Fairness Commission:
Evidence on tackling health inequalities in Redbridge

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1. **Purpose**

This pack aims to enable commissioners to gain an understanding of the profound nature of health and wellbeing inequalities and an indication of how this affects people living in Redbridge. It gives an overview of how Redbridge Public Health Team contributes to the Council and wider partners work to interrupt the cycle of inequality and reduce the effects of inequality.

2. **Public Health: What does it mean and how is it delivered?**

Health and wellbeing is more than the absence of disease. In terms of health we are not born equal, not least because of the impact of our gender and genetic constitution – which we can do little about. But many of the causes of what drives differences in health and wellbeing are preventable or modifiable, and both individuals and society have much to gain in the use of collective efforts to tackle them.

Addressing the source of inequality and addressing the many effects of inequality (the public’s health) is the responsibility of all. Public Health as a professional group has an important but not exclusive role within this goal.

Public Health is about improving the health of populations i.e. groups of people living in real and evolving communities, rather than treating the poor health of individual patients. The Public Health professional body is The Faculty of Public Health which has described Public Health as ‘The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society’. (Faculty of Public Health)

A Public Health approach is: Population based; Based on collective responsibility for health, it’s protection and prevention of disease; Concerned with the determinants of health; and founded in partnerships with all those who contribute to the health of the population.

The Redbridge Public Health Team (RPH) works with many other groups to monitor the health status of the communities they work with and for, identifying health needs, developing programmes to reduce risk and screen for early disease, controlling communicable disease, fostering policies which promote health, shaping and evaluating the provision of health and social care, and managing and implementing change.

3. **Transition following the Health and Social Care Act 2012**

Responsibility for public health transferred from the NHS to Local Authorities in April 2013. This means that Local Authorities have become responsible for improving the health and wellbeing of their population. As a result of the restructuring of the NHS, Public Health England (PHE) was also established to protect and improve the nation’s health, working closely with national and local government, the NHS, industry, academia and the public and community sector. Local government and local communities are seen as being at the heart of improving health and wellbeing and tackling health inequalities.

The Public Health Team in the London Borough of Redbridge includes the Director and Deputy Director of Public Health who are supported by a team of Consultants in Public Health and Public Health Specialists and other team members.
Training and education of the future Public Health workforce is regarded as a key function of the Local Authority Public Health Team. Since moving to LBR, the Redbridge Public Health Team has become established as a well-regarded accredited training location for Trainee GPs participating in the London Deanery’s Training Programme and Public Health Trainees from the London Deanery’s Speciality School in Public Health. In addition the team frequently host volunteers seeking to gain experience within the Public Health field.

4. **How does Redbridge Public Health Team work to address inequality?**

**Fairness: Key concepts**

Improving fairness is fundamental to the principles of Public Health, some of the key concepts that we work towards are listed below:

- Reducing inequalities in health is a matter of fairness and social justice.
- There is also a very strong economic rationale for action.
- There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged is not sufficient. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- In practice – we often focus on universal preventative activities/ interventions which are applicable to all residents (e.g. School Nursing Services), and targeted/ specialised services for individuals and communities who have specific needs (e.g. Smoking Cessation Services).

**Domains of Public Health action**

There are three key areas of Public Health practice. The Redbridge Public Health Team works across the three domains with partner organisations (both statutory and community) to improve wellbeing among the general population of Redbridge as well as targeted programmes for those with greater needs.

1. **Health improvement**
   a. Tackling health inequalities
   b. Wider determinants of health
   c. Family/community lifestyles
   d. Surveillance
   e. Monitoring of specific diseases and risk factors

2. **Improving services**
   a. Clinical effectiveness
   b. Efficiency
   c. Service planning
   d. Audit and evaluation
   e. Clinical governance
   f. Equity
3. **Health Protection**
   a. Infectious diseases
   b. Chemicals and poisons
   c. Radiation
   d. Emergency response
   e. Environmental hazards

In relation to these domains, primary prevention refers to stopping a health event, such as disease or injury, from occurring at all; secondary prevention aims to limit disease progression. In contrast, early intervention refers to the prompt identification of issues at an initial stage and rapid action to stop further escalation. Early Intervention is often targeted to specific groups while preventive measures are generally universal to the wider population.

**Public Health Team Responsibilities**

The mandatory Public Health services that the Council has responsibility for are:

a) Comprehensive open access sexual health services;
b) NHS Health Checks;
c) National Childhood Measurement Programme;
d) Protecting the health of the Redbridge population, ensuring relevant plans are in place to achieve this; undertaking a supporting role working with Public Health England in infectious disease surveillance and control and emergency planning;
e) Provision of Public Health expertise and advice to Redbridge Clinical Commissioning Group to support the development and commissioning of high quality, accessible health care services reflective of local health needs and priorities.

Redbridge Council is also responsible for providing a wide range of services to improve and protect the health of the local population. These include:

a) Drug and alcohol harm reduction, treatment and recovery – commissioning of an integrated Drug and Alcohol Service;
b) Commissioning School Nursing and Healthy Child Programme for 5-19 year olds (HCP for 0-5s is moving to the Council in October 2015);
c) Stop smoking and tobacco control;
d) Weight management and obesity;
e) Nutrition and healthy eating;
f) Physical activity;
g) Oral health promotion and prevention;
h) Mental health promotion, reducing stigma and preventing risk factors;
i) Preventing violence and social exclusion;
j) Health at work;
k) Reducing the effect of poverty.
**Universal and Targeted Services**

The healthy Child Programme is an example of a universal service commissioned by the Public Health team to improve wellbeing among all children and young people as well as supporting children and families with higher needs. It aims to improve the health and wellbeing of all children aged between 0-19 years and includes both School Nursing (which the Redbridge Public Health Team currently commissions) and Health Visiting (which the Redbridge Public Health Team will receive responsibility for commissioning in October 2015).

