The London Borough of Islington: Health Needs, Inequalities and ICS Priorities

Source: Islington Joint Health and Wellbeing Strategy 2025-2030

The Centre for Population Health January 2026

Introduction

This summary provides an integrated overview of The London Borough of Islington's population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence-based planning across health, social care and community partners.

The pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

Borough Overview

Islington is a compact 14.9 km² inner-London borough with 223,000 residents and 14,833 people per km², among England's highest densities.

38% of residents are from Black, Asian and minority ethnic groups, including 13.3% Black, concentrated across wards like Finsbury Park and Caledonian.

Deprivation is widespread: Islington ranks 53rd most deprived of 317 districts, with no areas in the 20% least deprived nationally.

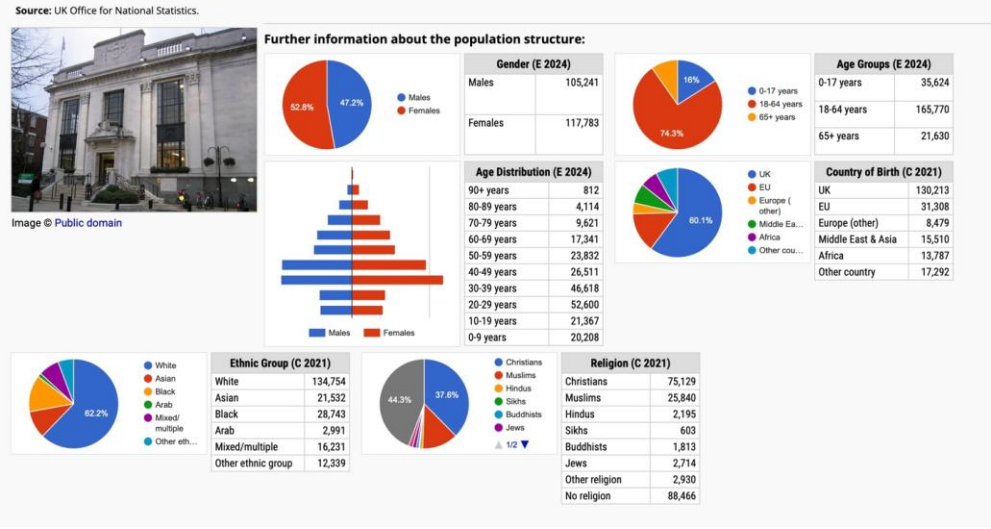
Child poverty reaches 43% after housing costs, significantly above the 30–35% London average, affecting families across multiple estates.

Housing pressures are severe, with 29% of residents lacking access to green space, high overcrowding, and extensive social housing across the borough.

Health inequalities persist, with premature mortality from cancer, cardiovascular and respiratory disease higher than London averages.

Population Characteristics

- Population is youthful: 74% aged 18–64, only 10% aged 65+, and 16% children, shaping service demand.
- Strong young-adult concentration, with 52,000 residents in their 20s and 46,000 in their 30s, far exceeding older age groups.
- Population mobility is high due to a large private rental sector, creating challenges for continuity of GP registration and preventive care.

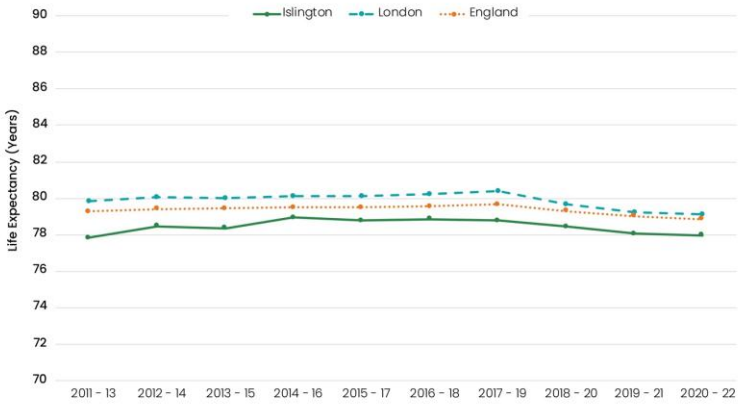


- Ethnic diversity includes 62% White and 38% minority ethnic groups, with significant Black African, Black Caribbean, Bangladeshi, Turkish and Somali communities.
- 40% of residents were born outside the UK, and 19% speak a language other than English, requiring accessible, culturally appropriate health services.
- Housing patterns include 30% social housing, high overcrowding, and many single-person households, influencing mental health and respiratory health needs.

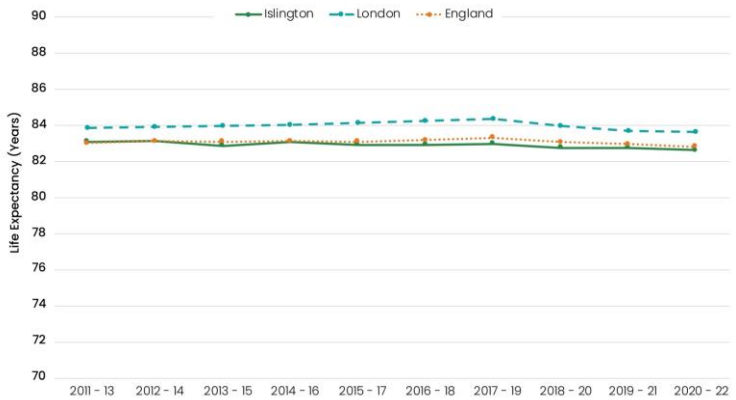
Key Health Inequalities: Life Expectancy

- Male life expectancy is 79.5 years and female 83.2 years, both around one year below London averages.
- Life expectancy gap between most and least deprived areas is around seven years for men and three to four years for women.
- Healthy Life Expectancy improved to 61.2 years for men and 63.8 years for women, rising five to six years since 2011.
- Men spend 16.5 years and women 19.4 years in poor health, reflecting long-term illness onset in midlife.
- COVID-19 caused a temporary decline in life expectancy before partial recovery in 2022 across Islington.
- Deprived communities experience earlier illness onset, often developing serious conditions in their 50s compared with late 60s in affluent groups.

