Hammersmith and Fulham :Health Needs, Inequalities and ICS Priorities

The Centre for Population Health

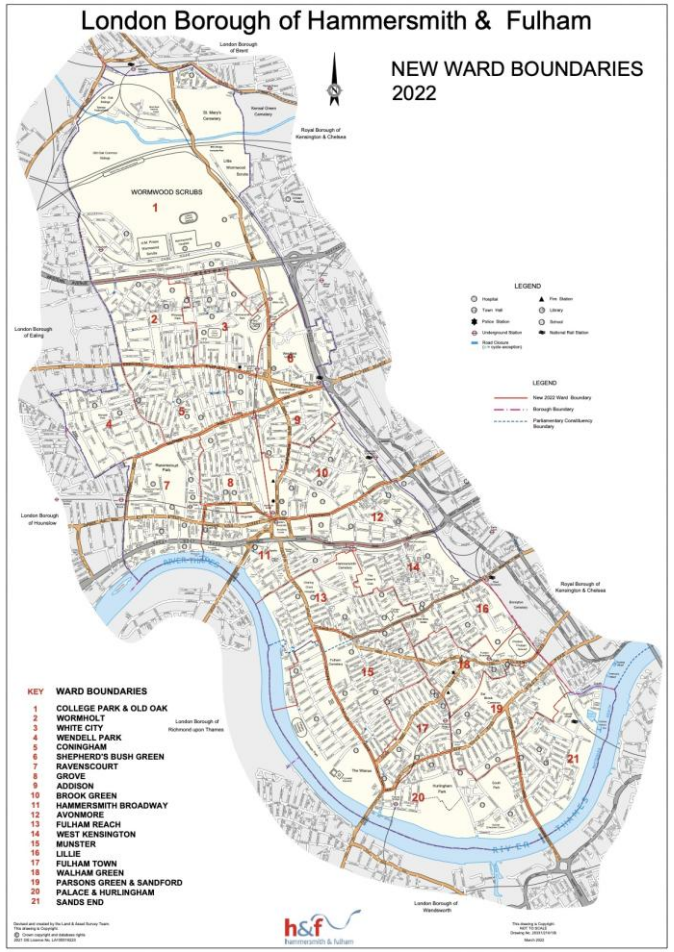
January 2026

JSNA Summary (Hammersmith and Fulham, 2026)

This summary provides an integrated overview of The Borough of Hammersmith and Fulham ’s population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence-based planning across health, social care and community partners.

This pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

BOROUGH PROFILE & POPULATION CHARACTERISTICS



Total Population (2021)

183,000

A relatively small but dense borough – about 183k residents in 2021.

Working-Age (18–64)

72%

The population is young: ~72% are aged 18–64 (London ~64%).

Older Residents (65+)

~11%

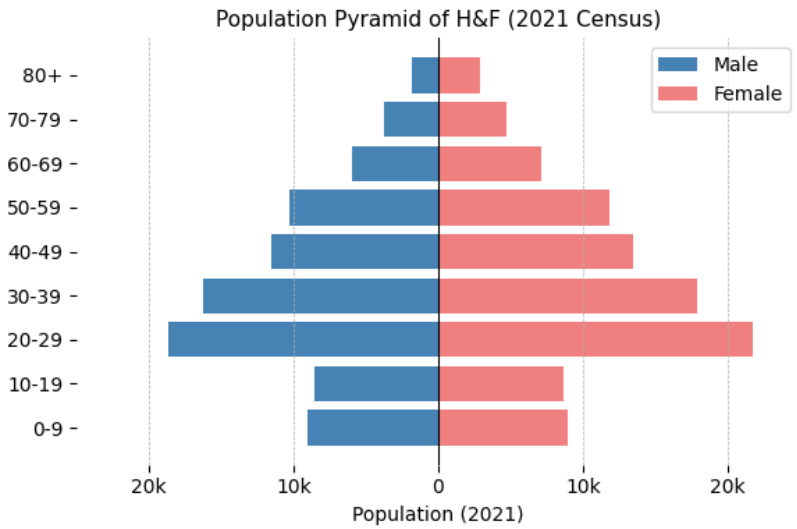
Only about 1 in 9 residents is 65 or older (11%), lower than England's 18%.

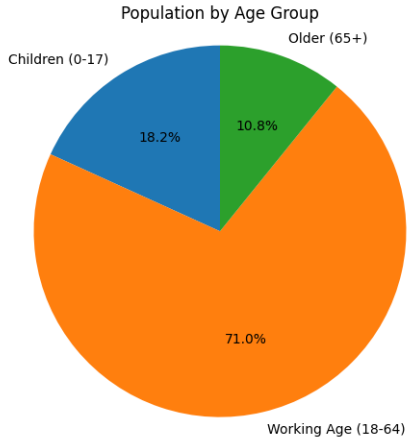
- Hammersmith and Fulham is a compact inner London borough beside the River Thames.
- It covers sixteen square kilometres and is one of the most densely populated boroughs.
- The borough combines affluent areas with neighbourhoods experiencing persistent deprivation and inequality.
- It includes Hammersmith, Fulham, Shepherd's Bush, White City, Sands End and West Kensington.
- The borough has strong transport links and a mix of residential and commercial zones.
- Housing pressures and limited undeveloped land shape the borough's character and population churn.

Population Size and Growth

- Mid-2022 population estimate was 185,238; 2025 update reports 183,300 residents in borough.
- Population growth has been modest, with a 1% increase between 2021 and 2022.
- Internal migration is slightly negative, while international migration contributes positively to growth.
- The borough has a high population turnover rate compared to national averages.
- Population churn is driven by high housing costs and frequent moves among private renters.
- Population change is shaped by affordability pressures and limited housing availability.

Age Structure





Population pyramids of H & F (2021 Census). Source: ONS Census 2021 population by age and sex.

- H&F has a younger population compared to national demographic averages across England.
- Over 72% of residents are of working age (18–64 years), reflecting borough's youth.
- Only 11% of residents are aged 65 and over, with some neighbourhood variation.
- Children and youth (0–17) make up about 17–18% of the total population.
- The median age is approximately 37 years across the borough's diverse communities.
- Older residents are concentrated in Fulham, West Kensington, and parts of Hammersmith.

