

MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 15TH JULY, 2021

AT 9.30 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

TO: MEMBERS OF HEALTH & WELLBEING BOARD (Quorum 3)

Chairman: Councillor Caroline Stock (Chairman),
Vice Chairman: Dr Charlotte Benjamin (Vice-Chairman)

Sarah McDonnell-Davies	Fiona Bateman	Dr Clare Stephens
Dr Tamara Djuretic	Councillor Sachin Rajput	Dawn Wakeling
Dr Nikesh Dattani	Councillor Richard Cornelius	Nitish Lakhman
Chris Munday	Caroline Collier	

Substitute Members

Dr Barry Subel	Councillor Rohit Grover	Dr Murtaza Khanbhai
	Councillor David Longstaff	Ben Thomas

In line with Article 3 of the Council's Constitution, Residents and Public Participation, public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is 10AM on Monday 12 July. Requests must be submitted to Salar Rida at salar.rida@barnet.gov.uk

You are requested to attend the above meeting for which an agenda is attached.
Andrew Charlwood – Head of Governance

Governance Services contact: Salar Rida 020 8359 7113, salar.rida@barnet.gov.uk
Media Relations Contact: Gareth Greene 020 8359 7039

ASSURANCE GROUP

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Decisions of the Health & Wellbeing Board

8 April 2021

AGENDA ITEM 1

Board Members:-

- * Cllr Caroline Stock (Chairman)
- * Dr Charlotte Benjamin (Vice-Chairman)

* Dr Tamara Djuretic	Cllr Sachin Rajput	* Fiona Bateman
* Dawn Wakeling	* Caroline Collier	Chris Munday
* Dr Nikesh Dattani	* Cllr Richard Cornelius	Dr Clare Stephens
* Cllr David Longstaff (Substitute)		Madeleine Ellis

* denotes Member Present

1. Minutes of the previous Meeting

The Chairman of the Health and Wellbeing Board, Councillor Caroline Stock welcomed all attendees to the virtual meeting.

It was RESOLVED that the minutes of the previous meeting of the Health and Wellbeing Board held on 14 January 2021 be agreed as a correct record.

2. Absence of Members

Apologies for absence were received from:

- Apologies have been received from Chris Munday
- Apologies received from Madeleine Ellis
- Apologies received from Dr Clare Stephens
- Apologies received from Councillor Sachin Rajput who was substituted by Councillor David Longstaff.

3. Declaration of Members' Interests

Dr Charlotte Benjamin, Vice-Chair of the HWBB declared a non-pecuniary interest on behalf of herself and Dr Nikesh Dattani in relation to the relevant agenda items as primary care providers via their respective GP Practices and GP Federation in the interest of transparency.

4. Public Questions and Comments

There were none.

5. Report of the Monitoring Officer

None.

6. List of HWBB Abbreviations

The Board noted the standing item on the agenda which lists the frequently used acronyms in HWBB reports.

7. COVID-19 Pandemic and Vaccination Programme verbal update

The Chairman welcomed Dr Tamara Djuretic, Director of Public Health and Vice-Chair Dr Charlotte Benjamin, NCL CCG to provide an update on COVID-19 in Barnet and the Vaccination Programme.

Dr Djuretic provided an update to the Board on COVID-19 cases within Barnet and noted that during the last few weeks there has been an increase within the 10-14 years age group due to the increased school testing however Barnet's rate remains low

It was further noted that currently approximately 160,000 people have been vaccinated in Barnet with the first dosage and the vaccination uptake is around 80% overall. Dr Djuretic referred attendees to the COVID update report which is published on the Council website [here](#)¹ and updated on a weekly basis.

A small number of wards showed a higher number of infections and lower vaccination uptake comparatively with other wards. Dr Djuretic informed the Board about the work undertaken with communities for tailored communication and the setting up of pop up clinics.

Dr Julie George, Deputy Director of Public Health gave an update on the work of the COVID-19 Health Champions noting that currently there were 245 registered Health Champions covering all wards in Barnet. Various communication channels have been utilised to disseminate key messages in 11 community languages. In addition, she noted that Health Champions are continuing to convey concerns and challenges faced by communities to ensure that these are addressed.

Dr Nikesh Dattani, NCL CCG updated the Board on the vaccination for care homes which had received the first and second dosage. Dr Dattani informed the Board that the feedback from care home patients has been positive and that being vaccinated has comforted patients about seeing visitors.

Dr Charlotte Benjamin provided an update on the immunisation programme. She spoke about the issue of safety in relation to vaccines and noted it being continuously monitored. Following a query about concerns around blood clots, Dr Benjamin noted that based on ongoing evidence, it is a very small number of people

¹ <https://www.barnet.gov.uk/coronavirus-covid-19-latest-information-and-advice/Barnet-weekly-COVID-19-dashboard#title-2>

who are impacted in certain age groups – in addition, the advice provided to certain age groups is tailored based on ongoing evidence.

The Chairman thanked the Board for the discussion and presentations.

8. Long COVID Verbal presentation

The Chairman welcomed Dr Katie Coleman (NCL CCG) GP Lead for Patient and Public Participation. Dr Coleman provided a presentation to the Board about the impact of Long COVID which is also referred to as post-COVID syndrome.

Dr Coleman spoke about the number of people affected by Long COVID across NCL and noted that Long COVID can be defined as signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis. The Board also noted the arrangements in place across NCL to support patients and to allow for patient management and close collaborative working.

The Chairman thanked Dr Coleman for the presentation and invited Dr Michael Webb Registrar at Barnet Hospital, to share his personal experience with Long COVID.

Dr Webb informed the Board about the impact of Long COVID on his physical and mental health. He noted that being able to work has had a positive impact on mental health, although tiredness was still persistent. Dr Webb noted that he was pleased with the support provided by UCLH Long COVID clinic integrated teams, as this is a new area and there is relatively less data available about Long COVID.

The Chairman thanked Dr Webb for sharing his experience with the Board.

9. COVID-19 and Recovery verbal update

Caroline Clarke Royal Free Group Chief Executive and Deborah Saunders Chief Executive Barnet Hospital were welcomed by the Chairman and joined the meeting.

The Board heard about the COVID patients which have been fewer in number in comparison to the previous update provided to the Board. The Board noted the working arrangements towards managing outpatient activity, the arrangements in place to manage waiting lists more effectively and the ways in which virtual NHS appointments have been facilitated. Board Members also noted the investment which has been made towards staff rest facilities and the support available for staff, particularly those affected by Long COVID.

The Chairman thanked Caroline Clarke and Deborah Saunders and staff at the Royal Free on behalf of the Board for all their continued efforts.

10. Barnet Joint Health and Wellbeing Strategy 2021-25

The Chairman welcomed the Joint Health and Wellbeing Strategy for 2021-2025 which sets a vision for creating a borough of health together with our residents, communities, NHS partners, Voluntary and Community Sector, Healthwatch, small and medium business, educational sector, police, fire and others.

The Chairman invited Dr Tamara Djuretic, Director of Public Health and Oliver Taylor, Public Health Strategist to present the item.

The Board noted the presentation and the three key areas to be delivered as part of the Strategy in order to drive integrated improvements in health and wellbeing in Barnet:

1. Creating a healthier place and resilient communities
2. Starting, living and ageing well
3. Ensuring delivery of coordinated holistic care, when we need it

The Board will be updated on the progress against the delivery of the Strategy through the Strategy Implementation Plan reported to the Board annually. (**Action:** Governance - Forward Work Programme)

Following a suggestion from Councillor Richard Cornelius, it was agreed that a succinct one-page summary of the Strategy would be developed. (**Action:** Public Health)

In response to a query raised by Councillor David Longstaff, Officers agreed to provide information to Councillor Longstaff about the source of information and the consultation on school meals for children and the quality of school meals. (**Action:** Public Health)

Councillor Longstaff referred to section 5.7.1 of the report and raised a query regarding the consultation for Looked After Children and their needs. Dr Djuretic explained that this matter has been discussed at the Children's Board and that it is unfortunate that no one from Family Services attended the HWB Board to provide further details.

The Board noted that the full consultation report would be circulated and agreed that the Strategy Report together with the consultation findings be reported to the July HWBB meeting for final sign off.

It was therefore **RESOLVED:**

1. **That the Health and Wellbeing Board agreed to defer the approval of the final version of the Joint Health and Wellbeing Strategy 2021-25 for implementation until July's HWB Board on 15th July.**
2. **That the Health and Wellbeing Board agreed to receive the final version of the Joint Health and Wellbeing Strategy 2021-25 at its July meeting together with the consultation findings.**

11. Cancer Screening for people with Learning Disabilities

The Chairman invited Ray Booth Chief Executive Barnet Mencap for a presentation on cancer screening for people with learning disabilities.

The Board welcomed the informative video presentation which explains the process of cancer screenings for bowel cancer, breast cancer and cervical cancer for people with learning disabilities, including reasonable adjustments that can be made.

Mr Booth noted that the video has been shared with partners across NCL and encouraged wider circulation through partners, NCL Cancer Alliance and GPs. The video is available to view [here](#)².

The Chairman thanked Mr Booth and the participants in the video for sharing their experiences on behalf of the Board.

12. Healthwatch Update on COVID-19

The Board noted that a follow up update will be provided at its future meeting.

The Chairman welcomed Caroline Collier CEO Inclusion Barnet who gave an update to the Board on the work delivered by Barnet Together on COVID-19 in providing support, training, resources and advice to Barnet's voluntary and community organisations.

13. Local Outbreak Management Plan

Dr Tamara Djuretic and Dr Janet Djomba Public Health Consultant presented the report which reflects the approach to the core aspects of the end-to-end COVID-19 response.

The Board welcomed the Plan and it was **RESOLVED**:

- 1. That the Health and Wellbeing Board approved the Local Outbreak Management Plan (LOMP).**
- 2. That in respect of the LOMP authority be delegated to the Director of Public Health and Prevention in consultation with the Chairman.**

14. Update Presentation on Barnet Integrated Care System and Integrated Care Partnership

Dawn Wakeling, Executive Director Adults and Health and Dr Charlotte Benjamin presented the item to the Board.

Board Members noted the work being delivered towards:

- The development of the integrated discharge team to support patients leaving hospital
- Support towards infection prevention control measures and other services

² <https://www.youtube.com/watch?v=WMR-yz5qqag>

- Responding to health inequalities that have been highlighted through the pandemic
- Multi-agency locality working around Primary Care Networks

It was agreed that a detailed update report will be brought to the next meeting of the HWBB which will include details about the priorities. (**Action:** Forward Work Programme)

The Chairman thanked the Board Members and all attendees for their contribution and presentations.

15. Any Items the Chairman decides are urgent

None.

The meeting finished at 12.15

Health and Wellbeing Board abbreviations

AOT	Adolescent Outreach Team
ACT	Adolescent Crisis Team
ACE	Adverse Childhood Events
ASC-FR	Adults Social Care Finance Return
ADHD	Attention Deficit Hyperactivity Disorder
ASC	Autism Spectrum Condition
BAME	Black, Asian and Minority Ethnic Groups
BAS	Barnet Adolescent Service
BCF	Better Care Fund (NHS and local government programme which joins up health and care services so people can manage health, live independently and longer)
BEH MHT	Barnet, Enfield and Haringey Mental Health Trust
BOOST	Burnt Oak Opportunity Support Team (multiagency team with staff from Jobcentre Plus, Barnet Homes, Councils Benefit Service, Education and Skills Team)
CAW	Case Assistant Worker
CBT	Cognitive Behaviour Therapy
CC2H	Barnet Care Closer to Home
CCG	Clinical Commissioning Group
CCS	Concepts care solutions
CEPN	Barnet Community Education Provider Networks
CHIN	Care and Health Integrated Networks
CETR	Care, Education and Treatment Reviews
CLCH	Central London Community Healthcare
CNWL	Central and North West London NHS Foundation Trust
CRAT	Carer Recruitment and Assessment Team
CWP	Children's Wellbeing Practitioners
CYP	Children and Young People
DCT	Disabled Children's Team
DPR	Delegated Powers Report
DPP	Diabetes Prevention Programme
DBT	Dialectical Behaviour Therapy
DPH	Director of Public Health
CWP	Children and Young People Wellbeing Practitioners
DSH	Deliberate Self Harm
DIT	Dynamic Interpersonal Therapy
DOT	Direction of Travel status
DRP	Disability and Resource Panel
DToC	Delayed Transfer of Care
EHC	Emergency Hormonal Contraception
EET	Education, employment and training
EP	Educational Psychologist
EPS	Electronic Prescription Service

AGENDA ITEM 6

FAB	Fit and Active Barnet
GLA	Greater London Authority
HCA	Health Care Assistants
HCC	Healthier Catering Commitment
HEE	Health Education England
HEP	Health Education Programme
HLP	Healthy London Partnership
HSL	Healthy Schools London Programme
IAPT	Improving Access to Psychological Therapy
iBCF	Improved Better Care Fund (Additional money given directly to local government)
ICS	Integrated Care System
ICP	Integrated Care Partnership
IPC	Infection Prevention and Control
IPS	Individual Placement Support
IPT	Intensive Psychotherapy Treatment
IRIS	Identification and Referral to Improve Safety
JCEG	Joint Commissioning Executive Group
JHWS	Joint Health and Wellbeing Strategy
JOY	Joining Old and Young
JSNA	Joint Strategic Needs Assessment
Kooth	Online Counselling and Emotional Wellbeing
KPI	Key Performance Indicators
LCRC	London Coronavirus Response Cell
LGA	Local Government Association
LGD	Local government declaration of sugar reduction and healthier eating
LOMP	Local Outbreak Management Plan
LOS	Length of Stay
LOCP	COVID-19 Local Outbreak Control Plan
LCS	Locally Commissioned Service
LTP	Local Transformation Plan
MDT	Community Multi-Disciplinary Team model
MTFS	Medium Term Financial Strategy
MASH	Multiagency Safeguarding Hub
MIT	Market Information Tool
MHST	Mental Health Support Team
MOMO	Mind of my own app
NCL	North London Clinical Group: Barnet, Camden, Enfield, Haringey and Islington
NCMP	National Child Measurement Programme
NEL	North East London

NP	Non-Pharmaceutical Interventions
OCHT	One Care Home in-reach Team
OT	Occupational Therapist
OHS	Occupational Health Service
PBS	Positive behaviour support
PPE	Personal Protective Equipment
PSED	Public Sector Equalities Duty
PSR	Priorities and Spending Review
PCN	Primary Care Network
PMHW	Primary Mental Health Worker
PQA	Performance and Quality Assurance
RAG	Red Amber Green rating
REACH	Resident, Engaged, Achieving Children Hub
RMN	Registered Mental Health Nurse
RFL	Royal Free London
SEAM	Sexual Exploitation and Missing
SENCO	Special Educational Needs Coordinator
STP	Sustainability and Transformation Partnerships
STPP	Short Term Psychoanalytic Psychotherapy
SPA	Sport and Physical Activity
QAM	Quality Assurance Monitoring Panel
QIPP	Quality, Innovation, Productivity and Prevention Plan
QIST	Quality Improvement Support Team
QWELL	Online support for professionals and parent/carers/staff
S7	Significant Seven Training to support staff in early identification of deterioration of patients
SAB	Safeguarding Adults Board
SAC	Safeguarding Adult's Collection
SALT	Short and Long Term support
SARG	Safeguarding Adolescents at Risk Group
SCAN	Service for children and adolescents with neurodevelopmental difficulties
SEND	Special Educational Needs and Therapy
SENDIASS	Special Education Needs and Disabilities Information, Advice and Support Services
STP	Sustainability and Transformation Plan
STPP	Short Term Psychoanalytic Psychotherapy
TOR	Terms of Reference
TTT	Test, Track and Trace
VARP	Vulnerable Adolescents at Risk Panel
VAWG	Violence Against Women and Girls
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise
VOC	Variants of Concern
VCSE	Voluntary Community and Social Enterprise
YCB	Your Choice Barnet

YOT	Youth Offending Team
WDP	Westminster Drug Project
WHO	World Health Organisation

**Health and Wellbeing Board
Work Programme**

2021-2022

Contact: Salar Rida (Governance) salar.rida@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision
15 July 2021				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key
COVID-19 Pandemic Update (verbal) and Barnet Hospital update	The Board to note the verbal update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	Non-key
Final Joint Health and Wellbeing Board Strategy Report including consultation findings	The Board to approve the final Strategy	Director of Public Health and Prevention	Public Health Strategist, Oliver Taylor	Key
North Central London Clinical Commissioning Group Strategic Review of Community and Mental Health Services	The Board to note and discuss the item	Executive Director of Transition, NCL CCG	Executive Director of Transition, NCL CCG	Non-key
North Central London Integrated Care System (ICS) Development presentation	The Board to note the presentation	Executive Director of Transition NCL CCG	Executive Director of Transition NCL CCG	Non-key
Update Report on the Barnet Integrated Care Partnership and Integrated Care Systems	The Board to note the report	Executive Director, Adults & Health, Vice Chair NCL CCG	NCL CCG Director of Integration, Barnet Borough	Non-key
Suicide Prevention Strategy 2021-2025	The Board to note and discuss the report	Director of Public Health and Prevention	Specialist Registrar in Public Health	Non-key
Healthwatch Update Presentation	The Board to note the recommendations and update.	Healthwatch Manager	Healthwatch Manager	Non-key

***A key decision is one which:** a key decision is one which will result in the council incurring expenditure or savings of £500,000 or more, or is significant in terms of its effects on communities living or working in an area comprising two or more Wards

Barnet Together Update Presentation	The Board to note the recommendations and update.	CEO Inclusion Barnet	CEO Inclusion Barnet	Non-key
Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet	The Board to note the update.	Director of Public Health and Prevention Deputy Director of Public Health	Director of Public Health and Prevention Deputy Director of Public Health	Non-key
New Warding Arrangements Presentation	The Board to note the presentation.	Head of Assurance and Business Development	Head of Assurance and Business Development	Non-key
30 September 2021				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key
COVID-19 Pandemic Update (verbal)	The Board to note the update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	TBC
Joint Strategic Needs Assessment Update and approval	The Board to note and approve the update report.	Director of Public Health and Prevention	Director of Public Health and Prevention	TBC
Vaccination – wider approach	To note the update.	NCL CCG	NCL CCG	Non-key
Deep Dive – (Joint Health and Wellbeing Strategy key area 1)	To note the report.	Director of Public Health and Prevention	Director of Public Health and Prevention	TBC
9 December 2021				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key

COVID-19 Pandemic Update (verbal)	The Board to note the update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	TBC
COVID-19 Champions	To note the update.	Director of Public Health and Prevention	Director of Public Health and Prevention	TBC
Neighbourhood Model Working (linked to key area JHWBS)	To note the report.	Director of Public Health and Prevention	Director of Public Health and Prevention	TBC
24 March 2022				
List of abbreviations	The Board to note the list	Chair of the HWB Board	Governance Officer	Non-key
Forward Work Programme	The Board to note the Programme	Chair and Vice Chair of the HWB	Governance Officer	Non-key
COVID-19 Pandemic Update (verbal)	The Board to note the update	Director of Public Health and Prevention Vice Chair of the HWB	Director of Public Health and Prevention Vice Chair of the HWB	TBC

Suggested future and standing agenda items	
Suggested future items	Standing agenda items
Cardiovascular Disease Prevention – Deep dive	Forward Work Programme
Enhanced care in Care Homes	ICP Updates
Air Quality	BCF update plan
SEND Strategy	

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AGENDA ITEM 9

	<h2>Health and Wellbeing Board</h2> <h3>15 July 2021</h3>
Title	Final Barnet Joint Health and Wellbeing Strategy 2021-2025
Report of	Director of Public Health and Prevention
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	<p>Appendix I: Final Barnet Joint Health and Wellbeing Strategy 2021-2025</p> <p>Appendix II: Barnet Joint Health and Wellbeing Strategy 2021-2025: one-page summary</p> <p>Appendix III: Draft outcome monitoring approach and draft implementation plan</p> <p>Appendix IV: Draft Barnet Joint Health and Wellbeing Strategy 2021-25: report of consultation findings</p>
Officer Contact Details	<p>Oliver Taylor, Health in All Policies Officer – oliver.taylor@barnet.gov.uk</p> <p>Kirsty Dutton, Project Development Manager - Kirsty.dutton@barnet.gov.uk</p>
<h2>Summary</h2>	
<p>This report provides the final update on the development of the Barnet Joint Health and Wellbeing Strategy (JHWS) 2021-25. Since the last update to the board in March 2021, progress has been made to finalise the Strategy. This report is asking for approval of the Strategy, in order to meet the Board’s statutory duties.</p> <p>Appendix I provides the final strategy document with the plan for its implementation; Appendix II provides a one-page summary of the strategy document; Appendix III provides an overview of the proposed approach to outcome monitoring and the draft implementation plan; Appendix IV provides the consultation findings report</p>	

Recommendations

- | |
|---|
| <p>1. That the Health and Wellbeing Board approve the final version of the Barnet Joint Health and Wellbeing Strategy 2021-25 for implementation.</p> |
| <p>2. That the Health and Wellbeing Board note and discuss the proposed approach to outcome monitoring and implementation plan, to be fully developed and presented at HWB Board in September.</p> |

1. WHY THIS REPORT IS NEEDED

- 1.1 Producing a JHWS is a statutory duty of the Health and Wellbeing Board and it is aimed to articulate vision and ambition to improving health and wellbeing outcomes for Barnet's residents. Current Strategy has been extended to July 2021 and therefore final Barnet JHWS 2021 to 2025 is produced across the partnership, for final approval.

2. REASONS FOR RECOMMENDATIONS

- 2.1 Developing a new JHWS is one of our key priorities and a statutory duty, even during this unprecedented period of the COVID-19 pandemic. Health and Wellbeing Board oversees and approves the Strategy for the borough. Following on from previous updates to the board, recommendations provide the board the opportunity to review the final draft, approve the strategy and enable start of the JHWS implementation phase. This strategy has been developed over the last 18 months through a process of engagement workshops with the Board, wide residents' engagement and consultations, the intelligence and insight provided in the Barnet Joint Strategic Needs Assessment (JSNA), other national and international research and review of evidence base and best practice.
- 2.2 Healthwatch was commissioned to engage with residents and gather views on COVID-19 pandemic impact, with a specific focus on engagement with various minority ethnic groups. Healthwatch findings have fed into the strategy development. Full report and findings can be accessed here: [Health and Wellbeing Strategy Engagement | Barnet Council](#)
- 2.3 As JHWS has been developed and reviewed during the pandemic, particular attention has been paid to learn lessons from the pandemic and incorporate some emerging opportunities as well as longer-term impacts of the pandemic into the strategy.
- 2.4 The priorities within this strategy have been refined through engagement with our partners across the health and care system and with key departments within the local authority. The direction of the JHWS has also been guided by changes to the national and local reconfiguration of health and social care, as per the White Paper: [Integration and Innovation: Working together to improve](#)

[health and social care for all \(HTML version\) - GOV.UK \(www.gov.uk\)](#) . This includes the North Central London merger of borough-based clinical commissioning groups, the national development of Integrated Care Systems and the development of the Barnet Integrated Care Partnership.

- 2.5 Finally, Barnet JHWS is supporting delivery of the Barnet Plan 2021 to 2025, in particular, the cross-cutting Prevention workstream.
- 2.6 The JHWS development process articulated the vision and defined three key areas of focus. Key Area 1 is focusing on the things that can be improved for all residents in Barnet to promote the overall health and wellbeing of the borough, Key Area 2 is focusing on support for people at risk of developing physical and mental ill health, while Key Area 3 is focusing on improving services for those who do need to access them.
- 2.7 Key Area 1 looks to create healthy environment where a healthy choice is an easier choice and to support local communities to be safe and resilient. We are approaching this priority by focusing on the ‘Healthier High Streets’ Programme.¹ High Streets have a unique position within our communities and can positively affect our social, environmental and economic capital and as such, play an important role on both the direct and indirect health of local communities. COVID-19 pandemic will have longer-term impact on the future ‘look and feel’ of our High Streets and it is important that potential negative impact on lifestyle is minimised through this environment.

With the “Healthier High Streets Programme” we want to maximise promotion of health and wellbeing via local businesses already operating within our high streets, and ensure that new retail, hospitality and leisure premises are conducive to health. We will work with local businesses to promote access to drinking water, changing places and to establish an engagement schemes aimed to improve the local food environment, social inclusion of older adults and breastfeeding parents.

- 2.8 Key Area 2 is focusing on preventing long-term conditions and mental ill health by taking life-course approach. The Marmot Review² emphasised the importance of having a best start in life and its impact on the rest of ones’ life. Therefore, improving life chances for children and young people by promoting good nutrition through breastfeeding, protecting from illness through vaccinations and ensuring that oral health is maintained, will set healthy foundations for later life. The COVID pandemic has demonstrated how children and young people’s mental health has been compromised by

¹ PHE 2018: Healthy high Streets [Healthy High Streets Briefing document \(publishing.service.gov.uk\)](#)

² Institute of Health Equity, 2020: Health Equity in England: Marmot Review, 10 years on. [Health Equity in England: The Marmot Review 10 Years On | The Health Foundation](#)

significant disruption to education, access to services and social contact. The Resilient Schools Programme, which has been in place for 3 years so far, aims to equip teachers and schools with the skills to support young people and provide environments which support mental and emotional wellbeing. This Programme is set to expand and strengthen over the coming years. Barnet has a large older population and people live long life locally however, on average, last 20 years are spent in poor health, mainly due to long-term conditions. Key Area 2 focuses on promoting healthy lifestyle behaviours, improving physical activity and mental wellbeing – factors that influence overall physical health.

- 2.9 The Barnet Integrated Care Partnership (ICP) within North London Partners in Health and Care have been developing closer integration of services across health and social care. This collaboration, particularly embracing the statutory and voluntary sectors, has strengthened further during the pandemic. Key Area 3 of the JHWS links to the priority areas identified for the ICP for 2021 (children and young people, mental health and health inequalities) and builds on the positive opportunities emerged during the pandemic, such as embracing digital consultation and better multidisciplinary work. Key Area 3 will also tackle big challenges caused by the pandemic in terms of clearing backlog and reducing existing waiting times for managing long-term conditions, as well as looking into impacts of long-Covid on local residents.
- 2.10 Although the Strategy aims to articulate vision and provide the overall priority framework, its implementation/action plan is seen as an iterative document that will be reviewed and updated on annual basis, to reflect local progress, identify further area of concern and integrate lessons learnt.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

- 3.1 Alternative options were not considered.

4. POST DECISION IMPLEMENTATION

- 4.1 Once the Strategy is approved, a communication plan will be developed to support its dissemination. It is proposed to socialise the strategy at various Committee meetings, where relevant (e.g Adults and Safeguarding Committee, Environment Committee etc.) in order to ensure cross-council engagement in improving residents' health and wellbeing outcomes. The implementation plan will be supported by a set of outcomes, aimed at tracking the progress. Regular updates to the Board on the progress of the strategy implementation will be made by the Director of Public Health and Prevention, in collaboration with local partners.

5. IMPLICATIONS OF DECISION

- 5.1 **Corporate Priorities and Performance**

5.1.1 The purpose of the Barnet Joint Health and Wellbeing Strategy is to improve the health and wellbeing of the local community and reduce health disparities for all ages. The priorities articulated in this Strategy will link to The Barnet Plan 2021 to 2025.

5.1.2 In addition to linking to corporate priorities, an outcome monitoring approach is currently being devised. This approach will provide outcomes and measurables for each key area and align with the implementation plan included in the final strategy document. An overview of the approach to implementation and outcome monitoring as well as the draft implementation plan are included as Appendix III.

5.2 **Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)**

5.2.1 Implementation of the Barnet JHWS will need to be affordable and funded within the existing budget and staffing from the (non-Covid-19) PH Grant and wider system. Opportunities for attracting external funding will be sought, going forward. For example, Public Health England's external funding was recently attracted to fund Healthy Weight pathway locally. It is envisaged to pursue similar opportunities during the life of the Strategy.

5.3 **Social Value**
Not applicable

5.4 **Legal and Constitutional References**

5.4.1 Developing a JHWS is a statutory responsibility of the Health and Wellbeing Board, as set out in the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012).

The requirements of the Equality act 2010, and in particular the Public Sector Equality Duty (PSED) under s149 apply when drafting the JHWS.

The PSED requires that public bodies have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between people from different groups; and
- Foster good relations between people from different groups.

5.4.2 Article 7 Committees, Forums, Working Groups and Partnerships of the Council's Constitution sets out the terms of reference of the Health and Wellbeing Board which includes:

- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.
- To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate
- To work together to ensure the best fit between available resources to meet

the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.

- Specific responsibilities for overseeing public health and developing further health and social care integration

5.5 Risk Management

- 5.5.1 Due to unpredicted nature of COVID-19 Pandemic, it is possible that the Strategy will not be finalised by July 2021. In order to mitigate those risks, development of the Strategy has started early, and sufficient time has been allocated to develop the Strategy, within limited capacity and resources that may be diverted to respond to the Pandemic.

5.6 Equalities and Diversity

- 5.6.1 A whole systems approach to prevention and health and care integration focus on health disparities which persist amongst groups with protected characteristics. By consulting and engaging with appropriate communities and stakeholders, it is expected that a whole systems approach to prevention will prevent unintended harms against marginalised groups and promote health equity. As the COVID-19 pandemic has shone a further light on disproportionality of the health outcomes amongst various groups, reviewed Health and Wellbeing Strategy process included an engagement with diverse communities with a particular focus on Black, Asian and Minority Ethnic Groups.

5.7 Corporate Parenting

- 5.7.1 As a result of the Health and Wellbeing Strategy development, the objectives set out in the strategy do provide opportunities to support the council's role as corporate parent through the health and wellbeing improvement interventions for children and young people residing in the borough, including children in care.

5.8 Consultation and Engagement

- 5.8.1 A consultation on the draft strategy was carried out between 29 January 2021 and 12 March 2021. This consultation consisted primarily of an online questionnaire with an engagement session taking place with Barnet MENCAP users. The option of alternative questionnaire formats was advertised but not taken up by respondents. 72 responses were received for the questionnaire.
- 5.8.2 Overall the feedback from the consultation was positive with the majority of respondents in agreement with the proposed vision, guiding principles and key areas. From the consultation there were some suggestions on changes to the strategy document which produced a series of recommendations from the findings. These recommendations have been included in the drafting of the strategy. The full findings report for this consultation and the recommendations are included as Appendix IV.
- 5.8.3 Healthwatch Barnet were commissioned by the Public Health Directorate to conduct engagement activities with a focus on gaining residents views on the draft strategy and how the pandemic has affected resident's health and access

to services. This engagement also included focused work with Asian, Jewish, Black African and Black Caribbean residents to gain an in-depth understanding of their experiences of the pandemic. Insights on residents' views provided through the course of the Healthwatch engagement have provided us with a valuable understanding of what is important to residents including those in BAME communities and we have applied this to our approach to developing and writing the new JHWS. The full findings of this engagement can be accessed here: [Health and Wellbeing Strategy Engagement | Barnet Council](#)

5.9 **Insight**

5.9.1 Barnet's Joint Strategic Needs Assessment informed development of the Strategy as well as in-depth information on COVID-19 impact in the borough.

6. **BACKGROUND PAPERS**

6.1 Final Joint Health and Wellbeing Strategy (April 2021) Available at: <https://barnet.moderngov.co.uk/documents/s64507/Final%20JHWS%20board%20Report.pdf>

6.2 The Barnet Plan 2021 to 2025, Available at: <https://www.barnet.gov.uk/your-council/policies-plans-and-performance/corporate-plan-and-performance>

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Barnet Joint Health and Wellbeing Strategy 2021-2025

Creating a borough of health together!



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Foreword

Barnet is an exciting and diverse borough that is growing rapidly and is a very special place to live, work and study. We are delighted to introduce the new Barnet Joint Health and Wellbeing Strategy that sets out a vision for creating a borough of health, working together with our residents and other partners including the NHS, Voluntary and Community Sector, Healthwatch, local businesses, the educational sector, the police, fire and ambulance services.

It is important now more than ever before that we join forces across the system to take all the lessons learnt from the COVID-19 pandemic and build upon and capture the excellent work taking place locally. The World Health Organisation defines health “as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. We are committed to improving the health and wellbeing of all Barnet residents. We also aim to focus on reducing inequalities and assisting those who need help most in a fast and effective way.

We have an ambition to make meaningful changes on the issues that people have told us matters most to them. Our priorities therefore cover commitments to work across the whole system to create an environment where the healthier choice is the first, easiest and most affordable choice. One of the keys for this to be effective is developing and coordinating an understanding of the root causes of issues, so that together we can achieve a shift in attitudes and culture, where we remove the barriers to healthy behaviours. Our aim is to create an environment that allows everyone to live a long and fulfilled life. We are committed to supporting the very best start for everyone and gaining an understanding of the ongoing needs for living and aging well. Additionally, where needed, the strategy aims to provide timely and appropriate access to local health and care services, in a seamless and integrated way. This gives the greatest chance that everyone of whatever background, is able to be well, independent and safe.

Having the right strategy that articulates commitments and vision is the first step and importantly what will count next is how we deliver our ambitions together. If we are to improve health outcomes, all sectors, organisations, and communities have a role to play to really make a difference for the health and wellbeing in Barnet.

Let's do it together!



**Councillor
Caroline Stock**
Chair, Barnet Health
and Wellbeing Board



Dr Charlotte Benjamin
Vice-Chair,
Barnet Health and
Wellbeing Board
Clinical Vice Chair, NCL CCG

Introduction

The Barnet Joint Health and Wellbeing Strategy (JHWS) sets out our whole system vision for improving the health and wellbeing of the people who live, study and work in Barnet. It describes:

- **Our strategy in context: The current health and care landscape, Barnet's key health data and our guiding principles.**
- **Our 3 Key Areas of focus for health and wellbeing: why they were chosen, what we plan to achieve, and how we will measure our success.**

For the next four years, the Barnet Health and Wellbeing Board (HWBB) will focus on delivering three Key Areas to drive forward integrated improvements in health and wellbeing in the borough. These areas are chosen as 'added value' where the local system partnership can come together to achieve accelerated changes. It is not intended to cover the whole breath of health and wellbeing business as usual. The three key areas are:

- 1 Creating a healthier place and resilient communities**
- 2 Starting, living and ageing well**
- 3 Ensuring delivery of coordinated holistic care, when we need it**

Within each of these areas we identified several priorities. Our priorities will inform the work we do over and above our current 'business as usual' in order to improve Barnet's health and wellbeing.

This strategy was written during the unprecedented national challenge of the COVID-19 pandemic. We have had to adapt to new ways of working, living, and providing services in response to this public health emergency which has had a vast impact on the overall physical, social, mental and economic health and wellbeing of the Borough. The long-term impact of the pandemic will likely extend beyond the four-year scope of this strategy. However, whilst we will continue to respond to the COVID-19 pandemic we will also use the capacity and resilience of our systems and partnerships to support the borough to recover.



THRIVE



FAMILY AND FRIENDS



HEALTHY



CLEAN SAFE AND WELL RUN

Alongside this, Barnet Council has also been developing a new Corporate Plan and has identified the strategic themes - Thriving, Family Friendly, Healthy and Clean Safe and Well Run as priority outcomes. These outcomes represent both existing strengths and challenges facing the borough. The themes and actions within each theme are designed to be mutually supportive and are underpinned by cross cutting work streams on Prevention and a stronger focus on Equalities, Diversity and Inclusion. We acknowledge that we do well in some areas of prevention and want to scale up local best practice to build on our successes. At a time when public services and finances are under pressure, and the local population is growing and living longer, there are further potential opportunities to transform how we work together with residents, communities and partners to support people to have good life experiences, while we achieve efficiency and deliver good quality services. The Council will embed a preventative culture based on positive aspects across the whole organisation. With our partners, we will be focussed on services, staff and solutions that build resilience, and are sustainable in the long-term. The Corporate Plan outcome of 'Healthy' and cross-cutting theme on Prevention are complemented by this Health and Wellbeing Strategy.

The Corporate Plan recognises that meeting the needs of residents and business is at the heart of our work and anticipates a deeper level of partnership working, particularly with the Voluntary, Community and Faith sectors, as the council take forward the priorities in the plan.

We know that we face some big health challenges in Barnet, but, if anything, COVID-19 pandemic just highlighted further existing public health challenges and disparities in health and wellbeing. By working together with local residents and partners, we can continue to make positive differences to everyone's wellbeing in Barnet.

Appendix I starts to define specific pieces of collaborative work that we are proposing to implement over the next four years. Implementation Plan development is an iterative process and will be reviewed and updated annually. Specific indicators will be developed to monitor progress of Joint Health and Wellbeing Strategy implementation.

PREVENTION



BARNET PLAN

Our Strategy in broader context

What is a Health and Wellbeing Board?

Key partners in Barnet come together to form the statutory Health and Wellbeing Board (HWBB). These are partners who are in a position to help make a difference to our health and wellbeing, and include local Councillors, the Council (including Adult Social Care, Family Services and Public Health), the NHS, local voluntary and community sector organisations, and Healthwatch Barnet.

Developing this JHWS is one of the statutory responsibilities of the HWBB as set out by the Health and Social Care Act 2012. All HWBB members including the local authority and the North Central London Clinical Commissioning Group (CCG) must regard this strategy in the delivery of their respective health and wellbeing responsibilities.

The Health and Care Landscape – National, regional and local

The fast-changing health and care landscape in England provides many opportunities to maximise the population health outcomes for people in Barnet through systems improvements and partnership working. Emerging Integrated Care Systems¹ and the NHS long-term plan² set out key ambitions for the NHS in reducing inequalities and commissioning for population health outcomes. This direction will give greater responsibilities across the system in engaging residents and voluntary and community sector, as well as other partners in improving the overall wellbeing of local residents. The Health and Wellbeing Board and its partnerships are central to local leadership of the whole system and we have been working very closely to articulate our ambition and vision through this strategy. Below is a brief description of the emerging structures.



North Central London Sustainability Transformational Programme (NCL STP)

Barnet works closely with partners across North Central London (NCL) to develop a strategic, place-based plan for transforming the health and care system. Joint working on this wider footprint will help in addressing the complex challenges we face and improve the health of the population and the NCL Population Health Plan is being delivered. This will form a central driver for commissioning and provision of health and care services via our emerging NCL Integrated Care System.



- 1 Change to Integration and Innovation: Working together to improve health and social care for all. Can be accessed here: <https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version>
- 2 NHS Long Term Plan: NHS Long Term Plan – Can be accessed here: <https://www.longtermplan.nhs.uk/>

Our Strategy in broader context

North Central London Clinical Commissioning Group (CCG)

In April 2020 Barnet, Camden, Enfield, Haringey, Islington CCG were brought together to form North Central London CCG. This supports commissioning of health services at-scale for North Central London, while retaining borough-level commissioning of local services where appropriate. It has supported an effective response to Covid and supports the integration of health services and wider care and support.

NCL Integrated Care System

NHS England is currently consulting on the future of Integrated Care Systems (ICS). These are proposed to drive health and care integration across our neighbourhoods, boroughs and NCL system. The proposals suggest that all STP footprints should have an ICS arrangement in place in 'shadow form' by 1st April 2021 and work towards a statutory organisation established fully by April 2022. Barnet Council and its residents will play an important role in health and care partnership across North Central London. The proposals will see NHS organisations take greater shared responsibility and accountability for services and outcomes and deepen joint working with local government and communities. The proposals are subject to primary legislation. Further details will be shared as they emerge.

Barnet Integrated Care Partnership

Barnet Integrated Care Partnership (ICP) is an alliance of Local Authority, NHS organisations and partners working together to deliver the integrated and coordinated care outlined above. Barnet ICP was established in Autumn 2019 and includes local hospitals, community services, mental health services, GPs, social care and public health. The ICP works closely with Healthwatch and the voluntary sector and reports to the Health & Wellbeing Board and CCG. It supports local collaboration and partnership working and articulates local needs into the wider system.

Barnet's Primary Care Networks

Primary Care Networks (PCNs) – these are networks of GP practices established to support joint working between local practices, continued development of local services close to home and the provision of proactive, personalised and coordinated health & care. In Barnet, seven PCNs have been formed and started working to address specific needs of their community. Our PCNs are innovative and include new roles and services for example Social Prescribing services.

Partnership working during COVID-19

Barnet will continue to contribute to and influence national structures such as Public Health England / UK Health Security Agency and NHS Test and Trace to ensure an efficient whole systems response to the pandemic.



What is our health and wellbeing locally?

Barnet is a growing, thriving and diverse borough

Barnet has

402,700

residents



By 2030, this is expected to grow to

446,400



80% of residents are economically active (higher than London (79.2%))

Target to build **31,340** new homes over the next 10 years (4th highest in London)



70% of residents are from backgrounds other than White British

Between 2018 and 2030 there will be a **33%** increase in people aged 65+

8th least deprived out of **33** London boroughs (IMD 2019)

The borough is generally healthy...

Average life expectancy is **82.9** years for males and **86.0** years for females

Average male and female life expectancies for Barnet are higher than London and England

2nd lowest mortality rate for cardiovascular diseases in London (51.1 per 100,000)





...but can be even healthier



An estimated **4,434** people aged 65+ in Barnet were living with dementia.

22,229
people live with diagnosed diabetes

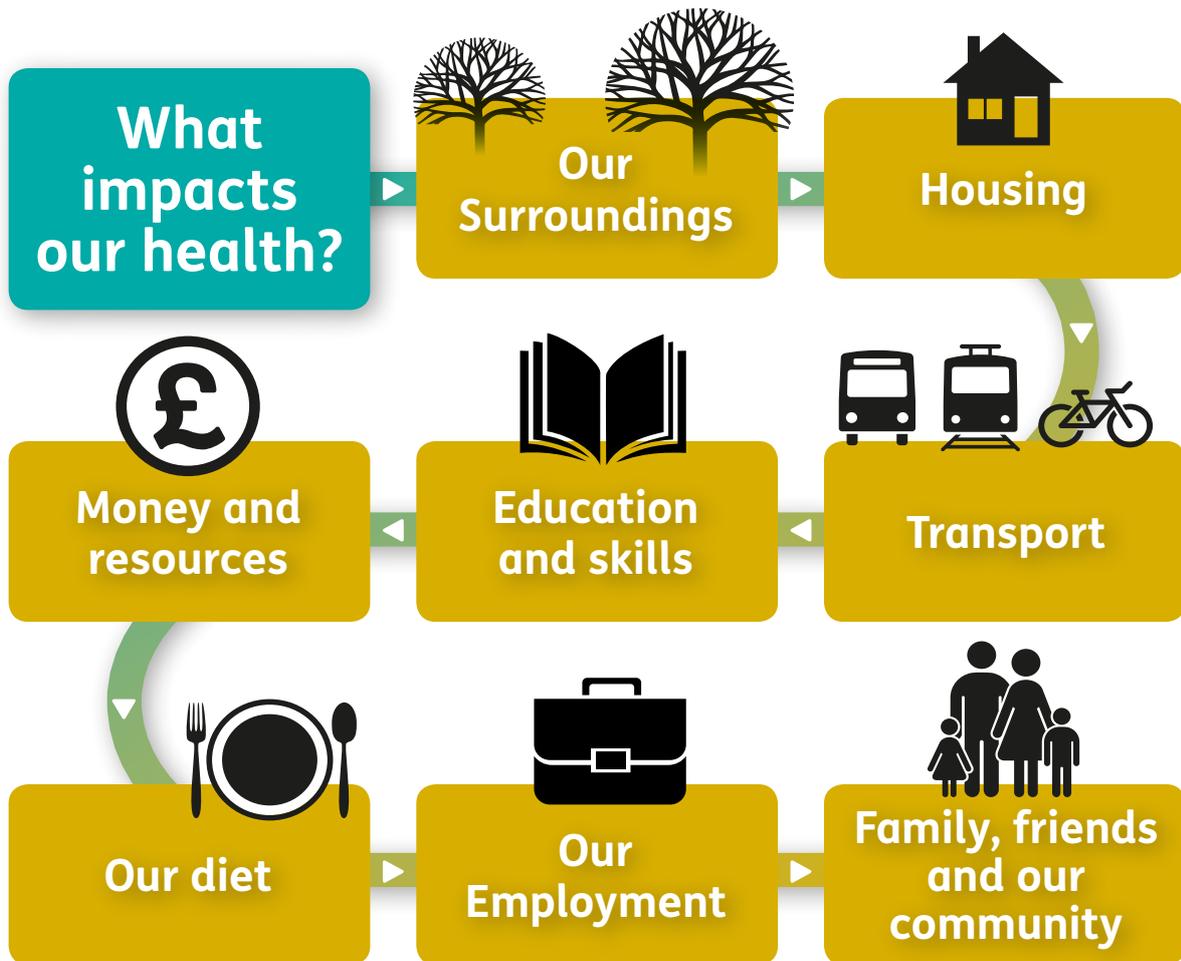
1 in 5
children aged 4-5 years in Barnet are overweight or obese

Just over a half
of Barnet adults (56.4%) are overweight or obese

Variation in local health outcomes

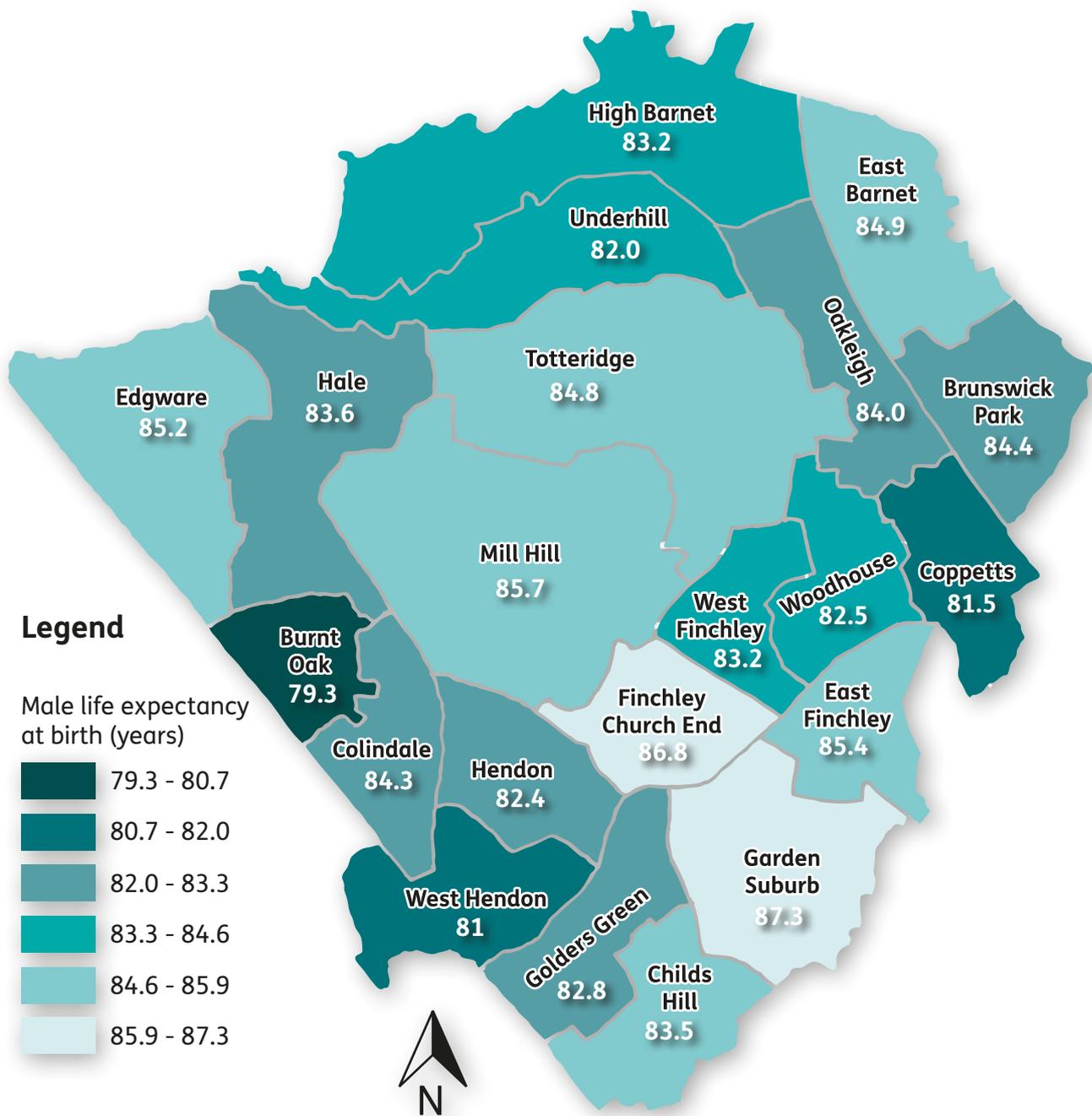
Health starts where we live, study and work

Access to healthcare can only improve up to 10% of our health and wellbeing outcomes, the rest is due to wider factors, as described in diagram below. In Barnet, people live long life on average, however there is a wide variation in life expectancy across the borough (see map).



Adapted from: The Health Foundation (What Makes Us Healthy?)

<p>Men in Burnt Oak have a life expectancy 8 years lower than those in Garden Suburb</p>		Lowest	Highest
	Men	79.3 yrs (Burnt Oak)	87.3 yrs (Garden Suburb)
	Women	82.7 yrs (Burnt Oak)	91.0 yrs (Garden Suburb)



Source: Office for National Statistics (Life expectancy at birth and age 65, England and Wales, 2017 to 2019)
 Contains National Statistics and Ordnance Survey data © Crown copyright and database right 2019

Impact of COVID-19 Pandemic on Barnet's residents

Given the age profile of our local residents and size of the borough, Barnet has been impacted significantly during the pandemic. Over 8% of the local population tested positive for the virus (with the highest numbers in people over 80 years of age) and of those, 748 died (as of June 2021). It is estimated that the total number of truly positive cases is much higher than that. The pandemic has also impacted a range of issues including waiting times for healthcare services, increased social isolation and fear amongst the population.

Figure 1: Trend in Barnet COVID-19 cases (n=30,779) as of beginning of December

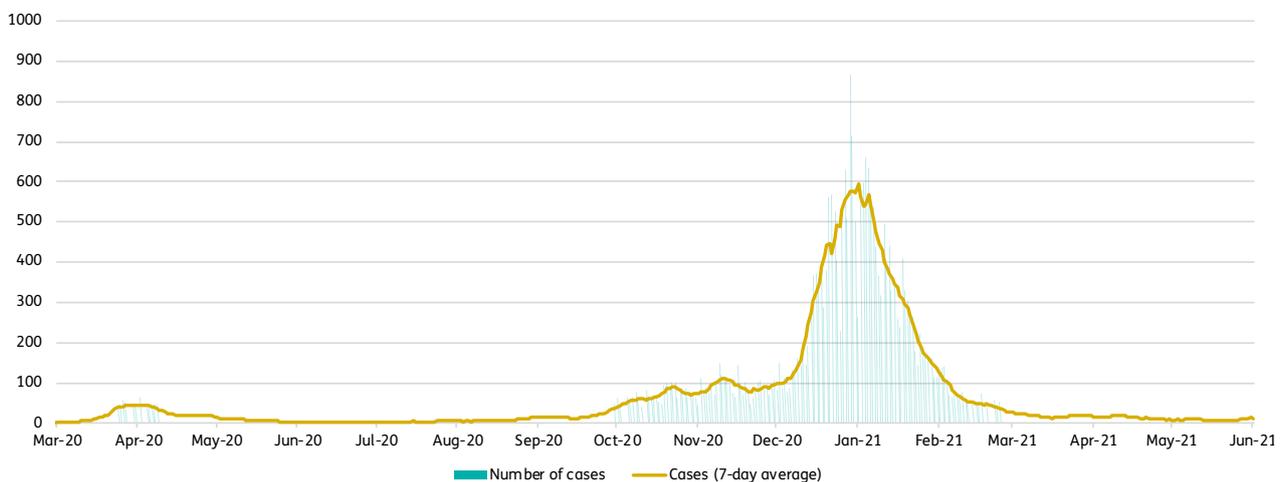
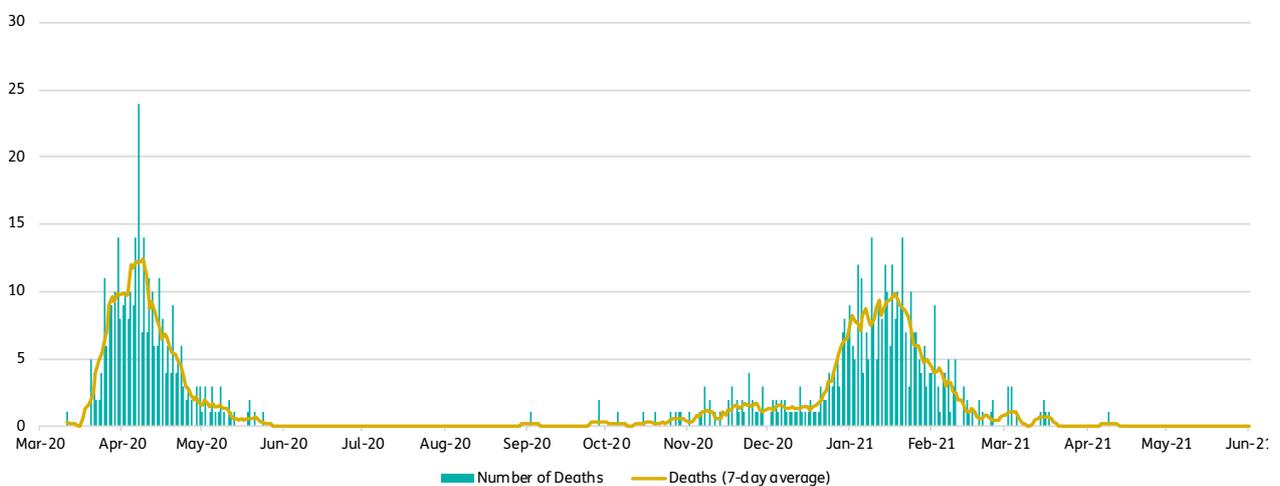


Figure 2: Number of deaths as COVID-19 on death certificate



The pandemic also has had an indirect impact on wider wellbeing aspects such as unemployment (over 40, 000 people furloughed locally), mental ill health, domestic violence, lack of physical activity and economic hardship. This is coupled with pressure on the NHS services, long waiting lists and impacts of post-COVID illness. Recent resident's survey conducted in October-November 2020, highlighted the following aspects on local residents' lives:

38% of residents strongly agree that they have been worried about COVID-19

43% of residents felt that their community has pulled together during the pandemic

49% of residents felt the pandemic has negatively impacted their personal relationships

The pandemic has had detrimental effects on all aspects of our life and highlighted a multitude of complex issues that indelibly impact on people's health and wellbeing. This strategy is aiming to incorporate lessons learnt into all we propose to deliver over the next four years.



Our vision and guiding principles



Our vision is to make Barnet the London Borough of Health

A healthy borough results in a healthy and happy population. It is where the environment around us supports and promotes our health and wellbeing. In a healthy borough, there is broad access to a good education, good quality housing and secure employment. A healthy borough supports access to open green spaces and active travel. High quality health and social care is available for anyone when they need it. A healthy borough reaches out to, supports and protects the most vulnerable, generating opportunities to thrive. With healthier and happier residents, communities are strengthened to support each other, and the local culture and economy flourishes.

Our five principles

1. Making health everyone's business

We will ensure health is everyone's business, not just for agencies primarily concerned with health and wellbeing, but also for those that work to improve wider determinants of health.

2. Collaborative partnership

We will work in collaborative partnership across organisations and learn from different viewpoints across the whole system. We will focus on the areas where collaborative work makes the most difference and the HWBB can add the most value. Key areas specified in the Strategy are therefore in addition to our 'business as usual'.

3. Evidence-based decisions

We will use a robust evidence base to inform our decisions, ensuring that our investment creates maximum value for money and our resources are distributed fairly.

4. Considering everyone's needs across the life course

We will consider the needs of all parts of the population in all that we do. This includes children and young people, women and girls and people with complex needs such as mental health issues, learning disabilities and autism and our ageing population. We recognise the importance of a healthy start to life for the health outcome of the rest of one's life and so the health and wellbeing of children and young people features throughout all three key priorities.

5. Co-design approach

We will involve residents in a co-design approach to resolve our challenges. We will make sure Barnet residents' needs are met and that the resulting services are practical and sustainable. This includes embedding co-production and meaningful public engagement in our development of policies and services.

How we developed this strategy

Under the sponsorship of the HWBB, this strategy has been developed through a rigorous process of triangulating the evidence base, HWBB's perspectives and residents' views on health and wellbeing in Barnet.

The Barnet Joint Strategic Needs Assessment (JSNA) formed the basis for this strategy. The JSNA provides detailed assessment of health needs in Barnet, and is available at: <https://jsna.barnet.gov.uk/>

HWBB members' perspectives on health needs and the board's role were gathered through one-to-one interviews.

We were also keen to understand residents' views in shaping our strategy.

This was done through:

- Online development survey (9th September – 13th October 2019)
- Engagement at the Annual Care Summit (26th September 2019)
- Engagement to gather views of young people at Youth Board (26th September 2019)
- Commissioned research from Healthwatch Barnet to engage with residents on Health and Wellbeing and the impacts of COVID-19. This included specific engagement with BAME communities in Barnet (October to December 2020)
- Engagement with various Boards during the consultation process

This strategy also links in with various other strategies and plans in Barnet, including Barnet Council's Corporate Plan and the CCG's Business Plan.



Our Key Areas of focus

We recognise that most of our health and wellbeing outcomes are influenced by our environment and wider determinants of health (app. 85%) while good quality access to health and care influences only 10-15% of the overall health and wellbeing outcomes. Our strategy therefore starts to identify the right balance of key transformational area that can be delivered across the system and will add value locally.

Barnet, the London Borough of Health



Key Area 1: Creating a healthier place and resilient communities

Why is this important in Barnet?

According to the World Health Organisation **toxic air is the leading environmental risk of early death**, with **3,598 to 4,096 deaths in London are attributable to air pollution with 201 deaths in Barnet (8.4 per 10,000)**. Long term exposure can produce respiratory symptoms and affect lung function, with high concentrations causing inflammation of the airways. Nitrogen Dioxide (NO₂) pollution within the borough is largely due to transport, areas of higher NO₂ pollution are mainly concentrated around the main roads and junctions, including the A1, M1, A406 and A1000.

In 2016/17, over half
(53%)
of adults in Barnet
had excess weight.



The food and drink environment is one of the main risk factors for obesity - the availability of calorie-rich food now makes it much harder for individuals to maintain healthier lifestyles.

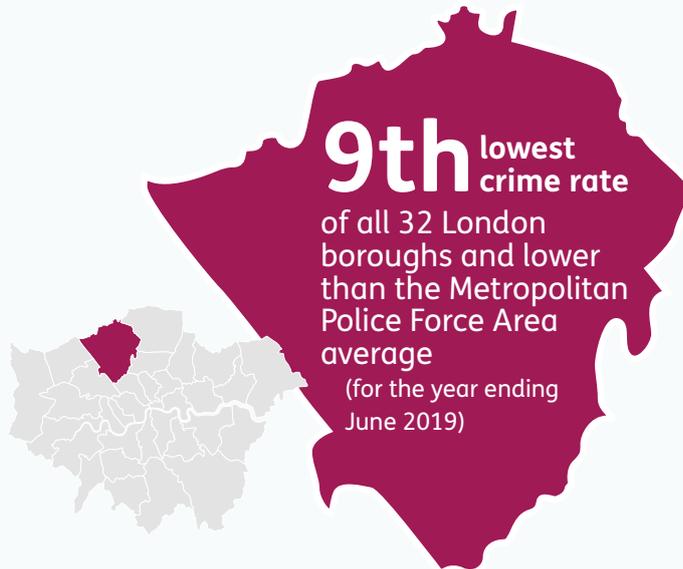


Residents have said that Barnet could be a healthier place to live, work and learn if:

- Air quality was improved, there was less road traffic and more support for active travel.
- There was an increased feeling of community safety.
- There was greater access to healthy food and junk food was less available.
- There was less child poverty and better social housing provision.

Barnet Joint Health and Wellbeing Strategy 2021-2025

Creating a borough of health together!



The burglary rate was slightly higher than the force average for the Metropolitan Police, but the violent, sexual and drug offences were lower than force average for the metropolitan police. In the rolling year to **December 2017**, there were **24 gang flagged offences in Barnet**, and **51 youth victims** (aged under 25) of knife crime with injury.

Violence against women is a major public health concern.

Number of domestic abuse offences in Barnet



What residents see as priorities:

- Clean air, streets and well-maintained parks and open spaces.
- Creating an environment where healthy eating is the easy choice.
- Building stronger communities by making community space and funding available.

Our priorities for Creating a healthier place and resilient communities

Integrate healthier places in all policies

Create a healthier environment

Strengthen community capacity and secure investment to deliver healthier places

Our commitments for creating a healthier place and resilient communities

Integrate healthier places in all policies

We will ensure that all of our policies and strategies across the system include specific actions on improving health and health equity through creating good housing, employment opportunities, active travel links and other economic and commercial conditions in Barnet



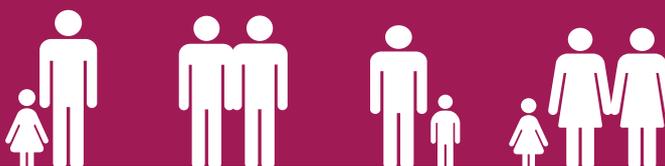
Create a healthier environment

We will create healthier choices locally with a focus on improving access to clean air, water, healthy food and physical exercise



Strengthen community capacity and secure investment to deliver healthier places

We will facilitate networking and capacity building between local communities and promote safety and cohesion while preventing violence and crime. We will make domestic abuse and violence against women and girls everyone's business.



Key Area 2: Starting, Living and Ageing Well

Why is this important in Barnet?

Taking a life course approach in Barnet enables us to prevent diseases at key stages of life from pre-conception, pregnancy, infancy, childhood, through to adulthood. Barnet has been forecast to have the largest number of children and young people (CYP) of any London borough in 2020 and we will continue to see a growth in the CYP up until 2025.

Tackling the wider determinants of health will enable us to focus on critical stages and settings (such as the early years, schools, opportunities for healthy lifestyles and workplaces) in order to improve health outcomes for Barnet.

Causes of death in Barnet

Circulatory disease

2,319 deaths

Cancers

1,853 deaths

Respiratory disease

996 deaths

Behavioural disorders

830 deaths

In adults, the top three broad causes of mortality, and the top three contributors to the gap in life expectancy between the most and least deprived quintiles in the borough for both sexes are circulatory diseases, cancers and respiratory diseases.

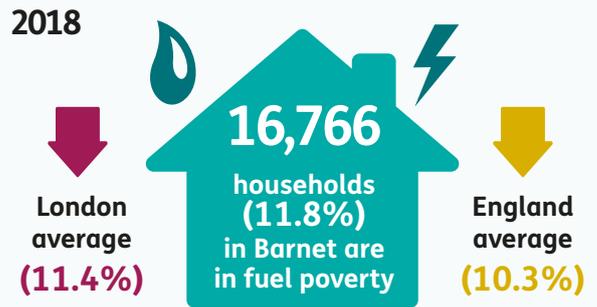


Residents have said that Barnet could be a healthier place to live, work and learn if:

- There was better support for active travel.
- They were enabled to eat healthily and do more physical activity.
- We used social media platform to communicate messaging by young people, for young people.
- There were clearer pathways to enable families to easily access the CYP services they require.
- It was dementia friendly.

Focusing on the life course allows us to intervene during these stages in life:

- Preconception and becoming a parent
- Infancy and early years (0-5)
- Childhood and adolescence (5-19)
- Working age (16-64)
- Ageing well



Barnet has the **6th** highest proportion of adults out of all the London boroughs who were physically inactive – **28.6%**.



Physical activity is importantly recognised as an essential component of our wellbeing; providing a positive contribution to our physical, mental and emotional health.

London Borough of Barnet (LBB) are committed to making the borough's parks and green spaces "amongst the best in London".

Active travel (including cycling and walking) offers a variety of health benefits including lowering the risks associated with cardiovascular disease, type 2 diabetes, depression, dementia and some forms of cancer. 54% of journeys originating in the borough are made by car - twice the proportion of trips made using active transport (27%).



As of **2015**, the total green space provision of the borough is **888** hectares (nearly 10% of the area).



What residents see as priorities:

- Mental wellbeing promotion
- Green space and affordable leisure facilities
- Support for employment and workplace health
- Child poverty and improving life chances

Our priorities for Starting, Living and Ageing Well

Improve children's life chances

Promote mental health and wellbeing

Get everyone moving

Support a healthier workforce

Prevent long term conditions

Our commitments for starting, living and ageing well

Improve children's life chances

We will improve children's life chances by supporting their health and wellbeing from very early age and through to their transition into adulthood.



Promote mental health and wellbeing

We will promote good mental and emotional health across all ages and different communities and work together to prevent severe mental illness, substance misuse and suicide.



Get everyone moving

We will improve choices for physical activities locally for all ages and abilities, and ensure residents know how to access it.



Support a healthier workforce

We will invest time and resources to ensure our workforce is supported to be healthy, happy and productive at work.



Prevent long term conditions

We will work with communities to understand what support can be offered to reduce risks of developing long term conditions and recognise early signs and symptoms.



