Health and Wellbeing Strategy

1 Aspiration

Health improvement is everyone's business. As health technologies become more advanced and more successful so should our efforts in improving health. A strategy for health improvement looks to engage both public sector and private sector organisations in its task there-by making health improvement part of mainstream systems for incentives, performance management, regulation and inspection.

2 Intro

The information supporting this strategy comes from a wide variety of sources. The discussion paper published prior to the stakeholder workshops and interviews is included as an appendix but other information is available from the NHS Harrow Annual Public Health Report 2009-10; the Joint Strategic Needs Assessment 2009-10 and the Harrow Vitality Profile.

The previously published Harrow framework for achieving health improvement and reducing health inequalities is shown below.

Prevention – focus on the wider determinants of health:

- Housing,
- Crime,
- Transport
- Poverty,
- Education,
- (un)Employment

Prevention and protection – lifestyle and risk factors

- Smoking, obesity, physical activity drugs, alcohol and sexual health
- Infection control
- Improving health and social care services

Equitable and efficient access (primary, secondary and social care)

- Self care, choice and control
- Focus on Diabetes

Sustainable development

- Corporate social responsibility
- Engaging communities and individuals- supporting vulnerable groups
- Learning disabilities
- Mental and emotional health

Supporting families, mothers and children

- Recognising that the lifestyle we have as children influences the life we live and the chances we have as adults

This strategy builds on the framework and reports on the consultations with stakeholders to examine whether these previously set priorities are accepted or whether there are additional priorities to consider.

3 Stakeholder process

A questionnaire was designed to elicit responses from key stakeholders across Harrow. The questions were based on a previously piloted questionnaire and had therefore been validated. However, following feedback from the fist few interviews, minor modifications to two of the questions were made to clarify the sort of responses required.

A number of workshops and one to one interviews were undertaken and the questionnaire was circulated through email and a version placed on the internet using Surveymonkey. Approximately 80 people had input into the process, including staff at NHS Harrow, staff at Harrow Council, Harrow Strategic partnership, HAVS, Harrow Health and Wellbeing Partnership Board and the Partnership of Older People.

4 Responses to questionnaire

4.1 Key concerns

The stakeholder questionnaire asked a range of questions to identify hopes and fears for health and wellbeing in Harrow. From these responses we are able to paint two divergent pictures of Harrow. The challenge will be to develop programmes to work towards the hopes and to minimise the fears.

4.2 The Harrow Utopia

The questionnaire respondents paint a picture of Harrow as a desirable place to live, where residents are happy and healthy and where people love to work. The local environment is clean and promotes physical activity by restricting cars, the existence of new cycle paths and safe, well lit paths. Obesity and smoking are things of the past helped by a policy of not licensing fast food outlets alongside promoting new local shops selling healthy and wholesome food and where smoking in all public places is banned – not only indoors but outdoors too. Children are active and well educated and family life is stable with opportunities for parents to get support when they need it. Diversity is valued and celebrated and newer communities are well integrated into the wider Harrow community without losing their own cultural identity. Older people are supported to remain independent and intergenerational opportunities in education and employment are actively sought. When people do need services, they can access appropriate and timely services close to home and delivered by well trained staff.

4.3 The Harrow Dystopia

The questionnaire respondents were asked to identify what life in Harrow would be like if action wasn't taken to address the health and well being issues existing in Harrow today. They painted a picture of Harrow that was bleak with businesses closing and being replaced by increasing numbers of fast food outlets and off licences. The residents of Harrow would begin life as fat children with low educational achievement and become overweight, unemployed teenage parents who smoke and have alcohol and drug problems. Crime, alcohol related antisocial behaviour, spitting in the street, littering and graffiti are rife. Community cohesion is a thing of the past and violence erupts frequently between different groups. People don't want to leave the apparent safety of their cars so congestion and pollution increase and most days the borough is gridlocked. Older people are increasingly marginalised and outreach services are lacking. People develop serious illnesses at a younger age and services can't cope leading to increased emergency attendances and admissions to hospital.

4.4 Measuring the change

There are a number of measures that were commonly mentioned by stakeholders. The most commonly mentioned are the existing longer term outcome measures:

- Life expectancy
- Mortality rates (by disease type)

Others focussed on traditional health-related process measures such as:

- Levels of physical activity in adults and children
- The number of smoking quitters
- Numbers of people using services or attending A&E

And others on novel structural measures

- Numbers of fast food outlets or number of fast food outlets per head of local population
- Miles of cycle lanes

There was a strong call for measures from local surveys. The sorts of data suggested were:

- Recall of health related messages/ campaigns
- Opinion of local statutory services

Finally, and perhaps the most difficult to measure, there was a very strong feeling that there needs to be a measure of "happiness" and "well-being". This clearly needs to be defined carefully. A regional working party is being set up in January

2010 to determine what robust measure of well being can be established across London and perhaps nationwide.

4.4.1 Recommendation

a. Life expectancy and difference in life expectancy should continue to be the main measure of success for the strategy.

Action: data monitoring by Public Health

b. When such a measure has been agreed, a measure of community wellbeing will be included as a success measure for the strategy.

Action: Public Health / Mental Health Delivery group

c. For each element of the strategy an appropriate measure will be agreed

Action: All

4.5 Key drivers and barriers to delivery

The stakeholder consultation raised a number of issues that need to be addressed as part of this strategy. The issues raised fell into four broad themes:

- Partnership working and stakeholder engagement
- Champions
- Finances/ resources
- Implementation

4.5.1 Partnership working and Stakeholder engagement

A strategy that delivers the sort of changes that are needed and desired cannot be achieved by a single agency and for this reason the ownership of the strategy will lie with a multiagency group – the Health and Wellbeing Partnership Board (HWPB). In developing the strategy, partners including the voluntary sector, have already been given the opportunity to have input into the themes for the strategy and will continue to be engaged in a number of ways. The voluntary sector has a representative member on the HWPB and will though their representation be integral to the agreement of the strategy and its implementation and monitoring. There will be a period of consultation after the draft strategy is published.

4.5.2 Champions

The need for high level champions was stressed by many stakeholders. A variety of champions need to be identified who are not just passionate about health improvement but who have both real and political influence and, most importantly, responsibility for delivery.

4.5.3 Resourcing

The resources available for implementing the strategy were raised by many. While it would be desirable to identify new resources, it will also be necessary to reprioritise existing resources to maximise health gain and establish a sustainable programme of health improving initiatives across the range of public services in harrow. Gaining support from business or identifying external support grants will also need to be examined.

4.5.4 Implementation

The first step to delivery is having a strategy to set the direction of travel. This will not result in delivery against objectives without a practical implementation plan. In this strategy, we will provide a broad high level strategy and implementation plan which will need further detailed and costed plans with milestones and timescales if we are to deliver the improvements we want. These detailed plans will be developed by the relevant delivery groups.

5 Themes and Priorities

A wide range of themes were identified in the stakeholder survey. However seven themes stand out among all others:

- Smoking and other tobacco issues;
- Obesity and healthy eating ;
- Increasing physical activity;
- Improving transport and the built environment;
- Promoting community cohesion, equality and respecting diversity;
- Reducing crime and fear of crime;
- And a final priority which should be a result of the other priorities - Building a happier Harrow.

Each of these will be considered separately in the following sections. This will include the issues identified by stakeholders and suggested measures and which of the partnership groups should lead on the actions necessary.

The consultation supported the theme of individual responsibility for health and self-care, which is a key element of recent health policy in England. The Wanless review of health care funding (2002) showed that health care be reduced through better public engagement with health. The public health White paper, Choosing Health (2004), looked at how healthy lifestyles could be made an easier option for people though provision of better information and services. The health and Social care White paper, Our Health, Our Care, Our Say (2006), assumed that individuals would manage their own health, health care and social care. Common to all of these policies are common ideas that:

- individuals should take greater responsibility for their health and health care
- individuals should adopt healthier behaviours to avoid ill-health in later life

- if individuals change their behaviours, the health improvements will reduce future health costs.

However, the consultation also recognised that in order to take responsibility, individuals need information, access to affordable services and support to make the necessary changes.

The "Better Together" Focus Group Review and Survey Questionnaire consultation has shown that most people think that they are healthy and have a healthy lifestyle but that others in the borough do not. This lack of acknowledgement of personal unhealthy behaviours will be a significant issue in initiating changes. Other elements of the focus group review involved discussion of the willingness of local people to get involved in maintaining or taking responsibility for their local environment. Although some elements were popular, e.g. undertaking minor property repairs; others were not, e.g. taking over the management of local park.

5.1 Recommendations for enablers to support the strategy

Health behaviours are deep-rooted in social habits that are not easily changed by one-off, short-lived measures[i]. Tackling unhealthy behaviours must get the support infrastructure right as well as addressing the behaviour change itself.

d. Increasing the level of data analysis. This should include increased data sharing across organisations and consideration should be given to having a centralised data warehouse that can be used across the strategic partnership.

