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Health and Wellbeing Strategy

2013 - 2016

Improving health and wellbeing for Redbridge

Foreword

We are delighted to present our first joint Health and Wellbeing Strategy for Redbridge. It outlines our high level priorities for improving the health and wellbeing of people living in the borough for the next three years. The priorities are based on the evidence presented in the Joint Strategic Needs Assessment (JSNA) for Redbridge. There continues to be on-going work in all areas with our partners, however we believe the priority areas listed in this strategy will have the greatest impact on improving the health and wellbeing of our residents.

Overall our residents enjoy a healthy life. We do know there are pockets of deprivation in our community and variations in life expectancy. We believe that everyone has the right to enjoy good health. We understand that to reduce health inequalities in the borough, we need to focus, not only on health, but also on the wider social and economic factors that impact on wellbeing.

The Redbridge Health and Wellbeing Board holds many of the levers for promoting health and wellbeing. It brings together the NHS, public health, social care, children's services, elected councillors and community and service user representatives to jointly consider local needs and plan the right services for our residents.

Our vision is to support our residents to improve their health and wellbeing and reach their full potential by tackling inequalities, providing timely access to high quality health and social care services and reaching out to communities through prevention and early intervention activities. We will work across borough boundaries to consider and agree the issues that need to be tackled across a wider area.

Through our joint commitment to the priorities and with a shared vision, we will be able to work in partnership to improve the health and wellbeing of the residents in Redbridge.

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Our Vision

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

Introduction

The Health and Social Care Act 2012 sets out responsibilities for the establishment of Health and Wellbeing Boards and the production of a Joint Strategic Needs Assessment (JSNA) and a joint Health and Wellbeing Strategy. Following consultation, 'Health and Wellbeing in Redbridge: The Redbridge Joint Strategic Needs Assessment' was published in May 2012, on www.redbridge.gov.uk.

Our Board aims to improve the health and wellbeing of people living in Redbridge. It is a partnership board, which brings together a range of public services including adult social services, housing, public health, children's services and community safety and GPs.

The concept of Health and Wellbeing, as defined by the World Health Organisation (WHO) is: *'a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.'*[1]

The JSNA presents a detailed analysis of the health and wellbeing needs of current and future Redbridge residents and how inequality affects people who live in Redbridge. It includes information regarding current service provision and reviews best practice guidance. The JSNA identifies commissioning considerations, regarding how services may need to adapt to meet the changing health and wellbeing needs of Redbridge residents. The JSNA presented six indicators identified within the Marmot Review[2], which were designed to investigate health inequalities in England. These are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

These principles are embedded throughout the priorities of the strategy.

Further detailed information regarding the effects of inequality on Redbridge residents was also presented in the JSNA.

[1] WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948.
[2] Sir Michael Marmot, 'Fair Society, Healthy Lives: The Marmot Review: Strategic Review of Health Inequalities in England post 2010', 2010.

Strategic Context

The Health and Wellbeing Strategy is an overarching strategy. It connects with other strategies and action plans across partner organisations aiming to improve the health and wellbeing of the people and communities of Redbridge. These include the Sustainable Community Strategy, Children and Young People's Plan, Housing Strategy and the Adult Prevention and Early Intervention Strategy which reflect national and local priorities and include measurable improvements. So it is important to note that this Strategy is building on a wealth of activity being carried out by partner organisations, which is regularly reviewed.

In addition to local activity there is significant work underway to ensure where possible we maximise the benefits of working across Borough boundaries, on health and social care issues in particular with the outer north east London boroughs of Barking and Dagenham, Havering and Waltham Forest. This includes identifying the best configuration of services to meet local needs within the resources available. An Integrated Care Coalition comprising of representatives from Adult Social Services and Clinical Commissioning Groups (GPs) across Barking and Dagenham, Havering and Redbridge, has been working together as an integrated commissioning system to improve quality and ensure best value for money. They have developed a set of core common objectives on integrated care, which were agreed by the Board and are described below:

- We will deliver improved pathways of care by redesigning services. The first priority will be improving care for frail older people and we will focus on re-ablement solutions/prevention and early intervention. We will improve our consistency of response and ensure equity of access based upon need.
- We will make better use of resources by reducing our reliance on a bed based service for care of frail elders and by providing more community based solutions. This will enable greater numbers of people to be supported and treated in their own homes, avoid unnecessary admissions to hospital and ensure shorter stays in hospital for people who have needed to be admitted.
- We will organise services around GP practices (including those provided through Community Service Providers) and social care to deliver effective community based services for practice populations. This will be done by taking a 'bottom up' approach to planning and ensure that the user voice is core to this planning process.
- We will enhance individuals' responsibilities, through involvement and participation, for their own health wellbeing and choices alongside effective safeguarding and provision for the most vulnerable in our community.

