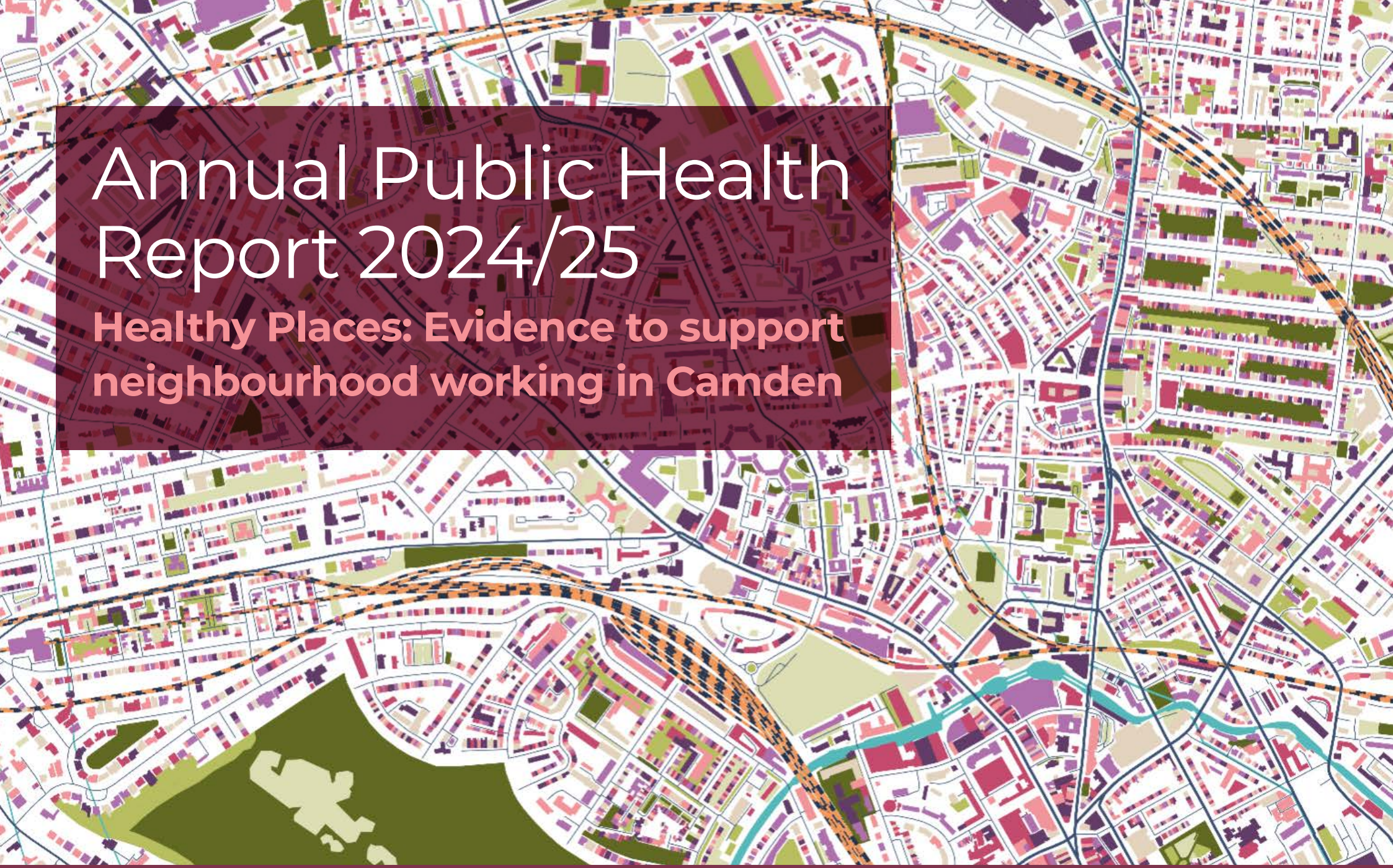


Annual Public Health Report 2024/25

Healthy Places: Evidence to support neighbourhood working in Camden

Camden

Foreword

In recent years there has a been a growing recognition of the fundamental role of “place” in shaping the health and wellbeing of individuals and communities. We know that our health is shaped not just by individual choices or healthcare services, but by the environments in which we live, work and spend our time. Our surroundings influence health and wellbeing in myriad ways, such as our sense of safety, opportunities for social connection, access to healthy food, access to services, leisure and recreational facilities, the built environment, and environmental exposures like air quality and green space. Recognition of these influences underpins the move of public health teams from the NHS into local government in 2012, where many of the levers exist to impact these broader determinants of health. National health policy drives over the last decade have emphasised the need for joined-up partnership working within local areas, between local government, the health and care system, community groups, residents and local businesses. Camden has a rich history of partnership working at neighbourhood-level, which aligns strongly with this agenda, and provides strong foundations for adopting and expanding such approaches.

In Camden, we are fortunate to have vibrant, diverse communities with a wealth of assets to draw upon. But our residents face many challenges, such as economic inequality, social isolation and mental illness, housing costs and the challenges of living in a dense and built-up urban environment. Many of these factors have resulted in Camden’s wide inequalities in health outcomes; men and women living in Camden’s poorest areas live shorter lives (13.5 years and 9.6 years respectively) than those in Camden’s richest areas and spend a greater proportion of their lives in poor health.

The aim of this report is to raise awareness of the influences of place and health, the activity already taking place across Camden, and how these can be built upon. First, we deep dive into the evidence base and rationale for place-based approaches to improving health and wellbeing, the approaches that have been tried elsewhere, and the current policy landscape. We then provide an overview of health needs across Camden’s neighbourhoods, and summarise activity already taking place in Camden, to serve as examples and enable connections between different strands of work. Finally, we look at the challenges and facilitators to place-based working and provide recommendations for taking this work forward. Addressing population health challenges in Camden through a ‘whole place’ lens will enable us to be both more responsive to the immediate health needs of communities, and allow us to build healthier, resilient and sustainable neighbourhoods for the future.

Kirsten Watters FFPH

Director of Health & Wellbeing
London Borough of Camden

Contents

1. Background and evidence

1. Background and evidence

1.1 Place or person?

Although there has been a long history of investigating geographical variations in health, interest in '*characteristics of place*' as a cause of ill-health is relatively recent. Historically, the predominant focus of health research was the relationship between individual-level risk-factors (such as gender, smoking status, education level, and income) and health outcomes. The mechanism for observed geographic variations in health outcomes was considered as being compositional, that is, as being due to the characteristics of the residents living within that area. By contrast, the role of 'area characteristics' as potential drivers of disease or health outcomes[1] was less explored.

Recently, there has been growing interest in how neighbourhoods or areas influence health, as part of a broader understanding of the wider social determinants (or 'building blocks') of health and wellbeing[2]. This shift in thinking suggests that neighbourhood effects on health may be independent of individual characteristics[3]. As a result, some epidemiological studies have sought to explore both the context (the characteristics of the neighbourhood) and composition (the characteristics of people living there) when examining geographic variations in health outcomes[4]. Academics have also emphasized the importance of a relational approach, recognising the reciprocal and interconnected relationships between people and the places they live[5].

1.2 The social determinants of health

We know that physical and mental health and wellbeing is intrinsically linked to the social, cultural, economic and environmental conditions in which we are born, grow, live, work and age: aspects such as early life experience, education, employment, housing, leisure, and the local environment. These factors can coalesce and reinforce one another to promote or limit opportunities for living a healthy life. It is well-established both in Camden and nationally that health outcomes are worse for people living in poverty or in areas of deprivation.

Taking a population health approach means fundamentally changing the way that organisations work to improve health, by coming together to take a broader system view in addressing the factors that influence health. The 'four pillars' model, first developed by the Kings Fund[6] and adopted in Camden's Health and Wellbeing Strategy[7] is a useful articulation of what a 'population health' approach means, and how each person and organisation can play a vital role in supporting good health.

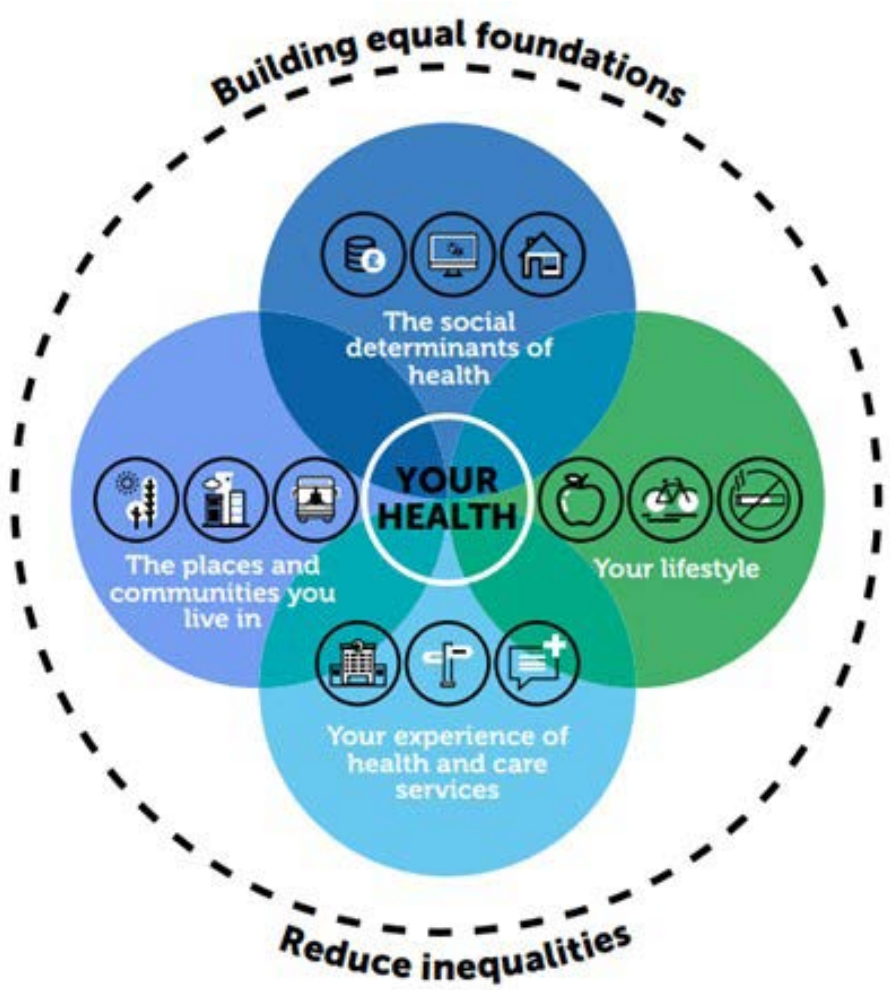


Figure 1 – The 'four pillars' model, adapted from the work of the King's Fund, Camden Health and Wellbeing Strategy.[8]

1.3 Research evidence: place and health

Research studies have demonstrated that the physical and social environments within a neighbourhood, as well as the local services available, have been linked to mortality, chronic health conditions, disability and birth outcomes as well as health behaviours, mental health, injuries and violence.

An early study using 1981 census data in Glasgow examined the differences in mortality between two areas of Glasgow, and investigated the features of the social and physical environment that might promote or inhibit health[9]. The area in the North West, with lower mortality, had double the recreational facilities (such as playing fields, swimming pools and tennis courts) as the area with high mortality in the South West. There were far fewer primary care assets, General Practitioners (37 versus 92), dental practices (10 versus 24) and Dentists (13 versus 38) in the area with high mortality. There were similar findings across a range of assets such as transport facilities and food availability; an identical basket of food was more expensive on average in the SW than the NW, with healthy food options proportionately more expensive than unhealthy options.

In another paper, Shouls et al[10] modelled inequalities in self-reported long-term illness based on data from the 1991 census. The results showed that both individual factors and area effects influenced the pattern of reported illness; there were areas where high levels of illness tended to be clustered which could not be fully explained by the individual characteristics of the people living there.

A Finnish study[11] examined the impact of neighbourhood characteristics and individual behavioural factors on a range of health outcomes. Those living in neighbourhoods that

underwent favourable changes (for example, an increase in green space, reduced unemployment levels and improved education), had a 16% lower risk of diabetes, 51% lower risk of stroke, 28% lower risk of skin disease, and 13% lower risk of osteoarthritis relative to those whose neighbourhoods did not undergo favourable changes. Living in a neighbourhood with improving characteristics was also associated with improvements in individual-level behavioural factors such as smoking, heavy drinking, physical inactivity and obesity. Length of exposure has an influence too - a recent longitudinal study conducted by economists at Harvard University found that the duration of childhood in a lower-poverty neighbourhood was associated with long-term economic outcomes[12].

Collectively, these studies demonstrate the impact of place on health and should lead us to consider ways in which neighbourhood improvements could improve the health and wellbeing of residents.

1.4 Mechanisms by which place impacts on health

A large body of literature has linked various aspects of neighbourhoods with health; for example the physical environment, access to services, and social conditions. Where we live affects our daily living conditions, which create or inhibit opportunities to be healthy. More deprived neighbourhoods often have increased crime levels[13], fast-food outlets[14], advertisements promoting alcohol and tobacco[15], and substandard, overcrowded housing[16] that can expose residents to mould, lead or cold. They may also have increased levels of air pollution[17] less green space[18] and fewer leisure facilities in which to exercise.

Whilst many of the health impacts of place are clearly established, for example, access to recreational facilities has been shown to be associated with greater physical activity among adults, adolescents, and children[19] and exposure to high levels of air pollution is associated with childhood asthma; other more complex mechanisms are also at play. One commonly used model by Labonte provides a simple conceptual framework for understanding how factors at place-level impact upon psycho-social wellbeing, health behaviours and physiological impacts, and how these factors both impact health directly and interact with each other.

