Appendix A

Health and Wellbeing Board

Draft Joint Hillingdon Health and Wellbeing Priorities
2025-2028

For Comment and Discussion

18 March 2025

Kelly O'Neill
Director of Public Health
London Borough of Hillingdon

Keith Spencer
Managing Director
Hillingdon Health and Care Partners

Purpose and Background

Purpose

The purpose of this document is act as a starting point to stimulate **discussion** on the draft priorities for the **Joint Hillingdon Health and Wellbeing Strategy** for the period 2025-2028. This 'first cut' has been informed by:

- The North West London Shared Needs Assessment (2024) and the Core20Plus 5 Framework
- The NWL ICB Joint Forward Priorities
- The HHCP Strategic Priorities
- The LBH Adult Social Care and Health Plan 2024-2027
- The Hillingdon Hospital Redevelopment Plan
- LBH Council Strategy 2022-2026

Draft metrics to measure the success for the Strategy are also included. Feedback from the Board discussion will inform the first Draft Joint Health and Wellbeing Strategy.

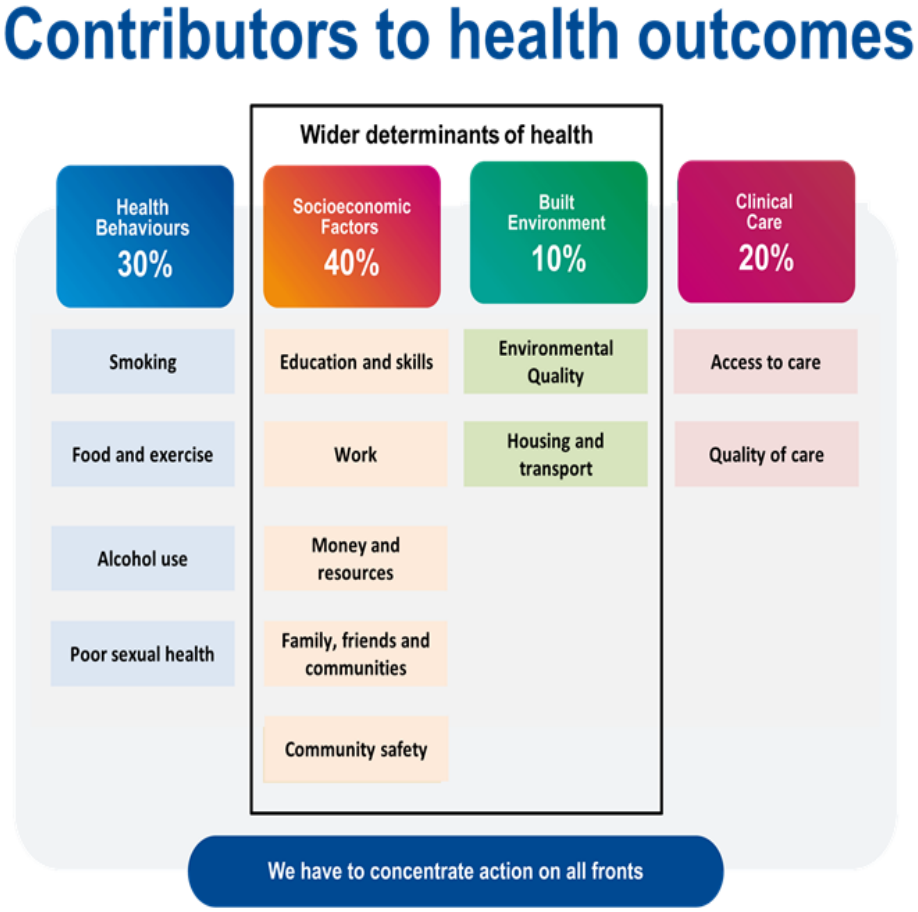
Background

Health outcomes for the people of Hillingdon are shaped by a **complex interaction** of factors, including **health behaviours (30%) socioeconomic conditions (40%), the built environment (10%), and clinical care access (20%). Specifically:**

- **Modifiable health behaviours** (diet, physical activity, smoking, alcohol use) are major contributors to chronic diseases.
- **Socioeconomic factors** (income, education, employment, and social support) influence access to healthcare and drive health inequality and disparities.
- **The Built Environment** (housing, neighbourhood safety, recreational spaces, and food access) impacts lifestyle choices and overall well-being.
- **Clinical Care Access and Quality** play a crucial role in preventing and managing diseases, reducing mortality and morbidity.

The Marmot Report (see figure 1 opposite) highlights how social determinants drive health inequalities across England, with disadvantaged groups experiencing poorer health outcomes. Addressing these disparities is essential for public health improvement**. A comprehensive, integrated approach is necessary to promote health equity, effective public health strategies and to tackle unsustainable rising health and social care utilisation in Hillingdon.**

Figure 1

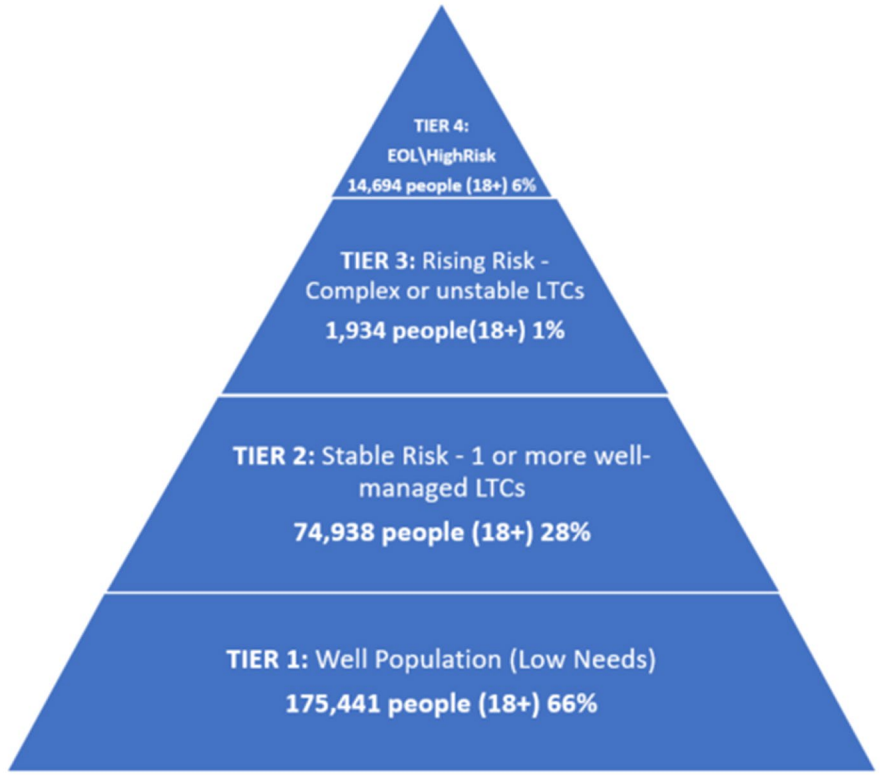


What does the Population Health Data tells us (slides 15-22)?

What does the Data tell us?

