North Central London Health and Care
Integrated Care System

Neighbourhood development in North Central London

Islington VCSE Advisory Group

Sept 2025

Introductions and Purpose

North Central London Health and Care
Integrated Care System

- Rhian Warner, Assistant Director for Place, Islington, NCL ICB
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Today we will will cover the following:

1. *Introduction to the Neighbourhood Health and Care Model*
    - The NCL Neighbourhood Health and Care model
    - Key features of the local approach (4 pillars of care)
    - Overview of current local health and care priorities and challenges in Islington
2. *Open Discussion: VCSE Perspectives*
    - Initial thoughts and reactions to the model
    - Opportunities and challenges for VCSE involvement
    - How might VCSE organisations see themselves contributing?
3. *Shaping Engagement: How Would You Like to Get Involved?*
    - Preferred methods and frequency of engagement
    - Communication channels and partnership working

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The NCL Neighbourhood Health and Care model

Why Neighbourhood Health and why now?

- The **NHS needs to change**. People are unhappy with the way they receive health and care. People don't get it when they need it. We've all had experiences of this.
- There is a **national and local mandate** for change. Most people agree the NHS needs to work better together, with other local health and care organisations, and listen to patients. We also know it needs help people earlier and needs to upgrade to the 21 century with data and technology.
- **We need to address the wider factors that affect health better** – such as housing, food security and caring responsibilities.
- **Neighbourhood Health is the way the Government wants to change this.**

The Government policy

- The **Government's 10 Year Health Plan for England** was launched in July, setting out a new course for the NHS.
- **It has been shaped by the experiences and expectations** of members of the public, patients, our partners and the health and care workforce across the country, reflecting the changes that people wanted to see.
- **The 'three shifts'** will help deliver more personalised and preventative care:
  1. from hospital to community
  2. from analogue to digital
  3. from treatment to prevention
- **Help us be a part of the solution** and think through how we implement this in Islington.

Our emerging vision for Neighbourhood Health

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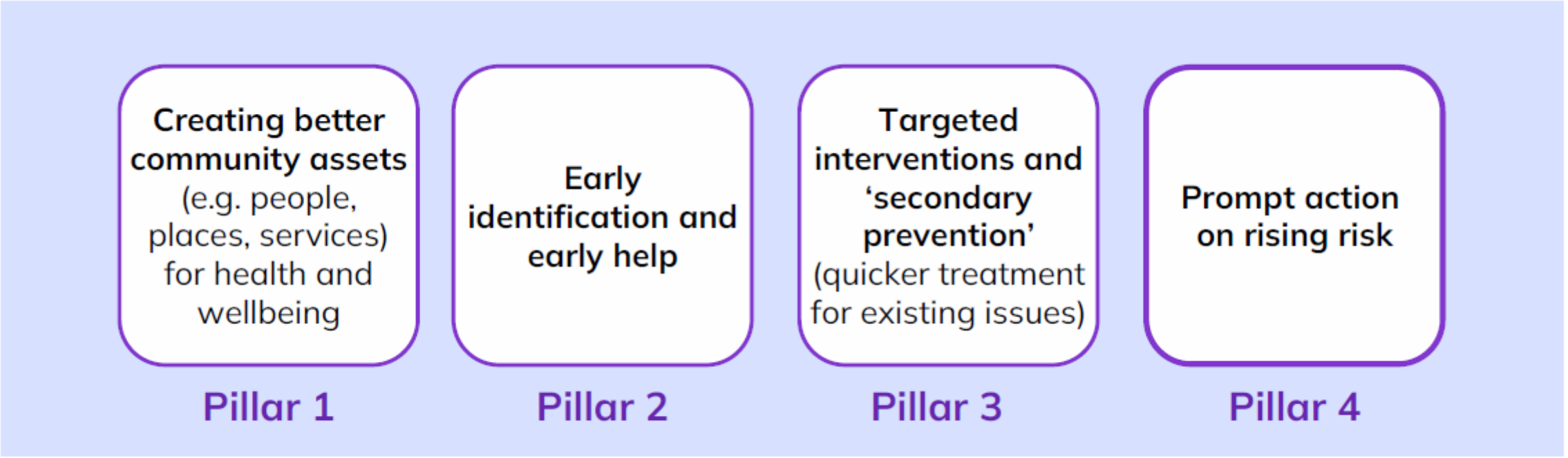

Integrated Neighbourhood Teams will work alongside local networks

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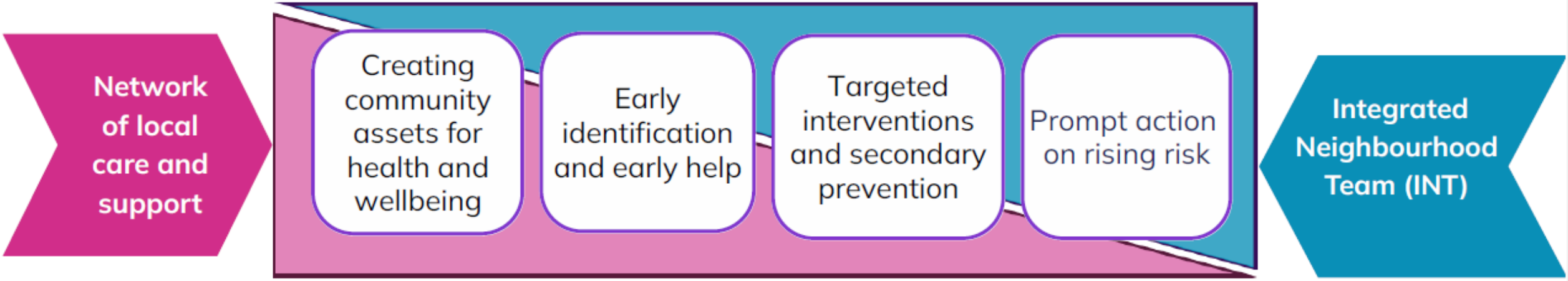

What Neighbourhood Health will feel like for people

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"I've suffered with **severe respiratory issues for the past three years**.

"Every time I see someone, I'm **just given more medication.**

"No one's ever asked me about my home or what might be making things worse."

