

IMPROVING OUR PUBLIC'S HEALTH

**The public health strategy for the
London Borough of Hammersmith and Fulham,
the Royal Borough of Kensington and Chelsea and
the City of Westminster**

2015 – 2025

INTERNAL DOCUMENT

For sharing with internal council directorates and the three CCGs only

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Foreword

Two years on from the transfer of public health responsibilities from the NHS to local government we have made great progress in taking on and developing our approach to the improvement of health and wellbeing in our communities and in reducing health inequalities.

There is an overwhelming consensus on the importance of prevention in limiting levels of ill-health and early death. This is not only important at an individual and a family level, where living with a long term condition such as diabetes or heart disease can present daily challenges, but it is also true for whole communities and wider society. We want to help create environments where people prosper and achieve their full potential, avoid preventable illness and live longer and more fulfilling lives.

The importance of prevention in helping achieve long term sustainability of the health and care system has been echoed in a range of national documents, from the Wanless Review in 2002, the Marmot review in 2010 to the NHS Five Year Forward Plan in 2014. Local authorities, with their new leadership role in improving health and wellbeing through public health services play a fundamental part in helping achieve this.

Since April 2013 public health functions have been embedded into the working of the three councils, making connections with other services, developing key programmes such as tackling rising rates of childhood obesity and providing seed funding across the councils to help deliver the improved public health outcomes we want to see. A structural review of how our public health capacity and capabilities work is currently in progress. This is expected to help deliver further efficiencies and focus in achieving our priorities.

This 10-year Public Health Strategy is designed to create sustained focus and action on the key areas that we believe will make a tangible difference to the lives of residents in our three boroughs. Our six shared priorities reflect the challenges that are common across all three boroughs and our individual priorities direct attention to those issues which are most important to each individual borough. Improving outcomes at this scale takes time and concerted effort across a range of partners and stakeholders. This strategy will serve to galvanise our collaborative efforts and deliver positive changes to the health and wellbeing of our residents.

As the public health lead cabinet members for the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and Westminster City Council, we endorse this strategy and encourage services across all three councils, and wider partners, to work together to help achieve these ambitions for our residents.



Cllr Vivienne Lukey
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| London Borough of Hammersmith and Fulham | Royal Borough of Kensington and Chelsea | Westminster City Council |
|--|---|--------------------------|



Transferring responsibility for the public's health back to local authorities is the biggest shift this area has seen for decades.

It's an exciting challenge and represents a huge opportunity for our three boroughs to work together and improve wellbeing, reduce health inequalities and enable the delivery of higher quality care.

This strategy sets out our priorities for the next ten years and while improvements won't be apparent overnight I believe we can lay the foundations to help our residents live long, healthy and fulfilling lives.

Our three councils cannot achieve this alone and we are committed to sharing learning and experience between council departments, clinical commissioning groups, GPs, third sector organisations and local people.

This strategy is ultimately about enabling council services to work together to deliver our public health priorities. It will be kept on track through annual updates and three-yearly reviews, which will link strongly to the three health and wellbeing strategies.

Liz Bruce

Executive Director of Adult Social Care and Health
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OUR PUBLIC HEALTH STRATEGY AT A GLANCE

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|--|---|-----------------------------------|-------------------------------------|----------------------------|---------------------------------|
| OUR VISION | | | | | |
| By 2025 Hammersmith & Fulham, Kensington & Chelsea and Westminster will be places where everyone starts life well, lives well and ages well | | | | | |
| OUR MISSION | | | | | |
| <ul style="list-style-type: none"> • To use our expertise and resources effectively and holistically • To work across all council services and with partners across the whole system • To tackle the health challenges within our boroughs • To address the wider determinants of health and health inequalities • To create opportunities for our residents to enjoy good health and wellbeing | | | | | |
| SHARED PRIORITIES | | | | | |
| The councils will work together, sharing services and approaches as appropriate to tackle our common health challenges and shared priorities: | | | | | |
| PRIORITY 1 | PRIORITY 2 | PRIORITY 3 | PRIORITY 4 | PRIORITY 5 | PRIORITY 6 |
| Reducing levels of obesity in children | Reducing smoking rates | Improving sexual health | Reducing levels of substance misuse | Improving mental wellbeing | Improving preventative services |
| BOROUGH SPECIFIC PRIORITIES | | | | | |
| We will also drive work individually to meet the challenges of particular importance to our boroughs: | | | | | |
| HAMMERSMITH & FULHAM | KENSINGTON & CHELSEA | WESTMINSTER | | | |
| Reducing the health inequalities associated with childhood poverty | Encouraging more people to be physically active | Overcoming barriers to employment | | | |
| MEASURING IMPACT | | | | | |
| A series of high level outcomes will be monitored annually and reviewed every three years to monitor our progress towards achieving our 2025 vision | | | | | |
| OUR UNDERPINNING PRINCIPLES | | | | | |
| USING THE EVIDENCE | WORKING IN PARTNERSHIP | INVESTING IN PREVENTION | A LIFE STAGE APPROACH | | |

1 INTRODUCTION

- 1.1 The Health & Social Care Act 2012 placed local leadership for public health within councils in order to benefit from their central role in providing and shaping many of the things that influence people's lives such as education, housing, employment, the built environment, social care and regulation.
- 1.2 Councils now have a statutory duty to improve the health of their residents, tackle health inequalities and ensure that robust plans are in place to protect the health of their local population.
- 1.3 The communities we serve experience marked inequalities in health caused by a range of factors¹:
 - the wider determinants of health, including employment, environment, education and housing;
 - the lives people lead, including tobacco and alcohol use, being overweight, levels of physical activity and social connectedness;
 - the health services people use, including the accessibility and of primary care (i.e. GPs), secondary care (i.e. hospitals) and preventative care (e.g. measures taken to prevent diabetes).
- 1.4 These affect many aspects of people's lives, including quality of life, health experienced and how long a person may live. We recognise that, in order to address these effectively, we need to work in different ways, work closely with our partners and work to reduce, and ultimately close the health inequalities gap experienced by many of our residents.
- 1.5 Our aim is to use the full range of council influence and functions to achieve this and to provide a clear focus on the priorities that will help make our boroughs places where everyone starts their life well, lives well and ages well.
- 1.6 This strategy will be reviewed every three years, with annual updates, in order to monitor our progress towards achieving our aims and to help ensure that our priorities remain relevant and focused.

Our Mission

- 1.7 By 2025 Hammersmith & Fulham, Kensington & Chelsea and Westminster will be places where everyone starts life well, lives well and ages well.

¹ DH (2010) Tackling inequalities in life expectancy in areas with the worst health and deprivation. <http://www.nao.org.uk/wp-content/uploads/2010/07/1011186es.pdf>

- 1.8 We will use our public health expertise and resources effectively, working across the councils and with partners to tackle the health challenges within our boroughs and to create opportunities for our residents to enjoy good health and improved wellbeing.
- 1.9 In doing this, we will work closely with our partners across the system and draw on the evidence of what works, including giving full consideration to what interventions and services are shown to be cost-effective, in order to invest in prevention across throughout a person's life.
- 1.10 In particular, we will enable all council services to contribute to the achievement of our public health priorities through work to address inequalities in health that result from the wider determinants.

