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

The Centre for Population Health

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# Introduction: Purpose and scope of JSNA

Summarises Brent's population health and wellbeing needs.

Covers demographics, health needs, inequalities, and ICS priorities.

Targeted at public health professionals, ICB executives, and community leaders.

Supports evidence-based planning for health and care services.

Highlights inequalities and key health challenges.

Informs Integrated Care System (ICS) priorities.

Includes examples of local good practice.

# Borough Profile Overview

Brent is a vibrant, diverse borough in North West London.

Outer London borough with inner-city characteristics

14th highest population density in England.

Divided into 22 wards and includes Wembley, Harlesden, Kilburn, Willesden, Kingsbury, Neasden.

Population: 353,000 in 2024, projected to reach 450,000 by 2041.

High population density: 8,164 people/km² – highest in Outer London.

Young median age: 34.9 years (vs 40.2 nationally).

Marked inequalities across communities and places.

Urban hubs and green spaces like Brent Reservoir.

# Population Size and Growth

Population grew from 311,000 (2011) to 353,000 (2024).

Growth slowed during 2014–2024 due to COVID-19 and lower birth rates.

Rebounded post-pandemic with 4% growth from 2021–2024.

Projected 26% growth by 2041 due to housing developments.

Wembley Park, Alperton, and South Kilburn are key growth areas.

# Age Profile

- 26% of residents are aged 20–34; 22–23% are under 18.
- Only 29% are aged 50+, compared to 38% nationally.
- 41,000 residents aged 65+; 60% of 80+ are women.
- 65+ population projected to grow 57% by 2041.
- Dual challenge: supporting youth and ageing population.

# Ethnic and Cultural Diversity

- 85% of residents from minority ethnic backgrounds.
- Largest group: Indian (19%), followed by Other White (16%).
- 149+ languages spoken; 40% do not speak English as first language.
- 1 in 4 residents have low English literacy.
- Public services must be culturally sensitive and multilingual.

# Geography of Deprivation

- Brent has both affluent and highly deprived areas.
- Stonebridge, Harlesden, Neasden among most deprived.
- Life expectancy gap of 11 years between wards.
- IMD 2025 shows worsening deprivation since 2019.
- Deprivation linked to poor health outcomes and early mortality.

# IMD 2025 Key Findings

- 28 LSOAs in most deprived 10% nationally (up from 5% in 2019).
- 53 LSOAs in most deprived 20%.
- No LSOAs in 20% least deprived.
- Newly deprived areas: Welsh Harp, Dollis Hill.
- Deprivation concentrated in Stonebridge, Roundwood, Harlesden.

# Income Deprivation (Children and Older People)

- Brent ranks 12th nationally for income deprivation.
- 58.7% of children live in income-deprived households.
- 25.8% of older people live in poverty (vs 14.2% England).
- High IDACI and IDAOPI scores reflect deep inequalities.
- Income deprivation impacts health, education, and wellbeing.

# Starting Well: Children and Early Years

Growing child and youth population: early years health is foundational.

Only 70% of children receive recommended vaccinations by age 5, below 95% target.

Tooth decay is widespread with 5-year-olds having twice as many decayed/missing teeth as national average.

Obesity is high: 29% of Reception children and 44% of Year 6 are overweight or obese.

Ethnic disparities exist: Black African/Caribbean children have higher obesity rates.

Low physical activity and limited access to safe play spaces contribute to poor health.

# Children's Mental Health and Inequalities

Rising rates of social, emotional, and mental health (SEMH) needs among schoolchildren.

COVID-19 likely worsened anxiety, depression, and behavioural issues.

High demand for CAMHS: early school and community support is critical.

Health outcomes vary by deprivation and ethnicity; obesity and immunisation gaps are stark.

A&E attendances for under-5s are higher in deprived southern wards.

Targeted, culturally sensitive interventions are needed to reduce inequalities.

# Living Well: Adults (18–64 years)

56%+ of adults are overweight or obese; 8.6% diagnosed with diabetes (true prevalence >11%).

Diabetes and obesity more common in South Asian and Black communities.