Ethnicity and Diversity

- H&F is ethnically diverse with residents from over 150 countries and cultural backgrounds.
- About 37% of residents are from Black, Asian or other minority ethnic groups.
- White British residents make up 46% of the population; 17% are other White backgrounds.
- Significant Black African, Black Caribbean, and South Asian communities live across borough.
- Diversity varies by neighbourhood, highest in White City, Shepherd's Bush and Fulham.
- Health services must be culturally competent and accessible to all ethnic and language groups.

Geography and Socioeconomic Contrast

- The borough is divided into affluent south and less affluent northern neighbourhoods.
- Northern wards have higher deprivation and more social housing estates and lower incomes.
- Southern wards like Parsons Green are affluent with high home values and incomes.
- Average household income is £55,000, above the London mean but masks inequality.
- Deprivation is concentrated in White City, Old Oak, and parts of Hammersmith.
- Housing inequality and affordability pressures are significant challenges across the borough.

Population Health Determinants

- Over 60% of adults hold university degrees, indicating high education levels borough-wide.
- Unemployment is low at 4–5%, with 77.7% of working-age residents in employment.
- 29% of children live in poverty after housing costs, matching London-wide averages.
- Air pollution exceeds WHO guidelines across the borough, especially near major roads.
- Low Traffic Neighbourhoods aim to reduce pollution in North Fulham and improve health.
- Cost of living and housing stress significantly impact health outcomes and wellbeing.

Health Status

Life expectancy in H&F is slightly higher than national averages overall.

Male life expectancy is 79.6 years, while female life expectancy reaches 83.1 years.

Healthy life expectancy is approximately 63 years for both men and women locally.

Around 87% of residents reported good or very good health in the 2021 Census.

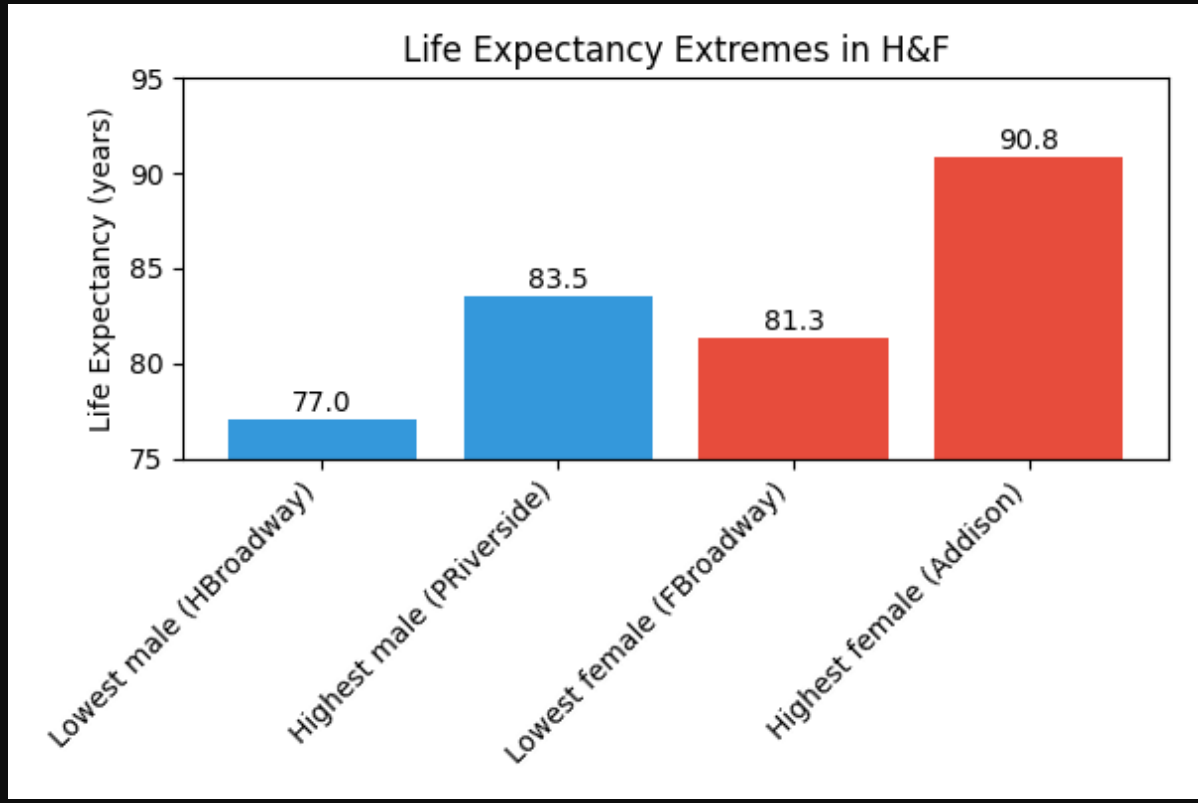
Only 4.2% of residents reported bad or very bad health, among England's lowest proportions.

Chronic conditions remain present but are influenced by deprivation, lifestyle factors, and service access.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Life Expectancy Inequalities

- Significant internal inequalities exist, with life expectancy varying sharply between borough neighbourhoods.
- Men in least deprived wards live 6.5 years longer than those in most deprived areas.
- Women experience an even wider gap, with a 9.5-year difference across deprivation levels.
- These disparities reflect socioeconomic conditions, housing quality, and long-term disease prevalence.
- Deprived areas experience higher rates of cardiovascular disease, cancer, and respiratory illness.
- Addressing these inequalities requires targeted prevention, early detection, and integrated community support.