Current voices

Photo for illustration

"Instead of just being offered more **medication, my local neighbourhood team took the time to understand what was going on in my life. I will be treated as an active partner in my care.**

They helped me identify that the damp and mould in my flat was making my health worse.

They prioritised getting that sorted and gave me medical support at the same time. **For the first time, I felt truly seen and supported.**"

Future voices

Mapping Integrated Neighbourhood Teams (INTs)

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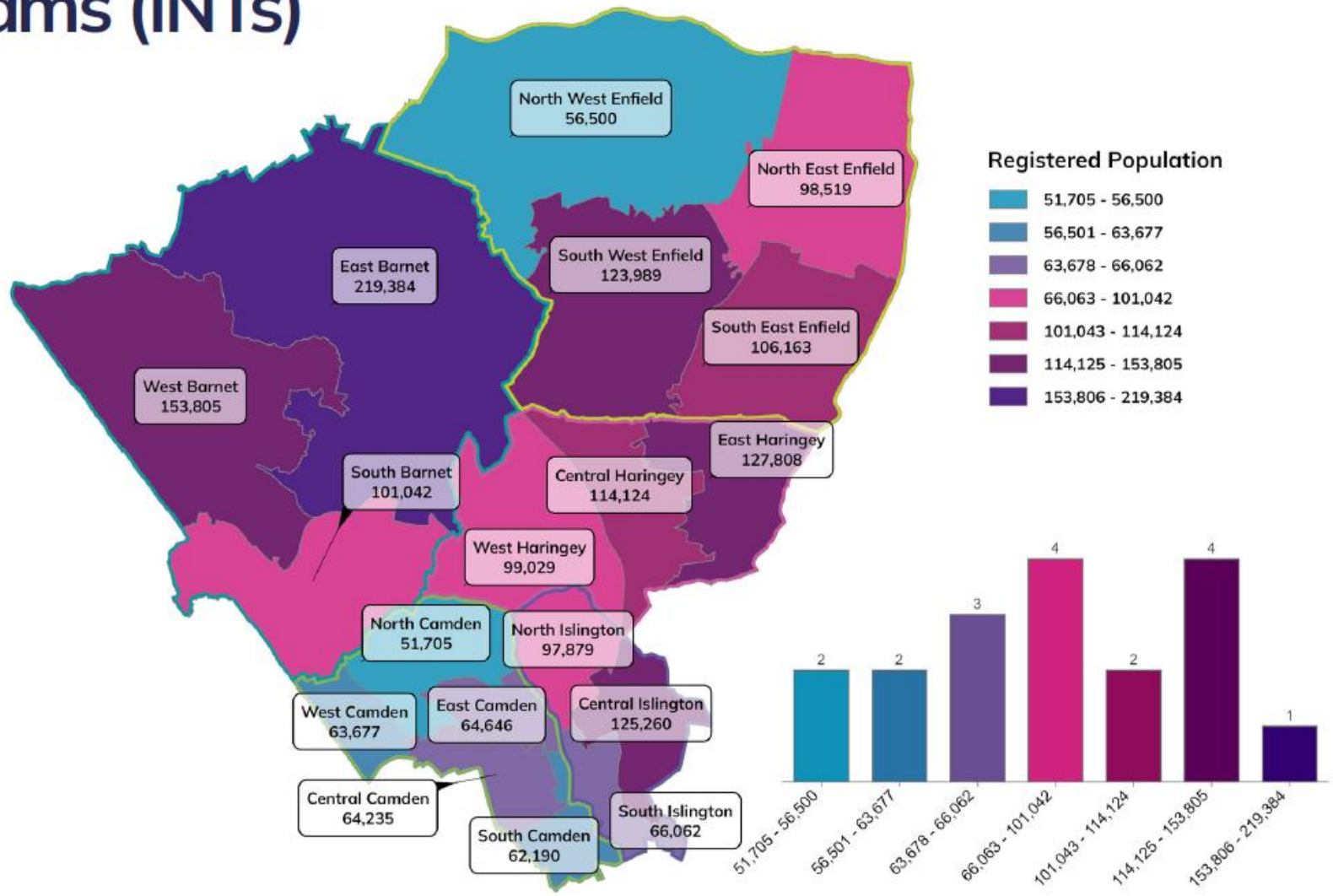
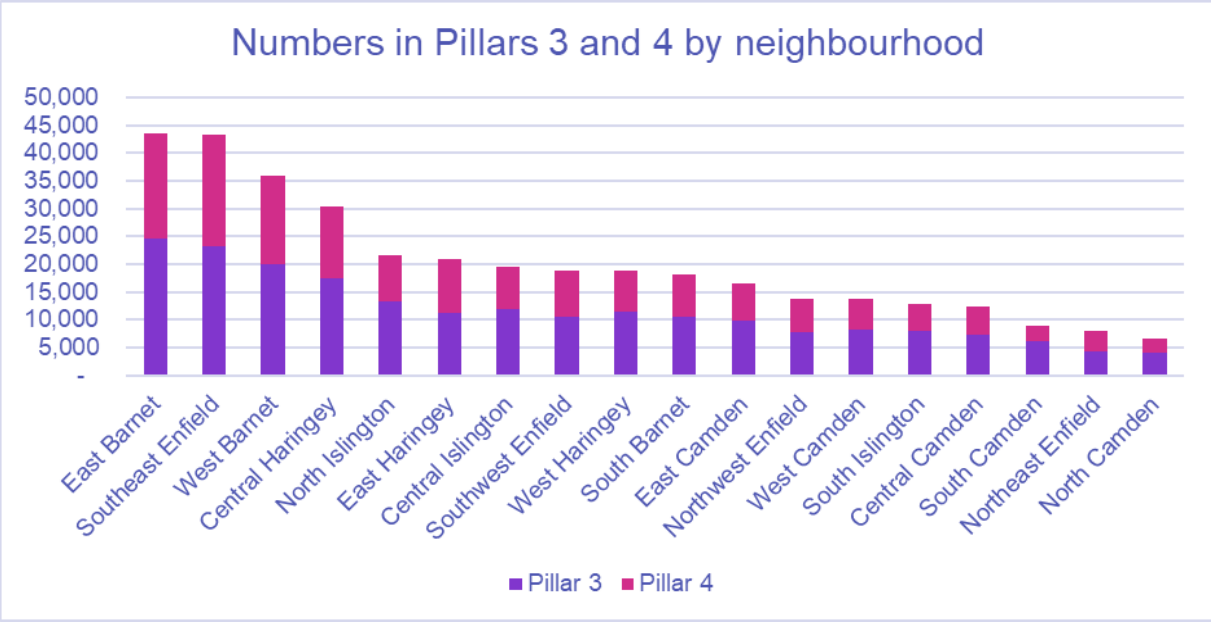