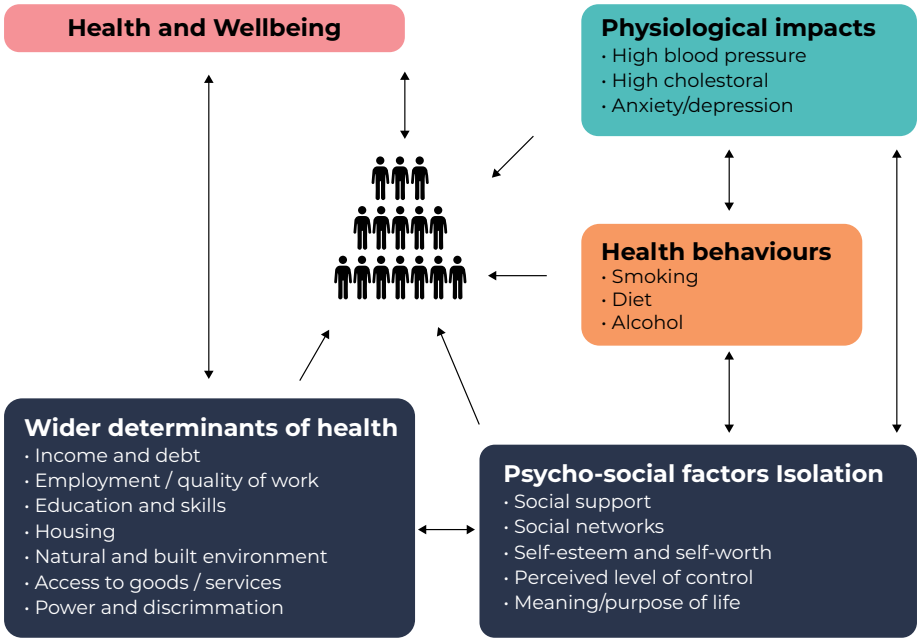


Figure 2 – Adapted Labonte model – Public Health England (2021) Place-based approaches for reducing health inequalities: main report

Children are particularly vulnerable to the effects of living in harmful neighbourhood environments. These adverse

neighbourhood contexts may limit the ability of caregivers to create supportive environments for their children, despite enormous efforts. Harmful neighbourhood conditions whilst growing up may also produce persistent stress that may overwhelm a child's ability to cope, also known as 'toxic stress'[20]. Children exposed to toxic stress have been shown to display differences in brain development resulting in impaired cognitive and emotional development[21] and have been shown to be more likely to engage in risky health behaviours such as illicit drug use and unprotected sex[22]. Childhood adversity and toxic stress have also been linked with long-term health conditions such as heart disease, diabetes, and premature mortality in adulthood[23].

The policy ambition to improve health through cross-sectoral action on the wider determinants of health is captured in the 'Health in all Policies' approach, which has influenced numerous initiatives and case studies around the world[24]. The approach emerged from the World Health Organisation in 2006 and requires policy in every sector of government and at all levels to consider and promote health and health equity[25].

1.5 Are place based approaches effective?

As a result of the emerging evidence around place and health, there has been a growing policy interest in taking 'place-based' approaches to improving health and wellbeing (see definitions and policy context below in section 2.1). But are these approaches effective? A literature review from Victoria University in Australia[26] that focused on child and youth outcomes of place-based approaches highlighted that although many place-based approaches and initiatives have been implemented, relatively few have been evaluated. Of those that have been, evaluations have tended to focus on process and implementation, rather than outcomes and impact. A common theme across the body of literature is the challenge in evaluating place-based approaches**.**

An evidence review of area-based approaches for the Welsh government [27] found evidence of benefits across a range of outputs, including employment, housing, and health outcomes. Larger projects described those that focused on modifying dimensions of place through overhauling the infrastructure of deprived areas. In some cases, these projects successfully generated positive outcomes, such as new affordable housing, perceptions of crime reduction, and more job opportunities. Some of these programmes successfully reduced area-based inequalities, for example, the URBAN II project which ran from 1999-2008 narrowed the gap in the unemployment rate in 39 deprived neighbourhoods in England[28]. Evaluations of medium-sized community programmes, described as 'bottom-up, locally-owned', showed that most of these programmes were able to engage communities in partnership. However, there were few large-scale quantitative impact evaluations to draw evidence from.

Analysis of community engagement in place-based approaches was also highlighted in a scoping review by Rong et al[29]. Trust, power, and cultural considerations were the most significant barriers and enablers to community participation in place-based approaches. Developing trust was described as key to the success of community-led, place-based initiatives.

Some reviews have focussed on the impact of place-based approaches in children. One such review found that they have been effective in engaging disadvantaged families in programmes and services, building supportive communities, building an infrastructure and creating the conditions for impact[30]. Another review had more mixed findings; while individual papers found benefits in dental care, parenting and child behaviours, there was overall insufficient evidence for other health outcomes, although this paper again highlighted

the challenges in evaluating place-based approaches given the heterogeneity of different types of intervention[31].

An umbrella review of thirteen systematic reviews evaluating 51 primary studies concluded that place-based interventions can be effective at improving physical health, health behaviours and social determinants of health outcomes[32]. Interventions that required a high level of individual agency were associated with greater improvements for those living nearer to the intervention, highlighting the importance of situating interventions close to local communities. The authors highlighted that future research needs to ensure that equalities data is collected as this was severely lacking in most of the assessed studies.

2. Policy context

2. Policy context

2.1 Defining place-based approaches

There is no universally agreed definition of place-based approaches. A review by the Institute for Voluntary Action Research for Lankelly Chase[33] provided the following definition –

"A range of approaches, from grant-making in a specific geographic area to long-term, multifaceted collaborative partnerships aimed at achieving significant change. In most cases, it is more than just a term to describe the target location of funding; it also describes a style and philosophy of approach which seeks to achieve 'joined-up' systems change."

The Scottish Government working-group on place-based approaches have proposed an operational definition that emphasises collaboration and community involvement.[34]

> **"A community of people bound together because of where they live, work or spend a considerable proportion of their time, come together to make changes to that place which they believe will improve the physical, social or economic environment and in doing so tackle issues of inequality."**

Shared decision-making and collaborative implementation have also been highlighted as an integral component by the Australian Government in their definition[35], whereas a framework developed by the Welsh government has differentiated between bottom-up place-based approaches that are driven by the community in the target area and top-down approaches that are driven by local government and shaped by strategic objectives[15].

In the UK health policy landscape, place-based partnerships have been described by the King's Fund *as*

> **"Collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. They are a key building block of the integrated care systems (ICSs) recently established across England and play an important role in co-ordinating local services and driving improvements in population health."[36]**

A report by the NHS Confederation and Local Trust[37] describe neighbourhood working as:

> **"A way of working where neighbourhoods (often self-defined and hyper-local) and statutory services work together to improve the health and wellbeing of their population. Neighbourhood working involves statutory and non-statutory stakeholders bringing their assets, capability, capacity and experience to a common goal."**

They describe a spectrum of community-led interventions and service-led interventions, with neighbourhood working existing in the middle, harnessing the benefits of both ends of the spectrum. Examples in Camden of place-based approaches to improving health and wellbeing are described in section 3.3.

2.2 Rationales for place-based approaches

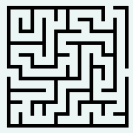
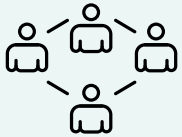
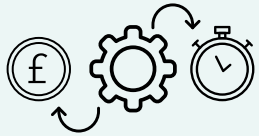
How do place-based approaches lead to better outcomes for residents and communities? A review by the Institute of Voluntary Action Research for Lankelly Chase[38] grouped the assumptions around theories of change into three broad categories:

- **Communitarian:** This assumes that the causes and solutions to disadvantage are linked to the characteristics of local areas and the residents that reside there. Programmes may focus on community development, skills training, capacity support and promoting self-help.
- **Systems:** Disadvantage is driven by poor integration and responsiveness of local systems and services. Place-based approaches might therefore focus on better integrated public services, community asset transfer, empowering residents to have a greater say in local decision-making or community involvement in local services and assets.
- **Structural:** The causes of disadvantage are structural and stem from economic changes and associated variations in the labour and housing markets. Place-based approaches may therefore concentrate on economic and physical regeneration. This might include working with local businesses or taking actions to bring in more jobs to the local area.

Multiple and varied rationales have been proposed to support the implementation of place-based approaches. These are outlined in Table 1.

Macintyre et al[39] have outlined five components of place that local government has the potential to influence:

- **Physical characteristics** of the local area including air and water quality.
- **Access to health promoting factors** including good quality housing, safe and secure employment, nutritious food, and recreational facilities.
- **Public or privately owned services** such as education, transport, community organisations, and health and welfare services.
- **Socio-cultural features** such as the political, economic, ethnic, or religious history of a place. This also includes other characteristics like community safety, integration, and networks of support.
- **Sense of place** or the internal and external perceptions of the area.

Table 1 - Table summarising the rationales for place-based approaches.	
Tackling place-based inequalities 	The targeting of support geographically provides the opportunity to tackle socio-economic, cultural, and environmental conditions that are associated with inequalities of outcome[40]. The Marmot reviews[41] have recommended that policy should focus on "creating and developing healthy and sustainable places and communities" and "improving community capital and reducing social isolation across the social gradient."
Developing locally tailored solutions 	Areas vary dramatically in terms of their levels of disadvantage, demographics, context, history and ways of working. Place-based approaches can accommodate these differences and tailor solutions or campaigns adapted to these contexts[42]. Local leaders, services, and community groups are better able to understand and respond to the needs and attitudes of people in their communities.
Tackling complex issues 	There is an increasing recognition that the complexity of existing policy problems requires more collaborative and integrated approaches, particularly when many negative outcomes within localities are interlinked and mutually reinforcing[43].
Capitalising on social capital 	Neighbourhoods are sites of identification and have meaning in people's lives. It is at this level that citizens most often meet and talk, both informally and in associations, about issues that affect them daily.[44]
Integration of services in a local area 	The neighbourhood provides a site for innovation in developing 'joined up' local action from a range of stakeholders and agencies to provide more integrated service provision.[19]
Improving local governance 	At the neighbourhood level there is the potential for improvement in accessibility, accountability and responsiveness in decision making.[19]
Improving efficiency and cost-saving 	Through neighbourhood working there is the potential for effectiveness and efficiency. There are potential cost savings from synergies between related services and reducing duplication. Neighbourhoods are sites where diverse citizens' needs can be more easily identified, so that more personalised and holistic services can be provided.[19]

2.3 Health policy context

Over the last decade healthcare policy reform and restructures have also been characterised by an emphasis on place-based integration. Integrated Care Systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas, formalised in the Health and Care Act 2022. There are 42 ICSs across England, covering populations of around 500,000 to 3 million people.

The *North Central London Integrated Care System* (NCL ICS) operates across five boroughs – Camden, Barnet, Enfield, Haringey and Islington. Within this, the NCL Integrated Care Board (NCL ICB) is the NHS statutory organisation that plans, coordinates and commissions activity across the system. Population health ambitions across the NCL ICS are captured in the population health and integrated care strategy, delivery plan and outcomes framework.

Integrated care systems have been structured to function through various geographic levels: 'system', 'place' and 'neighbourhood'. In this context, 'Places' cover populations of around 250,000 to 500,000 people, and their footprints in London are generally based on local authority boundaries. 'Neighbourhoods' cover populations of 30-50,000 people and include groups of GP practices called 'primary care networks' (PCNs) and multi-agency neighbourhood teams.

The Fuller Stocktake report – a comprehensive review carried out in 2022 by Dr Claire Fuller[45]– articulated a position on the future of neighbourhood care based on three related areas:

1. Helping people to stay healthy for longer through a more joined-up approach to prevention.
2. Providing more proactive, personalised and multi-disciplinary care for people with more complex needs.
3. Streamlining access to care and advice for patients who get ill but access healthcare infrequently, giving them more choice about how and where they access upstream care in their community.

At the heart of this approach was the concept of the 'integrated neighbourhood team' (INT): multidisciplinary professional teams able to provide more personalised and holistic care to ensure patients receive the care they need in the right place and at the right time, and taking an upstream, proactive care approach to ill-health prevention.

This approach was supported in Lord Darzi's independent review of the NHS for the incoming Labour Government in 2024[46] which highlighted as one of its themes the need for:

> **"Simplifying and innovating care delivery for a neighbourhood NHS, embracing multidisciplinary models that bring together a range of primary, community, mental health and wider services"**

Neighbourhood planning guidance from NHS England outlines ambitions and expectations around neighbourhood models of delivery, including improving coordination, personalisation and continuity of care for people with complex needs, tackling health inequalities, and population health management approaches[47].

2.4 Neighbourhood approaches in Camden

Camden has a long history of partnership working at neighbourhood level, predating more recent national health policy moves in this direction. In 2020, the Health and Wellbeing Board sponsored a Health and Care Citizens' Assembly made up of a representative cross-section of residents[48]. The objective was to build on the priorities of Camden, give residents the power to help shape the common purpose of the integrated care partnership and inform Camden's Joint Health and Wellbeing Strategy[7]. Throughout the assembly process, Assembly members' task was to determine a set of 'priorities', which have helped shape the council's neighbourhood's programme.