Action: HCEs & JAG

e. Improving the depth of understanding of community motivations through new data such as geodemographic segmentation to facilitate targeted interventions (building on the current Mosaic project);

Action: JAG

f. Increased sharing of data and actions to improve health and wellbeing through a new joint tasking and action group approach similar to that seen in the community safety work stream or widening the remit of the Joint Analytical Group together with funded sessions for joint working

Action: ?JAG

g. Adoption of social marketing[1] techniques to help people to live healthier lifestyles;

Action: JAG/ all delivery groups

h. Use of a variety of interventions to address the problem rather than a single type of intervention;

Action: All delivery groups

1 Sophisticated and targeted marketing techniques including those employed by commercial advertisers but applied to health and social care and used to promote socially desirable outcomes.

i. Inclusion of evaluation in all programmes to ensure both value for money and effectiveness of the interventions to deliver the required outcomes in a sustainable way;

Action: All delivery groups

j. Ensuring that all frontline staff, whether employed by health or local authority, are able to deliver at least the simplest level of health promotion interventions i.e. to know when and how raise an issue relating to healthy lifestyles, to help people chose and maintain healthier lifestyles and signpost them to appropriate services

Action: Public Health Team

k. Ensuring that all contracts include requirements for promoting healthy behaviours either with client or

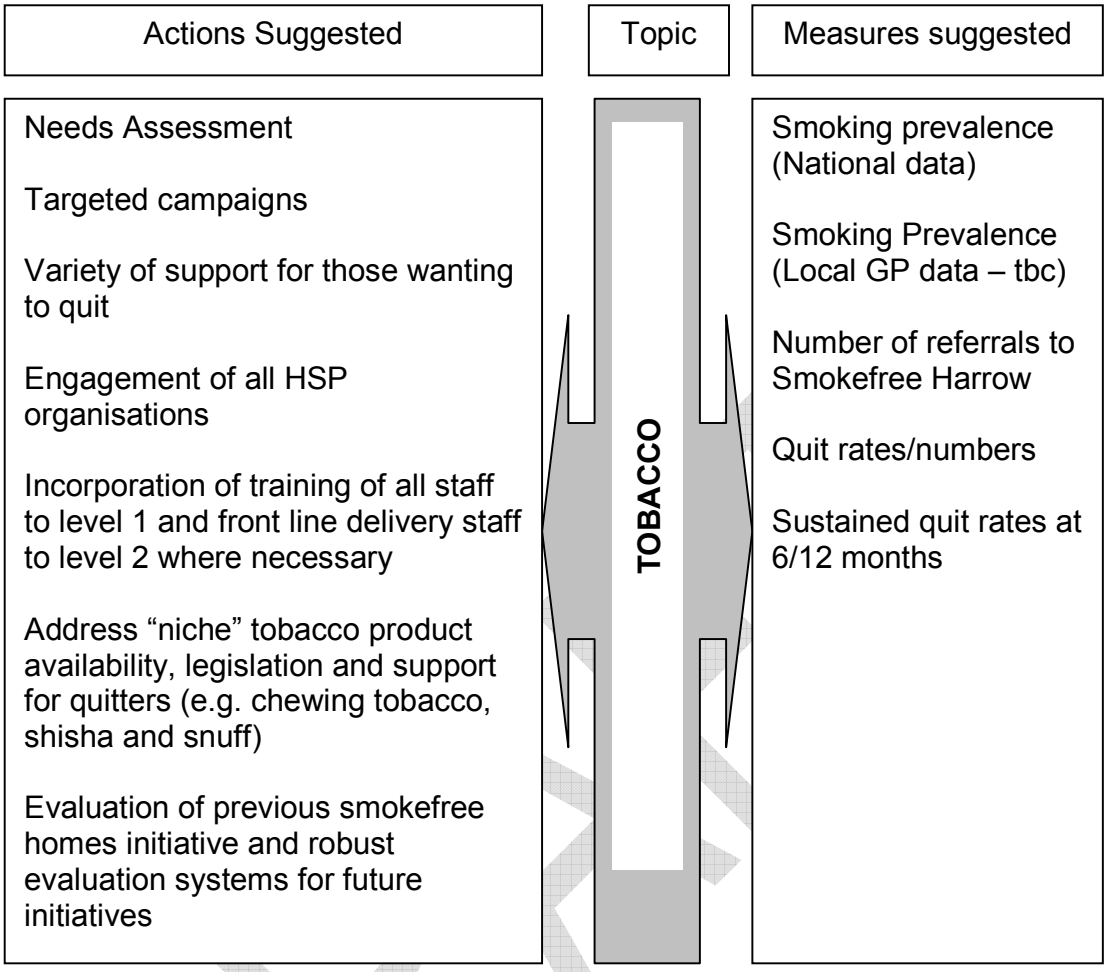
Action: Commissioners

l. Ensuring that all programmes and policies must have a Health Needs Assessment before they can be approved. To facilitate this, a local tool should be developed to be used across partner organisations.

Action: All to undertake HNA; Public health to develop tool

5.2 Smoking and other tobacco issues

Stopping smoking is the single most effective thing that someone can do to improve their health. This was clearly recognised in the consultation. Although a variety of services were mentioned in the stakeholder consultation, the Better together survey and focus groups found that Stop Smoking Clubs were the least likely to be popular with smokers. There was general scepticism of sign up campaigns such as the smoke free homes initiative which finished in March 2009. It is important to evaluate such schemes to inform future investments. A focus on some of the higher risk communities needs to be adopted. The high risk groups for tobacco use are people in routine and manual jobs; unemployed people and people with long-standing mental health problems. Some countries have higher smoking rates than the UK (e.g. Bangladeshi males, Turkish, Greek, and eastern Europe). It is assumed that immigrant communities have the same rate of tobacco use in their home country.



5.2.1 Recommendations for discussion

m. All HSP partners should engage on tobacco issues through the Harrow Tobacco Control Alliance (HTCA). This will include identification and referral of all smokers working within HSP organisations to Smokefree Harrow advisors at least once per year.

Action: HCEs/HSP

n. The HTCA should develop a strategy for Tobacco Control across Harrow for the next 5 years. This should be based on the needs assessment which is currently being developed.

Action: Harrow TCA

o. The HSP members should actively engage in lobbying for change in legislation on tobacco.

Action: HSP/ Harrow TCA

p. All visits to food preparation / distribution premises should include tobacco control requirements.

Action: Harrow Council

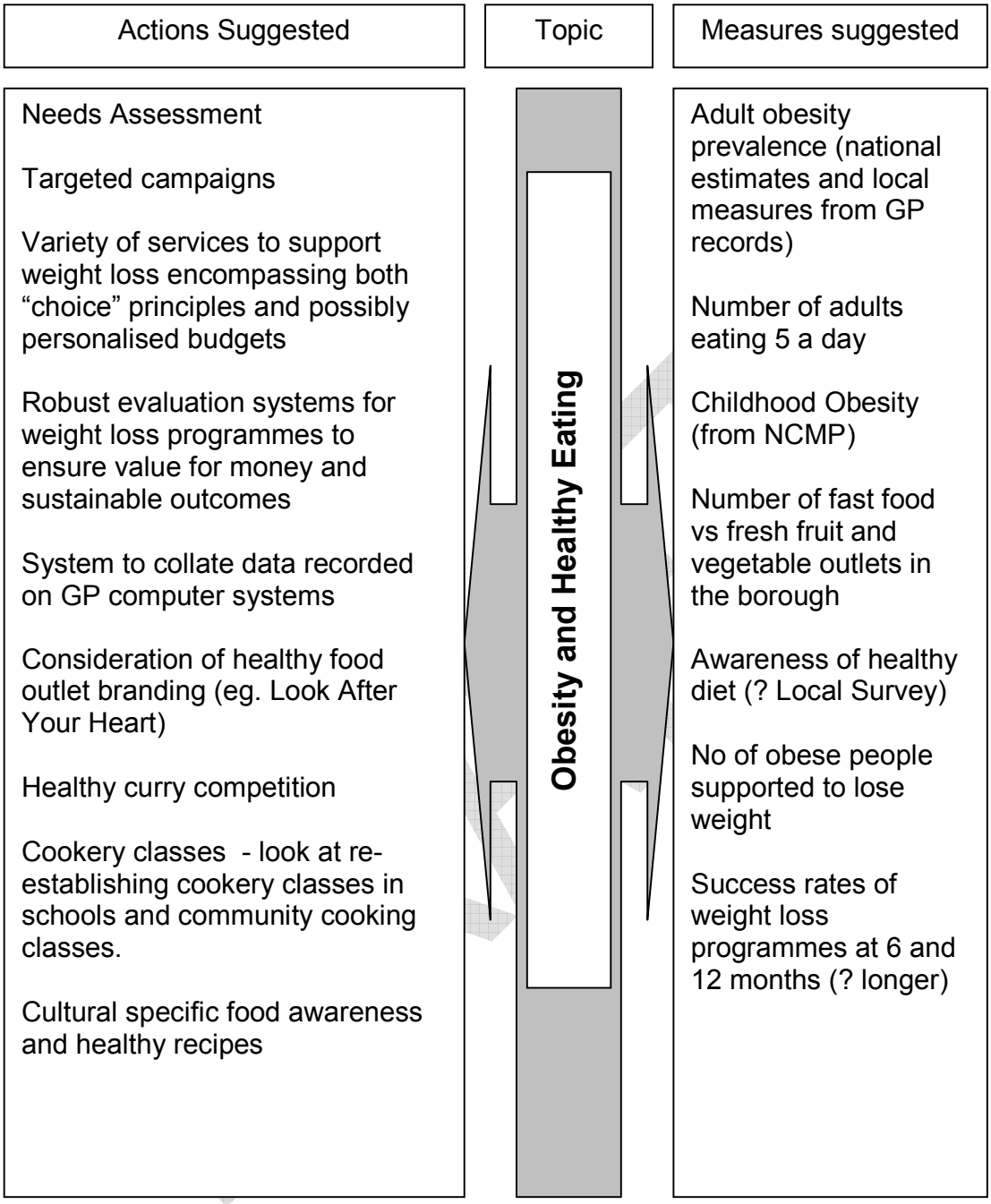
q. Data should be obtained from GP systems and analysed using Harrow segmentation data to allow targeted interventions.

Action: Harrow TCA/ Public Health

5.3 Obesity and healthy eating

Child and adult obesity are both real and perceived problems in Harrow. The need to curb the rising tide of obesity is well recognised. Many of the stakeholders focused on the accessibility of fast food and the lack of accessibility of healthy or fresh food.

Another key element is that cooking skills in the population are perceived to have decreased. The cost of healthy options and cooking nutritious and healthy meals is also a barrier to change. As previously mentioned, the Better Together survey found that most people think that healthy eating is not their problem and that they feed their families healthy food whereas "other people" do not. Raising general awareness of a healthy diet and a wider understanding of food labelling may help in these matters but each of this need to take into account the different communities within Harrow and the culturally specific products that are available. People with learning disabilities will also require tailored information on weight loss and healthy eating.