The purpose of having common strategic objectives is to help co-ordinate the planning and decision making process across the boroughs in relation to integrated care services and to ensure that concerted action is taken, and clear and consistent messages are given to all stakeholders about the importance of integrated care. The common objectives are not intended to limit or constrain individual borough's activities on integrated care, rather to ensure that these activities form part of a collective approach.

Strategic Priorities

The JSNA review set out the evidence base from which the Health and Wellbeing Board set its strategic priorities. These are areas in which the board identified would have the greatest positive impact upon health and wellbeing.

- **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.
- **Maximise the health benefits** for our communities by supporting children and vulnerable adults including older people and those with mental health needs to access good quality information advice and advocacy.

Because inequalities in wellbeing are wide ranging all of the strategic priorities and activities relating to them are connected. Therefore, good achievement in one area will have a positive impact in other related areas, as outlined below.

Figure 1: Strategic Priorities and outcomes

ALL COMMUNITIES	CHILDREN	YOUNG PEOPLE	ADULTS	Improving life chances for children	All children and young people are supported to achieve their potential by maintaining optimum physical and mental wellbeing and safety from the antenatal period to transition from children's to adults services.
				Healthy communities	Residents are supported to lead healthy lifestyles and manage risks to health and wellbeing.
				Prevention and early intervention (secondary prevention)	Services support residents to manage long term conditions and avoid unnecessary hospital admissions.
				Maximising the health benefits of our community	Maximise 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.
CROSS CUTTING PRINCIPLES FOR ALL SERVICES					
EQUITY - ACCESSIBILITY - INTEGRATION - EFFECTIVENESS - SUSTAINABILITY					

Prioritisation Process

Based on the evidence presented within the JSNA, the board members worked together to identify some specific areas to focus on over the next three years, to help achieve the four strategic priorities shown above. For example, a sub priority categorised in year two will have special focus from the board during that year of the action plan. However, service development and improvement is expected to continue in all areas throughout the three years.

Guiding Principles

The following guiding principles were agreed to be considered throughout the development and implementation of this strategy.

- **Equity**: making sure services are provided in a fair way.
- **Accessibility**: helping people use services and support in a timely way.
- **Integration:** ensure that services work together.
- **Effectiveness**: providing support and services where it makes the biggest difference to the health and wellbeing of Redbridge residents.
- **Sustainability:** effectively coordinating resources to meet the needs of Redbridge residents.
- **Engagement:** talking to people about what health and wellbeing and what issues are important to them.
- **Health and wellbeing:** to ensure that the Health and Wellbeing Strategy supports the development of services which promote dignity, safeguarding and good quality advice and information.

Measuring Success

Activities carried out by the Health and Wellbeing Board to improve the wellbeing of residents living in Redbridge will be monitored using a number of outcome measures identified from the following sources: the Public Health Outcomes Framework[3], Adult Social Care Outcomes Framework[4] and the NHS Outcomes Framework[5].

[3] Department of Health, 'Improving Outcomes and Supporting Transparency: Part 1 Public Health Outcomes Framework for England 2013-16', 2012.
[4] Department of Health, 'Transparency in Outcomes: A Framework for Quality in Adult Social Care: The 2012-13 Adult Social Care Outcomes Framework', 2012.
[5] Department of Health, 'NHS Outcomes Framework 2012-13', 2012.

Priority Framework

The following tables identify priority areas for years one, two, and three of the Health and Wellbeing Board priority framework. Although priorities are identified within specific years, service provision and development will progress throughout the three years. The priorities and their progress will be reviewed annually by the Board.

STRATEGIC PRIORITY	YEAR ONE	YEAR TWO	YEAR THREE
Improving life chances for children	• Early access to antenatal care • Childhood immunisation • Health needs of looked after children	• Breastfeeding • Development of health care pathways for children with complex health care needs	• Consanguinity • Young people and substance misuse • Transition from children's to adult services
Healthy communities	• Early detection of cancers and screening • NHS Health Checks • Promote wellbeing and help people contribute to their communities by access to employment, benefits and reducing social isolation	• Reducing the need for long term care • Identifying those at risk of falls • Support for carers • Reducing obesity, achieving healthy weight and increasing physical activity	• End of life care
Prevention and early intervention	• Managing long term conditions to avoid hospital admission • Improve the detection of irregular heartbeat in primary care to reduce the number of strokes cases		
Maximising health benefits	• Support for frail or isolated older people • Hard to reach groups • Dementia including Alzheimer's	• Safer communities and neighbourhoods • Sexual health including teenage pregnancy	

