# London Borough of Ealing: Health Needs, Inequalities and ICS Priorities

The Centre for Population Health

January 2026

# JSNA Summary (London Borough of Ealing, 2026)

This summary provides an integrated overview of Ealing'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.

# JSNA Summary: London Borough of Ealing

Population Needs, Inequalities, ICS Priorities and Local Good Practice

- Summarises key findings from Ealing's Joint Strategic Needs Assessment.
- Highlights population growth, demographic change and widening inequalities across communities.
- Outlines 10 Integrated Care System priorities based on identified local health needs.
- Includes detailed case studies demonstrating effective public health practice in Ealing.
- Concludes with alignment to ICB strategies and a final appreciation slide.

# Borough Overview

A Large, Diverse and Rapidly Growing Borough

Ealing has 367,100 residents, making it London's 3rd most populous borough.

Population increased 8.5% since 2011 and 19.5% since 2001.

Borough comprises 7 towns with distinct social, cultural and economic identities.

Strong transport links, schools and green spaces attract working-age adults.

Includes affluent neighbourhoods alongside areas experiencing deep deprivation.

Features inner-city fringes, suburban zones and industrial areas.

# Demographic Profile

Ethnic Diversity and Linguistic Complexity Across Ealing

57% of residents are from Black, Asian or Minority Ethnic backgrounds.

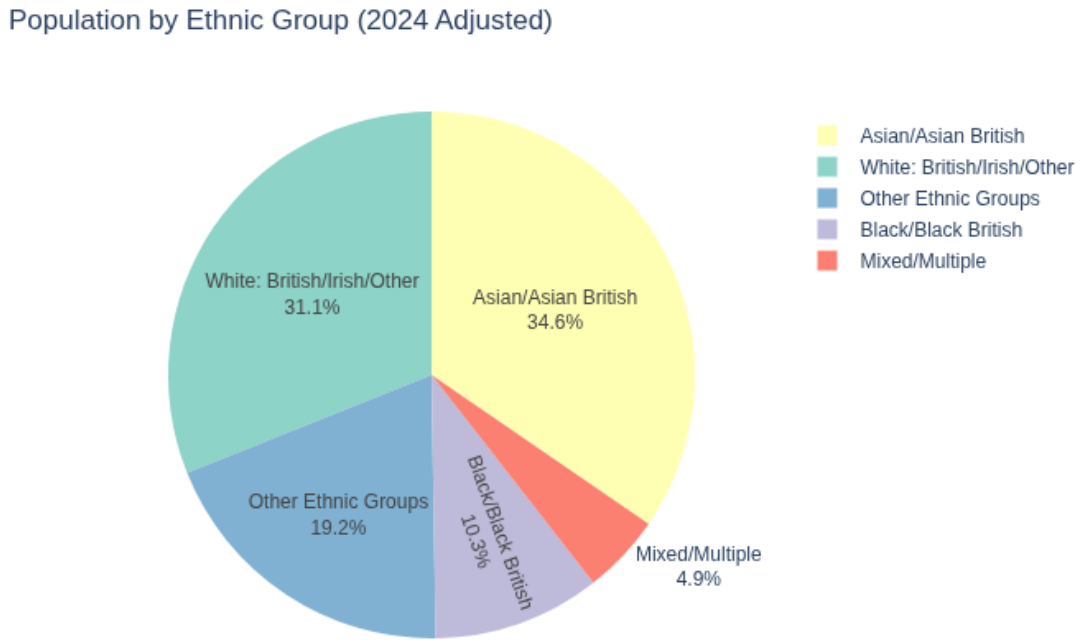
30% are Asian or Asian British, including Indian, Pakistani and Polish communities.

11% identify as Black or Black British, reflecting African and Caribbean populations.

More than 100 languages are spoken across the borough.

31% have a primary language other than English, affecting service access.

Panjabi (5%) and Polish (4%) are the most common languages after English.



# Age Structure

Young Borough with a Growing Older Population

40% of residents are aged 25–49, above England's 33% average.

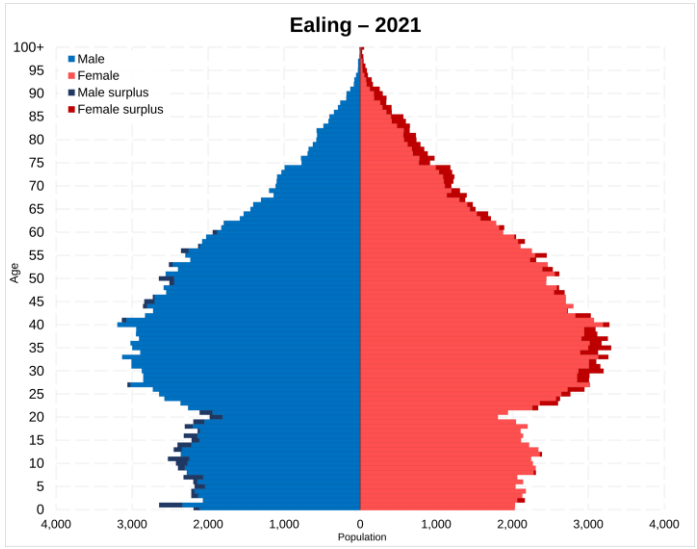
25% are aged under 19, creating significant demand for children's services.

