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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 14th July, 2016**
Time:	**4.00 pm**
Venue:	**Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP**

Members:

Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Melissa Caslake	Tri-borough Children's Services
Barbara Brownlee	Housing and Regeneration
Dr Philip Mackney	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Sarah Mitchell	Westminster Community Network
Dr David Finch	NHS England

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 6.00pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Toby Howes, Senior Committee and Governance Officer.

Tel: 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 16)**

I) To agree the Minutes of the meeting held on 26th May 2016.

II) To note progress in actions arising.

4. UPDATES ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER JOINT HEALTH AND WELLBEING STRATEGY **(Pages 17 - 64)**

To consider updates on the North West London Sustainability Transformation Plan and Westminster Joint Health and Wellbeing and Strategy.

5. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH **(Pages 65 - 84)**

To consider the Annual Report of the Director of Public Health.

6. HEALTH VISITING RE-PROCUREMENT **(Pages 85 - 92)**

To consider a report on Health Visiting Re-Procurement.

7. TACKLING CHILDHOOD OBESITY TOGETHER **(Pages 93 - 156)**

To consider a report on Tackling Childhood Obesity Together.

8. HEALTH AND WELLBEING HUBS **(Pages 157 - 162)**

To consider an update on the Health and Wellbeing Hubs Programme.

9. PRIMARY CARE MODELLING UPDATE **(Pages 163 - 166)**

To consider an update on Primary Care Modelling.

10. PRIMARY CARE CO-COMMISSIONING UPDATE **(Pages 167 - 176)**

To consider an update on progress on Primary Care Co-Commissioning.

11. MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 16 JUNE 2016 **(Pages 177 - 180)**

To note the Minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 16th June 2016.

12. WORK PROGRAMME **(Pages 181 - 184)**

To consider the Work Programme for 2016/17.

13. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
7th July 2016

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CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** Committee held on **Thursday 26th May, 2016**, Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP.

Members Present:

Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Neville Purssell
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barrie Taylor
Deputy Director of Public Health: Eva Hrobonova
Tri-Borough Director of Adult Services: Chris Neill (acting as Deputy)
Tri-Borough Children's Services: Melissa Caslake
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Representative of Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg

1 MEMBERSHIP

1.1 Apologies for absence were received from Barbara Brownlee (Director of Housing and Regeneration), Dr David Finch (NHS England) and Dr Eva Larsson (NHS England).

1.2 Apologies for absence were also received from Councillor Danny Chalkley (Cabinet Member for Children and Young People) and Liz Bruce (Tri-Borough Director of Adult Social Care). Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People) and Chris Neill (Director, Whole Systems) attended as their respective Deputies.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

1. That the Minutes of the meeting held on 17 March 2016 be approved for signature by the Chairman; and

2. That progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

3.2 In respect of the discussion on health and wellbeing hubs at the meeting on 17 March 2016, a Member commented that he would like Public Health to be engaged in the hubs providing youth services. In response, the Chairman advised that there was a children's workstream within the Health and Wellbeing Hubs programme, although it was yet to be developed. A review of the older people's hubs would be undertaken prior to an update on progress on the children's workstream.

4 DRAFT JOINT HEALTH AND WELLBEING STRATEGY AND NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

4.1 The Chairman introduced the item and thanked the Board for attending the draft Joint Health and Wellbeing Strategy workshop for Members. Two other workshops had taken place, one for commissioning teams and the other for community representatives and there had also been discussions with community groups. The Chairman reminded Members that this was the last discussion the Board would have on the draft Joint Health and Wellbeing Strategy before it was due to go to consultation at the beginning of July.

4.2 Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group) then provided an update on the North West London Sustainability and Transformation Plan (STP) and welcomed the collaborative and joined-up approach taken by the partner organisations in developing it. The workshops held had been successful and the commissioners and providers had worked together to take the STP forward. There had also been a constructive meeting with the Westminster Community Network. Matthew Bazeley advised that the Joint Health and Wellbeing Strategy refresh would play a critical role in driving the STP. He emphasised that the STP was pitched at North West London level under which each London borough would have its individual Joint Health and Wellbeing Strategy. Matthew Bazeley also advised that there was not to be a local tri-borough STP as had erroneously been mentioned in the report. The Board noted that the STP was due to be submitted to NHS England by 30 June 2016.

4.3 The Chairman added that there had been a constructive meeting of the eight North West London boroughs to discuss the STP on 23 May 2016 and it was crucial that local authorities were involved in developing the STP.

4.4 Meenara Islam (Principal Policy Officer) then gave a presentation on progress on the draft Joint Health and Wellbeing Strategy and explained that the three

workshops that had taken place had focused on: Working with Board Members to understand the strategic priorities for the future, including integration, transformation and sustainability; working with commissioners and officers in understanding service design and delivery and in making priorities relevant and encourage joint working across organisations; and working with delivery and service user representatives to understand challenges to accessing care and improving outcomes and the role of individuals, families and communities in improving health.

4.5 Meenara Islam advised that a vision and mission statement had been drafted, as well as four main priorities to underpin these:

- Improving outcomes and life chances for children young people
- Reducing risk factors for, and managing long term conditions such as dementia
- Improving mental health outcomes through prevention
- Creating and leading a local heath and care system fit for the future.

4.6 Meenara Islam advised that a joint engagement plan was being developed and the Board was asked to consider what other activities could be undertaken during the draft strategy's consultation. Members noted that the draft strategy was due to go to consultation at the beginning of July, with a view to proposing a revised strategy taking into account the views expressed at the November 2016 Board meeting and then adopting the strategy in December 2016.

4.7 During Members' discussions, Janice Horsman advised that Healthwatch Westminster's consultation framework was based on the draft Joint Health and Wellbeing Strategy's four priorities. A survey was being undertaken and the results would be shared with the Board. Janice Horsman added that Healthwatch Westminster would also be hosting a public forum to discuss the draft strategy on 14 June. A Member welcomed the draft strategy's style and the approachable language used and concurred that it was moving in the right direction, although the voluntary sector had made some suggestions about developing the draft strategy. She emphasised the need for the draft strategy to emphasise the need for a whole systems, cohesive approach and that it give examples of best practice or emphasise the areas that needed to be focused on. The focus on prevention was welcomed, however the need to improve childcare services was stressed. Another Member felt that a statement setting out what was expected of providers should be included in the draft strategy. He suggested that there should be regular engagement with the community to assess if the strategy was delivering. The Member also highlighted the need for the youth to be engaged in the process and he suggested that the draft strategy could be discussed at two upcoming youth conferences taking place in June and July. Another Member commented that there needed to be a process in place which allowed providers to gauge how well they felt they were delivering.

4.8 The Chairman stated that discussions on how the strategy would be implemented had started and it was recognised that it would be operating under a tight budget. There was also a requirement to provide statutory

services and so working in different ways, including increased partnership working, would be essential in being able to provide other services. She welcomed the suggestion that there be regular engagement with the community that would hold the Board to account and an annual health check could also be undertaken.

4.9 Matthew Bazeley felt that it was important to capture the thoughts and comments on the draft strategy from Westminster residents and he welcomed Healthwatch Westminster's role in leading on this through the sessions it was providing. He suggested that National Voices could help invigorate conversation on this issue. Matthew Bazeley highlighted the need to ensure that the strategy was a live and organic document that would be easily accessible and available online, as well as being easily viewed from a mobile phone.

4.10 Louise Proctor (Managing Director, West London Clinical Commissioning Group) commented on the importance of providing good quality end of life care. Members then concurred that the reference to end of life care be included in the draft strategy and it was suggested that this could be added to the second priority. Members also agreed to Matthew Bazeley's suggestion that the fourth priority be amended to read that "an increasingly collaborative approach is taken for a more effective local health and care system." The Chairman welcomed any further feedback before the draft strategy goes to consultation.

5 BETTER CARE FUND PROGRAMME 2016/17

5.1 Chris Neill (Director, Whole Systems) provided an update on the Better Care Fund (BCF) Programme and advised that the local allocation for the BCF for 2016/17 had been agreed at the end of 2015. It was proposed that the 2016/17 plan would continue with the same scope and focus as the 2015/16 programme and that it be updated accordingly to reflect the requirements of the STP. Chris Neill drew Members' attention to the summary of the 2016/17 BCF planned schemes as set out in the report.

5.2 Members asked if there were any proposals on how to use the additional £900,000 from the adult social care precept. The Chairman responded that there were no proposals as yet, however further information would be provided at a later date and she added that there were also a number of increasing costs to take into account.

5.3 **RESOLVED:**

That the arrangements for the 2016/17 Better Care Fund be noted.

6 PRIMARY CARE MODELLING

6.1 Stuart Lines (Public Health) introduced the report that provided an update on the work on primary care modelling. He advised that the Council was working closely with the Clinical Commissioning Groups (CCGs) in obtaining patient data. Stuart Lines referred to the three phases of the project, the first phase

being to produce a borough wide set of projections and disease burdens. The second phase involved measuring the impact of regeneration, housing and infrastructure plans and mapping the existing provision of GP services and the third phase in measuring the impact on the demand for frontline services. Stuart Lines advised that the project was also receiving the attention of other North West London local authorities and it would inform the STP.

6.2 Rianne Van Der Linde (Public Health Analyst) then gave a presentation on primary care modelling and informed Members of the findings to date. The next steps agreed at the primary care modelling workshop were to align data, sources and assumptions across health, local authority and other data held. This would involve producing a GP registered based variant and validating the model using local data. Rianne Van Der Linde advised that 80% of NHS Central London CCG's patients lived in Westminster. However, the number of NHS Central London CCG patients who were aged 19-25 exceeded Westminster's population for that age group and this could be attributed to students choosing to register with this CCG rather than the one where they otherwise normally resided. Members noted trends and changes to NHS Central London CCG's registered population, however it was still difficult to predict its future registered population.

6.3 During Members' discussions, it was queried when modelling data for NHS West London CCG would be available to be reported to the Board. It was also asked whether the project would include modelling data in terms of capacity and estates.

6.4 In reply, Stuart Lines advised that primary care modelling for NHS West London CCG would take place and Louise Proctor confirmed that two colleagues from the CCG were working on this, with the intention to use the model to project demand on frontline services. Rianne Van Der Linde advised that modelling on capacity and estates had not yet been undertaken, however this was planned in the future. Damian Highwood (Evaluation and Performance Manager) added that work was taking place in respect of validating costs for particular treatments and conditions and then checking to see if Westminster aligned generally with other London boroughs and London as a whole.

6.5 The Chairman welcomed progress to date and stressed the usefulness in modelling data for capacity and estates and working collaboratively with the CCGs to achieve this.

7 HEALTH AND WELLBEING HUBS

7.1 Eva Hrobonova (Deputy Director of Public Health) introduced the report and provided an update on the three work streams. In respect of the refresh of the Older People's Hubs, a need to provide further sites had been identified and further mapping work around libraries was to be undertaken to assess what they already offered and what could be additionally provided. In respect of the Newman Street project that provided housing for single, homeless adults, initial data had shown some success in increasing access to health services, including GPs and dentists, for those living in the block and this would have

the benefit of reducing demand on Accident and Emergency Services. Eva Hrobonova added that workshops were planned to help improve prospects of finding meaningful occupations. In respect of the Church Street Hub, Eva Hrobonova advised that there were long term plans to develop a hub providing a wide range of health, community and childcare facilities as part of the regeneration programme.

7.2 Steven Falvey (Commissioning Manager for Carers) then provided details of the Older People's Hub multi-stakeholders workshop that had taken place in May. He advised that the purpose of the workshop was to build on the project, consider what outcomes stakeholders wanted it to achieve and to extend the reach of the preventative offer. Members heard that 80 people from a number of partner organisations and groups had attended the workshop.

7.3 The Chairman advised that the Church Street Hub had been included under the programme as a joint project. She had been encouraged by progress on the Newman Street project which took services to homeless, single adults and provided greater engagement with them. An evaluation of the project's impact on health services would be undertaken, as well as seeing how the future of the group develops. The Chairman also welcomed progress on the Older People's Hubs and the workshop that had taken place.

7.4 In noting that the Older People Hubs provided activities aimed at improving mental and physical health, a Member stated that activities for improving these aspects for young people up to the age of 18 was also needed. A Member commented that the voluntary sector would like to be more involved and expressed particular interest in pursuing an opportunity for the voluntary sector to contribute in respect of the Newman Street project. The Chairman welcomed input from the voluntary sector to the programme and she commented that efforts were also being made to identify how the programme linked with other pieces of work. She added that a mapping exercise was being undertaken to see what activities were taking place in the various areas. A Member enquired whether males were still less likely to access services provided by the Older People's Hubs.

7.5 In reply to some of the issues raised, Steve Falvey advised that males were still less likely to access the Older People's Hubs and this was an issue that needed to be addressed. Eva Hrobonova explained that the programme was taking a multi-disciplinary approach, including developing digital services and undertaking an audit of available properties and Members would be updated on progress on these.

8 SHARED SERVICES FEMALE GENITAL MUTILATION PREVENTION PROJECT

8.1 Debbie Raymond (Head of Safeguarding, Review and Quality Assurance) presented the report and explained that initially the Shared Services Female Genital Mutilation (FGM) Prevention Project was initially based on a model devised by the Council in 2014 which had subsequently been rolled out across the tri-borough from May 2015 to May 2016. Evidence from 2014 estimated that around 770 girls and young women in Westminster were at

potential risk of FGM, however Children's Services had not received any referrals. The initial pilot FGM project in 2014 worked closely with ante-natal clinics, including health advocates, who had a greater understanding of the problem. This allowed women and families to discuss the implications of FMG and for many women this was the first opportunity for them to do so. Debbie Raymond advised that the project's successes had included referrals going from zero in the tri-boroughs to 77, with most families based in Westminster and the frequency of clinics at St Mary's Hospital had increased from monthly to weekly. The project had demonstrated a successful example of collaborative working between Children's Services and the heath, voluntary and community sectors, with the early interventions enabling families to understand the emotional and health implications of FGM and so improving health outcomes. This included midwives, social workers and health advocates all playing their role in early intervention in addressing FGM.

8.2 Debbie Raymond advised Members that the pilot project's success had led to it being successful in obtaining further funding from the Department for Education's (DfE) Innovation Fund to operate the project across the tri-boroughs and become part of the Mayor's Office for Policing and Crime (MOPAC). As the project developed, a further grant of £90,000 had been provided to enable the project to run until December 2016. However, alternative funding needed to be identified in order for the project to continue after this time.

8.3 During discussions, the Board welcomed the success of the project. A Member commented that FGM had been raised as a concern at the Neglect Campaign launch on 24 May and the Council was working with faith leaders to tackle this issue. In noting that the project would need to identify alternative funding if it was to continue beyond December 2016, Melissa Caslake (Tri-Borough Children's Services) advised that the Council was working collaboratively with health colleagues to consider how the project can be sustained. A Member remarked on whether the estimate of 770 girls and women in Westminster potentially being at risk of FGM was accurate and he asked whether there had been any engagement with the private sector on whether practices had been approached to undertake FGM. He felt that the Board should indicate its' support for the continuation of the project. Another Member felt that consideration needed to be given as to how the services the project provided could receive funding from mainstream funding as a clear need for these services had been identified. It was also remarked that consideration needed to given as to how families access psychological services support.

8.4 In reply to some of the issues raised, Debbie Raymond advised that the estimated of women and young girls potentially at risk of FGM in Westminster was at the lower end of what the actual number may be. She advised that communities practising FGM tended to have a large number of siblings that could potentially increase instances of FGM. However, the NHS had been collecting data on FGM cases over the last 18 months. Debbie Raymond advised that a number of FGM procedures were carried out overseas. She added that a few referrals had been received where families had approached GPs to request FGM.

9 COMMUNITY INDEPENDENCE SERVICE PROCUREMENT

9.1 Matthew Bazeley presented the report and advised that an evaluation of the Community Independence Service had been undertaken in November 2015. Positive outcomes included high satisfaction from patients and users, low complaint numbers and satisfaction with clinical engagement. Issues that needed to be looked at included the impact of focusing on in/out hospital pathways at the expense of supported living at home, the need to provide more alignment with local level of care and whole systems integrated care and the need for a single integrated information system. Matthew Bazeley commented that there were also competing priorities to consider and there had been some slippage in terms of commissioning intentions. However, he advised that the procurement process was almost complete and the Board would receive an update on the outcome of this.

9.2 The Board welcomed the update on the Community Independence Service procurement and Members expressed their interest in receiving details of the outcome of the procurement process.

10 MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 4 APRIL 2016

10.1 The Board noted the Minutes of the last Joint Strategic Needs Assessment Steering Group meeting held on 4 April 2016.

11 WORK PROGRAMME

11.1 The Board noted the work programme for 2016/17. In reply to a Member's query, Meenara Islam advised that the Pharmaceutical Needs Assessment was undertaken every three years.

12 ANY OTHER BUSINESS

12.1 On behalf of Members, the Chairman in recognition that Matthew Bazeley was leaving NHS Central London CCG, thanked him for the support he had given to the Board and his working in partnership with the Council. She also welcomed Jules Martin as the new Managing Director of NHS Central London CCG.

The Meeting ended at 6.02 pm

CHAIRMAN: _____ **DATE** _____

WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 26th May 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Members to provide any further input on the strategy before it goes to consultation at the beginning of July.	All Board Members	Members to provide comments by 30 June.

Meeting on Thursday 17th March 2016

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Strategy Refresh Update		
Members requested to attend Health and Wellbeing Board workshop on 5 April.	All Board Members	Workshop to take place on 5 April.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	
NHS Central and NHS West London Clinical Commissioning Group Intentions		
Clinical Commissioning Groups to consider how future reports are to be presented with a view to producing reports more similar in format and more user friendly.	Clinical Commissioning Groups	On-going.

Meeting on Thursday 21st January 2016

Action	Lead Member(s) And Officer(s)	Comments
Commissioning Intentions: (A) NHS Central London Clinical Commissioning Group; (B) NHS West London Clinical Commissioning Group		
Update on the Clinical Commissioning Groups' intentions to be reported at the next Board meeting.	Clinical Commissioning Groups	To be considered at the 17 March 2016 meeting.
Westminster Health and Wellbeing Strategy Refresh		
Draft proposals for the strategy refresh to be considered at the next Board meeting	Adult Social Care, Clinical	To be considered at the

	Commissioning Groups and Policy, Performance and Communication	17 March 2016 meeting.

Meeting on Thursday 19th November 2015

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Hubs Programme Update		
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 21 January 2016 meeting.
Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change		
Board to receive report on Future In Mind programme to include details of how it will impact upon Westminster and how the Board can feed into the programme to provide more effective delivery of mental health services.	Children's Services	To be considered at earliest opportunity.
Board to receive report on young people's services, including how they all link together in the context of changes to services.	Children's Services	To be considered at earliest opportunity.

Meeting on Thursday 1st October 2015

Action	Lead Member(s) And Officer(s)	Comments
Central London Clinical Commissioning Group – Business Plan 2016/17		
West London Clinical Commissioning Group to circulate their Business Plan 2016/17 to the Board.	West London Clinical Commissioning Group	
Westminster Health and Wellbeing Hubs Programme Update		
Board to nominate volunteers to be involved in the Programme and to be on the Working Group.	Meenara Islam	
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 19 November 2015 meeting.

Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	To be considered at the 21 January 2016 meeting.

Meeting on Thursday 9th July 2015

Action	Lead Member(s) And Officer(s)	Comments
Five Year Forward View and the Role of NHS England in the Local Health and Care System		
That a document be prepared comparing NHS England's documents with the Clinical Commissioning Groups to demonstrate how they tie in together.	Clinical Commissioning Groups/NHS England	To be considered at a forthcoming meeting.
Board to receive regular updates on the work of NHS England and to see how the Board can support this work.	NHS England	To be considered at future meetings.
Westminster Housing Strategy		
Housing Strategy to be brought to a future meeting for the Board to feed back its recommendations.	Spatial and Environmental Planning	To be considered at a forthcoming meeting.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	To be considered at a meeting in 2016.

Meeting on Thursday 21st May 2015

Action	Lead Member(s) And Officer(s)	Comments
North West London Mental Health and Wellbeing Strategic Plan		
That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process.	NHS North West London	To be considered at a forthcoming meeting.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	To be confirmed.
Children and Young People's Mental Health		
A vision statement be produced and brought to a future	Children's	To be

Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach.	Services	considered at a forthcoming meeting.
The role of pharmacies in Communities and Prevention		
Public Health Team and Healthwatch Westminster to liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society.	Public Health Healthwatch Westminster	Completed
Whole Systems Integrated Care		
That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time.	NHS North West London	First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Report being considered 9th July 2015
The Board to be informed more frequently on any new JSNA requests put forward for consideration.	Public Health	On-going.
Better Care Fund		
An update including details of performance and spending be provided in six months' time.		Update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Primary Care Co-Commissioning		
Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning.	Health and Wellbeing Board	In progress
Work Programme		
Report to be circulated on progress on the Primary Care Project for comments.	Holly Manktelow Health and Wellbeing Board	Circulated.
The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings.	Health and Wellbeing Board	To be confirmed.
NHS England to prepare a paper describing how they see their role on the Board and to respond to	NHS England	To be considered at the 9th July 2015

Members' questions at the next Board meeting.		Health and Wellbeing Board meeting.

Meeting on Thursday 19th March 2015

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.	Adult Social Care	Completed

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.
Child Poverty		
Work to be commissioned to establish whether and how all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Children's Services	In progress.
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	Completed.
Primary Care Commissioning		

A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

Action	Lead Member(s) And Officer(s)	Comments
Primary Care Commissioning		
The possible scope and effectiveness of establishing a Task & Finish Group on the commissioning of Primary Care to be discussed with Westminster's CCGs and NHS England, with the outcome be reported to the Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		
That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.	Director of Public Health.	Completed.
Primary Care Commissioning		
The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November	NHS England	Completed.
Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.	NHS England	Completed.
Measles, Mumps and Rubella (MMR) Vaccination In Westminster		
That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of	NHS England Public Health.	To considered at the forthcoming meeting in May

the number of patients who have had measles, be brought to a future meeting of the Westminster Health & Wellbeing Board in January 2015.		2015. This has been pushed back to later in 2015

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	Completed
Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	Being considered at the 9th July 2015 Health and

		Wellbeing Board
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	Completed.
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	Completed
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.

City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Updates on the North West London Sustainability Transformation Plan and Westminster Joint Health and Wellbeing and Strategy
Report of:	Councillor Rachael Robathan, Chairman, Health and Wellbeing Board Dr Neville Purssell, Vice-chair, Health and Wellbeing Board Jules Martin, Managing Director, NHS Central London Clinical Commissioning Group
Wards Involved:	All
Financial Summary:	Not Applicable
Report Author and Contact Details:	Daniela Valdes, Head of Planning and Governance, Central London CCG Meenara Islam, Principal Policy Officer, Westminster City Council (mislam@westminster.gov.uk)

1. Executive Summary

1.1 In May 2016 the Board received an update on the findings of the April engagement workshops with commissioners and patient/service user representatives. The outcomes of these workshops were used to produce a first draft of the refreshed strategy. The Board discussed the draft and provided feedback and suggestions which have been incorporated into a final draft which has now been published for public consultation (attached at Appendix A).

1.2 The Board also received an update on the development of the North West London Sustainability and Transformation Plan (NWL STP). The Board had agreed at its January meeting that the joint health and wellbeing strategy will act as the local delivery plan of the NWL STP.

1.3 This paper tables the final draft of the refreshed Joint Health and Wellbeing Strategy that was published for consultation on 6 July, sets out the consultation process and updates the Board on the latest developments of the North West London STP.

2. Key Matters for the Board

2.1 The Board is requested to:

- Put forward suggestions for the public engagement approach – including any suggestions for key groups or meetings which it would be good to include as part of the process; and
- Note the final draft of the Strategy which has now been released for public consultation; and
- Note the proposed consultation process and provide comment.

3. Background

3.1 The NHS Planning Guidance[1] released in December 2015 provided a clear mandate for local health and care systems to move to a place-based approach to strategic planning. This reflects the reality that local challenges cannot be effectively addressed by any one organisation alone. Collective action and cooperation is required between commissioners, providers and local authorities to jointly manage resources to secure a financially sustainable system. STPs are backed by potential funding from 2017/18 onwards to support future transformation.

3.2 At its previous meetings, the Health and Wellbeing Board considered papers outlining the refresh process of the strategy and the STPs. The Board endorsed an approach to the development of both the strategy and the STP that was consistent with strategic documents such as City for All[2] and the Better Care Fund. The Board agreed that the JHWS should continue to emphasise the importance of integration, collaboration, prevention, independence and community resilience in addressing health and care challenges.

[1] Delivering the Forward View, NHS Planning Guidance 2016/17 – 2020/21", Dec 2015
[2] Westminster City for All Year Two

4. An update on the North West London Sustainability and Transformation Plan (STP)

4.1 An STP evidence and policy "base case" establishing health and care priorities for Westminster, Brent, Ealing, Hammersmith & Fulham, Harrow, Hounslow, Hillingdon and the Royal Borough of Kensington and Chelsea was submitted to NHS England on 15 April. The document set out the needs of the North West London population, the emerging priorities, governance for implementing the plan and emerging delivery areas.

4.2 The emerging priorities have been identified by drawing on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government bodies, including, in Westminster's case, the City for All strategy, the local Better Care Fund plan and the published commissioning intentions of Central and West London CCGs. They seek to demonstrate how the local health and care geography will address the challenges of the questions posed by NHS England in the planning guidance in December 2015. These questions are:

- How will you close the health and wellbeing gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

4.3 In the base case submission these were set out as follows.

1. Supporting people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves;
2. Reducing social isolation;
3. Improving children's mental and physical health and wellbeing;
4. Ensuring people access the right care in the right place at the right time;
5. Reducing the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population;
6. Improving the overall quality of care for people in their last phase of life and enabling them to die in their place of choice;
7. Improving consistency in patient outcomes and experience regardless of the day of the week that services are accessed;
8. Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease; and
9. Reducing health inequalities and disparity in outcomes for the top 3 killers: cancer, heart disease and respiratory illness.

4.4 The emerging draft plan for addressing these priorities was submitted to NHS England for discussion on 30 June as part of a checkpoint submission. This will support a conversation that will take place between the NW London leadership team (led by Dr Mohini Parmar) and Simon Stevens, the Chief Executive of NHS England on the 14 July. The Board will be updated on developments as these arise.

4.5 In January, CCG and council officers formed a working group to provide local contributions to support the development of the North West London STP and to develop the Joint Health and Wellbeing Strategy. Further to this, the group has made joint submissions to the initial base case as well as to the drafts issued to NHS England in April and June. Strong participation from Central and West London CCGs, Public Health and whole systems colleagues has contributed to the development of the base case and the draft plan.

4.6 At North West London level, a number of colleagues represent the Health and Wellbeing Board in the Strategic Planning Group. In addition to this Charlie Parker, Chief Executive; Liz Bruce, Executive Director of Adult Social Care Services; Dr Fiona Butler, West London CCG Chair; Dr Neville Purssell, Central London CCG Chair and Cllr Rachael Robathan Health and Wellbeing Board Chair have been involved in discussions as part of the development of the documents.

4.7 Following feedback from NHS England, the draft STP will be subject to approval and agreement. Further engagement at North West London level is expected over the summer in preparation for implementation in the autumn.

5. Refreshing the Joint Health and Wellbeing Strategy

5.1. During May and June the Health and Wellbeing Board, Westminster Council Cabinet, Central London and West London CCG Governing Bodies all reviewed the draft Strategy. The feedback has been positive with suggestions centring on strong support for the addressing of ‘wider determinants’ of wellbeing such as housing, air quality employment and community resilience. Reflecting the feedback, a revised version of the draft strategy is attached as Appendix A.

5.2 Officers also attended Westminster Health and Wellbeing Network meetings throughout June. These networks will be revisited in September to discuss the draft strategy in further detail.

5.3 The public consultation on the draft strategy was launched on Wednesday 6 July and will run for 14 weeks until Sunday 16 October. Please see Appendix B for information on objectives and channels of consultation.

5.4 During the consultation period four consultation events for the following audiences/areas are proposed for September and October:

- Local business communities
- Providers of health and social care in Westminster
- Open house for the public in partnership with Healthwatch

5.5 The timeline for activities and progress between July and December:

July - October	Engagement through newsletters, social media, attending stakeholder events and forums Four targeted consultation events (dates TBC) Close of public consultation on 16 October Implementation planning
November - December	Review and revise draft strategy to reflect consultation outcomes Health and Wellbeing Board final approval at 17 November meeting Final reviews by Westminster City Council Cabinet, Central and West London CCG Governing Bodies Adoption
January 2017	Implementation begins

6. Implementation and Monitoring

6.1 Following public consultation and incorporation of the feedback, the final strategy will be presented to the Board for their final formal approval at or before the meeting on 17 November 2016.

6.2 A cross-organisational group of officers will be convened to develop an implementation approach which maximises on the use of existing resources to drive forward the plan. The strategy includes key outcomes and performance indicators against which the implementation of the Strategy can be measured.

6.3 From January 2017, papers to the Board will be asked to identify how they support and align with the priorities of the Strategy, and the Board will receive regular monitoring reports indicating progress in delivering the priorities and the outcomes identified in the Strategy.

7. Legal Implications

7.1 The duty in respect of Joint Health and Wellbeing Strategies is set out in s116A of the amended Local Government and Public Involvement in Health Act 2007.

7.2 There is also statutory guidance, the "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies" issued in March 2013. The Guidance states at paragraph 3.5 that Joint Health and Wellbeing Strategies are continuous processes and that it is a decision for the Health and Wellbeing Board to decide when to either update or refresh their JHWS or undertake a fresh process. There is not a requirement that the JHWS be undertaken from scratch each year so long as the Board is confident that their evidence based priorities are up to date and informing local commissioning plans.

7.3 The process being followed to refresh the Council's JHWS is set out in detail above at paragraph 5 and Appendix B of this report, which includes a proposed public consultation commencing in July 2016. Legal Services has had an opportunity to comment on the proposed consultation documentation and consultation process. It is confirmed as being a lawful process that discharges the Council's public and stakeholder's engagement responsibility to consult.

8. Financial Implications

N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

Appendix A – Draft Joint Health and Wellbeing Strategy

Appendix B – Consultation process

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Joint Health and Wellbeing Strategy for Westminster 2017-2022

Contents

Executive Summary

Our local health and care system (consisting of Westminster City Council, Central and West London NHS Clinical Commissioning Groups, health and care providers, the voluntary and community sector, individuals and communities) **has come together with a single vision*: that all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.*** This is an opportunity to transform the wellbeing of people who live, work and visit Westminster.

This vision is a response to the unique challenges and opportunities Westminster has as a result of its location at the centre of a national and global economic hub. The City is a destination for people seeking a new life both domestically and from abroad, and is therefore a home to a vibrant and diverse set of communities. It hosts numerous businesses, workers and visitors, often only for short periods of time, leading to high levels of population 'churn'. Some of the complex challenges we face include:

- **Services funded on the basis of resident population,** not reflecting the realities of a place with a changing population which can be up to four times larger during the day than the number of people who reside in Westminster;
- **Urban environment issues such as congestion and air quality,** high levels of road traffic accidents, and parts of the City which are among the worst performers in air quality tests in Europe;
- **Health outcomes are increasingly dependent on lifestyle choices and environmental factors;** and
- **The highest level of rough sleepers of anywhere in the country** with over 2,570 people being identified in 2014/15[1].

