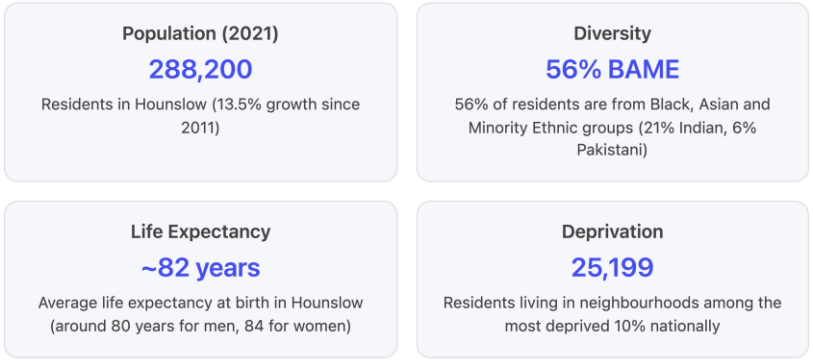
JSNA Summary (London Borough of Hounslow, 2026)

This summary provides an integrated overview of Hounslow'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.

Population Overview

- Hounslow's population has grown to 288,200 residents, placing sustained pressure on local health and care services.
- The borough has a younger age profile than England, increasing demand for maternity, education and family services.
- Life expectancy is similar to national averages but varies sharply between affluent and deprived neighbourhoods.
- Poorer health outcomes and long-term conditions are concentrated in areas experiencing persistent socio-economic disadvantage.
- Rapid population churn and international migration create continually shifting service needs and engagement challenges.
- Cultural and linguistic diversity requires flexible, accessible and culturally competent approaches across all services.

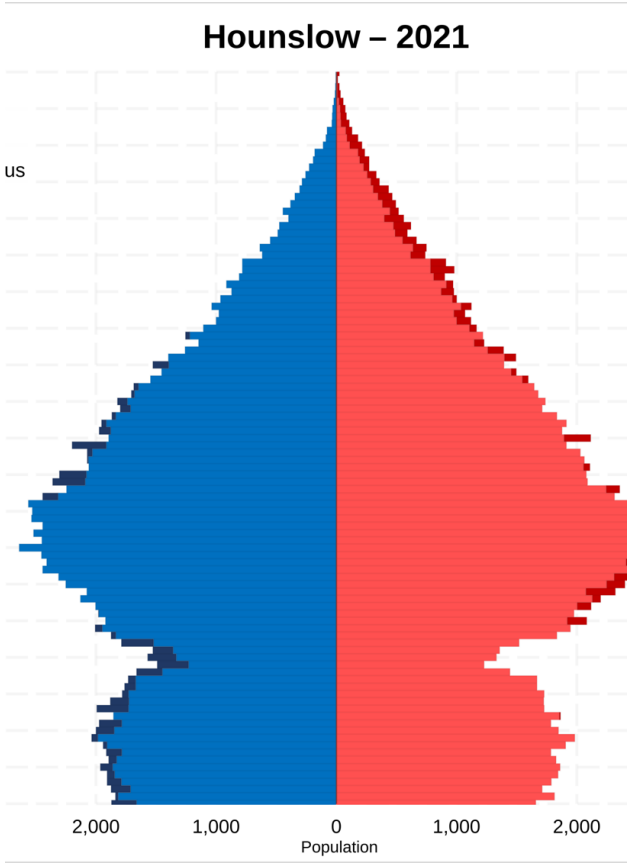


Geography and Communities

- Hounslow spans affluent eastern areas and more deprived western neighbourhoods, creating highly varied local health needs.
- The borough contains some of England's least deprived wards alongside areas within the most deprived 10 percent.
- Eastern communities benefit from higher incomes and amenities, while western areas face overcrowding and unemployment.
- Heathrow Airport shapes local employment, environmental exposure and health risks, particularly in nearby communities.
- High mobility and migration contribute to dynamic population patterns and complex service planning requirements.
- Levels of community cohesion differ across neighbourhoods, influencing resilience, engagement and health outcomes.

Population Growth and Age Profile

- Hounslow's population increased by more than 34,000 people in a decade, intensifying demand for core services.
- The borough's younger age structure means higher need for prevention, early intervention and family-focused support.
- Strong growth among adults aged 35–49 reflects Hounslow's appeal to young working families.
- Declining numbers of younger adults suggest affordability pressures and movement to cheaper areas outside London.
- The growing older population will increase future demand for frailty, social care and long-term condition management.
- Age patterns vary significantly between wards, requiring tailored planning for schools, primary care and community services.



Ethnic and Cultural Diversity

Hounslow is one of London's most diverse boroughs, with only 44 percent of residents identifying as White.

Large South Asian communities, particularly Indian and Pakistani groups, shape cultural norms and health needs.

Nearly half of residents were born outside the UK, contributing to varied health behaviours and service expectations.

More than 150 languages are spoken locally, requiring accessible communication and multilingual engagement approaches.

Cultural diversity influences disease patterns, including higher diabetes and cardiovascular risk in South Asian groups.

Effective engagement requires trust-building, cultural sensitivity and tailored outreach to underrepresented communities.

Socio-Economic Profile

- Hounslow contains areas of significant affluence alongside neighbourhoods facing persistent deprivation and poor health outcomes.
- Income inequality is substantial, with some wards experiencing high child poverty and reliance on Universal Credit.
- The borough's reliance on aviation and hospitality made it highly vulnerable to COVID-19 economic impacts.
- Overcrowding, insecure housing and homelessness remain major challenges affecting health and wellbeing.
- Air pollution from Heathrow and major roads contributes to respiratory illness and wider health inequalities.
- Fuel poverty affects many households, increasing risks of cold-related illness and excess winter mortality.
- Deprivation is strongly linked to higher chronic disease rates and lower uptake of screening and prevention services.

General Health Status

Around 5.4% of residents report “bad” or “very bad” health, matching both London and England averages

Life expectancy is 79.1 years for men and 83.1 years for women, with an upward trend since 2021

Inequalities remain stark, with a 10.5-year male and 8.3-year female life expectancy gap across wards

Hounslow ranks 146th of 331 districts on a composite health index, indicating mid-range national health

Residents in deprived neighbourhoods experience earlier onset of chronic illness and shorter healthy lives

Disability and long-term conditions are concentrated in high-deprivation areas, driving poorer outcomes

Chronic Disease Burden

- Over 60% of adults are overweight or obese, the 4th highest adult obesity rate in London
- Childhood obesity affects 21% of Reception children and 38% of Year 6 pupils, among the highest in London
- More than 25,000 residents live with diabetes, with 90% having Type 2, and 31,000 more at high risk
- Cardiovascular disease mortality under 75 is 74.3 per 100,000, with persistent inequalities across wards
- Thousands of residents have undiagnosed hypertension, significantly increasing preventable CVD events
- Smoking prevalence is 13.4% overall but 19.5% in routine/manual workers, strongly linked to deprivation

Infectious Diseases and Health Protection

- COVID-19 vaccination uptake reached around 70% for two doses, but significantly lower in some communities
- Flu vaccination uptake is below England averages, with deprived practices 10–15 points lower than affluent ones
- Tuberculosis incidence is around 20 per 100,000, among the highest in London due to population profile
- Health protection teams provide in-situ support in asylum seeker hotels, including catch-up vaccinations
- Routine immunisation recovery remains a priority following pandemic disruption across multiple programmes
- Air pollution and overcrowded housing contribute to respiratory infections, requiring targeted prevention

