Annual Director of Public Health Report 2022/23:

Health Inequalities in Harrow

DRAFT

LONDON BOROUGH OF HARROW

Introduction by the Director of Public Health

2022/23

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

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

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

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

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

Please click images for more information

Carole Furlong, Director of Public Health

How to use this report

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

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

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

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

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

Acknowledgements

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

1. Harrow's population

LONDON BOROUGH OF HARROW

Harrow's population - contents

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

Harrow's population – summary

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

Harrow's population – data sources (1)

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

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

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

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

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

Harrow's population – data sources (2)

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

For example:

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

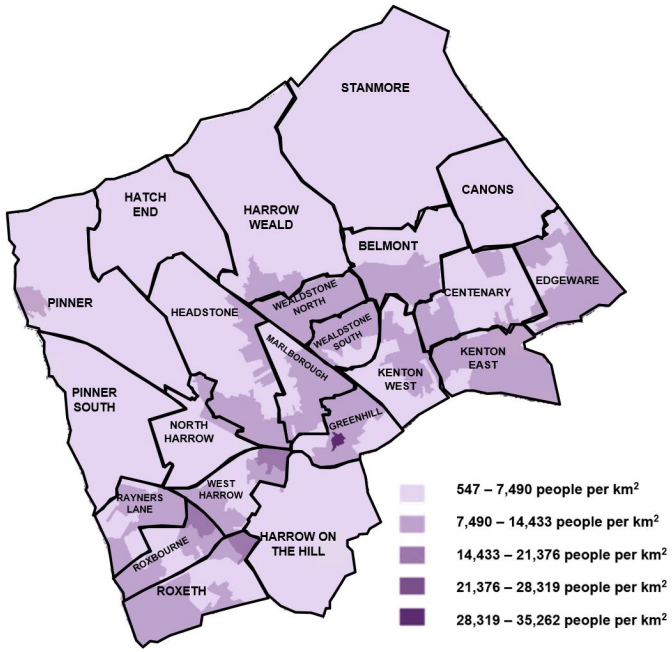
Harrow's population – population size (1)

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

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

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

This map shows the density of the population across Harrow.



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

Please click images to expand

Harrow's population – population size (2)

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

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

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

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

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

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

Data shown is from June 2022

Harrow's population – population growth (1)

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

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

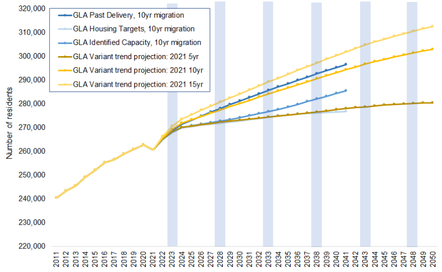
Harrow's population – population growth (2)

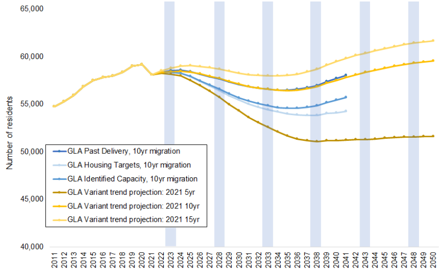
The GLA projections come in 2 groups. **Trend-based** – that is, following recent trends in birth, death and migration; and **Housing-based** – that is, following the Trend-based projections but capped by the likely availability of housing supply. Of the Trend-based projections, the projection based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

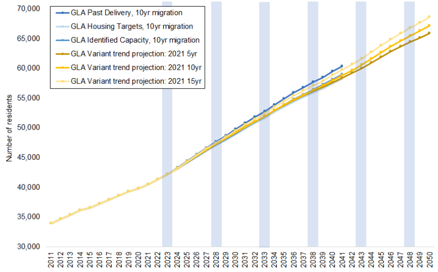
All the different projections for Harrow are shown together in Figure 1, below.

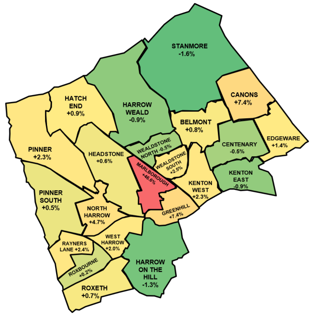
The models predict recent trends toward reducing children and increasing older people in Harrow will continue – see Figure 2 and Figure 3.

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









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Harrow's population – turnover

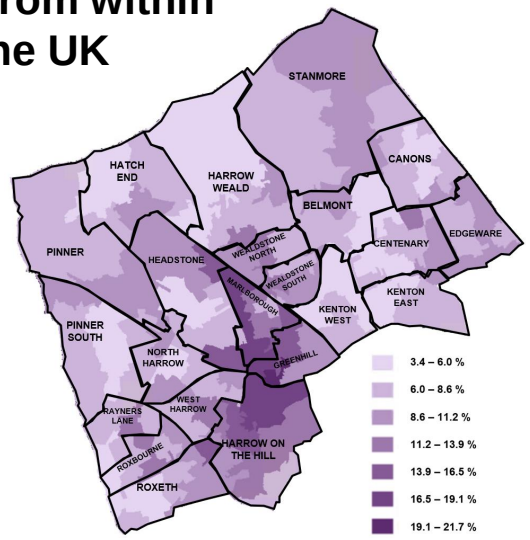
Across London, rates of population movement are high, especially among younger adults. Data from the 2021 Census shows that 10.0% of Harrow residents had moved into the area in the previous year - 8.6% from other parts of the UK and 1.4% from abroad.

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

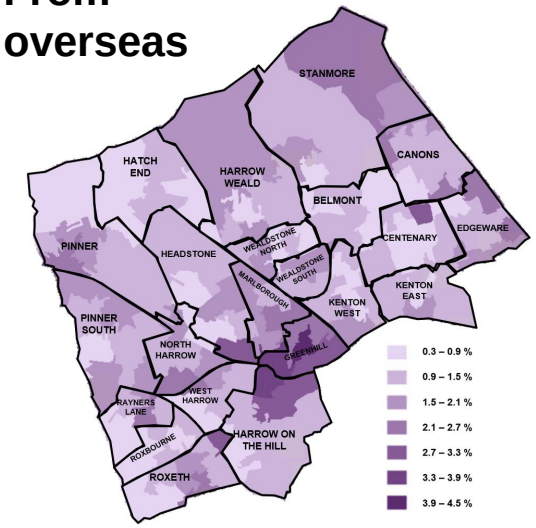
Other data shows for example, that in parts of Harrow, over half the population changed during the period 2011 to 2020.

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

From within the UK



From overseas



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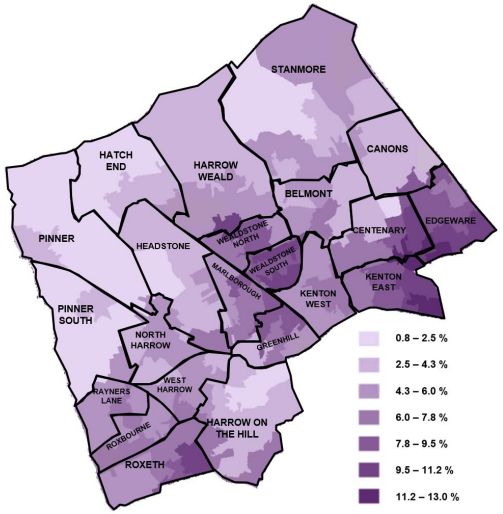
Harrow's population – languages

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

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

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



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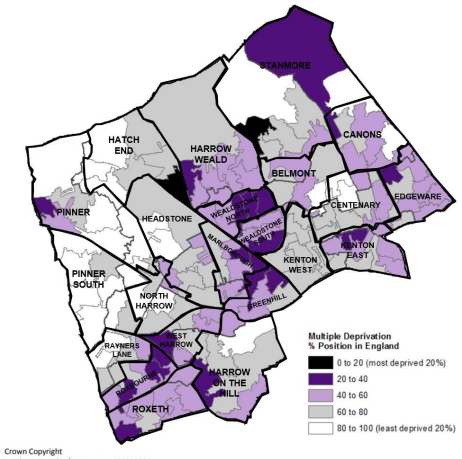
Main language spoken	Number of residents	% of Harrow population
English	174,443	69.3%
Romanian	18,987	7.5%
Gujarati	17,298	6.9%
Tamil	8,696	3.5%
Arabic	3,224	1.3%
Polish	2,886	1.1%
Persian or Farsi	2,716	1.1%
Pashto	2,128	0.8%
Urdu	1,866	0.7%
Hindi	1,823	0.7%
Nepalese	1,327	0.5%
Portuguese	1,250	0.5%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

Harrow's population – socioeconomic deprivation

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

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

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



Relative socioeconomic deprivation measures (IMD2019)

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

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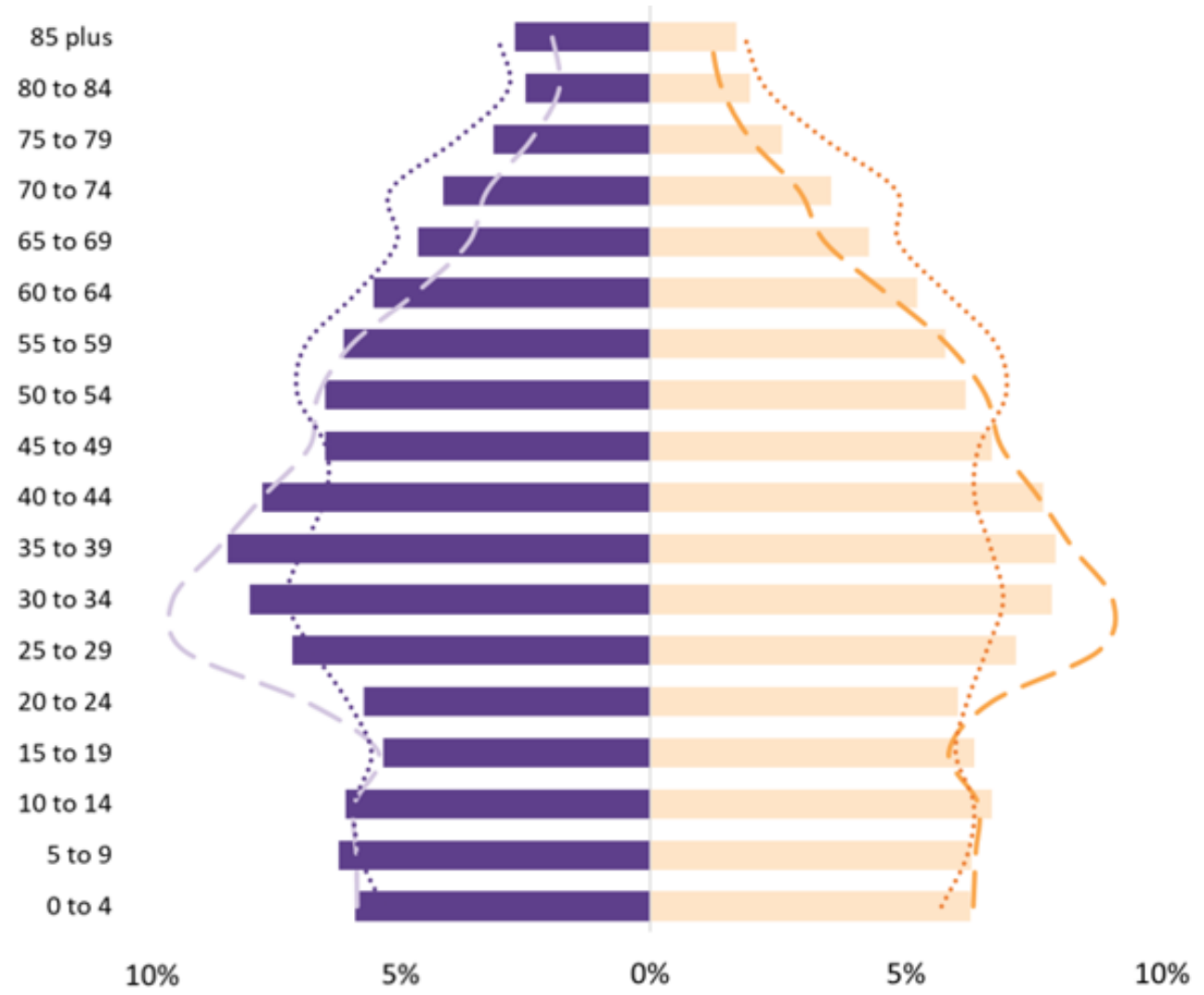
Harrow's population – age (1)

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

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



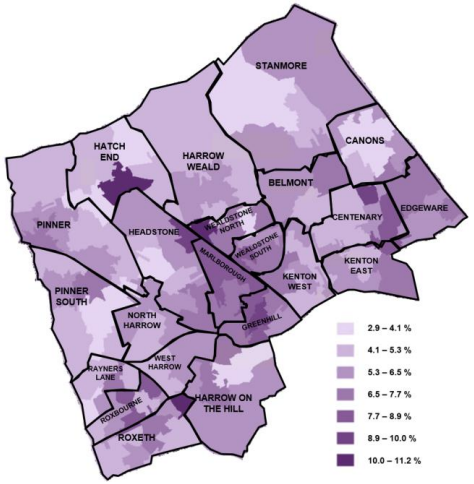
Harrow's population – age (2)

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

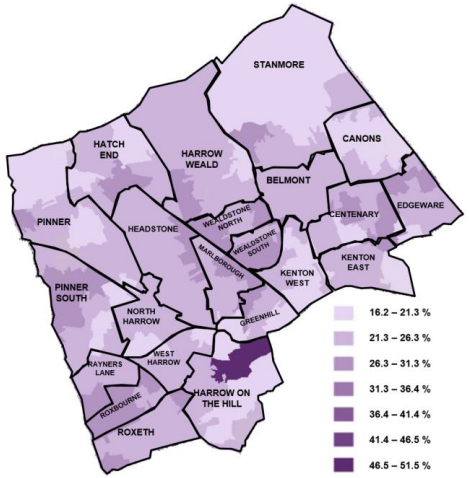
More detail is shown on the maps, below.

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

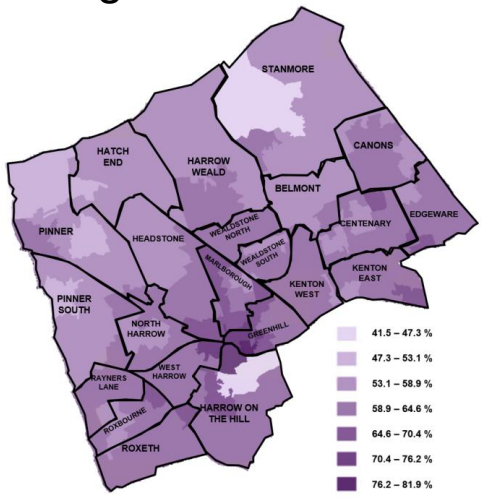
Under 5



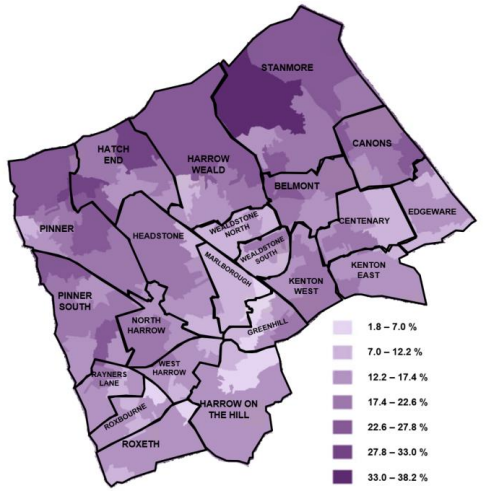
Under 20



Age 20 - 64



65 plus

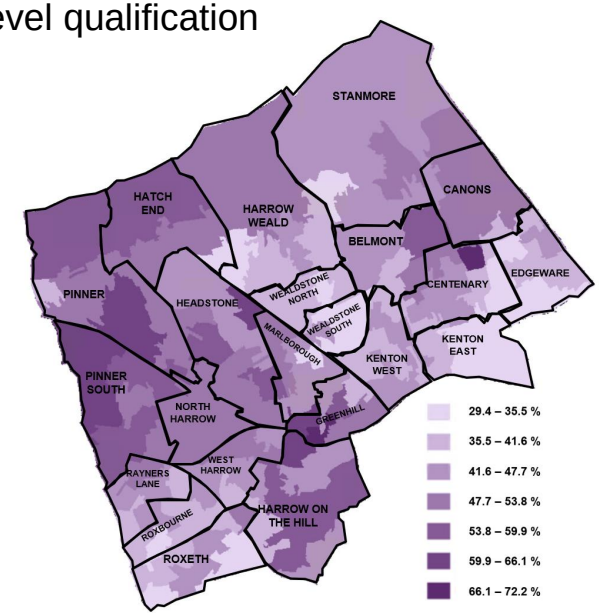


Harrow's population – education

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

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

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



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

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

Harrow's population – employment

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

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

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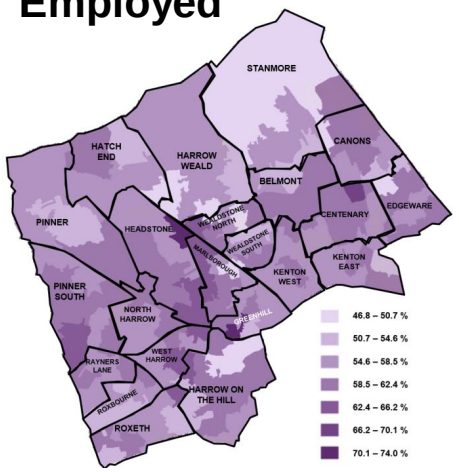
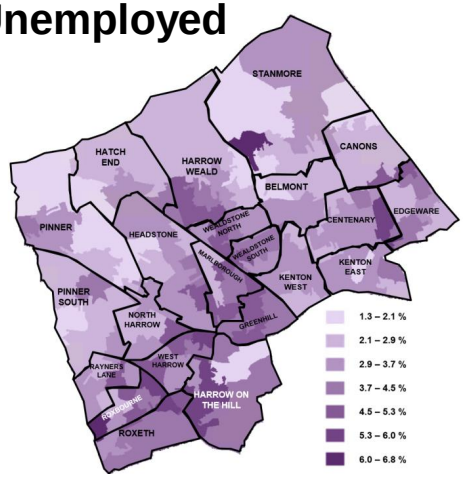
The maps below, show the variation within Harrow.

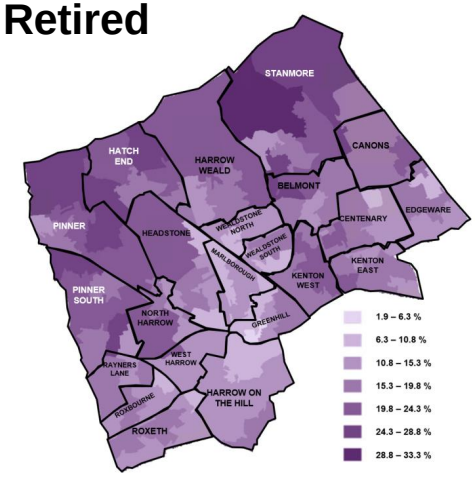
Employed



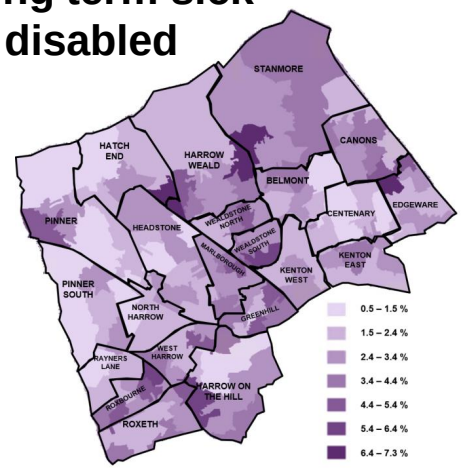
Unemployed



Retired



Long term sick or disabled



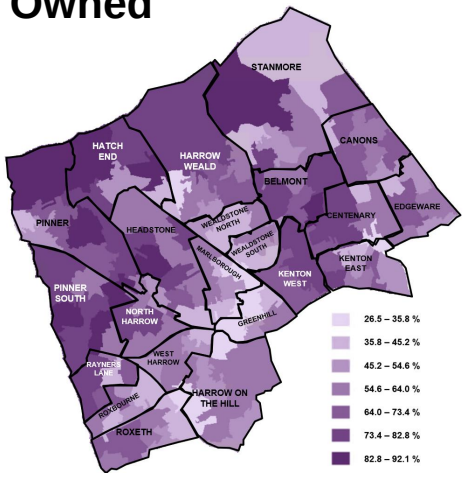
Harrow's population – housing (1)

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

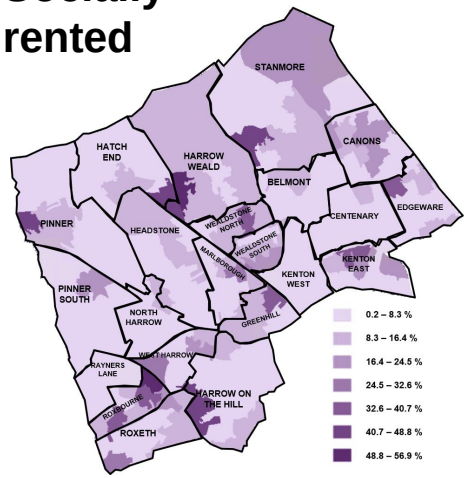
Housing tenure in Harrow is further detailed in the table and maps below.

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

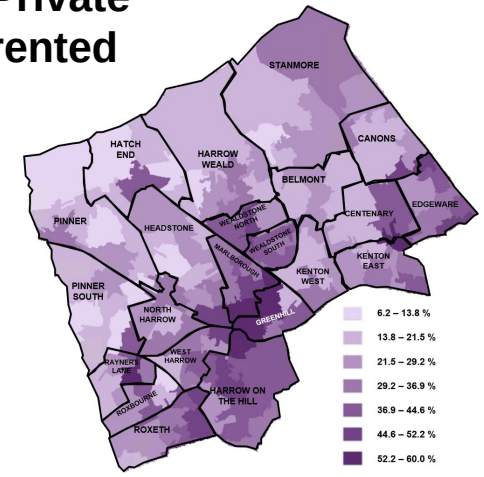
Owned



Socially rented



Private rented



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Harrow's population – housing (2)

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

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

Household composition in Harrow (2021 Census)

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

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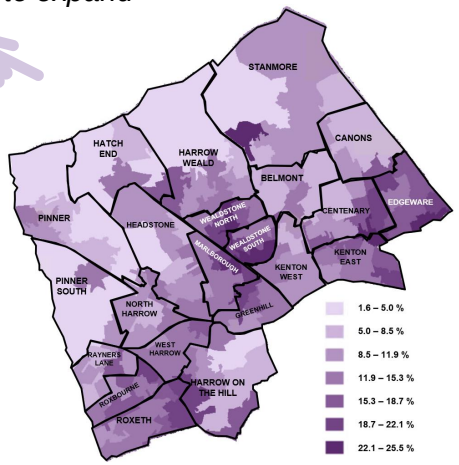

The ONS report that overcrowded housing has fewer bedrooms than needed for occupants. 12% of households in Harrow are overcrowded – higher than in London as a whole.

This map shows percentage of overcrowded housing across Harrow.