What this strategy will do

- 1.11 In order to ensure that we achieve our vision this strategy helps to begin the conversation with our residents and communities. It will help our residents to understand what we are currently spending our public health budget on and what this is achieving. This will enable us to set out how we will address the needs of our residents and communities and align our actions with both the councils' priorities and the Department of Health's Public Health Outcomes Framework (PHOF)². Some of these priorities are shared priorities which we will deliver across the three councils. However, as populations and needs differ across the three boroughs, specific priorities have been identified for each council.
- 1.12 The strategy identifies where priorities may be addressed through the use of public health resources to develop new, or re-commissioned, services for our residents. We are currently in the process of conducting comprehensive reviews of all our public health services. This will identify where there may be opportunities for improved ways of working across council departments and with our partners to help improve the wider factors that influence health, such as housing, environment, employment and education.
- 1.13 Much of the success of this strategy will be dependent on the positive engagement from services and wider partners. Achievement of these priorities will be delivered most effectively by different services working together and sharing aims. For example, action on effective tobacco control and encouraging cycling require coordinated effort across several council services. A key indicator of success therefore is the degree to which stakeholders are

² <http://www.phoutcomes.info/>

engaged and influenced to shape services that positively contribute towards addressing these priorities.

1.14 This strategy therefore prioritises:

- action in areas where there is the greatest evidenced need;
- where it is lacking building evidence through innovation, such as piloting initiatives, and evaluation;
- investment in services that support prevention and early intervention through promoting healthier behaviours and improve the wider determinants;
- reducing demand that results from preventable ill-health;
- delivery of sustainable outcomes;
- identification and use of local assets where possible; and
- building resilience at both the individual and community level.

2 BACKGROUND

What is public health?

- 2.1 Public health is about helping people to stay healthy, and protecting them from threats to their health. Rather than treating each case of disease or health condition as it occurs in an individual public health focuses on understanding and addressing the key patterns and causes of disease in a whole population.
- 2.2 This is done by using information to assess what people's health needs are now and what they are likely to be in the future, and then responding to these by using scientific evidence, data and other information to help create strategies, policies, environments and services which improve health, prevent illness and reduce health inequalities.
- 2.3 Public health's primary purpose is to prevent avoidable disease and to increase both quality and quantity of life (i.e. adding years to life and life to years) by working to protect and improve health and wellbeing for everyone throughout the course of their life. The underlying principle therefore is that prevention is better than cure.

Our statutory responsibilities

- 2.4 Section 12 of the Health & Social Care Act 2012^{3,4}, places a duty on local authorities to improve the health of the public, including ensuring the provision of:
- information and advice (for example giving information to the public about healthy eating and exercise) and important contributions to joint strategic needs assessments (JSNAs); and
 - services for the management of health risk factors such as such smoking, and overweight and obesity.
- 2.5 Regulations⁵ made under Section 6c of the NHS Act 2006 require local authorities to ensure the provision of:
- the weighing and measuring of children in reception class and Year 6 (the National Child Measurement Programme, NCMP);
 - health checks for people aged 40-74 years;
 - open access sexual health services;
 - a public health advice service to clinical commissioning groups (CCGs) in their area; and
 - information and advice on the preparation for and the management of threats to people's health such as infectious diseases, environmental hazards and extreme weather conditions.
- 2.6 The Health & Social Care Act 2012 also requires councils to have regard to the Department of Health's Public Health Outcome Framework (PHOF) which includes a range of measures across two key outcomes and four domains [see appendix].

Improving the public's health is everyone's responsibility

- 2.7 In helping councils undertake public health responsibilities, and in recognition of the cross-cutting nature of many health issues, public health professionals now provide a shared service across the three boroughs and work closely with many council departments. These public health professionals are led by the Director of Public Health (DPH) who has legally defined responsibilities for advocating and leading for the health and wellbeing of residents.

³ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm>

⁴ Local authorities' public health responsibilities <http://www.parliament.uk/business/publications/research/briefing-papers/SN06844/local-authorities-public-health-responsibilities-england>

⁵ <http://www.legislation.gov.uk/ukdsi/2012/9780111531679>

- 2.8 An important function of the DPH is to use a range of information and evidence to help understand local health needs in order to inform work with residents and local communities, so that council and local NHS services are designed to meet those needs. Much of this information will be presented in JSNAs and will be used by the health and wellbeing boards.
- 2.9 The cross-cutting nature of this strategy aligns with aspects of the councils' corporate strategies and will help achieve their commitments, particularly through its focus on achieving population level improvements in health, wellbeing and prevention. This strategy is also influenced by, and supports delivery of, each borough's health and wellbeing strategy. Each health and wellbeing board will be able to consider these priorities when reviewing their strategies^{6,7,8,9}.
- 2.10 The strategy will provide the framework and context for considering how relevant national, London-wide and partner¹⁰ strategies align with our priorities and will be reviewed every three years, with annual updates, to ensure that it remains relevant and focused.
- 2.11 Borough-specific public health business plans will be developed to ensure the delivery of our public health priorities. These will be further informed by detailed information provided by the JSNAs for each borough, and which provide a strategic overview of population health challenges over the coming years.

Using our public health budget effectively

- 2.12 Each council has a public health grant, currently ring-fenced, which allows us to commission and fund a range of services that contribute to achieving our aims.
- 2.13 In future the public health budget will be aligned to the identified priorities within this strategy and its use will be consistent with the key underpinning principles of using the evidence base and investing in prevention.

⁶ <https://www.westminster.gov.uk/sites/default/files/uploads/workspace/assets/publications/Westminster-Joint-Health-and-Well-1364920681.pdf>

⁷ http://www.kcsc.org.uk/sites/kcsc.org.uk/files/documents/RBKC_docs/Kensington%20and%20Chelsea%20JointHealth%20and%20Wellbeing%20Strategy%202013_2016%20Print%20docx.pdf

⁸ http://www.lbhf.gov.uk/Images/131104%20FINAL%2010_16jcw_health_and_wellbeing_strategy_2013_rev2_tcm21-184369.pdf

⁹ http://transact.westminster.gov.uk/docstores/publications_store/city_for_all/city_for_all_booklet.pdf

¹⁰ Including the NHS, HealthWatch, and the Voluntary and Charitable sector

2.14 Across the three councils the current public health budget stands at £73 million per annum. The individual borough allocations are:

| | |
|------------------------|-------------|
| Hammersmith and Fulham | £21 million |
| Kensington and Chelsea | £21 million |
| Westminster | £31 million |

[convert table to infographic]

2.15 A further £11 million per annum will be transferred from the NHS to the three councils in autumn 2015 to cover additional responsibilities for child health programmes (principally health visitor services) for the 0 to 5 year age group.

2.16 During the lifetime of this 10-year strategy, it is expected that the ring-fence will be removed and that the grant allocation may be reduced. Over this time it is also expected that wider council funding from central government will continue to reduce.

