**MEETING**

**HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**DATE AND TIME**

**TUESDAY 13TH OCTOBER, 2015**

**AT 7.00 PM**

**VENUE**

**HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ**

**TO: MEMBERS OF HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)**

Chairman: Councillor Alison Cornelius,
Vice Chairman: Councillor Graham Old

**Councillors**

| | | |
|---|---|---|
| Val Duschinsky | Caroline Stock | Laurie Williams |
| Arjun Mittra | Barry Rawlings | |
| Gabriel Rozenberg | Amy Trevethan | |

**Substitute Members**

| | | |
|---|---|---|
| Philip Cohen | Daniel Thomas | Maureen Braun |
| Shimon Ryde | Anne Hutton | Kath McGuirk |

**You are requested to attend the above meeting for which an agenda is attached.**

**Andrew Charlwood – Head of Governance**

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**ASSURANCE GROUP**

## ORDER OF BUSINESS

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**Decisions of the Health Overview and Scrutiny Committee**

6 July 2015

Members Present:-

AGENDA ITEM 1

Councillor Alison Corenlius (Chairman)
Councillor Graham Old (Vice Chairman)

Councillor Shimon Ryde
Councillor Arjun Mittra
Councillor Gabriel Rozenbert
Councillor Caroline Stock
Councillor Barry Rawlings
Councillor Amy Trevethan
Councillor Laurie Williamns

Also in attendance
Councillor Helena Hart

Apologies for Absence

Councillor Val Duschinsky

**1. MINUTES (Agenda Item 1):**

The Chairman noted that Councillor Phillip Cohen was no longer a member of the Health Overview and Scrutiny Committee and thanked him for his sterling work on the Committee over the course of the last municipal year.

The Chairman welcomed Councillor Laurie Williams to the Committee, following his appointment at the Annual Council meeting on 13 May 2015.

The Chairman noted that Councillor Rawlings had been contacted by a resident who had received a parking ticket at Barnet Hospital and that the hospital had subsequently cancelled his fine. The Chairman informed the Committee that she had obtained permission for leaflets setting out the new parking arrangements at Barnet Hospital to be displayed in all libraries within the Borough.

**RESOLVED that the minutes of the meeting of 11 May 2015 be agrees as a correct record.**

**2. ABSENCE OF MEMBERS (Agenda Item 2):**

Apologies for absence were received from Councillor Val Duschinsky, who was substituted for by Councillor Shimon Ryde.

**3. DECLARATION OF MEMBERS' INTERESTS (Agenda Item 3):**

The Chairman declared a non-pecuniary interest in relation to Agenda Item 8 (Liverpool Care Pathway and Hospitals) and Agenda Item 9 (Update Report: Royal Free London

NHS Foundation Trust) by virtue of being a Chaplain's Assistant at Barnet and Chase Farm Hospital.

Councillor Caroline Stock declared a non-pecuniary interest in relation to Agenda Item 8 (Liverpool Care Pathway and Hospitals) and Agenda Item 9 (Update Report: Royal Free London NHS Foundation Trust) by virtue of her husband being an Elected Public Governor of the Council of Governors at the Royal Free London NHS Foundation Trust.

**4. REPORT OF THE MONITORING OFFICER (IF ANY) (Agenda Item 4):**

None.

**5. PUBLIC QUESTIONS AND COMMENTS (IF ANY) (Agenda Item 5):**

None.

**6. MEMBERS' ITEMS (IF ANY) (Agenda Item 6):**

**(a) MEMBER'S ITEM – COUNCILLOR BARRY RAWLINGS**

At the invitation of the Chairman, Councillor Barry Rawlings introduced his Member's Item and noted that it was requesting information and forecasting on GP provision within the Borough. Councillor Rawlings requested that a future report include figures on the number of GPs expected to retire, regeneration programmes and the management of future seven day GP services.

Councillor Rawlings requested that NHS England which has responsibility for this provision be requested to provide the report and asked that NHS England liaise with the Barnet Clinical Commissioning Group in order to prepare the report.

The Committee requested that the Member's Item be brought to the next meeting of the Committee, on 13 October 2015.

**RESOLVED that the Committee note the Member's Item and request to be provided with a report as set out above at their meeting on 13 October 2015.**

**(b) MEMBER'S ITEM – COUNCILLOR ARJUN MITTRA**

At the invitation of the Chairman, Councillor Arjun Mittra introduced his Member's Item. Councillor Mittra noted that Dental care was a concern of residents and requested that the Committee receive a report from NHS England at their October meeting which would address the issue of dentistry in Barnet as well as the recommendations made in the recent Healthwatch Barnet report as referred to in the Member's Item.

The Chairman requested that the future report to the Committee also contains an appendix from Healthwatch Barnet which sets out what actions Healthwatch have taken since their report.

A Member commented that safeguarding issues can often be highlighted at dental treatments, as they can provide an opportunity for issues of neglect to be picked up on.

At the invitation of the Chairman, Councillor Helena Hart, Chairman of the Barnet Health and Wellbeing Board addressed the Committee. The Committee noted that Councillor Hart used to be a dental practice Manager. Councillor Hart informed the Committee that a system of "Units of Dental Activity" (UDA) had been introduced and when the UDA had been used up, the Practice would not be paid for any further work. Councillor Hart informed the Committee that NHS England had always maintained that there were enough UDAs within the Borough of Barnet to go around. The Committee noted that it was against the rules for price lists not to be displayed in dental practices.

**RESOLVED that the Committee note the Member's Item and request to be provided with a report by NHS England together with an appendix from Healthwatch Barnet at their next meeting on 13 October 2015.**

**7. MINUTES OF THE NORTH CENTRAL SECTOR LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Agenda Item 7):**

The Chairman introduced the minutes of the meeting of the North London Sector Joint Health Overview and Scrutiny Committee (JHOSC) which was held on 20 March 2015.

The Chairman commented that a further JHOSC meeting had been held on 26 June 2015.

The Chairman referred to the minutes and commented that the JHOSC had requested that a report be put together by all acute Trusts in the North Central Sector on what was being done to reduce the number of people attending A&E. The Chairman noted that the Royal Free London NHS Foundation Trust would be presenting an item on A&E later on in the agenda.

**RESOLVED that the Committee note the minutes of the meeting of the North London Sector Joint Health Overview and Scrutiny Committee dated 20 March 2015.**

**8. LIVERPOOL CARE PATHWAY AND HOSPITALS (Agenda Item 8):**

The Chairman invited Doctor Hannah Western, Consultant in Palliative Medicine, Deborah Sanders, Director of Nursing, and Tony Wright, PFI and Contracts Manager, all from the Royal Free London NHS Foundation Trust to the table.

The Chairman introduced the item and noted that the Committee had previously considered a report from the North London Hospice on the removal of the Liverpool Care Pathway.

In introducing the report, Dr. Western advised the Committee that the Liverpool Care Pathway (LCP) was in place until 2013, when the Neuberger review recommended that it be phased out by July 2014. The Committee noted that whilst this was prior to the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust, both Trusts had responded to the review in a similar way. The

Committee noted that in response to the removal of the pathway, the Leadership Alliance for the Care of Dying People was formed to provide national guidance for providers of healthcare on the care of dying patients.

Doctor Western informed the Committee that both Trusts had removed the Liverpool Care Pathway by September 2013 and had put temporary guidance in place.

In July 2014, the Royal Free London NHS Foundation Trust started work on a response to “One chance to get it right” which was informed by the report of the National Care of the Dying Audit for Acute Hospitals. Doctor Western informed the Committee that it had become clear that all the acute trusts in north London were doing similar work and that, as a result, the following Trusts resolved to collaborate: The Royal Free London NHS Foundation Trust, UCLH, The Whittington and North Middlesex.

The Committee noted that the hospitals met in November 2014 and agreed to develop an approach to incorporate the following aims:

- a protocol for care for the dying planning
- a nursing care plan for dying patients
- prescribing guidelines for care in the last few hours and days of life
- a leaflet explaining what to expect and the care planning process for patients and those important to them.

Doctor Western informed the Committee that there was an extensive plan for training and education on the subject at the Trust.

The Committee noted that the approach was in its infancy but that the Trust felt that it was being well received so far.

Ms. Sanders advised the Committee that the Task and Finish Group was very thorough and that the Group was keen to ensure that the Pathway wouldn’t be replaced with the same principles but under a different name. Ms. Sanders stressed the importance of having good governance around the issue.

Responding to a question from a Member, Dr Western advised the Committee that whilst the principles of care for the dying remain the same, they are now evidence based. Doctor Western emphasised that an important difference was to make it clear to patients and staff that plans should be agreed by the patient. Doctor Western commented that previously, when the pathway was used incorrectly, decisions were taken without the patient being consulted. The Committee noted that the new approach was focussed on getting care right for the patient in a way that the patient and their loved ones wanted it to happen.

A Member questioned if the new approach would apply only to hospice and hospital care and commented that often people would want to be in a familiar place, such as their own home. Doctor Western informed the Committee that the approach was about care planning for the patient and ensuring that all parties understand what that patient wants and what is available to them.

The Chairman advised that she had visited a care home where the spouse of a resident had become very distressed because their partner, who had been put on the Pathway, had had their fluids withdrawn. Doctor Western informed the Committee of the importance of having a full discussion with families and to consider the reasons for such


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treatment. Doctor Western informed the Committee that there was research to show that sometimes there is no benefit in giving fluids to a patient and that, in some instances, it can actually cause more harm. Doctor Western commented on the importance of explaining why clinicians decide to stop fluids and also what the correct treatment for the patient should be. The Committee noted the importance of communication in these circumstances so that people could understand the rationale of clinicians.

**RESOLVED THAT the Committee note the report from the Royal Free London NHS Foundation Trust.**

**9. UPDATE REPORT: ROYAL FREE LONDON NHS FOUNDATION TRUST (Agenda Item 9):**

The Chairman invited Doctor Hannah Western, Deborah Sanders, Director of Nursing, and Tony Wright, PFI and Contracts Manager, all from the Royal Free London NHS Foundation Trust to introduce the report.

Ms. Sanders noted the Committee's interest in 18 Week Referral to Treatment and commented that there had been performance issues in relation to this at Chase Farm Hospital. Ms Sanders informed the Committee that work had been done to data- cleanse the waiting list.

The Committee noted that work had been on-going at the Trust in relation to national reporting and that data would be publicly available within the next fortnight.

Ms. Sanders provided the Committee with an update in relation to the Acquisition. The Committee noted the following:

**The Redevelopment of Chase Farm Hospital**

- That on 12 March Enfield Council granted outline planning permission for the redevelopment, subject to signing off a section 106 agreement and a further application to deal with reserved matters later in the summer.
- That subject to approval of the final business case, the Trust expect to commence the main construction works in early 2016, with the new hospital due to open in April 2018.
- Enabling works started this April to the medical block, where various services will be relocated over the summer to enable construction of the new hospital building to begin. The services due to move include the Older Person's Assessment Unit (OAPU) in July and the urgent care centre in August.
- A public meeting had taken place on 30 June 2015 to update the public and local stakeholders about the redevelopment.

**Winter Pressures**

- That pressures were being faced nationally at A&E Units.
- Barnet Hospital and the Royal Free Hospital experienced a significant increase in demand over the winter which placed considerable additional pressure on accident and emergency services. December was particularly busy and attendances at Barnet Hospital were 13% higher in December 2014 compared with December 2013. Pressure on A&E was further increased by Delayed Transfers of Care.


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- The Trust has commenced building work at A&E at the Royal Free site which was originally built for 60,000 attendances a year, but is being redesigned for 120,000 attendances a year. The Trust intend to provide a full A&E service whilst building is in progress, but there is a process in place to stop work if it becomes too noisy for patients.

**Ambulance Handover Delays**

- Barnet Hospital has had the highest number of ambulance conveyances in London, with high numbers coming from the West.
- The communication between different Ambulance Services does not always work effectively.
- At Barnet Hospital there were 115 ambulance journeys where there was a handover delay of 30/60 minutes or more in April and May 2015. However, these numbers were the lowest since November 2014. Delays of over an hour have been significantly reduced from an average of 27 per month between December 2014 and March 2015 to three in April and zero in May 2015.
- That data for the Royal Free Hospital is less complete. There were seven journeys where the handover was delayed by over an hour in May 2015.

The Chairman invited Jon Dickinson, Assistant Director, Adult Social Car, to the table and requested that he provide the Committee with an update on Delayed Transfer of Care (DToC) from the point of view of the London Borough of Barnet. Mr. Dickinson commented that there were some very good working relationships between acute hospitals and Barnet Council. Mr. Dickinson expressed the need to meet the challenge of Delayed Transfer of Care and noted that the London Borough of Barnet provided a seven day social care service across both hospital sites.

Mr. Dickinson informed the Committee that, comparing the month of March over the last three years, Adult Social Care received 168 (2013) / 216 (2014) / 265 (2015) referrals from Barnet & Chase Farm acute hospitals. The Committee noted that this correlated with the rise in admissions of older people with complex needs who require community support.

The Committee noted that the Adults and Communities Delivery Unit were seeing a significant staffing challenge in order to meet demand.

Referring to Appendix A of the report, Mr. Dickinson noted that on 11 June 2015, the Trust had reported a total of 113 patients who were medically fit but whose transfer had either been formally delayed (DToC) or were medically fit but still in process. Mr. Dickinson informed the Committee that 36 of these 113 people were recorded as a delayed transfer of care, with 10 of these from Barnet, with 14 from Herts Valley, 5 from Haringey, 3 from Enfield, and 1 from East and North Herts NHS Trust, Brent, Camden and ‘other’ areas. The Committee noted that, of these 10 in Barnet, only 3 were attributed to delays in Adult Social Care.

The Committee noted that the London Borough of Barnet is working closely with colleagues to reduce DToC but that it is a challenging issue. Mr. Dickinson commented on the importance of dealing with complex needs in a dignified way and noted that did mean that occasionally more time was needed to ensure that the needs of a patient were met properly.

The Chairman asked Mr. Dickinson if he knew whether there were any particular care homes with Barnet who were slow at reassessing residents waiting to return from hospital. Mr. Dickinson replied that this could be an issue and, if it was, the Council would communicate the need for faster responses to these homes.

A Member commented on turnover delays and questioned if the Trust was able to provide any statistics on the proportion of ambulances coming into the Trust from the London Ambulance Service. The Royal Free London NHS Foundation Trust undertook to see if there was any available information on this matter that could be provided to Members.

Referring to the report, the Chairman noted that a recent Citizens Advice Bureau survey of 900,000 people found that 18-34 year olds are more than twice as likely to attend emergency departments or walk-in centres as those aged 55 and over and that they are far less likely than older people to see a GP when they need to. The Chairman questioned if more action was needed to reduce the number of people attending A&E when there are more suitable care pathways.

A Member commented on the large amount of regeneration that was taking place in the Kings Cross area of London which was attracting a young, mobile demographic and questioned if it would be possible for the Committee to see the age profile of people attending A&E at the Royal Free site. Officers from the Royal Free London NHS Foundation Trust undertook to provide this information if available.

Responding to a question from a Member on the number of beds there will be at the redeveloped Chase Farm Hospital site, Ms. Sanders informed the Committee a lot of work had been done on modelling for an appropriate number.

A Member expressed concern that the site approved for the redevelopment is too small for the growth of population that will occur in the area. Ms. Sanders undertook to pass the Member's comments onto colleagues.

The Vice Chairman noted that when the Committee had considered the Trust's Quality Account at their meeting in May, the Committee had requested to be provided with the available data for Barnet and Chase Farm Hospitals on the 62 day wait target for cancer diagnosis. The Vice Chairman noted that the Committee had received further information and commented that, to be effective, treatment for cancer needed to be sooner than 18 weeks. The Vice Chairman requested that the Trust provide further information on performance in relation to the 62 day wait. Responding to this question, Ms. Sanders informed the Committee that the Trust had had particular issues with diagnostics tests for urology, but a plan was in place to address this and that the current trajectory indicated that the Trust should return to compliance by December. The Vice Chairman commented that compliance was not good enough and that Britain performs poorly compared to the rest of Europe on Cancer treatment.

The Chairman asked whether Barnet Hospital was now using the "Forget-Me-Not" scheme for dementia patients instead of the "Butterfly" scheme so that it was consistent with the Royal Free London NHS Foundation Trust. The reply was affirmative.

The Chairman invited Mr. Tony Wright, PFI and Contracts Manager, to provide the Committee with an update in relation to the new parking scheme at Barnet Hospital. The Committee noted the following update:


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- That after a visit to the site by Councillor Alison Cornelius and Councillor Laurie Williams and a review with Disability Barnet, a complete signage review had been undertaken.
- That the Committee could be e-mailed the draft signage plan later in the week to review.
- That the Trust would be changing the signage for the front of the hospital to give people who were driving in more information.

The Chairman questioned if Members would be able to provide feedback on the draft plan. Mr. Wright advised the Committee that he would be able to send the plan to the Committee the following day, allowing Members of the Committee to make suggestions on the plan.

Following a question from a Member, Mr. Wright undertook to provide information to the Committee denoting if there had been a fall in the number of parking tickets being given at the hospital. The Committee noted that the number of parking tickets being disputed by motorists is less than 1%.

Mr. Wright extended an invitation to Members of the Committee to visit the site at Barnet Hospital in advance of providing feedback on the draft parking plan.

**RESOLVED that:-**

1. **The Committee request that the Trust provide further information on performance in relation to the 62 day wait.**
2. **The Committee request to be provided with information on the age profile of patients attending A&E at the Royal Free site.**
3. **The Committee note the update from the Royal Free London NHS Foundation Trust.**

## 10. HEALTHWATCH BARNET ENTER AND VIEW REPORTS (Agenda Item 10):

The Chairman invited Mike Rich, the new Head of Healthwatch Barnet, and Julie Pal, Chief Executive of Community Barnet, to the table.

A Member noted that Enter and View visits are conducted by trained volunteers and questioned if it was hard to recruit volunteers to undertake visits. Mr. Rich advised the Committee that they had been successful at recruiting a high number of volunteers and that Healthwatch Barnet was recognised nationally as having one of the biggest Enter and View programmes in the country, with over 30 visits per year being carried out.

Mr. Rich informed the Committee that over the last two years, Healthwatch Barnet had focussed Enter and View visits on care homes and mental health settings. The Committee noted that Enter and View visits had also focussed on mealtimes.

Mr. Rich noted that the role of Healthwatch, within the context of scrutiny, was to complement the work of the CQC. The Committee noted that one of the benefits of Enter and View reports was that they provided an opportunity for Healthwatch to pick up on “soft” intelligence so that they can alert authorities to any issues that need addressing.


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The Committee noted that most of the reports produced by the Enter and View team portray a generally positive outline of care providers and that the recommendations made by the reports are generally taken on board by the establishments visited.

Responding to a question from the Chairman, Mr. Rich advised the Committee that approximately six Enter and View volunteers were trained to visit mental health settings.

Referring to The Oaks report, a Member noted that the Oaks Ward was in a complex at the back of the Chase Farm Hospital site, which was poorly signposted and badly lit. The Chairman questioned if this matter would be taken any further. Mr. Rich informed the Committee that it would be added to a list of points that could be sent to the Royal Free and that, in many cases, the ward manager would address the issues raised in a report with the relevant manager in the hospital.

A Member of the Committee noted that the report stated that there was no alarm call system in the residents' rooms in Oakleigh House and questioned the action that Healthwatch was going to take in relation to this matter. Mr. Rich advised the Committee that Healthwatch Barnet would take this matter up and come back to the Committee with further information.

Responding to a question from the Chairman, Mr. Rich advised the Committee that the Adults and Safeguarding Committee would be receiving a report from Healthwatch Barnet which summarised the findings of Enter and View visits more widely and provide the Committee with a clear picture of the Healthwatch Programme.

**RESOLVED that the Committee note the report.**

## 11. EAST BARNET HEALTH CENTRE (Agenda Item 11):

The Chairman introduced the report and noted that the item had been put on the Committee Forward Work Programme as a result of a Member's Item in the name of Councillor Amy Trevethan.

The Chairman invited Alan Keane, the Assistant Head of Primary Care for North Central London at NHS England, Robert Braham, the Regional Asset Manager for NHS Property Services Ltd, and Hannah Murdoch, the Head of Communications (Acting) at London NHS Property Services Ltd, to the table.

The Chairman invited Mr. Braham to provide the Committee with an update. Mr. Braham advised the Committee that the centre was currently undergoing refurbishment and it was expected to be completed by end of September 2015. The Committee noted that there had been further asbestos discovered on the site and now that it had all been cleared, the full refurbishment should be completed by the autumn.

A Member questioned if service users had been consulted when the feasibility study for the East Barnet Health Centre was undertaken. The Committee also noted that NHS England had issued a letter to all patients in the autumn to inform them that the Centre would be closed for longer than first expected. The Committee were advised that in December 2014, a further review was undertaken and the four possible options arising were presented to patients at a meeting held at the beginning of February 2015. The Committee noted that the overwhelming view of patients was that they wanted the

existing centre refurbished, instead of re-built so that it could be re-opened as soon as possible.

Responding to a question from the Chairman, Mr. Braham advised the Committee that the work was on track and on budget.

The Vice Chairman welcomed the shuttlebus that was being used to transport patients to Vale Drive. The Committee noted that the shuttle service had been successful, although take up had been low. The Committee was informed that a review was being conducted to assess the number of people using the shuttle and to see if there were alternative options that would provide a method for those patients who have mobility issues to be transported to Vale Drive until the Health Centre is re-opened.

Responding to a question from the Chairman, Ms. Murdoch advised the Committee that in the last week an average of ten passengers per day had been using the shuttle bus. The Committee commented that they would like to see an increase in usage of the shuttle bus and noted that NHS Property Services were asking the practices to let patients with mobility issues know that the shuttle is there for their use. The Committee noted that the Practice Manager had agreed to put posters up in the local area. Members noted that NHS Property Services were concerned about people misusing the shuttle service, as it ran near a tube station.

A Member requested that NHS Property Service provide the Committee with the running costs of the shuttle bus.

A Member questioned if rents had been negotiated with the GPs for the buildings. The Committee noted that the GPs had been issued with initial documentation and that they would be invited to discuss the rents.

Responding to a question from a Member, Mr. Braham informed the Committee that, whilst service charges would cost more in a new building, there should be off-setting savings in maintenance charges.

The Committee commented that they would like to receive an update report on the East Barnet Health Centre from NHS England and NHS Property Service at their meeting in December 2015.

**RESOLVED that:**

1. **The Committee request to be provided with an update report on the East Barnet Health Centre from NHS England and NHS Property Service at their meeting in December 2015.**
2. **The Committee note the report.**

## 12. OPTIONS FOR UNSCHEDULED CARE SERVICES AT CRICKLEWOOD GP HEALTH CENTRE: UPDATE REPORT (Agenda Item 12):

The Chairman invited Regina Shakespeare, the Interim Chief Operating Officer at Barnet Clinical Commissioning Group, Dr. Sarkar, Barndoc Medical Director, and Alan Levett, Chief Operating Officer at Barndoc, to the table to introduce the report.

The Committee noted that the report stated that Barnet CCG had reconsidered the case for change regarding the walk-in service and had decided not to proceed with closing it at this time.

A Member commented that the walk-in centre was very important and that the Cricklewood was an area with insufficient GPs. The Member commented that the walk-in centre was not well signposted and that there were a number of site issues.

Responding to a question from a Member, Ms. Shakespeare advised the Committee that the original proposition was about consultation and engagement and included the current end date of the contract, not a provision for closure.

The Committee noted that the contract had been extended from 30 September until 31 December 2015.

The Committee were advised that the walk-in centre would continue to accept patients from within and outside Barnet. However, Barnet CCG would now receive money for each registered patient, regardless of where they live.

Responding to a question from a Member, Dr. Sarkar advised the Committee that a very broad demographic of patients attended the walk-in centre, ranging from young to elderly. The Committee noted that some attendees have said that they have attended because they were not able to book an appointment at their registered GP clinic. The Committee were informed that part one of the key performance indicators at the Centre was to ask attendees if they were registered.

Members noted that convenience played a large part in the attendance of some people. For example, some patients attended because the centre provided services that they could not access in their normal GP practice, such as ear syringing.

The Chairman questioned what BarnDoc were currently charging the CCG to run the Walk In centre at Cricklewood. The Committee noted that the contract set a cost of £35 per attendance for any patient who walks into the Centre, excluding patients already registered.

The Committee noted that the contract requires a Doctor to be on site from 8 am until 8 pm, 7 days a week, 365 days a year.

The Vice-Chairman asked if the CCG felt it could be counterproductive to encourage people to use walk in centres rather than register with their own GP. Ms. Shakespeare advised the Committee that clinicians believed in “excellent access to excellent primary care” and that this was a key consideration as to what should be commissioned for patients. Ms. Shakespeare noted the importance of both value for money and wellbeing and commented that many patients prioritise convenience.

The Committee noted that Barnet CCG had applied to obtain access to the Prime Minister’s Challenge Fund but were unsuccessful, despite a strong bid.

Responding to a question from a Member, Dr. Sarkar advised the Committee that the walk-in centre was required to offer their service to any unregistered patients, even if they resided outside of the Borough.


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A Member commented that the walk-in centre in Cricklewood was a long distance from the nearest A&E Department and questioned how the service could encourage higher numbers of people to register at the practice. Dr Sarkar informed the Committee that registration had picked up quite considerably in last few months.

The Committee requested to be provided with a further update report from the Committee at their meeting in December 2015.

**RESOLVED that:**

1. **The Committee note the report**
2. **The Committee request to be provided with a further report from Barnet Clinical Commissioning Group at their meeting in December 2015.**

## 13. WORK PROGRAMME (Agenda Item 13):

The Chairman invited Councillor Helena Hart, the Chairman of the Barnet Health and Wellbeing Board, and Dr. Andrew Howe, the Director for Public Health at Barnet and Harrow Councils, to the table.

Councillor Helena Hart advised the Committee that at their meeting on 30 July 2015, the Health and Wellbeing Board would be looking at the following items:

- Joint Strategic Needs Assessment refresh
- The Health and Wellbeing Strategy
- The draft substance misuse strategy
- An update report from Healthwatch Barnet
- A Tuberculosis report.

At the invitation of the Chairman, Dr. Howe advised the Committee of the role that Health Education England play in relation to GP provision.

The Chairman noted that the Committee would be receiving a report in the name of Dr. Howe at their next meeting on the issue of sexual health and requested that provision for under 25s be included within the report.

**RESOLVED that the Committee note the work programme.**

## 14. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 14):

At the invitation of the Chairman, Councillor Rawlings informed the Committee that he had requested the consideration of an item of urgent business on the agenda on the issue of the provision of Child and Adolescent Mental Health Services Out of Hours (CAMHS OOHrs)

The Committee noted that an addendum on this matter which provided an update from the London Borough Barnet had been published on the Council website in advance of the meeting and that hard copies of the agenda had been provided to Members of the public and the Committee.

Councillor Rawlings informed the Committee that he had been made aware that the contract for the provision of CAMHS OOHrs was due to end in March 2015 and that it had been extended to June 2015. Councillor Rawlings advised that he was concerned that on 1 July 2015, no service would have been commissioned.

The Chairman asked Ms. Shakespeare to provide an update to the Committee. Ms. Shakespeare advised the Committee that from 1st July 2015 a service had been put in place which consisted of a package that had been put together with Royal Free London NHS Foundation Trust.

The Committee noted that commissioners would continue to work across commissioning and provider services to develop a more consistent approach which will inform the new CAMHS out of hour's service going forward.

Responding to a question from the Chairman, Councillor Barry Rawlings advised that he was satisfied with the response that had been provided on the evening and that no further action was necessary.

**RESOLVED that the Committee note the urgent item.**

The meeting finished at 9:59


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AGENDA ITEM 7

# Health Overview and Scrutiny Committee

## 13 October 2015

| | |
|---|---|
| **Title** | **Finchley Memorial Hospital** |
| **Report of** | Governance Service |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | *No* |
| **Enclosures** | Appendix A – Update Report rom NHS England and Barnet Clinical Commissioning Group |
| **Officer Contact Details** | Anita O'Malley – Governance Team Leader<br>anita.vukomanovic@barnet.gov.uk 0208 359 7034 |

## Summary

At their meeting on 30 March 2015, the Committee considered a report which provided an update from NHS England and Barnet CCG on the provision of GP Services or a primary care facility at the Finchley Memorial Hospital site.

The Committee noted that the project was scheduled to develop a series of initial options for review in April 2015, which would then need appraisal and planning in order to work through the commissioning and costing consequences.

The Committee noted that the intention was to identify agreed options by the summer of 2015, with a view to commencing work on implementing the new models of service. The Committee have requested to consider a further update report to capture the agreed options which are due for agreement in the summer of 2015. This update report is set out in Appendix A.

Representatives from NHS England and Barnet CCG will be in attendance at the meeting to present the report and respond to questions from the Committee.

# Recommendations

1. **That the Committee note the update from NHS England and Barnet Clinical Commissioning Group, and ask appropriate questions.**

## 1. WHY THIS REPORT IS NEEDED

1.1 At the meeting of the Health Overview and Scrutiny Committee on 12 December 2013, the Committee received a Members Item in the name of Cllr. Geof Cooke GP in relation to NHS England seeking to relocate local GP practices onto the Finchley Memorial Hospital site.

1.2 The Committee requested a further update from NHS England at their meeting on 20 October 2014. After receiving an update at their October meeting, the Committee resolved to request a further update in March 2015. The report attached Appendix A sets out a joint submission from NHS England and the Barnet Clinical Commissioning Group.

1.3 The Committee received a further report at their meeting in March 2015 and noted the project was scheduled to develop a series of initial options for review in April 2015, which would then need appraisal and planning in order to work through the commissioning and costing consequences. The Committee were informed at this meeting of the intention to identify agreed options by the summer of 2015, with a view to commencing work on implementing the new models of service. The report attached at Appendix A provides an update on the options considered.

## 2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the site issues which have previously affected GPs moving into the premises, and be kept abreast of the future plans for healthcare at Finchley Memorial Hospital.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

## 4. POST DECISION IMPLEMENTATION

4.1 Following consideration of this item, the Committee will be able to determine any further actions that they wish to pursue.

## 5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 There are no financial implications for the council.

## 5.3 Social Value

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

## 5.4 Legal and Constitutional References

5.71 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

5.7.11 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

*"To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas."*

## 5.5 Risk Management

5.5.1 Not receiving this report would present a risk to the Committee in that they would not be kept up to date on issues surrounding the Finchley Memorial Hospital.

## 5.6 Equalities and Diversity

5.9.1 Equality and Diversity issues are a mandatory consideration in decision making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must fulfil its equality duty when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

5.9.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

*Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

*Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

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5.7 **Consultation and Engagement**

5.7.1 None in the context of this report.

5.8 **Insight**

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

## 6. BACKGROUND PAPERS

6.1 None.

**Report to Barnet Health Overview and Scrutiny Committee – 13th October 2015**

**Update on Barnet CCG plans for Finchley Memorial Hospital**

## 1. Introduction

At the Health Overview & Scrutiny Committee meeting on 30th March 2015 Barnet CCG presented an update on plans to develop new services at Finchley Memorial Hospital (FMH) and to improve utilisation of the building. The paper also discussed the issue of bringing GP services into the building. This paper provides an update for the Health Overview & Scrutiny Committee on the CCG's progress with this project.

## 2. Background & Process to Date

In January the CCG launched a project to review how it could make a more effective use of the new facilities at FMH to deliver its objectives for improving health care for the local population. The CCG has worked with NHS England (NHSE) on this issue as NHSE are responsible for commissioning GP services.

The project reviewed all commissioning plans and areas of local health care need and these were presented to a stakeholder workshop at the end of April. A long list of options was agreed at this workshop and these were reviewed in greater detail and presented to the CCG's Clinical Cabinet in July for discussion and to draw up a short list of preferred options.

## 3. Revised Service Vision and Preferred Options

The CCG's overarching preference is to make FMH a focus for services for older people, particularly the frail elderly. In particular, the CCG wants FMH to host a series of services designed to keep people safe and comfortable at home and independent for longer before they need to access acute hospital services.

The priority schemes are:

**A) An Older People's Assessment Service** (OPAS) - essentially a specialist resource which will assess older people to design the right service solutions to keep them at home and independent. (There is a successful model at Chase Farm for Enfield patients but currently nothing similar in Barnet.) The new service would work closely with the existing Falls Clinic at FMH.

**B) Filling the empty inpatient ward**. There are 17 unused beds at FMH and, on average, 18 - 20 Barnet residents in community rehabilitation beds at Chase Farm following transfer from Barnet General. Opening these beds will allow us to repatriate these patients back to Barnet.

**C) Breast Screening** - subject to more detailed space planning the CCG would like to accommodate a permanent breast screening service to replace the mobile service currently provided by the North London Breast Screening Service.

## 4. The General Practice Issue

Responsibility for commissioning GP services from FMH is held by NHS England and the CCG has been working with NHSE to explore different ways that primary care services can be brought into FMH. One option would be to set up a specialist GP primary care services to focus on the particular healthcare needs of frail elderly and care home patients. There are some exciting models in London and beyond where GP services have been targeted at groups with special needs for more focussed services in this way.

The CCG will work with NHSE to see how a specialist service such as this could be commissioned by them and if it could also (a) take new patient [general] registrations and (b) be designed to work more closely with the existing Walk in Centre, whilst being complementary overall with the other services which might be located at FMH. The model would also need to be assessed to see if it was best value for money.

## 5. Process

The FMH project has now moved into a detailed analysis phase and the CCG has set up a series of workstreams to explore each of the above options in more detail with a view to developing formal business cases for approval in the next 6 months.

There will be a series of workshops for stakeholders to be involved in helping to design the precise service model for each option and then issues of activity, cost and procurement will be analysed.

The CCG has set up a robust governance model with a Programme Board accountable to the Clinical Cabinet but clear separation of all procurement issues which will be considered by the CCG's Primary Care Procurement Committee.

## 6. Timescale

The aim is to develop the new service models for each option and take them through the project governance process for final submission to the CCG's Governing body in March 2016. Implementation would then follow once approved by the Governing Body and of course subject to necessary guidance in respect of consultation and procurement.

**Barnet CCG**
**October 2015**

AGENDA ITEM 8

# Barnet Health Overview and Scrutiny COmmittee

## 13 October 2015

| | |
|---|---|
| **Title** | **TB Situational Report for Barnet** |
| **Report of** | Dr Andrew Howe, Director of Public Health |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | No |
| **Enclosures** | Appendix 1: TB Awareness Evaluation Report (June 2015)<br>Appendix 2: Tuberculosis Report - Update from TB situational report for Health and Well Being Board (July 2015) |
| **Officer Contact Details** | Dr Laura Fabunmi, Consultant in Public Health Medicine<br>Laura.fabunmi@harrow.gov.uk |

## Summary

Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. Almost 40% of all cases nationally occur in London (41.2/100,000), which ranks as the city with the second highest TB rate in Europe, only behind Lisbon, Portugal (48.2/100,000).

Rates of TB in Barnet have dropped in the three-year average data, from 30.0/100,000 (2010-12) to 23.2 / 100,000 (2012-14). Although this is lower than the London average of 30.1 / 100,000 (2013), there are still hot-spots within the borough with rates above this level.

This report discusses some of the challenges in tackling TB, who is effected by TB, and what is happening, and what is planned, at both national and local levels to identify people with TB and provide the required treatment.

| Recommendations |
|---|
| 1. **The Health Overview and Scrutiny Committee to note the report and the steps taken by the public health team and other partners to reduce incidence of TB in Barnet.** |
| 2. **The committee to note the recommendations accepted by the Health and Well Being Board on 30th July 2015.** |

## 1. WHY THIS REPORT IS NEEDED

**1.1..1** Following the presentation of the Annual report of the Director of Public health to the Health Overview and Scrutiny committee on 9th February, 2015 a further update has been requested to understand**.**

- The epidemiology of TB in more detail
- Reasons why TB is difficult to eliminate
- What is currently being done to tackle TB
- Further proposals to tackle TB

**1.1..2** A report on TB went to the Barnet HWBB on 30th July and recommendations were agreed on supporting Tb awareness raising programmes and also providing strategic direction for the latent TB screening programme. This is attached in appendix 1.

### 1.2 Epidemiology of TB

#### 1.2..1 Rates of TB

**1.2..1.1** TB in Barnet is currently 23.2 / 100,000 based on a three year average from 2012-2014. This is a reduction from the previous three year (2010-12) which was 30.0/100,000. It is lower than the London average for the same period, 30.1 / 100,000, but is still higher than the England average of 14.8 / 100,000. In the past three years, rates of TB across Barnet, London and England have been dropping annually.

**1.2..1.2** For context, India has a TB incidence rate of 171/100,000 which equated to a total of 1,243,905 new and relapse cases in 2013. With such scale comes a similarly high programme budget for TB control; $252m USD[1].

**1.2..1.3** There is considerable difference in TB rates across London, which is largely the result of demographic differences. For example, Havering has a TB rate of 10.3 / 100,000, whereas Newham has a rate of 113.7 / 100,000. Population size is very similar in each borough, but the make-up of the populations are very different. Newham is one of the most ethically diverse London boroughs with 64.6% BME, while Havering is London's least ethnically diverse with just 17% from BME groups.

### 1.3 Who gets TB?

[1] WHO Tuberculosis country profiles www.who.int.tb.country/data/profiles/en/

**1.3..1** Whilst rates of TB found among the UK-born population living in London are twice that of those living anywhere else in the UK, a high prevalence of TB in London occurs in people born outside the UK who develop active disease several years subsequent to their arrival in London[2].

**1.3..2** In 2013, 83% of TB patients were born outside of the UK, and rates in the non-UK born remain nearly ten times greater than among those born in the UK. Majority of the cases in London are in people who have resided in the UK for long periods prior to being diagnosed with TB. The number of TB patients who were recent entrants to the UK (entered within the previous two years) has decreased. In 2013, only 266 and 9% of all TB patients were recent entrants to the UK

**1.3..3** TB rates are highest in those born in India with those born in Pakistan and Somalia following in frequency (table 1). The 2012 London LA profiles for TB showed Barnet has similar profile to London. The majority of new cases were in people of Indian ethnicity (30%) and mixed/other ethnicity was the next most common and reflects people with a range of backgrounds (26%).[3]

**1.3..4** The age/sex profile of cases shows that females aged 20-29 made up a larger than usual proportion, although patients were more often male across other age groups.

Table 1. Country of Birth for non-UK born London cases

| Rank | Country of Birth | N= | % of non-UK born patients |
|---|---|---|---|
| **1** | India | 756 | 32% |
| **2** | Pakistan | 309 | 13% |
| **3** | Somalia | 193 | 8% |
| **4** | Bangladesh | 141 | 6% |
| **5** | Nigeria | 101 | 4% |

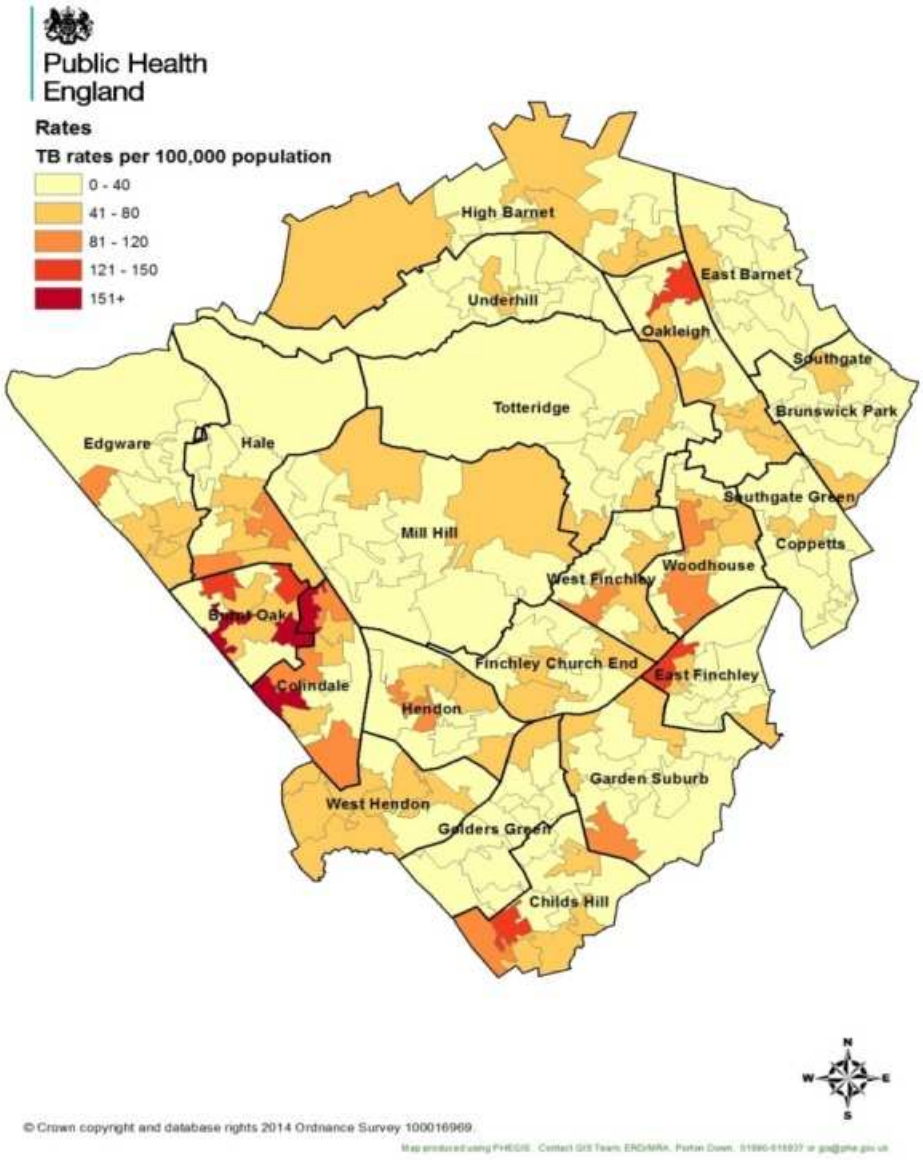
*Source: TB in London annual report 2013. PHE*

## 1.4 Where do people with TB live in Barnet?

1.4..1 Rates of TB vary across the borough of Barnet - see Figure 1. According to data received from PHE, the top three areas in Barnet are: Colindale, Burnt Oak and Oakleigh. It is important to note that these rates are based on small numbers.[4] Therefore, it is expected that specific figures for these areas within the borough will fluctuate year on year and area-specific data should be interpreted with care.

**Figure 1. London Borough of Barnet TB Incidence Rate by LSOA, 2012**

[2] London TB service specification 2013/14. November 2013.
[3] PHE. Local Authority TB Profiles, Barnet. October 2013. p. 4.
[4] Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.

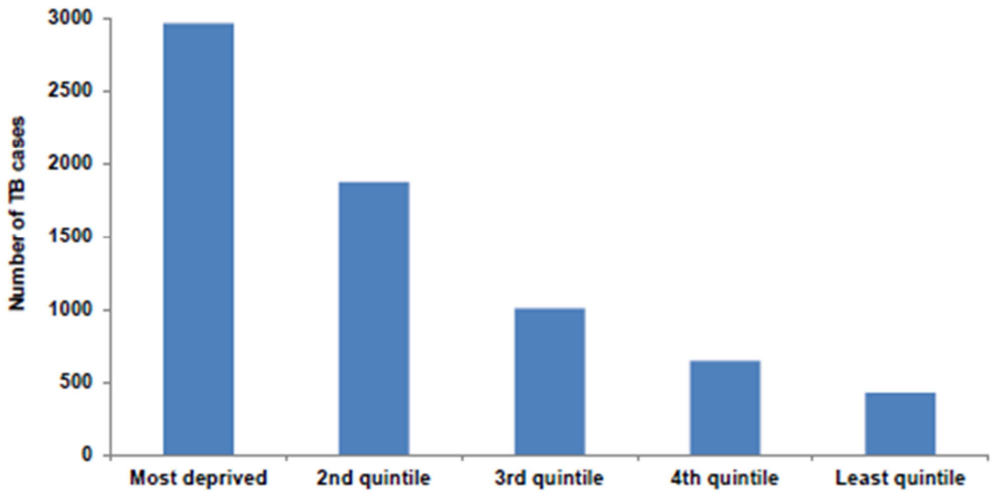



## 1.5 Challenges in reducing levels of TB

1.5..1 Similar to London and the UK, the majority of TB cases in Barnet arise due to reactivation of latent infection, thus the main challenge to reducing TB in Barnet is the identification and treatment of those with latent TB. Approximately 80% of people who develop active TB do so as a result of the reactivation of latent TB rather than through transmission from someone with active disease. The prompt identification of active cases of disease, supporting patients to successfully complete treatment and preventing new cases of disease is also important.

1.5..2 There is also a strong association between TB and social deprivation, with 70% of cases occurring among residents of areas in the two most deprived quintiles in the country (Figure 2), and 9% of all TB cases having at least one social risk factor (a history of alcohol or drug misuse, homelessness or imprisonment)[5]. In Barnet, the proportion of Tb patents with social risk factors – 3.9% is below the London average of 12.2%;it should be noted these percentages are based on small numbers

**Figure 2. Number of TB case reports by deprivation quintile of area of residence, (IMD 2010), UK, 2013.**




1.5..3 Another factor which challenges programmes aimed at tackling TB is the social stigma within many communities related to the disease. In some cultures, TB is associated with witchcraft. TB can be considered a 'curse' on a family, as the illness often affects multiple generations – we know that this is simply because TB is an airborne illness, which is more likely to be spread among people living in close proximity. Fear of discrimination can mean people with TB symptoms delay seeking help, making it much more likely that they will become seriously ill and infect others. This then perpetuates the myth that it is the TB treatment itself that causes deaths, as treatment is much less effective if left until the illness is in its advanced stages[6].

1.5..4 Furthermore, TB does not respect geographical boundaries, let alone the invisible borough boundaries, and as such tackling TB in Barnet must be part of the 2015 national strategy[7] .

[5] Public Health England. Tuberculosis in the UK. 2014 report. [Internet]. London: Public Health England; 2014. Available from: https://www.gov.uk/government/publications/tuberculosis-tb-in-the-uk

[6] TB Alert: http://www.tbalert.org/about-tb/global-tb-challenges/stigma-myths/?wb48617274=31A42E1E

[7] Collaborative Tuberculosis Strategy for England 2015 to 2020. Available from: https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

## 1.6 How is TB managed?

1.6..1 TB must be, and in to some extent, managed in both social and clinical contexts. The 2014 Annual TB Report[8] from PHE remind us that TB remains concentrated in the most deprived populations; in 2013, 70% of cases were resident in the 40% most deprived areas, nearly half (44%) of cases were not in employment and 10% had at least one social risk factor (history of alcohol or drug misuse, homelessness or imprisonment).

1.6..2 *Tackling TB, Local Government's Public Health Role*[9], produced by the LGA and PHE in 2014, highlights the importance of BCG vaccination for infants and young children. It continues, *"The most important factors are early detection and diagnosis, especially of infectious cases, and treatment completion. Early case detection and prompt initiation of treatment reduces onward transmission of the disease. Completing a full course of appropriate treatment is vital to prevent the disease relapsing, to prevent the development of drug resistant strains of TB, to prevent prolonged infectiousness and preventable death."*

1.6..3 Considerable evidence exists about what works in terms of TB prevention, treatment and control[10],[11] including published clinical and policy guidance[12],[13]. There is also clear evidence of the devastating consequences of failing to invest in TB services: disinvestment in services in New York in the 1970s and 1980s led to a tripling of cases and widespread community TB transmission, including major outbreaks of MDR-TB, which required more than one billion dollars of reinvestment to reverse.[14]

1.6..4 The target set by the Chief Medical Officer for England, based on the WHO target, for completion of treatment for TB is 85%. The percentage of patients completing treatment at 12-month has improved over recent years, as shown in table 2.

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[8] Tuberculosis in the UK: Annual Report 2014. PHE: https://www.gov.uk/government/publications/tuberculosis-tb-in-the-uk

[9] Available from: http://www.local.gov.uk/documents/10180/5854661/Tackling+Tuberculosis+-+Local+government's+public+health+role/20581cca-5ef1-4273-b221-ea9406a78402

[10] Abubakar I, Lipman M, Anderson C, Davies P, Zumla A. Tuberculosis in the UK--time to regain control. BMJ. 2011 Jul 31;343 (jul29 1):d4281–d4281.

[11] National Institute for Health and Care Excellence. Clinical guidance and management of tuberculosis, and measures for its prevention and control. CG117 [Internet]. 2011 [cited 2014 Feb 24]. Available from: http://www.nice.org.uk/nicemedia/live/13422/53638/53638.pdf

[12] Story A et al. Royal College of Nursing (Great Britain) BTS, Health Protection Agency (Great Britain) NNTA for SM. Tuberculosis case management and cohort review guidance for health professionals [Internet]. London: Royal College of Nursing; 2012 [cited 2014 Mar 10]. Available from: http://www.rcn.org.uk/%5F%5Fdata/assets/pdf%5Ffile/0010/439129/004204.pdf

[13] Department of Health - TB Action Plan Team. Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England [Internet]. London: Department of Health; 2007. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf

[14] Frieden TR, Fujiwara PI, Washko RM, Hamburg MA. Tuberculosis in New York City—turning the tide. N Engl J Med. 1995 Jul 27;333(4):229–33.

**Table 2. Percentage of TB Patients in London Completing Treatment.**

| Year | % |
|---|---|
| 2002 | 74% |
| 2003 | 76% |
| 2004 | 78% |
| 2005 | 79% |
| 2006 | 82% |
| 2007 | 83% |
| 2008 | 85% |
| 2009 | 86% |
| 2010 | 86% |
| 2011 | 86% |
| 2012 | 86% |

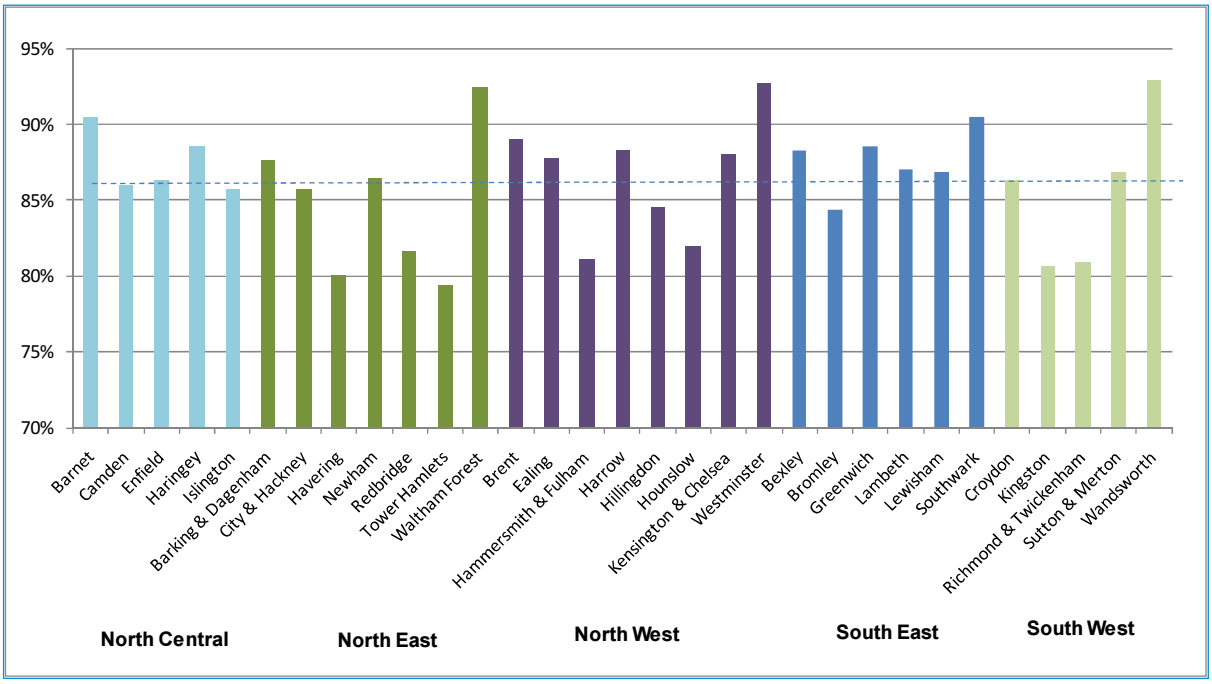
1.6..5 However, as figure 3 shows, treatment completion rates vary considerably across the boroughs, with Barnet ranking as one of the boroughs with higher completion rates at over 90%, which is higher than the London average.

1.6..6 Older patients were less likely to complete: just 74% of those aged 65 or older completed (206/278), with higher rates of death (18%, 50). Treatment completion was slightly lower among males (84%, 1,447/1,722 vs. 89%, 1,125/1,271): they were more likely to die (3.5%, 61 vs. 1.6%, 20) or be lost to follow up (5.1% 87 vs. 2.8%, 35).[15]

1.6..7 Treatment completion was similar among the UK born and those born abroad overall (87%, 444/513 vs. 86%, 2,104/2,442). Those born abroad were more often lost to follow up (4.7%, 114 vs. 1.2%, 6), while the UK born were more likely to die (3.7%, 19 vs. 2.3%, 57). The lowest completion rates were among the UK born white and black Caribbean ethnic groups, followed by white patients born outside the UK.

[15] Tuberculosis in London, 2013. PHE Report available from: https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

**Figure 3. Treatment completion rates by PCT, 2010**




## 1.7 Directly Observed Therapy (DOT)

**1.7..1** DOT is a way of helping people during their treatment. Instead of a TB patient being sent home with medication, they might visit a local hospital or pharmacy, or a nurse might visit them at home.

**1.7..2** DOT is used effectively in over 180 countries. Although it is more resource intensive, it has been shown in some studies to improve treatment completion. A Cochrane Review[16] found that "Overall, cure and treatment completion in both self-treatment and DOT groups was low, and DOT did not substantially improve this." However, it did note that the evidence related to injection drug users was poor, therefore, given the more chaotic lifestyles of drug users, DOT can be used as an effective method for ensuring completion of treatment.

## 1.8 How is TB being tackled currently?

### 1.8..1 National Strategy

**1.8..1.1** Public Health England and Department of Health published the Collaborative TB Strategy for England, 2015 to 2020[17], in January 2015. The collaborative TB strategy brings together best practice in

[16] Directly observed therapy for treating tuberculosis. The Cochrane Library. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003343.pub4/full

[17] Collaborative Tuberculosis Strategy for England 2015 to 2020. Available from: https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England.

**1.8..1.2** The strategy outlines how it's intended that resources and services should be organised to tackle TB. It focuses on building on the assets already in the NHS and the public health system, to support and strengthen local services in tackling TB (particularly in areas of high incidence), to ensure clear lines of accountability and responsibility, and to provide national support for local action.

**1.8..1.3** TB has been identified as a priority by PHE and NHSE, and indicators of TB incidence and TB treatment outcomes are included in the Public Health Outcomes Framework[18]. PHE and NHS England believe that concerted action, supported by national expertise, can significantly reduce the suffering and harm caused by the disease, meet the WHO End Strategy milestone of reducing TB incidence by 50% by 2025[19] and contribute eventually to the elimination of TB as a public health problem.

**1.8..1.4** To achieve the strategy ambitions and make significant advances in TB control, improvements need to be made in the following key areas:

**I.** Improve access to services and ensure early diagnosis
**II.** Provide universal access to high quality diagnostics
**III.** Improve treatment and care services
**IV.** Ensure comprehensive contact tracing
**V.** Improve BCG vaccination uptake
**VI.** Reduce drug-resistant TB
**VII.** Tackle TB in under-served populations
**VIII.** Systematically implement new entrant latent TB screening
**IX.** Strengthen surveillance and monitoring
**X.** Ensure an appropriate workforce to deliver TB control

**1.8..2** In order to achieve these ambitions, the London TB Control Board, along with sub-regional networks, will have a focus on the strategy ambitions.

**1.8..3** Treating latent TB infection (LTBI) is effective and can be successfully implemented. The strategy comes with a resource of £10m (national allocation) to set-up an LTBI identification and treatment programme. This programme would be run through GP practices and focused on new registrations. The funding formula takes into account local CCG TB numbers and rates and although Barnet's overall rate is not one of the highest, there are areas in the south and west with high rates.

[18] Department of Health. Public Health Outcomes Framework [Internet]. London: Department of Health; 2013. Available from: https://www.gov.uk/government/publications/healthy-livieshealthy-people-improving-outcomes-and-supporting-transparency
[19] World Health Organization. The End TB Strategy [Internet]. World Health Organization; 2014. Available from: http://www.who.int/tb/post2015_TBstrategy.pdf

1.9 **What is currently being done in Barnet?**

**1.9..1 TB awareness campaign**

**1.9..1.1** A TB awareness campaign was commissioned by public health and ran in Barnet from November 2014 – March 2015. TB Alert worked with national and local voluntary partners to deliver a series of workshops to community and faith leaders, and to clinical partners.

**1.9..1.2** The aims of the campaign were:

- To raise awareness of the signs and symptoms of TB amongst those communities at high risk.
- To dispel myth about TB and ensure all members of the community are aware of their rights to accessing health services.
- To deliver training and support to relevant local authority staff, and to voluntary and faith groups working in Barnet so as to provide them with the skills to educate and support the communities with which they work.

**1.9..1.3** To ensure that the message was relevant to the target communities, the public health team worked with TB Alert to develop a workshop programme. In Barnet the public health team worked with CommUNITY Barnet as they have an extensive network of smaller voluntary groups. Faith groups were also invited to attend the workshops through liaising with the Barnet Multi-Faith Forum and the CCG to promote the Royal College of General Practitioners online module, *Tuberculosis in General Practice*, which has been developed in partnership with Public Health England and TB Alert. And finally, clinicians including specialist TB nurses attended some of the events and engaged with members of the community in the awareness workshops.