Trends in life expectancy at birth, Islington, London and England, males 2011-13



Trends in life expectancy at birth, Islington, London and England, females 2011-13



Source: Fingertip, OHID

Key Health Inequalities: Premature Mortality

Cardiovascular under-75 mortality is 85.2 per 100k, higher than London (74.3) and England (76.0) averages.

Preventable cardiovascular mortality is 34.5 per 100k, exceeding England's 30.2, driven by smoking and hypertension.

Cancer premature mortality is 135.2 per 100k, far above London's 110.2 and England's 121.1 averages.

Preventable cancer deaths reach 67.4 per 100k, significantly higher than London's 43.3, linked to smoking and late diagnosis.

Respiratory premature mortality is 36.3 per 100k, compared with 22.5 in London, driven by COPD and air pollution.

Avoidable mortality overall is around 271 per 100k, reflecting concentrated risk factors in deprived neighbourhoods.

Key Health Inequalities: Mental Health

Islington has London's highest recorded depression prevalence at 8.3% of adults on GP registers.

Serious mental illness prevalence is among the highest in London, with affected residents dying 15–20 years earlier.

Employment gap for people in contact with secondary mental health services is around 65% compared with borough average.

Suicide rate is 7.9 per 100k, similar to London, with risks concentrated among middle-aged men and substance users.

Black men are over-represented in acute mental health admissions, reflecting structural and social inequalities.

Areas such as Finsbury Park show high mental health service contact, linked to deprivation and housing stress.

Key Health Inequalities: Obesity and Long-Term Conditions

Adult overweight/obesity is 51%, well below England's 63%, reflecting younger demographics and higher physical activity.

Childhood obesity affects 22.6% of Year 6 pupils, strongly linked to deprivation and food insecurity.

Smoking prevalence has fallen to 7.9%, lower than London's 11.7%, yet remains concentrated in deprived groups.

Diabetes prevalence is 6–7%, with higher rates among South Asian and Black communities and deprived households.

COPD prevalence is 1.2%, with emergency admissions above London averages, especially in older ex-smokers.

Cancer screening uptake remains low: 60% cervical, 66% breast, and around 50% bowel screening participation.

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Key Health Inequalities: Maternal and Child Health

Infant mortality is around 3 per 1,000 births, similar to England, but risk factors cluster in deprived families.

Smoking in pregnancy is 4% overall but higher among younger and disadvantaged mothers in social housing.

Teenage pregnancy rate is 15 per 1,000 females aged 15–17, reduced significantly but uneven across communities.

MMR vaccination coverage is 75–80%, below the 95% target, with lower uptake in transient and migrant families.

Childhood asthma admissions are higher in overcrowded and deprived areas, linked to housing and pollution.

Oral health inequalities persist, with tooth decay concentrated among low-income and minority ethnic children.

Key Health Inequalities: Wider Determinants

Islington has the 4th-highest income deprivation affecting older people and 10th-highest affecting children nationally.

Overcrowding affects around 11% of households, increasing infection spread and contributing to respiratory illness.

Fuel poverty affects 9–11% of households, worsening winter health outcomes for older and low-income residents.

Air pollution disproportionately affects residents living near main roads, often lower-income households.

Limited green space access affects 29% of residents, reducing physical activity and increasing stress.

Social isolation is common among older adults and BAME elders, increasing mental and physical health risks.

(IMD Overview)

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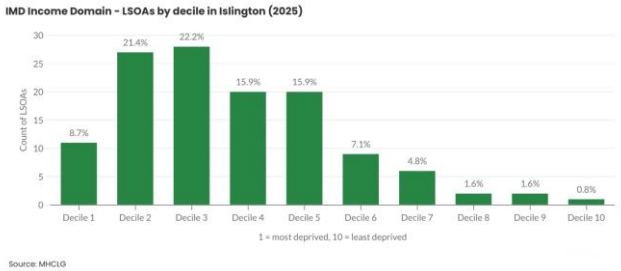
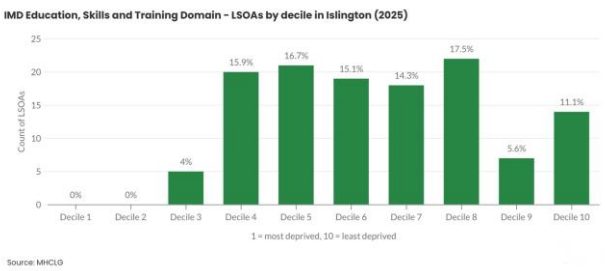
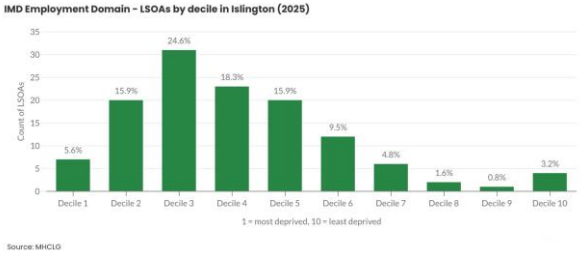
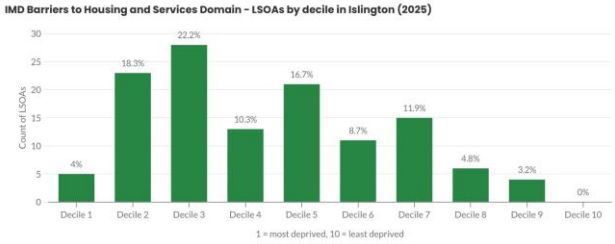
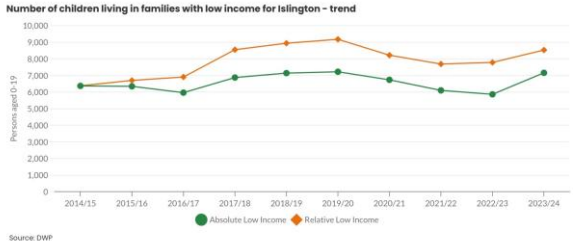
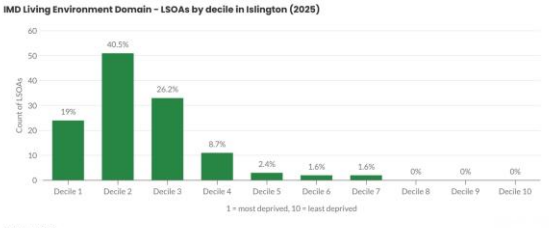