Examples of targeted services commissioned by the Redbridge Public Health Team include:

- **Primary Care Alcohol Scheme – Targeting people at risk of harm due to alcohol misuse**
  - Involves GPs diagnosing alcohol dependency and providing alcohol detoxification and/or preventative prescribing to prevent relapse.
  - GPs provide the medical management and a local substance misuse outreach service delivers all psychosocial interventions including home visits.
  - Of the 3000 estimated dependent drinkers in Redbridge only 13% access specialist services, this scheme allows a specialist clinical intervention to become more accessible and available to patients and avoids the stigma associated with attending a substance misuse service.
  - By treating an individual’s alcohol misuse/dependency results in significant improvements in their physical/mental health.
  - Individuals are in a far better position to access employment, training/education, engage in meaningful relationships and contribute to society as a whole.

- **Emergency Hormonal Contraception at Pharmacies – Targeting young people at risk of unwanted Teenage Conception**

As part of sexual health services targeted to young people, Emergency Hormonal Contraception is available in pharmacies to ensure easy access to young people (under 25 years) and those at risk of unwanted pregnancy. This aims to further reduce teenage conceptions and improve the potential impact on health, wellbeing and future life aspirations.

- **TB Awareness Project – Targeting communities at higher risk of TB**

Redbridge TB partnership is a collaboration between Public Health, Barking Havering and Redbridge University Trust (BHRUT), Redbridge Council for Voluntary Service and the wider voluntary sector, Redbridge Clinical Commissioning Group, TB Alert, NHS England, Public Health England and TB patients. The aim of the TB partnership group is to create and oversee the execution of a plan to increase awareness of TB to relevant communities at risk, the general public, healthcare professionals and ensuring that the relevant TB agencies are fully engaged with the work of the group. So far 15 Health Buddies have been trained who are able to speak a wide range of community languages. TB awareness sessions are conducted in groups as well as one to one interactions at various places like community groups, libraries, care homes, faith places and colleges. So far, they have reached over 2000 local residents through several sessions. As a result of these sessions, over 25 people have been referred to local TB services for investigation of TB and management.
5. The Determinants of Health Inequalities

The picture below identifies the key determinants of health.

Figure 1.

A significant review of health inequalities in the UK, and what could be done to address them, was undertaken by Michael Marmot and published in 2010 – ‘Fair society, healthy lives’.

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

The 2010 Marmot Review identified six policy objectives which are central to reducing health inequalities:

- 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 healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

Work to mitigate the effects of inequality is the responsibility of the Council as well as other Public Sector organisations, the voluntary sector and local communities. The Redbridge Public Health Team works with partners and other departments within the Council to address many of the wider determinants of health.

Deprivation and Health Inequalities

Deprivation is a key determinant of health, and refers to unmet needs caused by a lack of resources of all kinds, not just financial and can be defined in a broad way to encompass a wide range of
individual’s living conditions. The English Indices of Deprivation attempts to measure this using seven domains; income, employment, health and disability, education skills and training, barriers to housing and other services, crime and living environment.

The 2010 IMD ranks Redbridge as 22 out of 33 Boroughs. However within the Borough there are marked differences at ward level and below ward level. It is possible that the IMD 2010 does not provide evidence of the full impact of the economic down turn as it is based on historic data. A more up to date version has not been published yet.

Work was undertaken in London to identify what the impact of the economic downturn and policy change might be on health inequalities in London, with a particular focus on employment, income and housing. Profiles were produced for each London Borough and focused on a number of key indicators- the Redbridge profile is available at the link below.

http://www.lho.org.uk/lho_topics/data/economicdownturn.aspx

Key information arising from the Redbridge profile includes:

- Between 2008 and 2012 there was an increase in Redbridge households claiming housing benefit.
- Since 2004 there has been an increase in the percentage of economically active population who are unemployed among Redbridge residents.
- Since 2002 the percentage of Job Seekers Allowance claimants where the duration of claim is 12 months or longer has increased among Redbridge residents.
- There has been a decrease in the ratio between full and part time employment in Redbridge. Part time work often pays at a lower pro rata rate than comparable full time work, and can mean a relatively low level of income. A falling ratio of full to part time workers is likely to indicate an increase in people aged 16 to 64 with low incomes.
- Redbridge has a lower percentage of young people not in employment, education or training in comparison to London and England.
- Between 2008 and 2012 there has been an increase in Redbridge households claiming Council Tax benefit.
- Between 2002 and 2012 there was an increase in the rate of individual insolvencies per 10,000 persons in Redbridge (similar to London but lower than England).

Public Health is working with partners to collect the latest data in relation to these indicators in order to monitor trends.
**How do we monitor the wellbeing of people living in Redbridge?**

The following documents provide in-depth information regarding how health and wellbeing inequality affects people living in Redbridge.

