London Borough of Redbridge

Annual Public Health Report 2025/26

The role of public health in preventing, reducing and delaying demand for social care

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Foreword

From the Director of Public Health

As Director of Public Health and Commissioning, I hold responsibility for the commissioning of social care in Redbridge. This role compels me not only to consider what we do, but also how we work - ensuring that our approach to social care is thoughtful, responsive, and aligned with the needs of our community. It is my privilege to present this comprehensive report examining the landscape of social care in Redbridge. Our borough, like many others across the country, faces rising demand and changing needs within both adult and children's social care.

The Annual Public Health Report (APHR) provides an invaluable opportunity for the Director of Public Health to pause, take a step back, and reflect on the bigger picture, particularly in relation to priority areas within social care. That is precisely what we aim to accomplish in this report: to look beyond the day-to-day and assess the broader landscape, challenges, and opportunities before us.

Importantly, this report should be viewed as a starting point. The insights and learning we gather from this work will directly inform the prevention strategy that my social care commissioning leads are currently developing.

Projections indicate a significant increase in requests for adult social care, with similar pressures in children's services. The sustainability of our social care system depends on our ability to adapt, innovate, and foster partnerships between public health, social care, and our wider community.

Our collective commitment - across public health, commissioning, and social care - is to create a system that is not only sustainable and effective, but truly centred on the people it serves. I am grateful to all those who contributed to this work and to the ongoing efforts of our dedicated teams. Together, we can rise to the challenges ahead, creating a fairer, healthier, and more resilient Redbridge for everyone. I would also like to acknowledge the contributions from Alice Colthurst, Thurigah Logasounthiran, Zohaib Shaikh and Sue Matthews in producing this report.

Gladys Xavier

Director of Public Health & Commissioning

Foreword

From the Chair and Vice Chair of the Health and Wellbeing Board

Health and social care systems are under pressure, requiring us to work together to overcome the current and future challenges they face. As such, we welcome this year's Annual Public Health Report, which provides a public health lens on preventing, reducing and delaying demand for social care

Our social care teams work hard every day to support residents, often in tough situations, showing great care and commitment. Even though there are challenges, there are also many good things happening. Across Redbridge, people are working together to find new and better ways to support those who need care. From new technology to strong community partnerships, we see many examples of teamwork and creativity.

Our teams give vital help to our most vulnerable residents, but they cannot solve all problems alone. We need to work together - with the NHS, the council, our partners, communities, and those receiving care - to meet the increasing demands on our services.

This report gives an overview of what is working, what needs improvement, and how we can join forces to solve problems. By listening to everyone involved, we aim to build a social care system that is centred on people, welcoming, and able to last.

Let's move forward with hope and determination, making sure everyone in Redbridge has the chance to live a healthier, happier, and more independent life.

Cllr Mark Santos

Chair of the Health and Wellbeing Board

Dr Anil Mehta

Vice-Chair of the Health and Wellbeing Board

Executive Summary

This report offers a comprehensive examination of how systems can work together to prevent, reduce and delay demand for social care. It outlines the challenges and opportunities within the sector, highlighting the increasing pressures brought about by a growing and ageing population, as well as evolving health and social needs.

In recent years, there has been a growing and unsustainable demand for adult and children's social care support, mirroring a rise in demand for health services. As people's health and wellbeing get worse, they often lose some of their independence and start to need more social care support; for others, there may be a social care need from birth or early age. As such, this report underscores the urgent need for preventative approaches in health and social care, and considers Public Health's role in this agenda, demonstrating that the goals and responsibilities of different sectors are often aligned and inextricably linked. As such, it advocates for increased collaboration and partnership working, because we all share responsibility for the health and wellbeing of our population throughout their lives. As an anchor institution, the council can leverage its stable presence, resources and influence to champion this whole-system change.

But what should this change look like and where should we start? In this report, we have incorporated the perspectives of colleagues across wider Redbridge systems (including commissioners, social care leaders, voluntary sector representatives, health partners, and front-line staff). Building on their insights, we have highlighted national and local evidence on factors affecting social care demand; and examined our role in improving health and reducing inequalities to ease pressures on social care.

We have shined a spotlight on drivers of social care demand in Redbridge, including **frailty, falls, poverty, social isolation**, and the **health and wellbeing of carers**. For each of these, we have considered the impact of the wider determinants of health (the social inequalities that are termed the 'causes of the causes').

Central to addressing these drivers is an appreciation of the challenges facing social care systems, which influence how effectively we can enact change. Recommendations range from shifting mindsets (such as viewing people from the perspective of where they could be, not just where they are now), to valuing and supporting the wider social care workforce. They also emphasise the importance of strong foundations for innovation, and the need to improve data collection, analysis, and evaluation.

In summary, this report calls for a proactive, integrated approach between social care and Public Health grounded in prevention and early intervention. But it also demonstrates the need and potential to expand this work to other service areas, helping us work alongside caregivers, care recipients, and the wider workforce to meet current challenges and safeguard the future sustainability of services in Redbridge.

Introduction

In recent years, there has been a growing and unsustainable demand for adult and children's social care. Projections from the **Redbridge Health and Wellbeing Strategy (2024-2028)** indicate that demand for health and social care, amongst other services, will continue to rise (1). For example, Adult Social Care (ASC) is predicted to see over 21,000 requests for support by 2027-2028 (an increase of around 3,400 more requests per year than in 2019/20). A significant proportion of this demand could be prevented or delayed, but we need to ensure we are maximising all opportunities for prevention.

Social care is part of a very complex system of services that look after people throughout their lives. For children and young people, social services ensure they are safe, looked after, and have everything they need for their personal care (2,3). They are there to help and support families. As people enter adulthood, their care needs may continue, and they will need to transition to ASC. For others, their first interaction with social care may be in later life.

The demand for health services and social care is closely linked. As people's health and wellbeing get worse, they often lose some of their independence and start to need more social care support; for others, there may be a social care need from birth or early age. In either case, prevention, early intervention, and support can help build and maintain people's independence for as long as possible.

Where feasible, it is important to prevent the development of ill health and the loss of independence in the first place (6). Ageing well helps people to maintain their independence for longer, which can minimise the social care support they need throughout their lives. In circumstances where health, wellbeing and independence do start to decline, an increasing need for social care may develop; but we can restore the lost independence through identification and early intervention. This could involve targeted exercise classes to restore physical resilience and/or adapting the home environment with simple tools and mobility aids. If someone's needs have already progressed beyond this, then the focus shifts to slowing further progression, so that we can prevent worsening health and escalating care needs.

What is social care?

Social care refers to a range of services designed to help people with additional needs live independently and safely. This support may be required due to illness, disability, aging, or other challenges, and can include personal care, staying active, adapting the home, and supporting carers **(2)**.

Adult Social Care (ASC) is provided in homes, day centres, or care homes, and may be short-term (to regain independence) or long-term (ongoing support) **(4)**. Unlike NHS care, ASC is means-tested - individuals with assets over £23,250 usually pay for their care, while those below this threshold receive government support. In some cases, the NHS provides free social care, such as after a hospital stay or for complex health needs, following assessment **(5)**.

Children's social care (CSC) assists young people and families, from home visits and community support to statutory services like child protection and children looked after **(3)**. Early intervention aims to address issues before they escalate.

An outline of the resident's journey through the children's and adult social care systems in Redbridge is in the Appendices

Often, people using social care are experiencing the greatest inequalities (7). Individuals who experience factors such as homelessness or poverty may face health challenges or reduced independence at an earlier stage; that's why we need to address all these factors in social care (Figure 1). Focusing on health inequalities, prevention, early action, and support will likely bring the greatest benefits. To succeed, everyone in the system must work together.

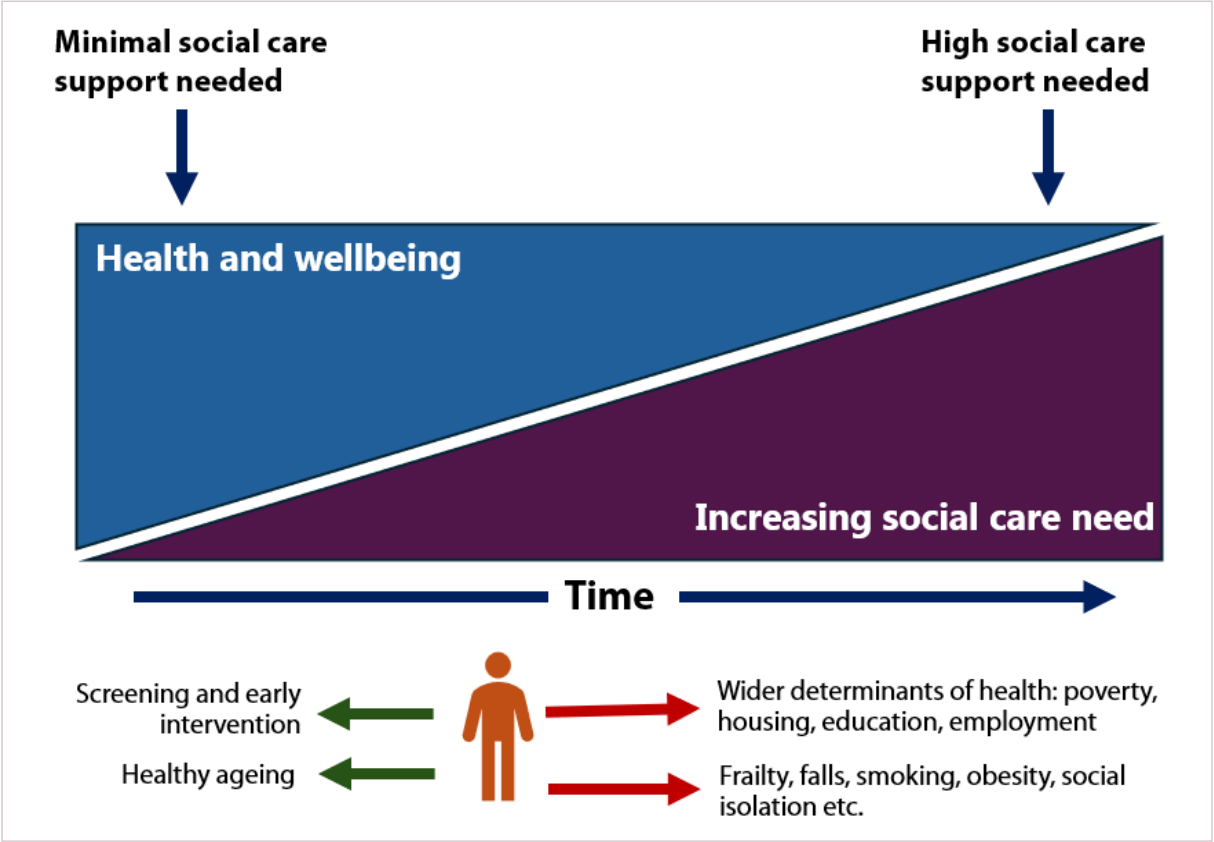


Figure 1: the factors influencing health and wellbeing, and social care need

Achieving a vision of a healthy, happy and independent population is a shared goal for social care and Public Health, which aims to prevent disease, promote health and reduce inequalities. From the perspective of social care, the Care Act 2014 identified 'promoting individual wellbeing' and 'preventing needs for care and support' as the first two of seven responsibilities for local authorities (7,8). However, there isn't a universal definition for what constitutes preventative activity; it can range from whole-population approaches that improve health and wellbeing, to targeted interventions for one person (8). It can be helpful to adopt certain frameworks when thinking about preventive approaches, such as the Prevention, Early Intervention, and Mitigation framework (Table 1); this takes a whole-system approach to prevention, and how to address people's needs at different stages of vulnerability (7,9).

	Prevention (primary prevention)	Early Intervention (secondary prevention)	Mitigation (tertiary prevention)
Focus	Stop problems before they start	Address issues before they escalate	Minimise harm and impact of existing issues
Timing	Before illness or dependency develops	At first signs of health or social decline	During or after crisis to prevent worsening or recurrence
Goal	Reduce demand for care altogether	Reduce intensity and cost of care needed	Stabilise a situation, reduce long-term consequences, and prevent escalation of need
Examples from public health services	Health visiting and school nursing, oral health promotion, weight management, exercise on referral, NHS Health Checks, sexual health and reproductive services, tobacco control and smoking cessation, mental health promotion, and drug and alcohol treatment services.	Social prescribing, perinatal mental health visitor, Family Nurse Partnership, oral health in care homes (as part of the oral health promotion service), wider work with drug and alcohol services working with health and social care	Social prescribing
Examples from across the system	Access to good quality information and advice, supporting safer neighbourhoods, promoting health and active lifestyles	Carer support, falls prevention/intervention, housing adaptations, support to manage money, and parenting support for families at risk	Community Treatment Teams, domestic abuse support and pathways into services

Table 1: The Prevention, Early Intervention, and Mitigation framework

The Social Care Institute for Excellence (SCIE) emphasises that prevention should be embedded at every level, involving a wide range of local professionals and stakeholders (9). Therefore, this report examines how Public Health supports the prevention, reduction and delay of the need for social care, incorporating the perspectives of colleagues across wider Redbridge systems (including commissioners, social care leaders, voluntary sector representatives, health partners, and front-line staff). Building on their insights, we have highlighted national and local evidence on factors affecting social care demand and examined the role of public health in improving health and reducing inequalities to ease pressures on social care. This aligns well with Redbridge's **Health and Wellbeing Strategy (2024-2028)** and the **Redbridge People Directorate Strategy (2024-2029)**, which aim to reduce health inequalities and enable people to live long, happy, independent lives in good health (1,2).

In the next chapter, we will describe in more detail the key characteristics of the borough, demand for social care, and the underlying factors driving this increasing need.

The demand for social care in Redbridge

This chapter will highlight key themes regarding our population and how this corresponds with demand for social care, and will start to explore the key drivers for this demand.