Source :- https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

Population estimates by Neighbourhood & Care Model Pillar

	Barnet	Barnet	Barnet	Camden	Camden	Camden	Camden	Camden	Enfield	Enfield	Enfield	Enfield	Haringey	Haringey	Haringey	Islington	Islington	Islington
Pillar Population Estimates	East Barnet	South Barnet	West Barnet	Central Camden	East Camden	North Camden	South Camden	West Camden	Northeast Enfield	Northwest Enfield	Southeast Enfield	Southwest Enfield	Central Haringey	East Haringey	West Haringey	Central Islington	North Islington	South Islington
Total Adult Pop	151,117	74,483	130,370	58,178	61,320	31,589	89,488	64,122	25,937	46,852	142,378	69,328	128,176	76,465	80,245	87,508	105,455	66,169
Pillars 1 & 2	107,694	56,417	94,442	45,722	44,827	24,961	80,453	50,278	17,824	32,987	99,059	50,518	97,771	55,610	61,491	67,866	83,908	53,395
Pillar 3	24,620	10,613	20,061	7,450	9,816	4,015	6,140	8,283	4,322	7,740	23,279	10,477	17,531	11,348	11,546	11,903	13,350	7,979
Pillar 4	18,803	7,453	15,867	5,006	6,677	2,613	2,895	5,561	3,791	6,125	20,040	8,333	12,874	9,507	7,208	7,739	8,197	4,795
% Pillar 3	16%	14%	15%	13%	16%	13%	7%	13%	17%	17%	16%	15%	14%	15%	14%	14%	13%	12%
% Pillar 4	12%	10%	12%	9%	11%	8%	3%	9%	15%	13%	14%	12%	10%	12%	9%	9%	8%	7%



Population numbers mapped to pillars 3 & 4 are of particular interest as they offer the opportunity to manage down need, risk and complexity and to optimise outcomes. These people may benefit from increased engagement support including outreach, person centred care planning, support to address non-medical needs, improved 'activation' (knowledge, skills, confidence), rapid access in response to rising risk. We see opportunities to affect planned and unplanned care. Existing spend across settings is being calculated.

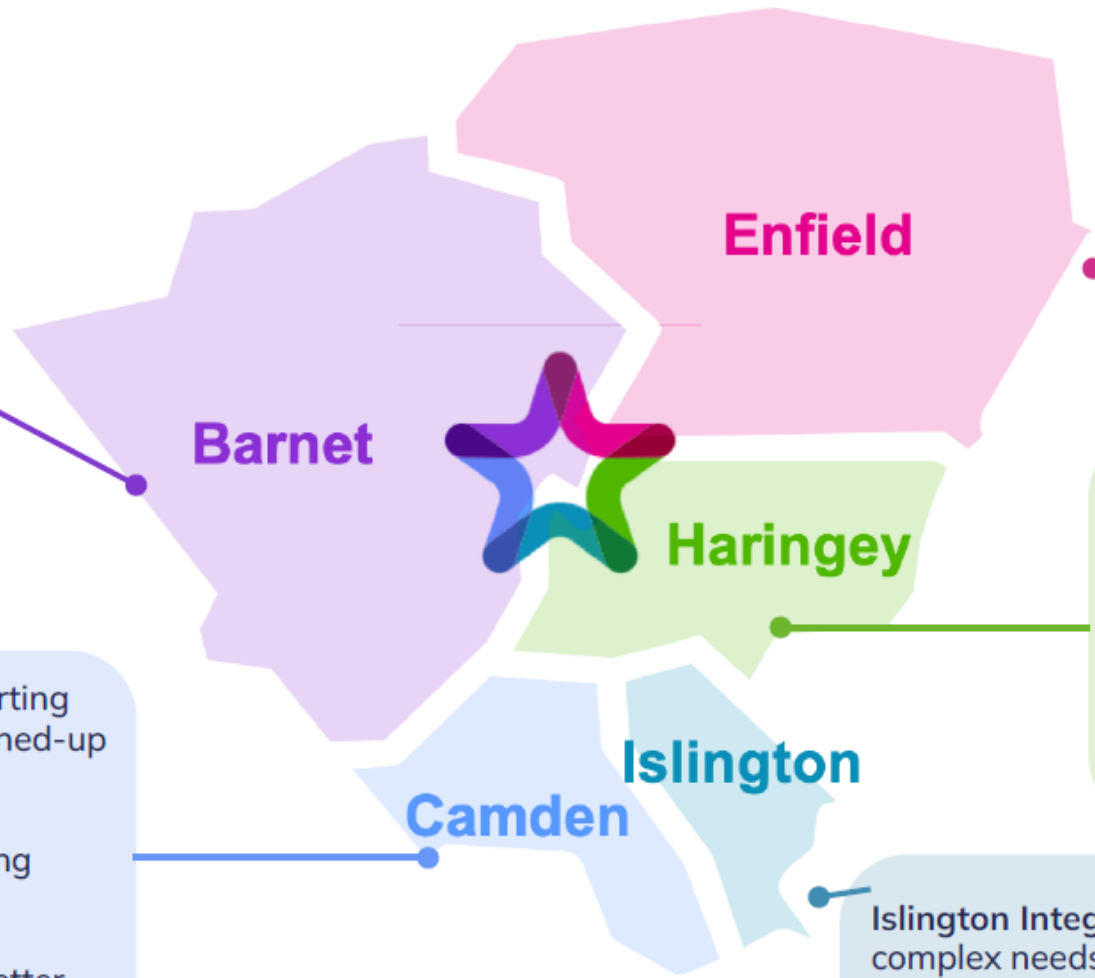
Note: Data is drawn from Healtheintent and will be transitioned across this year to the London Secure Data Environment (SDE). This is a point in time snapshot of population estimates by pillar and neighbourhood to inform planning through 2025/26. These figures will not remain static i.e. changes to the underlying population and the impact of interventions over time will mean that we will need to constantly refresh this categorisation.