Priority 1
Reduce health inequalities in the borough, Ensure that local services can tackle the impact of the pandemic on the most affected groups

Priority 2
Ensure my family, friends, neighbours and I can stay healthy, safe, and well in Camden, particularly our mental and emotional wellbeing

Priority 3
Ensure local services work together to meet the needs of residents, and communicate effectively with residents

Figure 3 - Priorities identified from Camden's Health & Care Assembly 2020

The importance of neighbourhoods is also emphasised in Camden Council's vision for the borough '*We Make Camden*'[49], which sets out the core missions for Camden's population. One of the four missions relates to 'Estates and Neighbourhoods': "*By 2030, Camden's estates and their neighbourhoods are healthy, sustainable and unlock creativity*".

Furthermore, Camden's 'Neighbourhoods Programme' supports the ambition to devolve power and deliver services at a local level in alignment with the wider offer of community-based support. It is a collective endeavour of the council, NHS and voluntary sector to support people closer to home, and enable healthy, happy and independent lives.

Neighbourhood-based infrastructure is an important delivery vehicle for the council's missions; however, the principle aim of the Neighbourhoods Programme is to provide effective joined-up support for people. Through neighbourhood working, the aim is to improve people's experience of local services and enable staff to work in closer collaboration across service and organisational boundaries. Neighbourhoods are a central part of Camden's commitment to prevention and early help - delivering holistic support within a local context. This commitment is captured within 'The Way We Work in Neighbourhoods' vision statement:

> **"In Camden, people and place lead the way. We are accessible to people where they live and want everyone to be empowered to live a good life. Our services are local, connected and built on relationships, enabling people to find solutions".**

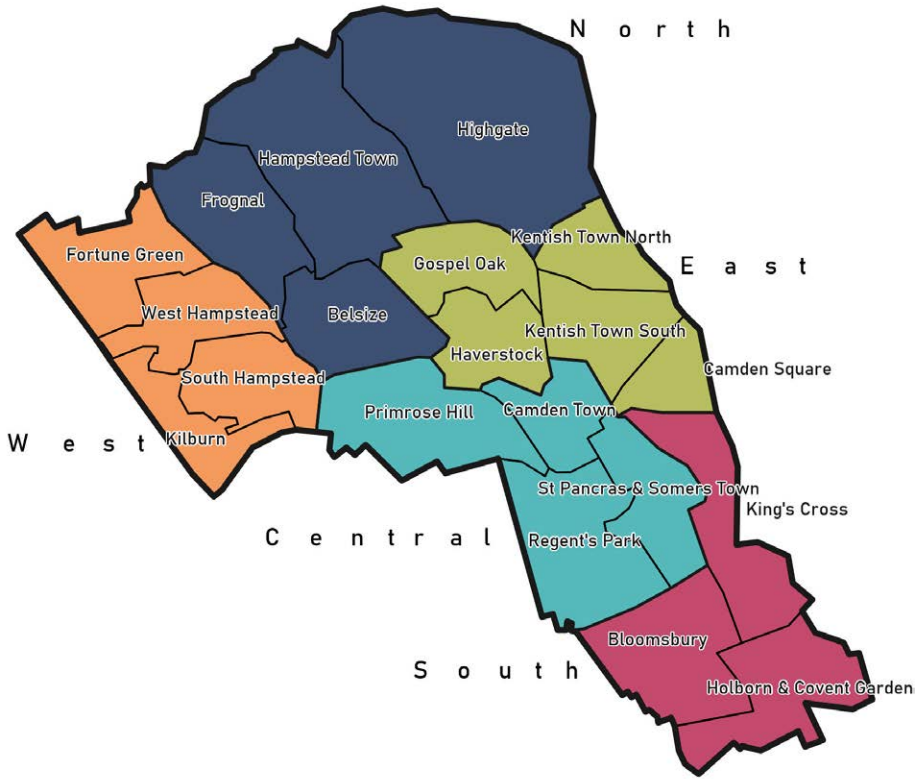
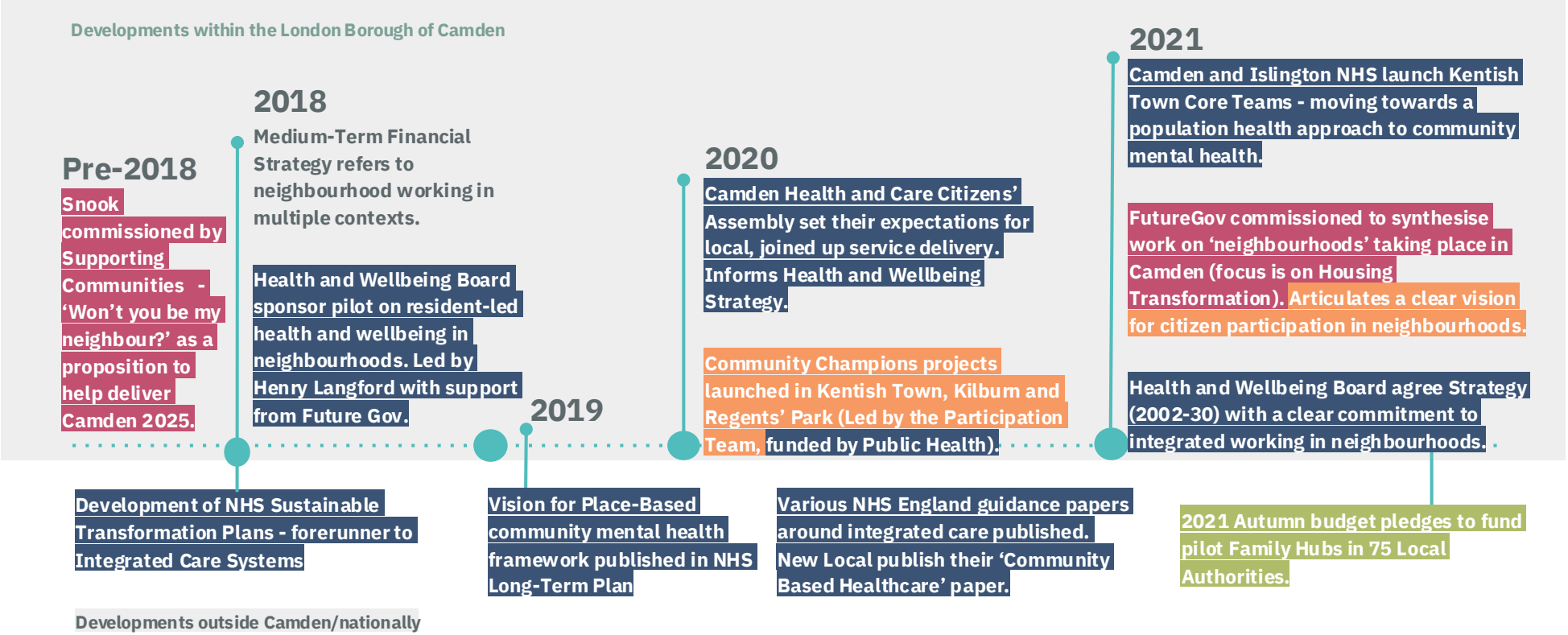


Figure 4 – Camden's Neighbourhoods and Wards

Camden's statutory organisations now have a consistent understanding of neighbourhoods with aligned geographical footprints: North, South, East, West and Central – each aligned to council ward boundaries and with approximately 3-4 wards per neighbourhood (Figure 4). For example, adult social care, housing and NHS community health all have service structures aligned to (or soon to be aligned to) these geographies. The rationale for aligned neighbourhood footprints was to allow for greater coordination across organisations and to more effectively match service provision to local need. It is worth noting however that local services are not compelled to deliver on neighbourhood footprints, nor should residents need to know which neighbourhood they live in – it is a system-facing tool. Camden's history of neighbourhood-based approaches over the last several years has been summarised by the Council's Strategy and Change Team below (Figure 5).

Figure 5: History of neighbourhoods approaches in Camden 2018-2024, Sophie Taylor, Strategy and Design Team, London Borough of Camden



2022

'We Make Camden' and 'The Way We Work' are published

'The Way We Work in Neighbourhoods', an overarching vision/narrative is developed.

Camden and Islington launch North West and South Core teams.

Camden Integrated Care Executive (CICE) visit City of Manchester to observe their Neighbourhoods Model.

Health and Care Act 2022: officially establishes Integrated Care Systems

The 'Fuller Stocktake' is published in May 2022. Integrated Neighbourhood Teams (INTs) described as the structure that will replace Primary Care Networks (PCNs).

Funding awarded to Camden to deliver Start for Life offer and Family Hubs by 2025.

2023

Camden Borough partnership establish their Neighbourhoods programme and begin preparing for INT test and learn. North/South/East/West/Central are agreed as Camden's Neighbourhood service delivery footprints.

Staff consultation goes live to transform Support and Safeguarding to 'Adult Social Care Neighbourhoods'. Housing Transformation Programme starts.

Holmes Road pilot begins.

Launch of Camden's Start of Life Offer on new families.gov.uk website.

Launch of Camden's 5 Children's Centres and Family Hubs. First two borough-wide Family Hub networks meetings hosted. Further development of co-location in Family Hubs with VCS partners and health colleagues (through perinatal mental health and Cost of Living crisis projects).

First Kentish Town Summit 'Celebration' at Kentish Town Community Centre.

Strategy and Design team join the Neighbourhoods work.

Stable Holmes Built on Love published. 'Family Help' as one support continuum will offer help close to home across a gradient of needs.

2024

Kentish Town Local Family Hub network meeting in February.

First members sharing session on Neighbourhoods work in February.

Kentish Town walkabouts begin to develop the Civic Circle. First official Kentish Town Summit event to take place in May (based on larger We Make Camden Summit), developing Camden's role as a convenor of the VCS.

Housing will move to a full a Neighbourhoods Delivery Model.

3. Understanding Camden

3. Understanding Camden

3.1 Camden – Borough Overview

Demography: Camden is a borough located in the heart of London covering almost 22 square kilometres and comprising an area that is 1.4% of the Greater London total. It has the 9th highest population density in London with ONS mid-year estimates from 2022 putting its population at 218,000 residents. It has the third highest student population in London being home to 11 higher education institutions; this large student population means that Camden has a higher population in the 15-40 age bracket than England. However, like most parts of the country, Camden has an ageing population with over 65-year-olds being the fastest growing age demographic.

Ethnicity: Camden's population is ethnically diverse. In 2021, 40% of Camden residents were from Black, Asian or other ethnic groups (up from 34% in 2011), compared to 46% in London and 19% across England. Camden is a diverse borough with an average of 3% of residents that cannot speak English at all or cannot speak it well. Kilburn is the ward with the highest level of non-English speakers (4.9%) and Hampstead Town the lowest (0.9%). The most spoken languages in the borough other than English are French (10%); Bengali (9%); Spanish (8%); Italian (7%); Arabic and Portuguese (5%); Somali and Greek (4%); and Albanian (3%).

Housing and homelessness: Camden experiences high levels of population churn – 42.3% of households have moved in or out of the borough within the decade, compared to 31% for England. 39% live in single occupancy households, higher than London (29%) and England (30%). 36% experience high levels of loneliness, higher than all other London boroughs. Camden also has the 9th highest population density in London and far more people in Camden live in flats or apartments than national average. Based on occupancy ratings, 22% of Camden households are overcrowded (ranging from 10% in Hampstead Town to 30% in Kilburn). 11% of households in Camden are single parent households, ranging from 5.7% in Hampstead Town to 19% in St Pancras & Somers Town. Costs of living are high in Camden; after housing costs are considered the childhood poverty rate rises from 20% to almost 40%, which is the 4th highest rate of child poverty (after housing costs) in London. 39% of households have no access to private green space. Around 570 households live in temporary accommodation.

Jobs: 37% of Camden residents are economically inactive, with 32% of these being attributed to long term sickness or disability. Bloomsbury and King's Cross have the highest proportion of economically inactive residents overall, which may be due to these wards being home to several universities and therefore a high student population. Kentish Town North has the highest proportion of economically inactive due to long-term sickness and disability, more than double the proportion in Frognal which has the

lowest (41% vs 14%). Just over 7 in 100 residents aged older than 5 years provide unpaid care in Camden.

Deprivation: The index of multiple deprivation (IMD) is an official measure of deprivation that encompasses seven facets of deprivation including income, employment, education, skills and training, health and disability, crime, barriers to housing and services and living environment. As shown in Figure 6, levels of deprivation are higher in the Central and Eastern parts of Camden, and in pockets of West Camden around Kilburn. The least deprived areas of Camden are in the North of the borough. There are also some deprived areas that are immediately adjacent to less deprived areas (for example in West Hampstead and Swiss Cottage). Presently Camden has the second highest crime rate in London (185 per 1000 residents) – only Westminster has higher crime rates, and the most common type of crime is theft (accounting for 46.3% of all crimes). A report by Lloyd et al. identified deprivation trajectories to show how socioeconomic conditions are changing in Camden, using longitudinal data for each of the seven domains of the Indices of Deprivation between the years of 2004-2019[50]. The different patterns of change and are summarised below (Figure 7).

Further maps of Camden across health and social indicators are shown in Figure 8 for childhood poverty, education skills and training, air quality, overcrowding, proximity to green space, health and disability.