2.17 It is therefore vital that we all use our resources wisely and effectively in order to encourage and embed the achievement of our priorities over the coming years. This will include reviewing all of our contracts, re-commissioning strategically relevant services in line with best value principles and using evidence wherever possible.

3 OUR HEALTH CHARACTERISTICS

3.1 Whilst each of our boroughs is a unique and distinct area, our residents share some common health characteristics and needs. These shared issues may best be addressed by working in partnership and providing joined up services across the boroughs so as to help improve value for money and outcomes for our residents.

Common features across the three boroughs

[use infographics]

3.2 All three boroughs show socioeconomic contrasts, with wide variations in affluence and deprivation within them. This is an important feature, with consequent impacts on health inequalities and health outcomes as less

affluent population groups generally tend to experience poorer health and shorter life expectancy.

- 3.3 The main causes of death in our three boroughs, as elsewhere in London and England, are cancer, heart disease, stroke and respiratory disease. However, improved health generally, reductions on the prevalence of smoking, and advances in healthcare and earlier diagnosis often mean that individuals live longer with long-term disease than would have been the case in previous generations. Lifestyles and external influences are significant factors for all of these causes of death and disease, with smoking, insufficient physical activity and inappropriate diet, as well as poor housing and unemployment, making significant contributions.
- 3.4 The three boroughs have a larger proportion of black and minority ethnic (BME) groups than the national average. Some people in BME groups have a higher incidence of some long-term conditions, such as diabetes and heart disease, than others. This has implications for the prevention services we commission as well as for the local provision of health and social care services.
- 3.5 There are some very positive health outcomes for children and young people across the three boroughs. For example, a comparatively low number of women smoke during pregnancy, there are low numbers of babies born that are underweight and breastfeeding levels at 6-8 weeks after birth are relatively high. These factors all help to give children a good start in life.
- 3.6 However, there are other outcomes where we are not doing as well as we could. For example, tooth decay and childhood obesity are higher than London and England averages and childhood immunisation rates are generally lower than London and England.
- 3.7 A significant number of our children and young people live in deprived areas, with ten wards across the three boroughs having over 40% of children classified as living in poverty. These children and families are more likely to experience poorer health and social outcomes. For example, whilst the number of under-18 year olds giving birth across the three boroughs is relatively low, the majority live within the same small, often deprived, areas. Many of our young people that are out of work and not in education also tend to live in the more deprived areas and households, and live in the poorest housing conditions.
- 3.8 The three boroughs all experience high levels of obesity in school year 6 children. This reflects national trends and indicates the scale of likely future

impact through increasing demand and ill-health associated with diabetes and cardiovascular disease (heart disease and stroke).

3.9 A key feature of the three boroughs is the larger than average proportion of the population of working age, with the consequent health related issues and behaviours associated with this age group. For example, the smoking rate in Hammersmith and Fulham is 22%, compared to the London average of 19%. Rates can often be more than double this in the more deprived areas within our boroughs and amongst particular groups.

3.10 All three of our councils have characteristics associated with urban environments, deprivation, mobile populations and changing social behaviours:

- all are in the top 12 of boroughs in England for the incidence of sexually transmitted infections (STIs) and for the prevalence of HIV infection;
- the estimated prevalence of drug and alcohol use across the three boroughs is high;
- although the number of people with learning disabilities is low in each of the three boroughs, and employment rates are on a par with London levels, people with learning disabilities tend to have worse employment prospects than other disability groups;
- sickness absence is estimated to cost the economy of the three boroughs around £84 million per annum in employer costs, health and social care costs and welfare¹¹, with mental ill-health being the main cause of long-term sickness absence, closely followed by musculoskeletal problems;
- the prevalence of mental health problems is estimated to be high across the boroughs;
- hotspots of very poor air quality are found across the three boroughs, which are likely to have a greater impact on more vulnerable residents such as those living with cardiovascular or respiratory disease;
- we have a large homeless population who tend to have much poorer health and a markedly different pattern of service use than the general population;
- incidence of tuberculosis (TB) in all three boroughs is significantly higher than England.

3.11 All three boroughs also attract a large number of daytime visitors and workers. This has an impact on health outcomes for our residents as well as leading to higher demand for some services which serve the working age population in particular, such as sexual health services.

¹¹ <http://www.jsna.info/sites/default/files/Employment%20Support%20JSNA.pdf>

- 3.12 Whilst all three boroughs have a smaller proportion of residents aged over 65 years compared to England, both Westminster and Kensington & Chelsea have a larger proportion than the London average, and Hammersmith & Fulham is only just below this level. With an ageing population it is estimated that the over-65 age group will increase by around 50% across the three boroughs over the next 20 years, with the most growth expected to be in the over-85s. Although such predictions cannot be completely accurate due to the effects of other factors such as migration, a substantial increase in demand for older people's care is expected.
- 3.13 The challenge of an ageing population therefore is to ensure that people are supported to maintain their health and independence for as long as possible. Many of the risk factors that can cause older people to lose their independence require collective action across a number of council services, the NHS and community and voluntary services. Vulnerable older people are likely to experience a number of risk factors or conditions including fuel poverty, social isolation, falls, malnutrition and dementia. Many of these issues are inextricably linked to the priorities set out in this strategy, for example, social isolation is a risk factor for poor mental wellbeing.
- 3.14 Alongside these common issues, each borough has individual challenges which require particular attention.

Hammersmith and Fulham

- 3.15 Thirty per cent of children in Hammersmith and Fulham are estimated to live in poverty. This is a slightly higher rate than the London average but a much higher rate than nationally. The areas with the highest rates of child poverty tend to be areas of social housing, which also tend to be the areas with the highest concentration of children. Wards with a particularly high proportion of children living in poverty include, College Park and Old Oak, Wormholt and White City.
- 3.16 Since the beginning of the 2008 recession the national and local profile of families in poverty has changed significantly. Previously, as workless families formed the majority of those living in poverty, measures to address this focused on reducing worklessness¹². However, those in poverty are now more likely to be in work, and with low wages being the main contributory factor to

¹² The term *worklessness* includes people who are unemployed and people who are economically inactive, such as people who are sick, disabled, students, carers and retired people. It is therefore a wider definition than those people classified as 'unemployed' and includes those people that may want to find employment but may be unable to because of caring responsibilities or other barriers.

child poverty rather than worklessness. Therefore fresh approaches are likely to be needed to address child poverty and its health impacts locally.

Kensington and Chelsea

- 3.17 Overall, residents in Kensington and Chelsea tend to have a higher than average life expectancy. However, there are some areas, predominantly in the north of the borough, where health outcomes are much poorer and where residents may need more support. Forty-seven per cent of the households in the borough are single person households. This is the highest in the country and almost half of older people live alone. This carries a significant risk of social isolation and poorer mental wellbeing, and means that older people may need more support to remain independent in their homes.
- 3.18 Estimates indicate that around 20% of people in Kensington and Chelsea undertake the recommended level of physical activity. Although similar to the England average, increasing levels of participation in physical activity, particularly in those groups and individuals that are the most inactive, are expected to contribute to improving many of these characteristics. Examples of such activities include healthy walks for older people which encourage both physical activity and social connectedness.

