Health Inequalities and Covid-19

FINAL REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

London Borough of Islington
March 2022

EXECUTIVE SUMMARY

The Committee took the decision, in view of the already widely differing health inequalities in the borough, to scrutinise the effect of the COVID 19 pandemic on Health Inequalities and whether COVID had exacerbated these and appropriate measures to be put in place to mitigate these– scrutiny initiation document attached at Appendix B

The Health Inequalities Post COVID 19 Inequalities presentation to the Committee is attached at Appendix C

1. Introduction

1.1 The Committee commenced the review in September 2021

1.2 The Committee also agreed to the following objectives:

Objectives

- To provide an overview of health inequalities in the borough pre-pandemic.
- To provide an overview of what is known about further direct and indirect impacts on health inequalities since the start of the pandemic in 2020 for communities and residents, focused on selected issues
- To explore local responses to health inequalities:
    - Through the pandemic period to date
    - Early recovery priorities and actions to date
    - Longer term priorities and actions
- Resourcing implications for the council, NHS and partners to reduce health inequalities, and the interface between local and central government support
- To recommend any actions that may need to be taken, in light of the findings of the review so that the council, NHS and other local partners can best support reductions in health inequalities going forward

1.3 The Committee has carried out a short scrutiny looking at health inequalities, who is affected, what do we know about residents lives, health and wellbeing of residents and communities, and what we know about the impact of COVID and how it has further affected these health inequalities. Given the short timeframe, and the ongoing impacts of COVID, the Committee has focused on a small number of subject areas that help to exemplify issues and examples of health inequalities, which are illustrative of these much wider causes, drivers and impact of health inequalities

1.4 The wider agendas of the Committee over the past 2 years has also repeatedly heard about the impact of COVID, how services have adapted, wider system changes, the ongoing efforts to protect and vaccinate the community against COVID, and how these have affected residents and service users, including health inequalities

1.5 Health inequalities are complex and diffuse in the borough, and are influenced by wider determinants of health. Over the past decade, Islington's deprivation ranking, alongside the rest of London, in national terms has changed significantly, from 15th. to 53rd. and it also ranks slightly lower in London over the same time frame. Islington is the most deprived borough within the NCL sub-region

1.6 The change in patterns and ranking of deprivation is driven in part by housing costs, as house prices and housing rents have increased, so more affluent people move into the borough. However this does not mean that deprivation has reduced for existing residents, and particularly those in social housing or housing in multiple occupation, indeed deprivation and levels of need have intensified in many of these groups

1.7 Some of the most significant inequalities are –

- At either end of the age spectrum, children and families and older people, experience some of the highest levels of deprivation in London and the country
- There are significant differences in health outcomes and inequalities between ethnic groups
- People with physical, mental, sensory and learning disabilities have poorer health and greater inequalities than the general community
- There is generally a strong co-relation between housing type and people experiencing the highest level of health inequalities, with the greatest concentrations in areas of social housing
- COVID has disproportionately affected people with pre-existing health inequalities in health and well-being both directly and indirectly. Local analysis shows that men and women from Black and Asian communities died disproportionately from COVID, reflecting the much wider health inequalities and deprivation experienced by these communities
- Islington has seen some significant improvements in overall life expectancy and healthy life expectancy, particularly for men, over the last decade, however even prior to COVID this progress had been affected

1.8 There have been significant improvements in major causes of premature and largely preventable deaths, cardiovascular, cancer and respiratory disease, narrowing health inequalities with the rest of the country

1.9 Similar to the national pattern however and exceptionally during the post-war period, these improvements have slowed or stalled for both men and women in recent years. This has coincided with national austerity measures affecting public services, widening income inequalities and job insecurity, and deepening deprivation affecting many of the most vulnerable. Although particular factors such as fluctuations in annual flu mortality have been advanced or considered as factors, most academic analysis attribute the halt in progress on life expectancy to these wider social and economic factors

1.10 Although life expectancy in the borough for women is similar to the national average and better for men, (self-reported), healthy life expectancy is noticeably and consistently worse than either

1.11 The 2019 Annual Public Health report made four high level recommendations on further ways to address health inequalities, which were broadly,

- Delivering and developing person and community-centred ways of working
- Matching/profiling investment, services and resources to need
- Focus on health inequalities and the experience and outcomes of people with disabilities
- Role of anchor institutions and realising social value to promote health and wellbeing and reduce inequalities

2. Recommendations

2.1 The Committee recommends –

1) That local government be recognised for its role in responding to national public emergencies, and in particular for its community leadership role; there is a need to go in early, be open and inclusive, together in dialogue with communities, the VCS, faith sectors and other community leaders and influencers;
2) That population health management should use data to help better meet needs, organise resources, target inequalities and monitor progress;
3) That service design and appropriate targeting be used to address health inequalities, and this be kept under regular review, e.g. culturally competent design, service delivery, specific targets for priority groups;
4) That recognition be given as how service changes/adaptations in response to COVID have affected areas, and outcomes across the community, including the use of telephone/online/remote services, and particularly regarding inequalities, benefits/problems, learning and development, particularly when changes are being retained. This point is particularly relevant for primary care, where there are concerns about availability on 'in person' consultations, as well as difficulty in accessing GPs;
5) That in relation to long COVID, there should be a focus on communication with residents as to where they can access advice, and remedial treatment, that may be available and where this can be accessed;
6) That there be a focus on prevention, and earlier diagnosis and management of long term and physical and mental health conditions, to improve outcomes
7) That hyperlocal and similar approaches to addressing health needs and health inequalities with communities be taken, and that wider determinants of health be addressed as part of programmes to improve health outcomes;
8) That there be a focus on the inequalities that have been widened by COVID, as part of the recovery and catch-up activities, including non-COVID illnesses, immunisations, screening, health checks, and case finding, and to ensure 'catch up' activities have a focus on addressing inequalities, which with risk inequalities may widen;

9) That there be a promotion of a mix of primary, care and community care delivered approaches;
10) That it be noted the Public Health Grant 2022/23 has been again cut in real terms, and reduced significantly since 2015, with potential new COVID responsibilities, at a time when recognition, and attention to the consequences of health inequalities, has been highlighted by the impacts of COVID, and this has led to the need for 'catch up' activity to address increased needs. The Committee call on the Government to increase the Public Health grant, which is a further example of the reductions to funding that are still taking place after 10 years of Government austerity measures. This has impacted on residents, especially the most vulnerable residents;
11) That NHS (NCL) understanding, and approach, on inequalities needs to be increased, particularly as 'place based' actions will play a much greater part in addressing health inequalities than 'system' level actions;
12) That recognition be given to the fact that there is a need to build on how communications, and community engagement has developed through the COVID period and to build on these;
13) That need and inequalities of residents be mapped against the new ward boundaries, when the 2021 census results emerge;
14) That further development and learning from anchor institution type approaches be encouraged, together with social value in the procurement and purchasing power of local public bodies, including the Council and Whittington Health;
15) That hospitals be encourage to develop their potential to directly improve health, as evidenced by the Whittington Health in its population report, including stop smoking support, and interventions that can take place together with alcohol harm reduction;
16) That initiatives be cross referenced to 'Lets Talk Islington,' and there be a wider focus on inequalities;
17) That recognising the impact that COVID has had on mental health issues for residents, and the fact that BAME groups are more likely to suffer disproportionately from mental health issues, efforts should be made for residents to engage in 'Talking Therapies', especially amongst BAME communities (where it is currently low);
18) That whilst recognising that Islington has relatively good access to NHS dentistry, compared to many other areas, there is concern that oral health may have suffered during COVID. There should be therefore more communication, and education provided to residents, about the benefits and availability of NHS dental services in the borough;
19) That the Committee recognise the good work that the Council is doing to reduce air pollution in the borough, with Safer Schools and Beat the Street initiatives, and People Friendly Streets. However, air pollution is a huge problem, especially young people with asthma, and the elderly, and the success of these initiatives should be measured in order to assess their effectiveness;
20) That the Committee feel that in the Executive Member Annual Report to the Committee there should be indicators measuring the health of Islington residents compared to neighbouring boroughs, together with national

comparators, in order to assess how measures being taken in the borough to improve health are progressing.

3. Main Findings

<u>Witness Evidence - Mental Health in Islington – Jill Britten and Sue Hogarth – Public Health</u>

3.1 The Committee was informed that Islington has one of the highest level of mental health needs in the country, and this is reflected in high levels of diagnosed conditions. Almost one in six adults in Islington is diagnosed with a common mental health illness, and women accounted for 61% of diagnoses. Middle - aged adults are more likely to have a common mental illness, and white British and white Irish followed by White and Black Caribbean ethnic groups have a higher prevalence compared to the Islington average. Islington has a higher prevalence of serious mental illness (SMI) (2018) figures, than London and England. Black and mixed ethnic white ethnic/black Caribbean ethnic groups have the highest prevalence of SMI. All groups experience mental health conditions, but prevalence rise significantly in groups experiencing deprivation, disadvantage and discrimination

3.2 The impact of COVID 19 on mental health and wellbeing has affected all ages and will continue to do so, some issues apply to all ages, and those with drug and alcohol issues. Large national surveys have found higher numbers of people experiencing anxiety and depression and social isolation is more widespread

3.3 In terms of modelling and needs assessment it has been determined that young people are worried about education, finances and future. Parents are concerned about children's mental health and wellbeing and women more worried than men. More BAME residents reported worries about COVID 19, and people not in paid work have poorer mental health than the full time employed. Mental health had deteriorated somewhat for LGBTQ residents, and there was a gap in services for people with learning disabilities. Unpaid carers have suffered anxiety about loss of available support. People who have had severe COVID 19 are at risk of anxiety and depression, especially health care professionals

3.4 Many Islington residents have tried to adapt to cope with the pandemic most commonly by spending more time with family and friends. For those who need further help there are many services and community support structures for example SHINE, Parks for Help, Financial and Debt advice, in work support, food provision, social and community assistance, healthcare services, and psychology groups

3.5 The Council has instituted a number of additional activities as a result of the pandemic, including ensuring that the Council has a good understanding of the issues, and ensuring a system wide strategic response, service and training developments for children, young people and families

3.6 The Committee noted that clinical support changes had been adopted at an early stage of the pandemic. The NCL CCG worked to bring forward Crisis Team

expansion, acute hospital psychiatric liaison, home treatment and community response, resulting in 24/7 crisis cover across NCL

3.7 In addition, there were specialist services and teams who were able to respond in a crisis. There was also increased support for young people with autism/Learning Difficulties and challenging behaviour, and increased support with schools, bereavement, mental health, first aid training for CYP workforce. As with all services, there was an expansion of remote working and digital solutions, but continuation with face -to - face services for the most at risk or excluded. The KOOTH mental health app has seen increased take up

3.8 Crisis services changed considerably during the pandemic, as there was a strong desire to reduce A&E attendance. A new urgent care Assessment and Treatment centre opened at the St.Pancras site, in order to relieve A&E departments, crisis recovery teams increased capacity to treat more people at home, i COPE changed to remote working, and introduced 30 minute emotional well-being sessions for all new referrals within 48 hours of referral. i COPE also offered 3 session short treatment for COVID psychological distress, and bereavement, and LBI also increased its VCS bereavement offer to match this. Community based services, such as Islington MIND moved to remote working offering telephone and video chat support etc.