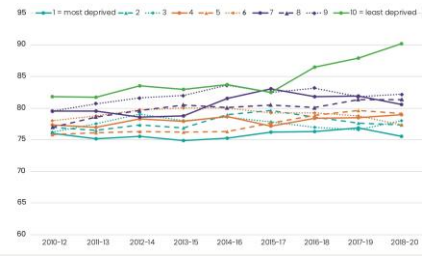




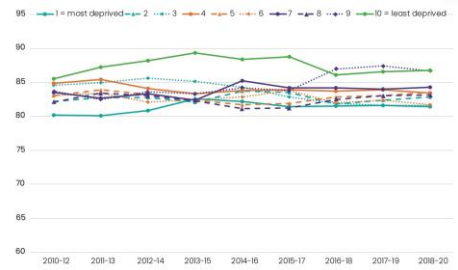




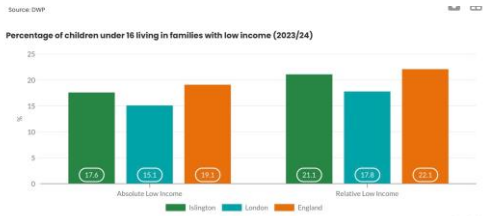




Life expectancy at birth in Islington males, by deprivation decile

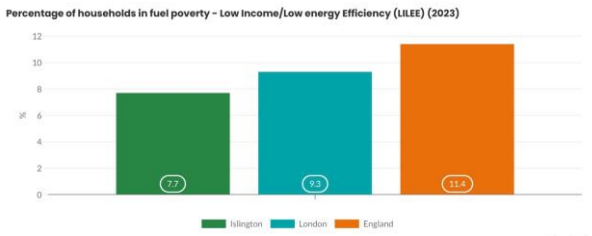


Life expectancy at birth in Islington females, by deprivation decile



	Islington	London	England
Number of children under 16 living in families with Absolute Low Income	5,625	255,694	2,030,841
Percentage of children under 16 living in families with Absolute Low Income	17.6	15.1	19.1
Number of children under 16 living in families with Relative Low Income	6,734	300,556	2,354,691
Percentage of children under 16 living in families with Relative Low Income	21.1	17.8	22.1

Date: 2023/24 Source: DWP



	Islington	London	England
Number of households in fuel poverty - Low Income/Low energy Efficiency (LILEE)	8,004	345,864	2,801,647
Percentage of households in fuel poverty - Low Income/Low energy Efficiency (LILEE)	7.7	9.3	11.4

Date: 2023 Source: BEIS

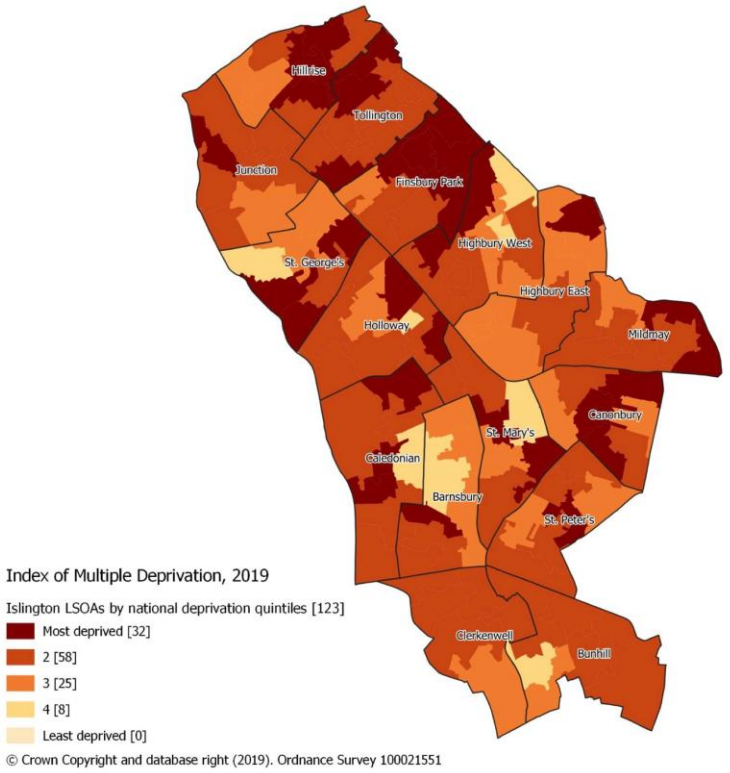
	Islington	London	England
Households owed a duty under the Homelessness Reduction Act	2,520	65,350	324,990
Households owed a duty under the Homelessness Reduction Act (rate per 1,000)	23	17.9	13.4

Date: 2023/24 Source: DHID

Households owed a duty under the Homelessness Reduction Act (main applicant 16-24 yrs) (2021/22)

Deprivation in Islington

- Islington ranked 53rd most deprived of 317 English authorities in 2019, improving from 24th in 2015.
- Borough remains in England's bottom deprivation quintile, with widespread need across all neighbourhoods.
- Most deprived areas include Finsbury Park, Junction, Hillrise, Tollington, Holloway and Caledonian wards.
- Clerkenwell, Barnsbury and St Peter's contain relatively better-off LSOAs but still lack affluent national decile areas.
- No Islington LSOAs fall within England's least deprived 20%, highlighting borough-wide deprivation.
- Deprivation drives higher illness onset, premature mortality and lower screening uptake across communities.



