

**Harrow**  
**Joint Strategic Needs Assessment**  
**2015-20**

Harrow Health and Wellbeing Board

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## Foreword

by Cllr Anne Whitehead as chair of HWB?- To be completed when Cllr W returns from holiday

*Points to make*

*Jсна is a statement of current health and wellbeing in Harrow underpinning the strategies of partner organisations*

*It can never include absolutely everything*

*An active process which will be added to over the coming years (reports and needs assessments and listening to the voice of our residents)*

*The challenge of the financial situation for statutory services and impact this may have on the levels of service provision in future.*

*Thanks to all the contributors*

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

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## Acknowledgements

The JSNA has been compiled by the Harrow Public Health Team and guided by the JSNA Steering Group in which Public Health, Adult Social Care, Housing, Cultural Services, Harrow Children's Services and Harrow Health watch were represented. Special thanks to the Public Health Team and all who contributed to the JSNA including the members of the public:

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## Introduction

### What is a Joint Strategic Needs Assessment?

A Joint Strategic Needs Assessment (JSNA) is an ongoing process by which local authorities, clinical commissioning groups and other public sector partners jointly describe the current and future health and wellbeing needs of its local population.

The aim of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages through ensuring commissioned services reflect need. It is used to help to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing. It does this not only through the Joint Health and Wellbeing strategy but through the other strategies and plans that partner organisations develop over the coming years.

### Harrow's approach to JSNA

Harrow's previous JSNA was completed in 2012 and has been added to by a series of needs assessments, reports on evidence and local profiles on a variety of topics. The local vision for the JSNA is that it will

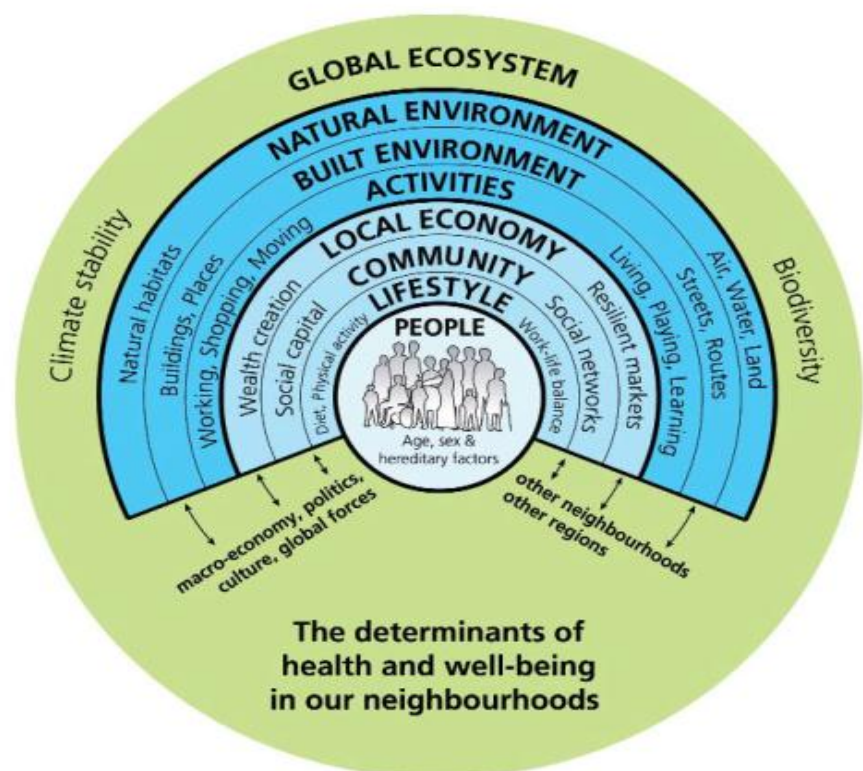
- provide an analysis of data to show the health and wellbeing status of local communities including where inequalities exist;
- describe local knowledge and evidence of effectiveness of current interventions

to identify any gaps in service provision; and

- form a key part of the evidence base on which commissioning decisions will be made.

Our health and well-being is influenced by a wide range of factors, many of which lie outside the remit of health and social care services. These factors include economic issues, the quality of the local environment and of housing, as well as how people connect to the wider society. The 2010 Marmot Review<sup>ii</sup> noted a 7 year gap in life expectancy between the richest and poorest neighbourhoods and the gap widens to 16 years when considering disability-free life expectancy.

Figure 1 The determinants of health



Source: H. Barton and M. Grant 2006<sup>iii</sup>

These differences are not just at a national level but are also apparent at a local level

and are a result of an accumulation of disadvantages through life. Therefore the conceptual model underpinning this JSNA is that, by creating health-promoting environments in the broadest sense, we can improve the health and wellbeing of people living within them and reduce health inequalities

Figure 1 illustrates this concept, showing the range of influences on a person's health.

The model acknowledges that:

- Health and wellbeing is not about health services alone. The biggest impacts on an individual's health and wellbeing are derived from the environment they are born in, that they live and work in; from their education and wealth; and from their relationships with others.
- Tackling determinants of health is required across the life cycle, using a life course approach (rather than at a single point in a certain time), using the Marmot approach which addresses health inequalities between vulnerable

and no vulnerable populations focusing on all ages and stages of life.

## Current Issues

Public Services are going through a period of unprecedented financial challenge. Reductions in local authority budgets and increasing pressure on both health and local authority budgets due to an increasingly aged population mean that over the next few years, some difficult decisions will have to be made to respond to these challenges.

This JSNA aims to identify what and where inequalities in health and wellbeing and the factors that influence it exist so that together, our strategies and action plans can improve the lives of the people of Harrow..

# A picture of Harrow and its people

## Harrow's Geography

Harrow is an Outer London Borough in North West London and approximately ten miles from central London, covering 50 square kilometres (20 square miles). Harrow is the 12<sup>th</sup> largest borough in Greater London in terms of size. Harrow borders Hertfordshire to the north and four London Boroughs: Barnet to the east, Brent to the south east, Ealing to the south and Hillingdon to the west.

## Population

Around 243,500 people live in Harrow. Just over half of them are female. 7% of the population are children under 5 years old and 7% are aged over 75. Compared to London, the population of Harrow has a greater proportion of older people and a lower proportion of people in their 20s and 30s.

Over the next ten years, the population of Harrow is expected to grow over all. The proportion of people who are of working age (16-64) will decrease by 4% and the proportion of those over 65 will increase by 4%.

Figure 2 Harrow Electoral Wards

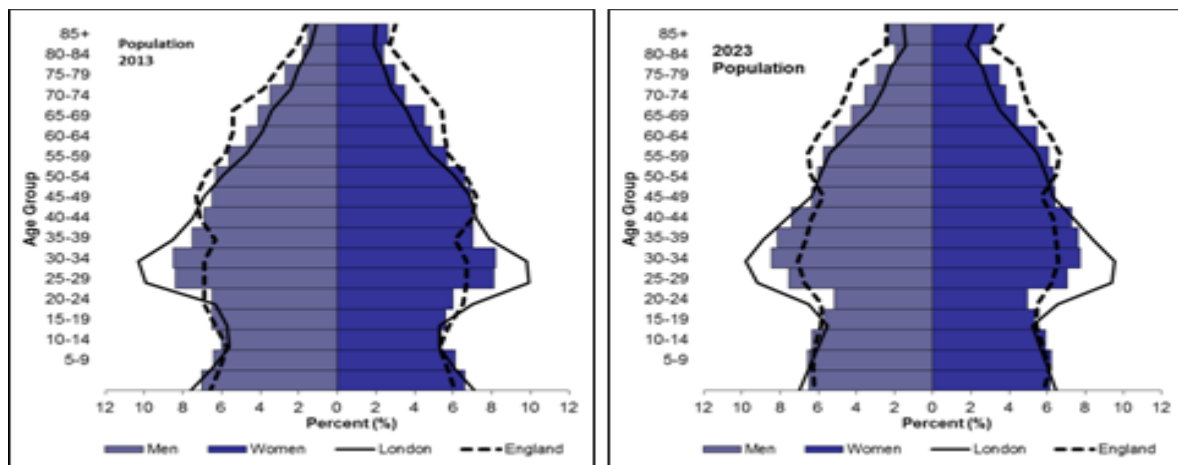


The age structure of the population varies across the borough with more children living in the south and central corridor and more people aged over 65 living in the north of the borough.

## Ethnicity

Harrow is one of the most ethnically diverse boroughs in the country. In 2011, 42% of the Harrow populations were from a white ethnic background, while 43% were

Figure 3 Population structure 2013 and projection for 2023



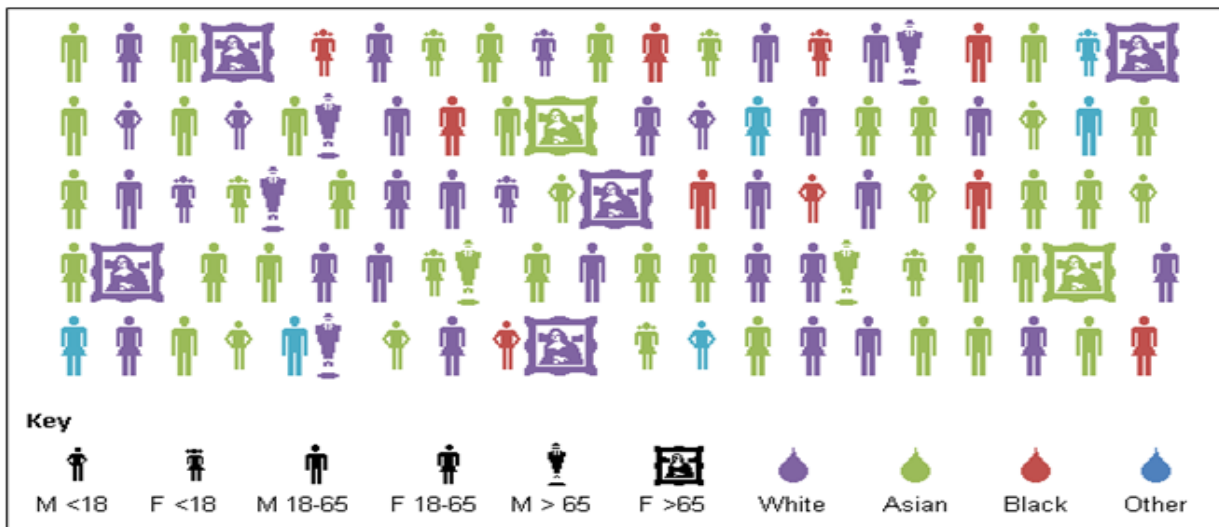
from an Asian/ Asian British background

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and 8% were from Black/ African/ Caribbean/ Black British ethnic

groups make up over 70% of the population. With the increase in BAME

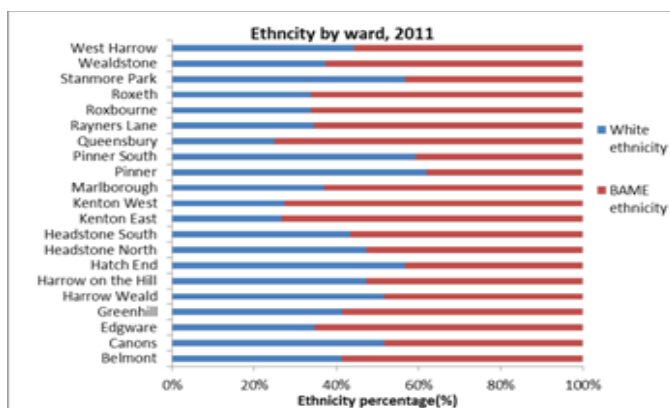
**Figure 5 Diversity in Harrow**



background. Over the next 10 years it is predicted that the local Black, Asian and minority ethnic (BAME) population in Harrow is projected to increase from almost 54% to 68%. Every year Harrow welcomes over 2,000 people new British citizens through citizenship ceremonies.

population, there may be different patterns of health and illness. For example, higher rates of diabetes and heart disease in BAME groups may require a different and culturally appropriate approach to prevention and treatment services

**Figure 4 Ethnicity across Harrow**



As with the age structure of the population, the ethnic mix also varies across the borough. In Pinner and Pinner South wards BAME groups make up around 40% of the population while in Queensbury, Kenton West and Kenton East, BAME

## Religious diversity

Together with the ethnic diversity, Harrow has great religious diversity. Harrow is home to one of the largest Hindu communities in the country, making up 26% of the population. There are also a greater proportions of people of Muslim and Jewish faiths than the national average.

## Sexual orientation

Although sexual orientation is a protected characteristic under equalities legislation, there is no robust data on the numbers of lesbians, gay men and bisexuals in the population as no national census has ever asked people to define their sexuality. The Government estimates that 5-7% of the population are lesbians, gay men or bisexual. Stonewall, a UK charity

supporting LGB rights, agrees with this estimate<sup>iv</sup>.

There is debate about whether same sex partnerships registrations can be used as a proxy measure for sexual orientation, as not all LGBT people will be in a relationship let alone have a civil partnership.<sup>v</sup>

Between December 2005, when the Civil Partnership Act<sup>vi</sup> came into force, and the end of 2013, there have been 71 civil partnerships in Harrow. On 29 March 2014, same sex couples have been allowed to marry<sup>vii</sup>, There is no data yet on how many marriages have taken place locally or how many of these are conversions from civil partnerships..

## **Deprivation**

The impact of deprivation on our health and wellbeing is well documented and includes a variety of factors such as housing, employment and income to give a single score. Harrow is ranked 203rd out of 354 Districts in England where 1st is the most deprived. Most deprivation is in the centre of the borough, with pockets of deprivation in the south and east Harrow's least deprived areas are found in the west of the borough. Not all disadvantaged people live in deprived areas and conversely, not everyone living in a deprived area is disadvantaged.

## **Mosaic Profiles**

Using segmentation provides us with a different dimension of looking at the residents of Harrow in terms of their lifestyle choices, preferences and attitudes. Harrow Council, with Experian, has created eight Harrow customer profiles or segments. They are based on Experian's

Mosaic Public Sector classification, which uses over 850 million pieces of information across 450 different data points condensed using the latest analytical techniques to identify 15 summary groups and 66 detailed types that are easy to interpret and understand. Not all of these groups or types are present in Harrow: 86.5% of Harrow households fall within just 5 of the 15 main groups and 96.5% of Harrow's households fall into 18 of the 66 detailed types.

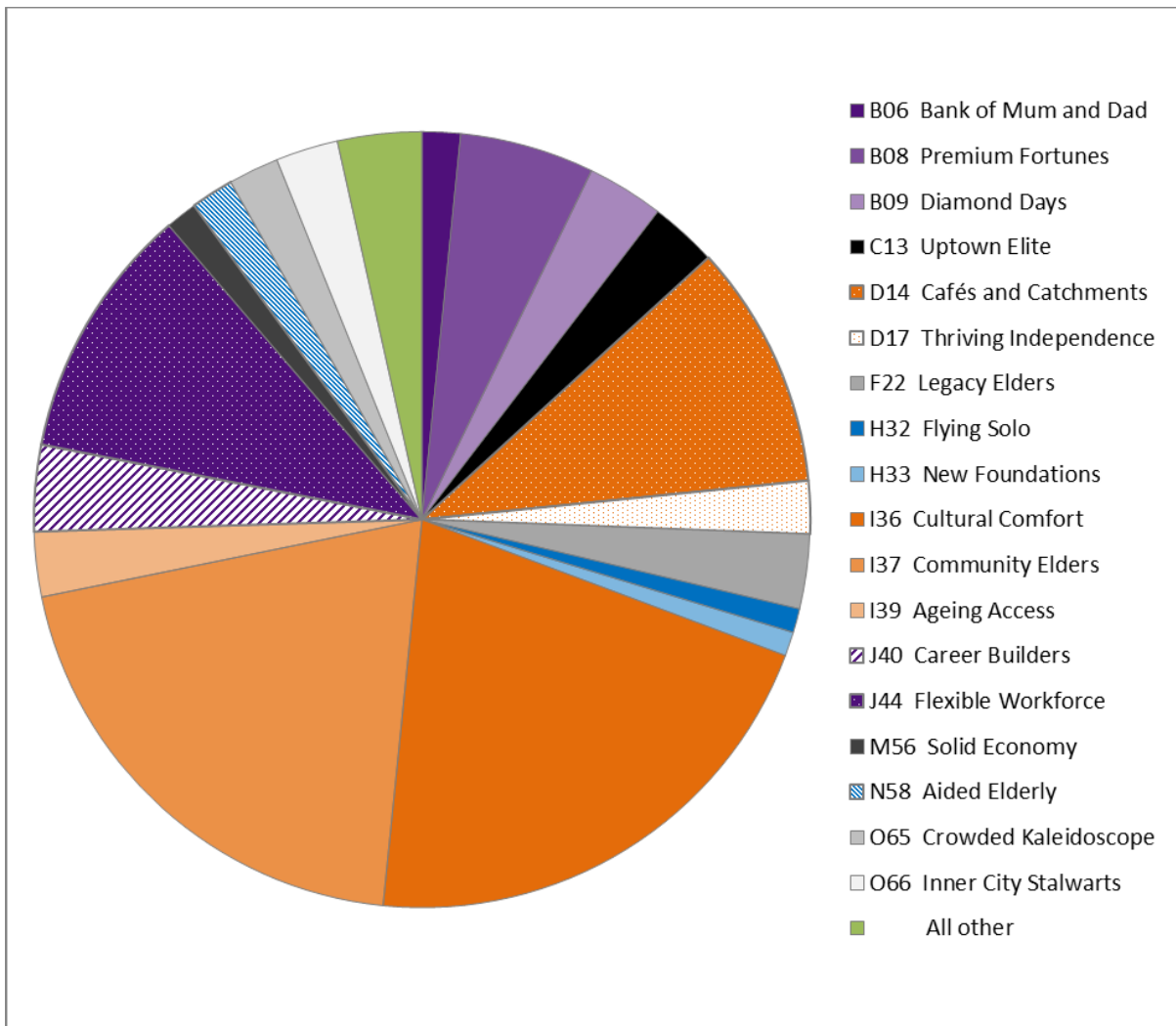
The segments provide a way of understanding the needs of Harrow residents and the ways in which they prefer services to be delivered. The profiles have proved informative in improving public services in Harrow.

The Mosaic segmentation confirms findings from the Census 2011 as it shows that Harrow is a family orientated place. Two thirds of households live in mixed households, with the majority of households having children, in some cases adult children living at home or a number of non-related families living in the same address. In particular due to the high level of owner occupier some segments can be classified as 'asset rich' and 'income poor' especially if they work in low paid or irregular employment patterns.

The data shows that 24% of households are single occupancy (differing age ranges) and 25% of households have a household income of £70,000 or more. The engagement and technology preferences reflect that email is the preferred communication method for all types in differing amounts although. 2.3%, over 1,600 Harrow households do not have internet access

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Figure 6 Harrow Experian Segments



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## Vulnerable groups

### Children and Younger people

Harrow is home to 55,800 children aged 0-17<sup>viii</sup>. About 3,100 children were in need of a service from Social Care between 01/04/2013 and 31/03/2014<sup>ix</sup>. This includes children looked after (CLA), those supported in their families or independently, and children who are subject of a child protection plan (CPP). In line with the Children Act, local councils

must identify the extent of need in their area and make decisions about the levels of service they provide. Harrow is ranked 65 in the 'Income Deprivation Affecting Children Index' (IDACI)<sup>x</sup> and the percentage of children living in poverty is just slightly below the England average.

### Children in need

Harrow's children 'in need' (CiN) rate has increased recently following a revision of thresholds for eligibility of social care

Figure 8 Children in need rate per 10,000 aged 0-17

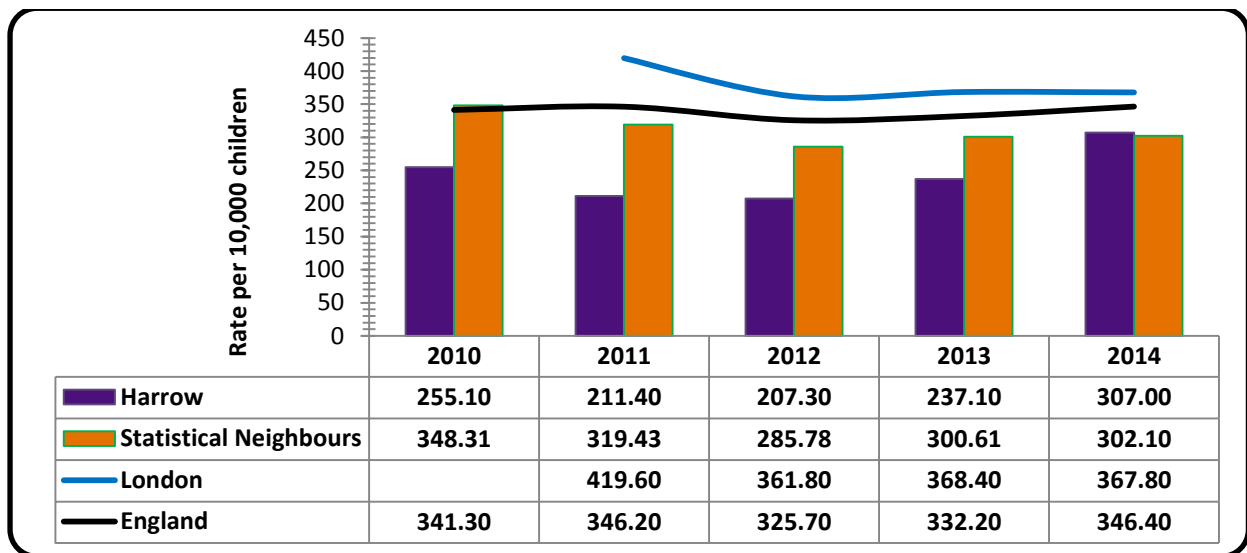
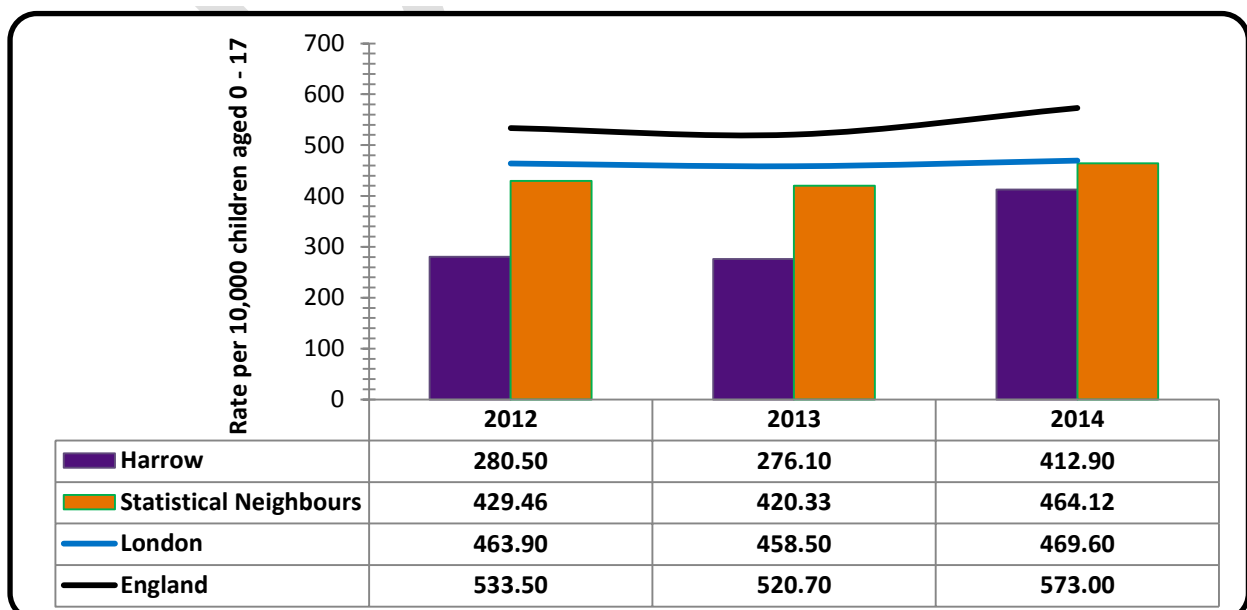


Figure 7 Rates of referrals to children's social services



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services. Harrow now has a similar proportion (rate per 10,000 children aged 0 -17) of children 'in need' (CiN) compared to our statistical neighbours. The local demographic changes showed an increase in the size of the under 18 population which is likely to result in additional demand on both universal and specialist services.

## Key issues and challenges

Nearly two-thirds of Harrow's under-18 CiN population are from BME groups and this is reflective of the borough's population.

Proportions of CiN of Asian and 'other' ethnic groups are higher than statistical neighbours, London and England. The table below indicates how the ethnicity of

As at 31 March 2014, approximately 54.8 (male) children were children in need compared to 43.7% (female) children in Harrow. This remains consistent with London, England and Harrow's statistical neighbours.

The number and rate of referrals per 10,000 children in Harrow had historically been low compared to national averages,

but 2013 -14 saw a rise due to revised thresholds & the changing demography.

There were 2,305 referrals made to children's social care services during 2013-14 compared to 1,529 in the previous year. Nationally there has been a rise in referrals by approximately 11%.

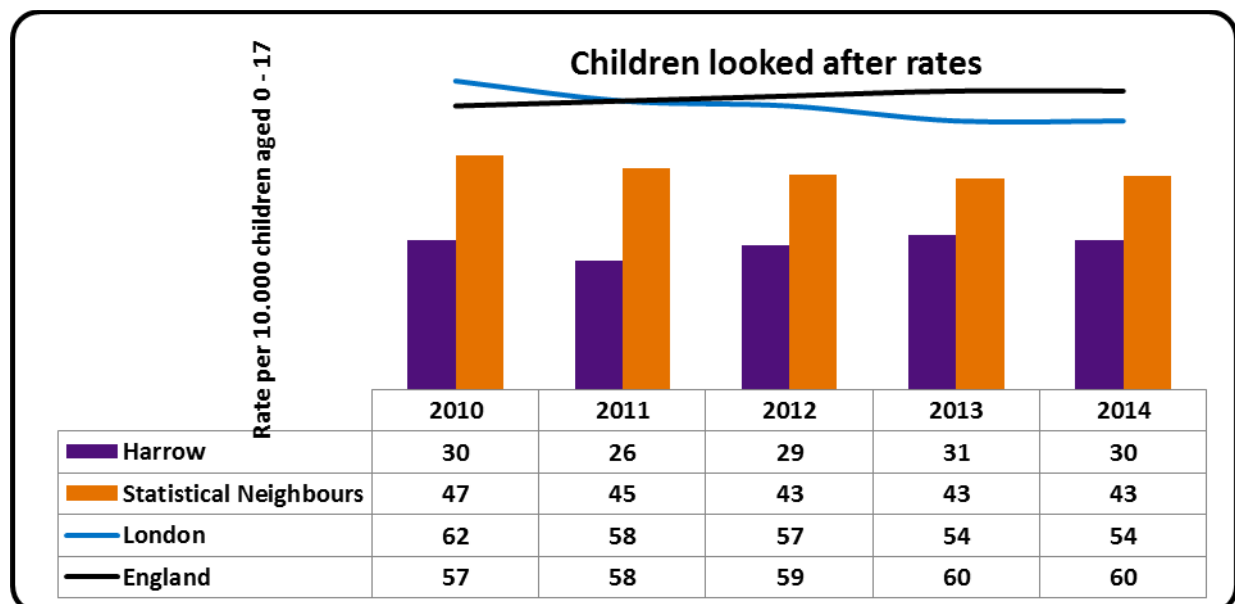
## Children Looked after

Under s.17.1 (a) of the Children Act 1989, local authorities have a duty to 'safeguard and promote the welfare of children within their area who are in need'. The Act is designed to ensure the safety and wellbeing of a child and if appropriate provide services that will allow the child to stay with their family.

Where there are serious concerns that a child is at risk of harm if she/he remains at home, the local authority may apply for a court order to remove the child. If this request is granted the child becomes a 'looked after' child.

The term 'looked after' includes all children being looked after by a local authority, i.e. those subject to court orders and those looked after on a voluntary basis through

Figure 9 Rates of Children Looked After





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an agreement with their parents under Section 20 of the Act.

At the end of March 2014, almost 69,000 children were looked after in England, an increase of 1% on the previous year and 7% compared to March 2010. This number has been increasing steadily over the past five years and is now at its highest point since 1985. Nationally, there are 60 looked after children per 10,000 children in the population.

Harrow's number and rate of looked after children are generally fairly stable and have historically been substantially lower than England, London and statistical neighbours (there was a temporary dip in the numbers during 2010-11). At 31st March 2014 there were 165 children looked after.

The rate in Harrow is significantly lower than the England rate at 30 per 10,000.

The main reason for children to become looked after across all councils including Harrow's statistical neighbours, London and England is due to abuse or neglect. For Harrow, the proportion in this group is higher than other councils, but lower due to absent parenting and family dysfunction.

Other reasons for becoming looked after could be due to the child's disability or that the family is in acute stress but these numbers are usually low.

Slightly more CLA are male than the National rate but this is not significantly different. As in the rest of London and in our statistical neighbours, there is a greater proportion of placements in private provision.

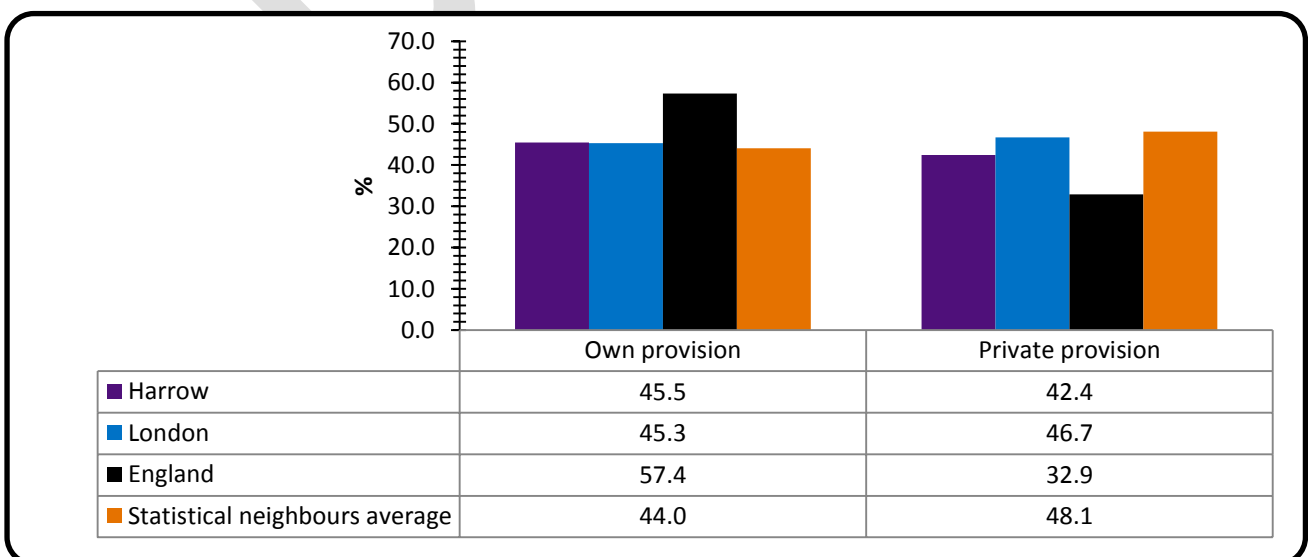
**Figure 11 Gender of Children Looked After at 31<sup>st</sup> March 2014 (%)**

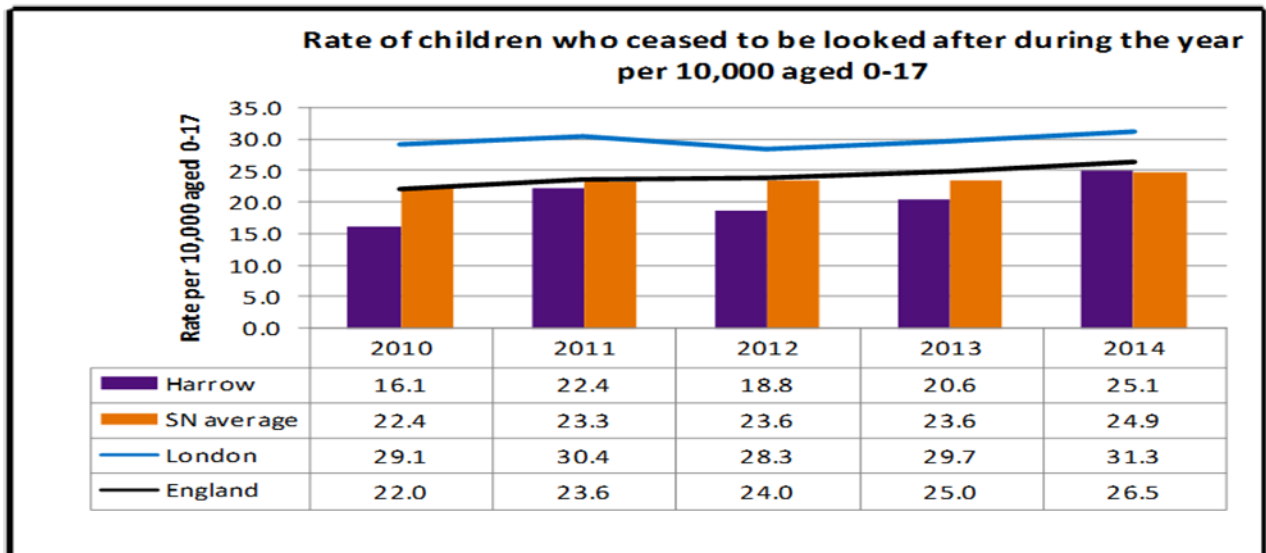
	Male	Female
Harrow	<b>60.6</b>	<b>39.4</b>
London	56.5	43.5
England	55.3	44.7
Statistical neighbours average	56.3	43.7

Source: DfE Children looked after in England including adoption

The rate of CLA who leave the service has been increasing over the past 3 years at a similar rate to that of England, London and our statistical neighbours.

**Figure 10 % LAC by placement provider at 31st March 2014**





### Unaccompanied asylum seeking children

There are nearly 2,000 unaccompanied asylum seeking children (UASC) looked after in England. Local authorities are legally obliged to ensure that they receive the same quality of care and protection as other children. Nationally, since 2010 the number of UASC has fallen. This is partly reflected in Harrow between 2010 and 2011, but the number since has been stable, and is now similar to statistical neighbours. Our statistical neighbours include Hillingdon who have high numbers of asylum seeking children and this is likely to have impacted on statistical neighbour averages.

**Figure 12 Number of unaccompanied asylum seeking children who are looked after**

	2010	2011	2012	2013	2014
<b>Harrow</b>	30	25	25	25	25
<b>London</b>	1,380	1,050	920	870	950
<b>England</b>	3,480	2,740	2,220	1,930	1,970
<b>Statistical neighbours</b>	38.3	34.4	26.1	24.0	26.7

Local authorities are responsible for ensuring children who are 'looked after' are able to achieve continuity of placement. Since 2010, the proportion of children who had three or more moves of placement within the year has fluctuated, from a high of 16% to a low of 10%. For the three years between 2011 and 2013 the proportion in Harrow was significantly higher than statistical neighbours, London and England, but this has now decreased and is less (10% compared to 12.6%). Age, behavioural difficulties and the absence of mental health support may contribute to placement breakdown.

The long term stability indicator measures the percentage of children aged under 16 who had been looked after for at least two and a half years, who had been living in their placement for more than two years. Harrow's long term placement stability has declined, from a high of 71% in 2012 to 45% in 2014. As relevant CLA numbers are small and performance can change quickly, close monitoring will need to continue. The proportion of children having three plus moves between 2011 and 2013 is impacting on the longer term stability of placements.

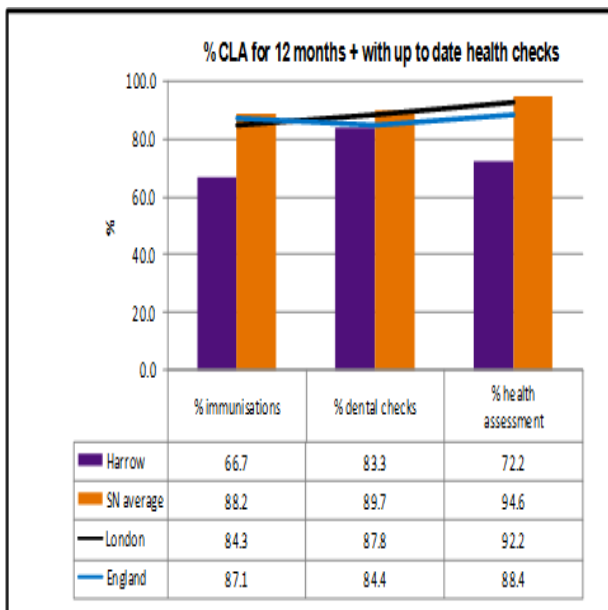
### Key issues and challenges

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## Health checks for CLA

Health checks for children who were being looked after for 12 months or more are a key tool in ensuring the health needs of all looked after children are identified. Initial and annual health assessments are important to ensure prompt identification of pre-existing, emerging and changing health needs

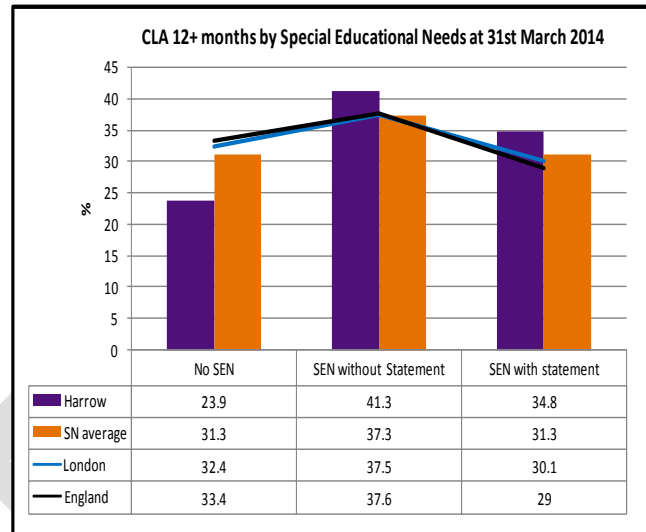
Harrow's performance in immunizations, dental and health checks is significantly lower compared to the statistical neighbours, London and England, and this has decreased since last year, when 94% of all LAC for 12 or more months had all three of these.



Source: DfE Outcomes for children looked after

In 2013-14, 10 out of 90 (11%) children/young people looked after for more than 1 year were identified as using alcohol or substances, compared to 6% across London. Referral pathways are in place between CLA and substance misuse services. Due to small numbers of looked after children Harrow's proportion of looked after children who misuse alcohol or substance appear higher.

