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HEALTH IN ISLINGTON: Key achievements

Presentation to Health and Social Care Scrutiny Committee
November 2021

Life expectancy

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- Since 20011-13, life expectancy has increased in Islington for men and remained unchanged for women.
- Life expectancy at birth for men in Islington is now 79.5 years, an increase of 1.6 years since 2011-13. However life expectancy for men in Islington remains lower than the London average (80.3) and is **the 9th lowest amongst all London boroughs**. It is similar to (slightly higher than) the national average.
- For women in Islington, life expectancy is 83.2 years, which is statistically significantly lower than the London average (84.3), **5th lowest amongst all London boroughs**, but similar to (slightly higher than) the national average.

Life expectancy at birth

Men	2011-13	2017-19	Percentage increase
Islington	77.9	79.5	2.1%
London	79.9	80.3	0.5%
England	79.3	79.4	0.1%

Women	2011-13	2017-19	Percentage increase
Islington	83.2	83.2	0%
London	83.9	84.3	0.5%
England	83.0	83.1	0.1%

Source: ONS, 2020

Healthy life expectancy

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- In Islington, men and women spend on average the last 16.1 and 23.4 years of life in poorer health respectively.
- Healthy life expectancy (HLE) for men in Islington is statistically similar to London and England, but for women it is lower.
- For both men and women, the change in average healthy life expectancy since 2011-13 has increased significantly compared to London and England. For men, this has closed the gap, but women's healthy life expectancy remained well below London and England averages.

Healthy life expectancy at birth

Men	2011-13	2017-19	Percentage increase
Islington	57.6	63.4	10%
London	63.4	63.5	0.2%
England	63.2	63.2	0%

Women	2011-13	2017-19	Percentage increase
Islington	57.6	59.8	3.8%
London	63.4	64.0	0.9%
England	63.2	63.5	0.5%

Source: ONS, 2020

Islington's Health and Wellbeing Board priorities

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Ensuring every child has the best start in life	Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities	Improving mental health and wellbeing
Improving outcomes for children and families.	Addressing wider causes of poor health: particularly housing, employment and isolation.	Increasing focus on mental health and wellbeing for children and families.
Driving integration across early childhood services.	Promoting and enabling healthier lifestyles.	Increase employment opportunities and workplace health.
Remaining focused on prevention and early intervention.	Providing a collaborative, coordinated, and integrated care offer to residents.	Focusing on reducing violence and the harm it causes.
		Improving the physical health of people with mental health conditions.
		Working better as a system to provide a better holistic service to people with multiple needs which include mental health.
		Focusing on dementia.
		Improving service access.

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Ensuring every child has the best start in life

2021 The Impact of Covid – Best Start in Life (Early Years)

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The Impact of Covid

- Babies and toddlers were extremely vulnerable through Covid with a lack of the usual support mechanisms for new parents, no access to play and stimulation, growing poverty and food insecurity for families, cramped housing, the exclusion of fathers from ante-natal appointments and early labour and a disproportionate impact on the most disadvantaged and on some BAME families.

The System Response

- Most **face-face services** closed immediately, but these were maintained throughout for the most vulnerable and for critical services including nursery and childcare provision for some children, community midwifery and health visiting services
- There was a **rapid and inventive mobilisation** of a wider alternative Bright Start offer including virtual new parents groups, distribution of play and learning packs, park listening walks, distribution of food parcels and healthy start vouchers, SEND picnics, and online family kitchen sessions.
- The provision of mandated universal **health reviews** was viewed **as a critical service** throughout Covid, using both remote and face-face contacts as appropriate. All babies were seen face-face either at the new birth contact with their health visitor or at the 6-8 week contact, and either in clinic or at home. These became vital points of contact and screening opportunities at a time of much reduced contact with services and activities.
- In 2020-21 **95% of new Birth Visits were completed within 14 days of birth** and 80% of 2 year olds were reviewed by 30 months of age. This compares favourably with London rates of 94% and 66% respectively.
- Other **critical activities such as breast-feeding peer support were maintained**, with the service maintaining a presence on labour wards throughout the pandemic
- **Integration with some services was enhanced** during Covid as a result of the move to remote working. This was particularly true of midwifery services
- Our diverse **Parent Champions**, speaking 16 community languages between them, provided a vital network of parent communication through WhatsApp

2021 Key achievements – Best Start in Life (Early Years)

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A major review of health visiting services was completed in early 2021. Some key recommendations from this review include:

- Ensuring proportionality of resources balancing universal and more complex needs
- Ensure the correct skill mix, training and resource is available to achieve continuity of care and sustained rapport, expecially with the most vulnerable families
- Improving monitoring of access by marginalised and vulnerable groups to inform targeted outreach
- Ensure services are accessible to all, tackling barriers to access

Bright Start, in conjunction with maternity partners, completed the Early Intervention Foundation's (EIF) **Maternity & Early Years Maturity Matrix**, a self-evaluation exercise, reviewed by an independent EIF panel.

