LONDON BOROUGH OF HARROW

Health and Wellbeing Board Agenda

Date: **Thursday 2 November 2023**

Time: **10.00 am**

Venue: **The Auditorium - Harrow Council Hub, Kenmore Avenue, Harrow, HA3 8LU**

Membership (Quorum 5)

Chair:	**Councillor Paul Osborn**
Voting Members:	
Members of Council Nominated by the Leader of the Council:	**Councillor Ghazanfar Ali** **Councillor Hitesh Karia** **Councillor Pritesh Patel** **Councillor Norman Stevenson**
Reserve Members:	Councillor David Ashton Councillor Marilyn Ashton Councillor Chetna Halai Councillor Anjana Patel Councillor Simon Brown
Representatives of North West London Integrated Care Board:	**Dr Radhika Balu (VC)** **Isha Coombes** **Vacancy** **Reserve:** Hugh Caslake
Representative of Healthwatch Harrow:	**Yaa Asamany** **Reserve:** Marie Pate
Representatives from the NHS:	**James Benson** **Simon Crawford** **Reserves:** Jackie Allain James Walters

Non Voting Members:

Director of Public Health	Carole Furlong
Chief Officer, Voluntary and Community Sector	John Higgins
Senior Officer of Harrow Police	Inspector Edward Baildon
Chair of the Harrow Safeguarding Children and Adult Board	Chris Miller
Managing Director of Harrow Borough Based Partnership	Lisa Henschen
Corporate Director People / Director of Adult Social Services, Harrow Council	Senel Arkut
Director of Children's Services, Harrow Council	Parmjit Chahal

Contact: Alison Atherton, Senior Professional - Democratic Services
Tel: 07825 726493 E-mail: alison.atherton@harrow.gov.uk

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Useful Information

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Attending the Meeting in person

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You will be admitted on a first-come-first basis and directed to seats.

Please:

(1) Stay seated.

(2) Access the meeting agenda online at Browse meetings - Health and Wellbeing Board – Harrow Council

(3) Put mobile devices on silent.

(4) Follow instructions of the Security Officers.

(5) Advise Security on your arrival if you are a registered speaker.

Filming / recording

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Agenda publication date: Wednesday 25 October 2023

Agenda - Part I

1. **Attendance by Reserve Members**
To note the attendance at this meeting of any duly appointed Reserve Members.

2. **Declarations of Interest**
To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from all Members present.

3. **Minutes** (Pages 7 - 12)
That the minutes of the meeting held on 13 September 2023 be taken as read and signed as a correct record.

4. **Public Questions**
To receive any public questions received.

Questions will be asked in the order in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, Monday 30 October 2023. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. **Petitions**
To receive petitions (if any) submitted by members of the public/Councillors.

6. **Deputations**
To receive deputations (if any).

7. **Harrow System Pressures Metrics Report** (Pages 13 - 44)
Report of Managing Director of Harrow Borough Based Partnership

8. **Annual Director of Public Health Report (ADPHR)** (Pages 45 - 256)
Report of the Director of Public Health

9. **Health and Wellbeing strategy Update: Healthy Places** (Pages 257 - 268)
Report of the Director of Public Health and Corporate Director of Place

10. **Harrow Safeguarding Partners' Annual Report** (Pages 269 - 320)
Report of the Safeguarding Partners

11. **Creating a smokefree generation and tackling youth vaping** (To Follow)

12. **Any Other Business**
Which cannot otherwise be dealt with.

Agenda - Part II - Nil

Data Protection Act Notice

The Council will record the meeting and will place the recording on the Council's website.

[**Note:** The questions and answers will not be reproduced in the minutes.]

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LONDON BOROUGH OF HARROW

Health and Wellbeing Board

Minutes

13 September 2023

Present:

Chair:	Councillor Paul Osborn		
Board Members:	Councillor Ghazanfar Ali		Harrow Council
	Councillor Hitesh Karia		Harrow Council
	Councillor Pritesh Patel		Harrow Council
	Councillor Norman Stevenson		Harrow Council
	Jackie Allain		NHS (Reserve)
	Yaa Asamany		Healthwatch Harrow
	James Benson		NHS
	Isha Coombes		North West London Integrated Care Board
Non Voting Members:	Parmjit Chahal	Director of Children's Services	Harrow Council
	Lisa Henschen		Harrow Borough Based Partnership
	John Higgins	Voluntary Sector Representative	Voluntary and Community Sector
	Chris Miller	Chair, Harrow Safeguarding Boards	Harrow Council
	Shaun Riley		Harrow Council

In attendance: (Officers)	Matthew Adams	Assistant Director of Climate Change & Natural Resources	Harrow Council
	Sebastien Baugh	Consultant in Public Health	
	Sam Howard		
	Johanna Morgan	Divisional Director, People Services Strategy; Commercialisation & Regeneration	Harrow Council
In attendance: (virtually)	Tony Bellis		
	Tim Bryan	Head of Culture & Leisure	Harrow Council
	Hugh Caslake		
	Simon Crawford		
	Shumailla Dar	Interim Assistant Director of Strategy & Partnerships	Harrow Council
	Anjali Joshi		
	Mavis Kusitor		Harrow Council
	Anoushka Lakhtaria		Harrow Council
Apologies received:	Senel Arkut Dr Radhika Balu	Carole Furlong	

51. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Members:

Ordinary Member	Reserve Member
James Benson	Jackie Allain
Carole Furlong	Sebastien Baugh
Senel Arkut	Shaun Riley

52. Declarations of Interest

RESOLVED: To note that there were no declarations of interests made by Members.

53. Minutes

RESOLVED: That the minutes of the meeting held on 22 June 2023, be taken as read and signed as a correct record.

54. Public Questions

RESOLVED: To note that no public questions, petitions or deputations had been received.

55. CQC Inspection of Community Nursing Services in Harrow

The Board received a presentation from the Director of Operations (Outer Northwest Division), Central London Community Healthcare NHS which provided an overview of the action taken by the Trust to meet the required areas for improvement identified in the CQC's findings following their inspection of the Community Nursing service in Harrow in October 2022.

Following on from the inspection, the trust was then given some recommendations and these recommendations were split into things which the trust should do and things which the trust must do.

The Board were informed that there were 3 should do actions and this related to ensuring that the handovers between the Community nurses and the teams included all the necessary key information and that a formal assessment of patient's capacity was recorded regularly to ensure staff reported on any safeguarding concerns to local authority.

In terms of the must do's, this related to ensuring that the trust put in place robust processes and systems in phase two to safely meet the needs of the patients and to ensure that clinical documentation is completed in sufficient time.

An Officer stated that in their experience the lack of proper formal assessment of mental capacity and their recording was widespread across several agencies and queried whether this was a hindrance to having joined up activity. It was confirmed that a survey had been designed to go out to staff to see how they felt, and it was picked up is that there was almost a fear of doing a mental capacity. It was stated that a supportive programme needed to be put in across the board to empower staff to be able to make these assessments.

In response to a Members question, it was confirmed that the production of the clinical triage function was as it is a more efficient and meant that patients were seen quicker.

Following a question from a Member, it was clarified that the current vacancy rate for staff was around 30%.

RESOLVED: That the Board notes the contents of the report and provided any feedback regarding the areas for improvement.

56. Health and Wellbeing Strategy Update: Healthy Places

The Board received 3 separate presentations which set out the work and commitments being taken forward as part of the healthy place domain of the health and wellbeing strategy.

The first presentation related to the Harrow economic strategy. The Board were informed that the Harrow economic strategy was a 3-year programme running from 2023 – 2026 and that the strategy closely aligned with the Council's vision of restoring pride in Harrow. The strategy was split up into 3 priorities: skills and employability, business growth and Job create and high streets.

Following on from a question relating to the recruitment and development of employability in the Borough, it was agreed that an Officer from the Council would contact a member of the NHS trust directly to ensure a joined-up approach. The Board noted that it would be helpful to have more joined up conversations to take a strategic approach to tackle this issue rather than drawing on the resources of any 1 partner.

As Portfolio Holder for Business and Employment, a Member wished to express that the idea of a joint up approach was a wonderful idea and believed that it was important to have a meeting where everyone got together to tackle the issues.

The Board then received a presentation regarding the Culture and Leisure in Harrow and how that supports mental health. It was noted that the Council plays a major role in providing access to sporting opportunities at a cost that is acceptable to the wider community and that the Council is a direct provider of entry level facilities such as free to use recreational spaces as well as pay and play summer and winter sports pitches, park tennis courts and leisure facilities.

The Leader of the Council noted that one of the real challenges of the next 5-10 years is the placement of the Leisure Centre and stated that having such facilities available is important in terms of health and wellbeing and preventing a lot of issues.

Lastly, the Board received a presentation which outlined the Climate and sustainability Strategy Consultation. The Officer set out the 4 key themes around which collective action is needed to meet the climate change response. These themes are: clean energy used efficiently, green mobility, a waste free economy and healthy places for us and nature.

It was suggested that a check and challenge session could be organised whereby key people from different organisations can come and talk about their initiatives and key issues surrounded the climate change response.

The Leader stated that it would be useful for a presentation on the local plan to be discussed at a future meeting of the board since it will include sections on healthcare provisions.

RESOLVED: That

(1) the board notes the work that is underway and planned to support the delivery of the health and wellbeing strategy;

(2) the board endorses the approach being taken to improve the health and wellbeing of Harrow.

57. Impact of Industrial Action on Elective Waiting List at London North West University Healthcare NHS Trust

The Board received a presentation which provided an overview of the junior doctor and consultant strikes to date across 2023 as per the British Medical Association (BMA) campaign.

The Board were informed that after every strike there was a process in place to ensure that patients were re-booked. Patients didn't go to the bottom of the piles, they were back on the waiting times that they were at and they were prioritised again initially through clinical urgency and then through the waiting times.

Members of the Board were then given the opportunity to ask any questions based on the presentation, however none were raised.

RESOLVED: That the Board notes the report.

58. Better Care Fund (BCF) 2023-25 Submission Update

The Board received an update regarding the Better Care Fund (BCF) 2023-25 submission.

The Better Care Fund submission draws together details or funding streams and actions that are taken locally to achieve the goals of the BCF which are to prevent admission to facilitate discharge from hospital and to maintain people's independence in the Community.

It was noted that although recommendation 2 of the report stated, “the Chair of the Health and Wellbeing Board, following consultation with the Director Harrow Place Based Partnership and Corporate Director People Services, be authorised to approve of the final submission for BCF 2023-25”, the BCF had been submitted already and therefore the recommendation to the Board is that the Board approves the submission.

RESOLVED: That

(1) the Board notes the details of the report;

(2) the Board approves the final submission for BCF 2023-25.

59. Introduction of Right Care, Right Person Model

The Board received an information briefing from the Metropolitan Police regarding the Introduction of Right Care, Right Person model.

The Model is set to be introduced on the 31 October 2023 and is aimed at making sure that the right agency deals with health-related calls instead of police being the first responder. It has been shown in Humberside to improve outcomes and reduce police demand. For victims of crime, this means freeing up police time officers can deploy to incidents in line with the core purposes of policing. For health patients, it means helping vulnerable patients to access the right care more quickly and also a policing response to a health issue can often lead vulnerable people feeling criminalised even where no crime has been committed.

The Board were informed that there were 4 elements to the Right Care, Right Person model that were being addressed. These are: concern for welfare, absent without leave from mental health establishments, transportation and the 4th is around Section 136 and voluntary patients.

A Member noted that the Humberside model took around 2 years to embed the whole process and sought the level of assurance that could be provided that all the agencies, partner agencies are prepared for this change. It was confirmed that this has been a process that's been ongoing now for some time. There have been regular meetings where every organisation has representation and quite largely there's already existing policies in place around a number of these key themes. The Officer also confirmed that there are additional Pan London processes being developed at that very top executive level.

In response to a question regarding the impact that this would have on Harrow, it was confirmed that these policies will be discussed at that executive level with the London wide or even national processes and policies disseminated out locally.

A Member sought reassurance in terms of the Police resource allocation for allowing the transitions to take place. The Officer stated that there will be a triage process in place, which will be for the initial call handling, and that will triage the calls.

The Leader of the Council stated that it would be a good idea for Officers and the Police to meet on a regular basis as this is implemented to pick up any unintended consequences and report back to the board at a future meeting.

RESOLVED: That the information briefing be noted.

(Note: The meeting, having commenced at 10.04 am, closed at 12.05 pm).

(Signed) Councillor Paul Osborn
Chair

LONDON BOROUGH OF HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	2 November 2023
Subject:	Harrow System Pressures Metrics Report
Responsible Officer:	Lisa Henschen, Managing Director, Harrow Borough Based Partnership
Public:	Yes
Wards affected:	All
Enclosures:	Appendix A: Winter System Pressures Metrics Appendix B: Harrow Borough Based Partnership winter plan

Section 1 – Summary and Recommendations

This report sets out a draft schedule of an expanded set of system pressures metrics that are designed to indicate:

- Demand pressure on the Harrow health and care system;
- The effectiveness of the system's response to that demand.

The first set of data will be circulated during October, although further work may be required after that date to secure data for some indicators.

Recommendations:

The Board is requested to note and comment on the contents of the schedule.

Section 2 – Report

The Harrow Borough Based Partnership currently discusses a set of indicators of demand pressure on the local health and care system at its fortnightly meetings.

The scope of these indicators is limited and largely reflects pressure on hospital based health services.

The Partnership's 2023/24 winter planning has included the development of an expanded list of metrics that will inform the system's response to increased demand during the winter period. Most of these indicators will be reported weekly or monthly, depending on the frequency with which the data is reported.

The report will be used to inform discussions at the Harrow Health and Care Executive of necessary mitigations when services are under high levels of pressure and of potential service improvements.

These indicators seek to illustrate the following aspects of the state of the system:

- Success of Prevention Measures eg vaccinations; Winter Wellness MECC training.

- Demand Pressure e.g., discharges to social care; A&E attendances; referrals to community health.

- Pathway Efficiency e.g. Delayed discharges from hospital

- Pathway Improvement e.g. Interface between GPs and the hospital

- Utilisation of Community Resources e.g., Use of community rehab beds

- System Stress i.e. indications that the effectiveness of part or parts of the system has deteriorated.

The set of measures are attached to this report as Appendix A and will be populated as an up to date system position and shared 5 days in advance of the Health and Wellbeing Board meeting.

The Harrow Borough Based Partnership winter plan is attached for reference in Appendix B.

Ward Councillors' comments N/A

Financial Implications/Comments

Whilst this report does not have any direct financial implications, the increased support is funded through targeted allocations (such as the winter pressures funding allocated through the BCF) with the metrics helping to ensure scarce organisational resources are being targeted to maximise value for money and achieve system outputs. The use of these metrics may, in time, support targeting of any additional resource allocations and consideration of wider system budget requirements as part of the annual budget setting process for partner organisations

Legal Implications/Comments

Terms of reference for the Health and Wellbeing Board include:
To promote integration and partnership across areas, including through promoting joined up commissioning plans across NHS, social care and public health.

Risk Management Implications

The indicators will support the monitoring of potential risks relating to increased demand for services during the winter period.

Risks included on corporate or directorate risk register? **N/A**

Separate risk register in place? **N/A**

The relevant risks contained in the register are attached/summarised below. **N/A**
The following key risks should be taken into account when agreeing the recommendations in this report:

Risk Description	Mitigations	RAG Status
The continuation of Junior Doctor and Consultant strikes over the winter period will impact the resilience of the system to manage winter pressures	Business Continuity Planning within Acute Trusts	Amber

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? **N/A**

Council Priorities

A place where those in need are supported.

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 17/10/2023

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 18/10/2023

Chief Officer: Senel Arkut
Signed by the Corporate Director
Date: 19/11/2023

Mandatory Checks

Ward Councillors notified: No, as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Hugh Caslake: AD Integration and Delivery (07958 196271)

Background Papers:

None

If appropriate, does the report include the following considerations?

1.	Consultation	NO
2.	Priorities	NO

Harrow Borough Partnership

DRAFT System Pressures Metric Report

Harrow Borough Based Partnership

Supporting better care and healthier lives

Harrow System Pressures Metrics (1/3)

	System Indicators	Status	Source	Cohort	Frequency
Success of Prevention Measures					
1	Autumn Campaign - Covid vaccination uptake by cohort		Foundry	Harrow	Weekly
2	Autumn Campaign - Flu vaccination uptake by cohort (including years 7 and 11)		WSIC/Immform	Harrow	Weekly
3	Paediatric Asthma Reviews within 48 hrs of AED attendance		Public Health	Harrow	Monthly
4	Paediatric Asthma Reviews within 48 hrs of ED Admissions		Public Health	Harrow	Monthly
5	Winter Wellness MECC sessions uptake		VAH	Harrow	Monthly
Demand pressure					
6	AED Attends		NWL BI	NPH	Weekly
7	AED Attends Paeds		NWL BI	NPH	Weekly
8	UTC Attends		NWL BI	NPH	Weekly
9	AED Emergency Admissions		NWL BI	NPH	Weekly
10	Community/District Nursing - Number of visits completed (in hours)		CLCH	Harrow	Weekly
11	Community/District Nursing - Number of rostered staff (in hours)		CLCH	Harrow	Weekly
12	Number of hospital discharges in month that required social care input		LA	Harrow	Monthly
13	Number of patients being worked with by social care		LA	Harrow	Monthly
14	MH Liaison AED Referrals		CNWL	Harrow	Weekly
15	MH Liaison AED Referrals - 1 hour response		CNWL	Harrow	Weekly
16	MH Liaison Ward referrals		CNWL	Harrow	Weekly
16	MH Liaison Ward referrals - 24 hour response		CNWL	Harrow	Weekly
17	Rapid Response - Number of visits completed (in hours)		CLCH	Harrow	Weekly
18	Rapid Response - Number of rostered staff (in hours)		CLCH	Harrow	Weekly
19	Number of referrals to drug and alcohol service		CNWL	Harrow	Monthly
20	Number of urgent referrals to drug and alcohol service		CNWL	Harrow	Monthly
21	Number of referrals to Harrow Housing pathway for homeless patients with mental health issues		LA Housing	Harrow	Monthly
22	Number of urgent referrals to Harrow Housing pathway for homeless patients with mental health issues		LA Housing	Harrow	Monthly
23	People contacting LA about Damp / Mould		LA Housing	Harrow	Monthly
24	Primary Care Patches Use / Availability		Primary Care	Harrow	Weekly
25	Covid Related 111 Calls		HLP	Harrow	Weekly

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Harrow System Pressures Metrics (2/3)

	System Indicators	Status	Source	Cohort	Frequency
Pathway Efficiency					
26	Community Bed DTOCs		Local Care	Harrow	Weekly
27	DTOCs by pathway @ NPH as % discharges vs NWL Boroughs		Local Care: Optica / NWL BI	Harrow	Weekly
28	NPH DTOCs: Awaiting equipment		NPH Discharge Hub / Optica	Harrow	Weekly
29	NPH DTOCs: Awaiting long term placement		NPH Discharge Hub / Optica	Harrow	Weekly
30	NPH DTOCs: Awaiting rehab bed		NPH Discharge Hub / Optica	Harrow	Weekly
31	NPH DTOCs: Homeless		NPH Discharge Hub / Optica	Harrow	Weekly
32	NPH DTOCs: Patient / family choice delays.		NPH Discharge Hub / Optica	Harrow	Weekly
33	NPH DTOCs: POC start / restart		NPH Discharge Hub / Optica	Harrow	Weekly
34	Number of pts waiting more than 48 hours on a P1 pathway escalated		NPH Discharge Hub / Optica	Harrow	Weekly
35	Number of pts waiting more than 5 days on a P1 pathways escalated		NPH Discharge Hub / Optica	Harrow	Weekly
36	Number of pts waiting more than 5 days on a P3 pathway escalated		NPH Discharge Hub / Optica	Harrow	Weekly
37	Number of pts waiting more than 7 days on a P3 pathway escalated		NPH Discharge Hub / Optica	Harrow	Weekly
38	Community Equipment Delays		Borough Team	Harrow	Monthly
39	Enhanced Frailty service - Current Caseload		Borough Team	Harrow	Monthly
40	Enhanced Frailty service - Step ups		Borough Team	Harrow	Monthly
41	Enhanced Frailty service - Step down		Borough Team	Harrow	Monthly
Pathway improvement					
42	Complete FIT notes in secondary care		NPH Discharge Hub / Optica	Harrow	Weekly
43	Discharges to Care Homes at Weekends		NPH Discharge Hub / Optica	Harrow	Weekly
44	Onward referrals (C2C referrals)		NPH Discharge Hub / Optica	Harrow	Weekly
45	Discharge Letters sent to GP Practices		NPH Discharge Hub / Optica	Harrow	Weekly

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Harrow System Pressures Metrics (3/3)

	System Indicators	Status	Source	Cohort	Frequency
Utilisation of community resources					
46	Capacity Access Improvement Plans - Additional capacity per site and number of redirections from UTC and 111		Borough Team	Harrow	Monthly
47	Community Rehab bedded care flow / Intermediate Care Beds - Utilisation and LOS		Local Care	Harrow	Monthly
48	Number of contacts at Community Pharmacy Consultation Service not requiring redirection		Borough Team	Harrow	Monthly
49	Uptake / Utilisation of: Enhanced Access Services		Borough Team	Harrow	Monthly
50	Virtual Ward contacts for Cardiology (Heart Failure and AF), Respiratory and Diabetes		Local Care	Harrow	Monthly
51	Uptake / Utilisation of: Care Home Support Service		Borough Team	Harrow	Quarterly
52	Uptake / Utilisation of: Childhood Asthma Clinics		Borough Team	Harrow	Quarterly
53	Uptake / Utilisation of: CYP Health Inequalities Clinics		Borough Team	Harrow	Quarterly
54	Uptake / Utilisation of: Additional Care for Complex Patients		Borough Team	Harrow	Quarterly
System Stress					
55	Hospital Capacity Status		NPH	NPH	Weekly
56	12 Hour AED Waits		NWL BI	NPH	Weekly
57	LAS Handovers - Total number of 60 min Breaches		NWL BI	NPH	Weekly
58	Community/District Nursing - Total number of visits deferred once		CLCH	Harrow	Weekly
59	Community/District Nursing - Total number of visits deferred more than once		CLCH	Harrow	Weekly
60	Rapid Response - Number of referrals with a 2 hour response time		CLCH	CLCH	Weekly
61	Rapid Response - Total number of initial visits triaged for a 2 hour response that were not completed within 2 hours of acceptance into service		CLCH	CLCH	Weekly
62	Rapid Response - Total number of referrals rejected due to capacity		CLCH	CLCH	Weekly
63	Community Services Sickness Absence		CLCH	CLCH Harrow	Weekly

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Harrow Borough Partnership Winter Plan

Winter 2023/24

Draft 3 - FINAL

Harrow Borough Based Partnership

Supporting better care and healthier lives

The Harrow Borough Based Partnership

Harrow Borough Based Partnership brings together our NHS organisations, Harrow Council, our GPs, and local Voluntary & Community Sector.

We strive to support each other and our communities as equal partners focussing on better health and wellbeing for all.

NHS North West London Integrated Care System	Harrow Council	Harrow's Primary Care Networks
NHS Central London Community Healthcare NHS Trust	NHS Central and North West London NHS Foundation Trust	NHS London North West University Healthcare
Harrow Together	Harrow Health Community Interest Company	St Luke's Hospice

Harrow Borough Based Partnership
Supporting better care and healthier lives

Introduction

It is the ambition of the Borough Based Partnership in Harrow that our winter plan is a plan for the Place for Harrow and its citizens and carers. We are seeking to achieve, through a collaborative planning process led by our Health and Care Executive, that we move away from a focus on individual organisational capacity planning towards a Place Plan. This winter plan for 23/24 will build on our system learning and evaluation of the Partnership's winter response in 22/23.

The Place plan for Harrow will focus on:

- Taking preventative action to mitigate where possible, the impact of illness of individuals, families and the health and care system, through our flu and COVID immunisation delivery, particularly amongst groups experiencing the highest levels of health inequalities;
- Harnessing our local assets in Harrow; our building and community spaces to provide a warm and safe places within our communities, where people can come together for company, extending this where possible to a range of community activities to support health and wellbeing of our citizens;
- Communication with local citizens to support them to navigate the local health and care offer, so care can be provided by the right service and/or individual in the right place;
- Addressing the wider determinants of health that will impact our local population over the winter, through a robust information, advice and support offer to support income maximisation, support home adaptations to create energy efficiencies and action to reduce the risks of homelessness.
- Continuing to strengthen our support and capacity in primary and community teams to prevent admissions to hospital and ensure a robust discharge pathway out of hospital to maintain effective care for people who need the support of hospital services;
- Deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place for in and out of hospital care;
- Securing a strong discharge pathway to reduce the length of time our citizens spend in hospital once medically fit to leave, delivering the best outcomes for our citizens and the wider functioning of our urgent and emergency care services.

Overview of the Harrow Winter Plan

Prevention and community winter wellness

- Health and wellbeing support through the Warm Hub programme
- Robust flu and COVID vaccination programme across all cohorts
- Addressing the wider determinants of health and admission risks
- Communication and engagement campaign with local communities, to include information about Talking Therapies and mental health perinatal services

Community based admission avoidance

- Securing primary care access and capacity
- Enhanced Frailty Service
- Rapid response and care home support
- Mental health – crisis alternative- Coves, stepdown beds, Home Treatment Team

In hospital care

- SDEC
- Acute Hospital Flow and increased bed capacity
- Community rehab bedded care flow
- Mental Health- in-reach to medical wards for people with alcohol problems from Substance Misuse provider

Discharge pathways

- Discharge Hub and Discharge Support Service
- Enhanced on-site social care
- Increased provision of step down beds
- Integrated intermediate care service, including reablement
- Increased provision for same day equipment
- Increased home care provision, including weekends
- Mental Health- need access to hospital discharge team, to improve flow

Winter demand and capacity modelling (1/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Success of Prevention Measures									
1	Autumn Campaign - Covid vaccination uptake by cohort		Foundry	Harrow	Weekly	0.05%	0.05%		
2	Autumn Campaign - Flu vaccination uptake by cohort (including years 7 and 11)		WSIC/Immform	Harrow	Weekly	5.90%			
3	Paediatric Asthma Reviews within 48 hrs of AED attendance		Public Health	Harrow	Monthly				
4	Paediatric Asthma Reviews within 48 hrs of ED Admissions		Public Health	Harrow	Monthly				
5	Winter Wellness MECC sessions uptake		VAH?	Harrow	Monthly				
Demand pressure									
6	AED Attends		NWL BI	NPH	Weekly	2,062	1,776		
7	AED Attends Paeds - Harrow		NWL BI	NPH	Weekly	160	160		
8	UTC Attends		NWL BI	NPH	Weekly	1,359	1,359		
9	UTC Attends Paeds - Harrow		NWL BI	NPH	Weekly	161	161		
10	Community/District Nursing - Number of visits completed (in hours)		CLCH	Harrow	Weekly	1,616	1,577		
11	Community/District Nursing - Number of rostered staff (in hours)		CLCH	Harrow	Weekly	1,455	1,471		
12	LA Demand Pressure		LA	Harrow	Weekly				
13	MH Liaison AED Referrals		CNWL	Harrow	Weekly	57	30		
14	MH Liaison AED Referrals - 1 hour response		CNWL	Harrow	Weekly	66.7%	72.7%		
15	MH Liaison Ward referrals		CNWL	Harrow	Weekly	20	73		
16	MH Liaison Ward referrals - 24 hour response		CNWL	Harrow	Weekly	83.3%	94.1%		
17	Rapid Response - Number of visits completed (in hours)		CLCH	Harrow	Weekly	272	332		
18	Rapid Response - Number of rostered staff (in hours)		CLCH	Harrow	Weekly	345	368		
19	Number of referrals to drug and alcohol service		CNWL	Harrow	Monthly				
20	Number of urgent referrals to drug and alcohol service		CNWL	Harrow	Monthly				
21	Number of referrals to Harrow Housing pathway for homeless patients with mental health issues		LA Housing	Harrow	Monthly				
22	Number of urgent referrals to Harrow Housing pathway for homeless patients with mental health issues		LA Housing	Harrow	Monthly				
23	People contacting LA about Damp / Mould		LA Housing	Harrow	Monthly				
24	Primary Care Patches Use / Availability		Primary Care	Harrow	Weekly				

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Winter demand and capacity modelling (2/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Pathway Efficiency									
25	Community Bed DTOCs		Local Care	Harrow	Weekly				
26	DTOCs by pathway @ NPH as % discharges vs NWL Boroughs		Optica / NWL BI	Harrow	Weekly				
27	NPH DTOCs: Awaiting equipment		LNWUHT / Optica	NPH/Harrow	Weekly				
28	NPH DTOCs: Awaiting long term placement		LNWUHT / Optica	NPH/Harrow	Weekly				
29	NPH DTOCs: Awaiting rehab bed		LNWUHT / Optica	NPH/Harrow	Weekly				
30	NPH DTOCs: Homeless		LNWUHT / Optica	NPH/Harrow	Weekly				
31	NPH DTOCs: Patient / family choice delays.		LNWUHT / Optica	NPH/Harrow	Weekly				
32	NPH DTOCs: POC start / restart		LNWUHT / Optica	NPH/Harrow	Weekly				
33	Number of pts waiting more than 48 hours on a P1 pathway escalated		LNWUHT / Optica	NPH/Harrow	Weekly				
34	Number of pts waiting more than 5 days on a P1 pathways escalated		LNWUHT / Optica	NPH/Harrow	Weekly				
35	mber of pts waiting more than 5 days on a P3 pathway escalated		LNWUHT / Optica	NPH/Harrow	Weekly				
36	Number of pts waiting more than 7 days on a P3 pathway escalated		LNWUHT / Optica	NPH/Harrow	Weekly				
37	Bridging Service Indicators		LA	NPH/Harrow	Fortnightly				
38	Community Equipment Delays		Borough Team	NPH/Harrow	Monthly				
39	Enhanced Frailty service - Current Caseload - Aug & July		Borough Team	NPH/Harrow	Monthly	191	207		
40	Enhanced Frailty service - Step ups - Aug & July		Borough Team	NPH/Harrow	Monthly	69	82		
41	Enhanced Frailty service - Step down - Aug & July		Borough Team	NPH/Harrow	Monthly	47	76		
Pathway Improvement									
42	Complete FIT notes in secondary care		LNWUHT	NPH/Harrow	Weekly				
43	Discharges to Care Homes at Weekends		LNWUHT	NPH/Harrow	Weekly				
44	Onward referrals (C2C referrals)		LNWUHT	NPH/Harrow	Weekly				
45	Discharge Letters sent to GP Practices		LNWUHT	NPH/Harrow	Weekly				

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Winter demand and capacity modelling (3/3)

To will be reviewed fortnightly by the Harrow Health and Care Executive.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Utilisation of community resources									
46	Capacity Access Improvement Plans - Additional capacity per site and number of redirections from UTC and 111		Borough Team	Harrow	Monthly				
47	Community Rehab bedded care flow / Intermediate Care Beds - Utilisation and LOS		Local Care	Harrow	Monthly				
48	Number of contacts at Community Pharmacy Consultation Service not requiring redirection		Borough Team	Harrow	Monthly				
49	Uptake / Utilisation of: Enhanced Access Services		Borough Team	Harrow	Monthly				
50	Virtual Ward contacts for Cardiology (Heart Failure and AF), Respiratory and Diabetes		Local Care	Harrow	Monthly				
51	Uptake / Utilisation of: Care Home Support Service		Borough Team	Harrow	Quarterly				
52	Uptake / Utilisation of: Childhood Asthma Clinics		Borough Team	Harrow	Quarterly				
53	Uptake / Utilisation of: CYP Health Inequalities Clinics		Borough Team	Harrow	Quarterly				
54	Uptake / Utilisation of: Additional Care for Complex Patients		Borough Team	Harrow	Quarterly				
System Stress									
55	Hospital Capacity Status		NPH	NPH	Tuesday	FCP	Black		
56	12 Hour AED Waits		NWL BI	NPH	Weekly	340	356		
57	LAS Handovers - Average number of 60 min Breaches per day		NWL BI	NPH	Weekly	0	2		
58	Community/District Nursing - Total number of visits deferred once		CLCH	Harrow	Weekly	0	1		
59	Community/District Nursing - Total number of visits deferred more than once		CLCH	Harrow	Weekly	0	0		
60	Rapid Response - Number of referrals with a 2 hour response time		CLCH	CLCH	Weekly	56	59		
61	Rapid Response - Total number of initial visits triaged for a 2 hour response that were not completed within 2 hours of acceptance into service		CLCH	CLCH	Weekly	4	14		
62	Rapid Response - Total number of referrals rejected due to capacity		CLCH	CLCH	Weekly	0	0		

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Management of interface for system efficiency

There is work being done at both local and NWL level to manage system efficiency. Following the 'Delivery plan for improving access to primary care' being published, there are three priorities that will be reviewed:

1. Onward referrals (C2C referrals),
2. Complete FIT notes in secondary care. Call and recall of patients to be done by trusts ,
3. GPs should have access to single email / primary care liaison officers in each trust. Clear points of contact at point of referral for GPs and patients to access secondary care and working GP bypass numbers for the trust to hold in their systems.

The above work is being picked up through 3 working groups which will be reporting to NWL System interface group. Data sharing between primary care and LNWHT; this will be through CIE and LCR. With the trust now switched to Cerner, this should become more seamless.

Over the coming period work will be done to ensure there is an updated contact list that includes bypass numbers for Harrow practices, community services and hospital services. This list will then be made available to health and care services within Harrow. LNWHT will be looking at amending templates for outpatient letters so that service contact details are available for patients and GPs. We are picking this up at Local interface group.

Work will be done with primary care colleagues to ensure referrals are sent through on the correct forms especially when referring to SDEC. Work is taking place within NWL to improve quality of discharge summaries with the possibility of an inclusion of a contact number for the pharmacy team that practices, and community pharmacies can use to discuss medication queries.

A letter will be drafted to be sent to clinical teams in LNWHT and GPs across Brent, Harrow and Ealing. The letter will be like that sent last year but with a refreshed set of priority areas for focus for primary care and LNWHT.

Sharing of performance data and agreed escalation processes

The Northwick Park discharge hub coordinates the patient level daily calls for system coordination of individual issues and barriers to discharge.

As part of our plan for winter, it is proposed that a more robust system of escalation is introduced to provide senior input for challenges to discharge.

Daily prioritisation of discharges is taking place involving the discharge hub and social care services. The nationally commissioned Optica system is being implemented in NWL ICB and will provide a common source of analysis on the discharge pathway.

Briefings will be circulated to the DASS and Managing Director Harrow BBP three times each week on patients that are delayed, using the following criteria:

- Patients waiting more than 48 hours on a P1 pathway
- Patients waiting more than 5 days on a P1 pathway
- Patients waiting more than 48 hours on a P2 pathway
- Patients waiting more than 5 days on a P3 pathway
- Patients waiting more than 7 days on a P3 pathway

To ensure parity briefing will also be established once a week for Mental Health and Learning Disability patients at NPH Mental Health Unit or on medical wards clinically ready for discharge but delayed in line as follows:

- Patients waiting more than 72 hours on any pathways

The system flow and winter planning workstream will take strategic oversight of delays in the system, beyond individual patient delays to focus on themes and system issues that are factors in delay, for a collective partnership response to support in addressing them.

Prevention and community winter wellness

Health and wellbeing support to warm hubs

Following the successful delivery and evaluation of the Harrow Winter Wellness programme in 22/23, the London Borough of Harrow will be supporting the scheme for the 23/24 winter, running from November 2023 until March 2024. This will be funded from the Public Health grant and BBP inequalities funds. Warm hubs will deliver the following interventions as part of the winter wellness scheme:

- Support the delivery of a number of activities aligned with specific priorities e.g. Making Everyone Contact Count, physical activity, healthy cooking and eating, reducing falls risk, smoking cessation.
- Targeted clinical outreach for specific priority areas through health checks for residents attending warm hubs.
- Distribute warm packs provided by public health.
- Support the community-based Conversation Café model delivery.
- Support the provision of information and advice services delivering from warm hubs.

We have built on last years evaluation through: focusing on expanding the proactive health checks in warm hubs; encouraging collaborative & innovative approaches to engaging with communities; developing an enhanced evaluation offer that will strengthen the evaluation of the programme this year.

Addressing the wider determinant of ill health and admission risk

MECC:

Voluntary Action Harrow have been commissioned to deliver the Winter Wellness MECC sessions this winter. The session will focus on how to eat better, stay warm and find the best health help. The session will be open to all colleagues including frontline staff.

Cost of Living Support and Housing:

Local Authority have set up a support page for residents to seek support with the cost of living crisis (Help with the cost of living – London Borough of Harrow). A working group has been set up to oversee this.

Housing-related support services including; EACH Counselling & Support, Age UK Hillingdon, Harrow & Brent. Fuel Poverty and Energy Advice; Seasonal Health Intervention Network (SHINE) run by Islington Council for Londoners and Green Doctor (Groundwork)

Damp and Mould work- working group, set up to work together on responding to the regulator/government on damp and mould, developing a comms plan, monitoring trends in the number of cases, developing a strategy.

Prevention and community winter wellness

Flu and COVID vaccination

- The Autumn campaign will commence on around early to mid October. The cohorts will be the same as Autumn 2022. All Harrow PCNs will be participating.
- Autumn flu plans to be jointly developed with COVID to reflect the need for co-administration wherever possible.
- Pathway for Newly severely immunosuppressed patients now available.
- The National Flu immunisation programme 2023/2024 has been published. It sets out which groups are eligible for flu vaccinations this coming flu season. 50-64 year olds are not part of the eligible groups.
- Secondary school children in years 7 and 11 are entitled to free flu jab but all school-based delivery will have a hard stop of 15th December to align with the Christmas break.
- Frontline H&SCWs are included in this year's flu programme and vaccinations should be delivered through occupational health schemes.
- Targets for flu will be 100% offer to all eligible and ambition to meet or exceed last year's position.
- All plans must have a strong emphasis on tackling inequalities and focus on groups not coming forward.
- The Immunisation and Flu Task & Finish Group will continue to meet on a monthly basis, moving to 2weekly as we near September (flu season) - Representation of the group is from Borough Team, Public Health, Local authority PCN management leads, Immunisation champions and community pharmacy representation.

Prevention and community winter wellness

Communication and engagement with local communities

NW London-wide communications and engagement winter plan I in place to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan will use data from previous winter campaigns and the Whole Systems Integrated Care Dashboard to target and support the right areas and communities. A local working group has been established across the NWL communication leads and Local Authority communication and BBP team to ensure coordination of efforts and a dynamic response based on vaccination uptake data and urgent care activity.

Specific areas of focus include:

- Full winter messaging flyers launching in October, with Flu campaign, Children and young people campaign and Self-care campaign launching and continuing throughout winter period, with focus on Urgent and emergency care - Vaccination (flu/*Covid booster) - Children and young people Primary care.
- Harrow Health Citizen Forum [online] in September, December, March with focus on Winter Wellness messaging.
- ‘Town hall’ style in person forum at prominent locations such as St. Peter’s Church with a focus on winter messaging.
- Regular ‘drop-in’ sessions with specific local communities, engagement and information, including co-ordination with local communities on immunisations i.e., Romanian - RCCT, Somalian - HASVO, Gujarati - SKLPC, as well as rhyme time library sessions targeting under 5s and young mothers.
- Local schools link-in to target under 18s and parent/guardians
- EOI process for commissioning local VCS groups to engage resident networks on winter wellness campaigns. This will be live until September, with community grants to be issued for roll-out September/October

Community based admission avoidance

Securing Primary Care Access and Capacity

- Care Home Support as a key focus for preventing winter admissions: a review will commence 02/10/23 of the support provided to care homes to minimise the avoidable use of the UEC system and ensure safe, timely discharges from hospital to care homes
- An action plan for improving reviews and follow up of Children with asthma is in development, which will include increasing training to expand capacity for asthma reviews across the Primary Care workforce, a focused mapping of the discharge and notification pathway for children attending or being admitted to A&E following asthma attack and regular data reporting and review at PCN level
- Two Initial Accommodation Centres established for asylum seekers providing health screening and GP registration
- Enhanced Access now fully embedded (commenced October 2022): additional GP appointments from 6.30pm to 8pm weekdays and 9am to 5pm on Saturday
- Capacity Access Improvement Plans being implemented through practice action plans to create more capacity and increase access, and GP Access Centre operating at the Pinn Medical Centre, targeting 90% utilisation, 7 days a week and bank holidays
- CYP Health Inequalities Clinics and Additional Care for Complex Patients (extended appointments) were implemented in June
- Additional services commissioned through NWL Standard offer implemented from June includes: spirometry; wound care; ABPM; ECG; ring pessaries.
- ehubs implementation improving across Harrow utilising ARRs clinicians. We are seeing high levels of e-consultation in Harrow.
- Community Pharmacy Minor Ailment Service to be rolled out Q3/Q4 once NHSE have resolved prescribing and liability issues
- Community Pharmacy Consultation Scheme: uptake to be improved through software to facilitate referral that will be purchased and implemented across NWL

Community based admission avoidance

Harrow Rapid Response

- The Harrow Rapid Response Team will maintain business as usual levels of activity for winter 2023/24 of 1000 patient contacts per month (inc Follow up visits).
- The service averaged 288 referrals per month for winter 2022/23.
- Current service performance is 97.6% against its KPI of a 2-hour response time for all referrals and it is anticipated that this will be maintained in line with performance over winter 2022/23

	Nov-22	Dec-22	Jan-23	Feb-23
Referrals	214	342	325	273

Care Home Support Team:

- The Harrow Care Home Support Team will be supported by Harrow Rapid Response if they see and increase referrals and if they meet Rapid Response criteria.
- Weekends and OOH will be covered by Harrow Rapid Response.
- Activity data for the Care Home support Team is not currently reported, however this will be established for winter 23/24.

Proactive frailty management

The Enhanced Frailty service operates all throughout the year and will be carrying on business as usual:

- Systematic proactive identification of frail patients and with escalating risks
- Timely triage
- Step-up to the service and provide appropriate interventions including integrated multi-agency teams bringing skills and capacity together based on the need of the individual
- Step-down and maintenance as appropriate.
- Work with wider system partners i.e. acute, social care etc. for seamless integrated service i.e. work towards a resilient system especially during winter.

Overall ensuring patient benefit from specific interventions and have better care and experience and avoiding non-elective admissions.

Additional Social Care

Increased social work capacity to be put in place to work with primary care to support people in the home to avoid hospital admission.

High Impact Area 2: Frailty - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
High Impact Area 8: Urgent Community Response - increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission

In-hospital care

Say Day Emergency Care (SDEC)

- SDEC
  - 7 day service that runs for 12 hours of the day.
  - The capacity is to see 75 appointments per day, this includes new and follow up appointments.

- Frailty service
  - Service that runs 5 days a week, from 9am-5pm.
  - The capacity of this service is to see 8 patients a day.
  - Inclusion criteria:
    - CFS ≥ 6
    - ≥ 65 years
    - NEWS ≤ 3

Acute Hospital Flow and increased bed capacity

- Modular unit comprising 32 additional beds for opening late Feb 24
- Recruitment commenced to build staffing capacity ahead of this
- 4 additional elderly care and 2 stroke beds opened winter 22/23 remain open
- TBC scoping of SAU capacity to convert 4-8 trolley spaces to overnight beds
- Virtual ward programs for
  - Cardiology - heart failure and atrial fibrillation (45 pts in each)
  - Respiratory (30 pts)
  - Diabetes (20 pts)
- Move of 10 gastroenterology beds in spring 23 to Central Middlesex Hospital (CMH) to facilitate increased GIM beds at Northwick Park Hospital (NPH).

High impact area 1: Same Day Emergency Care - reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
High Impact area 2: Frailty - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
High impact area 3: Inpatient flow and length of stay (acute): reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

In-hospital care

Community Rehab bedded care flow / Intermediate Care Beds

CNWL has open and locked adult rehab beds across the system which Harrow patients can access if required. Current access to open is immediate, locked rehab can take some time, in which case private providers are sourced to avoid delays.

CNWL has 7 stepdown houses with 40 beds, which Harrow patients can access for up to 2 weeks to support bed flow.

Starting in August 2023, there will be an increased focus on discharge from community rehab beds to ensure robust productivity and flow. This process is commencing with fortnightly meetings with the community rehab providers, social care, discharge hub and Borough Partnership team.

Mental Health

The core components of the approach for winter for mental health services are:

- Addressing the growth in delays for patients clinically ready for discharge but waiting for social care support. Exploring the potential for the hospital discharge team to oversee the discharge of patients from MH beds on the NPH site when the team is at full capacity
- Improve flow through housing pathway for patients with mental health issues. Seeking to broker a fast track pathway with housing services.
- CNWL referrals from mental health and learning disability inpatients to ASC with escalation of delays beyond 72hrs
- Improved access to drug and alcohol service through in-reach to medical wards and ED is now well established and effective. The next step is to support access to clinical records across CNWL and Drug and Alcohol service provider.
- Active promotion across the public and health and care professionals of crisis alternative services with capacity: Maternity and mental health perinatal services, IAPT and Coves

High impact area 4: Community bed productivity and flow: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes

In-hospital care / Discharge Pathway

Discharge Hub

- The overall aim is to relieve acute pressures by identifying patients to be managed with community support, instead of requiring an acute bed. This is achieved by clinical assessments undertaken by clinical screeners to share community knowledge of services and avoid any delay to discharge.
- NPH discharge hub, remains understaffed and has been supported and managed by LNW to continue to sustain flow.
- The hub is responsible for confirming discharge plans for patients across pathways 1-3 who have new or additional care needs on discharge.
- The NPH discharge team confirms the most daily discharges across the sector and receives on average 40 referrals daily to screening and processing for discharge.
- In advance of the winter, the focus will be on recruiting to the full team establishment, particularly the screeners to identify patients for the community.

Discharge Support Service

The discharge support service is an essential component of the discharge pathway in Harrow, focusing on both timely discharge for patients on the P0 and P1 pathways as well as focusing on avoiding readmissions through securing community based support for people at the point of discharge.

Over a 6 month winter period, the service will have the capacity to support 500 patients at discharge and 300 post discharge support.

The discharge element will include provision of accompanied taxi service or accompanying patient in Hospital transport if appropriate. There is a standard cohort of 4 staff with coordinator on site Monday to Friday who liaise with the Discharge team to receive referrals but also take direct referrals from other routes if these can be accommodated.

Post Discharge intervention can include telephone calls, referring and signposting onwards to suitable services, home visits and practical support that helps a discharge be successful, thus reducing the risk of readmissions.

High impact area 5: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed

Discharge pathways

Enhanced on-site social care

Seven-day hospital SW cover funded for the winter period.

Increased social work and OT staff to support hospital discharge process.

Provision of step-down care

Step down beds have to be purchased on a block rather than spot basis.

Current plans to mitigate additional pressure:

- 5 step down beds currently purchased, which will be increased to 8 from October.
- Funds available for 6 additional residential care beds (currently 558 LD / other)

Additional more complex step down beds (EMI) might be available in the market if additional funding were available.

Same day community equipment

Same day equipment delivery service (MRS) has been made available, at greater cost to reduce the longer lead times.

To be used as required to achieve planned discharge date.

Prescribers instructed in use of same day delivery.

Further work to review prescribing process to maximise efficiency of resource use while achieving fastest delivery of equipment.

Data will be made available on use of same day delivery services.

Home care provision, including weekends

Development of local bridging services, through the Autumn in advance of the critical winter period, tailored to relieve pressure in the local discharge pathway, to allow eligible P1 patients to be supported with packages of care following relevant assessments for onward support where necessary.

Increased provision of 72 hour domiciliary care or reablement as needed but a follow up or further assessment is needed to support patient recovery at home

High impact area 6: Intermediate care demand and capacity: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

Discharge pathways

Integrated Intermediate Care service, and reablement provision

The delivery of the Integrated Intermediate Care Service discharge pathway for facilitation of discharge and prevention of admission for the Winter of 23/24 will be supported through the following developments:

- **Discharge to Assess (D2A) and Short-term Rehabilitation:** CLCH will maintain Discharge to Assess (D2A) and short-term Rehabilitation Pathways in support of discharge delivering 1100 contacts per month over the winter of 23/24.
- **Northwick Park Discharge Hub:** The discharge hub lead post has been recruited to and the post holder starts in September 2023. Discharge hub Clinical screener post recruitment is ongoing with a view to these being fully recruited to by October 2023.
- **Carers Lead role:** Has been recruited to and will support service users and carer needs under the integrated pathway.
- **Training:** Has been implemented in support of the for the delivery of the integrated pathway for the winter of 23/24. Follow up training is planned for September or October 2023.
- **Single Referral Form:** Discharge 2 Assess (D2A) referral form used across NWL and will remain in use, however, CLCH has requested changes to make this form consistent with the single merged referral form for ICCS.
- **ICCS End-to-end patient pathway:** Pathway is complete following face to face sessions with leads.
- **SOP:** A draft SOP has been developed and is being reviewed by stakeholders for implementation for winter of 23/24.
- **Information sharing:** An interim solution to data sharing has been agreed with ICCS partners. Information sharing between Acute, Community and Primary Care Health Services will be facilitated with the go live of the Cerner Patient Administration and Records System in August 2023 at LNWHT using the London Care Record. A virtual desktop solution is proposed for access of across health and social care systems.

High impact area 6: Intermediate care demand and capacity: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

Additional winter schemes

We are currently working on the basis that all additional winter funding coming into the system is known and we will not be expecting additional funding allocations.

However, if this position changes, acknowledging that funding is likely to be focused on specific pressure areas, priorities for investment for Harrow, based on our evaluation of Winter 22/23, would be:

- Additional reablement schemes;
- Expanding the Discharge Support Service, including the addition of handyman services;
- Home First and Trusted Assessors to support patient flow.

Harrow system risks to the delivery of the winter plan 23/24

Risk	Risk Owner	Mitigations	Date for review
If CLCH are not commissioned to provide discharge to assess community rehabilitation provision, there is a risk to system flow through increased bed days for medically fit patients.	Jane Wheeler and Jackie Allain	Exploring how this service can be funded non-recurrently this year. Meeting with CLCH/Jane Wheeler soon to work out the details.	September 2023
If we do not address under-utilisation and delayed discharges of Harrow patients within the rehab beds, particularly at Woodlands Hall, there are financial risks to the system, and potential loss of Harrow provision	Melissa Mellett, Lisa Henschen, Shaun Riley Jackie Allain	Bi-weekly discharge group being established. Potential to increase scope of discharge hub to cover P2 beds (through integrated intermediate care team) but discharge hub needs full staffing to achieve. Stakeholder briefing to be held with NWL ICB	September 2023
If agreements for managing cross NWL and NCL arrangements for discharge support cannot be made in advance of winter pressures (for Harrow residents registered with Barnet GPs) we risk unnecessary delays at Northwick Park	Ian Robinson? Senel Arkut	TBC	TBC
If we are unable to secure a stoma care pathway for Harrow residents, we risk hospital delays	ICB (TBD) Senel Arkut	Explore with other London Boroughs how they are working with care providers to deliver stoma care	October 2023

Action Plan

Action	Lead	Delivery date
Domain: interface		
Update contact list and by-pass numbers for Harrow GPs. Share widely across acute and community providers	Rahul Bhagvat	9/10/2023
Update outpatient letter details to include names and telephone numbers of clinical teams	TBC	TBC
Ensuring Primary Care are using correct SDEC referral forms	Rahul Bhagvat	9/10/2023
System letter to support efficient ways of working to support winter pressures	Radhika Balu and Jon Baker	October 2023
Domain: data and escalation		
Implement local escalation processes for discharge delays as described in the winter plan	Natasha Harmsworth-Blythe, Shaun Riley, Santokh Dalal, Senel Arkut, Lisa Henschen	9/10/2023
Address any outstanding issues with local data collection for winter performance monitoring	Bharat Gami	9/10/2023

Action Plan

Action	Lead	Delivery date
Domain: prevention		
Implement 2023/24 winter wellness scheme for Harrow	Seb Baugh	November 2023
Deliver MECC winter programme	Laurence Gibson	November 2023
Domain: community based admission avoidance		
Secure our pathways of support to care homes for admission avoidance and ti y discussion – including Care Home Support Team and Primary Care Enhanced Service. Action plan to be developed.	Sandra Arinze Jenny Gorasia Patrick Laffey	20/10/2023
Domain: in-hospital care		
Secure robust discharge flow for patients in rehabilitation units	Lisa Henschen, Bharat Gami, Natasha Harmsworth-Blythe	09/10/2023

Action Plan

Action	Lead	Delivery date
Domain: discharge pathway		
Establish bridging service for Harrow	Senel Arkut, Johanna Morgan, Shaun Riley	October 2023
Explore closer alignment between PATCH (children's virtual ward service) and children's community health teams	Philomena Bouzemada and Claire Eves	October 2023
Implementation of the integrated intermediate care service	Jackie Allain and Shaun Riley	November 2023
Agree pathways for Harrow residents registered with Barnet GP (joint meeting between Harrow, Brent and Barnet)	Shaun Riley, Lisa Henschen	November 2023
Explore options for stoma patients through homecare providers	TBC	October 2023
Active promotion of mental health crisis alternatives to front line staff and the public	James Connell, supported by Mental Health workstream	October 2023
Explore potential for discharge hub supporting mental health discharges across health and social care – dependent on hub staffing	Gail Burrell, Natasha Harmsworth-Blythe, Lisa Henschen	December 2023
Implement regular briefings and escalation across discharge pathways for physical and mental health	Shaun Riley, Santokh Dalal, Lisa Henschen	September 2023
Seek to establish data sharing of clinical records across CNWL and Drug and Alcohol service provider	Seb Baugh, Gail Burrell, Deepti Shah-Armon	December 2023

LONDON BOROUGH OF HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	2 November 2023
Subject:	Annual report of the Director of Public Health
Responsible Officer:	Carole Furlong, Director of Public Health
Public:	Yes
Wards affected:	All
Enclosures:	Annual Report

Section 1 – Summary and Recommendations

This front sheet accompanies the main report. It covers background and introduction; some of the main findings of the report; how to make the most of the report and key recommendations.

The Annual Report of the Director of Public Health is an independent report from the Director of Public Health which reflects the local population's health and wellbeing needs. It addresses different topic each year, raising awareness and highlighting some of the key issues and challenges within the borough.

Previous years have focused on green spaces in Harrow, and local ward level health profiles. This year, the Annual Director of Public Health Report explores health inequalities in Harrow. Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.

The aim is for this interactive report to be used as a resource that highlights and compares a range of health inequalities in different dimensions across Harrow's diverse population and considers some of the ways we can address these inequalities. The report uses a lot of data from the 2021 Census, considered the best estimate available of the Harrow population and an opportunity to assess some of the inequalities among residents in Harrow, along with a range of other data sources.

Key recommendations from the report include:

- Complete a deep-dive into the impact of poverty on the wellbeing of Harrow residents, hearing from residents affected and taking into account best practice & guidance to tackle this challenging issue.
- Improving the recording of data in health, care and other relevant partners, in particular for:
  - Sexual orientation and trans status
  - Veterans
  - Asylum seeking status

Recommendations:

The Board is requested to:

- note the findings of the report
- support the recommendations of the report.

Section 2 – Report

- **How the report should be used**
  - This is an innovative report that is designed to encourage an interactive experience for the reader and audience.

  - It should be used as a reference point for understanding where health inequalities exist within Harrow, as evidence for building the case for change to address these avoidable and unfair differences, and to suggest approaches to tackle these issues.

  - The reader is prompted to use the navigation bar / menu to navigate through the report. This menu focusses on the population groups affected by health inequalities and each section encompasses a summary about health issues including risk factors, outcomes and services, as well as best practice in addressing the inequalities highlighted. Some maps and tables expand when they are clicked on, providing more detail for the reader to consider.

- **Findings from the report**

  - Harrow's population is growing, between the last two censuses (held in 2011 and 2021), the population of Harrow increased by 9.3%, from just under 239,100 in 2011 to around 261,200 in 2021.
  - Our population is also aging, with over 65s making up a growing percentage of residents, an increase of 19.4% in this age group since the last census. This is expected to further increase over the next 5-10 years.
  - Over half of residents responding to the 2023 residents survey report using less water, energy or fuel to save money, this increases to 72% amongst residents struggling to make ends meet. 43% of residents struggling to make ends meet reported they were buying less food to save money.
    - Smoking rates in the most deprived areas in Harrow are almost one in five adults, versus 1 in 10 in the least deprived areas.
  - One in five households across Harrow include one disabled member
    - Disabled residents are more likely to live in the more deprived parts of the borough.
  - Over 20,000 people reports being informal carers
  - There are over 1,000 households in temporary accommodation in Harrow in 2021/22

    - Fewer than 500 adults in Harrow were recorded on local GP recorded as being in some form of homelessness, of these 44.5% were smokers, a much higher rate than average
- More than half of residents of Harrow were not born in the UK
    - In Harrow, residents who don't speak English well, or at all, are more likely to live in more deprived parts of the borough.
    - During 2022/23, 670 immigrants received support from Harrow.
    - Evidence suggests there are higher levels of stress depression, anxiety and poor general mental health among migrants.
- Over 2,700 veterans over the age of 16 live in Harrow
    - 31% of veterans living in Harrow report having a disability, compared to 14% in the rest of the population (there will be a strong link with age)

- **Recommendations**

- The wider determinants of health (building blocks of good health e.g. housing, education, employment) are intrinsically linked to poverty, resulting in poor health outcomes and experiences in more deprived communities, or those that struggle to makes ends meet. A deep-dive into the impact of poverty on the wellbeing of Harrow residents, hearing from residents affected and taking into account best practice & guidance to tackle this challenging issue will support better understanding the problem and what can be done to address it.

- To support better understanding the needs of those experiencing health inequalities, improve the recording of data in health, care and other relevant partners, in particular for:
    - Sexual orientation and trans status
    - Veterans
    - Asylum seeking status

Financial Implications/Comments

Whilst there are no additional direct financial implications arising from this report, the prioritisation of the recommendations, through the wider system, will need to be contained within existing partner resources, which includes the annual public health grant.

Legal Implications/Comments

Section 116A of the Local Government and Public Involvement in Health Act 2007, stipulates that it is the responsibility of the local authority and integrated care boards to prepare a local health and wellbeing strategy.

The Health and Social Care Act 2012 provides responsibility to the Health and Wellbeing Board for the oversight of the local health and wellbeing strategy.

A key responsibility of the Health and Wellbeing Board is to therefore have oversight and accountability of the proposed strategy.

Risk Management Implications

The health and wellbeing strategy does not present any risks, or suggest any mitigation

Risks included on corporate or directorate risk register? **No**

Separate risk register in place? **No**

The relevant risks contained in the register are attached/summarised below. **n/a**

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? No

The focus of this year's Annual report for the Director of Public Health is health inequalities. The report highlights unjust and unfair inequalities experienced by residents and those protected under the equality act. The report makes recommendations, based on evidence and best practice, around how these inequalities can be addressed, to improve the health outcomes and experiences of those impacted by health inequalities.

Council Priorities

A place where those in need are supported

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 17/10/2023

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 19/10/2023

Chief Officer: Senel Arkut
Signed by the Corporate Director
Date: 19/11/2023

Mandatory Checks

Ward Councillors notified: NO as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Carole Furlong, Director of Public Health
Carole.Furlong@harrow.gov.uk

Background Papers:

Harrow Health and Wellbeing Strategy

If appropriate, does the report include the following considerations?

1.	Consultation	NO
2.	Priorities	NO

Annual Director of Public Health Report 2022/23:

Health Inequalities in Harrow

DRAFT

LONDON BOROUGH OF HARROW

Introduction by the Director of Public Health

2022/23

Our Annual Public Health Report this year explores health inequalities in Harrow .

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Harrow has significant health inequalities which could be reduced, to the benefit of our economy, and people all across our communities. We have a responsibility to many of the groups affected under the Equality Act of 2010.

We have much work already underway in Harrow to tackle these inequalities. For example, our smoking cessation services, our work to support residents to undertake more physical activity, and our work to support good mental health and wellbeing in both adults and children.

We are fortunate now to benefit from the 2021 Census as a data resource to support us in making strategic decisions to address these inequalities. More data from the Census will follow in the months ahead. This report highlights and compares a range of health inequalities in different dimensions across Harrow's diverse population, and considers some of ways we can address these – please use the buttons on the side to explore these. I encourage all organisations providing services to the public to collect the data which helps us to understand the needs of different groups in our community.

Policy approaches which cut across services, such as Making Every Contact Count and Health In All Policies have been shown to be particularly effective in reducing health inequalities. We know that many of the next generation in Harrow will adopt the behaviours and attitudes to health of their parents. This further increases all of our responsibilities to reduce these inequalities.

Please click images for more information

Carole Furlong, Director of Public Health

How to use this report

This report begins with the largest section on the population of Harrow. This covers the demographics of the borough, mostly using data from the 2021 Census. You can jump to this section by clicking on the **Population** button on the left hand menu.

Most of the other buttons on the left will take you to specific population groups – here you will find more information about these groups, including summary information about health issues including risk factors, outcomes and services, as well as best practice in addressing some of the inequalities mentioned. Local information is included where possible, or national information where this is not available.