1. **Joint Strategic Needs Assessment and other in depth needs assessments/ analysis**
   [http://www2.redbridge.gov.uk/cms/care_and_health/health/joint_strategic_needs.aspx](http://www2.redbridge.gov.uk/cms/care_and_health/health/joint_strategic_needs.aspx). This is renewed and published annually.

2. **Annual Public Health Report**

   This includes a national set of indicators covering the full spectrum of public health (including the wider determinants of health, health improvement, health protection and healthcare public health); these indicators are produced nationally and compare Redbridge against other local authorities and benchmarks against the England value.

6. **Population Health Measures**

The following section looks at measures of health and wellbeing to demonstrate how inequality affects people living in Redbridge. Nearly all measures of health and wellbeing that we could look at would demonstrate a socio economic gradient in wellbeing. Life expectancy and infant mortality are the two measures most commonly used to compare the health of different populations.

**Life Expectancy**

Life expectancy at birth is the average number of years a baby born now would expect to live based on contemporary mortality rates. In Redbridge life expectancy is higher than both the London and England averages for men and women. On average men in Redbridge are living over five years longer since 1991-1993 and women are living four years longer. The gap of 3.5 years in 2011-13 is lower than London (4.1) and England (3.7).

![Figure 2](image)

<table>
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<td>79.4</td>
<td>79.1</td>
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</table>

There are significant inequalities in life expectancy within Redbridge, and these are most commonly measured by looking at the deprivation index of the area. The charts below clearly show that there is an association between better life expectancy and lower deprivation in Redbridge, for men and women. Life expectancy is 5.7 years lower for men in the most deprived areas of Redbridge based on the latest slope index of inequality figures published (2011-13)- see below.
Slope Index of Inequality
The Slope Index of Inequality (SII) is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation.

PHOF Overarching Indicator - SII (Slope Index of Inequality), 2011-13

Figure 5

<table>
<thead>
<tr>
<th>Indicator No</th>
<th>Slope Index of Inequality</th>
<th>Male</th>
<th>Female</th>
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Male and female life expectancy at birth by ward, difference from England, 2010-12, ranked

Figure 6

Figure 7

Males

<table>
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<th>England and Wales (78.8)</th>
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</tr>
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<td>Bridge</td>
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</tr>
<tr>
<td>Roding</td>
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</tr>
<tr>
<td>Newbury</td>
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</tr>
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</tr>
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<td>Goodmayes</td>
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</tr>
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<td>Fairlop</td>
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<tr>
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<td>Loxford</td>
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Females

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<tr>
<td>Loxford</td>
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</table>
The ward-based data for 2010-12 shows that Loxford is the only ward in Redbridge where male and female life expectancy is significantly below the England and London average (75.6 years for males and 80.6 years for females).

Figure 8 - Improvements in life expectancy by ward

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>1999-2003</th>
<th>2009-2013</th>
<th>LE improvement in years</th>
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</tbody>
</table>

Source: Greater London Authority

Based on 2009-13 ward based data, Newbury ward has the highest gap in life expectancy at birth between males and females (6.6 years). In Redbridge, the life expectancy gap between males and females has narrowed from 4.4 years in 1999-2003 to 3.7 years in 2009-2013, whereas a few wards such as Clementswood, Fairlop, Goodmayes, Hainault, Loxford, Newbury and Wanstead have shown widening of the gap during the same period.
Between 1999-03 and 2009-13, life expectancy has increased by 3.4 years for men, and 2.7 years for women in Redbridge. These increases are lower than the overall improvements in London (3.9 years for men and 3.2 years for women). Among wards, the largest increase in life expectancy for men was in Fullwell (6.6 years) while the smallest was in Fairlop (1.7 years). The largest increase in life expectancy for women was in Newbury (5.7 years) and the smallest was in Chadwell (0.5 years).

Source: Greater London Authority
Figure 10: PHOF overarching indicator – HLE (Health Life Expectancy), 2010-12

<table>
<thead>
<tr>
<th>Area</th>
<th>Life expectancy at birth</th>
<th>Healthy life expectancy at birth</th>
<th>Lower confidence interval</th>
<th>Upper confidence interval</th>
<th>Proportion of life spent in ‘Good’ health (%)</th>
<th>Life expectancy at birth</th>
<th>Healthy life expectancy at birth</th>
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</table>

*Source: Office for National Statistics derived from Annual Population Survey (APS)*

**Life Expectancy at age 65 years**

Life expectancy at age 65 is the average number of years a person turning 65 years today would expect to live based on contemporary mortality rates. This again demonstrates marked socio economic gradient in life expectancy.

Figure 11
Healthy Life Expectancy (HLE)

This is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. Figures reflect the prevalence of good health and mortality among those living in an area in 2010-12.

The health of people in Redbridge is generally better than the England average. In 2010-12, healthy life expectancy (HLE) at birth in Redbridge was 66 years for males and 62.9 years for females. For males, HLE in Redbridge is almost three years higher than the value for England (63.4) and London (63.2).

On the contrary to the life expectancy at birth figures, the healthy life expectancy at birth for males is higher than the value for females in Redbridge. HLE for females in Redbridge in 2010-12 was lower than the national (64.1) and regional averages (63.6); these differences were not statistically significant.