Against this backdrop, our mission **is to focus on prevention and early intervention.**

When people experience mental or physical ill health we will come together to ensure timely, high quality, person-centred care is delivered with dignity and respect at all stages, including at the end of life.

Over the next five years, **we intend to achieve this by focusing our efforts on the following four priorities:**

1. Improving outcomes for children and young people;
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia;
3. Improving mental health through prevention and self-management; and

[1] (St. Mungo's Broadway, 2015/16)

4. Creating and leading a sustainable and effective local health and care system for Westminster.

Our vision to transform health and care is our way of delivering on the national policy shift toward greater devolution of control to local communities. For each priority, we intend to provide improvements in areas such as quality of life, quality of care, financially sustainable health and care, unrivalled professional experience and efficient operational performance of services across the City.

We understand that we need to work together to put in place the leadership and governance arrangements which will allow us to deliver this transformation. We will identify how we will jointly put into action our priorities working on key system enablers such as workforce, estates, information and data.

This strategy focuses on the most complex and critical needs identified by (and for) our communities, where we can all take action quickly and effectively over the next five years to transform the wellbeing and quality of life of people who live, work and visit Westminster. We welcome your input and active participation in the consultation and subsequent delivery of these aims.

Health and wellbeing is everyone's business, working in partnership with you.

Introduction

Our local health and care system consists of Westminster City Council, Central and West London Commissioning Groups, health and care providers, the voluntary and community sector, communities and individuals. It is a system with many moving parts, with different functions but with one sole purpose – to support and enable us all to live well, be well and stay well.

Our local health system is facing some of the greatest challenges it has ever faced. There are various and complex pressures – a burgeoning population (a small but increasing proportion of which is elderly, frail and living alone); growing numbers of people with long term conditions; and changing and increasing expectations of the public about how and when they can access care and support. Looking to the future, we know that these trends will only continue and doing nothing is not an option.

This strategy represents the whole system's commitment to prioritising prevention and early intervention. When anyone in our population experiences mental or physical ill health and requires support, the whole system will come together to work with them to ensure they experience high quality care delivered by an integrated, talented and diverse workforce in a setting that is appropriate and convenient.

The NHS Five Year Forward View[2] signalled a shift in attitude toward supporting prevention in health and care and called for local areas to work together and experiment with new models of care. The devolution agreement for London[3] encourages ambitious localities, such as Westminster, to prepare for potentially greater flexibilities, powers and responsibilities in the future.

The North West London Sustainability and Transformation Plan (STP)[4] will bring the NHS Five Year Forward View to life and set out the vision for health and care of eight Clinical Commissioning Groups and corresponding local authorities including Westminster. It will help us to implement an integrated system that is oriented towards upstream prevention, early intervention and care in the community by 2021. This Strategy is our local plan setting out how we will meet national commitments, including those in the STP, and deliver local priorities for the population of Westminster.

Organisations alone can only do so much. Our most significant and most valuable asset to achieve the mission of this strategy is not buildings or budgets – it is the coming together of talented, knowledgeable and passionate people, staff and local community groups. Working with local people, community groups and professionals to design local services is crucial to ensuring those services are meeting local needs.

[2] (NHS England, 2015)
[3] (London Councils, 2015)
[4] (NHS England, 2015)

It is important that our health and care system treats everyone with dignity and respect. This particularly applies to our vulnerable populations. For our large homeless and rough sleeping population, providing services that address their needs, proactively engage and empower them to make healthy choices is important. We will do all we can to ensure everyone in Westminster has fair access to health and care services to support and improve their health and wellbeing.

This strategy focuses on four targeted priorities which are based on evidence of local need and what we have heard from partners, local groups, communities and people. They are:

1. Improving outcomes for children and young people;
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia;
3. Improving mental health through prevention and self-management; and
4. Creating and leading a sustainable and effective local health and care system for Westminster.

We will deliver our priorities by addressing quality of life, people's experiences of services and the financial sustainability of our health and care system[5]. Outcomes for each priority set out our aspiration for health and wellbeing in Westminster. We will develop a detailed joint delivery plan that will identify how we will put our commitments into action. The delivery will be overseen by the Health and Wellbeing Board as the leader of the City's health and care system bringing together the Council, our two Clinical Commissioning Groups, voluntary and community groups and Healthwatch.

Our four priorities will be areas of focus for the Westminster Health and Wellbeing Board for the next five years. However, this does not mean that other issues and challenges are not important or will not be addressed during this time. The Strategy puts a spotlight on the most complex and critical needs identified in Westminster where the Health and Wellbeing Board can take action rapidly and effectively.

Health and wellbeing is everyone's business, working in partnership with you.

[5] (Healthier North West London, 2016)

Our communities

Westminster is a global city at the heart of the nation's capital and home to a highly diverse resident population of around 242,299 people. The population during the daytime is approximately 900,000 which is the highest daytime population of any London Borough, including residents, employees and visitors[6].

We have the highest level of international migration of any place in England. Just over half of our resident population was born outside of the UK. Black, Asian, Arabic and other minority ethnic groups comprise 30% of our population and there are estimated to be over 10,000 lesbian, gay, bisexual or transgender (LGBT) people in the City.

Our resident population has a high proportion of younger people, with 49% of our resident population aged between 18 and 44 years old. Almost half of households are single person households, the third highest proportion in London. We have the fourth highest proportion in the country of households that are occupied by lone pensioners.

Westminster has the highest level of rough sleepers of anywhere in the country with over 2,570 people being identified in 2014/15[7]. There are also tens of thousands of people who live in the City for short periods or on a part-time basis. The Westminster population is more changeable than any other area.

Looking at likely demographic, economic and social trends over the next 15 years, we estimate that the following changes will affect how people live and work in Westminster and in turn their health and wellbeing needs:

- There will be a projected 16% increase in the number of people aged over 85 years[8] living in Westminster. While a large proportion of this group will age in good health, there will be a significant rise in the number of older people living with long term conditions that will cause both minor and severe impacts on their mobility, care needs, health service needs and wider role in the community. Over the next five years alone we expect the annual cost of care for older people living with severe physical disabilities and long-term conditions such as dementia to grow by £10.4m[9].
- There will be a smaller proportion of children and young people living in Westminster by 2036 with the proportion of people aged less than 16 years as part of the overall population expected to decline from 16% to 14%[10].
- If nothing changes, more young people will be growing up with long term health conditions, (particularly obesity and mental health related conditions) that will likely follow them into adulthood. This could have significant impact on their ability to make

[6] (Greater London Authority, 2016)
[7] (St. Mungo's Broadway, 2015/16)
[8] (Greater London Authority, 2015)
[9] (Westminster City Council, 2015)
[10] (Greater London Authority, 2015)

the most of the opportunities of a changing social, economic and technological landscape[11].

- The City will be busier than ever with more commuters coming to work in Westminster every day, putting tremendous pressure on transport and public spaces[12]. While these people will be less likely to drive and will make more use of walking, cycling and taxis we do not expect a reduction in the number of vehicles on the roads. This is due to factors such as increasing use of taxis and ride-sharing transport, increasing need for movement of goods (logistics) driven by public expectation of rapid 'just in time' delivery of goods[13].

Westminster has much to celebrate and be proud of. However, we have challenges that we must tackle in partnership with everyone in the City. We want to support everyone to live healthy and fulfilled lives as active participants in their families, communities and workplaces. This involves tackling a range of issues that can be barriers to finding and maintaining long term occupations (including volunteering). Evidence tells us that good quality work or an equivalent meaningful occupation can alleviate some of the physical and mental symptoms of ill health[14].

In Westminster we are proud of our range of libraries, leisure centres, community centres, attractive open and green spaces, visitor-friendly cycling and walking routes and world class heritage sites. These community assets can help people to remain well, healthy and connected. We will work to ensure that everyone knows about and can access and enjoy these throughout their time in Westminster as a resident, worker or visitor.

We will do all we can to ensure that the built environment enables people to make choices that support their health and wellbeing. This includes aiming to ensure that housing is appropriate for different needs and life stages. We will work with schools and other educational establishments to support children and young people to be well and stay well through educating and enabling them to make healthy choices and ensuring they are provided with access to regular physical activity.

The socio-economic and environmental factors that can affect health and wellbeing cannot be tackled alone through public sector interventions. It requires businesses and communities to play their part to, for example, improve air quality to reduce pollution levels so that the neighbourhoods we live in are clean, accessible and welcoming, and that we all support and look out for those vulnerable people in our communities.

[11] (Westminster City Council, 2015)
[12] (Transport for London, 2015)
[13] (Transport for London, 2014)
[14] (Waddell & Burton, 2009)

Our unique health challenges

The vitality of Westminster is part of its appeal, but this can sometimes be a challenging landscape in which to help people to be well and stay well.

The life expectancy of our population can vary dramatically depending on where people live. Men living in the least deprived areas live nearly 17 years longer than men living in the most deprived areas. For women this gap is nearly 10 years. Additionally, the most deprived 20% of the population are likely to begin experiencing long-term disability 10 years earlier than the least deprived. This is because our population's health is not just related to the services they can access but also to the wider factors which can influence people's health and wellbeing, such as housing, education, employment and the environment.

We have unique challenges as a result of our being at the centre of a national and global economic hub. Westminster falls within the worst 20% of areas nationally for road traffic accidents, and parts of the City are among the worst performers in air quality tests in Europe[15].

Our large business and visitor populations are significant parts of the local, regional and national economy. However, these groups also put pressure on services and the wider urban environment. Services are often funded on the basis of resident population and so do not reflect the realities of our place where our population increases each day from 250,000 residents to over 900,000 people.

Westminster has a high level of population "churn" as people enter and leave the City rapidly. Every year over 20,000 people leave and approximately the same number of new people move in. This high level of population turnover and can make it more difficult for people to access services and for services to deliver the best outcomes.

The economic, cultural and social attractiveness of Westminster, and the restrictions on space that come with a dense urban environment, mean that the demand for housing is high[16]. The majority of people live in rented accommodation (both private and social housing)[17]. Some of these people can be more exposed to housing cost volatility and the potential to experience deprivation and poverty than people who own their own homes[18].

Westminster has the highest recorded population of rough sleepers of any local authority in the country. This population has higher rates of physical and mental health problems compared to the general population[19], and are at higher risk of complicating alcohol and or

[15] (Westminster City Council, 2015)
[16] (Westminster City Council, 2014)
[17] (Westminster City Council, 2014)
[18] (Joseph Rowntree Foundation, 2013)
[19] (St. Mungo's Broadway, 2015/16)

drug dependency[20]. Rough sleepers attend accident and emergency approximately seven times more often than the general population, and are also generally subject to emergency admission and prolonged hospital stays more often[21]. However, Westminster also has a wealth of knowledge and expertise in supporting and treating homeless people and rough sleepers. We aim to build on this expertise and deliver better health and wellbeing outcomes for those individuals and groups who are not in, or do not have, access to stable and appropriate accommodation.

Children and young people in Westminster live, grow and learn in an international hub of culture, heritage and opportunity. However, to focus on the opportunities alone would be to ignore the real challenges that will face children and young people as they grow and transition into adulthood. We will support them to have healthy relationships with their families, peers and communities and make positive decisions about their lives and be confident to seek help when they need it.

Westminster is blessed with an increasing older population. Retaining their life experience and knowledge adds immense value to our communities. People over 65 are economically, culturally and socially engaged, and often make up a largely unrecognised workforce in their provision of volunteering, caring (for partners and grandchildren and others) and civic support. Working with older people, the voluntary and community sector, carers and professionals, we want to empower everyone over 65, particularly those at risk of isolation, to maintain their independence and their health and wellbeing. We will do this through encouraging and supporting lifestyle changes and enabling self-management of conditions.

[20] (Joint Strategic Needs Assessment, 2013)
[21] (Joint Strategic Needs Assessment, 2013)

Our vision and goals

Overall vision: all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.

Mission: to focus on prevention and early intervention. When people experience mental or physical ill health we will come together to ensure timely, high quality, person-centred care which is delivered with dignity and respect at all stages, including at the end of life.

Building on the principles set out in the Marmot Review (2010) and the long term goals set in our *Healthier City, Healthier Lives (2013)* for 2013-2028, we will be focusing on the following four priorities over the next five years:

Strategic Priorities 2017-2022	1) Improving outcomes for children and young people; 2) Reducing the risk factors for, and improving the management of, long term conditions such as dementia; 3) Improving mental health through prevention and self-management; and 4) Creating and leading a sustainable and effective local health and care system for Westminster.			
Long Term Goals (2013-2028)	Improving the environment in which children and young people live, learn, work and play	More people live healthily for longer and fewer die prematurely	A safe supportive and sustainable Westminster where all are empowered to play as full a role as possible	People living with injury, disability, long-term conditions, and their carers have quality of life, staying independent for longer

These priorities will steer and challenge the way we deliver local health care to address and realise better outcomes for our population. Instead of focusing on how to cure ill health and poor wellbeing, we are taking a strategic approach to move our collective energy and assets to focus on prevention and early intervention.

For each priority we will aim to deliver improvements in:

- Quality of life;
- Quality of care;
- Financial sustainability for health care;
- Professional experience; and
- Operational performance of services.

Our commitments:

We have framed the outcomes from an individual perspective so people can see our aspirations for their health and wellbeing. The following overarching outcomes and expectations are common for all themes:

- I have access to appropriate and timely information required to make the right decisions and choices for my health and wellbeing;
- I am aware of the services and facilities available and accessible to me, my carer and my family to maintain or improve health and wellbeing;
- There is no “wrong door” for when I need care and support;
- When I am experiencing mental or physical ill health, the services and support I receive are high quality, joined up and delivered in an appropriate setting;;
- All my needs are viewed holistically, including both mental and physical health; and
- I am treated with sensitivity, dignity and receive care and support that is tailored according to my needs and preferences.

PRIORITY 1: Improving outcomes for children and young people

PRIORITY VISION: All children and young people live healthy lives and are supported to transition into healthy adults who contribute to society and share their positive learning and experiences with their families, friends and neighbourhoods.

The importance of focusing on children and young people

Children in Westminster are on average more likely to be overweight, have poor dental health, and experience poor mental health than their peers in London and the country[22]. This means that they are more likely to transition to and continue through adulthood in poor health, and they are less able to take advantage of the economic and social opportunities of living and learning in the City.

Our approach

We will support children and young people from before they are born to ensure that they have a safe and healthy childhood and that they transition to adulthood with the skills and connections necessary to remain healthy, well and active and enable them to make the most of their opportunities to live, learn and prosper.

We want to inform and support parents. This includes ante-natal, maternity and parental services which engage and enable parents to improve and maintain their health and form positive relationships with their children. Evidence in Westminster shows that child poverty (which is a large determinant of the health and wellbeing of children and young people) is directly related to the ability of parents to enter and maintain employment[23]. We will support training and work experience that enables parents to re-enter or obtain flexible employment that supports their parenting.

We will build on the North West London *Like Minded*[24] strategy, which recognises the role of wider determinants in the mental and physical health and wellbeing of children and young people. We value the role of schools and communities in supporting prevention and early intervention in mental health for children and young people. There is a continued need for local collaboration and joint working to address the wider determinants of health such as housing and education and bring a range of organisations together to address effectively these complex issues.

The approach of this strategy is to address the holistic mental and physical health and wellbeing of children and young people. We want the services they interact with to support

[22] (Public Health England)
[23] (JSNA, 2014)
[24] (Healthier North West London, 2016)

them and treat them as individuals capable of making decisions about their lives, health and care.

We want to prevent children and young people from becoming ill wherever possible. However, if they do experience poor or worsening mental or physical health we want to empower children and young people to access appropriate and reliable information, advice and expert care in ways that are convenient and tailored to them. Children and young people have different experiences and attitudes to accessing information, support and care. We will work with them to identify and jointly develop new or improved channels of access and support.

We have a number of assets in Westminster which children and young people will be encouraged to use to maximise their physical and mental health. These include libraries and leisure centres and also wider community assets such as a range of clubs and societies which support them to be socially and physically active. Our current and future provision of services to children, young people and families will provide opportunities for both public sector, voluntary and community services to collaborate and support all to live healthy, engaged and full lives.

How we want to improve the outcomes for children and young people

We want to begin at the earliest opportunity to ensure children and young people grow up in environments that are supportive to their health and wellbeing. This includes working with families to address and improve whole-family wellbeing. This begins as early as possible from the beginning of a child's life, for example introducing healthy meals and emphasising the importance of and creating opportunities for active play.

We know that being active is important for both physical and mental health[25]. There are links between increased physical activity and a reduction in depression and anxiety for children and young people. It is also important for self-esteem and has been shown to improve academic performance[26]. Studies show a strong link between poorer mental health and sedentary behaviour[27].

We need to provide a range of opportunities to engage in physical activities as part of education and daily living. This includes addressing barriers (real or perceived) that some children, young people and their families might face to accessing physical activity including cost, transport and availability of local open and green spaces. We will encourage children and young people to engage in physical activity every day. We want all children and young people to feel that they can find a type of physical activity they enjoy so that they can develop positive lifestyle behaviours for the future.

[25] (Joint Strategic Needs Assessment, 2016)
[26] (Ahn & Fedewa, 2011)
[27] (Biddle & Asare, 2011)

Through our existing services we will endeavour to provide support to the children and young people, parents and guardians who need it most, addressing collectively the determinants that could be detrimental to their health and wellbeing such as education, housing, parental employment and access to health care.

Our commitments:

To ensure that all children and young people are given the best start in life and supported to grow into adjusted, healthy and well adults we commit to:

- making the most of opportunities to engage with prospective, new and current parents to provide information and signposting, and identify opportunities to provide further targeted support to families where this is needed;
- ensuring front line staff (health visitors, GPs, housing and children's services staff) are working together to support parents and to help parents to access employment, education and training opportunities;
- ensuring that opportunities for parents to support each other and learn about their child's health and wellbeing are available and publicised;
- ensuring that Westminster's young people's emotional wellbeing and mental health is supported by accessible and collaborative local services;
- ensuring that children and young people are supported and encouraged to monitor and find sources of support to improve and maintain their own health;
- supporting, encouraging and rewarding children and young people who volunteer and engage in civic activities through Spice Time Credit Schemes and other programmes; and
- involving children and young people in co-designing mental and physical health services to ensure they are relevant, convenient, acceptable and accessible for them.

Population Group	Outcome
Children and young people	I have a healthy diet, am physically active, am a healthy weight and I have a safe and healthy place to live.
	At school I learn a variety of skills that integrate my social, emotional and educational development.
	My general health and wellbeing needs are recognised and supported to sustain a good level of health and I am referred on to specialist services where appropriate.
	I have, and am made aware of, opportunities to be involved in the design, delivery, and/or review of services that I use.
	I feel respected, valued, and supported by family/carers, and professionals.
	I can access green and open spaces and attend physical and social activities and I am given opportunities to engage in physical activity every day.
	I understand how to provide support to my peers about their emotional and physical health and where to direct them for further support.
	I am able to sustain a good level of mental health through self-management and accessing appropriate and timely information and support at school, in the community and at home if needed.

Working age adults	I feel able to access community services and resources to support myself and my children, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
	As a prospective parent I have access to information and support (including health visitors and midwives) to help me to prepare for parenthood and develop and maintain a healthy lifestyle during my pregnancy.
	I am supported to provide a safe, healthy and stable home for my family.
	I am supported to access employment training and flexible, accessible and affordable childcare.
	As a parent I am supported to maintain my own health and wellbeing, and understand how to model healthy behaviours for my children.
	As a carer for a child with mental or physical health needs, I am supported to understand my child's needs. My needs as a carer are assessed and addressed by services.
	As an educator, I have been trained to recognise, support and refer mental and physical health issues of children in my care.

PRIORITY 2: Reducing the risk factors for, and improving the management of, long term conditions such as dementia

PRIORITY VISION: The likelihood of people developing long-term conditions is reduced, particularly for those with identifiable risk factors, such as poor diet and insufficient physical activity. We will work with people, carers, communities and other public sector professionals to prevent or alleviate risk factors and improve quality of life. When a person nears the end of their life, we will support them, their families and their carers to plan support that is dignified and that honours their personal preferences.

The importance of tackling long term conditions

The largest expected growth in prevalence and costs to the health system relate to long-term conditions (both mental and physical) particularly for adults aged over 65. Nationally, people with long term conditions account for approximately 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient beds. Treatment for people with long-term conditions is expected to cost £7 in every £10 of health and care spend[28].

People over 65 with long-term conditions are more likely to experience other multiple and complex conditions. These complex and multiple conditions have a significant impact on quality of life, and restrict economic and social opportunities. Long-term conditions (such as dementia, diabetes and cardio-vascular diseases) are often linked to the wider determinants of health, including housing, social isolation, lifestyle (including risk behaviours such as alcohol or substance misuse), diet and physical activity.

Our approach

Our approach is three-fold:

1) reducing the risk factors associated with long-term conditions;
2) reducing the risks of developing complications from long-term conditions; and
3) improving the support and outcomes for people with long-term conditions.

How we will prevent long term conditions and improve outcomes for people with or at risk of developing them

We want to, where possible, prevent long-term conditions for all ages by intervening early to help prevent or reduce risk factors through awareness-raising, behaviour change and proactive support. We will work with people to maximise the fulfilment of appointments, prescriptions and the take-up of services, such as Health Checks, to make the best use of resources.

[28] (Department of Health, 2012)

Long-term conditions can often be risk factors for developing further long-term conditions. There is evidence that co-morbidities (multiple long-term conditions) are more common in our areas of deprivation in the City, particularly among those who also have mental health conditions.

Westminster has the highest population of rough sleepers in the country, and many of these people have complex and multiple mental and physical long-term conditions[29]. Evidence shows that 42% of people who sleep rough in Westminster have one or more support need, including alcohol/drug dependency and/or mental health conditions[30]. Rough sleeping is a unique challenge to Westminster's health and care system and one that we can best understand and address through collaboration and integration. We will work across organisations as part of the forthcoming Westminster City Council Rough Sleeping Strategy to prioritise the complex health conditions associated with rough sleeping and homelessness.

Based on what we have heard we know that making an active contribution to local areas makes people feel more engaged and invested in the place where they live, work or learn. This can help to prevent and alleviate short and long-term mental and physical conditions, as well as build community pride and resilience. We will work to ensure that there are a range of opportunities for people to engage in meaningful work.

[29] (Joint Strategic Needs Assessment, 2013)
[30] (St. Mungo's Broadway, 2015/16)

A spotlight on dementia

Dementia is an umbrella term used to describe symptoms resulting from diseases and conditions that affect the brain. There are many types of dementia but common types include Alzheimer's disease and vascular dementia. Regardless of type, dementia can have significant effects on the lives of those who experience it, their carers, families, friends and communities. Dementia can reduce life expectancy for sufferers - someone diagnosed between ages 70-79 loses on average 5.5 years of life[31].

Westminster has a rapidly ageing population. Our recent Joint Strategic Needs Assessment on Dementia[32] found that diagnoses of long term conditions associated with ageing, such as dementia and Alzheimer's, will see an increase of 56% between 2013 and 2033. As of 2015 we have a diagnosed population of 1,806 people. Over 2,600 people in the City will have dementia by 2030. This trend will continue beyond 2030 with over 760 new cases of dementia yearly[33].

There are a number of risk factors for vascular dementia. These are largely factors that result in poor cardiovascular health, such as unhealthy weight, low levels of physical activity and smoking. Improving overall physical health can have an impact on reducing the likelihood of developing vascular dementia, and itself improves quality of life as it relates to general physical health[34]. A study linked improved healthy lifestyles among men to a 20% decrease in the predicted incidence of vascular dementia amongst men over 65[35].

People with dementia are over three times more likely to die during their first admission to hospital for an acute medical condition[36]. Westminster has a high rate of emergency and inpatient admissions for people with dementia, accounting for a quarter of acute hospital beds. People with dementia are likely to have significant physical and mental co-morbidities, such as depression, congestive heart failure and Parkinson's disease. Four out of the five most common co-morbidities for which dementia sufferers are admitted to hospital are preventable, such as broken/fractured hips and bladder and chest infections[37].

[31] (International Longevity Centre UK, 2016)
[32] (Joint Strategic Needs Assessment, 2015)
[33] (Joint Strategic Needs Assessment, 2015)
[34] (Alzheimer's Society)
[35] (Matthews, et al., 2016)
[36] (International Longevity Centre UK, 2016)
[37] (International Longevity Centre UK, 2016)

Our commitments:

Where people are suffering from ill health, we will act early to tackle risk factors and ensure that they receive the best care and support that is tailored to their needs. We will:

- support working age adults to develop and/or retain active lifestyles and mitigate those risk factors that contribute to the development of long-term conditions;
- create the conditions for dementia-friendly communities, where an understanding of dementia supports communities to value the contributions of people experiencing the condition and their carers;
- consider the experiences and needs of people with long-term conditions and their carers by working with them when developing services and plans;
- support community resilience and ensure that a range of local services are available to support social engagement which acknowledge the diversity of experience and background of people with dementia and their carers;
- support and encourage retired people to volunteer and contribute their knowledge and expertise to Westminster through the Spice Time Credits scheme, which incentivises and rewards participants for community activity; and
- support the development of a workforce that is agile and responsive and which delivers joined up and high quality services. This will include an exploration of hybrid roles across specialisms, social prescribing and multi-disciplinary and multi-sector team working. This will also include ensuring health and care services continue to work closely together and integrate where it makes sense and is possible.

Outcome Domain	**Outcome**
Quality of life	I/my carer feel that the wider community has an understanding of my long-term condition and my/our experiences and I feel included in my community.
	I am empowered to live a healthy lifestyle and make healthy choices, including about my diet, physical activity and risk behaviours (such as smoking).
	I/my carer can access advice and support to remain independent and engaged in my/our community (e.g. dementia cafes and befriending services).
	I and/or my carer know what to do to keep myself/ourselves active and well, including understanding how to improve my physical and mental health through diet, physical activity and lifestyle choices.
	I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.

Quality of experience of services	I can access services which address my needs as an individual and have an awareness of how my lifestyle (including my housing situation) impacts my health and my access to services. My wider health needs, including accessing opportunities for physical activity, are addressed and supported.
	I/ my carer have developed my care plan in conjunction with my family (as much as I want) and my carers are supported to care for me and have their own needs recognised.
	I/my carer have a named point of contact who understands me/us and my conditions. I/my carer feel that the services and workers I/we engage with have been trained to understand my/our specific needs and listen to me/us.
	I/my carer believe that the professionals involved in my care talk to each other and work as a team.
	I am supported to remain independent and stay at home where possible.

PRIORITY 3: Improving mental health outcomes through prevention and self-management

PRIORITY VISION: People are equipped to maintain good mental wellbeing. Those with short or long term mental health illnesses receive the timely and effective support to reduce the impact of and manage their condition where possible, and are treated with dignity and respect.

The importance of tackling poor mental health

Nearly half of all ill health for under-65s is related to mental illnesses[38]. Poor mental health can affect quality of life, life expectancy and the ability to participate in, and contribute to, society. People in vulnerable or excluded groups such as the homeless or rough sleepers and those experiencing deprivation are often more likely to experience severe mental health conditions and the resulting physical health conditions[39]. Mental health can have varying degrees of impact on an individual's relationships and employment. The effects of poor mental health are far reaching and can be potentially devastating to individuals and those around them.

Our approach

Improving the quality of life and life expectancy for people with severe and enduring mental health conditions (SMI) requires us to treat and support them as whole individuals, and this means looking at the wider issues that may affect them. This includes their housing, employment, relationships, diet, physical activity, and risk behaviours (such as smoking and alcohol consumption)[40]. People with severe mental health conditions often receive poorer acknowledgement and treatment of their physical health conditions. Similarly, people with long-term physical conditions also often receive poorer treatment of their mental health[41]. We must ensure that as a health and care system, we are joining up mental and physical health treatment and treating people as individuals.

People with SMI such as schizophrenia often come into contact with multiple public services. For example staff in police and fire services, housing and probation often encounter people with SMI in the course of their work. It is important that there is an awareness of mental health issues across public service commissioners, providers and staff to ensure that we can refer and support each other to provide the most effective interventions and support.

[38] (Centre for Economic Performance, 2012)
[39] (Joint Strategic Needs Assessment, 2013)
[40] (BMA Board of Science, 2014)
[41] (NHS Improving Quality, 2014)

Compared to neighbouring areas, Westminster has more people receiving mental health social care services[42]. However, there is evidence that support for Westminster carers of people with SMI is lower than in neighbouring boroughs, with fewer carers receiving assessments[43]. We will work to ensure that everyone is aware of their entitlements and the availability of public sector and community organisations that are there to support their needs.

Most people with common mental health conditions (such as anxiety and depression) have the capacity to self-manage if they are empowered and equipped with the right information at the earliest opportunity. Low-level support such as talking therapies can support people to develop the skills to monitor and manage their mental health independently. Those with more severe and enduring mental health conditions or who are vulnerable in other ways may need support to ensure they are able to manage the side effects of their medication, eat healthily and stay active.

By looking at mental health within a wider context, and recognising the complex interaction of factors such as relationships, housing, education, and lifestyle, we will not only improve health and wellbeing, but reduce the stigma associated with mental health conditions.

How we will improve mental health outcomes

The Westminster Health and Wellbeing Board have endorsed and continue to support the implementation of *Like Minded,* a sub-regional strategy spanning eight boroughs and their corresponding CCGs in North West London. The delivery of the *Like Minded* Strategy depends on partnership working to deliver high quality and joined up mental health services to improve the quality of life for individuals, families and communities.

The Westminster Health and Wellbeing Board is not seeking to replicate the work on mental health that has been set out in *Like Minded.* The Board will instead focus on, and supplement, the ambitions embodied in *Like Minded* including:

"We will improve wellbeing and resilience and prevent mental health needs where possible by:

- *supporting people in the workplace*
- *giving children and young people the skills to cope with different situations*
- *reducing loneliness for older people."*

The Board, in its local leadership role, will use its collective influence and energy to accelerate progress of this ambition in Westminster through prioritising and embedding prevention, early intervention and a whole systems approach to stop and reverse the negative trends of poor mental health and wellbeing.

[42] (Public Health England, 2013/14)
[43] (Public Health England, 2013/14)

Mental health and employment

Unemployment and worklessness is a known cause for poor mental health in Westminster and poor mental health can also be a barrier to employment and meaningful occupations (such as volunteering). Stress and mental health disorders are one of the biggest causes of long-term absence and is increasing as a reason for short-term absence in employment[44]. We will work to champion a range of activities, from volunteering to part-time and full-time work, that are welcoming and supportive to people with mental health conditions. We will also work with employers to embed positive mental health messages and activities to alleviate work-related stress and build resilience in the workplace.

Loneliness and isolation

Positive social interactions are crucial to mental and physical health and wellbeing. Older adults tend to suffer more from long term and multiple conditions which can reduce mobility and limit social interaction. Sustained loneliness and lack of interaction with others can lead to poor mental health and subsequently poor physical health. We will work closer together with partners and communities to minimise loneliness and isolation.

