North Central London
Health and Care
Integrated Care System

NHS

Inequalities Fund

2025-2026

An overview of the programme, achievements and future development

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Inequalities Fund - outline

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- Context
- Inequalities Fund Programme Overview
- Outcomes Framework and Thematic Review
- Economic Evaluation
- Learning and next steps
- Appendix: Project highlights and list of projects

Context

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- Addressing health inequalities is a key ambition of **The Fit for the future: 10 Year HealthPlan for England** through a stronger focus on **prevention** and shifting care and resource into the **community**, particularly targeting socio-economically disadvantaged areas

- The **Inequalities Fund** is £5m per year investment to fund innovative partnerships that address the root causes of health inequalities, focusing on prevention, early help and wider determinants of health by working alongside communities through a co-production approach

- NCL ICB is also leading on the development of **neighbourhoods** to deliver a more preventative model of care through cross-sector partnerships that are rooted in communities, supported by pooled budgets

- The Inequalities Fund represents a pioneering approach to **improve health outcomes** through community-based partnership models that will support **neighbourhoods** and strengthen our focus on prevention

Funding allocation
Indices of Multiple Deprivation 2019

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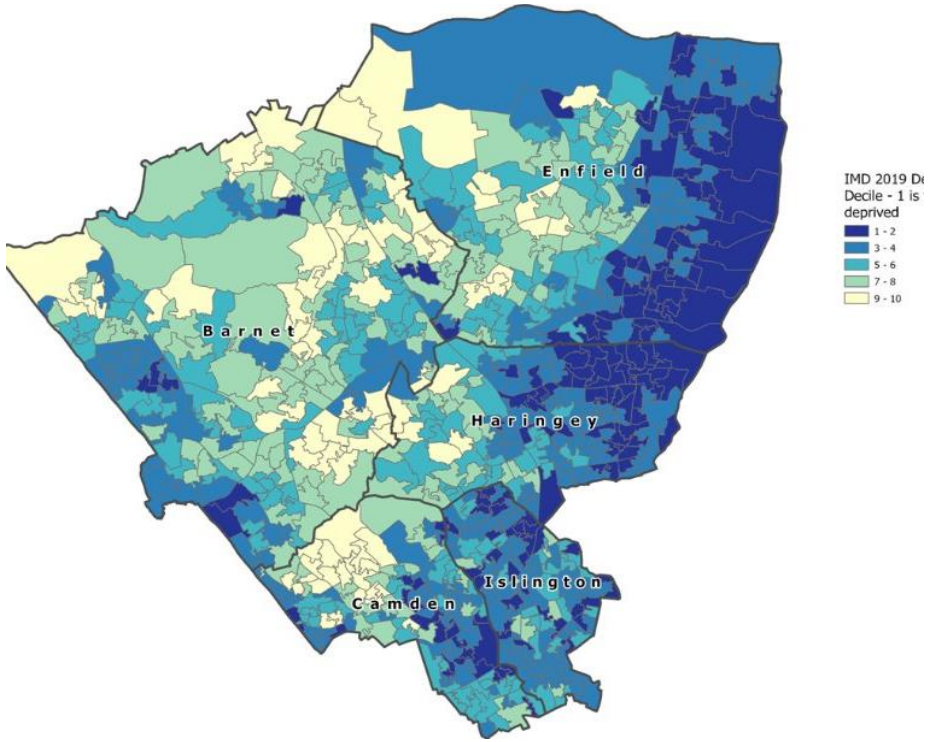
Funding was allocated into two ways:

1. **75% of funding is allocated to individual Boroughs**
   - Funding distribution based on relative number of Borough NCL residents living in England's Indices of Multiple Deprivation 2019 20% most deprived wards
   - Two-thirds of NCL's population in the 20% most deprived IMD2019 areas live in Haringey or Enfield, hence two-thirds of the funding is targeted at these Boroughs
   - Smaller allocations for Camden and Islington and no allocation to Barnet (with no wards in the IMD2019 20% most deprived areas)
2. **25% funding is retained in an 'NCL pool' to fund:**
   - Projects to support non-geographical inequalities and disadvantaged and under-served groups in NCL
   - Projects in Barnet – to recognise 'pockets' of the population in IMD2025 deprivation within specific wards in the Borough that needed some resource

Deprivation profile of NCL, by lower super output area



Source: Index of Multiple Deprivation (IMD_ 2019

Funding allocation
Indices of Multiple Deprivation 2025

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Implications of Moving from IMD2019 to IMD2025

- National IMD analysis recently update from 2019 to 2025, with slightly changed methodology
- Implications of IMD2025 for NCL & Programme the ICB & partners are exploring:
  - NCL became relatively more deprived v. England – 28% people living in IMD2025 20% most deprived areas nationally v. 21% in IMD2019
  - Relative increase more noticeable in Haringey & Enfield – already most deprived Boroughs - and to an extent in Barnet & Camden
  - Islington only Borough in which % of population living in 20% most deprived areas improved
  - Further factor to consider is people already living in 10% IMD2019 most deprived areas may have become relatively even less affluent in 2025
- ICB working towards reallocate its fixed Programme budget to reflect IMD2025 without destabilising long-standing projects in impacted Borough

Selection of IF schemes: Borough Partnership process

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- Funding is allocated to each Borough based on the proportion of their population living in the 20% most deprived areas.
- Borough Partnerships decide on project investments according to local healthcare inequalities enabling funding to be targeted to hyperlocal communities
- Examples include:
  - Complete Care Communities project targeting Somali and Bengali communities in Camden and the RISE project supporting the Somali community in Haringey
  - Improved management of diabetes and heart failure in east Enfield and Haringey
  - Targeted prevention and lifestyle change support for Healthy Heart among South Asian and Black communities in Barnet
  - Outreach cancer screening and targeted support to improve childhood immunization in Islington
- Borough Partnerships review each project annually to decide on future commissioning, to continue, stop or recommend changes for the project

Inequalities Fund 2025-26 Summary

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- **45** Inequalities Fund projects were delivered with many continuing from the previous year achieving greater impact (more people supported, improved models)
- Over 20,000 people supported across all the projects. 75% of project objectives were met
- Range of providers and partnerships including VCSE, Trusts and Primary Care; some match-funded through other sources
- Majority are focussed on wider determinants, prevention and early identification, targeting communities at highest risk
- There was evidence of extensive engagement, service-user feedback and co-production to develop and deliver the projects
- Wide range of data has been collected to demonstrate impact e.g. clinical markers, patient feedback, self-reported outcomes such as behaviour change, extent of unmet need identified, improvement in wider determinants of health (educational achievement)
- The following slides describe the multi-dimensional evaluation:
  1. Outcomes Framework
  2. Thematic review
  3. Economic evaluation
  4. Project highlights

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Population Health Outcomes Framework