In Redbridge, the proportion of life spent in ‘good’ health in 2010-12 was 82.2% of life for males and 74.8% of life for females; lowest in Tower Hamlets (68.2% of life for males, 69.7% of life for females) and highest in Richmond upon Thames (85.8% for males, 82.2 for females).
Segmenting life expectancy gaps by cause of death

Public Health England has developed ‘The Segment Tool’ which provides information on the causes of death that are driving inequalities in life expectancy at local area level, and provides charts and tables which segment the life expectancy gap in 2009-11 by major causes of death. The percentage contribution of the causes of death to the life expectancy gap and the number of excess deaths that this results from are provided.

Variation in the causes of death driving the life expectancy gap exists between males and females. However, cancer and circulatory diseases contribute to a large proportion of the total gap in both genders. Excess mortality from these two conditions contributes to over 30% of inequality in life expectancy in Redbridge.

Figure 13: PHOF overarching indicator – HLE (Health Life Expectancy), 2010-12

<table>
<thead>
<tr>
<th>Area</th>
<th>Healthy life expectancy at birth (PHOF 0.1i)</th>
<th>Males</th>
<th>Females</th>
<th>Proportion of life spent in 'Good' health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life expectancy at birth</td>
<td>Lower confidence interval</td>
<td>Upper confidence interval</td>
<td>Life expectancy at birth</td>
</tr>
<tr>
<td>Redbridge</td>
<td>80.3</td>
<td>66.0</td>
<td>63.7</td>
<td>68.3</td>
</tr>
<tr>
<td>London</td>
<td>79.7</td>
<td>63.2</td>
<td>62.6</td>
<td>63.7</td>
</tr>
<tr>
<td>England</td>
<td>79.2</td>
<td>63.4</td>
<td>63.2</td>
<td>63.5</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics derived from Annual Population Survey (APS)

Footnote: Circulatory diseases include coronary heart disease and stroke. Digestive diseases include alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide.
Deprivation quintiles are calculated by ranking LSOAs (Lower Super Output Areas) within the local authority based on their IMD score (Index of Multiple Deprivation), and then grouping the LSOAs into five groups (Quintiles) with approximately equal numbers of LSOAs in each. Quintile 1 covers the 20% most deprived areas within the borough, while quintile 5 covers the 20% least deprived areas of the borough.

Figure 15: Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile in Redbridge by cause of death, 2009-2011

<table>
<thead>
<tr>
<th>Broad cause of death</th>
<th>Cause of death</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of deaths in most deprived quintile</td>
<td>Number of excess deaths in most deprived quintile</td>
<td>Contribution to the gap (%)</td>
</tr>
<tr>
<td>Circulatory diseases</td>
<td>Coronary heart disease</td>
<td>98</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Stroke</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Other circulatory diseases</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>Cancer</td>
<td>Lung cancer</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Other cancers</td>
<td>109</td>
<td>9</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>Pneumonia</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Chronic obstructive airways disease</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Other respiratory diseases</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>Chronic liver disease including cirrhosis</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Other digestive diseases</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>External causes</td>
<td>Suicide</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Other external causes</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>Other causes</td>
<td>Infectious and parasitic diseases</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Mental and behavioural disorders</td>
<td>57</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>555</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Public Health England Segment Tool

Excess deaths are the number of additional deaths which occur in the borough in the three year period 2009-11, over and above the number which would occur if the most deprived quintile had the same mortality rate as the least deprived quintile for that cause of death. In Redbridge, for example, there were over 50 excess deaths in 2009-11 from circulatory diseases amongst males and around 30 excess deaths amongst females.

7. Health Outcomes in Redbridge

Cardiovascular Disease (CVD)

In Redbridge, the death rate from CVD has steadily declined over the last ten years. However, men are still twice more likely to die from CVD before the age of 75 than women and geographic inequalities in CVD mortality rates persist. This is one of the most common causes of preventable death in Redbridge killing over 500 people every year. More than a quarter (26%) of CVD deaths occur in the under 75 year age group. This means one in every four CVD deaths happen before the age of 75 years.
Since 2001-2003, premature deaths (deaths before the age of 75 years) in Redbridge have declined from 132 to 76 deaths per 100,000 of the population in 2010-2012. This represents a 42% fall. Within the broad category of cardiovascular disease, the two most important specific conditions are CHD (Coronary Heart Disease) and stroke. Inequalities in CVD deaths linked to deprivation persist in Redbridge. For instance, residents in the ward of Clementswood, Cranbrook and Loxford are twice as likely as residents in Snaresbrook to die from CVD before the age of 75 years. There are also gender inequalities – males are twice as likely as females to die from CVD before the age of 75 (males 106.5 and females 48.2 per 100,000 in 2010-12).

**Cancers**

Although Redbridge has lower mortality rates for cancers when compared to England and London it is still the most common cause of premature deaths (41%) in the borough. Nearly half (47%) of cancer deaths occur in the under 75 year age group. The most common cancers in Redbridge are lung cancer (18%), breast cancer (10%) and colorectal cancer (8%).

**Lung cancer**

Between 2001-03 and 2010-12, mortality rates from lung cancer in Redbridge have fallen by 24% in all ages (London: -11% and England: -6%). In 2010-12, the mortality rate due to lung cancer is 46 deaths per 100,000 of the population. Nearly half of Lung cancer deaths (47%) in Redbridge occur in the under 75 year age group.