Westminster

- 3.19 With a resident population of around 240,000, and with a four-fold daily increase due to visitors and commuters, Westminster's local economy is vibrant and diverse. However, there are wide socioeconomic differences across the borough, including high levels of children living in poverty in areas such as Church Street, Westbourne¹³, Queen's Park¹⁴ and Churchill and Harrow Road. These differences are also reflected in high local rates of mental ill-health. Westminster also has the largest concentration of rough sleepers in the country, accounting for three quarters of the rough sleeping population in London. These issues have associated impacts on physical health and wellbeing.
- 3.20 There is strong evidence to support the link between economic prosperity and better health and wellbeing. A key contributor to improving the health outcomes in some of these areas is through supporting vulnerable groups into employment and safe housing. Enabling the most vulnerable members of society into work, and helping people overcome some of the barriers to

¹³ Ranked 1st and 2nd highest proportion in London

¹⁴ Ranked 9th highest proportion in London

employment, such as parental responsibilities, is expected to lead to improved health and wellbeing outcomes.

4 WHAT WE WILL DO

- 4.1 We will work together, as councils and with our partners, to share services and approaches to tackle both our common and individual health challenges. In many cases, we will need to do this by investing our resources more effectively so that they are focussed on prevention in the areas of greatest need.
- 4.2 This 10-year strategy aims to maintain strong focus on the key areas that will produce tangible improvements in our residents' health and wellbeing.
- 4.3 We have six shared priorities. Of these, two are considered to fundamentally underpin achievement of the others and are therefore identified as 'underpinning priorities':

- Reduce childhood obesity by increasing the number of children that leave school with a healthy weight
- Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children
- Improve sexual health by reducing the rates of sexually transmitted infections and unplanned teenage pregnancy
- Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatments services
- Improve mental wellbeing by promoting and sign-posting to preventative and joined up services [*an underpinning priority*]
- Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion [*an underpinning priority*]

4.4 Alongside our shared priorities each council has identified individual priorities based on local needs and challenges:

- **Hammersmith and Fulham**
To reduce the health inequalities associated with childhood poverty
- **Kensington and Chelsea**
To increase the number of people being physically active
- **Westminster**
To overcome barriers to employment

5 OUR SHARED PRIORITIES

- **Reduce childhood obesity by increasing the number of children that leave school with a healthy weight**

To improve quality of life and reduce the future prevalence of diabetes

- 5.1 Childhood obesity is associated with a wide range of health problems in childhood including respiratory illness, interrupted breathing during sleep and high blood pressure. If obesity persists into adulthood there are also increased risks of developing diabetes, some cancers and cardiovascular disease.
- 5.2 We need to do much more to support children and families to eat well, move more and maintain a healthy weight. For example, by supporting parents and children to make positive behaviour changes through promoting participation in physical activity and encouraging healthy eating from an early age it helps embed positive lifestyle habits for life.
- 5.3 As behaviour is also affected by our physical environment we will also support approaches that help make the built environment less obesogenic and provide more opportunities for making healthy choices easy choices.

By 2025 there will be

- **a higher proportion of children leaving primary school with a healthy weight**

5.4 We will do this by:

- investing around £2.5 million per year in healthy weight services for children and families;
- investing in frontline staff in social care, education and health to ensure that those in most need are offered appropriate advice, support and services when in contact with professionals;
- working with relevant departments across the councils, and with our partners, to identify how we can make changes to the physical environment to enable healthier choices;
- working with children and families to design tools that will help them make healthier choices in their everyday lives;
- evaluating our actions and interventions rigorously to understand what works and how so we can share our learning widely.

- **Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children**

To reduce long term respiratory illness and early mortality

5.5 Although rates continue to fall, smoking remains the single largest contributor to preventable illness and premature death. Smoking is also costly, estimated at around £110m¹⁵ a year to the local economy. Although around 25% of these costs fall to the NHS through hospital admissions, GP consultations and prescriptions, the Government also pays for sickness/invalidity benefits, widow's pensions and other social security benefits for dependants and the economy as a whole pays in days lost to work.

5.6 Our councils already do a lot to help residents to stop smoking. In 2013, we invested £2.6 million in stop smoking services, including working with premises providing shisha, and in a service aimed at helping prevent young people from starting to smoke. Reducing smoking rates continues to be a key preventative public health priority for each of our boroughs so that we can support our residents to live longer, healthier lives.

¹⁵ Modelled estimates indicate that smoking related healthcare costs are around £25.8 million, with a similar cost due to loss of productivity (£22.8 million). Output loss due to early deaths was greater than hospital costs at £31.4 million.

By 2025 we will have

- ***reduced smoking prevalence in adults and children by a further 2% on the 2014 baseline***
- ***implemented initiatives that focus on harm reduction with people who are still smoking as part of individual plans to quit***
- ***reduced the proportion of people who start to smoke, especially children***

5.7 We will do this by:

- continuing to invest in high quality stop smoking services;
- working more closely with our service providers and health partners, such as GPs, pharmacies and hospitals, to target specific groups who may find it more difficult to stop smoking;
- using the wider powers that we have as councils to stop the illegal sale of tobacco to children and the sale of illicit cigarettes;
- working more closely with schools and young peoples' groups to support anti-smoking campaigns;
- support the Smoke Free Alliance to integrate the work on tobacco control across fire services, trading standards, licensing, environmental health, hospital and mental health trusts, community organisations and stop smoking services;
- prioritise the areas with the highest rates of smoking prevalence for the take up of stop smoking services;
- encourage referrals to stop smoking services through delivering the NHS health checks programme.

- **Improve sexual health by reducing the rates of sexually transmitted infections and halting the rise of unplanned teenage pregnancy**

To support personal resilience, self-esteem and promote healthy choices

5.8 All three councils are in the top 12 in England for the incidence of sexually transmitted infections (STIs) and for the prevalence of HIV infection. These diseases cause unpleasant short-term symptoms, are highly infectious and can lead to longer term health problems such as infertility, cancer and HIV.

5.9 Jointly, the three boroughs currently spend almost £13 million per year on testing and treatment services for STIs as well as £3.4 million on contraceptive services and £3.2 million on related services. This investment is among the highest in both London and England.

- 5.10 Despite this level of spending we still need to shift focus further to prevention. The money needed to support these services will continue to rise unless we halt the growing prevalence of STIs through unsafe sex.
- 5.11 It is therefore clear that a new approach is needed, which is based on an assessment of need, and that has a greater emphasis on prevention and early diagnosis, improved access to services, and that maximises the improvements that we can achieve through our investment.