The State of the Borough report provides further details of what life is like in Camden.[51]

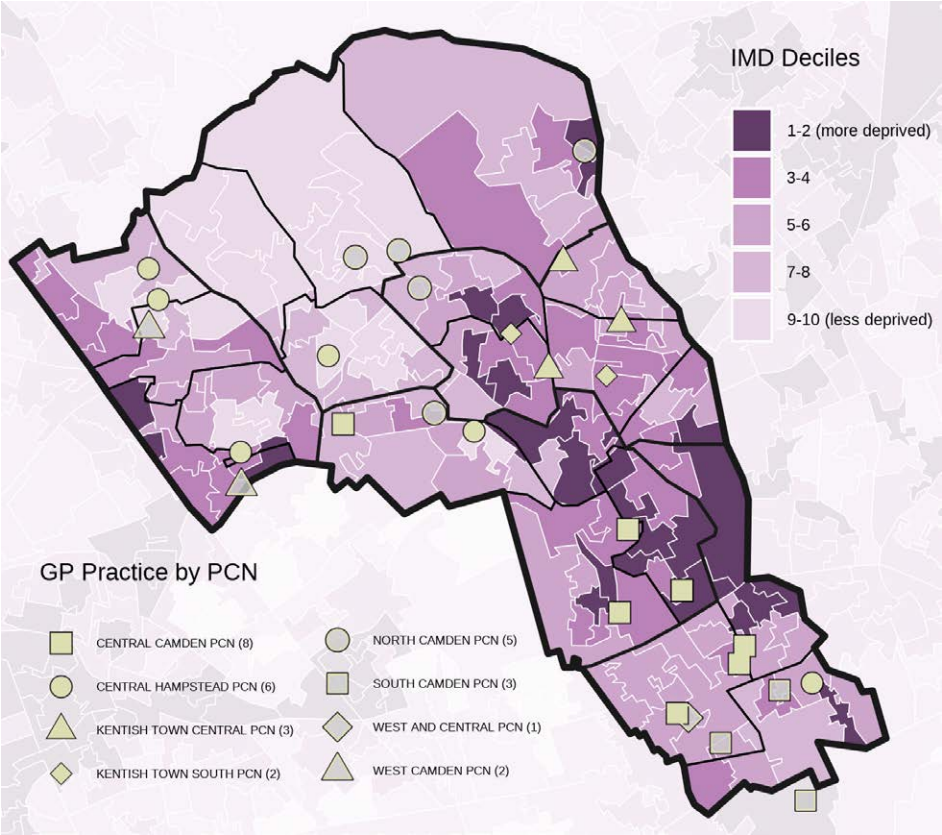


Figure 6 - Map of Camden showing index of multiple deprivation (IMD 2019) at lower layer super output area (LSOA) with neighbourhood boundaries overlaid and GP practices by primary care network (PCN)

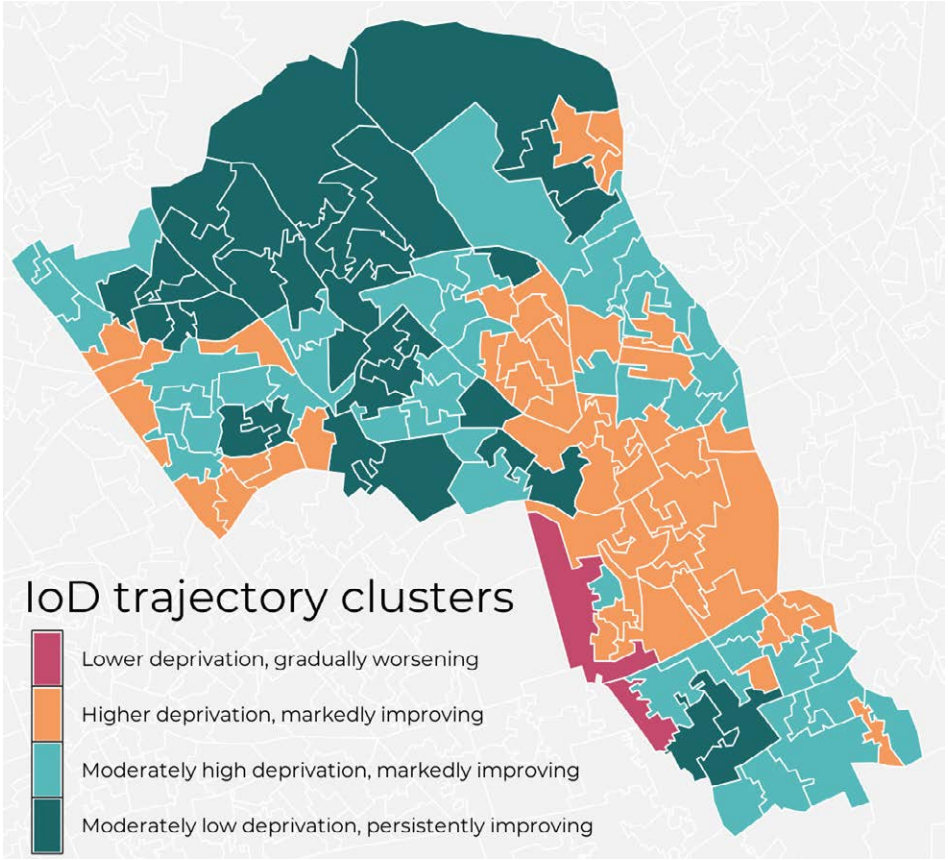
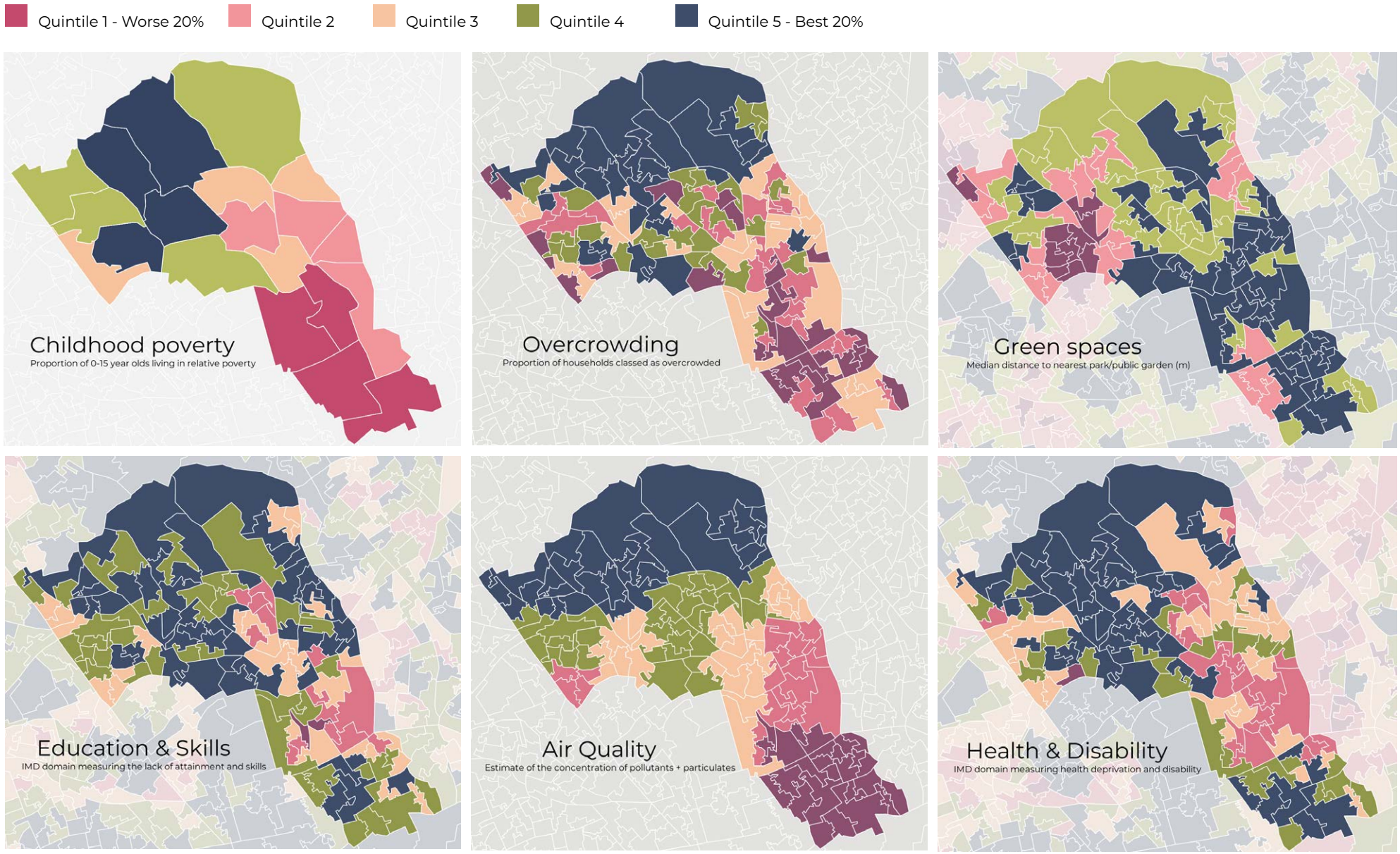


Figure 7: Change in deprivation in Camden by Lower Super Output Area (LSOA)

Figure 8: Maps of Camden, from left to right: childhood poverty, education skills and training, air quality, overcrowding, proximity to green space, health and disability



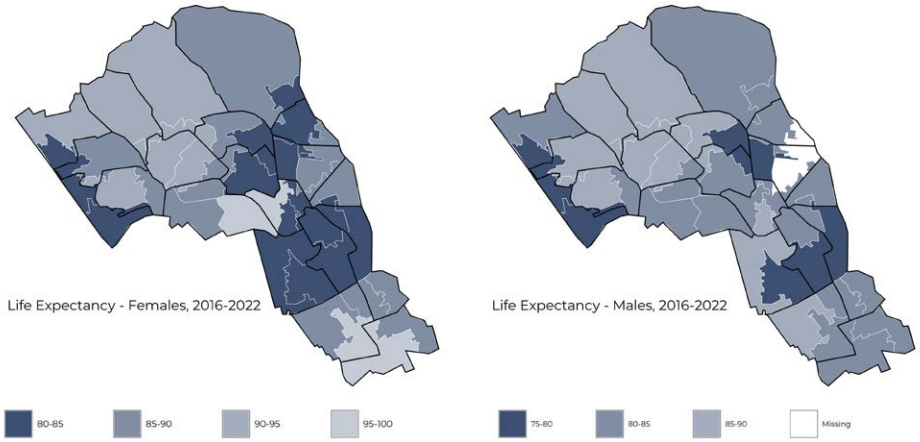


Figure 9 - Life expectancy at birth for men and women mapped to middle layer super output area (MSOA) with ward boundaries overlaid.

Life expectancy: According to 2019 estimates, the average life expectancy at birth in Camden was 82.8 for men and 87.4 for women, these are higher than the reported national averages. However, health inequalities are high in Camden; the gap in life expectancy between the most and least deprived areas is 13.5 years for males, (compared with 9.7 across England), and 9.6 years for females (compared with 7.9 across England) (2018-2020 figures)[52]. Life expectancy is generally lower in the central and eastern parts of the borough, following a similar pattern to deprivation, with some differences seen between men and women (Figure 9).

Long Term Condition Complexity: The prevalence of long-term conditions (LTCs) tends to be higher in older populations. As we get older, we are at risk of developing multiple long-term conditions, which result in higher needs for health care, and higher complexity in their management. Figure 10 shows the distribution of these patients with LTCs in Camden against deprivation. Pale areas have low levels of both deprivation and LTC complexity. The blue areas show areas of high levels of LTC complexity, but in affluent areas (largely in the North of the borough due to the older age demographic in these areas). Light green areas show high levels of deprivation but lower LTC complexity, largely due to the younger age demographic in these areas. Dark green areas, found in the Eastern and Central parts of the borough, and around Kilburn, exhibit both high deprivation *and* LTC complexity, and so it is these areas that are likely to have the highest health and care needs.

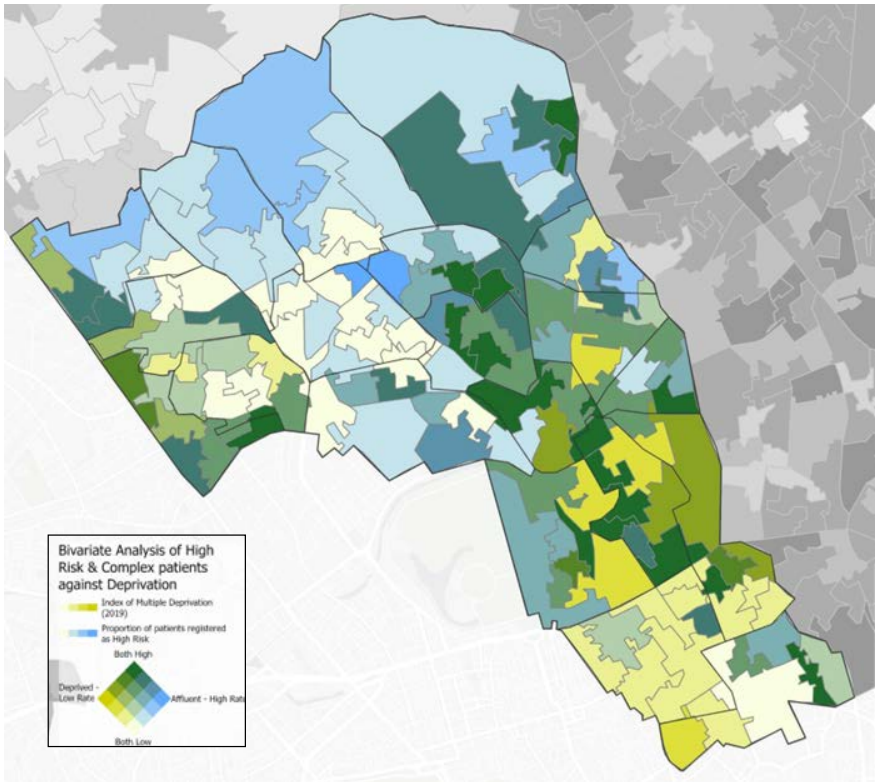


Figure 10: Bivariate analysis of high risk and complex patients with long term conditions, against deprivation (Index of multiple deprivation 2019). Source: NCL ICB Population Health Analytics Team

3.2 Patterns of ill-health across Camden's neighbourhoods

Patterns of ill-health and health determinants are evident across Camden's neighbourhoods and wards, across a range of indicators (Table 1, Table 2). They also allow us to see patterns between groups of indicators and see which factors might be related to one another. Indicators have been selected to present a range of indicators across health and wellbeing, demography, social and environmental determinants, but these are not exhaustive. It is also worth noting that many routine health statistics are only available at ward-level, but wards still represent relatively large geographic areas and may hide pockets of variation that exist within wards. These data tables have been summarised to provide an overview of the sociodemographic and health characteristics in each of Camden's five neighbourhoods: North, East, South, West, Central.