[44] (Butler, Bazeley, & Wheeler, 2016)

Our commitments:

Working with individuals, communities, professionals and employers we will improve mental health for Westminster people by:

- addressing the stigma associated with mental health conditions;
- treating and caring for people as individuals and recognise the complex factors that impact mental health;
- supporting people in the workplace and tackling complex barriers into work;
- working with communities to develop resilience and cohesion so that individuals, families and neighbours can support and look out for each other; and
- providing information through various mediums that is tailored for people of all ages and situations to access and use.

Population Group	Outcome domain	Outcome
Children and young people	**Quality of life**	I am educated and supported to understand and maintain my mental health as a child and young person.
		My transition from care for children and young people to adult care is planned and supported with my involvement.
Working Age Adults	**Quality of experience**	I am supported to maintain and improve my mental health and wellbeing, and to understand how to access information and support when I need it.
		I am involved in the design, delivery, management or review of services that I use and I have a level of control over the support I receive.
		I feel that the services I use understand my specific needs as an individual, including my cultural background.
		I am treated and cared for as an individual and I feel that my unique challenges and skills are recognised and acknowledged in plans for my care.
	Quality of life	I am supported to engage in my wider community through meaningful occupation (including volunteering and employment).
		I am supported in my workplace to maintain my mental health or seek information and care when necessary.
		I feel comfortable discussing my mental health with my employer.
		I feel an increased ability to manage instances of mental distress.

		I am able to manage and improve my mental and physical health and I can take regular and appropriate physical activity.
		I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
Adults over 65 years / Adults over 85 years	**Quality of experience**	I feel that my mental health needs are assessed separately from any preconceptions about conditions that may be associated with my age.

PRIORITY 4: Creating and leading a sustainable and effective local health and care system for Westminster

PRIORITY VISION: We will be an integrated and collaborative health and care system using our resources (such as data, technology, estates and workforce) to deliver person-centred information and care in the right place at the right time.

Westminster has a bold vision for health and care - we want to transform the wellbeing of people who live, work and visit Westminster and in parallel, support a clinically and financially sustainable model of health and care. This vision will require commitment from everyone in the City.

The Health and Wellbeing Board is already engaged in determining the way resources are directed and spent in the City. We see the transformation of primary care, the bedrock of the current and future health and care system, as fundamentally important to achieving our aims.

To realise our vision we will need to change the way we think about health and care locally and implement a shift in culture to move to a shared responsibility for health and wellbeing.

Leadership

The London Health and Care devolution agreement[45] sets out a vision of local people and their representatives taking greater control over decisions on matters that affect them.

One of our first tasks will be to put in place the leadership and governance arrangements necessary to make these important and strategic decisions in a robust, transparent and equitable way. We need to be able to share executive decision making across our organisations and position the Health and Wellbeing Board to continue to have the central coordinating and stewardship role on behalf of local people and communities.

Our implementation priorities:

- Delivering the priorities of this Joint Health and Wellbeing Strategy.
- Putting in place the governance and accountability arrangements which will help us to deliver our strategy, building on Westminster's strong history of joint working across health and care. A priority for us will be to involve local people as active contributors to the decision making process.
- Viewing our budgets and services "as one" in the same way as we have begun to view our priorities as common challenges. We will do this by modelling our spend and

[45] (London Councils, 2015)

priorities over the lifetime of this strategy, setting out how much we anticipate we will spend over this period and on what. We will then need to consider how best we can incentivise our whole system to deliver on this by learning from best practice elsewhere.

Workforce

The changing nature of needs and demands of our population means that we need to transform a workforce that has been trained to work on individual instances of ill health into one that is trained and equipped to work in integrated and multi-disciplinary teams in community settings to prevent and intervene before ill health occurs.

We need to invest in multi-skilled training of nurses and associated health professionals to deliver person-centred care in the community. There is a large and growing mismatch between the demand and expectations of care and the supply of health and care workers who will be able to deliver this, including a large undersupply of GPs.

We also need to review social and economic trends that might affect our workforce in the future, including the cost of living in central London. Improved connections into the City as a result of infrastructure projects, such as Crossrail, may mean more of our workforce will be able to commute into the City. We need to work together to create the conditions that will ensure that Westminster remains an attractive and viable place for health and care workers to live and work in.

Our early implementation priorities:

- Mapping our current workforce to understand gaps in our workforce now and in the future, as well as the skills required to meet changing needs. We have begun to map our demand in the future as part of the Primary Care Modelling project undertaken by the Health and Wellbeing Board[46] and we will use this tool alongside long-term scenario planning (including looking at the potential impact of technology) to understand a range of potential future issues and develop solutions.
- Considering how to capitalise on new technologies and ways of working. Technology has the ability to place more power in the hands of patients to self-manage their own conditions outside of hospital settings and tele-care (remote consultations through mediums such as live interactions via computers and tablets) will enable greater remote monitoring of patients by specialists.
- Working with partners to redesign the training and development system. Working with Royal Colleges, Health Education England and other teaching institutions to refocus local health and care worker training programmes towards the workforce characteristics and practices needed for the future. This is likely to include more

[46] (Westminster City Council, 2015)

specialist skills in primary and community care, more generalist skills in hospital care and more collaboration across hospital and community and mental health and physical health workers. We need to change the training curriculum to develop the skills to care for people with multiple conditions that span physical and mental health.

- Providing the right reward structures and contract flexibility to incentivise the creation of the right workforce. Greater flexibility of pay and terms of conditions must be addressed to incentivise the supply of staff where demand is greatest. We also need to support and harness better the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers.
- Looking after the mental and physical health and wellbeing of our workforce. The health and wellbeing of our workforce is just as important as that of the people for whom they deliver services. We will support and deliver programmes such as the Workplace Charter to support employers to improve the health and wellbeing of their staff.

Infrastructure

The rising cost of space in Westminster means that models of care built around individual locations for specific services are unsustainable. Partners in Westminster need to work together to share space and build the estate required to respond to the changing needs and demands of our population.

Our implementation priorities:

- Increasing the value of our estate in Westminster - better strategic management of our estate could realise multiple benefits including reducing and sharing fixed running costs, releasing land for housing for our workforce and reinvesting proceeds back into the local health and care system.
- Developing the estate required to facilitate new models of care and support - a new approach is needed that looks across the whole system and brings services together to improve access and experience for people and opportunities for provider innovation and collaboration. There are opportunities, for instance, for mental health providers, housing and employment services to explore integrated approaches that would better support service users and address discharge issues. A more flexible approach involving co-location of NHS and social care staff would make services more accessible and could release savings to be reinvested in patient care, staff and technology.

Technology and Information

Investing in information technology and data analytics will be crucial to enabling a successfully integrated health and social care system in Westminster that provides everyone with a good experience of care. We must work together to facilitate and enable information

exchange between organisations in a way that respects people's preferences for how we handle their information. Not doing so could hinder inter-organisational collaboration and innovation.

Our implementation priorities:

- All partners across Westminster must agree to share and pool information in a way that links data at an individual level and organises it into a format which enables better analysis and decision making by all organisations.
- Supporting the role of technology in enabling people to manage their own care. The extent to which a person has the skills, knowledge and confidence to manage their own health and care ("patient activation") is a strong predictor of better health outcomes, reduced healthcare costs and satisfaction with services. As little as a 5% increase in self-care could reduce the demand for professional care by 25%[47].

Finance

To encourage integrated care, payment incentives and business planning cycles need to be aligned. There is an urgent need for changing the nature of tariffs for NHS care, to enable greater investment in prevention. Commissioners also need to increase the use of pooled budgets as a way of enabling closer health and care collaboration. Using quality based incentive payments for providers across pathways of care might incentivise best practice models and partnership working, while ensuring that providers are encouraged to make a contribution to the health and wellbeing of the whole population. Personal health budgets would enable some patients and service users to commission their own care in ways that better meet their needs.

[47] (The Kings Fund, 2013)

Glossary

Early intervention – intervening as soon as possible to prevent health conditions becoming worse.

Enabling – putting people in charge so that they can improve their own health.

Integration – bringing services together so that they are based around the needs of people.

Life skills – the abilities needed to cope with the challenges of everyday life.

Lifestyle – a person's interests, opinions and behaviours in relation to their health.

Long-term condition – a condition that cannot be cured but can be controlled by medication and other treatments**.**

No wrong door approach – people get the help they need no matter what organisation they get in contact with first.

Outcome – improvements to the health and wellbeing of a person/people.

Person-centred – care based on the needs of the person.

Population – everyone who lives, works in, or visits Westminster.

Prevention – preventing ill health or slowing existing health conditions becoming worse.

Primary care – the first point of contact when you are unwell. In Westminster this is usually GPs.

Quality of Life – a person's assessment of how good their life is.

Risk behaviour – types of behaviour that we know cause disease or ill-health, such as smoking.

Risk factor – the ways we behave or the places where we live, visit or work that are known to cause disease or ill health. This might include being an unhealthy weight or living in an area with bad air pollution.

Secondary care – services provided by medical specialists that you are usually referred to by your GP. These services are usually based in a hospital or a clinic.

Self-management – people doing things for themselves to either stop themselves becoming ill or managing existing conditions.

Upstream – intervening as soon as possible to prevent health conditions becoming worse.

Whole system – the Council, health organisations and voluntary and community sectors working together in Westminster to provide care and help people stay well.

Wider determinants – the ways we behave or the places where we live, visit or work that are known to affect our health.

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Channels of partner communication for consultation materials

- Healthwatch Patient Participation Groups (PPG) newsletters
- Westminster Reporter
- Carers Network and Open Age Newsletter
- City West Homes Tenants Newsletters
- Notices on Council-managed websites such as People First, Young Westminster
- Internal communications – the Wire, WestWords, TriAngles (Adult Social Care newsletter) Frontline Briefing (internal newsletter for frontline staff)

Events & Meetings

Organisation	Description
BME Health Forum	A partnership between voluntary and community organisations, healthcare providers, commissioners and local authorities to improve the quality of health and social care services for patients from BME communities.
Westminster Community Network	A representative organisation for the voluntary and community sector in Westminster.
Westminster Mental Health in the Workplace Event	A workshop event for SME businesses in Westminster to learn about occupational health and mental health first aid in the workplace, organised by WCC occupational health team.
South West London Health and Wellbeing Network	A network bringing together health professionals, voluntary and community groups and local authority representatives to discuss specific health and wellbeing issues such as supporting carers.
Queens Park Community Council	The first Community Council in London which operates as a Parish Council for the Queen's Park area. The remit of the Council is to support community self-determination, particularly in the areas of education, social and economic wellbeing and local open and shared spaces.
Westminster Open Age	A community and voluntary organisation to enable anyone over 50 to sustain physical and mental fitness through social and creative activities.
Carers Network Coffee Morning	Supporting carers to find advice and care for themselves and their family member, and acting as an advocacy organisation for carers in health and wellbeing matters.
CLCCG AGM	Officers will attend the AGM and run a stall on the Joint Health and Wellbeing Strategy.
CNWL Recovery and Wellbeing College	A learning and development centre providing a range of educational courses, workshops and resources for people with mental health difficulties. Part of the course includes supporting people with mental health conditions to engage in the co-production and development of services for people with mental health conditions.
LGBT Jigsaw	A support organisation for LGBTQ young people in Westminster, providing health and wellbeing advice and referrals to other services.
Westminster Youth Council	A group of elected young people aged 12-19 interested engaging and influencing local issues affecting young people. Led by the elected Youth MP Hamza Taouzzale.
Westminster Youth Conference	A conference for young people in Westminster. Dates are TBC (it is currently proposed for September).
Community Champions	Using local people's experience and knowledge to design and improve services, and to engage the wider community in service design. Community champions also provide a point for distributing information and signposting.

City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Annual report of the Director of Public Health
Report of:	Director of Public Health
Wards Involved:	All
Policy Context:	The Director of Public Health (DPH) has a statutory requirement to produce an independent evidence based report about the health of local communities.
Financial Summary:	Not Applicable
Report Author and Contact Details:	Colin Brodie, Public Health Knowledge Manager cbrodie@westminster.gov.uk

1. Executive Summary

1.1 This paper presents the annual report of the Director of Public Health for consideration by the Health and Wellbeing Board

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is invited to consider the attached report and the three key messages on physical activity:

- Physical activity is good for both your mental and physical health and wellbeing;
- Any physical activity is better than none; and
- Simple, daily physical activity as part of everyday life is what we should aim for.

2.2 The Health and Wellbeing Board is invited to consider how the report and key messages can be used to support interventions to promote higher physical activity levels in Westminster

3. Background

3.1 The Director of Public Health (DPH) has a statutory requirement to produce an independent Annual Public Health Report (APHR). This report is the DPH's statement about the health of local communities. The report:

- Contributes to improving the health and wellbeing of the local population and reducing health inequalities;
- Promotes action for better health through measuring progress towards health targets and
- Assists with planning and monitoring of local programmes and services that impact on health over time

3.2 For the 2015-16 report the APHR has focussed on the theme of physical activity, and particularly the importance of physical activity to those segments of the population who are physically inactive.

3.3 This themed report affords an opportunity to use the APHR not only to deliver information on the state of population health but as a call to action, and to promote interventions that can increase levels of physical activity in our communities.

3.4 Physical inactivity presents a major public health issue as there is strong evidence that shows that physical inactivity and sedentary behaviour increases the risk of over 20 chronic conditions such as heart disease, type 2 diabetes, breast and colon cancers, mental health and musculoskeletal conditions. Research also shows a three year difference in life expectancy between people who are inactive and people who are minimally active.

3.5 According to the latest data 62% of adults (16+) in Westminster are classed as physically active, higher than the rate for England (57%). However, 26.5% of adults (aged 16+) in Westminster are inactive (less than 30 minutes per week of moderate physical activity). Participation in high quality PE and sports among children in Westminster (75%) is lower than London (83.3%) and England (86%).

3.6 Physical inactivity and sedentary behaviour presents an enormous and growing burden to society. The costs to the broader health and social care system are significant and there is a considerable impact on the economy as well as other public services. The costs of physical inactivity include:

- causes 11% of chronic heart disease, 19% of colon cancer, 18% of breast cancer, 13% of type 2 diabetes, and 17% of premature deaths
- in Westminster the estimated costs to the health service attributable to physical inactivity is £6,270,360
- across the three Boroughs the local economy loses £84million each year due to sickness absence, and associated costs

3.7 Trends from the Active People's Survey (APS) indicate that physical activity levels in adults in Westminster are on the increase, with approximately a 5% increase in active people since 2012. However, this does not include children and national evidence indicates an increase in the number of 5-15 year olds who do not meet recommended levels of physical activity.

3.8 In addition, evidence from the Physical Activity JSNA tells us that there is variation and inequalities in terms of physical activity levels, with BME groups, women, people with long term conditions and people living in more deprived areas often having lower participation rates.

3.9 In Westminster the ActiveCommunities programme will address these inequalities by promoting physical activity in less traditional settings and environments to inactive population groups and communities. The project will build a network of Physical Activity Champions who will maximise use of local assets and opportunities to engage with communities. ActiveCommunities is a joint venture between Sport, Leisure & Wellbeing, Public Health and the Health Improvement Team, to increase participation and achieve better social, health and wellbeing outcomes for residents and visitors to the City of Westminster.

3.10 Being active is good for our health and wellbeing, need not cost anything and is engaging. The APHR promotes a number of key messages around physical activity:

- physical activity is good for both your mental and physical health and wellbeing;
- any physical activity is better than none; and
- simple, daily physical activity as part of everyday life is what we should aim for.

3.11 The key messages in the APHR are consistent with the focus on the prevention agenda outlined in recent national strategy, including the Care Act 2014 and the NHS Five Year Forward View. It is aligned with the Public Health England framework to embed physical activity into daily life *Everybody Active, Every Day.* Locally, it supports the Westminster City Council's priority programme to tackle

childhood obesity, the Cycling Strategy and can inform a number of strategies currently in development – the Walking Strategy, Open Spaces Strategy and Active Westminster Strategy.

3.12 At the time of writing the Annual Public Health Report is due to be published on the WCC website on 1 July 2016. The next phase of the implementation will be to continue work with the Westminster Sports Unit, the Westminster City Council Communications Team and other key stakeholders, including Central London and West London Clinical Commissioning Groups to identify how the key messages from the APHR can be aligned with and support existing and future campaigns to promote physical activity levels in our communities.

4. Legal Implications

4.1 The Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority Section (Section 31 (5) of the Health and Social Care Act, 2012). Westminster City Council has a duty to publish the report (Section 31 (6) of the Health and Social Care Act, 2012)

5. Financial Implications

Not applicable

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:
'Sitting is the new Smoking': Report of the Director of Public Health 2015-16

‘Sitting is the new smoking’

Report of the Director of Public Health 2015-2016

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

Foreword

It's my pleasure to introduce the annual public health report covering the three boroughs of Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

This report is an independent evidence based statement about the health of local communities. Its function is to highlight important issues that affect our population, and aims to:

- Contribute to improving the health and wellbeing of local people
- Reduce health inequalities
- Promote better health through measuring progress towards health targets
- Support better planning and monitoring of local programmes and services

The report complements the Joint Strategic Needs Assessment (JSNA) work programme which identifies the current and future health and wellbeing needs of the population.

This year's report explores physical inactivity across Hammersmith & Fulham, Kensington and Chelsea, and Westminster. Promoting physical activity is a public health priority and the report builds on the Physical Activity JSNA published in 2014. It shows what we can do to encourage the least active to be more physically active, with suggestions how we can make physical activity a part of daily life.

We know…

- Physical activity is good for both your mental and physical health and wellbeing
- Any physical activity is better than none
- Simple, daily physical activity as part of everyday life is what we should aim for

Being active is good for our health and wellbeing, need not cost anything and is fun. I hope this report gives our readers some ideas and inspiration for how we can all make simple, positive changes.

Together, let's move more, every day

Mike Robinson

Director of Public Health for
Hammersmith & Fulham, Kensington and Chelsea,
and Westminster

Contents

Introduction

> **"If medication existed which had a similar effect to physical activity it would be regarded as a wonder drug or miracle cure."**
>
> Chief Medical Officer, 2010

Being active matters at every age.

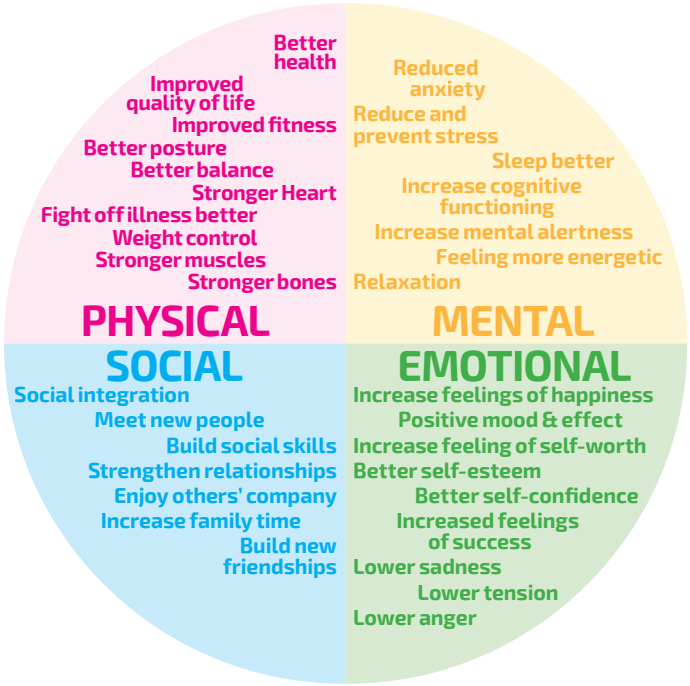
The more we move, the greater the benefit. Encouraging those who are inactive to embrace a significant level of activity would have the greatest benefit, but any shift helps.

Nationally, it's becoming increasingly recognised that physical activity as part of a wider wellbeing strategy can be integrated wherever we are: at work, school, home, and community settings. The Government funded Five Ways to Wellbeing draws particular focus to actions that can improve people's wellbeing. *Connect, Be Active, Take Notice, Keep Learning and Give are simple ways* that, when incorporated into our daily living, can have huge impact on our wellbeing.

In this report, we focus on the second of these – Be Active – but it's clear that moving and being physically active, especially when done in community, overlaps with other elements of the Five Ways to Wellbeing.

Research shows there is a three year difference in life expectancy between people who are inactive and people who are minimally active. Regular physical activity can reduce the risk of over 20 chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health and musculoskeletal conditions.

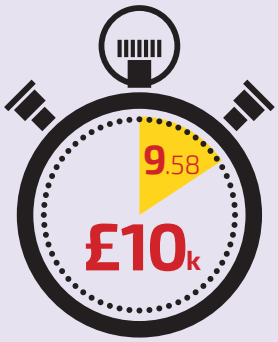
The benefits don't stop there. The figure below shows a wide range of health and wellbeing benefits to individuals.



Source: http://www.activegrand.ca/healthy-living-tips/benefits-regular-activity

Physical inactivity and sedentary behaviour have a considerable negative impact and cost for the individual, local communities and society.

In the time that Usain Bolt runs 100 meters (9.58 seconds) the **NHS spends around £10,000** on tackling preventable ill health. (Obesity £1,548, Diabetes £2,740, CVD £4,370, Depression and Anxiety Disorders £880 and Dementia £571).



Trends are not encouraging

If current trends continue, by 2030 the average number of hours we are sedentary each week will increase from 48 hours to 52 hours. There is an overall decline in physical activity, whether it is related to leisure, travel, domestic or occupation.

The challenge is how can we reduce that trend and be more active.

Sitting is the new smoking

So, how did we get here? One of the biggest challenges of sedentary behaviour and physical inactivity is that opportunities to be active are being designed out of our lives.

We drive more and further than ever, we sit for longer periods at our desks, and spend leisure on increasingly sedentary pastimes. The wonders of technology mean that even the simplest of tasks for daily living are becoming automated. Multiple car ownership has increased from 17% to 32% in the last 20 years and the number of journeys walked has declined by a third since 1995.

Physical inactivity – a cost too large to ignore

Physical inactivity presents an enormous and growing burden to society. The costs to the broader health and social care system are significant and there is a considerable impact on the economy as well as other public services. Physical inactivity is a cost we are all paying for nationally and in the three boroughs.

> **"Whatever our age, there is good scientific evidence that being physically active can help us lead healthier and even happier lives. We also know that inactivity is a silent killer."**
>
> Chief Medical Officer, 2011

Cost to the health service

- Physical inactivity causes 11% of chronic heart disease, 19% of colon cancer, 18% of breast cancer, 13% of type 2 diabetes. It causes 17% of premature deaths
- The estimated cost to the NHS of physical inactivity is £1.06 billion

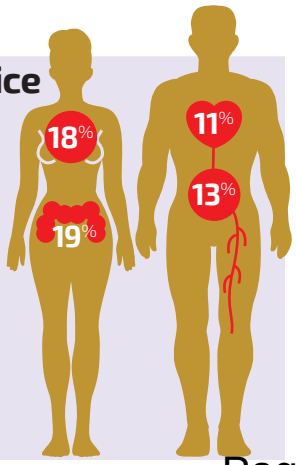


Table 1: Estimated costs to health care services attributable to physical inactivity [7]

Borough	Cost per year	Cost per 100,000 population
Hammersmith & Fulham	£2,331,126	£1,346,641
Kensington and Chelsea	£3,891,230	£1,933,313
Westminster	£6,270,360	£2,487,423

Cost to the local economy

- The local economy across the three boroughs loses £84million each year due to sickness absence, and associated employer, health and social costs and welfare
- Mental health problems and musculoskeletal problems are the two largest causes of sickness days, and physical activity has been proven to prevent both conditions.

Cost to Adult social care

£15.5 billion is spent nationally by local authorities on adult social care each year. Many of the conditions that affect mobility and functioning, such as dementia, depression, stroke, and falls, could be modified by greater levels of physical activity.

Cost to local authority

- A wide variety of issues can result from physical inactivity such as reduced readiness for school, lower educational achievement among school children and increased school sickness absence
- Greater car dependency contributes to air pollution which has an impact on people's health.

Meeting the challenge

The best opportunities for being active exist in all areas of daily life, whether in the workplace, at home, in neighbourhoods, in education or health settings. Physical activity need not cost anything; more importantly it can be a lot of fun and give us a sense of wellbeing.

Cost benefits of increasing physical activity

So, is there a business case for the councils to invest in encouraging physical activity? Yes, the cost benefits achieved through an increase of physical activity are substantial. The National Institute for Health and Care Excellence (NICE) established that a brief intervention for physical activity in primary care costs between £20 and £440 per quality-adjusted life year (QALY) with net costs saved per QALY between £750 and £3,150.

For Hammersmith & Fulham, Kensington and Chelsea, and Westminster savings of over £5 million could be achieved if 100% of the resident population achieved just the minimum recommended levels of physical activity. However, this is likely to be an underestimate as it does not take into account mental illness or dementia for example and only considers health care costs. If we add in costs to the council or society through improved work attendance, productivity and savings for social care or benefits, the savings could be far higher.

The King's Fund published useful guidance on interventions to increase physical activity. Their recommendations focus on two themes:

- reduction of car travel by improving cycling and walking provision and improving the urban realm, therefore encouraging active travel and
- improving access to green spaces which are associated with increased physical activity.

Here we explore the recommendations which could make an impact in the three boroughs:

Every pound spent on cycling provision recoups £4 in health care costs. **35p profit to the economy** is made with every mile travelled by bike instead of car.

Getting just one more person to **walk to school could recoup £768 a year** in terms of health benefits, productivity gains and reductions in air pollution and congestion.

Increasing use of parks and open spaces could reduce NHS costs of treating obesity by more than **£2 billion**.

Up to £23 is recouped for every £1 spent on leisure facilities in parks and public gardens in terms of better quality of life, reduced NHS use, productivity gains and more.

Free swimming initiatives attract a high proportion of people from disadvantaged backgrounds, thereby addressing health inequalities.

The solution - what should we be aiming for?

So, what do we mean by physical activity? Physical activity refers to all forms of activity. Everyday walking or cycling, active play, work-related activity, taking the stairs rather than the lift, working out in a gym, dancing, or gardening as well as organised and competitive sport – it all counts.

In 2011 new guidelines on the amount of activity recommended for health were published by the Chief Medical Officers of the four UK countries.

However, even small increases in physical activity have demonstrated health benefits, and so any activity is better than none.

Early Childhood (under 5 years)

1. Safe floor-based play and water-based activities from birth.
2. At least 3 hours of activity spread throughout the day for toddlers who can walk unaided.
3. Minimum amount of time being sedentary (being restrained or sitting) for extended periods (except time spent sleeping) in ALL children under 5

Adults (19 – 64)

1. Aim to be active daily. Over a week, activity should add up to at least 2½ hours of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to - for example do 30 minutes on at least 5 days a week.
2. Or 1 hour and 15 min of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Undertake physical activity to improve muscle strength on at least two days a week.
4. Minimum amount of time spent being sedentary (sitting).

Children and Young People (5 – 18 years)

1. Moderate to vigorous intensity physical activity for at least one hour and up to several hours every day.
2. Vigorous intensity activities, including those that strengthen muscle and bone, at least three days a week.
3. Minimum amount of time spent being sedentary (sitting).

Older Adults (65 and over)

1. Minimum recommended activity is the same as in younger adults.
2. Any amount of physical activity in older adults will bring health benefits. Some is better than none, and more physical activity provides greater health benefits.
3. One hour and 15 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity for those who are already regularly active.
4. Physical activity to improve muscle strength on at least two days a week is particularly important in the elderly.
5. Those at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. Minimum amount of time spent being sedentary.

How increased physical activity helps us all

High levels of physical activity benefit people, communities and society. When people move more, crime, pollution and traffic go down. Productivity, school performance, property values and health and wellbeing improve drastically.

Below we highlight how physical activity has a positive impact across the work and priorities of local government.

Health and wellbeing

Worldwide, physical inactivity is the direct cause of 10% of premature mortality. If inactivity could be reduced by only 10% it would prevent 1.3 million deaths every year globally

There is a **three-year difference in life expectancy** between people who are inactive and people who are minimally active.

Importantly, the length of time we are sedentary is also associated with ill-health. Even people who meet or exceed the recommended requirements for physical activity, but who sit for long periods of time, experience ill health.

Adult social care

Physically active residents can stay independent longer.

Older adults who are regularly active have a 30-50% lower risk of developing functional limitations

Physical activity can help to increase social interaction and tackle isolation and loneliness.

Children and family services

Physical activity can contribute to an increase in academic performance and attainment.

Sport and recreation can help to raise people's self-esteem and determination, both useful skills for learning and passing exams.

Employment and economic productivity

High levels of physical fitness are viewed favourably by employers, who associate fitness with greater productivity, potential to work longer hours and taking less sick leave.

Playing sport can help people build valuable skills like problem solving, communication and teamwork.

Climate change and air quality

Walking and cycling are pollutant free activities, and so increasing active travel can lower carbon emissions and reduce pollution. 75% of transport related emissions are from road traffic.

Planning, transport and the built environment

Getting the borough moving by tackling congestion, parking and traffic enforcement and developing road / cycle path capacity to support growth and regeneration

Increasing physical activity and active travel can help to lower carbon emissions.

Making walking and cycling safer and more enjoyable can contribute to fewer road traffic accidents.

Community safety

Physical activity can help to increase people's self-esteem and enable them to develop relationships and school skills, foster discipline and teach commitment. Cycling and walking have been shown to build a sense of community and belonging.

Social inclusion

Physical activity can foster community spirit and help to improve risk factors relating to crime and antisocial behaviour.

Active leisure can be used to reach out to at risk groups in society and the wider community and can play a role in promoting gender and disability equality.

Economic prosperity

Excessive dependence on motorised road transport has significant economic costs on society such as congestion; road casualties; physical inactivity; pollution and damage to the climate.

The average economic benefit-to-cost ratio of investing in cycling & walking schemes is 13:1.

Retail sales with a high quality cycle lane can increase footfall by up to 49%.

Physical Activity in the three Boroughs

In this next section, we explore what the local picture is, based on the national picture and incorporating local data where it is available.

Children

The national picture

In England, less than a quarter of children are classed as physically active. Overall, boys are more active than girls with 21% of 5-15 year old boys completing at least 1 hour of moderate intensity activity each day, compared to 16% of girls.

There is a decline in physical activity for both boys and girls as they get older. For boys, the numbers meeting the recommended levels of activity decline from 24% in 5 to 7 years olds to 14% in 13 to 15 year olds. For girls the decrease was from 23% to 8% respectively.

However, 41% of boys and 44% of girls do walk to and from school every day, and in school, most children participate in some type of physical activity (93% of boys and 92% of girls)

Children spent on average 3.3 hours each weekday on sedentary pursuits such as watching TV, reading etc. outside of school. This rises to around 4 hours on the weekend.

Children in the three Boroughs

Generally, children in the three boroughs have lower participation rates in high quality PE and school sport compared with their peers in London and England. For Hammersmith & Fulham this is 70% of pupils, Westminster is 75%, and 77% in Kensington and Chelsea.