Understanding our population

Redbridge is home to a highly diverse population. To deliver effective, equitable care, it is crucial to understand these varied needs and plan services accordingly. As such, we have highlighted some of the key characteristics of our population that particularly relate to the provision of social care (figure 2):

- Redbridge is a large borough that has seen an **11.2% increase in population size** between the Census in 2011 and 2021. The change in population has been **unequal** across the borough, and it is likely that this has **increased pressure for services** in some areas more than others (1).
- The age distribution of Redbridge's population is defined by a **high proportion of both the youngest and oldest** (1). Input from social care tends to be highest at the extremes of age. In 2021, 27% of the Redbridge population were **aged 0-19 years old**, which was a higher proportion than the London (24%) and England (23%) averages (2). Redbridge is expected to see one of the **most significant increases** in the **older population** in the next 20 years (3).
- It has been estimated that some Redbridge residents spend **over 16 years of life in poorer health**. Whilst life expectancy in Redbridge has increased over the last century (to 80.1 years for males and 84.1 years for females[1]), figures from 2021-2023 for Redbridge indicate a **healthy life expectancy** for males of **just 63.7 years**, and **63.8 years** for females (4,5).
- Nearly **1 in 8 Redbridge residents** live with a **disability** that limits daily activity either a little or a lot (6).
- There is **significant variation in deprivation and wealth** across Redbridge, affecting life expectancy, health and wellbeing (1). Areas with higher levels of deprivation tend to have poorer health and greater social care needs, leading to increased demand for social care.

1. Life expectancy and healthy life expectancy (see glossary) at birth (3-year range) from 2021-2023 (4,5).

Our Population

The population of Redbridge increased by 11.2% between the 2011 and 2021 Census

Population growth has been unequal across the borough (from 37% increase in Ilford Town to 2% increase in Wanstead Park) between the 2011 and 2021 Census

The age distribution of Redbridge's population is defined by a high proportion of both the youngest and oldest

47% of Redbridge's population is of Asian ethnic background
35% of Redbridge's population is of White ethnic background
8% of Redbridge's population is of Black ethnic background
5% of Redbridge's population is of Other ethnic background
4% of Redbridge's population is of Mixed ethnic background

Across Redbridge 31% of people identified as Muslim, 30% identified as Christian, 11% identified as Hindu, 6% identified as Sikh, and 13% stated they had no religion

Life expectancy for Redbridge males is 80.1 years and for Redbridge females it is 84.1 years

11 out of 161 neighbourhoods in Redbridge were in the 20% most deprived in England. More deprived areas were identified in the southern and northeastern parts of the borough

Healthy life expectancy for Redbridge males is 63.7 years and for Redbridge females it is 63.8 years

Approx. 12% have a disability that limits day-to-day activities a little or a lot

Figure 2: Population profile of Redbridge (1, 4-7)

In recent years, there has been a growing and unsustainable demand for adult and children's social care. We have explored requests for support in more detail (including who is accessing social care support and why) and highlighted any gaps in knowledge.

Adult Social Care (ASC)

We often think of ASC as either 'long-term' or 'short-term', both of which are regarded as 'formal' care and arranged by a local authority (8). Short-term care typically refers to a care package that is time limited; the aim is usually to support someone to return to their baseline level of independence, in the hope that they will no longer need care in the future (reablement). Long-term services are provided on an ongoing basis and range from more intensive nursing care support to community support **(See Appendix A for an outline of ASC in Redbridge)**.

In 2024/25, the ASC team in Redbridge received 10,124 requests for support from new or existing clients; this was an increase of nearly 5% compared to 2023/24[1] (9). A particular increase was seen in requests for reablement, with nearly 1 in 5 requests for support being for reablement in 24/25. Demand for long-term care has also remained high, with more than 4000 Redbridge residents receiving long-term care every year since 2021.

This high demand for ASC is attributed to significant costs. Compared to 2021, there has been a rise in the total expenditure on ASC within Redbridge. In 2023/24, gross current expenditure on ASC was £115,788,000 in Redbridge (a 16% increase compared to 22/23); the majority (80%) of this was attributable to long-term care (10).

What social care support do adults request in Redbridge?

Most older adults (aged 65 and over) accessed long-term care for physical support reasons, with nearly 4 in 5 having a primary support reason (PSR) related to personal care. PSRs for access and mobility or support with memory and cognition were also more common amongst older adults.

Contrastingly, support for learning disability was the most common PSR amongst younger adults (aged 18-64 years old). Mental health support, support for social isolation and sensory support were also more common amongst this cohort (9).

Who is accessing ASC services, and what could this tell us?

In 2024/25, nearly 2 in 3 people requiring long-term care were older adults (63%), and of these, nearly two thirds were female (63%) (9). This is perhaps unsurprising given that living in poor health can result in decreased independence (and increased care needs), and healthy life expectancy is just 63.7 years for Redbridge males and 63.8 years for Redbridge females (4).

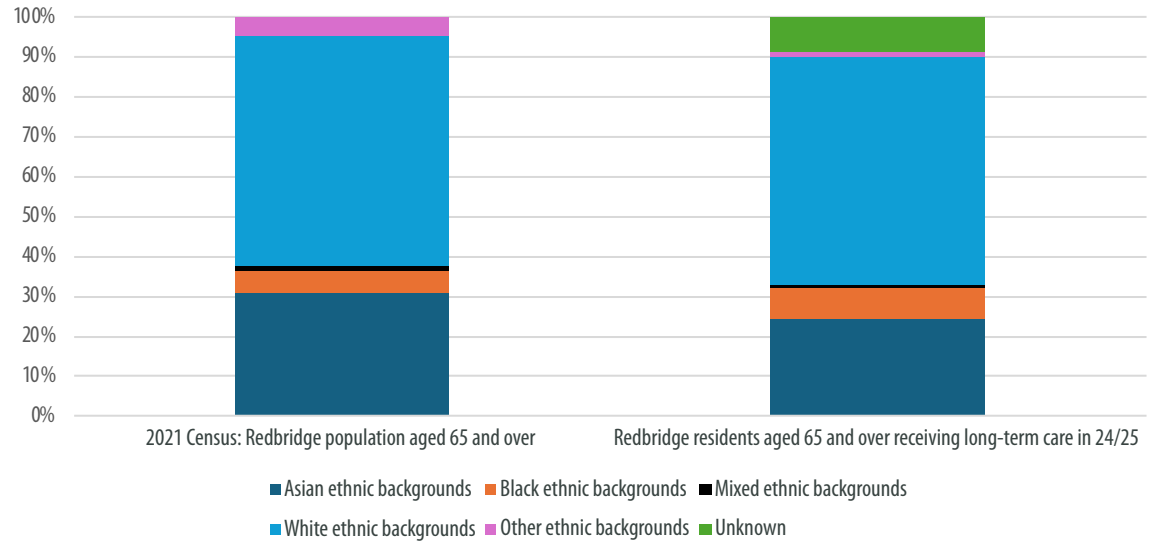
1. This doesn't include requests relating to safeguarding or Deprivation of Liberty Safeguards (DoLS)

The higher number of older females requiring care may in part be explained by their longer life-expectancy, and there are more older women living in Redbridge than older men (2). However, other factors may be at play – for example, being female is a risk factor for frailty, which is in turn a driver of demand for social care (11). Women are also more likely to suffer from osteoporosis, increasing their risk of sustaining a fracture after a fall which can increase care needs during recovery (12). This would require further exploration, perhaps through a healthy ageing needs assessment, to unpick the interplay of these factors further. This work should also extend to examine other demographics, such as ethnic background, where we noted differences amongst those accessing long-term care compared to our population estimates.

In 2021, approximately 1 in 8 (12%) of the Redbridge population were older adults (aged 65 and over) (6). Of these, 58% were of White ethnic backgrounds and 31% were of Asian ethnic backgrounds (Figure 3) (2). However, in 24/25, just 24% of older adults receiving long-term care were of Asian ethnic backgrounds, suggesting an underrepresentation of people in care amongst this cohort (9). A similar underrepresentation in long-term care was seen amongst older adults of Other ethnic backgrounds. It will be important to explore the reasons behind these differences further. This is explored later in the chapter entitled **"Health and wellbeing of carers"**, in which we discuss how some people from ethnic minority groups may face additional barriers to accessing social care, such as: difficulties understanding how systems work in the UK (if coming from a different culture and background), language barriers, and a lack of consideration regarding their cultural or religious requirements when care is organised (13).

Importantly, nearly 8% of those receiving long-term care in 24/25 had an unknown ethnic background, which introduces significant limitations for interpretation (9). As such, improving data completion is a key priority to be able to identify and address any potential inequalities in accessing social care.

Figure 3: the proportion of Redbridge residents aged 65 and over in the 2021 Census vs those recieving long-term care in 24/25, by ethnic background



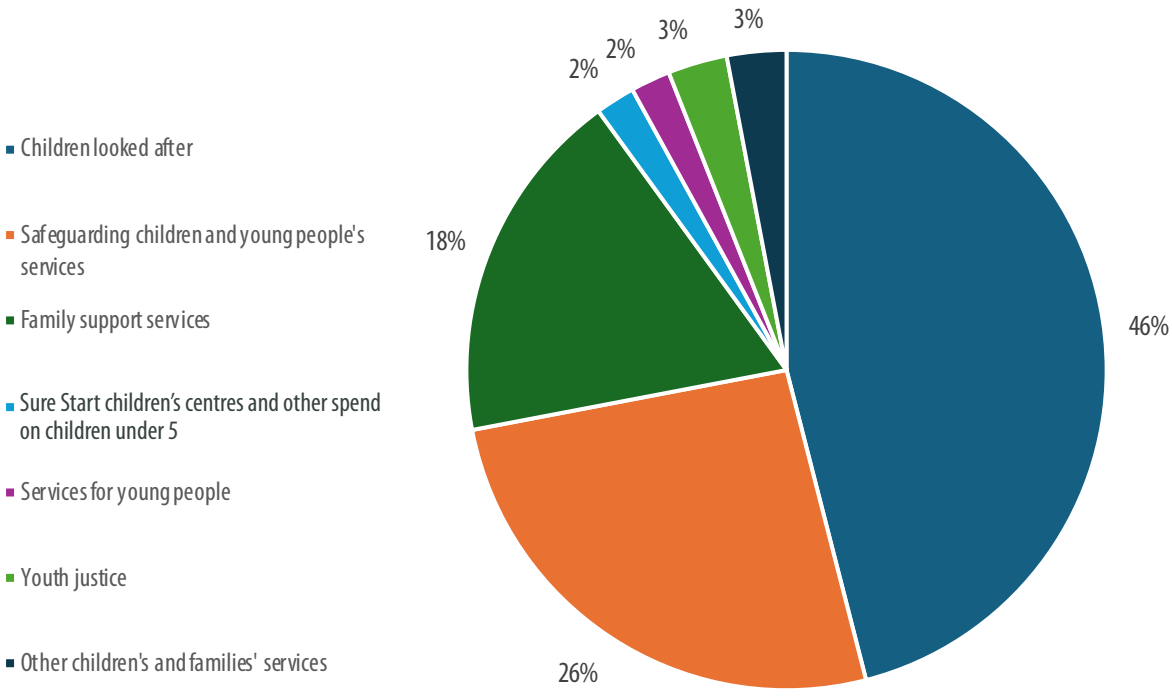
Children's Social Care (CSC)

Children's social care supports children, young people and families who need additional help to protect children and young people from harm (14,15). The support could be low-level, such as personal home visits to help a young person feel more connected to their community, or high-level in which a young person might enter care (children looked after) **(See Appendix B for an outline of CSC in Redbridge)**.

There has been a notable increase in the number of contacts to the front-door of Children and Young People's services in Redbridge. In 2024/25, the Redbridge Multi-Agency Safeguarding Hub (MASH) received 21,701 contacts, 1053 more contacts than the previous year (a 5% increase) (16). During engagement work, stakeholders highlighted that the complexity of individual cases has also increased, resulting in further service pressures.

This high demand for CSC services is attributed to significant costs. In 2023/24, Redbridge spent just over £69.5 million on children and young people's services, which was 21% higher than in 2022/23 (17). Just under half (46%) of the expenditure was for children looked after (£31,722,628) (figure 4). The top three areas of expenditure for children looked after were: fostering services (37%), residential care (19%) and leaving care support services (17%).

Figure 4: Proportion of total gross expenditure on children's and young people's services - Redbridge 2023/24



What is driving increased demand for social care in Redbridge?

It's important to consider the reasons for the increased demand for social care so that we can understand how we can reduce this demand, but most importantly intervene in a way that will improve the life chances of our most vulnerable children and adults.

It is widely reported that poor health and multimorbidity (the presence of two or more long term conditions), increase disability and increase adult social care costs. Social factors, such as, poor housing, poverty, language barriers, loneliness, social isolation, and lack of social capital are strong predictors for a future decline in functioning and need for intensive social care (18-27). There is therefore a significant overlap between what drives demands in health and social care, and public health plays a key role in reducing this demand.