- Islington was judged to have made substantial progress across the majority of elements of the matrix, and to be the most developed of all the areas completing the matrix.
- A key recommendation from this review is the development of a joint maternity and early years strategy, with a stronger focus on the perinatal experience for parents, and impact for priority vulnerable groups and those with protected characteristics, and development of the strategic partnership with maternity services.

Childhood immunisations have remained steady despite the pandemic.

- In common with London and England, rates of vaccination for the 6-in-1 vaccine, given to babies in 3 doses at age 2, 3 & 4 months (diphtheria, tetanus, Hib, polio, tetanus and whooping cough), and measured at age 1, fell slightly in Islington in 2020-21 to 85% (87.6% in 2019-20). These have recovered in the first quarter of 2021-22 to 86.8%, higher than the London rate of 85.1%.

2021 Key Achievements - Best Start in Life (School Age)

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Covid response

Supporting schools with Covid preventive and safety measures was a key and ongoing priority through the year, including preparations for return to school as schools re-opened, and support with the management of cases, outbreaks and similar situations among pupils and staff. This was accompanied by ongoing briefings and webinars with head teachers and other key staff in schools to keep up to date with guidelines, local arrangements and the local situation.

Mental Health

- Immediate mobilisation of a mental health in schools group led by Public Health and the Healthy Schools team
  - Regular communication on Covid status and guidance
  - Co-ordination of the Covid response to support mental health and wellbeing in schools
  - Guidance for phone check-ins with pupils during lockdown
- Trauma informed recovery curriculum to help pupils to be able to settle to learning again, feeling safe, supported and connected to the school community, and to manage stress and anxiety.
  - Support for staff, pupils and parents
  - Provision of curated resources to schools to support staff, pupils, parents and carers
  - Training for staff to complement the curriculum, to address the impact of coronavirus on pupils' mental health and look at practical ways to promote positive mental health and resilience in the classroom
- Provision of facilitated reflective support to staff
- Existing work supported through utilisation of the national Wellbeing for School Return grant
- Ongoing local development of the role of Senior Mental Health lead within schools, following national framework

2021/22 Forward look

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- Work has started on the Bright Start Equalities Project. Led by Manor Gardens, the project aims to **improve the reach of universal early integrated services** to refugees, migrants and non-English speakers, through better understanding of barriers to access, focussed pilot work to improve equality of access to identified activities, and recommendations for wider system changes.
- Refresh of the Bright Start vision and development of a **Maternity and Early Years Strategy**
- Implementing a **Health Visiting re-organisation** designed to achieve a better focus on outcomes, a fairer distribution and more targeted provision of resource to those with the greatest vulnerability, and to improve recruitment and retention of staff. This will include new pathways to meet higher levels of need and vulnerability. The re-organisation will also support new targeted checks for more vulnerable parents and babies, recommended though the national review of health visiting checks.
- Development of a strategic and system-wide approach to achieve **healthy weight in under-5s**
- Carrying out a new **health-related behaviour questionnaire** in primary and secondary schools, including on the impact of Covid on a range of health behaviours, which will inform future planning and actions

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Preventing and managing Long-term conditions (LTCs)

Key achievements – Long Term Conditions

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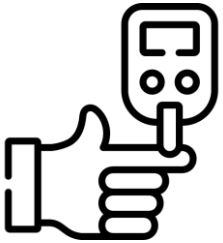

- **Diabetes:**
  - We continued to implement projects to increase referrals into the *NHS Diabetes Prevention Programme (NDPP)*.
  - A centralised referrals project to identify high risk pre-diabetic patients led to a tripling of referrals into NDPP from the prior month, with a high proportion going on to achieve programme milestones.
  - We completed a review of *Diabetes Structured Education* in North Central London. The findings and recommendations are being taken forward by North Central London CCG to improve accessibility and provision of these services which empower diabetes patients to better manage their condition.