3.9 Most services adapted to offer their interventions remotely or provide a mixed model. Some people preferred this mixed model, however some services have reopened buildings, with social distancing in place

3.10 Practice based mental health has been provided by Camden and Islington, A team of consultants, nurses and psychologists that worked alongside GP's and other primary care health professionals within practices. This offered mental health expertise, advice, training and consultation to GP's, and practice staff and sees patients for comprehensive medical assessment. Practice based mental health referrals have returned to pre-COVID levels

3.11 The Committee were informed that the i COPE service offers mainly cognitive behavioural therapy for a range of common mental health problems, alongside adapted therapy options for people living with long-term physical health conditions or medically unexplained symptoms. The service has seen an increase in clinical complexity of people

3.12 Crisis teams had also been provided by Camden and Islington. The teams operate 24/7 and undertake rapid assessment in the community for urgent and emergency referrals, and support crises at home. Black communities and White Irish people are likely to be in crisis than other ethnic groups, and this links to over representation in secondary care bed use amongst these groups. It was noted that White Irish residents were over represented in mental health issues, and it was stated that this could be generational and linked to social isolation issues

3.13 The Committee noted that many BAME residents did not want to admit to mental health problems due to stigma in the community, and it noted that work is taking

place with community organisations to support counselling, including language counselling around mental health and work is also taking place with Healthwatch in this regard. The Mental Health Transformation programme that is being instituted would also assist in this

3.14 An Islington Recovery Pathway has also provided by Islington MIND. This is Islington's main VCS mental health services operating in 3 locations across the borough. The services provide a range of practical and emotional support. Overall the number of people engaged with the service has increased, however new referrals are generally lower than pre-pandemic levels with the exception of LGBTQ residents

3.15 There is also enhanced bereavement support, and bereavement support training for services engaging with the Public, and increased capacity from existing counselling/bereavement providers. Bereavement service provided by the Accept service offers up to 10 weeks support for adults living in Islington and/or registered with a GP in Islington. This service is important for people who have experienced the death of a family member, relative or another important person in their life

3.16 The Committee was informed that the Public Health England Prevention and Promotion fund for better mental health forms part of the Government's Mental Health Action recovery plan 2021/22, in order to ensure the mental health aspects of COVID are rapidly addressed and allocated to top 40 most deprived boroughs. There is a long list of criteria, as to what, and what cannot be funded, and money needs to be spent and outcomes delivered in this financial year. Drawing on the rapid needs assessment and overview of service patterns and needs, investment through this grant was targeted to younger age groups, and addressing protective and risk factors for adults, both with a cross cutting focus on Black Asian and other ethnic minority community. The Committee also noted that funding was available for looking at behavioural issues in schools

3.17 The Committee felt that that there needed to be improved signposting of services on the website, and it was stated that this was being addressed in order to provide a more streamlined version with better signposting to services

3.18 The Committee also received evidence in relation to Health Inequalities and an overview of the situation in Islington

<u>Health Inequalities in Islington – An overview Mahnaz Shaukat Public Health</u>

3.19 The Committee was informed that health inequalities are largely due in Islington and throughout England, due to the unfair and unjust inequalities in society, in which people are born, live and age. These inequalities are structural and a consequence of the social and economic organisation some communities face, and in addition, factors such as education, housing and neighbourhood play a large part. These factors drive inequalities in physical and mental health. Poverty is also a key determinant of poor outcomes in health, and linked to a higher level of risk

behaviours, and lower protective levels of health. COVID 19 ha exposed these inequalities and the risk of dying or becoming seriously ill with COVID and was much higher amongst people suffering from deprivation and advantage.

3.20 Islington is one of the most ethnically diverse places in the country. Approximately 33% of Islington residents are from BAME communities, with the largest groups being. Other white and Black and African and Black Caribbean groups. There is a lot of uncertainty about the population, and that population figures could have been affected by COVID

3.21 In terms of deprivation Islington is the 6th. most deprived London Borough, and the 53rd. most deprived in England. The geographic pattern of deprivation is different to many other areas. Islington mix of housing means that deprivation is diseminated across the borough, and is mainly concentrated in social housing estates

3.22 Islington residents have a lower life expectancy overall, with women having a lower life expectancy, compared to the rest of London, but similar to national averages. Inequalies in life expectancy within Islington (the difference between the least and most deprived areas in Islington), is 9.8 years for men, compared to 7.2 in London and 9.4 in England. Inequality in life expectancy in Islington has widened, and improvements in life expectancy slowed. The main causes are cardiovascular disease, respiratory disease, cancer and those living in deprived communities have a higher death rate from avoidable health issues, compared to the NCL average

3.23 The Committee noted that he impacts of COVID relate to the immediate, and direct consequences of COVID, but the longer term consequences will extend far beyond. COVID has exacerbated existing health inequalities, and directly disproportionately impacted men, BAME communities, most deprived communities, people living in care homes, those with learning disabilities, those with a mental health condition, and those with underlying health conditions and physical disabilities

3.24 There have been a total 1,627 COVID admissions to hospital up until July 2021.The highest proportion was for other ethnic groups, which is 2.85 times higher than the average in Islington. The black and Asian populations also have a higher rate of COVID admissions than the Islington average, whilst those from a white group or mixed group had a lower of similar level of COVID admissions compared to the Islington average. The rate of admissions was higher for men, although the rate is significantly different from the Islington average. Residents aged 55 or over had higher rates of COVID admissions, compared to the Islington average, similar to national patterns

3.25 In terms of COVID Impacts mortality, the cumulative total of deaths up until 15 October was 161.3 (391 deaths with COVID mentioned, and this compares to 228.9 for London, and 251.4 for England. There have been two major waves, and ethnicity has not recorded on the death certificates, however details have been obtained by linking deaths data from GP's and hospitals. People from the white British group on average were less likely to have died from COVID, and those from Black and Asian groups more likely than average

3.26 The Committee was informed about the disparity of risks and outcomes in COVID. A national study has shown men are affected disproportionately by COVID, and despite making up to 46% of cases, they make up almost 60% of deaths, and 70% of admissions to intensive care. Similar ratios are found in Islington. Rates of diagnosis increase with age, and the majority of patients in critical care are between 50-70 years of age. Those aged over 80 were 70 times more likely to die from COVID, than those under 40 years of age

3.27 Those living in deprived communities were more likely to be infected by COVID, and had poorer outcomes. Urban areas such as London had higher rates of COVID diagnoses and deaths. Islington had a lower mortality rate than the national average. Co-morbidity included on the death certificate mainly were diabetes, hypertensive diseases, chronic kidney disease, COPD and dementia. The most profound link was with diabetes, listed on 21% of death certificates. In terms of occupations - nursing auxiliaries and assistants saw an increase in all cause deaths linked to COVID 19, and subsequent analysis has shown that health, social care and transport workers had a significantly higher risk of severe COVID

3.28 In terms of long COVID there are a wide range of symptoms that have been reported, including fatigue, breathlessness, aches, sleep disturbance, cognitive impacts. An estimated 1.15% of the London population report long COVID symptoms, which equates to 2.788 people in Islington. Of those with confirmed COVID an estimated 7.5% experience long COVID symptoms that have impacted significantly affect their daily life. Diagnosis rates are lower than this, which suggests many people may be unaware of sources of support in Islington

3.29 There has also been an impact of COVID on Start Well, including maternal, ante-natal and early years. There have been changes in availability and support in pregnancy, and for new parents, concerns about changes in unplanned pregnancy rates, risk of reduced access to immunisations, impacts on early socialisation and development, impacts on parental income and employment. In terms of school age children, there has been an educational attainment gap due to school closures, differential home schooling provision, reductions in physical activity and diet issues. In terms of transition to adulthood, there has been disruption to education and examinations, financial consequences, some possible disproportionate effect on young people's employment, an impact of early unemployment, and debt. Safeguarding and mental health have also been affected, with fewer opportunities to identify and monitor safeguarding concerns, and reduced access to support for children, domestic and child abuse increases. In addition there are factors affecting the mental health of children and young people, isolation, lack of routine, stress, anxiety and bereavement

3.30 The Committee noted that Islington is the most income deprived borough in London in relation to income deprivation affecting children. In 2019 28% of residents under 18 living in families facing income deprivation. Islington has similar outcomes for GCSE attainment compared to London, and better than the national average. Nearly a quarter of children in London are obese, and there are similar levels to London.

Hospital admissions for self-harm amongst young people are significantly lower than national averaged, although higher than the London average. Islington has a lower rate of childhood immunisations compared to London and England. MMR uptake is far below the herd immunity for measles. The pandemic is likely to have widened the gap between children in poverty and others

3.31 The Committee also heard evidence that in relation to Live Well, Islington has one of the highest prevalence of common mental health illness in London. Smoking, alcohol and obesity are major risk factors, and higher in Islington than London or nationally, although these have reduced over time. Islington has 11,500 people living with diabetes, 3,800 with heart disease, and approximately 4,000 with COPD. Air pollution levels were improving, however they remain higher in Islington compared to England

3.32 In terms of Age well, Islington has the 4th. Highest level of income deprivation affecting older people in London. 34% of residents over the age of 60 were facing income deprivation, compared to a London average of 22%. NHS screening programmes to prevent early death are in place, but there is a low take up of bowel screening, and aortic aneurysm, compared to London and England

3.33 A lower proportion of older people live alone in Islington, although the trend is increasing and levels of dementia are higher than the London average. However, this is due to much higher levels of early diagnosis, rather than population differences

3.34 Moderate or severe frailty prevalence is high in Islington, and there were also relatively higher rates of alcohol admissions amongst older people

3.35 The Committee noted evidence in relation to the impact of COVID on Live Well and Age Well. In relation to physical activity this has been limited by lockdown, there has been an increase in sedentary behaviour, and there is an opportunity to encourage active travel. In relation to healthy eating, there is evidence of a change in dietary behaviours, the impact of lockdown of food choices, rising food insecurity, and increased use of foodbanks. In terms of smoking there is mixed evidence of trends during lockdown, increased economic circumstances associated with increased smoking, and disruption to smoking cessation services. In terms of alcohol usage, there have been changes in patterns of use. There is concern about problematic drinking, and bereavement, isolation, troubled relationships, and job insecurity and these factors can contribute to this. In terms of substance misuse, there have changes, and a disruption to services during lockdown, and this has impacted on recovery, changes in drug supply, reports of increased on line gang recruitment and activity