Camden context I North neighbourhood

The North neighbourhood has **the lowest levels of ill health** across a wide range of outcomes and the **highest levels of affluence** of Camden's neighbourhoods**.**

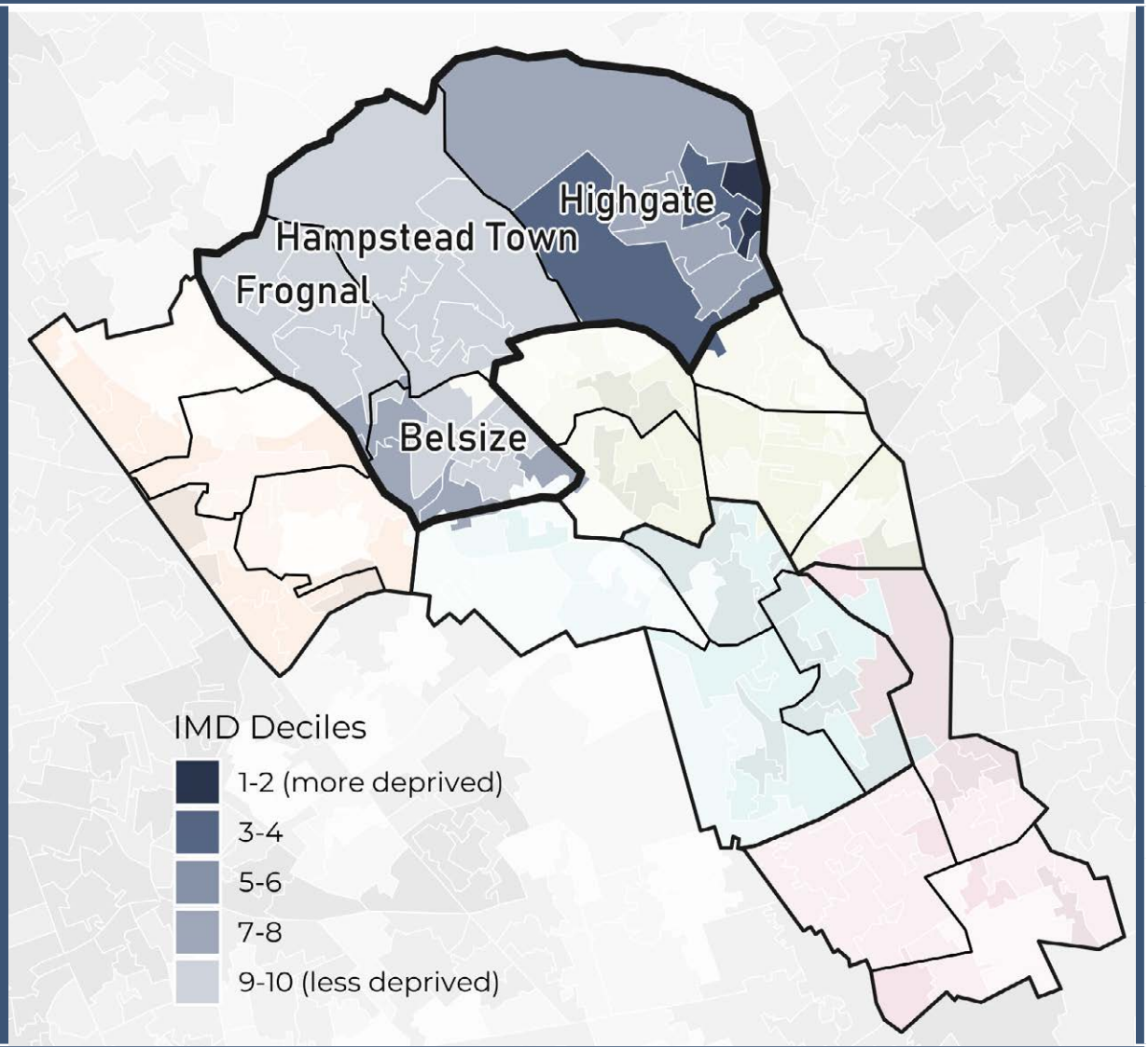
All wards follow this trend apart from **Highgate, which has high levels of alcohol dependence, depression, hypertension and asthma** – demonstrating a pocket of need and highlighting the importance of granular data analysis.

The North of the borough also has **better air quality** and relatively **good access to green space.**

>66

There are, however, higher numbers of residents over age 66 who live alone, which can contribute to **social isolation, and higher prevalence of hypertension**, again reflective of the age demographic.

Life expectancy is generally higher, and despite the older age demographic, there are **lower levels of disability and unpaid care**.

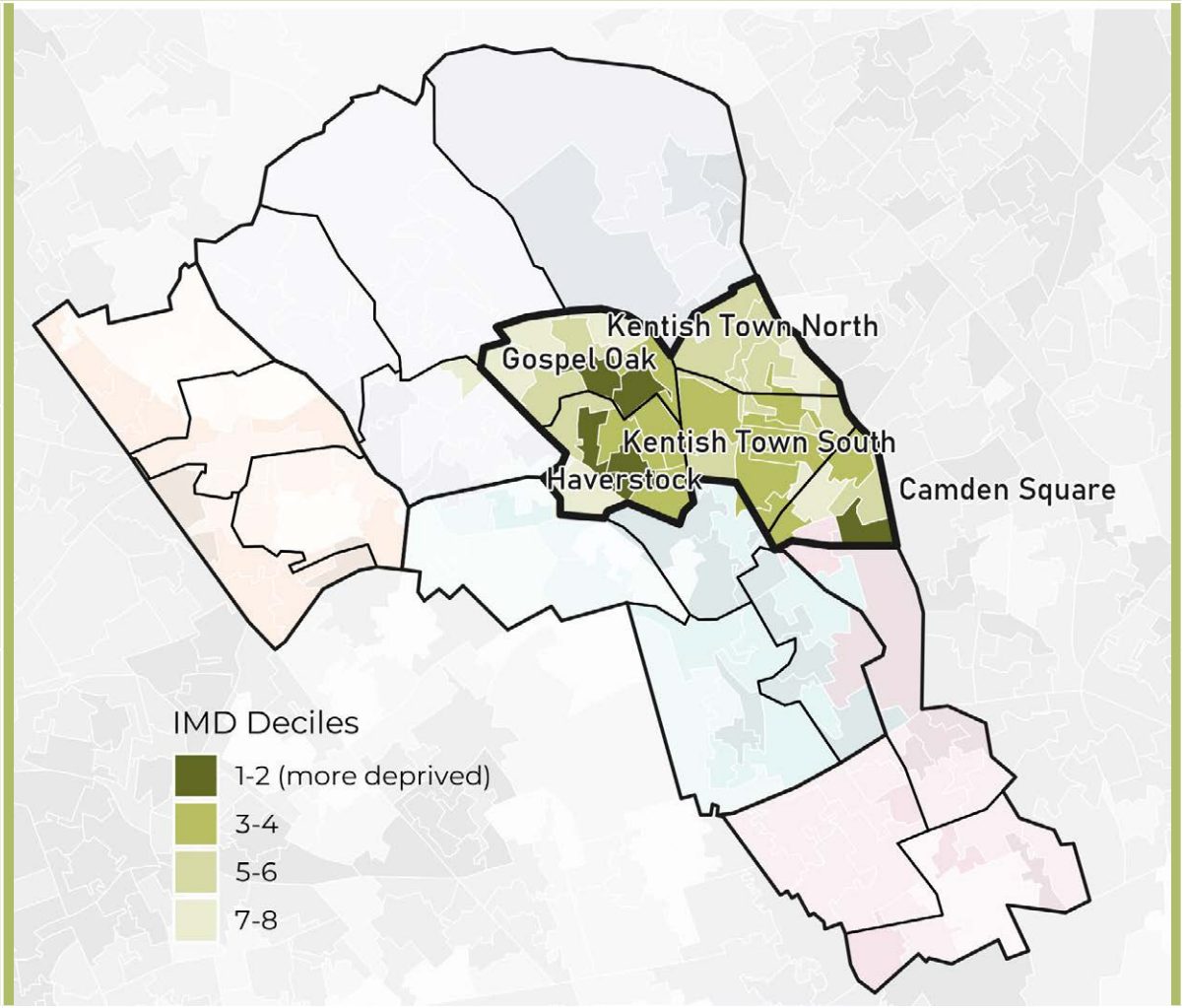


Camden context I East neighbourhood

The East neighbourhood demonstrates **poorer health outcomes** across a wide range of health indicators, including childhood and **adult obesity, alcohol dependence, smoking prevalence**, and prevalence of long-term conditions like **hypertension, depression and asthma**.

There are also **high levels of disability**, and perhaps related to this, a **high proportion of unpaid carers** as well.

The neighbourhood is **ethnically diverse** with sizable Bangladeshi and Black African populations.



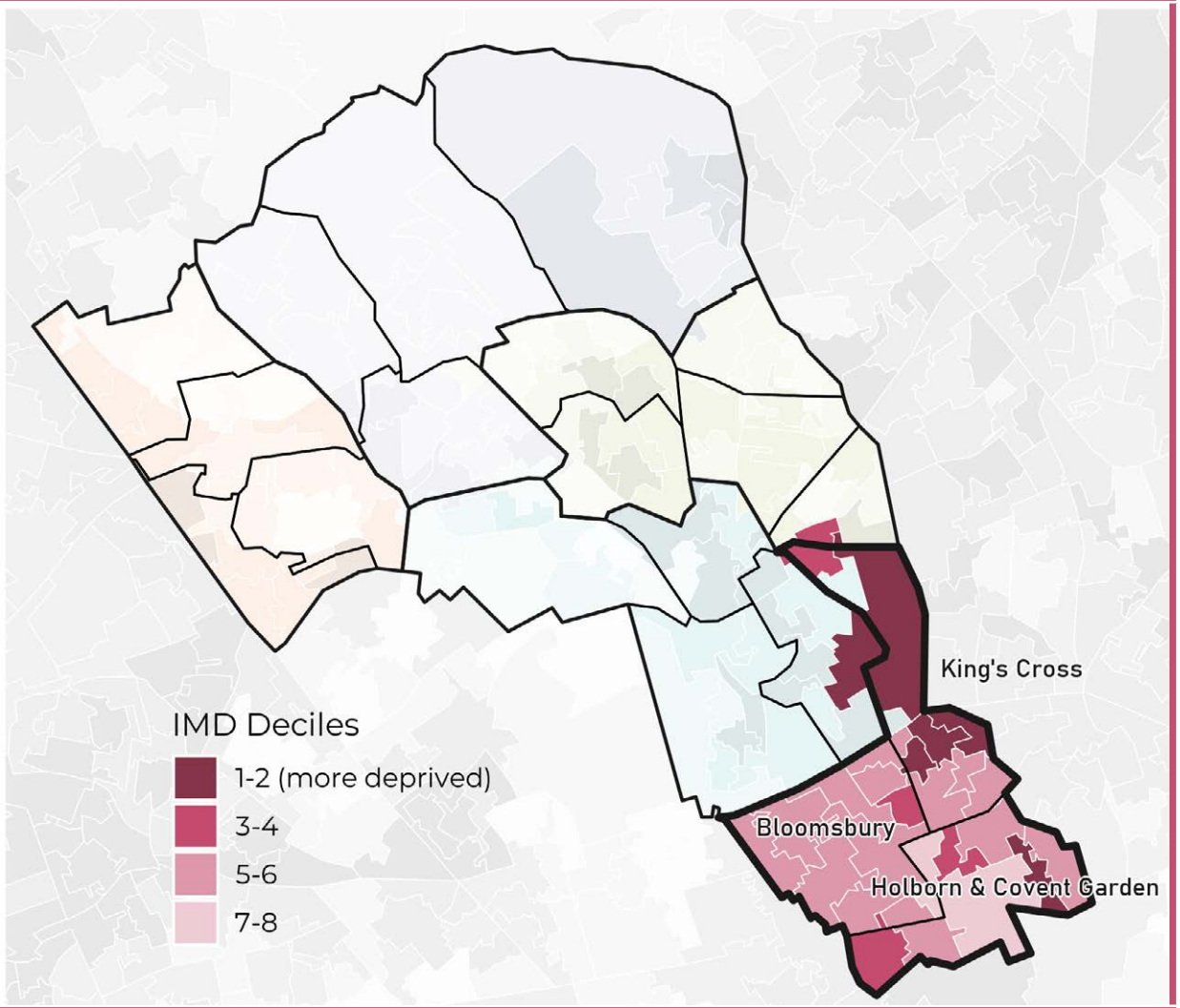
Camden context I South neighbourhood

The South neighbourhood has **high levels of economic inactivity**, which may be reflective of the large student population living in this part of the borough.