Early examples of neighbourhood working across NCL

Community Ageing Well Service: integrated MDT support for over-65s at risk of frailty, dementia, or loss of independence.

Who: CLCH NHS, Royal Free, NLFT, GPs, Age UK Barnet, social care.

Outcomes: Better patient and staff experience, care planning and, early indicication of a reduction in secondary care use.



Enfield Frailty MDTs: supporting people with frailty and rising risks.

Who: Enfield Council, Age UK, GPs, community nursing, social care.

Outcomes: Fewer avoidable admissions, better prevention and enablement.

MACCT: proactive, preventative care for people with frailty or complex long-term conditions.

Who: Whittington Health, Haringey Council, GP Federation, NLFT, Bridge Renewal Trust.

Outcomes: Improved wellbeing, 30% drop in A&E use.

Kentish Town Health Centre: supporting LTCs and complex needs through joined-up housing, health and social care.

Who: ICB, CNWL, Council, GPs, strong community involvement.

Outcomes: Stronger partnerships, better local service knowledge, simpler referrals.

Islington Integrated Networks: joined-up care for people with complex needs through GP cluster-based MDTs.
Who: Whittington Health, GPs, Islington Council, Age UK, NLFT.
Outcomes: Better care coordination, fewer avoidable admissions.

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NCL Neighbourhoods - evolving system working

Architecture for Neighbourhood Health

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Borough partnership

- **Local leadership:** shaping and driving neighbourhoods, collective accountability for shared outcomes.
- **Secures 'integrator' capacity and capability;** agrees the role within Borough Partnership to enable key decisions.
- **Builds a wider neighbourhood network:** Statutory, VCSE, Communities.

Integrator

- **Delivery capacity and leadership:** accountable for delivery and outcomes.
- **Neighbourhood leadership team:** Operational Leadership for INTs, coordination of work across all pillars and improvements to the model. Shaping and securing infrastructure for neighbourhoods.

Neighbourhood

- **Integrated Care Team (INT):** Delivery of an integrated offer and integrated support for priority groups and caseload.
- **Developing the Neighbourhood network:** Made up of statutory and voluntary sector services and working within a neighbourhood across all pillars.

System Planning, transformation and delivery support, 'once for NCL' actions and products, reshaping services and pathways, clinical transformation, convening and codesign, connecting implementation and system level decision making.

Accelerating delivery – role of an ‘integrator’

An Integrator is an organisation/s to work with borough partners alongside each Council as we transition to the Neighbourhood model in all 5 Boroughs. The integrator will be asked to provide **coordination and operational support to delivery** of the model. The provider will need a **key role in the borough partnership** which will drive **neighbourhood outcomes.**

Integrator Criteria

An organisation delivering services locally to partner with a local Council and lead borough level integration

Have credibility and maturity as a service provider at place

Well established relationships with partner organisations and knowledge of local care

Able to transact quickly

Able to attract and secure staffing capacity to transform services to deliver the neighbourhood model

Ready to release costs down the line if needed and increase value for money over time

Delivers on neighbourhood infrastructure requirements: neighbourhood leadership team, INT support and coordination

Operational capabilities to reorganise and align existing borough assets to form neighbourhood teams

Neighbourhood Integrator at Place

Role in Neighbourhood Delivery

- *Work with partners to align team members and services to neighbourhoods*
- *Ensure operational delivery of the care model*
- *Develop workforce model and OD*
- *Flexibly deploy resource according to operational need*
- *Provide PHM tools and support*
- *Host the neighbourhood leadership team*

Role in the Borough Partnership

- *Co-chairs or has a lead role in the Borough Partnership*
- *Coordinates neighbourhood steering and delivery groups*
- *Coordinates provider partner resource allocation to neighbourhoods*
- *Escalates strategic and operational risks to the BP & ensures these are resolved*
- *Delivers agreed BP priorities through the neighbourhood care model*
- *Reports to BP on outcomes, variation and health inequalities*

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Islington's Neighbourhood Approach

Our Shared Vision

DRAFT

Islington Borough Partnership

Our Vision is to enable and empower everyone in Islington to live healthier, happier, longer and more independent lives.

We will do this by reducing health inequalities, improving the health and wellbeing outcomes for our population, delivering holistic and integrated services and bringing care closer to home

What this means for our residents

- **Joined-up support** – health, care and community services working as one team , so you don't have to tell your story multiple times
- **Early support** – helping you with preventing problems before they become crises
- **Care Closer to home** – accessing help in your neighbourhood
- **Fair and inclusive services** – designed with you, reducing inequalities in access and outcome
- **Stronger communities –** relationships and connections that support wellbeing

What this means for our staff

- **Integrated ways of working -** Working with multi-disciplinary teams across health, social care and VCSE delivering a more holistic and person-centred and coordinated care
- **Reduced duplication and fragmentation -** A simpler more joined-up system where we all work towards the same shared outcomes
- **Focus on prevention and proactive care,** reducing escalation in need/crises
- **Equity and inclusion** at the heart of everything we do
- **Support to work flexibly, collaboratively and with purpose**

Our Priorities

Prevention and early intervention

Proactive care

Care closer to home

Equity and fairness

Partnership and trust

One vision. One team. Healthier communities

The four pillars of neighbourhood care in Islington

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- The following slides provide a **high-level overview** for each pillar of proactive care, bringing together a summary of
  - High level descriptor of the pillar
  - The relevant population segments, taken from the current draft NCL population segmentation model and the proportion of the population and absolute numbers this represents
  - Key partners in the local care network
  - Key programmes, interventions and current case-studies of work already underway (illustrative rather than exhaustive)
  - Key outcome domains
- Many of the **building blocks** and **requirements** of the pillars are already present within boroughs, as evidenced by the initial examples provided here.
- By way of next steps, borough partnerships will need to take ownership within their neighbourhood governance structures to create a **local iteration** of the neighbourhood care model and asset map within each pillar, identifying models of good leadership, existing building blocks and where there are gaps to address.

