can be difficult to find work especially if they have a lower level of educational attainment. This uncertainty can lead to low self-confidence and poor mental health which may have negative physical health outcomes. In addition, many people find that their benefits added to any potential earnings is not enough to support a healthy life—this includes having a healthy diet and taking part in physical activity.

The latest figure from March 2015 showed that 1.7% of Redbridge residents were claiming JSA; this is less than the national average of 2.0% and 0.4% of people were claiming JSA for more than 12 months. People not in education, employment or training (NEET) for lengthy periods of time are more likely to claim these benefits and are at risk of deteriorating mental health. Equally people with mental health problems or with complex health problems are more likely to be out of work or experience limited employment opportunities. The levels of economic inactivity also varied across the borough—this was lowest in Church End at 16.4% and highest in Loxford (35.6%). The level of meaningful activity reflects the scale of deprivation in each ward and highlights the social gradient across the borough.

Long-term conditions (LTCs)
These are the top five conditions experienced by adults in Redbridge according to their prevalence. (Information from the JSNA 2014/15)
- Diabetes
- Asthma
- Coronary Heart Disease (CHD)
- Chronic obstructive pulmonary disease (COPD)
- Congestive Heart Failure

Cardiovascular disease (CVD) is the most common cause of death in the United Kingdom. Similarly, in Redbridge, though the rate has declined in recent years, it remains the most common cause of preventable death for people under 75 years old. In Redbridge, the age standardised premature mortality rate for CVD was 76.4 per 100,000 in 2010-12 which is lower than the London rate (83.1). However, the difference between the richer and poorer wards has persisted meaning that people in Loxford are twice as likely to die from CVD compared to those living in Snaresbrook.

There is evidence to suggest that preventing and slowing the onset and progression of a chronic disease leads to a better outcome for the individual. We know that having one or more long-term condition (LTC) is detrimental to general wellbeing; therefore, it is no surprise that depression is up to seven times more likely in people with two or more LTCs and the most common mental health problem in people over 60. Providing an early intervention involves signposting people to services which can address their needs and promotes independence by people to be supported in their own environment. Furthermore, it prevents the scale and complexity of a need escalating to a level where social care services will be far more expensive to provide. This approach can lead to a more equal standard of
living in society and has wider benefits in economic terms- in practical terms this can be achieved by:

- Promoting independence and choice
- Improving coordination and collaboration between services
- Focusing on prevention and self-care
- Ensuring equal and easy access to services
- Adopting an individualised care approach

Cancer
Cancer is also another significant cause of death in Redbridge, although the rates are lower than in England and London. Similarly the rate of cancer in the more deprived population is higher. This means that excess deaths from both of these conditions accounts for 30% of inequality in Redbridge. Table 1 below shows that the prevalence of diabetes in higher than in London and England, which may be due to the ethnic makeup of Redbridge. The rates of asthma and CHD are also higher than the London average.

Table 1: Disease prevalence (prev) as a percentage of the population compared to North East London boroughs, London and England

<table>
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<th>DM prev</th>
<th>Asthma prev</th>
<th>CHD prev</th>
<th>COPD prev</th>
<th>HF prev</th>
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<td>6.0</td>
<td>3.3</td>
<td>1.7</td>
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</tr>
</tbody>
</table>

DM- diabetes mellitus, CHD- coronary heart disease COPD- chronic obstructive pulmonary disorder HF- heart failure

Source: Health and Social Care Information System

Ageing well
The World Health Organization (WHO) has said that ‘ageing well must be a global priority’ and defined ‘active ageing’ as “...the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age”.

Chronic diseases in older people can be more difficult to manage due to their changing physiology and poor functional reserve. These factors increase the complexity of care and present new challenges to health and social care professionals, who need a different approach to meet this demand. Nationally, admission rates to hospital have risen as well as the age of patients and their length of stay. Older people (over 75 years old) account for 40% of the total spent (£563 million) on emergency admissions and 80% of patients who stay in hospital for more than two weeks are over 65.

As previously stated, medical interventions reduce fatal events in the populations, however, the healthy life expectancy (HLE) provides a better indication of general wellbeing and equality in health outcomes. This is a measure of the average number of years an individual would expect to live in good health. The figure for Redbridge is higher than the average for London and England. In 2010-12, the HLE for males in Redbridge was 66 years and 62.9 years for females which represents 82.2% and 74.8% of life as a proportion for males and
females respectively. Early interventions can help prevent unnecessary hospital admissions, this can be done through:

- Improved integration between healthy and social care
- Community falls prevention services
- Flexible care pathways providing holistic care
- Empowering older people to use their skills as they wish – as volunteers or paid employees
- Engaging with older people’s voices about specific needs

The risk factors for non-communicable diseases start in childhood and are influenced by socioeconomic and environmental factors throughout life as identified in previous evidence. However, the effects of these diseases are most evident at an older age; this highlights the importance of addressing recognised risks factors earlier on in life and promoting a healthy lifestyle throughout the life course. Apart from the individual benefits of ageing well, there are also economic benefits as more people are fit to work for longer and there is reduced pressure on social care services. Interestingly, recent data suggests that a higher medical expenditure is not associated with old age but instead with disability and poor health. Therefore, promoting a healthy lifestyle throughout life and into older age can help prevent physical decline, reduce social isolation and improve mental wellbeing.

**Fuel poverty and Early Winter Deaths**

Fuel poverty in the UK is now defined as “when a household’s required fuel costs are above the median level; and if they were to spend what is required, then the household would be left with a residual income below the official poverty line” Professor John Hills.

This can occur if people with lower incomes live in energy inefficient homes and cannot keep up with the increasing energy prices. Fuel poverty disproportionally affects at risk groups – children, people with disabilities and older adults, especially those over 85. Living in a cold home can worsen some chronic conditions such as arthritis, respiratory and cardiovascular problems. In addition, older people are especially at risk of influenza and its associated complications. These factors all contribute to excess winter deaths (EWD).

The EWD index can be used to measure the number of extra deaths that occur in a particular area. In Redbridge the EWD index was 15.0 which is lower than the figure for London and England- this represents 83 deaths over a single year and 83% of these people were over 85. Young children are also affected by fuel poverty and can experience increased asthma exacerbations and respiratory infections resulting in missed days at school and a lower level of educational attainment. Families from lower socioeconomic backgrounds are most likely to be affected and these negative outcomes further increase inequalities in health and education. The fuel poverty risk score demonstrates inequalities in different areas; in Redbridge, Monkhams and Valentines were at opposite ends of the scale ranked 45th and 494th respectively out of 625 London wards.

The recent NICE guidelines on reducing the risk of death and ill health associated with living in a cold home aim to:

- Recognise high risk groups including
  - over 85s
  - frail older adults
  - people with co-morbidities- cardiovascular, respiratory and arthritis
  - very young children
- Promote energy efficiency legislation
- Support home energy improvements
- Reduce the risk of fuel debt or being disconnected from gas and electricity supplies
- Train health and social care teams to help people’s homes that are too cold
Life Course Diagram

The life-course diagram at the end of this section plots the routine contacts an individual has with health care professionals throughout life, starting in utero. It also shows the different stages in life where socioeconomic factors can influence health and wellbeing and highlights the opportunities for providing an intervention through health and social care services. This is an open-ended illustration of the current service provision and can be added to as new services and needs are identified.