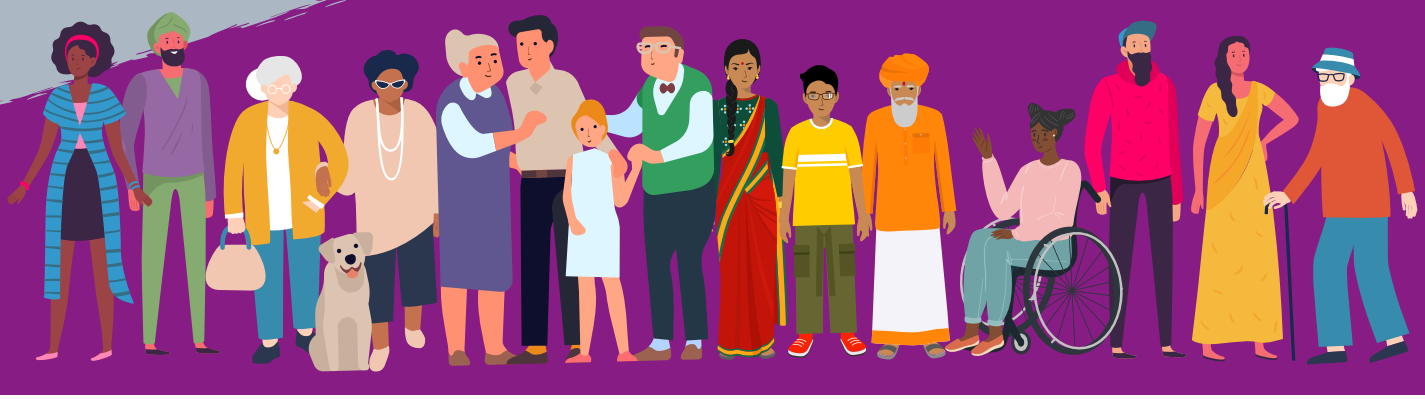
Recent reports show that the rise in demand for children's social care is largely due to population growth, an increase in unaccompanied asylum-seeking children, and higher poverty rates - especially in deprived neighbourhoods (27,28). Children from lower-income families and more deprived areas are much more likely to need social care interventions, and even a small rise in child poverty leads to more children entering care (29). The market for residential placements is struggling to keep up with demand, leading to higher costs for local authorities (30). There's also been an increase in the complexity of children's needs, making it harder and more expensive to find suitable placements, especially for those with complex care needs.

We asked stakeholders what they considered to be the main factors influencing demand for social care in Redbridge. The following drivers were identified and mirror what the evidence shows:

- Poverty and income deprivation
- Challenges related to housing
- Falls
- Frailty
- The impact of caring on the health and wellbeing of carers
- Social isolation
- Lack of awareness of services
- Workforce shortages
- Increased complexity of cases
- Increased need for parenting support and help with boundary setting (children's social care)

In this report, we focus on these drivers and highlight ways to prevent, delay, and reduce social care demand in Redbridge. These challenges often overlap; for example, someone who loses independence after a fall may also face frailty and social isolation, with each issue worsening the others. Recognising these connections can help us better support Redbridge residents and address the root causes together.

Frailty



Frailty has been identified as the strongest predictor of formal social care costs. It has been estimated that mean social care costs for people who are not frail are £321, compared with £2,895 for individuals with frailty (1).

Frailty is a word that is often misunderstood, with many confusing it with ageing, living with long-term conditions or disability.

Instead, frailty refers to a decreased resilience to stressors, which makes people more vulnerable to disease, disability, hospitalisation and social change (2). This means that a seemingly small set-back (such as a chest infection) can push someone living with frailty below the threshold for maintaining their independence in a way that wouldn't happen for someone

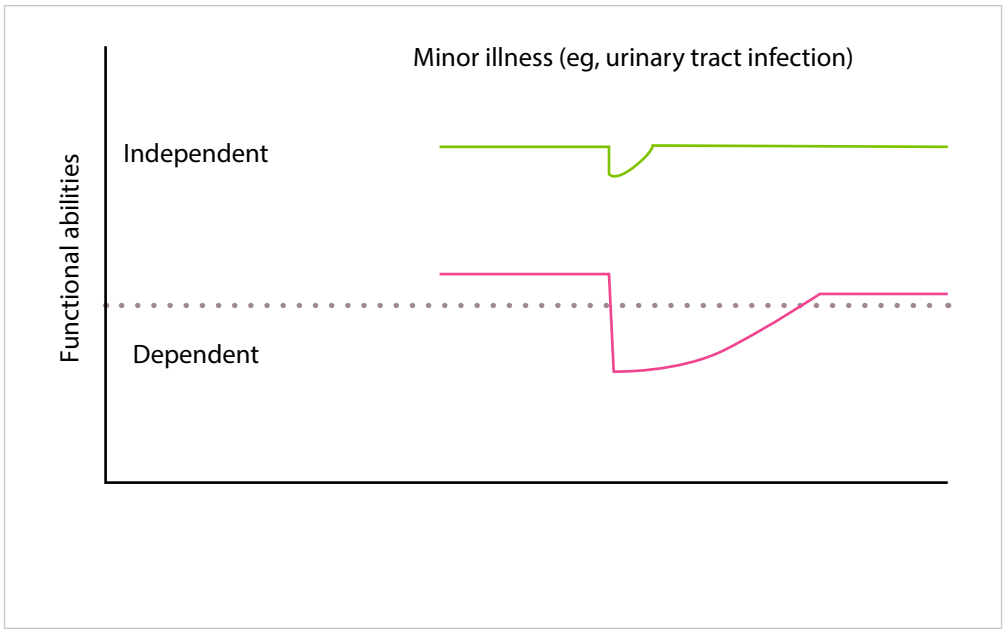


Figure 5: response to an adverse event in a non-frail vs frail older person (Clegg et al, Lancet 2013) (3)

who is not living with frailty (figure 5) (3). It becomes much harder to "bounce back" from things that affect your health or wellbeing.

Frailty is common

Frailty is difficult to define and measure, but estimates suggest it affects over 1 in 10 people over 65 living in the community, and up to half of those over 85 years old in the UK (4). In 2020, it was estimated that 6.5% of people in Redbridge aged over 50 years old were frail, and 7.8% were pre-frail (5).This would equate to over 5,700 Redbridge residents aged over 50 years old being frail, with a further 6,900 being pre-frail (5), based on 2021 Census data (6).

Frailty becomes more common as we age and occurs earlier in vulnerable groups.

People experiencing homelessness in their 40s and 50s can be frail (7). There are also major differences in frailty prevalence by gender, ethnicity and socioeconomic status (8). One study found that deprivation, Asian ethnicity, female sex and living in an urban area all increased the risk of living with frailty (9) which is particularly pertinent giving the demographics of our population in Redbridge.

Addressing frailty is important for individuals, their families, health and social care, and wider society

Frailty increases the risk of falls, hospitalisation, and loss of independence (10). About 5-10% of A&E attendances are by older people with frailty, leading to over 4,000 daily admissions for falls, minor infections, or medication issues (11). Nearly half of hospital inpatients over 65 have frailty, costing UK healthcare around £5.8 billion a year (12).

In a recent study, frailty was the strongest predictor of formal social care costs – averaging £2,895 per person with frailty versus £321 for those without (1). It was also estimated that for every 1% of nonfrail people not transitioning to frailty, savings of £4.4 million in annual expenditure on formal social care in England could be expected.

Frailty is not inevitable and many risk factors are modifiable

Whilst some risk factors for frailty cannot be modified, such as increasing age and being female, many are modifiable and include: low levels of exercise, malnutrition, lower body mass index, smoking and alcohol status, living alone, and polypharmacy (the use of multiple medications) (13). Preventing frailty therefore relies upon addressing these modifiable risk factors, as well as addressing the inequalities that can increase the chances of developing frailty or developing it at an earlier age.

Below we have highlighted some of the key frailty challenges and opportunities in Redbridge (informed by engagement work), alongside current good practices and future recommendations:

1. There is a common misconception that frailty and poor health are inevitable with increasing age, and awareness is low that healthy ageing is possible

As highlighted earlier in this report, Redbridge is expected to see one of the most significant increases in the older population in the next 20 years, and the most complex health and social care needs will see the greatest growth (14). Changing perceptions of ageing through positive, inclusive messaging and by reducing stigma is vital for supporting a healthier, more empowered older population.

The London Borough of Redbridge is continuing to work towards becoming an Age-Friendly Community

Age-friendly Communities ensure that the local environment, services and social networks enable people to age well and support intergenerational relations. In alignment with the World Health Organization (WHO) Age-friendly Communities Framework (15), the council is making a range of improvements including:

- A recent **age-friendly community survey** conducted in collaboration with Age UK Redbridge, Barking and Havering, in which 107 local older people told us what was important to them and what would support making Redbridge a really great place to live and grow older (16).
- **Positive Ageing Week 2024**; this included an event in which over 100 service users attended different stalls, stands and activities for health and wellbeing advice and free health checks. A similar event is planned for 2025.
- A new **Dementia Strategy** which will set out a clear vision for Dementia care and support in Redbridge

2. Preventive work in Public Health contributes to healthy ageing and reduces the demand for social care

Many of the Public Health initiatives across Redbridge aim to promote healthy ageing, which should in turn reduce social care demand. Figure 6 highlights how intervention is required across the life course at each level to maximise independence and reduce the level of disability across the borough (17).

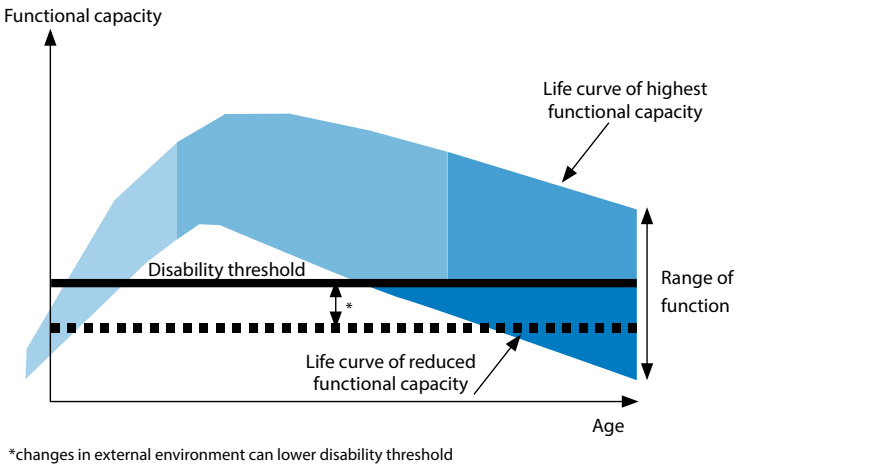
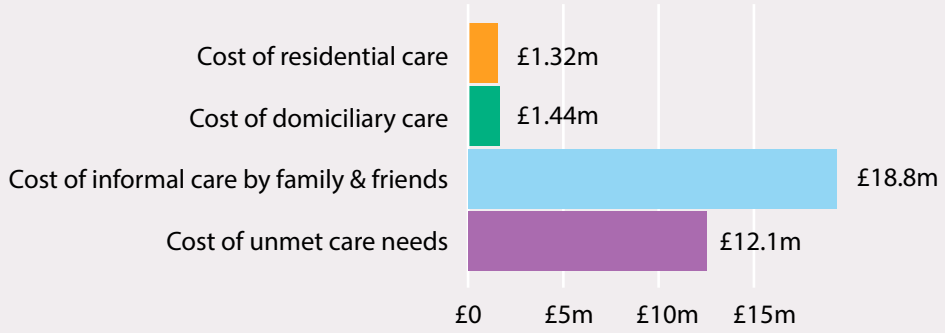


Figure 6 – A life-course perspective for maintenance of the highest possible level of functional capacity. Taken from: World Health Organisation (1999). A life course perspective of maintaining independence in older age (17).

Approaches are wide reaching and include (but are not limited to): the promotion of physical activity and healthy eating, smoking cessation and substance use support, cancer and screening, sexual health, mental health, diabetes support, and community engagement work.

The impact of smoking on social care:

- In 2021, Action on Smoking and Health (ASH) estimated that on average, smokers in England need care when they are 63 years old, 10 years sooner than non-smokers (18)
- The analysis, by Landman Economics for ASH, found that 1.5 million people needed help with everyday tasks, such as dressing, walking across a room and using the toilet due to smoking
- ASH have estimated that smoking costs Redbridge £128 million every year, £33.7 million of which is attributed to social care (19):



- Specialist smoking cessation services are the most effective way to quit.
- Quitting lowers long-term risks of cancer, lung disease, heart disease, and stroke, with heart attack risk halving after just one year.

The NHS RightCare Frailty Toolkit recommends we review our local healthy lifestyle services with regards to how they specifically support people at risk of or living with frailty (20). This is important for identifying how we can better support people to make lifestyle adjustments, and challenge barriers to a healthy lifestyle, in a more holistic way. This helps to promote supported self-care and encourage proactivity. If we consider physical exercise as an example:

Physical activity and preventing frailty

There is strong evidence that physical activity could help delay the onset of frailty and reduce its severity (4). Staying active is an investment in the future and is described by Age UK as 'paying into a physical pension plan' (21). Every bit of activity counts, but strength training and balance are particularly key.

In Redbridge, a wide range of exercise options are available for older adults, from Exercise on Referral (subsidised gym-based support for eligible residents with physical health conditions) to strength and balance classes through falls prevention services. Once people have gained the skills and confidence to engage in these physical activities, they can then carry these on at home independently.

Different activities may be more suitable for different cohorts; for example, Fit for Fun involves 20 weeks of free exercise classes which supported 282 Redbridge residents aged 56 years and over in 24/25. For those already living with frailty, modified approaches such as chair-based exercises may be more appropriate. It would be useful to map physical activity options available for older adults across the borough to identify any gaps or areas of duplication. A map of the available exercise opportunities by cohort (e.g. women's only sessions, those suitable for people with limited mobility) could then be provided in an accessible way for our diverse population.

We could also consider the role of adequate nutrition alongside exercise, recognising the intersectionality of risk factors for frailty. Malnutrition often goes unnoticed because many think that low body weight and weight loss is normal in ageing (22). Time constraints during care visits can make convenience foods common, giving way to the 'Tea and Toast' diet . Raising awareness about the importance of nutrition in older adults and providing practical resources for quick, healthy meals could help address these challenges and maximise any benefits from physical activity (23,24).