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

Harrow's population – sex

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

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

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

Harrow's population – transgender

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

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

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

Harrow's population – ethnicity (1)

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

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

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

Harrow's population – ethnicity (2)

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

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

Harrow's population – ethnicity (3)

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

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

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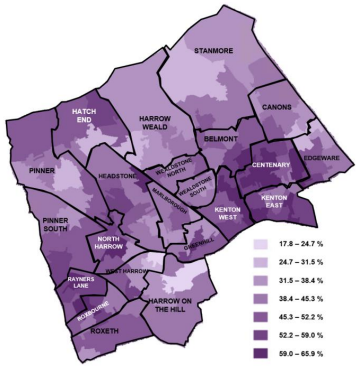
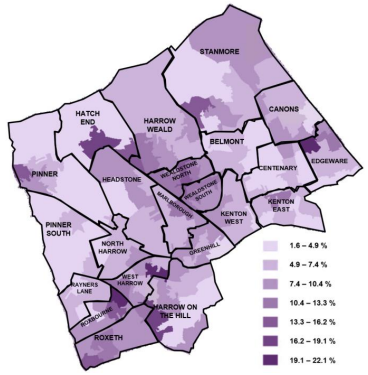
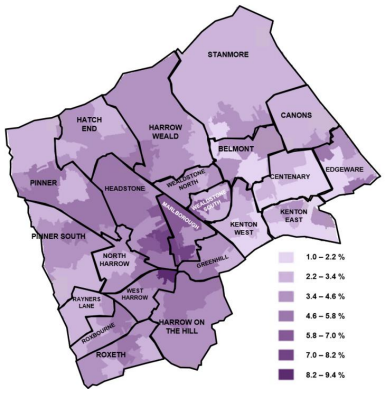
Asian



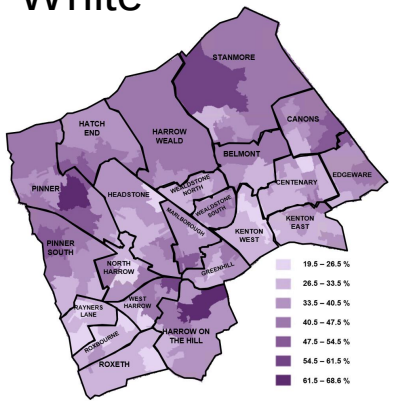
Black



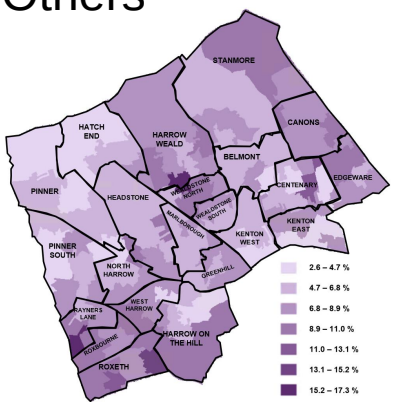
Mixed



White



Others



Harrow's population – sexual orientation

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

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

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

Harrow's population – religion

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

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

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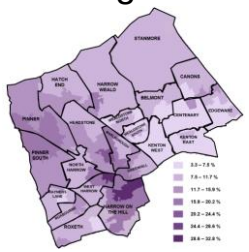
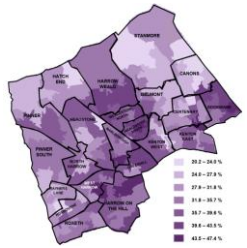
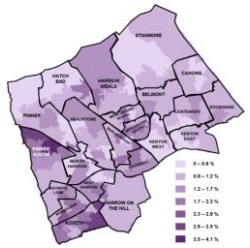
No religion



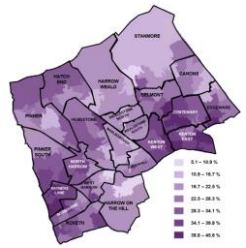
Christian



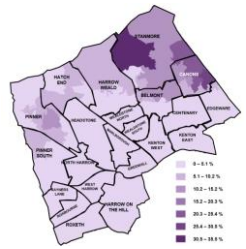
Buddhist



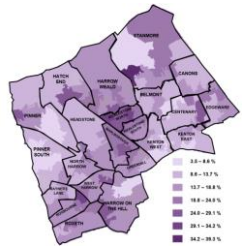
Hindu



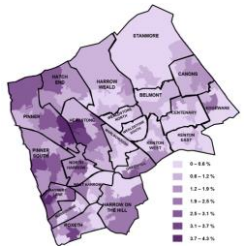
Jewish



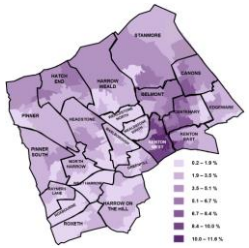
Muslim



Sikh



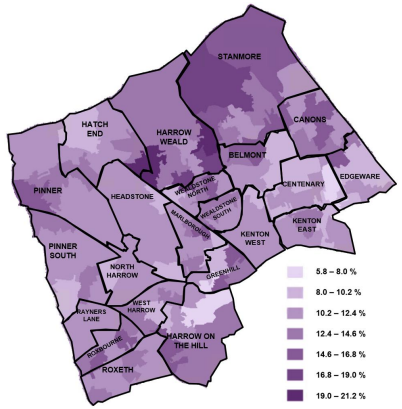
Other religions



Harrow's population – disability

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

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



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

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

Harrow's population – carers

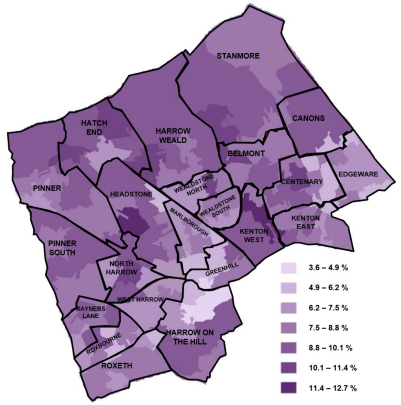
In Harrow over 20,000 people reported being informal carers in the 2021 Census – the map below shows where these people live. Approximately 10,000 (4.2%) residents reported providing 19 or fewer hours of unpaid care each week, almost 5,000 (1.8%) residents provided 20-49 hours per week, and over 5,000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

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

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

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

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



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

Harrow's population – pregnancy and maternity

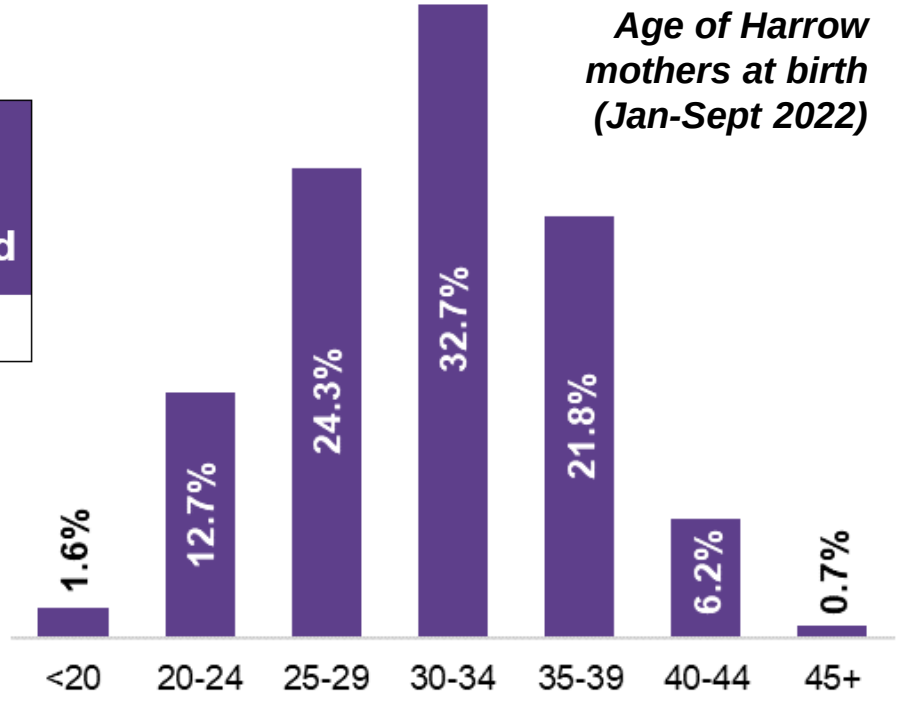
In 2020/21 there were 3,160 babies delivered to Harrow mothers. 10 of these babies were born to under 18s, 32 babies in twin or other multiple births, and 50% were born to mothers from BAME groups.

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

Population under 2 years old (2021 Census)

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

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

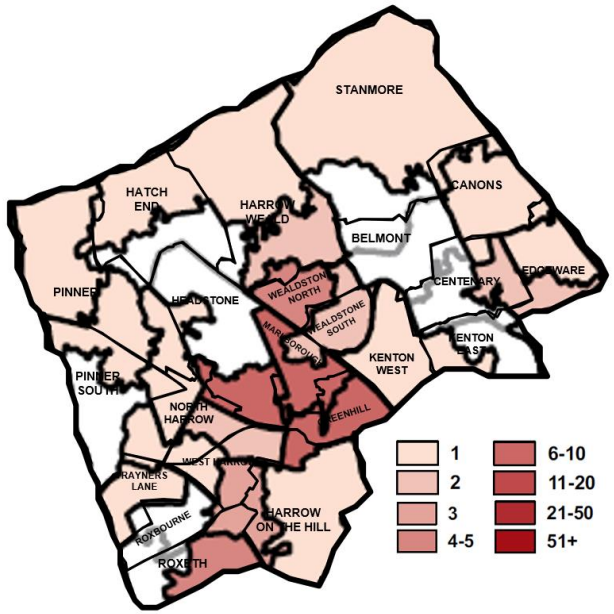


Harrow's population – homelessness

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

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

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



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

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

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

Please click images to expand

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

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

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

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

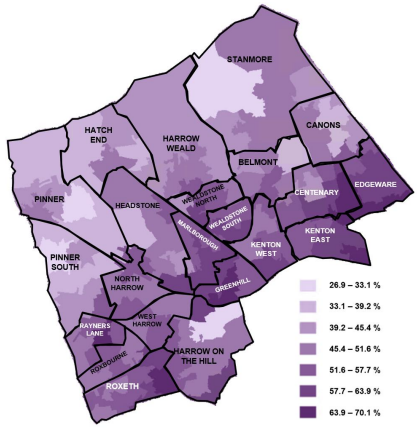
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
UK	127,612	48.9%	50.1%	59.4%	82.6%
Rest of Europe	41,677	15.9%	17.1%	15.5%	7.2%
Africa	26,748	10.2%	7.6%	7.1%	2.8%
Asia / Middle East	59,517	22.8%	20.4%	13.0%	5.7%
Americas / Caribbean	4,985	1.9%	4.0%	4.2%	1.4%
Australia,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

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

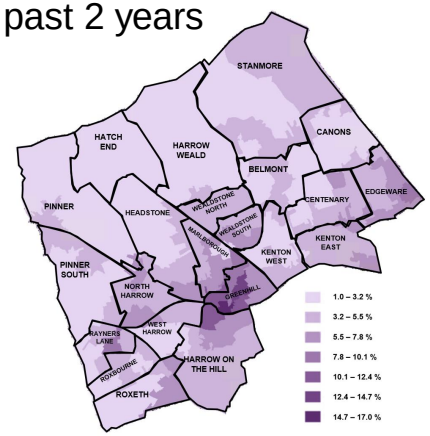
Nationally, and in Harrow, asylum seekers make up a small percentage of immigrants. During 2022/23, a total of 670 immigrants received support from Harrow. This includes 255 under Homes for Ukraine, 89 under Afghan Resettlement Programme, and 326 Supported Asylum.

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

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



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



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

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Harrow's population – veterans

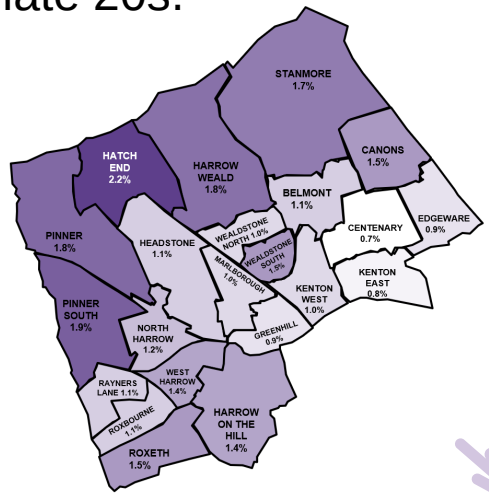
There are generally more veterans in areas of the country with larger active military populations. Both Northwood Headquarters and RAF Northolt are close to Harrow. In the borough itself, there is one reserve unit (131 Commando Squadron), and several active cadet units.

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

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

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

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



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Harrow's population – health

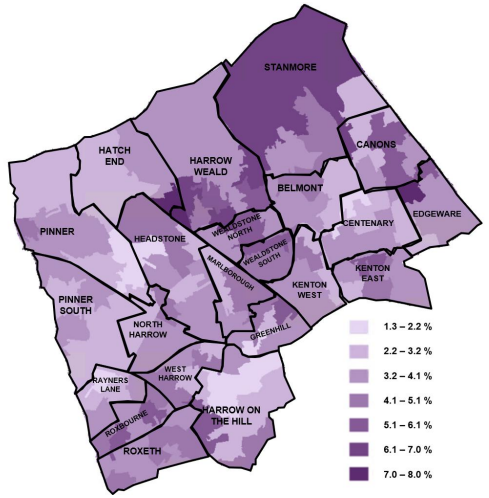
The 2021 Census asked Harrow residents about their health. Over 10,000 residents report that their health was either bad or very bad. This is closely linked to factors such as age and socioeconomic deprivation. There is more information about ill-health in Harrow in the local Joint Strategic Needs Assessment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

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

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

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

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



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

2. Poverty and health in Harrow

LONDON BOROUGH OF HARROW

Poverty and health - definitions

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

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

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

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

Other relevant indicators for low income are;

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

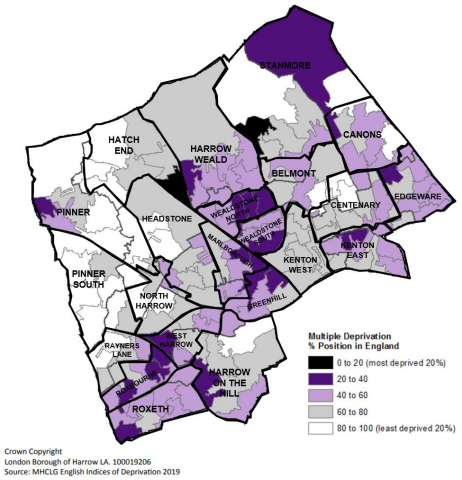
It should be noted that these measures of poverty use quantitative data and that there is an absence of routine information on people's own experiences and perceptions of their income, and the affordability of basic living essentials.

Poverty and health - numbers

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

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

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



Relative socioeconomic deprivation measures (IMD2019)

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

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Poverty and health – wider determinants (1)

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

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

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

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

Poverty and health – wider determinants (2)

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

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

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

Poverty and health – lifestyles and behaviour

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

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

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

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

Poverty and health – health outcomes

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

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

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

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

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

Poverty and health – use of services

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

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

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

Poverty and health – local case studies

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

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

Poverty and health – best practice (1)

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

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

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

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

Poverty and health – best practice (2)

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

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

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

3. Age and health in Harrow

LONDON BOROUGH OF HARROW

Age and health - definitions

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

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

Early years normally refers to under 5s.

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

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

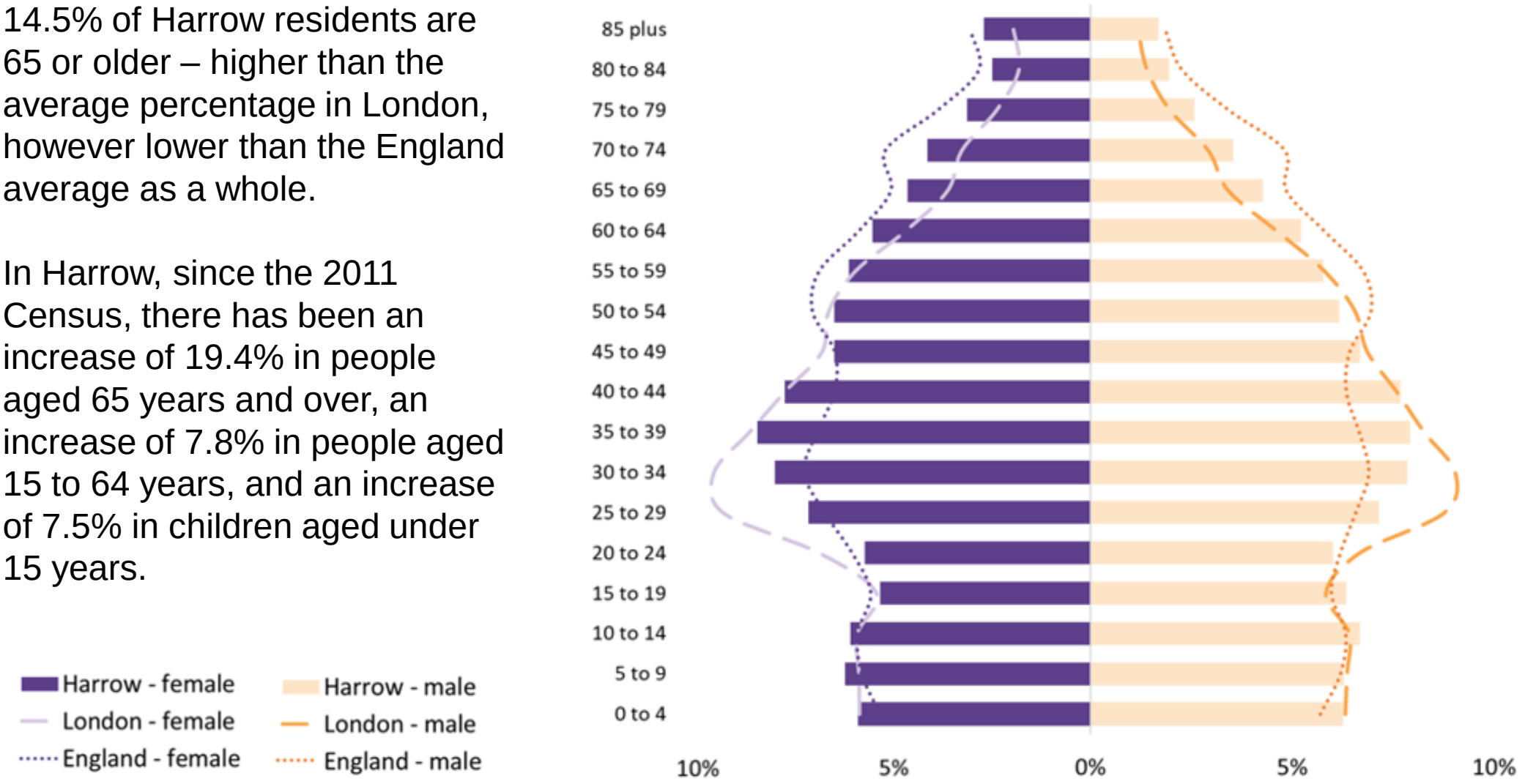
Older Adults are defined as those that are 65 Years of age and above. good health and wellbeing can be maintained well into older age with the right support and access to services. Recent years have seen a shift in attitudes towards older age with an increased recognition that older people continue to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

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

Age and health – numbers (1)

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

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



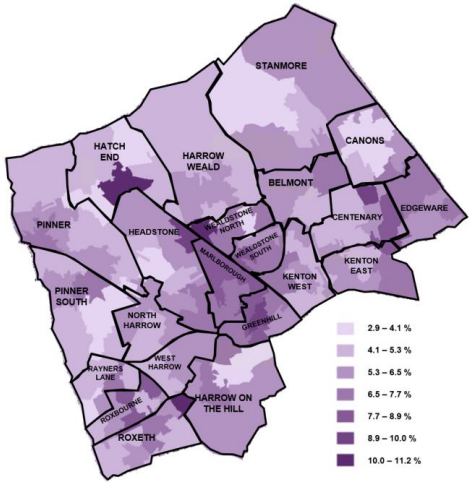
Age and health – numbers (2)

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

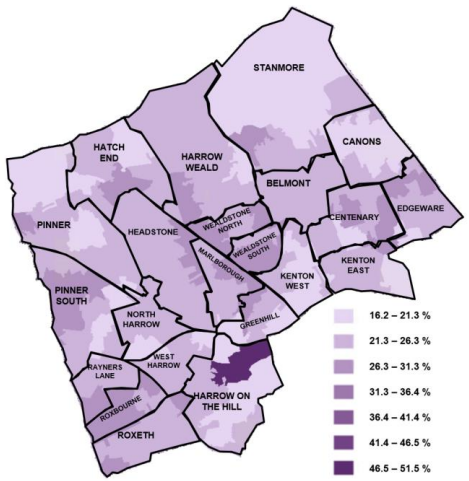
More detail is shown on the maps, below.

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

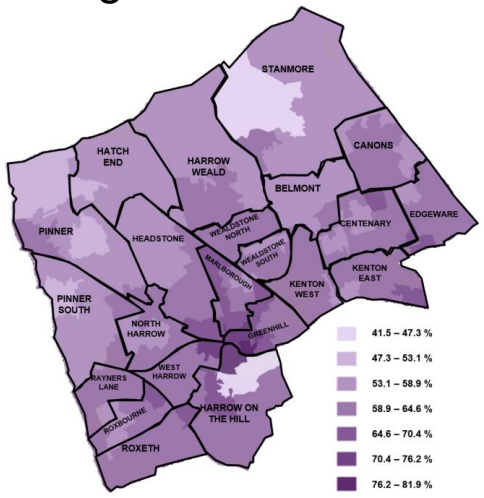
Under 5



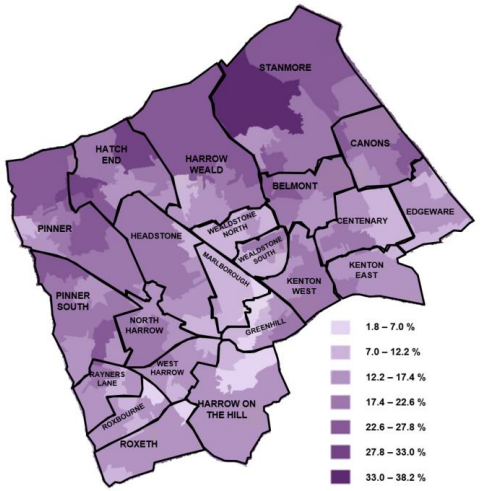
Under 20



Age 20 - 64



65 plus



Age and health – wider determinants (1)

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

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

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

Age and health – wider determinants (2)

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

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

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

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

Age and health – lifestyles and behaviour

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

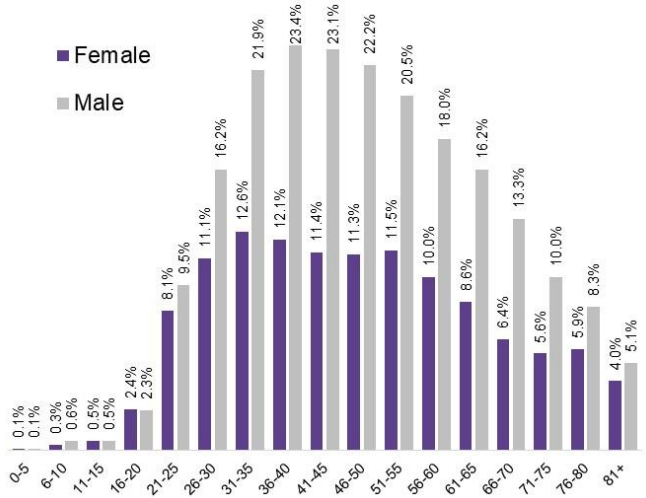
- Most young people feel they eat well and exercise regularly, although young people sometimes feel they are prevented from exercising because there are no suitable spaces or pitches near their homes.
- About 6% of them say they are stopped from being able to get out and exercise because of the need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

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

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

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

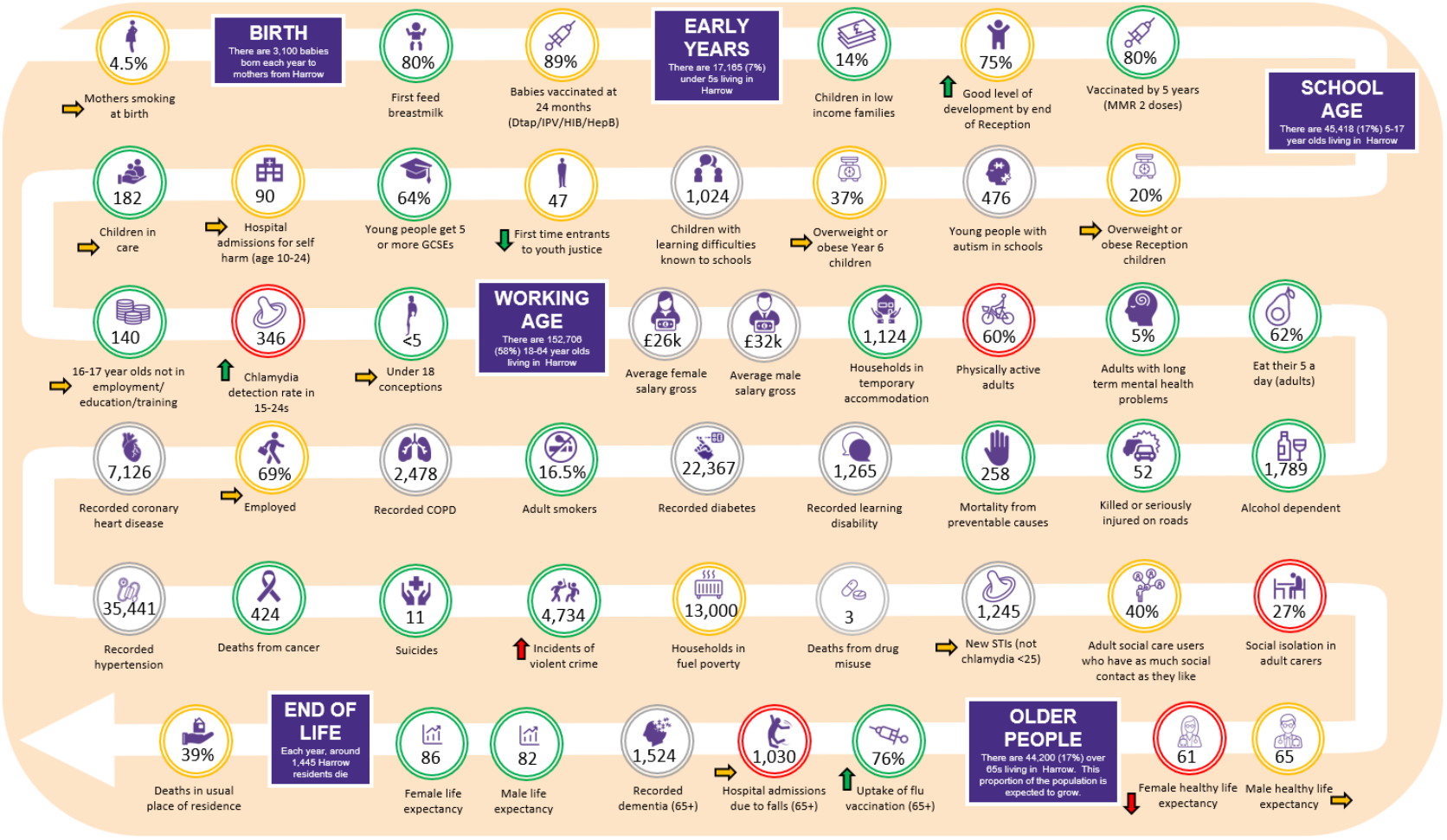
GP recorded rates of smoking in Harrow, by Sex and age (WSIC 2023)



Age and health – health outcomes

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

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



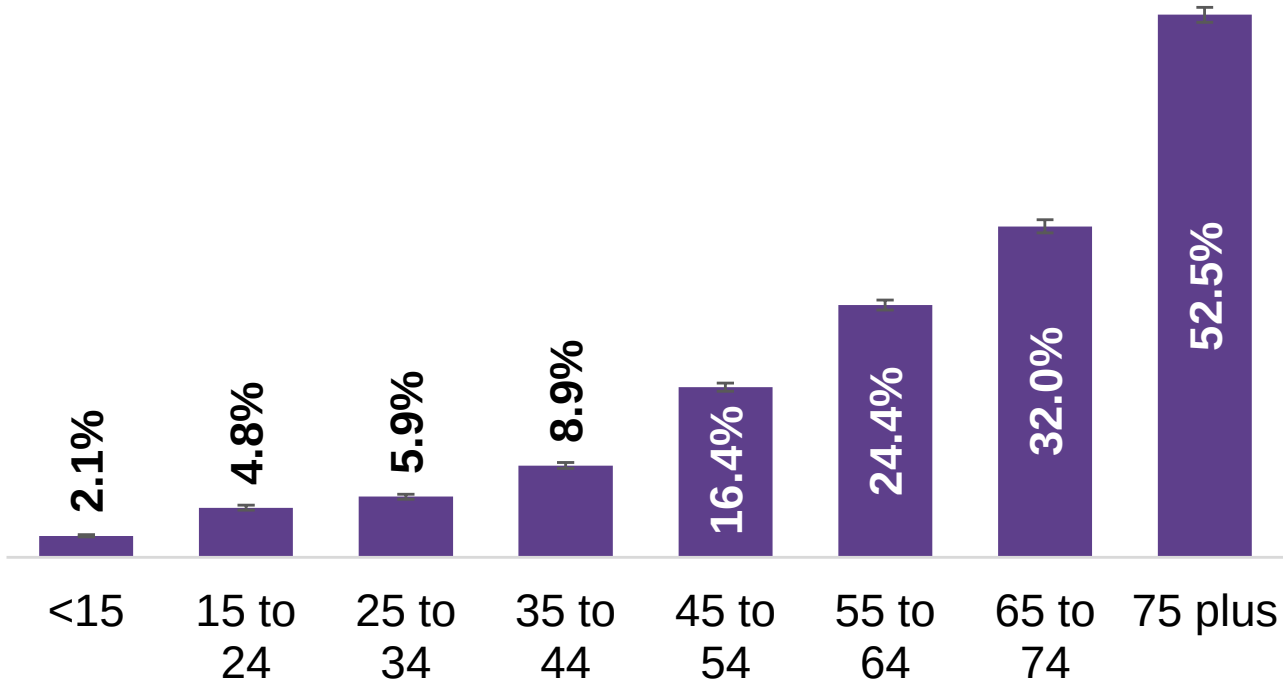
Please click images to expand

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

Age and health – health outcomes (2)

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

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



Age and health – use of services

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

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

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

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

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

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

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

Age and health – local case studies

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

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

Age and health – best practice

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

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

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

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

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

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Health inequalities in Harrow

4. Sex and health in Harrow

LONDON BOROUGH OF HARROW

Sex and health - definitions

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

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

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

Sex and health - numbers

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

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

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

Sex and health – wider determinants (1)

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

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

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

Sex and health – wider determinants (2)

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

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

Sex and health – lifestyles and behaviour (1)

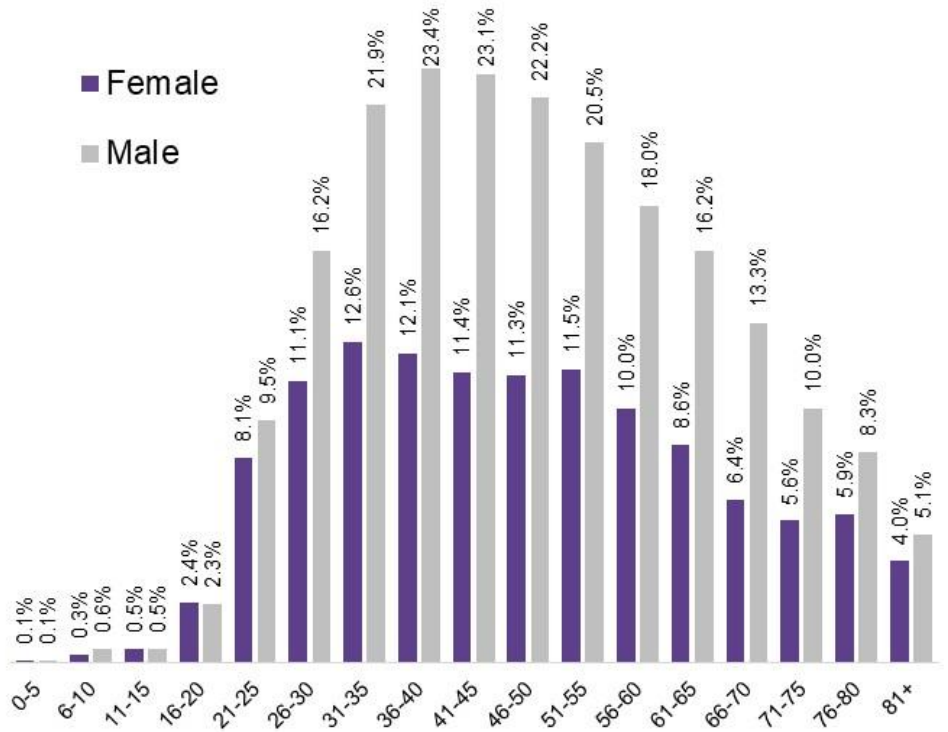
Gender is a key social determinant of health and how women and men engage in health behaviours. Sociocultural norms and attitudes shape the way women and men engage in health promoting or risky behaviours. Men are more likely to engage in risky lifestyle behaviours such as smoking, alcohol, substance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

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

Local smoking rates by gender are shown in the graph.