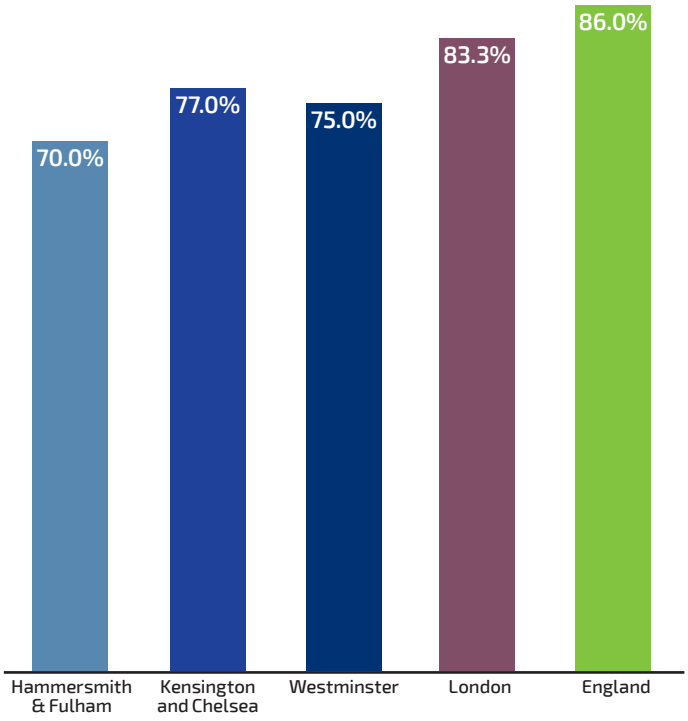


Figure 1: The percentage of state school children in Year 1-11 participating in at least two hours of high quality PE or school sport in a typical week (TNS Social Research, Annual Survey of School Sports Partnerships 2009/2010)

While participation in school PE has increased nationally, schools in deprived areas with a higher proportion of ethnic minority pupils, and pupils with special educational needs have the lowest level of participation in sports in and outside the school environment.

Unfortunately data on PE activity is no longer routinely available for all our Boroughs since the School Sport Partnerships came to an end. In order to monitor physical activity levels in children it is essential that data is collected across the three Boroughs.

Adults

The Active People Survey 2014/15 shows the most up to date data available nationally and locally on physical activity for people aged 16 and over.

The national picture

Nationally 67% of men and 55% of women aged 16 and over are classed as physically active. Over one in five men (20%) and one in four women (25%) are classified as inactive.

However, **over half of men and women spent four or more hours in sedentary time per day**, with men more likely than women to average six or more hours of total sedentary time on both weekdays (31% and 29% respectively) and at the weekends (40% and 35% respectively).

Activity decreases with age for men, from 83% in 16 to 24 year olds to 11% in those 85 years and over. The same is true for women, although activity levels peaks among 35 to 44 year old women (66%) before declining. After the age of 74 levels of decline in activity are similar in both sexes.

There is a link between physical activity and household income. 76% of men and 63% of women in the highest income group met the UK recommended levels of activity compared to 55% and 47% respectively in the lowest income group.

Physical activity rates are lower among those with a greater body mass index (BMI). 75% of men who are of healthy weight met physical activity guidelines, compared with 71% of overweight and 59% of obese men. Corresponding figures for women were 64%, 58% and 48%, respectively.

Adults in our three boroughs

The number of physically active people (aged 16+) stayed broadly similar from 2014 to 2015, with 56% in Kensington and Chelsea, 64% in Hammersmith & Fulham, and 62% in Westminster.

This appears to confirm a trend towards increasing inactivity, with the number of completely inactive people increasing in two boroughs and staying level in the other borough. Westminster and Hammersmith & Fulham are in line with the national average of 28% (27% in both) while Kensington and Chelsea has a higher level of inactivity (31%). Where data exists, the three boroughs are following national trends across sex, age, socio economic status, disability and employment status.

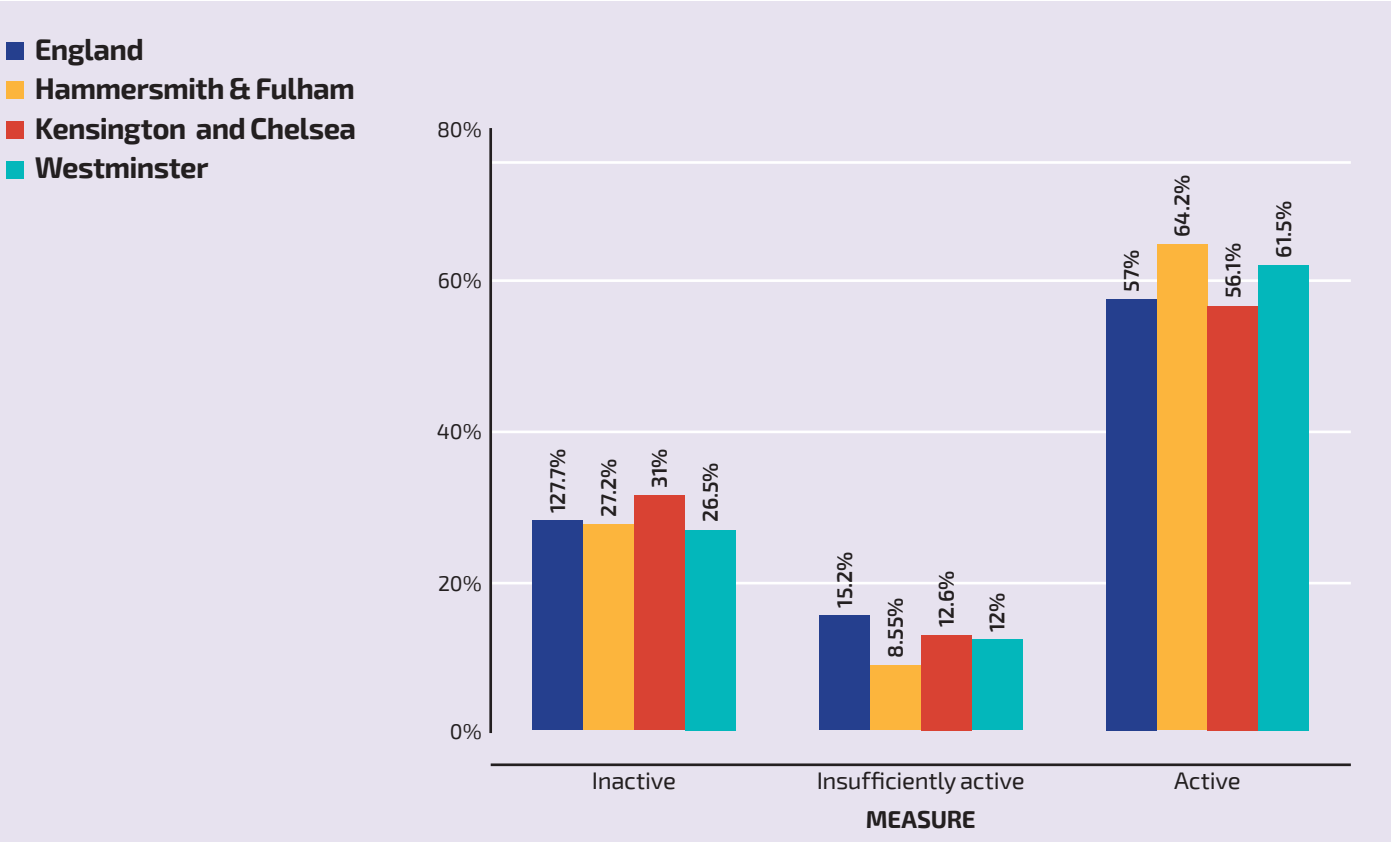


Figure 2: The percentage of adults (aged 16+) in the three Boroughs classed as Active, Insufficiently Active, and Inactive, compared with England (Source: Active People's Survey 2014/15)

Success stories

The best opportunities for keeping active exist in all areas of daily life, whether in the workplace, at home, in neighbourhoods, in education or health settings. Physical activity need not cost anything; more importantly it can be a lot of fun and give us a sense of wellbeing.

So how are we doing in the three boroughs when it comes to encouraging residents to get active? Below are some of our success stories.

London Borough of Hammersmith & Fulham - Bikeit Programme

Before April 2010, Tigist Negash, a 34-year old student and mum of three had never cycled in her life. For years Tigist spent the school run chasing after her two sons who liked to cycle to their primary school as their mum walked behind. Tigist was struggling to get to college on time in between dropping her sons at school and her daughter at nursery and couldn't rely on the bus or walk the distance quickly enough.

When Sustrans began working with her son's school to encourage more children to cycle, Tigist decided to take part in a cycling course, sponsored by the Council's Bikeit Programme. The course was created especially for parents and carers, to prove just how easy it is to cycle for short local journeys.

"Every morning, I cycle with them to school, then I go on to college in Hammersmith, about a mile away. I have to be there at 9.30am, and if I took the bus or walked I wouldn't be able to get there in time. Without being able to cycle, I wouldn't be able to go to college."

She now cycles every day and uses her bike to accompany her two sons to school and carry her daughter to nursery before going on to college to study English.

Royal Borough of Kensington and Chelsea: Charles Falope

Charles, a young man in his twenties, is a regular attendee at the weekly disability multi-sport session at Kensington Leisure Centre and he enjoys the activities that are on offer in the main sports hall like table tennis, volleyball, basketball, boccia and polybat. Charles has autism and can sometimes find it hard to play with others. This stops him from fully partaking in as many of the activities as he would like.

After discussions with Charles and with the support of Public Health funding and the Activate! Programme, it was decided he would benefit from attending a Disability Sports Coaching UK course, (a one day Adapted Sports Course). Charles had previously shown great interest in helping the coaches and the training has helped him engage more fully in the sessions. To make sure Charles continued to learn and develop into a proficient assistant coach, he received six weeks of mentoring.

Since Charles attended the course in November 2015 his progress has been amazing. Now he is helping the other coaches by setting up and setting down activities. By far the biggest change for him is that he now helps others take part in the activities. For example, at his last session he played Polybat with another participant, who has very little mobility and cannot communicate very well. Charles praised her every time she hit the ball back and this was very heartening to see. After this he invited her and another person to play bowls. Finally, the Head Coach made Charles responsible for the boccia match. He handed out the boccia balls and refereed the game in his referee's kit.

At the end of every session Charles asks the Head Coach 'How did I do?', 'How can I improve?' and each week the reply is 'You've done well Charles, keep up the good work'.

Active Westminster Walks for Health Scheme - Regents Park Walk Group

A Health Promotion Nurse from the Health Improvement Team leads a 60 minute health walk in Regents Park. The group, which has been running for several years, meets at the Clarence Gate, every Wednesday at 1.30pm. Adults of all ages, genders, abilities and backgrounds join in with the weekly walk. Some of the walkers have long standing mental health or social issues.

A female walker said that she feels secure in the group as the nurse is able to monitor the different health conditions the group participants may have and take action if needed. Especially concerned about her memory loss, she wanted to remain physically active without fear of getting lost. The group gives her a reason and confidence to get out of her flat, meet people and talk about different topics and interests such as gardening and dogs.

Group members are encouraged to choose a route as they enjoy walking varied routes and seeing beautiful locations within the park. The walking group provides support to socially isolated adults, with complex social, mental and physical health conditions, to participate in physical activity and connect with others. Next steps include plans to support some group members to complete Walk Leader training organised by the Health Improvement Team.

Looking forward

In the 5 year Forward View of the NHS, there is a clear emphasis on prevention and public health, as "...the health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on [it]". National action on obesity, smoking, alcohol, physical inactivity and other major health risks will now be in the spotlight.

Prevention starts at the earliest possible opportunity. Being physically active over the lifecourse means that we can enjoy a better quality of life through every age and stage. The solution to addressing these challenges – the miracle cure – is here.

We can meet the challenges, many of which are set out in this report, if we have the will and enthusiasm to do so.

Our hope is that the examples of good practice in our three boroughs, and the realities of what we face if we don't take action, will help to inspire us.

Together, let's move more, every day

Useful contacts

For information on ideas on how to be more active, and to access opportunities in your local area here are some helpful contacts and websites.

One You

One You is a national campaign to encourage us to move more, eat well, drink less and be smoke free. The website include ideas on how to include physical activity into our daily lives.

W www.nhs.uk/oneyou/moving

Get Active London

The Get Active London website provides a one stop shop for activities, clubs and venues across London.

W www.getactivelondon.com/

NHS Choices Live Well

The NHS Choices Live Well provides suggestions on how to build more physical activity into our daily lives for busy parents, families, young people, office workers, older people, and disabled people.

W www.nhs.uk/Livewell/fitness/Pages/Activelifestyle.aspx

People First

People First provides a wealth of information and resources covering the three boroughs, with a focus on older people, people living with disabilities, and those who look after others.

W www.peoplefirstinfo.org.uk/health-and-well-being/taking-care-of-yourself/exercise-and-sport.aspx -.

Hammersmith & Fulham

Community Sports Team

The Community Sports Team provides information on activities and facilities in Hammersmith & Fulham.

W www.lbhf.gov.uk/sport

E sportsdevelopment@lbhf.gov.uk

T 020 8753 3838

Get Going

The Get Going campaign brings together a range of free and low cost physical activity opportunities which help prevent long term illness and ageing.

W www.lbhf.gov.uk/getgoing

Kensington and Chelsea

Sports Development Team

The Sports Development Team provides information on activities and facilities in Kensington and Chelsea.

W www.rbkc.gov.uk/leisure-and-culture/sports-and-leisure

E SportandLeisure@rbkc.gov.uk

T 020 7938 8182

Go Golborne

Go Golborne is a new local campaign led by the Council that is all about supporting children and families to eat well, keep active and feel good.

W www.rbkc.gov.uk/subsites/citylivinglocallife/gogolborne/move.aspx

Westminster

Westminster Sports Unit

Westminster Sports Unit provides information on activities and facilities in Westminster.

W www.westminster.gov.uk/sports

E sport@westminster.gov.uk

T 020 7641 2012

Daily Mile

The Daily Mile is a simple and inclusive initiative to introduce daily physical activity into children's lives as part of everyday school life. Westminster is committed to rolling out this initiative to all schools within the city.

W http://thedailymile.co.uk/

Appendix 1: Health profiles

A purpose of the annual public health report is to report on the health of the local population. The health profiles that follow provide an overview for each Borough. Further information on the current and future health and wellbeing needs of our population can be found in the Joint Strategic Needs Assessment.

These profiles are provided from Public Health England, and are replicated here under the terms of the Open Government Licence. More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles.

Appendix 1: Health summary for Hammersmith & Fulham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ | England Average | England Worst | 25th Percentile | 75th Percentile | England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	47,048	26.3	20.4	83.8		0.0
	2	Children in poverty (under 16s)	7,575	25.6	19.2	37.9		5.8
	3	Statutory homelessness	385	4.8	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	720	65.6	56.8	35.4		79.9
	5	Violent crime (violence offences)	3,100	17.2	11.1	27.8		2.8
	6	Long term unemployment	1,168	8.9	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	71	3.1	12.0	27.5		1.9
	8	Breastfeeding initiation	2,065	89.4	73.9			
	9	Obese children (Year 6)	253	22.4	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	n/a	-	40.1	105.8		11.2
	11	Under 18 conceptions	47	21.3	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	21.4	18.4	30.0		9.0
	13	Percentage of physically active adults	279	64.0	56.0	43.5		69.7
	14	Obese adults	n/a	13.3	23.0	35.2		11.2
	15	Excess weight in adults	227	49.7	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	14.0	11.1	18.4	38.0		4.8
	17	Hospital stays for self-harm	184	99.9	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	938	657	645	1231		366
	19	Prevalence of opiate and/or crack use	1,390	10.1	8.4	25.0		1.4
	20	Recorded diabetes	7,376	4.4	6.2	9.0		3.4
	21	Incidence of TB†	54.0	29.9	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	2,949	2195	832	3269		172
	23	Hip fractures in people aged 65 and over	99	591	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	52.0	18.4	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	79.1	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	83.5	83.1	80.0		86.4
	27	Infant mortality	12	4.4	4.0	7.6		1.1
	28	Smoking related deaths	191	350.0	288.7	471.6		167.4
	29	Suicide rate	16	9.7	8.8			
	30	Under 75 mortality rate: cardiovascular	90	95.5	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	145	151.6	144.4	202.9		104.0
	32	Killed and seriously injured on roads	70	38.9	39.7	119.6		7.8

Indicator notes are included on page 15.

Appendix 2: Health summary for Kensington and Chelsea

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ England Average
England Worst 25th Percentile 75th Percentile England Best
England Range

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	36,584	23.5	20.4	83.8	0.0
	2	Children in poverty (under 16s)	4,090	20.9	19.2	37.9	5.8
	3	Statutory homelessness	539	6.9	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	552	74.4	56.8	35.4	79.9
	5	Violent crime (violence offences)	2,192	14.1	11.1	27.8	2.8
	6	Long term unemployment	629	5.7	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	23	2.0	12.0	27.5	1.9
	8	Breastfeeding initiation	1,476	91.3	73.9		
	9	Obese children (Year 6)	187	21.3	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	8.3	30.9	40.1	105.8	11.2
	11	Under 18 conceptions	33	19.0	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	17.8	18.4	30.0	9.0
	13	Percentage of physically active adults	266	57.5	56.0	43.5	69.7
	14	Obese adults	n/a	11.2	23.0	35.2	11.2
	15	Excess weight in adults	192	45.9	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	12.7	9.9	18.4	38.0	4.8
	17	Hospital stays for self-harm	138	87.9	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	607	433	645	1231	366
	19	Prevalence of opiate and/or crack use	1,065	9.2	8.4	25.0	1.4
	20	Recorded diabetes	6,422	4.2	6.2	9.0	3.4
	21	Incidence of TB†	38.3	24.5	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	2,107	1879	832	3269	172
	23	Hip fractures in people aged 65 and over	102	490	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	45.8	17.7	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	82.6	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	86.2	83.1	80.0	86.4
	27	Infant mortality	6	2.8	4.0	7.6	1.1
	28	Smoking related deaths	159	252.4	288.7	471.6	167.4
	29	Suicide rate	11	7.5	8.8		
	30	Under 75 mortality rate: cardiovascular	60	54.9	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	127	116.3	144.4	202.9	104.0
	32	Killed and seriously injured on roads	80	51.3	39.7	119.6	7.8

Indicator notes are included on page 15.

Appendix 3: Health profile for Westminster

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ England Average

England Worst 25th Percentile 75th Percentile England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	53,263	23.5	20.4	83.8		0.0
	2	Children in poverty (under 16s)	9,120	30.7	19.2	37.9		5.8
	3	Statutory homelessness	716	6.5	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,007	68.1	56.8	35.4		79.9
	5	Violent crime (violence offences)	5,871	26.2	11.1	27.8		2.8
	6	Long term unemployment	1,063	6.5	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	50	1.9	12.0	27.5		1.9
	8	Breastfeeding initiation	n/a	-	73.9			
	9	Obese children (Year 6)	340	25.6	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	10.0	28.4	40.1	105.8		11.2
	11	Under 18 conceptions	24	9.6	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	18.5	18.4	30.0		9.0
	13	Percentage of physically active adults	262	57.4	56.0	43.5		69.7
	14	Obese adults	n/a	17.9	23.0	35.2		11.2
	15	Excess weight in adults	295	52.6	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	8.3	4.9	18.4	38.0		4.8
	17	Hospital stays for self-harm	161	71.2	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	996	522	645	1231		366
	19	Prevalence of opiate and/or crack use	2,550	15.6	8.4	25.0		1.4
	20	Recorded diabetes	8,991	4.4	6.2	9.0		3.4
	21	Incidence of TB†	60.0	26.9	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	3,723	2246	832	3269		172
	23	Hip fractures in people aged 65 and over	118	438	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	47.0	13.3	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	81.7	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	85.9	83.1	80.0		86.4
	27	Infant mortality	11	3.8	4.0	7.6		1.1
	28	Smoking related deaths	192	236.1	288.7	471.6		167.4
	29	Suicide rate	22	10.1	8.8			
	30	Under 75 mortality rate: cardiovascular	99	74.8	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	165	122.4	144.4	202.9		104.0
	32	Killed and seriously injured on roads	177	78.9	39.7	119.6		7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Health Visiting Reprocurement
Report of:	Director of Public Health
Wards Involved:	All wards in Westminster
Financial Summary:	Not Applicable
Report Author and Contact Details:	Eva Hrobonova Deputy Director of Public Health ehrobonova@westminster.gov.uk Cynthia Folarin Director, Public Health Insights cfolarin@westminster.gov.uk

1. Executive Summary

1.1 In October 2015, local authorities became responsible for the commissioning of the 0-5 Healthy Child Programme (HCP). This included the Health Visiting service incorporating universal and targeted programmes and the Family Nurse Partnership (targeted services for first time teenage mothers). The NHS national service specification was used on transfer to the local authority, and the specification will remain in place until October 2017.

1.2 The move to commission children's public health by local authorities in 2015 is therefore an opportunity to take a fresh look at providing coherent, effective services for children locally and to focus on an integrated and responsive service.

1.3 The current service is provided by Central London Community Healthcare however this contract ends in October 2017, when the service will be retendered. Appendix 1 shows the original timeline for reprocurement. Some of the planned objectives have been delayed, of which the most important in terms of the timeline is the market engagement event, and presenting the strategy report.

1.4 The difficulties in recruiting a 0-5s commissioner have contributed significantly to these above identified delays. In addition some of the deadlines for the questionnaires were also extended due to poor response rate, and cancellation of focus groups.

1.5 These delays mean that mobilisation is unlikely to begin in July 2017 and as a consequence the current contract will need to be extended for a short period of time.

1.6 The draft strategy document is currently being finalised, which will be followed by a market engagement event. Thereafter the strategy will be submitted to the Cabinet Member and the relevant committee for approval.

2. Background

2.2 The provision of Health Visiting services by local authorities include services in five key areas:

- the antenatal health promotion review;
- the new baby review;
- the 6-8 weeks assessment;
- the 1 year old assessment;
- and the 2 to 2 ½ year old review.

The specification of these services has been for an initial period of 18 months following the transfer, until 31 March 2017.

2.3 The transfer of responsibility for the commissioning of health visiting is a significant opportunity for the Council and its partners to further ensure all children have the best start in life. Health visiting teams see every new mother and child born in Westminster and are trained to identify needs, provide support and ensure mothers and families are engaged in other services where necessary. The service includes screening tests, immunisations, developmental reviews, and information and guidance for every family to support parenting and healthy choices. They are of fundamental importance to ensuring early child health (through delivery of the healthy child programme), safeguarding and delivering an effective early help service at the point in life when services can make the most difference to children's life chances. This report provides an update on the commissioning developments of the public health services, for children aged 0-5 years.

3. Introduction to the Health Visiting Service

3.1 Health visitors are the lead professionals in the delivery of the Healthy Child Programme (pregnancy to 5 years). This programme includes both universal services and additional interventions for families with more complex needs. The programme includes health promotion, child health surveillance and screening, and services to be offered to families.

3.2 A wealth of evidence points to the importance of pregnancy and the early years in shaping an individual's life course. The Wave Trust's Conception to Age 2 report[1] outlined the importance of these years in developing and supporting emotional wellbeing, capacity to form and maintain positive relationships with others, brain development, language development, and ability to learn. UK studies have found that investment in pregnancy and early years support show returns of between £1.37 and £9.20 for every £1 invested in these programmes.

3.3 The Family Nurse Partnership (FNP) is a preventive programme for vulnerable first time young mothers aged under 20. It offers intensive and structured home visiting, delivered by trained nurses, from early pregnancy until the child is two. The FNP is a nationally licenced programme and is held to account by a local advisory board. All data for FNP is collated nationally and fed into a local advisory board. The FNP programme is commissioned to work with 25% of first time teenage parents.

3.4 FNP has a very clear evidence base, based on over 30 years of extensive research. Three large scale randomized control trials have tested the programme with diverse populations in different contexts. These have shown a range of long term benefits for children and mothers over the short, medium and long term. FNP has one of the best evidence bases for preventive early childhood programmes, being identified by many rigorous evidence reviews as having the highest quality of evidence and best evidence of effectiveness.

4. Service Delivery – Progress Made Locally

4.1 The current recorded frontline health visitor establishment across the whole three Boroughs (Westminster, Kensington and Chelsea and Hammersmith and Fulham) is just over 90 FTE staff. There is a quarterly contract meeting held, and stakeholders are involved through the health visitor partnership group.

[1] Wave Trust, Conception to Age 2 – the Age of Opportunity, 2013

4.2 An FNP advisory board meets quarterly to oversee progress. The three Borough FNP launched at the end of 2010. Since 2010, 220 parents have been supported as part of the programme, with 193 babies born to date. Most are contacted through the midwifery service. Each full time nurse can hold a caseload of 25 clients. There is an annual review due for the FNP service that will be carried out by the national team in July; this is part of their licensing role and will ensure that the programme is fit for purpose from a quality improvement perspective.

5. Service Review and Stakeholder Engagement

As part of the commissioning cycle we have undertaken an analysis of local needs and a service review to examine the extent to which the current service meets those needs.

5.1 Health Visitor Partnership Group:
This group meet at least bi-monthly since October 2015. The role of this group is to:

- Provide senior level leadership expertise and support to the redesign and re-commissioning of the service;
- Ensure maximum alignment with the Best Start in Life and the Connected Care for Children integrated approaches; and
- Update on and oversee the current provision of services.

It includes stakeholders from children's services, CCGs, Central London Community Hospital (CLCH), Healthwatch, GPs, a midwife and a parent representative. The groups are themed, and themes have included the antenatal contact, working with general practice, working with children's services, the transition from health visiting to school nursing, the integrated 2 year review, perinatal mental health and identifying need antenatally.

5.2 The group have struggled to engage either GPs or midwives on a regular basis. In order to mitigate this, we plan to write a short summary of the findings from the group and the recommendations from the needs assessment and send this to these stakeholders for information and comment.

6. Patient Engagement

6.1 Three focus groups have been undertaken as part of the service redesign process. The focus group in Westminster was held in the Stowe centre in Paddington. It included 8 local community and maternity champions.

6.2 We have undertaken questionnaires for health visitors, general practice staff, and children's services. The aim was to identify current service provision and to ask for input from frontline staff on their priorities for health visiting and for future service redesign. There were insufficient responses for each of the questionnaires, and therefore we left the online questionnaire open for a longer time than planned while we repeated publicity via children's services and the CCGs. The results are currently being compiled.

6.3 We have undertaken a health visiting needs assessment to inform the re-design of the new service across the three Boroughs. This is currently being circulated among partners for comments.

6.4 There are wide reaching changes currently being undertaken in Children's services, for which the consultation has just closed. We intend that the service specification will align to the new children's services offer in Westminster.

7. Commissioning

We intend that the new service should suit the needs of the local population. The following new elements will be included in the service specification:

7.1 Antenatal Preparation for Parenthood Classes

Increasingly it is being recognised that the antenatal period and the post-natal period is crucial, therefore ensuring that parents are prepared for parenthood is essential. Investment at this time saves money in the future. The service offered will include both antenatal visits and preparation for parenthood classes.

Two forms of antenatal classes are currently being piloted. There is a targeted class for young families which is a relatively new innovation by the NSPCC; it includes both home visits and antenatal and postnatal classes. In the areas where this model has been delivered previously, it has already shown good outcomes. The other class that is being piloted is a locally derived universal antenatal preparation for parenthood class; it is delivered in three sessions and includes midwives and children's centres workers in addition to health visitors. So far there has been a good retention rate of clients, as well as excellent attendee satisfaction. The evaluation is being led by the Public Health department.

7.2 Caseload

It is vital that health visitors remain a universal service; they are experts in early identification of need. However not all parents need the same amount of input. We will specify the caseload that health visitors carry, which will be evidence based and will reflect the deprivation variations across the City, so that health visitors are able to work more intensively with the families who need extra input.

7.3 Alignment with children's services

We intend to align health visiting team structures to those of children's services, but also (where possible) include team co-location. This will facilitate integration of the services so that they can best utilise available resources and avoid duplication. Currently all children's centres have a 'linked' health visitor. We will aim ensure that the service specification is written to fit with the delivery of children's services. Health visitors should form a lynchpin in the connection between health and children's services, and we expect them to retain excellent links with health services, particularly general practice.

7.4 High impact area leads

CLCH currently have leads for the 6 high impact areas in health visiting:

- Transition to Parenthood and the Early Weeks;
- Maternal Mental Health (Perinatal Depression);
- Breastfeeding (Initiation and Duration);
- Healthy Weight, Healthy Nutrition (to include Physical Activity);
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions); and
- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'**.**

The high impact area leads are responsible for training; developing new pathways and implementing service recommendations, and work on this role for two days per week. These professionals work across the whole service. CLCH are currently evaluating this initiative. We would like this service to be maintained and expanded in the new borough to provide a lead in each borough.

7.5 Use of technology

We will specify in the new service specification that the provider must maintain an up-to-date and relevant online presence with information for local families. We will also expect that the provider enables their staff to have remote access to

patient records so that they are able to input data while undertaking home visits. CLCH were selected as a pilot site for the e-red book which was launched in March 2016. This enables parents to access an online e-red book, which has information tailored to local parents, as well as links to online health information. We expect that the provider of the new service would continue to implement innovation such as this.

8. Next Steps

We have written a draft service strategy document. Once this has been finalised, a market engagement event will be organised and the strategy will subsequently be submitted to the Cabinet Member for approval.

9. Legal Implications

Not applicable

10. Financial Implications

Not applicable

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Tackling Childhood Obesity Together
Report of:	Eva Hrobonova, Deputy Director of Public Health
Wards Involved:	All
Policy Context:	Tackling childhood obesity is a key priority within Better City, Better Lives.
Financial Summary:	Overall cost of programme and services to tackle childhood obesity in Westminster is £1.2m per annum.
Report Author and Contact Details:	Catherine Brice, cbrice@westminster.gov.uk

1. Executive Summary

1.1 London has the highest rate of childhood obesity of any major global city. Obesity impairs lives and presents a major challenge to health and wellbeing as well as public services. It is associated with an increased risk of premature mortality in adults as well as poor health and development and poor educational attainment in children. The causes of obesity are multi-factorial - there is no single effective solution. The government's obesity strategy[1] recognises that local government "is uniquely well placed" to lead the drive to reduce obesity given that each community has different characteristics and problems that are best addressed at a local level.

1.2 The Tackling Childhood Obesity Together (TCOT) programme is a whole-council approach and cross-department commitment to tackle childhood obesity to deliver a healthier environment in Westminster. Obesity impairs lives and presents a major challenge to health and wellbeing. It is associated with an increased risk of premature mortality in adults as well as poor health and development and poor educational attainment in children.

[1] HM Government Department of Health Healthy Lives, Healthy People: A call to action on obesity in England (2011)

1.3 The aim of this programme is to halt and reverse the rising trend in childhood obesity. A strong focus is on the development of a whole-council partnership prevention approach to reduce the obesegenic environment in Westminster. The attached report outlines the three strands of the programme:

- Family healthy weight services - the substantial investment into and implementation of new equitable and effective family healthy weight services for families and children including a care pathway, workforce training and referral toolkit for families and professionals.
- Westminster Council whole system approach - working with internal partners within Westminster City Council (WCC) and external partners across Westminster to change the environment so that healthy choices become easy choices for residents.
- Community healthy lifestyle pilot - a community-led healthy lifestyle pilot project focusing on the ward of Golborne in the Royal Borough of Kensington and Chelsea (RBKC).