3. It is important to proactively identify those at risk of frailty, so we can intervene before they reach crisis point

There are always individuals close to needing social care; early identification and targeted support can prevent or delay this need (25). Recognising early signs of frailty, such as slowing down or a first fall, allows for timely intervention. For this to be effective, we need to have a shared awareness and understanding of frailty; and embed an approach to managing frailty as a long-term condition across health and social care systems (20).

Through better identification, we can then work together to sign-post or navigate individuals to the support they need to intervene earlier and really Make Every Contact Count (MECC). If services are not able to provide this advice themselves, it is important that they know how to sign-post to team members with expert knowledge of services in the borough, such as social prescribers and community navigators.

This area can be explored further through a healthy ageing needs assessment, which should include frailty and seek to re-imagine current services in the context of frailty prevention and early identification.

4. It is important to support people living with frailty to remain safe and independent at home as far as possible, to prevent escalating care needs and hospital admissions or readmissions

People with moderate to severe frailty often require more intensive support. Integrated multidisciplinary teams play a key role in rehabilitation and reablement, helping to slow decline and regain independence (20). Preventing avoidable hospital admissions is crucial, as hospital stays can worsen frailty. Rapid or crisis response services like the Community Treatment Team (CTT) have an important role in breaking the vicious admission-readmission frailty cycle (4) in Redbridge:

The Community Treatment Team (CTT) in Redbridge

The CTT for Barking & Dagenham, Havering, and Redbridge is a multidisciplinary team offering rapid, short-term support to adults in health or social care crises—helping them remain at home and avoid unnecessary hospital admissions (26). They manage cases from severe pain to chest infections, working across the community and A&E to coordinate safe discharge and reduce hospital stays.

Engagement work highlighted several challenges facing the CTT, from inappropriate referrals due to long social care wait-times, to unrealistic expectations regarding care packages (especially where an immediate solution is expected). Taking a system-wide approach to these challenges could support the CTT in developing their crucial role, helping to keep more people at home safely.

Finally, it is important to still consider the role of health promotion and prevention once someone is receiving social care support. For some people, their only regular contact with others may be when a care worker comes to the house; this is a key opportunity to identify someone who could benefit from preventive services (such as smoking cessation), before additional problems arise (such as new cardiovascular disease). This highlights a need to re-think how we commission services to promote proactive approaches to reducing frailty within social care settings.

RECOMMENDATIONS

- Recognise that primary prevention services should not be sacrificed when resources are limited; they have a key role in stemming the flow into health and social care services.
- Continue working towards becoming an Age-Friendly Community, taking a more positive, inclusive approach to growing older that tackles age-related stigma.
- Develop a shared awareness and understanding of frailty; and embed an approach to managing frailty as a long-term condition across health and social care systems.
- Complete a healthy ageing needs assessment to include frailty and falls, ensuring we review our current approach and any recommendations against the NHS RightCare: Frailty Toolkit. This should include a review of how our local healthy lifestyle services specifically support people at risk of or living with frailty.
- Explore opportunities for Making Every Contact Count (MECC) where the greatest impact can be seen. This could include identifying and assessing individuals for frailty in a broader range of settings, including supermarkets, libraries, pharmacies and other settings that form part of older people's daily lives.
- Continue to invest in services that support people living with frailty to remain safe and independent at home, taking a system-wide approach to addressing the challenges they face.

Falls

Redbridge is a large borough with the 2nd highest number of emergency hospital admissions due to falls in over 65-year-olds in North East London (1).

The consequences of falls can be severe, leading to reduced mobility, long-term ailments, and a decline in independence.

In approximately 1 in 20 cases (5%), a fall leads to a fracture and hospitalisation (2). They can lead to a loss of independence and a reduction in quality of life; and the fear of falling may cause people to avoid certain activities, which can contribute to social isolation (3).

For services, the impact is substantial. Falls are the number one reason older people are taken to the emergency department (2). Hospital admissions due to falls incur direct costs and often result in reduced independence for older adults, necessitating further care services.

Key definitions:

Falls are often defined as unexpected events where a person ends up on the ground, floor, or a lower level (4).

When someone experiences two or more falls within the past year, it is referred to as 'recurrent falls' (5).

For society as a whole, the effects are broad. Falls can impair a person's ability to work, volunteer, or look after others. Consequently, falls have impacts that extend far beyond the individual, affecting their close connections as well as the economy.

Falls are common with one in three people over the age of 65 and one in two individuals over 80 being affected each year (2).

The 2021 Census revealed that the Redbridge population aged over 65 has increased 14% since 2011 (6). Given the increased likelihood of falls with age, and the significant morbidity and mortality associated with them, it is a high priority to prevent falls amongst Redbridge residents, but they remain a common problem:

- In 2023/24, there were approx. 780 emergency hospital admissions in Redbridge related to falls for people aged 65 and over; the rates of emergency hospital admissions due to falls in Redbridge also appear to be increasing (7).
- In 2024, it was estimated that approximately 654 adult social care service users had a history of falls or sudden loss of balance in the previous two years (8).

Given this data, it is therefore unsurprising that the demand for falls services has also increased. In 2024/25, there were 1629 referrals to the Barking, Havering and Redbridge falls prevention service for Redbridge Place based clients; this was a 17.5% increase in the number of referrals compared to the previous year (9).

Falls are not a normal part of getting older and they are not inevitable.

Whilst the chance of having a fall increase as we age, they are caused by numerous risk factors that can affect people of all ages (10). The more risk factors a person has, the greater their risk of falling (figure 7).

Figure 7: examples of risk factors for falls (10,11)

- Reduced strength and balance
- Visual impairments
- Environmental hazards
- Poor sleep
- Polypharmacy (the use of several medications at the same time in the same individual)
- Specific medical conditions that might make a person more likely to fall (e.g. Multiple Sclerosis)
- Low blood pressure
- Infections, including urinary tract infections
- Foot problems, including pain

It is rarely just a case of "tripping over something". Perhaps someone fell because their eyesight has worsened and they could not see the trip-hazard, or maybe they have lost sensation in their feet due to progression of diabetes, which has affected their balance. Perhaps their shoes do not fit properly, or their new medication makes them feel dizzy; more likely, it was a combination of all these things. A fall is not a diagnosis – **a fall is a symptom of something else**.

There is no 'one size fits all' approach to managing or preventing a fall, and it is important to consider a wide range of potential risk factors.

Promoting healthy ageing can help prevent falls and their impacts by addressing risk factors like frailty (12). Over half of frail adults experience falls, often with significant consequences. Addressing frailty and other risk factors for falls requires a multidisciplinary approach. Tailored interventions include strength and balance classes, home hazard assessments, and simple modifications like installing grab rails or steps (13).

The Barking & Dagenham, Havering and Redbridge (BHR) Falls Service

The NHS delivers a multidisciplinary BHR Falls Service which treats and prevents falls for eligible Redbridge residents (14). They aim to promote independence and reduce hospital visits, with care tailored to each individual's needs.

Find out more at: Barking & Dagenham, Havering and Redbridge Falls Clinic | NELFT NHS Foundation Trust.

Redbridge also has several innovative projects underway aimed at identifying those most at risk of falling and offering them extra support:

Taking a proactive approach: The Falls PCN pilot in Seven Kings

This pilot proactively identified 400 people aged over 60 years old who were at higher risk of falls, to enable prevention and early intervention. Of the 287 people triaged, 87 were referred to the Falls team and 31 to other services. Through telephone screening, the team supported self-management, shared resources, arranged referrals, and provided updates to clinicians. Evaluation is currently underway.

Assistive technology: The Care Tech Pilot

The Care Tech Pilot, funded by the Government's Adult Social Care Technology Fund, is trialling assistive technologies to help Redbridge residents over 60 to stay safe and independent at home - focusing on fall prevention and health monitoring (15,16).

Redbridge is working in partnership with Care City and Apteligen to implement and evaluate the pilot respectively. The technology providers include Care City, MiiCare, Vayyar, Feebris, and Informetis. A range of devices including AI-powered sensors, health monitoring kits and fall detectors have been introduced in care environments; their effectiveness and cost-efficiency will be assessed. This approach allows for the trial of new solutions to current challenges, while building a local evidence base and contributing to national evaluation.

Developing innovative falls prevention approaches for at-risk individuals requires accurate data; but records of falls are fragmented across the system, introducing significant challenges for data intelligence.

Accurately estimating falls in Redbridge is challenging, as many incidents go unreported when individuals recover without seeking care. Data on falls are fragmented across sources like the London Ambulance Service, GPs, and A&E departments, making it hard to capture the full scope and impact.

Nevertheless, collecting accurate data is essential for identifying people at high risk of falls; because this helps in planning and directing services to those who need them most. Additionally, it is important to have a good understanding of the 'baseline' number of falls before implementing an intervention, so that we can properly evaluate its impact. Consistent identification of falls or near-misses, strong collaboration, and effective data-sharing amongst services ensures timely support for the individual, whilst also improving data intelligence to guide targeted population-level strategies.

RECOMMENDATIONS

- Increase the identification of hidden falls so that appropriate support can be offered before people's needs escalate; this could involve opportunistically asking people whether they have fallen in the last year during routine appointments/contacts.
- Review data sharing agreements and advocate for a collaborative approach to using local intelligence, so that 'at risk' individuals are identified across multiple 'touch points' in the system. Data intelligence should then be used to guide targeted population-level strategies.
- When at-risk individuals are identified, there needs to be strong collaboration amongst all relevant services to ensure that these individuals receive the necessary support.
- Prioritise prevention efforts that support healthy ageing, as this would help to prevent many of the risk factors and/or consequences of falls. This should include a focus on strength and balance, and osteoporosis.
- Continue to invest in falls prevention services that holistically assess at-risk individuals and address the relevant risk factors to prevent future falls.
- Continue trialling innovative projects that focus on falls prevention, ensuring they are rigorously evaluated to contribute to the development of a local evidence base regarding frailty and falls.

Poverty

Redbridge has the 6th highest poverty rate in London (1) and the 15th highest proportion of children living in poverty (after housing costs) of all London boroughs (2).

Poverty is when a person's resources are insufficient to meet their basic living needs (including social participation) (3).

It arises from an enforced lack of necessities and is dynamic in nature – resources rise and fall as do needs and people's ability to meet them. Many individuals are at risk of poverty, because they may be struggling but 'just about' able to meet their needs. Some may live their entire lives in poverty, whilst others may instead experience periods of it.

Poverty worsens people's health and cuts lives short (4)

It is well documented that poverty has significant effects on health and wellbeing. For example, in England, those living in the least deprived areas live on average 8 to 10 years longer compared to those who live in the most deprived areas (5). Poverty also affects an individual's sense of control, leading to increased stress levels, and reduced access to experiences and material resources (4). Those living in poverty often experience stigma, which can act as a barrier to accessing support. The impact is often most felt by children and young people, with emotional consequences including feelings of shame, embarrassment, humiliation, and low self-esteem.

Poverty drives demand for health and social care (and wider council services)

From a social care perspective, family and community deprivation and inequality remain the most acute issues underlying safeguarding pressures. A recent Association of Directors of Children's Services (ADCS) survey analysed responses from 86 of 153 authorities and identified that almost three-quarters of respondents had seen demand from families in poverty rise as a result of welfare reforms, particularly amongst larger families with three or more children (6). Interviews with Directors of Children's Services were dominated by comments about how wider determinants of health (the social inequalities that are termed the 'causes of the causes') drive demand for safeguarding services.

Poverty is expensive - high demand for services is linked to significant costs

There are direct costs to health and social care systems who treat the consequences of poverty, as well as wider economic costs in terms of lost opportunity and productivity (7).

In 2016, a report by the Joseph Rowntree Foundation estimated that (8):

- The public service costs of poverty amount to around £69 billion
- Around 20% of public spending goes towards addressing the effects of poverty on people's lives.
- **Adult social care** (one of the largest areas of local authority spending) is associated with **£4.6 billion** of the cost of poverty.
- **Children's services**, including both children's social services and early years provision, are estimated to include **£7.5 billion additional spending** associated with poverty.

Whilst addressing poverty may require increased initial spending, it can result in long-term social and economic benefits.

Redbridge has higher rates of poverty compared to other London boroughs

When defining poverty as less than 60% of median household income after housing costs (1):

- Redbridge has the 6th highest poverty rate in London with an estimated 34% of people living in poverty as at 2023/2024 (5-year pooled data). This is a significantly higher poverty rate than the London average of 26%
- 71% of Redbridge individuals living in poverty were in working households (i.e. a household where at least one member was in employment)
- In 2023/2024, it was estimated that 36% of children in Redbridge are growing up in poverty, which is more than 1 in 3 children. Redbridge has the 15th highest proportion of children living in poverty of all London boroughs (2).

The UK poverty line (9)

If you lined everyone up in the UK based on their income, the median income would be what the person in the very middle earns. The official UK poverty line is 60% of median income. This means you would be classed as living in poverty if you earn less than 60% of what the UK's median earner earns.

Poverty can be measured both with and without housing costs taken into account.

There are significant inequalities in poverty

For example, poverty rates are very high for some ethnic minority groups, poverty disproportionately affects children in the UK, and nationally we see that large families with 3 or more children have consistently faced higher poverty rates (10). Importantly, these inequalities rarely exist in isolation and people's experiences vary based on multiple intersecting factors.

Poverty can result from reduced resources, increased needs, or higher costs to meet those needs.

Where we live and our backgrounds shape our life chances. Major life events and circumstances can lower income, and without proper support, the effects may be lasting (11). In the UK, poverty can be caused by living with a disability, unemployment, low pay, limited education or skills, an ineffective benefits system, high living costs, having a caring responsibility and discrimination.

Addressing and preventing poverty is a matter of social justice

We must ensure equitable access to resources, opportunities and a basic standard of living for all Redbridge residents. Furthermore, when considering the economic implications, tackling poverty could lead to significant gains for health and social care systems, allowing us to provide more support to those who need it the most.