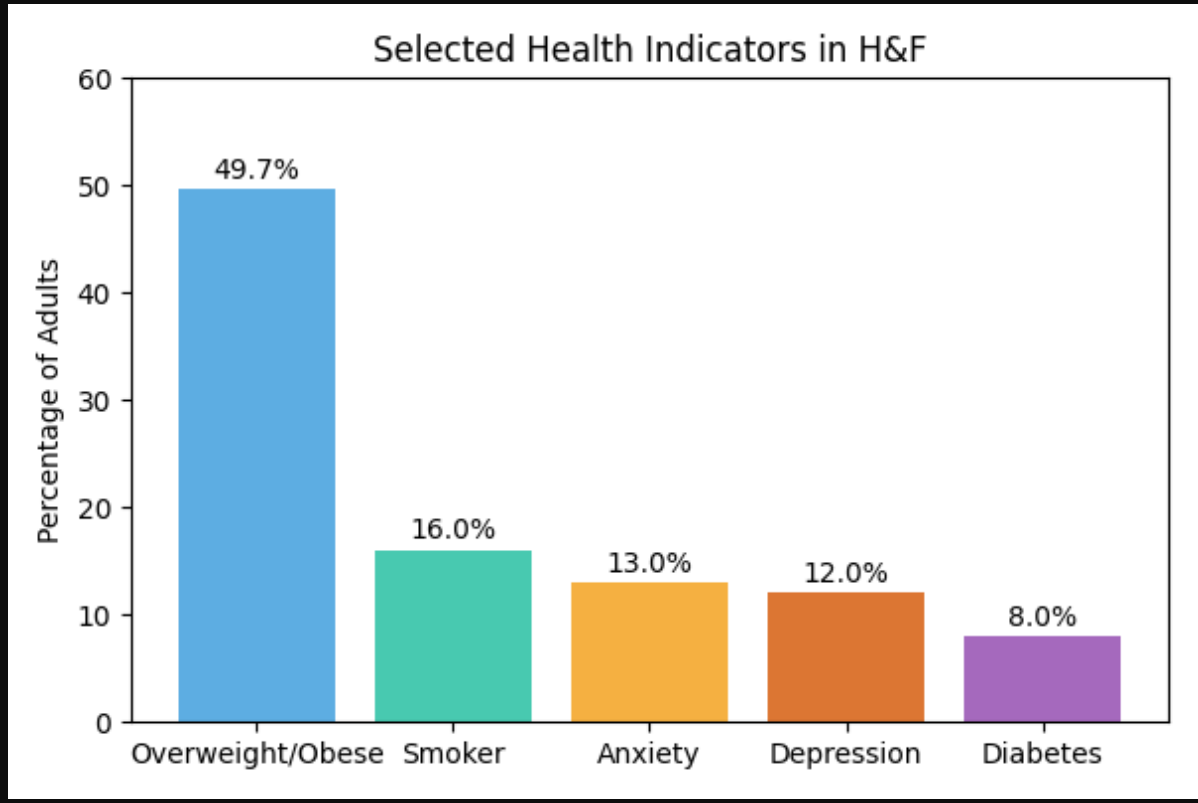


Major Causes of Death

- Cardiovascular diseases remain the leading cause of death, including heart disease and stroke.
- Cancer mortality is slightly higher than London averages, particularly among under-75 populations.
- Respiratory diseases contribute significantly to premature mortality, especially in deprived communities.
- Emergency admissions for coronary heart disease remain below national levels but still concerning.
- Approximately 77% of deaths occur at age 75 or older, indicating fewer early deaths.
- Chronic disease patterns mirror national trends but are intensified by local inequalities.

Lifestyle Factors

- Smoking prevalence is very low at 8.4%, significantly below the England average.
- Physical activity levels are high, with 74.3% of adults meeting recommended activity guidelines.
- Adult obesity stands at 16.8%, lower than national levels but still a health concern.
- Alcohol-related hospital admissions remain above London averages due to nightlife and young demographics.
- Substance misuse, including opiate and cocaine use, contributes to elevated drug-related deaths.
- Prevention efforts must address alcohol harm, drug misuse, and weight management across communities.



Disease Prevalence and Prevention

Recorded prevalence of hypertension, diabetes, and COPD is lower due to younger demographics.

Only 7.6% of adults have diagnosed hypertension, compared with 14% nationally.

Diabetes prevalence is 3.5%, though underdiagnosis means true levels are likely significantly higher.

COPD prevalence is 1%, reflecting younger populations but possible under-identification.

Screening uptake remains below national targets, including cervical and bowel cancer programmes.

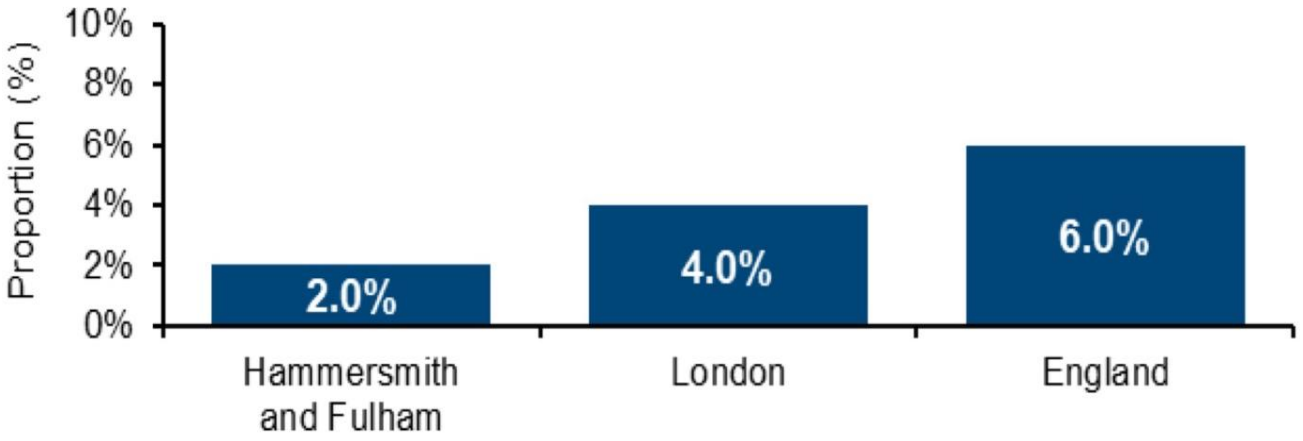
Improving early detection and screening participation is essential for reducing preventable disease burden.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Mental Health Overview