Ward based analysis reveals that Hainault has the highest premature mortality ratio due to lung cancer particularly amongst women (SMR=285). The residents of Hainault are five times (SMR=184) as likely as residents of Seven Kings (SMR=36) to die prematurely of lung cancer. In males, Goodmayes ward has the highest premature mortality ratio (SMR=204).

**Breast cancer**

Between 2000-02 and 2010-12, mortality rates from breast cancer fell by 27% in Redbridge, whereas the rate in England saw a 21% decline and London 25%. The breast cancer screening and treatment programmes are likely to explain in large part, the significant fall in breast cancer mortality. Since 2006-08, the breast cancer mortality rates have shown a steady decline in Redbridge. However, the mortality rates due to breast cancer continue to remain higher than London and England average.

**Liver disease**

In recent years early deaths due to digestive diseases have grown from 5.3% in 2000-02 to 7.7% in 2010-12. This suggests that prevalence of alcohol related conditions are continuing to rise in Redbridge. During the three year period 2010-12, the premature mortality rate from liver disease in persons less than 75 years has risen higher than the London and England average. Since 2001-03, premature deaths in Redbridge have increased from 14 to 19 deaths per 100,000 of the population in 2010-12. This represents a 36% rise, while London rates fell by 9% and England rates rose by relatively lesser proportion of 14%.
In 2010-12, there were 107 premature deaths from liver diseases (76 males and 31 females), of which more than quarter of the deaths (27%) were due to alcoholic liver disease.

Ward based analysis reveals that there is good correlation between liver disease and deprivation. Among males, Loxford, Valentines and Hainault wards experienced a higher mortality ratio to the rest of the borough. In females, Clementswood, Valentine and Chadwell were higher. In Valentines, the premature mortality from liver disease is significantly higher than the Redbridge average.

**Children**
Experiences in early life are increasingly being recognised as having a lasting effect on adult health both directly and through influencing adult health behaviours. Roughly half of the gradient in socio-economic mortality in later life can be explained by early life experience, including its influence on adult smoking rates (Kings Fund). It is therefore useful for the pack to provide information regarding the evidence of inequality among young children to enable commissioners to appreciate the entrenched and long term nature of inequality.

**Inequality during early years**
The early years population in Redbridge is growing in both number and need. Currently 7.8% of Redbridge residents are aged 0-4 years (compared to 6.3% in England and 7.4% in London). This age group alone is expected to grow by 2,552 between 2011 and 2016. Over the past decade (2003-2012) the number of live births has grown by nearly 42%. In some wards the growth has been as high as 83.6%. In 2012, Redbridge general fertility rate in Redbridge is 16% higher than the England average.

The chart below looks at numbers of children aged 0-5 years resident in each ward by deprivation. This shows that wards with higher deprivation levels also have higher numbers of young children resident. This is a key finding when we think of the importance of early life experiences and their lifelong impact.
As well as becoming increasingly ethnically diverse, local indications show that the vulnerability of the 0-5 population may be increasing.

- In 2012, there were 101 live births to mothers aged under-20, and 29 were to mothers aged under-18. Overall rates of teenage conception in Redbridge are lower than the London average, but there is considerable variation by ward, with two of the borough’s most deprived wards (Loxford and Goodmayes) having levels of teenage conception higher than the London average.
- Higher than the national average low birth weight (however this is likely to be due to ethnic diversity among Redbridge residents as women from South Asian backgrounds generally have smaller babies).
- Increasing ‘Hard to reach’ groups including a large Roma population.
- High proportions of families living in temporary accommodation (CHECK).
- Recent in movement of low income families housed in Redbridge from other boroughs.
- Large family sizes (than average for both London and England).
- Lower uptake of vaccinations for Measles, Mumps and Rubella (MMR) and Diphtheria, Tetanus, Polio and Haemophilus Influenza Type B (HIB).
- Increasing prevalence of obesity.
- Increasing domestic violence and other social care referrals.

**Infant mortality**

Infant mortality measures the number of deaths occurring among children under the age of 1 year. The chart below shows that there is a socio economic gradient whereby wards with higher levels of deprivation often have higher rate of deaths. Whilst the actual numbers of deaths remain small around a third are classified as preventable (having modifiable factors) in the Redbridge Child Death Overview Panel (CDOP) Annual Report 2012/13.
**Childhood Obesity**

One of the mandatory functions of the Redbridge Public Health Team is to commission the National Childhood Measurement Programme. This programme measures the height and weight of children at Reception (4-5 years) and Year 6 (10-11 years) and has been operating since 2007. When we look at the percentage of children who are obese in each ward by deprivation we can clearly see a correlation.
8. **How do we use the Public Health grant allocation?**

Determining how limited resources should be allocated to specific uses is a common issue affecting many public services, including public health. There are a number of key Health Economic concepts which can be applied to these issues.

**Technical efficiency** refers to production of a desired output for the lowest level of inputs. In Public Health, an example of this might be how to provide 1000 chlamydia screens for young people. If the cheapest way to provide these screens was to use existing general practitioners rather than to pay for additional community outreach workers to do this, then this would be technically efficient.

**Social efficiency** refers to the optimal distribution of resources to account for all the costs and benefits of the proposed service. These would include costs not just for the commissioner but also incurred by the user, while the benefits would include not only those for the immediate patient but for others in society too.