Priorities for Year 1

STRATEGIC PRIOIRTY	AREA PRIORTY
Improving life chances for children	• Early access to antenatal care • Childhood immunisation • Health needs of looked after children
Healthy communities	• Early detection of cancers and screening • NHS Health Checks • Promote wellbeing and help people contribute to their communities by access to employment, benefits and reducing social isolation
Prevention and early intervention	• Managing long term conditions to avoid hospital admission • Improve the detection of irregular heartbeat in primary care to reduce the number of strokes cases *(As these are long term conditions these will continue to be priorities over the three years of this strategy).*
Maximising health benefits	• Support for frail or isolated older people • Hard to reach groups • Dementia including Alzheimer's

Strategic Priority: Improving life chances for children

Early access to antenatal care

Why is it important?
Good foetal development has life-long benefits. Access to antenatal care at an early stage provides pregnant women with the opportunity to get both medical and social support. This means that potential complications around physical health problems, mental health needs or social issues such as domestic violence, can be identified early and avoided or addressed in a timely manner. Currently around 20% of pregnant women resident in Redbridge access antenatal services later than three months into their pregnancy.

Our vision
To ensure that all pregnant women resident in Redbridge are aware of the importance of early access to antenatal care and know where to go to get these services.

What can we do?
- Increase public awareness of the importance of early use of antenatal services.
- Conduct targeted marketing using family planning centres to inform clients of the importance of early antenatal care.

- Provide preconception clinics/workshops.
- Conduct targeted work with groups of residents who are less likely to access antenatal services early to encourage access.

Childhood immunisation

Why is it important?
The aim of the childhood immunisation programme is to protect all children against the vaccine preventable childhood infections of including: whooping cough, diphtheria, tetanus, polio, meningitis, measles, mumps, rubella and tuberculosis. Many of which can result in serious complications or even death.

Redbridge has a smaller percentage of children who were immunised for measles, mumps and rubella (MMR) by their second birthday than in England as a whole, with only 85% of children immunised compared to 89%. MMR2 (given at age five) were even lower at only 77% in Redbridge compared to the national target of 90%. However, Redbridge has seen significant improvement each year on MMR vaccination among children aged two to five.

Our vision
To increase the proportion of children who receive the full childhood immunisation programme.

What can we do?
- To ensure that health professionals are aware of the importance of immunisation within the recommended Department of Health schedule.
- A review of the 'call and recall' system to standardise practice and enhance uptake.
- Ensure that a trained and skilled workforce provides immunisation services.
- Ensure that staff have access to appropriate, good quality training and development to enhance their delivery and knowledge of immunisation.

Health needs of looked after children

Why is it important?
Evidence suggests that mental and physical health problems are more common amongst looked after children.

In addition, care leavers are more likely to become teenage parents; experience problems with drugs and alcohol and have general health concerns[6].

During 2011/12 Redbridge looked after a total of 319 children and young people. There are a significant number of children and young people who are looked after by other boroughs but are resident in Redbridge, some of whom are known to services others are not. These children use universal and specialist services and are likely to have similar levels of needs as Redbridge looked after children.

[6] Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children, (2009), DCSF Publications

Our vision
To provide support and care to all looked after children that enable them to have good mental and physical wellbeing to fulfil their potential during childhood and adulthood.

What can we do?
- Review and develop 'Responsible Commissioner' arrangements with other Clinical Commissioning Groups regarding children ordinarily resident in Redbridge who are placed outside the borough and those children placed in Redbridge by other boroughs.
- Develop skills and knowledge within universal services to ensure they support looked after children and prioritise their health needs by speedy referral where necessary.
- Develop a robust care leaver's pack/pathway for teenagers.
- To review and put systems in place to ensure that Strength Difficulty Questionnaires (SDQ) are used to enhance health assessments and are the basis for service development and delivery.

Strategic Priority: Healthy communities

Early detection of cancers and screening

Why is it important?
Cancer is a significant cause of premature death and poor health in Redbridge. Many deaths from cancer are preventable. Although premature death (death among people younger than 75 years) from cancer is lower in Redbridge than England, survival one year after diagnosis is lower than compared to London and England.

Early detection of cancer through screening is one of the important ways by which cancers can be prevented. Redbridge has implemented all the national cancer screening programmes (breast, cervical and bowel). Among Redbridge residents eligible for screening over 76% were screened for cervical cancer, 73% for breast cancer and 46% for bowel cancer (2010/11).

In Redbridge, there is a significant variation in the uptake of cancer screening - especially in the south of the borough where one of the common factors is a high predominance of people of Asian, black and minority ethnic origin. Poor uptake of screening in hard to reach groups is a major public health issue.

Our vision
To increase the uptake of cancer screening especially among groups where this is low.

What can we do?
Implement plans to increase screening uptake by:
- Encouraging practices to identify dedicated screening leads and screening teams.
- Encouraging all practices to adopt basic steps to improve uptake in cancer screening.