PILLAR 1: Creating Community Assets for Health & Wellbeing

North Central London

PILLAR DESCRIPTION	POPULATION SEGMENT	PARTNERS	SERVICES & PROGRAMMES			OUTCOMES

Creating the context for thriving communities and an improving context for health and well-being	**HEALTHY**
	People who do not meet criteria of any other segment.
	155,811 residents in Islington
		Local Care Network
		Public Health strategic leadership to drive the pillar 1 agenda, working with key local partners
		• Local government
		  • Public Health
		  • Healthy Communities/ Environment
		  • Public Assets
		  • Parks & Leisure
		  • Employment & Welfare Services
		  • Housing
		• VCSE
		• Local Communities
		• Faith Groups
		• Local Business Networks
		• Police & Community Safety
		
		INTs
		• General Practice
		• Community Pharmacies
			VCSE
			• VCSE community events e.g. Age UK get togethers, cook for good, MIND drop in events etc
			• Statutory funded e.g. Age UK – Helpline
			• Grant funded e.g.
			• Non statutory funded e.g.
			• Stuart Low Trust, Age UK, Octopus Network, Help on Your Doorstep, Manor Gardens
			• Islington Food Partnership
			
			NLFT
			• Better Lives
			
			Adult screening programmes
			- breast, bowel and lung cancers (delivered outside primary care)
			- AAA screening (regional programme)
			
			Islington Borough Wide
			• Health & Care Academy
			NCL ICB/ICS
			• Health Inequalities Programme
			• Longer Lives
			• Work Well
				LBI
				• Access hubs
				• Family hubs
				• Carers Hub
				• Cool spaces
				• Housing – damp & mould, repairs
				• Islington Life
				• Find your Islington
				• One You Islington
				• Bright LivesMoreLife - Tier 2 weight management service
				• Breathe - tobacco dependency service
				• London stop smoking service including app
				• LBI Income Maximisation service
				• SHINE
				• Bright Lives coaching service
				
				PRIMARY CARE
				General Practice
				• Vaccinations
				• Cervical screening
				• NHS Health Checks
				• SPLWs
				Community Pharmacies
				• Promotion of Healthy Lifestyles
				• Support for self care
				• Healthy Living Pharmacies
				• Vaccinations
				• Smoking cessation advanced service
				• Contraception service
					• Supporting the outcomes of each boroughs JSNA.
					• Community Connectedness & Asset Building
					
					DATA REQUIREMENTS
					• PHM Tool/Intelligence
					• AI driven Directory of Service

Local care network driven — **PILLAR 1** — **INT driven**

PILLAR 2: Early Identification & Early Help

North Central London

PILLAR DESCRIPTION	POPULATION SEGMENT	PARTNERS	SERVICES & PROGRAMMES		OUTCOMES
Primary care drives case-finding, the local care network plays an increased role in closing prevalence gaps, underpinned by common data insight and coordinated by the INT leadership. Work with communities, supported by trusted VCSE and others, to tailor the offer and outreach, reaching individuals and communities not engaged by existing offers.	**HEALTHY AT RISK** *3 or more A&E attends in year* *or* *On hypertension or asthma register only and well controlled* ***7,105 residents in Islington***	**Local Care Network** • Local authority • Carers services • Bright Lives • Access Hubs **INT** • Neighbourhood manager • Clinical lead • Coordinator • General Practice, including Primary care social prescribers (ARRS) • Community Pharmacy • Community LTC Teams	**VCSE** • Help on your doorstep • Age UK - Enablement Link Worker, Information and Advice Case Worker Planning for the Future Coordinator, Helpline • Islington Carers Hub • Hillside clubhouse – IPS. MHWI, Employment Advice in Talking Therapies • Islington MIND • Community Counselling –Nafsiyat, Bereavement (CCIW), Claremont, Maya **Whittington** • WH Community LTC teams running community outreach events – case finding and MECC • Community Audiology - outreach **All services** • Homeless Outreach Team **NCL ICB** • Work well programme • Inequalities programme	**LBI** • Access Hubs • Bright Lives Health Coaching • Early Help Community Offers • Family Hubs • Islington Learning Disabilities Partnership **NLFT** • iCOPE- Talking therapies **PRIMARY CARE** **General Practice** • Health Outreach • LTC LCS Case-finding • LTC LCS annual cycles, HTN/asthma • Advice and Guidance **Community Pharmacy** • BP checks for over 40s – hypertension finding • Pharmacy First • Signposting **GP Federation** • SMI Healthchecks	• Equitable closing of key prevalence gaps (expected to actual prevalence of key conditions) **DATA REQUIREMENTS** • PHM Tool/Intelligence • LTC LCS Dashboard • Islington Wellbeing Index • London Care Record • AI driven DoS

Local care network driven — **PILLAR 2** — **INT driven**

PILLAR 3: Targeted Interventions & Secondary Prevention

North Central London

PILLAR DESCRIPTION

Close working to ensure that all local resources are mobilised to support targeted work to close treatment gaps and provide early help.

POPULATION SEGMENT

SINGLE ILLNESS
One LTC OR Polypharmacy OR Mental Health (IAPT or MHMDS)

17,691 residents in Islington

LOWER COMPLEXITY
1 LTC and polypharmacy OR 2-3 LTCs OR LTC LCS Risk Group = Medium

10,453 residents in Islington

PARTNERS

INT

- Neighbourhood manager
- Clinical lead
- General Practice, incl. Primary care social prescribers (ARRS & Core Teams), ARRS roles
- Community pharmacists
- NHS community services (e.g. DNs, Community Therapies, LTC Teams)
- ILDP
- External partners (e.g. Breathe or Oviva)

Local Care Network

- Access Hubs
- Carers services
- Housing

SERVICES & PROGRAMMES

Whittington
- DN home visiting service
- REACH
- Neuro rehab
- MSK Therapies
- Community services clinics
- LD team
- LTC Teams (Respiratory, Bladder &Bowel, Diabetes, Heart Failure)
- Dietetics (pre diabetes, newly diagnosed diabetes, poorly controlled diabetes)
- Falls assessment
- PROFACC Team
- Community Audiology