Deprivation: Life Expectancy and Risk Patterns

People in most deprived areas face 80% higher risk of dying from preventable conditions than least deprived groups.

Male life expectancy increased from 77.1 to 78.0 years between 2009–11 and 2020–22 but remains below London.

Female life expectancy rose from 82.2 to 82.6 years, still trailing London's 83.6 years.

Men die 4.6 years earlier than women on average, reflecting higher exposure to risk factors.

Black residents face significantly higher preventable and treatable cardiovascular mortality than other ethnic groups.

COVID-19 caused a decline in life expectancy before partial recovery in 2022, especially in deprived wards.

Islington Key Priorities Overview

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1. Tackling Poverty and Socio-Economic Inequality

2. Best Start in Life – Improving Early Years Health and Development

3. Promoting Healthy Weight, Nutrition and Physical Activity

4. Improving Mental Health and Well-being

5. Reducing Alcohol and Drug Related Harm

6. Preventing and Managing Long-Term Conditions (CVD and Cancer)

7. Improving Respiratory Health and Air Quality

8. Supporting Healthy Ageing and Care for Older Adults

9. Improving Housing, Environment, and Community Safety for Health

10. Embedding Prevention and Community Engagement in the Health and Care System

Priority 1: Tackling Poverty and Socio-Economic Inequality

- Embed 'Health in All Policies' across council services to align housing, employment, and regeneration with health outcomes.
- Expand welfare outreach via GPs and social prescribers to help residents claim unclaimed benefits and access financial advice.
- Support food co-ops, community kitchens, and Healthy Start voucher uptake to reduce food poverty and improve child nutrition.
- Refer at-risk patients to SHINE for home energy audits, heating grants, and winter health support to reduce fuel poverty.
- Expand supported employment schemes like IPS for people with mental illness and link to local health/social care job pathways.
- Target Bright Start and Family Hubs to IDACI hotspots, prioritising early years support for the most deprived families.

Priority 1: Actions

- Expand welfare outreach through GP practices and Family Hubs to help 5,000+ low-income residents claim unclaimed benefits and reduce financial stress.
- Increase SHINE referrals across all PCNs to support 2,000 fuel-poor households with energy audits, heating grants, and winter health interventions.
- Deliver targeted food security programmes in 10 highest-need estates, increasing Healthy Start uptake by 20% and expanding community kitchens for families in crisis.
- Embed Health in All Policies by integrating health objectives into all major regeneration schemes, ensuring new housing improves warmth, safety, and affordability.
- Increase supported employment access by enrolling 300 residents with health barriers into IPS and local health/social care job pathways annually.
- Prioritise Bright Start outreach in top 20 IDACI hotspots, providing intensive early years support to 1,000 vulnerable families each year.

Priority 2: Best Start in Life – Improving Early Years Health

- Refer all pregnant smokers to Stop Smoking services and offer incentives or coaching to achieve smoke-free pregnancies.
- Promote breastfeeding through Baby-Friendly accreditation, peer support, and midwife/health visitor training in deprived communities.
- Deliver universal Healthy Child Programme reviews with enhanced visits for vulnerable families using MECSH or similar models.
- Expand parenting programmes like HENRY and Triple P in Family Hubs, targeting the first 1001 days and low-income families.
- Use Early Years Profile data to target speech/language support and nursery access in areas with low school readiness.
- Improve MMR uptake to 95% by offering drop-in clinics, co-locating with children's centres, and engaging hesitant communities.

Priority 2: Actions

- Ensure 100% of pregnant smokers receive Stop Smoking referrals, aiming for a 30% reduction in smoking in pregnancy across deprived wards.
- Increase breastfeeding continuation at 6–8 weeks by 15% through Baby-Friendly accreditation, peer supporters, and targeted sessions in Family Hubs.
- Deliver Healthy Child Programme reviews to all 0–5s, providing enhanced home-visiting to 1,200 high-risk families using MECSH or similar models.
- Expand HENRY and Triple P programmes to reach 800 families annually, focusing on nutrition, bonding, and early development in the first 1001 days.
- Improve school readiness by delivering targeted speech and language interventions to 600 children in areas with the lowest Early Years Profile scores.
- Raise MMR uptake to 95% by running monthly drop-in vaccination clinics in children's centres and conducting outreach to hesitant communities.

Priority 3: Promoting Healthy Weight, Nutrition and Activity

- Coordinate borough-wide Healthy Weight Strategy across planning, schools, healthcare, and community to align all efforts.
- Expand Families for Life workshops in schools and estates, ensuring culturally tailored sessions for minority ethnic families.
- Promote active travel via school streets, cycle training, and subsidised sports for low-income youth through Sport Islington.
- Restrict fast-food outlets near schools and support healthy food awards for cafes and takeaways in deprived areas.
- Enhance adult weight management referrals from GPs and offer accessible community sessions with childcare and outreach to men.
- Provide tailored exercise programmes for older adults and link social prescribing to walking groups and gardening clubs.

Priority 3: Actions

- Deliver Families for Life programmes in 20 schools and estates, engaging 1,000 families with culturally tailored healthy eating and activity sessions.
- Expand active travel by increasing school streets to 40 sites, providing cycle training to 3,000 children, and subsidising sports for low-income youth.
- Restrict fast-food outlets within 200 metres of schools and support 50 local businesses to achieve healthy food awards.
- Increase adult weight-management referrals by 25%, offering community sessions with childcare in high-obesity neighbourhoods.
- Link social prescribing to 50 weekly activity groups, including walking clubs, gardening sessions, and women-only exercise classes in community venues.
- Use NCMP data to target Year 6 obesity hotspots, delivering tailored interventions to 2,000 children in the highest-risk schools.