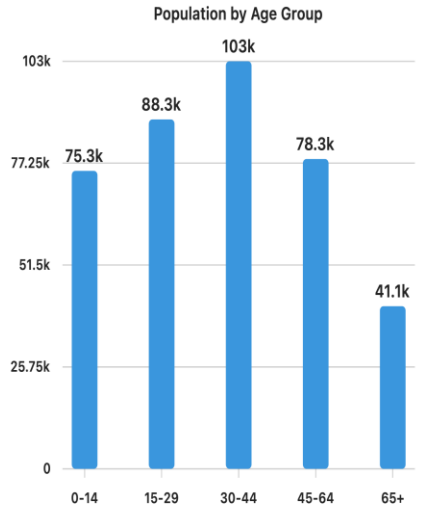
17% are aged 65+, below the national 24% figure.

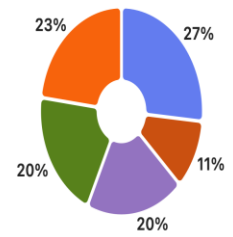
65+ population increased 23% in the past decade.

Many older adults live with multiple long-term conditions.

Healthy ageing is an emerging priority as life expectancy rises.




# Housing and Living Conditions

Housing Pressures, Overcrowding and Temporary Accommodation

More than 3,000 households live in temporary accommodation due to homelessness.

High rents and limited affordable housing make Ealing one of London's least affordable boroughs.

Overcrowding is common in Southall and Acton, affecting wellbeing.

Poor housing conditions contribute to respiratory illness and stress.

Housing instability disrupts healthcare continuity and schooling.

Addressing housing deprivation is essential for reducing inequalities.

# Health Status: Life Expectancy, Healthy Life Expectancy and Disease Burden

Life expectancy: 80.8 years (men) and 84.8 years (women), above England averages.

Healthy life expectancy is 63 years, leaving 15–20 years in poorer health.

Many long-term conditions are preventable but widespread.

Health outcomes vary sharply between affluent and deprived areas.

Preventable disease significantly reduces quality of life.

Reducing chronic illness is essential for narrowing health gaps.

# Long-Term Conditions

Diabetes affects 8% of residents, over 27,000 people.

CVD mortality under 75 is 75.5 per 100,000, above London averages.

Hypertension affects 23% of adults, with fewer than half diagnosed.

Asthma and COPD contribute to higher hospital admissions.

53% of cancers diagnosed early, but screening uptake varies.

Prevention and early detection remain essential.

# Mental Health Needs

High Prevalence of Common and Severe Mental Health Conditions

19.2% of adults experience common mental health disorders annually.

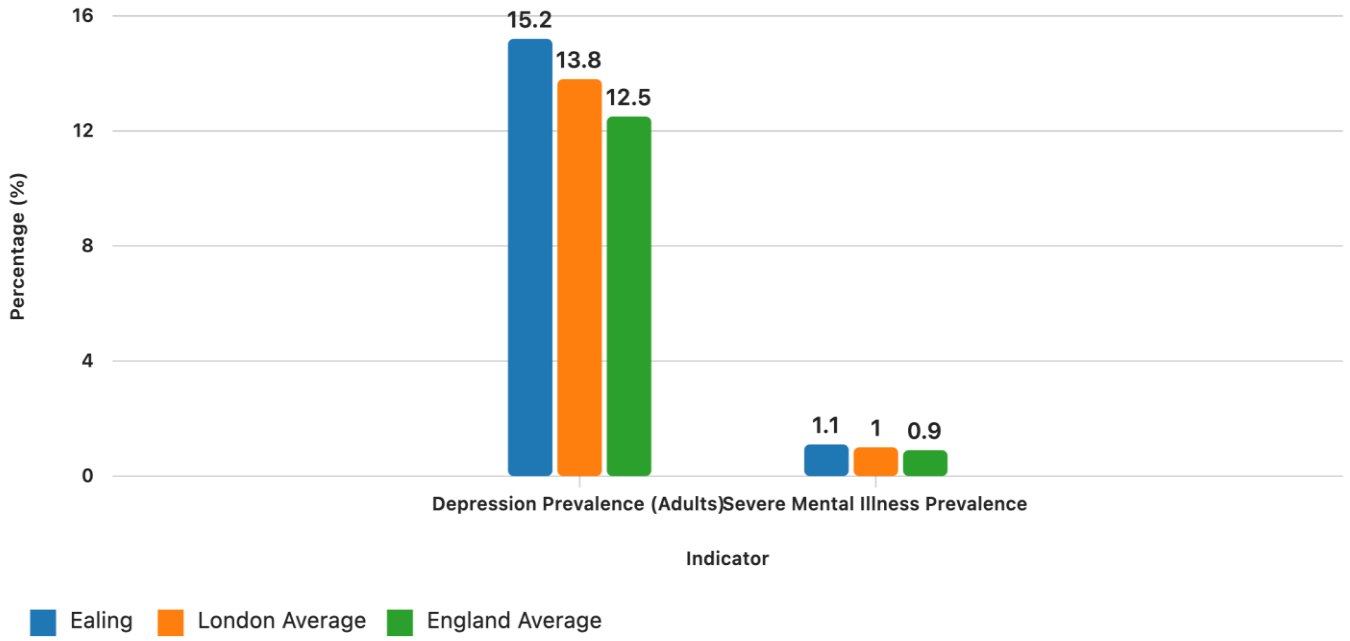
Depression prevalence is 15.2%, above London (13.8%) and England (12.5%).