All of the above are underpinned by on-going research, evaluation and evidence.

2. Key Matters for the Board

2.1 The Board is asked to:

- Note the progress of the programme outlined in the paper and the attached report (Appendix B);
- Note the whole-Council approach and suggest opportunities for cross-departmental collaboration and commitment to delivering a healthier environment in Westminster; and
- Consider and agree the annual report included as Appendix B.

3. Background

3.1 Childhood obesity presents a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults as well as poor health and development in children. Childhood obesity also impacts on mental wellbeing including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment. Problems related to overweight and obesity tend to start in childhood and often disproportionately affect disadvantaged socio-economic groups.

3.2 Preventing and treating childhood obesity requires a comprehensive approach including:

- Early intervention/prevention services that support children and families to maintain a healthy weight (as assessed using body mass index (BMI) calculations);
- Targeted lifestyle weight management services for overweight and obese children, young people and families; and
- A coherent, community-wide, multi-agency approach that addresses the obesegenic environment and supports behaviour change, integrated within broader regeneration and environmental strategies as well as other health improvement work.

3.4 Our approach crosses the whole system of our society, its environment and its culture and involves a partnership between local government, the NHS and the science, business and community sectors. It encompasses all children and family public health services relevant to nutrition provided previously across the three boroughs such as Healthy Start and Healthier Catering. We work particularly closely with relevant partner services such as Healthy Schools, School Nursing and Health Visiting to maximise effect and avoid duplication of effort.

3.5 The "Tri-borough Childhood Obesity Programme on a page" is attached as Appendix B.

4. Options / Considerations

4.1 Effective action to tackle childhood obesity is vital to prevent harm and govern resources wisely. The council's statutory responsibility for improving the health and wellbeing of residents is a collective responsibility. It requires a new way of working involving improved coordination and joint working across all departments.

4.2 Investment into family healthy lifestyle behaviour change services to support and motivate families to embrace change must be supported by wider societal and environmental changes to enable families to sustain the newly learned behaviours and to make healthy choices easy choices.

4.3 Commissioned services to reduce the prevalence of obesity in the City by helping children, young people and their families to eat healthier and be more active, have been in place since September 2016:

- **Prevention and weight management programmes for children and families:**
  delivered in schools and various community settings including children's centres and health care settings. These include:
  - MEND Mini and MEND Mums - a universal tier-one parent and child obesity prevention course to assist children aged up to four to maintain a healthy BMI.

- MEND 5-7 and MEND 7-13 - an accessible tier-two family healthy lifestyle child weight management course to assist children and young people aged between five and 12, who are on or above the 91st BMI centile, to reach and maintain a healthier BMI.
- MEND in Schools - an intensive programme of activities for primary schools whose pupils have a higher risk of obesity involving all children in years one and four and their parents.

- **Policy and workforce development:**
  To improve healthy choices in settings and empower the children's workforce and other relevant frontline staff to understand their role in and improve skills to address the obesity issue with clients. The majority of work is currently happening in schools and early years settings but the programme is also branching out into community settings.

4.4 109 families have participated in MEND courses across the three boroughs in the first four months of the service running (September - December 2015). Nine schools in Westminster (reaching 538 children) have been engaged to participate in MEND to date. This should increase to 1,100 children being reached through Westminster schools by September 2016. Up to the end of January 2016 workforce training has been delivered to 228 people across the three boroughs and MyTime Active has worked with 24 schools, supporting them to improve the health of their food offering. All services are being closely monitored and evaluated.

4.5 The whole council approach to tackling an obesogenic environment aims to work gradually with every council department to consolidate and strengthen activities that contribute to the prevention of childhood obesity by:

- Understanding work already underway across the Council that contributes to preventing childhood obesity;
- Identifying actions to be included in departmental business plans to deliver the corporate strategy;
- Understanding the areas where the council currently has limited control or opportunity to influence; and
- Identifying opportunity areas for further development.

4.6 The approach described below has been developed initially in Westminster before it is taken forward elsewhere. The approach includes:

- Food growing and education - pilot food growing projects in two schools and a housing estate in a regeneration area;

- Increasing physical activity - working with priority schools to engage with the school sports development team; and
- The Healthier Catering Commitment - working with food premises to improve the nutritional content and quality of their food.

Food growing

Three different food growing schemes have taken place in Westminster. They aim to develop sustainable and well-utilised garden resources to grow fresh produce and improve skills as well as knowledge and confidence in food growing, with a particular focus on children and families. Building on the success of these school and estate-based projects, options are currently being considered to develop a City-wide food growing programme.

Physical activity

The Public Health department, in collaboration with WCC's Sports, Leisure and Wellbeing team, has worked to maximise physical activity opportunities for children, with a particular focus on areas in the borough with higher levels of deprivation and obesity. This includes:

- Ensuring children have access to at least one hour of physical activity a day (part of the Active Westminster Strategy (2015-2020)).
- A range of competitive opportunities have been made available to primary and secondary schools, including festivals and multi-skill fun days that promote engagement and participation in physical activity.

Future plans include the strengthening of links to the Healthy Schools Partnership programme to develop individual school physical action plans, engagement with partners within the council and its external networks to scope the possibility of developing a 'Westminster Standard' for participation in PE and school sport and further development of the Active Westminster passport scheme to engage more children from target areas.

Healthy Catering Commitment

The Healthier Catering Commitment aims to supports food businesses to make straightforward changes to ingredients and preparation techniques in order to offer healthier food to customers.

To date, 19 businesses have successfully achieved Healthier Catering Commitment status and their efforts to serve healthier food were recognised at an awards ceremony at Westminster City Hall on 23rd February 2016.

Support will continue to be offered to all businesses signed up to the scheme with a target of awarding a further 20 businesses with the Healthier Catering Commitment award in 2016/2017. Monitoring reviews will also be incorporated

into future food hygiene inspections for those businesses that have been awarded to ensure they are maintaining their commitment. The introduction of a tiered scheme will be explored to encourage businesses to achieve the highest standard.

4.7 It is our intention that the TCOT programme is, where possible, evidence-based and that when evidence is lacking, the programme will generate evidence locally. With this in mind, we are piloting different approaches in different boroughs and using our learning to inform practice as the programme progresses.

4.8 To this effect and in addition to the above mentioned commissioned services and the whole council approach a bespoke pilot project has been initiated in the Golborne ward of RBKC to test a system-wide multi-strategy approach to tackling childhood obesity with the view of establishing a transferrable model of effective community-based intervention.

4.9 To ensure quality assurance of our innovative programme we have applied for and become the first local authority in England to gain membership of the prestigious EPODE European network of cities and places that systematically address childhood obesity. This membership offers learning and networking opportunities that enrich our programme and establishes our reputation as a City that systematically addresses one of the most pressing global public health issues.

5. Legal Implications

N/A

6. Financial Implications

An annual budget of £1.2million has been assigned by WCC Public Heath to the programme to finance the behaviour change commissioned services, to temporarily support other council departments in extending/initiating their work on tackling childhood obesity and to ensure appropriate evaluation and dissemination of the programme results.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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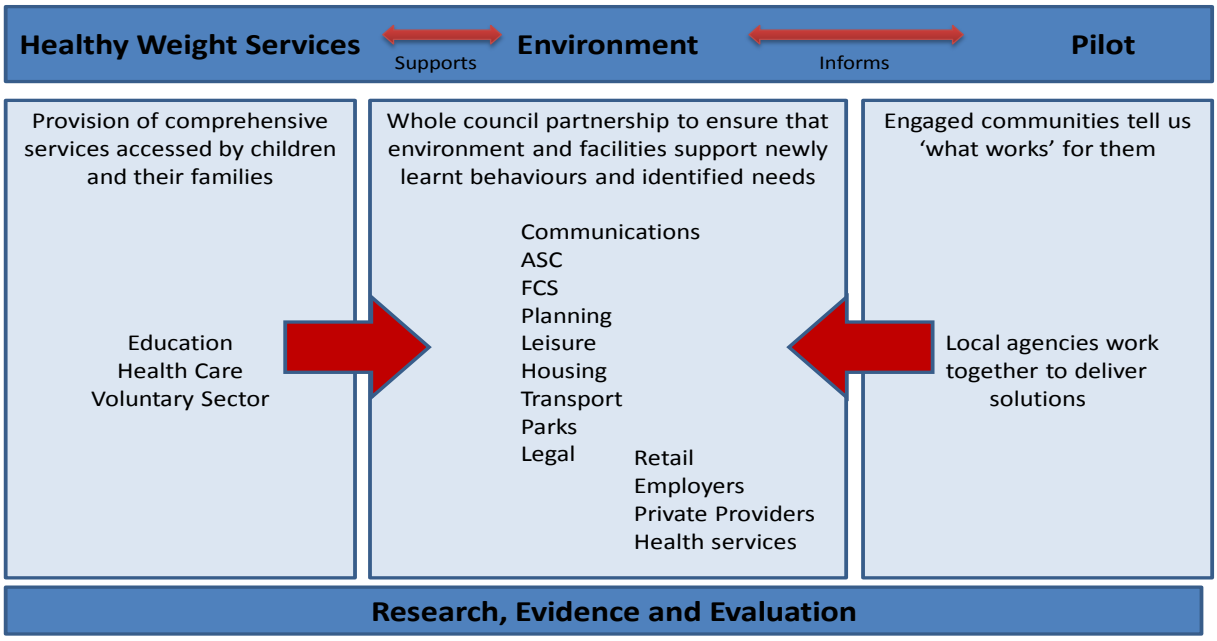
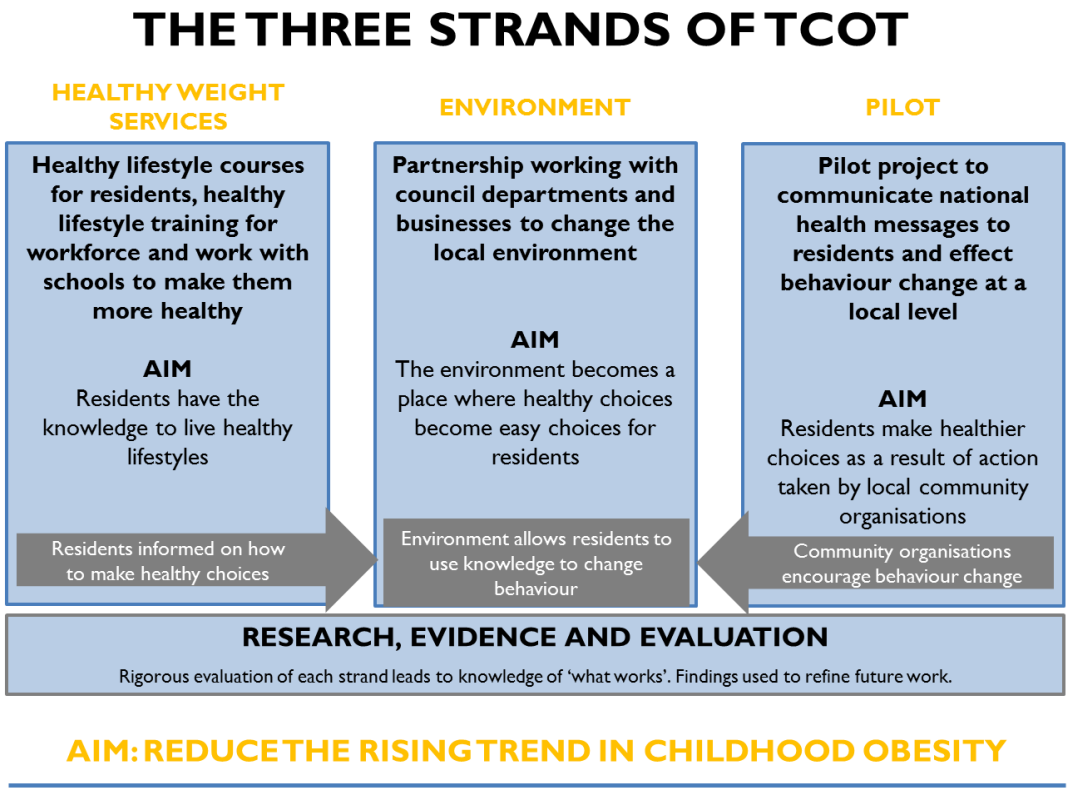
Appendix A: Tackling Childhood Obesity Together Programme - design for the integrated whole council approach



Appendix B: Tackling Childhood Obesity in the Tri-borough Programme – the three strands of TCOT



BACKGROUND PAPERS:

Appendix C - One year on, TCOT annual report 2015/16

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Tackling Childhood Obesity Together in the Three Boroughs (TCOT)

ANNUAL REPORT, 2016

June 2016

Produced by the tri-borough Public Health department covering the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster

Contents

CHAPTER 1: INTRODUCTION

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. There are a number of potential health consequences associated with childhood obesity including impacts on mental health, type 2 diabetes and the likelihood of continuing obesity into adulthood, which is linked to a range of unfavourable health conditions. The current UK government is committed to publishing its childhood obesity reduction strategy, which is expected in the summer of 2016. Speaking on the subject in February 2016, Health Secretary Jeremy Hunt said "we have got to do something about this. I've got a one-year-old daughter, and by the time she reaches adulthood a third of the population will be clinically obese. One in 10 will have type 2 diabetes. It is a national emergency."

Across the boroughs of Westminster, Kensington and Chelsea and Hammersmith and Fulham, nearly one in four children in reception (four to five-year-olds) and one in three children in year six (10-11-year-olds) are overweight or obese (National Child Measurement Programme (NCMP) 2014/2015). Each council is committed to tackling childhood obesity and as such the five year Tackling Childhood Obesity in the Three Boroughs programme (TCOT) has been developed.

With no single effective solution identified to tackle obesity, TCOT, drawing on local, national and international evidence, has been designed to systemically address the wide range of contributory factors to childhood obesity. The approach crosses the whole system of our society, its environment and its culture and involves a partnership between local government and the NHS and the science, business and community sectors. It encompasses all children and family public health services relevant to nutrition provided previously across the three boroughs such as Healthy Start and Healthier Catering and works particularly closely with relevant partner services such as Healthy Schools, School Nursing and Health Visiting to maximise effect and avoid duplication of effort.

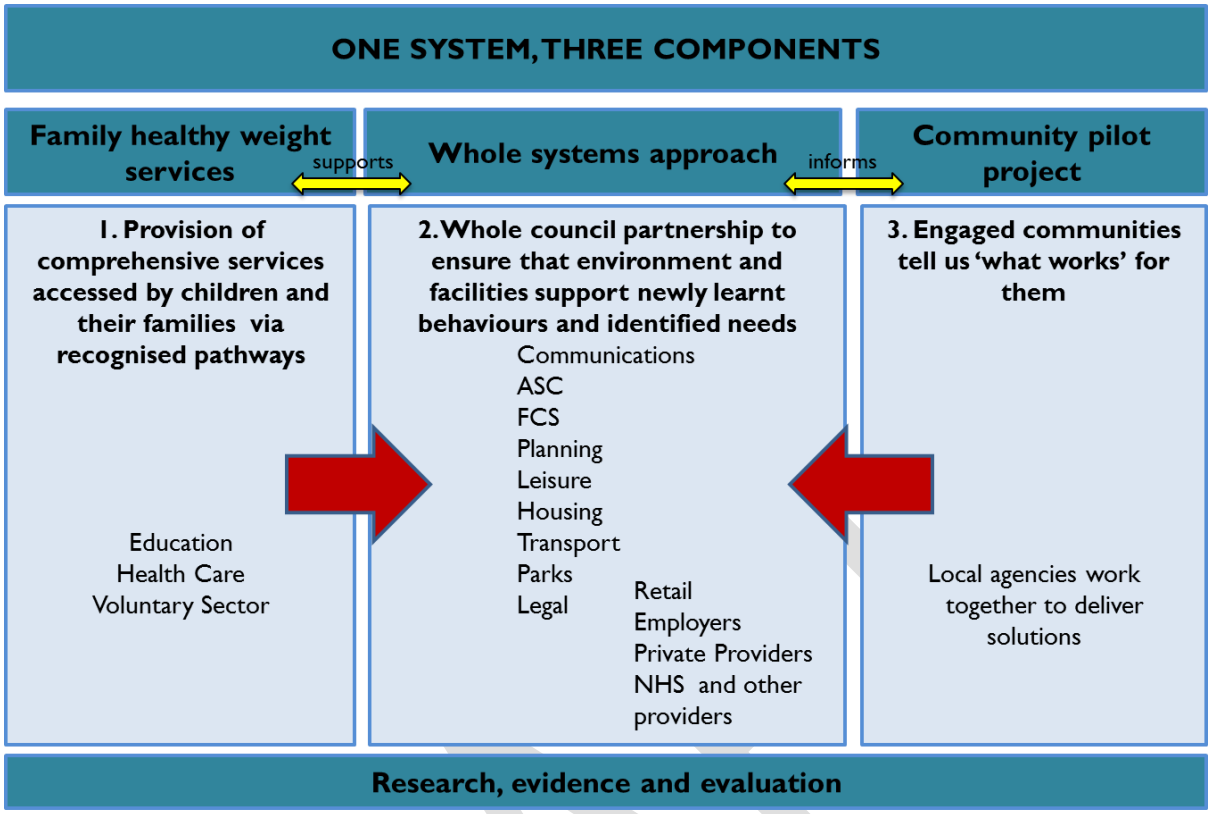
Figure 1: Vision of the TCOT programme

The key aim of the programme is to halt and reverse the rising trend in childhood obesity across the three boroughs.

It has three components:

- Family healthy weight services - the implementation of a family healthy weight care pathway, workforce training and family healthy lifestyle services across the three boroughs, led by the London Borough of Hammersmith and Fulham (LBHF).
- Whole system approach - working with internal partners within Westminster City Council (WCC) and external partners across Westminster to change the environment so that healthy choices become easy choices for residents.
- Community healthy lifestyle pilot - a community-led healthy lifestyle project, Go Golborne, focusing on the ward of Golborne in the Royal Borough of Kensington and Chelsea (RBKC).

Figure 2: The relationship between the three components of TCOT



These three programme components operate in close synergy and lessons learned are transferred and utilised across the three boroughs as they emerge. It is envisaged that, during the lifespan of the programme, different boroughs will test different approaches while rigorously evaluating them to inform future implementation of effective elements across the local geography to gradually achieve marked change in the environment, social norms and behaviours. We believe our approach is innovative, comprehensive and evidence-based where evidence exists.

Due to its comprehensive methodology, in November 2015 TCOT became the first UK local authority intervention to be accepted as a member of the EPODE International Network, a global network of community-based obesity prevention programmes.

This report describes the progress made during the first year of the programme.

CHAPTER 2: FAMILY HEALTHY WEIGHT SERVICES - OVERVIEW

Aim and summary

The aim of the family healthy weight services is to ensure that children and families in need are motivated and able to attend evidence-based, appropriate and acceptable preventative services to improve their chances of maintaining or regaining a healthy weight. With this in mind, a significant investment has been made by all three councils in a number of healthy lifestyle services for local families and a programme of workforce training and development. Additionally two care pathways have been designed in wide partnership to facilitate access, knowledge and uptake of these services.

What evidence is there to suggest that this approach will help to reduce childhood obesity?

The evidence base for childhood obesity prevention services for children aged up to 12 years is well established and includes the comprehensive Cochrane review[1], the Foresight report[2], the McKinsey report, Overcoming obesity: An initial economic analysis[3] and the National Institute for Health and Care Excellence's (NICE) guidance on nutrition and physical activity. In April 2014, the public health department in the three boroughs completed and published the Child Obesity Prevention and Healthy Family Weight Services Review [4], which clarified that service provision, as it stood then, was inadequate and unequal and that there was no overlap or duplication of relevant provision from any other part of the organisation/s. It also pointed out that a gap in evidence exists for teenage obesity prevention interventions, despite a clearly identified need for services targeted at this age group.

Findings from both the Child Obesity Prevention and Healthy Family Weight Services Review and the locally conducted 2013-14 Children and Families' Early Help Services' Compare and Contrast Review reinforced the need to include outreach services and taster activities in local community settings to engage more vulnerable children and families and to increase access to services.

The Child Obesity Prevention and Healthy Family Weight Services Review also highlighted the need to develop an integrated childhood obesity care pathway with clinical commissioning groups (CCGs) and health service providers to generate appropriate referrals to services. Additionally, the review identified a need to skill up the children's, NHS and other family service providers' workforce in understanding obesity prevention, motivational interviewing and delivering brief health promotion.

[1] Waters et al (2011), *Interventions for preventing obesity in children (Review), The Cochrane Collaboration*
[2] Butland et al (2007), *Tackling Obesities: Future Choices – Project Report, Government Office for Science*
[3] Dobbs, R and Sawers, C et al (2014) *Overcoming obesity: An initial economic analysis,* d*iscussion paper, McKinsey Global Institute*

What process was taken to develop the approach?

Initially, a review of current public health service provision across the three boroughs, which included an evaluation of current service provision, a health needs analysis, mapping of relevant activities and a consultation exercise was undertaken. This resulted in the publication of the Child Obesity Prevention and Healthy Family Weight Services Review.

This review, together with evidence of the size of the problem locally, was shared with lead politicians to establish childhood obesity prevention as a local priority for action. This has resulted in a mandate to plan and commission local services that will have the capacity and ability to effectively address the issue of individual behaviour change. It was also acknowledged that to maximise the effect of these interventions locally and to gain return on our investment, changes to the wider living environment and relevant policies will need to happen simultaneously.

In line with the evidence base, a holistic approach was taken to design the new services. This process brought together a number of essential partners and stakeholders to design locally tailored services procured through an open, competitive tendering exercise where quality of service was the paramount consideration. The successful service provider, MyTime Active (a social enterprise that currently delivers lifestyle preventative health services across the UK), commenced delivery of these services on 1st August 2015 under a three year contract.

A range of stakeholders from the public health and children's services three boroughs departments , local CCGs, acute and community NHS trusts, obesity prevention and weight management services and consumer champions, Healthwatch, worked together to produce a holistic, evidence-based and system-wide care pathway to maximise appropriate referrals and uptake of the new services. Engagement with these stakeholders ensured their sense of ownership of the pathways, as well as their familiarity with the process.

CHAPTER 3: FAMILY HEALTHY WEIGHT SERVICES – MEND (MIND, EXERCISE, NUTRITION…DO IT!)

Aim and summary

Following the Child Obesity Prevention and Healthy Family Weight Services Review in 2013/14, a range of new childhood obesity prevention and family healthy weight services have been commissioned by the public health department in close collaboration with the children's services department and local CCGs across the three boroughs. These aim to:

- Address the inequitable provision of services across the three boroughs.
- Provide effective evidence-based services to support families to make healthier choices for their children and themselves.
- Increase access to services through outreach activity to engage more vulnerable children and families in greater need.
- Ultimately result in a greater proportion of local children and families with a healthy weight.

The commissioned services delivered by MyTime Active are part of their MEND (Mind, Exercise, Nutrition…Do it!) programme and include:

- MEND Mini and MEND Mums - a universal tier one parent and child obesity prevention course delivered in community settings to assist children aged up to four to maintain a healthy body mass index (BMI).
- MEND 5-7 and MEND 7-13 - an accessible tier two family healthy lifestyle child weight management course to assist children and young people aged between five and 12, who are on or above the 91st BMI centile, to reach and maintain a healthier BMI.
- MEND in Schools - an intensive programme of activities for primary schools whose pupils have a higher risk of obesity involving all children in years one and four and their parents.

The above services aim to support families to make healthier choices easy through fun, interactive courses with sessions that cover healthy eating, physical activity and behaviour change in order to establish healthy patterns of eating and physical activity during the formative years. A pilot tier two service for children aged 13 and over is also to be co-designed by young people.

These services are underpinned by a comprehensive workforce development programme and support to deliver the Healthy Schools and Healthy Start programmes and the Healthier Catering Commitment as described in Chapter 5.

Evidence of need

The number of places available on the MEND courses to residents is based on the number of children in each borough (see Table 1 below). The courses for children aged up to four and their parents/carers were modelled on providing places for 30% of resident children and their parents/carers by the end of the third year of delivery. The courses for children aged 5 to 13 were modelled on providing places for 70% of children identified as obese by the NCMP by the end of the third year of delivery. Place numbers for both sets of courses increase each year to reflect the time it will take to generate demand to fill places.

Table 1: Projected numbers of places on MEND courses by the end of the third year of delivery

Local authority	No. of children aged 0-5 at any one time	30% of one year group	No. of obese children aged between six and twelve	No. of children identified as obese annually in reception and year six classes (NCMP)	70% of children identified as obese annually in reception and year six classes (NCMP)
LBHF	13,854	831	1,642	469	328
RBKC	10,827	649	1,268	362	253
WCC	14,797	887	1,931	552	386

For more detail on evidence of need and the effectiveness of the chosen interventions, see Chapter 2.

Process

The process of needs assessment, political support, wider stakeholder engagement, service design, procurement and implementation is described in detail in Chapter 2.

Benefits

To date, six months after the new services commenced, the MEND courses (Mini, Mums, 5-7 and 7-13) have received overwhelmingly positive feedback from participants. 109 families participated in courses from September to December 2015. 100% of families rated the courses 'good' or 'excellent' for their suitability to their needs, for meeting their goals and objectives of positive food behaviours, increased physical activity and self-efficacy and decreased sedentary activity and were 'very likely' to recommend them to friends or relatives. There will be 21 courses, held in children's centres, schools and community centres, on offer across the three boroughs during the forthcoming term (summer 2016).

MEND in Schools has proven popular with most available places already filled. In RBKC, all 10 places have been filled with participation from eight schools (reaching 444 children) and two more commencing in September. In LBHF, six schools (reaching 345 children) are currently participating with four more commencing in September and a further five to be recruited. In Westminster, nine schools (reaching 538 children) are currently participating with four schools commencing in September and five more to be recruited. Evaluation of the impact of MEND in Schools will take place at the end of the school year with early indications showing increases in water consumption, active play and reductions in confectionery consumption.

Next steps

Efforts will focus on increasing awareness of the services among families and the children's workforce, which will help to increase referrals and self-referrals to the programmes. Furthermore, schools will be recruited to the remaining available spaces on the MEND in Schools programme. Finally, a pilot programme, which will be designed, delivered and fully evaluated, will be developed in full with local young people. Insight from focus groups held with young people so far indicates that the programme needs to consider the following elements:

- Choices of activity are important.
- Parental presence should be at the discretion of the participants.
- Weekend programmes would be better than weekdays.
- Tone and approach must be carefully managed and consideration should be given to whether schools are the right setting for the programme.
- Location needs to be 'safe'.
- Social media content needs to generate enough interest to warrant further self-motivated interaction.

Table 2: The key milestones for family healthy weight services from years one to three

	Year 1	**Year 2**	**Year 3**
0-4 child obesity prevention programme places and one-to-one appointments	Maximum 900	Maximum 1,600	Maximum 2,420
5-13 child obesity treatment programme places	Maximum 384	Maximum 600	Maximum 968
Teenage pilot programme	• Focus groups and other engagement • Design of programme • Pilot first programmes in the summer term • Review of first programmes – additional co-design and adaptation	• 11 programmes delivered and evaluated • Additional co-design and adaptation	• 12 programmes delivered and evaluated
MEND in Schools programme	Recruitment of schools with 50% commenced by January 2016	43 schools participating	43 schools participating

Case study – MEND Mini

The MEND Mini course teaches parents creative ways to encourage children to taste and enjoy fruit, vegetables and other healthy snacks and to take part in active play. Each week children enjoy crèche-style activities while adults take part in discussion; topics include fussy eating, portion sizes and positive parenting. The following quotes taken from parents who attended the course demonstrate the positive impact of the programme:

- *"I now have more ideas for playing with Louis and I have gained good and interesting advice on nutrition. Louis now initiates playing games from MEND such as walking like giants and crabs at the park with his dad. I had to explain to Louis' dad what he was doing!"*
- *"I totally recommend MEND Mini! I have already recommended it to two other people. It's a really interesting programme and my child is always learning new things when we come to the programme. The children learn fun games and they develop new skills. I now use the traffic light game at street crossings to help Mikey follow commands."*

Figure 3: children take part in a MyTime Active MEND physical activity session

CHAPTER 4: FAMILY HEALTHY WEIGHT SERVICES – SCHOOL MEALS

Aim and summary

The provision of free school meals is a statutory provision within the Education Act 2003. Each governing body has a duty to provide free lunches for eligible pupils and to provide the opportunity for other pupils to buy lunch. Approximately 21,000 school meals are provided daily within 112 schools through contracts managed by the Children's Services Commissioning directorate.

When the Children's Commissioning directorate was formed, an opportunity was recognised to undertake a shared approach to procurement for school meals across the three boroughs. It was recognised that this process would maximise the opportunity of achieving financial efficiencies and savings relating to contract spend and delivery. Schools in the three boroughs were in support of councils procuring sovereign borough contracts on their behalf for the delivery of school meals. Schools have the opportunity to opt into the borough-wide contracts or to make their own arrangements.

Evidence of need

A successful school meal service has the potential for children and young people to enjoy their school lunch, educate their palates and embed positive eating habits for life. It will also enable them to get the most out of their learning in school by aiding concentration.

Healthy eating and being physically active are particularly important for children and adolescents. This is because their nutrition and lifestyle influence their wellbeing, growth and development. The nutritional requirements of children and adolescents are high in relation to their size because of their demands for growth, in addition to the requirements for body maintenance and physical activity.

In England only 1% of the packed lunches children bring to school meet the current school food standards. Therefore the school meal service has a vital contribution to make to the health of children and young people by improving the nutritional quality of their diets. Provision of school meals also plays a role in the overall strategy to help children maintain a healthy weight. Essential to this will not only be the quality of the food and beverages available throughout the school day but also the work done to encourage the enjoyment and consumption of the whole lunch.

Schools are supported to take a 'whole school approach' to healthy eating by the Healthy Schools Partnership. A key part of that approach will be the partnership working between the school and its catering provider.

Opportunities for school meal providers to contribute to health

- Maximise uptake of all school meals and free school meals in particular.
- Participation in School Nutrition Action Groups.
- Consultation with children as to how to improve the school lunch experience.
- Ensuring that children have time both to eat lunch and play by minimising queuing.
- Sharing facilities with breakfast clubs.
- Getting involved in teaching cooking skills.
- Engagement with parents to show them the school lunch, share recipes children enjoy at school etc.
- Support the national Change4Life campaign and any other relevant local campaigns.

Process

The school meals procurement was informed by the School Meals Working Party, which contained representation from schools and the public health and children's services departments. Schools were given the opportunity to shape the specification and tailor the technical quality evaluation questions and presentation topics to best reflect local priorities. The quality factors were weighted according to their importance, with greater percentage of the allocated 40% being based on meeting the specification and service outcomes, to ensure that the catering provision was of the highest quality and to mitigate any risks associated with health and safety, food hygiene and nutritional quality. The process of evaluating the food and quality from a nutritional point of view and to ensure adherence to nutritional guidelines and food quality was highly emphasised and reflected by the weightings. The tender evaluation process included supplier presentations as well as sample and scoring set meals produced by suppliers at the 'cook-off' session.

In developing the specification, consideration was given to provision of halal and non-halal meat within menu choices. Sample menus provided reflect the racial and cultural mix of pupils, including the requirement to provide a vegetarian option every day.