At the end, there is a shorter section called Intersectional - this explores how different population groups overlap and combine with each other. There is also a section called **Definitions** - this links to the pages in the report where the meanings of words are explained.

Throughout the report where there is a graph or map, please click on it to see a larger version.

If you have any problems, or comments, or would like further information, please contact us at publichealth@harrow.gov.uk

Acknowledgements

This report was written by:

Sebastien Baugh

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Andrea Lagos

Sophie Leinster

Sandy Miller

Ranjith Selvaraj

Patrick Simon

Shinelle Sutherland

Susan Willacy

Annual Director of Public Health Report 2022/23:
Health inequalities in Harrow

1. Harrow's population

LONDON BOROUGH OF HARROW

Harrow's population - contents

Please click on the links below to go to any section in the **Population chapter**:

Harrow's population – summary

- Harrow's population is growing – there were 261,200 residents at the time of the 2021 Census
- Our population is also aging, with over 65s making up a growing percentage of residents
- Residents of Harrow are relatively less socio-economically deprived overall than those in most other London boroughs. However, parts of the borough are much poorer, and housing is a significant issue
- Harrow's population is mobile with around 10% of residents moving into the borough during the previous year
- Harrow has among the most diverse populations in the UK, in terms of religion, ethnicity, languages, and place of birth
- There are a significant number of LGBTQ+ residents, and data is becoming available to better understand them
- Some data on other important groups, such as veterans, asylum seekers and Homeless is also available, from the census and other sources

Harrow's population – data sources (1)

The 2021 Census is considered the best estimate available of the population in Harrow. While the Covid-19 pandemic may have affected some aspects of resident responses, 97% of the usual resident population of Harrow returned their census forms. This is higher than the London average, and higher than in the 2011 Census.

Most of the 2021 Census population estimates are made up of people who responded to the census, however adjustments are made to reflect people missed or counted more than once in the census, so that estimates represent the whole population.

The first results of the 2021 Census were released in June 2022. Further detailed data will continue to be released in the months and years ahead.

This document uses a lot of data from the 2021 Census, along with several other data sources which are noted.

Throughout the document, figures are individually rounded for clarity. Figures may not add exactly due to this rounding.

Harrow's population – data sources (2)

The 2021 Census is an opportunity to assess some of the inequalities among residents in Harrow. However, many public services don't collect full data on people, which would allow us to understand, with more granularity, further inequalities.

For example:

- Ethnicity data is incomplete on some NHS systems. Disjointed systems across different public services and boroughs leads to data consistency issues
- Many services do not or cannot collect data on more detailed segments (i.e. sexual orientation, veteran status). This prevents us from having a full multi-dimensional view of the inequalities affecting our residents, or in some cases from providing tailored services.
- While the Index of Multiple Deprivation (IMD) provides a good general measure of poverty, services should also ask individuals about their experience

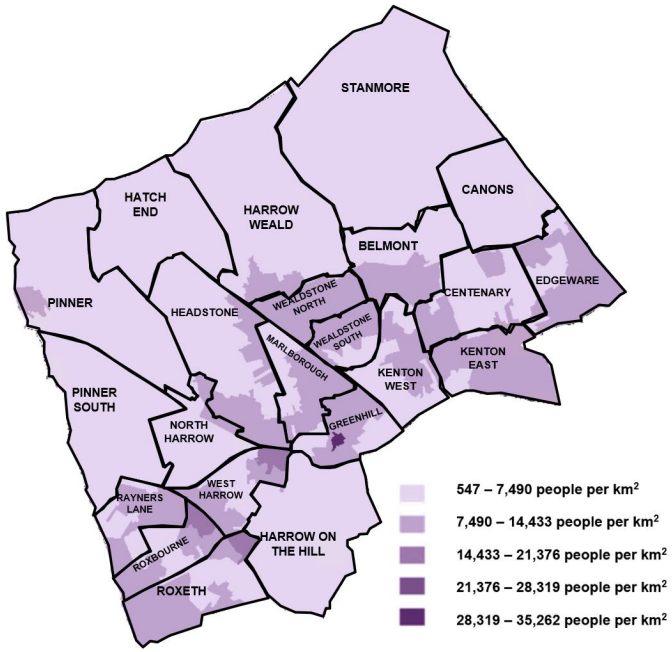
Harrow's population – population size (1)

The resident population of Harrow at the time of the 2021 Census was around 261,200 – by 2023, it is likely to have grown to 268,300.

The borough is among the 10% most densely populated areas in England, though slightly less than the London average, and with large green spaces particularly in the north.

	Harrow	NW London (average)	London	England
Residents per square km	5,175	7,491	5,598	434

This map shows the density of the population across Harrow.



In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that more socioeconomically deprived parts of the borough are more likely to be densely populated.

Please click images to expand

Harrow's population – population size (2)

This page focusses on the population of Harrow registered with the NHS through their GP.

Like most areas in England, there are higher numbers registered with the NHS than thought to be resident in Harrow – this is thought to be partly due to issues with updating records, and is particularly high in areas such as London, with more mobile populations.

Despite this, some Harrow residents will also not be registered with a GP. This may include for example younger healthier men, who are less likely to access services. However, there have also been concerns nationally in recent years that some more vulnerable populations may also not access services.

The tables below show that 83% of Harrow residents register with GPs in Harrow, and 93% with GPs in North West London. 89% of patients registered with GPs in Harrow live in the borough.

NHS Commissioning area		Harrow residents Number	%
NHS North West London		287,968	93.3%
	Harrow	*256,411*	*83.0%*
	Brent	*18,224*	*5.9%*
	Ealing	*6,098*	*2.0%*
	Hillingdon	*5,802*	*1.9%*
	Hammersmith & Fulham	*817*	*0.3%*
	Kensington & Chelsea	*342*	*0.1%*
	Westminster	*207*	*0.1%*
	Hounslow	*67*	*0.0%*
NHS North Central London		18,798	6.1%
NHS Herts Valleys		1,863	0.6%
GPs in other areas		120	0.0%
Total Harrow residents		**308,749**	

Local Authority of residence	Patients registered with Harrow GPs Number	%
Harrow	256,411	89.1%
Brent	17,590	6.1%
Hillingdon	5,771	2.0%
Barnet	4,471	1.6%
Ealing	1,349	0.5%
Three Rivers	928	0.3%
Hertsmere	292	0.1%
Watford	252	0.1%
Other local authorities	716	0.2%
Total Registered	**287,780**	

Data shown is from June 2022

Harrow's population – population growth (1)

Harrow's population grew by 9.3% between the 2011 and 2021 Census. This is slightly higher than the London average of 7.7%. Tower Hamlets had the highest growth in England at 22.1%, while Westminster (-6.9%) and Kensington & Chelsea (-9.6%), had the largest reductions in resident population nationally.

The Great London Assembly (GLA) produce regular estimates of projected population growth across the city, based on factors including births, death, migration and housing availability. The most recent projections were released in early 2023. These GLA projections begin to take account of the 2021 Census, however they are labelled "interim" as they acknowledge factors such as the extent of the post-pandemic rebound in London are still unclear. More information on the GLA projections is available at these links (here and here).

Harrow’s population – population growth (2)

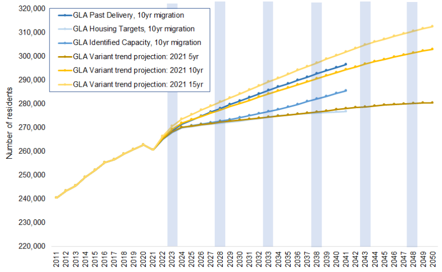
Introduction
Population
Poverty
Age
Sex
LGBTQ+
Ethnicity
Religion
Disability
Carers
Maternity
Homeless
Migrants
Veterans
Intersectional
Definitions

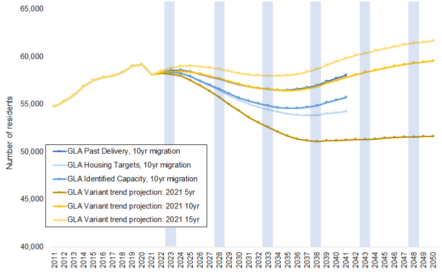
The GLA projections come in 2 groups. **Trend-based** – that is, following recent trends in birth, death and migration; and **Housing-based** – that is, following the Trend-based projections but capped by the likely availability of housing supply. Of the Trend-based projections, the projection based on the past 5 years are considered less reliable due to factors such as Brexit and the Pandemic causing perturbations. The three Housing based projections are “Past Delivery”, “Housing Targets”, and “Identified Capacity”. The GLA recommends that local authorities use Housing-based projections for most purposes.

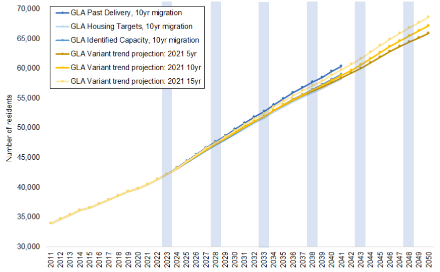
All the different projections for Harrow are shown together in Figure 1, below.

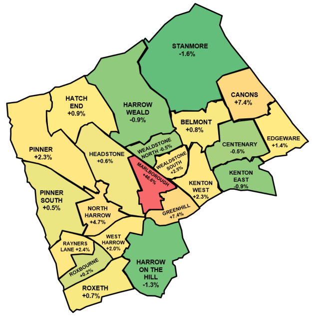
The models predict recent trends toward reducing children and increasing older people in Harrow will continue – see Figure 2 and Figure 3.

Note that projected growth is expected to be geographically uneven and focused on parts of Harrow – see Figure 4 for example.









Please click images to expand

Harrow's population – turnover

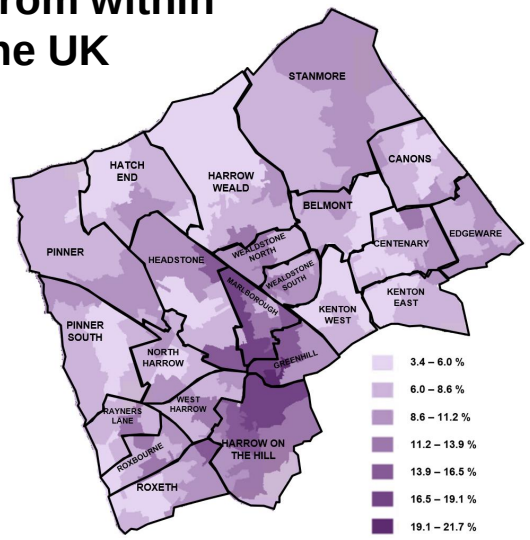
Across London, rates of population movement are high, especially among younger adults. Data from the 2021 Census shows that 10.0% of Harrow residents had moved into the area in the previous year - 8.6% from other parts of the UK and 1.4% from abroad.

Population movement can affect the provision of many public services, as well as influencing resident's sense of belonging in their community.

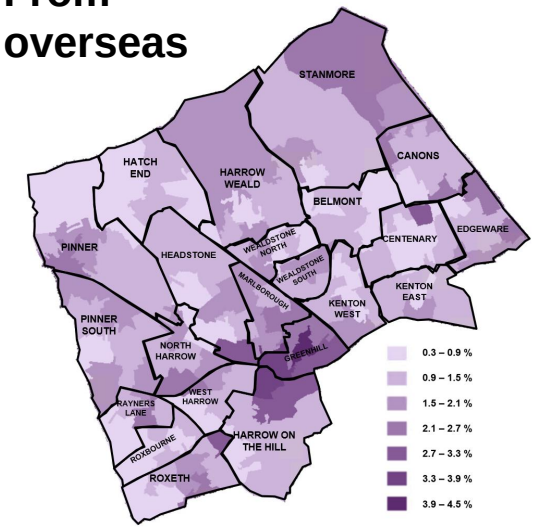
Other data shows for example, that in parts of Harrow, over half the population changed during the period 2011 to 2020.

The following maps show the percentage of new residents within Harrow:

From within the UK



From overseas



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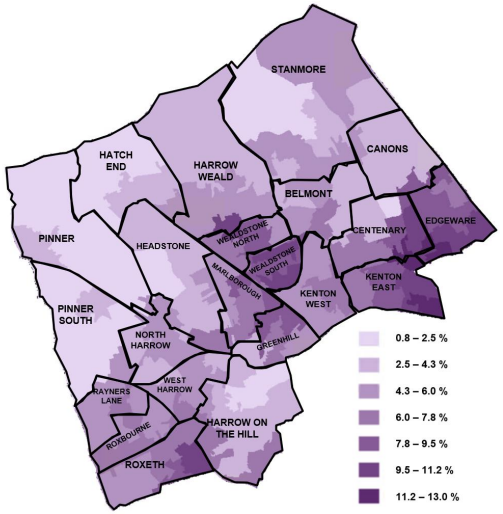
Harrow's population – languages

The diversity of Harrow's population is reflected in the languages spoken in the community. There are at least 86 different main languages spoken in the borough according to the 2021 Census. Harrow has the highest percentage of Romanian speakers in England.

The most common 20 main languages in Harrow are shown in this table.

The map below shows the percentage of the population of Harrow who cannot speak English either well, or at all, by area:



Please click images to expand

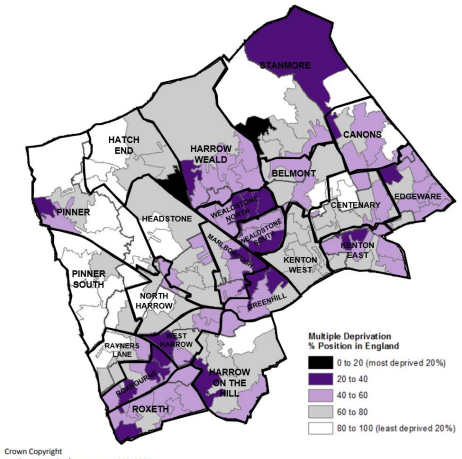
Main language spoken	Number of residents	% of Harrow population
English	174,443	69.3%
Romanian	18,987	7.5%
Gujarati	17,298	6.9%
Tamil	8,696	3.5%
Arabic	3,224	1.3%
Polish	2,886	1.1%
Persian or Farsi	2,716	1.1%
Pashto	2,128	0.8%
Urdu	1,866	0.7%
Hindi	1,823	0.7%
Nepalese	1,327	0.5%
Portuguese	1,250	0.5%
Somali	1,245	0.5%
Panjabi	1,127	0.4%
Spanish	786	0.3%
Italian	723	0.3%
Hungarian	653	0.3%
Albanian	652	0.3%
Sinhala	618	0.2%
Bengali	595	0.2%

Harrow's population – socioeconomic deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative socioeconomic deprivation in England. The IMD uses 39 separate indicators, organised across seven distinct domains of deprivation, which are combined and weighted. These are: - Income (22.5%) - Employment (22.5%) - Health Deprivation and Disability (13.5%) - Education, Skills Training (13.5%) - Crime (9.3%) - Barriers to Housing and Services (9.3%) - Living Environment (9.3%). IMD measure relative levels of deprivation at the level of small neighbourhoods of roughly 1,500 people. While Harrow is among the 30% of least deprived areas overall, it is in the lowest 10% for the "Barriers to housing and services" domain, like many London boroughs. "Education" and "health" are among the best 10%.

Within Harrow there are some considerably poorer areas (see map, below).

Within any neighbourhood there is also much variation, and individuals with extremes of poverty and wealth can live in close proximity.



Relative socioeconomic deprivation measures (IMD2019)

	Harrow	NW London	London	England
Average IMD score (*higher is more deprived*)	15.0	20.1	21.3	19.6

Please click images to expand

Harrow's population – age (1)

14.5% of Harrow residents are 65 or older – higher than the average percentage in London, however lower than the England average as a whole.

In Harrow, since the 2011 Census, there has been an increase of 19.4% in people aged 65 years and over, an increase of 7.8% in people aged 15 to 64 years, and an increase of 7.5% in children aged under 15 years.

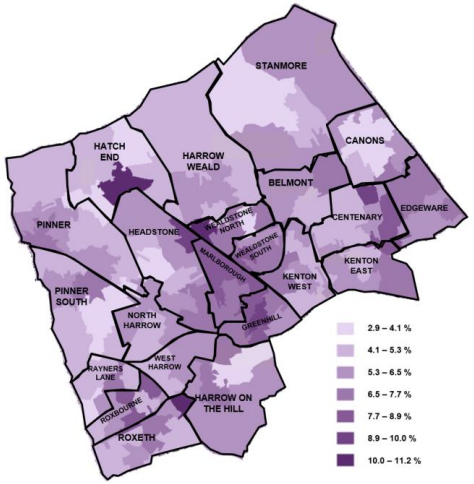
Harrow's population – age (2)

Broadly speaking, the population in northern parts of Harrow is older than in the south.

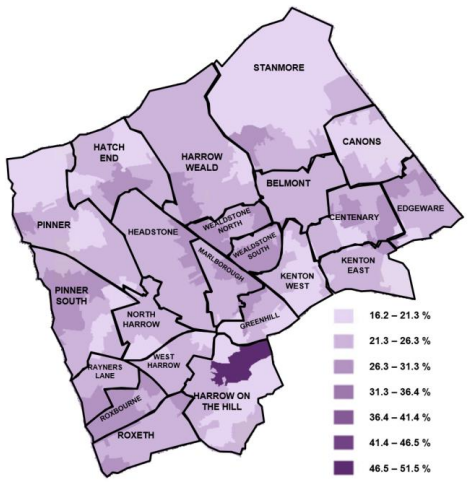
More detail is shown on the maps, below.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Under 5s	15,699	5.7%	5.4%	5.7%	5.2%
Under 20s	63,355	22.9%	21.8%	22.4%	21.9%
20 to 64	157,669	56.9%	60.9%	60.8%	55.5%
65 plus	40,177	14.5%	11.9%	11.2%	17.5%

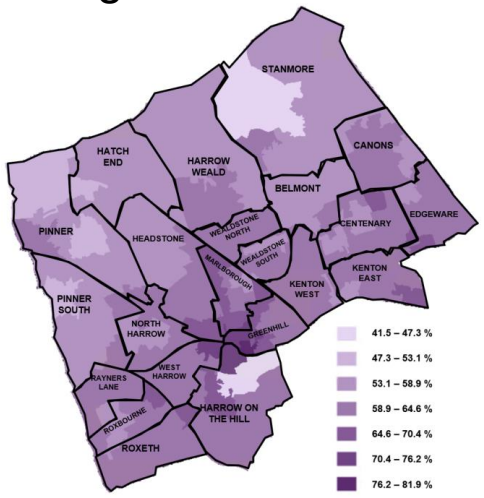
Under 5



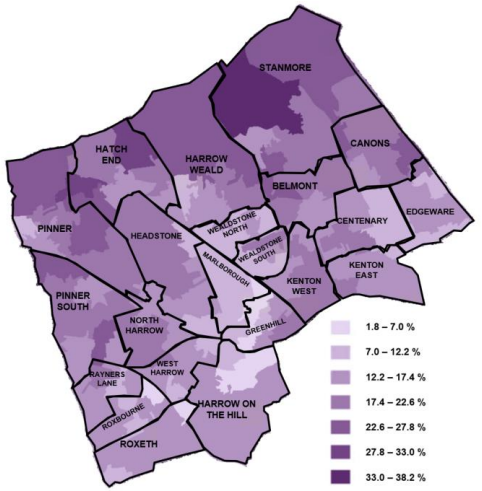
Under 20



Age 20 - 64



65 plus

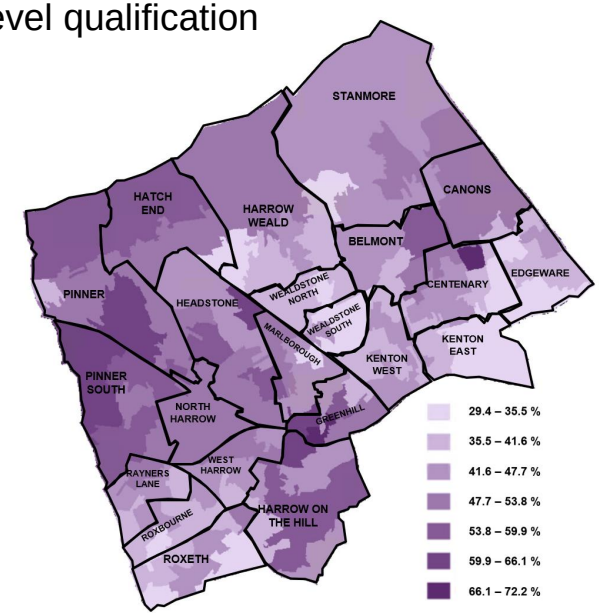


Harrow's population – education

Harrow's population is relatively highly educated compared to England. According to the 2021 Census, 83% of adults have some qualifications, including 45% at degree level or higher.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Qualifications equivalent to degree or above (age 16+)	94,317	45.0%	46.1%	46.7%	33.9%

Map showing percentage of adults within Harrow who have a degree or higher level qualification



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Percentage of adults in Harrow by qualifications held (Census 2021)

No qualifications	17.4%
Level 1 and entry level qualifications (e.g. 1 to 4 GCSEs grade A* to C)	8.2%
Level 2 qualifications (e.g. 5 or more GCSEs A* to C)	10.4%
Apprenticeship	3.2%
Level 3 qualifications (e.g. 2 or more A levels)	12.6%
Level 4 qualifications or above (e.g. degree or professional qualification)	45.0%
Other qualifications (e.g. work related qualifications)	3.2%

LONDON BOROUGH OF HARROW

Harrow's population – employment

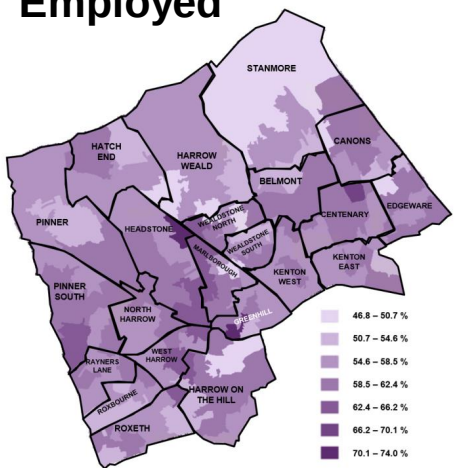
According to the 2021 Census, most adults (58%) in Harrow, are in employment. Significant percentages are also retired, students, looking after the home or family, unemployed, or long term sick and disabled.

	Number of Harrow adults (16+)	% of adults (16+)			
		Harrow	NW London	London	England
In employment	120,858	57.7%	57.4%	59.4%	55.7%
Unemployed	7,377	3.5%	4.2%	4.1%	2.9%
Retired	34,632	16.5%	13.1%	12.9%	21.5%
Student	14,225	6.8%	7.9%	7.2%	5.6%
Looking after home or family	13,544	6.5%	6.7%	6.0%	4.8%
Long-term sick or disabled	5,885	2.8%	3.5%	3.6%	4.1%

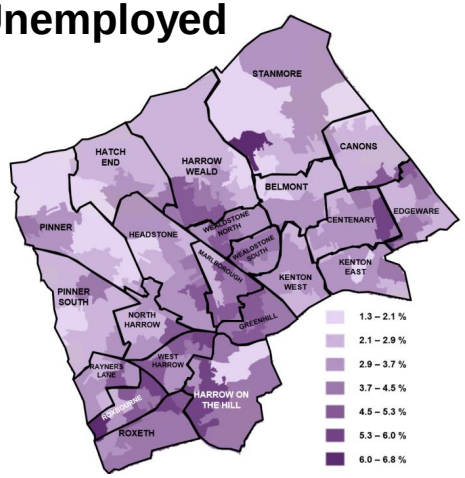
Please click images to expand

The maps below, show the variation within Harrow.

Employed



Unemployed



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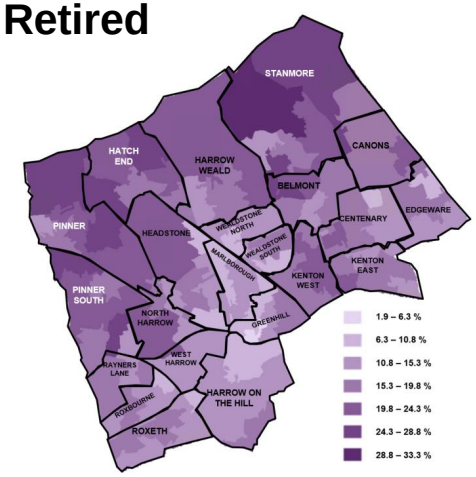
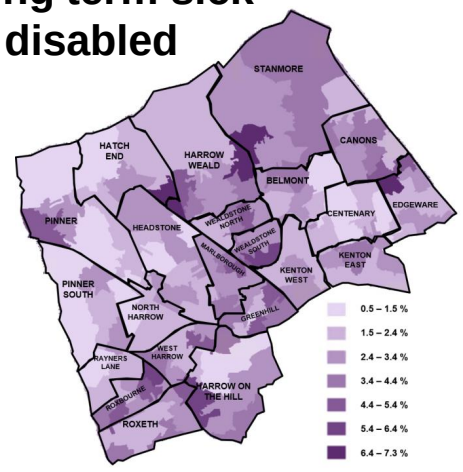


Long term sick or disabled



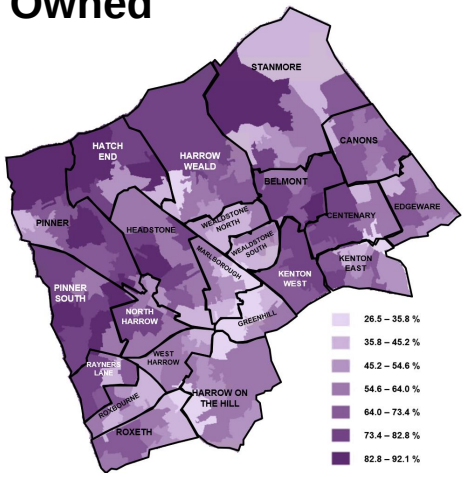
Harrow's population – housing (1)

According to the 2021 Census, there are 89,629 households in Harrow. 59% of households own their home (including with a mortgage), which has reduced by 6% since 2011. The percentage socially rented has stayed at just above 10%. 30% of households are privately rented – this is up from 22% in 2011.

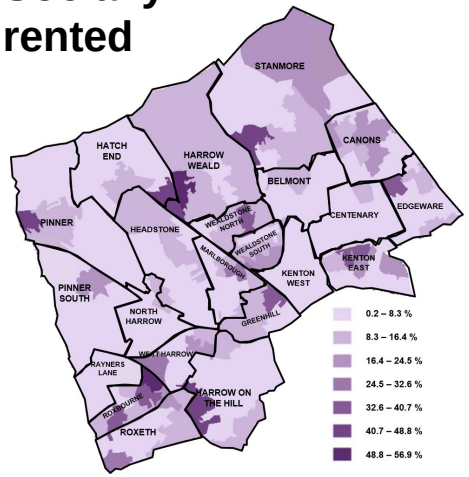
Housing tenure in Harrow is further detailed in the table and maps below.

	Number of Harrow households	% of households			
		Harrow	NW London	London	England
Owned	52,684	58.8%	42.9%	45.2%	61.3%
Socially rented	9,293	10.4%	21.2%	23.1%	17.1%
Privately rented	26,494	29.6%	34.1%	30.0%	20.5%

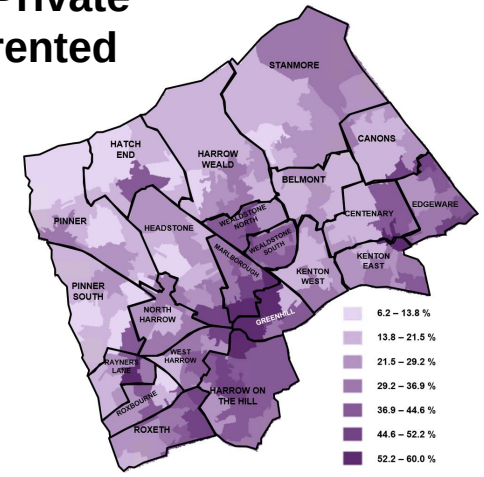
Owned



Socially rented



Private rented



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Harrow's population – housing (2)

The 2021 Census reports that a third of households in Harrow are couples with children. 11% of households are single parent families, and another 11% are couples without children. 22% of households have 1 person, with almost half of these being over 65s.

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that residents in social housing are much more likely to live in more deprived parts of the borough, and residents who own their home are more likely to live in less deprived areas.

Household composition in Harrow (2021 Census)

One person household	Age over 65	10.1%
	Other ages	12.1%
Single-family household	Cohabiting couple; no children	11.0%
	Cohabiting couple; children	33.1%
	Lone parent household	10.9%
Other household types		22.9%

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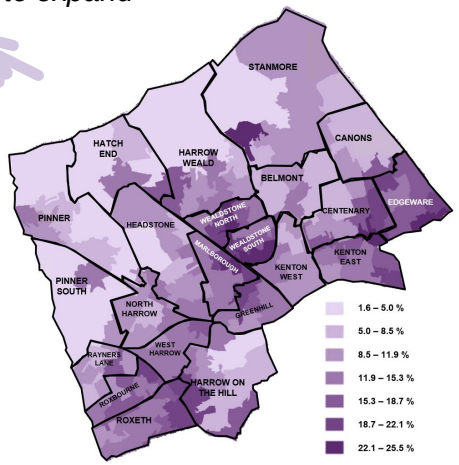

The ONS report that overcrowded housing has fewer bedrooms than needed for occupants. 12% of households in Harrow are overcrowded – higher than in London as a whole.

This map shows percentage of overcrowded housing across Harrow.

	Number of Harrow households	% of households			
		Harrow	NW London	London	England
Overcrowded	10,934	12.2%	12.4%	11.1%	4.3%

Harrow's population – sex

Just over half of Harrow's residents are female, and just under half, male. This reflects London and national patterns.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Female	132,406	50.7%	51.1%	51.5%	51.0%
Male	128,797	49.3%	48.9%	48.5%	49.0%

At older ages, there are more women than men in the population, due to higher life expectancy in females. This difference can be seen in the diagram in the Age section of this report.

Harrow's population – transgender

It is difficult to estimate the numbers of transgender people in Harrow - this data has not been routinely collected, and there are barriers including stigma and discrimination. Nationally, the government has tentatively estimated that 200,000-500,000 people in the UK may identify as being trans. GIREs estimate that around 1% of the population identify as trans. Data from the 2021 Census suggests that there are at least 1,888 transgender or non-binary residents, however 9% of residents did not answer this question, and it is likely to underestimate the true number.

Percentages are higher among younger adults. It's likely that this population is more underestimated among older adults.

	Number of Harrow adults (16+)	% of adults (16+)			
		Harrow	NW London	London	England
Transgender or non-binary	1,888	0.9%	0.9%	0.9%	0.5%

Harrow's population – ethnicity (1)

Harrow is ethnically diverse, with at least 285 different ethnic identities reported in the 2021 Census.

The most common 20 different ethnicities in Harrow are shown in this table.

Ethnicity	Number of residents	% of Harrow population
Asian - Indian	74,744	28.6
White - British (incl. English, Welsh etc)	53,563	20.5
White - Romanian	14,892	5.7
Asian - Pakistani	10,264	3.9
Asian - Sri Lankan	9,776	3.7
Asian - Afghan	6,514	2.5
Black - Caribbean	6,512	2.5
Other - Arab	6,239	2.4
White - Irish	5,608	2.1
Asian - Tamil	4,820	1.8
White - European mixed	3,962	1.5
Black - African unspecified	3,303	1.3
Mixed - White and Asian	3,140	1.2
White - Polish	2,976	1.1
Asian - Chinese	2,784	1.1
Black - Somali	2,784	1.1
White - Unspecified	2,518	1.0
Other - Tamil	2,468	0.9
Mixed - White and Black Caribbean	2,282	0.9
White - Other East European	2,187	0.8

Harrow's population – ethnicity (2)

Harrow ethnic groups from the 2021 Census are grouped into broad categories, with the make up of these given.

Ethnicity		Number of residents	% of Harrow population
ASIAN		**118,152**	**45.2%**
	Bangladeshi	1,820	0.7%
	Chinese	2,784	1.1%
	Indian	74,744	28.6%
	Pakistani	10,264	3.9%
	Other Asian	28,540	10.9%
BLACK		**19,151**	**7.3%**
	African	10,584	4.1%
	Caribbean	6,514	2.5%
	Other Black	2,053	0.8%
MIXED		**9,833**	**3.8%**
	White and Asian	3,140	1.2%
	White and Black African	1,104	0.4%
	White and Black Caribbean	2,187	0.8%
	Other Mixed or Multiple ethnic groups	3,402	1.3%
WHITE		**95,233**	**36.5%**
	English, Welsh, Scottish, Northern Irish or British	53,567	20.5%
	Irish	5,608	2.1%
	Gypsy or Irish Traveller	179	0.1%
	Roma	1,421	0.5%
	Other White	34,458	13.2%
OTHER		**18,836**	**7.2%**
	Arab	6,239	2.4%
	Any other ethnic group	12,597	4.8%

Harrow's population – ethnicity (3)

The ONS further groups ethnicities as reported in the 2021 Census into broad categories. The percentages of these are given below, and the maps show where residents from these ethnic groups live in the borough.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Asian	118,152	45.2%	27.8%	20.7%	9.6%
Black	19,151	7.3%	9.5%	13.5%	4.2%
Mixed	9,833	3.8%	5.2%	5.7%	3.0%
White	95,233	36.5%	49.1%	53.8%	81.0%
Others	18,836	7.2%	8.4%	6.3%	2.2%

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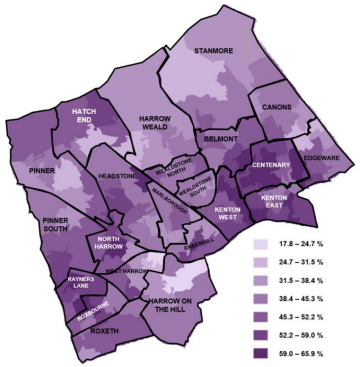
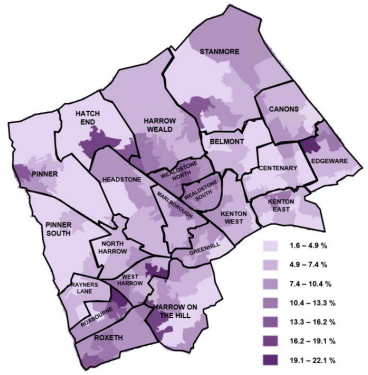
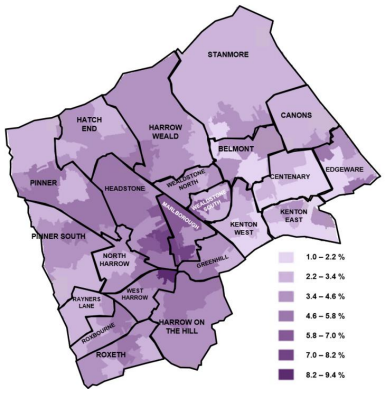
Asian



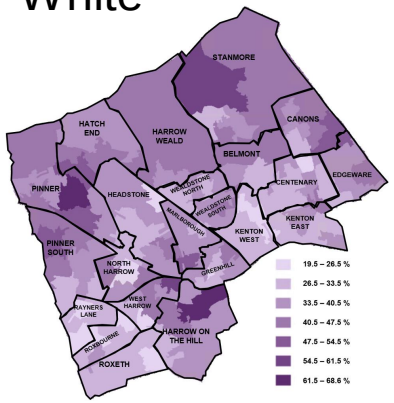
Black



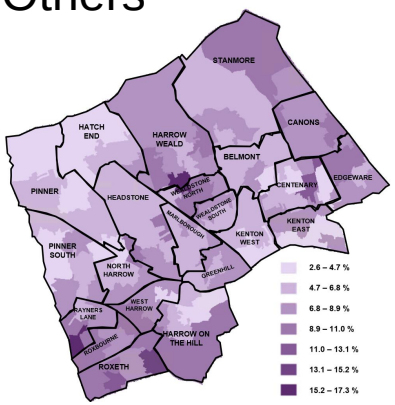
Mixed



White



Others



Harrow's population – sexual orientation

It is difficult to estimate the number of gay and bisexual people in Harrow - this data has not been routinely collected, and there are barriers including stigma and discrimination. A national survey suggests that around 5% of the population may identify as bisexual, and 4% gay or lesbian. However, another study suggests that around 25% of UK adults would not describe themselves as "completely heterosexual". Data from the 2021 Census suggests that there are at least 1,361 gay or lesbian residents, 1,873 bisexual, and 1,005 other sexual orientations. However 11% of residents did not answer this question, and it is likely to underestimate the true numbers. 8% of children and young people responding to the 2021 HAY Harrow survey reported that they were gay or bisexual.

Percentages of gay and bisexual orientation are higher among younger adults. It's likely that this population is more underestimated among older adults.

	Number of Harrow adults (16+)	% of adults (16+)			
		Harrow	NW London	London	England
Straight or Heterosexual	182,702	87.2%	86.2%	86.2%	89.4%
Gay or Lesbian	1,361	0.6%	1.7%	2.2%	1.5%
Bisexual	1,873	0.9%	1.3%	1.5%	1.3%
All other sexual orientations	1,005	0.5%	0.5%	0.5%	0.3%
Not answered	22,680	10.8%	10.4%	9.5%	7.5%

Harrow's population – religion

Harrow has among the most diverse communities in England in terms of religion. According to the 2021 Census, a third of the population are Christians, and a quarter Hindu - the highest percentage in England. There are also large populations of Muslims and people with no religion. There are also smaller numbers of Jews, Buddhists and Sikh, as well as Jains - who make up over 80% of the "other religion" category, in the table and maps below.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
No religion	27,748	10.6%	20.0%	27.1%	36.7%
Christian	88,602	33.9%	38.8%	40.7%	46.3%
Buddhist	2,812	1.1%	1.1%	0.9%	0.5%
Hindu	67,392	25.8%	10.6%	5.1%	1.8%
Jewish	7,304	2.8%	1.0%	1.7%	0.5%
Muslim	41,503	15.9%	16.6%	15.0%	6.7%
Sikh	2,743	1.1%	4.1%	1.6%	0.9%
Other religion	7,695	2.9%	1.1%	1.0%	0.6%

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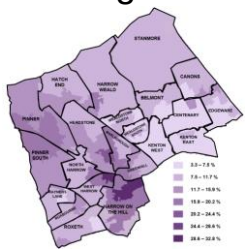
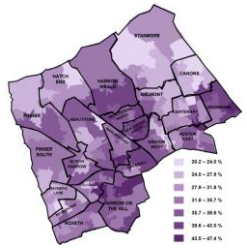
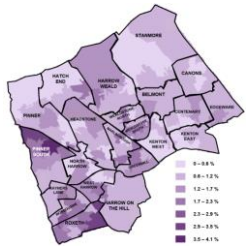
No religion



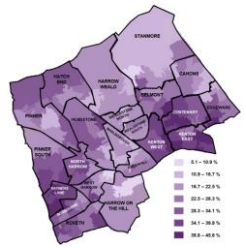
Christian



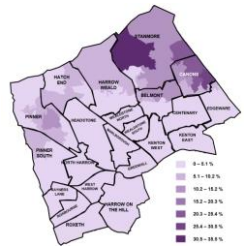
Buddhist



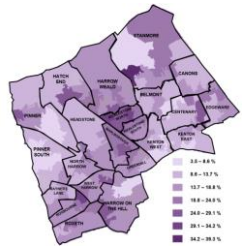
Hindu



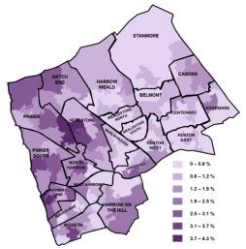
Jewish



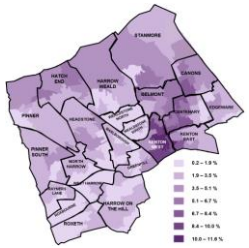
Muslim



Sikh



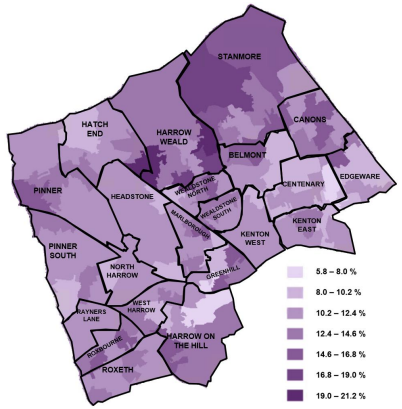
Other religions



Harrow's population – disability

The 2021 Census reports that 12% of people in Harrow are disabled under the Equality Act definition – that is, their day-to-day activities are limited. This figure decreased from the previous Census. This may due to how people perceived their health status and activity limitations during the COVID-19 pandemic.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Day-to-day activities limited a lot	13,808	5.3%	5.6%	5.7%	7.3%
Day-to-day activities limited a little	17,450	6.7%	6.9%	7.5%	10.0%
Has long term health condition but day-to-day activities not limited	11,509	4.4%	4.5%	5.2%	6.8%
No long term health conditions	218,436	83.6%	83.0%	81.5%	75.9%



The map shows the percentage of residents who have a health condition which limits their day-to-day activities.

In Harrow 18,747 (21%) households include one disabled member and 5,104 (6%) households include two or more people who are disabled.

Harrow's population – carers

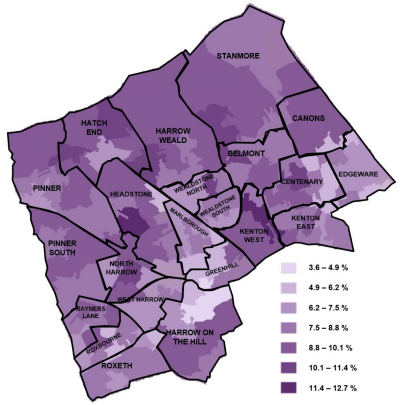
In Harrow over 20,000 people reported being informal carers in the 2021 Census – the map below shows where these people live. Approximately 10,000 (4.2%) residents reported providing 19 or fewer hours of unpaid care each week, almost 5,000 (1.8%) residents provided 20-49 hours per week, and over 5,000 (2.1%) people provided over 50 hours per week.

There was a large drop in the proportion of people reporting that they provided unpaid care since the 2011 Census across all local authorities in England. This may be due to the 2021 Census being undertaken COVID-19 pandemic, affecting how people perceived and managed their provision of unpaid care.

It is likely that the true number of carers is growing due to increases in life expectancy, and the number of people living with long-term health conditions.

In the 3rd quarter of 2023, 3,828 Harrow residents received Carer's Allowance.

Most carers are older working age adults, and are more likely to be female than male.



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	Number of Harrow residents (5+)	% of residents (5+)			
		Harrow	NW London	London	England
Provides no unpaid care	225,468	91.8	92.8%	92.8	91.2
Provides 19 hours or less unpaid care a week	10,225	4.2	3.5%	3.6	4.3
Provides 20 to 49 hours unpaid care a week	4,535	1.8	1.7%	1.7	1.8
Provides 50 or more hours unpaid care a week	5,275	2.1	2.0%	2.0	2.6

Harrow's population – pregnancy and maternity

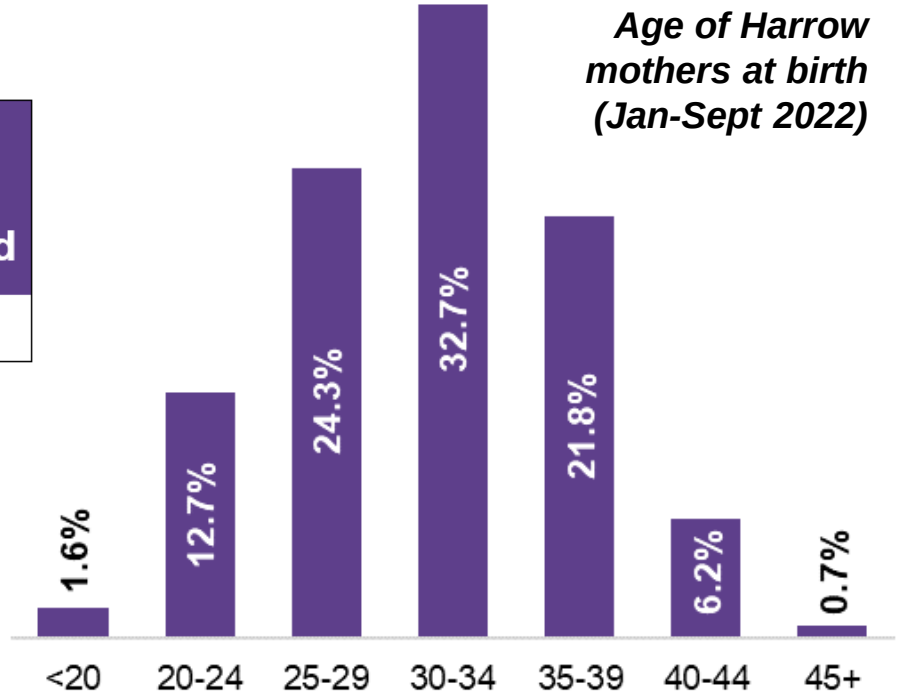
In 2020/21 there were 3,160 babies delivered to Harrow mothers. 10 of these babies were born to under 18s, 32 babies in twin or other multiple births, and 50% were born to mothers from BAME groups.

Of births to Harrow mothers during the first 9 months of 2022, most (53%) were born in Northwick Park Hospital. The other most used hospitals were Barnet (13%), Hammersmith (12%), Watford (6%) and the Royal Free (5%).

Population under 2 years old (2021 Census)

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Under 2	6,217	2.4%	2.3%	2.4%	2.1%

Age of Harrow mothers at birth (Jan-Sept 2022)



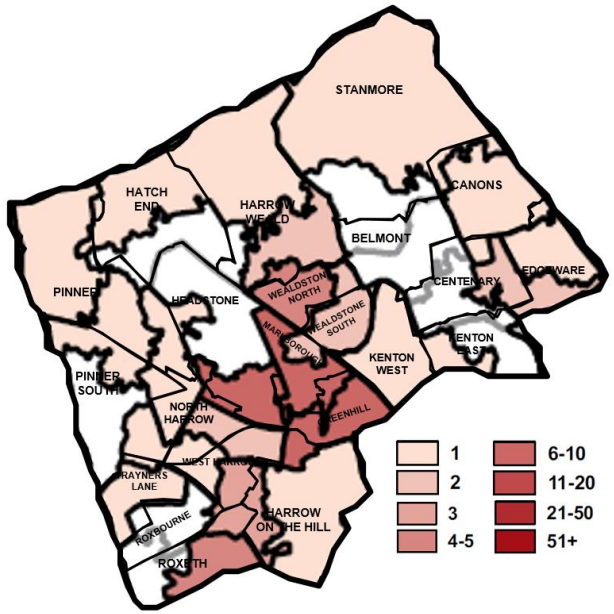
LONDON BOROUGH OF HARROW

Harrow's population – homelessness

According to government figures, there were over 1,000 households in temporary accommodation in Harrow in 2021/22. This is over 1% of households – higher than the rate across England.

	Number of Harrow households	% of households			
		Harrow	NW London*	London	England
Households in temporary accommodation	1,073	1.2%	1.2%	1.6%	0.4%

** Harrow, Ealing, Hammersmith & Fulham, and Hillingdon only*



The Combined Homelessness and Information Network (CHAIN) database records the number of rough sleepers seen in London. They report that during 2021/22, there were 58 rough sleepers in Harrow.

Most (78%) of these people were new rough sleepers, and just over half (53%) were born in the UK. 83% were male.

The map shows where in Harrow these people were seen bedded down.

Please click images to expand

Harrow's population – migrants and asylum seekers (1)

More than half the residents of Harrow were not born in the UK, according to the 2021 Census. This is higher than the percentage in London. The 10 most common other countries of birth are shown in this table. Most residents born overseas arrived in the UK as children or young adults.

Detailed country of birth	Number of residents	% of Harrow population
England	125,093	47.9
India	26,376	10.1
Romania	21,082	8.1
Kenya	10,859	4.2
Sri Lanka	10,706	4.1
Other South and Eastern Africa	8,058	3.1
Afghanistan	4,825	1.8
Pakistan	4,485	1.7
Poland	3,602	1.4
Other Middle East	3,303	1.3

The percentage of residents born overseas is higher than the London and England percentages. Harrow has particularly high number of residents born in Asia and Africa.

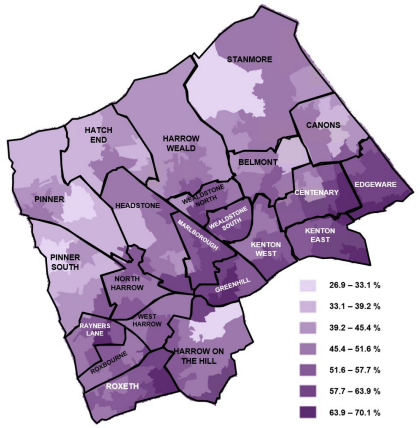
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
UK	127,612	48.9%	50.1%	59.4%	82.6%
Rest of Europe	41,677	15.9%	17.1%	15.5%	7.2%
Africa	26,748	10.2%	7.6%	7.1%	2.8%
Asia / Middle East	59,517	22.8%	20.4%	13.0%	5.7%
Americas / Caribbean	4,985	1.9%	4.0%	4.2%	1.4%
Australia, Antarctica and others	664	0.2%	0.8%	0.8%	0.3%

Harrow's population – migrants and asylum seekers (2)

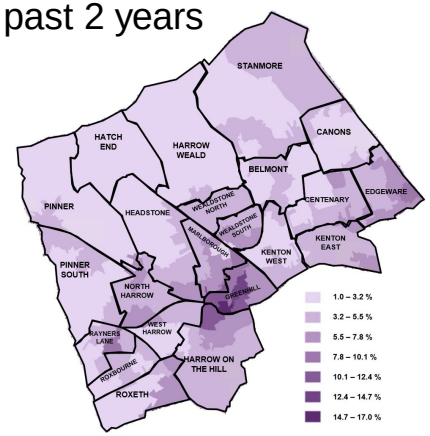
Nationally, and in Harrow, asylum seekers make up a small percentage of immigrants. During 2022/23, a total of 670 immigrants received support from Harrow. This includes 255 under Homes for Ukraine, 89 under Afghan Resettlement Programme, and 326 Supported Asylum.

	Number in Harrow	% of resident population			
		Harrow	NW London	London	England
Total supported in 2022/23 *(incl. Homes for Ukraine, Afghan Resettlement Programme, Supported Asylum)*	670	0.26%	0.68%	0.49%	0.35%

Map shows the % of the population of Harrow born outside the UK.



Map shows % of the population of Harrow who moved to the UK in past 2 years



It is difficult to estimate the number of irregular migrants living in Harrow.

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Harrow's population – veterans

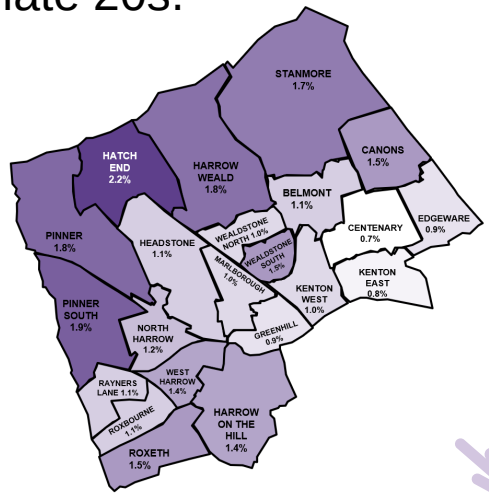
There are generally more veterans in areas of the country with larger active military populations. Both Northwood Headquarters and RAF Northolt are close to Harrow. In the borough itself, there is one reserve unit (131 Commando Squadron), and several active cadet units.

The 2021 Census reports that 2,723 veterans over the age of 16 live in Harrow. This is 1.3% of adults – compared with 1.4% across London and 3.8% nationally. The number of veterans in the population is expected to decline in coming years.

Nationally, almost half of veterans are over 75 years old. Older veterans may have served in WW2 or subsequent conflicts, with national service ending in 1963. Younger veterans may have served in a range of operations at home and overseas. Almost 90% are male. Officers are most likely to leave service in their early 40s, and other ranks in their late 20s.

Harrow residents who have previously served in the UK armed forces (2021 Census)

	Number of Harrow residents	% of population			
		Harrow	NW London	London	England
Veterans	2,723	1.3%	1.3%	1.4%	3.8%



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Harrow's population – health

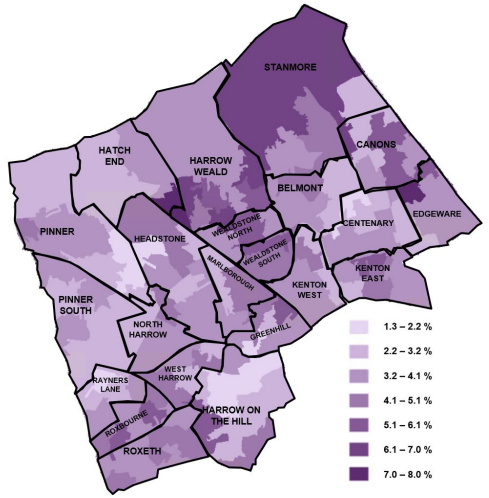
The 2021 Census asked Harrow residents about their health. Over 10,000 residents report that their health was either bad or very bad. This is closely linked to factors such as age and socioeconomic deprivation. There is more information about ill-health in Harrow in the local Joint Strategic Needs Assessment (JSNA). Rates of self reported ill-health are lower in Harrow than across London or nationally.

	Number in Harrow	% of resident population			
		Harrow	NW London	London	England
Bad or very bad health	10,149	3.9%	4.2%	4.2%	5.2%
Age standardised percentage*	-	4.5%	5.2%	5.4%	5.3%

** This figure is adjusted to exclude the effect of age on the percentages*

This map shows the percentage of residents reporting bad or very bad health across Harrow.

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that residents with bad or very bad heath are much more likely to live in more deprived parts of the borough.



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LONDON BOROUGH OF HARROW

2. Poverty and health in Harrow

Poverty and health - definitions

Poverty is when a person's or family's resources are well below their minimum needs. It means not being able to heat your home, pay your rent, or buy the essentials for your children and family.

Two widely used indicators for poverty are based on the Family Resources Survey in conjunction with benefits data - the proportion of households below average income; and the proportion of children in low-income families. These ask a sample of households nationally about their income and expenditure.

We have recently had a period where inflation is rising, which makes the cost of living more expensive - this is not reflected in measures which calculate the number of people with below average income. Other measures for poverty such as universal credit claimant data, and numbers of children in receipt of free school meals are often more timely and routinely available at local level.

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England – this is discussed more on the next page.

Other relevant indicators for low income are;

- Child poverty – often defined as low-income families, are those in receipt of out-of-work benefits or tax credits or whose reported income is less than 60 percent of median income
- Fuel poverty which is when a household spend the required amount to heat a less efficient home, and are left with a residual income below the official poverty line

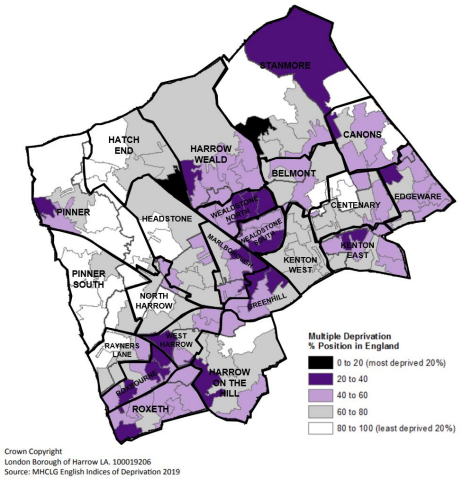
It should be noted that these measures of poverty use quantitative data and that there is an absence of routine information on people's own experiences and perceptions of their income, and the affordability of basic living essentials.

Poverty and health - numbers

The Index of Multiple Deprivation (IMD) is the official measure of relative socioeconomic deprivation in England. The IMD uses 39 separate indicators, organised across seven distinct domains of deprivation, which are combined and weighted. These are: - Income (22.5%) - Employment (22.5%) - Health Deprivation and Disability (13.5%) - Education, Skills Training (13.5%) - Crime (9.3%) - Barriers to Housing and Services (9.3%) - Living Environment (9.3%). IMD measure relative levels of deprivation at the level of small neighbourhoods of roughly 1,500 people. While Harrow is among the 30% of least deprived areas overall, it is in the lowest 10% for the "Barriers to housing and services" domain, like many London boroughs. "Education" and "health" are among the best 10%.

Within Harrow there are some considerably poorer areas (see map, below).

Within any neighbourhood there is also much variation, and individuals with extremes of poverty and wealth can live in close proximity.



Relative socioeconomic deprivation measures (IMD2019)

	Harrow	NW London	London	England
Average IMD score (*higher is more deprived*)	15.0	20.1	21.3	19.6

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Poverty and health – wider determinants (1)

The wider, or social, determinants of health are intrinsically linked to poverty.

Poverty is dynamic – people's needs change throughout their lives and the resources they require to meet their needs change too. Some groups face a greater risk of poverty than others. Those at high risk include: workless households, those where no one works full time, single parents (more likely to be women) and single pensioners, working-age people with a disability and some ethnic minority groups.

Unaffordable housing also damages health. Professor Marmot reported that 21 percent of adults in England said a housing issue had negatively impacted their mental health, even when they had no previous mental health issues, and housing affordability was most frequently stated as the reason. Poor quality housing, particularly damp and cold homes, directly harm physical and mental health and poor housing conditions continue to widen health inequalities nationally.

Many of the ways we can examine the role of our environment on our health show that conditions are worse in more deprived areas, in fact these measures show a linear relationship – the more deprived the area the worse the conditions, including quality of high streets. For example the things we would categorise as unhealthy in our high streets are more likely to be located in more deprived areas; and these include the highest number of fast food outlets, betting shops, more littering and fouling, noise and air pollution, unhealthy retail outlets, crime and fear of crime and road traffic accidents.

Poverty and health – wider determinants (2)

Lower income experienced during school years have lifelong impacts – in terms of income, quality of work and a range of other social and economic outcomes including physical and mental health. Young people living in more deprived areas continue to have significantly lower levels of attainment during secondary school, measured by GCSE results and attainment 8 scores, which measures pupils' performance in eight GCSE-level qualifications.

It is likely that more socio-economically disadvantaged residents will experience worse impacts from external events such as pandemics and climate change.

In the 2023 residents survey, most people in Harrow (58%) reported recently using less water, energy or fuel to save money – this was 72% among people who reported that they were struggling to make ends meet. 43% of residents struggling to make ends meet reported that they were buying less food to save money.

Poverty and health – lifestyles and behaviour

Smoking, poor diet, physical inactivity and harmful alcohol consumption are leading risk factors that drive preventable ill health and premature mortality in England. There is an association between many of these risk factors and disadvantaged groups including those on low incomes.

For example, in England in 2019, the proportion of adults who were smokers in the lowest income quintile was 27 per cent, compared to 10 per cent in the highest income quintile. The prevalence of multiple higher-risk behaviours varies significantly by deprivation. In 2017, the proportion of adults with three or more behavioural risk factors was 27 per cent in the most deprived fifth, compared with 14 per cent in the least deprived fifth.

National data shows that physical activity levels are generally lower in those who live in more deprived areas.

GP recorded rates of adult smoking in Harrow, by IMD deprivation quintile (WSIC 2023, 16+)

Poverty and health – health outcomes

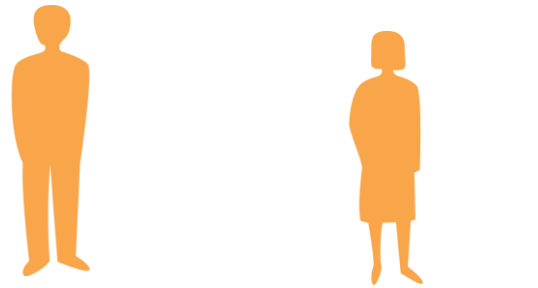
Life expectancy tends to be shorter the lower income for example in 2018 to 2020, males living in the most deprived areas of England were living 9.7 years fewer than males living in the least deprived areas, with the gap at 7.9 years for females. Both sexes have seen statistically significant increases in the inequality in life expectancy at birth since 2015 to 2017.

The difference between people living in the most-deprived and the least-deprived areas is wide in healthy life expectancy, which is a measure of how much time people spend in good health over the course of their lives. Those in the most deprived areas can expect to live 18 fewer healthy years than those in the least deprived areas. Also only people in the three least-deprived deciles are likely to retire in good health, and those in the most-deprived centiles can expect to live some of their working life in poor health.

Research suggests that over a recent 15 year period, over 1,300 Harrow residents died prematurely (under 75) due to the effects of socio-economic inequality.

Rates of almost all health conditions, ranging for child tooth decay to epilepsy, hypertension and diabetes, are more common in more deprived areas in Harrow (WSIC 2023), as well as child obesity, a key risk factor for future ill health. Mortality rates from Covid-19 have been higher in more deprived areas than in less deprived areas. Up to March 2022, the Covid-19 mortality rate was 2.6 times higher for the most deprived decile in England than for the least deprived decile.