UCLH

NLFT
- iCOPE -Talking therapies
- Mental health Core teams (MDT).
- CDAT, R and R, ED, AOT
- Better Lives

All services
- Homeless Outreach Team

NCL ICS Programmes
- Longer lives
- Work Well

Miscellaneous
- Self-Management Programmes
- Personal Budgets
- National Diabetes Prevention Programme
- Diabetic eye screening programme

LBI
- Carers services – Carers Hub
- Housing - Hostels
- ASC
- Islington Learning Disabilities Partnership
- Healthwise - GLL delivered exercise on referral service for people with LTCs who are currently inactive
- Oviva pathway to remission service for reversing type 2 diabetes
- Access Hubs
- Connect to Work

VCSE
- Age UK Care Navigators, Carers Case Work, Community MH Keyworker, Planning for the Future Coordinator
- IPS
- Solace Women aid
- London Friend and Elfrieda Society
- Community Counselling –Nafsiyat, Bereavement (CCIW), Claremont, Maya

PRIMARY CARE

General Practice
- QOF
- LTC LCS Outcomes
- PCN Weighted payment
- Advice and Guidance
- SPLWs
- Meds reviews
- Care Coordination

Community Pharmacy
- Pharmacy First
- Signposting

GP Federation
- Community services clinics
- SMI Healthchecks

OUTCOMES

- Improved condition management and reduced variation
- Reduction/lack of increase in targeted risk stratification scores
- Reduced escalation and demand for acutes

DATA REQUIREMENTS

- PHM Tool/Intelligence
- London Shared Data Evidence (SDE) Record
- London Care Record
- Interoperability of clinical systems
- AI driven DoS

Local care network driven — **PILLAR 3** — **INT driven**

PILLAR 4: Prompt Action On Rising Risk

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PILLAR DESCRIPTION

Strong INT leadership. Provision of individual care coordination/ Case management is greatest.

Coordinated primary, community and secondary care input is streamlined. There is a case-load and accountability needs to be clear and unambiguous.

POPULATION SEGMENT

HIGHER COMPLEXITY
2+ LTCS & polypharmacy OR 4+ LTCs OR LTC LCS risk group = High Risk

17,422 residents in Islington

END OF LIFE
Palliative Care (acute diagnosis) OR Cancer (acute diagnosis) - end of life diagnoses

464 residents in Islington

PARTNERS

INT
- Neighbourhood Manager
- General Practice incl. ARRS Pharmacist, Care Coordinator, SPLW
- Age UK Care Navigator
- Proactive Frailty and Complex Care Team
- Community Matrons
- District Nurses
- Social Worker
- MH Core Team
- Community Pharmacist

Local Care Network
- Access Hubs
- Housing

SERVICES & PROGRAMMES

Whittington
- CHC
- Complex LTC Service
- PROFACC Team INC, PAWS, ICAT
- Community Matrons
- Virtual Ward
- Specialist secondary care services, e.g. Rapid Access Chest Pain Clinic, Urgent Heart Failure Clinic
- High Intensity Users team
- Specialist palliative care – inpatients

LBI/Whittington
- Rapid response
- Integrated Front Door

UCLH

LBI
- Housing – supported living, care homes, assessments
- Carers services – Carers Hub
- ASC services – carers assessment

EoL
- Community specialist palliative care – CNWL
- St Joe's Hospice (Hackney)

NLFT
- MH Crisis Team - Crisis interventions, crisis hubs and acutes. SAMHs, Memory assessment and ongoing support (dementia),
- MH Core Team
- Early intervention service
- Acute provision

VCSE
- Age UK - Care Navigators, PAWS Navigation Case Worker, Community MH Keyworker, Planning for the Future Coordinator
- Crisis Café
- Crisis House

PRIMARY CARE
GP Federation
- Community services
- Bridging service

General Practice
- Care home LCS
- Advice and Guidance
- INC GPs
- SPLWs
- LTC LCS

Community Pharmacies
- Supply of EoL medicines

OUTCOMES

- Improved condition management
- Reduction/lack of increase in targeted risk stratification scores
- Reduced escalation and demand for acutes

DATA REQUIREMENTS

- PHM Tool/Intelligence
- London Care Record
- Interoperability of clinical systems
- London Shared Data Evidence (SDE) Record
- AI driven DoS

Local care network driven ← **PILLAR 4** → **INT driven**

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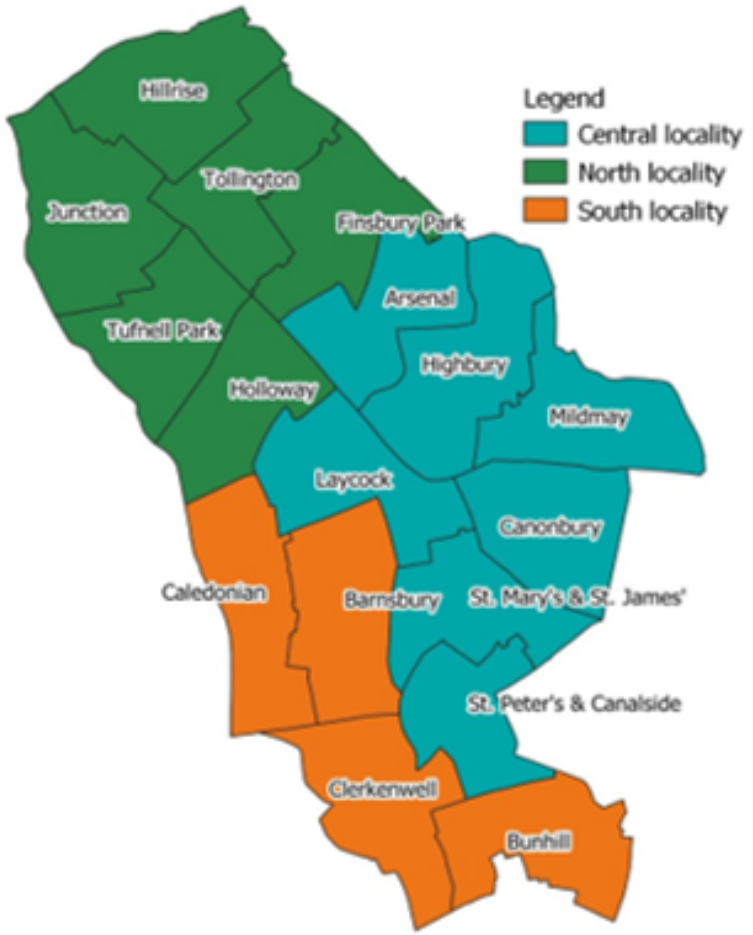
Islington's current health and care priorities and challenges