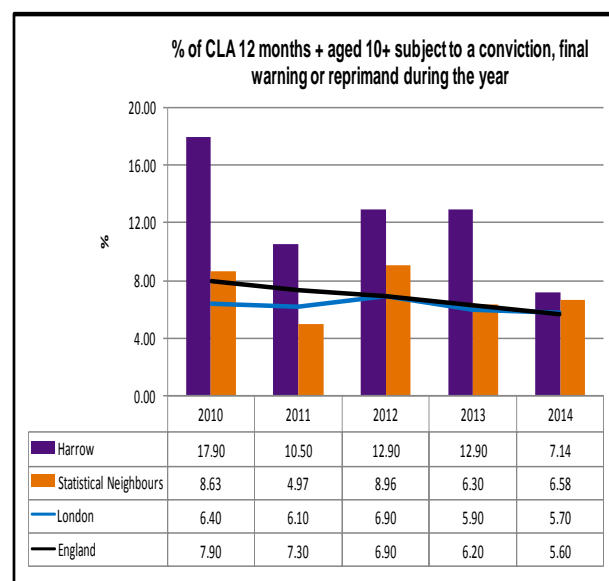
Harrow has a higher proportion of CLA with SEN both with and without a statement compared to statistical neighbours, London and England



and England

## CLA offending

The proportion of Harrow looked after children cautioned or convicted has historically been high when compared with London, England and statistical neighbours; this improved during 2013-14 – the offending cohort is going down (from 10 in 2012-13 to 5 in 2013-14) and the remaining young people include persistent offenders

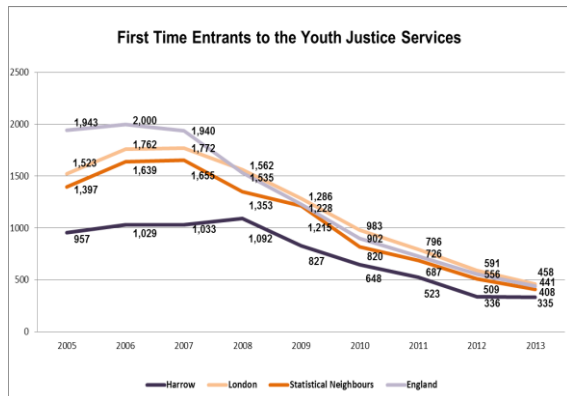
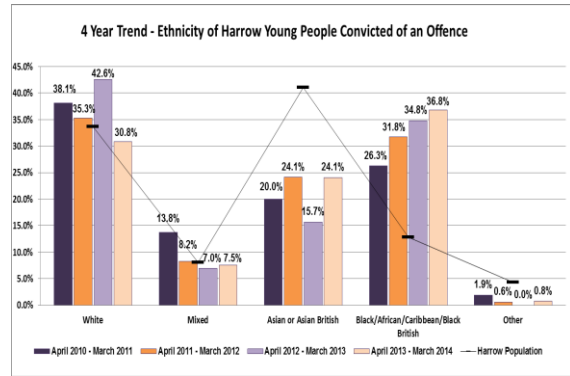


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Source: DfE Outcomes for children looked after

## Youth offending

An offence is defined as a first offence if it results in the person receiving their first reprimand, warning, and caution or court conviction, for example if the individual has no previous criminal history recorded on the PNC

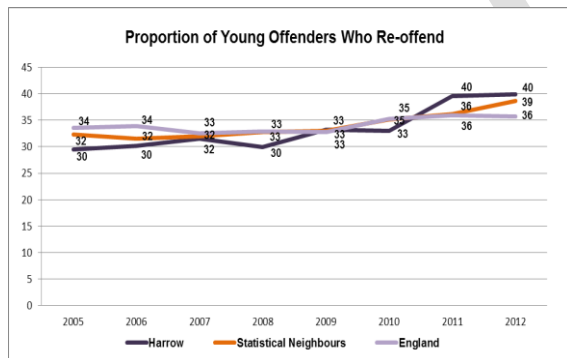


### Key issues and challenges

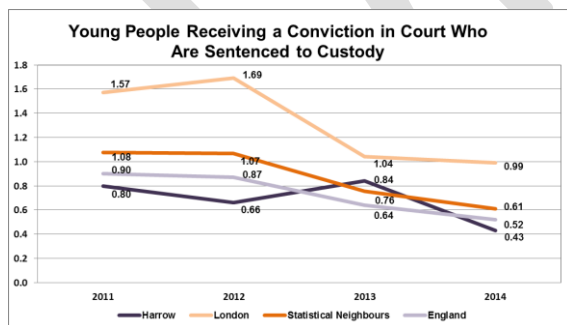
Over the past 4 years (2010/11 to 2013/14), Harrow has experienced some key changes to the ethnic make-up of its offending population.

Asian/Asian British makes up 41.1% of Harrow's 10-17 population, yet only accounts for 24.1% of the young offending population in 2013-14. Asian/Asian British have been consistently under represented over the past 4 years, falling as low as 15.7% in 2012-13.

Young people of Mixed Ethnicity make up 8% of Harrow's 10-17 population. 2013-14 young offending figures are in line with this coming in just under at 7.5%. This rate has been relatively stable over the past 3 years with figure's being significantly higher back in 2010-11 at 13.8%.



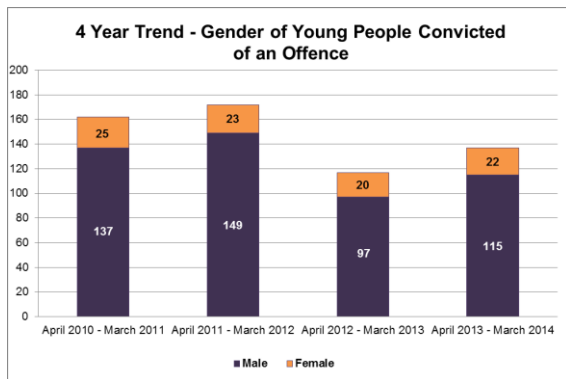
33.7% of Harrow's population is the White British population aged between 10-17 population. In 2013-14 30.8% of Harrow's young offending population were White British. This represents a significant drop on the previous year (2012-13) where White British had risen to 42.6% of the young offending population.



12.9% of Harrow's population is made up of Black/African/Caribbean/Black British population aged between 10-17 population. This ethnic group is considerably over represented, making up only 12.9% of

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Harrow's 10-17 population but 36.8% of the youth offending population in this group were reported in 2013/14. Over the past four years this group have been consistently over represented in youth offending services but this has risen year on year from 26.3% in 2010-11 to 36.8% in 2013-14.



In 2013/14 the gender split of young people convicted on an offence was Nationally 80.9% Male to 19.1% female. In London females represent a smaller proportion with 13.9% to 86.1% male and for the YOT statistical neighbours they represent 15.3% to 84.6% Male.

Over the past 4 years harrow's figures have been variable between 13.4% female to 17.1% female. The 2013/14 breakdown is 16.1% females (22) and 83.9% Males (115).

Harrow has a slightly lower proportion of females convicted of an offence (16.1%) than the national average (19.14%). Although, this is slightly higher than the London (13.92%) and Statistical Neighbour averages (15.32%) averages.

Over the past four years the average number of females convicted of an offence each year is 22.5 (lowest 20 and highest 25). For males this figure is more variable with the average being 124.5 (lowest 97 and highest 149).

## Children with learning disabilities

The estimated prevalence of special educational needs in Harrow has remained consistent over time (2.6%) and is lower than the London (2.7%) and England average (2.8%). The number per 1,000 of children with moderate learning disabilities in Harrow is lower than the London average but higher for children with severe learning disabilities.

## Children with sensory impairments

It is estimated that there are around 25,000 blind and partially sighted children and young adults aged 0 to 16 in the UK, and 15,000 aged 17-25<sup>xi</sup>

Approximately 180 children are reported to be deaf in Harrow and known to services and of these, 178 deaf children receive support such as teaching, visits to the family, liaison with the family and school teachers and provision of hearing aid checks.

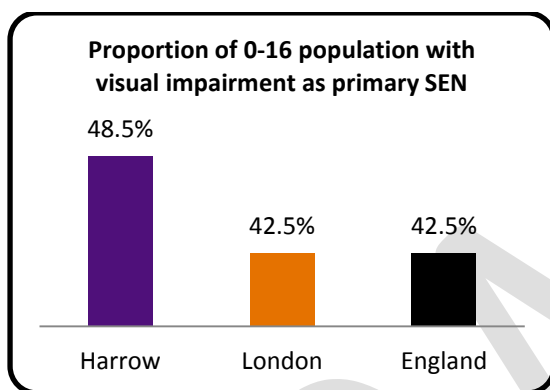
### No of deaf children by service<sup>xii</sup>

	No of deaf children	No of deaf children supported
Harrow	180	178
Hillingdon	210	186
Hounslow	204	148
Kingston Upon Thames	86	63
Merton	142	135
Redbridge	245	193
Richmond	91	85
Barnet	300	143
Bromley	214	204
Sutton	138	120

## Key issues and gaps

Approximately one third of blind and partially sighted children have additional needs and fifty pupils in the borough have a statement of special education needs (SEN) or School Action Plus with visual impairment as their primary SEN.

10% are taught in special schools, while the rest attend mainstream schools. A greater proportion of children in Harrow have visual impairment as primary SEN than the national and regional average



The number of blind children and young people between 0 and 17 known to Harrow council (i.e. registered) is 20 and the number who are partially sighted is 30<sup>xiii</sup>.

During the period of 2013/14, there were no new registered blind or partially sighted CYP in this age group.

The numbers registered children with sensory impairment are likely to be an underestimated. Two percent of under 18 year olds registered blind or partially sighted had an additional disability. The percentage is much higher in the 18 to 64 year old age band and increases to about 3 in 4 of those aged 65 and older<sup>xiv</sup>.

A gap in lack of information on children and young people with sensory impairment is reported. Information on sensory

impairment compared to adults with sensory impairments.

Sight loss due to diabetes is included in the Public Health Outcomes Framework (PHOF), which incorporates data for young people aged 12 and adults, therefore distinguishing the prevalence against adults is challenging.

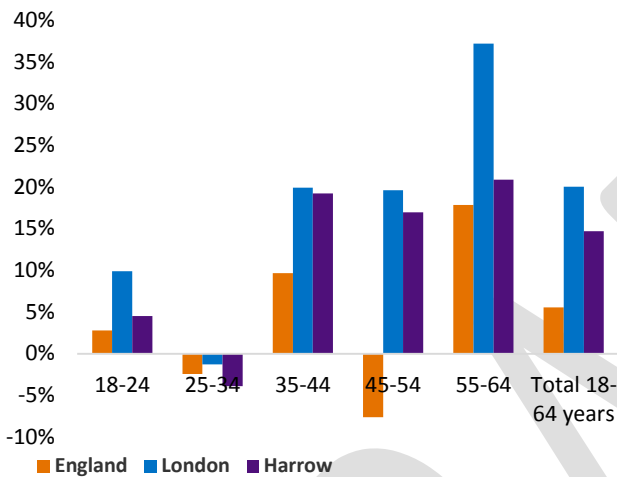
Nationally it is reported that young deaf people moving from children to adults services are often “lost to follow up” during the transition process<sup>x</sup>

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

## Physical Disability

Approximately 240,000 people living in Harrow are reported to have long term health problems or disability. Of these, 15% reported that day to day activities are limited either a lot or a little compared to 17.6% in England and 14.1% in London.<sup>xv</sup>

**Figure 13 Predicted change in percentage of people with a moderate physical disability from 2014-2030**

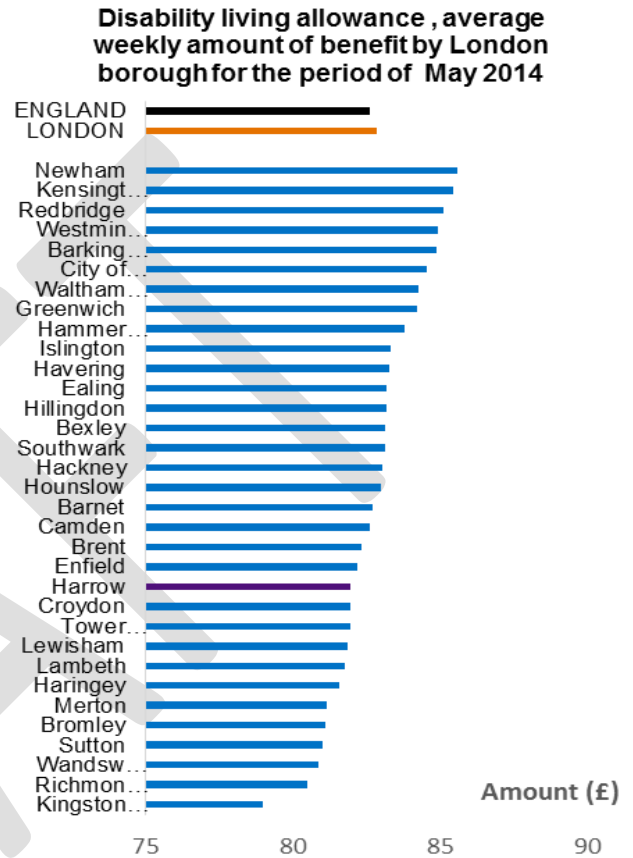


There are approximately 15,000 people aged 16 to 64 with moderate or serious physical disability living in Harrow and this number is predicted to increase to 16,000 by 2020 (a 15% overall). These trends are similar to those predicted for London with the largest proportion increases being in the 55 to 64 age group.

In London the number of working age people who are disabled is about 811,000 and the disabled employment rate is 44.8% which is lower than the average for Great Britain; 46.1%. In London and Harrow, the number of people receiving disability allowance is highest in the 45 to 69 age group. Compared with other London boroughs, the average amount of weekly benefit across all claimants is in the lower in Harrow (50%) and is below the London and England average

The average amount of weekly disability living allowance in Harrow is 12<sup>th</sup> lowest in London and is below the England average.

**Figure 14 Average DLA (£) in London Boroughs**



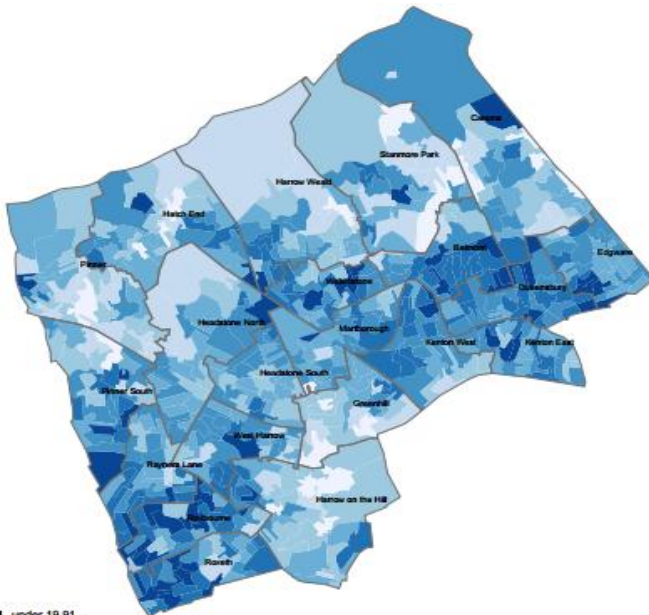
### Key issues and challenges

The highest proportion of Disability Living Allowance claimants in Harrow live in Roxbourne, Stanmore and Greenhill.

Across the borough, 75% of all claimants have been receiving benefits for five years or more. In Stanmore, Greenhill and Hatch End, this proportion is closer to 80%.

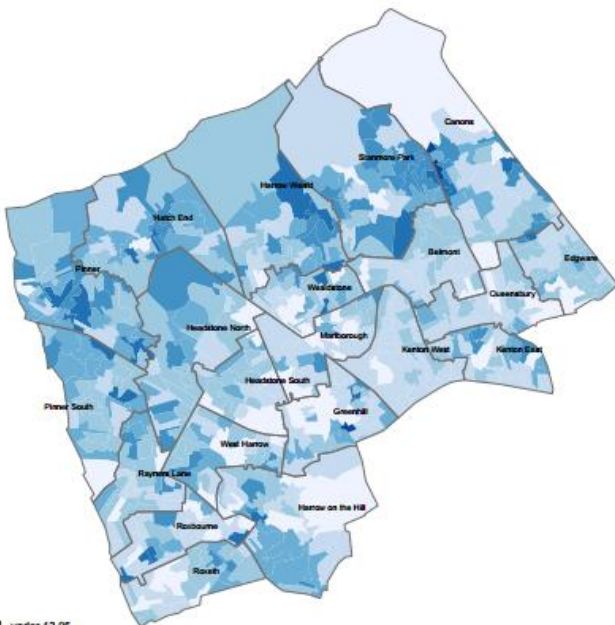
As of April 2013, Personal Independence Payment (PIP) replaced Disability Living Allowance for eligible working aged people making new claims and in 2014 the proportion claiming disability living allowance began to decrease nationally.

Adults not in employment and dependent children and persons with long-term health problem or disability for all households (Dependent children in household: All ages).



I under 19.91  
 I 19.91 to 26.67  
 I 26.67 to 32.24  
 I 32.24 to 37.16  
 I 37.16 to 42.41  
 I 42.41 to 48.63  
 I over 48.63

Adults not in employment and dependent children and persons with long-term health problem or disability for all households (No adults in employment in household: No dependent children).

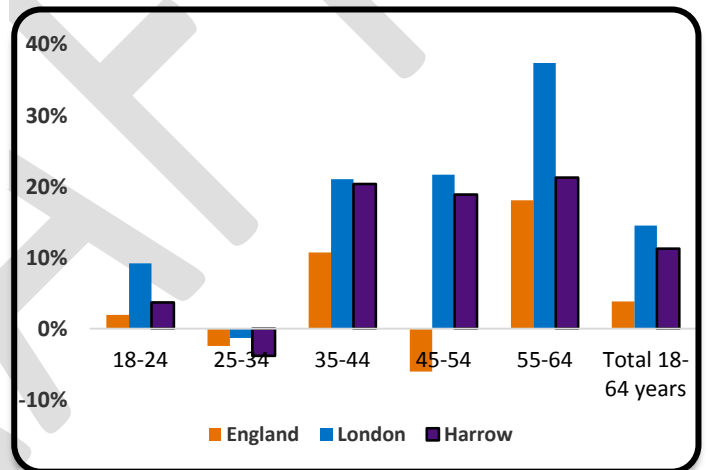


I under 13.95  
 I 13.95 to 19.14  
 I 19.14 to 24.49  
 I 24.49 to 31.63  
 I 31.63 to 42.31  
 I 42.31 to 57.91  
 I over 57.91

## Learning disability

There are around 3,800 adults with a learning disability in Harrow, with the largest number in the 25 to 34 year old age band<sup>xvi</sup>, and these numbers are projected to increase over the next 15 years by 11%. the largest increase being those aged 55 to 64 years (21.3% increase), and those with Autistic Spectrum Disorders (13.6% increase). These increases are likely to be due to improved survival rates and increased birth rates which may likely to have an impact on service provision.

**Figure 15 Projected increase in people with a learning disability 2015-30**



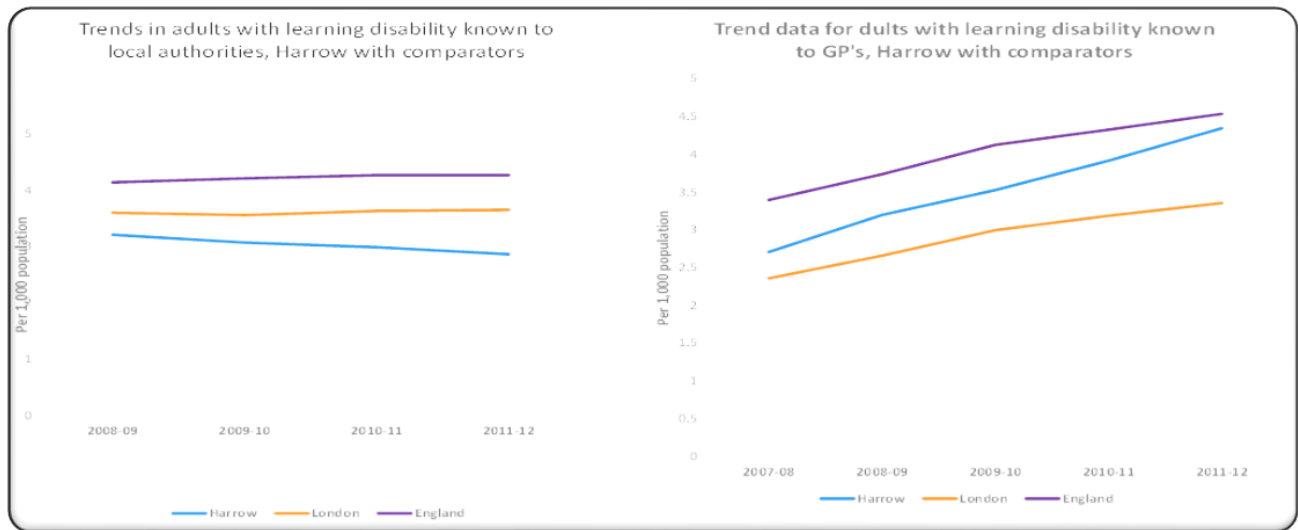
Of the estimated 3,782 people with learning disabilities living in Harrow only 435, just over 1 in 10, are known to the Harrow Council Adult and Social Care Services (2.86 per 1,000) placing Harrow in the 2% of local authorities in England with the lowest rate of people with learning disabilities accessing services, Planning based on these numbers is likely to be an under estimate of actual need.

The number of people known to local authorities has been decreasing over time, suggesting probability of barriers to accessing social provision.



# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

Figure 16 Trend in number of people with learning disabilities known to services (Local authority-left; Primary Care – right)



The number of adults with learning disability known to GP's is steadily increasing in Harrow at a rapid rate compared to London and England, with an increase of over 50% since 2007-08 to 760 in 2011-12. Most of this is due to increased recording rather than a real increase.

Government policy is that people with a learning disability should lead their lives like any other person, with the same opportunities and responsibilities, and be treated with the same dignity and respect. This means inclusion, particularly for those who are most often excluded, empowering those who receive services to make decisions and shape their own lives.<sup>xvii</sup>

The [NHS Outcomes Framework](#) has a number of indicators intended to improve outcomes for adults with a learning disability in settled accommodation by improving their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes quality of life, prevents the need to readmit people into hospital or more costly residential care;

and ensures a positive experience of social care.

### *Health checks for People with a Learning Disability*

Health checks are important in the detection, treatment and prevention of early adverse health conditions especially in people with learning disabilities<sup>xviii</sup>. In Harrow, the proportion of adults with a learning disability having a health check exceeds the national and regional proportion and has been increasing over time. These numbers are exclusive of those not registered with a GP or identified as having a learning disability and those known to social services.

### *Preventable Emergency Hospital Admissions*

Approximately, 8 out of every 100 hospital admissions are emergencies that may be preventable<sup>xix</sup>. Data for emergency admissions show that the proportion has been decreasing over time and in 2008-09 was lower in Harrow compared to London and England and lowest compared to statistical neighbours.

Admissions for specific illnesses and number of in-patients with learning disabilities for Harrow is also reported to be

low (see Learning Disability Needs Assessment).

### *Employment of people with learning disabilities*

Harrow has a high proportion of people with learning disabilities who are in paid employment, particularly women; compared to statistical neighbours.

### *People with learning disabilities in stable accommodation*

In 2013/14, in Harrow 69.8% of adult females and 73.8% of adult males with a learning disability who are known to the council were recorded as living in their own home or with their family . These figures are higher for both males and females with learning disability compared to the regional averages (M- 67.7% and F -69.8%). However, rates are lower than national averages (M- 74.5% and F - 75.4%).

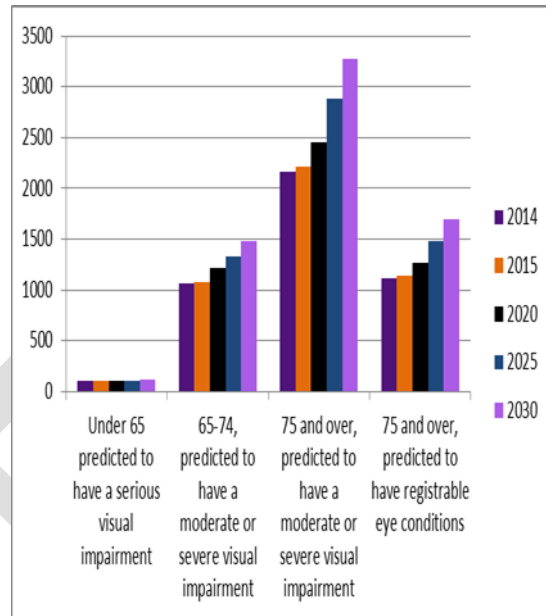
### **Adults with Sensory impairment**

According to NHS data, as of March 2011 there were 410 registered blind or partially sighted people living in Harrow who were also registered as deaf or with severe hearing loss. (6) The recorded figures are likely to be far lower than the actual prevalence. Sense UK has estimated that there are 1,207 people in Harrow who are deafblind. (23) An increase of 60% is forecast over the next 18 years.

The majority of people with a visual or hearing impairment are not born with the condition but acquire it through their lifetime. A number of factors increase the risk of visual impairment. The main risk factor is age and certain conditions such as diabetes, hypertension, and cardiovascular disease can also affect vision. There are also modifiable risk factors. Smoking increases risk of developing some types of vision problems and causes them to

happen at an earlier age. Obesity and long term alcohol abuse also increase risk.

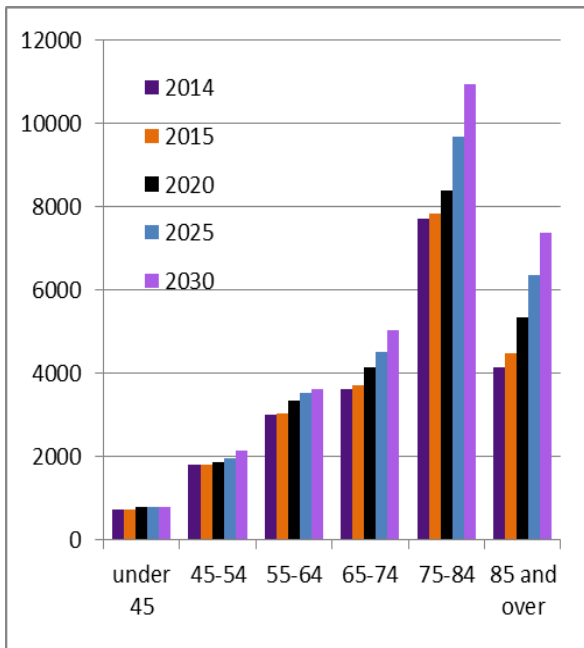
**Figure 17 Projected numbers of adults with a visual impairment in Harrow**



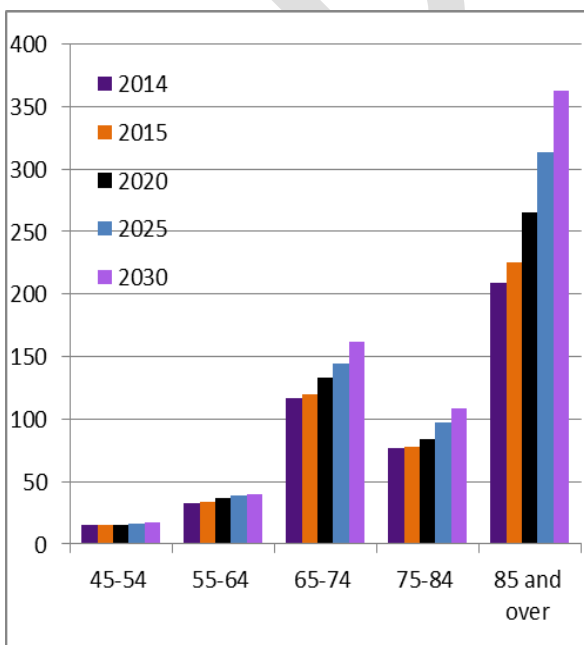
Acquired hearing impairment can be of two main types: Sensorineural and conductive hearing loss. Sensorineural hearing loss is caused by damage to the sensitive hair cells inside the inner ear or damage to the auditory nerve. This occurs naturally with age or as a result of injury due to repeated exposure to loud noises over time, or suddenly after exposure to an exceptionally loud noise, such as an explosion, or due to a viral infection such as mumps, measles or rubella. Risk is also increased due to diabetes, hypertension, and cardiovascular disease. Conductive hearing loss happens when sounds are unable to pass from your outer ear to your inner ear, often because of a blockage such as earwax or glue ear.

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

**Figure 18 Predicted number of adults with predicted moderate or severe hearing impairment in Harrow**

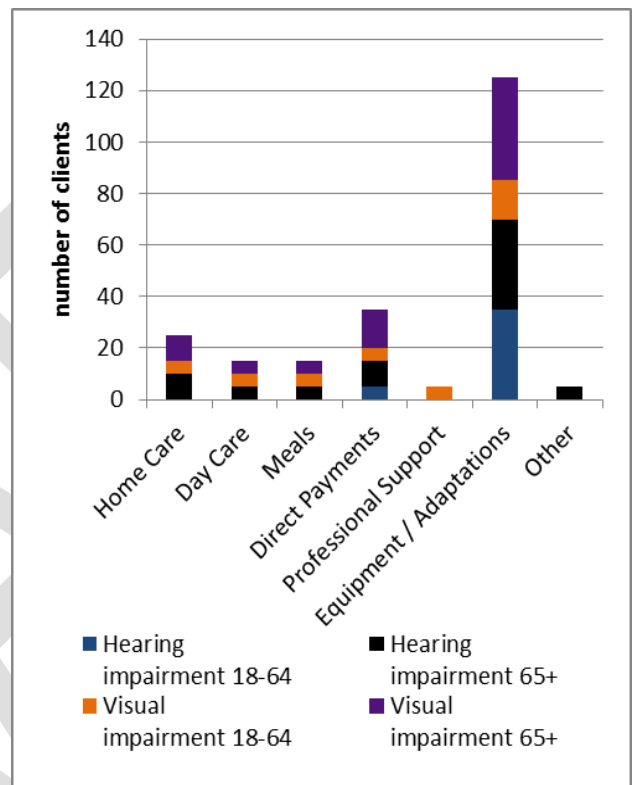


**Figure 19 Number of Adults predicted to have a profound hearing impairment in Harrow**



is available under Fairer Access to Care Services (FACS) and it can occur in the community, residential or nursing care settings. The people who do receive support from FACS mostly require equipment and adaptations.

**Figure 20 Support received through FACS by age and type of sensory impairment**



The vast majority of people with a sensory impairment live independently with no need for support from adult social care. Support

## Carers

Carers are adults and children who undertake unpaid care of adults or disabled children. Carers provide care to people who are ill, frail or living with a disability and who cannot manage on their own. Carers also look after partners, spouses, parents, children, other family members, friends or neighbours.

In the 2011 census, 5.8 million people in England and Wales identified themselves as carers, compared with 5.2 million people in 2001.

The Department of Health<sup>1</sup> estimated 12 per cent of people aged 16 or over in England in 2009/10 were looking after or giving special help to a sick, disabled or elderly person. Half were caring for someone who was living with them. The census (2011) showed there were 24,620 carers in Harrow, an increase of over 4,000 (almost 20%) from ten years earlier

**Figure 21 Demography of carers**

Source:	Carers in Households (England 2009-10)	Carers Survey (Harrow 2012-13)
% of carers		
who are female	60%	67%
who are older (65+)	25%	33%
from BAME	8%	50%
in employment		
(caring < 20 hrs/wk)	35%	47%
(caring > 20 hrs/wk)	17%	27%
of family member (or co-resident)	72%	(74%)
of someone aged 75+	50%	59%

In the local 2012 Carers Survey, carers in Harrow were more often women, with 33%

of carers falling into the age group of 65+ Half of carers surveyed described their ethnicity as 'White' followed by 'Asian or Asian British' at 39%. The differences between the national and local surveys show the greater diversity in Harrow but probably also reflect that the local Carers Survey is only sent to carers who have received some support from the council in the twelve months prior to the survey

The surprising finding is that more carers remained in employment than on average in England, despite their significant caring responsibilities (27% remaining in work despite caring more than 20 hours a week)

**Figure 22 Reasons for providing care**

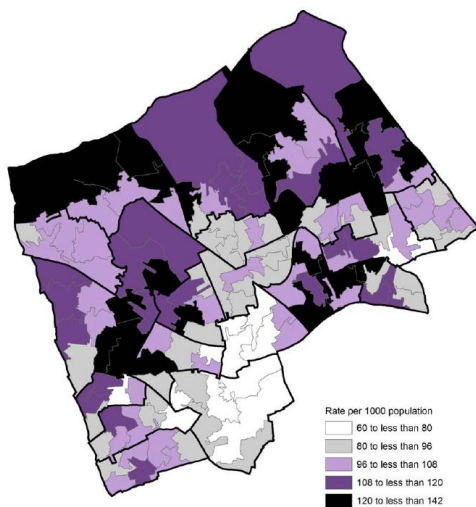
Reasons for providing care to cared-for (more than 1 may apply)	Source: Carers Survey (Harrow 2012-13)
Physical disability	59%
Issues relating to ageing	45%
Long standing illness	39%
Sensory impairment	30%
Learning disability	19%
Mental health problems	18%
Dementia	18%
Terminal illness	4%
Drug/alcohol dependency	1%

The reasons for providing care vary and can include more than one reason. In the Harrow Carers' Survey, the 3 out of 5 carers were caring for someone with a physical disability. 45% of Harrow carers were caring for an older person which is significantly higher than the national average. Around 1 in 5 were caring for someone with a mental health problems and a similar proportion for someone with a learning disability.

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

**Figure 23 Distribution of carers**

Carers, 2011  
Source: 2011 Census, Key Statistics KS301EW, ONS, Crown Copyright



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**Figure 24 Adult social care outcome framework indicators**

Across the borough carers are found in the areas where there are more older people in the north of the borough. The lowest concentration is in the centre of the borough.

The [Adult Social Care](#) (ASCOF) is the national tool used by the Department of Health to assess progress in adult social care and takes four of its measures from the Carer Survey. The results show that Harrow's outcomes are similar to those of

England as a whole, although overall satisfaction of carers with social care was slightly lower.

The Quality of Life results of carers receiving support from the Council (including information and advice) in Harrow was rated as 3<sup>rd</sup> highest in London<sup>xx</sup>, based on 6 questions around use of time, personal care, sense of control, perceived safety, social participation and feeling encouraged and supported.

Carers felt included and consulted, with Harrow's results ranked 4<sup>th</sup> out of 33 London boroughs. Finding information about carers support was thought to be fairly easy - Harrow ranked 18<sup>th</sup> of 32 councils in London on this measure.

Satisfaction was ranked 22<sup>nd</sup> in London (out of 33) but was in line with the England average. 33% of carers said they were 'extremely' or 'very' satisfied, with another 33% stating they were 'quite' satisfied. 12% stated there were either quite, very or extremely dissatisfied. The 2014 survey will include many more opportunities for feedback, which should allow a much better understanding of why carers feel one way or the other. In addition, new statistical analysis will be possible to better understand the factors driving positive and negative outcomes for carers.

**Figure 25 Components of the Quality of Life**

	2012-13 England	2012-13 Harrow
<b>1D: Carer reported quality of life.</b>	8.1	8.5
<b>3B: Overall satisfaction of carers with social services.</b>	36%	33%
<b>3C: The proportion of carers who report they have been included or consulted in discussions about the person they care for.</b>	74%	73%
<b>3D: The proportion of people who use services and carers who find it easy to find information about services (joint with client survey)</b>	69%	69%

## indicator

Quality of Life Questions*	All needs met (%)	Some needs met (%)	No needs met (%)
Safety	87	12	1
Personal Care	62	27	11
Control	37	54	10
Spending time**	34	53	13
Social Participation	49	39	12
Encouragement and Support	45	38	17

In the Carers Survey, quality of life rated almost 30% higher for carers who received only information and advice, compared to those who were in receipt of costed support (e.g. respite breaks). A possible explanation is that those who receive a costed service have more serious needs and so even with support, have a lower quality of life. If people providing informal care identify themselves as carers early, they can get the information, advice and support they need when they need it. This includes getting advice about looking after their own health. GPs and their teams are uniquely placed to recognise if someone is, or is about to become, a carer. GP practices are usually the first place that carers have contact with health services

### **Key issues and challenges**

Additional carers in Harrow may come forward for assessment following introduction of the Care Act in April 2015, but it is difficult to estimate how many new carers may come forward, as most will not already have been in contact with the council previously. Their levels of need, eligibility for local authority support, cannot reliably be predicted. Depending on the charging policy the Council adopts, there

may be a substantial financial impact on the local authority.

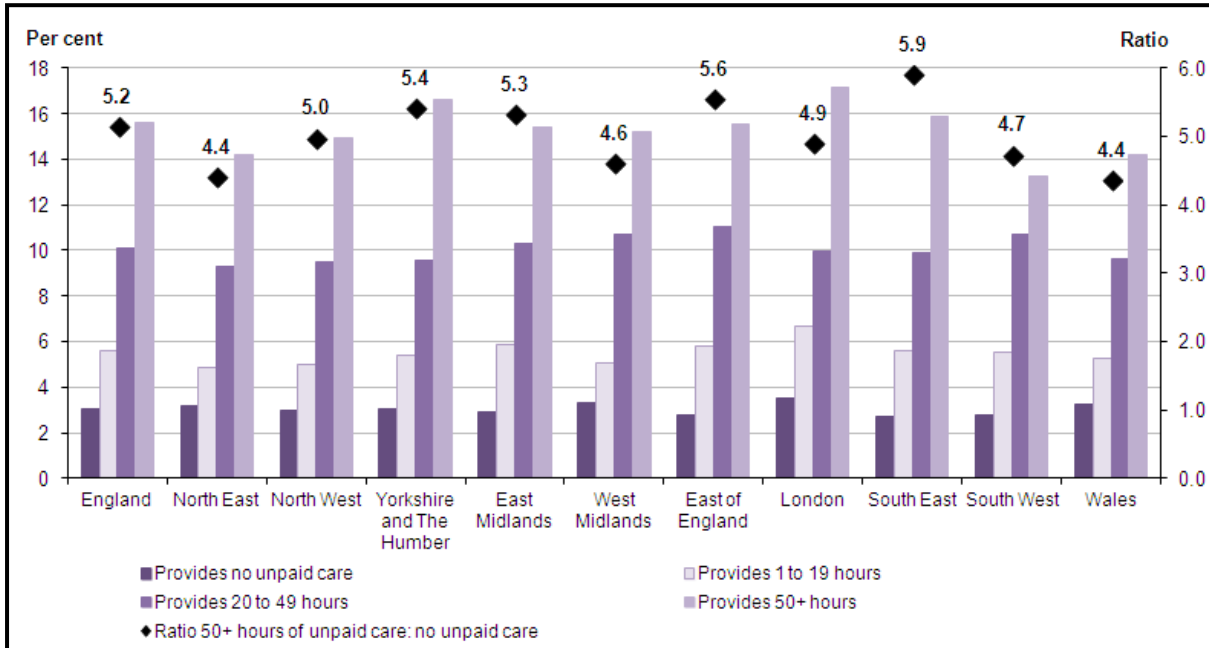
### **Young carers**

A “young carer” refers to children and young people under 18-years-old (aged 5 to 17), who provided unpaid care for family members, friends, neighbours or others because of long-term physical or mental ill-health, disability, or problems relating to old age. There is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly in young carers<sup>xxi</sup>

Evidence also reveals how young carers gain fewer qualifications and are therefore less likely to earn a decent living. Many young carers are reported to be coming from hidden and marginalised groups, including children caring for family members with mental illness or a substance dependency. This group of young carers is reported to be not captured in the latest census. Children are recommended to be allowed to thrive and enjoy their childhoods, not be relied upon to take caring roles that are too often inappropriate.