People in our poorest neighbourhoods **die earlier** by more than 4 years compared to people in the wealthiest parts of Harrow



Poverty and health – use of services

Inequitable access can result in particular groups receiving less care to address needs which often leads to poorer outcomes and health. Research suggested demand for some services such as mental health services is higher among more deprived communities. Despite having a higher disease prevalence more deprived areas tend to have fewer GPs per head and lower rates of admission to elective care than less deprived areas. People from more deprived areas may also be less likely to seek early or preventative care, which can lead to worse outcomes.

People in poverty have higher risks of poor health but all too often the system only engages when they present with more acute and complex needs. The Centre for Health Economics found that the cost of poverty to hospital inpatient care alone was £4.8 billion per year while the Joseph Rowntree Foundation estimated that poverty cost the NHS and social care systems more than any other part of public services: £29 billion per year.

In Harrow, older people in poorer areas are more than twice as likely to be in contact with Adult Social care Services compared with working age adults who are 1.5 times more likely (WSIC 2023).

Poverty and health – local case studies

London Community Kitchen's Harrow based 'Surplus Food Market' provide all items on a 'pay as you feel' basis, with a variety of fresh produce and food donated as surplus by businesses. The market is open to everyone without any referral system in place and there is also a community café serving hot meals using surplus ingredients that would otherwise end up in landfill with a tiered payment system to ensure affordability. During the crisis caused by increased cost of living hundreds of people have used this service each week in Harrow.

During the winter from January 2023 as the cold set in and temperatures plummeted, Harrow residents were guaranteed a safe, warm and inclusive welcome at Harrow's Warm Hubs. The Hubs, created by a number of community and faith organisations in the borough, provided a safe space for residents, including those who may have been struggling to heat their homes due to soaring energy prices. Refreshments were provided, and residents came along, not only to stay warm, but to socialise and get tips and advice about keeping safe and well. Staff were available to signpost people to advice and other support services.

Poverty and health – best practice (1)

The 6 policy areas within the Marmot Review provide a prioritised list for action to address inequalities in health – they are set across the life course and listed below:

- best start in life
- maximising capabilities through skills and education over the life course
- good employment
- healthy standard of living
- sustainable places and communities (including housing)
- strengthening the role and impact of ill-health prevention

Areas of lower income can be identified geographically and effective place-based action requires action on civic, service and community interventions, along with system leadership and planning. The aims of place-based approaches for reducing health inequalities' are to:

- reinforce a common understanding of the complex causes and costs of health inequalities
- provide a practical framework and tools for places to reduce health inequalities

Poverty and health – best practice (2)

The combination of actions from all parts of this system are needed to reduce inequalities. Public Health England have produced Place-based approaches for reducing health inequalities tool. To follow this approach a local area can utilise the a sequential approach using the range of data available to agree priorities for health inequalities which includes:

- identify priorities for local area using measure of burden/risk factors
- consider comparators, national standards or local targets to estimate relative size of gaps (for example other similar local authorities or CCGs)
- examine within-area inequalities
- examine the main factors driving inequalities across the full causal pathway including conditions, behaviours and wider determinants
- consider care pathways relevant to care priorities. Look to other systems with similar populations but better outcomes

Annual Director of Public Health Report 2022/23:
Health inequalities in Harrow

3. Age and health in Harrow

LONDON BOROUGH OF HARROW

Age and health - definitions

Age is a key determinant of health – the risk of illness generally increases as we age. Age is also a legally protected characteristic under the Equality Act 2010.

Children and Young People (CYP) are commonly defined as under 20 years of age. However in some cases, CYP services includes children up to 25 years for children with special needs (SEND).

Early years normally refers to under 5s.

Early years and childhood are crucial periods in shaping a person's future health and wellbeing. Over a fifth of Harrow residents are under 20, and over 5% are under 5.

Over half of Harrow residents are aged 20 – 64, also sometimes referred to as working age adults.

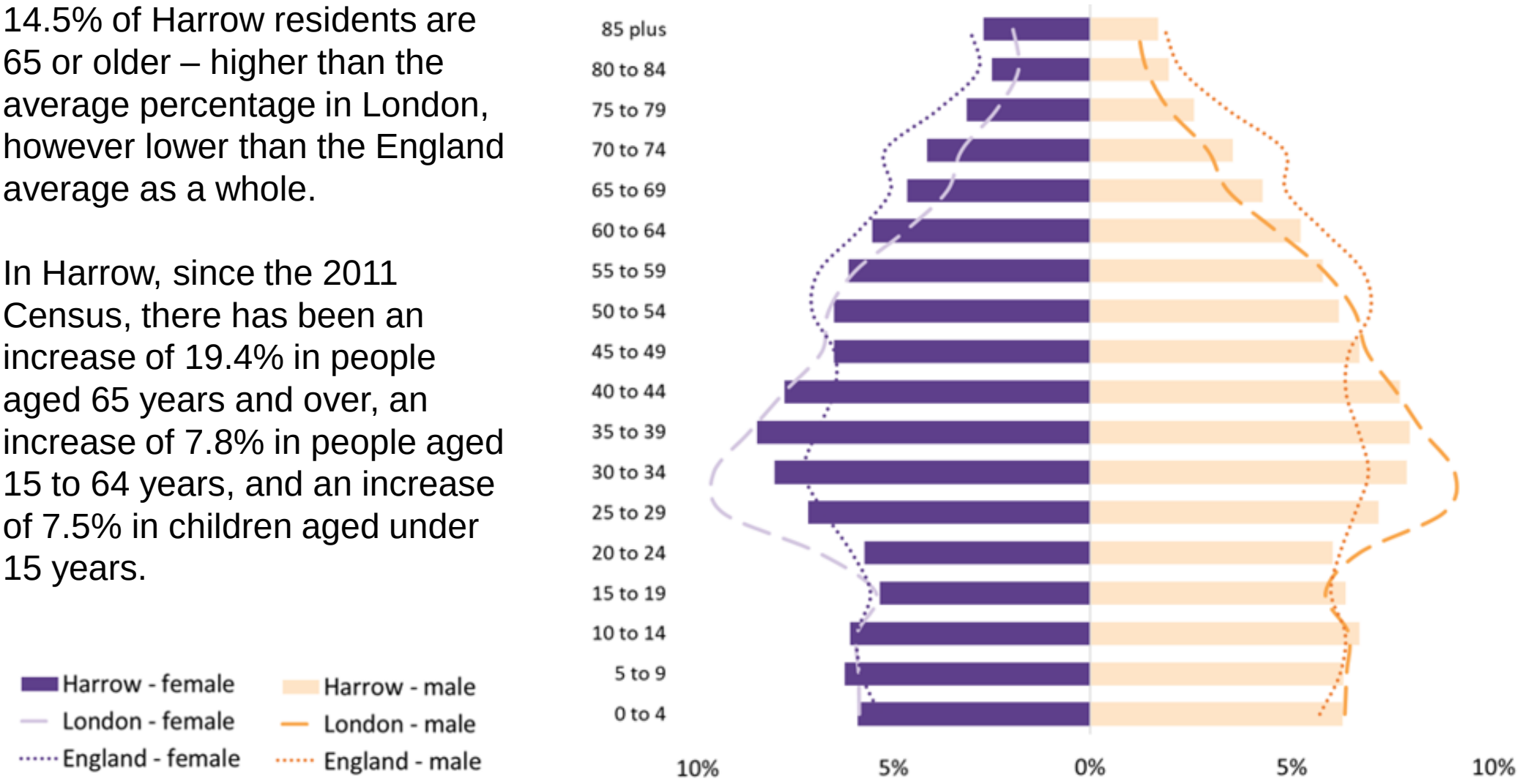
Older Adults are defined as those that are 65 Years of age and above. good health and wellbeing can be maintained well into older age with the right support and access to services. Recent years have seen a shift in attitudes towards older age with an increased recognition that older people continue to give back to their communities, even after they have reached retirement age.

In public health, a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

Age and health – numbers (1)

14.5% of Harrow residents are 65 or older – higher than the average percentage in London, however lower than the England average as a whole.

In Harrow, since the 2011 Census, there has been an increase of 19.4% in people aged 65 years and over, an increase of 7.8% in people aged 15 to 64 years, and an increase of 7.5% in children aged under 15 years.



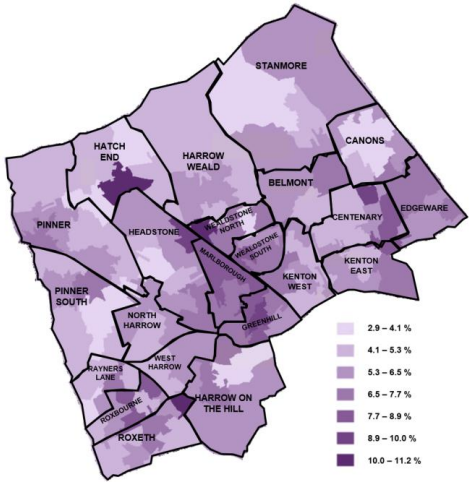
Age and health – numbers (2)

Broadly speaking, the population in northern parts of Harrow is older than in the south.

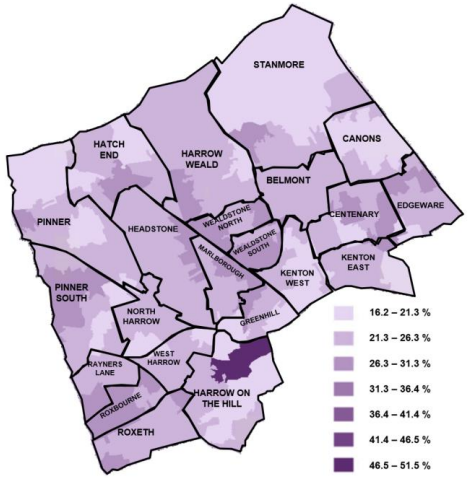
More detail is shown on the maps, below.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Under 5s	15,699	5.7%	5.4%	5.7%	5.2%
Under 20s	63,355	22.9%	21.8%	22.4%	21.9%
20 to 64	157,669	56.9%	60.9%	60.8%	55.5%
65 plus	40,177	14.5%	11.9%	11.2%	17.5%

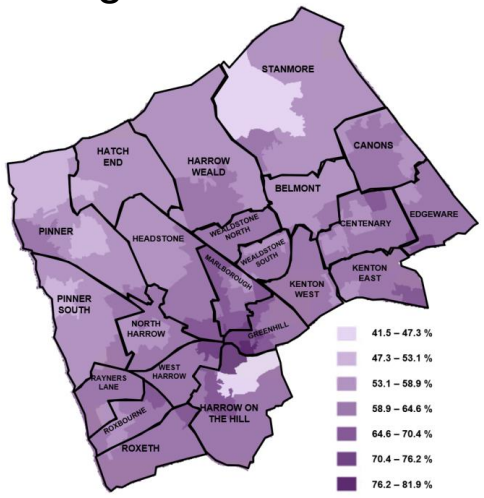
Under 5



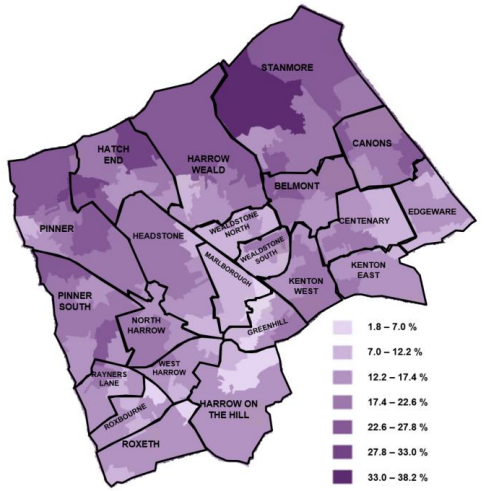
Under 20



Age 20 - 64



65 plus



Age and health – wider determinants (1)

The health and wellbeing of Harrow residents are influenced throughout life by the wider determinants of health. Early years and childhood are crucial periods in shaping a person's future health and wellbeing. Economic hardship, access to good quality education and community services, as well as healthy behaviours developed during this time can have a significant impact on life expectancy, premature mortality and the onset of long-term health conditions.

Older children spend a large proportion of their time in schools. A wealth of evidence has demonstrated a strong link between children's health and their capacity to learn. Creating positive and healthy school environments can therefore have significant benefits in improving health, wellbeing and academic achievement, and reducing inequalities.

Good quality employment is a key influence on health and wellbeing in working age adults. Earnings from paid employment can provide access to a good standard of living and being in work is linked to a positive sense of wellbeing. People who are not working have a higher risk of poor physical and mental health, have fewer social connections and are less active on average. Long-term unemployment is particularly bad for health, with the effects lasting for many years.

Age and health – wider determinants (2)

The risk of poor health generally increases as we age. However, good health and wellbeing can be maintained well into older age with the right support and access to services. Social isolation is a risk to both the mental and physical health of older residents. According to the 2021 Census, 24% of older adults in Harrow live alone, compared with 6% of working age adults.

Recent years have seen a shift in attitudes towards older age with an increased recognition that older people continue to give back to their communities after they have reached retirement age. Older people can continue to be an asset to local communities if supported to maintain independence and take part in community life. This, in turn, can help maintain their own health and wellbeing.

Key measures of poverty in children and older people, published alongside IMD, are Income Deprivation Affecting Children (IDACI) and Income Deprivation Affecting Older People (IDAOPI). Scores for Harrow for ICACI are in the top 30% nationally, similarly to the over IMD. However, IDAOPI is in the worst 30%, suggesting that this is a relatively worse issue. Almost 1 in 5 older adults in Harrow are considered to be income deprived. Overall across London, rates of poverty are highest in households with children.

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that older residents are more likely to live in less deprived parts of the borough.

Age and health – lifestyles and behaviour

The HAY Harrow survey is a key source of information on children's health and wellbeing in Harrow. During 2021 a total of 6,052 children and young people were surveyed. Some key findings include:

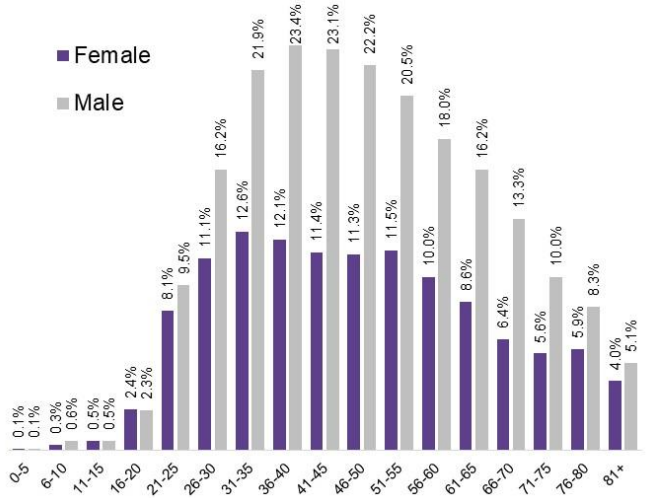
- Most young people feel they eat well and exercise regularly, although young people sometimes feel they are prevented from exercising because there are no suitable spaces or pitches near their homes.
- About 6% of them say they are stopped from being able to get out and exercise because of the need to look after others in the family
- In comparison with previous national data, far less young people drink, smoke, take drugs or vape than other surveys have shown.

Survey data shows that only 62% of adults in Harrow reach recommended levels of physical activity each week – this is lower than similar boroughs. On the other hand, 62% of adults also eat 5 fruit or vegetables each day – this is better than similar boroughs. Physical activity levels generally decline with age, particularly in those over 75.

Healthy life expectancy, the age a resident can expect to live in good health, in Harrow is 61 for females, and 65 for males. Both are comparable to similar boroughs.

The graphs on the right shows how smoking rates vary across age in Harrow. Some young children are recorded as 'smokers' by the GP – this may include passive smoking in the household. Smoking rates peak in younger working age adults, and decline into older age.

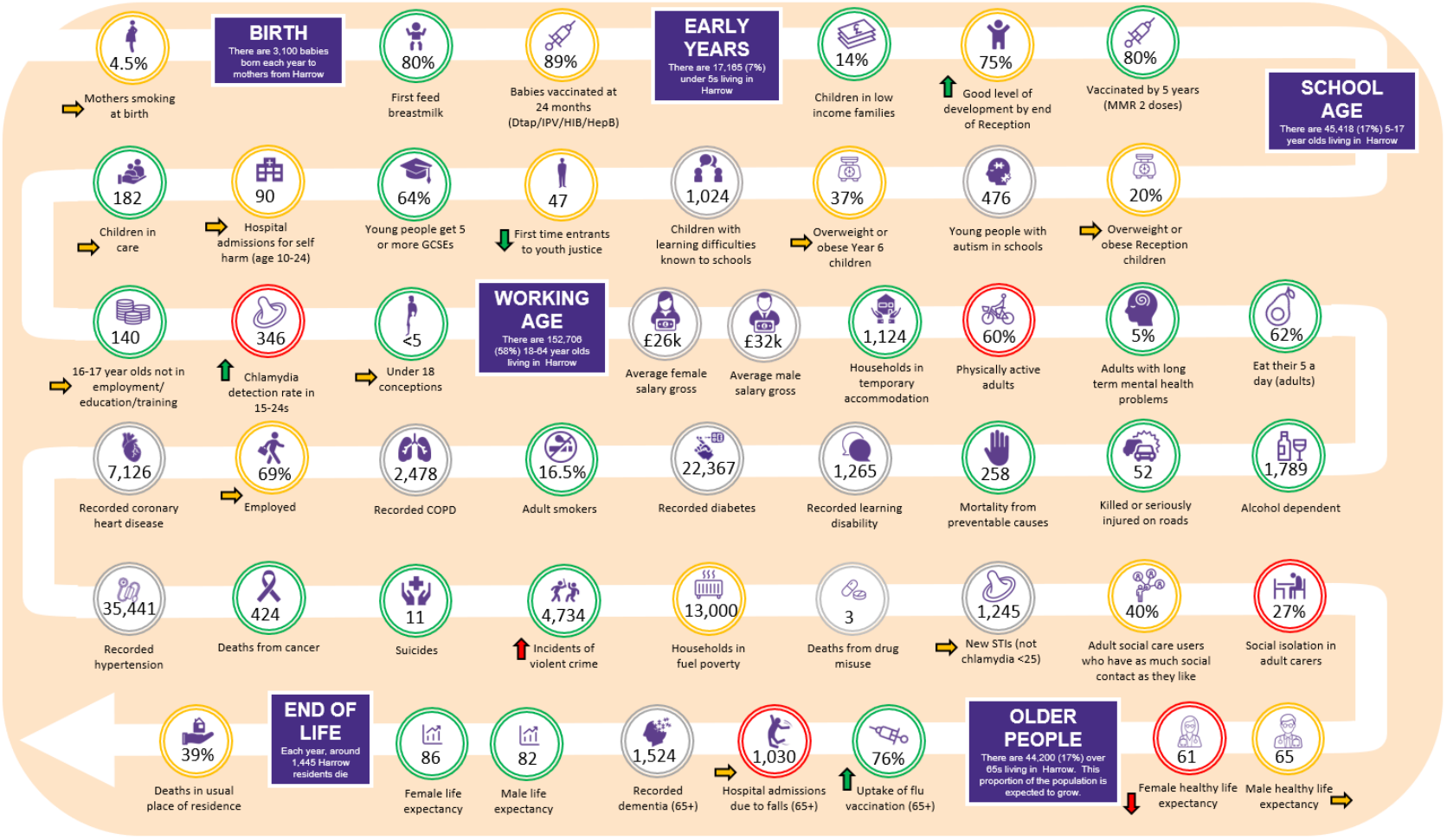
GP recorded rates of smoking in Harrow, by Sex and age (WSIC 2023)



Age and health – health outcomes

The diagram below shows a range of health data from Harrow, from a life course perspective. The colours indicate where figures are better, worse, or similar to London as a whole.

Many of the indicators for Harrow are good – reflecting our relatively wealthy population. However, data shows that we have high rates of diabetes, hypertension and falls in older adults, for example. These problems may grow as the population ages. Vaccination uptake is also relatively low in older adults.



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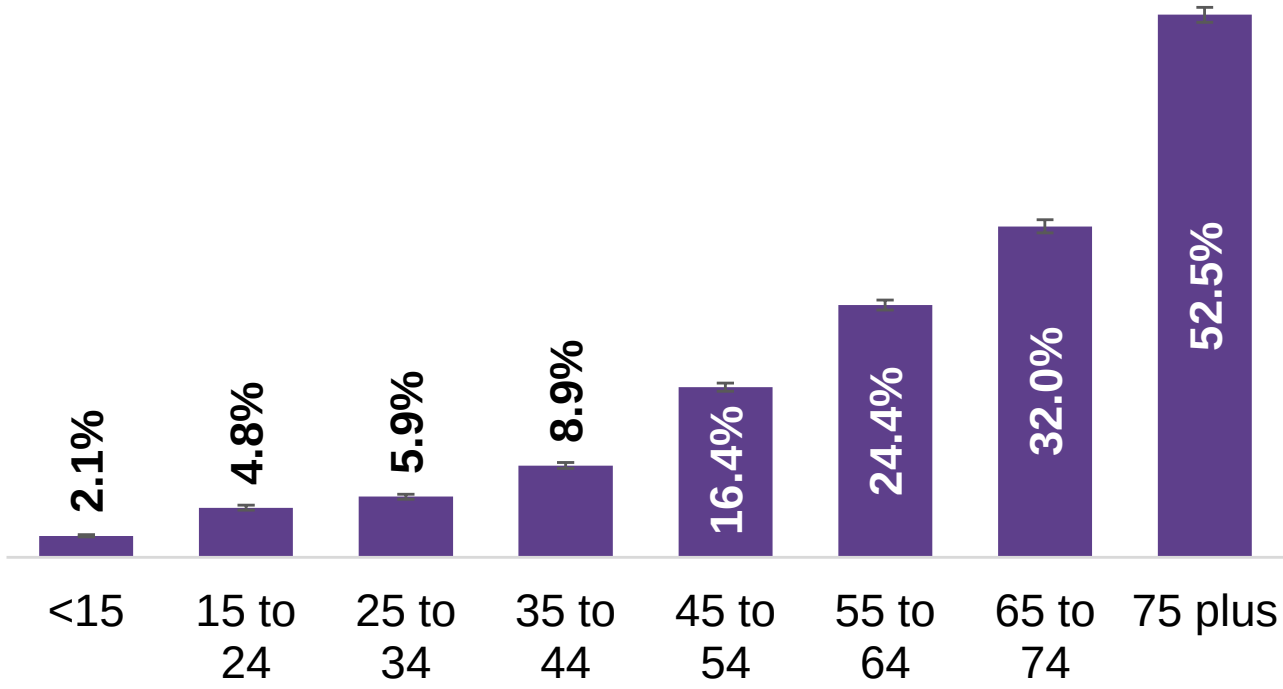
Data sources: Public Health Outcomes Framework, May 2022; Annual Survey of Hours & Earnings 2021; GLA 2020 based housing led population projections. **Notes:** Numbers are for the latest year available, and in some cases cover an average for a one year period, where numbers rather than percentages are shown. Some numbers have been rounded for clarity – please refer to the original data. Red indicates worse than the London average, amber similar, and green better. Grey indicates that the direction of the indicator isn't necessarily good or bad. Arrows indicate recent trend where available – green indicates improvement, red indicates worsening, and amber indicates no significant change.

Age and health – health outcomes (2)

Figures from the 2021 Census (graph below) show that self reported ill-health increases with age in the population of Harrow. Around a quarter of residents report being in bad health by age 55 to 64, and over half of residents over the age of 75. This trend is similar to national evidence, which shows that most people have a long term health condition by the age of 50, for example, with people in the poorest areas experiencing this around 10-15 years earlier on average.

Percentage of Harrow residents in bad health by age (2021 Census)



Age and health – use of services

Access to maternity and postnatal care is discussed in that section.

Council research has shown that we have sufficient children's services in place, and that services perform well compared to regional and national benchmarks for educational and inspection outcomes.

The NHS Health Check is a key opportunity to identify and prevent the onset of cardiovascular disease and other long term conditions, for eligible residents aged between 40 and 74. A key aim of this programme is to reduce unwarranted health inequalities. Over 21,000 Harrow residents have received these over the past 5 years – higher than the national rate:

	Number to Harrow residents	% of eligible population aged 40-74			
		Harrow	NW London	London	England
NHS Health Checks *(2018/19 Q1 - 2022/23 Q4)*	21,586	30.6	43.1	34.1	27.4

As of March 2023, there were 24 older adult care homes in Harrow, comprising of 13 residential homes and 11 registered nursing homes – the council's market assessment process has identified some specific challenges in local care markets. 2,695 older adults accessed long term social care in Harrow during 2021/22 and 1,510 residents aged 18-64.

Older residents are considered to be at higher risk of digital exclusion, when accessing health and care services. Older residents of Harrow consider health services to be more important than younger ones, according to the 2023 residents survey.

Local surveys have found that across age bands residents are generally satisfied with GP services and pharmacies.

Age and health – local case studies

Compass is a free, confidential service for children and young people (aged 10-24) who need support around drug or alcohol use. They operate a helpline, an online system, and a drop in. The service is co-located with other children's services.

Age UK provide support for older adults in Harrow, including help with attending hospital and other medical appointments. They recently launched a Homeshare service – this matches older people with a spare room, with younger people in need of low cost accommodation. In return, the older person receives 10 hours of practical support or companionship each week.

Age and health – best practice

An OHID resource summarises key interventions at critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing, following a life course approach.

There are a wide range of NICE resources relevant to children and young people's health. These include one which specifically focusses on social and emotional wellbeing in the early years, for example. It makes recommendations on the following:

- Strategy, commissioning and review
- Identification of vulnerable children and assessing their needs
- Antenatal and postnatal home visiting for children and their families
- Early education and childcare
- Service delivery

Alongside specific guidance on area such as falls and winter deaths, NICE produces guidance on independence and mental wellbeing in older people. Key areas include:

- Group based activities
- 1:1 activities
- Volunteering
- Identifying those most at risk of a decline in their independence and mental wellbeing

4. Sex and health in Harrow

Sex and health - definitions

Sex is a legally protected characteristic under the Equality Act 2010. Sex can mean either male or female, or a group of people like men or boys, or women or girls.

In the 2021 Census, two options were given for sex – female and male.

In previous censuses, the 'male' option was listed first, reflecting the normal practice at this time. As with ethnicity, it is now recommended to list options in alphabetical order. A new question was also added in the 2021 Census asking respondents whether they identify with the gender they were assigned at birth – there is more information on this in another part of this report.

Sex and health - numbers

Just over half of Harrow's residents are female, and just under half, male. This reflects the London and national patterns.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Female	132,406	50.7%	51.1%	51.5%	51.0%
Male	128,797	49.3%	48.9%	48.5%	49.0%

At older ages, there are more women than men in the population, due to higher life expectancy in females. This difference can be seen in the diagram in the Age section of this report.

Sex and health – wider determinants (1)

In Harrow 125,400 residents aged 16 to 64, equating to 82.1% of the working age population, were economically active from October 2021 to September 2022. The employment rate for males in Harrow is 81.7% and 70.1% in females. The difference in employment between sexes in Harrow residents is 10% compared to 7% nationally . In the UK, the median hourly pay for full time employees was 8.3% less for women than for men and part time employees was 2.8% higher for women than for men. The gender pay gap is higher for all employees than it is for full-time or part-time employees which is due to women filling more part-time jobs which in comparison to full time jobs have a lower hourly median pay.

In Harrow, 23.5% of residents were estimated to be earning below the Living Wage in 2021. In the UK 19% of working age males and 20% of working age females are living in poverty. The family type with the highest poverty rate is lone parent families which are predominantly female . Furthermore, given that women generally live longer than men and are more likely to have gaps in employment history, older women have higher poverty rates.

A key driver in economic inequality between men and women is the unequal distribution in unpaid care work. On average a women will carry out 60% more unpaid work than men. The estimated value of unpaid childcare in 2015 was 132.4 billion, with 69% of that value accounted for by females. The responsibility of caring for ageing parents falls primarily on women and the proportion of unpaid care for adults undertaken by women has increased.

Sex and health – wider determinants (2)

Women are more likely to go to university and gain a first class or upper second degree than compared to men. However, after studies men are more likely to be in “highly skilled” employment or further study. Male earnings are around 8% higher than female earnings from one year after graduation, which increases to 32% after 10 years

The understanding of gender inequality in housing for men and women is limited. It is reported that single men dominate the numbers of people sleeping rough. However, women also suffer disadvantages through housing. On average, women earn less than men and have less capital, therefore women have trouble in accessing housing through the market. In 2017/18 women made up 57% of adults in social renting and 49% in private renting. Furthermore, women have distinctive housing needs such as location, tenure, cost and housing-related support. This is due to women often taking on caring roles, receiving lower pay, and facing a greater risk of domestic violence.

Sex and health – lifestyles and behaviour (1)

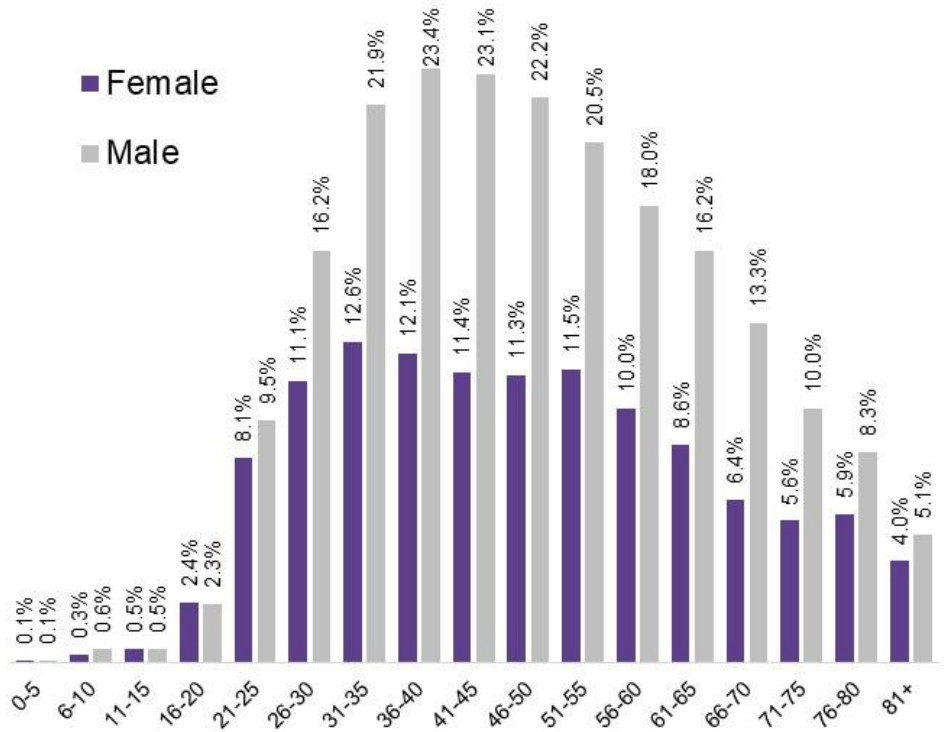
Gender is a key social determinant of health and how women and men engage in health behaviours. Sociocultural norms and attitudes shape the way women and men engage in health promoting or risky behaviours. Men are more likely to engage in risky lifestyle behaviours such as smoking, alcohol, substance misuse and gambling. Health is often a socially constructed female concern, men are less likely than women to use a general practice or visit a pharmacy. In addition, men have lower levels of health literacy and are less likely to acknowledge illness or seek help when sick.

The proportion of current smokers, all person aged 18 years and over in Harrow is reported at 7.9% which is lower than the national average 13.3%. Nationally, 15.1% of men smoked compared with 11.5% of women; this trend has been consistent since 2011.

Local smoking rates by gender are shown in the graph.

In the UK, 55% of males reported drinking alcohol at least once a week compared to 41% of females. Daily alcohol consumption in the UK is reported 8% in males compared to 5% of females. Furthermore, males make up 60% and females 40% of treatment given for alcohol use.

GP recorded rates of smoking in Harrow, by gender and age (WSIC 2023)



Sex and health – lifestyles and behaviour (2)

The suicide rate for males in the UK in 2021 was 16 deaths per 100,000 compared to 5.5 deaths per 100,000 for females. The largest increase in suicide rate since 1981 is in Females aged 24 or under. In Harrow, the suicide rate for males is 7.0 per 100,000 and for females 5.2 per 100,000.

Young women have been identified as a high-risk group with 26% experiencing a common mental disorder compared to 9.1% of men. Although, women are more likely to experience common mental health issues than men, around 74% of suicides in 2021 were male. Health seeking behaviours for mental health vary between genders and there is debate about the true prevalence of common mental health disorders in men. The referrals for NHS talking therapies in the UK are predominantly women, with only 36% of referrals for men. Men are less likely to recognise or act on warning signs and seek out emotional support. A survey conducted for the Mental Health Foundation in 2016 found that 28% of men had not sought professional help for the last mental health problem they experienced compared to 19% of women. Furthermore, men are more likely to sleep rough and become dependent on alcohol and drugs which will have substantial impacts on mental health.

In the UK, 5% of adults (6.9% women and 3% men) aged 16 years and over experience domestic abuse - this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men). Domestic abuse related crimes disproportionally affect females with 74.1% of crimes the victim was female and 72.1% of victims of domestic homicide were female.

According to the 2023 residents survey, female residents of Harrow are significantly less likely to feel safe after dark (60%) than males (79%).

Sex and health – health outcomes (1)

In England, the average life expectancy is 79.4 years for males and 82.9 years for females. In addition, there is a 27-year difference in life expectancy for men depending on location and mostly due to poverty. Male deaths during the working age of between 15 and 65 years in the UK make up 17.5% of all deaths compared to 11.4% being females. It is estimated that 36% of male deaths are preventable compared to 19% of women. In Harrow, life expectancy for males is higher than the national average at 82.2 years and 85.7 years for females.

In England in 2021 ischaemic heart disease was the overall leading cause of death for males accounting for 12.4% of all male deaths, while dementia and Alzheimer's disease were the leading cause of death for females and accounted for 14% of all registered female deaths. In Harrow, the under 75 mortality rates for all cardiovascular disease in males is 80.9 per 100,000 in comparison to 33.9 in females. The age standardised mortality rates are higher in males (916.6 per 100,000) than females (713.2 per 100,000).

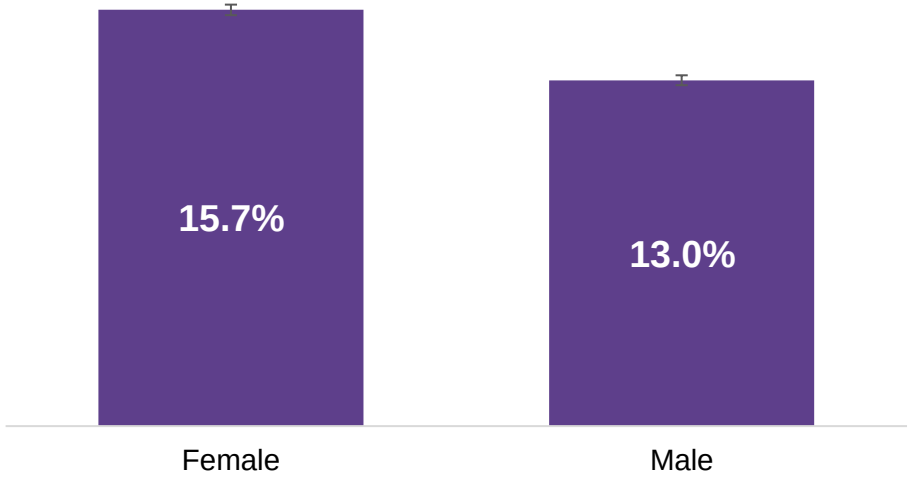
Sex and health – health outcomes (2)

The COVID-19 pandemic impacted men and women in different ways. In Harrow, the mortality rate for deaths involving COVID-19 for males under 75 was 108.6 per 100,000 and for females 63.2 per 100,000, both rates worse than the national rate. There was an 18% difference in the total number of COVID-19 related deaths for men (63,700) and women (53,300) in the UK. Although more men died from COVID-19, the well-being of females was more negatively affected during the first year of the pandemic due to a variety of reasons. The pandemic significantly increased the burden of unpaid care, which is disproportionately carried by women.

Work sectors dominated by women such as hospitality, tourism and retail were heavily affected. This created economic instability and deprived women of their livelihoods. Furthermore, Sex-based violence intensified. Lockdowns left many women feeling trapped with their abusers and isolated from social contact and support networks.

The graph shows data from the 2021 Census – self reported ill-health is more common in women than men in Harrow.

Percentage of Harrow residents in bad health by gender (2021 Census)



Sex and health – use of services

Gender is an important determinant of accessing and the uptake of healthcare. Men are generally deterred from seeking diagnosis and treatment, a UK-based study found that men were 8% less likely to consult a doctor than a woman. Due to gender socialisation, engaging with healthcare is perceived by many men as incompatible with the masculine “norms” of strength and stoicism. Consequently, the reluctance for men to access services increases the likelihood for men to become less willing to overcome practical barriers to healthcare such as travel, cost and time. Certain groups of men may encounter more barriers, such as those with low incomes who work and have less flexible schedules, as well as homeless and traveling men who may not be registered with a GP.

Women face challenges in access to reproductive healthcare services. These services are often fragmented in delivery and the geographical location making access to these services difficult.

Sex and health – local case studies

Hestia Harrow provides emotional and practical support for people experiencing domestic abuse living in Harrow. The service provides refuge, floating support, and advocacy through independent domestic violence advisors.

Resourceful Women's Network is a women's centre and registered charity determined to make a positive impact on the lives of local women. They provide services which include counselling, legal advice and a range of workshops which aim to empower women in need and hardship.

Mind in Harrow is a charity which is committed to improving access for men to mental health support, either through services Mind provide or campaigning and working with others.

Sex and health – best practice

The government's first Women's Health Strategy for England sets out how to improve the way in which the health and care system listens to women's voices and improves health outcomes for women and girls. It takes a life course approach, focused on understanding the changing health and care needs of women and girls across their lives, from adolescents and young adults to later life.

Women's Aid is a national charity working to end domestic abuse against women and children. The charity provides frontline domestic abuse services, supporting women and children at the most challenging times of their lives.

Men's Health Forum is a charity supporting men's health in England which advocate for men's health through research, raising awareness and providing information and advice. The men's forum aids in the development of specific men's health policies and supports local authorities in increasing access to health services for men.

5. LGBTQ+ people and health in Harrow

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LGBTQ+ people and health - definitions

The acronym LGBTQ+ covers sexual identity (LGB = Lesbian, Gay, Bisexual), Sex identity (T = transgender) and sexual and / or Sex identity (Q = Queer / Questioning). The '+' covers a number of other acronyms that fit under the umbrella of sexual / gender identity including: I = Intersex, A = Asexual. For a fuller list see the Stonewall website.

Sexual identity does not necessarily reflect sexual attraction and/or sexual behaviour, which are separate concepts.

Heterosexual/straight refers to a man who has a romantic and/or sexual orientation towards women or to a woman who has a romantic and/or sexual orientation towards men.

The terms transgender or trans are commonly used for those whose gender diverges from that assigned to them at birth, though many terms are used. Trans identity can be "non-binary" in character, located at a (fixed or variable) point along a continuum between male and female; or "non-gendered".

Cisgender or Cis is the term for someone whose gender identity is the same as the sex they were assigned at birth.

Some people reject any categorisation of their sexual and / or gender identity.

Sexual and gender identity can be a controversial area from political, religious and societal perspectives.

Sexual orientation and gender reassignment are legally protected characteristics under the Equality Act 2010.

LGBTQ+ people and health – numbers (1)

It is difficult to estimate the number of gay and bisexual people in Harrow - this data has not been routinely collected, and there are barriers including stigma and discrimination. A national survey suggests that around 5% of the population may identify as bisexual, and 4% gay or lesbian. However, another study suggests that around 25% of UK adults would not describe themselves as "completely heterosexual". Data from the 2021 Census suggests that there are at least 1,361 gay or lesbian residents, 1,873 bisexual, and 1,005 other sexual orientations. However 11% of residents did not answer this question, and it is likely to underestimate the true numbers. 8% of children and young people responding to the 2021 HAY Harrow survey reported that they were gay or bisexual.

Percentages of gay and bisexual orientation are higher among younger adults. It's likely that this population is more underestimated among older adults.

	Number of Harrow adults (16+)	% of adults (16+)			
		Harrow	NW London	London	England
Straight or Heterosexual	182,702	87.2%	86.2%	86.2%	89.4%
Gay or Lesbian	1,361	0.6%	1.7%	2.2%	1.5%
Bisexual	1,873	0.9%	1.3%	1.5%	1.3%
All other sexual orientations	1,005	0.5%	0.5%	0.5%	0.3%
Not answered	22,680	10.8%	10.4%	9.5%	7.5%

LGBTQ+ people and health – numbers (2)

It is difficult to estimate the numbers of transgender people in Harrow - this data has not been routinely collected, and there are barriers including stigma and discrimination. Nationally, the government has tentatively estimated that 200,000-500,000 people in the UK may identify as being trans. GIREs estimate that around 1% of the population identify as trans. Data from the 2021 Census suggests that there are at least 1,888 transgender or non-binary residents, however 9% of residents did not answer this question, and it is likely to underestimate the true number.

Percentages are higher among younger adults. It's likely that this population is more underestimated among older adults.

	Number of Harrow adults (16+)	% of adults (16+)			
		Harrow	NW London	London	England
Transgender or non-binary	1,888	0.9%	0.9%	0.9%	0.5%

LGBTQ+ people and health – wider determinants (1)

There have been huge positive changes in societal attitudes towards LGBT people that the British Social Attitudes surveys have noted since the 1980s. Over 65% of respondents to the survey in 2018 said that sexual relations between two adults of the same sex are “not wrong at all” which is up from below 20% in 1983.

That said, the liberalisation in attitudes has slowed down which the report authors attribute to “the marked divides between the attitudes of religious and non-religious people in this sphere”.

National surveys show that there is still a sizeable minority who hold discriminatory attitudes towards LGBT people. In 2017 1 in 5 LGBT people reported that they had experienced a hate crime based on the fact they were LGBT in the last 12 months, this rises to 2 in 5 of trans people.

30% of bi men and 8% of bi women say they cannot be open about their sexual orientation with any of their friends, compared to 2% of gay men and 1% of lesbians.

Discrimination also comes from within the LGBTQ+ community. A 2018 Stonewall reported that significant numbers of LBGT people experienced prejudice from within the LGBT community on the basis of ethnicity, religion or disability.

LGBTQ+ people and health – wider determinants (2)

Data from 2018 suggests that LGBT people are more likely to suffer from domestic abuse with more than 11% of LGBT people having faced domestic abuse from a partner in the last year in comparison to 6% of women and 3% of men in the general population who experienced domestic abuse from a partner in the past year. 42.8% of LBT women said that they had experienced sexual violence compared to an estimated 20% of all women in the UK.

24% of homeless people aged 16-24 are LGBT and 69% of these people believe parental rejection was a main factor in becoming homeless.

The 2021 Trans lives survey found that 27% of those responding reported having experienced homelessness at some point, with similar results from other studies – this was in part due to transphobia at home leading them to leave home unexpectedly.

More than a third of trans students have reported experiencing negative comments or conduct from staff. Comparisons on LGBTQ+ pupils educational attainment are difficult due to no formal studies or data available on this.

LGBTQ+ people and health – lifestyles and behaviour

In 2018, 1 in 6 LGBT people reported drinking almost every day in the last year, this compares to 1 in 10 adults in the general population who report drinking alcohol on five or more days per week.

28.4% of LGB adults had taken drugs in 2014, including 33% of GB men and 22.9% of LB women. This compared to 8.1% of heterosexual adults. A study from 2016 found that 6.6% of men who have sex with men in England used any one of the three chemsex drugs in the previous 4 weeks, this rises to 21.9% of those living with HIV. Those using chemsex drugs were found to be much more likely to have unprotected sex.

Smoking rates are significantly higher among the LGB population. National data from 2016 indicates that while 18.8% of heterosexual people smoked, this compares to 27.9% of lesbian women; 30.5% of bisexual women; 23.2% of gay men; 26.1% of bisexual men. Sexual orientation is not widely recorded on GP records in Harrow, making it difficult to detail health needs, such as local smoking rates. Similarly, local rates are not available for transgender or non-binary residents.

55% of gay, bisexual and trans men were not active enough to maintain good health, compared to 33% of men in the general population. However, the Active Lives surveys have found that gay and bisexual people were less likely to be inactive that heterosexual people. Use of sport and leisure services can be difficult for trans people – in the Scottish Transgender Survey, 46% reported they had never used any sport or leisure services.

LGBTQ+ people and health – health outcomes

There is a lack of comprehensive research on the rates at which LGBT people experience ill health and disease, making it sometimes difficult to draw comparisons to the general population. This is compounded by issues around data recording in health and care services.

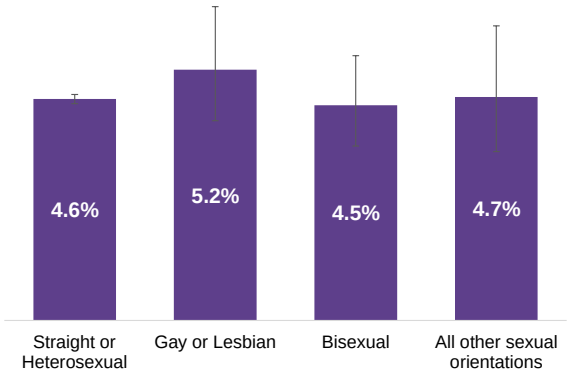
45% of LGBT pupils, including 64% of trans pupils, report being bullied for being LGBT at school. 45% of trans young people (aged 11-19) and 22% of cis LGB young people have tried to take their own life. Among the general population the NHS estimates this figure to be 13% for girls and 5% for boys aged 16-24. In 2017, 52% of LGBT people reported experiencing depression in the previous year. This includes 67% of trans people and 70% of non-binary people.

The HIV diagnosed prevalence rate per 1,000 aged 15 to 59 was 2.42 in Harrow in 2021. This is lower than the London average of 5.35 but higher than the England average of 2.34. Gay and bisexual men make up a disproportionate number of those with HIV. For example, of the 4,139 people diagnosed with HIV in the UK in 2019, 41% were gay or bisexual men.

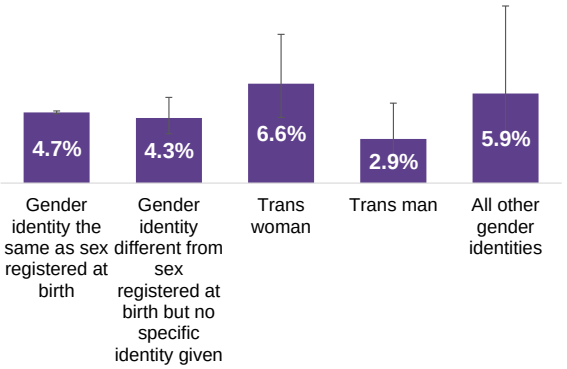
The graphs shows data from the 2021 Census – there is no clear relationship between sexual orientation or gender identity and self-reported health in Harrow.

Please click images to expand

Sexual orientation



Trans or Cis Gender



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LGBTQ+ people and health – use of services (1)

In 2018 it was found that 23% of LGBT people have at one time witnessed anti-LGBT remarks by healthcare staff. It also showed that LGBT patients have a disproportionately greater dissatisfaction with NHS services.

93% of LGBT specialists and service users consider that more work needs to be done to improve end of life services for LGBT people.

Surveys reported healthcare staff lacked understanding of trans people when being seen, and many feel being known to be transgender has impacted on their care, with some even describing being refused care.

21% felt of trans people interviewed in the National LGBT survey felt their needs were ignored or not taken into account when accessing health services. 14% reported being refused GP care on account of being trans or non-binary, and 57% reported avoiding going to see a doctor when unwell.

There are historically long waits for secondary care Sex Identity clinics, and 2 in 5 reported dissatisfaction in the time it took to receive treatment. Waits are usually in years and the wait for commencing treatment can be even longer, with 80% of trans individuals in one survey described difficulty accessing Gender Identity services, and many had chosen to go abroad as an alternative. For example the Tavistock and Portman Gender identity clinic which is our London referral hub, reports seeing patients referred in 2018, a 4 year wait currently.

LGBTQ+ people and health – use of services (2)

Barriers to trans people becoming parents have been reported due to uncertainty regarding funding for gamete storage and fertility treatment.

The NHS provides a range of screening programmes which are usually available to a subsections of the population, primarily age or gender based. There is evidence that many trans people find this challenging at times, with 27% in one study reported avoiding their GP for routine cervical or prostate checks. In contrast, access to sexual health services was felt to be relatively good, with positive feedback regarding staff and attitudes in these settings.

The National LGBT survey reported that 30-40% of trans individuals had accessed mental health services in the past 12 months. When seeking help within mental health services, numerous negative experiences were described.

LGBTQ+ people and health – local case studies

In Harrow the LGBT Support Group provides supports for LGBT 14-18 year olds, with both group and individual support. The Mosaic Trust also provides support for LGBT+ under 18's.

NWLLGG is a Gay, Lesbian, Bisexual, transgender, queer group providing support for adults in Harrow and surrounding areas.

LGBTQ+ people and health – best practice

The LGBT Foundation has the Pride in Practice scheme to encourage GP practices to be more LGBT+ friendly. This includes:

- Collecting better data on sexual orientation and trans status
- Staff knowing what support groups exist
- Staff having training to understand better issues that LGBT+ patients face, increasing staff confidence in knowing how to talk about certain issues and the language that helps in doing so, understanding how to talk with patients with learning disabilities about sexuality etc.
- Having posters in the surgery

The General Medical Council has produced a guide on how LGBT+ patients should expect to be treated by their GP surgery.

The Royal College of General Practice has guidance that GP's should show the same level of support, dignity, respect, sensitivity and understanding, to patients with gender dysphoria or trans patients, as they would with any other patient, and calls for expanded access for Gender Identity clinics to try and redress the extremely long waiting lists.

In 2018 the Government launched the LGBT+ Action Plan which sets out how public services need to respond to the needs of the LGBT+ population.

6. Ethnicity and health in Harrow

Ethnicity and health - definitions

Ethnicity refers to a shared cultural identity and heritage that differentiates one group of people from another. In the United Kingdom, ethnicity is often associated with characteristics such as language, nationality, traditions, religion and skin colour.

Although 'race' is a term that is often used alternatively to ethnicity, its definition given by the Equality Act 2010 does not cover the cultural experiences outside a person's physical or national identity.

This distinction in definition means that ethnicity can be seen as more subjective and therefore makes self-identification complex. This potentially means that two people of a similar race could identify with different ethnic groups.

The 2021 Census listed 19 ethnic groups in England and Wales for people to identify with, which are sorted into the following broad categories: White or White British, Black or Black British, Asian or Asian British, Mixed or Multiple Ethnicities and Other. At least 285 ethnic groups were identified by the 2021 Census in Harrow. However this report will focus on the 19 established groups.

Ethnic minorities is used to described people from ethnic backgrounds that are outside those who self-describe as White British – however, the term global majority is now increasingly used instead.

Black Asian and Minority Ethnic (or Black Minority Ethnic or BAME) is a phrase that was used to collectively describe ethnic minorities in the UK until recently when it was agreed by various organisations that as the term minimises other groups such as those with mixed, other white and Gypsy, Roma and Traveller backgrounds, as well as missing the variation between different groups.

Ethnicity and health – numbers (1)

Harrow is ethnically diverse, with at least 285 different ethnic identities reported in the 2021 Census.

The most common 20 different ethnicities in Harrow are shown in this table.

Ethnicity	Number of residents	% of Harrow population
Asian - Indian	74,744	28.6
White - British (incl. English, Welsh etc)	53,563	20.5
White - Romanian	14,892	5.7
Asian - Pakistani	10,264	3.9
Asian - Sri Lankan	9,776	3.7
Asian - Afghan	6,514	2.5
Black - Caribbean	6,512	2.5
Other - Arab	6,239	2.4
White - Irish	5,608	2.1
Asian - Tamil	4,820	1.8
White - European mixed	3,962	1.5
Black - African	3,303	1.3
Mixed - White and Asian	3,140	1.2
White - Polish	2,976	1.1
Asian - Chinese	2,784	1.1
Black - Somali	2,784	1.1
White - Unspecified	2,518	1.0
Other - Tamil	2,468	0.9
Mixed - White and Black Caribbean	2,282	0.9
White - Other East European	2,187	0.8

Ethnicity and health – numbers (2)

Harrow ethnic groups from the 2021 Census are grouped into broad categories, with the make up of these given.

Ethnicity		Number of residents	% of Harrow population
ASIAN		**118,152**	**45.2%**
	Bangladeshi	1,820	0.7%
	Chinese	2,784	1.1%
	Indian	74,744	28.6%
	Pakistani	10,264	3.9%
	Other Asian	28,540	10.9%
BLACK		**19,151**	**7.3%**
	African	10,584	4.1%
	Caribbean	6,514	2.5%
	Other Black	2,053	0.8%
MIXED		**9,833**	**3.8%**
	White and Asian	3,140	1.2%
	White and Black African	1,104	0.4%
	White and Black Caribbean	2,187	0.8%
	Other Mixed or Multiple ethnic groups	3,402	1.3%
WHITE		**95,233**	**36.5%**
	English, Welsh, Scottish, Northern Irish or British	53,567	20.5%
	Irish	5,608	2.1%
	Gypsy or Irish Traveller	179	0.1%
	Roma	1,421	0.5%
	Other White	34,458	13.2%
OTHER		**18,836**	**7.2%**
	Arab	6,239	2.4%
	Any other ethnic group	12,597	4.8%

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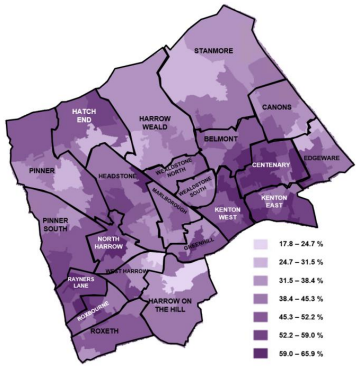
Ethnicity and health – numbers (4)

The ONS groups ethnicities as reported in the 2021 Census into broad categories. The percentages of these are given below, and the maps show how where residents from these ethnic groups live in the borough.

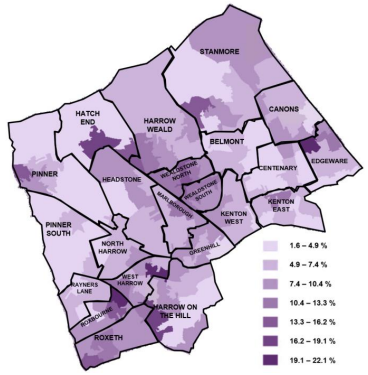
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Asian	118,152	45.2%	27.8%	20.7%	9.6%
Black	19,151	7.3%	9.5%	13.5%	4.2%
Mixed	9,833	3.8%	5.2%	5.7%	3.0%
White	95,233	36.5%	49.1%	53.8%	81.0%
Others	18,836	7.2%	8.4%	6.3%	2.2%

Please click images to expand

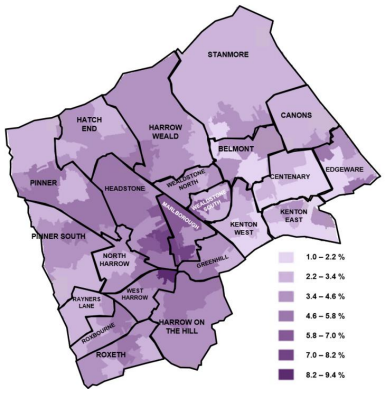
Asian



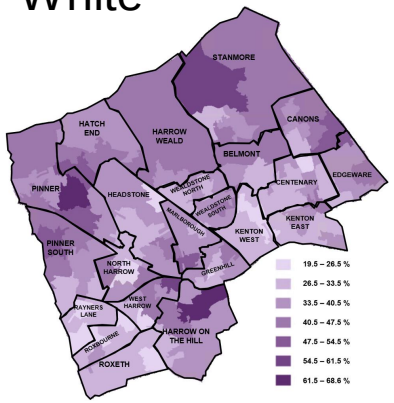
Black



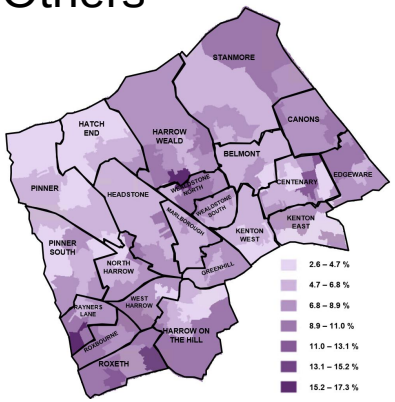
Mixed



White



Others



Ethnicity and health – wider determinants (1)

The Kings Fund found that 22% of people in the most deprived areas were from ethnic minorities. This is despite the fact that ethnic minorities groups represent only 15% of the population in the UK. In particular, 31.1% of people from a Bangladeshi and 19.3% of people from a Pakistani background were recorded to live in these areas. There is a strong link between high levels of deprivation- which comprises of a variety of different socio-economic factors - and negative health outcomes (see Deprivation).

The arrival of the pandemic had a significant impact on the unemployment rates for all ethnicities. However, the rate for those of an ethnic minority background was more than twice the rate of people from a white background in 2022, at 6.9% compared to 3.2%. Of all the ethnic minorities, the Indian group was the lowest at 4.2 and the Chinese group highest at 12.4%.

The experience of the quality and affordability of housing shows significant inequalities across the population. The Joseph Roundtree Foundation reported that issues of overcrowding and damp disproportionately affected ethnic minorities groups, although numbers on damp are based on a smaller sample.

Around 25% of minority ethnic workers are paying unaffordable housing costs, compared to 10% of workers from white groups. This does not however include Indian workers. The report suggests that this could be linked to the reduced likelihood of being a homeowner and living in high costs of rent. 68% of White British households are more likely to own a home compared to 20% of Black African households, 40% of Black Caribbean households, 46% of Bangladeshi households and 58% of Pakistani households.

Ethnicity and health – wider determinants (2)

The report also suggests that there are limitations to certain households to access benefits, which affects their ability to afford living costs. This is especially the case for ethnic minority households, of which 8 of 20 are affected.

An important factor to consider is the impact of racism and discrimination on health. The Lancet strongly proposes that racism should be considered as a wider determinant that impacts health and wellbeing, especially in ethnic minorities. Some of the key factors identified that exacerbate this include:

- An overactive stress response triggered by discrimination that increases the likelihood of developing long term health conditions and shorter life expectancy.
- The structural racism embedded in systems that create an unfair disadvantage to people with a minority ethnic background.
- Spatial Determination or how near you are to environmental and geographic elements that could impact health such as access to green spaces, poor air quality from pollution and neighbourhood deprivation
- The impact of climate change on marginalised communities

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that residents of Black ethnicity are much more likely to live in more deprived parts of the borough. This data is supported by the 2023 Harrow residents survey which found that black residents were least likely to feel financially comfortable.

Ethnicity and health – lifestyles and behaviour (1)

Around a third of White British men were found to consume alcohol at a 'hazardous, harmful or dependent level.

Illegal drug use and dependency is higher in black adults than other groups. Just over 1 in 10 Black adults were likely to engage in illicit drug use. Although, this is not far from white British adults at 8.9%. Black male adults had the highest reported rate of drug dependency, according to the Adult Psychiatric Morbidity Survey.