Priority 4: Improving Mental Health and Well-being

- Expand Local Wellbeing Networks and train residents in Mental Health First Aid to build community resilience.
- Target IAPT outreach to BAME groups using multilingual promotion and diverse therapists to reduce access gaps.
- Embed mental health practitioners in PCNs to support patients with comorbid mental and physical health needs.
- Support school-based counselling and peer mentoring, especially for young Black men and those at risk of self-harm.
- Deliver culturally specific mental health sessions in Turkish, Somali, and Arabic through trusted community organisations.
- Achieve 70%+ SMI health check coverage and expand IPS employment support and peer mentoring for recovery.

Priority 4: Actions

- Train 1,000 residents in Mental Health First Aid through Local Wellbeing Networks to strengthen early identification and community resilience.
- Reduce IAPT access gaps by delivering multilingual outreach in Finsbury Park, Holloway, and Caledonian, increasing uptake among BAME residents by 20%.
- Embed mental health practitioners in all PCNs, supporting 5,000 patients annually with co-existing mental and physical health needs.
- Expand school-based counselling and peer mentoring to reach 2,500 pupils, with rapid follow-up for all young people presenting with self-harm.
- Deliver culturally specific mental health sessions in Turkish, Somali, Arabic, and Bengali, engaging 1,200 residents through trusted community organisations.
- Increase SMI physical health check coverage to 70%+, ensuring 1,800 patients receive annual checks, smoking cessation, and metabolic monitoring.

Priority 5: Reducing Alcohol and Drug Related Harm

- Train all front-line staff to screen for alcohol/drug use and deliver brief advice using AUDIT-C and referral pathways.
- Ensure rapid access to alcohol detox and follow-up via Alcohol Care Teams at Whittington and community services.
- Expand opioid substitution therapy and Naloxone distribution to users, families, hostels, and police for overdose prevention.
- Scale IPS employment support and housing for people in recovery to reduce relapse and promote reintegration.
- Strengthen dual diagnosis pathways with co-located mental health and substance misuse teams for integrated care.
- Implement IRIS in all GP practices and expand youth A&E outreach to prevent reoffending and support recovery.

Priority 5: Actions

- Train 2,000 front-line staff to screen for alcohol/drug use using AUDIT-C and deliver brief interventions across GP practices, pharmacies, and A&E.
- Establish rapid alcohol detox pathways at Whittington, ensuring 100% of high-risk admissions receive follow-up from community alcohol teams.
- Expand opioid substitution therapy to 1,200 opiate users, introducing long-acting buprenorphine and increasing Naloxone distribution by 50%.
- Scale IPS employment support to 300 people in recovery, linking them to stable housing and job placements across Islington.
- Strengthen dual-diagnosis pathways by co-locating mental health and substance misuse teams in all treatment hubs.
- Expand A&E youth violence and substance misuse outreach to reach 500 young people annually, reducing reoffending and repeat harm.

Priority 6: Preventing and Managing Long-Term Conditions

- Increase NHS Health Check uptake in deprived groups and follow up high-risk patients with lifestyle and medication support.
- Expand community BP checks in pharmacies and libraries and provide home monitors for telemonitoring and early diagnosis.
- Ensure 80% of hypertensive patients meet BP targets using pharmacist-led titration and practice dashboards.
- Increase bowel, breast, and cervical screening uptake using reminders, community outreach, and culturally tailored education.
- Promote smoking cessation in LTC patients with easy access to NRT, varenicline, and inpatient-to-community quit referrals.
- Advocate for lung cancer screening via mobile CT in high-risk areas and train GPs in early symptom recognition.

Priority 6: Actions

- Increase NHS Health Check uptake to 65%, prioritising men and BAME groups, and follow up all high-risk patients with statins or lifestyle support.
- Deliver 10,000 community BP checks annually in pharmacies, libraries, and faith centres, referring all high readings to GP practices.
- Achieve 80% BP control in diagnosed hypertensive patients using pharmacist-led titration and digital home monitoring.
- Raise bowel, breast, and cervical screening uptake by 15% through targeted outreach in estates with the lowest participation.
- Provide smoking cessation to 100% of COPD, CVD, and diabetic patients, offering NRT, varenicline, and structured quit support.
- Advocate for targeted lung cancer screening, delivering 1,500 low-dose CT scans annually in high-risk neighbourhoods.

Priority 7: Improving Respiratory Health and Air Quality

- Ensure all COPD/asthma patients who smoke receive cessation support, including NRT, varenicline, and pulmonary rehab integration.
- Implement asthma action plans for all children and conduct annual reviews with inhaler checks and housing assessments.
- Scale up pulmonary rehab access via GP/hospital referrals and offer home-based options for frail or immobile patients.
- Support LTNs, school streets, and anti-idling enforcement to reduce NO_2 exposure in deprived, traffic-heavy neighbourhoods.
- Promote flu, COVID, and pneumococcal vaccination among COPD patients and over-50s to reduce winter respiratory admissions.
- Maintain TB screening and treatment completion rates over 90%, especially in high-risk migrant and overcrowded communities.

Priority 7: Action

- Provide cessation support to all 3,000 COPD/asthma patients who smoke, integrating NRT and varenicline into pulmonary rehab pathways.
- Ensure 100% of children with asthma have action plans, annual reviews, and housing assessments for damp/mould risks.
- Increase pulmonary rehab uptake by 30%, offering home-based programmes for frail patients and community sessions in local leisure centres.
- Reduce NO_2 exposure by expanding LTNs to cover 25% of the borough, enforcing anti-idling outside all schools.
- Achieve 85% flu vaccination and 75% COVID booster uptake among COPD patients and adults aged 50+.
- Maintain TB treatment completion above 90%, screening 1,000 high-risk migrants annually through primary care.