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

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



Sex and health – lifestyles and behaviour (2)

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

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

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

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

Sex and health – health outcomes (1)

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

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

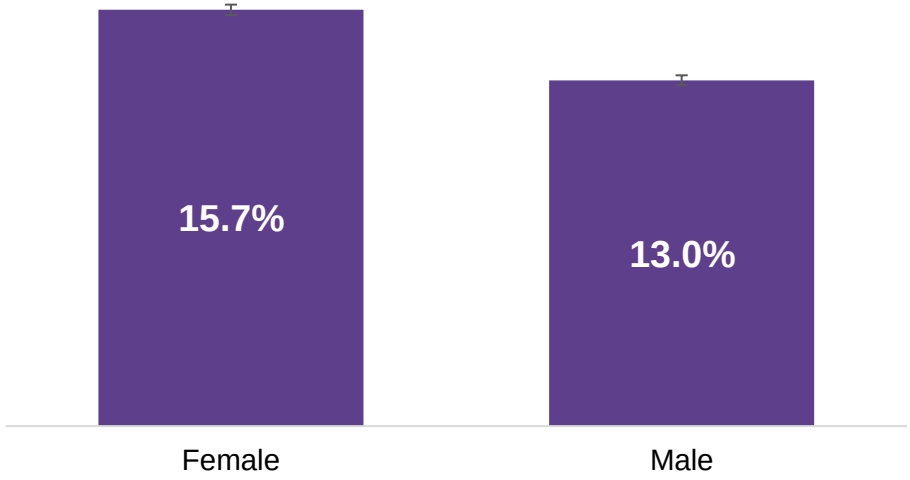
Sex and health – health outcomes (2)

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

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

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

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



Sex and health – use of services

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

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

Sex and health – local case studies

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

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

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

Sex and health – best practice

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

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

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

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5. LGBTQ+ people and health in Harrow

LONDON BOROUGH OF HARROW

LGBTQ+ people and health - definitions

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

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

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

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

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

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

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

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

LGBTQ+ people and health – numbers (1)

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

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

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

LGBTQ+ people and health – numbers (2)

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

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

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

LGBTQ+ people and health – wider determinants (1)

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

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

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

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

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

LGBTQ+ people and health – wider determinants (2)

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

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

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

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

LGBTQ+ people and health – lifestyles and behaviour

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

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

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

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

LGBTQ+ people and health – health outcomes

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

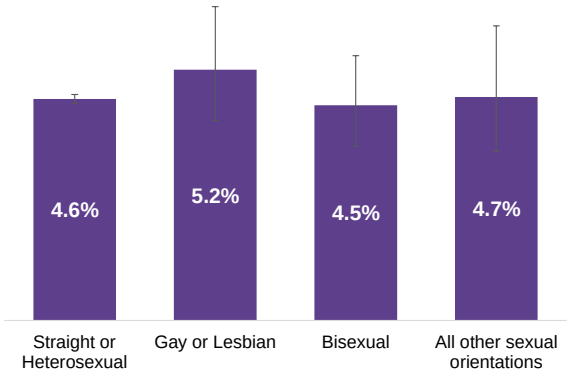
45% of LGBT pupils, including 64% of trans pupils, report being bullied for being LGBT at school. 45% of trans young people (aged 11-19) and 22% of cis LGB young people have tried to take their own life. Among the general population the NHS estimates this figure to be 13% for girls and 5% for boys aged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

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

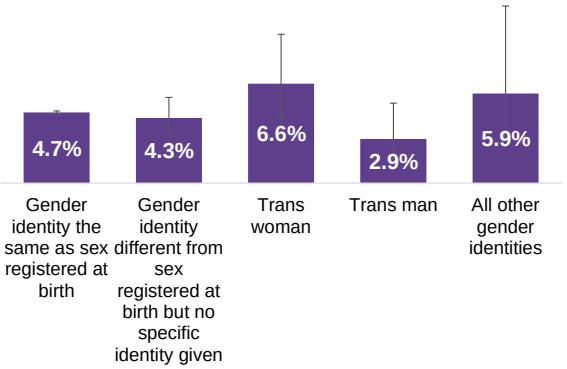
The graphs shows data from the 2021 Census – there is no clear relationship between sexual orientation or gender identity and self-reported health in Harrow.

Please click images to expand

Sexual orientation



Trans or Cis Gender



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

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

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

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

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

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

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

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

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

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

LGBTQ+ people and health – local case studies

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

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

LGBTQ+ people and health – best practice

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

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

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

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

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

Annual Director of Public Health Report 2022/23:
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6. Ethnicity and health in Harrow

LONDON BOROUGH OF HARROW

Ethnicity and health - definitions

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

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

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

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

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

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

Ethnicity and health – numbers (1)

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

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

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

Ethnicity and health – numbers (2)

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

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

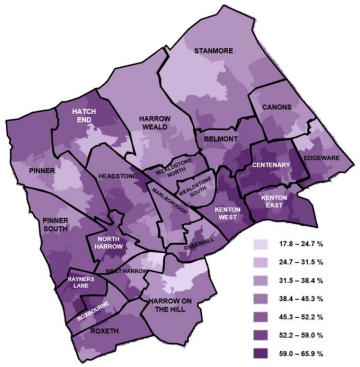
Ethnicity and health – numbers (4)

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

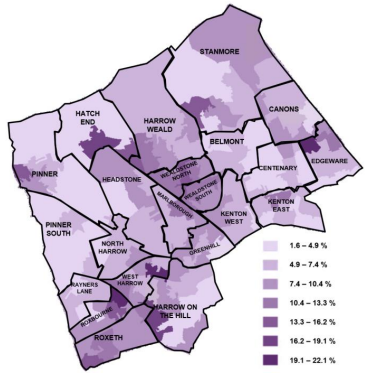
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Asian	118,152	45.2%	27.8%	20.7%	9.6%
Black	19,151	7.3%	9.5%	13.5%	4.2%
Mixed	9,833	3.8%	5.2%	5.7%	3.0%
White	95,233	36.5%	49.1%	53.8%	81.0%
Others	18,836	7.2%	8.4%	6.3%	2.2%

Please click images to expand

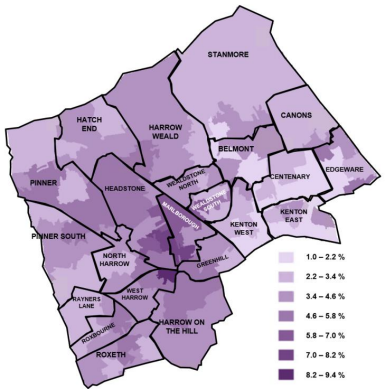
Asian



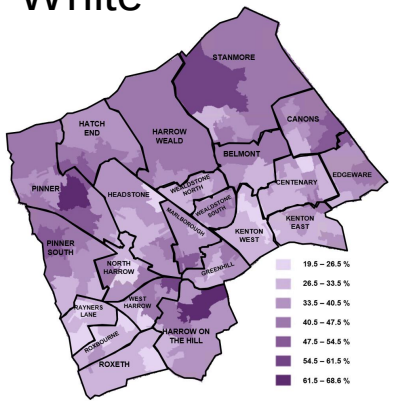
Black



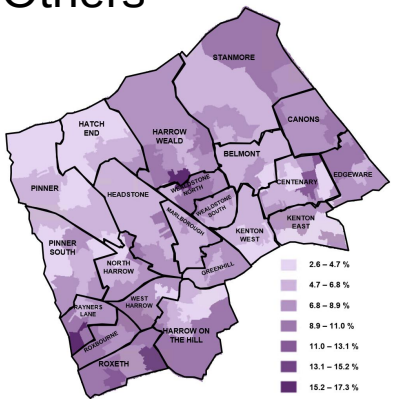
Mixed



White



Others



Ethnicity and health – wider determinants (1)

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

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

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

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

Ethnicity and health – wider determinants (2)

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

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

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

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

Ethnicity and health – lifestyles and behaviour (1)

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

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

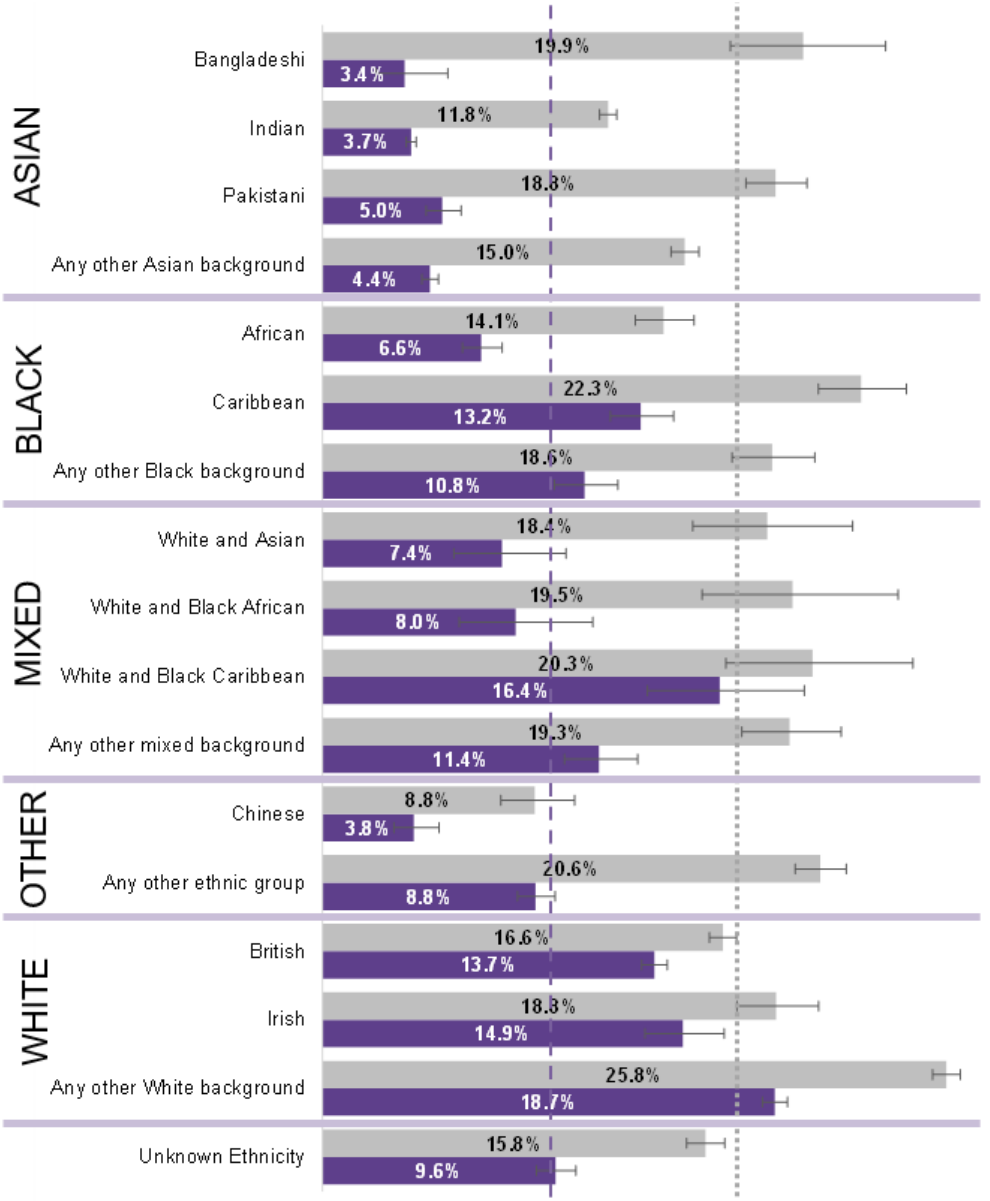
There are high levels of physical inactivity in ethnic minorities, with at least 50% reported to achieve less than 30 minutes of exercise a week compared to the recommended amount of weekly exercise of 150 minutes. The Active Lives Survey (2022) found that 7 in 10 men from mixed groups and 64.7% of white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

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

Ethnicity and health – lifestyles and behaviour (2)

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

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



Ethnicity and health – health outcomes (1)

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

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

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

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

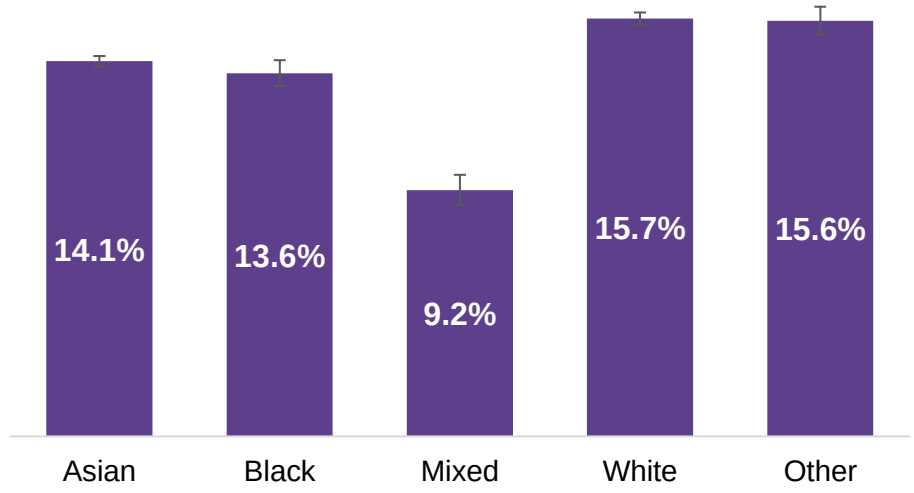
Ethnicity and health – health outcomes (2)

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

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

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

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



Ethnicity and health – use of services

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

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

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

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

Ethnicity and health – local case studies

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

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

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

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

Ethnicity and health – best practice

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

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

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

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7. Religion and health in Harrow

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Religion and health - definitions

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

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

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

Religion and health - numbers

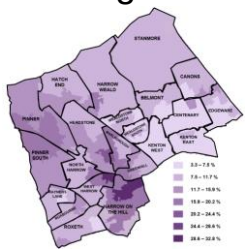
Harrow has among the most diverse communities in England in terms of religion. According to the 2021 Census, a third of the population are Christians, and a quarter Hindu - the highest percentage in England. There are also large populations of Muslims and people with no religion. There are also smaller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

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

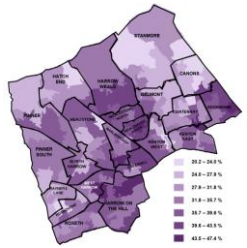
Please click images to expand

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

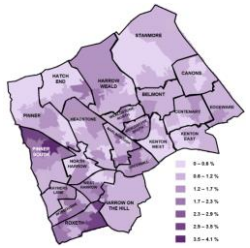
No religion



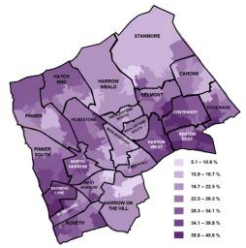
Christian



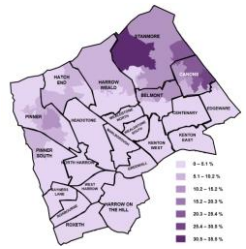
Buddhist



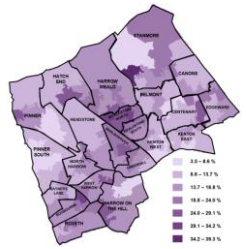
Hindu



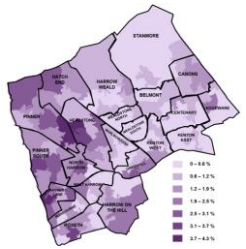
Jewish



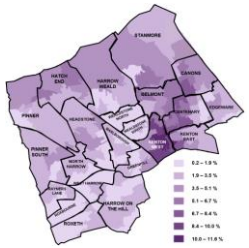
Muslim



Sikh



Other religions



Religion and health – wider determinants (1)

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

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

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

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

Religion and health – wider determinants (2)

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

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

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

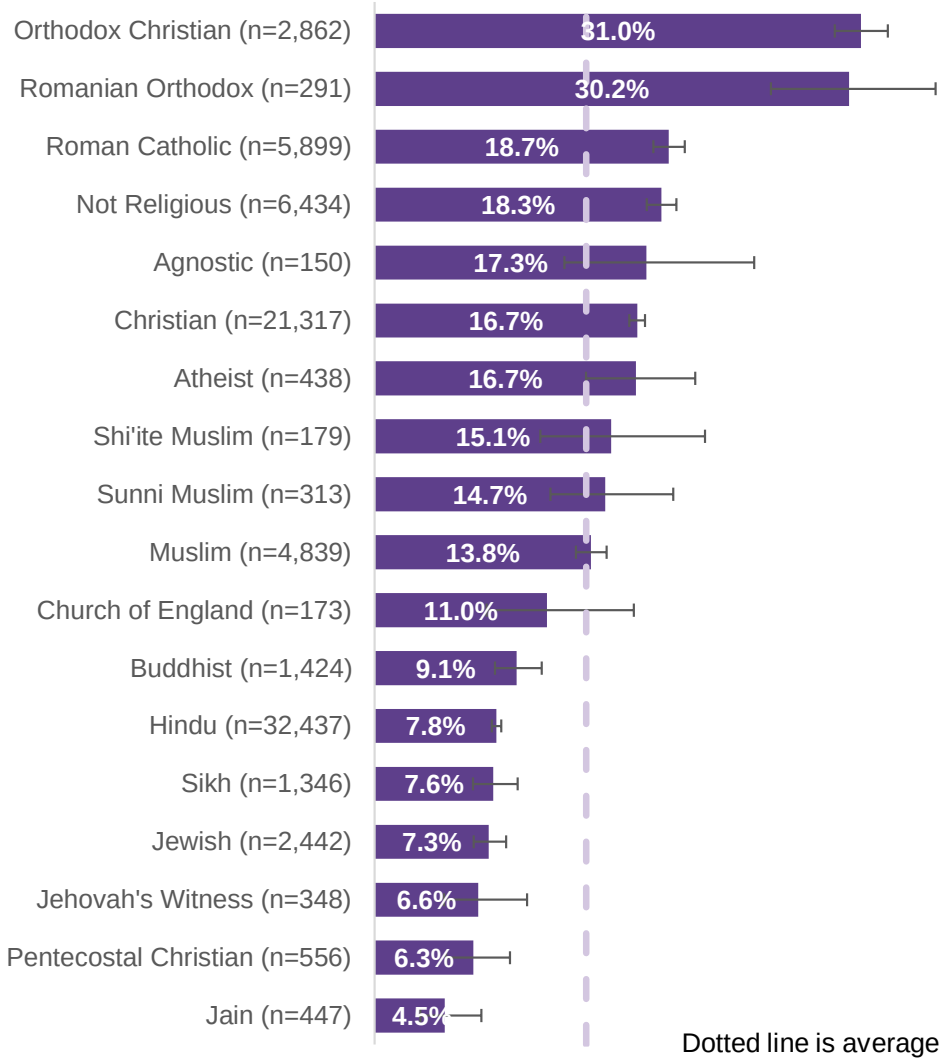
In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that Muslim residents are much more likely to live in more deprived parts of the borough. Sikh residents are more likely to live in less deprived areas.

Religion and health – lifestyles and behaviour (1)

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

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

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



Religion and health – lifestyles and behaviour (2)

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

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

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

Religion and health – health outcomes (1)

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

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

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

Religion and health – health outcomes (2)

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

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

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

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

Religion and health – use of services

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

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

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

Religion and health – local case studies

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

Religion and health – best practice

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

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

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

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

8. Disability and health in Harrow

LONDON BOROUGH OF HARROW

Disability and health - definitions

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

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

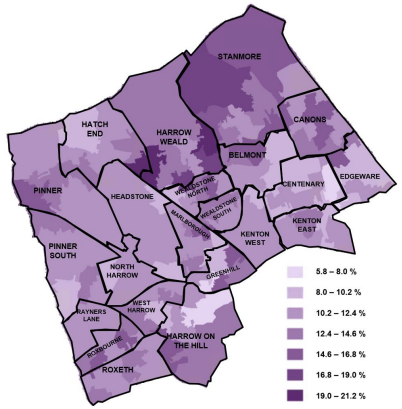
Disabilities could include physical disabilities, including mobility impairment, personal care needs, sensory impairments (such as hearing or sight loss), and learning disabilities.

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

Disability and health - numbers

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

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



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

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

Disability and health – wider determinants (1)

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

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

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

Disability and health – wider determinants (2)

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

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

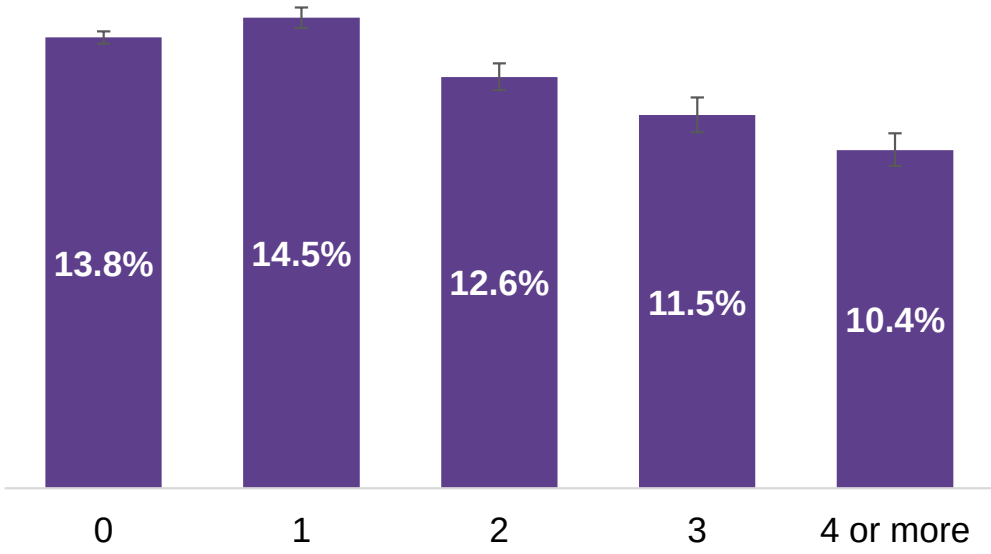
In Harrow, data from the 2021 Census and the Index of Multiple Deprivation show that disabled residents are more likely to live in more deprived parts of the borough.