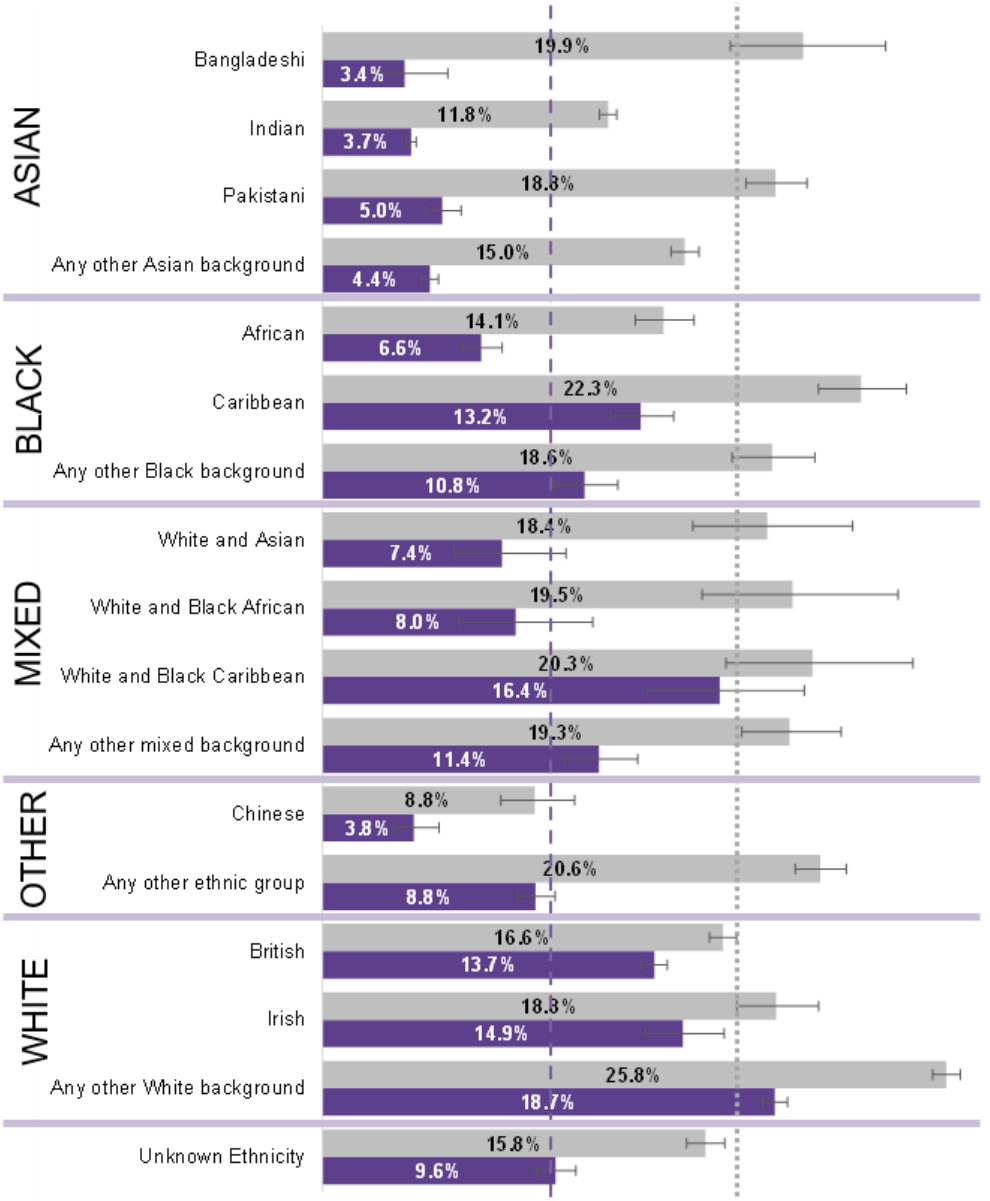
There are high levels of physical inactivity in ethnic minorities, with at least 50% reported to achieve less than 30 minutes of exercise a week compared to the recommended amount of weekly exercise of 150 minutes. The Active Lives Survey (2022) found that 7 in 10 men from mixed groups and 64.7% of white British men reported themselves to achieve the 150 minutes. In contrast, there are concerning levels of physical inactivity seen in South Asian and black women, at 46.6% and 52.1% respectively. A variety of barriers have been identified as reasons why these groups are less likely to engage in physical activity including practical issues such as affording activities and childcare, concerns over maintaining social responsibilities and unsuitable environments to engage in physical activity.

Obesity varies across ethnicities. While Asian, Other and Mixed groups experience the lowest levels, almost 3 out of 4 people from a black background surveyed reported themselves to be overweight or obese. This makes people more vulnerable to conditions such as COVID, CVD and diabetes.

Ethnicity and health – lifestyles and behaviour (2)

This graph shows how smoking rates vary across ethnicity and Sex in Harrow, based on data from local GPs (WSIC 2023).

Smoking rates are significantly higher in males across most ethnic groups. However, the Sex differences are widest in Asian ethnic groups, where women are less likely to smoke than average. Indian men and women, the largest ethnic group in Harrow, are less likely to smoke than average. People from other white ethnic groups, which will include our large Romanian population, and other European groups, have particularly high smoking rates in both men and women.



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Ethnicity and health – health outcomes (1)

The 2014 Adult Psychiatric Morbidity Survey found that adults from some ethnic minority backgrounds were overrepresented in poor mental health outcomes. For example:

- Black men were ten times as likely to be screened for psychosis compared to men from white backgrounds
- People from a black background are four times more likely to be detained under the Mental Health Act
- Older South Asian women have been reported to be at a higher risk of suicide than other groups
- Black women are more likely to experience a common mental illness such as anxiety or depression

The causes of these could be related to socio-economic inequalities, as well as racism, discrimination and cultural stigma around mental health. Reports show that the prevalence of mental health difficulties was exacerbated by the pandemic.

Cardiovascular disease (CVD) has a high prevalence in Asian and black groups. South Asian groups in particular have an increased likelihood of developing or dying from the disease. This could be explained by the higher probability of risk factors such as obesity, lower levels of exercise and insulin resistance. Black groups are also at risk, with a likelihood of developing hypertension or stroke.

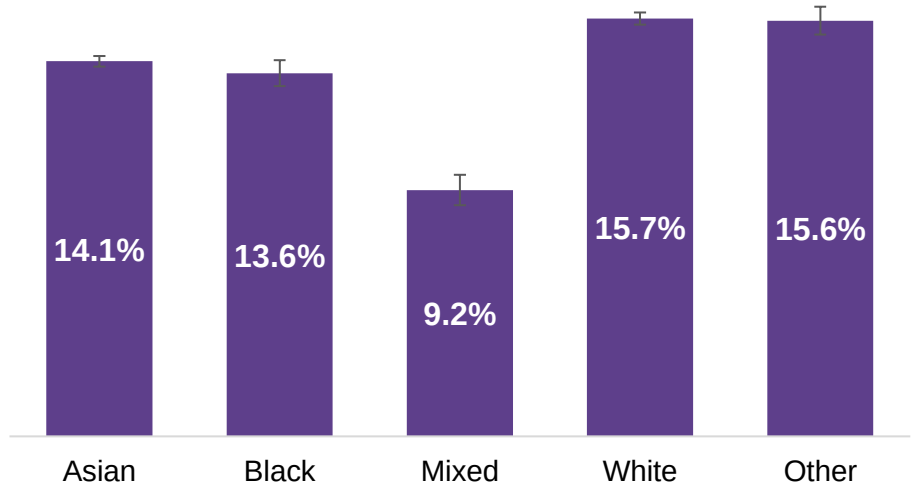
Ethnicity and health – health outcomes (2)

COVID-19 had a significantly worse outcome for ethnic minorities, leading to higher levels of severity and deaths compared to white groups. In addition, it exposed the 'structural inequalities' that unfairly impact ethnic minorities in terms of health. Many reasons have been highlighted as to why. A high proportion of ethnic minorities work in key worker roles where they are more likely to be exposed to the disease. In addition, the increased likelihood of risk of obesity and other long term health conditions meant that the risk of being admitted to critical care or mortality was higher. Black groups saw the highest risk - four to five times more likely than average.

Diabetes is another condition that is highly common in ethnic minorities, spurred on by higher risk factors such as an excessive BMI and lack of physical activity, as well as genetic factors that increase risk. One fifth of the diabetes population is from South Asian groups and black groups are three times more likely to develop the condition.

The graph shows that overall rates of self reported ill-health in Harrow are highest in White and Other ethnic groups – these are likely to be closely related to the age profile of the populations.

Percentage of Harrow residents in bad health by ethnicity (2021 Census)



Ethnicity and health – use of services

Across all ethnic groups, a poorer experience of healthcare services has been reported. Of those who took part in the 2022 GP Patient Survey, the experience of making an appointment is low, ranging between 43-59%, although Pakistani, Bangladeshi and Gypsy or Irish Traveller groups had the least positive experience.

The NHS Race and Health Observatory found significant inequalities for ethnic minorities in access to and quality of care in mental healthcare and maternal healthcare compared to people from a white British background. The findings particularly highlighted language barriers, experiences of discrimination and mistrust.

Poorer outcomes were also found at an significant level for those from ethnic minority backgrounds for preventable long term health conditions such as CVD and diabetes.

The pandemic saw a sharp increase in the growing dependence on 'digital technologies' to improve patient access to health services. However, this put people from minority ethnic groups at a higher disadvantage compared to white British groups. Initial reports found that only a third downloaded the NHS COVID app compared to half of people from a white background. The digital divide is particularly pointed in those from people over 75 with an Asian background, with almost 30% online compared to 47% of people from a white background. The Lancet suggests that barriers such as lower digital literacy, lack of access, language barriers and financial difficulties especially for those in less affluent areas could be worsening digital exclusion in ethnic minorities.

Ethnicity and health – local case studies

Harrow is abundant with cultural community groups and organisations that work to minimise the impact of the wider determinants, indirectly improving on an ethnic minority's health and wellbeing. These include:

- HASVO
- Harrow Ghanaian Association
- Harrow African Caribbean Association
- Ignite Trust

There are also specific services catered to tackling the health inequalities in certain cultural groups. Mind in Harrow runs two such projects (EKTA for South Asian residents and Somalian Hayaan Project for Somalian residents) to support those with mental health difficulties within their own community.

Coffee Afrik is a newly commissioned service in Harrow that aims to support and signpost people from marginalised communities dealing with substance misuse through community street outreach.

Ethnicity and health – best practice

The Core20PLUS5 initiative from NHS England aims to 'inform action to reduce healthcare inequalities at both national and system level' in marginalised communities. They are particularly focusing on reducing these inequalities in maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

The Office for Health Improvement and Disparities released guidance for national and local organisations in 2018 on ways to minimise health inequalities in ethnic minorities.

Both the Kings Fund and the Rapid Review have highlighted the importance 'active engagement' in ethnic minorities and 'culturally adapted interventions' to cater to the unique health concerns of each group. Key actions suggested in the Rapid Review to achieve this included improving resources in NHS interpreter services, addressing the effect of structural racism in services through research and improving monitoring of ethnicity of patients to attain more accurate data on health outcomes.

7. Religion and health in Harrow

LONDON BOROUGH OF HARROW

Religion and health - definitions

A religion is a set of beliefs and practices often associated with the transcendent, potentially involving mystical, supernatural, and enlightenment. These generally involve a code of morality, values, or expected behaviour and views about life after death. However, individuals may affiliate with religions regardless of their actual beliefs and practices.

Many religions in England are often closely associated with particular ethnicities and nationalities.

Religion and belief are legally protected characteristics under the Equality Act 2010.

Religion and health - numbers

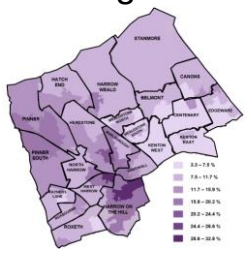
Harrow has among the most diverse communities in England in terms of religion. According to the 2021 Census, a third of the population are Christians, and a quarter Hindu - the highest percentage in England. There are also large populations of Muslims and people with no religion. There are also smaller numbers of Jews, Buddhists and Sikh, as well as Jains - who make up over 80% of the "other religion" category, in the table and maps below.

In 2023, there were 81 places of worship in Harrow registered for Marriages under the Marriages Act.

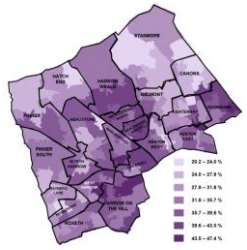
Please click images to expand

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
No religion	27,748	10.6%	20.0%	27.1%	36.7%
Christian	88,602	33.9%	38.8%	40.7%	46.3%
Buddhist	2,812	1.1%	1.1%	0.9%	0.5%
Hindu	67,392	25.8%	10.6%	5.1%	1.8%
Jewish	7,304	2.8%	1.0%	1.7%	0.5%
Muslim	41,503	15.9%	16.6%	15.0%	6.7%
Sikh	2,743	1.1%	4.1%	1.6%	0.9%
Other religion	7,695	2.9%	1.1%	1.0%	0.6%

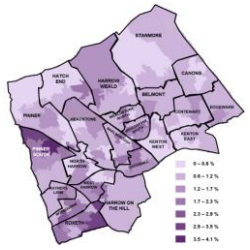
No religion



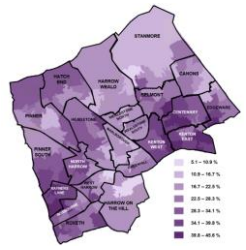
Christian



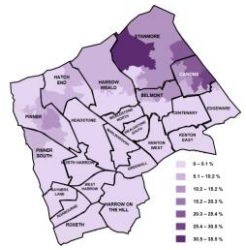
Buddhist



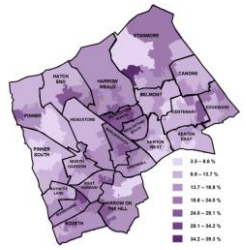
Hindu



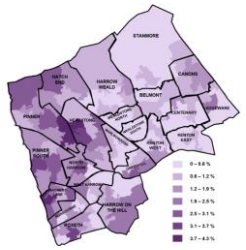
Jewish



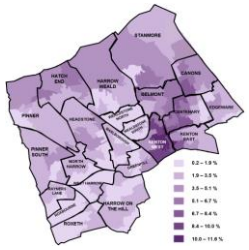
Muslim



Sikh



Other religions



Religion and health – wider determinants (1)

The Office for National Statistics (ONS) published a report on the educational and employment characteristics of religious groups in England and Wales between 2012 and 2018.

Those identifying as Hindu, Jewish, and Buddhist were most likely to have degree level qualifications. This was consistently lowest among those identifying as Christian. In 2018, this was 59%, 56%, 48%, and 30% respectively. Having no qualifications was higher among those identifying as Muslim than most other groups.

Economic inactivity was consistently highest among those identifying as Muslim, particularly women. However, staying at home to mind family or home was significantly higher among these women than in other groups. Those identifying as Christian were more likely to be economically active than those affiliated with Buddhism, Judaism, or any other religion.

In 2018, median hourly income was highest among those identifying as Jewish (£15.17), followed by those identifying as Hindu (£13.80), and lowest among those identifying as Muslim (£9.63). The former two groups have also had the highest rates of having “high-skill” occupations, 46% and 41% respectively. Working in a managerial role was highest among those identifying as Jewish (40%), while lowest among those identifying as Muslim (15%).

Religion and health – wider determinants (2)

After controlling for confounders, such as age, sex, ethnicity, marital status, region of residence, and highest qualification held, gaps between religious groups narrowed, but still existed.

Religious activity may enhance social networks by bringing likeminded members of the community together, leading to opportunities of friendship, emotional support, and practical assistance.

Members of religious communities are frequently affected by ill treatment. According to the 2021-22 Survey of Londoners, Muslim and Jewish residents were disproportionately affected by religion-based discrimination as compared to the general population (27%, 18%, and 6% respectively). Furthermore, according to the Home Office, the year ending March 2022 had the highest number of religious hate crimes recorded (8,730) since 2012. 41% of these cases involved violence against the victims, while 5% involved criminal damage and arson. The most common victims were the Muslim (42%) and Jewish (23%) communities. Certain events, such as the terrorist attacks in 2017, have been associated with an increase in the number of hate crimes.

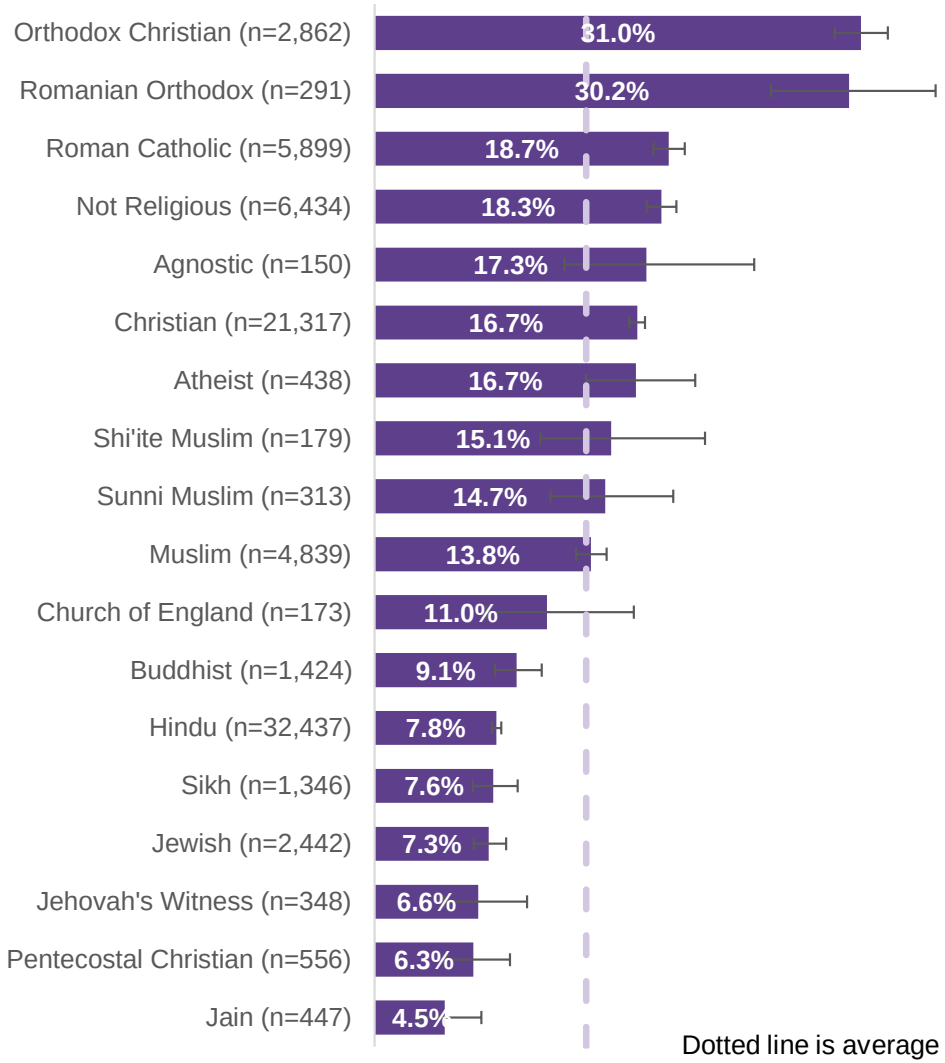
In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that Muslim residents are much more likely to live in more deprived parts of the borough. Sikh residents are more likely to live in less deprived areas.

Religion and health – lifestyles and behaviour (1)

Religious beliefs may have a positive effect on lifestyle. On the one hand, religious individuals may be less likely to participate in activities detrimental to health, as tobacco, alcohol use, and risky sexual behaviour are regarded negatively by many religions[1]. Consequently, there may be lower rates of smoking and substance abuse among these religious communities. According to the ONS, smoking prevalence in 2020 was significantly higher among those with no religion (18%) than those identifying with Muslim (11%), Christian (11%), Hindu (5%), Jewish (4%), Sikh (2%), or other religion (9%).

Fewer than 90,000 GP patients in Harrow have their religion recorded – however, this makes in possible to look at local smoking rates by religious identity. The following graph shows some of this data for Harrow, limited to the most common religious identities:

GP recorded adult smoking rate in Harrow, by most common religious identities (WSIC 2023)



Religion and health – lifestyles and behaviour (2)

On the other hand, religious individuals may be more likely to participate in activities beneficial to health. Some studies suggests that meditation and prayer practiced in many religions may alleviate stress and improve brain and immune function.

Moreover, there is evidence of higher rates of regular exercise within religious communities.

Fasting is a ubiquitous phenomenon amongst several religions, that may have a protective effect against non-communicable diseases and ageing. However, it may be challenging for some patients, such as those with diabetes or certain presentations of infectious diseases.

Religion and health – health outcomes (1)

The relationship between religion and health is complex - it may depend on wider determinants, and be specific to local contexts. However, a positive correlation has been suggested in religiously diverse populations, such as that of the UK.

The ONS published a report on the health of religious groups in England and Wales in 2020. A lower percentage of those with no religion (64%) were estimated to be satisfied with their health than those of Christian (68%), Hindu (72%) or Jewish (77%) faith. This difference was even greater between those of other religions (52%) and the aforementioned three religious groups.

The prevalence of long-standing impairment, illness or disability was lower among those identifying as Sikh (22%) than those identifying as Hindu (27%), Muslim (35%), Christian (36%), other (53%), or no religion (35%). Similarly, those identifying as Sikh (11.5%) were less likely to have mental health illnesses than those identifying as Christian (18.2%), other (32.5%), or no religion (18.9%).

Religion and health – health outcomes (2)

Mental functioning was higher among those identifying as Sikh, Hindu, or Christian than those with no religion. Similarly, these scores were also higher among those identifying with Christian, Muslim, Hindu, Sikh, or no religion than those with other religion. Physical functioning score was higher in those identifying as Hindu (48.8), Sikh (49.0), Christian (49.7), Buddhist (49.9), Jewish (51.4), or with no religion (49.3) than those with other religion. Those identifying with Christian, Jewish, or no religion had also higher scores than those identifying as Muslim.

These differences remained statistically significant after adjusting for age, sex, broad ethnic group, and region. Although, it must be noted that the study was based on self-reported data and hence may reflect health perception more suitably than actual health status.

The graph shows the 2021 Census for Harrow found that self-reported bad health was highest in the Jewish community – this is likely to be related to the older age profile of this community.

Percentage of Harrow residents in bad health by religion (2021 Census)

LONDON BOROUGH OF HARROW

Religion and health – use of services

There is evidence for both positive and negative effects of religiosity to adherence to medication in patients with cardiovascular disease. Medication from animal sources may also cause issues, especially amongst those with stronger beliefs. Moreover, religious individuals, such as some members of the Jehovah's Witnesses community, may refuse to administer some or all blood products. This may be further complicated when a parent is refusing treatment for their child.

There is particular stigma regarding mental health conditions and service use, as mental illness is frequently misinterpreted as a "sign of weakness" in some communities.

Abortion, contraceptive, and palliative services may also be opposed or viewed under a specific set of rules by various religions.

Religion and health – local case studies

Across the country, many religious organisations supported local communities during the COVID-19 pandemic. For example, the Hindu charity BAPS Swaminarayan Sanstha Connect and Care which is based at Neasden Temple, offered a tiffin (packed meal) service for the elderly and vulnerable residents of Harrow, Brent and other areas. The charity also delivered snacks and an appreciation letter delivered to NHS staff working at Northwick Park Hospital, and developed health awareness videos and presentations in English and Gujarati.

Religion and health – best practice

Generally, the care of religious patients is provided with careful consideration within the NHS. The Department of Health has developed practical guidelines on religion and belief-sensitive approaches within the health service. The document promotes a critical and thoughtful approach to religious individuals and the inclusion of patients in religion appropriate but clinically appropriate decision-making. Topics include diet, modesty, contraception, termination of pregnancy, prenatal medicine, childbirth, beginning and end of life, circumcision, palliative care, mental health issues, suicide, and certain drugs and treatments.

For example, modesty is a crucial idea in many religions. However, conventional hospital gowns are too revealing according to certain beliefs. Aimed mainly at Muslim women, Lancashire Teaching Hospitals NHS Foundation Trust has introduced an “inter-faith” gown designed to accommodate both religious codes and inpatient services.

As another example, circumcision is culturally significant in certain religions. The NHS only provides this service if it is clinically indicated. This lead to the emergence of unregulated practitioners and therefore, suboptimal or unsafe practice. To address such issues, the NHS has implemented a circumcision clinic in the Tower Hamlets, as a public health intervention. The service resulted in great patient satisfaction due to improved safety, reduced pain, and appropriate bedside manner.

8. Disability and health in Harrow

LONDON BOROUGH OF HARROW

Disability and health - definitions

The Equality Act (2010) defines disability as a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on someone's ability to do normal daily activities.

This definition of a disabled person meets the harmonised standard for measuring disability.

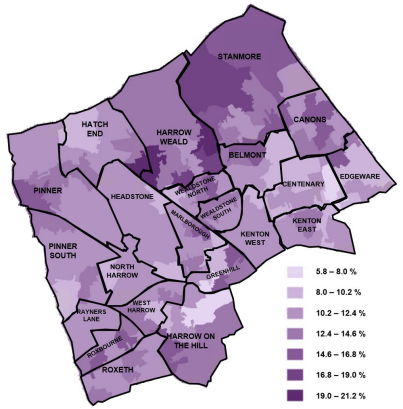
Disabilities could include physical disabilities, including mobility impairment, personal care needs, sensory impairments (such as hearing or sight loss), and learning disabilities.

The causes of disabilities are broad and often multifactorial. Impairments can arise as a consequence of congenital causes or can be acquired later in life. The average disability free life expectancy at birth in Harrow for males is 65.9 and for females 62.9 – both are higher than the national average.

Disability and health - numbers

The 2021 Census reports that 12% of people in Harrow are disabled under the Equality Act definition – that is, their day-to-day activities are limited. This figure decreased from the previous Census. This may be due to how people perceived their health status and activity limitations during the COVID-19 pandemic.

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Day-to-day activities limited a lot	13,808	5.3%	5.6%	5.7%	7.3%
Day-to-day activities limited a little	17,450	6.7%	6.9%	7.5%	10.0%
Has long term health condition but day-to-day activities not limited	11,509	4.4%	4.5%	5.2%	6.8%
No long term health conditions	218,436	83.6%	83.0%	81.5%	75.9%



The map shows the percentage of residents who have a health condition which limits their day-to-day activities.

In Harrow 18,747 (21%) households include one member with disability and 5,104 (6%) households include two or more people who are disabled.

Disability and health – wider determinants (1)

The UK has approximately 7 million people of working age with a disability or long-term health condition, yet almost half of them are not in work. Disabled people are more likely to have lower skilled occupations, work part time, work in the public sector and be temporarily away from work. The disability pay gap in 2021 was 13.8%, with disabled employees earning a median of £12.10 per hour and non-disabled employees a median of £14.03 per hour. The disability pay gap is wider for disabled men than disabled women. In 2021 median pay for disabled men was 12.4% less than non-disabled men and for disabled women 10.5% less than non-disabled women. The disability pay gap varies depending on the type of disability, with disabled employees with autism having the largest pay gap to non-disabled people. The disability employment rate in Harrow 2020/21 was 43.7% and the disability employment gap was 28.2%

Four million people with disabilities in the UK are living in poverty and an additional 3 million non-disabled people in poverty live in a household where someone else is disabled. Poverty is especially high in families where there are both disabled adults and children and at 40% is almost double the rate of families where no-one is disabled. There are several drivers of poverty for disabled people. The cost of living is higher for disabled people due to additional costs associated with disability and disabled people are less able to access work. Given that work is often limited for disabled people, many rely on benefits as a source of income, which will likely lead to an increase in poverty rates.

There are considerable differences in levels of education between disabled and non-disabled people with 19% of disabled adults having a degree or above compared to 35% of non-disabled people.

Disability and health – wider determinants (2)

The ability to live independently is protected under the UN's convention on rights of persons with disability. However, only 9% of homes in the UK provide features that are accessible, and research has shown approximately 400,000 wheelchair users in the UK are living in homes that are not adapted for their needs. Inaccessible housing can have serious debilitating effects on a person's health and well-being. It can increase risk of falls and injuries, restrict social participation, negatively impact their quality of life and increase the burden on caregivers.

Disabled people are less likely to own their home (39.7%) or to live with parents (16.4%) than non-disabled people (53.3% and 19.2% respectively).

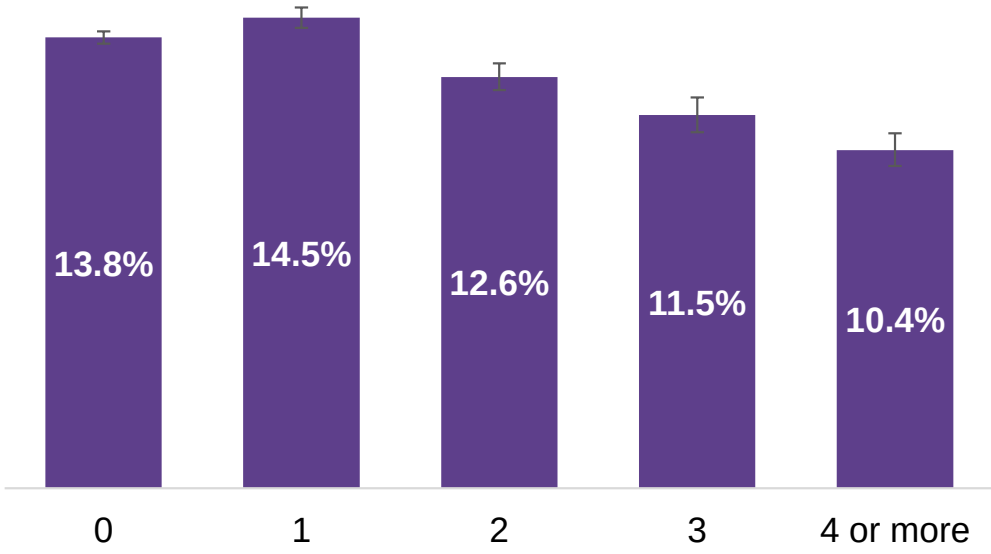
In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that disabled residents are more likely to live in more deprived parts of the borough.

Disability and health – lifestyles and behaviour (1)

Disabled people are more likely to have risk factors for non-communicable disease such as smoking, poor diet, alcohol consumption and lack of physical activity. Although barriers such as education, time and cost can impact non-disabled people, disabled people may face additional barriers such as the reliance on caregivers and lack of facilities for their personal needs. In addition, disabled people face further barriers that prevent them from being more physically active and may require professional and tailored intervention to encourage exercise.

There is limited information on differential rates of key health behaviours in disabled people. Although, there is evidence to suggest adults with disabilities are more likely to smoke with higher rates among younger adults. Use of drugs, alcohol and cigarettes have all been linked to mental health problems. Also, disabled people will generally be part of a smaller social circle and have fewer opportunities in life than non-disabled people which may all have a damaging impact on the well-being and mental health of people with a disability leading them to engage in risky health behaviours.

GP recorded rates of smoking in Harrow, by number of long term health conditions (WSIC 2023)



Disability and health – lifestyles and behaviour (2)

Numerous studies have looked at the extent of substance misuse in people with learning disabilities. Overall, the evidence indicates that people with learning disabilities have an increased risk of substance misuse if they have borderline to mild disabilities, are young and male and have mental health problems. Qualitative research has shown that people with learning disabilities use drugs and alcohol due to psychological trauma, social isolation and loneliness. Further risk factors that are associated with substance misuse are living independently, unemployment, lack of family contact, limited social skills and low self-esteem.

Disability and health – health outcomes (1)

The life expectancy of a woman with a learning disability is 19 years shorter than for women in the general population and for men with a learning disability 14 years shorter than for men in the general population. Given that people with a disability face a disproportionate risk of exposure to socio-economic disadvantage, it puts these people at risk of poorer health outcomes.

The COVID-19 pandemic disproportionally impacted disabled people due to various factors; an increased risk of poor outcomes from the disease itself, limited access to routine health and social care, and the adverse social impacts of the guidelines put in place to mitigate the pandemic. Although most people faced additional barriers during the pandemic, disabled people were affected the most and long-standing inequalities were exacerbated. In the first year of the pandemic, 60% of those who died from COVID-19 were disabled. Access to health and social services and support at home was reduced during the pandemic. A survey showed that 60% of disabled people struggled to access essential supplies, including food during the early months of the pandemic. Specific rules and measures which people with sensory impairment may have struggled to follow such as face masks and physical distance may of lead to stigmatisation. In addition, many disabled children were affected by a lack of access to face-to-face schooling and digital exclusion.

Disability and health – health outcomes (2)

Disabled people are generally disadvantaged in opportunities for social participation which can have negative effects on their health and well-being. Consequently, leading to poor health and an increase in mortality risk. In the UK, on average disabled people have poorer ratings of life satisfaction and report poorer well-being levels than non-disabled people. Furthermore, disabled people are more likely to report feelings of loneliness, with those that reported being limited in their day-to-day activities more than twice as likely to feel lonely.

A variety of factors put disabled people at higher risk of social exclusion:

- Disabled people are more likely to experience income poverty
- Reduced employment opportunities
- Disabled people are more likely to have restricted social networks and looser ties to their local community
- Discrimination and prejudice against disability
- Victims of bullying and hate crime
- Disabled people are often segregated in educational and residential settings

Disability and health – use of services

The Social Model of Disability has reframed disability as being the responsibility of how society is organised, rather than by a person's impairment. It looks at removing barriers that restrict the life choices of disabled people.

Several barriers prevent disabled people from accessing services, an ONS survey showed disabled people reported barriers such as transport, difficulty using pavements/footpaths, difficulty moving around buildings, accessing toilets and unpleasant attitudes from others. Difficulties in transportation was the largest difference between disabled (22.9%) and non-disabled (6.1%) identified as a barrier to accessing services.

The data surrounding access to services for disabled people is limited. However, people with a disability face structural (transportation, inaccessible buildings), financial and cultural (misconceptions about disability, perceived needs) barriers when accessing healthcare. Disabled people often report low satisfaction with services and feel that their needs go unrecognised by services.

Disabled people are significantly less likely than the general population to have internet access and 25% of disabled adults have never used the internet compared to 10.2% of the entire UK population. It is important for disabled people to be digitally included as it can provide lots of benefits such as digital skills, social inclusion, accessing online services and employment opportunities. Although, there are many barriers that prevent disabled people from accessing these benefits such as website accessibility, financial constraints, lack of digital infrastructure and challenges with support staff and carers.

Disability and health – local case studies

Harrow Mencap are an important provider of person-centred support to people with learning disabilities, mental health problems, dementia, physically disabled people, autistic people and older people.

The Harrow Association of Disabled People is a small grass roots organisation which supports disabled people and aims to promote and bring about inclusion and equality for all disabled people in all areas of life.

Disability and health – best practice

The Cabinet Office Disability Unit aims to break down the barriers faced by disabled people in the UK. The Disability Unit is responsible for the national strategy and coordinating the implementation of the UN Convention on the Rights of Persons with Disabilities across the government. They were a joint author of the National Disability Strategy in 2022.

Disability Rights UK is a charity with the aim of representing the needs and expectations of disabled people in the UK.

Scope is a disability charity that campaigns to change negative attitudes about disability and provides direct services which include practical information and emotional support.

Annual Director of Public Health Report 2022/23:
Health inequalities in Harrow

9. Carers and health in Harrow

LONDON BOROUGH OF HARROW

Carers and health - definitions

Carers include any people – such as a family members, friends or neighbours – who give regular, ongoing assistance to another person without payment for the care given.

Some of the support provided by friends and family can be seen as part of the routine way in which people form relationships, which can make it difficult to identify when a person is termed a 'carer'.

Carers do not include professional 'care workers' who are employed to provide caring support for others. Informal carers may be in receipt of Carer's Allowance, which is money (provided by central government) to support people in their caring role. This is not the same as being paid to provide care to others as a 'care worker' in a professional capacity.

Adult carers provide care for other adults (usually a family member or friend), and adults who have caring responsibilities for a child they are not parenting. Parent carers are adults with a parental role for a child who has additional caring needs. Young carers are children and young people who care for others (usually family members).

Many carers do not identify themselves as such, and many are also not identified by health and care services.

Carers and health - numbers

In Harrow over 20,000 people reported being informal carers in the 2021 Census – the map below shows where these people live. Approximately 10,000 (4.2%) residents reported providing 19 or fewer hours of unpaid care each week, almost 5,000 (1.8%) residents provided 20-49 hours per week, and over 5,000 (2.1%) people provided over 50 hours per week.

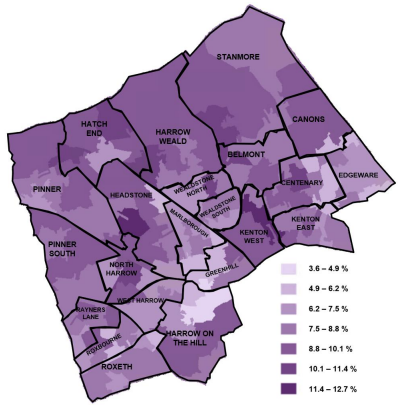
There was a large drop in the proportion of people reporting that they provided unpaid care since the 2011 Census across all local authorities in England. This may be due to the 2021 Census being undertaken COVID-19 pandemic, affecting how people perceived and managed their provision of unpaid care.

It is likely that the true number of carers is growing due to increases in life expectancy, and the number of people living with long-term health conditions.

In the 3rd quarter of 2023, 3,828 Harrow residents received Carer's Allowance. Around 10,000 residents have been identified as carers by their GP, and around 5,000 by social care services.

Most carers are older working age adults, and are more likely to be female than male.

Please click images to expand



	Number of Harrow residents (5+)	% of residents (5+)			
		Harrow	NW London	London	England
Provides no unpaid care	225,468	91.8	92.8%	92.8	91.2
Provides 19 hours or less unpaid care a week	10,225	4.2	3.5%	3.6	4.3
Provides 20 to 49 hours unpaid care a week	4,535	1.8	1.7%	1.7	1.8
Provides 50 or more hours unpaid care a week	5,275	2.1	2.0%	2.0	2.6

Carers and health – wider determinants (1)

The UK has approximately 7 million people of working age with a disability or long-term health condition, yet almost half of them are not in work. Disabled people are more likely to have lower skilled occupations, work part time, work in the public sector and be temporarily away from work. The disability pay gap in 2021 was 13.8%, with disabled employees earning a median of £12.10 per hour and non-disabled employees a median of £14.03 per hour. The disability pay gap is wider for disabled men than disabled women. In 2021 median pay for disabled men was 12.4% less than non-disabled men and for disabled women 10.5% less than non-disabled women. The disability pay gap varies depending on the type of disability, with disabled employees with autism having the largest pay gap to non-disabled people. The disability employment rate in Harrow 2020/21 was 43.7% and the disability employment gap was 28.2%

Four million people with disabilities in the UK are living in poverty and an additional 3 million non-disabled people in poverty live in a household where someone else is disabled. Poverty is especially high in families where there are both disabled adults and children and at 40% is almost double the rate of families where no-one is disabled. There are several drivers of poverty for disabled people. The cost of living is higher for disabled people due to additional costs associated with disability and disabled people are less able to access work. Given that work is often limited for disabled people, many rely on benefits as a source of income, which will likely lead to an increase in poverty rates.

There are considerable differences in levels of education between disabled and non-disabled people with 19% of disabled adults having a degree or above compared to 35% of non-disabled people.

Carers and health – wider determinants (2)

The ability to live independently is protected under the UN's convention on rights of persons with disability. However, only 9% of homes in the UK provide features that are accessible, and research has shown approximately 400,000 wheelchair users in the UK are living in homes that are not adapted for their needs. Inaccessible housing can have serious debilitating effects on a person's health and well-being. It can increase risk of falls and injuries, restrict social participation, negatively impact their quality of life and increase the burden on caregivers.

Disabled people are less likely to own their home (39.7%) or to live with parents (16.4%) than non-disabled people (53.3% and 19.2% respectively).

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that there was no clear relationship between the proportion of people with caring responsibilities and living in more deprived parts of the borough.

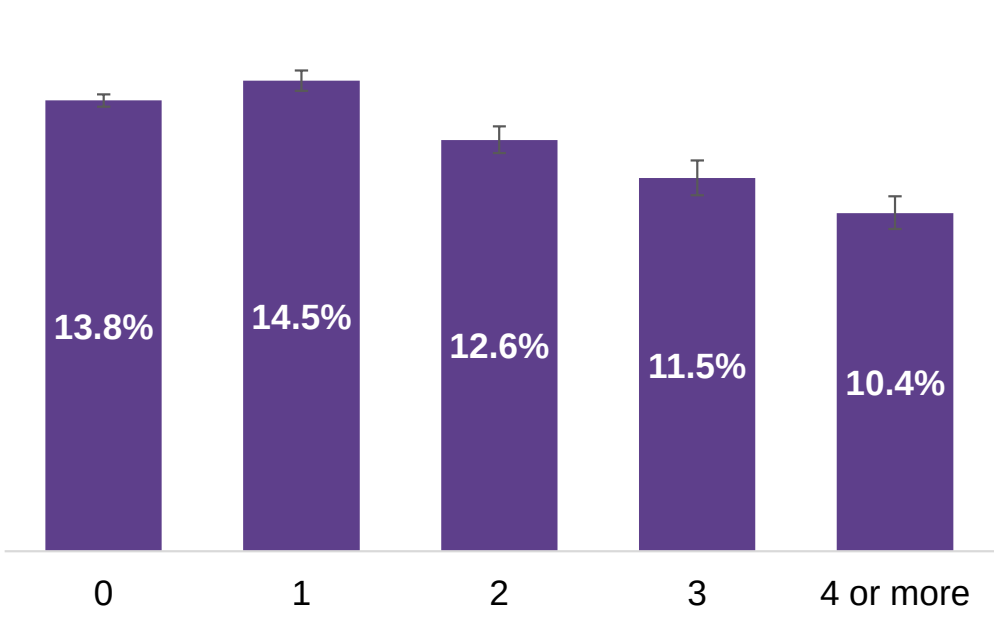
Carers and health – lifestyles and behaviour (1)

Caring responsibilities can be detrimental to a person's health, with direct impacts including physical strain from lifting or as a result of disrupted sleep patterns.

Caring can also have an indirect effect on a person's ability to maintain and support their own health and wellbeing – for example, caring for another person can change behaviour, which can result in poor diet, lack of exercise and increased stress. [6] [7] [8]

GP systems are not routinely used to record or monitor the number of people who provide unpaid care. While a 'carer' code is available to use by GP[illegible] there is potential for practitioners to interpret and u[illegible] residents in Harrow are recorded on GP systems [illegible] carers on the GP system, 10.5% are smokers, cor[illegible] 2023).

GP recorded rates of smoking in Harrow, by number of long term health conditions (WSIC 2023)



Carers and health – lifestyles and behaviour (2)

Numerous studies have looked at the extent of substance misuse in people with learning disabilities. Overall, the evidence indicates that people with learning disabilities have an increased risk of substance misuse if they have borderline to mild disabilities, are young and male and have mental health problems. Qualitative research has shown that people with learning disabilities use drugs and alcohol due to psychological trauma, social isolation and loneliness. Further risk factors that are associated with substance misuse are living independently, unemployment, lack of family contact, limited social skills and low self-esteem.

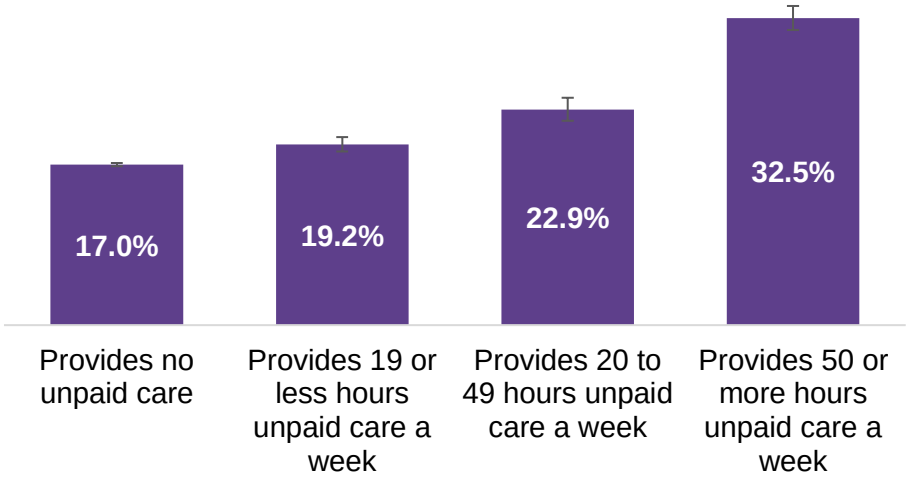
Carers and health – health outcomes (1)

The life expectancy of a woman with a learning disability is 19 years shorter than for women in the general population and for men with a learning disability 14 years shorter than for men in the general population. Given that people with a disability face a disproportionate risk of exposure to socio-economic disadvantage, it puts these people at risk of poorer health outcomes.

The COVID-19 pandemic disproportionally impacted disabled people due to various factors; an increased risk of poor outcomes from the disease itself, limited access to routine health and social care, and the adverse social impacts of the guidelines put in place to mitigate the pandemic. Although most people faced additional barriers during the pandemic, disabled people were affected the most and long-standing inequalities were exacerbated. In the first year of the pandemic, 60% of those who died from COVID-19 were disabled. Access to health and social services and support at home was reduced during the pandemic. A survey showed that 60% of disabled people struggled to access essential supplies, including food during the early months of the pandemic. Specific rules and measures which people with sensory impairment may have struggled to follow such as face masks and physical distance may of lead to stigmatisation. In addition, many disabled children were affected by a lack of access to face-to-face schooling and digital exclusion.

Carers and health – health outcomes (2)

Percentage of Harrow residents in bad health by hours of unpaid care provided (2021 Census)



Carers and health – use of services

The London Borough of Harrow's recently published strategy for carers, outlines the council's commitment to XXX

Local data shows that there was a 20% increase in support for **child carers in Harrow** from 2019 to 2022 (51 to 85 children aged **5-10 years)**

Carers and health – local case studies

Harrow Carers is a local charity dedicated to supporting unpaid carers in the borough. They provide specialist advice, information & access to a wide range of support services. There is specific support for young carers.

Carers and health – best practice

There is evidence that the physical and mental impact of caring can be lessened by providing practical and financial support to carers. In a national survey in 2012, when carers were asked about the factors they believe have affected their physical and mental health, 64% identified a lack of practical support as being a contributing factor, and 50% stated that a lack of financial support had had an impact. In the same survey, 84% carers reported that they were known to their GP, but only 23% reported having been offered a health check by their GP. 66% of carers felt that health professionals do not signpost them to information of support. Charities and support groups were identified as the main providers of this information.

Early intervention and provision of support to carers should be a priority, and the timing of appropriate interventions for carers has been emphasised. Support should be person-centred and respond to differing needs. It should also be noted that early identification and intervention may present challenges, as individuals often do not see themselves as carers - rather, they may see their role as a spouse, sibling, son, daughter or friend. This can mean carers are less likely to seek out formal support, and that there is a greater need for services to proactively identify carers to meet their needs. There may be a particular opportunity for health professionals, including GPs, to support this. Proactive identification and intervention to support carers is likely to be particularly beneficial for those at higher risk of poor physical and mental health.

The Care Act 2014 states that supporting individual wellbeing applies equally to carers as to those they care for, and emphasises the responsibility of local authorities. Guidance has been produced by the National Institute for Health and Care Excellence (NICE) on provision of support for adult carers.

Carers UK provide best practice briefings on a range on topics, for example, supporting LGBTQ+ carers and Black, Asian and minority ethic carers.

10. Maternity and health in Harrow

Maternity and health - definitions

Pregnancy is 'the condition or period of being pregnant' which usually lasts anywhere between 37 weeks to 42 weeks from the first day of your last period. Pregnancy is divided into three stages called trimesters; the first from weeks 4-12, second from weeks 13-27 and the third from weeks 28-41.

Maternity can be defined as 'the state of being a mother' and starts during pregnancy and continues in the period after childbirth. It is linked to maternity leave in the employment context. For this report, were are considering the first 2 years of motherhood.

Pregnancy and maternity are legally protected characteristics under the Equality Act 2010.

Maternity and health - numbers

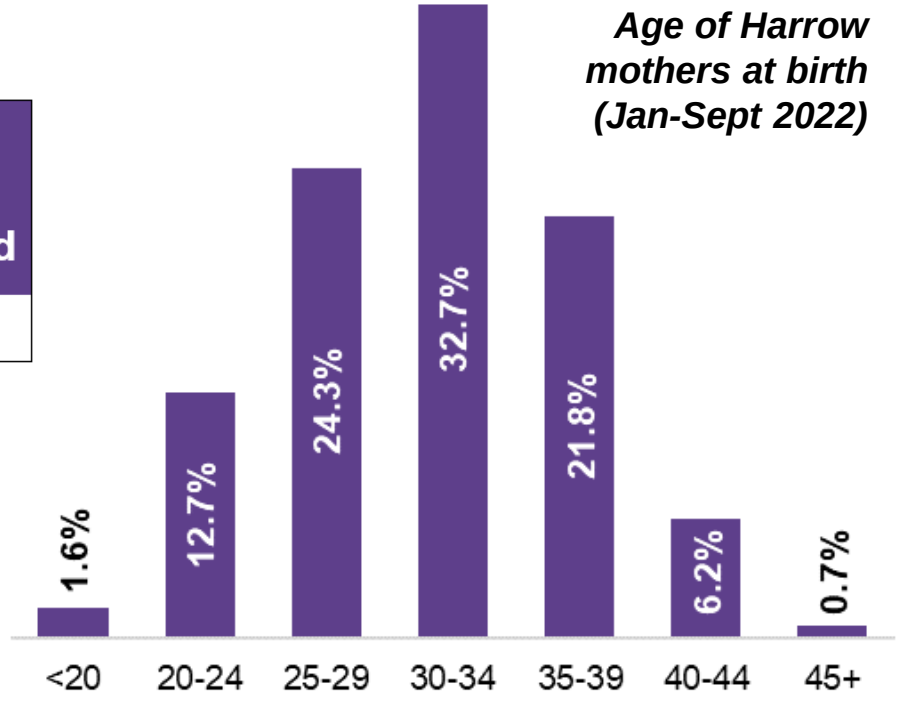
In 2020/21 there were 3,160 babies delivered to Harrow mothers. 10 of these babies were born to under 18s, 32 babies in twin or other multiple births, and 50% were born to mothers from BAME groups.

Of births to Harrow mothers during the first 9 months of 2022, most (53%) were born in Northwick Park Hospital. The other most used hospitals were Barnet (13%), Hammersmith (12%), Watford (6%) and the Royal Free (5%).

Population under 2 years old (2021 Census)

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Under 2	6,217	2.4%	2.3%	2.4%	2.1%

Age of Harrow mothers at birth (Jan-Sept 2022)



Maternity and health – wider determinants (1)

Pregnancy and maternity can be a difficult transition for many women. Alongside the physical and mental side effects of pregnancy, women will have to consider and prepare for how maternity will change their life circumstances.

Most women will take Statutory Maternity Leave which is 52 weeks. The first 26 weeks are Ordinary Maternity Leave and the last 26 weeks are Additional Maternity Leave. Women do not have to take 52 weeks but they must take 2 weeks' leave after their baby is born (or 4 weeks if working in a factory).

Finances are often a deciding factor in how long women decide to take maternity leave; Statutory Maternity Pay (SMP) is paid for up to 39 weeks, with women receiving 90% of their average weekly earnings (before tax) for the first 6 weeks. For the next 33 weeks, it is £156.66 or 90% of average weekly earnings

Costs for raising a child can include essentials such as nappies, clothing, formula milk etc; childcare, education/activities, on top of housing, bills and food. Recent estimates from the Child Poverty Action Group's Cost of a Child report put the average cost of raising a child to the age of 18 in the UK in 2021 at £160,692 for a couple and £193,801 for a single parent. Single parents are therefore more vulnerable to financial pressures, and this burden often falls on mothers as the primary carers.

Maternity and health – wider determinants (2)

Recent research from the Food Foundation found that there was a sharp increase in the proportion of households with children experiencing food insecurity in September 2022 at 25.8%, up from 12.1% in January 2022. Inflation has led to increases in food prices and unfortunately food tends to be the first expenditure cut when finances are tight. Mothers may be forced to skip meals to be able to feed their children or turn to cheaper calorie-dense and nutrient-poor foods, contributing to poorer maternal nutrition with risk of overweight and malnourishment/deficiency which is particularly concerning if the mother is still breastfeeding and thus reliant on a more nutritious diet.

Whilst it is illegal for employers to discriminate on women on the basis of pregnancy, childbirth and maternity, mothers may find that their change of circumstances affects their ability to carry out their employment as before, and may require changes in working hours, days and place of work to fit in with their parenting duties, which may or may not be accommodated by their employer. This in turn can affect mothers' professional progression and income; the 'motherhood penalty' has been shown to make up 80% of the Sex pay gap

These wider determinants can contribute to poorer mental health and stress, with data showing that the number of pregnant women and mothers requesting mental health support increased by 40% between 2019 and 2021

Maternity and health – lifestyles and behaviour

Pregnant women are advised not to smoke, take drugs or drink alcohol to reduce risk of complications to them and their baby including birth defects, miscarriage, stillbirth and premature labour .

In particular, the risk of miscarriage in the first three months of pregnancy means it's particularly important not to drink alcohol at all during that period. Research has shown that in the UK, up to 1 in 13 babies whose mother drank during pregnancy is affected by Fetal Alcohol Spectrum Disorder (FASD). Drinking alcohol and smoking during pregnancy often go hand in hand; one review of the evidence found that smoking during pregnancy was the most consistent predictor of alcohol use during pregnancy, with 17%, 50% and 42% more likely to drink if also smoking, across three separate cohorts.

Latest national figures show that the Smoking Status at Time of Delivery (SATOD) for pregnant women has fallen to 9.1% in 2021-22, the lowest annual rate on record, down from 15.8% in 2006-07. In Harrow, while 10.4% of pregnant people were recently recorded as a smoker on their GP record (WSIC 2013), on 3.2% reported smoking at the time of delivery.

Pregnant and postnatal women are encouraged to eat a healthy balanced diet and aim for at least 30 minutes of moderate intensity activity per day . Research from the Active Pregnancy Foundation and UKActive in 2020 found that 53% of pregnant and postnatal women had been less active since the Coronavirus lockdown (35.6% responded 'a lot less' active and 17.4% 'a bit less' active each week respectively). Only 24.1% reported managing to achieve 150 minutes or more during lockdown.

Maternity and health – health outcomes (1)

The COVID 19 pandemic had a huge impact on most pregnant and postnatal women. With pressures on the NHS and health services, pregnant and postnatal women may have found it harder to book routine appointments and receive support, potentially impacting on maternal mental and physical health, as well as decisions that affect the child, such as infant feeding method and immunisations.

A recent meta analysis of eight studies including 7,750 pregnant or postnatal women found that anxiety scores were much higher during the COVID-19 pandemic. Pregnant women in particular were and are at greater risk if they contract COVID-19 (as well as other infectious diseases such as flu) which may have impacted usual routines such as going out and socialising or exercising, further affecting maternal mental, social and physical health.

Complications during pregnancy can include high blood pressure, deep vein thrombosis (DVT), gestational diabetes, pre-eclampsia, etc. The risk of complications is higher in women who are aged 35+, are overweight, and who drink or smoke during pregnancy.

Having children may have a protective effect against certain cancers such as breast, ovarian and endometrial. An early first full-term birth could reduce a woman's lifetime risk of developing breast cancer by up to 50%, and risk declines further with each additional full-term pregnancy.

Maternity and health – health outcomes (2)

Breastfeeding is also known to have positive health outcomes on both mother and child, such as reducing risk of infection, diarrhoea/vomiting, sudden infant death syndrome and obesity/cardiovascular disease in adulthood for the newborn, and reducing risk of breast/ovarian cancer, osteoporosis, cardiovascular disease and obesity for the mother.

In Harrow, breastfeeding initiation rates compare favourably to the England average, at 81.5% compared to 67.4%, however it is well documented that continued breastfeeding rates (especially exclusively) drop significantly thereafter – by 6 months, exclusive breastfeeding rates in the UK are around 1%.

Maternity and health – use of services

In England, pregnant women are offered the following with an NHS midwife or doctor.

- Up to 10 antenatal appointments
- 2 pregnancy ultrasound scans at 8 to 14 weeks and 18 to 21 weeks
- antenatal screening tests to find out the chance of the baby having certain conditions, such as Down's syndrome
- blood tests to check for syphilis, HIV and hepatitis
- screening for sickle cell and thalassaemia

They may also be offered antenatal classes, including breastfeeding workshops, depending on local services available. Post birth, midwives will provide care until around 10 days after birth when care is handed over to health visitors. Women will be offered a 6-8 week postnatal check with their GP.

Research suggests that mothers from some ethnic groups, and from poorer socio-economic backgrounds are more likely to access antenatal care late. This is associated with poorer pregnancy outcomes, including pre-term birth and low birth weight.

Abortion rates may be considered as an indictor of good access to contraception services and advice – in 2021, abortion rates in Harrow were similar to the national and London figures:

	Number to Harrow residents	Rate per 1,000 females aged 15-44			
		Harrow	NW London	London	England
Abortions	913	19.3	21.8	21.2	19.2

Maternity and health – local case studies

In Harrow, maternity services are provided by London North West Healthcare NHS Trust.

Other support and services available to new parents include:

- Child Health Clinics
- Children's/Early Support centres (in Harrow there are two main Early Support Hubs: Cedars and Hillview, which provide services and activities to families with children aged 0-7 years
- Family Information Service
- Advice Centres including Citizens Advice Bureau, Housing Aid

Locally, the following organisations are also available:

- Brent and Harrow Perinatal Community Mental Health Team
- Harrow Infant Feeding Support Group

Maternity and health – best practice

The National Institute for Clinical Excellence (NICE) produce and update guidelines on both antenatal and postnatal care for clinical settings

The antenatal care guidelines cover organisation and delivery of antenatal care; routine antenatal clinical care; information and support for pregnant women and their partners; interventions for common problems during pregnancy.

The postnatal care guidelines cover organisation and delivery of postnatal care; postnatal care of the woman; postnatal care of the baby; symptoms and signs of illness in babies; planning and supporting babies' feeding.

The NHS provides general advice to the public on pregnancy and the postnatal period

The following are some of the national organisations who advocate for maternal and child rights and provide information, advice and support for pregnant and postnatal women:

- UNICEF
- NCT
- Maternity Action
- Maternal Mental Health Alliance
- La Leche League

11. Homeless health in Harrow

LONDON BOROUGH OF HARROW

Homeless health - definitions

The legal definition of homelessness is that a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough, the Housing Act 1996 defines a person as homeless if they either:

- have no accommodation available to occupy
- are at risk of violence or domestic abuse
- have accommodation but it is not reasonable for them to continue to occupy it
- have accommodation but cannot secure entry to it
- have no legal right to occupy their accommodation
- live in a mobile home or houseboat but have no place to put it or live in it

Local authorities in England have a statutory duty to secure accommodation for unintentionally homeless households who fall into a 'priority need' category – defined as **Statutory Homelessness**. There's no duty to secure accommodation for all homeless people.

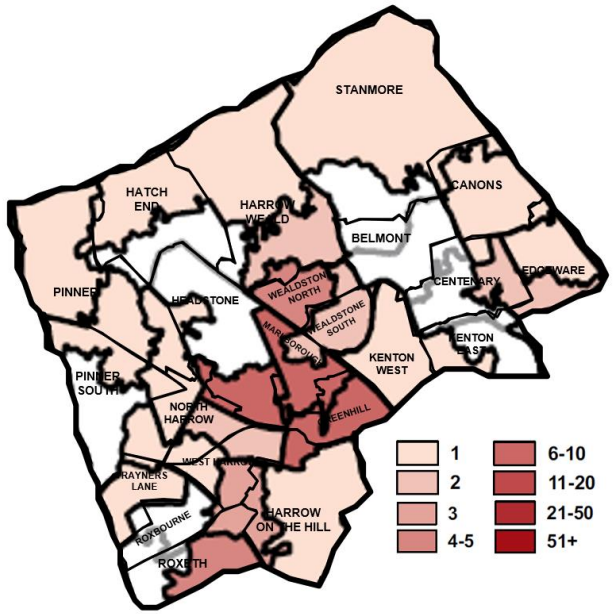
Rough sleepers are defined as people bedded in the open air (including tents, doorways, or encampments), or in buildings or other places not designed for habitation (e.g. stairwells, sheds, cars, derelict boats or stations).

Homeless health - numbers

According to government figures, there were over 1,000 households in temporary accommodation in Harrow in 2021/22. This is over 1% of households – higher than the rate across England.

	Number of Harrow households	% of households			
		Harrow	NW London*	London	England
Households in temporary accommodation	1,073	1.2%	1.2%	1.6%	0.4%

** Harrow, Ealing, Hammersmith & Fulham, and Hillingdon only*



The Combined Homelessness and Information Network (CHAIN) database records the number of rough sleepers seen in London. They report that during 2021/22, there were 58 rough sleepers in Harrow.

Most (78%) of these people were new rough sleepers, and just over half (53%) were born in the UK. 83% were male.

The map shows where in Harrow these people were seen bedded down.

Please click images to expand

Homeless health – wider determinants

Evidence shows that there are two broad categories for the explanation and causes of homelessness - individual and structural factors. Poverty can put people at risk of being homeless, as well as having significant impacts on people's health and well-being. The causes of poverty are inextricably linked to other causes of homelessness such as employment, housing market conditions and the cost of living, as well as welfare and income policies.

Being unemployed, in a low-income job, or in insecure employment, is a risk factor for homelessness. The Government's annual homelessness report reveals that the leading employment status for lead applicants of households was registered unemployed – this was 35.7% of applications. Unemployment and underemployment lie at the core of poverty. If you're struggling to make ends meet, including paying monthly housing and associated costs, this increases the risk of becoming homeless.

Across England, and particularly in London, rent levels have been rising making accommodation less affordable. There is a lack of housing supply in the social rented housing sector. More people are having to rent to private landlords and paying higher rents, and there are well-known barriers to private renting for people that are homeless or at risk of becoming homeless. Buying a home is becoming even more unaffordable. All these factors are factors in making people and families become homeless.

Social, welfare, housing and economic policy have a significant impact on homelessness. The pandemic saw the 'Everybody In' initiative reduce 'core homelessness' (e.g. rough sleeping, sofa surfing, unsuitable temporary accommodation) in the short term through 2020. However, it is predicted that the cost of living crisis, economic downturn, and various policy reforms risks a substantial increase by one-third of 'core homelessness between 2019 -2024.