Mental Health and Wellbeing

One in five adults experience common mental health disorders weekly, similar to London averages

Under-18 mental health admission rates exceed England averages, especially in deprived neighbourhoods

Over 1,600 asylum seekers in hotels face trauma-related mental health needs requiring targeted support

Depression and anxiety are more frequently recorded in deprived communities, reflecting socioeconomic stress

Social isolation affects older adults and disabled residents, with 6.8% of the population reporting disability

Suicide rates average 10.9 per 100,000, with emergency self-harm admissions at 117 per 100,000

Child and Maternal Health

Infant mortality is 3.3 per 1,000 births, close to national averages but with variation across wards

MMR vaccination coverage at age 2 is around 83%, below the 95% target but similar to London norms

Dental decay affects 36% of five-year-olds, the 5th highest rate in London, linked to diet and access barriers

Breastfeeding continuation at 6–8 weeks is around 50%, with lower rates among younger disadvantaged mothers

Childhood asthma admissions are high, driven by air pollution and poor housing conditions in some areas

School readiness varies, with only around 70% achieving a good level of development in deprived wards

Health Inequalities Overview

Life expectancy varies dramatically, with a 10.5-year gap for men and 8.3-year gap for women between the most and least deprived areas

Under-75 mortality from all causes is 329.4 per 100,000, improving overall but significantly higher in deprived neighbourhoods

Chronic conditions such as diabetes, COPD, hypertension and depression cluster heavily in the borough's Core20 areas

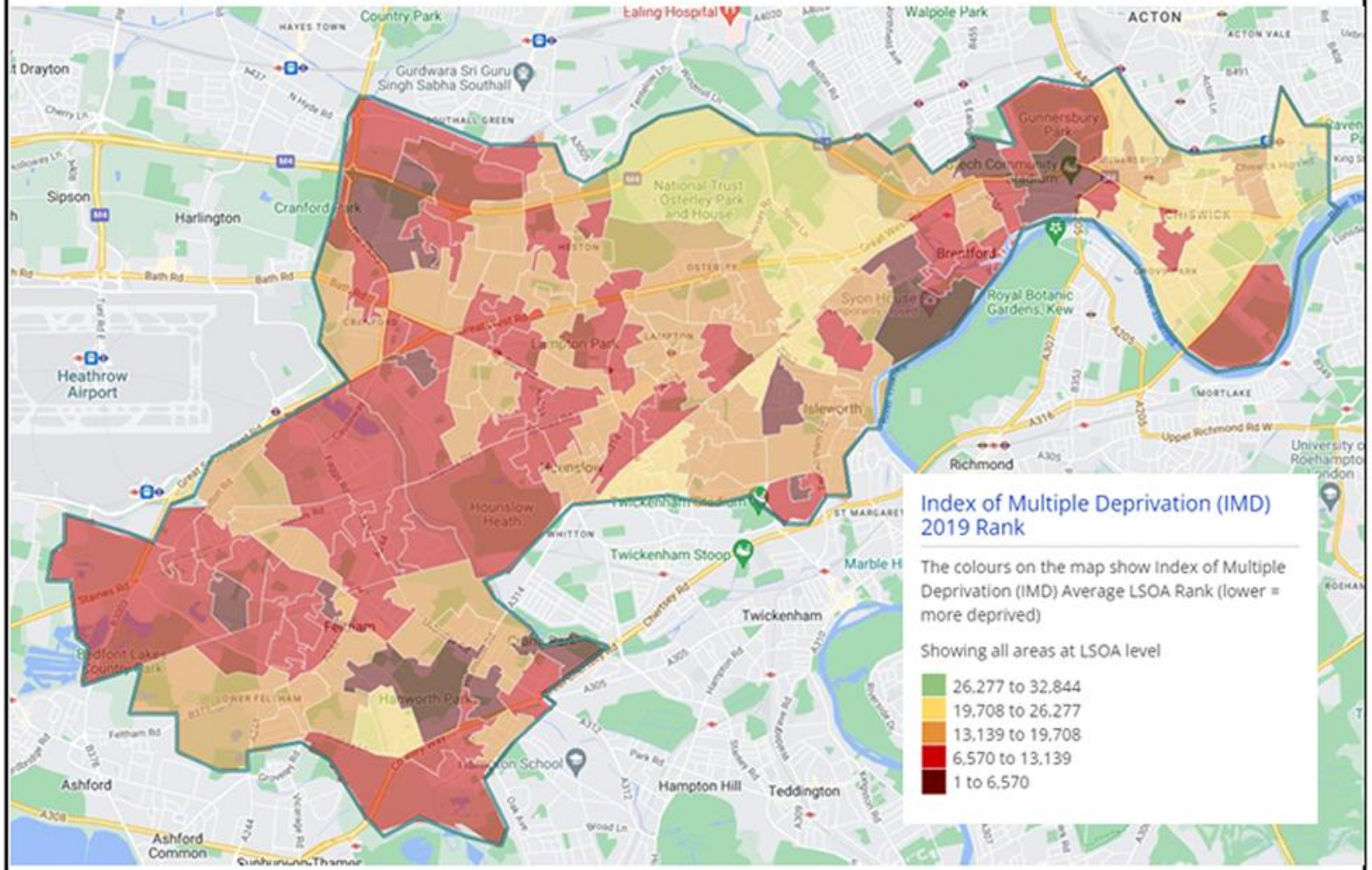
Preventive service uptake is lower in deprived wards, including breast and bowel screening coverage well below borough averages

Environmental risks such as air pollution, overcrowded housing and limited green space disproportionately affect low-income communities

COVID-19 impacts were concentrated in areas with overcrowding and higher BAME populations, widening pre-existing inequalities

IMD 2025 Overview

Index of Multiple Deprivation (IMD) 2019 Rank across LSOA neighbourhoods in Hounslow



Source: Ministry of Housing Communities and Local Government (MHCLG)

IMD 2025 Overview

Hounslow shows moderate overall deprivation, but with pockets of severe deprivation concentrated in central and western neighbourhoods

Only 2% of Lower Super Output Areas fall into the most deprived 10% nationally, but these areas contain around 25,199 residents

Income deprivation affects 22.1% of children under 16, with the highest rates in Feltham, Heston and Hounslow Central

Employment deprivation remains high in aviation-dependent communities following Heathrow-related economic shocks

Fuel poverty affects an estimated 14% of households, particularly those in older, less energy-efficient housing

Deprivation patterns have remained persistent since IMD 2019, indicating long-standing structural challenges

IMD 2025 Key Insights

Income deprivation exceeds 30% in the most affected neighbourhoods, with many families relying on Universal Credit

Child poverty stands at 35% after housing costs, significantly above the London average of 26%

Education and skills deprivation persists in areas with high proportions of adults with low or no qualifications

Housing deprivation includes overcrowding affecting 16% of households and insecure tenancies in lower-income areas

Living environment deprivation is driven by air pollution from Heathrow and major roads, and by poor housing conditions

Deprived areas show overlapping disadvantage across income, employment, health, education and environment domains

Priority 1: Tackling Health Inequalities

Health inequalities in Hounslow reflect deep differences in outcomes linked to deprivation, ethnicity and geography.