Disability and health – lifestyles and behaviour (1)

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

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

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



Disability and health – lifestyles and behaviour (2)

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

Disability and health – health outcomes (1)

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

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

Disability and health – health outcomes (2)

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

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

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

Disability and health – use of services

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

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

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

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

Disability and health – local case studies

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

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

Disability and health – best practice

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

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

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

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9. Carers and health in Harrow

LONDON BOROUGH OF HARROW

Carers and health - definitions

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

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

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

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

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

Carers and health - numbers

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

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

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

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

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

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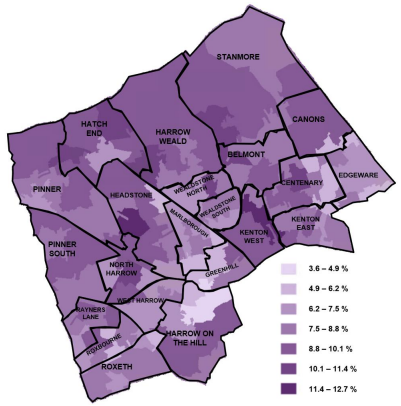

	Number of Harrow residents (5+)	% of residents (5+)			
		Harrow	NW London	London	England
Provides no unpaid care	225,468	91.8	92.8%	92.8	91.2
Provides 19 hours or less unpaid care a week	10,225	4.2	3.5%	3.6	4.3
Provides 20 to 49 hours unpaid care a week	4,535	1.8	1.7%	1.7	1.8
Provides 50 or more hours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

Carers and health – wider determinants (1)

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

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

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

Carers and health – wider determinants (2)

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

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

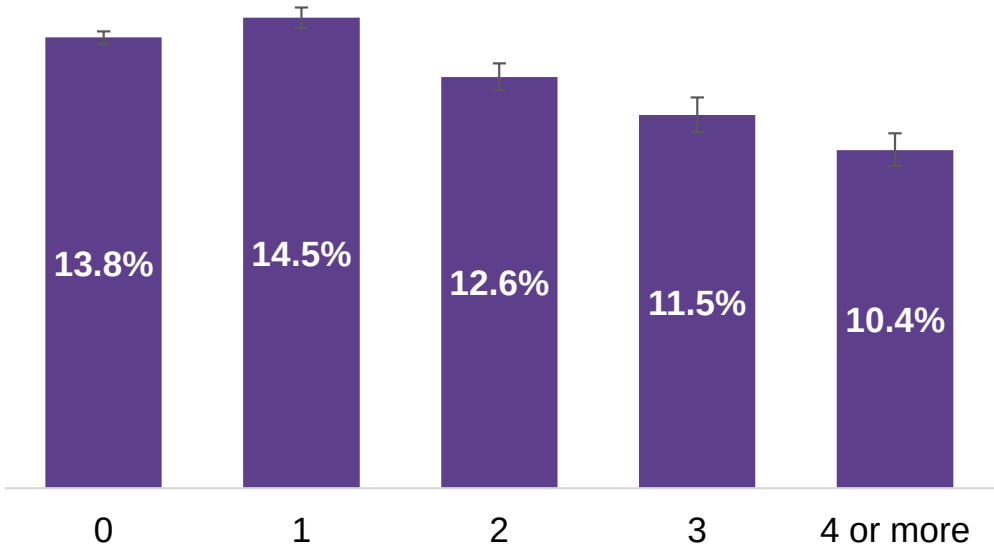
Carers and health – lifestyles and behaviour (1)

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

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

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

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



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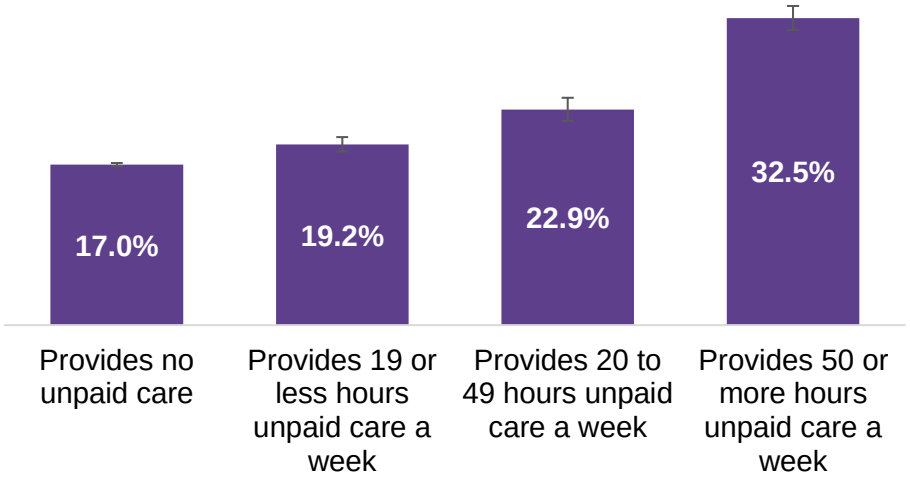
Carers and health – health outcomes (2)

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



Carers and health – use of services

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

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

Carers and health – local case studies

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

Carers and health – best practice

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

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

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

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

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

10. Maternity and health in Harrow

LONDON BOROUGH OF HARROW

Maternity and health - definitions

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

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

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

Maternity and health - numbers

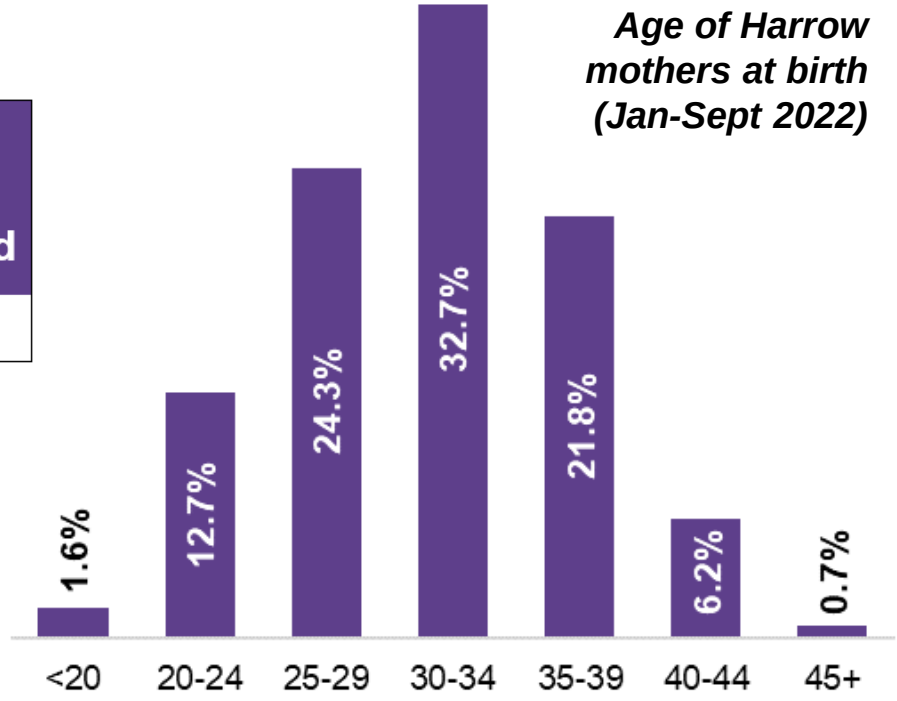
In 2020/21 there were 3,160 babies delivered to Harrow mothers. 10 of these babies were born to under 18s, 32 babies in twin or other multiple births, and 50% were born to mothers from BAME groups.

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

Population under 2 years old (2021 Census)

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

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



Maternity and health – wider determinants (1)

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

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

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

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

Maternity and health – wider determinants (2)

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

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

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

Maternity and health – lifestyles and behaviour

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

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

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

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

Maternity and health – health outcomes (1)

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

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

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

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

Maternity and health – health outcomes (2)

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

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

Maternity and health – use of services

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

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

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

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

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

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

Maternity and health – local case studies

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

Other support and services available to new parents include:

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

Locally, the following organisations are also available:

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

Maternity and health – best practice

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

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

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

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

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

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

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

11. Homeless health in Harrow

LONDON BOROUGH OF HARROW

Homeless health - definitions

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

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

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

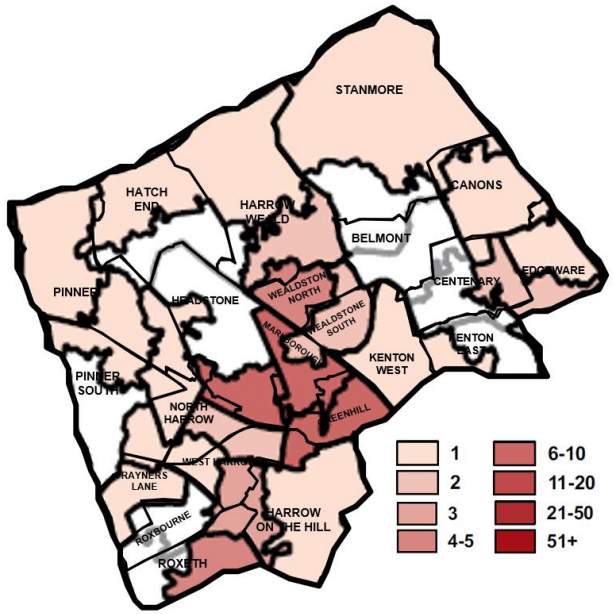
Rough sleepers are defined as people bedded in the open air (including tents, doorways, or encampments), or in buildings or other places not designed for habitation (e.g. stairwells, sheds, cars, derelict boats or stations).

Homeless health - numbers

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

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

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



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

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

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

Please click images to expand

Homeless health – wider determinants

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

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

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

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

Homeless health – lifestyles and behaviour

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

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

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

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

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

Homeless health – health outcomes (1)

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

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

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

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

Homeless health – health outcomes (2)

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

Homeless health – use of services

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

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

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

Homeless health – local case studies

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

Homeless health – best practice

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

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

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

Annual Director of Public Health Report 2022/23:
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12. Migrant health in Harrow

LONDON BOROUGH OF HARROW

Migrant health - definitions

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

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

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

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

Migrant health – numbers (1)

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

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

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

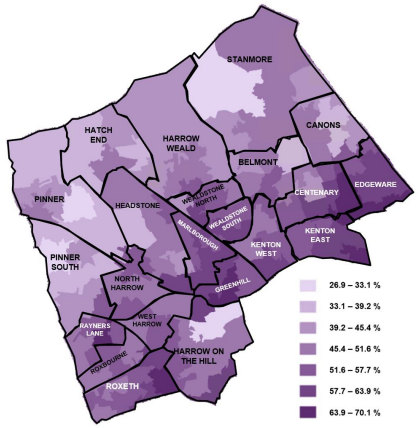
	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
UK	127,612	48.9%	50.1%	59.4%	82.6%
Rest of Europe	41,677	15.9%	17.1%	15.5%	7.2%
Africa	26,748	10.2%	7.6%	7.1%	2.8%
Asia / Middle East	59,517	22.8%	20.4%	13.0%	5.7%
Americas / Caribbean	4,985	1.9%	4.0%	4.2%	1.4%
Australia,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

Migrant health – numbers (2)

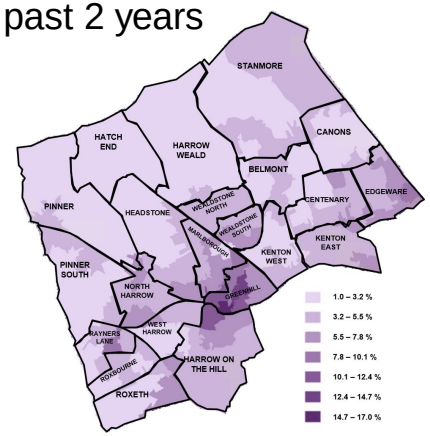
Nationally, and in Harrow, asylum seekers make up a small percentage of immigrants. During 2022/23, a total of 670 immigrants received support from Harrow. This includes 255 under Homes for Ukraine, 89 under Afghan Resettlement Programme, and 326 Supported Asylum.

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

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



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



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

Please click images to expand

Migrant health – wider determinants

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

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

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

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

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

Migrant health – lifestyles and behaviour

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

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

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

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

Migrant health – health outcomes (1)

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

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

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

Migrant health – health outcomes (2)

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

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

Migrant health – use of services

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

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

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

Migrant health – local case studies

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

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

Migrant health – best practice

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

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

There is specific guidance for language services.

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

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

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13. Veterans health in Harrow

LONDON BOROUGH OF HARROW

Veterans health - definitions

Veterans are former UK Armed Forces personnel.

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

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

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

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

Veterans health - numbers

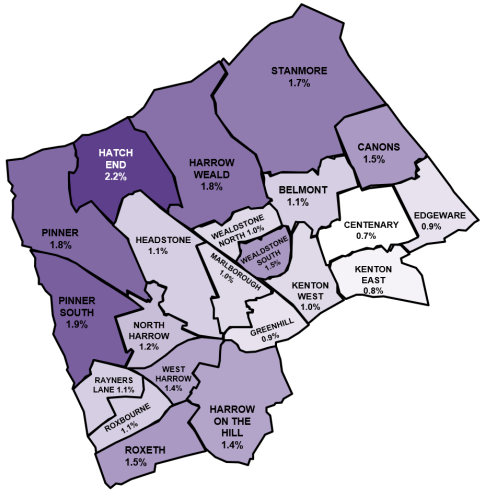
There are generally more veterans in areas of the country with larger active military populations. Both Northwood Headquarters and RAF Northolt are close to Harrow. In the borough itself, there is one reserve unit (131 Commando Squadron), and several active cadet units.

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

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

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

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



Please click images to expand

Veterans health – wider determinants

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

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

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

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

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

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

Veterans health – lifestyles and behaviour

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

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

Veterans health – health outcomes

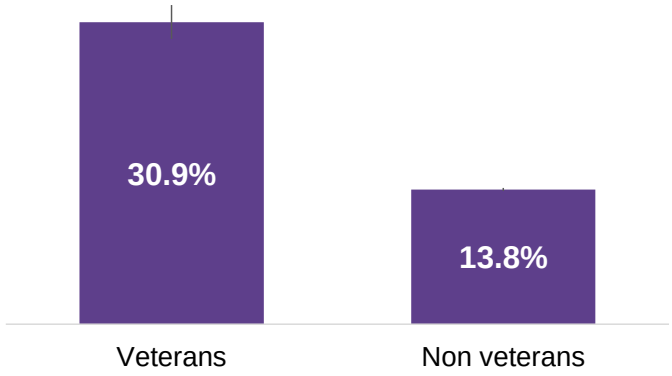
There is limited reliable evidence of the long-term physical effect of military service. MOD reviews of veterans suggest personnel are likely to suffer the same range of health and welfare issues as the general population – this includes depression, back problems, arms, legs, feet, and sight problems,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

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

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

Please click images to expand

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



Veterans health – use of services

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

Veterans health – case studies

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

Veterans health – best practice

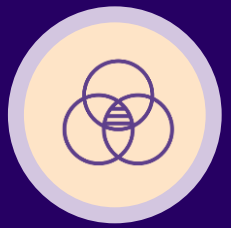
The MOD's 2018 Strategy for our Veterans sets out the current context for delivery of public services. The aim is that "those who have served in the UK Armed Forces and their families, transition smoothly back into civilian life and contribute fully to a society that understands and values what they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

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

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

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

14. Intersectional inequalities in Harrow



Intersectional health inequalities - definitions

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

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

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

Intersectional health inequalities - examples

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

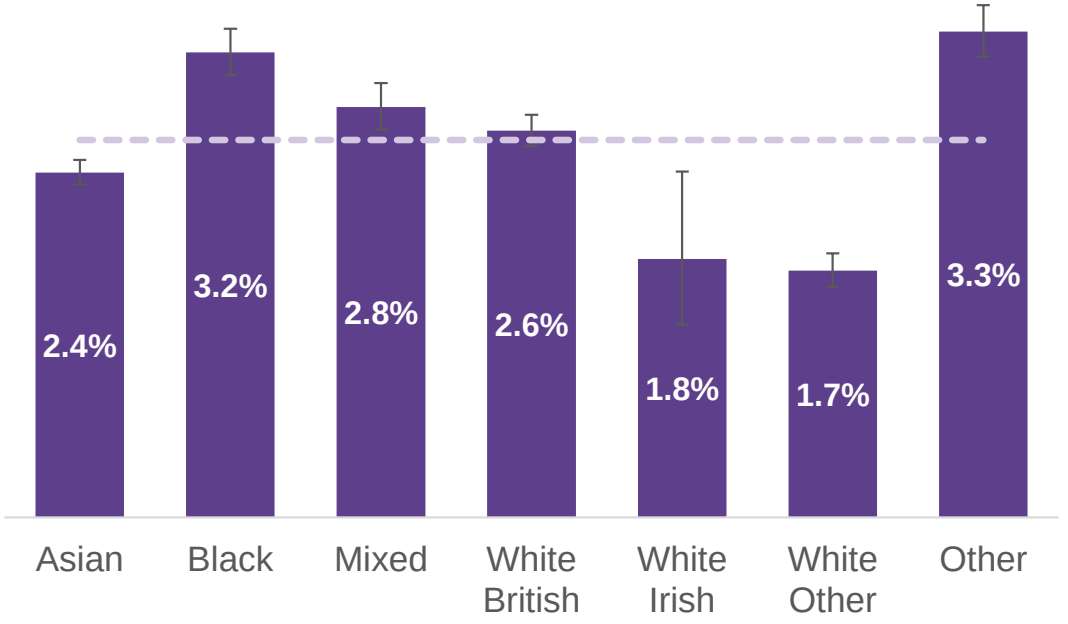
The graph shows the higher rate of self reported ill health in young black people (and other ethnicities) in North West London in the 2021 Census.

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

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

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

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



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

Definitions

LONDON BOROUGH OF HARROW

Definitions

Please click on the buttons to go to the definitions section of this report:

Poverty

Age

Sex

LGBTQ+

Ethnicity

Religion

Disability

Carers

Maternity

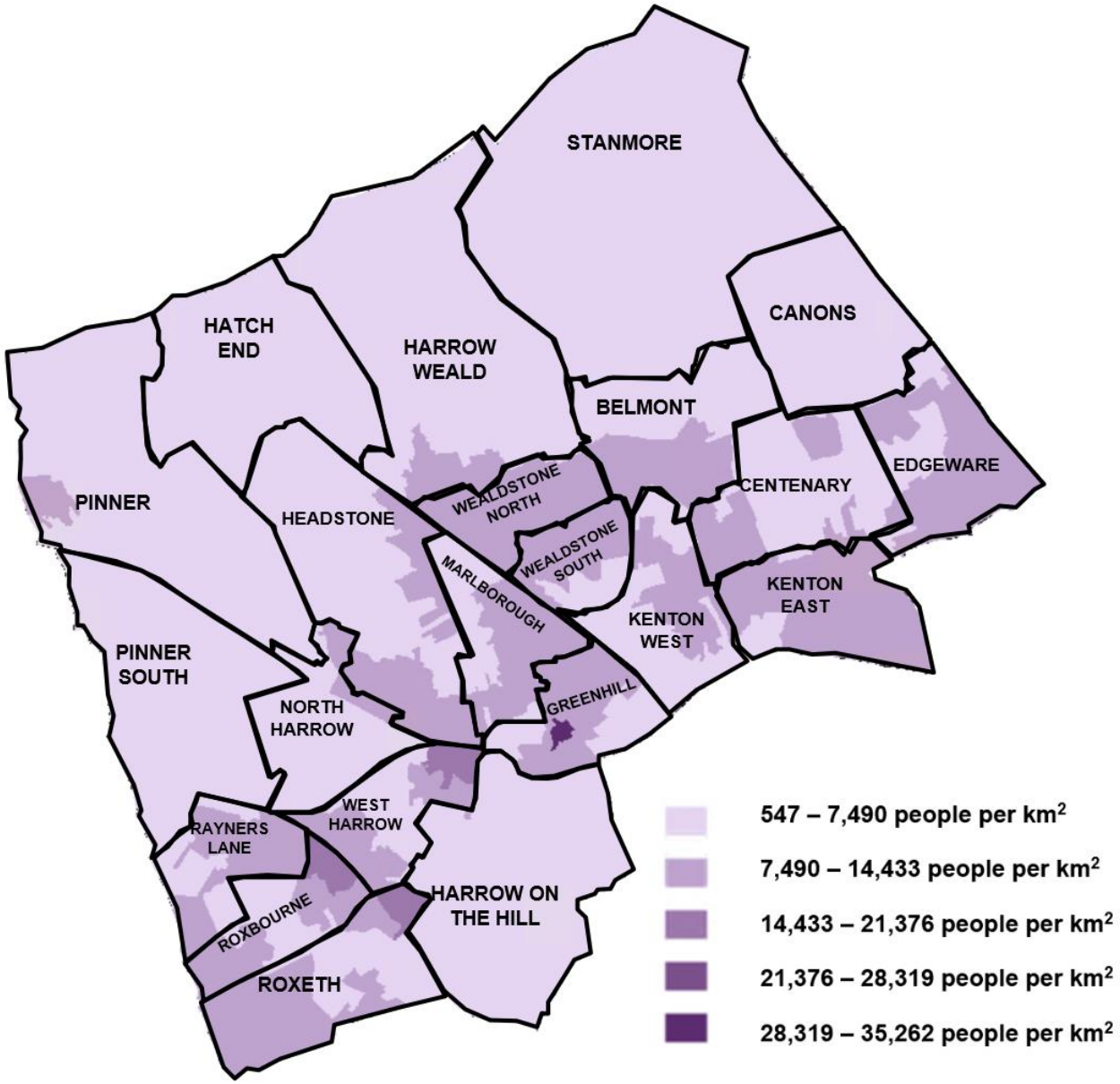
Homeless

Migrants

Veterans

Intersectional

Density of the Harrow population (Census 2021)



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

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

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

Data shown is from June 2022

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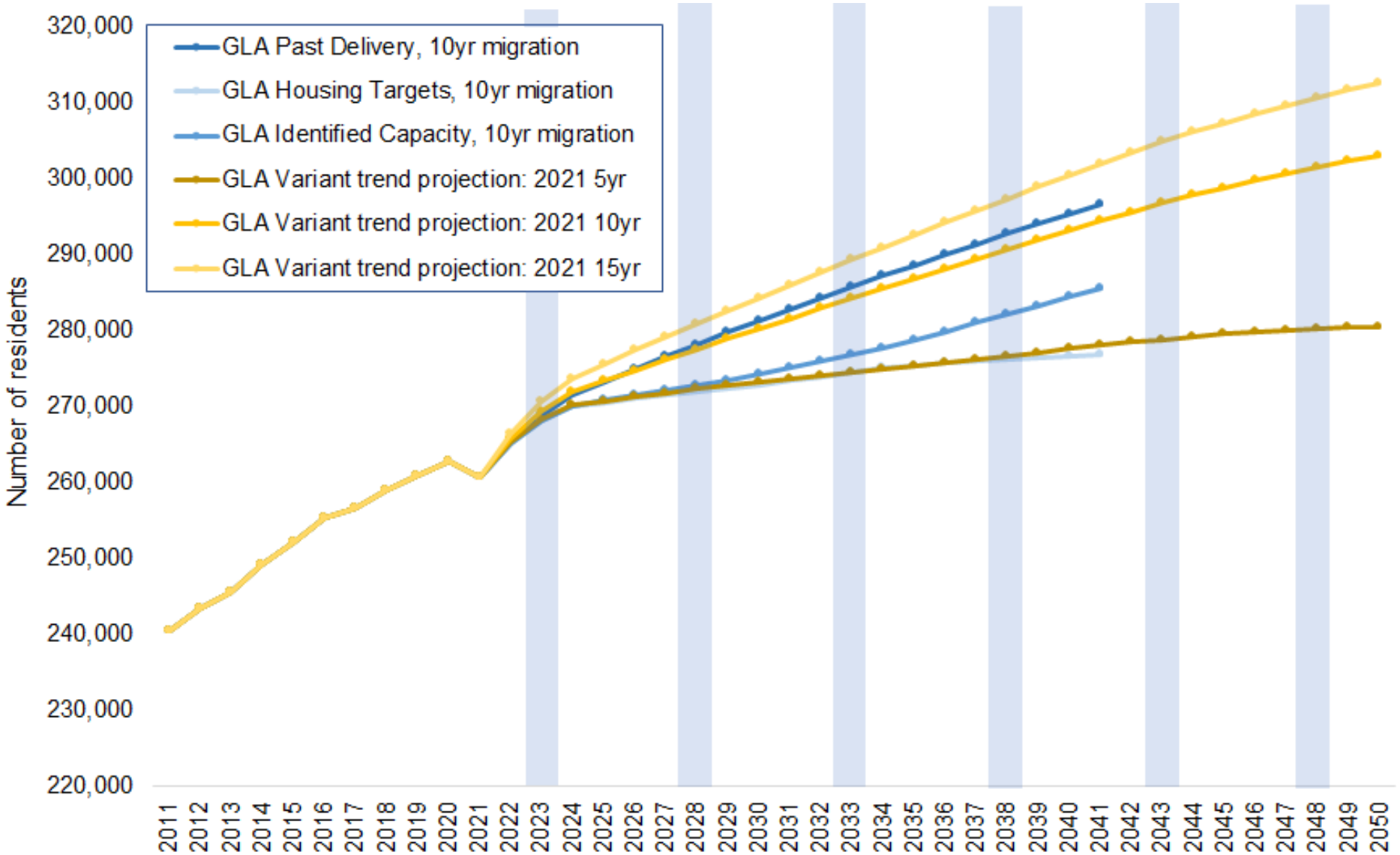
Population projections for Harrow showing possible future growth scenarios (GLA interim projections 2023)



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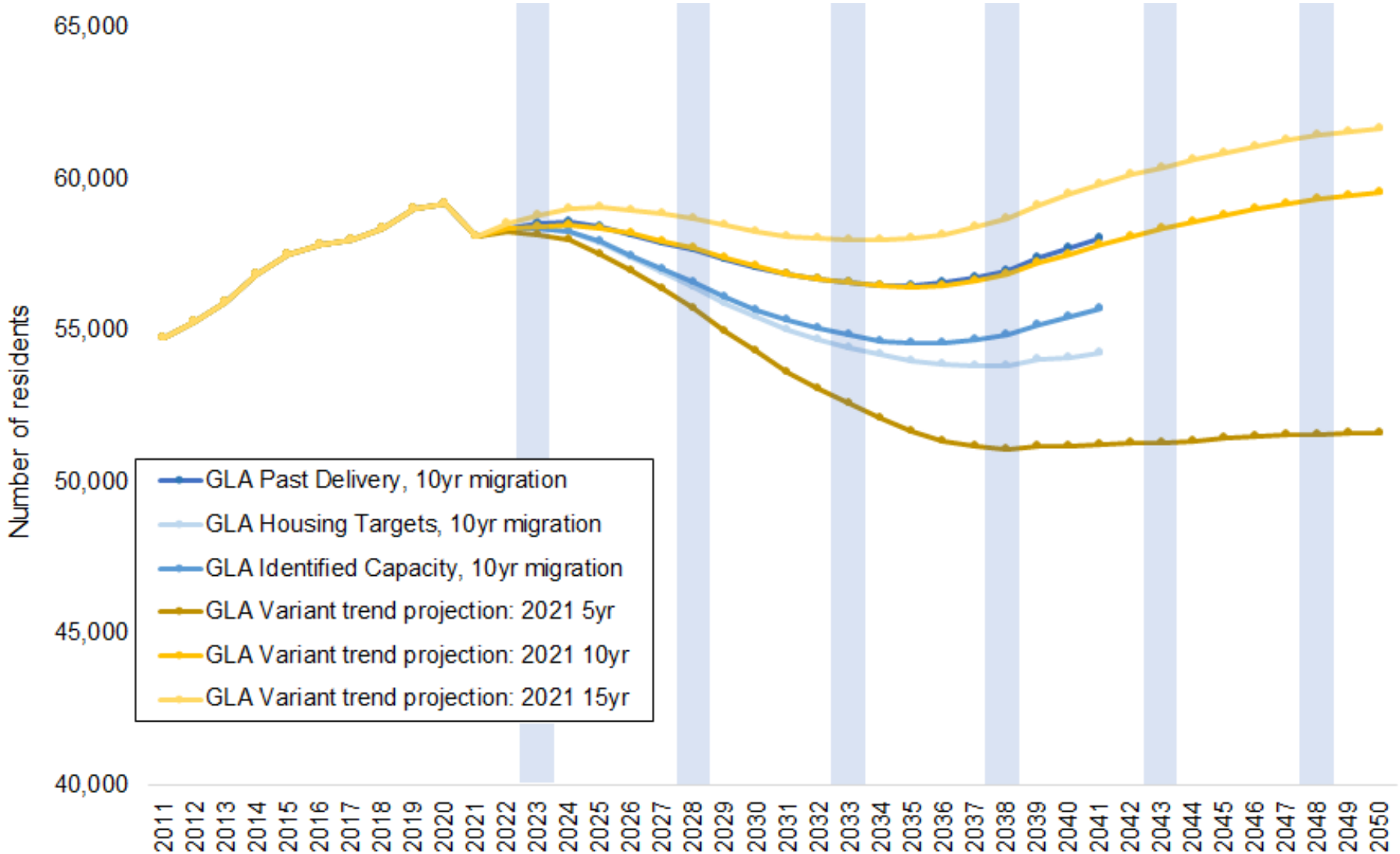
Population projections for under 18s in Harrow showing possible future growth scenarios (GLA interim projections 2023)