Caring for someone takes its toll on the health of young carers. Compared to their counterparts that do not have carer responsibility, young carers in London are almost five times more likely to report being in poor health themselves.

**Figure 26 Percentage of young unpaid carers with 'Not Good' general health and ratio not good health of those providing 50 or more hours per week compared to those providing no unpaid care in English regions and Wales, 2011.**



was poor there was a strong correlation with poor exam results

It is difficult to estimate the number of young carers although the 2011 Census shows 2,272 self-declared young carers aged 0 – 24 years old in Harrow. The vast majority of these are hidden, i.e. not known to social care or receiving any support.

An independent assessment carried out with 26 primary schools, 13 high schools and the Tuition Service in Harrow during the summer term of 2014 reported that every school believes numbers of young carers are far greater than currently assessed.

It showed that in both mathematics and English, 63% of young carers were below levels expected by their school and well below national expectations for these subjects. The majority of young carers achieve expected levels of attendance which may indicate that school is an important part of their lives, somewhere safe and supportive. Where attendance

The assessment also found that Mental health needs amongst parents and carers is an area that schools are identifying as one of growing concern, particularly in the primary schools. It also suggested that primary school engagement is key to the future success of any work around young carers. Many have been very receptive to the further development of work to raise awareness and identify this vulnerable group.

An online survey of young carers accessing the young carers project at Harrow carers carried out during 2013 showed that the majority of young carers felt that they had benefited from attending the project. The benefits ranged from meeting other young carers to enjoying the activities delivered.

In June 2014, young carers who were not accessing support were consulted as part

of the redesigning of the service provision. Some of the suggestions as to what should be considered as part of the redesigning included:-

- More learning in schools about what it means to be a young carer to reduce the stigma attached to it – from both adults and peers.
- Better marketing of the services available to those with caring responsibilities
- PSHE specific young carers lessons twice a year
- To consider supporting young carers coming into years 7 and 8 through a mentoring programme
- Specific groups/activities for carers as well as supporting young carers to attend generic groups/activities.
- Conference with GP's, Schools and Young Carers
- Better use of Social Media.
- Would like support to do things as a family that they currently are unable to.

### *Prevention of ill health among young carers*

Being a young carer can often have a severe, significant and long-lasting impact on a young person's health and wellbeing. The [Care Professional Trust](#) and the [No Health without mental Health](#) campaign recommend:-<sup>xxii</sup>

- Assessing the health needs of young carers: The initiative aims to undertake comprehensive health assessments of children and young people targeted by the young carers' service in Harrow. It supports collaborative working between health, social care and education and ensures a more coordinated pathway of care.

- Online support for young carers: This acts as a virtual youth club where young carers can come together, relax, chat and access support and advice from workers and each other.
- Young carer-led and age-appropriate respite for young carers: This will provide respite breaks and activities for young carers, but with young carers right at the heart of decision making, from choosing what activities they do to educating professionals about young carers' needs.
- Summer activities for young carers: This will provide activities that give young carers a chance to get out of the house and socialise with others

### **Homelessness**

There are three main categories of homelessness. They are statutory homeless; single homeless/rough sleepers; and hidden homeless.

Data is available on those accepted as homeless and with priority need (the statutory homeless). The majority of homeless people living with family members, squats or other insecure accommodation (hidden homeless) are excluded in the homeless figures. The Charity Crisis estimates that 62% of single homeless people are not included in official homeless figures<sup>xxiii</sup>.

Nationally and across London, statutory homeless numbers decreased between 2005 and 2009. Harrow's figures however, increased year on year until 2008 when there was a dramatic reduction. Since 2010, the rate of homelessness has been increasing locally, regionally and nationally.. The increase is steeper in

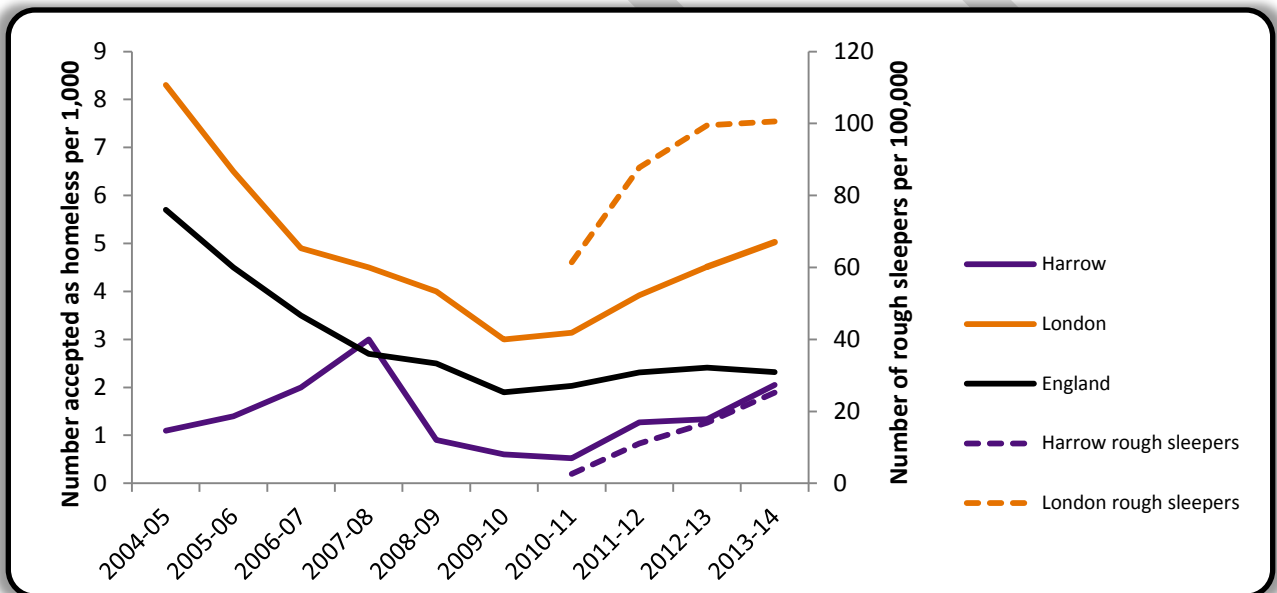


# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

Harrow and mirrors that of London compared to a small increase nationally. It is thought that the increase across London is due to increasing house prices and market rent prices while wages and benefits have not increased or have decreased in relative terms.

The estimated number of rough sleepers has increased in London and in Harrow. Rough sleepers are at significant risk of poor health, the impact of cold weather and the impact of drugs and alcohol.

**Figure 27 Trends in number of households accepted as being homeless and in priority need over the last decade and rough sleepers**



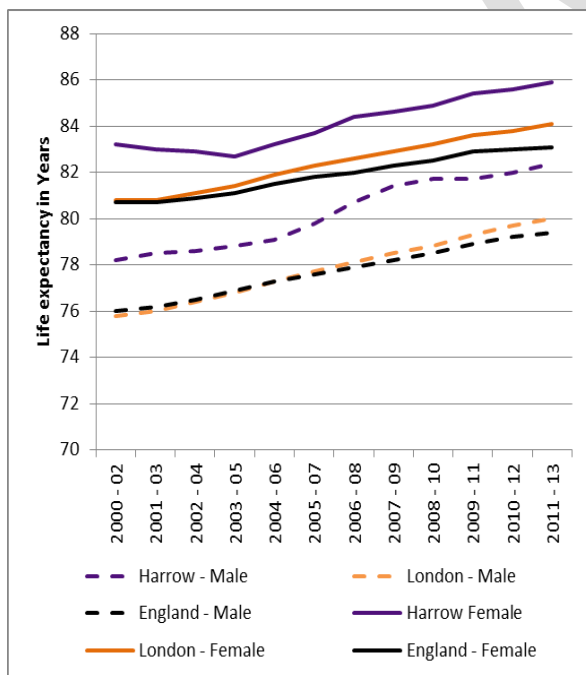
## A Picture of Health in Harrow

The health of people in Harrow is generally better than the England and London averages<sup>xxiv</sup>. This chapter will look at different aspects of health in Harrow.

### Life Expectancy

Life expectancy for both men and women is higher the England and London averages. For men in Harrow Life expectancy in 2011-13 was 82.4 years and for women 85.9 years. Over the past 13 years life expectancy has increased year on year and the gap between harrow and London and England has been maintained in women and slightly widened in men.

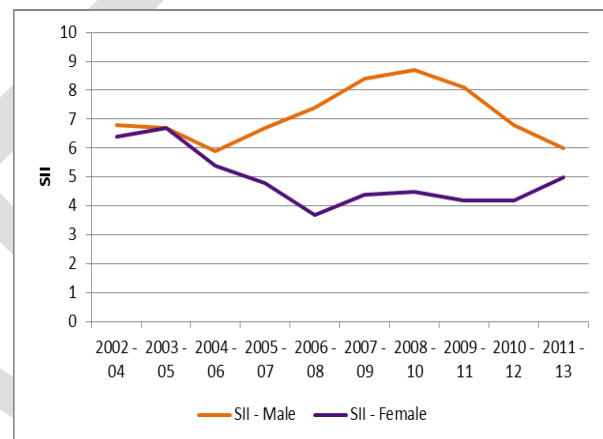
**Figure 28 Life expectancy trends in Harrow, London and England 2000 to 2013**



Despite this high life expectancy, there are large differences within the borough. The SII (Slope Index of Inequality) is an indicator of within borough inequalities in life expectancy. The SII trend shows that

the gap in life expectancy between the most deprived and most affluent men in Harrow grew from the 2002-4 baseline but has since fallen and is now 6 years, which is below the baseline figure. In women the SII almost halved but has since risen slightly but it is still below the 2002-4 baseline. Both of these show that the gap in life expectancy within Harrow is decreasing.

**Figure 29 Trends in SII in Harrow**



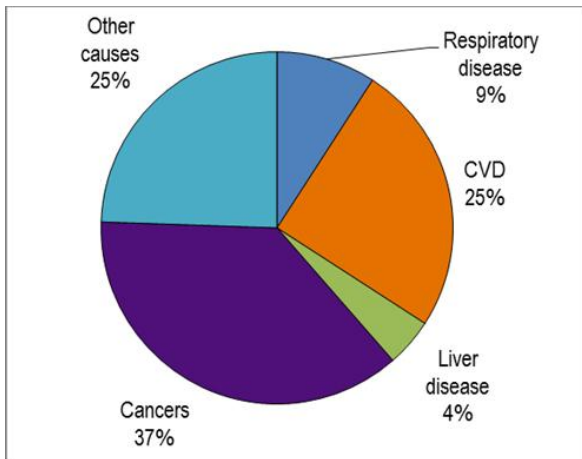
The length of our lives is not the only overarching indicator of health in the borough; we can also consider how much of that life expectancy we live in health. This data has not been available for as long as the life expectancy data but in the three years it has been, it shows an increasing trend towards longer healthier lives. Men can expect to live on average 65.3 of their 82.4 years in health and for women, on average 68.1 of their 85.9 years will be lived in health.

### Mortality

Cancers are the biggest cause of deaths in Harrow accounting for almost 2 out of every 5 deaths. A quarter of all deaths are due to heart disease and stroke.

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

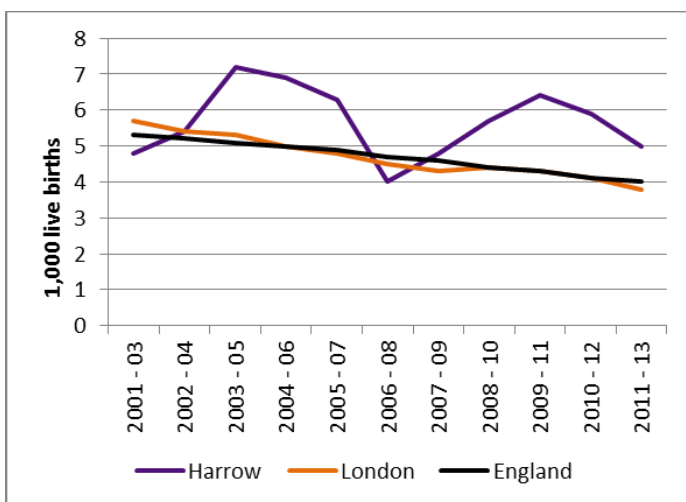
**Figure 30 Main causes of death all ages 2011-13 in Harrow**



The mortality (death) rates for major causes in all ages and those classed as premature mortality (deaths under age 75) are lower than those for England and London. In many cases, mortality rates from specific causes in Harrow are amongst the lowest in the country. The exception is for deaths from communicable diseases (including influenza and pneumonia) in men, where the rate is higher than that of England.

Infant mortality in Harrow has reduced in the latest data and is now statistically similar to the .England average. However,

**Figure 31 Infant Mortality trends**

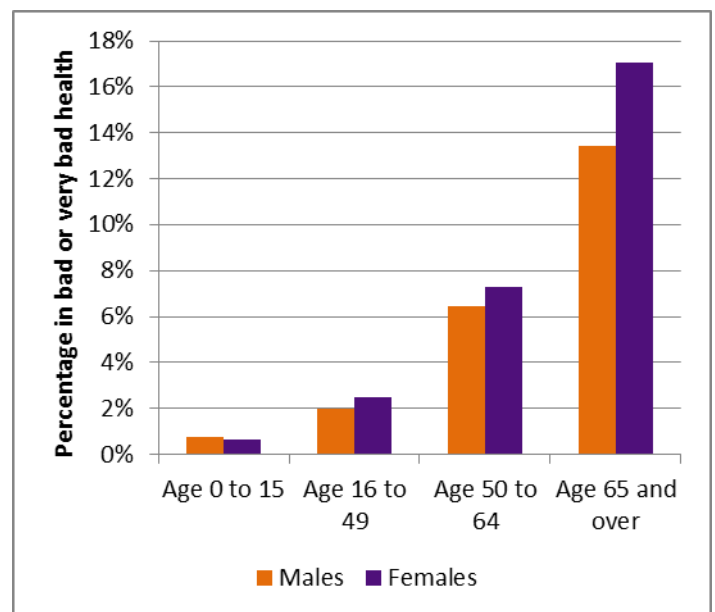


as this fluctuates we need to maintain a watchful eye on it. All deaths in children under 18 are reviewed by the Child Death Overview Panel and recommendations made and implemented if there are learning points that might avoid future deaths..

## Self Reported Health, long term illness and disability

The census asks about people’s general health. Four out of five people in Harrow rate their health as good or very good and only one in twenty rate their health as bad or very bad. However, there are differences in people’s health status within the borough. The proportion of people in bad or very bad health increases dramatically with age and in all age groups except the under 16s, women report higher rates of poor health than men. In the 65 and over age group, one in seven men and one in six women report being in poor health. This pattern is the same across all ethnic groups, although higher rates of poor health are reported in the Asian and “other” ethnic groups.

**Figure 32 Proportion of Harrow people with bad / very bad health – 2011 Census**

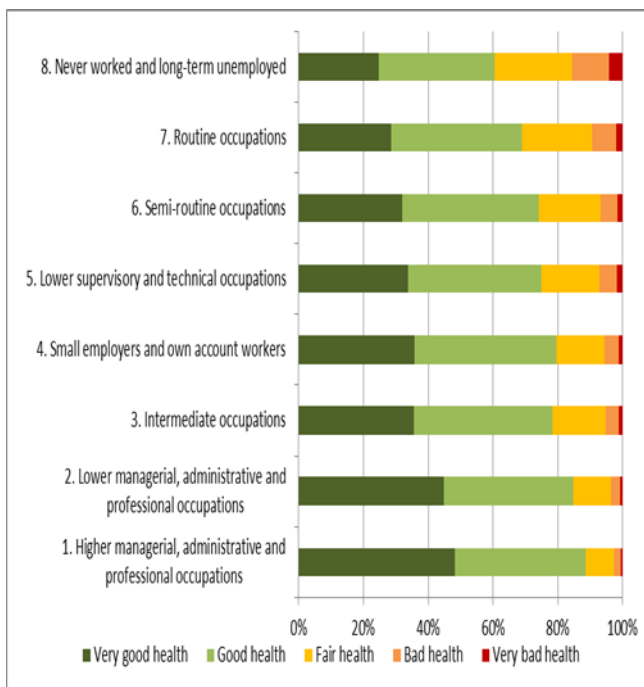


# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

Source: Census 2011, ONS (extracted from NOMIS)

Health status is also affected by socio-economic group. Almost 90% of people in groups 1 and 2 (professional and higher management) report that their health is very good or good compared to only 60% in those who have never worked and the long term unemployed.

**Figure 34 Health Status by Socio-economic group (Harrow, 2011 census)**



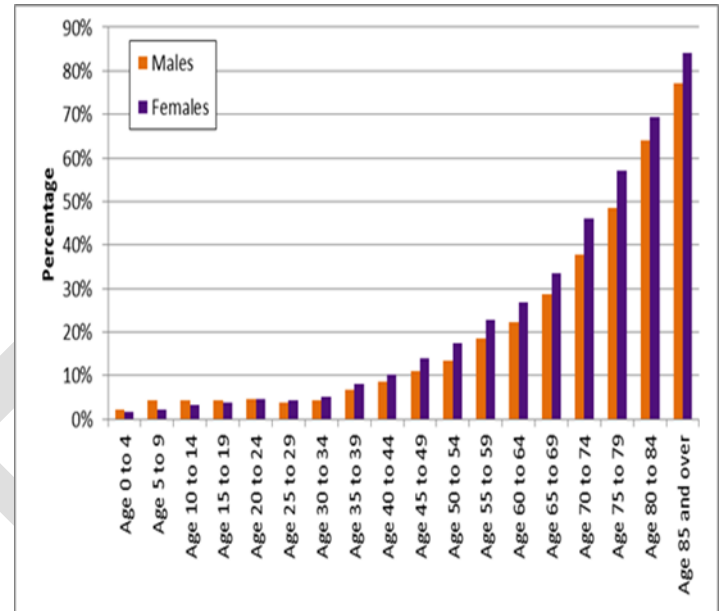
Nearly 34,000 people in Harrow reported having a long term illness or disability that limited their day to day activities in some way. Under half of these reported that their activities were affected a little and over half a lot. As expected the rates increase with age and in all age groups over 25, a greater proportion of women are affected than men.

## Births

Birth rates in Harrow are significantly higher than the national average and there

is a greater proportion of births to mothers over 40 than in England as a whole<sup>xxv</sup>. Over the past 10 years, the number of

**Figure 33 Long term health problem or disability by sex by age**



births to families living in Harrow has increased by 39% and now stands at around 3,600 per year. The number of births is affected by both the fertility rates and by the size and structure of the female population.

## Maternity

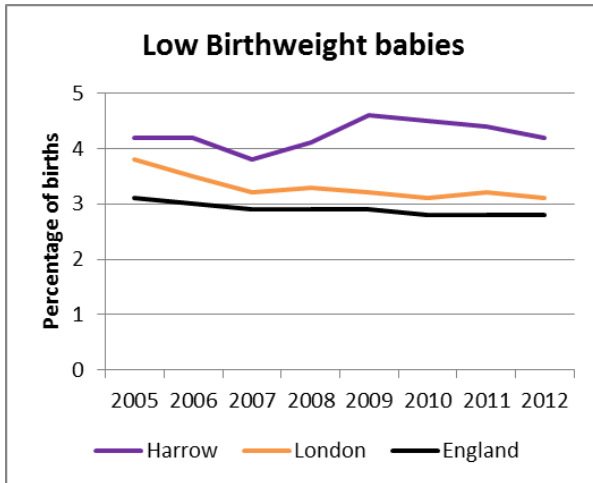
Over 40% of pregnant women in Harrow do not receive an antenatal assessment within 12 weeks. This is significantly higher than the England average.

The rate of caesarean section in Harrow is significantly higher than the England average. This applies to both elective and emergency caesarean rates.

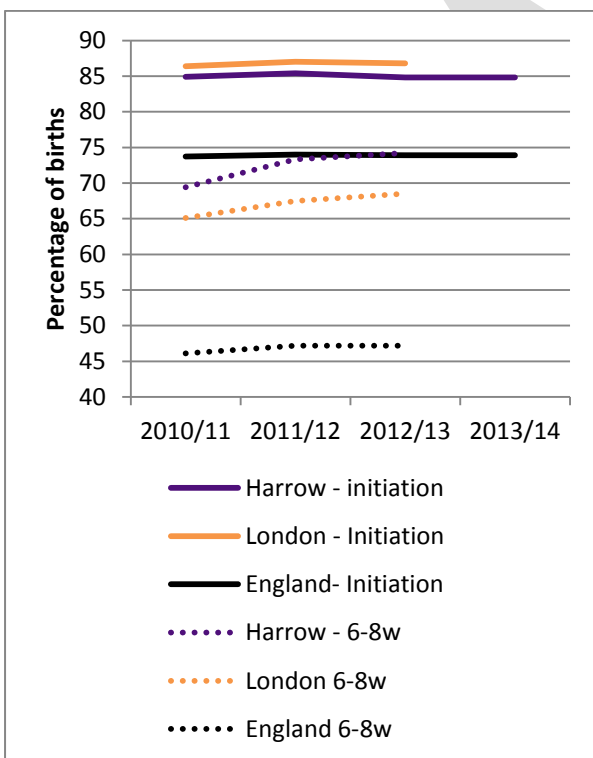
The proportion of babies born with low birth weight in Harrow is significantly higher than the national average and while some of this is thought to be due to the ethnic mix of the population, there may be other factors. Smoking in pregnancy rates are

lower than the national average but have increased in the past year at Northwick Park Hospital.

**Figure 35 Low Birthweight babies**



**Figure 36 Breast feeding rates**



Breast feeding gives babies the best start in life. Considerable work had been done over the past five years to gain the Unicef Baby-friendly status and to support mothers to start and continue breast feeding through an active peer support

network. Initiation of breast feeding is significantly higher than the rate for England but slightly below the rates for London. Continuation of breast feeding at the 6-8 week check has been increasing year on year and three quarters of Harrow's new mothers breast feed their babies for at least 6-8 weeks.

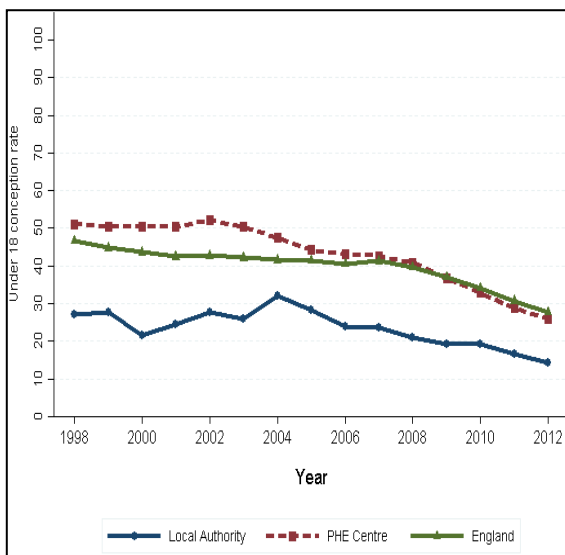
### Teenage pregnancies

[The Department of Health](#) Framework for Sexual Health Improvement in England (2013) reported that up to 50% of pregnancies are unplanned, which can have a major impact on individuals, families and wider society. Teenage pregnancy, in particular, is a health inequality and social exclusion issue that leads to poor health and social outcomes for both the mother and the child. Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS<sup>14</sup>. Similarly, repeat termination is another important aspect of women's health, which requires health promotion and education about Long Acting Reversible Contraceptives (LARC). Preventing unwanted pregnancies rather than abortion post conception is preferable considering the physical and mental health of the young woman involved and the utilisation of NHS resources.

[The Faculty of Sexual & Reproductive Healthcare](#) highlights the importance of knowledge, access and choice for all women and men to all methods of contraception to aid in the reduction of unwanted pregnancies and the importance of reducing teenage conception is reflected by its inclusion within the [The Public Health Outcomes Framework](#) which focuses on reducing the number of "under 18 conceptions".

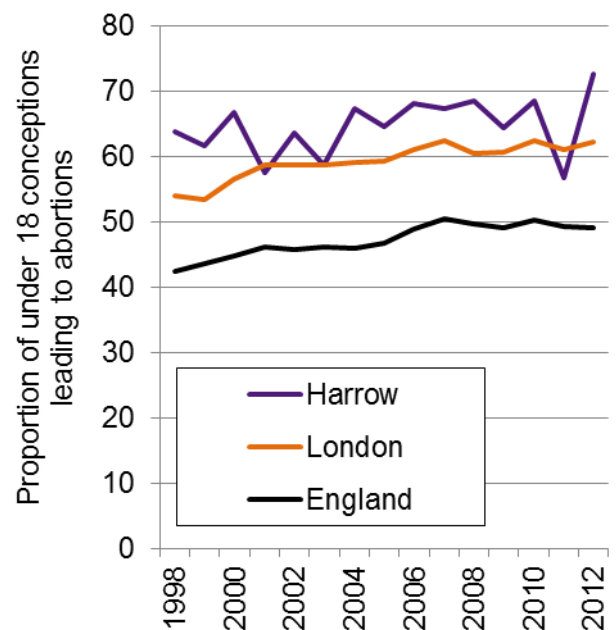
The number of teenage conception dropped from 105 in 1998 to 62 in 2012. In 2012, under 18 conception rate in Harrow was 14.2 per 1000 females aged 15 to 17 which is lower than the rate for London (25.9) and England (27.7). Harrow is in the lowest 5% of boroughs and is ranked 308 out of 324 (1st has the highest rate). It is predicted that the rate of reduction will slow in the next five years to around 13.6 per 1000 females by 2020.

**Figure 37 Rate of teenage pregnancy 1998-2012**



Among the under 18 conceptions, the proportion of those **leading to abortion** was 72.6% which is higher than the London average (62.2%) and England average (49.1%) (fig 15). Harrow is ranked 14 (out of 311) within England for the under 18 conceptions leading to abortion (1st has the highest percentage)

**Figure 38 Proportion of under 18 conceptions leading to abortions**



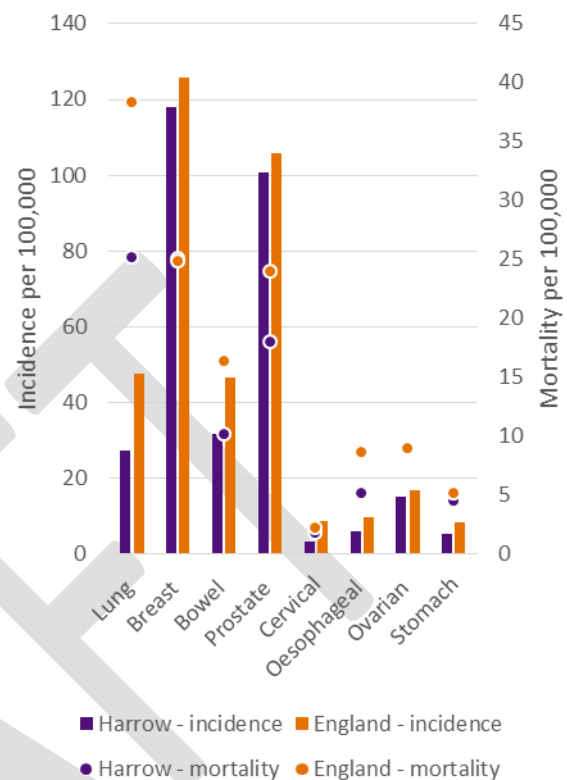
## Health topics

### Cancer

Cancer incidence for all cancers is lower in Harrow than the England average with rates for specific cancers such as lung, cervical and prostate being similar or lower. The same is true for mortality and Harrow has the lowest premature cancer death rate of all boroughs in England.

Early diagnosis is important for improving survival rates. Harrow does better than the national average in almost all aspects of early diagnosis. Emergency presentations through A&E which can be indicative of late diagnosis and waiting time for diagnostic tests are low. However, treatment within 31 days of decision to treat is lower than the English average (96.7% compared with 98.2%).

**Figure 39 Rates of incidence and mortality by type of cancer, Harrow compared with the national average**



Survival is indicative of early diagnosis and access to optimal treatment. For one year survival, Harrow is in the top 5% of boroughs in England, at five years the proportion is equal to England; about 1 in 2 people.

National data show that survival rates are lower for people living in deprived areas. The largest observed deprivation gap at one-year survival is for bladder cancer in females and oesophageal cancer in men<sup>1</sup>. Breast cancer is the only one of the top 10 cancers in which incidence rates are higher among women in higher socio-economic groups but survival rates still lower among women in lower socio economic groups. There is also increased risk of certain

<sup>1</sup> Deprivation gap is the absolute difference (%) between relative survival in the most deprived and the most affluent groups; derived from variance-weighted regression.

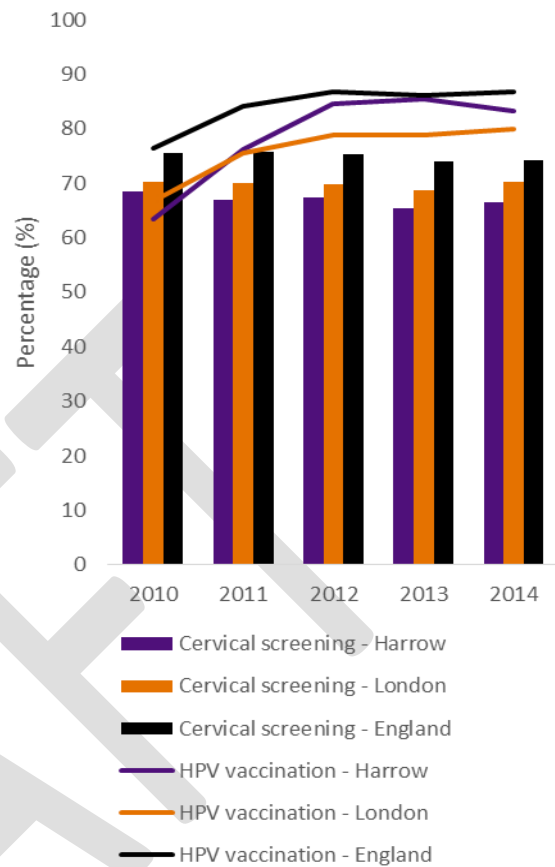
cancers in Asian and Black ethnic groups and women from these groups have a lower under-65 survival rate for breast cancer and higher risk of cervical cancer in those over 65 years.

Lung cancer deaths have been increasing in Harrow since 2007-09 and national data show they are the most common cause of cancer deaths in men accounting for almost one in four (235). Since smoking causes 90% of all lung cancer; these deaths will also disproportionately affect those from lower socioeconomic backgrounds.

Where Harrow performs poorly is cancer screening. Bowel and breast screening rates are lower than the England average and breast screening rates do not meet the national minimum target of 70%. Where Harrow does worse though is cervical screening, rates among younger women (25 to 49 years) for whom the uptake is approximately 11% lower than the national average (60.6% compared with 71.5%). This is almost 20% short of the national minimum target (80%). In addition, vaccination against Human Papilloma Virus (HPV) – which causes almost all cervical cancer – is lower than the England average (83.2% compared with 86.7%) and decreased by about 2% between 2012/13 and 2013/14.

High deprivation and an ethnically diverse population have been linked with low levels of screening. South Asians in particular are significantly less likely to respond to routine invitations for breast screening. However health promotion work has been shown to make a substantial improvement in some London boroughs such as Tower Hamlets. Interventions and support for people with disabilities for screening should also be an integrated part of screening programmes.

**Figure 40 Cervical Screening and HPV vaccination rate trends**



Despite low rates of cancer incidence and mortality generally, Harrow CCG recognises that gains in life expectancy can still be made and inequalities reduced, particularly for breast and lung cancer. Tackling some of the difficult issues around differences in screening rates by ethnic and socio-economic group and disparities in survival rate through targeted health promotion/social marketing and access to treatment may help increase life expectancy for all groups.

### Liver disease

Deaths from liver disease remain a persistent problem. Much liver disease is preventable and is caused by lifestyle factors such as obesity and excess alcohol consumption. Rates of preventable liver-disease have remained lower than the

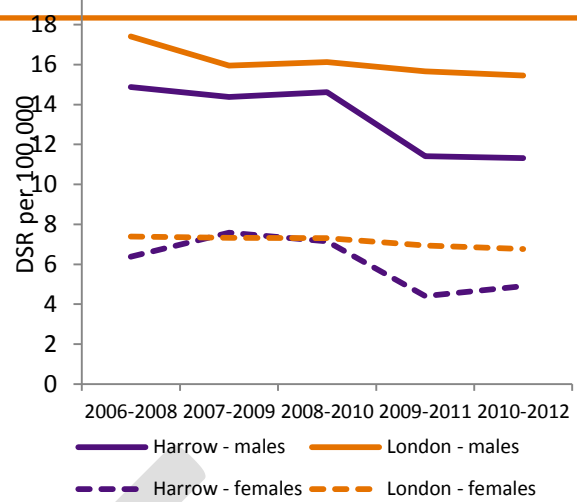


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national and London average in Harrow. However, after an apparent decrease in 2009-11, rates appear to be increasing again particularly among females. As well as this, the difference in rates between males and females remains smaller in Harrow than in London and may be decreasing.

Inequalities persist and there is evidence at the national level that rates of premature mortality from liver disease (considered preventable) among those in the most deprived areas is twice that of rates in the least deprived areas. Hepatitis B and C are risk factors for liver disease. Hepatitis C is more prevalence in South Asian populations and so the number of expected in infections in Harrow may be an under estimate. Hepatitis B is also a risk factor for liver disease and is vaccine preventable however no data are available for Harrow on the proportion vaccinated attending sexual health clinics, or on the proportion of babies born to hepatitis B-infected mothers. Over 1 in 10 adults in Harrow are thought to be high risk drinkers and alcohol related hospital admissions continue to increase for both males and females. In addition, one third of 10 and 11 year olds are overweight or obese, higher than the England average.

Alcohol-specific mortality and mortality from chronic liver disease has decreased since 2006-2008 but in order for the downward trend to continue, renewed efforts to reduce obesity and address excess alcohol consumption are needed. Initiating lifestyle changes with older people in the community may have some impact on premature death but engaging with children and young people on making the right food choices and sensible drinking



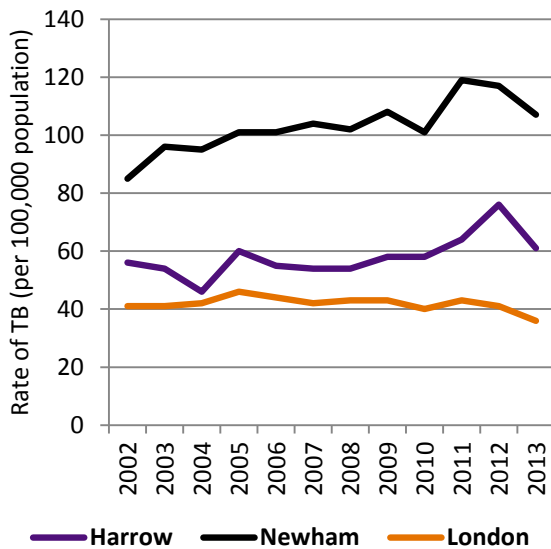
is essential for reducing the death rate in decades to come.

### Tuberculosis (TB)

Tuberculosis is an important health issue in Harrow. The borough has the fifth highest incidence of TB in London; 61 per 100,000 in 2013 compared with 36 in London overall. Trends over time are similar to those seen in Newham where incidence is the highest in London. New infections in Harrow have been increasing since 2008 and exceed the level at which vaccination of infants aged 0 to 12 months is recommended<sup>2</sup>. Incidence varies within borough and hotspots are located in central and south eastern LSOAs.

Figure 42 Annual TB incidence rate 2002-13

<sup>2</sup> Universal vaccination is recommended to all infants aged 0 to 12 months where the annual incidence of TB is 40/100,000 or greater.



The highest rate of TB is in the non UK-born Pakistani population 286 per 100,000 followed by non UK-born Indian population (220 per 100,000). This compares with 11 in the White non-UK born population. Most of these non-UK born people do not enter the country with active TB but develop it within 1 to 5 years of arrival. It is unclear whether new infections are being acquired in the UK or latent TB is becoming active shortly after arrival. An agreement to screen immigrants arriving at Gatwick and Heathrow airports has been in place since 2005 but is no longer considered effective on either clinical or financial grounds<sup>3</sup>. There is a link between overcrowding and transmission of active TB; therefore it is likely that transmission and clustering of TB occurs within family units.

Levels of drug resistance remain below or similar to London levels as is the proportion of patients completing treatment; 85%. However adherence to treatment is slightly lower for people in Harrow with pulmonary TB 78% compared with 85% in London. This is less likely to

be due to social risk factors such as homelessness or drug and alcohol abuse (only 1% of patients) but may be influenced in part by cultural factors such as perceived stigma and social context.

Treatment of latent disease is vital in preventing conversion to active disease, to improve national guidance; Harrow is currently working with PHE to develop a test programme for identification and treatment. Awareness of symptoms and the importance of seeking and adhering to treatment among non-UK residents from high TB-prevalent countries are essential in maintaining the recent but apparent downturn in new infections.

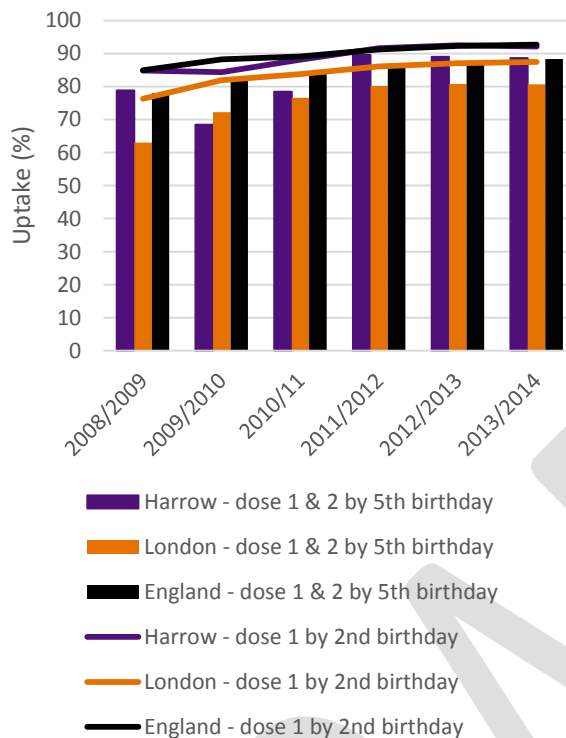
### Childhood Immunisations

The uptake of childhood immunisations in Harrow is high. Diphtheria, pertussis, tetanus, hib (Haemophilus influenza b) and PCV (pneumococcal infection) immunisation uptake at first birthday exceed the 95% level required for herd immunity. This means even children not vaccinated will gain indirect protection from the infectious disease. At second birthday, uptake of PCV drops to 90.7% but remains higher than the London average.

<sup>3</sup> It is thought that at best only 6% of those who will develop active TB will be detected.