**1.9..1.4** Although extensive outreach was carried out in Barnet, engagement in the workshops was not as good as hoped. Feedback from CommUNITY Barnet was that many of those contacted did not feel that the workshops were relevant to them.

**1.9..1.5** This belief was the same in the community/voluntary sector as it was within the local authority staff groups; there was limited interest in the workshop organised specifically for London Borough of Barnet staff.

**1.9..1.6** In contrast, the campaign also ran in Harrow, which has a higher incidence of TB, and level of engagement was much higher

**1.9..1.7** Full details and results of the campaign are available in the evaluation report [see appendix]. However, the headlines are:

- 3 community events occurred in Barnet with 27 attendees. These included, but not limited to, schools and children's centres, homeless charities, BME community groups, and people working with those with substance misuse issues.

- Unfortunately, there was poor sign-up to Barnet Council staff, which resulted in the event not going ahead. However, any interested staff were invited to attend an event in Harrow.
- Twenty-three attendees completed the pre- and post-session questionnaire assessing the change in knowledge of TB. Eight questions were asked, with an overall score out of 10. In the analysis by TB alert, the average pre-session score was 5.26 (n=23) and the average post-session score was 7 (n=21). There was evidence of an increase in knowledge of types of TB, symptoms, risk factors and transmission methods. There appeared to be no change in the perception that TB is "confined to specific communities". This shows that although there was increased knowledge, there is still work to be done.
- For the same Barnet attendees, the majority reported that they had or would use this knowledge in their work with the client group. Whether the organisations do so and if it has an impact on the population will become more apparent after phase 2 of the project.

1.10 **Next Steps**

- Phase 2 of the TB Awareness Campaign is a community grant programme whereby smaller charities, faith groups and community organisations can apply for a grant of up to £500 to run their own TB Awareness Campaign amongst their volunteers, members and client groups. The aim of the grant is to encourage voluntary groups to apply their learning from the workshops and implement their own programmes.

- Barnet CCG are discussing the development of a latent TB screening service with NCL Primary Care Leads. There is currently a question regarding whether this should be provided on an individual CCG or NCL wide basis. Barnet CCG are waiting for NHSE to provide the number of potential patients by GP practice. Once received this information will inform future arrangements.

## 2. REASONS FOR RECOMMENDATIONS

These recommendations allow the Health Overview and Scrutiny Committee to note the work by Public Health and partners in responding to the national TB strategy and steps that have been taken locally with respect to management of TB.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

The Collaborative TB Strategy is part of a National programme and, therefore, opting out of the programme is not a viable option, hence it should not been considered.

## 4. POST DECISION IMPLEMENTATION

Following the consideration of the report, the Barnet Health Overview and Scrutiny Committee can consider if they wish to receive any further reports on this matter.

## 5. IMPLICATIONS OF DECISION

### 5.1 Corporate Priorities and Performance

The Barnet Corporate Plan 2015-2020 states that Public Health will be an integrated priority across all service areas. It states that "Public Health within the council ensures that increasing health and well-being and reducing health inequalities is a central theme to all activities across the council by 2020."

The Barnet Health and Wellbeing Strategy has four themes, one of which is Care When Needed. The recommendations of this report relate strongly to that theme. But it also relates strongly to overarching aim of "Keeping Well", which refers to a belief in 'prevention is better than cure.' Implementation of an LTBI programme would be a way of preventing a treatable disease from developing.

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

The amount of funding is unknown at this stage. However, there is a £10m fund to be used nationally and each borough will receive a large proportion of this due to the high incidence of TB in the capital. The funding will be allocated to CCG's.

### 5.3 Social Value

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. The next steps for the TB work in Barnet will benefit all members of the community, but particular those in disadvantaged groups, such as homeless people and those with substance misuse problems, and also people from particular ethic background, who may live in economically disadvantaged areas of the borough.

### 5.4 Legal and Constitutional References

The 2012 Health and Social Care Act imposes duties on Councils to deliver a number of public health functions including taking steps to protect the health of the population.

The Care Act 2014 also imposes duties on local authorities to promote individual well-being (section 1) and promote integration of care and support with health services (section 3)

The Council's Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health Overview and Scrutiny Committee. The Committee's responsibilities include the following:

- To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.
- To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

## 5.5 Risk Management

If the control of TB is not prioritised in Barnet, the rates will not fall or will start to increase leading to widespread community TB transmission and possible outbreaks of multi-resistant TB. This could cost hundreds of thousands of pounds to reverse. Studies have shown that for every pound invested in TB case finding, there is a return of £30 pounds in savings from averted illnesses and deaths.[20]

Barnet would also not meet the objective set by the London TB Control Board to reduce rates by 50% by 2018. This risk could be mitigated by following the recommendations set out in the final section of this report.

## 5.6 Equalities and Diversity

The National TB Strategy, which this reports' recommendations are based on, includes the following statement:

*Equality statement Promoting equality and addressing health inequalities are at the heart of NHS England's and PHE's values. Throughout the development of the policies and processes cited in this document, we have:*

- *given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.*
- *given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities*

For the purposes of the Public Sector Equalities Duty and by virtue of the Equality Act 2010, the relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

## 5.7 Consultation and Engagement

An extensive consultation took place when developing the national strategy.

A wide range of stakeholders were consulted during the three-month consultation from 24 March to 24 June 2014. Approximately one quarter of the 111 responses were from local authorities, a quarter from the NHS, a quarter from PHE (including collective responses of local stakeholders made up of PHE, NHS, clinical commissioning groups, local government, the third sector and others) and a quarter from other stakeholder groups including the National Institute for Health and Care Excellence, the British Thoracic Society, local government, the Association of Directors of Public Health and third sector organisations. Once received, all consultation responses were analysed through a rigorous three-phase process.

The complete consultation is available on request.

## 6. BACKGROUND PAPERS


6.1 Tuberculosis in London, 2013. Pg39, Table Bii. PHE Report available from: https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

6.2 WHO Tuberculosis country profiles www.who.int.tb.country/data/profiles/en/

6.3 London TB service specification 2013/14. November 2013.

6.4 PHE. Local Authority TB Profiles, Barnet. October 2013. p. 4. HTTPS://WWW.GOV.UK/GOVERNMENT/PUBLICATIONS/TUBERCULOSIS-TB-REGIONAL-REPORTS

6.5 Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.

6.6 Public Health England. Tuberculosis in the UK. 2014 report. [Internet]. London: Public Health England; 2014. Available from: https://www.gov.uk/government/publications/tuberculosis-tb-in-the-uk

6.7 TB Alert: http://www.tbalert.org/about-tb/global-tb-challenges/stigma-myths/?wb48617274=31A42E1E

6.8 Collaborative Tuberculosis Strategy for England 2015 to 2020. Available from: https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

6.9 Tuberculosis in the UK: Annual Report 2014. PHE: https://www.gov.uk/government/publications/tuberculosis-tb-in-the-uk

6.10 Available from: http://www.local.gov.uk/documents/10180/5854661/Tackling+Tuberculosis

+-+Local+government's+public+health+role/20581cca-5ef1-4273-b221-ea9406a78402

6.11 Abubakar I, Lipman M, Anderson C, Davies P, Zumla A. Tuberculosis in the UK--time to regain control. BMJ. 2011 Jul 31;343 (jul29 1):d4281–d4281.

6.12 National Institute for Health and Care Excellence. Clinical guidance and management of tuberculosis, and measures for its prevention and control. CG117 [Internet]. 2011 [cited 2014 Feb 24]. Available from: http://www.nice.org.uk/nicemedia/live/13422/53638/53638.pdf

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6.14 Department of Health - TB Action Plan Team. Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England [Internet]. London: Department of Health; 2007. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf

6.15 Frieden TR, Fujiwara PI, Washko RM, Hamburg MA. Tuberculosis in New York City—turning the tide. N Engl J Med. 1995 Jul 27;333(4):229–33.

6.16 Tuberculosis in London, 2013. PHE Report available from: https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

6.17 Directly observed therapy for treating tuberculosis. The Cochrane Library. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003343.pub4/full

6.18 Collaborative Tuberculosis Strategy for England 2015 to 2020. Available from: https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

6.19 Department of Health. Public Health Outcomes Framework [Internet]. London: Department of Health; 2013. Available from: https://www.gov.uk/government/publications/healthy-liveshealthy-people-improving-outcomes-and-supporting-transparency

6.20 World Health Organization. The End TB Strategy [Internet]. World Health Organization; 2014. Available from: http://www.who.int/tb/post2015_TBstrategy.pdf

6.21 COST OF Inaction: *A report on how inadequate investment in the Global Fund to Fight AIDS, Tuberculosis and Malaria will affect millions of lives.* http://icssupport.org/wp-content/uploads/2010/04/COST-OF-INACTION-Sep-12th-2013.pdf

# TB Awareness Evaluation Report

Nalini Iyanger
Public Health Registrar
Harrow and Barnet Shared Public Health Team
26 June 2015

## 1 Introduction

Barnet and Harrow Public Health team commissioned a series of TB awareness events over January to April 2015. The mandate for this project came from Barnet and Harrow Health and Wellbeing Boards (HWB)[1] where the following recommendations made by the public health team were agreed.

- *Barnet/Harrow Council should commission a proactive programme of awareness raising with population-specific communication campaigns to dispel the myths about TB in partnership with the NHS. The communication campaign should also include staff in regular contact with high-risk groups so they can seek medical advice when necessary. Relevant local authority services may also be able to provide links for staff and service users to appropriate NHS services for immunisation, diagnosis and treatment.*
- *There is a role for the Council to ensure services that support vulnerable groups (commissioned by the local authority or voluntary sector) are facilitated to link into the multidisciplinary TB team for support and educational materials.*

This paper presents an evaluation of the awareness project and makes recommendations for the future in the event that the project is repeated.

### Scope of the evaluation

Following the Health and Wellbeing Board (HWB) mandate, the awareness project was planned to be implemented in two phases. The first phase consisted of delivering awareness sessions to local community groups. The second phase, which is yet to be completed was to make small grants available to these organisations so they can work with their client groups to disseminate this information. This evaluation covers activities in the first phase of the project, that is, community and staff awareness sessions commissioned from TB Alert and targeted at local community organisations.

The evaluation does not cover the second phase of the project (small grants), which is currently being implemented. It also does not cover the ad-hoc GP targeted activities in the first phase of the project, such as promoting online TB education. The seminar held at Harrow Council on World TB Day (24th March 2015) is also not included in the evaluation.

## 2 Project Description

Following the mandate by the HWBs, TB Alert were commissioned to deliver awareness training and two local voluntary organisations (Voluntary Action Harrow and Community Barnet), umbrella organisations supporting the voluntary and community sector in their respective boroughs, were commissioned to co-ordinate the delivery of training sessions. Target audience for the awareness sessions was agreed to be the community organisations that "deliver services to communities who are regarded by Harrow and Barnet Public Health as being at higher risk of having, contracting or being in contact with individuals with TB"[2].

Another aspect of this project was to engage with GPs and encourage the uptake of RCGP online training on TB. GPs were also offered TB posters and other promotional material.

The second phase of this project aims to disseminate TB awareness in the general population of Harrow and Barnet through the work of the community organisations that attended the awareness sessions. These organisations can bid for further work they wish to do with their client group using small grants issued by public health. This phase of the project is yet to be completed.

[1] Harrow Health and Wellbeing Board on 1 May 2014 and Barnet Health and Wellbeing Board on 12 June 2014
[2] Proposal document by CommUNITY Barnet, Dec 2014

## 2.1 Model of delivery

The following model of delivery was planned (Fig 1).

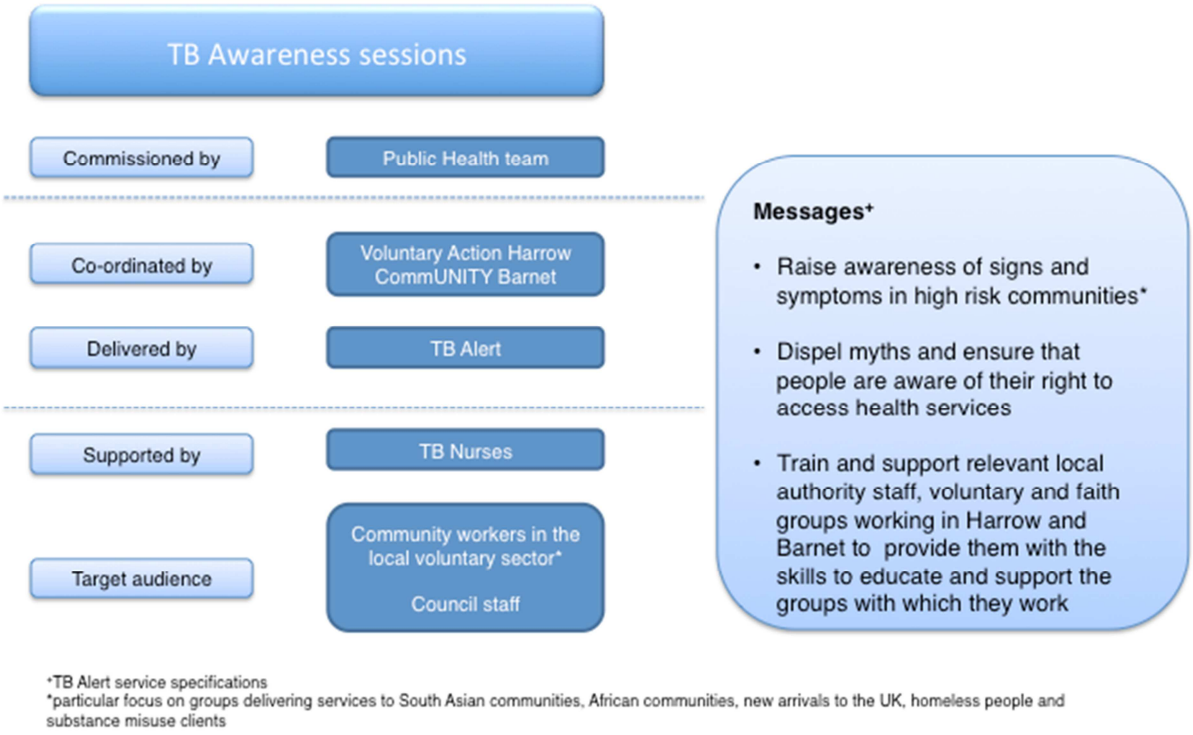


**Figure 1: Model of delivery for the awareness project**

## 2.2 Responsibilities

The organisations involved in the delivery of the awareness sessions had the following responsibilities as per their contracts, service specifications and proposals from providers.

**Table 1**

| Provider Organisation | Responsibility |
|---|---|
| **Public health team** | • Commissioning delivery and co-ordination of sessions and agree provider responsibilities<br>• Sourcing promotional material from TB Alert for information packs<br>• Organise staff awareness sessions for council staff<br>• Encouraging GP uptake of RCGP online training for TB<br>• Organising TB seminar on World TB Day |
| **TB Alert**[3] | • Deliver workshops to awareness sessions to community groups and council staff<br>• Facilitate a monthly teleconference for attendees where information can be shared and questions answered<br>• Provide all training and promotional material<br>• Provide a resource pack for attendees, including recommendations on how they can increase TB awareness in their organisations<br>• Promotional material to be disseminated to GPs<br>• Provide advice to commissioner regarding a grants scheme<br>• Provide end of project and evaluation report |

[3] Contract with TB Alert and service specification dated October 2014 and subsequent communication between PH Team and TB Alert

| Provider Organisation | Responsibility |
|---|---|
| **Voluntary Action Harrow[4]/ CommUNITY Barnet[5]** | • Identify groups to target<br>• Arrange venues<br>• Co-ordinate awareness sessions<br>• Publicise sessions to the target audience using mailing list, social media, direct contact and newsletter items<br>• End of project report<br>• Manage the distribution of the small grants funding |

## 2.3 Planned Activities[45]

### 2.3.1 Barnet

Four community sessions and one staff session were to be delivered in Barnet.

### 2.3.2 Harrow

At least three community sessions and one staff session were to be delivered in Harrow.

Community sessions were to be advertised by CommUNITY Barnet and Voluntary Action Harrow and to be delivered by TB Alert. Staff sessions in both Harrow and Barnet were to be advertised by Public Health team and delivered by TB Alert. Each session was intended to be a half-day workshop.

## 2.4 Costs[745]

Table 2

| Organisation | Costs committed |
|---|---|
| **TB Alert** | £3,500 |
| **Voluntary Action Harrow** | £5,000 |
| **CommUNITY Barnet** | £5,000 |

This does not include costs of promotional material.

£10,000 has been committed for phase 2 of this project (small grants) with £3,000 available to organisations in Barnet and £7,000 available to organisations in Harrow based on the interest in both areas to the community workshop and relative burden of disease.

# 3 Methods

## 3.1 Framework used

The evaluation follows the Donabedian Framework[6] of a review of structure, process and outcomes (fig 2).

[4] Memorandum of Understanding with Voluntary Action Harrow, dated 21 January 2015
[5] Memorandum of Understanding with CommUNITY Barnet, dated 23 January 2015
[6] Donabedian A. The criteria and standards of quality. Ann Arbor, Mich.: Health Administration Press; 1982.

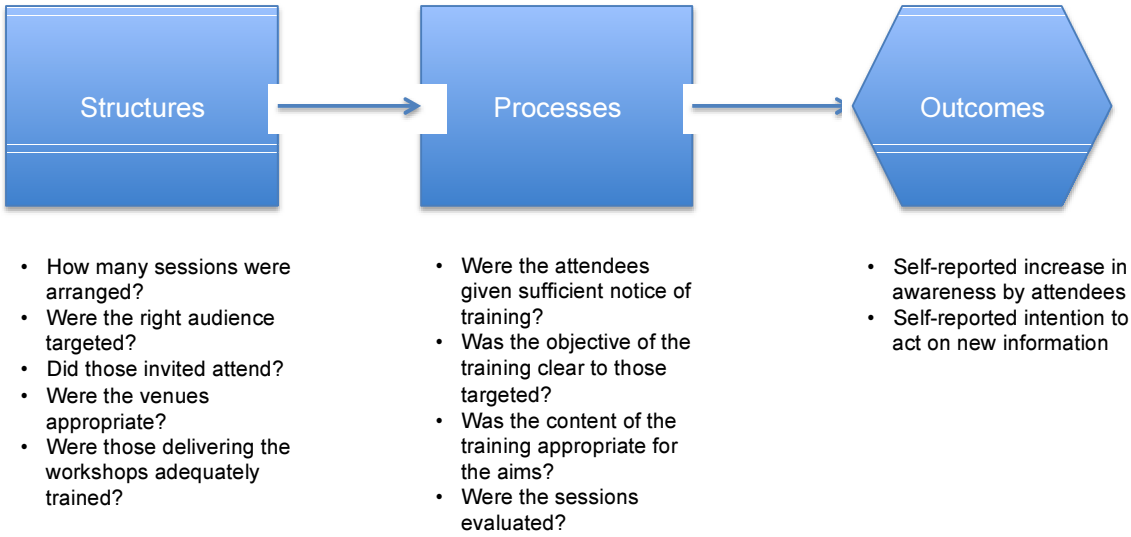


**Figure 2: Questions asked in the evaluation using the Structure, Process, Outcome framework**

The framework has been used to describe the components of the project and structure the questions asked in the evaluation. The overall question of the evaluation is whether the project achieved its aim of increasing awareness of TB in the community.

**Defining Outcomes**

The ultimate aim of any health awareness campaign is to increase appropriate use of health care for people with relevant symptoms with the aim of increasing diagnosis. However, the short timeframe of this project, combined with limited programme of activities, will not allow any quantifiable and attributable change to take place in the community. Therefore, outcomes to be assessed in this evaluation have been defined as the community groups'

- Self-reported increase in knowledge of TB
- Self-reported intention to act on new information

## 3.2 Engagement with people involved in the projects

The evaluation is based on discussions and surveys of individuals. Table 3 describes the groups of people who were involved in the project and how they were engaged in the evaluation. Responsibilities of the various groups engaged are noted in table 1 in section 2.2.

**Table 3**

| Group | Role in project | Engagement Activity |
|---|---|---|
| Project staff in Public Health team in Harrow and Barnet | Planned and commissioned the project | Discussion |
| Voluntary Action Harrow (VAH) | Co-ordinated the project in Harrow and organized sessions, venues and invited audience | Discussion |
| CommUNITY Barnet (CB) | Co-ordinated the project in Barnet and organized sessions, venues and invited audience | Discussion |
| TB Alert | Delivered awareness sessions and provided promotional material | Discussion |
| Community voluntary | Were invited to awareness sessions and TB | End of project survey |

| Group | Role in project | Engagement Activity |
|---|---|---|
| organisations in Barnet and Harrow | seminar | Post session evaluations |
| Council staff in Harrow and Barnet | Were invited to awareness sessions and TB seminar | End of project survey<br>Post session evaluations |

# 4 Results

## 4.1 Commissioning awareness sessions [7]

Following the mandate from HWB, the public health team commissioned TB Alert in August 2014, following a competitive process, to deliver a campaign over the next few months. TB Alert is an established national TB charity and were considered to experts in the subject by the commissioners, so the best candidates for delivery of the awareness sessions. Local voluntary sector umbrella organisations were commissioned to engage with community groups.

Experience from the elsewhere suggested that standard awareness campaigns focusing on mass media had low specificity in that they were not likely to reach those most at-risk and could result in an increase in inappropriate demand. Commissioners also felt it necessary to be cognisant of the impact of messages from local government ahead of the general election, particularly considering the groups of residents at highest risk of TB. For these reasons, a traditional awareness campaign was considered to be inappropriate and likely to be lacking in impact. The model, as described in section 2.1, was agreed so that information on TB could be disseminated through voluntary groups that work with groups at greatest risk of TB. These groups would be invited to attend awareness sessions and then encouraged to use this information in their day-to-day contact with the community, with access to small grants to facilitate this (fig 3).

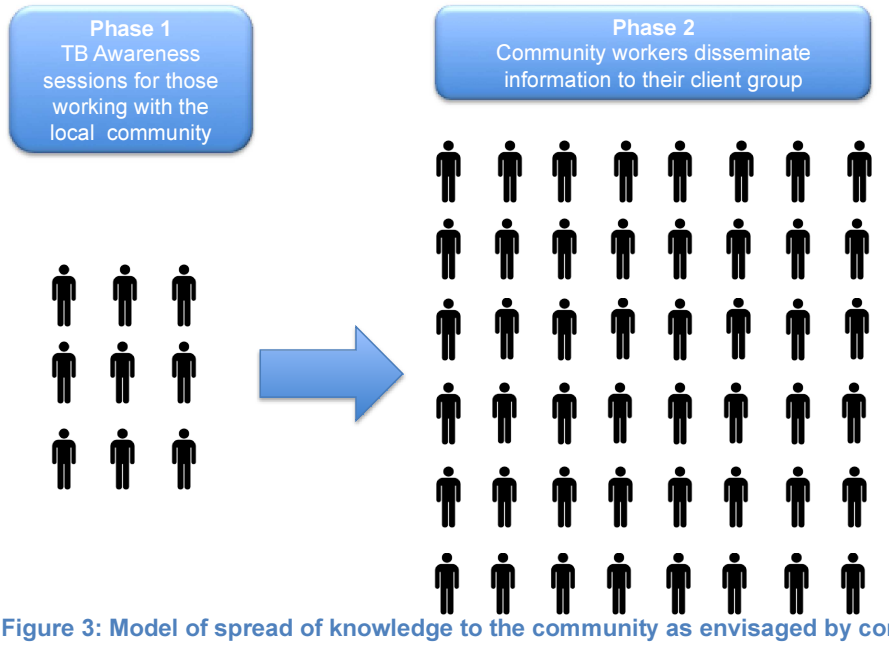


Figure 3: Model of spread of knowledge to the community as envisaged by commissioners

There were no further specific objectives set for this project other than the broad aims presented to the HWBs of raising awareness in the community and the delivery of a specified number of sessions to be delivered in each borough.

[7] Personal communication with commissioner and project manager in public health team

## 4.2 Delivering awareness sessions

### 4.2.1 Barnet[8]

Three community awareness sessions were delivered over February and March 2015, attended by twenty-seven people from a variety of community groups including organisations (table 4).

Table 4

| | Event | Attendance[9] | Types of organisations that attended[9] |
|---|---|---|---|
| **February** | Two community events | 27 for all three events<br><br>(attendance list for each event not available) | Organisations working with<br>• Black and Minority Ethnic community<br>• Refugees/asylum seekers<br>• People with specific health issues<br>• Substance misusers<br>• Homeless people<br>• Prisoners/ex-prisoners<br>• Students in further education<br>• School and children's centre<br>• People with Mental health issues<br>• Elderly<br>• Healthwatch Barnet<br>• Homes providers |
| **March** | One community event | | |

The sessions were advertised via existing email networks and social media (Twitter, Facebook and blog in local paper) and followed up by telephone calls. CommUNITY Barnet estimate that approximately 120 organisations were reached in this way. The following four groups were particularly targeted, as per discussion with the PH team: BME groups, faith groups, homelessness/substance misuse groups and Healthwatch.

A staff event was not organised due to lack of take up. PH team advertised the events vua the Barnet Council communications team. The Barnet Council communications team considered the event to be relevant to frontline staff only and circulated it to Adults and Community, Family Services and Housing staff[10]. There was no interest from these groups.

All there community sessions were evaluated by TB Alert. This included pre- and post-session questionnaires on the change in knowledge of TB before and after the session.

### 4.2.2 Harrow

The sessions were advertised over late December 2014 and January 2015 by emails to existing networks followed up by phone calls and advertisement at other events organized by Voluntary Action Harrow[11].

Forty-three members of the community attended the five community sessions between January and March 2015. Several people expressed an interest in attending but did not find the dates to be suitable. Attendees were from a variety of organisations. Table 5 gives details of attendance[12].

[8] Personal communication with CommUNITY Barnet
[9] TB Alert evaluation report.
[10] Communication from Barnet Comms dated 20 February 2015
[11] Personal Communication with Voluntary Action Harrow
[12] Attendance list provided by Voluntary Action Harrow.

Table 5

| | Event | Attendance | Types of organisations |
|---|---|---|---|
| **January 2015** | Two community events | Event 1 – 15 people<br>Event 2 – 5 people | • Children's Centre<br>• Older Person's charity<br>• Community resource centre<br>• Somali organization<br>• Pre-school/nursery<br>• Charity providing health and social care<br>• Substance misuse charity<br>• Women's Centre<br>• Young people's charity<br>• Harrow resident |
| **February 2015** | One community event | Community event- 5 people | • Asian Support group<br>• Substance misuse provider/charity<br>• Pre-school/primary school |
| **March 2015** | One community event | Event 1- 8 people<br>Event 2- 10 people | • Afghan charity<br>• Health charities/providers/health champions<br>• Children's services<br>• Deaf Club<br>• Harrow resident<br>• Learning disability charity<br>• Older persons charity<br>• Substance misuse charity/provider<br>• Homeless charity |

Four of the five community sessions were not evaluated. The last session was evaluated by VAH, including pre- and post-session change in knowledge of TB.

The staff event was attended by 13 members of council staff[9]. Housing and environmental health presence was particularly strong. The discussion at the event suggested that these staff had first-hand experience of coming into contact with people with TB and the stigma and barriers to access to council services that might result from a known TB status, such as contractors refusing to go into their homes to provide services.

Table 6

| | Event | Attendance | Council departments that attended |
|---|---|---|---|
| **February** | One staff event | | • Housing<br>• Environmental Health |

Staff sessions were evaluated by TB Alert.

### 4.2.3 TB Alert

TB Alert delivered all the half-day workshops and attended the World TB Day seminar. The contract and specification (dated 9th October 2014) specified 4 full day workshops for voluntary and community groups, (2 in Harrow and 2 in Barnet) and 2 half-day workshops for council staff (one per borough)[3]. This was later changed to eight half-day workshops. The requirement for monthly teleconference with attendees was removed. Eight community workshops were delivered as planned- five in Harrow and three in Barnet.

At the time that the contract was discussed, all the workshops were intended to be delivered by one facilitator. As this facilitator left his job with TB Alert over the time that the workshops were intended to be delivered, they were delivered by various people from TB Alert.

TB alert provided a pack for attendees containing

- DVD (not included in pack for Harrow attendees[11])
- Posters and leaflets on TB in English and other languages

## 4.3 Feedback from commissioners and providers

### 4.3.1 Commissioner feedback

Commissioners of the project considered the approach taken to commissioning the awareness sessions to be appropriate[7]. The decision to use local umbrella organisations to engage with the local community groups was thought to be successful as the invitations to attend sessions came from an organisation that was already well known to the target group and trusted and so had greater impact. Commissioners felt this approach had the added advantage of building links between public health and local voluntary organisations that can be used for other work.

The number of sessions and demand for sessions was considered to be broadly in line with expectations, except in Barnet where demand from community groups was lower than expected and so three sessions were organised instead of the planned four. There was no demand for staff sessions in Barnet. The commissioners hypothesised that this reflected the low prevalence of TB in Barnet (relative to Harrow and London) and therefore perceptions of severity of TB and likelihood of getting TB which feed into the perception of the threat[13] were such that there was a lack of demand.

There were specific aspects of the project that commissioners thought could have been improved

- Greater clarity in agreement with CommUNITY Barnet and Voluntary Action Harrow on what was to be delivered, particularly in relation to phase 2
- Delivery of awareness sessions by TB Alert was commissioned on the basis of the availability of an experienced facilitator who left TB Alert before the agreement could be delivered. The awareness sessions were delivered by other members of the TB Alert team. There was a feeling that the impact of the sessions was lower than expected.
- Provision of leaflets by TB Alert was not as efficient as could have been hoped as delivery of material took much longer than expected.
- It may have been better to commission one co-ordinating organisation across Harrow and Barnet rather than one for each borough.
- CCG GPs and staff and local councillors had limited involvement in the project (with notable exceptions in Harrow). Strengthening this aspect would have benefitted the project. Although, this was due to circumstances outside of the control of the public health team such as lack of nominated staff in CCGs.

The staff session at Harrow (organised by the public health team) was thought to have attracted the expected number of people with the attendees representing front line staff who were most likely to come across clients with or at risk of TB (housing and environmental health). Staff raised some practical queries on dealing with client groups with TB and dealing with outside contractors who were concerned about delivering services to residents known to have TB. The commissioners thought staff expressed some good ideas on how to disseminate this information to their client group e.g. environmental health giving information to people in multiple occupancy housing.

### 4.3.2 Feedback from providers[8][11][14]

The providers (VAH, CB) all considered the model employed by the Public Health team to be appropriate in terms of targeting relevant groups and felt they were able to use their goodwill and relationships to create demand for sessions. The providers are considered to be a trusted source by the voluntary and community sector. They were able to use their existing networks and personal relationships to publicise the sessions.

[13] Health belief model
[14] Personal communication with CEO of TB Alert

TB Alert also considered this to be a good model and a good way of keeping the umbrella groups involved and abreast of the work being done with their member organisations. Targeting of awareness activities, was thought to be better than a mass publicity, especially as the mass media approach can be expensive, unsustainable and result in unnecessary fears in the community.

TB Alert noted that there is limited history of the inclusion of the voluntary sector in TB work and much greater use of the voluntary sector in delivering TB services by Harrow and Barnet would be a good next step.

The demand for sessions in Barnet (both by community organisations or staff) was considered to be disappointing. There was no direct feedback from those who did not attend to suggest reasons for this. The providers considered it to be due to a lack of understanding of the burden of disease in Barnet or TB not being considered a serious or prevalent enough disease relative to other health concerns.

The training delivered by TB Alert was considered to be very good by one provider and not very engaging by another. This may relate to the use of different facilitators for different sessions. TB Alert wanted to use one facilitator for all sessions but this was not possible.

VAH and CB expected the sessions to be evaluated by TB Alert. However, TB Alert did not consistently evaluate all sessions. Only the three community sessions in Barnet and none of the sessions in Harrow were evaluated. The last community session in Harrow was evaluated by VAH themselves using the TB Alert forms. VAH also attempted to get ad-hoc feedback from the attendees of the four sessions that were not evaluated by TB Alert but had a poor response.

The contracts were agreed in mid-December 2014. At least one provider thought that the responsibility for the small grants was added to the contract at the last minute and without much prior discussion. Additionally, the payment for the contract was not made until after all the sessions were delivered, putting the financial risk on the provider.

The providers considered the timescales for the workshops to be too rushed and would have liked more time to plan for sessions. PH team put a great emphasis on delivering sessions by end of February because of the availability of the facilitator from TB Alert. This was thought to compromise the planning and publicity that providers were able to do once the contracts were agreed in mid-December 2014. The providers thought that better results could have been obtained by joint planning between CommUNITY Barnet, VAH and TB Alert but there was little opportunity for this.

Both providers felt strongly that the awareness sessions and small grants work should have been done in tandem, that is, the arrangements for small grants for community organisations should have been finalised before the awareness sessions were advertised so that those attending knew that there was an expectation of further work based on the awareness sessions and they could use the information from the sessions in a more productive way. This was also likely to have increased demand for the sessions. The small grants were mentioned at some sessions and, where mentioned, were only briefly and vaguely described.

Providers also thought that the PH team could have created demand for sessions by making press statements about the burden of disease. Although, they understood the sensitivities of making such statements.

## 4.4 Feedback from participants

### 4.4.1 Barnet

#### *4.4.1.1 TB Alert evaluations*

All three sessions for community organisations were evaluated by TB Alert. The evaluation questions are given in Appendix 1 (TB Alert evaluation report). The evaluation included scores on usefulness of sessions as well as an 8-point pre- and post-session questionnaire on knowledge of TB.

In all, 27 responses were received from the community session attendees. The training was well regarded with the training receiving high scores for most presentations (scale used: 2 = Good, 1 = Average, 0 = Poor) and positive comments. The group work, which was designed to get attendees to think about using this knowledge for their client groups, was considered to be the least useful.

Twenty-three attendees completed the pre- and post-session questionnaire assessing the change in knowledge of TB. Eight questions were asked, with an overall score out of 10. In the analysis by TB alert, the average pre-session score was 5.26 (n=23) and the average post-session score was 7 (n=21). There was evidence of an increase in knowledge of types of TB, symptoms, risk factors and transmission methods. There appeared to be no change in the perception that TB is "confined to specific communities".

It was not possible to calculate any further statistics using this data (confidence intervals, p value) as the way the data was collected did not make it possible to match the pre-session answers to the same subject's post session answers.

#### *4.4.1.2 Harrow PH Team evaluations*

A follow up survey was sent out to the attendees via Survey monkey in June 2015 by the PH team via CommUNITY Barnet, particularly to ask about use of the posters handed out during training and the attendees' intention to use the knowledge from awareness sessions. The response to this survey was very poor (4 responses out of possible 27). These results are not included in this document.

A telephone survey was conducted by to in the hope of getting a better response. The following questions were asked.

1. On a scale of one to 10, with 0 being no knowledge and 10 being complete knowledge
   How much did you know about TB before the training
   How much did you know about TB after the training

2. Do you plan on using or have you used this information with your client group?

CommUNITY Barnet conducted the survey. 13 out of 27 attendees responded.

Question 1 responses

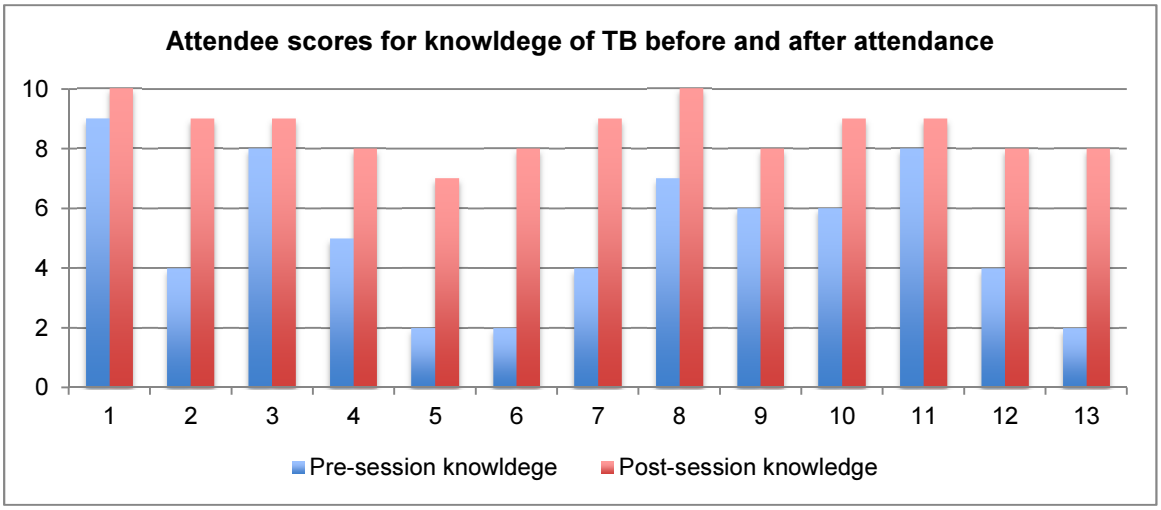


**Figure 4: Chart showing pre- and post session self reported knowledge by those who attended session in Barnet (n=13)**

All attendees reported an increase in knowledge after attending sessions (fig 7).

**Table 7**

| | |
|---|---|
| Pre-session knowledge of TB (mean score) | 5.15 |
| Post-session knowledge of TB (mean score) | 8.62 |

| | |
|---|---|
| Mean change in score | 3.46 |
| 95% confidence intervals for change in mean score | 2.34 – 4.58 |
| P value for change in mean score (95%) | <0.001 |

As the observations are paired, it is possible to test whether the mean change in scores is statistically significant i.e. there is an actual change in scores that is not just accounted for by chance.

Table 9 shows that the 95% confidence intervals for the change in scores are 2.34 – 4.58 i.e. at a 95% significance level, the change in mean score lies between 2.34 and 4.58. The p value for the change in mean score suggests that there is strong evidence that the mean change in scores is not just due to chance.

#### Question 2 responses

Of the 13 who responded, 3 have not used and are not planning on using the TB knowledge with their client groups. So, the majority of attendees, 77% have used or plan on using their knowledge with client groups.

### 4.4.2 Harrow

Evaluation for the community sessions is only available for one of the five sessions (7 of the 43 attendees). This report is attached as Appendix 2. All attendees rated the session as good (scale used: 2 = Good, 1 = Average, 0 = Poor) with positive comments. Although some comments suggested that the attendees had the expectation that dissemination in the community will be done by someone else.

Pre- and post session knowledge question questionnaires were completed by attendees at the last Harrow session, however, the format of the results does not allow the differentiation of pre-session results from post-session results. Therefore, it is not possible to calculate any statistics from the data.

The staff session was evaluated by 13 people. The results of this are included in the TB Alert evaluation report (Appendix 1). It is assumed that all those who attended completed an evaluation. Majority of the attendees at the staff event evaluated the presentation as being good or very good (scale used: Very good = 3, Good = 2, Average = 1, Poor = 0). Comments suggested that attendees felt their knowledge of TB symptoms, transmission and treatment increased after the sessions. The TB nurse's attendance at the event event was valued. A number of attendees wanted follow up sessions or similar sessions in the future.

Pre- and post-session knowledge was not evaluated.

## 5. Cost-effectiveness

At a cost of £13,500 for the project and 83 attendees in total (70 community attendees and 13 staff), the cost per attendee was approximately £163 (£121 per attendee in Harrow and £250 per attendee in Barnet).

## 6. Conclusions

### 6.1 What went well

#### Structure

The structure of the project, that there were two phases with clear expectations from each phase was an effective way of planning. Targeting community groups that work with groups of interest was generally agreed to be an effective way of reaching the target group, whilst avoiding the inappropriate demand that might result from a mass media campaigns. Involving Voluntary Action Harrow and Community Barnet was considered to be a good way of delivering the message via organisations trusted by the audience as well as building relationships that could be used in the future.

Decisions were made in advance of the groups to target and CommUNITY Barnet and Voluntary Action Harrow were able to prioritise these groups. These groups were relevant to the distribution of TB in the population. The attendees were largely from this group so the targeting was successful.

A nationally recognised charity was selected to deliver the training sessions, ensuring quality of content. TB nurses from Northwick Park attended two of the sessions and were able to provide clinical expertise and local context during these sessions.

### Process

Voluntary Action Harrow and CommUNITY Barnet were able to use existing networks to advertise the events. Sessions were advertised via multiple routes.

There was a consistent format for all sessions and consistent method of evaluation. Where evaluations were completed, the majority of the attendees evaluated the sessions as being good or very good.

### Outcome

Where evaluations were done, attendees thought they had more knowledge of TB than before the sessions. For the sessions held in Barnet, where there was the opportunity of further analysis, there was strong evidence that the change in knowledge (as measured by self –reported change in knowledge) was significant, that is, the sessions achieved their aim of imparting information about TB.

For the same Barnet cohort, the majority of the attendees reported that they had or would use this knowledge in their work with the client group. Whether the organisations do so and if it has an impact on the population will become more apparent after phase 2 of the project.

## 6.2 What could have gone better

### Structure

The providers felt the project to be rushed and that more demand could have been generated and so more organisations could have been reached with more time and greater joint planning. This included planning with the Public Health team on increasing demand, especially in Barnet, by using the media to increase knowledge of the burden of disease and, more importantly, by making the small grants funds available, or at least publicised, much earlier in the process to get organisations interested.
The providers would have liked an opportunity for more joint planning between the various parties involved. This is likely to have resulted in clearer understanding of roles and responsibilities at the beginning of the project.

It is not possible to tell whether the lower than expected demand in Barnet was due to public perception of the threat of TB in Barnet (this was frequently hypothesised) or a difference in the process of contacting and following up community organisations and council staff in the two boroughs. Although significant efforts appear to have been made to engage organisations via emails, telephone and online activities.

A lack of demand in Barnet meant that none of the front line council staff received any training on TB. The HWB mandate refers not only to council staff but also to staff or services commissioned by the council and so invitations should have been extended to all commissioned services, regardless of whether the council provided or otherwise.

The TB team at Barnet Hospital did not attend any of the sessions and it was not possible to speak with them to find out why this was.

The HWB mandate suggested that the sessions were commissioned in conjunction with the NHS but involving the CCG was not possible because there was no named TB lead at the CCG.

The contract between the PH Team and all providers could have been specified with greater clarity, especially, from the provider's point of view, regarding the delivery of phase 2. All contracts mentioned some form of end of project report (which have not been delivered yet) but none of the contracts were clear on the lead organisation responsible for evaluation.

### Process

Everyone felt that having one facilitator, particularly the facilitator originally employed to deliver sessions, would have resulted in better sessions and more engaged participants.

The sessions did not include any information on the local context of service provision of TB that is, whether there is a vaccination programme and who to contact if someone suspects that they have TB.

The objective of the sessions may not have been clear to all attendees, particularly that the organisations were expected to use this information with their client group. However, there was a discussion at each session on ideas for using the knowledge in their organisations. The small grants were not consistently mentioned or explained at all sessions.

The sessions were not consistently evaluated. CommUNITY Barnet, Voluntary Action Harrow and the Public Health team were clear that TB Alert were responsible for evaluations. The lack of evaluations only became apparent once all the sessions had concluded and there seemed to be no mechanism for providers to report to commissioners on such issues during the project, although the contracts specified regular reporting.

The venues for the sessions were not always appropriate and in at least one case was thought to be to small for the expected group.

### Outcome

The lack of evaluations for all sessions make it difficult to reach firm conclusions on the impact of the sessions. It is not possible to evaluate the impact on the population (and not just the individuals who attended) until phase 2 is completed.

Additionally, it is not clear that all the aims of the project, as recommended to the Health and Wellbeing Board were fully achieved. The awareness raising was intended to result in knowledge that might help local authority staff and other services refer people to the NHS. Given the lack of consistent discussion about local service provision at the sessions, it may not be possible for attendees to know where to direct people with relevant symptoms, other than generic advice to visit the GP.

## Appendices

Appendix 1:  TB Alert evaluation report

Appendix 2: VAH evaluation reports

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| | |
|---|---|
| | **Health and Wellbeing Board**<br><br>**30 July 2015** |
| **Title** | **Tuberculosis Report –<br>Update from TB Situational Report (2014)** |
| **Report of** | Director of Public Health |
| **Wards** | All |
| **Date added to Forward Plan** | September 2014 |
| **Status** | Public |
| **Enclosures** | Appendix 1: Local plan for new migrant LTBI testing and treatment services<br>Appendix 2: TB Awareness Evaluation Report (June 2015) |
| **Officer Contact Details** | Dr Laura Fabunmi, Consultant in Public Health (Medicine)<br>Laura.fabunmi@harrow.gov.uk<br>Garrett Turbett, Public Health Specialist<br>Garrett.Turbett@harrow.gov.uk |

## Summary


Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. Almost 40% of all cases nationally occur in London (41.2/100,000), which ranks as the city with the second highest TB rate in Europe, only behind Lisbon, Portugal (48.2/100,000). (Table 1.)

Rates of TB in Barnet dropped slightly in the three-year average data, from 30.0/100,000 (2010-12) to 25.8 / 100,000 (2011-13). Although this is lower than the London average of 35.5 / 100,000 (2013), there are still hot-spots within the borough with rates above this level. (Figure 3)

The 2014 situational report on TB to the Board recommended, "*Barnet Council should commission a proactive programme of awareness raising with population-specific communication campaigns to dispel the myths about TB in partnership with the NHS*."

From November 2015 to March 2016 the Public Health team worked with voluntary partners to deliver an awareness raising campaign, details of which are provided within this report.

In January 2015, Public Health England and Department of Health released the Collaborative TB Strategy for England, 2015-2020. This report to the Barnet Health and

| |
|---|
| Wellbeing Board considers the implications for Barnet and makes recommendations for the different organisations so they can work together and take a new approach to TB control. |

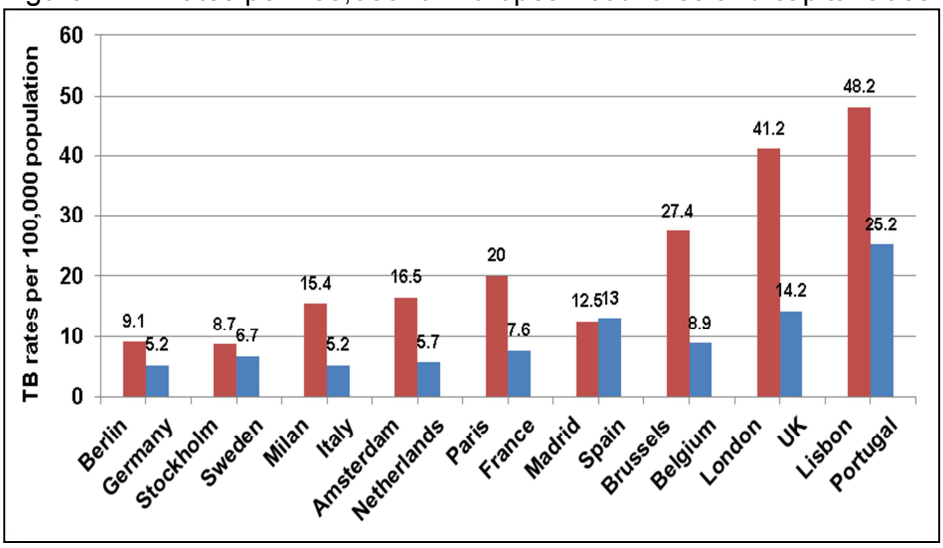
| Recommendations |
|---|
| 1. **The Health and Wellbeing Board is asked to consider the information provided following the 2014/15 TB awareness campaign and ask partners to support continued awareness raising programmes of work.** |
| 2. **The Health and Wellbeing Board is asked to consider the information provided in the National TB strategy in relation to the Latent TB Infection screening programme and provide on-going strategic direction for Barnet in relation to developing a local programme.** |

## 1. WHY THIS REPORT IS NEEDED

### 1.1 Background

1.1.1 Most cases of TB occur in major cities, particularly in London, where 38% of all UK cases are reported. TB is concentrated in a number of specific high-risk groups, including drug users, homeless communities in urban areas and those born abroad in countries with high rates of TB; rather than being a disease of the general population. In 2014, as in previous years, almost three quarters of TB cases (73%) occurred among people born outside the UK; only 15% of these were recent migrants (diagnosed within two years of entering the UK).[1]

Figure 1. TB rates per 100,000 for European countries and capital cities




1.1.2 The majority of TB cases in the UK arise due to reactivation of latent infection. Among immigrant groups, 83% of individuals with TB in 2013 were born outside the UK, TB rates decreased in the non-UK born London population[2]. The infection is likely to have been acquired abroad (figure 2.) whereas

[1] Tuberculosis in the UK: Annual report 2014. PHE.

[2] Tuberculosis (TB) in London. Annual Report 2013. PHE.

among the elderly UK-born population, the infection is likely to have been acquired in earlier years when TB was highly prevalent in the UK. The policy of targeting active TB cases for treatment will not be sufficient alone to control and eventually eliminate TB in the UK.

1.1.3 The identification and treatment of individuals with latent TB infection (LTBI) who are at high risk of developing active TB, is the core purpose of the funding attached to the national strategy, and is seen as an essential additional measure provided that:

- true LTBI can be identified (and distinguished from prior BCG vaccination):,
- the probability of developing active TB in people with untreated LTBI can be determined; and
- the intervention strategy available (treatment of latent infection) is effective and can be successfully implemented.

Figure 2. Country of Birth for non-UK born London cases

| Rank | Country of Birth | N= | % of non-UK born patients |
|---|---|---|---|
| **1** | India | 756 | 32% |
| **2** | Pakistan | 309 | 13% |
| **3** | Somalia | 193 | 8% |
| **4** | Bangladesh | 141 | 6% |
| **5** | Nigeria | 101 | 4% |

*Source: TB in London annual report 2013. PHE*

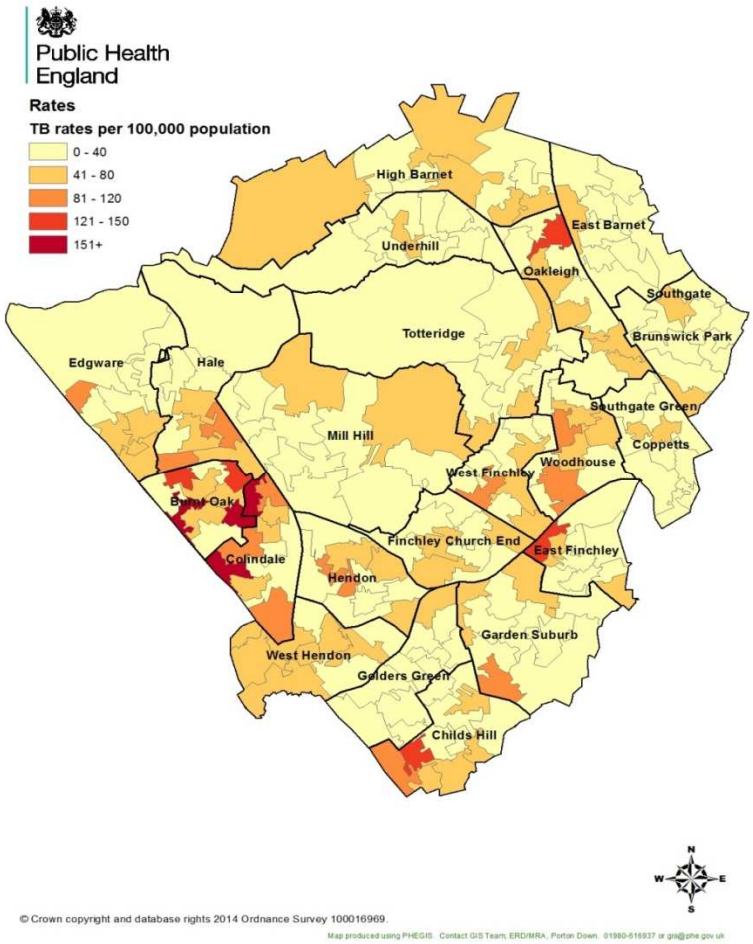
1.1.4 TB rates remain highest in northwest and northeast London.[3] North London has one of the highest rates of TB in the capital, and although Barnet does not rank as one of the boroughs with the highest rates, overall rates can mask smaller areas of very high incidence.

1.1.5 Rates of TB vary across the borough of Barnet - see Figure 3. According to data received from PHE, the top three areas in Barnet are: Colindale, Burnt Oak and Oakleigh. It is important to note that these rates are based on small numbers.[4] Therefore, it is expected that specific figures for these areas within the borough will fluctuate year on year and area-specific data should be interpreted with care.

1.1.6 However, there are similarities within these areas and other high incidence areas in terms of population demography and levels of socio-economic deprivation. These similarities increase our understanding of how TB services can be targeted for maximum impact.

Figure 3: London Borough of Barnet TB Incidence Rate by LSOA, 2012

[3] London TB service specification 2013/14. November 2013.
[4] Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.




1.1.7 A situation paper regarding TB was brought to the Health and Wellbeing Board in June 2014 which outlined the current burden of TB in Barnet and the responsibilities for the prevention and treatment. Recommendations identified from the report to report back on included:

- Barnet Council to commission a proactive programme of awareness raising with population-specific communication campaigns to dispel the myths about TB in partnership with the NHS
- CCG to provide assurance that services are adequately staffed to support adequate case finding of active and latent TB and provision of DOT
- Barnet CCG needs to prepare to commission universal neonatal BCG in 2015/16 as per the London TB Model of Care recommendations
- Barnet CCG to work with PHE/NHSE to consider how to implement latent TB case finding

1.2 **Latent Tuberculosis Infection (LTBI) Screening Programme**

1.2.1 Public Health England and Department of Health published the Collaborative TB Strategy for England, 2015 to 2020, in January 2015. This strategy has five ambitions:

- To achieve a year on year reduction in TB incidence in England
- To reduce health inequalities

- To contribute to eventual elimination of TB as a public health problem
- Brings together best practice in clinical care, social support and public health to strengthen TB control
- Stimulates action in all local areas, with a particular focus on areas where incidence is highest and the greatest reductions can be achieved

1.2.2 In order to achieve these ambitions, the London TB Control Board, along with sub-regional networks, will have a focus on the strategy ambitions. There will need to be borough-level networks to feed into these and to act as a voice for Barnet.

1.2.3 As mentioned above, treating latent TB infection (LTBI) is effective and can be successfully implemented. The strategy comes with a resource of £10m (national allocation) to set-up a LTBI identification and treatment programme. This programme would be run through GP practices and focused on new registrations. The funding formula takes into account local CCG TB numbers and rates.

1.2.4 To obtain this funding, each CCG will be required to submit a business plan, entitled "Local plan for new migrant LTBI testing and treatment services", a draft template for which is available in [see appendix 1].

1.2.5 CCGs will 'hold' the money on behalf of the TB networks and these will identify local priorities meeting national objectives, as set out in the national strategy and coordinated by the regional TB control boards. Funding for each area would be based on rates of TB. As such, Barnet would have to ensure that the borough hot-spots are highlighted to the London TB control board within their business plan.

1.2.6 A portion of this resource will be used to support regional or sub regional procurement of the IGRA test (Interferon-Gamma Release Assays (IGRAs) are whole-blood tests that can aid in diagnosing TB infection) to ensure best value, database support and primary care costs.

1.2.7 Support and oversight will be through the London TB Control Board and the National TB Programme team (funded by PHE).

1.3 **Local TB Awareness Campaign**

1.3.1 The TB awareness campaign, which ran in both Harrow and Barnet from November 2014 – March 2015, worked with national and local voluntary partners to deliver a series of workshops to community and faith leaders, and to clinical partners.

1.3.2 The aims of the campaign were:

- To raise awareness of the signs and symptoms of TB amongst those communities at high risk.
- To dispel myth about TB and ensure all members of the community are aware of their rights to accessing health services.

- To deliver training and support to relevant local authority staff, and to voluntary and faith groups working in Harrow and Barnet so as to provide them with the skills to educate and support the communities with which they work.
- To inform the work of TB Alert (national charity) within the Harrow & Barnet areas.

1.3.3 To ensure that the message was relevant to the communities we wanted to reach, we worked with TB Alert to develop a workshop programme. In Barnet we worked with CommUNITY Barnet as they have an extensive network of smaller voluntary groups. We also invited faith groups to attend the workshops through liaising with the Barnet Multi-Faith Forum. We worked with the CCG to promote the Royal College of General Practitioners online module, Tuberculosis in General Practice, which has been developed in partnership with Public Health England and TB Alert. And finally, we worked with clinicians and were pleased to have specialist TB nurses attend some of the events.

1.3.4 Although extensive outreach was carried out in Barnet, engagement in the workshops was not as good as hoped, nor was it as good as we experienced in Harrow with the same levels of outreach. Feedback from CommUNITY Barnet was that many of those contacted did not feel that the workshops were relevant to them.

1.3.5 This belief was the same in the community/voluntary sector as it was within the local authority staff groups; there was limited interest in the workshop organised specifically for London Borough of Barnet staff.

1.3.6 Full details and results of the campaign are available in the evaluation report [see appendix 2]. However, the headlines are:

- 3 community events occurred in Barnet with 27 attendees. These included, but not limited to, schools and children's centres, homeless charities, BME community groups, and people working with those with substance misuse issues.
- Unfortunately, there was poor sign-up to Barnet Council staff, which resulted in the event not going ahead. However, any interested staff were invited to attend an event in Harrow.
- Twenty-three attendees completed the pre- and post-session questionnaire assessing the change in knowledge of TB. Eight questions were asked, with an overall score out of 10. In the analysis by TB alert, the average pre-session score was 5.26 (n=23) and the average post-session score was 7 (n=21). There was evidence of an increase in knowledge of types of TB, symptoms, risk factors and transmission methods. There appeared to be no change in the perception that TB is "confined to specific communities". This shows that although there was increased knowledge, there is still work to be done.
- For the same Barnet attendees, the majority reported that they had or would use this knowledge in their work with the client group. Whether the organisations do so and if it has an impact on the population will become more apparent after phase 2 of the project, which is a community grants

programme to support community groups to develop their own TB awareness programmes of work.