- **Cancer:**
  - We supported an NCL-wide communications campaign, '*The Small C Campaign*' to increase awareness of cancer symptoms, through digital and physical materials and over 70 events working with 15 VCS partners
  - We conducted *analysis of inequalities in cancer screening and cancer awareness*, the findings of which will inform more targeted approaches to increasing uptake and awareness going forwards.

- **Cardiovascular Disease:**
  - *NHS Health Checks* uptake fell during the pandemic. We continue to support recovery of Health Checks, including a switch back to activity-based commissioning which was paused during the pandemic

Key achievements – Long Term Conditions

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- **Dementia**
  - In January 2021, Islington was awarded the status of *Dementia Friendly Community* by the Alzheimer's Society. We will continue working alongside partners to raise awareness and train people up to become Dementia Friends, developing an an action plan based on local priorities, and involving people affected by dementia by including them in the steering group, visiting services, or through hosting community events.

- **Long Covid**
  - Long Covid is a poorly understood condition that may affect up to 10% of people infected with Covid-19, and a wide range of symptoms and syndromes are reported. We completed a *Long Covid Needs Assessment* to understand the burden of long covid across NCL. The findings are being used to inform ongoing work, including awareness raising, improvements to data, and refining of pathways and service delivery.

- **Data and Intelligence**
  - We developed *HealtheIntent dashboards* to better understand population health needs and inequalities around long term conditions, which will be used by the system to support more strategic and data-driven commissioning and initiatives.

Key achievements – Long Term Conditions and Smoking

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- Tobacco addiction causes and/or exacerbates long term conditions, such as COPD and complications from diabetes. Low incomes are associated with higher rates of LTCs. Rates of smoking are also high among low income groups thereby exacerbating LTCs and deepening health inequalities. Smokers are also more likely to become seriously ill and die from Covid-19: smoking impairs lung immune function and damages upper airways, increasing risks of contracting and severity of infectious diseases.
- Breathe (Islington's Stop Smoking Service) successfully adapted their model to safely provide support to Islington residents who wanted to quit smoking during the pandemic:
  - Increasing their reach to residents who would normally access stop smoking support in pharmacies or their GP.
  - Adapted their service model to telephone/online consultations with delivery of nicotine replacement therapy by post.
  - This flexible provision was very well used by residents and remains the preferred option by the majority of service users.
- In 2020/21 **702** residents who attempted to stop smoking did so successfully, representing a 58.3% quit rate.
  - 176 service users disclosed a history of mental health problems (51% stopped smoking).
  - 132 residents unable to work due to sickness and disability accessed the service and 58% stopped smoking.
  - Of the 107 residents referred to Breathe form the Whittington, 77 successfully quit (72% quit rate).
  - 105 patients with COPD stopped smoking (53% quit rate).

Forward look – Long Term Conditions

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- **Partnership working:** The coming year will see increased work with partners across NCL's Integrated Care System (ICS) to improve the lives and care of people with long term conditions, and reduce health inequalities, through more holistic and joined up care.
- **Diabetes:** We will continue to implement projects to increase referrals into NDPP, in particular amongst ethnic minority and deprived groups, who experience poorer diabetes outcomes. We will do this through community engagement and testing events, and use of facilitators to increase referrals to the programme from primary care.
- **Long Covid:** We will continue our iterative needs assessment in this evolving space to better understand and address Long Covid needs locally, and are working with Healthwatch colleagues to incorporate qualitative insights into our analysis.
- **Cancer:** Our cancer analysis identified low screening uptake and awareness in ethnic minorities and deprived groups. The next phase our cancer prevention work will use these results to take a more targeted approach to cancer prevention among low uptake groups, including community engagement.
- **Dementia:** We will undertake focus groups and surveys for people with dementia, to better understand whether their needs are being addressed and inform next steps for our local dementia group.
- **Data and Intelligence:** We will work with partners to utilise new opportunities for our integrated population health dataset HealtheIntent, including a new dashboard for people with poorly controlled long term conditions.
- **Smoking.** The NHS is providing additional investment to the Whittington to increase offer and support stop smoking attempts in hospital to patients and staff, and also improve outcomes for pregnant women who smoke. This will work in tandem with LA funded stop smoking provision to support quit attempts continuing into the community.