5.3.1 Recommendations for discussion

r. A new Harrow Heart healthy scheme needs to be established to promote healthy eating outside the home. The scheme should encompass local competitions for healthy recipes – both from professionals and from the community – to be published in a local healthy recipe directory.

Action: Harrow Council & Health Living Delivery group

s. Teaching food preparation and cookery skills should be introduced for children and adults.

Action: Health Living Delivery group

t. The Local Authority should ensure that it uses all of its powers to limit the number of fast food providers in the borough.

Action: Harrow Council & Health Living Delivery group

u. A range of weight loss providers should be compiled and a personalised budget given to people with a high BMI to access these services. Providers will be expected to record attendance and weight loss and continued payment will be contingent on achieving target weight loss.

Action: Health Living Delivery group

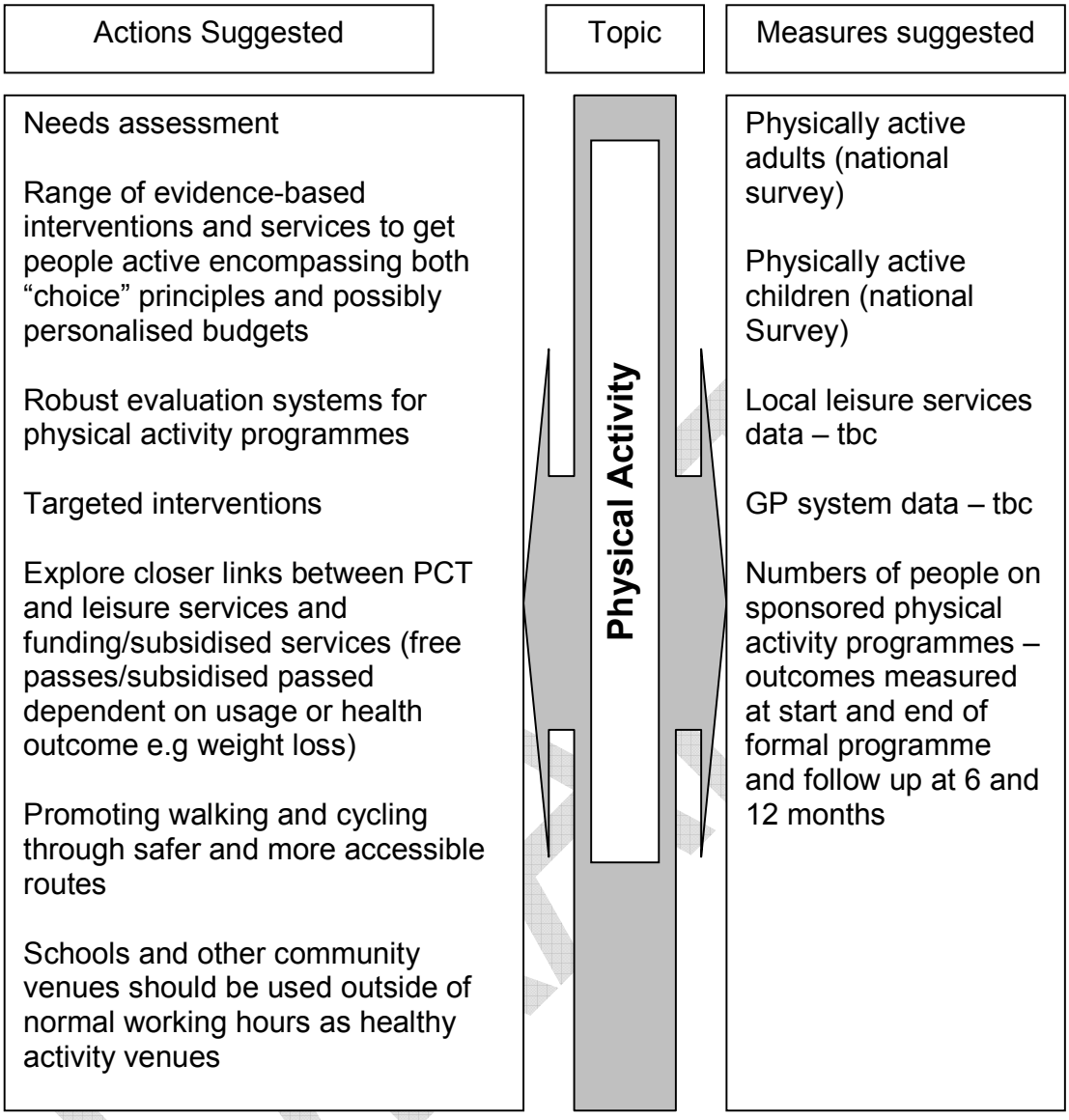
v. Data should be obtained from GP systems and analysed using Harrow segmentation data to allow targeted interventions.

Action: Health Living Delivery group / Public Health

5.4 Increasing physical activity

Linked to the obesity and healthy eating theme was a strong themes about increasing levels of physical activity. This theme also has strong links with the transport and built environment theme. Physical activity is an important factor in maintaining a healthy weight and is an independent risk factor for heart disease, stroke, diabetes and some cancers. Physical activity is also important in maintaining good blood pressure control, improving lung capacity (especially in people with smoking related breathing problems) and also helps with mental ill health, particularly for people suffering from depression. Physical activity is also important for people with physical or learning disabilities and programmes need to reflect this.

Increasing opportunities for sport and exercise, choice of types of exercise/ physical activity, and reducing car use/promoting active travel were the most commonly mentioned topics.



5.4.1 Recommendations for discussion

w. Bigger schemes are needed to maximise the benefits of physical activity programmes.

Action: Health Living Delivery group

x. Subsidised access to sports facilities should be considered. Subsidies should be based on attendance or health outcomes or both.

Action: Health Living Delivery group

y. Comprehensive joint needs assessment should be undertaken to assess the evidence, viability and potential outcomes from these programmes.

Action: Health Living Delivery group

5.5 Improving transport and the built environment

The environment we live in has a big impact on our health and stake holders recognised this. Although housing was occasionally mentioned, street cleanliness and changes to the road layout, access and safety of the environment and of public transport and the links to active transport were most commonly mentioned.

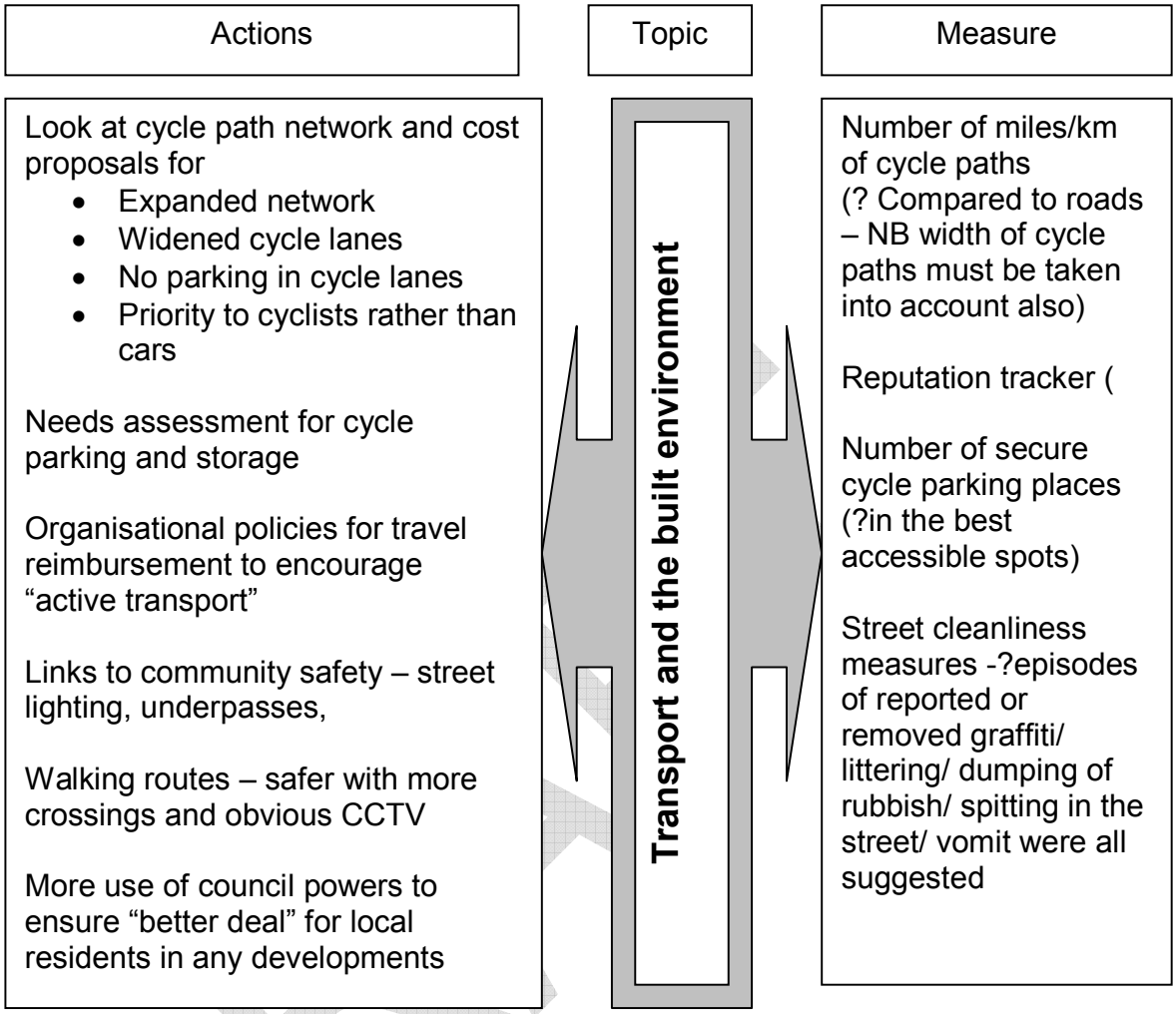
The Annual public health report and JSNA both identify the need to focus on the health inequalities that are apparent in Harrow. These most commonly occur in the central corridor from Harrow on the Hill ton centre, up through Wealdstone towards Harrow Weald. There are also health inequalities seen in a band across the south of Harrow.