Benefits

The procurement exercise has delivered the best possible outcome for schools from both quality and financial perspectives. The procurement process was extremely competitive, resulting in strong

bids. The new service will provide consistently high quality meals and maximise value for money to achieve efficiencies. There has been active involvement from schools throughout the commissioning process to ensure that local priorities shape the outcome and subsequent service delivery.

Next steps

Following consultation with the Schools Heads Forum and Heads Executive Group it was agreed that RBKC would be first to call-off from the Framework Agreement, followed by WCC and then LBHF. The call-off and contract start dates are January 2016, April 2016 and June 2016 respectively.

Public Health and its Healthy Schools Partnership will be working closely with the Children's Services Commissioning Directorate and the new school meals providers to maximise the opportunity these new contracts provide to drive improvements in the nutrition of the children attending schools in the boroughs.

CHAPTER 5: FAMILY HEALTHY WEIGHT SERVICES - WORKFORCE DEVELOPMENT

Aim and summary

In addition to the family healthy lifestyle services detailed in Chapter 3, a second programme of work was commissioned to equip those working with children to further support efforts to tackle childhood obesity. It aims to:

- Improve settings such as schools and food outlets to make healthy choices, easy choices for children and families.
- Support the workforce to understand its role in obesity prevention and to have the skills and confidence to discuss children's weight with parents/carers, motivate them towards a healthy lifestyle and signpost them to relevant services.

More specifically, the commissioned services:

- Provide training, guidance and support to all state maintained schools to work towards achieving the relevant Healthy Schools awards (bronze, silver or gold). The awards recognise schools for supporting the health and wellbeing of their pupils. This will be delivered in collaboration with the Healthy Schools Partnership, the organisation which administers the awards.
- Provide training, guidance and support for early years settings (nurseries, nursery classes and children's centres) to take a whole settings approach to healthy eating including meeting the Children's Food Trust Eat Better/Start Better guidelines. In addition they will provide support around the physical development aspects of the Early Years Foundation Stage Framework for Physical Development in order to attain the Healthy Early Years Award.
- Provide a rolling programme of training to priority members of the children's workforce on how to support children, young people and their families to achieve positive healthy eating and physical activity habits and subsequent healthy weight management. Examples of courses available include nutritional guidelines, active playtimes and cooking in the curriculum.
- Support the implementation of the Healthier Catering Commitment through the provision of specialist nutrition support.
- Provide training on the NHS's Healthy Start programme, which provides free vouchers to some pregnant women and parents of children aged up to four to buy healthy food and drink and coordinates the distribution of vitamins locally.

In addition to these commissioned services, a care pathway that supports professionals to refer children to relevant services was developed.

Evidence of need

Evidence was gathered from national sources such as NICE's Obesity Prevention guidance and the WHO's Population-Based Approaches to Childhood Obesity Prevention and local evidence such as the Child Obesity Prevention and Healthy Family Weight Services Review and the Healthy Early Years Westbourne project in 2011-12. Findings strongly indicated the need to equip frontline staff with the knowledge and skills to approach the issue of weight with families and children in an effective manner and the need to improve settings to make healthy choices easier for children and families. The previously commissioned training did not offer sufficient capacity to cover the extent of identified need. For more detail, see Chapter 2.

Process

The process of needs assessment, support and wider stakeholder engagement, service design, procurement and implementation is described in detail in Chapter 2.

Benefits

Workforce training

Up to the end of January 2016 training has been delivered to 228 people across the three boroughs. Training is offered either as a rolling programme in a central location or bespoke to a group within their own setting which, for example, can be Community Champions, school or children's centre staff or school nurses. Modules on offer include obesity: the whole picture, nutritional guidelines, cooking in the curriculum, active playtimes, obesity: raising the issue and delivering physical activity.

Advice and guidance for schools and early years settings

Mytime Active has successfully built relationships with schools across the three boroughs. In the first term they were working with 24 schools and will be working with a further 26 in the spring term. Mytime Active's nutritionists have been supporting schools in evaluating themselves against the healthy eating criteria of the Healthy Schools bronze award and advising on changes that the school needs to make to attain the award, such as reviewing their school food policy. They have also been reviewing with schools on how they can improve lunchtimes, carrying out lunchbox audits and running workshops for parents as well as running healthy eating sessions with children including fruit and vegetable tasters, a sugary drinks activity and a session discussing the Eat Well plate.

Family healthy weight care pathway and toolkit

Two family healthy weight care pathways (one for children aged up to four and one for children aged between five and 19) and an accompanying toolkit have been developed, distributed and are available online. These resources provide a consistent set of messages, information about a range of universal preventative services and appropriate referral guidance for those who are already overweight or obese. They also reinforce the opportunities to intervene at key life stages from before birth until early adulthood and again during pregnancy.

Next steps

Training will continue to be offered with a greater focus on planned engagement with the wider children's workforce. This will include:

- Further work with the children's services department to ensure the training offer is visible to all staff.
- Ensuring that the school nursing and health visiting workforce has had relevant training modules.
- Mytime Active including tracking of who is attending training in their reporting.
- Mytime Active attending borough community sports and physical activity networks to enable them to promote both the training offer and prevention and treatment programmes.

Work with schools and early years settings to support them to achieve Healthy Schools and Healthy Early Years awards will continue.

The Family Healthy Weight Care Pathway working group will be reconvened to review the pathway and evaluate it. The pathway will continue to be promoted at GP locality meetings and other means of promoting the use of the pathway will be investigated, including laminated copies for all GPs and practice nurses and other health professionals.

Case study – Essendine Primary School

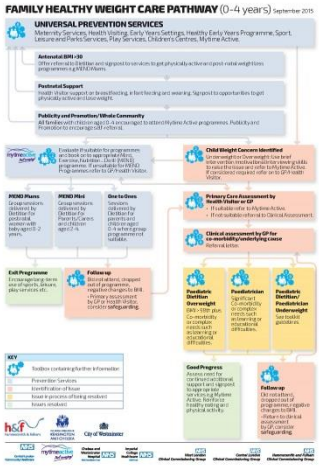
Essendine Primary School in north Westminster has achieved the Healthy Schools silver award for the priority area of healthy weight. MyTime Active is currently working with the school on the following activities to progress them towards achievement of their gold award:

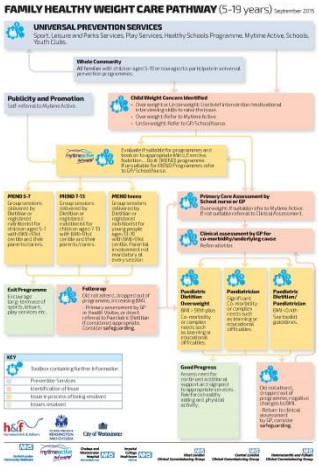
- Lunchbox audit **–** following an audit of 49 children's lunchboxes, recommendations were made to the school to improve the quality and variety of food items within them.

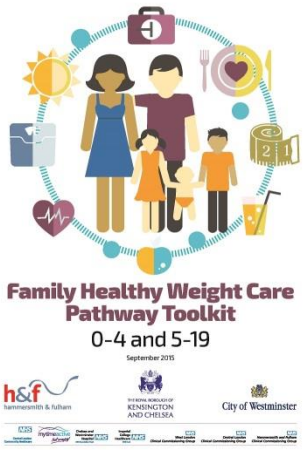
- Cooking in the curriculum **–** practical training sessions for school staff demonstrating how to deliver effective and safe cooking lessons.
- Active playtimes **–** practical training sessions for school staff, particularly teaching assistants and midday supervisors, to support them to encourage children to be active during play times.

Support has been well received by teachers and pupils and the school is on track to achieve the Healthy Schools gold award this year.

Figure 4: from L to R, Family Healthy Weight Care Pathway (0-4), Family Healthy Weight Care Pathway (5-19) and the Family Healthy Weight Care Pathway Toolkit







CHAPTER 6: WHOLE SYSTEM APPROACH - OVERVIEW

What is the 'whole system approach' and what are its objectives?

To ensure that the environment across the three boroughs is conducive to healthy lifestyles, we have been working with numerous partners within WCC to test and evaluate the effects of a whole system approach.

Our aim is to identify opportunities, first within the council and then across external networks, to work with partners to make positive changes to the wider environment within the borough that contribute to reducing childhood obesity.

We want to ensure that children and young people, their families and whole communities as well as visitors to the borough benefit from an orchestrated effort to collaborate, co-design and implement changes to the current obesogenic environment. This effort will involve work between our colleagues in other departments, for example sport and leisure, planning and housing, children and family services, as well as partners across the local geography and economy including the NHS, education, academia, catering and retail.

The key aims of this component are to work with every council department to consolidate and strengthen activities that contribute to the prevention of childhood obesity by:

- understanding work already underway across the council that contributes to preventing childhood obesity;
- identifying actions to be included in departmental business plans to deliver the corporate strategy;
- understanding the areas where the council currently has limited control or opportunity to influence; and
- identifying opportunity areas for further development

This approach is being developed in Westminster initially before being taken forward in the other two boroughs.

What evidence is there to suggest that this approach will help to reduce childhood obesity?

In 2014 McKinsey published a discussion paper that aimed to start a global discussion on the components of a successful societal response to overcome obesity. One of the main findings of the

paper concluded that no single solution creates sufficient impact to reverse obesity; only a comprehensive systemic programme of multiple interventions is likely to be effective.[5]

This approach has been at the heart of our programme design. The evidence of behavioural change interventions at an individual level (our significant investment into the preventative behaviour change services) necessitating interventions at a societal/living environment and policy environments (our whole council approach). [6]

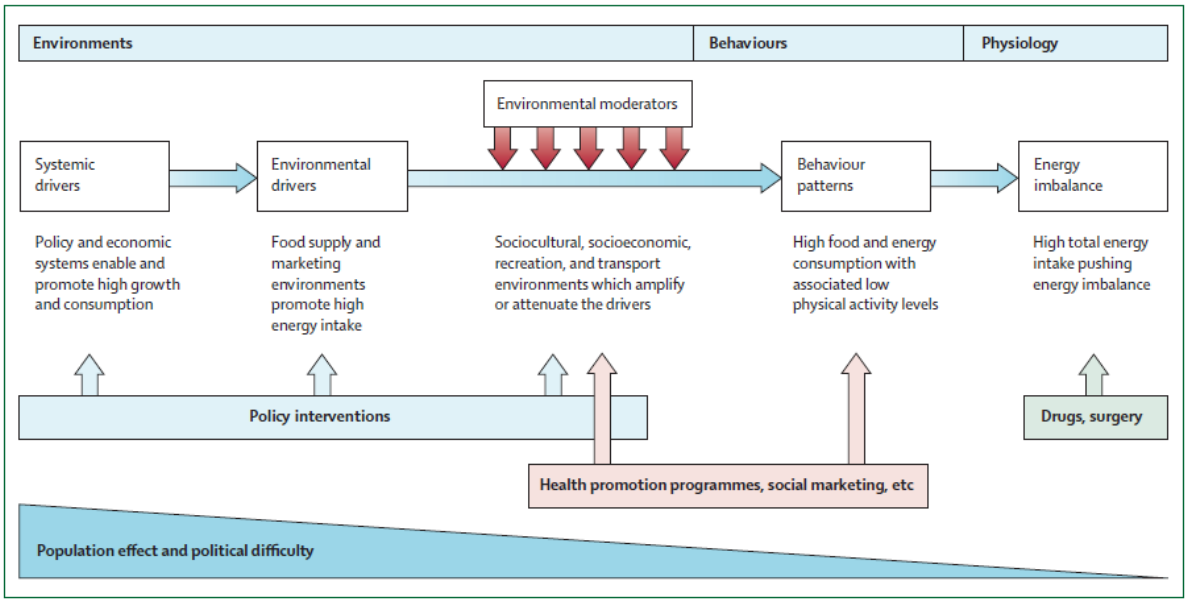


Figure 4: **A framework to categorise obesity determinants and solutions**
The more distal drivers are to the left and the environmental moderators that have an attenuating or accentuating effect are shown, along with some examples. The usual interventions for environmental change are policy based, whereas health promotion programmes can affect environments and behaviours. Drugs and surgery operate at the physiological level. The framework shows that the more upstream interventions that target the systemic drivers might have larger effects, but their political implementation is more difficult than health promotion programmes and medical services.

What process was taken to develop the whole council approach?

Initial scoping work identified the most relevant partner departments, followed by engagement with senior managers to discuss aims, recognise synergies, current work and identify future opportunities. Early cross-service workshops developed the first tranche of action plans signed off by members and officers. These cover:

- Food growing and education - pilot food growing projects in two schools and a housing estate in a regeneration area.
- Increasing physical activity - working with priority schools to engage with the school sports development team membership offer and services.

[5] Dobbs, R and Sawers, C et al (2014) *Overcoming obesity: An initial economic analysis,* discussion *paper, McKinsey Global Institute*

[6] Swinburn et al (2011), *The global obesity pandemic: shaped by global drivers and local environments, The Lancet*

- The Healthier Catering Commitment - working with food premises to improve the nutritional content and quality of their food.

The progress against each action plan is described in more detail over the following pages. Further developments with other departments are also highlighted.

CHAPTER 7: WHOLE SYSTEM APPROACH – FOOD GROWING

Aim and summary

Three different food growing schemes were identified for Westminster, all of which aimed to develop sustainable and well utilised garden resources to grow fresh produce and improve skills, knowledge and confidence in food growing, with a particular focus on children and families. The three schemes identified were 1) school food growing and education, 2) community food growing in Church Street and 3) a temporary pop-up community food growing resource at Lisson Street Community Gardens.

Evidence of need

The benefits of gardening and community food growing for both physical and mental health are well documented[7]. In schools, food growing has been shown to increase the take-up of school meals, support higher educational attainment, improve attitudes to healthy eating and develop employment skills[8]. In the community, further benefits include fostering a stronger sense of community developed through creating positive interaction between neighbours and safer environments.

The Social Return on Investment (SROI) of the Master Gardener programme, a report produced by the University of Gloucestershire, indicates that for every £1 invested in gardening initiatives, on average £10.70 is returned to society in the form of social, economic and environmental outcomes including health and wellbeing, community participation and training[9].

Process

A successful food growing programme is well established in RBKC, therefore the initial stages of this project focused on sharing best practice and developing a toolkit to support the development of the schemes. A steering group to oversee the process and ensure that relevant perspectives were addressed was also set up.

Scheme 1 – School food growing and education

King Solomon and Gateway academies were chosen as pilot sites for this project. Key members of staff were identified and plans tailored to each school according to need and opportunity. For example, a successful gardening club was already established at Gateway Academy so the focus was

[7] Shmutz et al., 2014 The benefits of gardening and food growing for health and wellbeing
[8] Orme et al., 2011 Food for Life Partnership Evaluation
[9] Schmutz, P, Ulrich, B, and Courtney, E (2014) *The Social Return on Investment (SROI) of the Master Gardener Programme.* technical report.

to maximise use of the existing garden resource. At King Solomon Academy there was very little existing provision but space to expand, therefore this was the initial focus.

Hammersmith Community Gardener's Association (HCGA) was commissioned to provide community gardener support at both school sites. This included 'teach the teacher' sessions, developing lesson plans, weekly gardening sessions for pupils and setting up gardening clubs for pupils and parents.

Scheme 2 – Community food growing in Church Street

In collaboration with the Church Street futures steering group (an established resident group), the Fisherton Estate was chosen as the community pilot site as it had nine existing plots and the space and demand to expand. 11 new plots were installed and residents were invited to apply for a plot, with priority for families. CityWest Homes agreed to install an additional water point close to the plots.

HCGA was commissioned to provide community gardener support and set up a series of regular gardening sessions for both plot holders and other residents of the estate.

Scheme 3 - Temporary food growing pilot at Lisson Street Community Gardens

It was decided not to pursue a project at this site as it was considered to be too dark for food growing and proposals exist to significantly alter the site within the next two years as part of the wider redevelopment of the area.

Benefits

The number of participants who benefited from the projects is estimated as 288 pupils at King Solomon Academy and 112 pupils (including 10 who regularly attend a gardening club) at Gateway Academy. There are 20 community plots in the Fisherton Estate with 70% allocated to families. Many plot holders involve their whole families in their maintenance. Attendance at the regular gardening sessions has fluctuated; however, as the project has gained momentum, there have been attendances of up to 22 at sessions.

Initial surveys have been carried out at all sites to understand participants' knowledge and attitudes towards healthy eating and food growing at the start of the project. These results will be compared against those of the follow-up survey, which is anticipated to be completed in May 2016, one year after the projects were established.

Ongoing qualitative evaluation has taken place and examples are provided below:

- Feedback from staff at King Solomon Academy suggests that they value the expertise HCGA provides and that they are committed to offering food growing to as many children in school as possible. To date they have focused resources on younger children, as they have more flexibility in their timetables and food growing fits well with foundation core outcomes. They are looking to extend this to older age groups next term.
- An observation from the community garden was made by one parent of two girls saying how wonderful it was that her daughters were digging in the soil and that they would never have got their hands dirty before.

Next steps

Community gardener support in the two schools will continue to be offered until July 2016. The current focus for HCGA is to support the schools to embed food growing into their school programme to ensure the project is sustainable in the long term.

HCGA will continue to offer support to the residents of the Fisherton Estate until May 2016, at which point the Church Street Neighbourhood Upkeep Project is due to launch. It is anticipated that gardening support at Fisherton Estate will be continued beyond this point.

Throughout 2016, eight further sites will be identified and prioritised for implementation before March 2017. These will comprise a combination of school and community sites and will include sites in the south of the borough. Particular care will be taken to choose sites based on their long-term viability to ensure projects are self-sustainable after March 2017.

Building on the success of these initial projects, it is anticipated that a borough-wide food growing programme can be developed across Westminster and be sustained beyond the life of the current funding. Options for how the programme can be taken forward in the future, including sponsorship or business partnership, are being considered.

Political support to progress any of these options is vital. There is a line in the Capital Programme over the coming years to support the WCC's Open Space Strategy, which is designed to improve the quality, management, accessibility and usage of parks and other open spaces in the city and provide new facilities where there are deficits in provision. Although this has to be secured on a year-by-year basis, there is potential to support the food growing programme to achieve one of the

strategy's emerging aims: to encourage food growing within communities to contribute to healthy lifestyles (and the sustainability agenda).

Case study – The Fisherton Estate community pilot

Despite initial engagement being slow due to delays that led to the project beginning during Ramadan, take-up of and interest in the Fisherton Estate plots has been good. The project began with a 'getting started' workshop in which participants were provided with seedlings and given advice on other plants to grow. One participant brought her daughters, who were very keen to get started and plant the bed, with her. Watching them, she commented how wonderful it was and that they would never have got their hands dirty before the project! Over the next few weeks, attendance rates at the workshops increased as the weather improved and plants started to grow.

During the school holidays the community gardener encouraged lots of interest and participation from a wider range of children from the estate by holding child-focused workshops that included a smoothie bike activity in which 20 children took part, enjoying the healthy smoothies they created!

Over the winter months when food growing activity was reduced, HCGA arranged a series of 'keeping in touch' days to retain momentum of the project and strengthen community cohesion. These were a great success and saw increasing attendance rates with visits to Columbia Road Market, Spitalfields City Farm and Kew Gardens.

Figure 5: (L to R) Plots at the Fisherton estate, proud plot holders, children with smoothies created using a smoothie bike

CHAPTER 8: WHOLE SYSTEM APPROACH - HEALTHIER CATERING COMMITMENT

Aim and summary

The Healthier Catering Commitment is based on the principle that small changes can make a big difference. It aims to supports food businesses to make straightforward changes to ingredients and preparation techniques in order to offer healthier food to customers. Once businesses have met certain criteria they are awarded different levels of the Healthier Catering Commitment award.

In Westminster, this project aimed to support 20 small and medium-sized food premises in 2015/2016 in the borough's most deprived areas to successfully achieve the award.

Evidence of need

The increasing consumption of fast food is thought to be one of a number of contributory factors leading to rising levels of obesity[10]. Fast food tends to be more energy dense and has a higher fat content than meals prepared at home[11]. Furthermore, outlets are often concentrated in areas of deprivation, where obesity levels are highest[12].

Process

This project was open to all independent point of sale food businesses in Westminster, with a particular focus on those in the most deprived wards including Harrow Road, Queens Park, Edgware Road and Churchill.

Prior to engaging businesses, five environmental health officers successfully completed Healthier Catering Commitment training, which covered the aims of the project, award criteria and how to support businesses to implement the changes needed. Later, three officers went on to complete the Chartered Institute of Environmental Health (CIEH) level 2 award in healthier food and special diets.

Following identification of eligible businesses, a letter was sent out to 163 businesses inviting them to consider their involvement in the project. The letter explained what the Healthier Catering Commitment was, including the key points of the project and the benefits of joining the scheme.

[10] GOS, 2007 Tackling Obesities: Future Choices Government Office of Science, Department for Innovation, Universities and Skills, London

[11] Prentice, A & Jebb S (2003) Fast foods, energy density and obesity: a possible mechanistic link. Obesity Review 4(4) 87-94

[12] Fraser et al (2010) The geography of fast food outlets: a review. International Journal of Environmental Research and Public Health. 7 (5) 2290-2308

Shortly after, visits were made to the 100 most eligible businesses with the intention of engaging the relevant person at the business to explain the project, Healthier Catering Commitment criteria and begin to undertake the audit. The amount of time taken to engage businesses varied, depending on whether the manager worked on site, the perceived relevance staff thought Healthier Catering Commitment had to the business and the business food hygiene rating.

As described by CIEH (PDF), for a business to achieve the Healthier Catering Commitment award, they have to conform to a minimum of eight criteria from a list of 22, which includes conditions in relation to the use of fats, oils, salt, availability of lower sugar drinks and snacks, fruit and vegetables. Joint visits between environmental health officers, dieticians and nutritionists supported businesses to implement the necessary changes.

Furthermore, a selection of food samples from businesses who had signed up to the scheme was submitted for nutritional analysis. The reasons for this were twofold: firstly to support engagement of the businesses with the scheme and secondly to evaluate the success of the Healthier Catering Commitment by comparing results from samples of food before and after the business had implemented the changes needed to achieve the award (the latter results are currently being awaited).

Benefits

Over the course of the project, 23 businesses in Westminster signed up to work towards achieving the Healthier Catering Commitment award.

To date, 19 businesses have successfully achieved Healthier Catering Commitment status and their efforts to serve healthier food were recognised at an awards ceremony at Westminster City Hall on 23rd February 2016.

The main catering changes made by businesses include:

- Use of grilling and baking methods rather than frying wherever possible.
- Use of low fat fillings for sandwiches.
- Use of semi-skimmed milk as a default for hot drinks.
- Removal of high sugar drinks from prominent displays.
- Offering smaller portion sizes.
- Actively promoting healthier choices to customers.

A survey with businesses is due to be conducted in April 2016 to gather views about the Healthier Catering Commitment and recommendations for future. A further follow-up survey will be completed to review how many of the changes implemented by businesses have been maintained.

Next steps

Support will continue to be offered to all businesses signed up to the scheme to date and a target of awarding a further 20 businesses in target areas with the Healthier Catering Commitment award in 2016/2017 has been set. We will however continue to work closely with colleagues in the city management department to explore opportunities to extend this initiative on a larger scale as well as to seek opportunities for better balance of retail on our streets.

The Healthier Catering Commitment award is valid for up to two years. Therefore monitoring reviews will be incorporated into future food hygiene inspections for those businesses who have been awarded to ensure they are maintaining their commitment, while minimising environmental health officer time to review this.

The introduction of a tiered scheme will be explored to encourage businesses to achieve the highest standard.

The Healthier Catering Commitment and successful businesses who have achieved the award will be further promoted to the public through the development of a page on WCC's website and social media presence.

Case study - Fishing for a healthier option

Little Venice Fish Bar is located on Harrow Road, W9, and is situated on the corner directly opposite Westminster Academy and beside the Harrow Road Health Clinic. The business is owned locally by Mr Nawid Aiobi who was very keen to be involved in the scheme from the start. Most of the customers are children and local residents with whom the business has a very good relationship and it was evident from visits that the business plays a very important part in the community.

Through working with environmental health officers and dieticians throughout the year, Little Venice Fish Bar has made subtle healthier alterations to the food they provide to improve the health and wellbeing of its customers. The business does not add salt to its chips and gives the option to its customers. The salt shaker used has fewer small holes which prevent too much salt being added to a portion of chips. Further changes include using rapeseed oil, which has a lower amount of saturated fat compared to other oils, for deep fat frying and where soft drinks are sold the business positions

healthier fruit drinks and water in a more prominent position to encourage its customers to choose the healthier option.

The Healthier Catering Commitment in RBKC and LBHF

The Healthier Catering Commitment is well established across the other two boroughs. In RBKC, 99 businesses have successfully achieved the award to date with many premises located in the most deprived wards in the north of the borough. RBKC's environmental health team has targeted specific businesses in Golborne in order to support the Go Golborne project.

In LBHF, nearly 30 businesses have successfully achieved the Healthier Catering Commitment award. Similarly, many of these premises are located in the most deprived wards in the north of the borough.

Environmental health departments across all three boroughs have been supported by nutritionists from MyTime Active as part of the work to improve settings within the commissioned services.

Figure 6: Businesses are presented with the Healthier Catering Commitment awards at a ceremony at Westminster City Hall on 23rd February 2016

CHAPTER 9: WHOLE SYSTEM APPROACH - INCREASING PHYSICAL ACTIVITY

Aim and summary

The aim of this project is to increase opportunities for children and young people to participate in high quality physical activity, with a particular focus on areas in the borough with higher levels of deprivation and obesity.

The public health department in collaboration with WCC's sports, leisure and wellbeing team has worked to bring together a range of activities in order to maximise physical activity opportunities for children.

Evidence of need

Regular physical activity is a key contributor to energy balance, helping to prevent excess weight and obesity[13]. The Department of Health recommends that children and young people (aged five to 18) should engage in moderate to vigorous intensity physical activity for at least 60 minutes every day. However, the proportion of those meeting these recommendations is low; amongst five to 15 year olds, only 24% of boys and 22% of girls in London achieve the guidelines[14].

Westminster is faced with high levels of inactivity that are even more prevalent in areas of high deprivation. There is also mounting evidence that participation in PE and school sport has plateaued, if not decreased, in some areas. In addition to quantity, the quality of physical activity offered, particularly in PE and school sport is also an important consideration[15].

The Physical Activity Joint Strategic Needs Assessment (JSNA), produced by the public health department, highlights that there is good evidence that school-based interventions are effective in increasing the duration of physical activity but not in increasing the levels of physical activity in leisure time. Multi-component school-based strategies are the most effective and should encompass physical education, classroom activities, after-school sport, active transport and a family/home component.

[13] Butland B, Jebb S, Kopleman P, McPerson K, Thomas S, Mardell J et al., (2007) Tackling obesities: future choices – project report, London

[14] British Heart Foundation (2015) Physical Activity Statistics 2015 file:///Q:/bhf_physical-activity-statistics-2015feb.pdf

[15] Ofsted (2012) Beyond 2012 – outstanding physical education for all

Process

Active Westminster is a partnership of organisations with an interest in physical activity in Westminster that works to improve opportunities that encourage those who live, work and study in Westminster to participate in sport and physical activity. The sports, leisure and wellbeing team (part of WCC's City Management and Communities department) is responsible for developing and promoting Active Westminster's sport and physical activity strategy through sports development and PE and school sport for all those that live, work and study in Westminster.

One area of cooperation has been the re-procurement of the new leisure service contract. The new service will come into effect in July 2016. As part of the revision and development of the service specification, the team has worked closely with colleagues in the public health department and WCC's procurement department to incorporate key areas identified in the action plan.

Another key area of work has been the development of the Active Westminster Strategy (2015-2020) in collaboration with a wide range of partners across the council and its external networks. The strategy highlights the links to childhood obesity and emphasis has been placed on creating better connections at a local level through the Active Communities programme, which aims to develop opportunities for formal/informal and everyday activity in less traditional and more accessible locations, and maximising public health opportunities.

Benefits

Increasing physical activity opportunities for children

Active schools **-** we will work closely with our schools and partners to ensure all schoolchildren in Westminster have access to at least one hour of physical activity a day.

Active communities - the new programme will include over 130 hours of free activities, which will take place in a variety of community venues including parks and open spaces, city estates, schools, colleges and community halls, every week. Delivery of the programme has been approved through the new leisure centre contract, which commences on 1st July 2016 for 10 years.

School sport competitions - a range of competitive opportunities have been made available to primary and secondary schools, including festivals and multi-skill fun days that promote engagement and participation in physical activity.

World beating events **-** the Westminster Mile is set to become the largest and most inclusive event of its type in the world, attracting 10,000 participants in 2016.

Quality of PE in school

Approved by all schools in Westminster, the Continuing Professional Development programme is currently training teachers to understand the importance of increasing levels of physical activity through efficient delivery plans and techniques. Work is underway to integrate key messages from the Making Every Contact Count concept and youth volunteering programme, Active Champions into training.

Forest Schools

The Forest School process focuses on child-led learning, allowing children to be independent, explore the environment and discover nature. A pilot scheme is being delivered at Paddington Recreation Ground in collaboration with St. Saviours, Edward Wilson and Essendine Primary Schools. The pilot is working with nine classes (250 children) from nursery to year four.

Physical activity strategy

The Active Westminster Physical Activity Strategy 2015-2020 is currently in development and will include priority work that links to TCOT.

Next steps

One of the key areas of focus will be on strengthening links with the Healthy Schools Partnership programme and prioritising those schools with the highest prevalence of overweight and obesity to develop individual physical action plans as part of achieving the Healthy Schools bronze award.

Work will also focus on engaging partners within the council and its external networks to scope the possibility of developing a 'Westminster Standard' for participation in PE and school sport to ensure all children and young people have the opportunity to be active for at least five hours per week.

Further development of the Active Westminster passport scheme to engage more children from target areas will also be considered. The scheme offers free and discounted access to leisure services to young people resident in Westminster.

Case study

Case study to be provided.

CHAPTER 10: WHOLE SYSTEM APPROACH – ENGAGEMENT WITH SERVICES

In addition to the three initial action plans agreed with council departments, a number of other activities have been imitated and some delivered to maximise the levers offered by the council. These more informal pieces of work, which are at different stages, have been summarised below.

Social supermarket application for funding to the Greater London Authority (GLA)

The social supermarket model works by securing high quality residual food from retail and manufacture supply chains that would otherwise be sent as waste to landfill and sells this food to social supermarket members at a reduced price. Membership is carefully targeted at residents on the lowest incomes. Members are also supported by a range of on-site support services, including money advice, employability and vocational skills training and courses on healthy eating and cooking on a budget.

In July 2015, the GLA invited applications from London boroughs to bid for capital funding to support the development of a social supermarket. A joint bid was developed with WCC's economic regeneration department, together with a number of partners in the voluntary sector, with potential premises identified on Harrow Road. Although unsuccessful on this occasion, other opportunities to implement this model in Westminster are being explored.

Planning and regeneration

The public health department is working with colleagues to maximise opportunities to promote health within large scale regeneration projects, including Church Street and Harrow Road.