Targeted interventions include community outreach, improved primary care access and stronger partnerships addressing social determinants.

The CORE20PLUS5 framework guides focus on deprived populations and vulnerable groups with highest clinical risks.

Key areas include maternity, severe mental illness, respiratory disease, early cancer diagnosis and hypertension management.

Inequalities drive avoidable mortality, increased service pressure and persistent intergenerational disadvantage across communities.

Deprived areas experience higher smoking rates, limited green space access and lower engagement with preventive services.

Priority 1: Tackling Health Inequalities (Why It Matters)

Over 25,199 residents live in highly deprived areas, experiencing significantly worse health outcomes and risks.

Life expectancy varies dramatically, with over ten-year gaps between most and least deprived neighbourhoods.

Under-75 mortality remains higher in deprived areas, despite overall borough improvements in recent years.

Ethnic disparities persist, including elevated diabetes and cardiovascular risks among South Asian communities.

Deprivation clusters in western wards, influenced by housing, employment, pollution and environmental exposures.

Alignment: Strongly aligned with ICS priorities, CORE20PLUS5, and national Health Inequalities Strategy 2025–2028.

Priority 2: Promoting Healthy Weight and Active Lifestyles

This priority reduces obesity through integrated nutrition, physical activity, healthy food environments and community-based support.

Key actions include promoting healthy diets, restricting unhealthy food marketing and expanding weight-management services.

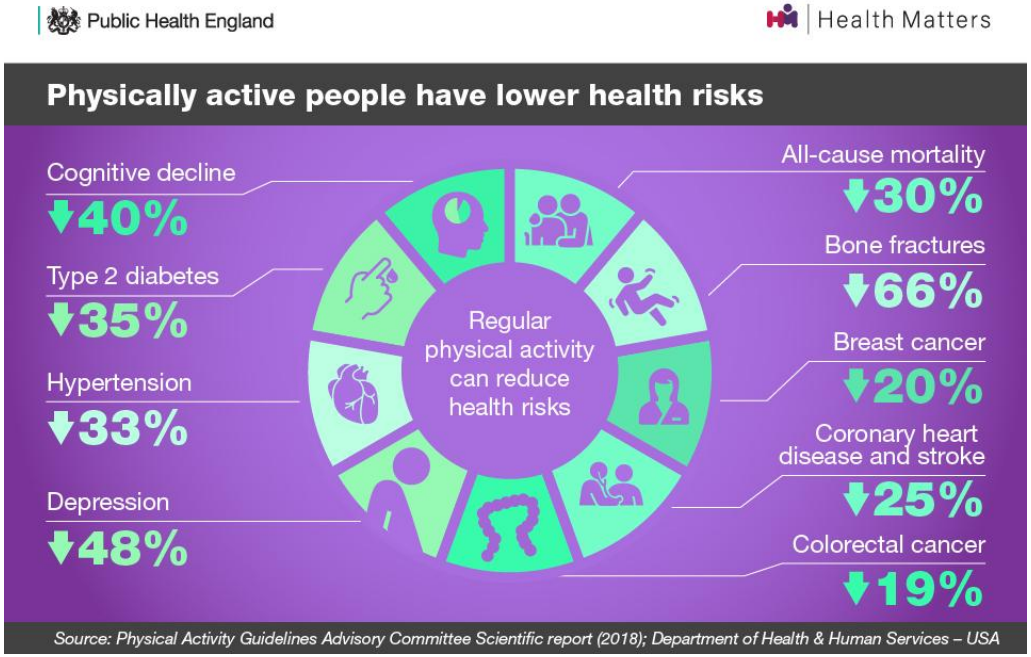
Schools, primary care and community programmes collaborate to encourage healthier eating and regular physical activity.

Healthy Hounslow and the borough's Healthier Food Advertising Policy are central to delivering this priority.

Community dietitians, fitness coaches and local campaigns support residents to adopt sustainable healthy lifestyle changes.

Programmes emphasise culturally appropriate dietary advice tailored to Hounslow's diverse communities and cuisines.

Benefits of physical activity in reducing health risks



Priority 2: Promoting Healthy Weight and Active Lifestyles (Why It Matters)

Over 60 percent of adults are overweight or obese, increasing risks of diabetes and cardiovascular disease.

Childhood obesity is high, with nearly forty percent of Year 6 pupils above a healthy weight.

Deprived neighbourhoods face greater barriers, including limited green space and high availability of unhealthy foods.

Low physical activity levels contribute to chronic disease, poor wellbeing and reduced quality of life.

Early intervention prevents lifelong illness and reduces future demand on health and care services.

Alignment: Supports NHS Long Term Plan, Childhood Obesity Plan, Sport England strategy and NWL ICB prevention goals.

Priority 3: Preventing and Managing CVD and Diabetes

This priority strengthens prevention, early detection and management of cardiovascular disease and diabetes across Hounslow.

NHS Health Checks identify high blood pressure, high cholesterol and pre-diabetes among adults aged forty to seventy-four.

Community outreach screens high-risk groups, including South Asian communities, for hypertension and diabetes.

Primary care teams intensify management of hypertension, atrial fibrillation, cholesterol and established diabetes.

Lifestyle interventions, including NDPP referrals, support residents at risk of developing Type 2 diabetes.

Integrated care teams provide structured education, medication optimisation and rehabilitation for affected residents.

Priority 3: Preventing and Managing CVD and Diabetes (Why It Matters)

Over 25,000 residents live with diabetes, with numbers rising by around 1,500 each year.

More than 31,000 residents have pre-diabetes, creating substantial future risk without early intervention.

Uncontrolled hypertension and diabetes drive heart attacks, strokes, kidney failure and premature mortality.

Cardiovascular risk is concentrated in deprived areas and communities with high South Asian populations.

Improving detection and management prevents avoidable deaths and reduces long-term healthcare pressures.

Alignment: Fully aligned with NHS Long Term Plan, Core20PLUS5 hypertension focus and NWL ICB prevention framework.

Priority 4: Improving Mental Health and Well-being

This priority expands prevention, early intervention and community-based mental health support across all life stages.

Integrated primary care mental health teams and wellbeing hubs provide accessible local support for residents.

Children and young people benefit from strengthened counselling, CAMHS capacity and school-based mental health programmes.

Outreach focuses on underserved groups, including perinatal women and culturally diverse communities.

Suicide prevention, trauma-informed practice and crisis support form essential components of this priority.

Strong partnerships between NHS, council and voluntary sector underpin holistic mental health provision.

Priority 4: Improving Mental Health and Well-being (Why It Matters)

One in five adults experiences common mental health disorders, with rising post-pandemic complexity.

Children face increasing anxiety, self-harm and behavioural issues, reflected in higher hospital admission rates.

People with serious mental illness experience major physical health inequalities and reduced life expectancy.

Economic pressures, social isolation and trauma contribute significantly to local mental health needs.

Early support prevents crises, improves wellbeing and reduces pressure on emergency and acute services.