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Improving mental wellbeing

Key achievements - Mental wellbeing

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- A **mental health and wellbeing needs assessment** was completed over the winter of 20/21 to understand the sub-clinical needs of residents. The assessment pulled together the findings of the recent resident survey and a range of stakeholder views and information. The assessment led to a number of actions that have received oversight from the local All-age Mental Health Partnership Board.
- A strong theme of the needs assessment was the lack awareness about where residents can get support for their mental health and wellbeing. To that end a **programme of communications** has been developed in conjunction with residents, external stakeholders and LBI corporate Communications Team. This programme responds to what we are hearing from residents so that our messaging is relevant and targeted. To support residents whose first language is not English, we have worked with community groups to translate voicemail messages that can be easily disseminated.
- We **worked with *We Are Islington* colleagues** to up-skill and develop scripts for staff to ensure they are able to talk to residents about mental health and wellbeing and direct them to relevant support.
- In the run up to the changes in Universal Credit, we worked with relevant teams across the council and externally, who work with **those claiming benefits**, to ensure that mental health and wellbeing messages and the support available is included in their communications with residents.
- A **data modelling exercise** was completed to understand the expected increase in mental health clinical diagnoses. This informed system partners in terms of thinking through future service demands.
- **Bereavement support** has been improved during the pandemic. Bereavement awareness training has been delivered to more than **500** community workers (both internal to Council, VCS and volunteers). Bereavement support counselling upskilled and capacity increased. A bereavement resource leaflet has been developed and support card has been printed for distribution via registrars.

Key achievements - Mental wellbeing

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- **Making Every Contact Count and Mental Health awareness training** (Mental Health Awareness, Mental Health First Aid, Mental Health in the workplace for managers) has been moved to online delivery. **868** people have received mental health training since April 2020.
- A **Social Connectedness Network** was convened to bring together statutory and community partners to work together to support residents to stay connected during the pandemic. The Network continues to meet. A briefing was developed early in the pandemic to increase the awareness of support available.
- A large well-attended workshop was held in May 2021 with the aim of **improving links between community groups, VCS organisations and statutory services to ensure early and appropriate support for the mental health and wellbeing of residents**. The workshop facilitating participants to meet and connect with colleagues working across organisations in Islington, to share what they offer residents andn increase the understanding of how local people can access the rich support we have in the borough.
- In terms of **suicide and suicide prevention**, an NCL Support after Suicide Service to provide support for those affected by suicide, who themselves are at increased risk of suicide, has been procured and mobilised. *Managing Suicidal Conversations* training has been completed by 162. Our local **Suicide Prevention Strategy** was updated in April 2021. An action plan is currently being developed with stakeholders.
- Our **Covid-19 Health Champions** launched in September 2020. We provide ongoing support to residents through a weekly newsletter and regular on-line drop-in sessions. The programme's aim is to disseminate trustworthy information and support to residents, participants have reflected that having an avenue to obtain information and connect with the council on this has elevated anxieties related to the pandemic.
- We developed a successful bid to secure **£325,000 of Public Health England funding** to support 18 projects to improve the mental health and wellbeing of residents across all ages with a particular emphasis on our most vulnerable residents and Black, Asian and other minority ethnic communities disproportionately affected by Covid.

Key challenges - Mental wellbeing

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- Due to the nature and the length of the pandemic, there is and will continue to be **pressure on residents and staff in terms of their mental health and wellbeing**. It is important that we continue to pre-empt and keep abreast of the issues that people are facing to ensure that we are providing the right training, information and linking them into the right support at the earliest time. We will complement the existing focus on wellbeing and understanding of mental health issues and how to help, with greater attention to the lived experience with mental health conditions.

- The relationship between **poor mental health outcomes and deprivation/social disadvantage** works in both directions; factors such as poor housing, poverty, unemployment and other causes of deprivation increase the risk of mental illness, but these issues/factors are also caused or exacerbated themselves by mental health conditions. Drawing on our own recent needs assessment, we will continue to work across the council, with the NHS and community and voluntary sector to help address these factors.

- Physical health and mental health are inextricably linked. **Life expectancy is lower among people with some mental health conditions,** and this is **largely attributed to long term physical conditions**. Younger people (aged 15 to 34 years) with SMI experience the greatest level of health inequalities. They are 5 times more likely to have 3 or more physical health conditions than the general population. We will continue to ensure that our own commissioned services addressing risk and protective health factors include a focus on people with mental health conditions, and in our work with the NHS on improving earlier diagnosis and management of long term conditions.