Homeless health – lifestyles and behaviour

People experiencing homelessness are more likely to smoke, use drugs and alcohol compared to the general population, although prevalence estimates of these behaviours in this population can vary between studies. A national Homeless Health Audit in 2022, aggregated data representing 2,776 individual responses demonstrated that.

- Over half of respondents (54%) reported drugs use in the previous 12 months
- 29% of respondents report they have, or are in recovery from, an alcohol problem
- 76% of respondents reported that they smoke cigarettes, cigars or a pipe. Of those who smoke, 50% (156) would like to give up, although 46% of respondents stated they had not been offered smoking cessation advice or help.

Self-medicating with drugs and alcohol to help them cope with their mental health can be common for people experiencing homelessness. This is accompanied by some in this cohort feeling as though they do not get enough support for their mental health issues.

Poor diet and food insecurity are key indicators of health inequalities, with diet inequality being one of the leading causes of avoidable harm to health. Food and diet insecurity, as well as the ability to eat healthily, is a commonly reported issue in this population.

Fewer than 500 adults in Harrow were recorded on local GP records as being in some form of homelessness (WSIC 2023). Of these, 44.5% were smokers – a much higher rate than average.

Homeless health – health outcomes (1)

The impact on health outcomes of people experiencing homelessness is well documented. This is relevant across the life course, from children and young people through to older populations. Poor physical and mental health is both a cause and consequence of homelessness.

Homeless children are more likely to experience stress and anxiety, leading to depression and behavioural issues. A report by Shelter revealed that children who have been in temporary accommodation for more than a year are over three times more likely to demonstrate mental health issues compared to non-homeless children. Other issues include; children being less likely to be immunised and be registered with a GP, further compounding health inequalities.

Young people who experience homelessness are more at risk of sexually transmitted infections and unwanted pregnancies; they are more likely to have experienced trauma, abuse and other adverse experiences; and there are high levels of self-reported mental health problems, self-harm, drug and alcohol use.

Through adult and working age, many of the previous issues remain. Mental health issues remain prevalent, with 72% of respondents to the Homeless Health Audit report experiencing depression. Poor musculoskeletal (issues with muscles, joints and bones) and dental health are also commonly reported in this cohort. People experiencing homelessness have poor uptake of services aimed at preventable conditions e.g. screening, vaccination and immunisation, therefore increasing their risk of developing these conditions. This population is also more likely to report having a long-standing illness or disability.

Homeless health – health outcomes (2)

People who experience rough sleeping over a long period are, on average, more likely to die young than the general population. Drug poisoning, suicide, and alcohol related deaths are the main reasons for deaths in this population or those using emergency accommodation. Over 85% of deaths in rough sleepers are men. The average age of death for people experiencing homelessness is just 45 for men and 43 for women. Compared to the national average age of death in the UK (79.4 for men and 83.1 for women), this highlights the stark inequalities experienced by people sleeping rough.

Homeless health – use of services

FEANSTA have reported that people that experience homelessness are not per se digitally excluded, they face many challenges and barriers that prevent them from fully participating in digital society. This can inevitably have an impact on accessing and using services.

Access to primary care can be a significant issue for these individuals. It has been reported that homeless cohorts can be 40 times less likely to be registered with a mainstream general practice compared with the general population. A qualitative study exploring perspectives of people who experience homelessness in the UK showed that participants perceived inequality in access, and mostly faced negative experiences, in their use of mainstream services. Some of those key barriers included being denied registration at the mainstream general practices, lack of continuity of care because of having unstable accommodation, lack of health professionals' awareness of the homeless cohorts' complex health and care needs and perceived stigma and discrimination from other patients and professionals.

Furthermore, issues with access to dental services, being admitted to the hospital because of a mental health condition and overuse of emergency services, such as ambulance services and emergency departments, is reported. The Homeless Health Audit also highlighted that common life experiences among these populations include: time spent in prison, spent time in local authority and spent time in a young offender institution.

Homeless health – local case studies

The charity FirmFoundation is based in Harrow, and provides local support to homeless people. This includes a seasonal night shelter service, supported accommodation, and drop in support.

Homeless health – best practice

From a legislative perspective, the Homelessness Reduction Act 2017 puts responsibilities on local authorities to ensure that all homeless people are able to get help, to focus on preventing people from becoming homeless in the first place and that families with children are prioritised for housing if that's the best way to help them. As part of the Homelessness Reduction Act, certain public services are required to notify a local authority of service users they consider may be homeless or threatened with homelessness – the Duty to refer. Furthermore, under the Homelessness Act 2002, all housing authorities must have in place a homelessness strategy based on a review of all forms of homelessness in their locality. An overview of the homeless legislation has been published. The latest government strategy "Ending rough sleeping for good", focuses on four themes – Prevention, Intervention, Recovery and a Transparent and Joined up System

There is an abundance of best practice guidance and standards available aimed at meeting the needs of this population. NICE guidance aims to improve access to and engagement with health and social care, ensuring that care is coordinated across different services. Pathway has published a document outlining a minimum set of standards for planning, commissioning and providing healthcare for homeless people. The Local Government Association recently published 'Making the case for investing in homelessness prevention'; outlining the strategic and economic case for tackling this challenging issue from a prevention perspective.

Some studies have also shown the benefit of delivery specialist primary care services for patients experiencing homelessness, improving continuity of care, ease of access and person-centered approaches.

12. Migrant health in Harrow

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Migrant health - definitions

A migrant is any person residing outside of their country of origin. It is important to distinguish between voluntary and forced migration, the latter of which is predominantly caused by persecution and disasters related to natural or artificial hazards.

An asylum seeker is a person who has applied for asylum under the 1951 Refugee Convention and its 1967 Protocol.

A refugee is a person who has been granted asylum under the 1951 Refugee Convention and its 1967 Protocol.

Immigration policies of the UK have a longstanding history of aiming to reduce net immigration and creating a hostile environment for migrants without proper documentation, disproportionately affecting asylum seekers. While there may be programmes aiming at displaced populations with specific nationalities, most of those fleeing disasters or persecution lack the means to reach the UK safely and satisfy all its bureaucratic requirements. Moreover, since leaving the EU, European laws no longer protect asylum seekers in the UK and migration between the country and the continent has become more difficult.

Migrant health – numbers (1)

More than half the residents of Harrow were not born in the UK, according to the 2021 Census. This is higher than the percentage in London. The 10 most common other countries of birth are shown in this table. Most residents born overseas arrived in the UK as children or young adults.

Detailed country of birth	Number of residents	% of Harrow population
England	125,093	47.9
India	26,376	10.1
Romania	21,082	8.1
Kenya	10,859	4.2
Sri Lanka	10,706	4.1
Other South and Eastern Africa	8,058	3.1
Afghanistan	4,825	1.8
Pakistan	4,485	1.7
Poland	3,602	1.4
Other Middle East	3,303	1.3

The percentage of residents born overseas is higher than the London and England percentages. Harrow has a particularly high number of residents born in Asia and Africa.

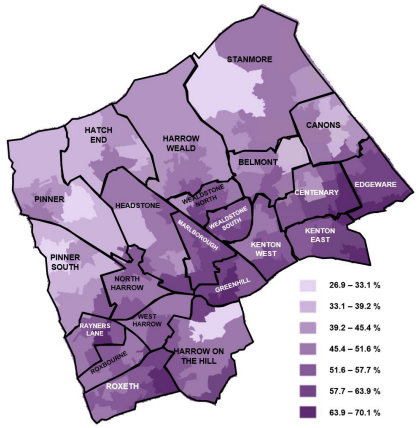
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
UK	127,612	48.9%	50.1%	59.4%	82.6%
Rest of Europe	41,677	15.9%	17.1%	15.5%	7.2%
Africa	26,748	10.2%	7.6%	7.1%	2.8%
Asia / Middle East	59,517	22.8%	20.4%	13.0%	5.7%
Americas / Caribbean	4,985	1.9%	4.0%	4.2%	1.4%
Australia, Antarctica and others	664	0.2%	0.8%	0.8%	0.3%

Migrant health – numbers (2)

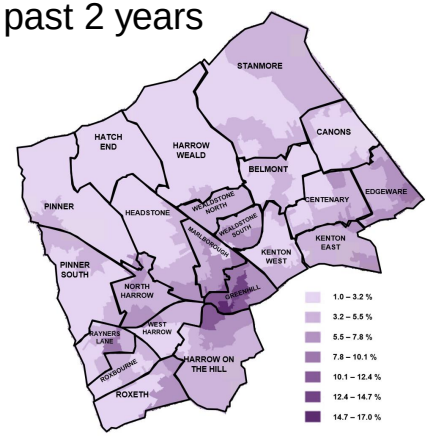
Nationally, and in Harrow, asylum seekers make up a small percentage of immigrants. During 2022/23, a total of 670 immigrants received support from Harrow. This includes 255 under Homes for Ukraine, 89 under Afghan Resettlement Programme, and 326 Supported Asylum.

	Number in Harrow	% of resident population			
		Harrow	NW London	London	England
Total supported in 2022/23 *(incl. Homes for Ukraine, Afghan Resettlement Programme, Supported Asylum)*	670	0.26%	0.68%	0.49%	0.35%

Map shows the % of the population of Harrow born outside the UK.



Map shows % of the population of Harrow who moved to the UK in past 2 years



It is difficult to estimate the number of irregular migrants living in Harrow.

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Migrant health – wider determinants

Migrants are more likely to have degree level or non-standard qualification but also no qualifications than those born in the UK. Education rates are higher among voluntary migrants than those forcibly displaced.

Compared to the UK-born, migrants have lower wages and are less likely to be employed, work in a specialised or managerial role, and have full-time hours. This affects forced migrants disproportionately.

Asylum seekers are predominantly not permitted work by law and can only rely on a daily £5.84 cash support for all expenses, including food, sanitation, and clothing. Since the introduction of this limit in 2000, its inflation-adjusted value has decreased by 27%.

Migrants are more likely to live in low-quality, rental, and overcrowded housing than those born in the UK. They may also lack a social network, proficiency in the English language, and a good understanding of services and job seeking.

In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that residents who don't speak English well, or at all, are more likely to live in more deprived parts of the borough.

Migrant health – lifestyles and behaviour

Migrants in the UK form an immensely diverse sub-population that may differ from the UK-born in numerous ways, to varying degrees based on the level of integration and their country of origin.

For instance, migrants may have a strong cultural identity, different customs, and beliefs, may seek a social network within diasporas, and may experience bereavement, isolation, or a lack of support networks [13-[ii]].

There is some evidence suggesting significantly lower smoking and alcohol consumption among some migrant groups.

There is more about the Healthy Migrant Effect later in this report.

Migrant health – health outcomes (1)

The health of migrants is multifaceted. While many disparities exist, these are complex and may be affected by several confounding factors, such as ethnicity and socioeconomic status (see relevant sections of this report). Some migrant groups may be disproportionally affected by non-communicable diseases compared to other migrants and non-migrants, including diabetes, stroke, specific cancer types, and coronary heart disease. Cardiovascular disease risk may vary among groups, including decreased obesity rates that increase with time spent in host country.

Moreover, migrants are disproportionately affected by communicable diseases, including respiratory, blood- and vector-borne, and parasitic infections. This is further exacerbated by forced displacement, poverty, crowding, and migration from endemic areas.

There is evidence of stress, depression, anxiety, and poor general mental health among migrants. Forced migrants are especially susceptible and further affected by a high prevalence of post-traumatic stress symptoms and psychosis. Unaccompanied children and those detained are among the most vulnerable.

Migrant health – health outcomes (2)

The ‘healthy migrant effect’ describes the finding that new migrants to a country are often healthier than the average person in the country they arrive in. Studies show that migrant communities can have longer and healthier lives overall. This may be explained by the characteristics of people who travel to and are accepted, by the new country they migrate to, with new migrants being more educated, employable and physically fitter.

Over time, this health advantage is often eroded as migrant populations adapt to new ways of living, adopting different cultural practices and being exposed to risk factors for disease. This process of ‘acculturation’, the gradual adoption of the dominant culture, has been attributed to reported declines in health status among migrant populations. Longer length of residency in a new country has been found to be a risk factor for convergence to the average health outcomes in that country.

Migrant health – use of services

There is evidence suggesting increased rates of accident and emergency services visits and hospitalisations partially explained by decreased levels of utilisation of screening and outpatient services among migrants. GP registration rates may also be lower, particularly among migrants from countries without free primary care systems.

A plethora of barriers to service uptake exist, including lack of knowledge about (free) opportunities, (direct or indirect) costs, stigma, logistics, and language barriers.

There is more information about English skills and the different languages spoken in Harrow elsewhere in this report. In 2023, the Harrow Health Visiting and School nursing service did an analysis of languages requiring interpreting services for example - Romanian, Gujarati and Arabic were particularly common.

Migrant health – local case studies

Several organisations provide support to refugees, asylum seekers, and other migrants in Harrow and North West London, including Afghan Association of London (Harrow), Harrow Association of Somali Voluntary Organisations, Harrow Citizens, Harrow Iranian Community Association.

These organisations usually focus on communities with specific countries of origin and offer immigration and general (such as housing, health, and employment) advice and advocacy, as well as youth, educational, cultural, sport, and other community activities.

Migrant health – best practice

The GLA have produced a guide to health services for migrants in London.

The UK government also produce a detailed guide for healthcare workers and commissioners. It includes links to a range of different organisations supporting specific vulnerable groups such as child migrants, people who have been trafficked, and migrant sex workers.

There is specific guidance for language services.

Doctors of the World run a Safe Surgeries scheme for GP practices, including advice and a toolkit to help ensure that there are no barriers to primary care services. Another toolkit is available for Primary Care Networks to self-assess their services.

There is also relevant guidance produced by the BMA and by the World Health Organisation.

13. Veterans health in Harrow

Veterans health - definitions

Veterans are former UK Armed Forces personnel.

They are defined by The Ministry of Defence (MOD) as: "Anyone who has served for at least one day in His Majesty's Armed Forces (Regular or Reserve), or Merchant Mariners who have seen duty on legally defined military operations."

Many veterans prefer to call themselves "ex-service".

A wider definition of the "Armed Forces Community" includes current serving personnel, volunteer and regular reservists, family members and bereaved family members.

Veterans of foreign forces are likely to have some shared health needs with UK veterans though less information is available on this group.

Veterans health - numbers

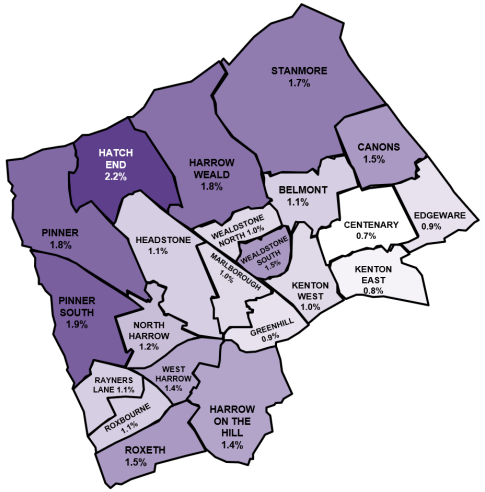
There are generally more veterans in areas of the country with larger active military populations. Both Northwood Headquarters and RAF Northolt are close to Harrow. In the borough itself, there is one reserve unit (131 Commando Squadron), and several active cadet units.

The 2021 Census reports that 2,723 veterans over the age of 16 live in Harrow. This is 1.3% of adults – compared with 1.4% across London and 3.8% nationally. The number of veterans in the population is expected to decline in coming years.

Nationally, almost half of veterans are over 75 years old. Older veterans may have served in WW2 or subsequent conflicts, with national service ending in 1963. Younger veterans may have served in a range of operations at home and overseas. Almost 90% are male. Officers are most likely to leave service in their early 40s, and other ranks in their late 20s

Harrow residents who have previously served in the UK armed forces (2021 Census)

	Number of Harrow residents	% of population			
		Harrow	NW London	London	England
Veterans	2,723	1.3%	1.3%	1.4%	3.8%



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Veterans health – wider determinants

"Transition" is the term used to describe the period of time when personnel leave the Armed Forces to return to civilian life. Most studies suggest that generally veterans suffer from the same range of health and welfare issues as the general population and make a successful transition, although a small percentage struggle.

Employment can be an important factor – overall veteran employment rates are similar to the general population, though veterans are more likely to work in public service roles for example.

A 2018 survey of the Armed Forces Community found that one in four veterans reported that they feel lonely and socially isolated 'always' or 'often'. An earlier survey found that more than three in ten veterans have just one or no close friends, and more than half admitted that they would be unlikely to discuss any feelings of loneliness. These problems may have been compounded by the Covid-19 pandemic in some cases.

Armed Forces recruitment is disproportionately drawn from individuals with deprived backgrounds and lower educational achievement. Almost 90% of veterans face financial challenges. Veterans are less likely than the general population to have a degree level qualification.

Veterans are thought to still be over-represented among rough sleepers in London, though these figures have fallen over recent years.

"Early Service Leavers" (ESL) are veterans who leave the Armed Forces either voluntarily before completing an initial four years of service; or compulsorily due to medical or disciplinary reasons. These veterans may be at higher risk of worse health and wellbeing. LGBTQ veterans may also to face particular challenges.

Veterans health – lifestyles and behaviour

Historically, smoking was very common within the UK Armed Forces though smoking rates in veterans are now similar to the general population. Local data is not available as veteran status is not routinely recorded on NHS data systems.

There is evidence for higher levels of alcohol use in veterans, including its use as a coping strategy during transition.

Veterans health – health outcomes

There is limited reliable evidence of the long-term physical effect of military service. MOD reviews of veterans suggest personnel are likely to suffer the same range of health and welfare issues as the general population – this includes depression, back problems, arms, legs, feet, and sight problems, as well as long term conditions such as diabetes.

A confounding factor is that Armed Forces recruitment is disproportionately drawn from individuals with more deprived backgrounds which are associated with poorer health and lower life expectancy.

Battlefield injuries and combat stress can affect the health of some veterans in the long term. There is little evidence that mental health problems are more common in veterans overall, though there is concern about the impact of addictions and PTSD (post-traumatic stress disorder). Evidence regarding suicide rates is uncertain.

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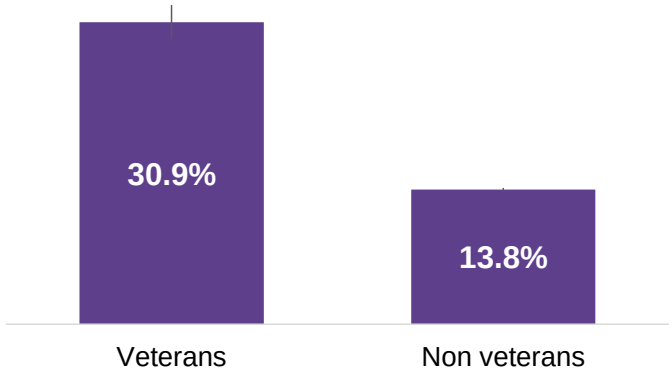
In the 2021 Census, 31% of veterans living in Harrow reported having a disability, compared with 14% in the rest of the population. This is related to the age of this population.



Veterans health – use of services

There is evidence that many veterans are relatively resilient, though they may show more reluctance to seek medical help for health problems, leading to missed opportunities for earlier intervention. This can be part of a need to be seen as 'tough'.

Veterans health – case studies

The charity SSAFA (Soldiers, Sailors, Airmen, and Families Association) have a branch in North West London which provides direct support to people in Harrow leaving the armed forces. This can include support with housing, addiction, relationship breakdown, debt, PTSD, depression, and disability for example. SSAFA can provide local caseworkers and have a free confidential helpline and email service.

Veterans health – best practice

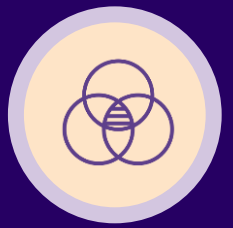
The MOD's 2018 Strategy for our Veterans sets out the current context for delivery of public services. The aim is that "those who have served in the UK Armed Forces and their families, transition smoothly back into civilian life and contribute fully to a society that understands and values what they have to offer".

The Armed Forces Covenant is an informal understanding of the mutual obligations between the nation and the Armed Forces highlighting moral obligations. Principles are that the wider Armed Forces community should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given the most such as the injured or the bereaved. Communities, businesses, and charitable organisations can sign the Covenant and pledge their support to the Armed Forces community, with a national fund available to support suitable projects. Harrow Council signed the Covenant in 2013.

The NHS offers specific guidance to support services for the Armed Forces Community nationally.

The Royal College of General Practice has a *Veteran Friendly GP Practice Accreditation Programme* – by early 2023 there were several practices in North West London, though not in Harrow as yet. They recommend that all GPs ask their patients - "Have you ever served in the Armed Forces?"

14. Intersectional inequalities in Harrow



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Intersectional health inequalities - definitions

An intersectional approach recognises that different facets of a person's identity 'intersect' to shape the lived experience of any individual.

Factors such as ethnicity, occupation, sex, socio-economic status, veteran status, sexual orientation, migration status, and other sociodemographic factors discussed through this report - including the characteristics protected by the 2010 Equality Act - are often considered separately when planning services. These factors are more interdependent and complex. As a result, policymaking can fail to consider where health inequalities are further worsened by multiple disadvantages. Furthermore, potential solutions, including health promotion strategies for example, may be best targeted to very specific population groups.

Understanding intersectional equality needs good quality data collection in health and care systems. There has been growing interest in the approach nationally, particularly in light of health inequalities highlighted by the COVID-19 pandemic.

Intersectional health inequalities - examples

Young black men are a group of residents who experience particular inequalities in Harrow. There is evidence that rates of long-term health conditions such as asthma, learning disabilities and epilepsy are higher in this group locally (WSIC 2023), and that there are disparities in mental health conditions and treatment. Young black men are more likely to experience risk factors for poor health outcomes, such as worse housing and educational attainment, as well as racism.

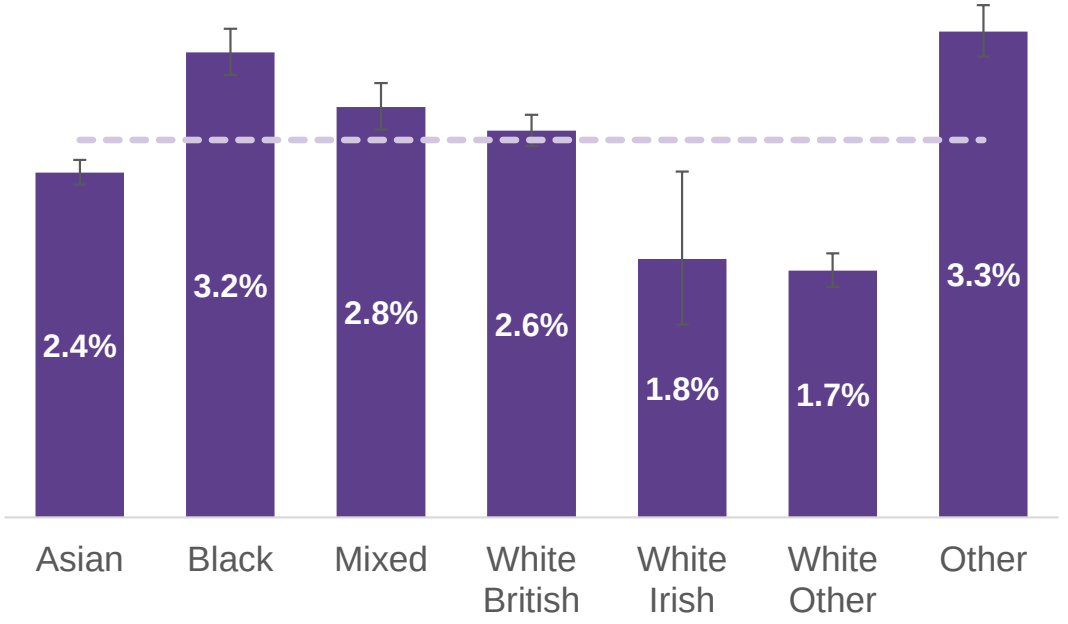
The graph shows the higher rate of self reported ill health in young black people (and other ethnicities) in North West London in the 2021 Census.

Evidence also shows that the COVID-19 pandemic had particular impacts on this group.

Mind and the Centre for Mental Health, for example, have tailored programmes to work with this group, aiming to address these inequalities.

Other specific groups who may benefit from an intersectional approach could include older LGBTQ+ adults, homeless people who are military veterans, or migrants with learning disabilities who may be at higher risk of being exploited in modern slavery.

Percentage of children in North West London reporting bad or very bad health by ethnicity (<15; 2021 Census)



Definitions

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Definitions

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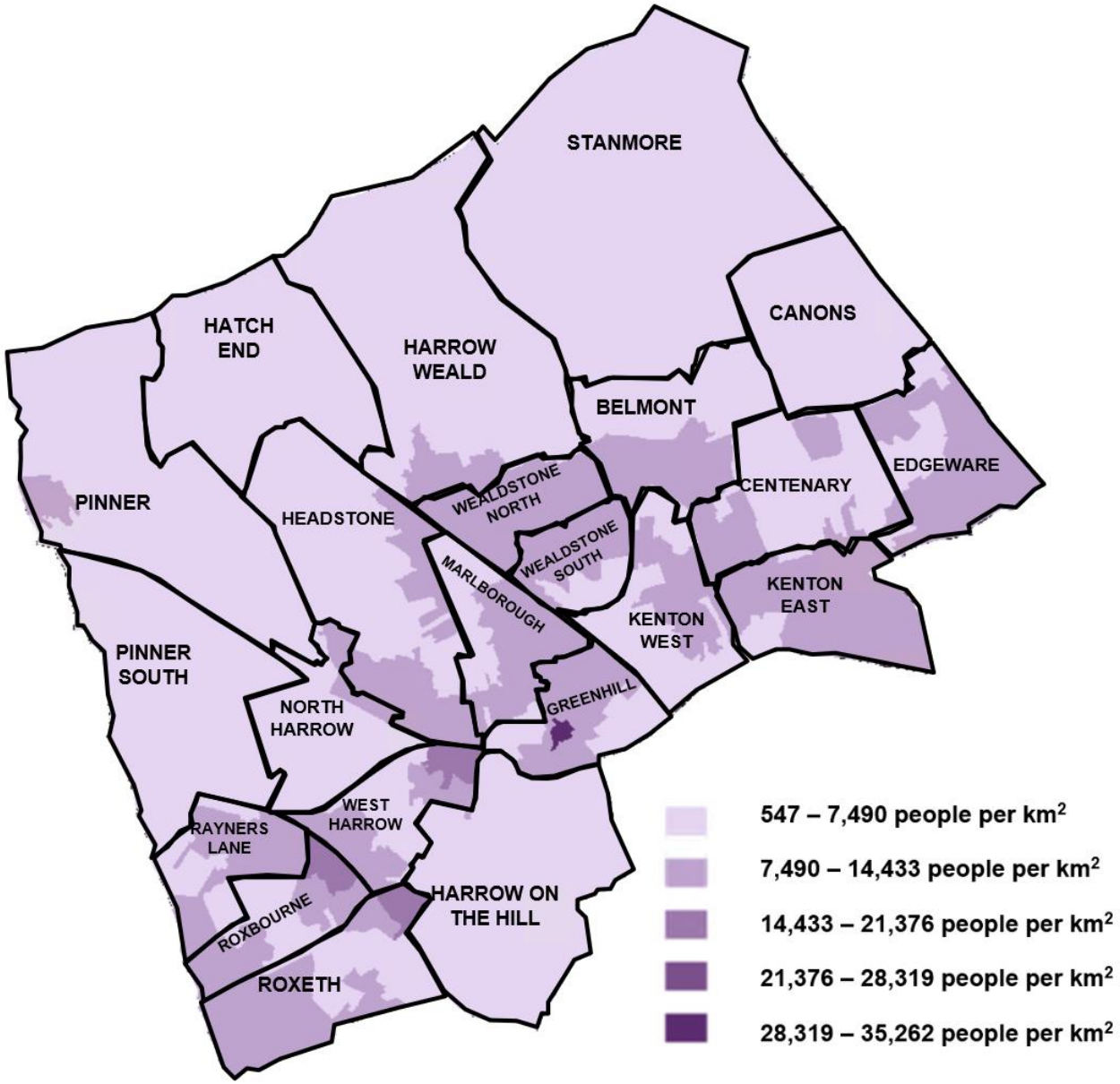
Density of the Harrow population (Census 2021)



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Area of residence and GP registration in Harrow (NHS Digital)

NHS Commissioning area		Harrow residents Number	%
NHS North West London		287,968	93.3%
	Harrow	*256,411*	*83.0%*
	Brent	*18,224*	*5.9%*
	Ealing	*6,098*	*2.0%*
	Hillingdon	*5,802*	*1.9%*
	Hammersmith & Fulham	*817*	*0.3%*
	Kensington & Chelsea	*342*	*0.1%*
	Westminster	*207*	*0.1%*
	Hounslow	*67*	*0.0%*
NHS North Central London		18,798	6.1%
NHS Herts Valleys		1,863	0.6%
GPs in other areas		120	0.0%
Total Harrow residents		**308,749**	

Local Authority of residence	Patients registered with Harrow GPs Number	%
Harrow	256,411	89.1%
Brent	17,590	6.1%
Hillingdon	5,771	2.0%
Barnet	4,471	1.6%
Ealing	1,349	0.5%
Three Rivers	928	0.3%
Hertsmere	292	0.1%
Watford	252	0.1%
Other local authorities	716	0.2%
Total Registered	**287,780**	

Data shown is from June 2022

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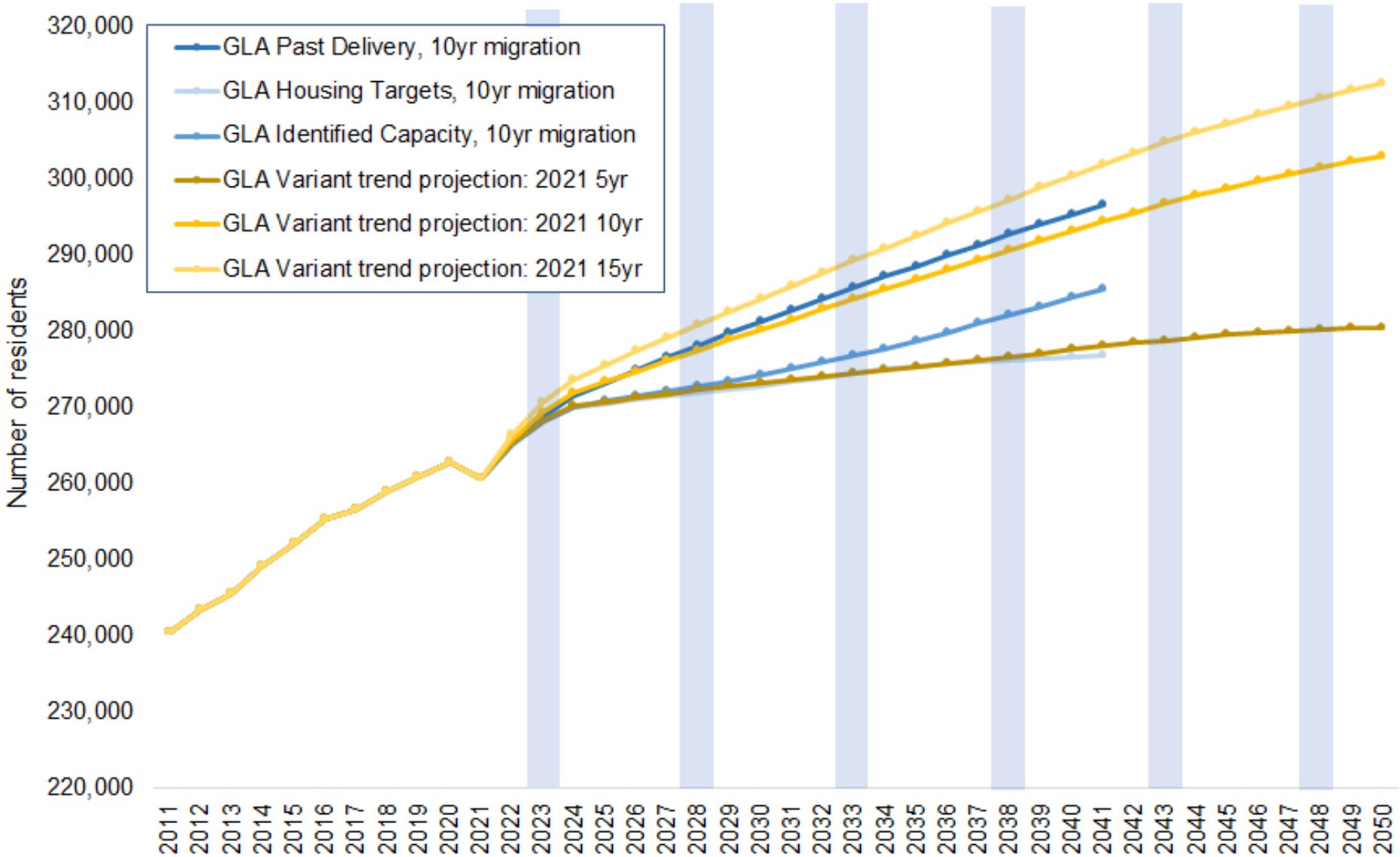
Population projections for Harrow showing possible future growth scenarios (GLA interim projections 2023)



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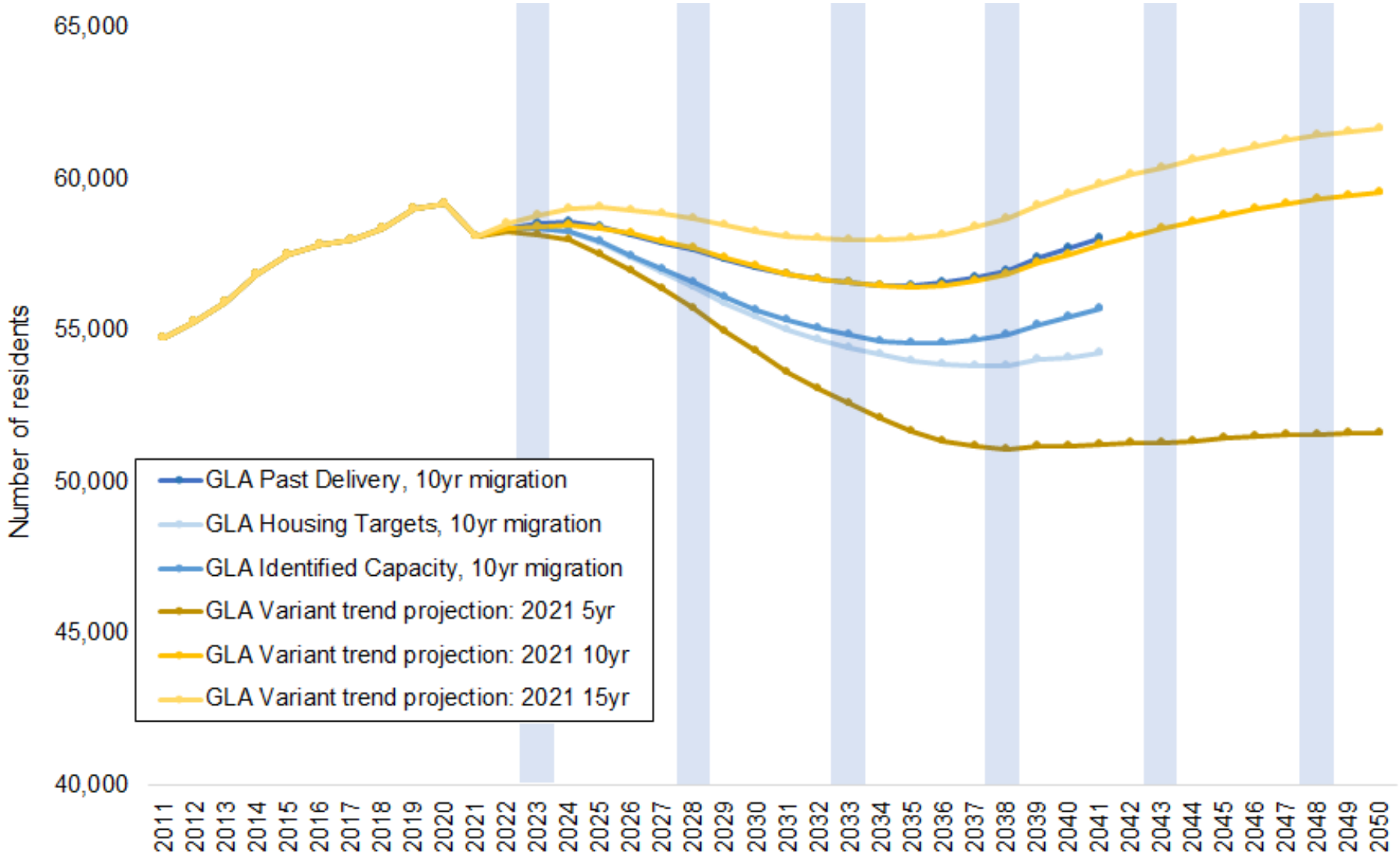
Population projections for under 18s in Harrow showing possible future growth scenarios (GLA interim projections 2023)



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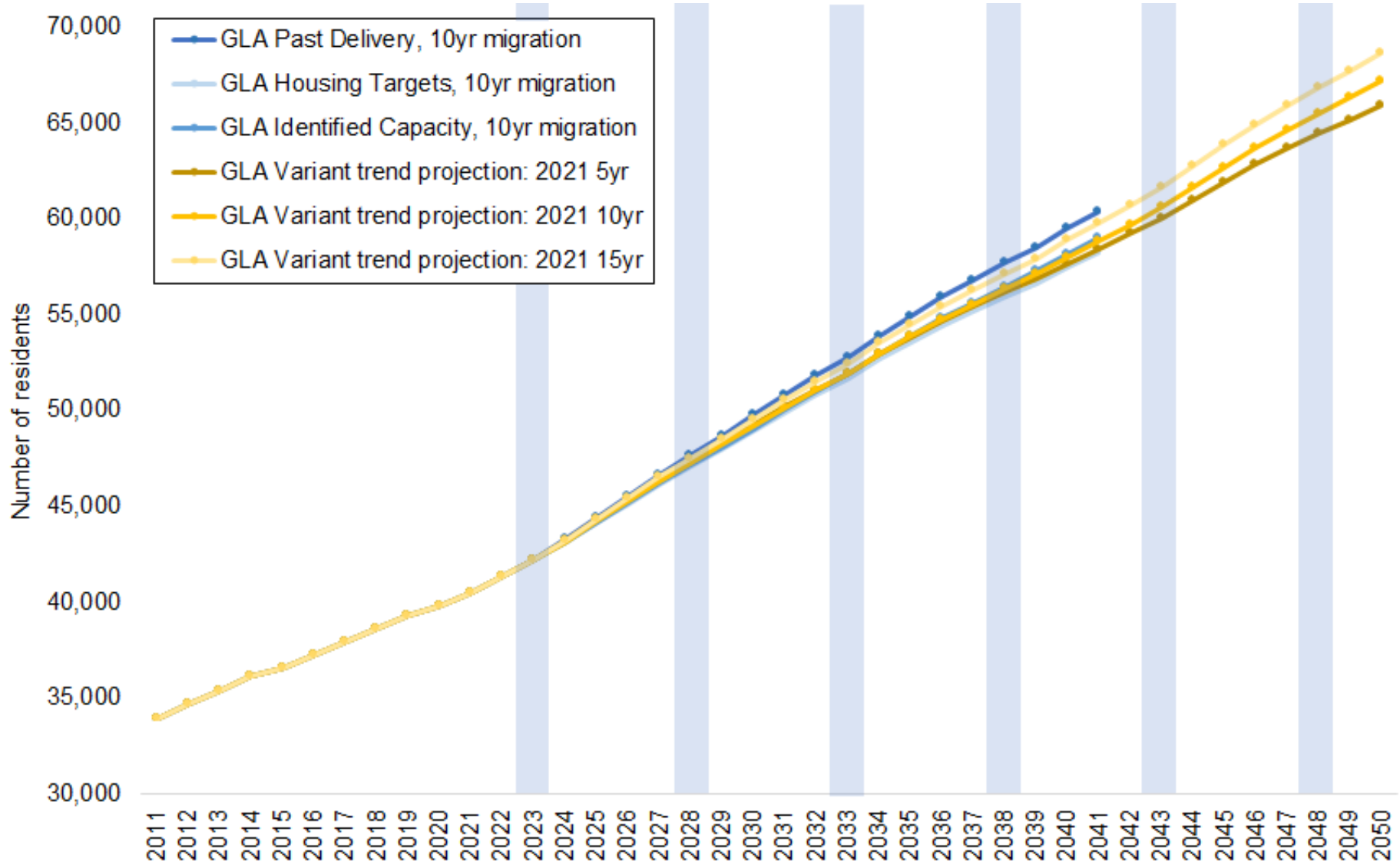
Population projections for 65+ people in Harrow showing possible future growth scenarios (GLA interim projections 2023)



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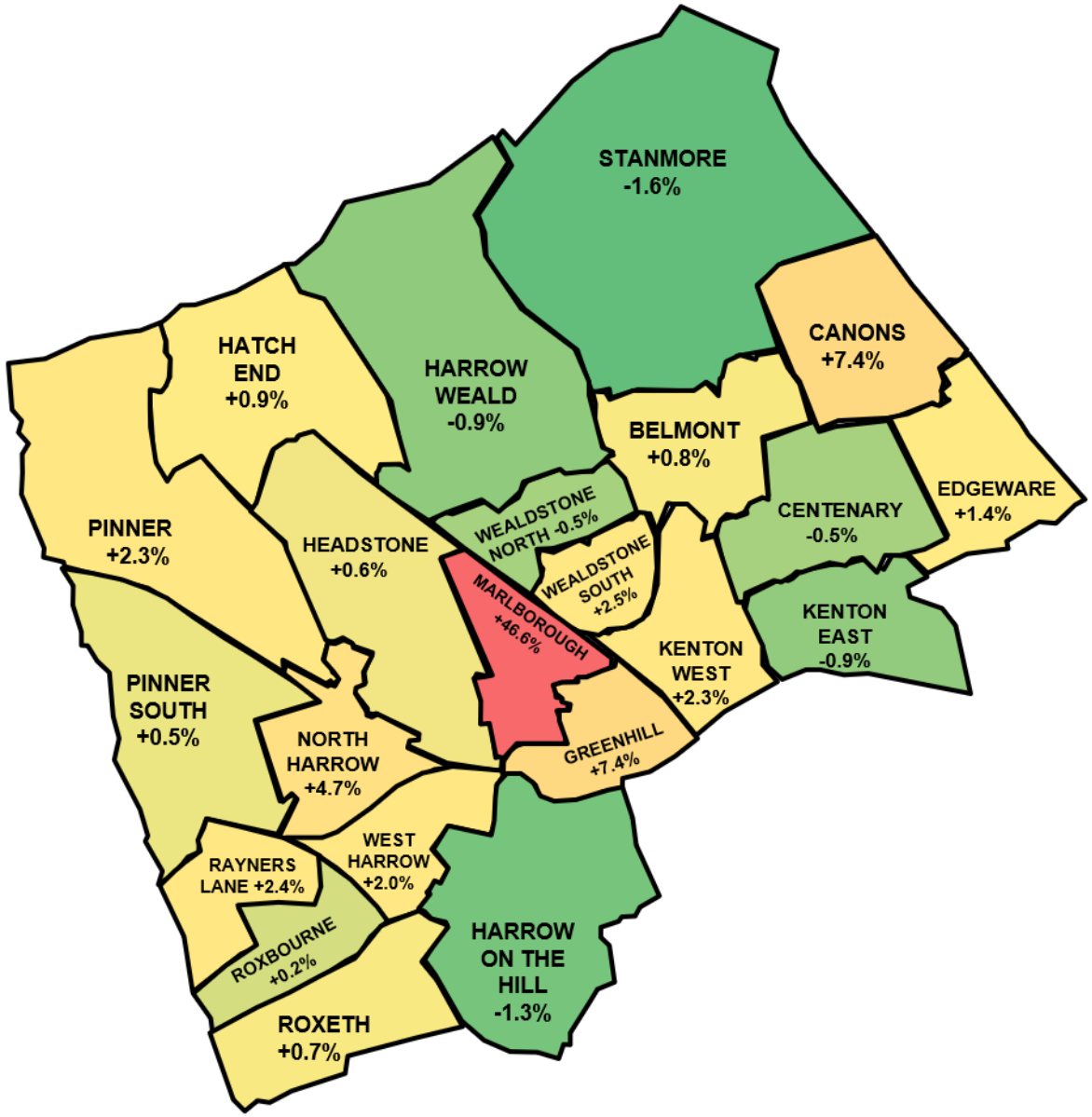
Population projections for Harrow by Ward, showing possible future growth from 2023 to 2033

(GLA Identified Capacity model; 10yr growth trend based)



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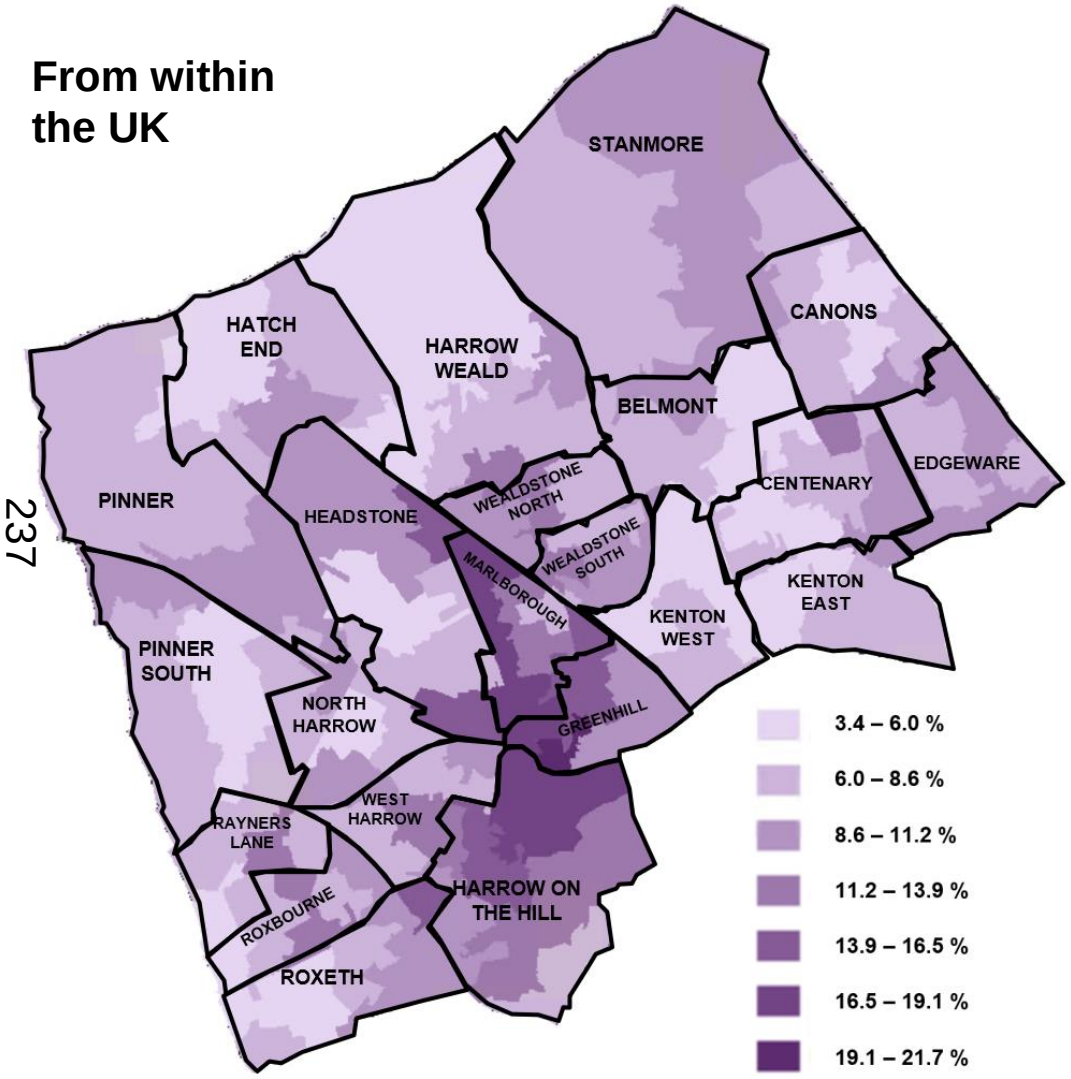
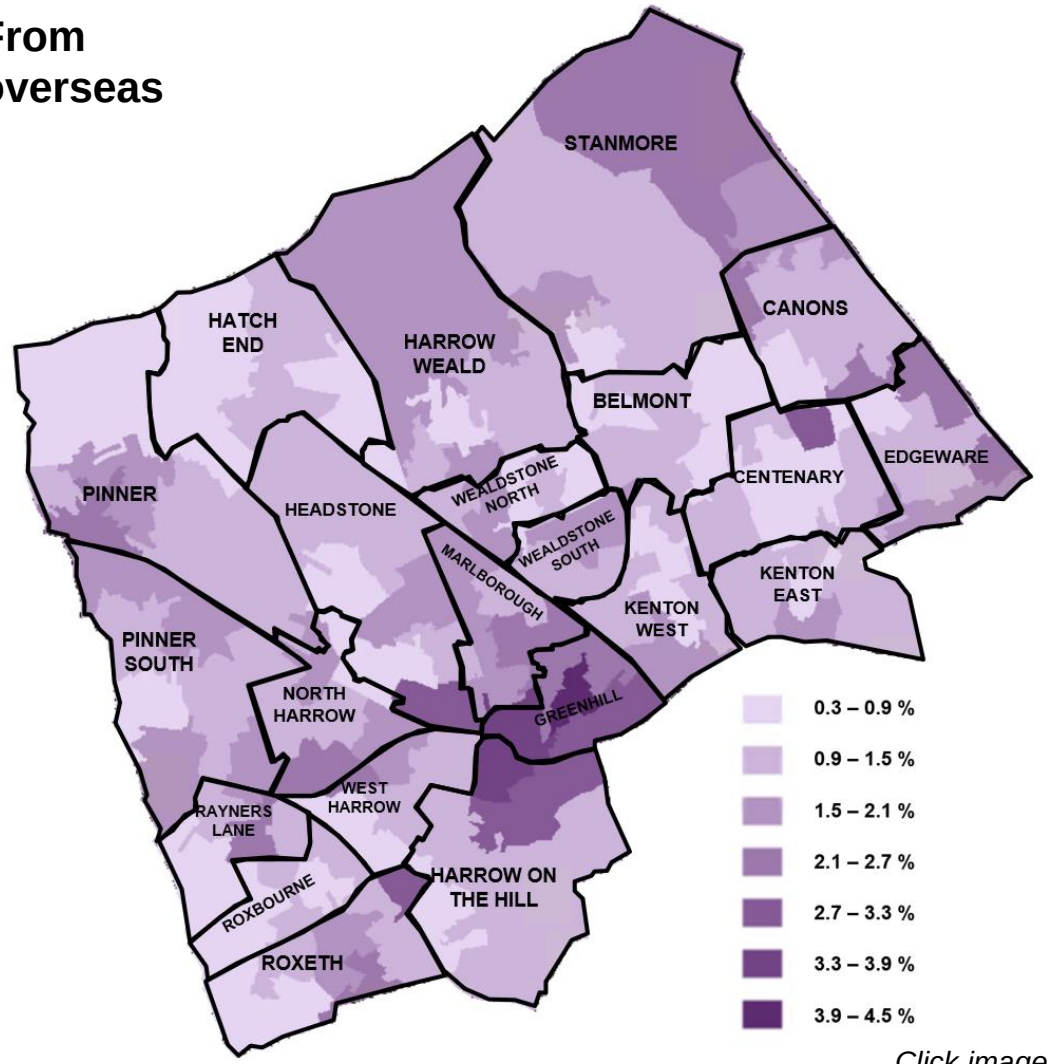
Percentage of Harrow residents who moved into the area during the past year (Census 2021)

From within the UK



From overseas



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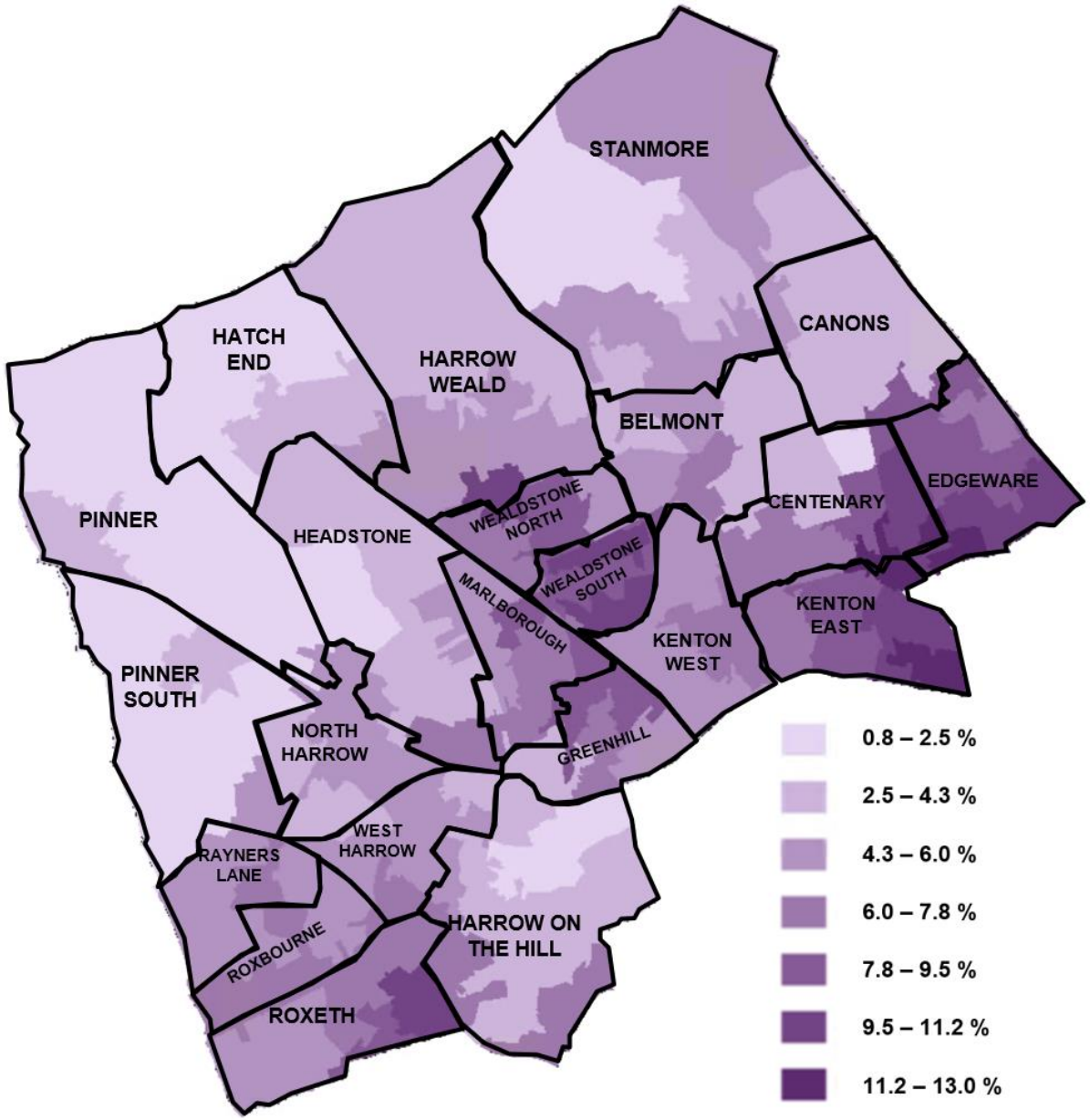
Percentage of Harrow residents who cannot speak English well, or at all (Census 2021)



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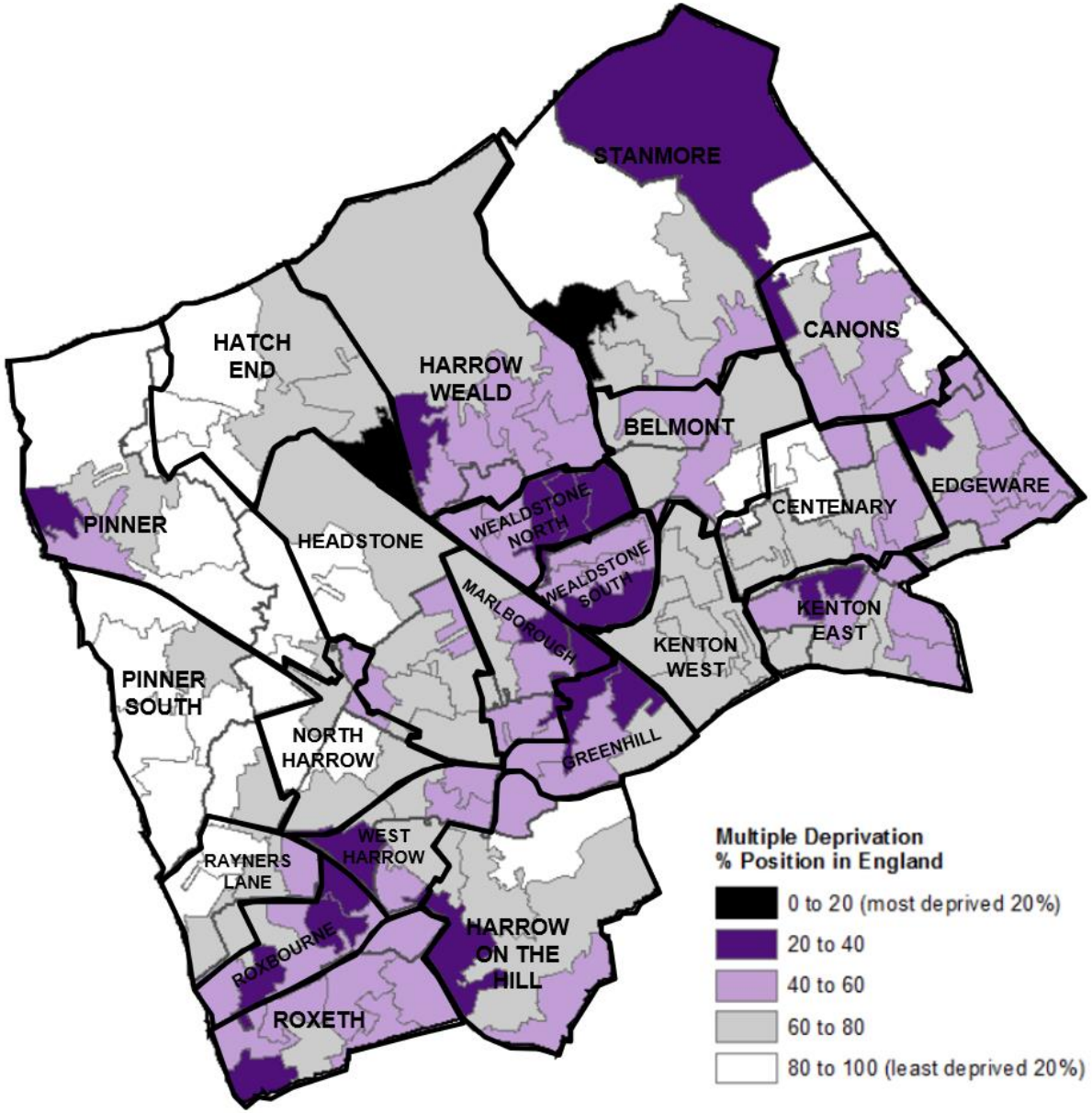
Socio-economic deprivation in Harrow (IMD 2019)



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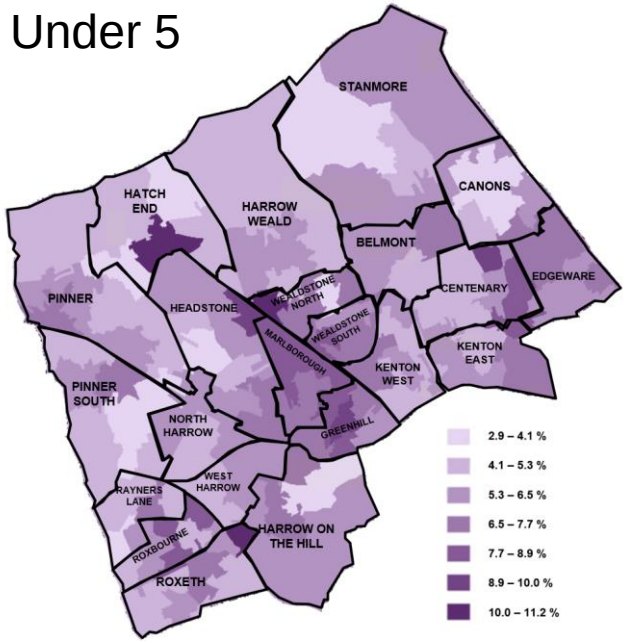
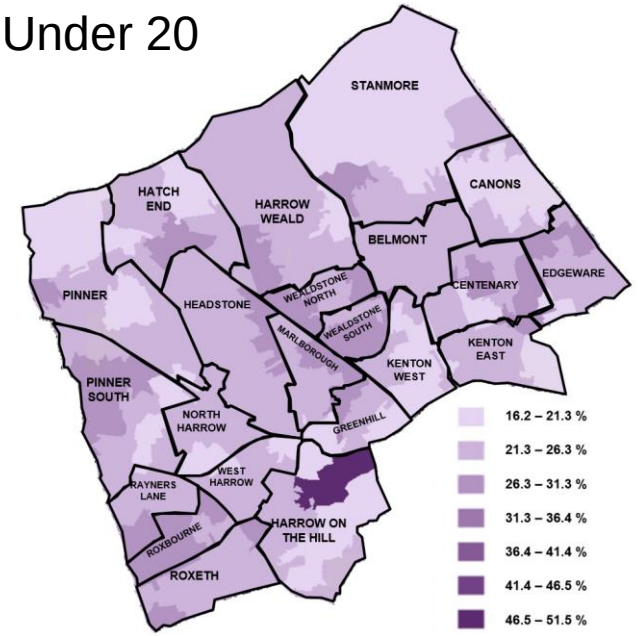
Age profile of the Harrow population (Census 2021)