Population Health Outcomes

North Central London

Vision

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities & the gap in healthy life expectancy

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and newborn screening coverage
- All children are supported to have good speech, language and communication skills
- Children have improved oral health

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Improved physical health in people with serious mental health conditions
- Reduced racial and social inequalities in mental health outcomes
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity
- Improved air quality
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

- Reduced unemployment and increase in people working in fulfilling employment
- People live in stable and healthy accommodation and are safer within the communities in which they live

Age well

People live as healthy, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier intervention and improved care for people with dementia

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

Population Health Outcomes and Inequalities Fund

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Start Well	
Increased immunisation	**Childhood immunisations Islington** • Partnership across VCS and primary care. Targeted approach to improve childhood immunisations (joint project across Healthwatch and primary care) • 384 parent/carers engaged • 29 booked appts (from 275 successful call attempts) out of a target list of 530 children
Early identification and proactive support for mental health conditions	**Mental health, arts and sports project Haringey for young people (Open Door)** • Over 1000 hours of support provided: including: 650 Individual psychotherapy/CBT sessions, • 28 active programs and 80 workshops/trainings, including sport, lunch clubs and holiday camps • 82% self-reported progress in 'prosocial 'behaviour (SDQ) • 71% improved quality of relationships (therapist assessment through talking with young people) • 73% started in moderate-severe depression range, 72% reporting improvement (self-rated clinically validated measure- PHQ9) – which is a marker for successful treatment
Reduced prevalence of children and young people who are overweight or obese	**Childhood weight management, Haringey** • 650 children seen out of a target of 850. • On average children were reported to have made 2 diet changes and 1 exercise change. • On average 50% of children either reduced or maintained BMI

NCL Outcomes Framework
https://nclhealthandcare.org.uk/our-working-areas/population-health/ncl-outcomes-framework/

Population Health Outcomes and Inequalities Fund

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Live Well

Reduced racial and social inequalities in mental health outcomes	**Tottenham Talking Haringey** • 48% of the users were from age 40-65 years and 60% from N15 and N17 post codes. Almost 40% were from global majority communities. • Over 206 participants seen and significantly improved self-reported mental wellbeing outcomes (feeling of usefulness, optimism about the future, social connections). • 37.5% of service users (n=?) surveyed reported that they would have had a crisis or hospital admission if they were not engaging with Tottenham Talking
Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity	**VCS & Primary Care based smoking cessation in Enfield** • Turkish and Romanian speaking staff to target Non-English speaking (168 out of 217), entrenched health beliefs, high risk of obesity • 55 out of 217 who joined programme quit (25%) • 134 out of 286 (46%) patients quit (12 week quit rate)
Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease	**Type 2 diabetes (Enfield and Haringey)** • On average 64% of 258 patients (164) had an improvement in HbA1c (target 60-70%) • 70% improved self-management • Reduced A&E attendance by 18-27% (Jan-Sep 2024)

Population Health Outcomes and Inequalities Fund

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Age Well

People get timely, appropriate and integrated care when they need it and where they need it	**High Intensity Users (Enfield and Haringey)** • 131 individuals with a total of over 2590 A&E attendances since 2022 • A&E attendances for 18 individuals fell by 287 from 2662 to 2375 (11%) over 2 years

People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age	**Enfield Community Hub Outreach**
	• 880 people seen in outreach and social events; providing information, advice and guidance
	• Outreach - 95% of enquiries are related to housing e.g. inadequate housing conditions, evictions, difficulty paying rent
	• Hubs – most queries related to financial assessment followed by housing
	• Events with health services:
	  • 425 people screened for diabetes since August 2023 – 57 people diagnosed as having pre-diabetes
	  • 84 blood pressure checks – 22 of which outside of normal ranges
	  • 10 people spoke to homeless GP outreach service
	  • 20 residents engaged with Cancer screening awareness conversations

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Thematic evaluation

Inequalities Fund Outputs - Themes

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Output themes	Description	Examples and types of metrics
Project 'Reach' into Population	Number of people engaged with project. What % of specific 'targeted population' does projects reach?	• Reach: 20,000+ individuals • % annual reach for project is c. 15+% of targeted groups. but can be higher (examples below).If projects are at this 15% level, likely to have impact at targeted popn level
Community Health checks & screenings	Thousands of community health checks and screenings delivered through the schemes.	• Example – 1,722 enhanced health checks by a health care assistant with enhanced training. (Camden Brondesbury Medical Centre) - % reach c. 13%-15% of target popn. • Example – 425 diabetes screening, 84 blood pressure checks, 20 cancer screening discussion (Enfield Community Hub Outreach) – % reach c. 15% for Community Hub
Training & capacity building	Working with local needs and assets to build capacity in our communities.	• Example – 51 community champions created and trained in mental health first aid (Camden Complete Care Communities). • Example – 45 community champions retained, 12 of which became breastfeeding champions who undertook level 2 BFN peer supporter training (ABC parents).
Mental and physical wellbeing support	Schemes recorded over 16 types of weekly activities across specific under-served communities in NCL	• Example – 296 buddy journeys delivered, with the majority going to access green spaces, shopping or for leisure (hand in hand Islington). • Example – 128 females attended social and physical activities, with scheme working with 350+ individuals (Somali Mental Health) - % annual reach c. 22% of this popn.
Community outreach and engagement	Schemes oversaw multiple pop-up health events and culturally adapted activities.	• Example – Happy Health Halloween event (Healthwatch Islington – Childhood Imms) • Example – 17 Healthy Hearts events totally attendance of 1,361 people and leading to 493 BP checks/lifestyle advice (Healthy Hearts Barnet) - % reach c. 17%

Inequalities Fund Outcomes - Themes

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Outcome themes	Description	Examples and types of metric to consider
Health & Wellbeing improvements	Schemes consistently reported high levels of improvement in physical and mental health.	• Example – Work with 800 young people - 82% self-reported progress in prosocial behaviour & 78% reduction in self-harm, 67% reduction in violence/aggression and 80% reduction in drug/alcohol misuse. (Haringey Arts and Sports) - % reach c. 31%
Reduction in NEL and A&E attendance	A key theme running through the schemes is that of significant reductions in emergency or avoidable attendances.	• Example – 114 'High Intensity Users' of A&E engaged at NMUH, all needing additional support due to multiple disadvantage or complex needs. Reduction of 20% & 50% in future A&E attendances and hospital admissions for participants (Haringey & Enfield High Impact Users) - % reach c. 21%.
Empowerment & self-management	Empowering our communities to feel confident in taking control of their health & wellbeing.	• Example – 27% increase in patients from the most deprived quintile booking appointments digitally and a 14% increase in this group of patients using online Services such as the NHS App. (Camden Brondesbury Medical Centre).
Social connectedness and participation	The schemes oversaw the bringing together of communities to participate in health & wellbeing activities.	• Example – 70% felt more connected to the community and 81% felt more confident making friends since coming to their Tea & Toast initiative. (Enfield Community Hub Outreach).
Staff empowerment and system change	Many schemes reported positive impact on staff through a combination of training and wellbeing opportunities.	• Example – 100% of staff felt fulfilled to see the impact of their intervention to empowering clients. (WHATIF scheme). • Example – Staff felt more empowered by having structured programmes and clear guidelines to address health inequalities. (Targeted community outreach worker).