1.4 **Barnet CCG**

1.4.1 Barnet CCG have committed to the following actions in relation to the previous situational paper and to ensure the development of the LTBI programme:

- Stock take on current capacity and what is currently in place and where the gaps might be.
- Preparation of the Business case to NHSE regarding access to Latent TB funding.

1.4.2 The agreed approach going forward will ensure that recommendations for the CCG contained in the report are fully responded to, which have been identified as follows:

- Barnet CCG needs to ensure that it is commissioning TB services locally against the London TB Service Specification. Particular areas that need to be addressed with the provider include:
  - Ensuring that the multidisciplinary TB teams have the right of the skill and resource mix necessary to manage those who are from hard-to-reach groups and also those who are not. Also, the teams are adequately equipped to provide ongoing TB awareness-raising activities for professional, community and voluntary (including advocacy) groups.
  - Rapid access TB clinics for hard-to-reach groups.
  - Assurance that services are adequately staffed to support adequate case finding of active and latent TB and provision of DOT.
  - Support providers to use the services of Find & Treat for TB patients who have become non-adherent and lost to follow up.
  - Continuing participation in cohort reviews.

1.4.3 Furthermore, discussions have taken place with NHSE regarding immunisation plan and acceptance of universal BCCG. A paper on Immunisation to Clinical Cabinet is scheduled for August where universal BCG will be included.

## 2. REASONS FOR RECOMMENDATIONS

2.1 The recommendations have been made to gain the strategic support of the Health and Wellbeing Board in developing a Latent TB Infective screening programme in London Borough of Barnet. This will require a local programme network to develop and establish. This recommendation is made in light of the National TB Strategy and associated funding available for the development of an LTBI screening programme.

2.2 These recommendations have also been made to gain the strategic support of the Health and Wellbeing Board to support continued awareness raising work around TB, which will be particularly important as part of the development of an LTBI screening programme.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The Collaborative TB Strategy is part of a National programme and, therefore, opting out of the programme is not a viable option, hence it should not been considered.

## 4. POST DECISION IMPLEMENTATION

4.1 A member of Barnet CCG is requested to appoint a lead for TB and to develop the local business case in partnership with colleagues in public health, primary and secondary care.

## 5. IMPLICATIONS OF DECISION

### 5.1 Corporate Priorities and Performance

5.1.1 The Barnet Corporate Plan 2015-2020 states that Public Health will be an integrated priority across all service areas. It states that "Public Health within the council ensures that increasing health and well-being and reducing health inequalities is a central theme to all activities across the council by 2020."

5.1.2 The Barnet Health and Wellbeing Strategy has four themes, one of which is Care When Needed. The recommendations of this report relate strongly to that theme. But it also relates strongly to overarching aim of "Keeping Well", which refers to a belief in 'prevention is better than cure.' Implementation of an LTBI programme would be a way of preventing a treatable disease from developing.

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

5.2.1 The resource available to Barnet is unknown at this stage. However, there is a £10m fund to be used nationally and each borough will receive a large proportion of this, with the funds held by the CCG's, due to the high incidence of TB in the capital.

### 5.3 Legal and Constitutional References

5.3.1 The 2012 Health and Social Care Act imposes duties on Councils to deliver a number of public health functions including taking steps to protect the health of the population.

5.3.2 The Care Act 2014 also imposes duties on local authorities to promote individual well-being (section 1) and promote integration of care and support with health services (section 3)

5.3.3 The Council's Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health and Wellbeing Board. The responsibilities include:

- 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 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 well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
- To directly address health inequalities through its strategies and have a specific responsibility for regeneration and development as they relate to health and care. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.
- Specific responsibilities for overseeing public health and developing further health and social care integration.

5.4 **Risk Management**

5.4.1 If the control of TB is not prioritised in Barnet, the rates will not fall or will start to increase leading to widespread community TB transmission and possible outbreaks of multi-resistant TB. This could cost hundreds of thousands of pounds to reverse. Studies have shown that for every pound invested in TB case finding, there is a return of £30 pounds in savings from averted illnesses and deaths.5

5.4.2 Barnet would also not meet the objective set by the London TB Control Board to reduce rates by 50% by 2018. This risk could be mitigated by following the recommendations set out in the final section of this report.

5.5 **Equalities and Diversity**

5.5.1 The National TB Strategy, which this reports' recommendations are based on, includes the following statement:

*Equality statement Promoting equality and addressing health inequalities are at the heart of NHS England's and PHE's values. Throughout the development of the policies and processes cited in this document, we have:*

- *given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.*
- *given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities*

5.5.2 For the purposes of the Public Sector Equalities Duty and by virtue of the Equality Act 2010, the relevant protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

[5] COST OF Inaction: *A report on how inadequate investment in the Global Fund to Fight AIDS, Tuberculosis and Malaria will affect millions of lives.* http://icssupport.org/wp-content/uploads/2010/04/COST-OF-INACTION-Sep-12th-2013.pdf

5.6 **Consultation and Engagement**

5.6.1 An extensive consultation took place when developing the national strategy.

5.6.2 A wide range of stakeholders were consulted during the three-month consultation from 24 March to 24 June 2014. Approximately one quarter of the 111 responses were from local authorities, a quarter from the NHS, a quarter from PHE (including collective responses of local stakeholders made up of PHE, NHS, clinical commissioning groups, local government, the third sector and others) and a quarter from other stakeholder groups including the National Institute for Health and Care Excellence, the British Thoracic Society, local government, the Association of Directors of Public Health and third sector organisations. Once received, all consultation responses were analysed through a rigorous three-phase process.

5.6.3 The complete consultation is available on request.

## 6. BACKGROUND PAPERS


6.1 Tuberculosis (TB): collaborative strategy for England, 2015. PHE. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403231/Collaborative_TB_Strategy_for_England_2015_2020_.pdf

6.2 Latent TB Testing and Treatment for Migrants 2015. PHE and NHS England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442192/030615_LTBI_testing_and_treatment_for_migrants_1.pdf

6.3 Situational Report on TB in Barnet, Health and Wellbeing Board 27 June 2014, item 11; https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7780&Ver=4

6.4 Tuberculosis in the UK: Annual report 2014. PHE. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/360335/TB_Annual_report__4_0_300914.pdf

6.5 Tuberculosis (TB) in London. Annual Report 2013. PHE. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385823/2014_10_30_TB_London_2013_data__1_.pdf

6.6 COST OF Inaction: *A report on how inadequate investment in the Global Fund to Fight AIDS, Tuberculosis and Malaria will affect millions of lives.* http://icssupport.org/wp-content/uploads/2010/04/COST-OF-INACTION-Sep-12th-2013.pdf

AGENDA ITEM 9

# Barnet Scrutiny Committee report 13th October 2015

| | |
|---|---|
| **Title** | **Barnet Sexual Health Strategy 2015-2020** |
| **Report of** | Dr Andrew Howe, Director of Public Health |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | No |
| **Enclosures** | Appendix A - Sexual Health Strategy 2015-2020 (Health and Wellbeing Board November 2014) |
| **Officer Contact Details** | Dr Wazirzada M.R. Khan, Senior Health Improvement Specialist<br>02083592530<br>Wazi.khan@harrow.gov.uk |

## Summary

This paper responds to the scrutiny committee's queries about plans to prevent sexually transmitted infections (STIs) among Barnet residents in general and for the older population in particular and provides a summary of the sexual health strategy approved by the Health and Wellbeing Board on November 2014.

The strategy aims to improve access to contraception and sexual health services in the community thus reducing reliance on costly hospital based provision and reducing onward transmission of STIs.

## Recommendations

1. **That the committee notes that whilst there has been a significant increase in rates of STIs amongst those aged 45 and over in recent years, the numbers remain small and rates of infection are far below those of younger age groups.**

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|---|
| **2. The committee notes the need for an integrated sexual health service (Genitourinary Medicine and Contraception and Sexual Health Services) comprising of primary, community and acute provision which ensures improved access to holistic and comprehensive services – both locally and across the North London region.** |
| **3. That the Committee notes that Public Health team are participating in collaborative commissioning of genitourinary medicine (GUM) services.** |

## 1. WHY THIS REPORT IS NEEDED

1.1 In May 2015, Barnet Scrutiny committee asked Public Health team for their plans to prevent STIs among Barnet residents in general and for the older population in particular in the light of the increased incidence of STIs reported in the 2015 Annual Director of Public Health report.

1.2 There has been a rise in rates of STIs amongst those over 45 years of age from 214.2/100,000 to 267.8/100,000 between 2010 and 2013 (Genitourinary Medicine Clinic Activity Data - GUMCAD). However, the actual numbers of STI diagnosis remain small compared to other age groups.

In 2013, the individuals under the age of 35 years had the highest prevalence of STIs in Barnet. During this period, males aged 25-34 years represented 21.8% of the male population but had **43.9%** of STI diagnosis. Similarly, females aged 20-24 years represented 7.5% of the female population but had **35.9%** of the STI diagnosis. In comparison, men over the age of 45 years represented 43.5% of the male population but had **11.6%** of the STI diagnosis; and women in the same age group represented 46.6% of the female population but had **4.8%** of the STI diagnosis.
With regard to the key STIs, e.g. for Gonorrhoea, Barnet has a diagnose rate of 60.2 per 1000,000 which is higher than the England average of 52.9 per 100,000. The highest rate of gonorrhoea infection is amongst the 20 -24 and 25 – 34 year olds. Similarly, for Chlamydia, 49% of all diagnosis is made amongst the under 25 year olds.
In 2013, 743 adult residents (aged 15 years and older) in Barnet received HIV-related care: 423 males and 320 females. Among these, 37.8% were white, 41.9% black African and 3.2% black Caribbean. With regards to exposure, 32.4% probably acquired their infection through sex between men and 59.0% through sex between men and women.

The Sexual Health Strategy recommended further research and stakeholder engagement. As a result, a Sexual Health Needs Assessment and Service Review was recently been undertaken to assess need, examine demand, map provision and assess gaps in sexual health services locally. Stakeholder engagement was an integral part of this review; service users, local residents from particular target groups, service providers including GPs and pharmacies were consulted during this project. Initial conclusions highlight the need for a coordinated and integrated service model (which include GUM and CASH) with improved access to local services within the community and primary care. The review has also highlighted the need for:

- Increased STI and HIV testing with a particular focus on early diagnosis
- Targeted outreach work with vulnerable and high risk communities
- Improved collaboration between service providers across all elements of the service pathway.
- The engagement of local community organisations in the dissemination of clear messages and promotional campaigns to vulnerable and high risk groups.

1.3 An easily accessible sexual health and reproductive service that is closer to home will encourage individuals to seek medical care promptly and this will in turn minimise the risk of onward transmission of infections and unintentional pregnancies.

1.4 The Public Health team has, and will continue to work, to raise awareness of STIs and local services. Recent activities include:

- Sexual Health Promotion
- Community based HIV screening/ testing for high risk individuals
- HIV media awareness
- HIV and local sexual health services information leaflets

A dedicated webpage on local sexual health services with contact information has been developed on the Council website to signpost individuals to key local services in the borough.
https://www.barnet.gov.uk/citizen-home/public-health/Sexual-Health-Services.html

The Needs Assessment and Sexual Health Review described above will inform future service development. There is an intention that the development of new service specifications will incorporate both health promotion and STI prevention as part of the contracts.

Around a third of the Public Health grant is currently spent on sexual health services. The largest element of spend relates to GUM services - approximately £3.1 million in 2014/15. Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) are statutory services. GUM services are provided on an open access basis which means that local residents are entitled to visit sexual health facilities, in any part of the country, without the need for a referral from GP or other health professional. This open access requirement service puts the Council under financial uncertainty as the level of activity is unpredictable. These open access services are demand led and have seen growth in the region of 8% in recent years. In 2014-15, Barnet residents attended 18231 appointments in a GUM clinic in England. However due to the nature of this service, only 24%

of these appointments were in Barnet with 36% in Camden, 15% in Islington and 12% in Westminster.

In recognition of the interdependencies across London borough boundaries, the pan London Sexual Health Transformation project was initiated in June 2014; boroughs agreed to jointly review the needs and provision of GUM services across the capital. The 22 councils involved in this project account for 83% of this spend and clinics operating in the areas covered by those 20 councils were responsible for delivering approximately 79.1% of all the GU activity for London in 2013/14.

1.5 To date, Barnet and Harrow Joint Public Health Service involvement in the collaborative project has led to better value for money, improved patient experience and sexual health outcomes for local residents in 34 GUM clinics across London.

1.6 The next phase of the collaborative project is for boroughs to procure a newly designed system which will address patient flow, local needs and demands, as well as improve outcomes and provide value for money. The new system will be procured in two parts:

1.6.1 **Sub regional project**

Considerable work has been done to map and understand how patients currently move around the system. As illustrated above, over 70% of Barnet GUM clinic attendance is outside of the borough; with the majority in Camden, Islington, Haringey and Enfield (respectively). These boroughs have agreed to work together as a sub-regional group to procure a new integrated sexual health system across borough boundaries. As Barnet residents also access services in Westminster, links will be made with the Central London procurement.

1.6.2 **Pan-London Online Procurement Project**

The Pan-London Online Procurement Project forms an integral component of the wider SH Transformation Programme. The primary aim of SH On-Line will be to ensure that high volume, low risk predominantly asymptomatic activity is controlled and managed where appropriate out of higher cost clinic environments.

The scope of the Pan-London Online Procurement Project incorporates the following elements:

- Triage and Information (“Front of house”);
- Self-Testing;
- Partner Notification; and

- Appointments (Booking system) (dependent on ability to interface with existing clinic systems).

Barnet and Harrow Joint Public Health Service plan to present a report to the November Health and Wellbeing Board, which will set out in more details the procurement timetable and the benefits that this project intends to achieve.

## 2. REASONS FOR RECOMMENDATIONS

2.1 GUM patient activity and associated costs have increased steadily in recent years beyond any changes in rates of STIs. This is financially unsustainable.

2.2 There is also a need to reduce reliance on hospital based services by improving access to community based services at lower cost. Improved access will in turn reduce onward transmission of infections and prevent unintentional pregnancies.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Continuation of the current GUM contract with no changes would be financially unsustainable in medium to long run due to a rise in patient activity. The proposed changes aim for improved outcomes and greater financial control.

## 4. POST DECISION IMPLEMENTATION

4.1 A service review is under way in support of the recommendation of the sexual health strategy as we move to implementation.

4.2 Barnet and Harrow joint public health service is working in collaboration with the West London Alliance (WLA) and Borough across London as part of collaborative GUM commissioning arrangements. A major new service tendering is expected in 2017.

## 5. IMPLICATIONS OF DECISION

### 5.1 Corporate Priorities and Performance

5.1.1 The Barnet Health and Wellbeing Strategy 2012–2015 Identifies sexual health in relation to commitments to:

- Easily accessible services for early diagnosis and prompt treatment of STIs (including HIV) to reduce the onward disease transmission.
- Better availability and choice of contraception to reduce unintentional pregnancies.

5.1.2 Barnet's Sexual Health Strategy (2015-2020),would also be a significant contributor to the delivery of the following key priority outcomes of the Barnet Council's Corporate Plan 2014-15:

- To maintain a well-designed, attractive and accessible place with sustainable infrastructure across the borough.

- To create better life chances for children and young people across the borough.
- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health.

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

5.2.1 Delivery of open access sexual health and reproductive services is a mandatory responsibility of the local authority's public health team.

5.2.2 Around a third of the public health grant is currently spent on sexual health services. The largest element of spend relates to GUM services - approximately £3.1m in 2014/15. A London wide collaborative commissioning of GUM service along with provision of basic sexual health and contraceptive services in primary care and community settings are expected to deliver savings to compensate growth and the expansion in other sexual health services (including preventative services).

5.3 **Social Value**

5.3.1 For consideration once the future service model has been clearly established.

5.4 **Legal and Constitutional References**

5.4.1 The Terms of Reference of the Health Overview and Scrutiny Committee are set out in the Council's Constitution (Responsibility for Functions; Annex A) and has following responsibilities:

-To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

-To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

-To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, Health Watch and/or other health bodies.

-To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships in the public, private and voluntary sectors.

5.3.2 The local authority's responsibilities for commissioning sexual health services are detailed in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Regulation 6 requires local authorities to arrange for the provision of:-

Open access sexual health services for everyone present in their area;

- Covering free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and
- Free contraception and reasonable access to all methods of contraception.

5.3.3 The Local Authority, in respect of its health service functions, must have regard to the NHS Constitution in accordance with s2 Health Act 2009.

## 5.5 Risk Management

5.5.1 There is a need for boroughs to work together in order to address the financial risk associated with the escalating cost of mandatory open access, GUM services. The rise in cost of these services is directly linked with an increase in patient level activity. We have taken this risk into consideration and have added budgetary growth plus containment through collaborative commissioning of GUM services at a multi-borough level. We are also proposing the expansion of sexual health and reproductive services in primary care and community settings at a lower unit cost price than hospital based services.

## 5.6 Equalities and Diversity

5.6.1 Poor sexual health is much more common amongst people who already experience inequality associated with ethnicity, sexuality or economic status.

5.6.2 The Council needs to comply with the Equality Act 2010 in the provision of public health services in the area.

5.6.3 The public sector equality duty is set out in s149 of the Act:
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

5.6.4 The protected characteristics are
Age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

5.6.5 An initial equalities impact assessment on the sexual health strategy had been carried out on the key recommendations. There was no indication of adverse effects to local population and the recommendations were anticipated to bring more uniformity and improved access to the services for the whole community. There are plans to incorporate further EqIA at the implementation stages to ensure the equality and diversity of the proposals is maintained throughout the process.

## 5.7 Consultation and Engagement

5.7.1 The team carrying out the review of local sexual health and contraceptive services is currently consulting the key stakeholders and priority groups in the Borough. The consultation and engagement will be incorporate questionnaire and focus groups.

## 6. BACKGROUND PAPERS

6.1 Sexual Health Strategy 2015-2020 (Health and Wellbeing Board November 2014) page 151-160 https://barnet.moderngov.co.uk/documents/g7783/Agenda%20frontsheet%2013th-Nov-2014%2010.00%20Health%20Well-Being%20Board.pdf?T=0

6.2 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013; www.legislation.gov.uk/uksi/2013/351/contents/made

# London Borough of Barnet

## Sexual Health Strategy 2015 – 2020

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Additional contributions: This strategy is an outcome of continued collaboration between the joint Barnet and Harrow Public Health and commission teams with an invaluable support and contribution of the following colleagues.

Dr Jeffery Lake – Public Health Consultant
Oasis Azeez-Harris – Public Health Commissioning Officer
Audrey Salmon – Head of Public Health Commissioning
Annie Roy – Interim Public Health Commissioner – Sexual Health Services
Dr Sarah Crouch – Public Health Consultant
Brian Jones – Business Manger
Dr Andrew Howe – Director of Public Health

We would also like to thank Barnet Health Watch team for their feedback to this document.

Date produced: 27 October 2014

## Executive Summary

Sexual health is an essential element of the physical and emotional health and well-being of individuals, couples and families. It is influenced by a range of social, economic and cultural factors. Provision of free, easily accessible and confidential sexual and reproductive health services is vital for the well-being of individuals and their communities.

Sexually Transmitted Infections (STIs) can cause long term and life threatening complications. These complications and rates of onward transmission increase when diagnosis and/or treatment are delayed with significant implications for the individual, community and the public sector finances, particularly NHS. Unintended pregnancies, whether they result in terminations or not, also have significant implications for the individual, community and public sector finances. Teenage pregnancies for example can lead to intergenerational patterns of dependency and diminished life chances.

Since April 2013, the commissioning responsibilities for most sexual health interventions and services is transferred to local governments and the provision of "open access" sexual health services is one of the mandatory tasks for the Councils' Public Health teams. In light of this new responsibility, the joint Barnet and Harrow Public Health team have developed a five years sexual health strategy that explores the local epidemiology, key priority groups and existing services. The report also sets out our future strategic direction to provide robust, easily accessible, modern, coherent, cost effective and integrated services to our residents at primary care, secondary care and community level.

The open access nature of sexual health services means that individuals are entitled to attend the service of their choice, in any part of the Country, without the need for a referral from GP or other health professional. However, the payment responsibility remains with the Public Health team from the area of residence. The costs for the provision of these services is increasing and currently around a third of the local Public Health grant is spent on sexual health services with the majority spent on contracted and non-contracted Genitourinary Medicine (GUM) activity. The present service model is not financially sustainable. Whilst epidemiological data showed a reduction in rates of STIs in Barnet between 2012/13, the GUM patient activity rose by 8% during this period.

In order to provide a robust and cost effective service, the strategy recommends participation in collaborative commissioning of GUM services at a multi-Borough level with an expansion of provision in primary care and community.

The provision of sexual health screening and family planning services are not homogeneously distributed in primary care and community settings e.g. pharmacies (especially in deprived areas of the Borough). The strategy recommends expansion of services in these settings in order to provide an easily accessible and closer to home venues to our population. The proposal would lead to early diagnosis, quick referral and a reduction in onward transmission of STIs. The provision of these services would entail lower unit cost price compared with the hospital based services

providing efficacy savings and a reduction in over-reliance on hospital based services e.g. for chlamydia testing.

There is a low uptake of chlamydia screening among young people aged 15-24 years and a higher rates of newly diagnosed HIV infections among individuals from black or black ethnic background, heterosexual females and men who have sex with men (MSM). There is a lack of community based programmes for young people with poor awareness and signposting of locally available services. The strategy takes these areas into consideration and makes relevant recommendations for improving these services.

# 1 Introduction

This report provides an insight into the epidemiology of sexual health along with the current services available in the London Borough of Barnet. It aims to provide a strategic direction for the commissioning and delivery of future sexual health services based on local demographic needs.

## 1.1 - Context and background

According to the World Health Organisation (WHO) [1], sexual health is:

"A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction and infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled". (WHO, 2006a)

Sexual health is an important area of Public Health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. There is a strong link between deprivation and rates of sexually transmitted infections (STIs), teenage conceptions and abortions. The highest burden of sexual ill health is borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups[2, 3]. The consequences of sexual ill health have wider consequences for both the individual and society. If left untreated, many STIs can lead to long-term health implications for the individual such as infertility, ectopic pregnancy, miscarriage, cervical and other genital cancers, hepatitis and liver disease while social exclusion, unemployment, discrimination and stigma have a negative impact on the society as a whole.

Evidence indicates that sexual health outcomes can be improved by;

- the provision of accurate, high-quality, targeted and timely information to help individuals in making informed decisions about relationships, sex and sexual health
- the availability of and easy access to confidential, open-access sexual health services in a variety of settings with suitable opening times
- timely and accurate diagnosis with effective treatment of all STIs along with the partner notification to prevent the spread of onward transmission
- preventative interventions and collaborative work between all stakeholders in primary care, secondary care, community and voluntary sector.

The Public Health white paper "*Healthy Lives, Healthy People* (2011)"[4] identifies sexual health as a key Public Health priority and proposes a comprehensive

commissioning of sexual health services by local authorities. The proposal was followed by the publication of a Framework for Sexual Health Improvement in England[5] (2013) which aims to:

- Reduce inequalities and improve sexual health outcomes
- Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex; and
- Recognise that sexual ill health can affect all parts of society.

The importance of improving sexual health is also acknowledged by the inclusion of three indicators (2.4, 3.2 & 3.4) in the Public Health Outcomes Framework (PHOF) [6] (2013). These indicators have been prioritised as each represents an important area of Public Health that requires sustained and focused effort in order to improve outcomes. The indicators are:

- under-18 conceptions
- chlamydia diagnoses (15–24-year-olds)
- people presenting with HIV at a late stage of infection

1.2 **- New commissioning arrangements**

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) including HIV and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practices, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector[5].

Since April 2013, local authorities are responsible for commissioning the majority of sexual health services and interventions, but some elements of care are commissioned by the NHS England and Clinical Commissioning Groups (CCGs) – please see appendix 1A. Local authorities, through their Public Health teams, are required to provide open access sexual health services for their residents with the following new commissioning responsibilities[5,7,8].

Comprehensive sexual health services, which includes:

- Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local Public Health contracts (such as arrangements formerly covered by LESs and NESs)
- Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local Public Health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
- Sexual health aspects of psychosexual counselling

- Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies

Social Care services (for which funding sits outside the Public Health ring-fenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:

- HIV Social Care
- Wider support for teenage parents

### 1.3 - Purpose of the document

In light of the above, the following report provides a snapshot of the local epidemiology with current commissioning arrangements and future strategic direction for a robust sexual health and reproductive services in Barnet. It aims to demonstrate our commitment to improving the sexual health of our population and the best use of finite resources.

### 1.4 - Strategy vision and objectives

Our vision is to improve the sexual health and wellbeing of Barnet residents and service users by delivering an accessible, modern, coherent, integrated and related set of services at primary care, secondary care and community level.

Our objectives are to:

1. Prevent and reduce the transmission of sexually transmitted infections (STIs).
2. Reduce the prevalence of undiagnosed HIV infection and improve early diagnosis particularly among target groups.
3. Expand the provision of sexual health and reproductive services in primary care and community settings.
4. Increase the uptake of contraception throughout the Borough by providing more choice in different healthcare settings.
5. Reduce the rates of unintended pregnancies particularly repeat pregnancies.
6. Improve the provision of services designed for young people's sexual health needs and to promote sex and relationship education.
7. Promote the welfare of children and reduce the risks of child sexual exploitation (CSE) in Barnet.
8. Reduce the stigma associated with HIV and STIs.
9. Expand sexual health promotion and reduce sexual health inequalities among vulnerable groups.

### 1.5 - Values and Principles

*Equity and accessibility:* We believe that Barnet residents should have equal access to services, which are appropriate to their needs and which take account of age, gender, disability, sexuality, race and religious and cultural beliefs

*Reduction of sexual health inequalities:* We will target health promotion and prevention initiatives at those groups most at risk and at those areas of the Borough which are most deprived. We will ensure that timely treatment and advice for sexual health is accessible to all Barnet residents, particularly vulnerable groups.

*Areas for integration with other services:* During the period of this strategy, we will ensure that appropriate integration is established and maintained with other services such as; children and young people services, adult Social Care, drugs and alcohol services, safeguarding and vulnerable adults, offender health and mental health. We will work in collaboration with local partners such as; Barnet Safeguarding Children Board (BSCB), the Multi-agency Safeguarding Hub (MASH), the Multi Agency Sexual Exploitation Panel (MASE), Early Intervention and Community Safety teams, and Children and Adult Mental Health services (CAMHS) to identify and protect children and families impacted by violence, child sexual exploitation, child trafficking, missing from care and gangs.

*Evidence based practice:* We will ensure that we use research evidence of what is effective when developing services

*Effective multi-agency working*: We will work in collaboration with our sexual health service providers, Public Health England, NHS England and Pan London networks to ensure shared understanding and vision for both the commissioning and the delivery of services.

## 2 - Sexually transmitted infections (STIs) & Genitourinary Medicine (GUM) services

Sexually transmitted infections (STIs) are illnesses that have a significant probability of transmission between humans by means of sexual behaviour. Genitourinary Medicine (GUM) services offer confidential specialist advice, screening, treatment and partner notification for sexually transmitted infections (STIs). GUM clinics operate by self-referral and referral from other services. All GUM services are open access, that is, services are provided to anyone, irrespective of their place of residence.

### 2.1 - Epidemiology of STIs nationally [9,10] *(appendix 2)*

- In 2013, a total of 446,253 sexually transmitted infections (STIs) were diagnosed in England at a rate of 832.4 per 100,000 population. Compared to 2012 data, there was a slight drop (-0.6%) in the number (448,775) of STIs in England.
- Similarly, the number of STIs in London also dropped slightly from 112,275 in 2012 to 110,706 in 2013 (-1.4%).
- Nationally, chlamydia was the most common STI, making up 47% of all diagnoses (208,755) in 2013, while gonorrhoea diagnoses saw a large rise, up 15% from 2012 to 2013 (29,291).
- The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM).

## 2.2 - Epidemiology of STIs in Barnet [10, 11] *(appendixes 2,3&4)*

- In 2013, a total of 2,680 acute STIs were diagnosed in Barnet residents at a rate of 736.4 per 100,000 population. Similar to national and regional figures, the actual number of acute STIs in Barnet dropped by 8.1% between 2012 and 2013 (2,919 cases at a rate of 802 per 100,000 population in 2012).
- Based on the proportion of acute STIs by ethnicity in Barnet, the highest proportion of acute STIs in 2012 were seen among individuals from white ethnic background (57.3%), followed by black and black British (17.5%) and Asian or Asian British (8.3%) ethnic groups.
- However, in terms of rate per 100,000 population of acute STIs among ethnic groups in Barnet in 2012, the highest rates were seen among individuals from black ethnic background (1648) while the rates in white and Asian ethnic groups were (647) and (325). This indicates that based on population size, the individuals from black ethnic background are disproportionately affected by acute STIs in Barnet. In comparison, the rates of acute STIs by ethnic groups in England in the same order of ethnic groups were 1833, 532 and 288 respectively.
- Where recorded, 38.8% of acute STIs diagnosed in 2012 in Barnet were in people born overseas.
- Between 2009 to 2012, 18.9% (n=878) of the acute STIs were seen among MSM in Barnet (based on the cases in men where sexual orientation was recorded).
- Reinfection with an STI is a marker of persistent risky behaviour, improper use of prescribed drugs or lack of partner notification for screening and treatment. In Barnet, an estimated 9.9% of women and 12.3% of men presenting with an acute STI at a GUM clinic during the four-year period from 2009 to 2012 became reinfected with an acute STI within twelve months. It is close to national figure of 9.6% of women and 12% of men.
- There is considerable geographic variation in the distribution of STIs in Barnet. In 2012, the highest rates of STIs were seen in 1st and 2nd most deprived areas of Barnet indicating a positive correlation between STIs and socio-economic deprivation (please see appendix 3 for further details).

## 2.3 – STIs among young people in Barnet *(chlamydia is discussed in more detail as a specific STI among young people in section 3)*

- Young people between 15 and 24 years old experience the highest rates of acute STIs. In Barnet, 42% of diagnoses of acute STIs in 2012 were in young people aged 15-24 years. The rates were higher among young females compared to young males. In comparison, 41% of acute STI diagnoses in London residents were in those aged 15-24 (please see appendix 3 for rates and age profile).
- Young people are also more likely to become reinfected with STIs contributing to infection persistence and health service workload. In Barnet, an estimated 9.5% of 15-19 year old women and 8.8% of 15-19 year old men presenting with an acute STI at a GUM clinic during the four-year period from 2009 to 2012 became reinfected with an STI within twelve months.

- In 2012, 16% of 15-24 year old in Barnet were tested for chlamydia with an 8% positivity rate. In comparison, nationally, 26% of 15-24 year olds were tested for chlamydia with an 8% positivity rate.

**2.4 - National recommendations and evidence** *(disease specific recommendations on chlamydia and HIV are mentioned in relevant sections of the document)*

Achieving good sexual health for individuals has been set out as one of the ambitions in government's recent framework for improving sexual health in England[5] and reducing the burden of STIs among individuals of all ages requires a sustained Public Health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

NICE Public Health intervention guidance-3 (2007)[12] focuses on one to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups.

BHIVA (2008)[13] advises that individuals who test negative for HIV but who are at risk of other sexually transmitted infections (particularly MSM) should be encouraged to attend local GUM services for testing for other infections.

BASHH (2014)[14] advises that the service providers should offer appointments to 98% of the patients within 48 hours of their contact with the GUM services in order to avoid any delay and stress related to STIs.

The Gonorrhoea Resistance Action Plan for England and Wales (2013)[15] recommends that health professionals should ensure prompt diagnosis and adherence to prescribing guidelines along with the identification and management of potential treatment failures to reduce further transmission.

**2.5 - Current GUM services for adults and young people in Barnet**

Barnet and Harrow joint Public Health service commissions majority of the GUM patient activity from the Royal Free London NHS Foundation Trust (RFL), however, due to the national open access requirement placed on all local authorities, the team are also responsible for the non-contracted GUM activity for its residents from other part of the Country.
RFL provides GUM services at the following sites;

- Clare Simpson Clinic – RFL Barnet site
- Clare Simpson Clinic – Edgware Community Hospital
- MarlBorough Clinic – RFL Hampstead site

In 2012, the majority of Barnet residents (36%) attended a GUM clinic at Barnet hospital followed by The Royal Free hospital (20%) and Archway sexual health clinic (11.8%). The remaining patients attended a range of clinics nationally as part of the GUM/sexual health open access agreement[9] (please see appendix 4).

The GUM services at Clare Simpson Clinic offer clinics from Monday to Saturday including a men's only clinic on Monday and a young person clinic on Wednesday of the week. The MarlBorough Clinic offers clinics on Monday to Friday including a young person's clinic on Monday. The clinics offer full sexual health screening for STIs including HIV and offer treatment for STIs.

Currently, eight GP surgeries in Barnet offer full STI screening as part of a primary care contract with LBB.

**2.6 – Sexual health services specific for young people**

In addition to the above mainstream services, the London Borough of Barnet (LBB) provides a primary school based Sex and Relationship Education (SRE) consultancy service as part of the Barnet Primary Schools Well-being Programme. The SRE service is offered to all local primary schools on an 'opt in' basis. The overall aim of this service is to build capacity in primary schools so that they are able to implement well-being programmes.

**2.7 - Case for change**

Although based on the latest figures above, the numbers of STIs among Barnet residents have dropped by 8.1% between 2012 and 2013, yet, the actual GUM patient activity has gone up by 8% during this time. Barnet and Harrow joint Public Health service currently spends the largest proportion (31% approx.) of their budget on sexual health service provision. The PH grant is only ring-fenced until the end of 2015-16. Local authorities need to achieve significant cost reductions across their service remit. Hence, the provision of an integrated, open access, robust and cost effective sexual health service is a vital commissioning priority for the Public Health team.

Just below half (42%) of all acute STIs in 2012 were among young individuals, however, London Borough of Barnet (LBB) does not have specific programmes for young people. At present, there is no Clinic In a Box (CIB) programme in Barnet and the provision of current SRE programme is only limited to primary schools level. Based on the local need and the gap in the service, it is essential to have programmes that address the needs of the young people.

There is evidence of some targeted sexual health screening in family planning services. In light of local epidemiology, and especially with highest rates of STIs among young females, family planning can provide a valuable support in screening, treatment and reduction of STIs.

At present, there is no pharmacy based contract to screen for STIs in Barnet. Pharmacies are easily accessible and provide a good platform for screenings of some STIs in the community along with signposting individuals to relevant local services.

There is good engagement between the LBB and primary care services in Barnet, which can be further improved with the addition of more primary care providers.

Finally, there is a need to participate in community based schemes such as “C-Card” and “Freedom” schemes. Both these schemes provide free condoms to eligible young or at risk population respectively in order to prevent STIs and unintended pregnancies.

**2.8 - Future strategic aspiration for GUM services** (adults and young people combined)

In the next five years, we aspire to reduce the number of new and repeat STIs among all age groups, including at risk groups, by providing robust and cost effective GUM services while expanding provision for STIs screening and treatment in primary care, family planning and community settings.

Recommendations

1- Participate in a **collaborative commissioning of GUM services** across North West London Boroughs. The details of how this collaboration will work are currently being developed by the Pan London Sexual Health Transformation Project. The project is hosted by the West London Alliance (WLA) and is developing proposals for the medium to long term commissioning of sexual health services. It is anticipated that a collaborative commissioning of GUM services will offer the best opportunities to deliver effective contract management, value for money, robust clinical risk management and data collection, analysis, dissemination and distribution. Barnet and Harrow joint Public Health commissioning team is taking a leading role in this collaborative work. A separate report on this work will be available at the end of October 2014.
2- Expand the provision of services in the **primary care settings** especially in relation to screening of all basic sexual health infections by involving more GP surgeries from high incident and deprived areas of the Borough. This will not only provide an easily accessible service to the local population but will also release the pressure on GUM services.
3- Enrole local **pharmacies** in providing screening for STIs (e.g. chlamydia screening) along with signposting individuals to relevant services.
4- Provide basic sexual health screening in **family planning services** on an opt-out basis.
5- Consider providing programmes that target the **needs of young people** in educational and non education settings e.g. outreach services, school nursing and SRE in secondary schools. The suggested option also supports the aim of Barnet’s Health and Well-Being Strategy, “keeping well and keeping independent”.
6- Sign up to “C-Card” and “Freedom” condom distribution schemes via local pharmacies and GP surgeries.
7- Ensure and support the development of multiagency policies and pathways for an effective identification, assessment and intervention for children at risk of child sexual exploitation (CSE) and female genital mutilation (FGM).
8- Review and map the current services in Barnet to get a better understanding on user preference and uptake of available services. The review will also highlight any gaps in the current services especially around the needs of individuals with disabilities.

9- Launch an awareness and signposting campaign especially targeting young people and those who would not normally consider themselves to be at risk of STIs, but are sexually active. In addition, publicise awareness message through non-traditional routes such as social media and seek support from voluntary, third sector and religious institutions. These activities will provide reliable and consistent information about locally available sexual health services especially those in the primary care and community settings.

## 3 - Specific STI among young people

### 3.1 - Chlamydia screening

Chlamydia is a bacterial infection and one of the most common sexually transmitted infections (STI) in the UK. It affects both men and women with a considerably higher disease rates in young sexually active adults (15 – 24 years old). The majority of chlamydia infections are asymptomatic but can have serious health consequences (including infertility) if untreated.

The National Chlamydia Screening Programme (NCSP)[16] in England was established in 2003 and has led the implementation of chlamydia screening across England. NCSP sets standards, monitors activity and quality assures chlamydia screening. Its aim is to reduce chlamydia prevalence through early detection and treatment of asymptomatic infection, thereby reducing onward transmission and the consequences of untreated infection.

In England, chlamydia screening is delivered on an opportunistic basis and chlamydia tests are available to under 25 year olds free of charge from a variety of venues including GP surgeries, community sexual and reproductive health services, pharmacies, self-sampling kits ordered through the internet or from specialist genitourinary medicine (GUM) services [16,17].

### 3.2 – Epidemiology of Chlamydia [9,11,18] *(Please see appendixes 3&4)*

- In 2013, chlamydia was the most common STI, making up 47% of all diagnoses (208,755) in England.
- During the year, over 1.7 million chlamydia tests were carried out in England among young people aged 15 to 24 years, with over 139,000 chlamydia diagnoses made.
- Locally in Barnet, a total of 7137 chlamydia tests were carried out among 15-24 years old in 2012. Around (57% n=4092) of these tests were carried out in **GUM clinics** and the remaining (43% n=3045) were carried out in other settings. Of those outside the GUM services, only 40% (n=1218) were tested in GP surgeries.
- The above number constitutes 16% of 15-24 years old population who were tested for chlamydia with an 8% (564) positivity rate. In comparison, nationally 26% of 15-24 year olds were tested with a similar 8% positivity rate. This indicates the low uptake of chlamydia screening in Barnet.
- More recently, the number of new chlamydia diagnosis among 15-24 in Barnet went down from 564 in 2012 to 485 in 2013.

- Based on 2013 data, the chlamydia diagnosis rate per 100,000 15-24 years old in Barnet was 1,098 that is significantly lower compared to 2,179 for London and 2,016 for England.

### 3.3 - National recommendations and evidence

The majority of chlamydia infections are asymptomatic but early diagnosis and treatment can reduce the duration of infection and onward transmission. Early treatment also reduces the future complications of the disease. According to Public Health England (PHE)[19] chlamydia screening has been found to be widely acceptable among young adults, although there is evidence that fewer young men take chlamydia tests than young women[8].

The importance of reducing chlamydia infection is reflected by its inclusion within the Public Health Outcomes Framework (PHOF, 2013)[6], which focuses on reducing the number of "chlamydia diagnosis among 15-24 years old".

In the light of above, Public Health England (PHE, 2014)[17] recommends that local areas should work towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 population aged 15-24 year - a level which is expected to produce a decrease in chlamydia prevalence. This ensures that the programme is effectively targeting those young people at highest risk of infection.

NCSP[16] also recommends that all sexually active under-25 year old men and women should be tested for chlamydia annually or on change of sexual partner (whichever is more frequent). Screening should be delivered opportunistically, i.e. sexually active young adults should be offered a test when they attend services such as GPs, community sexual and reproductive health services, pharmacies, and specialist genitourinary medicine services. All young adults who test positive should also be offered a re-test around 3 months after treatment.

Partner notification and treatment is a core element of reducing onward transmission of infection. BASHH (2014)[14] recommends partner notification for chlamydia infections at a rate of at least 0.6 contacts per index case. A partner notification rate of 0.6 is achieved when 0.6 sexual partners are successfully treated for every positive case of chlamydia, or in simpler terms 6 partners for every 10 positive chlamydia cases.

### 3.4 - Current activities for chlamydia testing in Barnet

At present, chlamydia screening is offered to all individuals (as part of the sexual health screening) in genitourinary medicine services (GUM services) in Barnet.

Family planning services at Edgware Community Hospital, Vale Drive Health Centre, Torrington Park and Grahame Park offer chlamydia screening as part of the Central London Community Hospital (CLCH) family planning contract.

Barnet and Harrow joint Public Health service also has a contract with primary care services to provide chlamydia testing. In addition, 17 GP surgeries, that are signed

up to provide Intra Uterine Contraception Devices (IUCD) as part of the National Enhanced Service (NES), also perform chlamydia test prior to fitting an IUCD.

### 3.5 - Case for change

As evident from the local epidemiology, the proportion of 15-24 years old tested for chlamydia is less than half of the national figure and the chlamydia diagnostic rate in Barnet is well below the national recommendation to achieve a decrease in chlamydia prevalence.

More than half of the chlamydia diagnoses are made in GUM services that are expensive to commission and although there is a good evidence of chlamydia testing being carried out in the primary care settings, there is a need to further expand primary care services.

Currently, there is a lack of programmes that target young population. The rates of chlamydia infection are considerably higher among young sexually active adults in general and providing a confidential and easily accessible service to this population is essential in bringing down the rates of chlamydia infection.

Finally, there is no pharmacy based contract to offer chlamydia testing in the community.

### 3.6 - Future strategic aspirations

Our future strategic aspirations are to provide information and awareness about chlamydia as a sexually transmitted infection and to set up primary care and community based screening facilities. By providing an easily accessible and confidential screening, treatment and partner notification service in the community, we expect a reduction in chlamydia referrals to GUM services and a potential cost savings on GUM contract. Evidence suggests that diagnosis rate of at least 2,300 per 100,000 population aged 15-24 year, together with a partner notification rate of at least 0.6 per index patient, will contribute to the reduction in the prevalence of chlamydia.

<u>Recommendations</u>

1- Continue and expand chlamydia screening in the **primary care** settings especially in deprived areas of the Borough.
2- Work in collaboration with the **local pharmacies** (community settings) to provide chlamydia testing alongside emergency hormone contraception (EHC). Pharmacist should be encouraged to continue to receive sexual health and contraception training so as to advise and sign post young people to available services.
3- Obtain registration for free online chlamydia screening in Barnet.
4- Launch a robust chlamydia awareness campaign in the community and promote information on facilities that are available for chlamydia testing such as free online self-testing chlamydia kits.

5- Support the implementation of the National Chlamydia Screening Programme in Barnet by working in collaboration with our providers to ensure the provision of easily accessible services for young people.
6- Work in collaboration with abortion services to encourage chlamydia screening.
7- Continue with chlamydia screening in GUM services and family planning services.

## 4 - Family planning – Community Contraception and Sexual Health (CaSH) services

Family planning services provide a full range of high quality accessible and confidential sexual health and contraception service to meet the needs of the population.

There are 15 types of contraceptives available in the UK, 2 for men and 13 for women. Most common methods in use are oral contraceptive pills, Long Acting Reversible Contraceptives (LARC) and male condoms. Long acting reversible contraceptives are of four different types, i.e. injectables, implants, Intra Uterine Contraceptive Devices (IUCD) and Intra Uterine System (IUS). LARCs are considered to be the most effective methods of contraception as they are not dependent on the patient remembering to use them.

### 4.1 - Contraception usage *(Please see appendixes 5)*

- The Office of National Statistics (ONS) opinion survey report (2008/09)[19] shows that 58% of women aged 16-49 reported using at least one non-surgical method of contraception in Great Britain.
- Nationally, in 2012/13, 1.2 million women attended NHS community contraceptive clinics, which is a decrease of 5% (58,000) on the previous year.
- Of these approximately, 11% (37,000) of females were aged 15 and 3% (22,000) of females were under 15 (based on the female population aged 13 and 14).
- In terms of the usage, oral contraceptives were the most consistently popular method of contraception chosen by women of all ages attending NHS community contraceptive clinics. The percentage of females attending NHS community contraceptive clinics who chose oral contraception according to age was, 15 year olds (45%) for those aged 16-17 (48%), 18-19 (53%), 20-24 (54%), 25-34 (46%) and 35 and over (33%)[20].
- Locally in Barnet, the rate of LARC prescribed by GP's in 2013 was 19.4 per 1000 females, which is lower in comparison to the rate for London 25.1 and England 52.7.
- Similarly, in 2013, the total numbers of abortions in Barnet were 1,624 at a rate of 19.9 per 1000 females that is lower compared to London (22.8) but higher compared to England (16.6).

### 4.2 - National recommendations and evidence

It is recognised that investing in contraceptive services can deliver cost savings for the NHS through preventing unintended conceptions (and the costs associated with

maternity and abortion services). NICE (2003)[21] concludes that effective contraceptive services are highly cost effective in preventing teenage pregnancy.

With regard to cost effectiveness of different contraceptive methods, NICE (2005)[22] suggests that long-acting reversible contraception (LARC) methods are more clinically and cost effective than the combined oral contraceptive pill even at 1 year of use. While in comparison among the four LARC methods, the injectable is less cost effective than the IUD, IUS and implant, with the latter (IUD, IUS and implant) becoming more cost effective with longer duration of use.

Quality statements set out by the Faculty of Sexual and Reproductive Healthcare (2014)[23] informs that all individuals within the area requiring contraception to minimise the risk of unintended pregnancy should have a timely and open access service to a chosen methods of contraception directly through a contraceptive provider or by effective referral pathways.

The Faculty of Sexual and Reproductive Healthcare (2011)[24] recommends that walk in clinics should aim to see patients within 2 hours and services that operate an appointment system should provide an appointment within 2 working days and according to The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (2011)[25], no women should have to wait for longer than 3 weeks from her initial referral to termination of pregnancy.

### 4.3 – Family Planning or CaSH services in Barnet

Barnet and Harrow joint Public Health service has a family planning contract with Central London Community Healthcare (CLCH) NHS Trust. Family planning services are provided through its four main hubs i.e. Vale Drive Primary Care Centre, Edgeware Community Hospital, Torrington Park health Centre, Grahame Park Health Centre.

The services are open 6 days a week with late evening sessions on 4 days of the week and provide a full range of contraceptive choices, including oral contraception, condoms and diaphragms, long acting reversible contraception (LARC), emergency hormonal contraception (EHC) and emergency IUD. The Trust has four young person's clinics from Monday to Thursday evenings. The services operate on an open access basis and are available to anyone requiring care, irrespective of their place of residence or referral.

With regard to their usage, in 2013/2014, there were a total of 7636 visits (new and existing users) to the CASH service. The majority of the patients who were seen in the CASH service (1812) were LARC users, followed by combined oral contraceptive users (1052) and progesterone only pill users (515).

In terms of contraceptive preference among news users at CASH services, 1316 preferred LARC (322 implants and 1176 IUD/IUS), followed by 719 who chose combined oral contraception and 380 who were prescribed the progestogen only pill. In addition to the above, CASH services prescribed oral emergency hormonal

contraception pills to 369 patients and fitted 19 emergency postcoital intrauterine devices.

Barnet also has provision of contraceptive services via primary care settings and has a NES contract with 17 local GP surgeries for IUD and IUS fittings and a sexual health contract for contraceptive implants. In 2013, GP surgeries provided a total of 547 IUD and IUS fittings and 161 implants.

Barnet also has a contract with seven local pharmacies to provide emergency hormone contraception. In 2013, they dispensed a total of 105 EHC to the target group of 13-19 year olds.

**4.4 - Family planning needs of young people** *(includes teenage pregnancy, abortion and repeat pregnancy)*

Teenage pregnancy is a health inequality and social exclusion issue that leads to poor health and social outcomes for both the mother and the child[26].

While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty[26].

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS[26]. Similarly, repeat termination is another important aspect of women's health, which requires health promotion and education about Long Acting Reversible Contraceptive (LARC). Preventing unwanted pregnancies rather than abortion post conception is preferable considering the physical and mental health of the young woman involved and the utilisation of NHS resources.

The key findings from the research carried out by Department for Children and Families (2010)[27], identified that teenagers continue to have unprotected sex when they are fully aware of the possible consequences, and when they do not want to become pregnant. Underlying issues behind this included; feeling out of control, maybe because of drugs or alcohol, or because of the dynamics of the sexual relationship; reliance on user-dependent contraceptive methods and problems young women may experience in negotiating for safer sex. The research also identified that young people struggled to use their preferred methods of contraception (principally user dependent i.e. condoms and the pill) effectively; and when became pregnant, they viewed abortion as 'immoral' making abortion decision-making difficult and stressful.

**4.5 – National and local picture among young people** [5, 18]

*(Please see appendix 5)*

- Nationally, there has been a substantial decline in the rate of under 18 conceptions and in 2011. The rate fell to 30.7 per 1,000 women, which is the lowest since records began.

- In Barnet, the **conception rate among women under 18** has dropped by almost 50% between 2002 -2012 and has been below both the London and national rates. The number of teenage conception dropped from 192 in 2002 to 91 in 2012. In 2012, under 18-conception rate per 1,000 in Barnet was 14.7 per 1000 girls compared with 25.9 for London and 27.7 for England.
- There has also been a steady decline in **under 18 abortion rates** in Barnet in the last 10 years (2002-2012). In 2012, abortion rate in women under 18 years in Barnet was 10.3 per 1000 females compared with 16.1 in London and 13.6 in England.

**4.6 - National recommendations and evidence around teenage conception**

The importance of reducing teenage conception is reflected by its inclusion within the Public Health Outcomes Framework (PHOF,2013)[6] which focuses on reducing the number of "under 18 conceptions".

A framework for health improvement in England (2013)[5] also prioritises the reduction of under 18 conceptions with the availability of appropriate information and education for young people to enable them to make informed decisions with access to the full range of contraceptive methods and information on where to access them. Target groups are young women and men aged under 18 and parents of young people aged under 18.

The teenage pregnancy strategy (2010)[26] looked at the international evidence-base and identified the delivery of comprehensive SRE programmes and provision of accessible, young people-centred contraceptive and sexual health (CaSH) services as the two factors with the strongest impact on reducing teenage pregnancy rate.

**4.7 – Family planning services for young people in Barnet**

The CLCH, provide community based CaSH services for young people from Monday to Thursday (evenings) of each week.

Young people can also access the family planning services via primary care settings who provide these as part of the NES and LES arrangements.

In addition to these, local pharmacy services provide advice on contraception and family planning and prescribe EHC, however, the uptake of EHC via pharmacies has dropped from 125 in 2012-13 to 105 in 2013-14.

Finally, there is a Sex and Relationship Education (SRE) programme which provides consultancy support to those primary schools engaged in SRE development and provide opportunities to train the trainers for a sustained delivery of SRE in schools in the future.

**4.8 - Case for change** (adults and young people combined)

The above figures suggest a local preference to use GP surgeries for family planning needs, however, only a small number (17) of GP surgeries are currently providing

the service. There is a need to engage with more GP surgeries to expand the provision of family planning services especially from hotspot and deprived areas of the Borough.

Young people require dedicated services that can address their concerns around access, confidentiality, child sexual exploitation (CSE) and female genital mutilation (FGM). At present, young people do not have outreach programmes at school or community level and there is a need to provide easily accessible services to young people especially in the deprived areas of the Borough. There is also a need to work in collaboration with partner agencies to address wider aspects such as CSE, FGM and providing advice on negotiating safe sex.

Pharmacies provide an easily accessible platform and at present the role of pharmacies in family planning is limited to providing advice, EHC and pregnancy testing and there is a need to expand role beyond the current services.

In addition to these programmes, LBB should also participate in community schemes such as “C-Card” and “Freedom” condom distribution schemes. These schemes provide a dual service by providing protection against STIs and unintended pregnancies.

**4.9 - Future strategic aspiration** (adults and young people combined)

In the next five years, we aspire to provide a comprehensive and cost effective family planning services for our residents by expanding the role of primary care and pharmacies especially in deprived areas of the Borough. We would also like to ensure that our local population especially young people have appropriate information and access to all available services that offer advice and the choice of contraception. In addition, we would like to raise awareness and develop special programmes for the young people.

<u>Recommendations</u>

1. Maintain the existing CaSH services especially the out of hour clinics for young people.
2. Expand the provision of current family planning services in primary care by enrolling more GP surgeries especially those based in deprived areas of Barnet.
3. Expand the role of pharmacies beyond the current provision of EHC and pregnancy testing and include the provision of C-Card scheme and counselling on future contraception.
4. Align existing and develop new programmes based on the needs of young people e.g. school nursing, expansion of sex and relationship education and health champion for young people. Health champions can raise awareness and signpost young people in venues like youth clubs, gym and social clubs.
5. Increase the number of young people friendly sexual health services especially at GP practices and pharmacies with ‘You’re Welcome’ accreditation.

6. Actively engage with all key partners who have a role in reducing teenage pregnancies – health, education, social services, youth support services and the voluntary sector.
7. Actively engage in the development of multiagency policies and pathways for an effective identification, assessment and intervention for children at risk of child sexual exploitation (CSE) and female genital mutilation (FGM).
8. Launch a local awareness campaign to provide reliable and consistent information about all available family planning and contraceptive services in the Borough.
9. Engage in publicising contraception and sexual health services in non-traditional settings e.g. social media.
10. Map and review of all current services and contracts in Barnet with a detailed breakdown on the preference to use different services and the choice of contraceptives by age and ethnicity. A review will also identify any gaps in the current primary care, secondary care and pharmacy services.

## 5 – HIV testing

HIV remains one of the most important communicable diseases in the UK. It is associated with serious morbidity, significant mortality and high numbers of years of life lost. There are high costs associated with both treatment and care of HIV [11, 13].
The late diagnosis of HIV is the most important predictor of HIV-related morbidity and short-term mortality. A late diagnosis of HIV infection is where the person has a CD4 count of less than 350 cells per $mm^3$ within 91 days of the diagnosis[28].
Late HIV diagnosis can result from missed opportunities for earlier diagnosis, and can have adverse consequences for both the individual and Public Health through onward transmission. Early diagnosis and prompt treatment of HIV can lead to near normal life expectancy for the individual. Patients treated successfully can achieve undetectable viral load (<50 copies/mL) and this can eliminate their risk of passing the infection through sexual contact[29,30]. This supports the Public Health goal of reduction in onward transmission of the disease. In addition, the cost of HIV treatment and care are lower in individuals' diagnosed earlier[31].

### 5.1 - HIV epidemiology in the UK[28, 29]

- In 2012, there were an estimated 98,400 (95% CI 93,500 – 104,300) people living with HIV in the UK, representing an overall prevalence of 1.5 per 1,000 population (1.0 in women and 2.1 in men). Of the above, an estimated 21,900 (1 in 5) were unaware of their HIV positive status, and this number of undiagnosed people has remained relatively constant over recent years.
- There were 6,360 **new** HIV diagnoses made in the UK in 2012, representing a diagnosis rate of 1.0 per 10,000 population. Of these, 5,864 were from England. Among large cities, London had the highest number (2,832) of new HIV diagnosis.
- Of the 6,360 new HIV diagnoses in the UK, **47%** (2,990) were diagnosed late and 28% (1,770) were severely immuno-compromised (<200 CD4 cells/µl blood).

- Late diagnosis was highest among **heterosexuals**, with two-thirds of men (65%; 750/1,160) and over half of women 57% (860/1,730) were diagnosed late followed by 34%; (1,105/3,205) for MSM.
- Most HIV transmission in the UK occurs through **sexual contact**; the two groups most at risk of HIV infection are men who have sex with men (MSM) and the black African heterosexual population. It is estimated that in 2012, 40,900 MSM, and 31,800 black African men and women *(11,100 men and 20,700 women)* were living with HIV in the UK representing a prevalence of 26 per 1,000 for African-born men and 51 per 1,000 for African-born women.

**5.2 - HIV epidemiology in Barnet** [11] *(please see appendixes 5)*

- In 2011, 676 adult Barnet residents (378 males and 298 females) received HIV-related care.
- Of these, 45% were black African, 34% were white and 17% were from other ethnic groups.
- The main route of infection in Barnet was sex between men and women (64%) with a further (29%) attributed to MSM.
- Between 2010 and 2012, 54% (95% CI 45-63) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm3 within 3 months of diagnosis) compared to 45% for London and 48% for England.
- Based on 2011 data, 59% (95% CI 44-71) of heterosexuals and 40% (95% CI 21-64) of men who have sex with men (MSM) were diagnosed late.
- In 2012, a HIV test was offered to 74% of eligible attendances at GUM clinics among residents of Barnet and, where offered, a HIV test was done in 91% of these attendances. Nationally, a HIV test was offered to 79% of eligible attendances at GUM clinics and, where offered, a HIV test was done in 81% of these attendances.
- In 2012, the prevalence of diagnosed HIV in Barnet was 2.92 per 1,000 population aged 15-59 years compared to 5.54 in London and 2.05 per 1000 in England [14].
- 76% of the Barnet MSOAs had HIV prevalence rates higher than 2 per 1,000 population. This is above the BHIVA recommendation which states that local authorities with a diagnosed HIV prevalence greater than 2 per 1,000 population should offer routine HIV testing into non-traditional settings.