All of these issues, and many of the other priority areas, have a significant place shaping[2] element. The local place shaping strategy has a number of objectives that are relevant to the health and well being strategy. They are :

- Ensure development meets the needs of all residents and businesses, without compromising the well-being of future generations.
- Locate development where it will enable local residents to access jobs and key services in a sustainable manner.
- Promote community safety in the design of new developments.
- Ensure all residents have a choice of good quality and affordable housing and in particular larger affordable family housing.
- Promote walking and cycling and access to reliable public transport.
- Ensure the greenbelt, parks and open spaces are accessible to all.
- Ensure new developments are of a high quality design and enhance the built and public realm (particularly in and around Harrow Town Centre).
- Ensure global sustainability initiatives are integrated into all developments
- Ensure that in the development of the Council's property assets, facilities are available in the right place, to meet future customer and service requirements.

It will be important that health and well being outcomes are included in the success measures of this strategy.

[2] Place Shaping has been defined by the government as "the creative use of powers and influence to promote the general wellbeing of a community and its citizens."



5.5.1 Recommendations for discussion

z. Local authorities have powers under Section 106, to ensure that local requirements are included in planning applications. These need to be stringently used to provide a health promoting environment, e.g. more and wide cycle lanes; integration of community meeting places for all ages into heart of development; local shops providing fresh food, health and social care venues

Action: Sustainable Development and Enterprise Group

aa. To ensure that health impacts are included in assessment of all elements of the Place Shaping Strategy

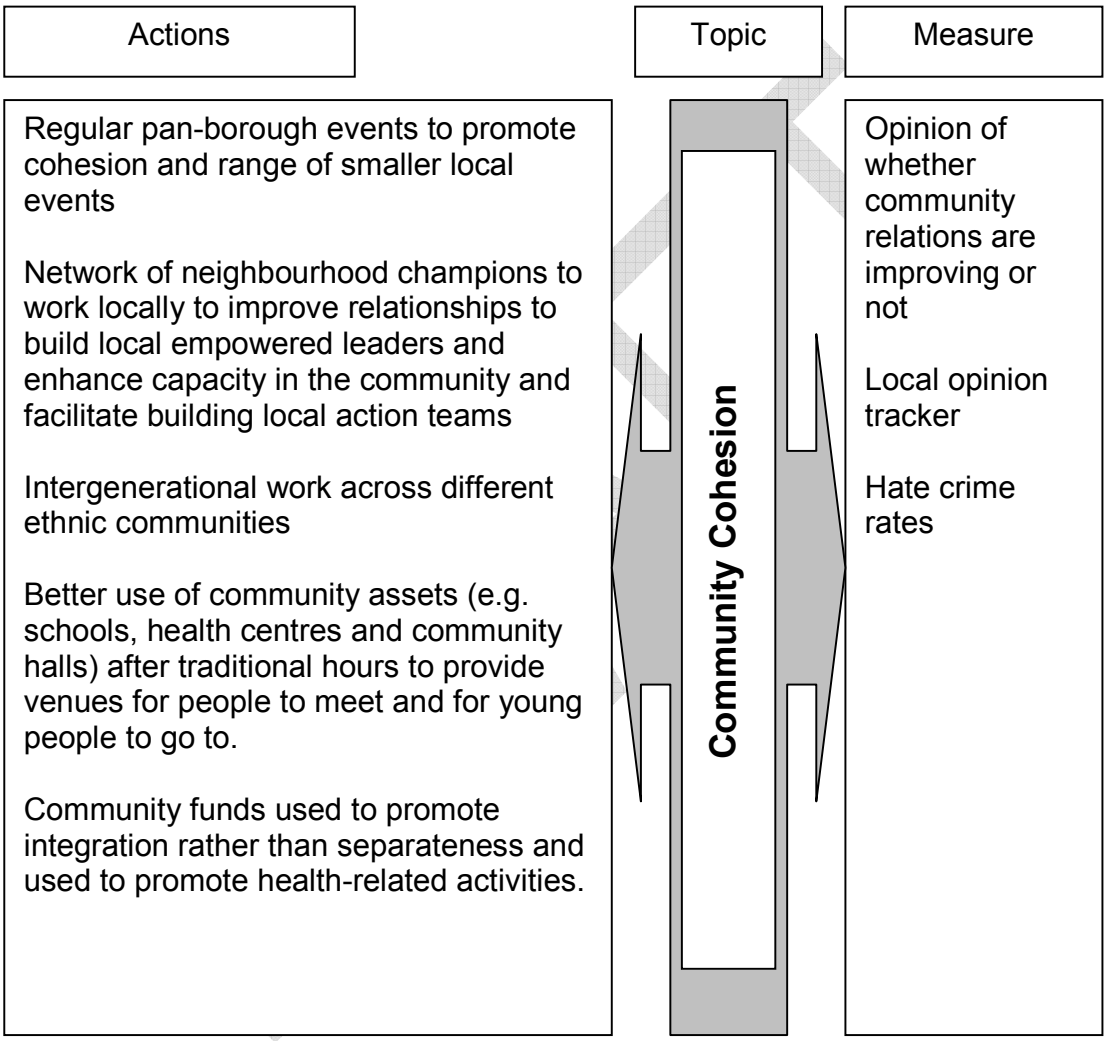
Action: Sustainable Development and Enterprise Group

bb. To focus actions on the areas suffering the most health inequalities .i.e. the central and southern parts of Harrow

Action: Sustainable Development and Enterprise Group and all partners

5.6 Promoting community cohesion, equality and respecting diversity

Throughout the stakeholder consultation there was recognition that Harrow is a borough of wide diversity and that the relatively rapid changes in the population structure have the potential to cause some community tension. There was strong feeling that actions to improve community cohesion should be included in the strategy.



5.6.1 Recommendations for discussion

cc. To look at the specification for neighbourhood champions and identify gaps in training needs to enable them to deliver health promoting activities

Action: Sustainable Development and Enterprise Group

dd. To organise pan-Borough events and plan for a series of local events linked to the weeks of action to promote community relations

Action: Sustainable Development and Enterprise Group

ee. To agree that the criteria for community funding bids to explicitly include robust measures of health and community cohesion

Action: Sustainable Development and Enterprise Group

5.7 Reducing crime and fear of crime

Although the rates of crime in Harrow are on the whole low compared to London and the country as a whole, there is a high rate of fear of crime. The Harrow Crime and Disorder partnership and the Safer Harrow Partnership Board will continue to lead on this area of work. There is already an active operational group (Joint Analytical Tasking and Action Group, JATAG) that meets monthly to evaluate the actions necessary to address local crime and disorder hotspots. This also includes low level environmental problems such as graffiti and littering which are known to have a significant impact on the perception of community safety and fear of crime.

Suggested actions	Topic	Measure
Needs assessment (undertaken as the Crime and Disorder strategic Plan) and continuation of JATAG Proposal for a local intergeneration programme (reducing fear by enhancing interaction) Look at the impact of economic recession on crime and disorder To improve the rates of reporting of domestic violence Link to built environment to make neighbourhoods feel safe by reducing graffiti and littering etc Alcohol diversion scheme to be implemented and evaluated	**Crime and Fear of Crime**	Crime rates Episodes of graffiti, dumping of waste etc Fear of crime rate Alcohol related crime/ violence/ A&E attendances and hospital admissions

5.7.1 Recommendations for discussion

ff. Improved data collection including data from the acute Trust A&E department to assess the impact of violence on health services

Action: Safer Harrow/JATAG

gg. Evaluation of effectiveness of hospital based alcohol brief intervention scheme

Action: Alcohol delivery group

hh. Introduction of alcohol diversion scheme

Action: Safer Harrow/ Alcohol delivery group

5.8 Towards a Happier Harrow

Many of the actions suggested and concerns raised by the stakeholder consultation were about physical health but often the aspiration was for happiness or wellbeing. This is clearly a measure of mental health or social health. There is evidence for the positive impact of physical activity, environmental improvements and crime reduction on the mental health of both individuals and the population in general. As such the elements of the strategy that have already been mentioned will contribute to improved mental health.

In terms of a measure of mental health or wellbeing, there are measures from national surveys. However, these are extrapolations or synthetic estimates rather than real measures. The local surveys and reputation trackers will give a more local estimate but the questions need to be correctly phrased and validated. Work is currently being undertaken by Government Office for London about a standard method for measuring well-being. Harrow volunteered to work on this pilot but was not chosen to be in the pilot groups. We will, however be in the wider stakeholder groups for the project. Recommendation b picks up on this.