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Economic evaluation

System Impact of Inequalities Fund Programme in 2025/26

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- Projects were evaluated in Oct-25. The table estimates the IF Programme impact on health and care system in mitigated activity/costs.
- Projects were divided into 2 groups:
  - **Projects focussed on engagement, healthy lifestyles and primary prevention**, where you might expect the impact to be longer-term. However, as many of the projects are well-established (3+ years), we estimated the extent this mitigation was achieved – and to consider the impact on healthcare activity and costs on a 3-5 year basis
  - Projects focussed on projects to **promote screening, earlier diagnosis and improved planned health management** often with the aim of mitigating demand 'downstream', i.e. reducing demand for typically secondary care/mental health activity.

  For example, the proportion of non-elective acute admissions decreased by 25% amongst people 50+ from these deprived areas in 2025 v. 2019. We estimate the IF Programme contributed c. 20% of this decrease.

Estimated Return on Investment Cost Mitigation for Evaluated Projects in 2025/26

Project Type	Neighbourhood Pillar	No. Participants	Annual Costs	Cost Mitigation*	Net ROI Benefit	Type of Activity Mitigated
Earlier Diagnosis / Health Management	Pillar 3 – Health Management	10,460	£2.0m	£3.0m	+£981k	Includes unplanned care and MH activity (3,086 ED attendances, 470 NEL admissions, 547 MH interventions)
Preventative Solutions	Pillars 1-2 – Community Assets and Early Help	8,770	£1.6m	£2.35m	+£732k	Includes planned and unplanned healthcare activity in primary care, community, acute.
All	**Pillars 1-3**	**19,770**	**£3.6m**	**£5.3m**	**+£1.7m**	

The table shows both project types resulted in positive net ROI cost mitigation – £5.3m mitigation v. £3.6m cost (of projects included in 2025/26 evaluation). ***This means £1.47 activity-based cost mitigation for every £1 spent.***

Summary of Evaluation by Borough 2025/26

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	All Projects	Results from Projects Evaluated in Stock-Take				All Projects
Borough	No. Projects	Amount Invested in Evaluated Projects	Est. No. Participants 2025/26	% of Project Objective Met	Est. Cost Mitigation in Healthcare Utilisation	**Borough Summary:** ✓ Different foci of investment in different Borough portfolios ✓ All Boroughs showed net positive cost-benefit analysis ✓ Opportunity for sharing learning into neighbourhood models
Barnet	2 (1 evaluated in stock-take)	£26k	1,200 (but part of wider project)	100%	£57k	One project, Healthy Hearts, is part of a wider project with the Council and VCSE. The second project mobilised part year.
Camden	10 (4)	£237k	2,880	75%	£454k	Four continuing projects and six projects mobilising in year. All addressing a mix of health and social outcomes and targeting vulnerable groups.
Enfield#	11 (10)	£1,147k	10,250	80%	£2,081k	Continuing VCSE and statutory partnership projects tackling empowerment, long term conditions and health determinants.
Haringey#	13 (10)	£1,514	5,840	90%	£1,955k	Continuing partnership projects across statutory services and VCSE focussing on more complex mental and physical health.
Islington	10 (9)	£676k	1,390	78%	£764k	Greater focus on mental health including those focussed on more vulnerable groups. Most are collaboration with mix of statutory and VCSE projects.

- Enfield and Haringey share 2 joint projects cross-border. Est. No. of Participants counted in both Enfield & Haringey rows for these projects, so total number of participants slightly over-estimated. However, split of funding is 50:50 for these projects between the two Boroughs, and est. cost mitigation specific for each Borough

Inequalities Fund and Neighbourhood development

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- Neighbourhood development will be prioritised in areas of high inequalities, which have been the target areas for the Inequalities Fund
- The partnership approach, insight, learning and reach into the communities through the Inequalities Fund provide the foundations for improving health outcomes
- Majority of the projects are aligned to Neighbourhood pillars 1-3 with a few aligned to pillar 4:

  Pillar 1: Creating community assets for health and wellbeing

  Pillar 2: Outreach and early identification

  Pillar 3: Targeted interventions and secondary prevention

  Pillar 4: Prompt action on rising risk

Inequalities Fund – Learning

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What works

- ✓ IF projects **reached deep into communities** that face highest levels of health inequalities e.g. Bengali, Somali, young black men, people experiencing homelessness and **upskilling** them as community champions
- ✓ **Extensive engagement**, co-production, service user feedback which was then incorporated into delivery approaches
- ✓ **Wide ranging partnerships** especially across statutory services and VCSE and across multiple VCSE organisations and across IF projects (outreach events)
- ✓ Most projects employed a **holistic approach** delivering health promotion, group work and individual support for health and **wider determinants of health** matters
- ✓ Continuing projects for a couple of years have enabled them to **improve delivery models**, expand their reach and collect data

What to improve

- **Commissioning and administering the Programme is complex** in context of changing procurement requirements, provider vulnerabilities and partnership arrangements. However, the IF programme has been led by oversight from Borough Partnerships, shaping projects for place-based delivery.
- **Several successful projects have ended – as their approaches were absorbed into 'business as usual' models.** However, more providers could adopt this approach, improving services and making best use of resources. This is a conversation the ICB is having with several more providers into 2026/27.
- **Data and intelligence recording and reporting** as part of evidencing outcomes and impact has improved over the years, the challenge is how we make greater use of qualitative insights alongside quantitative data to understand benefits. Attribution is complex, particularly for prevention-type interventions, which take longer to materialise. Variety of project types (from increasing participation to improving access and early identification) make evaluation and analysis complex.
- Cost mitigation is considered in this analysis; but one issue is extent to which **'shift left' Return on Investment approaches cashable –** resolving this will be key to progressing 'shift left' and improving sustainability.

Inequalities Fund – next steps

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Over the next year, we will align the Inequalities Fund programme with West and North London ICB's strategic priorities:

- Strengthen **neighbourhoods** by linking place-based Inequalities Fund projects with the emerging borough models and closer working with borough Integrators; majority of projects focus on prevention, early identification and targeted intervention. The deep knowledge of the communities and connections provide a strong basis for proactive population health management at place.
- Focus on **improving outcomes** for key groups: adults with serious mental illness, integrated care for children and young people, people approaching end of life through specific Inequalities Fund projects and by embedding the learning from these into our wider services.
- Target investment towards areas newly identified as highly deprived as per **IMD 2025** with insight from Borough Partnerships (next slide) to improve equity across boroughs.
- Streamline **commissioning arrangements** in partnership with VCSE partners and statutory organisations building on current models, such as lead provider and provider partnership arrangements.
- Embed a **robust data collection and evaluation** approach to help demonstrate the impact of the programme and inform wider commissioning.