Key Area 3: Ensuring delivery of coordinated and holistic care, when we need it

Why is this important in Barnet?



Barnet has an aging population with an estimated **15% of residents being aged 65 and over.**

In 2018/19, **50% of those admitted to hospital** for an emergency admission longer than 1 day **were 65 or over.** The large population of Barnet also means it has **85 care homes** which is the largest number of care beds for over 65s in London.



The ICP's vision is to maximise health and wellbeing for all people of Barnet by working together as an integrated care partnership. Its aims are:

- A population health management approach that considers the wider determinants of health
- Addressing the challenging commissioning issues to develop integrated solutions
- Addressing performance issues where Barnet is an outlier
- Support residents in self-care and prevention



Residents have said that Barnet could be a healthier place to live, work and learn if:

- They had better access to primary care including GPs, with shorter referral times.
- Technology was embraced but not leave anyone behind.
- Care was joined-up and coordinated and met their holistic needs.
- Mainstream healthcare services addressed specific needs of people with complex needs e.g. Learning Disability, Mental Health (long waiting time for a consultation in busy waiting room is a very distressing experience for people with LD).

Barnet Joint Health and Wellbeing Strategy 2021-2025

Creating a borough of health together!

Barnet has approximately
2,500
care beds,



one of the largest number in London and it has the largest care market in North Central London. Residents in care settings have been heavily affected by COVID-19 pandemic and it is of a paramount that we work across the partnership to ensure we support residents to live healthy and independent life as long as possible and safeguard those most vulnerable.

Embedding a preventative approach meets the triple aim of:

1. improving outcomes for local residents and patients,
2. saves costs for health services
3. reduces the impact on planned care of unplanned events which are common with more severe conditions such as cardiovascular disease.

What residents see as priorities:

- Access to GPs and out of hours services (walk in centres and community pharmacies).
- Supporting carers to look after their own health.
- Services to help prevent long term conditions such as weight management, stop smoking and promoting self-care



Our priorities for Ensuring delivery of coordinated and holistic care, when we need it

Support digital transformation of services

Enable carers health and wellbeing

Deliver population health integrated care

Our commitments for ensuring delivery of coordinated and holistic care, when we need it

Support digital transformation of services

We will work together to provide digital care and support for all who can benefit from it, as well as using the power of linked electronic health and care records to improve population health.



Enable carers health and wellbeing

We will support care staff and informal carers to look after their health and wellbeing.



Deliver population health integrated care

We will work together to ensure the Barnet Integrated Care Partnership is centred around resident's need, aims to reduce health inequalities, promotes good physical and mental health and enables seamless access to health and care services across the life course, delivered in collaboration with local communities at neighbourhood level.



Appendix I: JHWS 2021-25 implementation plan

Key Area 1: Creating a healthier place and resilient communities

Integrate healthier places in all policies

What have we done so far?

- Put health and wellbeing at the forefront of policy development such as Growth Strategy, Local Plan, Long Term Transport Strategy, Infrastructure Delivery Plan, Local Plan and Air Quality Action Plan, Housing Strategy and Community Safety Strategy.
- Created a temporary, light segregated cycle lane along the A1000 to enable and promote active travel. As one of the main north-south routes through the borough, the A1000 links key town centres. This work is intended to provide an easily installed cycling route allowing residents to access a number of important local centres and transport hubs (including tube stations).
- Produced Healthy Equity Impact Assessment on Long Term Transport Strategy, Health Impact Assessment on Local Plan and Growth Strategies. These assessments evaluate the potential direct and indirect health impacts policies and strategies may have on the health of residents, with particular focus on those who are most vulnerable.

What are we going to do next?

- Support the delivery of strategic outcomes across council departments which promote health and wellbeing through behaviour change interventions, improving built environment or improving air quality.
- Comprehensive evaluations of health benefits obtained from the delivery of strategic outcomes to identify what works well. This will take the form of health impact assessments, consultations with residents and data available from public health outcomes framework.
- Continue to work with partners to promote health and wellbeing through the built environment with strategy and policy.
- Promote WHO Dementia Friendly Neighbourhoods.
- Work with communities to identify felt needs and priorities when developing programmes and policies. Require policies to consider the needs of older adults and children and young people.
- Continue to delivery health equity and health impact assessments where appropriate. Require large developments to provide HIAs in line with the draft local plan policy CHW02.

What will show our progress?

- Inclusion of health and wellbeing in strategies/masterplans
- Ownership of healthy places related activities and projects by other council departments.
- Feedback from Consultation/evaluations. HIAs and the public
- Measure use of temporary cycle lanes
- Board reports (non-HWBB) have a section detailing how it is relevant to health? How will this report contribute to health?
- Use of relevant health data within applications
- Consultation with different age groups as part of built environment delivery plans.
- References to dementia friendly communities within strategies and reports/masterplans
- Health equity assessments

What have we done so far?

- Produced the Air Quality Action Plan 2017-2022 to contribute to London Local Air Quality Management. It outlines the action the council will take to improve air quality in the borough. It replaces the previous action plan which delivered successful projects, such as the Air Quality Champion project.
- Adopted the Barnet Tree Policy, which lays out the borough's plans for the improving the tree planting and maintenance across the borough. It commits us to planting an additional 4,500 trees between 2018-2023
- Adopted our new Long-Term Transport Strategy 2020-2041, which lays out our commitment to making travel across the borough more sustainable by supporting and encouraging residents to use active modes of transport.
- Installed over 100 Electric Vehicle Charge Points across the borough
- Developed an overarching Healthy Weight Strategy which promotes access to good food across the life course. This includes Healthier Catering Commitment, Sugar Smart and a food security action plan.
- Barnet has become partners with Refill London to promote access to free drinking water.
- Successfully negotiated for a 200m ban of unhealthy food advertising from schools within the new council advertising contract.
- Developed an evidence paper for the draft local plan to limit access to takeaways at key points in the borough.

What are we going to do next?

- Conduct air quality audits and implement measures on all schools with high air pollution (as identified by TfL). Continue to encourage schools to join the TfL STARS accredited travel planning programme and pilot school streets programmes where appropriate.
- Continue to invest in measuring air quality across the borough to ensure we can evaluate whether air quality is improving or not; particularly when new interventions are being assessed.
- The council is delivering the first phase of a new temporary light cycle lane along the A1000 going north from East Finchley. Once installed, officers will assess the initial impact of the cycle lane and will determine whether recommendations should be made to extend this further, in line with the Draft Long-Term Transport Strategy.
- Develop a Council-wide advertising policy which limits unhealthy food advertising where appropriate.
- Continue to tackle obesity by shifting towards a healthier food cultures as a part of our Local Government Declaration on Sugar Reduction and Healthier Eating by expanding and Healthier catering commitment, Refill London and Sugar Smart.
- Explore opportunities for public access to drinking water within council premises.
- Consult with partners around the development of an alcohol licensing scheme that considers health and wellbeing impacts
- Support the ratification of Local Plan policy TOW03 which prevents new hot food takeaways from opening near schools and requires all new takeaways to have signed up to the Healthier Catering Commitment.
- Work together to ensure all large local organisations such as Barnet Council and local NHS are established anchor institutions and create a healthier environment by addressing sustainability and the environment within their own organisations.

What will show our progress?

- Realisation of Air quality action plan
- Number of schools participating in air quality audits
- Measuring progress against the targets laid out in the Barnet Tree Policy
- Progress updates on cycle lanes and charge point usage within the borough
- Delivery of council-wide advertising policy which limits unhealthy food advertising where appropriate
- Availability of free drinking water
- Number of schools, businesses and other stakeholder participating in Sugar Smart initiatives.
- Monitor policy TOW03 in the Barnet Local Plan.

What have we done so far?

- Recruited 15 Social Prescribing Link Workers. Invested in a digital platform to enable effective reporting. Public health was a leading partner for developing induction and training.
- Promoted and supported VCS with utilising available tools and training such as Club Matters and 'Join In' to increase their volunteering offer and develop the confidence to engage and support volunteers.
- Put in place a comprehensive community safety strategy which public health and health partners support.
- Supported the Community Safety Partnership to develop an evidence-based Violence Against Women and Girls (VAWG) Strategy
- Invested £41.5m into 2 brand new leisure facilities at Barnet Cophall Leisure Centre and New Barnet Leisure Centre.
- Delivered a £5.5m transformation of Montrose Playing Field and Silkstream Park, which also included a combination of grants from the Greater London Authority, Environment Agency and London Marathon Charitable Trust.
- Directed £450,000 of revenue investment into the borough to support delivery of interventions since implementation of the FAB Framework.
- Secured investment from the London Marathon Trust to deliver a sports development initiative at Montrose Playing Fields.
- Submitted bids totalling approximately £12.1M to the Department of Transport (DfT), Transport for London (TfL) and the Ministry of Housing, Communities and Local Government as part of COVID-19 recovery within town centres (including liveable neighbourhoods, cycle lanes etc.).
- Invested in a software to enable data entry by all partners involved in the delivery of social prescribing.

What are we going to do next?

- We will roll out training for Making Every Contact Count (MECC) and further build the Social Prescribing infrastructure locally to strengthen communities, through these techniques, to be able to address underlying causes of ill-health.
- Adopt an innovative approach to volunteering, to ensure community benefit is at the very core. Provide access to high quality, diverse volunteering opportunities that fulfil personal needs, enable utilisation of skills and the development of new skills and experiences
- Support the VAWG delivery group to develop appropriate preventative interventions that tackle the root causes of violence, which includes challenging societal and cultural norms that can lead to violence, and placing greater emphasis on the wider determinants of health.
- Lead on multiple vulnerabilities: Working collaboratively across the partnership to identify those most at risk of multiple complexities and intervening early.
- Embed public health approaches to serious youth violence.
- Securing investment through developer contributions (CIL, S106) to support physical activity and community safety infrastructure as outlined in the Infrastructure Delivery Plan.
- Be prepared for funding opportunities: With Covid-19 significantly changing the funding landscape there is likely to be increased demand for 'shovel ready' projects, i.e. those that are fully scoped and can be delivered within a relatively short space of time. It remains critical that the council continue to develop and scope works in accordance with council strategy to ensure that we remain in position to access funding.
- Actively seek out opportunities for additional funding; monitoring the DfT and TfL for opportunities.

What will show our progress?

- Directed Enhanced Services (DES) outcomes are achieved
 - Continued VCS participating in social prescribing.
 - Monitor actions as outlined within the defined multiple vulnerabilities action plan.
 - A long-term reduction in violence and abuse at population level
 - Serious youth violence: a reduction in crime.
- We will measure progress against measures in the Jtag. Focus on crimes over-reported in key areas such a Grahame Park-including violent crime and vehicle crime.
- Funding applications submitted across the council.
 - Secured third part funding to support improvement/ opportunities

Key Area 2: Starting, living and ageing well

Improve children's life chances

What have we done so far?

- Worked with the multiple agencies on the Family Service led Life Chances strategy, our HWB strategy will be aligned with this strategy. We have multiple programmes to improve life chances through the Healthy Child Programme, Healthy Schools London and Healthy Early Years London, Resilient Schools, and the healthy weight pathway.
- Worked across the council to improve quality of school lunches and holiday hunger programme, during COVID worked with wider council to work on access to essential supplies and free school meals.
- Immunisation action plan for Barnet was implemented in 2019, this has been paused during COVID to focus on working with the CCG and commissioned providers to ensure access to pre-school vaccination, promotion of flu immunisations, and catch up for school aged immunisations post lockdown.
- Commissioned and delivered oral health programmes in the borough.
- Commissioned and delivered health coaches programmes in the borough to support vulnerable families and parenting.
- Engaged with secondary schools on period poverty and raised awareness of the issue with schools and various forums.
- Routinely record breastfeeding data and rates at 6 – 8 weeks and have shown a year on year increase
- Commissioned preventative health promotion groups and workshops in the borough to reduce inequalities, improve parenting and school readiness.
- Undertook an CYP COVID-19 health impact assessment drawing on information fed in by young people, local partners and data, and national research and data will help to inform ongoing planning
- Developed a whole school approach to raising awareness of mental health across all schools as part of the CAMHS Transformation Plan

What are we going to do next?

- Ensuring access to adequate and healthy Food.
- We are committed to upholding the UN Convention on the Rights of the Child (UNCRC) including doing all we can to ensure that every child develops to their full potential. The results of our CYP COVID-19 health impact assessment drawing on information fed in by young people, local partners and data, and national research and data will help to inform these commitments.
- Promote oral health by building on the commissioning of the oral health team and promoting it widely with partners
- Work with partners and stakeholders to reduce risk of vaccine preventable infectious diseases by improving uptake of childhood vaccination.
- Provide information and education to boys and girls about periods, period poverty and hygiene to help remove the stigma around talking about this subject
- Encourage schools to access the PHS Group period poverty portal and make period products available to all pupils.
- Collaborate with service users, partners and stakeholders to write an infant feeding strategy and pathway to ensure breastfeeding is normalised and a parents first choice of nutrition for their infant.
- Introduce a 'Breastfeeding welcome' scheme to Barnet and promote with business linking to other Public Health initiatives e.g. access to drinking water and accessible toilets.
- Continue to support sexual health education and healthy relationships among our young people
- Ensure that a universal approach is delivered to all schools to raise awareness of mental health and reduce stigma

What will show our progress?

- Increased number of eligible children accessing free school meals
- Improved school meal quality.
- Improved Life satisfaction as reported by young people.
- Reduced percentage of children with one or more decayed or missing teeth.
- Increased engagement and co-production with young people throughout CYP relevant programmes
- Percentage of children living in low income families (for monitoring purposes).
- Increased uptake of Flu, MMR, and other CYP routine immunisations
- Increased knowledge of the impact of mental across all ages groups and confidence to get help
- Increased breastfeeding rates at 6 – 8 weeks
- Percentage of schools that access the PHS portal and provide free period products to school aged children
- Engagement in sexual health and healthy relationship education and support

What have we done so far?

- Established the Fit & Active Barnet (FAB) Framework, FAB Partnership Board, launch of the Fit & Active Barnet Campaign and introduction of the Fit & Active Barnet (FAB) Hub and Card.
- Delivered targeted interventions and indicatives in partnership with a range of organisations.
- Delivered our leisure management contract, which measurably improves the health and wellbeing of residents.
- Engaged with residents and stakeholders to develop the; Barnet Playing Pitch Strategy, Barnet Indoor Sport & Recreation Study, Parks and Open Spaces Strategy and Fit & Active Barnet Framework.
- Adopting a “movement through entire lifespan” approach in promoting physical activity and working closely with sport and leisure colleagues
- Engagement through digital behavioural change intervention for Active Travel.
- Established the Fit & Active Barnet Hub; a dedicated website providing information, advice and guidance on physical activity.
- Installed new technology (facial recognition and cashless) within leisure facilities.
- Provided remote appointments for service users during COVID
- Developed the healthy weight pathway for Barnet

What are we going to do next?

- Support health intervention pathways, harnessing the relationship between health and activity (e.g. post health check, children & young people healthy weight pathway, weight management, falls prevention and cardio vascular disease).
- Review of the existing FAB Framework to focus on wider engagement for physical activity amongst various population groups (expires March 2021)
- Improve strategic alignment to ensure opportunities are concentrated and a range of facilities are utilised to sustain future activity; via the workplace, community, leisure, education, travel and open environment.
- Review of partnership strategic outcomes.
- Work with relevant partners to develop a new Barnet physical activity strategy which will promote leisure, daily and transport related physical activity and support Barnet residents being active through their lifespan.
- Maximise the use of facilities and identify opportunities for co-location and community hubs, widening access to ensure that facilities and open spaces are better used by the communities they serve.
- Review the connectivity of all interventions and infrastructure that supports delivery of active travel in the borough e.g. Active Trails,
- Provide more opportunities for residents to engage in physical activity for recreation and to engage with their local area such as Health Walks and Heritage Walks
- Review where digital innovation developed during COVID may be beneficial to continue as part of a mixed remote and face to face model post COVID, the enhance service user experience and access.
- Develop a healthy weight management strategy that support schools promote a healthy environment and to support key target groups
- Increasing green space and capitalising on the national interest in daily exercise.
- Demographic specific approach to physical activity / active travel, including working with schools to promote active travel.

What will show our progress?

- Increase in percentage of the population taking part in sport and physical activity (as defined by Sport England / CMO)
- Increase in the percentage of children and adults utilising outdoor space for exercise.
- Securing investment in parks, open spaces and leisure to create and improve facilities.
- Delivery of masterplan proposals.
- Increased children and adults engaging in active travel.
- Service user feedback
- Group participation level
- Appointment attendance
- NCMP data (increased children of healthy weight in reception and year 6).
- Primary school engagement with physical activity projects
- Increase in percentage of the population taking part in sport and physical activity including those with physical and sensory impairments

What have we done so far?

- Set up the LBB Workplace Health and Wellbeing Working Group and produced an action plan with actions including mental health, physical activity, healthy eating, workplace health and safety
- Achieved London Healthy Workplace Award (LHWA) Excellence Award
- Provided Mental Health First Aid training
- Commissioned the Working Well service (job retention support to employees of SMEs (Small and Medium Enterprises) and working with employers to work towards becoming a Mindful Employer)
- Introduced 'Able Futures' a staff welfare support service, to run alongside our Employee Assistance Programme and mental health first aiders

What are we going to do next?

- Continue to support local employers to create healthy and inclusive workplaces. Barnet Council to lead by example by ensuring our policies and processes are modern and fit for purpose, healthy workforce and equality is promoted throughout our workforce
- Encourage local organisations to consider staff wellbeing and achieve the LHWA
- Continue to help people to gain employment. This includes employability support, removing barriers to work and developing strategies to cope with difficulties that people are going through while seeking employment.
- Continue to help people to maintain their employment. E.g. continue to work with SMEs and their employees to prevent job losses due to mental health problems
- Support local NHS organisations as anchor institutions to support a healthier workforce by taking forward staff health and wellbeing within their own organisations.

What will show our progress?

- Delivery of the Workplace Health Action Plan
- Maintain LHWA Excellence status
- Increased SME engagement with the Working Well programme
- Increased number of Mental Health First Aiders from the baseline
- Working Well service contract targets are achieved
- Reduction in work related ill health and incidents
- Staff feedback and satisfaction

What have we done so far?

- Provided specific services for children and young people in Barnet such as the Resilient Schools (RS) Programme, the Healthy Schools London programme, the Healthy Child Programme, sexual health promotion and healthy lifestyles programmes.
- Worked alongside partners to implement the CAMHS transformation plan.
- Produced yearly suicide prevention action plans through the multi-agency suicide prevention working group
- Commissioned comprehensive sexual health clinical services and as well as a sexual health promotion services for young people.
- Developed the healthy weight pathway for Barnet
- Social Prescribing within the Primary Care Networks
- Patient participation groups
- Completed an Autism needs assessment to inform the joint autism action plan
- Improved access to improving access to psychological therapies (IAPT) and increased provision in the borough through work by the CCG
- We have a long-established Adult Social Care enablement network
- The CCG have commissioned the Barnet Wellbeing Service for all residents in the borough
- Worked closely with Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) to deliver community mental health services and support including intensive support
- Developed perinatal Mental Health service including perinatal mental health coaches.
- Commissioned digital options and a new substance misuse provider with a focus on alcohol use, prevention and early intervention

What are we going to do next?

- Support children aged 0-5 and their families to enable them to have a healthy and happy start.
- Provide comprehensive mental and physical health support to schools, including staff education to enable support for children with long term health conditions (eg asthma or mental illness).
- Work with partners to improve access to mental health support for CYP, and implement relevant recommendations from the local CYP COVID HIA (which has been informed by local young people).
- Work with partners to promote parity of access to mental and physical health services for children, young people and adults with mental illnesses or SEND.
- Embed a new model of Social Prescribing in the borough, including referral to activities which support the 5 ways to wellbeing
- Sustain and broaden our digital offer of wellbeing support to the wider population
- Develop and implement a refreshed Barnet Suicide Prevention Strategy which includes reviewing lives lost to suicide amongst mental health service users as well as broader prevention aims.
- Continue developing the perinatal mental health service including pathway design and promotion
- Working with partners to support implementation of a new community framework for mental health
- Increase alcohol screening and improve access to support for people who are using alcohol problematically

What will show our progress?

- Number of schools participating in the RS programme and with trained MH first aiders, peer mentors, and teachers delivery mindfulness and first aid awareness in schools.
- Number of schools and EYs settings with bronze/silver/gold awards. healthy schools award and holistic healthy lifestyle policies.
- Life satisfactions scores among CYP
- A clear CYP mental health pathway.
- Breastfeeding rates at 8 weeks.
- Primary school engagement with physical activity projects
- Increase in percentage of the population taking part in sport and physical activity
- Directed Enhanced Services (DES) outcomes are achieved
- Reduction in DSH admissions
- Suicide data from ONS, PHE and Thrive London database and feedback from partners.
- Healthy child programme service data and service user and stakeholder feedback.
- Reduction in number of self-harm attempts and lives lost to suicide amongst users of mental health services
- Sexually health data regarding infections and service use
- Improved access to mental health support and services
- Improved performance of SMI physical health checks for people with severe and enduring mental illness
- Uptake of perinatal mental health coaches and service referrals
- Increase the number of annual health checks for people with learning disabilities
- Increase number of people accessing brief and structured interventions for alcohol use

What have we done so far?

- Encouraged high quality employment and work experience through the sports and physical activity sector to benefit local residents e.g. supporting the implementation of London Sport's disability sport employment programme 'Activity Works
- Commissioned the COVID 19 Health Champions programme
- Practice pharmacist virtual clinic review of AF (atrial fibrillation) register for anticoagulation improvement.
- 85% of places taken up for first contract of National Diabetes Prevention Contract completed July 2019. Increased equity of access to programme with targeted primary care communications to practices in areas of high deprivation and eligible population.

What are we going to do next?

- We will develop a cardiovascular disease (CVD) prevention programme, supporting residents to avoid developing CVD or better manage existing conditions, addressing inequalities in outcomes from CVD.
- We will focus on collaborating with communities at higher risk (including Black, Asian and other ethnic minority communities)
- We will work on cancer prevention through addressing inequalities in uptake of national screening programmes and increasing awareness of common risk factors, signs and symptoms in underserved groups.
- We will empower community health champions to engage their family, friends, neighbours and communities on how to make positive health promoting choices, building from the COVID champion programme.
- We will improve our digital prevention offer, providing a coherent range of options across multiple platforms

What will show our progress?

- Champions reflect on the key demographics of the Barnet population, with a focus on under-served communities
- Reduction in new diagnoses of CVD, while reducing inequalities
- Reduction of hospital admissions due to CVD, while reducing inequalities
- Improved uptake of NHS Health Checks in underserved groups
- Improved uptake of National Diabetes Prevention Programme in underserved groups

Key Area 3: Ensuring coordinated and holistic care, when we need it

Support digital transformation of services

What have we done so far?

- The 'Talk before you walk approach' has been widely adopted in many GPs due to COVID-19.
- We are a national leader in use of technology in care
- Provision of preventative programmes like the National Diabetes Prevention Programme on-line.

What are we going to do next?

- Integrate our data to provide longitudinal view of the patient to support direct patient care and population health management
- Further develop our digital offer to support prevention and provide timely accessible care, including risk monitoring
- Address inequalities in access to digital services

What will show our progress?

- Wider range of health and care professionals able to see whole patient record
- Reduction in variation in care through use of population health management approaches
- Difference in participation between the digital deprived and general population

Enable carers health and wellbeing

What have we done so far?

- Barnet Flu programme with additional focus on care setting, carers and others
- Specialist dementia support team
- Care Quality Support team
- Commissioned services for carers – wide range in place
- Carers strategy in place for both adult and young carers
- Commissioned additional support during COVID restrictions for older carers of adults with learning disabilities
- Identification of informal carers to support them to access the COVID vaccination programme.

What are we going to do next?

- Build on approaches to identifying informal carers so they can be supported to continue in their caring role.
- Ensure our care staff and informal carers are supported to look after their own health and wellbeing
- Address the COVID risk to staff from Black Asian and Other Minority ethnic groups
- Developing a new carers and young carers strategy

What will show our progress?

- Reduction in carers who feel isolated
- Increase satisfaction in carers
- Carers and young carers strategy 2021-2026
- Increase in contingency plans for older carers of adults with learning disabilities

What have we done so far?

Integrating health and social care, to improve CYP's mental health, physical health and wellbeing

- Developed a Perinatal service which includes perinatal mental health services
- Commissioned the Healthy Child Programme for Barnet

Integrated care and pathways

- Scoping work completed regarding existing provision of clinics for older people in
- Barnet service mapping complete
- Public Health population health outcomes presentation completed to support Integrated Care Partnership Workforce (ICPW) development for frail/ older people and LTCs ICPW's work
- Key findings of PCN 2 frailty and palliative care MDT shared
- Long Covid clinics across NCL open to all NCL residents – Barnet General Hospital, Royal Free, University College London Hospital

Care settings

- Worked with NCL leads to align the Barnet Multi-disciplinary Team (MDT) model
- Worked with NCL leads to align proposed Barnet MDT process
- Specialist dementia support team
- Care Quality team

Impact of COVID and LTCs on BAME groups

- Work with Healthwatch to gather residents' views

Same day access and discharge

- Completion of NCL Gap Analysis of the IDT and Peer Review Meeting with CNWL completed
- Review of IDT data reporting across all IDTs being undertaken to ensure consistency of reporting
- Community bed sharing arrangement implemented across NCL units
- Additional brokerage support now available at weekends to support flow, including access to Your Choice Enablement, the default provider for Barnet Borough
- Increased usage of 111 to triage minor illness away from local services

Supporting those with complex needs

- Use of health services by different segments of the population.
- Integrated care in mental health, learning disabilities, urgent care/hospital discharge and primary care networks across Barnet
- 0-19 hubs and integrated support for young people with complex needs in place
- Long standing Prevention and Wellbeing model in Barnet, including a team of local area co-ordinators and supported by a network of commissioned evidence-based prevention services
- Conducted a Homeless Health Needs Assessment and developed a multi-agency response to supporting homeless people through the covid-19 pandemic

What are we going to do next?

Integrating health and social care, to improve CYP's mental health, physical health and wellbeing

- Continue working with partners from across the system of children's services so that we can work toward integrating services better for the benefit of CYP and their families.

Integrate clinical pathways including primary and secondary prevention by:

- focussing on areas identified from population needs assessment i.e. frail elderly and cardiovascular disease pathways to make greatest impact reducing inequalities and improving health outcomes
- Continue to develop understanding and approach to addressing the health needs of local residents with long COVID

Continue integration of health and care in care settings by:

- Increasing range of services participating in MDTs and rolling out model across all areas

Build on the neighbourhood model of service delivery by:

- Collaborating with local communities to co-design services

- Embed prevention in PCN work through use of population health management and collaboration with preventative services

Address the Impact of COVID and LTCs on BAME groups

- Co-produce our plan and interventions with members from affected communities, taking into account findings from Healthwatch consultation with different communities on impact of COVID on them.
- Lead by example within each organisation involved in this programme;
- Ensure that any materials we produce are accessible in terms of channels used, ease of language and translated languages used (as appropriate); and
- Deploy cultural competence in developing our approaches taking inspiration for existing strategies such as the NHS People Strategy

Supporting those with complex needs by:

- Ensuring rapid access to care in the most appropriate way
- Implement a strategic framework and action plan to respond the needs of the homeless population, driven by findings of the homeless needs assessment

What will show our progress?

Integrating health and social care, to improve CYP's mental health, physical health and wellbeing

- Development of aligned intervention pathways

Integrated pathways

- Each partner contribution to specific pathways evidenced
- Overall impact on disease-relevant outcomes
- Reduction in health inequalities for frail elderly population and cardiovascular disease areas of focus.

Care settings

- Reduction in impact of COVID on care staff from Black, Asian and other ethnic groups compared to first wave
- Each partner contribution to specific pathways evidenced
- Overall impact on disease-relevant outcomes
- Reduction in health inequalities for frail elderly population and cardiovascular disease areas of focus

- Reduction in emergency admissions from care homes for ambulatory care sensitive conditions

Impact of COVID and LTCs on BAME groups

- Uptake of prevention programmes proportionate to the local ethnic group and their risk of LTCs
- Improvement in risk factor measures across all ethnic groups

Same day access and discharge

- Maintenance of low number of cases of COVID in care settings
- Reduction in delayed discharges
- Improvement in same day access to medical/professional support using variety of approaches

Supporting those with complex needs

- Increase in carer's and patients' satisfaction
- Fewer people rough sleeping and a reduction of A and E presentations for homeless people



Barnet Joint Health and Wellbeing Strategy 2021-25: Creating a borough of health together!

The Barnet Joint Health and Wellbeing Strategy sets out our vision for improving the health and wellbeing of the people who live, study and work in Barnet. For the next four years the Health and Wellbeing Board will focus on three key areas to drive improvements in health and wellbeing within the borough.

Our guiding principles

1. Making health everyone's business

We will ensure health is everyone's business, not just for agencies primarily concerned with health and wellbeing, but also for those that work to improve wider determinants of health.

2. Collaborative partnership

We will work in collaborative partnership across organisations and learn from different viewpoints across the whole system. We will focus on the areas where collaborative work makes the most difference and the HWBB can add the most value. Key areas specified in the Strategy are therefore in addition to our 'business as usual'.

3. Evidence-based decisions

We will use a robust evidence base to inform our decisions, ensuring that our investment creates maximum value for money and our resources are distributed fairly.

4. Considering everyone's needs across the life course

We will consider the needs of all parts of the population in all that we do. This includes children and young people, women and girls and people with complex needs such as mental health issues, learning disabilities and autism and our ageing population. We recognise the importance of a healthy start to life for the health outcome of the rest of one's life and so the health and wellbeing of children and young people features throughout all three key priorities.

5. Co-design approach

We will involve residents in a co-design approach to resolve our challenges. We will make sure Barnet residents' needs are met and that the resulting services are practical and sustainable. This includes embedding co-production and meaningful public engagement in our development of policies and services.

Our Vision for health in Barnet

A healthy borough results in a healthy and happy population. It is where the environment around us supports and promotes our health and wellbeing. In a healthy borough, there is broad access to a good education, good quality housing and secure employment. A healthy borough supports access to open green spaces and active travel. High quality health and social care is available for anyone when they need it. A healthy borough reaches out to, supports and protects the most vulnerable, generating opportunities to thrive. With healthier and happier residents, communities are strengthened to support each other, and the local culture and economy flourishes.

Our key areas and commitments

Creating a healthier place and resilient communities

Integrate healthier places in all policies

We will ensure that all of our policies and strategies across the system include specific actions on improving health and health equity through creating good housing, employment opportunities, active travel links and other economic and commercial conditions in Barnet

Create a healthier environment

We will create healthier choices locally with a focus on improving access to clean air, water, healthy food and physical exercise

Strengthen community capacity and secure investment to deliver healthier places

We will facilitate networking and capacity building between local communities and promote safety and cohesion while preventing violence and crime. We will make domestic abuse and violence against women and girls everyone's business.

Starting, living and ageing well

Improve children's life chances

We will improve children's life chances by supporting their health and wellbeing from very early age and through to their transition into adulthood

Promote mental health and wellbeing

We will promote good mental and emotional health across all ages and different communities and work together to prevent severe mental illness, substance misuse and suicide

Get everyone moving

We will improve choices for physical activities locally for all ages and abilities, and ensure residents know how to access it

Support a healthier workforce

We will invest time and resources to ensure our workforce is supported to be healthy, happy and productive at work.

Prevent long term conditions

We will work with communities to understand what support can be offered to reduce risks of developing long term conditions and recognise early signs and symptoms.

Ensuring delivery of coordinated and holistic care, when we need it

Support digital transformation of services

We will work together to provide digital care and support for all who can benefit from it, as well as using the power of linked electronic health and care records to improve population health

Enable carers health and wellbeing

We will support care staff and informal carers to look after their health and wellbeing

Deliver population health integrated care

We will work together to ensure the Barnet Integrated Care Partnership is centred around resident's need, aims to reduce health inequalities, promotes good physical and mental health and enables seamless access to health and care services across the life course, delivered in collaboration with local communities at neighbourhood level.

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Appendix III – Measuring Success of The Joint Health and Wellbeing Strategy 2021 – 2024

Draft for information (subject to refinement and alignment to The Barnet Plan)

This paper is starting to describe our process for monitoring the progress of the Strategy implementation over the next four years. Implementation plan will be delivered in three phases: Year 1-2; Year 2-3 and Year 3-4.

For each Key area of the Strategy, three outcomes have been identified with proposed key performance indicators, baseline performance and a specific target that will be set to enable progress to be monitored.

All of the outcomes proposed and targets are 'work in progress' and are presented here as a draft. Further alignment against Barnet Plan indicators will take place over the next few months.

It is proposed to bring a full set of outcomes, indicators, baseline and targets to the Health and Wellbeing Board meeting in September.

Outcome	What is being measured	Baseline	2025 Target
KEY AREA ONE: CREATING A HEALTHIER PLACE AND RESILIENT COMMUNITIES			
Barnet is a healthy place to live, work and study	Number of free drinking water stations installed in the borough	tbc	One free drinking station per town centre
	Number of businesses involved in Healthier High Streets programme	tbc	30% of businesses
	The proportion of overweight or obese children at Year 6 (ages 10-11)	2019-20 34.4%	Align with national targets
Air we breathe in Barnet is cleaner	Number of deaths attributable to air pollution	201 deaths in Barnet (8.4 per 10,000)	Align with national targets
	Number of trees planted a year along Barnet's road network	tbc	100 trees per year on the highway
	Proportion of residents who walk or cycle for travel (at least once a week)	2018-19 Cycling – 5.5% Walking – 49.1%	Cycling – 7% Walking – 60%
Barnet communities are resilient and safe	Number of people in contact with social prescribers/Prevention and Wellbeing Co-ordinators	tbc	tbc
	Domestic abuse incidence per 1,000 population	2019-20 33.3	tbc
	Violent crime – violence offences per 1,000 population	2019-20 18.9	tbc
KEY AREA TWO: STARTING, LIVING AND AGING WELL			
More children and young people will have good health	Proportion of 2 years old who received MMR first dose	March 2021 84%	95%
	Proportion of 5 year olds with visibly decayed teeth	2018-19 24.5%	20%
	Proportion of infants known to be partially/totally breastfed at their 6-8 week health visitor review.	May 2021 60%	75%
More residents will be physically active	Proportion of physically active adults	2019-20 63.7%	80%
	Proportion of outdoor spaces used for recreation/physical activity	tbc	tbc
	Proportion of schools engaged in physical activities (e.g. MGK, Daily Mile etc.)	tbc	tbc
More adults will enjoy good mental and physical health for longer	Year on year reduction in suicide rates per 100,000	2017-19 6.7	Yearly 10% reduction in rate
	Proportion of people with serious mental illness who have physical checks	tbc	tbc

	People with diabetes Type 2 who have their BMI recorded	2018-19 82%	95%
KEY AREA THREE: ENSURING DELIVERY OF COORDINATED AND HOLISTIC CARE, WHEN WE NEED IT			
Carers have good health and wellbeing	Carer's satisfaction scores	tbc	tbc
	Reduction in impact of COVID on care staff disproportionately impacted on (e.g. Black, Asian and other ethnic groups)*	tbc	tbc
	Proportion of carers who feel socially isolated	tbc	tbc
Barnet's health and care is digitally enabled	Proportion of people digitally excluded		
	Emergency admissions from care homes for ambulatory care sensitive conditions	tbc	tbc
	tbc		
People will access seamless care timely	Hip fractures in people aged 65 and over per 100,000	2019-20 515.9	
	tbc		
	tbc		
OVERARCHING INDICATORS			
We will reduce life expectancy gap in Barnet	Inequality in life expectancy at birth	2017-19	
	Female	6.3	
	Male	6.8	
We will decrease a number of years people live in poor health	Healthy Life Expectancy at birth	2017-19	
	Female	61.8	
	Male	63.9	

*Please note that HWB Strategy interventions are aimed at reducing COVID-19 impact to all care staff but this indicator is measuring our success for those groups that have been disproportionately impacted by the pandemic.

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Barnet

Draft Health and Wellbeing Strategy 2021-2025 Consultation

Report of consultation findings

June 2021

Oliver Taylor,
Health in All Policies Officer
Public Health Directorate

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Executive Summary

This report sets out the consultation findings from the Draft Joint Health and Wellbeing Strategy 2021-2025 that was carried out between 29 January 2021 and 12 March 2021.

Response to the consultation

The engagement activities during the consultation period consisted of two activities. The option of alternative questionnaire formats was advertised but not taken up by respondents.

Consultation method	Element	Number of responses/participants
Quantitative	Online questionnaire	72
Qualitative	Engagement session with Barnet MENCAP	15
Total		87

Summary of key findings from the questionnaire

Views on the vision

- Four fifths (79%) of respondents agreed with our vision for health and wellbeing (39% strongly agree and 40% tend to agree).
- A minority of respondents (14%) disagree with our vision (8% strongly disagreed and 6% tend to disagree) and 7% of respondents were neutral.

Reasons why respondents disagreed with the vision

- Respondents who disagreed with the vision were asked why. Answers to this question were received by 11 respondents.
- The most common themes (2 or more comments) are summarised below:
 - Suggestions for environment and green spaces wording (2 comments)
 - Comments on health and social care (2 comments)
 - Comments on the Hendon area (2 comments)
 - Residents needs that are missing (2 comments)
 - Comments on delivery of the vision (2 comments)

Views on the guiding principles

- The majority of respondents agreed with the guiding principles (between 72% and 88%).
- The highest level of support was for considering everyone's needs across the life course which 88% of respondents agreed with (55% strongly agreed and 33% tend to agree).

- The next highest was making health everyone's business which 83% of respondents agreed with (40% strongly agreed and 43% tend to agree).
- Similar levels of agreement were received for evidence based decision and collaborative partnership which 78% and 77% of respondents agreed with respectively.
- Co-design approach received the least agreement with 72% agreeing (40% strongly agreeing and 32% tend to agree). However, this is still the majority that agree with the principle.
- A minority of respondents neither agreed or disagreed with the guiding principles (between 5% and 17%).
- Few respondents disagreed with the principles (between 10% and 5%) and around 3% of respondents were not sure or didn't know.

Reasons for disagreement with the guiding principles

- Respondents who disagreed with the guiding were asked why. Answers to this question were received by 9 respondents.
- The most common themes (2 or more comments) are summarised below:
 - Views on evidence-based decisions (3 comments)
 - Corporate language is unclear and comments on government's role (3 comments)
 - Negative views on engagement activities (2 comments)

Views on areas to consider in the guiding principles

- Respondents were asked if they felt anything else that should be considered in the guiding principles. 23 respondents answered this question.
- The most common themes (2 or more comments) are summarised below:
 - Green spaces and the environment should be considered (6 comments)
 - Identifying health care needs and suggested areas for this (4 comments)
 - Comments on co-design and collaboration (2 comments)
 - Resident engagement (2 comments)
 - Suggestions around the strategy approach (2 comments)

Views on key areas of the strategy overall

- The majority of respondents agree with the key areas (between 91% and 85%).
- The highest level of agreement was for creating a healthier places and resilient communities which 91% of respondents agreed with (53% strongly agreed and 38% tend to agree).

- The second highest agreement was for starting, living and ageing well which 89% of respondents agreed with (62% strongly and 27% tend to agree). This was the highest strongly agree of the three key areas.
- Ensuring delivery of coordinated holistic care when we need it received the lowest level of agreement with 85% agreeing (49% strongly agree and 36% tend to agree). This is still a majority of respondents.
- A small number of respondents were neutral on the three key areas with between 4% and 2% neither agreeing or disagreeing.
- The minority of respondents disagreed with the key areas with disagreement being between 9% and 6%.
- On average 2% of respondents were not sure whether they agreed with the key areas.

Reasons for disagreement with the key areas

- Respondents who disagreed with the key areas were asked why. Answers to this question were received by 8 respondents.
- The most common themes (2 or more comments) are summarised below:
 - Areas identified as missing from key area 2 (2 comments)
 - Areas identified as missing from key area 3 (2 comments)
 - Suggestions of wider elements to focus on (2 comments)
 - Other comments on the strategy delivery more generally (2 comments)

Views on areas to consider in the key areas

- Respondents were asked if they felt anything else that should be considered in the key areas. 18 respondents answered this question.
- The most common themes (2 or more comments) are summarised below:
 - Suggestions for additions to key area 2 (3 comments)
 - Queries relating to council tax (2 comments)
 - Suggestions for programmes (2 comments)
 - Suggestions of broader areas to consider (2 comments)
 - Comments on the approach of the strategy (2 comments)
 - Comments on the borough and local area (2 comments)

Views on priorities of key area 1

- Respondents were asked to rank the priorities within this key area by how important they were to them. 47 respondents answered this question.
- Create a healthier environment was the most important priority with in this key area with a weighted average of 2.37.

- This was followed by strengthen community capacity and secure investment to deliver healthier places with an average of 1.98.
- Integrate healthier places in all polices was least important with an average of 1.59

Views on priorities to include in key area 1

- Respondents were asked if there were any other priorities they felt should be included in this key area. 17 answers were received for this question.
- The most common themes (2 or more comments) are summarised below:
 - Include more on green spaces and transport (4 comments)
 - Consider climate change and air quality (3 comments)
 - Include more on poverty, housing and community safety (3 comments)
 - Comments related to the council and its approach (2 comments)
 - Communicate information clearly and engage with communities (2 comments)
 - Suggestions for activities (2 comments)

Suggestions of projects or interventions in key area 1

- Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 25 respondents answered this question.
- The most common themes (2 or more comments) are summarised below:
 - Projects relating to transport (5 comments)
 - Comments relating to green spaces (4 comments)
 - Comments related to sports and leisure (3 comments)
 - Comments on housing and development (4 comments)
 - Programmes for supporting local communities (3 comments)
 - Programmes suggested for CYP (4 comments)
 - Comments related to finance and council tax (2 comments)

Views on priorities of key area 2

- Respondents were asked to rank the priorities within this key area by how important they were to them. 41 respondents answered this question.
- The most important priority was improve children's life chances with a weighted average of 3.68.
- This was followed by promote mental health and wellbeing (average of 3.51) and get everyone moving (average of 3.1).
- The least important priority was support a healthier workforce with an average of 2.1.

Views on priorities to include in key area 2

- Respondents were asked if there were any other priorities they felt should be included in this key area. 13 answers were received for this question.
- The most common themes (2 or more comments) are summarised below:
 - Inclusion of green spaces (5 comments)
 - Include active travel and transportation (4 comments)
 - More services for adults and those with disabilities (2 comments)

Suggestions of projects or interventions in key area 2:

- Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 19 respondents answered this question.
- The most common themes (2 or more comments) are summarised below:
 - Suggestions on active travel and transportation (4 comments)
 - Suggestions around green spaces (3 comments)
 - Ideas for community and wellbeing activities (6 comments)
 - Comments on healthy eating (2 comments)
 - Ideas for physical activity programmes (2 comments)
 - Comments related to digital access (2 comments)

Views on priorities in key area 3

- Respondents were asked to rank the priorities within this key area by how important they were to them. 39 respondents answered this question.
- Deliver population health integrated care was the most important priority with a weighted average of 2.38.
- This was followed by enable carers health and wellbeing (average of 2.05) and support digital transformation of services with an average of 1.56.

Views on priorities to include in key area 3

- Respondents were asked if there were any other priorities they felt should be included in this key area. 10 answers were received for this question.
- The most common themes (2 or more comments) are summarised below:
 - Comments on integrated working (4 comments)
 - Comments around access to services (2 comments)

Suggestions of projects or interventions in key area3

- Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 13 respondents answered this question.
- The most common themes (2 or more comments) are summarised below:
 - Comments on access to digital and information access (4 comments)
 - Suggestions for wellbeing and community programmes (3 comments)

Views on the whole strategy

- Respondents were asked if they had any other comments on the draft JHWS after completing the questions on specific sections of the strategy. 12 responses to this question were received.
- The most common themes (2 or more comments) are summarised below:
 - Comments on community support (3 comments)
 - Comments on the borough or local area (3 comments)
 - Comments on engagement activities (2 comments)

Views on health and wellbeing services in Barnet

- Respondents were asked to what extent they agree with statements on health and wellbeing services in Barnet. 38 respondents answered this question.
- Respondents were in agreement that they were satisfied with hospital services in the borough (weighted average of 3.08).
- The second and third highest agreed statements were about finding it easy to access information on health and wellbeing services (average of 2.87) and that respondents were overall satisfied with health and wellbeing services (weighted average of 2.82).
- The other statements had slightly lower levels of agreement with views on children's social care being the lowest with an average of 1.87. This was the statement that received the highest number of response that residents didn't know their thoughts on that statement.

Comments on health and wellbeing services

- Respondents were also asked if they had any comments on health and wellbeing services in Barnet. 16 responses to this question were received.
- The most common themes (2 or more comments) are summarised below:
 - Need for more communications (3 comments)
 - Comments on mental health services (3 comments)
 - Comments related to the pandemic (2 comments)

- Comments related to the JHWS (2 comments)
- Suggestions for Health and Wellbeing Board (2 comments)
- Comments related to CYP social services (2 comments)

Recommendations

The overall findings of this consultation were that residents were positive about the draft strategy and its proposed direction. The consultation highlighted some areas of the strategy that can be updated prior to the final approval of the strategy.

A summary of the key recommendations is below:

- **Vision:** Review the vision statement and consider if the wording should be changed to emphasise the role of the environment and green spaces in supporting the vision.
- **Guiding principles:** Review the guiding principles and ensure that the language used is clear to what the principles mean to the wider population. Consider amending the principles to include more definition of the role of public engagement.
- **Key areas:** Review each key area and consider amending the commitments with areas raised as important to stakeholders and residents. For key area 1, review the wording on community safety and consider a clearer statement on work to make domestic abuse and violence against women and girls everyone's business.
- **Programmes and interventions to deliver the strategy:** This consultation provided a range of suggestions from residents for programmes for each key area. Findings of this consultation to be shared with relevant officers to provide insight for the development of public health interventions and other strategies in addition to the JHWS.

The recommendations and suggested from this consultation were included in the drafting of the strategy.

Introduction

The Draft Joint Health and Wellbeing Strategy (JHWS) is our vision for how to improve the health and wellbeing of Barnet residents. This strategy will run from 2021 to 2025. It is a statutory duty of the Health and Wellbeing Board to produce this strategy.

The strategy has three key areas of focus. These key areas are:

1. Creating a healthier place and resilient communities
2. Starting, living and ageing well
3. Ensuring delivery of coordinated and holistic care, when we need it

Prior to the consultation, multiple engagement activities were conducted to develop the strategy and shape the priorities within it. These include:

- A priority development questionnaire which ran from 9th September to 13th October
- A workshop at the Annual Care Summit (26th September 2019) and with the Barnet Youth Board (26th September 2019)
- A workshop for internal staff and partners to discuss the draft key areas and the emerging strategy on 29th July 2020.

The Health and Wellbeing Board approved the draft strategy to go for consultation on 14th January 2021.

Consultation approach

Consultation methods

The Draft JHWS 2021-25 consultation began on 29th January 2021 and concluded on 12th March 2021. The consultation ran for six weeks.

The consultation consisted of two elements:

1. An online questionnaire published on engage.barnet.gov.uk together with the draft strategy and consultation document. The questionnaire and consultation is included as appendices I and II. Paper copies were available upon request.
2. A virtual meeting held with Barnet MENCAP to discuss the priorities and what was important to its members.

The ongoing coronavirus pandemic did have an effect on the consultation approach taken. Due to social distancing and national guidance, face-to-face engagement could only take place virtually. This meant that the primary method of consultation was the online questionnaire whereas before the pandemic the consultation would feature many in person engagement elements that were not feasible for this consultation.

Promotion of the consultation

The consultation was actively promoted using social media, existing council communications channels and via email.

Activities to promote the consultation included:

- Social media posts via Twitter and targeted posts on Facebook
- An article on the Barnet First e-newsletter to advertise the consultation.
- Emails to relevant partners inviting them to participate in the consultation
- A news item in the Communities Together Network newsletter
- consultation place as a 'featured consultation' on the homepage of the barnet.gov.uk website
- promotion amongst Barnet internal staff communications channels.

Findings of the questionnaire

Questionnaire design

The questionnaire was developed to ascertain views on the Draft JHWS and the key areas within it. The consultation invited views on:

- Our vision for health and wellbeing in Barnet
- The guiding principles of our strategy
- The key areas we would like to focus on for the next four years

Throughout the questionnaire links were provided to the relevant section of the strategy document and to the consultation document.

The following types of questions were included:

- Questions whether respondents agreed or disagreed with the vision, guiding principles or key areas
- Open ended questions, where respondents were asked to provide reasons for areas they disagreed with or felt was missing from the strategy. The questionnaire also asked for suggestions for relevant programmes or interventions.

Response to the questionnaire

A total of 72 questionnaires have been completed. All of these responses were via the online questionnaire or correspondence via email.

This report includes comments provided by respondents in free text questions. Whilst the majority of these comments are included in this report verbatim please note that some have been edited to remove any identifiable information included in responses to questions.

Response profile

Table 1 shows that the majority of those who responded to the questionnaire were Barnet residents (33%). For this consultation few responses were received from voluntary/community organisations (6%) or public sector organisations (3%). It is important to note that over half of the respondents (53%) did not answer this question.

Table 1: Profile of those who responded to the Draft JHWS consultation

Stakeholder	%	Number
A Barnet resident	33%	24
A person who works in the London Borough of Barnet area	6%	4
A Barnet business	0%	0
A Barnet business and Barnet resident	1%	1
Representing a voluntary/community organisation	6%	4
Representing a public sector organisation	3%	2
Total who answered this question	47%	34
Not answered this question	53%	38
Total response to the consultation	100%	72

Profile of protected characteristics

The council is required by law (the Equality Act 2010) to pay due regard to equalities in eliminating unlawful discrimination, advancing equality of opportunity, and fostering good relations between people from different groups.

The protected characteristics identified in the Equality Act 2010 are age, disability, ethnicity, gender, gender reassignment, marriage and civil partnership, pregnancy, maternity, religion or belief and sexual orientation.

To assist us in complying with the duty under the Equality Act 2010 we asked the respondents to provide equalities monitoring data and explained that collecting this information will help us understand the needs of our different communities and that all the information provided will be treated in the strictest confidence and will be stored securely in accordance with our responsibilities under data protection legislation (such as the General Data Protection Regulation or the Data Protection Act 2018).

Table 2 shows the profile of these who answered these questions.

Table 2: Protected Characteristics, profile of those that completed the questionnaire

	Number	%
Gender		
Female	16	22%
Male	10	14%
Prefer not to say	3	4%
Not answered	43	60%
Answered	29	40%
Total	72	100%
Age		
16-17	0	0%
18-24	1	1%
25-34	3	4%
35-44	4	6%
45-54	7	10%
55-64	7	10%
65-74	4	6%
75+	0	0%
Prefer not to say	3	4%
Not answered	43	60%
Answered	29	40%
Total	72	100%

Is the gender you identify with the same as your sex registered at birth?		
Yes, it's the same	26	36%
No, it's different	0	0%
Prefer not to say	3	4%
Not answered	43	60%
Answered	29	40%
Total	72	100%
Disability		
Yes	6	8%
No	21	29%
Prefer not to say	2	3%
Not answered	43	60%
Answered	29	40%
Total	72	100%
Ethnicity		
Black	1	1%
Asian	2	3%
Mixed	1	1%
White	21	29%
Other	1	1%
Prefer not to say	3	4%
Not answered	43	60%
Answered	29	40%
Total	72	100%
Faith		
Baha'i	0	0%
Buddhist	0	0%
Christian	7	10%
Hindu	1	1%
Humanist	1	1%
Jain	0	0%
Jewish	1	1%
Muslim	0	0%
Sikh	0	0%
No religion	10	14%
Prefer not to say/not stated	8	11%
Other Faith	1	1%
Not answered	43	60%
Answered	29	40%
Total	72	100%

Pregnancy		
Pregnant	0	0%
On maternity leave	0	0%
Prefer not to say	2	3%
Neither	15	21%
Not answered	53	74%
Answered	19	26%
Total	72	100%
Sexuality		
Bisexual	2	3%
Gay or Lesbian	1	1%
Straight or heterosexual	22	31%
Prefer not to say	4	6%
Other sexual orientation	0	0%
Not answered	43	60%
Answered	29	40%
Total	72	100%
Marital Status		
Single	7	10%
Co-habiting	6	8%
Married	10	14%
Divorced	0	0%
Widowed	0	0%
In a same sex civil partnership	0	0%
Prefer not to say	6	8%
Not answered	43	60%
Answered	29	40%
Total	72	100%

Views on the vision

Respondents were asked whether they agreed or disagreed with the vision statement in the draft strategy and their views are shown in table 3.

Four fifths (79%) of respondents agreed with our vision for health and wellbeing (39% strongly agree and 40% tend to agree). A minority of respondents (14%) disagree with our vision (8% strongly disagreed and 6% tend to disagree) and 7% of respondents were neutral.

Table 3: Respondents level of support for our vision

To what extent do you agree or disagree with our vision for health and wellbeing in Barnet?	Number	%
Strongly agree	28	39%
Tend to agree	29	40%
Neither agree nor disagree	5	7%
Tend to disagree	4	6%
Strongly disagree	6	8%
Don't Know	0	0%
Total	72	100%

Reasons for disagreement with the vision

Respondents who disagreed with the vision were asked why. Answers to this question were received by 11 respondents.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 4:

- Suggestions for environment and green spaces wording (2 comments)
- Comments on health and social care (2 comments)
- Comments on the Hendon area (2 comments)
- Residents needs that are missing (2 comments)
- Comments on delivery of the vision (2 comments)

Table 4: Reasons why respondents disagreed with the vision

Why do you disagree with the guiding principles?	
Number of respondents who completed this question	11
Description / Type of verbatim comments	Number of comments
Environment and green spaces suggestions It is where the environment around us supports and promotes our health and wellbeing. / A healthy borough supports access to local green spaces and active transport.	2
The emphasis on social and environmental influences on health and wellbeing is absolutely crucial. The vision statement needs to include that the health of our natural systems also need to flourish. I am interested in how the HWB will consider the tension between economic 'growth' and our natural resources - and so I worry about the idea of the economy 'flourishing' - what do we really mean? We really mean everyone will have their material needs met - so let's make it about people and natural systems not about the 'economy flourishing'.	1

Why do you disagree with the guiding principles?	
Number of respondents who completed this question	11
Description / Type of verbatim comments	Number of comments
Comments on health and social care High quality health and social care is available for anyone when they need it. / we cannot get doctors appointments, we can wait years for hospital treatment that is not life-threatening,	2
Concerns about local area I have lived in the same area all my life. Barnet does not put its Residents first at all. For example, Hendon library services have been whittled down, Hendon (by the Town Hall) is neglected, Sentinel Square run down and any mention of redevelopment is for the benefit of Middlesex University. Residents put up with the anti-social behaviour of the students and multiple lets. Our children have nowhere to go. Shame on Barnet!!!/ You do not think of your residents. Hendon (around Middlesex University) is neglected and run down. Residents put up with multiple let properties, families cannot get on the housing ladder and anti-social behaviour from Middlesex University students. This is turning into a campus. Drug paraphernalia in gutters and litter stuffed in hedges! If past recent performances anything to go on you are not succeeding, so much apartment building, you are overcrowding, we cannot get doctors appointments, we can wait years for hospital treatment that is not life-threatening, the amount of people and the overcrowding of cars on the road, the pollution, and few houses being built which people want, Nothing at all for older residents, we can't move we stay in three bedroomed houses we don't need. Barnet used to be a good place to live but sadly, not anymore.	2
Comments on delivering vision "collaborative partnership across organisational boundaries" is highly problematic if it is the implementation of private healthcare services and providers. collaboration is an unrealistic expectation. / Does it include outsourcing? Does it include any form or type of privatisation? These two Qs carry the foot print of Barnet London Borough's approach.	2
Residents needs that are missing Don't include the digital needs of residents. / Nothing at all for older residents	2
Complete waste of taxpayers money	1
Rather woolly	1

Views on the guiding principles

Respondents were asked whether they agreed or disagreed with the guiding principles in the draft strategy. These guiding principles were:

- Making health everyone’s business
- Collaborative partnership
- Evidence based decisions
- Considering everyone’s need across the life course
- Co-design approach

Table 5 shows that the majority of respondents agreed with the guiding principles (between 72% and 88%).

The highest level of support was for considering everyone’s needs across the life course which 88% of respondents agreed with (55% strongly agreed and 33% tend to agree).

The next highest was making health everyone’s business which 83% of respondents agreed with (40% strongly agreed and 43% tend to agree).

Similar levels of agreement were received for evidence based decision and collaborative partnership which 78% and 77% of respondents agreed with respectively.

Co-design approach received the least agreement with 72% agreeing (40% strongly agreeing and 32% tend to agree). However, this is still the majority that agree with the principle.

A minority of respondents neither agreed or disagreed with the guiding principles (between 5% and 17%).

Few respondents disagreed with the principles (between 10% and 5%) and around 3% of respondents were not sure or didn’t know.

Table 5: Views on the guiding principles

Principle	Strongly agree		Tend to agree		Neither agree or disagree		Tend to disagree		Strongly disagree		Not sure/Don't know		Total
	%	No	%	No	%	No	%	No	%	No	%	No	
Making health everyone's business	40%	24	43%	26	5%	3	5%	3	3%	2	3%	2	60
Collaborative partnership	50%	30	27%	16	12%	7	3%	2	5%	3	3%	2	60
Evidence based decisions	43%	26	35%	21	13%	8	2%	1	3%	2	3%	2	60
Considering everyone’s needs across the life course	55%	33	33%	20	5%	3	2%	1	3%	2	2%	1	60
Co-design approach	40%	24	32%	19	17%	10	5%	3	5%	3	2%	1	60

Reasons for disagreement with the guiding principles

Respondents who disagreed with the guiding were asked why. Answers to this question were received by 9 respondents.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 6:

- Views on evidence-based decisions (3 comments)
- Corporate language is unclear and comments on government's role (3 comments)
- Negative views on engagement activities (2 comments)

Table 6: Reasons why respondents disagreed with the guiding principles

Why do you disagree with the guiding principles?	
Number of respondents who completed this question	9
Description / Type of verbatim comments	Number of comments
Collaborative partnership I would like to see a strong lead on this. Collaborative is all very well but can lead to nothing happening.	1
Evidence Based decisions the HWB need to be aware that community level interventions and/or community-led interventions rarely have the resources to complete RCTs etc. This is therefore going to promote more medical model, individualised approaches. can there also be a guiding principle of 'practice-based evidence' or an acknowledgement that 'evidence' itself is not equally available/possible. / We would amend to "We will use a robust evidence base to inform our decisions across all areas of the Council. We will ensure our direct investment creates maximum value for money, our resources are distributed fairly and decisions support and improve health and wellbeing across the borough. / I need to see evidence, a practical one, if possible.	3
Making health everyone's business we would amend to not just for agencies and departments primarily concerned with"	1
What does co-design mean?	1
This is a waste of time and more importantly money	1

Why do you disagree with the guiding principles?	
Number of respondents who completed this question	9
Description / Type of verbatim comments	Number of comments
Negative views on engagement I have served on the PCT CCG PPG All just talking shops. / Stop wasting our money on useless consultations to tick boxes.	2
As a long term Resident of Hendon, I have watched the area change and definitely not for the better. Residents and families have been forgotten about. We will need places to come together as a community after this pandemic not investment in a transient student population, who will be in the area for a short while. Invest in your Residents!!	1
Views on corporate language or government role Councils need to stop using words which exclude people who don't understand the specific language of councils. / Less government, not more. / This all sounds a bit like corporate mumbo jumbo and is open to interpretation but some of the terms sound like NHS privatisation which I am completely in favour of.	3

Views on areas to consider in the guiding principles

Respondents were asked if they felt anything else that should be considered in the guiding principles. 23 respondents answered this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 7:

- Green spaces and the environment should be considered (6 comments)
- Identifying health care needs and suggested areas for this (4 comments)
- Comments on co-design and collaboration (2 comments)
- Resident engagement (2 comments)
- Suggestions around the strategy approach (2 comments)

Table 7: Areas respondents felt should be considered in the guiding principles

Is there anything else you think we should consider for our guiding principles?	
Number of respondents who completed this question	23
Description / Type of verbatim comments	Number of comments
Green spaces and the environment should be considered Consider green spaces, trees, nature and access to wildlife and animals. Restrict developments that reduce green space and provide incentives to build on brownfield and / or run down / derelict buildings and	6

Is there anything else you think we should consider for our guiding principles?	
Number of respondents who completed this question	23
Description / Type of verbatim comments	Number of comments
land. / Yes environment should be given a place. A lot of health is linked to environment. Green spaces locally are hugely important as the lockdowns have shown. / Heavy fines for engine idling. Tree planting programme. New houses must have gardens. Pedestrianise as much as possible. Protect open spaces such as Whale Bone Park. Once they're gone they're gone. / Stop overcrowding people in massive apartments, don't allow building unless infrastructure is improved. Hi pollution has come and traffic jams because of so many people now living in the borough as no infrastructure has been improved. / I hope this will help, some areas in Barnet are neglected, streets are not cleaned at regular basis. Some areas need help like providing free skips as done years back for households who do not have cars for example.	
Health in all policies is crucial - I would argue that the guiding principle 'health is everybody's business' is not transparent enough in terms of what that means to the population.	1
Comments on co-design and collaboration I would also argue that a guiding principle needs to be coproduction not just codesign. Afterall that is what is in the NHS Long Term Plan. Co-design and collaborative should be either brought together or made more explicitly different / who are the collaborative partnership with?	2
Resident engagement Keep hearing the voices of all communities even the ones that are not easy to approach. Isolation has provided with challenging situations among the most vulnerable and often are not aware of the facilities or resources. Would be a good idea to allocate a resident with a strong sense of community to supervise, promote wellbeing and be the voice for them. / These Consultations show how far removed you are.	2
Identifying healthcare needs and suggested areas Barnet has the highest elderly population in England and has very bad health and social care policies and manpower to carry these out. / More obscure disabilities catered for . / Integrated care does not require commercial contracts and the involvement of corporates. Health care should not lead to marketisation and fragmentation of the NHS. care should be publicly provided and publicly accountable with no reduction in services. / How to adapt to CYP with SEND	4
Broader areas to consider Our safety. / Promoting health	2
The people who have voted you in and are putting up with their services being trashed by a Council intent on just investing in the local University. As youngsters, my children went to the local library practically 2 to 3 days a week - baby groups and to borrow books. Over the years, Barnet have chipped away at the service. When your now 16 year old says that, "Mummy we spent so much time there. Now they seem to turn us away. It's got smaller and smaller. If there wasn't a pandemic, I still wouldn't be able to get in there. There's no where to study." Still, the University has an amazing state of the art 24/7 library building. You have ruined my children's education!!! No where for them to go. Community fed up. Lack of investment in your Residents and children/families is heart breaking. These Consultations	1

Is there anything else you think we should consider for our guiding principles?	
Number of respondents who completed this question	23
Description / Type of verbatim comments	Number of comments
show how far removed you are. Meritage Centre closed and now looking to move on PDSA and Citizens Advice. All aimed at this area becoming a campus to the detriment of those who pay Council Tax and struggle to bring children up in the area. Barnet should be embarrassed of themselves. Will only be improved to enrich the University and definitely not for the benefit of locals.	
Principles wording suggestions would suggest the guiding principles be edited as below:	1
a) Making health everyone's business, not just for agencies and departments primarily concerned with	
c) We will use a robust evidence base to inform our decisions across all areas of the Council. We will ensure evidence based decisions happen fairly in the Borough	
d) Considering everyone's needs across the life course, and with a particular focus on women and girls (as women and girls use public transport more (and therefore more exposed to poor air), more likely to be carers, and more likely to interact with playground or open space design.	
Suggestions around strategy approach We need to see evidence at every step published detailed approach. / Hope you get more specific.	2

Views on the key areas of the strategy overall

Respondents were asked to what extent do they agree or disagree with the key areas of the strategy. These key areas were:

1. Key Area 1: Creating a healthier place and resilient communities
2. Key Area 2: Starting, living and ageing well
3. Key Area 3: Ensuring delivery of coordinated and holistic care, when we need it

Table 8 shows that the majority of respondents agree with the key areas (between 91% and 85%).

The highest level of agreement was for creating a healthier places and resilient communities which 91% of respondents agreed with (53% strongly agreed and 38% tend to agree).

The second highest agreement was for starting, living and ageing well which 89% of respondents agreed with (62% strongly and 27% tend to agree). This was the highest strongly agree of the three key areas.

Ensuring delivery of coordinated holistic care when we need it received the lowest level of agreement with 85% agreeing (49% strongly agree and 36% tend to agree). This is still a majority of respondents.

A small number of respondents were neutral on the three key areas with between 4% and 2% neither agreeing or disagreeing.

The minority of respondents disagreed with the key areas with disagreement being between 9% and 6%.

On average 2% of respondents were not sure whether they agreed with the key areas.