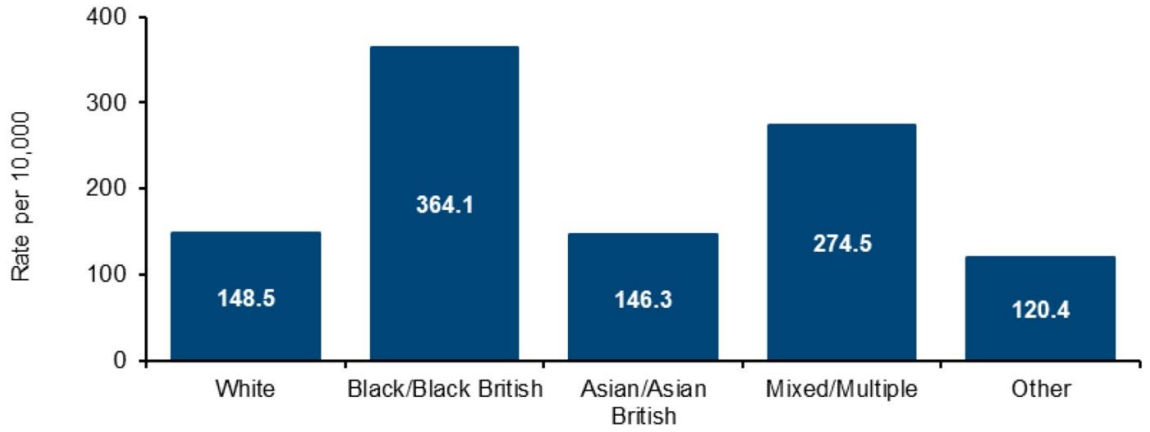
- Mental health needs are substantial, with 1.7% of adults having severe long-term mental illness.
- Common mental health conditions such as anxiety and depression affect approximately one in eight residents.
- Young adults and deprived communities report higher stress linked to housing and financial pressures.
- Self-reported wellbeing scores remain slightly below national averages across multiple survey indicators.
- Mental health conditions often coexist with substance misuse, creating complex dual-diagnosis challenges.
- Strengthening integrated mental health and physical health pathways is essential for improved outcomes.

Proportion of adults in contact with secondary mental health services in paid employment (2022-23)



Serious Mental Illness (SMI)

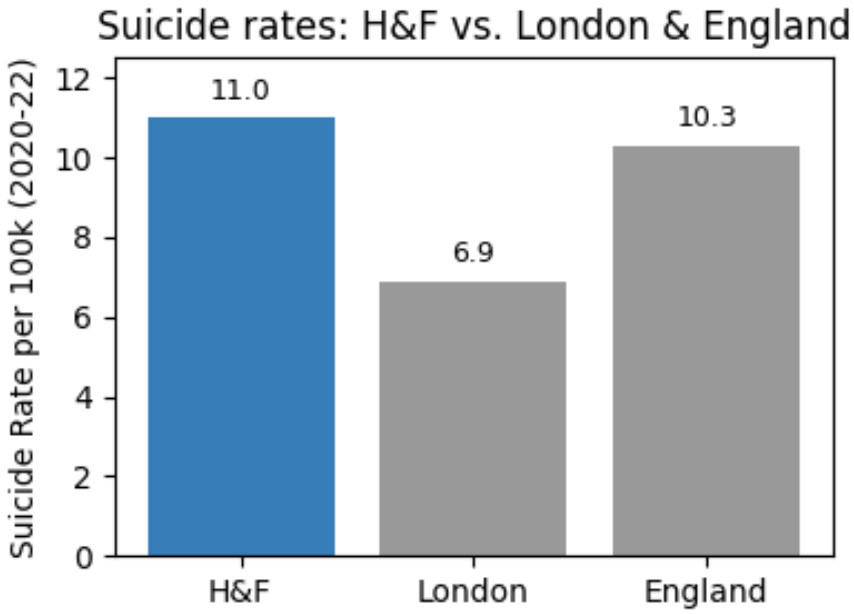
- SMI prevalence is significantly above London averages, affecting nearly 3,000 registered adults locally.
- Black residents experience disproportionately high SMI rates compared with White residents borough-wide.
- Adults with SMI face premature mortality rates far exceeding London and England averages.
- Many deaths among SMI patients result from preventable physical illnesses such as heart disease.
- Employment rates among adults in contact with mental health services remain extremely low at 5.3%.
- Addressing SMI requires integrated care, physical health monitoring, and targeted community support.



Rate of residents and registered patients with a severe mental health condition by ethnic group, per 10,000 of the respective ethnic group's adult population.

Suicide in H&F

- The borough has one of London's highest suicide rates, reaching 11.0 deaths per 100,000 residents.
- H&F is notably above the London average.
- This equates to approximately fifteen to twenty suicide deaths occurring each year locally.
- Middle-aged men, isolated older adults, and LGBTQ+ residents represent key high-risk groups.
- Social isolation, financial stress, and mental illness contribute significantly to suicide vulnerability.
- Local suicide prevention efforts have intensified in response to persistently elevated rates.
- Strengthening early intervention, crisis support, and community outreach remains a critical priority.



Suicide death rates (per 100,000 population, 2020–22) Source: H&F Borough Council

Social Determinants of Mental Health

- Mental health outcomes shaped by unemployment, financial insecurity, and unstable housing conditions.
- Only 5.3% of adults in secondary mental health services are currently in paid employment.
- Many entering drug or alcohol treatment have co-occurring mental health conditions diagnosed.
- Loneliness is widespread, especially among older adults and isolated ethnic minority communities.
- Only 30% of adult social care users report sufficient social contact with others regularly.
- Addressing social determinants requires coordinated action across housing, employment, and community support systems.