6 Summary of Recommendations

a. Life expectancy and difference in life expectancy should continue to be the main measure of success for the strategy.
b. When such a measure has been agreed, a measure of community wellbeing will be included as a success measure for the strategy.
c. For each element of the strategy an appropriate measure will be agreed
d. Increasing the level of data analysis. This should include increased data sharing across organisations and consideration should be given to having a centralised data warehouse that can be used across the strategic partnership.
e. Improving the depth of understanding of community motivations through new data such as geodemographic segmentation to facilitate targeted interventions;
f. Increased sharing of data and actions to improve health and wellbeing through a new joint tasking and action group approach similar to that seen in the community safety work stream

g. Adoption of social marketing[3] techniques to help people to live healthier lifestyles;
h. Use of a variety of interventions to address the problem rather than a single type of intervention;
i. Inclusion of evaluation in all programmes to ensure both value for money and effectiveness of the interventions to deliver the required outcomes in a sustainable way;
j. Ensuring that all frontline staff, whether employed by health or local authority, are able to deliver at least the simplest level of health promotion interventions i.e. to know when and how raise an issue relating to healthy lifestyles, to help people chose and maintain healthier lifestyles and signpost them to appropriate services
k. Ensuring that all contracts include requirements for promoting healthy behaviours either with client or
l. Ensuring that all programmes and policies must have a Health Needs Assessment before they can be approved. To facilitate this, a local tool should be developed to be used across partner organisations.
m. All HSP partners should engage on tobacco issues through the Harrow Tobacco Control Alliance. This will include identification and referral of all smokers working within HSP organisations to Smokefree Harrow advisors at least once per year.
n. The HTCA should develop a strategy for Tobacco Control across Harrow for the next 5 years. This should be based on the needs assessment which is currently being developed.
o. The HSP members should actively engage in lobbying for change in legislation on tobacco.
p. All visits to food preparation / distribution premises should include tobacco control requirements.
q. Data should be obtained from GP systems and analysed using Harrow segmentation data to allow targeted interventions.
r. A new Harrow Heart healthy scheme needs to be established to promote healthy eating outside the home. The scheme should encompass local competitions for healthy recipes – both from professionals and from the community – to be published in a local healthy recipe directory.
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v. Data should be obtained from GP systems and analysed using Harrow segmentation data to allow targeted interventions.

3 Sophisticated and targeted marketing techniques including those employed by commercial advertisers but applied to health and social care and used to promote socially desirable outcomes.

w. Bigger schemes are needed to maximise the benefits of physical activity programmes.
x. Subsidised access to sports facilities should be considered. Subsidies should be based on attendance or health outcomes or both.
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z. Local authorities have powers under Section 106, to ensure that local requirements are included in planning applications. These need to be stringently used to provide a health promoting environment, e.g. more and wide cycle lanes; integration of community meeting places for all ages into heart of development; local shops providing fresh food, health and social care venues
aa. To ensure that health impacts are included in assessment of all elements of the Place Shaping Strategy
bb. To focus actions on the areas suffering the most health inequalities .i.e. the central and southern parts of Harrow
cc. To look at the specification for neighbourhood champions and identify gaps in training needs to enable them to deliver health promoting activities
dd. To organise pan-Borough events and plan for a series of local events linked to the weeks of action to promote community relations
ee. To agree that the criteria for community funding bids to explicitly include robust measures of health and community cohesion
ff. Improved data collection including data from the acute Trust A&E department to assess the impact of violence on health services
gg. Evaluation of effectiveness of hospital based alcohol brief intervention scheme
hh. Introduction of alcohol diversion scheme

7 Implementation plan

7.1 2010

The following table is a proposed implementation plan for the first year of the strategy.

	Action	Responsible Manager	Due date	Presentation to HWBPB
F1	Agree available funding	HSP Brain Jones	March 2010	
HIA1	Development of local health impact assessment tool to be used across the HSP by NHS Harrow Public	Carole Furlong		March 2010

	Health team			
NA1	Needs assessment on tobacco	Sally Cartwright	March 2010	March 2010
NA2	Needs assessment on obesity	TBC	May - July 2010	?July 2010
NA3	Needs assessment on physical activity	Sally Hone/ Anu Singh?	April - May 2010	July 2010
NA4 +	Proposal for needs assessments on other topics	TBC	Starting June 2010	? October 2010
S1	Proposal for future of JAG and development of data warehouse	Liz Defries /Carole Furlong/Sunil Galoria		October 2010
S2	Development of segmentation tool	Ben Jones	March-June 2010	June 2010
T1	Annual training plan for smoking cessation	Sally Cartwright	March 2010	March 2010

Key
F= Funding
HIA = Health Impact Assessment
NA = Needs assessment
S = supporting programmes
T = Training

a. 2011 onwards

Implementation plan to be confirmed

Appendix 1: Briefing paper

Setting the scene

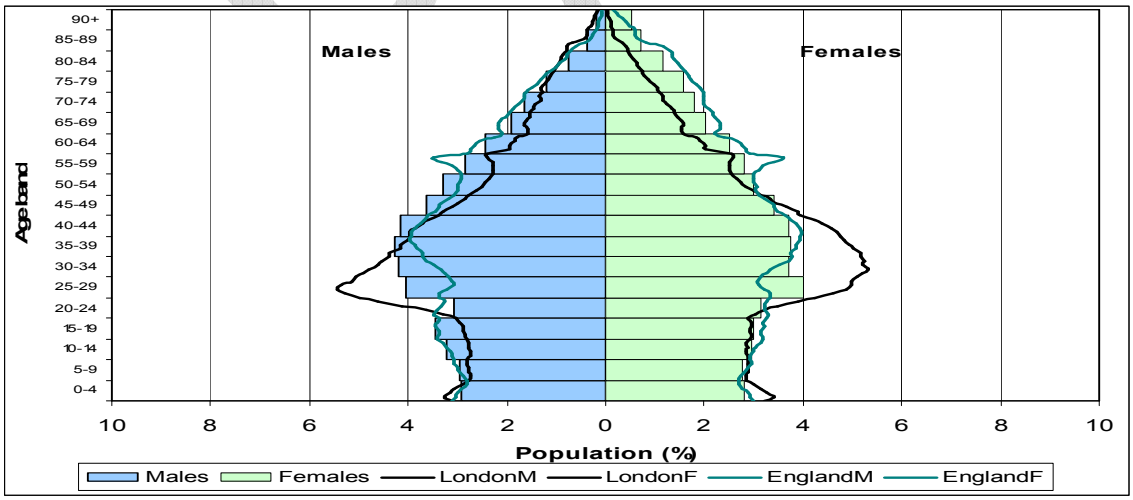
Harrow, for the purposes of this paper, covers the geographical area and population of the London Borough of Harrow. Where data is provided at a GP level, the population relates to the registered population, which includes people who are resident in other boroughs and registered with a Harrow GP and excludes those patients who are resident in Harrow but registered with a GP from another PCT.

b. The people of Harrow

The population structure of Harrow is more similar to the England average than London (Figure 1). There is a lower proportion in the 20-40 age group in males and 20-50 in females and a greater proportion in the over 50s, particularly in females, compared to London. Unusually, Harrow does not see the "baby boomer" peak in the 55-65 age group that is seen elsewhere. The population structure varies across Harrow.

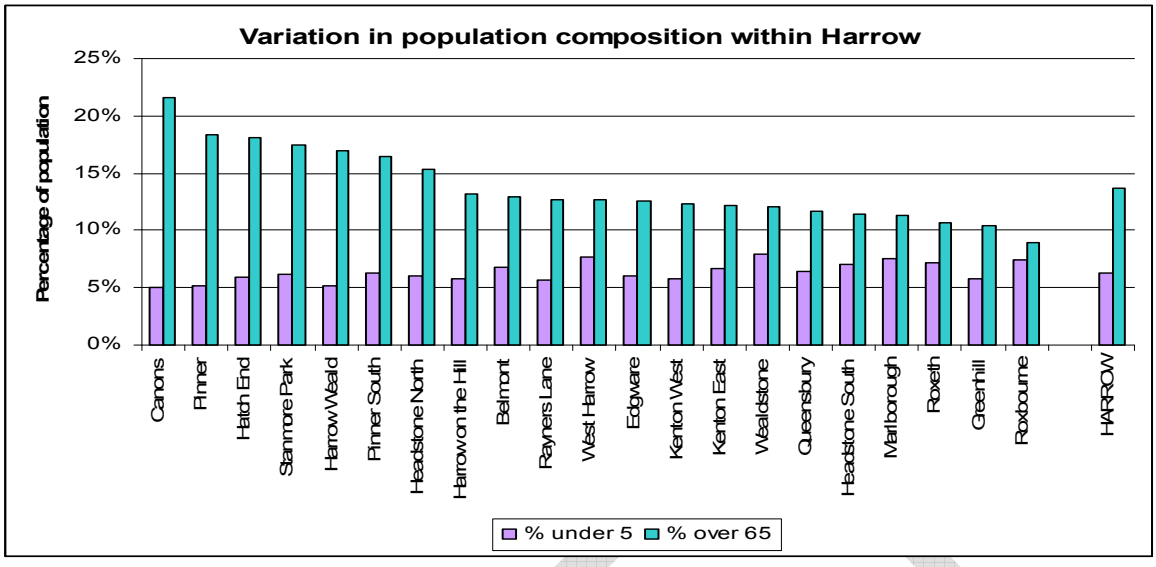
Harrow's population, of around 215,000, is projected to grow over the next ten years, with the greatest growth in the older age groups (45-59 and 60+). There is also a predicted increase in numbers of children under 15 but a predicted reduction in the 15-44 age group.

Figure 1 Population of Harrow by age and gender



Source: ONS

Figure 2 Variation in population composition within Harrow

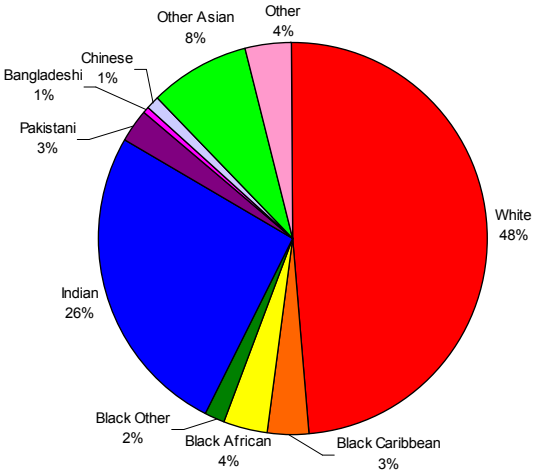


Source: GLA

More than half of Harrow's population are from Black and minority ethnic groups, making Harrow one of the most ethnically diverse boroughs in the country. The largest group, after White, is Indian. There is variation within the borough and wards in the south-east of Harrow tend to have a higher proportion of population from black and minority ethnic groups.