By 2025 we will have

- ***halted the year-on-year rise in sexually-transmitted infections***
- ***transformed our delivery systems to ensure that best outcomes are achieved through sustainable and cost effective services***

5.12 We will do this by:

- developing a stronger and more whole-system strategic approach, following assessment of health and behaviour needs;
 - investing in prevention services to encourage and enable people in all age, ethnic, cultural, faith and socio-economic groups to be better informed and better skilled at practising safer sex and reducing teenage pregnancy rates;
 - supporting work in schools and other settings to help educate children and young people about healthy relationships and choices using the most effective interventions;
 - encouraging and enabling earlier diagnosis of STIs to increase treatment effectiveness and reduce the risk of transmission;
 - increasing the availability of appropriate sexual health prevention and treatment services in the community;
 - working in collaboration with other London boroughs and acute trusts to develop affordable and sustainable genito-urinary medicine (GUM) treatment services and pathways.
- **Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatment services**

To support healthy choices and improve life chances

- 5.13 There is significant evidence that investing in the prevention and treatment of drug and alcohol misuse improves an individual's socioeconomic status and physical and mental wellbeing. Improved levels of mental wellbeing are generally also likely to reduce the prevalence of substance misuse.
- 5.14 A wide range of services are commissioned to deliver substance misuse treatment, including needle exchanges, psycho-social interventions, specialist prescribing, inpatient detoxification and residential rehabilitation. The provision of such treatment is generally cost-effective and delivers a range of benefits for the individual and wider society. As individuals recover from their addiction or problem use they increase their ability to access education, training and employment, sustain appropriate housing, commit fewer offences and improve relationships, often reconnecting with their families and gaining positive social networks.
- 5.15 In addition to those who are already dependent, it is important that services provide information and advice that enables people to make informed choices about responsible drinking and gives harm reduction messages to those who choose to use substances.
- 5.16 Being able to accurately identify the prevalence of misuse and dependence is difficult. Those who misuse can often remain hidden within the population until the use escalates to a level where the consequences may result in significant physical or mental health issues or criminality. The estimated number of adults misusing substances across the three boroughs is:

| | Hammersmith & Fulham | Kensington & Chelsea | Westminster |
|----------------------|---------------------------------|---------------------------------|--------------------|
| Dependent drug users | 4,353 | 3,595 | 5,626 |
| Dependent drinkers | 7,667 | 6,332 | 9,966 |

Source: Projecting Adult Needs and Service Information System October 2014

- 5.17 There is a clear need to address the gaps in current service provision, particularly in relation to preventing harm from new and emerging drugs and in the different groups that may misuse alcohol. These people typically do not access services. We therefore intend to transform drug and alcohol services and to work collaboratively to build an inclusive, sustainable and flexible model of service that maximises value for money and quality.
- 5.18 The 'toxic triangle' of poor mental health, substance misuse and domestic violence can have profound impacts on the safety, health and wellbeing of children. We will support work in a variety of settings, including schools, to

help prevent children and young people starting to use harmful substances, working closely with the Children's Services team. It is clearly important that we work across the council to ensure safeguarding principles are followed.

By 2025 we will have

- ***improved the health and wellbeing of drug and alcohol misusers, including their families and communities***
- ***ensured that those people in need of services have access to the full range of prevention, treatment and recovery opportunities***
- ***reduced costs and improved service effectiveness***

5.19 To achieve this we will:

- commission services to improve effectiveness and ensure resources are deployed effectively and efficiently to achieve value for money, and to reduce costs whilst delivering improved outcomes;
- jointly commission services and share resources to achieve best outcomes;
- collaborate effectively with key partners across the statutory and voluntary sector;
- fully embed a recovery-oriented whole system approach from first point of access through to successful completion;
- innovate to respond to changing patterns of substance misuse;
- develop a stronger and more whole-system strategic approach, following assessment of health and behaviour needs;
- invest in prevention services to encourage and enable people in all age, ethnic, cultural, faith and socio-economic groups to be better informed and equipped to not misuse drugs and alcohol;
- support work in schools and other settings to help educate children and young people about substance misuse.

- **Improve mental wellbeing by promoting and sign-posting to preventative and joined up services**

To support positive states of mind and body

This is an underpinning priority

5.20 Good mental wellbeing involves having a positive state of mind and body, feeling safe and able to cope, and having a sense of connection with people,

communities and the wider environment. It may fluctuate through a person's life and will be influenced by many of the factors considered to be the wider determinants of health, such as good jobs, homes and friends. Mental wellbeing is linked to better physical health; people with higher levels of wellbeing are less likely to smoke, tend to eat more healthily and have lower rates of substance misuse and poor sexual health. Equally, more healthy behaviours tend to promote better mental wellbeing.

- 5.21 Good mental wellbeing is crucial to enabling us to make positive life choices and achieve our aspirations in life. It is important that we invest in the promotion, prevention and early intervention of mental illness and increase opportunities for good mental wellbeing for people across all ages.
- 5.22 On average, mental illness will affect 1 in 4 of us in our lifetimes. All three of our boroughs have higher than national average rates of reported mental health problems and a higher than average burden of severe and enduring mental illness compared to London. Unfortunately, they are often undiagnosed or inadequately treated, leading to poorer health outcomes and sometimes premature death. It is crucial that we work with partners in the health system to improve diagnosis and treatment rates locally.
- 5.23 Although many mental health problems start in early life others may develop later in life, such as dementia. The severity of such conditions is often linked to the availability and quality of social support networks and level of connectedness people feel. It is therefore important that the broad range of services provided for older people adequately address this need.

By 2025 we will have improved the mental health and wellbeing of our residents by

- **helping people with mental health problems to have the same opportunities as everyone else**
- **improving access and awareness to support and advice services to help maintain mental wellbeing**

- 5.24 We will do this by developing a comprehensive mental health programme which:
- invests in the promotion of mental wellbeing, prevention of mental ill-health, early intervention, and prevention of suicides across all population groups;
 - improves access to primary mental health services with a clear focus on prevention, early identification and self-management;

- invests in initiatives that strengthen individual and community resilience as well as reducing structural barriers to mental health, such as increasing opportunities and reducing barriers to employment;
 - conducts equality impact assessments to ensure all at risk population are targeted equitably;
 - enables us to work better with partners to improve the design of mental health diagnosis and treatment services for children and adults (including whole system approaches to address problems at points of transition, such as from child to adult services and lack of whole family approaches when parents have poor mental health);
 - considers how to both reduce the onset of dementia and how to mitigate its impact once diagnosed;
 - works across all parts of the councils to identify and sign-post to appropriate services.
- **Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion**

To deliver upstream interventions to reduce levels of ill-health and demand

This is an underpinning priority

- 5.25 Prevention is better than cure. Many diseases and causes of ill-health and early death are preventable. This is true of many strokes, heart attacks and new diagnoses of diabetes, but it is also true of fractured hips, depression, measles and a large number of other health problems.
- 5.26 Services for preventative care include immunisations against infectious diseases, screening for cancer, and risk assessments for cardiovascular disease. These important preventative interventions are often delivered through primary care services but are also offered in a range of settings by different providers to encourage and support uptake amongst different groups. An example is the NHS Health Checks programme, which helps address health inequalities in higher risk groups.
- 5.27 Although commissioning responsibility may be split (for example, immunisations and screening are currently commissioned by NHS England and cardiovascular risk assessments are commissioned by councils) preventative services are an extremely cost-effective way of reducing health inequalities and reducing both morbidity and mortality, and so need to be promoted throughout the system.