Housing and Health

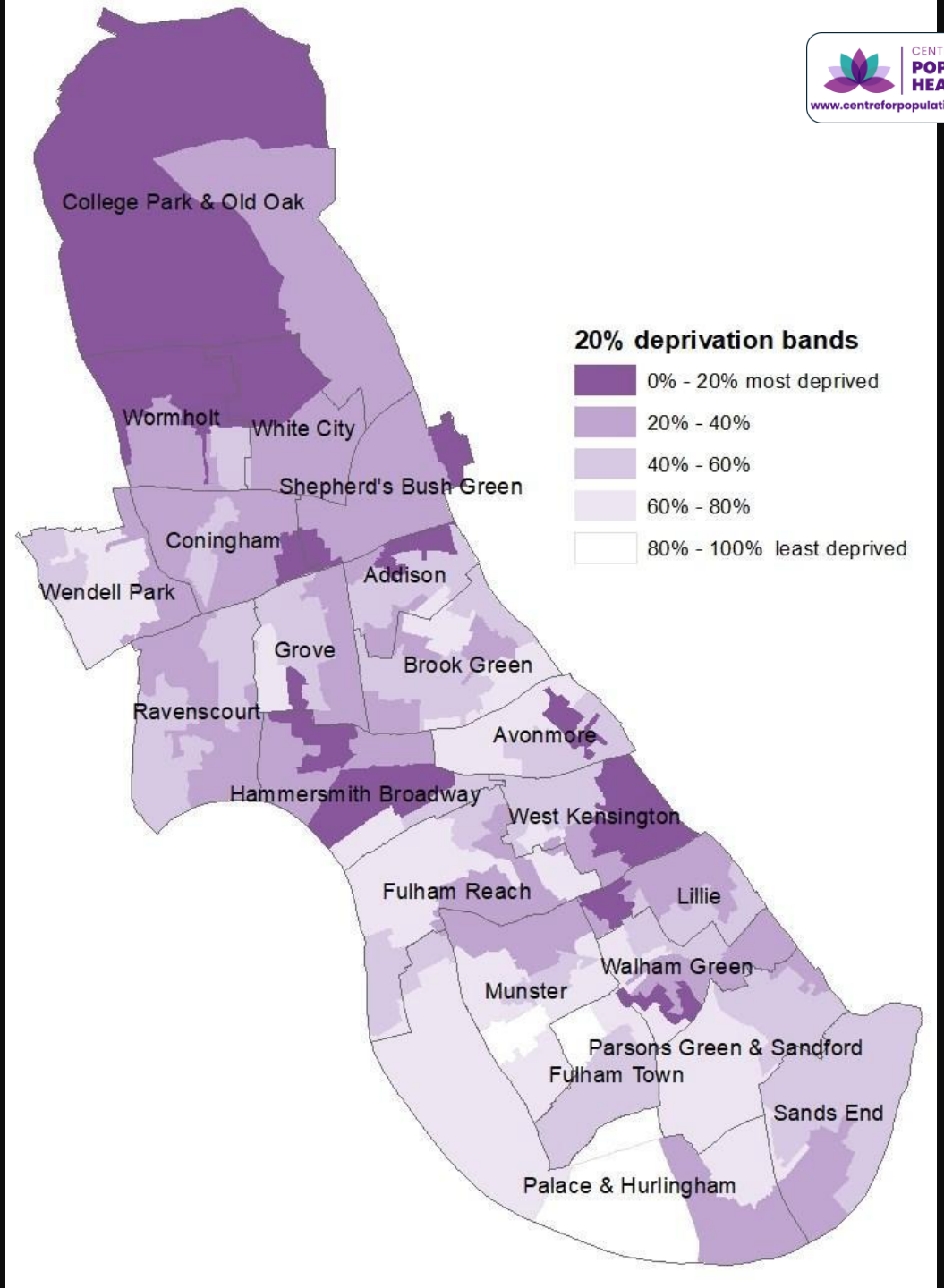
- 61% of supported accommodation residents have an identified mental health condition diagnosed.
- Homelessness and mental illness frequently overlap, requiring coordinated multi-agency support responses.
- Overcrowding and poor housing contribute to respiratory illness, stress, and infectious disease spread.
- High rental costs force frequent moves, disrupting continuity of care and community stability.
- Social housing estates in northern wards experience higher deprivation and poorer health outcomes.
- Improving housing quality and stability is essential for reducing borough-wide health inequalities.

Health Inequalities Overview

- Strong average health outcomes mask deep internal inequalities across borough neighbourhoods.
- Deprivation influences life expectancy, chronic disease prevalence, and mental health outcomes significantly.
- Children in deprived families experience higher obesity rates and lower physical activity levels.
- Ethnic disparities persist in screening uptake, mental illness rates, and condition diagnosis.
- Preventative service access varies significantly across neighbourhoods and demographic groups borough-wide.
- Reducing inequalities requires targeted interventions, community engagement, and integrated health strategies.

IMD Overview

- The borough ranks 112th out of 317 English local authorities in the IMD 2019.
- Deprivation has decreased since 2010, though inequalities remain across borough neighbourhoods.
- Only one LSOA remains in the most deprived 10% nationally, down from eight.
- Nineteen areas fall within second most deprived decile, mainly in northern neighbourhoods.
- 18% of residents live in the bottom quintile of deprivation nationally, indicating persistent inequality.
- Deprivation is highly concentrated, with stark contrasts between affluent and disadvantaged areas.



IMD Domain Performance

- Living Environment ranks 25th most deprived nationally, borough's worst-performing IMD domain.
- Barriers to Housing and Services ranks 34th, driven by extreme housing affordability pressures.
- Income deprivation affects 24% of residents, with notable child and pensioner poverty levels.
- Education and employment outcomes are stronger but vary significantly by neighbourhood.
- Crime levels and environmental quality differ sharply between northern and southern borough wards.
- IMD trends show improvement overall but persistent deprivation in White City and Wormholt.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

H&F Top 10 Health and Wellbeing Priorities

- Reducing Health Inequalities (Cross-Cutting Priority)
- Tackling Poverty and the Social Determinants of Health
- Improving Mental Health and Well-being
- Promoting Healthy Weight, Nutrition and Physical Activity
- Preventing and Managing Long-Term Conditions (Diabetes, CVD, Hypertension)
- Cancer Prevention and Early Diagnosis
- Supporting Children and Young People's Health and Well-being
- Healthy Ageing and Care for Older People
- Improving Access to Primary Care and Integrated Services
- Environmental Health and Climate Resilience (Healthy Places)

Priority 1: Reducing Health Inequalities

Health inequalities remain among London's widest, affecting life expectancy and disease burden.