Severe mental illness prevalence is 1.1%, above national levels.

Only 14% accessed IAPT in 2019 despite high need.

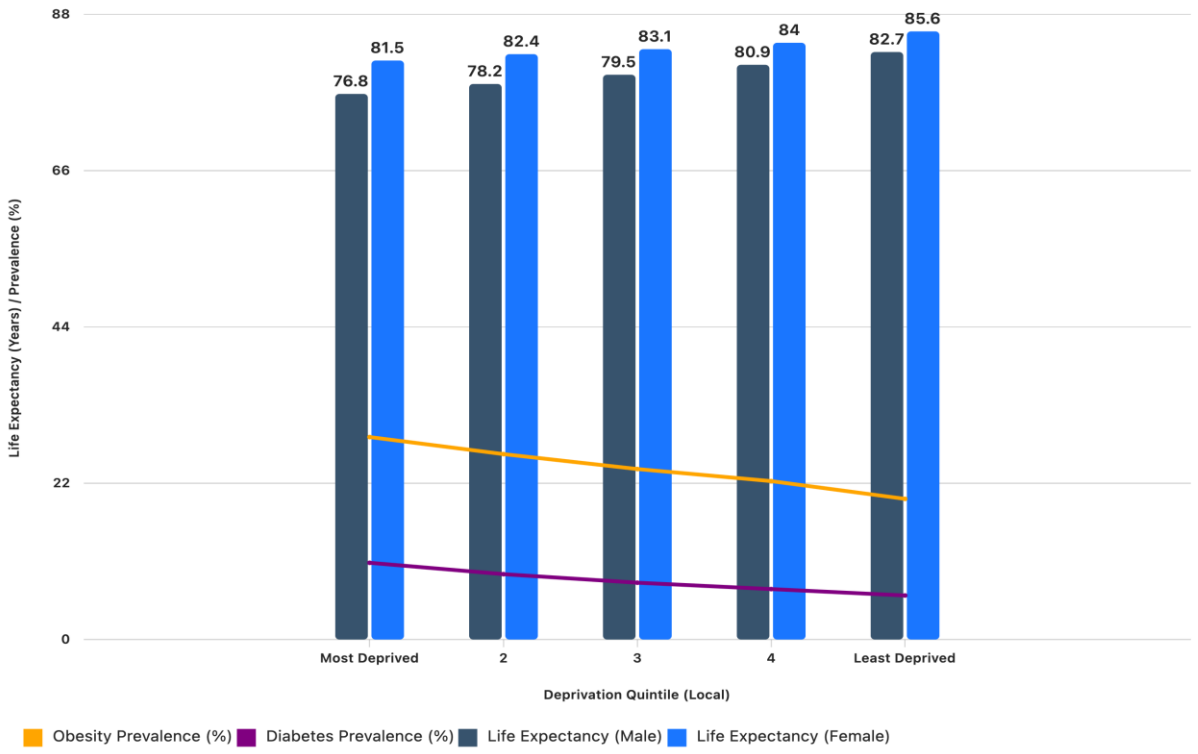
33% of young people report frequent stress symptoms.

Early intervention and culturally sensitive support are essential.



# Lifestyle Risk Factors

- Obesity, Smoking, Alcohol and Physical Inactivity Challenges
- 24.3% of Year 6 pupils are obese, above England's 20.2% average.
- 62% of adults are overweight or obese, exceeding London averages.
- Smoking prevalence is slightly above 20%, highest in England.
- Alcohol-related admissions: 650 per 100,000, above national levels.
- 80% of dependent drinkers are not in treatment.
- One-third of adults are inactive, increasing disease risk.




Selected Health Indicators by Deprivation Quintile (Ealing, 2023-2025 Averaged Data from Fingertips)

# Infectious Diseases and Immunisation

Tuberculosis, Immunisation Gaps and Infection Risks

TB rates remain higher than national averages.

MMR uptake at age 2 is around 80%, below 95% target.

Low immunisation leaves children vulnerable to outbreaks.

Hepatitis and other infections require targeted outreach.

Overcrowding increases transmission risks.

Strengthening immunisation programmes is essential.

# Health Inequalities Overview

Deep and Persistent Health Inequalities Across Ealing

Outcomes vary significantly between affluent and deprived neighbourhoods.

33% live in areas among England's most deprived 20%.

Another 33% live in least deprived 20%, showing stark contrasts.

Life expectancy gap: 5.8 years for men across deprivation levels.