If we consider Chlamydia screens again, there would be a potential cost to young people of travelling to their local general practice, which was not previously considered. In addition, there are extra benefits to the rest of the society by screening and treating Chlamydia infection, as the spread of infection to others is also prevented.

Therefore, the higher cost of using another delivery model to target Chlamydia screening to groups of young people at high risk, who cannot easily travel to their general practice, would be socially efficient; this would be justified by the wider benefits of preventing the spread of Chlamydia infection to others. This example demonstrates how achieving social efficiency helps address inequalities and realise wider benefits for the community.

The size of the overall Public Health grant which Redbridge receives from national government is determined by historical Public Health spending, prior to the transition of Public Health to the Local
Authority. The size of the Public Health grant per person of the population is currently lower than many other London local authorities, including neighbouring local authorities such as Barking and Dagenham and Waltham Forest, despite Redbridge experiencing comparable levels of ill health and facing several other challenges such as a rapid population growth and the needs of an ethnically diverse population.

Figure 20

Source: Redbridge Public Health

Another example of the challenges faced in public health funding is related to the commissioning of Health Visitor Services. These services play a vital role within the first two years of life, and are therefore key to improving the health of children and addressing early many factors that exacerbate inequalities. As responsibility for commissioning these services also transfers to Redbridge Public Health in 2015, lower levels of Health Visitor spending have also been identified for Redbridge compared to other London boroughs. Redbridge has successfully argued for increased funding (from the red bar to the blue bar, in the chart below) but disparities with other London boroughs still exist.
Another challenge for Public Health is to decide how the limited resources in the Public Health budget are allocated to local health needs. Public Health is obliged to provide certain health services (such as comprehensive sexual health services). However, Public Health is also required to improve the overall health and wellbeing of the whole population, which requires further decisions on how to allocate these resources.

This will always prove challenging as there are a broad range of health needs. In Public Health, we aspire to optimise the distribution of public health resources across the population to achieve the best possible health benefits. If we are able to achieve this, then it would not be possible to re-allocate resources to improve the health of one group without worsening others’ health – this is known as “allocative efficiency”.

To help achieve allocative efficiency, interventions are often compared in terms of their effectiveness. This has been previously expressed for new medicines in terms of improvements in life expectancy and associated quality of life using a term called “Quality adjusted life years (QALYs)”. However, this does not capture the wider benefits to the community and so its use for public health interventions is currently under discussion.

Currently, the largest areas of public health spending (see Chart below) for Redbridge are Substance Misuse and Sexual Health services (GUM) which the Public Health department is mandated to provide. The rest of the public health budget is spent on a range of public health services including NHS Health Checks, the National Child Measurement Programme (which monitors overweight and obesity in children) and programmes to improve physical activity in Adults and Children, among
others. It should be remembered that the public health spending in these areas represents only a proportion of total public spending related to these. For instance, public health physical activity initiatives complement services provided by Vision.

Figure 22

Public Health Budget 2014/15 - £11.4 M
9. **Key Messages**

1. The case for tackling health inequalities is strong - from both an economic and social justice perspective.

2. The Marmott review and subsequent work has identified 6 key policy objectives, and the evidence base for action is clear but still evolving.

3. There are significant health inequalities in Redbridge, and these will need to be re-described as the Borough grows and changes.

4. The transfer of Public Health from the NHS into Local Government provides a significant opportunity to re-focus efforts to tackle inequality and health inequality.

5. However, the Redbridge Public Health Grant itself is relatively small, and the funding position for many Local Authorities including Redbridge is extremely challenging. We need to make the case for Redbridge.

6. The NHS, voluntary sector and other partners continue to make an important contribution to improving health and tackling inequalities. For example, clinical interventions provided by the NHS have made a significant contribution to reducing premature mortality from cancer and cardio vascular disease.

7. Not all action requires additional resource, and there is significant scope to raise our ambition in tackling inequalities in Redbridge- for example through:

   - Maximising the opportunities arising from the transfer of the Healthy Child programme and Health Visiting Service;

   - Developing a local approach to health in all policies;

   - Making every contact count in improving health and wellbeing;

   - Helping service commissioners and providers to embed equity considerations in service planning.
Introduction

During January and February 2015 Council Officers from the Policy, Performance and Equalities team interviewed 10 local community organisations and service user groups involved in the provision and/or receipt of services relevant to the theme of, “Healthy Lives”.¹

The purpose of these interviews was to facilitate the engagement of organisations and individuals who were able to provide a first-hand account of the issues that were affecting the health of our community. Interviews were based on a semi-structured questioning format and this was used consistently across all interviews.

Summary of key findings

Although the groups engaged were related to health concerns and support, the issues that arose varied and related to a number of themes the Commission will be looking at. Below is a summary of the key findings.

Access to Health Services – poor access to GP services; long waiting times across primary and secondary care. Concerns about lack of awareness from front-line staff on how to deal with people with disabilities and vulnerable groups, together with the cost and quality of care

Employment and Skills – more opportunities for supported work placements for people with disabilities, including learning disabilities and the need to raise awareness of disability through education

Needs of Carers – identified the increased threshold for care in the borough and the lack of support for carers

Housing concerns – Lack of permanent, affordable and good quality housing critically impacting on health and well-being for vulnerable groups

Transport and Public access – limited access to transport and condition of the public realm causing social isolation and impact on mental health

¹ A number of other interviews with front line staff were also carried out but could not be analysed in time for inclusion in this summary. Details of these interviews will be provided at a later date.
Encouraging social responsibility – Increasing volunteering to empower vulnerable groups and make Redbridge a more disability friendly borough

Advocacy and participation – the need for better support to enable people to access services and ensuring inclusive contributions in service delivery and design

Breakdown of findings by key issues

Below are series of extracts which detail all of the issues that were raised in the interviews that took place with community and service user groups.