Priority 8: Supporting Healthy Ageing and Older Adults

- Expand strength and balance classes and exercise-on-referral for 65+ to prevent frailty and reduce falls.
- Use frailty index in primary care to offer CGA and refer to falls prevention, nutrition, and sensory support.
- Strengthen MDTs and virtual wards to manage complex older patients with single care plans and rapid response.
- Provide respite, assessments, and flu jabs for carers and include them in contingency planning and care reviews.
- Train care home staff in end-of-life care and ensure timely hospice referrals and shared electronic care plans.
- Expand befriending, digital inclusion, and dementia cafés to reduce isolation and support ageing in place.

Priority 8: Actions

- Deliver strength and balance classes to 2,000 older adults, reducing falls-related fractures by 15% in high-risk estates.
- Use frailty index screening for all adults 65+, providing CGA and referrals to falls, nutrition, and sensory services.
- Expand MDT and virtual ward support to 1,500 complex older patients, reducing avoidable admissions by 20%.
- Provide respite and carer assessments to 3,000 unpaid carers, ensuring access to breaks, flu jabs, and wellbeing checks.
- Train all care home staff in end-of-life care, increasing advance care plans and reducing unnecessary hospital transfers.
- Expand befriending and digital inclusion programmes to reach 1,000 isolated older residents, reducing loneliness and improving wellbeing.

Priority 9: Improving Housing, Environment and Community Safety

- Refer patients in poor housing to council teams for damp, mould, and hoarding interventions via health professionals.
- Target insulation and heating grants to fuel-poor COPD patients and expand SHINE referrals from GPs and nurses.
- Ensure hospital discharge teams link homeless patients to housing support and GP registration before leaving hospital.
- Support planning policies for green space, restrict betting shops, and improve play areas in new developments.
- Expand A&E youth violence outreach and MARAC referrals for domestic abuse survivors with trauma-informed care.
- Use A&E assault data to map violence hotspots and inform police and community safety interventions.

Priority 9: Actions

- Refer 1,500 households with damp, mould, or overcrowding to council housing teams through GP and health visitor pathways.
- Target insulation and heating upgrades to 1,000 fuel-poor homes, prioritising COPD and frail older adults identified through SHINE.
- Ensure 100% of homeless hospital discharges receive housing support, GP registration, and follow-up through the Homelessness Forum.
- Support planning policies restricting betting shops and improving green/play spaces in all major new developments.
- Expand A&E youth violence outreach to reach 400 young people, linking them to mentoring and community safety programmes.
- Use A&E assault data to identify 10 violence hotspots, coordinating police and community safety interventions.

Priority 10: Embedding Prevention and Community Engagement

- Train NHS, council, and voluntary staff in MECC and include prevention in appraisals and service specifications.
- Co-produce services with residents via advisory boards and forums to ensure relevance and trust in new initiatives.
- Support Local Wellbeing Networks to tailor solutions by neighbourhood, e.g., youth clubs or diet programmes.
- Recruit and train Health Champions from mosques, churches, and sports clubs to promote screening and healthy lifestyles.
- Develop multilingual, low-literacy health materials and run NHS navigation and medication workshops in libraries and community centres.
- Track service uptake by ethnicity and estate, and run targeted outreach where gaps in access are identified.

Priority 10: Actions

- Train 3,000 NHS, council, and voluntary staff in MECC, embedding prevention into appraisals and service specifications across all sectors.
- Co-produce services with 500 residents annually through advisory boards and community forums in every locality.
- Strengthen Local Wellbeing Networks in all 6 neighbourhoods, tailoring interventions to local needs such as youth clubs or diet programmes.
- Recruit and train 200 Health Champions from mosques, churches, sports clubs, and community groups to promote screening and healthy lifestyles.
- Develop multilingual, low-literacy materials and deliver monthly NHS navigation workshops in libraries and community centres.
- Use service-uptake dashboards to identify gaps by ethnicity and estate, delivering targeted outreach to 2,000 underserved residents.

Best Public Health Practice Examples from Islington

- Bright Start Family Hubs - Integrated Early Childhood Services
- Community-Led Mental Health Outreach for BAME Communities
- “Parks for Health” - Harnessing Green Spaces for Wellbeing
- Integrated Substance Misuse Support with Employment (IPS Into Work)
- High-Performing Sexual Health Services & HIV Prevention

Bright Start Family Hubs

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Description of Best Practice

- Bright Start delivers integrated early childhood services through Family Hubs, supporting families from pregnancy to age five and engaging nearly 6,000 families annually across Islington.
- Universal access combined with targeted outreach ensures equitable engagement, with 65% of families in the most deprived quintile using services compared with 60% in the least deprived.
- Parenting programmes, health visiting, antenatal clinics and stay-and-play sessions support early development, with 1,500 children and caregivers attending play groups in 2023.
- Co-located services provide holistic support, generating over 300 referrals annually to housing, debt advice, mental health support and domestic violence services.

Why It's a Best Practice

- Integrated multidisciplinary teams reduce duplication and improve coordination, contributing to 95% of new mothers receiving a health visitor visit within 14 days of birth.
- Proportionate universalism narrows inequalities, contributing to school readiness rising from 60% in 2013 to 73% in 2019, reducing gaps between disadvantaged and affluent children.
- Culturally inclusive services delivered in community languages build trust, reflected in 90% of parents reporting increased confidence and reduced isolation in the 2021 user survey.
- Strong workforce development, including trauma-informed training for all staff, enhances early identification of developmental delays, safeguarding concerns and parental mental health needs.

Bright Start Family Hubs

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Key Lessons Learned

- Whole-family approaches improve outcomes, demonstrating that supporting parental wellbeing alongside child development strengthens resilience and reduces future demand for specialist services.
- Removing access barriers through flexible hours, community-based delivery and non-stigmatising environments significantly increases engagement among vulnerable families and working parents.
- Effective integration requires strong communication, shared case discussions and joint governance, ensuring families do not fall through gaps and receive timely, coordinated support.
- Data-driven targeting improves equity, enabling outreach to under-represented groups and prompting service adaptations such as Saturday sessions for dual-earner families.