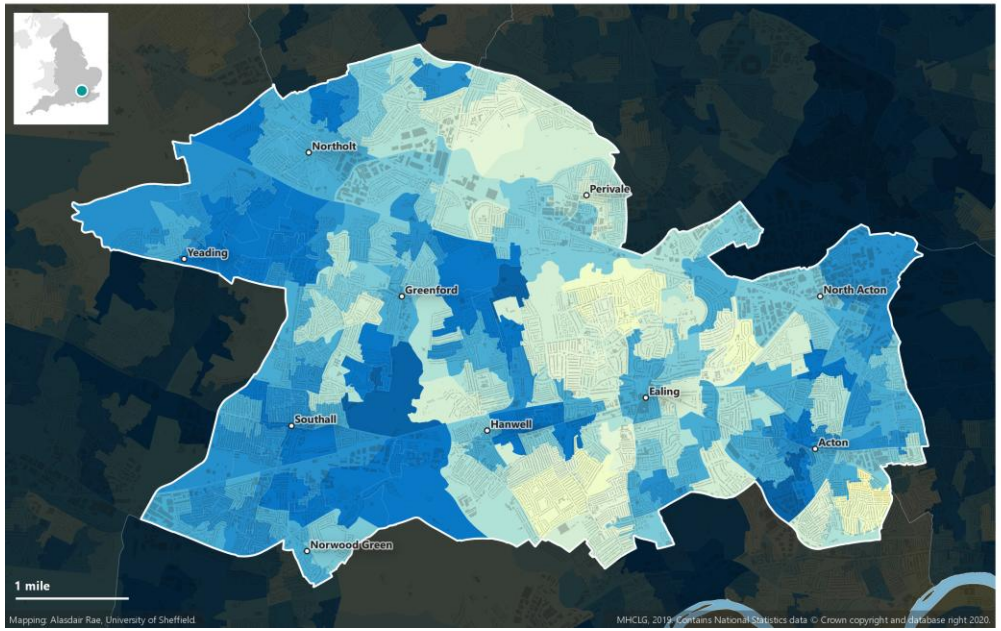
Women experience a 3.6-year life expectancy gap.

Inequalities reflect income, housing, employment and access.

## Index of Multiple Deprivation 2019

Ministry of Housing, Communities & Local Government

### EALING




### Local authority profile

% of LSOAs in each national deprivation decile

MORE DEPRIVED

| | |
|---|---|
| 1 | 2.0% |
| 2 | 14.8% |
| 3 | 14.8% |
| 4 | 18.4% |
| 5 | 11.2% |
| 6 | 15.8% |
| 7 | 11.2% |
| 8 | 5.6% |
| 9 | 5.6% |
| 10 | 0.5% |

LESS DEPRIVED

### What this map shows

This is a map of Index of Multiple Deprivation (IMD) 2019 data for **Ealing**. The colours on the map indicate the deprivation decile of each Lower Layer Super Output Area (LSOA) for England as a whole, and the coloured bars above indicate the proportion of LSOAs in each national deprivation decile. The most deprived areas (decile 1) are shown in blue. It is important to keep in mind that the data relate to small areas and do not tell us how deprived, or wealthy, individual people are. LSOAs have an average population of just under 1,700 (as of 2017).

More deprived — Less deprived

Relative level of deprivation

# IMD 2019 Overview

- Severe deprivation concentrated in Southall, Northolt and Acton.
- Several LSOAs fall within England's most deprived 10–20%.
- Deprived areas experience overcrowding, low income and poor housing.
- Affluent areas include Ealing Broadway and Hanger Hill.
- Deprivation correlates with higher diabetes and CVD.
- Clear east-west divide in socioeconomic outcomes.

# IMD 2025 Domain Insights

Barriers to Housing and Services" affects 45% of LSOAs.

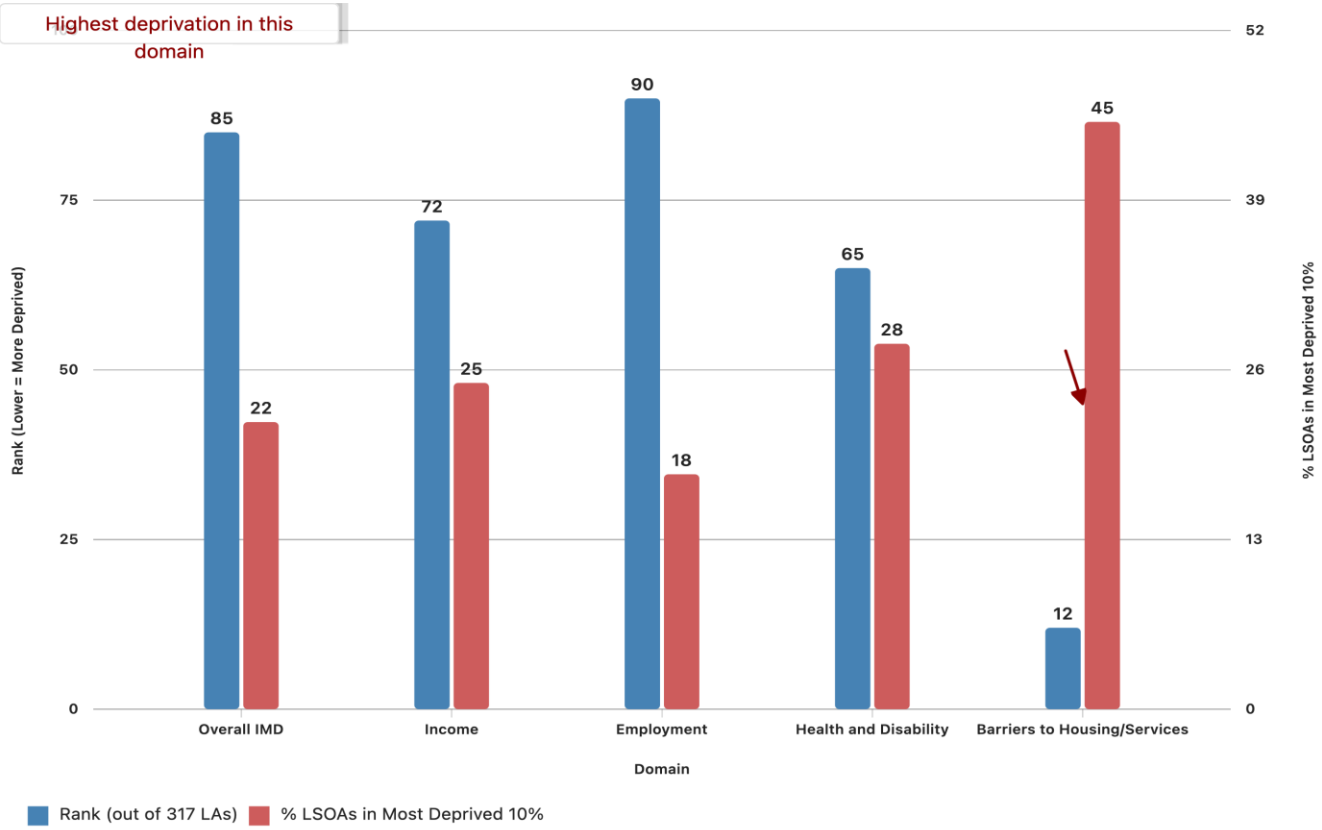
Ealing ranks 12th worst nationally for housing access.