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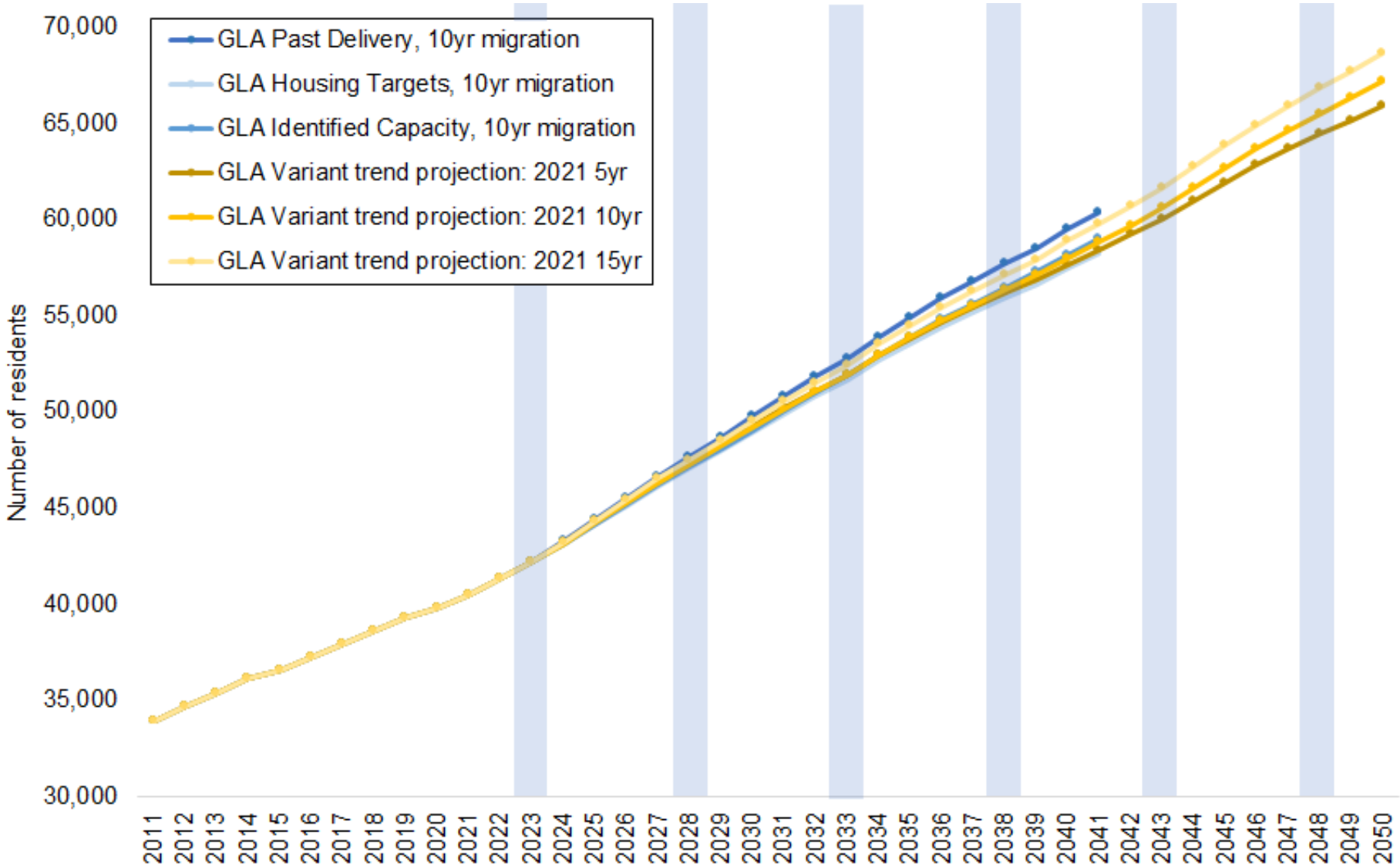
Population projections for 65+ people in Harrow showing possible future growth scenarios (GLA interim projections 2023)



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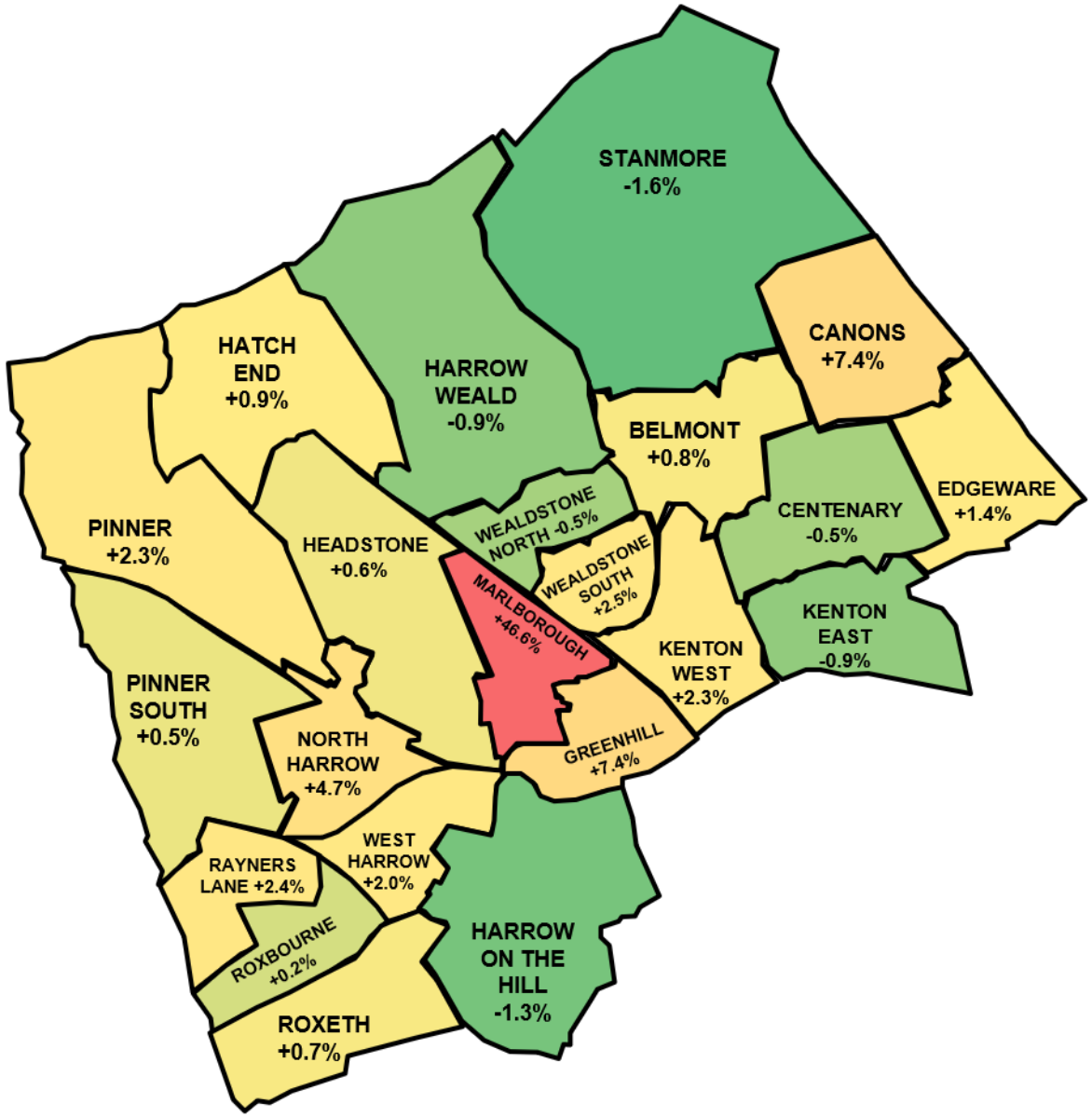
Population projections for Harrow by Ward, showing possible future growth from 2023 to 2033

(GLA Identified Capacity model; 10yr growth trend based)



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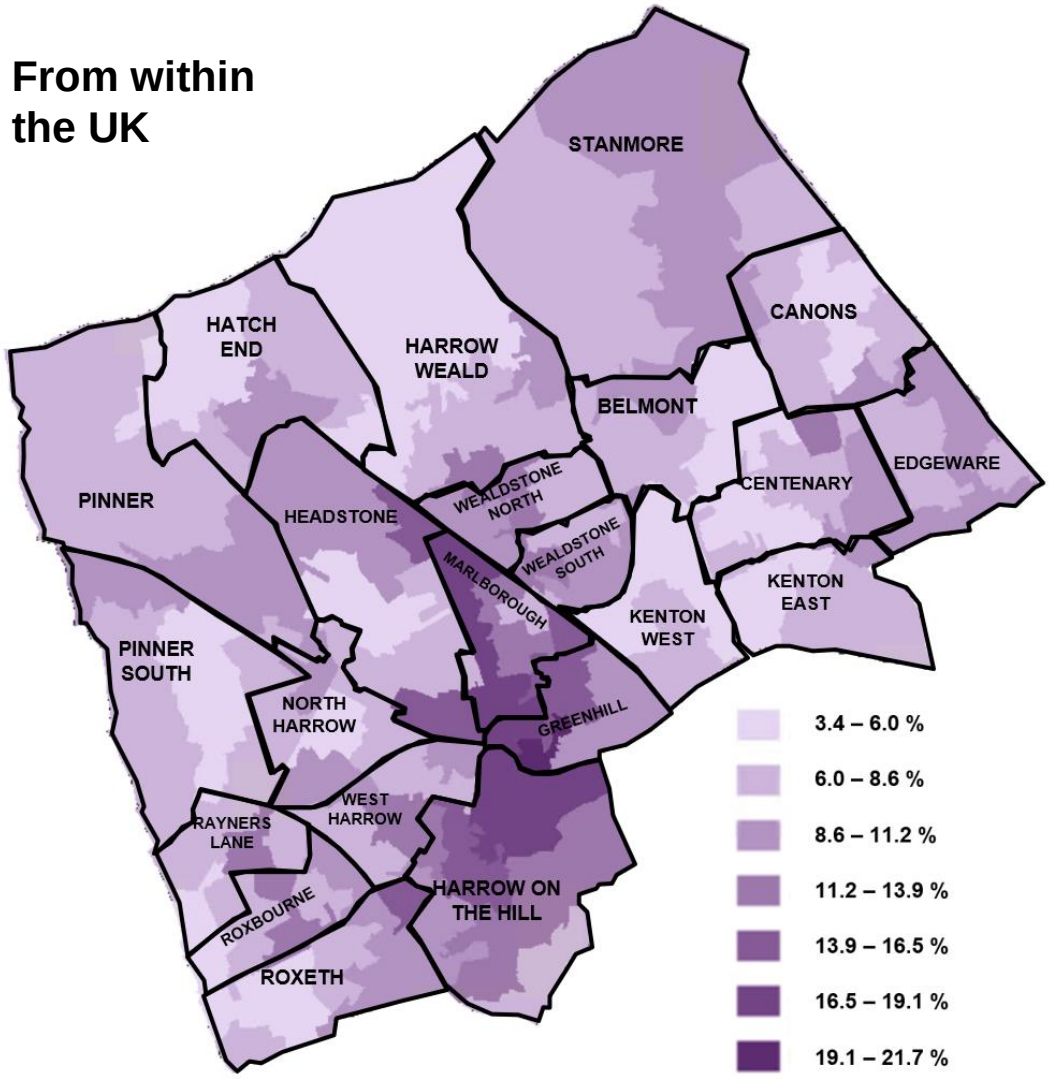
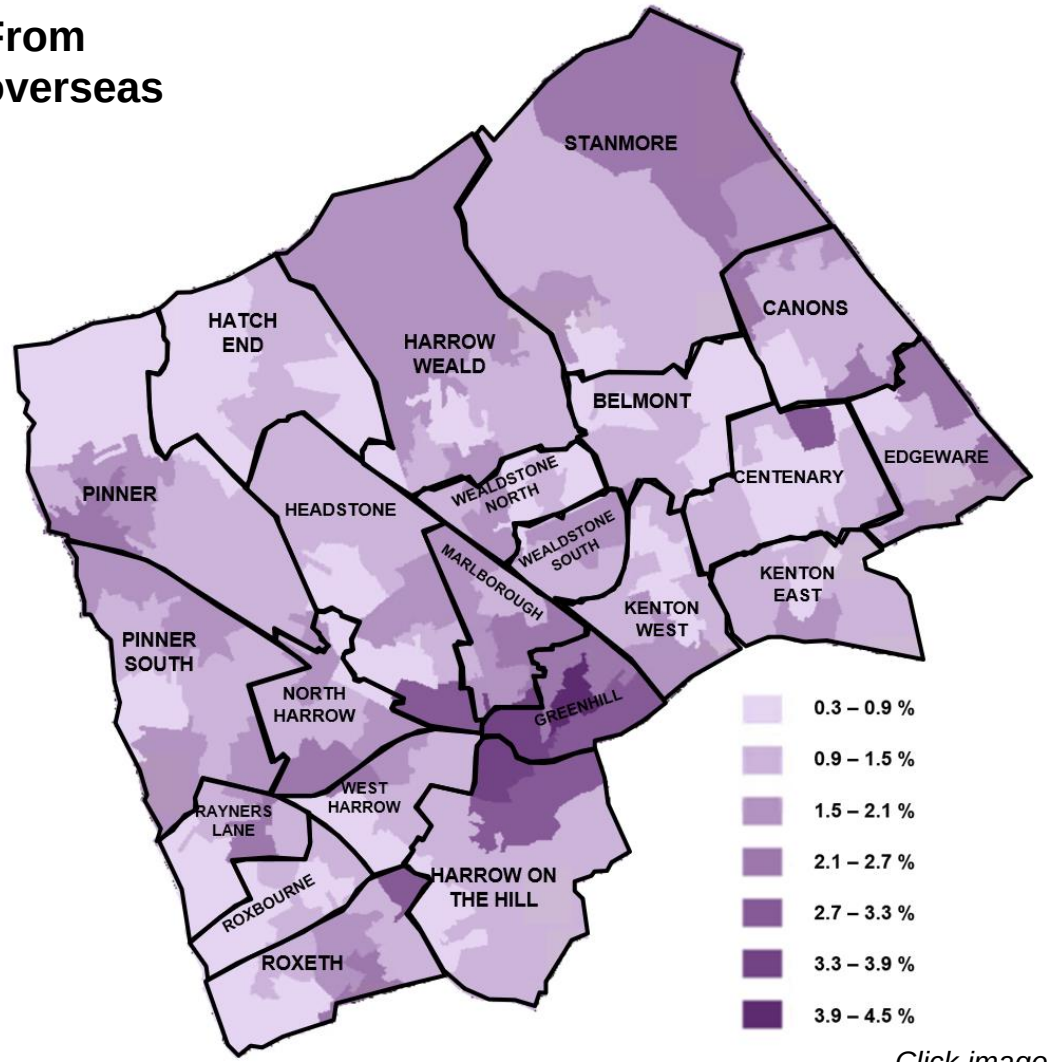
Percentage of Harrow residents who moved into the area during the past year (Census 2021)

From within the UK



From overseas



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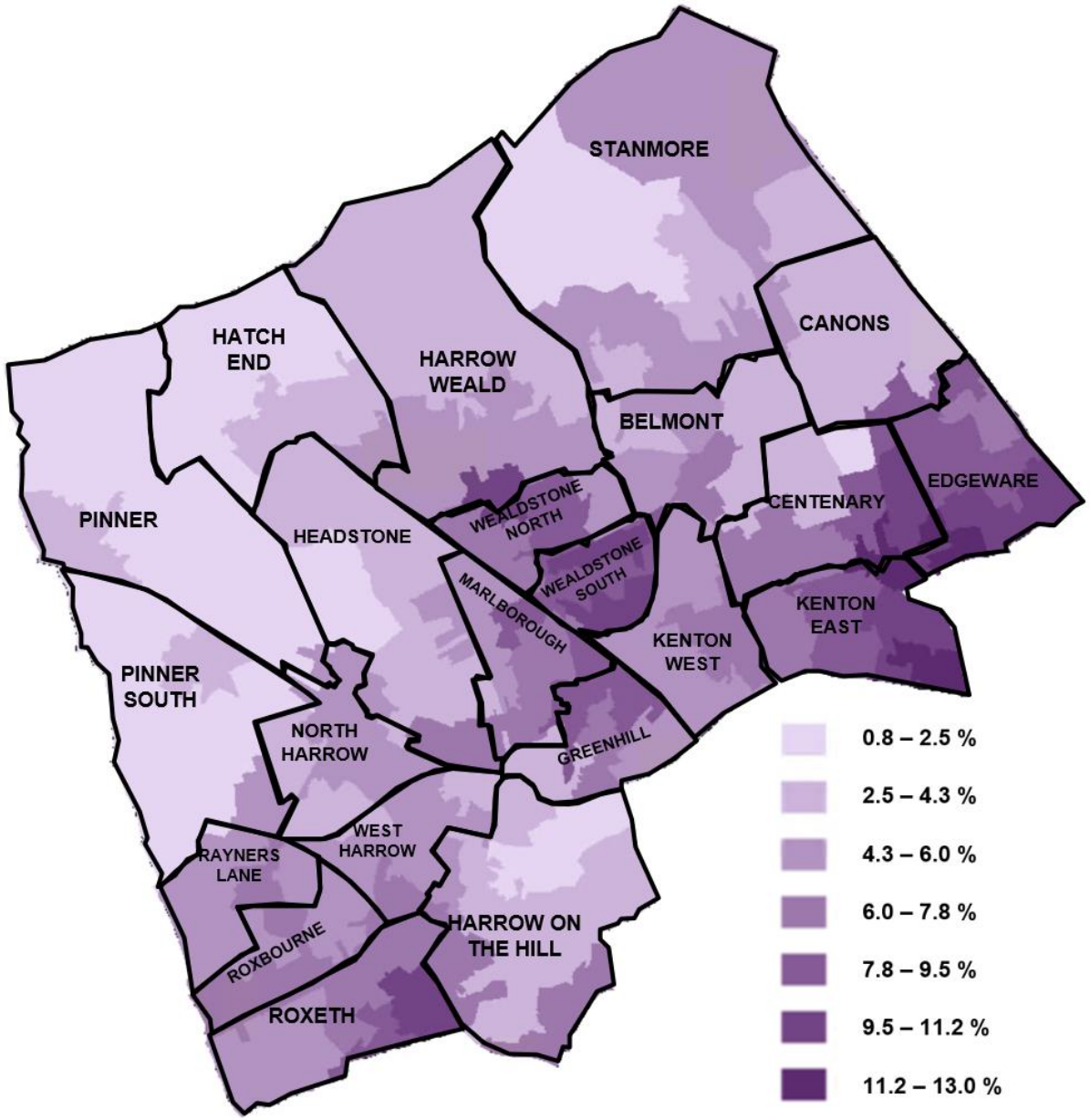
Percentage of Harrow residents who cannot speak English well, or at all (Census 2021)



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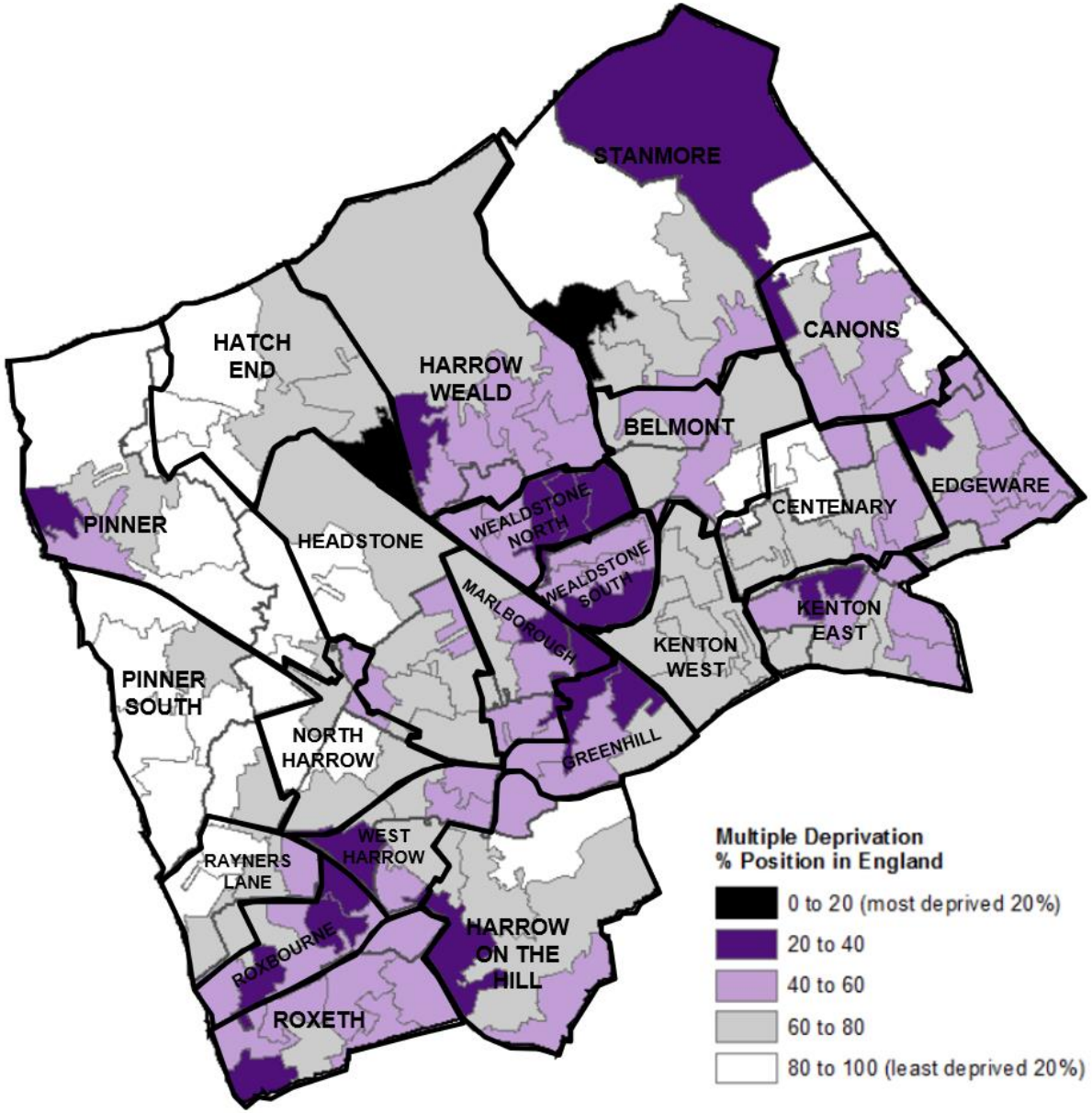
Socio-economic deprivation in Harrow (IMD 2019)



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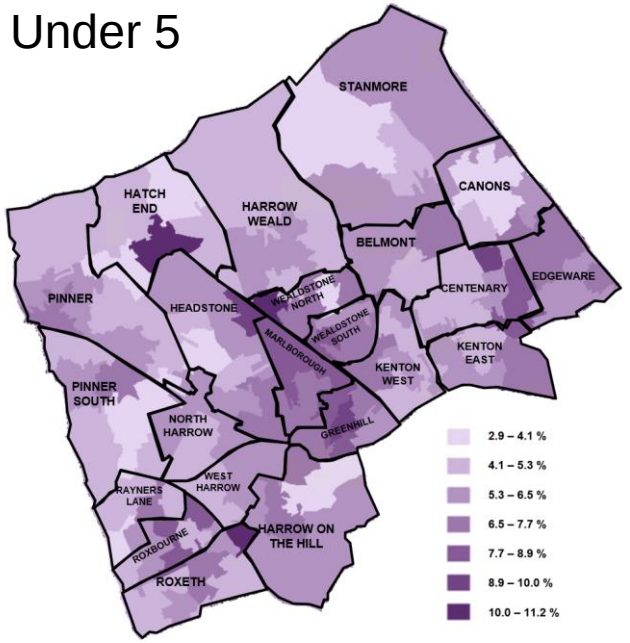
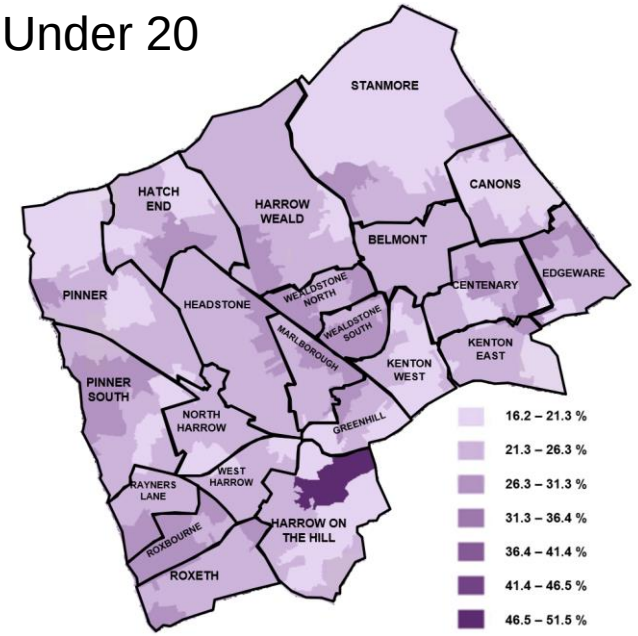
Age profile of the Harrow population (Census 2021)