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**Figure 43 Trends in MMR vaccine coverage 2008 to 2014**



Since the late 1990's and the controversy linking the measles, mumps, rubella (MMR vaccine) with Autism in children, uptake of MMR has been low. In Harrow in 2013/14 dose 1 by second birthday is 92.1%, dose 1 and 2 by fifth birthday is 88.6%. This is much better than the low of less than 80% seen nationally in 2005. Coverage has been increasing since 2009/10 but has plateaued in recent years. While coverage in Harrow remains better than other London boroughs, the risk of measles outbreaks remains if the 95% herd immunity level is not reached. Those less likely to be vaccinated and therefore at greater risk of infection are those not registered with a GP, younger children from big families and children of gypsy travellers, asylum seekers or homeless. Vaccine coverage data is not available by ethnic group so it is unclear where there is variation in uptake by this demographic. A large proportion of Harrow residents are

non-UK born and rates of tuberculosis (TB) are high in Harrow (61 cases per 100,000). However, there is currently no vaccination programme for infants under 1 year.

In 2013/14 a national programme was introduced to provide protection against flu, initially for 2 and 3 year olds. Data on coverage is not currently available at borough level but nationally uptake is about 40%. Rates of vaccination against human papillomavirus (HPV) have been steadily increasing in Harrow since the programme was introduced in 2009-10 and coverage is currently 83.2% for three doses; better than the London average.

Collaborative work should continue to ensure vaccine coverage rates continue to increase and barriers to vaccination for the most vulnerable and disadvantaged children and young people are minimised. Using GP data to improve coverage in localities where it is low and to improve errors in coding data will improve borough level uptake.

## Mental Health

Mental health is a high public health priority area in the country and addressing mental health problems in all age groups and improving outcomes and relevant services are suggested in the 2011 mental health strategy for England entitled "[No health without mental health](#)". Tackling mental health is important because poor mental health not only costs too much for the economy and the health system but also leads to and is associated with inequalities.<sup>xxvi</sup>

## Adult Mental Health

In Harrow, the prevalence rate of depression (recorded in adults aged 18 and over) was 3.4% (6,471 persons of the total 191,072 GP registered population aged 18+) for the year 2012-13. The

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Harrow rate is lower than the average rate for England (5.8%).<sup>xxvii,xxviii</sup> There were 1,019 new cases of depression recorded in GP registers during 2012-13 showing the incidence rate of 0.8% for Harrow, which is lower than the average national rate (1%).<sup>xxviii,xxix</sup> The prevalence of mental health problems including schizophrenia, bipolar affective disorder and other psychoses in all ages recorded on GP disease registers in Harrow is 0.93%, which is higher than the average rate for England (0.84%).<sup>xxvii,xxviii</sup>

The average rate of people with a mental illness in residential or nursing care per 100,000 population in Harrow (16.4) is similar to England (32.7). Harrow has a higher percentage of mental health service users who were inpatients in a psychiatric hospital (3.6%) compared to the national average (2.4%). However, the rate of detentions under the National Mental Health Act per 100,000 population in Harrow (23.3) is similar to the average for England (15.5). In addition, Harrow rates for attendances at A&E for a psychiatric

disorder (361.8 per 100,000 population) and number of bed days (6,227 per 100,000 population) are higher than the average national rates (243.5 and 4,686 per 100,000 population, respectively).

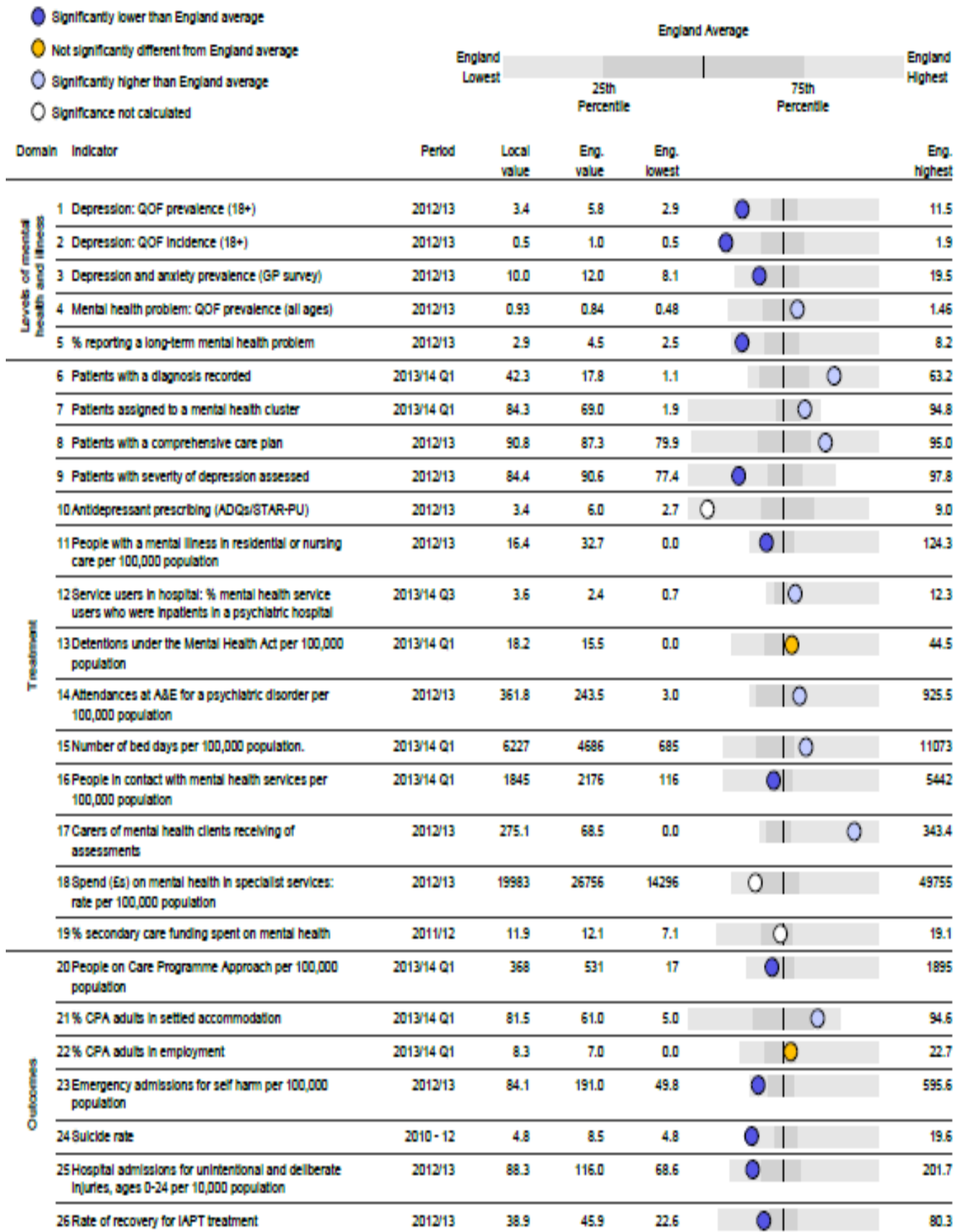
Moreover, the rates of emergency admissions for self harm (84.1 per 100,000 population) and hospital admissions for unintentional and deliberate injuries in aged 0-24 years (96.9 per 10,000 population) in Harrow are lower than the average for England (191.0 / 100,000 and 116.0 / 10,000 population respectively).

The suicide rate in Harrow (4.8 per 100,000 population) is also lower than the average national rate (8.5 per 100,000 population).

A summary of mental health related indicators for Harrow benchmarked against England reveals that most of Harrow indicators are better than the corresponding indicators at the national level.

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Figure 44 Mental health indicators for Harrow<sup>xxx</sup>



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## Children's and Young People's Mental Health and Wellbeing

In Harrow children aged 5-16 years, the estimated prevalence of any mental disorder (8.8%), emotional disorders (3.4%), conduct disorders (5.3%) and hyperkinetic disorders (1.4%) are lower than the average rates for England (i.e. 9.6%, 3.7%, 5.8% and 1.5% respectively).<sup>xxxvi</sup>

In Harrow, the hospital admissions rates (per 100,000) for mental health and alcohol specific conditions in children (aged less than 18 years), self-harm in young people (aged 10-24 years), substance misuse and unintentional and deliberate injuries in young people (15-24 years old) and unintentional and deliberate injuries in children (less than 15 years old) are lower than the average rates for England.<sup>xxxvii</sup>

The National Service Framework for Children, Young People and Maternity Service (2004)<sup>xxxviii</sup> suggests providing early and effective services to help children and young people with emotional, behavioural, psychological and mental health problems using the Child and Adolescent Health Services (CAMHS) strategic framework, which comprises 1 to 4 tiers.<sup>xxxix</sup> Providing

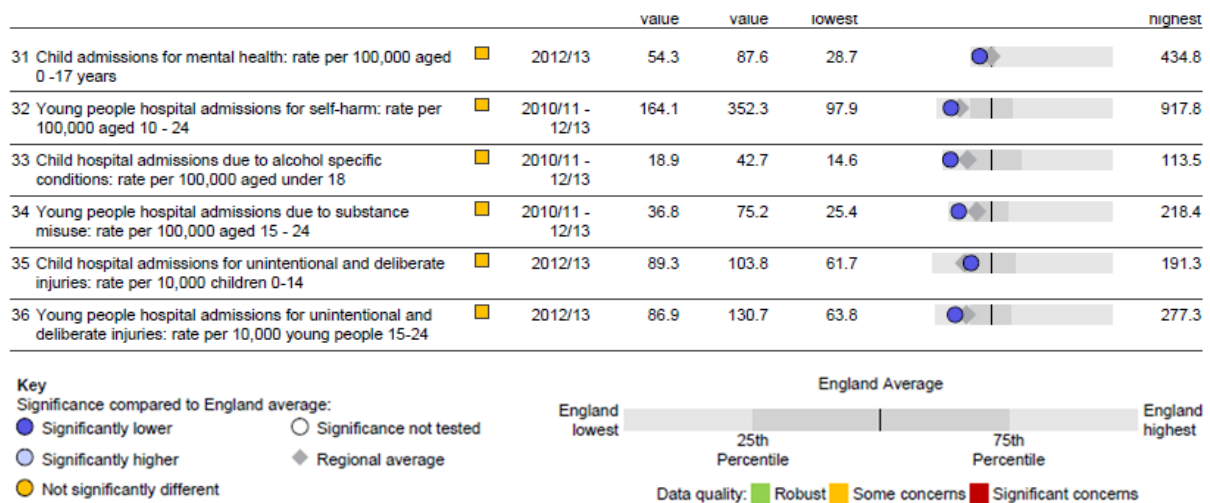
the CAMHS services at tiers 2-3 is the responsibility of the clinical commissioning groups (CCGs) while commissioning of the tier 4 CAMHS services is the responsibility of NHS England since April 2013.<sup>xxxv</sup> In Harrow, the estimated number of children aged less than 18 years requiring Tier 3 CAMHS services was 1,025 and those requiring the Tier 4 CAMHS services was 45 (as per estimation of 2012).<sup>xxxvi</sup>

## Action on Mental Health

A Mental Health Promotion and Wellbeing Task and Finish group (MHP&WTFG) has been setup for tackling mental health and wellbeing issues in Harrow. The Group has representations from the Harrow Council's different directorates i.e. Public Health, Adult Social Care, Children and families as well as Harrow NHS CCG, the third sector and local schools. The group will provide advisory services to the Harrow Health and Wellbeing Board with regard to developing a mental health promotion strategy and associated programmes and interventions.

Need something from CCG in this section

Figure 45 Child and Adolescent Mental health indicators for Harrow vs England



## Diabetes

Diabetes remains a major health issue in Harrow and prevalence is predicted to increase by 45% in the next 20 years. There is a 3-fold increased risk of diabetes among people of South Asian origin compared with white people and risk increases at a younger age and lower BMI.

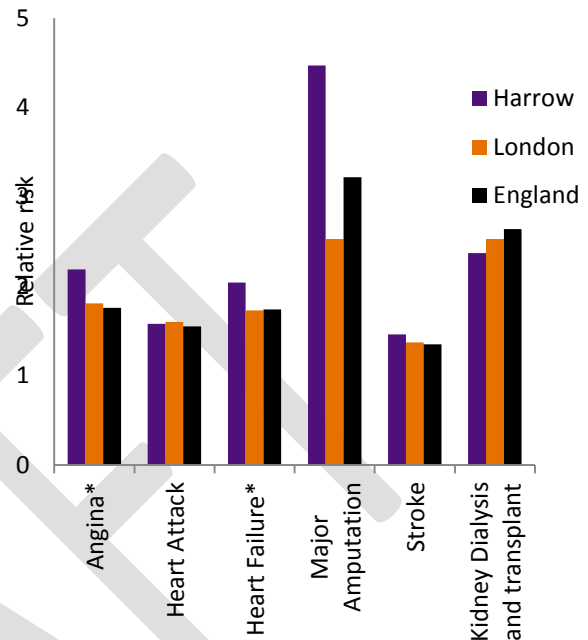
Prevalence in Harrow is the highest of any London borough, over 16,000 (8.5% of the adult population) are registered practice disease registers, an increase of about 3% since 2010/11. Modelled estimates, incorporating undiagnosed diabetes, predict prevalence is actually about 10% of the adult population in Harrow; a further 2,800 people. Both diagnosed and undiagnosed prevalence is significantly higher than the London (6%) and England (6.2%) average.

Variation between practices ranges from 5.3% to 16.2% which may reflect different local age and ethnic profiles but also reflect differences in detection between practices. The risk of diabetes-related complications for angina and heart failure are higher in Harrow than the England average; relative risk of 1.7 in England compared with over 2 in Harrow. Despite the increased risk of cardiovascular disease associated with diabetes, CVD related mortality is similar to the England average and lower compared with London. In addition, the current total spend on diabetes prescribing per person in Harrow is about £205; this is within the lowest 25% of all CCG's nationally.

The NHS health checks programme provides an opportunity for early intervention for diabetes, however rates of offer are lower in Harrow than the England average; 11.8% compared with 18.4% in England and 21.1% in London. Of those offered however, over half accept a check

and this is higher than the national average.

**Figure 46 Relative risk of diabetes associated complications Harrow data with comparators 2010/11 - 2011/12**



\* Relative risk statistically higher than the England average

Among children with diabetes, emergency admissions to hospital are 57 per 100,000 population; this has been increasing since 2010/11 and is now equal to the England average. In London overall, admissions have plateaued at around 50 per 100,000. Each admission costs £57 and this amounts to about £54,000 total cost per 100,000 population aged 0 to 18 years. If Harrow could reduce emergency admissions to the level seen in the best performing 25% of CCG's, it is estimated that about £19,000 could be saved per 100,000 population.



**Figure 47 Trends in emergency hospital admissions for paediatric diabetes (0 to 17 years), with comparators, 2009-13**



Emergency admissions are associated with high costs, can be distressing for children and increasing levels can also be indicative of poor management in the community. In Harrow there is a commitment to fully implement the paediatric diabetes Best Practice Tariffs to support care planning and management. This may help tackle variations in emergency admissions compared with other CCGs. Given the high prevalence of diabetes and ethnic profile of the local population, diabetes has been prioritised by the Health and Wellbeing Board as a long term condition that needs to be addressed.

### Cardiovascular disease

Cardiovascular diseases (CVD) such as heart disease and strokes, accounted for nearly a third (28%) of all deaths registered in England and Wales in 2013. Heart disease was the leading cause of death for men in 2013 accounting for 37,797 deaths (15%) while strokes accounted for 14,058 deaths (6%) and were the fifth leading cause of death. Among women, heart

disease was the second most common cause of death accounting for 26,075 deaths (10%) followed by strokes with 20,706 deaths registered (8%).

Despite the high numbers of deaths attributed to cardiovascular diseases, there have been steady declines in mortality rates of this condition in England and Wales largely because of improvements in treatment and diagnosis but also because of a range of initiatives to improve people's health through better diet and lifestyle. As a result we tend to focus on preventing these deaths in people under the age of 75 years, considered to be premature mortality.

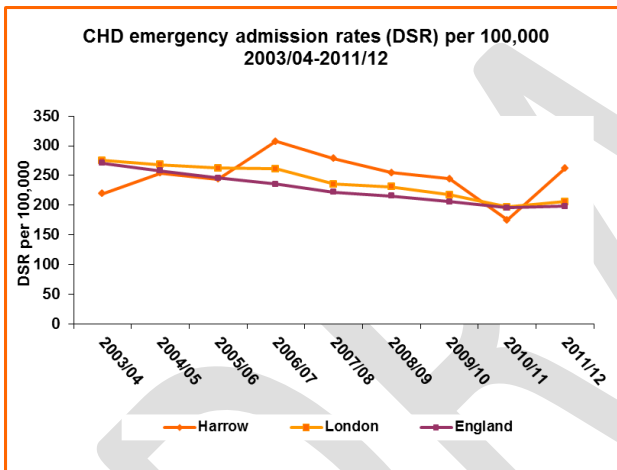
Cardiovascular disease is the leading cause of death in Harrow when all ages are considered and is the second largest cause of death after cancer in people aged under 75 years. During 2011-13, the premature mortality rate from all cardiovascular diseases in Harrow was 70.3 per 100,000, significantly better than the national average (78.2 per 100,000). The premature mortality rate consider preventable from all CVD among men under 75 years of age during 2011-13 was 74.3 per 100,000 while in women it was 20.9 per 100,000, these rates did not differ significantly from the national average (76.7 per 100,000 and 26.5 per 100,000 respectively). In 2014, the early CVD mortality rate in Harrow for persons under 75 years is predicted to be reduced by one third compared to 10 years ago. The percentage of CVD deaths as a proportion of all deaths was 23.% for people aged under 75 years and 40% for people aged 75 and above.

Coronary heart disease (CHD) led to 14% of all deaths for those under 75 and 15% for all ages. In 2014, the mortality rate for CHD in Harrow is predicated to be reduced

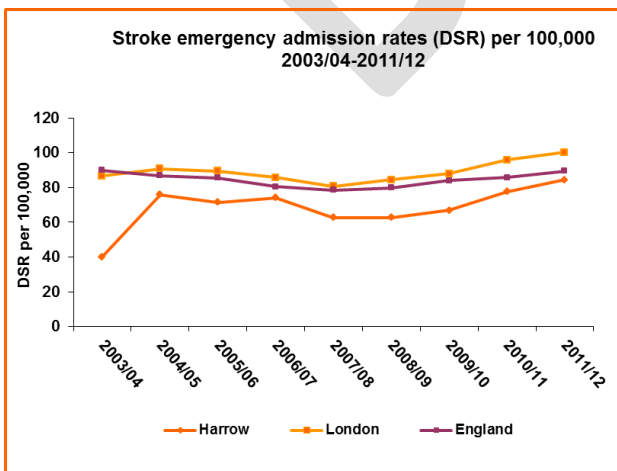
by half for men and women compared to 10 years ago.

Emergency admissions for CHD in Harrow are significantly higher than those of London and England. As with deaths from CHD, emergency admissions tend to be higher in men than in women. Emergency admissions for heart failure are higher than England but significantly lower than London and over the past eight years, rates have decreased by 26% (figure 1 and 2). However, emergency admissions for stroke in Harrow are lower than England and significantly lower than London.

**Figure 48: CHD Emergency admission rates (DSR) per 100,000, 2003/04 – 2011/12**



**Figure 49: Stroke emergency admissions rates (DSR) per 100,000, 2003/04-2011/12**



Demographic and lifestyle factors can in part explain the rates of CVD deaths and admissions in Harrow. Currently 15% of Harrow's population are of pensionable age, age is a key factor in cardiovascular disease. The prevalence of cardio vascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 or over in Harrow is expected to increase slightly over the next ten years. Forty three per cent of Harrow's population are of Asian/Asian British ethnicity and 8% were from Black/ African/ Caribbean/ Black British ethnicity. South Asian men are more likely to develop CHD at a younger age and have higher rates of heart attacks, while black people tend to have higher stroke mortality rates. BME groups in Harrow are predicted to increase from 54% to 68%. Although rates of smoking (13%), drinking (estimated that 20% of the population have increasing or high risk drinking behaviour) and excess weight in adults (59%) are lower or do not differ significantly from the London or England average.

The rate of medical intervention among patients in Harrow is generally higher than that observed at the national and regional level. The rates of angiography procedures among men in Harrow are 1.8 times greater than that observed in women. Over the past eight years rates have increased by 34% while at the national and regional level they have increased by 8% and decreased by 0.7% respectively.

### NHS Health Checks

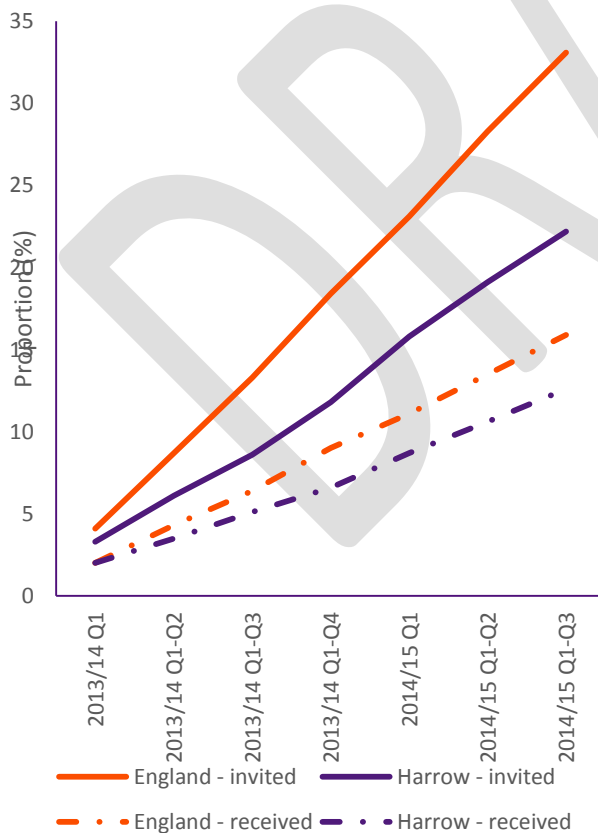
The purpose of the national NHS health check programme is early detection of cardiovascular disease such as heart disease and stroke with a view to then reducing risk. Since quarter 1 2013/14 uptake of all those eligible has increased

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about 6-fold in a 21 month period to a cumulative 12.6% (period comprises quarter 1 2013, to quarter 3 2014/15). This means just over 1 in 10 eligible 40 to 74 year olds in Harrow have had a check.

The cumulative proportion of people invited for an NHS health check and uptake of all those eligible is significantly lower than the England average and has not increased as steeply over time. However, of those invited uptake levels are higher than those seen nationally; 56% for Harrow compared with 49%. In 2013/14 about 50% of people known by their GP to have a learning disability had a GP health check. This compares to 44% nationally.

**Figure 50 Trends in the cumulative proportion of eligible people invited and accepting an NHS health check, Harrow compared with national data**



People with diabetes have about twice the risk of developing a range of CVD

compared with those without diabetes. Of those registered with a GP, about 8.3% have diagnosed diabetes. One GP practice sees prevalence as high as 16.2%; the England average is 6.2%. South Asians are at 3 and a half times the risk of diabetes as white people (age and sex standardised) and are higher risk at lower BMI and younger age (about 10 years earlier). South Asian communities also have higher rates of coronary heart disease; about twice as high as for white people.

A higher proportion of women in Harrow are receiving health checks, and the difference in uptake between men and women is most noticeable between 40 and about 60 years of age. This is despite risk being highest among men and may relate to how checks are accessed. In contrast, Asian men and women are having the highest number of health checks compared with any other ethnic group which is in line with their increased risk. Similarly, people in deprived areas are more likely to be at risk of cardiovascular disease but national data show they are also more likely to receive a health check.

With diabetes prevalence in Harrow set to increase by 45% in the next 20 years and an ageing population, increasing the proportion of eligible residents being offered and receiving health checks at a more rapid rate is crucial in having an impact on premature mortality. There is evidence of inequity of provision in Harrow. Health checks are generally delivered by GP practices and there is wide variation in uptake between them. Alternative models of delivery are being considered and discussions should include ways in which alternatives could increase offer and uptake, especially among those most at risk. Importantly, clear referral pathways

and financial provision for this should be in place to maximise risk reduction efforts.

## Falls in Older People

Older people, particularly women, are at greatest risk of falling and the morbidity associated with falls. Women experience a higher rate of associated injury including hip fractures; have less timely surgery for hip fractures and are more likely to be readmitted after hip replacement. Health and social care costs associated with falls are high and set to increase as the population ages; falls per year in Harrow are predicted to rise from 12,650 per year to 23,800 in the next 20 years. Currently NHS costs for hip fracture alone are estimated to be almost £3 million in Harrow, and this does not include any associated social care costs.

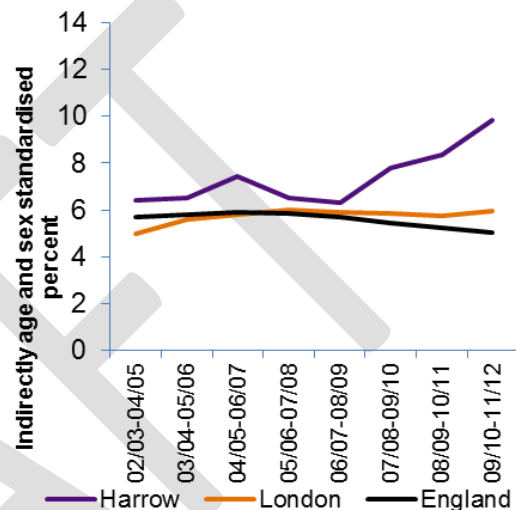
Rates of hip fracture, mortality within 30-days of hip fracture and readmission to hospital with 28 days are all linked to deprivation and this should be considered when improving integrated health, social and voluntary care/support.

Rate of readmission after hip fracture is increasing for females, despite a plateau in rates for males, and is higher than the London and England rate. This can be indicative of variation in social services or inadequate care and support on discharge. It is not possible to know whether timely surgery is related to the probability of readmission but both are linked to higher mortality rates and the proportion of females receiving timely surgery in Harrow is about 12% lower than the London and England average.

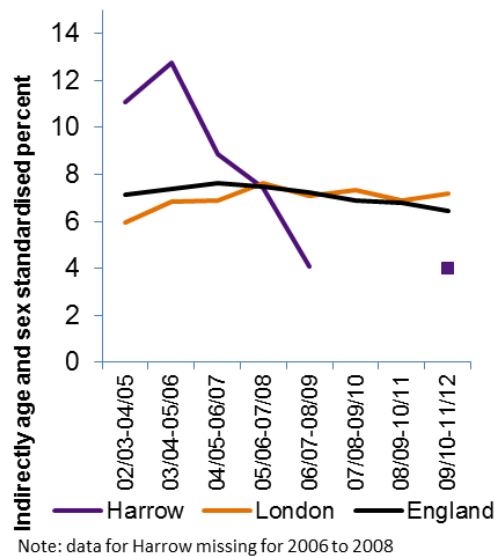
The proportion of women returning home, rather than into institutional care, is almost 3-fold lower than the best performing local authority and significantly lower than the England average. The proportion of older

people offered rehabilitation services following discharge from hospital has also been decreasing in both males and females in 2013/14 but remains higher than the England average.

**Figure 51 Emergency readmissions to hospital within 28 days of discharge: primary hip replacement, pooled data for females 2002 to 2012**



**Figure 52 Emergency readmissions to hospital within 28 days of discharge: primary hip replacement, pooled data for males 2002 to 2012**



Fractures in older people can result in costly hospital and social care. Evidence-based primary and secondary prevention strategies need to cut across agencies and providers to maximise impact. Fall risk assessment for patients already in hospital and population level interventions for older people in residential and nursing care are among some of the recommendations that have already been made nationally. Along with the implementation of robust hip fracture programmes and fracture liaison services. For females in particular, data for Harrow shows variation from the national average which needs to be understood and reduced.

## Respiratory Disease

Chronic obstructive pulmonary disease (COPD) and asthma impact across the life course; prevalence of COPD being highest among people over 65 and peak prevalence of asthma in 5 to 10 year olds. Both are under diagnosed and emergency hospital admissions are costly.

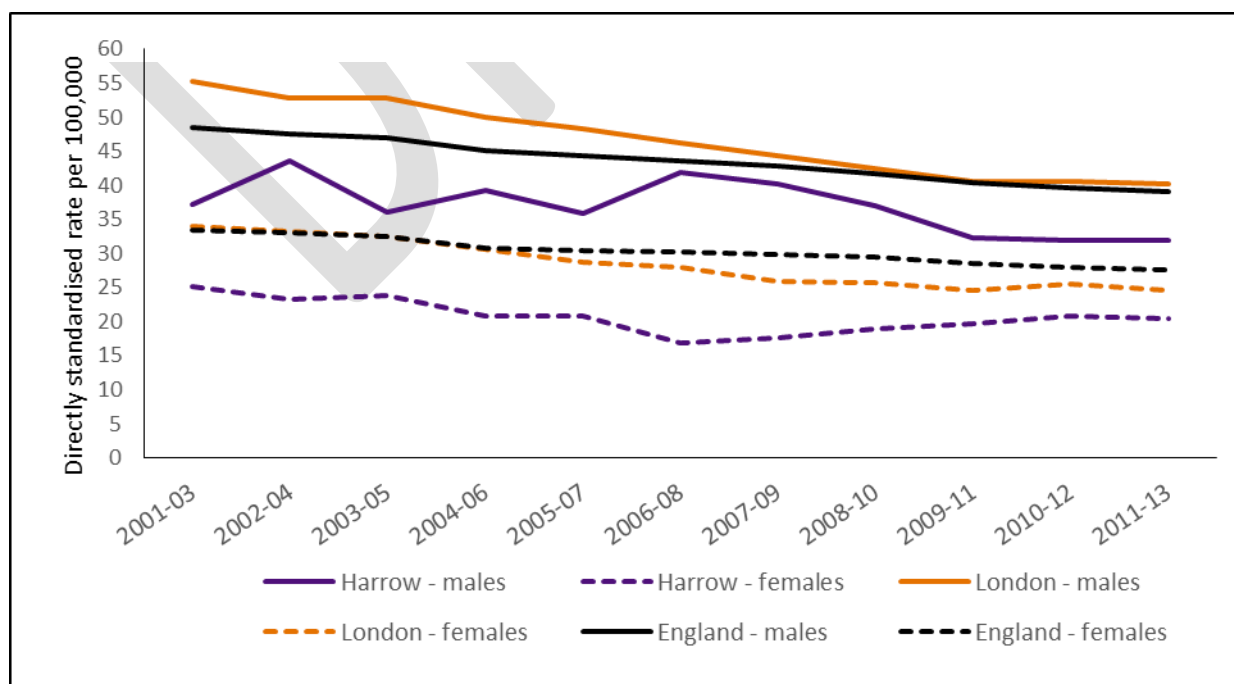
Adults over the age of 40 who have a history of smoking are the primary

population at risk from COPD. Locally smoking rates are lower than the national average but there remain a large number of smokers who should be targeted for stop smoking advice and support.

Premature deaths from COPD are lower than average in Harrow and lowest for females. However rates for females have been increasing since 2006-08, narrowing the gap between the COPD death rate in males and females. This has not happened in London and England and death rates among females have continued to decrease.

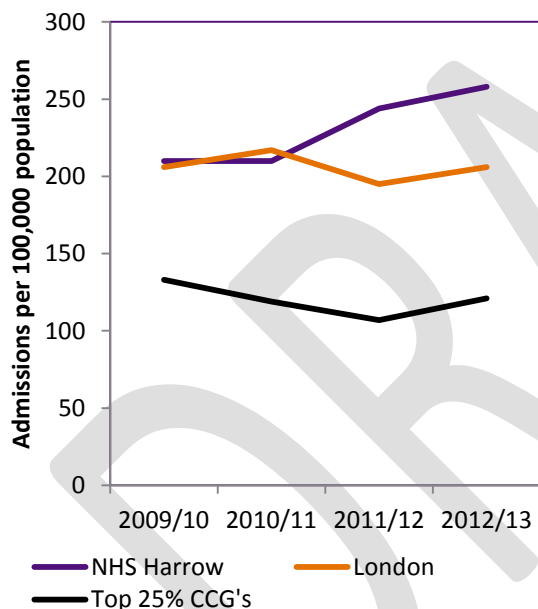
Emergency hospital admissions and subsequent bed days are low in Harrow. Trends show that admissions have been decreasing since 2008/09, while in England and London they have been increasing. Spend and outcome data published by Public Health England for Harrow CCG show that while spend is lower than average, better outcomes are higher than average, which suggests resources for respiratory disease are being effectively allocated.

**Figure 53 Trends in under 75 mortality rate from respiratory disease (primarily COPD), by sex**



Conversely, hospital admissions for asthma have been increasing in Harrow since 2006/07 and rates have exceeded those in London and England since 2010/11. In addition, costs per admission are higher in Harrow; £964 compared with £918 in England. Data on paediatric asthma show a marked difference between emergency admissions for the combined 25% of CCG's with lowest admissions compared with Harrow. The cost saving if Harrow could match these levels is estimated to be about £46,200<sup>xxxvii</sup>.

**Figure 54 Trends in paediatric asthma emergency admissions (aged under 19 years)**



As the older population in Harrow increases in the coming decades the challenge will be to keep overall COPD mortality rates stable and tackle under-diagnosis and increasing deaths among females. Asthma is most effectively and cost-efficiently dealt with in the community, it is estimated that 75% of admissions for asthma are preventable. Therefore, it would be beneficial to reduce emergency hospital admissions and costs per visit. This could be done by improving pathways

for accessing care and support for managing childhood asthma perhaps via asthma clinics and specialist asthma nurses working with schools.

## Oral Health

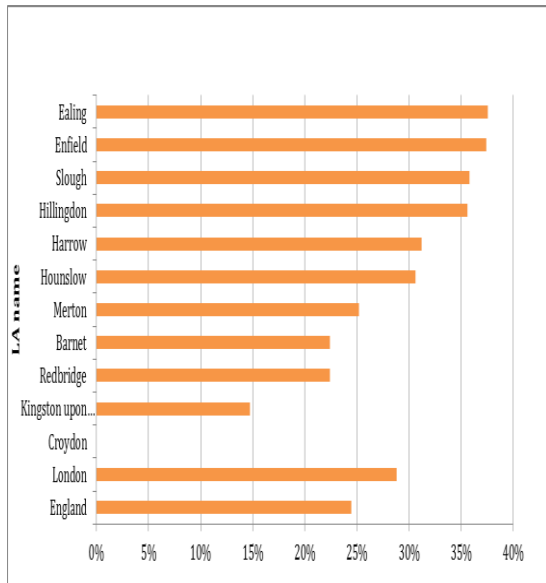
Oral diseases are among the most common chronic health diseases in the UK. Poor oral health can cause pain and discomfort and limit a person's ability to eat and speak. Oral disease can have serious consequences in children as severe tooth decay can result in poor dietary intake, sleep deprivation, days off school and reduced nutritional intake and growth. As a consequence, oral health can significantly affect quality of life and overall wellbeing.

Levels of oral disease in children in Harrow are relatively high. Survey results from 2012 showed almost a third (31%) of five-year-old children residing in Harrow had one or more untreated decayed teeth in 2012 (figure 1). Five-year-old children in Harrow had an average of 1.36 teeth with tooth decay experience (decayed, missing or filled teeth). This is higher than the London average (1.23) and England average (0.94) (figure 2).

In the 24 months preceding June 2013, 60% of children under the age of 17 years attended a dentist. This is lower than the London (63%) and England (69%) figures. In the same time period, 44% of adults attended a dentist. This is lower than the London (47%) and England (53%) figures. Dental attendance in Harrow has followed the London and England trend, with access increasing between March 2011- March 2013. Dental decay is the leading cause for non-emergency hospital admissions in Harrow. In 2012/2013 322 children aged 0-19 years had hospital admissions for the extraction for decayed teeth.

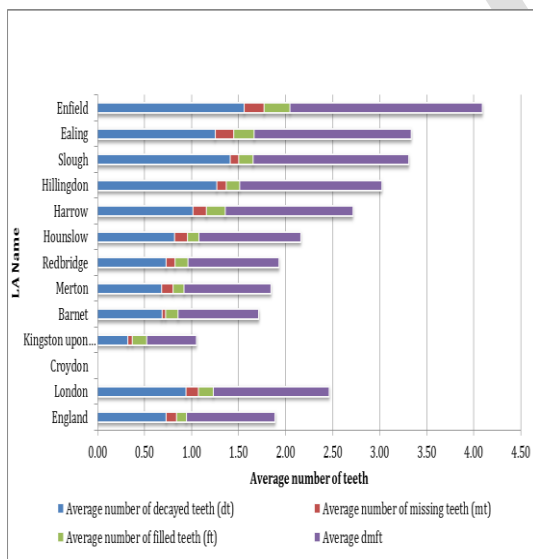
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**Figure 55: Percentage of 5 year olds with one or more untreated decayed teeth, 2012**



widespread evidence in the literature that the oral health of older people living in care homes is poorer than that of their peers living within the wider community, and that access to dental services is restricted for older people in care homes, with most homes accessing dental care and medication that affect salivary flow (causing dry mouth), means that older people in care homes are at higher risk of dental problems.

**Figure 56: Average number of decayed, missing and filled teeth (dmft) in 5 year old children, 2012**

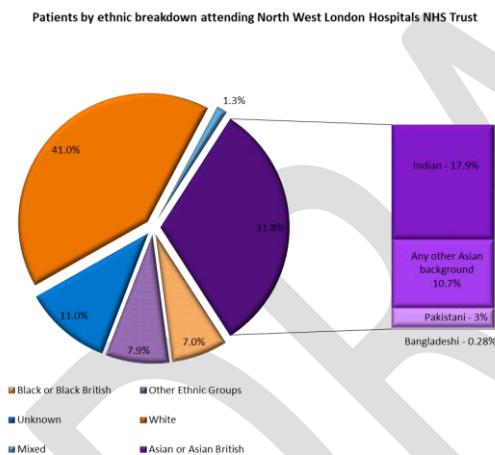


No local data exist on the oral health of adults or older people in Harrow. However, data from the national adult dental health survey which was undertaken in 2009 shows that adults in London had 12.2 decayed, missing or filled teeth, the England average was 14. Among older adults there is no national programme in place for collecting data on the oral health needs of older people. There is however,

## Attendance at Accident and Emergency Department

Patients registered with Harrow GPs account for 77% of accident and emergency hospital activity at North West London (NWL) Hospital NHS Trust; over 30,000 attendances in 2014-15. Emergency care for Harrow GP patients is also provided by Barnet and Chase Farm Hospitals Trust (5% of their total attendances), West Hertfordshire Hospitals NHS Trust (4%), Royal Free Hampstead NHS Trust (2%), The Hillingdon Hospital NHS Trust (2%) and a variety of other hospitals (combined total 11%).

**Figure 57 Ethnicity of Harrow registered patients attending NWLH**



People attending A&E cover the diverse ethnic groups found locally in Harrow. As not all Harrow Residents are registered with Harrow based GPs and not all GP patient live within the borough, it is not possible to directly compare with the resident population data. 41% of people registered with Harrow GPs who attended NWL hospital trust were classified as white and almost 32% were Asian or Asian British. This latter group would appear to be under represented, particularly for the Indian group; However, more than 3,300 attendances did not have ethnicity

classified (11%) and this may account for the differences.