Poverty is complex and multifaceted

Poverty involves interconnected social, economic, and structural challenges. Low income often leads to housing difficulties and debt, so addressing poverty requires a comprehensive approach, not just focusing on debt. Issues in one area typically indicate problems in others, highlighting the need for professional curiosity and preventive strategies.

Many of the key causes of poverty require action at a national level (for example, an adequate benefits system, unemployment and low wages, and the high cost of living) (11). Nevertheless, local governments, businesses, service providers and residents all have a role to play in ending poverty and can make a real difference for their communities.

This report highlights key challenges identified by stakeholders in the borough: housing, debt, cost-of-living pressures, and care expenses. Targeting services to these issues could most benefit residents. These challenges are highly complex and cannot be fully addressed in detail within this report.

Housing

Many people experience 'housing-cost induced poverty' after paying for their accommodation (12). Living in poverty can limit access to housing options or make them difficult to sustain. Research has shown that people living in poor housing **develop care needs eight years earlier** than people living in a home without any housing issues (13). Additionally, those living in social housing have a **59% increased chance of developing care needs** compared to those living in their own home (14).

Affordable rents, such as council and housing association rents, have an important role in reducing 'housing-cost induced poverty' (12). However, Redbridge has the smallest council housing stock of all London boroughs, with approximately 4500 homes (15). Rising private rental costs and the cost-of-living crisis are contributing to an increased demand for housing assistance. At the end of March 2023, there were over 7,500 households waiting on the housing register for a home in Redbridge, including around 2,980 homeless households in temporary accommodation. Housing quality also varies, and factors such as drafts, damp and mould can have a determinantal effect on people's health, especially those who are already vulnerable.

Implementing the recent Redbridge Housing Strategy to increase the supply and quality of housing will improve living conditions for those in poverty, and help prevent or delay the onset of care needs.

Social prescribing in Redbridge

Social prescribing can support people who are at risk of requiring formal social care by helping to address the social factors (e.g. social isolation, access to benefits and wider social issues) that impact on health and wellbeing. For example, social prescribers can connect people to community activities and social support.

Housing is one of the biggest issues identified by social prescribers in Redbridge. Work is currently underway to improve pathways into housing for social prescribing teams to ensure that we maximise support for our most vulnerable residents.

Debt and the cost of living

An increasing number of individuals are accruing debt in order to manage basic living expenses (16). Income from benefits has not kept pace with the true cost of living, and energy and housing costs remain high, resulting in many households being unable to meet their financial obligations (17). Citizens Advice recently reported that there has been a significant rise in people seeking assistance with household bill related debts, like energy, rent and council tax.

Accumulating debt creates a vicious cycle, that is difficult to break, making it increasingly challenging to repay existing obligations (16). Nationally, it has been estimated that 5 million people, including 1.5 million children, are in a household with a negative budget (17). Furthermore, there is substantial amount of debt that remains unreported. In England in 2022, it was estimated that as many as 1.08 million people could be borrowing from an illegal money lender (known as a loan shark) (18).

Expanding support locally will help mitigate some of the effects of debt and the cost-of-living crisis on our residents. Policy in Practice recently estimated that nearly £23 billion in social security payments and other assistance is going unclaimed across the UK (19). Many Redbridge residents are not aware of their entitlements, and the systems put in place to support people who are struggling can feel confusing and inaccessible. In response, Redbridge has commissioned Citizens Advice Redbridge to deliver in person specialist debt advice to Redbridge residents. Additional support for families is provided by the Families First for Children Pathfinder programme which includes targeted roles to support families affected by financial hardship.

Citizens Advice Redbridge

Citizens Advice Redbridge offers crucial support by helping residents with debt advice, benefit claims, and referrals to additional services. In 2023/2024, they assisted over 4,000 clients resulting in millions of pounds in financial gains and economic benefits (20). New initiatives, like the debt advice booth in Ilford's Central Library provide confidential, personalised guidance to help people manage and escape debt (21). The booth is discreet and completely soundproof to help preserve people's privacy when they drop in. These efforts play a significant role in preventing and alleviating poverty, improving long-term health and social care outcomes for residents.

Families First for Children Pathfinder programme

The Families First for Children (FFC) Pathfinder programme is a government-funded initiative designed to reform children's social care by integrating early help and child protection services into a seamless, multidisciplinary model (22). In Redbridge, the programme has been co-developed with local partners and includes targeted roles such as welfare benefit and debt advisors, family support workers, and parental advocates with lived experience. These roles aim to mitigate the effects of poverty and financial hardship by offering practical support, income maximisation, and debt management guidance. The programme also promotes family-led decision-making through Family Network Support Packages, enabling families to devise their own solutions in crisis situations. By addressing the interconnected challenges of financial instability, housing insecurity, and mental health, the Pathfinder seeks to break cycles of deprivation and foster resilience in vulnerable households.

The cost of care

Adult social care is rarely free and can be expensive, often forcing people to significantly adjust their standard of living or even sell their homes to pay for care. This leads to inequalities in the range and quality of care people can access.

Choice and control in care is important. 'Direct payments' - where local authorities provide cash instead of arranging care - offer flexibility and autonomy for those eligible, allowing them to arrange services that meet their needs (23). Engagement work highlighted that making direct payments more accessible can help more people manage their own care, lower costs, and improve quality of life by increasing choice. However, it is important to note that support is still needed to help recipients manage responsibilities like spending and employing care workers (24).

The cost of caring

Unpaid carers are under huge financial pressure

In the 2021 Census, it was estimated than more than 1 in 20 people in Redbridge (21,395 residents) were providing unpaid care (25). Informal carers are much more likely than those with no caring responsibilities to be living in poverty (10). With a reduced ability to work, it is estimated that unpaid social-care givers experience an average pay penalty of £414 a month. The vital role that carers play in society needs to be recognised and rewarded fairly; this involves change at a national level, as well as ensuring targeted support is available locally, as described in more detail in the **'Health and Wellbeing of Carers'** chapter of this report.

Adult social care workers are among the lowest paid in the UK

Evidence suggests that residential care workers in the UK face among the highest rates of poverty and experience financial difficulties, like being unable to pay rent (26,27). Analysis by The Health Foundation found that between 2021/22 and 2023/24:

- 1 in 5 residential care workers lived in poverty and over 1 in 10 relied on Universal Credit
- There are inequalities amongst the care workforce; for example, around 1 in 3 residential care workers born outside the UK lived in poverty, compared with 1 in 10 residential care workers born in the UK
- The poverty rate for residential care staff (19.9%) was higher than for health workers (8.2%)
- For people working in the UK, working in residential care doubles the risk of going without enough food
- 1 in 10 children of residential care workers went without essentials like a warm winter coat.

Low pay in social care is a consequence of chronic underfunding and a lack of implementation of a strategic workforce plan (26,28). Locally, it is important for us to continue to recognise the role of our social care workforce and invest in services that support people living in poverty, who likely include members of our social care workforce.

Priorities for action

There is considerable amount of work underway across the council to address many of the themes highlighted above and the poverty lead is working across the system to develop a joined-up approach to prevent and mitigate the impact of poverty.

Helping local people with limited resources meet their basic needs depends on two factors:

1. **Effectively identifying individuals** who are at risk of poverty or are living in poverty. Stigma often leads to poverty being kept secret, and people may experience feelings of shame which prevents them from opening up about their circumstances (4). It is important to ensure a wide range of people have the skills needed to initiate these conversations, to identify people experiencing hardship across a range of touchpoints in the borough, including social care. This also provides important intelligence regarding the prevalence of poverty, and the need for different approaches or services across the borough.
2. Ensuring we have the **right support available** for people (taking a whole system approach) and that we can effectively navigate them towards this. Professionals, residents, family and friends should all be able to find these services and access them easily.

Local evidence shows that protective preventative spending in children's services can reduce the number of children looked after. For example, a London council that maintained preventative spending despite national funding cuts saw a steady decrease in children looked after in the borough (29). Public health commissions a range of services dedicated to the early identification of families experiencing poverty, including health visitors and school nurses. Health visitors primarily address early childhood development and family support, while school nurses deliver health education, interventions, and ongoing support for school-aged children. Within this universal support offer, Redbridge also has specialised roles, such as the inclusion specialist health visitor, that provide targeted support to some of the most vulnerable families:

Redbridge's Inclusion Specialist Health Visitor (ISHV)

The ISHV supports asylum seeker and refugee families in hotels, temporary housing, and Mother and Baby Units. They conduct home visits to understand each family's needs - covering areas such as finance, health, education, volunteering, safeguarding, and faith - and offer tailored support.

Case study

A family with three children (aged 2.5, 7, and 9) moved into temporary accommodation in Redbridge. The youngest child had chronic lung disease and frequent hospitalisations. Upon arrival, the ISHV provided:

- **Healthcare coordination:** Liaised with the hospital and connected the family to community nursing services.
- **Education and childcare:** Helped with school and nursery applications.
- **Financial and practical support:** Referred to charities, issued food bank vouchers, and accessed the Family Support Fund.
- **Community integration:** Shared information on children's centres, found nearby mosques, encouraged joining a Refugee Group Pilot Project, and signposted to the Holiday Activities and Food programme.

Examples of other targeted support services include NHS programmes such as the Family Nurse Partnership, which helps support young mothers and their children, thereby reducing reliance on social care.

Together, this workforce identifies support needs amongst the most vulnerable children and families, and addresses these holistically through close partnership with other sectors (such as early years services and children's social

RECOMMENDATIONS

care).

- Adopt a "health and social care in all policies" approach: the wider determinants of health (such as housing, education and unemployment) should be viewed as the wider determinants of health and social care, because variation in these determinants also drives demand and inequality in social care.
- Map the range of different touchpoints across Redbridge in which individuals living in poverty could come into contact with services, and ensure professionals are equipped with the skills and knowledge to identify and signpost people to the support they need.
- Make Every Contact Count by upskilling the wider workforce, so they can identify and facilitate early intervention for both children and adults to prevent escalation of need.
- Ensure sustained investment in The Healthy Child Programme (health visiting and school nursing) with a clear workforce development plan to address ongoing challenges experienced nationally and locally.
- This year the UK government published plans to roll out up to 1,000 Best Start Family Hubs nationwide by 2028 to provide comprehensive support for families with the aim of improving early childhood development and reducing inequalities. This provides an excellent opportunity to deliver the aims to address some of the impacts highlighted in this report and increase access to support.
- Advocate for change at a national level to tackle poverty, whilst simultaneously continuing to invest and strengthen support for local residents at risk of or living in poverty in Redbridge.
- Explore how direct payments could be made more accessible and uptake increased, to restore more power and control to people requiring care. Individuals would need support to ensure they meet their responsibilities and that this could be evidenced.

Social isolation

Loneliness is as harmful to health as smoking 15 cigarettes a day (1). It has significant impacts on health and wellbeing and drives demand for health and social care (2).

Social isolation and loneliness shorten lives, and have profound impacts on physical and mental health.

Social isolation and loneliness are frequently linked to early deaths, and their health impacts are thought to be on par with other modifiable risk factors such as obesity or smoking (3). For example, it has been estimated that social isolation and loneliness increase the risk of developing dementia by up to 50%, stroke and heart disease by up to 30% and early death by 25% (4).

Loneliness also has serious impacts on mental health, increasing the risk of depression, anxiety, suicide and self-harm (3, 4).

Key definitions:

Social isolation and loneliness are two different concepts that are related to each other (3):

Social isolation is the objective state of having few relationships and therefore minimal interactions with others.

Loneliness is a subjective feeling of being alone, regardless of the number of social connections an individual may have.

It is possible for an individual to feel lonely despite having plenty of social connections.

As a result, people affected by social isolation and loneliness are more likely to use health and social care

Individuals who experience loneliness may have more frequent GP appointments, with reports indicating that three out of four GPs see up to five patients daily primarily due to loneliness (5,6). Loneliness is also associated with longer hospital stays and increased reliance on formal care (7), particularly in the absence of informal support networks. Each theme in this report is interconnected; for example, research shows a significant association between loneliness, social isolation, living alone, and an increased risk of falls among older adults, which can lead to greater care needs.

Consequently, social isolation and loneliness are associated with significant economic implications. For example, the combined wellbeing, health and productivity impacts associated with severe loneliness are estimated to be at least £9,976 per person experiencing severe loneliness per year (8).

Loneliness and social isolation are common, despite many cases remaining hidden

In Redbridge, estimates indicate that approximately 7.5% of adults felt lonely 'often' or 'always' from 2021/22 to 2022/23; an increase from 5.2% between 2019/20 and 2020/21 (9). Research suggests that loneliness may follow a U-shaped curve, peaking twice across the lifespan during early and older adulthood; therefore, these groups could experience rates above the general population estimates (10). For example, an Age UK survey on social isolation and loneliness amongst local people in Redbridge found that nearly 1 in 3 respondents (30%) aged 65-74 years old felt they lacked companionship[1] (11). Prevalence also varied by health status, with 73% of respondents in poor health feeling isolated, compared with just 2% of those in good health.

Those receiving formal social care are also at increased risk of loneliness. In 2023/2024, the Adult Social Care Survey (ASCS[2]) identified that 9.9% of respondents aged 18 and over (who use long-term care services) reported they 'often or 'always' felt lonely, with 28.6% feeling lonely 'some of the time' (14). Proportions varied according to age, with 43.6% of 18–24-year-olds feeling lonely 'some of the time'; this highlights that loneliness affects people receiving care across all age groups, not just older adults.

Regarding receiving support for loneliness, over 1 in 4 (25.8%) ASCS respondents in Redbridge felt that care and support services did not help them in maintaining social contact (14). This again varied according to age; 87.2% of 18–24-year-olds felt that care and support services facilitate social contact, compared with 34.7% of people aged 65-74 years old. This could suggest a targeted approach to social isolation might be warranted for older adults in receipt of social care, although small survey response numbers limit interpretation.