Income, employment and health deprivation persist in Southall and Northolt.

31% of residents live in poverty after housing costs.

Child poverty affects 35% of children borough-wide.

Pensioner poverty affects 22.3% of older residents.




IMD 2025 Domain Rankings for Ealing (Selected Domains)

# Inequalities by Ethnicity and Geography

South Asian communities experience higher diabetes and heart disease rates.

Black communities face higher hypertension and lower mental health support.

Childhood obesity exceeds 30% in some Southall wards.

COVID-19 mortality higher in deprived, diverse neighbourhoods.

Some GP networks show under-diagnosis of depression.

Culturally tailored outreach is essential.

# ICS Priority 1:Tackling Obesity and Promoting Healthy Weight

Reduces obesity through improved diets, activity and supportive environments.

Uses whole-systems approaches involving schools, families and communities.

Expands weight-management services and active travel infrastructure.

Addresses fast-food density and unhealthy advertising.

Supports Healthy Schools and Let's Go Southall initiatives.

Reduces long-term risks including diabetes and CVD.

# ICS Priority 1: Why Tackling Obesity Is Essential for Ealing

24.3% of Year 6 children are obese, higher in deprived wards.

62% of adults overweight or obese, driving chronic disease.

Obesity strongly correlates with deprivation.

High rates threaten future life expectancy gains.

Reducing obesity improves child health and wellbeing.

Prevention reduces long-term healthcare demand.

# CS Priority 2: Improving Mental Health and Wellbeing

Focuses on prevention, early intervention and accessible support.

Expands community-based mental health services.

Integrates mental health into primary care pathways.

Targets young people, ethnic minorities and high-need groups.

Strengthens crisis care and talking therapies.

Supports delivery of renewed mental health strategy.

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## ICS Priority: Why Mental Health Must Be a Top Priority

19.2% of adults experience mental health disorders annually.

Depression prevalence is 15.2%, above national averages.

25% of young people show anxiety symptoms.

33% report frequent stress following pandemic impacts.

Ethnic minorities face barriers to accessing support.

Strengthening services reduces crisis presentations.

# ICS Priority 3: Reducing Alcohol and Substance Misuse Harm

Focuses on prevention, early identification and integrated treatment for alcohol and drug misuse.

Expands outreach to individuals not currently accessing treatment or support services.

Integrates addiction support into GP practices through PCN health hubs.

Strengthens harm-reduction approaches including naloxone and virus testing.

Supports community-based recovery programmes and targeted campaigns.

Works with licensing and enforcement teams to reduce alcohol-related harm.

# ICS Priority 3: Why Reducing Substance Misuse Is Critical for Ealing

Alcohol-related hospital admissions are 650 per 100,000, above national averages.

80% of dependent drinkers are not in treatment, representing major unmet need.

Substance misuse contributes to homelessness and community safety concerns.

Ealing has 300+ opiate and crack users in treatment, many more unengaged.

Dual diagnosis is common, requiring integrated pathways.

Effective intervention reduces A&E attendances and long-term harm.

# ICS Priority 4: Smoking Cessation and Tobacco Control

Aims to dramatically reduce smoking rates through strengthened cessation support.

Expands stop-smoking services with targeted outreach to high-prevalence communities.

Integrates cessation into all clinical contacts using MECC principles.

Enhances enforcement against illegal tobacco sales and underage access.

Delivers campaigns highlighting smoking harms and youth vaping risks.

Supports national Smokefree 2030 ambitions.