It also has relatively **high levels of overcrowded housing**. Despite **generally good access to green spaces**, the South of the borough experiences the **highest exposure to air pollution.**

The South neighbourhood has the highest proportions **of households with children living in relative poverty.**

In addition to **large Bangladeshi populations** in Holborn & Covent Garden (14%) and Kings Cross (13%), there are **significant Chinese populations** in Bloomsbury (9.3%) and King's Cross (7.7%).



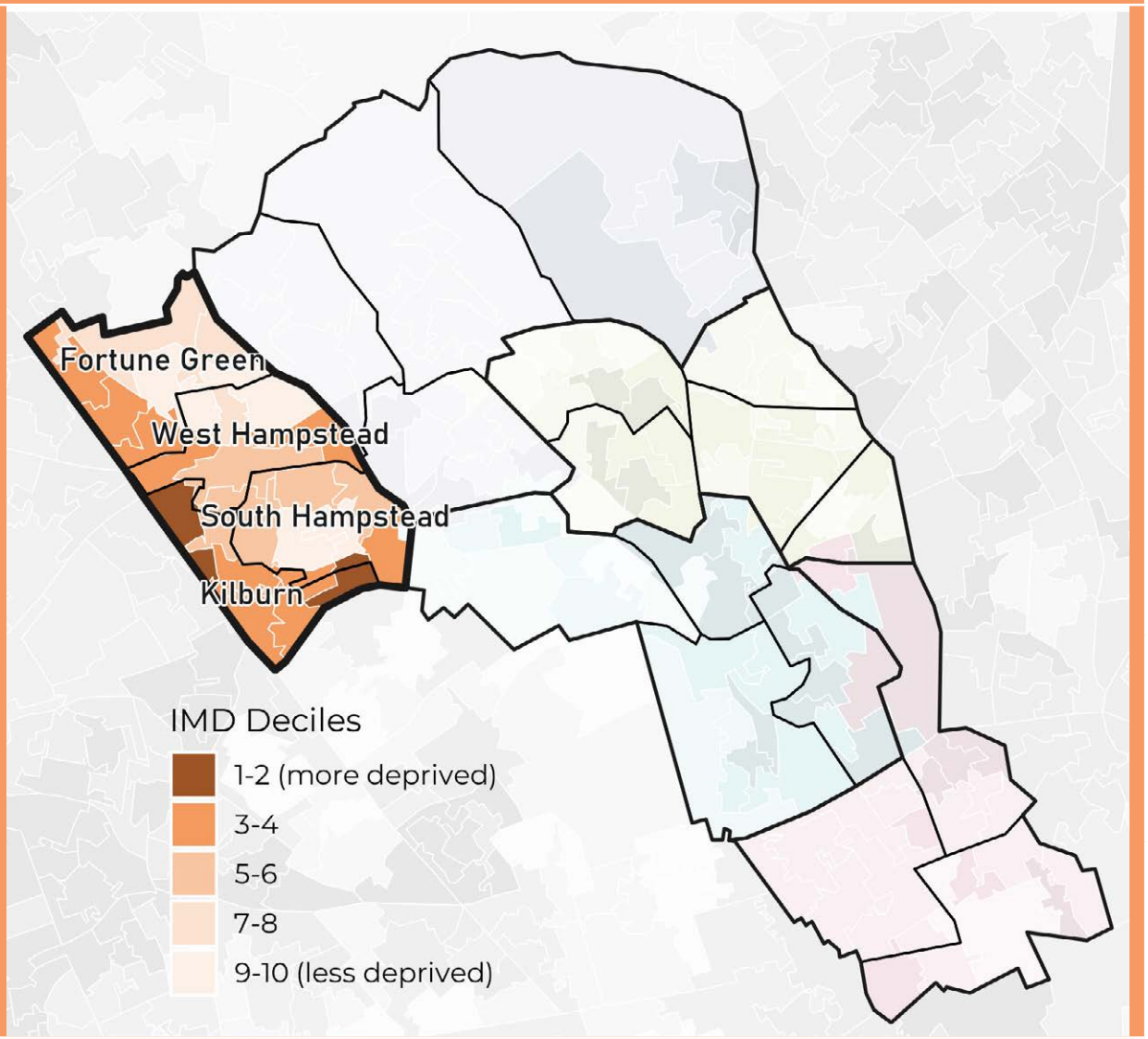
Camden context I West neighbourhood

The West neighbourhood demonstrates **variability in health outcomes** between wards, with areas of both affluence and deprivation.

In comparison to other wards in the West neighbourhood (Fortune Green, South Hampstead and West Hampstead) **Kilburn ward stands out, demonstrating poorer health outcomes** across the range of indicators considered: **childhood and adult obesity, alcohol dependence, smoking prevalence, and prevalence of long-term conditions**.

Kilburn also has **higher levels of economic inactivity, household overcrowding** and a high percentage of residents with limited English proficiency.

Kilburn ward is **ethnically diverse** and has significant Black African (10%) and Arab (6.7%) populations.



Camden context I Central neighbourhood

The Central neighbourhood demonstrates **variability between wards**.

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Camden Town and St Pancras and Somers Town, **areas with higher deprivation**, have high levels of crime, household overcrowding, disability, limited English proficiency, and experience **poorer health outcomes**.

By comparison, Primrose Hill ward has **lower levels of deprivation** and experiences **better health outcomes** across a range of indicators.

Childhood obesity levels in Year 6 are high across all wards in Central Camden, which may be reflective of lower access to healthy food.

St Pancras and Somers Town, Regents Park and Camden Town have **significant Bangladeshi** populations (9-17% of residents) and **Black African populations** (9.3-12%).

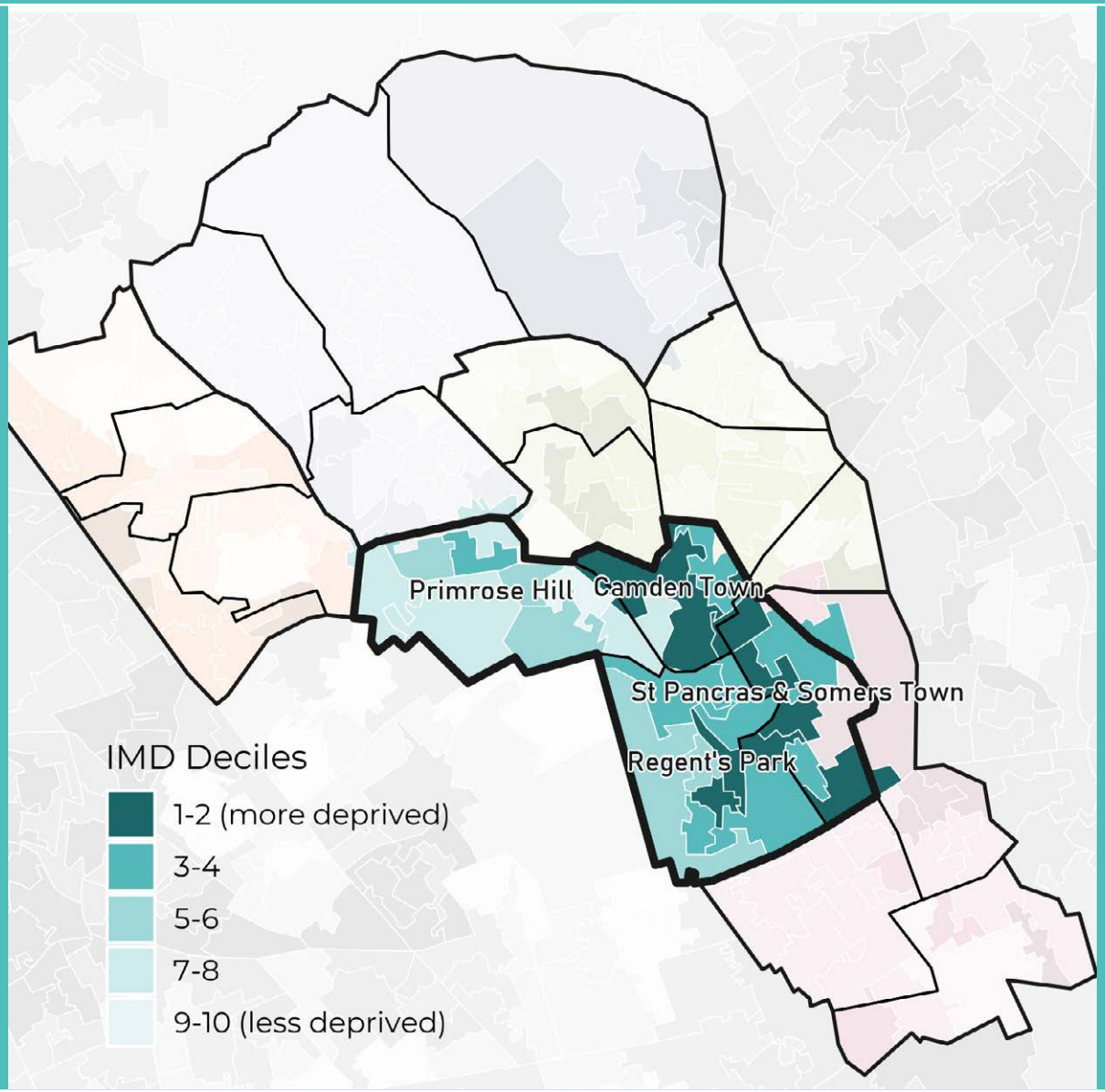


Table 1 – Health and social indicators (proportions or rank) by ward and neighbourhood colour coded from low levels of need (lightest) to high levels of need (darkest)

Neighbour-hood	Wards	IMD 2019 1 = Least deprived, 5 = Most deprived	Limited English proficiency %	Live alone 66+ %	Economically inactive %	Overcrowded %	Disability in households %	Disability %	Unpaid care %	Crime rate Per 1,000 population
Central	Camden Town	5	3.9	16	39	23	31	17	8.1	552
	Primrose Hill	1	2.5	37	37	18	24	13	7.1	86
	Regent's Park	5	4	24	43	28	31	16	7.6	199
	St Pancras & Somers Town	5	4.3	24	47	29	37	19	8.1	142
East	Camden Square	4	3.0	24	34	21	30	17	7.5	106
	Gospel Oak	3	2.7	29	36	22	33	18	8.6	109
	Haverstock	4	3.7	31	37	22	34	18	8.3	96
	Kentish Town North	2	1.7	21	28	18	26	16	7.7	101
	Kentish Town South	4	3.2	27	37	22	32	17	7.9	122
North	Belsize	1	1.4	27	28	19	18	10	5.5	74
	Frognal	1	2.0	35	35	10	20	10	6.3	65
	Hampstead Town	1	0.9	38	33	10	21	11	7	103
	Highgate	3	1.3	40	38	13	32	17	9	106
South	Bloomsbury	3	3.0	22	51	26	26	16	6.4	532
	Holborn & Covent Garden	3	3.5	23	41	24	29	17	8.1	546
	King's Cross	4	4.4	20	48	25	29	16	6.8	257
West	Fortune Green	2	2.7	25	29	21	25	13	6.8	85
	Kilburn	5	4.9	31	38	30	31	17	7.4	170
	South Hampstead	2	2.5	24	30	20	23	12	6.3	90
	West Hampstead	2	2.8	21	28	22	24	14	6.2	129

Table 2 – Health and social indicators (proportions) by ward and colour coded from low levels of need (lightest) to high levels of need (darkest).

Neighbour-hood	Wards	Overweight Reception %	Overweight Year 6 %	Obesity %	Alcohol %	Smoking %	Bad General Health %	Depression %	Hypertension %	Asthma %
Central	Camden Town	8.9	50	17	3.5	19	5.0	13	9.2	4.4
	Primrose Hill	15	40	13	3.4	13	4.4	9.3	10	3.4
	Regent's Park	15	39	17	2.3	16	5.5	11	9.4	4.1
	St Pancras, Somers Town	19	41	18	2.6	16	7.3	12	9.3	4.4
East	Camden Square	33	26	15	3.6	17	5.4	13	9.0	4.2
	Gospel Oak	20	39	18	4.2	17	6.8	13	12	4.7
	Haverstock	24	47	18	3.8	19	6.1	14	11	5.0
	Kentish Town North	7.5	33	14	4.3	18	5.2	11	10	4.5
	Kentish Town South	24	39	15	3.7	17	5.9	11	8.8	4.0
North	Belsize	18	31	10	2.3	12	2.7	8.6	8.0	2.7
	Frognal	10	18	11	1.9	10	2.4	7.6	10	2.7
	Hampstead Town	11	16	9.1	2.5	10	2.5	8.9	11	3.0
	Highgate	18	23	16	6.2	17	5.6	14	13	5.0
South	Bloomsbury	16	45	8.5	1.9	10	4.6	8.4	5.5	2.1
	Holborn, Covent Garden	10	38	13	2.5	14	6.7	11	9.5	3.2
	King's Cross	25	25	12	1.9	12	5.1	10	6.6	2.8
West	Fortune Green	18	30	17	3.9	17	4.2	11	12	3.7
	Kilburn	25	47	21	4.2	20	6.5	13	12	4.2
	South Hampstead	Missing	Missing	15	3.1	15	3.5	10	10	3.7
	West Hampstead	20	28	16	4.2	18	4.8	13	11	3.7