3.36 The Committee were also informed that there have been physical health impacts on residents, due to COVID, some of which is temporary, and these included managing delayed diagnosis of long term conditions, additional costs to health. There were issues, such as delayed diagnosis due to missed appointments, backlog of waiting lists, changes in service delivery, due to lockdowns, disproportionate impact of the

virus on BAME, carers, older people, dementia, mental health needs, and learning disabilities

3.37 There will be also be longer - term service pressures, inequalities in health, distrust, and a potential increase in obesity. Large national surveys have shown that there are a higher number of people experiencing anxiety, and depression, than before the pandemic. Local residents, and stakeholders views, show that a large majority 81% of residents are somewhat, or very worried, about the impact of COVID, and 26% worried about mental health and wellbeing. Modelling predicts there may be 28,266 new cases of moderate/severe anxiety, and 38,671 new cases of depression in the borough. Social isolation is more widespread and residents living alone are much more likely to experience extreme loneliness,

3.38 The Committee noted that some people have suffered from the effects of COVID than others in relation to mental health and wellbeing, and that these levels are highest amongst women, young adults, people who live alone or with children or urban areas, or are BAME residents. The Committee noted that whilst there had been investment in mental health services, there is a need to make the case for more investment in mental health services to address inequalities from NCL

3.39 In terms of COVID resident engagement, the findings of the engagement study highlighted social inequalities. BAME communities were significantly more worried than others, and mental health was the most common concern. Finances, employment, relationships and access to services were also issues of concern. VCS and community groups have played a key role however in supporting residents through the pandemic

3.40 The Committee were informed that going forward COVID will exacerbate further inequalities, and that this will lead to poorer health outcomes in coming years. The Council is working with the NHS regarding a population health management approach to improve wellbeing, and to reduce health inequalities, and this is being developed across NCL. There needs to be a strong focus on recovery, and should on evidence based preventative interventions, together with planned hospital care, and targeting most affected groups. Mental health is also important, with more individualised support for people with complex mental health problems. The population health management approach will be informed by the information gathered from the pandemic

3.41 The Committee noted that Islington had one of the highest deprivation income levels in London, and it was illogical the way Government were making funding decisions on health services. In addition, it was noted that work was taking place to address this issue with the CCG and ICS

3.42 The Committee also noted that many BAME residents who were elderly tended to be more deprived, due to migration and lower income employment. The Chair stated that this may be a possible topic for a scrutiny review in the next municipal year

3.43 Population health management provides a way to use data in a more joined up and real time way to plan and run services, to deliver more holistic services and care to communities and individuals, to identify and target resources and activities to inequalities or gaps in care and outcomes across the population, and to track progress and performance. Islington has provided a significant level of leadership and support in the development of the new NCL wide system, and there is a keenness to see the potential fully utilised to address inequalities going forward

3.44 It is important that the design, targeting and monitoring of services to improve health and prevent or diagnose diseases early have a regularly reviewed and refreshed focus on health inequalities. There should be a particular focus on ethnicity and disability. The design and delivery of programmes to address health inequalities should be linked, or joined up, with other important determinants, and drivers of those health inequalities. For example, debt and financial worry, especially on people with low incomes

3.45 The NHS inequalities model (CORE20PLUS5) does not capture the extent or complexity of needs and inequalities in Islington. It is important the NCL forms into an ICS, it continues to work with Public Health and other local system partners, to deepen its approach and understanding of inequalities to ensure that services are designed and delivered to address inequalities and improve outcomes, and that Islington receives a fair share of resources

3.46 In response to the impacts of COVD, it is important that the Council and partners continue to engage with communities and patients to understand the range and extent of the impacts, which continue to emerge, and to co-design approaches to address and overcome these impacts. Mental health and wellbeing is one impacted area of health which has been felt very widely, and should be a continuing area of focus. Catch up activities for example around missed diagnoses, waiting list initiatives or addressing other missed or deferred needs, must bring a clear focus on health inequalities, to ensure groups or communities are not missed or left out, with the risk of further widening inequalities

3.47 Communication and engagement with residents and communities has developed significantly through COVID. It is important to ensure that this remains a central focus of work on health inequalities, effective practice is not lost and progress is built upon

3.48 There are programmes of work and policies that support the role of local public bodies, such as the Council and Whittington Health to act as anchor institutions within the community, and to derive social value from their purchasing power, role as major employers etc. This is welcomed, and there is a need to look forward and see how this establishes and evolves over time to address key inequalities, and offer greater opportunities to local communities and residents. With the imminent new ward boundaries and first 2021 census results expected later this year, mapping inequalities across the borough will be important to help ensure resources are profiled along these new boundaries, and in the light of updated population data

Diabetes in Islington

3.49 Dr. Wikum Jayatunga, Public Health Consultant, Camden and Islington Public Health gave evidence to the Committee at its meeting on 21 February 2022

3.50 The Committee noted that diabetes is a life-long condition that causes a person's blood sugar level to become too high. There are two types of diabetes Type 1 and Type 2.Type 2 diabetes is the most common, and is associated primarily with excess weight, which is increasing in prevalence amongst the population

3.51 Diabetes affects 3.8m adults and accounts for 10% of all NHS spending, and these are expected to rise

3.52 4.8% of the LBI population has a recorded diagnosis of diabetes, but it is estimated that around 7.7% of the population has diabetes prevalence

3.53 The Committee noted that managing the condition is key as it can lead to other more severe problems. This means that 38% of residents may have unknown diabetes. This is important as the condition needs to be managed to alleviate more severe complications and conditions

3.54 64% of residents have other long term conditions in addition to diabetes, which are mainly hypertension, and heart disease. Diabetes risk increases by age and slightly more males have diabetes than females, across all age groups

3.55 Diabetes levels are higher in the more deprived areas, in the fifth most deprived areas the prevalence is 8.4%, and in Islington black and Asian communities are more than double at risk of diabetes than other ethnic groups. Risk factors for diabetes include smoking, diet, physical inactivity, weight, wellbeing and healthcare

3.56 The Committee noted that NHS health checks are carried out for adults between 40 -74 years of age. This is to identify early signs of certain conditions, including diabetes. COVID has led to delays and reduced activity in carrying out these checks, however from Quarter 2 payments to GP's have been resumed, in order to carry out these checks. During COVID some cases of diabetes may have been missed, or treatment delayed

3.57 The NHS diabetes prevention programme is a programme designed to identify those at risk of Type 2 diabetes, and focuses on exercise, nutrition and an action plan to maintain long- term changes. The service has had to adapt during the pandemic, and new approaches include self-referral pilot, digital/remote delivery, centralised referral project, and ongoing project. Centralised referrals highlights specific use of population health data for targeted case finding, and reducing health inequalities. From GP health records, patients are identified including BAME patients who have a long term condition, and likely to develop diabetes. Invitations/texts are sent to them to tell them of risks, and to contact GP or be referred to NDPP. Referrals increased 70% during the project

3.58 The Diabetes structure education programme is an evidence based education programme for people newly diagnosed with diabetes, to determine how they can live with a long term health condition, usually in the form of group based educational courses. Key findings to date included lack of consistent offer/lack of capacity, unmet linguistic and cultural needs, low quality referrals, and lack of awareness, and complexity. The recommendations for improvement included adopting a hub model, increased language offer, engaging with primary care, and expanded digital provision

3.59 The Committee noted that going forward there would be diabetes community engagement and testing events, Healtheintent using population health data, NCL long term condition locally commissioned service, and the NCL diabetes and weight management network

3.60 In terms of a diabetes system overview, this would focus on prevention, a healthy catering commitment, obesity reductions and prevention, 'one you' providing lifestyle advice, and making every contact count. Detection initiatives would include NHS Health checks, National diabetes prevention programme, locally commissioned services, and a 'know your risk' online health tool assessment. In terms of treatment and care, there will be locally commissioned services, a low calorie diet service, structural education, flu immunisations for people with long-term conditions, diabetes eye screening, intermediate diabetes specialist service, diabetes in patient specialist nurses, and multi-disciplinary foot team hot clinic

3.61 It was noted that some residents, particularly younger residents did not visit their GP regularly, and therefore did not always get tested, and it was also noted that diet plays a large part in diabetes in younger people. The issue of child obesity was a complex one, and likely to be exacerbated by the cost of living crisis. It was important that the Council's free school meals programme included healthy food options, and that physical activity was promoted

Whittington NHS Trust

3.62 The Committee considered written evidence from Whittington NHS Trust

3.63 Islington is a diverse community with a younger population, which is expected to rapidly grow and age. There are significant disparities in health outcomes between the rich and poor

3.64 Smoking, alcohol, and obesity remain key preventable causes of ill health, and Making Every Contact count is important to improve patient's lives. The social determinants of health are housing, poverty, employment and access to care. The COVID 19 pandemic has further deepened health inequalities and shown the importance of focusing on population health within the community

3.65 The top three diagnosed long-term conditions in August 2021 were hypertension, asthma and diabetes, and in order to make the greatest impact on population health

the focus must be on health behaviours and lifestyles, places and communities we live in, and an integrated health and care system

3.66 The Whittington key objective is to play its role as an anchor institution to prevent ill-health and empower self-management, making every contact count, engage with the community, become a source of health advice and education, tackling inequalities facing people with learning disabilities and/or autism and serious mental ill-health. Whittington is partnering with Healtheintent programme, to create a single integrated care records for residents across NCL, together with a data driven approach

3.67 Population health is an approach to reduce health inequalities across an entire population, promote health and wellbeing, and improve mental and physical health outcomes. Islington has a mixed ethnicity population, and in 24% of Islington the population lives in the most 20% deprived neighbourhoods in England. These areas are the most ethnically diverse, and it was noted that 47% of the population in Islington is white Britishg the best start in life, compared to London averages. Vaccination rates are low, chidren are in low-income families, mothers are smoking at birth, children in care, GCSE attainment, and preventable deaths are high. Flu vaccination uptake is below the rest of London, and the high rate of sexually transmitted diseases should be a focus for future work. Islington life expectancy is also lower than the London average

3.68 About 6400 residents in Islington (4%), are on disability benefits due to mental illness, 3 out of every 4 claims. There is also a link between deprivation and respiratory disease, often due to smoking, high pollution rates, poor housing and exposure to occupational hazards

3.69 People in Islington on average live the last 20 years of their life in poor health

3.70 Whittington also intend to address inequalities by being a good employer, trying to procure services, where possible, through local suppliers, manage land and physical assets to maximise local benefits to the community, delivering inequality funding projects, and work with localities to amplify public health messages. In addition to deliver business plans to include action on how ICSU's, and corporate services, are going to identify and tackle health inequalities. Whittington are also agreeing priorities, and targets, with Anchor networks, and work collaboratively to deliver them. As part of the strategy to manage land and assets, the aim is to create a Trust Environmental Policy and Carbon net zero strategy action plan, and part of this process is to ensure local employment will be considered as part of the social value score