# ICS Priority 4: Why Smoking Cessation Is Critical for Ealing

Smoking prevalence slightly above 20%, highest of any English borough.

Tobacco use drives lung cancer, COPD, heart disease and stroke.

Rates significantly higher in deprived communities, widening inequalities.

Reducing smoking narrows life expectancy gaps.

Relaunched 2024 service achieved 100+ verified 4-week quits.

Cutting smoking reduces admissions and improves maternal health.

## ICS Priority 5: Preventing and Managing Diabetes and Cardiovascular Disease

Focuses on prevention, early detection and optimal management of diabetes and CVD.

Expands NHS Health Checks for adults aged 40–74.

Strengthens primary care management of BP, cholesterol and glucose.

Provides culturally tailored education for high-risk communities.

Improves uptake of preventive interventions and lifestyle support.

Enhances specialist input through community diabetes nurses and cardiac rehab.

# CS Priority 5: Why Diabetes and CVD Prevention Is Essential for Ealing

Diabetes affects 8% of adults, with many undiagnosed.

23% of adults have hypertension, fewer than half diagnosed.

South Asian communities face higher risks of early-onset disease.

CVD mortality under 75 is 75.5 per 100,000.

Poorly controlled diabetes leads to severe complications.

Prevention reduces admissions and long-term harm.

# ICS Priority 6: Supporting Maternal, Children's and Young People's Health

Ensures every child receives the best start through improved maternity support.

Strengthens perinatal mental health, breastfeeding and smoking cessation in pregnancy.

Improves childhood immunisation uptake, especially MMR.

Addresses child poverty through coordinated family support.

Enhances school nursing, health visiting and adolescent mental health services.

Focuses on early intervention for developmental concerns.

# ICS Priority 6: Why Maternal and Child Health Must Be Prioritised

25% of Ealing's population is aged under 19, creating high service demand.

Child poverty affects 35% of children after housing costs.

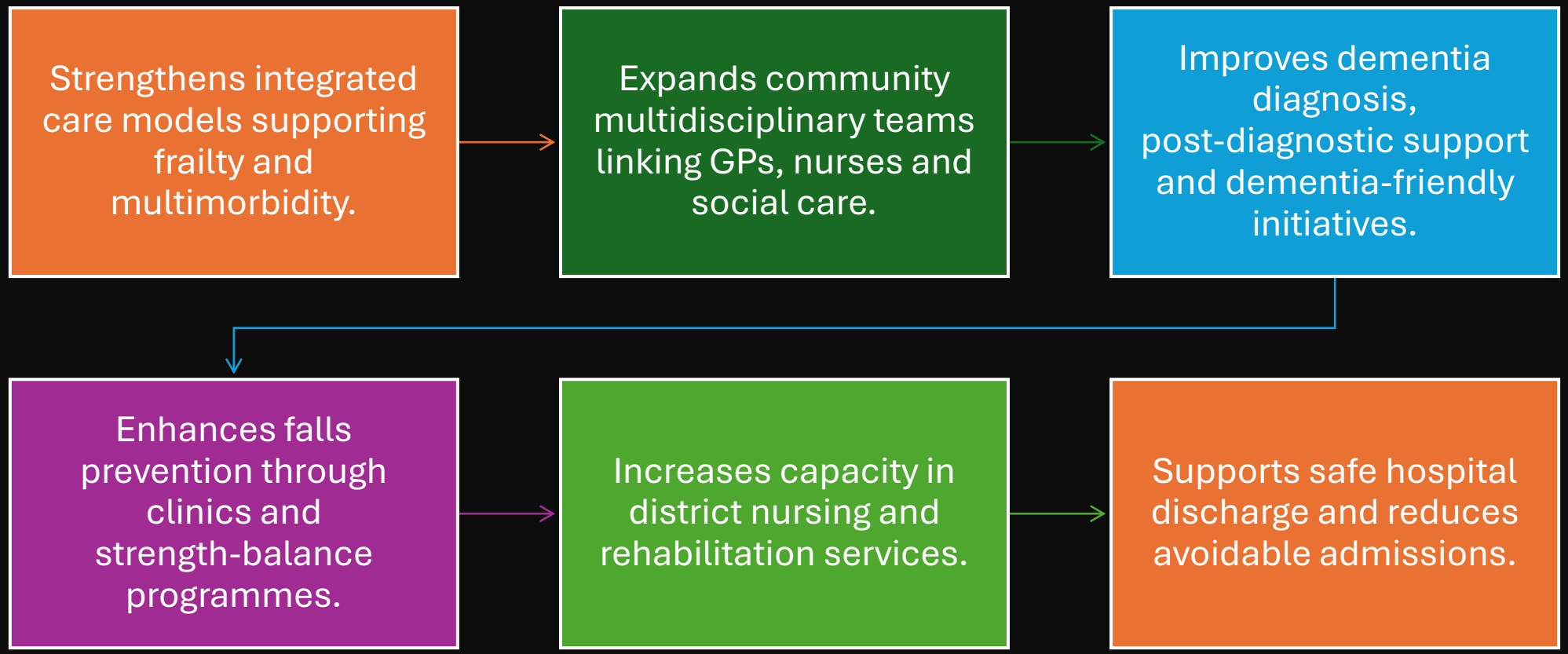
MMR uptake remains around 80–85%, below herd immunity levels.