Only 55–60% of adults meet physical activity guidelines: inactivity linked to deprivation.

CVD is a leading cause of premature death: hypertension and high cholesterol are common.

Cancer is top cause of death, screening uptake is low, especially in deprived areas.

Respiratory issues (asthma, COPD) linked to air pollution and poor housing.

# Adult Mental Health and Substance Misuse

- 1 in 4 adults experience mental health issues: high anxiety levels reported.
- Severe mental illness (SMI) more prevalent in Brent than national average.
- Black Caribbean men face higher SMI and detention rates: need for culturally competent care.
- Substance misuse: declining treatment success (33% completion for alcohol), rising complexity.
- Hidden alcohol misuse among middle-aged men and gambling emerging as a concern.
- Improved access to IAPT and community-based mental health support is needed.

# Sexual and Reproductive Health

High STI burden; HIV prevalence above national average, below London average.

95% of HIV-positive residents are diagnosed and on treatment.

Late HIV diagnosis remains a key concern: testing coverage is high but declining.

STI diagnosis rates among highest in England: chlamydia screening stable.

Teenage pregnancy rates have declined, aligning with London trends.

Cultural and access barriers affect screening and early diagnosis.

# Tuberculosis and Smoking

Brent has one of the highest TB rates in London: diagnostic delays decreasing.

100% of TB cases offered HIV testing in 2022: treatment completion improving.

Smoking rates decreasing but remain higher than London and England averages.

Low ex-smoker rates and high smoking at delivery among pregnant women.

Smoking remains a key contributor to poor health outcomes.

Air quality and housing conditions exacerbate respiratory illnesses.

# Employment and Wider Determinants

Brent's employment rate is 70%, below London and England averages (75%).

Long-term unemployment nearly double national rate (3.6 vs 1.9 per 1,000).

In-work poverty common due to low wages and high living costs.

Housing insecurity, overcrowding, and illegal HMOs impact wellbeing.

Crime, gang violence, and air pollution affect community health.

Regeneration projects offer opportunities but must ensure equitable benefits.

# ICS Priorities for Brent

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| Focus on | Focus on prevention and early intervention across the life course. |
| Tackle | Tackle health inequalities by targeting deprived and high-risk groups. |
| Improve | Improve access to culturally competent and integrated care services. |
| Enhance | Enhance mental health support, especially for children and vulnerable adults. |
| Address | Address wider determinants: housing, employment, environment. |
| Align | Align local actions with NW London ICB strategic goals. |

# Starting Well (Children and Early Years)

| Increase | Expand | Implement | Enhance | Improve | Strengthen |
| --- | --- | --- | --- | --- | --- |
| Increase childhood immunisation uptake through targeted outreach in low-coverage wards. | Expand access to early years oral health programmes in nurseries and schools. | Implement culturally tailored obesity prevention initiatives for families. | Enhance early identification and support for children with SEND and SEMH needs. | Improve access to safe play spaces and active travel routes for children. | Strengthen school-based health promotion and mental wellbeing programmes. |

# Living Well (Adults)

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| Promote | Promote healthy lifestyles through workplace wellness and community campaigns. |
| Increase | Increase uptake of cancer screening in deprived and ethnic minority communities. |
| Expand | Expand diabetes prevention and management programmes in high-risk groups. |
| Improve | Improve access to physical activity facilities in underserved areas. |
| Support | Support smoking cessation and alcohol reduction through targeted services. |
| Enhance | Enhance culturally competent health literacy and self-care education. |

# Ageing Well (Older Adults)

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| Develop | Develop integrated care pathways for frailty, dementia, and multimorbidity. |
| Expand | Expand social prescribing and befriending schemes to reduce isolation. |
| Improve | Improve access to falls prevention and rehabilitation services. |
| Ensure | Ensure older adults receive regular health checks and medication reviews. |
| Support | Support carers through respite services and peer support networks. |
| Promote | Promote digital inclusion and access to telehealth for older residents. |

# Tackling Health Inequalities

Use data to identify and target the most deprived and at-risk populations.

Co-produce services with marginalised communities to ensure relevance and trust.

Embed equity impact assessments in all commissioning and service redesign.