NHS Health Checks

Why is it important?
The NHS Health Check is a preventative service provided by General Practices, which identifies people who are at risk of developing or have early signs of vascular disease (including coronary heart disease, stroke, diabetes and chronic kidney disease).

Vascular diseases are the biggest cause of death in the UK and health checks could help people lead healthier lifestyles, prevent deaths and allow individuals to have better management of their conditions and have improved quality of life.

By ensuring that all eligible residents have an NHS Health Check we have an opportunity to mitigate some of the effects of health inequalities, particularly those relating to socio-economic grouping, ethnicity and gender.

Our vision
To ensure that all eligible residents can take the opportunity to have a NHS Health Check.

What can we do?
- Continue to work with primary care to ensure delivery of NHS Health Checks to local residents.
- Continue to raise awareness and uptake of NHS Health Checks through the development of social marketing campaigns targeted towards different groups of residents.
- To explore opportunities for the provision of NHS Health Checks in venues outside General Practice, such as community pharmacies, so as to widen accessibility of this service.

Promote wellbeing and help people contribute to their communities by supporting access to employment, benefits and reducing social isolation

Why is it important?
Being in employment (either as a volunteer or paid) is protective of health and wellbeing including mental health. Unemployment contributes to poor mental and physical health. Therefore, getting people into work is a key component for reducing health and social inequalities (Marmot 2010).

Vulnerable people such as those with mental health needs or disabilities are least likely to be in employment despite the benefits of employment being especially positive.

Our vision
To increase the numbers of residents participating in paid employment especially among those who have disabilities or mental health needs, and ensure that all eligible residents receive the appropriate benefits.

What can we do?
- Providing children and staff with the best possible education to maximise participation in employment and voluntary work.

- Providing adults with good vocational training aimed at available employment and obtaining better paid work.
- Ensuring that vulnerable people such as those with a disability or long term condition including mental health needs are supported to gain employment opportunities.

Strategic Priority: Prevention and early intervention

Managing long term conditions to avoid emergency hospital admissions

Why is it important?
The proportion of residents who have long term conditions (diabetes, asthma, coronary heart disease, and congestive heart failure) is increasing. Diabetes is a particularly important long term condition for Redbridge as the proportion of residents who have diabetes is the highest in north east London. Diabetes is one of the major causes of blindness among working aged adults and cause of lower limb amputations.

The early identification of people who are at risk of developing disease, or who have early disease is essential to enable people to manage their condition and maintain quality of life. Emergency hospital admissions for people with long term conditions can be an indication of poor disease management which puts people at risk of complications, poor quality of life and premature death.

A range of services are provided within primary care and the community to meet the growing needs of patients.

Our vision
To reduce unplanned hospital admissions, due to long term conditions, and support earlier discharge from hospital, by providing early intervention.

What can we do?
- Implement integrated management to improve care for patients with long term conditions.
- Ensure GP practices use the correct disease codes to categorise patients with long term conditions.

Improve the detection of irregular heart beat in primary care to reduce the number of strokes cases

Why is it important?
Atrial fibrillation (quickening of the heart muscle) is the most common type of abnormal heartbeat. It primarily affects people aged over 65, however some young people also known to have it. About five in every 100 people aged over 65, have atrial fibrillation. All practices in Redbridge offer everyone aged over 65 a routine pulse check as part of their NHS Health Check for people aged between 40 and 74 years old.

A range of risk factors are known to contribute to atrial fibrillation including people over 65, heart disease, high blood pressure, binge drinking and an overactive thyroid gland.

Our vision
To identify early, residents with atrial fibrillation by ensuring that practices offer a pulse check within the NHS Health Check; when the annual seasonal flu injection is given, as well as opportunistically checking the pulse of patients over the age of 65.

What can we do?
- To work with North East London Cardiovascular Network to enhance the diagnosis of atrial fibrillation in primary care.

Strategic Priority: Maximising health benefits

Support for frail older people

Why is it important?
Frail and isolated older people are very vulnerable to poor health and wellbeing. Estimates show that within Redbridge there is likely to be an increase in older residents who have long term conditions, who are finding increasingly difficult to carry out domestic and self-care tasks and have poor mobility.

Excess winter deaths affect all age groups although older people, especially those who have long term conditions are disproportionately affected. Redbridge has a high excess winter death rate especially for deaths among people who have respiratory diseases.

Our vision
To support older people to improve their quality of life and reduce excess winter deaths.

What can we do?
- Ensure maximum coverage of seasonal flu vaccination amongst at risk groups.
- Ensure maximum coverage of pneumococcal vaccination amongst at risk groups.
- Ensure all partners are aware and identify groups at risk of winter deaths and offer preventative advice and information.
- Implementation of the Cold Weather Plan.