Evaluation Results

- Bright Start engaged 58% of all families with under-5s in 2022/23, demonstrating exceptional reach and equitable uptake across socioeconomic groups.
- Breastfeeding continuation at 6–8 weeks reached ~75%, significantly above the England average of 50%, supported by specialist infant feeding clinics.
- Child protection plan rates for under-5s fell from 60 to 53 per 10,000 between 2018 and 2023, reflecting earlier identification and intervention.
- Economic modelling suggests £3–£4 long-term savings for every £1 invested, driven by improved early development, reduced obesity and lower future service demand.

Community Mental Health Outreach

Description of Best Practice

- Community-led outreach delivers culturally tailored mental health sessions in trusted venues, engaging over 250 residents through multilingual workshops addressing stress, depression and help-seeking.
- Barbershop and faith-based outreach reaches groups under-represented in services, with trained barbers initiating over 20 direct referrals and supporting informal conversations with Black men.
- More than 500 residents, frontline workers and community leaders have completed Mental Health First Aid training, creating a borough-wide network of wellbeing champions.
- Co-located IAPT sessions in community venues, delivered by culturally matched therapists, significantly improve accessibility and reduce Did-Not-Attend rates to around 5%.

Why It's a Best Practice

- Culturally relevant delivery reduces stigma and increases trust, enabling open dialogue in communities historically reluctant to engage with mental health services.
- Empowering residents through MHFA training builds sustainable capacity, with champions independently organising over 25 wellbeing events across the borough.
- Innovative use of non-traditional settings such as barbershops and cafés reaches men and young people, groups typically under-represented in primary mental health services.
- Early intervention is strengthened through direct community referrals, enabling earlier treatment and reducing reliance on crisis or acute mental health pathways.

Community Mental Health Outreach

Key Lessons Learned

- Delivering support in everyday community spaces significantly increases engagement, demonstrating that meeting people where they are is essential for reaching underserved groups.
- Cultural competence is vital, with co-designed, multilingual sessions proving far more effective than professionally led workshops without community partnership.
- Training community members builds sustainable capacity, creating advocates who support peers, promote wellbeing and extend the programme's reach beyond formal services.
- Leveraging existing networks accelerates engagement, with partnerships enabling rapid mobilisation and deeper insight into community needs and preferences.

Evaluation Results

- Community referrals from Black British and Turkish residents increased by around 30% in 2022, demonstrating improved help-seeking among historically underserved groups.
- Engagement among men reached 40% of attendees, significantly higher than typical primary care mental health forums, supported by barbershop outreach.
- Stigma reduction was evident, with 88% of participants reporting increased comfort discussing mental health and 90% likely to encourage others to seek help.
- MHFA training produced lasting impact, with 70% of trainees using their skills and champions delivering over 25 independent wellbeing events.

Parks for Health

Description of Best Practice

- Parks for Health transforms green spaces into health-promoting environments, delivering over 120 activities annually and attracting 3,500 attendances across Islington's parks.
- Green social prescribing integrates nature-based activities into healthcare, with Age UK Islington making over 450 referrals for older residents since 2019.
- Co-designed programming targets non-traditional park users, including women-only fitness classes, accessible guided tours and intergenerational gardening clubs.
- Park staff trained as Health Champions engage visitors, promote activities and identify vulnerable individuals, fostering welcoming and inclusive park environments.

Why It's a Best Practice

- Cross-sector collaboration aligns parks, public health and NHS partners, enabling integrated delivery and shared investment in green space as a public health asset.
- Targeted inclusion strategies address inequalities, increasing park use among deprived communities and minority ethnic groups, with usage rising 8–10% in targeted parks.
- Community co-design builds ownership, with residents shaping activities and sustaining volunteer-led walking groups and gardening clubs.
- Evidence-driven planning uses demographic data and health indicators to refine programming, ensuring interventions effectively address inactivity, loneliness and unequal access.

Parks for Health

Key Lessons Learned

- Health and environmental goals align strongly, demonstrating that parks can function as essential public health assets when jointly planned and resourced across sectors.
- Addressing barriers such as safety concerns, cultural unfamiliarity and accessibility needs is essential for increasing park use among historically excluded groups.
- Piloting and iterating activities enables continuous improvement, allowing successful initiatives to scale across multiple parks and reach diverse communities.
- Engaging and training park staff fosters a culture shift, empowering frontline workers to support wellbeing and encourage participation.

Evaluation Results

- Park usage increased by 8–10% in targeted sites, with older residents rising from 5% to 12% of weekday visitors in Highbury Fields.
- Structured activities recorded 3,540 attendances in 2022, with 68% of participants continuing independent park use three months later.
- Wellbeing scores improved by around 20% after 12-week programmes, with 75% of previously inactive participants becoming active (>150 minutes weekly).
- Over 100 volunteers contributed to activities, reducing isolation among older adults from 32% to 10% in one cohort.

IPS Into Work

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Description of Best Practice

- IPS Into Work integrates employment support within substance misuse treatment, supporting around 60 clients in its first year and aligning job goals with recovery plans.
- Embedded IPS specialists collaborate with clinicians, enabling rapid job search, personalised support and coordinated care across treatment, housing and mental health services.
- Individualised support helps clients secure competitive employment, with tailored CV development, interview preparation and direct employer engagement.
- Ongoing in-work support assists clients and employers, helping sustain employment and prevent relapse during early recovery.

Why It's a Best Practice

- The programme addresses unemployment as a core social determinant, significantly strengthening recovery and reducing relapse risk through meaningful employment.
- Applying the evidence-based IPS model ensures fidelity to proven principles, including zero exclusion, rapid job search and time-unlimited support.
- A strengths-based, client-centred ethos empowers individuals, increasing motivation, engagement and hopefulness during recovery.
- Integrated, wrap-around care coordinates employment, housing and mental health support, preventing fragmented service experiences and improving outcomes.