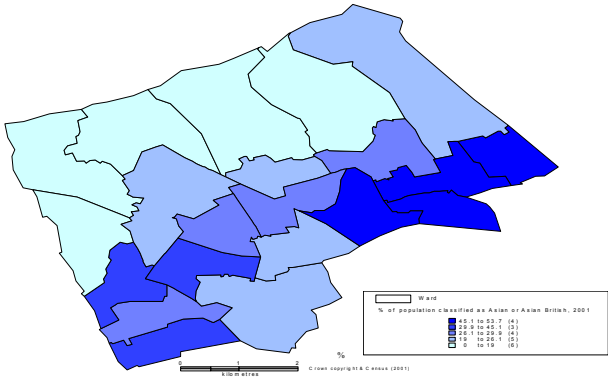
The composition of the population of Harrow is forecast to change over the next 10 years according to the GLA projections. All non-white ethnic groups are forecast to increase: Asian by 18%, Black by 11% Chinese by 2% and all other ethnicities by 37%. Over the same time period, the White population is forecast to decrease by 17%.

Figure 3 Ethnic composition of Harrow's population



GLA 2006 Round Ethnic Group Projections - RLP High

Figure 4 Proportion of population classified as Asian or Asian British in the 2001 Census



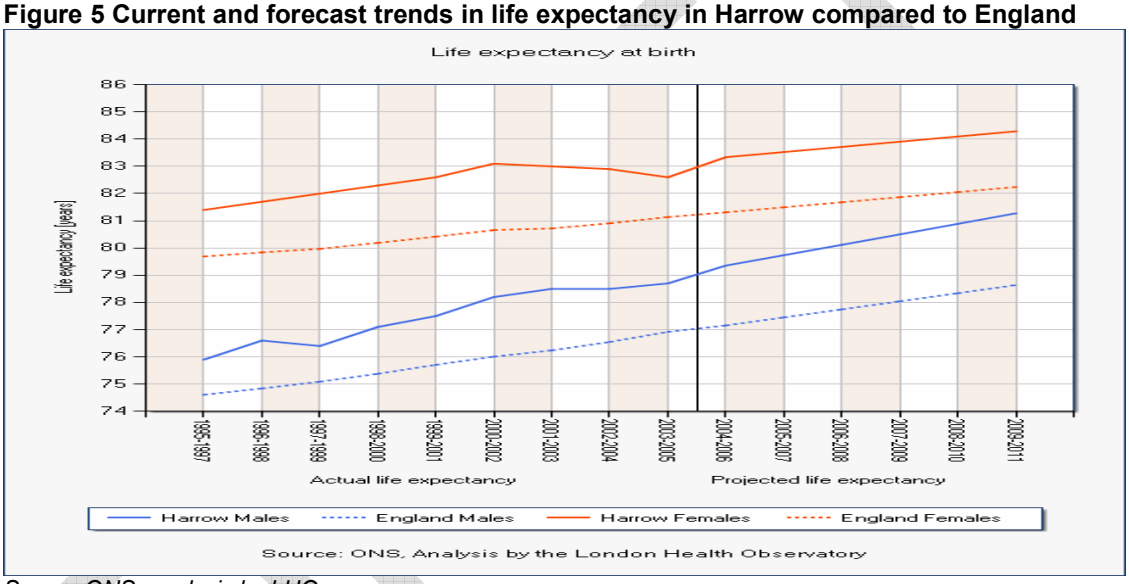
c. *Health Inequalities in Harrow*

Inequalities result from differences in health outcomes (i.e. mortality rates, life expectancy, etc.) which occur as a consequence of differences in health status (socio-economic, deprivation, life styles and behaviour).

i. Life expectancy

Life expectancy is an estimate of the number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life. It is calculated by gender and area of residence. Life expectancy in Harrow is above the England average for both males and females and is increasing at the same rate as England in females and a greater rate than England in males (Figure 5).

Figure 5 Current and forecast trends in life expectancy in Harrow compared to England

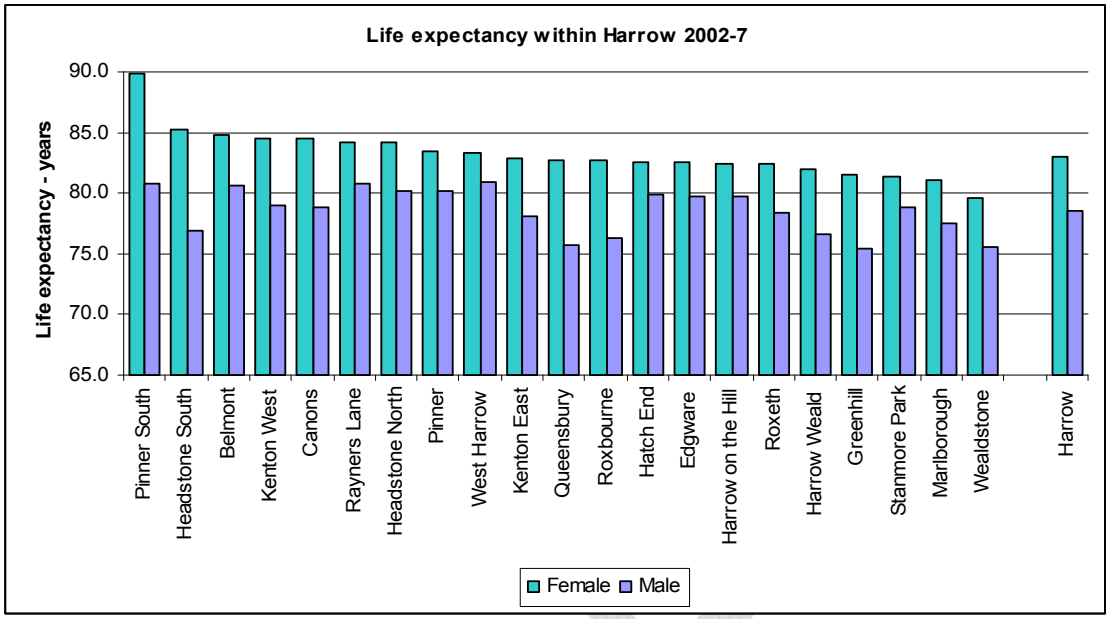


Source ONS, analysis by LHO

There are huge inequalities in life expectancy within Harrow. Women in Pinner South can expect to live more than 10 years longer than women in Wealdstone. Men in West Harrow can expect to live for five and a half years longer than men in Greenhill ward. (Figure 6)

In every part of Harrow, women live longer than men. On average men in Harrow can expect to live 78.7 years and women for 81.6 years. This gap between male and female life expectancy varies throughout Harrow. In West Harrow ward, the gap is only 2.5 years but in Pinner South women can expect to live more than nine years longer than men.

Figure 6 Life expectancy within Harrow 2002-7



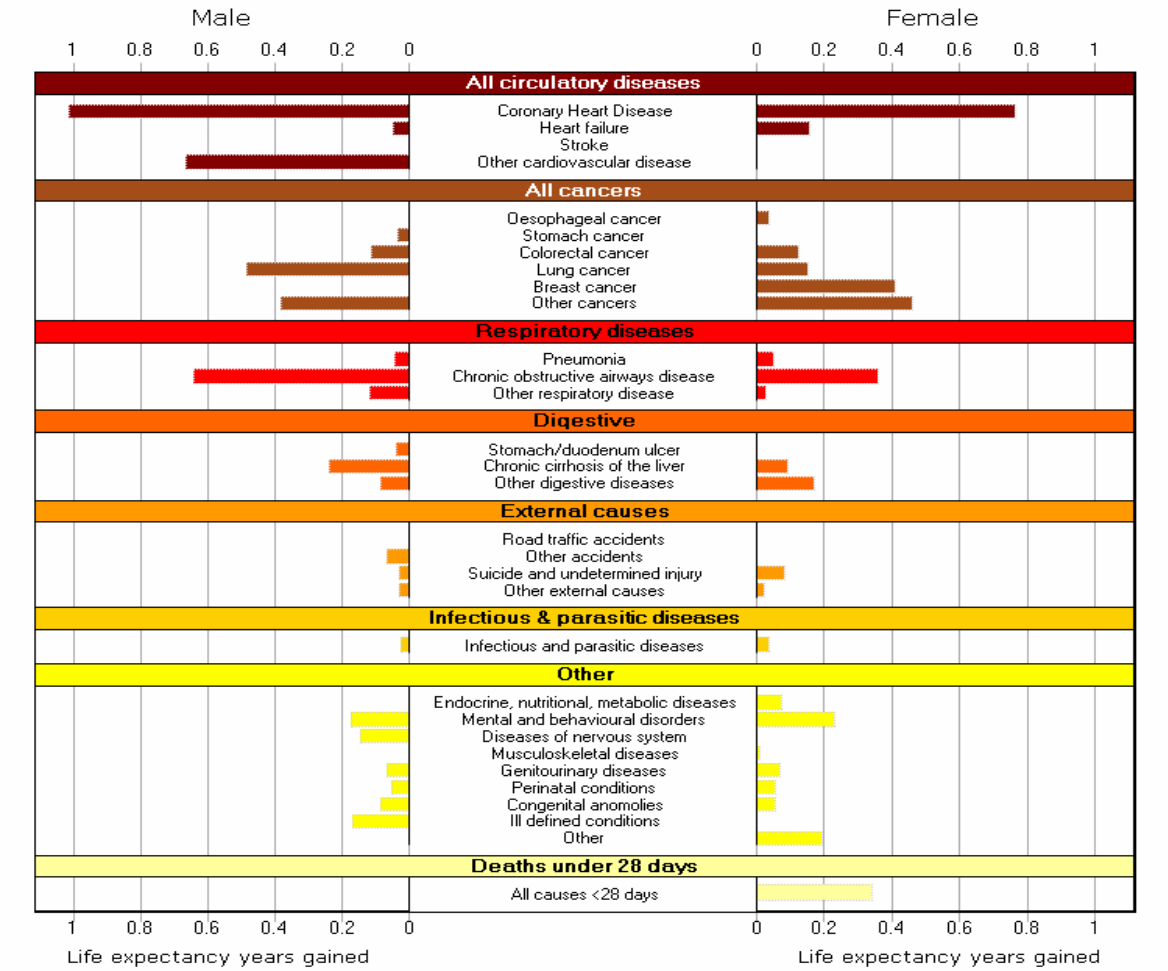
Source: LHO

ii. What is driving this gap in life expectancy?