1. **The long-term London Shared Needs Assessment (2024) and the Core20Plus 5 framework highlights that Hillingdon's long term population health is deteriorating :**
   - Significant socio economic and environmental deprivation factors are driving the increasing prevalence of long term conditions particularly in our most deprived communities: **Yiewsley, Hayes, and West Drayton.** This includes a high child poverty rate (31%), low mean income post housing costs, food insecurity and higher than NWL average rates of overcrowding and homelessness
   - 48% (127,264) of the Hillingdon registered Adult (18+) population are currently living with 1 or more Long Term Conditions; making Hillingdon joint highest with Harrow in NWL for the highest weighted average % of patients with LTCs. The Top 5 LTC's within the Borough are: Hypertension, Anxiety, Depression, Obesity & Diabetes.
   - Double the number of people are now recorded as living with one or more LTC compared to 2017

2. This combination of socio economic and environmental deprivation factors and increasing prevalence of LTCs in our poorer neighbourhoods is driving **higher health and social care utilisation rates including GP attendances, unplanned acute bed days, ED attendance and referrals to ASC:**
   - There has been a 40% increase in referrals to LBH ASC since 2019/20.
   - The 65+ age group, although comprising only 14% of the total population, utilise up to 40% of all healthcare in Hillingdon
   - Hypertension accounts for nearly 50% of all unplanned bed days in Older Adults and 20% of all unplanned bed days in Adults and is increasing year on year
   - A small group of 4,400 patients (1.6% of the adult population) account for 50% of all Non elective (emergency) admissions to hospital in Hillingdon
   - The most deprived Neighbourhood has the highest prevalence of LTC's and drives most emergency activity at The Hillingdon Hospital
   - Long Term Care Home placement costs in Hillingdon have doubled since 2019/20 from £15 to £30m



What are the Key Challenges?

Key Challenges:

A detailed analysis of the North West London Shared Needs Assessment (2024) as it relates to Hillingdon is set out in slides 14-22 below. In summary our key challenges are:

1. Socioeconomic and Housing-Related Health Risks

- **A High child poverty rate (31%)**, which exceeds the NWL average, impacts childhood nutrition and future health risks.
- **Low mean income post housing costs (£31,581**) limits healthcare access and preventive care affordability.
- **Higher than NWL average rates of Overcrowding and homelessness (22.6 per 1000 households)** contribute to stress and mental health conditions, exacerbating hypertension and cardiovascular risks.

2. Environmental Health and Air Pollution particularly its Impact on Hypertension

- **Air pollution from Heathrow Airport increases the risk of hypertension, cardiovascular disease, and respiratory illness.**
- **Prolonged exposure to pollutants contributes to high blood pressure and heart disease**.
- Poor air quality is also associated with **higher stroke risk** in hypertension patients

3. Hypertension and Cardiovascular Health

- **Hypertension is highly prevalent in Hillingdon (43k people)**, particularly among older adults **and deprived Neighbourhoods**. (**Yiewsley, Hayes, and West Drayton).** Yiewsley is identified as one of only 2 areas in **North West London with a high percentage of multi-morbidity** (2 or more LTC's) across different age groups.
- **Disparities in prevalence**:
  - **South Asian and Black ethnic groups** are disproportionately affected.
  - **Lower-income populations** have higher hypertension rates due to stress, poor diet, and reduced healthcare access.
- **Hypertension contributes to**:
  - Increased **stroke and heart attack risk**.
  - Higher **hospital admission rates** for cardiovascular conditions.
  - More **unplanned hospital bed days**, straining the healthcare system. Hypertension accounts for nearly 50% of all unplanned bed days in Older Adults and 20% of all unplanned bed days for Adults in Hillingdon.
- **Access to hypertension management programs is limited**, with gaps in early detection and lifestyle interventions.

What are the Key Challenges?

4. Obesity and Its Impact on Hypertension

- Obesity is a major driver of hypertension in Hillingdon, particularly in older adults:
  - 16.1% of older adults are obese, exceeding the NWL average.
- Deprivation-driven obesity:
  - Food insecurity, poor dietary habits and low access to healthy food options in deprived Neighbourhoods increases the risk of obesity and hypertension.
- Obesity-related conditions such as diabetes further complicate hypertension management.

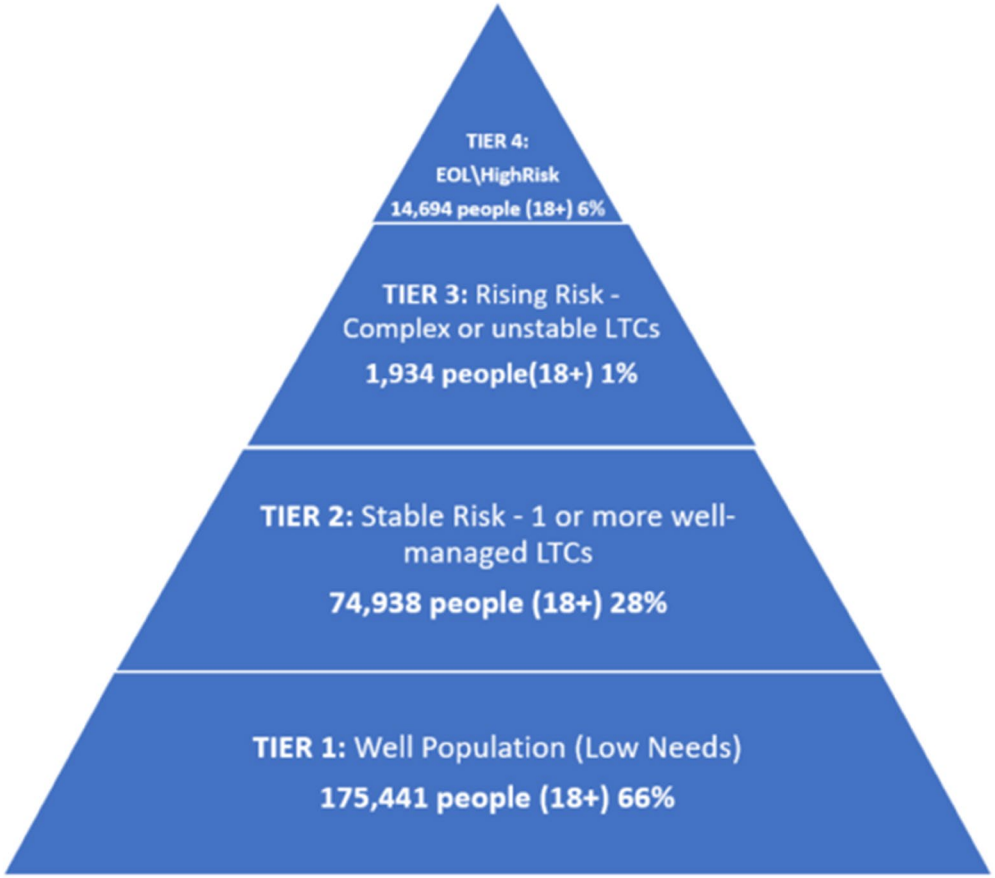
5. Mental Health and Unplanned Hospital Admissions

- Depression and anxiety are increasingly linked to hypertension, particularly in younger adults.
- Unplanned hospital admissions for mental health disorders are significantly high in Hillingdon accounting for over 20% of unplanned bed days in Adults and have grow significantly over the last 5 years
- Black ethnic groups have disproportionately high hospitalization rates for mental health-related conditions, including stress-induced hypertension.

What are the Key Challenges?