Indicator	Definition
IMD 2019 1 = Least deprived, 5 = Most deprived	Local quintiles, ranked population-weighted average Index of Multiple Deprivation score, Ministry of Housing, Communities and Local Government, 2019
Limited English proficiency %	Percentage of residents aged 3 years and over who cannot speak English or cannot speak English well, ONS Census, 2021
Live alone 66+ %	Percentage of residents aged 66+ years living alone, ONS Census, 2021
Economically active %	Percentage of residents aged 16+ years who were economically inactive, ONS Census, 2021
Overcrowded %	Percentage of households that are overcrowded (household has fewer bedrooms than required according to the Bedroom Standard), ONS Census, 2021
Disability in households %	Percentage of households with 1+ disabled residents living in the household, ONS Census, 2021
Disability %	Percentage of residents who are disabled under the Equality Act, ONS Census, 2021
Unpaid care %	Percentage of residents aged 5+ years who provide unpaid care, ONS Census, 2021
Crime rate per 1,000 population	Recorded crime and disorder offences rate per 1,000 resident population, Metropolitan Police Service and ONS population estimates, 2023
Green space 1 = Best, 5 = Worst	Local quintiles, the amount of accessible green space (the amount of green space within 900m of the centroid of the Lower Super Output Area), population weighted into Wards, Access to Healthy Assets & Hazards (AHAH), CDRC Data, 2024
Overweight Reception %	Percentage of resident children in Reception who are overweight, National Child Measurement Programme, 2022/23

Indicator	Definition
Overweight Year 6 %	Percentage of resident children in Year 6 who are overweight, National Child Measurement Programme, 2022/23
Obesity %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who are obese, HealtheIntent, July 2024. Caveat: calculated for people who have a BMI coded in their health record.
Alcohol %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who have a history of alcohol abuse or dependency, HealtheIntent, July 2024. Caveat: calculated for people who have an alcohol status coded in their health record.
Smoking %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who are current smokers, HealtheIntent, July 2024. Caveat: calculated for people who have a smoking status in their health record.
Bad General Health %	Percentage of residents who are in bad or very bad health general health, ONS census, 2021
Depression %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who have a diagnosis of depression, HealtheIntent, August 2024.
Hypertension %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who have a diagnosis of hypertension, HealtheIntent, August 2024
Asthma %	Percentage of residents aged 19+ years registered with a North Central London GP Practice who have a diagnosis of asthma, HealtheIntent, August 2024

Examples of place-based activity in Camden

On this page are listed some of the place-based activities happening in Camden, but this list is by no means exhaustive.

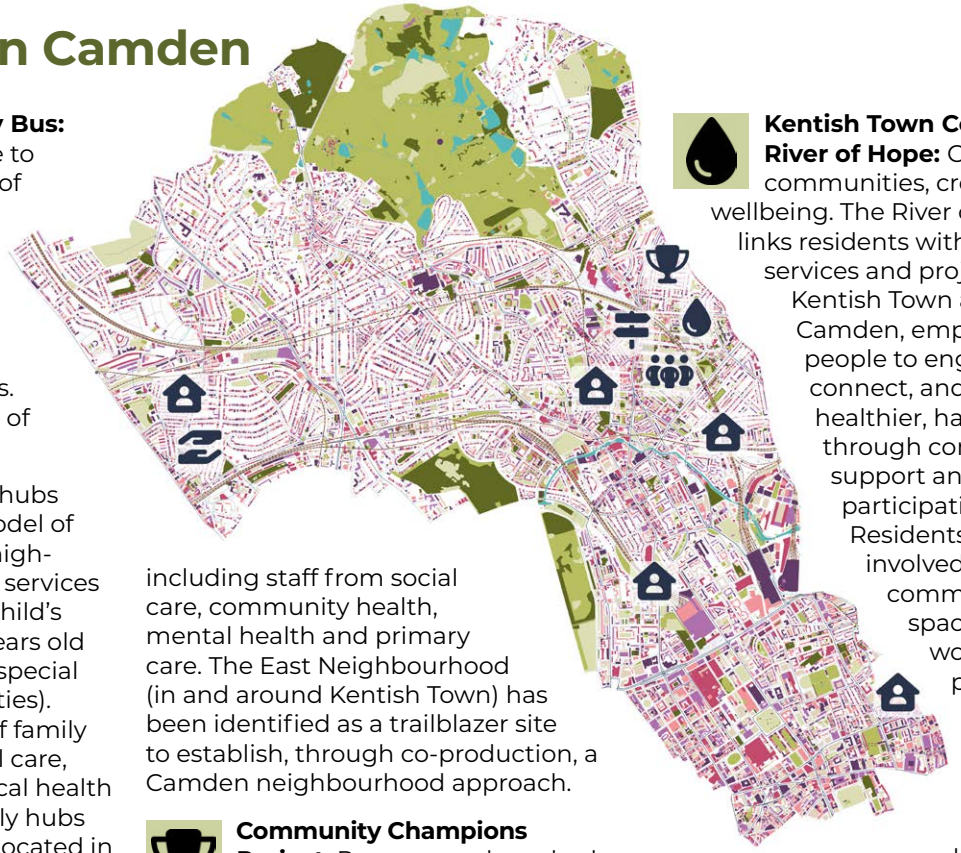
Embedding health and wellbeing measures into Camden's Draft Local Plan: the plan has an important role in shaping how Camden's places look and feel, promoting inclusion, reducing inequality, enhancing the environment, tackling climate change and securing sustainable neighbourhoods. Health Impact Assessments must be undertaken for major applications and developments that the Council considers would have the potential to give rise to significant adverse health impacts. These are a useful tool that helps to ensure that health and wellbeing is properly considered as part of the planning process. The need to mitigate the impacts of physical features such as air quality are specified.

One Kilburn: is a collaborative community partnership that brings together residents, organisations (including councils), and businesses to work towards improving the quality of life for everyone in Kilburn. Programmes include work with Kilburn Older Voices Campaign to support their campaign for public toilets in Kilburn by trialling a community-led toilet scheme in a local park and approaching businesses to allow use of their toilets for non-customers

Camden Community Bus: Originally an initiative to improve the equality of COVID-19 vaccination during the pandemic, the bus is now a frontline community service aid**,** supporting various NHS and Council initiatives to support their missions and challenges. Outreach is targeted at areas of high deprivation.

Family Hubs: Family hubs are a system-wide model of providing joined-up high-quality whole-family support services from conception through a child's early years until they are 19 years old (or 25 for young people with special educational needs or disabilities). They offer a 'one stop shop' of family support services across social care, education, mental and physical health needs. Camden has five family hubs located at children's centres located in areas of deprivation to support families with the greatest need.

Integrated Neighbourhood Teams: The Neighbourhoods programme supports Camden's corporate ambition to devolve power and deliver services at a local level in alignment with the wider offer of community-based support. It is a collective endeavour of the council, NHS and voluntary sector to support people closer to home, and enable healthy, happy and independent lives. It aims to align services through co-location of multi-agency multidisciplinary teams including staff from social care, community health, mental health and primary care. The East Neighbourhood (in and around Kentish Town) has been identified as a trailblazer site to establish, through co-production, a Camden neighbourhood approach.



Community Champions Project: Programme launched in 2020 to deliver resident-led approaches to health and wellbeing. Focussed on housing estates in three areas in Camden (Regent's Park, Kentish Town and Kilburn). The Champions will be working across each neighbourhood over the next three years, with one programme in each neighbourhood, focussing on different areas. The Community Champions programme has supported improved health and wellbeing outcomes for participants, especially in mental health and community connection, but also in food access, physical activity, and community safety.

Kentish Town Connects/ River of Hope: Connecting communities, creating wellbeing. The River of Hope links residents with local services and projects in Kentish Town and Camden, empowering people to engage, connect, and live healthier, happier lives through community support and participation. Residents can get involved by visiting community spaces for workshops, picking up one of the free maps at Kentish Town library, reading health advice in eight different categories, and signing up to the fortnightly newsletter.

Holmes Road Pilot: A pilot project since July 2023 to co-locate mental health, community safety and housing services at Holmes Road in the East Camden neighbourhood. Co-location has fostered relationships between teams that is leading to better collaboration and problem solving across services to support residents.

4. Evidence for best practice

4 Evidence for best practice

4.1 Challenges and enablers of place-based approaches

What can we learn from the literature when designing and implementing effective place-based and neighbourhood interventions and policies? The literature points to a number of challenges that are important to consider.

Catchall term: Place or neighbourhood-based approaches are often vaguely defined, and there is therefore a risk of the term becoming a catchall for a wide range of policy objectives with the risk of overload. A review by What Works Scotland[53] highlighted that:

> **"In the context of increased demand and reduced budgets there is a risk that 'a place-based approach' becomes a catchall in which to put an array of potentially inconsistent policy agendas. These agendas and rationales do not necessarily reflect a shared understanding of what is meant by 'a place-based approach' or the evidence on when a localised approach works best."**

Structural barriers: It has been highlighted that place-based approaches may neglect the underlying structural causes of poverty and might therefore be ineffective in isolation. Even robust place-based development strategies may fail to improve local outcomes in the face of broader and regional economic pressures[30]. Moreover, a significant investment of funds may be needed to reduce inequalities through implementation of place-based approaches in areas of deprivation[29].

Geographic boundaries: People tend to define their own neighbourhood in ways that reflect the geography, history and culture of where they live – which could be a single street or an area of 50,000 people. While statutory-led case studies of neighbourhood work tend to use administrative boundaries such as wards or primary care networks, community-led examples often use more flexible boundaries [54]. For example, the Kilburn community cuts across the local authority boundaries of Camden, Brent and Westminster. Examples also exist of defining a neighbourhood as a 'community of interest' – such as the homeless population in a city, or expectant mothers. Deprivation data can be used to target work to address inequalities (such as the Camden Community Bus, which is targeted to travel to areas of deprivation in Camden). Building a singular consensus around geographic borders is likely to be an impossible task, and instead we should appreciate that neighbourhood action can occur concurrently across overlapping geographies and at multiple levels.

Community involvement: Literature cites the importance of including wide representation of community voices and consideration of the balance or power within partnerships[55]. Many residents may lack the time, interest, or inclination to be involved in the decision-making processes, leaving it to a few highly engaged residents[30].But the social network of a neighbourhood is complicated, encompassing many

communities that live in the same geographical area but may not share the same views on issues like health, the local environment or use of local resources. In all communities there are underrepresented groups who face barriers to public participation, including language barriers, people with disabilities, people who experience homelessness, and those from minoritised ethnic backgrounds[56], and there should be efforts to hear from a broad range of voices.

Deprivation and community involvement: Place-based approaches are usually situated in areas of high deprivation to tackle place-based inequalities. However, there is some evidence that those living in areas of deprivation report lower levels of social cohesion in their area and weaker sense of attachment to their communities[57]. This may pose challenges when one of the key tenets of place-based approaches aims to capitalise on the assumption that neighbourhoods act as sites of identification and meaning in people's lives. Residents in these areas may also be distrustful of or let down by the system, viewing services or initiatives with suspicion or apathy, which needs to be taken into consideration when approaching these residents – it may take time to build trust and relationships.

Local relevance: One of the key rationales for place-based approaches is that they are tailored to the specific needs of an area, with interventions developed in collaboration with a community of interest, and designed to address the unique conditions of the place that they are located in. The interventions may therefore emerge iteratively and flexibly through interactions rather than by a fixed design. Evidence from case studies and pilots tried elsewhere may be less applicable within that particular context, or require adaptation to be made more locally relevant. Implementation issues have occurred where broad programme guidance and training materials developed elsewhere have not been locally adapted to local context or built on existing local relationships[58].

Meaningful co-design with local staff and residents reflected local expertise and insights into issues, opportunities and assets, leading to more bespoke interventions that are more likely to be impactful and sustainable[54].

Governance and administrative capacity: Given that place-based approaches frequently aim to improve outcomes through partnership working with diverse stakeholders, a focus on good governance is central to success[59]. There is no clear consensus on the components of effective governance in place-based approaches[60] however, these should include agreeing a shared purpose and common goals between partners at the outset, alongside a process for tracking progress[54]. While much neighbourhood work involves building on existing commitments, energies and assets, bringing together organisations and cultures requires time and investment in administrative capacity to coordinate efforts[61]. It has also been noted that successful programmes often have a single 'backbone' organisation responsible for governance[62] that can coordinate schedules of work, plan agendas, gather data and keep other organisations focused on their shared mission[63]. Availability of buildings and spaces for partners to come together has also been raised as an issue[57].

Timelines: Place-based programmes may take years to overcome the complex and entrenched disadvantages that communities face. Impacts on long-term outcomes may therefore require many years of follow-up, and so approaches to monitoring and evaluation will need to consider short-term proxy measures to understand if efforts are on track. A Welsh government review found that for many place-based projects, the anticipated impact had been overly ambitious. They concluded that it is important to be realistic (and specific) in terms of assessing what can be achieved, how far along a theory of change model it is possible to progress, and which specific changes will be generated, within the lifetime of a project[53].

A clear theory of change, and plan for measuring progress towards clearly defined goals, as well as a timeline for reaching them, can aid shared understanding and accountability[64].

Impact measurement varies across case studies, with some examples of very strong quantitative and qualitative data and others where there is limited evidence gathered[56]. However, most places can 'see and feel' the difference they're making - they may have done a formal evaluation but might also rely on observations or anecdotal evidence from staff, community members and residents. More statutory led examples tended to have more robust metrics that are established at the outset of projects, and if impact on the wider system isn't built in as a measure at the start, it can be hard to retrofit a methodology. However, evaluations that go beyond recording of activity and reach into outcomes are not available in all case studies, partly due to lack of resources. Some areas have partnered with local academic institutions to support the evaluation of outcomes which is a potentially powerful way of building evidence and learning locally and nationally[56].