Transformation Programmes

Drug and alcohol services

Throughout the pandemic, it has been critical to maintain drug and alcohol services. At the start of the Covid-19, the focus was on maintaining access to medication which required the ongoing availability of:

- Assessments
- Treatment starts and restarts
- Substitute prescribing

Whilst the service was always open for some face to face work, the majority of support at the start of the pandemic was offered by phone or online. As lockdowns eased, the service has been working to increase the volume of face to face appointments and to restart groups. However, capacity for this work remains limited compared with pre-Covid activity due to the need to maintain social distancing and other infection control measures.

Other areas of priority work undertaken during the Covid period included:

- Following individual risk assessment, and where clinically safe to do so, reducing the frequency of opiate substitute medication dispensing. This was required to ease pressures on community pharmacies and in conjunction with the Local Pharmaceutical Committee
- As a result of this service users would have more of their opiate substitute with them so there was a push to increase the provision of naloxone to users and their family members (naloxone is an injectable medication administrated to reverse the effects of opiates) to safeguard against potential overdoses
- Supporting rough sleepers accommodated as part of the '**Everybody In**' initiative

Drug and alcohol services

- The service saw a significant increase in the numbers entering treatment as a result of the pandemic. In Q1 20/21 the service saw 142 new people enter treatment (of which 83 were opiate users), this compares to 94 new treatment starts in the same quarter the previous year (of which 29 were opiate users). In addition, the treatment service has actively been retaining people in treatment (instead of discharging them) in order service users are supported during the pandemic, when a lot of the wider recovery support was not available. This has resulted in a substantial increase in the total number of people in drug treatment and keyworker caseloads.
- The success of 'Everybody In' was recognised across London and as a consequence Islington received targeted funding to support rough sleepers in addressing their drug and/or alcohol use. This funding was initially provided for 1 year (2021/22) but public health have received recent confirmation of a second year of funding (2022/23). The design of this new service was done is collaboration with partners within the council (community safety) and external (Fulfilling Lives).
- There has also been 1 year Universal Grant funding to the borough. This is being used to target support to people in contact with the criminal justice system and to improve harm reduction initiatives.
- Whilst this funding is hugely beneficial it is unclear whether this will continue beyond March 2023. Public Health will need to ensure that services are remodelled to accommodate the learning from this initiative and that rough sleepers are still able to receive the care and support they need from local services.

What next?:

- Re-establishing links with services - recent feedback from service users has primarily focussed on the need to reconnect with treatment services but also with the other support provision which has been affected by Covid. Service users are indicating that the absence of this other provision – social spaces; access to learning opportunities – has impacted on their recovery progress.
- Review of service models – Covid has changed the way services operate and current specifications no longer reflect what is being delivered. This includes understanding what digital offers work and for whom – during Covid there was a lot of support offered online. Whilst an efficient way of providing services there has not yet been enough time to evaluate the effectiveness of this support.

Sexual Health Services

Sexual Health support is provided in a range of settings across the borough.

Young people's services

Young People's Sexual Health (YPSH) services remained available throughout the Covid period with face to face contact prioritised for vulnerable young people, and the introduction of remote contraceptive prescribing and online testing without the need to go into clinic as appropriate.

These services are currently being re-procured with a new service to be in place by April 2022. The new service model has been co-designed with young people involved at every stage. The model will provide clearer transition arrangements to other sexual health services or GPs for young adults 21 and over, appropriate to their needs; and develop a peer network of trained young people able to support and guide people through the service

Primary care

Primary care delivered interventions have been significantly restricted during Covid due to the requirements placed on the NHS to prioritise care to support Covid responses and practical and continuing impacts of infection control measures on physical capacity.

This has particularly affected Long Acting Reversible Contraception (LARC); commissioners have worked with local sexual health services to prioritise LARC capacity during recovery, and identified new capacity, including separate clinics provided by trained staff working within abortion services.

Sexual Health Services

Adult integrated sexual health services

Adult integrated sexual health services remained available throughout the Covid period with face to face contact maintained for higher risk and vulnerable adults. During the pandemic the services were managing with significantly fewer staff as their workforce were redeployed into Covid response roles throughout London. Service capacity remains very affected by infection control measures at the current time.