6. High Health and Care Utilisation rates

- This combination of socio economic and environmental deprivation factors and increasing prevalence of LTCs in our poorer neighbourhoods (Yiewsley, Hayes, West Drayton) is driving **higher health and social care utilisation rates including GP attendances, unplanned Acute bed days, ED attendances, Care home placements and referrals to ASC:**
  - 40% increase in referrals to ASC since 2019/20.
  - Long Term Care Home placement costs in Hillingdon have doubled since 2019/20 from £15m to £30m
  - The 65+ age group, although comprising only 14% of the total population, utilise up to 40% of all healthcare
  - A small number of 4,400 patients (1.6% of the adult population) account for 50% of all Non elective episodes in Hillingdon
  - Hypertension accounts for nearly 50% of all unplanned bed days in Older Adults and 20% in Adults. Depression accounts for 25% of all unplanned bed days in Adults. Asthma is the single biggest driver in Children's unplanned admissions.
  - There is a strong correlation between deprivation and the prevalence of these conditions and the rate of unplanned bed days. The Core 20 group is the most likely group to have many of the conditions reported for adults and older adults.
  - **If these rates of growth continue at the current pace, the activity assumptions for the new hospital will be under threat**



The Core20Plus5 framework reinforces the NWL Shared Needs Assessment

The **Core20PLUS5** framework is an NHS England initiative aimed at reducing healthcare inequalities. It focuses on the most deprived 20% of the population (**Core20**), additional marginalized groups (**PLUS**), and five key clinical priority areas (**5**). Below is an analysis of how these priorities relate to **Hillingdon**:

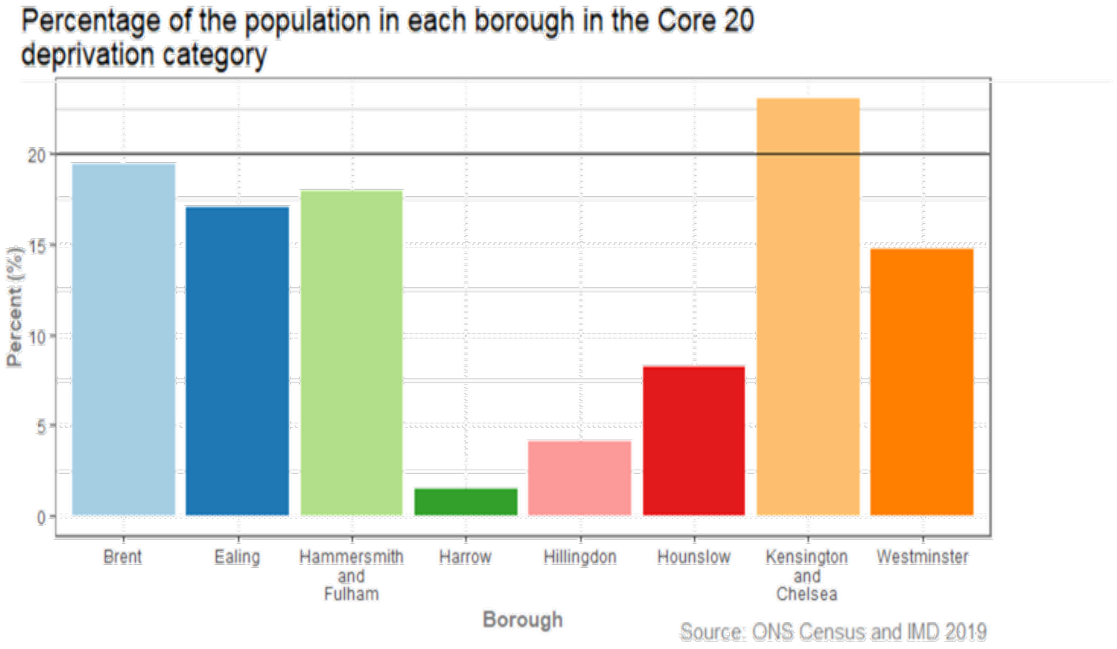
Core20: Deprivation and Health Inequalities in Hillingdon

- Hillingdon is ranked **174th** in the Index of Multiple Deprivation (IMD), meaning it is relatively less deprived compared to other North West London boroughs.
- However, pockets of **significant deprivation** exist, particularly in areas such as **Hayes, Yiewsley and West Drayton**, leading to **health disparities**.
- Targeted intervention in these deprived areas will be crucial going forward to **reduce health inequalities**.

PLUS: Targeted Groups in Hillingdon

The **PLUS** element of Core20PLUS5 emphasizes groups experiencing disproportionate health inequalities. In Hillingdon, these include:

- **Ethnic minority populations**: Hillingdon has a large South Asian and Black community, which has higher rates of conditions such as diabetes and cardiovascular disease.
- **Asylum seekers and refugees**: With Heathrow Airport nearby, Hillingdon has a significant transient population, including asylum seekers who may have **limited access to healthcare**.
- **Homeless population**: Hillingdon has a notable **homeless population**, particularly around Uxbridge and Hayes.
- **People with learning disabilities**: Ensuring equitable access to healthcare services for individuals with learning disabilities remains a challenge.



The Core20Plus5 framework reinforces the NWL Shared Needs Assessment

Five Clinical Priority Areas ("5") and Hillingdon's Context

- **Maternity Care**
  - Hillingdon Hospital provides maternity services, but **inequalities persist in maternal health outcomes**, particularly for **Black and South Asian women**.
  - Addressing **lower uptake of antenatal care** and **higher rates of maternal complications** among these groups is key.
- **Severe Mental Illness (SMI)**
  - Hillingdon faces challenges with mental health service accessibility, particularly for deprived and ethnic minority communities.
- **Chronic Respiratory Disease**
  - High smoking prevalence in certain deprived parts of Hillingdon contributes to chronic obstructive pulmonary disease (COPD) and asthma.
  - Air quality concerns near Heathrow Airport may exacerbate respiratory conditions.
- **Early Cancer Diagnosis**
  - Cancer screening uptake is lower in deprived and ethnically diverse communities in Hillingdon.
  - Late-stage diagnosis rates remain a challenge,.
- **Hypertension and Cardiovascular Disease (CVD)**
  - Hillingdon has a high prevalence of hypertension and diabetes, particularly in South Asian and Black populations.

We are suggesting a small number of Draft Priorities, High Impact Actions and KPI's…….