Year 6 obesity at 24.3% increases early metabolic and emotional risks.

1 in 5 young people experience mental health difficulties.

Early intervention improves lifelong outcomes and reduces inequalities.

## ICS Priority 7: Enhancing Care for Older Adults and Ageing Well



## CS Priority 7: Why Ageing Well Is a Growing Priority for Ealing

65+ population increased 23% in the past decade.

Many older adults manage multiple long-term conditions.

Falls remain a major cause of injury and emergency admissions.

Approximately 2,200 residents have diagnosed dementia.

22.3% of older adults live in income-deprived households.

Strengthening community support improves independence and wellbeing.

## ICS Priority 8: Addressing Housing, Homelessness and Health

Tackles health impacts of homelessness, overcrowding and poor housing conditions.

Strengthens prevention and rapid rehousing through ICS-council collaboration.

Expands health support for homeless individuals via GP inclusion services.

Addresses damp, cold and unsafe housing contributing to illness.

Improves continuity of care for families in temporary accommodation.

Supports multi-agency case management for complex housing-related needs.

# ICS Priority 8: Why Housing and Health Must Be Addressed Together

- More than 3,000 households live in temporary accommodation.
- Poor housing worsens asthma, respiratory illness and mental health.
- Overcrowding increases infectious disease transmission risks.
- Homeless individuals often experience tri-morbidity and severe unmet needs.
- Housing instability disrupts immunisations and screenings.
- Improving housing conditions reduces inequalities and improves outcomes.

# ICS Priority 9: Improving Air Quality and Environmental Health

Reduces exposure to air pollution across high-risk neighbourhoods.

Addresses pollution hotspots near A40, Uxbridge Road and Heathrow.

Supports London-wide clean air and emissions reduction strategies.

Promotes active travel to reduce car dependency.

Strengthens monitoring of particulate matter and nitrogen dioxide.

Protects vulnerable groups including children and older adults.

# ICS Priority 9: Why Air Quality Must Be Addressed in Ealing

- More than 1 in 20 deaths attributable to air pollution exposure.
- Pollution contributes to respiratory disease, heart disease and early mortality.
- Children and older adults disproportionately affected by poor air quality.
- Pollution highest near major roads and deprived areas.
- Improving air quality reduces asthma and COPD admissions.
- Cleaner environments support healthier lifestyles.

# ICS Priority 10: Improving Equitable Access and Reducing Inequalities

- Ensures all communities access timely, culturally appropriate health services.
- Strengthens outreach to underserved ethnic minority and low-income groups.
- Improves screening uptake, immunisation coverage and early diagnosis.
- Expands community engagement through Champions and voluntary partners.
- Uses population health management to target interventions.
- Embeds equity across all ICS programmes.

# ICS Priority 10: Why Reducing Inequalities Is Central to Ealing's Strategy

Life expectancy differs by 5.8 years for men across deprivation levels.

Diabetes, obesity and CVD rates higher in deprived wards.

Ethnic minority communities face barriers to mental health support.

Child poverty affects 35% of children borough-wide.

Housing instability worsens health outcomes for thousands.

Reducing inequalities strengthens community resilience.

# Alignment with North West London ICB Priorities

Prevention priorities support ICB goals on proactive population health.

Obesity, smoking and diabetes priorities align with ICB prevention commitments.

Mental health priority supports ICB community and crisis transformation.

Older adult priority aligns with ICB Ageing Well and UCR programmes.

Housing priority supports ICB inclusion health and complex needs work.

Air quality priority aligns with ICB environmental sustainability aims.

# Alignment with London and National Public Health Strategies

Priorities align with NHS Long Term Plan prevention commitments.

Smoking priority supports Smokefree 2030 and tobacco treatment expansion.

Child health priority aligns with Best Start in Life and London strategies.

Diabetes priority supports NDPP and national CVD ambitions.

Air quality priority aligns with UK Clean Air Strategy.

Inequalities priority reflects Marmot principles on wider determinants.

# Local Public Health Good Practice Examples in Ealing

Let's Go Southall: community-led physical activity movement improving health in deprived areas.

PCN Health Hubs: integrated addiction support delivered within GP practices.

Community Champions: resident-led health messaging improving trust and engagement.

Homeless Health Outreach: targeted clinical support for rough sleepers and hostel residents.

Healthy Schools and Early Years: borough-wide programme improving child health and wellbeing.

Each example demonstrates scalable, effective approaches aligned with ICS priorities.

## Example 1: Let's Go Southall – Community-Led Physical Activity Movement

Community-driven programme tackling inactivity in Southall's diverse, deprived neighbourhoods.

Developed through Sport England's Local Delivery Pilot.

Trains local residents as "activators" to design and lead activity sessions.

Offers walking groups, cycling clubs, women-only swimming, dance classes and family events.

Uses parks, community centres, temples and streets for accessible delivery.

Removes barriers through free sessions and culturally tailored activities.

Builds community ownership by empowering residents.

Targets inactive groups including women, older adults and people with long-term conditions.

# Let’s Go Southall – Success Factors, Evaluation and Public Health Lessons

Increased physical activity levels by an estimated 8 percentage points.