**5.3 - National recommendations and evidence**

The importance of reducing late presentation of HIV is reflected by its inclusion within the Public Health Outcomes Framework (PHOF, 2013)[6], which focuses on reducing the number of "people presenting at a late stage of diagnosis".

In order to promote early diagnosis, one of the recommendations from HIV Prevention Needs Assessment for London (2013)[32] focuses on the expansion of HIV testing in settings that are outside of sexual health services to normalise and promote HIV testing.

BHIVA[13] (2008) guidelines state that a HIV test should be offered to patients attending genitor-urinary medicine or sexual health clinics, antenatal services, termination of pregnancy services, drug dependency programmes, and services for tuberculosis, hepatitis B and C, and lymphoma.

BHIVA[13] also recommends that local authorities with a diagnosed HIV prevalence greater than 2 per 1,000 population should consider offering routine HIV testing into non-traditional settings. This includes all men and women registering in general practice and all general medical admissions.

Testing for HIV is considered cost-effective as long as the positivity rate is more than 1 per 1000 tests. Testing is likely to be most effective if targeted at people aged between 15 and 59 years of age. Early testing and diagnosis of HIV reduces treatment costs – £12,600 per annum per patient, compared with £23,442 with a later diagnosis[14].

Public Health England (PHE, 2013)[27] advises that those individuals who are at increased risk such as; men who have sex with men (MSM) should have an HIV and STI screen at least annually, and every three months if having unprotected sex with new or casual partners and black-African men and women should have an HIV test and a regular HIV and STI screen if having unprotected sex with new or casual partners.

**5.4 - Current activities for HIV testing in Barnet**

Currently, patients seen at local genitourinary medicine services (GUM services) are offered a HIV test on an opt-out basis.

A HIV test is offered universally to all patients attending antenatal services, termination of pregnancy services, drug dependency programmes, and healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma**.**

Barnet and Harrow joint Public Health service has a primary care contract with 8 GP surgeries who offer a HIV test to eligible patients.

Family planning services in Barnet can perform a HIV test on request from the patient and currently only offer it to patients at increased risk.

The drug and alcohol team offer HIV test to all patients as part of the blood borne viruses screening.

LBB are also actively involved with London HIV Prevention Programme (LHPP). The service is funded by individual LAs and has specific areas of work predominantly aimed at men who have sex with men (MSM) and African Communities. The three elements of their work are media/communication campaigns, condom procurement and distribution and outreach work (for MSM only). The service does not offer screening for HIV.

## 5.5 - Case for change

The data evidence from 2011 shows that the main route of HIV infection in Barnet is heterosexual exposure (64%) followed by MSM (20%) exposure, with high rates of late diagnosis (58%) for those who had a heterosexual exposure. An estimated 10% of Barnet population is from black or black ethnic groups, but just below half of all cases (45%) were from black African background. Among new HIV diagnosis, there were more heterosexual female cases compared to the heterosexual male cases. This indicates a specific population who either do not consider themselves to be at risk of HIV or do not have access to easily accessible and opportunistic HIV test offers. There is an urgent need to raise awareness and promote HIV testing among these groups.

There is lack of information on the actual number of HIV tests carried out in current settings and hence a need to conduct a detailed service review looking into the local acceptability rate for a HIV test and the preference to use different services by age, gender and ethnicity.

Only eight GP surgeries in Barnet are participating in HIV screening as part of the full STIs screening in Barnet. There is a need to enrole more GPs to offer HIV screening especially from hotspot areas for HIV epidemiology.

A HIV test is not offered to all individuals attending family planning services. Based on the Barnet's HIV epidemiology, with higher rates and late diagnosis among heterosexual females, family planning services are best placed to offer the test to individuals who engage in risky behaviour i.e. unprotected sex.

There is no outreach work for HIV awareness and testing in the community and no pharmacy based HIV testing in Barnet at present and although there are media campaigns organised by London HIV Prevention Programme, they lack screening element. In order to reduce late diagnosis of HIV and to encourage more testing in the community, we need to consider piloting outreach work and pharmacy involvement and to signpost individuals to the appropriate services.

## 5.6 - Future strategic aspirations

Our future strategic aspirations are to reduce the number of new and late HIV diagnosis through targeted work with at risk groups along with establishing confidential and easily accessible HIV testing sites in the community. By directing more testing in the community we aim to reduce the number of HIV screening referrals to GUM services. The offer of HIV tests outside the GUM settings will attempt to reduce stigma and discrimination, encourage uptake of tests and reduce the number of patients presenting at a late stage of the illness.

<u>Recommendations</u>

1. Undertake a service review of the current facilities offering HIV tests in Barnet to identify demand, patient preference and gaps in existing service provision.

2. Promote information on facilities that are available for HIV testing in the local areas including information on free online **self-sampling HIV kits** via Dean Street and Terrence Higgins Trust and free **self-testing kits** expected to be launched in the UK by the end of 2014 or early 2015.
3. Work in collaboration with PHE led London wide self-sampling service for HIV, expected to start from February 2015.
4. Continue with HIV testing in the primary care settings and enrole additional GP surgeries from hotspot areas of the Borough to offer HIV test to **all** new GP registrations and individuals in the risk groups.
5. Collaborate with the drug and alcohol team in promoting HIV testing as part of the screening for blood borne viruses.
6. Offer a routine HIV test on an opt-out basis to **all** patients seen in family planning clinics.
7. Continue to offer a routine HIV test on opt-out basis to **all** patients seen at GUM services as per national recommendation[3]**.**
8. Pilot and evaluate the HIV testing via local pharmacies.
9. Pilot and evaluate community based HIV testing via outreach team.
10. Work in collaboration with commissioners of services where HIV testing is currently offered universally to all patients i.e. TB, antenatal services, infectious disease wards.
11. Work in collaboration with "Find and Treat" and "The Hepatitis C Trust" who offer free HIV testing to hard to reach groups in addition to other services.

## 6 – Conclusions

1- Barnet has a diverse population with distinct needs as well as a diversity of cultural barriers to address sexual health. The main priorities in Barnet are similar to its neighbouring Boroughs. The key priority groups in the Borough are young people, BME communities, heterosexual females and MSM.

2- GUM patient activity in Barnet has risen in the past years and there is an urgent need to address the rising cost of GUM services in secondary care. The existing contracts and services evolved from within the NHS environment and have transitioned to Local Authority responsibility with very little change. In order to provide a robust, open access and cost effective sexual health services, it is essential to maintain participation with WLA's work around medium to long term commissioning of these services.

3- There is a need to consider redirecting basic sexual health screening from secondary care to primary care and community settings e.g. HIV, gonorrhoea and chlamydia testing. Expanding the provision of sexual health and reproductive services in primary care and pharmacy settings (especially in deprived areas of the Borough) would offer easily accessible and non-discriminatory venues to our population when seeking advice and care. Both these services can also raise awareness, support schemes such as "C-Card" and "Freedom" and signpost patients to appropriate secondary care services if required.

4- The needs of young people are different to adults. Young people require dedicated services which can address their concerns around access, confidentiality, child sexual exploitation and provide education on safe and healthy relationships. The existing services cover some aspects of these but there are limited school programmes beyond the investment made this year from Public Health budgets. There is a need to review the existing services to ensure they incorporate the needs of our growing young population and the current SRE programme should be extended to secondary schools. In addition, we should consider training sexual health champions for non-traditional settings i.e. youth centers, gym and social clubs. These champions can raise awareness about sexual and reproductive health and signpost young people to local services.

5- There is good evidence of declining teenage pregnancy rates in Barnet in recent years, however, 42% of all acute STIs in 2012 in Barnet were among 15-24 year olds. Similarly, the information about where existing services , their locations and what they offer is not easily available. This indicates that in addition to expanding our services, we need to launch a robust awareness campaign with clear messages about sexual risk-taking, signs and symptoms of STIs (including HIV), benefits of STI screening and information on family planning and reproductive health. The campaign should also market the local facilities offering sexual health and family planning services and should explore social media platforms and voluntary and charitable organisations in spreading the message to wider audiences.

6- The epidemiology of HIV among Barnet residents is different to London in general. There are more cases of HIV infections among heterosexual females compared to heterosexual males and the main route of HIV infection in Barnet is heterosexual exposure. There is also a higher percentage of new HIV cases among black or black ethnic groups, which is disproportionate to their actual population size in Barnet. Similarly, the percentage of late HIV diagnosis in Barnet is higher compared to London and England. In light of the above, we need to promote and encourage HIV testing among at risk population groups via easily accessible and opportunistic testing facilities in primary care, family planning and community settings.

7- Currently, there are gaps in the accurate information on the demography of actual and potential service users by disability, ethnicity, sexual orientation and existing health conditions. Similarly, there is poor evidence of the local populations preferences for service access. In order to better understand the needs of the local population and to identify any further gaps, it is essential to map and review all current sexual health services.

8- Finally, local PH commissioners should agree performance and data reporting targets, with the providers of commissioned services, in line with service needs, national standards and Public Health Outcomes Framework.

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**Appendix 1A – Sexual health commissioning responsibilities by organisation from April 2013** *(adopted from "A guide to whole system commissioning for sexual health, reproductive health and HIV"- Public Health England 2014)*[8]

**Local authorities commission;**
Comprehensive sexual health services which includes:

1. Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local Public Health contracts (such as arrangements formerly covered by LESs and NESs)
2. Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local Public Health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
3. Sexual health aspects of psychosexual counselling
4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies
5. Social Care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:
   - HIV Social Care
   - Wider support for teenage parents

**Clinical commissioning groups commission;**

1- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see "NHS England commissions")
2- Female sterilisation
3- Vasectomy (male sterilisation)
4- Non-sexual health elements of psychosexual health services
5- Contraception primarily for gynaecological (non-contraceptive) purposes
6- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)

**NHS England Commissions**;

1- Contraceptive services provided as an "additional service" under the GP contract
2- HIV treatment and care services for adults and children, and cost of all antiretroviral treatment
3- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (i.e. not part of Public Health commissioned services, but relating to the individual's care)

4- HIV testing when clinically indicated in other NHS England-commissioned services
5- All sexual health elements of healthcare in secure and detained settings
6- Sexual assault referral centres
7- Cervical screening in a range of settings
8- HPV immunisation programme
9- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
10- NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

## Appendix 2A – Benefits of investment in effective services and interventions for individuals, the public and commissioners *(adopted from "A guide to whole system commissioning for sexual health, reproductive health and HIV"- Public Health England 2014)*[8]

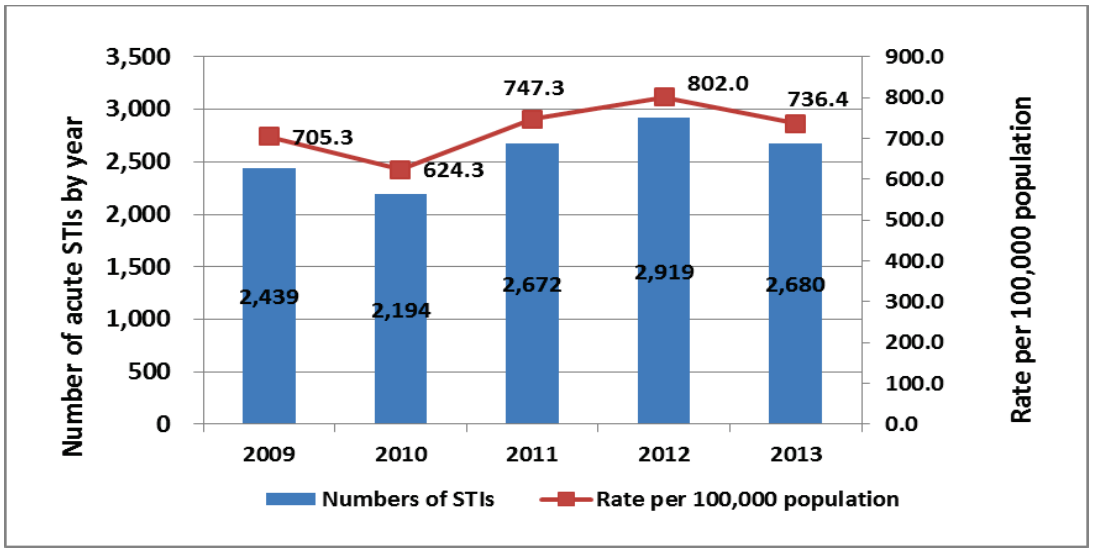
| Key objectives in 'A Framework for Sexual Health Improvement in England' | Benefits at the individual level | Benefits at the public health/population level | Other benefits (economic, health and social outcomes) ✔ = benefit for specified commissioner(s) |
|---|---|---|---|
| Objective:<br>Continue to reduce the rate of under 16 and under 18 conceptions<br><br>Commissioning intention:<br>Ensure choice and timely access to young people-friendly reproductive health services and all methods of contraception | Control over fertility through increased use of contraception<br><br>Greater ability to pursue educational and employment opportunities<br><br>Improved self-esteem<br><br>Improved economic status/reduction in family and child poverty | Fewer unwanted pregnancies<br><br>Improved health outcomes for mothers and babies<br><br>Better educational attainment<br><br>Better employment and economic prospects | Improved infant mortality rates ✔ CCGs<br><br>Reduced A&E admissions/ childhood accidents ✔ CCGs<br><br>Decrease in abortions ✔ CCGs<br><br>Reduced use of mental health services ✔ CCGs<br><br>Reduced use of social services ✔ LAs<br><br>Fewer young people not in education, employment or training ✔ LAs<br><br>Reduction in family and child poverty ✔ LAs |

| Key objectives in 'A Framework for Sexual Health Improvement in England' | Benefits at the individual level | Benefits at the public health/population level | Other benefits (economic, health and social outcomes) |
|---|---|---|---|
| Objective:<br>Reduce rates of STIs among people of all ages<br><br>Commissioning intention:<br>Encourage uptake of chlamydia screening and testing for under 25 year olds | Treatment of STIs<br><br>Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy) | Reduction in prevalence and transmission of infection<br><br>Opportunities to test for other STIs/HIV in those diagnosed with chlamydia<br><br>Reaching young people with broader sexual health messages<br><br>Increased uptake of condom use | Reduced use of gynaecology services (to manage other health consequences) ✔ CCGs<br><br>Increased uptake of sexual health services by young people ✔ LAs<br><br>Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence ✔ LAs |
| Objective:<br>Reduce onward transmission of HIV and avoidable deaths from it<br><br>Commissioning intention:<br>Ensure access to HIV testing, early diagnosis and treatment initiation | Access to treatment<br><br>Better treatment outcomes/prognosis<br><br>Improved ability to protect partner from HIV | Fewer people acquiring HIV<br><br>Greater contribution of people living with HIV to workforce and society<br><br>Less illness and fewer avoidable deaths | Lower health and social care costs for HIV ✔ NHS England, CCGs and LAs<br><br>Lower healthcare costs for associated conditions and emergency admissions ✔ CCGs<br><br>Enhanced public health/ prevention ✔ LAs |
| Objective:<br>Reduce unintended pregnancies among all women of fertile age<br><br>Commissioning intention:<br>Ensure access to high quality reproductive health services for all women of fertile age | Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods<br><br>Optimisation of health for women prior to becoming pregnant<br><br>Fewer abortions and repeat abortions for individual women<br><br>Improved quality of family life | Fewer unwanted pregnancies<br><br>Improved pregnancy outcomes<br><br>Improved maternal health and reduced maternal mortality | Investment in contraception is cost effective in reducing pregnancies and abortions ✔ CCGs<br><br>Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes ✔ CCGs<br><br>Reduced social care costs for infant and child care ✔ LAs |

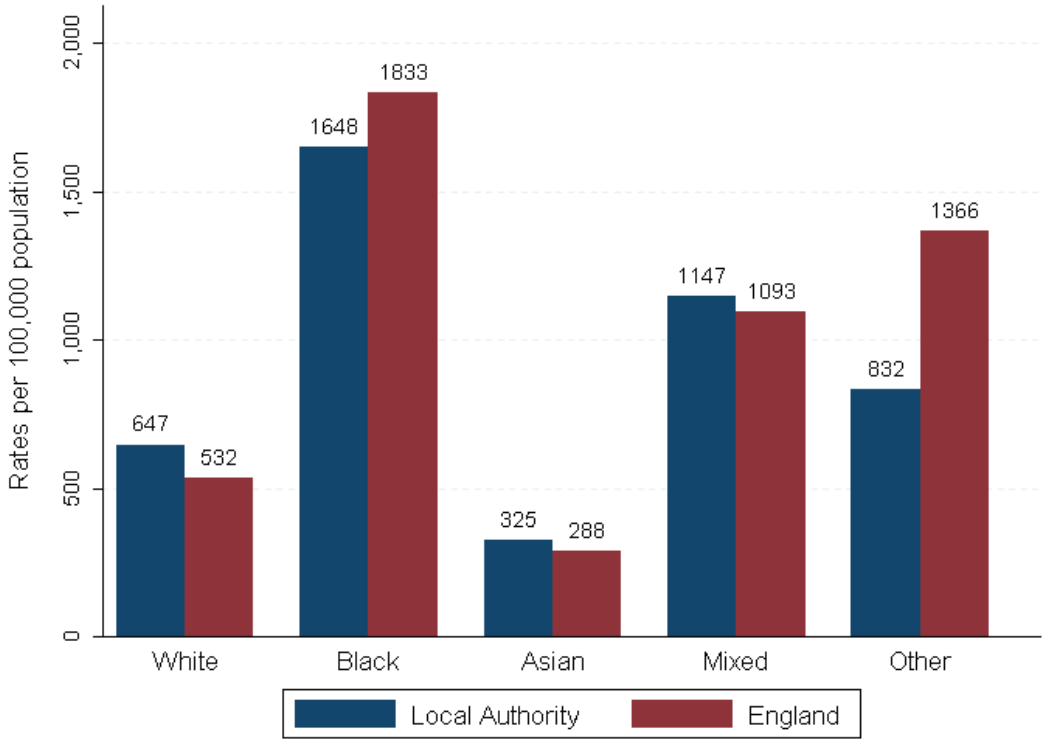
## Appendix 1B – Comparison of main STIs between London and Barnet 2012-2013

| | | Chlamydia | | | | | | Gonorrhoea | | Herpes | | Syphilis | | Warts | | All new STIs | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 15-24 | | 25+ | | Total | | | | | | | | | | | |
| | | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 | 2012 | 2013 |
| London | Number of cases | 23,701 | 23,421 | 18,274 | 19,668 | 42,245 | 43,386 | 10,862 | 12,915 | 7,590 | 7,473 | 1,410 | 1,642 | 13,918 | 13,615 | 112,275 | 110,706 |
| London | Rate per 100,000 population | 2,205.3 | 2,179.3 | 322.9 | 347.5 | 508.5 | 522.2 | 130.7 | 155.4 | 91.4 | 89.9 | 17.0 | 19.8 | 167.5 | 163.9 | 1,351.3 | 1,332.5 |
| Barnet | Number of cases | 564 | 485 | 494 | 509 | 1,067 | 998 | 243 | 219 | 279 | 233 | 24 | 22 | 458 | 447 | 2,919 | 2,680 |
| Barnet | Rate per 100,000 population | 1,277.0 | 1,098.1 | 199.6 | 205.7 | 293.2 | 274.2 | 66.8 | 60.2 | 76.7 | 64.0 | 6.6 | 6.0 | 125.8 | 122.8 | 802.0 | 736.4 |

## Appendix 2B - Number and rates of acute STIs among Barnet residents between 2009 - 2013

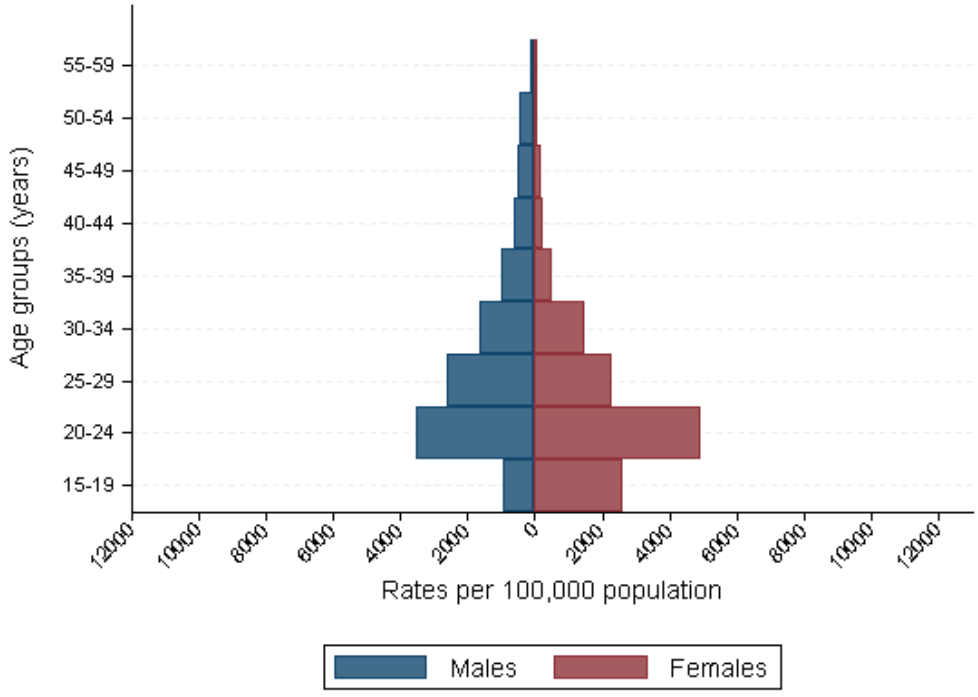


## Appendix 1C - The rate per 100,000 of acute STIs by ethnic group in Barnet and England: 2012



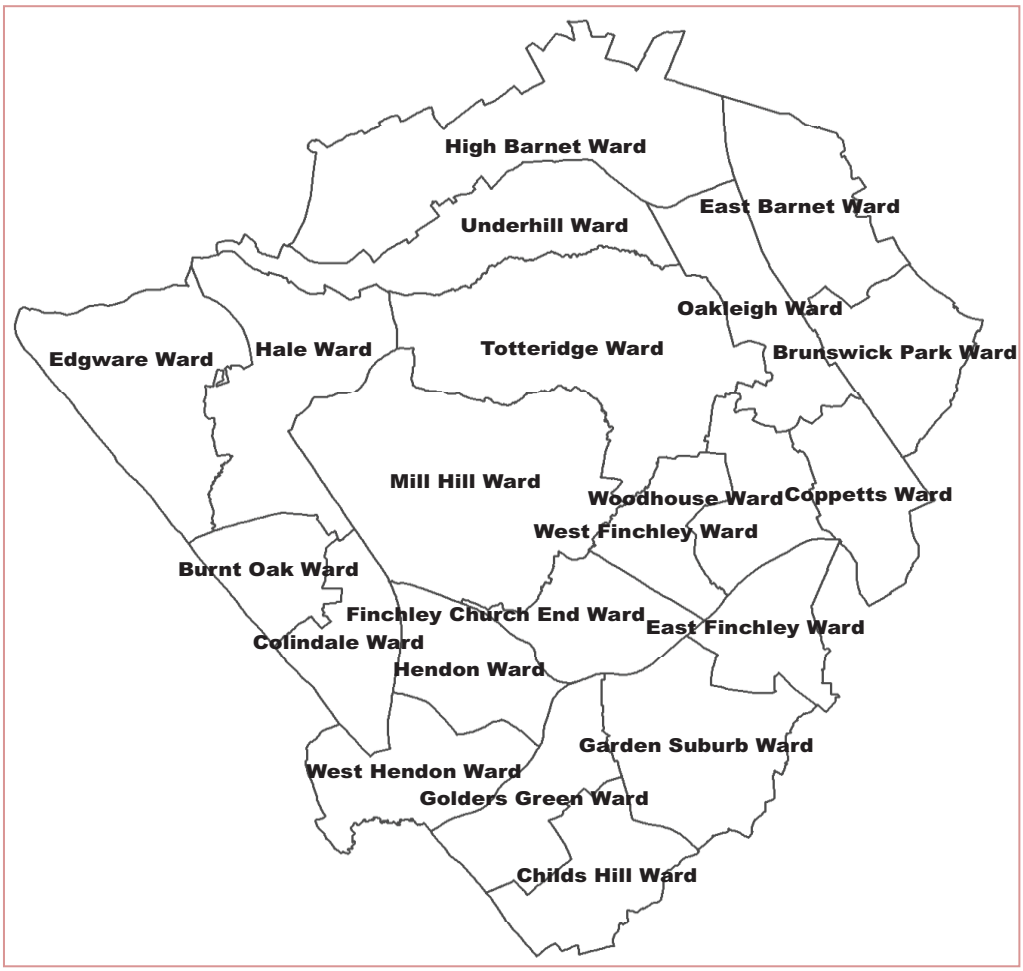

Source: Data from Genitourinary Medicine clinics

## Appendix 2C - Age group and gender of cases of acute STIs in Barnet: 2012

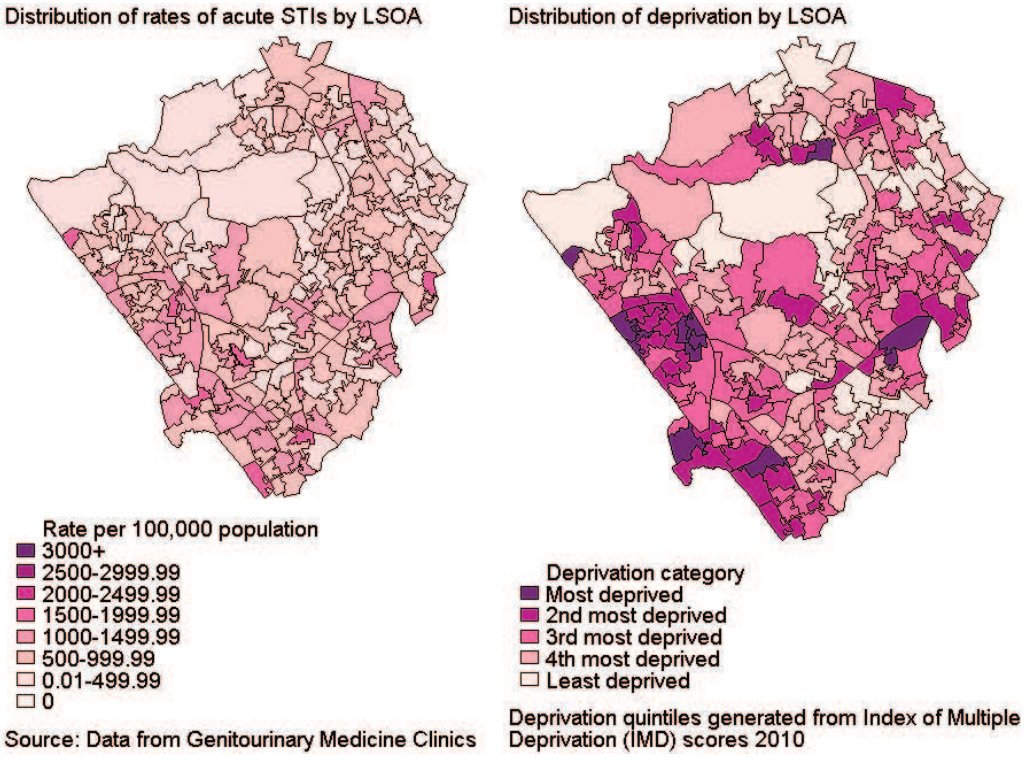



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

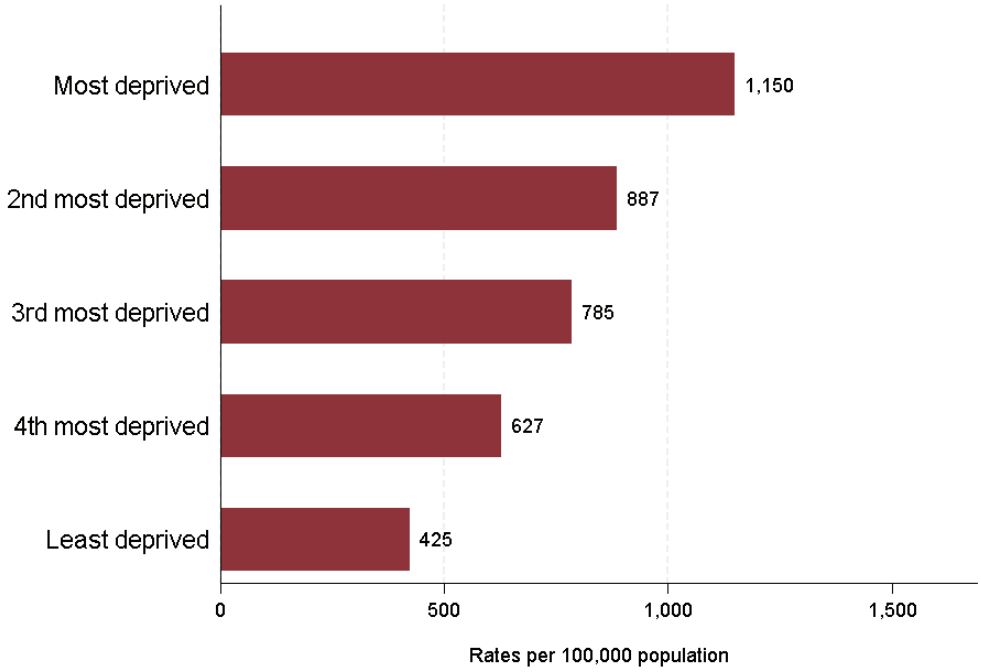
## Appendix 3C - London Borough of Barnet by Ward names and boundaries




## Appendix 4C - The rate per 100,000 of acute STIs by LSOA* in Barnet: 2012



## Appendix 4D - The rate per 100,000 of acute STIs by deprivation category in Barnet: 2012

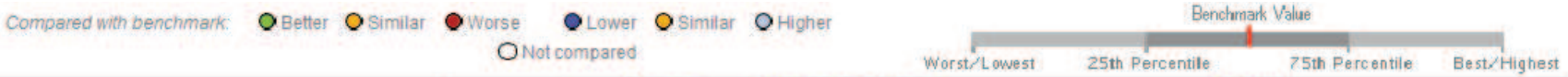



Source: Data from Genitourinary Medicine Clinics

## Appendix 4- Percentage of all attendees by Barnet residents at GUM clinic 2012

| *Clinic name* | *% of all attendances* |
|---|---|
| Barnet Hospital | 36.0 |
| The Royal Free Hospital | 20.4 |
| Archway Sexual Health Clinic (GUM) | 11.8 |
| Mortimer Market Centre | 6.3 |
| St Mary's Hospital London | 4.9 |
| Dean Street Clinic | 4.6 |
| Northwick Park Hospital | 2.9 |
| Central Middlesex Hospital | 1.8 |
| St Bartholomew's Hospital | 1.2 |
| Town Clinic | 1.0 |
| Guy's Hospital | 1.0 |
| St Ann's Hospital | 1.0 |
| St Thomas' Hospital | 0.9 |
| Charing Cross Hospital | 0.8 |
| The Royal London Hospital | 0.7 |
| Watford General Hospital | 0.6 |
| John Hunter Clinic | 0.6 |
| Homerton Hospital | 0.6 |
| Margaret Pyke Centre (GUM) | 0.4 |
| St Albans Hospital | 0.2 |
| Hertford County Hospital | 0.2 |
| King's College Hospital NHS Foundation Trust | 0.2 |
| Leeds General Infirmary | 0.1 |
| Ealing Hospital, Pasteur Suite | 0.1 |
| Whittall Street Clinic | 0.1 |
| Newham General Hospital | 0.1 |
| West Middlesex University Hospital | 0.1 |
| Royal Sussex County Hospital | 0.1 |
| Queen Mary's Hospital (GUM) | 0.1 |
| St George's Hospital (GUM) | 0.1 |
| Kingston Hospital | 0.1 |
| Whipps Cross University Hospital | 0.1 |
| Tudor Centre | 0.1 |
| The Garden Clinic | 0.1 |
| Barking Hospital | 0.0 |

## Appendix 5 - Barnet's Sexual and Reproductive Health Profile (as of September 2014)




| Indicator | Period | Barnet | | Region | England | England | | |
|---|---|---|---|---|---|---|---|---|
| | | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Syphilis diagnosis rate / 100,000 | 2013 | 22 | 6.0 | 19.8 | 5.9 | 90.9 | | 0.0 |
| Gonorrhoea diagnosis rate / 100,000 | 2013 | 219 | 60.2 | 155.4 | 52.9 | 533.2 | | 3.6 |
| Chlamydia diagnosis rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300 | 2013 | 485 | 1,098 | 2,179 | 2,016 | 840 | | 5,758 |
| Chlamydia diagnosis rate / 100,000 aged 15-24, pre-2012 data <2,000 2,000 to 2,400 ≥2,400 | 2011 | 598 | 1,347 | 2,190 | 2,097 | 948 | | 4,911 |
| Chlamydia proportion aged 15-24 screened | 2013 | 7,087 | 16.0% | 27.7% | 24.9% | 10.6% | | 58.2% |
| Chlamydia proportion aged 15-24 screened, pre-2012 data | 2011 | 8,069 | 18.2% | 32.0% | 29.7% | 14.4% | | 51.6% |
| Genital warts diagnosis rate / 100,000 | 2013 | 447 | 122.8 | 163.9 | 133.4 | 288.6 | | 70.7 |
| Genital herpes diagnosis rate / 100,000 | 2013 | 233 | 64.0 | 89.9 | 58.8 | 182.9 | | 21.4 |
| HIV testing uptake, MSM (%) | 2013 | 1,101 | 97.4% | 95.7% | 94.8% | 86.1% | | 100% |
| HIV testing uptake, women (%) | 2013 | 5,248 | 86.0% | 82.4% | 75.8% | 29.0% | | 94.4% |
| HIV testing uptake, men (%) | 2013 | 4,803 | 92.2% | 89.7% | 84.9% | 58.4% | | 95.9% |
| HIV testing coverage, MSM (%) | 2013 | 820 | 86.0% | 86.6% | 86.1% | 63.3% | | 100% |
| HIV testing coverage, women (%) | 2013 | 4,614 | 66.5% | 67.8% | 65.6% | 26.0% | | 85.2% |
| HIV testing coverage, men (%) | 2013 | 4,162 | 79.8% | 80.6% | 77.5% | 50.6% | | 86.9% |
| Percentage of adults (aged 15 or above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (PHOF indicator 3.04) | 2010 - 12 | 73 | 54.5% | 44.9% | 48.3% | 0.0% | | 80.0% |



| Indicator | Period | Barnet | | Region | England | England | | England |
|---|---|---|---|---|---|---|---|---|
| | | Count | Value | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| Abortions under 10 weeks (%) | 2013 | 1,301 | 83.8% | 82.9% | 79.4% | 55.6% | | 87.4% |
| Under 25s repeat abortions (%) | 2013 | 169 | 30.1% | 32.6% | 26.9% | 49.2% | | 13.9% |
| Total abortions rate / 1,000 | 2013 | 1,624 | 19.9 | 22.8 | 16.6 | 32.4 | | 9.0 |
| GP prescribed LARC rate / 1,000 | 2013 | 1,582 | 19.4 | 25.1 | 52.7 | 7.5 | | 96.3 |
| GP prescribed LARC rate / 1,000 (old version - PCT based) | 2012/13 | 1,610 | 18.0 | 23.2 | 49.0 | 6.2 | | 99.4 |
| Pelvic inflammatory disease (PID) admissions rate / 100,000 | 2012/13 | 120 | 146.8 | 217.6 | 228.3 | 693.9 | | 70.9 |
| Ectopic pregnancy admissions rate / 100,000 | 2012/13 | 96 | 117.4 | 118.5 | 94.7 | 173.1 | | 14.0 |
| Cervical cancer registrations rate / 100,000 | 2009 - 11 | - | 7.0 | 6.7 | 8.8 | 17.4 | | 3.0 |
| Under 18s conception rate / 1,000 (PHOF indicator) | 2012 | 91 | 14.7 | 25.9 | 27.7 | 52.0 | | 14.2 |
| Under 16s conception rate / 1,000 (PHOF indicator) | 2012 | 16 | 2.6 | 4.4 | 5.6 | 15.8 | | 2.0 |
| Under 18s conceptions leading to abortion (%) | 2012 | 64 | 70.3% | 62.2% | 49.1% | 27.3% | | 79.5% |
| Under 18s abortion rate / 1,000 | 2012 | 64 | 10.3 | 16.1 | 13.6 | 7.1 | | 25.8 |
| Under 18s birth rate / 1,000 | 2012 | 27 | 4.4 | 9.8 | 14.1 | 3.0 | | 33.8 |

AGENDA ITEM 10

# Health Overview and Scrutiny Committee

## 13 October 2015

| | |
|---|---|
| **Title** | **Joint Strategic Needs Assessment and draft Joint Health and Wellbeing Strategy** |
| **Report of** | Director of Public Health<br>Commissioning Director Adults and Health |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | Non-key |
| **Enclosures** | Appendix 1: Barnet's Joint Strategic Needs Assessment (2015 – 2020)<br>Appendix 2: Joint Strategic Needs Assessment (2015 – 2020) Executive Summary<br>Appendix 3: Draft Joint Health and Wellbeing Strategy (2016 – 2020) |
| **Officer Contact Details** | Luke Ward, Commissioning Lead, Entrepreneurial Barnet,<br>Email: luke.ward@barnet.gov.uk, Tel: 020 8359 2672<br><br>Zoë Garbett, Commissioning Lead, Health and Wellbeing<br>Email: zoe.garbett@barnet.gov.uk, Tel: 020 8359 3478 |

## Summary

This report contains Barnet's Joint Strategic Needs Assessment (JSNA) 2015 – 2020 (Appendix 1). The JSNA has been recently updated and was agreed by the Health and Wellbeing Board on 17 September 2015. Using the JSNA as an evidence base, the Borough's Joint Health and Wellbeing Strategy has been updated (Appendix 3). The Joint Health and Wellbeing Strategy is currently out for public consultation prior to final consideration and approval by the Health and Wellbeing Board on 12 November 2015.

# Recommendations

1. **That the Committee comment on how the JSNA could be used to inform council and public sector decision making in Barnet, and recommend any topics where additional future research into population-level need may be required.**

2. **That the Committee comment on the proposed vision, priorities and actions contained in the draft Joint Health and Wellbeing Strategy**

## 1. WHY THIS REPORT IS NEEDED

### 1.1 Background

1.1.1 In November 2014 the Health and Wellbeing Board commissioned a refresh of the 2011 Joint Strategic Needs Assessment (JSNA), to inform the development of a new Joint Health and Wellbeing Strategy (JHWB Strategy)

1.1.2 Producing and publishing a JSNA is a legal requirement of the Public Involvement in Health Act (2007). Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint duties to prepare JSNAs and JHW Strategies, through the Health and Wellbeing Board

### 1.2 What is the JSNA?

1.2.1 The JSNA is the evidence base for understanding population-level need in Barnet. It has been designed to inform joined up, evidence-based decision making and commissioning of the Barnet Health and Wellbeing Board, Barnet CCG, social care, public health, the wider public and voluntary sectors, and providers.

### 1.3 Using and maintaining the Barnet JSNA

1.3.1 The 2015-2020 JSNA is somewhat broader than the 2011 JSNA. The vision from the outset has been that **it should focus on being a commissioning evidence base for decision making in Barnet**, with a deeper level of member and senior officer engagement and ownership than was the case previously. The intention is that this will inform and help facilitate both the delivery of the Health and Well Being Strategy and the leadership-level discussions that will be taking place over the coming years around closer alignment and developing a different model of commissioning and delivery that focuses on longer-term demand management and early intervention across organisational boundaries.

1.3.2 A number of broad principles were applied from the outset to guide the development of the JSNA. These were that it:

1. Focuses on **demand management, prevention and early intervention**
2. **Uses existing data only, with no primary data collection.** Where data we want in the JSNA does not exist or is not accessible this has been logged to be followed up or commissioned at a later date if required.
3. In addition to identifying need over the next 3-5 years, **looking ahead 20-30 years to identify longer-term trends and needs** that will have implications for public sector decision making.

4. Aligns with and **support existing and more specific service-level needs assessments e.g. for mental health**
5. Is **a dynamic way of working, not a static document** e.g. via a new JSNA "micro-site" which will be updated and refreshed on an ongoing basis.
6. **Provides non-political, impartial analysis** with no recommendations about priorities (which is the function of the Health and Well Being Strategy), only identification of need and differential outcomes.

1.3.3 Alongside the written "paper" JSNA that is contained in Appendix 1, **there will be an accompanying online JSNA "microsite" that will be updated regularly and be accessible to (and be owned by) both council and NHS commissioners,** and the public more widely. The Microsite would be branded jointly and equally with London Borough of Barnet (LBB) and Barnet CCG logos.

1.3.4 The intention is that the website would be updated on a rolling basis by officers across Barnet CCG and Barnet Council, for instance to reflect significant new analysis of identified needs. The website would also be the repository of all more detailed service-level needs assessments (where it is appropriate for these to be in the public domain), for instance relating to mental health or pharmaceutical needs. The day to day operation and maintenance of the website would be undertaken by the Public Health Team on behalf of the Health and Well Being Board.

1.4 **Methodology**

1.4.1 The approach to developing the JSNA to date has a number of characteristics make it different from the 2011 JSNA:

1. **Focus on developing ownership** at senior level across LBB and Barnet CCG, alongside the actual analytical work. Emphasis throughout that we have collectively contributed to and own the JSNA and the analysis it contains.
2. **Co-production** - the majority of the JSNA has been produced outside of the council's Commissioning Group with the support of officials in the CCG and other council service areas.
3. Focus has been on **identifying top-level strategic needs for decision makers** that are grounded purely in insight and evidence. De-emphasis on simple descriptive statistics that do not correspond to a specific identified need, and are therefore of lower value to commissioners.
4. **Clear messages communicated to partners about of the Strategic function of the JSNA**, not just as a "nice-to-have" evidence base, but as a plank for aligned strategic commissioning and priority setting across Barnet and through the Health and Well Being Board e.g. potentially to inform LBB Corporate Plan and demand pressures, CCG operational plans etc.
5. **Supporting the Health the Wellbeing Board, CCG and Council jointly agree the shape and needs in the population.** Enabling more detailed discussions in the future about co-commissioning of services, aligned priorities, and addressing cost-shunting between health and social care (either way).

1.5 **Contents of the JSNA**

1.5.1 The JSNA contains twelve sections that have been designed to cover the determinants of health and wellbeing, and to provide analysis that is directly relevant to commissioners and decision makers across the health and social care system. The sections are:

1. Demography
2. Socio-economic and environmental context
3. Barnet population segments
4. Health
5. Lifestyle
6. Primary and secondary care
7. Children and young people
8. Adult social care
9. Community safety
10. Community assets
11. Residents voice
12. Public sector finances

1.6 **What is a Joint Health and Wellbeing Strategy**

1.6.1 The Joint Health and Wellbeing (JHWB) Strategy sets out the priorities for Barnet's Health and Wellbeing Board, with the aim of improving health and wellbeing for all Barnet residents. The priorities within the Strategy are based on the evidence provided by the JSNA and reflect feedback from consultation.

1.6.2 The JHWB Strategy refresh was offered an opportunity to review and improve the focus of the HWBB and its partners.

1.6.3 Key features of the JHWB Strategy refresh have been -

- Focus on specific areas of highest impact
- A plan that drives partnership working; health and wellbeing is everyone's business and responsibility
- Added value to current plans and strategies and becomes a guiding document of the work of the HWBB and its partners

1.7 **Work to date**

1.7.1 The current Health and Wellbeing Strategy has been reviewed in light of the JSNA 2015-2020 refresh, local strategies (current and draft), national guidance and policy and discussions with Barnet Council, Barnet Clinical Commissioning Group (BCCG), Healthwatch and the 5 Partnerships Boards (Older People's Partnership Board; Mental Health Partnership Board; Learning Disabilities Partnership Board; Carers Strategy Partnership Board; Physical and Sensory Impairments Partnership Board) which are made up of service users, carers and voluntary and community sector organisations.

1.7.2 The aims of the updated are Strategy –

- Keeping well

- Promoting independence

1.7.3 The current Strategy has four themes; the four themes have been retained with updated priorities. Each section of the Strategy (appendix 3) highlights activity since the last Strategy, key data from the updated JSNA, planned activity to meet our objectives in the area as well as targets. The table below gives an overview of each section –

| **Vision** | To help everyone to keep well and to promote independence | | | |
|---|---|---|---|---|
| **Themes** | Preparation for a healthy life | Wellbeing in the Community | How we live | Care when needed |
| **Objectives** | Improving outcomes for babies, young children and their families | Creating circumstances that enable people to have greater life opportunities | Encouraging healthier lifestyles | Providing care and support to facilitate good outcomes and improve user experience |
| **What we will do to achieve our objectives** | Focus on early years settings and supporting parents especially older and first time mothers | Focus on improving mental health and wellbeing for all | Focus on reducing obesity through promoting physical activity | Focus on identifying carers and improving the health of carers (especially young carers) |
| | | Support people to gain and retain employment work and promote healthy workplaces | Assure promotion and uptake of screening (breast cancer and cervical cancer) and the early identification of disease | Work to integrate health and social care services |

1.8 **Consultation**

1.8.1 A number of engagement and consultation events have taken place already to inform the draft JHWB Strategy including discussions with Barnet's Youth Board, the Partnership Boards, Barnet's Safeguarding Boards, Healthwatch and colleagues at Barnet Council and BCCG.

1.8.2 The Strategy is currently out for public consultation which runs until the 25 October. The consultation aims to gain the views of partners, colleagues and

residents on the draft JHWB Strategy. The consultation includes an online feedback form promoted through a number of channels including CommUNITY Barnet, Healthwatch, Patient Participation Groups, Barnet's Communication team, local events and organised visits and meetings to specific groups such as schools and the Practitioner's Forum. The consultation can be found here - You will find the online consultation on Barnet Council's Engage Space - https://engage.barnet.gov.uk/commissioning-group/joint-hwb-strategy-2016-2020

1.8.3 Feedback from the consultation will inform the final JHWB Strategy 2016-2020 and will be reported to the Health and Wellbeing in November with the final Strategy.

## 2. REASONS FOR RECOMMENDATIONS

2.1.1 The recommendations provide the Committee with the opportunity to highlight issues of interest from the updated JSNA and make comments about the content of the draft JHWB Strategy.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

## 4. POST DECISION IMPLEMENTATION

4.1 The recommendations made by the Committee will be taken forward. The JSNA comments will be consider as areas of focused are developed and the comments on the Strategy will be incorporated into the final document.

## 5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The JSNA supports evidence-based decision making across the Health and Wellbeing Board and partners. The JSNA informs the priorities set out in the Health and Wellbeing Strategy.

5.1.2 The JHWB Strategy supports evidence-based decision making across the Health and Wellbeing Board and its partners. The JHWB Strategy has been developed to align and bring together national and local strategies and priorities including Barnet Council's Corporate Plan 2015-2020 and BCCG's strategic plans.

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

5.2.1 The JSNA is simply an evidence base to inform local priorities and commissioning decisions. The JSNA does not say which areas resource should be committed to, which is the function of the Health and Well Being Strategy. The JSNA will support work to focus on improving the health and wellbeing of the population, and on placing emphasis on effective and evidence-based demand management activity and so will indirectly support

improved public sector efficiency and reducing demand for public resources as people live healthier lives.

5.2.2 The JSNA website that is being developed alongside the written analysis is being developed jointly by LB Barnet and Barnet CCG, and will be completed by December 2015.

5.2.3 The JHWB Strategy directs the Health and Wellbeing Board priorities for the period 2016 – 2020, building on current strategies and focusing on areas of joint impact within current resources towards sustainability. The priorities highlighted in the Strategy will be considered by organisations when developing activities. The Strategy will support the work of all partners to focus on improving the health and wellbeing of the population and places emphasis on effective and evidence-based distribution of resources for efficient demand management. Each project will be individually funded however, using the existing resources of the participating organisations.

5.3 **Social Value**

5.3.1 The JHWB Strategy focuses on health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of addressing wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing. The JHWB Strategy will inform commissioning.

5.3.2 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 Producing a JHWB Strategy is a legal requirement of the Public Involvement in Health Act (2007). Local authorities and CCGs have equal and joint duties to prepare JSNAs and JHWSs, through the Health and Wellbeing Board.

5.4.2 The Terms of Reference of the Health Overview and Scrutiny Committee are set out in the Council's Constitution (Responsibility for Functions; Annex A) and has following responsibilities:

- To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.
- To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

- To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, Health Watch and/or other health bodies.
- To scrutinise and review promotion of effective partnerships between health and social care, and other health partnerships
- in the public, private and voluntary sectors.

5.5 **Risk Management**

5.5.1 There is a risk that if the JSNA and therefore JHWB Strategy is not used to inform decision making in Barnet that work to reduce demand for services, prevent ill health, and improve the health and wellbeing and outcomes of people in the Borough will be sub optimal, resulting in poorly targeted services and avoidable demand pressured across the health and social care system in the years ahead.

5.6 **Equalities and Diversity**

5.6.1 The JHWB Strategy has used evidence presented in the JSNA to produce an evidence based resource which has equalities embedded at its core, explicitly covering the current and future needs of people in Barnet from each equalities group and socio-economic background relevant to Barnet.

5.6.2 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to 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. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.7 **Consultation and Engagement**

5.7.1 Then JSNA development process has involved engagement with a wide range of partners, services, and organisations including Barnet CCG, Barnet council, CommUNITY Barnet, and Barnet Health Watch. Contributions towards it have been made by over 40 individual experts covering the key areas of activity in all these organisations.

5.7.2 The emerging findings of the JSNA have been tested with a range of internal and external groups to ensure they are focusing on the right areas and that different partners have some ownership of the final JSNA. Service users were engaged with and views sought at the Barnet Partnership Summit on 9 July 2015. In total the JSNA findings so far have been presented to and tested with over 160 partners, officers, and board members between May and July 2015.

5.7.3 See point 1.8. A number of partners have been involved in the development of the JHWB Strategy and a public consultation is currently underway ahead of the final JHWB Strategy being produced in November.

5.8 **Insight**

5.8.1 The JSNA is an insight document and pulls together data from a number of

sources including Public Health Outcomes Framework, GLA population projections, Adults Social Care Outcomes Framework and local analysis. The Joint HWB Strategy has used the JSNA as an evidence base to develop priorities.

## 6. BACKGROUND PAPERS

6.1 Draft Joint Strategic Needs Assessment (JSNA) and emerging priorities for the Health and Wellbeing Strategy, Health and Wellbeing board, 30 July 2015, item 6:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8382&Ver=4

6.2 Health and Wellbeing Priorities for 2015 – 2020, Health and Wellbeing board, 13 November 2014, item 7:
https://barnet.moderngov.co.uk/documents/s19164/Health%20and%20Well-Being%20Priorities%20for%202015-20.pdf

6.3 Joint Strategic Needs Assessment 2015 – 2020, Health and Wellbeing Board, 17 September 2015, item 6:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8384&Ver=4

6.4 Draft Joint Health and Wellbeing Strategy, Health and Wellbeing Board, 17 September 2015, item 7:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8384&Ver=4

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# Barnet's Joint Strategic Needs Assessment

*2015-2020*

# Foreward

The production of the Joint Strategic Needs Assessment is one of the most important responsibilities of the Barnet Health & Wellbeing Board - the Board which brings together the most senior Members and Officers of the Council and the local NHS together with Healthwatch and NHS England to collaborate and work together to improve health and wellbeing in Barnet.

We can only do this - and try to ensure at the same time that all of our very many and varied local communities enjoy not only longer lives but healthier and happier lives - if we all have a clear evidence base and shared understanding of the needs of people in Barnet and this JSNA provides that base.

It has been developed as a truly shared endeavour with just the right balance achieved between professional analysis and extensive engagement with both individuals and a wide variety of organisations across the Borough - thereby ensuring its credibility as an impartial, high quality and up-to-date base for decision making.

I would like to thank the wide range of professionals and experts from Barnet Council, Barnet Clinical Commissioning Group and Healthwatch, as well as other partners and everyone else involved in the production of this excellent, reasoned, relevant and readable JSNA. It will be invaluable in formulating our Health & Wellbeing Strategy as well as supporting alignment across the public sector in Barnet and ensuring that every penny of public money is spent effectively and efficiently to improve health and wellbeing in Barnet.

Councillor Helena Hart
Chairman, Barnet Health and Wellbeing Board

The development of the Joint Strategic Needs Assessment has been a very important undertaking in ensuring that the Health and Wellbeing Board and local partners have a true appreciation and understanding of the health and social care needs of our population in Barnet.

Working collaboratively to co-produce this strategy has proved enormously beneficial because the output is a high quality document which enables us to, not only set out our priorities for the borough, but also explore new opportunities and find solutions to existing challenges. In addition I think that it is written in a way that is interesting and accessible to all.

I am pleased to have been a part of this significant piece of work, and along with the Chairman, would like to thank the various stakeholders and partners who have made valuable and lasting contributions to the JSNA.

Dr Debbie Frost
Vice Chair, Barnet Health and Wellbeing Board

# Acknowledgements


## JSNA Delivery Team

| | |
|---|---|
| Luke Ward | London Borough of Barnet (Commissioning Group) |
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Thanks also to members of the Health and Wellbeing Board for their clear guidance and engagement throughout the development of the JSNA, and to many other experts across the Health and Wellbeing partnership too numerous to mention individually for their contributions.

# CONTENTS

# Barnet's JSNA 2015 – 2020

# Executive Summary

## Structure



## 1. Demography

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases more in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by natural change in the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% BAME backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a BAME background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less than the average for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth 78.8 years.**
- The west of the Borough has the highest concentration of more deprived LSOAs, with **the highest levels of deprivation in Colindale, West Hendon**

**and Burnt Oak**. However, the **most deprived LSOA in Barnet is located in East Finchley, specifically the Strawberry Vale estate**, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst both men and women. **As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Some areas, particularly Golders Green, Colindale and Mill Hill, will get younger, bucking the trend of an ageing Borough.

## 2. Socio-Economic and Environmental Context

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently, the significant majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established community and family networks locally.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.

- **There are shortages of people available to fill vacancies in the caring, leisure and services sector, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.
- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

## 3: Health

- Barnet is healthy borough overall. Coronary Heart Disease is the number one cause of death amongst men and women. **As male life expectancy continues to catch up on and converge with women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- **There is an 8 year difference in male life expectancy between Burnt Oak and Garden Suburb wards.** Bigger differences exist at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Smoking, diet and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is the case.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **Smoking is less prevalent in the Borough than the national average. However, women in Barnet are significantly less likely to quit smoking in pregnancy** than women on average in London.

- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later in life.** Particularly HPV, flu and pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.
- **Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate** and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

## 4: Lifestyle

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost to the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill, and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet, although the Borough is the 20$^{th}$ lowest borough in England in terms of the rate of high-risjk drinkers.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England,** and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.
- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing**

**interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy**, and **good parenting classes**.

## 5: Primary and Secondary Care

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in such hospital.
- **There is increasing demand for urgent and emergency care,** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **The 95% national target for Accident and Emergency (A&E) patients waiting no longer than four hours from the time of booking in to either admission to hospital or discharge** was missed in quarter 4 14/15 (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- **Obesity growth in middle-age population** (45-65) year olds places additional risk of them developing long-term conditions.

## 6: Children and Young People

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and minimise referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably west);** targeted multi-agency, locality based interventions could better support families.

- **The Young Carers Act and Children and Families Act 2014** represent significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**
- The number of post-16 pupils remaining in special schools is placing **pressure on the availability of places for admission of younger pupils.**
- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing.** However, there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years and 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.
- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 14/15, averaging 5 or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

## 7: Adult Social Care

- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- **Mental disorder** is responsible for the **largest burden of disease in England** – 23% of the total burden. Within Barnet, by far the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently** and **within the community** as possible. This places significant pressure on ensuring that the right services such as **appropriate housing and support needs** are available to **meet their requirements**.

- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, local based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in **elderly women who live alone**, especially in **areas of higher affluence and lower population density.**
- **Demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people, 3.3% of the 65 and over population**, which indicates a **deficiency or potential unmet need of around 800 people.**
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average **carers are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.
- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021, the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

## 8: Community Safety

- **Barnet has the 5th highest rate of Residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to Feb 2014. When considering underreporting the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the 12 months.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to address possible underreporting.

- **Despite constituting just 6.5% of offences, violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs.**
- **Domestic violence is more familiar and bedded down within some services and organisations than other Violence Against Women and Girls (VAWG) issues**; further work needs to take place to identify if additional VAWG services are needed within the Borough.

## 9: Community Assets

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with VCS groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is, however, the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).
- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. However, there **is weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- More generally, there are opportunities to:
  - **support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).

- **rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**
- respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be better engaged with to deliver health and wellbeing outcomes.

## 10: Resident Voice

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and** '**Repair of roads' as being poor or extremely poor services** provided by the council.
- The **top three concerns** for residents according to the spring 2015 Residents' Perception Survey were '**Conditions of roads and pavements (38%); Lack of affordable housing (33%); and Crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live, whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

# 1 Introduction

## 1.1 What is the JSNA?

This refreshed Joint Strategic Needs Assessment (JSNA) is the evidence base for understanding population-level need in Barnet. It has been designed to inform joined up decision making and commissioning by the Barnet Health and Wellbeing Board, Barnet CCG, social care, public health, the wider public and voluntary sectors, and private sector service providers.