Deprived communities face higher chronic illness, mental health issues, and early mortality rates.

Ethnic disparities persist in serious mental illness, screening uptake, and long-term condition diagnosis.

Children in deprived families face higher obesity rates and poorer long-term health outcomes.

Reducing inequalities aligns with NHS priorities and local Health and Wellbeing Strategy goals.

Improving equity is essential for population health and reducing long-term system pressures.

Priority 1: Reducing Health Inequalities

Expand	Expand targeted prevention programmes in deprived areas for cardiovascular disease and cancer.
Increase	Increase screening uptake through culturally tailored outreach and improved primary care access.
Strengthen	Strengthen community partnerships addressing housing, employment, and social isolation determinants.
Improve	Improve data sharing across agencies to identify high-risk groups and monitor outcomes.
Enhance	Enhance support for families in poverty through integrated early-years and family services.
Embed	Embed health equity assessments across all ICS planning, commissioning, and service redesign processes.

Priority 2: Improving Early Detection and Prevention

- Many long-term conditions remain underdiagnosed due to low screening and health check uptake.
- Only 56% of estimated diabetes cases are diagnosed, indicating substantial unmet clinical need.
- Hypertension prevalence appears low but likely reflects under-identification, not genuine absence.
- Early detection reduces avoidable hospital admissions and long-term system pressures significantly.
- Screening participation for cervical and bowel cancer remains below national targets across communities.
- Strengthening prevention aligns with NHS Long Term Plan and local public health priorities.

Priority 2: Improving Early Detection and Prevention (Actions)

Expand	Expand NHS Health Checks outreach targeting deprived neighbourhoods and underrepresented population groups.
Increase	Increase cancer screening uptake through culturally tailored communication and flexible appointment options.
Strengthen	Strengthen partnerships with community organisations to promote preventative health literacy and awareness.
Improve	Improve digital access and reminders to support timely attendance for screening and checks.
Embed	Embed opportunistic testing for hypertension, diabetes, and atrial fibrillation in primary care.
Monitor	Monitor inequalities in screening uptake and adjust interventions to ensure equitable service access.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Priority 3: Strengthening Mental Health and Wellbeing

- Mental health needs are high, with burdens of anxiety, depression, and severe mental illness.
- SMI prevalence exceeds London averages, with disproportionate impact on Black communities locally.
- Suicide rates remain among the highest in London, requiring sustained multi-agency intervention.
- Employment rates for adults in mental health services are low, worsening social exclusion.
- Young adults experience heightened stress linked to housing insecurity and financial pressures.
- Strengthening mental health support is essential for reducing inequalities and improving wellbeing.

Priority 3: Strengthening Mental Health and Wellbeing (Actions)

Expand	Expand community-based mental health hubs offering integrated psychological and physical health support.
Strengthen	Strengthen crisis prevention pathways including rapid response, peer support, and outreach services.
Improve	Improve physical health monitoring for people with SMI to reduce preventable early mortality.
Increase	Increase culturally competent mental health provision tailored to diverse ethnic communities.
Enhance	Enhance employment support programmes for adults in secondary mental health services.
Strengthen	Strengthen suicide prevention initiatives targeting high-risk groups including men and LGBTQ+ residents.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Priority 4: Tackling Substance Misuse and Related Harm

Drug-related deaths are significantly higher than London averages, indicating unmet treatment needs.

Substance misuse frequently co-occurs with mental illness, creating complex dual-diagnosis challenges.

Alcohol-related hospital admissions exceed London averages due to nightlife and young demographics.

Vulnerable groups include individuals experiencing homelessness, social isolation, and long-term deprivation.

Substance misuse contributes to crime, poor health outcomes, and emergency service pressures.

Addressing substance harm is essential for improving safety, wellbeing, and long-term outcomes.

Priority 4: Tackling Substance Misuse and Related Harm (Actions)

- Strengthen integrated drug and alcohol treatment pathways with improved access and rapid assessment.
- Expand harm-reduction initiatives including naloxone distribution and safe-use education programmes.
- Improve dual-diagnosis support through coordinated mental health and substance misuse interventions.
- Enhance outreach services targeting rough sleepers and individuals with unstable accommodation.
- Increase community-based alcohol harm reduction programmes targeting high-risk population groups.
- Strengthen data-driven monitoring to identify emerging trends and target interventions effectively.

Priority 5: Supporting Children and Young People

- Children in deprived families experience higher obesity rates and poorer long-term health outcomes.
- Mental health needs among young people have increased significantly post COVID-19 pandemic.
- Childhood poverty affects approximately 29% of local children after housing costs are considered.
- Access to early-years services varies across neighbourhoods, contributing to developmental inequalities.
- Young carers and vulnerable adolescents face heightened risks of poor health outcomes.
- Supporting children early is essential for breaking deprivation cycles and improving life chances.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Priority 5: Supporting Children and Young People (Actions)

Expand	Expand early-years support programmes targeting families experiencing poverty and housing instability.
Strengthen	Strengthen school-based mental health services and early intervention pathways for young people.
Increase	Increase access to physical activity and healthy eating initiatives in deprived neighbourhoods.
Improve	Improve coordination between education, social care, and health services for vulnerable children.
Enhance	Enhance targeted support for young carers through dedicated outreach and respite services.
Monitor	Monitor childhood obesity and mental health trends to inform targeted prevention strategies.

Priority 6: Improving Housing, Environment and Healthy Neighbourhoods

Poor housing conditions contribute to respiratory illness, stress, and wider health inequalities.

Overcrowding remains common in deprived wards, increasing infectious disease transmission risks.

Air pollution exceeds WHO guidelines, especially near major roads and transport corridors.

Housing instability disrupts care continuity and increases vulnerability for low-income households.

Living Environment is H&F's worst IMD domain, ranking 25th most deprived nationally.

Improving housing and environment is essential for long-term health improvement and equity.

Priority 6: Improving Housing, Environment and Healthy Neighbourhoods (Actions)

- Strengthen partnerships with housing providers to improve quality, safety, and home maintenance.
- Expand programmes addressing damp, mould, and overcrowding in high-risk neighbourhoods.
- Increase investment in clean air initiatives targeting pollution hotspots near major roads.
- Support community-led neighbourhood improvements promoting safety, green space, and active travel.
- Enhance data sharing between housing, health, and care to identify vulnerable households.
- Integrate housing support into multidisciplinary care pathways for residents with complex needs.