3.71 Following consideration of the evidence the Committee focused on the following –

Developing and delivering person and community centred ways of working

- Engaging with residents and communities at all levels designing how services and professionals work with and relate to patients and communities

- Person centred care which engages with how people live their lives, is culturally competent and draws on and recognises their strengths
- Recognises and builds on community assets to help improve health and well-being of individuals and communities. Example is how diabetes prevention 'know your risk' tool and structured initiatives have been reviewed and redeveloped to be more culturally competent and to proactively reach out to people from BAME groups at higher risk. This will need initial piloted interventions and targeted interventions successfully reaching and identifying more people, with or at risk of diabetes, with statistics. This is an example of an ongoing programme to review and redevelop the targeted focus on inequalities across Public Health services and inteventions

Matching/Profiling investment, services and resources to need

- Considering how resources can be redeployed strategically and collectively to reflect differing levels of needs and inequalities between communities and across the borough
- Giving a high priority to prevention and early intervention in investment decisions
- Ensuring a focus on outcomes narrows the gap for those experiencing inequalities, not simply looking at average outcomes. Example – investment decisions made through Population Mental Health grant, albeit small value, reflected differential impacts on mental health and well-being, with a focus on prevention and early intervention, including wider determinants such as environment and debt, and boosted service capacity, targeted to children and young people, BAME groups and other ethnic minority groups and people experiencing deprivation

Focus on ethnic inequalities and the experience and outcomes of people with disabilities

These are essentially 'cross cutting' priorities across the other themes and include –

- Data analysis, and quality completeness of data, particularly important to help highlight inequalities, and outcomes, experienced by these groups, linked to engagement and involvement
- Use of Equality impact assessments drawing on improved data and insight, earlier on in the review, and development of service charge proposals
- Building the skills and knowledge about health promotions, and what services are available within communities, and community and faith organisations, including with community leaders, and influencers. Examples – the Population Health Management development work is bringing together data from various bodies, initially NHS and expanding to include social housing, supporting targeted and joined-up care where there are gaps or poorer outcomes. There is parallel work across the Council to develop and improve data analysis in support of Challenging

Inequalities programme. The first application of ethnicity to mortality data, with an initial focus on the disproportionate impact of COVID. Mental health and COVID champion type interventions during the COVID period

Role of Anchor institutions and realising social value to promote health and well-being and reduce inequalities

- Islington is developing its strategic approach in this area, and is led corporately by the Community Wealth Building team. The annual reports' recommendations included using social value levers as organisations to address factors that drive inequalities within our communities, and make a difference to people in groups experiencing inequalities. Capitalising on organisations roles as employers, to improve health and well-being, with a focus on lower paid staff, many of whom live locally. In addition, developing as 'anchor organisations' locally to deliver change over the medium and long term. Example – Whittington Health's Population Health report 2021 summarised a gap analysis against the features of anchor institutions under the headings of employment, procurement, bricks and mortar, service delivery, and corporate and civic role, in order to inform its Health Inequalities Strategy and Action Plan, which it organised under those headings

4. Conclusions

4.1 The Committee noted the witness evidence given, and that the COVID 19 pandemic has exacerbated the inequalities in health already in existence in the borough.

4.2 The Committee would like to thank witnesses that gave evidence in relation to the scrutiny and The Executive are asked to endorse the Committee's recommendations.

APPENDIX A

MEMBERSHIP OF THE HEALTH SCRUTINY COMMITTEE – 2021/22

Councillors:
Councillor Clare Jeapes (Chair)
Councillor Jenny Kay (Vice-Chair)
Councillor Tricia Clarke
Councillor Osh Gantly
Councillor Phil Graham
Councillor Sara Hyde
Councillor Martin Klute
Councillor Jilani Chowdhury

Substitutes:
Councillor Gary Heather
Councillor Bashir Ibrahim
Councillor Anjna Khurana
Councillor David Poyser
Councillor John Woolf

Acknowledgements:
The Committee would like to thank all the witnesses who gave evidence to the review.

Officer Support:
Jonathan O'Sullivan – Director of Public Health
–
Peter Moore – Democratic Services

Witnesses
Sue Hogarth, Jill Britten, Mahnaz Shaukhat, Jonathan O'Sullivan - L.B. Islington Public Health, Dr. Wikum Jayutanga,, Public Health Consultant, Camden and Islington Public Health, Whittington NHS Trust

Appendix B

SCRUTINY REVIEW INITIATION DOCUMENT (SID)
Review: **Scrutiny theme** *A review of health inequalities in the context of the Covid 19 pandemic in Islington. Has Covid exacerbated inequalities? What can the council, the NHS, VCS and other partners do to reduce health inequalities?*
Scrutiny Review Committee: Health and Care Scrutiny Committee
Director leading the review: Jonathan O'Sullivan
Lead Officers: Miriam Bullock with Public health leads for selected areas of focus
Overall aims: To highlight the impacts of Covid19 on existing health inequalities in Islington, and how these have been further affected through the Covid19 pandemic. To share how services/communities are responding to the challenges through the pandemic, including lessons learned and new ways of working. To share how plans and approaches to recovery can best focus on addressing the health inequalities.
Objectives • To provide an overview of health inequalities in the borough pre-pandemic. • To provide an overview of what is known about further direct and indirect impacts on health inequalities since the start of the pandemic in 2020 for communities and residents, focused on selected issues. • To explore local responses to health inequalities: o Through the pandemic period to date o Early recovery priorities and actions to date o Longer term priorities and actions • To highlight organisational or resourcing implications for the council, NHS and partners to reduce health inequalities, and the interface between local and central government support. • To recommend any actions that may need to be taken in light of the findings of the review so that the council, NHS and other local partners can best support reductions in health inequalities going forward.
Scope of the Review: To assess progress against recommendations of the Health Inequalities aspect of the Annual Public Health report. The recommendations from this APHR include: 3.9.1 We need a systematic shift to more person and community centred ways of working across the public sector system to improve health and wellbeing. To do this, we need to: ▪ Consider how community-centred approaches that build on individual and community assets can become an essential part of mainstream strategies and local plans to improve health and wellbeing.

- Work with a wide range of statutory and community partners to develop an asset-based community development approach, which involves mapping local community assets as well as needs as part of the joint strategic needs assessment (JSNA) process.

- Value, harness and support the role of people and communities in their health and wellbeing, including through co-production, volunteering and social movements for health.

- Ensure that accessible, inclusive and meaningful resident and service user engagement and involvement is embedded at all levels across the system.

- Enable health and care professionals and the wider workforce to understand and work in person- and community-centred ways, including a focus on kindness.

3.9.2 We need to determine how we invest and use resources to reduce health inequalities across the system. To do this, we need to:

- Agree how resources are coordinated and used in a systematic way to address strategic goals for reducing health inequalities.

- Think differently about resource decisions which are designed to prevent problems and promote good health and wellbeing, compared with decisions which are primarily about efficiencies in how services are delivered and the delivery of shorter term savings.

- As we increasingly shift to a system focused on outcomes, we need to ensure those people or communities experiencing inequalities are not left further behind by focusing on 'population averages'. Outcomes need to be 'levelled up' across the population.

3.9.3 We need a continued and concerted focus on ethnic inequalities, and given the findings from our kindness survey, on improving experience and outcomes for people living with a disability. To do this, we need to:

- Improve data recording, collection, analysis and reporting across the whole health and care system for ethnicity and disability.

- Meaningful use of detailed Equality Impact Assessments (EIA) that are well thought through, robust, and collaborative before service and system level changes are made.

- Increase health literacy of key community and faith leaders in order to promote health and wellbeing including signposting to key services within the system.

- Engage and involve BAME communities in the planning, development and implementation of interventions and services.

- Education and training for the workforce on diversity, cultural competency, unconscious bias and conscious inclusion.

3.9.4 We need to capitalise on the opportunities we have as anchor organisations and embed social value across the system to achieve our goals for prevention, early intervention and resilience. To do this, we need to:

- Use our social value leavers to address factors that contribute to health inequalities and reach those communities and groups experiencing significant inequalities.

- Capitalise on public sector organisations as employers, to improve health and wellbeing, with a focus on lower paid staff, many of whom live locally.

- Scale and sustain action across 'anchor organisations' locally to deliver change over the medium and longer-term.

The recommendations included in this APHR should be considered in combination with those outlined in a recently published report from Public Health England, which aimed to understand the extent that ethnicity impacts upon COVID-19 risk and outcomes[1]. Recommendations in the PHE report largely align with, and bolster, those outlined in this APHR, signalling where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities.

Additional Information:

- Session one – themed Scrutiny meeting on subject of mental health and wellbeing – including social connectedness and isolation
- Session two – an overview of health inequalities in the borough; including the direct and indirect COVID impact

- Sessions three/four/five (timetabled to availability of speakers)
- Whittington Health
- People with disabilities, inequalities and Covid
- Diabetes and health inequalities – prevention, help-seeking and care management

In carrying out the review the committee will consider equalities implications and resident impacts identified by witnesses. The Executive is required to have due regard to these, and any other relevant implications, when responding to the review recommendations.

Programme	
Key output:	To be submitted to Committee on:
1. Scrutiny Initiation Document	Agreed sign-off via Chair's Action – to circulate ahead of, or for, the October committee
2. Draft Recommendations	It was agreed that an interim set of recommendations from the first three committee meetings on inequalities would be considered in February; the March meeting would receive an update
3. Final Report	The Scrutiny Ctte will need to finalise recommendations from the final session in order to complete the report to the available time.

Health inequalities and the Impacts of Covid-19

Jonathan O'Sullivan, Acting Director of Public Health
Mahnaz Shaukat, Head of Health and Care Intelligence
October 2021

Content of report

This report is intended to provide an overview of health and health inequalities across the borough, as they existed in the period before Covid and since the impact of Covid. It draws together a mix of local analysis with national analysis and evidence.

The report begins with a brief overview of health inequalities, and the factors that shape them, together with a population overview.

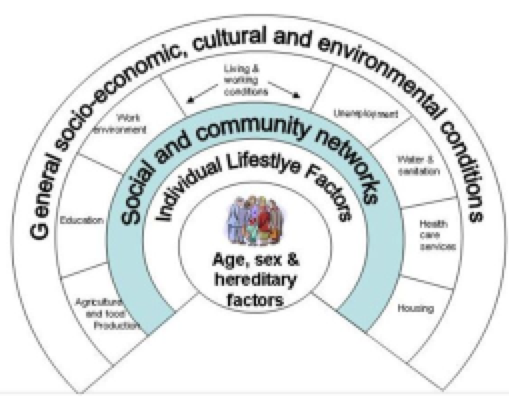
It then moves on to review the direct impacts of Covid on the population, including local reviews of admissions and deaths, national findings on the impacts on health inequalities between different groups, and local estimates of persistent long Covid.