Priority Area	Objective	High-Impact Actions	Delivery Model	Timeline	Key KPIs

Thriving Healthy Households
 	
Core20Plus5 national equity priorities addressed:
• Chronic Respiratory Disease
• Hypertension
• Smoking Cessation
• Oral Health
	• Whole-population approaches to prevent ill health and promote wellbeing through self management
	• Tackling the Social Determinants of Poor Health
	• Improving Air quality and Built Environment
		1. **Develop and implement a universal wellbeing offer** which is Neighbourhood focused and community asset delivered covering:
		  • Physical Activity & Healthy Lifestyles
		  • Mental Wellbeing & Resilience
		  • Falls Prevention & Strength-Based Support
		  • Deployment of Digital & Assistive Technology
		2. **Implement Healthy eating and the programmes that support supplementation of women's diets during pregnancy** and in the first stage of a child's life, promoting breast and infant feeding.
		3. **The universal vaccination programme** for children and young people and seasonal vaccination programmes for older people
		4. **Promote evidence based 'Brush For Life' campaigns** in schools to reduce childhood cavities and decay by up to 30-50%
		5. **Provide Same Day Access to Urgent Primary Car**e to improve primary care capacity and to avoid unnecessary ED attendance for those people without underlying health concerns but who experience an episodic illness
		6. **Expand affordable housing and financial support programmes** for vulnerable groups in target Neighbourhoods (South East & South West with particular emphasis on Yiewsley, West Drayton , Hayes)
		7. **Better food security initiatives** to tackle obesity and malnutrition in most deprived neighbourhoods
		8. **Tackling loneliness and social isolation** keeping people engaged with their neighbourhoods through the **development of wellbeing and community networks.**
		9. **Expand air pollution monitoring**
		10. **Promote Active travel programmes**
		11. **Develop Green Spaces in deprived neighbourhoods**
			• **Integrated Neighbourhood Hubs** and Teams providing multi-agency preventative support and same day urgent Primary Care
			• **Universal Wellbeing Offer**
			• **Single Digital Point of Information, Access and Referral**: dedicated portal for professionals and public
			• **Digital inclusion programs** to reduce health inequalities
			• Development and expansion of **Carers Networks**
			• **Vaccination Programmes**
				24-60 months	• Increase childhood vaccination rate to 85 %
					• Reduce child poverty rate from 31% to 25%
					• 15% decrease in homelessness.
					• 15% fewer air pollution-related hospital visits
					• % Increase in physical activity participation (e.g., uptake of Neighbourhood exercise programs)
					• % Reduction in obesity prevalence
					• % Reduction in smoking prevalence (including quit rates via smoking cessation services)
					• % Reduction in alcohol-related harm (alcohol-related hospital admissions per 100,000)
					• **25% and 18% reduction in UTC/ED attendances over 2019/20 baseline**
					• % Increase in people living in homes meeting Decent Homes Standards (housing quality & insulation)
					• Reduce unplanned hospital bed days by 50% for cavities amongst children

We are suggesting a small number of Draft Priorities, High Impact Actions and KPI's…….

Priority Area	Objective	High-Impact Actions	Delivery Model	Timeline	Key KPIs
Early Intervention and Prevention **Core20Plus5 national equity priorities addressed:** • Chronic Respiratory Disease • Hypertension • Smoking Cessation • Oral Health • Mental Health	• Optimising Preventative Care for People with LTCs with an emphasis on hypertension. • Maximising Independence and choice • Preventing reliance on Health and Care Services	1. **Expand Neighbourhood based Risk stratification, Proactive Case Finding and Targeted outreach** focused on hypertension, diabetes, and obesity in the first instance. 2. **Streamline access to information, advice and guidance (IAG)**: Facilitating access to IAG to enable people to make informed choices and promote self-care . 3. **Expansion of Care and case Co-ordination** 4. **Reduce Variability in Care Quality**: Standardize LTC pathways across the borough and **implement neighbourhood-level dashboards to track outcomes** 5. **Implement evidence-based Neighbourhood interventions including for Hypertension:** Good Nutrition (DASH diet), exercise referrals, smoking cessation, alcohol reduction programmes, community based Blood Pressure monitoring schemes, use of remote monitoring, peer networks, self management and digital support 6. **Reducing Health Inequalities and Addressing Wider** Determinants through: • Deployment of Community Champions to engage with high-risk groups. • Faith and Community Leader-Led BP Initiatives: Use trusted voices to promote hypertension awareness. • Food and Nutrition Policy Advocacy: Local authority policies on food quality, salt reduction, and healthy eating. • Developing pre and post diagnosis options for autistic people. • Developing supported accommodation options for people with learning disabilities and people with mental health needs. 6. **Integrate Mental Health professionals within Neighbourhood hubs** to provide early intervention for anxiety and depression. Expand Digital CBT programmes, scale social prescribing	• **Integrated Neighbourhood Hubs** and Teams providing multi-agency preventative support including Mental Health. • **Adult Social Care single point of access** provides a centralised IAG hub supported by VCSE IAG contract. • **Clear care and case co-ordination model** built from a coherent Neighbourhood **Hypertension Intervention Programme** • **Third Sector Offer** to Integrated Neighbourhoods • **Single Digital Point of Information, Access and Referra**l: dedicated portal for professionals and public • **Neighbourhood Level Digital Dashboards** to track outcomes (Blinx)	12-36 months	• **90% of hypertensive patients with BP under control** • **30% reduction in associated non elective admissions for (hypertension) over 2019/20 baseline** • 25% fewer emergency mental health admissions. • 10% obesity reduction • 50% reduction in GP mental health referrals to secondary care • Reduce unplanned bed days by 50% for cavities amongst children. • **Increase the proportion of people who received Reablement Service during the year who previously were not receiving services and where no further request was made for ongoing support from 2024/25 baseline.** • **Increase proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge from 2024/25 baselin**e. • Increase proportion of people who received long-term support with a primary support reason of learning disability, who live in their home or with family (people aged 18 to 64) from 2024/25 baseline.

We are suggesting a small number of Draft Priorities, High Impact Actions and KPI's…….

Priority Area	Objective	High-Impact Actions	Delivery Model	Timeline	Key KPIs
Targeted Long Term Care and Community Support for People with Complex Health and Care Needs **Core20Plus5 national equity priorities addressed:** • Chronic Respiratory Disease • Hypertension • Mental Health	• Provide **proactive, personalised, and integrated** case management and Care across primary, community, mental health, social care and voluntary services for **high-need, high-utilisation patients** in order to: • maintain their independence for as long as possible • reduce non elective presentations • Reduce admissions to long term care .	1. **Proactive Identification and Risk Stratification to identify high risk individuals (multi morbidity >= 2 LTCS)** using **NHS & ICS Data Dashboards currently 4,400 patients** 2. **Personalised Case Management & Care Coordination** through multi disciplinary **Integrated Neighbourhood Teams** utilising a single holistic assessment and care plan. 3. **Enhanced Primary Care-Based Case Management** through continuity of care and extended GP Consultations: Regular structured reviews for high-risk patients. 4. **Integration of Urgent and Community Response models to enhance admission avoidance and optimise hospital discharge** 5. **Medication Optimisation and Pharmacy led interventions** for medication adherence support and poly pharmacy reduction 6. **Integrated Mental Health Support for High-Risk Patients** 7. **Social Prescribing & Voluntary Sector Partnerships:** Targeted interventions for patients with housing instability, financial hardship, and isolation. Community. Local voluntary sector support for self-management and care planning. 8. **Carer and Family Support:** Carer Identification and Assessments: Proactive support for unpaid carers at risk of burnout. 9. **Technology Enabled Care (TEC):** • **Wearables & Smart Devices**: BP monitors, pulse oximeters, glucose monitors for real-time tracking, falls detection systems, seizure monitors. • **AI-Based Risk Prediction Tools**: Identifying patients at **risk of crisis escalation**. • **Smart Home Assistants** that can make daily living tasks easier. • **Enhanced safety and monitoring** through smart home devices • **NHS App Integration**: Self-management tools and patient access to care plans. • **Emergency response systems** to enable help to be quickly summoned.	• **Establish Integrated co-located multi agency Neighbourhood Teams (INTs**) in primary care and community settings with dedicated case managers. • **Expand Proactive Case Management**: Implement a targeted care coordination program focusing on early intervention and risk stratification including use of digital innovation • **Improve Primary Care Access** particularly to ensure continuity of care for patients with multi morbidity • **Integrate Urgent and Community Response models** : Scale Same Day Urgent Primary Care Hubs to divert 18-28% of A&E visits and implement a Single **Borough-Wide Reactive Care Service** to deliver community-based urgent responses. • **Develop a Third Sector Offer** to Integrated Neighbourhoods • **Digital solutions** to track and case manage the 4,400 high utilisation group through **a Reactive Care Co-ordination centre**	6-12 months	• 10% NEL admission reduction over 2019/20 baseline • 25% and 18% reduction in UTC/ED attendances • Reduce average length of stay in THH Medicine and Rehabilitation for the 21+ day long length of stay cohort by 5.2 days and the 7+ cohort by 1.7 days • **Flatline permanent admissions to care homes based on 2025/26 baseline.** • 85% care coordination compliance. • **30% of carers (2021 census baseline) on the carer register.** • **% adult carers receiving a carers assessment per 1,000 adult carers (2021 census).**

We are suggesting a small number of Draft Priorities, High Impact Actions and KPI's…….