Priority 7: Strengthening Integrated Care and Service Coordination

- Fragmented service pathways create barriers for residents with complex or long-term conditions.
- Many individuals require coordinated support across health, social care, and voluntary sectors.
- Integrated care improves outcomes by reducing duplication and improving service transitions.
- Residents with serious mental illness often experience poor physical health monitoring.
- Older adults living alone need coordinated support to reduce isolation and admissions.
- Strengthening integration aligns with ICS commitments to person-centred, neighbourhood-based care.

Priority 7: Strengthening Integrated Care and Service Coordination (Actions)

Expand	Expand multidisciplinary teams linking primary care, mental health, and social care services.
Improve	Improve shared care records to support timely information exchange across partner organisations.
Strengthen	Strengthen hospital discharge pathways ensuring safe transitions and community follow-up support.
Enhance	Enhance voluntary sector involvement in care coordination for vulnerable, isolated residents.
Develop	Develop integrated care plans for individuals with complex multi-agency support needs.
Monitor	Monitor outcomes to ensure integrated care reduces inequalities and improves patient experience.

Priority 8: Reducing Obesity and Improving Healthy Lifestyles

- Adult obesity is lower than national averages but affects nearly 17% of residents.
- Childhood obesity remains significantly higher in deprived families, widening health inequalities.
- Physical activity levels are high but vary between neighbourhoods and income groups.
- Diet-related risks contribute to diabetes, hypertension, and cardiovascular disease burden.
- Cost-of-living pressures reduce access to healthy food for low-income households.
- Reducing obesity is essential for preventing chronic disease and improving wellbeing.

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Priority 8: Reducing Obesity and Improving Healthy Lifestyles (Actions)

Expand	Expand community-based physical activity programmes targeting inactive and deprived neighbourhoods.
Strengthen	Strengthen school-based healthy eating and physical activity initiatives for children.
Increase	Increase access to affordable healthy food through partnerships and community food networks.
Promote	Promote active travel by improving walking, cycling, and green space infrastructure.
Support	Support weight-management services tailored to diverse cultural and socioeconomic groups.
Monitor	Monitor obesity trends to ensure interventions reduce inequalities across communities.

Priority 9: Improving Access to Primary and Community Care

High population turnover creates challenges for maintaining GP registration continuity.

Some communities face barriers accessing timely primary care and preventative services.

Underdiagnosis of long-term conditions reflects gaps in access and engagement.

Language barriers affect service use among diverse ethnic communities.

Strengthening access supports early intervention and reduces hospital admissions.

Improving access aligns with ICS goals for equitable, community-centred care.

Priority 9: Improving Access to Primary and Community Care (Actions)

Expand	Expand extended-hours primary care appointments for working-age residents.
Strengthen	Strengthen outreach and registration support for residents experiencing housing instability.
Increase	Increase availability of interpreters and culturally competent communication in primary care.
Enhance	Enhance community pharmacy roles in prevention and long-term condition management.
Improve	Improve digital access support for residents with limited skills or technology.
Monitor	Monitor access inequalities and adjust service models to ensure equity.

Priority 10: Supporting Ageing Well and Older Adults

Older adults in some areas experience high isolation and limited social contact.

Many older residents live alone in social housing, increasing vulnerability.

Falls, frailty, and long-term conditions drive hospital admissions among older adults.

Dementia prevalence is rising, requiring coordinated health and social care support.

Older adults face challenges accessing digital services and modern care pathways.

Supporting ageing well reduces urgent care pressure and improves quality of life.

Priority 10: Supporting Ageing Well and Older Adults (Actions)

Expand	Expand community-based social connection programmes for isolated older residents.
Strengthen	Strengthen falls prevention services including home safety assessments and activities.
Improve	Improve dementia diagnosis pathways and post-diagnostic support for individuals and carers.
Enhance	Enhance home-based care services enabling independence for older adults.
Increase	Increase digital inclusion support for older residents accessing online services.
Strengthen	Strengthen multidisciplinary care planning for older adults with complex needs.

Hammersmith & Fulham Best Practice Case Studies

- Dementia Friendly Community Initiative - H&F Dementia Action Alliance
- Nourish Hub - Tackling Food Insecurity and Nutrition Through a Community Kitchen
- Community Champions Programme - Empowering Residents to Improve Local Health
- School Streets Plus - Creating Safer, Healthier Streets for Children
- Better Lives - Integrated Drug and Alcohol Service

Dementia Friendly Community Initiative - H&F Dementia Action Alliance

Borough-wide alliance led by residents, council, NHS, businesses, and voluntary groups.

Over 1,100 residents trained as Dementia Friends to support people with memory loss.

Businesses display 'Dementia Friendly' symbols and train staff in empathy and awareness.

Monthly Memory Cafés and dementia-friendly physical activities like dance and cycling.

Libraries improved signage; crossings adjusted; blue stickers link to dementia info.

People with dementia and carers co-design services via regular user forums.

Dementia Friendly Community Initiative - H&F Dementia Action Alliance - Best Practice

- Achieved Alzheimer's Society recognition as a Dementia-Friendly Community in 2023.
- Strong political, NHS, and grassroots leadership drove borough-wide transformation.
- Holistic approach: awareness, service improvement, and social inclusion combined.
- Used existing community assets like sports clubs and volunteers for sustainability.
- Created practical tools like GP-issued Dementia Information Packs at diagnosis.
- Responded directly to carer feedback with peer support and information resources.

Lessons Learned

- Community engagement ensures services meet real needs and build trust.
- Cross-sector collaboration extends reach beyond health and social care.
- Simple changes like signage and staff training improve daily life navigation.
- Celebrating success reduces stigma and builds momentum for change.
- Embedding practices in mainstream services ensures long-term sustainability.
- Involving carers and people with dementia in planning increases relevance.