The report next considers health and health inequalities along the life course (organised by Start Well, Live Well (adults of working age) and Age Well (older adults), and what is currently known about (or are areas of concern arising from) the indirect impacts of Covid, as well as a summary of resident engagement on the wider impacts of Covid after the first wave. This engagement survey is currently being repeated, which will give a longer term perspective on the impacts after the second and this current third wave of Covid infections.

Finally, the report briefly considers population health management, which is a data and insight-led approach using real time data to identify and address inequalities in access, care and outcomes.

1. Background: population, deprivation and health inequalities in Islington

Context: health inequalities

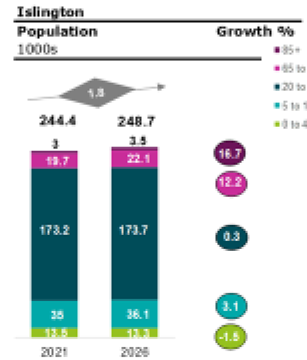


- Health inequalities are largely due to the unfair and unjust inequalities in society in which people are born, live, work and age. These inequalities are structural (a consequence of the social and economic organisation of society) and avoidable.
- Inequalities are driven by a high level of deprivation among some communities, affecting all aspects of people's lives from their childhood, education, employment, income, housing and neighbourhood. These factors drive inequalities in physical and mental health, reducing an individual's ability to stay well and healthy, prevent sickness, or to take action and access early help or treatment when ill health occurs.
- Poverty is a key determinant of poor outcomes in health and wellbeing and is linked to a higher level of risk behaviours and fewer protective factors for health, increased risk of early and serious ill health, reduced quality of life and early death.
- International analysis of countries with similar income levels shows that societies with high levels of inequalities have poorer health outcomes across the general community too, compared to countries with lower levels of inequalities
- The COVID-19 pandemic has starkly exposed these structural inequalities: the risk of becoming seriously ill or dying with Covid-19 was much higher among people experiencing deprivation and disadvantage, including significant differences by ethnicity, deprivation, disability and gender.

Context: Population and Expected Growth

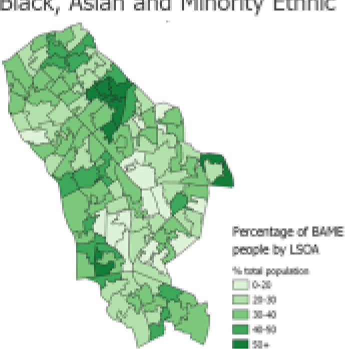
ISLINGTON

- The London borough of Islington has an estimated population of about 244,400 people. Pre-Covid was expected to increase by approximately 2% by 2026, with the largest percentage growth expected amongst the older population (65 and over).
- The population is relatively young compared with the national average, with a notably larger young adult population of those aged 20-39.
- Islington is one of the most ethnically diverse places in the country. Approximately 33% of Islington residents are from Black, Asian, or other minority ethnic communities, with the largest groups being 'Other White' and Black African and Black Caribbean groups.
- There is a lot of uncertainty about the current size of the population. Historically there has been a lot of migration, nationally and internationally. These may have been significantly affected by the impacts of Covid-19, Brexit and benefit changes, among other factors. The 2021 Census will provide some assessment of this impact.



Source: GLA housing-led estimates 2016

Black, Asian and Minority Ethnic



GLA, Housing-led population projections, 2016

Deprivation

ISLINGTON

- The level of deprivation in an area can be used to identify those communities who may be in greatest need of services. The Index of Multiple Deprivation (IMD) is a measure of the level of deprivation. Deprivation scores are ranked nationally from most deprived to the least deprived areas.
- In 2019, Islington was the 6th most deprived London borough, and the 53rd most deprived in England. Deprivation is strongly concentrated into children and families and older people in Islington, who have among the highest deprivation levels in the country.
- The geographic pattern of deprivation in Islington is very different from many other areas. Whereas many boroughs have clear distinctions between poorer and more affluent wards, Islington's mix of housing means that deprivation is very disseminated across the borough and is strongly concentrated into social housing estates in Islington.

Figure 1. Map of social housing estates in Islington

Figure 2. Index of multiple deprivation 2019, national quintiles

Index of Multiple Deprivation, 2019

Inequalities in Life Expectancy

- Islington residents experience lower life expectancy, and women lower healthy life expectancy, compared to London, but are similar to national averages.
- Inequality in life expectancy (the difference between the least and most deprived areas within Islington is 9.8 years for men (compared to 7.2 in London and 9.4 in England) and 5.1 for females (similar to London and lower than England).
- Inequality in life expectancy in Islington has widened, and improvements in life expectancy slowed, since the middle of the last decade. This trend has been seen in other deprived areas nationally and in London, and represents a marked break in the post-war trend of improving life expectancy.
- Main underlying causes of early death in Islington are cardiovascular disease, cancer and respiratory diseases, with those living in the most deprived communities in Islington having a 80% higher death rate from avoidable causes of death compared to the NCL average. For cardiovascular disease, there are clear ethnic inequalities with Black communities more likely to die prematurely from preventable (e.g. smoking) or treatable (e.g. atrial fibrillation detection) causes.

Those living with serious mental health illnesses and learning disabilities also experience large inequalities, as do the homeless. For example, the premature mortality rate for those with serious mental illness in Islington is three times higher than the rest of the population.

Life expectancy and healthy life expectancy

	England	London	Islington	Trend for Islington*
Life expectancy at birth: Male	80	81	80	↑ (2013)
Inequality in life expectancy: Male	9.4	7.2	9.8	↑
Life expectancy at birth: Female	83	85	83	↑ (2013)
Inequality in life expectancy: Female	7.6	5.1	5.1	↑
Healthy life expectancy at birth - Male	63	64	63	→ (2013)
Healthy life expectancy at birth - Female	64	64	62	→ (2013)

Significantly BETTER than London average | Significantly WORSE than London average

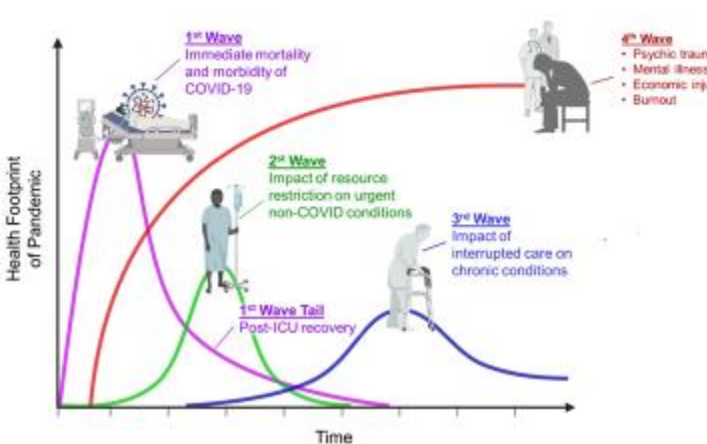
Public Health England, Overarching indicators, Life expectancy (2017-2019) and healthy life expectancy (2016-2018)

*Trend for Islington based on change of indicator in last 10 years or nearest baseline year provided

Significantly worsened ↓ ↑
No significant change →
Significantly improved ↓ ↑

2 How Covid-19 directly and indirectly impacts health and health inequalities

Health impacts of Covid-19 Projected health impacts of Covid-19



- The impacts of Covid relate to the immediate and direct impacts of Covid-19, and the longer term consequences which extend well beyond.
- Covid-19 has exacerbated existing health inequalities and directly disproportionately impacted:
  - Men
  - Black, Asian and Minority Ethnic communities
  - Most deprived communities
  - People living in care homes
  - Those with learning disabilities
  - Those living with a mental health condition
  - People with underlying health conditions and physical disabilities

3 Direct impacts of Covid-19 and health inequalities in Islington

Deaths

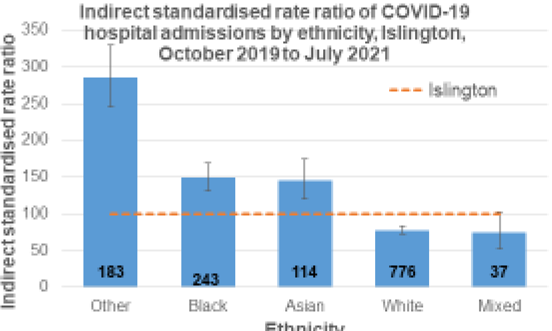
Admissions

Inequalities

Long Covid

Hospital admissions

- There had been a total of 1,627 COVID-19 admissions among residents up to July 2021.
- The highest rate of hospital admissions in Islington was for people of Other ethnic groups, which is 2.85 times higher than the average in Islington. It is also higher than the rate in any other ethnic group. This may be due to how hospitals have coded ethnicity, compared to nationally derived local population estimates.
- The Black population and Asian population also have a higher rate of COVID-19 admissions compared to the Islington average, whilst those from a White group or mixed had a lower or similar rate of COVID-19 admissions compared to the Islington average.
- The rate of hospital admissions for males was higher compared with females in Islington, although the rate was not significantly different from the Islington average.
- Residents aged 55 and over had higher rates of COVID-19 admissions compared to the Islington average, which is similar to national patterns of increasing risks with older age.