The intention is that by having a shared understanding of the size and nature of Barnet's residents in one place that focuses on 1) the needs of the population, irrespective of organisational or service boundaries, 2) areas of common interest and 3) reducing demand for public resources, the JSNA will act as a tool to help partners come together to share expertise and resources to improve the prospects of people living here. It will also ensure that every penny of public money is used as efficiently as possible and with maximum positive impact.

A large number of officers, analysts and service users have been involved with developing the refreshed JSNA across the CCG, the Council and CommUNITY Barnet between January 2015 and July 2015, requiring a significant focus on partner engagement, communications and expectations setting, alongside high quality multi-disciplinary analytical work to actually write the JSNA documentation.

This balance between engagement at a senior level and analysis has been a critical part of developing a successful JSNA because it has:

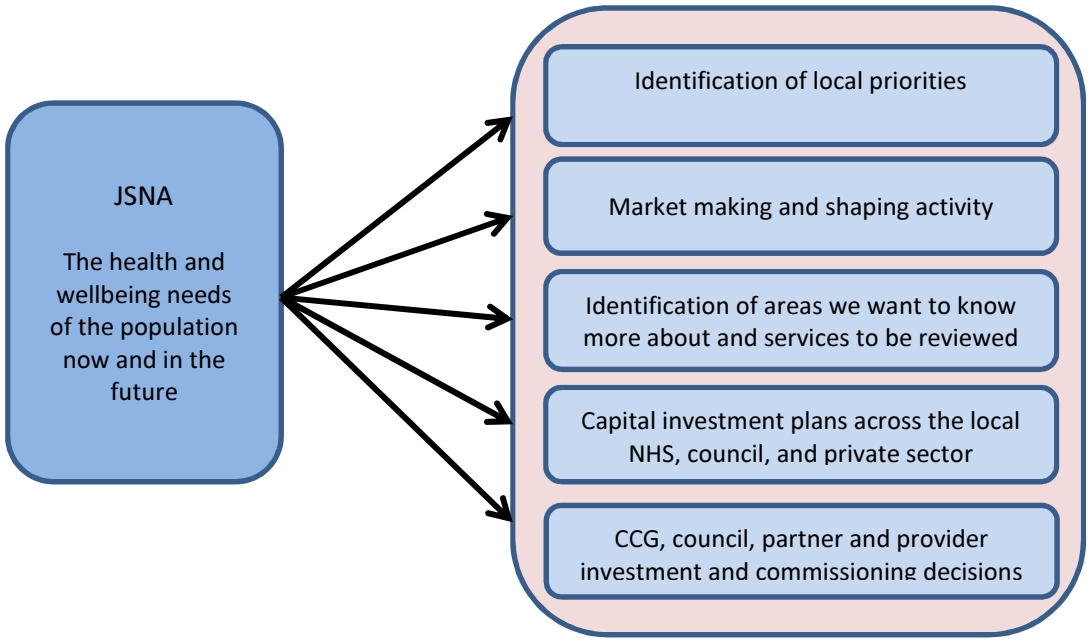
1. allowed the JSNA team to tailor the content to reflect what local partners want, value, and consider important
2. resulted in a JSNA that has credibility locally as an impartial, high quality, and up-to date evidence base for effective and joined up decision making across all sectors.

## 1.2 Purpose of the JSNA

The purpose of a JSNA is to allow local partners to improve the health and wellbeing of the population and to reduce inequalities for all groups, leading to reduced demand for public services and better lives for people who live in Barnet. It does this by acting as a common, shared evidence base across partners in the Health and Well Being Board and wider public services, enabling alignment of activity and resources around common issues and needs.

There is an opportunity in the JSNA to use it to ensure that public services more broadly are supporting the wellbeing of the population in a more joined up way. For example, to ensure that sports centres, parks and open spaces, employability and apprenticeship schemes, and use of community assets are explicitly targeting their services at those groups in the population who stand to benefit most from using them.

***Figure 1: How to use the JSNA***




## 1.3 Principles

It is important that the JSNA does more than just describe statistics and information relating to the Borough's population. To add real value it is important that it aligns with and informs the big strategy decisions that need to be made across the public sector, including health and social care, over the next five years. With this in mind **the following principles have been developed to guide the development of the JSNA**.

This Barnet JSNA will:

1. **Focus on prevention, early intervention and demand management:** Delivering better outcomes for individuals and communities whilst also meeting the challenges of scarce public resources means that it is more important than ever to encourage and support all residents to live longer, healthier, happier lives that are free of long-term conditions and illness. With that in mind, every section of this JSNA is based around understanding the root drivers of need for different services and providing commissioners across the public sector with the intelligence and insight they need to address them and to reduce long term demand for things like hospital beds, social care, and mental health services.
2. **Identify shared agendas across public services:** The nature of JSNA as a joint evidence base means that the issues it focuses on should be cross-cutting "shared" agendas by definition. For example, mental health, carers, and long-term conditions. Crucially though, it also includes any early intervention opportunities that evidence shows can reduce the probability of an individual developing higher needs later on in life such as child immunisations and promoting good dental health in children, good parenting classes, quality housing, improving the effectiveness of smoking cessation activity, and promoting healthy lifestyles. The JSNA supports different agencies to

identify the links between different service areas, keeping the person at the centre of care irrespective of who is providing it.

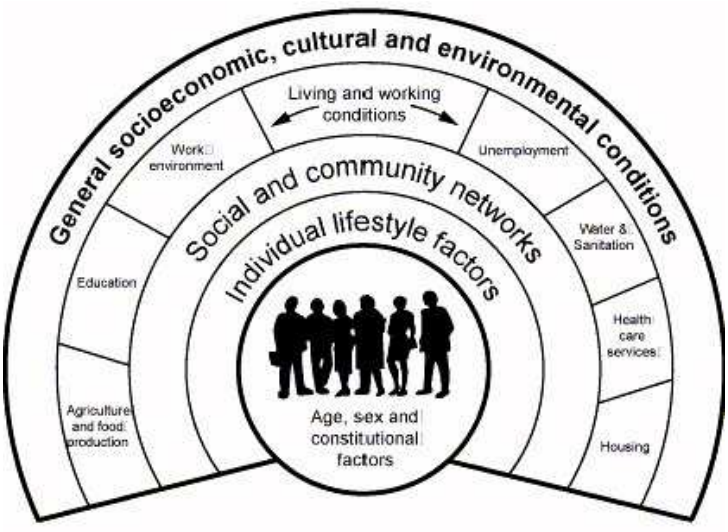
3. **Use existing data only:** There has been no primary data collection associated with this JSNA, which only includes insight and analysis that already exists in the Public Sector. This reflects the fact that analyst time is increasingly valuable and scarce, but also the huge amount of information that already exists in the Barnet public sector and which could be used more effectively to inform decision making than has always been the case in the past.
4. **Look ahead up to 20 years:** As well as looking at the more current needs of the population over the next 3-5 years, this JSNA adopts a more strategic time horizon of up to 20 years, enabling a longer term approach to prevention, early intervention and demand management than has always been the case in the past. This approach is prudent given the long-term increase in population level demand and continued constraints on resources that we know will be a feature of strategy and decision making for the foreseeable future.
5. **Support and align with existing service-level needs assessments:** The JSNA draws on the significant amount of high quality needs assessment that has already been undertaken by the Council and the CCG, for example relating to mental health, special educational needs (SEN) and parks and green spaces. What the JSNA does is contextualise these and draw connections between them at a more strategic level, as well as makes their findings available to a wider audience of commissioners, members, and strategic decision makers.
6. **Be a way of working, not a document or product:** The JSNA will be updated as required over the coming years. In particular, the new Barnet JSNA micro-site will be updated with current analysis as soon as it is available and interpreted for commissioning purposes. This will reduce the risk of the JSNA losing its usefulness as the data within it becomes increasingly out of date.

## 1.4 Theoretical underpinnings

The focus on prevention, early intervention and demand management embedded across the JSNA requires a broad view of health and wellbeing that accounts for the wider socio-economic factors affecting the health and happiness of individuals and communities now and in the future.

This JSNA uses Dahlgren and Whitehead's Model of Health and Well Being as its theoretical basis, and incorporates not only the important lifestyle and health behaviours of the population, but also wider issues such as employment, volunteering, crime, and housing because all the evidence tells us that these issues are important to engage with if we want to improve health and wellbeing for the population and reduce demand for scarce public resources:

Figure 1: *Dahlgren and Whitehead's model of the wider determinants of health*




## 1.5 Structure of the JSNA

The JSNA consists of a written document and an interactive, constantly updated website that has been designed to be accessible and useful to residents, elected members, commissioners, and providers. The written JSNA consists of the following sections, with connections made between them in the analysis where relevant:

1. Demography
2. Socio-economic and environmental context
3. Barnet Customer Segments
4. Health of the population
5. Lifestyle
6. Primary and Secondary Care
7. Children and Young People
8. Adult Social Care
9. Community Safety
10. Community Assets
11. Resident voice
12. Public Sector Finance

## 1.6 Who should use the JSNA?

The JSNA is a public, published document and is available to anyone who wants to understand the local population and its associated needs and trends. There are a number of specific groups who will either need or want to use the JSNA to inform priority setting and strategic commissioning, or to shape the targeting and delivery of front-line services at the areas of highest population need:

- Barnet Health and Well Being Board members
- Elected members
- NHS Clinical Cabinet Board members
- Senior officers
- commissioners
- Providers who want to develop services to be commissioned by the Barnet public sector
- Strategic planners who want to understand and plan for future demand pressures
- Voluntary and Community Sector organisations

## 1.7 Methodology

The JSNA contains a wide range of data from national and local sources, and where possible this has been benchmarked against other areas and put into time series so that the major trends in Barnet can be understood over time and compared.

The JSNA was developed in four distinct phases:

1. *SCOPING (January-February 2015)*
2. *DATA COLLECTION (February – March 2015)*
3. *ANALYSIS, DRAFTING, VALIDATION, TESTING INTERNALLY (April – June 2015)*
4. *BOARD AND PARTNER ENGAGEMENT AND FINALISATION (July – September 2015)*

## 1.8 Alignment and Strategic fit

From the outset the JSNA has been designed to support and inform the wider strategic agendas of the Barnet public sector, in particular:

- Barnet's Health and Well Being Strategy
- Barnet CCG's Operational Plan
- Barnet Council Corporate Plan 2015-2020
- Service planning and management agreements across Barnet CCG and Barnet Council
- More holistic, cross-boundary "place-based" commissioning
- A strategic shift to long-term prevention and early intervention across the Barnet public sector
- Acts as the Borough's Child Poverty Needs Assessment
- Development of a wider "ecosystem" approach to developing the Barnet supply chain, in particular making greater use of the large network of established voluntary and community groups in the Borough to deliver improved health and wellbeing outcomes for people in Barnet.

## 1.9 Caveats

Whilst every effort has been made to ensure that the Barnet JSNA is as accurate and up to date as possible, having undergone an extensive process of validation and proofing with contributors, it remains important to note a number of caveats:

- The project team and contributors have tried hard to ensure high data quality throughout, but where errors or inaccuracies are identified they will be logged and corrected.
- Where there are gaps between what we want to know and what data/insight we have this has been highlighted in section 1.10 below so that work can be commissioned to fill them if identified as a priority by commissioners and decision makers.
- The JSNA is by its nature a broad piece of work; however it can't be everything to all people. It should align with and complement more detailed service-level needs assessments produced by individual service areas across the public sector, but does not replace them because the level of detail they contain will in some cases be more appropriate for detailed service-level planning than the JSNA.

## 1.10 Further Research

Areas of possible future research have been identified throughout the development process:

- Understanding the specific impacts of reduced home ownership on the long-term financial viability of social care.
- More work is needed to determine the prevalence and needs of young carers within the Borough.
- Further research is needed to understand why Barnet has a significantly higher rate of mental health admissions to hospitals for young people than the national average.
- More work is needed to better understand which areas in the community might be disproportionately affected by Violence Against Women and Girls (VAWG) issues, to establish if there a need for any additional VAWG services within the Borough.
- Understanding the drivers behind the growing income inequality between different wards in the Borough.
- Further research is needed to model the future demand pressures in Barnet associated with increases in the incidence of dementia.
- Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand what is driving this.
- Additional research is needed to develop a better understanding of the level and type of needs of people with learning disabilities and autism.
- More research is needed to understand why there are significantly fewer men aged 65 and over using Adult Social Care services than women.

- Additional work is needed to understand and quantify the impact that different services and support has on a carer's ability to perform their role, achieve their outcomes, and impact their overall health and wellbeing.
- Further research is needed to understand the impacts of educational outcomes for those with learning disabilities on their long-term health and wellbeing outcomes.

# 2 Demography

## 2.1 Key Facts

- The most recent population projections indicate that the population of Barnet will be 367,265 by the end of 2015.
- The overall population of Barnet will increase by 13.7% between 2015 and 2030, taking the population to 417,573.
- The number of people aged 65 and over is projected to increase by 34.5% by 2030, over three times greater than other age groups.
- The Barnet population is projected to become increasingly diverse, with the Black, Asian and Minority Ethnic population projected to increase from 38.7 to 43.6% of the total Barnet population.
- By religion, Christianity is the largest religion in Barnet accounting for 41.2% of the total population. The next most common religions are Judaism (15.2%) and Islam (10.3%).
- Barnet is an attractive place for international migrants, with the GLA estimating a net international net migration into Barnet of almost 50,000 over the period 2002 – 2013.

## 2.2 Strategic Needs

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by growth within the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% Black, Asian and Minority Ethnic backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a Black, Asian and Minority background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth of 78.8 years. For the slightly different measure of life expectancy from 65 years old, Coppetts has the lowest life expectancy of 18.0 years, which equates to 83 years old**.
- The west of the Borough has the highest concentration of more deprived Lowest Super Output Areas (LSOAs)[1], with **the highest levels of deprivation in Colindale, West Hendon**

[1] A Lower Layer Super Output Area (LSOA) is a GEOGRAPHIC AREA. Lower Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

**and Burnt Oak**. However, the **most deprived LSOA in Barnet is located in East Finchley, specifically the Strawberry Vale estate**, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst men and women. **As male life expectancy continues to converge with women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Driven by regeneration within the Borough, some areas will get younger, bucking the trend of an ageing, different health and wellbeing needs.

## 2.3 Population Structure

The 2013 round of GLA ward level projections, estimated the population of Barnet to be 367,265 by the end of 2015, making it the most populous Borough within London.

Table 2-1 shows the annual population growth within Barnet since the 2001 Census. The population of Barnet has grown by 14.9% (47,765).

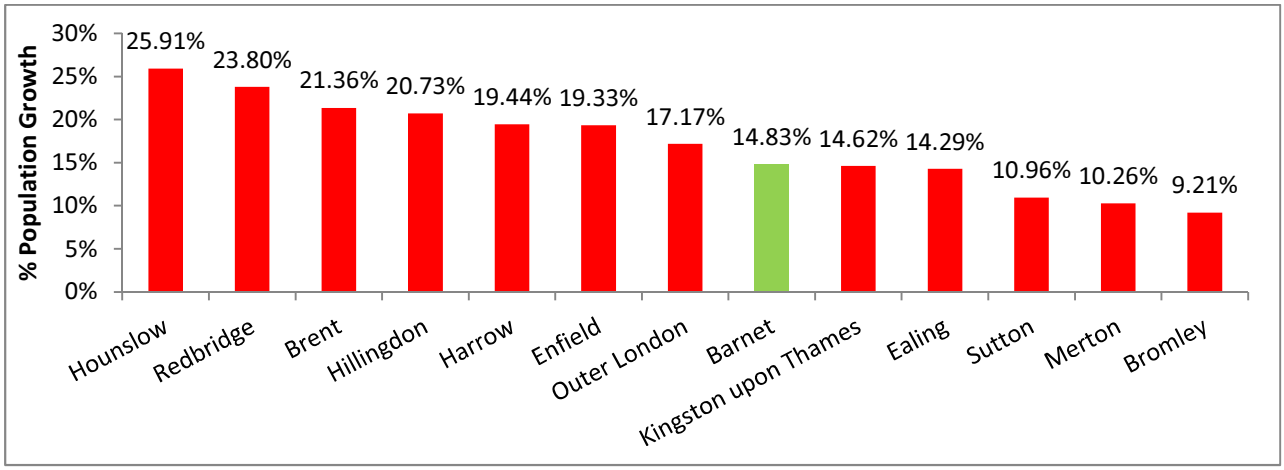
**Table 2-1: Barnet Population Growth, 2001 – 2015**

| Year | Total Population |
|---|---|
| 2001 | 319,500 |
| 2002 | 320,500 |
| 2003 | 321,800 |
| 2004 | 323,700 |
| 2005 | 327,500 |
| 2006 | 330,800 |
| 2007 | 334,900 |
| 2008 | 339,200 |
| 2009 | 345,800 |
| 2010 | 351,500 |
| 2011 | 357,500 |
| 2012 | 363,958 |
| 2013 | 361,504 |
| 2014 | 364,481 |
| 2015 | 367,265 |

Source: ONS Vital Statistics Table 4 and Nomis Labour Market Profile

Figure 2-1 shows the population growth for Barnet, compared against statistical neighbours – outlined in the chart - and the Outer London average. Barnet experienced a slower rate of growth compared to the Outer London average which grew by 17.17% between 2001 and 2015. When compared against statistical neighbours, Barnet had the sixth lowest rate of growth, whereas Hounslow had the highest growth of 19.6%.

**Figure 2-1: Population Growth, 2001 – 2015 (Barnet, Statistical Neighbours, and Regional)**




Source: Census 2001 and GLA Projections 2013 (Preferred Option Projections)

## 2.4 Population Growth

Table 2-2 shows the 2013 based population projections from the GLA. These projections provide an indication of the future size of the Barnet population, if current trends in fertility, mortality and migration continue.

The projections suggest that between 2015 and 2021, the population of Barnet will continue to grow by 6.6% reaching 391,472[2], an increase of 24,207 people. This is close to the same growth as Outer London, which is projected to see experience a rise of 6.4% in the population. Between 2021 and 2030 the rate of growth will begin to slow, although the population will continue to rise by a further 6.7% to 417,753.

[2] Projections used within this report are taken from the 2013 GLA Borough Preferred Option Projections. These are based on Barnet's actual future development plans that have been provided by LBB to the GLA. The GLA produces a variety of different projections, additional information on these can be found here https://londondatastore-upload.s3.amazonaws.com/jYs%3Dtechnical-note-guide-gla-popproj-variants.pdf

**Table 2-2: Population Projections 2015, 2021 & 2030 (Barnet and Outer London)**

| Year | Barnet | | Outer London | |
|---|---|---|---|---|
| | Total Population | % Growth (Compared to 2015) | Total Population | % Growth (Compared to 2015) |
| 2015 | 367,265 | | 5,236,869 | |
| 2016 | 369,887 | 0.7% | 5,303,352 | 1.3% |
| 2017 | 373,680 | 1.7% | 5,368,535 | 2.5% |
| 2018 | 377,316 | 2.7% | 5,421,057 | 3.5% |
| 2019 | 382,508 | 4.2% | 5,472,589 | 4.5% |
| 2020 | 386,752 | 5.3% | 5,523,280 | 5.5% |
| 2021 | 391,472 | 6.6% | 5,573,017 | 6.4% |
| 2022 | 394,769 | 7.5% | 5,621,245 | 7.3% |
| 2023 | 399,599 | 8.8% | 5,668,045 | 8.2% |
| 2024 | 402,814 | 9.7% | 5,713,235 | 9.1% |
| 2025 | 406,341 | 10.6% | 5,756,814 | 9.9% |
| 2026 | 409,063 | 11.4% | 5,798,827 | 10.7% |
| 2027 | 410,596 | 11.8% | 5,839,289 | 11.5% |
| 2028 | 412,959 | 12.4% | 5,878,703 | 12.3% |
| 2029 | 414,798 | 12.9% | 5,917,139 | 13.0% |
| 2030 | 417,573 | 13.7% | 5,954,635 | 13.7% |

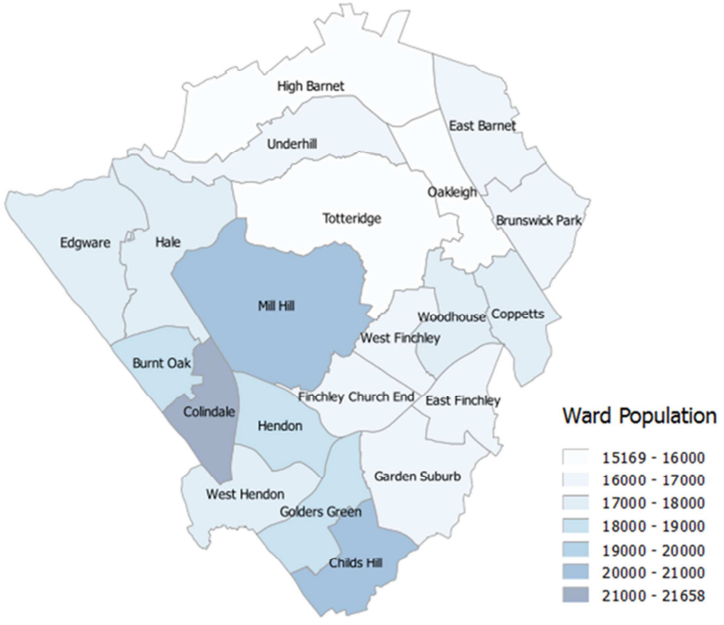
Source: GLA 2013 Projections (Preferred Option Projections)

## 2.5 Population by Wards

The GLA projections also provide an indication of the population by Ward. In 2015, Colindale was the most populous Ward within the Borough, containing 5.9% (21,658) of the total population. Totteridge is the least populous ward, containing 4.1% of Barnet's total population (15,169).

**Figure 2-2: Barnet Population by Ward in 2015**

| Ward Name | Total Population | % of Population |
|---|---|---|
| Brunswick Park | 16,402 | 4.5% |
| Burnt Oak | 18,090 | 4.9% |
| Childs Hill | 20,695 | 5.6% |
| Colindale | 21,658 | 5.9% |
| Coppetts | 17,236 | 4.7% |
| East Barnet | 16,173 | 4.4% |
| East Finchley | 16,285 | 4.4% |
| Edgware | 17,927 | 4.9% |
| Finchley Church End | 16,015 | 4.4% |
| Garden Suburb | 16,078 | 4.4% |
| Golders Green | 18,979 | 5.2% |
| Hale | 17,353 | 4.7% |
| Hendon | 18,886 | 5.1% |
| High Barnet | 15,367 | 4.2% |
| Mill Hill | 20,187 | 5.5% |
| Oakleigh | 15,774 | 4.3% |
| Totteridge | 15,169 | 4.1% |
| Underhill | 16,153 | 4.4% |
| West Finchley | 16,959 | 4.6% |
| West Hendon | 17,961 | 4.9% |
| Woodhouse | 17,919 | 4.9% |

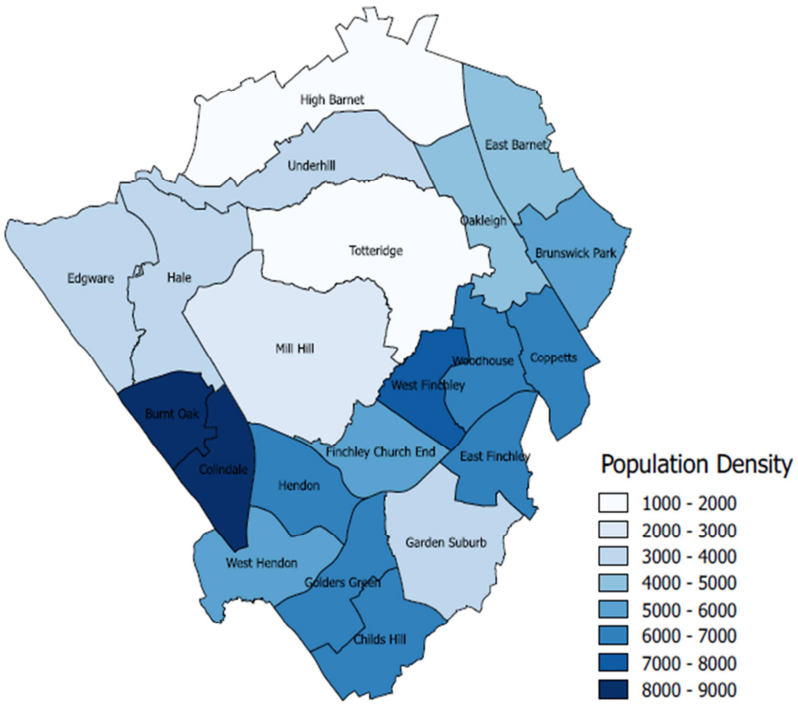



Source: GLA Projections 2013 (Preferred Option Projections)

There is a significant difference in the size of wards within Barnet. Therefore, it is beneficial to view the population density of each ward as this takes into account the population size by area. In 2015, Burnt Oak was the most densely populated ward, with 8,774 residents per square km; whereas, Totteridge was the least densely populated ward with 1,733 residents per square km**.**

**Figure 2-3: Barnet Population Density by Ward in 2015**

| Ward Name | Population by Km² |
|---|---|
| Brunswick Park | 5,179 |
| Burnt Oak | 8,774 |
| Childs Hill | 6,708 |
| Colindale | 8,237 |
| Coppetts | 6,352 |
| East Barnet | 4,325 |
| East Finchley | 6,506 |
| Edgware | 3,235 |
| Finchley Church End | 5,891 |
| Garden Suburb | 3,410 |
| Golders Green | 6,401 |
| Hale | 3,208 |
| Hendon | 6,671 |
| High Barnet | 1,855 |
| Mill Hill | 2,156 |
| Oakleigh | 4,766 |
| Totteridge | 1,733 |
| Underhill | 3,559 |
| West Finchley | 7,860 |
| West Hendon | 5,252 |
| Woodhouse | 6,854 |




Source: GLA Projections 2013 (Preferred Option Projections)

Since 2001 Census the population of all Barnet's Wards have increased, with the highest increase in population numbers experienced in Colindale and Mill Hill; which grew by 7,801 and 4,819 respectively. Underhill increased by only 425 people making it the Ward which had the smallest population increase. Colindale and Underhill also experienced the highest and lowest respective percentage population increases (56.3% and 2.7%).

**Table 2-3: Population Growth by Ward, 2001-2015**

| Area name | 2001 | 2015 | Change | % Change |
|---|---|---|---|---|
| Brunswick Park | 14,644 | 16,402 | 1,758 | 12.0% |
| Burnt Oak | 15,242 | 18,090 | 2,848 | 18.7% |
| Childs Hill | 17,263 | 20,695 | 3,432 | 19.9% |
| Colindale | 13,857 | 21,658 | 7,801 | 56.3% |
| Coppetts | 14,500 | 17,236 | 2,736 | 18.9% |
| East Barnet | 15,339 | 16,173 | 834 | 5.4% |
| East Finchley | 14,522 | 16,285 | 1,763 | 12.1% |
| Edgware | 14,823 | 17,927 | 3,104 | 20.9% |
| Finchley Church End | 13,804 | 16,015 | 2,211 | 16.0% |
| Garden Suburb | 14,706 | 16,078 | 1,372 | 9.3% |
| Golders Green | 16,272 | 18,979 | 2,707 | 16.6% |
| Hale | 15,661 | 17,353 | 1,692 | 10.8% |
| Hendon | 15,371 | 18,886 | 3,515 | 22.9% |
| High Barnet | 13,846 | 15,367 | 1,521 | 11.0% |
| Mill Hill | 15,368 | 20,187 | 4,819 | 31.4% |
| Oakleigh | 14,739 | 15,774 | 1,035 | 7.0% |
| Totteridge | 14,445 | 15,169 | 724 | 5.0% |
| Underhill | 15,728 | 16,153 | 425 | 2.7% |
| West Finchley | 14,260 | 16,959 | 2,699 | 18.9% |
| West Hendon | 14,593 | 17,961 | 3,368 | 23.1% |
| Woodhouse | 15,544 | 17,919 | 2,375 | 15.3% |

Source: 2001 Census and GLA Projections 2013 (Preferred Option Projections)

## 2.6 Population Projections by Ward

Table 2-4 provides a breakdown of the projected population growth by Ward, for the period 2015 – 2021 and 2015 – 2030.

- Colindale is projected to rise by a further 79.4% (17,917) during the period 2015-2030, whereas Mill Hill will grow by 24.1% (4,875).
- Golders Green is projected to experience the highest rate of growth (113.9%, an additional 21,625 people).
- Not all Wards are projected to increase in population size over this period with the largest proportional decreases projected in Coppetts (-3.1%, a reduction in 541 people) and Hale (-2.3%, a reduction in 402 people).

**Table 2-4: Population Growth by Ward 2015, 2021 & 2030**

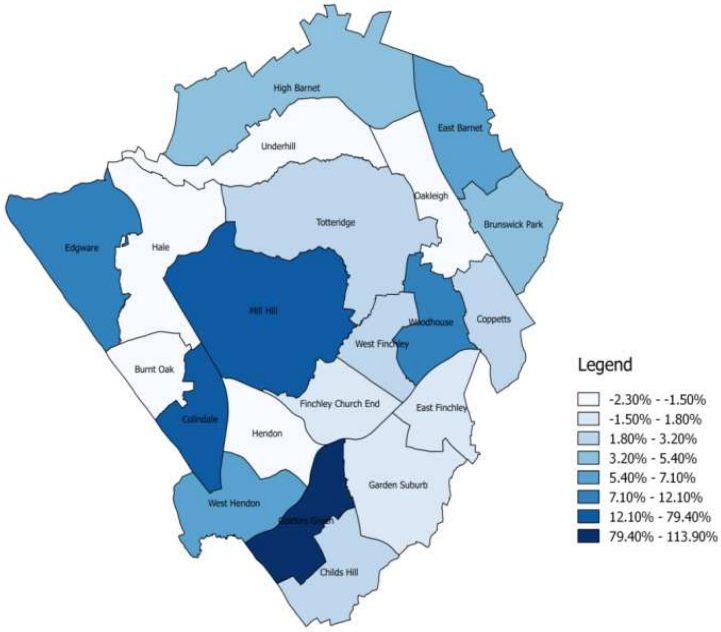
| Area name | 2015 | 2021 | Change | % Change 2015-2021 | 2030 | Change | % Change 2015-2030 |
|---|---|---|---|---|---|---|---|
| Brunswick Park Ward | 16,402 | 17,093 | 691 | 4.2% | 17,093 | 691 | 4.2% |
| Burnt Oak Ward | 18,090 | 18,238 | 148 | 0.8% | 17,814 | -276 | -1.5% |
| Childs Hill Ward | 20,695 | 21,251 | 556 | 2.7% | 21,351 | 656 | 3.2% |
| Colindale Ward | 21,658 | 32,895 | 11,237 | 51.9% | 38,855 | 17,197 | 79.4% |
| Coppetts Ward | 17,236 | 17,061 | -175 | -1.0% | 16,695 | -541 | -3.1% |
| East Barnet Ward | 16,173 | 16,443 | 270 | 1.7% | 17,238 | 1,065 | 6.6% |
| East Finchley Ward | 16,285 | 16,256 | -29 | -0.2% | 15,985 | -300 | -1.8% |
| Edgware Ward | 17,927 | 19,431 | 1,504 | 8.4% | 20,098 | 2,171 | 12.1% |
| Finchley Church End Ward | 16,015 | 16,273 | 258 | 1.6% | 16,207 | 192 | 1.2% |
| Garden Suburb Ward | 16,078 | 16,099 | 21 | 0.1% | 15,974 | -104 | -0.6% |
| Golders Green Ward | 18,979 | 24,841 | 5,862 | 30.9% | 40,605 | 21,626 | 113.9% |
| Hale Ward | 17,353 | 17,245 | -108 | -0.6% | 16,951 | -402 | -2.3% |
| Hendon Ward | 18,886 | 18,751 | -135 | -0.7% | 18,483 | -403 | -2.1% |
| High Barnet Ward | 15,367 | 15,482 | 115 | 0.7% | 16,199 | 832 | 5.4% |
| Mill Hill Ward | 20,187 | 22,551 | 2,364 | 11.7% | 25,062 | 4,875 | 24.1% |
| Oakleigh Ward | 15,774 | 15,682 | -92 | -0.6% | 15,466 | -308 | -2.0% |
| Totteridge Ward | 15,169 | 15,750 | 581 | 3.8% | 15,590 | 421 | 2.8% |
| Underhill Ward | 16,153 | 16,064 | -89 | -0.6% | 15,902 | -251 | -1.6% |
| West Finchley Ward | 16,959 | 17,523 | 564 | 3.3% | 17,358 | 399 | 2.4% |
| West Hendon Ward | 17,961 | 18,247 | 286 | 1.6% | 19,245 | 1,284 | 7.1% |
| Woodhouse Ward | 17,919 | 18,296 | 377 | 2.1% | 19,402 | 1,483 | 8.3% |

Source: GLA Projections 2013 (Preferred Option Projections)

One of the major driving forces of growth in the west of the Borough is the planned development taking place, with the Wards with the greatest projected increases in population, directly correlating with the planned regeneration localities of Colindale and Brent Cross Cricklewood (as shown in Figure 2-4 and 2-5).

**Figure 2-4 : Planned Regeneration Works**


**Figure 2-5: Barnet Population Growth by Ward 2015-2030**




Source: GLA Projections 2013 (Preferred Option Projections)

## 2.7 Age and Gender Structure

This section of the report looks at the population of Barnet by age and gender. Ages are broken up by broad age categories (0-15, 16-64 and 65+); and by five year age bands.

The overall Barnet distribution by age group is displayed is shown in Table 2-5 below. When viewed by broad age band, Barnet has a similar population profile to Outer London. Whereas, when compared to the United Kingdom, Barnet and Outer London have a higher rate of people within the 0-15 category and a lower proportion of people in the 65 and over category. The differences in these age structures is further emphasised when broken down by five year age band, as shown in Table 2-5.

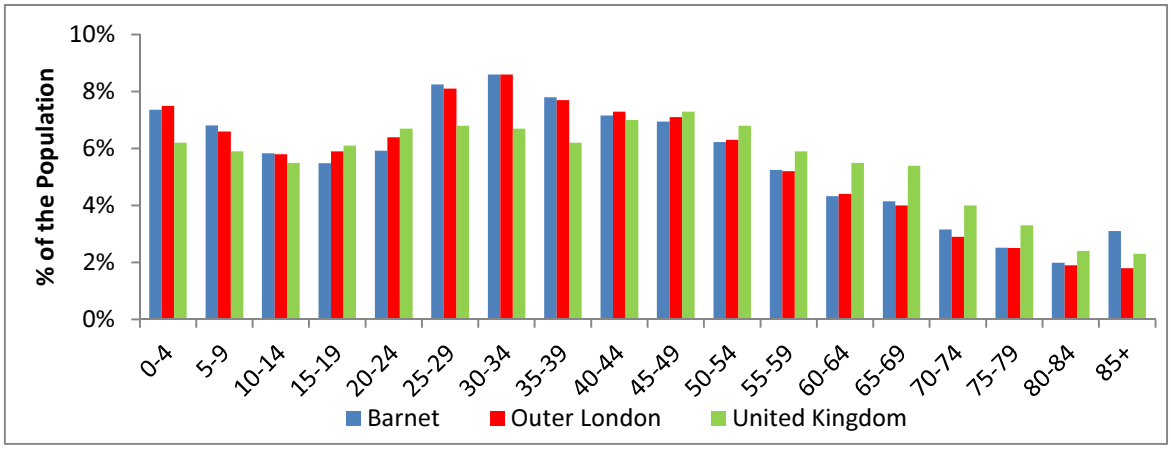
**Table 2-5: Population 2015, by Broad Age Group (Barnet, Regional and National)**

| Age | All Persons | | Outer London | | United Kingdom | |
|---|---|---|---|---|---|---|
| | No. of People | % of People | No. of People | % of People | No. of People | % of People |
| **0 - 15** | 77,789 | 21.2% | 1,075,500 | 21.2% | 12,058,700 | 18.8% |
| **16 - 64** | 237,901 | 64.8% | 3,340,500 | 65.7% | 40,915,200 | 63.8% |
| **65 and over** | 51,575 | 14.0% | 665,100 | 13.1% | 11,131,800 | 17.4% |
| **Total** | 367,265 | 100.0% | 5,081,100 | 100.0% | 64,105,700 | 100.0% |

Source: GLA 2013 Projections (Preferred Option Projections) (Barnet and Outer London) and ONS Mid-year Projections 2012 (UK)

- Within Barnet and Outer London, the largest proportion of the population is within the 30-34 and the 25-29 age groups. Whereas, within the UK as a whole, 45-49 and 50-54 are the largest age bands in terms of population size.
- Barnet has a higher proportion of people aged 85 and over (3.1%) compared to Outer London (1.8%) and the UK (2.3%). This is reflective of high life expectancy within the Borough.
- Although, data from the 2011 Census indicates that as a whole, Barnet has a younger population than the average for England as a whole. The average age of people living within Barnet is 36.8, compared to 39.3 for England. This is represented within the age groups, as 40.6% of the UK population is aged between 45 and 84, compared to 34.6% in Barnet.

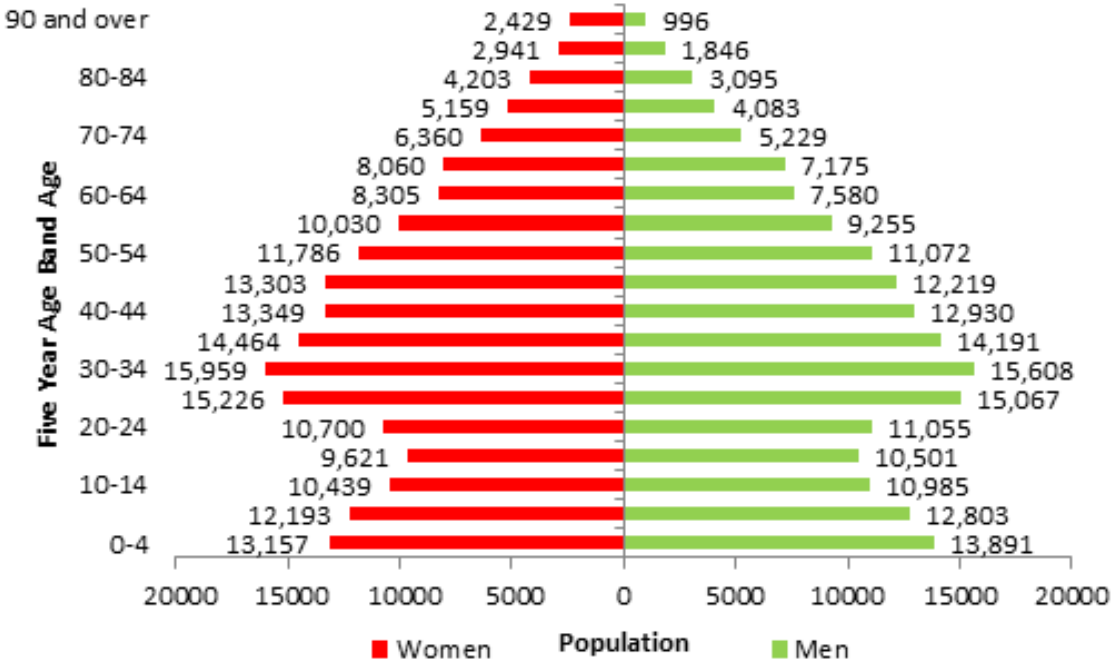
**Figure 2-6: Population % by Five Year Age Band in 2015 (Barnet, Regional and National)**




Source: GLA 2013 Projections (Preferred Option Projections) (Barnet and Outer London) and ONS Mid-year Projections 2012 (UK)

By gender, women account for a larger proportion of the Barnet population than men. 51.1% (187,685) of the population are women and 48.9% (179,580) of the population are men. As shown in Figure 2-7, the proportion of men to women is roughly equal below 65, whereas above 64, women account for 56.5% of the population (29,152) compared to men who account for 43.5% (22,423). This reflects the longer lifespans of women.

**Figure 2-7: Barnet Population by Age Band and Gender in 2015**




Source: GLA 2013 Projections (Preferred Option Projections)

### 2.7.1 Population Projections by Age

Table 2-6 identifies the population projections by broad age structure for the period 2015 – 2021, and 2015 – 2030.

**Table 2-6: Population Projections by Broad Age Structure 2015, 2021 & 2030 (Barnet)**

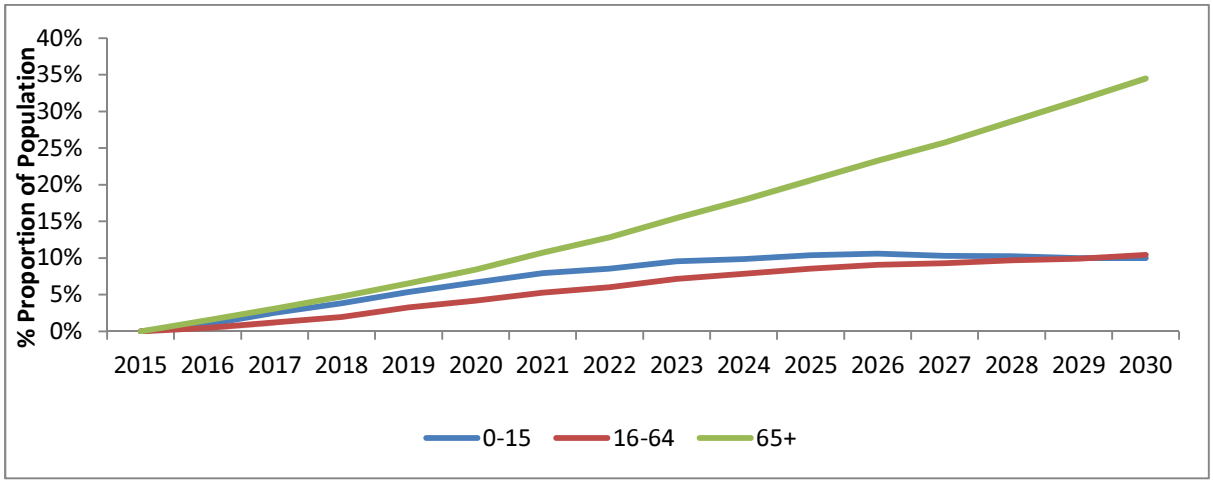
| Age Group | 2015 | 2021 | Change | % Change 2015-2021 | 2030 | Change | % Change 2015-2030 |
|---|---|---|---|---|---|---|---|
| 0-15 | 77,789 | 83,966 | 6,177 | 7.9% | 85,560 | 7,772 | 10.0% |
| 16-64 | 237,901 | 250,408 | 12,507 | 5.3% | 262,648 | 24,747 | 10.4% |
| 65+ | 51,576 | 57,098 | 5,522 | 10.7% | 69,364 | 17,789 | 34.5% |

Source: GLA Projections 2013 (Preferred Option Projections)

Growth is projected across all three age groups however; it is not a uniform rise. As with the whole of England, Barnet's population is projected to become proportionally older as the over 65's age group grows at a much faster rate than the 0-15 and 16-64 age bands. This is a significant concern for Barnet as it will likely drive up the dependency ratio within the Borough.

The 0-15 age group shows growth at a greater rate than the 16-64 age group until 2026 after which the child population is expected to slightly decline. The 16-64 population is expected to increase steadily through to 2030. This pattern of growth suggests that families are moving to Barnet with children for school and choosing to stay into older age once children leave for university or begin careers outside Barnet.

**Figure 2-8: Barnet Population Growth by Broad Age Structure 2015 –2030**




Source: GLA Projections 2013 (Preferred Option Projections)

Table 2-7 below shows the proportion of people aged 65 and over by ward. Currently both Garden Suburb and High Barnet have the largest proportion of people aged 65 and over, 18.1%. By 2030, although Garden Suburb's 65 and over population is projected to have increased to 21.6% of the population; High Barnet's is projected to have increased to 22.9%.

Although, over this period Brunswick Park and Hale are projected to experience the highest levels of growth in the proportion of the population of people aged 65 and over, increasing by 5.8% and 5.5% respectively.

Interestingly, the wards that are projected the highest levels of overall population growth over the period 2015-2030, Golders Green and Colindale are also projected to see the smallest increase in the proportion of the population who are 65 and over. In fact Golders Green is projected to reduce by 2.4%. This is due to growth in these areas is predominantly being driven by development which will bring younger people into the Borough.

**Table 2-7: 65 and Over Proportion of Total Population in Barnet by Ward, 2015 –2030**

| Ward Name | 2015 | 2021 | 2030 | Change from 2015-2030 |
|---|---|---|---|---|
| Brunswick Park | 16.5% | 17.9% | 22.3% | 5.8% |
| Burnt Oak | 9.5% | 10.3% | 13.3% | 3.8% |
| Childs Hill | 12.6% | 13.3% | 15.2% | 2.7% |
| Colindale | 8.1% | 7.6% | 9.0% | 0.9% |
| Coppetts | 11.3% | 12.8% | 16.0% | 4.7% |
| East Barnet | 15.2% | 16.7% | 19.9% | 4.7% |
| East Finchley | 13.8% | 14.6% | 16.9% | 3.0% |
| Edgware | 15.2% | 16.6% | 19.5% | 4.3% |
| Finchley Church End | 17.0% | 17.7% | 19.7% | 2.7% |
| Garden Suburb | 18.1% | 19.0% | 21.6% | 3.6% |
| Golders Green | 12.0% | 10.7% | 9.6% | -2.4% |
| Hale | 14.7% | 16.5% | 20.2% | 5.5% |
| Hendon | 12.0% | 12.5% | 14.3% | 2.2% |
| High Barnet | 18.1% | 19.6% | 22.9% | 4.9% |
| Mill Hill | 13.8% | 14.5% | 17.2% | 3.4% |
| Oakleigh | 17.6% | 18.9% | 22.0% | 4.4% |
| Totteridge | 18.0% | 18.8% | 21.7% | 3.7% |
| Underhill | 17.1% | 18.3% | 21.3% | 4.2% |
| West Finchley | 13.2% | 13.9% | 16.7% | 3.5% |
| West Hendon | 11.6% | 12.2% | 14.0% | 2.4% |
| Woodhouse | 14.0% | 14.9% | 17.1% | 3.2% |

Source: GLA Projections 2013 (Preferred Option Projections)

## 2.8 Ethnicity

Table 2-8 displays the ethnic profile of Barnet in 2015. Compared to the Outer London average, Barnet has a higher proportion of people within the White ethnic group; 57.8% and 61.3% respectively. Barnet also has higher rates of the population within Other; Other Asian and Chinese ethnic groups.

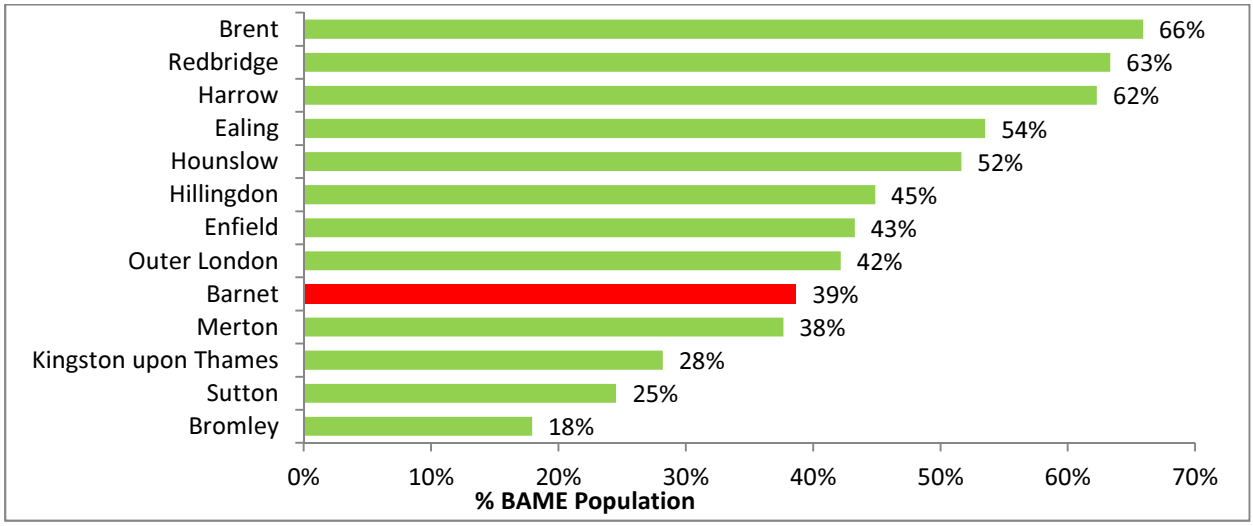
**Table 2-8: Population by Ethnicity, 2015 (Barnet and Regional)**

| Ethnicity | Barnet | | Outer London | |
|---|---|---|---|---|
| | No. of People | % of Population | No. of People | % of Population |
| All Ethnicities | 367,264 | 100.0% | 5,236,869 | 100.0% |
| White | 225,192 | 61.3% | 3,028,406 | 57.8% |
| Black, Asian and Minority | 142,076 | 38.7% | 2,208,463 | 42.2% |
| Other Asian | 34,296 | 9.3% | 420,406 | 8.0% |
| Indian | 27,530 | 7.5% | 466,540 | 8.9% |
| Other | 25,916 | 7.1% | 249,337 | 4.8% |
| Black African | 21,174 | 5.8% | 353,533 | 6.8% |
| Black Other | 11,588 | 3.2% | 217,968 | 4.2% |
| Chinese | 8,804 | 2.4% | 65,236 | 1.2% |
| Pakistani | 5,699 | 1.6% | 187,598 | 3.6% |
| Black Caribbean | 4,615 | 1.3% | 178,809 | 3.4% |
| Bangladeshi | 2,454 | 0.7% | 69,036 | 1.3% |

Source: GLA Projections 2013 (Preferred Option Projections)

In comparison to Barnet's statistical and geographical neighbours, Barnet has a relatively low Black, Asian and Minority Ethnic population (39%); whereas 66% of Brent's population are Black, Asian and Minority Ethnic.

**Figure 2-9: Population by Black, Asian and Minority Ethnic Groups, 2015 (Barnet, Regional)**

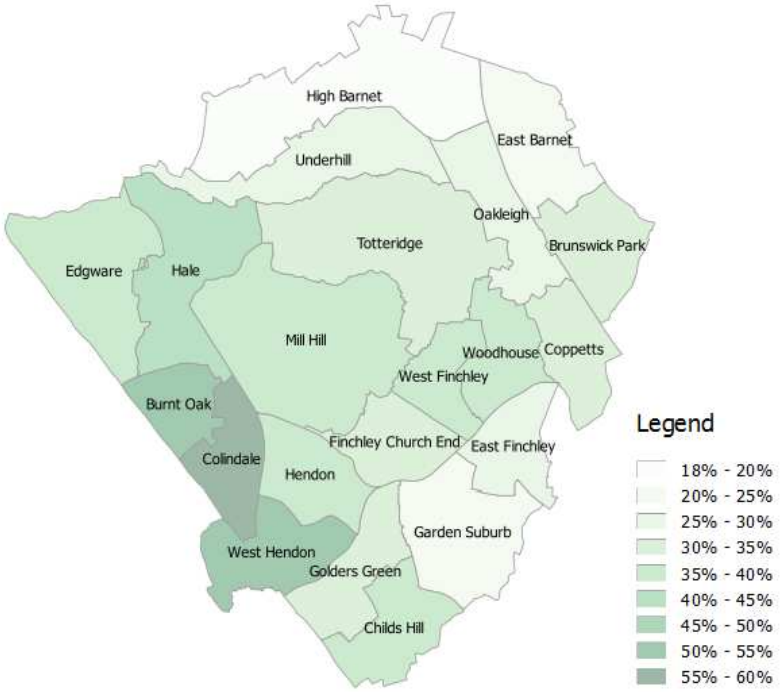



Source: GLA Projections 2013 (Preferred Option Projections)

However, certain areas within the Borough have a higher proportional Black, Asian and Minority population than the Borough average. Data from the 2011 Census provides a breakdown of the ethnic profile of Barnet by Ward.

The Black, Asian and Minority population in Barnet varies significantly by Ward, with the highest rates of Black, Asian and Minority populations generally found to the West of the Borough. Based on the 2011 Census, Colindale, Burnt Oak and West Hendon all have populations where Black, Asian and Minority residents make up over half of the population; this is significantly above the Borough wide average of 39%.

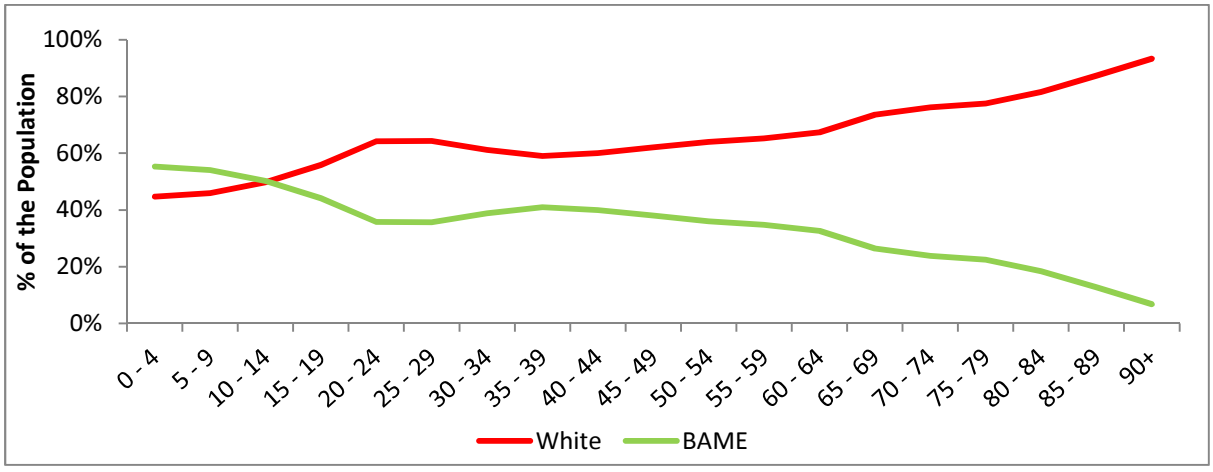
**Figure 2-10: Population by Black, Asian and Minority Ethnic Groups by Ward, 2011**




Source: 2011 Census

By age, the highest proportion of the population from White ethnic backgrounds are found in the 90 and over age group (93.3%); whereas the highest proportion of people from Black, Asian and Minority Ethnic groups are found in the 0-4 age group (55.4%).

**Figure 2-11: Barnet Population by Ethnicity by Age, 2015**




Source: 2013 GLA Projections (Preferred Option Projections)

Table 2-9 contains the projected population growth by ethnicity for the period 2015-2021 and 2015-2030. Barnet's population is projected to become increasingly diverse as the White British population is projected to decrease in proportion to the total population (from 61.3% in 2015 to 58.4% in 2021 and 56.4% in 2030).

Whereas, the proportion of the population who are Black, Asian and Minority is projected to increase by 4.9% (40,040), rising from 142,074 to 182,144. This will mean that the Black, Asian and Minority proportion of the total population will rise from 38.7% to 43.6%.

All Black, Asian and Minority Ethnic groups are projected to increase in number during the period 2015 to 2030. Although over this period the proportion of individuals from Indian ethnic groups will reduce from 7.5% of the total population to 7.1%.

**Table 2-9: Projections of the population by Ethnicity between 2015-2021 and 2015-2030**

| Ethnic Group | 2015 | 2021 | 2030 | Ethnic Composition in 2015 | Ethnic Composition in 2021 | Ethnic Composition in 2030 |
|---|---|---|---|---|---|---|
| White | 225,193 | 228,741 | 235,457 | 61.3% | 58.4% | 56.4% |
| Black Caribbean | 4,617 | 4,781 | 5,002 | 1.3% | 1.2% | 1.2% |
| Black African | 21,174 | 23,524 | 25,472 | 5.8% | 6.0% | 6.1% |
| Black Other | 11,588 | 13,978 | 16,377 | 3.2% | 3.6% | 3.9% |
| Indian | 27,530 | 28,632 | 29,512 | 7.5% | 7.3% | 7.1% |
| Pakistani | 5,698 | 6,364 | 6,941 | 1.6% | 1.6% | 1.7% |
| Bangladeshi | 2,453 | 2,814 | 3,139 | 0.7% | 0.7% | 0.8% |
| Chinese | 8,805 | 9,859 | 11,015 | 2.4% | 2.5% | 2.6% |
| Other Asian | 34,296 | 41,616 | 48,638 | 9.3% | 10.6% | 11.6% |
| Other | 25,917 | 31,164 | 36,012 | 7.1% | 8.0% | 8.6% |
| Black, Asian and Minority | 142,074 | 162,729 | 182,114 | 38.7% | 41.6% | 43.6% |

Source: GLA Projections 2013 (Preferred Option Projections)

## 2.9 Religion

The only reliable data set for religion within the Borough comes from the 2011 Census results. Table 2-10 provides a breakdown of religion in Barnet in the 2001 and the 2011 Census.

Over the ten years between the 2001 and 2011 Census the religious makeup of Barnet has become increasingly diverse, with proportionate growth in most religions except Christianity and Hinduism. The largest increase was in the number of Muslims within the Borough, which increased by 4.2%, although people with no religion had the second highest rate of growth and now accounts for 16.1% of the population.

After Christianity, Judaism was the second most common religion, with Barnet continuing to have the largest Jewish population in the country.