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Appendix: Project highlights

1. Healthy Heart, Barnet
2. Complete Care Communities, Camden
3. Health Heroes Unite, Enfield
4. #What If, Enfield
5. Community Diabetes, Haringey
6. Young Black Men and Mental Health, Islington
7. Learning Disability health checks

Healthy Heart, Barnet

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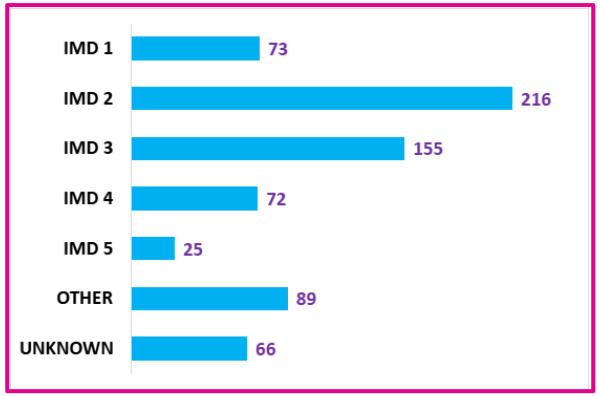
- ➢ Culturally and linguistically targeted information resources, brief and extended advice, courses and workshops to South Asian and global majority communities to encourage and embed healthy lifestyle behaviours
- ✓ Improved understanding and adoption of healthy behaviour and preventative actions

Improve heart health with South Asian and global majority communities in Barnet

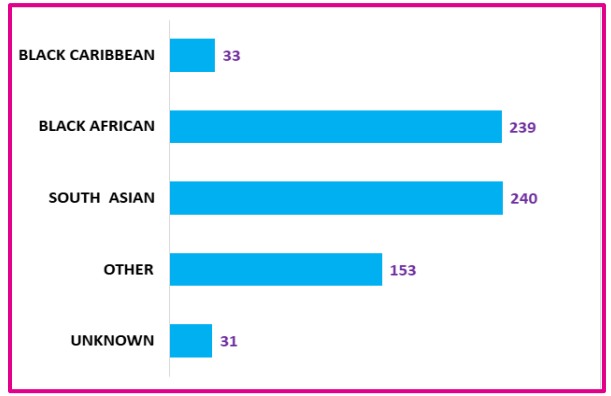
- Partnership with 16 community organisations
- Delivered 696 brief and extended brief interventions to event attendees and 41% from IMD 1 and 2 wards (highest deprivation)
- Provided over 83 in-depth interventions during courses and workshops.
- 176 Resource Packs in English, Somali and Gujarati given out

Behaviour change – intensive course impact (21 attendees)

- Knowledge: 100% understood lifestyle changes to lower high blood pressure.
- Behaviour Plans: 95% planned to adopt healthier habits.
- Confidence: 95% knew to seek help for high blood pressure.
- Healthcare Use: 95% felt more confident accessing local services.



IMD breakdown (interventions)



Ethnicity breakdown (interventions)

A leader in the Nepalese community said:

"Your efforts in educating our members about healthy eating, regular exercise, and lifestyle improvements have been truly inspiring and impactful…thanks for explaining these important concepts in simple Hindi and Urdu, ensuring that everyone could easily understand and apply the advice to lead healthier lives."

Complete Care Communities, Camden

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- ➢ Working with Camden's underserved communities at high risk (Somali and Bengali) to improve physical and mental health
- ➢ Training community champions and taking a culturally informed approach to healthcare
- ✓ Improved engagement with healthcare services including health checks, self-management and peer-support

✅ Aims & Objectives

- Empower mental health resilience and improve physical health in Camden's Bengali & Somali communities.
- Recruit community advocates and pathfinder groups to co-design culturally appropriate interventions.
- Reduce stigma, promote healthy lifestyles, and increase access to mental health and long-term condition care.

👥 Reach into communities

- Target: Bengali (13,116) & Somali (5,398) residents in Camden (IMD 2nd centile – most deprived 20%).
- Majority female; socially isolated carers and mothers identified as inclusion groups.

📋 Activities & Outputs

- Mental Health First Aid training for 51 community champions.
- Over 1,000 community members engaged via workshops, cooking classes, exercise groups, and health checks.
- Estimated unique individuals seen: 590 (plus >2,000 contact episodes).
- WhatsApp support groups formed; advocates co-located in Kentish Town Health Centre.

📈 Outcomes

- 68% Somali participants reported reduced stress/anxiety; 40% women improved wellbeing.
- Uptake of NHS Health Checks and LTC reviews increased (SMI reviews: Somali 73%, Bengali 64%).
- Growing trust and engagement with statutory services.

💬 Quote & Case Study

"I really enjoyed the first session. It has made my understanding of mental health really good. This is something that is missing from the Bengali community and it is not spoken of."

Case Study: Sara, a domestic abuse survivor, rebuilt her life through emotional support, therapy, community integration, and employment—now a Mental Health Champion mentoring others.

Complete Care Communities, Camden

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Mandeeq "Market Place" event.
supporting parents of children with special educational needs (SEN). Event in partnership with SENDIASS Camden, Children and Young People Disability Service (CYPDS) Camden and Nafsiyat . Over 150 attendees.

Mandeeq Programme: Somali Community (Complete Care Communities

Pre-diabetes education event Whole day event including 2 nurses doing pre-booked appointments (BP, BMI and point of care HBA1C testing), Yoga sessions, mental health champion education and drop -in sessions, drug and alcohol councillors and a Somali councillor.

40% of attendees were referred to their GPs for further investigation

47% referred to weight management, diet and/or exercise programs.

39 one to one nurse appointment pre-booked slots were attended plus many on the day also attended. Unfortunately, 20 drops-ins wanting to see the nurses could not be accommodated as maximum capacity reached.

Health Heroes Unite, Enfield

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- ➢ Working with vulnerable groups including care leavers, young people and global majority communities in areas of high deprivation to improve access to healthcare through co-production
- ➢ Multiple models of engagement including events, focus groups and health screening
- ✓ Improved participation and ownership of community-based healthcare

Aims & Objectives

- Improve physical & mental health for Children Looked After (CLA), Care Leavers, and LGBT+.
- Address health inequalities in Black, Asian & Minority Ethnic (BAME) groups using Core20PLUS5.
- Engage youth in co-designing mental health services.
- Build capacity through partnerships and community consultations.
- Deliver actionable projects/events to reduce exclusion and improve health equity.