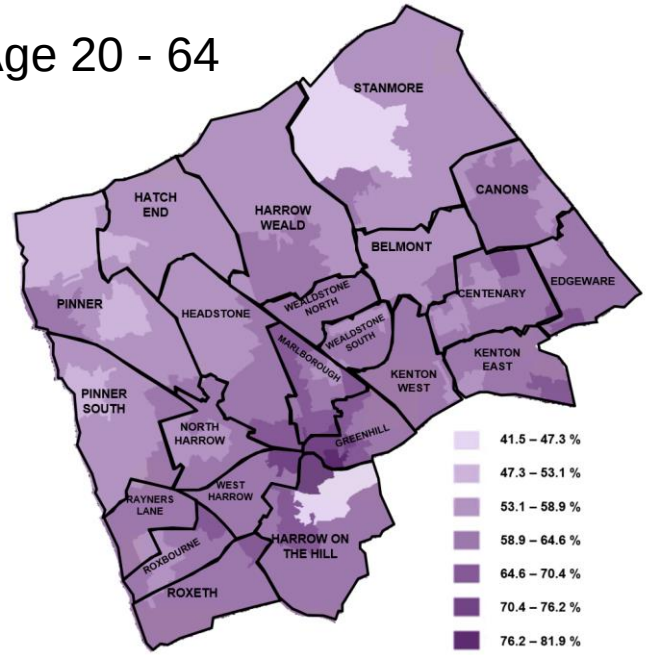
Under 5



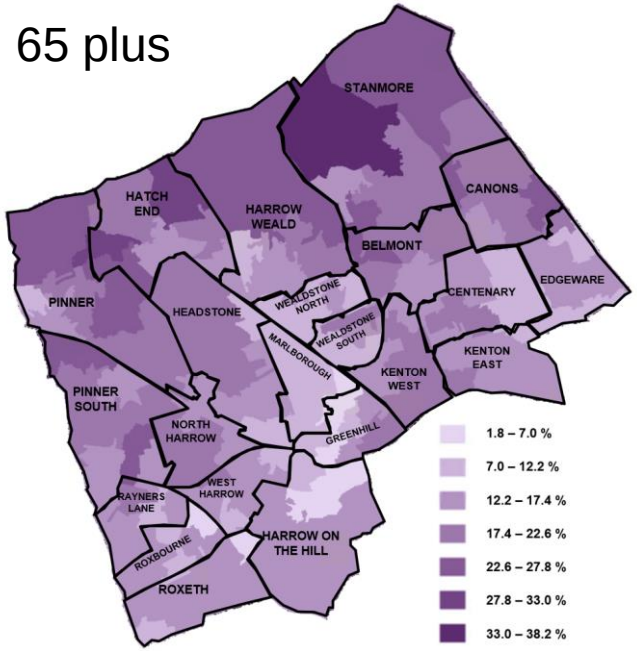
Under 20



Age 20 - 64

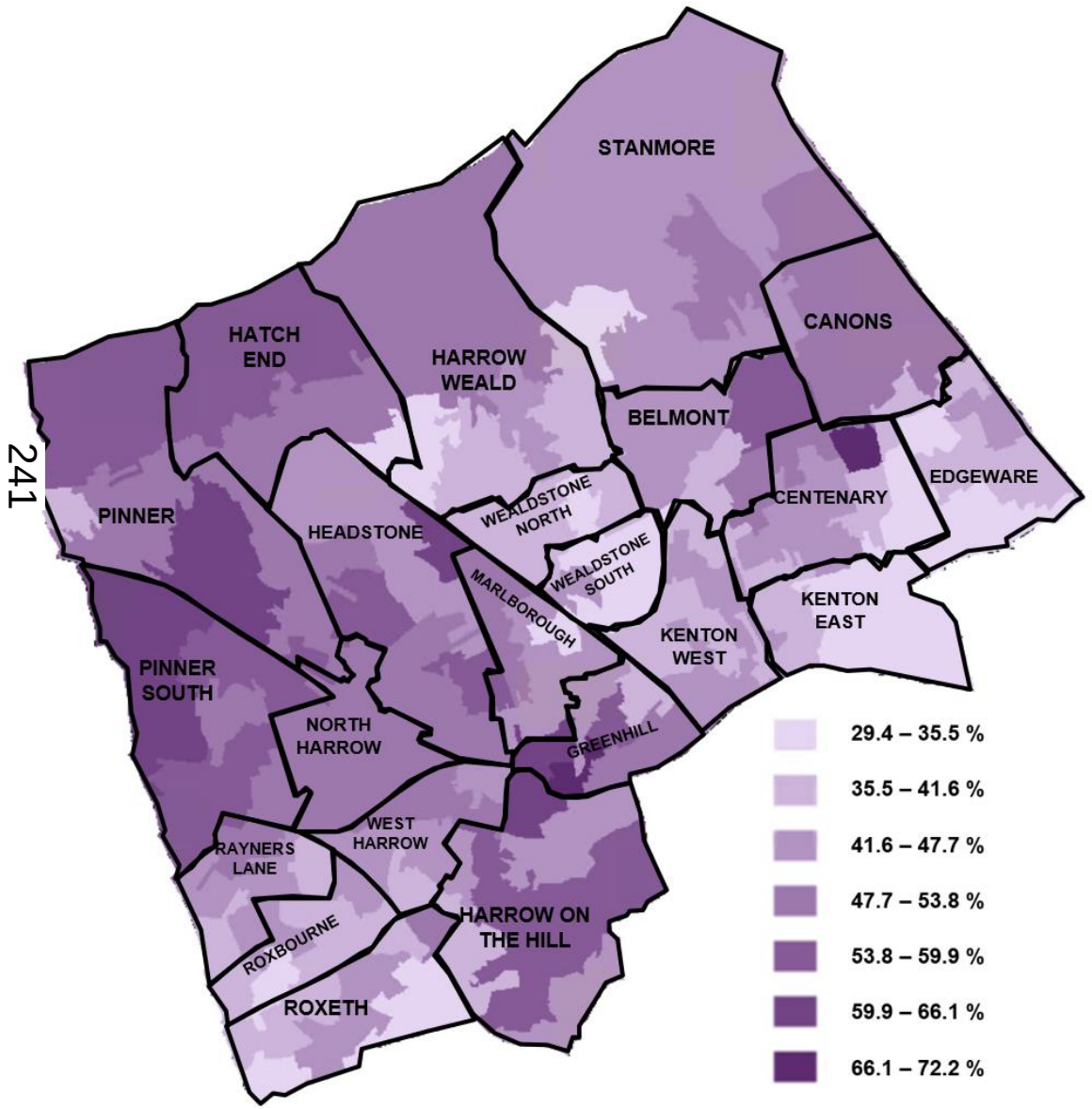


65 plus



Click image to return

Percentage of the Harrow population who have a degree level qualification or higher (Census 2021)



Percentage of adults in Harrow by qualifications held (Census 2021)

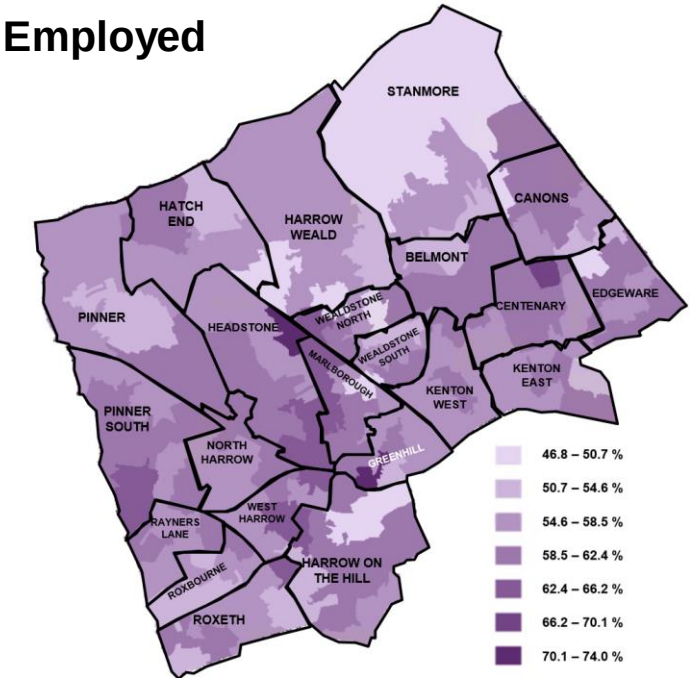
No qualifications	17.4%
Level 1 and entry level qualifications (e.g. 1 to 4 GCSEs grade A* to C)	8.2%
Level 2 qualifications (e.g. 5 or more GCSEs A* to C)	10.4%
Apprenticeship	3.2%
Level 3 qualifications (e.g. 2 or more A levels)	12.6%
Level 4 qualifications or above (e.g. degree or professional qualification)	45.0%
Other qualifications (e.g. work related qualifications)	3.2%

Click image to return

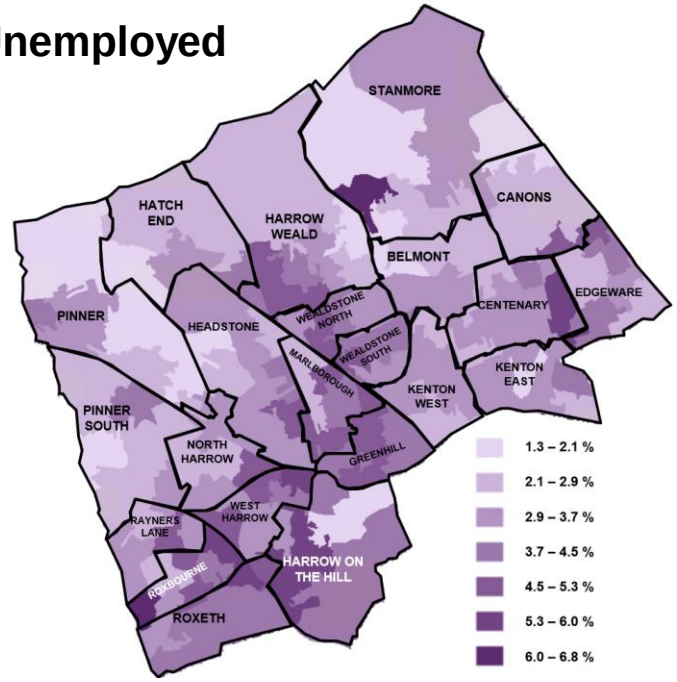
Employment profile of the Harrow population (Census 2021)

Click image to return

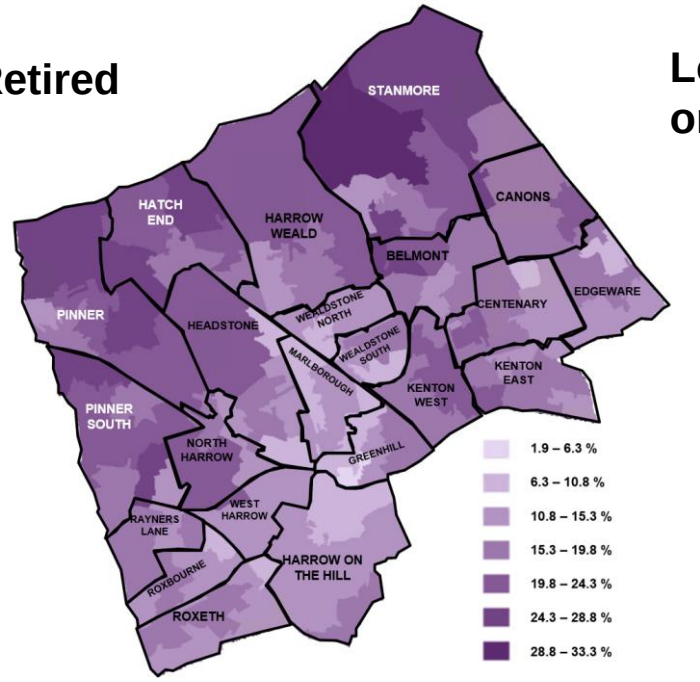
Employed



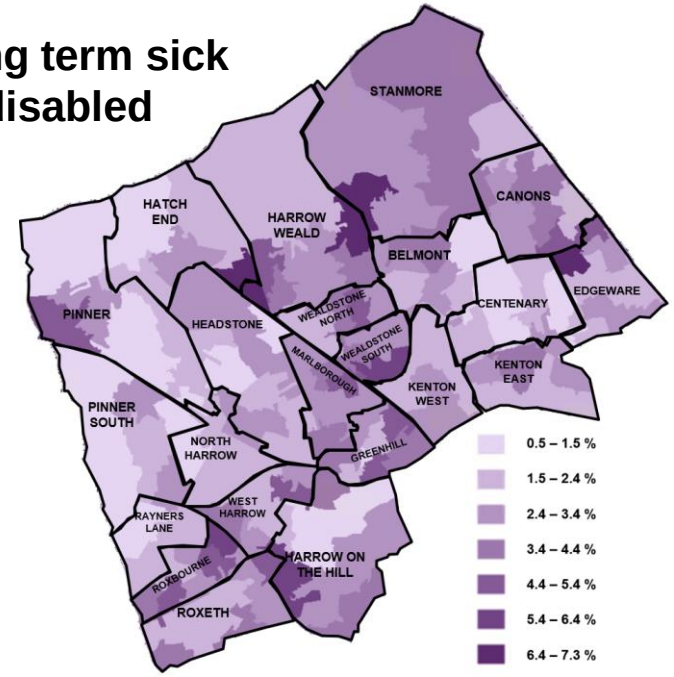
Unemployed



Retired

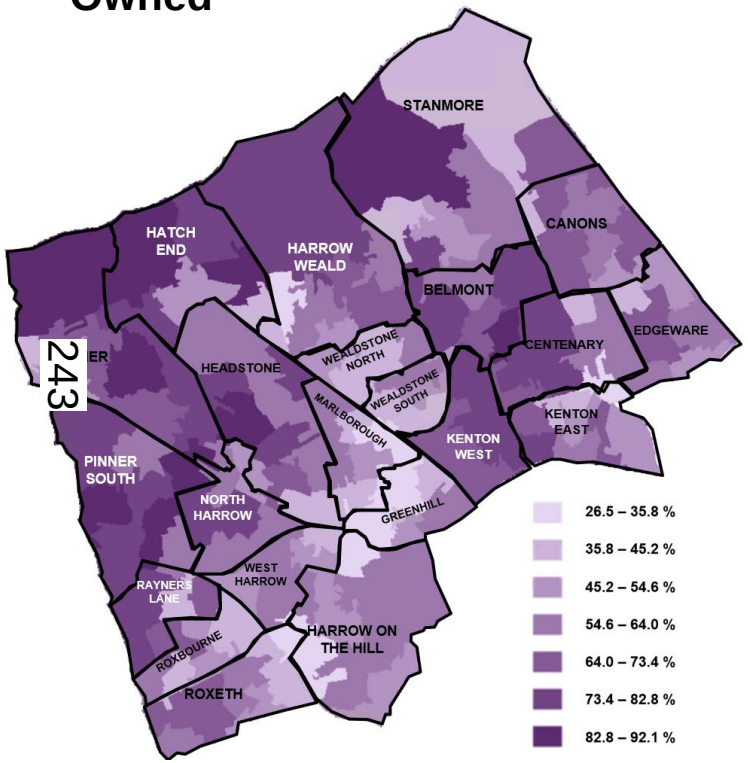


Long term sick or disabled

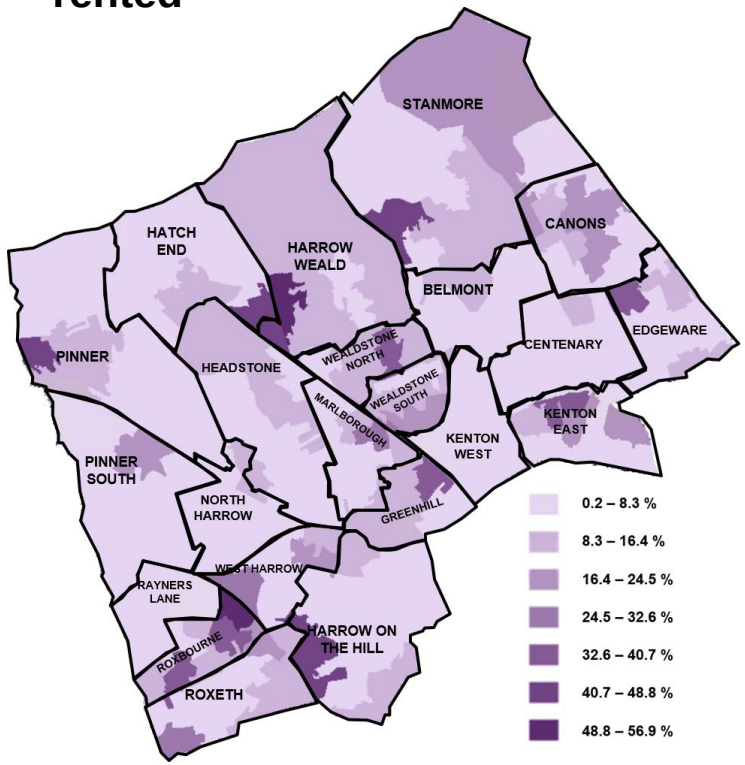


Housing tenure of the Harrow population (Census 2021)

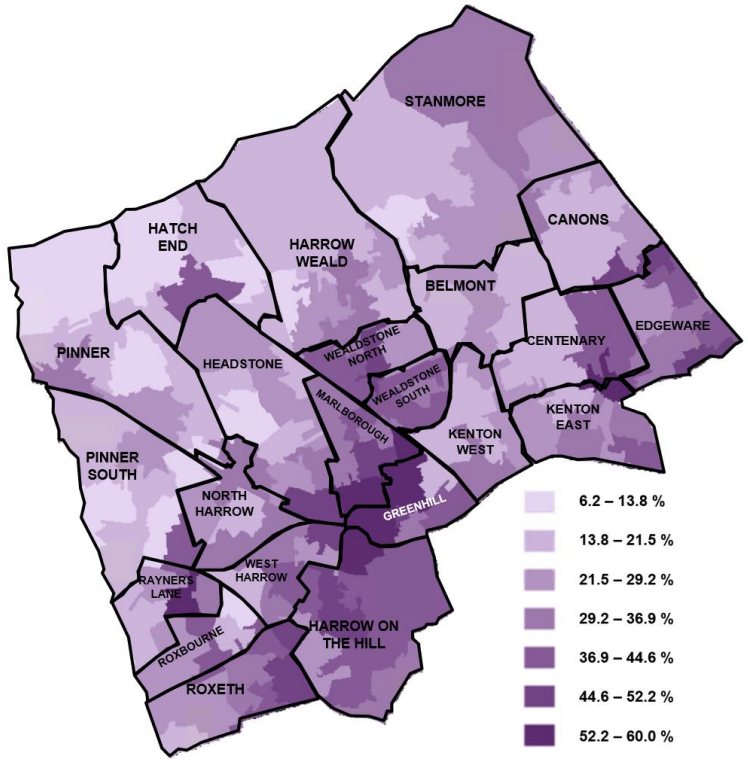
Owned



Socially rented



Private rented



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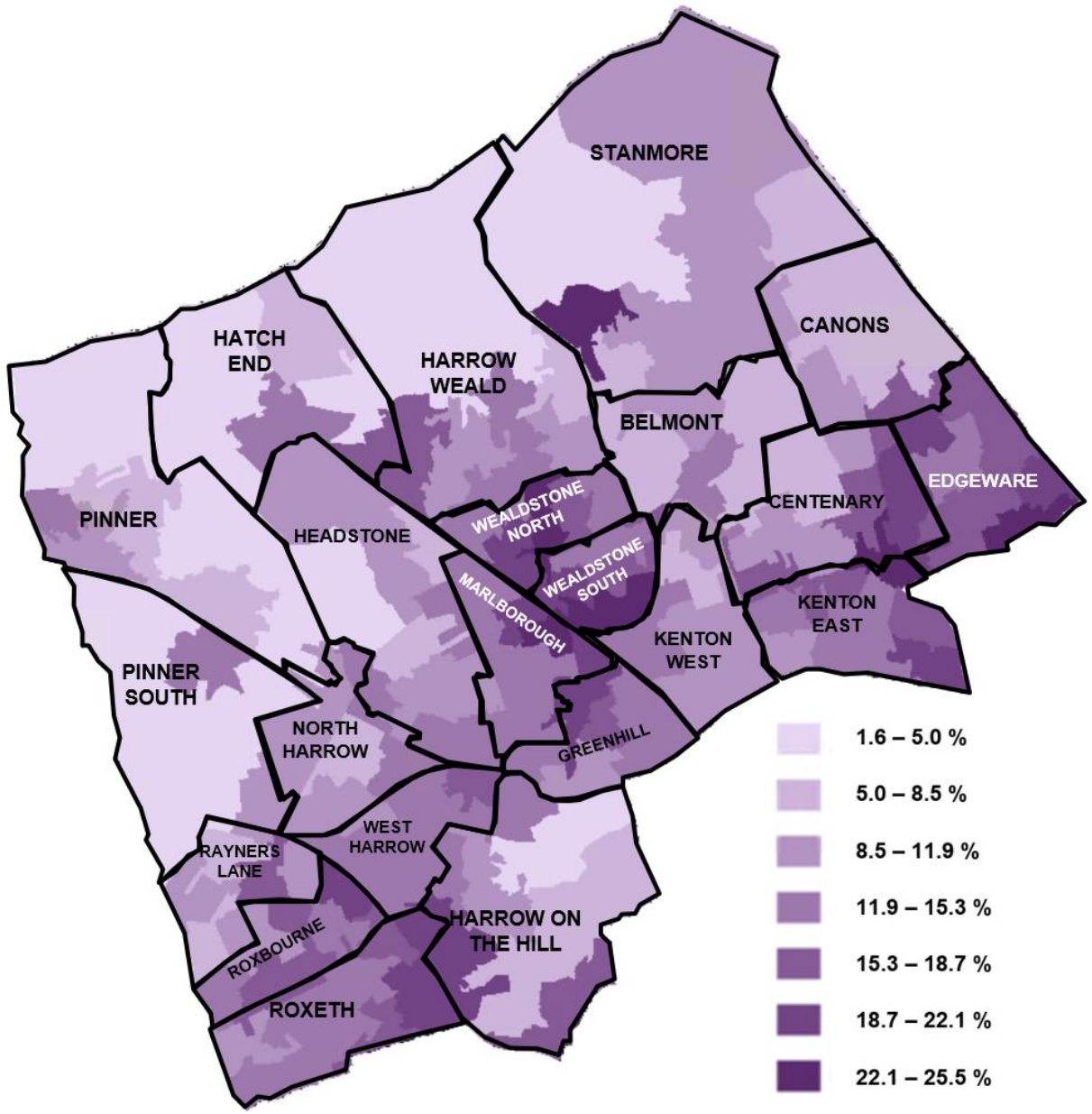
Overcrowded housing in Harrow (Census 2021)



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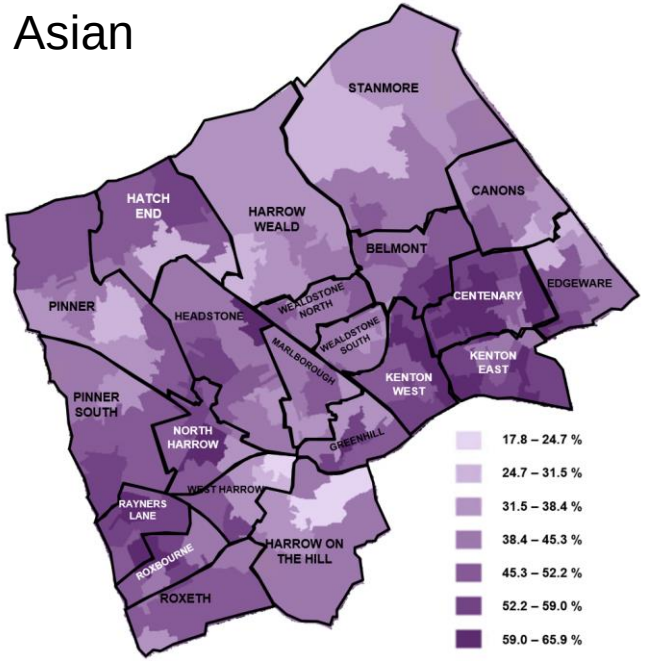
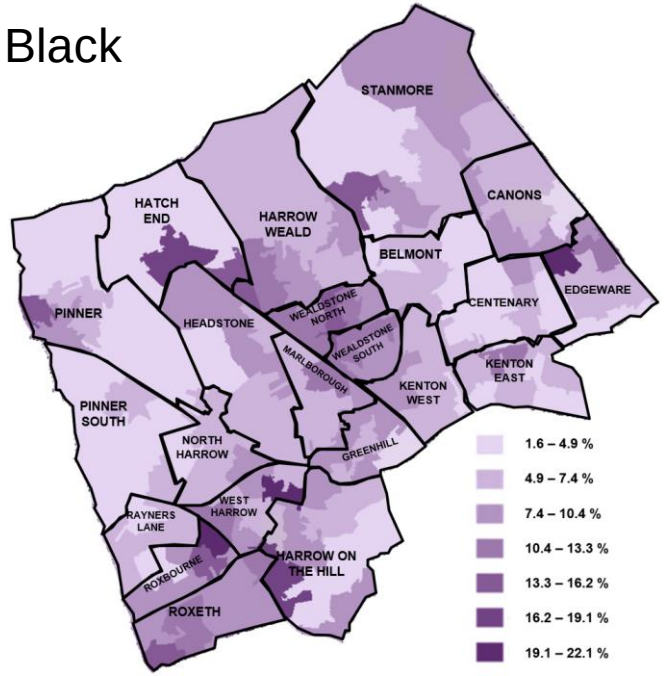
Ethnicity of the Harrow population (Census 2021)

Click image to return

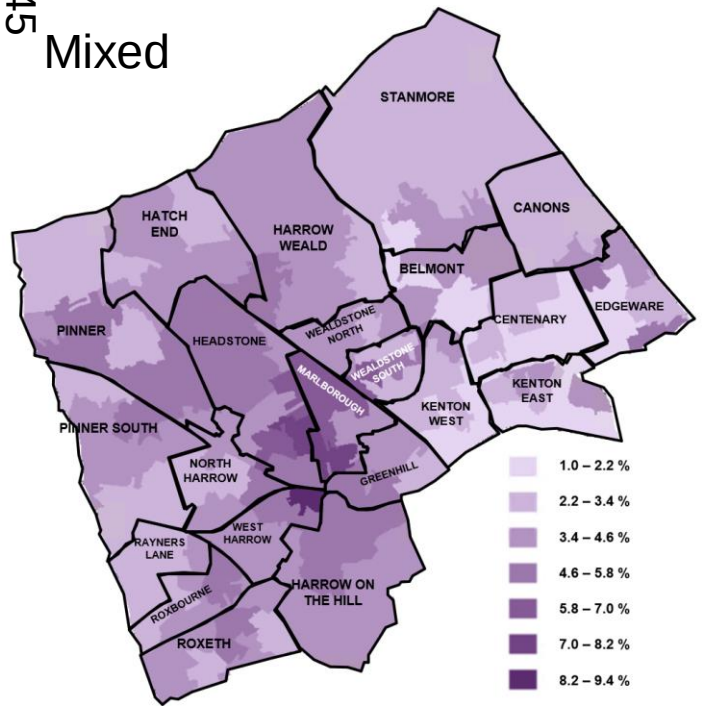
Asian



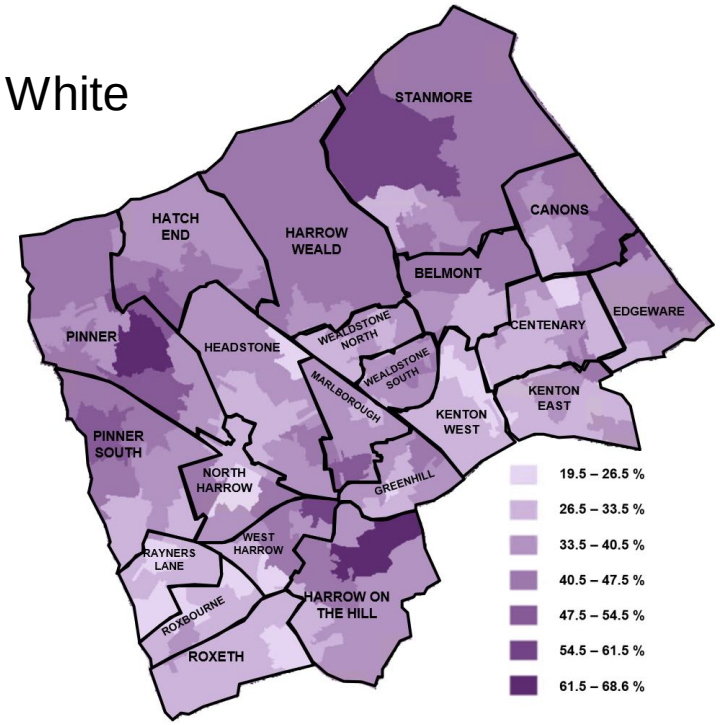
Black



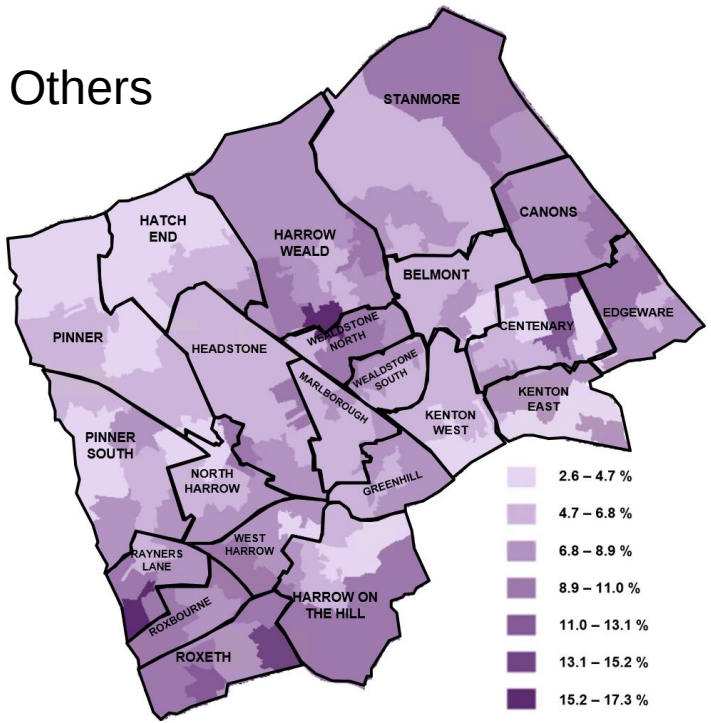
Mixed



White



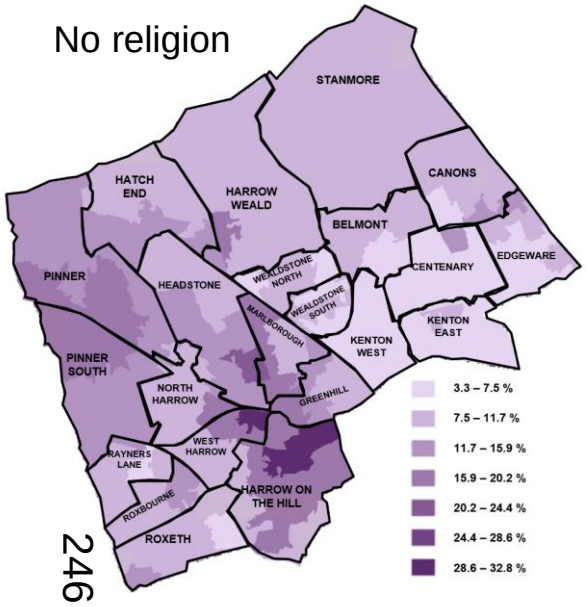
Others



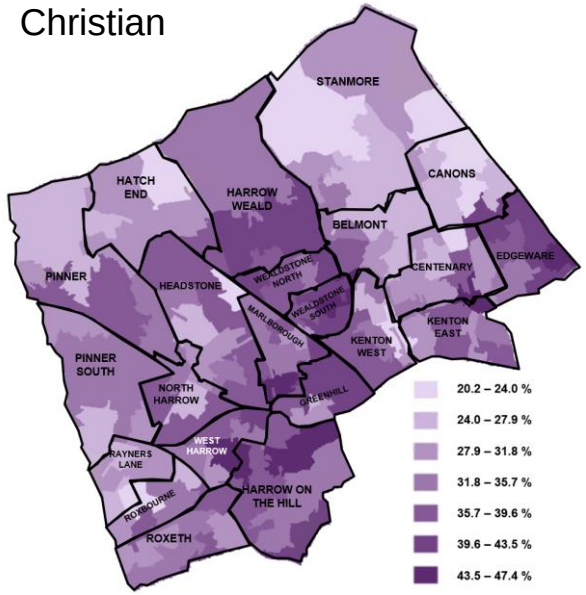
Religions of the Harrow population (Census 2021)

Click image to return

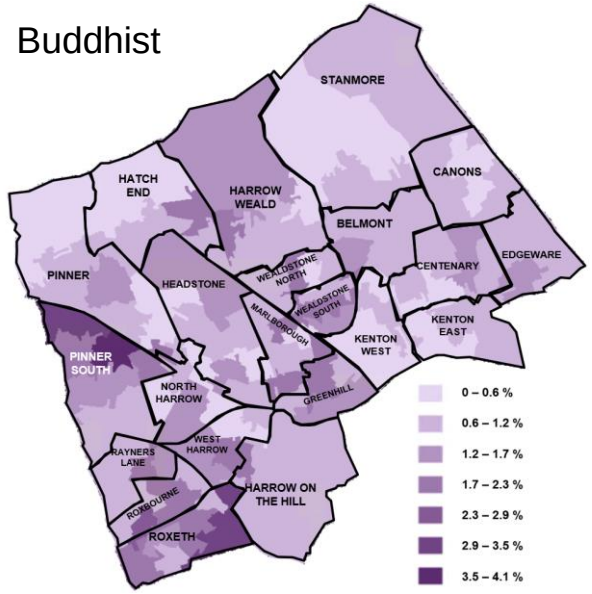
No religion



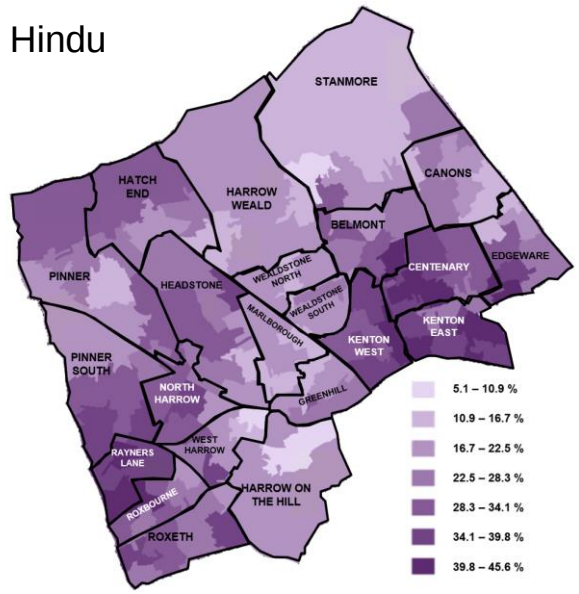
Christian



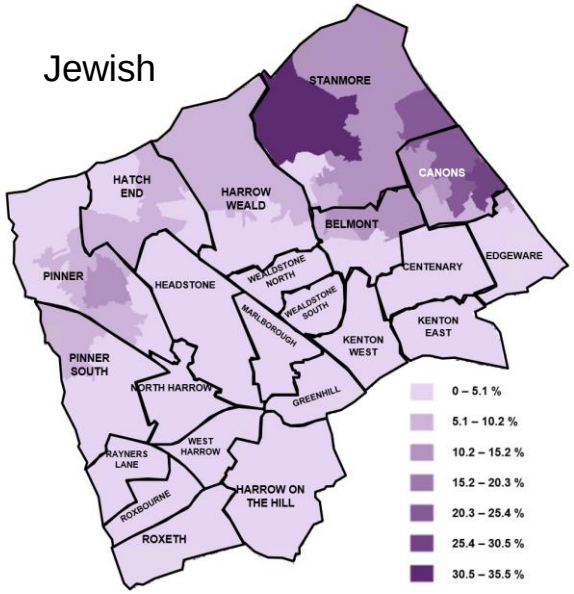
Buddhist



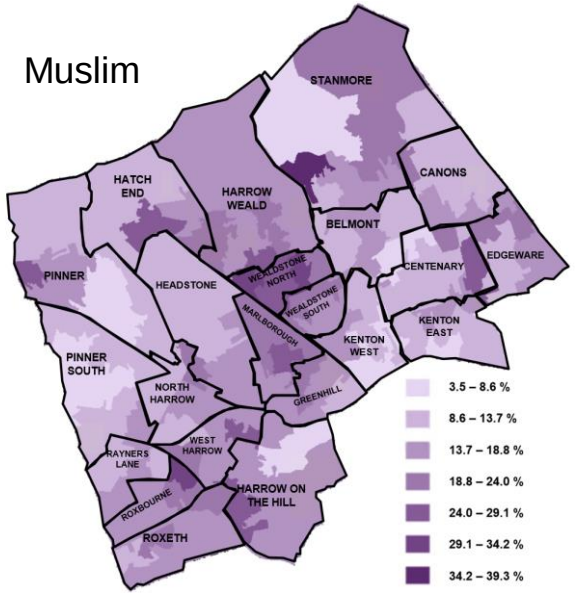
Hindu



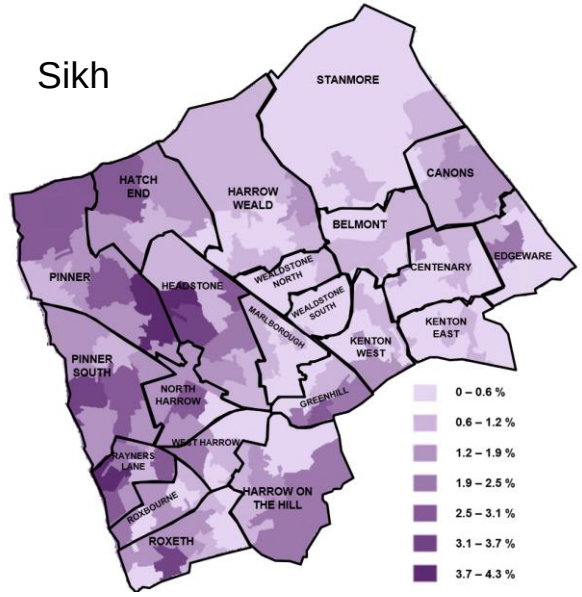
Jewish



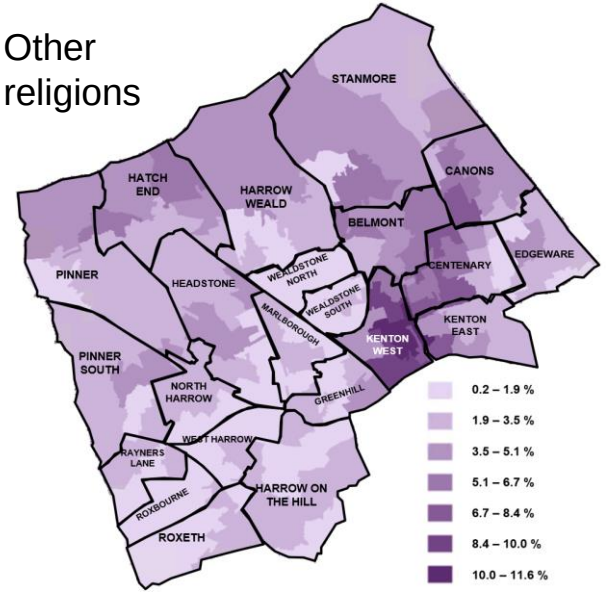
Muslim



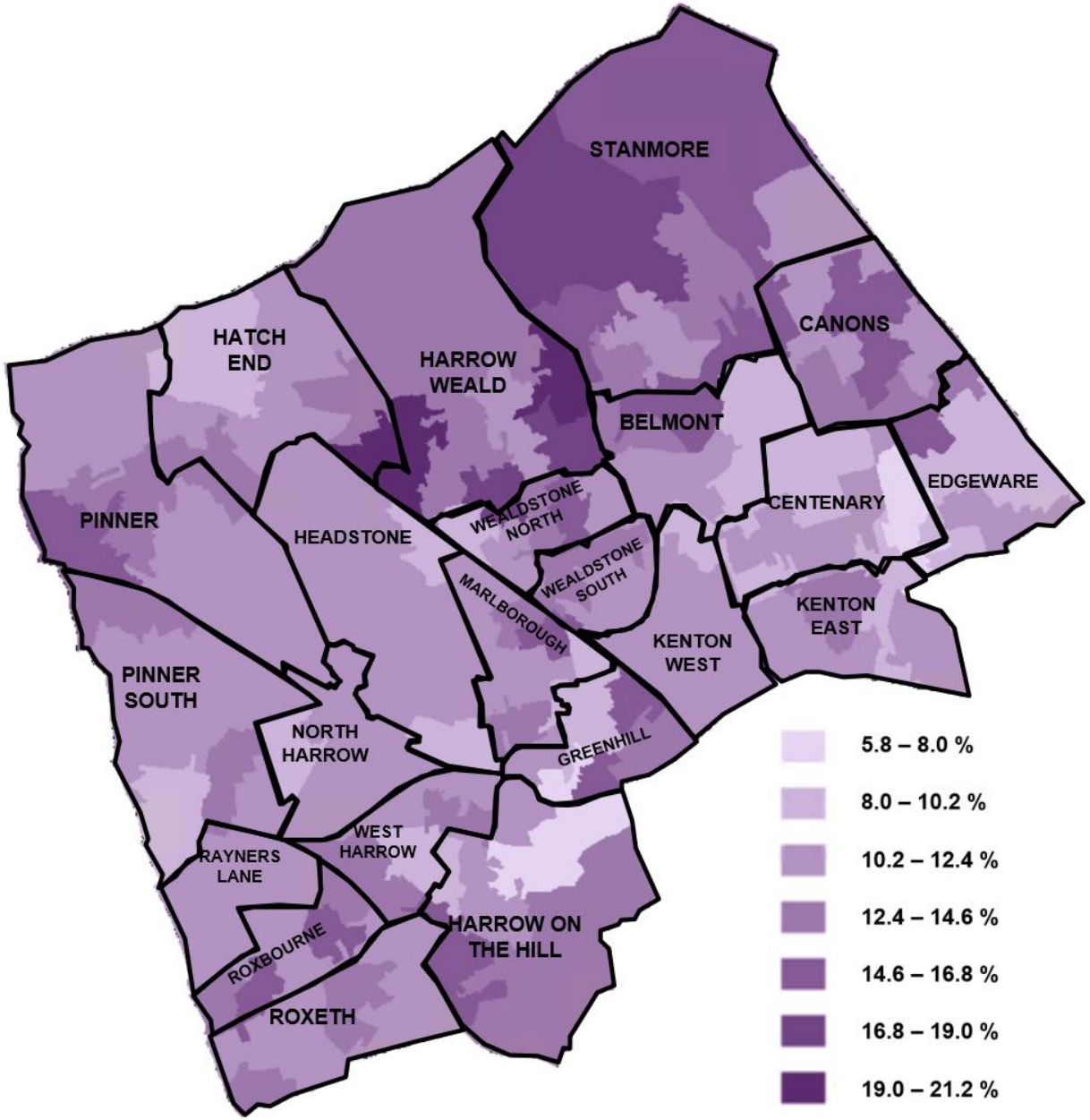
Sikh



Other religions



Percentage of Harrow population with a health condition which limits day to day activities (Census 2021)



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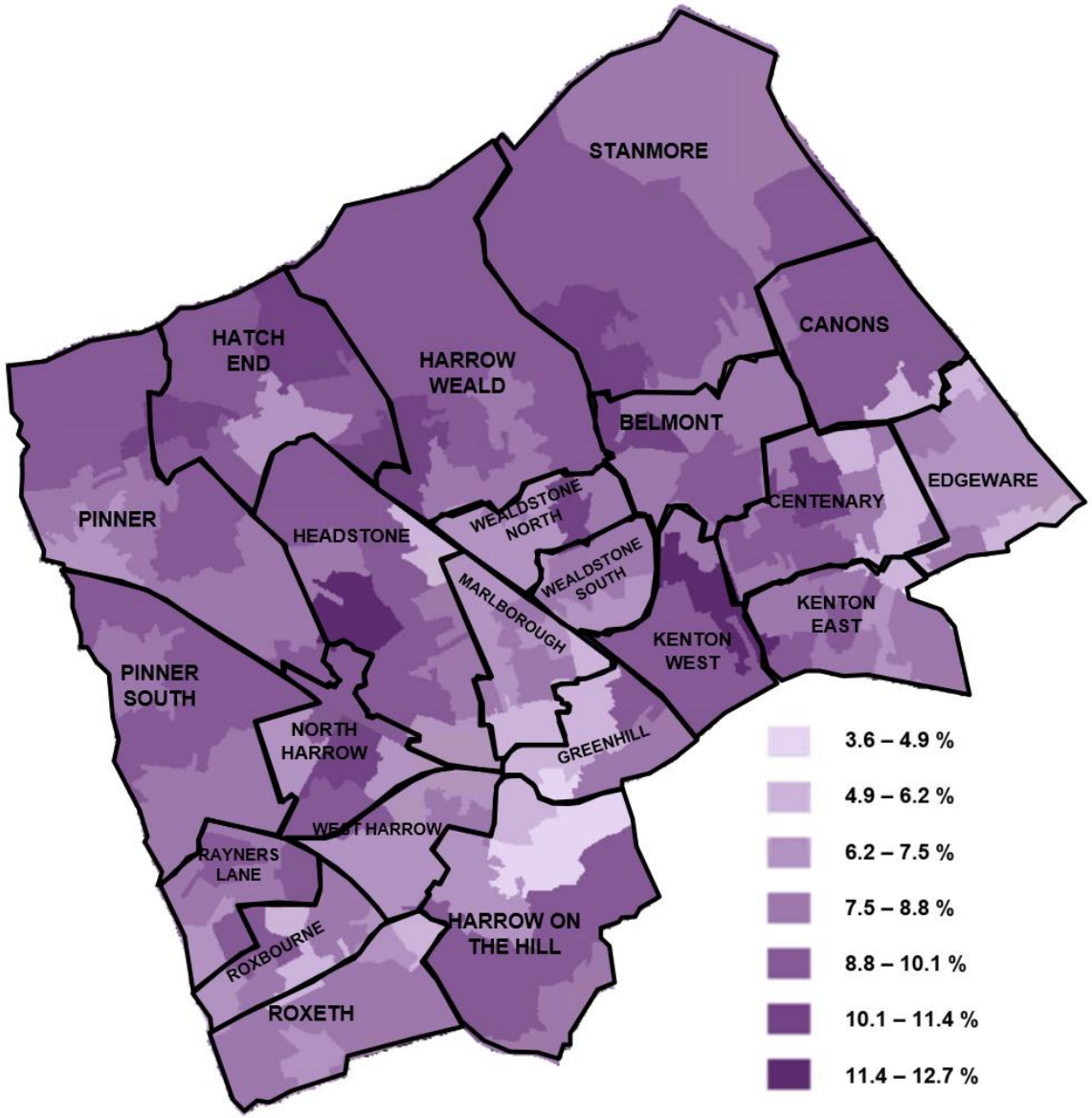
Percentage of the Harrow population who provide any unpaid care (Census 2021)



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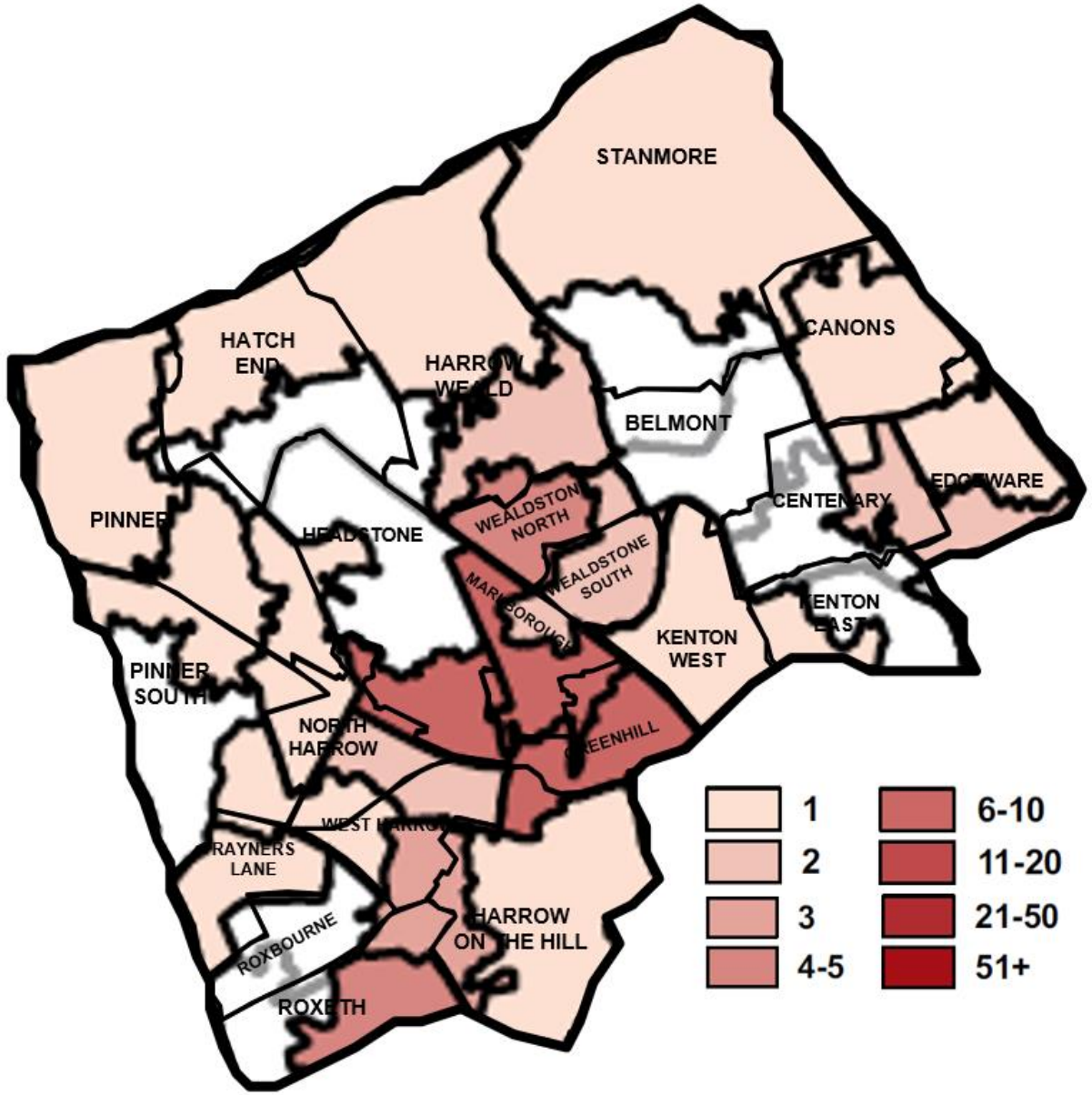
Area in Harrow where rough sleepers seen during 2021/22 (CHAIN)



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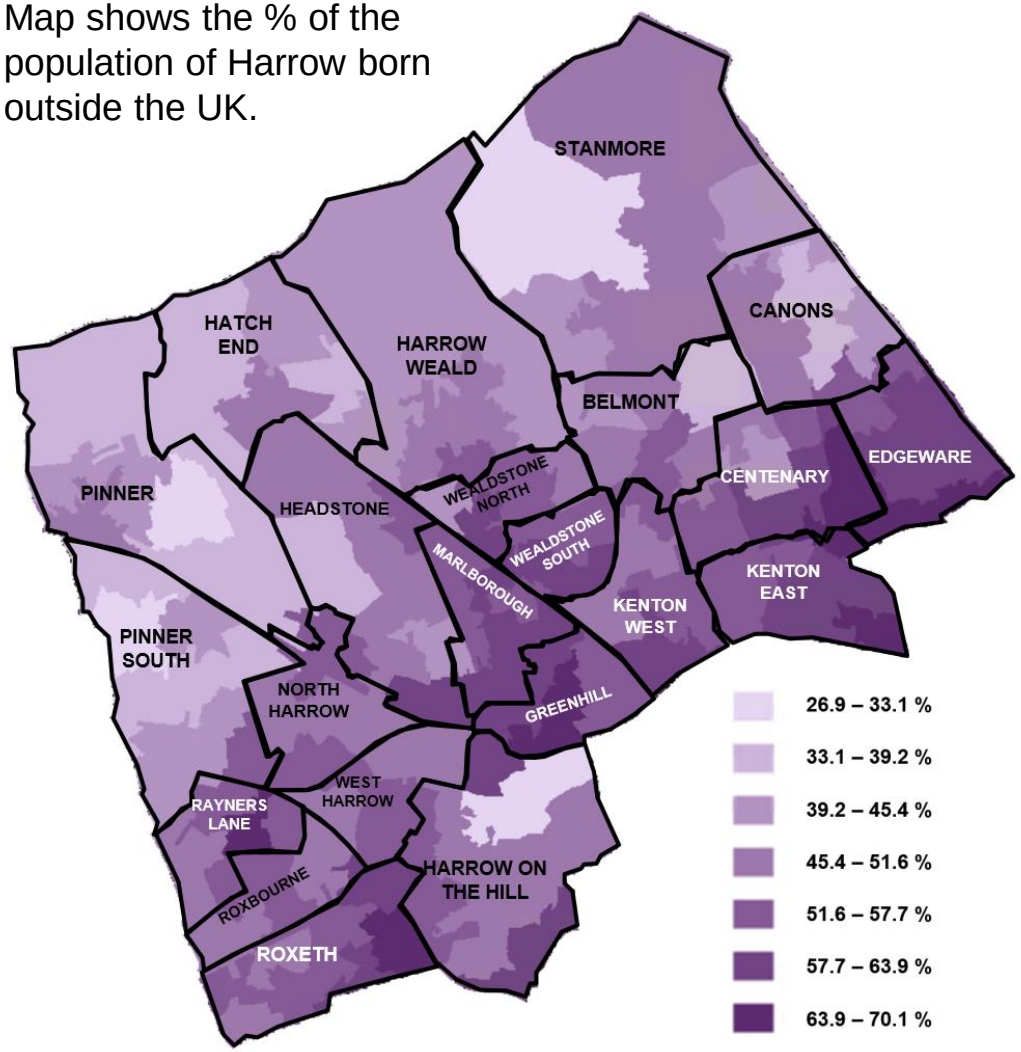
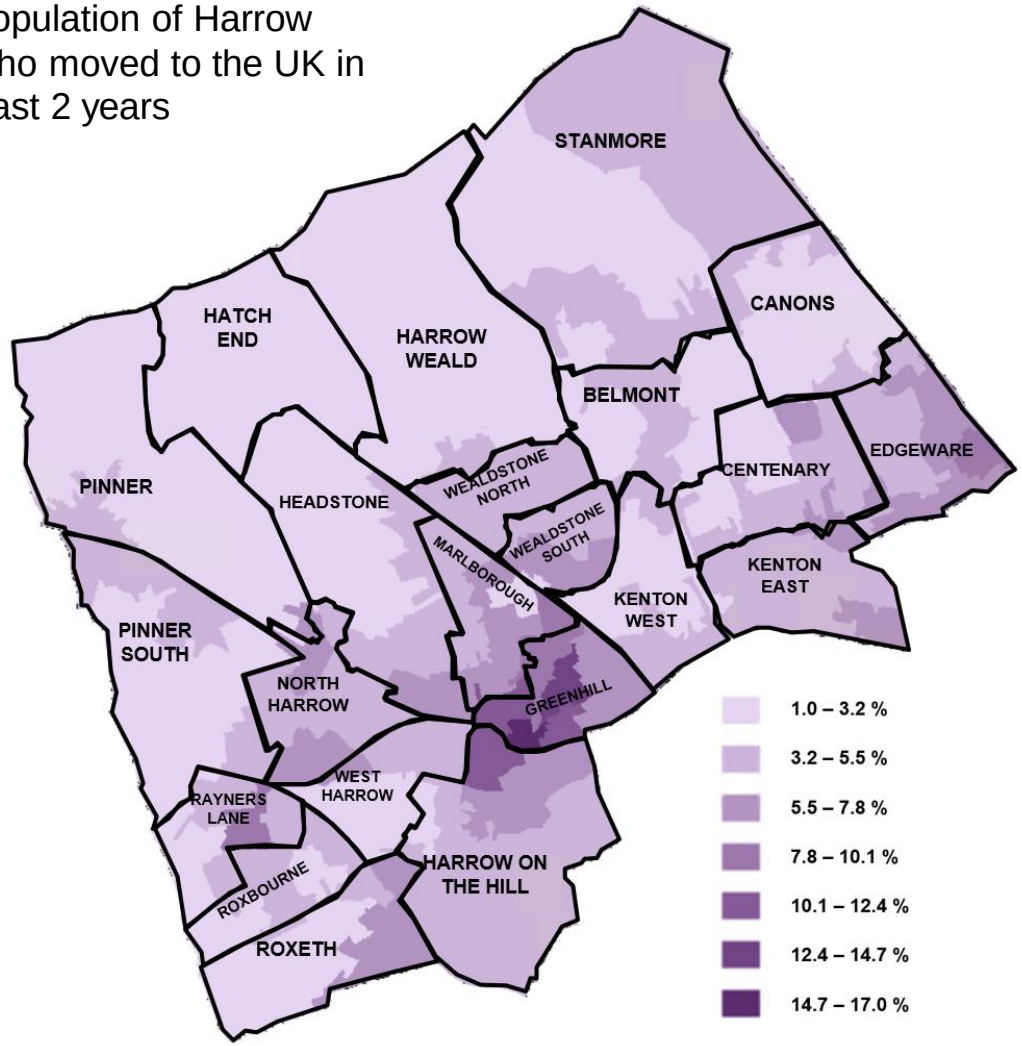
Migrants in Harrow (Census 2021)

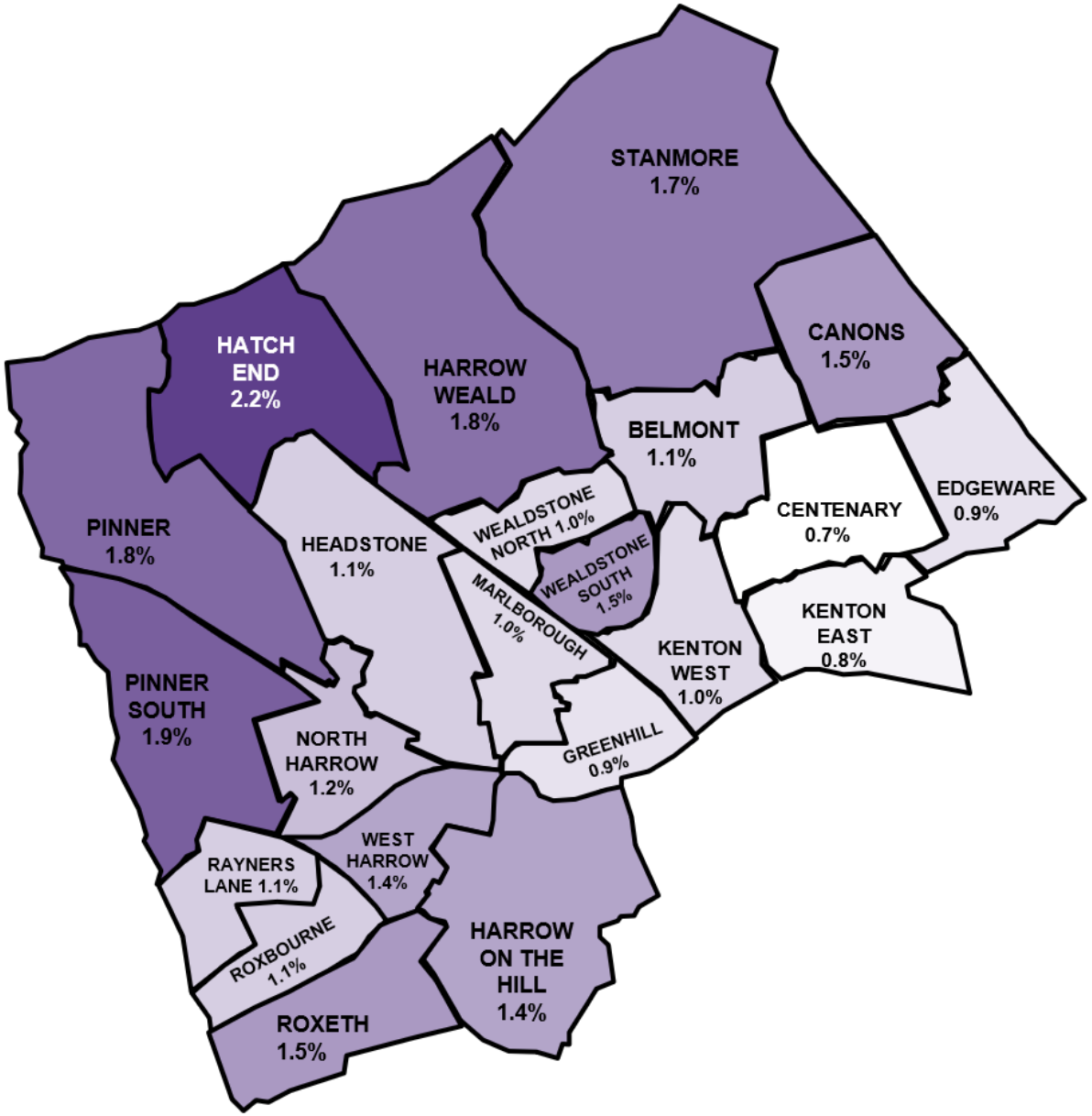
Map shows the % of the population of Harrow born outside the UK.