Priority Area	Client Group	High-Impact Actions	Impact Level	Timeline	Key KPIs
Regulated Adult Social Care provider market	Residents/ Patients	• Review model of ICB/LA care home support to ensure integrated approach. • Develop a regulated care market sufficiency plan to ensure sufficient capacity to respond to demographic change. • Implement supported housing regulatory oversight requirements.	Medium-High	6-24 months	• % registered providers assessed by CQC as at least 'good'

Workforce and Digital	Staff/Patients	• Merge and Integrate teams under single leaders within Neighbourhoods and Borough wide reactive care service
		• Restructure Workforce Models: Implement a Borough-Wide Workforce Passport to enable flexible staff deployment across organisation and setting
		• Digital Innovation:
		  • Deploy Blinx for tracking and case managing high-risk patients combined with use of remote monitoring and wearable technology to continually monitor vital signs and alert healthcare teams in real time.
		  • Deploy AI powered risk prediction and Early Intervention to predict health deterioration
			High	6-24 months	• Workforce Integration: 80% of staff enrolled in Workforce Passport within 18 months.
					• Digital System Utilization: 95% of high risk patients enrolled in digital tracking and case management and utilising some form of remote management technology to drive a 40% reduction in admissions for COPD
					• Staff Productivity Increase: 10% improvement in efficiency through streamlined workforce allocation.

Estates	Staff/Patients	• Develop and implement a Neighbourhood Estates Strategy for the co-location of 3 Integrated Neighbourhood Teams and the creation of Super Hubs as a focal point for delivering out-of-hospital care. • Super Hubs will enhance integrated service delivery, reduce fragmentation, and improve access to community-based health and social care services in the light of the development of a new hospital for Hillingdon.	Medium-High	12-36 months	• 30% increase in hub utilization • Improve Primary Care Access

Data Slides

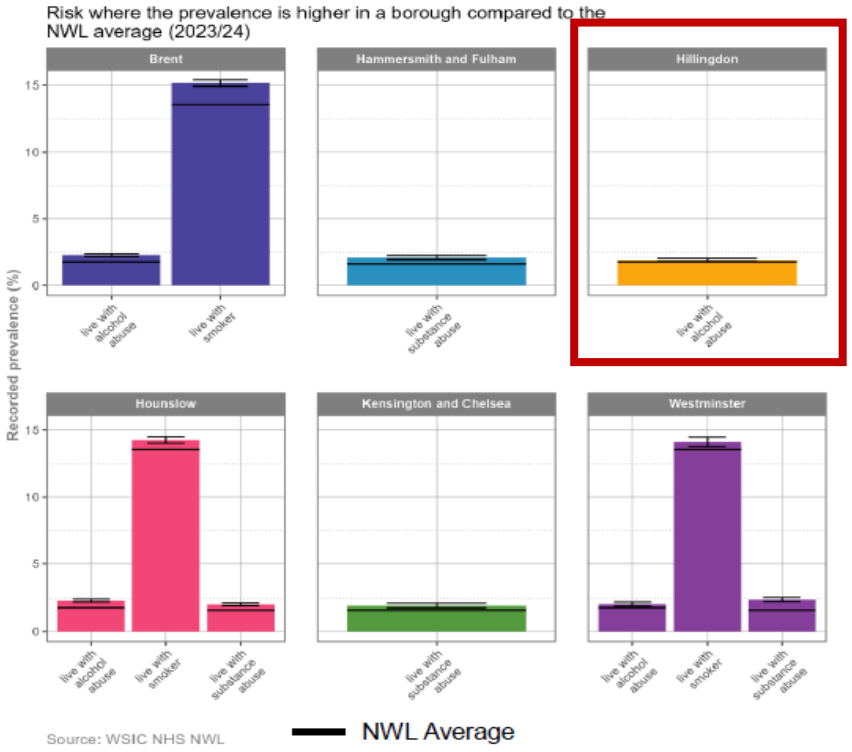
Wider Determinants of Health

The table below shows the wider determinants of health in which Boroughs perform worse than the North West London average with the red highlighting indicating the borough that performs the worst in North West London. None of the boroughs perform

Borough	Wider determinant worse than NWL	Borough Value	NWL Value
Brent	Percentage of population the in the Core 20	19.4%	12.7%
	Proportion on children in poverty	36%	30.2%
	Mean income after housing costs	£26,953	£33,142
	Unemployment	6.7%	6.0%
	Homelessness - households per 1,000 population	18.4	16.5
	Fuel poverty (decile average)	3.6	5.1
	Food poverty (decile average)	4.2	5.9
	Overcrowding	16.8	12.4
Ealing	Percentage of population the in the Core 20	17.1%	12.7%
	Proportion on children in poverty	32%	β0.2%
	Mean income after housing costs	£30,826	£33,142
	Unemployment	6.5%	6.0%
	Homelessness - households with dependent children per 1,000 population	28.6	21.9
	Homelessness - households per 1,000 population	23.9	16.5
	Fuel poverty (decile average)	4.7	5.1
	Food poverty (decile average)	4.5	5.9
	Overcrowding	14.8	12.4
Hammersmith and Fulham	Percentage of population the in the Core 20	18.0%	12.7%
	Fuel poverty (decile average)	5.0	5.1
Harrow	Proportion on children in poverty	31%	30.2%
	Mean income after housing costs	£32,533	£33,142
Hillingdon	Proportion on children in poverty	31%	30.2%
	Mean income after housing costs	£31,581	£33,142
	Percentage of persistent school absentees	22.2%	21.9%
	Homelessness - households with dependent children per 1,000 population	22.6	21.9
	Homelessness - households per 1,000 population	19.2	16.5
	Food poverty (decile average)	4.3	5.9
Hounslow	Proportion on children in poverty	32%	30.2%
	Mean income after housing costs	£31,064	£33,142
	Unemployment	6.6%	6.0%
	Food poverty (decile average)	4.3	5.9
	Overcrowding	13.4	12.4
Kensington and Chelsea	Percentage of population the in the Core 20	23%	12.7%
	Percentage of persistent school absentees	23.2%	21.9%
	Crime rate per 1,000 population	155	125
Westminster	Percentage of population the in the Core 20	14.8%	12.7%
	Proportion on children in poverty	31%	30.2%
	Percentage of persistent school absentees	26.0%	21.9%
	Crime rate per 1,000 population	485	125
	Homelessness - households with dependent children per 1,000 population	25.2	21.9

Unhealthy Behavioural Risks – Children

Risks summary for children: Living with a smoker has the biggest impact on the under 18s in North West London



There is a substantial amount of variation in recorded prevalence for each risk within each borough which is greater than the variation between boroughs. Notably, Harrow has some big outliers across all risks. To see this in more detail refer to the appendix.