Table 8: Views of respondents on each key area

Key area	Strongly agree		Tend to agree		Neither agree or disagree		Tend to disagree		Strongly disagree		Not sure/Don't know		Total
	%	No	%	No	%	No	%	No	%	No	%	No	
Key Area 1: Creating a healthier place and resilient communities	53%	29	38%	21	2%	1	2%	1	4%	2	2%	1	55
Key Area 2: Starting, living and ageing well	62%	34	27%	15	4%	2	2%	1	4%	2	2%	1	55
Key Area 3: Ensuring delivery of coordinated and holistic care, when we need it	49%	27	36%	20	4%	2	4%	2	5%	3	2%	1	55

Reasons for disagreement with the key areas

Respondents who disagreed with the key areas were asked why. Answers to this question were received by 8 respondents.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 9:

- Areas identified as missing from key area 2 (2 comments)
- Areas identified as missing from key area 3 (2 comments)
- Suggestions of wider elements to focus on (2 comments)
- Other comments on the strategy delivery more generally (2 comments)

Table 9: Reasons why respondents disagreed with the key areas

Why do you disagree with the key areas?	
Number of respondents who completed this question	8
Description / Type of verbatim comments	Number of comments
<p>Areas identified as missing from key area 1 Under creating a healthier place, we would include the concept of healthy high streets, limiting planning and licencing for businesses that are detrimental to health and wellbeing, such as for gambling, tanning salons etc and favouring those that are health promoting, as espoused n the Royal Society for Public Health - Health on the High Street - Running on Empty Report 2018 and Healthy High Streets 2018 published by Public Health England and the Institute of Health Equity. I would include under the healthier environment access to green spaces, including micro greenspaces in town centres, and play and exercise facilities. We would include equalities issues in the assessment and design of greenspaces, playspaces and high streets.</p>	1
<p>Areas identified as missing from key area 2 Under Key Area 2 we would link this to the environment - specifically access to green space and healthy high streets as well as to access to support from health, care, and voluntary sector services. / age span 16-25 often gets overlooked but for many young people living in poverty etc this is transitionally difficult time.</p>	1
<p>Areas identified as missing from key area 3 I think holistic care should be provided every time because we always act when the problem is there, but we should act before the problem happens and then try to solve them when they might not have a solution. / Under Key Area 3 we would amend to read "We will create circumstances where access to digital care can be easy and safe for all who need it, and that alternatives remain available and accessible. We would explicitly refer to the Glasgow/ Public Health approach to gang crime and youth violence.</p>	2
<p>Areas that have been missed or suggestions to focus on / I think this also part of the individual . everyone as a role to play on their own health . Maybe what is needed is more education. / Focus on reducing council tax, nothing else.</p>	2
<p>Other comments on the strategy delivery more generally From what I have seen living in Barnet over 49 years, your Residents and their well being is definitely not at the top of your agenda. / These are all admirable principles- but possibly difficult to deliver without adequate resources.</p>	2

Views on areas to consider in the key areas

Respondents were asked if they felt anything else that should be considered in the key areas. 18 respondents answered this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in Table 10:

- Suggestions for additions to key area 2 (3 comments)
- Queries relating to council tax (2 comments)
- Suggestions for programmes (2 comments)
- Suggestions of broader areas to consider (2 comments)
- Comments on the approach of the strategy (2 comments)
- Comments on the borough and local area (2 comments)

Table 10: Areas respondents think should be considered in the key areas

Is there anything else you think we should consider for our key areas?	
Number of respondents who completed this question	18
Description / Type of verbatim comments	Number of comments
Suggestions for KA1 Suggest introduction of the concept of healthy high street, see here: https://www.gov.uk/government/publications/healthy-high-streets-good-place-making-in-an-urban-settin	1
2 - Suggestions for KA2 Suggest targeted access to green spaces and play spaces, throughout residents lives./ Expand on ageing well, in the title it draws on pre-conception pregnancy etc and then finishes at adulthood, it does not expand on adulthood. / ageing wellbeing for later life	3
Suggestions for KA3 Suggest adopting the Glasgow/ public health approach to youth crime and gang violence, see here: https://www.gov.scot/policies/crime-prevention-and-reduction/violence-knife-crime/	1
Poverty reduction in all ages and across the whole Borough needs to be considered and in a way that isn't just about getting people back into a precarious poorly paid job - and including in work poverty. The local authority and central government need to consider what actually works in reducing poverty and not just trying the same old things again and again.	1
Queries related to council tax How much is this all costing the rate payers and will it work? / Reducing council tax.	2
Suggestions for programmes To prevent loneliness especially for the elderly, providing subsidies or free recreational activities of day outings at a long cost. / Maybe more mentors for young people and spaces for young and old people to connect .	2

Is there anything else you think we should consider for our key areas?	
Number of respondents who completed this question	18
Description / Type of verbatim comments	Number of comments
Broader areas to consider Does cover digital exclusion / Equalities issues.	2
Comments on strategy approach Keep communication strong and helping hand around. A good place would be community centres to be open even virtually and free. / Publish all evidence focussing in detailed approach.	2
Comments on local area Please consider your Residents. Get people on board who live in the area, know the area and its make-up. Usually it's people who know nothing of the area making decisions or people who live in mansions and have no idea about the day to day running of the area. They get in cars and have little idea if what it's actually like to live in the area, walk in the area, shop in the area or try to visit the local library. When I was a school Governor, I found you would sometimes get people on the Board who had had children at the school 20 or so years ago. I used to always reiterate, communities changed and they needed to come on site to see how that changed a school's dynamics. Hendon to me is now just being aimed at becoming a University Campus, with no thought to the Residents, their families and well being. As a long term, Council paying Resident, I cannot even get on the property ladder. As I walk around, I see everything neglected and what services we had destroyed - think about what that does to people's health. Massive high rises planned everywhere. Who would actually like to live there? Then, they're all about profit!! Where is the infrastructure? Awful!! Shame on Barnet. Put right all that's ruined Barnet over the past few years.	2

Views on creating a healthier place and resilient communities

Respondents were asked their views on this key area including the proposed commitments and how important they were to them.

The commitments within this key area were:

- Integrate healthier places in all policies
- Create a healthier environment
- Strengthen community capacity and secure investment to deliver healthier places

Level of importance of each priority

Respondents were asked to rank the priorities within this key area by how important they were to them. 47 respondents answered this question.

Create a healthier environment was the most important priority with in this key area with a weighted average of 2.37. This was followed by strengthen community capacity and secure investment to deliver healthier places with an average of 1.98. Integrate healthier places in all polices was least important with an average of 1.59. This is shown on chart 1.

Table 11 shows the responses from the question with the ranking answers for each priority.

Chart 1: Weighted average for most important priority in key area 1

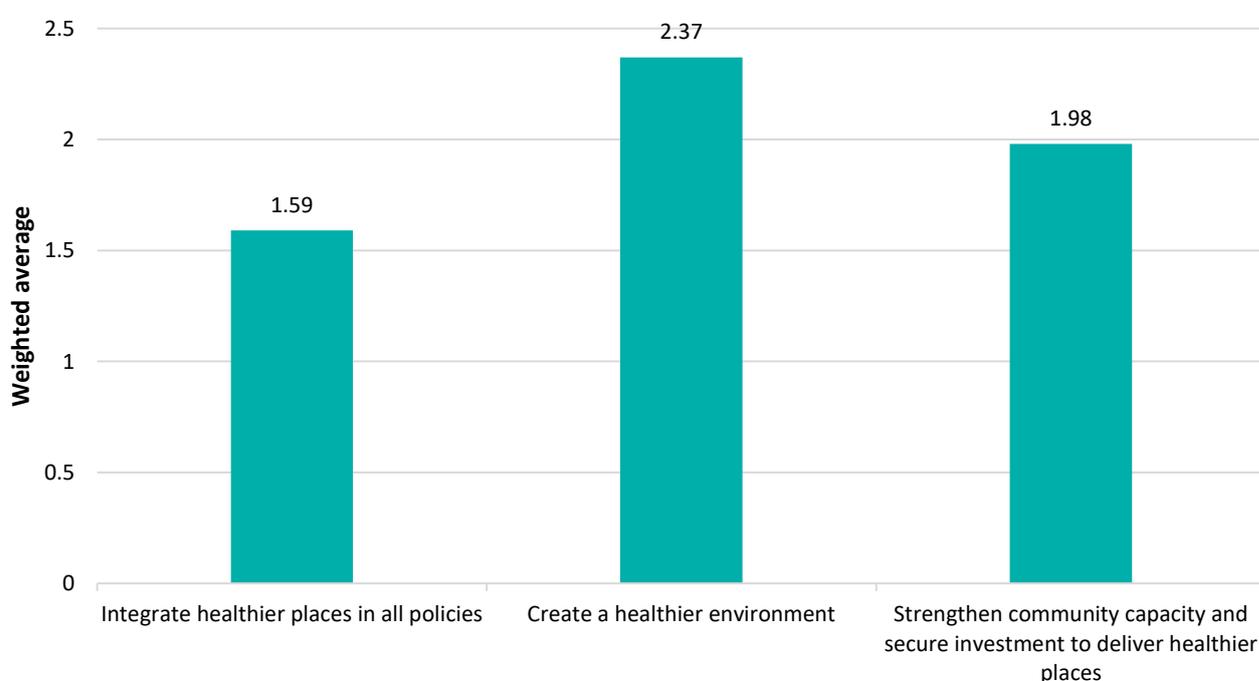


Table 11: Views on 1st, 2nd and 3rd most important priority in key area 1

Priority	1st Most Important		2nd Most Important		3rd Most Important		Don't know/not sure		Total
	%	No	%	No	%	No	%	No	
Integrate healthier places in all policies	17%	8	24%	11	59%	27	0%	0	46
Create a healthier environment	48%	22	41%	19	11%	5	0%	0	46
Strengthen community capacity and secure investment to deliver healthier places	34%	16	34%	16	28%	13	4%	2	47

Views on priorities to include in this key area

Respondents were asked if there were any other priorities they felt should be included in this key area. 17 answers were received for this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 12:

- Include more on green spaces and transport (4 comments)
- Consider climate change and air quality (3 comments)
- Include more on poverty, housing and community safety (3 comments)
- Comments related to the council and its approach (2 comments)
- Communicate information clearly and engage with communities (2 comments)
- Suggestions for activities (2 comments)

Table 12: Additional priorities respondents think should be included in key area 1

What other priorities should be included in this key area?	
Number of respondents who completed this question	17
Description / Type of verbatim comments	Number of comments
<p>Include more on green spaces and transport - Investing in an accessible public transport infrastructure. Ensure there is access to quality greenspace within 10-15 minutes walk of everyone. Access to green space and nature. Difficult to achieve, given that Central Government overrule planning decisions and current Tory gov proposals include less consultation with residents and communities. There has been a growing understanding of the vital role that parks, and green spaces play in the promotion and maintenance of both mental and physical health and wellbeing in recent years. The evidence base to support this is growing. This has been reinforced during the COVID pandemic, with many finding solace, activity and play in open spaces as an essential daily ingredient in their locked down life. Over the same period austerity has drawn considerable funding away from the maintenance and upkeep of our parks and green spaces. There needs to be a new approach and a considerable increase in funding to recognise the value and maintenance requirements of these spaces. In addition, new approaches to the way we manage these green spaces should be adopted. No longer should our Parks be the single preserve of the parks and recreation department. A more holistic approach encompassing traditional parks management should be combined with the NHS, social care, and the voluntary sector. We need a Modern Park Keeper. Clean accessible toilets especially in parks not locked by 6pm</p>	4
<p>Consider climate change and air quality Consider climate change in design standards. / Climate change is missing / I would particularly stress clean air and active travel in promoting a healthier place.</p>	3
<p>communications and community engagement Promote these actions and give clear information to the public, make people engage in the process and give them a voice, from the youngest person to the elderly. Most of the times people don't know that these actions</p>	2

What other priorities should be included in this key area?	
Number of respondents who completed this question	17
Description / Type of verbatim comments	Number of comments
or propositions exist. The Council should promote more, with stronger communities will have more involvement in the projects. / Consider and implement what Barnet residents want.	
4 - More activities or suggestions healthy food available and more free activities like yoga and mindfulness. / More activities for the ages 18-35.	2
Comments on poverty, housing and community safety - Glasgow/ public health approach to youth crime and gang violence. / Poverty reduction - doesn't appear to be mentioned in the next steps of health in all policies approach. / Affordable social housing	3
Comments on council and approach No outsourcing and No privatisation by the back door. / This needs to get better... you need to educate people. / More local government more efficient and reduce costs.	3
Families struggling to stay in the area when we're unable to buy and community is gone. There is none.	1
Apathy	1
All accesses	1

Suggestions of projects or interventions in this key area

Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 25 respondents answered this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 12:

- Projects relating to transport (5 comments)
- Comments relating to green spaces (4 comments)
- Comments related to sports and leisure (3 comments)
- Comments on housing and development (4 comments)
- Programmes for supporting local communities (3 comments)
- Programmes suggested for CYP (4 comments)
- Comments related to finance and council tax (2 comments)

Table 12: Suggestions for projects or interventions within key area 1

Do you have any suggestions for projects or interventions that should be done within this key area?	
Number of respondents who completed this question	25
Description / Type of verbatim comments	Number of comments
<p>Projects relating to transport Developing an accessible public transport infrastructure. Encouraging walking and cycling. Supporting the introduction of the ULEZ (Ultra Low Emissions Zone) to the south of the borough this year and its extension to the rest of the borough later on.</p> <p>Create: Cycle lanes, Traffic free areas, Walking routes, Ban engine idling. Help short journeys be made by bike, by creating cycle routes. Walk days / cycle days/ use the green belt / off road paths</p>	5
<p>Provide an app or tool where people can decide what is most important and provide whatever it takes to makes the priorities of the people happen. Also not just request the people answers, let the people ask questions and propose ideas and projects.</p>	1
<p>Green spaces</p> <p>Ensure allotment spaces are allocated fairly. Encourage allotments to offer plots to community groups. Listen to local communities when they tell you they want to protect local green spaces and prevent planning dept going in the opposite direction and permitting development. Access to green spaces, including micro-greenspaces on the high street, playspaces, within 10-15 minutes walk. Explicit reference to equalities issues in design of high streets, green spaces and playspaces. / There has been a growing understanding of the vital role that parks, and green spaces play in the promotion and maintenance of both mental and physical health and wellbeing in recent years. The evidence base to support this is growing. This has been reinforced during the COVID pandemic, with many finding solace, activity and play in open spaces as an essential daily ingredient in their locked down life. Over the same period austerity has drawn considerable funding away from the maintenance and upkeep of our parks and green spaces. There needs to be a new approach and a considerable increase in funding to recognise the value and maintenance requirements of these spaces. In addition, new approaches to the way we manage these green spaces should be adopted. No longer should our Parks be the single preserve of the parks and recreation department. A more holistic approach encompassing traditional parks management should be combined with the NHS, social care, and the voluntary sector. We need a Modern Park Keeper.</p>	4
<p>Sports and leisure Have you integrated the Sport England Movement specifically https://www.sportengland.org/why-were-here/uniting-the-movement/what-well-do/connecting-communities into this part of your strategy? Could we know what impact the FAB Framework has had since its implementation and the direct impact of the £450,000 investment into 'interventions'. What are these interventions? Is it reflective of the whole community that a company (GLL/Better) are managing the FAB campaign for you? Free online courses to improve knowledge in fields of interests, weekly sports activities,</p>	3

Do you have any suggestions for projects or interventions that should be done within this key area?	
Number of respondents who completed this question	25
Description / Type of verbatim comments	Number of comments
workshops and interchangeable skills to improve connections. Creating more sports and youth activities. For example, our nearest gymnastics hall is 40 mins in a car, 1 1/2 hrs on bus. How can Allianz park cater for those in East Barnet adequately.	
Comments on housing and development Challenge property developers re their affordability of housing and review use (or not) of section 106 money across the Borough and if it is being used in line with these priorities. Stop use of inappropriate and poor temporary accommodation for children and families - this is clearly very bad for their health and wellbeing. The concept of the Healthy High St (Public Health England 2018 and RSPH 2018) should be explicitly referenced. Help leaseholders who are being forced to pay for fixing historical fire defects that are not their fault on a building they don't own. The damage this is causing to mental health is extensive. Barnet Council Building Control signed off on these buildings, and you have a responsibility to help. Stop any more building, improve infrastructure, stop crowding people into apartments, stop the relative high-rises that developers are trying to implement.	4
Programmes for supporting local communities Those relying on others to access digital services will always be dependant on others to gain health knowledge and vulnerable to missing out on services and the LVS offer. wellbeing for elderly people. . youth groups connect to elders people , we would keep young people out of streets and busy and old people loneliness .	3
Programmes for CYP Tackling child poverty - bringing back an initiative similar to the Sure Start initiative. / Young people need a place to socialise and unwind. /Education/ start young in the schools/ build into families. / Supporting young men so they won't join gangs or commit suicide	4
think body positive approach would be good - recognising there is no one size fits all around body image/ looks. Emphasis on health rather than size. Also encouraging employers to be inclusive to enable people to feel welcome rather than worry about their condition/ diagnosis/ etc may impact on them getting a job.	1
Comments related to finance Reduction in council tax. / Invest in your Residents.	2

Views on starting, living and ageing well

Respondents were asked their views on this key area including the proposed commitments and how important they were to them.

The commitments within this key area were:

- Improve children's life chances
- Support a healthier workforce
- Get everyone moving
- Promote mental health and wellbeing
- Prevent long term conditions

Level of importance of each priority

Respondents were asked to rank the priorities within this key area by how important they were to them. 41 respondents answered this question.

The most important priority was improve children's life chances with a weighted average of 3.68. This was followed by promote mental health and wellbeing (average of 3.51) and get everyone moving (average of 3.1). The least important priority was support a healthier workforce with an average of 2.1. The results of this is shown in chart 2.

Table 13 shows the responses from the question with the ranking answers for each priority.

Chart 2: Weighted average for most important priority in key area 2

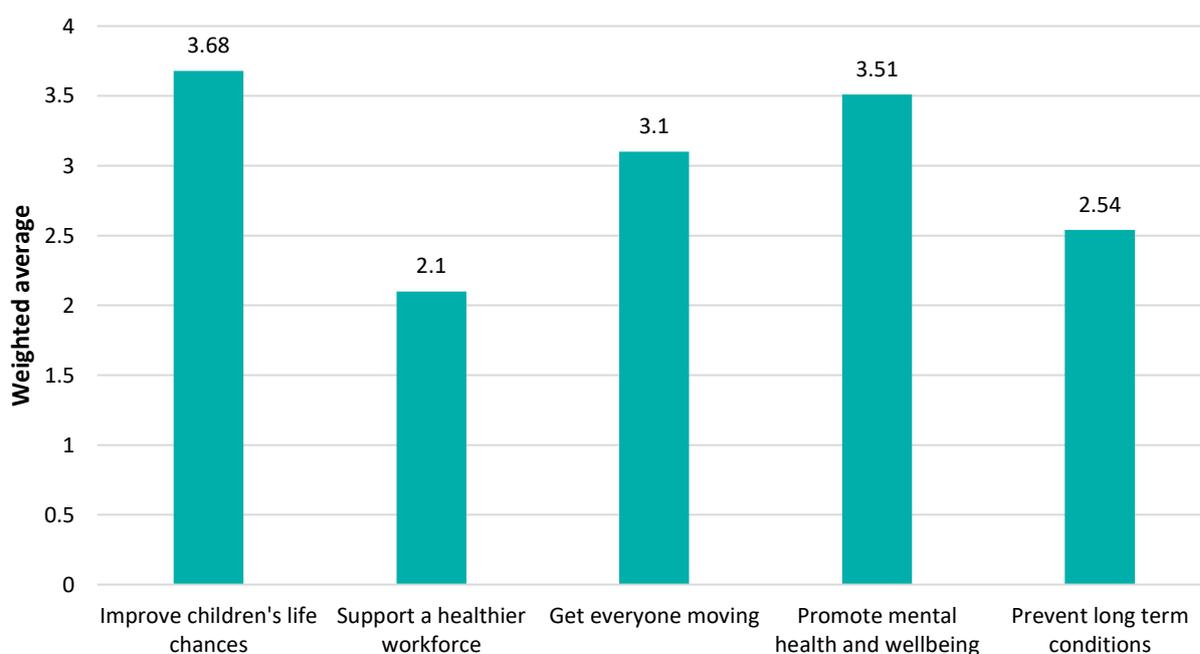


Table 13: Views on most important priority in key area 2

Priority	1st Most Important		2nd Most Important		3rd Most Important		4th Most Important		5th Most Important		Don't know/not sure		Total
	%	No	%	No									
Improve children's life chances	32%	13	37%	15	12%	5	10%	4	7%	3	2%	1	41
Support a healthier workforce	5%	2	12%	5	12%	5	29%	12	41%	17	0%	0	41
Get everyone moving	20%	8	22%	9	22%	9	22%	9	15%	6	0%	0	41
Promote mental health and wellbeing	32%	13	22%	9	24%	10	12%	5	7%	3	2%	1	41
Prevent long term conditions	12%	5	7%	3	29%	12	27%	11	22%	9	2%	1	41

Views on priorities to include in this key area

Respondents were asked if there were any other priorities they felt should be included in this key area. 13 answers were received for this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 14:

- Inclusion of green spaces (5 comments)
- Include active travel and transportation (4 comments)
- More services for adults and those with disabilities (2 comments)

Table 14: Additional priorities respondents think should be included in key area 2

What other priorities should be included in this key area?	
Number of respondents who completed this question	13
Description / Type of verbatim comments	Number of comments
Green Spaces - Access to green spaces. / Actively leaving greenspaces within communities deficient in green space to benefit community and not allow building. / Green spaces and gardens. / Ensure access to parks and green spaces; stop building on / selling off public land. / Improvements to children's play grounds	5
Active travel and transportation Cycle paths. / Improve active travel; more bike lanes through the borough. Improve air quality; more low traffic neighbourhood, stop rat running on residential streets and implement school streets around all schools. Do everything	4

What other priorities should be included in this key area?	
Number of respondents who completed this question	13
Description / Type of verbatim comments	Number of comments
possible to get children of all ages walking and cycling to schools and ensure parents get out of their cars to ensure the long term health and wellbeing of their children and community. / Get people out of cars. / If we talk about getting people moving, I live about 6 miles from my nearest sports centre with an hours travelling time which, appears to me, ridiculous in London. Why don't we have proper sports of facilities within easy reach of people and not just leisure facilities?	
More services for adults and those with disabilities People aged between 25-55 fall through the gaps in services. Many see their 55th birthday as a date when they will finally have access to services they require but are unavailable at 52. / More support and better coordinated support for parent of children with disabilities	2
More on child poverty (beyond food poverty though of course that is essential). Child welfare inequalities - suggest this needs to be incorporated ie the inequalities between the interventions families are offered by Children's Services according to their deprivation level within the Borough	1
Obesity prevention. Nutrition education -making right choices.	1
Public access to data.	1
Where are all these amazing things meant to happen??? We have no community centres. Perhaps the University could allow us to use their facilities for free, since we put up with litter, foot fall and students drug taking around campus.	1
They are all priorities because its a cycle, if we are active and our mental health is healthy the physical side will follow . And another priority should be jobs	1

Suggestions of projects or interventions in this key area

Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 19 respondents answered this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 15:

- Suggestions on active travel and transportation (4 comments)
- Suggestions around green spaces (3 comments)
- Ideas for community and wellbeing activities (6 comments)
- Comments on healthy eating (2 comments)
- Ideas for physical activity programmes (2 comments)
- Comments related to digital access (2 comments)

Table 15: Suggestions for projects or interventions within key area 2

Do you have any suggestions for projects or interventions that should be done within this key area?	
Number of respondents who completed this question	19
Description / Type of verbatim comments	Number of comments
Green spaces More green spaces and cycle path development. Increased investment in the maintenance and improvement of childrens playgrounds and playspaces across the borough. Access to green spaces. Create programs to reconnect people with green spaces, to understand that we should respect them and take care of them	3
Active travel and transportation Cycling and pedestrian infrastructure. / cycle week, walking week. / Increased investment to aid active travel in the development and maintenance of a strategic footpath network across the Borough aimed at both recreation and access to work, schools etc. A strategic network plan is available. / Reduce traffic pollution and improve opportunities for cycling	4
Community and wellbeing activities Provide guides about mental health and physical well-being. Promote community projects that work on this. Help therapist, artists get involved in this project. Create a local network like Mutual Aid where everyone is intergenerationally connected. / Weekly gardening classes, birdwatching, cycle week, walking week, Dog walking day. Baking challenges, family activities online. / Community centres for locals offering facilities. pre-emptive well being support and work to reduce stigma. Encourage employers to buy in to health and well being and make it more accessible and part of everyday. / Social prescribing - including funding things that people can do, or personal budgets. / Interventions involving animals, nature, food growing etc target all these priorities.	6
services for CYP Review and audit LBB CHildren's Services according to child welfare inequalities evidence (eg Paul Byswater's work) and work to address any inequity Support the development of youth-led enterprises Advocate for a stronger welfare system as we recover from the pandemic	1
Healthy eating Speak with supermarkets to reduce sugary products on the shelves and promote a vegan lifestyle or at least based more on vegetables, grains and healthy food. Restrict 'wrong' food shops. A new cake shop has just opened in N Finchley right next door to another cake shop both opposite Creams and Mac Donalds. No more fast food outlets and reduce those we have.	2
Physical activity Could you please update with the new Sport England Uniting the Movement Strategy key outcomes as the 5 outcomes all fit into sub sections of this strategy - https://www.sportengland.org/why-were-here/uniting-the-movement . / Free out door exercise classes. / More sports centres	2

Do you have any suggestions for projects or interventions that should be done within this key area?	
Number of respondents who completed this question	19
Description / Type of verbatim comments	Number of comments
Digital access More digital access 25-54, particularly those with disabilities who feel excluded from their peers & information without access to broadband. Access to data/ Wifi	2
There is much discussion about the importance of integrating health and social care. Housing is the third leg of that tripod, without which it is not stable. Housing needs to be available, affordable, and appropriate.	1

Views on ensuring delivery of coordinated holistic care, when we need it

Respondents were asked their views on this key area including the proposed commitments and how important they were to them.

The commitments within this key area were:

- Support digital transformation of services
- Enable carers health and wellbeing
- Deliver population health integrated care

Level of importance of each priority

Respondents were asked to rank the priorities within this key area by how important they were to them. 39 respondents answered this question.

Deliver population health integrated care was the most important priority with a weighted average of 2.38. This was followed by enable carers health and wellbeing (average of 2.05) and support digital transformation of services with an average of 1.56. These results are shown in chart 3.

Table 16 shows the responses from the question with the ranking answers for each priority.

Chart 3: Weighted average for most important priority in key area 3

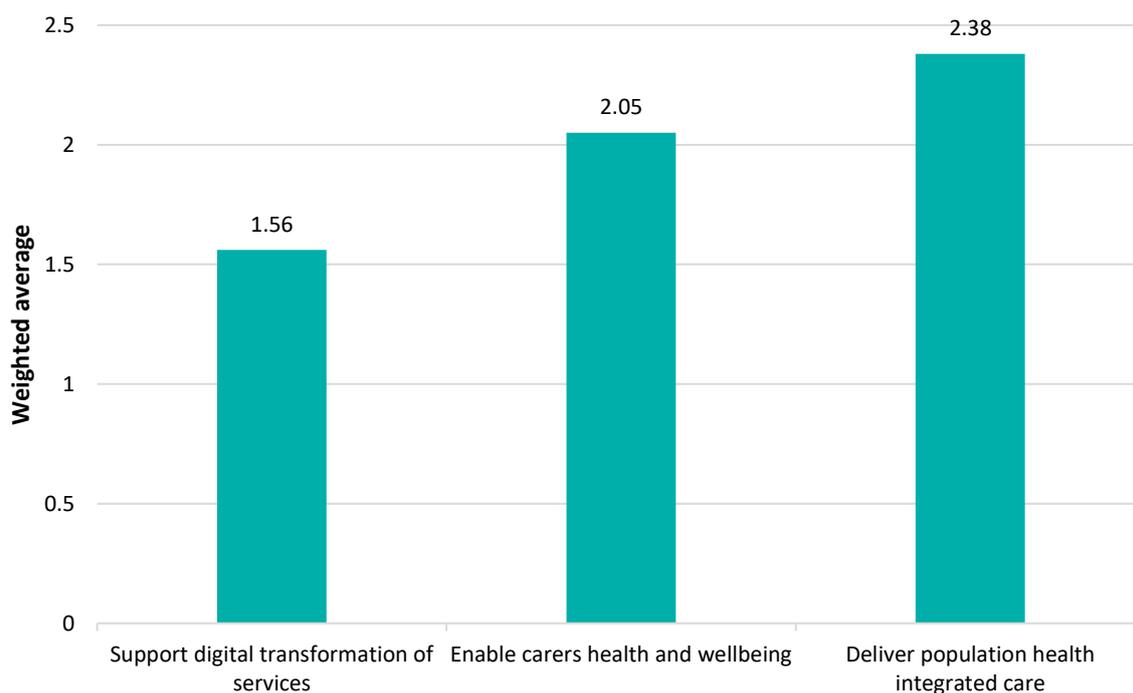


Table 16: Views on most important priority in key area 3

Priority	1st Most Important		2nd Most Important		3rd Most Important		Don't know/not sure		Total
	%	No	%	No	%	No	%	No	
Support digital transformation of services	13%	5	31%	12	56%	22	0%	0	39
Enable carers health and wellbeing	31%	12	44%	17	26%	10	0%	0	39
Deliver population health integrated care	56%	22	26%	10	18%	7	0%	0	39

Views on priorities to include in this key area

Respondents were asked if there were any other priorities they felt should be included in this key area. 10 answers were received for this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 17:

- Comments on integrated working (4 comments)
- Comments around access to services (2 comments)

Table 17: Additional priorities respondents think should be included in key area 3

What other priorities should be included in this key area?	
Number of respondents who completed this question	10
Description / Type of verbatim comments	Number of comments
<p>Access to services</p> <p>Support easy and safe access of services</p> <p>- We are very concerned about how easy it will be to hide domestic abuse, child abuse and elder abuse if all appointments are digital first.</p> <p>New priorities to add in: Embed safeguarding practice and awareness into any online consultations. Ensure accessibility to appointments for those who request them. / Access to digital services would be empowering and reduce pressures on staff but will continue to leave those without digital access (or limited data) behind and dependant on others/service to support.</p>	2
<p>Prevention with holistic care. Not care when is too late.</p>	1
<p>Comments on integrated working Integrated working with housing. / Ensuring services work together and act quickly, don't leave people waiting e.g. for social services to review care needed. / Integrated children social care and therapies. / Barnet Integrated Care Partnership should have no private healthcare services or providers. ICP should not replace experienced clinicians – including doctors and nurses – with technologies, and introduce lower skilled and lower paid roles, such as physician and nurse associates. Barnet's ICP is being introduced at reckless speed, with no robust evidence.</p>	4
<p>Yoga and mindfulness are great activities to promote wellbeing and stay sharp.</p>	1
<p>Disabled people.</p>	1

Suggestions of projects or interventions in this key area

Respondents were asked if they had any suggestions for programmes or interventions that could be done within this key area. 13 respondents answered this question.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 18:

- Comments on access to digital and information access (4 comments)
- Suggestions for wellbeing and community programmes (3 comments)

Table 18: Suggestions for projects or interventions within key area 3

Do you have any suggestions for projects or interventions that should be done within this key area?	
Number of respondents who completed this question	13
Description / Type of verbatim comments	Number of comments
Promoting mental health well-being for all ages. Providing spaces for mental health well-being projects to happen.	1
Comments on information access and access to digital Community hubs, where people can access information face to face. Lots of people don't want to, or are unable to communicate via machines and computers. A return to human interaction would be welcome. / We are concerned about move to digital consultations by default. We are specifically concerned about safeguarding under these circumstances and disclosure or discovery of domestic abuse, child abuse and elder abuse. Alternatives must be easily available, without creating barriers for those who are frightened. / Data pooling, free wifi would actually reduce the cost of some 25-54year old on services because they could have social engagement online, and access services independently. have digital access points more readily available in the borough.	4
Suggestions for programmes or more resource Provide inclusive programs where people from different backgrounds can help and work together. / Weekly classes and meditation workshops. / Have more respite options available.	3
Locating these group of people and providing services eg creating slipways /lifts for easy assess to help with transportation such as in underground and train stations.	1
Invest in the well-being of your Residents.	1
Don't know much about this area, don't know what is needed, what is missing or how good the services currently are	1
There needs to be more resource in the children's therapies teams.	1
All services must be publicly owned and publicly operated, fully transparent, accountable to the local community. Personal social care provided on the same terms as health, free at the point of use and paid for from public funding. ICP must have full public involvement and meaningful consultation for all areas.	1

Views on the whole draft JHWS

Respondents were asked if they had any other comments on the draft JHWS after completing the questions on specific sections of the strategy. 12 responses to this question were received.

The most common themes (2 or more comments) are summarised below and more detailed comments are in table 19:

- Comments on community support (3 comments)
- Comments on the borough or local area (3 comments)
- Comments on engagement activities (2 comments)

Table 19: Any other comments from respondents on the draft JHWS

Do you have any other comments on our Draft Joint Health and Wellbeing Strategy?	
Number of respondents who completed this question	12
Description / Type of verbatim comments	Number of comments
<p>Comments on engagement Thank you for putting it together and inviting comments! / Ensure enough and fair resources are available for the CVS sector including for gathering practice based evidence Ensure enough resources and time are available for meaningful codesign and coproduction. As a CVS provider we are often asked if we 'have any young people who can speak about X in a pre arranged Forum etc' - this is tokenism. Codesign and coproduction take time and relationships and this is rarely accounted for in commissioning or by statutory services and as a result it remains highly tokenistic. I would like to see a lot more about how the HWB will enable codesign and coproduction of these interventions.</p> <p>I would also like to see a lot more explicitly about racial justice within the strategy and other forms of inequalities being made explicit - not hidden away in equality impact assessment language.</p>	2
<p>comment on community support I really appreciate the emphasis on healthier communities and places. Thank you so much. BPSS would be keen to be involved in this strategy. We have been supporting schools, communities and other organisations for over 15 years across Barnet for Physical Education and Sport including specific projects on Physical Literacy, Daily Physical Activity, Health and Inclusion. I would contact all people in the well-being field to create a community in the community and provide with tips and places to improve the mental state.</p>	3
<p>The desire to maintain the self-reliance of residents means that a small group of complex cases never have the consistent long-term support they need and deteriorate. By being consistently open and closed because we have no open-ended support for those people (often with complex mental health), they actually become more work as worker after worker gets to know them but has to close them at some point (both ADC, LVS & NHS). It would be cheaper and better for the resident to have a small provision for consistent long-term support.</p>	1

Do you have any other comments on our Draft Joint Health and Wellbeing Strategy?	
Number of respondents who completed this question	12
Description / Type of verbatim comments	Number of comments
Comments on the borough or local area Please don't ignore the issue leaseholders are facing. It is more damaging to mental health for those caught up in it than lockdowns are. / All I have known is Barnet. At the moment, I'm seeing a very bleak future. Barnet does not think of or focus on their Residents. All profit based. We don't deserve a local Museum, a local well stocked and welcoming library, parks offering play areas and beautiful gardens (these can be uplifting to the soul). During lockdown, I've walked around the area on a daily basis; it's neglected. A few pros ... due to the students being off campus, don't smell drugs in the air, less litter, can walk the streets without having to walk in the gutter, as students 3 to 4 a breast to and from Hendon Central Station. / Only that Barnet was a great place to live at one time but there has just been a gradual deterioration over my lifetime and it's not good now.	3

Views on health and wellbeing services in Barnet

The final set of questions in the questionnaire was around respondent's views on health and wellbeing services in the borough. Respondents were given a list of statement and asked to rate whether they agree or disagree with them.

Respondents were asked to what extent they agree with statements on health and wellbeing services in Barnet. 38 respondents answered this question.

Respondents were in agreement that they were satisfied with hospital services in the borough (weighted average of 3.08). The second and third highest agreed statements were about finding it easy to access information on health and wellbeing services (average of 2.87) and that respondents were overall satisfied with health and wellbeing services (weighted average of 2.82).

The other statements had slightly lower levels of agreement with views on children's social care being the lowest with an average of 1.87. This was the statement that received the highest number of response that residents didn't know their thoughts on that statement.

Chart 4 summarises the weighted averages for this question and table 20 provides the detailed views of respondents.

Chart 4: Weighted average for views on health and wellbeing services

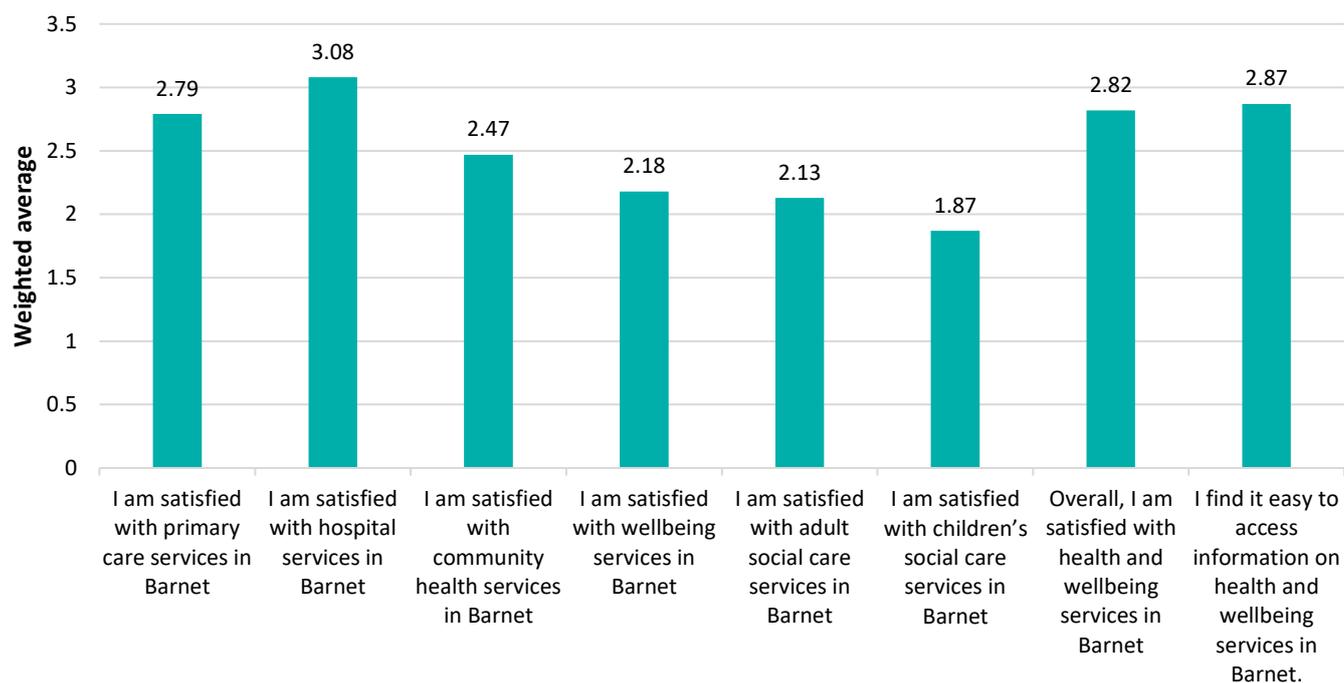


Table 20: Views on health and wellbeing services in Barnet

Statement	Strongly Agree		Tend to Agree		Neither Agree nor Disagree		Tend to Disagree		Strongly Disagree		Don't Know		Total
	%	No	%	No	%	No	%	No	%	No	%	No	
I am satisfied with primary care services in Barnet	8%	3	34%	13	24%	9	11%	4	11%	4	13%	5	38
I am satisfied with hospital services in Barnet	13%	5	39%	15	24%	9	3%	1	8%	3	13%	5	38
I am satisfied with community health services in Barnet	5%	2	24%	9	34%	13	8%	3	8%	3	21%	8	38
I am satisfied with wellbeing services in Barnet	11%	4	5%	2	34%	13	16%	6	11%	4	24%	9	38
I am satisfied with adult social care services in Barnet	13%	5	5%	2	29%	11	16%	6	8%	3	29%	11	38
I am satisfied with children's social care services in Barnet	13%	5	3%	1	29%	11	8%	3	8%	3	39%	15	38
Overall, I am satisfied with health and wellbeing services in Barnet	11%	4	26%	10	32%	12	11%	4	8%	3	13%	5	38
I find it easy to access information on health and wellbeing services in Barnet.	8%	3	32%	12	26%	10	16%	6	11%	4	8%	3	38

Comments on health and wellbeing services

Respondents were also asked if they had any comments on health and wellbeing services in Barnet. 16 responses to this question were received.

The most common themes (2 or more comments) are summarised below and more detailed comments are in Table 21:

- Need for more communications (3 comments)
- Comments on mental health services (3 comments)
- Comments related to the pandemic (2 comments)
- Comments related to the JHWS (2 comments)
- Suggestions for Health and Wellbeing Board (2 comments)
- Comments related to CYP social services (2 comments)

Table 21: Comments from respondents on health and wellbeing services in Barnet

Do you have any comments on health and wellbeing services in Barnet?	
Number of respondents who completed this question	16
Description / Type of verbatim comments	Number of comments
Comments related to the COVID-19 pandemic We have been going through a global pandemic, and believe that the Council have generally been doing good work on the ground. / This has been an extremely difficult year. Whilst not everything has gone perfectly, neither would that be expected. We would like to extend our thanks to health, care, voluntary sector and members of the community who have stepped up during this pandemic.	2
Comments related to the strategy The Council have changed their way of working significantly to include co-production and co-design which is wonderful. / One of the most exciting changes we have noted has been an increase in co-production and sharing of power	2
Suggestions for Health and Wellbeing Board We would suggest adding some voluntary sector voices to the Health and Wellbeing Board. / We would like to see this extended to include key voluntary sector partners represented directly on the Health and Wellbeing Board, with voting rights, rather than by invitation to address the board, or via Healthwatch.	2
Communications Is very difficult to find information about programs, there is no promotion. Should be information outside tube stations, supermarkets and other hot spots where the population could be informed and ask questions or active community boards in different places where people can see what activities are going on in the community. / Not easy to find the information and availability of people that offer those services. / Barnet Council Website is not for purpose and is a barrier to finding up to date information, when it should be the starting point, collaborating all the hard work done by all the LBB Teams, LVS & CCG.	3

Do you have any comments on health and wellbeing services in Barnet?	
Number of respondents who completed this question	16
Description / Type of verbatim comments	Number of comments
<p>CYP social services need Just reference again within Children's Social Care HWB need to be reporting and acting on child welfare inequalities / There's nothing for autistic teenagers. Hard to get support. Barnet SeN Department is very bad.</p> <p>There's no support to carers and not enough holistic support for disabled children in education setting and medical setting.</p>	2
<p>Mental health services Mental Health services have suffered from huge cuts since 2010. The Health and Social Care Act developed by Andrew Langsley has been a disaster! As clinicians across the spectrum agreed at the time. Discharge of large numbers of people with mental health difficulties back to GP care, to solve funding issues and cuts to mental health services, when they were previously supported by multi disciplinary CMHTs, will cause huge problems for Primary Care services in the future and patients will not be adequately supported. / I have lots of experiences with myself and my family but it may as well be non-existent now! Try understanding the people individually as a person NOT a statistic! Chase up MH patients when they go ghost on services. Have 1 place to go for GP, MH, Cahms, Adult services so person doesn't have to keep repeating their story to everyone. STOP thinking parents are to BLAME for a young person's problems with MH and such! And COMMUNICATE with EACH person properly! Have staff that actually have a clue on what areas and school's patients are from, to give a proper understanding of INDIVIDUAL needs instead of stereotyping! Not one consultant etc seen in the past has a clue about SCHOOLS here or services offered or NOT offered with this area. Make it EASIER for someone to WANT TO contact ANY services offered. Give people a peak at what is offered and actually KNOW the people seeking help! Keep an eye on patients and what is going on with their lives! TRY ACTUALLY CARING! That's what does not exist with ANY services already in place, they DO NOT CARE enough of patients and are seen as a drain on funding etc and I feel there really is NO proper understanding of MH in kids or adults here! Looks good BUT really is rubbish! Fact! / here isn't enough support for high functioning neuro-diverse adults (esp Autism & ADHD), who don't feel Mencap is appropriate.</p>	3
<p>Waiting lists. If you want to go private, no problem. Services closed and yet you still build and invite more people to the area. Where is your infrastructure? Working in education, all I hear is the waiting lists for CAMHS is awful. Your Residents are suffering and your services underfunded and neglected. Waiting lists will get longer and longer. It's a disgrace.</p>	1
<p>These services tend to be limited in certain areas. Consideration should be population of the area and wealth. The facilities should be spread out.</p>	1
<p>Dentist has been difficult to access during covid. GP appointments are now all on the phone and about half the time this doesn't work well enough</p>	1

Do you have any comments on health and wellbeing services in Barnet?	
Number of respondents who completed this question	16
Description / Type of verbatim comments	Number of comments
I believe all areas are underfunded. Major increase in funding and staffing is required to meet targets and affect change	1
One trial cycle route will not increase a cycling culture. I would love to cycle, as I always cycled everywhere when I lived in Bristol. There I could go anywhere and have a dedicated safe cycling route and safe cycle parking wherever I stopped. I would want a similar situation before I filled a large proportion of my living space with a bicycle.	1
I feel that better air quality is very important to long term health. I hear amazing things about provision for the over 55s.	

Findings of qualitative engagement

A session was held with Barnet Mencap on 8th March 2021. This event had 15 invitees and was held as a virtual meeting via Zoom. Attendees at the event were given a short presentation on the draft JHWS which led to a facilitated discussion around three questions. These questions were:

1. What is important to you around health and wellbeing?
2. What is important to where you live?
3. What health and community services do you use?

The majority of answers to question one was around physical activity and green spaces. Multiple comments were received on parks being well kept and a want for them to remain tidy. Recreation activities were important to respondent including physical activity such as attending a leisure centre and social activities such as performing arts.

Attendees agreed that a variety of shops and parks were important to where they lived. Responses to this question included wanting more places to sit and to meet people.

Services that were discussed as being widely used by this group were public transport, green spaces and a variety of healthcare setting. The majority of answers to this question were around community services such as parks, gyms and libraries.

Appendix I: Draft strategy consultation questionnaire

Introduction: Joint Health and Wellbeing Strategy 2021-2025

The Joint Health and Wellbeing Strategy will provide our vision for health and wellbeing in the borough for the 2021 to 2025 and sets out a few key areas that we would like to focus on. Each Health and Wellbeing Board must produce this strategy based on its population's needs. The strategy will help shape how we work as partners to improve the health and wellbeing for the people who live, work and learn in Barnet.

The strategy has been structured around three key areas:

Creating a healthier place and resilient communities

Starting, living and aging well

Ensuring delivery of coordinated and holistic care, when we need it

The consultation document is available to read [here](#)

The full draft strategy is available to read [here](#)

Thank you for your time – your participation in this important consultation is greatly appreciated.

Please select 'Next' to continue on to the next page.

SurveyMonkey and data protection

Barnet Council uses SurveyMonkey to host questionnaires, and to store and analyse the data collected through these questionnaires. The council has investigated SurveyMonkey and is satisfied with its data assurance and legal framework.

The council does not collect personal information in this questionnaire, which means the information you provide is anonymous. We do not ask for your name, address, email address, telephone number, full post code or any other information that would allow us to identify you. The information you choose to give us in the equalities questions is also anonymous so we cannot identify you from it.

Since the data we collect is anonymous, it is not considered to be personal data under data protection legislation (such as the General Data Protection Regulation or the Data Protection Act 2018).

If you have any questions about this statement please email first.contact@barnet.gov.uk.

Instructions for completing questionnaire

We have tried to make the questionnaire as easy as possible to complete.

Many of the questions have a range of options for you to choose from. Please choose the option closest to your opinion and tick the relevant option or options.

Hyperlinks to particular sections of the strategy have been provided throughout the questionnaire where relevant to a particular question or series of questions. These give additional information about our proposed key areas. When you click on the hyperlink a new window will open. Once you have read the information, close the window and then complete the relevant questions.

Please select 'Next' to continue on to the next page.

Section 1: Our vision and guiding principles

Our vision for health in Barnet:

A healthy borough makes healthy people. It is where the environment around us supports and promotes our health and wellbeing. In a healthy borough, everyone has access to a good education and can experience good and secure housing and employment. High quality health and social care is available for anyone when they need it. A healthy borough reaches out to the most vulnerable, giving everyone opportunities to thrive. With healthier and happier residents, communities are strengthened to support each other, and the local culture and economy flourishes.

Further information on our vision and guiding principles is available [here](#)

1. To what extent do you agree or disagree with our vision for health and wellbeing in Barnet?
(Please tick one option only)

Strongly agree

Tend to agree

Neither agree nor disagree

Tend to disagree

Strongly disagree

Don't know

2. If you disagree, please give reasons for your answer? (Please type in your answer)

3. To what extent do you agree or disagree with the guiding principles of the strategy?
 (Please tick one option on each row)

	Strongly Agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Not sure/ Don't know
Making health everyone's business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collaborative partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence based decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considering everyone's needs across the life course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-design approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. If you disagree with any of these please give a reason for your answer, stating the principle you are referring to?

5. Is there anything else you think we should consider for our guiding principles? (Please type in your answer)

6. To what extent do you agree or disagree the key areas included in the strategy? (Please tick one option on each row)

Key areas	Strongly Agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Not sure/ Don't know
Key area 1: Creating a healthier place and resilient communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Key area 2: Starting, living and ageing well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Key area 3: Ensuring delivery of coordinated and holistic care, when we need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. If you disagree with any of these please give a reason for your answer, stating the Key Area you are referring to?

8. Is there anything else you think we should consider for our Key Areas? (Please type in your answer)

Section 2: Creating a healthier place and resilient communities

Key Area 1 is about creating a healthier place and resilient communities. This area covers our work on healthy places, the build environment and supporting communities.

Further information about this key area is available [here](#) [PDF of the two KA1 pages]

9. Referring to the priorities within this key area, please indicate how important these are to you. (Please tick one box per row and column)

	1 st Most Important	2 nd Most Important	3 rd Most Important	Don't know/not sure (please tick this OPTION if you don't know or are not sure)
Integrate healthier places in all policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Create a healthier environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strengthen community capacity and secure investment to deliver healthier places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Are there any other priorities you think should be considered in this Key Area? (Please tick one option only)

- Yes..... Go to Q11
- No Go to Q12

11. What other priorities should be included in this Key Area? (Please type in your answer)

12. Do you have any suggestions for projects or interventions that should be done within this Key Area? (Please type in your answer)

Section 3: Starting, living and ageing well

Key Area 2 is about starting, living and ageing well. This area covers our work on physical and mental wellbeing, life chances and physical activity.

Further information about this key area is available [here](#)

13. Referring to the priorities within this key area, please indicate how important these are to you. (Please tick one box per row and column)

	1 st Most Important	2 nd Most Important	3 rd Most Important	4 th Most Important	5 th Most Important	Don't know/not sure (please tick this OPTION if you don't know or are not sure)
Improve children's life chances	<input type="checkbox"/>					
Support a healthier workforce	<input type="checkbox"/>					
Get everyone moving	<input type="checkbox"/>					
Promote mental health and wellbeing	<input type="checkbox"/>					
Prevent long term conditions	<input type="checkbox"/>					

14. Are there any other priorities you think should be considered in this Key Area? (Please tick one option only)

Yes..... Go to Q15

No Go to Q16

15. What other priorities should be included in this Key Area? (Please type in your answer)

16. Do you have any suggestions for projects or interventions that should be done within this Key Area? (Please type in your answer)

Section 4: Ensuring delivery of coordinated and holistic care, when we need it

Key Area 3 is about ensuring delivery of coordinated and holistic care, when we need it. This area covers our work on supporting care settings and carers, supporting those with complex needs and integrating health and social care.

Further information about this key area is available [here](#)

17. Referring to the priorities within this key area, please indicate how important these are to you. (Please tick one box per row and column)

	1 st Most Important	2 nd Most Important	3 rd Most Important	Don't know/not sure (please tick this OPTION if you don't know or are not sure)
Support digital transformation of services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enable carers health and wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliver population health integrated care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Are there any other priorities you think should be considered in this Key Area? (Please tick one option only)

Yes..... Go to Q19

No Go to Q20

19. What other priorities should be included in this Key Area? (Please type in your answer)

20. Do you have any suggestions for projects or interventions that should be done within this Key Area? (Please type in your answer)

Section 5: Draft Joint Health and Wellbeing Strategy

21. Do you have any other comments on our Draft Joint Health and Wellbeing Strategy? (Please type in your answer)

Section 6: Health and Wellbeing in Barnet

A variety of health, care and wellbeing services are provided in Barnet.

- Primary care services include general practice, community pharmacy, eye health and dental services.
- Hospital services include accident and emergency services and the care you receive in hospital after a referral from a GP.
- Community health services are these offered outside of a GP or hospital but instead in the community or people’s homes such as child health services, district nursing, health visiting and sexual health services.
- Barnet also commissions wellbeing services via the voluntary sector such as the Barnet Wellbeing Hub.
- Adult social care in Barnet offers information, advice and support for people who; want to stay well and independent, have a physical and/or sensory impairment, have a learning disability and learning difficulties, have mental health support needs, are over 65 years and are struggling, care for a friend or relative or need support to keep people safe.
- Children’s social care services support children with additional needs, protect children from harm and provide foster and residential care services.

22. To what extent do you agree or disagree with the following statements about health and wellbeing services in Barnet? (Please tick one option on each row)

	Strongly Agree	Tend to Agree	Neither Agree nor Disagree	Tend to Disagree	Strongly Disagree	Don't know
I am satisfied with primary care services in Barnet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with hospital services in Barnet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with community health services in Barnet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with wellbeing services in Barnet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am satisfied with adult social care services in Barnet	<input type="checkbox"/>					
I am satisfied with children’s social care services in Barnet	<input type="checkbox"/>					
Overall, I am satisfied with health and wellbeing services in Barnet.	<input type="checkbox"/>					
I find it easy to access information on health and wellbeing services in Barnet.	<input type="checkbox"/>					

23. Do you have any comments on health and wellbeing services in Barnet? (Please type in your answer)

Section 7: About you

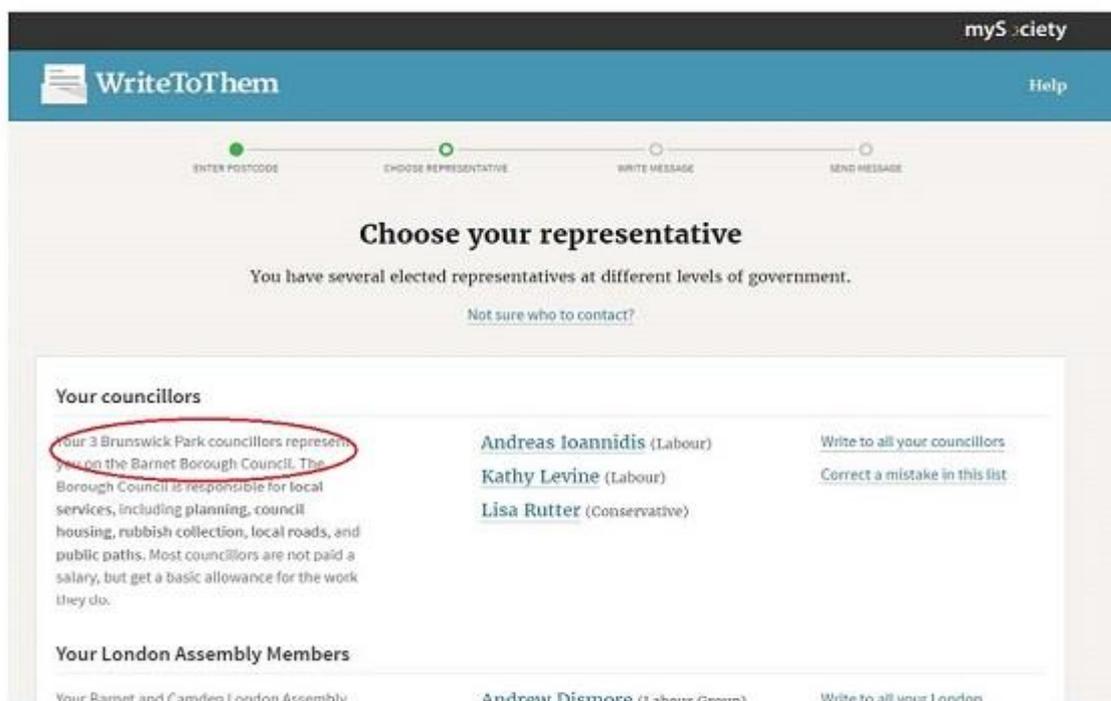
When consulting with our residents and service users Barnet Council needs to understand the views of our different communities.

Please be assured that all your answers will be treated in the strictest of confidence and will be stored securely in an anonymous format.

We have taken every care to ensure that questionnaires are carried out and the information stored in compliance with all relevant legal and regulatory requirements, including the General Data Protection Regulation 2018.

So that we can analyse the findings by different locations in the borough, please can you provide the Barnet ward that you live in.

If you do not know the Barnet ward that you live in you can find it by clicking [here](#) and entering your postcode. You should then see a page like the image below - you will find the name of your ward on the left-hand side of the page under the heading "Your councillors". In this example, the name of the ward is Brunswick Park.



24. Which ward do you live in? If you live outside Barnet please select other and specify(Please select one option only)

Brunswick Park
Burnt Oak
Childs Hill
Colindale
Coppetts

East Barnet
East Finchley
Edgware
Finchley Church End
Garden Suburb
Golders Green
Hale
Hendon
High Barnet
Mill Hill
Oakleigh
Totteridge
Underhill
West Finchley
West Hendon
Woodhouse
Other

25. **Optional: Please provide the first half of your postcode (e.g. NW11):** (Please type in your answer)

--

26. **Are you responding as:** (Please tick one option only)

A Barnet resident	<input type="checkbox"/>	Go to Q 27
Barnet business	<input type="checkbox"/>	Go to Q 27

A person who works in the London Borough of Barnet area	<input type="checkbox"/>	Go to Q 27
A Barnet business	<input type="checkbox"/>	Go to Q 27
Representing a voluntary/community organisation	<input type="checkbox"/>	Go to Q 25
Representing a public-sector organisation	<input type="checkbox"/>	Go to Q 26
Other (please specify)	<input type="checkbox"/>	Go to Q 27

27. Please specify the type of stakeholders or residents your community group or voluntary organisation represents: (Please type in your answer)

28. Please specify the type of public sector organisation you are representing: (Please type in your answer)

Community Group, Voluntary, or Public-Sector Organisation - Route to end of questionnaire

29. Are you currently employed, self-employed, retired or otherwise not in paid work?
(Please tick one option only)

- An employee in a full-time job (31 hours or more per week)
- An employee in a part time job (Less than 31 hours per week)
- Self- employed (full or part-time)

- On a Government supported training programme (e.g. Modern Apprenticeship or Training for Work)
- In full- time education at school, college or university
- Unemployed and available for work
- Permanently sick or disabled
- Wholly retired from work
- Looking after the home
- Doing something else (please specify)

30. Does your household own or rent this accommodation? (Please tick one option only)

- Own* Owned with a mortgage or loan
- Own* Owned outright
- Own* Other owned – record word for word
- Rent* Rented from Council
- Rent* Rented from a Housing Association or another Registered Social Landlord
- Rent* Rented from a private landlord
- Rent* Other rented or living here rent free – record word for word

Both Part rent and part mortgage (shared ownership)

Don't know –

Section 7: Diversity monitoring

The Equality Act 2010 identifies nine protected characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and requires the council to pay due regard to equalities in eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations between people from different groups. We ask questions about the groups so that we can assess any impact of our services and practices on different groups. The information we collect helps the council to check that our policies and services are fair and accessible.

Collecting this information will help us understand the needs of our different communities and we encourage you to complete the following questions.

All your answers will be treated in confidence and will be stored securely in an anonymous format. All information will be stored in accordance with our responsibilities under the Data Protection Act 1998.

For the purposes of this questionnaire we are asking ? of the protected characteristics included in the Equality Act 2010.

31. In which age group do you fall? (Please tick one option only)

16-17	<input type="checkbox"/>	55-64	<input type="checkbox"/>
18-24	<input type="checkbox"/>	65- 74	<input type="checkbox"/>
25-34	<input type="checkbox"/>	75+	<input type="checkbox"/>
35-44	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
45-54	<input type="checkbox"/>		

32. Are you: (Please tick one option only)

Male	<input type="checkbox"/> Go to Q32	Female	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/> Go to Q32
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If you prefer to use your own term please provide it here: (Please type in your answer) (Go to Q29)

Females only: Pregnant and on maternity leave

As part of the Equality Act 2010 the council has a statutory requirement to collect information in relation to 'protected characteristics' which includes information on women who are pregnant and on maternity leave. Answering this question will assist us in meeting our legal obligations. It will also help us understand the different needs of our communities.

33. Are you pregnant and/or on maternity leave? (Please tick one option on each row)

	Yes	No	Prefer not to say
I am pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am currently on maternity leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As part of the Equality Act 2010 the council has a statutory requirement to collect information and pay due regard in relation to 'protected characteristics' which includes gender re assignment. Answering this question will assist us in meeting our legal obligations. It will also help us understand the different needs of our communities.

34. Is your gender identity different to the sex you were assumed to be at birth? (Please tick one option only)

Yes, it's different	No, it's the same	Prefer not to say
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. What is your ethnic origin? (Please tick one option only)

Asian / Asian British		Other ethnic group	
Bangladeshi	<input type="checkbox"/>	Arab	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Any other ethnic group (✓ AND TYPE BELOW)	<input type="checkbox"/>
Indian	<input type="checkbox"/>	White	
Pakistani	<input type="checkbox"/>	British	<input type="checkbox"/>
Any other Asian background (✓ AND TYPE BELOW)	<input type="checkbox"/>	Greek / Greek Cypriot	<input type="checkbox"/>

Black / African / Caribbean / Black British		Gypsy or Irish Traveller	<input type="checkbox"/>
African	<input type="checkbox"/>	Irish	<input type="checkbox"/>
British	<input type="checkbox"/>	Turkish / Turkish Cypriot	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Any other White background (✓ AND TYPE BELOW)	<input type="checkbox"/>
Any other Black / African / Caribbean background (✓ AND TYPE BELOW)	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Mixed / Multiple ethnic groups		
White & Asian	<input type="checkbox"/>		
White & Black African	<input type="checkbox"/>		
White & Black Caribbean	<input type="checkbox"/>		
Any other Mixed / Multiple ethnic background (✓ AND TYPE BELOW)	<input type="checkbox"/>		

Disability

The Equality Act 2010 defines disability as ‘a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’.

In this definition, long-term means more than 12 months and would cover long-term illness such as cancer and HIV or mental health problems.

36. Do you consider that you have a disability as outlined above? (Please tick one option only)

Yes No (Please go to Q33)

If you have answered ‘yes’, please select the definition(s) from the list below that best describes your disability/disabilities:

Hearing (such as deaf, partially deaf or hard of hearing)	<input type="checkbox"/>	Reduced Physical Capacity (such as inability to lift, carry or otherwise move everyday objects, debilitating pain and lack of strength, breath energy or stamina, asthma, angina or diabetes)	<input type="checkbox"/>
Vision (such as blind or fractional/partial sight. Does not include people whose visual problems can be corrected by glasses/contact lenses)	<input type="checkbox"/>	Severe Disfigurement	<input type="checkbox"/>
		Learning Difficulties (such as dyslexia)	<input type="checkbox"/>
Speech (such as impairments that can cause communication problems)	<input type="checkbox"/>	Mental Illness (substantial and lasting more than a year, such as severe depression or psychoses)	<input type="checkbox"/>
Mobility (such as wheelchair user, artificial lower limb(s), walking aids, rheumatism or arthritis)	<input type="checkbox"/>	Physical Co-ordination (such as manual dexterity, muscular control, cerebral palsy)	<input type="checkbox"/>
Other disability, please specify			
Prefer not to say <input type="checkbox"/>			

37. What is your religion or belief? (Please tick one option only)

Baha'i	<input type="checkbox"/>	Jain	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	Jewish	<input type="checkbox"/>
Christian	<input type="checkbox"/>	Muslim	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	Sikh	<input type="checkbox"/>
Humanist	<input type="checkbox"/>	No Religion	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>	Other religion/belief (Please specify)	<input type="checkbox"/>

38. What is your sexual orientation? (Please tick one option only)

Bisexual	<input type="checkbox"/>	Lesbian	<input type="checkbox"/>
Gay	<input type="checkbox"/>	Other	<input type="checkbox"/>
Heterosexual	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>

In addition, if you prefer to define your sexuality in terms other than those used above, please let us know below: (Please type in your answer)

5. End of the questionnaire

Thank you for taking part in our questionnaire. Once you press 'submit' your responses will automatically be submitted to Barnet Council.

Barnet Draft Health and Wellbeing Strategy 2021-25 Consultation

Consultation Document

29th January 2021 to 12th March 2021



Introduction

The Barnet Joint Health and Wellbeing Strategy sets out our vision for improving the health and wellbeing of the people who live, study and work in Barnet. For the next four years the Health and Wellbeing Board will focus on three Key Areas to drive improvements in health and wellbeing within the borough.

Barnet is a growing, thriving and diverse borough that is generally healthy, but it is not equally healthy in all parts of the borough. This strategy is our vision to make the whole of Barnet the London Borough of Health and details our priorities to make that happen.