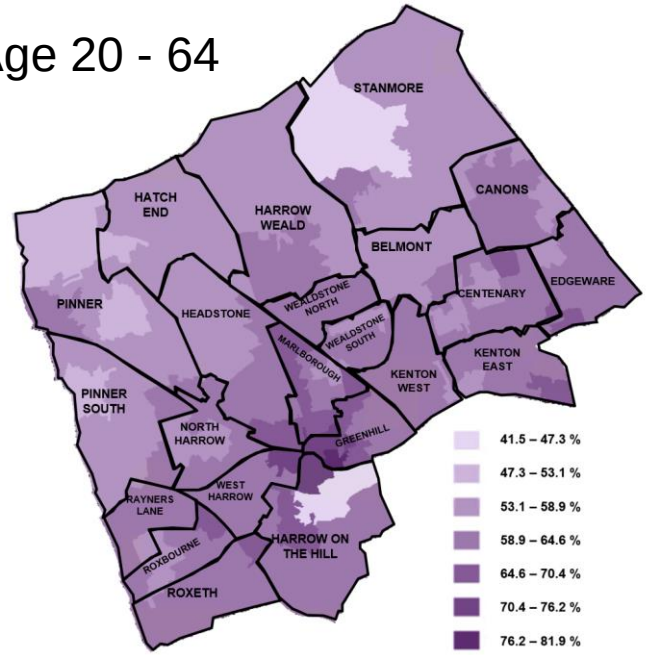
Under 5



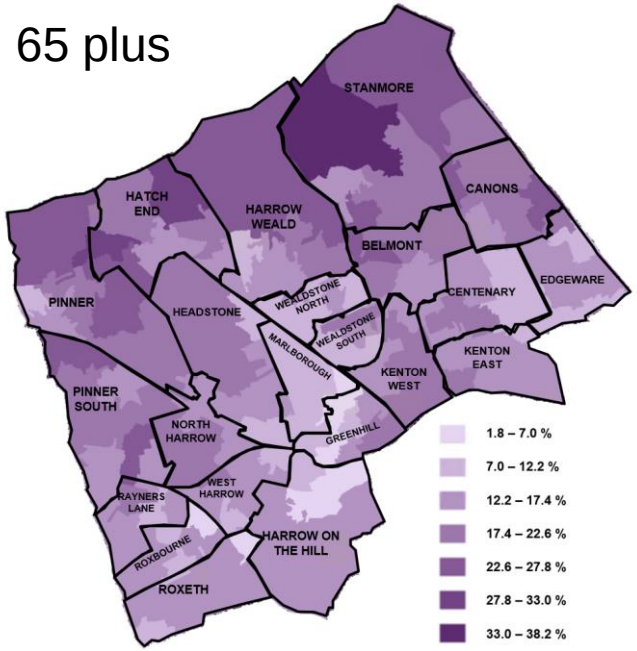
Under 20



Age 20 - 64



65 plus



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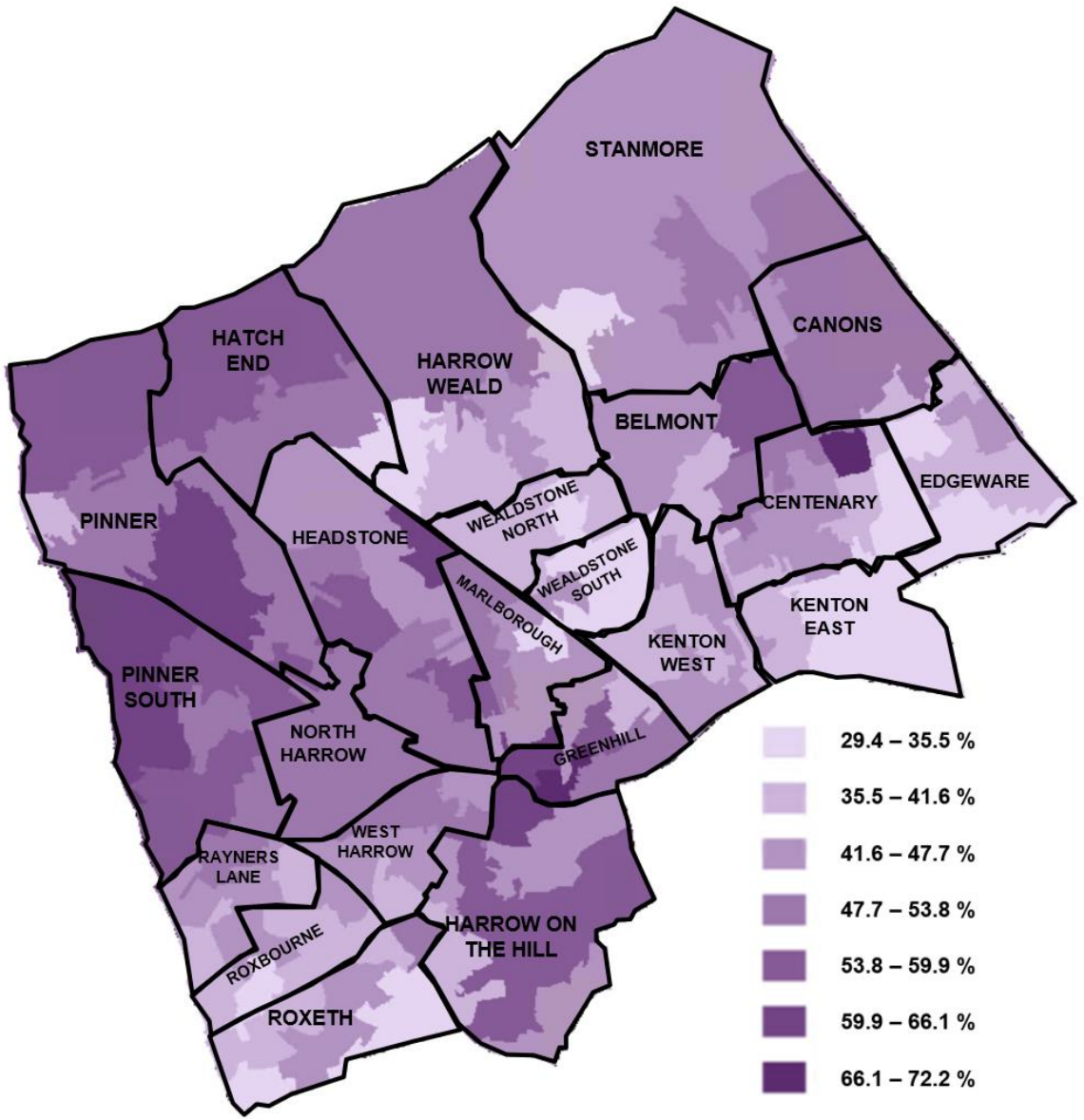
Percentage of the Harrow population who have a degree level qualification or higher (Census 2021)



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

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

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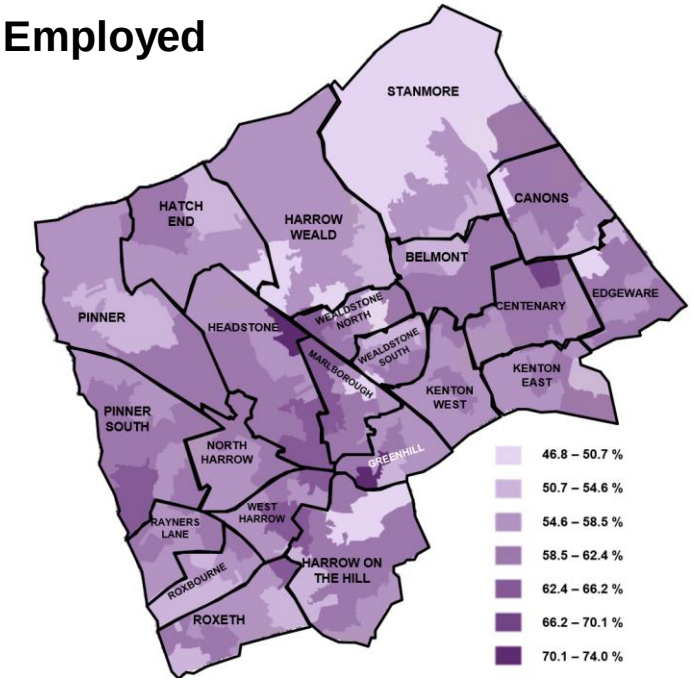
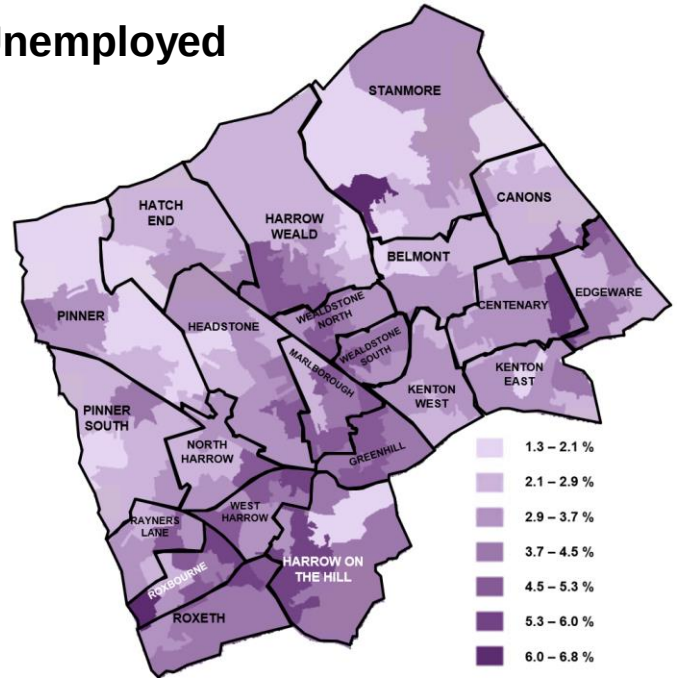
Employment profile of the Harrow population (Census 2021)

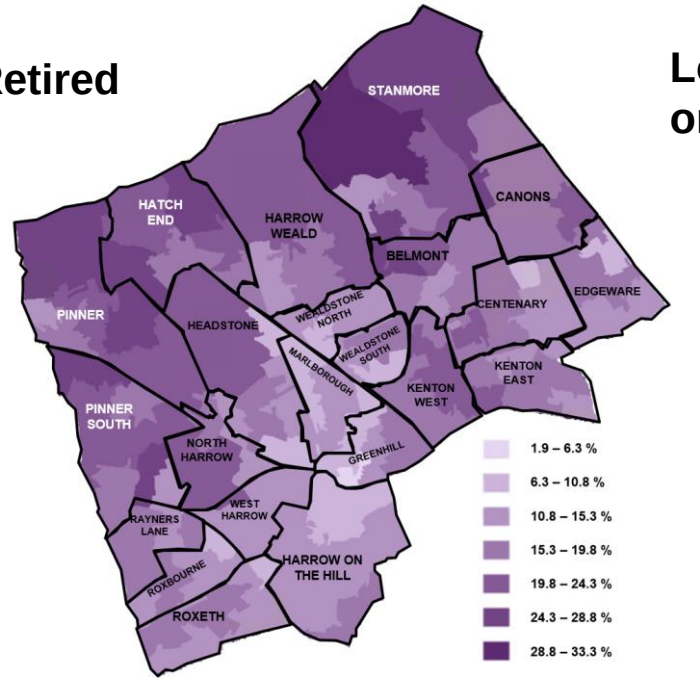
Employed



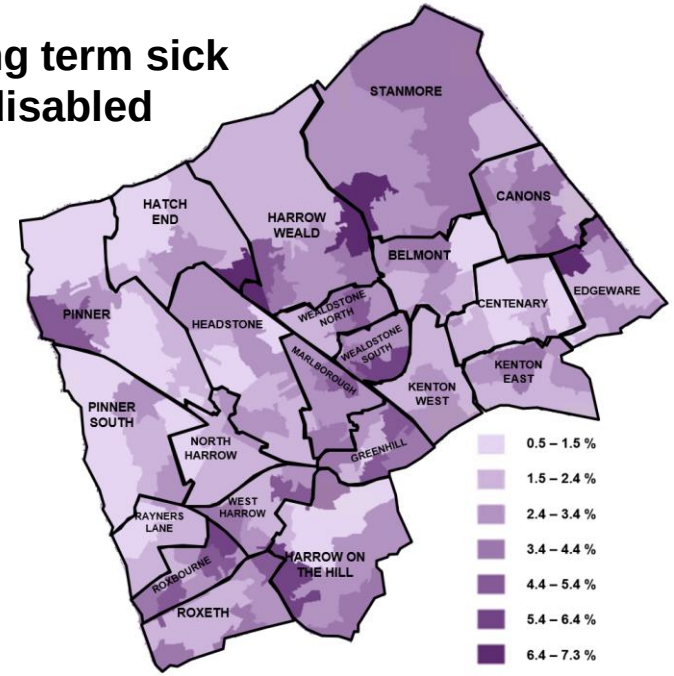
Unemployed



Retired



Long term sick or disabled



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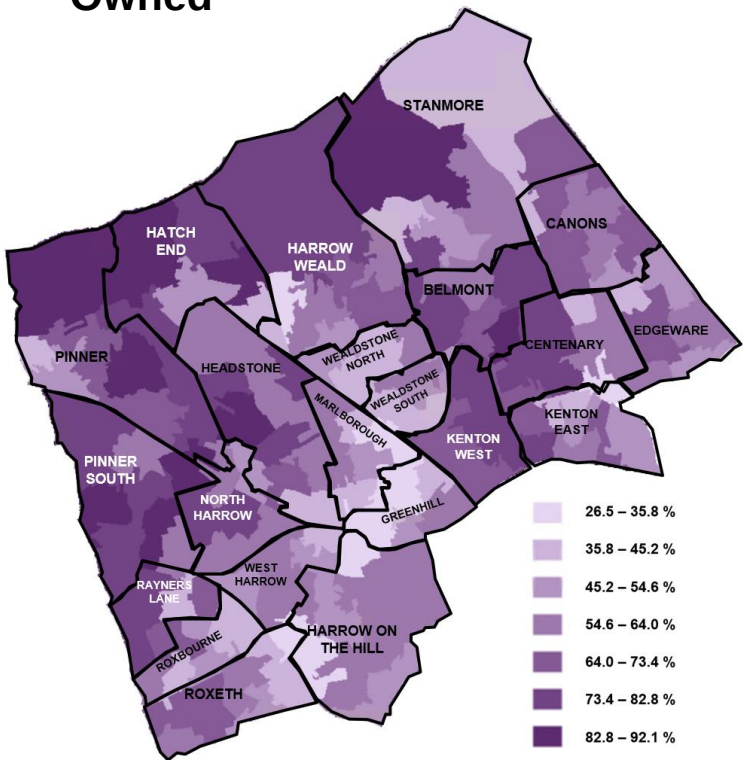
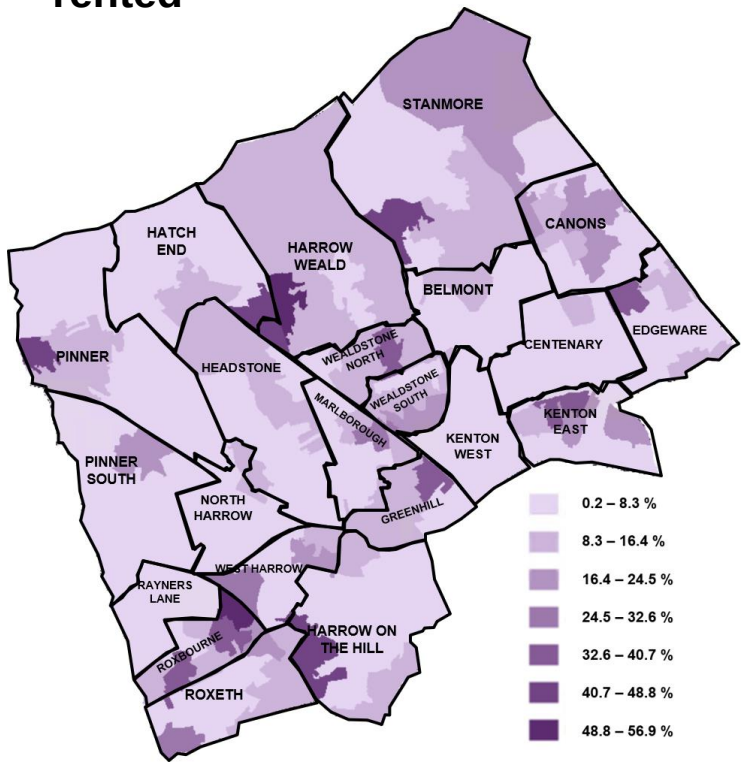
Housing tenure of the Harrow population (Census 2021)

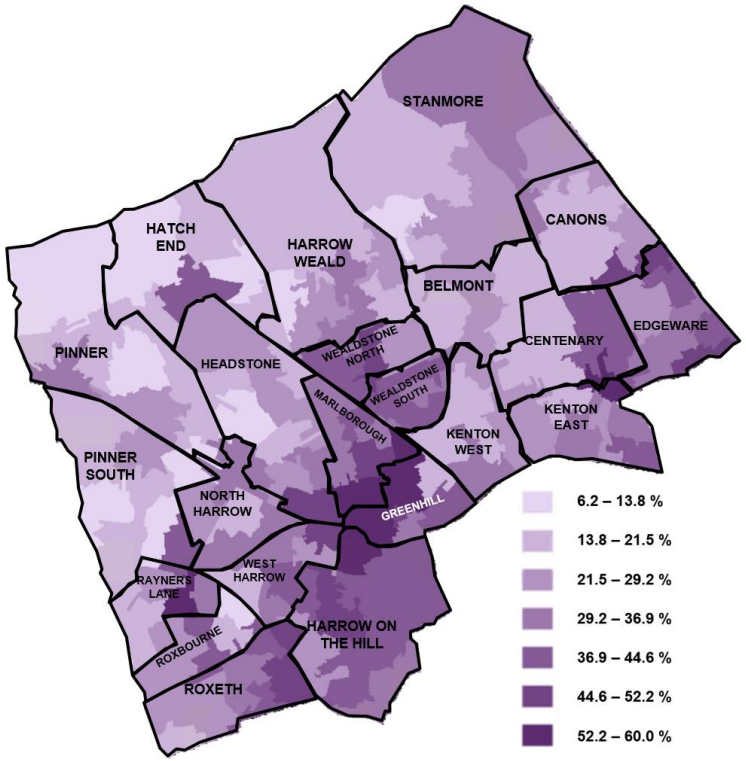
Owned



Socially rented



Private rented



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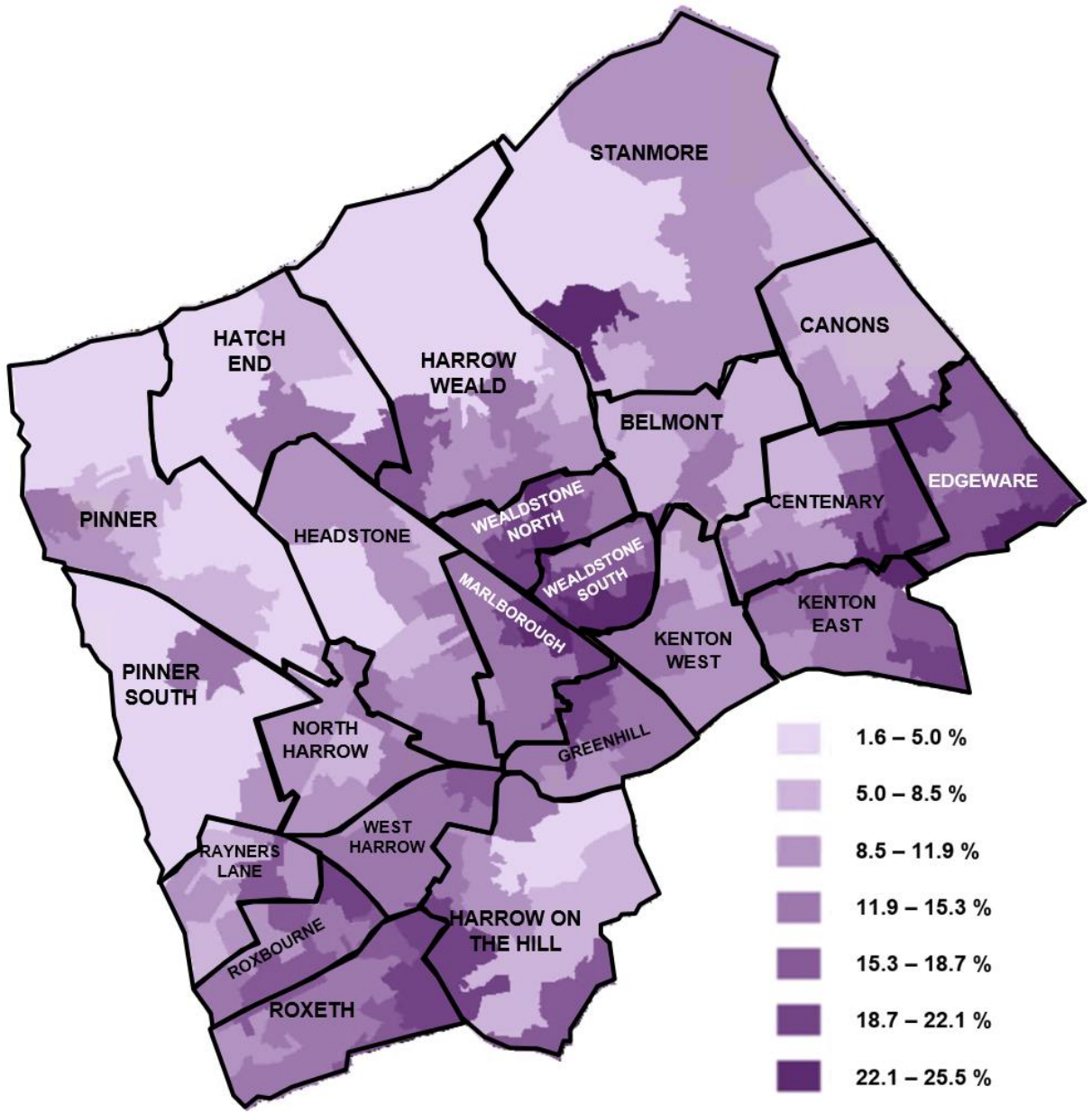
Overcrowded housing in Harrow (Census 2021)



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Ethnicity of the Harrow population (Census 2021)

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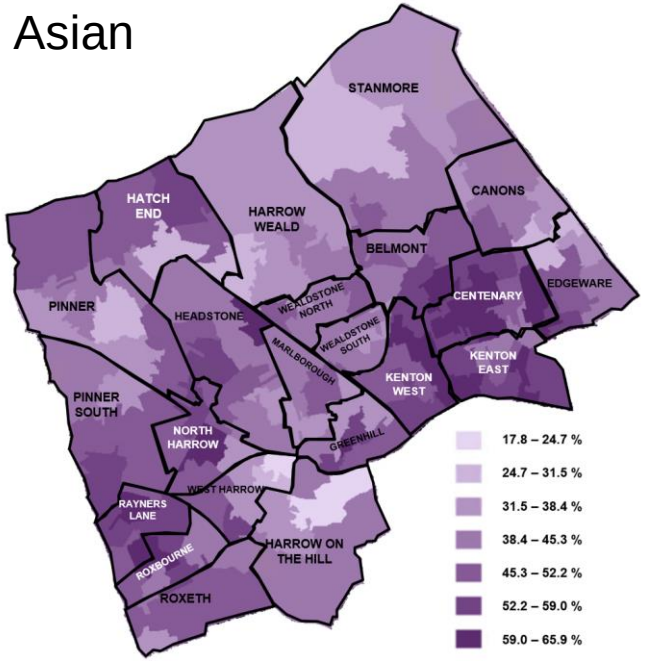
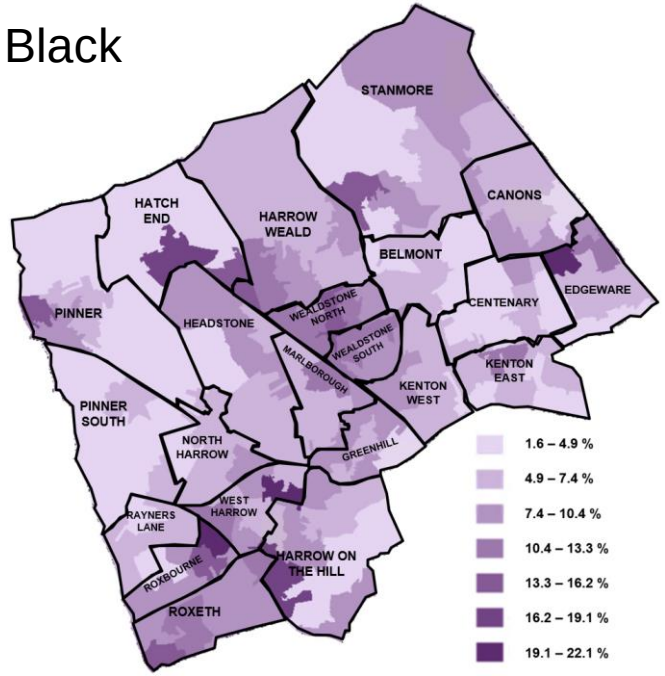
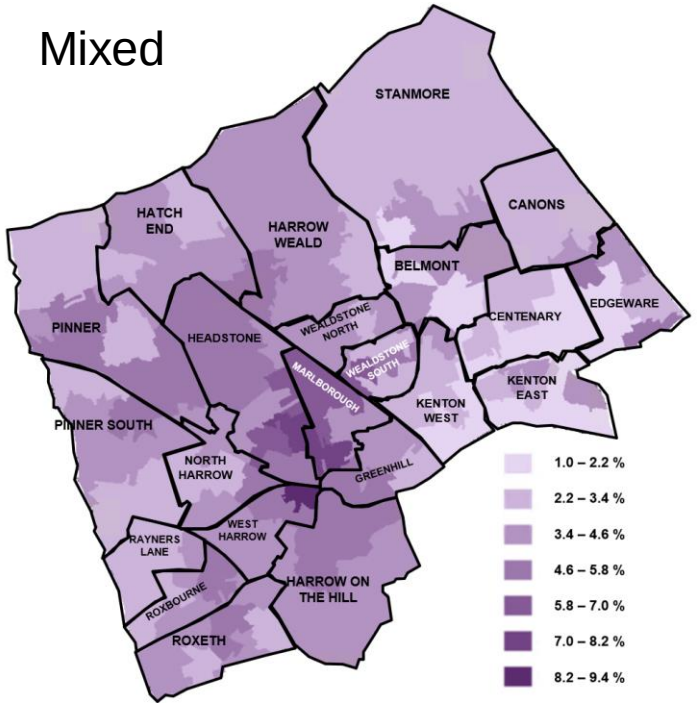
Asian