The Church Street renewal programme has commenced and incorporates a work stream around the public realm. A key element of this work stream is the development of a 'green spine' running north to south across the neighbourhood, connecting green spaces such as children's play areas and community gardening projects. The intention is to encourage active travel around the neighbourhood and active play/leisure for residents and visitors of all ages.

The Harrow Road management plan is at an earlier stage in its development. Drivers for change include the high level of obesity among young children but also poor environmental air quality, traffic and congestion, poor public realm and a reduced retail offer, all of which deter active travel and leisure in the area. Renewal of Harrow Road therefore affords a set of opportunities including improvements to the canal frontage and to footpaths and cycle ways to encourage active travel and

leisure and an improved surrounding area to create an appealing and genuine local retail offer, potentially including the above mentioned social supermarket model.

Housing and social landlords

A series of discussions are underway with Westminster housing provider CityWest Homes to explore how they might engage with their residents to improve health and wellbeing. The emphasis of the engagement is on prevention, supporting residents to engage with their own health and wellbeing and to choose healthier lifestyles, including increasing physical activity levels and eating well.

Similarly registered social landlords are recognised as having a vital connection with residents who might not engage with other services. A number of providers are engaged with the Community Champions programme and we are keen to build on existing partnership work to explore other opportunities for engagement with their residents, many of whom are vulnerable.

Strategy development

The public health department is also working with colleagues across the council to maximise public health opportunities as part of the development of new strategies, including walking, cycling, open spaces and biodiversity strategies and the air quality action plan.

Procurement

Initial discussions have taken place with WCC's procurement department to incorporate quality standards and assurance for vending machines and other food provision within council contracts.

Beat the Street

The Beat the Street project aims to inspire people to walk and cycle more by engaging the whole community in a physical activity game over a period of six weeks. Participants compete for points by walking or cycling around the local area and scanning smart cards onto sensors known as 'Beat Boxes' to record their journeys. We have worked closely with Central London CCG to develop a proposal for this programme in Westminster.

CHAPTER 11: COMMUNITY HEALTHY LIFESTYLE PILOT – GO GOLBORNE: OVERVIEW AND LAUNCH

What is Go Golborne and what are its objectives?

Go Golborne is a healthy lifestyle initiative that launched across the Golborne area of RBKC in May 2015. It aims to support a 'whole system' approach to promote healthy lifestyles by supporting a network of local agencies and groups to increase opportunities for children and families to make healthy choices.

The objective of Go Golborne is for children and families in Golborne to increase their awareness, knowledge and skills of how to live healthy lifestyles leading to increased levels of physical activity and healthy eating. It aims to do this by maximising the use of assets in the area, making changes to the local environment and providing consistent healthy lifestyle messages. Local stakeholders will be supported and trained to implement healthy lifestyle activities in Golborne. Additionally, the initiative aims to contribute to the evidence base on community-led approaches to tackling childhood obesity.

What evidence is there to suggest that this approach will help to reduce childhood obesity?

Go Golborne is a unique model developed as a result of a review of international evidence on 'what works' to effectively prevent childhood obesity at a local level. Evidence suggests that effective strategies need to include action on multiple levels across a wide range of domains. Given the complex number of factors that influence a child's ability to eat well and keep active it can be difficult to understand and adequately address them at scale. Emerging evidence from research suggests there is much to be gained from developing 'whole system' approaches in smaller geographical areas so that actions can be shaped to meet the unique needs of local communities.

We also consulted local children, families and community organisations through workshops and creative consultation activities at local festivals and events to identify what is needed locally and inform our plans. The model is being piloted in Golborne with a view to extending its reach to other areas of the borough once we've gained sufficient insight into its impact and effectiveness.
Evidence suggests that preventative interventions targeting children and young people pay off – the upfront costs of most preventative interventions will usually be small in comparison with the future health benefits and long term cost savings across the economy from reductions in type 2 diabetes, cardiovascular disease and some cancers[16].

[16] National Institute for Health and Care Excellence (2006) Obesity: *Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (NICE)

What process was taken to develop Go Golborne?

The area of Golborne was chosen as a test bed for this initiative as it is one of the most deprived areas of RBKC and levels of childhood obesity are high relative to more affluent areas of the borough. Furthermore, there was potential to reach a large number of children (around 2,000) and a range of local amenities that provide opportunities to explore how the local environment can help support healthy lifestyles.

A scoping exercise took place to map out the organisations and key stakeholders operating across Golborne that support children and families and play a role in shaping the local environment. Meetings and workshops took place to build a multi-agency network of relevant colleagues. A Go Golborne 'supporter pack' was developed to set out the scope of the project and the benefits of getting involved.

A small steering group was established to oversee the development and implementation of the project. It includes senior level representatives from key council departments (such as leisure services and community engagement), a local councillor and leads from the local school nursing team, nutrition service and voluntary sector. This group acts as a 'sounding board' to critically appraise project plans and progress against key aims and objectives.

Following considerable consultation with partners, it was agreed to develop a range of activities that include a comprehensive social marketing campaign, a small grants scheme for local organisations to deliver activities, continual growth of the community network to inform the development of the campaign and collaborative work with other council departments to influence the environment.

It was agreed that the programme should feature a different 'headline' mini-campaign every six months, which are as follows:

- Five a day - to increase consumption of fruit and vegetables.
- Sugar swaps - to reduce consumption of sugary drinks and snacks.
- Snack check – to encourage healthy snacking habits.
- Active travel – to encourage walking and cycling.
- Screen time – to reduce the amount of time children spend on screens.
- Active play – to encourage physical activity.

How will Go Golborne be evaluated?

The University of Kent's Centre for Health Service Studies is conducting an independent evaluation of Go Golborne to assess the extent to which the project achieves its aims and objectives. It includes both quantitative and qualitative methods – including an annual child and parent survey administered via schools and interviews with key stakeholders involved in the project. The university will also look at information gathered via an extended version of the NCMP to investigate if and how this work correlates to any significant increase in the number of local children who are a healthy weight.

Figure 7: Logo created for Go Golborne

CHAPTER 12: COMMUNITY HEALTHY LIFESTYLE PILOT – GO GOLBORNE: 5 A DAY YOUR WAY

Aim and summary

The objective of 5 A DAY Your Way, the first of Go Golborne's six mini-campaigns, was to promote fruit and vegetable consumption among children in Golborne. The campaign aimed to do this by increasing the access, availability and affordability of fruit and vegetables and improving children and parents' attitudes, awareness and skills towards eating healthily.

The campaign incorporated a range of different activities, including:

- The creation of new materials to communicate key five a day messages such as a song written by a local musician with the help of local children, a family healthy eating magazine, a wallchart encouraging children to take part in a challenge to eat five portions of fruit and vegetables every day for 20 days, the design of cartoon superhero characters to inspire children to complete the challenge and collateral including shopping bags, posters, flyers and fridge magnets with positive healthy eating messages.
- A series of family events delivered in collaboration with community partners to reinforce messaging including:
    - A family fun day.
    - Pop-up fruit and vegetable snack stalls in school playgrounds.
    - Healthy cooking workshops.
    - Themed rhyme time sessions in the local library.
    - 'Create and play' workshops at a local play centre.
    - An 'eat the rainbow' photo competition in conjunction with RBKC's markets department that culminates in a pop-up healthy eating event for children at Portobello Market Square on Saturday 26th March.
- Hosting themed assemblies at five schools in Golborne.
- Work with partners across the council to explore other opportunities to increase access to fruit and vegetables – such as identifying local food outlets to join the Healthy Catering Commitment scheme and supporting local market traders to accept Healthy Start vouchers for fruit and vegetables.

Process

A systematic social marketing process was used to develop the campaign. Initially, desk research was conducted to identify key learning from other similar initiatives and relevant local reports. Two

multi-agency workshops with local organisations were delivered to shape the mini-campaign. The Food Access Model[17] was used as a framework for discussion, which encouraged the group to consider factors including access, affordability and awareness. Children and families were also consulted through local events.

Evidence of need

Eating five portions of fruit and vegetables a day plays a key role in maintaining healthy weight. However, very few children (or adults) manage to achieve it: among 11-18 year olds only 10% of boys and 7% of girls meet the recommendation. Children in lower income groups eat up to 50% less fruit and vegetables than those with a higher income[18]. This was also considered to be a high priority by partner organisations during consultation.

Benefits

To date around 1,500 children have taken part in the 20 day challenge, approximately 200 people attended the family fun day and 2,500 magazines were distributed in the community. Social marketing activities have been further developed to enhance messaging. Channels include dedicated content on the Go Golborne website, social media engagement and print advertising.

The impact of the 5 A DAY Your Way campaign will be explored by the University of Kent as part of the wider evaluation of Go Golborne. As part of this, levels of fruit and vegetable consumption among local children will be analysed. Positive feedback about the campaign has been received with some examples of quotes below:

- *"My daughter has been trying really hard with her wallchart – she loves the superpower characters!"* (parent)
- *"Thanks, it was a lovely event. My son enjoyed the art and crafts and make your own fruit and veg activity. I loved the face painting. I will make more soups at home."* (parent)
- *"Jibril made a special wrap, it was a really good experience. Especially the bike blender soup, that was something new. Thank you."* (parent)
- *"(the fun day) was the first time my son tried to eat vegetables."* (parent)

[17] Dowler EA, Dobson BM, (1996) Nutrition and poverty in Europe: an overview
[18] Public Health England (2011), National Diet and Nutrition Survey

Next steps

Planning for the next mini-campaign with partners will commence in March 2016. The theme will focus on reducing 'screen time' and increasing levels of physical activity. Five a day messages will continue to be promoted and reinforced throughout.

Case study: 5 A DAY Your Way Family Fun Day

A family fun day was held at a Golborne-based community centre, the Venture Centre, in November 2015 and was attended by over 200 families. Many local organisations and volunteers helped run the event that featured a host of fun activities that encouraged children to experiment with fruit and vegetables – from making soup with smoothie bikes to blind tasting games. Fruit and vegetable physical activity games took place in the outside play area and local musician Alexander D Great performed the song commissioned by the project, which includes healthy eating messages, with local children. Free health checks, recipe cards and information on the local services that support healthy lifestyles for families were available to parents.

Figure 8: Logo created for the 5 A DAY Your Way mini-campaign for Go Golborne

Figure 9: Local songwriter, Alexander D Great, and local children perform his healthy eating song, 5 A DAY Your Way, written specially for Go Golborne at the 5 A DAY Family Fun Day

CHAPTER 13: THE CHILDHOOD OBESITY JOINT STRATEGIC NEEDS ASSESSMENT

Aim and summary

The Childhood Obesity JSNA was published in February 2016. It explores the causes and consequences of childhood obesity and provides a local picture of the prevalence in our local communities, identifying those groups who are most at risk. The JSNA also aims to capture a range of existing programmes of work that support the development of healthier environments and identify further opportunities that can further focus our joint efforts to tackle this issue.

Evidence of need

The JSNA was developed in order to provide a baseline against which progress of the TCOT programme will be measured. In addition to quantitative data regarding the prevalence of childhood obesity, existing programmes of work both within the council and through its external partners were to be identified in order to capture the wide range of work currently being delivered.

Process

Following an initial application to the JSNA steering group and subsequent approval, a comprehensive literature review was undertaken, as well as extensive data analysis and service mapping. Drafts were circulated to a range of internal and external partners. The JSNA was taken to the governing bodies and/or transformation redesign groups of the three local CCGs, as well as a range of voluntary sector forums including the BME forum and Kensington and Chelsea Children and Youth Forum for feedback.

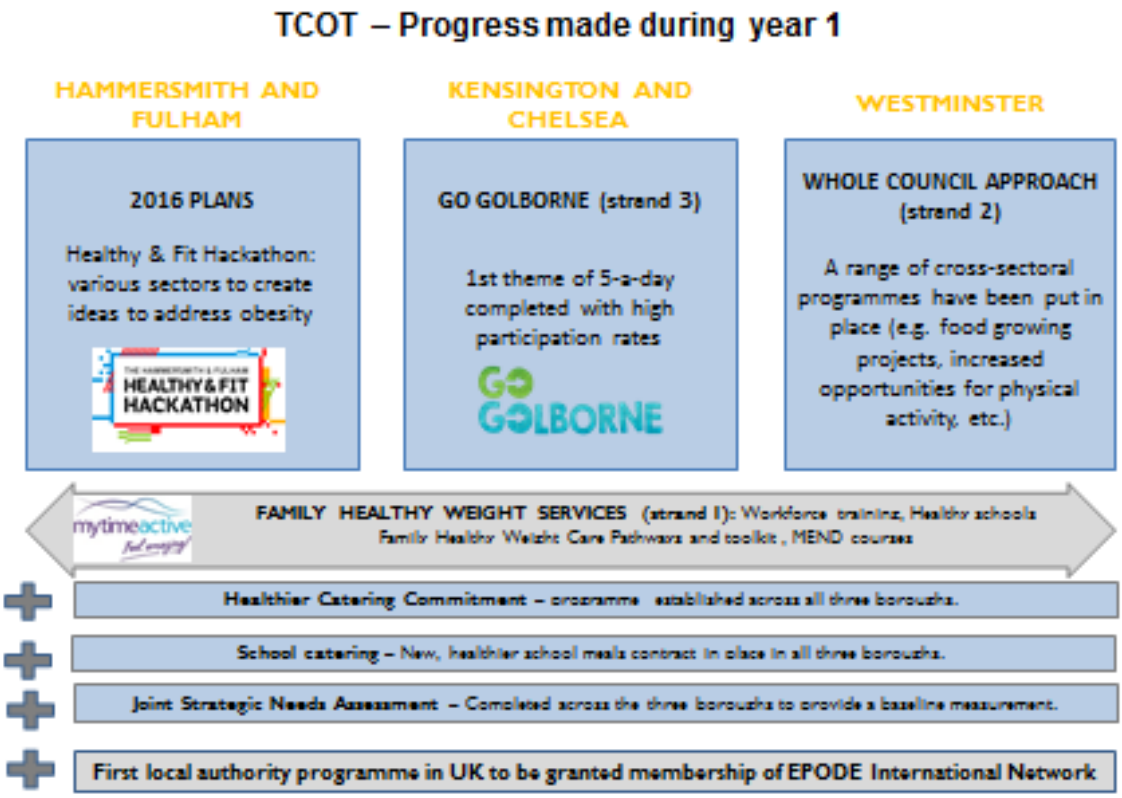
Three stakeholder workshops were held with partners to identify any further gaps in the JSNA and to develop recommendations. The JSNA was taken back to the JSNA steering group, before being signed off by the Health and Wellbeing Boards in each borough.

Next steps

Key recommendations from the JSNA highlighted that every department and organisation has a role to play in creating and supporting increasing healthier environments and all engagement opportunities with partners should be used to achieve shared understanding of the need to address this issue collectively.

Additionally, the importance of developing clear and consistent messages that are readily understood by all audiences and delivered though the optimal communication channels for each audience was

emphasised, in addition to a particular focus on early years. Finally, the need to act on and increase the evidence base and contribute to and keep abreast of national and regional developments was also raised.



CHAPTER 14: NEXT STEPS FOR TCOT

Westminster – whole council approach

Three broad specific areas of work likely to be pursued in Westminster during the next year will be:

- Improving accessibility to water – to counter the effects of widespread consumption of sugary drinks, we will explore the possibilities of introducing water fountains to residential areas to provide free, healthy refreshment to residents.
- Increasing accessibility to low-cost, nutritious food – we will explore the idea of creating a 'social supermarket' in Westminster. Social supermarkets provide members with cheap, nutritious food by redistributing surplus food.
- Promoting health supporting build environment – utilising the opportunity of large developments such as Harrow Road and Church Street to improve play and recreation environments as well as street layouts to encourage physical activity and active travel.

Existing areas of work including food growing project and the Healthier Catering Commitment will also be expanded upon during the next year. Additionally the Creating Healthy Places – a whole system approach to food and active living framework will be used to identify further areas of work across the council addressing opportunities to create healthy eating and moving supporting environments within neighbourhoods, high streets, new developments , connecting routes and institutions environments, using the Creating Healthy Places Toolkit for Local Authorities.

Hammersmith and Fulham

Details of the next steps to be taken in Hammersmith and Fulham are being worked out following the outcomes of the H&F Healthy and Fit Hackathon which took place in May 2016. The ideas, energy and enthusiasm was captured on the day in mini films, and by a graphic illustrator. To include artwork

- Better at it – an inter-school challenge to help young people improve their skills at physical activities.
- Fitness Phood – an app that calculates the amount of physical activity you'd need to do to burn off the food you're about to eat. (the people's choice)
- My Lifestyle – an app to help you get more fit.
- Fun Free Fitness – a programme of free activities and sessions that take place around existing facilities such as parks.
- Cook Local – an app that helps people cook healthy food.
- Shake It, Make It – an app that gives people ideas for healthy lunches.
- Breast Friends – a social movement and initiative to support women to breastfeed in public.
- Real Beauty – a marketing campaign to improve people's attitudes to body image.

Kensington and Chelsea – Go Golborne

The Go Golborne initiative will launch two further mini-campaigns, following 5 A DAY Your Way during the next year. The first mini-campaign, Unplug and Play, will be launched in June 2016 and will encourage children and families to reduce the amount of time spent using screens such as phones, laptops and televisions and increase the amount of time spend participating in physical activity. The main focus of the following campaign is to be decided but will focus on changing food habits.

We would also like to expand our work with local retailers and shoppers to understand the barriers to buying and selling fresh produce and prioritising this when it comes to e.g. shop offers.

CHAPTER 15: LESSONS LEARNED FROM TCOT YEAR ONE

- Political support at a local level is crucial.
- Taking time to engage communities is well spent.
- Developing partnership and exploring synergies with own and partner's services pays off in creating a whole system.
- Using positive language and looking for suitable changes in asset based approach is key to engagement.
- There is never enough communication..
- The NHS engages willingly but more capacity is needed to promote the programme and the Family Healthy Weight Care pathways in particular
- Space is a real limitation, especially for schools.
- Synchronisation of activities could be improved to boost uptake of e.g. NCMP timing and recruitment to MEND programmes.
- Where connections/synergies have been made, effect is beginning to show.
- Creativity, flexibility and engaging children and families as early in the planning process as we can is essential in order to gain their interest and to align activities with local unmet needs.
- Where and when presented to experts, the programme has been highly commended for its comprehensive, systematic and evaluative approach.
- Robust evaluation must continue and where possible external partners should be engaged to enhance the process and increase credibility.
- Setting up an expert advisory body may be beneficial.

CHAPTER 16: EVALUATION

TCOT takes a complex, novel and somewhat experimental approach to a difficult problem and as such warrants rigorous evaluation.

To this end, the public health department has developed a number of partnerships with leading academic institutions and individuals. These include the University of Kent, public health physician,

Harry Rutter, Professor of Nutrition and Childhood Obesity at Leeds Becket University, Pinki Sahota, and the Department of Primary Care and Public Health at Imperial College, London. Additionally, the department has partnered with social enterprises such as MyTimeActive and other institutions including Public Health England to deliver a high quality evaluation of the programme.

MyTime Active

An important part of evaluation is collection of the right kind of data. In collaboration with MyTime Active we are collecting data on skills, attitude and confidence following workforce training with their trainers. This includes data on their knowledge of childhood obesity and their strategies to broach the topic with parents and children and motivate them towards a healthy lifestyle and signpost them to relevant services. We collect extended NCMP data to include all school years and repeat measurements for four years to monitor change, as well as collecting data on healthy eating, physical activity and behaviour change. We will be able to look at the uptake of the MEND courses and whether particular parents and children need extra help to change, if there are gaps in service and if so, what ways there are to remedy them. We are also looking at ways health professionals can help. The evaluation of MEND in Schools will be carried out at the end of each school year measuring increases in water consumption and active play and reductions in the consumption of unhealthy food.

Whole system approach

We are evaluating the impact and costs of collaborative initiatives between council departments that support healthy lifestyles to identify future opportunities to create maximum impact on health. The approach is currently being piloted in Westminster with a view to rolling out across Kensington and Chelsea and Hammersmith and Fulham in future.

The public health department is working with colleagues in the business intelligence and adult social care departments in an effort to unify the way strategies are evaluated for impact on council targets as well as public health outcome framework indicators.

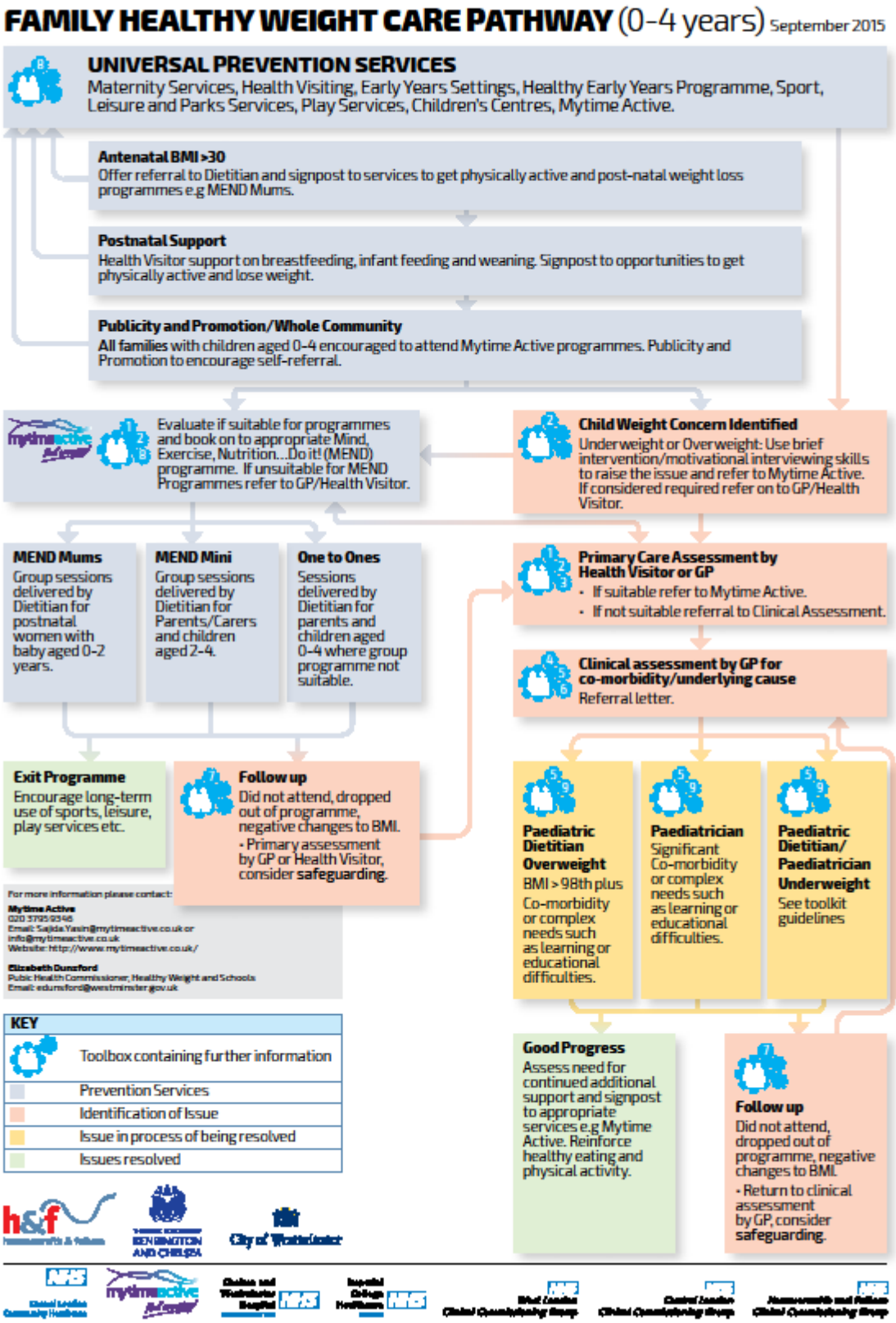
Go Golborne

The University of Kent's Centre for Health Service Studies is conducting an independent evaluation of Go Golborne to assess the extent to which the project achieves its aims and objectives. The public health department and the University of Kent have developed a 'theory of change' framework to guide the evaluation.

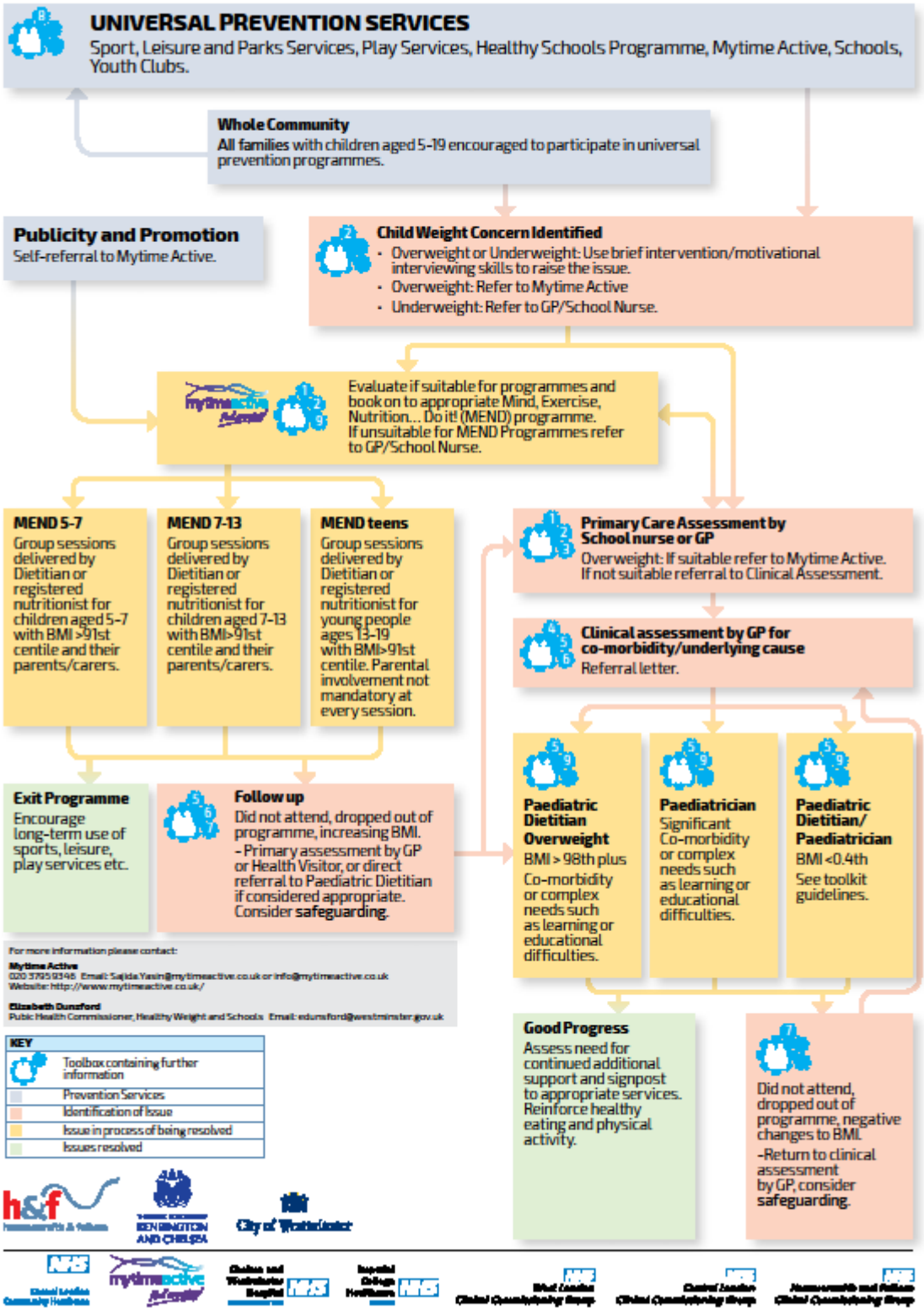
Baseline data on diet, physical activity and screen time is currently being collected and follow-up questionnaires will be repeated annually. NCMP data will help correlate information and tell us whether changes in lifestyle happen in the children outside of the healthy weight range.

Qualitative data will also be collected with stakeholders to give rich context to the findings and identify the main drivers of any change. Process and cost data will also be collected in order to develop a toolkit to help other communities run similar programmes to implement sustained change.

APPENDIX 1: THE FAMILY HEALTHY WEIGHT CARE PATHWAYS AND TOOLKIT (click to open PDFs)



FAMILY HEALTHY WEIGHT CARE PATHWAY (5-19 years) September 2015



Family Healthy Weight Care Pathway Toolkit

0-4 and 5-19

September 2015

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

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City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Health and Wellbeing Hubs
Report of:	Liz Bruce, Executive Director of Adult Social Care
Wards Involved:	All
Policy Context:	The Health and Wellbeing Hubs programme explores the potential for using our estate to greater effect, developing multi-disciplinary, person-centred service hubs which increase access to prevention and early intervention services, particularly among those at risk of developing multiple needs.
Financial Summary:	Not Applicable
Report Author and Contact Details:	Meenara Islam mislam@westminster.gov.uk Rebecca Fuhr rfuhr@westminster.gov.uk

1. Executive Summary

1.1 The Health and Wellbeing Hubs programme was initiated to explore and test how best to improve the lives and outcomes of disadvantaged groups and individuals through changing the way we work within the Council and with our partners. The focus is on improving the use of our estates and our collective resources to increase access to preventative services for those at risk of experiencing complex and multiple needs.

1.2 This paper builds on the previous Health and Wellbeing Board paper on this topic considered on 26 May 2016. It outlines latest developments in the programme including the results of a large scale multi-agency workshop on older people's services provision, and work to measure and demonstrate the impact of service innovations at the Newman Street temporary accommodation site.

2. The Health and Wellbeing Board is asked to note the progress the Council and partners have made in this programme thus far and its further proposals and next steps. The Board is also asked to consider how:

- This programme of work can move forward with greater scale and pace in light of the STP and H&WBS; and
- Partners can contribute to the future development of this programme of work.

3. Background

3.1 The approach of Health and Wellbeing Hubs is based on public service reform principles around co-location and joint working between multiple sectors and professions to build services around individuals. The mission of the programme is to intervene early with high risk cohorts to prevent them from requiring complex and often costly public services, such as admissions to Accident and Emergency departments, emergency service call outs or long term social care. We will do this through changing the way we work to deliver existing services, rather than by developing new ones.

3.2 There are three work streams within the Health and Wellbeing Hubs programme:

- Testing out new approaches to improving health and wellbeing outcomes and reducing dependency on public services among single homeless adults in temporary accommodation;
- Refreshing the existing older people's hubs to improve access for those who need the services most and to reduce social isolation; and
- Developing upon the nascent plans within the Church Street Renewal Programme for a health and wellbeing community hub on the site of 4 Lilestone Street / Penn House.

4. Optimising Older People's Hubs

4.1 This work stream focuses on looking at the full range of services available to older people in the south of Westminster, reducing duplication, increasing integration with partners and making the best use of the existing, successful Older People's hubs.

4.2 Following extensive discussion and analysis of the existing service offer, a large scale multi-stakeholder workshop was held in May. The workshop was well

attended, with representation from Council senior management (including Adult Social Care, Public Health and others), the Clinical Commissioning Group, housing providers and other local partners. The aims of the session were to:

- Share knowledge of the successes achieved so far.
- Encourage greater joint service delivery across organisations; and
- Plan for the new 'landscape' – developing proposals to improve the 'reach' of our preventative offer, increase efficiency and use collective resources most effectively.