1. Access to Health Services

- People need to be treated with dignity and respect (HW CG1, HW CG 3)
- Inaccessible appointment systems at GP surgeries.
- Education and awareness training for front line staff (HW CG1)
- Access needs e.g. interpreters, signers are not being met. (HW CG3)
- Investment into ongoing support, education and motivation for patients in drug and alcohol rehabilitation (HW CG1)
- Long waiting time for GP appointments (HW CG 8)
- Increased threshold for access to mental health care increasing the demand on other agencies (HW CG 8)
- Newer communities are not reflected in the take up of some services that they would be expected to, which may be a reflection of linguistic or cultural barriers (HW CG 8)
- More investment in transition services (children to adult) for people with physical and or learning disabilities (HW CG2).
- GPs need to monitor attendance of appointments for people with learning disability (HW CG1).
- The wheelchair service is poor (HW CG3)
- People are not being given appropriate care around mental health (HW CG3)

2. Employment and Skills

- London living wage needs to be adopted by agencies procured by the Council and NHS (HW CG3)
- Lack of awareness or consideration to Disabled people locally, which could be addressed in part by a concentration on education, particularly in schools (HW SUG 4)
- Not enough employment placements for people with physical or learning disabilities. More should be created by the Local Authority (HW CG2)
- Employment opportunities/supported placements could be a requirement of planning conditions (HW CG3)
3. **Needs of Carers**

- More consideration for the demands on older carers for their own needs, e.g. prioritised health appointments (HW SUG 4)
- Lack of awareness about direct payments and individual budgets (HW CG3)
- More needs to be done to ensure quality in care from agencies and the salaries that are paid (HW CG3)

4. **Housing concerns**

- There is a short supply of affordable rental properties particularly for those on benefits, which exacerbates their existing social, economic and health issues (HW CG 8)

5. **Transport and Public access**

- Lack of attention to the condition of the public realm, limiting mobility for many Disabled people (HW SUG 4)
- People in the borough are not sensitive to the needs of Disabled people, particularly in crowded public places, e.g. bus stops (HW SUG 4)
- Inconsistent support available across the local public transport network for people with mobility needs (HW SUG 4)
- Attendance at support clubs is dependent upon transport and carer support. There is not enough transport for this and carers are very expensive (HW CG4)

6. **Encouraging social responsibility**

- Services need to be procured from local providers (HW CG1)
- Incentivise people to get involved and increase their community contribution (HW CG1)
- Encourage people who are property rich/Income poor to provide supported housing for people with learning disabilities. This could be mutually beneficial (HW CG2)

7. **Advocacy and participation**

- Disabled people need more support in accessing information and in completing forms, which is increasingly on-line (HW SUG 4)
- More information about available services (HW CG2)
- Provision for advice and advocacy around welfare benefits is lacking. More investment by the Local Authority. There also needs to be quality control around advice (HW CG3)
- On-line consultation is not inclusive. Not everyone has access to I.T. The Local Authority needs to speak to people (HW CG1)
- People with learning disabilities/disability are being left out of consultations. Easy read versions need to be available at the start of a consultation (HW CG2)
- Lack of resources prevents people from having access to technology (HW CG2)
• Changes to benefit system are disproportionately affecting people with disabilities (HW CG2)
• More funding for advocates who can provide face to face support for form filling and advice (HW CG2)
• Directory of support by health condition would be useful (HW CG4)

Methodology

Groups and individuals consulted

The Policy, Performance and Equalities team conducted informal interviews over a three week period with community and voluntary organisations, service users and front-line staff. The interviewees, organisations and services were identified by reference to the focus of the first meeting of the Fairness Commission on ‘Healthy Lives’. The interviews each lasted approximately an hour and were structured with an agreed framework to guide the officers. An element of deviation from the structure was incorporated to allow for the disparate capacity, locations and time pressures of the interviewees together with the context of the organisations area of operation and the number of people interviewed at one time. However, each interview was started with an introduction and explanation of the purpose, structure and process of the Fairness Commission.