Engaged more than 5,000 residents, many previously inactive.

Trained over 120 volunteers, creating sustainable community capacity.

Delivered strong cultural tailoring through bilingual and women-only sessions.

Evaluation shows improved mental wellbeing and social connection.

Successfully engaged South Asian women.

Recognised nationally as a model for community-led health improvement.

Aligns with ICS priorities on obesity, inequalities and empowerment.

## Example 2: PCN Health Hubs – Integrated Substance Misuse Support

- Primary-care-based model integrating alcohol and drug treatment into GP practices.
- Operates across Southall, Acton and Northolt.
- Provides addiction prescribing, harm-reduction supplies and mental health screening.
- Uses multidisciplinary teams including GPs, nurses and keyworkers.
- Offers open access and self-referral, reducing stigma.
- Supports dual-diagnosis patients through collaboration with mental health teams.
- Conducts proactive outreach to frequent A&E attenders.
- Designed to reach underserved groups including women and South Asian communities.

# PCN Health Hubs – Success Factors, Evaluation and Public Health Lessons

- Engaged more than 350 patients in the first year.
- Achieved DNA rates below 15%.
- Delivered 60% reduction in AUDIT scores among alcohol-dependent patients.
- Supported 45 opioid users to stabilise through OST.
- Demonstrated improved liver function among high-risk drinkers.
- Reduced alcohol-related A&E attendances by 20% year-on-year.
- Increased engagement among South Asian men and women.
- Aligns with ICS priorities on substance misuse and inequalities.

## Example 3: Ealing Community Champions – Resident-Led Health Engagement

- Volunteer programme training residents as trusted public health messengers.
- Includes 89 Champions representing diverse ages, ethnicities and languages.
- Provides training on health literacy and communication.
- Champions share accurate health information using culturally relevant approaches.
- Supports campaigns on vaccination, screening, mental health and activity.
- Champions gather community concerns and feed insights back to public health teams.
- Enables co-produced projects such as mother-and-baby groups.
- Strengthens trust between communities and the health system.

## Community Champions – Success Factors, Evaluation and Public Health Lessons

- Built trust by using respected community members.
- Delivered multilingual outreach across 20+ languages.
- Provided rapid myth-busting during COVID-19.
- Enabled targeted outreach for screening and immunisations.
- Generated valuable community insight for service redesign.
- Supported peer-led groups addressing isolation.
- Demonstrated strong engagement of migrant communities.
- Aligns with ICS priorities on inequalities and prevention.

## Example 4: Homeless Health Outreach – Inclusion Health in Ealing

- Provides targeted clinical support for rough sleepers and hostel residents.
- Delivered through GP inclusion health services and outreach teams.
- Offers primary care, vaccinations, mental health support and substance misuse interventions.
- Works closely with Rough Sleeper Team and local charities.
- Provides podiatry, optometry and dentistry through drop-in clinics.
- Supports individuals with tri-morbidity.
- Ensures continuity of care for people frequently moving between accommodations.
- Addresses barriers including documentation issues and mistrust.

# Homeless Health Outreach – Success Factors, Evaluation and Lessons

- Improved access to primary care for disconnected individuals.
- Delivered essential vaccinations and screenings.
- Strengthened multi-agency case management.
- Reduced emergency hospital use through proactive support.
- Demonstrated value of bringing healthcare directly to residents.
- Supported stabilisation of chronic conditions.
- Addressed severe health inequalities.
- Aligns with ICS priorities on housing and inclusion health.

# Example 5: Healthy Schools and Early Years – Improving Child Health

- Borough-wide programme supporting schools to promote healthy eating and activity.
- Implements Healthy Schools London framework.
- Encourages daily physical activity including Daily Mile.
- Supports improved school meals and nutrition education.
- Provides oral health promotion in early years settings.
- Works with families on healthy routines.
- Supports emotional wellbeing through school-based mental health initiatives.
- Targets inequalities by focusing on deprived neighbourhoods.

## Healthy Schools and Early Years – Success Factors, Evaluation and Lessons

- Improved child nutrition and physical activity.
- Supported reduction of dental decay.
- Strengthened school engagement with families.
- Enhanced emotional wellbeing through school-based support.
- Demonstrated strong impact in deprived wards.
- Reinforced whole-systems approach linking schools and families.
- Provided scalable model for borough-wide improvement.
- Aligns with ICS priorities on obesity and child health.

## Bringing It All Together – Priorities and Local Action

- Ten ICS priorities address obesity, mental health, substance misuse and long-term conditions.
- Housing, air quality and inequalities priorities reflect wider determinants.
- Local good-practice examples demonstrate effective, scalable community-led models.
- Programmes show strong engagement of deprived and diverse communities.
- Integrated care approaches strengthen prevention and early intervention.
- Alignment with ICB and national strategies ensures coherence.
- Evidence highlights importance of culturally tailored approaches.
- Combined priorities and practices create strong foundations for improved health.

# Conclusion

- This work reflects collaboration across health, care and community partners.
- Insights support shared action to reduce inequalities and improve wellbeing.
- Local examples demonstrate what is possible through partnership and innovation.
- ICS will continue working with residents to deliver meaningful improvements.
- We welcome continued engagement as we shape Ealing's future health system.

# Thank You