Alignment: Supports NHS Long Term Plan, Community Mental Health Framework and Core20PLUS5 SMI priorities.

Priority 5: Early Detection and Treatment of Cancer

- This priority improves cancer outcomes through earlier diagnosis, faster pathways and high-quality treatment access.
- Screening uptake is boosted through targeted outreach, reminders and culturally appropriate engagement approaches.
- Public awareness campaigns encourage earlier help-seeking for symptoms such as lumps, bleeding or persistent coughs.
- Diagnostic capacity expands through community diagnostic hubs offering scans and tests closer to home.
- Fast-track GP referrals and streamlined pathways reduce delays in suspected cancer diagnosis.
- Targeted Lung Health Checks and HPV screening strengthen early detection for high-risk groups.

Priority 5: Early Detection and Treatment of Cancer (Why It Matters)

Cancer is Hounslow's leading cause of death, with many cases diagnosed at late stages.

Screening coverage remains below national targets, particularly in deprived and ethnically diverse communities.

Late diagnosis leads to more invasive treatment, poorer survival and greater emotional and economic burden.

Early detection significantly improves survival, especially for breast, bowel and cervical cancers.

Community-focused engagement is essential to address cultural, linguistic and access barriers to screening.

Alignment: Supports NHS early diagnosis target, NWL Cancer Alliance priorities and Hounslow's Health and Wellbeing Strategy.

Priority 6: Respiratory Health and Cleaner Air

This priority strengthens prevention and management of asthma, COPD and tuberculosis across the borough.

High vaccination uptake for flu and COVID reduces respiratory infections among vulnerable groups.

Smoking cessation services are expanded to reduce COPD risk and improve long-term respiratory health.

Proactive asthma and COPD care includes regular reviews, self-management plans and pulmonary rehabilitation.

Air quality improvements involve pollution monitoring, traffic reduction and active travel promotion.

Housing interventions address damp and mould, reducing respiratory triggers in vulnerable households.

Priority 6: Respiratory Health and Cleaner Air (Why It Matters)

Childhood asthma prevalence and hospital admissions remain high, especially in pollution-exposed neighbourhoods.

COPD and asthma cause avoidable deaths each year, often linked to smoking and late diagnosis.

Air pollution contributes to over five percent of local deaths, among the highest rates nationally.

Major roads and Heathrow Airport create persistent environmental health pressures for nearby communities.

TB incidence remains above national averages, requiring strong screening and early treatment pathways.

Alignment: Reflects Core20PLUS5 respiratory focus, NHS Long Term Plan and national clean air and TB strategies.

Priority 7: Supporting Maternal, Child and Family Health

This priority strengthens maternity care, perinatal mental health support and reduces pregnancy risks like smoking.

It boosts uptake of antenatal and newborn screening, ensuring early identification of health concerns in infants.

Health visiting and early years services provide developmental checks, parenting support and targeted help for vulnerable families.

Childhood immunisation efforts intensify, improving uptake of routine vaccines and increasing MMR coverage toward herd immunity.

Programmes improve childhood nutrition and oral health through healthy food initiatives and supervised toothbrushing schemes.

School health services address healthy weight, emotional wellbeing and routine vision and hearing screening for pupils.

Safeguarding systems identify and support children at risk of adverse experiences or developmental harm.

Priority 7: Supporting Maternal, Child and Family Health (Why It Matters)

- Hounslow records around 4,500 births annually, requiring strong maternity, early years and family support systems.
- Low birth weight affects 3.4 percent of babies, slightly above England averages, indicating persistent health inequalities.
- Breastfeeding initiation is high, but sustained breastfeeding drops significantly by six to eight weeks postpartum.
- Childhood obesity, dental decay and low immunisation coverage highlight urgent need for early preventive action.
- Maternal mental health issues affect up to fifteen percent of mothers, impacting bonding and child development.
- Alignment: Supports Best Start in Life, Healthy Child Programme, LMNS priorities and Core20PLUS5 maternity objectives.

Priority 8: Vaccination and Health Protection

- This priority improves uptake of childhood, adolescent and adult vaccines through targeted outreach and accessible clinics.
- It strengthens COVID-19 booster delivery, flu vaccination and HPV immunisation for eligible groups across the borough.
- Health protection includes rapid response to outbreaks, including measles, TB, foodborne illness and emerging infections.
- Infection prevention measures in care homes and healthcare settings reduce transmission among vulnerable populations.
- Public communication campaigns address vaccine misinformation and build trust within diverse community groups.
- Point-of-care testing and surveillance systems support early detection and containment of infectious disease threats.

Priority 8: Vaccination and Health Protection (Why It Matters)

- COVID-19 caused over 600 local deaths, highlighting the importance of strong vaccination programmes.
- Flu vaccination uptake remains below national ambitions, increasing winter pressures and avoidable hospitalisations.
- MMR coverage is below herd immunity thresholds, leaving children vulnerable to preventable measles outbreaks.
- Hounslow's diverse, mobile population increases risk of imported infections and rapid disease transmission.
- Strong outbreak response protects NHS capacity and prevents avoidable illness, disability and premature mortality.
- Alignment: Supports NHS Immunisation Strategy, UKHSA health protection goals and NWL ICB vaccination improvement plans.

Priority 9: Healthy Ageing and Care for Older People

This priority expands falls prevention through community exercise classes, home safety checks and balance training programmes.

Dementia diagnosis and support improve through timely assessments, carer support and dementia-friendly community initiatives.

Integrated frailty teams deliver comprehensive geriatric assessments and coordinated care across health and social services.

Enhanced Health in Care Homes provides regular clinical input, reducing avoidable hospital admissions for residents.

End-of-life care improves through advance care planning and support for preferred place of death.

Social connectivity programmes reduce loneliness through befriending, volunteering and community participation opportunities.

Priority 9: Healthy Ageing and Care for Older People (Why It Matters)

- Over 28,000 residents are aged sixty-five or older, with numbers rising as the population ages.
- Falls cause hundreds of emergency admissions annually, often leading to disability, loss of independence or death.
- Dementia affects around 1,800 residents, with many more likely undiagnosed and missing essential support.
- Older adults account for high A&E attendance and unplanned admissions, often for preventable conditions.
- Many residents prefer home-based care, requiring strong community services and rapid crisis response.
- Alignment: Supports NHS Ageing Well, Enhanced Health in Care Homes and ICS frailty and dementia priorities.

Priority 10: Reducing Smoking, Alcohol and Substance Misuse

Smoking cessation services provide behavioural support, nicotine replacement and free vape kits through Healthy Hounslow.

Targeted outreach focuses on deprived areas, high-risk occupations and communities with elevated smoking prevalence.

Alcohol interventions include brief advice in primary care, specialist treatment and hospital in-reach for dependent drinkers.

Drug services offer opiate substitution therapy, needle exchange, recovery support and diversion from criminal justice pathways.

Prevention programmes educate young people on risks of smoking, alcohol and drug misuse in schools and communities.

Public campaigns promote smoke-free environments, alcohol awareness and harm reduction across neighbourhoods.

Priority 10: Reducing Smoking, Alcohol and Substance Misuse (Why It Matters)

Smoking prevalence is 13.4 percent, higher than England and London averages, driving major health inequalities.

Smoking causes around 250 deaths annually, contributing to cancer, COPD, heart disease and premature mortality.