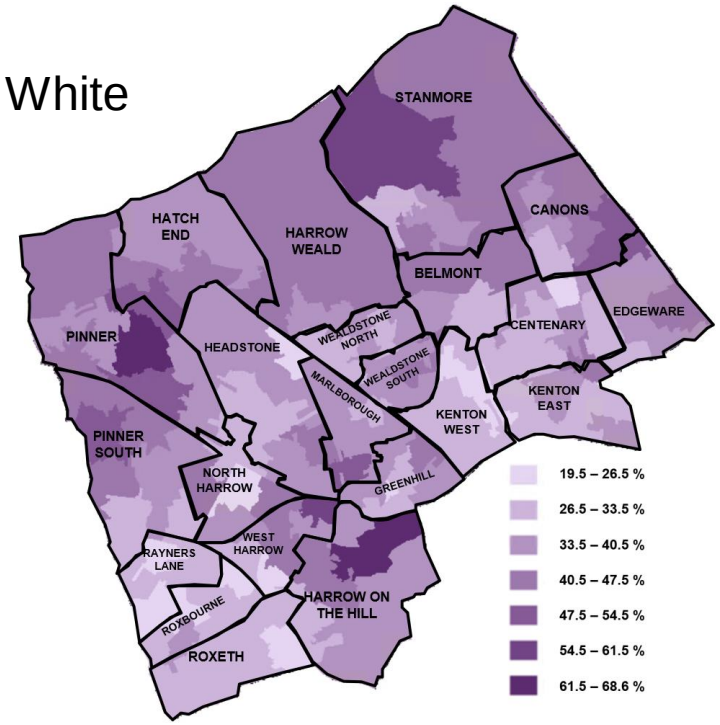
Black



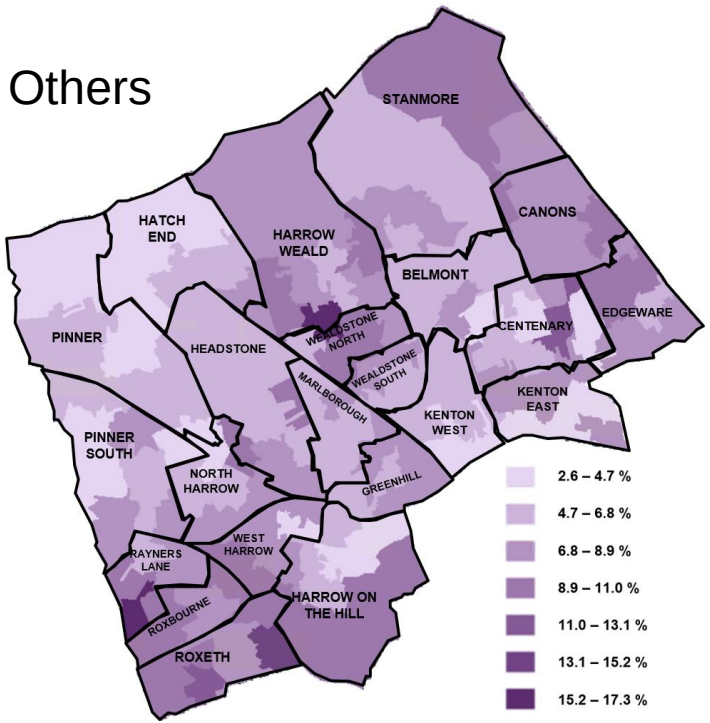
Mixed



White



Others



Religions of the Harrow population (Census 2021)

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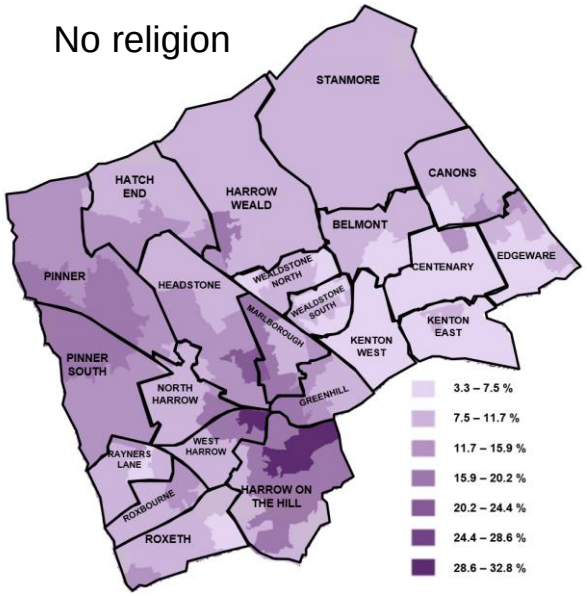
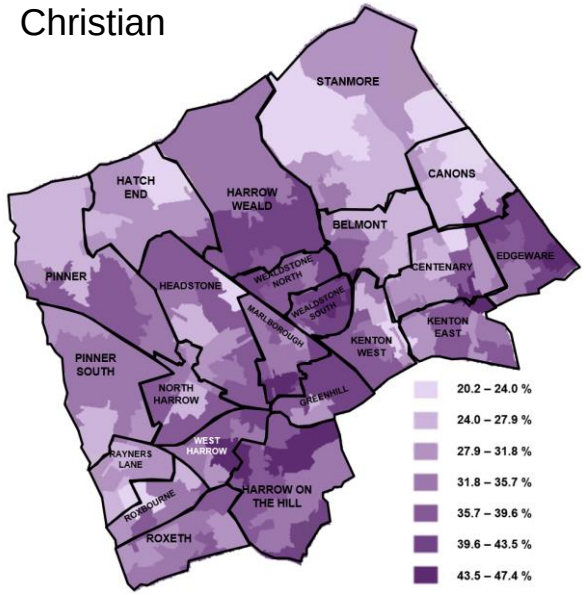
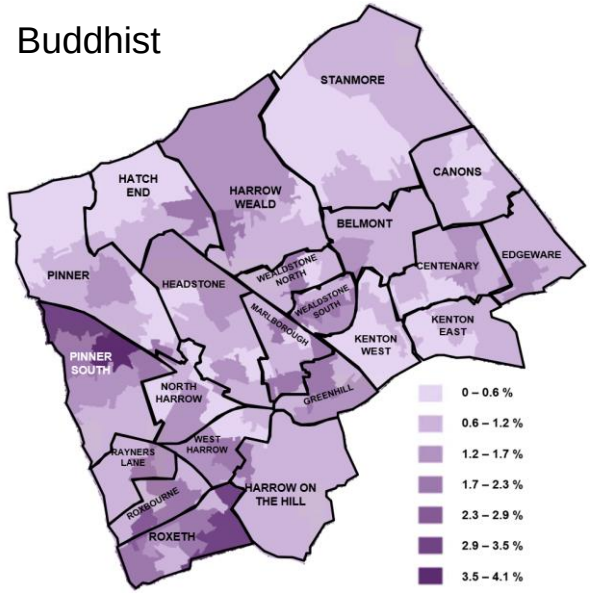
No religion



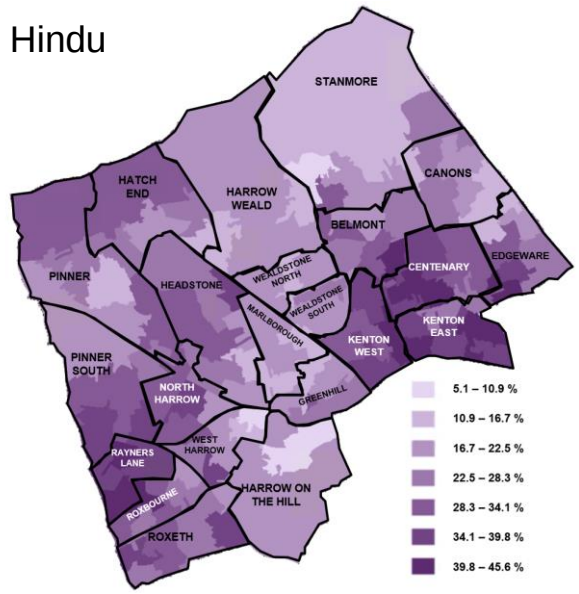
Christian



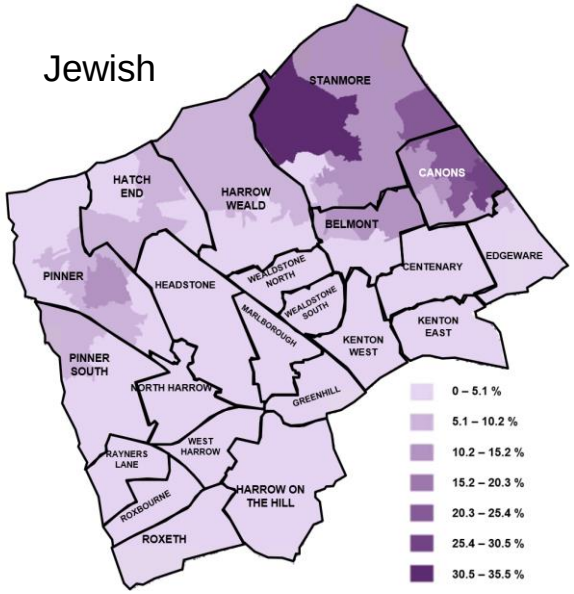
Buddhist



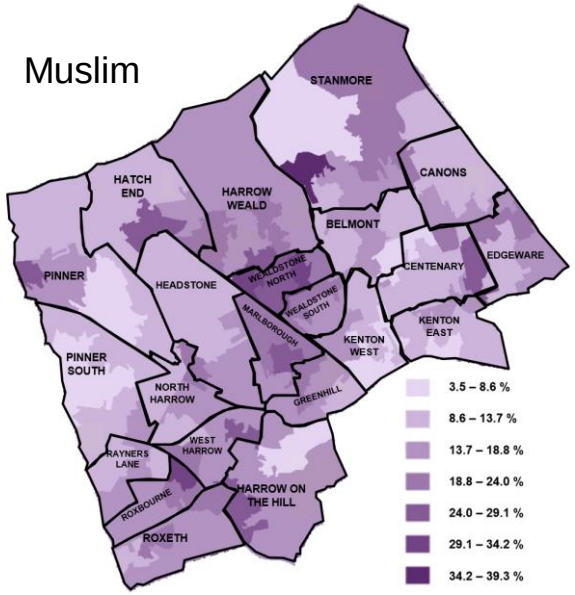
Hindu



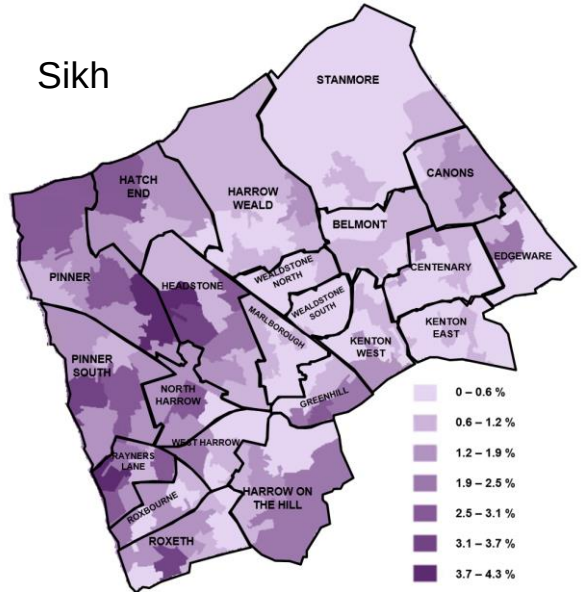
Jewish



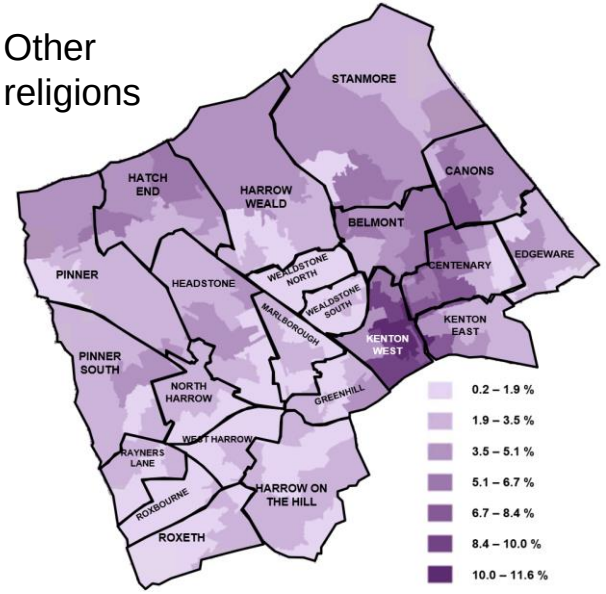
Muslim



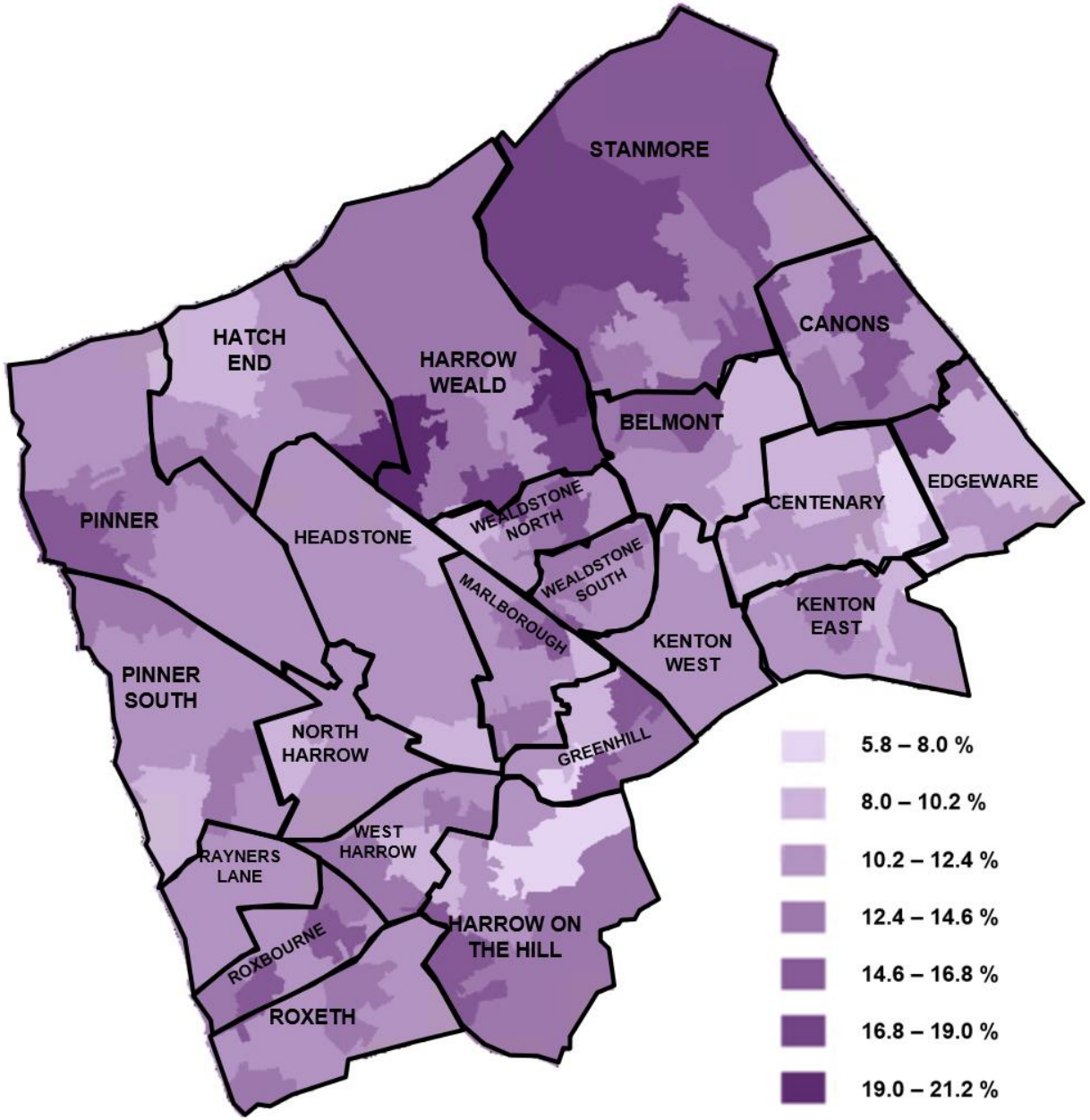
Sikh



Other religions



Percentage of Harrow population with a health condition which limits day to day activities (Census 2021)



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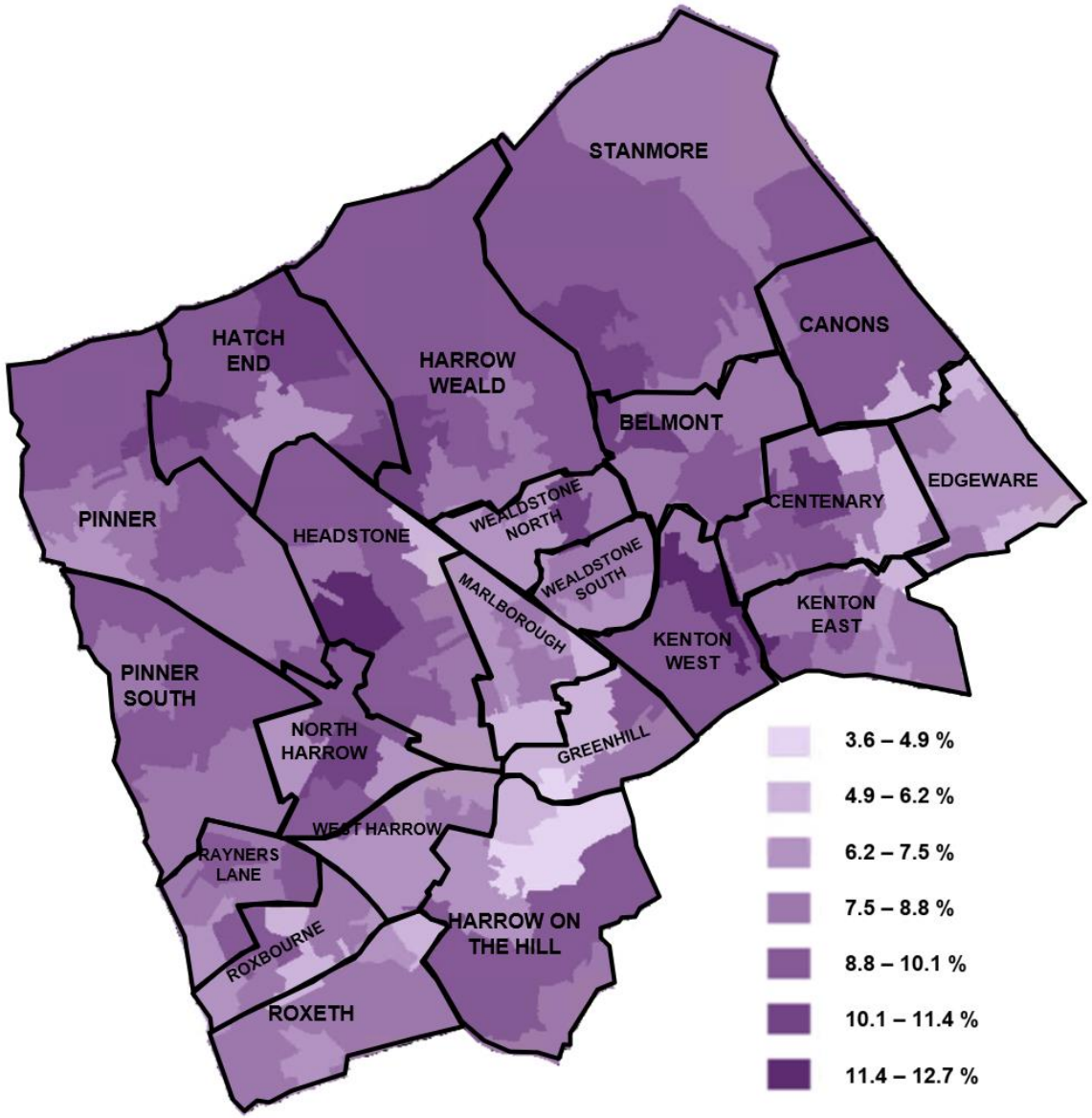
Percentage of the Harrow population who provide any unpaid care (Census 2021)



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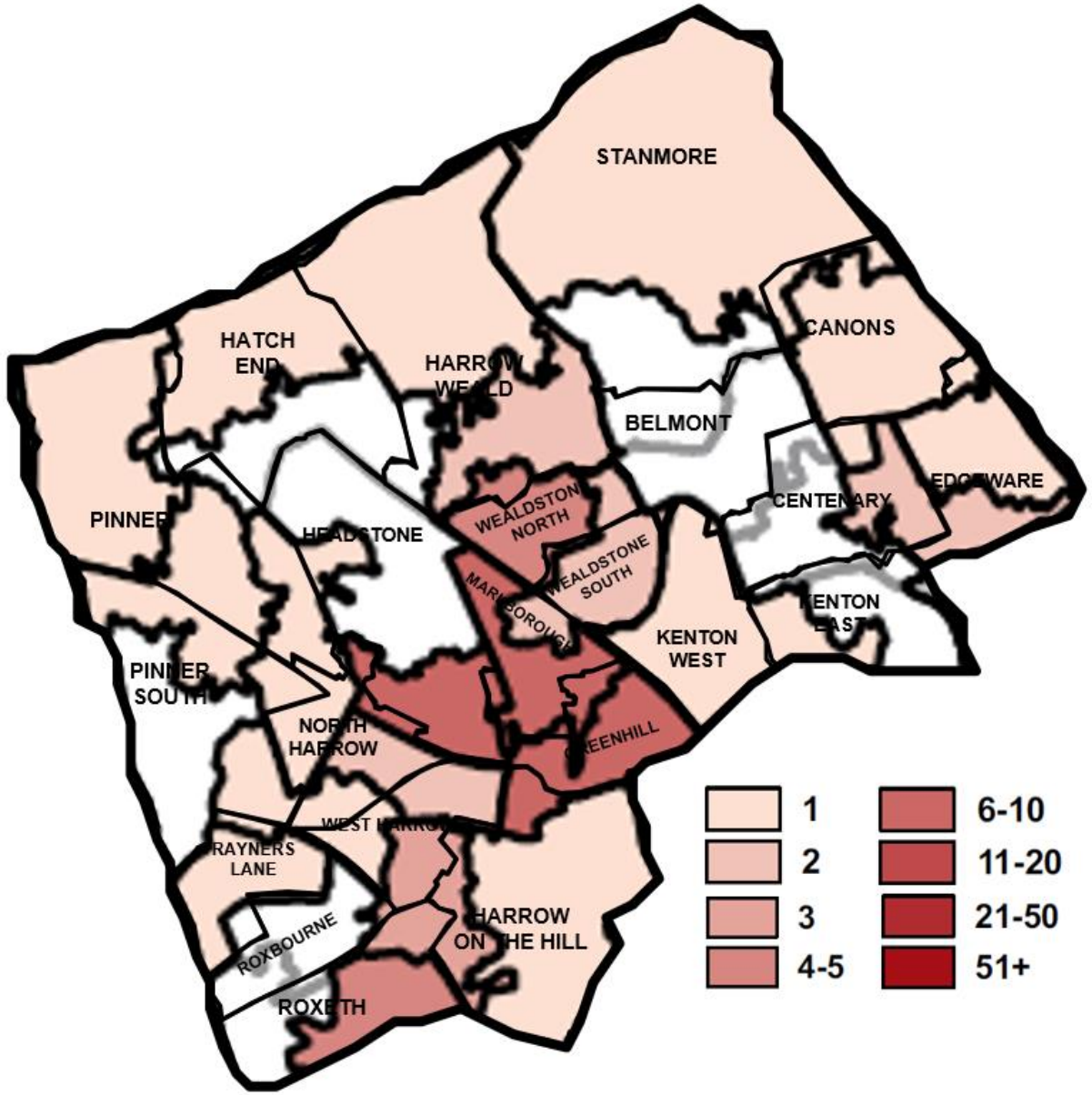
Area in Harrow where rough sleepers seen during 2021/22 (CHAIN)



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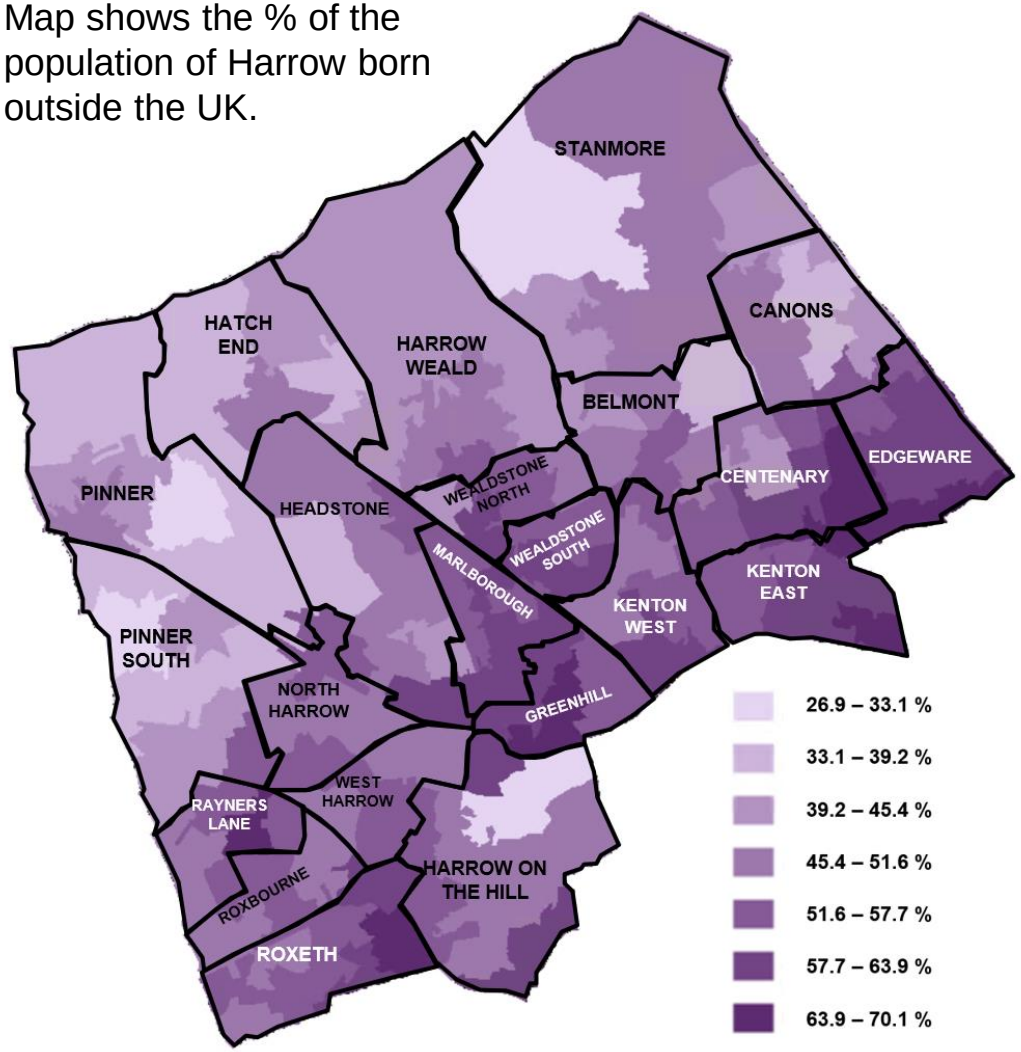
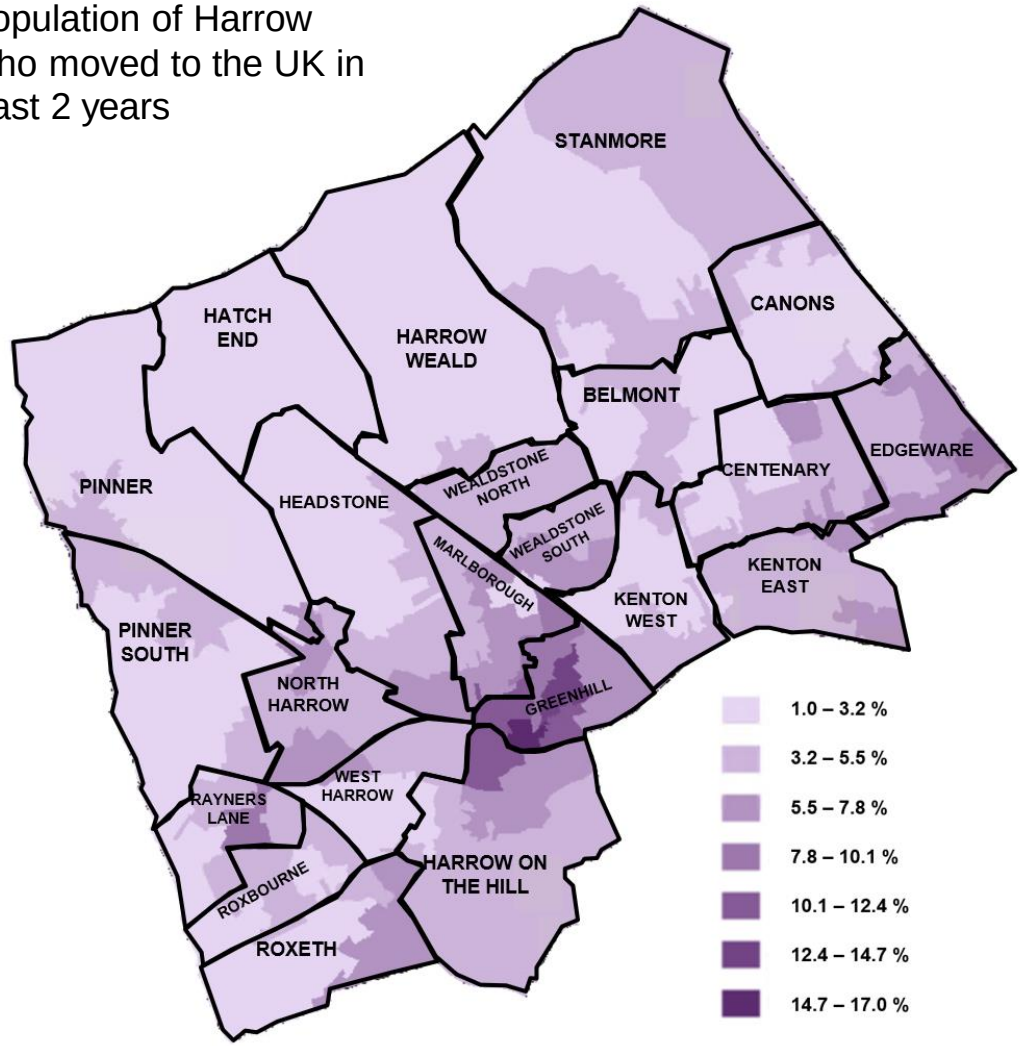
Migrants in Harrow (Census 2021)