Reach into communities

- Target groups: CLA, Care Leavers, LGBT+, BAME communities, Gypsy Roma Traveller (GRT), and youth.
- High deprivation areas in Enfield (IMD lowest quintiles).
- Inclusion of people with disabilities and digitally excluded groups.

Activities & Outputs

- 20+ health & wellbeing events across Edmonton & Enfield
- Services offered: GP registration, mental health checks, ENT, diabetes screening, dementia support, cancer awareness, blood pressure monitoring.
- Youth engagement: mentoring, forums, festivals, mental health focus groups.
- Partnerships with 12 VCSEs and local schools; creation of Community Chest funding programme.

Outcomes

- Increased access to hyper-local health services.
- 68% of surveyed participants reported improved wellbeing.
- Strengthened borough partnerships and co-production models.
- Uptake of health checks and mental health support among underserved groups.

Quote & Case Study

"I have been sitting at home after losing my job and coming to this session has made me realise, I am not alone and I can get the help I need."

Care Leavers Forum 'All About You' project provided mentoring, mental health support, and creative activities, improving confidence and resilience among young care leavers.

Health Heroes Unite, Enfield

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DISPLACED
YOUR BACKGROUND IS YOUR POWER

MAKING ENFIELD HAPPIER

Supported by: Health Heroes Unite
Edmonton Community Partnership · NHS North Central London

The Making Enfield Happier programme aims to develop a shared understanding of the needs of young residents in Enfield, focusing on reducing health inequalities and improving mental wellbeing. The programme created a space to identify key issues and co-produce solutions that address barriers to accessing services. The core of this effort is amplifying the voices of young people, so their insights and experiences can shape the delivery of strategies for tackling local health challenges.

Through capacity-building sessions, practical workshops, and peer research, participants reported that their self-awareness and ability to express increased. This process not only deepened their understanding of their own mental health but also strengthened their ability to support their peers. As a result, participants grew in confidence and are able to begin taking an active role in advocating for change within their community.

IMPACT ON PARTICIPANTS

- **89%** of participants reported speaking to Enfield residents about their experiences of health and wellbeing services.
- **86%** of participants reported a significant increase in self awareness and learning how to talk to others about mental health.
- **70%** of participants reported learning more about the mental health of Enfield's ethnically minoritised residents.
- **57%** of participants reported a significant improvement in their social connectedness.
- **50%** of participants reported learning more about their own mental health.

A **20% increase** from the middle of the programme.

- Participants were **paid** London Living Wage for the interviews they conducted.
- Participants received **AQA accreditations** on Training As A Peer Researcher and Understanding Mental Health.

Impact of the facilitation style:

- **100%** of participants reported strongly agreed to feeling listened to, valued and respected.

WHO ARE THE PEER RESEARCHERS?

- Children and young people who are ranging from 13 - 22 years old.
- From 1st and 2nd generation migrant backgrounds.
- Peer researchers identified as Black African, British Bangladeshi, Black Carribean and Mixed ethnic backgrounds.
- Local residents of Enfield, majority of which are living in Edmonton.

WHO ARE THE INTERVIEWEES?

- **74%** are aged 13-17
- **26%** are aged 18-25
- **20%** from migrant backgrounds
- **20%** from 2nd generation migrant backgrounds
- **68%** live in Enfield
- **17%** live in Haringey
- All interviewees were from ethnically minoritised communities.

#WhatIf project, Enfield

North Central London Health and Care

➢ Mentoring, therapeutic and education support for young people and families in areas of high deprivation (addressing wider determinants of health)

✓ Improved educational attainment and mental wellbeing for parents and young people

✅ Aims & Objectives

- Provide mental health, well-being, and educational support to Inclusion Health Groups (children aged 8–15 from Eastern European, Black, Asian & Minority Ethnic communities in Edmonton schools).
- Improve access to culturally sensitive mental health services.
- Enhance emotional resilience and educational attainment by addressing mental health barriers.
- Build capacity for families and schools to support mental health.
- Reduce stigma and create safe spaces for mental health discussions.

👥 Reach into communities

- Target: Children & young people (8–15), families, and staff in Edmonton schools.
- High deprivation areas (IMD lowest 20%).
- Majority from BAME and Eastern European backgrounds; 95% pupils with English as an Additional Language (EAL).
- Inclusion of SEND students and families under severe social/economic stress.

📋 Activities & Outputs

- Unique individuals seen 88 (#Whatif project); overall Edmonton Community Partnership engagement: 135
- Partnerships with 11 schools; mentoring and therapeutic support for 445+ young people.
- Literacy & numeracy programmes for 575 children and young people (CYP); 85% pass success in Year 4 multiplication checks.
- 37+ parents accessed talking therapy; 15 staff trained in mental health support.
- Safe spaces and well-being rooms established in schools.

📈 Outcomes

- 68 CYP reported improved mental health and well-being.
- 518 CYP (90%) showed improved educational outcomes.
- 65% increase in referrals to services; stronger family-school engagement.
- 100% staff reported feeling empowered by impact of interventions.

💬 Case Studies

Client KB overcame emotional challenges linked to care experience through 8 therapeutic sessions, improving self-esteem, relationships, and emotional regulation.

Another young person improved literacy and confidence via one-on-one tutoring, passing all exams successfully.

Community Diabetes, Haringey

North Central London Health and Care

- ➢ Proactive identification and early intervention to manage diabetes, including culturally-tailored education, self-help resources and support to change lifestyle for communities in areas of high deprivation
- ✓ Improved diabetes control, dietary changes and adherence to medication reducing risk of complications

Aims & Objectives

- Reduce health inequalities in **Black African, Black Caribbean, Asian, and East European communities** with Type 2 diabetes in Northumberland Park.
- Identify and risk-stratify adults with **HbA1c >75 mmol/mol**.
- Empower self-management through culturally tailored education and behavioural change programmes.
- Promote independent functioning and signpost to community resources.
- Increase engagement and reduce hospital admissions via proactive case finding and MDT collaboration.

👥 Reach into communities

- Target: Adults with Type 2 diabetes in **N15 & N17 (20% most deprived areas)**.
- Ethnicity: Black Caribbean (30), Black African (21), Turkish (9), Other (15).
- Gender split: Male & Female across 6 GP practices.
- 76% from most deprived quintile; includes patients with multiple LTCs and disabilities.

📋 Activities & Outputs

- **434 patients triaged** from GP lists; **136 seen in IDSS clinics**, 298 discussed in MDT.
- **504 patients engaged in 2023/24**; 434 April–Sept 2024.
- **African-Caribbean group education:** 132 invited, 79 attended; 64% improved HbA1c.
- 6 MDT meetings; 3 community health promotion events; culturally tailored dietary sessions.
- Planned reach: 200 patients/year.