Table 1: Summary of Interviews carried out for the “Healthy Lives” theme

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Description of groups area of focus</th>
<th>Category of engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome Centre</td>
<td>Provides a range of targeted services that meet the needs of Homeless and Vulnerable adults</td>
<td>Community</td>
</tr>
<tr>
<td>Redbridge Forum</td>
<td>Work with groups and individuals to improve the quality of life of people with a learning disability and their carers in Redbridge</td>
<td>Community</td>
</tr>
<tr>
<td>Redbridge Concern for mental health/Disability Consortium</td>
<td>Promoting, improving and protecting the mental health and emotional well-being of the wider community. Disability consortium work to develop high quality, accessible services for disabled groups, working in partnership to influence policy and outcomes affecting disabled groups</td>
<td>Community</td>
</tr>
<tr>
<td>Organisation</td>
<td>Description of groups area of focus</td>
<td>Category of engagement</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Stroke Association</td>
<td>Information for stroke patients, their families and carers. Follow up hospital discharge patients.</td>
<td>Community</td>
</tr>
<tr>
<td>Punjabi Centre</td>
<td>Advancing education and awareness in matters relating to their mental health and cultural matters.</td>
<td>Community</td>
</tr>
<tr>
<td>STAAR - Autistic young people</td>
<td>To provide information and support. Raise awareness and highlight the needs of those with Autism, Asperger’s Syndrome and related disorders. To provide social opportunities for children and adults with Autism, Asperger’s Syndrome and related disorders and for their families and carers</td>
<td>Community</td>
</tr>
<tr>
<td>Redbridge Carers Support</td>
<td>Providing carers with a range of services, support and recognition.</td>
<td>Community</td>
</tr>
<tr>
<td>Redbridge Open Access Drugs Service (Foundation 66)</td>
<td>Commissioned drug user support service</td>
<td>Community</td>
</tr>
<tr>
<td>Centre for Independent and Inclusive Living -Redbridge</td>
<td>Group of service users promoting independence, inclusive living who provide a voice for Redbridge people</td>
<td>Service User group</td>
</tr>
<tr>
<td>Concessionary Transport Team</td>
<td>Administration of the Blue Badge Scheme and Redbridge Mobility Card</td>
<td>Front-line service team</td>
</tr>
</tbody>
</table>


Overview

To support the Fairness Commission’s investigation into how poverty and inequality affects people’s lives, several forms of engagement activity will be ongoing throughout the life of the Commission. One strand of engagement is a general ‘Call for Evidence’ to solicit the views of anyone who wants to contribute to the Commission’s examination.

The ‘Call for Evidence’ is an online platform on Redbridge Council’s web pages that went live on Monday, 9 February. Respondents are asked to submit evidence pertinent to the theme however, the questions asked are generic to allow for evidence to be gathered throughout the Commission process.

The two questions asked are:

- How do you think the Council and its partners can make Redbridge a fairer place to live?
- What can residents do to make Redbridge a fairer and more equal place to live for everyone?

The full set of responses is set out in Appendix A.

Summary of responses

How do you think the Council and its partners can make Redbridge a fairer place to live?

Responses received so far relate to:

- Schools
- Young people
- Welfare payments and benefits
- Housing
- Crime
- Transport

Schools

Concerns raised about:

- the impact of allocating different schools to siblings on working parents
- the lack of choice in the type of school offered
• raising standards for white working class children

**Young people**

Concerns raised about

• the lack of funding available to enable young people to study
• cost of living
• lack of youth provision

**Welfare payments and benefits**

Concerns raised about:

• the cost of travelling to appointments
• the length of time the Council takes to process claims

**Housing**

Concerns raised about:

• the allocation of housing causing upheaval to families
• fraudulent activity in Houses of Multiple Occupation
• the lack of housing and infrastructure available to support the growing population

**Crime**

Concerns raised about:

• Increasing CCTV to reduce crime
• Cutting MPS services

**Transport**

• General concern raised about the need to improve transport infrastructure

What can residents do to make Redbridge a fairer and more equal place to live for everyone?

Responses received so far relate to people driving more safely and being more considerate.
## Appendix A

### How do you think the Council and its partners can make Redbridge a fairer place to live? 

| Response |  
|----------|---|
| 1. For working parents especially mothers, the council should ensure that their children of primary age are allocated to the same school, so that parents can get to work on time after dropping them. Further there should always be after school clubs available. Further everyone should be entitled to a place at an ordinary state school. Parents should not have to accept academies, free schools or faith schools if they do not want them. Access to benefits should be easier. Claimants should not have to take 2 or 3 buses each way - at a cost they cannot afford - to attend interviews in Seven Kings Job Centre. It is not easily accessible. Further, the Council should make decisions more quickly in housing benefit cases, and whilst it is right to be vigilant, it should not automatically assume that the claim is not a proper one because there is a mistake in it. People can lose their tenancy because of the delay caused by over-zealous processing of claims, thus making the housing problem worse. Redbridge should also ensure as far as possible that the homeless are not placed in distant places, so that parents lose jobs and children lose school places. this is no way to treat families who face a crisis of homelessness. |  
| 2. Make sure all the houses (Legal & illegal) of multiple occupation pay their way and are not claiming benefits to which they are not entitled. |  
| 3. First of all you, should provide those youth with EMA. The youth that have a clean criminal record, and a history of good attendnace. This will prevent EMA payments been given to those who dont deserve it. I am 18 in collledge, and i can say i am suffering without this EMA, the government and the council have let me down. Secondly the council needs to spend more on youth club and they need to lower the costs of electricity etc. Ive had days where i felt like the council rather have the community. |  
| LASTLY, MORE CCTV PLEASE!!!!! Ilford lane needs far more cctv. Infant cctv should be increased all over redbridge. More cctv = less criminals roaming the streets. |  
| 4. Help the white working class aim for greater attainment in our schools, and support CAMHS. |
What can residents do to make Redbridge a fairer and more equal place to live for everyone?

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| 1. Ensure that there are the services and infrastructure in place to support the burgeoning growth in people moving into the borough.  
   Ensure that there are no further cuts to the MPS service in the borough.  
   Ensure that the transport infrastructure is improved. |
| 2. They need to start driving safer. They also need to refrain from negative attitude whilst driving and refraining from blasting loud music at late hours. |