There are several factors that increase an individual's risk of loneliness or social isolation, including:

- **Age** - loneliness appears to peak twice across the lifespan during **early** and **older adulthood** (10)
- Experiencing a **mental or physical health problem** (12)
- **Living alone** – in 2021, 23% of households in Redbridge were 1-person households, 42% of which were people aged 65 and over (12,13)
- Experiencing a **divorce** or **bereavement** (12)
- **Low income** or **unemployment**
- People who identify as **gay**, **lesbian or bisexual**
- People who have **migrated**
- Being a **victim of abuse**

1. This survey was conducted by Age UK Redbridge, Barking and Dagenham and Havering from August-November 2023; 120 local people in Redbridge completed the survey.
2. The Adult Social Care Survey (ASCS) is a survey of individuals aged 18 and over who use long-term care services funded by the social care sector. The data here refers to those who completed the survey in Redbridge in 2023/24. It should be noted the number of responses vary according to demographics, with only approx. 20 respondents being aged 18-24 years old.

Tackling social isolation and loneliness requires a system-wide approach that goes beyond commissioning individual services

Coordinated action is essential across the council and partners in Redbridge - including the NHS, voluntary groups, faith organisations, and businesses - to address structural causes of loneliness like poverty and unemployment. Collaboration with housing, transport, education, planning, social care, and public health is needed. This joint effort can create lasting change and reduce pressure on health and social care.

In addition to systemic change, the impacts of social isolation and loneliness can be reduced through targeted prevention and early intervention work.

Age UK have collaborated with "The Campaign to End Loneliness" to develop a framework to tackle loneliness (15). The framework outlines three types of direct interventions focusing on: maintaining existing relationships, building new connections and a change in thinking.

Maintaining existing relationships

A first step towards **preventing loneliness** involves nurturing existing relationships. To do this, people need to be able to connect either in person or virtually. Accessible and affordable transport is essential so that residents can travel with ease for a wide range of reasons, including the development of social connections. Future work should focus on improving transport options for older residents; for example, by addressing barriers like digital payment systems for parking, and supporting the continued availability of freedom passes (16).

Digital connections are also important, however, a recent Age UK digital skills survey[1] identified that only 39% of Redbridge respondents aged 75 to 89 felt confident with using a smartphone (17). In Redbridge, Age UK Digital Champions provide opportunities for older residents to become more skilled and confident with technology through regular group or individual sessions (18).

Future work could involve increasing awareness of the support sessions on offer, as well as exploring whether multilingual trainers are available to tailor requirements to the diverse Redbridge population.

1. This survey was conducted by Age UK Redbridge, Barking and Dagenham and Havering from April-August 2023; 121 local people in Redbridge completed the survey.

New connections

Forming new connections can help people to overcome feelings of loneliness, but it can feel overwhelming to take the first step. Forming new social connections can be supported through group-based approaches and/or buddying schemes:

Community Connection Opportunities in Redbridge

Redbridge offers a variety of group-based activities and buddying schemes to help residents build connections and reduce isolation including:

Universal Community Cafes such as (19):

- **The Café at Loxford** – a welcoming space for residents to socialise, access free food and refreshments, and speak with council officers about health and wellbeing. Activities include arts and crafts, board games, legal advice, and help with benefits and forms.
- **Coffee mornings at Hainault Forest Community Association** - weekly gatherings that promote conversation and connection. Local services attend to support residents with housing, benefits, and employment. Activities include chair-based exercises and arts and crafts.

Find out more at: Redbridge - Community engagement and cafes

Community spaces for socialising that focus on shared interests or identities, such as:

- **Perfect Mix in Loxford** - a free weekly community cooking and socialising initiative connecting refugees and asylum seekers with residents through cooking (19).
- **Black Women Kindness Initiative Wellbeing Hub** – a dedicated space for black women to connect and engage in workshops, discussions, and wellbeing activities (20).

Buddying schemes that pair individuals with regular visitors or callers, such as:

- **Age UK's telephone befriending** - a free telephone service for those aged 55 and over (21)
- **Talking Bubble** - over-the-phone befriending services in a variety of languages (22)

Change thinking

Psychological interventions like Mindfulness and Cognitive Behavioural Therapy (CBT) can help tackle loneliness by challenging negative thoughts and encouraging social engagement (23,24). These approaches rely on strong partnership working with mental health services to ensure identified individuals are signposted to the support they need, and that social isolation and loneliness is prioritised alongside other mental health challenges.

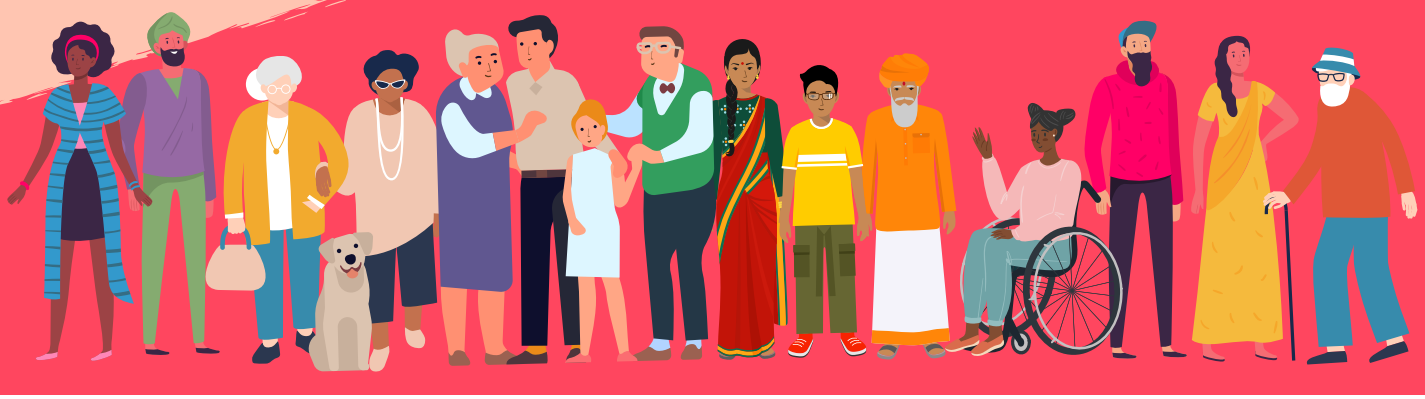
For all approaches that address social isolation and loneliness, stigma can prevent people from accessing the help they need (25).

Overcoming stigma and openly discussing loneliness are crucial to ensure people seek support. Initiatives such as Making Every Contact Count (MECC) can help frontline staff identify and support individuals affected by social isolation and loneliness. For this to be effective, it must be easy for professionals to find out about services available within Redbridge, so they can signpost people accordingly. Services must also have easy self-referral routes that do not digitally exclude individuals, so that everyone can access the help they need more independently.

RECOMMENDATIONS

- Recognise that tackling social isolation and loneliness requires a system-wide approach that goes beyond commissioning individual services.
- Nevertheless, it is important to continue specific prevention and early intervention activities that tackle social isolation and loneliness (such as the universal community café sessions).
- Explore further opportunities for initiatives/programmes that target groups at increased risk of social isolation, perhaps with a shared identify or interest.
- Challenge stigma around loneliness and raise awareness of its consequences on health and wellbeing.
- Improve awareness of the services available to combat social isolation and loneliness amongst residents and the wider health and social care workforce; this will help to maximise the impact of MECC through signposting to appropriate support.
- Continue work to improve digital literacy amongst all Redbridge residents, ensuring support is accessible and appropriate for all members of our diverse population.

Health and wellbeing of carers



Nationally, approximately 9% of the population act as carers. They are estimated to contribute £162 billion annually to the economy – this is almost equivalent to the entire NHS budget (1).

Carers provide invaluable support, often putting the needs of the cared-for adult or child above their own

Carers play a vital role in supporting both the physical and mental wellbeing of those they care for, from offering social interaction that reduces loneliness to assisting with daily tasks. Their involvement helps manage health needs, improves access to services (2), and is linked to better medication adherence (3) and reduced hospital admissions (4).

Carers also report a great deal of satisfaction at carrying out their supportive role. Providing a caring role can help strengthen relationships, teach new skills and knowledge and ensure loved ones are well looked-after.

Key definitions:

A **carer** is anyone, including children and adults, who **looks after a family member, partner or friend** who needs help because of their illness, frailty, disability, a mental health problem or an addiction and **cannot cope without their support**. The care they give is **unpaid** (5).

A **'hidden carer'** refers to an informal carer who may not recognise themselves as a carer, and is not already in contact with a carers support organisation.(5).

Without the support from carers, millions of people in the UK may struggle to find the help they need, turning to the social care system instead.

A large proportion of overall care in the UK is provided by unpaid carers, with estimates of 50% or higher (7). Recent Census data shows there are 5.8 million people providing unpaid care in the UK. Nearly a third of these (1.9 million) contribute 50 hours per week or more (8). Data modelling has predicted a further increase of nearly 1 million carers by 2035, driven primarily by the aging UK population, reflecting the likely rise in demand for formal social care too (9).

Support from unpaid carers is invaluable in reducing the burden on residential and domiciliary care. The absence or withdrawal of their care would lead to demands on formal care to compensate, further exerting an already strained system.

More than one in twenty Redbridge residents deliver unpaid care; however, this is likely to be an underestimate

The 2021 Census recorded over 21,000 Redbridge residents as carers, with more than a quarter providing 50 or more hours of unpaid care weekly (figure 8) (10). However, actual numbers may be higher, as many people do not identify themselves as carers (typically believing that it is their "responsibility", commonly for friends or family in need) and are therefore not represented in the data.

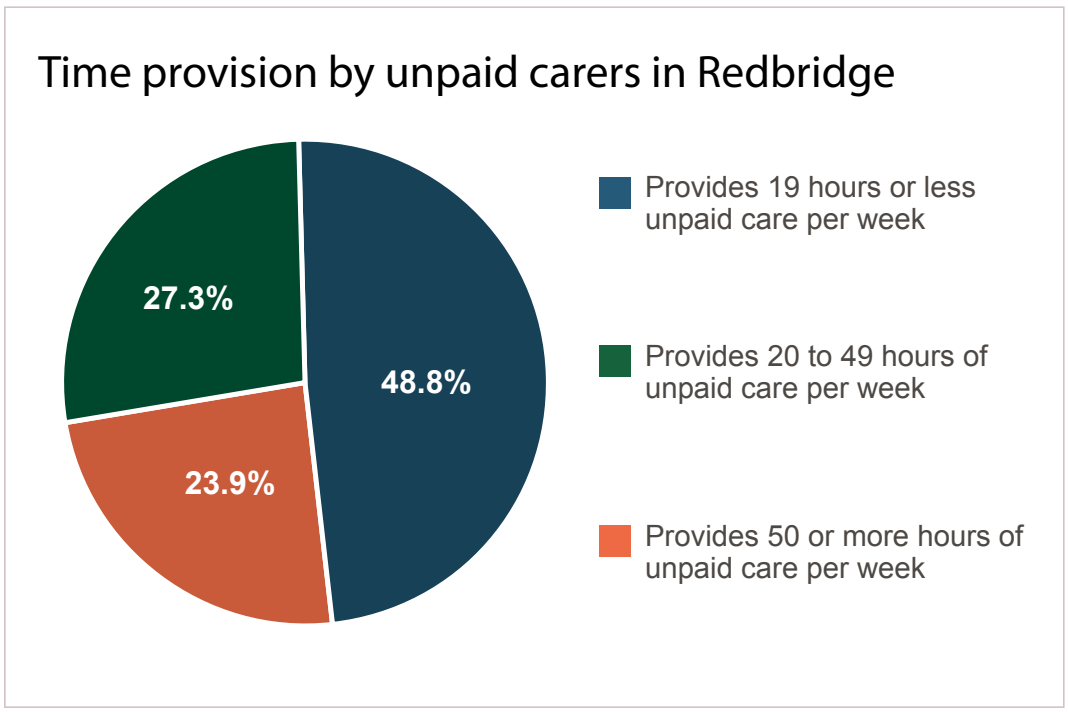


Figure 8: Hours spent providing care per week by unpaid carers in Redbridge, Census 2021 (10)

The 2021 Census data identified that there are inequalities amongst the carer population in Redbridge, as there are nationally

Evidence suggests that carers are more likely to be over the age of 50 and female (1,11). In Redbridge, according to the 2021 Census, approximately 3 in 4 (74%) self-reported carers were over the age of 50, and 58% were female (12). Amongst younger adults, over 1,750 self-reported carers were aged 24 years old or under, with nearly 1 in 5 aged 15 years old or under.

The ethnic makeup of self-reported carers in Redbridge matches the borough's diversity; for example, 47% are of Asian backgrounds, aligning with local demographics (10,12). Evidence suggests carers from ethnic minority groups are often younger, of working age, face greater financial challenges, and provide longer care hours (13). In Redbridge, 52% of carers of Asian ethnic backgrounds were aged 25-49 years old, vs just 28% of carers of White ethnic backgrounds (12). Although Redbridge has a similar proportion of carers (7.4%) as England (8.7%) and London (7.3%) (10), the boroughs diversity may lead to unique challenges, increasing the need for support.

The crucial support provided by carers can come with significant challenges

A carer's role can be stressful, demanding and time consuming, as well as physically and mentally draining (1). Carers often have their own long-term conditions and disabilities (14), and they are more likely to feel lonely or socially isolated (15). Economic impacts can be significant: carers experience poverty (27%) at a greater rate than the general population (18%); a third of unpaid carers reported a need to cut back on essentials; and long hours of care can make it difficult for unpaid carers to stay in employment (16).