4.3 The challenges and opportunities were looked at in both short and long term, resulting in a rich discussion about the potential impact of the Central London CCG Whole Systems project (which will trial an enhanced offering in the form of extra staffing in three of the GP Villages, including South Westminster) and rationalisation of both council and NHS estates. Attendees also explored how we can work together to provide the services people need locally.

4.4 In respect of short to medium term actions, the opportunity to work alongside council libraries services was identified. Libraries offer a familiar and non-stigmatising venue for service provision, at the heart of the local community (most Westminster residents live within one mile of their nearest library). They are also known to be well used by the older population. Some health and wellbeing services are already provided through libraries, but there is a broader opportunity to optimise this and further enhance their role in our preventative agenda.

4.5 Longer term, the focus will need to be on how council services align with new models of provision by the CCG. There was discussion of how the open access, on-going services provided through the Council's Older People's Hubs would complement the more time-bound interventions arising from Social Prescribers. A Social Prescriber will take responsibility for the well-being of patients, linking them in with the voluntary and community services that best fit the patient's requirements and levels of motivation. It has been proposed that some analysis is undertaken to establish how the two will slot together in practice. Referral routes from GPs and via non-clinical Care Navigators (who assist each Village to identify complex, high-risk patients and manages multi-disciplinary team discussions), were also explored. There is a need to ensure that robust, fit for purpose, mechanisms are in place, to manage potential demand as service delivery models evolve.

5. Newman Street

5.1 Newman Street is a block of temporary accommodation which at any one time houses around 70 homeless individuals with particularly significant and complex

needs. Under the Hubs programme, a partnered service of floating support workers and pathways officers was introduced to increase resident engagement with relevant services, focusing on basic preventative interventions.

5.2 An evaluation completed in April 2016 showed a high engagement rate with support services from residents since they were introduced. A reduction in safeguarding alerts and a consistent number of pathways placements demonstrate this positive change. Residents in Newman Street are better linked to health services and the multi-agency approach provides more holistic support for the very vulnerable and complex cases. Following the changes and improvements that are being made reports on the performance of the Newman Street project have been outlined in previous reports to the Board on 21 January[1] and 26 May 2016[2]. However, there is more work still to do - incident numbers remain high and the uptake in employment support and the overall move from benefits to paid employment are still among our ambitions for residents.

5.3 To ensure that services are timely and effective officers have produced a number of key performance indicators (KPIs). The KPIs are based on learning and best practice from the hostel and supported housing sector, and are designed to show the outcomes and benefits of a support and intervention system based around residents in a hub environment.

5.5 The KPIs therefore focus on the main ways in which this would be achieved: engagement (GP, support and employment), outcomes (shorter stay and increase positive 'move-on' options) and environment within the block (reduction in incident and call outs).

	KPIs
1	**Positive Move On** 75% of residents move on positively into more independent accommodation and suitable accommodation
2	**Reduced stays** 50% of new residents move-on within 6 months
3	**Engagement in health and support services** • 100% registered with a GP • 100% engagement with other relevant support services (substance misuse and mental health)
4	**Reduction in Serious Incidents** • 100% accurate classification of all incidents • 0% Repeat Serious Incidents • Risk management plan produced and circulated within 24 hours of all serious incidents • Reduction in unplanned ambulance call outs (currently c.3%)

[1] Health and Wellbeing Hubs, 21 January 2016, Westminster Health and Wellbeing Board

[2] Health and Wellbeing Hubs, 26 May 2016, Westminster Health and Wellbeing Board

5	**Engagement in workshops that promote employment, training and education** 20% residents deemed fit to work engaging in workshops that promote employment, training and education.

5.6 Monitoring of these KPIs will support us to assess and evidence the cost and benefit of the changes made at Newman Street, feeding into our understanding of the advantages of taking a 'hubs' approach to improving local services. Support and statutory functions within Newman Street will be directed to achieving these outcomes and performance will be reported and monitored at the monthly partnership meetings held at Newman Street. These meetings take place between the representatives for the Newman Street project, a homeless specialist officer, floating support workers and team leaders. Other people may attend on an ad hoc basis. With the collection of this data benchmarking across schemes with similar cohorts will be possible. A performance report will be bought to the Health and Wellbeing Board in early 2017.

6. Church Street Health and Wellbeing Community Hub

6.1 As noted previously, the physical building that the Church Street Community Health and Wellbeing Hub will be delivered from will not be built until 2021. Current activity is therefore focused on developing the vision for what the Hub will deliver and making sure that this meets the needs of the community and the strategic objectives of the council, the NHS and wider local partnership.

6.2 Working with the Health and Wellbeing Working Group, (chaired by Ruth Runciman - local resident and former Chair of the Central & Northwest London NHS Foundation Trust) the Church Street Project Team has been developing a 'Theory of Change' and Outcomes Framework for the regeneration activity in Church Street. Building on the Futures Plan[3], this strategic document will guide us towards realising our long term ambition for Church Street to become 'London's Most Liveable Neighbourhood'. The Hub will be a key project in the delivery of this ambition.

6.3 Primarily, 'London's Most Liveable Neighbourhood' is a place where people thrive, so promoting health and wellbeing through the regeneration activity is the 'golden thread' running through this work. Our approach draws heavily from the Housing and Health JSNA and the joint Health and Wellbeing Strategy refresh currently being developed and positions 'Quality of Life' as the primary outcome we are working towards. Enablers of this are 'Developing Excellent Services and Facilities', 'Building Economic Independence' and 'Improving the Physical

[3] https://www.westminster.gov.uk/futures-plan-for-housing

Environment'. The 'bedrock' upon which everything rests is a strong, resilient community.

6.4 We aim to set out what Church Street would look and feel like once the ambition has been realised, then work backwards from that to identify how that change will happen, including who needs to be involved, what activities we need to undertake and how we will measure success. This will be translated into a set of long term goals and medium term priorities that will inform the work plans for the various working group reporting to the Future Steering Group.

6.5 The Church Street Futures Steering Group grew out of development of the Plan and is supported by 10 working groups including groups looking at Health and Wellbeing, Infrastructure and Public Realm and Employment and Skills, as well as the development of the Hub and wider work of the Church Street Project Team. Progress will be measured via a dashboard of indicators and measures currently being developed with the Business Intelligence Team and various others who will input into this.

6.6 A draft of the document will be presented to the Future Steering Group in July and it is anticipated that this will be finalised in August. Development of the detailed work plans for the various working groups will follow.

7. Legal Implications

None at this time

8. Finance Implications

None at this time

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Primary Care Modelling
Report of:	Councillor Rachael Robathan, Chairman, Westminster Health and Wellbeing Board
Wards Involved:	All
Policy Context:	Population modelling for primary care
Financial Summary:	Not applicable
Report Author and Contact Details:	Damian Highwood dhighwood@westminster.gov.uk Meenara Islam mislam@westminster.gov.uk

1. Executive Summary

1.1 This report sets out the progress made by Westminster City Council (WCC), Central London Clinical Commissioning Group (CLCCG) and West London Clinical Commissioning Group (WLCCG) with the Primary Care Modelling project.

2. Key Matters for the Board

2.1 It is requested that the Westminster Health & Wellbeing Board:

- Reviews progress to date and notes the close collaboration between partners in developing the model; and
- Agrees the next steps proposed.

3. Background

3.1 The Health & Wellbeing Board agreed to undertake three phases of work:

- **Phase 1**: Establish a borough-wide base set of projections on future disease burden which can be used by all partners as a single agreed set of figures. This will take into account the different populations supported by both the NHS and the council to maximise the use of the data for both sectors.

- **Phase 2**: Overlay the impacts of regeneration, housing and infrastructure plans and proposed local authority and health policy on the estimates modelled and build a tool that enables the manipulation of these impacts according to a number of variables. This will include the mapping of primary care services.

- **Phase 3**: A joint programme to analyse how the needs of the Westminster population will impact on the demand for primary care health services. In the first instance, the aim is for this to inform the analysis that will be used by the local authority, NHS England, CLCCG and WLCCG to plan for future primary care provision before being rolled out to be used to inform the shape of other service provisions.

4. Progress to date

4.1 The first phase of work is nearing completion. We have produced a local model that segments the population projected at local level by age and sex into 15 health population groups. These groups were introduced by the London Health Commission in 2011 and give us confidence that our needs model has an empirically evidenced link between likely ‘health needs’ and the future population.

4.2 The model currently reflects both the Westminster resident population and Westminster GP registered population. The projections of our resident population uses a standard Greater London Authority (GLA) methodology (which aligns with the London Plan) using past trends to project forward population numbers accounting for planned developments of housing as well as demographic factors. The GP registered population uses a similar method also based on past trends but there is no equivalent standard projection model to adopt. In its place, a mixture of GLA forecasts and changes in past GP registration has been used to get local figures.

4.3 Our model can be currently used to project up to 15 years ahead to estimate:

- The prevalence of different health conditions across the city at both a city-wide and ward level; and

- The cost of the conditions on different services, including acute care, community care, GP visits, mental health, prescribing and social care.

4.4 Officers will undertake the following steps during the summer to further refine the modelling work in order to:

- Match GP lists to the 15 population groups;
- Improve the accuracy of the data on costs provided by the model;
- Fully incorporate data from WLCCG;
- Readjust the current projections in light of a growth in the Office for National Statistic's mid-year forecasts and the potential impacts on migration of the UK's decision to leave the EU.

5. Next steps for Phase 2 and 3

5.1 We are now initiating the second phase of work and this will overlay the impacts of regeneration, housing and infrastructure plans on the estimates modelled and build a tool that enables the manipulation of these impacts according to a number of variables. This will include the mapping of the existing provision of GP services both in terms of numbers of clinicians and also physical estate.

5.2 Once phase two is complete, we will then commence the third and final stage. This will consist of a joint analysis of how the needs of the Westminster population will impact on the demand for frontline services (including primary care) with a view to this informing the analysis that will be used by the local authority, NHS England, CLCCG and WLCCG to plan for future primary care provision. This analysis will include the identification of local authority and voluntary sector levers (such as estates and planning policy) that could be used to support the provision of primary care to match population needs.

6. Legal Implications

Not applicable.

7. Financial Implication

Nor applicable.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

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City of Westminster

Westminster Health & Wellbeing Board

Date:	14th July 2016
Classification:	General Release
Title:	Primary Care Co-Commissioning – General Update
Report of:	NHS Central London Clinical Commissioning Group and NHS West London Clinical Commissioning Group
Wards Involved:	All
Policy Context:	Central London CCG and West London CCG have jointly co-commissioned primary care with NHS England since April 2015. This brings the CCGs and the CCG's stakeholders - including the Health & Wellbeing Board – into the commissioning of local GP services and, through this, enables them to align the development of primary care with the wider transformation of local health and care services.
Financial Summary:	This update includes details of the CCG's technology bids to the national Estates and Technology Transformation Fund and the review of local GPs' PMS contracts, which is focused on ensuring best value is secured from the money invested in general practice in Westminster.
Report Author and Contact Details:	Helena Stokes Delivery Manager – Primary Care Central London CCG helena.stokes@nw.london.nhs.uk Christopher Cotton Primary care transformation lead North West London Collaboration of CCGs chris.cotton@nw.london.nhs.uk

1. Executive Summary

1.1 This report updates the Health and Wellbeing Board on issues related to the co-commissioning of primary care in Westminster. This update includes:

- Information on the bids to the national Estates and Technology Transformation Fund (ETTF); and
- the Primary Medical Services (PMS) review.

2. Key Matters for the Board

2.1 The Board is asked to:

- Note and discuss the content of this report.

3. Background

Estates and Technology Transformation Fund (ETTF)

3.1 The ETTF (formerly the Primary Care Transformation Fund) is a national investment fund to accelerate the development of infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients. Overall total capital investment over the next five years will be £900 million.

3.2 In June 2016, CCGs were invited to put forward technology bids to the fund for investment between 2016 and 2020, to improve access and the range of services available in primary care, through investment in premises, technology, the workforce and support for working at scale across practices.

Technology

3.3 The criteria for the technology bids shows that they should look to support one or more of the following:

- increase capacity for primary care services out of hospital;
- commitment to a wider range of services as set out in commissioning intentions to reduce unplanned admissions to hospital;
- improving seven day access to effective care; and
- increase training capacity.

3.4 In North West London, the approach to the ETTF technology bids is to support digital transformation of primary care at scale, aligned to the priorities of the Sustainability and Transformation Plan. The CCGs have developed seven linked digital bids for the eight CCGs.

3.5 The linked bids request funding of £30m over four years. This equates to an additional investment of £19,000 per practice per annum to improve overall digital maturity and to support primary care professionals and patients.

3.6 The linked bids cover a range of activities:

- digital workforce and innovation;
- digitally-enabled patients;
- integrated care standards;
- videoconferencing;
- integrated telecoms for patients and professionals;
- care home pilot; and
- new models of primary care.

3.7 Overall benefits of the investment will increase the digital maturity of primary care to provide a productivity and efficiency opportunity of up to £58m over 4 years to help primary care practices and professionals to manage demand and complexity of future healthcare.

3.8 The diagram below shows the unifying objectives of the bids, more detail on each bid, and the benefits expected from each bid.

7 North West London Linked Digital Bids

1. *Contribute to 7 day access to effective care*	7. New Models of Care	• Provide IT design, specification and support for clinical systems & applications, data sharing including critical business intelligence to support primary care with movement to Accountable Care Organisations.	Benefit: Support mobilisation of new organisational forms, functions and services for the delivery primary care.
	3. Integrated Care Standards	• Multidisciplinary professional to accelerate with support of national delivery partners the development of technical standards for Integrated Care. • Building on NWL Integrated Care Pilots, Hillingdon Early Adopter care plans.	Benefit: Deliver of a national recognised standard, PRSB Accreditation that can be shared and used by health and social care organisations working together to provide joined up care
2. *Increase capacity of Primary Care*	4. Videoconferencing	• Implement video consultation systems and processes to support professionals and patient care	Benefit: Reduce unnecessary physical visits by professionals to MDTs meeting and patient's homes whilst supporting isolated people to receive care in their homes.
	5. Integrated Telecoms for Patient Management Systems	• Software, hardware and telephony solutions to enable a personalised and integrated patient centric offers which promotes, supports and informs health and wellbeing and provides rich intelligence data back to the service providers and commissioners in order to improve services and communication.	Benefit: the patient, the carer and the GP practice staff. The patient experience will improve through access to primary care services by personalised interactions.
3. *Enable access to wider range of services to reduce unplanned admissions to hospital*	2. Digitally Enabled Patients	• Support digital inclusion and look at digital motivation of NWL citizens. • Engage with voluntary sector and local patient groups to encourage use of digital tools. • Work in partnership with HLP on the process to support a 'citizen account'. • Seed fund the apps for local NHS urgent care service and learning and disability. • Navigate patients to right services, right care at the right time and promote self-care.	Benefit: Navigate patients to right services, right care at the right time and promote self-care reducing visits to care professionals and enabling patients to stay well for longer in their homes.
	6. Care Homes	• Fund 16 care home pilots through an EoI. • Support digital maturity of communication between primary care and care homes to Increase information sharing across care setting to provide joined up care. • Decrease physical professional visits, hospital admissions and keep residents well for longer.	Benefit: Decrease physical professional visits, hospital admissions and keep residents well for longer and support care staff to make the right decisions about residents care without the need for emergency care in an acute setting.
4. *increase training capacity in general practice*	1. Digital Workforce and Innovation	• Increase digital literacy of the workforce through training and support. • Make best use of digital tools already available SystmOne, EMIS, eReferrals, SCR, Docman/DTS, CIE.	Benefit: Reduce inefficiency, optimise productivity and increase digital confidence.

3.9 The table below shows how the investment would be divided between the projects and across the years to 2020:

	16-17 (£1,000)	17-18 (£1,000)	18-19 (£1,000)	19-20 (£1,000)	Total (£1,000)	Per Practice (400) (£1,000)	Per Practice per year (£1,000)
Digital Workforce and Innovation	4,352	5,506	1,100	1,133	12,090	30.2	7.6
Digitally Enabled Patients	530	518	178	184	1,410	3.5	0.9
Integrated Care Bids	328	0	0	0	328	0.8	0.2
Videoconferencing	422	207	58	56	742	1.9	0.5
Patient & Primary Care Integrated Communication System	5,311	760	637	656	7,363	18.4	4.6
New Models of Primary Care	2,737	2,004	1,486	1,618	7,846	19.6	4.9
Care Homes	152	23	23	24	222	0.4	0.1
Total	**13,832.1**	**9,018.0**	**3,481.4**	**3,670.4**	**30,001.9**	**74.8**	**18.7**

3.10 The draft bid documents were discussed at the NWL-wide primary care co-commissioning meeting in common on 16 June 2016[1].

Estates

3.11 The CCG is also submitting estates bids to the ETTF.

3.12 The process is different to the one outlined above for the technology bids. Firstly it is subject to an initial bidding process where the CCG makes recommendations to NHS England to support the funding of improvements or developments in practices in CCG area. Recommendations will need to demonstrate that they meet one or more of the criteria set out below;

- increase capacity for primary care services out of hospital;
- commitment to a wider range of services as set out in commissioning intentions to reduce unplanned admissions to hospital;
- improve seven day access to effective care; and
- increase training capacity.

Each CCG has uploaded the bids it is endorsing to a portal by the 30th June 2016. There is no set allocation per area – NHS England will evaluate each bid on its own merit against a national fund. The CCG was required to prioritise any bids it was submitting against areas defined by NHS England, identified below:

Meets additional criteria for technology schemes			
Clear identified need	X / √	Demonstrates that the CCG has considered IG	X / √
Demonstrates alignment with the Local Digital Roadmap	X / √	Sustainable in the long term	X / √
Demonstrates a process for monitoring, measuring and evaluating expected benefits.	X / √	Deliverable within financial years April 2016 to March 2019 (the end point for PCTF)	X / √
Consistent with primary care commissioning plans	X / √	Evidence of patient involvement and engagement across the local health economy	X / √

[1] Papers available at http://www.centrallondonccg.nhs.uk/news-publications/publications.aspx?n=2755

3.13 **Central London CCG**. The CCG received four bids for consideration under the estates element of the scheme. Three bids represent practices coming together to share new fit for purpose estates where one or more is at risk of losing premises in the short term and the final bid was developed by the CCG speculatively to address the shortage of premises within the Maida Vale area. This bid does not currently have a lead practice identified although interest has been expressed. All bids were assessed and ranked in priority order based on the criteria listed earlier in the paper. Those bids from with member practice support have been prioritised above the CCG initiated bid.

3.14 **West London CCG**. The CCG has developed proposals in partnership with local practices based on identified need to deliver Estates solutions which will support delivery of the CCG's Out of Hospital strategy. For 2016/17 none of these proposals fall within the QPP area. However the CCG is currently finalising its Estates strategy which will ensure that requirements in QPP form a key part of future planning and investment.

The PMS (Personal Medical Services) contracts review

3.15 NHS England is leading a national review in April 20165 all GP Primary Medical Service (PMS) contracts. Given the advent of primary care co-commissioning, making decisions about the future shape of these contracts is now a joint responsibility of the CCGs.

3.16 PMS contracts are a type of GP contract introduced in 2004 to support Primary Care Trusts (now defunct) to commission additional services from GPs, linked to the specific needs of local populations. They exist mainly in contrast to General Medical Services (GMS) contracts, which provide for 'core' GP services. Nationally, PMS practices attract approximately £14 of additional funding per patient.

3.17 Both Central London CCG and West London CCG have a relatively high concentration of PMS contracts – 16 out of 35 practices and 22 out of 49 practices respectively. In Central London CCG, two PMS practices are designated as specialist practices and will be reviewed separately. Across North West London as a whole, approximately one quarter of GP practices hold a PMS contract.

3.18 In Central London CCG, the premium invested in PMS practices is £1.9m. In West London CCG it is £6.1m. This is the money invested in practices above that provided for the provision of 'core' GP services. The purpose of the review is to ensure that this additional investment, or 'premium' funding, represents value for money and creates equity for patients and practices.

3.19 Additional background information to the review is contained in the last primary care co-commissioning update to the Board, in March 2016.

3.20 **Central London CCG**. The CCG is currently seeking feedback from members on the draft service specification for a local service it is commissioning with the investment from the PMS Review, alongside the mandatory Key Performance Indicators (KPIs) developed across NHS London. This service specification is an important element in the CCG's Whole Systems work and seeks to support General Practice to move from a reactive model of care to a proactive one. The KPIs cover areas such as cervical screening and immunisations.

3.21 **West London CCG**. The CCG is progressing a work programme to develop local commissioning intentions for reinvestment of relevant funding within local practices. Key priority areas for reinvestment have been identified as follows; i) Access, ii) Co-ordinated care, and iii) Pro-active care. Once service specifications have been finalised relevant services will be commissioned from local practices in addition to the KPI areas specified within the London PMS offer. The timeframe for investment will be linked to the financial transition profile for practices which will ensure stability through this period of change.

4. Legal Implications

4.7 The PMS review will involve changes to the contracts held by some GPs in Westminster. Under joint co-commissioning, these contacts continue to be held by NHS England rather than the CCGs. The negotiation of new contracts will be undertaken by NHS England.

5. Financial Implications

5.7 The ETTF technology bids are applying solely for non-recurrent funding. There is no request to CCGs for commitment to on-going costs after the funding period.

5.8 The estates bids will have a potential revenue impact for the practices or the CCG however any bids that NHS England approves will be subject to due diligence and a full business case which will confirm the on-going revenue costs.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

BACKGROUND PAPERS:

Primary Care Co-Commissioning - Update to the Health and Wellbeing Board, February 2016 - http://committees.westminster.gov.uk/ieListMeetings.aspx?CommitteeId=162

NHS England Guidance for the EFFT Fund - https://www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/

NHS England information on the PMS review - https://www.england.nhs.uk/wp-content/uploads/2014/02/rev-pms-cont.pdf

https://www.england.nhs.uk/wp-content/uploads/2014/09/pms-review-guidance-sept14.pdf

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Joint Strategic Needs Assessment (JSNA) Steering Group

Thursday 16th June 2016 2.00-4.00pm

Holland Room, Freeman Suite, Kensington Town Hall

Notes

In attendance	
Daniela Valdés (Chair) (DV)	Head of Planning and Governance, Central London CCG
Jessica Nyman (JN)	JSNA Manager, Public Health
Anna Waterman (AW)	Strategic Public Health Advisor
Samar Pankanti (SP)	Public Health Project Manager, CLCCG
Steve Bywater	Policy Officer, Children's Services
Angelica Silversides (AS)	Healthwatch K&C
Siobhan McCormack	West London CCG
Ben Gladstone	Head of Older People, ASC Commissioning
Angela Spence	CEO, Kensington and Chelsea Social Council
Apologies: Stuart Lines, Shelley Prince, Colin Brodie, Kerry Doyle	

Minutes

1. Welcome and introductions

2. Minutes of last meeting and matters arising

Correct the spelling of DV's name

Retain as matters arising:

- **TJ to circulate link and feedback form to JSNA Steering Group when online JSNA is ready.**
- **PMJ to circulate slides – keep running.**

Further actions:

- **JN to start planning deep dive programme already based on the draft Health and Wellbeing Strategies across the three. Present a plan at the next meeting**

3. JSNA updates

Young Adults JSNA: Care Leaver work is almost complete. Other areas of focus will be substance misuse, eating disorders and crime and violence.

Online JSNA: The first stage of technical development of the online JSNA is now complete and was presented at the ESRI UK annual conference at the QEII conference centre on the 17th of May. The tool has also been selected for presentation at the Public Health England annual conference in September later this year. The next stage will be the release of discrete data products within the framework to support the work of the JSNA starting with the JSNA Highlight Reports which will be rolled out over the coming few weeks.

JSNA Review: papers have been sent to the Health and Wellbeing Board to approve governance recommendations.

4. Housing and Care JSNA

A discussion was led by AW on the Housing and Care JSNA's key findings and recommendations, following a stakeholder workshop on June 8th.

Some key points from Anna:

- The project has had a long gestation period due to challenge of the large scope and key personnel leaving
- JSNA aims to take a 360 degrees view on the issues of housing and care rather with a focus on those which need integrated solutions to provide better care for residents and provide better use of money
- There are currently 26 recommendations, which fall into 5 themes.
    - ❖ Prevention and early intervention
    - ❖ Personalised housing support and care
    - ❖ Support for carers
    - ❖ Supporting people with serious and multiple disadvantage
    - ❖ Improving the housing offer for older people

Discussion points

- The role of the Voluntary and Community Sector (VCS) is not sufficiently explicit in the report.
- MECC recommendations must include providers and non-statutory services, frontline health services, home care and services who engage with families.
- Isolation came out top on Healthwatch polls – older people living alone, transient people coming to work in London
- Community development and cohesion element needs to be have a strong emphasis in the document
- The recommendations are a mix of strategic and operational in focus. They can be reframed to improve flow and to present the key stakeholders.
- There was discussion about the issue of affordability of living in the three boroughs and lack of social rented housing / affordable housing for keyworkers. This is not covered in the JSNA's key finding and recommendations as these focus on where we can effect change, and where we focus on joint and integrated working.
- The intention of the JSNA is to facilitate exploration of integrated solutions to what are shared challenges.
- Private rented sector is a key issue as the key cause of homelessness. Conditions of private rented stock is also a significant issue – could the recommendations pertaining to the private rented sector be more ambitious?
- Clarify link to Whole Systems
    - ❖ **Angeleca to help link the JSNA into NWL SMT's work on housing and health and to champion it at**

the North West London STP Panel

- Health Education North West London – education and training of workforce elements such as MECC.
- Implementation stage – need to bring together the relevant people on each recommendation to discuss how to bring it together

❖ **JN to circulate the consultation document when ready**

5. Children's Services Presentation

At each JSNA Steering Group meeting, we are hearing from different members about the work that is going on in their areas to facilitate better understanding and support for how the JSNA programme can best work with partners and be part of their work.

SB reported on major projects in Children's Services (CS):

- Focus on practice – how CHS work with families, links to MECC. Aim to be more purposeful with the way we work with children and families, enable social workers to spend more time with residents, including training on systemic practice, motivational interviewing and evidence based parenting programme
- Partners in Practice – selected by the Government with other authorities to lead on ongoing development of effective practice which will contribute to overall improvement in the sector, with a particular emphasis on deregulation

  Other commissioning projects include:
- Semi-independent accommodation – links to young adults JSNA
- Unaccompanied asylum seeking children – numbers have increased in the last 18 months - work taking place on how best to meet their needs
- FGM – working with hospital trusts to tackle this issue
- Local care placements and special educational provision
- Different models of providing youth offer
- Childcare – to realise the 2 year olds and 30 hour offer in context of pressure of central London CAMHS transformation
- Alan Wood report on the future of Local Safeguarding Children Boards

Links to JSNAs

- Ofsted inspectors expected Family Services to make use of JSNA information. Annual highlight reports don't tend to provide information that was not previously known. The Online JSNA will be very helpful for this going forward so specific questions about need can be posed and answered about the needs of particular localities in each borough.
- New Strategy and Partnership team will play role in Horizon scanning and needs assessments as part of the Commissioning Cycle – an opportunity to better link to and influence JSNA programme as part of commissioning.

  Comments from the steering group:
- Suggestion: work with school nursing teams to educate children on health management
- Issue: transition from children to adulthood where they may not be eligible for Services – (SB responded that the Children and Families Act means that SEN children will have EHC plans up to age 24. CHS are working with Adults Services and other agencies on this). Mechanism now in place to do this better in the

future.

- Noted that Camden are piloting CIVICS programme – health and social care education in schools – get involved in community life.

6. AOB

- ❖ Need to cancel July meeting – there will be one in August instead although we may wish to change it due to school holidays.

All to notify of availability for next meeting ASAP

Date of next meeting: August 18th, venue tbc

Westminster Health & Wellbeing Board
Work Programme
2016/17
DRAFT

KEY

FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
BUSINESS ITEMS			
Meeting Date: 15 September 2016			
STRATEGIC ITEMS			
NHS 111 AND INTEGRATED URGENT CARE MODEL		**NWL CCGs**	**For discussion**
MENTAL HEALTH	Update on supporting mental health in Westminster	**CCG/PH**	**for discussion**
DISCUSSION ITEMS			
CHILDREN AND FAMILIES ACT IMPLEMENTATION AND PREPARATION FOR LOCAL AREA INSPECTION	Update for discussion	**CCG/ChS**	**For discussion**
JOINT HEALTH & WELLBEING STRATEGY	Update on the progress of public consultation	**ASC/CCG/PH**	**For discussion**
YOUNGER ADULTS 18-25 JSNA DEEP DIVE	Consider findings of the JSNA deep dive and approval ahead of publication	**PH**	**For discussion**
HEALTH HUBS			
PRIMARY CARE MODELLING UPDATE	Comprising: • Co-commissioning • Primary care modelling	**CCG**	

ROUGH SLEEPING	Report on the development of the Rough Sleeping Strategy		
HOUSING JSNA	Consider findings of the draft JSNA	**PH**	**For noting**
BUSINESS ITEMS			
Meeting Date: 17 November 2016			
STRATEGIC ITEMS			
STP DELIVERY PLANING UPDATE	Update	**NWL CCG**	**For discussion**
DISCUSSION ITEMS			
SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16	Consider strategic alignment and lessons for integrated commissioning	**Independent Chair**	**For discussion**
SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16	Consider strategic alignment and lessons for integrated commissioning	**Independent Chair**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	Adoption of the Strategy	**ASC/CCG/PH**	**For discussion**
HEALTH HUBS			
PRIMARY CARE UPDATE	Comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			
Meeting Date: 19 January 2017			
STRATEGIC ITEMS			
BETTER CARE FUND PLANNING UPDATE + ALLOCATIONS 2017/18		**ASC**	**For decision**
JOINT HEALTH AND WELLBEING STRATEGY	Discussion of the development of the delivery and performance measurement plan	**ASC**	**For discussion**
DISCUSSION ITEMS			
HEALTH HUBS			
PRIMARY CARE UPDATE	Comprising: • Co-commissioning • Primary care modelling	**CCG**	

BUSINESS ITEMS			
Meeting Date: 23 March 2017			
STRATEGIC ITEMS			
HEALTH + SOCIAL CARE INTEGRATION PLANS	Update on planning for full integration by 2020	**CCG/ASC**	**For decision**
LEARNING FROM THE LONDON DEVOLUTION PILOTS	Review of the learning from first year of London devolution pilots	**ASC**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	Discussion focusing on a particular aspect of the Strategy	**ASC**	**For discussion**
CCG OPERATING PLANS 2017/18	Operating plans for 2017/18	**CCG**	**For discussion**
DISCUSSION			
HEALTH HUBS			
PRIMARY CARE UPDATE	Comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			

KEY

STRATEGIC ITEMS – items concerning system level issues (e.g. health and care integration, devolution, primary care transformation)

DISCUSSION ITEMS – items of interest focusing on a specific part of the system such as a specific health condition, service or population group (e.g. JSNA deep dives)

BUSINESS ITEMS – items for the board's approval or information but which do not require a discussion (e.g. items that have been agreed offline but require formal approval by the Board)

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