IPS Into Work

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Key Lessons Learned

- Timing must be flexible, offering employment support whenever clients express readiness, recognising that early engagement can strengthen motivation and treatment retention.
- Employer engagement is achievable through proactive outreach, with many businesses willing to offer opportunities when supported by IPS specialists.
- Confidentiality and stigma require sensitive handling, with IPS staff helping clients navigate disclosure decisions and educating employers about addiction recovery.
- Integration succeeds when clinicians and employment specialists learn from each other, supported by cross-training and joint supervision.

Evaluation Results

- In year one, 21 of 60 clients secured paid employment, achieving a 35% placement rate and exceeding national IPS trajectory expectations.
- Employment retention was strong, with 85% remaining in work at three months and 14 sustaining employment at six months.
- Recovery stability improved, with 90% of participants remaining engaged in treatment and relapse episodes becoming shorter and less severe.
- Quality-of-life scores increased by 40% after six months, with clients reporting improved structure, confidence and social connection.

Sexual Health Services and HIV Prevention

Description of Best Practice

- Integrated one-stop clinics provide STI testing, HIV prevention, PrEP, contraception and rapid treatment, serving over 30,000 attendances annually across Islington.
- Proactive HIV prevention includes targeted PrEP outreach, rapid “test and treat” pathways and home sampling, contributing to a 50% reduction in new HIV diagnoses since 2015.
- Youth-friendly services and school-based education significantly reduced teenage pregnancy, with under-18 conception rates falling from 50+ per 1,000 to 11.8 per 1,000.
- Digital innovations such as online testing and remote triage expand access, with over 5,000 home testing kits requested in 2022.

Why It’s a Best Practice

- Exceptional outcomes include high LARC uptake, reduced HIV transmission and strong partner notification metrics, demonstrating sustained public health impact.
- Integrated clinics improve continuity, enabling residents to receive STI care, contraception and HIV prevention in one setting, reducing fragmentation and missed opportunities.
- Preventive focus combines education, outreach and community engagement, ensuring early intervention and increased testing across diverse groups.
- Inclusive, culturally competent services tailored to LGBTQ+ communities, young people and minority groups ensure equitable access and narrow disparities.

Sexual Health Services and HIV Prevention

Key Lessons Learned

- Easy access through walk-ins, pharmacies, online testing and integrated clinics increases uptake, ensuring residents receive timely support without administrative barriers.
- Sustained investment in prevention delivers long-term impact, demonstrating that consistent effort is essential for reducing HIV transmission and teenage pregnancy.
- Normalising sexual health conversations reduces stigma, encouraging earlier testing, proactive contraception use and more open communication.
- Digital tools expand reach, with online testing and text-based results improving convenience and increasing screening coverage.

Evaluation Results

- New HIV diagnoses fell from 45 in 2015 to 20 in 2022, with late diagnosis rates improving from over 50% to around 33%.
- Teenage pregnancy rates dropped to 11.8 per 1,000, significantly below national averages, supported by high LARC uptake and accessible emergency contraception.
- Over 30,000 clinic attendances were managed efficiently, with 94% of users reporting easy access and 96% satisfied with care.
- PrEP uptake exceeded 1,000 users, with near-zero infections among PrEP users and significant long-term economic savings.

Cross-Cutting Insights from Best Practices

- Community engagement consistently increased uptake, with programmes reporting participation rises between 30% and 75% across priority groups.
- Integrated models improved outcomes, contributing to 20–40% improvements in wellbeing, school readiness, treatment retention and early intervention metrics.
- Targeted inequality-focused approaches narrowed gaps, increasing access among deprived communities by 5–20 percentage points across multiple services.
- Prevention programmes delivered measurable returns, reducing future demand and achieving £3–£4 savings per £1 invested in early years.
- Co-production strengthened cultural relevance, increasing engagement among minority groups by 30%+, particularly in mental health and HIV prevention.
- Data-driven targeting improved reach, enabling services to identify under-served groups and increase participation by 10–25% in key cohorts.

System Recommendations and Implications for the Borough and ICS

System Recommendations

- Embed Health in All Policies to align planning, housing and employment decisions with measurable health inequality reduction targets.
- Scale preventive programmes across life stages, aiming for 10–20% increases in early intervention coverage and healthy lifestyle participation.
- Strengthen data sharing and analytics to track inequalities, enabling real-time monitoring of outcomes by deprivation and ethnicity.
- Enhance neighbourhood integration through MDTs, targeting reductions in avoidable A&E attendances and unplanned admissions by 10–15%.

Implications for Borough, ICS and Public Health System

- Reducing inequalities requires sustained investment, targeting communities with highest deprivation scores and poorest life expectancy indicators.
- Prevention focus must shift resources upstream, reducing long-term acute demand and improving healthy life expectancy by measurable margins.
- Integrated care must address physical, mental and social needs, improving continuity indicators and reducing service fragmentation.
- Community empowerment strengthens outcomes, increasing uptake of services and preventive programmes by 20% or more in priority groups.

What This Means

- Inequality reduction must remain central, targeting measurable improvements in life expectancy gaps and chronic disease outcomes across deprived wards.
- Prevention investment should increase significantly, aiming for higher screening uptake, reduced risk factors and improved early diagnosis rates.
- Neighbourhood MDTs must expand, reducing duplication and improving care coordination for high-need cohorts by 10–20%.
- Community empowerment should deepen, increasing participation in co-produced programmes and volunteer networks by 25%.
- Workforce development must strengthen capacity, improving trauma-informed practice, cultural competence and community outreach coverage.
- Data intelligence must guide decisions, enabling targeted interventions that improve outcomes for priority groups by measurable percentages.