Some carers in Redbridge find it difficult to access information and services, and many carers are not registered with support services

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people (17). Data from ASCOF in 2023/24 identified that just over half (53%) of carers surveyed felt it was easy to find information about services in Redbridge. Over 3,000 carers are registered with the Redbridge Carers Support Service (RCSS), identifying a significant shortfall in reaching, registering and supporting the carers in our borough, although this is improving (18). The diverse population of Redbridge could mean that carers face additional challenges when accessing services. Reduced carer identification and support amongst ethnic minority groups appears to be multifactorial, and can include: language barriers, lack of awareness of services, concerns about cultural appropriateness of any support, and the perception that care is part of a 'family responsibility' (19).

Identification of all carers is a crucial first step in establishing support and building robust carers networks

Increased awareness, education and identification of carers in our communities can lead to better access to support, benefits and respite. Supporting carers in Redbridge starts with first identifying them:

Identifying carers in Redbridge

Four main access touchpoints have been identified and strengthened to help find and support identify carers across Redbridge:

1. **Hospitals** –a hospital discharge carer support officer has been recruited at King Georges to work with teams at discharge and identify existing unregistered carers so these individuals can be signposted to RCSS and other services.
2. **GP surgeries** – the carers teams have worked with local GP surgeries to help identify carers through promotional materials (e.g. posters and newsletters) to raise awareness of caring and encourage self-referrals. The Redbridge Carers Charter has also been printed and is being rolled out to all 41 GP practices.
3. **Schools** – young carers frequently go unrecognised, and identification of their responsibilities are often unearthed through educational establishments. The team have been working with schools to identify young carers and provide them with extra support;
4. **Community engagement** – through work with local faith and diversity groups, engagement officers raise the profile of caring, identify people who may carry out this role, and refer and signpost them to the appropriate teams and services.

Once identified, it is important that carers know what support they are entitled to, and that they can exercise their rights to get the care and support they deserve.

Supporting carers in a holistic way helps them to continue their valuable caring role, whilst also helping delay or prevent the dependence on formal social care systems.

The Redbridge Carer's Support Service (RCSS) provides a range of support for carers, including peer groups (with tailored sessions for young carers, parents, and dementia carers), as well as mental health and wellbeing support such as a counselling and coaching (21). RCSS also offers advice on carers' rights and welfare benefits through their Advice Surgery. In partnership with the council, Endorphins delivers short break sessions for young carers aged 8-19 years old, offering activities to reduce loneliness and build key life skills (22).

Did you know…?

Unpaid carers who are employed in other work are entitled to one week per year of unpaid leave for caring duties (24). They are also eligible to apply for Carer's Allowance if they provide 35 or more hours of care per week. Nationally, estimates suggest that £2.3 billion of Carer's allowance is unclaimed by eligible people **(24).**

Carers and The Care Act 2014

The care act put in place significant new rights for carers in England (20), including:

- A focus on promoting wellbeing
- **A duty on local councils** to prevent, reduce and delay need for support, including the needs of carers
- **A duty on local councils** to provide information and advice to carers in relation to their caring role and their own needs
- A right to a carer's assessment based on the appearance of need
- A right for carers' eligible needs to be met
- A duty on NHS bodies to co-operate with local authorities in delivering the Care Act functions

Supporting carers helps prevent breakdown and significantly reduces social care demand

Carer breakdown (when carers can no longer continue their role due to factors like declining health or financial strain), often leads to costly interventions such as hospital or care home admissions. These crises also have a significant emotional impact on both carers and those they support.

Preventive measures are more effective and cost-efficient; Department of Health data suggests that investing £292.8 million more in carer support would save councils £429.3 million in replacement care costs. Another report estimated that every £1 invested in carers yields a potential reduction in local authority costs of £5.90 (25).

Respite care provides carers with necessary breaks, reducing stress and helping prevent burnout; in Redbridge, this is provided by organisations like TuVida and Redbridge Respite Care Association. These services are in high demand, and investing in strengthening and expanding them could help delay or prevent carer breakdown, and reduce reliance on formal care services. Respite placements are only available for adults aged 18 years and over. Over 800 Children with Disaibilities receive social care services from Redbridge. A review of the respite support available to parent carers in the borough may be warranted in the future.

Making unpaid caring the 10th protected characteristic would ensure carers are recognised within the council and across Redbridge systems

The development of Redbridge Carer's Charter 2024-2027, and its associated action plan, sought to act as a framework for the development and delivery of services to support carers across the council (18). It consists of a series of "I…" statements, developed through direct engagement with carers and stakeholders, to demonstrate commitment to working with and for carers locally.

The Carer's Charter is essential because supporting carers in Redbridge requires a system-wide approach in which the role and importance of carers is fully recognised by everyone. There are growing calls for unpaid caring to be introduced as the 10th protected characteristic, to bolster legal protection and guard against discrimination for caring duties. Roughly one fifth of carers report unfavourable treatment by the general public and similar numbers at work (26). Existing protections are indirect, through the 2010 Equality Act, whereby it is illegal to discriminate against someone with a protected characteristic – i.e. carers cannot be discriminated against due to their association with their cared-for individual who may have a protected characteristic. This, however, does not provide solid legal footing directly for carers.

By establishing caring as a protected characteristic, we could support carers by preventing direct discrimination, ensuring organisations advance equality of opportunity for carers and encourage detailed collection of data to review the impact of policies. Examples exist of local authorities advancing carers status as a locally protected group in their equality and diversity policies. North Tyneside council list "carer" as a non-legally protected characteristic (27), and Leeds city council list "caring responsibilities" alongside the existing protected characteristics (28). By adopting a similar policy, the council could ensure carers are locally protected by:

- Including them formally in Equality Impact Assessments and workforce monitoring
- Requiring service providers to consider impact to carers
- Embedding carer's experience into policy design and procurement.

RECOMMENDATIONS

- Recognise caring as a protected characteristic and use this as a vehicle to address inequalities in outcomes for carers, by ensuring their needs are considered in the planning and implementation of all services.
- Recognise the importance of improving and maintaining the physical and mental wellbeing of carers, and the challenges they may face when accessing services for themselves whilst balancing this with a need to ensure the cared-for person is appropriately supported.
- Continue to improve the identification of carers across a wide-range of potential touchpoints, including hospitals, GPs, schools and through engagement work.
- Continue to raise the profile of carers, highlighting the value and importance of their roles and the support available. Ensuring our approach is tailored to our diverse population could help with self-identification of carers and subsequent uptake of support.
- Encourage people to register as carers, signposting them to carer support organisations in the borough, so they can access the help they need and deserve.
- Explore expanding support for parent carers and young carers in the borough, as respite services are currently only available for those aged 18+ and RCSS primarily supports carers aged 16 and over.

Challenges and opportunities of the social care system

In this report we have highlighted some of the key drivers of increasing social care demand in Redbridge, ranging from frailty to poverty. Across all areas, stakeholders raised several challenges related to social care systems (both nationally and in Redbridge), which influence how effectively we can address these drivers. We have collated these challenges into themes and reframed them into eight cross-cutting recommendations; these should be considered when addressing any of the drivers discussed in this report:

1. Increase awareness of services amongst residents and the health and social care workforce
2. View people from the perspective of where they could be, not just where they are now
3. Ensure care is proportionate to need
4. Manage increasing demands in the face of limited resources
5. Value and support the wider social care workforce
6. Enhance data intelligence in health and social care by including input from service users and people with lived experience, and ensure all interventions are properly evaluated to build a local evidence base of effective and ineffective approaches
7. Acknowledge the complexity of health and social care systems, and the importance of partnership working
8. Recognise the need for whole system change to address unsustainable increases in health and care demand

1. Increase awareness of services amongst residents and the health and social care workforce

Engagement work highlighted that there are a wide range of health and wellbeing services in Redbridge. However, awareness and access of these services before people reach crisis point remains a significant challenge. Information is often fragmented across sources, and no single, comprehensive publicly available directory exists; this can result in lost institutional knowledge, especially in areas of quicker staff turnover.

Many of the recommendations in this report focus on Making Every Contact Count (MECC), but this depends on professionals having quick and easy access to up-to-date service information, so that MECC can be incorporated into their already busy workloads. This requires understanding the needs of the **workforce**, and how we can best support them to remain up to date with a wide range of services.

At the same time, understanding how **residents** find services can help us improve early awareness and access. Many rely on online search engines, so exploring and optimising these searches is essential. This approach aims to shift from the assumption that individuals always require professional assistance, potentially increasing supported self-management for those who are more self-sufficient. Nevertheless, self-management may not be adequate for some residents, particularly those experiencing significant inequalities (such as domestic violence or navigating systems as an asylum seeker), in which case additional assistance or dedicated navigation services (such as social prescribing) may be necessary.

Finally, any approach to improving awareness and access needs to be culturally appropriate and consider the diverse demographics of the borough. It must focus on improving access for those experiencing the greatest health inequalities, and it is likely that a variety of approaches will be needed to meet the needs of our residents. For example, digital platforms may be a convenient and cost-effective solution for many, but as demonstrated in the social isolation chapter, they can digitally exclude some older residents. This does not mean that digital solutions can't be considered, but rather that they should be considered alongside other approaches too.

Social Prescribing in Redbridge

Social prescribing involves referring people to a range of local, non-clinical services to address their needs in a more holistic way (1). In Redbridge, we are currently undertaking a review of social prescribing, considering how our approach can be adapted so that it works for everyone in the future, including social care.

2. View people from the perspective of where they could be, not just where they are now

A central theme identified during engagement work was the balance between addressing individuals' current care needs whilst still supporting their skill development. Reduced focus on an individual's potential may lead to a progressive decline in their independence.

Reablement is a short-term service that helps patients to regain independence and therefore reduce long-term care needs (2). This approach could be widened and applied to other settings, so that it becomes 'business as usual'. This involves moving away from the view that reablement is a distinct service delivered in a particular way. For example, Redbridge has piloted ward-based reablement, starting support during hospital stays to ease the transition home and prevent dependency. Another approach includes preventative reablement, in which professionals identify and refer patients to prevent deterioration and avoid hospital admission, without waiting to do this until an event has already occurred.

Adopting a reablement approach more broadly in social care faces challenges. Homecare is often task-focused, and supporting someone to do tasks themselves can take longer than doing it for them. Whilst integrating reablement can boost resident confidence and reduce care needs in the long-term, it requires more resources and a cultural shift amongst residents, families, and carers.

3. Ensure care is proportionate to need

In risk-averse societies, people may receive excessive social care as workers aim to avoid harm. However, this can strain the system without clearly improving outcomes for children and adults. People may not always need a formal service but would instead benefit from a community connection, short-term help, or access to assistive technology. Avoiding unnecessary care packages relies on understanding the individual's needs and having the knowledge and confidence to accurately assess and address these. In complex cases, a multidisciplinary team (MDT) approach may be necessary, incorporating expertise from social care, community services and the provider. In either case, the priority remains the same – care must be proportionate to need, with an acknowledgement that an individual's requirements may increase or decrease over time.

Care packages should be reviewed annually, yet these reviews are often delayed, resulting in unchecked care levels (3). Annual reviews in Redbridge ensure better outcomes for service users and the system overall. Promptly addressing increased needs prevents crises, while reducing unnecessary care reallocates resources effectively. Improving the review process will help ensure timely completion and address any obstacles.

4. Manage increasing demands in the face of limited resources

Adult and children's social care providers report that caseloads are increasing while resources remain limited and budgets have not expanded to meet rising costs. As a result, providers are prioritising acute needs within the legislative framework, leaving less capacity for broader initiatives such as prevention and early intervention. Balancing upstream measures aimed at reducing issues like poverty and social disadvantage with effective systems to identify families at risk, alongside adequate investment for intervention and support, is necessary to address intergenerational cycles. Increasing resources would allow more time to be allocated to prevention work, as current capacity within the system is limited.

Meanwhile, strengthening connections between social care and Public Health is crucial as prevention also falls under Public Health's responsibilities. Social care should be involved in discussions regarding public health prevention and early intervention initiatives. A useful example of this approach can be found with the hidden harms worker, who works across substance use services and social care in Redbridge:

Addressing Hidden Harm

Substance use doesn't just affect individuals - it also impacts families, especially children, who can suffer significant emotional and social harm, often unnoticed. In Redbridge, a Hidden Harm Worker supports young people affected by a family member's substance use, helping them understand and cope with their experiences, and build resilience. Raising awareness of hidden harm is crucial for increasing referrals and reducing stigma, enabling early intervention that can prevent families from reaching crisis.

We should also ensure that health needs assessments include the perspectives of health **and social care** colleagues, sharing the findings and recommendations more widely across teams. As described in the chapter entitled **'Poverty'**, we should reframe the wider determinants of health to be the "wider determinants of health **and social care**". As such, our colleagues in social care should be included in conversations across a wide range of council services, from housing to transport.

Public Health has advocated for a 'health in all policies approach', but really, this should be a **'health and social care in all policies approach'**.

5. Value and support the wider social care workforce

Nationally, there is considerable need for better incentives, acknowledgement and celebration for the crucial work that is delivered by care workers. Working in health and social care is emotionally and physically draining, and yet the toll of care work has been consistently underrecognised. For example, within the social care workforce during the Covid-19 pandemic, it was felt that care staff were not appreciated in the same way as those working in the NHS (4).

"The NHS were not the only heroes. The quiet, underpaid, overworked, undervalued, overlooked domiciliary care workers were and still are [heroes too]!"
Domiciliary care worker, England – UK Covid-19 inquiry, Every Story Matters, ASC Sector (4)

In addition to challenges at work, many face significant struggles at home - as described in the 'Poverty' chapter, 1 in 5 residential care workers lived in poverty and over 1 in 10 relied on Universal Credit between 2021/22 and 2023/24 (5). Providers are consistently being asked to do more for less. Low pay, increasing workloads and limited opportunities for career progression are all contributing to reduced morale, workforce burnout and rapid staff turnover.