Hard to reach groups

Why is it important?
Some groups of residents find it difficult to use services. This likely to be due to a range of complex factors and can include a number of groups of residents who often find it difficult to use services. For example, this may be because they:

- Lead very transient lifestyles
- Experience domestic violence
- Are excluded young people

- Belong to some ethnic or nationality groups such as the Roma population and people from new EU countries (who have no recourse to public funds)
- Are Carers
- Are people who have mental health needs, disabilities or who misuse alcohol or substances
- Living in temporary or poor quality housing.

One notable concern is that approximately 20% of pregnant women resident in Redbridge do not use antenatal services before 12 weeks gestation. Evidence shows that when residents find services difficult to use, this can have a negative impact on their health and wellbeing.

There are many groups of residents who we have very little information about and therefore, we are not able to tell whether they are receiving the appropriate services.

Our vision
All residents are able use services by ensuring that the right information regarding service provision is widely available and that resident's experience of using services is positive.

What can we do?
- Ensure suitable information regarding service provision is available.
- Ensure positive service user experience.
- Targeted support for hard to reach groups.
- Ensure that all universal services offer services that are accessible to 'hard to reach' groups including people who have mental health needs and people who have learning disabilities.
- To ensure that Equality Impact Assessment processes are conducted effectively.

Dementia including Alzheimer's

Why is it important?
The term 'dementia' is used to describe a collection of symptoms including a decline in memory, reasoning and communication skills with a gradual loss of ability to carry out everyday tasks. It is caused by illness that affects the brain, of which Alzheimer's disease is the most common form. The National Dementia Strategy for England 'Living Well with Dementia' provided a number of objectives that should be locally implemented. It should be based on three key themes:

- Good quality early diagnosis and intervention
- Raising awareness and understanding
- Living well with dementia

It is estimated that current recorded prevalence covers approximately 30% of the total number of people expected to have dementia. This suggests that across Redbridge there is still under-diagnosis of dementia within most GP practices. The Health Care for London's Dementia Services Guide has reported that in Redbridge the prevalence of

dementia will increase by 17% by 2021. Numbers of people with dementia are expected to increase from 2,448 in 2010 to 3,344 in 2030.

Dementia is rarely the primary cause for admission, but people with dementia often stay longer in hospital and require more vigilant care. They are also affected by their socio-economic position and their living arrangements vary accordingly to age, severity of the condition and personal and family circumstances. Living alone is recognised as being an indicator of isolation and lack of access to informal support. It is predicted that there will be increasing numbers of older adults who will live alone.

Our vision
To provide good quality diagnosis and early intervention, in order to help people living with dementia and their carers better understand and manage the condition.

What can we do?
- Ensure good quality early diagnosis and intervention
- Raising awareness and understanding
- Implementation of the Dementia Strategy in Redbridge

Priorities for Year 2

STRATEGIC PRIORITY	AREA PRIOIRTY
Improving life chances for children	• Breastfeeding • Development of health care pathways for children with complex health care needs
Healthy communities	• Reducing the need for long term care • Identifying those at risk of falls • Support for carers • Reducing obesity, achieving healthy weight and increasing physical activity
Prevention and early intervention (See year 1)	• Managing long term conditions to avoid hospital admission • Improve the detection of irregular heartbeat in primary care to reduce the number of strokes cases
Maximising health benefits	• Safer communities and neighbourhoods • Sexual health including teenage pregnancy

Strategic Priority: Improving life chances for children

Breastfeeding

Why is it important?
The Department of Health and the World Health Organisation recommend that babies are breastfed exclusively for at least six months.

Breastfeeding reduces the risk of gastroenteritis, ear and respiratory infections, allergic disease, diabetes and obesity in later childhood. Mothers also benefit as breastfeeding reduces the risk of ovarian and breast cancer as well as osteoporosis.

Redbridge has a significant degree of mixed feeding which local analysis has identified is more prevalent among families of Asian backgrounds.

Redbridge Community Services have recently achieved UNCIEF Baby Friendly Status Stage One. The UNICEF Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF. The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. Organisations are awarded Stage 1, 2 or Full Award in recognition of the level service provision and quality of service offered to families.

Our vision
To increase the proportion of women who choose to breastfeed and successfully maintain exclusive breastfeeding for at least six months.

What can we do?
- Redbridge Community Services are currently working towards achievement of Stage Two of the UNICEF Baby Friendly status.
- Develop baby friendly sites in all public areas in Redbridge.
- Target services and social marketing outside the home environment across the borough to support women at risk of stopping breastfeeding.
- Develop peer support services with the aim of extending support offered to families.
- Ensure all staff have received appropriate levels of training to encourage and support women to breastfeed.
- Continued improvement in data collection at key contact times with parents.
- Consider reducing formula milk advertising on billboards in Redbridge.