The left hand graphs show the conditions in which an individual borough has a higher prevalence of risk compared to the North West London average. Ealing and Harrow do not have any risks that have a prevalence than North West London, so are not included.
The table below highlight the order in which risks are likely to have the biggest impact to the children in North West London. These are obtained by considering how many people have the risk (prevalence), the strain of the risk on a person and the healthcare system (unplanned bed days) and the inequality that lies within the prevalence of the risk.

Living with a smoker has the biggest system impact on children across the risks, driven by its much higher prevalence than the other risks. Brent, Hounslow, and Westminster all have a higher prevalence of their children living with a smoker than the North West London average.

Risks by biggest impact in NWL taking into account; prevalence, rate of unplanned bed days and inequality score

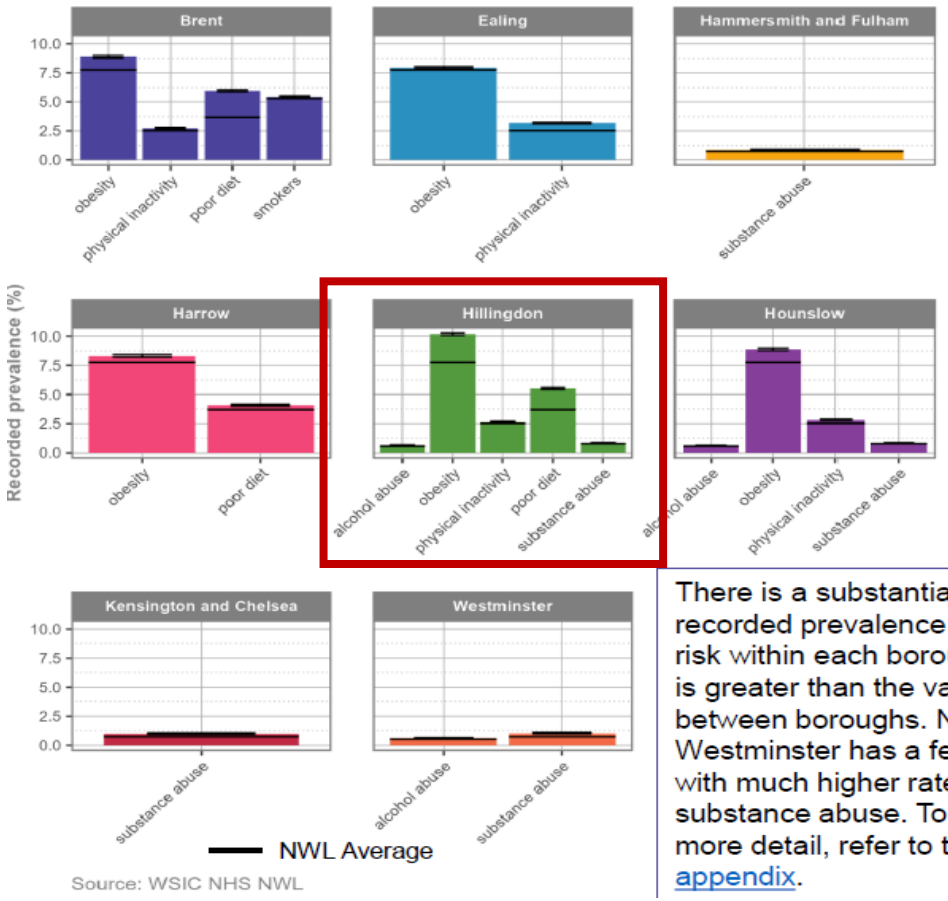
Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Live with smokers	13.5	→	101	↑	0.103	→
Live with substance abuse	1.63	→	120	→	0.169	↑
Live with alcohol abuse	1.79	→	69.8	↑	0.09	→

North West London Integrated Care System

Unhealthy Behavioural Risks – Adults

Risks summary for adults: Smoking has the biggest impact on the adult population in North West London

Risk where the prevalence is higher in a borough compared to the NWL average (2023/24)



Source: WSIC NHS NWL

There is a substantial variation in recorded prevalence for each risk within each borough, which is greater than the variation between boroughs. Notably, Westminster has a few LSOAs with much higher rates of substance abuse. To see this in more detail, refer to the appendix.

The left-hand graphs show the conditions in which an individual borough has a higher prevalence of risk compared to the North West London average.

The table below highlights the order in which risks are likely to have the biggest impact in North West London. These are obtained by considering how many people have the risk (prevalence), the strain of the risk on a person and the healthcare system (unplanned bed days) and the inequality that lies within the prevalence of the risk.

Smoking is the risk behaviour that has the biggest system impact on the adult population of North West London, despite the overall decrease in prevalence. Brent is the only borough that has a higher rate of smoking prevalence compared to the North West London average

Risks by biggest impact in NWL taking into account; prevalence, rate of unplanned bed days and inequality score

Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Smokers	5.29	↓	2,264	↑	0.219	↑
Substance abuse	0.75	→	4,365	↑	0.299	↑
Obesity	7.75	↑	441	→	0.237	→
Poor diet	3.70	→	469	→	0.244	↑
Alcohol abuse	0.55	→	2,991	↑	0.205	→
Physical inactivity	2.52	→	359	→	0.216	→

NHS North West London

Unhealthy Behavioural Risks – Older Adults

Risks summary for older adults: Obesity has the biggest impact in the North West London older adult population

Risk where the prevalence is higher in a borough compared to the NWL average (2023/24)

Source: WSIC NHS NWL

There is a substantial amount of variation in recorded prevalence for each risk within each borough which is greater than the variation between boroughs. Notably, Ealing has a big variation in poor diet. To see this in more detail, refer to the appendix.

The left-hand graphs show the conditions in which an individual borough has a higher prevalence of risk compared to the North West London average.

The table below highlights the order in which risks are likely to have the biggest impact on the older population in North West London. These are obtained by considering how many people have the risk (prevalence), the strain of the risk on a person and the healthcare system (unplanned bed days) and the inequality within the prevalence of the risk.

Obesity is the risk behaviour that has the biggest system impact on the older adult population of North West London, and the prevalence of this risk is increasing, as well as the rate of unplanned bed days per person with this risk. Brent, Ealing, Hillingdon and Hounslow all have higher rates of obesity compared to the North West London average.