Summary of barriers and enablers

A joint project by the NHS Confederation and Local Trust[65] explored a range of case studies from across England to understand common success factors around neighbourhood working to improve health and wellbeing. Their work points to a growing number of examples of inspiring community-led work across the country that highlight both ongoing barriers to change and the conditions for success (Table below).

Table of barriers and enablers to neighbourhood working, from NHS Confederation (2024), Neighbourhood working in a nutshell.

BARRIERS	ENABLERS
1. Funding challenges: Long-term, flexible funding is difficult to secure, and managing multiple streams is resource intensive.	**1. Trust-building:** Establishing trust between communities, VCSE organisations, and statutory partners is key, especially for residents with previous negative experiences and distrust of statutory services.
2. Neighbourhood definition: Statutory boundaries often do not align with how residents define their neighbourhoods.	**2. Agreed approaches:** Using flexible, context specific methods allows neighbourhoods to tailor interventions to local needs.
3. Leader dependence: Relying on a small number of leaders creates a risk if they leave or shift priorities.	**3. Co-design:** Involving communities in designing solutions ensures relevance, buy in, and adaptability over time.
4. Short vs long-term focus: Immediate needs often compete with long term investments in neighbourhood health.	**4. Shared goals:** A clear, shared purpose from the start helps maintain focus, track progress, and secure funding.
5. Data sharing: Different systems and privacy requirements make sharing data between partners challenging.	**5. Resource devolution:** Giving neighbourhoods control over funding and decisions builds trust and creates ownership.
6. Diverse views: Reaching consensus in diverse communities can be difficult, with the risk of catering to the loudest voices.	**6. Flexible and long-term funding:** Sustainable initiatives require funding that is adaptable and sustainable over time.
7. Partner engagement: Not all partners fully commit to neighbourhood working, limiting its impact.	**7. Collaborative governance:** Inclusive governance ensures representation from all stakeholders, promoting sustainability.
8. Volunteer reliance: High volunteer turnover and uneven distribution of volunteers can disrupt continuity and spread of neighbourhood working.	**8. Management support:** Dedicated staff improve coordination and appropriately handle administrative tasks, increasing efficiency.
9. Performance targets: Centralised, short term performance measures do not align with long term neighbourhood goals.	**9 Community infrastructure:** Access to physical spaces and social networks facilitates collaboration and engagement.
10. Limited infrastructure: Neighbourhoods with poor infrastructure face additional challenges in collaboration and engagement.	**10 Impact tracking:** Appropriate evaluation frameworks ensure the ability to measure and adjust efforts effectively

In their accompanying report "*The case for neighbourhood health and care*"[66] The NHS Confederation state that a change is needed in the approach taken by statutory organisations, with a willingness to:

- Let go of elements of performance management and control
- Enter into longer-term contracts and funding arrangements
- Tolerate work that is less ordered and consistent than their own
- Balance tensions between standardisation and economies of scale, and the need for local adaptation and ownership

4.2 Using data to understand place

The value of high-quality, granular data at the level of the programme or intervention is a common theme. Local data can promote a better understanding of neighbourhood context amongst stakeholders, improve programme planning and allow decision-makers to quantify the resources required and target them effectively[67]. Data gathering and analysis might include asset mapping, needs assessments and service gap analyses and social science research[68]. Broader insights beyond routine quantitative data can allow programme developers to understand an area's history and culture, social and political dynamics, and institutional strengths.

However, there are challenges in using data to develop a sufficiently comprehensive understanding of people and places at the scale and depth required to guide the development of policy and interventions. These difficulties fall into two broad categories: scale and scope.

Scale 	Place-based approaches are often hyper-local, focused on an estate or street. Much routinely collected data is limited to higher spatial resolutions and can therefore mask variation within areas. Should granular data be available there can be further challenges in ensuring data is sufficiently robust and precise to inform policy. As with all data analysis, an assessment of the level of confidence the data allows should be undertaken however, with small areas, data is inherently less precise and more subject to random (stochastic) variation, partly due to the greater proportional impact of each data point. Small area data can therefore have relatively large uncertainty estimates with implications for how confidently data-driven decisions can be made at this level. Similarly, any errors in data will have a bigger effect with a small sample size.
Scope 	Place-based approaches often attempt to tackle cross-cutting, complex issues. This can mean multiple organisations are invested in the process, be they public, private or third sector. A lack of routine or locally collected data may limit the ability to monitor progress. Identifying the stakeholders and beneficiaries in a place, developing a theory of change, and measuring enablers and progress towards change can be resource intensive. Low levels of data literacy among project partners or gaps in local knowledge and expertise may mean that local practitioners lack the resources and capacities to collect, analyse and interpret data To establish a shared understanding of place it can be necessary to combine multiple datasets from across different organisations – datasets which may vary in resolution, format, quality, and availability. This can introduce challenges related to technicality (of data linkage) and information governance (particularly in the case of person-level data sharing). Similarly place-based approaches often, at least in part, intend to effect less tangible concepts such as shared identity and community engagement. These can be difficult to measure directly or consistently across different interventions and places and even suitable proxy measures may not be routinely collected with the recency and granularity required. This can make assessing needs or evaluating impact difficult.

While these challenges are likely to be persistent, they do not prevent place-based approaches adopting a data-driven method and can be mitigated through establishing capabilities to link data, generate new evidence, and tie evidence and data to outcomes.

Linked Data 	Establishing routine linked datasets at a granular level is vital to undertaking a place-based approach. By linking data at an individual, household, and small area level a more accurate understanding of place can be formed and, if sufficiently diverse data sources are included, better evidence for targeting interventions and evaluating success is possible. Whilst there can be governance challenges, especially when transferring data between organisations, linked datasets within organisations which share levels of granularity can still provide considerable benefit; for instance, building cohorts of smaller groups that can be shared at an aggregate level but preserve their underlying characteristics. **Example:** Identifying an agreed set of Unique Property Reference Numbers that are houses of multiple occupation in both Council and NHS data allows sharing of aggregate statistics (such as the prevalence of a disease or quality of housing) in a way that is actionable for all organisations.
Robust Theory 	Linking evidence to outcomes through processes such as Theory of Change allows for a wider array of proxy measures to be identified and used. By establishing why a change in a proxy measure will affect an outcome, it is possible to demonstrate impact indirectly, better account for confounding factors, and potentially to establish shorter term measurements that may indicate positive or negative changes more quickly. **Example:** Attempting to directly evidence a change in community cohesion may be very difficult but is a plausible aim for a place-based approach. With a Theory of Change it is possible to identify the outputs of activities, the outcomes these are expected to lead to, and how these link to the impact desired. In this case outputs may include participation rates in community events or footfall in community spaces while outcomes may include civic engagement and community safety. These intermediaries are more likely to be measurable and show progress in the short term.

Robust Methods	Suitable analytical methods and approaches to extract usable meaning from data are required, especially when working at hyper-local levels common in place-based working. Recognising where analytical methods can and cannot inform action is important as well as how this may differ depending on the nature of the question; for instance, providing inference about how a factor may impact on health may require a large sample size and be severely impacted by uncertainty, while merely identifying people with a characteristic may face less uncertainty. The wider evidence base can also demonstrate effects that may not be easy to demonstrate at a local level, but which are likely to exist locally. This evidence can be drawn from larger Camden-wide work or from wider literature. The choice of analytical methods also has an impact on how applicable data is. For example, the use of regression to control for confounding effects or the use of weighting and small area estimation to improve the representativeness of surveys provide mechanisms to improve the robustness of evidence. In all cases, whilst accounting for statistical uncertainty can make decision making harder it is vital that it is included in analysis to prevent overly confident assertions from data. **Example:** Evidencing the impact of housing on health may be difficult at a small area due to small numbers, creating large uncertainty in the results. However, at a Camden, London, or national level it mayw be possible demonstrate the impact, controlling for cofounders like income, and to couple this with wider literature on the relationship. Camden Council has a strong history of resident engagement, including related to housing and health through interviews and surveys. These may not reflect the precise characteristics of the place of interest but could be the basis for modelling an estimate of the likely responses to inform policy.
Primary Data Collection	In some cases, evidence about the views, needs, and characteristics of a place or suitable metrics to evaluate the impact of interventions will not be available. Primary research and data collection can be used to gather the additional information required, for instance through surveys, focus groups, interviews, and observations. These methods can require considerable resource and planning but can provide unparalleled relevance and depth to questions that may not be otherwise answerable, and evidence of effectiveness that cannot be captured through quantitative metrics alone. 'Realist' evaluation approaches are about investigating context and underlying causal mechanisms to understand 'what works, for whom and under what conditions.' Participatory research can also form part of the intervention, for example increasing community buy-in by having a process where residents can be actively involved in the research or data collection process. **Example:** Place-based interventions often attempt to address issues in a way that gives residents power and control. Doing this requires an understanding of what matters to residents and what facilitators can be put in place to assist them to be empowered. Given the specificity of geography and local issues, primary data collection and research is likely required.

5. Recommendations

5. Recommendations

Camden should continue and strengthen its neighbourhood approaches to health and wellbeing

- Places and neighbourhoods impact our health and wellbeing in numerous and interconnected ways. Residents, third-sector organisations, services and state actors all play a role in shaping what a place is.
- Local government is uniquely placed to influence and modify many aspects of neighbourhood environments to become health promoting through adopting and encouraging a 'health in all policies' approach. Neighbourhood approaches to health and wellbeing are also being adopted widely across the health system.

We must improve our collective understanding of place, including local assets and networks

- Camden has begun to organise around five neighbourhood geographies, helping partners coalesce, and further work is taking place at other levels such as social housing estates. However, it is important to remember that administrative boundaries do not always reflect how a community understands itself.
- Better understanding of and awareness of Camden, its people and places, and variation in needs, may lead to new connections and opportunities by tapping into existing local assets and networks at a hyper-local level.

We must improve access and reach into communities by connecting with existing assets, settings and spaces

- Efforts such as the Camden Community Bus and Community Champions groups have the potential to strength connections to between communities, the Council, and local health and VCS partners.
- We should consider how we can improve access to services and expand use of existing settings, institutions and community events in the delivery of health and wellbeing initiatives (such as pharmacies, family hubs, schools, workplaces, community venues and public spaces).

We must improve the granularity, breadth, and utility of quantitative data at a place level

- Addressing cross-cutting issues at a hyper-local level requires precise data spanning the determinants of health and wellbeing, and understanding of variation in needs between areas of Camden
- While progress has been made, data is still often siloed and coarse. Data within Camden Council and wider partners must be integrated in line with the organisational Data Strategy.
- In order to provide robust evidence, data must be analysed with appropriate statistical methods, incorporating uncertainty whilst providing sufficient clarity to guide action.

Multiple types of evidence are needed to inform policies and interventions at place

- Quantitative and qualitative evidence must both play a role in informing work at a place level to inform the opportunities and challenges at a granular level, and to evidence what may work. This includes learning from existing literature and evidence in the design of policies and interventions.
- Combining this evidence to guide policy requires time for the

development of theory of change models, which detail why we think a policy will be effective, while avoiding unintended consequences.

Primary data collection to capture resident and staff voices is likely to be vital

- The far-reaching potential of place-based interventions is likely to require information that is not currently routinely collected by services, both to inform policy development and evaluate the success of work. This information may be quantitative or qualitative in nature, but requires considered and measured approaches to ensure residents and staff are effectively engaged, and that evaluation captures the full range of impact of initiatives.
- Working in novel ways will require the production of new information or knowledge. This may include testing an idea, theory, or new intervention. Undertaking ethical, effective, and impactful research requires new infrastructure, capabilities, and capacity.

Trust, power, and cultural considerations are imperative to successful place-based working

- Community involvement is a crucial element to the success of place-based approaches, but trust, power and cultural considerations are important to consider.
- Time, resources and administrative capacity is needed to build relationships, establish a shared vision, and coordinate activity.

Ambitions, and timescales, must be realistic in the face of complex, ingrained challenges

- Achieving significant, sustained change takes time and while signals of progress may be visible a robust evaluation and understanding of impact may take time. Realistic ambitions and timelines are needed to avoid disappointment and loss of momentum.

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Glossary

A&E – Accident and Emergency Department (of hospital)

ACE – adverse childhood experiences

AFS – Asthma Friendly Schools

AMHS – adult mental health services

APHR – Annual Public Health Report

ARFID – avoidant restrictive food intake disorder

CAMHS – child and adolescent mental health services

CSE – child sexual exploitation

CITB – Construction Industry Training Board

CYP – children and young people

DfE – Department for Education

EHCP – educational health and care plan

FSM – free school meals

HSE – Health Survey for England

ICS – integrated care system

IPS – Integrated Paediatric Service

ITIP – trauma-informed practice

IYSS – Integrated Youth Support Service

iMHARS – Islington Mental Health and Resilience in Schools

LCS – locally commissioned service

LSOA – Lower Super Output Area

MHST – mental health support teams

NCL – North Central London

NEET – not in education employment or training

NICE – National Institute for Health and Care Excellence

Ofsted – Office for Standards in Education, Children's Services and Skills

ONS – Office for National Statistics

PAAP – personalised asthma action plan

PE – physical education

PRU – pupil referral unit

PSHEE – personal social health and economic education

SEND – special educational needs and disabilities

TYS – targeted youth services

VAWG – violence against women and girls

VRU – Violence Reduction Unit

Acknowledgments

I would like to thank everyone involved in the production of this report, including:

Hannah Davies (Public Health Registrar)

Polly Kaplan (Public Health Registrar)

Wikum Jayatunga (Public Health Consultant),

Annie Yu (Senior Public Health Intelligence Analyst)

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