The COVID-19 pandemic has had a profound impact on the nation's health, and highlighted key public health issues such as the need for the prevention of long-term conditions and disparities in health. We will be incorporating lessons learnt into this strategy and will be informed by residents how to respond to the long-term impacts of the pandemic.

How to have your say

This consultation is open to everyone who lives, works or studies in Barnet including voluntary/ community organisations.

You can give your feedback by completing our online questionnaire at engage.barnet.gov.uk

If you require a paper copy of the questionnaire, or another format, please email: HealthandWellbeingStrategy@barnet.gov.uk or phone [REDACTED]

Your input will be used by the council to shape the final version of the Joint Health and Wellbeing Strategy that will be presented to the Health and Wellbeing Board in April 2021.

The consultation is open from **29th January 2021** to **12th March 2021**

Our vision is to make Barnet the London Borough of Health.

A healthy borough makes healthy people. It is where the environment around us supports and promotes our health and wellbeing. In a healthy borough, everyone has access to a good education and can experience good and secure housing and employment. High quality health and social care is available for anyone when they need it. A healthy borough works well with their communities, reaches out to the most vulnerable and gives everyone opportunities to thrive. With healthier and happier residents, communities are strengthened to support each other, and the local culture and economy flourishes.

Our five guiding principles

1 Making health everyone's business

We will ensure health is everyone's business, not just for agencies primarily concerned with health and wellbeing, but also for those that work to improve wider determinants of health.

2 Collaborative partnership

We will work in collaborative partnership across organisational boundaries and learn from different viewpoints across the whole system. We will focus on the areas where collaborative work makes the most difference and HWBB can add the most value.

3 Evidence-based decisions

We will use a robust evidence base to inform our decisions, ensuring that our investment creates maximum value for money and our resources are distributed equitably.

We are seeking your views on:

- to what extent do you agree or disagree with our vision for health and wellbeing in Barnet?

4 Considering everyone's needs across the life course

We will consider the needs of all parts of the population in all that we do. This includes children and young people and people with complex needs such as mental health issues, learning disabilities and autism.

5 Co-design approach

We will champion a co-design approach to resolve our challenges, making sure Barnet residents' needs are met and resulting services are practical and sustainable.

We are seeking your views on:

- to what extent do you agree or disagree with the guiding principles of the strategy?
- is there anything else you think we should consider for our guiding principles?

Our 3 Key Areas for Improving Health and Wellbeing

We are seeking your views on:

- to what extent do you agree or disagree the Key Areas included in the strategy?
- is there anything else you think we should consider for our Key Areas?

To make Barnet a healthier borough, we identified three Key Areas:

- Creating a healthier place and resilient communities.
- Starting, living and ageing well.
- Ensuring delivery of coordinated, holistic care, when we need it.

Key Area 1:

Creating a healthier place and resilient communities

This Key Area is about our place-based approach and our work on areas such as air quality, community safety, food environments and the built environment. It includes the projects that we should look at to make Barnet a healthier place for all.

Our priorities for Creating a healthier place and resilient communities

Integrate healthier places in all policies

Create a healthier environment

Strengthen community capacity and secure investment to deliver healthier places

Our commitments for creating a healthier place and resilient communities

Integrate healthier places in all policies

We will ensure that all of our policies and strategies across the health system include specific actions on improving health and health equity through creating good housing, employment opportunities, active travel links and other economic and commercial conditions in Barnet

Create a healthier environment

We will create healthier choices locally with a focus on improving access to clean air, water and healthy food



Strengthen community capacity and secure investment to deliver healthier places

We will facilitate networking and capacity building between local communities and promote safety and cohesion while preventing violence and crime. This involves supporting local communities to work together to benefit each other



We are seeking your views on:

- how important the priorities are to you?
- are there any other priorities you think should be considered in this key area?
- do you have any suggestions for projects or interventions that should be done within this key area?

Key Area 2:

Starting, living and ageing well

This Key Area is about supporting people across the whole life course. It includes priorities that enables us to prevent diseases at key stages of life from pre-conception, pregnancy, infancy, childhood, through to adulthood.

Our priorities for Creating a healthier place and resilient communities



Our commitments for starting, living and ageing well

<p>Improve children's life chances</p> <p>We will improve children's life chances by supporting their health and wellbeing from a very early age and through to their transition into adulthood</p> 	<p>Promote mental health and wellbeing</p> <p>We will promote good mental and emotional health across all ages and different communities and work together to prevent severe mental illness and suicide</p> 	<p>Get everyone moving</p> <p>We will improve choices for physical activities locally for all ages and abilities, and ensure residents know how to access it</p> 
<p>Support a healthier workforce</p> <p>We will invest time and resources to ensure our workforce is supported to be healthy, happy and productive at work</p> 	<p>Prevent long term conditions</p> <p>We will work with communities to understand what support can be offered to reduce risks of developing long term conditions and recognise early signs and symptoms</p> 	<p>We are seeking your views on:</p> <ul style="list-style-type: none"> • how important the priorities are to you? • are there any other priorities you think should be considered in this key area? • do you have any suggestions for projects or interventions that should be done within this key area?

Key Area 3:

Ensuring delivery of coordinated and holistic care, when we need it

This Key Area is about how we integrate health and social care and support those with complex needs. It sets out our priorities to ensure that those who need it receive excellent care and have a health care system that works for them. This includes the Barnet Integrated Care Partnership, an alliance of Local Authority and NHS organisations that works together to deliver coordinated care.

Our priorities for ensuring delivery of coordinated and holistic care, when we need it

Support digital transformation of services

Enable carers health and wellbeing

Deliver population health integrated care

Our commitments for ensuring delivery of coordinated and holistic care, when we need it

Support digital transformation of services

We will create circumstances where access to digital care can be easy for all who need it



Enable carers health and wellbeing

We will support care staff and informal carers to look after their health and wellbeing



Deliver population health integrated care

We will work together to ensure the Barnet Integrated Care Partnership is centred around resident's need, promotes good physical and mental health and enables seamless access to health and care services across the life course



We are seeking your views on:

- how important the priorities are to you?
- are there any other priorities you think should be considered in this key area?
- do you have any suggestions for projects or interventions that should be done within this key area?
- do you have any other comments on our Draft Joint Health and Wellbeing Strategy?

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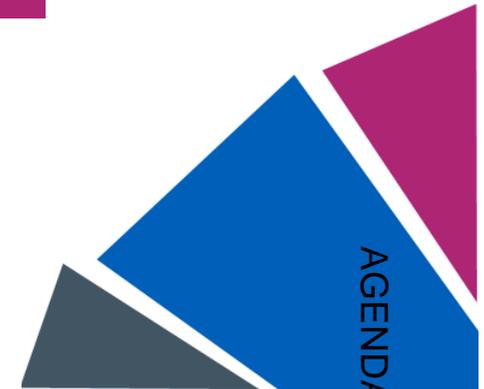


NORTH LONDON PARTNERS
in health and care

NCL ICS Development

Building on new ways of working across partners to improve outcomes for residents

June 2021



AGENDA ITEM 10

Context

- Over the last year, we have **continued to work closely with local authorities, our residents, our partners and with NHS** to respond to the pandemic and to strengthen our health and care system
- While the pandemic has **increased the strength of our relationships and ability to work as one system**, it has also **cast a spotlight on the health inequities within our sector**.
- As next steps, we are committed to working together as a system to **tackle these inequities and improve the outcomes and experience of our residents**.
- As part of the work to develop an integrated care system in North Central London we are developing a joint plan based on work already underway, building on good practice seen in the pandemic response and working to understand how the changes outlined in the NHS White Paper (slide 4) can accelerate joint working and the positive impact we can have for residents.
- This document outlines our progress to date in **visioning what this means for our residents (Slides 6-8)** , outlines **ongoing engagement (Slide 9)** and **recent progress (Slides 10-13)** and provides **an overview of some of the next steps (Slide 14-16)** in line with our ways of working since the Long Term Plan.
- Over the next 9 months, as we progress in this journey, **our development plan remains a work in progress**, continuing to develop in line with local partner ambitions and national guidance.



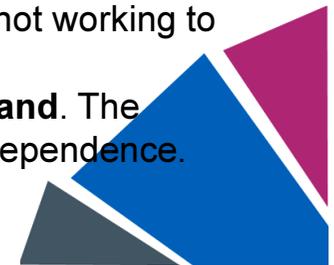
Our journey towards an Integrated Care System

- We have a **track record of working closely with partners, NHS and LA**, through NCL programmes of work through the STP and other collaborative programmes of work.
- In April 2020 the five Clinical Commissioning Groups in North Central London (NCL CCGs) – Barnet, Camden, Enfield, Haringey and Islington – **merged to form one CCG** in line with the NHS Long Term Plan.
- Alongside this, **borough partnerships have been formed in each borough** to support working at a ‘place’ level and we have **32 thriving primary care networks** across the area.
- Over the last year system partners have **worked closely together, with the CCG, Councils, NHS providers, general practices, voluntary and community organisations**, working to respond to the pandemic.
- We have also continued to **progress towards a more strategic approach to health commissioning** and beginning a strategic reviews of services across NCL and **within our borough partnerships through continued work on population health, health inequalities**.
- **As part of the white paper, the next stage of this work is to transition to an integrated care system with the aims of:**
 - improving outcomes in population health and healthcare
 - tackling inequalities in outcomes, experience and access
 - enhancing productivity and value for money
 - helping the NHS to support broader social and economic development



High Level Outline of Whitepaper Changes

- **Integrated Care Systems (ICSs) will become statutory organisations and will be responsible for strategic commissioning and an ICS will be set a financial allocation by NHS England.**
- **Services will continue to be coordinated and delivered at Place level.**
- **There will be a duty to collaborate.** NHS providers will work together in provider collaboratives and organisations across the health and care sector will have a duty to collaborate.
- **There will be reduced bureaucracy across the system to remove transactional barriers to collaborative working.** The NHS will be able to organise itself without the involvement of the Competition and Markets Authority.
- **Population health is at the heart of these proposals.** Changes to the National Tariff will enable it to work more flexibly with longer term population health contracts, rather than focussing on activity-led inputs.
- **The government will have the power to impose capital spending limits on Foundation Trusts, as it currently does on NHS Trusts.** The government will have the power to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts which are not working to prioritise capital expenditure within their ICS.
- **NHS England will formally merge with NHS Improvement and be designated NHS England.** The merged entity will be accountable to the Secretary of State, while maintaining operational independence.



In some ways, we have been working like an ICS through the pandemic response

- Despite all of the challenges of the past 18 months, we have still managed to **build stronger partnerships, relationships, and new ways of working as a system** across social, primary and secondary care.
- 2020 informally brought partners together to **think and act more like system**, aiming to deliver the best and seamless care for our population through the pandemic. We have already started focusing work on a number of areas.
 - Through our response to and recovery from the Covid-19 pandemic we have worked collaboratively with system partners to tackle challenges and find solutions to meet the needs of local people.
 - Establishing five borough-based integrated care partnerships focused on the coordination, integration and development of out of hospital services based on population needs.
 - Supporting the development of Primary Care Networks.
 - A move to single strategic commissioner for health services.
 - Ensuring resident voice is heard at all levels of work.
- A current example of **successful system working** is our Covid-19 vaccination programme, where enablers such as HealthIntent are supporting our system response, boroughs deploy their local know-how to plan for delivery based on local needs; while neighbourhood pharmacies and PCNs continue to effectively serve their populations through local interventions.



Our Vision for an Integrated Care System in NCL

We want to enable our residents to **Start Well, Live Well and Age Well**

We asked our residents what Integrated Care means for them; and this is what they told us...



What will the integrated care system mean for our residents?



Our Integrated Care system can not just focus on how healthcare services operate. Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare.

Therefore we need to work with partners to look at the bigger picture, including:

- | | | | |
|---|---------------------|---|--|
|  | Fulfilling work |  | Education and skills |
|  | Our surroundings |  | The food we eat |
|  | Money and resources |  | Transport |
|  | Housing |  | The support of family, friends and communities |

What will be different?

“Joan is 80 years old and lives in Camden. She has heart disease and diabetes, and recently has been forgetting to take her medication. She has found it more difficult to manage over the last six months but wants to keep living at home. Joan's GP and social worker have developed a Care Plan in discussion with Joan. This means that the GP practice, district nursing and social care know how to work together to help Joan stay well and at home safely. If Joan's GP becomes concerned about something, he uses the 'Rapid Response' service to assess her the same day at home, which helps avoid trips to A&E. When Joan did fall last year and needed to be seen in hospital, she was assessed within 2 hours and a plan was in place quickly to get her home as soon as she was ready. Joan was supported to stay at home with a *care package provided by social care, her domiciliary care workers* were increasingly concerned about her forgetfulness so referred her to the memory clinic for a *dementia assessment*.”

How integrated care can help

- ✓ Clearer information about local services and how to use them will be available to help residents access the right support.
- ✓ Better access to mental health care, with residents given more support to find the help they need.
- ✓ Patients ready to leave hospital will be discharged, through hospitals, community services and social care working together.
- ✓ Ensuring all people have their mental health care needs met, and providing interim support for when people are on waiting lists for complex care treatment.

What Will the Integrated Care System Mean for Our Residents? Julianah's Story

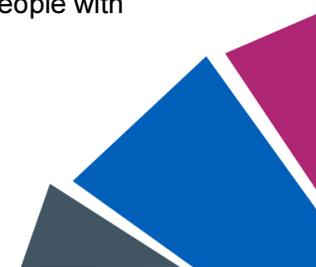


What will be different?

“Julianah works as a social prescribing link worker providing support to local people. Julianah spends most of her time working with residents who have long term conditions, mental health needs or complex social needs. People can be referred to Julianah through the council, local NHS services or self-refer and she is able to connect them to community groups and local agencies for practical and emotional support. She has flexibility to signpost activities that people may not have tried before, such as arts, cultural activities, community exercise classes, gardening, singing and outdoor activities. Julianah has also helped people sign up to volunteering and work opportunities that can sometimes lead to paid work. She feels that the people she works with really benefit from these activities and she is helping to provide an improved quality of life and better emotional wellbeing.”

How Integrated Care Can Help

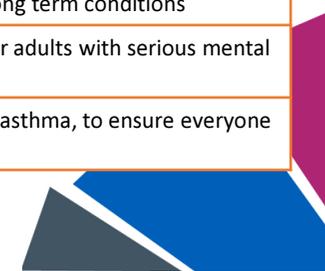
- Residents are supported to make their own decisions about their care, and care is planned around each individual
- Staff show empathy, understanding and sensitivity to cultural or disability-related needs
- Personal care is designed for people with long term or complex needs, care home residents, frail elderly people and people with learning disabilities
- Personal health budgets give control to residents over their care, including for mental health



Themes from Resident Engagement

Insights generated through our engagement with residents will inform the development of our NCL Integrated Care System, building on work we are already doing in response to what they have told us is important:

What residents told us was important	Examples of what we are doing...
Better access to services	Introducing care navigators to signpost people to the right services
Patients involved in discussions and shared decisions about their care	Children and young people with epilepsy and their families being involved in the development of local epilepsy services
Access to clear and accessible information, including easy read versions and access to interpreters	Healthy Futures providing clear, accessible information for people with diabetes on how to look after their condition
Empathy and understanding around cultural or disability-related needs	Trialling a new pathway for self-sampling smear tests
Patients given knowledge about how to keep themselves well and support wellbeing	Social prescribing in GP practices to support people to stay active, eat well, reduce isolation and contribute to their communities
Patients given choice and care is planned and delivered to meet each individual's needs	Residents supported to have personal health budgets, including for mental health, to best meet their individual needs for care
Use of technology both to increase access to services and to health information	Residents having access to online and video consultations and supported to feel digitally included
Better joint working between health and social care	Working across services to proactively support people at risk of long term conditions
A focus on prevention and proactive care	Increased community teams and ensure physical health checks for adults with serious mental illness and learning disabilities are being carried out
Everyone gets the same quality of care regardless of where they live	Whole system approach to tackle some issues, such as childhood asthma, to ensure everyone gets the same high-quality care



Our partnerships at place and provider collaboratives

As an ICS we are committed to integration between system partners at place, to improve outcomes for our residents

Place-based arrangements

- Borough Partnership Executive Boards x 5
- Borough Delivery Boards x 5
- Working Groups / T&F Groups (numerous in place to progress partnership priorities)

Purpose:

- Agree shared borough priorities & ambitions (feeding into Joint H&WB Strategies)
- Shape and deliver integrated health & care locally (relationships, systems, processes)
- Ensure joined up, efficient and accessible services for residents
- Address inequalities in access, experience, outcomes
- Develop Population Health, with emphasis on prevention and develop proactive care models
- Address the wider determinants of health
- Codesign with patients / residents

Partner organisations

- NHS Trusts
- Local Authorities
- PCNs x 32 and GP Federations x 6
- Local VCSE partners
- Healthwatch x 5
- Other key partners:
Care Providers
Patient groups
Cllrs
Other statutory services (Police, Fire)
- Working with:
Local patients/residents and communities

Provider Alliance

- Provider Alliance Board
- Provider Alliance Partners Group

Purpose:
The purpose of the NCL Provider Alliance is to create a membership organisation where members work together to improve health value (health life expectancy/ costs) for the population we collectively serve; by improving the quality and reducing costs of health services for patients / service users / residents and staff above and beyond what each member organisation could achieve working on its own.

Borough Partnership and provider collaborative priorities align with our overall ICS vision

Our five Borough Partnerships (ICPs): Key Features

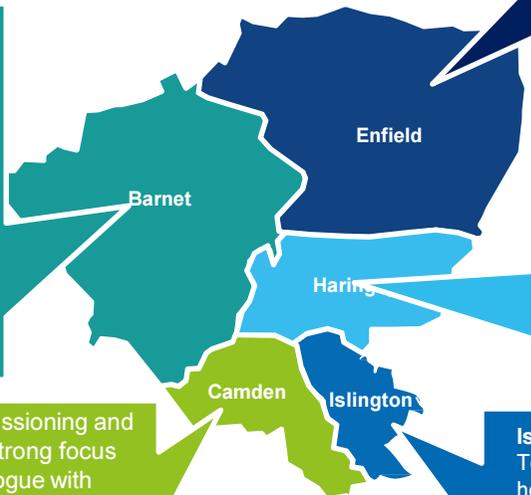
- Partnerships are maturing locally. COVID and the acceleration of the ICS has furthered existing partnership working.
- Place-based leaders are working together to shape the ICP role, priorities, local structures & teams and ways of working.
- There are common features, but local nuances within each partnership.

Barnet – partnership accelerated in last 18 months. Significant NHS engagement plus strong community focus and local govt leadership. Older population gives rise to focus on proactive care, same day urgent care and support to remain independent.

- 425,395 registered population
- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs
- Chair of Exec: rotating (CCG, Council, Barnet Hospital, GP Federation)
- Co-chairs of ICP: Dawn Wakeling (DASS), Colette Wood (CCG Director of Integration)

Camden – long partnership history with integrated commissioning and partnership development of integrated delivery models. Strong focus on CYP, MH, citizen's engagement/coproduction and dialogue with families and communities, as well as a developing Neighbourhood model. New areas of focus include accelerating provider developments at PCN and borough level and connecting with local communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of ICP/8 PCNs)
- Chair Exec: Martin Pratt, Deputy Chair Kate Slemeck
- Chair of ICP: Graeme Caul, CNWL



Enfield – Newly formed partnership. COVID has helped accelerate integrated working. Priorities have been expanded from an initial focus areas following success around flu and Covid vacs. Provider Integration Partnership oversees delivery of 425,395 registered population

- 10 'organisations' represented (25+ members of delivery board)
- 4 PCNs (not geographical – neighbourhoods within @ 50k)
- Chair Exec: Binda Nagra and Dr Chitra Sankaran
- Co-Chairs of ICP – Mo Abedi BEH and Alpesh Patel Enfield GP Federation

Haringey – established and ambitious partnership with strong relationships. Focused on expansion of community based care models, MH, wider determinants and inequalities and a local strengths based approach that also addresses risks driven by deprivation.

- 298,418 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs
- Chair Execs: Zina Etheridge, Siobhan Harrington
- Chair of ICP: Rachel Lissaeur (Director of Integration)

Islington – active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (including police, fire, housing). Senior leadership from Islington Council and CCG. Emphasises joint commissioning, operational joint working and expansion of neighbourhood level delivery. New Delivery Board established to drive key workstreams:

- 257,135 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 4 PCNs
- Chair Exec: Dr Jo Sauvage (CCG), Cllr Kaya Comer-Schwartz (Leader)
- Co-Chairs of ICP John McGrath (CCG GB) and Stephen Taylor(Islington Borough)

Our 5 Borough Partnerships (ICPs)

- **Each Borough has a Partnership Executive in place** – these were established when partnership boards formed. The Execs tend to meet every other month and each partner organisations CEX or their deputy is a member. All Exec partnership boards have a ToR. Exec is in place to provide sponsorship of the work locally, oversight of progress, guidance and resourcing. The members reflect senior leaders also in ICS / System leadership roles – over time the link back to NCL-wide forums has become more important and the role of the Exec in this regard will need consideration as we transition to ICS.
- **Each Borough has a ‘Delivery Board’ in place** – broadly this is the route through which senior operational and clinical leaders for local services, alongside Healthwatch, the VCS, care providers, CCG, Council and others come together to shape and drive priorities and delivery. These tend to meet monthly. Increasingly these are led by provider colleagues (Enfield, Camden). Each ICP has increased the scope of their partnership work over time. All have considered priorities and set 21/22 plans reflecting local needs post COVID.
- **Each borough has T&F or working groups in place** – all have active working groups or ‘task & finish’ groups supported by partners. They are focused on a range of medium term objectives and progression of key steps towards these. All have adopted a ‘PMO’ approach with significant coordination of activity supported predominantly by CCG and Council staff. Provider colleagues are increasingly providing the SRO function for these groups.
- All partnerships are at the stage of **information sharing, coordination and collaboration around delivery** as opposed to local decision making or governance.
- All are focused on **honing their purpose and role** and on **building relationships and trust**.
- Partnerships are also generally working on **aligning more staff / teams** from their home organisations to this way of working.

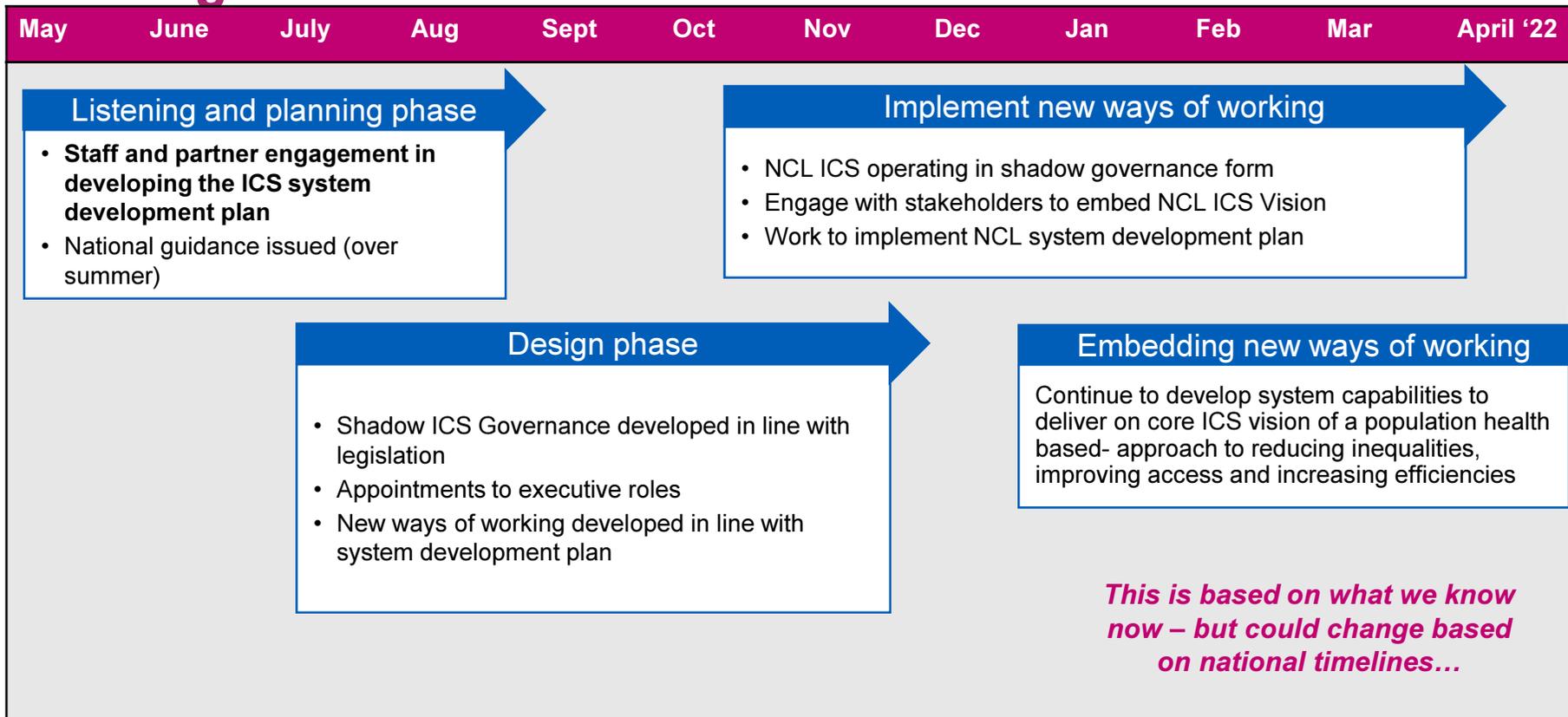
Summary - Priorities at a Glance

All 5 partnerships:

- **Shift to proactive care (early intervention & prevention)** – partnerships are focused on how they can make the move to delivering more proactive care through the use of population health management tools (e.g. risk stratification, case management, etc).
- **Cross-sector workforce planning and skills development** – partnerships have identified the need to develop collective workforce plans.
- **Supporting care homes/providers** – all partnerships are focused on providing enhanced support to care homes.
- **Inequalities & deprivation** – all boroughs are gathering data related to inequalities are working towards addressing them as part their priority areas of work.
- **Digital inclusion** – partnerships have acknowledged the need to emphasize digital inclusion and learn from resident experiences related to the use of technology over the pandemic.
- **Vacs & Imms** – partnerships are working together to deliver COVID vacs and delivered and highly successful flu campaign.



As next steps we will continue to strengthen system working



Key areas we will work with partners to develop

Area	Example questions to explore with partners...
The impacts and benefits of becoming a statutory ICS	<ul style="list-style-type: none"> • What does the change to a statutory ICS mean we could do differently for residents to improve outcomes/reduce health inequalities? • What does this mean to your organisation – what would work differently? • What changes between now and April 2022 to get us closer to our vision?
NCL's Population Health & Inequalities Strategy	<ul style="list-style-type: none"> • How should we adapt to embed a population health approach? • What are the key areas of variance in outcomes across NCL? • Where are the common areas we should work together? • What might we do at a borough level? • What should we do as a system over the next 9 months to embed a Population Health Approach?
Principles for collectively agreeing priorities at a place level	<ul style="list-style-type: none"> • How will each place/borough partnership agree priorities? • How do we work to the principle of subsidiarity? • What should the interface between ICS and ICP priorities look like?
Impact of system oversight framework	<ul style="list-style-type: none"> • Do we have transparency of process, shared accountability and joint decision-making? • How do we continue to embed that across the system? • What is our approach to aligning system-wide operational and strategic plans
ICS Financial Framework	<ul style="list-style-type: none"> • How will we best spend money for maximum impact? • What is our plan for sharing financial risk and opportunity? • How do we balance system financial sustainability with organisational sustainability?
Clinical Leadership Development	<ul style="list-style-type: none"> • How do we establish appropriate clinical and professional leadership • What is the role of leadership within system, place and provider collaboratives • What is our approach to achieving multi-professional leadership including primary care and speciality
Role of Strategic Commissioning	<ul style="list-style-type: none"> • How can strategic commissioning lead to better outcomes for our residents and patients? • What changes in the way we engage with local authorities and other system partners? • What additional skills and competencies should commissioners have to embed a strategic commissioning approach?

Immediate Next Steps...

1. Working with borough partnerships on a programme of engagement and system design; and principles for collectively agreeing priorities.
2. Developing a NCL Population Health Strategy
3. Engagement with staff and residents on key aspects of integrated care- identifying champions and collecting lived experiences- through multiple forums
4. Engagement with clinical and professional leaders to set a vision for clinical leadership in an ICS

Feedback on this presentation and other questions or queries are most welcome, please send these through to: northcentrallondonics@nhs.net

AGENDA ITEM 11

	<h2>Health and Wellbeing Board</h2> <h3>15th July 2021</h3>
Title	An update on the Barnet Integrated Care Partnership and Integrated Care Systems
Report of	Dawn Wakeling, Executive Director, Adults & Health Dr Charlotte Benjamin, NCL CCG, Vice Chair
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Colette Wood, Director of Integration, Barnet Borough Colette.wood1@nhs.net Dawn Wakeling, Executive Director – Adults and Health Dawn.wakeling@barnet.gov.uk
Summary	
<p>Since the last report on integrated care to the Health and Wellbeing Board, officers across the NHS and the council have been working to develop the Barnet Integrated Care Partnership (ICP), with associated programmes of work.</p> <p>The NHS Long Term Plan (LTP), published in 2019 proposed organisational change for the NHS through the development of ‘integrated care systems’ (ICS), based on the same geographical areas as Sustainability and Transformation Partnerships (STP). The White Paper, ‘Integration and Innovation: working together to improve health and social care for all’, published in February 2021, sets out the legislative proposals for a Health and Care Bill which will put ICSs on a statutory footing, as well as including proposals covering social care.</p> <p>This report updates the Board on the progress of the Barnet Integrated Care Partnership and sets out some key information on the White Paper.</p>	

Recommendations
<p>1. The Health and Wellbeing Board is asked to note and comment on the content of the report.</p>

1. WHY THIS REPORT IS NEEDED

- 1.1 Since the last report to the Board on integrated care, a significant amount of work has taken place to develop the Barnet Integrated Care Partnership. This report outlines the achievements to date and future priorities.
- 1.2 The Council, the Barnet directorate of NCL CCG and NHS provider organisations have a history of collaborative working and there are a range of integrated services and programmes of work in place.

2. THE WHITE PAPER AND INTEGRATED CARE SYSTEMS

- 2.1 In England, Integrated Care Systems (ICSs) will be established as statutory bodies. Clinical Commissioning Groups will be abolished and their functions transferred to ICSs. Integrated care systems are defined by NHSE as systems where “NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.”
- 2.2 Integrated Care Systems will have two governing entities. The first, the ‘ICS NHS Body’ will be responsible for the day to day running of the ICS and consist of NHS organisations. It will have specific requirements to develop a plan to meet the health needs of the population within their area, to set the strategic direction of the ICS and develop a capital plan for NHS providers within the ICS. The ICSs will be required to meet financial objectives set by NHS England, which require financial balance to be delivered across the ICS area. The requirement for NHS commissioners to procure NHS care and treatment services competitively, will be removed. The ICS will not have the power to direct providers, and providers’ relationships with the Care Quality Commission will remain unchanged.
- 2.3 The second governing entity, the ‘ICS Health and Care Partnership’ will include local government and other stakeholders, and have the responsibility to develop a plan to address the system’s health, public health and social care needs. The ICS and relevant local authorities will be required to have regard to this plan. The White Paper indicates that local areas will be able to develop their ICS partnership body based on local need and building on pre-existing local partnerships.
- 2.4 The NHS and local government will be given a duty to co-operate with each other and the ICS will have a duty to have regard to the local Joint Strategic Needs Assessment and the Health and Wellbeing strategy.

- 2.5 The White Paper emphasises the importance of working at ‘place’ level to deliver effective integration: “A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary” (White Paper, para 1.14, p.10).
- 2.6 Subject to parliamentary business, the intention is that the proposals in the White Paper will begin to be implemented in 2022.
- 2.7 The link to the full White Paper is below:
<https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version>

3. THE BARNET INTEGRATED CARE PARTNERSHIP

- 3.1 The Barnet ICP’s current work programme has 3 workstreams: integrated pathways; same day access and discharge; & support to care homes.
- 3.2 **Integrated pathways:** The workstream has focused on the development of a community multi-disciplinary team (MDT) model to better support frail older residents in Primary Care Network 2, which covers East Barnet, Oakleigh, Brunswick Park and Coppetts, where 17% of its population of 60, 500 are aged 65 or over. The intention has been to develop a model that could be scaled across Barnet.
- 3.3 The MDT works with residents aged 65 or over who are moderately or severely frail; and dependant on the clinician’s judgement, with people who are (if outside criteria) within the last 12 months of their life expectancy or on the palliative care register. The MDT provides an holistic, personalised, preventative model of care. The MDT consists of GP practices, Central London Community Health, Social Care, secondary care and the voluntary sector and is coordinated by a frailty specialist nurse. The nurse undertakes home visits and completes comprehensive geriatric assessments which, in discussion with patients and their families, are used to create personalised care plans via the MDT.
- 3.4 The MDT has been evaluated and the findings are that the MDT has helped to improve outcomes for people and their carers, as well as improving end of life care. Since the launch of the frailty MDT, there has been a reduction in non-elective and A&E admissions in the PCN, whilst also facilitating closer working between system partners.
- 3.5 In addition, a further MDT focusing on dementia is being piloted in PCN 5, which covers Hendon, Brent Cross, Golders Green and Childs Hill. The aim is to develop a model which provides pre-diagnostic support, support at the point of diagnosis and post diagnosis, creating a blended approach for not just the adult with dementia, but also the carer of that person. The model has already placed a dementia nurse and a VCS co-ordinator within the PCN, as well as embedding

cognitive stimulation therapy. The model went live in November 2020 but the MDT element was delayed due to the second wave of Covid-19. This work is now being re-started.

3.6 The next step is to develop a plan for MDTs for older people to be rolled out across all Barnet PCNs. The plan will take into account the continued pressures of the pandemic, recovery and the vaccination programme.

3.7 **Clinical support to care homes** This workstream has focused on the roll out of GP primary care support to care homes via the Nursing Homes Locally Commissioned Service (LCS), which provides a named GP for each care home & weekly GP-led ward rounds in care homes. The workstream has also created a dedicated clinical in-reach team for care homes. The One Care Home in-reach Team (OCHT) was set up in May 2020. The team’s role is:

- a) To support the review of patients identified as a clinical priority for MDT assessment and care, identified through the General Practice weekly ward round with care homes.
- b) To support with the delivery of personalised care and support plans for care home residents.
- c) To support the provision and medication support to care homes.
- d) To provide training (including infection prevention and control -IPC), support and empowerment of staff.
- e) To provide a dedicated clinical support line, 7 days a week, 8a.m-8p.m for patient referrals and/ or queries to improve support and access for care home residents to multi-disciplinary clinical support.
- f) To ensure that, wherever possible, individuals who require support to live independently have access to the right health services in the place of their choosing

3.8 The OCHT are supporting 91 care homes and supported living schemes in the borough to date:

Number of Homes/ schemes	Type of Residence	Number of Beds
23	Older People’s Nursing Homes	1099
16	Mental Health Care	172
25	Learning Disabilities Care	146
27	Older People’s Residential Homes	1073

- 3.9 The Team has carried out approximately 350 community matron-led resident reviews and 259 physiotherapy reviews. In addition, the MDT has supported 129 residents to date. The MDT includes community matrons, allied health professionals, Barnet and Enfield Mental Health Trust consultants and Barnet Hospital Consultant Geriatricians. Further work is underway to promote the offer and raise awareness of the MDT sessions with the PCNs, as well as looking at ways to strengthen the feedback process to GPs.
- 3.10 During the pandemic the team delivered a wide range of support including:
- Testing approximately 629 residents and 515 staff
 - Working with public health and the care quality team to support bedded care settings experiencing outbreaks.
 - Delivering Infection Prevention and Control (IPC) and Coordinate My Care training
 - Care planning and support alongside GPs.
- 3.11 The team has received positive feedback, highlighting the benefits of interdisciplinary working, the enhanced speed of escalation and resolution of patient's health care needs, the training benefits for Care Home staff and community matrons and enabling more proactive and supportive care of residents within their home setting.
- 3.12 **Same Day Access and Discharge** This workstream contains two elements: development of an urgent treatment centre model at Finchley Memorial Hospital, building on the walk-in centre there, and the implementation of the integrated discharge team and discharge to assess model, as required by the national pandemic discharge guidance.
- 3.13 Urgent Treatment centres are GP-led, open at least 12 hours a day, offer appointments that can be booked through 111 or via GP referral and can diagnose and treat the most common ailments for which people attend A&E. It is anticipated that the work on the urgent treatment centre model at Finchley will be complete by summer 2021. In addition, as services are reinstated as the recovery from the pandemic continues, Finchley Memorial Hospital Walk-in Centre is preparing for a return to usual operating hours. There has also been the establishment of better links with NHS 111 to start the transition to a book ahead approach for same day access, enabling more effective triage. This will develop further in the next twelve months.
- 3.14 The integrated discharge team was set up in rapid time, in response to national requirements and to ensure effective flow in hospital during the pandemic. The team operates across Barnet Hospital and the community hospitals and consists of community health, CCG and council staff. The discharge to assess model will become an on-going statutory requirement for councils and the NHS, as set out in the White Paper, and the council is working with the other north

London councils and ICS partners to develop a permanent model across the ICS. National NHSE funding for discharge has also been extended until September 2021. The team has achieved a great deal in the time it has been in operation:

- There is a better experience for residents – less time spent waiting in an acute hospital bed when they don't need to be there. In the first year of operation, the team have enabled over four thousand residents to leave hospital to the right place for them.
- It has had a significant impact in helping save bed days by reducing length of stay and avoiding what would have been delayed transfers of care. Average length of stay in Barnet Hospital between February to April 2019 was 21 days, whilst in the same period in 2020 it was 8 days.
- There is staff capacity available at the right time to support timely discharge, 8a.m – 8p.m, seven days per week, from community health, continuing health care, social care brokerage and social work.
- The Home First principle has been applied across the whole process, with three quarters of patients going home.
- It is easier to find appropriate residential / nursing and extra care placements for individuals – communications between ward staff, consultants and those working on discharge have been improved to ensure needs are properly understood and there has been a change to focus on a quick initial move to further assess and understand ongoing needs.
- A more flexible approach to the use of NHS community rehabilitation beds has helped with improving flow across the system.
- The streamlining of arrangements has meant hospital staff can focus more on meeting the needs of patients.
- Feedback from patients and their families has been positive.

3.15 Future priorities

In addition to the workstreams above, the ICP is in the early stages of scoping programmes of work in the following areas:

- Mental health and dementia
- Children and young people's health
- Reducing health inequalities
- Neighbourhood models of integrated care
- Engagement and co-production

3.16 Consultation and Engagement

Engagement in the ICP work programme will be achieved through the co-production workstream and through liaison with HealthWatch, the council's

adult social care Involvement Board, and engagement mechanisms for children and young people.

4. REASONS FOR RECOMMENDATIONS

- 4.1 The White Paper sets out significant changes that are relevant to the remit of the Health and Wellbeing Board. It is important that the Board is informed of these proposals, along with local and NCL developments.

5. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

- 5.1 Not applicable in the context of this report.

6. POST DECISION IMPLEMENTATION

- 6.1 Officers will bring back further reports at the appropriate points in the development of the ICS and ICP, and as the social care proposals are fleshed out.

7. IMPLICATIONS OF DECISION

7.1 Corporate Priorities and Performance

- 7.1.1 This area of work is clearly aligned to the Barnet Corporate Plan's Healthy priority, which has integrated care at its core. The priorities will also support the delivery of the Joint Health and Wellbeing Strategy.

7.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

- 7.2.1 Engaging with the ICP and ICS development process will be delivered within existing resources. The aim of developing a strong borough based partnership would be to invest in more pro-active and preventative models of care that would support efficient use of social care and health resources.

7.3 Social Value

- 7.3.1 We are seeking to strengthen our partnership arrangements in such a way that addresses wider determinants of health, such as employment and housing challenges, and has a strong voice for Barnet voluntary sector and social care providers.

7.4 Legal and Constitutional References

- 7.4.1 Under the Council's Constitution, Article 7 Committees, Forums, Working Groups and Partnerships the terms of reference of the Health and Wellbeing Board includes the following responsibilities:
- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.
 - To promote partnership and, as appropriate, integration, across all necessary

areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate

- To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.
- Specific responsibilities for overseeing public health and developing further health and social care integration

7.4.2 The timescale for the legislative proposals in the White Paper (Integration and Innovation: working together to improve health and social care for) to begin being implemented is from April 2022. Some of the key legislative proposals outlined in the new whitepaper include:

NHS and local authorities have a duty to collaborate

Building on its ambitions of integrating care to support better patient outcomes, the White Paper details two forms of integration which will be underpinned by the legislation. They are: integration within the NHS to remove some of the boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

The NHS and local authorities will be given a duty to collaborate with each other. There will be measures for statutory integrated care systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body.

The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care

Discharge to Assess model

Introduced nationally in March 2020, the discharge to assess (D2A) model focuses on discharging patients from hospitals into the appropriate setting, considering what care they might need after being discharged from hospital, whether that is care at home or going into a care home, for instance.

Now, the government is looking to bring forward measures to update approaches to this process to help facilitate smooth discharge, by putting in place a legal framework for a D2A model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care, replacing the existing legal requirement for all assessments to take place prior to discharge.

7.4 Risk Management

7.4.1 Risks will be managed in relation to Barnet's corporate approach to risk management.

7.5 Equalities and Diversity

7.5.1 In developing proposals we will have regard to the council's Equalities Policy together with our strategic Equalities Objective - as set out in the Corporate Plan - that citizens will be treated equally with understanding and respect; have equal opportunities and receive quality services provided to best value principles.

7.6 Corporate Parenting

7.6.1 In line with Children and Social Work Act 2017, the council has a duty to consider Corporate Parenting Principles in decision-making across the council. In engaging with this process, officers will ensure that the health and care needs of looked after children and young people; and care leavers, are considered by those developing the ICS and ICP.

7.7 Consultation and Engagement

7.7.1 Engagement in the ICP work programme will be achieved through the co-production workstream and through liaison with HealthWatch, the council's adult social care Involvement Board, and engagement mechanisms for children and young people.

8. BACKGROUND PAPERS

None.

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AGENDA ITEM 12

	Health and Wellbeing Board 15 July 2021
Title	London Borough of Barnet Suicide Prevention Strategy 2021-2025
Report of	Director of Public Health and Prevention
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	London Borough of Barnet Suicide Prevention Strategy 2021-2025.
Officer Contact Details	Dr Elliott Roy-Highley, Elliott.Roy-Highley@barnet.gov.uk Seher Kayikci, Seher.Kayikci@barnet.gov.uk Dr Julie George, Julie.George@barnet.gov.uk
Summary	
<p>The Barnet Suicide Prevention Strategy 2021-2025 provides an update to the Barnet Suicide Prevention Action Plan 2019-2020. The overall strategic intention is that every year, the number of Barnet residents lost to suicide falls.</p> <p>The strategy was co-produced with the multi-agency Barnet Suicide Prevention Partnership to be appropriate to the national and our local context, to be insight-led, informed by evidence of what works, and importantly to be practical, achievable, and effective.</p> <p>The strategy organises our whole-system suicide and self-harm prevention response under three themes: our foundation for action, prevention, and postvention activities. Under these themes we have identified eight areas within which we can act to improve our prevention efforts:</p> <ul style="list-style-type: none"> • Insights from data, research, and people with lived experience • Leadership and collaboration • Awareness • Interventions • Services & Support • Wider determinants of mental health and wellbeing • Bereavement support • Community response <p>Within each area, this strategy defines one aim and several objectives that we will strive to achieve over the four-year duration of the strategy. The strategy includes the first biennial action plan (2021-2023) outlining the priority suicide prevention activities agreed by Partners of the Barnet Suicide Prevention Partnership. To ensure that over the lifetime of the strategy our actions remain focussed yet responsive to emerging insights, we intend to collectively review our priorities and form a second biennial action plan in 2023.</p>	

Recommendations

- 1. That the Board discuss and note the report.**
- 2. That the Board receive an annual update in 2022 and 2023 following a review of progress against the 2021-2023 action plan.**
- 3. That the Board receive the 2023-25 action plan in 2023.**

1. WHY THIS REPORT IS NEEDED

- 1.1 This report outlines the approach the Barnet Suicide Prevention Partnership intends to take to improve suicide prevention in Barnet through local activities and joint working with sector and regional partners.
- 1.2 The death of someone by suicide is a tragedy that has devastating effects across families, friends, schools, workplaces, and communities. In the last four years for which we have data (2016-2019), Barnet lost 89 people to suicide: on average one person every sixteen days. The annual four-year rolling average for 2016-2019 was 22. The suicide rate in 2019 for England and Wales is the highest in men since 2000, the highest in women since 2004, and the highest recorded in 10-24-year-old women since 1981. In Barnet, the suicide rate rose through 2014 to 2017, and has since fallen with rates in 2018 and 2019 consistent with those seen during 2002 to 2013.
- 1.3 We are currently gripped by a health and economic crisis caused by COVID-19, of which the long-term effects on physical health, mental health and prosperity are unknown. This strategy recognises the potential for COVID-19 to increase suicidal behaviour due to the negative impact of the pandemic and associated restrictions on mental wellbeing, and the already evident increase in multiple risk factors for suicide and self-harm such as bereavement, social isolation and loneliness, domestic violence, and unemployment. Following previous recessions where there has been high unemployment, rates of suicide have increased. Mitigating the negative impact of the pandemic on the lives of people in Barnet is an urgent necessity.
- 1.4 The Barnet Suicide Prevention Partnership has produced annual action plans for suicide prevention since 2014, which are reviewed annually by the Barnet Health Oversight Scrutiny Committee. The Barnet Suicide Prevention Strategy 2021-2025 was developed to move to a longer-term strategic approach to suicide and self-harm prevention in Barnet.
- 1.5 Development of a local suicide prevention strategy is a recommendation by the National Institute for Health and Care Excellence (Guideline 105: Preventing suicide in community and custodial settings). The need for a local strategy is set out in the government's national strategy for preventing suicide in England and is a key recommendation in 'the Five Year Forward View for Mental Health'.

2. REASONS FOR RECOMMENDATIONS

- 2.1 To ensure the resources available to the multi-agency Barnet Suicide Prevention Partnership have the greatest impact by taking a longer-term strategic approach to suicide prevention activities.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

- 3.1 None.

4. POST DECISION IMPLEMENTATION

- 4.1 Public Health and the Barnet Suicide Prevention Partnership partners will begin implementing the actions described in the action plan. The Partnership will meet formally twice-yearly to discuss progress against actions and course corrections.
- 4.2 Public Health will report on progress against the Suicide Prevention Strategy to the Health and Wellbeing Board; the Health Oversight Scrutiny Committee will also be briefed as requested.
- 4.3 The Barnet Suicide Prevention Partnership will develop and agree a second biennial action plan for 2023-2025 by 2023.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

- 5.1.1 The Barnet Corporate Plan 2021-2025 includes the aim to be the healthiest borough in London by focussing on mental health and wellbeing. This includes a commitment to support the mental health of children and young people and adults, including prevention, early identification of mental health issues, increasing mental health awareness, appropriate access to mental health support from mild to crisis.
- 5.1.2 The Health and Wellbeing Strategy includes focus on improving mental health and wellbeing for all and makes specific reference this Suicide Prevention strategy.
- 5.1.3 The Joint Strategic Needs Assessment identifies the suicide rate and rate of hospital admissions for self-harm in Barnet and compares this with the national and London rate.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

- 5.2.1 Suicide prevention is delivered within existing staffing and financial resources in Public Health and Partner agencies such as NHS, Local Authority, Police, Voluntary and Community sector organisations who are funded from diverse sources and for a wide range of purposes.
- 5.2.2 North Central London Suicide Prevention activities are funded from awarded NHS England Suicide Prevention Wave 3 funding.

5.3 Social Value

Not applicable

5.4 Legal and Constitutional References

- 5.4.1 Barnet Council Constitution, Article 7 – Committees, Forums, Working Groups and Partnerships, Health and Wellbeing Board responsibilities:

(2) To agree a Health and Wellbeing Strategy (HWBS) for Barnet taking into account the findings of the JSNA and strategically oversee its implementation to ensure that improved population outcomes are being delivered.

(3) To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.

(5) Specific responsibilities for overseeing public health and promoting prevention agenda across the partnership.

5.5 Risk Management

5.5.1 The Barnet Suicide Prevention Strategy 2021-2025 requires collective effort across the multi-agency Barnet Suicide Prevention Partnership (BSPP) to reduce the number of lives lost to suicide in Barnet. If the council or partners do not engage with the strategy and progress their actions, it may lead to poor overall delivery of the 2021-23 Action Plan. Poor engagement may also lead to failure to agree a 2023-2025 Action Plan. This could have a detrimental impact on local suicide and self-harm prevention.

5.5.2 The following controls and mitigations are in place:

5.5.2.1 The multi-agency Barnet Suicide Prevention Partnership was consulted throughout initial strategy development and co-owns the strategy and action plans.

5.5.2.2 The Barnet Suicide Prevention Partnership meets twice-yearly to re-engage partners, align activities, and implement changes based on new insights.

5.5.2.3 The strategy includes by design a requirement for all partners to re-engage in 2023 to assess progress, re-prioritise and agree the Action Plan for 2023-2025.

5.5.2.4 The Barnet Suicide Prevention Strategy is presented to the Health and Wellbeing Board and included in Barnet's Health and Wellbeing Strategy. Partners' progress against the action plan is reported annually to the Health and Wellbeing Board and Health Overview Scrutiny Committee as requested.

5.5.2.5 Barnet's Council's Suicide Prevention activities are supported by the North Central London Suicide Prevention Strategy Group and its activities.

5.6 Equalities and Diversity

5.6.1 Nationally there are variations in suicide rates by age, gender, disability, maternity, and sexual orientation. This strategy is cognisant of the disparity in the risk of suicide across different groups with protected characteristics and aims to address this disproportionate risk through targeted actions for high-risk groups.

5.7 Corporate Parenting

5.7.1 It is intended that the suicide prevention actions in this strategy improve the mental wellbeing and reduce the risk of self-harm and suicide for children and young people including children in care.

5.8 **Consultation and Engagement**

5.8.1 This strategy was co-produced with the Barnet Suicide Prevention Partnership through a series of workshops and written consultation.

5.8.2 The group comprises a broad range of local partners including representatives from the Barnet Clinical Commissioning Group, Police, NHS Health Trusts, Barnet Enfield and Haringey Mental Health Trust (BEHMHT), Children's and Adult Social Care, Voluntary and Community Sector, and people with lived experience of suicide.

5.9 **Insight**

5.9.1 Our strategy, prevention framework, aims, objectives and actions are built upon the national evidence of the risk factors for suicide and self-harm, 'what works' for prevention, and insights from local and national data such as suicide rates, rates of emergency admissions for self-harm, and indicators of the wider determinants of mental health and wellbeing. The insights, evidence, and policy context which informed this strategy are described in the report Appendix.

6. **BACKGROUND PAPERS**

6.1 [Suicide Prevention Plan Update, Health Oversight Scrutiny Committee, 5th October 2020.](#)

<https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MID=10208>

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London Borough of Barnet
Suicide Prevention Strategy
2021-2025

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Introduction

The death of someone by suicide is a tragedy that has devastating effects across families, friends, schools, workplaces, and communities. In the last four years for which we have data (2016-2019), Barnet lost eighty-nine people to suicide: on average one person every sixteen days¹. In the UK, suicide is the leading cause of death in people aged 15-24, and the biggest killer of men under 49.

The time to act is now - self-harm and suicide rates could rise further without action.

Nationally, suicide rates are rising. After several years of decline during 2014 to 2017, the suicide rate in 2019 for England and Wales is the highest in men since 2000, the highest in women since 2004, and the highest recorded in 10 to 24-year-old women since 1981². In Barnet the suicide rate rose through 2014 to 2017 and has since fallen, with rates in 2018 and 2019 consistent with those seen during 2002 to 2013¹.

Self-harm is the most important risk factor for subsequent death by suicide; over half of people who die by suicide have a history of self-harm, many with an episode close to their death³. Most people who self-harm do not die by suicide, but the strength of the association between self-harm and suicide means this is a signal that cannot be ignored. The rate of emergency hospital admissions for intentional self-harm in Barnet is currently similar to the London average, but has remained stable over the past four years. We want to see admissions for self-harm decrease, so we must do more to prevent and support people who self-harm.

We are currently gripped by a health and economic crisis caused by COVID-19, of which the long-term effects on physical health, mental health and prosperity are unknown. This strategy recognises the potential for COVID-19 to increase suicidal behaviour due to the negative impact of the pandemic and restrictions on mental wellbeing, and the already evident increase in multiple risk factors for suicide and self-harm such as bereavement, social isolation and loneliness⁴, domestic violence, and unemployment⁵. Alarming, following previous recessions where there has been high unemployment, rates of suicide have increased⁶. Mitigating the negative impact of the pandemic on the lives of people in Barnet is an urgent necessity.

We can make a difference - suicide is preventable.

Significant reductions in suicide rates have been achieved in US healthcare systems following the introduction of a systematic approach to suicide prevention and quality improvement⁷. The first to apply these methods, the Henry Ford Health System in Detroit, achieved a 75% reduction in suicides in patients known to the service in the first four years, with no patient suicides in 2009⁸. By understanding the risk factors for suicide and mitigating these through targeted interventions, we *can* prevent deaths by suicide.

¹ Office for National Statistics (2020), [‘Suicides in England and Wales by local authority’](#),

² Office for National Statistics (2020), [‘Suicides in England and Wales: 2019 registrations’](#),

³ The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), [Annual Report: England, Northern Ireland, Scotland and Wales 2021](#), University of Manchester

⁴ Office for National Statistics (2020), [‘Coronavirus and loneliness, Great Britain: 3 April to 3 May 2020’](#)

⁵ Office for National Statistics (2021), [‘Employment in the UK: May 2021’](#),

⁶ Barr B, Taylor-Robinson D, Scott-Samuel S et al. (2012), [‘Suicides associated with the 2008-10 economic recession in England: time trend analysis’](#), BMJ, Volume 345, e5142

⁷ Labouliere C, Vasan P, Kramer A, et al (2019), [‘Zero Suicide - A model for reducing suicide in United States behavioral healthcare’](#), Suicidolog, Volume 23, Issue 1, pages 22 to 30

⁸ Covington D, Hogan M (2019), [‘Zero Suicide: The Dogged Pursuit of Perfection in Health Care’](#), Psychiatric Times, Volume 36, Issue 1

We need to act together - suicide prevention is everyone's business.

Suicide is a complex behaviour with no single explanation or cause. Risk factors for suicide can occur at the individual, community, and societal level⁹. Most people who lose their lives to suicide in England have no prior contact with health services – only 27% of suicides in the UK in 2008 to 2018 were in people under mental health care, and the rate of suicide in this group has been falling since 2011³. Excellent mental health care is important, but to reach that majority with no service contact, suicide and self-harm prevention must be embedded across our community. The myriad risk factors mean that in order to successfully prevent deaths from suicide, it is critical that we work in wide-ranging partnerships, across all our communities, to systematically improve the lives and wellbeing of everyone that lives, works, and studies in Barnet.

Our ambition is to create a practical, achievable, and effective suicide prevention strategy, that uses the resources available to the multi-agency Barnet Suicide Prevention Partnership (BSPP) to have the greatest impact. We believe that through the collective actions of the Partners we can achieve the objectives set in this strategy. We will move Barnet closer to each aim, and each year the number of Barnet residents lost to suicide will fall.

⁹ Samaritans (2017), ['Socioeconomic disadvantage and suicidal behaviour'](#), March 2017

Our Intention

Every year, the number of Barnet residents lost to suicide falls.

Our Principles

This strategy was developed with the multi-agency Barnet Suicide Prevention Partnership (BSPP) on the following principles:

- A local strategy that takes a whole-system approach and builds on regional and national programmes and policy.
- Multi-agency design, with co-produced solutions that are insight-led and evidence-informed.
- Shared implementation of a strategy that is responsive and adaptive year on year.

The evidence underpinning the development of this strategy is summarised in the Appendix.

Our Commitment to Improvement

Our Action Plan 2021-2023 was collectively agreed by the multi-agency Barnet Suicide Prevention Partnership (BSPP) in June 2021. We believe it is practical, achievable, and effective. To ensure that over the lifetime of this strategy our actions remain focussed yet responsive to emerging insights, we intend to collectively review our priorities, cross-cutting concerns of notable focus, and actions after the first two years, in order to develop a new biennial action plan for 2023-2025. Some objectives have also built in responsiveness to emerging insight so we can make course corrections in-year.

Our Structure – Barnet’s Suicide Prevention Framework

The Barnet Suicide Prevention Framework was devised specifically for this strategy as a structure to design and evaluate Barnet’s longer-term suicide prevention work. This approach was agreed by the BSPP in November 2020. Our framework draws on the wide range of national and regional guidance on suicide prevention; notably the National Suicide Prevention Strategy seven key areas, NICE Suicide Prevention Quality Standard [QS189] and Guideline [NG105] and the London Suicide Prevention Framework 9 pillars (Appendix – policy context).

Figure 1: Barnet Suicide Prevention Framework

Theme	Foundation for action		Prevention of suicide and self-harm				Postvention	
Area for action	Insights from data, research, and people with lived experience	Leadership and collaboration	Awareness	Interventions*	Services & Support	Wider determinants of mental health and wellbeing	Bereavement support	Community Response
Cross-cutting concerns	1. Each area should address high-risk groups 2. Each area should consider the need for tailored approaches for specific groups 3. Each area should mitigate the impact of high-risk distressing life events							

**In this strategy, interventions are actions which delay or disrupt suicidal thoughts or actions; for example, reducing access to means, increasing the opportunity or capacity for human intervention, and providing opportunities for help seeking.*

The Barnet Suicide Prevention Framework (figure 1) organises our whole-system suicide and self-harm prevention response under three themes: our foundation for action, prevention, and postvention activities. Under these themes we have identified eight areas within which we can act to improve our prevention efforts. Within each area, this strategy defines one aim and several objectives that we will strive to achieve over the four-year duration of the strategy. Our framework is action-oriented, making a clear distinction between the area within which we are striving for improvements (e.g. awareness), and the actions (e.g. campaigns, education, training) we will take to achieve our objectives.

Our Cross-Cutting Concerns

Our cross-cutting concerns reflect the priorities identified in the national suicide prevention strategy and from local insights. These concerns require action within all eight strategic areas to adequately reduce the risk posed to these groups or by these life events.

The national strategy identified a large number of groups at heightened risk. The BSPP agreed to align our collective effort on achieving improvements for a more focussed number for our first two-year action plan. These are shown in the table below in bold italics as cross-cutting concerns of notable focus. Our concerns of notable focus will be reviewed for the second two-year action plan to ensure our activities remain responsive to emerging insights and the changing suicide and self-harm prevention landscape.