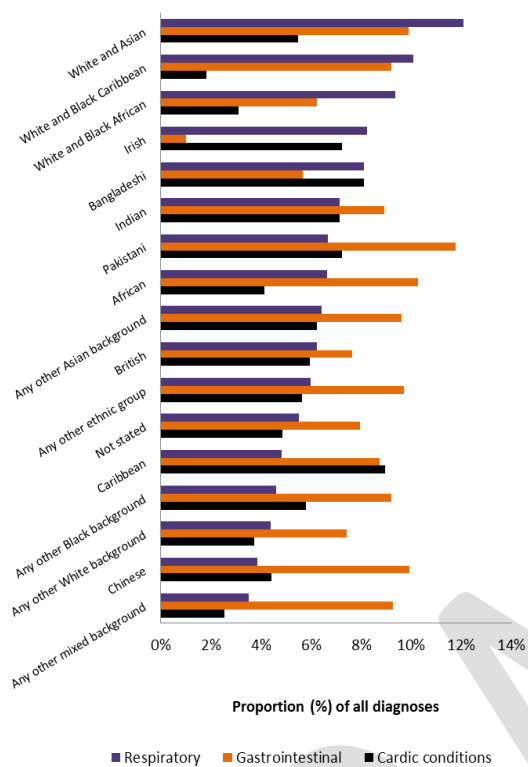
Of all attendances at A&E by local residents (any hospital), more than 4 in 10 – 43% - did not have a diagnosis recorded, either because the diagnosis was not classifiable, nothing abnormal was detected or the diagnoses was not coded. With this level of missing diagnoses

Of conditions that were recorded; gastrointestinal (8.5%), respiratory (6.1%) and cardiac (5.8%), were the most common. There was variation according to ethnic group. Cardiac conditions were the most common in the Caribbean community (9%); similarly for the Bangladeshi community along with respiratory conditions (both 8.1%). Respiratory conditions were more common amongst most mixed sub-groups; White and Black Caribbean (10%), White and Asian (12%) and White and Black African (9.4%) although numbers are small. For all other ethnic groups, the most common condition was gastrointestinal.



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**Figure 58 Three most common diagnosis/description of A&E attendances by ethnic group**



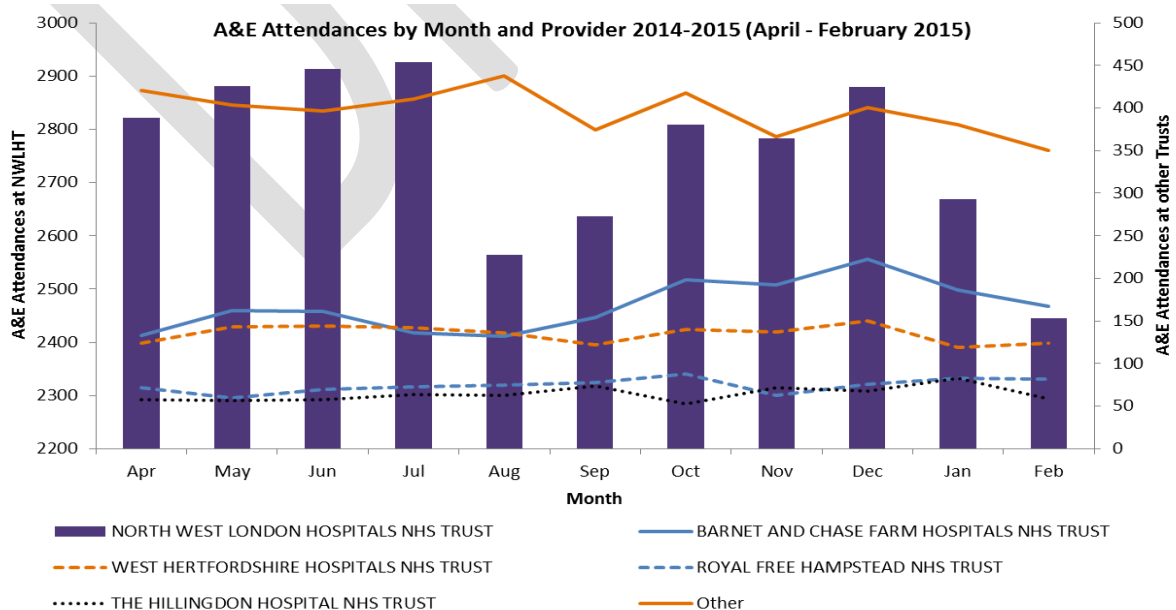
occurred in the early summer months; June and July and again in December with the lowest number of attendances in the holiday month of August. Broad trends are largely similar in other hospitals used by Harrow residents but numbers are small. Nationally, the busiest month was July with the quietest single week in December. Within a 24 hour period, the busiest time is around midday with fluctuations throughout the afternoon. Attendances decline most steeply from 9pm reaching the quietest point at 6am. This pattern is mirrored across trusts.

### Four Hour waiting time

The key measure of A&E waiting times is the proportion of patients waiting over 4 hours before admitted, transferred or discharged. In 2013/14, 12.8% of patients attending the North West London Hospital NHS Trust waited more than 4 hours. That's an increase from 12% in 2012/13 and places the hospital rank 137; in the top worse 10 performing NHS trusts in England. The national figure was 6.5% and of A&E departments used by Harrow residents, only West Hertfordshire

Monthly A&E attendance data show that in the North West London Hospital NHS Trust, peaks in attendance last year

**Figure 59 A&E attendance by month**



Hospitals NHS Trust (6.5%) and The Royal Free Hampstead NHS Trust (3.7%) performed similar to, or better than the England average. National trends in waiting times exceeding 4 hours have been showing fairly steady increases since 2010-11 and performance on this indicator is generally worse across London in the month of April. National data show that increased A&E activity does not necessarily correlate with an increase in waiting times.

### *Admissions from A&E*

The North West London Hospital ranks within the top 10 trusts with the highest proportion of admissions via A&E at 38%. This compares with 18% for Barnet and Chase NHS Trust; one of the 10 trusts with the lowest proportions. Reducing the number of emergency hospital admissions is important in reducing costs as well as preventing disruptions to inpatient waiting lists.

## Lifestyle

It is the overarching intention for the Harrow JSNA to improve the health and well being of the Harrow population and to reduce inequalities across the Borough. The focus will be:-

- linking the environment, lifestyle choices and the health and well being
- Causes of premature mortality
- Need for healthy lifestyle choices

This section will summarise some of the factors which contribute to maintaining a healthy lifestyle. These will ultimately have a positive effect on improving the health and well being of the people in Harrow and help to reduce the health inequalities which are apparent in our borough. Some of the overarching considerations are highlighted in this section, which will help to inform decision making about the services we provide to improve health outcomes in Harrow.

The sections include: Smoking, Alcohol, Substance Misuse, Sexual Health, Teenage Pregnancy, Diet, Nutrition and Physical Activity.

## Physical Activity

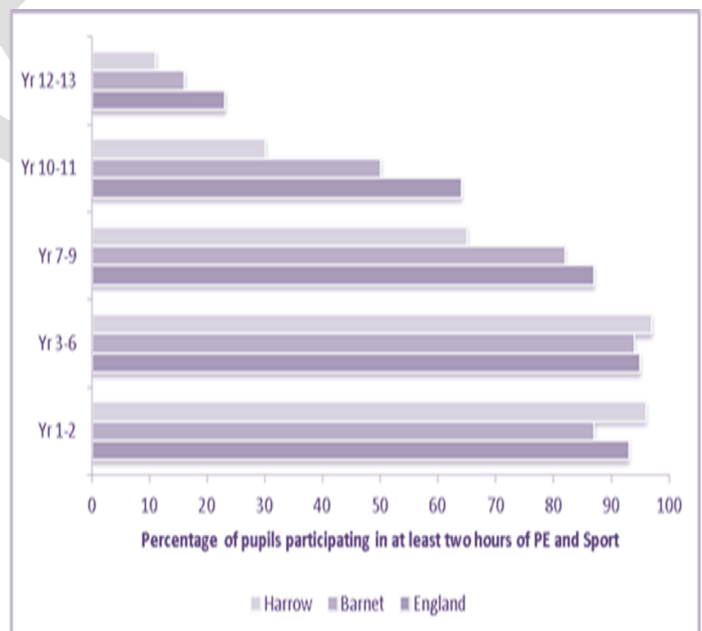
The amount of physical activity children take decreases as they get older. In Harrow, young people who are 15 or 16 years old (year 10 to 11) are almost 3 times less likely to participate in at least two hours of PE and sport per week than children aged 6 and 7. The difference is much larger than for England where the rate of participation for older children is only a third less than the younger ones.

Nationally, on average only a third of adults take enough physical activity according to

guidelines. In Harrow this is even lower. Areas within the south east of the borough have the highest levels of inactivity.

Data from a recent meta-analysis found that compared with individuals of normal weight, unfit individuals had twice the risk of mortality regardless of BMI. Other evidence suggests regular physical activity can improve diabetes control<sup>xxxviii</sup>. South Asian populations are at higher risk of type 2 diabetes at lower BMI and there is some evidence that levels of physical activity are lower among South Asian groups than the general population; which may contribute to increased risk of diabetes and coronary heart disease.

The link between inactivity and obesity is established and given that the proportion of 10 to 11 year olds in Harrow with excess weight is higher than the England average and the particular risks for the South Asian population, getting the population more regularly active is very important.



The borough offers many opportunities for exercise for people across the life course; some programmes focus on young people, those with disabilities, mental health

problems, on referral and some are located in (and target those) in more deprived areas. A sports centre has been set up in Harrow that offers football and gym sessions. Since it opened there have been 1,000 visits per week and additional benefits have been a reduction in crime by 25% and antisocial behaviour.

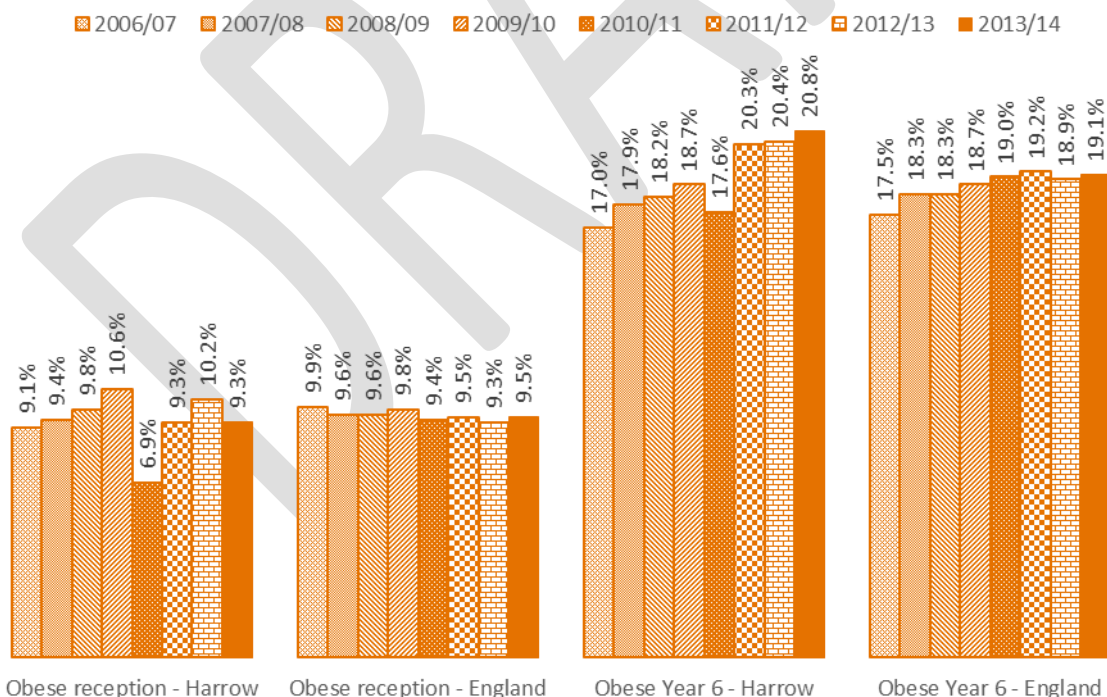
Though opportunities to exercise are many and the borough takes an inclusive approach to improving fitness among residents, motivation to begin and continue to exercise is key. Rigorous evaluation of the effectiveness of initiatives based on clear, measurable outcomes is required to ensure value for money and help measure the long term impact on health and wellbeing in the community. This should be

## Obesity in children

Overweight and obesity in 10 to 11 year olds is increasing in Harrow and the proportion is almost 4% higher than 8 years ago. Although obesity levels are lower than the London and England average for 4 and 5 year olds, the decrease in prevalence seen in London and England over time has not been seen in Harrow. The borough's obesity strategy states a commitment to no further rises in excess weight in both age groups in the coming years.

It is not clear whether interventions targeting young children in reception will have an impact on obesity levels among older children and there is currently no evidence about the effectiveness of any

Trends in obesity in reception and year 6 children in Harrow and England



considered as part of the Sports and Leisure Strategy currently being developed for Harrow.

programmes aimed at children under 6 years old. Recent research however, suggests that children that are obese at 5 years old have obese parents<sup>xxxix</sup>. This highlights the importance of engaging

adults and particularly parents, in patterns of healthy eating in order to impact obesity levels of very young children. The Healthy Child Programme contact points and the NCMP process may provide opportunities for this. Plans are underway to develop an obesity pathway for Maternity and Early Years as part of the obesity strategy. Better outcomes for children at age 5 may be among other benefits of getting obese expectant mothers on a care pathway.

By teenage years, young people are influenced by peer pressure and are likely to be making independent choices about what to eat. Establishing healthy eating patterns before then may help counterbalance the negative effects of an obesogenic environment. Both physical activity as well as food consumption are linked to obesity. Whilst there are many opportunities to involve borough residents in increasing physical activity levels, there are no specific obesity programmes. Through the Obesity Strategy there is a commitment to treat at least 500 children annually in tier 2 weight management interventions. Evaluating an intervention however, is key for looking at impact on future excess weight prevalence and national guidance is available<sup>xi</sup>. In conjunction with rigorous evaluation, an evidence-based approach for any programme or intervention is essential. Using lessons learned from programmes implemented in other local areas may also be beneficial.

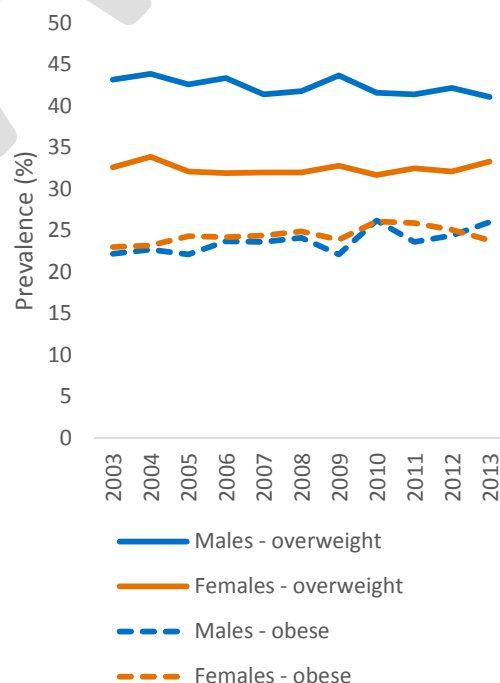
Tackling childhood obesity requires a strategic and systematic approach, including using better use of local datasets such as NCMP to target obesity hotspots and inform equity in commissioning weight management services. The association between deprivation and higher child obesity levels is strongest for children in year 6. This is evident in Harrow, where

some of the more deprived wards in the East of the borough such as Kenton East and Edgware have obesity prevalence of greater than 1 in 5 children. Detailed local statistical analysis of obesity and deprivation using NCMP is planned for 2015, as is the implementation of the obesity strategy for the borough.

## Obesity in Adults

The Active People Survey estimates that 59% of adults in Harrow are overweight or obese; similar to the England average and suggests there are 44,000 obese adults living in Harrow. National sources of trend data all have limitations, however GP collected Quality and Outcomes Framework data and model-based estimates from HSE both suggest national prevalence is increasing, particularly for obese males.

**Figure 60 Obesity and Overweight in the adult population in England 2013**



Linked to obesity levels; the percentage of physical activity adults in the borough is low and the prevalence of diabetes is high. This is despite a wide variety of options to

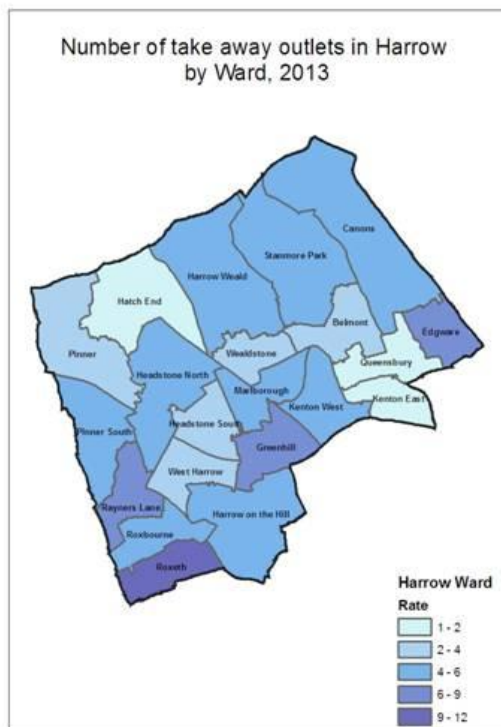
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exercise forms and promotion of physical activity continuing throughout the borough. Similarly, when looking forward to the future, the significantly higher-than-national average prevalence of excess weight in 10-11 year olds is also relevant. Furthermore, there is no tier 2 and a scant tier 3 provision in place in the borough.

In response to this, an obesity strategy group has been formed and will strive to set up obesity pathways for maternity and early years, as well as adults.

Socio-economic status plays a large role in lifestyle choices amongst Harrow residents with those on lower incomes consuming more fatty and processed food, fizzy drinks and less fruit and vegetables. Mapping of fast food outlets across the borough shows the highest rates in the most deprived areas of the borough Edgware, Roxeth and Rayners Lane as well as in the main town centre, Greenhill ward.

**Figure 61 Mapping fast food outlets in Harrow 2013**



The association between deprivation (using education level as a proxy) and excess weight is strongest for women and overweight prevalence among females is now higher than the prevalence for males in the 16 to 24 year old age group; the only age group where this is the case. In addition the prevalence of maternal obesity (associated with health risks for mother and child) is higher in areas of greater deprivation and of the 261 national maternal deaths in 2000-02, 30% were in obese women. The obesity strategy for the borough is being implemented this year to deal with some of these issues.

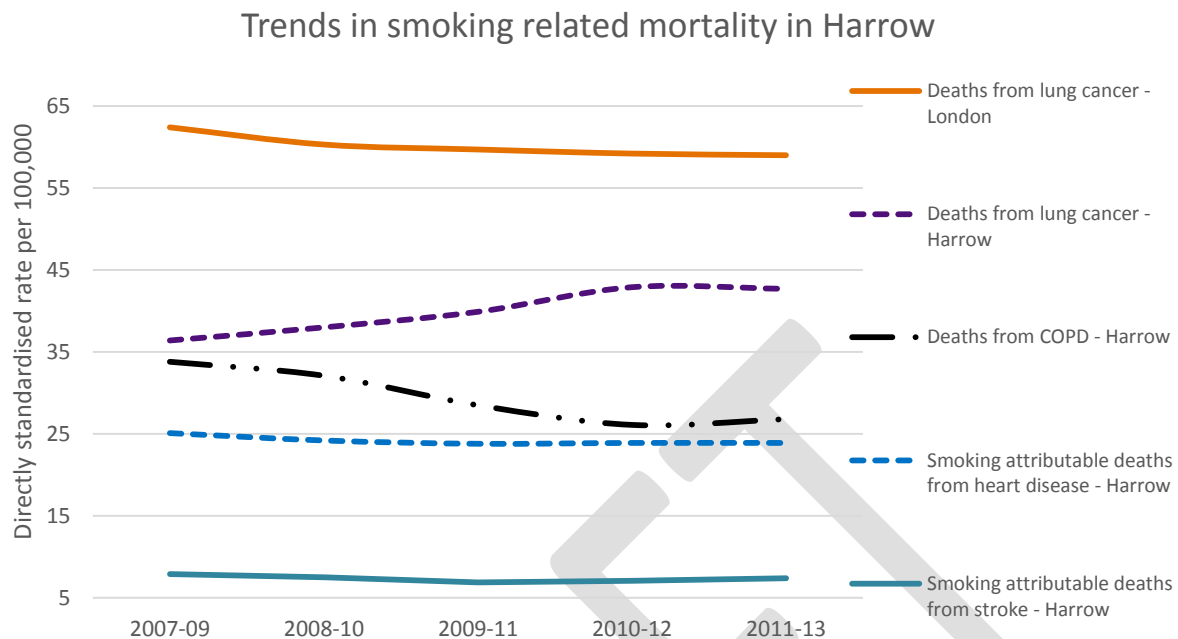
## Tobacco and Smoking

Smoking prevalence, hospital admissions and smoking related mortality rates in Harrow are lower than the England and London average. However the local cost of tobacco in Harrow per year is estimated at £230 per person and the loss of 12 and 16 years of life for men and women respectively that smoke regularly.

People in lower socioeconomic groups are more likely to smoke and spend a larger proportion of their income on cigarettes. The prevalence of smoking in routine and manual groups is estimated to be about 5% higher than in the overall population of Harrow (17.6% compared with 12.8%). In addition, lung cancer deaths have been increasing in Harrow since 2007-09 unlike London; with the largest burden among those in deprived areas.

Smoking rates among women are now almost equal to that among men, particularly in the 20-24 year old age group in which smoking prevalence is highest. This may cause increases in smoking morbidity and mortality in future decades and may have some impact on current rates of smoking at time of delivery, especially among younger women.

Figure 62 Trends in Smoking related mortality in Harrow



The quit rate of people accessing cessation services is lower than the national average. This is in part due to low smoking rates in the borough but to address inequalities related to smoking it is essential that services reach those most at risk. Recording of ethnic and socio economic group is vital for ensuring equity of service provision as is targeting services at those with greatest need. Incorporating stop smoking services into other health and wellbeing services or at locations used by local communities at high risk (such as Bangladeshi men), may improve equity.

There is limited data on smoking rates of young people and how this may vary by ethnic group. Keeping smoking prevalence low among children and young people will provide NHS related cost savings for the future and reduce premature mortality. Local efforts to engage young people about the harmful effects of smoking through the Cut Films programme has been ongoing. The programme has engaged with around 2,000 young people in Harrow over the past 2 years.

The challenge for the borough is to keep smoking prevalence levels low, maintain quit rates and to minimise the initiation of smoking among young people while tackle the inequalities associated with tobacco.

## Drugs and Alcohol

A detailed drug and alcohol assessment for Harrow was completed in 2014. It found that dependency in Harrow is generally low and alcohol-related mortality, including liver disease, is decreasing, as is alcohol-related recorded crimes. However, hospital admissions continue to rise most steeply among males, but also among females. Despite high abstinence levels, partly due to the ethnic and religious breakdown of the community, it's estimated that of those that drink, about 6.5% of them are higher risk drinkers and it may be this group contributing to the increase in hospital admissions.

Trends for young people, previously depicted in the media as the main (most visible) culprits of binge drinking, are showing declines. Data on alcohol consumption suggest the proportion of 16

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to 26 year olds drinking in a given week was 48% in 2010 compared with 71% in 1998. A similar trend can be found among those ever having had illegal drugs. Alcohol specific alcohol admissions among under-18 year olds have shown a year on year consistent decline since 2009/10.

Data suggest older people 45 to 60 are the age group most likely to be in drug treatment and those aged 55 to 64 are the group most likely to make an alcohol related ambulance call outs. This suggests a growing level of need among older people and the call out data highlights how this group may be more likely to receive medical treatment for health problems related to alcohol rather than the dependency itself.

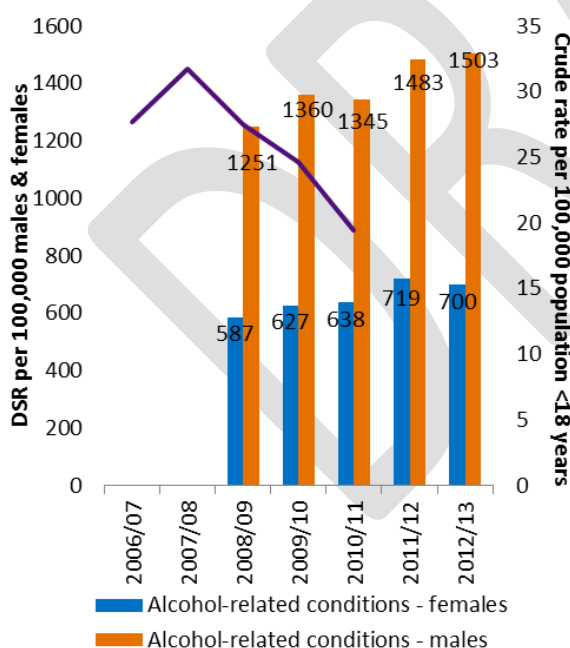
suggests that binge drinking rates may be high in these groups. The Chemsex study suggests there is a small but vulnerable group of gay and bisexual men using drugs such as crystal methamphetamine which is increasing the likelihood of risky sexual behaviour, which may increase the risk of sexually transmitted infections and HIV.

Substance misuse amongst people entering prison with substance dependence issues, who were not previously known to the community substance misuse services in Harrow, is higher compared to England.

Of all people in treatment, dual use of opiates and crack has increased over time in Harrow. Hospital admissions due to drug related mental health and behavioural disorder have increased nationally by 15% in the last decade and admissions are highest in London. In Harrow, about one fifth of people accessing drug or alcohol abuse services are having concurrent contact with mental health services. This is likely to reflect the important and on-going work of services in Harrow such as Compass and highlights the complexity of designing strategies that address drug/alcohol and mental health issues. Treatment completion rates for opiate and non-opiate are good and there is evidence that drug treatment has a clear cost-benefit of £3.20 for every £1 spent.

Locally, Greenhill is the main hotspot for alcohol and drug related-call outs from the London ambulance; for alcohol; the number is twice that of the next highest ward; Harrow on the Hill and about 17 times the number in Pinner South (the ward with the smallest number). In 2011 to 2013, there were 233 call outs specifically for binge drinking in Greenhill. The next highest ward was Harrow on the Hill; 123. Access to these data provide the opportunity to target outreach work to local

**Figure 63 Admissions for alcohol related conditions in Harrow**



The drug and alcohol assessment highlights the need for more information about lesbian, gay, bisexual transgender people in drug and alcohol treatment and



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communities more in need of service provision and support.

## Sexual Health

Sexual health is an important function of physical and emotional health and well-being of individuals, couples and families. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy illness or disease.

Sexual health is an important area of Public Health and from April 2013, the commissioning responsibilities for most sexual health interventions and services has been transferred to local governments. The provision of “open access” sexual health services is now one of the mandatory tasks for the councils’ Public

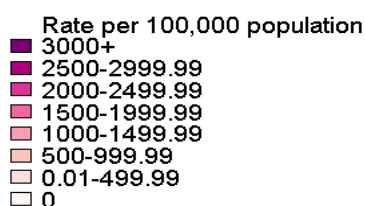
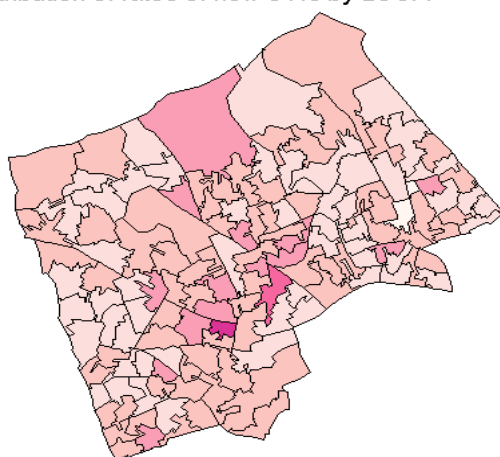
Health teams.

In 2013, a total of 1607 new STIs diagnosed were seen among Harrow residents (887 in males and 720 in females) at a rate of 663.0 per 100,000 residents. In comparison to London (1332.5) and England (834.2) the overall rates of STIs in Harrow are low. Harrow was ranked 146 out of 326 local authorities in England for rates of new sexually transmitted infections (STIs); (1 being the highest rates)<sup>4</sup>. There has been a small but steady increase in both the number and rates of new STIs in Harrow over the last four years.

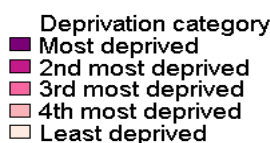
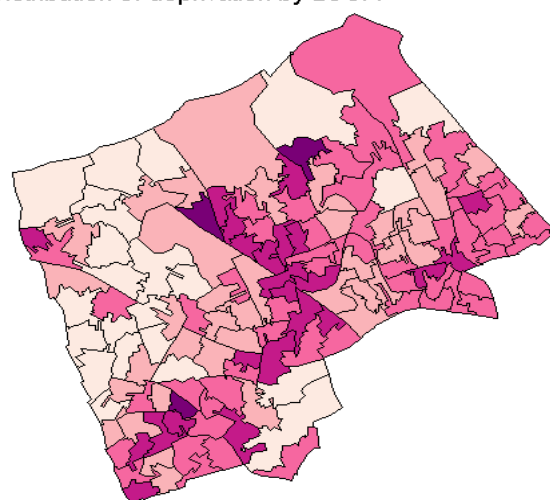
Nationally, there is a clear link between rates of sexual ill-health and socio-economic deprivation (SED). The relationship between STIs and SED is probably influenced by a range of factors such as the provision of, and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. There

**Figure 64 Distribution of rate of new cases of sexually transmitted infections and link with deprivation**

Distribution of rates of new STIs by LSOA



Distribution of deprivation by LSOA



Source: Data from Genitourinary Medicine Clinics  
Rates based on the 2011 ONS population estimates

Deprivation quintiles generated from Index of Multiple Deprivation (IMD) scores 2010  
Rates based on the 2011 ONS population estimates

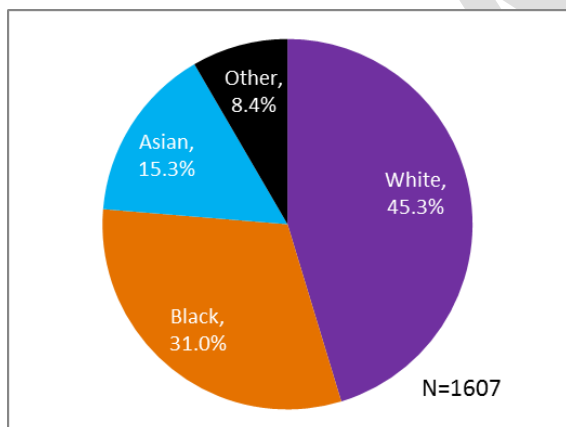
is considerable geographic variation in the distribution of STIs in Harrow. In 2013, the highest rates of STIs were seen in 1<sup>st</sup> and 2<sup>nd</sup> most deprived areas of Harrow indicating a positive correlation between STIs and socio-economic deprivation<sup>xli</sup>.

There are three priority groups that we need to address to reduce the impact of STIs in Harrow: people from the Black ethnic group; men who have sex with men; and young people (15-24)

### **Ethnicity**

Although the highest number of new STIs was in the white population, the rates were disproportionately high in the Black population, making them a key priority group for sexual health promotion work.

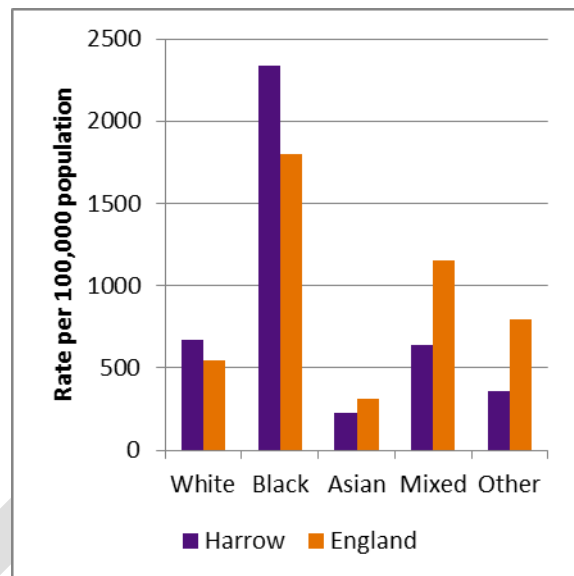
**Figure 65 Number of STIs by ethnicity**



### **Sexuality**

The new STIs among men who have sex with men (MSM) have risen year on year and this is one of the key priority group in Harrow. In 2013, for cases in men where sexual orientation was known, an approximately 15.6% (n=133) of the new STIs were among men who have sex with men (MSM). The proportions of syphilis and gonorrhoea infections were consistently higher among this group.

**Figure 66 Rate of STIs by ethnicity**



### **Age**

Young people between 15 and 24 years old experience the highest rates of new STIs and are one of the key priority groups for prevention of STIs in Harrow. In 2013, 46% of all new STIs diagnoses in Harrow were seen among young people aged 15-24 years (compared to 55% in England). Based on the age and gender profile, it is evident that the rates are particularly higher among young females compared to young males.

Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. The increased risk of reinfection could be associated with the lack of skills and confidence to negotiate safer sex. In Harrow, an estimated 16.7% of 15-19 year old women and 9.7% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became re-infected with an STI within twelve months<sup>4</sup>.

### **Human Immunodeficiency Virus (HIV)**

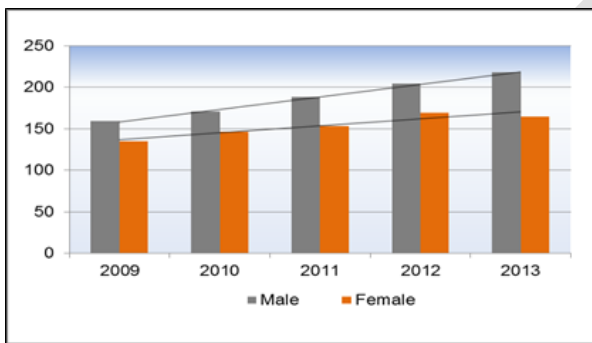
HIV remains one of the most important communicable diseases in the UK. It is

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

associated with serious morbidity, significant mortality and high numbers of years of life lost. There are high costs associated with both treatment and care of HIV.

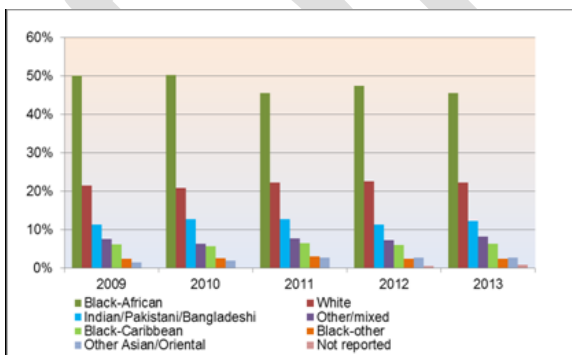
In 2013, 375 adult residents (aged 15 years and older) in Harrow received HIV-related care - 214 males and 161 females. Approximately half of all HIV cases were between the ages of 35-49 years. The number of people diagnosed and receiving HIV care in Harrow has risen by 30% since 2009.

**Figure 67 HIV rates per 100,000 in Harrow**



The highest proportion of HIV cases are in the Black African ethnic group.

**Figure 68 HIV cases by ethnicity**



The prevalence of HIV in Harrow is 2.2 per 1,000 population aged 15-59 years is similar to that of England (2.1 per 1,000) and low in comparison with London (5.6 per 1,000)<sup>xliii</sup> However, an estimated half of the Middle Super Output Areas (MSOAs) in Harrow have a prevalence rate higher than

2 per 1,000 population. This is above the BHIVA recommendation<sup>8</sup> which states that local authorities with a diagnosed HIV prevalence greater than 2 per 1,000 population should offer routine HIV testing into non-traditional settings.

### *Gaps identified in the needs assessment*

A small proportion of sexual health screenings are carried out in primary care and family planning services but there is no specific primary care contract with the local GP practices for screening of STIs including HIV screening.

An HIV test is only offered to those patients that are considered to be at risk of infection in family planning services. Based on the local HIV epidemiology, with higher rates and late diagnosis among heterosexual females, family planning services are best placed to offer the test to individuals who engage in risky behaviour i.e. unprotected sex.

There is a lack of pharmacy or community based facilities to offer information, advice and screening. Pharmacies are easily accessible and can provide a good platform for screenings of some STIs in the community along with signposting individuals to relevant local services.

The uptake of C-Card condom scheme is considerably low in Harrow. Therapy audit team, who manage C-Card scheme, identified an approximately 80 young people from Harrow using C-Card services in Hillingdon in 2012-13 while only 30 young people used this service in Harrow. This indicates a shortage of easily accessible and well-advertised services in the borough.

## Community and Social Networks

### Social Capital

Social capital refers to the links that connect people within and between their communities, which are created through organisations, community structures and networks. Social capital includes information, ideas, social norms, emotional support, goodwill, trust, civic participation and cooperation, which are not personal assets belonging to individuals, but exist within the networks of relationships. By capitalising on these collective contributions, communities can get things done and value their collective achievement.

Social capital provides a source of resilience; a buffer against social isolation and risks of poor health. It provides support which promotes physical and mental well-being, through the networks that help people find work, learn and develop skills and cope with economic and social difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their well-being and, as a result, to other outcomes.

Social capital comprises:

- Participation in social networks
- Trust between individuals and groups
- Reciprocity – doing things for each other
- Influence over decisions that affect the community

By choosing to invest differently and ensuring that policies are both owned by those most affected and are shaped by their experiences, social capital can be

built at a local level to influence healthier and more sustainable communities in Harrow.

Indicators of social capital used in this JSNA include :(see [social capital](#)).

- Feelings of belonging to the neighbourhood
- Civic participation/involvement
- Participation in regular volunteering
- Perceptions that people treat one another with respect and consideration
- Community safety (how safe do you feel when outside in your local area.

### **Key issues and Challenges**

In Harrow, volunteering at least once a year has been reported to have increased since 2009 from 65% in 2010, to 2011 to 71% in 2012, with an even bigger increase in the proportion of people volunteering regularly<sup>xliii</sup>

The 2007 MORI survey, based on the views collected from 2000 households asked the people in Harrow, "Do you agree that people of different backgrounds get along together in their local area". This showed that over half (51%) of Harrow residents agree or strongly agree that people from different backgrounds get on well together in their local neighbourhood. This was a slight reduction since the previous year (2006). Low responses to this question were obtained from Harrow's four wards Edgware, Rayners Lane, Roxbourne and Roxeth, indicating that people were less likely to be positive about community cohesion.

Also in the survey, 54% of residents said that, in their area, people respect ethnic differences with only 12% disagreeing. However, 6% of residents say that they do

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not regularly meet and talk to people from different ethnic origins.

Three in ten (31%) residents think that treating others with respect is a very big problem or fairly big problem although this is lower than the regional rate (37.2%) and similar to the national average (31.2%).

Almost 2 out of five residents (39.7%) said that they think it is safe or fairly safe after dark. This is lower than the regional and national averages (44.1% and 50.9% respectively). Four out of five (81.9%) feel it is safe or fairly safe during the day, again low compared to regional and national averages (84.6% and 87.9% respectively).