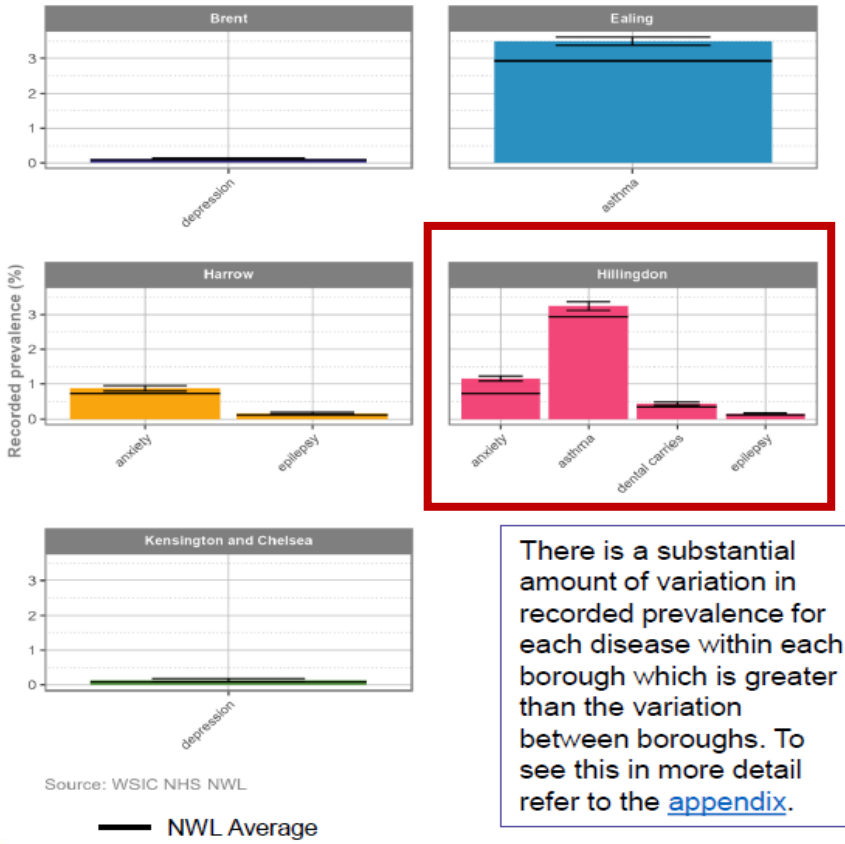
Risks by biggest impact in NWL taking into account; prevalence, rate of unplanned bed days and inequality score

Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Obesity	16.1	↑	1,545	↑	0.155	↓
Smokers	6.72	→	2,264	↑	0.247	↑
Poor diet	7.64	↓	2,521	↑	0.175	↑
Substance abuse	1.48	→	9,782	↑	0.195	↑
Physical inactivity	5.93	→	1,620	↑	0.160	→
Alcohol abuse	1.07	→	2,285	↑	0.143	→

Health – Conditions and Diseases: Children

Conditions summary — children: The conditions that have the biggest system impact are asthma, epilepsy, anxiety, cancer and diabetes

Conditions where the prevalence is higher in a borough compared to the NWL average (2023/24)



Source: WSIC NHS NWL

There is a substantial amount of variation in recorded prevalence for each disease within each borough which is greater than the variation between boroughs. To see this in more detail refer to the appendix.

The left-hand graphs show the conditions in which an individual borough has a higher prevalence of disease compared to the North West London average. Westminster, Hammersmith and Fulham and Hounslow do not have any conditions that have a higher prevalence than North West London', so are omitted.

The table below highlights the conditions likely to have the biggest system impact on the children in North West London. These are obtained by considering how many people have the conditions (prevalence), the strain of the conditions on a person and the healthcare system (unplanned bed days) and the inequality within the disease's prevalence.

Asthma has a much higher prevalence compared to the other diseases and therefore has the overall biggest system impact in North West London's under 18. However, to note, cancer and diabetes are reporting an increase in prevalence, rate of unplanned bed days and inequality. Ealing and Hillingdon have higher rates of asthma compared to North West London.

Top 5 conditions likely to have the biggest impact in NWL taking into account; prevalence, rate of unplanned bed days and inequality score (2023/24)

Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Asthma	2.93	→	123	→	0.190	↓
Epilepsy	0.10	→	2,786	↑	0.189	→
Anxiety	0.74	↑	241	→	0.225	→
Cancer	0.10	↑	2,801	↑	0.102	↑
Diabetes	0.21	↑	847	↑	0.139	↑

Health – Conditions and Diseases: Adults

Conditions summary — adults: The conditions that have the biggest system impact are depression, diabetes, anxiety, hypertension and asthma

Conditions where the prevalence is higher in a borough compared to the NWL average (2023/24)

NWL Average

There is a substantial amount of variation in recorded prevalence for each disease within each borough which is greater than the variation between boroughs. For the diseases in the table Kensington and Chelsea often as a lower mean and median prevalence but the greatest variation between small geographic. To see this in more detail refer to the appendix.

Source: WSIC NHS NWL

The left-hand graphs show the conditions in which an individual borough has a higher prevalence of disease compared to the North West London average. Westminster has no conditions higher than the average and, therefore, is excluded.

The table below highlights the conditions that are likely to have the biggest system impact on the adults in North West London. These are obtained by considering how many people have the conditions (prevalence), the strain of the conditions on a person and the healthcare system (unplanned bed days) and the inequality within the disease's prevalence.

Depression has the overall biggest impact on the adult population of North West London, followed by diabetes and anxiety, both of which are seeing an increase in prevalence, unplanned bed days and inequality. Hammersmith and Fulham, Hillingdon and Kensington and Chelsea have higher rates of depression compared to North West London.

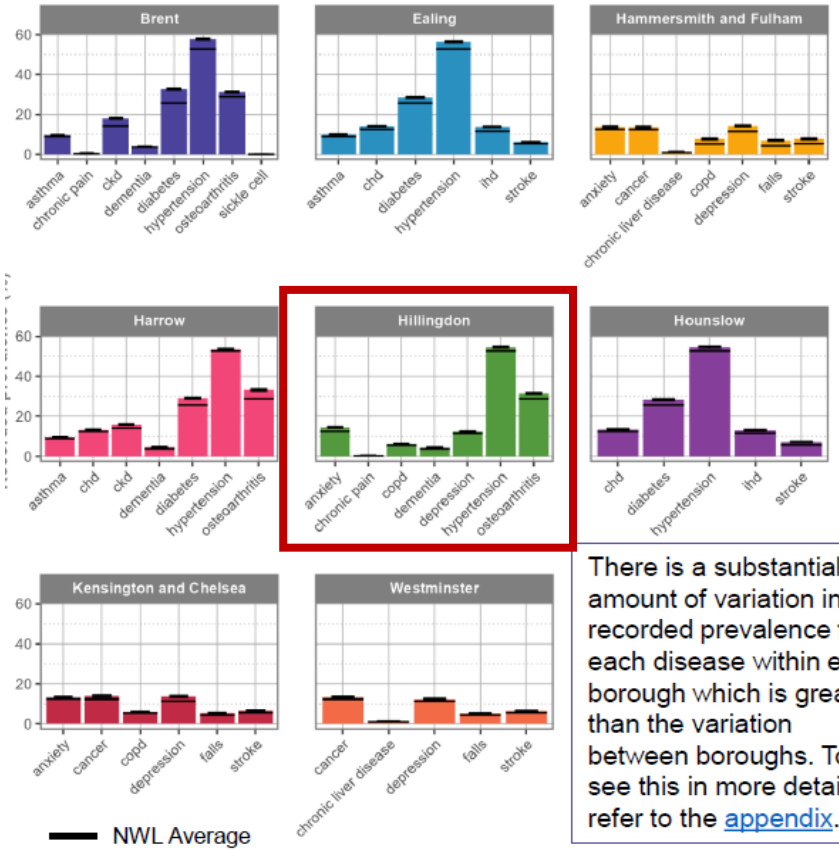
Top 5 conditions likely to have the biggest system impact in adult population of NWL taking into account; prevalence, rate of unplanned bed days and inequality score

Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Depression	9.64	↑	445	→	0.190	↓
Diabetes	4.73	↑	702	↑	0.226	↑
Anxiety	10.6	↑	347	↑	0.184	↑
Hypertension	7.30	↑	549	↑	0.147	→
Asthma	3.77	↑	472	↑	0.209	↓

Health – Conditions and Diseases: Older Adults

Conditions summary — older adults: The conditions that have the biggest system impact are diabetes, falls, hypertension, CHD, and osteoarthritis

Conditions where the prevalence is higher in a borough compared to the NWL average (2023/24)



There is a substantial amount of variation in recorded prevalence for each disease within each borough which is greater than the variation between boroughs. To see this in more detail refer to the appendix.