Alcohol misuse leads to around two thousand hospital admissions each year, affecting families and community safety.

Drug misuse contributes to preventable deaths, infections and exploitation, requiring strong outreach and treatment pathways.

Reducing these risks improves life expectancy, wellbeing and reduces long-term NHS and social care costs.

Alignment: Supports NHS Long Term Plan, national Drug Strategy and tobacco and alcohol harm-reduction frameworks.

Priority 11: Reducing Smoking, Alcohol and Substance Misuse

Smoking cessation programmes provide behavioural support, nicotine replacement and free vape kits through Healthy Hounslow services.

Targeted outreach focuses on deprived communities, routine and manual workers and residents with long-term health conditions.

Alcohol interventions include brief advice in primary care, specialist treatment pathways and hospital in-reach for dependent drinkers.

Drug services deliver opiate substitution therapy, needle exchange, recovery support and diversion programmes with criminal justice partners.

Prevention initiatives educate young people on smoking, alcohol and drug harms through schools and community engagement.

Public campaigns promote smoke-free environments, alcohol awareness and harm-reduction approaches across neighbourhoods.

Priority 11: Reducing Smoking, Alcohol and Substance Misuse (Why It Matters)

Smoking prevalence is 13.4 percent, above national averages, driving major inequalities and preventable chronic disease.

Smoking causes around 250 deaths annually, contributing to cancer, COPD, cardiovascular disease and premature mortality.

Alcohol misuse results in approximately 2000 hospital admissions each year, affecting families and community safety.

Drug misuse contributes to preventable deaths, infections and exploitation, requiring strong outreach and treatment engagement.

Reducing these behaviours improves life expectancy, wellbeing and reduces long-term NHS and social care pressures.

Alignment: Supports NHS Long Term Plan, national Drug Strategy and tobacco and alcohol harm-reduction frameworks.

Mapping of Hounslow's priorities

Priority	Aligned ICB/National Strategy
Healthy Weight (Obesity)	NWL Prevention Plan; Childhood Obesity Strategy; London Mayor's Healthier Food Ad Policy.
CVD & Diabetes	Core20PLUS5 (Hypertension); NHS Long Term Plan CVD prevention; NDPP expansion.
Mental Health	NWL Mental Health Strategy; NHS Long Term Plan MH ambitions (24/7 crisis, community MH teams); Suicide Prevention.
Cancer Early Diagnosis	75% early stage by 2028; NWL Cancer Alliance programmes; National Screening uptake targets.
Respiratory Health	Core20PLUS5 (COPD & flu vax); Clean Air Strategy; NHS Greener Plan (air pollution reduction synergy).
Maternal & Child Health	LMS Better Births; 50% stillbirth reduction; Healthy Child Programme; Start for Life funding uses.
Vaccination & Protection	NHS immunisation goals (MMR 95%, Flu 75%); UKHSA Infectious Disease plans; ICS EPRR (Preparedness) duties.
Healthy Ageing	Ageing Well (2-hour crisis response; EHCH in care homes); Dementia Strategy; Falls prevention consensus.
Smoking, Alcohol, Drugs	Tobacco Control Plan 2030; NHS Alcohol Care Teams; National Drug Strategy outcomes; Core20 (smoking in SMI).
Wider Determinants	ICS Population Health & Inequalities Strategy; Marmot Review recommendations; Levelling Up health mission.

Alignment of Priorities with ICB

Priorities 1–6 align strongly with Core20PLUS5, addressing inequalities, maternity, SMI, respiratory disease and hypertension.

Tackling inequalities supports national Health Inequalities Strategy and ICS commitments to reduce outcome variation.

Healthy weight and active lifestyles align with NHS Long Term Plan obesity goals and Childhood Obesity Programme.

CVD and diabetes prevention reflects NHS ambitions for improved detection, risk management and reduced premature mortality.

Mental health improvements support Community Mental Health Framework and parity-of-esteem commitments across the ICS.

Early cancer detection aligns with NHS 75 percent early-stage diagnosis target and NWL Cancer Alliance priorities.

Respiratory health supports Core20PLUS5 respiratory focus, clean air strategies and national TB control objectives.

Alignment of Priorities with ICB

- Start Well priorities align with Best Start in Life, Healthy Child Programme and NWL Local Maternity System objectives.
- Vaccination and health protection support NHS Immunisation Strategy, UKHSA outbreak control and ICS prevention frameworks.
- Healthy ageing aligns with NHS Ageing Well, Enhanced Health in Care Homes and ICS frailty transformation programmes.
- Smoking, alcohol and substance misuse priorities support national Tobacco Control Plan and Drug Strategy implementation.
- All priorities collectively support ICS life-course model, prevention agenda and Levelling Up healthy life expectancy goals.
- The full priority set strengthens integrated care, reduces inequalities and aligns with national and regional health strategies.

Reducing Chronic Disease

- Cardiovascular disease, diabetes and respiratory illness remain leading causes of premature mortality in Hounslow
- Adult overweight and obesity prevalence exceeds 60%, contributing to rising long-term condition burdens
- Diabetes affects over 25,000 residents, with South Asian communities experiencing significantly higher risk
- Thousands of residents have undiagnosed hypertension, increasing risk of heart attacks and strokes
- Lifestyle risk factors such as smoking, inactivity and poor diet are strongly patterned by deprivation
- Reducing chronic disease is essential to improving healthy life expectancy and narrowing inequalities

Key Priority Actions

Expand	Expand NHS Health Checks and targeted hypertension detection in high-risk communities and Core20 areas
Strengthen	Strengthen diabetes prevention programmes, particularly for South Asian and deprived populations
Improve	Improve long-term condition management pathways across primary care, including digital and community-based support
Promote	Promote healthy eating and physical activity through schools, workplaces and community partnerships
Increase	Increase smoking cessation outreach in deprived neighbourhoods and among routine/manual workers
Use	Use population health management data to identify and support residents at highest risk of complications

Priority 2: Improving Mental Health and Wellbeing

Around one in five adults experience common mental health disorders weekly, reflecting significant borough-wide need

Under-18 mental health admission rates exceed England averages, with the highest rates in deprived neighbourhoods

Over 1,600 asylum seekers housed in local hotels present complex trauma-related mental health needs

Depression and anxiety are more frequently recorded in deprived communities, linked to economic stress and poor housing

Social isolation affects older adults and disabled residents, with 6.8% of the population reporting disability

Suicide rates average 10.9 per 100,000, with emergency self-harm admissions at 117 per 100,000

Priority 2 Actions

Expand	Expand early intervention and community-based mental health support, particularly in high-need neighbourhoods
Strengthen	Strengthen mental health pathways for children and young people, including crisis support and school-based services
Provide	Provide trauma-informed support for asylum seekers, refugees and newly arrived migrant communities
Increase	Increase social connection programmes for older adults, disabled residents and isolated groups
Improve	Improve access to culturally appropriate mental health services for diverse communities across the borough
Integrate	Integrate mental health into primary care and community hubs to improve early identification and support

Priority 3: Giving Children the Best Start

Infant mortality is 3.3 per 1,000 births, close to national averages but with variation across wards

Childhood obesity remains high, with 21% of Reception children and 38% of Year 6 pupils overweight or obese