- 5.28 Current levels of immunisation coverage for children in all three boroughs are low and may be insufficient to prevent isolated outbreaks of avoidable infections. For example, the proportion of children aged less than one year that had all three doses of the ‘five-in-one’ vaccine¹⁶ has been reported as being lower than 80% across the three boroughs. To provide adequate herd immunity against outbreaks, immunisation coverage needs to be in the order of 95%. There is also insufficient coverage for measles, mumps, German measles, flu and pneumococcal disease. During 2015 we plan to undertake a detailed assurance process to ascertain what the true immunisation coverage rates are amongst local children to enable better targeting of activities to increase immunisation rates.
- 5.29 Similarly, we have poor recorded levels of people taking part in cancer screening programmes. For example, the of breast screening coverage in 2012 was 77% in England, but 65% in Hammersmith & Fulham, 62% in Westminster and only 59% in Kensington & Chelsea. However, we have an especially low incidence of cancers overall. Our national ranking out of 150 local authorities is Hammersmith & Fulham 103, Kensington & Chelsea 150, and Westminster 148. In addition, our age-standardised mortality rate from cancers is also good. Our national ranking out of 150 local authorities for this is Hammersmith & Fulham 87, Kensington & Chelsea 149, and Westminster 150. Whilst we will seek to improve the detection of cancers by screening and to contribute to reduce cancer mortality, there are other health improvement areas, highlighted in this strategy, which we consider to be of higher priority at the moment.
- 5.30 Prevention also includes a wider range of interventions which link strongly with and underpin many of the other priorities in this strategy. The wider preventative agenda includes support and focus in many diverse areas and throughout life, such as helping reduce social isolation in older age groups through the use of assistive technology, and helping improve life opportunities for young people through good parenting and education.
- 5.31 Our overarching aim of preventing ill-health therefore links to a wide range of areas, such as those covered in the Care Act 2014 and the Children and Families Act 2014 which have this principle embedded within them.
- 5.32 The effective embedding of this preventative approach requires the identification of priority areas, which are often those with the biggest health and financial impact, such as the cost of a fall in a frail elderly person. Public

¹⁶ Protecting against diphtheria, tetanus, whooping cough, polio and haemophilus influenzae type b (which can cause a number of different infections in babies and children such as meningitis, pneumonia, septicaemia, osteomyelitis).

health seeks to provide insight into such costs to enable the commissioning of effective and cost-effective preventative services.

By 2025 we will have

- **provided leadership, via our health & wellbeing boards, to enable the NHS to achieve immunisation and screening uptake to levels sufficient to meet national recommendations**
- **delivered coordinated and joined up preventative initiatives throughout life that help reduce long term health and economic consequences, especially for cardiovascular disease by significantly increasing the uptake of health checks.**

5.33 To achieve this we will:

- work with the NHS (including NHS England, CCGs and GPs) to establish ways to improve immunisation and screening uptake, such as GP capturing accurate practice data;
- work with our partners to encourage more people to take advantage of free immunisation and screening services to reduce the incidence of avoidable diseases;
- deliver the NHS health check programme effectively to the eligible population, focusing on those at greatest risk, and refer them to services which help reduce their risks by stopping smoking, losing weight, becoming more active, reducing alcohol use, and treating high blood pressure, cholesterol and diabetes;
- encourage community based prevention campaigns which help spread messages through peer and social networks, such as the community champions;
- work with the council communications teams, local communities, libraries and the *People First* website to improve health promotion messages through social media to increase uptake of screening programmes and other preventative initiatives;
- work with commissioners to help design services that address prevention and that are effective and cost-effective, and that reduce health inequalities;
- work across all parts of the councils to identify and sign-post to appropriate preventative services.

OUR INDIVIDUAL PRIORITIES

5.34 Alongside these six shared priorities, there are challenges unique to each of our individual boroughs which must also be addressed. Each council has selected a specific priority which will be driven forward and championed within our individual boroughs.

a. *Hammersmith and Fulham*
Reducing the health inequalities associated with childhood poverty

5.35 A key priority in Hammersmith and Fulham is addressing child poverty. Child poverty, both its causes and its effects, are closely linked with many of the priorities outlined in this strategy. Whilst there are drivers of child poverty that cannot be addressed locally, there is scope for significant impact through local intervention to help reduce its impact on health and wellbeing.

5.36 The determinants of health, for example parental employment and adequate housing are opportunities for local action to both reduce child poverty in the long term and reduce its impact in the short term.

5.37 The health inequalities associated with childhood poverty require focus and a coordinated response across council services, and with our partners, to help give children the best start in life.

By 2025 Hammersmith and Fulham will have

- **improved key health and wellbeing outcomes of the most disadvantaged children in the borough, ensuring that all strategies and policies contribute towards a reduction in child poverty**

5.38 We will do this by working across the council and with partners on the issue of child poverty, contributing to the priorities outlined in the Child Poverty JSNA.¹⁷ This will include helping:

- develop a joint approach to engaging and supporting hard to reach families;
- assist with coordinated local commissioning of employability support and employment advice and assessment;
- ensure that childcare provision is appropriate, tailored and targeted to meet the needs of low income families;

¹⁷ http://www.jsna.info/sites/default/files/Child%20Poverty%20JSNA%20-%20April%202014_0.pdf

- encourage joint planning to ensure that council services such as planning and housing contribute effectively to reducing the effects of child poverty;
- influence to ensure appropriate healthcare is delivered at the right time;
- support employment programmes targeted at parents;
- work across all parts of the council to identify and sign-post to appropriate services.

b. *Kensington and Chelsea*
Encouraging more people to be physically active

5.39 There is good evidence that being more physically active both promotes greater independence in later life and reduces the risk of developing obesity and a number of long term conditions, including cardiovascular disease, diabetes, cancer, musculoskeletal conditions and mental health problems. Being physically active also reduces the likelihood of falls in later life and increases the chances of an individual remaining independent as they get older.

5.40 A recent JSNA on physical activity¹⁸ highlighted a number of key messages:

- that any amount or type of physical activity is better than none;
- significant health gains can be made by getting the physically inactive to become active;
- physical activity helps promote physical and mental health and wellbeing and helps reduce social isolation;
- there are a range of barriers, real and perceived, which can block uptake;
- the importance of incorporating physical activity into everyday life, such as through active travel;
- work across all parts of the council to identify and sign-post to appropriate services.

5.41 We will enable more people to increase their levels of physical activity by supporting and enabling people to incorporate physical activity into daily life, such as by making short trips by bicycle or on foot, walking up stairs instead of taking a lift, as well as enabling people to do whatever they enjoy that encourages more activity, e.g. sport, exercise or dance.