Development of health care pathways for children with complex health care needs

Why is it important?
Children with complex health needs often have a combination of conditions or disabilities which result in poor physical and mental wellbeing. In addition, an increase in the number of children resident in Redbridge there is a disproportional increase in the proportion of children who have disabilities and complex needs. The provision of early identification, intervention and support can result in improved outcomes.

Our vision
To ensure that children and young people with complex health needs and disabilities are supported through early identification and intervention to have the best possible outcomes.

What should we be doing?
- To monitor the implementation of all current clinical care pathways with particular focus on children and young people with Autistic Spectrum Disorder.
- To promote joint working that supports children with disabilities to be healthy and participate in their day to day life.
- To address the mental wellbeing of children, young people and families with particular focus on key transition points.

Strategic Priority: Healthy communities

Reducing the need for long term care

Why is it important?
Maintaining independence and control is essential for quality of life for older people, people with long term conditions, people with physical and learning disabilities and people with mental health needs. In Redbridge there are increasing numbers of older adults, adults with long term conditions and adults with physical and learning disabilities. A variety of services are currently commissioned to reduce the need for long term care. These include respite care, re-ablement services, falls prevention, lifeline telephone response, housing related support, community based services provided to people who live in their own homes (supported/sheltered accommodation, home care, day care and meals), and supported discharge from hospital and direct payments.

Our vision
To support older people and a range of people with long term conditions, physical and learning disabilities, mental health needs and other vulnerable adults to have control and maintain independence thereby preventing, where appropriate, the need for long term care.

What can we do?

- Encourage a proactive approach to the pooling or aligning of budgets across health and social care to provide coordinated and integrated packages of care.
- Build on our joint working arrangements which support jointly agreed strategies to improve clarity and efficiency through the integration of community based teams and commissioning arrangements.
- Ensure that a whole system approach to integrated care supports older adults to maintain independence, control and quality of life.
- Explore the potential to develop a first contact scheme, which involves a wide range of agencies coming in contact with vulnerable or isolated adults.

Identifying those at risk of falls

Why is it important?
There are increasing numbers of older people with risk factors for falls. The consequences of falls and the fear of falling can lead to a decrease in physical, psychological and social functioning which can impact on quality of life. Falls impose a high cost to NHS and social care services, because of the high cost of treatment and long term rehabilitation. As serious falls can also result in death, preventing older people from falling is important as the consequences of falls cut across all local agencies working with older people.

Redbridge integrated falls service works to prevention falls as well as provide treatment, care, re-enablement and rehabilitation to restore independence after a fall.

Our vision
To reduce the numbers of older people who have falls and reduce deaths due to falls.

What can we do?

- Ensure that Redbridge meets the good practice guidelines on effective interventions on prevention and management of falls.
- Review and promote further the falls care pathway to ensure it meets older people's needs and that it captures all relevant services.
- Achieve the national standards for hip fracture treatment.

Support for carers

Why is it important?

The National Strategy for Carers[7] states that a carer is 'someone who spends a significant proportion of their life providing unpaid support to family and potentially friends'. This could be caring for a relative, partner or friend who is ill, frail, disabled or has a mental health problem or substance misuse problems.

The 2001 census found that approximately 10% of the Redbridge residents provided unpaid care. The results of a questionnaire to local carers found that just under 75% of carers had health problems with long term conditions and mental health needs identified as the most common problems.

It is estimated that there may be 650 young carers resident in Redbridge. Young carers are vulnerable to negative effects of caring responsibilities. The Redbridge Carers Strategy 2010-2013 sets out local direction and priorities. A range of services are commissioned by the NHS and London Borough of Redbridge to provide support for carers. There are also a number of other local and national voluntary and statutory organisations that provide information, advice and advocacy. Specific services are commissioned to support carers of people with dementia.

Our vision

'Carers (including young carers) will be recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet the individual's needs enabling Carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.' [8]

What can we do?

- Review capacity of services for carers in light of increasing numbers of carers in the borough.
- Ensure that hard to reach carers are empowered to access services and receive support.
- Continue to commission responsive services which effectively identify carers, and offer support and early intervention including advice, information and advocacy.

[7] Department of Health, 'Carers at the heart of 21st century families and communities', 2008.
[8] 'Carers at the heart of 21st century families and communities'

Reducing obesity, achieving healthy weight and increasing physical activity

Why is it important?
Overweight, obesity, poor nutrition and physical inactivity can result in long term physical and mental health problems and are linked to some of the leading causes of death and poor wellbeing in Redbridge including cancers, diabetes, heart disease and depression. Just over one out of every ten reception pupils and two out of every ten year six pupils in Redbridge are obese.