**Table 2-10: Population by Religion, 2001 & 2011(Barnet, London and England)**

| Religion | Barnet | | | | | London | England |
|---|---|---|---|---|---|---|---|
| | 2001 | % | 2011 | % | % Change | % in 2011 | % in 2011 |
| **Christian** | 148,844 | 47.3% | 146,866 | 41.2% | -6.1% | 48.4% | 59.4% |
| **Buddhist** | 3,422 | 1.1% | 4,521 | 1.3% | 0.2% | 1.0% | 0.5% |
| **Hindu** | 21,011 | 6.7% | 21,924 | 6.2% | -0.5% | 5.0% | 1.5% |
| **Jewish** | 46,686 | 14.8% | 54,084 | 15.2% | 0.3% | 1.8% | 0.5% |
| **Muslim** | 19,373 | 6.2% | 36,744 | 10.3% | 4.2% | 12.4% | 5.0% |
| **Sikh** | 1,113 | 0.4% | 1,269 | 0.4% | 0.0% | 1.5% | 0.8% |
| **Any other religion** | 3,215 | 1.0% | 3,764 | 1.1% | 0.0% | 0.6% | 0.4% |
| **No religion** | 40,320 | 12.8% | 57,297 | 16.1% | 3.3% | 20.7% | 24.7% |
| **Religion not stated** | 30,580 | 9.7% | 29,917 | 8.4% | -1.3% | 8.5% | 7.2% |

Source: 2001 and 2011 Census

The Jewish and Muslim population make up over a quarter of the total population of Barnet. Figure 2-12 and 2-13 show the population of the Borough by Ward, by Jewish and Muslim.

**Figure 2-12: Barnet Jewish Population by Ward**

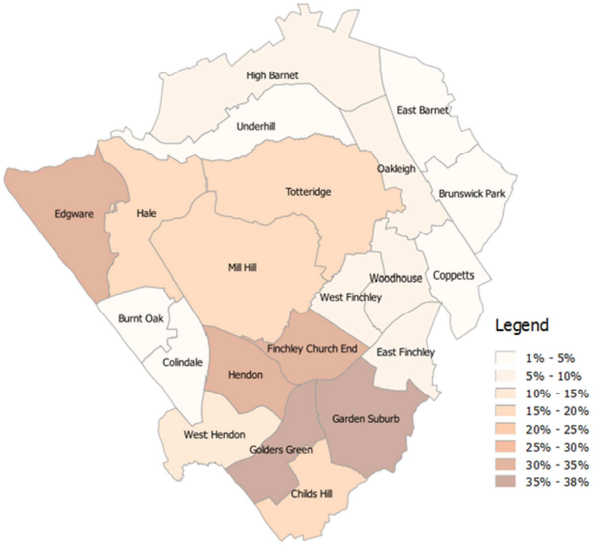
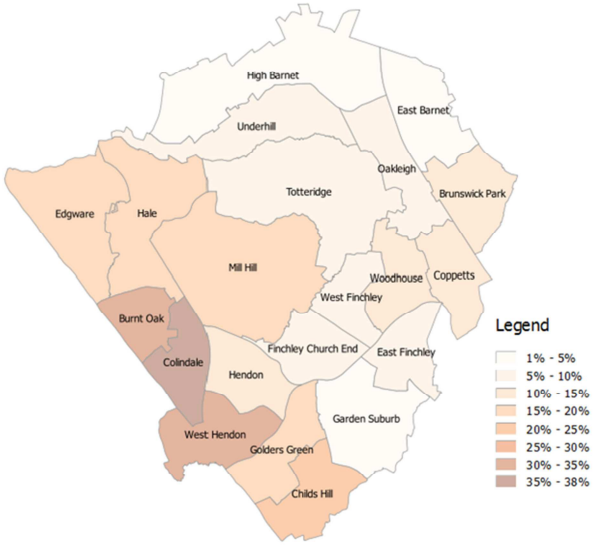



**Figure 2-13: Barnet Muslim Population by Ward**




Source: 2011 Census

- Wards situated in the North / Eastern areas of Barnet tend to have the highest proportions of Christians compared to other areas of the Borough.
- A large portion of the Jewish community is centred in the south of the Borough, with the largest population in Garden Suburb (38.2% (6,090)), followed by Golders Green (37.1% (6,975)). Although, Edgware has the third largest Jewish community (32.6% (5,447)).
- The largest proportion of the Muslim community is located towards the South West / South of the Borough, with the largest population in Burnt Oak (18.4% (3,356)) followed by Colindale (19.3% (3,301) and West Hendon (17.1% (2,971)).

## 2.10 Drivers of Population Growth

Population change is determined by the number of births, deaths and migration in and out of the Borough.

### 2.10.1 Natural Change

Births and deaths are natural causes of population change. The difference between the birth rate and the death rate is called the natural increase, calculated by subtracting the death rate from the birth rate. The 2013 GLA projections provide trend based assumptions around the level of births and deaths within Barnet in the future.

- There are 90,827 live births projected to occur within Barnet during the period 2015-2030.
- Between 2015 and 2021, birth rates are projected to remain relatively stationary, with the number of rates increasing by an average annual rate of only 0.1% (an additional eight births per year).
- After 2021, the number of births is projected to start marginally decreasing by an average 0.1% each year (a decrease of 8 births per year). Therefore, in 2030 there is projected to be 5,635 births in Barnet, 24 less than in 2015.
- There are projected to be 39,354 deaths within Barnet between 2015 and 2030.
- Up until 2020, the downward trend in mortality rates is projected to continue, with the number of deaths projected to reduce by an average -0.5% (12 less) each year.
- In 2021 the number of deaths within the Borough is projected to begin rising by an average 0.9% (an additional nine) each year, all the way up until 2030. This means that in 2030 there is projected to be 2,607 deaths within Barnet, 144 more deaths than in 2015.
- This reduction in births and increased deaths means that there is a projected annual decline of -4.9% (156) in natural change over the period 2015-2030.

### 2.10.2 Migration

Migration consists of two elements 'internal migration' and 'international migration'. Internal migration refers to people within a country moving to another location within its borders, whereas international migration refers to the act of moving across borders from one country to another.

The GLA publishes historical data for internal and international migration by local authority. Internal migration figures are derived from re-registrations recorded at the National Health Service Central Register. International migration figures are from International Passenger Survey results. This data is not perfect and does not capture all movement in and out of the Borough; however it does provide an indication of the major trends within Barnet.

Table 2-11 shows the internal, international and net migration within Barnet for the period 2002 – 2013.

**Table 2-11: International and Internal Migration in Barnet, 2002-2013**

| Year | Internal Net Migration | International Net Migration | Net Migration |
|---|---|---|---|
| 2002 | -3,727 | 4,151 | 424 |
| 2003 | -3,527 | 3,822 | 295 |
| 2004 | -2,979 | 3,917 | 938 |
| 2005 | -2,388 | 4,945 | 2,557 |
| 2006 | -1,538 | 3,183 | 1,645 |
| 2007 | -2,096 | 4,274 | 2,178 |
| 2008 | -2,537 | 4,730 | 2,193 |
| 2009 | 598 | 3,886 | 4,484 |
| 2010 | -48 | 3,392 | 3,344 |
| 2011 | -1,348 | 4,982 | 3,634 |
| 2012 | -834 | 3,905 | 3,071 |
| 2013 | -1,732 | 3,912 | 2,180 |

Source: GLA, Net Migration and Natural Change, Region and Borough

- Apart from 2009, net internal migration has been negative for every year since 2002. This means that more UK residents have been moving out of the Borough, than into it.
- International migration has been positive throughout this period. With an average annual net migration of 4,092 people into the Borough.
- Throughout the period 2002-2013 net migration has been positive, meaning that migration has been a major driving force of population growth within the Borough.
- Although, since 2009 the total net migration figure has begun to reduce from 4,484 to 2,180 in 2013.

The latest GLA projections provide an indication of the future net migration levels in Barnet[3].

- During 2014-2023, there is a projected net migration of 5,626 people coming into the Borough; this accounts 16.0% of total population growth over this period.
- After 2020, net migration is projected to begin decreasing, with an aggregated net migration of a loss of 4,216 people during 2024-2030.
- Research by the Office for National Statistics (ONS) suggests that during this time, international migration will remain positive; however there will be a higher number of people leaving the Borough through internal migration, making overall net migration negative.
- A 2014 report by the ONS *Internal Migration, England and Wales, Year Ending June 2013* found that as people reach 30 and above, more people move out of London than into it. The report suggests that the drivers of this could be:

[3] These projections are trend-based, with assumptions made based on recent trends in migration. They give an indication of what future migration levels might be if recent trends continued. They are not forecasts and take no account of policy nor development aims that have not yet had an impact on observed trends and so actual migration levels are likely to be different.

- The cost of housing - Young couples wishing to buy their first house, or a larger one for a growing family, may find prices in London prohibitively expensive and therefore choose to live outside of London.
- People moving out of London to raise a family. This could be because they are looking for somewhere more rural and quieter, and may also perceive that a less urban neighbourhood offers a better social and educational environment for children.

Table 2-12 displays the population projections for the period 2015-2030, with the drivers of growth (births, deaths and net migration) shown against them.

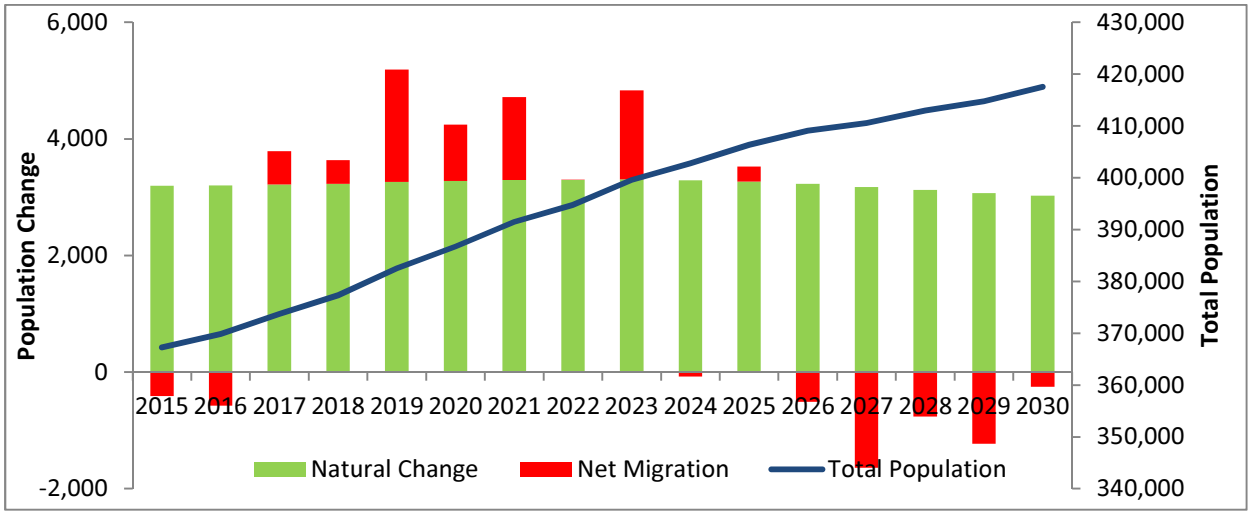
**Table 2-12: Population Projections by Drivers of Growth (2015-2030)**

| Year | Population Projections | Births | Deaths | Natural Change (births - deaths) | Net Migration |
|---|---|---|---|---|---|
| 2015 | 367,265 | 5,659 | 2,463 | 3,195 | -412 |
| 2016 | 369,887 | 5,637 | 2,437 | 3,200 | -578 |
| 2017 | 373,680 | 5,639 | 2,420 | 3,218 | 574 |
| 2018 | 377,316 | 5,638 | 2,406 | 3,232 | 405 |
| 2019 | 382,508 | 5,669 | 2,405 | 3,265 | 1,927 |
| 2020 | 386,752 | 5,680 | 2,403 | 3,277 | 967 |
| 2021 | 391,472 | 5,704 | 2,406 | 3,298 | 1,422 |
| 2022 | 394,769 | 5,701 | 2,409 | 3,293 | 5 |
| 2023 | 399,599 | 5,731 | 2,423 | 3,308 | 1,523 |
| 2024 | 402,814 | 5,725 | 2,436 | 3,290 | -75 |
| 2025 | 406,341 | 5,725 | 2,455 | 3,270 | 257 |
| 2026 | 409,063 | 5,710 | 2,478 | 3,232 | -510 |
| 2027 | 410,596 | 5,676 | 2,503 | 3,174 | -1,640 |
| 2028 | 412,959 | 5,660 | 2,535 | 3,125 | -763 |
| 2029 | 414,798 | 5,638 | 2,568 | 3,070 | -1,231 |
| 2030 | 417,573 | 5,635 | 2,607 | 3,028 | -254 |

Source: GLA Projections 2013 (Preferred Option Projections)

- As can be seen by Figure 2-14, up until 2023, population growth within Barnet is projected to be driven by natural change and net migration. However, after 2023, more people are projected to leave the Borough than enter it, resulting in growth being solely driven by natural change.
- As the natural change remains relatively stable, and net migration becomes negative, the rate of population growth will slow down after 2023.

**Figure 2-14: Population Projections by Drivers of Growth (2015-2030)**

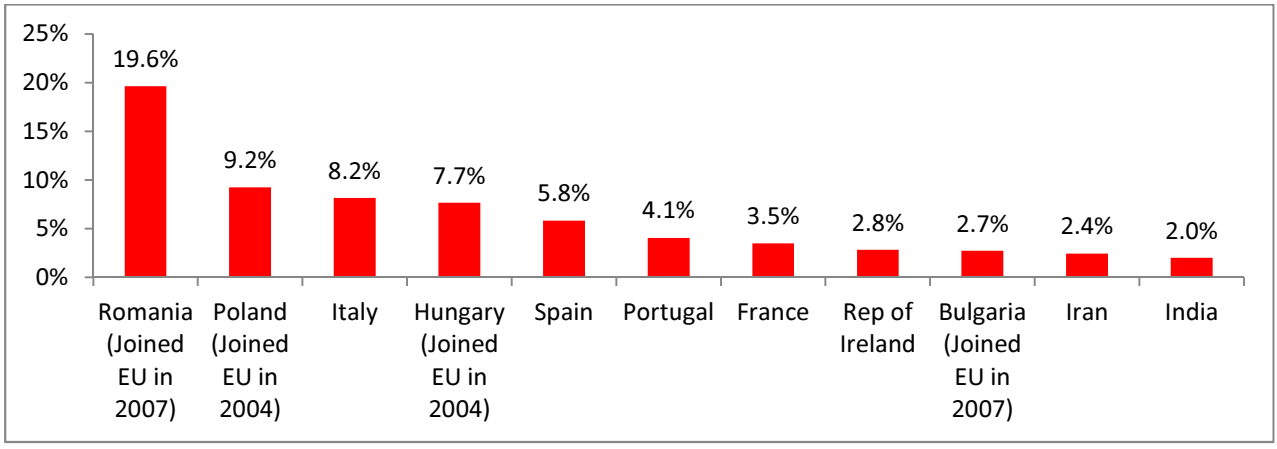



Source: GLA Projections 2013 (Preferred Option Projections)

### 2.10.3 International Migration

National Insurance registrations of overseas nationals can be used as an indication of the nationality of international migrants. Figure 2-15 displays the National Insurance registrations of overseas nationals into Barnet, for the 2013/14 financial year. In total there were 9,406 national insurance registrations of overseas nationals during this period, which accounted for approximately 4.0% of the Barnet working age group. Romanians accounted for 19.6% of overseas migrations, followed by Polish workers who accounted for 9.2%. All other groups of new migrant overseas workers were relatively small which is why they are not displayed.

**Figure 2-15: Number of New Migrant Workers by their Country of Origin, 2013/14**

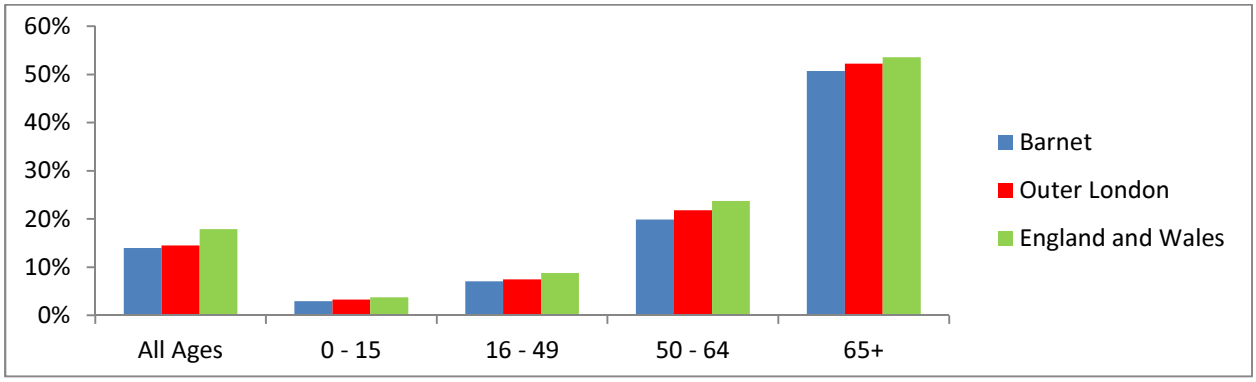



Source: Department for Work and Pensions 2014; National Insurance Number Registrations of Overseas Nationals, Borough

## 2.11 Disability

In the 2011 Census, residents were asked to assess whether their day-to-day activities were either 'Limited a lot' or 'Limited a little' because of a health problem or disability. These include any problem related to old age, which has lasted, or is expected to last, at least 12 months.

**Figure 2-16: Proportion of Population who Self-Reported that their Activity is 'Limited a lot or a little' by Age (Barnet, Regional, and National)**




Source: 2011 Census

- As is expected, the proportion of people with disabilities increases as the age range increases.
- Across all ranges, Barnet has a lower proportion of people with disabilities compared to Outer London and England and Wales.

By gender, there were more females aged 16 and above with disabilities than men. For those aged under 16, proportionally more males reported limitations in their day-to-day activities. This was the same across all geographical areas.

**Table 2-13: Proportion of Population Whose Activity is 'Limited a lot or a little' by Age and Gender 2011 (Barnet, Regional, and National)**

| Area | All Ages | | 0 - 15 | | 16 - 49 | | 50 - 64 | | 65+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Barnet | 12.6% | 15.4% | 3.6% | 2.3% | 6.8% | 7.3% | 18.8% | 20.8% | 45.9% | 54.3% |
| Outer London | 13.1% | 15.9% | 3.9% | 2.6% | 7.1% | 7.8% | 20.5% | 23.1% | 48.1% | 55.5% |
| England and Wales | 16.6% | 19.2% | 4.6% | 2.9% | 8.5% | 9.0% | 22.9% | 24.6% | 50.3% | 56.3% |

Source: 2011 Census

- By Ward, Underhill had the largest proportion of residents who reported having their day-to-day activities limited in some way, (17.2%) with 8.2% of these residents assessing themselves as having their day-to-day activities limited a lot.
- Even though Underhill has one of the smallest actual populations within the Borough (15,915 in 2011), it still had the third largest number of people who reporting having their day-to-day activities limited a lot (1,311).
- Burnt Oak and Childs Hill had the highest number of residents who assessed themselves as having their activities limited a lot, 1,499 and 1,390 respectively.

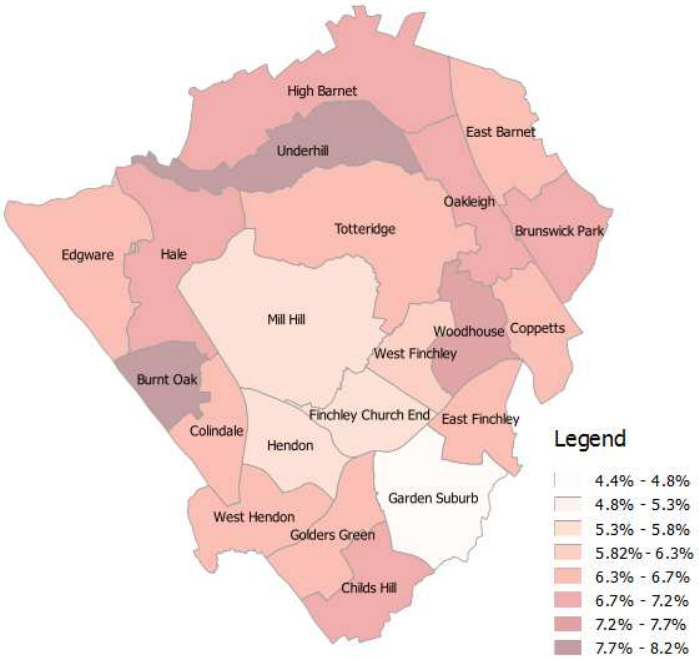
**Table 2-14: Proportion of Population Whose Activity is 'Limited a lot or a little' in 2011 (Ward, Barnet, Regional, and National)**

| Area | Total Population | Number of People with day-to-day activities limited | | | % of People with day-to-day activities limited | | |
|---|---|---|---|---|---|---|---|
| | | Limited a Lot | Limited a Little | Total | Limited a Lot | Limited a Little | Total |
| Barnet | 356,386 | 23,475 | 26,428 | 49,903 | 6.6% | 7.4% | 14.0% |
| Outer London | 4,942,040 | 335,759 | 382,917 | 718,676 | 6.8% | 7.7% | 14.5% |
| England and Wales | 56,075,912 | 4,769,712 | 5,278,729 | 10,048,441 | 8.5% | 9.4% | 17.9% |
| | | | | | | | |
| Brunswick Park | 16,394 | 1,117 | 1,361 | 2,478 | 6.8% | 8.3% | 15.1% |
| Burnt Oak | 18,217 | 1,499 | 1,390 | 2,889 | 8.2% | 7.6% | 15.9% |
| Childs Hill | 20,049 | 1,429 | 1,283 | 2,712 | 7.1% | 6.4% | 13.5% |
| Colindale | 17,098 | 1,079 | 1,167 | 2,246 | 6.3% | 6.8% | 13.1% |
| Coppetts | 17,250 | 1,160 | 1,198 | 2,358 | 6.7% | 6.9% | 13.7% |
| East Barnet | 16,137 | 1,042 | 1,301 | 2,343 | 6.5% | 8.1% | 14.5% |
| East Finchley | 15,989 | 1,074 | 1,259 | 2,333 | 6.7% | 7.9% | 14.6% |
| Edgware | 16,728 | 1,075 | 1,298 | 2,373 | 6.4% | 7.8% | 14.2% |
| Finchley Church End | 15,715 | 857 | 1,229 | 2,086 | 5.5% | 7.8% | 13.3% |
| Garden Suburb | 15,929 | 694 | 968 | 1,662 | 4.4% | 6.1% | 10.4% |
| Golders Green | 18,818 | 1,254 | 1,228 | 2,482 | 6.7% | 6.5% | 13.2% |
| Hale | 17,437 | 1,182 | 1,301 | 2,483 | 6.8% | 7.5% | 14.2% |
| Hendon | 18,472 | 1,078 | 1,286 | 2,364 | 5.8% | 7.0% | 12.8% |
| High Barnet | 15,307 | 1,050 | 1,242 | 2,292 | 6.9% | 8.1% | 15.0% |
| Mill Hill | 18,451 | 1,047 | 1,406 | 2,453 | 5.7% | 7.6% | 13.3% |
| Oakleigh | 15,811 | 1,073 | 1,172 | 2,245 | 6.8% | 7.4% | 14.2% |
| Totteridge | 15,159 | 951 | 1,121 | 2,072 | 6.3% | 7.4% | 13.7% |
| Underhill | 15,915 | 1,311 | 1,430 | 2,741 | 8.2% | 9.0% | 17.2% |
| West Finchley | 16,533 | 1,023 | 1,136 | 2,159 | 6.2% | 6.9% | 13.1% |
| West Hendon | 17,402 | 1,172 | 1,243 | 2,415 | 6.7% | 7.1% | 13.9% |
| Woodhouse | 17,575 | 1,308 | 1,409 | 2,717 | 7.4% | 8.0% | 15.5% |

Source: 2011 Census

Figure 2-17 provides map of the Barnet population by residents who reported having their day-to-day activities limited a lot. As you can see from the map, this indicator appears less impacted by locality, with a fairly even spread across the whole Borough.

**Figure 2-17: Proportion of Population Whose Activity is 'Limited a lot' by Ward, 2011**




Source: 2011 Census

### 2.11.1 Types of Disability

There is no definitive data on the amount of people with disabilities within the Borough, although by applying national prevalence rates to the Barnet population it is possible to get an indication of this. The rates are taken from research undertaken by Oxford Brookes University.

**Table 2-15: The Estimated Number of People in Barnet with Moderate or Severe Learning Disabilities, 2015, 2021 & 2030**

| Age Range | Prevalence Rate | Number of People: 2015 | Number of People: 2021 | Number of People: 2030 |
|---|---|---|---|---|
| 15-19 | 0.68% | 137 | 143 | 164 |
| 20-24 | 0.60% | 131 | 128 | 139 |
| 25-29 | 0.53% | 161 | 158 | 153 |
| 30-34 | 0.54% | 170 | 174 | 167 |
| 35-39 | 0.61% | 175 | 191 | 191 |
| 40-44 | 0.62% | 163 | 177 | 189 |
| 45-49 | 0.56% | 143 | 144 | 161 |
| 50-54 | 0.48% | 110 | 120 | 123 |
| 55-59 | 0.55% | 106 | 122 | 127 |
| 60-64 | 0.43% | 68 | 79 | 92 |
| 65-69 | 0.36% | 55 | 53 | 66 |
| 70-74 | 0.34% | 39 | 47 | 51 |
| 75-79 | 0.23% | 21 | 25 | 27 |
| 80+ | 0.18% | 28 | 32 | 44 |
| **Total** | | 1,507 | 1,591 | 1,694 |

Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI)

- The 15-19 age group has the highest proportion of people with moderate or severe learning disabilities (0.68%). However, as the 35-39 has a bigger overall population, the largest number of people with learning disabilities is estimated to be within this age group.
- Due to the projected population increase in the 65 and overs, the number of people aged over 65 with moderate or severe learning difficulties is estimated to rise from 143 in 2015 to 187 in 2030; a rise of over 30%.

**Table 2-16: The Estimated Number of People in Barnet Aged 18-64 with Moderate or Severe Physical Disabilities, 2015, 2021 & 2030**

| | | | Moderate | | | Serious | | |
|---|---|---|---|---|---|---|---|---|
| **Age Range** | **Prevalence Rates - Moderate Disability** | **Prevalence Rates - Serious Disability** | **2015** | **2021** | **2030** | **2015** | **2021** | **2030** |
| 18-24 | 4.10% | 0.80% | 1,188 | 1,181 | 1,306 | 232 | 230 | 255 |
| 25-34 | 4.20% | 0.40% | 2,598 | 2,604 | 2,511 | 247 | 248 | 239 |
| 35-44 | 5.60% | 1.70% | 3,076 | 3,344 | 3,456 | 934 | 1,015 | 1,049 |
| 45-54 | 9.70% | 2.70% | 4,693 | 4,899 | 5,279 | 1,306 | 1,364 | 1,470 |
| 55-64 | 14.90% | 5.80% | 5,240 | 6,026 | 6,636 | 2,040 | 2,346 | 2,583 |
| **Total** | | | 16,795 | 18,054 | 19,188 | 4,759 | 5,203 | 5,596 |

Source: Projecting Adult Needs and Service Information (PANSI)

- Unlike learning disabilities, the prevalence of physical disabilities increases as the population becomes older, with the highest rates of both moderate and serous disabilities located within the 55-64 age group. It is likely that people aged 65 and over will have higher rates of moderate or serious physical disabilities; however POPPI doesn't produce this data.
- Across all age groups, more people have physical disabilities than learning disabilities.

**Table 2-17: The Estimated Number of People in Barnet with Mental Health Problems by Gender, 2015, 2021 & 2030**

| | Prevalence Rates | | Males | | | Females | | |
|---|---|---|---|---|---|---|---|---|
| | **Males** | **Females** | **2015** | **2021** | **2030** | **2015** | **2021** | **2030** |
| Common Mental Disorder | 12.50% | 19.70% | 14,098 | 14,927 | 15,680 | 22,960 | 24,045 | 24,993 |
| Borderline personality disorder | 0.30% | 0.60% | 338 | 358 | 376 | 699 | 732 | 761 |
| Antisocial personality disorder | 0.60% | 0.10% | 677 | 717 | 753 | 117 | 122 | 127 |
| Psychotic disorder | 0.30% | 0.50% | 338 | 358 | 376 | 583 | 610 | 634 |
| Two or more psychiatric disorders | 6.90% | 7.50% | 7,782 | 8,240 | 8,656 | 8,741 | 9,154 | 9,515 |

Source: Projecting Adult Needs and Service Information (PANSI)

- Over 10% of men and almost 20% of women aged 18-64 have some form of common mental health disorder. Apart from antisocial personality disorders, women have a higher prevalence across all types of mental health disorder.
- In comparison to learning and physical disabilities, only moderate physical disabilities among the 55 and over age group have a higher prevalence rate within the population.

### 2.11.2 Disability and Employment

The Office of National Statistics' Annual Population Survey provides data on the working age population (aged 16 – 64) who are disabled. This includes people who are either disabled under the disability discrimination act (DDA) or who have a work-limiting disability, as a percentage of all people aged 16-64 years.

**Figure 2-18: % aged 16-64 who are EA core disabled[4] or work-limiting disabled (Barnet and Statistical neighbours)**


Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

- In comparison to statistical neighbours, Barnet performs well on the proportion of the people of working age with a disability, with the lowest rate of 12.5%. Barnet also performs well compared to the average Outer London rate of 16.1% and the UK rate of 19.0%.

**Figure 2-19: % aged 16-64 who are EA core or work-limiting disabled, by gender (Barnet and Statistical neighbours)**


Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

- By gender, Barnet has a higher rate of working age women (16.1%) who are disabled, compared to men (8.80%). Although this is in line with national and regional trends, the difference between genders is significantly higher in Barnet than in many other areas, with 83% more disabled women of working age, than men.

[4] **EA Core disabled** includes those who have a long-term disability which substantially limits their day-to-day activities

**Table 2-18: % of Population Aged 16-64 who are EA Core or Work-limiting Disabled**

| | Men | Women | % Difference |
|---|---|---|---|
| **Barnet** | **8.8%** | **16.1%** | **83.0%** |
| Sutton | 10.0% | 17.7% | 77.0% |
| Ealing | 14.3% | 21.0% | 46.9% |
| Hounslow | 12.3% | 17.1% | 39.0% |
| Reading | 11.1% | 15.2% | 36.9% |
| Redbridge | 15.0% | 20.4% | 36.0% |
| Outer London | 14.1% | 18.2% | 29.1% |
| Milton Keynes | 15.8% | 19.3% | 22.2% |
| United Kingdom | 17.6% | 20.4% | 15.9% |
| Hillingdon | 15.6% | 16.6% | 6.4% |
| Kingston upon Thames | 13.1% | 13.4% | 2.3% |
| Merton | 13.0% | 12.4% | -4.6% |
| Bromley | 16.2% | 14.1% | -13.0% |

Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

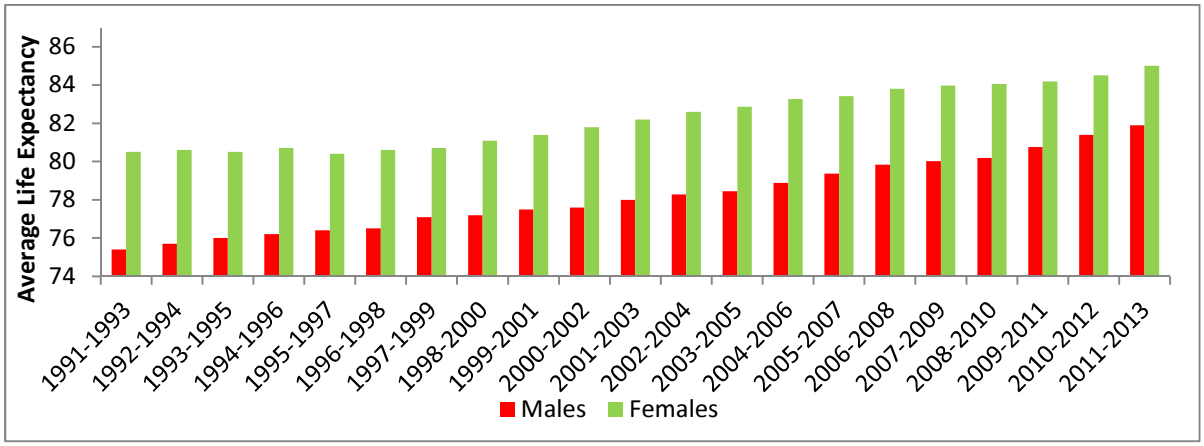
## 2.12 Life Expectancy

Life expectancy is a good measure of the overall health of a population. People in Barnet continue to enjoy a better health experience than the national average and this is reflected in their life expectancy.

Figure 2-20 displays the life expectancy from birth for men and women within Barnet for the period 1991 – 2013. In Barnet, as in the rest of the country, Women have a higher average life expectancy than. However, as you can see from Figure 2-20, the life expectancy of men has increased at a higher rate than for women, reducing the life expectancy gap between genders from 5.1 years to 3.1 years.

Furthermore, the difference in healthy life expectancy between men and women is much smaller; 68.0 years for men and 68.8 years for women. This indicates that although women are living (on average) longer than men, a larger proportion of their life is spent unhealthy; 19.1% (16.2 years) for women and 17.0% (13.9 years) for men.

**Figure 2-20: Life Expectancy at Birth within Barnet by Gender, 1991-2013**




Source: ONS 2013, Life Expectancy at Birth

Life expectancy can be measured in two ways; from birth and from age 65. Against regional land national comparators, Barnet is performing well across all these measures of life expectancy.

However, this strong performance in life expectancy when compared to other areas masks the inequalities that exist between areas within Barnet.

From 2009/2010 the London Health Observatory introduced the "Slope Index" of inequality. This is a single score which represents the gap in years of life expectancy between the least deprived and most deprived within a Borough, based on a statistical analysis of the relationship between life expectancy and deprivation scores. The latest data from the London Health Observatory indicates that:

- On average men who live in the 10% most deprived areas live 7.6 years less than those living in the least deprived decile. And for men who are disabled this is even worse, with life expectancies reducing by 9.2 years.
- Whereas, women who live in the 10% most deprived areas most live on average 4.7 years less than those living in the least deprived decile. And disabled women will live 8.1 years, on average, less than a woman who isn't disabled

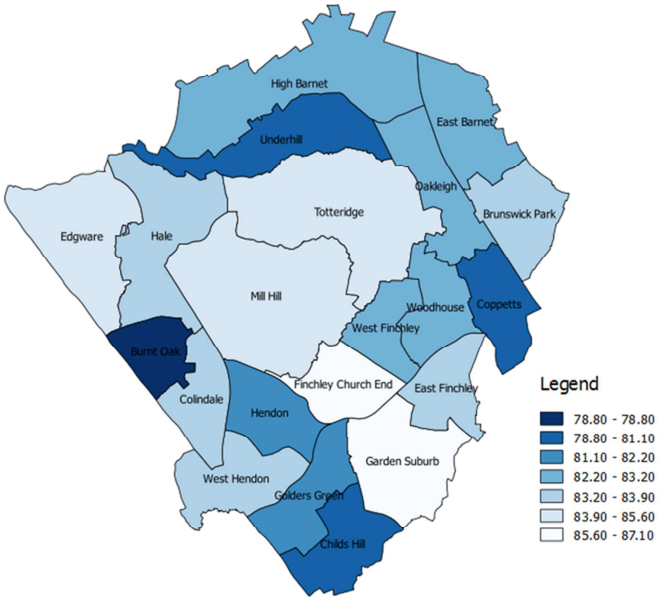
The ONS provides pooled figures on the life expectancy rates by Ward. Table 2-19 and Figure 2-21 display the latest figures for Barnet. Although many of the Wards have life expectancies close to the Borough average, there are some significant outliers.

- Burnt Oak has the lowest life expectancy from birth, 78.8. This is 4.2 years behind the Barnet average and 8.3 years behind Garden Suburb, which has the highest age of 87.1.
- Whereas, Coppetts has the lowest life expectancy at 65, 18.0. This is 3.1 years below the Barnet average of 21.1 and 6.3 years below Edgware, which has the highest age of 24.3.

**Table 2-19*: Life Expectancy within Barnet by Ward, 2009-2013***

| Ward name | Life Expectancy at Birth | Life Expectancy at 65 |
|---|---|---|
| Garden Suburb | 87.1 | 24.0 |
| Finchley Church End | 86.4 | 23.8 |
| Edgware | 85.6 | 24.3 |
| Mill Hill | 85.2 | 23.8 |
| Totteridge | 84.5 | 22.0 |
| Colindale | 83.9 | 22.6 |
| Hale | 83.7 | 21.9 |
| East Finchley | 83.6 | 21.7 |
| Brunswick Park | 83.5 | 21.3 |
| West Hendon | 83.4 | 21.2 |
| East Barnet | 83.2 | 21.1 |
| High Barnet | 83.1 | 20.9 |
| Woodhouse | 83.1 | 21.0 |
| Barnet | 83.0 | 21.1 |
| West Finchley | 83.0 | 20.9 |
| Oakleigh | 82.7 | 20.8 |
| Hendon | 82.2 | 20.9 |
| Golders Green | 81.6 | 20.3 |
| Childs Hill | 81.1 | 19.1 |
| Underhill | 81.0 | 20.1 |
| Coppetts | 80.6 | 18.0 |
| Burnt Oak | 78.8 | 18.1 |

**Figure 2-21*: Life Expectancy at Birth within Barnet by Ward, 2009-2013***



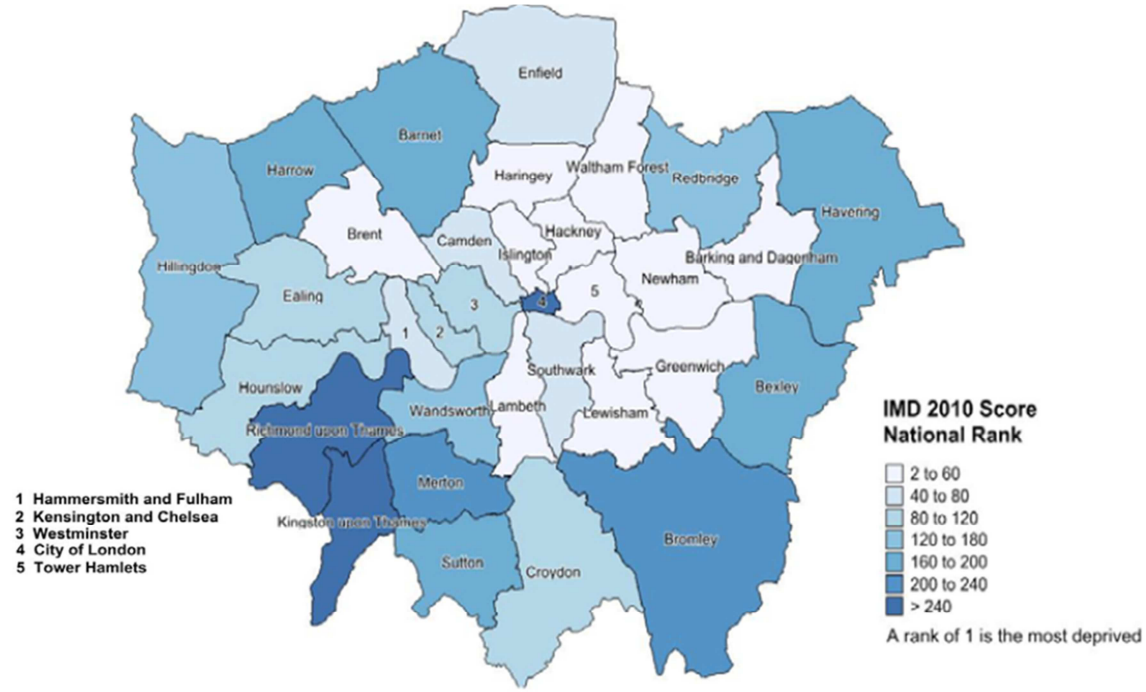

Source: ONS 2013, Life expectancy at birth by ward

## 2.13 Indices of Deprivation

The Index of Multiple Deprivation (IMD 2010) is the primary source for measuring deprivation in England and Wales. The Index is made up of seven categories known as 'indices', each for a distinct type or 'domain' of deprivation. These domains relate to income, employment, health and disability, education, skills and training, barriers to housing and services, living environment and crime, reflecting the broad range of deprivation that people can experience.

- The 2010 update to the Index of Multiple Deprivation, ranks Barnet 176th out of the 326 local authorities in England and Wales for deprivation – just slightly below the average (163; the authority ranked 1 is the most deprived). This is 48 places higher than 2007 (128th) and 17 places lower than 2004 (193rd).
- Relative to other London Boroughs, Barnet is ranked 25th out of 33 local authorities. This is four places less deprived than 2007 (21st) and one place higher than 2004 (23rd).
- Nearly all of the LSOAs in Barnet have become less deprived relative to the rest of London since 2007.

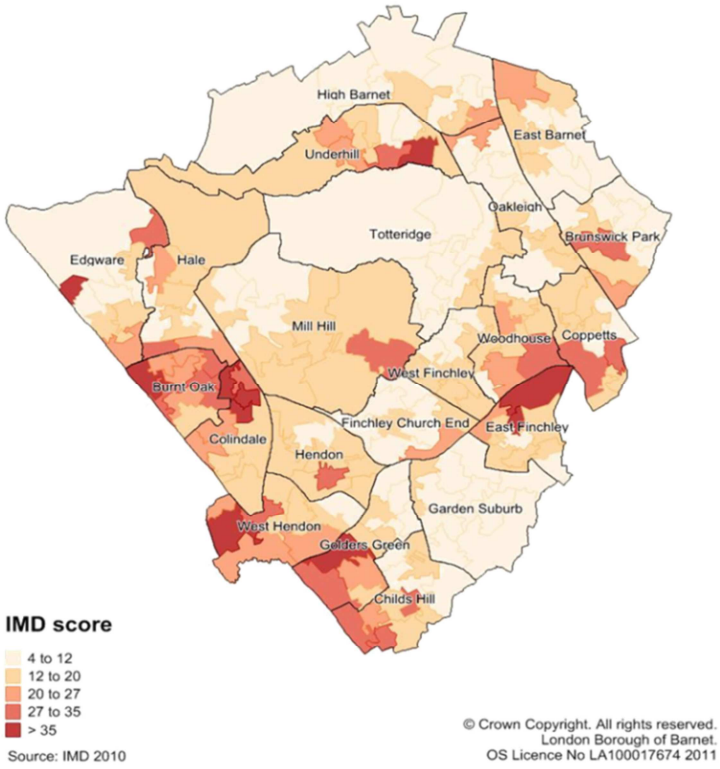
**Figure 2-22: National Rank of IMD 2010 Scores for London Local Authorities**




Source: ONS LA ID 2010

Within Barnet, the 2010 figures show the west of the Borough has higher levels of deprivation in Colindale, West Hendon and Burnt Oak. These areas also include large scale regeneration projects. Under this index the Strawberry Vale estate in East Finchley is identified as the most deprived area of the Borough and falls within the 11% most deprived in the country.

**Figure 2-23: IMD 2010 Scores for 2010 by LSOA**




By domain overall Barnet performed well in comparison to other areas. However there are certain areas within the Borough that experience high levels of deprivation.

- 13 of Barnet's LSOAs rank within the 10% most income deprived nationally and eight fall within London's 10% most deprived. These areas are found within Colindale, Edgware, Burnt Oak and East Finchley.
- Stonegrove in Edgware and Grahame Park in Colindale fall into the 10% most deprived nationally for employment.
- Regionally, two LSOAs within the Dollis Valley estate in Underhill fall within the 10% most deprived areas for education, skills and training.
- The area around Cricklewood Station in Childs Hill, the area around Hendon Thameslink Station and the West Hendon estate all fall within the 10% most deprived LSOAs nationally for the living environment domain.
- The area around Cricklewood Station in Childs Hill is the 71st most deprived area in London for crime and disorder. This places it within the 1.5% most deprived across the capital and Barnet's most deprived result on any domain.

## 2.14 Wellbeing

People with higher levels of wellbeing are likely to live longer, healthier and happier lives. They are also likely to have lower levels of ill health and recover quicker and for longer and have better physical and mental health (HM Government, 2010).

Using data from the Annual Population Survey, the ONS measure personal wellbeing across four variables: life satisfaction; worthwhileness; happiness and anxiety. Each variable is scored out of 10. The highest levels of life satisfaction, worthwhileness and happiness include ratings of 9 or 10 out of

10. For anxiety, ratings of 0 or 1 out of 10 indicate the lowest levels of anxiety and therefore the highest wellbeing.

- In 2013/2014 Barnet residents compared favourably to other London Boroughs in happiness and anxiety. It scored on average 7.53 for happiness (ranked 4th out of all London Boroughs) and 2.61 for anxiety (ranked 2nd).
- The life satisfaction and worthwhileness scores weren't as positive, with Barnet scoring 7.39 for life satisfaction (ranked 16th out of all London Boroughs) and 7.69 for worthwhileness (ranked 14th). Both of these variables 'have experienced declining scores since 2011.

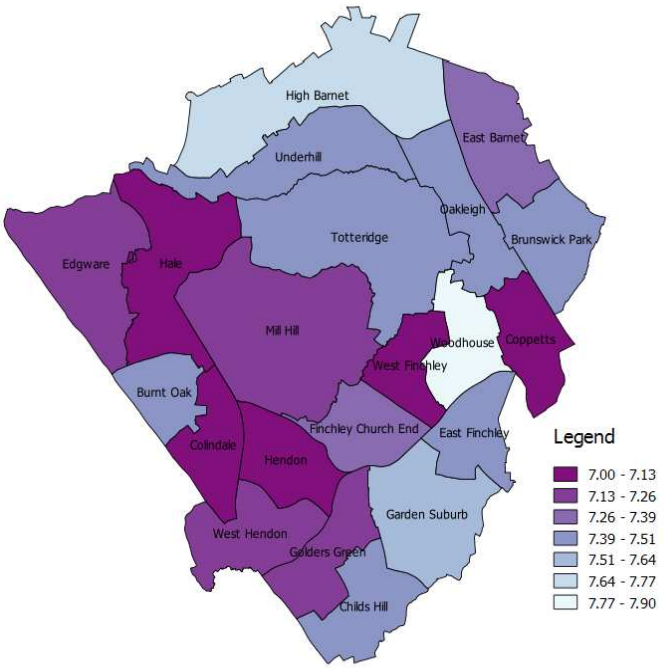
**Table 2-20: Wellbeing Scores 2011-2014 (Barnet)**

| | 2011-12 | 2012-13 | 2013-14 |
|---|---|---|---|
| Life Satisfaction | 7.45 | 7.35 | 7.39 |
| Worthwhileness | 7.72 | 7.79 | 7.69 |
| Happiness | 7.26 | 7.27 | 7.53 |
| Anxiety | 3.33 | 2.63 | 2.61 |

Source: ONS Annual Population Survey 2011 - 2014

There isn't a breakdown of each wellbeing variable by ward; however the ONS does provide an aggregated score, which is comprised of a combination of all four variables.

**Figure 2-24: Wellbeing Score by Ward**




Source: ONS Annual Population Survey

- Within Barnet, the Wards that reported the highest levels of wellbeing are Woodhouse (7.9); High Barnet (7.7); and Garden Suburb (7.6).
- Whereas the lowest rated areas based on wellbeing are found within Hendon (7.0); Hale (7.1); Coppetts (7.1); Colindale (7.1); and West Finchley (7.1).
- Overall, it appears that the areas of low wellbeing appear to be in the similar localities to the areas that had the highest levels of deprivation in the 2010 IMD figures.

# 3 Socio-Economic and Environmental Context

## 3.1 Key Facts

- At the time of the 2011 Census there were 135,916 households in Barnet. 58% of households were owner-occupied, 14% socially rented and 26% privately rented. In 2013, the GLA estimated that the number of households had increased to 141,386.
- Barnet is an expensive place in which to live with average house prices in December 2014 at £451,231.
- Between 2009 and 2012 Barnet's business population increased by 5.3%, to a total of 18,920 business units, a greater increase than for Greater London (4.6%).
- In September 2014, Barnet's employment rate was 70.9%, versus 71.5% for Outer London and 72.1% for the UK.
- In August 2014 there were 22,410 people claiming out-of-work benefits in Barnet, 9.5% of the total 16-64 population. This is below the Outer London and UK rates of 10.9% and 12.6% respectively.
- Barnet's average raw household income in 2015 was £41,658; this was 44.5% higher than the Great Britain average of £28,696.
- Between 2012 and 2015 Barnet's average household income increased by 17.6%, compared to the Great Britain average which increased by 1.0%.

## 3.2 Strategic Needs

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently the large majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established, local community and family networks.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.

- **There are shortages of people available to fill vacancies in the caring, leisure and services sectors, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.
- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

## 3.3 Housing

### 3.3.1 Housing Profile

At the time of the 2011 Census there were 135,916 households in Barnet. 58% of households were owner-occupied, 14% socially rented and 26% privately rented. In 2013, the GLA estimated that the number of households had increased to 141,386.

28% are one-person households, 6% contain only people aged 65 or more, 32% contain married or civil partnership couples with or without children, 7% cohabiting couples with or without children, 12% lone parents and 14% other household types.

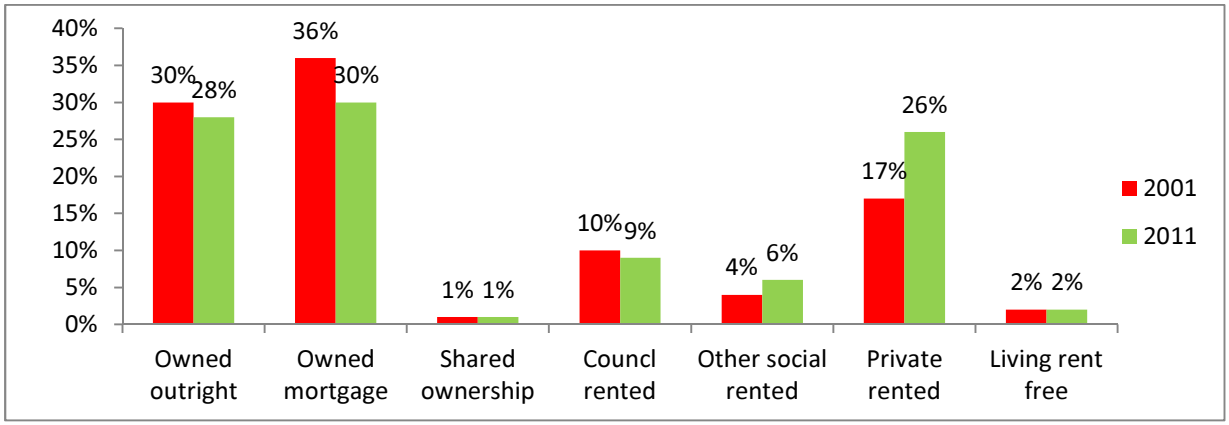
Data from the last census indicates that in 2011 the average household in Barnet consisted of 2.6 persons and 2.7 bedrooms.

Following the 2008 economic downturn, mortgage repossessions in Barnet increased significantly peaking at over 56 repossessions per quarter in 2008. This figure has now significantly reduced, with repossessions per quarter in single figures for the first three quarters of 2014.

### 3.3.2 Tenure

Over the last 10 years there has been a marked change in the tenure pattern of households living in Barnet as there has been across London. Figure 3-1 below compares the results of the censuses in 2001 and 2011 for Barnet. Owner occupation reduced by 8% between 2001 and 2011, while there was a 9% increase in private renting over the same period. There was only a 1% increase in council or housing association renting.

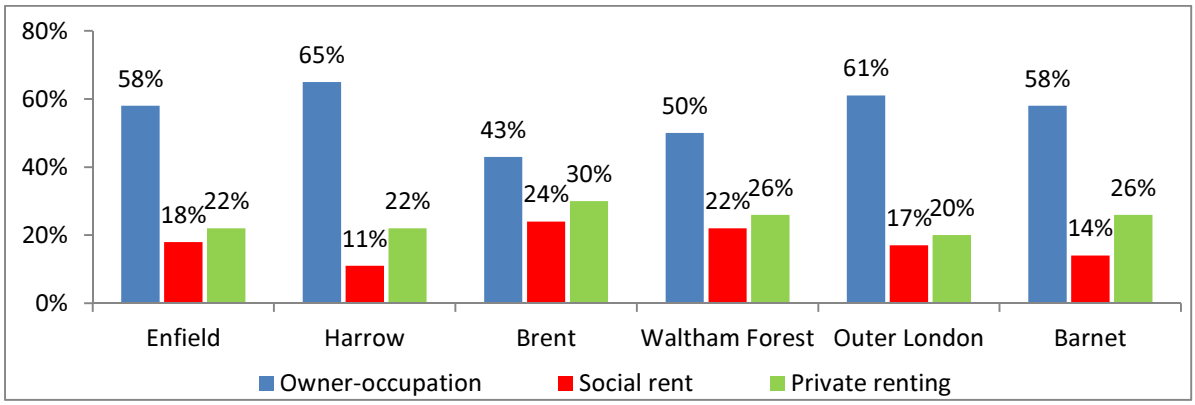
**Figure 3-1: Housing Tenure in Barnet, 2001 and 2011**




Source: Census 2011 & Census 2001

Barnet now has a lower percentage of owner occupiers than the average for Outer London and more private renters than the average Outer London Borough.

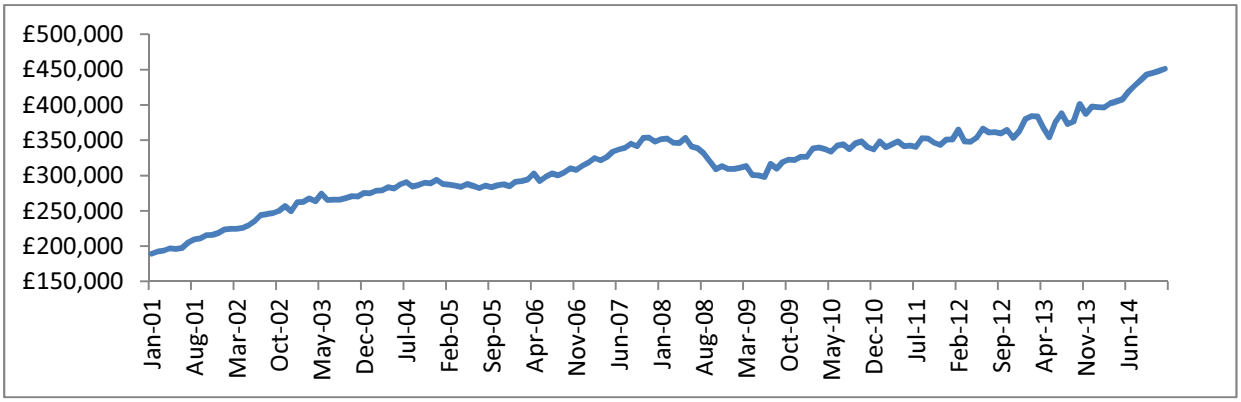
**Figure 3-2: Housing Tenure by Borough, 2011**




Source: Census 2011

The shift in housing tenure has largely been driven by affordability issues. Home ownership is very expensive in Barnet. Median house prices in Barnet rose by **16%** during the year to December 2014. The Barnet average house price in December 2014, **£451,231** is over **10X** the Barnet average income meaning that for many households home ownership is an unaffordable aspiration.

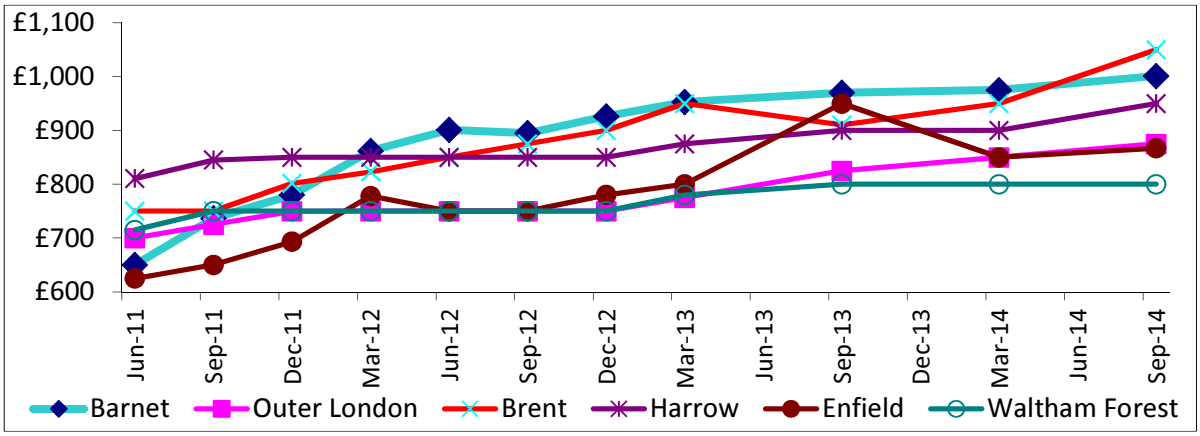
**Figure 3-3 Average House Prices in Barnet, January 2001 – December 2014**




Source: Land Registry House Price Index 2015

Private renting has also become more expensive in Barnet as can be seen in the chart below. Barnet lower quartile private rents have increased by £351 between June 2011 and September 2014. Barnet was below the average for Outer London and is now the 4th most expensive Outer London Borough.

**Figure 3-4: Lower Quartile Monthly Rents, 2011 – 2014 (Regional)**




Source: Valuation Office Agency 2015

Given the fact that Barnet is set to become London's most populous Borough in 2015 and that the population is projected to continue to increase, more homes will need to be built across the housing tenures. Most of the new housing will come from small private developments that collectively play a significant contribution to alleviating demand.