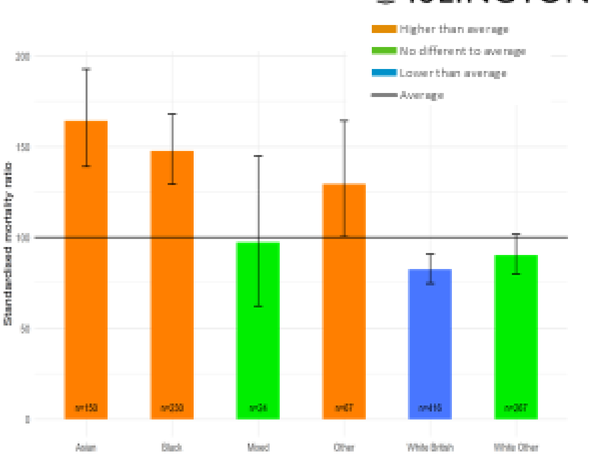


Note: Those with unknown ethnicity have been excluded from the analysis (17%). Number indicates the number of admissions by ethnic group.
Source: CSU data warehouse, September 2021

COVID-19 impacts: mortality

ISLINGTON

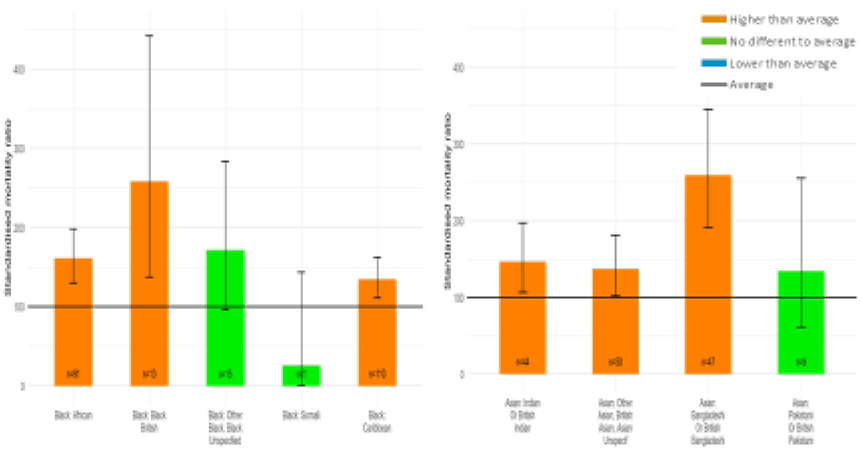
- The cumulative overall death rate in Islington, for deaths that occurred up to 15th of October is 161.3 rate (391 deaths with COVID-19 mentioned), this compares with 228.9 for London and 251.4 for England.
- There have been two major waves of Covid-19 deaths. The first wave from March 2020 to August 2020 caused 155 deaths (death rate 63.9 per 100,000) in Islington, compared to 96.2 in London and 89 per 100,000 in London and . The second wave from September 2020 to April 2021 caused an addition 211 COVID-18 deaths (87 per 100,000) London 119.6 per 100,000 and England 146.1.
- Ethnicity is not recorded on death certificates. However, by linking deaths data to local data from GP's and hospitals an ethnicity can be derived. Using this methodology an analysis of deaths from COVID-19 for the period 1st of January 2020 to 11th of August 2021 shows that people from the Black and Asian ethnic groups are more likely to have died from COVID-19 than average. (NB: Due to small numbers data for Camden, Islington and Haringey was combined for the local mortality analysis.)
- People from the White British group were less likely to have died from COVID-19 than the average.



Source: 01-Jan-2020 to 11-Aug-2021 ONS Mortality data linked to NHS GP/SUS data for ethnicity. Population data from registered GP patients.

Deaths recorded between 01 Jan 2020– 11 Aug 2021 for Camden, Haringey and Islington

Standardised mortality ratio (ISRx100) for **COVID-19** deaths for Black and Asian ethnic subgroups



- Breaking down the Black and Asian ethnicity groups into subgroups shows that Black African, Caribbean, British and Asian Indian/Other or Bangladeshi were more likely to have died from COVID-19 than average.

Deaths recorded between 01 Jan – 11 Aug 2021 for Camden, Haringey and Islington

Disparity in risks and outcomes in COVID-19

Professor Kevin Fenton led Public Health England's national review of key inequalities impacts after the first wave of infections, which found multiple impacts especially linked to age, ethnicity and deprivation. As further analyses have been carried out and through the second wave, these findings have been re-enforced, as well as insight into the inequalities impacts on people with disabilities, pregnancy women and their babies and occupational groups.

Category	Public Health England National Findings[1]
Gender	Men are disproportionately affected by COVID-19. Despite making up 46% of diagnosed cases, men make up almost 60% of deaths from COVID-19 and 70% of admissions to intensive care units. Overall, age-standardised mortality rates were 74 per 100,000 males and 34 per 100,000 females. A very similar ratio of admissions has been seen in Islington.
Age	Rates of COVID-19 diagnoses increased with age. However, the majority of patients in critical care are aged 50-70. In terms of survival, those aged 80+ were 70-times more likely to die from COVID-19 than those under 40, following adjustment for demographic variables. Across all age groups, males had higher death rates than females, however, the differences decreased as age increased. A similar increase in risk was observed locally.
Ethnicity	Age-standardised diagnosis rates of COVID-19 per 100,000 were highest in those of Other ethnicity (1,076 in females and 1,101 in males), followed by Black ethnicity (486 in females and 649 in males) and lowest in those of White ethnicity (220 in females and 224 in males). Disparity in death rates per 100,000 also existed, with those of Other (234 in females and 427 in males) Black (119 in females and 257 in males) and Asian (78 in females and 163 in males) ethnicity more likely to die from COVID-19 than those of White Ethnicity (36 in females and 70 in males). A similar position was seen in Islington during the first wave; in the second wave, rates among Asian communities as a whole was higher than among the Black communities.

Long Covid

- Post Covid Syndrome (PCS) is a term used to describe the signs and symptoms caused by Covid-19 infection that persist **beyond 12 weeks**.
- A very **wide range of symptoms and syndromes** are reported including fatigue, breathlessness, aches, sleep disturbance, cognitive impacts
- An estimated **1.15%** of the London population report symptoms of Long Covid (which would equate to **2,788 people in Islington**) (ONS, Aug 2021)
- Of those with confirmed Covid-19, an estimated **7.5%** experience Long Covid symptoms that have a **significant impact on their daily life**
- **Diagnosis rates** of Long Covid in Islington are far lower than this, which suggests that many people may be unaware of sources of support

4 Pre-Covid health and inequalities in Islington and Covid impacts

The Fairer Together Partnership is organised along the life course, with three age groupings. Health outcomes, inequalities and indirect Covid-19 impacts are considered under the headings of:

Start Well

Live Well

Age Well

Findings from the resident engagement survey, carried out over the summer of 2020, are summarised around the wider impacts of Covid.

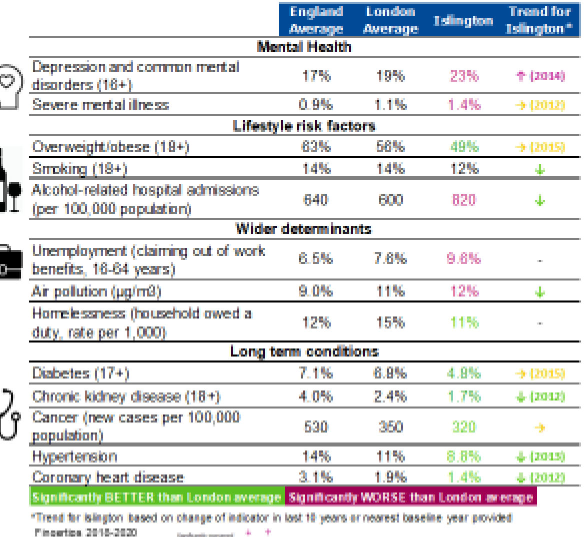
Impact of COVID19 on Start Well

Maternal, antenatal and early years (0-5)	• Changes in availability and support in pregnancy and for new parents • Concerns about potential changes in unplanned pregnancy rates • Risks of reduced access to routine immunisations leading to potential future outbreaks • Impacts on early socialisation and development • Impacts on parental employment and income
School-aged children (5-16)	• Concerns around educational attainment gap due to school closures • Differential home schooling provision, environment and equipment • Changes (reductions?) in physical activity and diet for children – child obesity was already high in London and links with deprivation • Family financial circumstances, poor housing and food insecurity impacts on children
Transition to adulthood	• Disruption to education and exams, along with financial constraints, may limit future opportunities • If there is an economic recession, likely to have a disproportionate impact on young people's employment • Young adults have been more likely to lose jobs, be furloughed, and work in a sector forced to close than other age groups. They are less likely to be able to work from home. • Scarring impacts of early unemployment and debt on health over the life course
Safeguarding and mental health	• Fewer opportunities to identify and monitor safeguarding concerns, and reduced access to support for children and families • Evidence that child maltreatment and domestic abuse increase during periods of economic recession • Multiple stressors impacting mental health of children and young people, including changes to or lack of routine, increased isolation, uncertain future, stress and anxiety and bereavement

Source: The wider impacts of COVID19 and recovery of population health in London. PHE. ADPH. Mayor of London

Live Well

- Islington has one of the highest prevalence of common mental health illness and serious mental illness in London. The Covid-19 pandemic has had an adverse impact on some people's mental health, so mental health needs in Islington are predicted to increase.
- Smoking, alcohol and obesity are major risk factors for early death. Smoking rates and alcohol admissions are higher in Islington compared to London and England average, although both have reduced over time.
- In Islington there are about 11,500 people living with diabetes, 3,800 with heart disease and approximately 4,000 with serious respiratory disease (COPD).
- The wider determinants of health are critical for health and wellbeing too. Islington has significantly higher proportion of residents claiming out of work benefits compared to London and England.
- Air pollution levels are improving but remain higher in Islington compared to England.



Live Well indicators ISLINGTON

	England Average	London Average	Islington	Trend for Islington*
Mental Health				
Depression and common mental disorders (16+)	17%	19%	23%	↑ (2014)
Severe mental illness	0.9%	1.1%	1.4%	→ (2012)
Lifestyle risk factors				
Overweight/obese (18+)	63%	56%	49%	→ (2015)
Smoking (18+)	14%	14%	12%	↓
Alcohol-related hospital admissions (per 100,000 population)	640	600	820	↓
Wider determinants				
Unemployment (claiming out of work benefits, 16-64 years)	6.5%	7.6%	9.6%	-
Air pollution (µg/m3)	9.0%	11%	12%	↓
Homelessness (household owed a duty, rate per 1,000)	12%	15%	11%	-
Long term conditions				
Diabetes (17+)	7.1%	6.8%	4.8%	→ (2015)
Chronic kidney disease (18+)	4.0%	2.4%	1.7%	↓ (2012)
Cancer (new cases per 100,000 population)	530	350	320	→
Hypertension	14%	11%	8.8%	↓ (2013)
Coronary heart disease	3.1%	1.9%	1.4%	↓ (2012)

Significantly BETTER than London average | Significantly WORSE than London average

*Trend for Islington based on change of indicator in last 10 years or nearest baseline year provided
Fingertips 2018-2020

Age well

- Islington has the 4th highest levels of income deprivation affecting older people in London. 34% of residents over the age of 60 were facing income deprivation, compared to a London average of 22%.
- NHS screening programmes help to prevent early death. Islington has a low uptake of bowel cancer screening and aortic aneurysm compared to London and England.
- A lower proportion of older people live alone in Islington although the trend is increasing and with increased risk of social isolation.
- Levels of dementia are higher than the London average in Islington, with around one in twenty older people diagnosed. This is primarily due to much higher levels of early diagnosis through the local memory assessment service, rather than to population differences.
- Moderate or severe frailty prevalence is high in Islington with Islington also having relatively higher rates of alcohol admissions among older people.