Cross-Cutting Concerns [CC] for Barnet Suicide Prevention Strategy 2021-2025 <i>Cross-Cutting Concerns of Notable Focus for Action Plan 2021-2023</i>		
CC1: Each area should address these high-risk groups:	CC2: Each area should consider the need for a tailored approach in these specific groups:	CC3: Each area should mitigate the impact of high-risk distressing life events**
<ul style="list-style-type: none"> • <i>Young and middle-aged men.</i> • <i>People with a history of self-harm.</i> • <i>People identified locally as potentially at increased risk, e.g. Eastern European migrants.</i> • <i>People who misuse drugs or alcohol.</i> • <i>People in the care of mental health services.</i> • <i>People in contact with the criminal justice system.</i> • <i>People with long term health problems.</i> • <i>Older adults.</i> 	<ul style="list-style-type: none"> • <i>Children and young people.</i> • <i>People with a family history of suicide.</i> • <i>People with autism and learning difficulties.</i> • <i>Black and other ethnic groups.</i> • <i>People who identify as LGBTQIA+.</i> • <i>Veterans;</i> • <i>Asylum seekers.</i> • <i>Survivors of trauma, abuse or violence.</i> 	<ul style="list-style-type: none"> • <i>Economic wellbeing e.g. redundancy, debt, unemployment, unsecure accommodation / homelessness.</i> • <i>Social wellbeing e.g. people who are living alone, socially isolated, or excluded, and young people impacted by social media.</i> • <i>Emotional wellbeing e.g. family conflict or breakdown, relationship breakdown or divorce.</i> • <i>Psychological wellbeing e.g. bereavement (particularly by suicide), bullying, family mental health problems, perinatal mental health.</i>

*****High-risk distressing life events are those where there is evidence for an increased risk of suicidal thoughts or behaviour in people following that life event.***

Our Suicide Prevention Strategy 2021-2025 and Action Plan 2021-2023

Key to Lead Teams

PH Adults	Barnet Public Health Adults & Healthcare	NCL SP	North Central London Suicide Prevention Strategy Group
PH CYP	Barnet Public Health Children & Young Persons	NCL D&I	NCL Suicide Prevention Data & Insights Subgroup
BEHMHT	Barnet, Enfield, Haringey Mental Health Trust	NCL SaS	NCL Suicide Prevention Support After Suicide Subgroup
NCL CCG	NCL Clinical Commissioning Group		

Theme: Foundation for action	Area for action	Insights from data, research, and people with lived experience Aim: Enhanced insights on every suicide that occurs in the borough to inform future prevention work, using both qualitative and quantitative information.																																			
	Our current position	<p>BARNET The Barnet Suicide Prevention Partnership (BSPP) has produced annual Suicide Prevention Action Plans since 2014, informed by local and national insights. Data on deaths by suicide confirmed following a coroner’s inquest are provided by the Office for National Statistics, however, these can include a time lag of months to years. Partners of the BSPP also contribute to local insights – for example, Middlesex University is currently undertaking a review of safeguarding cases involving suicidal ideation and intent. People with lived experience are represented in the Barnet Suicide Prevention Partnership and provide qualitative insights for our prevention work– but we can and should do more to ensure that our actions are informed by the experiences of people who have encountered suicide.</p> <p>NORTH CENTRAL LONDON The North Central London (NCL) Suicide Prevention Strategy Group was formed in 2021. A data and insights sub-group was also formed in 2021, with the aim of improving the completeness and local response to data in the Thrive London Suicide Prevention Information Sharing Hub.</p> <p>LONDON The Thrive London Suicide Prevention Information Sharing Hub is a Real Time Surveillance System (RTS) launched in 2020. The RTS Hub provides data on local suspected suicides uploaded by the Metropolitan Police Service and NHS Mental Health Trusts and shared with key partner institutions. The Thrive London Hub presents new opportunities to quickly identify and respond to emerging trends, as well as implement regional learnings on a local level.</p>																																			
	What we want to achieve	Strategic Objectives 2021-2025 How we will move towards our aim	Biennial Action Plan <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #e1eef6;">Strategic Actions 2021-2023</th> <th style="background-color: #e1eef6;">Action Outcome Measures</th> <th style="background-color: #e1eef6;">Lead Team</th> <th style="background-color: #e1eef6;">Review</th> </tr> <tr> <th style="background-color: #e1eef6;">How we will progress our objectives</th> <th style="background-color: #e1eef6;">How we will measure our efforts</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td rowspan="3">1. Improve the processes for identifying local emerging trends and incorporating sector learnings into the Barnet Suicide Prevention Partnership’s activities.</td> <td>○ A standardised process has for monitoring and acting upon Real Time Surveillance (RTS) has been agreed by the NCL Data and Insights subgroup and implemented locally.</td> <td>NCL D&I</td> <td>2022</td> </tr> <tr> <td>○ A process for incorporating NCL Data & Insights Subgroup learnings into Barnet suicide prevention activities has been established.</td> <td>PH Adults</td> <td>2022</td> </tr> <tr> <td>○ An agreed process for learning to be shared has been established.</td> <td>PH CYP</td> <td>2021</td> </tr> <tr> <td rowspan="3">2. Investigate signals indicating local groups that may be at higher risk. [CC1, CC3].</td> <td>○ Learnings from Drug Related Death Panels are shared with the BSPP regularly and recommendations for action are incorporated into Action Plan 2023-25.</td> <td>PH Adults</td> <td>2022</td> </tr> <tr> <td>○ NCL RTS insights report is shared with the data and insights group.</td> <td>NCL D&I</td> <td>2021</td> </tr> <tr> <td>○ The annual BSPP progress report incorporates data on local rates of self-harm.</td> <td>NCL CCG</td> <td>2022</td> </tr> <tr> <td>f) Work as part of the North Central London Suicide Prevention Group to understand how across the sector we can work to best to prevent suicides in the context of the criminal justice system.</td> <td>○ Recommendations for local action from the NCL Suicide Prevention Group are incorporated into our Action Plan 2023-25.</td> <td>NCL SP</td> <td>2023</td> </tr> </tbody> </table>			Strategic Actions 2021-2023	Action Outcome Measures	Lead Team	Review	How we will progress our objectives	How we will measure our efforts			1. Improve the processes for identifying local emerging trends and incorporating sector learnings into the Barnet Suicide Prevention Partnership’s activities.	○ A standardised process has for monitoring and acting upon Real Time Surveillance (RTS) has been agreed by the NCL Data and Insights subgroup and implemented locally.	NCL D&I	2022	○ A process for incorporating NCL Data & Insights Subgroup learnings into Barnet suicide prevention activities has been established.	PH Adults	2022	○ An agreed process for learning to be shared has been established.	PH CYP	2021	2. Investigate signals indicating local groups that may be at higher risk. [CC1, CC3].	○ Learnings from Drug Related Death Panels are shared with the BSPP regularly and recommendations for action are incorporated into Action Plan 2023-25.	PH Adults	2022	○ NCL RTS insights report is shared with the data and insights group.	NCL D&I	2021	○ The annual BSPP progress report incorporates data on local rates of self-harm.	NCL CCG	2022	f) Work as part of the North Central London Suicide Prevention Group to understand how across the sector we can work to best to prevent suicides in the context of the criminal justice system.	○ Recommendations for local action from the NCL Suicide Prevention Group are incorporated into our Action Plan 2023-25.	NCL SP	2023
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Area for action		Leadership and collaboration					
		Aim: Co-ownership of strategic success					
Theme: Foundation for action	Our current position	<p>BARNET Suicide prevention work within Barnet is coordinated through the multi-agency Barnet Suicide Prevention Partnership (BSPP), who have produced and reviewed our annual suicide prevention action plans since 2014. The group brings together a range of local partners including representatives from the Clinical Commissioning Group, Police, NHS, Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), Children's and Adult Social Care, Education and Family services, schools and universities, and organisations in the Voluntary and Community Sector.</p> <p>Partners are committed to suicide prevention. In Barnet Council, suicide prevention is a key objective in the Barnet Joint Health and Wellbeing Strategy 2021-2025 and this strategy is reviewed by Barnet's Health and Wellbeing Board and Health Oversight Scrutiny Committee. Other Partners, such as Middlesex University and CommUNITY Barnet, are championing suicide prevention with commitment from the senior leadership team and provision of wellbeing services.</p> <p>NORTH CENTRAL LONDON North Central London (NCL) Sustainability and Transformation Partnership (STP) has successfully bid for NHS England Suicide Prevention Programme Wave 3 funding. Barnet is hosting the Programme Manager for this work; details on the programme are included in the Appendix (policy context).</p> <p>LONDON Barnet is a member of the Thrive LONDON Suicide Prevention Partnership, which aims to improve the mental health of Londoners and has a zero-suicide ambition for London.</p> <p>NICE Suicide Prevention Quality Standard [QS189] Statement 1: "Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures."</p>					
	What we want to achieve	<p>Strategic Objectives 2021-2025 How we will move towards our aim</p>	<p>Strategic Actions 2021-2023 How we will progress our objectives</p>	<p>Biennial Action Plan</p> <p>Action Outcome Measures How we will measure our efforts</p>			<p>Lead Team</p>
	<p>3. Partners of the Barnet Suicide Prevention Partnership (BSPP), will co-produce, co-own, and co-lead the delivery of this strategy.</p>	<p>g) Partners will collaborate to deliver their committed actions for 2021-23, and we agree new priorities and actions in 2023.</p> <p>h) People with lived experience are equal partners in the BSPP and represented in all meetings and workstreams.</p> <p>i) Partners will advocate for suicide and self-harm prevention within their organisations</p>	<p>o Updated Terms of Reference for the BSPP have been agreed.</p> <p>o BSPP partners will report annually on successful completion of actions and make recommendations for adjustments.</p> <p>o A biennial Action Plan is agreed for 2023-25.</p> <p>o Meet our aim for more than 90% of BSPP meetings and workstreams to have people with lived experience represented.</p> <p>o Partners have a named suicide and self-harm prevention champion.</p> <p>o Barnet council has an exemplar corporate approach with enhanced policies, procedures and practices to addressing risk of suicide and self-harm and supporting those affected by suicide.</p>	<p>All partners</p> <p>PH Adults</p> <p>All partners</p> <p>Barnet Council</p>	<p>2021</p> <p>2022</p> <p>2023</p> <p>2023</p> <p>2023</p> <p>2022</p>		
	<p>4. BSPP strategic actions will contribute to and enhance wider suicide and self-harm prevention activities.</p>	<p>j) Ensure the actions within this strategy are aligned with North Central London (NCL) and London-wide suicide prevention activities.</p>	<p>o Barnet Public Health will actively participate in the North Central London (NCL) Suicide Prevention Group and Thrive London Suicide Prevention Group.</p>	<p>Selected partners</p>	<p>2023</p>		

Area for action		Awareness				
Aim: Everyone that lives, studies, or works in Barnet knows where to find help if they are thinking about suicide or are concerned about someone else.						
Our current position	<p>BARNET Barnet Council has mapped the available suicide prevention training and uptake in the Borough, including face to face Making Every Contact Count (MECC) training. Barnet Public Health raised awareness of suicide and self-harm prevention at events and workshops throughout 2020, including for World Mental Health Day and World Suicide Prevention Day. During COVID-19, there was a shift to raising awareness and promoting online resources such as Zero Suicide Alliance's (ZSA) online suicide prevention training.</p> <p>NORTH CENTRAL LONDON North Central London Clinical Commission Group has been leading on the expansion of community-based education in suicide awareness across the sector. During the pandemic, in-person training was suspended, and the focus has shifted to raising awareness of online digital mental health support services such as Kooth, Good Thinking and Able Futures.</p> <p>LONDON Papyrus have been awarded funding to deliver suicide awareness education across London to faith-based charities, schools, colleges and universities.</p>					
What we want to achieve	Strategic Objectives 2021-2025 How we will move towards our aim	Strategic Actions 2021-2023 How we will progress our objectives	Biennial Action Plan How we will measure our efforts			
			Action Outcome Measures	Lead Team	Review	
Theme: Prevention of Suicide and Self-Harm	5. Raise general awareness and reduce stigma around suicide and self-harm so that everyone feels able to start conversations about mental wellbeing, self-harm, and suicide.	a) All partners of the BSPP will internally promote the Zero Suicide Alliance (ZSA) online training .	o Partners have established baseline engagement with ZSA online training in their organisation and agreed a trajectory for an increase in uptake over the remainder of this strategy.	All Partners	2022	
		b) Promote suicide prevention training for all primary care staff.	o ZSA or other suicide prevention training has been promoted or offered to all primary care staff.	NCL CCG	2023	
		c) Raise awareness of suicide and self-harm in schools.	o Report the proportion of Barnet schools taking part in the Resilient Schools programme, with an aim to increase the level from 50% to 75% by the end of academic year 2021/22.	PH CYP	2022	
			o All Barnet schools have a Youth Mental Health First Aider	PH CYP	2022	
			o A localised self-harm prevention toolkit based on the Essex self-harm prevention toolkit has been produced and shared with all schools.	PH CYP	2022	
			o Emotional health support by school nurses is promoted via PSHE and assemblies in all schools.	PH CYP	2022	
	d) Raise awareness of suicide and self-harm in further education and higher education settings.	o All further education settings have a self-harm and suicide prevention document within their safeguarding policy	PH CYP	2022		
		o All further education settings have a suicide prevention champion.	NCL SP	2022		
	6. Increase community knowledge of the first place to turn to access suicide and self-harm services in Barnet and make this information easier to find.	e) Maintain an up-to-date, brief resource that clearly signposts the first place to turn to in Barnet for self-harm and suicide prevention services.	o Maintain an online 'one-page' resource for adults signposting to local self-harm, suicide prevention, and crisis support.	NCL CCG / PH Adults	2021	
			o Refresh the Making Every Contact Count (MECC) CYP mental health action card and share with partners. o MECC card is reviewed and updated every six months along with all public health cards.	PH CYP	2021	
		f) Develop an engagement campaign that aims to reduce stigma around self-harm and suicide and raise awareness in Barnet of the first place to turn to seek help.	o Awareness of Barnet's brief resources for local suicide prevention support (action 'e', above). o Report on the reach and engagement of the campaign with Barnet Residents.	NCL CCG / PH Adults	2022	
			o Pilot an expansion of the Resilient Schools programme to include awareness-raising with parents, including promotion of the ZSA online training.	PH CYP	2023	
g) Engage with children and young people to understand how well awareness-raising is performed and how it can be improved across school years.		o Evaluate the pilot Peer Champion Scheme and use feedback to guide future initiatives.	PH CYP	2023		
h) Engage with local LGBTQIA+ groups to understand how we can better meet the needs of local LGBTQIA+ communities.		o Recommendations produced through engagement are included in Action Plan 2023-25.	PH Adults	2023		
i) Produce culturally competent communications specifically for high-risk groups to highlight local self-harm and suicide prevention service.	o Development of tailored communications materials for each group in CC1 and CC2.	All Partners	2023			

Area for action		Interventions*			
		Aim: Provide timely and accessible information at potential trigger events.			
Our current position	<p>*In this strategy, interventions are any actions which delay or disrupt self-harm or suicidal thoughts or actions.</p> <p>BARNET A recent review of local data has not identified any local frequently used locations.</p> <p>NORTH CENTRAL LONDON Barnet, Enfield, Haringey Mental Health Trust (BEHMHT) have unmanaged risk forums in all boroughs to review and support clinicians working with cases where suicide risk remains high. BEHMHT work with the British Transport Police to create suicide prevention plans, identify and work with those at high risk of suicide. A trial of pop-up reminders on GP computer systems that alerts doctors if a patient has previously self-harmed or attempted suicide began in 2019.</p> <p>LONDON Thrive London's 'reducing access to medications as a means' project aims to help community clinicians and primary care staff reduce medication as a means of suicide for those people identified as at risk. Suicide prevention policies are currently being developed by the Metropolitan Police and British Transport Police. Nationally, there is ongoing work with technology and media companies on responsible reporting and social media, including interventions around online posts that encourage self-harm or suicide.</p>				
	Biennial Action Plan				
What we want to achieve	Strategic Objectives 2021-2025 How we will move towards our aim	Strategic Actions 2021-2023 How we will progress our objectives	Action Outcome Measures How we will measure our efforts	Lead Team	Review
	7. Support regional and sector-led programmes aiming to: <ul style="list-style-type: none"> ○ reduce access to means, ○ identify high frequency locations, ○ prevent and responds to clusters. 	j) Collaborate with Thrive London and NCL Suicide Prevention Groups to monitor data on geography and means, identify emerging areas of risk, and initiate a co-ordinated response.	○ Participation in NCL Suicide Prevention Strategy Group and Thrive London Suicide prevention group.	PH Adults	2023
		k) Collaborate as part of North Central London Suicide Prevention group to create a media plan for monitoring and supporting local media to report responsibly on self-harm and suicide.	○ Production of a NCL Cluster Response Plan.	NCL D&I	2023
			○ Review of current media monitoring across the NCL boroughs and the production of a joint media plan for a systematic, standardised approach.	NCL SP	2023
	8. Increase individual capacity and confidence for bystander intervention in Barnet's communities by teaching suicide intervention skills.	l) Prioritise suicide intervention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.	○ Map of organisations in Barnet that support high risk groups or support people around high-risk distressing life events, for example Citizens Advice Bureau, Job Centre Plus, Department for Work and Pensions, Homeless Action Barnet, faith groups, community organisations.	PH Adults	2022
			○ The organisations identified above have been engaged and encouraged to provide regular self-harm and suicide prevention training for employees and community leaders.	PH Adults	2023
			○ Audit of the number of schools that have added the suicide prevention document template co-produced with schools to their safeguarding policy.	PH CYP	2022
			○ All staff that have contact with young people in schools, colleges, and universities receive an annual update on the services and support available for their students, including promotion of the ZSA online training.	PH CYP	2022
			○ Perinatal Health coaches attend suicide prevention training and raise awareness as appropriate with clients.	PH CYP	2022
			○ Co-produced 'guidelines for training' has been shared with the BSPP.	NCL SP	2023
9. Increase the likelihood of early help seeking by decreasing the time from people experiencing high-risk events to receiving signposting information to local self-harm and suicide services.	m) Co-design 'guidelines for accessible training', to ensure that all locally promoted training takes account of approaches needed for specific groups, such as people with autism.	n) Include mental health, self-harm and suicide prevention information with written notifications that may negatively impact on mental wellbeing.	○ Signposting is included on council materials such as financial abuse materials, penalty notices, and council tax bills.	Barnet Council	2023
			○ Signposting information is included in Homeless Action Barnet assessments next to mental health and suicide questions.	Homeless Action Barnet	2021
			○ Signposting is sent to all residents who become unemployed, and after six months unemployment.	BOOST	2022
			○ Signposting information is sent to all people living in Barnet in a building that meets RICS criteria for an EWS1 assessment.	Barnet Homes / Council	2022

Area for action		Services and Support			
		Aim: Ensure that services are available, integrated, accessible and appropriate for all members of the Barnet community.			
Our current position	BARNET	<p>Local service mapping has been undertaken of the support available for further education, crisis pathways, and emergency department pathways. There are many mental health support services available to Barnet residents, from wellbeing support through The Barnet Wellbeing Hub, to crisis support such as the Barnet Crisis Café, Crisis Teams, and 24/7 CAMHS crisis line. Barnet, Enfield and Haringey Mental Health NHS Trust provides Tier 3 and 4 commissioned services. Several services exist for Barnet residents with thoughts of suicide or self-harm, such as Maytree which provides residential respite care for people who are feeling suicidal, and a drop-in service provided by North London Samaritans. The Barnet Community Mental Health Service transformation programme is underway, focussing on improving access, patient experience, patient outcomes and tackling inequalities in mental health. Work includes mental health needs assessments, service mapping, and a series of engagement events with the aim of co-producing an equalities action plan.</p> <p>In 2018 Barnet undertook a thematic review of death by suicide in children and young people (CYP). The review took an overview of strategy, services, and user experiences to identify and analyse areas of good practice and areas for improvement. The recommendations from this review have been integrated with this strategy. The Barnet Multi-Agency Safeguarding Hub (MASH) for Children and Vulnerable Adults MASH are multi-agency partnerships that share key information about children, families, and vulnerable adults in order to make safe and timely decisions about the help children and vulnerable adults need. Barnet has the CYP continuum of help and support, a guidance document to support professionals working with children and young people to consider their needs and any risks to welfare in the context of the range of support available. The Resilient Schools Programme is an early intervention and preventative approach based on the THRIVE concept – looking at the two first quadrants of ‘coping’ and ‘getting some help’. The programme is being developed as a whole school approach to mental health and resilience by providing training to staff, parents and pupils, to raise awareness and provide coping strategies, to commission providers, and to use ‘schools champions’ to build a bank of knowledge, resources and shared learning to support vulnerable members of school and the wider community. Barnet CYP team is undertaking a series of focus groups with children and young people to understand how the universal CYP offer could be improved.</p>			
	NORTH CENTRAL LONDON	<p>North Central London Clinical Commissioning Group (CCG) are leading on projects to improve responses to self-harm, such as the expansion of the Brandon Centre to Barnet & Enfield, and a pilot of peer-support for young people who self-harm who are at the threshold for statutory mental health services.</p>			
LONDON	<p>Online digital mental health support is available to Barnet residents through several platforms such as Kooth, Good Thinking and Able Futures.</p>				
What we want to achieve	Strategic Objectives 2021-2025 How we will move towards our aim	Biennial Action Plan			
		Strategic Actions 2021-2023 How we will progress our objectives	Action Outcome Measures How we will measure our efforts	Lead Team	Review
	10. The Barnet Suicide Prevention Partnership has a complete understanding of all local services and support for self-harm and suicide, and uses this knowledge to quickly identify gaps in services in response to local insights.	o) Collaborate with BSPP partners, VCFS organisations, and the Barnet Integrated Care Partnership to understand service provision and identify gaps.	o Care pathway map and gap analysis of the support for individuals and their families following a suicide attempt.	NCL SP	2023
			o Care pathway map and gap analysis of the support for individuals and their families following self-harm.	NCL SP	2023
			o Work with schools and school nurses to build preventative support for CYP at transition from mainstream schools – such as transition from tier 4 CAMHS, home schooling, or post-exclusion.	PH CYP	2023
		p) Understand the local resilience support available to professionals whose work involves people with suicidal thoughts or behaviours.	o Map of the resilience support for first responders in Barnet, including police, fire, healthcare staff, and park rangers.	PH Adults	2023
		q) Understand whether the uptake of early help services reflects the groups known to be at an increased risk of suicide.	o Monitor the use of the online counselling and wellbeing services commissioned for CYP (Kooth) and report the proportion of users by gender to guide awareness-raising activity in schools.	PH CYP	2022
		r) Engage with children and young people to co-produce ideas for service improvement.	o Share learning from CYP focus groups for service improvement for the universal CYP offer with the BSPP.	PH CYP	2021
		s) All partners engage with CC1 and CC2 groups that they support to identify and mitigate barriers to access and to improve service provision.	o Partners have worked during the first year to improve accessibility for people with high functioning autism, and people with learning disabilities.	All partners	2023
	11. Use a quality improvement approach to improve local services and pathways, involving service users and people with lived experience as equal partners in improvement.		o The results of the joint commissioning unit mental health inequalities survey have been shared with Partners.	NCL CCG	2021
		t) Provide community pathways to access self-harm and suicide support e.g. self-referral, voluntary, community, and faith organisations.	o Community referral pathways to self-harm and suicide prevention support services for young men have been developed for NCL boroughs.	NCL SP	2023
			o Community referral pathways to suicide prevention services for people who are homeless have been developed.	PH Adults / NCL SP	2023
	u) Review how primary care is informed of vulnerable persons and how support is activated e.g. notification by the Public Protection Unit/Liaison Team	o Review has been shared with BSPP and recommendations are incorporated into the Action Plan 2023-25.	NCL CCG	2023	
	v) Review how people seen by the crisis team subsequently engage with other services.	o Review has been shared with BSPP and recommendations are incorporated into the Action Plan 2023-25.	NCL CCG	2023	

Area for action		Mental health and wellbeing																							
		Aim: Support and improve the mental wellbeing of Barnet residents																							
Theme: Prevention of Suicide and Self-Harm	Our current position	<p>Improving our offer for general wellbeing support, and preventative mental health services should help to prevent people reaching crisis point.</p> <p>BARNET The Barnet Wellbeing Service provides mental health and wellbeing support to residents, connecting residents with community organisations to improve their wellbeing and prevent them from escalating to the point of crisis. Middlesex University is working to promote mental wellbeing in students by promoting healthy lifestyles, providing financial support, societies and engagement, and wellbeing activities in addition to clinical services and therapeutic support. Ways to improve the mental wellbeing support for overseas students is currently being explored.</p> <p>The Barnet Integrated Care Partnership (ICP) brings together all NHS organisations working in the borough, the council, HealthWatch and Voluntary, Community and Faith Sector (VCFS) representatives to provide better health care to Barnet residents. Barnet's ICP has a focus on expanding housing and employment opportunities for people with learning disabilities and autism and is developing a new community model for care and support for adults with Severe Mental Illness (SMI). The new community-based offer will improve holistic care for residents with SMI including physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. The new offer will have prevention embedded throughout, apply a population health management approach, and proactively focus on reducing health inequalities. As part of this, Core Community Mental Health Teams will be redesigned and expanded to move towards new multidisciplinary services across health and social care aligned with primary care networks to support people who have the most complex needs.</p> <p>NORTH CENTRAL LONDON Work is underway to address inequalities in mental health, engaging with racialised communities to improve mental health services and co-produce a mental health inequalities action plan. For example, this workstream includes addressing physical health needs of those at risk from COVID such as people on SMI registers from BAME communities, improving psychological support for racialised communities with culturally appropriate therapies, ensuring crisis prevention is accessible, developing the mental health community model, and increasing capacity for community support to residents with social prescribers, suicide prevention and mental health first aiders. North Central London will focus on improving access, people's experience of care, and treatment outcomes.</p> <p>LONDON Thrive London is an initiative by the Greater London Authority aiming to improve Londoners' mental health and wellbeing. Thrive London and partners work to reduce mental health stigma, support community actions, raise awareness of mental health, support children and young people, improve services, foster a healthy, happy workforce, and have a zero-suicide ambition. Projects supported include training mental health first aiders, supporting the Healthy Schools London programme, problem solving booths, and the London Healthy Workplace Charter. The GLA is currently consulting on the COVID-19 recovery plan for mental health and wellbeing with the mission is that 'By 2025, London will have a quarter of a million wellbeing ambassadors, supporting Londoners where they live, work and play.'</p>																							
	What we want to achieve	<p>Strategic Objectives 2021-2025 How we will move towards our aim</p> <p>12. Partners in the Barnet Suicide Prevention Partnership will lead by example and provide comprehensive mental wellbeing support for their employees and/or volunteers.</p> <p>13. The community mental health transformation programme should address risk factors for self-harm and suicide.</p> <p>14. Gain new insights on local priorities by bringing together data on self-harm and suicide and data on wider determinants of mental wellbeing and use these to shape future actions.</p>	<p>Biennial Action Plan</p> <table border="1"> <thead> <tr> <th>Strategic Actions 2021-2023 How we will progress our objectives</th> <th>Action Outcome Measures How we will measure our efforts</th> <th>Lead Team</th> <th>Review</th> </tr> </thead> <tbody> <tr> <td>w) Partners will review their existing mental wellbeing provision and address any gaps in their in-house provision.</td> <td>o All partners have a mental wellbeing offer for their staff or volunteers.</td> <td>All partners</td> <td>2022</td> </tr> <tr> <td>x) Partners will train and promote mental health first aiders within their organisations.</td> <td>o All partners have mental health first aiders within their organisation proportionate to the size of the organisation.</td> <td>All partners</td> <td>2022</td> </tr> <tr> <td>y) Improve digital resilience in children and young people.</td> <td>o Co-produce and promote a film on digital resilience with and for Barnet's young people.</td> <td>PH CYP</td> <td>2023</td> </tr> <tr> <td>z) Collect and analyse local data on wider determinants of mental wellbeing such as employment security, student demographics, social isolation, and housing quality with self-harm and suicide data.</td> <td>o A report outlining the trajectory of local risk factors is shared with the BSPP and insights are incorporated into the prioritisation and action plan setting for 2023-2025.</td> <td>PH Adults / Insights</td> <td>2022</td> </tr> </tbody> </table>				Strategic Actions 2021-2023 How we will progress our objectives	Action Outcome Measures How we will measure our efforts	Lead Team	Review	w) Partners will review their existing mental wellbeing provision and address any gaps in their in-house provision.	o All partners have a mental wellbeing offer for their staff or volunteers.	All partners	2022	x) Partners will train and promote mental health first aiders within their organisations.	o All partners have mental health first aiders within their organisation proportionate to the size of the organisation.	All partners	2022	y) Improve digital resilience in children and young people.	o Co-produce and promote a film on digital resilience with and for Barnet's young people.	PH CYP	2023	z) Collect and analyse local data on wider determinants of mental wellbeing such as employment security, student demographics, social isolation, and housing quality with self-harm and suicide data.	o A report outlining the trajectory of local risk factors is shared with the BSPP and insights are incorporated into the prioritisation and action plan setting for 2023-2025.	PH Adults / Insights
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Area for action		Bereavement Support				
Area for action		Aim: Provide support to everyone that wants it after bereavement by suicide				
Theme: Postvention	Our current position	<p>NORTH CENTRAL LONDON Rethink Mental Illness, commissioned by NCL, launched a Support after Suicide service in October 2020. The Thrive LONDON Information Sharing Hub is used, with consent, to proactively reach out and connect those recently bereaved by suicide into the service. The service offers engagement with those bereaved by suicide, one-to-one emotional and practical support and advice, group-based support, and peer support where possible, both face-to-face and online.</p> <p>NICE Suicide Prevention Quality Standard [QS189] Statement 5: "People bereaved or affected by a suspected suicide are given information and offered tailored support".</p>				
	What we want to achieve	Strategic Objectives 2021-2025	Biennial Action Plan			
		How we will move towards our aim	Strategic Actions 2021-2023	Action Outcome Measures	Lead Team	Review
		How we will progress our objectives	How we will measure our efforts			
15. Increase the number of people supported by the NCL Support after Suicide Service.	a) Use the Thrive London Real Time Surveillance Hub to proactively identify and offer help from the NCL Support after Suicide service.	o Meet the target for all contacts identified on the Thrive London Hub to be offered support.	NCL SaS	2022		
	b) Raise awareness of the NCL Support after Suicide service in Barnet by ensuring service details are included in Barnet resources.	o The percentage of online and in-print council owned mental health resources that include details of the NCL Support after Suicide service.	NCL CCG / PH Adults	2023		
		o Liaise with the educational psychology service who support schools after suicide and update them on the current offer of services available in Barnet, including the NCL Support after Suicide service.	PH CYP	2022		

Area for action		Community Response				
Area for action		Aim: Ensure a co-ordinated local response of partners with every death by suicide.				
Theme: Postvention	Our current position	<p>BARNET The death of a child by suicide triggers a Serious Incident Review, with provision of support and resources, for example assembly and class materials to the school. 'Working with children in Barnet: The Education escalation policy' is a document that informs schools of the procedure to follow should a critical incident take place, and the support that the local authority will provide. Jami, a mental health service for the Jewish community, co-ordinates and leads the Emergency Response Initiative Consortium (ERIC). Partners have written a guide for Barnet schools to help them respond to sudden traumatic death and suicide and put in place actions to prevent suicide such as training and staff awareness and safeguarding in relation to suicide. ERIC trained First Responders can be mobilised by Jami to go into schools to support grieving students and staff.</p> <p>LONDON Thrive London are reviewing and improving the current mechanisms for identifying and responding to potential clusters across London.</p>				
	What we want to achieve	Strategic Objectives 2021-2025	Biennial Action Plan			
		How we will move towards our aim	Strategic Actions 2021-2023	Action Outcome Measures	Lead Team	Review
		How we will progress our objectives	How we will measure our efforts			
16. Support local organisations to respond sensitively following a death by suicide and support to individuals following a suicide.	c) Ensure that all secondary and further education settings in Barnet have a postvention plan.	o Engage with the educational psychology service to better understand how they work with schools after suicide and agree a process for sharing school-level plans with relevant partners to ensure sensitivity, particularly around the time of anniversaries and memorials.	PH CYP	2022		
	d) Set-up a Postvention Response to support public and private sector workplaces with postvention advice and resources.	o Scope options for a postvention response at a local and/or sector level e.g. resource pack, or postvention response team e.g. Emergency Response Initiative Consortium (ERIC) model , led by Jami, and share with BSPP.	PH Adults	2022		

APPENDIX

Strategy Development

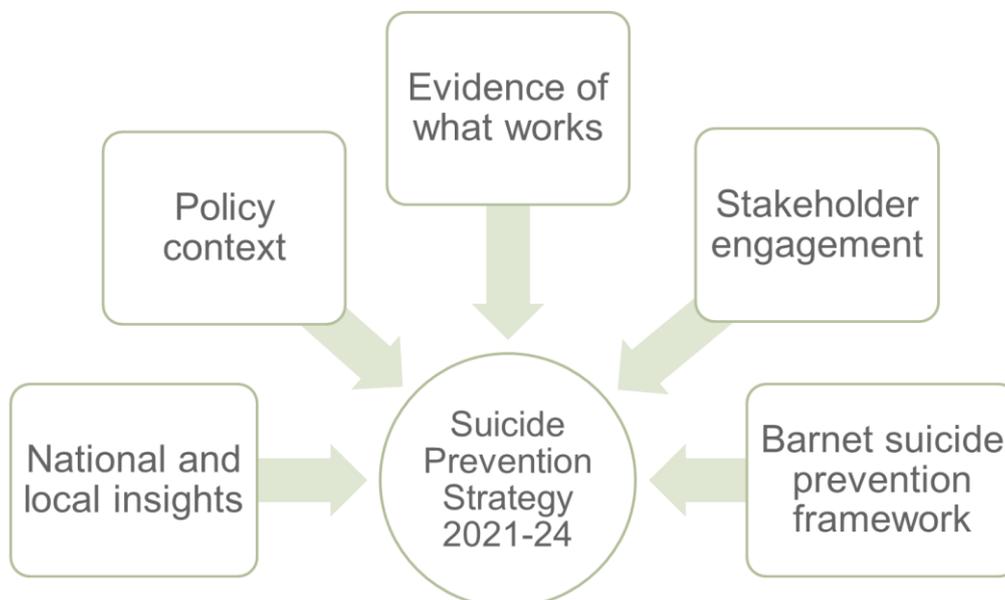
This strategy was co-produced with the multi-agency Barnet Suicide Prevention Partnership (BSPP) to be appropriate to the national and our local context, to be insight-led, informed by evidence of what works, and importantly to be practical, achievable, and effective.

The BSPP has worked together to prevent people dying by suicide since 2014, producing annual action plans and reporting to the Barnet Health Oversight Scrutiny Committee. The group comprises a [broad range of local partners](#) including representatives from the Barnet Clinical Commissioning Group, Police, NHS Health Trusts, Barnet Enfield and Haringey Mental Health Trust (BEHMHT), Children’s and Adult Social Care, and the Voluntary and Community Sector. The Barnet Suicide Prevention Strategy 2021-2025 provides an update to the BSPP Action Plan 2019-2020.

Development of this strategy followed four stages:

- Development of our Barnet Suicide Prevention Framework.
- Co-production of our aims and initial objective scoping through a workshop and consultation with the Barnet Suicide Prevention Partnership.
- Consolidation of objectives using national and local insights and evidence of what works.
- Joint priority setting and commitment to Action Plan 2021-23 through workshops and written consultation with the BSPP and wider stakeholders.

Figure 2 – Inputs to the Barnet Suicide Prevention Strategy



Policy Context

This strategy exists amongst an extensive backdrop of national and regional guidance, strategies, and action plans for preventing self-harm and suicide in the UK. Our strategy aligns with these national priorities, integrates with local strategies supporting mental health and wellbeing, and supports sector-level programmes aiming to prevent self-harm and suicide.

The National Institute for Health and Care Excellence (NICE) produces guidance and pathways to inform evidence-based practice. [NICE Guideline 105](#) and [NICE Quality Standard 189](#) include recommendations for local authorities relating to suicide prevention partnerships, strategies, and action plans which have been incorporated into this strategy.

Barnet's objective to reduce deaths by suicide in each year of the four years of this strategy is consistent with the national ambition set in the [Five Year Forward View for Mental Health \(2016\)](#) to reduce deaths by suicide nationally by 10% over five years from 2016/17 levels. The Five Year Forward View Implementation Plan includes a recommendation for all local authorities to develop multi-agency suicide prevention plans that address the areas for action outlined by the [Suicide Prevention Strategy for England \(2012\)](#), and accompanying progress reports ([2013](#), [2015](#), [2017](#), [2019](#)). The national strategy set two objectives:

- A reduction in the suicide rate in the general population in England.
- Better support for those bereaved or affected by suicide.

To achieve these objectives, there are seven key areas of action:

1. Reduce the risk of suicide in key high-risk groups.
2. Tailor approaches to improve mental health in specific population groups.
3. Reduce access to the means of suicide.
4. Provide better information and support to those bereaved or affected by suicide.
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Support research, data collection and monitoring.
7. Reduce rates of self-harm as a key indicator of suicide risk (added 2017).

The [London Mayor Health Inequalities Strategy \(2018\)](#) includes the objective (2.5) that 'Action is taken across London to prevent suicide, and all Londoners know where they can get help when they need it'. The Strategy includes a pledge to support a long-term vision for London as a 'zero-suicide city', with funding for Thrive London – an initiative to improve the mental health and wellbeing of all Londoners, and to prevent suicide. The [London-wide Suicide Prevention Framework, 2018](#), recommends the following as priority areas for London boroughs; reducing the risk in men, engaging BAME (black, Asian and minority ethnic) communities, bereavement support, preventing and responding to self-harm, mental health of children and young people, acute mental health care, supporting primary care, tackling high frequency locations, reducing isolation and loneliness, and media engagement. The London-wide Suicide Prevention Framework sets out Nine Pillars for prevention plans:

1. Background Framework
2. Leadership / Governance
3. Areas of high frequency, individuals at high risk, reducing access to means and promoting support
4. Training
5. Intervention and support
6. Suicide bereavement, postvention and the prevention of 'suicide clusters'
7. Evaluation measures
8. Sustainability and capacity building
9. Suicide Prevention, Mental Health and Wellness Promotion & Awareness

In March 2021, the Department of Health and Social Care announced the [COVID-19 Mental Health and Wellbeing Recovery Action Plan](#) for 2021 to 2022, to mitigate and respond to the impact of the COVID-19 pandemic on mental health, and prevent or support people at risk of self-harm or suicide. The recovery plan bolsters our local actions on wider determinants with national support to reduce inequalities and mitigate risk factors for self-harm and suicide.

Reducing deaths by suicide is a priority for the NHS. The [NHS Long Term Plan](#) committed to implementing a new Mental Health Safety Improvement Programme as well as rolling out suicide bereavement services across the country. The [Mental Health Crisis Care Concordat](#) is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together to make sure that people get the help they need when they are having a mental health crisis, focussing on increasing access to support before crisis, access to crisis care, improving care when in crisis, and supporting recovery after crisis. In 2018, the Secretary of State for Health and Social Care launched a zero-suicide ambition for mental health inpatients. The **Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) Zero Suicide Ambition Suicide Prevention, Learning and Support Strategy 2020** aims to achieve a 20% reduction in suspected suicides amongst patients under their care by the end of 2021, with a zero-suicide goal for all in-patients.

The North Central London Sustainability and Transformation Partnership (NCL) successfully bid for wave one and wave three funding from the [Suicide Prevention National Transformation Programme](#). The Barnet Suicide Prevention Strategy 2021-25 works synergistically with the planned activities of the **North Central London Suicide Prevention Programme**. North Central London utilised wave one funding to introduce a Support after Suicide Service in October 2020. The NCL programme plan for wave three includes several elements:

- a. Programme management (hosted by Barnet) and establishment of an NCL Suicide Prevention Strategy Group.
- b. Gap analysis and quality improvement of responses to self-harm.
- c. Development of specific service improvements to address identified gaps including support for young adults (18-25), other non-statutory services with a focus on middle-aged men, and a specific trial of psychologically informed peer support following self-harm.
- d. Expansion of community-based training in suicide awareness.

Prevention of suicide and self-harm and the improvement of mental health and wellbeing is a priority in Barnet. The implementation of this strategy is an objective of **The Barnet Joint Health and Wellbeing Strategy 2021-2014**. The [Barnet Corporate Plan 2021-2025](#) priority of 'Healthy' has improving mental health and wellbeing as a key outcome, work which is supported by the North Central London [Integrated Care System \(ICS\)](#) community mental health transformation programme.

Insights

Local and Regional

This section provides a summary of local and national trends on deaths by suicide. It is important to note that in May 2019, the standard of proof for a suicide conclusion at inquest changed from the criminal standard (so that you are sure) to the civil standard (more likely than not). The significance of this in comparing data before and after 2019 has not yet been elucidated.

The four-year average annual number of suicides for Barnet residents was 22 in 2019 (for 4-year period 2016-19). In 2019, the median registration delay for suicides in Barnet was 149 days, down from 162 days in 2018. The most recent Office of National Statistics (ONS) data available (2017-19) for deaths by suicide registered in Barnet shows a count of 66 deaths and an age standardised rate of 6.7 deaths per 100,000 persons. This rate is:

- Significantly lower than England (10.1 per 100,000).
- The 6th lowest rate in London.
- Not significantly different to North Central London boroughs (except Camden) with whom the borough shares mental health services.

Suicide rates in North Central London Boroughs, London and England, 2017-2019						
Area	All		Men		Women	
	Rate*	Count**	Rate*	Count**	Rate*	Count**
Enfield	5.9 (4.3-7.8)	50	7.9 (5.3-11.3)	32	4.1 (2.4-6.5)	18
Barnet	6.7 (5.2-8.6)	66	9.7 (7.1-13.0)	48	3.8 (2.2-6.0)	18
Haringey	9.6 (7.2-12.4)	65	14.0 (9.7-19.3)	46	5.6 (3.3-8.8)	19
Islington	10.4 (7.6-13.9)	54	15.0 (10.0-21.5)	37	6.1 (3.3-10.2)	17
Camden	11.3 (8.7-14.5)	69	17.4 (12.6-23.3)	48	6.0 (3.6-9.2)	21
London	8.2 (7.8-8.6)	1,845	12.4 (11.7-13.1)	1,359	4.3 (3.9-4.6)	486
England	10.1 (9.9-10.3)	14,788	15.5 (15.2-15.8)	11,145	4.9 (4.7-5.1)	3,643

*three year age-standardised death rate and **total deaths
[Office for National Statistics - Suicides in England and Wales: 2019 registrations](#)

In Barnet, the emergency hospital admissions for intentional self-harm was 98.8 per 100,000 (95% CI 89.2-109.2) in 2019 to 2020 this rate:

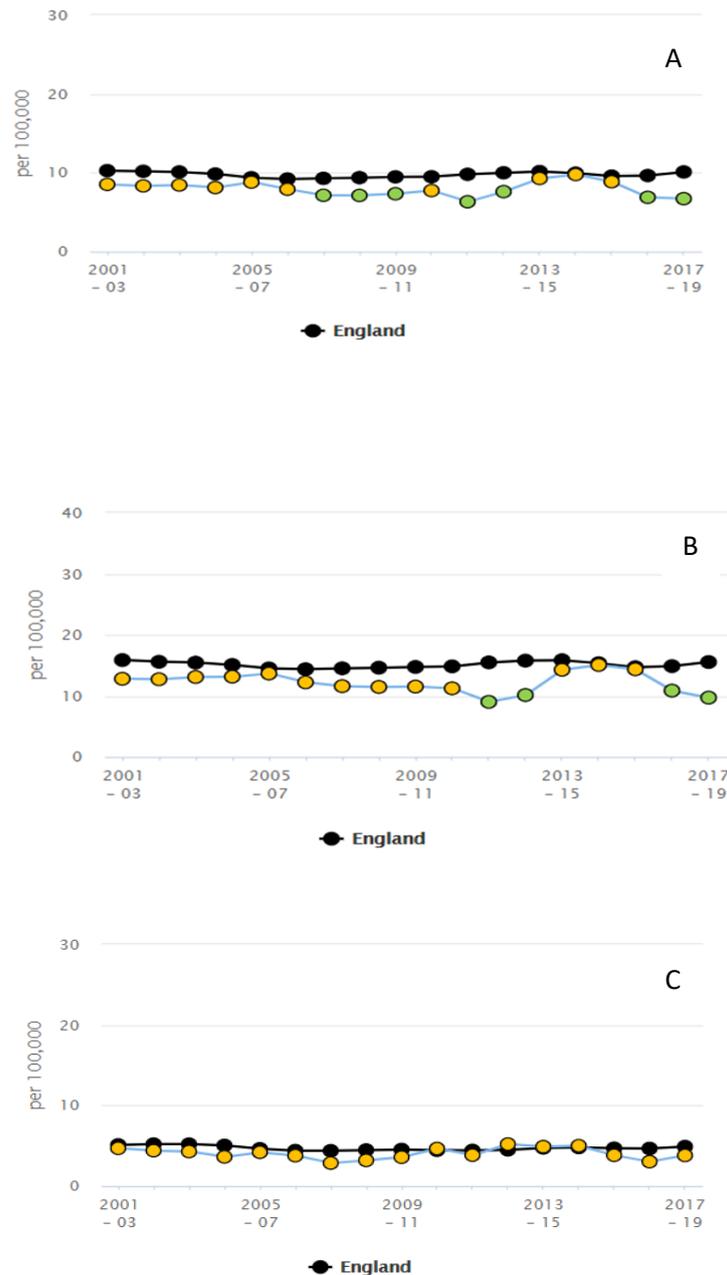
- Is significantly lower than the rate in England (193.4 per 100,000)
- Is similar to the average rate in London at 88.4 per 100,000 versus 81.6. per 100,000.

The rate of emergency admissions for intentional self-harm has not significantly changed over the previous decade.

RECENT TRENDS

Since 2001, the Barnet rate of suicide in men has been higher than women, in keeping with the national picture. The rate for men has decreased significantly from 14.3 (2015-17) to 9.7 per 100,000 (2017-2019), while the suicide rate for women has remained static at 3.8 per 100,000.

Figure 3. Trends in Suicide Rate in Barnet in comparison to England. A = Persons. B = Men. C = Women. [Office for National Statistics – Suicides in England and Wales: 2019 registrations.](#)

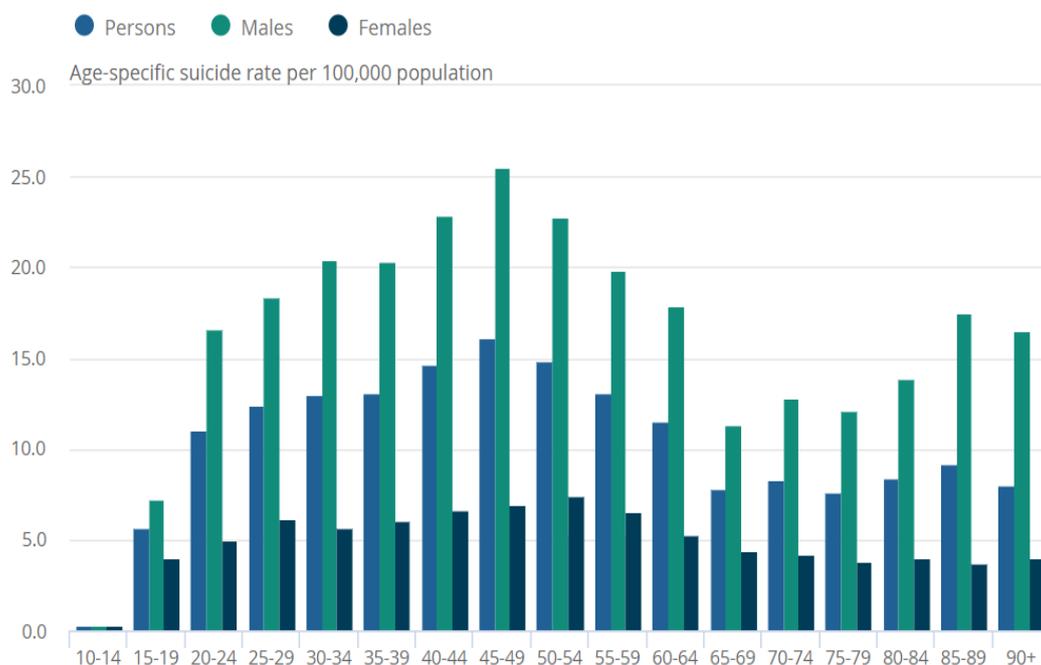


National (England and Wales)

National data shows us that suicide affects some groups more than others. These insights have been used to guide our cross-cutting concerns. For example, men are three times more likely to die by suicide compared with women. People in the lowest socio-economic group, living in the most deprived areas are ten times more at risk than those in the highest socio-economic group, living in the least deprived areas.

In 2019, there were 5,691 suicides in England and Wales, an age standardised rate of 11.0 deaths per 1000,000 population. Three quarters of the deaths registered were among men². When analysed by five-year age group, there is a double peak in suicide rates; ages 45 to 49 and ages 85 to 89. Men aged 45 to 49 years have the highest age-specific suicide rate overall -25.5 deaths per 100,000 men. For women, the age group with the highest rate was 50 to 54 years, at 7.4 deaths per 100,000.

Figure 4: Age-specific suicide rates by sex and five-year age groups, England and Wales, registered in 2019. [Office for National Statistics – Suicides in England and Wales: 2019 registrations.](#)



As seen in previous years, the most common method of suicide in the UK was hanging, accounting for 61.7% of all suicides among men and 46.7% of all suicides among women.

RECENT TRENDS

Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old women where the rate has increased significantly since 2012 to its highest level with 3.1 deaths per 100,000 women in 2019.

Evidence that informed our strategy

Our strategy, prevention framework, aims, and our objectives are built upon the national evidence of the risk factors for suicide and self-harm and ‘what works’ for prevention. Wide ranging evidence authoritatively and comprehensively summarised in reports elsewhere has been used to inform this strategy. To maintain the usability of this strategy, this section briefly covers some of the key evidence that informed our thinking when deciding our local priorities and choosing our strategic actions for the first two years.

This strategy aligns with the evidence and recommendations in recent national reports and guidelines including:

- [NICE Quality Standard 189 \(Suicide Prevention\)](#), [NICE Guideline 105 \(Preventing suicide in community and custodial settings\)](#), [Clinical Guideline 16 \(Self-harm in over 8s: short-term management and prevention of recurrence\)](#), [Clinical Guideline 133 \(Self-harm in over 8s: long-term management\)](#). This strategy is cognisant that NICE guidelines on self-harm are due for review.
- [Public Health England’s Suicide Prevention Resources](#) including The National Suicide Prevention Strategy for England (2012), accompanying progress reports (2013, 2015, 2017, 2019), and the [Local Suicide Prevention Planning Practice Resource](#).
- National Confidential Inquiry into Suicide and Safety in Mental Health Annual Reports (latest [2021](#)) and guidance (e.g. [Safer Services Toolkit](#))
- Reports and guidance such as [From Grief to Hope \[University of Manchester\]](#), [Dying from Inequality \[Samaritans\]](#), [All Party Parliamentary Group Inquiry into the support available for young people who self-harm](#).

This strategy addresses, and through our action plan meets the recommendations in the NICE Quality Standard and Guidelines for suicide prevention.

NICE Quality Standard 189: Suicide prevention
Statement 1: Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures
Statement 2: Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local information.
Statement 3: Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice when reporting on suicide and suicidal behaviour.
Statement 4: Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.
Statement 5: People bereaved or affected by a suspected suicide are given information and offered tailored support.

NICE Guideline 105: Preventing suicide in community and custodial settings
1.1 Suicide prevention partnerships
1.2 Suicide prevention strategies
1.3 Suicide prevention action plans
1.4 Gathering and analysing suicide-related information
1.5 Awareness raising by suicide prevention partnerships
1.6 Reducing access to methods of suicide
1.7 Training by suicide prevention partnerships
1.8 Supporting people bereaved or affected by a suspected suicide
1.9 Preventing and responding to suicide clusters
1.10 Reducing the potential harmful effects of media reporting of a suspected suicide

Evidence that informed our strategic priorities for 2021-2023

Suicide is a complex behaviour with no single explanation or cause. There are numerous risk factors for suicide, present at the individual, community, and societal level, as shown in Figure 5. The wide range of risk factors for suicide shows how critical it is that we work across the whole system in wide-ranging partnerships.

In order to make a difference in Barnet, it is crucial that we understand and focus our prevention efforts on reducing the impact of the risk factors that are most significant for our local residents. This section provides an overview of some of the key insights that have informed our choice of strategic priorities, such as the cross-cutting concerns of notable focus, for the Action Plan 2021-2023.

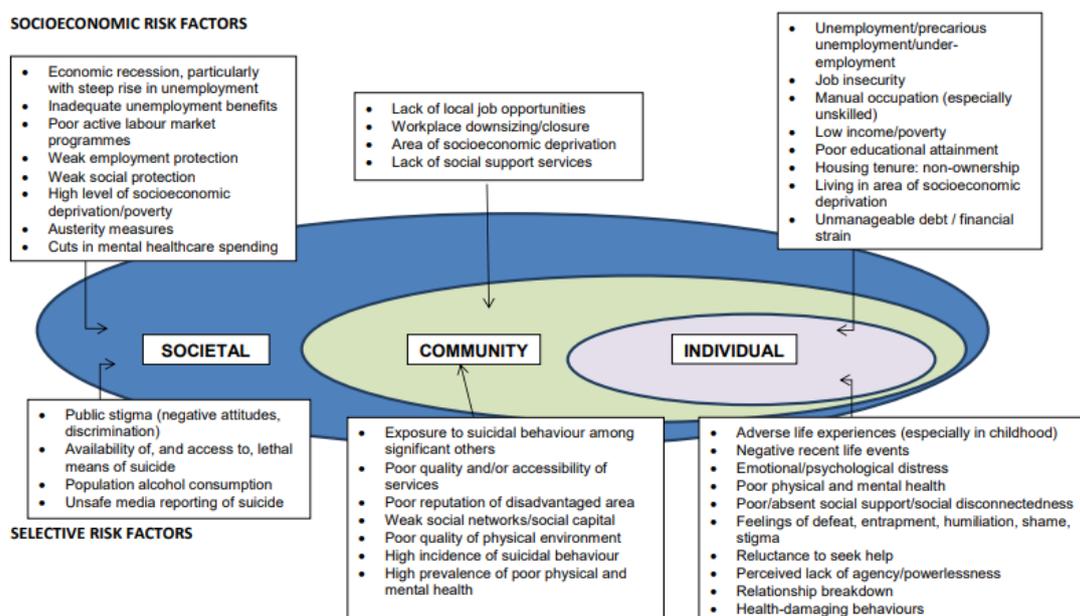


Figure 5: Model of suicidal behaviour, highlighting socioeconomic risk factors. Reproduced from: Samaritans (2017), '[Socioeconomic disadvantage and suicidal behaviour](#)', March 2017

[Cross-Cutting Concerns of Notable Focus for Action Plan 2021-2023](#) were chosen by the Barnet Suicide Prevention Partnership as locally important areas that demanded immediate collective effort to achieve improvements.

- Young and middle-aged men

In the UK and in Barnet, men are three times more likely to die by suicide than women. Men aged 45 to 49 have the highest suicide rate in the UK. In 2017, of the 1,516 men aged 40-54 who died by suicide, 30% were unemployed at the time of death, 27% were in the most deprived areas in England, and 45% reported living alone. Physical health conditions were present in over half (52%), while bereavement and substance misuse occurred in over one third (34% and 49% respectively) of cases. Strikingly, 91% had been in contact with at least one front-line service or agency – 67% within 3 months of deaths¹⁰. This is an opportunity for intervention. There is emerging evidence of a preference for informal, de-medicalised provision such as peer-led support, community and work-based based initiatives, and non-clinical spaces and respite.

¹⁰ The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), [Suicide by middle-aged men 2021](#), University of Manchester

- People with a history of self-harm

Self-harm is the most important risk factor for subsequent death by suicide; half of people who die by suicide have a history of self-harm, many with an episode close to their death, and some presenting to hospital within the year before their death⁸. NICE guidance [CG16](#) and [CG133](#) provides comprehensive recommendations for the short and long term management of people over 8 years old who self-harm. Particularly in patients known to mental health services, recent self-harm is an important antecedent of suicide, with 29% of people who died by suicide between 2006-16 recently self-harming¹⁷.

Findings from many community-based studies show that around 10% of adolescents report having self-harmed, of whom some will report some extent of suicidal intent underpinning their self-harm. Presentation to hospital occurs in only about one in eight adolescents who self-harm in the community, being more common in those who take overdoses¹¹. While many people will not present to health services, they may confide in family and, particularly for young people, in friends¹². This is an opportunity to provide help. We can support residents by working to raise awareness of self-harm, build community skills in having conversations about suicide, and make it easier to find locally available services and support.

- People who misuse alcohol and drugs

Misuse of alcohol or drugs is an aggravating factor that further increases risk in particular sub-groups including men, people who self-harm, and people with a mental health diagnosis. In patients who died by suicide in England (2008 to 2018), 45% had a history of alcohol misuse and 34% had a history of drug misuse³. The 'Better care for people with co-occurring mental health and alcohol/drug use conditions (2017) report'¹³ emphasises the importance of specialist service provision, joint working, 24/7 crisis response, and accessible care pathways to meet the complex needs of this groups.

- Children and young people (CYP)

Suicide is the leading cause of death for young people. Since 2017, there has been a significant increase in the suicide rate for men aged 10 to 24, rising to 8.2 per 100,000 in 2019. For women aged 10 to 24, the 2019 suicide rate for England and Wales is the highest recorded since 1981 at 3.1 per 100,000, almost doubling from 1.6 per 100,000 in 2012, when the rate began to rise². [The Early Intervention Foundation Social and Emotional learning briefing](#) recommends PSHE, a whole-school approach to emotional skills-based interventions, and delivering targeted evidence-based support for CYP with emerging mental health needs. There is evidence for the success of school strategies, mental health first aiders, peer support, staff training for awareness and signposting, and clear referral routes into specialist services¹⁴. Young people have expressed a desire for trusted sources of information and not wanting to negotiate complex systems to access services¹⁵. In 2018, the Department of Education [published guidance for schools supporting CYP with their mental health](#). The guidance advocates that each school creates a whole school culture for mental wellbeing, identifies, assesses and creates a plan to support children at risk of mental health problems, which could include working with external agencies and services.

¹¹ Hawton K, Saunders KEA, O'Connor RC (2012). Self-harm and suicide in adolescents. *Lancet*; 379:2373–82. doi:10.1016/S0140-6736(12)60322-5

¹² Royal College of Psychiatrists London (2010). [Self-harm, suicide and risk: helping people who self harm](#), College Report CR158.

¹³ Public Health England (2017), '[Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers](#)', June 2017.

¹⁴ Public Health England (2019), '[Universal approaches to improving children and young people's mental health and wellbeing](#)', Report of the findings of a Special Interest Group, October 2019.

¹⁵ Public Health England (2014) [Improving young people's health and wellbeing: A framework for public health](#), January 2015.

- People who experience distressing life events

High-risk distressing life events are those which negatively impact on an individuals' mental wellbeing and increase their risk for suicidal thoughts and behaviours. High risk events may influence mental health by impacting upon:

- Economic wellbeing e.g. redundancy, debt, gambling addiction.
- Social wellbeing e.g. people who are living alone, socially isolated, or excluded, and young people impacted by social media.
- Emotional wellbeing e.g. family conflict or breakdown, relationship breakdown or divorce.
- Psychological wellbeing e.g. bereavement (particularly bereavement by suicide), family mental health problems, recently relapse of substance misuse, recent self-harm, bullying.

It is likely that for many, COVID-19 will have caused or exacerbated these events, which already disproportionately affect those in high risk groups for suicide. Of all mental health patients who died by suicide in England in 2008-2018, 48% were living alone and 46% unemployed³. There is a higher rate of key risk factors and distressing life events in men who die by suicide when compared to the incidence in the general population. Most (57%) had experienced economic problems (unemployment, finance, or unstable accommodation) at the time of death, while some experienced distressing events in the 3 months prior to their death such as problems with; family relationships (36%), alcohol misuse (36%), bereavement (34%), substance misuse (31%), finance (30%), housing (24%), problems at the workplace (24%), or divorce/separation (21%). The number of men living in the most deprived areas (27%) losing their life to suicide is almost twice that of those in the least deprived areas (14%)¹⁰. Unemployment is a key risk factor for suicidal behaviour in men, and this higher risk is exacerbated during a downturn or period of economic growth⁹. Following the 2008 Global financial crisis, there was an increase in the rate of suicide in England.

There is opportunity for intervention following distressing life events. 53% of men who died by suicide in 2008-2018 expressed ideation or intent at some time, 20% in the week prior to their death. 91% had been in contact with at least one frontline service or agency, (most often primary care – 82%). Services can provide support following for example unemployment, for debt, social isolation, family breakdown, homelessness, and bereavement. A focus within these services should be on recognising risk, responding to unmet need, and better joint working across support services, primary and secondary care, social care, and local authority. Upskilling frontline staff and providing gatekeeper training is critical in building system capacity to recognise risk and intervene.

Theme 1 – Foundation for Action

Insights from data, research, and people with lived experience

Robust data and relevant insights underpin the development of effective suicide prevention activities. Making progress towards our first strategic aim for 'enhanced insights on every suicide that occurs in the borough to inform future prevention work' will enable us to improve our local evidence base where there are known current gaps, such as in ethnicity and sexual orientation, as well as better inform our prevention activities. Co-produced solutions form the core of our second principle in the development of this strategy. Involving people affected by suicide brings a crucial perspective that can help to identify gaps between policy and practice, and ground prevention work in the real-life impact of self-harm and suicide.

Public Health England’s Local Suicide Prevention Planning recommends local authorities to focus on the collection and analysis of local information that could provide additional insights alongside close consideration of the national data¹⁶. A limitation of our local data is the relatively small annual numbers makes it difficult to detect significant differences between nationally and locally important risk factors, and longer timescales are needed to evaluate the impact of our suicide prevention activities. Local data can be improved and used to produce more responsive prevention activities by reducing the time from suicide events to data analysis⁴. Current data from the Office for National Statistics is published annually, but registrations of suicide deaths following a coroner’s inquest can be delayed by days or months – currently in Barnet the median registration delay for suicides is 149 days (2019)¹. Real-time surveillance systems can help to close this gap.

Leadership and collaboration

The [All-Party Parliamentary Group on Suicide and Self-Harm Report](#) advises the establishment of a multi-agency suicide prevention group as one of the main elements to successful suicide prevention work. This is also recommended by [The National Suicide Prevention Strategy](#) and [NICE QS 189](#) based on evidence that “By combining expertise and resources, partnerships can cover a much wider area more effectively and implement a range of activities” and that “when partnerships share knowledge and experience, this is of greater benefit than working individually.” For a successful whole-system approach that tackles the wider determinants of health and wellbeing, we need to collaborate across public, private and health services. Involvement of our Health and Wellbeing board should provide further opportunities for multi-agency working.

Theme 2 – Prevention of Suicide and Self-Harm

Awareness

In this strategy, ‘awareness’ is the first action area within the theme ‘prevention of self-harm and suicide’. This action includes building general awareness of mental wellbeing, self-harm, and suicide, as well as raising awareness of the services and support available locally.

Collecting research evidence demonstrating the effectiveness of raising awareness would be challenging. Our expert view is that building general awareness is the first step of prevention as it aims to increase general understanding of mental wellbeing, improve skills that build positive mental wellbeing, and reduce barriers to help seeking such as stigma and discrimination.

There is evidence that bystander interventions as well as timely signposting can be effective in preventing suicides¹⁷. We believe that raising the awareness of the local services and support available to those in need amongst everyone in Barnet is the crucial second step that will enable timely help-seeking or effective bystander intervention.

Increasing awareness of suicide and self-harm support across the population in Barnet will help us reach our aim that ‘everyone in Barnet knows where to find help if they are thinking about suicide or are concerned about someone else’.

¹⁶ Public Health England (2020), [‘Local suicide prevention planning: A practice resource’](#), September 2020.

Interventions

Timely interventions that interrupt the suicidal process can be lifesaving: they buy the time needed to give people the chance to reconsider, and they increase the likelihood that help reaches out to that person in time¹⁷. Interventions that delay or disrupt a suicidal act could include:

- Reducing access to means

This includes restricting access to high frequency locations, package size for medications and medication reviews, removing ligature points in inpatient settings, and reducing access to weapons. Reducing access to means is known to be one of the most effective methods of preventing suicide. There has been a significant reduction in deaths by paracetamol overdose since the pack sizes of paracetamol reduced, and there is evidence demonstrating an 86% overall reduction in deaths when structural interventions are carried out at high risk locations for suicide by jumping, with little evidence of substitution to other potential jumping sites¹⁷. Currently, the most common method of suicide is hanging. Removal of ligature points in criminal justice and inpatient settings has shown to reduce deaths but designing interventions for hanging in the home remains difficult.

- Increasing the opportunity for intervention

Evidence shows that passer-by interventions are most likely to come from strangers. This is why raising general public awareness of suicide prevention and interventions is so important. The opportunity for human intervention can also be increased by specifically training frontline staff to recognise the risk factors for suicide - education of primary care doctors targeting depression recognition and treatment has been identified as one of the most effective interventions in lowering suicide rates¹⁵.

- Increasing opportunities for help-seeking

Timely signposting of services and support around high risk events increases the chance that a person with suicidal thoughts can reach out for help. For example, signs that encourage help seeking at high frequency locations, inclusion of signposting information with written notices that may be distressing, and timely provision of signposting to individuals known to be at higher risk, such as following a bereavement.

Services & Support

Early access to effective support can save lives. The latest data and recommendations for suicide prevention of those in the care of mental health services can be found in the [National Confidential Inquiry into Suicide and Safety in Mental Health \(NCISH\)](#) annual report. Evidence shows that patients with the highest risk are inpatients, those who refuse treatment, and those recently discharged, greatest within the first few days to first week.

It is important we provide high quality services that are accessible. NCISH have published a [‘Safer Services Toolkit’](#)¹⁸ with ten ways to improve patient safety, which are incorporated in Barnet, Enfield and Haringey Mental Health Trust’s Suicide Prevention Strategy. Recommendations include personalised risk management, follow-up within three days of discharge from in-patient care, 24-hour crisis care, following [NICE guidance for depression](#) and self-harm, and local services for dual diagnosis that work jointly with mental health services. Improving care across the system is also important, with clear pathways between emergency, primary, secondary, community, and specialist services.

¹⁷ Public Health England (2015), [‘Preventing suicide in public places: A practice resource’](#), November 2015.

¹⁸ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017), [‘Safer service: A toolkit for specialist mental health services and primary care. 10 key elements to improve safety’](#), updated March 2021.

Theme 3 – Postvention

People who are bereaved by suicide have an increased risk of suicide and suicidal ideation compared to people bereaved through other causes¹⁹, and bereavement can result in depression and poor social or occupational functioning. Bereavement by suicide affects not only immediate family, but entire communities; school friends, work colleagues, neighbours, and those whose work brings them into contact with suicide such as frontline emergency services staff, teachers, and faith leaders. Timely and effective support to those bereaved or affected by suicide may reduce the risk of these consequences.

A joined-up community response is essential in providing support to those impacted after a suicide and preventing further suicides. One suicide can trigger a cluster of suicides within the family or community, particularly among young people²⁰. This can be exacerbated by news reports, which have been associated with imitative suicidal behaviours²¹. Evidence shows the risk of clusters can also be reduced with community-level post-suicide interventions at schools, workplaces, and healthcare settings, and that implementing guidelines on responsible reporting has been associated with sustained reductions in numbers of suicides. Significant work to promote responsible reporting is conducted at a national level with the Samaritans, and includes collaboration with news media and internet companies on responsible reporting and removal of content which encourages suicide or self-harm.

¹⁹ Pitman A, Osborn D, Rantell K, et al. (2016), '[Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults](#)', BMJ Open, 2016 Volume 6, e009948, doi: 10.1136/bmjopen-2015-009948.

²⁰ Department of Health (2012), '[Preventing suicide in England. A cross-government outcomes strategy to save lives](#)', September 2012.

²¹ Sisask M, Värnik A, (2012), 'Media roles in suicide prevention: a systematic review'. Int J Environ Res, Public Health. Volume 9, Issue 1, pages 123 to 138.

Barnet Suicide Prevention Partnership Members

The Barnet Suicide Prevention Partnership has representation from the following organisations:

- London Borough of Barnet Council teams; Public Health, Mental Health, Safeguarding, Human Resources, Commissioning, Community Safety, Adult Social Care, Early Intervention, Enablement, BELS (Barnet Education and Learning Service).
- People with lived experience
- Central London Community Healthcare NHS Trust
- Barnet, Enfield, Haringey Mental Health Trust
- North Central London Clinical Commissioning Group
- Metropolitan Police
- British Transport Police
- BOOST
- Barnet Homes
- Middlesex University
- Mind in Barnet
- Trinity London
- Colindale Communities Trust
- Young Barnet Foundation
- Barnet Mencap
- Inclusion Barnet
- Change, Grow, Live
- AgeUK Barnet
- Young Barnet Foundation
- Meridian Wellbeing
- Jami UK
- Barnet Carers Centre
- CommUNITY Barnet
- Samaritans
- New Citizens Gateway
- Unitas Youth Zone
- Your Choice Barnet

Acronyms

APPG	All Party Parliamentary Group.
BAME	Black, Asian, minority ethnic, and racialised communities.
BEHMHT	Barnet, Enfield, and Haringey Mental Health Trust.
BOOST	Partnership with Barnet Homes, JobCentre Plus, Barnet & Southgate College a number of local community organisations.
BSPP	Barnet Suicide Prevention Partnership.
CAMHS	Child and Adolescent Mental Health Services
CC1	Cross Cutting Concern 1 (each area should address identified high-risk groups).
CC2	Cross Cutting Concern 2 (each area should consider the need for a tailored approach in identified specific groups).
CC3	Cross Cutting Concern 3 (each area should mitigate the impact of high-risk distressing life events).
CCG	Clinical Commissioning Group.
CYP	Children and Young People.
ICP	Integrated Care Pathway.
ICS	Integrated Care System.
LBB	London Borough of Barnet.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and people with non-normative gender identities or sexual orientations.
MECC	Making Every Contact Count.
NCISH	National Confidential Inquiry into Suicide and Homicide
NCL	North Central London.
NCL D&I	NCL Suicide Prevention Data & Insights Subgroup.
NCL SaS	NCL Suicide Prevention Support After Suicide Subgroup.
NCL SP	North Central London Suicide Prevention Strategy Group.
NICE	National Institute of Health and Care Excellence.
PH	Public Health.
PSHE	Personal, social, health and economic education.
RTS	Real Time Surveillance system.
SMI	Severe Mental Illness
VCFS	Voluntary, Community, and Faith Sector
ZSA	Zero Suicide Alliance

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	Health and Wellbeing Board 15th July 2021
Title	North Central London Clinical Commissioning Group Strategic Review of Community and Mental Health Services
Report of	NCL CCG - Strategic Review of Community and mental health services
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 - NCL Community and Mental Health Services Strategic Review
Officer Contact Details	Jo Murfitt Programme Director for NC London CCG Strategic Reviews of Community and Mental Health Services 07557419258 joanne.murfitt1@nhs.net

Summary

The paper is to provide information on two strategic service reviews being undertaken within the North Central London System covering the Community and Mental Health Services delivered by the NHS in North Central London (NCL). The reviews were launched in March 2021 and initial work, supported by our external partners Carnall Farrar will be completed by mid-September 2021.