However, the results from this survey did not include the views of young people and newly migrated groups such as the Somali community and the East Europeans at that time of the survey<sup>xiv</sup>.

## Crime

Harrow has the lowest overall crime rate of London's 32 Metropolitan boroughs. 50.4 offences per 1,000 populations based on the 2011 Census, compared to 84.4 crimes per 1,000 in London as a whole are recorded. Residential burglary in Harrow is still relatively high, as this crime has accounted for 13% of the total crime within the borough which was the highest percent in Greater London.

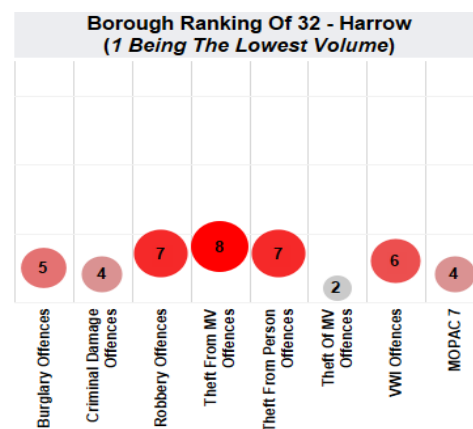
The Mayor's Office for Policing And Crime (MOPAC) is the strategic oversight body which sets the direction and budget for the Metropolitan Police Service on behalf of the Mayor. It ensures the Metropolitan Police Service is run efficiently and effectively and holds it, and other criminal justice services, to account on behalf of Londoners. The [Police and Crime Plan 2013-2016](#) outlines the priorities and objectives for tackling crime and making

London safer. Seven priority crime types have been identified.

- Violence with Injury
- Robbery (Total)
- Burglary (Total)
- Theft From Person Offences
- Theft/Taking Of Motor Vehicle Offences
- Theft From Motor Vehicle Offences
- Criminal Damage Offences

The MOPAC 7<sup>xlv</sup> crime figures from March 2012 to March 2014 financial years reveal that in five of the seven crime types, there has been a decrease in Harrow from the baseline. Thefts from the person have remained at the same level but Violence With Injury (VWI) offences have seen an increase – as has been seen in all but 3 of the 32 London boroughs. Harrow ranks well against all other London boroughs coming 4<sup>th</sup> (where 1 is the lowest volume of MOPAC 7 crimes). Despite the local increase in VWI, Harrow ranks 6<sup>th</sup> best in London. Over all there has been a 28% reduction in MOPAC 7 crimes – the third largest reduction in London.

**Figure 69 MOPAC 7 Borough Ranking for Harrow**



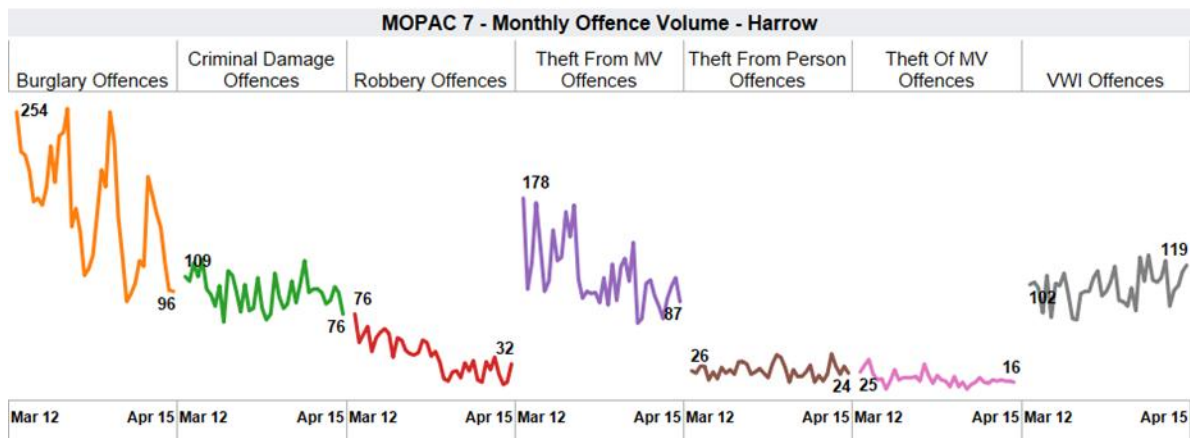
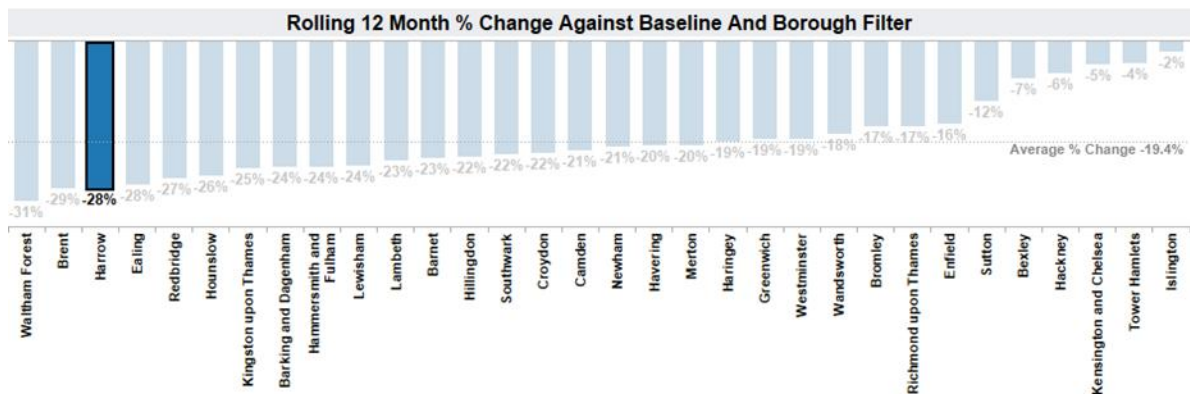
# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

Figure 70 MOPAC 7 Monthly number of offences and % change against baseline – Harrow March 2012 - April 2015

## MOPAC 7 LONDON BOROUGH 12 MTH % CHANGE & MONTHLY PERFORMANCE MAYOR OF LONDON OFFICE FOR POLICING AND CRIME

- All MPS boroughs are recording a reduction in total MOPAC 7 crime.
- Violence With Injury (VWI) offences have seen an increase in all but 3 of the 32 London boroughs.
- Use the drop down menu below to view the % changes year on year in specific MOPAC 7 crime types by borough.
- Click on the borough to view the monthly offence volume and how it has changed month on month.

Crime Type  
MOPAC 7



A population tracker looks at the local population's perceptions about five aspects of policing:

- **Confidence:** How good a job do you think the police are doing in this area? %Excellent/Good
- **Engagement:** % agree that the police are dealing with community issues
- **Fair Treatment** % agree that the police treat people fairly

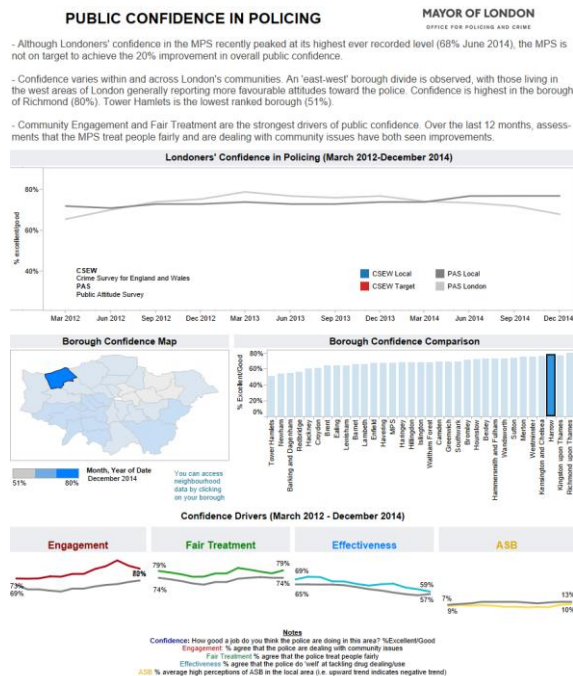
- **Effectiveness** % agree that the police do 'well' at tackling drug dealing/use
- **ASB** % average high perceptions of ASB in the local area (i.e. upward trend indicates negative trend)

Confidence in the police is high in Harrow, with 77% reporting that the police are doing an excellent or good job – the third highest in London. Engagement, fair treatment and effectiveness are all higher than the London averages. There is a perception however, that antisocial

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behaviour has increased slightly, although this remains a little lower than London as a whole.

**Figure 71 Public Confidence in policing – Harrow December 2014**



## Domestic violence

Domestic violence is the abuse of one partner within an intimate or family relationship. It is the repeated, random and habitual use of intimidation to control a partner. The abuse can be physical, emotional, psychological, financial or sexual. Anyone forced to alter their behaviour because they are frightened of their partner's reaction is being abused.

Domestic violence is a devastating crime. One woman is killed by a current or former partner every three days in England and Wales. 1 in 4 women experience domestic violence over their lifetimes and between 6-10% of women suffer domestic violence in a given year<sup>xlvi</sup>. It has a higher rate of repeat victimisation than any other crime<sup>xlvii</sup>

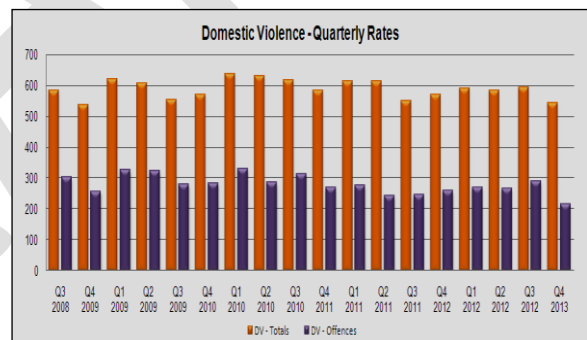
It not only affects the victim but also their family – 90% of incidents in family households occurred with a child in the next room and 50% also involved abuse of children. This can have an impact on a child's behaviour, educational attainment and in their lifelong attitudes and perceptions about relationships. It also has a negative impact on the wider community<sup>xlviii</sup>.

The Ready reckoner tool (Home-office)<sup>xlix</sup> and the ONS estimated population 2011 (239,100), provides the estimated prevalence of domestic violence, sexual violence and stalking in Harrow.

## Key issues and challenges

5617 women and girls aged 16-59 in Harrow have been a victim of domestic abuse in the past year.

**Figure 72 Quarterly domestic violence reported rates**



Of those reported incidents of domestic violence within the reporting period, 91% of all victims recorded were females and less than 9% of victims were male.

## Child Sexual Exploitation (CSE)

Child Sexual Exploitation is not a not a new phenomenon. However a series of high profile cases have heightened awareness through professional and public agendas this includes the cases in: Derbyshire, Rochdale, Oxfordshire, Rotherham, Manchester and more recently the Midlands. A number of strategies have

been set up by the various local authorities to manage the growing problems and some have gone as far as setting up a CSE Teams in children social care services / police departments.

Harrow has set up the Multi-Agency Sexual Exploitation panel since July 2014. The panel has met monthly and has been chaired by Harrow CID unit and co-chairs are Service Manager's for Children and Families Service. The panel's role and responsibilities is to provide advice and guidance to practitioners in relation to individual young people, where CSE or the potential for CSE has been identified and support is required to develop plans to reduce the risk. The meeting is also used to share intelligence and information relating to CSE activity in Harrow or surrounding areas to inform partner agencies and look into the trends or problem locations and ensure they are dealt with through actions taken by all members. The gathering of intelligence is an area that requires further development.

Once the case has been discussed, the responsibility for the oversight, monitoring and implementation of any plans remains with the professional network working with the young person and in Harrow this often still remains with the allocated Social Workers with Children Social Care. In Harrow we also have a number of services who are completing the on-going work with victims and post abuse support. This varies from Early Help services to Voluntary sector such as the WISH Centre.

The Harrow police data indicates they have flagged CSE risks on 45 cases between 2013 and 2015 and 20 cases as non-crime CSE reports between 2013 to 2015. The police have reported all these incidents and crimes via the MASH team for decisions on thresholds.

In comparison to our statistical neighbours we have lower figures of reporting CSE in Harrow however, when comparing similar size local authorities, we are in line with our reporting figures (Merton 45, Sutton 45 and Harrow 44).

Work has commenced in relation to raising awareness amongst the communities and professions of Harrow. Operation Make Safe has been launched and a number of leaflets and posters are being distributed.

### Female Genital Mutilation

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It became illegal in the UK in 1985 under the Female Genital Mutilation Act. This was later replaced by the Female Genital Mutilation Act 2003 to extend the legislation to include anyone taking a girl or woman outside of the UK to perform FGM.

FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates the woman's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

It is difficult to gain an accurate picture of the true extent of prevalence of FGM as there are low levels of reporting, and as such it remains largely hidden. Data generated from referral information into Children & Families suggest that in 2012, there was only 1 case referred flagging



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concerns of FGM and a further case in 2013.

Local police data (CRIS) provides information where a police officer has been dispatched to an incident regardless of whether a crime has been committed. This information source suggests that in a four year period 30 Jan 2010 – 30 Jan 2014, only 2 cases of FGM were reported to them.

In comparison to Police figures, incidence of the discovery of FGM in the North West London Hospital Trust is significant, although it cannot be determined how many of these FGM procedures took place in the UK, nor the residence of women, nor the age of the women when the procedure took place. For some, it would have taken place in childhood before they came to live in the UK.

69.1% of Harrow's population are from a Black or Asian Minority Ethnic (BAME) background. While it may not be possible to report on high prevalence levels of FGM locally, it is reasonable to estimate high levels of prevalence based on the proportion of residents from communities that practice FGM.

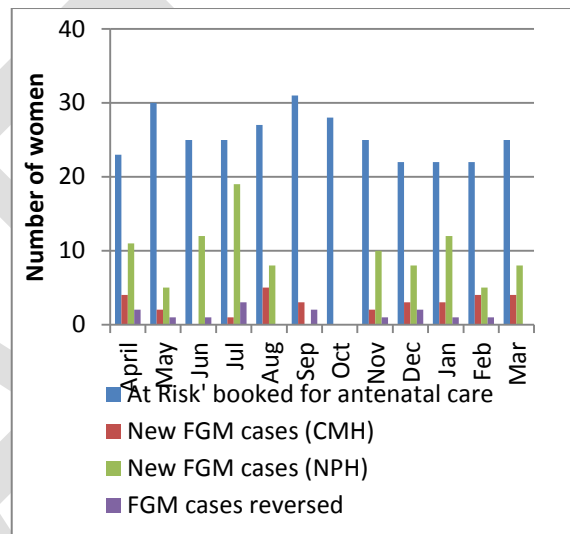
The 2011 Census data has identified that 50.6 per cent of Harrow's residents are females and at least 35%, or 42,300 of Harrow's female population are from communities that practice FGM (based on the Census broad ethnic group categories of Asian/Asian British – Indian & Pakistan; Black/Black British - African; and Other ethnic group – Arab).<sup>1</sup>

FGM is usually performed on girls under the age of 18 years – this is approximately 24% of Harrow's female population. In UNICEF's (2013) Statistical Survey, FGM was conducted on girls less than 5 years of age in half of the countries surveyed. In

the rest of the countries, it was done between the ages of 5 to 14 years.<sup>ii</sup>

Since April 2014, all NHS hospitals have been able to record if a patient has undergone FGM or if there is a family history of this, and by September 2014, all acute hospitals started to report this data to the Department of Health, on a monthly basis.

**Figure 73 FGM risk and new cases in 2014 at Northwest London Hospitals Trust.**



Local data shows in the first year of recording this data, there were around 20 to 30 women at risk of FGM each month booking for antenatal care. Around 3 new cases per month were identified at Central Middlesex hospital and 8 new cases per month at Northwick Park Hospital. Not all of these will be Harrow residents as the trust also covers Brent.

## Prevention

The population at risk in Harrow is more than 10,000 girls under the age of 18 from specific backgrounds. The hidden nature of this form of violence suggests that community awareness raising of its criminal status is likely to be the most effective way of identifying and preventing its continuation.

## Local Economy

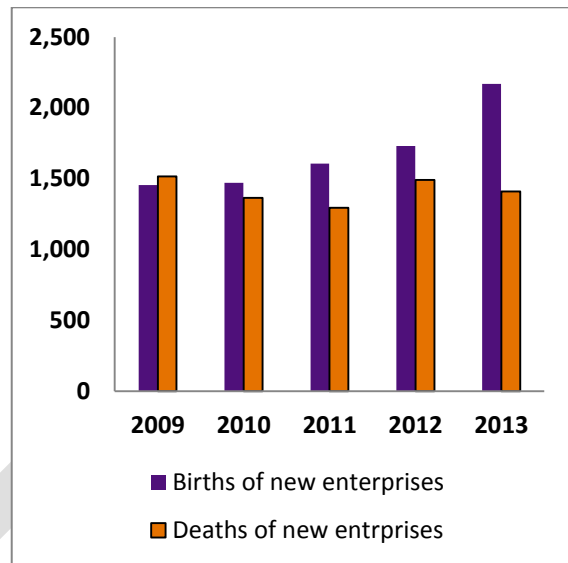
A strong local economy, with a high number of successful businesses across a wide range of sectors, is essential to provide a sufficient number and range of jobs to meet the needs of the local workforce and population.

The availability of local jobs in a population helps to address overall levels of deprivation, creating wealth and tackling issues such as mental and physical health problems that are caused by unemployment.

A borough with a strong economy that supplies a wide range of jobs across sectors can help its marginalised people such as the disabled population to find work suitable to their needs, minimising the distance travelled to work.

The most recent recession had a negative effect on enterprise birth rates (decrease) and enterprise death rates (increase)<sup>lii</sup>.

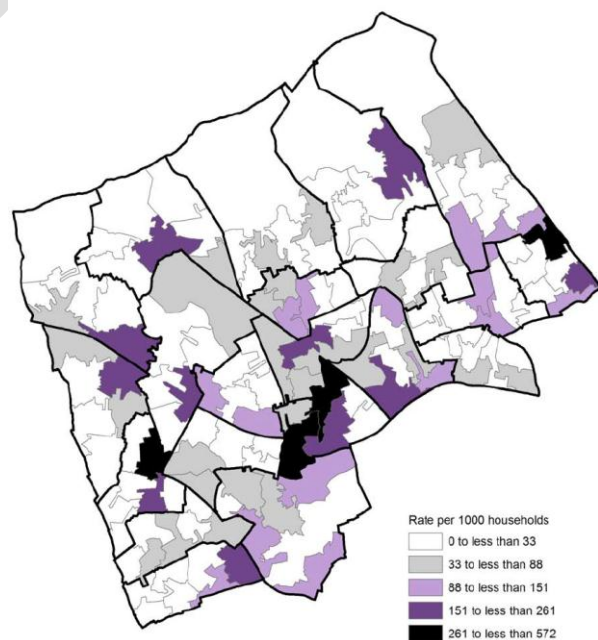
Figure 74 Status of enterprise start-up in Harrow between 2009-13



Source: ONS Business demography 2013 Enterprise births and deaths and survivals

Enterprise births are identified as business that are present in year t, but did not exist in year t-1 and year t-2 ([see background notes](#)). Births are identified by making comparison of annual active population files and identifying those in the latest file, but not the two previous ones<sup>liii</sup>.

Business rates as at April 2013<sup>liiv</sup>



During the period 2009-13, 715 new enterprises were born in Harrow<sup>lv</sup> approximately 60 enterprise deaths were experienced in 2009 during the recession. 291 new businesses were started up in July 2014, 64 more than the previous month. The most start-ups were recorded in Greenhill and Wealdstone recorded the least.

The effect of enterprise births is increased employment, thus lowering the unemployment rate, which can either have be positive or negative to the population, impacting health.

Enterprise deaths is defined as business that were on the active file in year t, but was no longer present in the active file in t+1 and t+2, meaning that the business is inactive. Between there was a slight increase in enterprise deaths in 2009, 2012 and 2013 years 2009 and 2013.

The effect of enterprise births is increased employment, thus lowering the unemployment rate, which can either have be positive or negative to the population, impacting health.

### ***Key issues and challenges***

Unemployment is generally highest in the wards close to the town centre and south-west of Harrow.

In June 2014 the unemployment rates in Wealdstone and Marlborough were 4.4% and 4.1% respectively, higher than London's overall rate of 3.8% and the national rate of 3.4%.

Wages in Harrow are generally lower than in London and in West London as a whole.

People working in Harrow earn, on average, less than the average weekly pay for Harrow residents. **(insert employment)**.

Working age benefit claims provide a measure of low income levels<sup>lvi</sup>. The figure of those who claimed working age benefit in Harrow as at May 2013 was reported to be significantly lower (9.7%) compared to London (12.9%).

In Harrow as at October 2013, 0.5% people claimed Jobseeker's Allowance (JSA) significantly better than the London average (0.7%).

As at August 2013, the percentage of claimants for housing benefit in Harrow was reported to be lower (19.8%) compared to London (25.2%).

## Activities

### Education

Education is important and affects our physical and mental health, and our life prospects.

### School Provision and ranking

There are 61 schools in Harrow, 44 primary schools with nursery classes in 26 of these schools, 11 high schools, 1 all-through free school, 2 primary special schools, 2 high special schools and 1 pupil referral unit. 8 high schools in Harrow have acquired academy status.

A high proportion of Harrow's schools are judged good or outstanding. As at October

of Asian other (21%), Indian (19%) and White British (14.5%) ethnic origin.

Between 2006 and 2014, the proportion from the Asian other and White Other groups have increased from 13% to 21% and from 4.2% to 11% respectively.

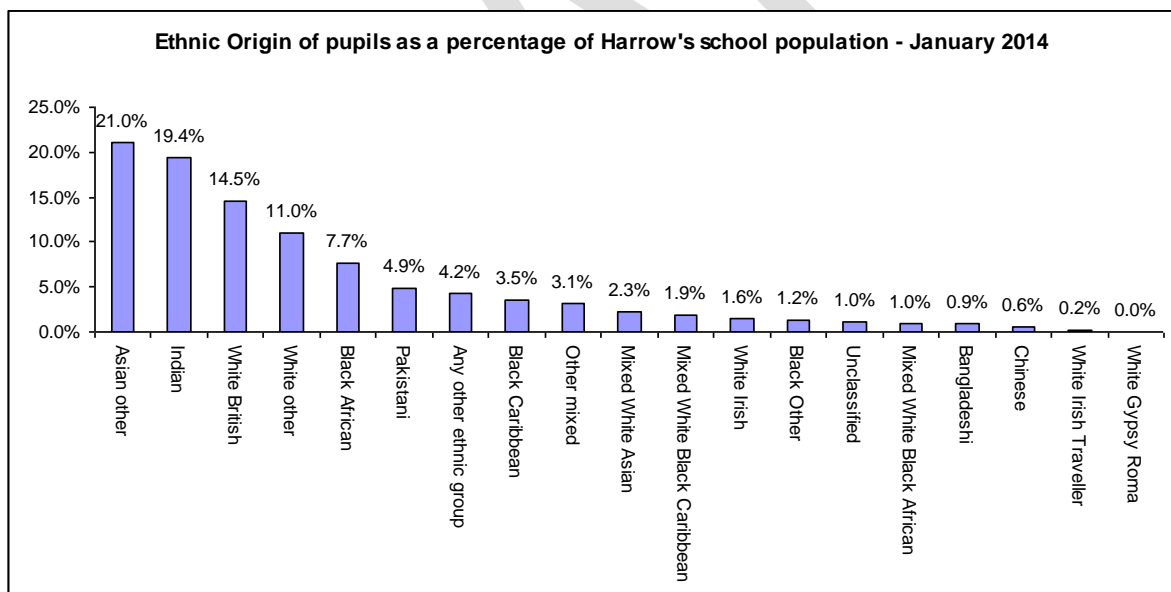
### Primary Phase

As at January 2014, 8.8% of Harrow schools' Reception children reside outside the borough, and 8.7% of Harrow's resident Reception age children attended schools outside Harrow, resulting in a minimal 0.1% net difference.

The number of out of borough primary age pupils attending Harrow's schools also increased from 1,805 in January 2013 to 1,884 in January 2014, an increase of 4%.

A majority of pupils imported into Harrow

**Figure 75 Ethnic origin of Harrow's school population - Jan 2014**



2014 87% (51 schools) of Harrow's schools were good or outstanding, 12% (7 schools) requiring improvement and 2% (1 school) judged inadequate.

### Current school population

Harrow's school population reflects the rich diversity of the borough. The largest proportions of pupils in Harrow schools are

schools mainly come from Harrow's neighbouring boroughs - Brent (754), Hertfordshire (329), Hillingdon (287), Ealing (277) and Barnet (204).

### Secondary Phase

As at January 2014 14.1% of Harrow schools' Year 7 pupils reside outside the borough, whilst 27.2% of Harrow's resident Year 7 children attend schools outside

Harrow, resulting in a -17.9% net difference.

In January 2014, 3,115 secondary age Harrow residents attended schools outside the borough; this is significantly higher than the number of out of borough pupils attending Harrow's high schools (1,549). A majority of Harrow's secondary aged resident pupils went to schools in Brent (758), Hillingdon (761), Barnet (665) and Hertfordshire (561).

There has been a 23% increase between 2010 and 2014 in the number of out of borough secondary aged pupils attending Harrow schools from 1,192 in January 2010 to 1,453 in January 2013 and to 1,549 in January 2014. The majority of pupils come from Brent (790), Barnet (256), Ealing (236) and Hillingdon (106).

## Children with Special Educational Needs

Special educational needs (SEN) that affect a child's ability to learn can include their:

- behaviour or ability to socialise, eg not being able to make friends
- reading and writing, eg they have dyslexia
- ability to understand things
- concentration levels, eg they have Attention Deficit Hyperactivity Disorder
- physical needs or impairments

Different types of educational support available for children with SEN:

School Action ("SA") is used when there is evidence that a child is not making progress at school and there is a need for action to be taken to meet learning difficulties.

School Action Plus ("SA+") is used where SA has not been able to help the child make adequate progress. At SA+ the school will seek external advice from the LEA's support services, the local Health Authority or from Social Services.

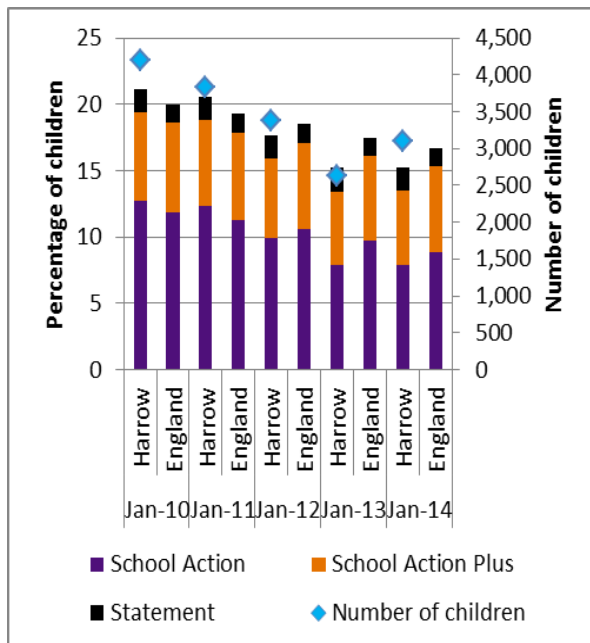
Where a child is still not making adequate progress at the SA+ stage then the child's school or parents can request a Statutory Assessment, which may lead to them receiving a Statement of SEN. Statements of SEN are being replaced over the next four year by Education, Health and Care (EHC) plans. Within the new EHC planning system, there is a focus on working together across education, health and care for joint outcomes. This imposes clear duties on all of the relevant partners involved to work collectively to support children and young people with SEN with the provisions (educational, health and social care) they need.

The type of SEN primary need has changed over the past 5 years with Speech, Language & Communication Needs, Autistic Spectrum Disorder and Visual Impairment all increasing and Behaviour, Emotional & Social Difficulties, Moderate Learning Difficulty, and Other Difficulty/Disability all decreasing in number.

### *Primary Schools*

In Harrow Primary schools, the proportion of children with SEN has decreased and has gone from being higher than the national rate to being lower. However, due to the increasing size of the school population, the number of children with SEN has increased in the past year to 3,096.

**Figure 76 Proportion of Harrow primary school children with SEN**



## Special Schools

The number of pupils with a statement in Harrow's special schools has increased year on year from 330 in January 2009 to 391 in January 2014, - an 18% increase. Almost all of these children have a statement of SEN.

## Future School populations

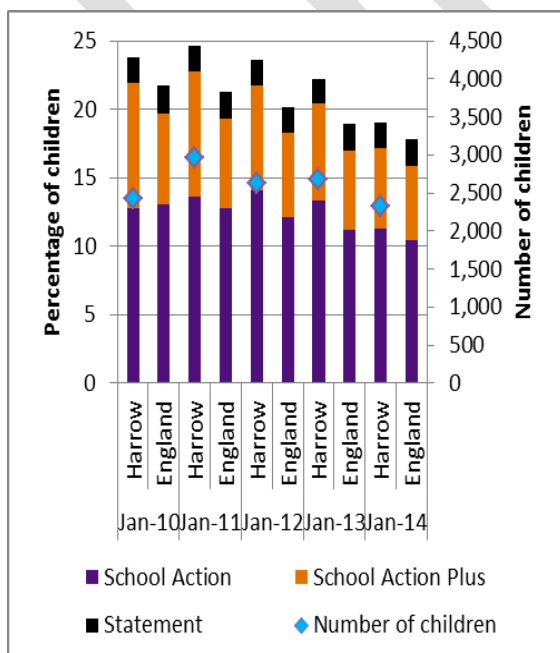
Harrow's population is now at the highest recorded level, based on records going back to 1901. There have also been increases across all the statutory school age groups. The 0-4 age group has already increased by 41% between mid 2001 and mid 2013. Population projections suggest that this group will continue to rise by a further 22.1% to 25,467 to by 2024.

## Secondary Schools

In Harrow secondary schools, the proportion of children with SEN is higher than that of England as a whole. The Proportion has been decreasing year on year and the number has also decreased to 2,327.

From 2015, the number of 11-15 year olds in the population (14,139) is also projected to increase and will continue rising to 16,810 in 2024 and beyond. There is a projected increase of 15.6% from 2012 to 2024. The timing of this increase reflects the current surge in Reception numbers

**Figure 77 Proportion of Harrow's high school children with SEN**



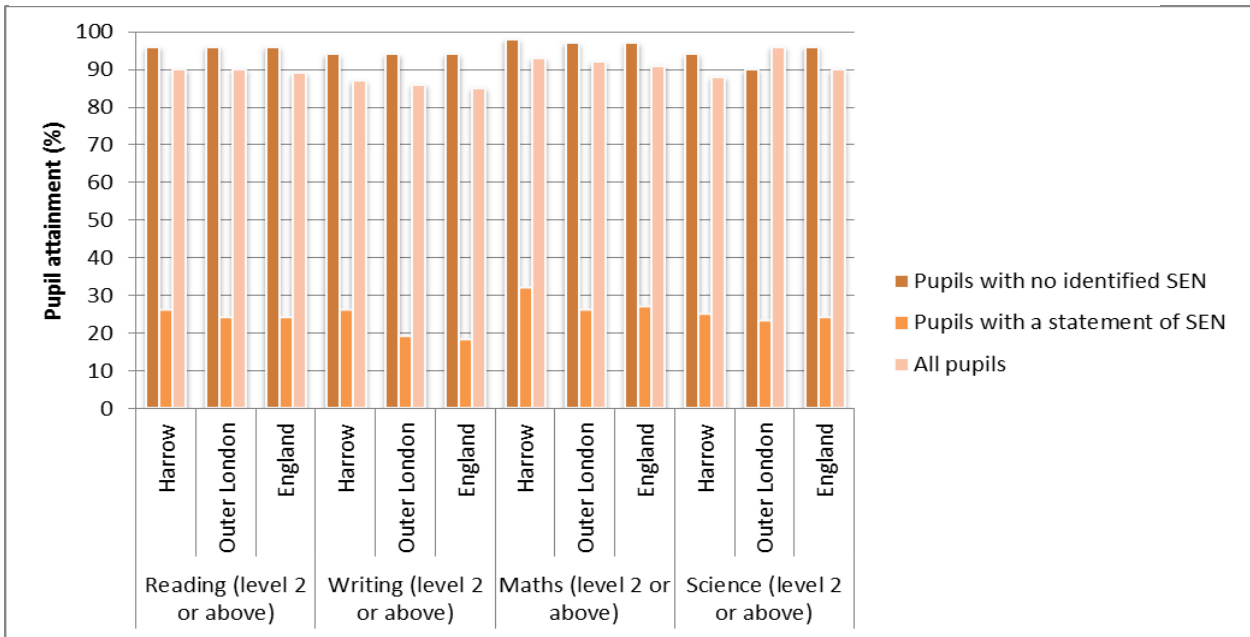
## Education outcomes

A lower than average proportion of children are assessed as having achieved a good level of development at the end of the foundation stage, with 44.7% achieving this milestone. The foundation stage assessment is completed in the final term of the academic year in which a child reaches the age of five.

In 2013 in Harrow, primary school aged children without an identified special educational need (SEN) tend to do better than the national or regional average. At key Stage 1, the end of year 2, children with a statement of SEN also fair better than national and regional peers.

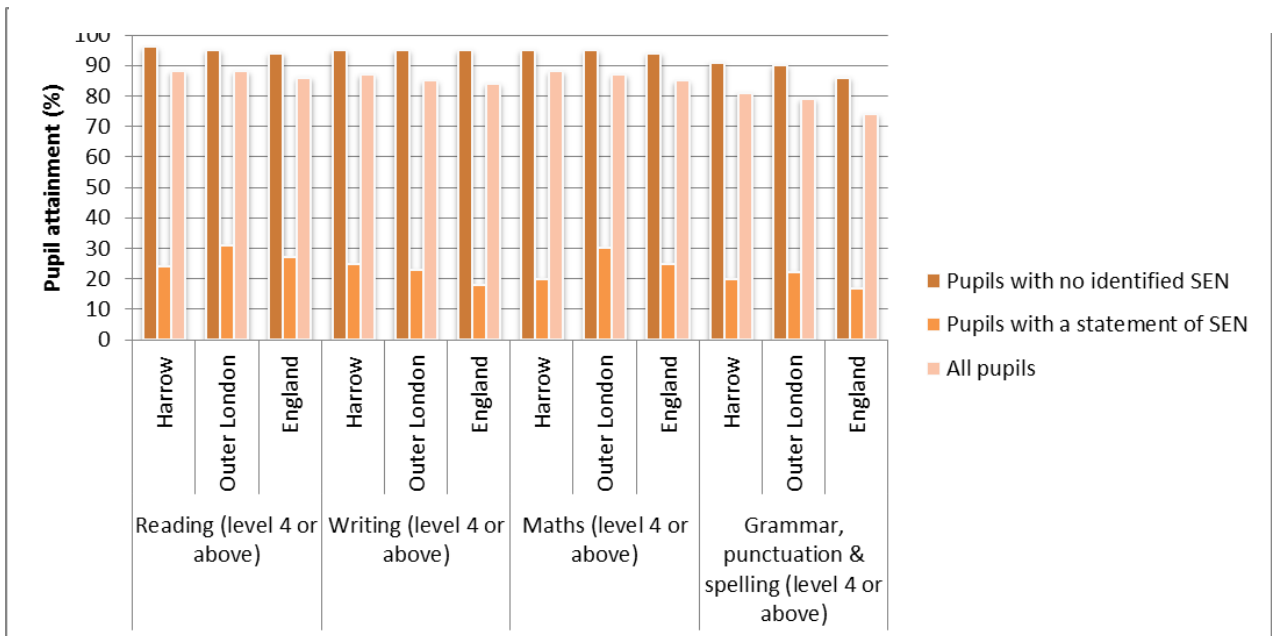
# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

**Figure 78 Achievements at level 2 or above in Key Stage 1 by SEN provision for all genders, 2013**



However this has not been translated at key stage 2 (end of year 6), where in 2013 pupils compared less favourably with national or regional peers in terms of their expected levels in reading, maths and grammar, punctuation & spelling.

**Figure 79 Achievements at level 4 or above in Key Stage 2 by SEN provision for all genders, 2013**

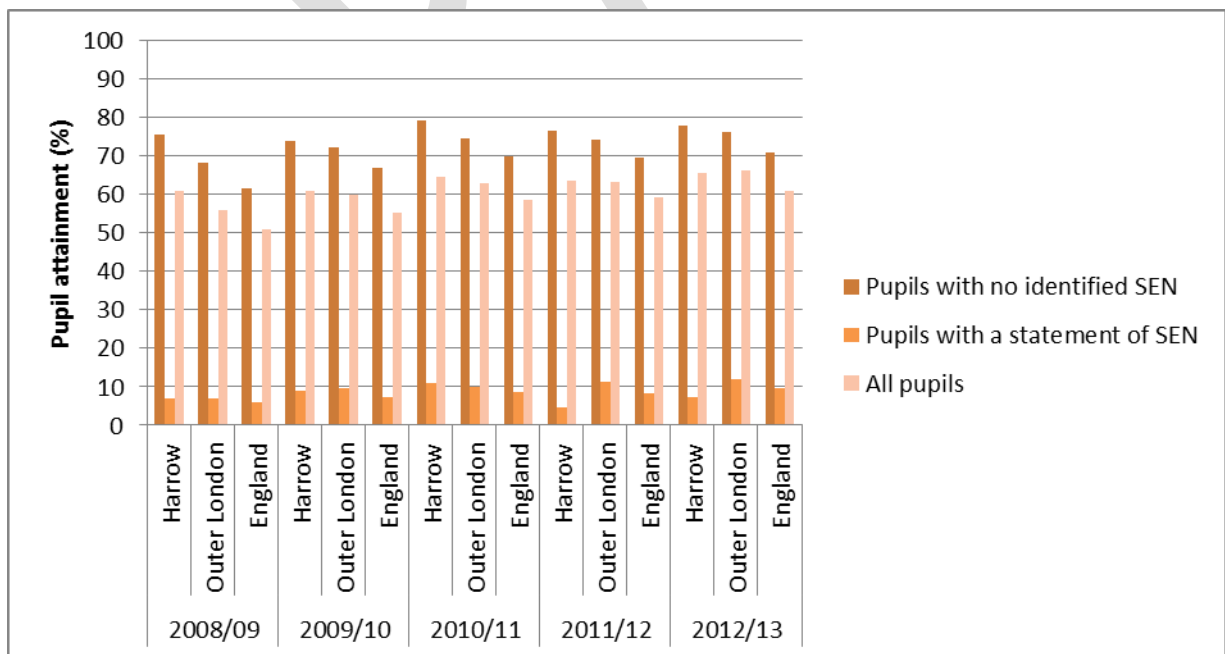


# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

At GCSE level among all pupils in Harrow, regardless of statement, more girls than boys achieve the benchmark of five or more GCSEs at grade A\* to C (including English and Maths). Between 2008/09 and 2012/13 the percentage of girls achieving five or more GCSEs at grade A\* to C including English and Maths increased by 6.8% while for boys during this time the increase was only 1.6%.