If we look at the causes of death in the most affluent and the most deprived wards in Harrow, we can get an idea of the diseases that are causing this cap in life expectancy. We see that the biggest impact on life expectancy could be made by focusing on circulatory disease. If mortality rates from Coronary Heart Disease in the most deprived parts of Harrow were to reduce to the rate seen in the most affluent, life expectancy would increase by over a year in males and over 9 months in females. Lung cancer in men, breast cancer in women and COPD[iv] in both sexes are the other areas where significant gains in life expectancy could be made.

[iv] Chronic obstructive pulmonary disease – lung diseases such as emphysema and chronic bronchitis which are largely caused by smoking

Figure 7 Diseases driving the life expectancy gap within Harrow



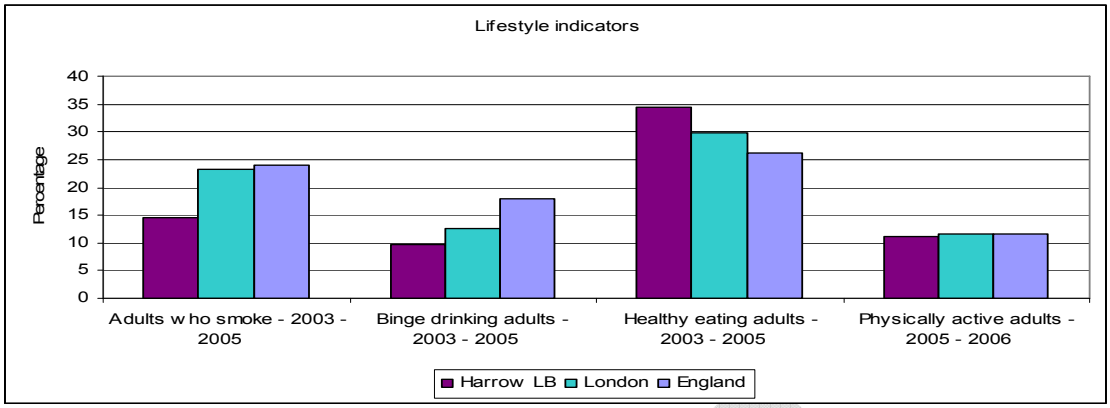
Source: London Health Observatory

d. Lifestyle

How we chose to live our lives influences our health. Smoking is the biggest cause of preventable ill health. In 2007, there were 687 deaths related to smoking in Harrow. Obesity is in the news a lot these days. In Harrow, 19.1% of adults are estimated to be obese. 9.4% of reception year children and 17.9% of year 6 children were found to be obese in 2007-8. The World Health Organisation reported in 2002 that 9.6% of male deaths and 11.5% of female deaths were related to obesity in England. In 2007, in Harrow this would equate to 156 deaths per year.

The proportion of people who smoke (14.5%) or binge drink (9.7%) in Harrow is lower than that of London and England as a whole and a higher proportion of people eat healthily (5 or more portions of fruit and vegetables per day). However, a slightly lower proportion of people take regular exercise. (Figure 8)

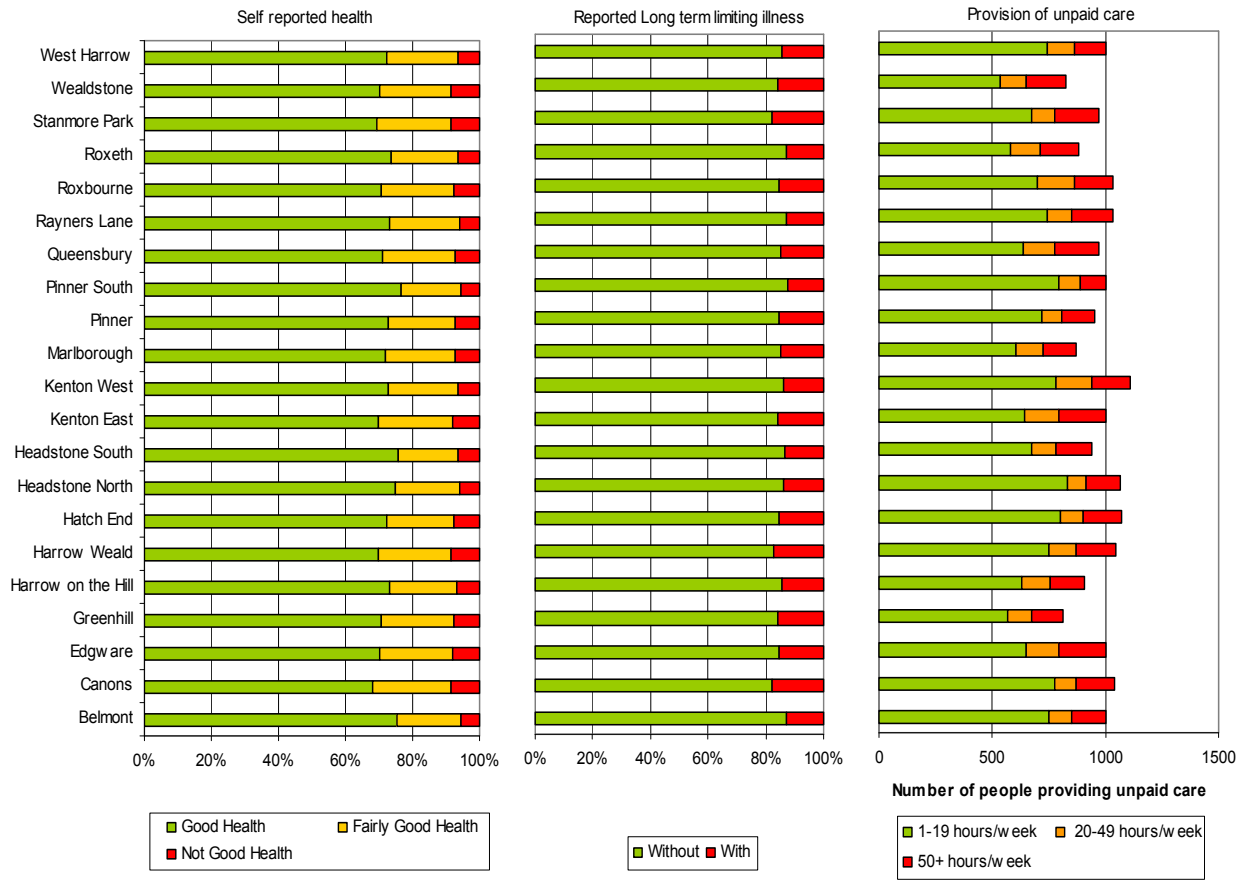
Figure 8 Lifestyle indicators



Source: ONS/NHS Information centre

Of course, health and wellbeing is not only about the diseases that we die from but also the things that impact on our quality of life. The highest proportion of people reporting that they had poor health are found in Harrow Weald (8.6%) compared to the lowest in Pinner South (5.4%). Pinner south also has the lowest percentage of people reporting a long term limiting illness (12.5%) compared to 17.8% in Stanmore Park. The number of people providing unpaid care was highest in Kenton East and the lowest in Wealdstone.

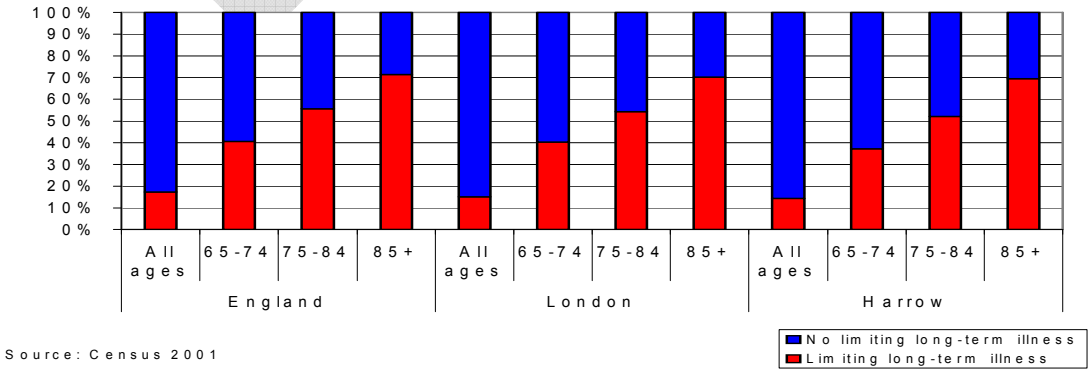
Figure 9 Ward level indicators affecting quality of life



Source: Neighbourhood statistics, from 2001 census

As would be expected as people age they report that they suffered from a limiting long-term illness more often. In Harrow the proportion of those reporting limiting long term illness who were aged 65 to 74 years was 37%, increasing to 52% in those aged 75 to 84 years and to 70% in those aged 85 years and above. In all age groups, the proportion of Harrow's population reporting limiting long-term illness was a little lower than the corresponding figures for England and London

Figure 10 Percentage of people in each age group reporting long term limiting illness