Map shows % of the population of Harrow who moved to the UK in past 2 years



Percentage of Harrow adult population who have previously served in the UK armed forces by Ward (Census 2021)



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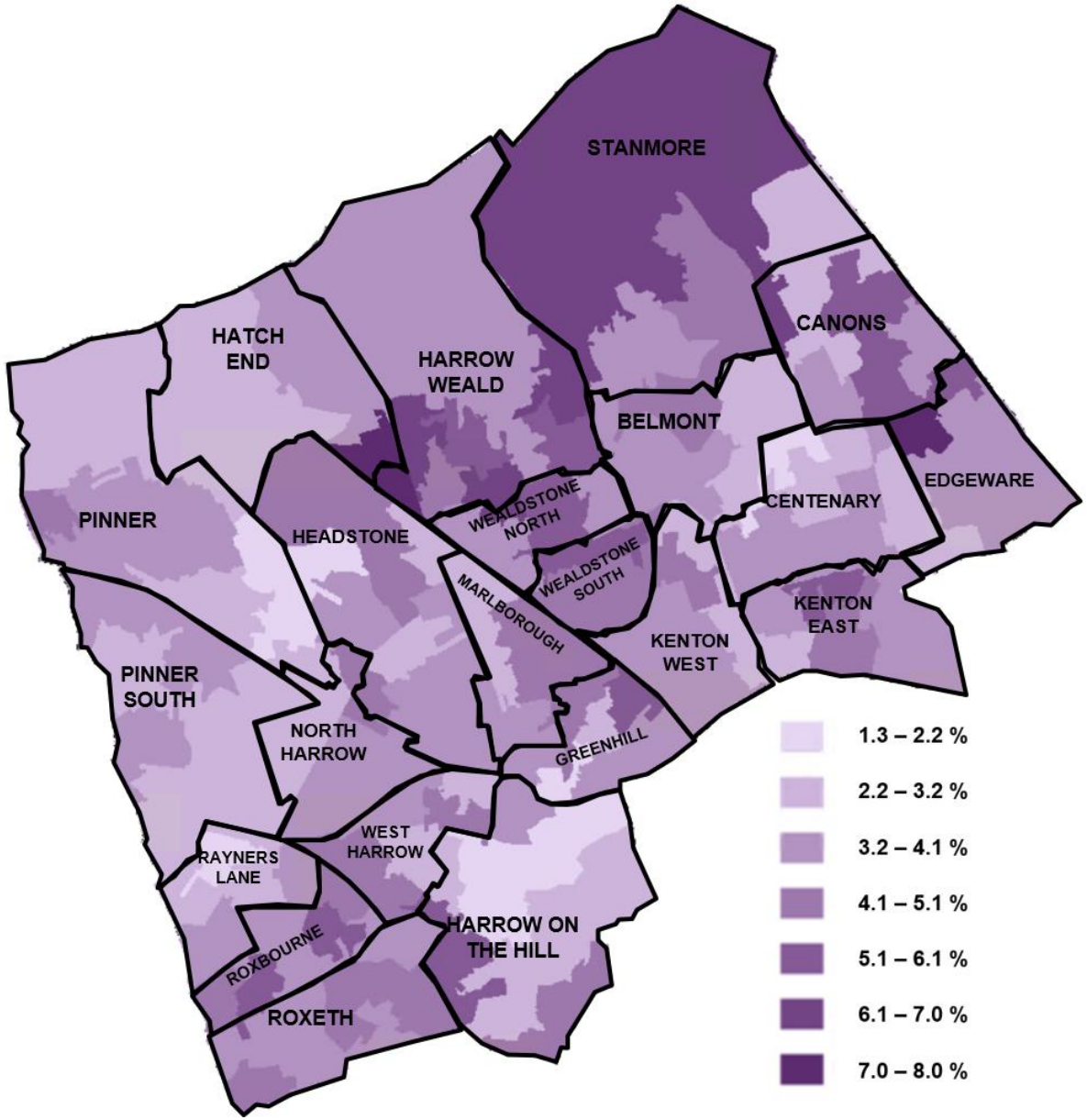
Percentage of Harrow residents reporting bad or very bad health (Census 2021)



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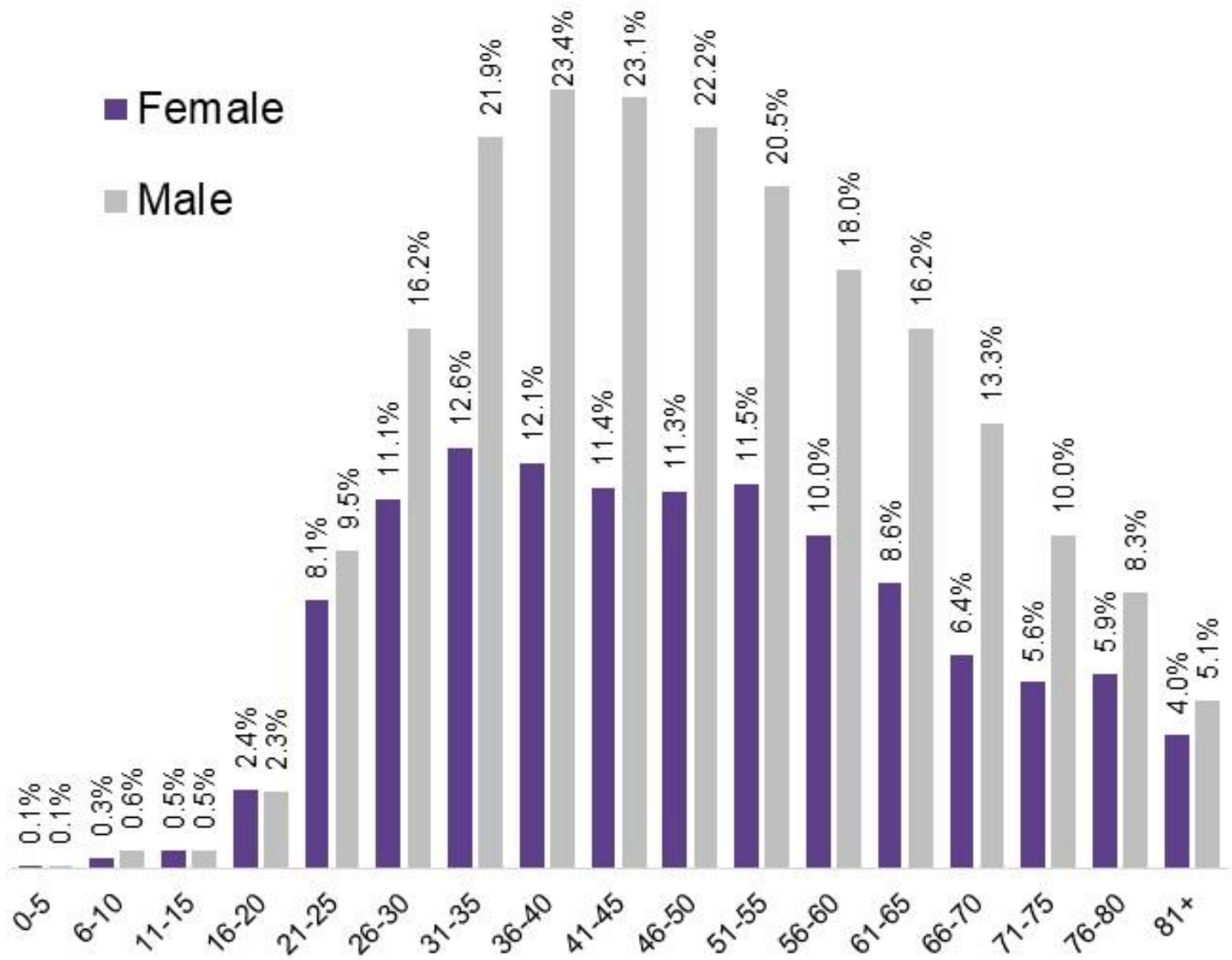
GP recorded rates of smoking in Harrow, by Sex and age (WSIC 2023)



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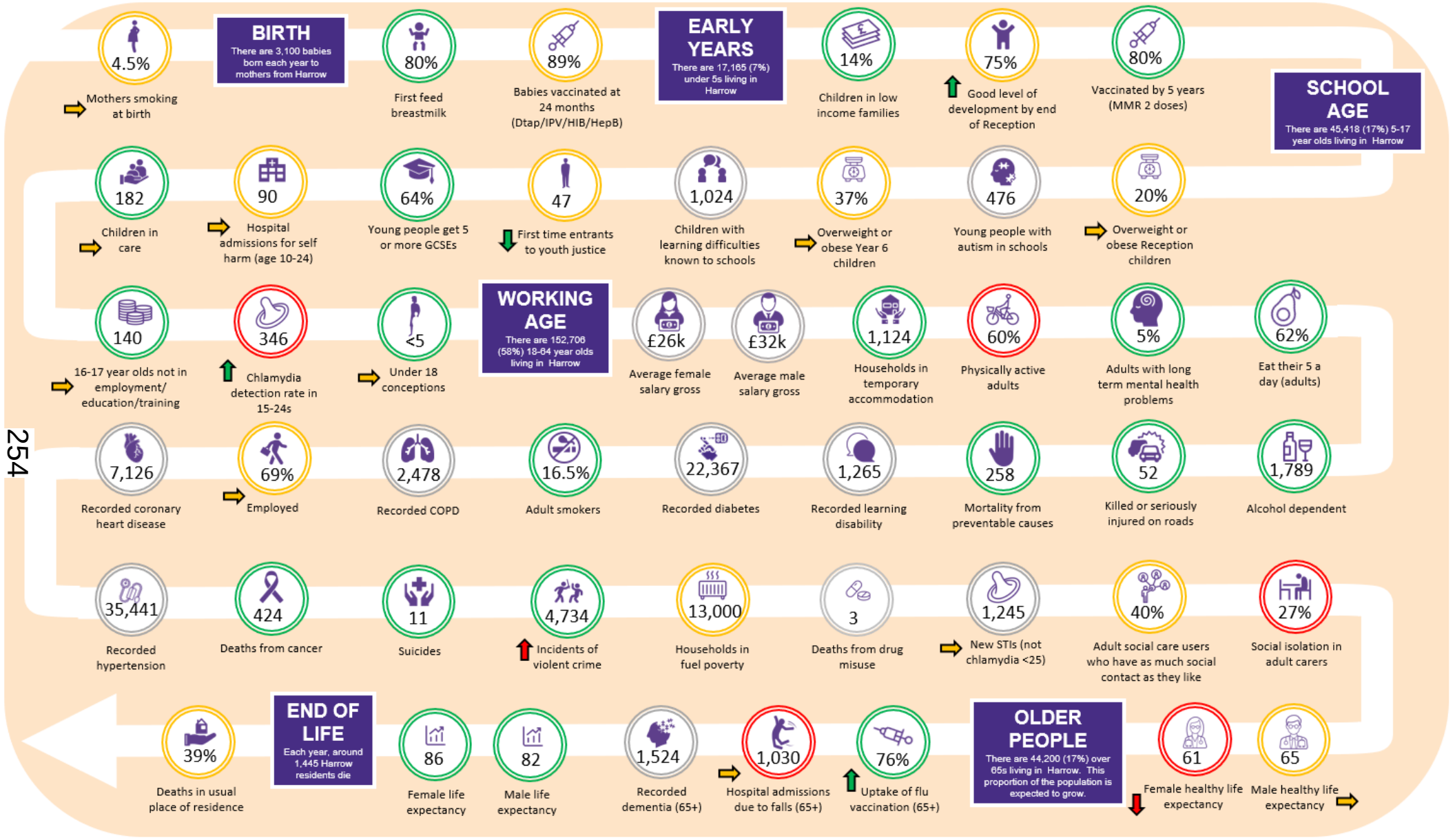
Population health across the lifecourse in Harrow

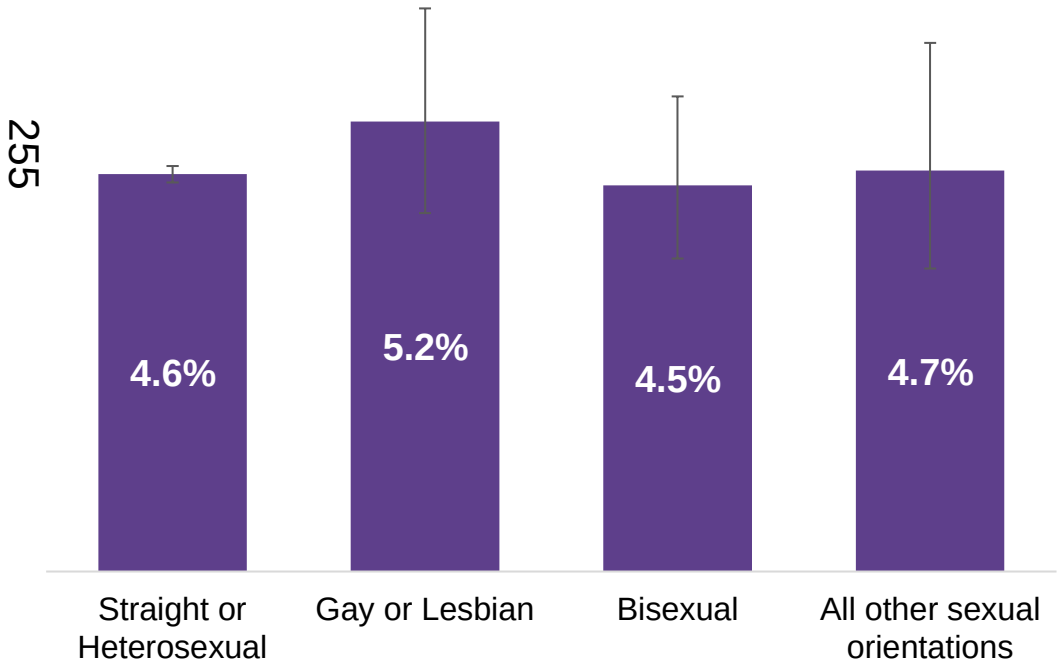


Data sources: Public Health Outcomes Framework, May 2022; Annual Survey of Hours & Earnings 2021; GLA 2020 based housing led population projections. **Notes:** Numbers are for the latest year available, and in some cases cover an average for a one year period, where numbers rather than percentages are shown. Some numbers have been rounded for clarity – please refer to the original data. Red indicates worse than the London average, amber similar, and green better. Grey indicates that the direction of the indicator isn't necessarily good or bad. Arrows indicate recent trend where available – green indicates improvement, red indicates worsening, and amber indicates no significant change.

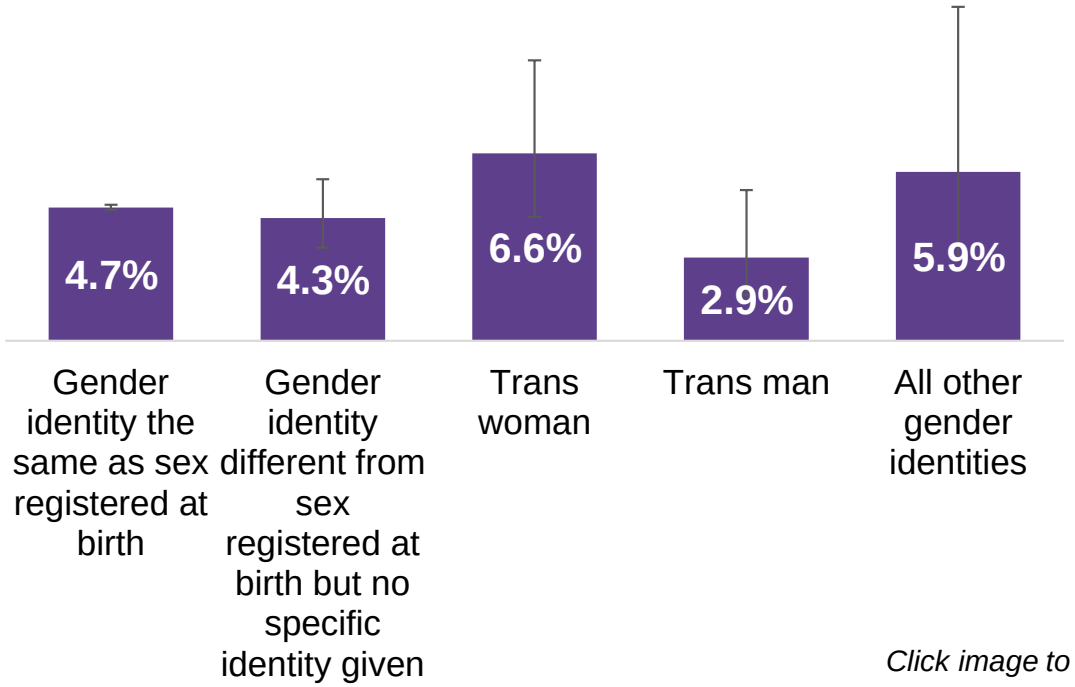
Click image to return

Harrow residents reporting poor or very poor health by sexual orientation and gender identity (Census 2021)

Sexual orientation

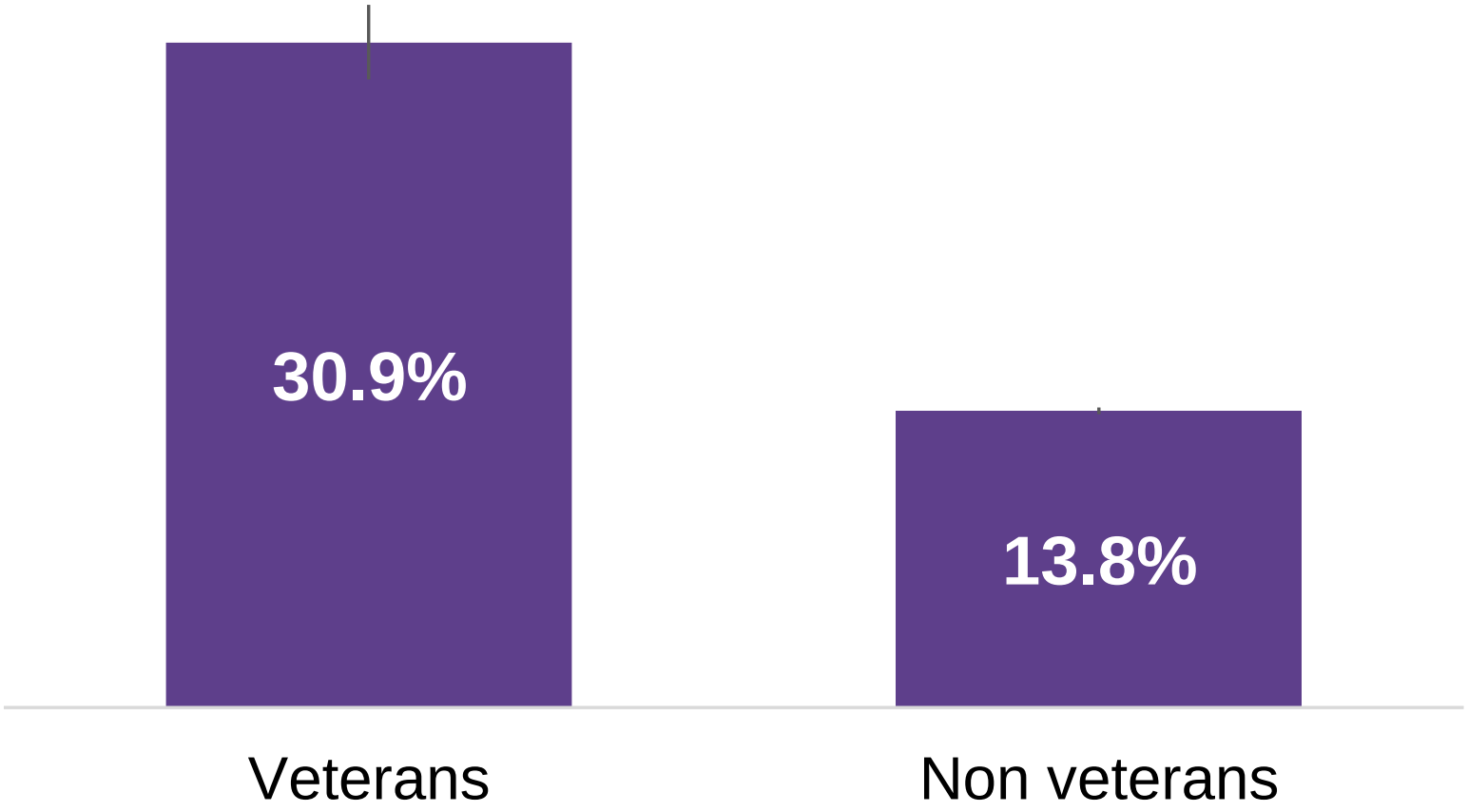


Trans or Cis Gender



Click image to return

Percentage of Harrow adult population who have previously served in the UK armed forces who report having a disability (Census 2021)



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LONDON BOROUGH OF HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	2 November 2023
Subject:	Health and Wellbeing strategy Update: Healthy Places
Responsible Officer:	Carole Furlong Director of Public Health Dipti Patel, Corporate Director of Place
Public:	Yes
Wards affected:	All
Enclosures:	Presentation

Section 1 – Summary and Recommendations

This report sets out the work and commitments being taken forward as part of the healthy place domain of the health and wellbeing strategy. This includes community safety and housing.

Recommendations:
The Board is requested to:

- Note the work that is underway and planned to support the delivery of the health and wellbeing strategy
- Endorse the approach being taken to improve the health and wellbeing of Harrow

Section 2 – Report

This update of the health and wellbeing strategy will cover aspects of the healthy places domain of the strategy. At this meeting, there will be a presentation of the community safety strategy and an update on housing including: homelessness, damp and mould, increasing the quality of existing council homes, and new affordable homes, with reference to partnership working.

They are being presented to the health and wellbeing board because each has an impact on the health and wellbeing of residents and those working and visiting the borough.

Community Safety

Harrow's community safety strategy is a statutory requirement for all community safety partnerships. This 3-year strategy sets the vision for one this administration's key priorities, to create a borough that is clean and safe, and has been produced in collaboration with key agencies to create an ambitious plan to ensure Harrow remains a borough with one of the lowest crime rates in London.

The process to produce this strategy involved collecting and analysing data which highlighted crime trends and areas where focus was most needed. These findings were taken to consultation workshops with Members, statutory partners and VCS organisations were all given the opportunity to reflect and inform the discussion and raise any community safety concerns identified by Harrow residents. Post-workshop engagement also took place to ensure we fully captured the discussions. This process allowed us to identify priorities and shape the key outcomes and actions outlined in this plan.

The strategy identifies six key community safety priorities for Harrow and outlines how each of these will be measured and progress monitored. The priorities are as follows:

- Tackling and Reducing Violence Against Women and Girls (VAWG)
- Reducing incidents of Burglary / Motor Vehicle Crime / Robbery
- Reducing the number of violent incidents in the borough
- Tackling and reducing offences and harm caused by drugs
- Tackling Hate Crime
- Perception of Crime and Anti-Social Behaviour

We anticipate that by working closely with our partners to implement this strategy we will ensure that Harrow remains one of the safest boroughs in London. A range of appropriate forums have been identified to deliver the action plan over the next three years.

Housing

1. Homelessness

London is in a severe housing affordability crisis due to the cost of living and changes in the Private Rented Sector (PRS). Average rents have gone up and there are limited housing options locally for families who need help from Housing Benefit or Universal Credit for housing costs and for families affected by the Benefit Cap.

Loss of private rented accommodation is the most common cause of homelessness in Harrow. Due to the small social housing stock in the borough private rented accommodation is the main housing solution but affordability is a challenge.

As it is difficult to find alternative affordable accommodation in Harrow, it is important for residents at risk of homelessness to try to avoid losing their current home and to seek help as early as possible. The Housing Needs service is successfully preventing more homelessness as a result of the early intervention initiatives in the B&B Elimination Strategy, such as the outreach programme. However, there are currently over 1000 households in temporary accommodation, with an increase in the use of nightly paid accommodation and B&B accommodation.

The Housing Needs service has a programme of initiatives to support rough sleepers in Harrow, offering them a route back to settled accommodation, including:

- an Outreach Team where specialist council officers tour the borough twice a week, building rapport with rough sleepers in order to support them off the streets
- a first stage Rough Sleeping Hub, with five private bedrooms which give service users a safe place to stay for 28 days and the opportunity to provide intensive support for personal issues
- a Rough Sleeping Accommodation Programme scheme, where 9 flats have been purchased to provide accommodation for rough sleepers and a Housing First style support service is delivered by a local VCS organisation.

The annual street count will take place on the night of 23 November. The Outreach Team, alongside partner agencies, will visit hot spots across the borough to identify the number of rough sleepers bedded down.

Housing works with a range of partners, both statutory and voluntary and community sector, who come together at the Harrow Homelessness Reduction Board and the Operational Sub-group. The Board aims to work in partnership to deliver the objectives of the council's Homelessness and Rough Sleeping Strategy. Colleagues from Public Health and the NHS are represented on the board.

On an operational level, Housing Needs works closely with Health, Children's and Adult Social Care on a range of important issues, including hospital discharge, care leavers and move on from supported housing. Housing Needs also works closely with services across the council on asylum accommodation and refugee resettlement.

2. Damp and Mould

The death of toddler Awaab Ishak in Rochdale, in which the coroner found that damp and mould contributed to his death, highlighted the need for all social landlords to ensure their approach to damp and mould is appropriate and effective. The London Borough of Harrow must deal with damp and mould effectively both as a local authority landlord and as an environmental health service.

It is usually the tenant's responsibility to prevent condensation and to remove mould when it appears, including taking steps to ventilate and heat their home adequately. This may be particularly challenging currently, in the context of the cost of living. If problems with damp and mould continue after the tenant takes basic steps to address them, they should report the problem to their landlord or accommodation provider. They should carry out an inspection and fix any issues that are caused by a repair problem or that are affecting the health and safety of the occupants.

If the landlord or accommodation provider does not respond or adequately address the problem the tenant should contact Environmental Health, particularly if they cannot use some rooms or the damp or mould is affecting their health. The Environmental Health Domestic Team is responsible for checking conditions in private rented accommodation and targets properties that are poorly maintained, overcrowded, and/or have damp and mould issues. The team works with landlords and managing agents, using enforcement powers where necessary to serve legal notices.

Residential licensing is also used in Harrow to improve standards in the private rented sector, with both mandatory and additional HMO licensing across the borough and selective licensing in specific wards.

Housing is leading a cross-council working group on damp and mould, with representatives from Environmental Health, Public Health, Children's, and other services. The group reviews data, is developing a strategy, and has commissioned a campaign which is being delivered by the Communications Team. The campaign includes improved information on the website, posters, leaflets, videos and social media resources. The leaflet will be translated into a range of community languages. The group is also promoting services that assist residents with energy efficiency and fuel poverty, such as the pan-London service SHINE (delivered by Islington Council) and the new Harrow Energy Advice and Support with the Cost-of-Living Project (funded by the UK Shared Prosperity Fund).

Within council housing stock, the Asset Management service responds to reports of damp and mould. A surveyor is responsible for carrying out inspections and instructing repairs works. A specialist contractor is used when needed. A decrease in reports would be expected in spring and summer

months, but this has not been the case this. This may be due to a Housing Satisfaction Survey in March which asked tenants whether they experienced damp and mould in their property, and a national government campaign to encourage tenants to complain to their social landlord about disrepair.

The new Asset Management Strategy commits to developing a Damp Risk Assessment programme. This will help identify potential problems so that the appropriate preventative measures can be planned, such as improving ventilation, and in turn minimising response repair works.

As part of the approach to decarbonisation, energy efficiency and reducing fuel poverty, the worst performing homes are being targeted. A fabric first approach is being taken with those properties where energy surveys indicate a rating of D and below. These improvements include insulation and ventilation systems which will help combat damp and mould.

3. Increasing the quality of existing council homes

Housing has secured £2.1 million from the government's Social Housing Decarbonisation Fund, which together with £3 million of investment by the London Borough of Harrow, is funding a two-year programme of extensive works to more than 236 council homes. This includes new windows, doors, roofs, ventilation and will boost the energy efficiency of the borough's poorest performing homes. The scheme will also pilot new green technologies including the installation of solar panels, under floor insulation and low energy lighting. These council tenants will benefit from lower energy bills and warmer homes.
As part of its ambition for council tenants to have good quality, secure, well-maintained homes, Housing has developed its 3-year capital programme. This includes programmes for new kitchens and bathrooms, replacement windows and doors, and Homesafe 3 (security and compliance).

4. New affordable homes

After many years in the making, Harrow has completed the first new homes in the regeneration of the Grange Farm Estate. The moving in process started this summer and the Housing Regeneration service is working with the secure tenants to support them through the transition. There are 69 social rented homes and 20 homes that are being marketed for sale as shared ownership properties.

There are 54 homes currently being built that received some grant from the GLA, under the Building Homes for Londoners programme (BCHfL). These are located on Milton Road, Brookside Close, Charles Crescent and Waxwell Lane, consisting of 28 London Affordable Rent and 26 shared ownership units.

The council has also received a grant allocation under the GLA Affordable Home Programmes 2021-2026 to deliver 175 homes (60 for social rent and 115 for shared ownership). These will be delivered via the Harrow Strategic Development Partnership (HSDP).

Housing Regeneration works in partnership with Planning, the HSDP, and Registered Providers (housing associations) to ensure that opportunities for affordable housing in the borough are maximised.

Housing Regeneration also works closely with Health, Children's and Adult Social Care on developing housing needs assessments for different groups in the community (i.e. older people, mental health, learning disability) and identifying appropriate housing solutions.

Financial Implications/Comments

There are no direct costs associated with delivering the health and wellbeing strategy.

Whilst there are no additional direct financial implications arising from this report, the prioritisation of strategy, through the wider system, will need to be contained within existing partner resources, which includes the annual public health grant.

Legal Implications/Comments

Section 116A of the Local Government and Public Involvement in Health Act 2007, stipulates that it is the responsibility of the local authority and integrated care boards to prepare a local health and wellbeing strategy.

The Health and Social Care Act 2012 provides responsibility to the Health and Wellbeing Board for the oversight of the local health and wellbeing strategy.

A key responsibility of the Health and Wellbeing Board is to therefore have oversight and accountability of the proposed strategy.

Risk Management Implications

The health and wellbeing strategy does not present any risks, or suggest any mitigation

Risks included on corporate or directorate risk register? **No**

Separate risk register in place? **No**

The relevant risks contained in the register are attached/summarised below. **n/a**

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? No

Harrow's Health and Wellbeing strategy plays a crucial role in advancing the equality, diversity, and inclusion agenda across the borough. By addressing the unique health needs of a diverse population, committing to addressing the

building blocks of good health as a priority, as well as ensuring that health and care services are accessible and tailored to different demographics, this therefore reduces health disparities and promotes equality. It also fosters inclusivity by actively engaging with underrepresented groups and involving them in the planning and implementation of initiatives - a key priority for this strategy. This strategy can help create an environment where all residents, regardless of their background or circumstances, feel valued, supported, and empowered to lead healthier lives, ultimately contributing to a more inclusive and equitable society.

Council Priorities

A council that puts residents first

A place where those in need are supported

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 17/10/2023

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 17/10/2023

Chief Officer: Senel Arkut
Signed by the Corporate Director
Date: 19/10/2023

Mandatory Checks

Ward Councillors notified: NO as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Carole Furlong, Director of Public Health,
Carole.Furlong@harrow.gov.uk

Background Papers:

Harrow Health and Wellbeing Strategy

If appropriate, does the report include the following considerations?

1.	Consultation	NO
2.	Priorities	NO

Safer Harrow Governance

LONDON BOROUGH OF HARROW

The Community Safety Strategy outlines Safer Harrow's three-year plan on how we will work to create a borough that is safe and clean, ensuring Harrow remains one of the safest boroughs in London.

There are 6 priority areas outlines in the Strategy:

- Tackling and Reducing Violence Against Women and Girls (VAWG)
- Reducing Burglary / Motor Vehicle Crime / Robbery
- Reducing the Number of Violent Incidents in the Borough
- Tackling and Reducing Offences and Harm Caused by Drugs
- Tackling Hate Crime
- Perception of Crime and Anti-Social Behaviour

The implementation of this strategy is delegated under each of these priority areas in the form of sub-groups via the **Community Safety Delivery Plan.**

Format of each sub-group

LONDON BOROUGH OF HARROW

Each sub-group will:

- Be chaired by a Senior Responsible Officer (who attends Safer Harrow) – this will be the direct link between Safer Harrow and the delivery of each priority area.
- Create an Delivery Plan which appropriately outlines actions and measures to achieve tangible outcomes.
- Identify relevant partners and subject matter experts who will sit on the sub-group, but will be supported by an officer for the running and management of their sub-group.
- Meet monthly to ensure actions are progressing against their delivery plan.
- Report back to Safer Harrow on a quarterly basis.

Delivery Plan Sub-Group Reporting

LONDON BOROUGH OF HARROW

Community Safety Strategy Theme:	Outcomes delivered under following sub-group:	Senior Responsible Officer
Theme 1 - Reducing incidents of Burglary / Motor Vehicle Crime / Robbery	Police Tasking meeting	Matt Cray
Theme 2 - Tackling and Reducing Violence Against Women and Girls (VAWG)	VAWG sub-group	Janice Altenor
Theme 3 - Tackling and reducing offences and harm caused by drugs	Combatting Drugs Partnership	Carole Furlong
Theme 4 - Perception of Crime / Anti-social Behaviour **Theme 5** - Tackling Hate Crime	Harrow Enforcement Safety Panel	Cathy Knubley / Shumailla Dar
Theme 6 - Reducing the number of violent incidents in the borough	Serious Violence Panel	Shumailla Dar

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LONDON BOROUGH OF HARROW

REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	2 November 2023
Subject:	Harrow Safeguarding Partners' Annual Report
Responsible Officer:	Produced on behalf of the Safeguarding Partners and presented by the Independent Chair of HSCB and Independent Scrutineer of the HSAB, Chris Miller
Public:	Yes
Wards affected:	Not applicable
Enclosures:	HSP Annual Report

Section 1 – Summary and Recommendations

This Harrow Safeguarding Annual Report covers the work of the partnership to safeguard both adults and children. This joint report reflects the integration of the support structures and funding for the Partnership as well as the joint work to strengthen awareness and understanding of safeguarding issues as they impact on all members of the family – so that children's services are able to identify and refer safeguarding concerns to adult services and vice versa.

It focuses on the activity of the Partnership carried out through the work of the sub-groups and the work of Board members to deliver Partnership objectives in their own services.

Recommendations:
The Board is requested to comment on and endorse the Annual Report.

Section 2 – Report

Ward Councillors' comments

Not applicable

Financial Implications/Comments

The Harrow Safeguarding Partnership budget is included in the appendices of the annual report.

The Harrow Strategic Safeguarding Partnership expenditure 2022-23 totalled £235k of which £72k was funded by partner contributions, leaving the balance of £163k funded by the Council.

There are no financial implications arising as a result of this report.

Legal Implications/Comments

As set out in the Report Summary, Annual Reports are required from the Adults and Children Safeguarding Partners under the terms of the Care Act 2014 and The Children Act 2004 respectively.

The key responsibilities for the Health and Wellbeing Board include

3.1.9. To provide a forum for public accountability of NHS, public health, social care and other health and wellbeing services.

Risk Management Implications

None

Equalities implications / Public Sector Equality Duty

None – Whilst the Statutory Safeguarding Partnership arrangements is not a separate public body with duties prescribed to it under The Equality Act 2010, partner agencies, who are public bodies are, in the course of their work, subject to the Act's Public Sector Equality Duty under s149.

Council Priorities

The Partners work to agreed multi-agency priorities and this report describes how they work together to help children thrive and to keep them safe from harm

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Statutory Officer: Jo Frost
Signed on *behalf of/by the Chief Financial Officer
Date: 19/10/2023

Statutory Officer: Sharon Clarke
Signed on *behalf of/by the Monitoring Officer
Date: 19/10/20232

Chief Officer: Senel Arkut
Signed by the Corporate Director
Date: 19/10/2023

Section 4 - Contact Details and Background Papers

Contact: Alison Renouf - Harrow Safeguarding Partnership Manager. Available on: alison.renouf@harrow.gov.uk

Background Papers: N/A

HARROW SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2022/2023

Alison Renouf

HARROW SAFEGUARDING PARTNERSHIP MANAGER

1. Introduction

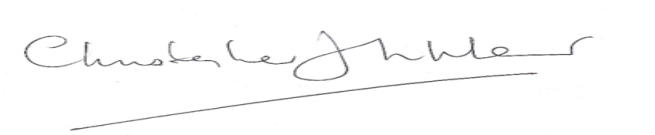
This Harrow Safeguarding Annual Report covers the work of the partnership to safeguard both adults and children. This joint report reflects the integration of the support structures and funding for the Partnership as well as the joint work to strengthen awareness and understanding of safeguarding issues as they impact on all members of the family – so that children's services are able to identify and refer safeguarding concerns to adult services and vice versa.

It focuses on the activity of the Partnership carried out through the work of the sub-groups and the work of Board members to deliver Partnership objectives in their own services.

2. Report of the Chair of the Safeguarding Adult Board and Scrutineer for the Safeguarding Children Board

Introduction - June 2023

The Partnership is generally reflective and cooperative and demonstrates that it is capable of learning and improving. This report and the more in depth and focused JTAI review of Early Help both set the HSSP some questions about how they can ensure that their Arrangements remain effective.



Chris Miller
Independent Chair of and Scrutineer to
Harrow Safeguarding Children Partnership

Context

The Children and Social Work Act 2017 and Working Together 2018 (WT18) requires the three key Harrow Safeguarding partners - the North West Basic Command Unit of the Metropolitan Police, the North West London Integrated Care Board (ICB) and Harrow Council (the Partners) to establish in Harrow effective Multi-Agency Safeguarding Arrangements (for children). The Partners are also required to establish for Harrow a safeguarding adults board (HSAB).[1] The current safeguarding arrangements, which relate to both children and adults, ***The Harrow Safeguarding Partnership Arrangements***[2] (the Arrangements) were originally published in June 2019[3] and were revised in February 2022. The HSAB is required to publish an annual strategic plan. In common with many other safeguarding adults' boards

[1] Care Act 2014 Sec 43 and Schedule 2.
[2] https://www.harrowscb.co.uk/wp-content/uploads/2023/03/Harrow-Safeguarding-Children-Arrangements-Revised-Feb-2022-2-003.pdf
[3] As required by the Children Act 2004 sec 16 G (2)'

HSAB, in 2021, published a three-year plan[4]. Annually the Partners are required to report both on what they have achieved in relation to their SAB strategic plan[5] and also what they have achieved in relation to the Arrangement and how effective those arrangements have been[6].

Independent Scrutiny

The partners are also required to provide for independent scrutiny of their Arrangements[7]. The Children Act does not describe how the Partners should go about providing independent scrutiny. They can provide this scrutiny how they see fit. The way that the Partners in Harrow provide for this is described at section 13 (page 20) of the Arrangements**.** Independent scrutiny should provide assurance about the effectiveness of the Arrangements and should include scrutiny of how the Partners identify and review serious child safeguarding cases. The independent scrutiny requirement is a feature of the Children Act but not of the Care Act but Harrow's partners have decided that where it is possible to do so the same scrutiny arrangements should apply to the safeguarding of adults as well.

The Six Steps for Independent Scrutiny[8]

This independent scrutiny report deals with the following six areas,

- The three core partner leads are actively involved in strategic planning and implementation
- The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and adults.
- Appropriate quality assurance procedures are in place for data collection, audit and information sharing
- There is a process for identifying and investigating learning from local and national case reviews
- There is an active programme of multi-agency safeguarding training.
- Children, young people, families and service users are aware of and involved with plans for safeguarding children and adults.

The three core partner leads are actively involved in strategic planning and implementation

The Partners exercise oversight of and provide support to the safeguarding children board and the safeguarding adults board through its strategic safeguarding partnership. (HSSP) The Arrangements (page 13) describe the membership and function of this group and it meets three times a year. The HSSP is chaired on a rotational basis by the three strategic partners and attendance of the HSSP of all

[4] https://www.harrow.gov.uk/downloads/file/29124/hsab-strategic-plan-2021-24
[5] Care Act 2004 Schedule 2 (sec 4)
[6] Children Act 2004 sec 16 G (7)
[7] Children Act 2004 sec 16 G (3)

[8] Taken *from Six Steps for Independent Scrutiny: Safeguarding Children arrangements. Institute of Applied Social Research, University of Bedfordshire, Pearce, J (2019)*

members of the core agencies is good, which demonstrates cooperative and active involvement in the delivery of the safeguarding function in Harrow. However, since the original publication (2019) and subsequent revision (2022) of the Arrangements the membership of the group, which for a strategic grouping was already large has grown even larger. Its strategic planning and implementation functions are not as distinct from the operation of the HSCB and HSAB as the Arrangements suggest they should be.

The Joint Targeted Area Inspection (JTAI) of Services for Children and Families who need Help,[9] which took place in the performance year (albeit the letter reporting the JTAI findings was published outside the reporting year) discovered weaknesses in the oversight function of the HSSP in relation to Early Help.

Whether an inspection of HSSP's oversight of other aspects of multi-agency safeguarding would deliver a concurring finding is moot, but the recent JTAI offers an opportunity for HSSP to restate and review its strategic function.

The Arrangements rely heavily on the work of three subgroups to deliver multi-agency oversight. The chairing and management of the subgroups is shared by a range of partners, but unlike the HSSP this responsibility is not rotated among the partners. Retaining the same chair and management regime for the subgroups provides helpful stability but does not necessarily lead to shared understanding and ownership. HSSP does not have a work plan with milestones for delivery. Some sort of forward planner that provides a calendar of future reports and scheduled activities would provide purpose and focus to the HSSP. Historically the funding for the support of the Arrangements by the three core partners has lacked equity and transparency. Harrow Council have borne the burden of this by contributing the lions' share of the funding. This has been raised in independent scrutiny and other annual reports for a number of years and remains unresolved.

Recommendations

- The HSSP reviews its membership and its frequency of meeting (see para 18) so that it better reflects its strategic oversight function.
- The HSSP reviews the chairing arrangements of the subgroups to ensure that continuity is retained while sharing the responsibility fairly.
- The HSSP develops a forward work programme/ planner to enable the group to structure its work.
- The HSSP agrees a multi-agency budget, to support the Arrangements which is equitable and transparent.

[9] Accessed at https://files.ofsted.gov.uk/v1/file/50217932

The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and adults.

The Arrangements[10] describe a wide range of relevant and other agencies who contribute to the safeguarding function in Harrow. Their attendance at the HSCB and HSAB is generally good and many agencies are involved in the sub groups. One of the sub groups is chaired by a school colleague and another by a Health provider trust. The involvement of schools and colleges in the work of the partnership is strong, and the designated safeguarding leads group for schools is a key network for informing, consulting and working with a key partner. The serious incident group, which brings together schools, businesses, the Council, the Metropolitan Police and other relevant agencies to review incidents involving school age children is a strong expression of continued multi agency innovative working.

The Harrow Social Workers in Schools project which began in September 2020 is one of 21 similar projects across England and Wales and brings significant benefits to schools. It is now being extended. It demonstrates good cross sector working between partners and is warmly welcomed by schools.

One of the ways in which the Partners discharge their responsibility in relation to the active participation of other agencies in safeguarding is to conduct a section 11 /42 audit[11], which enables organisations to assess themselves as to their effectiveness at safeguarding. This process is very resource intensive and its value from time to time is questioned. HSSP should review this audit arrangement to see whether it provides the necessary engagement of other agencies and reasonable assurance as to those other agencies' safeguarding competence and capacity.

Harrow does not have a named GP for adult safeguarding, nor does it have a designated doctor for child death. This has been a longstanding situation that needs to addressed by the HSSP. It does have a named GP for child safeguarding and there is good liaison between the primary care network and local GPs through the work of the that named GP.

The Arrangements describe a range of voluntary, sports and religious agencies[12] who as relevant agencies are important contributors to safeguarding. Through the work of Voluntary Action Harrow, the safeguarding partners have good contact with the local voluntary network. The HSAB and the HSCB are both attended by a range of third sector bodies.

There is little engagement with the religious sector or sports associations/ bodies. Other local partnerships have developed a variety of ways of engaging faith and sporting bodies, and these may be worth exploring.

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[10] Appendix 1

[11] Named after sec 11 Children Act 2004 and sec 42 Care Act 2014, which both describe how agencies are required to cooperate with the safeguarding function

[12] Appendix 1

Recommendations

- The HSSP reviews the sec 11 and sec 42 audit process.
- The HSSP reviews the arrangements for the provision of named and designated safeguarding professionals and ensures that the required posts are filled.
- The HSSP reviews the contribution to the Arrangements made by sports and religious bodies locally and take appropriate steps to ensure that their involvement is proportionate to the part they play in local safeguarding

Appropriate quality assurance procedures are in place for data collection, audit and information sharing

The past year has seen little multi agency audit of safeguarding activities. This was once a strength of the partnership but has been highlighted by JTAI now as a weakness. An audit of Child Sex Abuse cases is currently in train and the Quality Assurance Group, which previously focused on examination of data has been repurposed as an audit group. This repurposing of the sub group was a pragmatic decision in the face of the difficulties of obtaining staff to conduct multi agency audits in addition to their other sub group responsibilities. It generally falls to the same staff who attend the QA group to participate in audits. It does mean that how and when data is scrutinised at a partnership level is now less certain.

The data scrutinised by the Partners is not a balanced data set. Local Council data is rich and plentiful and there is also a reasonable amount of health data. There is currently no regular police data set. It is reported that the MPS has almost completed a safeguarding data set which it will share with partners. This will be a significant step forward, but the real value from a blended data set will come from analysis and commentary. The HSSP will need to resource this function.

In relation to information sharing a separate scrutiny exercise during the year found some weaknesses in the workforce's understanding of why it is often inappropriate to seek consent before sharing information. If consent is inappropriately sought then either the sharing is delayed or it may not happen at all. In any event seeking consent inappropriately potentially misleads the data subjects about the status of their information.

The JTAI found that although there were good examples of information well used and properly shared there were also weaknesses in this aspect of professional practice. Given the frequency with which the failure to share information arises in safeguarding reviews this is an issue that the HSSP needs to keep under review.

Recommendations

- The HSSP develops a plan for multi-agency audits and the scrutiny of partner data, including how these activities can be resourced.
- The HSSP notes the findings of the Harrow scrutiny report into information sharing and the JTAI observations on information sharing and takes the necessary steps to ensure that professional practice in this regard meets the requirements of WT 18 (p 18ff) and Care Act Guidance (sec 14)

There is a process for identifying and investigating learning from local and national case reviews

In the past year the Partnership concluded a SAR that had been commissioned in the previous year and conducted a rapid review into an infant death. The requirement for reviews tends to be highly unpredictable and whereas in the two previous years the case review group was continuously engaged in assessing cases for review, commissioning reviews, conducting rapid reviews and acting on the learning, in the past year far fewer cases have been referred for consideration for review.

The two previous years have shown the Partnership in a good light in this regard. The JTAI also comments favourably on the implementation of learning from reviews. However, the HSSP should review whether the lack of cases referred for review in the past 12 months is a statistical "blip" or is the result of a change in behaviour by staff.

Recommendation

- HSSP satisfies itself that partner agencies are referring for review all appropriate serious safeguarding cases.

There is an active programme of multi-agency safeguarding training

The Partnership have offered 18 different multi agency courses in the past year. A large number of different agencies have attended. Schools are particularly good attenders. The take up by third sector bodies, non-school educational providers and various council departments is also quite high. The Police and the Health Service (save for Central and North West London NHS Foundation Trust (CNWL)) are less frequent attenders. This is common in many partnerships. This is something for the HSCB and the HSAB to review.

The courses that are offered (apart from the standard introductory and advanced safeguarding courses) arise from case reviews, local requests and national themes. A good example of a course arising from a review was the offering of a course on adverse childhood experiences, which was initiated following the completion of SARs A and B, both of which explored this issue.

The Learning and Delivery group run surveys to assess the extent to which training changes the workforce's level of knowledge and the way they carry out their duties. The JTAI identified little by way of multi-agency training for matters concerned with Early Help. The HSSP will want to explore this.

Recommendations

- HSCB and HSAB reviews regularly the attendance of staff at multi agency training.
- HSSP commissions the L and D group to develop a multi-agency training programme for Early Help that is consistent with the Arrangements.

Children, young people, families and service users are aware of and involved with plans for safeguarding children and adults with care and support needs

Harrow has a strong record (noted also by the JTAI) of consulting and communicating with service users, children and families.

The HAY [13]survey provides the Partners with a rich data set that helps them understand the need for services and the impact that those services are having. The Partnership has strong representation of the third sector in both boards, but particularly on the HSAB. This means that the representative voice of the service user is heard by the Harrow Safeguarding Partners.

Another way in which families and service users could impact the quality and design of services would be to involve them in the audit process suggested above.

Working with Other Boards

WT 18 says: '*To be effective, these arrangements should link to other strategic partnership work happening locally to support children and families. This will include other public boards including Health and Wellbeing Boards, Adult Safeguarding Boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs.'*

There is a degree of join up in Harrow in relation to the interoperability of the various multi agency boards as described in WT 18. This is partly because many of the attendees of these various boards are the same individuals. However, the JTAI identified a gap between what might be expected from a series of partnership boards attended by many of the same staff and the reality of how well the HSSP is supplied with the information it needs. As an illustration of this the Health and Wellbeing Board in its 2022-2030 Health and Wellbeing Strategy has allocated joint oversight of its "Start well" strategy[14] to the HSCB without previously flagging that to the HSCB. Preventing this strategic gap is relatively easily achieved and mapping out how the HSSP links with these other boards would reap strategic dividends.

Recommendation

- The HSSP maps its relationship with other strategic multi agency boards and describes what information needs to flow between the various and the mechanism for achieving that.

Leadership

There has been significant leadership churn among the key partner agencies over the reporting period. This has led to a degree of drift and delay in the direction of the Partnership. It may be that meeting three times a year is too infrequent a schedule to ensure the necessary resilience.

[13] ***How Are You*** is a survey of 6000 young people in Harrow conducted as a collaboration between the Young Harrow Foundation, CNWL and Public Health Harrow.

[14] The first 1000 days of a child's life

Recommendation

- The HSSP reviews the frequency of its meeting schedule to ensure resilience and continuity in the Partnership

4. Areas for development 2023/24

Joint HSAB and HSCB

- Work more closely with Community Safety and related Boards to consider areas of joint interest ensuring we maximise the use of resources.
- Review the effectiveness of the children and adults safeguarding arrangements.

Adults

- Review progress on the priorities in the Strategic Plan
- Work with partners to develop a new three-year Strategic Plan for 2024/27 and associated draft action plan.
- Work with partners to develop a SAB Risk Register.
- Establish a task and finish group to review safeguarding adult data and intelligence.
- Review mechanisms to ensure learning from SARs in embedded in practice.
- Prepare for the CQC Framework

5. Learning from reviews

Audit - Safeguarding Adults Reviews A and B

Introduction

Annie Ho, an independent auditor was commissioned to carry out a review following the completion of SAR A and SAR B. SAR A highlighted the need for learning in relation to the response to hoarding; working with resistant service users [or involuntary clients]; elective home education; young carers and perplexing presentations. SAR B highlighted the need for learning in regard to professionals understanding of the Mental Capacity Act and the impact of adverse childhood experiences on carers.

The audit focused on the following identified themes:

- The use of mental capacity assessments where citizens are refusing care and/or treatment.
- The allocation of self-neglect and hoarding cases to experienced staff and supervision support
- Multi-agency decision making in cases of resistant citizens.
- A safe process for closing cases where there is non-engagement with citizens.

The Audit Process

The audit process includes 2 stages.
Stage 1: two-part Self-assessment Tool [SAT]
Stage 2: one-day Partnership Audit Workshop [29/09/2022]
Attendance at the workshop: Harrow ASC – PSW and Safeguarding; Harrow ASC – Learning and Development; NWLUHT; CNWL; CLCH; Housing; Police

Summary of self-assessment on understanding of SAR

- Most partners understand all agencies have a duty to make a SAR referral, but not everyone is aware that anyone (including the public) can make a SAR referral.
- Most partners are aware that it is the SAB's duty to carry out a SAR, but the mixed responses from partners appear to indicate an assumption that the local authority takes the lead in decision making.
- Most partners understand the criteria for making a SAR referral, for people who died from known or suspected abuse or neglect, but not everyone is aware that a SAR referral can be made for people who are alive and have experienced known or suspected serious abuse or neglect.
- Most partners are aware of the referral and decision-making process via the case review group. Some partners who are 'distant' from the case review group are unclear about frontline staff's access to the SAR referral form.
- Apart from Harrow ASC, most partners were unable to provide details of specific learning or improvement action from SAR A. Generic responses included raising awareness about self-neglect and promoting good information sharing.

- Apart from Harrow ASC, most partners were unable to provide details of specific learning or improvement action from SAR B. Generic responses included improving partnership working including using the escalation policy and promoting professional curiosity.
- ASC shared SAR specific responses including new training on hoarding/self neglect and ACE, the specialist team, the self-neglect protocol and the self-neglect and hoarding panel, although some partners are not aware of / have not accessed the relevant training courses, policies and processes.

Self-neglect

Top challenges in self-neglect cases

- Embedding learning from SARs
- MCA literacy and application
- Including the person's view and ensuring that intervention is person-led
- Attendance and engagement of appropriate partners at
- meetings, including, in particular, the GP
- Sharing burden of risk management and decision making
- Multi-agency collaboration and exercising powers to intervene

Improvements in self-neglect work

- Review of self-neglect policy and guidance
- More robust overview of self-neglect cases
- Consideration of a think-family approach
- Employment of a floating support worker

Sharing and Learning from Case Studies

The case studies demonstrated good single-agency management of complex cases, but this appears to have been hampered by multi-agency level barriers.

- The 'surprises' in these cases illustrate that self-neglect/hoarding behaviours could apply to different people including, for example, a highly skilled medical consultant. Professional curiosity was clearly demonstrated by a staff member's observations of P's appearance, odour and low-level concerns over a period of time.
- The assessment of mental capacity with regards to executive functioning is challenging. One case study illustrates the impact of alcohol on the person's behaviours. One partner shared his 'surprise' about how intelligent P was when not intoxicated.
- The 'satisfaction' came from supporting P in their wishes, e.g. regaining contact with family, returning home.
- In cases where it was difficult for professionals to engage with P, 'satisfaction' came from one 'good relationship' between P and one worker. The staff member was able to spend time with P exploring their past and engage with them in a meaningful way.
- The 'dissatisfactions' in the case studies appear to indicate barriers to effective multi-agency work.
- Housing shared their learning from a safeguarding (non self-neglect) case. Partners learned that Housing holds a vulnerable adults list which includes

people who have mobility needs, disability, have debits on their accounts or have not initiated contact for repairs. People on the list have a 6-monthly review.

Child Safeguarding Practice Review: Child M [2020]

August 2022. Clinical Record Keeping: A Dip Sample of Groups and Relationships recording on System One

Background / Rationale

It was identified at the Child M, safeguarding practice review that within a child's SystmOne records, 'Groups and relationships' had not been maintained or updated, leading to a poor overall assessment of the child, the wider family and that child's place within the family. A recommendation from the safeguarding practice review was to merge SystmOne systems across a broad section of children's community health services.

Aims & Objectives

The aim of the audit is:

- To ensure compliance with relevant national, regional, professional and local clinical record keeping requirements.

The objectives of the audit are:

- To give evidence-based assurance that clinical record keeping standards and best practice is being carried out within the service.
- To identify any areas of concern within clinical record keeping practices.
- To ensure a consistent approach to clinical record keeping practices.
- To highlight areas of good practice that can be shared with other services.
- To identify areas of concern and develop an action plan. This was an outcome of a safeguarding practice review within the Harrow partnership in 2021.
- To identify gaps or areas for future training.

Record keeping is a tool for professional practice that aids the care process. Records form a permanent account of the patient/client journey (BMJ. January 2014). Health records are also created and maintained as evidence for legal purposes. With this is mind, our audit was originally going to look at the broader spectrum of all aspects of record keeping, but in light of the findings and recommendations of the safeguarding practice review in to Child M in 2021, we extended the section on 'Groups and relationships'.

Methodology

This was a randomised and anonymised review of records held on the SystmOne database for the Harrow 0-19 service. A total of 58 records were reviewed from both the health visiting and school nursing services universal plus and universal partnership plus caseloads.

Conclusions

Whilst the majority of records were clearly written and elements of the process are being completed, it is clear from the data that, overall, practitioners are not compliant with the requirements in the Trust's Clinical Record Keeping Policy (auditing of patient records) and related policies and procedures.

The findings of the audit are also in line with the observations made by Safeguarding Advisers during the composure of chronologies, completion of MASH checks and during supervision sessions.

The audit highlights that there is an obvious need for further training in order to ensure that all staff involved in clinical record keeping have an increase awareness of the relevant requirements, professionalism and efficiency in these processes.

Recommendations

- Record keeping training being offered on a 6-weekly basis.
- Chronology training being offered on a 6-weekly basis.
- Record keeping discussed at both group and individual safeguarding supervision sessions, team meetings and forums.
- Record keeping to be discussed at Level 3 training.
- Ad-hoc record keeping training to be offered if required.
- It is anticipated that this audit will be revisited in early 2023 to review and evaluate the impact and effectiveness of the training delivered by the safeguarding team to the Harrow 0-19 service.

The findings from the audit will be discussed and presented at:

- Health visiting and school nursing team meetings
- Health visitor and school nursing forums
- Harrow safeguarding team meetings
- Safeguarding supervision group session
- Internal CNWL meetings
- Harrow Safeguarding Partnership Board meetings

The above recommendations form the basis of the audit action plan.

Was Not Brought Audit: RNOH

An action from the Child M CSPR was for health agencies to remind professionals of their organisation's 'Was Not Brought' policy and the importance of compliance. RNOH carried out an audit of compliance with their 'Was Not Brought' policy

Introduction

- A Was Not Brought Appointment (WNB) is defined as a scheduled appointment that is missed without prior arrangement by the parent/carer.
- When the child is not brought to an appointment it is the parent/carer who does not attend.

- To minimise the risk to children, if a parent chooses not to attend, there should be consideration around the risk to the child.
- All children have the right to have their health needs met. When children are not brought to appointments this may represent a risk of harm which could be significant.

Methodology

- On the day of the data collection, all Was Not Brought appointments for children and young people under the age of 18 years, for the month of June 2022, were extracted from Insight.

Findings

- This small spot audit indicates a lack of consistency when it comes to following the current Was Not Brought Policy.
- The Safeguarding Children Team and / or GP were not routinely informed following a second consecutive Was Not Brought appointment or when a Vulnerable Child was not brought to appointment.