📈 Outcomes

- **64 patients** reported positive health impact (medication adherence, self-management).
- **109 patients** improved HbA1c and dietary habits.
- 53 patients improved relationships with carers; 66 increased social engagement.
- 79 group attendees scored high on confidence and motivation.

💬 Quote and Case Study

"I thought nobody cared, they just give you medication. After the session, I understood why it matters. I even agreed to go to A&E for a foot wound that could have led to amputation."

Case Study: Mrs J (65) improved diabetes control and accepted psychological therapy after motivational interviewing; Mr S (52) engaged in culturally relevant education, leading to HbA1c reduction and lifestyle changes.

Young Black Men and Mental Health, Islington

North Central London Health and Care
Integrated Care System

- ➢ In partnership with Islington Council, multiple approaches to improve mental health and wellbeing for young people through mentoring, therapeutic and anti-racist practice training
- ✓ Improved mental wellbeing, social engagement and school attendance with related impact on serious youth violence

Aims & Objectives

- Improve mental health and wellbeing outcomes for young Black men (aged 13–25).
- Reduce Serious Youth Violence and improve life chances.
- Deliver four pillars:
  - **Becoming a Man (BAM):** School-based counselling & mentoring.
  - **Elevate Hub:** Community therapeutic support for high-risk youth.
  - **Barbers Round Chair:** Train barbers as mental health ambassadors.
  - **System Change Training:** Cultural competency & anti-racist practice for professionals.

Reach into communities

- Target: Young Black and mixed-heritage men in Islington (population ~28,743).
- High deprivation: Islington has **2nd highest child poverty rate in London**.
- Cohort includes those affected by trauma, SYV, care experience, and mental health risks.

Activities & Outputs

- **BAM:** 3 schools (Central Foundation, Beacon High, AMSI); 175 young men supported.
- **Elevate:** 97 referrals; 83 active cases; 72–84 receiving 1:1 support per quarter; 29 parents engaged.
- In total, over 200 individuals supported
- Barbers: 15 trained as mental health ambassadors.
- System Change: 20 training sessions; 359 professionals trained in cultural competency.

Outcomes

- 80% reported improved mental & overall health.
- 60% improved relationships; >75% increased social engagement.
- Reduction in Serious Youth Violence (60 → 48 incidents) and knife crime (123 → 86).
- Improved school attendance: Beacon High (71% → 93%), AMSI (76% → 97%).

Quote and Case Study

"Without this programme, these young men would likely have escalated to tier 4 hospital admissions or further criminal justice involvement."

Case Study: *Elevate supported a young man with severe trauma, psychosis, and SYV involvement through long-term therapeutic engagement, advocacy, and housing support—preventing further deterioration and promoting stability.*

Learning Disability
Annual Health Check Quality Improvement, Camden

Inequalities Fund project to enable improvement in quality and uptake of Annual Health Checks by working with people with lived experience, Learning Disability staff and primary care teams through a Health Facilitator in Camden.

Achievements

- ✓ **90.5%** of adults with a learning disability in Camden had their Annual Health Check at their GP practice between April 2024 and March 2025.
- ✓ Additionally, young people aged 14–17 achieved **83.6%** uptake rate, well above the national target of 75% set by NHSE.

Why Annual Health Checks Matter

People with learning disabilities often face significant health inequalities, leading to poorer physical and mental health and lower life expectancy.

Since 2008, GP practices in England have been offering Enhanced Annual Health Checks (AHCs) to individuals with learning disabilities, and in 2014, this was extended to young people aged 14 and above. These checks play a crucial role in early detection and intervention, helping to address previously unidentified health concerns, optimise management of long-term conditions, and provide preventative care.

How CLDS is Supporting Access

The CLDS Health Facilitator collaborates with GP practices to ensure better access to Annual Health Checks. This includes:

- ✅ Considering Reasonable Adjustments under the Equality Act 2010
- ✅ Providing Easy Read Health information via the newly launched CLDS Health Library: www.cldsinfo.net/health.
- ✅ Identifying individuals who haven't yet attended or been supported to their Annual Health Check.

The Power of Co-Production

Community involvement plays a vital role in improving health outcomes. Camden residents with learning disabilities have contributed through:

- 🎥 Creating promotional AHC videos. www.cldsinfo/health
- 🎶 Producing a rap about Annual Health Checks. www.cldsinfo/health
- 💡 Organizing focus groups.
- 🗣️ Co-facilitating training sessions to raise awareness and draw on their knowledge as 'experts by experience'

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 042	NCL	Barnet	London Borough of Barnet	Peer Support for Cardiovascular Disease Prevention in Barnet. Empower local residents from South Asian, African, or Caribbean heritage to better manage their own cardiovascular disease through the provision of outreach, systematic peer support and culturally competent resources in order to reduce health inequalities in CVD disease outcomes.	£ 25,732.00
NCL IF 075	NCL	Barnet	Barnet GP Feds / GP practice	Improve health outcomes for people living in Grahame Park with health conditions and access to community & clinical services with a focus on those at risk of or experiencing poor heart and lung health and mental health that are supported by the Holistic Case Workers (HCWs) and reduce demands on statutory health and wellbeing services of the people that are supported.	£ 120,000.00
NCL IF 003	Camden	Camden	South Kentish Town PCN	Complete Care Communities – Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities	£ 60,000.00
NCL IF 007	Camden	Camden	Brondesbury Medical Centre	Kilburn Ward outreach bus to detect risk factors for Type 2 Diabetes Mellitus	£ 64,800.00
NCL IF 044	Camden	Camden	Camden Health Evolution Ltd (Central Camden PCN)	Patient-centred approach to improving lifestyle behaviours. Improve health and wellbeing through free exercise and nutrition programmes, targeting deprived communities and supporting patients to adopt sustainable healthy behaviours.	£ 55,249.00
NCL IF 047	Camden	Camden	London Borough Camden	Annual Health Check (AHC) Quality Improvement Project. Improve uptake and quality of Annual Health Checks (AHCs) for people with learning disabilities (LD) aged 14+, mitigate health inequalities highlighted in LeDeR reports, strengthen cross-agency collaboration, and amplify the voice of people with LD in AHC development.	£ 56,697.00
NCL IF 078(b)	Camden	Camden	Camden GP Feds	Understanding Populations Living in Deprived Areas in Neighbourhoods. Support for Integrated Neighbourhood Teams (INTs) to work with local VCS organisations and communities to codesign interventions within each neighbourhood footprint to improve understanding of local priorities and need and explore new approaches to help people manage health & well-being, particularly for those with long term conditions.	£ 34,749.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 078(c)*	Camden	Camden	Sub co: Camden GP Feds	Coffee and Care in the Community. Community well-being initiative targeted at isolated and under-served populations in Central Camden. Initiative include health checks, well-being talks, and workshops in collaboration with healthcare professionals, including cardiovascular screening and self-management (HTN & diabetes), addressing social isolation with VCSE groups and a digital CBT solution for frail older adults supported by digital champions.	£ 7,500.00
NCL IF 078(d)	Camden	Camden	Camden GP Feds	Digital Inclusion in West Camden PCN. Digital Inclusion Lead and supporting team to work with specific communities to promote digital inclusion/digital literacy and developing Digital Health Ambassadors within those communities – supporting them in using the NHS app, onward digital signposting, and booking appointments/re-ordering prescriptions.	£ 20,000.00
NCL IF 078(e)	Camden	Camden	Camden GP Feds	Castlehaven Interclude. VCSE offer for personalised physical and mental health activities for those with a neurodivergent diagnosis (ADHD or autism) in partnership with GP practices.	£ 4,012.50
NCL IF 078(f)	Camden	Camden	Camden GP Feds	CamPain-Chronic Pain Care for communities affected by health inequity. Community based chronic pain group - supported by clinicians from UCLH - to explore, develop and evaluate co-designed, co-produced ongoing patient-led pain management support projects to provide peer support, physical activity, advice and promote health and well-being.	£ 9,000.00
NCL IF 078(g)	Camden	Camden	Camden GP Feds	Youth Justice Nurse for comprehensive health check. Employment of a Youth Justice Nurse in Integrated Youth Support Service (IYSS) to provide health screening and a holistic approach to physical, emotional and mental health & well-being in most deprived and global majority populations.	£ 30,000.00
NCL IF 009	Enfield	Enfield	Caribbean and African Health Network	Black Health Improvement Programme (BHIP) for Enfield Primary Care, NHS North Central London CCG and development of Enfield Caribbean and African Community Health Network. To support efforts to improve health outcomes and service engagement for Enfield's Black Caribbean and African community by addressing cultural, religious, language, and racial barriers to primary care access, whilst building community capacity through co-design, outreach, and partnerships between residents, VCFSE organisations, and statutory services.	£ 98,950.00