Dental decay affects 36% of five-year-olds, the 5th highest rate in London, linked to diet and access barriers

MMR vaccination coverage at age 2 is around 83%, below the 95% target and requiring targeted improvement

School readiness varies significantly, with only around 70% achieving a good level of development in deprived wards

Childhood asthma admissions are elevated, driven by air pollution and poor housing conditions

Priority 3 Actions

Strengthen	Strengthen early years support, including health visiting, parenting programmes and targeted outreach
Improve	Improve childhood immunisation uptake through community engagement and culturally tailored approaches
Expand	Expand oral health programmes, including supervised toothbrushing and targeted dental access initiatives
Reduce	Reduce childhood obesity through whole-system approaches involving schools, families and local environments
Enhance	Enhance early identification of developmental needs, including speech and language support post-pandemic
Improve	Improve air quality and housing conditions to reduce asthma and respiratory illness in children

Priority 4: Tackling Infectious Diseases

COVID-19 vaccination uptake reached around 70% for two doses, but uptake varies significantly by community

Flu vaccination rates remain below England averages, with deprived practices 10–15 points lower than affluent ones

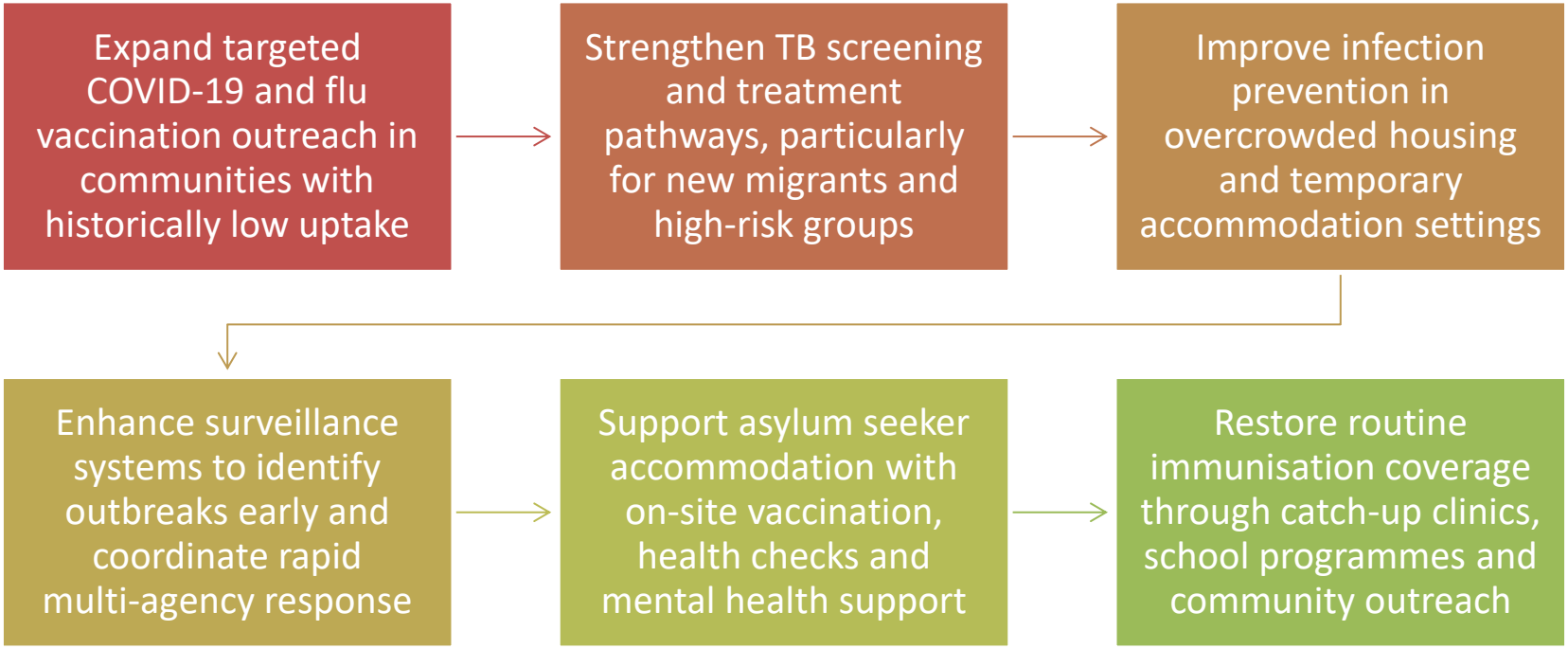
Tuberculosis incidence is around 20 per 100,000, among the highest in London due to population profile

Asylum seeker accommodation requires ongoing health protection support, including catch-up vaccinations

Routine immunisation recovery is a priority following pandemic disruption across multiple programmes

Air pollution, overcrowding and mobility patterns contribute to respiratory infections and health protection risks

Priority 4 Actions: Tackling Infectious Diseases



Improving Healthy Environments

Air pollution remains a major health risk, particularly around Heathrow and major road corridors

Overcrowded housing affects 16% of households, contributing to respiratory illness and poor wellbeing

Fuel poverty affects an estimated 14% of households, increasing risks of cold-related illness and excess winter deaths

Access to green space varies significantly, with deprived areas having fewer high-quality outdoor environments

Noise pollution from aviation disproportionately affects communities in the west of the borough

Poor housing quality, damp and mould contribute to asthma, COPD and other long-term conditions

Priority Actions

Expand	• Expand air quality improvement initiatives, including monitoring, community alerts and pollution-reduction schemes
Improve	• Improve housing conditions through enforcement, landlord engagement and targeted home improvement programmes
Reduce	• Reduce fuel poverty through insulation, energy-efficiency upgrades and targeted support for vulnerable households
Increase	• Increase access to green spaces through investment in parks, active travel routes and community-led projects
Work	• Work with Heathrow and transport partners to mitigate noise and environmental impacts on local communities
Embed	• Embed healthy urban planning principles into regeneration, housing and transport developments

Strengthening Prevention and Early Intervention

Preventable conditions such as diabetes, hypertension and obesity remain major drivers of poor health outcomes

Screening uptake for breast, bowel and cervical cancer is significantly lower in deprived communities

Smoking prevalence is 13.4% overall but nearly 20% in routine and manual workers

Physical activity levels are 67.4% overall but lower in deprived groups and some ethnic communities

Alcohol-related admissions are rising, reaching 504 per 100,000 in 2023/24

Early intervention is essential to reduce long-term health and social care demand across the borough

Actions

Increase	Increase uptake of NHS Health Checks and targeted screening in high-risk and underserved communities
Expand	Expand smoking cessation services, with tailored outreach for routine/manual workers and deprived areas
Promote	Promote physical activity through community programmes, active travel schemes and workplace initiatives
Strengthen	Strengthen alcohol harm reduction through brief interventions, community outreach and targeted support
Improve	Improve early detection of long-term conditions using population health management and proactive case-finding
Embed	Embed prevention across all services, ensuring every contact counts for lifestyle and wellbeing support

Supporting Vulnerable and High-Need Groups

Asylum seekers (over 1,600 locally) require coordinated support for health, trauma, immunisation and basic needs