### 3.3.3 Overcrowding

According to the Integrated Household Survey from ONS, in 2010 there were 6.7% overcrowded households in Barnet; this is less than the London average of 7.5%. Given the high demand for housing in the Borough, overcrowding in itself is unlikely to enable a household to be rehoused by the council, unless there is severe overcrowding- at least 3 bedrooms short.

The 2006 Barnet Housing Needs Survey estimated that there are an estimated 38,000 households who are under occupying larger properties – many of whom are older people whose families have grown up. By ensuring that new homes meet the Lifetime Homes standard[5] and increasing the housing choices available for the elderly, it is expected that some older owner occupiers will opt to move into smaller more manageable accommodation, freeing up larger properties. In addition, Barnet Homes operate a successful *trade down* scheme to help council tenants under-occupying larger units move to smaller flats freeing up homes for larger families who need them.

There continues to be a need to work to ensure that the best use is made of council housing by operating a trade down scheme and ensuring that those affected by the under-occupancy charge are given the opportunity to move into homes that meet their bedroom requirements.

[5] Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society– Communities & Local Government Feb 08

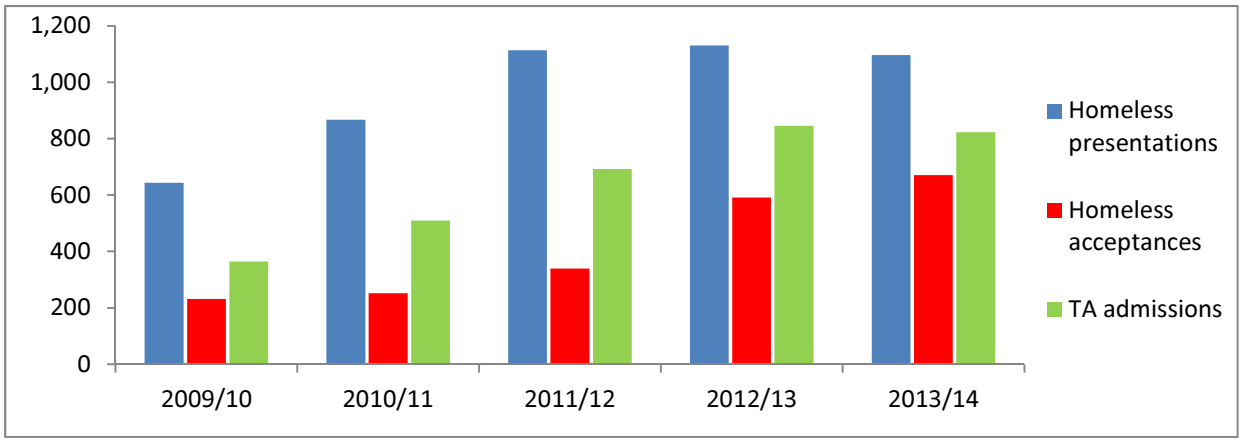
### 3.3.4 Temporary Accommodation and Reducing Homelessness

The number of households presenting as homeless and the number of households being accepted as homeless have increased significantly over the past five years. The number of new temporary accommodation admissions has also risen.

The key reasons for the increased demand on services include:

- Increased housing costs, combined with restrictions on housing benefit, has resulted in more households moving out of Central London to Outer London Boroughs, including Barnet. This is evidenced by a significant increase in the number of households claiming housing benefit in Barnet and a fall in housing benefit claims in Central London.
- Other welfare reforms, particularly the overall benefit cap, have resulted in the Council and its partners working proactively with affected households living in the private sector to assist them into work or move into more affordable accommodation.
- The number of households seeking help with their housing has been increasing throughout London because of the high cost of owning or renting a home.
- Private sector rents have increased faster in Barnet than in other parts of London and they are the 4th highest out of 16 Outer London Boroughs, meaning that more low-income households may approach the Council for assistance with their housing.

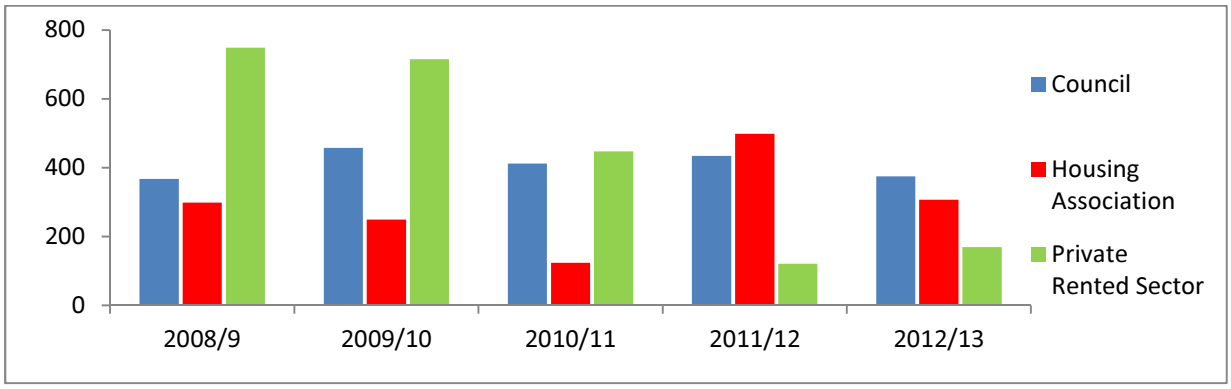
**Figure 3-5*:* Increased demand for housing within Barnet, 2009-2014**




Source: Barnet Council Data

Housing supply has not kept up with increased demand for housing services. As can be seen from Figure 3-6, below, the number of properties available for the Council to allocate reduced from 2009/10. This has particularly been the case for private rented sector homes. As a result of better services and incentives introduced through the Let2Barnet service at Barnet Homes, the number of private rented properties available has increased significantly since 2012. This has resulted in more households being rehoused in 2013/14 than in the previous two years.

**Figure 3-6: Reduced supply of accommodation within Barnet, 2009-2014**



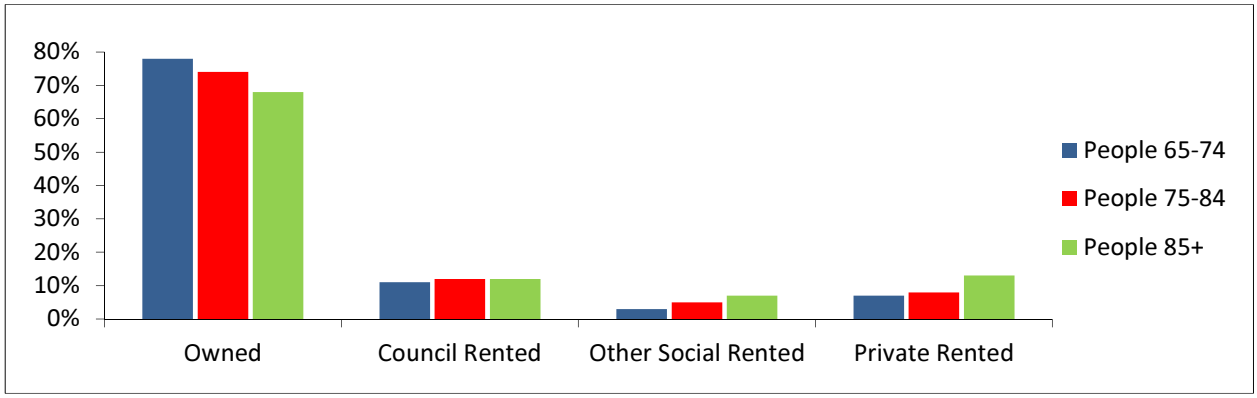

Source: Barnet Council Data

It is likely that there will continue to be a high demand for housing in the Borough as housing costs are expected to remain high. This will mean that the Council and Barnet Homes will need to maximise the supply of accommodation available for housing applicants including in the private rented sector.

### 3.3.5 Social Isolation

The majority of older people own their own home but 12% of the over 75s live in the private rented sector.

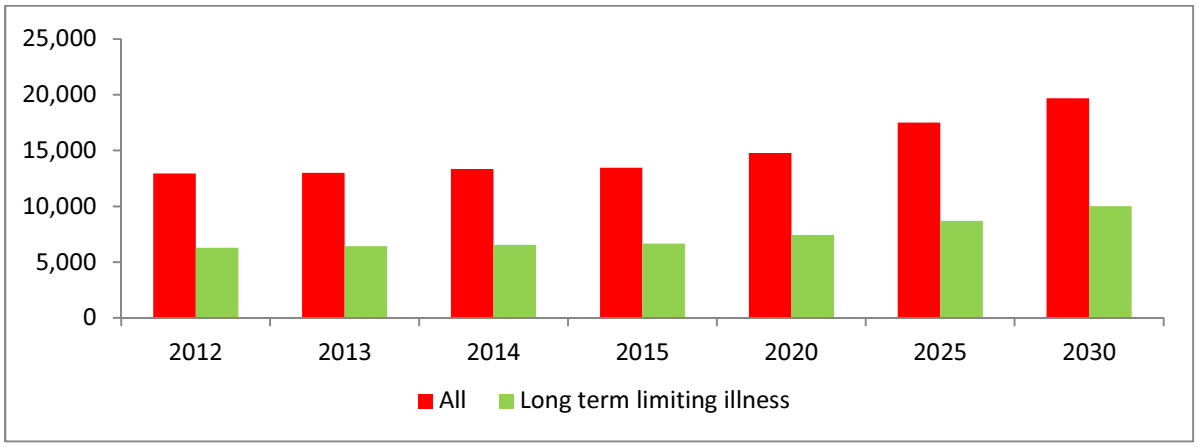
**Figure 3-7: Older People and Housing Tenure, 2011**




Source: GLA 2013 Projections (Borough Preferred Option) & 2011 Census

The number of older people living alone in the future is projected to increase, including those with a long term limited illness.

**Figure 3-8: Number of people aged over 75 projected to be living alone in Barnet, 2012-2030**




Source: GLA 2013 Projections (Borough Preferred Option) & 2011 Census

The older population in Barnet is set to increase significantly over the next 30 years. However, older people should not be viewed as a homogenous group and a variety of housing options will be needed to meet their needs and expectations.

Whilst many older people will remain independent for longer, it is inevitable that as the older population grows, the number of people requiring care will also increase, particularly amongst those that live beyond the age of 85.

At present there are an estimated 24,162 people aged 65 or over with a limiting long term illness. The Projecting Older People Population Information (POPPI) system projects these figures to increase by more than 12% by 2020.

**Table 3-1: Projected Number of Older People with a Limiting Long Term Illness in Barnet, 2015-2020**

| Age | 2015 | 2020 | Change | |
|---|---|---|---|---|
| | | | No. | % |
| **65-74** | 9,241 | 10,138 | 897 | 9.7% |
| **75-84** | 9,208 | 10,346 | 1,138 | 12.4% |
| **85+** | 5,713 | 6,776 | 1,063 | 18.6% |
| **All 65+** | 24,162 | 27,260 | 3,098 | 12.8% |

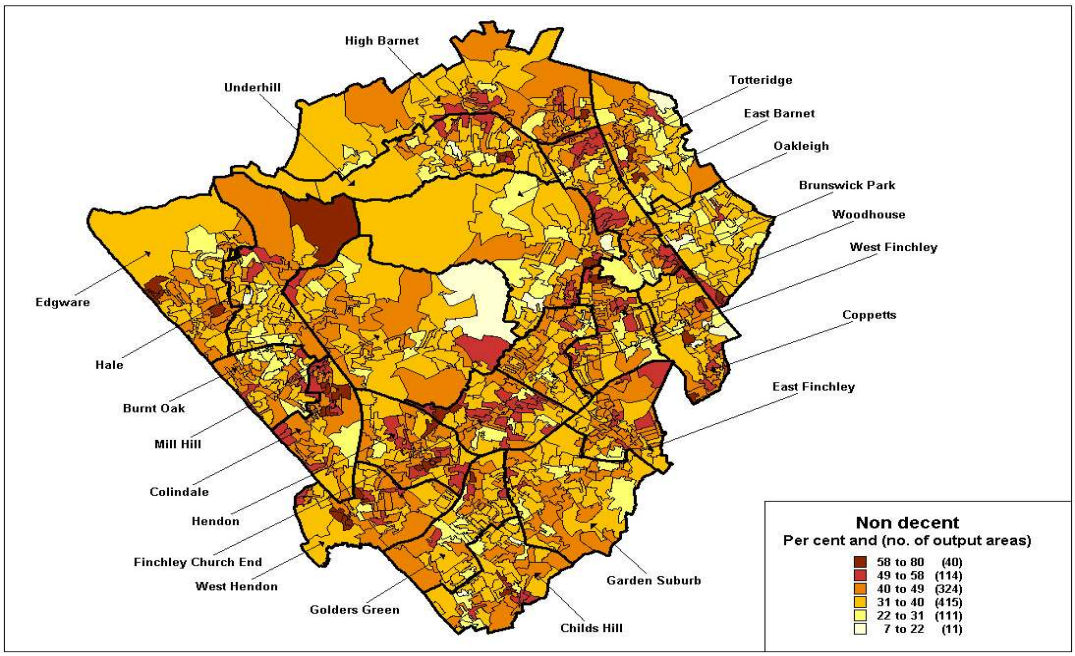
Source: Projecting Older People Population Information System (POPPI) 2015

### 3.3.6 Existing Housing Stock

Barnet Homes was created to deliver improvements to the condition of the Council's housing stock through the government's Decent Homes programme and to improve services to tenants and leaseholders. Barnet Homes was successful in delivering the Decent Homes programme, in 2011, on homes that were not due for demolition as part of a regeneration scheme.

Estimations of non-decent homes in the private sector (owner occupied and rented) are shown in the map below. They are present across the Borough.

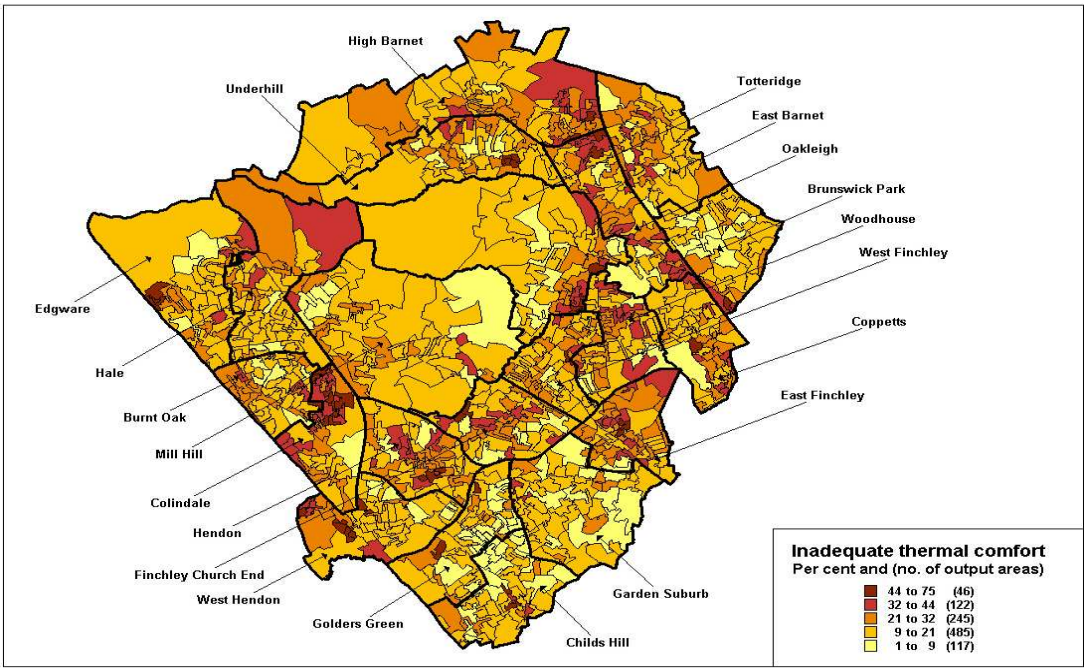
**Figure 3-9: Non-decent homes in the private sector within Barnet, 2009**




Source: BRE Stock Projections Update 2009

The same data shows that there are relatively few areas of the Borough with high levels of private sector homes with inadequate thermal comfort.

**Figure 3-10: Number of homes with inadequate thermal comfort within Barnet, 2009**




Source: BRE Stock Projections Update 2009

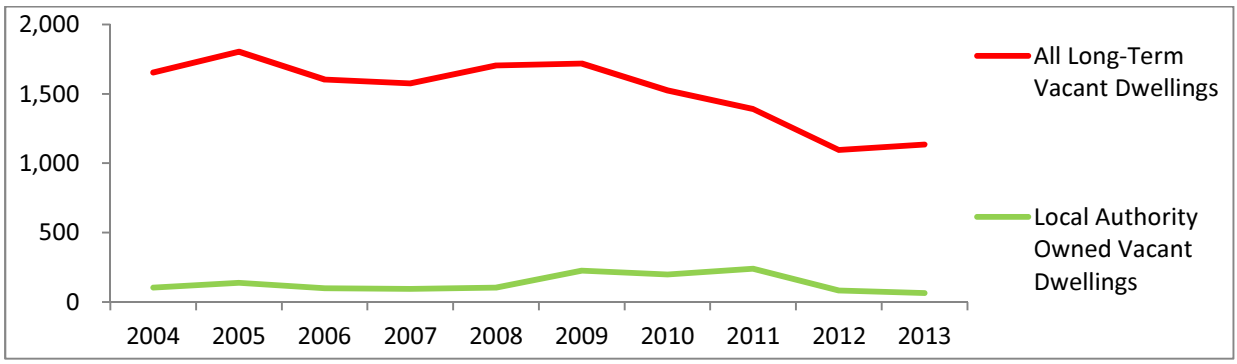
The role of the private rented sector in meeting the housing needs of the Borough has increased significantly over the last decade. Between 2001 and 2011, the number of private rented homes rose from 17% to 26% of homes in the Borough. Analysis of affordability and housing need going forward suggests that the private rented sector will continue to grow over the next ten years by a further 9%, to represent 25% of homes in the Borough.

The private rented sector provides homes for people in a way that provides flexibility and choice. However, the nature of the market means that there are many small scale landlords, often with only one or two properties, which makes it more difficult to ensure a consistent quality across the sector. It is therefore necessary to look at ways to improve the condition of properties in the private rented sector.

### 3.3.7 Empty Homes

Data published by the Department for Communities and Local Government shows that the number of long-term (at least 6 months) vacant dwellings has declined in the past 10 years. Most vacant dwellings are in the private sector and the council is working with owners of empty properties to bring them back into habitable use.

**Figure 3-11: The number of long-term vacant dwellings in Barnet, 2004-2013**



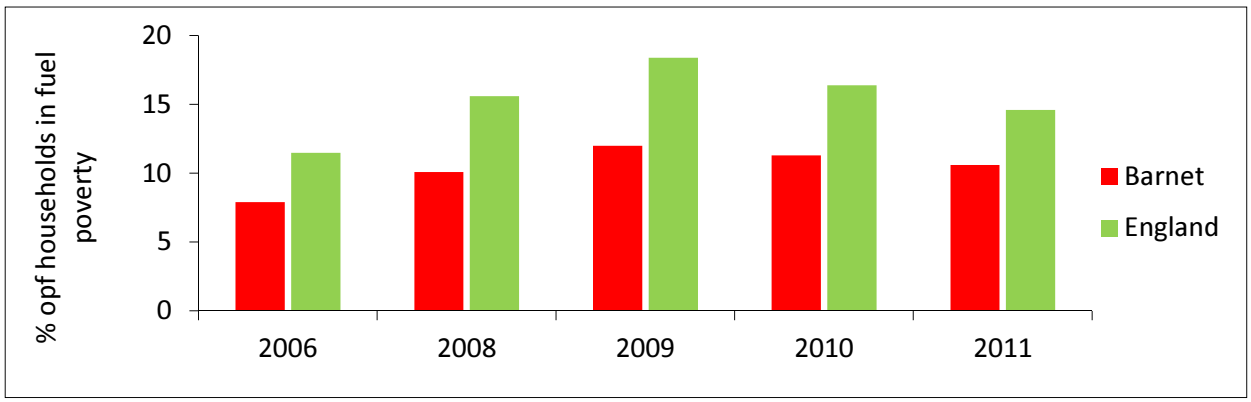

Source: Department for Communities and Local Government, local authority vacant dwellings, England 1989 to 2013

Given the high demand for housing in the Borough, the Council will look at bringing empty properties back into residential use. Currently, there are approximately 1,300 homes in Barnet that have been empty for 6 months or more. Where owners wish to bring properties back into use, the Council will provide financial assistance in the form of Empty Property Grants.

### 3.3.8 Fuel Poverty and Central Heating

Data produced by the Department for Energy and Climate Change shows that in 2011 10.6% of Barnet's households, or 13,628 homes, were fuel poor.

**Figure 3-12: The proportion of households in fuel poverty, 2006-2011**




Source: Department for Energy and Climate Change, sub-regional fuel poverty data: low income high costs indicator 2006-2011

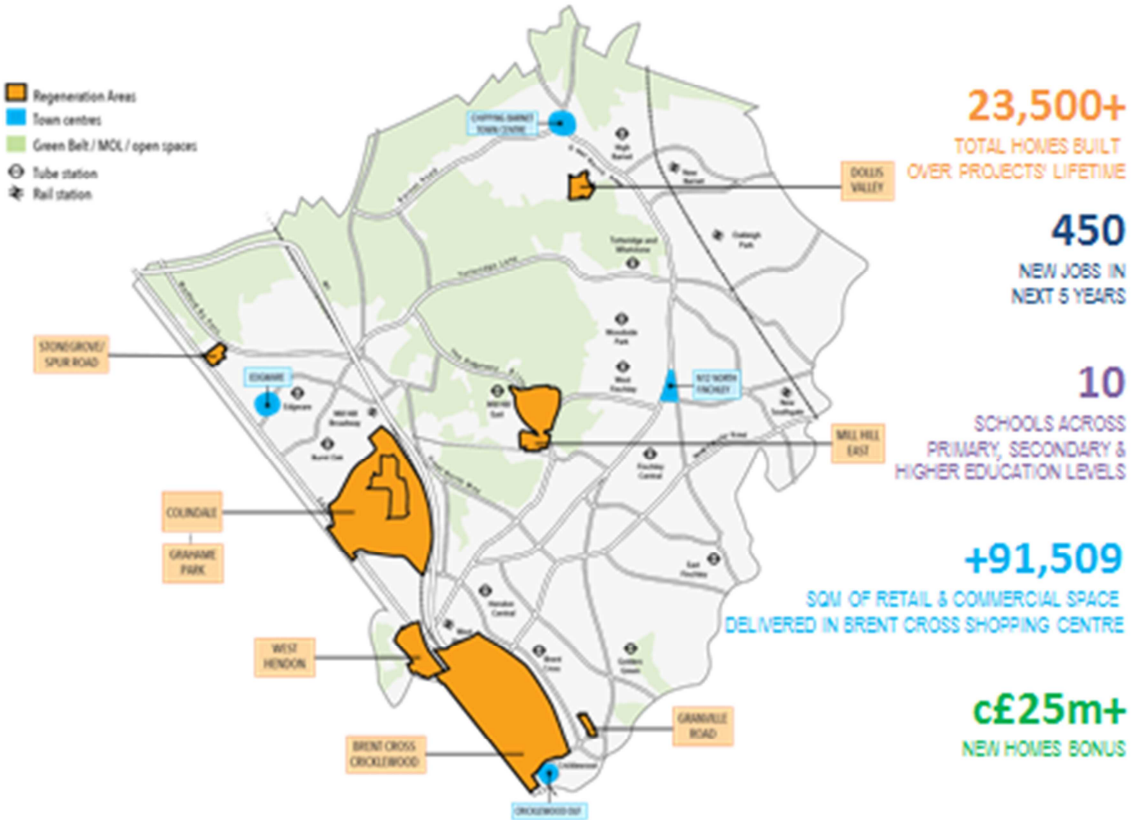
The level of excess cold hazards is considered an issue given the increasing numbers of older residents in Barnet.

### 3.3.9 Housing Supply

Housing is critical to Barnet's success as a Borough. It plays a key role in the Borough's ambitious plans for growth, providing the catalyst for the major regeneration programmes at Dollis Valley, Stonegrove/Spur Road, West Hendon, Grahame Park and Brent Cross/Cricklewood. Delivering these regeneration programmes will transform the more deprived areas of the Borough and create better places in which to live. There will be more housing tenure choice, increased employment and training opportunities, improved transport infrastructure, better education opportunities and better housing and management services for residents in these areas.

New housing will not only be delivered through the major regeneration programmes. The council is making use of new freedoms arising out of Housing Revenue Account self-financing and the reinvigorated Right to Buy, to build more homes on housing land, including affordable homes. The first three council homes to be built by Barnet Council, in partnership with Barnet Homes, have already been let and there are plans for a further 300 homes over the next 5 years on infill sites across the Borough.

**Figure 3-13: Planned Regeneration Works within Barnet**




### 3.3.10 Residents Voice

The Residents Perception Survey 2013 found an increase in concern from residents about lack of affordable housing and homelessness (with Barnet residents more concerned about the former compared to the London average).

**Table 3-2: Residents Perception Survey Responses, 2013**

| Significant increases in concern | % listing this as top concern | Barnet % point change since 2012/13 | London % point change since 2012/13 | % difference to London 2013/14 |
|---|---|---|---|---|
| Lack of affordable housing | 27% | +6% | -3% | +4% |
| Number of homeless people | 8% | +3% | -1% | -1% |

Source: London Borough of Barnet, Resident's Perception Survey

In the last four years, overall tenants' satisfaction with the services provided by Barnet Homes has risen by 8.5%. It currently stands at 81.1%. The next challenge is to continue to provide high quality services to ensure that satisfaction rates remain high.

## 3.4 Environment

### 3.4.1 Carbon Emissions

The Council recognise the need to reduce carbon dioxide (C02) emissions in the Borough, and that this has to be approached through behavioural change by public services, citizens and businesses.

In 2012, per capita, CO2 emissions in Barnet were 4.4 tonnes per person, down from 5.4 tonnes per person in 2005. This was the fifteenth lowest in London, and below the Greater London rate of 5.2[6].

In 2012, the biggest source of CO2 emissions within Barnet was from homes (51.4%), with industry and commercial activity generating 24.3% of emissions and road transport creating 24.1%. The overall level of carbon emissions in Barnet fell from 1,759,400 tonnes of CO2 in 2005 to 1,600,300 tonnes of CO2 in 2012.

### 3.4.2 Air Pollution

For the majority of the population the health impacts of air pollution are not obvious, however, smaller numbers of the population are more vulnerable to the effects of air pollution, as exposure to pollution can exacerbate existing health conditions including cardiovascular and respiratory disease. This can lead to restricted activity, hospital admissions and even premature mortality[7].

The UK Air Quality Standards Regulations 2000, updated in 2010, sets standards for a variety of pollutants that are considered harmful to human health and the environment. Despite reductions in the majority of the pollutants, levels of PM10 and Nitrogen Dioxide (NO2) continue to exceed the national air quality standards and objectives in some areas of London.

Figures 3-14 and 3-15, spatially represent the annual mean concentrations of NO2 and PM10 in Barnet in 2011. Generally the levels of NO2 and PM10 are quite low within the Borough, although there are concentrated areas of higher pollution levels around some of the main arterial roads within the Borough.

[6] AEA for the Department of Energy and Climate Change: Local and regional CO2 Emissions Estimates for 2005-2012
[7] https://www.london.gov.uk/sites/default/files/Air%20Quality%20for%20Public%20Health%20Professionals%20-%20LB%20Barnet.pdf

**Figure 3-14: Annual Mean Concentrations of PM10 in Barnet, 2011**

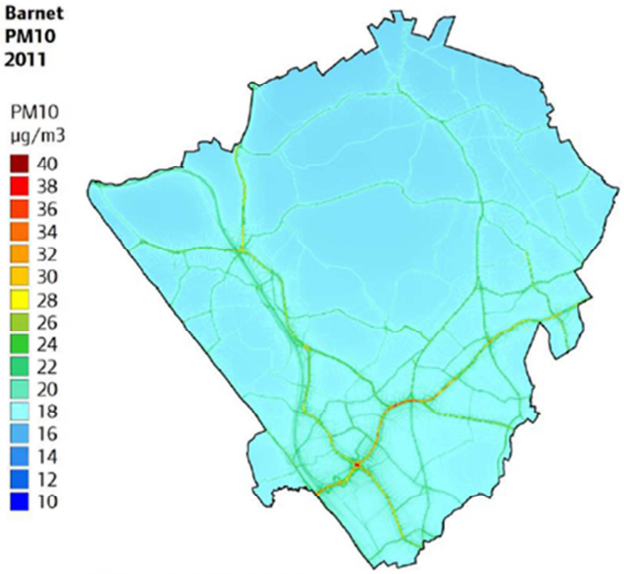
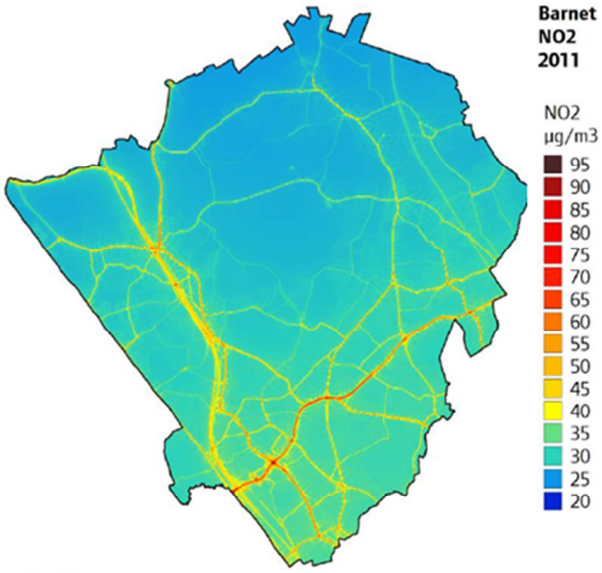



**Figure 3-15: Annual Mean Concentrations of NO2 in Barnet, 2011**

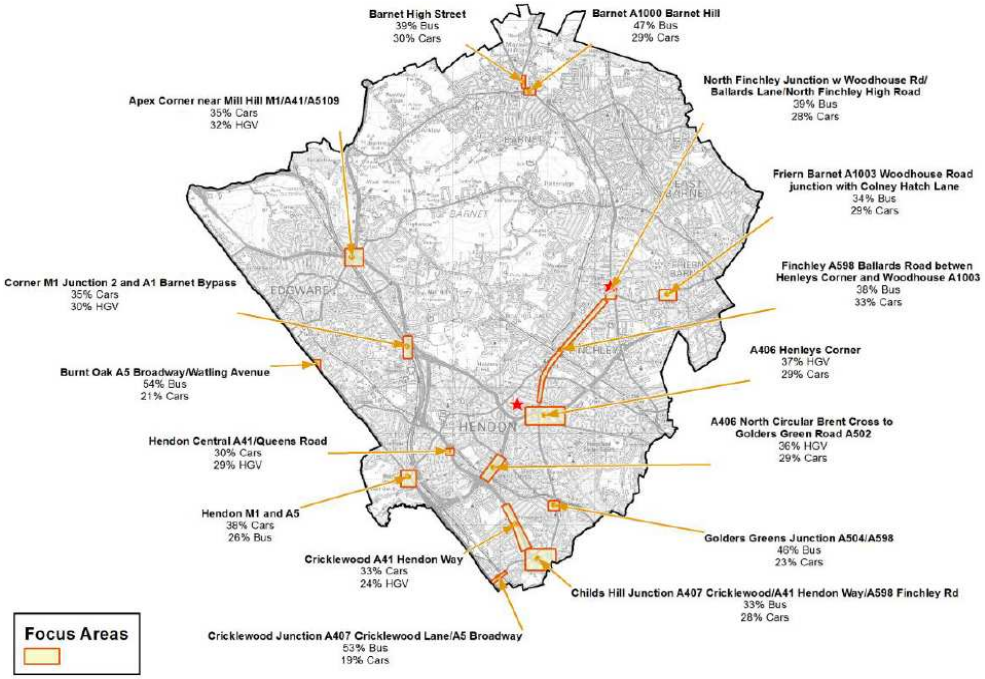



Source: Air Quality in Barnet a Guide for Public Health Professionals, 2013

In 2011 air quality focus areas were selected by the GLA, as areas where there is the most potential for improvements in air quality within the Capital. These areas have been selected through an analysis of factors such as current and predicted air quality; population and traffic patterns.

In 2011 the GLA identified eight Air Quality Focus Areas within Barnet, outlined in Figure 3-16 below. The red stars represent the location of the monitoring equipment and the percentages under each location display the primary sources of Nitrogen Oxide emissions for that area.

**Figure 3-16: Barnet Focus Areas and Air Quality Monitors**




Source: Air Quality in Barnet a Guide for Public Health Professionals, 2013

### 3.4.3 Green Spaces

Parks are widely recognised for their health benefits as they can be used as a setting for casual or organised exercise. In Barnet, parks and green spaces are the most popular location for exercising, accounting for over 50% of exercise in the Borough[8]. Frequenting a park has also been found to reduce stress-related illness which has a positive effect on mental wellbeing[9].

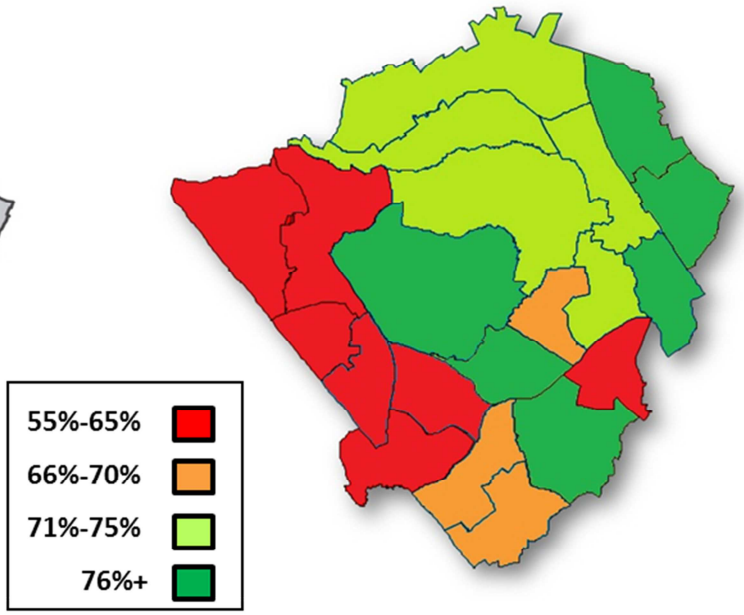
Figure 3-17 shows the location of parks and green spaces in Barnet, and Figure 3-18 shows satisfaction with parks and green spaces by ward. In 2014, the average satisfaction rate for parks and green spaces in Barnet was 70%. Burnt Oak residents had the lowest level of satisfaction (55%) whereas Garden Suburb had the highest (86%)[10].

Generally speaking, the west of the Borough had lower satisfaction with parks than the east. With the exception of East Finchley, the wards with the lowest satisfaction were all in the Hendon constituency.

**Figure 3-17: Barnet's Parks and Green Spaces**

Source: Capita Insight

**Figure 3-18: Resident Satisfaction with Parks and Green Spaces**




Source: Residents' Perception Survey 2014

A strategic assessment of the parks and green spaces within Barnet was undertaken in 2014. The key findings from the report were:

- Wards that have higher rates of crime that could take place in a park or green space (for example, assault, robbery, and sexual harassment) tend to also have the lowest level of satisfaction with parks.
- Safety and provision have been highlighted as factors that could increase the use of parks. The Leisure Services Survey (2013) notes that park use could be increased if facilities were improved, and if feelings of safety and security were increased.

[8] SPA Consultation, 2013
9 Grahn, P., and Stigsdotter, U.A. (2003). Landscape planning and stress. Urban Forestry and Urban Greening 2 (1): 1-18.
[10] Residents' Perception Survey, 2014

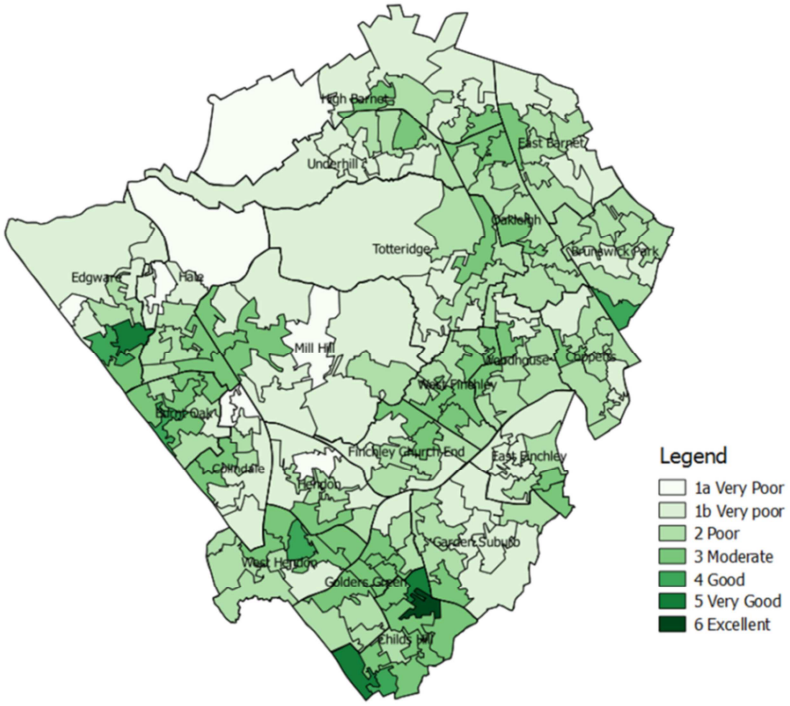
- There are a higher proportion of flats in the west of the Borough, indicating a lack of private open space. This suggests an increased need for public open space within this area.
- Burnt Oak, West Hendon, and Underhill have a higher proportion of residents who are very unlikely to volunteer in parks. This indicates a general disengagement with parks. Higher engagement could be encouraged from these groups by holding events that are targeted to appeal to the population of these wards.

### 3.4.4 Transport

#### *3.4.4.1 Access to Public Transport*

Lack of mobility is viewed as a contributing factor to deprivation, social disadvantage and exclusion as it inhibits people from accessing things such as friends, jobs and education[11]. Transport for London (TfL) produces an annual review of accessibility to public transport for each Borough, broken down by Lowest Super Output Area.

**Figure 3-19: Public Transport Accessibility Levels in Barnet, 2014**




Source: Transport for London 2014, Public Transport Accessibility Levels

Overall, Barnet is rated as having 'poor' access to public transport which is below the 'moderate' rating given to London as a whole.

However, when compared against other Outer London Boroughs, only Brent and Waltham Forest have 'Moderate' accessibility; all other Outer London Boroughs are rated as either 'poor' or 'very poor'.

Furthermore, within Barnet the areas with the lowest accessibility scores are primarily located in areas with high levels of green belt land.

11 Lucas, K. (2012) Transport and social exclusion: Where are we now? Transport Policy, 20, 105-113

### 3.4.4.2 *Trips and Mode of Transport*

Data from the TfL's Travel Demand Survey provides an indication of the amount of trips people within Barnet make each day, and the types of transport they use, for journeys that commence in the Borough.

**Table 3-3: Trip Rates and Modes of Transport, 2007/08 to 2009/10 (Barnet and Outer London)**

| Borough | Trips per Day per Person | Rail | Underground & DLR | Bus / Tram | Taxi / Other | Car & Motorcycle | Cycle | Walk |
|---|---|---|---|---|---|---|---|---|
| Barnet | 2.9 | 2% | 8% | 11% | 1% | 47% | 1% | 30% |
| Outer London | 2.5 | 5% | 5% | 12% | 1% | 49% | 1% | 27% |

Source: TfL Travel Demand Survey, 2011

- Compared to the Outer London average, Barnet residents make more trips each day, 2.5 and 2.9 respectively.
- In line with Outer London trends, cars and motorcycles are the primary mode of transport accounting for 47% of journeys.

Although cycle usage currently only makes up 1% of journeys within the Borough, the Local Plan and Local Implementation Plan include targets to increase cycling usage to 4.3% of journeys by 2026. Local Plan policies state "We will seek to make cycling and walking more attractive for leisure, health and short trips."

Barnet has an extensive road network, the second highest length of public road in London, and contained within this are notable barriers to cycling, including the M1, the North Circular Road, A1000 and the Midland Mainline Railway. However, the Borough also contains a number of parks and green field spaces that offer quiet off road cycling opportunities away from traffic.

The London Mayor's Vision for Cycling includes a programme for delivery of Quietways across London. The routes intended to appeal to new and less confident cyclists are envisaged to be mainly on quiet roads. Potential routes in Barnet have been identified for consideration.

A cycle strategy for the Borough is in development and this aims to identify policy influences, a series of objectives, and delivery plans.

## 3.5 Town Centres

Barnet's high streets are highly valued by the people who use them and the businesses that operate in them; however, the last ten years has seen the most profound change in the way people spend their time and money for half a century.

The biggest change has been the rise of the internet and online shopping, which made up 13.5% of all purchases in 2010 and is projected to reach 23% by 2016. In 2008 53% of adults bought something online. In 2014 this figure had increased to 74%[12]. This trend has resulted in high street sales of items like electronic equipment, clothes, music and shoes all falling sharply.

There are also opportunities. For example, there has actually been some growth in things that consumers can't access online; like restaurants, beauty salons, gyms and other products related to

[12] http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2014/sty-digital-day-2014.html

lifestyle, food and leisure. There are opportunities associated with an ageing population too; older adults often have higher disposable incomes, and use the internet less than some other groups.

It is important that people are encouraged to visit and live in town centres and that any barriers to them doing this are minimised. Research by London Councils in 2012 showed that:

- Around 77% of people get to their local town centre by foot, public transport or bicycle rather than by car. These people spend more each month on average in town centres than drivers.
- On average, shoppers say that traffic reduction and environmental improvements would improve the shopping experience most, with cheaper parking being less important.[13]
- Only about 19% of journeys to a town centre in outer London are made by private car.

## 3.6 Economy

### 3.6.1 Overview

Between 2009 and 2012 Barnet's business population increased by 5.3%, to a total of 18,920 business units, a greater increase than for Greater London (4.6%). Amongst neighbouring local authorities only Haringey (8.3%), Harrow (9.1%) and Redbridge (13.6%) had higher growth over this period[14].

### 3.6.2 Key Sectors

Table 3-4 shows the number of business units by sector for Barnet, London and England in March 2012, compared with March 2009.

- In March 2012, the largest business sectors in Barnet were professional scientific/technical; construction; retail; info-communications; and Property.
- Barnet has higher proportions, than for Greater London, of construction property and wholesale.
- Barnet's sectors exhibiting the greatest business unit increase for 2009-2012 were education (22.9%), health (21%), property (15.9%), Professional, Scientific and Technical (PST) (15.8%), information & communication (9.9%) and motor trades (8.8%), with all except information & communication out performing Greater London sector growth.
- The greatest areas of decline were exhibited in public/administrative, production and business/administrative sectors, all performing worse than for London as a whole.

[13] http://www.londoncouncils.gov.uk/policylobbying/transport/parkinginlondon/parkingurban.htm
[14] IDBR annual data for March 2009 to March 2012

**Table 3-4: Business Unit by Sector (Broad SIC2007) for March 2012 and change compared with March 2009 for Barnet, London and England**

| | Barnet | | | Greater London | | | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2012 | % | % change | 2012 | % | % change | 2012 | % | % change |
| Agriculture, forestry & fishing | 35 | 0% | 17% | 565 | 0% | -6% | 94,235 | 4% | 0% |
| Production | 540 | 3% | -6% | 13,755 | 3% | -6% | 128,370 | 6% | -6% |
| Construction | 1,905 | 10% | -4% | 33,775 | 8% | -2% | 232,845 | 11% | -8% |
| Motor trades | 310 | 2% | 9% | 6,215 | 2% | 4% | 66,330 | 3% | 0% |
| Wholesale | 1,300 | 7% | -1% | 20,595 | 5% | -1% | 108,845 | 5% | -2% |
| Retail | 1,860 | 10% | 1% | 41,190 | 10% | 3% | 240,595 | 11% | -2% |
| Transport & storage | 325 | 2% | 7% | 9,515 | 2% | 1% | 70,465 | 3% | -4% |
| Accommodation & food services | 845 | 4% | -2% | 25,675 | 6% | 1% | 139,370 | 6% | -5% |
| Information & communication | 1,830 | 10% | 10% | 47,435 | 11% | 14% | 153,575 | 7% | 6% |
| Finance & insurance | 495 | 3% | 7% | 14,490 | 4% | -1% | 56,965 | 3% | -2% |
| Property | 1,640 | 9% | 16% | 20,390 | 5% | 5% | 80,100 | 4% | -1% |
| Professional, scientific & technical | 3,475 | 18% | 16% | 85,070 | 20% | 11% | 329,060 | 15% | 8% |
| Business administration and support services | 1,385 | 7% | -6% | 33,530 | 8% | -5% | 157,510 | 7% | -9% |
| Public administration and defence | 85 | 1% | -15% | 2,570 | 1% | 6% | 20,315 | 1% | 3% |
| Education | 430 | 2% | 23% | 8,810 | 2% | 10% | 56,555 | 3% | 4% |
| Health | 1,010 | 5% | 21% | 21,425 | 5% | 18% | 126,690 | 6% | 11% |
| Arts, entertainment, recreation & other services | 1,450 | 8% | -1% | 34,730 | 8% | 2% | 156,390 | 7% | -3% |

Source: Annual IDBR data for years ending March 2012 and March 2009

- Between 2008 and 2011 employment in Barnet's businesses decreased by 1.9% to 118,461 (an overall loss of 2,202 jobs), compared to a decrease of 0.9% for Greater London as a whole[15].
- The largest employment wards in Barnet are West Hendon and Colindale, located to the west of the Borough along the A5 corridor, and West Finchley in the centre of the Borough on the Ballard's Lane access route[16].

'The Economic Outlook for London'[17] indicates that between 2012-15 the main employment growth sectors will be professional, scientific/technical, business administration, info-communications and construction, whilst education and health may exhibit some decline. This does not appear entirely in step with Barnet, where there is currently growing demand for health and education services against the context of a growing and ageing population.

[15] NOMIS annual BRES data 2008 to 2011
[16] BRES 2011
[17] Oxford Economics: http://web.oxfordeconomics.com/FREE/PDFS/UKMFEAT3_1012.PDF

## 3.7 Employment

Table 3-5 shows the employment and unemployment rates within Barnet, compared against Outer London and UK averages. Against both comparators, Barnet has the lower employment rate of 70.9%, compared to 71.5% for Outer London and 72.1% for the UK.

Of people employed, Barnet has a much higher rate of people who are self-employed (19.0%) compared to the Outer London rate of 12.3% and the UK rate of 10.0%. This implies a strong entrepreneurial flair within the Borough.

**Table 3-5: Employment Rates for 16-64 Year Olds, (Barnet, Regional and National), October 2013 – September 2014**

| | Barnet | | Outer London | | United Kingdom | |
|---|---|---|---|---|---|---|
| **All People** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| Economic activity | 176,699 | 74.6% | 2,580,500 | 77.1% | 31,349,500 | 77.2% |
| In employment | 167,935 | 70.9% | 2,393,800 | 71.5% | 29,261,400 | 72.1% |
| Employees | 121,510 | 51.3% | 1,967,300 | 58.8% | 25,005,300 | 61.6% |
| Self-employed | 45,004 | 19.0% | 412,700 | 12.3% | 4,054,500 | 10.0% |

Source: Labour Market Profile Nomis, 2015

- By Ward in 2011, the highest rates of employment were located within East Finchley (74.9%); High Barnet (74.5%) and West Finchley (74.2%).
- Whereas, the lowest employment levels are generally located in the West of the Borough, with Colindale (61.9%) and Burnt Oak (63.7%), having the lowest employment rates.

## 3.8 Unemployment

Following the recession, unemployment rates for within Barnet raised from 5.0% in 2008 to 9.3% in 2012[18]. However, since this time, the unemployment has begun to reduce with a rate of 5.0% in September 2014. In line with national trends, the highest rate of unemployment (11.9%) is within the 16-24 age group, although this is below the Outer London rate of 20.4% and the UK rate of 17.5%.

- By Ward, the lowest rate of unemployment in 2011 was located in Garden Suburb (3.6%), Totteridge (4.1%) and High Barnet (4.5%).
- The Wards with the highest rates of unemployment were once again located towards the West of the Borough in Colindale (8.4%) and Burnt Oak (8.1%).

## 3.9 Skills and Qualifications

54% of respondents to the 2014 CBI, Employment Trends Survey, claim that low skill levels will be the biggest threat to the labour market for the next five years. Skills gaps can reflect misalignment between the skills the workforce has and those that employers need, suggesting that the content of qualifications and training may not be fully meeting employer needs.

[18] ONS Labour Market Profile – based on 16-64 age group

**Table 3-6: Density of Skills Shortages by Occupation Type in Barnet, 2013**

| Occupation Type | % Skills Shortage |
|---|---|
| Managers | 1.36% |
| Professionals | 7.13% |
| Associate professionals | 37.61% |
| Administrative/clerical staff | 1.46% |
| Skilled trades occupations | 13.23% |
| Caring, leisure and other services staff | 38.50% |
| Sales and customer services staff | 0.71% |
| Machine operatives | 0.0% |
| Elementary staff | 0.0% |
| Unclassified staff | 0.0% |

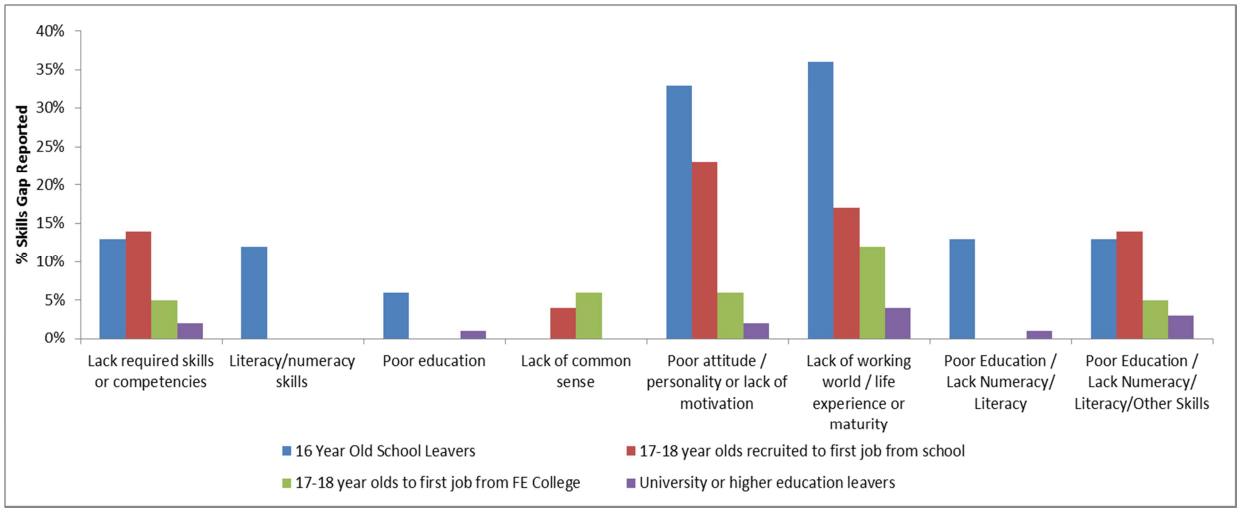
Source: UK Commission Employer Skills Survey 2013

- Caring, leisure and other service occupations have the highest density of skills shortages within Barnet (38.50%). The ageing population is projected to drive up demand for services within this sector and so there could be opportunity for substantial growth within this segment in the future.
- Associate professionals are the third largest occupation type in Barnet, accounting for 13.3% of total jobs; however, it has the second largest level of reported skills shortages. The reported skills shortages within this occupation could be why it is underrepresented when compared to the UK where it accounts for 14.0% of the total jobs market.

Barnet performs well on in job skills shortages, when compared against other regions. 13.0% of Barnet employer's report that Barnet employees did not meet their skills requirement, the lowest in London where the average is 18.0%.

However, as can be seen from Figure 3-20, skills gaps vary significantly depending on the qualification level held by the employee. There is a significant reduction in reported skills shortages for employees who have attended University or Higher Education. This is especially apparent within 'lack of working/life experience or maturity' and 'poor attitude/personality or lack of motivation' which reduce by 32% and 31% respectively.

**Figure 3-20: Percentage Skills Gaps within Barnet, by Qualification Type, 2013**




Source: UK Commission Employer Skills Survey 2013

Positively, 50.4% of Barnet's working age population hold at least an NVQ level 4 qualifications. This is above the UK rate of 35.1% and the London rate of 48.4%[19]. In line with national and local trends, the proportion of the Barnet population with NVQ level 4 or above qualifications is likely to increase in the future[20].

## 3.10 Welfare Reform

The current programme of reform to the benefit system, which started in 2011, constitutes the biggest shake up of the welfare state in over 60 years. The reforms that have been rolled out are wide ranging and include changes to some out of work and disability related state benefits, uprating of a wide range of benefits and the locally administered housing benefit and CTS schemes.

As part of these changes, the Government expects reforms to reduce the overall benefits bill. In Barnet, the total reduction in benefits received by eligible residents is expected to be £81.4m in 2015/16 – the 10th highest reduction in the country. The average loss for each claimant household is £2,100[21].

### 3.10.1 The Impact of Welfare Reform in London

The London Poverty Profile shows that 26% of households in London received housing benefit in 2012, which was higher and has grown faster than the average for England. Average housing benefit values are also much higher in London at £134 per week compared with £92 per week for England.

A quarter of households in London received council tax benefit in 2012, two percentage points higher than the average for England. As a result, the recent changes to Housing Benefit will likely have a wider and deeper impact in London.

[19] NOMIS Labour Market Profile: ONS Annual Population Survey Jan 2013 – Dec2013
[20] GLA London Labour Market Projections, 2014
[21] LGA, August 2013

Sheffield Hallam University has also researched the cumulative impacts of the reforms. Although the findings in the report are estimates, the data is taken from the Treasury's estimates of the financial savings and the government's impact assessment and benefit claimant data.

The findings indicate that the largest impact of welfare reform will be in London. These include not just those areas that have traditionally been identified as 'deprived' but also Boroughs with high benefit receipt and exceptionally high housing costs, which combine to give very large impacts per household, such as Westminster, Kensington and Chelsea and Enfield.

### 3.10.2 The Impact of Welfare Reform in Barnet

In Barnet, high rents and high levels of benefit receipt have combined to mean that overall welfare reforms can lead to very large financial losses. Research by the Centre for Economic & Social Inclusion commissioned by LGA, estimates that in 2015/16 nearly 40,000 households in Barnet will be affected by at least one of the reforms, the 10th highest in England and the average loss per household will be the 7th highest after Westminster, Kensington & Chelsea, Brent, Wandsworth, Camden and Hackney.

In Barnet 60% of the losses from welfare reforms affect working households and the biggest financial losses are from changes to working tax credits (£26.5 m) and Local Housing Allowance rates (£23.2m). Of the 20,000 affected by the changes to Council Tax support, there are around 3,500 working households claiming Working Tax Credits.

Overall, Welfare Reform means that the 20,000 or so working age claimants of Council Tax support, that will be affected by any changes to Council Tax support, are currently losing nearly £20m already as a result of the locally administered HB and current localised Council Tax Support scheme. In addition to these losses they will also be affected by one or more reductions to Central government administered benefits such as:

- Child Tax Credits
- Working Tax Credits
- DLA replacement with PIP
- 1% up rating (instead of using consumer price index) of all benefits
- ESA

### 3.10.3 Out of Work Benefits

In August 2014 there were 22,410 people claiming out-of-work benefits in Barnet, 9.5% of the total 16-64 population (table 8). This is below the Outer London and UK rates of 10.9% and 12.6% respectively.