At a national level, we must continue to advocate for fair pay and improved working conditions in social care (5,6). Locally, we should also review and explore further opportunities for workforce development. Care workers have a wide range of transferrable skills and can progress upwards to become senior care workers or specialise in particular care areas (such as palliative care). They can also change course and bring their expertise and insight into social work or healthcare. To facilitate this, it is important to provide people with opportunities to try something new. One example of this is the Enhanced Homecare pilot currently being implemented by Care City:

The Enhanced Homecare Pilot

Care City, in partnership with the London Borough of Redbridge, Wanstead and Woodford PCN and care provider Care Nexus, has launched the Enhanced Homecare pilot earlier this year (7). As part of the programme, care workers receive training to take their clients' vital signs using the Blue Box by telehealth provider Whzan. The observations are recorded every fortnight or whenever concerns arise.

The data indicates a risk score, which allows for early detection of health concerns. The pilot is also looking at improving escalation protocols to enable faster response times when escalating concerns.

The pilot is looking to provide benefits for patients, care staff, care providers, and the wider system.

Collaborative networks, such as **Care Providers Voice** in North-East London, are also invaluable for providing free access to training opportunities, promoting collaboration across boroughs through forums and shared resources, and offering tools to help develop the workforce (8). They also work closely with local authorities to ensure that the voice of the care sector is heard in local and regional policymaking.

6. Enhance data intelligence in health and social care by including input from service users and people with lived experience, and ensure all interventions are properly evaluated to build a local evidence base of effective and ineffective approaches

Accurate data collection is vital for effective service planning in health and social care. Identifying challenges faced by residents and gathering input from service users provides valuable insights. Sharing data amongst partners is necessary, because data is often fragmented across systems, making it difficult to understand the full picture (as discussed in more detail in the "Falls" chapter). We also need the expertise and capacity for analysis, since large datasets require significant time and skill to interpret. Investing in analytics is key to addressing major challenges, identifying those at risk, and evaluating the impact of interventions.

Although prevention is central to social care, it remains under-researched. Most literature focuses on health outcomes rather than whether interventions help maintain independence or reduce social care needs (9). Measuring prevention's impact on service demand is challenging, especially since many interventions are community-based and subject to external factors (unlike controlled clinical trials) (10). Long-term observation is often necessary, and success may be indicated by the absence of negative outcomes, which can go unnoticed. However, with proper expertise and evaluation, we can build a local evidence base (9). Data analysis (understanding) and evaluation (judging quality) are distinct but both essential, and targeted investment in each is required for effective preventative approaches.

7. Acknowledge the complexity of health and social care systems, and the importance of partnership working

Social care is part of a very complex system of services that look after people throughout their lives. Small adjustments in one area, like referral processes or staffing, can trigger cascading impacts elsewhere. Rather than trying to control these systems, it may be more effective to understand their dynamic nature, anticipate unintended consequences, and work collaboratively to achieve constructive outcomes.

Collaboration between agencies is important, because working in isolation can increase risks to residents and reduce resource efficiency. Engagement with stakeholders identified that residents can experience service gaps during high-risk transitions, such as being discharged from hospital to the community. Limited health service capacity can mean that patients are discharged into the community earlier without adequate discharge planning; this can lead to readmissions and increased care needs, resulting in higher system costs. For example, ensuring that a resident has access to necessary equipment, such as a working fridge for medication, can help maintain treatment plans and prevent rehospitalisation. The complexity of service systems can make it unclear who is responsible for providing such equipment, highlighting the need for all involved parties to consider their respective roles in finding resolutions. No one has complete responsibility, but collaboration enables more effective responses that reflect the needs of those receiving support. Effective collaboration between public health and social care is also crucial to ensure a holistic and coordinated approach to supporting children and families.

Examples of collaboration highlighted in this report:

- Health visitors work closely with social care teams to identify and support families at risk.
- Council and public health initiatives, like those focused on reducing poverty, can help prevent problems that might lead to social care involvement.
- Joint working across public health and social care can improve access to preventative and early intervention services e.g. social prescribing.

8. The need for whole system change to address unsustainable increases in health and care demand

There was a clear recognition that we also need to consider broader systemic changes and foster a cultural shift. The council is launching an extensive modernisation and regeneration programme, presenting an exciting opportunity to ensure that these efforts are inclusive and do not unintentionally increase or exacerbate inequalities. Inclusive regeneration emphasises ensuring that all community members - particularly those facing poverty and social exclusion - benefit from regeneration initiatives. Additionally, we have the chance to rethink service delivery as part of this process. Housing serves as a key example; stability in housing creates a virtuous circle by reducing demand on social care, especially for children.

Hilary Cottam's report, "A Radical New Vision for Social Care," highlights the importance of involving both caregivers and recipients in system design through co-design and co-leadership (11). It emphasises carers' central economic role and calls for fair pay, recognition, career progression, and a move from cost-based metrics to impact-driven investment. Innovative approaches have been implemented in other councils through initiatives like the Wigan Deal and Radical Place Leadership (12,13). These approaches move from siloed services to integrated, place-based systems, emphasising collaborative leadership, early intervention, human-centred practice, and sustainable investment.

As an anchor institution, the council can also leverage its stable presence, resources, and influence to drive innovative partnerships, champion whole-system change, and ensure regeneration efforts are inclusive and responsive to the needs of all community members.

Finally, to succeed in changing culture, reducing reliance on services and promoting community resilience is essential to understand what motivates our residents and families. A stakeholder highlighted that education is a significant driver, observing, **"Parents are aspirational. If we can link community action to educational outcomes, we'll achieve better engagement."**

Conclusion

In summary, addressing key risk factors in social care through small incremental improvements across multiple services (for example systematic early access to preventative services and improvements to care pathways) can collectively lower demand; however, to deliver sustained impact at scale requires a commitment to whole systems change which includes a **'Health and Care in all Polices approach'** and strong leadership across all public sector agencies as anchor institutions.

Feedback from our engagement work demonstrated both a commitment and desire to implement new approaches, and the discussions were both insightful and inspiring. This transformation calls for not only a rigorous approach to evaluation and evidence, but also a significant shift in the skills and abilities of our workforce. Crucially, it means moving away from a paternalistic model of service delivery towards one that empowers and enables local communities to co-develop their own solutions. By investing in change (and not just services), we can foster genuine collaboration, build resilience, reduce inequalities, and support innovation that is rooted in the strengths and aspirations of our residents. Only through this kind of comprehensive, inclusive change can we create a sustainable and responsive social care system for the future.

This report serves as a successful starting point for addressing these challenges. However, to achieve sustained impact, it is crucial to continue the conversation with the wider public and service users.

References

Introduction

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Appendices

Appendix A – the adult social care system in Redbridge

Below is a stepwise timeline of a resident's journey through the adult social care system in Redbridge:

Step 1 – Universal offer

The Redbridge council website provides information and resources for adults on finances, wellbeing, independence, safety, and safeguarding. If further help is needed, individuals can contact adult social care.

Step 2 – Requesting help

Referrals to adult social care can be made by the individual, their next of kin, or professionals, either online or by phone.

Step 3 – First Contact Team

A First Contact Team (FCT) practitioner reviews the referral and connects the individual with appropriate community support, or refers them to Redbridge Community Health and Social care (HASS) if needed.

Step 4 – Planning care and support

A social worker reviews the case, creates a 'Care and Support Plan,' and may arrange a welfare visit. A financial assessment determines care funding.

Step 5 – Delivering care and support

The brokerage team secures suitable care services, considering the person's needs and preferences, then care is delivered.

Step 6 – 6-week review

A review takes place six weeks after care starts to ensure it meets the individual's needs. Adjustments can be made if necessary.

Step 7 – Annual review

A yearly review determines if ongoing care is needed. If not, the case is closed with advice on re-accessing services if required.

Appendix B – the children's social care system in Redbridge

In Redbridge, children's social care is known as Family Help Services. Below is a stepwise timeline of a resident's journey through this service in Redbridge.

Step 1- Referral received and screened

A referral is received by the Multi-Agency Safeguarding Hub (MASH) which is the family front door. The referral is screened against criteria to decide whether the case would benefit from going through the MASH. If the referral does not meet the criteria, the team can signpost to practical support to prevent a problem from escalating. When there is a single issue that needs addressing, MASH will offer access to resources from central teams, such as parenting group work or the Reach Out Domestic Abuse Services.

Step 2- Information gathering

Each MASH case is assigned to a social worker who gathers information about the child/family concerned from their colleagues in the multi-agency team. The social worker then checks the information, writes a summary and recommends what further action should be taken.

Step 3- Making a decision

The Head of the MASH reviews the record and decides on the most appropriate action. Outcomes will include:

- Progression to the Multi Agency Child Protection Team if there are serious concerns about the case.
- Progression to the Family Help team if the case does not raise serious concerns but meets the threshold for targeted early help or statutory children's social care.
- Progression to a partner agency for a single agency response (mentioned above).
- No further action if no concerns are raised.

Step 4- Family Help Teams

All referrals for early help and children's social care will be managed within family help teams. These teams are responsible for the needs assessment and delivery of the child/family plan.

There are 5 family help teams in the Redbridge model:

1. Team 1 and 2- supports families who are struggling with issues causing family crisis and breakdown e.g. debt, domestic abuse and homelessness
2. Children with Disabilities- supports children with Special Educational Needs and Disabilities (SEND)
3. Contextual Safeguarding- supports children at risk of exploitation
4. Pre-Post Birth- supports vulnerable new mothers to look after their babies and keep them safe

Each team consists of a mix of social workers and family support workers. The current model in Redbridge is a circular model with the family in the middle and services stepping in and out of the circle, as required. A lead practitioner coordinates a bespoke team around the family to ensure the right support is available.

Glossary

The following list provides a glossary of common terms used throughout this Annual Public Health Report:

Terminology	Definition
Assistive technology	Any product or service that helps people with disabilities, health conditions or ageing to function better.
Buddying	A one-on-one approach to combat loneliness where a volunteer, specifically matched to the individual's requirements, visits or calls them on a regular basis
Care and Support Plan	A plan that will set out how an individual's social care needs will be achieved.
Carer	Anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.
Carer's allowance	Financial support that a carer can receive if they care for someone at least 35 hours a week and they get certain benefits.
Child protection	Measures and structures to safeguard children from violence, exploitation, abuse, abandonment, and neglect.
Children looked after	A child who has been in the care of their local authority for more than 24 hours is known as a child looked after.
Cognitive Behavioural Therapy (CBT)	A type of talking therapy where a therapist helps an individual to change the way they think and act.
Community treatment team	A service made up of a multidisciplinary team who provide short term intensive care and support to adults experiencing an urgent health and/or social care crisis. The service aims to support individuals to remain at home, rather than attending A&E.
Direct payments	Receiving cash payments from the local authority instead of care services. People can then arrange their own care services using this money as long as it is spent on things that meet their agreed care plan.
Early intervention	An approach to provide effective early support to adults, children, young people and families who are at risk of poor outcomes.
Equality Impact Assessments	An approach designed to help organisations ensure that their policies, practices and decision-making processes are fair and do not present barriers to any protected groups from participation.
Frailty	A decreased resilience to stressors, which makes people more vulnerable to disease, disability, hospitalisation and social change.
Group-based approaches	Group-based approaches involve individuals coming together in a community setting for a particular activity.

Terminology	Definition
Health inequalities	Socially produced differences in health, such as homelessness or living in more socio-economically deprived areas.
Healthy life expectancy	The average number of years an individual will live in good health calculated from self-reported 'good health' in survey data and life expectancy.
Hidden carer	Refers to unpaid, informal carers who are not already in touch with carers support organisations.
Home care/ domiciliary support	Support that is provided in people's homes.
Loneliness	A subjective feeling of being alone, regardless of the number of social connections an individual may have.
Long term services/care	Services that are provided on an ongoing basis and range from more intensive nursing care support to community support.
Make Every Contact Count (MECC)	An established national initiative that can help frontline staff turn everyday interactions into meaningful opportunities to connect people with support.
Malnutrition	A condition where the diet does not contain the right amount of nutrients. It can refer to undernutrition (not getting enough nutrients) or overnutrition (getting more nutrients than needed).
Means-tested	Based on your income and how much capital you have. This creates a fairer system where benefits are given to those who need it most.
Multi-Agency Safeguarding Hub (MASH)	The front door system for safeguarding the local population in Redbridge. All referrals go through the MASH.
Multi-disciplinary team (MDT)	A combination of health and care professionals who come together to plan and coordinate people's care.
Polypharmacy	The use of several medications at the same time in the same individual.
Poverty	When a person's resources are insufficient to meet their basic living needs (including social participation).
Reablement	Short term care with the aim to support someone to return to their baseline level of independence.
Recurrent falls	When someone experiences two or more falls within the past year.
Respite care	Carers taking a break from caring, while the cared-for person is looked after by someone else.

Terminology	Definition
Social care	An umbrella term used to describe a wide range of activities that help people with increased care needs, so that they can live independently and stay well and safe. Help might include support with 'personal care', such as washing and dressing, or help to stay active or engaged with communities. It could involve the provision of aids or adaptations to the home, or the provision of information and advice. It can also extend to helping those that care for others (carers).
Social isolation	The objective state of having few relationships and therefore minimal interactions with others.
Social prescribing	Involves referring people to a range of local, non-clinical services to address their needs in a more holistic way
Statutory services	Public services that the law requires the government and local authorities to provide. They ensure that everyone has access to support if needed, regardless of their circumstances or background.
The Care Act 2014	A law that sets out the rights and responsibilities of local authorities, care providers and individuals in England with regards to care and support.
The First Contact Team (FCT)	The team that receives adult social care referrals in Redbridge. They will contact the referrer to find out more information about the individual and the type of support required.
The Redbridge Carer's Support Service (RCSS)	The lead local voluntary sector organisation commissioned to provide a wide range of support to carers across the borough.

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