Click image to return

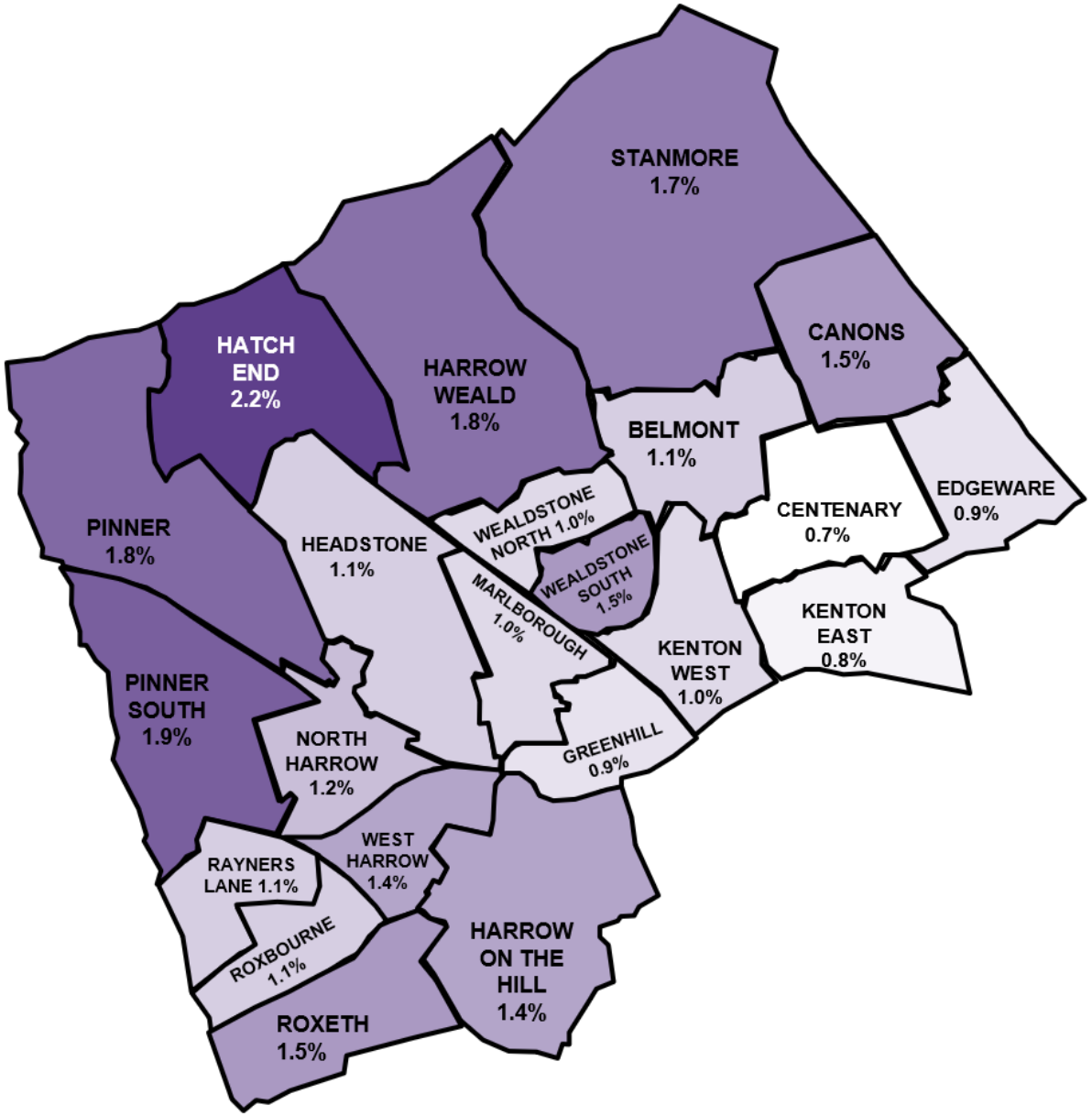
Map shows the % of the population of Harrow born outside the UK.



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



Percentage of Harrow adult population who have previously served in the UK armed forces by Ward (Census 2021)



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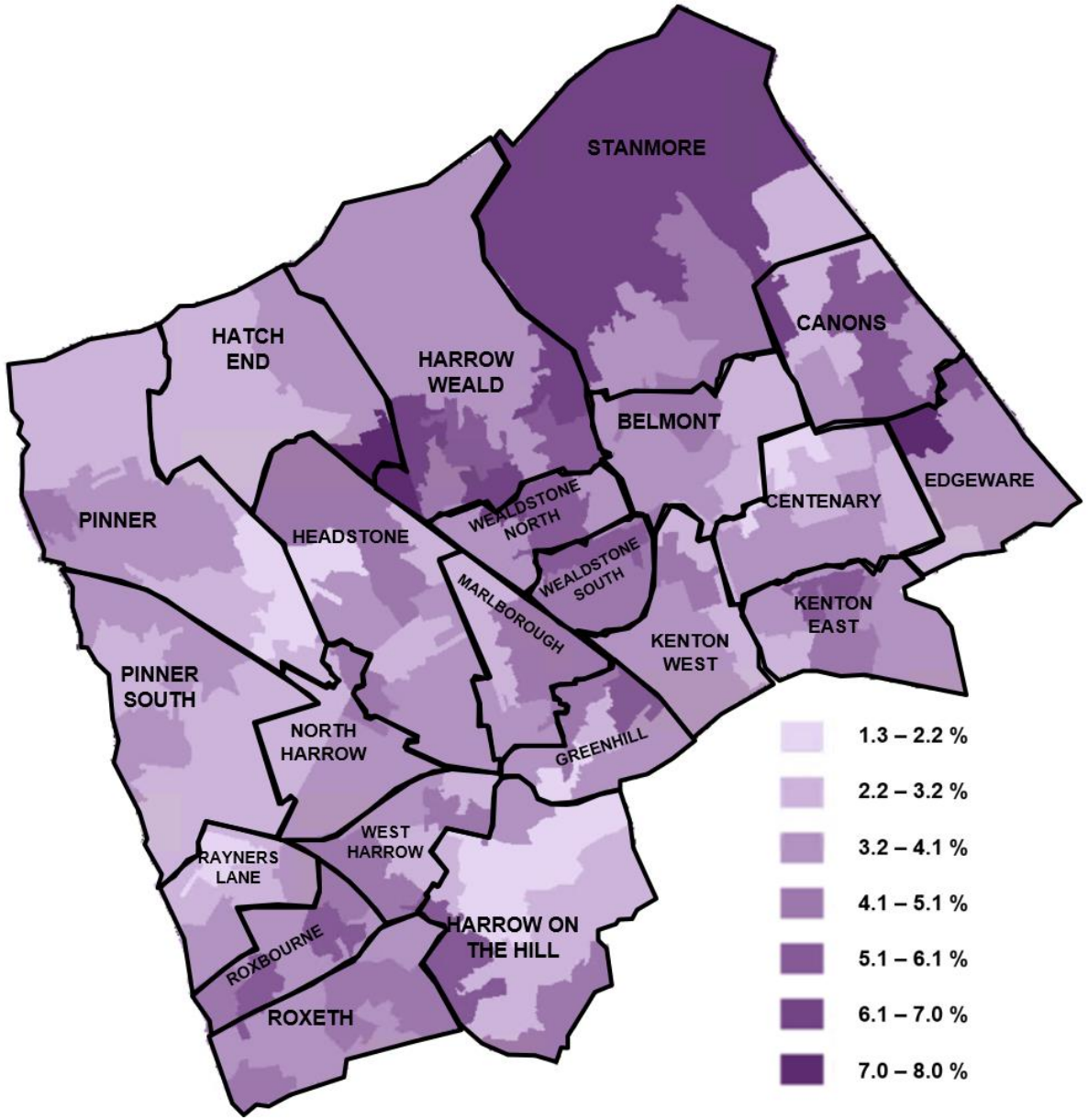
Percentage of Harrow residents reporting bad or very bad health (Census 2021)



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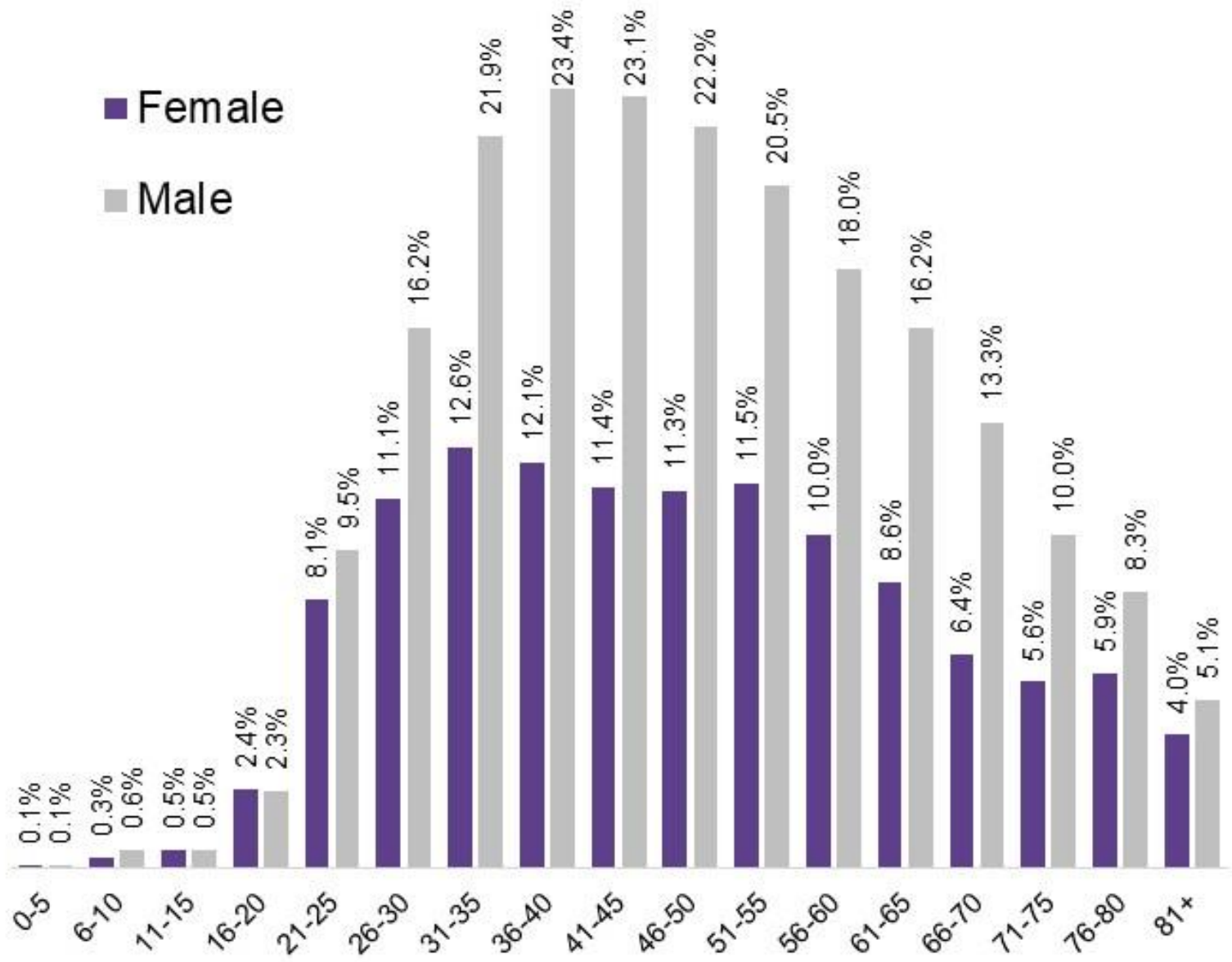
GP recorded rates of smoking in Harrow, by Sex and age (WSIC 2023)



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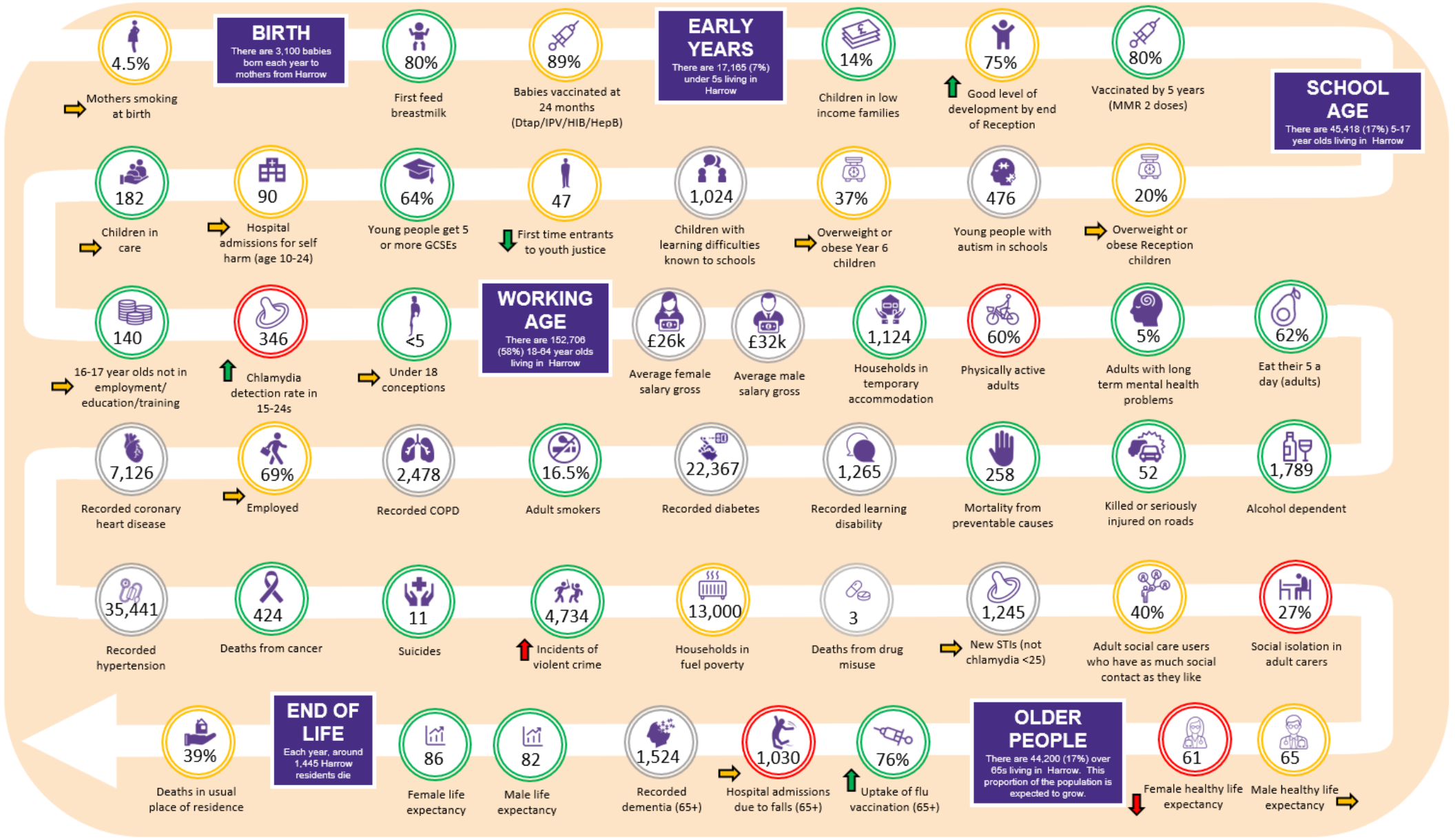
Population health across the lifecourse in Harrow



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

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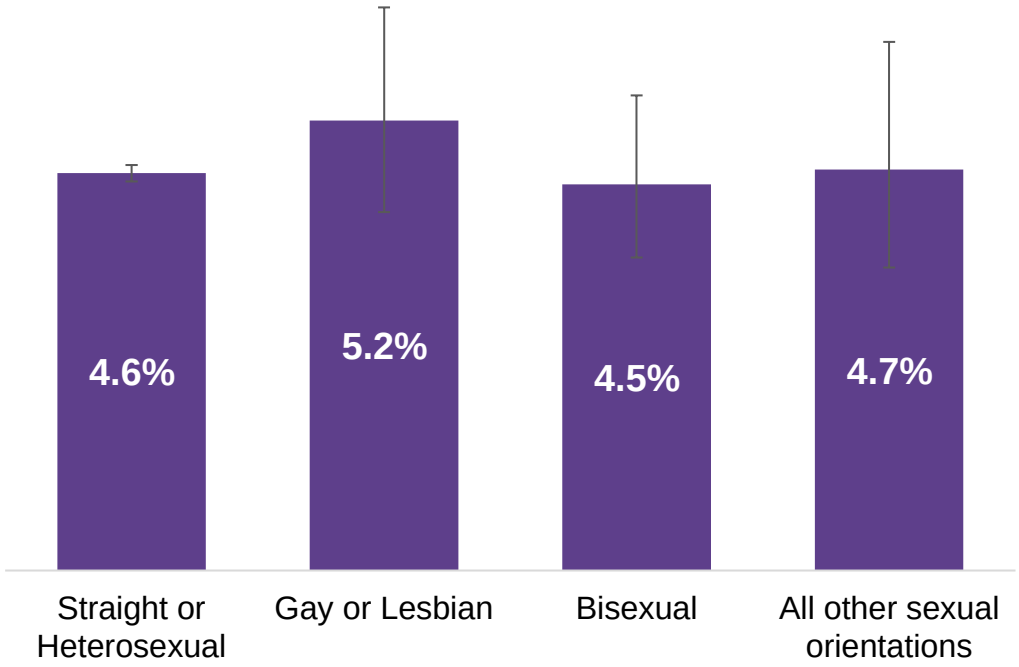
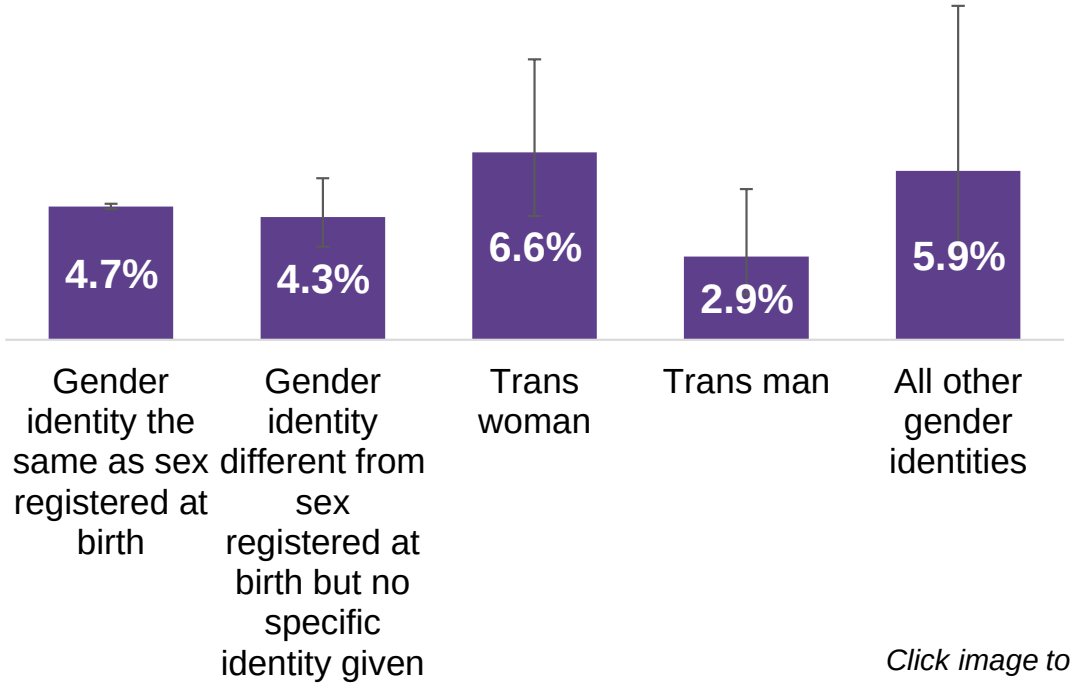
Harrow residents reporting poor or very poor health by sexual orientation and gender identity (Census 2021)

Sexual orientation



Trans or Cis Gender



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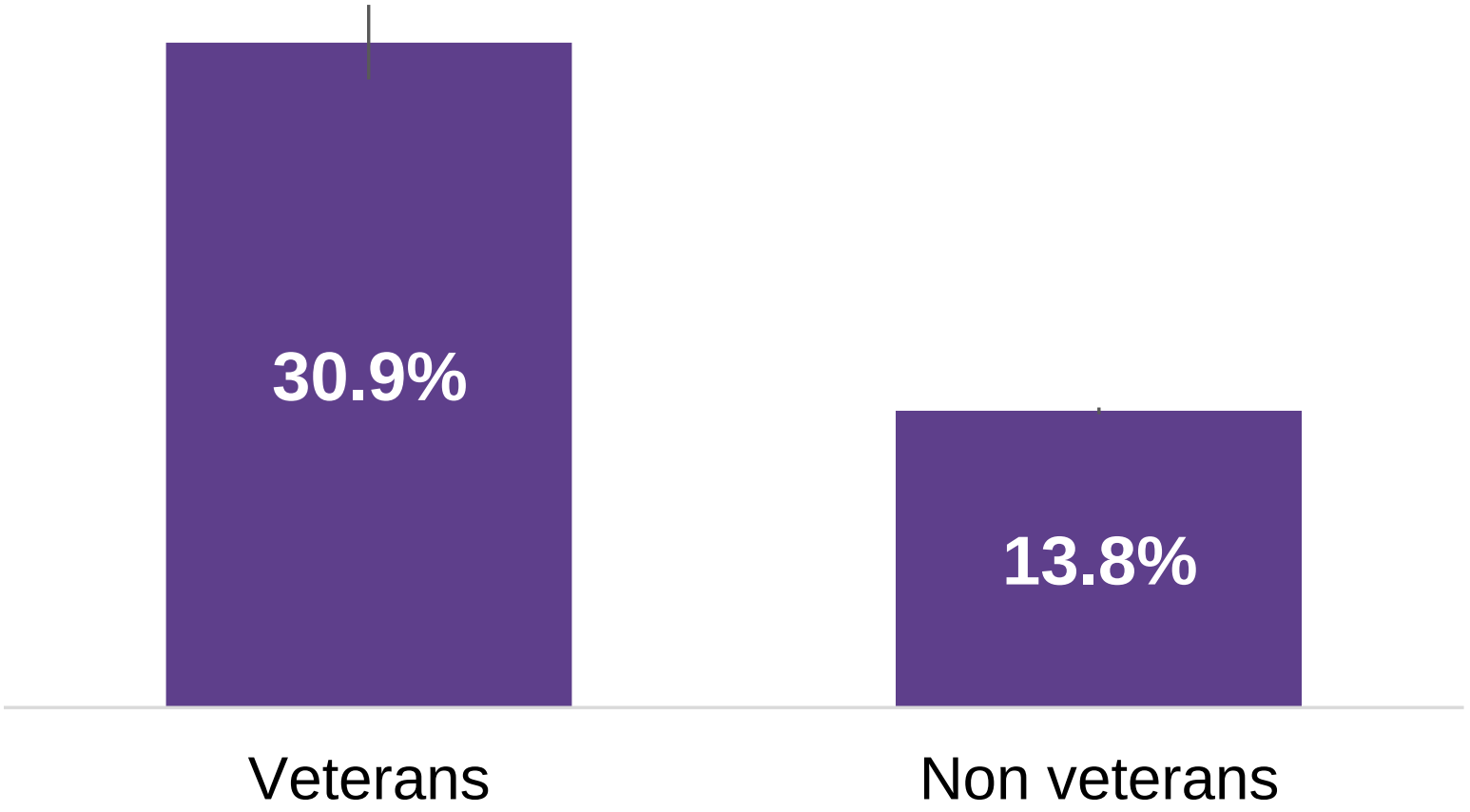
Percentage of Harrow adult population who have previously served in the UK armed forces who report having a disability (Census 2021)



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