Address language and literacy barriers in health communication materials.

Ensure equitable access to primary care and specialist services.

Monitor and publish disaggregated outcomes by ethnicity, age, and deprivation.

# Improving Mental Health

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| Expand | Expand early intervention services for children and young people (e.g. CAMHS). |
| Increase | Increase access to culturally appropriate talking therapies (IAPT). |
| Integrate | Integrate mental health support into primary care and community settings. |
| Train | Train frontline staff in trauma-informed and anti-racist practice. |
| Address | Address social isolation through community connectors and peer support. |
| Improve | Improve crisis response and reduce detentions under the Mental Health Act. |

# Preventing and Managing Long-Term Conditions

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|---|---|
| Improve | Improve detection and management of hypertension, diabetes, and CVD. |
| Promote | Promote self-management through digital tools and structured education. |
| Increase | Increase uptake of NHS Health Checks in underserved populations. |
| Integrate | Integrate care across primary, community, and secondary services. |
| Target | Target lifestyle interventions to reduce obesity and inactivity. |
| Use | Use population health data to stratify risk and personalise care. |

# Addressing Wider Determinants of Health

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| Work | Work with housing to reduce overcrowding and improve living conditions. |
| Support | Support employment and skills programmes for disadvantaged groups. |
| Tackle | Tackle food insecurity through community food hubs and vouchers. |
| Improve | Improve air quality through transport and planning policies. |
| Reduce | Reduce fuel poverty via home energy efficiency schemes. |
| Embed | Embed health in all policies across council and partner organisations. |

# Strengthening Community Partnerships

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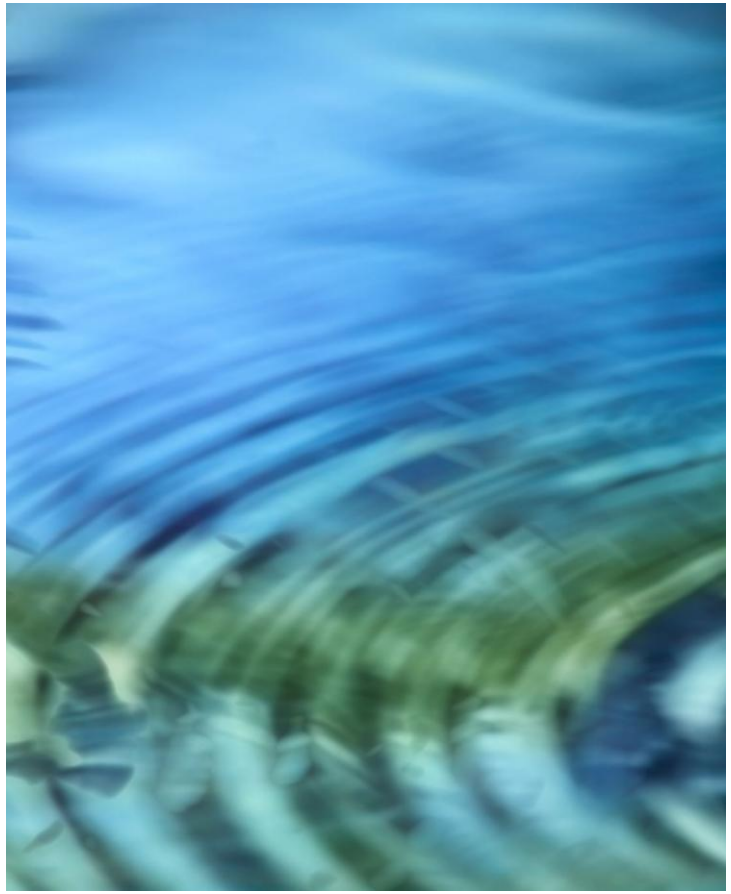
|---|---|
| Invest in | Invest in voluntary and community sector to co-deliver health initiatives. |
| Develop | Develop community champions to promote health messages and services. |
| Support | Support culturally specific organisations to reach underserved groups. |
| Facilitate | Facilitate co-production of services with residents and local leaders. |
| Build | Build trust through sustained engagement and transparency. |
| Use | Use community assets (e.g. faith centres, schools) as health hubs. |



# Brent Key Strategic Priorities

# Priority 1: Tackling Health Inequalities and Deprivation

- Target deprived wards (e.g., Stonebridge, Harlesden) with tailored health interventions.
- Expand outreach and mobile clinics to improve access in underserved communities.
- Embed equity impact assessments in all service planning and commissioning.
- Provide multilingual health information to address language and literacy barriers.
- Co-produce services with local communities to build trust, uptake and relevance.
- Monitor outcomes by ethnicity, deprivation, and geography to track progress.