It is estimated that just over two out of every ten adults resident in Redbridge are obese, that seven out of ten adults do not have a healthy diet and nearly half of men and six out of ten women do not participate in any physical activity.

Additionally, obesity during pregnancy presents a series of health risks to the mother and foetus and increases the risk of complications during pregnancy and birth.

The Department of Health published 'Healthy Lives, Healthy People: a call to action on obesity in England'. This calls for a partnership in the fight against overweight and obesity to achieve a sustained downward trend in the level of excess weight in children and adults by 2020.

Our vision
To reduce obesity among our residents by increasing physical activity, healthy eating and healthy lifestyle choices.

What can we do?
- Establish a coordinated approach to reducing obesity by developing strategic direction and an evidence based pathway focusing on prevention, management and treatment.
- Address the inequalities among the least active groups in the borough, those with a limiting disability and those in the lower socio-economic groups including those who have never worked and people who are long-term unemployed.

Strategic Priority: Maximising health benefits

Safer communities and neighbourhoods

Why is it important?
Good community cohesion and community safety are protective of health and wellbeing. Factors affecting community safety include crime, domestic violence and substance misuse. There are links between crime, domestic violence and substance misuse; both victims and perpetrators are likely to be vulnerable to poor health and wellbeing.

Community safety and community cohesion affects us all. Issues such as domestic violence, mental ill health and substance misuse have been identified as common features of families where harm to children has occurred.

In Redbridge there has been an increase in crime (Total Notifiable Offences) during the last two years. In 2011/12, 170 domestic violence cases were discussed at the borough Multi Agency Risk Assessment Conference (MARAC), these cases involved 220 children and are reported to represent 10% of the total number of domestic violence cases. Hospital admissions due to alcohol have risen from 846 per 100,000 in 2002/3 to 1,946 in 2010/11. It is estimated that there were 1,480 opiate and crack users in Redbridge during 2009/10.

Redbridge Council working in partnership with the NHS commission a range of treatment services for substance and alcohol misuse for both adults and young people. A range of agencies also provide support to offenders to prevent reoffending, families experiencing domestic violence, victims and residents who have experienced hate crime and rape crisis provision.

Our vision
To support residents to feel safe by preventing crime, alcohol and substance misuse and identifying families early who may require support.

What can we do?
- Further development of crime prevention and local services to support victims of crime and anti-social behaviour.
- Prevent substance misuse and ensure effective treatment services.
- Offer early support to families in need.
- Ensure early access to preventative and support services.

Sexual health including teenage pregnancy

Why is it important?
The consequences of poor sexual health can be serious and include Sexually Transmitted Infections (STIs), Human Immunodeficiency Virus (HIV), or infertility and unplanned pregnancy. All of which have a number of financial, human and psychological costs. In Redbridge (as well as nationally), there are increasing numbers of people who develop STIs, increasing numbers of abortions and too many people living with HIV are diagnosed late.

Unplanned pregnancy has a significant impact on individuals, especially young people; and termination can have long term physical and psychological effects. Teenage pregnancy often leads to poor health and social outcomes for the mother and baby. There is an increase in teenage pregnancy in most deprived wards. Young people and some minority ethnic groups are disproportionally affected by poor sexual health.

Our vision
To improve the sexual health of Redbridge residents (especially young people and some minority ethnic groups) by ensuring the provision of widely available, easy to use and timely sexual health services.

What can we do?
- Strengthen the delivery of sexual health services from all local providers.

- Strengthen sexual health training including Long Acting Reversible Contraception (LARCs), STI and HIV to testing for local sexual health care professionals.
- Actively promote long acting reversible contraceptives to high risk women aged 20-35 years.
- Actively promote HIV testing to black African communities and gay men.
- Work with primary care to sign post 'at risk' groups to the local Point of Care HIV testing service and other services.
- Expand access to HIV testing to include healthcare settings such as general practice, medical assessment units and local Accident and Emergencies units, as well as in the community.
- Increase health promotion activities to raise awareness of the risk factors and identify what works locally with emphasis on behavioural change interventions facilitated by community champions, health trainers and peer groups.
- Enhance plans to strengthen Sex and Relationships Education (SRE) provision in the borough.
- Address the underlying risk factors of teenage pregnancy such as low educational attainment and aspirations and lack of engagement in learning post-16 and the effects of poverty.