Evaluation Results

- Dementia diagnosis rates rose from 60% to over 70% after programme launch.
- Over 1,100 trained Dementia Friends now support community members daily.
- Memory cafés and classes attracted 50+ regular attendees across borough.
- Carers report improved confidence and reduced isolation in surveys.
- Recognition by Alzheimer’s Society validates borough-wide impact.
- Model shared with other boroughs for replication and scaling.

Nourish Hub -Tackling Food Insecurity and Nutrition Through a Community Kitchen

- Community kitchen in Shepherd’s Bush offering affordable, nutritious meals daily.
- Operates 'pay as you feel' café using surplus food and volunteer chefs.
- Hosts cooking classes, nutrition workshops, and children’s food education.
- Partners with GPs and social prescribers for dietary and food insecurity referrals.
- Creates inclusive, stigma-free environment with communal dining and events.
- Funded by H&F Council and Mayor’s Good Growth Fund; opened in 2022.

Best Practice

- Combines food aid with education to build long-term healthy eating habits.
- Reduces food waste by rescuing surplus from supermarkets and restaurants.
- Inclusive model attracts diverse users, reducing stigma of food support.
- Financially sustainable through mixed funding and volunteer support.
- Strong multi-agency collaboration with NHS, council, and local businesses.
- Adapted quickly during COVID-19 to deliver meals to shielded residents.

Lessons Learned

- Food aid and education together improve diet quality and food security.
- Dignified service model increases participation and reduces stigma.
- Social impact evaluation is vital for funding and programme credibility.
- Volunteers build ownership and sustain community engagement.
- Holistic support addresses linked issues like debt and mental health.
- Community kitchens can improve nutrition and reduce loneliness.

Evaluation Results

79% of users reported reduced financial pressure from food costs.

70% said they ate more nutritious food after attending classes.

82% of residents and 92% of volunteers met new people at Hub.

150+ completed cooking courses; some gained jobs or qualifications.

Saved 2 tonnes of food monthly from landfill through surplus use.

Model being replicated in other H&F community centres.

School Streets Plus - Creating Safer, Healthier Streets for Children

- Launched in 2024 to reduce traffic and pollution around primary schools in H&F.
- Timed road closures during school drop-off and pick-up to create safer environments.
- Implemented at three schools with retractable bollards and camera enforcement systems.
- Sidewalks widened, trees planted, and scooter parking added to improve public realm.
- Air quality and traffic monitored using real-time sensors from tech partner CitiSense.
- Community-led design with parent associations and residents consulted before launch.

School Streets Plus – Best Practice

- Addresses air quality, safety, and active travel through a single integrated intervention.
- Early results showed 90% traffic reduction and 23% drop in nitrogen dioxide levels.
- Comprehensive approach included greening, education, and community engagement.
- Data-driven design with before-and-after monitoring to assess impact and adjust.
- Improved walking rates among children from deprived areas near participating schools.
- Cross-sector collaboration between transport, health, schools, and tech partners.

School Streets Plus – Lessons Learned

- Built environment changes can rapidly improve health and safety for schoolchildren.
- Community engagement and transparent communication build support and trust.
- Cross-sector collaboration enhances design and implementation effectiveness.
- Children can be powerful advocates for behaviour change in their communities.
- Real-time monitoring enables responsive adjustments and continuous improvement.
- Pilot data supports scaling to more schools and informs broader policy decisions.

School Streets Plus - Evaluation Results

- NO_2 levels dropped by 20–23% during school hours at pilot school locations.
- Walking to school increased from 54% to 67% at Wendell Park Primary School.
- Car usage dropped from 18% to 9% among pupils after one term of implementation.
- No road collisions reported during operational hours since programme launch.
- 90% of parents now feel school routes are safe, up from 60% pre-intervention.
- 80% of nearby residents support continuing the programme after the trial phase.

Better Lives - Integrated Drug and Alcohol Service

- Integrated drug and alcohol service launched in 2018 to replace fragmented care.
- Offers detox, therapy, harm reduction, housing, employment, and mental health support.
- Multidisciplinary team includes NHS clinicians, peer mentors, and social workers.
- Drop-in café and mobile outreach unit engage hard-to-reach and homeless clients.
- Specialist services for women and young adults with tailored support pathways.
- Focus on recovery and reintegration through skills training and peer mentorship.

Better Lives – Best Practice

Integrated care model improved retention and outcomes for complex client needs.

Treatment completion rates for opiate users rose from 15% to 25% in three years.

Peer mentors with lived experience enhanced engagement and trust in services.

Co-location of services enabled immediate access to housing and employment help.

Trauma-informed care and non-judgmental approach reduced stigma and dropout.

Model cited in national best practice and replicated in other boroughs.

Better Lives - Lessons Learned

- Integrated services reduce silos and improve client retention and satisfaction.
- No wrong door approach ensures access regardless of referral source or readiness.
- Peer mentors provide credibility, hope, and support for sustained recovery.
- Addressing housing and employment is essential for long-term recovery success.
- Service user feedback led to flexible hours and women-only clinics for comfort.
- Bringing services to people (e.g., hospital inreach) reaches underserved groups.

Better Lives – Evaluation Results

Structured treatment engagement rose 22% from 2018 to 2024 across all clients.

Alcohol treatment completion increased from 35% to 50%, top quartile nationally.

Opiate completion rose from 6% to 8%, exceeding national average of 6%.

25 overdose reversals recorded using distributed naloxone kits in one year.

Needle sharing dropped from 27% to 11%, reducing infection transmission risks.

88% of clients rated care as good/excellent, up from 60% pre-integration.

Conclusion – How These Case Studies Address H&F's Public Health Needs

Dementia Friendly Community Initiative: Creates inclusive environments that reduce isolation and support healthy ageing.

Nourish Hub: Tackles food insecurity and poor nutrition, addressing core social determinants of health.

Community Champions Programme: Mobilises trusted residents to improve access, engagement, and health equity.

School Streets Plus: Reduces pollution and road danger, promoting safer active travel for children.

Better Lives Integrated Service: Provides whole-person addiction care, improving outcomes for highly vulnerable residents.

Overall Impact: These initiatives collectively strengthen prevention, reduce inequalities, and align with H&F's population health priorities.