¹⁸ <http://www.jsna.info/document/physical-activity-0>

By 2025 Kensington & Chelsea will have

- **worked with partners and key stakeholders to have become frontrunners in the promotion of the participation in physical activity**
- **ensured that physical activity messages are embedded within all strategies and policies related to health and wellbeing**

5.42 We will do this by:

- encouraging more people, particularly the most inactive, to be more physically active as part of their everyday lives;
- as part of promoting workplace health and wellbeing, working with employers to help them encourage and enable their staff to be more physically active;
- working with schools and other organisations to encourage and enable more children and young people to be more physically active;
- support local activity champions and community champions to promote getting people moving;
- encouraging the uptake of NHS health checks which refer people to services that support behaviour change around physical activity;
- working with local parks and leisure services to increase activity in our community;
- promoting active transport schemes.

c. *Westminster* ***Overcoming barriers to employment***

5.43 Worklessness is associated with poorer physical and mental wellbeing. The health and social impacts of long periods of worklessness may last for years, with consequent impacts on individuals, families and communities. Insecure and poor quality employment may also have adverse effects on health¹⁹. Amongst groups identified as experiencing higher unemployment rates are people with disabilities, people experiencing mental ill-health and people with substance misuse problems.

5.44 Estimates indicate that 7.8% of Westminster adult residents with a learning disability were in paid employment during 2013/14,²⁰ which is lower than for London (8.8%). Around 87% of residents attending an initial assessment with

¹⁹ Marmot M (2010) Fair Society, Healthy Lives

²⁰ Adult Social Care Outcomes Framework (ASCOF) data

substance misuse services in 2013/14 in Westminster were not employed. It is also known that many people in these groups would like to work and that participation in work can play an important role in recovery in relation to mental health and substance misuse^{21,22}.

5.45 Supporting local people into sustained and good quality employment is a shared objective across council departments and contributes to the aims around health improvement and economic development. The Employment Support JSNA²³ highlighted the evidence that specialist employment support, tailored to the needs of clients with mental illness or disabilities, can support individuals into work and that these approaches can deliver:

- improved individual health and wellbeing;
- increased personal income;
- reduced use of health and social care services;
- reduced levels of child poverty.

By 2025 Westminster will have

- **reduced the barriers to employment for many people, particularly those with learning disabilities, who have caring responsibilities and who are vulnerable**
- **improved the health and wellbeing of our residents who find it difficult to access employment by facilitating improved access to local integrated employment support and volunteering opportunities**

5.46 We will do this by:

1. helping commissioners use local intelligence and evidence to ensure that locally commissioned employment support is designed and targeted to address the needs of those experiencing difficulties accessing and sustaining work opportunities, including parents;
2. implementing joint planning, commissioning and integrated service design;
3. developing a coordinated and integrated support pathway;
4. adopting models with a focus on early intervention and prevention;
5. leading by example through the council offering supported employment and volunteering opportunities for priority groups;
6. identifying and addressing employment barriers associated with parental responsibilities including child care;
7. supporting volunteering as a pathway into employment;

²¹ http://www.centreformentalhealth.org.uk/pdfs/briefing37_Doing_what_works.pdf

²² HM Government (2010) *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life*. London: TSO

²³ <http://www.jsna.info/document/employment-support>

8. working across all parts of the council to identify and sign-post to appropriate services.

6 MEASURING IMPACT

- 6.1 It is important that our residents are able to hold us to account for the delivery of the actions and targets set out in this 10-year strategy. To help do this, we have identified how we will measure the impact of the actions we have set out.
- 6.2 Every year we will provide an update on how we are performing against each of our priorities and pledges. Every three years we will review progress and strategic direction of the overall strategy to ensure that it remains relevant, focused and outcome-orientated. The annual public health report (APHR), produced by the Director of Public Health, will also comment on our progress in these priority areas.
- 6.3 Lead officers from across the councils will be held to account by our residents, our council leadership, our scrutiny committees and our health and wellbeing boards for progress made in delivering improvements in these important public health priorities.
- 6.4 We will report annually against progress in improving the relevant outcomes listed in the Department of Health's Public Health Outcome Framework. This information will be provided and benchmarked against our statistical neighbours and national data, and will allow us to continually review our progress in achieving our priorities.

7 SUMMARY

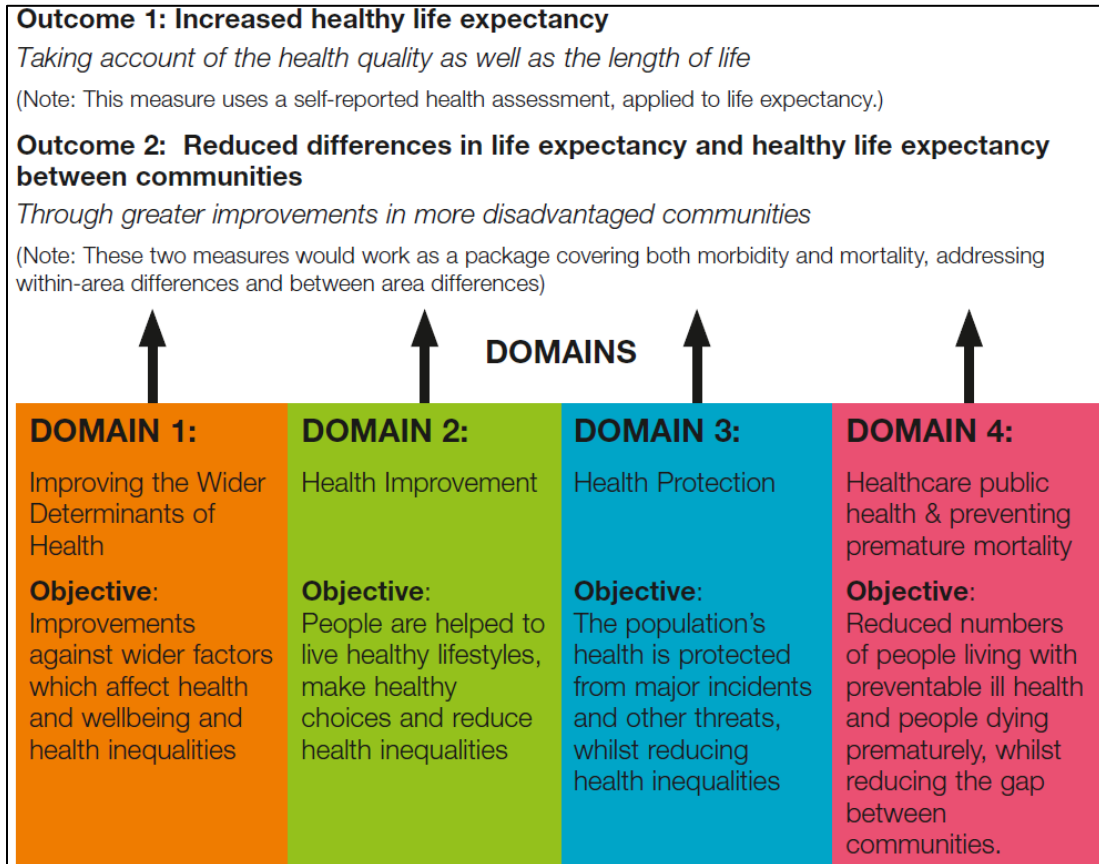
| Borough | Priority | Pledge | Indicators |
|---------|---|---|---|
| All | Reduce childhood obesity by increasing the number of children that leave school with a healthy weight | By 2025 there will be a higher proportion of children leaving primary school with a healthy weight | <ul style="list-style-type: none"> • Increased proportion of school children leaving with a healthy weight; • Joint working processes established that make positive changes to the physical environment; • Tools designed and rolled out that assist families to make healthier choices in their everyday lives; • Clear recommendations from the evaluation to inform how public health expertise can be embedded across all council areas to reduce childhood obesity. |
| | Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children | By 2025 we will have <ul style="list-style-type: none"> • reduced smoking prevalence in adults and children by a further 2% on the 2014 baseline • implemented initiatives that focus on harm reduction with people who are still smoking as part of individual plans to quit • reduced the proportion of people who start to smoke, especially children | <ul style="list-style-type: none"> • Sustained lower smoking prevalence rates in each borough • Sustained lower prevalence rates amongst 15-18 year olds |
| | Improve sexual health by reducing the rates of | By 2025 we will have <ul style="list-style-type: none"> • halted the year-on-year rise in sexually-transmitted | <ul style="list-style-type: none"> • Improved outcomes evidenced through reduced prevalence of STIs and reduced teenage pregnancy rates |