Age Well indicators

	England Average	London Average	Islington	Trend for Islington*
Healthy lifestyle				
Health-related quality of life (65+, 0 to 1 score)	0.74	0.73	0.69	→
Abdominal aortic aneurysm screening	76%	63%	59%	↓ [2013]
Bowel cancer screening	64%	56%	53%	↑ [2015]
Lifestyle risk factors				
Alcohol-related conditions admissions (65+, per 100,000 population)	1050	1040	1450	→
Wider determinants				
Older people in poverty (60+, IDAOPI)	14%	NA~	34%	→ [2015]
Fuel poverty (65+)	10%	11%	11%	→ [2015]
Older people living alone (65+)	12%	10%	8.1%	-
Ageing				
Dementia (65+)	4.0%	4.2%	4.8%	↓ [2017]
Moderate or severe frailty (eFI classification)^	NA	NA	31%	↑ [2018]

Significantly BETTER than London average | Significantly WORSE than London average

Fingertips 2018-2020

GP records, individuals registered with GP on eFI frailty classification, Snapshot of records 14th August, 2021

~London average not available, values compared to England average

^Healtheintent data not available for England or London

*Trend for Islington based on change of indicator in last 10 years or nearest baseline year provided

Impact of COVID19 on Live well and Age well: 1. Risk and protective factors

Physical activity	• Activity limited by lockdown, working from home and school closures • Change in levels and type of physical activity • Possible increase in sedentary behaviour • Opportunity presented by policy encouraging and facilitating active travel, e.g. TfL Streetspace
Healthy eating	• Evidence of change in dietary behaviours • Psychological impacts of lockdown impact food choices • Rising food insecurity and use of food banks • Challenges around measuring changes to physical activity and diet, and obesity levels
Smoking	• Mixed evidence of trend in smoking behaviour during lockdown, early signs of reduction but later reports of increased smoking among 18-24s • Insecure economic circumstances associated with increased smoking and smoking inequalities – as is affordability of cigarettes • Disruption to smoking cessation support services, in particular face to face services • Motivation for smokers to quit due to campaigning around links to COVID-19
Alcohol	• Changes in patterns of alcohol use • Concern around potential increases in problematic drinking – one survey found nearly a fifth of daily drinkers in the UK had further increased the amount they drank during lockdown • Potential drivers for increasing alcohol consumption include changing habits, bereavement, isolation, troubled relationships, job insecurity
Substance misuse	• Changes and disruption to support services during lockdown, though unclear on the extent and impact • Impact on recovery, eg loss of 'recovery capital' social, employment, education/training • Changes in London drug supply and availability • Reports of increased online gang recruitment and activity

Source: The wider impacts of COVID19 and recovery of population health in London. PHE. ADPH. Mayor of London

Impact of COVID19 on Live well and Age well: 2. Physical Health Impacts

Temporary

- **Managing delayed diagnoses of long term conditions** and the deterioration of conditions will be addressed
- **Additional cost** to the health and social care system due to the pandemic should decrease
- **Medical Optimisation approach** (temporary health response to manage demand such as early discharge) will be monitored to ensure it does not become BAU
- The **loss of social connection** may be short lived and could be reversed if built effectively into all age early intervention and prevention services (social connectedness has significant impacts on physical as well as mental health)

Short-medium term

- The short-medium term impacts of **"Long Covid"** (~7.5%)
- **Delayed diagnoses** due to missed appointments resulting in later presentations or worse outcomes for long term conditions such as cancer, diabetes, strokes and dementia
- **Backlog of waiting lists** for surgery and elective care that had to be postponed due to the pandemic
- **Changes in service delivery due to lockdowns:** Increasing use of remote technologies, with both benefits and drawbacks (such as digital exclusion)
- **Disproportionate impact of virus** on:
  - People from Black, Asian and Minority Ethnic communities
  - Carers
  - Older people
  - People living with dementia, with mental health needs and with learning disabilities

Long term

- The long term impacts of **"Long Covid",** currently unknown (some experiencing symptoms >1yr)
- **Service pressures** such as:
  - Unmet needs, late presentations and waiting lists in primary, community and secondary care
  - Greater need for prevention and early intervention due to social isolation
  - Health and social care staffing pressures
  - Risk that other respiratory diseases (e.g. flu) will cause more disruption
- **Inequalities** in health outcomes, as well as inequalities in take up of the vaccine and access to services and information
- **Distrust** and experience of authorities among disadvantaged communities
- **Potential increase in obesity** linked to reduced levels of physical activity and consequent health impacts

Impact of COVID19 on Live well and Age well: 3. Mental Health and Wellbeing

Large national surveys[1] have found **higher numbers of people** experiencing **anxiety and depression** than before the pandemic and people's satisfaction with life is now lower. It is as yet unclear whether these impacts are temporary or lasting.

Local residents' and stakeholders'[2] views paint a similar picture. A large majority (81%) of residents are somewhat or very worried about the impact of Covid-19[3], particularly on **mental health and wellbeing (26%).**

Modelling predicts there may be **28,266 new cases of moderate-severe anxiety** and **38,671 new cases of depression** in adults in the borough (a rise of 16 and 22%)[4]. There may be 12,052 new cases of depression (a rise of 19.5%) in the under-25s[4]; those who were shielding or bereaved are most at risk[4]. The number of people affected by mild illness and reduced wellbeing (the scope of this piece of work) is likely to be higher.

Social isolation is more widespread[2,3] and particularly acute for some people[3] (e.g. people who were shielding, those from LGBT+ communities, or people with learning disabilities who rely on services which have closed). Local residents who live alone are much more likely to experience extreme loneliness[3].

Some people have suffered more from Covid-19's effects on mental health and wellbeing. The wider determinants of health, including but not limited to ethnicity, gender, family and employment status, have an influence. Levels of depression and anxiety are still highest[1] among, for example: **women, young adults, people who live alone or with children or in urban areas**, or are from **Black, Asian and Minority Ethnic (BAME) backgrounds**.

1 UCL Covid-19 Social Study Results Release 25, Nov 2020
2 Stakeholder meetings and stakeholder survey
3 Covid-19 resident engagement, Camden and Islington Public Health team, Oct 2020
4 Centre for Mental Health Forecast Modelling Toolkit. Nov 2020 – results available on request

Covid Resident Engagement 2020: Wider impacts of Covid-19

Engagement findings highlighted social inequalities. The wider impacts of the pandemic, such as employment and education were disproportionately affecting Black, Asian and ethnic minority residents. Other groups such as those with physical/ cognitive/ sensory impairments, carers or those facing multiple disadvantage had been greatly affected.

- Majority of Islington resident survey respondents were somewhat (42%) or very worried (39%) about the pandemic. **Asian, Black and Other ethnic groups** were significantly more worried compared with white ethnicities.
- **Mental health** (47%) was Islington residents' **most common concern** during the pandemic, followed by **physical health** (43%), **fear of contracting the virus** (42%), **health and wellbeing of loved ones** (40%) and **feeling worried about the future** (28%).
- A significantly higher proportion of respondents from **Asian (60%) and Black ethnicities (40%)** chose **"household or personal finances"** as one of the factors that worries them most compared to those from White ethnicities (20%).
- Covid-19 has wide-ranging impacts on residents, **most frequently mentioned impacts** were related to **employment, mental health and wellbeing, relationships and finances**. Free text analysis suggests the impact on **'access to services, information or support'** was twice as high for residents from Black, Asian or other ethnic minority backgrounds (14%) than residents from White backgrounds (6%); and also for concerns over impact on **'children's education'**, which was twice as high for residents from Black, Asian and other ethnic minority backgrounds (10%) than for residents from White backgrounds (5%).
- There have been many acts of kindness across Islington. The levels of community cohesion have been greater since the outbreak. VCS and community organisations play a key role in supporting at-risk residents in the borough. Formal and informal support are equally important.

"Since this pandemic it's been near on impossible to find a job and so financially, that's quite devastating"

"I had a couple of breakdowns, really bad breakdowns, I started crying, I literally locked myself away in a room for six months... I wasn't talking to no-one... I literally just switched off"

5 Population health management

Going Forward: Population health management approach to health inequalities

- The widespread impacts of Covid-19 on population health appears likely to contribute to further inequalities and poorer health outcomes in coming years. The evidence base about the nature and extent of these is still developing.
- Working in partnership with the NHS, a population health management approach to improving wellbeing and reducing health inequalities is being developed across North Central London. The approach identifies inequalities, gaps in care and variations in care, and develops interventions to address the inequalities. This includes a significant development in the use of real time data as part of the HealthEIntent data system that supports services to monitor needs and track improvements in care by population characteristics and area/service/practice/team level. This data and intelligence-led approach is envisaged as a key part of Integrated Care Systems going forward.
- Alongside recovery of planned hospital care, there needs to be a strong focus on recovery of evidence-based preventative interventions that will reduce early deaths, targeted to groups most affected. These disproportionately impacted groups include those living in the most deprived communities and many ethnic groups.
- Mental health recovery is equally important, ranging from more individualised support for people with complex mental health problems through public mental health programmes, including tackling social isolation and anxiety.

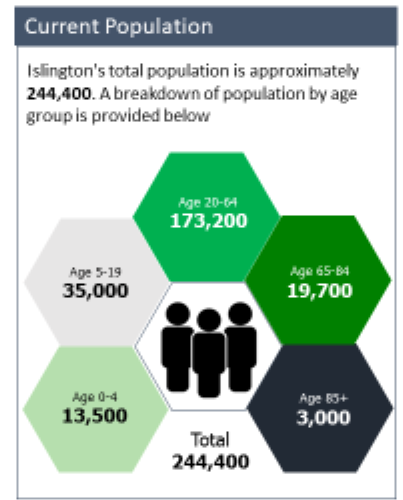
APPENDIX B

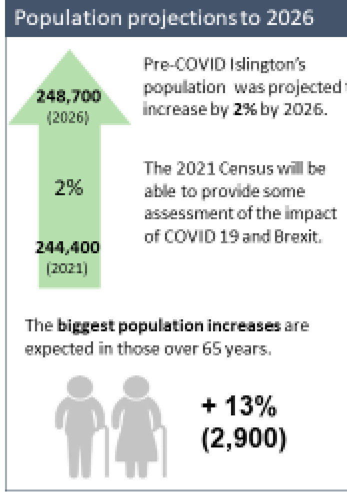
Agenda

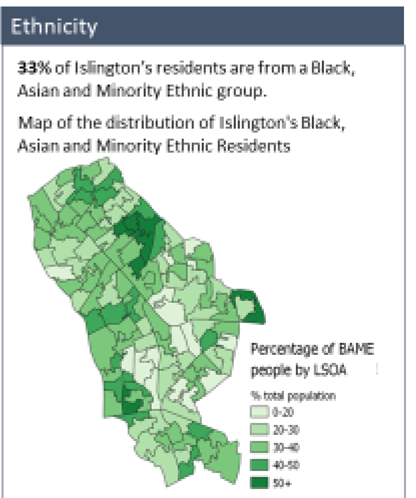
Time	Activity	Lead
18:15-18:30	Arrival and refreshments	All
18:30-18:40	Welcome and introductions	Cllr Nurullah Turan
	The challenge	
18:40-18:50	Scene setting and priorities for Islington	Cllr Kaya Comer Schwartz
18:50-19:05	The picture of inequality in Islington	Mahnaz Shaukat
19:05-19:10	Experiences of inequality in the voluntary and community sector	Navinder Kaur
19:10-19:20	Reflections from the group	Cllr Nurullah Turan
	The mission	
19:20-19:25	Let's Talk Islington and the role of the Inequality Task Force	Linzi Roberts-Egan
19:25-19:30	Unlocking community power	Adam Lent and Nicola Steuer
	Working together	
19:30-19:40	Shared values and next steps	Amy Buxton-Jennings
19:40-19:55	Reflections from the group	Cllr Nurullah Turan
19:55-20:00	Closing words	Cllr Nurullah Turan