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Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 010 NCL IF 011	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	Enhanced Health Management of People with Long-Term Conditions in Deprived Communities in Enfield. This involves identification, management and interventions for adults at risk of developing/with LTCs targeted in Enfield's eastern deprived neighbourhoods. A focus on CHD/CVD, diabetes, COPD/respiratory and multi-morbidity is particularly relevant to underlying need and associated with high NEL admissions/complications, in these communities.	£ 322,186.00
NCL IF 012	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services. This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey & Enfield who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services.	£ 70,000.00
NCL IF 013	Enfield	Enfield	Royal Free London (North Middlesex NHS Trust)	ABC Parenting Programme delivering workshops covering child health, Basic Life Support (BLS), illness prevention, and health services education for young parents to prevent unnecessary childhood A&E attendances.	£ 163,500.00
NCL IF 014	Enfield	Enfield	London Borough of Enfield	DOVE project (Divert and Oppose Violence in Enfield) Public Health approach to reducing Serious Youth Violence. To help young people who are involved in or at risk of youth violence or child sexual exploitation through the Early Help Team in Enfield.	£ 66,186.00
NCL IF 015A	Enfield	Enfield	Enfield GP Federation	Healthy Lifestyles. To provide a structured, equitable, and culturally competent healthy lifestyle and weight management service for Enfield residents aged 18–50 (with an initial focus on 30–50), living with obesity and at least one long-term condition, or at high risk of developing one. The service aims to promote behavioural change, reduce weight, and improve health outcomes and quality of life	£ 90,000.00
NCL IF 035	NCL	Enfield	Enfield GP Federation	Enhanced Homeless Primary Care Health Service. The project aims to provide accessible, comprehensive healthcare to individuals experiencing homelessness in Enfield, addressing their unique needs and barriers to care. By delivering tailored services directly to this vulnerable population, we seek to improve their health outcomes and overall well-being.	£ 75,000.00

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ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 056	Enfield	Enfield	Edmonton Community Partnerships	Health Heroes Unite - Drop in events. GP Registration in Enfield. Through active community and youth engagement, we raise awareness of local health services, strengthen links with community providers, and promote physical and social activities, ultimately improving access to care and reducing pressure on GP practices and A&E departments.	£ 130,000.00
NCL IF 057	Enfield	Enfield	Enfield Patient Participation Group (PPG) Network	Enfield Patient Participation Network (PPG). To increase patient participation through out Enfield and the GP surgeries. To enhance the skills of the patients.	£ 60,675.00
NCL IF 059	NCL/ Enfield	Enfield	Well-Being Connect	Family Support model - early intervention therapeutic support – Wellbeing Connect & Edmonton Partnership. to provide mental health, well-being, and educational support to key Inclusion Health Groups, particularly children and young people aged 8-15 from Eastern European, Black, Asian, and Minority Ethnic communities in Edmonton Schools.	£ 80,000.00
NCL IF 077	Enfield	Enfield	Enfield GP Federation	Fore Street Project: Tackling Health Inequalities in Neighbourhoods. Development of a CHWW model in Enfield – to work often intensively with c. 700 households in the 10% most deprived LSOAs in Enfield to better engage, identify and provide a strength-based approach to supporting residents and patients and managing their health needs.	£ 145,000.00
NCL IF 081	NCL	Enfield	Enfield GP Federation	Evaluation of and Support for Thriving Communities Zone (TCZ) and impact of Inequalities Fund Programme. TCZ hypothesis is to test whether concentrated system engagement and investment in a defined very deprived sub-Neighbourhood area, focussing on key population groups leads to accelerated improvements in Core Metric and other health and social outcomes and mitigated demand, utilisation and costs of statutory health and care. This element of investment is to support evaluation of TCZ IF investments included.	£ 60,000.00

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Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 020	Haringey	Haringey	Royal Free London (North Middlesex University Hospital NHS Trust)	ABC Parenting Programme delivering workshops covering child health, Basic Life Support (BLS), illness prevention, and health services education for young parents to prevent unnecessary childhood A&E attendances.	£ 163,500.00
NCL IF 021	Haringey	Haringey	Open Door, Young People's Consultation Service	Engaging our most vulnerable Haringey young people with mental health support through creative arts, activities and sports. VCS partnership project that aims to target and to support young people with histories of multiple Adverse Childhood Experiences (ACEs), who would not normally engage with mental health services, through arts, sports, creative ventures, tailored and adapted therapies, mentoring and other activities co-produced and designed with the young people themselves and delivered by people trained in trauma awareness and supported by therapists.	£ 250,000.00
NCL IF 022	Haringey	Haringey	North London NHS Foundation Trust (BEHMHT)	Tottenham Talking. Partnership project between VCS and NLMHT to encourage service users at risk of admission, those needing post-admission support, or individuals living in the community to join groups and activities, support employment, and empower positive life changes.	£ 271,930.00
NCL IF 023	Haringey	Haringey	Whittington Hospital NHS Trust	Enhanced Health Management of People with Long-Term Conditions in east Haringey. To reduce diabetes-related health inequalities for underserved communities in Northumberland Park (East Haringey), focusing on patients with Type 2 diabetes from Black African, Black Caribbean, Asian, and Eastern European backgrounds.	£ 139,561.00
NCL IF 024	Haringey	Haringey	Royal Free London (North Middlesex University Hospital NHS Trust)	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services. This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey & Enfield who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services.	£ 70,000.00
NCL IF 063	Haringey	Haringey	Haringey GP Group Ltd	Health Neighbourhoods in our locality (Childhood Weight Management). Proactively identify children at or above the 91st centile for BMI registered in East Haringey and provide culturally sensitive, non-stigmatising support to reduce or maintain BMI. This is achieved through clinical, wellbeing input and personalised interventions that wrap around care for the child and their family.	£ 209,420.00