# Priority 2: Cardiovascular Health – Preventing and Managing CVD (Hypertension, Diabetes, Heart Disease and Stroke)

- Increase detection of hypertension and diabetes through community screening.
- Expand structured education and self-management support for CVD patients.
- Promote healthy eating and physical activity in high-risk populations.
- Improve medication adherence through pharmacist-led reviews and digital tools.
- Integrate care across primary, community, and hospital settings for CVD.
- Use population health data to identify and target high-risk individuals.

# Priority 3: Mental Health and Wellbeing (Including Mental Illness and Substance Misuse)

- Expand access to culturally appropriate talking therapies (IAPT).
- Integrate mental health support into schools, primary care, and community hubs.
- Train staff in trauma-informed and anti-racist mental health practices.
- Improve crisis response and reduce detentions under the Mental Health Act.
- Address social isolation through peer support and community connectors.
- Enhance dual diagnosis services for co-occurring mental illness and substance misuse.

# Priority 4: Early Years, Children and Young People – a Healthy Start in Life

- Increase uptake of childhood immunisations through targeted outreach.
- Expand oral health and nutrition programmes in early years settings.
- Address childhood obesity through school-based and family interventions.
- Improve access to CAMHS and early mental health support in schools.
- Enhance identification and support for SEND and SEMH needs.
- Promote active travel and safe play environments for children.

# Priority 5: Promoting Healthy Lifestyles – Physical Activity, Nutrition, and Weight Management

- Deliver borough-wide campaigns promoting healthy eating and exercise.
- Subsidise access to gyms and sports facilities in deprived areas.
- Expand weight management services for adults and children.
- Support active travel infrastructure (e.g., walking and cycling routes).
- Engage communities in co-designing culturally relevant lifestyle programmes.
- Train frontline staff to deliver brief interventions on diet and activity.

# Priority 6: Cancer Prevention and Early Detection

- Increase uptake of bowel, breast, and cervical screening in low-uptake groups.
- Use community champions to raise awareness of cancer symptoms and screening.
- Address cultural and language barriers to early diagnosis and screening.
- Integrate cancer prevention into primary care health checks.
- Promote smoking cessation and HPV vaccination to reduce cancer risk.
- Monitor screening uptake and stage at diagnosis by ethnicity and deprivation.

# Priority 7: Substance Misuse and Addictions (Drugs, Alcohol, Gambling)

- Improve access to drug and alcohol treatment services in high-need areas.
- Expand outreach and harm reduction services for vulnerable populations.
- Address hidden alcohol misuse among middle-aged men through targeted campaigns.
- Support recovery through peer-led programmes and housing support.
- Tackle gambling harms through regulation and community education.
- Integrate substance misuse and mental health services for dual diagnosis clients.

# Priority 8: Older People's Health and Care – Frailty, Dementia, and Integrated Care for Ageing

- Develop integrated care pathways for frailty, dementia, and multimorbidity.
- Expand falls prevention and rehabilitation services for older adults.
- Support carers with respite, training, and peer support networks.
- Promote digital inclusion and access to telehealth for older residents.
- Use social prescribing to reduce isolation and improve wellbeing.
- Ensure regular health checks and medication reviews for older people.

# Alignment with NW London ICB Priorities

Tackling inequalities: Brent's focus on deprived wards aligns with NWL ICB's overarching goal to reduce health gaps.

Improving access: Expansion of outreach clinics and culturally competent services supports ICB's drive for equitable access.