The reviews are all age and will look at all CCG funded community and mental health services. Current patterns of service are based on the legacy CCGs and are different in terms of services available, access criteria, and opening hours etc. The CCG's aim is to ensure all residents have access to a core service offer that is equitable for all residents on North Central London.

The report sets out the governance we are applying and the risks we are managing through the reviews as well as describing its communication and engagement strategy.

Members of the Barnet Health and Wellbeing Board are asked to consider how they can work with the CCG to ensure that it achieves a good level of use engagement from local residents and advise on other actions the CCG could take to ensure achieve this aim.

Recommendations

The Health and Wellbeing Board is asked to note the progress of the reviews of community and mental health services and advise on further engagement actions that would support these reviews.

1. INTRODUCTION

- 1.1 This paper provides the Barnet Health and Wellbeing Board with a report on the current strategic services review of both community and mental health services. The two reviews are being held concurrently in recognition of the number of NCL residents needing services for both their mental health and physical health needs. In addition a number of Trusts involved in the reviews provide both mental health and community services so it is more efficient to undertake the reviews in parallel, which will identify interdependencies and reduce duplication of work associated with the reviews.
- 1.2 The CCG has inherited a range of community and mental health services from its 5 legacy CCGs. This has led to a variation in access to services the approach to delivering care and to patient outcomes. The purpose of the review is therefore to better understand this variation and then to develop a core service offer that will bring about greater consistency in access to community and mental health services for all NCL residents, driving out unwarranted variation whilst allowing local services to respond to variable patient need.
- 1.3 The CCG has engaged Carnall Farrar as its design partners to work alongside a CCG programme team. This strategic service reviews will take place between March and September 2021, when Carnal Farrar will present to the CCG an options appraisal and transition plan for the recommended option. The options appraisal will consider a range of impact assessments including affordability and feasibility, to support implementation of the recommended option.
- 1.4 This paper provides information on the purpose of the review, its aims and objectives and governance. It will also update on progress, risks, set out next steps and provide details on how users and residents are being engaged in both reviews.

2. BACKGROUND TO THE REVIEW

- 2.1 NCL CCG inherited from its 5 legacy CCGs a varied pattern of services both for community and mental health services. The variation across NCL exists in access to services, in terms of opening hours and thresholds for clinical access to services. For example, information gathered as part of the Baseline Review shows there is variation in the clinical services staff provide, and therefore what services are available across NCL, to housebound patients. Although each Borough has access to a rapid response team they vary for example as to when referrals can be accepted. Some are 24/7 but others only take referrals up to 8pm which limits the support available overnight to patients, acute trusts etc. For mental health services, dementia services in Camden and Islington have twice the rate of contacts compared to the three other Boroughs which may indicate different services are being provided.
- 2.2 The baseline reviews sets out the case for change provides further details on the differences in provision of services, differential funding, and workforce. The report also contains details of, for example, different waiting times as well as differences in patient outcomes.

3. AIMS AND OBJECTIVES OF THE REVIEWS

- 3.1 The aim of the reviews is to ensure a consistent and equitable core service offer for the NCL population that is largely delivered at a neighborhood/Primary Care Network level. The core offer of equitable access to services will be based on identified local needs and fully integrated into the wider health and care system ensuring outcomes are optimised, as well as ensuring services are sustainable in line with the CCG's financial strategy and workforce plans.

3.2 Objectives of the review

The provision of a core & consistent service offer that is delivered locally based on identified needs and that works to reduce inequities of access and improves health outcomes.

- The provision of community and mental health services that optimises the delivery of care across NHS Primary, Secondary, Tertiary services and the wider system with Local Authority and Voluntary & Charitable Sector (VCS) partners and services.
- It will move the CCG closer to the national aspirations around the delivery of care as close to home as clinically appropriate and ensuring it is as accessible as possible.
- It will provide a set of population health outcome measures that will help monitor progress supported by some key performance Indicators.
- Ensuring that community and mental health services are financially sustainable system both now and into the future based on the growing and changing needs of our population.
- Ensure the delivery of national planning guidance including the Long Term Plan and Mental Health Investment Standards.

3.3 In addition, as part of the reviews a set of design principles are being developed. These will be used as a test or touch point against which the outputs of the review will be measured. The design principles have been reviewed by a number of groups including the Community Service Review Programme Board, and at the first design workshop. The design principles reflect an ambition for a forward looking review which puts service users and residents at the heart of the service delivery and which has a focus on prevention, early access and personalisation of care.

4. SCOPE OF THE REVIEW

4.1 The reviews include all CCG funded community and mental health services, both inpatient services and those provided in the community. It is an all age services review and it should be complimentary to other reviews the CCG is undertaking e.g. the review of maternity, neonatal and paediatrics as well as the review of Borough contracts. It has a number of exclusions to try and manage the scope of the reviews e.g. primary care services, Continuing Health Care, acute services etc. are excluded from the scope of these reviews.

5. GOVERNANCE OF THE REVIEWS

5.1 Both Service Reviews have established governance arrangements, underpinned by a Programme Board, which are both chaired by the CCG's Accountable Officer. Each Programme Board comprises a Governing Body GP lead and a Governing Body Lay member lead as well as representatives from Provider Chief Executives, senior leadership from Local Authorities; Chief Executive leads, Directors of Adult and Children's Services Leads and a Director of Public Health lead. Membership also includes the CCG Chief Finance Officer, ICS Lead Nurse and the Executive Director of Strategic Commissioning as the Senior Responsible Officer of the Service Reviews. Both Boards have or are in the process of identifying service user membership.

5.2 Each Programme Board meets monthly and is supported by an internal combined steering group which includes clinical lead GPs, representatives from the CCG's Quality, Communities, Communications and Engagement, Finance, Operations and Business Intelligence teams as well as Population Health input. The steering group meets bi-weekly and it oversees the work with Carnall Farrar as well as reviewing and supporting the review and ensuring alignment to the wider work of the CCG. There are various sub groups which report into the steering group, including a finance and communications and engagement sub group.

6. STRUCTURE OF THE REVIEWS

6.1 Both the Community and mental health services reviews follow a 3 phase approach.

6.2 Phase 1 - Data Gathering to drive shared understanding of the problems

- This includes data analysis to look at financial, contract and workforce data. Information was also collected on population needs both existing but given the impact of Covid particularly on mental health services, on future demand. Data gathering also included interviews with senior leaders from the CCG, Trusts and Local Authorities, group interviews with Local Authority colleagues and a survey which was sent out to a wide circulation list of GP, Trusts, Local Authority colleagues, CCG and voluntary sector/users etc.
- The initial phase of the Community Services Review was between March- April. As part of their work Carnall Farrar interviewed 56 senior leaders, and there were 228 survey forms returned. For the Mental Health services review, which started in May, 45 senior leaders were interviewed and 221 survey forms were returned.
- Information from phase 1 has been analysed and presented in the form of baseline reviews which summarises the data collected and sets out a case for change as to why the review is required. The baseline reviews are still being finalised but is anticipated to be completed within the next few weeks. The relevant Programme Boards will sign off the baseline reports.

6.3 Phase 2 - Design Workshops

- Phase 2 started at the beginning of June and consists of a series of design workshops. The launch meeting was on 2nd June and 108 colleagues attended from Providers, GPs, Local Authority, users and a small number of voluntary sector groups. The meeting reviewed the work on draft design principles, a draft outcomes framework and a draft population health model that would be used to structure service planning. There was a lot of discussion and challenge as to the proposed models and feedback is now being reviewed and incorporated into revised draft documents. During June and through to mid-July there will be a series of deep dives on primary care and its interface with community and mental health services, and deep dives for community and mental health services followed by a series of design workshops to review and iterate the discussions from the deep dive sessions. This iterative process should result in an agreed draft core service offer.

6.4 Phase 3 - Impact Assessment

Phase 3 is from mid-July to mid-September. The Programme team will work with Carnall Farrar to understand the impact of the draft core service offer from a quality, workforce, financial, inequalities etc. impact and understand

the impacts of the proposals. These will then need to be reviewed by the Programme Boards before any recommendations can be presented to the Governing Body.

7. EMERGING THEMES FROM BASELINE REVIEWS

7.1 Themes Emerging From Community Services Review:

- Need to address health inequalities; includes a recognition there are unwarranted variations and that both within and between Boroughs people do not receive the same service offer. This can lead to different population and patient outcomes
- Discrepancy between need/prevalence and provision; resources (finance and workforce) are not distributed equitably across NCL. Challenge seen as how to support those with greatest level of need and support NCL commitment to reduce health inequalities
- Relationships and Integrated Working; Reflection that historically relationships between providers have not always been good, reflecting competition and access to resources. However, the pandemic has improved how Community Providers work together. The challenge is now how to embed collaborative working
- Organisational Form; Concern that the review should focus on best models of care to meet different population outcomes and should not focus on Provider Form. This could be considered once core service offer had been designed

7.2 Themes Emerging From Mental Health Services Review

- Variation and growth in population need
- Overall gaps in access and significant service variation across NCL
- Models of care not fit for purpose e.g. focus on crisis, not prevention and early access
- Lack of integration (within mental health and with primary care etc.)
- Inequity of Funding; based on historic spends – mirroring discrepancy between need/prevalence and provision as with community services baseline review
- Outcomes; Poor data especially on clinical outcomes

7.3 Further work required in relation to the following in the next iteration of the baseline review for mental health services includes:

- Understanding the voluntary sector contribution commissioned both by CCG and Local Authority
- Benchmarking with Getting it Right First Time (GIRFT)

- Explore co-morbidity further
- Triangulate quality, spend and outcomes

7.4 Both baseline reviews have overlaps in terms of themes particularly relating to variation, models of care and differential outcomes. Information from the baseline reviews will inform design work and the development of an outcomes framework to guide the development of a core service offer.

7.5 **Other Emerging Themes**

Not specifically noted but identified as part of discussion with Borough colleagues, was the challenge of a centrally led strategic services review at the same time as local Borough teams were working with partners across the local Integrated Care Partnerships to develop specific local transformation plans for Primary Care Networks as the geographic basis for service delivery.

To mitigate this challenge the programme steering group has representatives from across the CCG and is working with local Directors of Integration and with local Integrated Partnerships to ensure there is a close working with the leadership of the Boroughs to understand how the reviews will sit with their transformational plans.

8. **USER AND RESIDENT ENGAGEMENT**

8.1 A key design principle is that users and residents are at the heart of work. The Programme has developed an active communications and engagement strategy to support this intention. Communications includes setting up information on the CCG's website and developing a resident's survey. We have sent out a series of letters to key partners and offered to attend and talk to a wide range of community groups. We have included updates in a number of CCG bulletins for GPs, community and mental health staff. We have also, through our GP leadership on the Programme, presented the reviews on recent GP webinars.

8.2 We have attended a series of Integrated Care Partnership (ICP) boards across the Boroughs and have started to attend Borough Health and Well Being Boards. We have invitations to the NCL Joint Health Overview and Scrutiny Committee and are attending a range of other community groups such as the Barnet Seniors Association, the Camden Patient and Public Engagement Group etc.

8.3 We have also convened a resident reference panel which had its first meeting on June 3rd. It includes two lay members from the Governing Body and at the first meeting we had 22 residents join the meeting for a very helpful discussion.

They were all keen to be involved with the work and brought a wealth of experience to the discussions. However, the challenge will be to try and ensure that their suggestions are incorporated into design work. As part of the background reading for the meeting the Programme Team reviewed a number of recent reports undertaken by Health Watch, Local Authorities, Trusts etc. and synthesised these into a series of themes which we had planned to test with the panel and check their relevance. However, it was clear from the discussion that many of the themes raised in these reports were still very alive and not resolved. For example, we heard comments on challenges with access, long waiting times for treatment especially for autism and young people's mental health, the lack of cultural competency for some services, sharing of information and the need to not to constantly repeat histories. There was a discussion on the impacts of Covid on more marginalised communities and a focus on inequalities both from ethnicity but an age and sexuality perspectives as well. We are in discussion with Carnall Farrar as to how we incorporate these very informative comments into the design process.

- 8.4 The programme team have also been in conversation with the CCG communities team to understand how best to talk to those groups that are seldom heard. Part of the service review especially for mental health has highlighted that the expected prevalence for some conditions does not match the actual numbers in service, indicating a gap which may be due to a number of causes including inaccessible services. Starting to address this gap will be part of the work of the review but will clearly need a much wider effort on behalf of many partners not just the CCG.
- 8.5 Users, carers and voluntary sector organisations were invited to our Design Workshop and we are trying to support users e.g. colleagues from the Expert by Experience Group to attend and contribute to the workshops give the very important perspective that they bring to discussions. We have invited user representatives to join the Programme Boards as part of the senior oversight and assurance process.
- 8.6 We have developed a communication and engagement strategy which we are keeping under constant review to ensure as wide as possible engagement to ensure that the engagement supports the aims and objectives of the programme.

9. RISKS

- 9.1. There are a number of risks that the programme is facing. This is the first opportunity the CCG has had, post Covid, to undertake its strategic commissioning role and expectations are very high. There is pressure to both extend the scope of the review into areas that are not part of the CCG's statutory

responsibilities although the CCG has a role to play in addressing issues related to the wider determinants of health such as employment and housing. The reviews are also attempting to address some quite long standing challenges in terms of the funding for services as well as challenges that existed pre Covid, such as the workforce.

- 9.2. As noted the Pandemic has also focused attention on health inequalities and whilst the reviews will address the issue of inequalities and inequitable access to care this cannot on their own address the whole inequalities agenda but they must play their part. The reviews also need to ensure they address NHS England planning guidance such as the requirement to provide a 2-hour rapid response as part of the Ageing Well Programme. In addition, mental health has a very active programme to deliver the Mental Health Investment standards and a lot of work has already been expended to set up and deliver work on crisis such as the new crisis café, or investment in Child and Adolescent services. The challenge is to find ways to ensure that this work is not lost but incorporated both systematically and sustainably into the work of the reviews.
- 9.3. The support from Carnal Farrar ends in September when the CCG should receive a transition plan including financial and equalities impact assessment. These will form part of the transition plan and work will be needed with partners as part of the Integrated Care System to agree how the plans will be funded. There are some new funding streams associated with Ageing Well (urgent care standards) and the Mental Health Long Term plan deliverables but these will be insufficient, so agreement will be required on how the gap will be met within the CCG/ICS financial framework.
- 9.4. The reviews are actively engaging with local residents and users and carers to ensure there is support for the proposals that the CCG will receive in September. However, the changes may not be supported by everyone and at this stage it is not clear if any formal consultation on service change will be required but this will be determined on the basis of the transition plan.
- 9.5. In addition, staff from the CCG and Trusts are working at a time of huge challenge in trying to recover and restore services post Covid-19 as well as managing the pent-up demand for care that developed during the pandemic. The programme is trying to balance keeping colleagues informed and involved whilst recognising the huge challenge that clinical practice faces and trying to make most effective use of clinical time.

10. CONCLUSIONS

- 10.1. The reviews are wide in scope and have to deliver a wide range of expectations. The pandemic has highlighted a number of inequities for many of the NCL's

deprived and diverse communities. The CCG has highlighted its commitment to addressing these inequalities through a range of its work including these reviews. However, to be able to fund the recommendations that will arise from these reviews some difficult choices in terms of financial investment will need to be made. The new funding available is unlikely to be sufficient to address the historic differences between Boroughs and the CCG will therefore need to decide how to fund the core offer it wishes to provide. Working increasingly within an ICS framework could provide the opportunity for a system wide discussion on how the services are funded and the timescales to achieve a more equitable service pattern.

- 10.2. Engagement of service users and residents is central to the delivery of the reviews of community and mental health services. As far as possible the programme is working with other colleagues from within the CCG to ensure that advantage can be made of existing links, and it is also working with other partners such as Provider Trusts and Local Authorities to try and reach out to the diverse communities that use services currently and to those who communities who do not or who are not able to currently access services.
- 10.3. The review and transition plan will also need to be sufficiently granular to be able to use as a basis for a financial and impact assessment but not so detailed that Providers feel they are being told how to deploy their staff. As part of the initial interviews a number of comments were made on form and function and a concern that the review was being used as an opportunity to drive a provider re-configuration. Although this is not the purpose of the review it is inevitable that some discussion on the current pattern of service provision may take place as part of post review discussions on implementation.
- 10.4. The work of the reviews has also to compliment and support local work within boroughs on integration, transformation and the development of local neighbourhoods as the place for the delivery of services. Whilst every effort is being made to ensure representatives from Boroughs are involved and are helping shape and influence the direction of the review, inevitably there will be tension between what is being proposed centrally with what is happening at Neighbourhood level. The reviews and subsequent transition plans will need to be sufficiently flexible to allow local delivery this has to be within an agreed framework to ensure the CCG can achieve its ambition for a consistent core service offer to all its residents

11.IMPLICATIONS OF DECISION

11.1 Corporate Priorities and Performance

11.1.1 One of the aims of the Barnet Joint Health and Wellbeing Strategy is to improve the health and wellbeing of the local community and reduce health disparities for all ages which is aligned to the Council's Corporate Plan.

11.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

11.2.1 Not applicable in the context of this report.

11.3 Legal and Constitutional References

11.3.1 The terms of reference of the Health and Wellbeing Board, which is set out in the Council's Constitution Article 7, includes the following responsibilities:

- To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health. To explore partnership work across North Central London where appropriate
- To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.
- Specific responsibilities for overseeing public health and developing further health and social care integration

11.4 Insight

11.4.1 As set out above.

11.5 Social Value

11.5.1 Not applicable in the context of this report.

11.6 Risk Management

11.6.1 N/a

11.7 Equalities and Diversity

11.7.1 Decision makers should have due regard to the public sector equality duty in making their decisions. The equalities duties are continuing duties they are not duties to secure a particular outcome. The equalities impact will be revisited on each of the proposals as they are developed. Consideration of the duties should precede the decision. It is important that Cabinet has regard to the statutory grounds in the light of all available material such as consultation responses. The statutory grounds of the public sector equality duty are found at section

149 of the Equality Act 2010 and are as follows:

A public authority must, in the exercise of its functions, have due regard to the need to:

- a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
- c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- a) Tackle prejudice, and
- b) Promote understanding.

Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act. The relevant protected characteristics are:

- a) Age
- b) Disability
- c) Gender reassignment
- d) Pregnancy and maternity
- e) Race
- f) Religion or belief
- g) Sex
- h) Sexual orientation
- i) Marriage and civil partnership

11.8.1 Decision makers to consider whether the decision may have a direct or indirect impact on looked after children and care leavers. If there are likely impacts, to consider and detail what steps have been taken to mitigate them.

11.9 Consultation and Engagement

11.9.1 As set out above.

12. BACKGROUND PAPERS

12.1 N/a

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NORTH LONDON PARTNERS
in health and care

North Central London's sustainability
and transformation partnership



Update on the NCL Community and Mental Health Services Strategic Review Barnet Health and Well Being Board

July 2021

Background to the Community and Mental Health Services Strategic Review

- North Central London (NCL) CCG **spends £595 million** annually across a range of NHS, Local Authority and Private Providers delivering a wide range of **Community Services and Mental health services** that supports our 1.7m population across the 5 Boroughs.
- Before the formation of the NCL CCG services were commissioned by each of the 5 legacy CCGs in isolation **leading to substantial variation in service delivery** models and **the range of services provided**, e.g. opening hours, provision of a community IV service, different models of dementia care etc. This has led to **variations in outcomes and inequalities in access to provision**. It has also created opportunities to identify improvements.
- With the formation of the NCL CCG and as **we move toward an Integrated Care System (ICS)** along with the development of Borough Based Integrated Care Partnerships (ICPs) we are in a position to address both the issues highlighted in the initial review as **well as accelerate the development of PCN/neighbourhood based services in line with the Long Term Plan**.
- This work will also enable us to create **sustainable community and mental health services** that starts to improve health outcomes, and **address inequities in access and disproportionality** and also drives better value from our current spend.
- Following discussion with **Trust and Local Authority partners** we have agreed that we would **run the two reviews in parallel**. This will enable us to consider the **overlap and interdependencies** for people with complex co-morbidities and both physical and mental health needs.
- The CCG have **commissioned Carnall Farrar as design partners** to deliver the two strategic reviews. Both reviews have active **Programme Boards** which include Trusts and Local Authority senior leadership along with service users and clinical representatives.
- The **ambition of the reviews** is to agree with partners a **consistent and equitable service core offer** for our population that is delivered at a neighborhood/PCN level based on identified local needs and that is fully integrated into the wider health and care system ensuring outcomes are optimized as well as ensuring our services are sustainable in line with our financial strategy and workforce plans.

Scope of the Community and Mental Health Services Strategic Review

The scope of the Community and Mental Health Strategic Review is summarised below:

In Scope	Out of Scope
<p>All NHS funded Community Services (meaning Adult and Children and Young People services delivered outside of a hospital setting and not part of an Acute Spell) delivered by both NHS Community and Acute Providers. All NHS funded mental health services (including Perinatal, Children and Young People, Adults and Older Adults and People with a Learning Disability).</p>	<p>Continuing Health Care</p>
<p>All NHS funded Community Services delivered by Private and other Providers (Voluntary and Charitable Sector etc). This includes Community Services delivered by Primary Care partners that are not part of a Primary Care Core Contract, Locally Commissioned Service/Directed Enhanced Service or similar arrangement.</p>	<p>Care Providers / Care Homes (except non Continuing Healthcare NHS Services delivered in a Care Setting)</p>
<p>The scope also includes services such as Discharge (Integrated Discharge Teams) etc, End of Life Care , services for people with Long Term Conditions etc where these are funded by the NHS and delivered outside an acute episode of care.</p>	<p>NHS Acute Services</p>
	<p>Primary Care contracts including core GP contracts and additional NHS service contracts</p>
	<p>Statutory Homelessness Services</p>
	<p>Local Authority Commissioned Services with the NHS (except where jointly funded)</p>
	<p>0-19 Services Delivered by Local Authorities</p>
	<p>Specialist Mental Health Services for Adults and Children/Young People</p>
	<p>Learning Disability Services (Transforming Care cohort of people)</p>

Interdependencies will need to be considered and this review is being undertaken in conjunction with a strategic review of mental health services to take into account population co-morbidities and the need for integrated services for some people.



Key messages from the baseline analysis of NCL mental health services



There is significant **variation in demographics** both across and within NCL boroughs which is associated with **different needs** for support from mental health services:

- 10.8% of the Enfield has a diagnosis of depression compared with 7.9% in Barnet and 8.2% London wide
- NCL STP has the highest prevalence of SMI of STPs in England, with particularly high levels of need in Camden, Haringey and Islington



Analysis of finance and activity show that **service provision and investment do not correspond to the level of need:**

- In Haringey CYP have higher mental health needs relative to other boroughs, with highest number of CYP presenting at A&E with mental health needs, but the spend per head is lower than NCL average
- Enfield and Islington have higher diagnosed rates of depression but spend less per head on IAPT services, potentially contributing to more presentations in A&E due to depression and self-harm



There are **significant health inequalities** including significant disparity by ethnicity:

- The black population are higher users of acute mental health services, with 27% of admitted patients being black, compared to representing 11% of the NCL population
- C. half of patients admitted are unknown to services; this is particularly high among black population groups



There appears to be **a large focus on crisis response** rather than early intervention and there is recognition that further investments are needed for more preventative offers

- Workforce is concentrated in Community Mental Health Teams and Crisis Response and Home Treatment Teams; there are over 3 times as many staff in NCL in Crisis Response teams compared to Early Intervention in Psychosis teams
- Rejected referrals to community mental health teams are most likely to be referred onwards to crisis teams

Key messages from the baseline analysis of NCL community services



There is significant **variation in demographics** both across and within NCL boroughs which is associated with **different needs** for support from community health services:

- 25% of Year 6 pupils in Islington have childhood obesity compared to 11% in the least deprived London borough
- Enfield and Haringey have over 30% of LSOAs in the 2 most deprived deciles; research has shown that people in the most deprived areas develop long-term conditions approximately at least 10 years earlier



Analysis of finance and activity show that **service provision and investment do not correspond to the level of need:**

- Waiting times for children's therapy assessments are between 5-7 times as long in Barnet as in Camden, which is linked to the size of the workforce which is 5 times as large in Camden as in Barnet
- Enfield has over twice the prevalence of diabetes as Camden yet has a community diabetes resource that is less than half the size



This disparity appears **related to levels of historic and current funding**

- Camden spends 1.2 times as much on community health services per weighted head of population compared to Enfield
- In boroughs with lower levels of community spend, survey respondents felt patients were less likely to be effectively supported

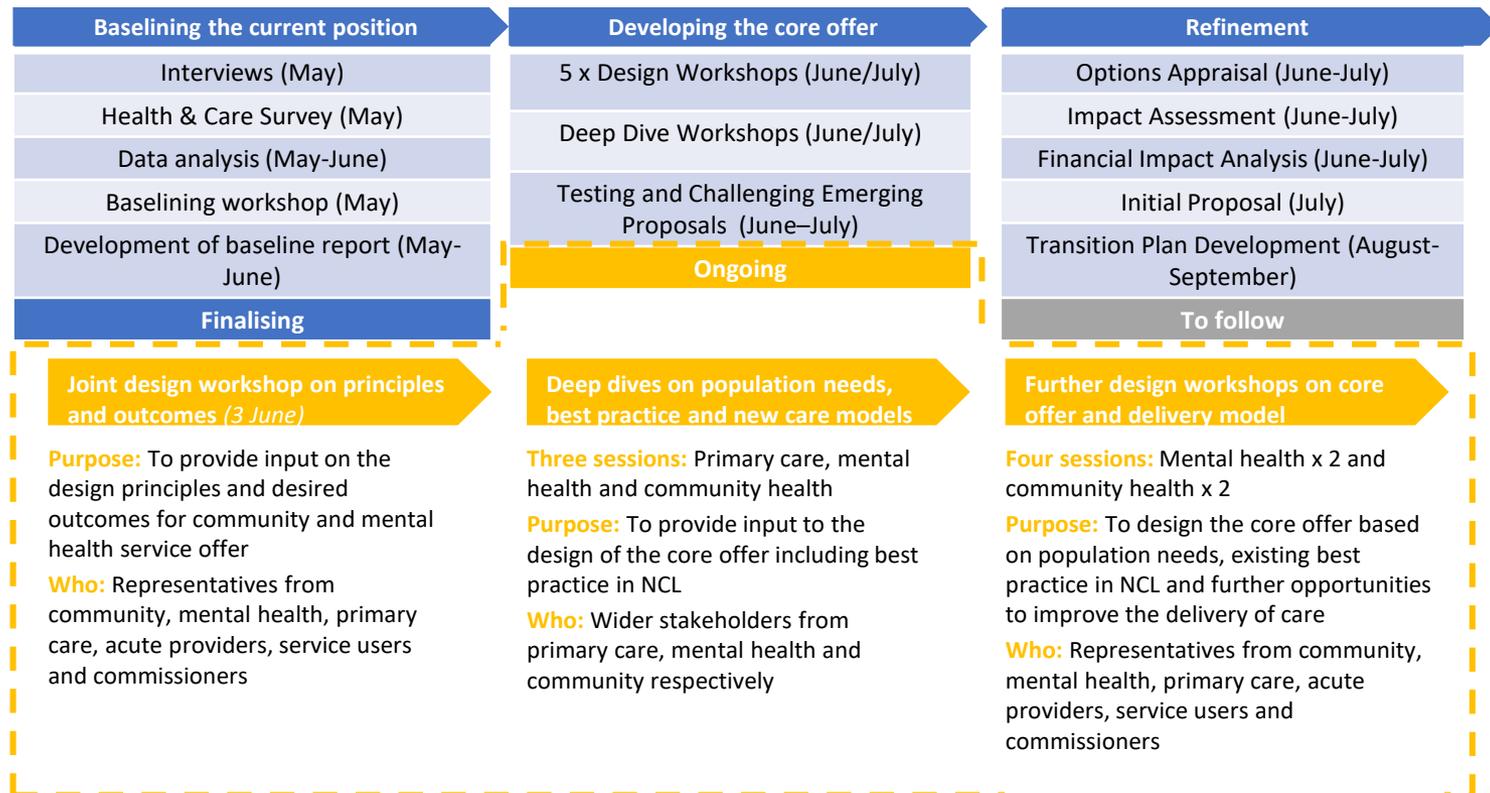


There are **significant health inequalities and inequities in outcomes** for patients across NCL

- Barnet has 3 times as many care home beds per 65+ population as Haringey. However, Barnet also has the lowest coverage of care home in-reach
- Enfield has the lowest % of diabetics receiving the 8 care processes or attending structured education. However Enfield, has lower rates of admissions for hypo- and hyper-glycaemia



Work completed to date and ongoing design process



Pen portraits shown below were discussed and elements of a core offer and were considered in context of their holistic needs

Increasing holistic needs



Children &
Young People



Working age
adult



Older people

1. Jack, 10, lives in Edmonton and has behavioral problems. For over ten weeks he has been waiting for CAMHS treatment. He is progressively worse and now unable to attend school. He has low mood and parents are very worried. His family is from Ghana. There are multiple safeguarding concerns around Jack and siblings and parents want to take him abroad for treatment.

2. Freya 14, lives in Enfield, suffers from an eating disorder and is known to RFH Eating Disorder Service. She engages in self-harm and is admitted to an acute hospital following an overdose. She has been waiting for an inpatient MH bed for over 3 weeks. She continues to lose weight and harm herself in acute hospital.

3. Joseph is 17 and is a looked after child. He was moved out of Haringey because of his involvement with gangs. Had first episode of drug induced psychosis which resulted in a CYP MH inpatient stay. He has not been compliant with his medication and has had another episode of psychosis.

4. Asha is 30, Asian and does not speak English. She is experiencing postpartum depression after her second child was born. Her husband works long hours and she is struggling to cope with 2 young children, one of whom has a learning difficulty.

5. Daniel is 25, lives in North Islington and is black. He suffers from psychosis and has been in and out of mental health facilities since he was 16. His family are supportive but cannot contact him when in crisis. He usually turns up in A&E when he is in crisis.

6. Jake is 55, he is about to be released from prison. He was diagnosed with personality disorder and episodes of psychosis and substance misuse. He has lived most of his adolescence and adult life in prisons. Most of his contacts have been with prison healthcare

7. Vera is 70, white, lives in Bounds Green and is hospital for pneumonia. She is isolated and in debt. While in hospital, she is very anxious and tells staff her neighbours caused her illness. She also needs reablement.

8. Paul is 72, recently widowed, lives in Edgware and is Black Caribbean. He is diabetic and now partially sighted. His son noticed he has lost interest in activities and is withdrawn. His son noticed he is confused and finds it hard to engage in conversation and he has been getting lost. Paul does not think there is a problem and declines any help.

9. Yasmiin is 80, socially very isolated and hates people coming into her home. She witnessed her family being murdered during the war in Somalia. She is depressed and hears distressing voices of her deceased family members. She wishes she were dead and thinks about suicide, but says she won't act on these thoughts. She is neglecting herself and losing weight. The GP has excluded any underlying physical illness.

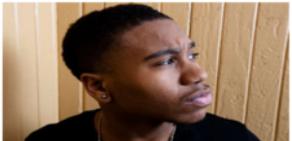


Elements of the pen portraits resonated; however, attendees reflected that there is a need to further bring out the complexity that mental health services see . This was also reflected in the comments on the community pen pictures ; complexity and acuity an a need to provide care in a personalized and way a person centred approach

Reflections on the Mental Health pen portraits



Children & Young People



Working age adult



Older people

The pen portraits broadly resonated and are representative of the presentations that colleagues see day to day

An adult case with LD could be helpful to illustrate their needs as opposed to just CYP

There isn't anyone with a presentation of mania / bipolar

Some more common Mental Health issues are missing – the portraits reflect the people that we see with more complex needs but we need to make sure we have an offer for everyone

We recognise funding issues and long waits for treatment

People transitioning face a 'cliff edge', and people entering the service at 18 are treated as adults

Examples including prison are missing which make up the entirety of people within the forensic service

Societal things (debt, general anxiety, employment support) could be reflected more

Dementia offer is different across NCL - services as well as models of care and that needs to be considered

• Please note these are not direct quotes but a collection of the themes from the discussions



The themes from the core offer discussion for the pen portraits aligned with themes from the community and primary care deep dives

Patient-led care and support

- It is important to understand the individual's wishes and to engage on that basis
- There should be a proportional plan based on personal aspirations and strength-based approach, and this should be holistic not just clinical
- The service user's circumstances should be understood, and services nuanced and provided on that basis (e.g. language services, culturally designed care)
- People should be empowered through education of their condition and where and how to seek help

Workforce

- To deliver the core offer, staff need to be supported and receive adequate training and education
- Resources are constrained, so we should be innovative to maximise what we have

Holistic considerations and flexibility

- Individuals need to be considered within the context of their holistic needs
- All a user's environment and demographics should be reflected; e.g. their family situation, the likelihood & method of engagement (some people may struggle to engage and shouldn't be disengaged with after missing an appointment), their employment, their housing etc.

Integration considerations

- Need to have a joined-up service for drug, alcohol, mental health and community services – involvement of VCS and Local Authority is crucial
- For C&YP need improved links between the school, health service, GP, Community, Acute and Mental Health & support at transitional stages

Digital enablers

- Patient records should be integrated, shared and accessible to all those providing care

Case management

- It is not just what services exist, but how people engage with the service and navigate the system that needs to be considered
- For complex service users who need to engage with multiple services, we need to ensure we have a case holder to support both the individual, the family and the clinicians

Examples of Local Best Practice were also referred to, including:

THRIVE Model

It conceptualises need in five categories; Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support.

Mind the Gap

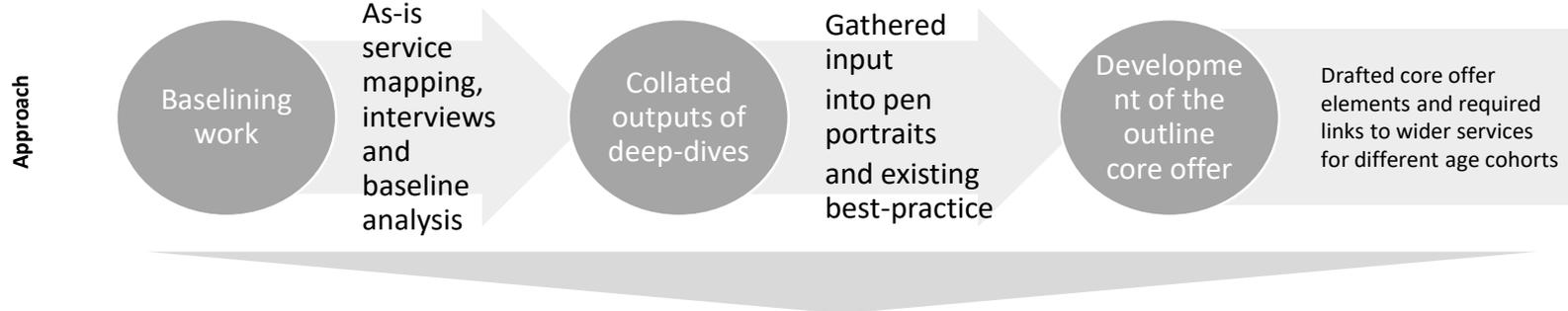
This supports young people's transition from agencies working with young people into adult mental health services. It also reviews cases in adult services where there is concern about young people disengaging from services and/or risky behaviours in the context of their mental health needs.

Co-Production Collective

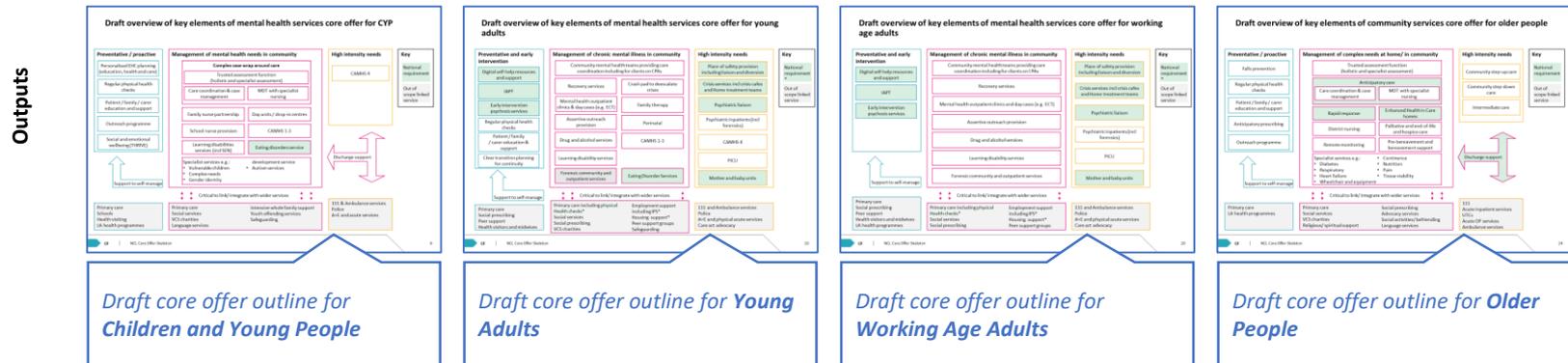
UCL-based facilitator for co-production



Development of a draft outline for the core offer



Through this approach we have drafted an outline of the core offer split by age profile



Service user and resident engagement

Resident Reference Group established

- 20+ volunteers recruited comprising service users, carers, residents, representatives from patient groups and who are broadly representative of each of the five boroughs and in terms of diversity.
- Discussions relating to service user and carer experiences. Examples of themes included:
 - Fragmented services, constantly changing, so difficult for service users and carers to navigate
 - Lack of responsiveness of services, long waiting times, but in particular unacceptably long waits for mental health support
 - Repeating their story to different NHS providers as no shared records, causing re-trauma and distress
 - Barriers to access – services not responsive to the needs of those with sensory impairments, language / communication barriers, cultural competence and responding to the needs of our diverse population
 - A more holistic or person centred approach to care needed, to be treated as a whole person, not just their diagnosis or health condition
- Reference Group feedback to be incorporated into the co-design workshops as part of review process and also shared with commissioners for ongoing discussions with providers. Three further Resident Reference Group meetings planned.

Residents survey launched

- We are inviting feedback from service users and carers on their experiences of services, both mental health services and / or community health services, in terms of what is/isn't working well and what could be improved. <https://feedback.camdenccg.nhs.uk/north-central-london/resident-survey-ncl-community-mental-health/>



Key Actions/Next Steps for the Community and Mental Health Service Reviews Programme

- We held **2 workshops in w/c 20th June** to move discussion from high level population 'pen pictures' and the very helpful feedback received to have a more granular discussion as to type of function e.g. care planning, community nursing, rapid response required by cohorts of population
- Use the forthcoming **July Design Workshops to further iterate and agree more granular details** on the core service offer e.g. on type of skills and competencies staff will need to deliver core offer but review will not address how these required skill and competencies will be delivered. This will be for partner in Provider Trusts to decide as part of transition and implementation planning
- Working with colleagues from Community Provider Trusts to **complete gap analysis on Ageing Well Programme** with a focus on Urgent Crisis Response, Enhanced Care in Care Homes and Anticipatory Care. Working closely within community services review Programme to **ensure delivery of guidance** happens quickly and gaps identified as part of our assessment are incorporated within the community services core offer work
- Continue to **work with partners from Mental Health Trust** to understand the work all ready in place or at a detailed planning stage to **deliver on national mental health requirements** e.g. on crisis care, on the community mental health framework to agree how it is incorporated with the mental health services core offer
- Continue work to review the **use of intermediate beds as part of community services programme** to ensure they are commissioned to support future surge requirements and population need
- Continue to link into the **ICS work on financial and workforce planning** as well as linking into **estates and digital work streams** across NCL
- Work closely with colleagues from Mental Health and Provider Trusts and Local Authorities to **test, challenge and review emerging recommendations** to ensure a no surprises approach to the September recommendations
- Continue to **engage with the voluntary and charitable sector, with service user/residents groups** etc. to ensure there is sufficient **co design and co-production** of the emerging core service offer for community and mental health services

Healthwatch Barnet Q1 Update

Health and Wellbeing Board

July 2021



Recently Completed Projects



Hospital Transport - Insight Report

- In March 2021, we were contacted by community organisations expressing difficulties in using hospital transport. We held focus groups to gather qualitative data.
- We have already reviewed the topic of hospital transport in 2017 and 2019 and Healthwatch England produce their report in 2019 too.
- **2021 update findings:**
 - Difficulties in booking the transport & long waiting times.



They tell me to wait 2.5 hours before an appointment and I'd rather they give me a realistic time. If I have an appointment at 10am then I have to be ready at 7:30am but I know they won't be there at 7:30am so if they gave me a more realistic time and I wouldn't be so tired by the time I get back home.



Hospital Transport - Insight Report

- High parking cost and difficulty in finding car parking spaces on hospital sites.
- Lack of information about available transport schemes, from the NHS and charities upon arrival, and different travel options.



It's been a positive experience with people, that's been fine. It's logistics that are the challenge, you either use hospital transport or don't.



- Impact of COVID-19 for in-person appointments for the future with digital healthcare.



As a deaf person, I would have difficulties in using more digital appointments in the future and would require an interpreter.

Not everyone has internet at home and it can be hard to communicate online sometimes for people with learning difficulties.



Deaf People's GP Challenges - Insight Report

- In April 2021 we attended a forum at the Jewish Deaf Association (for people of all faiths and none) and Barnet deaf residents shared their challenges with GP services. Consequently, we held focus groups to gather in-depth qualitative data.
- **Key Findings**
 - Lack of provision for qualified interpreters and over-reliance on family/friends.



I don't want my partner or family members to translate for me because they're not qualified interpreters, I don't feel confident and leave the doctor's feeling insecure.

Without communication, it affects our confidence and is a waste of time. It's not up to us to provide family members as a substitute.



Deaf People's GP Challenges - Insight Report

- GP staff not trained on being deaf aware.



Staff were wearing masks and I couldn't lip read them. Staff need to drop their masks when talking to deaf people. It was a very bad experience for me. I think the treatment was unfair, and deaf people suffer.

The worst time has been during COVID because I can't meet my doctor, I can't visit the surgery, they can't visit me, and the doctor always wants to talk to me with speech, but I can't use speech because I'm profoundly deaf.



- Negative impact upon deaf patients' mental wellbeing.



When I come home, I'm very down. I'm out but haven't understood anything that's going on around me. My family are worried about me, people are worried about me.

It's not just a hearing aid, it's an intrinsic part of our wellbeing and if we don't have it, it can affect our day to day lives in a big way.



Deaf People's GP Challenges - Insight Report

- Accessibility in the use of written language.



The GP surgery does not understand for deaf people English is not our first language. The English in letters has to not be so complex and at such a high level for us to understand.

Hearing people can phone and get an on-the-spot response but as a deaf person, I have to email, which gets a slow response.

- Difficulty with physical accessibility to GP surgeries.



I was outside the door [of the GP surgery] and there was a buzzer, there's a voice through the buzzer and a queue behind me. They don't know I'm deaf, there's a camera and I'm waving and saying I'm deaf, I need to get in. They should be aware that I'm deaf. Someone in the queue helped me and I had to tell them my name, but I had to rely on a stranger to help me.



Virtual Visit Pilot

- The pandemic has hindered all local HW's abilities to perform their Enter and View function.
- COVID-19 restrictions have continued in some form or another for almost the last 16 months, and beyond the hope that things will go back to some normality in Q3 2021 to allow us to start again, there is no guarantee.
- Healthwatch Barnet have been proactive & followed the steps of a few other local HWs that have carried out Virtual Visits as an alternative engagement tool whilst maintaining the spirit of Enter and View.
- There are known pros and cons to Virtual Visits.

Virtual Visit Pilot

- We conducted a pilot Virtual Visit in a residential care home. We used all 3 staff and 3 volunteers.
- We spoke with 8 staff members, 3 residents, and 12 relatives after the visit.
- Expect for a physical check of the building and a sense of smell and physical feel, this visit was as a comprehensive review of all areas of the service as it would be for an Enter and View visit.
- We have produced a report with 8 core recommendation for the service's management and they are currently producing their response to the report.

Recently Completed Community Events



Community Events

- April 2021 - Q&A with the senior management team of the Barnet division of BEH Mental Health Trust to answers questions from local residents.



It was very informative and useful to learn about the exciting news about the forthcoming transformation in Barnet.

- May 2021 - Dying Matters Awareness Week event and Q&A together with North London Hospice and Jewish Care. Panel included leading palliative care experts. Encouraging people to start their own ‘what matters to me’ conversations.

Thanks to the great panel, thought-provoking discussion and sensitive facilitation.

- June - Long COVID Event and Q&A together with Barnet COVID-19 Champions. Panel included Barnet GP, CCG and Long COVID reps.

Thank you Healthwatch Barnet for providing this useful information session and for taking Long COVID seriously/



Ongoing Projects



Accessing GPs through Remote Consultations Project

- COVID-19 has accelerated the use of digital technology in health and social care services.
- Digital healthcare has already been planned prior to COVID - NHS LTP
- There are pros and cons to accessing your GP/Nurse remotely.
- We have been gaining insight about people's experience of accessing and using GP practices remotely since Q1 2021.
- We have engaged with over 250 residents through 1-2-1, focus groups and an online survey.
- Final report is due at the end of July 2021.

Long COVID Project

- Recent data from ONS has shown 1 million people are self-reported to be suffering from long COVID that is impacting their daily live. The CCG anticipates, using national data, the prevalence in the NCL area is approximately 14,000 people.
- Given the novelty of the condition, in May 2021 we started a project to gain insight into people's experience of long COVID and the support availability locally, and identify if there are any gaps/areas of improvement within the long COVID pathway and feed that back into the CCG.
- In June we hosted an online event with local health leaders and the Barnet COVID-19 Health Champions and engaged with approx. 55/60 people. We have also started to collect insight through 1-2-1 interviews and an online survey and have engaged with an additional 25 more residents using those channels. Expected completion August.
- We will also be working with all 5 NCL HW's on an NCL wide Long COVID Project. Q2 start and the expected completion is December.



Barnet Together

Our Vision for Barnet Communities



Barnet Together

**YOUNG
BARNET**
FOUNDATION

**VB VOLUNTEERING
BARNET**
Inspiring and supporting volunteering

The power of experience
ib inclusion
barnet



Barnet Together

Our vision



A better Barnet for all those who live and work in the Borough,
based on real partnership and active collaboration.

Our mission



As representatives of a thriving and important stakeholder in the Borough, to work collaboratively with local government, in all its forms to ensure that all those who work or live in Barnet are getting the services and support that they deserve, while also recognising the constraints within which we all work.

Providing support, recognition and a voice



Supporting a large and diverse sector, which in turn supports a large and diverse population

1



Recognising the financial and social impact of the work we do

2

3

Making sure that we have a proper say in the development of services in the Borough



Our two high level outcomes



Barnet Together

1. Improve community and personal well-being
2. Build community and individual resilience with the local VCSE and Partners

Central to our offer is...



Barnet Together

Providing support for critical VCSE Sector roles:

1. **Creating and delivering, flexible, independent services** responding to residents needs.
2. **Enabling resident and community activity;** from volunteering to setting up local Community Interest Companies.
3. **Responding to residents needs** through organisational support
4. **Working independently or collaboratively** with public services informing and delivering public services to best meet the needs of residents from all backgrounds.
5. **Enabling residents, communities and groups to have a voice,** provide insight, influencing local decision making.



What we did, as a partnership, during the pandemic



Barnet COVID-19 Community Response

PROGRAMME MANAGEMENT STRUCTURE

Strategy and programme management

Executive SRO

BECC

Dawn Wakeling
Executive Director, Adults and Health

Director Lead

Jess Baines-Holmes
Assistant Director, Adults Joint Commissioning

LBB programme management
• William Cooper
• Emma Coles
Strategy Team

VCS strategic leads (Barnet Together)
• Katrina Baker
Volunteering Barnet
• Caroline Collier
Inclusion Barnet
• Janet Matthewson
Young Barnet Foundation

Workstreams

VOLUNTEERING

Strategic leads
Katrina Baker, VB
William Cooper, Strategy

SUPPLIES & DISTR.

Strategic leads
Chris Smith, AD Estates

ADULTS

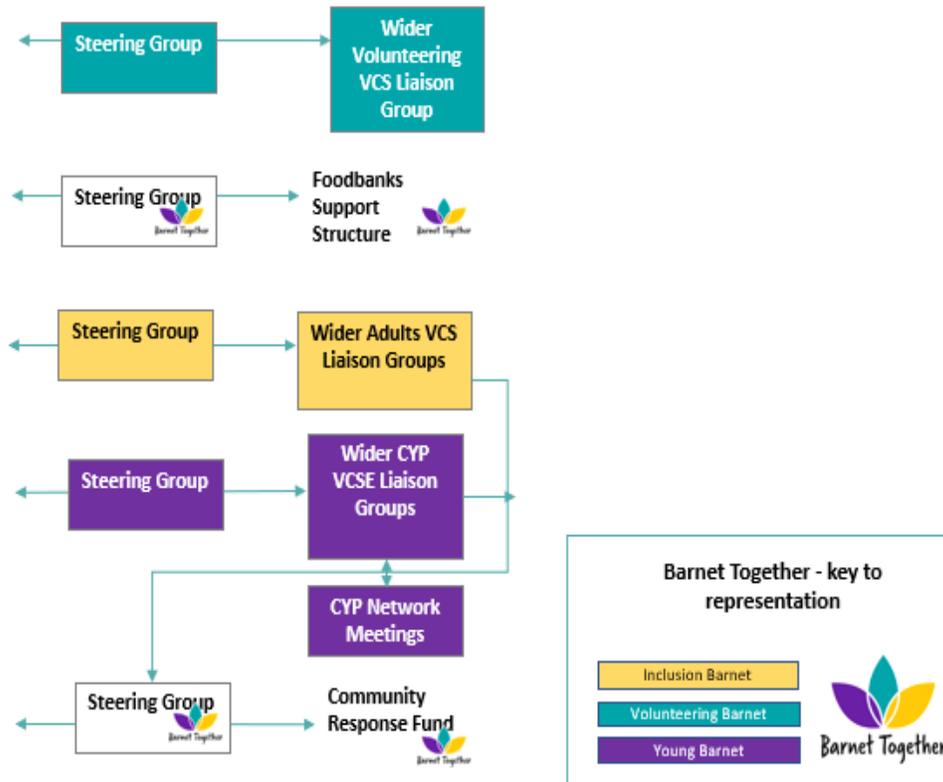
Strategic leads
Claire Desouza, Adults
Sarah Perrin, Adults / CCG

CHILDREN & YOUNG PEOPLE

Strategic leads
Grace Walker, Family Services

COMMUNITY & FAITH

Strategic leads
Katrina Baker, Groundwork
Caroline Collier, IB
Janet Matthewson, YBF



Barnet Together

Forming partnership with LA and wider partners

Trusted relationships to achieve outcomes quickly



Working Together Works

Highlights of strands building resilience...



Barnet Together

- **Response liaisons groups**
Adults - Children - Community & Faith - Volunteering
Food Supplies
- **MHLD Strategic partnerships**
- **CEOs network**
- **Investing in the sector** - Local Grant Funds – Space2Grow CYP Fund/Barnet Community Response Fund /ICP Fund

All built on the ethos of Generous Leadership

Barnet Together Connecting...



Barnet Together

Barnet Together continue to facilitate a number of networks:

- Adult Services Liaison Group
- Volunteering steering group and Liaison Group
- Community & Faith Network

- CEO Network
- CYP Community Network Meeting
- VCS Safeguarding Forum
- Environmental network
- Grassroots Groups network

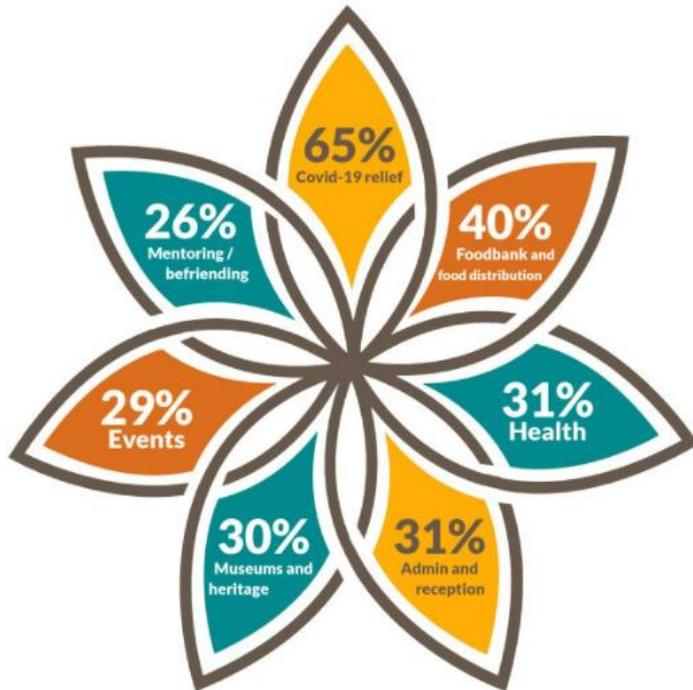
Mental Health Strategic Partnersip

Inclusion Barnet is also supporting the Mental Health Strategic Partnership and the Learning Disabilities Strategic Partnership. These groups will have a direct reporting link to the Health and Wellbeing Board, and aim to facilitate cross sector working to tackle strategic issues.

CYP partnerships

Young Barnet is working in partnership with Family Services across a number of boards to strengthening cross-sector relationships to improve outcomes for our Children/Young People

Volunteering Together ...



Types of volunteering by popular interest (of 210)



Screen shot of Volunteering Barnet Website: Covid-19 support

Barnet Together

- Response volunteering
- Central programme
- Local group support
- Partnerships and Networks

Volunteering supporting communities ...



Barnet Together

Call & Recall pilot
Working in partnership with NHS and other North Central London Boroughs on a Call and Recall volunteer role to support the uptake of the Covid-19 Vaccine by calling vaccine-hesitant patients.
Together Barnet has driven forward the first pilot for this role across NCL boroughs.

Covid Health Champions Development
Working with Public Health to set up Covid19 Health Champions to create a representative network of over 250 local people communicating Covid messagagin and sharing insight across every ward in the Borough

Vaccine roll out
In January 2021, Volunteering Barnet partnered with the NHS, North Central CCG, local pharmacies and GP practices to recruit and deploy volunteers to support the Covid-19 vaccination rollout across Barnet.

From the 11th January 2021 until 9th April, we supported 8 vaccination sites across Barnet, with a total of 1045 volunteer shifts deployed.

2,347 new volunteers

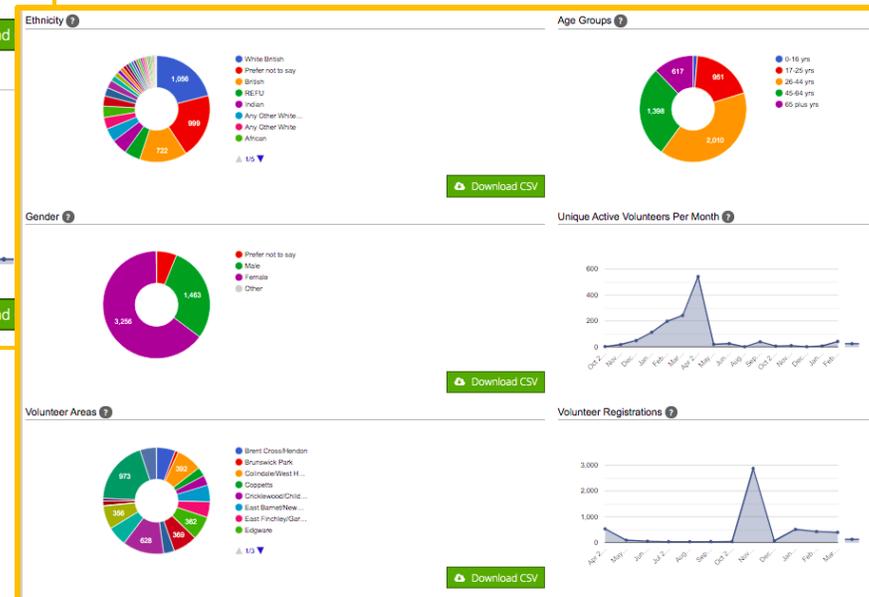
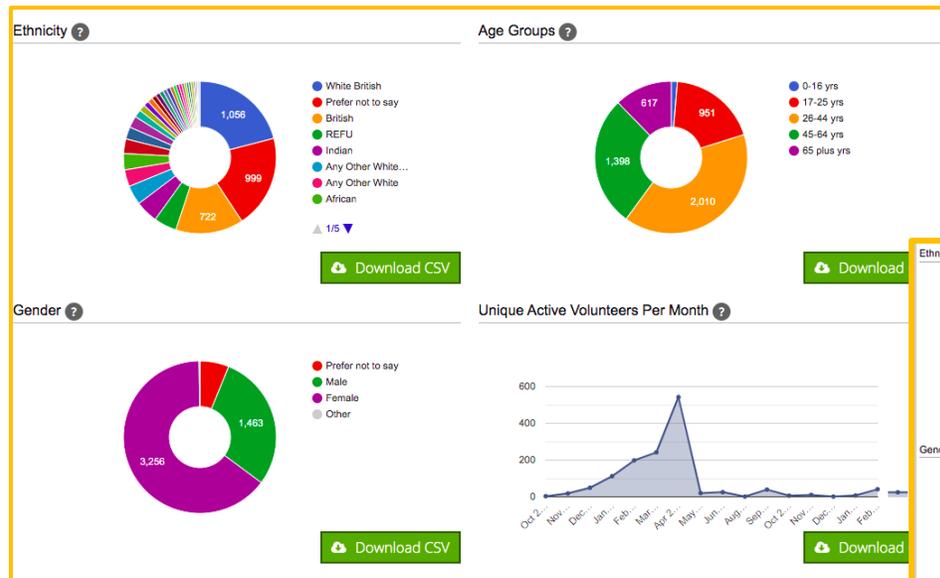
- 82% Volunteers from 2020 volunteered to help others
- 62% of volunteers felt more connected to Barnet through volunteering
- 77% of volunteers wanted to continue to volunteer post Covid

Doing things differently



Managing Volunteering Data

Barnet Together



Utilising Technology and digital solutions

Active management of volunteering levels and support

Ability to manage large scale coordination and deployment, with flexibility

Providing a passport for ongoing volunteering

More engaged residents

Working together to bring funding to the local sector..



Barnet Together

£200K

BACE HOLIDAYS

Barnet Active Creative Engaging holidays - BACE is an inclusive programme for children and young people who are in receipt of free school meals. Designed to experience active and healthy activities with an emphasis on physical, emotional, and nutritional wellbeing during the school holidays.

REGISTER NOW

Sign up at: barnetyouth.uk/BACEHolidays

Dates: Easter Holidays
Ages: 5-16 years
Location: Online and venues across the Borough of Barnet

FREE To find out about other projects that all children and young people in Barnet can access visit: www.barnetyouth.uk

Logos: FAMILY FRIENDLY BARNET, Department for Education, YOUNG BARNET FOUNDATION, BARNET LONDON BOROUGH

Barnet Community Response Fund



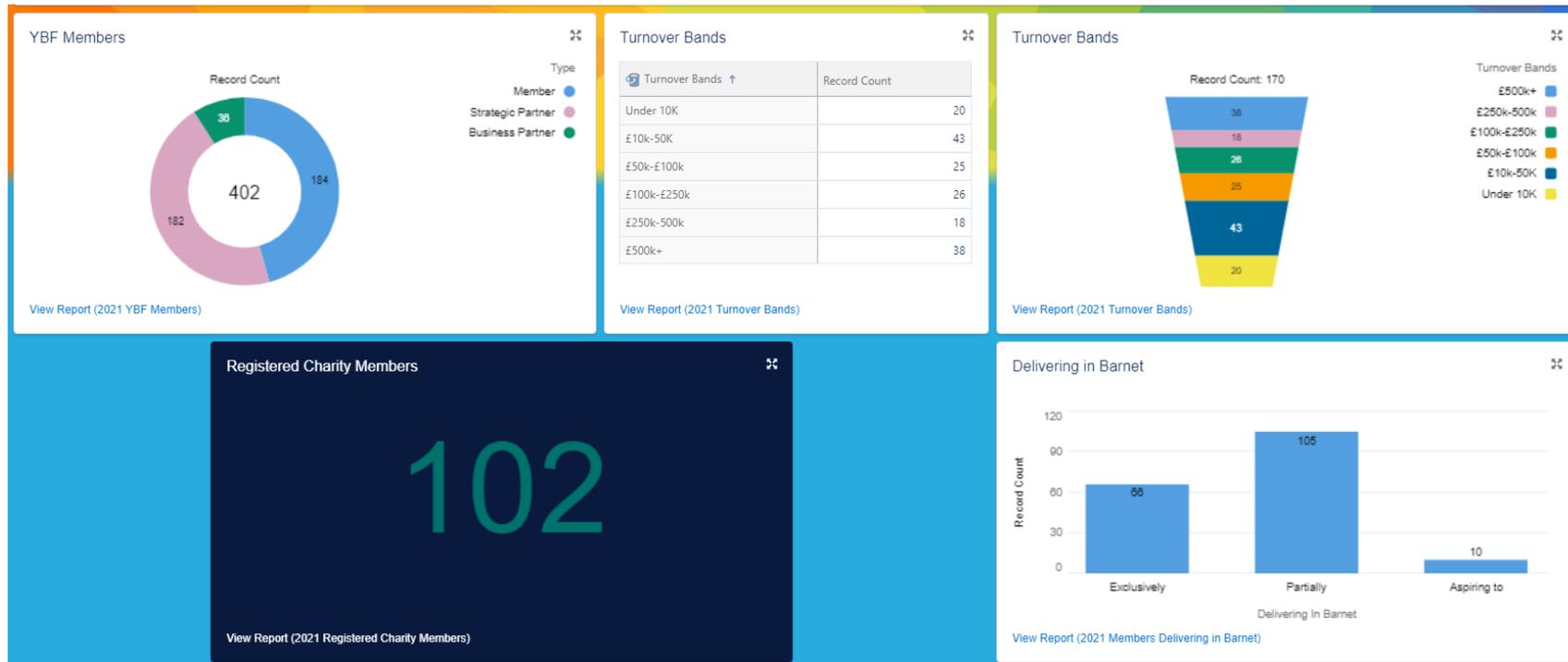
Local funding to meet local needs

Doing things differently



Capturing Better Data

Barnet Together



Barnet Together to continue its mission to introduce step changes within the sector that will enable us to

- to capture up to date information on our members - salesforce - annual membership (free)
- share information within a State of the Sector Report

Together we can focus on



Barnet Together

Supporting and developing the sector to:

1. **Identify, and appropriately meet unmet needs** and gaps in service provision (providing development/helicopter view).
2. **Enhance the capacity of the voluntary and community sector** by providing and promoting technical and practical support services (Support & Quality).
3. **Encourage networking, enabling the voluntary/community/faith** sector to share knowledge, information and skills, and to promote liaison between the voluntary, public and private sectors (Liaison/trusted relationships).
4. **Ensure effective and accountable representation** of voluntary and community sector views and interests (Representation).
5. **Broker an effective role for the voluntary/community sector at a strategic level** (Strategic Partnerships).



Healthy thriving sector



Barnet Together

Building for the future ...
Strengthening Partnerships and
building an alliance within and
for our community

Announcement

Generous Leadership...



Barnet Together

We, as Barnet Together, want to continue to build on our ethos of Generous Leadership and encourage all our members and partners to do the same. We want everyone to commit to being Generous Leaders - to be generous with their time, support, skills, information, resources, power, and in recognising the contributions of others.

Generous leadership creates that space to motivate, inspire and empower all of us to do more within our communities, it allows us to trust and collaborate so that our residents are the true beneficiaries. So, as Generous Leaders let's look up and forward so that together we can help create safer, stronger, more connected communities in Barnet, so all our residents thrive.

Working towards a Stronger, Safer, More Connected Community!

Questions?



Contact Details



Barnet Together

Barnet Together - <https://barnettogether.org.uk/>

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AGENDA ITEM 16

	<h2>Health and Wellbeing Board</h2> <h3>15th July 2021</h3>
Title	Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet
Report of	Public Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 – Health & Wellbeing Needs Assessment of Rough Sleepers in Barnet – Full Report
Officer Contact Details	Louisa Songer – Public Health Strategist Louisa.Songer@Barnet.gov.uk 020 8359 7587

Summary

In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. These arrangements ended in Barnet on 10th August 2020. At this time, London Borough of Barnet (LBB) continued to provide accommodation for those who had been placed in accommodation during the pandemic and also continued to offer accommodation to verified rough sleepers who were assessed as being vulnerable.

To appropriately address the needs of homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed this needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID brings additional complexities that are to be considered. The partnership included representatives from:

- Barnet Homes Housing Options Service
- Homeless Action in Barnet
- LB Barnet Public Health
- LB Barnet Community Engagement & Participation
- LB Barnet Adults & North Central (NCL) CCG Joint Commissioning Team
- North Central London (NCL) CCG

There are many different definitions of homelessness, but where the term 'homeless' is used in the need's assessment, it is intended to capture current rough sleepers and people with a history of rough sleeping who are now in temporary or communal accommodation.