In the 2011/12 and 2012/13 academic year, pupils without an identified SEN consistently achieved the required standard of five or more GCSEs at grade A\* to C including English and Maths. The rate of achievement is greater than that of London and of England. However, stated children in Harrow have not performed as well as their peers in Outer London and England.

**Figure 80: Achievements at GCSE and equivalent by SEN provision for all genders,**



2008/09 – 2012/13



## Access to Adult learning

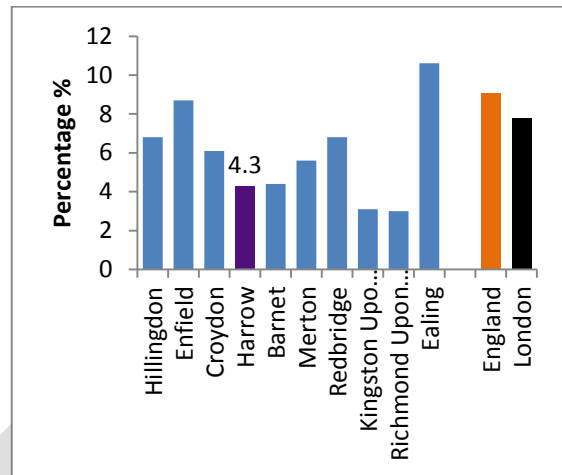
Adult learning can have indirect health benefits by improving social capital and connectedness, health behaviours, skills, and employment outcomes, each of which affect health.<sup>lvii</sup>

Lack of access to adult learning opportunities, or low skill levels in English, Maths, ICT or Language, can have a negative impact on the physical and mental health, chances of obtaining employment, educational attainments of children in the family and on community cohesion.

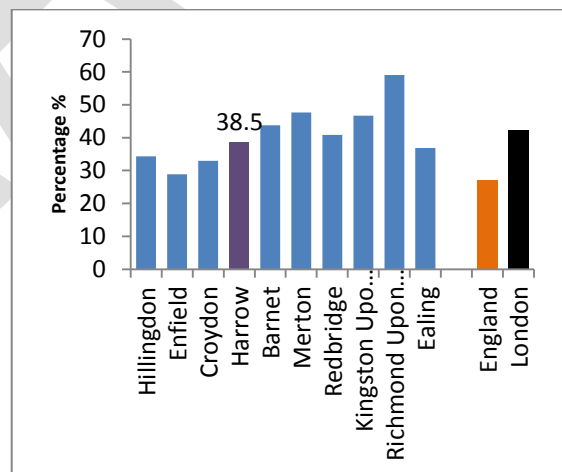
Conversely, research has indicated that participation in adult learning has a positive impact on self-rated health and wellbeing, on mental health, on improved confidence and ability to deal with stress, on delayed dependency, on family relationships and on community cohesion.

The possession of appropriate skills and qualifications directly influences people's employment options, and hence their income and economic security.

Figure 81 Proportion of working age people with no qualifications in Harrow compared to its statistical neighbours 2013<sup>lviii</sup>



Proportion of working age people with a degree or equivalent and above in Harrow compared to its statistical neighbours in 2013<sup>lix</sup>



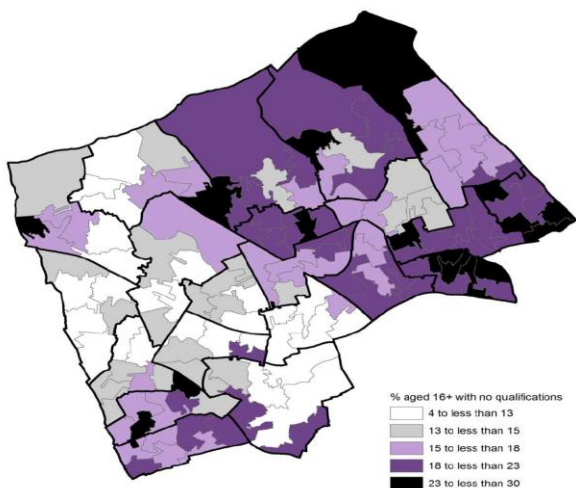
In general the working age people in Harrow with no qualifications is lower compared to its statistical neighbours, regional and national average, while the working age population with a degree, equivalent and above is higher compared to the national average, but lower for the regional average.

Demographic changes in the Harrow's population are likely to increase the need for learning in key areas. There has been a growth in numbers needing ESOL skills, including Somali, Afghan and Romanian families. The lack of language skills can create a barrier for employability and also means some parents have little contact with their children's schools and lack the skills to assist their children's progress.

The areas with the highest % of the population unable to speak English or speak English well are in the South east in Kenton East, Queensbury and Edgware wards, South Harrow in Roxeth ward, and Wealdstone and Marlborough wards.

Generally this co-incides with areas with the highest indices for multiple deprivation, and low levels of literacy and numeracy skills

Areas in Harrow with population with no



Qualifications 2011<sup>ix</sup>

## Employment

## Recreation

Recreational physical activity is important in order to reduce obesity, the risk of osteoporosis and cancer, colon and prostate in men and breast cancer in women.

Recreational activities are reported as being communal or solitary, active or passive, outdoors or indoors, healthy or harmful, and useful for society or detrimental, such as reading, playing or listening to music, watching movies or TV, gardening, sports, studies, and travel.

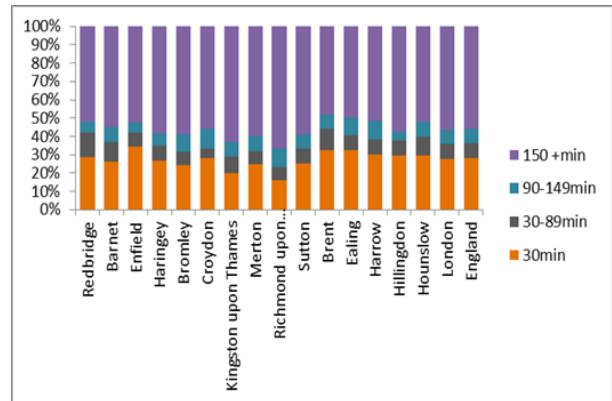
However, public spaces such as parks are essential venues for various recreational activities help to reduce diseases associated with less physical activity, promoting social cohesion, improving balance and stamina in older people, thus promoting independence and reducing social isolation.

There are indicators that are routinely monitored from the Public Health Outcomes Framework to monitor the use of recreational space/physical activity which include:-

- Childhood obesity and overweight at age 5-6 and 10-11
- Proportion of the population who are physically active and physically inactive
- Utilisation of outdoor space for exercise/health reasons

Current data reporting excess weight in 10-11 year olds shows that, during the period 2013/14, the rates in Harrow are similar compared to the regional, but higher than the national level. However, these rates have been steadily increasing since 2006

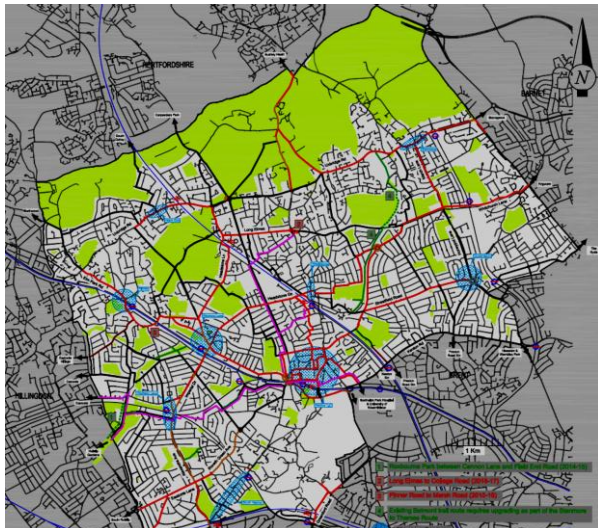
**Figure 82 Physically active and inactive people by Borough**



The percentage of physical active adults is lower compared to the regional and national average, while the percentage of the physically inactive is similar to the national average.

The Active people survey 2013/14<sup>ix</sup> is the largest survey of sport and active recreation undertaken in Europe. It identifies how participation varies from place to place and between different groups in the population. The Active People Survey 2013/14 reports that, Harrow had the highest proportion of those participating in sports and activity recreation at least 30 minutes per week and 90-149 minutes per week compared to the Regional and National average. However, Harrow results from this survey for 30-89 minutes were similar to the National and Regional average and lower for 150+ minutes compared to the Regional and National average.

The Harrow cycle-map



40.68 Km	On Road Cycle Routes
4.76 Km	Off Road Cycle Routes
8.47 Km	Greenway Cycle Routes
<b>PROPOSED INFRASTRUCTURE</b>	
8.71 Km	Proposed Greenway Cycle Routes (2014-15)
9.70 Km	Proposed On Road Cycle Routes (2015-17)
45.54 Km	Aspirational Cycle Links (Forward Plan)
10.45 Km	Proposed Quietways Route (subject to TfL approval)

Increasing rates of physical activity can be achieved by ensuring public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity. They should also be accessible by public transport. Public open spaces and public paths need to be maintained to a high standard. They should be safe, attractive and welcoming to everyone. Both neighborhood design and recreational environment variables have small but significant associations with multiple types of physical activity. Minutes of walking and of moderate-intensity activity is related to quality of pavements; accessibility of shopping and public transportation.

## Improving the environment – and local diets

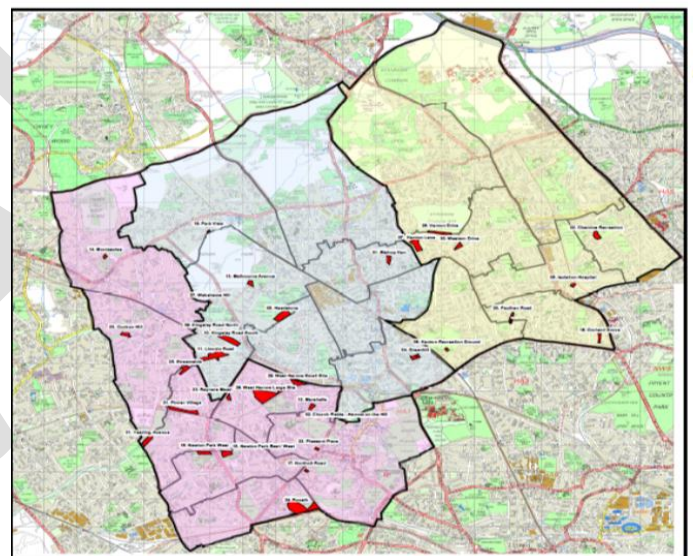
Local authorities have a need to set targets and priorities to address factors that are known to contribute to diet-related health inequalities such as better access to healthy and affordable food through

neighbourhood retail outlets, street markets, food co-operatives and food growing schemes.

Therefore, environmental or structural factors such as access to retailers selling healthy and affordable food, housing quality, availability of health-care services, employment, transport, opportunities to take part in physical activity should be made accessible to reduce inequalities in health.

## Food growing schemes

Food growing schemes are implemented in Figure 83 allotment sites in Harrow



- | WEST                                   | CENTRAL                 | EAST                         |
|--|-------------------------|------------------------------|
| 02. Church Fields - Harrow on the Hill | 01. Bishop Ken          | 06. Isolation Hospital       |
| 03. Cuckoo Hill - Cranbourne Drive     | 04. Greenhill           | 07. Kerton Lane              |
| 12. Marshalls                          | 05. Headstone           | 08. Kerton Recreation Ground |
| 14. Montesoles                         | 09. Kingsley Road North | 18. Orchard Grove            |
| 15. Newton Park East                   | 10. Kingsley Road South | 20. Paulhan Road             |
| 16. Newton Park West                   | 11. Lincoln Road        | 26. Vernon Drive             |
| 17. Northolt Road                      | 13. Melbourne Avenue    | 30. Western Drive            |
| 21. Pinner Village                     | 19. Park View           | 32. Chandos Recreation       |
| 22. Pleasant Place                     | 27. Wakehams Hill       |                              |
| 23. Rayners Mead                       |                         |                              |
| 24. Roweth                             |                         |                              |
| 25. Streamside                         |                         |                              |
| 28. West Harrow Large Site             |                         |                              |
| 29. West Harrow Small Site             |                         |                              |
| 31. Yeading Avenue                     |                         |                              |



Harrow to promote access to healthy food. The most recent annual free-to-enter gardening competition Harrow Estates in Bloom is held in Harrow, inviting all residents living on Harrow Council estates, homeowners and Housing Association tenants, to participate in the gardening competition. Other horticultural projects underway include the Harrow in LEAF; The

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

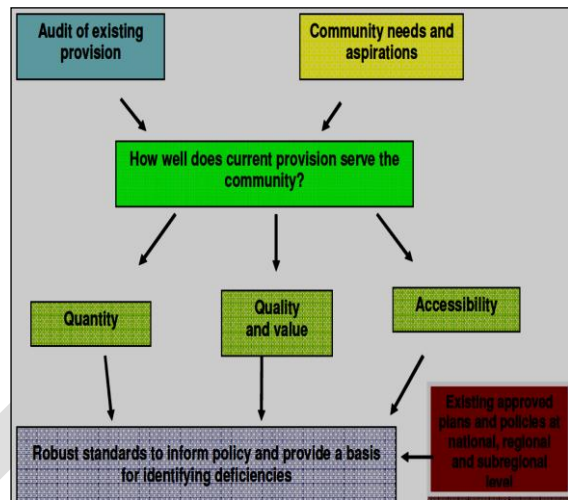
Shaw Trust Project and the Fruitables Project, which is at present running in 4 schools in Harrow. There are also 34 allotment sites in Harrow which are rented out to local residents.

A study examined Harrow’s open spaces and indoor sports facilities from two points of view: an expert audit against established criteria, and a comprehensive appraisal, through consultation, of public expectation of different types of open space. The study has been designed to be compliant with Government requirements, as set out in PPG17 and associated guidance. It has been guided by the Best Practice Guidance and Supplementary Planning Guidance, which supplement the London Plan, the Mayor of London’s strategic planning documents, which provide the policy framework within which individual Boroughs must set their local planning policies.



The PPG17 process is undertaken in Harrow to implement “playable” spaces that have good design, offer a range of leisure and recreational opportunities for people of all ages and enable to development of social networks and a

sense of community belonging.<sup>lxii</sup> This Supplementary Planning Guidance sets out clear standards.



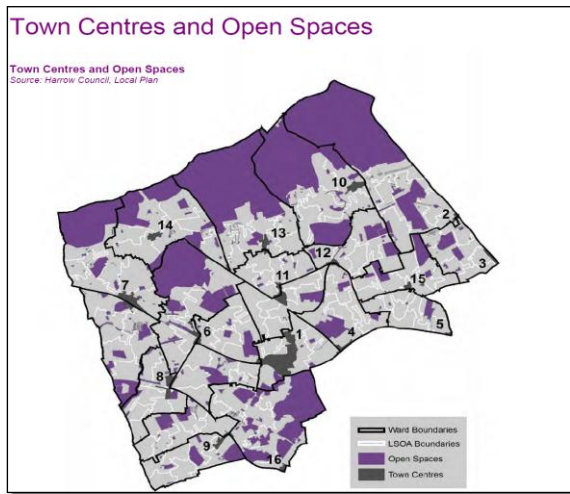
There are 37 allotment sites in Harrow, and over 1,350 plots; the waiting list for plots (not usually a precise indicator of demand) suggests a substantial latent demand for more provision.

There are no allotment sites at all in the north-eastern sub-area and demand is highest in the southeast.

Quality scores are mixed, and poorer quality sites are more commonly found in the south of the Borough and Headstone being the benchmarking site for quality that would address concerns raised in the consultation

Therefore, reducing fast food outlets and increasing access to healthy food outlets both in street markets and retail markets will help to improve the health of the people in Harrow, thus reducing obesity, cardiovascular diseases and cancers.

**Figure 84 Town centers and open spaces in Harrow**



**Metropolitan Centres:**  
1. Harrow Town Centre

**Major Centres:**  
2. Edgware

**District Centres:**  
3. Burnt Oak  
4. Kenton  
5. Kingsbury  
6. North Harrow  
7. Pinner  
8. Rayners Lane  
9. South Harrow

**District Centres (con)**  
10. Stanmore  
11. Wealdstone

**Local Centres:**  
12. Belmont  
13. Harrow Weald  
14. Hatch End  
15. Queensbury  
16. Sudbury Hill

## Built environment

### Access to health services

Harrow CCG has ambitious plans to transform the way care is provided in Harrow so that the patient receives the best possible treatment through high quality integrated care.

#### *Transforming primary care*

Harrow CCG are developing greater capacity in primary care services in Harrow through a range of measures including providing more bookable GP appointments; greater cooperation between practices through forming networks to provide additional services and support improved primary care; and commissioning additional services in primary care.

#### *Whole systems integrated care*

Harrow CCG successfully applied with Harrow Council, North West London CCGs, providers and other councils to become one of 14 Pioneer sites in England for whole system integrated care, which joins up health and social care. We will also receive funding through the Government's new better care fund to support specific services that are provided to patients using health and social care.

#### *Shaping a healthier future*

'Shaping a healthier future' is the major programme of improvements which the NHS is implementing across the eight boroughs in North West London (Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster).

The key principle that underpins the reconfiguration programme is the centralisation of most specialist services (such as A&E, maternity, paediatrics, emergency and non-elective care). Having highly skilled clinicians, supported by excellent facilities, will lead to better clinical outcomes and safer services for patients.

In order to achieve this, five of the existing nine hospitals in North West London will become major acute hospitals. These are The Hillingdon Hospital in Hillingdon, Northwick Park Hospital in Brent, St Mary's Hospital in Westminster, Chelsea and Westminster in Kensington and Chelsea and West Middlesex Hospital in Hounslow.

Three other hospitals will become local hospitals: Ealing Hospital in Ealing, Charing Cross Hospital and Hammersmith Hospital in Hammersmith and Fulham. Central Middlesex Hospital in Brent will become an elective hospital.

In 2014/15 the CCGs, working closely with these hospitals, began the implementation

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

of their reconfiguration plans. This includes the transition of A&E services from Hammersmith Hospital and Central Middlesex Hospital to alternative sites, and the opening of a new A&E department at Northwick Park Hospital.

Harrow CCG commissions services from a number of providers. The most significant provider is London Northwest Hospitals Trust who provide acute As there is no major acute hospital located in the borough of Harrow, patients are mainly referred to Northwick Park Hospital in Brent. Mental health services are provided by Central and North West London NHS Foundation Trust and community health services are provided

## GP surgeries

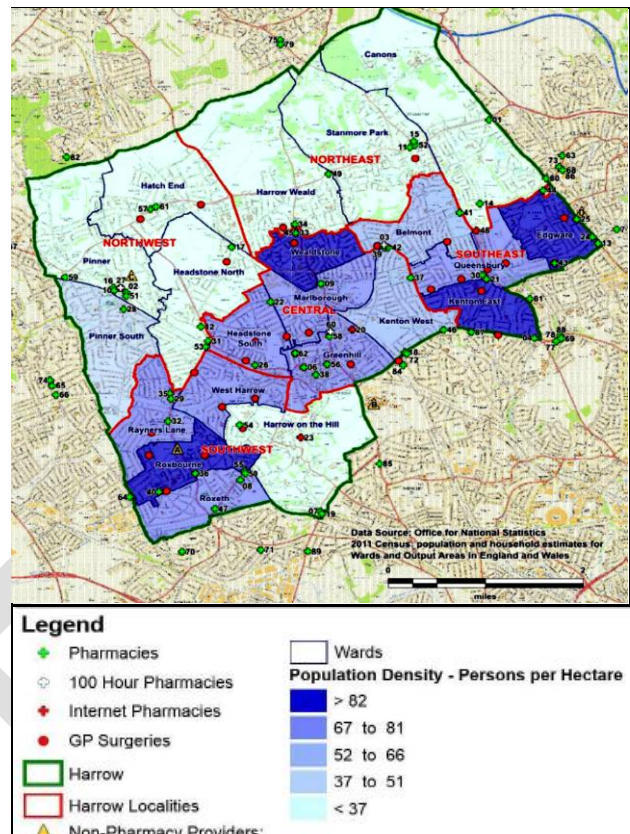
There are 34 GP surgeries across Harrow.

The majority of surgeries have a patient participation group which enables patients to get involved and help direct how the practice provides local health schemes and services.

(Needs GPMAP in here)

## Pharmacies

There are 62 community pharmacies in Harrow which provide pharmaceutical services under the Community Pharmacy Contractual Framework. While most pharmacies provide a standard 40 hour service contract, there are also three 100 hour pharmacies and three distance selling (Internet) Pharmacies which do not provide local services.



Pharmacies are well dispersed across the borough and the recent pharmaceutical needs assessment found that there was no need for further pharmacies over the next 3 years.

The PNA recognises that access could be improved for the working population through extended opening hours and weekend opening; and that by broadening the commissioning of services within available resources, access to advanced, enhanced, and locally commissioned services could be improved for the whole population.

The future aspirations are not mandatory will need to be balanced with available resources and be economically viable for pharmacists

## Housing

Housing has a significant role to play in health and quality of life, and contributes to a wide range of outcomes.

Lack of access to housing that is affordable and secure, with no immediate threat of homelessness or being forced to move can affect mental as well as physical health. Malnutrition, alcohol and substance abuse, depression and mental health diagnoses are all far more common in homeless people. Those living in temporary or emergency accommodation may not have cooking facilities and/or private bathrooms, and may be housed far from their support network

Poor quality housing where conditions include cold, damp, hazards or overcrowding can significantly affect health, particularly in children and the elderly, contributing to many health problems including respiratory illness, hypothermia, arthritis, cancer, heart attacks and strokes, as well as accidents in the home. Cold or overcrowded households, where it becomes difficult to do homework, can have significant negative effects on the educational development of children and their long-term opportunities for sustained employment. Harrow has the second largest average household size in England and at the 2011 Census almost 5,000 Harrow families were 'severely overcrowded' i.e. at least 2 bedrooms short of the national 'bedroom standard'

Lack of housing advice and support for vulnerable groups such as the elderly, those with learning or physical disabilities, drug or alcohol problems, those facing domestic violence, or with financial management issues can also affect health.

The associated stress and anxiety that often goes hand-in-hand with unsuitable housing can also lead to feelings of helplessness and increases the risk of depression and other mental health conditions. Therefore, effective housing and support services improve people's health, reducing the demand and

pressures on acute health and care services.

### *Housing affordability*

Health is strongly correlated with housing, and affordability is a major issue. Harrow is an expensive borough to live in with only about 4% of properties in Council Tax bands A and B. The economic downturn that began during 2008 has adversely affected the housing market. Mortgage availability has decreased and the deposit required in order to secure a mortgage has increased for both first-time buyers and those wanting to move home. The recession and government austerity measures have affected many of Harrow's residents, and not just those traditionally thought of as vulnerable.

The TGI Financial Stress Survey revealed that, just over 25% of all respondents and 35% of the largest group (younger, settled, extended families) find it 'difficult' or 'very difficult' to live on their household income. This may be reflected in overcrowding and a reduced ability to maintain properties to a 'decent' standard. Secured lending for home improvements has become more difficult since the credit crunch, particularly for those with insecure credit history.

### *Fuel Poverty*

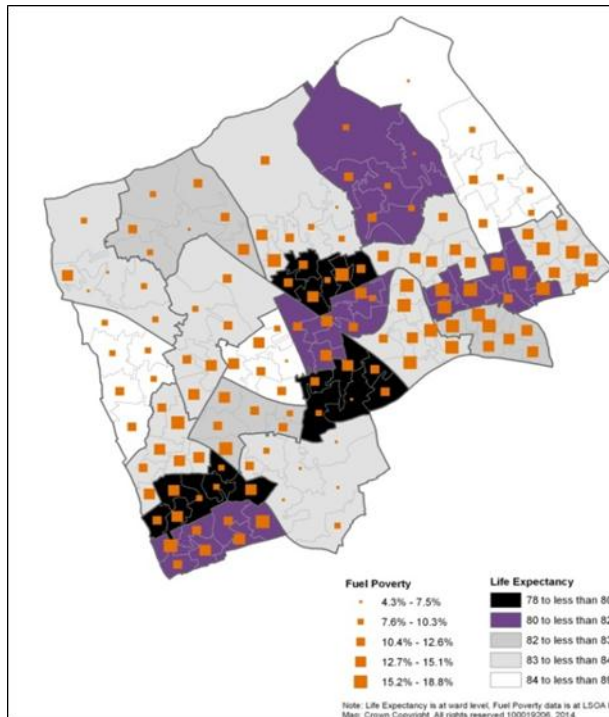
Fuel poverty has increased and Harrow is ranked the second-worst in London (at 11.7%) by the Department of Energy and Climate Change (DECC) based on an income/cost analysis. Harrow has a high proportion of family houses coupled with modest income levels. Indirect risks include carbon monoxide poisoning if boilers, cooking, or heating appliances are poorly maintained or poorly ventilated.

The map below shows the relationship between fuel poverty and life expectancy in Harrow. Lower life expectancy is lower in the Greenhill, Wealdstone, Roxbourne,



Roxeth and some areas of Rayners Lane Wards with higher rates of fuel poverty.

**Figure 85 Map showing the relationship between fuel poverty and life expectancy**



Local authorities have both legal powers and duties to deal with unsatisfactory housing conditions in the private sector. The Council's preferred approach is one of enabling higher standards rather than enforcement.

Welfare reform, a very limited supply of social housing and a buoyant private rented market add to the Council's pressures from homelessness leading to higher numbers in Bed & Breakfast, rising costs and enforced moves out of borough.

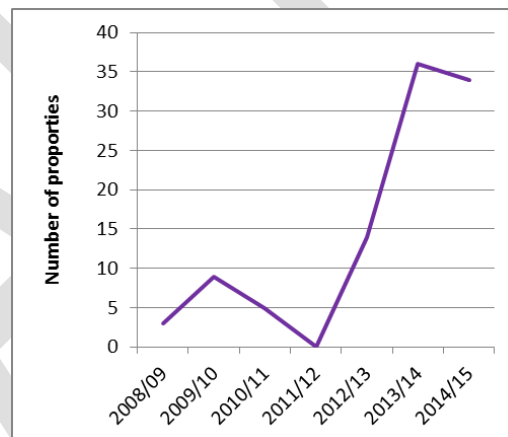
### **Social Housing**

Harrow has the lowest proportion of social housing of any of the London boroughs (10%), with just over 4,900 council properties, and a similar number of housing association properties at September 2014. Roxbourne Ward, which

contains the Rayners Lane Estate, has Harrow's highest proportion of social rented properties at one quarter of all households.

Availability of council stock for rehousing households in priority need continues to decline, as the increased 'Right to Buy' discount since 2012 means sales of family sized homes are far outstripping the ability to replace them. Social housing stock will be further reduced by the Conservative government's policy to introduce 'Right to Buy' for housing association tenants.

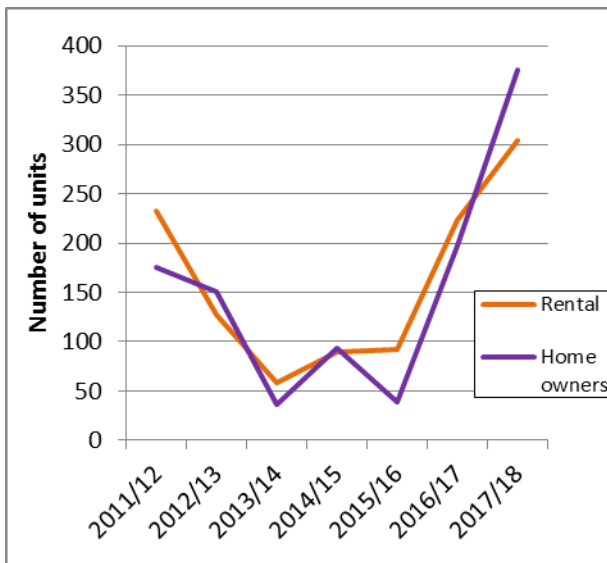
**Figure 86 Number of LA properties sold under 'Right to Buy'**



### **Housing Demand**

Housing demand has increased substantially as Harrow's population has increased from around 200,000 in 2000 to over 250,000 in 2014 and is projected to be around 270,000 by 2020. The number of households is also projected to rise by another 10% between now and 2020. Between 2009 and 2013 Harrow delivered 2,157 units, 40% of which were 'affordable' with 753 delivered in 2012/13, of which 278 were 'affordable'.

**Figure 87 Number of 'affordable' units built/planned**



The 'Homes for Harrow' initiative, a number of major planning applications now coming forward, the adoption of the Local Plan and the recent designation in the London Plan of the Harrow Town Centre Intensification Area as an Opportunity Area means that Harrow's house building will remain strong over the next five years and will go some way towards but not fully meet demand.

Issues affecting housing associations (HAs) include the Conservative government's policy to introduce 'Right to Buy' for HA tenants, which will reduce stock. Changes in the grant regime for development of new affordable housing in the GLA's 2012-15 funding programme, (particularly new build affordable rented housing), and the recent market conditions have led to a drop in affordable housing being delivered during this period. This is projected to improve from 2016 onwards when schemes now coming forward for planning in the improved market conditions will start to be delivered, albeit with potentially lower levels of 'affordable'

housing due to funding and financial constraints.

In 2015's rising market, HAs are encountering increased competition from other developers who may be able to offer higher purchase prices to secure sites, and build costs are increasing. The new affordable rent product requires rents for new social housing to be up to 80% of market rent, resulting in rents for larger family housing which are unaffordable to low income or non-working households. Reduction or limiting of rents for family-sized affordable housing in order to keep them affordable has a knock on effect on the finances of development schemes, meaning that it is now more difficult to deliver family-sized accommodation unless it is at the expense of overall affordable housing numbers. The Council continues to work with HAs and the GLA to maximise the provision of affordable housing on development sites.

### *Housing Benefit and Council Tax Benefit claims and the impact of welfare reforms*

Housing Benefit and Council Tax Benefit claimants have risen across London and England over the last few years, but trends in Harrow are steeper. Housing Benefit or Local Housing Allowance (LHA) has been reformed, and since 2012 it has been more restricted and less generous. Council Tax Benefit has been replaced by local schemes and reduced central funding, meaning recipients of this benefit now have to pay something or pay more towards their Council Tax.

Welfare reforms have impacted on private landlord behaviour, as some are refusing to renew tenancies for those on Housing Benefit in advance of the switch to a direct payment policy because they fear the risk of arrears.

Relocation to a more affordable area, perhaps many miles from Harrow (either through the social or private sector), can mean separation from existing support of family, friends and health and wellbeing services. Education may also be disrupted.

Relocation to a more affordable property within the same area might give rise to overcrowding, and may mean a less desirable property and/or location, with poorer quality housing and a less pleasant neighbourhood.

Around ¾ of all properties in Harrow were constructed before 1945. The 2008 Stock Condition Survey revealed many private sector properties within the borough were in poor condition and not meeting the government's Decent Homes Standard (DHS). Whilst local authority housing has undergone a major programme of improvement, private sector renovation grants (other than the [Disabled Facilities Grant](#)) have been discontinued.

### *New Challenges*

The introduction of the [Care Act 2014](#) has created several new duties since April 2015 that could impact on Housing's resources. Delivery or provision of care and support will need to be integrated with an assessment of the home, including general upkeep and scope for aids and adaptations as well as community equipment or other modifications that could reduce the risk to health and help maintain independence and/or support reablement or recovery. There is likely to be an increase in demand for assessments (e.g. from carers) which could add pressure to demand for housing and related services.

The Council is consulting residents on a programme of savings 2015-19 which will affect a number of services. There are no

further details available at the time of writing.

### **Transport**

Transport opportunities in the built environment can have a range of positive and negative effects on people, communities and places. Positive effects include opportunities for walking and cycling and access to employment, education, shops, social support networks, health services and the countryside. There are also negative effects such as pollution, traffic injuries, noise, stress and anxiety, danger, land loss and planning blight, and physical segregation of established communities.

Over-reliance on the car impacts on air quality and noise, and can promote weight gain. Children living in deprived communities are much more likely to be casualties of a road accident. Lack of affordable and appropriate transport is a barrier to employment, healthcare and social, cultural and sporting activities

### **Figure 88 Harrow Public Transport Accessibility Map**

Equality issues have been considered throughout the planning and implementation of our transport actions. The Council considers all projects that promote alternatives to the car to be to the benefit of increased social inclusion.

### **Public Transport**

In terms of transport infrastructure, Harrow is well served by public rail transport, with 4 underground lines, the Metropolitan, the Bakerloo, the Jubilee and the Piccadilly lines and over-ground railways connecting the borough with Clapham Junction, London Euston and London Marylebone stations to the south and Watford, Aylesbury and Birmingham to the north.

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

There is also a comprehensive network of bus services in the Borough, with around 37 bus routes including five night bus services. The central part of the Borough, particularly around the centres of Harrow and Wealdstone has the highest public transport accessible.

## *Improve transport connectivity to hospitals and other health facilities*

Harrow residents frequently raise their concerns about public transport links to Northwick Park Hospital. Bus route 182 southbound passes the hospital but does not drive into the hospital grounds. In addition, extending route 204 into the hospital would also be of significant local benefit.

In addition the borough is concerned with the poor public transport linkages to health care facilities in the borough including the link between Stanmore station and the Royal National Orthopaedic Hospital and the service provided to Alexander Avenue clinic. The Royal National Orthopaedic Hospital is served by a private bus from Stanmore station.

## *Improving transport access to green spaces and tourism spots*

There is poor transport connectivity within Harrow to some of the greener parts of the borough and to some of Harrow's tourist attractions such as Harrow on the Hill. These locations are important for tourism in the borough.

## *Improving accessibility*

The lack of step-free access at Harrow on the Hill station is a major accessibility problem for the town centre, the whole borough and also the wider community who wish to use the facilities of the town centre. Accessibility of Stanmore station lacks the facilities of what is required for a station to be fully accessible.

In Harrow, it is estimated that, by 2016, there will be 3,100 more people over the age of 65, including 500 more people aged 80-84 and 500 more people aged 85+ compared with 2008. There will also be an increasing number of older people living alone, living without their own transport and/or caring for someone whilst in poor health themselves. Harrow on the Hill station and Harrow and Wealdstone station hampers journeys that involve this modal interchange

## *Public transport safety*

Although bus route crime is very low, it is markedly higher on route 140 and route H12. How safe people feel about their local area has a significant impact on how much people will consider walking or cycling in their local area.

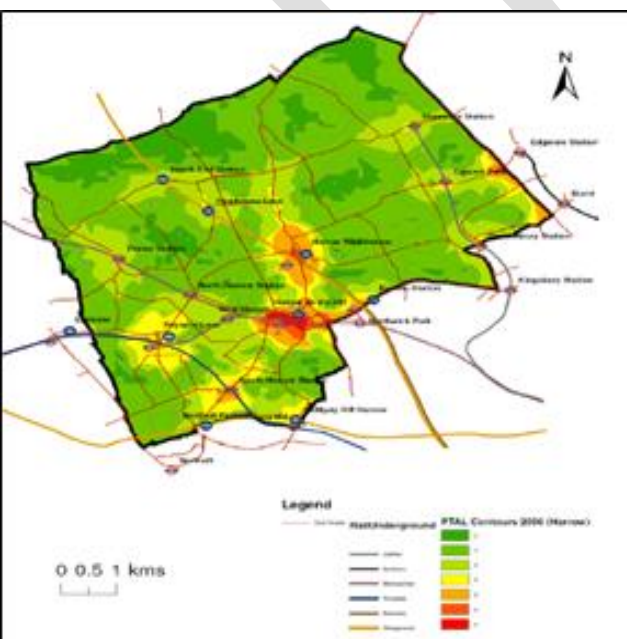
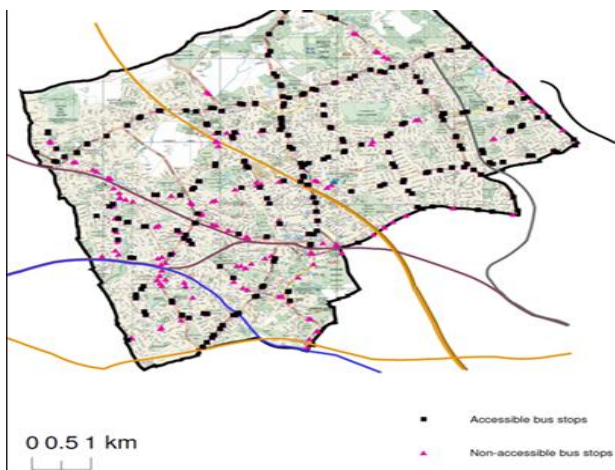


Figure 89 Bus stop accessibility in Harrow.

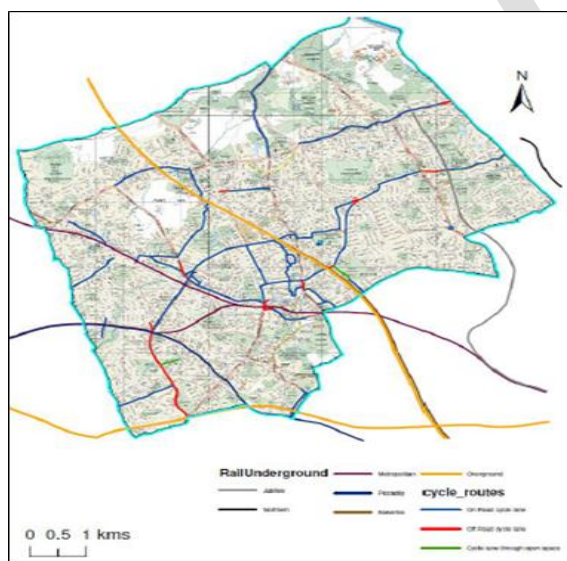


### Cycle Lanes

There are 41 km of cycle lanes in the borough. These have been introduced to link key trip generators and places of interest such as stations, shopping areas, schools, open spaces etc

The lack of appropriate cycle parking near Harrow on the Hill station and Harrow and Wealdstone station hampers journeys that involve this modal interchange

Figure 90 Harrow cycle routes



### Car Ownership

Car ownership in Harrow is high and certainly increased because of the

## NEEDS ASSESSMENT 2015-20

geographical location of the borough on the outskirts of London. Based on the 2001 Census, 23% of all households have no car or van and 33% have 2 or more cars or vans. The percentage of households with no car or van is not only lower than all London Boroughs bar Hillingdon, but is in fact lower than all of England and Wales where 27% have no car or van. (The number of households with no car or van in all of London is 37%).

Harrow is also the Borough with the second highest percentage of households owning two or more cars. As a result of this, encouraging drivers to change their mode of transport to a more sustainable form of transport is extremely challenging.