Prevention and early intervention: Brent's emphasis on childhood immunisations, obesity prevention, and NHS Health Checks mirrors ICB priorities.

Integrated care: Coordinated pathways for CVD, dementia, and frailty reflect ICB's ambition for seamless health and social care.

Workforce resilience: Training staff in trauma-informed, anti-racist practice contributes to ICB's workforce development agenda.

Data-driven planning: Brent's use of disaggregated data supports ICB's commitment to evidence-based decision-making.

# Local Good Practice Examples

Community-led obesity prevention in schools and families.

Faith-based diabetes awareness campaigns in South Asian communities.

Air Quality Action Plan targeting North Circular pollution hotspots.

Mental health outreach in schools to support early intervention.

Regeneration projects (e.g. Wembley Park) integrating health equity goals.

Lessons include co-production, cultural tailoring, and place-based delivery.

# Case Study 1: Brent Healthy Weight Strategy – Tackling Childhood Obesity

Launched a borough-wide Healthy Weight Strategy to address high childhood obesity rates.

Focused on Year 6 pupils, where 42–44% were overweight or obese, especially in deprived areas.

Implemented school-based nutrition education, physical activity promotion, and healthy food policies.

Partnered with schools, parents, and community organisations to co-design interventions.

Monitored BMI trends and tailored programmes for high-risk ethnic groups (e.g., Black and South Asian children).

Early results show improved awareness and modest reductions in obesity rates among Reception children.

# Case Study 2: Faith-Based Diabetes Awareness Campaigns

Recognised high diabetes prevalence (>11%) in Brent, especially among South Asian and Black communities.

Partnered with local mosques, temples, and churches to deliver culturally relevant health education.

Used trusted community leaders to promote diabetes screening and healthy lifestyle changes.

Held health checks and information sessions during religious gatherings and festivals.

Addressed stigma and myths around diabetes through multilingual materials and peer educators.

Resulted in increased diabetes awareness, early diagnoses, and improved community engagement.

# Case Study 3: Brent Air Quality Action Plan and Public Health Collaboration

Developed a borough-wide Air Quality Action Plan to address pollution hotspots (e.g., North Circular Road).

Collaborated across public health, transport, and planning teams to align health and environmental goals.

Installed air quality monitors in schools and high-traffic areas to track pollution levels.

Promoted active travel and anti-idling campaigns to reduce vehicle emissions near schools.

Engaged residents in co-designing local solutions, including green infrastructure and clean air zones.

Helped raise awareness of air pollution's health impacts and informed future planning decisions.

# Case Study 4: Mental Health Support in Schools – Early Intervention

# Case Study 5: Inclusive Regeneration (Health in the Wembley Park Redevelopment)

- Wembley Park regeneration included 7,000+ new homes, public spaces, and transport links.
- Public health worked with planners to embed health equity into the regeneration strategy.
- Ensured access to green spaces, active travel routes, and affordable housing in new developments.
- Addressed air quality, noise, and safety concerns through design and community input.
- Created opportunities for local employment and community cohesion through inclusive planning.
- Demonstrated how regeneration can reduce health inequalities when health is integrated early.

# Key Considerations for Brent

Deprivation and inequality: Address entrenched gaps across wards, where life expectancy differs by up to 11 years.

Demographic pressures: Balance needs of a young, diverse population with a rapidly growing older adult cohort.

Chronic disease burden: High prevalence of obesity, diabetes, and cardiovascular disease requires sustained prevention and management.

Mental health demand: Rising child and adult mental health needs, compounded by COVID-19, call for expanded early support.

Community partnerships: Voluntary and faith-based organisations are vital for culturally tailored interventions.

Regeneration impacts: Ensure large projects (e.g. Wembley Park) deliver equitable health benefits and avoid widening inequalities.

# Conclusions and Next Steps

- Brent faces deep-rooted health inequalities and complex population needs.
- Young, diverse, and growing population requires tailored interventions.
- Focus on prevention, early years, and ageing population support.
- Strengthen community partnerships and culturally competent care.
- Use data and local insights to guide equitable health planning.
- Align borough actions with ICS and NWL ICB strategic priorities.