Through the pandemic, Barnet accommodated almost 200 single people who were currently or at imminent risk of rough sleeping. Homeless Action in Barnet were at the time supporting 113 rough sleepers. This indicates that the actual number of rough sleepers in Barnet in the spring of 2020 was at least 113 people but could as many as 200. Many of those individuals remain in temporary accommodation whilst their support needs are assessed, and longer-term housing options are explored. However, some have returned to the street and although slow, there remains a continued new flow of people rough sleeping. It is estimated that in the spring of 2021, between 15-30 people were actively rough sleeping in Barnet.

The full Needs Assessment, including an Executive Summary, is provided as an Appendix to this report. The Needs Assessment provides information on the policy context, local specialist services, impact of the wider determinants of health on this group of residents, health and homelessness, health-related behaviours in homeless, mental health & suicidal ideation, substance misuse and multiple exclusion homelessness. Recommendations based on the findings of the report cover governance for the work arising out this needs assessment, furthering prevention opportunities, further insight and intelligence work, addressing barriers to suitable healthcare, housing and support pathways, addressing substance misuse and migrant health. Some work is already underway addressing these issues including a specialist project addressing substance misuse and homelessness.

Recommendations

1. **That the Board note the finding and recommendations of the needs assessment**
2. **The members of the Board commit to joint working to addressing the needs identified through the needs assessment of this underserved population**
3. **That the Board agree to receive future reports on action plans and progress on implementation of the recommendations of the needs assessment.**

1. WHY THIS REPORT IS NEEDED

- 1.1 In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. This meant that for the first time, Barnet accommodated all rough sleepers, regardless of whether they met eligibility criteria. This included people with no recourse to public funds who the council do not normally have a duty to accommodate.

In order to provide support to these residents, both in the short term during the pandemic, and on a more long-term basis, a partnership working group was established who led in the development of a health needs assessment.

This report summarises the findings and recommendations of the needs assessment, and what is required from the Health and Wellbeing Board to support successful delivery of the recommendations.

2. REASONS FOR RECOMMENDATIONS

- 2.1 The proposed recommendations are based on policy, evidence, best practice examples and experiences of local service providers.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

- 3.1 Not applicable

4. POST DECISION IMPLEMENTATION

- 4.1 The recommendations of this report will be delivered via the delivery mechanisms (Homeless Forum and strategic board) detailed in the report.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

- 5.1.1 Addressing homelessness and the longer-term impacts of COVID-19 is a key priority of the Barnet Corporate Plan 2021-25 within the “healthy” priority. The recommendations in this report directly support partners to achieve this priority.

- 5.1.2 Addressing the needs of rough sleepers in Barnet aligns with the priority to deliver integrated health services in the Health and Wellbeing Strategy 2021-25. Developing a health-focussed action plan to improve outcomes for homeless people and reduce avoidable secondary care presentations is specified within the strategy.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

- 5.2.1 There are no immediate financial implications for this report. The action plan arising out of the recommendations in the needs assessment will be delivered within existing staffing and financial resources in Public Health and Partner agencies such as NHS, Voluntary and Community sector organisations who are funded from diverse sources and for a wide range of purposes.

- 5.2.2 Grant funding has been obtained to date from the Ministry of Housing, Communities and Local Government (MHCLG) and Public Health England (PHE) to deliver specific programmes relating to homelessness. £286,598 has been received for deliver from March 2021 – April 2022. Confirmation of extension for a further 12 months is expected.

- 5.2.3 Evidence has indicated that addressing the health needs of homeless people at an early stage results in improved outcomes for the person and cost-savings across health and social care services.

5.3 Social Value

N/A

5.4 Legal and Constitutional References

5.4.1 The relevant legislation has been referred to in part 4 of the report.

5.4.2 Barnet Council Constitution, Article 7 – Committees, Forums, Working Groups and Partnerships, Health and Wellbeing Board responsibilities:

“(2) To agree a Health and Wellbeing Strategy (HWBS) for Barnet taking into account the findings of the Joint Strategic Needs Assessment (JSNA) and strategically oversee its implementation to ensure that improved population outcomes are being delivered.”

(3) To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing”

“(5) Specific responsibilities for overseeing public health and promoting prevention agenda across the partnership”

5.5 Risk Management

5.5.1 No specific risks associated with this decision.

5.6 Equalities and Diversity

5.6.1 The proposals in this report do not impact negatively on any protective characteristic group, or any other groups. The report demonstrates how people who are homeless often have worst health and wellbeing than the general population. The recommendations would result in this group having improved access to services and their specific needs met more suitably.

5.7 Corporate Parenting

5.7.1 N/A

5.8 Consultation and Engagement

5.8.1 This report and attached needs assessment have been developed in collaboration with key partners from:

- Barnet Homes Housing Options Service
- Homeless Action in Barnet
- LB Barnet Public Health
- LB Barnet Community Engagement & Participation
- LB Barnet Adults & North Central London CCG Joint Commissioning Team
- North Central London CCG

Consultation with staff working in and service users accessing homelessness services in the borough was also conducted as part of the report.

5.9 **Insight**

5.9.1 The findings in this need's assessment are informed by three main methods:

1. Service user and staff feedback and experience:

Service user feedback and the experiences of staff were collated by Homeless Action Barnet both for the purpose of this needs assessment and to inform continued service improvement.

2. Analysis of local and national data

An information sharing agreement was signed by local partners which allowed the partnership data to be analysed by the Public Health team. National data was utilised from a range of sources referenced in the report.

3. Applying principles from national evidence

Rapid literature review was undertaken exploring the impact of homelessness on health. National evidence is applied to help interpret local data and draw conclusions where data is incomplete.

6. **BACKGROUND PAPERS**

6.1 Full references for papers cited in the needs assessment are provided in the reference section of the needs assessment.

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Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet

Author: Louisa Songer

Role: Public Health Strategist – London Borough of Barnet

Date: June 2021

Contributors to report:

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1. Executive Summary

In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. These arrangements ended in Barnet on 10th August 2020. At this time, London Borough of Barnet (LBB) continued to provide accommodation for those who had been placed in accommodation during the pandemic and also continued to offer accommodation to verified rough sleepers who were assessed as being vulnerable.

People who are homeless were considered particularly vulnerable to COVID-19 for several reasons:

- Up to 60% of homeless people are at increased risk of severe illness from COVID-19 – primarily due to high levels of chronic illness.
- People who are street homeless, living in hostels (with shared dining and bathroom facilities and sometimes with shared rooms) and emergency accommodation will not always be able to follow government advice on social distancing and self-isolation.
- There is strong evidence of premature aging in the homeless population with the average age of death being 46 for men and 43 for women.
- Homeless people over the age of 55 often have an underlying co-morbidity, although this may not be diagnosed due to lack of access to services.
- In communal settings there will be a very high likelihood of outbreaks with high attack rates.
- Many have other complexities such as substance misuse and mental health issues.

To appropriately address the needs of homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed this needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID brings additional complexities that are to be considered. The partnership included representatives from:

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- LB Barnet Community Engagement & Participation
- LB Barnet Adults & NCL CCG Joint Commissioning Team
- NCL CCG

As a partnership, we are committed to delivering the effective and accessible services to our residents. Case studies and quotes in the needs assessment detail the experiences and feedback from people who use and work in services that support people who are homeless. We are committed to addressing the barriers and stigma described and continuing with the things that work well.

“The majority of people do not have any address/ proof of address. Although this are not required for homeless people to register with a GP, many GP practices do not accept this.”

“Some people who do have a GP get removed from the GP list as, due to their transient lifestyle, are out of the catchment area.”

“When homeless people try to engage or seek help, they often feel judged and marginalised because of their homelessness and often feel they are not being treated fairly or humanly.”

“The majority of homeless people already feel they don't have any value or worth. When you add mental health issues, or the negative response they often get in a GP Surgery or A&E it often stops them asking for help ever again.”

There are many different definitions of homelessness, but where the term 'homeless' is used in the need's assessment, it is intended to capture current rough sleepers and people with a history of rough sleeping who are now in temporary or communal accommodation.

It is not intended to capture the broader definition of homelessness that encompasses families living in temporary accommodation provided by the local authority.

The number of rough sleepers in Barnet is difficult to assess. It is estimated that in the spring of 2021, between 15-30 people were actively rough sleeping in Barnet but up to 200 could be at risk of street homelessness most of whom are currently accommodated in temporary accommodation. Barnet specialist service (HAB) have around 115 clients on their client list while regional estimates from CHAIN indicate that Barnet has 178 long term homeless residents.

Key findings:

1. Analyses of the wider determinants of health in two cohort's

There are many factors that cause homelessness and rough sleeping in Barnet, and it is likely that, as elsewhere in London, these cluster around two main factors: firstly people being asked to leave their accommodation for reasons including anti-social behaviour, rent arrears and relationship breakdowns and secondly relating to financial reasons linked to lack of employment. Approximately 90% of rough sleepers in Barnet are of working age; however, only 40% are in work or receiving job seekers allowance. This means that the other 60% of rough sleepers are either not eligible for benefits or eligible to work, or not able to work for health and other reasons. This finding demonstrates the need to focus on opportunities relating to employment, both in terms of prevention for people who are at economic risk and providing suitable employment and training options for people who are already homeless.

Secondly, the data indicates that a large proportion of Barnet rough sleepers are migrants, most commonly from Romania and Poland. Although there is work underway to support migrants to obtain settled status, these groups will need tailored support to access and engage with health and support services.

2. Health and Homelessness

The needs assessment has demonstrated that people who are homeless have different experiences of health services. Whilst some have good access to primary care, others appear to have no access or have been excluded. Case studies show homeless people experienced multiple, chronic health conditions which are often exacerbated by rough sleeping. They also identify that standard services are often not equipped to manage

these patients, as a more flexible approach is required that often involves longer appointments, in different settings, and include street-based outreach from clinical staff. The evidence indicates that homeless people experience a wide range of health issues, including mental health, musculoskeletal issues, skin conditions and respiratory conditions. There is therefore a need to consider how local health services can improve prevention, diagnosis and treatment of those conditions that disproportionately impact on homeless people. Additionally, people who are not originally from the UK face increased personal and structural barriers to utilising and navigating health services; and those people who were restricted from accessing secondary care felt their needs could not be adequately met and therefore risked developing serious illness that would result in emergency care.

3. Health-related behaviours:

The evidence in this report emphasises the need for all healthcare professionals to use their skills and relationships to maximise their impact on avoidable illness, health protection and promotion of wellbeing and resilience. The partnership has worked proactively and collaboratively to protect homeless people from the risks of COVID-19; however, further work must be done to ensure that other key public health interventions such as smoking cessation, cancer screening and immunisations are accessible.

4. Mental Health & Suicidal Ideation

Mental health concerns are a theme that present throughout this report. Case studies and feedback from staff and service users demonstrate how mental health pathways can be difficult to navigate, with staff working in homelessness services often feeling like they have no specialist support when working with people with multiple and complex needs. There is therefore certainly a need to clarify pathways and improve access to mental health support.

Furthermore, it is apparent that homeless people are at increased risk of suicide and there is certainly an opportunity to maximise suicide prevention work with this high-risk group.

5. Substance Misuse:

Comparable to London and national data, the rates of substance misuse reported in Barnet rough sleepers is low. As substance misuse can be both a driver for and an outcome of homelessness, it is probable that the Barnet data under-reports local prevalence. The reasons for the under-reporting are unclear and can be the result of poor identification, poor recording and reporting or the absence of suitable services. The PHE grant secured to develop specialist rough sleeping and substance misuse provision will address these issues and aims to improve the identification and access to support for homeless people.

6. Multiple Exclusion Homelessness

The reasons for homelessness are often a combination of structural and personal factors. What is clear from the literature is that many of those who find themselves as homeless, do so because of early exposure to significant trauma or adverse experiences in early childhood.

In order to address the issue of homelessness, it is essential to understand the circumstances, experiences and severe and multiple deprivation/social exclusion, which have impacted significantly on those individuals who have found themselves as homeless, and to recognise that there isn't a single intervention that can tackle this on its

own, at population, or at an individual level. Better-integrated working across health and social care is needed to help people to access and navigate the range of physical and mental health and substance misuse services they require to sustain stable accommodation. Furthermore, it is essential to develop a life-course approach to preventing homelessness across partnerships.

Recommendations:

1. Governance, Oversight and Prevention Opportunities

- Establishing and improving governance and oversight
- Updating LB Barnet Homeless and Rough Sleeper Strategy including opportunities for secondary prevention of homelessness
- Developing clear links to LB Barnet Suicide Prevention Strategy

2. Improving insight and intelligence:

This needs assessment highlighted some specific areas where improved consistency in record keeping would help the insight into this group of people, as well as some areas where information is lacking. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. This routine collation and sharing of information would also support the partnership to develop a joint client list to facilitate holistic care.

3. Addressing barriers to accessing suitable health care:

- There are a range of resources developed by Healthy London Partnership that can be adapted and reviewed for local implementation. This could help improve access to primary care services.
- Reviewing the NCL CCG locally commissioned homeless health service with consideration to how this service works proactively and flexibly, and facilitates pathways into other health services
- Improved collaboration between LB Barnet and NCL CCG to develop local implementation of the proposed London workplan
- Engage with the Barnet Integrated Care Partnership (ICP) health inequalities priority to consider opportunities for homelessness prevention through the life-course.
- Improved access to routine screening and immunisations programmes

4. Housing and Support Pathways

The recent COVID-19 pandemic has highlighted the need to review pathways for single homeless people, particularly for those with multiple or complex needs, with a focus on improving access when there are mental health concerns.

5. Addressing Substance Misuse Issues

Specific resources should be directed to:

- upskill the current workforce to improve identification
- identify additional resources to work with people with multiple complexities such as dual diagnosis and substance misuse to provide appropriate treatment and support.

6. Improving Migrant Health

There are a range of services and initiatives to help people sleeping rough sleeping who are not from the UK to come off the streets and rebuild their lives. However, many non-UK rough sleepers do not engage with local services and as a result little is known about their health and support needs. Consideration must be given to suitable ways to engage with non-UK rough sleepers to understand their specific health and support needs.

2. Background & Introduction

In March 2020, in response to the COVID-19 pandemic, the government announced that all homeless people in the UK should be supported into accommodation. These arrangements ended in Barnet on 10th August 2020. At this time, London Borough of Barnet (LBB) continued to provide accommodation for those who had been placed in accommodation during the pandemic and also continued to offer accommodation to verified rough sleepers who were assessed as being vulnerable.

(Note: A “verified” rough sleeper is one that has been seen rough sleeping by an outreach worker and had their unique details recorded on the CHAIN¹ database)

The partnership included representatives from:

- Barnet Homes Housing Options Service
- Homeless Action in Barnet
- LB Barnet Public Health
- LB Barnet Community Engagement & Participation
- LB Barnet Adults & NCL CCG Joint Commissioning Team
- NCL CCG

To appropriately address the needs of homeless people in Barnet through the pandemic, a multi-agency partnership task and finish group was established. This group developed this needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID brings additional complexities that are to be considered.

COVID-19 is a novel coronavirus that was first discovered as a human outbreak in Wuhan, China in December 2019. As this is a novel virus it is thought that everyone is susceptible to an initial infection with the COVID-19 virus and that there is no evidence of prior immunity other than from COVID-19 infection.

Whilst all people of all ages are susceptible to infection, older people and people with pre-existing medical conditions appear to be more vulnerable to being seriously ill with the virus. Whilst most people will have a mild illness and recover, some people will become seriously ill and there can be a rapid transition from mild symptoms to life-threatening illness and death. Death rates from COVID infection vary by age, ethnicity, and gender.

People who are homeless were considered particularly vulnerable to COVID-19 for several reasons:

- Up to 60% of homeless people are at increased risk of severe illness from COVID-19 – primarily due to high levels of chronic illness.
- People who are street homeless, living in hostels (with shared dining, bathroom, and sometimes with shared rooms) and emergency accommodation will not

always be able to follow government advice on social distancing and self-isolation.

- There is strong evidence of premature aging in the homeless population with the average age of death being 46 for men and 43 for women.
- Homeless people over the age of 55 often have an underlying co-morbidity, although this may not be diagnosed due to lack of access to services.
- In communal settings there will be a very high likelihood of outbreaks with high attack rates.
- Many have other complexities such as substance misuse and mental health issues.

Scope:

To appropriately address the needs of homeless people in Barnet through the pandemic and beyond, a multi-agency partnership task and finish group was established. This group developed this rapid needs assessment to understand the support needs and complexities of this group. Whilst this needs assessment is a broad health needs assessment, COVID-19 brings additional complexities that are to be considered.

The findings will be used to:

- a) ensure suitable health and care support is available for homeless people in Barnet
- b) support homeless people in Barnet to access and maintain appropriate housing
- c) support new rough sleepers to access suitable support and housing.

There are many different definitions of homelessness, but where the term 'homeless' is used in this document, it is intended to capture rough sleepers and people with a history of rough sleeping who are now in temporary or communal accommodation. It is not intended to capture the broader definition of homelessness that encompasses families living in temporary accommodation provided by the local authority.

Governance:

The formal governance for the delivery mechanism of recommendations from this needs assessment is to be established. A recommendation is to establish a Strategic Homelessness Forum. Sub-groups of this forum may then be established to deliver particular themes, including an operational group focusing on substance misuse and homelessness. The Homelessness Forum will report progress to the Health and Wellbeing Board and Housing & Growth Committee.

3. Aims & Objectives

Aim:

The aim of this needs assessment is to understand the health and support needs of rough sleepers in Barnet, and to support them in to, and to maintain, appropriate housing.

Objectives:

- Identify the population that are rough sleeping or in hostels/hotels/temporary accommodation in Barnet and their demographics
- Identify the priority health needs for this group
- Identify any barriers to health services

- Identify the services already in place to improve access to health services
- Inform support and commissioning
- Inform step-down arrangements post COVID-19

4. Policy Context

The key legislation and other policy drivers and implications for local services are summarised below.

Housing Act 1996:

The primary homeless legislation - Part VII of the Housing Act 1996 provides the statutory foundations for action to prevent homelessness and provide assistance to people who are either threatened with homelessness or who are homeless. The Act includes:

- The principal criteria for determining which duties a local authority will owe to a homeless applicant
- Duties to inquire into an application
- How and when an applicant should be notified of a decision
- Main accommodation duties and the ways in which they can be discharged
- How a decision can be challenged

The Housing Act since having been introduced has been reviewed and amended multiple times. Notably, The Homelessness Act 2002 placed a requirement on local authorities to regularly review the levels and likely future levels of homelessness in their areas and ensure a more strategic approach to preventing and tackling homelessness by requiring a homelessness strategyⁱⁱ. The Localism Act 2011 amended the 1996 Act further by giving local authorities powers to end the main housing duty by arranging an offer of suitable accommodation in the private rented sector.

The Homeless Reduction Act (HRA) 2017:

Implemented on 3 April 2018 was arguably the most significant change to homeless legislation to have taken place in recent times. The HRA placed new duties on local authorities to assess an applicant's need, intervene earlier to prevent homelessness and take reasonable steps to relieve homelessness for all eligible applications, regardless of whether they are considered as having a priority need under the Act. The HRA does not replace previous legislation but 'bolts on' new duties and only applies to those who applied as homeless after 3 April 2018. The purpose of the Act aims to reduce homelessness by:

- Improving quality of available advice
- A renewed focus on prevention work by local authorities
- Increase the support for single people
- A focus on partnership and joined up working from different services to provide better support for people especially those leaving institutions and other groups at increased risk of homelessness

Homelessness Code of Guidance:

The Homelessness Code of Guidance for Local Authorities is issued by the Ministry for Housing, Communities and Local Government (MHCLG) and provides statutory

guidance on how to interpret and apply homelessness legislation. Whilst not legally binding, local authorities are required to have regard to it where failure to do so could be used as a basis for judicial review challenge. The Code is periodically reviewed and was last updated at the end of June 2020, making changes to the chapter on Priority Need to reflect groups who are vulnerable from COVID-19 due to their health or history of rough sleeping. The main changes were that:

- Housing authorities should carefully consider the vulnerability of applicants from COVID-19. Applicants who have been identified by their GP or other specialist as clinically extremely vulnerable are likely to be assessed as having a priority need during the ongoing COVID-19 pandemic. The vulnerability of applicants with underlying health conditions that increase the risks from COVID-19 should also be considered in the same context.
- Housing authorities should also carefully consider whether people with a history of rough sleeping should be considered vulnerable in the context of COVID-19, taking in to account their age and any underlying health conditions.

“Everyone in”:

On 26th March 2020, during the early stages of the COVID-19 pandemic, the government launched its “Everyone In” campaign. Everyone In required local authorities to take urgent action to house rough sleepers, and those at risk of rough sleeping, to protect people’s health and reduce wider transmission of COVID-19. This included rough sleepers who would not normally meet eligibility criteria for housing and those people with no recourse to public funds (see below for definition). This required ‘self-contained’ rooms (with toilets and food service) or rooms with minimal sharing of facilities and increased cleaning (for example, if more than one person had to share a bathroom) to enable people to practise social distancing and self-isolate, as appropriate.

This marked a truly health-led response to rough sleeping in London. The NHS, local authorities and voluntary-sector organisations came together to triage people according to their risk level from COVID-19 and support them into the most appropriate type of accommodation available:

- COVID Care, providing a higher level of medical support for those presenting with symptoms
- COVID Protect, providing support and care for people who are most at risk
- COVID Prevent, providing support and care for those who are less vulnerable.

“No Recourse to Public Funds”

The term “no recourse to public funds” (NRPF) is used through this report and applies to people who are ‘subject to immigration control’ and, as a result of this, have no entitlement to certain welfare benefits, homelessness assistance and an allocation of social housing through Barnet Homes. This includes non-EEA (European Economic Area) nationals who require leave to enter or to stay in the UK, but do not have such leave; non-EEA nationals who do have leave which is subject to a condition that they have no recourse to public funds or have leave which is subject to a maintenance undertaking. Examples of people with NRPF include those with refused asylum claims, illegal entrants, and visa overstayers.

EEA nationals are not ‘subject to immigration control’ under section 115 of the Immigration and Asylum Act 1999, and therefore are not automatically excluded from

claiming benefits or housing assistance. They will however be ineligible for these if they fail the right to reside and/or habitual residence tests. They are often referred to as having NRPF. An EEA national who is not exercising treaty rights e.g. working or in training or education is not usually eligible for homelessness services.

NHS Long Term Planⁱⁱⁱ

Following announcements from the Government of additional funding for the NHS, the NHS developed their plan and vision to make sure the NHS has a bright future ahead of it. The plan, developed collaboratively with national leaders and partners, sets a vision for how people working in the NHS will be supported to deliver that care and identifies the actions to be taken.

Regarding homelessness specifically, the plan identifies that the NHS England will invest up to £30 million extra on meeting the needs of rough sleepers, to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services.

Beyond this, the plan commits to more NHS action on prevention and health inequalities which is certainly relevant to homeless populations.

Public Health England guidance “Homelessness: Applying all our health

Finally, the Public Health England guidance^{iv} outlines that for most people who are at risk of, or experiencing, homelessness and rough sleeping there isn't a single intervention that can tackle this on its own, at population, or at an individual level. The guidance goes on to describe the action required to support better-integrated health and social care, and to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation.

Health and care professionals play an important role, working alongside other professionals to:

- Identify the risk of homelessness among people who have poor health, and help prevent this
- Minimise the impact on health from homelessness among people who are already experiencing it
- Enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own.

The guidance recommends that there needs to be clear local action, strategic partnership working (across the local authority, clinical commissioning group and other local organisations) and understanding and alignment of commissioning decisions to prevent and respond to homelessness across the life course.

This could include:

- Strategic partners recognising homelessness as evidence of health (and wider) inequalities in their policies, and taking appropriate action to contribute to homeless prevention and reduction
- Health and Wellbeing Boards recognising homelessness in their Joint Strategic Needs Assessment, and if appropriate, in their Health and Wellbeing Strategies

- Developing local data systems to ensure recording of information about patients and service users housing circumstances, including homelessness, and that this is used to inform integrated, person-centred, commissioning and delivery across sectors and services
- Monitoring feedback on access to services and outcomes to local commissioners, as experienced by homeless patients or other homeless service users

5. Methods

The findings in this need's assessment are informed by three main methods.

- Service user and staff feedback and experience**
Service user feedback and the experiences of staff were collated by Homeless Action Barnet both for the purpose of this needs assessment and to inform continued service improvement.
- Analysis of local and national data**
An information sharing agreement was signed by local partners which allowed the partnership data to be analysed by the Public Health team.

Much of the data provided by local partners is self-reported. Obtaining accurate and representative data on this population is challenging, due to poor uptake of health services, formal diagnosis data may underestimate condition and self-reported data may also under-represent due to lack of disclosure. However, triangulation of multiple local data sources which can be supplemented and compared with national data sets allow us to form reasonable conclusions for this need's assessment.

The main local data reviewed was:

Barnet Homes:

Barnet Homes manages and maintains Barnet Council's housing stock and provides various housing functions including Barnet's Housing Options Service.

Analyses of Housing Options (HO) cohort

Barnet Home's Housing Options (HO) Service provided a list of rough sleepers (n=190) which had been accommodated through the COVID-19 pandemic. The data included some basic demographic information and limited information relating to housing need.

Analyses of demand data

Barnet Home's Housing Options Service also provided some service usage data for their departments.

Homeless Action Barnet:

Homeless Action in Barnet (HAB) offers practical services including food parcels, access to Wi-Fi and shower facilities but focus on working with people to achieve and sustain the change they want in their lives. They work with people who are at risk of losing their place to stay, and people who are currently homeless.

Homeless Action in Barnet (HAB) gained the consent of 83 homeless people to share the data collected as part of their assessment and engagement with the service.

Analyses based on combined HAB consented people and Housing Options (HO) data:

The data for the 83 homeless people consented by HAB was combined with Housing Options data to form a new combined list of 48 individuals, which was composed of 44 males and 4 females.

North Central London (NCL) CCG Homeless Report:

Data on homeless people within Barnet at GP practice level was received from North Central London (NCL) CCG. The report identifies 663 homeless people across 52 GP practices in Barnet. It is unclear on what criteria GPs use to classify and record an individual as a rough sleeper and therefore it is expected that this cohort includes people who fall into broader homeless categories beyond rough sleeping, and that many of this cohort may not be currently homeless or rough sleeping.

Stay Club report:

On 10th June 2020, there was a site visit to the Stay Club hotel by Brent GPs. At the time of the visit, there were 59 residents within the hotel, of which 43 were seen. The report includes basic summary information of the doctors' appraisals.

There are a range of regional and national data sources available that have been used as part of the analysis throughout this report, both to supplement what is known about the local population and to allow national comparison.

CHAIN:

CHAIN is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping.

CHAIN allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population and to identify emerging needs.

Homeless Link Data:

Homeless Link are the national membership charity for organisations working directly with people who become homeless in England. They publish up-to-date information, including good practice resources and research. They also use data to identify trends and gaps in provision and provide relevant sector intelligence.

iii. Applying principles from national evidence

Rapid literature review was undertaken exploring the impact of homelessness on health. National evidence is applied to help interpret local data and draw conclusions where data is incomplete.

Limitations:

Data quality: The local data used in this report was captured for assessment and housing purposes and therefore not necessarily collected in a systematic way across providers.

Combined data sets to assess multiple needs: Data was not collected specifically for the purposes of this needs assessment and therefore retrospective consent had to be

obtained for some analysis. Additionally, it was not possible to analyse personal data from multiple sources to provide a richer picture of individual's needs.

6. Service User Experience

As a partnership, we are committed to delivering the effective and accessible services to our residents. The following case studies and quotes detail the experiences and feedback from people who use and work in services that support people who are homeless. We are committed to addressing the barriers and stigma described and continuing with the things that work well.

Client 1

Client has progressively deteriorating vision. He presents with mental health problems and distress which he consistently does not acknowledge. He becomes agitated at the mention of any psychological difficulties.

His vision causes problems with orientation. A degree of peripheral vision has been retained but his ability to orientate himself is becoming more difficult. Reading his post is impossible, he can't send a text message.

Some months ago, his optician suggested an urgent referral to Moorfields. Client will not allow us to support him to access outpatient ophthalmology. We have only been able to snatch a glance at the clinical report from the optician.

Client 2

Client has Korsakoff Syndrome, historic head injury and a history of substance misuse. He presents with amnesiac syndrome mimicking dementia.

He has had 4 hospital admissions plus police involvement over the last 4 months due to wandering and getting lost.

Social services (older adults) assess client as having capacity and reject client on the basis of continued substance misuse.

The symptoms he experiences are evident to staff that support him but a comprehensive neuro/psych assessment is hard to access due to his complexities and resulting behaviour.

HAB staff and service users were asked for feedback regarding general barriers to services. The following was provided:

The majority of people do not have any address/ proof of address. Although this are not required for homeless people to register with a GP, many GP practices do not accept this.

Some people who do have a GP get removed from the GP list as, due to their transient lifestyle, are out of the catchment area.

Some homeless people do not trust “the system” or simply do not understand it.

Many of those who die homeless have mental health issues and even though the issue of mental health is being talked about more, rough sleepers find it incredibly difficult to engage.

When homeless people try to engage or seek help, they often feel judged and marginalised because of their homelessness and often feel they are not being treated fairly or humanly.

The majority of homeless people already feel they don't have any value or worth. When you add mental health issues, or the negative response they often get in a GP Surgery or A&E it often stops them asking for help ever again.

Language barriers.

Major difficulty in both arranging and keeping appointments. Other things can take over and seem more important.

Travel issues – many can't afford to get to their appointments.

If they don't understand the system most will only look to seeing a doctor once they are unwell.

No routine check-ups or health screening takes place as they cannot be reminded.

People can often be discharged back to the streets from hospital. On several occasions recently ambulances have brought discharged patients to our Centre.

Hospitals are reluctant to admit people for surgery if they know they won't have an address to be discharged to.

Nowhere to send Hospital appointments to that will guarantee they know about them before the appointment date. I've often seen a client open a letter which says the appointment was a week ago.

Access to dental care is almost impossible as you cannot get an appointment for the day its needed, so you end up with all the problems relating to appointments.

Early intervention isn't possible unless there is adequate and appropriate outreach. This often means things don't get picked up until they are more serious – this is not cost effective.

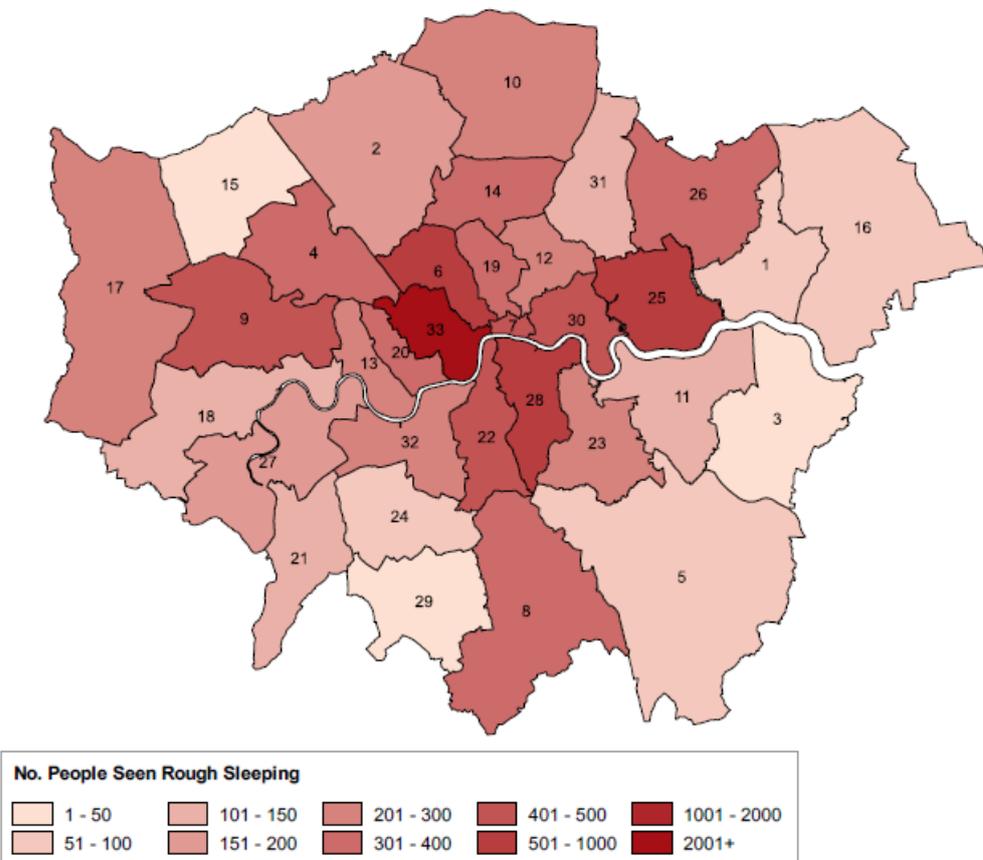
Providing services via the Centre is a much better solution – this can be seen from the high uptake of flu and pneumonia vaccinations and the TB screening by the mobile unit that comes every 6 months. This has already picked up one case of TB which meant treatment could be given and contacts traced etc.

7. The Local Picture

Figure 1 below shows the number of rough sleepers registered on the CHAIN database in 19-20 across London. Although the numbers of rough sleepers in Barnet are slightly lower than inner London boroughs, they continue to grow at a similar rate. It is also expected that boroughs in inner London would see higher numbers than outer boroughs. Barnet is similar to neighbouring borough Enfield but higher than many other outer London boroughs.

Total rough sleepers by borough: Map

The map below shows a colour coded representation of the total number of people seen rough sleeping during the year in each borough.



Key	Borough	Total	Key	Borough	Total	Key	Borough	Total
1	Barking & Dagenham	85	12	Hackney	275	23	Lewisham	229
2	Barnet	178	13	Hammersmith & Fulham	266	24	Merton	92
3	Bexley	42	14	Haringey	327	25	Newham	724
4	Brent	320	15	Harrow	45	26	Redbridge	330
5	Bromley	67	16	Havering	71	27	Richmond	152
6	Camden	639	17	Hillingdon	270	28	Southwark	548
7	City of London	434	18	Hounslow	147	29	Sutton	34
8	Croydon	306	19	Islington	367	30	Tower Hamlets	459
9	Ealing	493	20	Kensington & Chelsea	316	31	Waltham Forest	133
10	Enfield	206	21	Kingston upon Thames	124	32	Wandsworth	203
11	Greenwich	133	22	Lambeth	431	33	Westminster	2757
						34	Heathrow	241

Figure 1: The number of rough sleepers registered on the CHAIN database in 19-20 across London

A rough sleeper “snap shot” called a street count is conducted every year. This snap shot provides a picture of how many people are rough sleeping on a single autumn night. It’s a useful way to assess the change in numbers of people sleeping rough over time and for providing information on basic characteristics of a boroughs rough sleeping population. In 2019, the number observed in Barnet on a November evening was 24. In 2020, the number was 6. It is likely that this observed decrease is as a direct result of the governments drive for “everyone in” during the pandemic. It is impossible to determine the exact number of rough sleepers in a borough as many do not come in to contact with any services and remain hidden.

Through the pandemic, Barnet accommodated almost 200 single people who were currently or at imminent risk of rough sleeping. Homeless Action in Barnet were at the time supporting 113 rough sleepers. This indicates that the actual number of rough sleepers in Barnet in the spring of 2020 was at least 113 people but could be as many as 200.

Many of those individuals remain in temporary accommodation whilst their support needs are assessed and longer-term housing options are explored. However, some have returned to the street and although slow, there remains a continued new flow of people rough sleeping. It is estimated that in the spring of 2021, between 15-30 people were actively rough sleeping in Barnet.

Local Service Provision

There are various specialist services in Barnet that address the needs of people who are rough sleeping directly. These are:

- Homeless Action Barnet (HAB) – HAB are a local charity that offer practical support like food, clothing, washing machines, wi-fi and showers, but also personalised support to help people who are at risk of losing their accommodation, and for people who are already homeless. Through the pandemic, HAB kept in regular communication with people who were or had been recently rough sleeping, ensuring they had access to food and other essentials and supporting the co-ordination and delivery of their support packages.
- Barnet Homes’ Rough Sleeper Team - The Rough Sleeper Team engages with people who are sleeping rough around Barnet through a persistent and assertive outreach approach. They were a vital link to ensuring that people who were sleeping rough during the pandemic were supported into accommodation.
- GP in-reach – Homeless people can register with any GP, but two local GP’s deliver a satellite session in the HAB day centre to ensure that the physical and mental health needs of people who are homeless are not overlooked. They support their patients to access suitable healthcare and treat any presenting health problems. Through the pandemic, they continued to offer phone support to a number of their patients who had recently been homeless.
- Together in Barnet – winter night shelter delivered by the faith community across various locations in Barnet and resourced by volunteers. Due to the COVID-19 pandemic and restrictions around using shared spaces, the winter shelter was unable to deliver the usual model through the winter of 2020-21. Together in

Barnet successfully bid for a grant from the MHCLG Winter Transformation Fund to provide 16 hotel bed spaces for winter of 2020-21.

Services Commissioned by GLA/Mayor's office

The Mayor and GLA commission and fund a range of services to help rough sleepers come off the streets and rebuild their lives. These complement those provided by London's councils.

- **Streetlink**
StreetLink enables members of the public to tell specialist outreach teams about rough sleepers, ensuring that people are linked in with the most appropriate local support as quickly as possible.
- **Rapid Response Outreach**
This is an outreach service which focusses on rapidly responding to StreetLink referrals for rough sleepers. This supports our own outreach team by freeing up capacity to work with more people and allows us to focus on longer term rough sleepers within the borough.

In addition, people who are rough sleeping are supported to access other local services when required such as substance misuse treatment, mental health services and other social care services. Feedback from professionals supporting people who are rough sleeping, and from the residents themselves indicates that these services are often difficult to access and engage with for various reasons. This view is supported by the fact that a high number of people disclose additional support needs; however, many of these people are not receiving support for these needs. This will be explored in more detail later.

8. Analyses of the wider determinants of health in two cohort's

Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health. Such factors determine the extent to which different individuals have the physical, social, and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

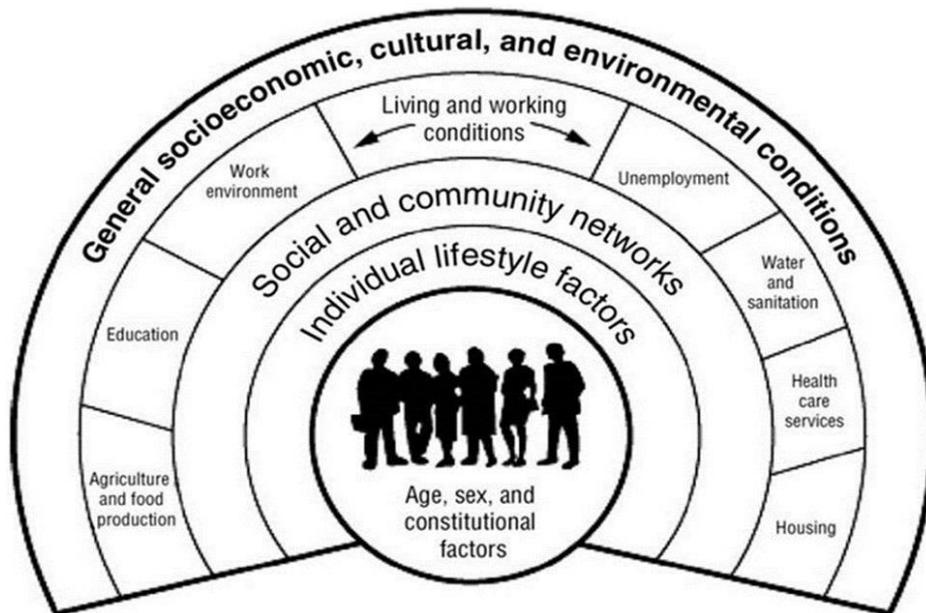


Figure 2: The Dahlgren and Whitehead model of health determinants^v

Analyses of Housing Options (HO) cohort

Barnet Home’s Housing Options (HO) Service provided a list of rough sleepers (n=190) which had been accommodated through the COVID-19 pandemic on which the following analyses were based.^{vi}

Age & Gender:

This HO cohort of rough sleepers is composed of 32 females (17%) and 158 males (83%) and has an age range of 18-75 years (mean age = 40.5 years). As with the HAB consented cohort, the most common age group for this HO homeless cohort is aged 30-39 years and once again this accounted for around a third of the overall group under consideration (35%, n=66) (refer to Figure 3). This is similar to the London picture (annual Chain report), where 17% of the sample were female and 83% male. Also, 32% of the sample in 2019-20 were aged 36-45 and 27% were aged 26-35.

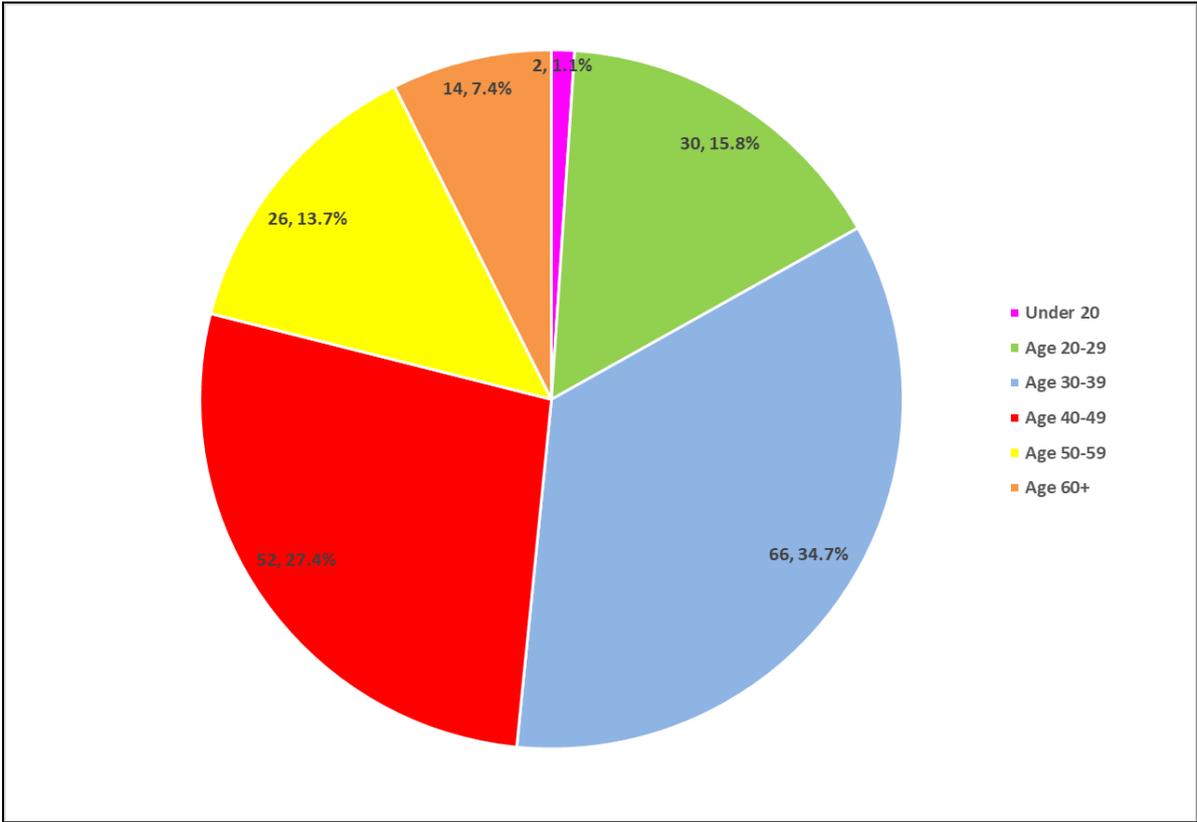


Figure 3: Age groups in rough sleeper cohort, July 2020 (n=190)
 Source: Housing Options (HO)

Nationality:

Table 1 shows the nationality of the HO cohort, based on counts and percentages. The most common nationality was UK national, 37%, followed by Romanian nationality for 15% (n=29) of the HO rough sleeper cohort. Similarly, across London, 48% of people who were rough sleeping were UK nationals and 30% were from countries in central eastern Europe. Like Barnet, people from Romania account for 15% of the London sample. This group has also grown the most over the last three years. In 2017/18 there were 664 people from Romania rough sleeping in London. Last year, this increased to 1,491.

Nationality	Count	Percentage
UK national habitually resident in UK	70	36.8%
Not available	31	16.3%
Romania	29	15.3%
Non-EEA country national	26	13.7%
Other EEA country national	14	7.4%
Poland	10	5.3%
Czech Republic	3	1.6%
Lithuania	3	1.6%
Bulgaria	1	0.5%
Hungary	1	0.5%
Latvia	1	0.5%
Slovakia	1	0.5%
Total	190	100.0%

Table 1: Nationality of Rough Sleepers (n=190)
Source: Housing Options (HO)

Reason for homelessness:

In 2019, The Ministry of Housing, Communities and Local Government and the Department for Work and Pensions commissioned Alma Economics to undertake a feasibility study^{vii} on the causes of homelessness and rough sleeping.

The review found that most research divides causes of homelessness and rough sleeping into structural factors (wider societal and economic issues that affect the social environment for individuals) and individual factors (personal circumstances of individuals).

Structural factors leading to homelessness include:

- Lack of affordable housing
- Decline of social sector housing as a proportion of all housing
- Tighter mortgage regulation and higher costs for first time buyers
- Unfavourable labour market conditions / rising poverty levels
- Growing fragmentation of families
- Reduced welfare provision

Individual factors include:

- Traumatic events
- Relationship breakdown (including domestic abuse and violence)
- Mental illness
- Addiction
- Discharge from prison
- Leaving the care system
- Financial problems

Beyond this, the factors can be categorised as social determinants of health. These are non-medical factors that influence health outcome

There is certainly an interaction of structural factors alongside individual factors. Structural factors create conditions within which homelessness is likely to occur, and people with personal problems that leave them at risk of homelessness are more vulnerable to being affected by these adverse conditions. In this way, the high concentration of people with complex personal problems in the homeless population can be explained by their susceptibility to adverse structural forces and not solely by their personal circumstances. Furthermore, the economic impact of coronavirus is exerting further pressure on people already pushed to the brink by low wages and high rents. This means we can expect a continued new flow of people experiencing homelessness.

Unfortunately, we are unable to report on the reason for homelessness for the Barnet cohort as this data was not captured in a meaningful way. For nearly two-thirds of the Barnet cohort (63%, n=119), the reason for homelessness was given as “Rough Sleepers Project,” which is not a specific reason for homelessness. Going forward, recording an alternative response to “Rough Sleepers Project” as the main reason for homelessness, would shed more light on the circumstances surrounding the entry into homelessness for the individual (see Table 2).

When “Rough Sleepers Project” is set aside as a reason for homelessness, the most popular response was “no fixed abode” (n=25, 13%). This still does not provide us with any meaningful information relating to the reason for homelessness.

Reason for homelessness	Count	Percentage
Rough Sleepers Project	119	62.6%
No fixed abode	25	13.2%
Relative or friends NTQ	9	4.7%
Parental NTQ	5	2.6%
Domestic violence and abuse from partner/husband	4	2.1%
Leaving prison	4	2.1%
Not provided (blank)	4	2.1%
AST term not rent arrears	3	1.6%
SWEP	3	1.6%
Affordable	2	1.1%
Leaving hospital	2	1.1%
NASS accommodation terminated	2	1.1%
Other loss tied accommodation	2	1.1%
Domestic violence and abuse from family member/associated person	1	0.5%
Emergency Fire or Floor	1	0.5%
Leaving institution	1	0.5%
Medical reason	1	0.5%
Private Sector arrears	1	0.5%
Sexual harassment and bullying	1	0.5%
Total	190	100.0%

Table 2: Reasons for homelessness for rough sleeper cohort, July 2020 (n=190)

Source: Housing Options (HO)

Key: NTQ = Notice to quit. SWEP: Severe Weather Emergency Protocol

Figure 4 below shows Information is available on reason for homelessness at a London level from the Chain annual report 2019/20. The data available is for approximately 50% of the London sample. It shows the leading driver of homelessness relates to people being asked to leave their accommodation. This could be for a range of reasons including anti-social behaviour and rent arrears. The second largest reason relates to financial reasons relating to lack of employment, and the third relating to relationship breakdown.

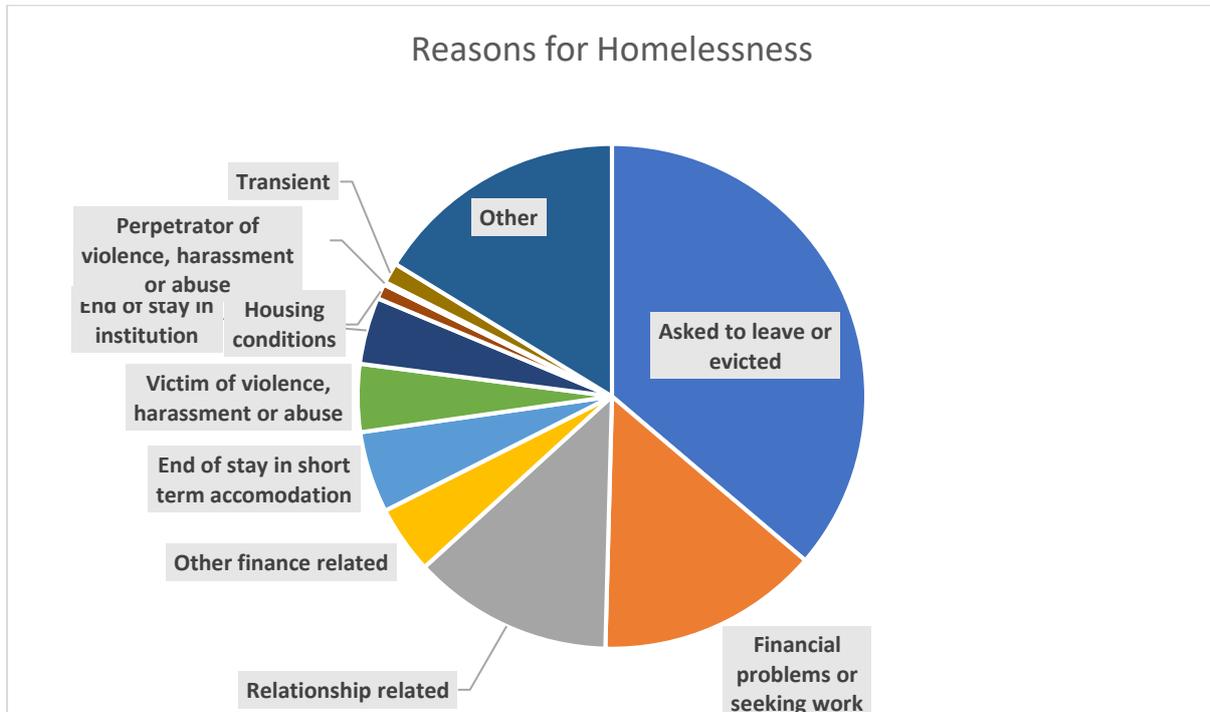


Figure 4 Reason for homelessness at a London level Chain Annual Report 2019/20.

Location of placements:

The most common borough for placing homeless people within this cohort was Brent, which accounted for over a third of placements (38%, n=73). Almost two-thirds of this cohort were placed in either Brent or Barnet (65%, n=124) and over three-quarters (76%, n=144) were living in either Brent, Barnet, or Haringey (refer to Table 3).

London Borough	Count	Percentage
Brent	73	38.4%
Barnet	51	26.8%
Haringey	20	10.5%
Enfield	14	7.4%
Not available (blank)	13	6.8%
Camden	6	3.2%
Harrow	6	3.2%
Hackney	5	2.6%
Ealing	1	0.5%
Islington	1	0.5%
Total	190	100.0%

Table 3: Where homeless people have been placed, by borough, July 2020 (n=190)
Source: Housing Options (HO)

Type of placements:

An analysis of the type of accommodation provided to this group of homeless people (based on “Construction type”), revealed that “studio” was the most common option, followed by “house of multiple occupation” and then “hotel room.”

During the COVID-19 lockdown and following government guidance, the HO Service has managed to provide temporary accommodation to significant numbers of rough sleepers (Table 3). The increased demand from this cohort posed a significant challenge on the HO service due to the increased number of applicants and reduced availability of accommodation. Several agents that Barnet Homes frequently use were closed or providing a limited service with not many new properties being available to them. Further, the UK wide ban on evictions which came into effect on 18 March 2020 meant that there was little to no movement from emergency accommodation for those already accommodated and thus resulted in reduced turnover. At the beginning of the lockdown in mid-March 2020, the majority of hotels we use for emergency accommodation were also closed.

Nevertheless, Barnet Homes put enormous efforts into securing accommodation for rough sleepers as part of the ‘Everyone In’ scheme in April 2020 within the borough or as close to the borough as possible. They were able to procure a few larger units where rough sleepers could receive ongoing support, as well as units where a custodian/security reception were open around the clock for support. When hotel or Houses in Multiple Occupation (HMO) placements were procured, cooking facilities or microwaves were placed in the rooms to allow clients to self-isolate in line with government guidance.

Throughout allocating properties, multiple factors were considered including:

- What accommodation was available at the time
- What accommodation was suitable to meet the applicant’s needs
- Whether or not the client was required to shield

- Any potential risks to the health and/or safety of the client or others
- Whether the client could access relevant support
- Whether bills needed to be included in certain cases (for example, for clients with No Recourse to Public Funds, etc.)

Table 4 shows the numbers and proportions of this cohort based on the type of accommodation allocated to them, as of mid-July 2020. Over half of the cohort were accommodated in a studio (55%, n=105), whilst 17% were in a house of multiple occupation (17%, n=33) and only 7% were in a hotel room (7%, n=14). 80% of this cohort of homeless people were accommodated in either a studio, house of multiple occupation or hotel room in mid-July 2020 (n=152).

Type of accommodation	Count	Percentage
Studio	105	55.3%
House of Multiple Occupation	33	17.4%
Not specified	21	11.1%
Hotel Room	14	7.4%
Flat	12	6.3%
Room or bedsit	5	2.6%
Total	190	100.0%

Table 4: Type of accommodation for homeless cohort, July 2020 (n=190)
Source: Housing Options (HO)

Analyses of Homeless Action Barnet (HAB) cohort

HAB gained the consent of 83 homeless people to share data that had been collected as part of their assessment processes. Much of the HAB data presented later in this report is based on self-reported information and therefore allows for a richer picture of personal circumstances.

Age & Gender:

The cohort ranged in age from 20 – 65 years (mean age = 41 years). The most common age group was 30-39 years, which accounted for around a third of the cohort (n=27; 33%). Less than one in ten of the cohort of consented homeless people were aged 60 and over (n=7, 8%). (refer to Figure 5). This is similar to the age range of the housing options cohort.

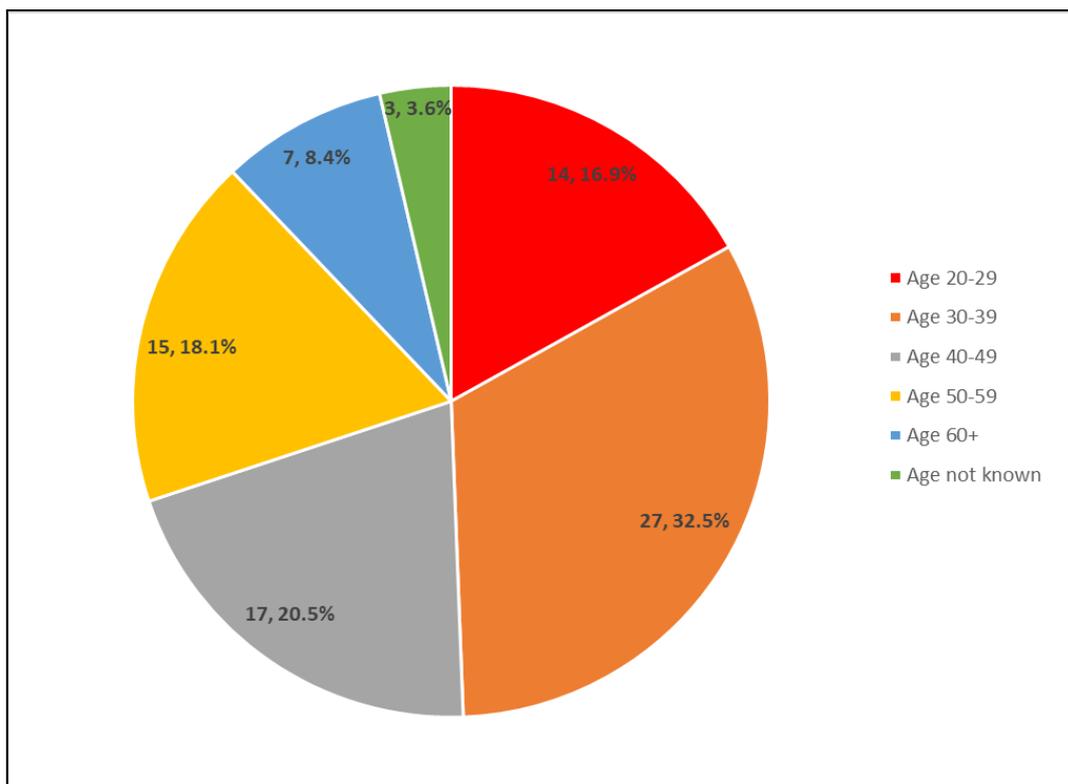


Figure 5: Age groups within the cohort of homeless people (n=83)
Source: Homeless Action in Barnet (HAB)

This is comparable to the Housing Options cohort.

Age range	HO Cohort %	HAB Cohort %
Under 20	1	0
20 – 29	16	17
30 – 39	35	33
40 – 49	27	21
50 – 59	14	18
60+	7	8
Unknown	0	4

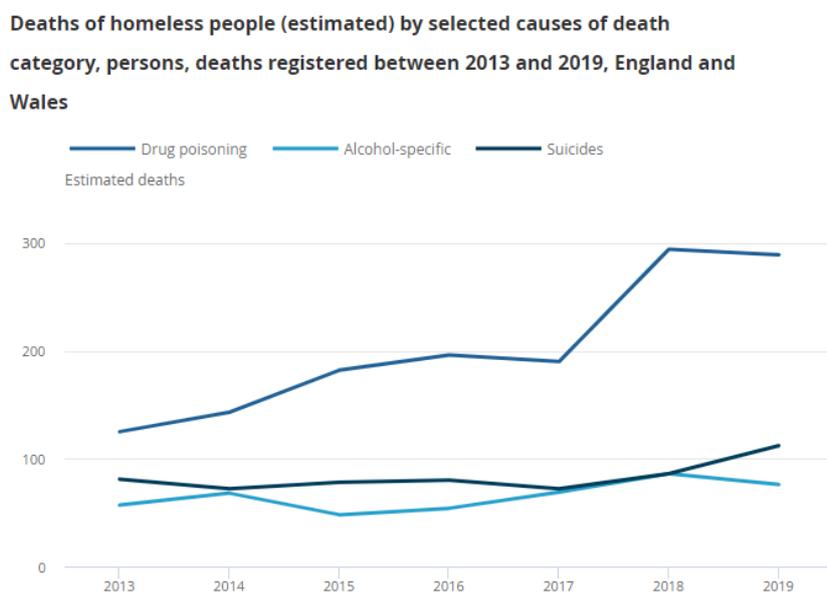
Table 5: Age comparison between HO Cohort and HAB Cohort

Age is relevant when considering homeless health needs; as mentioned earlier in this report, there is strong evidence of premature aging in the homeless population, with recent ONS^{viii} data showing an average age of death of 46 for males and 43 for females; in the general population of England and Wales, the mean age at death was 76 years for men and 81 years for women.

As in the general population, homeless people die from a broad range of causes such as accidents, diseases of the liver, ischaemic heart diseases, cancers, and influenza and pneumonia.

However, the ONS data also shows that in 2019 37% of deaths in the homeless population in England and Wales were related to drug poisoning. Suicide and alcohol-specific causes accounted for 14% (112 deaths) and 10% (76 deaths) of estimated deaths of homeless people in 2019 respectively.

Whilst deaths from drugs and alcohol have remained relatively stable, deaths from suicide have increased by 30% from 2018 to 2019. Suicide prevention work is explored later in this report.



Source: Office for National Statistics - Death registrations

Figure 6: Death of homeless people (estimated) by selected cause of death between 2013-2019

In terms of gender, the group was 84% male (n=70), 10% female (n=8), 1% transsexual (n=1) and 5% unknown (n=4). A larger percentage of female people (17% n=32) were accommodated by the housing options team through the pandemic.

On sexuality, 78% of this group were heterosexual (n=65) and one was bisexual (1%), whilst 10 preferred not to say (12%) and 7 did not provide data (8%). We do not have comparable data for the housing options cohort.

Nationality:

Data on country of origin was used as a proxy for nationality. Based on this data, the most frequent nationalities were Romanian, UK and Polish. Romania was reported as the nationality for a quarter of the homeless people (n=21, 25%) and the same proportion came from the UK (n=21, 25%). Ten homeless people (12%) were from Poland and a further 9 from Asian nations (11%).

Over half of the homeless people consented were from either Romania or the UK (n=42: 51%). Nearly two-thirds of the cohort were from Romania, Poland, or the UK (n=52, 63%).

Country of Origin	Total	Percentage
Romania	21	25.3%
UK	21	25.3%
Poland	10	12.0%
Asian Nation	9	10.8%
African Nation	7	8.4%
Lithuania	4	4.8%
Czech Republic	2	2.4%
Bulgaria	1	1.2%
European Nation (Non EU)	1	1.2%
Greece	1	1.2%
Ireland	1	1.2%
Portugal	1	1.2%
Slovakia	1	1.2%
South American Nation	1	1.2%
Not provided (blank)	2	2.4%
Total	83	100.0%

Table 6: Nationality of HAB consented cohort (n=83)
Source: HAB data on country of origin

Looking at the HO cohort in comparison to the HAB cohort, UK nationals form a larger percentage and accessed accommodation more than other nationalities.

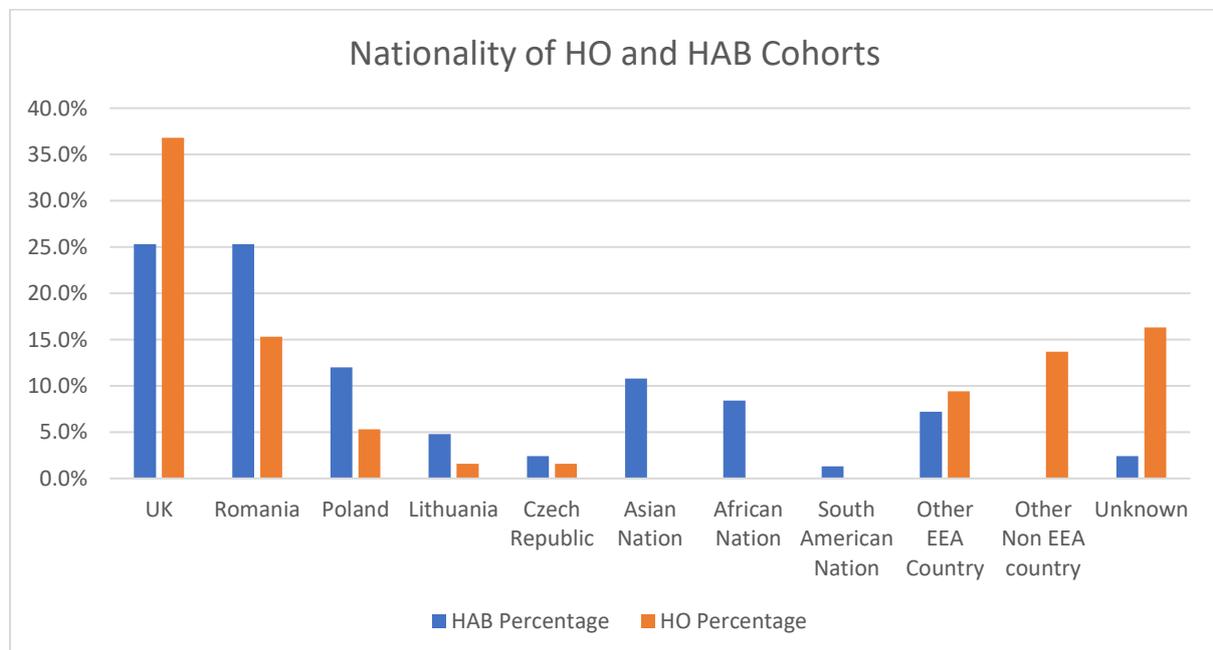


Figure 7: Comparison of nationality between HAB and HO cohorts

Economic Status:

Figure 8 depicts the composition of the cohort in terms of economic status. Jobseekers accounted for the largest proportion (39%; n=32), followed by those with no recourse to public funds (21%; n =17) and then people who were long term sick / disabled (16%; n=13).