Inequality in Islington

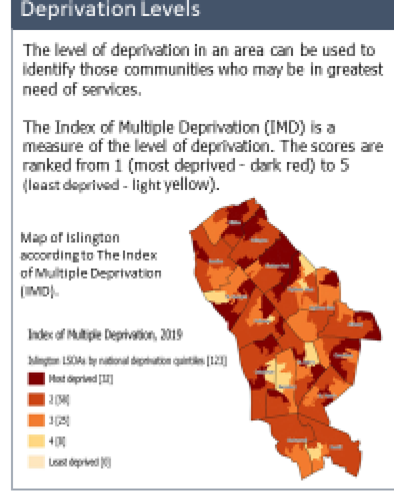
Projected five year population growth



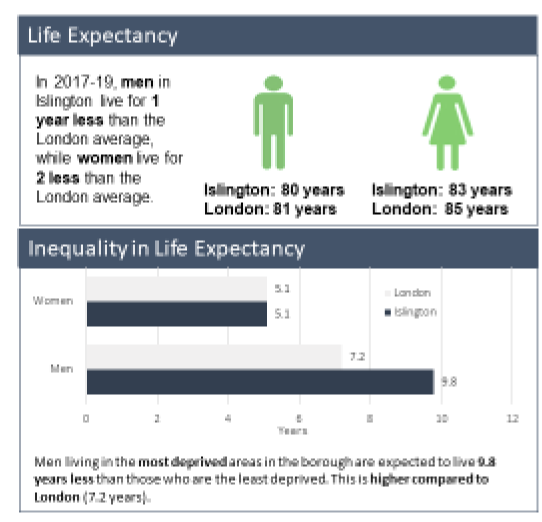


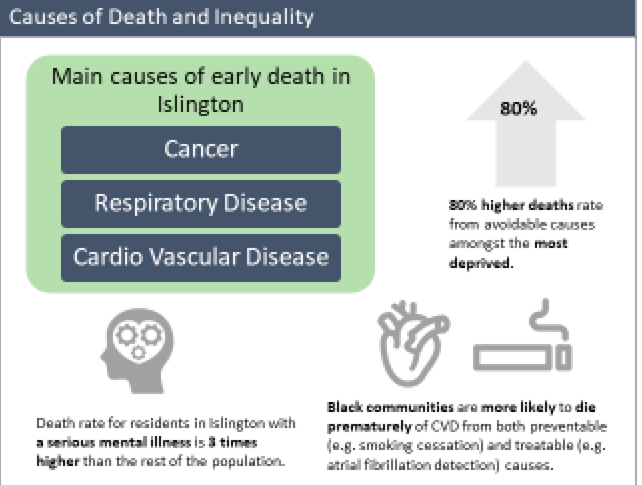


Deprivation



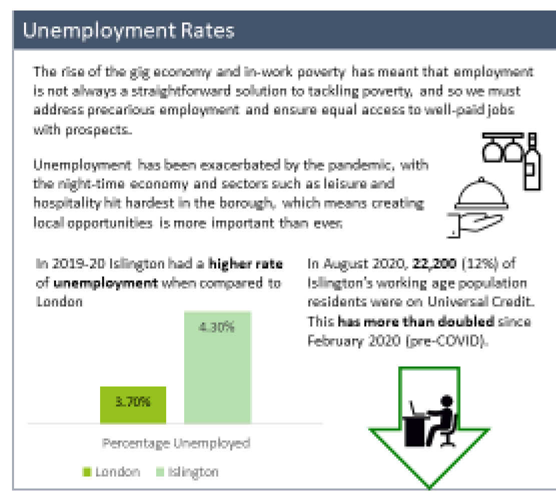
Inequalities in life expectancy

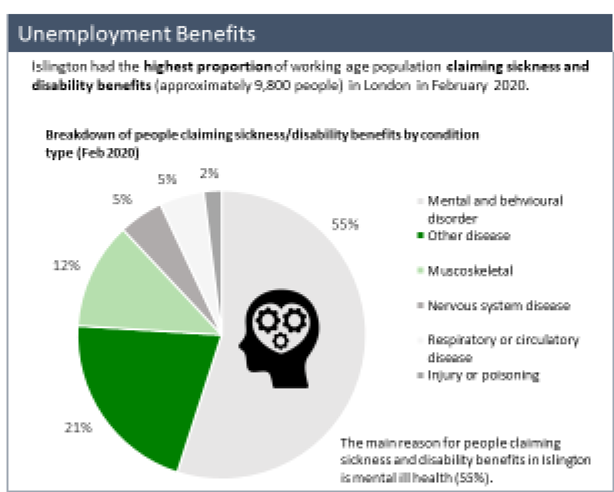




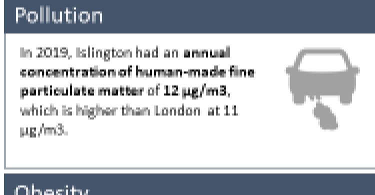
Strategic priorities

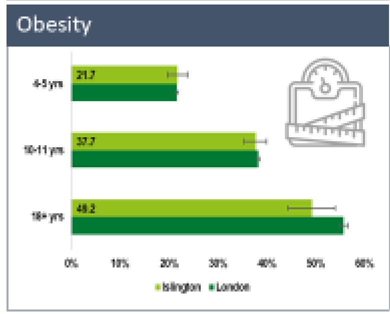
Investing in local jobs and businesses





Cleaner, greener, healthier





LTC and MH prevalence

Long-term condition	Percentage	Number of people
Hypertension	10%	23,577
Serious Mental Illness	10%	24,149
Diabetes	5%	11,385
CKD Stage 3,4,5	2%	4,460
COPD	2%	4003
Cancer	2%	5,819
Stroke/TIA	1%	1,362

The climate emergency threatens to exacerbate even further the extreme health inequalities exposed by COVID-19. But addressing the climate emergency also provides answers to addressing health inequalities - **mental and physical health, plus life expectancy.**

Standing with our communities

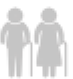
Community

The experience of the last year has shown us the power of communities in coming together to look out for each other.

We want Islington to be a place made up of strong communities, where regardless of background, people feel safe, connected and have the resources they need to make change in their local areas

Fuel poverty and deprivation

11% of Islington households experience fuel poverty.

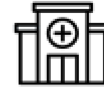


34% Adults aged 60 or over living in income-deprived households. This is more than double the England average (14%).

Violence

In been 2020/21, Islington had **24.2 violent offences per 1,000 population.** This is **significantly lower than Englai** of 29.5 per 1,000.

However **Hospital admissions** for violence (including sexual violence) were **higher in Islington than in London.**

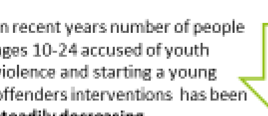


Sexual offence rate per 100,000 **is lower in Islington** (1.6) than in England (2.3).

Youth Violence

Of the 100 people accused of youth violence in 2019, **89% were men.**

51% of people enrolled in the youth offending service were Not in Education, Employi or Training (NEET).



In recent years number of people ages 10-24 accused of youth violence and starting a young offenders interventions has been **steadily decreasing**

103 ambulance call outs occurred for youth violence in Jan-Sep 2019

Nurturing our children and young people

Children in low-income households

Young people in Islington as a group are **more likely** to live in deprivation than the rest of the population.

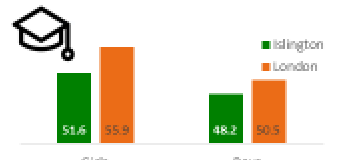
28% of children aged under 16 lived in **income deprived families** this is the highest percentage in London and the 10th highest in England.

Within Islington, **Canonbury** had the **highest proportion** of under 16s living in income deprived families (33%).

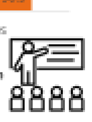
GSCE Attainment

We know that early life experiences have a **significant effect on future life chances** and we also know from studies that interventions have the greatest effect in the early years.

Average attainment 8 Score for both girls and boys living in **Islington is lower** than the London average.



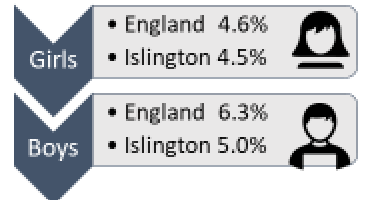
We will be relentless in our goal to become an exclusion-free borough an eliminate disparities in educational achievement.



NEET

'NEET' is used to describe young people who are not in employment, education or training. Evidence shows that time spent NEET can have a significant detrimental effect on long-term outcomes and physical and mental health

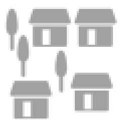
The percentage of boys and girls in Islington categorised at NEET in 2021 was **lower than the London average.**



Making sure everyone has a place to call home

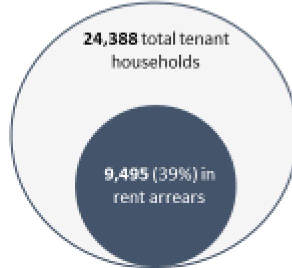
Homelessness and housing

1,600 homelessness applications are received every year. We believe that nobody should ever be without a decent roof over their heads and we will also work to eliminate rough sleeping and support people experiencing homelessness.



120,000 properties are in the borough, private rented and owner-occupied properties each account for about 35,500 properties. Socially rented properties make up 35% of the borough - 25,400 are rented out by the Council, and 16,500 are rented out by Housing Associations.

Rent Arrears



The total rent arrears were **£8,684,666.69.**

£914.66 is the average arrears for those in arrears (£356.10 is the average when considering all households)

On average in Islington, **rent accounts for about 70% of gross earnings.** We are in the midst of a severe housing crisis and the need to secure genuinely affordable homes for our residents has never been greater.