Overview of Islington's x3 *Neighbourhoods*



North

- Registered population of 128,925 or 98,105 resident pop.
- Highest levels of deprivation relative to Central and South neighbourhoods.
- Highest proportion of residents from a non-white background are those identifying as Black.
- Wards with the lowest life expectancy for males
- Highest percentage of overcrowded households
- Higher prevalence of long-term conditions compared to Central and South neighbourhoods and highest rates of avoidable admissions
- Highest prevalence of risk factors: smoking, obesity and lowest uptake of cervical screening and breast screening
- Highest numbers of residents "not healthy" in Finsbury Park

Central

- Largest population,104,419 registered pop or 125,337 resident pop
- Higher proportion of residents identifying as White relative to North and South
- Wards with higher Life expectancy for males and females relative to North and South
- Similar prevalence of risk factors of smoking and obesity compared to Islington average

South

- Has the smallest population, 77,570 registered pop (smallest NCL) or 65,986 resident pop, and lower levels of deprivation relative to North and Central.
- High proportion of population aged 20-24, likely to be students.
- Highest proportion of residents from a non-white background are those identifying as Asian
- Highest number of people "not healthy" Caledonian ward
- Lowest level of overall avoidable admissions but highest rate of COPD avoidable admissions. Lowest levels of childhood vaccination at age 2 and 5 years
- Highest rates of crime

North Summary

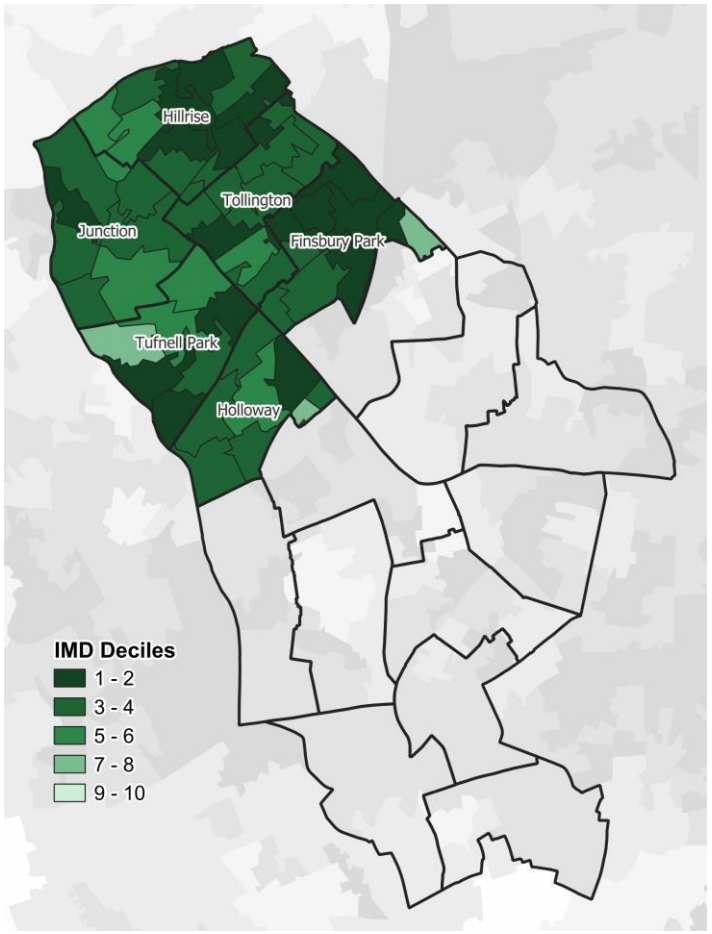
- 128,925 registered pop
- 98,105 resident pop
- 59% Reg pop located in NH (some in Central Islington)
- 40% born outside of Islington
- Higher proportion of people from Black background relative to other neighbourhoods
- Age distribution similar to Islington(higher proportion aged 25-34 compared to NCL)

Housing

- Highest rate of homelessness in Islington
- 18% of households are overcrowded
- 9% of households are in fuel poverty

Poverty

- 38% live in most deprived quintile
- 26% (n=3,362) of children live in relative poverty. Finsbury park has the highest rate of childhood poverty in Islington (37%).



Risk factors

- 16% are current smokers
- 17% are obese/severely obese
- 3% have alcohol dependency (high relative to NCL)
- **Below average childhood vaccination rates**

Health

Population segmentation (still in development)

- 73% “Healthy” – similar to NCL/ Islington average

Long term conditions

- 15% diagnosed with depression – highest in Islington
- 9% diagnosed with hypertension – highest in Islington
- 5% diagnosed with asthma
- 2% diagnosed with SMI – highest in Islington
- High proportion of population in LTC cohort (81%): – high rates of COPD