Priorities for Year 3

STRATEGIC PRIORITY	AREA PRIORITY
Improving life chances for children	• Consanguinity • Young people and substance misuse • Transition from children's to adult services
Healthy communities	• End of life care
Prevention and early intervention (See year 1)	• Managing long term conditions to avoid hospital admission • Improve the detection of irregular heartbeat in primary care to reduce the number of strokes cases

Strategic Priority: Improving life chances for children

Consanguinity

Why is it important?
There is evidence that children whose parents are blood relatives are more likely to have genetic conditions leading to disability and/or premature death. Among some minority ethnic groups including Bangladeshi and Pakistani communities the tradition of first cousin marriage is common. The Child Death Overview Panel found that approximately a quarter of children who died during 2009/10 had consanguineous parents.

Our Vision
To raise awareness among communities of the risks associated with child death, life threatening conditions and disability among children of consanguineous parents.

What can we do?
- Fully engage and involve community leaders including faith groups to address the issue among relevant groups.
- Identify and investigate good practice elsewhere in the country and seek to implement this in Redbridge.
- Encourage education services and schools to incorporate awareness raising in the curriculum.
- Engage youth services in targeting teenagers in awareness raising programmes.
- Commission training to raise awareness amongst professionals.
- Improve Child Death Overview Panel data collection and analysis of deaths due to chromosomal, genetic or congenital anomalies.

Young people and substance misuse

Why is it important?

Any substance misuse among young people under 18 years is a cause for concern. Drugs and alcohol can damage health, (including mental health) and development; disrupt education, negatively affect families and are associated with teenage pregnancies and risk taking behaviour. There is relatively little information available regarding alcohol and drug misuse among young people resident in Redbridge. Information that is available suggests that levels of misuse are lower than nationally. Between 2005/6 and 2009/10 the directly standardised rate of hospital admission for substance misuse was 55.2 per 100,000 young people aged 15 to 24 years. This was lower than the national average. Alcohol specific hospital admissions for those under 18 years of age were also lower than the national average (2006/7 to 2008/9). However, mental health admissions associated with alcohol were the most common type of mental health admission for those aged under 17 years of age and are increasing (2006/7 to 2010/11).

Smoking is a major preventable cause of cancers, long term conditions and early death. Children and young people who smoke are more likely to become adults who smoke.

Our vision

- To reduce alcohol and substance misuse and related harm amongst young people resident in Redbridge.
- To help prevent children and young people from taking up smoking and reduce the proportion of those who smoke.

What can we do?

- Work to reduce the number of hospital admissions due to alcohol and substance misuse.
- Commission preventative work to reduce substance and alcohol misuse amongst young people and use early identification and intervention to ensure minimised harm and impact on physical and mental health and wellbeing for those at risk, or who use substances or alcohol.
- Commission preventative work to reduce smoking prevalence among young people.

Transition from children's to adult services

Why is it important?

Transition between children's and adult services is an important period in the life of a young person. Good quality transition planning can assist young people and their families to ensure that young people reach their aspirations. In contrast when transition is not well planned it is costly to young people and families in personal and financial terms. Effective transition pathways can prevent young people 'falling through the net' and re-entering services during crisis or developing complications of long term conditions requiring hospitalisation and impacting on quality of life.

Transition planning should involve a range of organisations including health, housing, education, employment and leisure. Additionally relevant information and access to quality advice and support are key to successful transition.

Our vision
To ensure that transition processes enable young people with disabilities, long term conditions, end of life care needs and mental health needs to participate in their local communities and have fulfilling lives.

What can we do?
- Commission information for young people and families to support successful transition.
- All services should identify numbers of young people requiring transition over the next five years and use this to plan transition and service development.
- Development of transition pathways.

Strategic Priority: Healthy communities

End of life care

Why is it important?
It is estimated that there are people in need of end of life care who are not currently receiving services. Active case finding and good disease management would enable the majority of deaths to be anticipated and the end of life planned for. In 2008/9, 195 patients were estimated to be receiving end of life care in comparison to an estimated number of 2,102 who may have needed end of life care (NHS Comparators 2010).

General palliative care is provided through a variety of professionals in the community who support patients to manage their symptoms, signpost and refer them to specialist services. District nurses and GPs are the main providers of general end of life care. Additionally, Redbridge has a 24/7 primary care nursing service. Other multi-disciplinary professionals may be involved such as physiotherapists.

Our vision
To improve availability of good quality, locally accessible, affordable and flexible end of life care for our residents.

What can we do?
- Commissioning for end of life care should be based on the published 'End of Life Care pathway'. Four elements should be embedded throughout the commissioning process; information for patients and carers, psychological, bereavement and spiritual care services, support for carers, and social care bereavement services also need to be available for the carers and families of patients who do not die in hospice provision but in the community.
- Using the necessary levers, commissioners should ensure that providers are compliant with national guidance, including NICE guidance and recommendations on best practice to facilitate improvements in provision of end of life care services, such as the Gold Standard Framework, Preferred Priority for Care and the Liverpool Care Pathway. This should include the provision of 24/7 specialist advice.