Disabled residents (6.8% of the population) experience higher rates of isolation, poor housing and long-term conditions

Older adults in deprived areas have higher rates of frailty, falls and emergency hospital admissions

People experiencing homelessness face significant barriers to healthcare, with higher rates of mental illness and chronic disease

Vulnerable families face compounded challenges including poverty, overcrowding, food insecurity and limited access to services

Priority Actions

Sstrengthen multi-agency support for asylum seekers, including health checks, vaccinations and trauma-informed care

Expand targeted support for disabled residents, including accessible services and community-based wellbeing programmes

Improve outreach and case-finding for older adults at risk of frailty, falls and social isolation

Enhance homelessness health services, including mobile clinics, mental health support and continuity of care

Provide integrated support for vulnerable families through early help, financial advice and community partnerships

Use population health data to identify high-need groups and coordinate proactive, personalised interventions

Strengthening the Health and Care System

Demand for health and care services continues to rise due to population growth, long-term conditions and inequalities

Primary care faces pressure from high levels of chronic disease, complex needs and workforce challenges

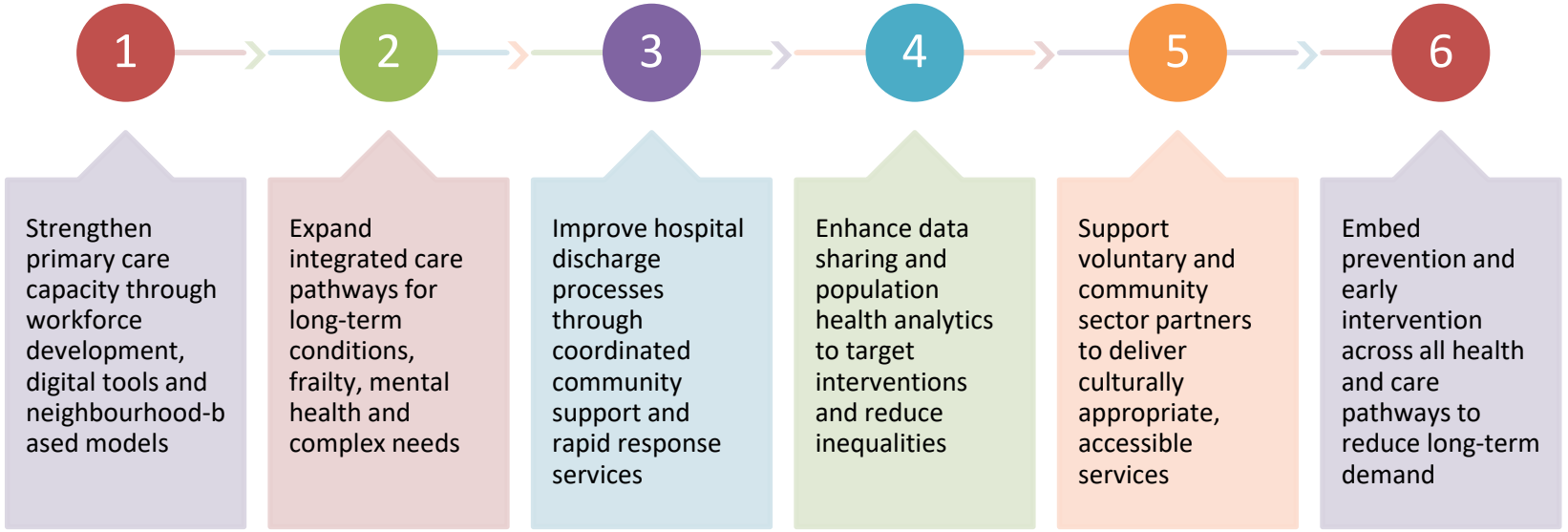
Hospital activity remains high, with emergency admissions driven by chronic illness, frailty and respiratory conditions

Mental health services face increasing demand, particularly for children, young people and deprived communities

Integration across NHS, council and voluntary sector partners is essential to address complex, multi-factorial needs

Digital tools and population health management offer opportunities to improve prevention and targeted care

Priority Actions



Cross-Cutting Themes

- Inequalities must be addressed across all priorities through proportionate universalism and targeted action
- Community engagement is essential to ensure services reflect the needs, cultures and experiences of residents
- Workforce development is critical, including recruitment, retention and culturally competent practice
- Digital inclusion must be prioritised to ensure all residents can access online health and wellbeing services
- Partnership working across NHS, council, VCS and communities is vital for sustainable impact
- Prevention, early intervention and healthy environments underpin improvements across the whole system

Example 1: Healthy Hounslow - Integrated Lifestyle Support Service

Healthy Hounslow brings together smoking cessation, weight management, physical activity support and NHS Health Checks into one integrated lifestyle service that is easier for residents to access.

The service assigns each resident a dedicated Healthy Lifestyle Coach who provides personalised, culturally competent support across multiple behaviour-change needs.

Delivery is coordinated through a partnership including MoreLife, Lampton Leisure, BeeZee Bodies and Hounslow and Richmond Community Healthcare NHS Trust, ensuring specialist expertise across all lifestyle areas.

Strong community outreach and branding increase visibility and trust, with more than sixty percent of residents self-referring through GP surgeries, pharmacies, community events and faith settings.

Digital tools such as remote coaching, video sessions, text reminders and multilingual support reduce barriers for working adults, parents and residents with language needs.

The integrated model reflects the reality that unhealthy behaviours often cluster together, allowing residents to address smoking, diet and physical activity in a coordinated and supportive way.

Success Factors, Stakeholders, Lessons, and Impact

The service succeeds because it combines multi-partner collaboration, culturally tailored coaching, strong branding, digital access and rigorous monitoring to support sustained behaviour change.

Stakeholders including Public Health, GPs, Primary Care Networks, leisure services, community leaders and service users co-designed pathways that reflect local needs and build trust across diverse communities.

A key public health lesson is that integrating lifestyle services increases uptake, reduces stigma and enables residents to address multiple risk factors simultaneously rather than through fragmented programmes.

The model aligns with Integrated Care System priorities on obesity, smoking, diabetes and prevention by providing a scalable, community-centred approach to behaviour-change support.

Early evaluation shows strong outcomes including a sixty-five percent four-week quit rate, clinically significant weight loss for nearly half of participants and seventy-two percent of inactive adults becoming moderately active.

The service demonstrates strong reach and equity impact, with fifty-eight percent of users from Black, Asian and Minority Ethnic backgrounds and forty-eight percent from the most deprived areas of the borough.

Example 2: Healthier Food Advertising Policy

Hounslow introduced a borough-wide restriction on advertising high-fat, salt and sugar foods across all council-controlled advertising sites to reshape the local food environment.

The policy is the first in the United Kingdom to restrict commercial baby food advertising that does not meet healthy nutritional standards, addressing misleading marketing targeted at infants.

Development of the policy involved expert collaboration with Sustain and First Steps Nutrition Trust to ensure robust nutritional criteria and legal defensibility.

A public consultation with more than one thousand residents demonstrated strong support and helped refine definitions, strengthen legitimacy and build community ownership.

The policy includes a clear enforcement mechanism in which Public Health reviews all advertising submissions and removes non-compliant adverts quickly and consistently.