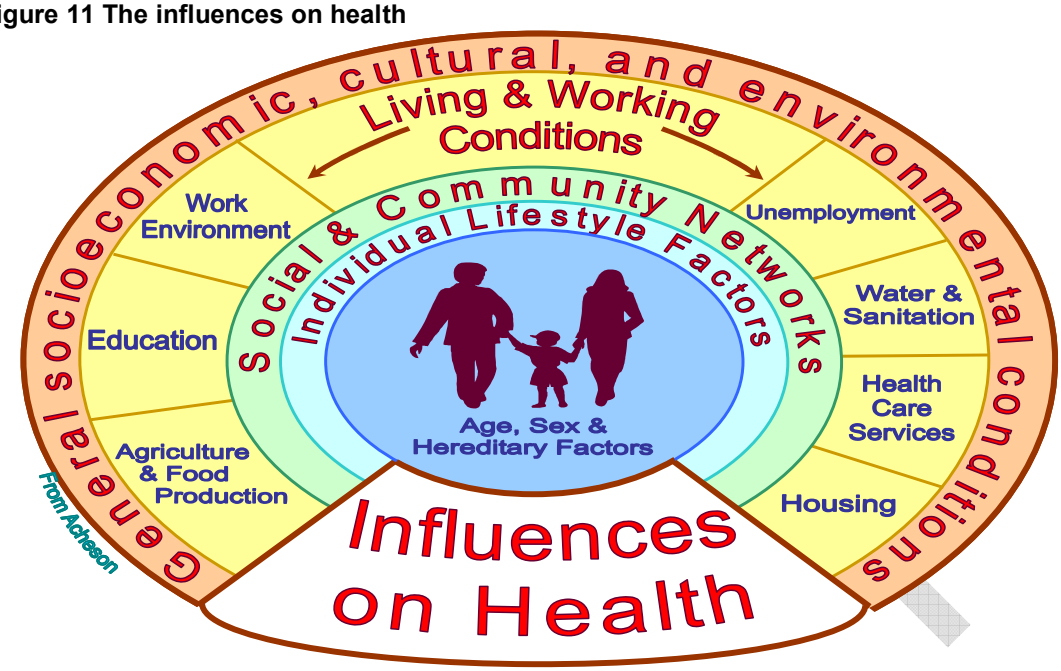
Source: Census 2001

e. Wider determinants of health

As we have already said health and well being is everyone's business. No single person or agency determines a population's health

- Our age, gender and genetic make up are something we can't get away from. Some diseases are more common in one gender; some conditions increase with age; some people are genetically predisposed to certain diseases.
- The decisions we take about our lifestyle will influence our health. Do we eat healthily, take enough exercise, smoke, drink alcohol, use drugs, sunbathe, have unprotected sex, or engage in high risk behaviours? All of these and more will have an impact on our health and wellbeing
- Our family and social networks and the way we interact with society around us also have an impact on our health. Our health habits are shaped as children and many of our health behaviours are influenced by our peers. Socially isolated people are more likely to have poorer health – and people with poorer health can become socially isolated.
- Where we live, what we do, how much we earn, the quality of our food, our water, our natural and built environment and what services are available to us can make us more or less healthy. Health services are only a small part of this whole picture. They are important in responding to ill health and in promoting good health.
- Taxation policy, funding of public services, global warming, intra- or international conflicts and economic recession are all issues that affect health and wellbeing but which have to be dealt with at a national and sometimes global level.

Figure 11 The influences on health



Source: Adapted from Dahlgren and Whitehead

Figure 12 shows some specific examples of how lifestyle and wider determinants impact on various health conditions.

Figure 12 Lifestyle and environmental determinants of observed mortality and morbidity

Condition	Lifestyle and environmental determinants
Circulatory disease	Smoking, alcohol abuse, nutrition, obesity, exercise, access to quality healthcare
Cancer	Smoking, nutrition, obesity, exercise, alcohol abuse, access to quality healthcare
Asthma and other respiratory problems	Environmental conditions, smoking, access to quality healthcare
Accidents and injuries	Inappropriate use of alcohol and drugs, lack of exercise, road traffic speed, unsafe housing design, inadequate supervision of young children, access to emergency care
Neuropsychiatric disorders	Alcohol abuse, drug abuse
Infections	Nutrition, food and water safety, drug abuse, sexual behaviours, travel, access to quality healthcare
Low birth weight	Smoking, nutrition, alcohol abuse, drug abuse, access to quality healthcare, prematurity

Source: The Health Status of the European Union: Narrowing the Health Gap, European Commission, 2003 and the Department of Health.

f. What can we do to improve health and wellbeing?

There is growing evidence that shifting the focus of health and wellbeing from providing services to respond to health needs to providing services to reduce the likelihood of future ill health through prevention and early intervention will be the most cost effective way forward.

The two Wanless reports[v][vi] showed that generally, about one third of the people, who are mostly living in the most deprived areas of the country, have much poorer health than the rest of the population and are more likely to die prematurely. We have shown in this briefing that this is also true in Harrow.

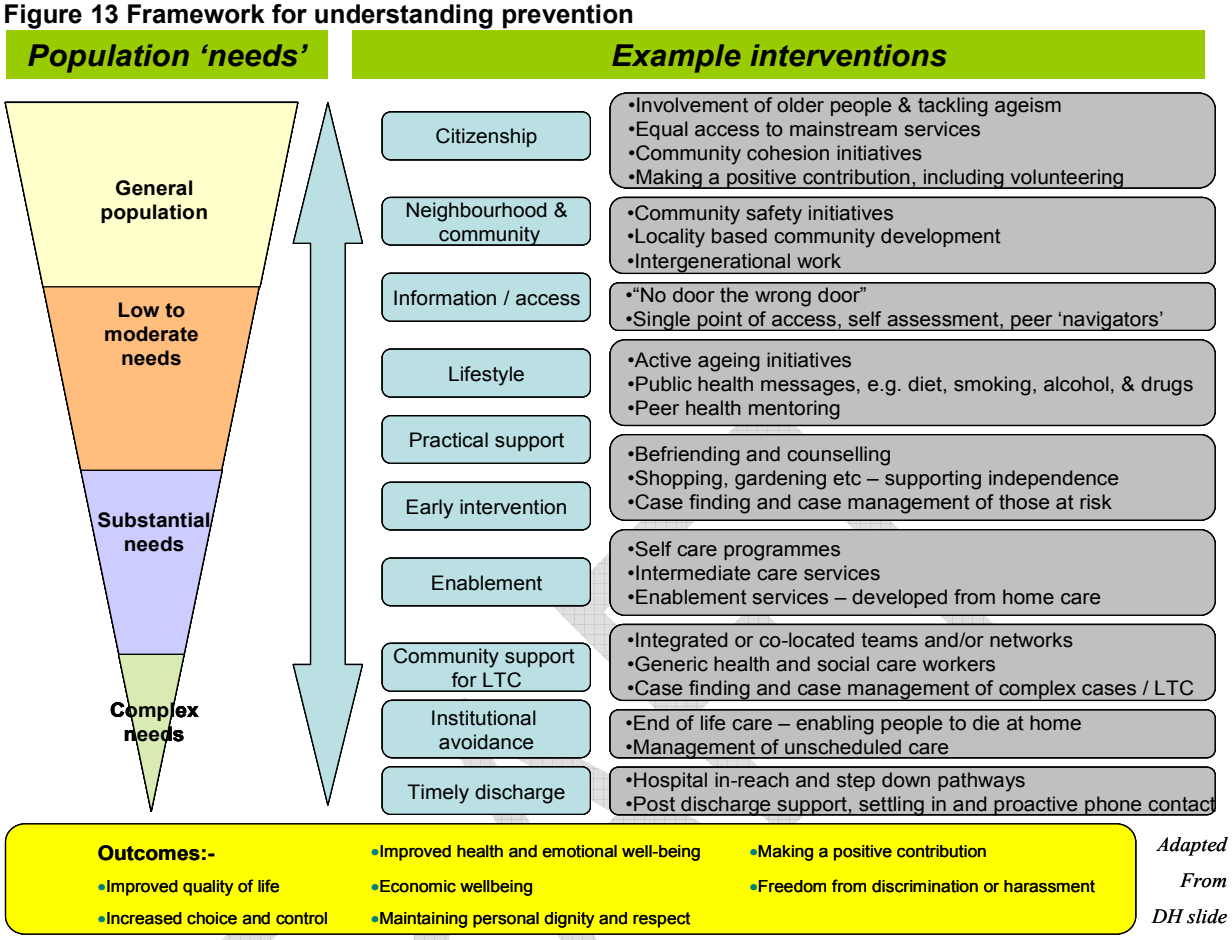
Wanless called for a 'fully engaged' scenario. This is characterised by high levels of public engagement in relation to their health; public confidence in the health system; public demand for high quality care; a responsive health service with high rates of technology uptake, particularly in relation to disease prevention; and the efficient use of resources. He said that this would achieve a greater increase in life expectancy; a dramatic improvement in health status and a lower increase in health and social care costs. This then must be our ultimate aim for health and wellbeing in Harrow.

Other evidence shows that for every £1 spent on preventive services to older adults, there is on average a £1.73 benefit and that good specialist support services improve not only health outcomes in terms of how many people end up in hospital but also the quality of life. (Partnerships for Older People Project, DH 2009).

We can only achieve these improvements in health and wellbeing by coordinated efforts of the “whole system”. Figure 13 shows the health triangle and suggests the sort of activities that could be undertaken to improve the health at people at different levels of health need. Obviously efficient, effective and targeted health and social care services are needed to address those with complex or substantial needs. This is already being addressed by the health sector and local authority. Where we can make a big difference is in the coordinated actions to address the needs of those with low and medium need and, of course, the general population.

[v] Securing our Future Health: Taking a Long-Term View, 2003
[vi] Securing Good Health for the Whole Population, 2004)

Figure 13 Framework for understanding prevention



Source: Adapted from Department of Health, Putting People First, 2009

[i] Dixon A. *Commissioning and behaviour change: Kicking Bad Habits final report.* The Kings Fund, 2008.