To support access, including to clinic for people who are vulnerable or who need face to face services, there has been a significant shift to online testing through Covid, which is currently accounting for around 60% of testing (c.f. one-third in the year before). Some treatments and contraceptives can now be managed online/remotely.

Additional funding has come into the PH Grant over the last two years for PrEP (anti-HIV Pre-Exposure Prophylaxis), which became routinely commissioned from October of last year. By July 2021, at least 838 residents had newly started PrEP (fifth highest in London at that time), and this number is expected to increase through the rest of 2021/22.

Public health have invested in the development of a dedicated IDVA role within the service, possibly the first, or one of the first, in the country. This has already demonstrated substantial positive impact for the individuals the IDVA has contact with but also for staff identifying and supporting people experiencing domestic violence.

What next?:

- Ensuring the financial sustainability of our local adult service provider given the current Covid pressures
- Taking stock of the role of online and telephone/remote clinical services going forward
- Identifying options for integrating sexual health interventions in other services and settings

Islington's Joint Health and Wellbeing Strategy

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- Planning has started for the **development of Islington's new Joint Health and Wellbeing Strategy**
- The new strategy provides an opportunity to:
  - set out an updated **shared vision** for improving health and wellbeing of residents and reducing health inequalities to make Islington a fairer place
  - Develop a **population health management approach** for Islington, with an increased focus on prevention and early intervention
  - help maintain a focus on **the key issues that impact on the health and wellbeing** of Islington residents
  - build on the work taking place to deliver the **integration of health and care** across the borough, supporting a system shift away from high cost services to more community-based models of health, care and support, and making more efficient use of system resources
  - bring a renewed and greater focus on reducing health inequalities and improving outcomes for people from Black, Asian and other minority ethnic communities and people in our most deprived areas and groups
- The strategy will be refreshed with partners and with engagement with residents
- We welcome Health Scrutiny committee engagement and input into the new strategy as it develops, during the course of this year and into 2022

Appendix 1:Measuring progress against
Islington's HWBB priorities

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		Islington				London
		Time Period	Value	Value 3 Years	3 Year Trend (where	
Ensuring every child has the best start in life	Percentage of new births that received a visit within 14 days	2019/20	95%	94%	→ No change since 2017/18	93%
	Percentage of two year olds receiving a development check	2019/20	81%	78%	↑ Increase since 2017/18	74%
	Percentage of children achieving a good level of development at the end of Reception	2018/19	71%	70%	→ No change since 2016/17	74%
	Percentage of 3-4 olds accessing funded early education programmes	2019	86%	86%	→ No change since 2016	82%
	Percentage of reception children who are overweight or obese	2019/20	22%	21%	→ No change since 2017/18	22%
Preventing and managing long term health conditions	Rate of Smokers that have successfully quit at 4 weeks (CO validated)	2018/19	2,400 per 100,000	2,500 per 100,000	→ No change since 2016/17	1,432 per 100,000
	Rate of hospital admissions for alcohol related conditions	2018/19	692 per 100,000	746 per 100,000	↓ Decrease since 2016/17	556 per 100,000
	Gap in employemnt rate between those with a long term condition and overall employment rate	2019/20	9.8%	9%	→ No change since 2017/18	12%
	Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition)	2017/19	30.5 per 100,000	34.7 per 100,000	↓ Decrease since 2015/17	27.6 per 100,000
	Under 75 mortality rate from cancer considered preventable (2019 definition)	2017/19	70.8 per 100,000	71.7 per 100,000	→ No change since 2015/17	48.2 per 100,000
	Under 75 mortality rate from respiratory disease considered preventable	2017/19	24.7 per 100,000	22.7 per 100,000	↑ Increase since 2015/17	17.3 per 100,000
Preventing and managing long term health conditions	The number of people entering IAPT services as a proportion of those estimated to have anxiety and/or depression	2019	17%	16%	↑ Increase since 2016	
	Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2017/19	25.3 per 100,000	27.9 per 100,000	→ No change since 2015/17	
	Gap in employment rate for those in contact with secondary mental health services and overall employment rate	2019/20	70%	74%	↓ Decrease since 2017/18	68%

London Comparison:

- Significantly better than London average
- Similar to London average
- Significantly worse than London average

Trend:

- ↑ Significantly better
- → No change
- ↓ Significantly worse