Recommendations

- Sharing and communication of WNB Policy through supervision and presenting findings at the Trust Audit and Paediatric Audit days to ensure staff awareness of the following:
- What to do when a child is not brought to appointment
- When to involve the safeguarding children team
- Use of WNB letter templates
- Re-audit of WNB process in 12 months following sharing and communication of the current policy.
- Share audit findings at the Safeguarding Sub Committee and Integrated Governance Risk Committee

Learning Lessons Review [LLR]: Baby O

Introduction

Baby O tragically died shortly after birth as a result of severe abnormalities. The decision was made to carry out a LLR because the young mother, who was homeless and in temporary accommodation, had not engaged with ante-natal care and, hence, the abnormalities were not identified pre-birth prior to the baby being born h and no planning was therefore possible for the birth. The LLR sought to understand if anything could have been done differently to engage the mother in antenatal care.
The LLR" was presented, with a series of recommendations, to the HSSP [21.2.23] and the HSCB [3.3.23]. The Report was reviewed and discussed, and the recommendations accepted. They continue to be progressed.

The outcome of the Review: Recommendations

- A pathway is developed for un-booked pregnancies.

- The London CP Procedures are amended to emphasise the risk to women being un-booked in pregnancy
- Draft amendments to be proposed to the Editorial Board of the London Child Protection Procedures.
- That a midwifery outreach service is set-up to support vulnerable women with their pregnancies
- That the mother is offered support and accommodation on a long-term basis
- A multi-borough service is developed for women at risk of repeat removals
- CSC To review the decision to NFA the police referral in March 2022 that the mother was pregnant again
- To encourage dialogue between adult and children's services
- The partnership to review the NHS Patient Safety Incident Response Framework with a view to implementing it, as appropriate, across agencies
- Housing – safeguarding training and engagement in CP processes
- That senior leaders in Housing are engaged in complex cases to allow, where appropriate, for normal processes to be over-ruled in the best interests of a child [unborn in this instance].
- Housing to review job roles and determine what level of safeguarding children and adults' training is required for assessment officers; housing prevention and solutions officers; and other relevant roles [Managers to have a higher level of training]

6. Training and Development

Introduction

The Learning and Development Officer for the Safeguarding Partnership ensured that a comprehensive training programme was provided for the workforce. The programme was aimed at supporting the needs identified from local and national Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs) and the Harrow Safeguarding Partnership (HSP) priorities:

- Domestic Abuse
- Contextual Safeguarding
- Mental Health

Attendance on the day has improved, however, some courses have only just had sufficient attendance to go ahead and some courses have had to be cancelled because of poor attendance.

In October 2021 the partnership moved to SS4e as the booking system for HSCB courses. This has taken some time to embed and for practitioners to create accounts, however, in the last year, 466 delegates have attended HSCB courses via this booking system.

Putting learning into practice

The HSP needs assurance that training is making a difference to working practice, especially learning, which has been identified in CSPRs and SARs. Initial course feedback has been received electronically and similarly impact evaluation. Impact evaluation is the area that we would most like to strengthen.

Multi-agency Training

2022/23 had 466 delegates attending 23 HSCB courses promoted via SS4e (Appendix A). There has also been training commissioned from external agencies such as YGAM and the Child Sexual Abuse [CSA] Centre not included within the above figures. Two CSA events in December 2022 and March 2023 had a total of 81 delegates attending.

Date	Training course	Organisation/setting attendance	No. attended
Dec 12th 2022	Harrow CSA Training www.csacentre.org.uk	Schools 18 Health 18 Harrow People Services 2 Charities/Voluntary 2	40
March 8th 2023	Harrow CSA Training www.csacentre.org.uk Kingston and Richmond Safeguarding Children Partnership HOST	Cafcass 2 Health 1 CYPS (including MASH/CIN/Keeping Families Together/1st Response) 33 Adolescent Safety Team 4 Probation 1	41

Each term the Designated Safeguarding Lead (DSL) forum continues to attract a high number of delegates. The success of these events is due to the active participation of, school DSLs, the support from bespoke presenters/experts and regular attendees including:

- Metropolitan Police Service NW BCU safer schools and engagement team
- Harrow Social workers in school team
- Virtual school
- MASH education lead

A range of topics have been covered over the year including:

- Child Q: Lessons Learned
- Online Safety Bill
- Mind in Harrow
- Core CAMHs, an overview of the service and processes (CAMHS Mental Health Support Team)
- Virtual School update
- Professional Supervision (Public Health)
- Service Introduction from NW London Clinical Commissioning Group
- Information Sharing
- Supporting parents to accept appropriate help to support their child's additional needs
- An introduction to Young Gamers & Gamblers Education Trust
- HAY Children and Young People Survey – next steps
- Social Workers in Schools projects and next steps

In response to DSL feedback, the learning and development team designed a bespoke refresher training package for the February 2023 forum, attended by 42 delegates. This training included:

- Child/Young person disclosure – What you should know
- Domestic Abuse Guidance
- Updates in Keeping Children Safe in Education.
- Victim Blaming – Direct and Indirect
- How to challenge Victim Blaming
- Online Safety – What should you be asking?
- Threshold – Continuum of Need Matrix (London Child Safeguarding Procedures Update)
- Child Protection Chair – Updates
- Learning from Child Q – Guidance on Searches in Schools
- Safer Schools Officer – Guidance to police
- Learning from Child Safeguarding Practice Reviews
- Safeguarding Concerns and allegations against staff
- Harrow Challenge and Escalation Procedure
- Information Sharing

The theme for the 2023 safeguarding conference "Adverse Childhood Experiences" was chosen following consultation and feedback from 72 practitioners. The

cancellation of the 2023 conference was disappointing but, due to the support from Harrow Early Help team a workshop did go ahead - “How Adverse Childhood Experiences (ACEs) Fuel Conflict - Parental Conflict Through a Trauma Lens” with 46 practitioners attending.

15 training events, (these courses do not feature in the figures), were cancelled due to;

- 8 trainer not available
- 6 insufficient delegate numbers

Courses cancelled due to trainer availability (often due to illness or extreme weather conditions without technology access) included:

- perplexing presentations
- modern slavery
- LADO training
- child mental health
- digital exploitation training

Courses where there were insufficient practitioner numbers included:

- drug awareness
- safer recruitment
- child mental health
- click path to protection (online sexual abuse)
- digital exploitation

Despite requests for online abuse training there were insufficient practitioner numbers for some of these sessions. The reasons for the low numbers should be explored by the partnership.

Across all courses there were 541 bookings, 75 delegates did not attend. The most common reason for delegate cancellations were work commitments or sickness absence. (HSCB have a cancellation policy whereby failure to attend without notice is liable for charges).

Name	Delegate No	Attended	Not Attended
HSCB Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility	14	13	1
HSCB Domestic Abuse:- Understanding Domestic Abuse and its impact Foundation Stage	6	6	0
Hoarding and Self-neglect: Children and Adult Services	12	10	2
Online Platforms and Extremist Content	13	11	2
Safeguarding in Education Termly Seminar	57	49	8
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	29	28	1

HSCB Domestic Abuse:- Responding to Domestic Abuse - Enhanced	8	7	1
Managing Allegations Against Staff and Volunteers (LADO)	10	9	1
HSCB Drug Awareness	7	5	2
HSCB Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility	21	20	1
HSCB Understanding Child Mental Health	9	7	2
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	28	26	2
HSCB Parental Mental Health Workshop	9	9	0
Safeguarding in Education Termly Seminar	85	74	11
Domestic Abuse and Mental Health	10	8	2
HSCB Drug Awareness	7	6	1
Digital Exploitation, Fraud methods (Crypto currency) – CSE/CCE	13	9	4
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	39	37	2
Responding to perpetrators of Domestic Abuse	11	8	3
Safeguarding in Education Termly Seminar	54	41	13
Adult Safeguarding; Modern Slavery & Child Exploitation Awareness	18	17	1
Managing Allegations Against Staff and Volunteers (LADO)	24	20	4
How Adverse Childhood Experiences (ACEs) Fuel Conflict - Parental Conflict Through a Trauma Lens	57	46	11
	541	**466**	**75**

Organisations attending the training

Organisations are required to ensure staff are confident and competent in responding and managing safeguarding concerns. In 2022-23 delegates were drawn from a range of roles (Appendix B).

Of the 466 delegates the highest attendance was from education. For the 3 key partners the lowest attendance was police.

- 272 from education (including colleges, schools and nurseries) ,
- 55 from health
- 53 from Harrow social workers (including early help).
- 2 from police (1 delegate for the modern slavery and exploitation session and 1 delegate for adverse childhood experiences session).

Who is delivering training?

Most of the multi-agency training programme is delivered by experienced staff in specialist roles from across partner organisations. These staff have included trainers from;

- Shaftsbury High School
- Norbury School
- RNOH
- WDP/Compass
- Harrow LADO

- Social workers from Harrow Adolescent Safety Development Team (ASDT)
- Social work apprentice from Early support
- An independent safeguarding trainer
- Detective sergeant from NW BCU public protection team
- MPS modern slavey and child exploitation team
- CNWL mental health team.

All have prioritised sharing skills and expertise with the workforce, and this is greatly appreciated by delegates and the safeguarding partnership.
The training pool has lost experienced members through retirement and change of role away from Harrow, including;

- Dr Arlene Baroda Consultant Paediatrician- Designated Doctor for Safeguarding Children, LAC and CDOP - Brent CCG for the perplexing presentations session,
- DS Helen Purcell from NW BCU for the foundation and advanced domestic abuse sessions.

We have been fortunate that Holly Thomas, Domestic Abuse Prevention Coordinator, Central North West London NHS Trust provided Domestic Abuse training which enhanced our domestic abuse training offering which included sessions focusing on the perpetrator.

The Intra Familial Child Sexual Abuse training, hoarding and neglect training and the ACE training have been commissioned from external trainers (funding for the CSA training was through the London Safeguarding Children Partnership, and the ACE training through the Harrow Early Help team).

HSCB collaborate with external agencies and organisations to promote safeguarding training from other providers – including:

- The Amber project - enhancing the response to child abuse linked to faith or belief
- Marie Collins Foundation - when a child is sexually abused online
- YGAM - safeguard young people against gaming and gambling harms.
- NWG - child exploitation (CE) and trafficking within the UK.
- Counter-Extremism Division Regional Prevent Co-Ordinator Department of Education
- London Safeguarding Partnership for Pan London training

Evaluation

Identifying the impact of training on practice and reporting those changes to the Safeguarding Partnership remains a challenge for partner agencies. Impact analysis evaluation implemented in 2021/2022 is heavily dependent upon learning from QA audits and learning from the case review group.
Course participants are offered the opportunity to complete a short course evaluation immediately after attending an event to gain feedback on course satisfaction, relevance to working practice and gauge how the course has improved their knowledge. Then 6-8 weeks after the training event impact evaluations are sent with

more specific questions for participants to review how the learning has impacted on their workplace, their working practice and ultimately the outcomes for children and young people. A course certificate is then issued.

Training Priorities

The training programme will always evolve as there will be provision built in to allow for change and further development such as lessons from local and national reviews, relevant reports, inquiries, legislative policy changes or research. There will be a core offer of safeguarding training:

- Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility
- Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection
- Managing Allegations Against Staff and Volunteers (LADO)

Safeguarding Adults Training

The following safeguarding adults training was provided:

- Basic Awareness, 31/05/2022 – 16 attended.
- Basic Awareness, 11/07/2022 – 20 attended.
- Domestic Abuse Training, 12/09/2022 – 14 attended.
- Basic Awareness, 13/09/2022 – 30 attended.
- Basic Awareness, 22/11/2022 – 71 attended.
- Basic Awareness, 17/01/2023 – 40 attended.
- Basic Awareness, 07/03/2023 – 35 attended.

Voluntary and community sector safeguarding training

The Harrow SCB has commissioned Voluntary Action Harrow (VAH) to provide safeguarding children training and advice to the private, voluntary and faith sectors for several years. VAH has a very successful track record in reaching and supporting these sectors.

In 2021/22, VAH delivered the following:

- 3 Single agency safeguarding training sessions [Level 2]
- 10 multi-agency safeguarding training sessions [Level 2]
- 3 safeguarding sessions for nominated safeguarding leads [Level 3]
- 3 safeguarding support forums
- 6 safeguarding newsletters
- 16, 1:1 support sessions

Total reach:

- 143 Organisations
- 325 Participants

Alongside the training and 1:1 support, VAH also represents the voluntary sector on the quality assurance and learning and development sub-groups providing valuable community input and using the learning to inform their advice.

VAH – priorities

HSSP priority areas

- The safeguarding outreach team will continue to embed learning in the sector linked to the HSP priority areas. This includes learned lesson reviews.

Hard to reach groups

- The safeguarding outreach team will continue to focus on hard to reach groups including faith based groups, sports groups to build relationship and strengthen existing relationships in order to ensure safeguarding is a priority area for all.

Partnerships & sharing information

- The safeguarding outreach team will be increasing the new shorter training sessions to get more sector organisations to attend training and really get messages across strongly. The safeguarding outreach team will look at growing existing partnerships and creating further partnerships in the borough.

Single agency safeguarding training and development

LNWUH NHS Trust

LNWUH NHS Trust continues to develop and embed a culture that puts the “Voice of the Child” and “Making Safeguarding Personal’’ at the centre of care delivery. This approach interlinks with all three shared priorities for adults and children - domestic abuse, contextual safeguarding and mental health. LNWUH is fully committed to supporting all three priorities and ensuring they are included in our daily practice. These three priorities also form some of our internal key priorities for 2023 -2024:

- Continue to embed Mental Capacity Act (MCA) and DoLS knowledge and practice through training, supervision, Trust wide PULSE communication, bespoke face to face sessions with Teams, presentation at grand round, forums, etc.
- Update training and policy in line with the Serious Violence Duty 2022 and Domestic Abuse Statutory guidance - this supports our prioritisation of domestic abuse.
- Achieve Trust target of 90% for level 3 safeguarding training which will include elements of contextual safeguarding.
- Continue our work with CAMHs and Social Care to address safe management and timely discharge of patients admitted with mental health conditions. This demonstrates our commitment to improve overall wellbeing of our patients with mental health.
- Rollout of the Oliver McGowan Mandatory Training in Learning Disability and Autism.

In addition, key achievements include:

- CQC Inspection Report: the CQC carried out an unannounced inspection of the Trust in February 2022 and an announced inspection of the trust in March 2022. The report stated, “Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.”

- The Trust Maternity and Emergency Department (ED) were involved in the Harrow Early Help Joint Targeted Area Inspection (JTAI) in March 2023. Initial feedback was, “voice of the child was captured, and appropriate referrals to early help were made by staff. Young children were seen by Youth workers from the NEON project to explore their health, educational, social circumstance, and aspiration. The ED SafetyNet meeting and Maternity Psychosocial meeting is robust in ensuring Early Help, as all children, pregnant women and parents with children who attend ED, Urgent Care Centres and Maternity are screened by the Safeguarding Children Team and rag rated for appropriate referrals to 0-19 services and case discussion at the weekly multi-agency SafetyNet and Psychosocial meetings.”

- The Trust was commended by NHS England for the work done in fast-tracking patients with LD and Autistic People through electronic notification and invited to give a presentation at the National LD Improvement Standards event.

- Electronic Safeguarding Referrals: The Trust rolled out electronic safeguarding adult referrals in 2022. This means staff can make timely safeguarding children and adult referrals electronically to Social Care. The Safeguarding Team are also able to review referrals and provide assurance in a timely manner to ensure effective protection of children, adults and families from abuse.

- Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS)/Liberty Protection Safeguards (LPS) Steering Group: The Safeguarding Team has continued with bi-monthly MCA, DoLS/LPS Steering Group meetings. As the implementation of the LPS has been delayed beyond the life of the current Parliament, we recognised that we now have the best opportunity to understand and instrument the MCA/DoLS more robustly across the Trust.

- Training Compliance: Safeguarding children and adults training compliance at all levels met the Trust target of 85%. The Trust has now increased the training target to 90% and this compliance is being achieved at levels 1 and 2 safeguarding training. The Team is working with service managers and regular reminders are sent to staff to help in meeting the 90% target for Level 3 training.

- Operational Safeguarding Procedures for Liaison Psychiatry Service (LPS): A new Safeguarding Operational Policy has been implemented to facilitate communication between LPS and Acute hospital staff at LNWH, West London NHS Trust and Central and North-West London NHS Foundation Trust, to ensure that

Local Authorities receive timely contemporaneous information to enable them to process safeguarding children and adult referrals.

- Safeguarding Champions: The Safeguarding Team successfully recruited Champions for Safeguarding, Falls, Dementia, Learning Disabilities and Autism. The Champions act as a resource and point of contact for colleagues who require support, guidance and signposting.

- Timely completion of National Audits: The Older People and Dementia Team completed the National Audit for Dementia on time with good feedback. The team is implementing actions from this audit.

- The Team also introduced monthly and quarterly Trust wide Falls Audit which has helped in steering the Falls Improvement Plan. The Trust is also involved in the ongoing National Audit for Falls.

- The Learning Disabilities and Autism Team also completed the National LD and Autism Survey on time with good feedback. The team is implementing actions from this survey.

CNWL

Safeguarding Adults

In September 2022, CNWL held a Trust-wide Safeguarding Adults Away Day to strengthen partnership working, highlight organisational structures, promote legal literacy and learning from a Harrow SAR. It also focussed on the complex issues regarding hoarding, self-neglect and mental capacity.

SAR training

In January 2023, CNWL gave a presentation to Harrow adult social care staff, outlining CNWL Safeguarding staffing structure, referral pathways and processes. It also raised awareness of the SAR process and criteria for SARs, explored common themes/learning from SARs, how to resolve professional disagreements and follow the escalation process.
Harrow mental health services remain the highest reporters of safeguarding adults in their division predominantly across community mental health hubs. Mandatory adult safeguarding compliance is 91%.

Disaggregation of Local Authority and CNWL Mental Health Services Section 75 Agreement

- For more than 10 years under section 75 of the Health and Social Care Act, Harrow Community Mental Health Services have been delivered through a partnership agreement between Harrow Council and Central and North West London NHS Foundation Trust (CNWL).

- In July 23 this agreement came to an end and the responsibility for both social care staff management and service delivery was transferred to the Local

Authority Adult Social Care department. These services include support with direct payments and care packages, support with accommodation and daily living – and assessments and support for carers/family members. In effect this means there are now 2 mental health teams in Harrow – a health team provided by CNWL and a social care team provided by the Local Authority. This will allow both services to be much more focussed on their own areas of expertise whilst working together to provide seamless care.

- Much of 2022 was focussed around preparing staff and services for this transition. All staff working under the Section 75 agreement (this included social workers/personal budget staff/admin staff) were transferred over to the local authority. All clients under mental health services were also to be 'disaggregated' i.e. screened and assessed as to which service would most appropriately provide treatment/support for them – in many cases this might be both services.

- It was also a period of restructuring CNWL mental health services in order to meet the new service remit and configuration e.g. Harrow Mental health services now comprise one Mental Health Hub (as opposed to 3) and a dedicated Triage and Assessment Team.

Domestic Abuse

- CNWL continue to grow their Domestic Abuse Ambassador network across all services Trust-wide. This has led to a number of disclosures of DA from colleagues. We have a policy on DA for staff – this means they are supported and managers are clear on which policies have flexibility to support staff in such circumstances.

- We have developed a network of staff with Lived Experience with a dual function of providing support and a safe space to share experiences and also to ensure that those with lived experience have a voice in service planning and development.

- CNWL hosted it's fifth annual Domestic Abuse conference during the White Ribbon period in December 22. This was a virtual conference attended by over 650 participants. It was themed around the Domestic Abuse Act and whether this had gone far enough – what gaps in policy and strategy still remained. Speakers included Charlotte Proudman, leading barrister and campaigner for women's rights, Emma Katz internationally renowned expert in Domestic Abuse and coercive control and Jess Phillips, shadow minister for Domestic Abuse.

- CNWL continue to facilitate quarterly round table DA webinars. The aim of these is to take a 'non expert' stance and for staff to share different experiences (personal and professional) of the same theme. Webinars over the last year have included – parent to child Domestic Abuse, Intersectionality and sibling abuse. There is always a large attendance – demonstrating the appetite of staff to know more and be involved in discussions around the subject.

- We continue to support the Routine Enquiry of all women entering CNWL services. We have introduced a Routine Enquiry template over the last 18 months in order to be able to record this information systematically.

- Following the introduction of the guidelines to support staff experiencing Domestic Abuse we have been working more closely with Human Resources and Occupational Health in order to improve support systems for staff who disclose.

7. Allegations Against Staff and Volunteers - children's workforce

Each year the HSCB requires the Local Authority Designated Officer (LADO) to report on activity around the management of allegations.
In 2022/23:

- The Local Authority Designated Officer (LADO) role continues to comply with the London Child Protection Procedures and the Working Together to Safeguard Children (2018) Guidance (updated 2020).

- The service has continued to maintain its profile within the children's workforce and maintains awareness raising within the children's community within Harrow by way of training sessions and workshops.

- The case work recording system is fully incorporated in the social care MOSAIC system in a standalone and secure system. The MOSAIC system provides embedded monthly and annual performance reports.

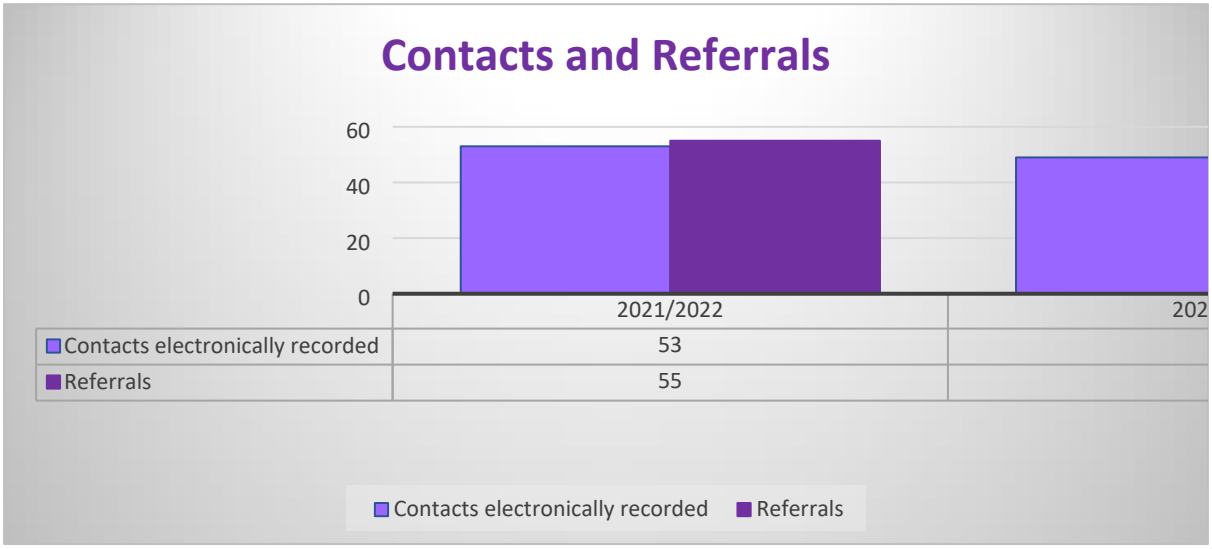
Profile of LADO Referral Activity & Analysis 1st April 2022 - 31st March 2023

Contact and Referrals - Consultations

The numbers of consultations demonstrates the level of advice and guidance the LADO services provides to organisations providing services to children and young people and these include safer recruitment advice, support in managing staff conduct and behaviour where it might lead to safeguarding issues. This level of preventative work is valued and well received by partners, particularly schools and early years settings.

On average there are far more contacts in respect of concerns resulting in LADO oversight of internal management investigations than those cases that met threshold requiring a formal LADO ASV Strategy /Evaluation Meeting. The finding may suggest that that partner agencies within Harrow are unclear about LADO threshold given the level not meeting threshold nor criteria for formal LADO involvement. Alternatively, this may mean partner agencies prefer to discuss low level concerns and allegations; not all low-level concerns specifically those not meeting contact level were electronically recorded by the LADO. The highest number of referrals continues to come from education where children have the most contact with adults who work with children. Generally reporting from schools is higher as a result of the schools' statutory guidance which has existed for some years. Over time this has enabled more staff to be familiar with the managing allegations procedure and the expectations to report any concerns about inappropriate behaviour of colleagues.

Number of contacts/ referrals received - 1st April 2022 to 31 March 2023

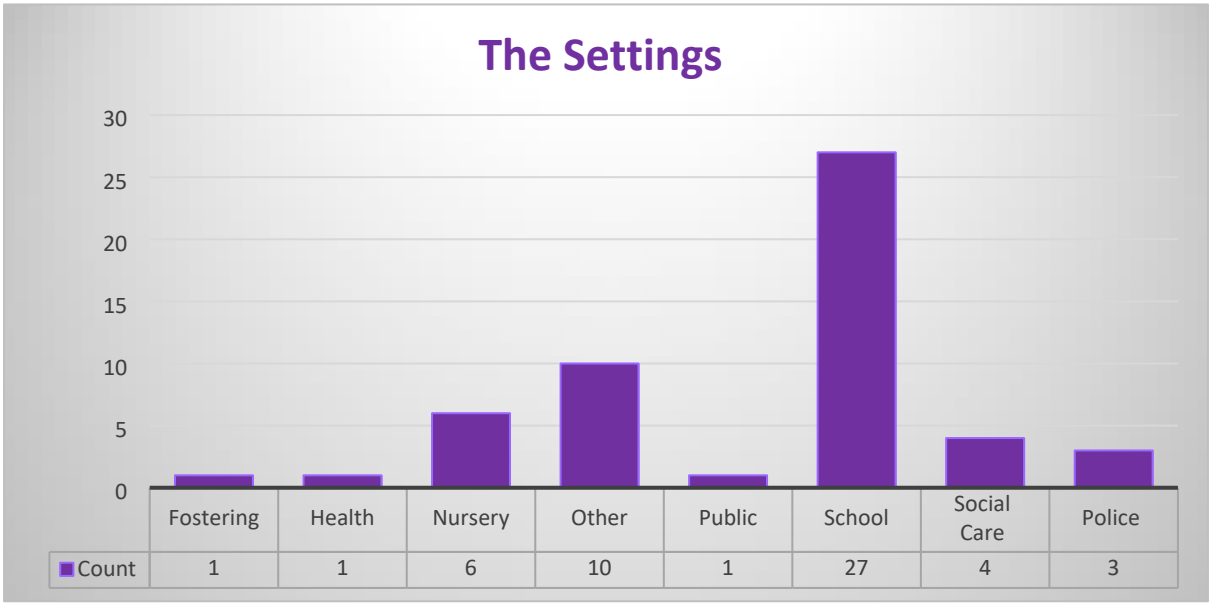


Referrals /contacts on average received via email and telephone requesting consultation. Whereas, in cases where there was a clear allegation identified, or contact in respect of internal management investigation required, the referral method was a LADO referral form submitted via email. Not all telephone contacts regarding low-level concerns which are clearly conduct issues are electronically recorded by the LADO.

Professional Suitability & Personal Life

LADO has seen an increasing number of concerns and allegations related to Transferable Risk, where there are concerns within a staff member or volunteer's personal life that can impact on their professional suitability to continue working with children. Examples of this may include domestic violence, physical chastisement of one's children, mental health, or substance misuse issues in their home life. Pressures related to the higher cost of living, housing insecurity and pressures on lone-parent families are some of the pressure points on workers that are impacting on their ability to cope at work and in their home life.

Where referrals came from between 1st April 2022 to 31 March 2023



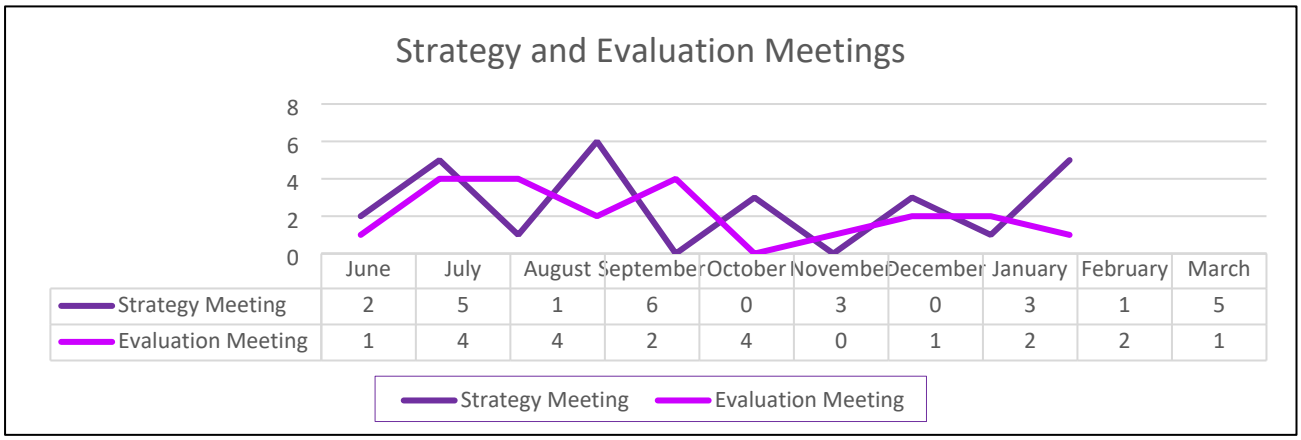
This table shows the type of agency that submitted referrals within the reporting period. Education continues to represent the largest proportion of referrals to the LADO service. Most contacts have come from regulated settings such as mainstream schools and OFSTED-registered nurseries. This finding suggests that regulated settings generally have safeguarding procedures embedded in their organisation culture and are more likely to seek advice when there is a concern or allegation.

Police: The LADO is mindful again there were no referrals in relation to Police Officers in this reporting period. It needs to be noted that the Police Officer would need to be in a position of power and control over children to meet the threshold for LADO involvement. All other Police complaints/allegations are made to the Police complaints committee. However, the LADO remains concerned about the lack of involvement with service, and it would appear they address matters internally rather than refer to LADO or at least consult with the LADO. There were no contacts regarding suitability/position of trust during the reporting year.

Referral Trends

The LADO continues to receive allegations related to unregulated workers and manager-less organisations such as music schools and child-minders. Issues related to these referrals are complex and unique. LADO continues to follow best practice related to allegations related to unregulated workers and manager-less organisations and consults best-practice when responding to these settings.

Strategy and Evaluation Meetings



	June	July	August	September	October	November	December	January	February	March
Strategy Meeting	2	5	1	6	0	3	0	3	1	5
Evaluation Meeting	1	4	4	2	4	0	1	2	2	1

47 Strategy / Evaluation (ASV) meetings were held following the referrals. 26 of these were strategy meetings. The meetings held covered review meetings held on some individuals due to complexity of the cases.

The evaluation meeting held are when the threshold of significant harm is not clearly met, and further information is required. This may lead to closure, ongoing enquiries, or pass back to the Organisation for an internal management investigation.

LADO Training and Development/ Consultation Sessions

Harrow LADO participates in the national and regional LADO groups and is active within the regional LADO group to ensure that current practice follows best practice related to the statutory guidance.

- 31 August 2023 - Child Protection Advisors
- 28 February 2023, Early Years (DSL) LADO Training
- 19 October 2023, Family Placement Service
- LADO lunchtime/bitesize sessions for Children's social care are scheduled to take place 17th January 2024 and will continue a quarterly basis.

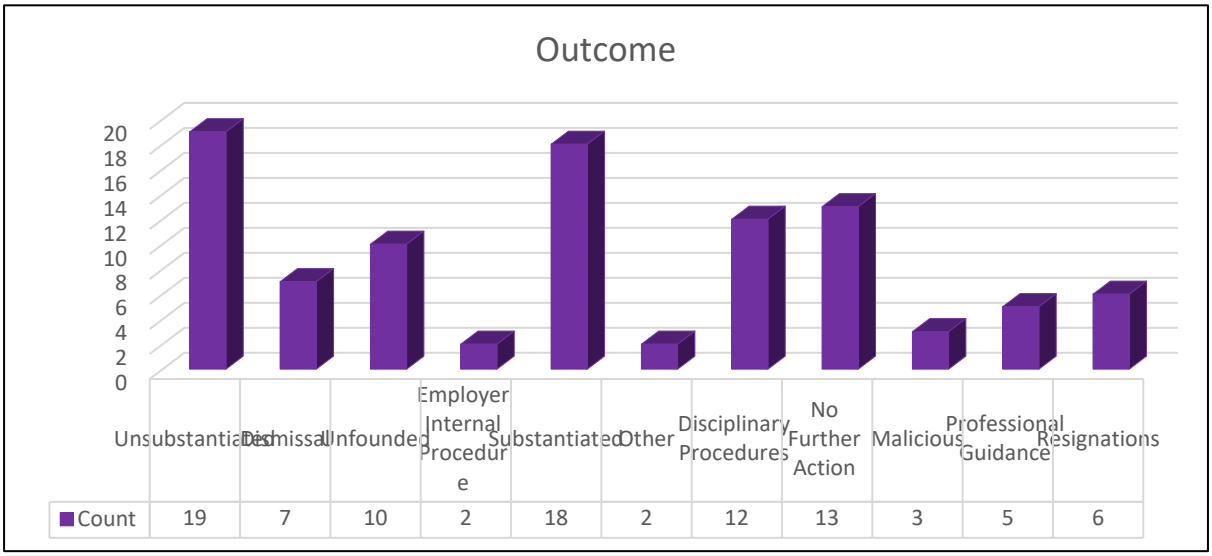
Safer Recruitment

The LADO Service provides training, advice and support to organisations, and in particular schools, working with children in relation to safe recruitment practices. This includes discussions around references, and advice on issues where recruits may have positive DBS checks. This has complimented HR guidance and advice and provided a safeguarding context to recruiting staff.

Outcomes of Allegation

The chart below shows the LADO outcome, using the LADO framework of Unfounded, False, Malicious, Unsubstantiated and Substantiated.

The secondary outcome would be in relation to the organisation involved and show internal management and no further action following an internal enquiry.



Outcomes are defined against two thresholds, where harm or the risk of harm has been caused, and where the standard of care fell below that which could be reasonably expected. In cases where the harm threshold is met, criminal prosecutions are normally considered and referrals to DBS and professional regulatory bodies take place. Over the last twelve months 18 of cases which met the harm threshold were substantiated

The overall outcomes of the cases referred during this reporting period, 18 were substantiated, 19 were unsubstantiated, 10 were unfounded, no malicious outcomes within this reporting year and at the time of writing this report, there were 6 ongoing cases. There were no false outcome recordings.

Consultations Meeting/Not Meeting Threshold

There are a number of consultations with the LADO service which were dealt with and resolved without the need for formal LADO intervention. These are often contacts where staff conduct, or behaviour is of concern or where a complaint has been received relating to safeguarding concerns. Many can be resolved quickly with advice/guidance or referrals to Human Resources. [There is no current facility to record these contacts on the LADO electronic file/Mosaic]

The numbers of consultations demonstrates the level of advice and guidance the LADO services provides to organisations providing services to children and young people and these include safer recruitment advice, support in managing staff conduct and behaviour where it might lead to safeguarding issues. This level of preventative

work is valued and well received by partners, particularly schools and early years settings.

Investigations

Whilst it is no longer an indicator required to be reported on by the Department of Education, where an investigation is initiated, investigations can be stressful for all concerned and clearly the quicker they can be concluded appropriately, the better. Where allegations are investigated by employers oversight by the LADO can ensure that the matter is concluded in a timely manner. As a result, 77% of allegations are completed within a month and 89% within 3 months. However, there remain some cases where investigations take longer, and these are as a result of police investigations where the “beyond reasonable doubt” threshold requires lengthier processes.

Conclusion

The LADO remains confident about the timely level of responses to LADO enquiries regarding allegations and investigations by professionals internally and externally. This year has seen updates to the LADO referral process to ensure clear and concise recording and reporting to ensure more efficient recording and reviewing of LADO cases. The year has seen more frequent contact from a wider range of services with an increased low level enquiries, with a slight increase of substantiated outcomes. The LADO service continues to establish itself within the safeguarding network in Harrow and is seen as a positive and supportive provision. Professionals have fedback the benefits of learning and knowledge acquired as a result of working with LADO. *[An electronic LADO feedback form was introduced summer 2023* **please go to** https://forms.office.com/e/k9k5X6arQR]

8. Appendices

HSSP Budget & Expenditure 2022-23

Harrow Safeguarding Partnership 2022/23	Outturn
NHS NWL Integrated Care Board	40,000
Training Income	10,580
Mayor's Office for Policing & Crime	10,000
North West London NHS Trust	5,000
Royal National Orthopaedic Hospital	5,000
Probation Service Harrow and Barnet PDU	1,000
Total Income	**71,580**
Partnership Manager	68,381
Business Support	32,724
Learning & Development Manager (0.8 FTE)	30,315
Learning & Development Co-ordinator (0.5 FTE)	21,574
HSCB Chair	20,800
HSAB Chair	10,049
Voluntary Action Harrow	14,000
Independent Reviews	0
Total Staffing & consultancy expenditure	**197,843**
Council charges	29,879
Realise	2,678
TASP	1,750
Phew	1,097
Formsite	801
Legal fees	358
Mobile Phones	283
Adobe	269
Total Delivery Costs	**37,115**
Total Expenditure	**234,958**
Net Expenditure funded by LB Harrow	**163,378**

HSCB	July-22	Dec-22	Mar-23	Total
Independent Chair	1	1	1	3/3
Vice Chair/Lay Member	1	1	0	2/3
Elected Member	1	1	1	3/3

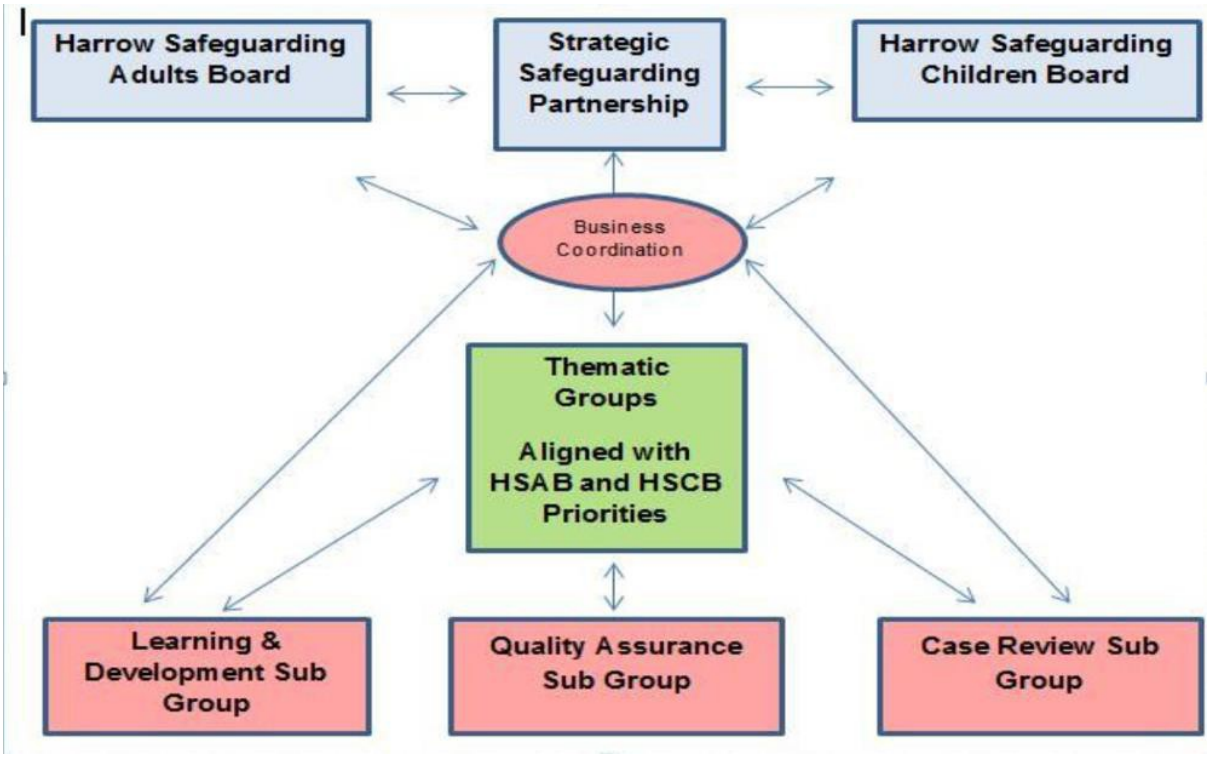
Meeting attendance

Harrow Strategic Safeguarding Partnership	Oct-23	Feb-23	Total
Independent Chair	0	1	1/2
Elected Member	0	0	0/2
CCG	0	1	1 /2
Metropolitan Police Service	1	1	2/2
Local Authority	1	1	2/2
Schools - Primary	1	1	2/2
Schools - Secondary	0	1	1/ 2
Designated Nurse - Children	1	1	2/2
Designated Nurse - Adults	0	1	1/ 2
London Fire Brigade	1	0	1/2

HSAB	Jul-22	Jan-23	Total
CCG	1	0	½
CLCH	1	0	½
Elected Councillor	1	0	½
RNOH	1	0	½
Lay Member	0	0	0/2
LNWHT	1	1	2/2
Business Intelligence	1	0	½
WDP	1	1	2/2
MPS	1	1	2/2
Probation	0	0	0/2
Chair of HSAB	1	1	2/2
Commissioning	0	0	0/2
London Fire Service	1	1	2/2
CNWL	1	0	1/2
Healthwatch Harrow	0	0	0/2
Community Connex	1	0	1/2
Mind in Harrow	0	0	0/2
DBS	0	0	0/2
Harrow Association of Disabled People	1	1	2/2
Housing	1	1	2/2
Harrow Council - Children Services	1	0	1/2

CCG	0	0	1	1/3
Met Police	1	1	1	3/3
Local Authority	1	1	1	3/3
Designated Nurse	1	1	1	3/3
CNWL	1	0	1	2/3
LNWUHT	1	1	1	3/3
RNOH	1	1	1	3/3
Secondary Schools	1	0	0	1/3
Special Schools	1	1	1	3/3
Independent School	1	0	0	1/3
Colleges	0	0	0	0/3
WDP	0	0	0	0/3
Voluntary Sector Rep	1	1	1	3/3
Public Health	1	1	0	2/3
Housing	0	1	1	2/3
Probation	0	0	0	0/3
London Ambulance Service	0	0	0	0/3
London Fire Brigade	1	0	1	2/3
CAFCASS	0	0	0	0/3

Harrow Safeguarding Partnership Structure

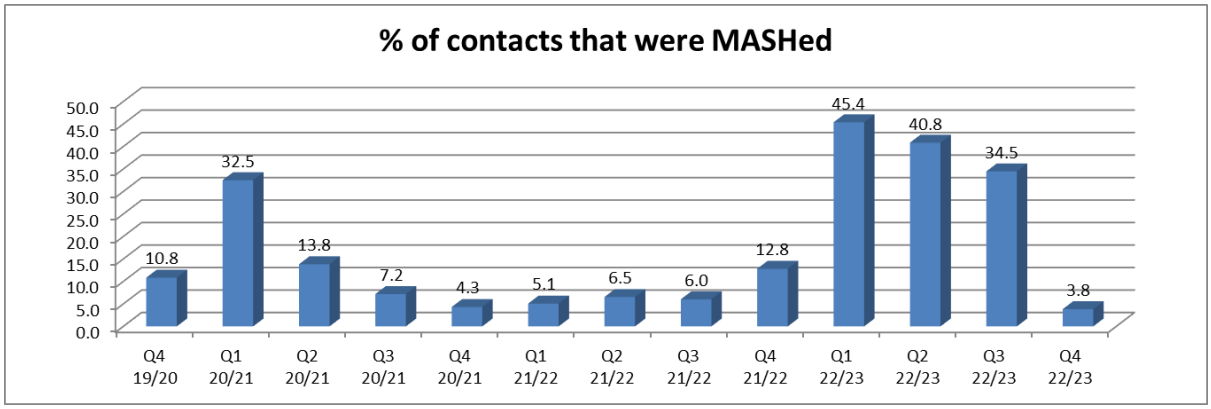


Children's social care - safeguarding data

Contacts

Number of contacts processed each quarter

	Q4 20-21	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23
Number of contacts	2710	2881	2755	3051	2810	2832	3087	2910	3002
Number of contacts that were MASHed	117	146	180	184	360	1285	1261	1003	115



Sources of contacts

Year to date, the most frequent source of contact was Police accounting for 26.5% of the total, this was followed by totalled Education Services and Health Services accounting for 22.5% and 18.2% respectively.

Contacts YTD - Contact Source	Count	%
Police	3143	26.5%
Education Services - Schools, school nursery	2670	22.5%
Legal Agency -eg courts, probation, immigration, CAFCA	979	8.2%
Health Services - A&E and Ambulance Service	902	7.6%
Health Services - Other (eg Hospital, CAMHS, hospice)	785	6.6%
Other - eg children's centres, independent or voluntary or	748	6.3%
LA Services - Non - Harrow Local Authority departments	610	5.1%
Individual - Family member / relative / carer	372	3.1%
Health Services - GP, walk in centre, 111	353	3.0%
Education Services - Other (admissions, SENCO, nursery	311	2.6%
LA Services - Internal Social Care Dept. eg Adults, EDT	274	2.3%
LA Services - Early Support	159	1.3%
Individual - Self	129	1.1%
LA Services - Internal other e.g. Youth Offending	129	1.1%
Health Services - Health Visitor	102	0.9%
LA Housing dept or housing association	98	0.8%
Individual - Acquaintance eg. neighbours / child minders	42	0.4%
Individual - Other (Including strangers, MPs, Councillor)	23	0.2%
Anonymous or name not to be shared	18	0.2%
Health Services - School Nurse	17	0.1%
Unknown	8	0.1%
Health Services - Primary (e.g. Dentist, Optician)	2	0.0%
Total	**11874**	

Top 10 presenting issues

The most common presenting issue for contacts year to date is Parenting Support accounting for 34.9% of the total. This was followed by Request for Information and totalled abuse & neglect accounting for 11.5% and 8.6% respectively.

Rank	Presenting Issues YTD	No.	%
1	Parenting Support	5676	34.9%
2	Request for information	1868	11.5%
3	Totalled Abuse and Neglect*	1072	8.6%
4	Domestic Abuse	1202	7.4%
5	Missing from education	984	6.0%
6	Mental Health Concerns (Parental)	543	3.3%
7	Illness or Disability - Child	389	2.4%
8	Socially Unacceptable Behaviour (Victim)	334	2.1%
9	Mental Health Concerns (Child/Young Person)	312	1.9%
10	Housing - other issues	260	1.6%

*Totalled Abuse and Neglect	No.	%
Abuse - Physical	709	4.4%
Abuse - Neglect	369	2.3%
Abuse - Emotional	183	1.1%
Abuse - Sexual	139	0.9%
Total	1400	

Contact outcomes

The main outcome from contacts completed in the quarter was NFA - Contact (52%), this was followed by Social Work Assessment accounting for 23%.

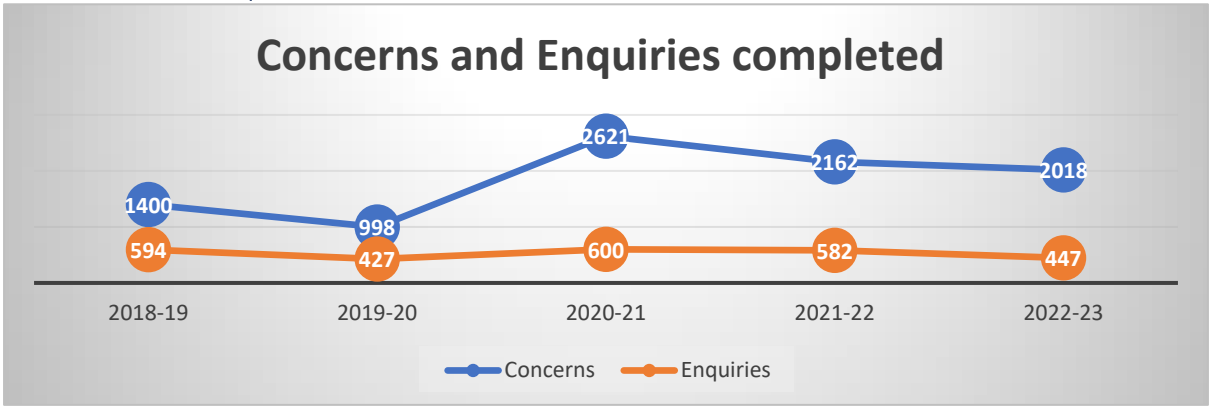
Completed Contacts Outcomes YTD*	Count	%
NFA	6121	51.5%
Social Work Assessment	2784	23.4%
Early Support	1798	15.1%
Referral to Education	848	7.1%
Core Offer Short Breaks	144	1.2%
Strategy Discussion	88	0.7%
Occupational Therapy	32	0.3%
Prevent CISR	25	0.2%
CP Transfer In Conference	14	0.1%
Adoption Support Request	5	0.0%
Special Need Housing Assessment	3	0.0%
Enablement Referral	1	0.0%
LADO Allegation Referral	1	0.0%
Private Fostering Assessment	1	0.0%
Total	**11874**	

Adult Social Care - Safeguarding Adults Data

Key facts

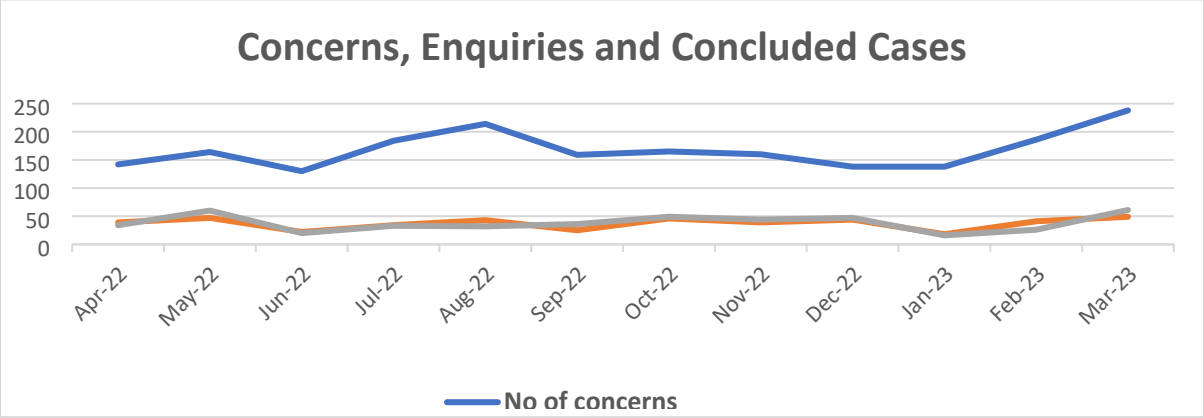
- Data collected for the financial year 2022-23 for all over 18s with a safeguarding concern (which may lead to enquiry and further work)
    - concerns
    - enquiries
    - completed work
    - Making Safeguarding Personal
    - Reduction of Risk

Concerns and Enquiries



In Harrow the number of concerns and enquiries have reduced 7% and 23% respectively compared with the previous year. Conversion rate: 22% in 2022-23; 27% in 2021-22

Demand – Concerns, Enquiries and Concluded cases



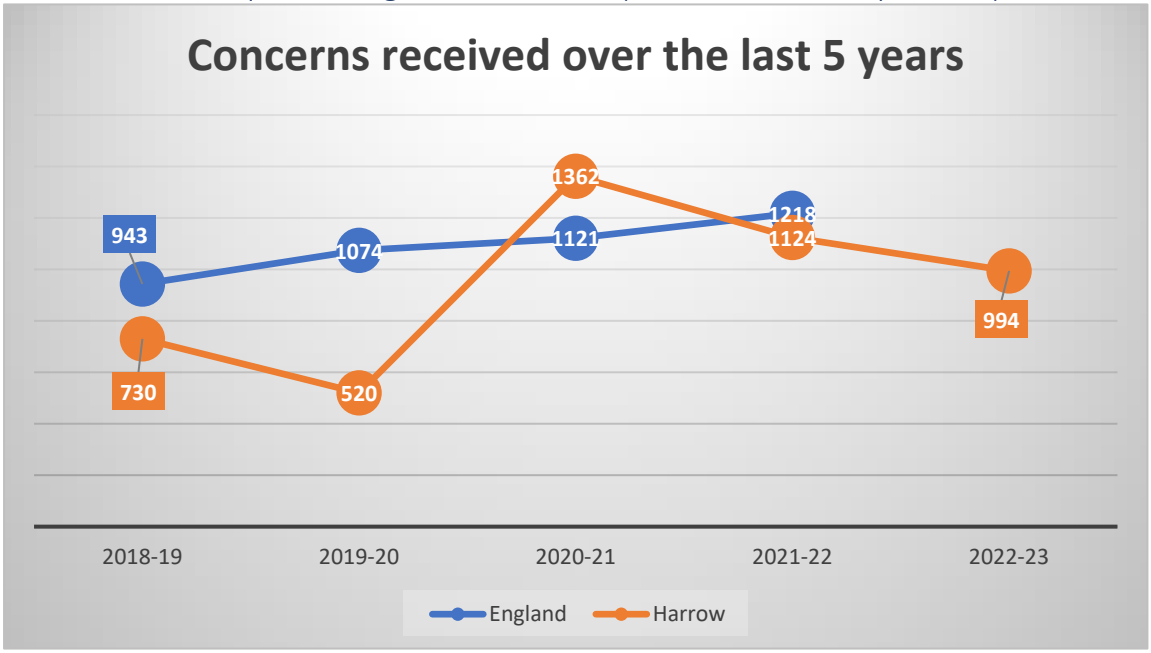
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Grand Total	Average
Concerns	142	164	130	184	214	159	165	160	138	138	186	238	2018	168
Enquiries	39	47	22	34	43	25	46	39	44	18	41	49	447	37
Concluded Cases	34	60	20	33	32	36	49	44	47	16	26	61	458	38
Conversion rate	27%	29%	17%	18%	20%	16%	28%	24%	32%	13%	22%	21%	22%	22%

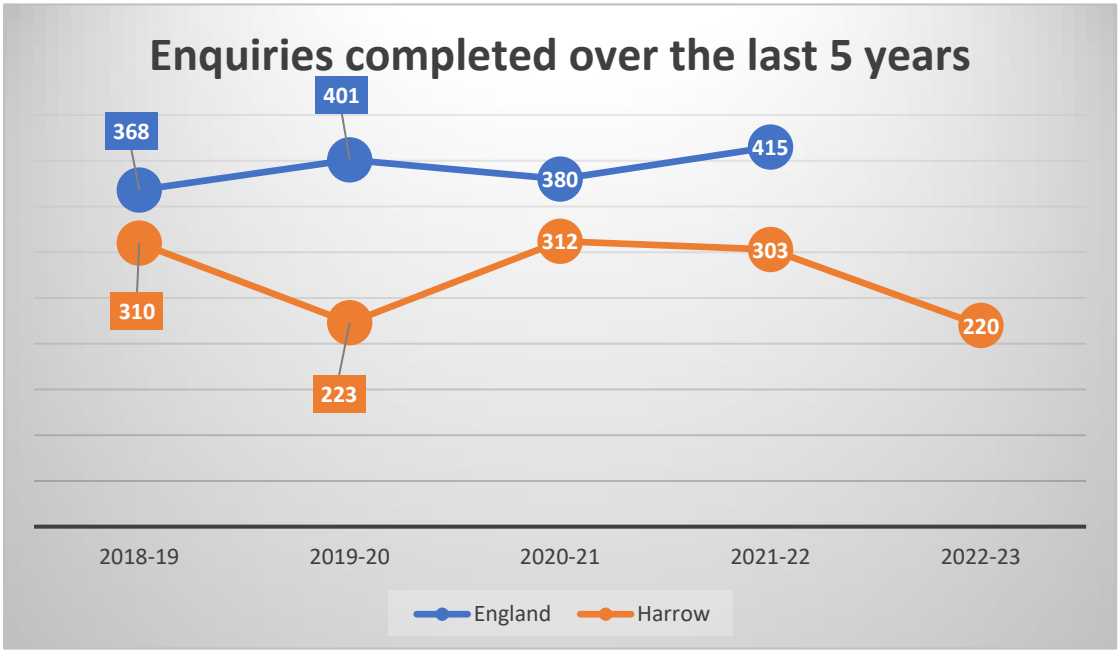
Concerns – volume and change in types of abuse

Type of Abuse	2021-22	2022-23	Change
Psychological Abuse	633	530	-16%
Neglect and Acts of Omission	608	497	-18%
Self-Neglect	533	490	-8%
Physical Abuse	472	328	-31%
Financial or Material Abuse	325	278	-14%
Domestic Abuse	224	268	20%
Sexual Abuse	86	73	-15%
Sexual Exploitation	23	27	17%
Discriminatory Abuse	9	11	22%
Organisational Abuse	9	6	-33%
Modern Slavery	8	5	-38%
Grand Total	2930	2513	-14%

Overall a 14% reduction in the types of abuse reported in 2022-23 compared with 2021-22. Although we can see a reduction in most types of abuse reported, domestic abuse has increased along with sexual exploitation and discriminatory abuse.
Note: in Q1 of 2021-22 Harrow was still recording all Merlins (from the Police) as concern as we did in 2020-21. This practice ended towards the end of Q1.

Concerns and Enquiries: England Vs Harrow (Per 100K adult Population)





When comparing the previous year per 100K adult population we can see a slightly bigger reduction in the number of concerns (12%) and enquiries (27%) compared with the previous year. This is due to the increase in the mid year estimates for 2021 which as increase by almost 11k residents.
Note: England figures includes section 42 and other enquiries while Harrow only submits Section 42 enquiries.

Concerns - Age groups and the types of abuse that affect them

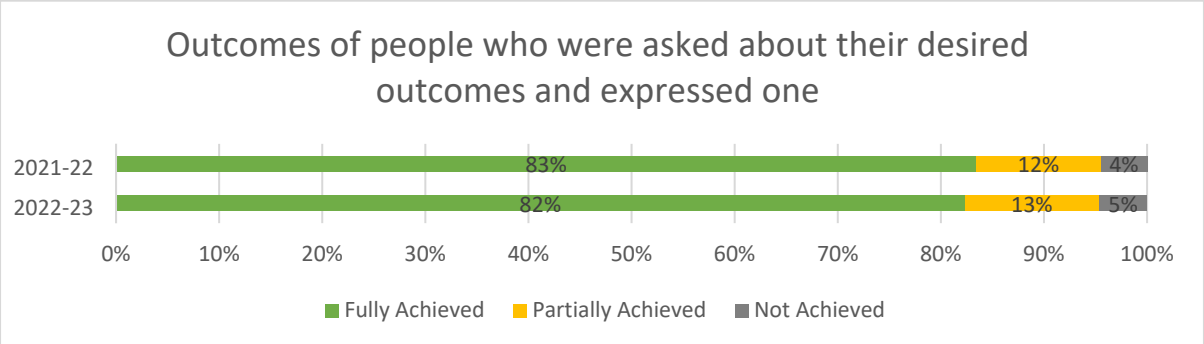
Older age group still mainly affected by Neglect, while younger adults mainly affected by Psychological abuse and Self-Neglect

2022-23				
	18-64	65+	85+	Nos.
Neglect and Acts of Omission	12%	33%	47%	416
Self-Neglect	20%	17%	10%	382
Psychological Abuse	25%	14%	9%	409
Physical Abuse	13%	14%	14%	276
Financial or Material Abuse	11%	13%	17%	234
Domestic Abuse	13%	7%	2%	206
Sexual Abuse	4%	1%	1%	58

Concluded Cases – Making Safeguarding Personal

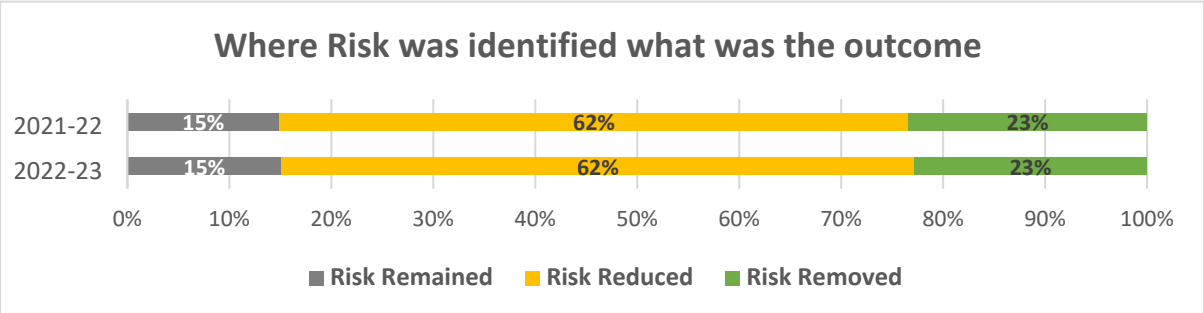
In 81% of cases in 2022-23 people were asked for their desired outcomes compared with 84% in 2021-22.

The proportion of outcomes that were fully and partially met are similar to the previous year.



Concluded Cases – Risks Identified

In 72% of cases Risk was identified in 2022-23 compared with 71% of cases in 2021-22. The proportion of reduced and removed are similar.



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