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 063	Haringey / NCL	Haringey	Haringey GP Federation	Health Neighbourhoods in our locality (Long Term Conditions). Reduce healthcare inequalities experienced by Turkish, Kurdish and Afro-Caribbean patients residing in the East of Haringey - through early detection, diagnosis and management of the following long-term conditions: Chronic Kidney Disease (CKD), Hypertension (HTN) & Chronic Obstructive Pulmonary Disease (COPD), (Pre-diabetes and Diabetes & raised cholesterol are also picked up as part of the health check).	£ 165,192.00
NCL IF 063	NCL	Haringey	Haringey GP Federation	Health Neighbourhoods in Our Locality (Empowering People) VCS Partnership - Community Empowerment to include Community Involvement in Neighbourhood Development. It aims to meaningfully involve residents and patients from across Central and East Haringey in the design, development and implementation of neighbourhood working with a particular emphasis on addressing health inequalities.	£ 64,000.00
NCL IF 038	NCL	Haringey	RISE PROJECT (VCS)	NCL Somali Mental Health Support. VCS partnership project focussing on three key areas: youth engagement, parental engagement, and community wellbeing. Each area works to support the Somali community in improving mental health and overall wellbeing through culturally sensitive services and by encouraging early access to statutory support.	£ 135,000.00
NCL IF 078(i) and element of NCL IF 077	Haringey	Haringey	Haringey GP Federation	Diabetes structural education project. Scheme to improve referral rates to structured education on diabetes utilising and testing roll out of digital solutions to deprived (and often diverse) communities – funding will support implementation of NHSE-approved dedicated diabetes app to provide an alternatives available to nearly 100 written or verbal languages building on existing work on diabetes in Borough, and with support from a Health Coach for English and non-English speakers.	£ 67,142.00
NCL IF 078(h)	Haringey / NCL	Haringey	Haringey GP Federation	Haringey Community Asset Fund. CSE-related investment pot to support key priority outcomes in 20% more deprived neighbourhoods in Haringey (alongside TCZ which is focussed on even more deprived neighbourhood).	£ 100,154.35
NCL IF 080	NCL	Haringey	Haringey GP Federation	Thriving Communities Zone (Haringey). TCZ hypothesis is to test whether concentrated system engagement and investment in a defined very deprived sub-Neighbourhood area, focussing on key population groups (best start in life, those with MH issues, people 45/50+ at risk of/with LTCs or multi-morbidity, particularly vulnerable groups) leads to accelerated improvements in Core Metric and other health and social outcomes and mitigated demand, utilisation and costs of statutory health and care	£ 230,943.88

Inequalities Fund projects 2025-26

North Central London Health and Care
Integrated Care System

ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 079	NCL	Haringey	Haringey GP Federation	Thriving Communities Zone (Haringey). Part of this funding and approach will be used to tackle some of the wider determinants and work with particularly vulnerable individuals, e.g. those who are carers, with disabilities or other health inclusion groups.	£ 240,000.00
NCL IF 017	Islington	Islington	Islington Council	Early Prevention Programme – Black Males & Mental Health. Multi-agency collaboration to engage with & provide earlier support to young black men with MH issues, particularly those living with trauma, to improve health & social outcomes	£ 130,000.00
NCL IF 040 NCL IF 040a	NCL	Islington	Islington GP Group Ltd	Islington Homelessness Health Inclusion Programme – Physical Health Needs. Identify and treat the physical health needs of PEH in Islington using a combination of engagement, diagnostic tools, health navigation, outreach nursing, and the provision of flexible GP appointments in at least one surgery in the four most deprived wards.	£ 111,013.00
NCL IF 060	Islington	Islington	North London NHS Foundation Trust (Camden and Islington Foundation Trust)	Hand in Hand Islington – A Volunteer Peer Buddy Scheme. Project to establish Peer Buddy scheme of volunteers with experience of mental health issues to accompany vulnerable residents to appointments and events	£ 100,552.72
NCL IF 061	Islington	Islington	Healthwatch Islington	Community Research & Support Programme. Project to build community empowerment amongst residents/patients from under-served groups vis to take part in community participatory research and build trust.	£ 72,056.74
NCL IF 066	Islington	Islington	Brandon Centre	Leaving Care Counselling & Psychotherapy Service (Suicide Prevention). VCSE project to provide intensive therapeutic interventions to targeted care leavers thought to be at risk of SMI or suicide	£ 19,570.00
NCL IF 067	Islington	Islington	Brandon Centre	Progression to adulthood. VCSE-led collaboration to provide therapeutic interventions to targeted young people at risk of SMI/suicide.	£ 66,950.00

Inequalities Fund projects 2025-26

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ID	Lead Borough	Borough benefiting	Provider	Project description	2025/26 Funding
NCL IF 069a	Islington	Islington	Healthwatch Islington	Mental health inequalities tool kit. VCSE led collaboration to develop toolkit with people with experience of MH issues and professionals to improve access, experience & outcomes in services for under-served groups.	£ 14,641.45
NCL IF 069b	Islington	Islington	MIND	Mental health inequalities tool kit. VCSE led collaboration to develop toolkit with people with experience of MH issues and professionals to improve access, experience & outcomes in services for under-served groups.	£ 21,408.55
NCL IF 070a	Islington	Islington	Healthwatch Islington	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 48,713.79
NCL IF 070b	Islington	Islington	Islington GP Group Ltd	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 21,344.38
NCL IF 070c	Islington	Islington	North2 Islington Primary Care Network	Childhood Immunisations. Multi-agency project to improve uptake of childhood immunisations in under-served communities	£ 13,371.83
NCL IF 071a	Islington	Islington	Healthwatch Islington	Cancer Screening. Project to fund community participation research into improving cancer screening of patients from non-White British backgrounds to inform future cancer screening developments	£ 33,990.00
NCL IF 071b	Islington	Islington	Islington GP Froup Ltd	Cancer Screening. Project to fund community participation research into improving cancer screening of patients from non-White British backgrounds to inform future cancer screening developments	£ 22,864.85