Service utilisation

- Higher GP referrals and A&E Admissions

Outcomes

- High treatable mortality relative to NCL

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NHS

ISLINGTON For a more equal future

Central Summary

Demographics

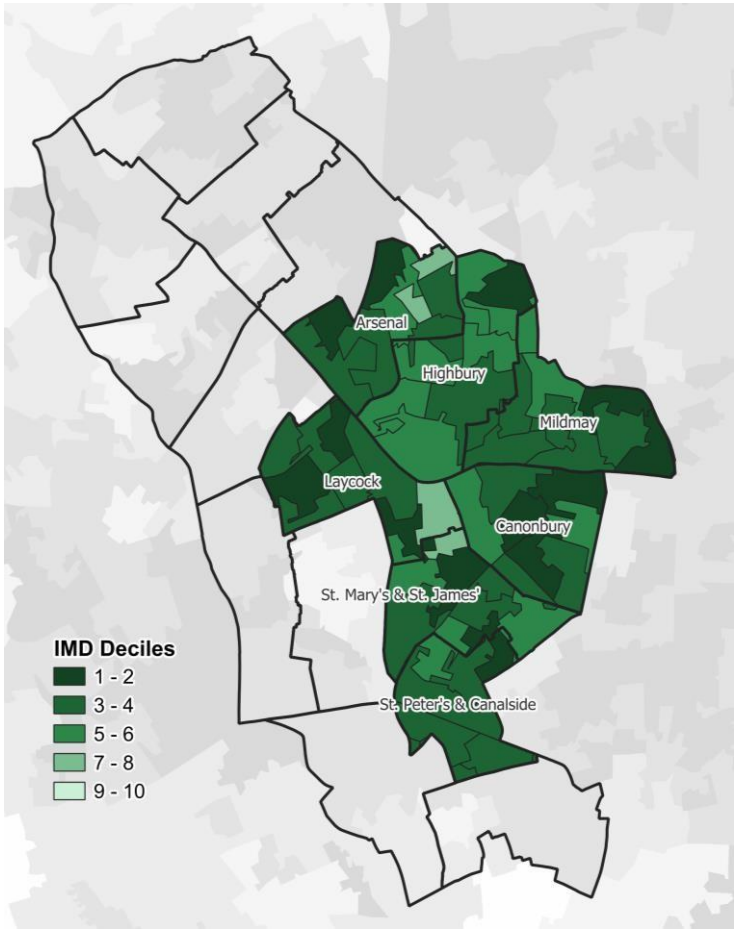
- 104,419 registered pop
- 125,337 resident pop
- High White pop (58% relative to NCL and Islington)
- 38% born outside of the
- Age distribution similar to Islington (higher proportion aged 25-39 compared to NCL)

Housing

- Low homeless relative to NCL
- 14% of households are overcrowded
- 7% of households are in fuel poverty

Poverty

- 22% live in most deprived quintile
- 24% (3,396) of children live in relative poverty.



Risk factors

- 14% are current smokers
- 15% are obese/severely obese
- 3% have alcohol dependency (high relative to NCL)
- Below average cancer screening rates
- Low early cancer diagnosis rates

Health

Population segmentation (still in development)

- 75% “Healthy” – similar to NCL/ Islington average

Long term conditions

- 14% diagnosed with depression
- 8% diagnosed with hypertension
- 5% diagnosed with asthma
- LTC cohort: 12,316 – above average rates Asthma; COPD; Learning Disabilities

Service utilisation

- Higher A&E Admissions
- Below average RTT waiting list

Outcomes

- High Avoidable Mortality

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South Summary

Demographics

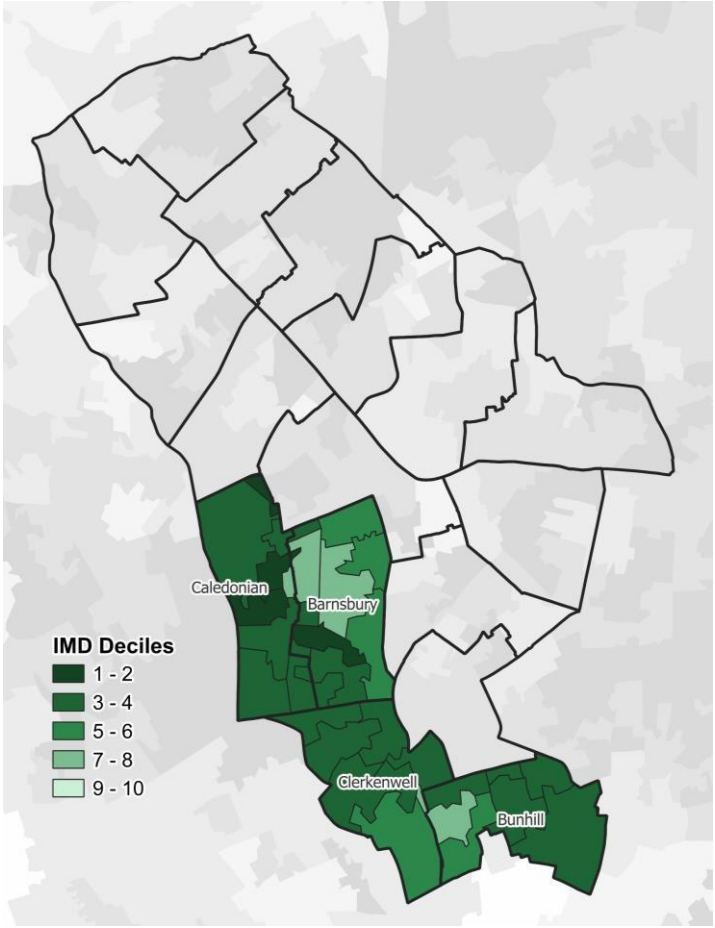
- 77,570 registered pop (smallest NCL)
- 65,986 resident pop
- 16% are from an Asian ethnic group
- 44% born outside of the UK
- Higher proportion of 20-24 compared to Islington

Housing

- High homeless relative to NCL and Islington
- 15% of households are overcrowded
- 7% of households are in fuel poverty

Poverty

- 10% live in most deprived quintile
- 28% (n=1,777) of children live in relative poverty. However, number of children in relative poverty is lowest in Islington



Risk factors

- 13% are current smokers
- 14% are obese/severely obese
- 3% have alcohol dependency
- High early cancer diagnosis (66%)
- Below average childhood vaccination rates

Health

Population segmentation (still in development)

- 78% “Healthy” – higher than NCL/ similar to Islington average.

Long term conditions

- 13% diagnosed with depression
- 8% diagnosed with hypertension
- 5% diagnosed with asthma
- LTC cohort - high rates of Heart Failure; Osteoporosis; Peripheral Artery Disease

Service utilisation

- Higher A&E Admissions vs NCL
- Low GP referrals
- Low RTT waiting list

Outcomes

- High Avoidable Mortality and High Treatable Mortality relative to NCL

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