| | | | |
|--|--|---|--|
| | sexually transmitted infections and unplanned teenage pregnancy | <p>infections</p> <ul style="list-style-type: none"> transformed our delivery systems to ensure that best outcomes are achieved through sustainable and cost effective services | <ul style="list-style-type: none"> System redesign implemented and efficiencies achieved Decommissioned ineffective services |
| | Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatments services | <p>By 2025 we will have</p> <ul style="list-style-type: none"> improved the health and wellbeing of drug and alcohol misusers, including their families and communities ensured that those people in need of services have access to the full range of prevention, treatment and recovery opportunities reduced costs and improved service effectiveness | <ul style="list-style-type: none"> Communication strategy implemented Service redesign implemented Increase in successful completion rates Reduced drug related crime and reoffending rates Reduced infection and transmission rates of blood borne viruses (BBVs) Increased proportion of people with substance misuse successfully completing drug treatment Increased proportion of people with substance misuse entering the workforce or participating in meaningful activities and less dependent on benefits |
| | Improve mental wellbeing by promoting and sign-posting to preventative and joined up services [an underpinning priority] | <p>By 2025 we will have improved the mental health and wellbeing of our residents by</p> <ul style="list-style-type: none"> helping people with mental health problems to have the same opportunities as everyone else improving access and awareness to support and advice services to help maintain mental wellbeing | <ul style="list-style-type: none"> Promotion of mental wellbeing, prevention of mental ill-health, early intervention across all population groups; A completed equality impact assessment, ensuring all at risk populations are equitably considered; Improved whole system design of mental health early diagnosis and treatment services for children and adults; reduced levels of dementia and a mitigation plan in place once diagnosed. |

| | | | |
|--------------------------------------|--|---|--|
| | <p>Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion [an underpinning priority]</p> | <p>By 2025 we will have</p> <ul style="list-style-type: none"> • provided leadership, via our health & wellbeing boards, to enable the NHS to achieve immunisation and screening uptake to levels sufficient to meet national recommendations • delivered coordinated and joined up preventative initiatives throughout life that help reduce long term health and economic consequences, especially for cardiovascular disease by significantly increasing the uptake of health checks | <ul style="list-style-type: none"> • An established mechanism that captures GP practice data on immunisation and screening rates; • A developed programme with GPs, hospital providers and community services that encourages more people to take advantage of both free immunisation and screening services; • Improved immunisation rates; • Improved screening rates; • Improved NHS health check programme uptake; • Delivery of community based prevention campaigns; • Better designed services that address prevention and that are effective and cost-effective, and that reduce health inequalities. |
| <p>Hammersmith and Fulham</p> | <p>To reduce the health inequalities associated with childhood poverty</p> | <p>By 2025 Hammersmith and Fulham will have improved key health and wellbeing outcomes of the most disadvantaged children in the borough, ensuring that all strategies and policies contribute towards a reduction in child poverty</p> | <ul style="list-style-type: none"> • Improved parental employment rates; • Improved rates for school readiness amongst those with the highest proportion of children from families with low income; • Improved take up of the early years childcare offer for low income families; • An adopted approach implemented to continue and develop programmes which engage and support hard to engage/reach families; • Joint commissioning in place to support local commissioning of employability support; • Established joint working protocols with key council departments and partners to inform the reduction of the effects of child poverty. |

| | | | |
|--------------------------------------|---|--|--|
| <p>Kensington and Chelsea</p> | <p>To increase the number of people being physically active</p> | <p>By 2025 Kensington & Chelsea will have</p> <ul style="list-style-type: none"> • worked with partners and key stakeholders to have become frontrunners in the promotion of the participation in physical activity • ensured that physical activity messages are embedded within all strategies and policies related to health and wellbeing | <ul style="list-style-type: none"> • Increased levels of people participating in physical activities for more than 30 minutes a day; • Employers engaged in helping staff to be more physically active; • More children and young people physically active; • Delivery of health promotion initiatives promoting positive behaviour change. |
| <p>Westminster</p> | <p>To overcome barriers to employment</p> | <p>By 2025 Westminster will have</p> <ul style="list-style-type: none"> • reduced the barriers to employment for many people, particularly those with learning disabilities, who have caring responsibilities and who are vulnerable • improved the health and wellbeing of our residents who find it difficult to access employment by facilitating improved access to local integrated employment support and volunteering opportunities | <ul style="list-style-type: none"> • Increased successful treatment outcomes; • Reduced drug related crime and reoffending rates; • Improvement in literacy, numeracy and computer skills; • Increased proportion accessing and sustaining work opportunities and/or participating in meaningful activities; • Increased proportion of local businesses/organisations participating in London Healthy Workplace Charter or similar. |

Public Health Outcomes Framework (PHOF)²⁴



1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- School readiness
- Pupil absence
- First-time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation
- People in prison who have a mental illness or a significant mental illness
- Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime (including sexual violence)
- Re-offending levels
- The percentage of the population affected by noise
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social isolation
- Older people's perception of community safety

²⁴ <http://www.phoutcomes.info/> 2015

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions*
- *Child development at 2-2½ years (under development)*
- Excess weight in 4-5 and 10-11 year olds*
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- *Smoking prevalence – 15 year olds (placeholder)*
- Self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible*
- Self-reported wellbeing
- Falls and injuries in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Fraction of mortality attributable to particulate air pollution
- Chlamydia diagnoses (15-24 year olds)*
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for Tuberculosis (TB)
- Public sector organisations with board-approved sustainable development management plan
- Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Indicators

- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases
- Excess under 75 mortality in adults with serious mental illness
- Suicide rate
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health-related quality of life for older people
- Hip fractures in people aged 65 and over
- Excess winter deaths
- Estimated diagnosis rate for people with dementia