Implementation required cross-departmental coordination and negotiation with advertising contractors to mitigate financial impacts and maintain revenue stability for the council.

Success Factors, Stakeholders, Lessons, and Impact

The policy succeeded because of strong political leadership, expert partnerships, public consultation and a clear enforcement process that ensured consistent application.

Stakeholders including residents, advertisers, Sustain, First Steps Nutrition, council departments and NHS partners contributed to shaping the policy and supporting its implementation.

Upstream interventions addressing commercial determinants of health require boldness, persistence and evidence but can shift norms and reduce harmful exposures.

The policy aligns with Integrated Care System priorities on obesity, diabetes and health inequalities by reducing environmental drivers of unhealthy diet, particularly in deprived areas.

Early evaluation shows a ninety-four percent reduction in high-fat, salt and sugar advertising on council sites, rising public support and early behavioural signals from schools and young people.

The policy has influenced other boroughs to adopt similar measures, demonstrating how local innovation can drive wider regional and national policy change.

Example 3: Stay Steady and Active

Stay Steady and Active reframes falls prevention as enjoyable, social and empowering, reducing stigma and encouraging participation among older adults.

The programme integrates exercise classes, health checks, vision screening, medication reviews and home-safety advice into a single community-based offer.

Events have attracted more than three hundred older residents, demonstrating significant unmet demand for accessible, non-clinical prevention activities.

Co-production with older adults led to practical innovations such as the Slipper Exchange, which addresses real-world hazards identified by the community.

Delivery involves strong partnership working across the Integrated Care System including leisure services, community physiotherapists, frailty nurses, Age UK and the London Fire Brigade.

Local venues, free transport options and culturally sensitive promotion ensure accessibility for isolated, frail or mobility-limited older adults.

Success Factors, Stakeholders, Lessons, Impact

The programme succeeded because it combines enjoyable events, integrated clinical and social support, co-production and sustained follow-on classes to create a comprehensive prevention pathway.

Stakeholders including Public Health, Lampton Leisure, NHS community teams, Age UK, pharmacists and the Fire Brigade collaborate to deliver a seamless, multi-agency model.

Bringing prevention into community venues increases uptake, reduces isolation and identifies hidden risks such as vision issues or medication side effects.

Aligns with Integrated Care System priorities on frailty, ageing well, falls prevention and community-based care by reducing pressure on primary and acute services.

Early impact includes high attendance, strong engagement and early identification of health risks that contribute to preventing falls and improving wellbeing.

The programme improves equity by providing transport support, local venues and culturally sensitive promotion that enable participation from isolated and deprived older residents.

Example 4: Hounslow Health Outreach Team – Roving Care for the Hard-to-Reach

- The Health Outreach Team is a multidisciplinary mobile service that brings healthcare, vaccinations, health checks and social support directly to residents who face significant barriers accessing traditional services, including people who are homeless, asylum seekers, traveller communities and residents of deprived estates.
- The team operates a mobile clinic that sets up pop-up health stations across the borough, enabling residents to receive vaccinations, wound care, blood pressure checks, blood sugar tests and rapid referrals without needing GP registration or formal appointments.
- The outreach model is built on a person-centred, no-wrong-door approach that allows individuals to receive medical care, harm-reduction supplies, mental health support and housing assistance in a single encounter, reducing the risk of people falling through service gaps.
- The team proactively engages vulnerable groups by visiting rough sleepers early in the morning, attending asylum seeker hotels, and positioning themselves in community settings such as faith centres, markets and traveller sites to maximise accessibility.
- The service removes traditional barriers to care by offering flexible hours, informal engagement, multilingual support and a trauma-informed approach that builds trust with individuals who may have experienced stigma, trauma or negative interactions with authorities.
- The outreach model has significantly increased engagement with underserved groups, improving vaccination uptake, identifying undiagnosed conditions and connecting hundreds of residents to GP practices, social care and housing support.

Success Factors, Stakeholders, Lessons, and Impact

- The service succeeds because it is delivered by a dedicated, multi-skilled team that combines clinical expertise, social care knowledge, trauma-informed practice and cultural competence to address health and social needs simultaneously.
- Strong partnerships with community organisations, faith groups, homelessness charities, refugee support groups and traveller community leaders enable the team to build trust, identify need early and deliver warm handovers into wider services.
- Proactive, relationship-based outreach is essential for engaging groups traditionally labelled “hard to reach,” demonstrating that services must adapt to residents rather than expecting residents to adapt to services.
- The model aligns with Integrated Care System priorities on deprivation, inclusion health, vaccination, chronic disease prevention and early identification by reaching groups with the poorest access and highest unmet need.
- Evaluation shows substantial impact, including more than 14,000 engagements, hundreds of vaccinations, dozens of new diagnoses of hypertension and diabetes, multiple TB cases identified, and significant reductions in A&E attendance among intensively supported individuals.
- The service demonstrates that trust, continuity and low-barrier access are critical for improving health outcomes among marginalised populations, offering a replicable model for reducing inequalities across the ICS.

Example 5: Integrated Domestic Abuse Outreach – Health and Safety Together

- The Integrated Domestic and Sexual Violence Outreach Service provides survivor-centred, trauma-informed support that reaches individuals at risk of or experiencing domestic or sexual abuse through proactive engagement in community and healthcare settings.
- The service uses dedicated outreach advocates who act as a single point of contact for survivors, coordinating safety planning, legal support, housing assistance, mental health referrals and health follow-up in a seamless, integrated manner.
- Advocates are co-located in key settings such as A&E, maternity services, GP practices, police units and housing offices, enabling immediate intervention when abuse is disclosed or suspected and preventing survivors from being lost between agencies.
- The team reflects the borough's cultural and linguistic diversity, enabling survivors from communities where abuse is often hidden to disclose safely and receive support in their preferred language without stigma or fear of community repercussions.
- The service provides comprehensive, wraparound support that includes legal advocacy, emergency accommodation, mental health referrals, financial advice, children's support and coordination with police and courts, reducing the burden on survivors to navigate complex systems alone.
- The outreach model includes strong prevention and early-intervention components, delivering community education, training frontline professionals and engaging with faith groups, schools and salons to identify abuse earlier and increase self-referrals.

Success Factors, Stakeholders, Lessons, and Impact

- The service succeeds because of its multi-agency collaboration, with co-located Independent Domestic Violence Advisors working alongside police, NHS services, housing teams and voluntary organisations to provide immediate, coordinated support.
- Trauma-informed and culturally sensitive staffing ensures that survivors feel safe, understood and empowered, enabling engagement from groups who previously underused domestic abuse services due to stigma, fear or language barriers.
- Domestic abuse must be treated as both a health and social issue, requiring integrated responses that address safety, mental health, physical health, housing, financial stability and legal protection simultaneously.
- The model aligns with Integrated Care System priorities by addressing a major health inequality, improving early identification in maternity and primary care, and ensuring survivors receive rapid access to mental health and safeguarding support.
- Evaluation shows increased early disclosure, faster engagement with support services, improved mental wellbeing among survivors, reduced repeat victimisation and stronger coordination between police, health and social care partners.
- The service demonstrates that a single-advocate, one-stop-shop model significantly improves outcomes for survivors, reduces system fragmentation and strengthens community awareness and prevention of domestic abuse.