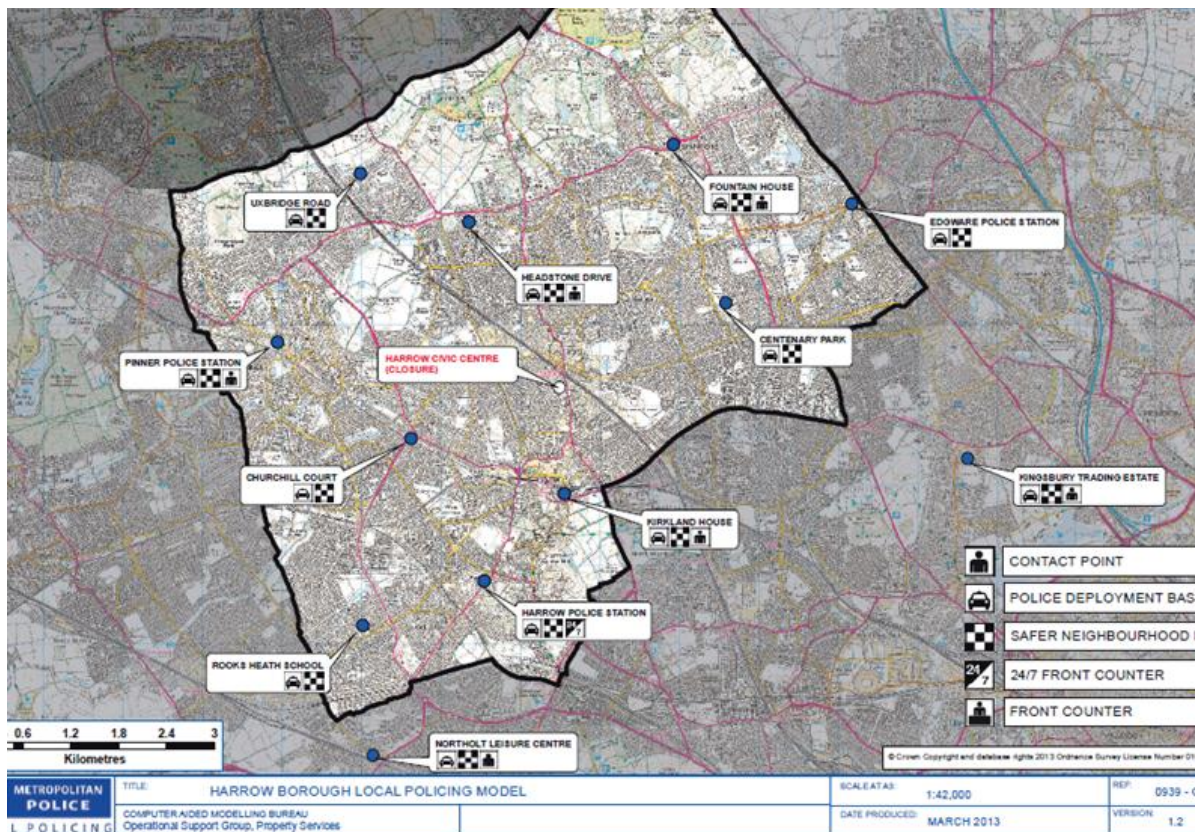
### Improving the journey experience

Engineering works interrupting services, traffic congestion, poorly maintained roads and pavements, low frequency public transport services particularly at night, overcrowded buses or trains, lack of convenient cycle parking, unexpected local parking charges particularly at the borough boundaries and rushes of school children interchanging on buses across the network at the end of the school day all impact on the quality of the journey experience and are all issues that do occur in the borough.

### Community Policing

Four types of community policing points are found in Harrow:

- Conventional police station Front Counters which offer all policing services with secure and private facilities;



- Contact Points which are locations for non-urgent face-to-face contact, where the public can meet their local police at regular known times;
- Deployment bases for the borough's Safer Neighbourhood Teams, Borough Tasking Teams and / or Emergency Response and Patrol officers and PCSOs start and end their tours of duty and
- Other bases where the borough's Safer Neighbourhood Teams work. These will only be occupied when officers and PCSOs are not out on patrol and are not public access points.

A consultation found that the existing Harrow Police Station will not meet longer term policing needs and alternative facilities will be required nearby to meet future policing requirements including Front Counter facilities with appropriate public access. Harrow Police Station will be retained until alternative facilities are operational to provide Front Counter and deployment facilities. It also identified the need to provide 24/7 Front Counter

facilities separate to the core custody facilities. The 24/7 Front Counter facilities will be provided at Harrow Police Station supported by four Contact Point facilities across the borough

### Food Safety

Poor food safety places a significant burden on the UK economy in addition to personal suffering in terms of morbidity, mortality and economic loss. Poor food safety practices greatly increase the risk of contaminating food, resulting in a risk of food poisoning.

While the number of premises hitting 0, 1 and 2 seems static, this does not show the work taking place with them by Inspectors to put in place sustainable change. Until this change has been demonstrated, Officers will maintain the premises at a low level to ensure sufficient scrutiny.

There are approximately 1500 food premises in Harrow, including a mix of commercial and domestic locations. This tends to remain static, but with a 15-20% turnover annually. Since 2007, all food

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

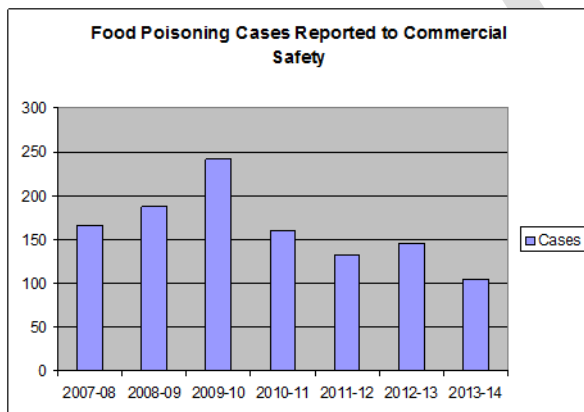
premises that serve direct to the final consumer have their ratings displayed publicly.

**Figure 92 Number of Food Establishments and Ratings**

Number of establishments in each rating											
FHRS Rating	Mar - 14	Apr - 14	May - 14	Jun - 14	Jul - 14	Aug - 14	Sep - 14	Oct - 14	Nov - 14		
5 - Very good	289	288	291	291	291	285	284	284	284		
4 - Good	203	204	207	207	207	214	212	212	212		
3 - Generally satisfactory	329	333	325	325	325	309	308	308	308		
2 - Improvement required	103	102	104	104	104	113	116	116	116		
1 - Major improvement required	94	100	102	102	102	95	94	94	94		
0 - Urgent improvement required	2	2	2	2	2	3	2	2	2		
Total rated establishments	1020	1029	1031	1031	1031	1019	1016	1016	1016		
Establishments with rating of 3 or better	821	825	823	823	823	808	804	804	804		
Awaiting inspection	164	181	205	205	205	232	234	234	234		
Exempt	37	45	46	46	46	55	56	56	56		
Sensitive	1	1	1	1	1	1	1	1	1		
Excluded	118	118	118	118	118	119	120	120	120		
Total establishments	1340	1374	1401	1401	1401	1426	1427	1427	1427		

Source: Harrow Council

**Figure 93 Food poisoning cases related to Commercial Safety**



Source: Harrow Council

Harrow has few outbreaks associated with food. There have been two in the last 5 years, one associated with a domestic caterer and one with a commercial caterer. Individual cases of food poisoning, normally associated with travel or home cooking, is the norm in Harrow leading to advice and guidance being given to the individuals and their associates.

Food poisonings reported to the Commercial Safety Team over the last 7

years show a decline in food poisoning cases since 2009-10

## The Challenge of diversity

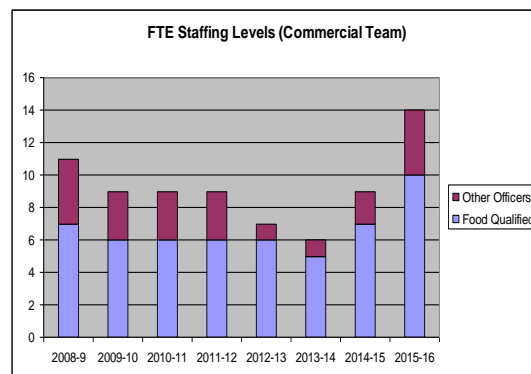
Harrow is one of the most diverse populations nationally and this, more than a transient population, has the greatest impact on food hygiene. This has led to a full range of different food premise types and food processes, with Kosher, Halal and other methods distinct in the borough. Along with this comes a culture and language challenge, getting across the requirements of EU legislation and the complexities associated including setting up a proper food hygiene management system.

Harrow is in a strong position due to the quality of officers, as well as the diversity of training they are able to offer, including in a number of languages, which assists in the understanding of their local population.

## Challenges and key issues

The Commercial Safety Team, responsible for food safety and standards inspections of food premises, has undergone a lot of change in the last few years, especially with low staffing figures, resulting in a backlog of inspections including new premises.

**Figure 94 Staffing and training levels in Environmental Health**



Source: Harrow Council

As can be seen above, a more sustainable approach is also being introduced, with a projection of increased staffing levels across the Commercial Team. A service plan is being prepared to reflect these changes, and the approach to be taken going forward, and this will seek to be approved by Cabinet at the start of the next financial year and then published for public access.

## Fly tipping

Fly-tipping is the illegal deposit of waste on land contrary to the Environmental Protection Act 1990<sup>lxiii</sup> Fly-tipping is a significant blight on local environments; a source of pollution, a potential danger to public health; a hazard to wild life and a nuisance. It also undermines legitimate waste businesses where unscrupulous operators undercut those operating within the law. Local authorities and the Environmental Agency both have the responsibility in respect of illegally deposited waste.

Local authorities have a duty to clear fly-tipping from public land, investigating these and carrying out a range of enforcement actions. The Environment Agency investigates and enforces against the larger, more serious and organised illegal waste crimes. Both Local Authorities and the Environment Agency are required to collect data on their activities and report these to the Fly Capture Database.

It is estimated that fly-tipping costs the public sector over £36 million a year and private landowners £50-150 million or more a year in clean up and disposal costs alone.

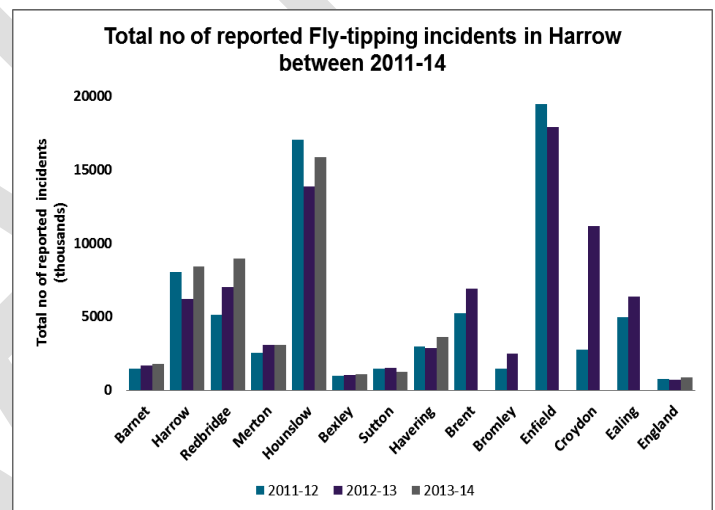
### Key issues and challenges

Harrow had the third highest total number of reported fly-tipping incidents in 2011 and

second highest in 2014 compared to its statistical neighbours.

Whilst the number of national fly-tipping incidents on highway land (public highways or roads) continued to fall, in Harrow, the highest proportion of reported incidents (91%) occurred on this type of land during 2012-13.

In 2011-12, 59% of waste type in Harrow was reported to be primary waste and in 2012-13, 42% waste from black bags



(house-hold waste).

Source: Department of Environment, Food and Rural Affairs (2014).

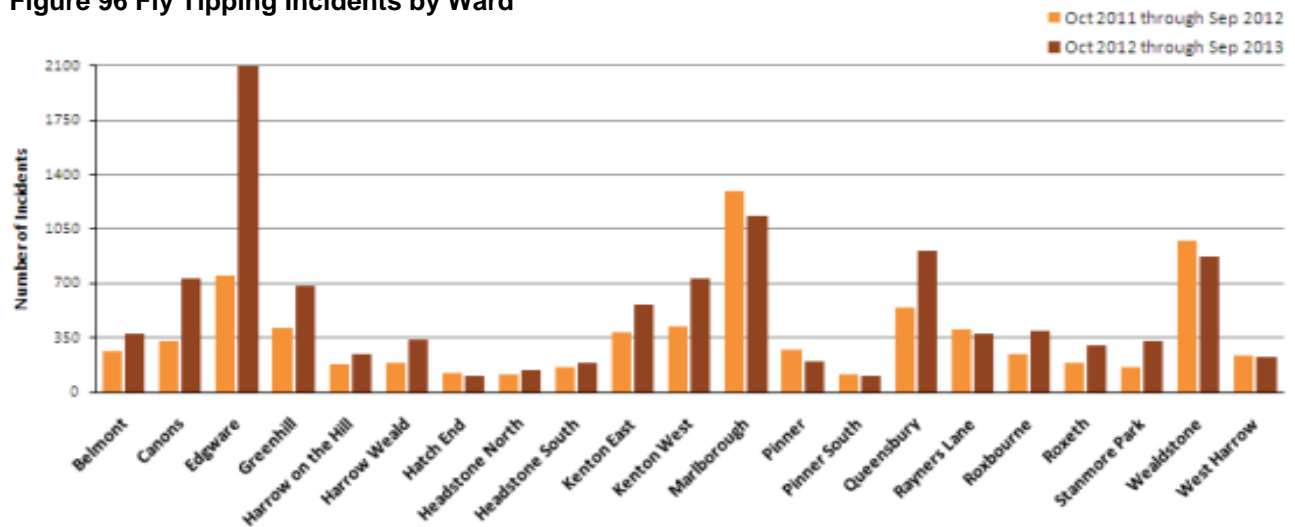
During the period of 2011-14, **14 out of 21 wards** in Harrow have shown an increase in fly tipping over the periods except for Pinner (-26.3%), Marlborough (-12.6%) and Pinner South (-12.2%) which showed the largest percent decrease in incidents

## Waste management

Local authorities have statutory duties to collect and dispose of waste. How they fulfil these duties is important for local people and the wider environment.



Figure 96 Fly Tipping Incidents by Ward



Decisions on how to manage household waste by LA, impact on expenditure of the local authorities concerned. Those decisions also influence the type and quality of service people receive, and how people and the environment are protected from pollution from waste in the future<sup>lxiv</sup>

The Harrow Council provides a weekly combined garden / food waste collection service and alternating weekly collections of dry recyclables and residual waste from over 72,000 domestic properties in the borough. Bins are often marked with the following signs highlighting that fly-tipping is an offence. The following services are available to prevent fly-tipping:-

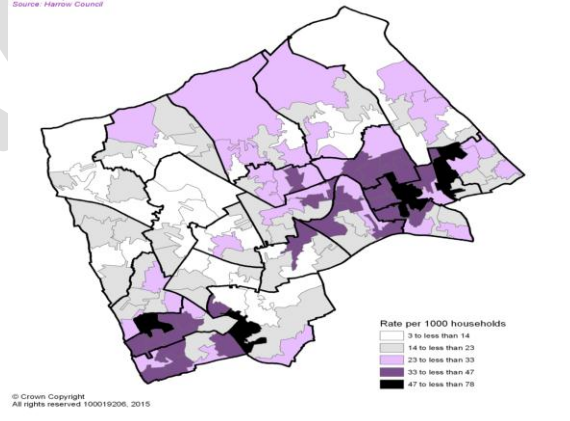
- What goes in which bin leaflet
- 'Wheelie' useful guide
- Flats: blue and grey bins
- Recycling banks
- Ordering a new bin or bin repair
- The rubbish tip: household waste
- Residents are encouraged to report fly-tipping.
- Bulky or heavy collections
- Hazardous waste collection
- Literature disseminated at public events and through the Community Champions, promotion of CA site on

regular basis and campaigns with West London Waste Authority which promote waste minimisation.

## Pest control

Pest control refers to the regulation or management of a species defined as a pest, usually because it is perceived to be detrimental to a person's health, the

Pest Complaints 2014 - 2015  
Source: Harrow Council



ecology or the economy.

Many pests carry an associated health risk, and those that spread diseases are termed 'Public Health' pests. Rats for example carry a number of diseases including the potentially fatal Weils disease (Leptospirosis), and common houseflies carry a number of pathogens

Harrow Council provides a highly professional and competitively priced pest control service providing a range of treatments to residents, businesses and others both with concessions

There were 1,986 pest related enquiries or requests for service in Harrow in 2014/15, an 8.05% increase on 2013/14. The majority of pest related enquiries are from households reporting infestations in their own homes, with many saying that the primary source was due to reasons beyond their control, including commercial waste and damaged sewerage systems.

### Figure 97 Pest Complaints 2014-15

Roxbourne had the highest number of pest call-outs (146), around 7% of the total for Harrow. Areas from central to east and in the south of the borough tend to have higher numbers of requests for treatment. Edgware, Kenton East, Roxeth and Stanmore Park have had the largest drop in the number of call-outs since 2013/14.

The 2011/12 season was notable for the number of wasp nests, 1,085 cases. These tend to come in cycles depending on patterns of weather from one year to another

## Noise pollution

Excessive noise seriously harms human health and interferes with people's daily activities at school, at work, at home and during leisure time. It can disturb sleep, cause cardiovascular and psycho physiological effects, reduce performance and provoke annoyance responses and changes in social behaviour

Types of noise complaint include loud music, house or car alarms, fireworks (seasonal), noise from construction sites, machinery, and general domestic sources

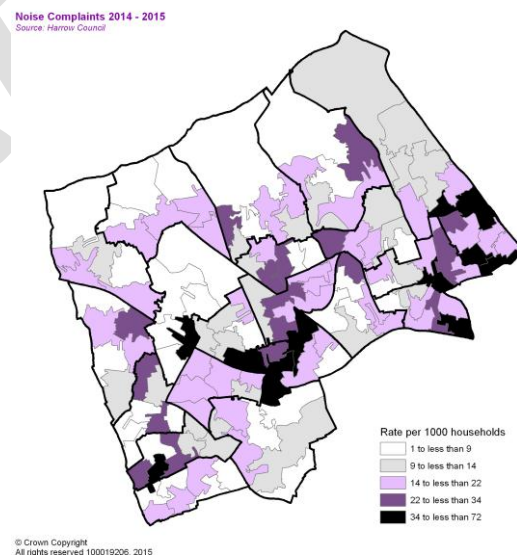
such as music and DIY. Out of hours complaints were mainly about parties, pubs, clubs and alarms

In 2014/15 there were 1700 noise complaints in Harrow, a decrease of 13.76% compared to 2013/14. Most noise complaints were made in the central and eastern parts of the borough. Edgware and Greenhill had 141 and 137 complaints respectively - around 8% of all complaints in each ward. Kenton West had the fewest noise complaints with 43 complaints.

There was a significant decrease in noise complaints in the Roxeth (52%) and Stanmore Park (46%) wards since last year.

Edgware ward had the most registered noise complaints in 2014/15 with Greenhill the second highest with.

### Figure 98 Noise Complaints



## Natural environment

### Air quality

Air pollution refers to the introduction of particulates, biological molecules or other harmful materials into the earth's atmosphere that may cause disease, death to humans, and damage to other living organisms such as food crops or the natural or built environment.

Air quality is critical for health and well being with many vulnerable people, including children, older people and those with existing heart and lung conditions being restricted in the activities they can undertake due to poor air quality. see the most up to date information on [London dedicated air quality website](#)

Fine particles in the air can be carried deep into the lungs, where they can cause inflammation and worsen existing conditions, such as heart and lung diseases. In addition, they may carry surface-absorbed carcinogenic compounds into the lungs. Both short-term and long-term exposure to ambient levels of particulate matter (PM) is consistently associated with ill-health

Nitrogen dioxide (NO<sub>2</sub>) at high concentrations NO<sub>2</sub> causes inflammation of the airways and long-term exposure can affect lung function and respiratory symptoms. It can also increase asthma symptoms. The health impacts of NO<sub>2</sub> are less well understood than those of PM<sub>10</sub> as less research has been undertaken in this area<sup>lxv</sup>

In the UK, the main pollutants which are of particular concern due to the public health issues associated with them are:

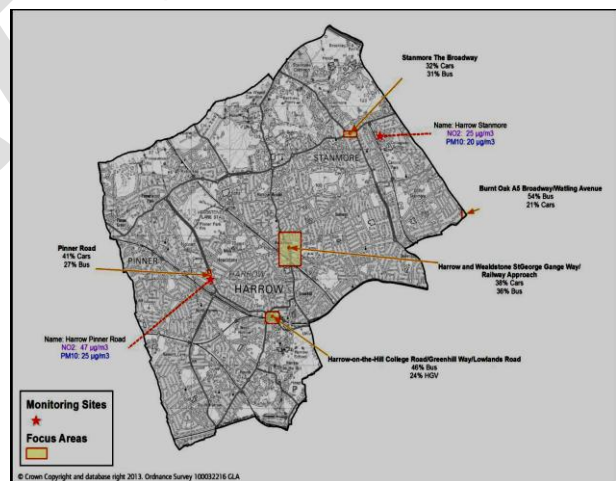
- Particulate matter (PM<sub>2.5</sub>, PM<sub>10</sub>)
- Oxides of nitrogen (NO<sub>x</sub>)

- Ground level ozone (O<sub>3</sub>)

Air quality is monitored at two automatic monitoring sites in the borough. These sites are affiliated to the national Automatic Urban and Rural Network (AURN) managed by DEFRA. The data from these 2 sites is used by DEFRA to report annually on the UK's air quality to the EU. In addition there are 14 diffusion tube locations across the borough, monitoring for NO<sub>2</sub>.

There are two continuous monitoring stations within the London Borough of Harrow. One of continuous monitoring sites is an urban background site located at Stanmore (Harrow 1) in the north east of the borough. The second continuous monitoring station is a roadside site located at North Harrow (Harrow 2) in the west of the borough.

**Figure 99 LB Harrow Focus Areas and Air Quality Monitors, London Atmospheric Emissions Inventory**



### Emissions Inventory

The Air Quality Objectives for NO<sub>2</sub> and Particles (PM<sub>10</sub>) require the levels not to exceed the annual mean of 40µg/m<sup>3</sup><sup>lxvi</sup>

The results below show that there has been very little change of the last few years

in station 1 with Station 2 exceeding the target since 2007.

**Figure 100 Annual Mean Concentration mg/m<sup>3</sup>**

Site ID	2007	2008	2009	2010	2011	2012
Station 1	27.2	25.1	25.7	27.1	25.1	25
Station 2	44.3	40.3	43.8	48.2	43.4	47

### *Transport accessibility as a measure to reduce air pollution*

An efficient transport network has positive effects on health by enabling access to recreational amenities, social networks, health services, education and employment.<sup>lxviii</sup> However, car ownership in Harrow is reported to high.(see car ownership in Harrow), which in particular, can have a negative impact on health by contributing to air pollution, causing road traffic injuries, reducing physical activity levels, increasing noise pollution, contributing to community severance and increasing levels of stress and anxiety.

A safe highway network which increases the attractiveness for more vulnerable highway users (e.g. pedestrians) have considerable benefits for air quality and physical and mental health.

### *Climate Change*

Ozone, which is caused by pollutants such as NOx and volatile organic compounds (VOCs) reacting in sunlight are powerful greenhouse gases which contribute to global warming directly. Also black carbon (which is part of the particulate emissions from diesel engines) contributes to climate change

## Water

Safe clean drinking water is fundamental to our daily lives. A failure of the quality or quantity of water risks causing outbreaks of infectious disease and can seriously affect

commercial activities and everyday living.

A risk based approach to regulating the supply of safe clean drinking water has been developed and the [EU Drinking Water Directive](#)

recommendations continue to be considered in Harrow on properties that have their own PWS e.g. borehole or well. This policy ensures that water intended for human consumption is consumed safely on a life-long basis, which represents a high level of health protection. The main pillars of the policy are to:

- Ensure that drinking water quality is controlled through standards based on the latest scientific evidence;
- Secure an efficient and effective monitoring, assessment and enforcement of drinking water quality;
- Provide the consumers with adequate, timely and appropriately information;
- Contribute to the broader EU water and health policy

The main drinking water supply in Harrow is [Affinity Water](#). There are no Private Water Supplies (PWS) in the Borough of Harrow as defined by the EU Directives. There are only two PWS in Harrow. One is situated at Harrow School, utilised for the irrigation of sporting pitches and sanitary use in one of the school's new housing blocks, and the other at the Kodak factory site which is also not for human consumption.

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Local authorities had until December 2014 to identify and risk assess all relevant private supplies in their areas. This is to determine whether a supply poses a potential danger to human health, to take action to safeguard public health in the short term and to improve supply in the long term. No risk assessments have been carried out in Harrow as no PWS are available for human consumption.

## **Swimming Pool Water Quality:**

All swimming pools that are open to the public should undertake monthly water quality sampling to check that the treatment systems that they have in place are operating correctly.

The responsibility for the upkeep and maintenance including sampling of the pools, rests with the owners/operators and their responsibilities under Health and Safety legislation. Pools would be dealt with as part of any Health and Safety inspection for example that may be carried out, but only in regard to ensuring that they are being maintained in a way that protects the health safety and welfare of the user, operator etc. and that they are carrying out their responsibilities in this regard.

The Harrow council investigates complaints about swimming pools and outbreaks that are thought to be related to a given pool in conjunction with Public Health England and the Health and Safety Executive.

## **Bio-diversity**

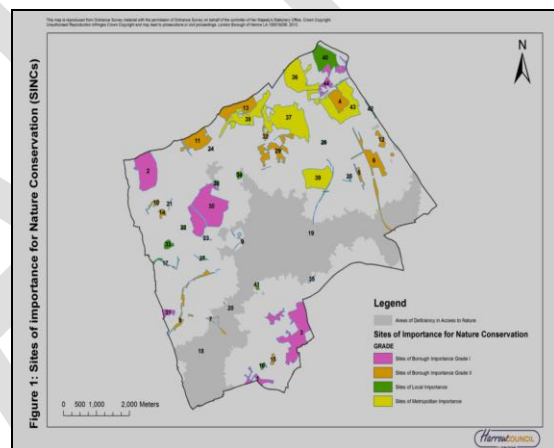
Biodiversity plays a vital role in providing clean air, reducing the effect of the 'urban heat island' (hot temperatures in summer) and helping to control water run-off, thus reducing flooding

Harrow is fortunate to be one of greenest boroughs in Greater London, which consists of more than 500 hectares of

greenspaces and a range of habitats and sites many of which are important ecological resources. Within the borough there are:

- 79 formal open spaces which include parks, gardens, allotments and burial grounds.
- 28 Parks and gardens 195.2 ha
- 28 Natural and semi-natural greenspace 225.8 ha
- 18 Green corridors 15.0 ha
- 37 Allotments 36.1 ha
- 14 Churchyards & cemeteries 43.5 ha

**Figure 101 Site of Importance for nature conservation**



Our greenspaces include areas of regionally and nationally important habitats such as species-rich grassland and ancient woodland. Some Green Belt agricultural land to the north of the borough is fringed with hedges and ditches which have changed little since medieval times. Our borough is home to an array of wildlife including some less common animal and plant species like the stag beetle, southern wood-ant, heath spotted-orchid and coralroot.



Coralroot *Cardamine bulbifera*, Stanmore Common – photo: Denis Vickers

Many of our more biodiverse areas are in the Green Belt to the north of the borough but there are also wildlife-rich sites within more built-up areas of Harrow. The [Biodiversity Action Plan](#) about more than protecting wildlife in the borough. Providing a network of quality biodiverse greenspaces contributes to our own health, wellbeing and economic prosperity as well as ensuring that we are well placed to adapt in the face of climate change. Our quality of life is also improved as greenspaces offer us opportunities for recreation, education and contemplation.

The Council is a major landowner in Harrow and has a role in community leadership. It has a responsibility to conserve, protect and enhance our natural habitats and leave a lasting legacy for future generations. The Biodiversity Action Plan highlights our commitment to the conservation of biodiversity. Going forward it points the way and facilitates actions that we will integrate into our programmes, policies, plans and strategies

Harrow Council believes that the conservation and enhancement of the natural environment and biodiversity is important for a number of reasons:

- For health and wellbeing

- To meet legal commitments under the Natural Environment and Rural Communities Act 2006.
- Helps to regulate the local environment
- Helps to impart a sense of place and community pride
- To provide an education and engagement resource

The Biodiversity Action Plan (BAP) covers 5 themes:

- The Natural Environment and Ecosystems Services
- Green Belt Woodland and the Urban Forest
- The Built Environment
- Climate Change and Sustainability
- Engaging with Nature

### *Key issues and challenges*

In Harrow the main challenges of maintaining diversity in are:-

- Maintaining greenspaces in the face of ever increasing pressure to develop them for housing.
- As the population increases, there is increased use of greenspaces. They can become victims of the own success as sensitive wildlife can be displaced.
- Mistreatment of greenspaces is a problem e.g. people running dog-walking businesses where on occasions they have had up to 12 dogs some not on leads. These chase wildlife and if the mess is not cleared up, it poisons the soil and encourages undesirable plant species to grow.
- As a borough (and in the general economic climate) we lack sufficient funds to manage all our greenspaces in an optimum way.
- Lack of education and apathy of some people is a problem as they might not realise what they are doing is not wildlife friendly.

# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

## Summing up

The evidence we have presented in the preceding chapters has highlighted the needs for health and wellbeing in Harrow. Addressing the inequalities in health and wellbeing outcomes and in the factors that affect health and wellbeing requires a

strong focus on prevention, on reducing duplication and supporting integration of services to benefit local people; .

## Action on Inequalities

The [public health outcome framework](#) shows that the majority of Harrow indicators are either better or similar to the national level; however, there are a few indicators where Harrow performs worse

Figure 102 Inequalities in health across Harrow

Indicator	Unit	Best ward	Worse ward
Life expectancy (females)	Years	Pinner South (91.2)	Wealdstone (81.7)
Life Expectancy (males)	Years	Headstone North (86)	Wealdstone (77.8)
Stroke mortality	SMR	Pinner South (41.6)	Wealdstone (127.9)
Emergency hospital admissions for stroke	SAR	Pinner (69.0)	Harrow-on-the-Hill (130.8)
Breast cancer incidence	SMR	Edgware (69.8)	Greenhill (137.5)
Colorectal cancer incidence	SMR	Queensbury (44.7)	Wealdstone (100.8)
Lung cancer incidence	SMR	Headstone South (45.6)	Wealdstone (92.7)
Prostate cancer incidence	SMR	Headstone South (72.9)	Pinner (128.6)
All cancers Incidence	SMR	Queensbury (72.2)	Pinner (93)
COPD hospital admissions	SAR	Rayners Lane (41.5)	Kenton East (101.4)
Fertility rate (per 1,000 females aged 15-44)	CFR	Edgware (78.7)	Headstone North (54.2)
Low birth weight babies(less than 2500 g)	Proportion (%)	Hatch End (7.6%)	Kenton West (12.3%)
Smoking in adults (estimated prevalence, 18 years +)	Proportion (%)	Pinner South (12.0%)	Kenton East and Wealdstone (13.5%)
Modelled prevalence of regular smoking in children age 11-15 years	Proportion (%)	Kenton West (0.5%)	Belmont (5.1%)
Modelled prevalence of regular smoking in children age 15 years	Proportion (%)	Kenton West (1.9%)	Belmont (12.8%)
Modelled prevalence of regular smoking in young people aged 16-17 years	Proportion (%)	Kenton West (3.5%)	Belmont (22.6%)
Obesity in adults (modelled estimates)	Proportion (%)	Pinner South (16.4%)	Roxbourne (22.5%)
Obesity in reception year children (prevalence)	Proportion (%)	Rayners Lane (3.9%)	Kenton East (12.4%)
Obesity in year six children (prevalence)	Proportion (%)	Stanmore Park (14.4%)	Roxbourne (22.3%)
Binge drinking in adults (modelled estimates)	Proportion (%)	Kenton East (4.8%)	Pinner (10.3%)
Hospital admissions for alcohol attributable conditions	SAR	Pinner South (68.7)	Roxeth (99.5)

than the England average. They vary widely but most can be addressed through public health prevention and health improvement interventions

- High rate of statutory homelessness
- High rate of fuel poverty
- High percentage of adult social care users who do not have as much social contact as they would like
- High rates of low birthweight babies
- High rates of excess weight in 10-11 year olds
- Low amount of fruit and vegetables eaten
- Low amount of exercise taken
- People entering prison with substance misuse problems who are not already known to community services
- Low rates of cervical cancer screening
- Low rates of health checks
- Low rates for HPV, PPV and flu vaccination
- High rates of late diagnosis of HIV
- High rates of TB
- High rates of tooth decay in children

Although these are the indicators that are worse on average than the England average, many indicators show a difference within Harrow which highlights local inequalities in health and wellbeing.

In general, poor health indicators are found in the more deprived parts of the borough and better outcomes in the more affluent parts. This suggests that targeting services at the areas showing the worst health outcomes would be the most beneficial in reducing inequalities.

## **Action on Prevention**

The [Marmot Report \(2010\)](#) recommended that the objective of ill-health prevention could be achieved by increasing investment in prevention, implementing evidence-based ill health preventive

interventions and public health focus on interventions that reduce the social gradient. This could be reduced by adopting preventative strategies that could focus on the primary, secondary and tertiary levels of preventing ill health,<sup>lxxvi</sup>.

## **Primary prevention**

Primary prevention initiatives try to tackle the root causes of poor health and wellbeing either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups. From the list of areas where Harrow performs poorly under the PHOF, it is clear that many of these include elements of primary prevention. Multiple unhealthy behaviours have a cumulative effect on health. Someone in mid-life who smokes, drinks too much, exercises too little and eats poorly is four times as likely to die over the next 10 years than someone who does none of those things.

## **Secondary prevention**

Secondary prevention is about systematically detecting the early stages of disease and intervening before full symptoms develop is. Preventing ill health needs addressing the common causes of major diseases that lead to high rates of premature mortality. Forty per cent of the UK's overall disability-adjusted life years lost are caused by tobacco, high blood pressure, overweight and obesity and low physical activity (2010 figures). This is through their contribution to diseases such as heart disease, stroke and lung cancer.

## **Tertiary Prevention**

Tertiary prevention supports people to make changes to reduce the damage caused by symptomatic disease by focusing on mental, physical, and social rehabilitation.



# HARROW JOINT STRATEGIC NEEDS ASSESSMENT 2015-20

Prevention is also cost effective. The Kings Fund report<sup>lxviii</sup> outlined 'what works' in improving public health and reducing inequalities. These are summarised in the table. It shows that for a wide range of prevention initiatives, there is a good economic basis and a return on the

investments we make on prevention.

**Figure 103 Examples of the return on investment of prevention initiatives** <sup>lxix</sup>

<p><b>Walking or Cycling to School</b></p> <p>The costs to society of transport-induced poor air quality, ill-health and road accidents exceed £40 billion per year. Getting one more child to walk or cycle to school could pay back as much as £768 or £539 respectively in health benefits, NHS costs, productivity gains and reductions in air pollution and congestion.</p>	<p><b>Befriending</b></p> <p>Social support plays an important role in increasing resilience to illness, helping recovery and improving wellbeing. Befriending services have been estimated to pay back around £3.75 in reduced mental health service spending and improvements in health for every £1 spent.</p>
<p><b>Parenting programmes</b></p> <p>Parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested.</p>	<p><b>School-based public health interventions</b></p> <p>These can be good investments. Smoking prevention programmes in schools can return as much as £15 for every £1 spent</p>
<p><b>Warmer homes</b></p> <p>Housing interventions to keep people warm, safe and free from cold and damp are an efficient use of resources. Every £1 spent on improving homes saves the NHS £70 over 10 years.</p>	<p><b>Teenage Pregnancy</b></p> <p>Every £1 spent preventing teenage pregnancy saves £11 in health care costs.</p>
<p><b>Motivational Interviewing</b></p> <p>Every £1 spent on motivational interviewing and developing supportive networks for people with alcohol or drug addiction returns £5 to the public sector in reduced health care, social care and criminal justice costs.</p>	<p><b>Reducing Unemployment</b></p> <p>Worklessness costs the economy more than £100 billion every year. Business in the Community estimates that its programmes getting disadvantaged groups back into work return £3 in reduced costs of homelessness, crime, benefits and NHS care for every £1 spent.</p>
<p>Source: The Kings Fund: Making the case for Public Health</p>	

It is important to remember that when we are talking about improving health and wellbeing we are also including mental health as this underpins or is inextricably linked with many other issues. Mental illness is associated with deprivation and drives inequality. Low income, debt, violence, stressful life events and unemployment are key risk factors for mental illness<sup>lxx</sup>.

Mental health is central to quality of life and economic success. Outcomes could include improved educational outcomes, increased productivity at work, fewer missed days off work, improved social cohesion, reduced antisocial behaviour, crime and violence.

Mental illness is linked to the development and management of chronic illnesses and the development of unhealthy lifestyles. Action could therefore result in reduced smoking, alcohol, drug misuse and risk taking as well as improved physical health, recovery from physical illness and self-management.

### **Working together**

One of the messages of this report is that there is no simple easy answer to the question about what impacts on our health and wellbeing.

To this end, it is imperative that we work together across agencies to maximise the benefits to local people and make our services as cost effective as possible.

Making Every Contact Count<sup>lxxilxxii</sup> is a concept which aims to improve lifestyles and reduce health inequalities. Identifying people with modifiable risk factors is the beginning but it also requires training on how to facilitate behaviour change and a pathway to refer people to. This may mean that services covering these activities would require remodelling and

adjustments so that they meet specific needs of the clients and are suitable and accessible to local people, irrespective of their physical (dis)abilities and social, demographic and ethnic background. For example, preventing smoking in people with serious mental illness, during pregnancy, and among young children and women of ethnic minority groups would require programmes that are tailored to the needs of the targeted clients

### **Building Capacity**

The [Marmot Report](#) (2010)<sup>lxxiii</sup> suggested strengthening the role and impact of ill-health prevention as one of the six policy objectives for improving people's health and wellbeing and reducing inequalities, which result in premature illness and death. For example, the vital role of inequalities in obesity, which is more prevalent in people who are older in age, less educated, most deprived and BME in origin.<sup>lxxiv</sup> The key stakeholders that can effectively engage in preventing ill health and promoting physical and mental health and wellbeing include the NHS England, Public Health England, National and local governments, the NHS and the CCGs.<sup>lxxv</sup> However, the general practices / practitioners (GPs) can play a very vital role in preventing ill health and promoting public health because they as primary healthcare providers are directly and more frequently in contact with patients than any of the other key stakeholders mentioned above.<sup>lxxvi</sup> In addition, the active engagement of patients themselves, local communities and the third sector (also known as the community sector or voluntary sector) is equally important in the ill health prevention agenda.

At the start of this JSNA, we noted that the public sector is going through an unprecedented change in funding. It is more important than ever that we identify

what assets we have locally and build on them. Harrow has a vibrant voluntary sector and a good reputation for volunteering. We need to capture this enthusiasm and commitment to ensure that together, we can reach and help more people to start their lives healthily, to have a fulfilling healthy life and to stay healthy for longer.

### **Moving forward**

This document is not the final word on health and wellbeing in Harrow. The knowledge base will be added to by profiles and needs assessments and reviews over the coming years with the intention that we reduce health inequalities within the borough and make Harrow a healthy, happy place.

The actions needed to achieve this will be developed in the Joint Health and Wellbeing Strategy which has as it's draft vision:

*To work together to do more than we could alone to improve the health and wellbeing of those with the greatest needs in Harrow to enable them to start well, develop well, live well, work well and age well*

## Glossary

To be added prior to publication – currently asking people to highlight terms they do not understand or require clarity on.

DRAFT

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