Source: WSIC NHS NWL

The left-hand graphs show the conditions in which an individual borough has a higher prevalence of disease compared to the North West London average.

The table below highlights the conditions that are likely to have the biggest system impact on older adults in North West London. These are obtained by considering how many people have the conditions (prevalence), the strain of the conditions on a person and the healthcare system (unplanned bed days) and the inequality within the disease's prevalence.

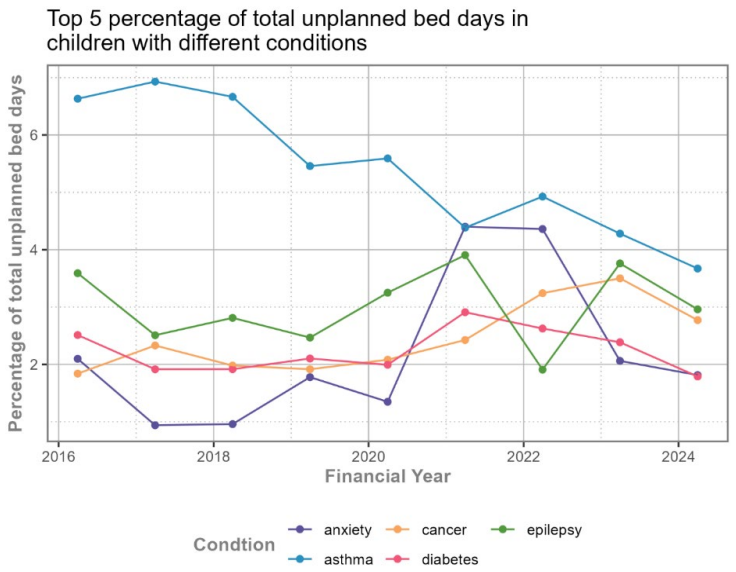
For all the top 5 conditions that have the biggest impact, the trend in prevalence and rate of unplanned bed days is increasing. If the rate of increase for these diseases maintains its current rate, then the prevalence of diabetes is likely to overtake the prevalence of osteoarthritis in the next 10 years. Currently, diabetes has the overall biggest impact on the older adult population of North West London and Brent, Ealing, Harrow and Hounslow have higher rates of diabetes compared to the North West London average.

Top 5 conditions likely to have the biggest impact in NWL taking into account; prevalence, rate of unplanned bed days and inequality score.

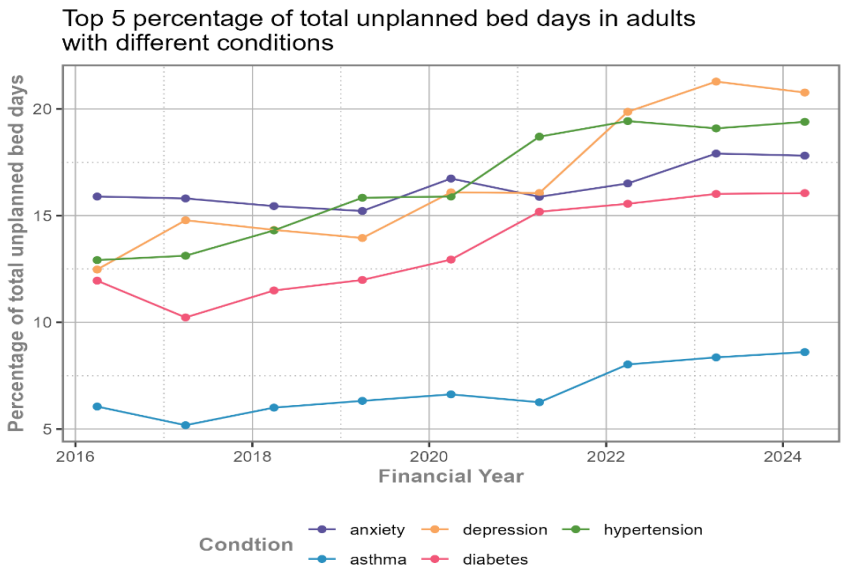
Metric	Prevalence (%)	Trend	Rate of unplanned bed days (per 1,000 population)	Trend	Equity Score	Trend
Diabetes	25.6	↑	1958	↑	0.170	→
Falls	4.42	↑	10,483	↑	0.180	→
Hypertension	52.7	↑	1,790	↑	0.078	↑
CHD	12.5	↑	2,867	↑	0.194	↑
Osteoarthritis	28.8	↑	1,843	↑	0.129	↓

Unplanned Bed Days – By Age Cohort

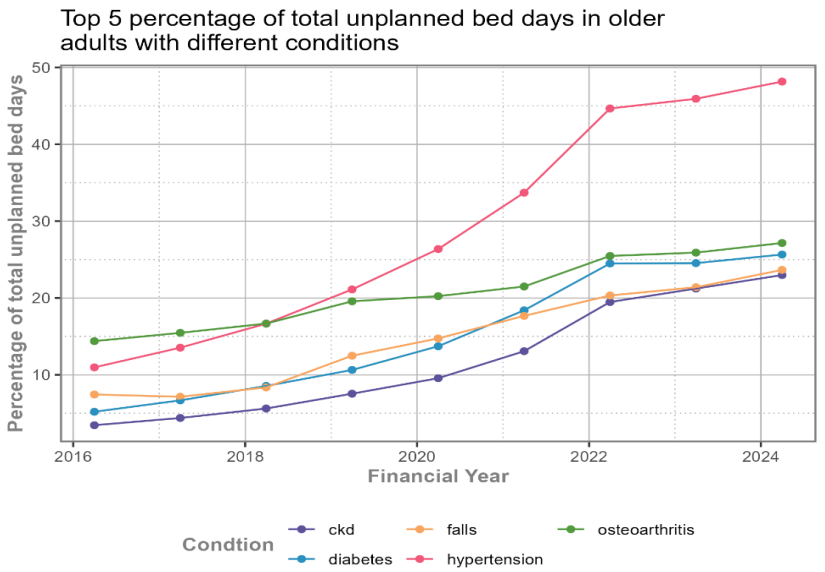
Unplanned bed days can be used as a proxy measure for unmet need. Hypertension accounts for nearly 50% of all unplanned bed days in Older Adults and 20% in Adults. Asthma is the single biggest driver in Children's unplanned admissions. There is a strong correlation between **deprivation and the prevalence of these** conditions and **the rate of unplanned bed days**. The Core 20 group is the most likely group to have many of the conditions reported for adults and older adults. **The 65+ age group, although comprising only 14% of the total population, utilise up to 40% of all healthcare in Hillingdon**



Source: NHS NWL WSIC



Source: NHS NWL WSIC



Source: NHS NWL WSIC