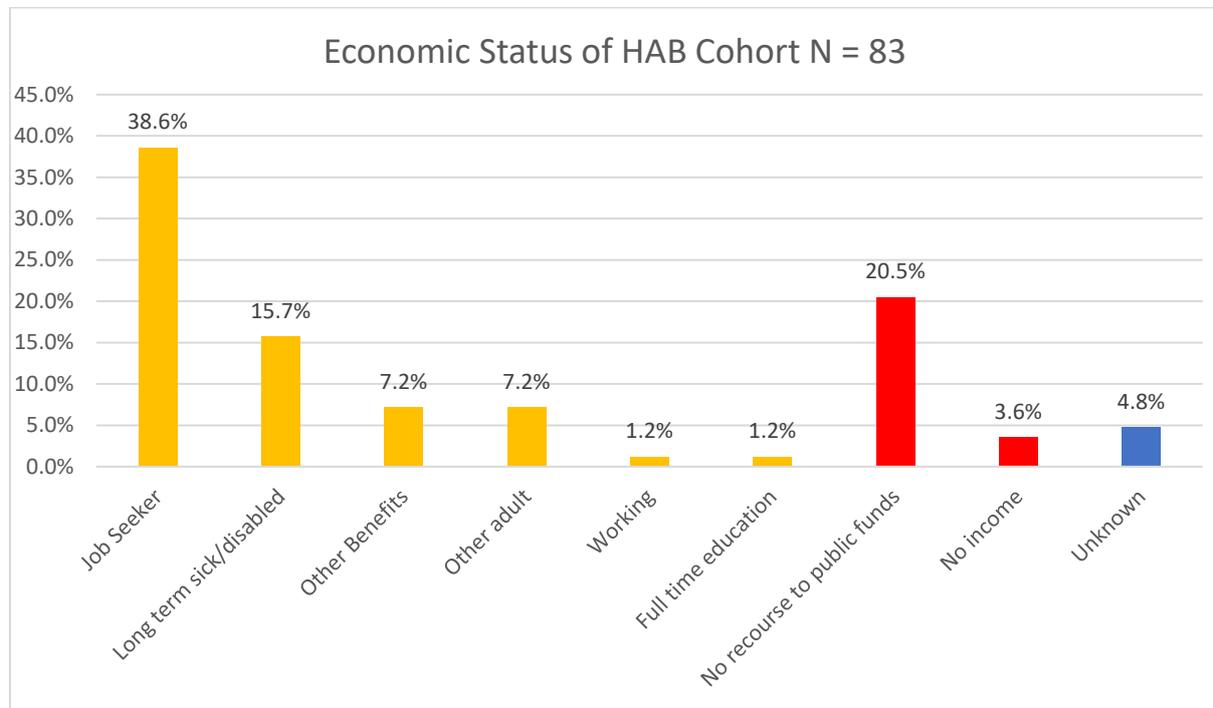


Figure 8: Economic Status of HAB cohort
Source: HAB data

Whilst unemployment, low income and a lack of recourse are already significant drivers of homelessness, the COVID-19 pandemic will have surely worsened this with its reported impact on the economy. It is expected that unemployment rates will increase and the long-term impact of the furlough scheme unknown.

Those people with no recourse to public funds are not usually entitled to any housing or welfare support; however, local authorities were directed to temporarily suspend usual eligibility rules in order to respond to the COVID-19 public health emergency and protect all rough sleepers by providing accommodation, regardless of their immigration status.

Migrants with no recourse often work in informal, undocumented ways in industries like hospitality, cleaning, and construction. Therefore, migrants who have lost their job during this pandemic are at risk of destitution if they cannot access public funds or are forced to take up less stable, more exploitative employment out of desperation.

The health inequalities of migrant groups are well documented, groups of vulnerable migrants living in the UK include^{ix}:

- asylum seekers and refugees
- unaccompanied children
- people who have been trafficked
- undocumented migrants (those who are living in the UK with no legal status)
- low paid migrant workers

Conclusions:

There are many factors that cause homelessness and rough sleeping in Barnet, and it is likely that similarly to elsewhere in London these cluster around two main factors: firstly people being asked to leave their accommodation for reasons including anti-social behaviour, rent arrears and relationship breakdowns and secondly relating to financial reasons relating to lack of employment. Approximately 90% of rough sleepers in Barnet are of working age; however, only 40% are in work or receiving job seekers allowance. Meaning the other 50% of rough sleepers are either not eligible for benefits/eligible to work, or not able to work for health and other reasons. This includes a large group of people from Romania and Poland.

This demonstrates the need to focus on opportunities relating to employment, both in terms of prevention for people who are at economic risk and providing suitable employment and training options for people who are already homeless.

Secondly, the data indicates that a large proportion of Barnet rough sleepers are migrants, most commonly from Romania and Poland. Although there is work underway to support migrants to obtain settled status, these groups will need tailored support to access and engage with health and support services.

9. Health and Homelessness:

It is well documented that the health and wellbeing of people who experience homelessness is poorer than that of the general population. We know that homeless people have poorer health outcomes than the general population and an average age of death 30 years below the national average at 46 years, and even lower for homeless women, at just 43 years.^x

Homelessness can make people vulnerable to illness, poor mental health and drug and alcohol problems,^{xi} therefore co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is common.

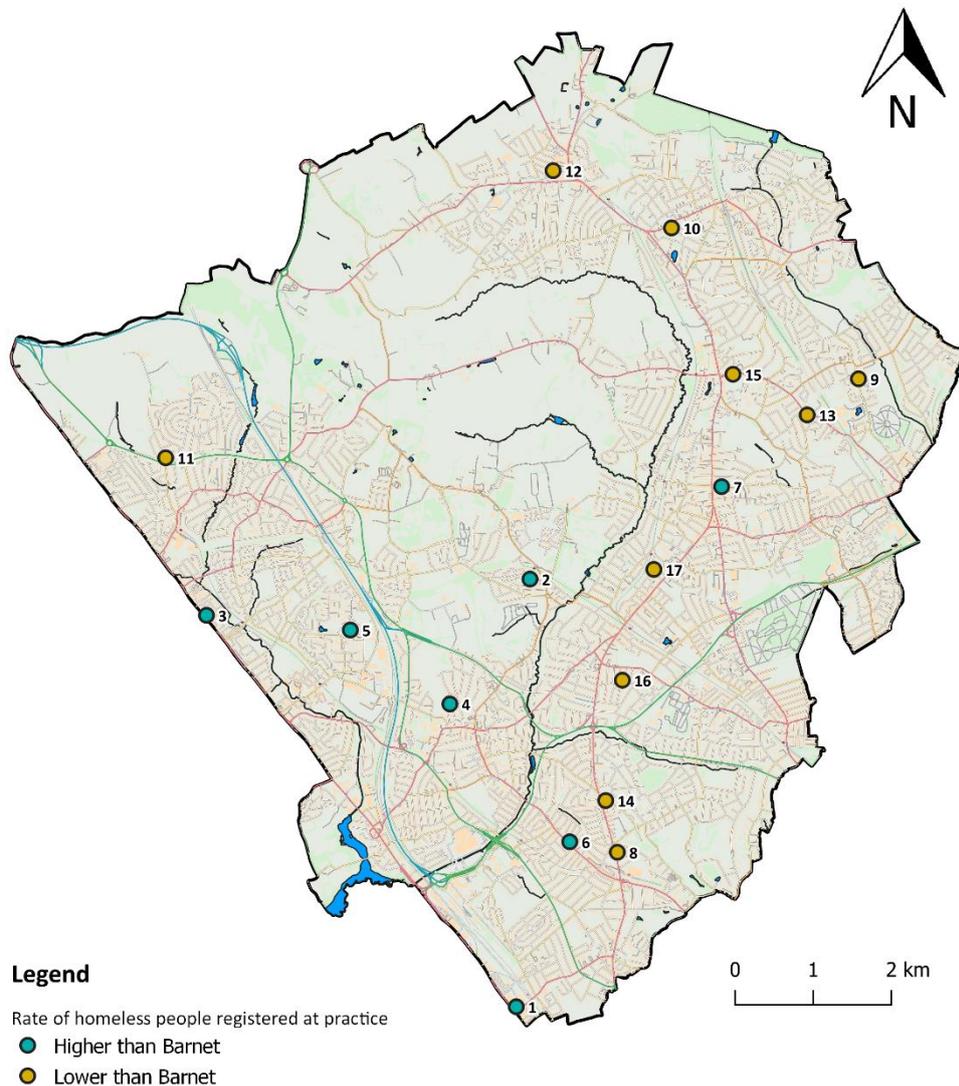
Homeless people often seek medical treatment at a later stage during illness, leading to costly secondary health care and worsened health outcomes. Exacerbated by this is the reduced potential for recovery due to many homeless people returning to insecure accommodation or even rough sleeping after medical treatment.

It is not uncommon for homeless people to not be registered with a GP. Groundswell's *More than a Statistic research*^{xii} revealed that one of the key barriers that people who are homeless face to getting healthcare is registering and making use of a GP practice.

59 rough sleepers accommodated by LB Barnet in the Stay Club hotel in Brent were assessed by a GP during a visit. A quarter (n=15, 25%) were not registered with a GP. This is similar to the HAB consented cohort, in which 29 out of the 83 consented sample (35%) were not registered with a GP. In comparison to national data, this is an unusual picture and is indicative of positive partnership work delivered locally. HAB and Barnet Homes have been supporting people to register with a GP as part of their packages of care. However, service user and staff feedback demonstrate that there remains work to be done here as many report problems registering and accessing local GP services.

Data on homeless people within Barnet at GP practice level was received from NCL CCG.^{xiii} The CCG Homeless Report identifies 663 homeless people across 52 GP practices in Barnet, for July 2020. Within this cohort, roughly two-thirds are male (66%, n=434) and a third female (35%, n=229). The majority, 95% had been seen in Barnet General Practice within the last 12 months. There is no definition of what “homeless” means in this context, and it is likely that the majority of this sample are not rough sleeping. Many people who become homeless do not show up in official figures. This is known as hidden homelessness. This GP sample could include hidden homeless people, this includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation.

For Barnet GP practices in Barnet, the overall rate for July 2020 is 152.76 per 100,000. Seven out of 52 GP practices in the borough were found to have a statistically significantly higher rate than Barnet overall. In contrast, 10 GP practices in Barnet have rates of homeless (per 100,000) within their practice lists which are significantly lower than Barnet GP practices overall. These practices are displayed on a map below. Those practices with higher than average numbers mostly cluster in the west of the borough, whilst those with lower numbers are distributed across the north, east and south. Interestingly, this clustering aligns with the fact that the west of the borough exhibits higher levels of deprivation than the East.^{xiv} In addition, the one practice in the west with higher rates of homelessness is also the closest practice to the HAB day centre.



Contains National Statistics and Ordnance Survey data © Crown copyright and database right 2020

Figure 9: Map of Barnet GP's with higher and lower than average registered numbers of patients who are homeless

Source: Barnet Homeless Report, NCLCCG.

Summary of Health Conditions:

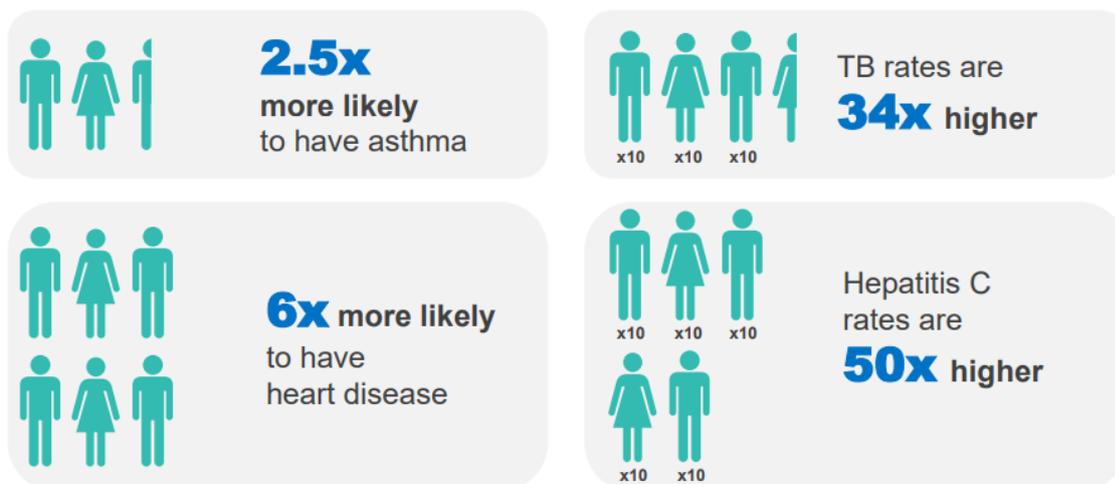
Prevalence data on a number of conditions was available and the most prevalent conditions are summarised in Table 7. Based on this data, the most prevalent type of condition was “mental health,” which affected over half of the sample (54%, n=356). Over one in five of this homeless cohort within Barnet GP practices had musculoskeletal and physical trauma (23%, n=154) or skin and subcutaneous tissue disease (23%, n=151).

Condition	Count	%
Mental Health	356	54%
Musculoskeletal and physical trauma	154	23%
Skin and subcutaneous tissue disease	151	23%
Respiratory condition	108	16%
Circulatory system/Endocrine diseases	104	16%
Neurological/Head injury	38	6%
Pregnancy	24	4%
Liver Disease	14	2.1%

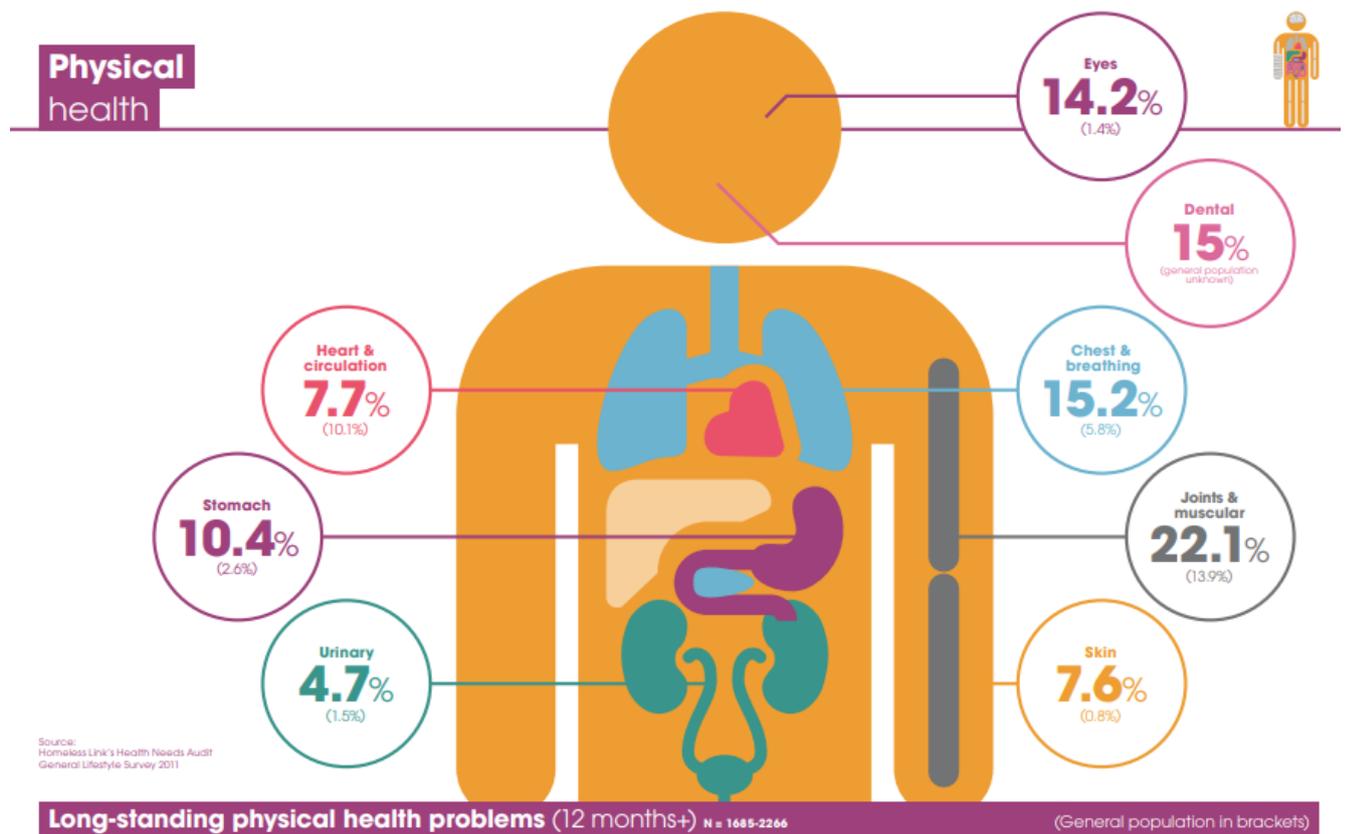
Table 7: Most prevalent conditions of homeless people within GP practices in Barnet, July 2020

Source: Barnet Homeless Report, NCLCCG.

The NCLCCG report did not allow us to compare the incidence of these illnesses in the homeless population to the entire Barnet population; however, it is likely that the homeless population will see a higher rate of these conditions. The Healthy London Partnership conclude that people who are homeless suffer more health problems than housed people. ^{xv}



A health audit^{xvi} by Homeless Link found the following:



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Interestingly although it is unclear who is included in the Barnet GP cohort, there are certainly some similarity in the types of illnesses and rates observed.

NCL CCG have been reviewing opportunities for improving the health of homeless people and have been taking the following areas forward:

- Working with local public health and homelessness teams to develop proactive approaches to vaccinating homeless people against COVID-19. This includes mobile vaccination services and designated clinics.
- Securing funding to develop models including specialist homeless intermediate care, specialist step-down accommodation, and move on co-ordinators. These models will be piloted and evaluated to decide future investment.
- Working on a local programme taking into account the London vision and workstreams

NCL CCG share the London vision shown in the Figure below.



Conclusions:

The needs assessment has demonstrated that people who are homeless have different experiences of health services. Whilst some have good access to primary care, others appear to have no access or have been excluded. Case studies show homeless people experienced multiple, chronic health conditions which are often exacerbated by rough sleeping. They also identify that standard services are often not equipped to manage these patients as a more flexible approach is required that often involves longer appointments, in different settings, and include street-based outreach from clinical staff.

The evidence indicates the homeless people experience a wide range of health issues, including mental health, musculoskeletal issues, skin conditions and respiratory conditions. There is therefore a need to consider how local health services can work collaboratively and in partnership to improve prevention, diagnosis and treatment of those conditions that disproportionately impact on homeless people. Consideration should be given to taking forward this work through the Health Inequalities priority of the Barnet Integrated Care Partnership.

Additionally, people who are not originally from the UK face increased personal and structural barriers to utilising and navigating health services; and those people who were restricted from accessing secondary care felt their needs could not be adequately met and therefore risked developing serious illness that would result in emergency care.

Health-related behaviours:

In terms of public health outcomes, 29 people had undertaken cervical smears in the last 15 months, which is 13% of the female sub-sample of homeless people within Barnet practices (n=229). Roughly one in ten of female homeless people within this population (11%, n=24), had declined a smear test.

Almost two-thirds of this homeless sample (62%, n=414) had their smoking status recorded, and almost a third (30%, n=201) received smoking advice during the last 15 months.

Within the entire sample (n=663), a Hepatitis B vaccination had been given to 45 individuals (7%), whilst 2% had declined a Hepatitis B test (n=11). For HIV, 4% of this

homeless sample declined an HIV test (n=24) and only one individual had undertaken an HIV test in the last 15 months (0.2%). Around one fifth of this homeless population had received a vaccination for influenza in the last 15 months (22%, n=143), and 18% had received a pneumococcal vaccination (n=119). It is possible that uptake of immunisations is higher than recorded as there is a particular focus on vaccinations in the satellite health clinic that operates in HAB. This emphasises the need for improved data recording.

Conclusions:

The evidence in this report emphasises the need for all healthcare professionals to use their skills and relationships to maximise their impact on avoidable illness, health protection and promotion of wellbeing and resilience. The partnership has worked proactively and collaboratively to protect homeless people from the risks of COVID-19; however, further work must be done to ensure that other key public health interventions such as smoking cessation, cancer screening and immunisations are accessible.

Mental Health & Suicidal Ideation:

As mentioned earlier in this report, people who are homeless are more likely to experience poor mental health than the general population and suicide is a leading cause of death in homeless people.

Three Stay Club residents (5%) were “supported for immediate GP referral in view of mental health concerns,”^{xvii} which is similar to the 15% of the HAB consented sample with reporting diagnosed an undiagnosed mental health issues (n=12).

The picture in the CCG GP cohort is different. Mental health was recorded in over half of the sample (54%, n=356). Within this group, 4% (n = 29 people) had a history of suicide or and 2% (n= 16) had psychotic illness recorded.

When HAB service users were asked about possible risk of suicide, the response was concerning. Over half of the cohort cite some suicidal ideation, with 38% reporting they feel at high risk of suicide.

In addition, feedback from service users and staff working within homelessness services consistently state that they have experienced barriers to accessing mental health services. The Homeless Link health audit^{xviii} identified that 86% of respondents disclosed a mental health problem, and 44% had a diagnosed mental health condition. Mental health issues are high in homeless people as they are both a cause and an outcome of homelessness. People with poor mental health are more likely to become homeless, and people who are homeless are more likely to develop mental health as a result of their circumstances.

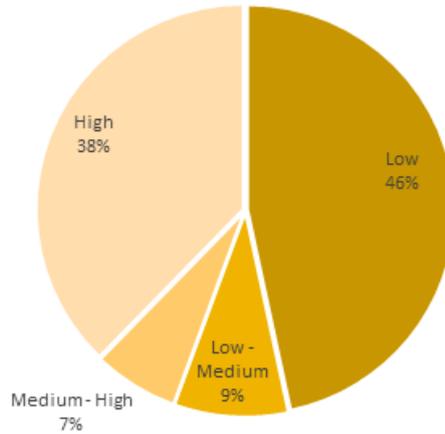


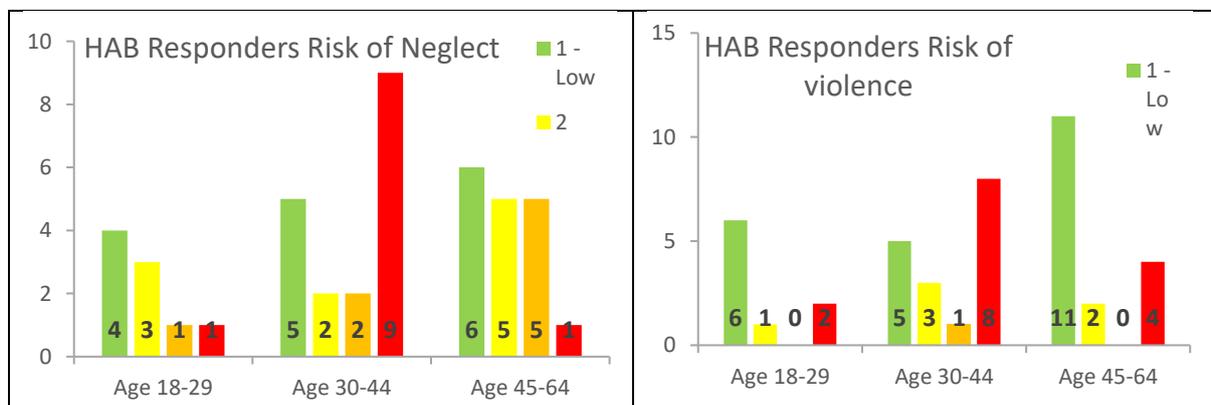
Fig 11 Risk of Suicide
Source: HAB data

Samaritans research^{xix} links deprivation with an increased risk of suicide and shows that homeless people are particularly at risk as deprivation, debt, and inequality, all of which can increase suicide risk.

The ONS data also shows that drug-related deaths of homeless people increased by 52 per cent over five years, and that homeless people accounted for 5% of all drug poisoning deaths, 1% of alcohol specific deaths and 2% of suicides in England and Wales in 2017.

The graphs below show how HAB service users categorise their risk of neglect, violence, and suicide, grouped by age. Interestingly, when looking at this assessment data from HAB service users, it appears that those aged 30-44 are most likely to categorise themselves as high risk in all three of those areas. The data also shows us that this group are also more likely to be job seekers rather than long term sick/disabled and generally have no physical health problems.

The most recent ONS report^{xx} on suicides in England and Wales states that Males aged 45 to 49 years had the highest age-specific suicide rate (25.5 deaths per 100,000 males). Although the highest risk group in the Barnet homeless cohort is slightly younger than this, the age range is similar, and it is possible that many of the risk factors are similar and compounded by factors relating to homelessness.



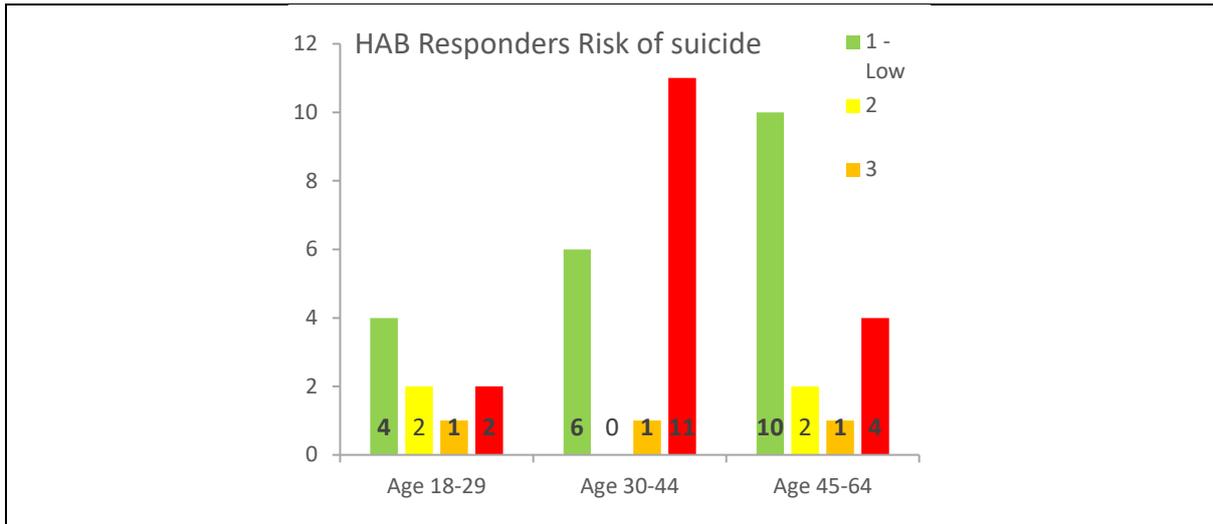


Figure 10: Graphs to show self-reported scores of risk of neglect, violence, and suicide, in HAB cohort, grouped by age.

Conclusions:

Mental health concerns are a theme that present throughout this report. Case studies and feedback from staff and service users demonstrate how mental health pathways can be difficult to navigate, with staff working in homelessness services often feeling like they have no specialist support when working with people with multiple and complex needs. There is therefore certainly a need to clarify pathways and improve access to mental health support.

Furthermore, it is apparent that homeless people are at increased risk of suicide and there is certainly an opportunity to maximise suicide prevention opportunities.

Substance Misuse:

For the HAB consented sample, seven homeless people (8%) were identified as alcohol dependent, which was not statistically significantly different for from the proportion of alcohol dependent Stay Club residents (5%, n=3). However, around 15% of the CCG GP homeless cohort were recorded as showing alcoholism or harmful alcohol use, whilst less than one in ten (7%, n=43) having received alcohol advice in the last 15 months.

The comparison between the two groups in terms of drug use is tenuous. Within the HAB consented homeless cohort, 17% reported drug dependency (n=14), compared to 4 heroin users and 6 regular cannabis users in the Stay Club setting. Assuming these are completely separate people, this would equate to 17% drug dependency within the residents of the Stay Club, which coincidentally is the same as that reported within the HAB consented cohort. Within the CCG GP cohort, 2% (n=14) of this homeless sample were recorded as having a current or past history of substance misuse, whilst only 4 people had no history of substance misuse, clearly underlining the challenges of collecting complete and reliable data in this area.

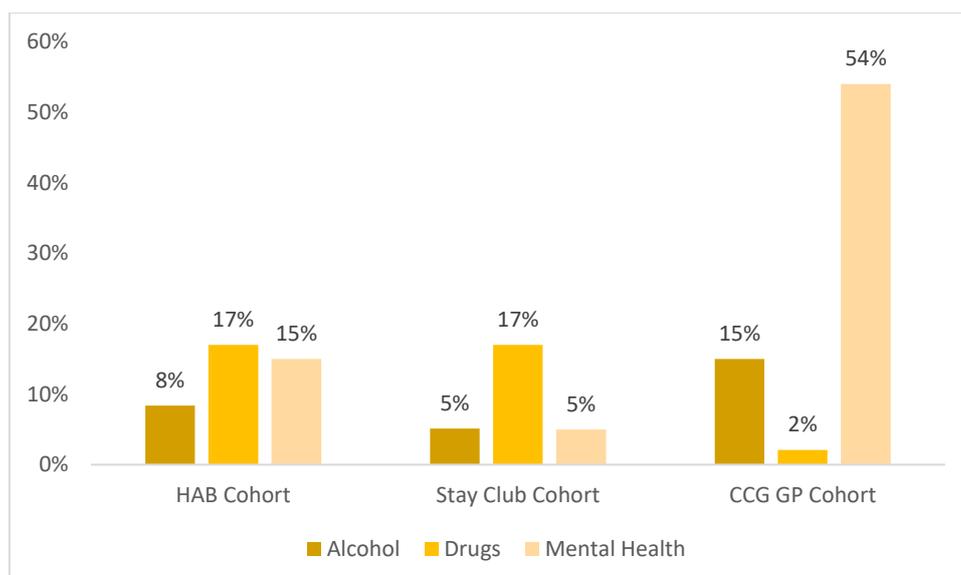


Figure 11: Substance misuse and Mental health in three cohorts: HAB, Stay Club and GPs

Source: HO data, HAB data, NLCCG homeless report

It is important to note the validity and accuracy of this data. There are relatively small sample sizes, small counts for each of the conditions (alcohol dependency, mental health and drug dependency), as well as disparities in the way people were grouped, which all contribute to limiting comparability between the HAB consented and Stay Club samples. Additionally, this data is captured by self-report to professionals and therefore is likely that mental health and substance misuse are largely underreported.

Last year the Advisory Council on the Misuse of Drugs published a report^{xxi} into homelessness and drug misuse. The report reviewed evidence relating to prevalence rates and concluded that due to different methodologies, it is difficult to assess accurately the extent of drug use among homeless populations. There is however evidence of an association between being homeless and an increased risk of problematic drug use. The report highlighted that there is likely to be differences in substance misuse between rough sleepers and those in temporary accommodation, with more than one study finding that half of rough sleepers were alcohol dependent and 29% misused drugs. The type of drug use does however vary from area to area. Homeless Link reported^{xxii} that 27% of people that participated in their Health Audit had alcohol problems and 41% had previous or current drug dependency issues.

In December 2020, LB Barnet Public Health were successful in their bid to PHE for grant monies to address substance misuse in homeless people. The grant funding will support the development of a specialist outreach team to support current rough sleepers and those in temporary accommodation to address their substance misuse issues. The service will also include a specialist homelessness nurse post, a complex needs post and a Romanian speaking post.

Conclusions:

Comparable to London and national data, the rates of substance misuse reported in Barnet rough sleepers is low. As substance misuse can be both a driver for and an outcome of homelessness, it is probable that the Barnet data under-reports local prevalence. The reasons for the under-reporting are unclear and can be the result of poor identification, poor recording and reporting or the absence of suitable services.

The PHE grant secured to develop specialist rough sleeping and substance misuse provision will address these issues and aims to improve the identification and access to support for homeless people.

Wellbeing and Social Functioning:

Staff at HAB have conducted holistic assessments with people accessing the service. The graphs on the following pages will provide a summary of these assessments.

The following data has been extracted from the assessments completed by staff at HAB. A score of 1 demonstrates the person feels very inadequate in this area. A score of 3 or 4 indicates the person feels fair to middling in this area. A score of 6 shows the person feels they are excellent in this area.

Key: 1 = Very Poor, 2 = Poor, 3 & 4 = Fair to middling, 5 = Good, 6 = Excellent

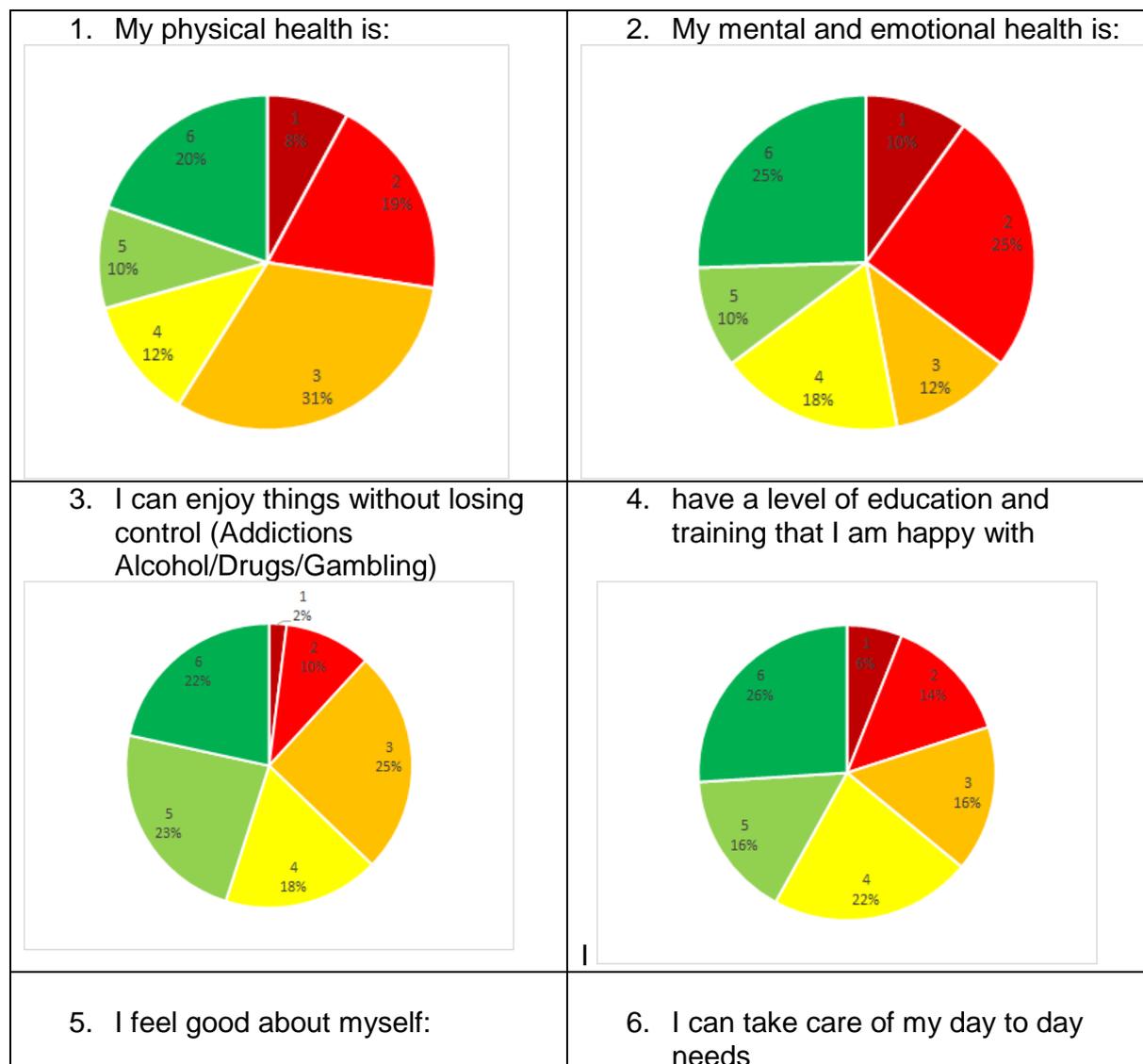




Figure 12: Summary of wellbeing questions asked in HAB assessment
Source: HAB data

It is apparent that responses are varied with people displaying a range of support needs. Whilst around 20% - 30% seem to rate themselves positively, the majority of the cohort identify at least one area of weakness.

Most notably, areas where people are rated most poorly include money management, meeting their day to day needs, assessment of physical health and assessment of emotional and mental health.

Furthermore, it is likely that where an individual has more than one support need, their vulnerability and complexity increase substantially. It is also well known that these issues tend to cluster together.

10. Multiple Exclusion Homelessness

As mentioned earlier, the reasons for homelessness are often a combination of structural and personal factors. What is clear from the literature^{xxiii} is that many of those who find themselves as homeless, do so as a result of early exposure to significant trauma or adverse experiences in early childhood.

Such childhood trauma/adverse experiences include:

- physical abuse

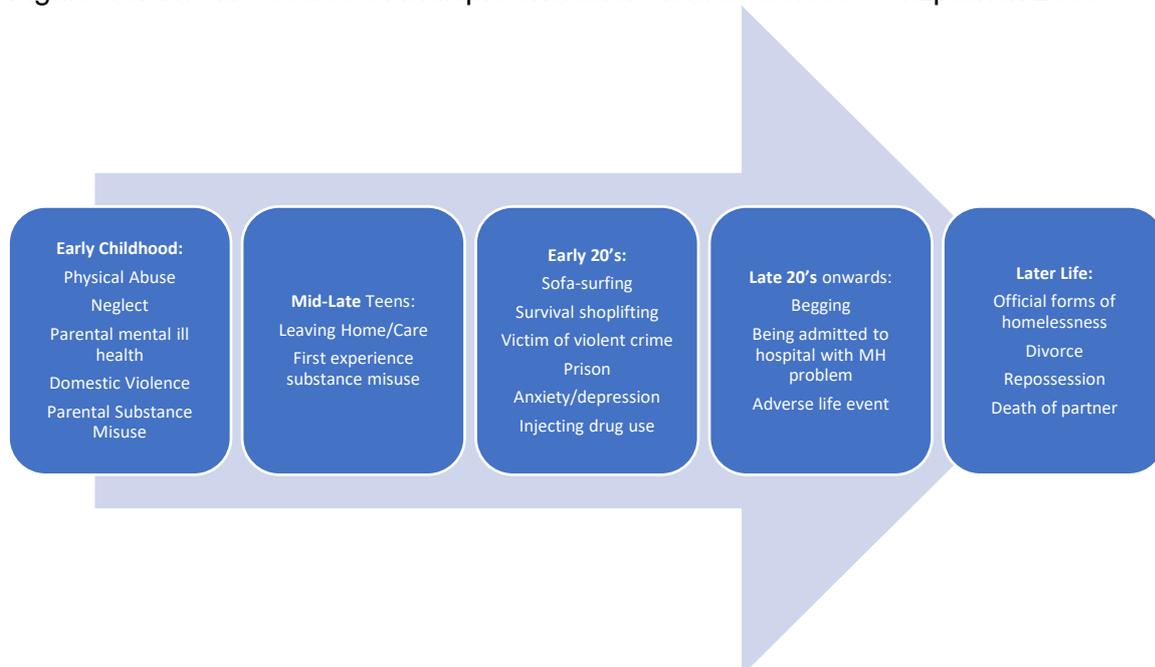
- neglect
- there sometimes not being enough food to eat at home
- homelessness
- domestic abuse in the household
- parental substance misuse
- parental mental health issues
- poor family functioning
- socio-economic disadvantage/poverty
- separation from parents of care givers

In order to address the issue of homelessness, it helps to understand the circumstances, experiences, and severe and multiple deprivation/social exclusion, which have impacted significantly on those individuals who have found themselves as homeless.

Multiple Exclusion Homelessness (MEH) can be described^{xxiv} as; 'People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work)'

Fitzpatrick et al describe pathways into MEH almost as a life course, with particular MEH experiences happening through our lives, which then increase the likelihood of us experiencing homelessness and other complex issues such as mental ill health and substance misuse. Through their work, they were also able to 'cluster' MEH experiences and identify subgroups within the MEH population with similar sets of experiences.

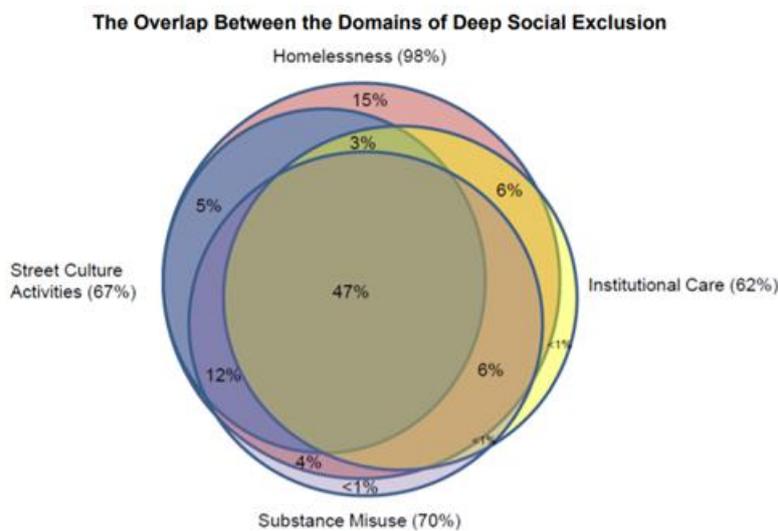
Figure 13: The life course of multiple exclusion homelessness – Fitzpatrick 2013



Fitzpatrick et al advise that preventative interventions should focus on earlier signs of distress wherever possible, including preventing childhood adversity and/or finding ways of mitigating against the negative outcomes. For example, with schools, drug and

alcohol services, and the criminal justice service who are likely to come into contact with those vulnerable to homelessness well before housing and homelessness agencies do. For this to happen, an inclusive and integrated approach to homelessness and the commissioning of services is required to improve the health and wellbeing of vulnerable people.

The study also demonstrated that the experience of specific domains of deep social exclusion (homelessness, institutional care, substance misuse and street culture activities) was extremely widespread amongst this population. The graphic below shows the complex nature of the interactions between the domains and indicates that almost all had experienced homelessness (98%); 70% had experienced substance misuse; 67% had experienced street culture activities and 62% had experienced institutional care. The degree of overlap is huge and some 47% of people have experienced all 4 domains.



Source: Fitzpatrick, 2012.

The annual CHAIN report 2019/20 reported the support needs identified in assessments by those people working with rough sleepers. Whilst 41% had no support needs, the majority of these people were people who had only been seen rough sleeping once or twice. Of those longer term rough sleepers, a variety of issues were noted, as shown in figure 14 below. 47% of people assessed disclosed mental health issues, and 40% disclosed a multiplicity of issues. These rates are much higher than seen in the general population.

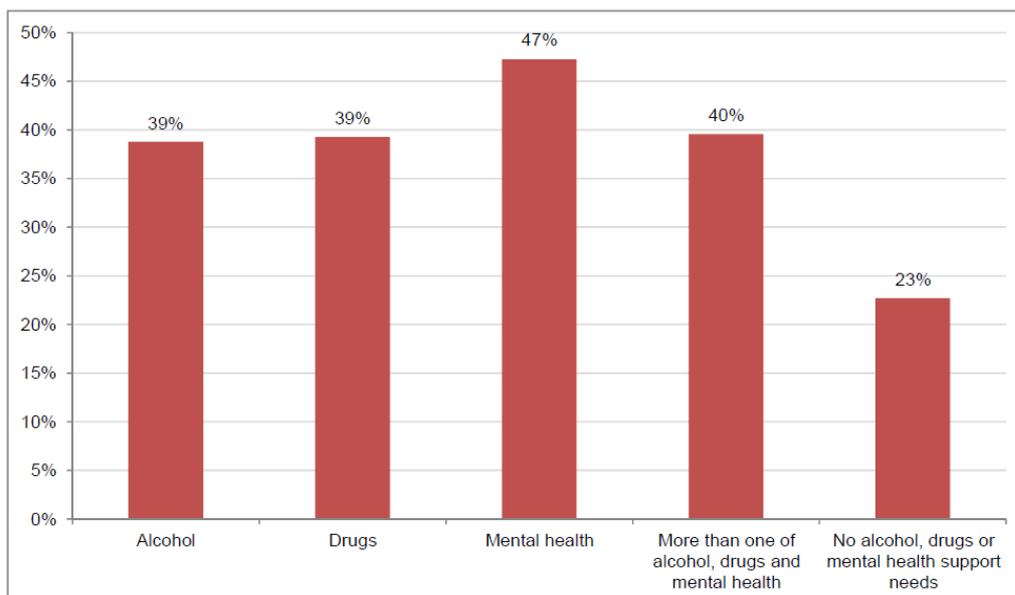


Figure 14: Support needs identified in London rough sleepers, CHAIN 2019/20

11. Recommendations

I. Governance, Oversight and Improving Prevention Opportunities

To support strategic delivery, formal partnership delivered through good governance is essential. There is a need to establish formal governance arrangements to provide leadership and accountability for improving health and homelessness outcomes, including delivery of needs assessment recommendations. These governments arrangements should include a forum where commissioning arrangements can be discussed.

LB Barnet Homeless and Rough Sleeper Strategy

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 district. The strategy must be renewed at least every 5 years. The social services authority must provide reasonable assistance; and the strategy must set out the authority's plans for the prevention of homelessness and for securing that sufficient accommodation and support are or will be available for people who become homeless or who are at risk of becoming so. The Barnet strategy is due for review in 2024; however, given recent unprecedented events including the impacts of Brexit and the recent COVID-19 pandemic, it is proposed that work begins on reviewing the strategy imminently. The partnership can take this opportunity to consider what action is needed to ensure i) people do not return to rough sleeping and homelessness ii) there is a suitable health-led response to homelessness locally and iii) what wider systemic change is needed to prevent future homelessness and respond effectively to COVID-19 impacts.

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. Primary prevention, relates to those measures that can be taken to prevent homelessness early, thus reducing the risk of someone being at risk of homelessness in the future; and secondary prevention, relates to prompt measures that can be put in place once a person is at risk of homelessness to stop the problem escalating in severity.

It is clear that there are opportunities within existing primary prevention interventions to address risk factors for future homelessness, and that secondary prevention opportunities such as using the “duty to refer” provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

As mentioned earlier, studies highlight the way in which the risk of becoming homeless in the future is increases significantly if there are particular experiences in early childhood thus key primary prevention opportunities to prevent or reduce such outcomes would be to identify and intervene at the earliest opportunity. Preventing childhood adversity and/or finding ways of mitigating against the negative outcomes associated with such experiences is crucial.

However, for the purpose of this needs assessment, we will focus more on secondary prevention opportunities. Ways that we can do this is:

- Identification of people with financial vulnerability and debt: The recent COVID-19 pandemic has had a lasting economic impact, resulting in increasing levels of unemployment and financial insecurity. This is suspected to result in a new demand from people who would not ordinarily come in to contact with council housing and support services. A proactive approach must be taken to ensure people at risk of financial vulnerability are supported.
- Furthermore, suitable employment, training and education services must be extended to all people currently or recently homeless. This includes suitable support for non-UK nationals.
- Increasing access to tenancy sustainment and floating support for people with addictions, mental health, and other vulnerabilities such as people who have spent time in prison and ex armed forces. Models such as Housing First^{xxv} have shown to be effective. Housing First is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs.
- Upskilling front-line professionals to work in a trauma-informed way in order to support people with multiple complexities

LB Barnet Suicide Prevention Strategy

In response to the findings of this need’s assessment, the Barnet Suicide Prevention Strategy (2021-2025) and plan recognise the risk of suicide in people that are homeless and identify opportunities for action.

II. Improving insight and intelligence:

This needs assessment highlighted some specific areas where improved consistency in record keeping would help the insight into this group of people, as well as some areas where information is lacking. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. This routine collation and sharing of information would also support the partnership to develop a joint client list to facilitate holistic care.

This includes a focus on recording in primary care, particularly on the type of homelessness (for example, differentiating between who is rough sleeping and who is in temporary accommodation). Additionally, more information is required on what data is available from secondary care.

III. Addressing barriers to accessing suitable health care:

Healthy London Partnership (HLP) has reviewed how to improve the health of homeless people^{xxvi}. HLP have developed a number of resources for health professionals that can be used locally. These include:

- An e-learning training package for GP receptionists and practice managers to equip them with the skills and knowledge to better identify and support homeless people^{xxvii}
- Credit card sized plastic cards designed to be carried by adults who are homeless across London, including people who sleep rough, live in hostels, sleep on family and friend's sofas, or who are chronically insecurely housed. They can be used to remind GP receptionists and other practice staff of the national patient registration guidance from NHS England^{xxviii}
- Developed a resource pack including useful websites and additional sources of information relating to homelessness^{xxix}

In addition to implementing these resources locally, it is recommended that:

- a thorough review of the locally commissioned homeless health service is conducted, with consideration to how this service works proactively and flexibly and facilitates pathways into other health services.
- LB Barnet and NCL CCG collaborate to develop the proposed local programme considering the London vision and workstreams.
- LB Barnet and NCL CCG to collaborate to develop models including specialist homeless intermediate care, specialist step-down accommodation, and move on co-ordinators.
- LB Barnet and NCL CCG to collaborate to ensure improved access to routine health screening and vaccinations is reflected in the work programme.
- Engage Barnet Integrated Care Partnership (ICP) to consider opportunities for homelessness prevention through the life-course approach.

IV. Housing and Support Pathways

The recent COVID-19 pandemic has highlighted the need to review pathways for single homeless people, particularly for those with multiple or complex needs. The needs assessment has identified gaps in the current pathway including:

- Improving access to social care support – During the COVID-19 pandemic, Barnet Homes and LB Barnet trialed an alternative pathway for homeless service users to access care-act assessments. This was reported to be affective and therefore consideration should be given to this when agreeing the pathway.
- Clarifying and improving access to mental health support by working with Barnet, Enfield & Haringey Mental Health Trust to establish clearer pathways and consider opportunities for a more targeted and proactive offer.
- Throughout the pandemic Barnet rough sleepers have been placed in temporary accommodation in neighbouring boroughs due to the lack of affordable supply in the borough. This has been challenging when accessing services in times of crisis. A clear pathway is required for support workers working operationally to access crisis intervention.
- As mentioned above, there is currently no provision or pathway for accessing more supported accommodation for those with complex needs but do not meet care act eligibility criteria. Accommodation options are needed for those limited number of cases in Barnet that have high and complex needs. Linked to this is the discharge of

vulnerable single homeless people from hospitals or recovery houses who are deemed capable of independent living and are placed into temporary accommodation without the necessary care planning and support being put in place. This will hopefully be addressed by the funding obtained by NCL CCG.

- Access to physical activity – although the borough is well served by outdoor gyms, the partnership identified that improved access to physical activity services, particularly for people in begin their housing journey, could improve the overall health and wellbeing of rough sleepers.

V. Addressing Substance Misuse Issues

Lastly, the needs assessment has shown that the number of people who are homeless in Barnet, and misuse substances, is lower than expected. Whilst this might be in fact the case, it is more likely that there is poor identification of substance misuse and subsequently poor engagement with substance misuse treatment. It is therefore recommended that specific resources be directed to a) upskill the current workforce to improve identification, b) identify additional resources to work with people with multiple complexities such as dual diagnosis and substance misuse to provide appropriate treatment and support.

As mentioned earlier in the report, a specialist team is currently being developed to support homeless people with substance misuse needs. This team will be key in developing our local understanding of the problem locally and ensuring we develop sustainable ways to support this cohort.

VI. Improving migrant health

There are a range of services and initiatives to help people sleeping rough sleeping who are not from the UK to come off the streets and rebuild their lives, and whilst there are some restrictions to what people with no recourse can access, in Barnet, a public health and support-led approach has been in place throughout the pandemic to ensure equitable access to housing and support.

Having said this, many non-UK rough sleepers do not engage with local services and as a result little is known about their health and support needs. Consideration must be given to suitable ways to engage with non-UK rough sleepers to understand their specific health and support needs.

12. References:

- ⁱ CHAIN database, St Mungo's - [CHAIN - St Mungo's \(mungos.org\)](#)
- ⁱⁱ Barnet Rough Sleeper Strategy - [Housing strategy | Barnet Council](#)
- ⁱⁱⁱ NHS Long Term Plan - [NHS Long Term Plan](#)
- ^{iv} Homelessness: Applying all our health, PHE, 2019: [Homelessness: applying All Our Health - GOV.UK \(www.gov.uk\)](#)
- ^v The Dahlgren and Whitehead model of health determinants, 1991: Dahlgren G, Whitehead M. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Sweden: Institute for Futures Studies.
- ^{vi} Barnet Homes Housing Options (HO): data extract for 16th July 2020, received on 17th July 2020.
- ^{vii} [Causes of homelessness and rough sleeping feasibility study - GOV.UK \(www.gov.uk\)](#)
- ^{viii} [Deaths of homeless people in England and Wales - Office for National Statistics \(ons.gov.uk\)](#)
- ^{ix} [Vulnerable migrants: migrant health guide - GOV.UK \(www.gov.uk\)](#)
- ^x Crisis, Homelessness: A silent killer, 2011: [Homelessness: A Silent killer \(crisis.org.uk\)](#)
- ^{xi} Homeless Link, The Unhealthy State of Homelessness, 2014: [The unhealthy state of homelessness FINAL.pdf](#)
- ^{xii} Groundswell, More than a statistic, 2017: [NHS100012_More-than-a-statistic-Final-2017-1.pdf \(groundswell.org.uk\)](#)
- ^{xiii} Barnet Homeless Population Report (21st July 2020). Received from NCL CCG on 22nd July 2020.
- ^{xiv} [Socio-economic data | Barnet Council](#)
- ^{xv} Healthy London Partnership, Resource Pack, 2017: [PowerPoint Presentation \(healthylondon.org\)](#)
- ^{xvi} Homeless Link, The Unhealthy State of Homelessness, 2014: [The unhealthy state of homelessness FINAL.pdf](#)
- ^{xvii} Stay Club Site Report data received from Housing Options on 10th June 2020 from NWL STP Homeless Hotels COVID response team.
- ^{xviii} Health Needs Audit, Homeless Link: [Health Needs Audit - explore the data | Homeless Link](#)
- ^{xix} Socioeconomic disadvantage and suicidal behaviour, Samaritans, 2017: [Inequality and suicide | Samaritans](#)
- ^{xx} [Suicides in England and Wales - Office for National Statistics \(ons.gov.uk\)](#)
- ^{xxi} Report into homelessness and drug misuse, ACMD, 2019: [Report into homelessness and drug misuse published - GOV.UK \(www.gov.uk\)](#)
- ^{xxii} Health Needs Audit, Homeless Link: [Health Needs Audit - explore the data | Homeless Link](#)
- ^{xxiii} Evidence Review – Adults with complex needs, PHE: [Adults with complex needs who are homeless: evidence review \(publishing.service.gov.uk\)](#)

^{xxiv} Fitzpatrick, S; Bramely, G and Johnson, S (2012). *Multiple Exclusion Homelessness in the UK: An overview of key findings*. Institute of Housing, Urban and Real Estate Research, Heriot-Watt University, 2012.

^{xxv} Evidence Review – Adults with complex needs, PHE: [Adults with complex needs who are homeless: evidence review \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

^{xxvi} Homeless Health, Healthy London Partnership: [Homeless health - Healthy London Partnership Partnership](#)

^{xxvii} Homeless Health E-Learning, Healthy London Partnership: [Homeless health elearning - Healthy London Partnership](#)

^{xxviii} Homeless Health 'My right to access' cards, Healthy London Partnership: [Homeless healthcare cards - Healthy London Partnership](#)

^{xxix} Homeless Health Resource Pack, Healthy London Partnership [PowerPoint Presentation \(healthy london.org\)](#)

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Barnet's Wards are changing from May 2022

How will this affect your organisation?

- Two-councillor wards
- Three-councillor wards

AGENDA ITEM 17

Background

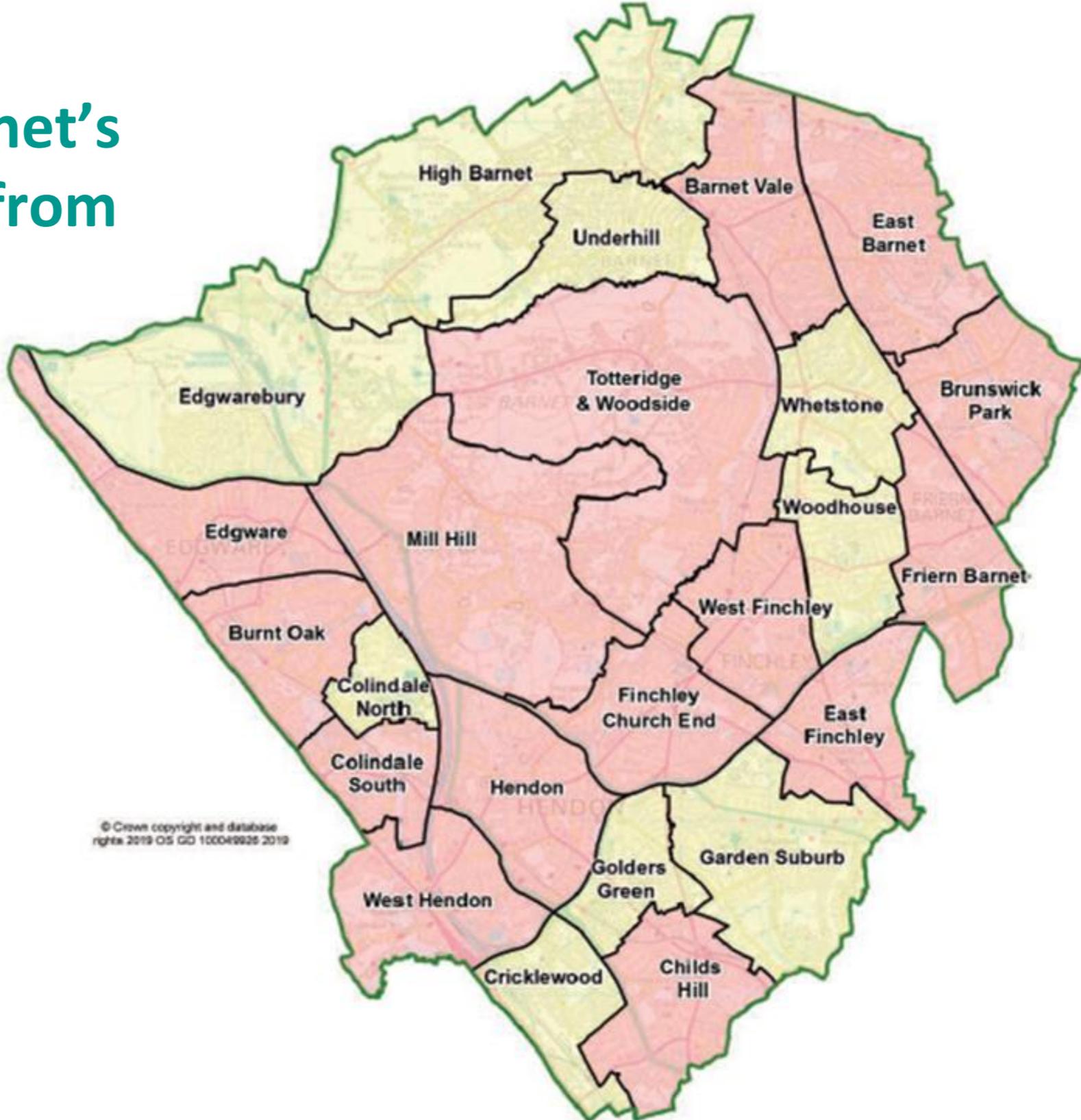
- Between May 2018 and January 2020, the **Local Government Boundary Commission for England (LGBCE)** carried out a statutory review of the London Borough of Barnet's electoral arrangements.
- The last review of the borough's ward boundaries was in 1999, since then Barnet's population has grown significantly (and will continue to do so).
- The LGBCE review set out to:
 - **Establish electoral equality** - *all councillors representing approximately the same number of electors*
 - **Promote community identity** - *strong ward boundaries that represent communities*
 - **Allow effective and convenient local government** - *coherent wards with good internal transport links.*

LG BCE review - final outcomes:

- Barnet will continue to be **represented by 63 councillors**
- Number of wards increased **from 21 to 24 wards**
(15 three-councillor wards and 9 two-councillor wards)
- **Every ward has boundary changes** (none remain exactly as now!)
- New electoral arrangements **will come into effect** at the Local Government elections on **5 May 2022**.

London Borough of Barnet's new Ward boundaries from 5 May 2022

- ❖ New wards: *Barnet Vale, Cricklewood, Edgwarebury, Friern Barnet, Whetstone*
- ❖ *Coppetts, Oakleigh, Hale* will no longer exist
- ❖ Colindale becomes *Colindale North and Colindale South*
- ❖ *Totteridge* becomes *Totteridge and Woodside*



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Two-councillor wards
Three-councillor wards

Current and new ward arrangements

Existing Ward Arrangements		
	Ward Name	Number of Councillors
1	Brunswick Park	3
2	Burnt Oak	3
3	Childs Hill	3
4	Colindale	3
5	Coppetts	3
6	East Barnet	3
7	East Finchley	3
8	Edgware	3
9	Finchley Church End	3
10	Garden Suburb	3
11	Golders Green	3
12	Hale	3
13	Hendon	3
14	High Barnet	3
15	Mill Hill	3
16	Oakleigh	3
17	Totteridge	3
18	Underhill	3
19	West Finchley	3
20	West Hendon	3
21	Woodhouse	3
	TOTALS	63

Recommended Ward Arrangements		
	Ward Name	Number of Councillors
1	Barnet Vale	3
2	Brunswick Park	3
3	Burnt Oak	3
4	Childs Hill	3
5	Colindale North	2
6	Colindale South	3
7	Cricklewood	2
8	East Barnet	3
9	East Finchley	3
10	Edgware	3
11	Edgwarebury	2
12	Finchley Church End	3
13	Friern Barnet	3
14	Garden Suburb	2
15	Golders Green	2
16	Hendon	3
17	High Barnet	2
18	Mill Hill	3
19	Totteridge & Woodside	3
20	Underhill	2
21	West Finchley	3
22	West Hendon	3
23	Whetstone	2
24	Woodhouse	2
	TOTALS	63

What will the changes mean for the Council?

- **Electoral Services**
 - Polling places and polling districts must change to serve the new Wards
 - Electoral Register to be updated (as published by Ward and Polling District)
 - Delivery of local elections (for example - Count arrangements) to be revised
- **Governance and decision making**
 - Proportionality; member and political party engagement affected
 - Area based committees, Resident Forums revised to reflect new arrangements
- **Operational delivery of services**
 - Delivery of services by ward areas - for example Street Cleansing?
- **Insight - Data collection and comparison by ward**
 - For example - Public Health (COVID19 reporting is currently Ward based)
- **Resident and stakeholder engagement**
 - Raising awareness of the changes - many residents will be in a different ward!

Timeline

Key Activity	Date	Description
<ul style="list-style-type: none"> Parliamentary approval of London Borough of Barnet (Electoral Changes) Order 2020 (after 40 sitting days) 	16 Sept 2020	The Order became legislation for the new electoral arrangements in Barnet.
<ul style="list-style-type: none"> Constitution & General Purposes Committee 	4 Oct 2021	Presenting 1 st draft of new polling district and polling places – for CGP Committee discussion and feedback
<ul style="list-style-type: none"> Consultation on proposed polling places and polling districts 	Oct-Nov 2021	Public consultation inviting comments on the proposed polling places and polling districts for the new wards
<ul style="list-style-type: none"> Constitution & General Purposes Committee 	6 Jan 2022	Final polling district and polling places report – for CGP committee final approval.
<ul style="list-style-type: none"> Publication of Register 	1 March 2022	Publication of register in time for Local Election 5 May 2022
<ul style="list-style-type: none"> Local Government Elections Polling Day 	5 May 2022	
<ul style="list-style-type: none"> Annual Council 	May 2022	Following the local elections, new councillors will be allocated to committees

What will the changes mean for service development and delivery?

- **Delivery of operational services and processes** based around wards, localities or Lower-layer Super Output Areas (LSOAs) **will need to be reviewed**
- **Partnership or commissioning arrangements** may need to be revisited if ward or 'Place' based
- **Ward based intelligence gathered** and used to inform future policy or service development will need **comparison of old verses new**
- **Services delivered area based operating model** (e.g. on the 3 parliamentary boundaries) to allow a more balance split of workload, **will need to be revised**
- **Local and national reporting comparisons** could be impacted year to year
- **New Ward boundaries potentially splitting regeneration** and new build development sites

How will your organisation be affected?

- Consider the implications of the new ward arrangements in your organisation, in terms of:
 - Governance arrangements
 - Operational delivery
 - Use of ward-based data insight and comparisons
 - Ward based local area profiles i.e. population, identify issues to plan delivery of services, etc.
 - Ward councillors will change – mix of 2 and 3 councillors representing the different wards

New warding arrangements are coming!

Be prepared:

- Speak to your services/teams about the ward changes and identify possible areas of impact
- Discuss what needs to happen in preparation for the new wards
- Think about what information/support/insight you may need to implement the changes
- Develop a plan of activity to deliver the changes
- Don't leave it too late!

Useful Websites:

- Local Government Boundary Commission England - www.lgbce.org.uk/barnet
- Barnet Council - www.barnet.gov.uk/your-council/electoral-review-barnet-ward-boundaries

Further information

- **Barnet Council Project Lead to implement the new warding arrangements:**
 - Emily Bowler, Head of Assurance and Business Development (emily.bowler@barnet.gov.uk)
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