**Table 3-7: Benefit Claimants, August 2014 (Barnet, Regional and National)**

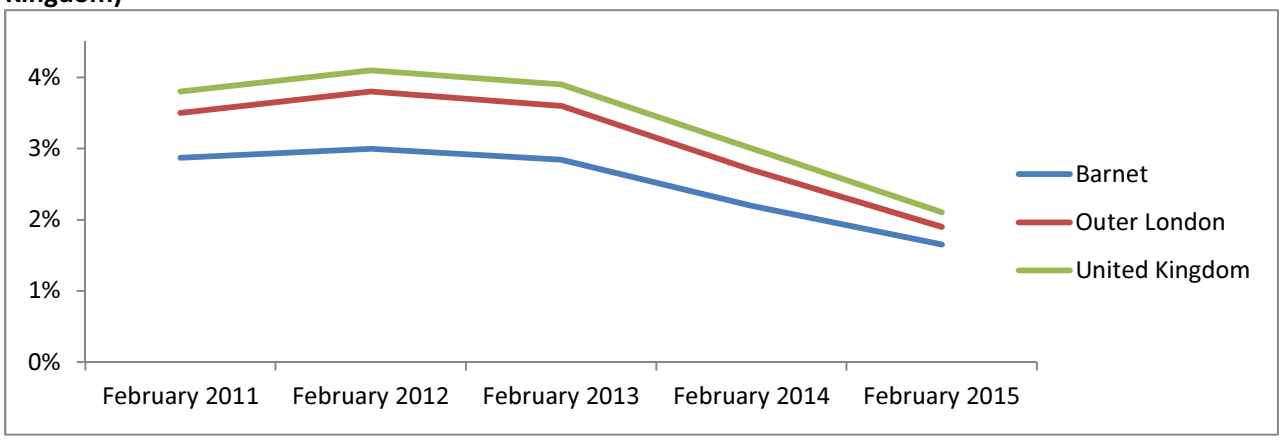
| | Barnet | | Outer London | | England and Wales | |
|---|---|---|---|---|---|---|
| | Number | % of 16-64 Population | Number | % of 16-64 Population | Number | % of 16-64 Population |
| Total Claimants | 22,410 | 9.5% | 361,200 | 10.8% | 4,553,720 | 12.6% |
| **By Statistical Group** | | | | | | |
| Job seekers | 4,150 | 1.8% | 70,940 | 2.1% | 773,250 | 2.1% |
| ESA and incapacity benefits | 11,030 | 4.7% | 167,350 | 5.0% | 2,229,760 | 6.1% |
| Lone parent | 2,160 | 0.9% | 41,220 | 1.2% | 433,190 | 1.2% |
| Carer | 2,260 | 1.0% | 36,810 | 1.1% | 520,400 | 1.4% |
| Others on income related benefit | 540 | 0.2% | 9,070 | 0.3% | 115,410 | 0.3% |
| Disabled | 1,920 | 0.8% | 30,330 | 0.9% | 416,820 | 1.1% |
| Bereaved | 360 | 0.2% | 5,470 | 0.2% | 64,900 | 0.2% |
| **Key out-of-work benefits**[22] | 17,880 | 7.6% | 288,590 | 8.6% | 3,551,610 | 9.8% |

Source: DWP benefit claimants - working age client group 2015

The latest data from the ONS indicates that in February 2015, 3,932 (1.7%) people in Barnet were receiving Job Seekers Allowance (JSA). Of those, 2,327 (59.2%) were male and 1,605 (40.8%) were female. This is below the Outer London and UK rates of 1.9% and 2.1% respectively.

Figure 3-21 shows that, apart from a slight increase in JSA claimants in 2012, there has been an overall downward trend in the amount of JSA claimants within the Borough, this has also occurred with the level of regional and national claimants.

**Figure 3-21: The Percentage of People Claiming JSA, 2011-2015 (Barnet, Outer London and United Kingdom)**

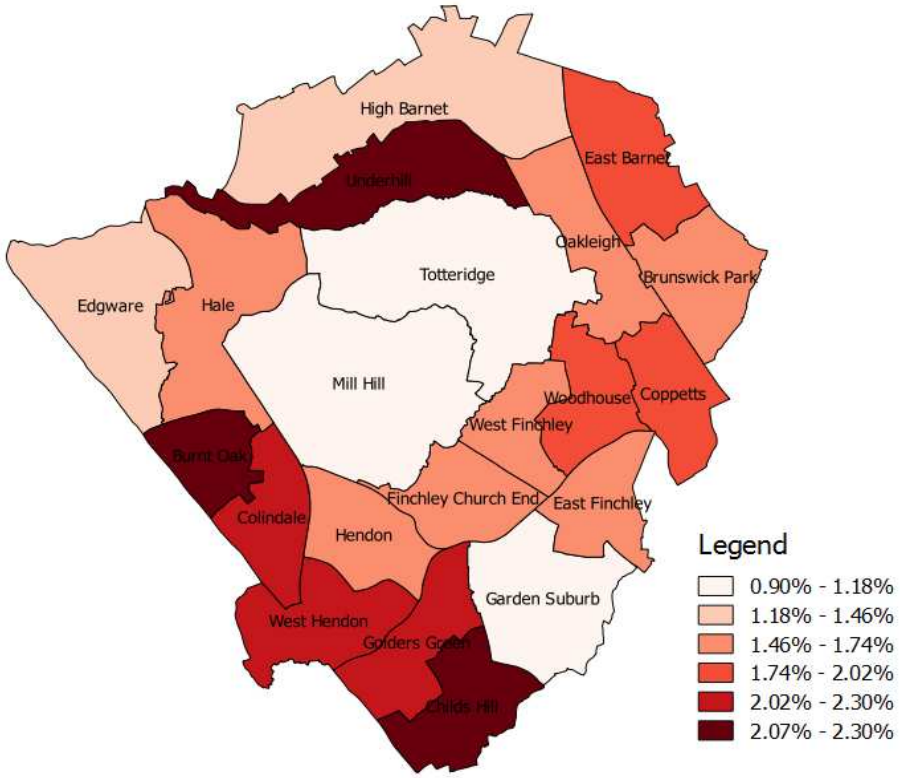



Source: ONS claimant count 2015

Figure 3-22 shows the proportion of JSA claimants by Ward. Many of the areas with high rates of JSA claimants are situated in the West of the Borough, with Child Hills having the largest proportion (2.3%).

[22] Key out-of-work benefits include the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits.

**Figure 3-22: Proportion of JSA Claimants by Ward by total 16-64 Population, February 2015**




Source: ONS claimant count 2015

Table 3-8 breaks down JSA claimants by the average length of time the person has been claiming; less than 6 months; 6-12 months; and over 12 months. Interestingly, although Child's Hill has the largest proportion of claimants who have been claiming for over 6 months (33.8%), over a quarter of High Barnet's and Garden Suburb's claimants have been claiming for over 12 months.

**Table 3-8: JSA Claimants by Ward by Length of Time Claiming, February 2015**

| Ward Name | Number | % of Total Population | Up to 6 Months | 6-12 Months | Over 12 Months |
|---|---|---|---|---|---|
| Brunswick Park | 147 | 1.4% | 63.3% | 16.7% | 20.0% |
| Burnt Oak | 265 | 2.2% | 62.3% | 17.0% | 20.8% |
| Childs Hill | 325 | 2.3% | 55.4% | 10.8% | 33.8% |
| Colindale | 293 | 2.0% | 67.8% | 11.9% | 20.3% |
| Coppetts | 213 | 1.8% | 61.9% | 11.9% | 26.2% |
| East Barnet | 190 | 1.8% | 61.5% | 15.4% | 23.1% |
| East Finchley | 173 | 1.6% | 68.6% | 14.3% | 17.1% |
| Edgware | 131 | 1.2% | 59.3% | 18.5% | 22.2% |
| Finchley Church End | 145 | 1.4% | 62.1% | 13.8% | 24.1% |
| Garden Suburb | 100 | 1.0% | 60.0% | 15.0% | 25.0% |
| Golders Green | 216 | 1.9% | 51.2% | 16.3% | 32.6% |
| Hale | 176 | 1.6% | 65.7% | 14.3% | 20.0% |
| Hendon | 202 | 1.6% | 62.5% | 15.0% | 22.5% |
| High Barnet | 125 | 1.3% | 60.0% | 8.0% | 32.0% |
| Mill Hill | 146 | 1.1% | 62.1% | 17.2% | 20.7% |
| Oakleigh | 149 | 1.5% | 70.0% | 10.0% | 20.0% |
| Totteridge | 87 | 0.9% | 64.7% | 17.6% | 17.6% |
| Underhill | 210 | 2.1% | 65.9% | 12.2% | 22.0% |
| West Finchley | 184 | 1.6% | 65.8% | 15.8% | 18.4% |
| West Hendon | 234 | 1.9% | 60.4% | 16.7% | 22.9% |
| Woodhouse | 221 | 1.8% | 66.7% | 11.1% | 22.2% |
| Barnet | 3,932 | 1.70% | 62.5% | 14.1% | 23.4% |

Source: ONS claimant count 2015

In August 2014 there were just over 11,000 people on a health related benefit within Barnet (ESA & IB), the 15th largest amount in London[23]. Taking population size into account, this only represents 4.7% of the 16-64 population, the 12th lowest across all London Boroughs, and below the Outer London average of 5.0%.

Table 3-9 shows the top five conditions of claimants of either Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) within Barnet in August 2014.

- Across all locations 'mental and behavioural disorders' are the most common condition reported by claimants. Although only small, there is a higher proportion of claimants with these conditions in Barnet (44.9%) compared to London (44.5%) and these are both above the England rate (43.5%).
- In comparison to London, Barnet is also overrepresented with the proportion of 'diseases of the nervous system' 6.8% and 8.0% respectively. Although Barnet is still below the England rate of 9.1%.

**Table 3-9: Incapacity Benefit (IB) & Severe Disablement Allowance (SDA) by Claimant Type, August 2014 (Barnet, Regional and National)**

[23] Nomis Labour Market Profile: DWP benefit claimants - working age client group

| Condition | Barnet | London | England |
|---|---|---|---|
| Mental and behavioural disorders | 44.9% | 44.5% | 43.5% |
| Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified | 12.8% | 13.9% | 15.0% |
| Diseases of the musculoskeletal system and connective tissue | 11.8% | 12.2% | 12.1% |
| Diseases of the nervous system | 8.0% | 6.8% | 9.1% |
| Injury, poisoning and certain other consequences of external causes | 3.7% | 3.5% | 3.2% |

Source: NOMIS Labour Market Profile: DWP benefit payments - incapacity benefit/severe disablement August 2014

## 3.11 Disability and Employment

### 3.11.1 Mental Health

Unemployment can lead to diminished social networks and social functioning, as well as decreased motivation and interest which can lead to apathy. People suffering from mental health problems are especially sensitive to these negative effects of unemployment[24]. Whereas, the social exclusion that they experience as a result of mental ill health is reduced by work and aggravated by unemployment[25].

The Health and Social Care Information Centre measures the number of people by Borough who are in contact with Mental Health Services and in employment[26], the latest data for Barnet is displayed in Table 3-10.

- Within Barnet, for the period 2013/2014, 5.7% of people who were known to mental health services were in employment. In comparison to other regions this is quite low; as only Bromley, Redbridge and Milton Keynes had a lower rate.
- By gender, Barnet is performing better for women where 7.3% of people known to mental health services are known to be in employment. This is above the Outer London average of 7.0%, although it is still below the England average of 8.5%.
- For men, only 4.5% of males known to mental health services in Barnet were in employment in 2013/14. This was the second lowest rate of all statistical neighbours, and below the Outer London and England averages of 5.0% and 5.8% respectively.

[24] Bennett, D. (1970) the value of work in psychiatric rehabilitation. Social Psychiatry 5, 224230

25 Social Exclusion Unit (2004) Mental Health and Social Exclusion. London: Office of the Deputy Prime Minister

[26] http://ascof.hscic.gov.uk/Outcome/717/1F

**Table 3-10: Proportion of adults in contact with secondary mental health services in paid employment, 2013/14**

| Area | Total | Male | Female |
|---|---|---|---|
| Reading | 12.7% | 10.6% | 15.9% |
| Sutton | 9.7% | 8.0% | 11.7% |
| Merton | 9.2% | 7.1% | 11.9% |
| Kingston upon Thames | 8.6% | 5.8% | 11.7% |
| Hillingdon | 8.3% | 7.2% | 9.8% |
| England | 7.0% | 5.8% | 8.5% |
| Hounslow | 6.7% | 6.6% | 6.8% |
| Ealing | 5.8% | 5.2% | 6.5% |
| Outer London | 5.8% | 5.0% | 7.0% |
| **Barnet** | **5.7%** | **4.5%** | **7.3%** |
| Bromley | 5.5% | 4.7% | 6.7% |
| Redbridge | 4.4% | 3.7% | 5.4% |
| Milton Keynes | 3.7% | 4.7% | 2.3% |

Source: Health and Social Care Information Centre, 2013/14

### 3.11.2 Learning Disabilities

People with learning difficulties find it much harder to get a job than people without learning difficulties. It is estimated that around 65% of people with learning difficulties would like to work, and with the right support they make highly valued employees[27].

- In February 2015 the proportion of adults known to Social Care with learning disabilities who were paid in employment was 9.4%, compared with the Outer London average of 9.9% and the England average of 6.7% (Table 3-11).
- By gender, across most areas females with learning disabilities tend to have a lower rate of employment than men. This is the case in Barnet, where 10.2% of males with learning disabilities are in paid employment compared to only 8.3% of females.

[27] http://www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187693/

**Table 3-11: Proportion of adults with a learning disability in paid employment, February 2015**

| | Total | Male | Female |
|---|---|---|---|
| Redbridge | 15.2% | 12.3% | 18.8% |
| Kingston upon Thames | 14.3% | 17.6% | 9.6% |
| Milton Keynes | 11.7% | 12.2% | 11.0% |
| Bromley | 11.5% | 11.8% | 11.1% |
| Merton | 11.3% | 14.6% | 6.1% |
| Hounslow | 10.6% | 11.4% | 9.5% |
| Outer London | 9.9% | 10.6% | 8.9% |
| **Barnet** | **9.4%** | **10.2%** | **8.3%** |
| Ealing | 9.2% | 10.6% | 6.9% |
| Reading | 7.8% | 9.1% | 6.0% |
| England | 6.7% | 7.4% | 5.8% |
| Sutton | 4.4% | 5.4% | 3.1% |
| Hillingdon | 1.4% | - | - |

Source: Health and Social Care Information Centre, 2013/14

## 3.12 Incomes

CACI PayCheck is an estimate of household income at postcode level. It is based upon government data sources together with income data for UK homes collected from lifestyle surveys and guarantee card returns. PayCheck models gross income before tax to provide an estimated income for every household within the UK. Income values can be shown as 'nominal values' or 'real values'. The values shown below are 'nominal values'.

- According to data from the 2015 CACI PayCheck, Barnet's average raw household income in 2015 was £41,468; this is 44.5% higher than the Great Britain average of 28,696.
- Between 2012 and 2015 Barnet's average household income increased by 17.1%, compared to the Great Britain average which increased by 1.0%.

### 3.12.1 Ward Level

Although average incomes are rising in Barnet, there is significant variation in incomes across the Borough. Table 3-12 shows the median household income by ward for 2008, 2012 and 2015.

Growth in incomes is predominantly being driven by more affluent Boroughs, with the wards with the lowest average incomes in 2015; Burnt Oak, Colindale and Underhill stagnating and even falling in real terms[28]. This results in higher income inequality between different areas in Barnet.

[28] Real term values or 'real values' are dereived by adjusting the actual or 'nominal value' by inflation, to take into account the changing value of money ovetime.

**Table 3-12: Median Household Income by Ward, 2008, 2012 & 2015**

| Area Name | 2008 | 2012 | 2015 | Change: 2008-2015% | Change: 2012-2015% |
|---|---|---|---|---|---|
| Brunswick Park | £35,249 | £35,740 | £41,266 | 17.1% | 15.5% |
| Burnt Oak | £27,274 | £25,745 | £25,930 | -4.9% | 0.7% |
| Childs Hill | £34,924 | £36,192 | £42,165 | 20.7% | 16.5% |
| Colindale | £28,028 | £27,295 | £30,125 | 7.5% | 10.4% |
| Coppetts | £37,622 | £36,402 | £41,726 | 10.9% | 14.6% |
| East Barnet | £35,394 | £35,204 | £41,491 | 17.2% | 17.9% |
| East Finchley | £35,199 | £35,905 | £40,907 | 16.2% | 13.9% |
| Edgware | £34,596 | £35,705 | £44,158 | 27.6% | 23.7% |
| Finchley Church End | £40,359 | £39,201 | £49,814 | 23.4% | 27.1% |
| Garden Suburb | £44,220 | £44,701 | £55,491 | 25.5% | 24.1% |
| Golders Green | £33,240 | £32,625 | £40,877 | 23.0% | 25.3% |
| Hale | £35,070 | £34,527 | £41,148 | 17.3% | 19.2% |
| Hendon | £34,022 | £33,579 | £41,557 | 22.1% | 23.8% |
| High Barnet | £40,111 | £39,765 | £48,540 | 21.0% | 22.1% |
| Mill Hill | £38,146 | £38,524 | £44,596 | 16.9% | 15.8% |
| Oakleigh | £37,661 | £37,558 | £45,919 | 21.9% | 22.3% |
| Totteridge | £38,946 | £39,875 | £49,783 | 27.8% | 24.8% |
| Underhill | £32,336 | £31,100 | £34,342 | 6.2% | 10.4% |
| West Finchley | £37,842 | £38,348 | £47,000 | 24.2% | 22.6% |
| West Hendon | £31,992 | £31,773 | £36,642 | 14.5% | 15.3% |
| Woodhouse | £36,348 | £34,946 | £41,549 | 14.3% | 18.9% |

Source: CACI PayCheck 2008, 2012 and 2015

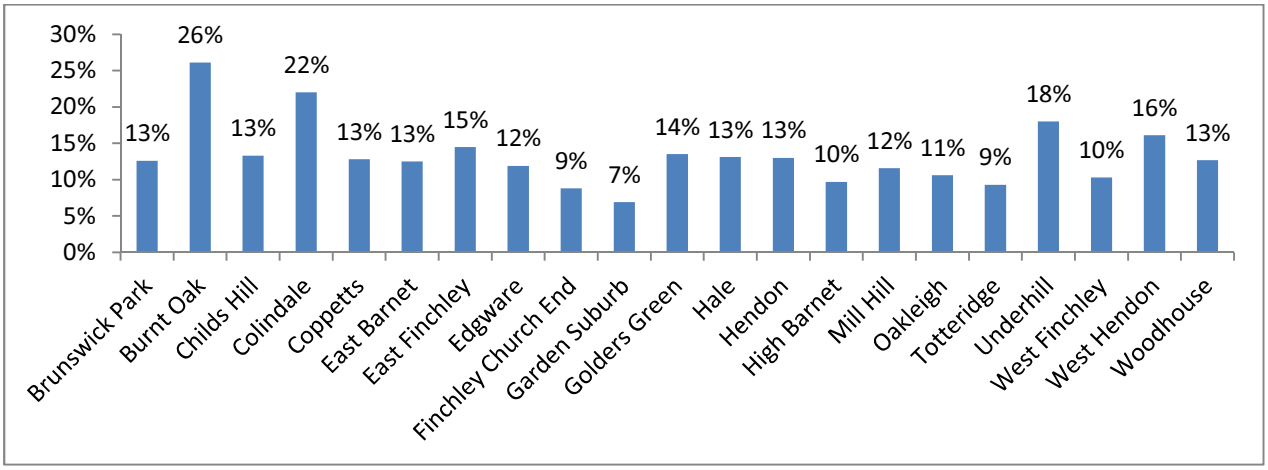
### 3.12.2 Poverty Measures

The poverty line is defined by the government as 60% of median net income. Using Paycheck 2015 unequivalised Great Britain data, the official poverty line is equivalent to £17,217.

In 2015, 13.5% of households had a household income of below £15,000; this is above the London rate of 18.0% and the Great Britain rate of 24.0%. In comparison to other London Boroughs, Barnet has the sixth lowest rate of households with a total income of less than £15,000 per year. Richmond has the lowest (9.3%) whereas Barking and Dagenham has the highest (27.1%).

Figure 3-23 shows the proportion of households by ward with a household income of below £15,000. More than one in four households in Burnt Oak earn below £15,000 per year and around one in five households in Colindale and Underhill earn below £15,000 per year; this compares to Garden Suburb where fewer than one in ten households earns below £15,000 per year.

**Figure 3-23: % 0-15k Household Income by Ward, 2015**




Source: CACI PayCheck 2015

# 4 Barnet Customer Segments – Overview

## 4.1 Introduction

Each person in Barnet has been grouped into 1 of 17 customer segments which are customer portraits based on CAMEO demographic and lifestyle data produced by Call Credit Information Group. The segments are created at household level and every person in a household belongs to the same customer segment. People in each group broadly have the same characteristics which drive their common needs, interests and behaviours. Understanding the characteristics of the customer segments will help to better deliver services to Barnet residents[29].

This chapter introduces the 17 Barnet customer segments and describes them by their age, income, life-stage and where they live. Self-reported health of each of the segments is detailed along with the effect of limiting long-term illness on peoples' ability to work. This chapter concludes with a section that suggests which customer segments will be the heaviest users of health services in the borough and how addressing their needs will have a wider socio-economic impact.

## 4.2 Profile of Barnet Customer Segments

To introduce relevant characteristics of the 17 customer segments, a brief description of each is presented below. The CAMEO information that can be used for profiling health data is relatively limited, but the key findings are summarised in the segment description.

### 4.2.1 Educated, Affluent Families (17% of Barnet households[30])

Households from this segment are highly affluent and educated, with young children. These are residents of all ages, often earning over £50,000, and owning large, expensive homes. They often engage in fun family sports and are active parents. A staggering 86% report good health, and a further 10% fairly good health, making them the healthiest segment in Barnet.

### 4.2.2 Sophisticated Singles (15%)

They are educated, affluent singles or divorcees who own pricey properties. Their age ranges from 25 to 65 and their earnings are mostly upwards of £30,000. These residents enjoy summer sports and travelling. An impressive 86% report very good health, and 10% fairly good health, placing them 3rd among the healthiest Barnet segments.

### 4.2.3 Low Income House sharers (13%)

These residents are low income, blue collar or unemployed house sharers. They can be friends, family or same-sex couples living in pairs, who are renting or owning small, low value properties. They can be of all ages and earn in the range of £15,000 - £30,000. The residents in this group often spend their leisure time exercising and are health aware. They enjoy a reasonably good health, with 5% reporting poor health.

### 4.2.4 Financially Secure Retirees (10%)

The residents in this segment are financially secure, educated pensioners who own expensive properties. They are either couples or widowed singles aged 65 and over, with a household income of £30,000 or more. They enjoy traditional sports and playing with their grandchildren. A health

[29] All analyses in this chapter are based on CAMEO CallCredit data (February, 2015), which comprises individual-level and household-level information about 235,529 Barnet residents aged 16+.
[30] Due to rounding, percentages may not total 100%

aware segment, they mostly report a good (85%) and fairly good health (10.9%), being in the top quartile of healthiest residents.

#### 4.2.5 Comfortable Older Families (8%)

These growing family households are economically active, educated, white collar, owning large average-value properties and are often burdened by large mortgages. They can be of mixed ages, ranging from 20 to 70 and bring home an income between £20,000 and £50,000. They enjoy spending time with their family and playing golf. While their health is generally good, slightly over 5% report poor health, placing them in the second quartile of healthiest residents.

#### 4.2.6 Affluent Singles (8%)

These residents are highly affluent, educated, upwardly mobile, energetic and ambitious singles who share or own high value properties. They are generally aged 25 to 45 and earn over £40,000. The residents in this group often spend their leisure time exercising and are health aware. They are the second healthiest segment in Barnet, with just 4% reporting poor health.

#### 4.2.7 Penny-wise Pensioners (6%)

These are households of minimal income, formerly blue collar, settled elderly couples or widowed singles who own small, low-value properties or live in residential homes. They are aged 65 and over and their income is often below £20,000. A rather high proportion report poor health (5.56%), placing them in the medium high group of least healthy Barnet segments. They are likely to have health problems and spend most of their time in their home.

#### 4.2.8 Financially Restricted Single Parents (5%)

These residents are financially restricted, white collar, part-timers or home-makers, government supported single parents of all ages. They are living in council homes or renting low value properties, and usually have an income of under £30,000. With 5.14% reporting poor health, these residents are in the medium high group of least healthy Barnet segments.

#### 4.2.9 Secure older people (4%)

These households are comfortably retired, well settled, established couples or widowed singles of mixed former occupations who own modest properties. Aged over 55, they have an income between £20,000 and £30,000. They are a health aware group and often spend their time gardening. With 83.7% reporting good health and a further 11.7% fairly good health, they fall into the second quartile of healthiest Barnet residents.

#### 4.2.10 Contended Greys (4%)

These are empty house and full wallet households of educated, settled couples, either reaching or starting to enjoy their retirement years. Aged 45 to 65, they usually have an income of over £40,000 and own large, expensive homes. They like to keep active and often spend their leisure time travelling, gardening and playing golf. An impressive proportion enjoys good (84.8%) and fairly good (10.9%) health, placing them in the top quartile of most healthy Barnet residents.

#### 4.2.11 Low Income Singles (3%)

These are households of financially constrained, blue collar or unemployed, single residents who are renting low quality housing or living in council homes. They are generally aged 40 to 65, mostly living alone, with an income below £20,000 and often in receipt of benefits. Among this non-sporty group

the proportion of residents who report poor health is rather high (5.78%), placing them in the highest group of least healthy Barnet segments.

#### 4.2.12 Well Educated and Employed Single Parents (2%)

The residents in this segment are financially secure, educated, working single parents who share or own high value properties. Their age ranges between 20 and 45 and their income is usually over £30,000. They enjoy spending time with their kids and travelling. A health aware group, they mostly enjoy a good (85.5%) and fairly good (10.3%) health, being among the top quartile of healthiest segments in the borough.

#### 4.2.13 Financially Restricted Single Students and Friends (2%)

These residents are financially limited, young independent singles, students and friends living together in rented low value properties. They are aged 20 to 45 and have an income of less than £20,000. Although they spend a lot of their leisure time exercising, 5.98% report a poor health, which places them among the least healthy segments.

#### 4.2.14 Prosperous Young Couples Without Kids (2%)

These are extremely affluent households of educated young couples with dual incomes and no kids who live in mortgaged medium to high value properties. Aged 25 to 45, they often earn over £50,000. They are a health aware group and enjoy travelling. With 85.1% reporting a good health and 10.7% a fairly good health, this segment is among the healthiest in Barnet.

#### 4.2.15 Financially Secure Singles (1%)

They are financially comfortable, educated singles living alone who rent or own average value properties. They are aged 25 to 45 and earn in the range of £25,000-£30,000. A health aware group, they spend much of their leisure time exercising. With a moderate 4.64% rating their health as poor, they fall into the second quartile of healthiest Barnet segments.

#### 4.2.16 Struggling Families (1%)

These very low income households, of blue collar or unemployed families with children live in council properties or in owned low-priced properties. They can be of mixed ages and usually earn below £20,000.

#### 4.2.17 Low Income Couples (1%)

These are low income households of blue collar or unemployed couples with no children who rent low price properties or live on council estates. They are generally aged over 40 and earn in the range of £20,000-£30,000, often receiving benefits. This non-sporty group is the least healthy segment in Barnet, with 6.36% of residents reporting poor health.

### 4.3 Profile of Barnet

Barnet is older, has a larger proportion of families and has higher household incomes compared to the rest of London. As would be expected, Barnet has a broad similar distribution of segments when compared to its statistical neighbours[31], though when contrasted against Hounslow and Merton, Barnet's population is again older and more family oriented. Comparing Barnet to Kingston-upon-Thames, the two populations are very similar. Throughout this document, Barnet is compared to

[31] Local authorities with similar characteristics used for benchmarking and comparing performance.

statistical neighbours. Kinston-Upon-Thames can be used as an exemplar approach when it outperforms Barnet at addressing certain health problems.

**Table 4-1: Segment composition of Barnet compared to statistical neighbours**

| Customer Segments | Barnet | Hounslow | Kingston upon Thames | Merton | LONDON |
|---|---|---|---|---|---|
| A - Affluent singles | 7.59% | 8.44% | 9.44% | 8.42% | 7.85% |
| B - Prosperous young couples without kids | 1.59% | 1.87% | 3.24% | 3.73% | 2.26% |
| C - Educated, affluent families | 16.53% | 9.18% | 18.93% | 13.61% | 10.19% |
| D - Well educated and employed single parents | 2.45% | 1.59% | 2.44% | 2.12% | 2.08% |
| E - Sophisticated singles | 14.78% | 11.66% | 14.69% | 11.30% | 10.63% |
| F - Wealthy and nearing retirement | 3.55% | 3.41% | 5.28% | 5.23% | 3.96% |
| G - Financially secure retirees | 9.58% | 5.36% | 9.48% | 6.05% | 5.90% |
| H - Financially secure singles | 1.07% | 1.03% | 1.30% | 1.54% | 1.31% |
| I - Low income couples | 0.98% | 1.42% | 0.86% | 1.40% | 1.80% |
| J - Low income house sharers | 12.81% | 21.59% | 10.58% | 15.79% | 17.65% |
| K - Comfortable older families | 8.32% | 11.06% | 6.81% | 10.06% | 9.22% |
| L - Secure older people | 3.78% | 2.59% | 4.25% | 3.40% | 2.88% |
| M - Financially restricted single students and friends | 2.14% | 3.39% | 1.39% | 1.90% | 4.58% |
| N - Low income singles | 2.55% | 2.75% | 1.91% | 2.39% | 4.42% |
| O - Struggling families | 0.98% | 1.55% | 0.41% | 0.93% | 1.39% |
| P - Financially restricted single parents | 5.12% | 5.42% | 3.87% | 4.56% | 5.50% |
| Q - Penny-wise pensioners | 6.18% | 7.68% | 5.11% | 7.55% | 8.38% |

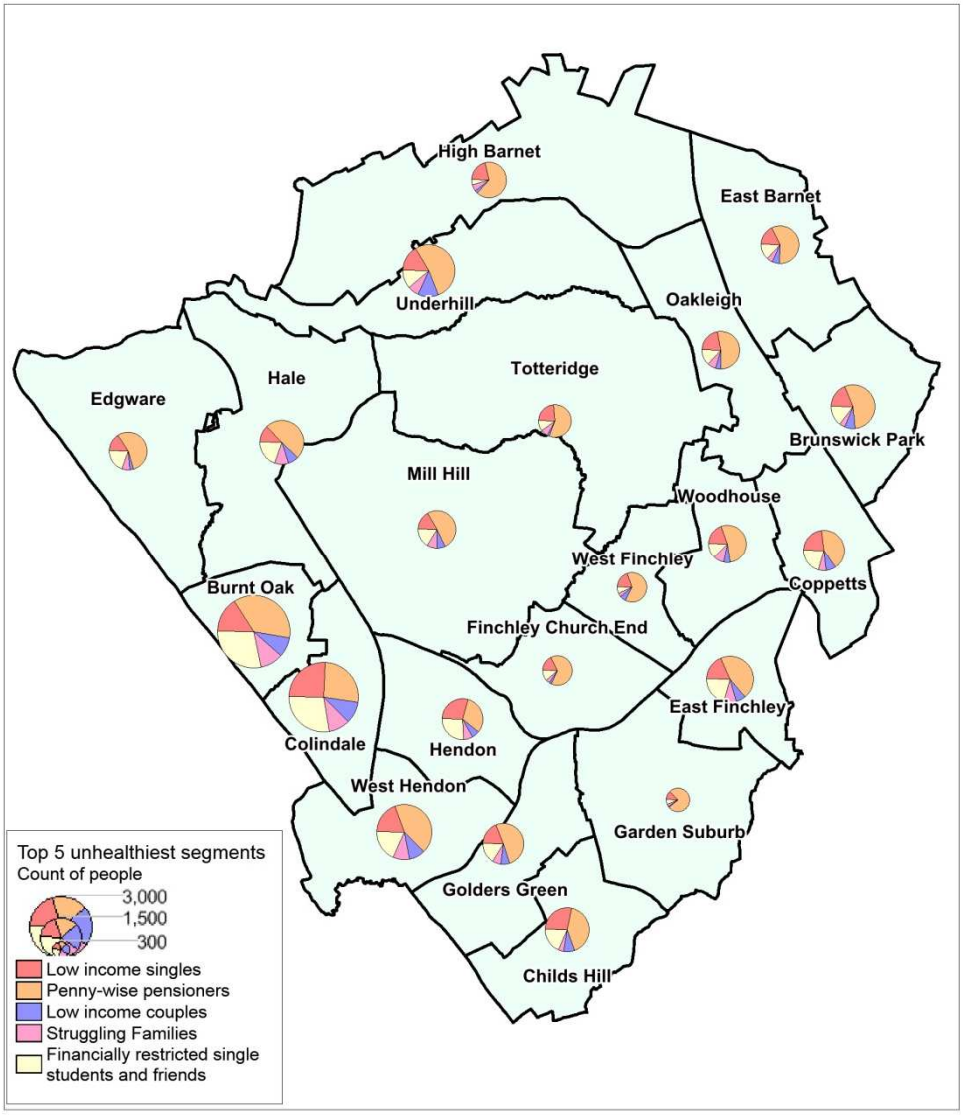
Different areas in Barnet have different profiles, meaning that services should be tailored to best serve their local populations. The east of the borough, along the A5 corridor is home to a younger population dominated by *Low income house sharers* sharing high density living while attending University or working lower paid jobs. It is also the location of Barnet's largest housing estates which account for the higher than average populations of *Low income singles*, *Struggling families* and *Low income couples.*

Following the High Road north through the centre of Barnet from Child's Hill to Totteridge, households are mostly comprised of families (*Educated, affluent families, Comfortable Older Families*), professionals (*Affluent Singles*, *Prosperous young couples without kids*, *Sophisticated Singles*) and affluent retirees (*Financially secure retirees*, *Wealthy and nearing retirement*). These areas are the most affluent parts of the borough with high levels of employment, income and education.

The west and north of Barnet is a mixture of all segments, with larger proportions of families (including the highest proportions of *Comfortable Older Families*) and older households (*Secure older*

*people* and *Wealthy and nearing retirement*). People in these areas tend to be of mid-level affluence compared to the rest of the borough.

**Figure 4-1: Location by ward of the five segments with the worst self reported health**




## 4.4 Data Related to Health in the Segments

While limited, the segments include data on self-reported health, long-term illness and long-term illness affecting worklessness. The five customer segments with the poorest self-reported health are also the segments in Barnet with the lowest household income (*Pound Stretching Twosomes, Financially restricted single students and friends, Struggling families, Low income singles and Pennywise Pensioners*). Segments comprised of the more affluent older population (*Secure older people* and *Wealthy and nearing retirement* and *Financially secure retirees*) do not report their health as being any worse than other younger more affluent segments in the borough.

Economic inactivity, limiting long-term illness and household income are inextricably linked -to Barnet's customer segments. The same five customer segments noted above (*Pound Stretching Twosomes, Financially restricted single students and friends, Struggling families, Low income singles and Pennywise Pensioners*) have the lowest household incomes, poorest self-reported health and

highest occurrences of health affecting their ability to work. Those five groups comprise 13% of Barnet's population; an improvement to their health would have further reaching societal impact.

**Table 4-2: Economic inactivity and long-term illness**

| Customer Segments | Economically inactive residents aged 16-74 permanently sick/disabled | Residents with limiting long-term illness | Residents of working age with limiting long-term illness |
|---|---|---|---|
| A - Affluent Singles | 2.53% | 12.57% | 6.01% |
| B - Prosperous young couples without kids | 2.76% | 13.40% | 6.31% |
| C - Educated, affluent families | 2.08% | 12.79% | 5.42% |
| D - Well educated and employed single parents | 2.69% | 12.98% | 6.16% |
| E - Sophisticated Singles | 2.44% | 12.99% | 5.84% |
| F - Wealthy and nearing retirement | 2.73% | 13.81% | 6.35% |
| G - Financially secure retirees | 2.24% | 13.90% | 5.62% |
| H - Financially secure singles | 3.43% | 13.65% | 7.25% |
| I - Low income couples | 5.00% | 17.00% | 8.97% |
| J - Low income house sharers | 4.00% | 15.10% | 7.95% |
| K - Comfortable Older Families | 3.67% | 14.99% | 7.59% |
| L - Secure older people | 2.93% | 14.91% | 6.52% |
| M - Financially restricted single students and friends | 4.94% | 15.71% | 8.99% |
| N - Low income singles | 4.64% | 15.88% | 8.55% |
| O - Struggling families | 4.63% | 15.94% | 8.54% |
| P - Financially restricted single parents | 3.80% | 14.92% | 7.68% |
| Q - Penny-wise pensioners | 3.96% | 16.30% | 7.75% |

## 4.5 Conclusion

The top 5 customer *segments most likely to require health services are Low income couples, Financially restricted single students and friends*, *Struggling families*, *Low income singles*, and *Penny-wise pensioners* as they are the residents most likely to report less good health, to have a limiting long-term illness or a disability. They are mostly living in the east of the borough, particularly Burnt Oak and Colindale and represent 13% of Barnet's population (about 30,000 residents). *Penny-wise pensioners* represent the largest of this group (about 14,500 residents) and are likely to have more complex health care needs due to their advanced age.

# 5 Health

## 5.1 Key Facts

- In Barnet, the top three broad causes of mortality in both men and women are circulatory diseases, cancers and respiratory diseases. Circulatory diseases led to 2254 deaths, cancers caused 1949 deaths and respiratory diseases resulted in 693 deaths during 2010-2012.
- Smoking, alcohol, air pollution, poor diet, high blood pressure, obesity and hepatitis are the most common causes of ill health leading to premature mortality.
- Cardio Vascular Disease, CVD is the top cause of premature mortality, especially among the population under 75 years of age. In 2011-2013 the Barnet death rate due to preventable CVD in those aged less than 75 years was 39.7 per 100,000 and was higher in males (58.3) compared to females (23.3).
- There were 5,187 live births in Barnet during 2013 (only 1.5% by mothers aged less than 20 years and 37% by mothers aged 30-34 years). The highest live birth rate was in women aged 30-34 years (115.6 / 1,000) in Barnet, which was higher than the rates for London (14.7) and England (19.8) in women of the same age group.
- In 2008-2012 the proportion of babies born with a low birth weight (i.e. less than 2500 g) was highest amongst women resident in Finchley Church End (9.1%); Burnt Oak (8.5%); Colindale (8.3%); and Edgware (8.3%). The lowest proportion of underweight births was in the Hendon (5.9%); Coppetts (6.3%); and East Finchley (6.4%).

## 5.2 Strategic Needs

- Coronary Heart Disease is the number one cause of death amongst men and women in Barnet. **As male life expectancy continues to converge with women it is likely that dementia will become an increasingly** significant cause of death in the future.
- **There is eight years difference in male life expectancy between Burnt Oak and Garden Suburb wards.** The life expectancy differences are bigger at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Diet, smoking, and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **Child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **On average women in Barnet are significantly less likely to quit smoking in pregnancy** than women in London.
- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later on in life.** Particularly HPV, flu and

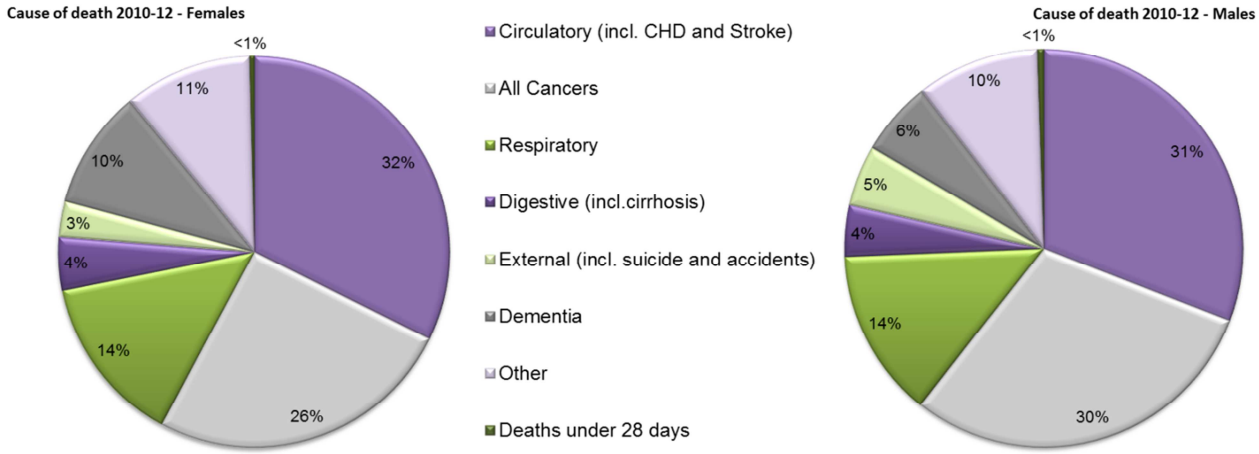
pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.

- **Overall the percentage of diabetic people having all eight health checks in Barnet is below the national rate** and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

## 5.3 Causes of Death

In Barnet, the top three broad causes of mortality in both men and women are circulatory diseases, cancers and respiratory diseases[32]. Circulatory diseases led to 2254 deaths (males 1002, females 1252), cancers caused 1949 deaths (males 963, females 986) and respiratory diseases resulted in 693 deaths (males 445, females 248) during 2010-2012. In the same period, dementia, another leading cause of death in Barnet, resulted in 579 deaths, which involved more females (n=383) than males (n=196).**Error! Bookmark not defined.**

**Figure 5-1a & b: Causes of death in females and males in Barnet (2010-2012)**

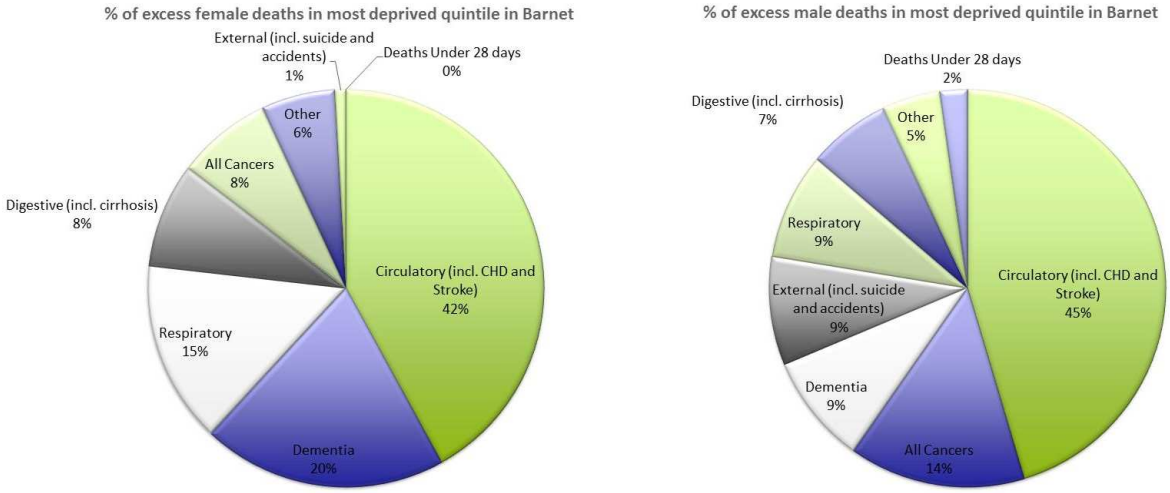



There are inequalities in life expectancy in Barnet by gender, locality / ward and the level of deprivation. Life expectancy at birth in females (85.0 years) is higher than males (81.9 years), and overall life expectancy for both the male and female population in Barnet is higher than the average for England (male =79.4 years, female =83.1 years).[33] The Garden Suburb ward has the highest life expectancy for both males (84.1 years) and females (88.5 years) while the Burnt Oak ward has the lowest life expectancy for both males (75.8 years) and females (81.6 years). In addition, the life expectancy gap is wider and mortality is higher in the most deprived areas compared to the least deprived areas in Barnet (Figure 5-2a&b).

[32] Public Health England. Segment Tool 2015

[33] Public Health England. Barnet indicators. Public Health Outcomes Framework. 3 February 2015 http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E09000003.pdf

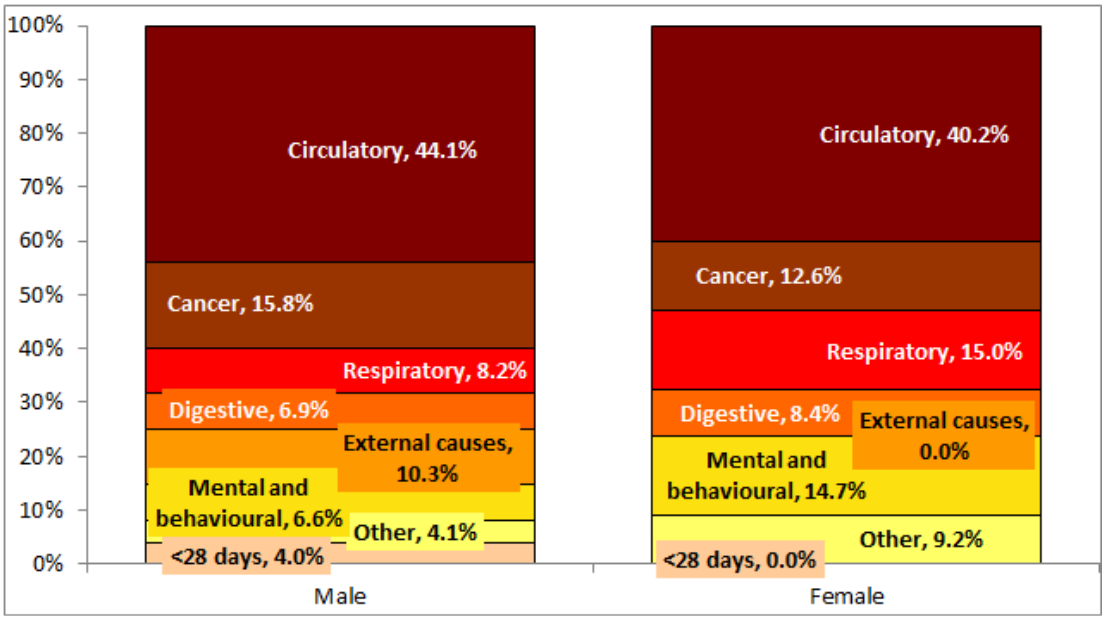
**Figure 5-2a&b. Percentage excess deaths[34] in males and females: the most deprived quintile vs. the least deprived quintile in Barnet (2010-2012)**




The greatest contributor to the life expectancy gap in the most deprived quintile versus least deprived quintile in Barnet is in circulatory diseases, in both the male and female population. The second and third highest contributors to the life expectancy gap in Barnet are cancers and external causes (i.e. injury, poisoning and suicide) in males and respiratory diseases and mental and behavioural illness in females (Figure 5-3).

In Barnet's most deprived areas, the three leading causes of excess deaths include CHD, stroke and cancer in males and dementia, CHD and COPD in females. These excess deaths can be avoided by reducing inequalities between different areas of Barnet.

**Figure 5-3: The breakdown of the life expectancy gap between the most deprived quintile and the least deprived quintile in Barnet by broad cause of death and gender (2010-2012)**




[34] Excess mortality is the number of deaths, or mortality, caused by a specific disease or condition. It's a measure of the deaths which occurred over and above those that would be predicted (in the absence of that negative defined circumstance) for a given population.

## 5.4 Causes of Ill Health

In Barnet, smoking, alcohol, air pollution, poor diet, high blood pressure, obesity and hepatitis are the most common causes of ill health leading to premature mortality[35]. Based on a total 1,981 premature deaths during 2011-13, Barnet ranks the 7th best out of 150 local authorities in England and the 2nd best within 15 similar local authorities. Table 5-1 below shows Barnet statistics on common causes of illness and the major diseases / conditions that are the leading causes of local premature mortality, rates of premature mortality by cause, and the Barnet rank and premature mortality outcomes compared to other local authorities (LAs).

**Table 5-1: Common causes of major illness, major diseases leading to premature mortality, premature mortality rates by cause, and premature mortality ranks and outcomes in Barnet**

| Common causes of major illnesses causing premature mortality | Major diseases / causes of premature mortality | Premature deaths (per 100,000)† for 2011-13 | Rank out of 150 local authorities* | Premature mortality outcomes | Rank within 15 similar local authorities* | Premature mortality outcomes |
|---|---|---|---|---|---|---|
| Smoking, poor diet, alcohol | Cancer (all) | 118 | 3 | | 2 | |
| Smoking, poor diet, alcohol | Lung cancer | 46 | 13 | | 2 | |
| Smoking, poor diet, alcohol | Breast cancer | 22 | 70 | | 6 | |
| Smoking, poor diet, alcohol | Colorectal cancer | 12 | 46 | | 6 | |
| High blood pressure, poor diet, smoking, physical inactivity | Heart disease and stroke | 63 | 16 | | 3 | |
| High blood pressure, poor diet, smoking, physical inactivity | Heart disease | 35 | 24 | | 6 | |
| High blood pressure, poor diet, smoking, physical inactivity | Stroke | 13 | 39 | | 7 | |
| Smoking, air pollution | Lung disease | 10 | 23 | | 3 | |
| Alcohol, hepatitis, obesity | Liver disease | 12 | 6 | | 1 | |
| | Injuries | 7 | 14 | | 3 | |

†Standardised rate of premature deaths (deaths before age of 75 years) per 100,000 population

*The lowest rank number refers to the best outcome

Best  Better than average  Worse than average

Data source: Public Health England. Healthier Lives: Premature mortality

[35] Public Health England. Healthier Lives: Premature mortality.

The common causes of the major diseases that are leading to premature deaths under 75 years of age (Table 5-1) are lifestyle related factors; these could be modified to reduce and prevent premature mortality in Barnet (as described in lifestyle chapter). The major diseases leading to premature mortality in Barnet are reported below.

## 5.5 Cardiovascular Disease

Cardiovascular disease (CVD) involves diseases of the heart and blood vessels and vascular diseases of the brain. CVD includes coronary heart disease (CHD) including heart attack and angina, hypertension, stroke and congenital heart disease[36].CVD is the number one killer disease globally and one of the major causes of preventable mortality (WHO, 2011)[36]. The global burden of CVD was 17.5 million deaths in 2012[37]. In the UK, CVD caused 160,000 deaths in 2011[38] and there are an estimated 7 million CVD patients in the country[39]. A higher proportion of men are affected by CVD compared to women. In the UK, the standardised death rate (per 100,000) due to CVD was 140.6 in males and 86.7 in females in 2012[40].

In the London Borough of Barnet (LBB), CVD is the top cause of premature mortality, especially among the population under 75 years of age. Data for 2011-2013 show that the Barnet death rate due to preventable CVD in those aged less than 75 years was 39.7 per 100,000 and was higher in males (58.3) compared to females (23.3). In addition, CVD mortality rate in age under 75 years was also higher in males than in females i.e. 89.6 vs. 39.4 respectively; however, these Barnet rates were lower than the average rates for the London region (males = 113.5, females = 49.6) and England (males =109.5, females = 48.6) (Figure 5-4).

**Figure 5-4: CVD mortality rates (under 75) in Barnet**

| Indicator | Period | England | London | Barking and Dagenham | Barnet | Bexley | Brent | Bromley | Camden |
|---|---|---|---|---|---|---|---|---|---|
| 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons) | 2011 - 13 | 50.9 | 50.2 | 64.0 | 39.7 | 43.6 | 56.4 | 39.8 | 42.0 |
| 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female) | 2011 - 13 | 26.5 | 26.3 | 32.0 | 23.3 | 22.9 | 31.4 | 17.7 | 20.0 |
| 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male) | 2011 - 13 | 76.7 | 76.4 | 99.7 | 58.3 | 66.3 | 83.3 | 64.6 | 66.3 |
| 4.04i - Under 75 mortality rate from all cardiovascular diseases (Female) | 2011 - 13 | 48.6 | 49.6 | 56.8 | 39.4 | 40.6 | 60.5 | 37.3 | 37.3 |
| 4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons) | 2011 - 13 | 78.2 | 80.1 | 97.5 | 62.9 | 68.3 | 93.5 | 64.4 | 70.8 |
| 4.04i - Under 75 mortality rate from all cardiovascular diseases (Male) | 2011 - 13 | 109.5 | 113.5 | 142.4 | 89.6 | 98.9 | 129.1 | 94.8 | 107.5 |

Compared with benchmark: Better | Similar | Worse — Lower | Similar | Higher

Benchmark: England

Source: Public Health England. Public Health Outcomes Framework http://www.phoutcomes.info/

[36] World Health Organisation (2011) Global Atlas on cardiovascular disease prevention and control, Geneva.
[37] World Health Organisation (2015) Cardiovascular diseases (CVDs), Fact sheet N°317 (Updated January 2015), Geneva.
[38] NHS Choices. Cardiovascular disease (Page last reviewed: 15/09/2014)
[39] British Heart Foundation. Cardiovascular Disease Statistics Factsheet (Last reviewed and updated: 13/02/2015)
[40] World Health Organisation (2014) Global status report on noncommunicable diseases 2014. Geneva.

### 5.5.1 Coronary Heart Disease

The prevalence of coronary heart disease (CHD) in Barnet (2.6%) was less than the national prevalence (3.3%) in 2013/14[41]. For the same period, 10,273 people were diagnosed with CHD, which was lower than the expected 13,400 cases of CHD in Barnet[41]. The national general practice profile data show that hospital emergency admissions rate (per 100 patients on the register) due to CHD in Barnet was 6.4% in 2010-2012, which was lower than the national average (7.1%).

### 5.5.2 Stroke

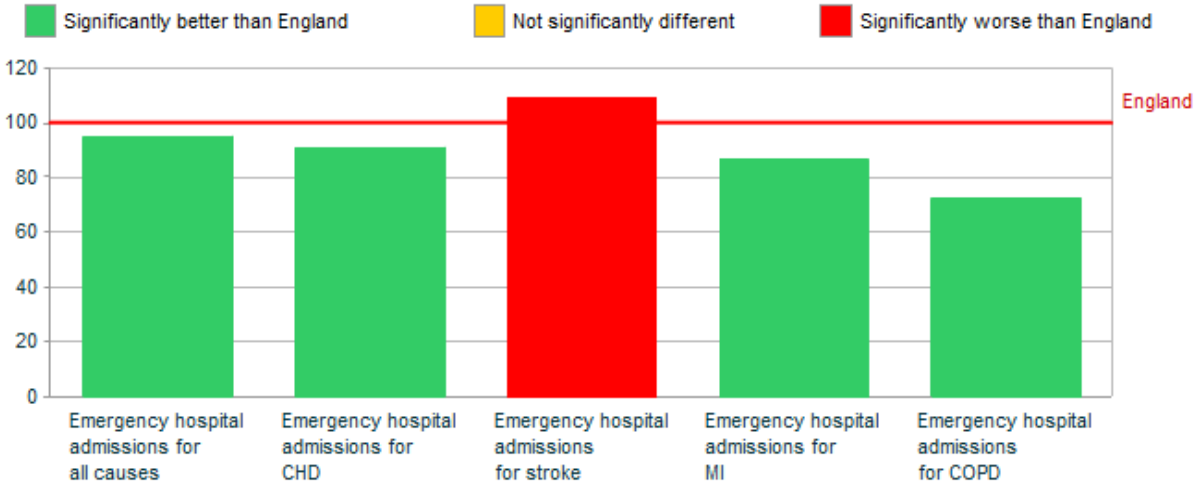
In 2013/14, the prevalence of stroke or transient ischaemic attacks (TIAs) in Barnet was 1.3% compared to 1.7% in England. In the same period, 4,957 people were diagnosed with a stroke and the rate of stroke mortality under 75 years of age was 12.4 / 100,000 people, which was similar to the average rate for England (13.7 / 100,000 people)[42].

In Barnet, the standardised mortality ratio (SMR) for deaths from stroke (at all ages) by ward was the highest in Childs Hill (117.7), Colindale (115.5) and Burnt Oak (110.3) wards while the lowest were in Finchley (47.9), Mill Hill (51) and Garden Suburb (53.1) wards for the period 2008-2012.

The rate of emergency hospital admissions for stroke in Barnet (235.4 / 100,000 people) was higher than the national rate (174.3 / 100,000 people) (Figure 5)[42]. Overall, the emergency hospital admissions rate due to stroke in Barnet increased by 51.9% from 2003-04 to 2013/14[42].

For the period 2008-2012, the standardised admission ratios (SAR) for emergency hospital admissions for stroke (all ages, persons) in Barnet was the highest in Burnt Oak (173), Colindale (152.3) and Coppetts (132.3) wards while the lowest were in Garden Suburb (78.9), Hendon (91.9) and Brunswick (93.7) wards.

**Figure 5-5: Emergency hospital admissions in Barnet compared to England (standardised admission ratios) (from 2008-09 to 2012-13)**




*Source: Public Health England, HSCIC © Copyright 2014*
www.localhealth.org.uk

[41] http://www.yhpho.org.uk/ncvincvd/pdfs/Heart/07M_Heart.pdf
[42] http://www.yhpho.org.uk/ncvincvd/pdfs/stroke/07M_Stroke.pdf

### 5.5.3 CVD Prevention

In Barnet, there are variations in the prevalence of CHD and stroke at GP[41, 42] and ward levels[43]. The higher prevalence in particular Barnet wards and GP registered populations merits further investigation. Barnet people of Black, Asian and Minority Ethnic (BAME) origin are more likely to experience CHD or stroke.

CVD can be prevented by reducing a number of behavioural risk factors such as tobacco use, unhealthy diet, obesity, physical inactivity and use of alcohol by means of population-wide strategies[37]. A number of initiatives aimed at reducing the behavioural risk factors associated with CVD have been initiated, such as the NHS Health Check program, which involves carrying out medical tests including measuring blood cholesterol levels among people aged 40-74 years. In 2013/14, 91,139 persons in Barnet were eligible for an NHS health check; of these 14,657 people (16.1%) were offered a health check but only 37.3% of these (n=5,469 persons) actually received an NHS health check. Overall, NHS Health Check appointments offered and received in Barnet are lower than the average values for England (18% offered and 49% received).

## 5.6 Cancers

Cancers of the breast, bowel, lung, and prostate are the most common cancers in England. The prevalence rate of these cancers in Barnet is lower than in the London region and England[44].

### 5.6.1 Cancer Incidence

The incidence rate for all cancers in Barnet (356.7 per 100,000) is lower than the average for England (398.1 per 100,000)[45]. The incidence rates (per 100,000) of breast cancer (126.6), prostate cancer (99.8 per 100,000), cervical cancer (6.7), ovarian cancer (14.9) and stomach cancer (8.1) are similar to the national average rates of these cancers (i.e. 125.7, 105.8, 8.8, 16.7 and 8.4 per 100,000, respectively)[45]. The incidence rate of lung cancer (35.6 per 100,000) and bowel cancer (403 per 100,000) in Barnet are lower than the average rates of these cancers in England (47.7 and 46.5 per 1000,000 respectively)[45].

Data for 2007-2011 shows that new cases of cancer (standardised incidence ratio) vary by the type of cancer across Barnet wards. Breast cancer incidence was the highest in Mill Hill ward (118.2) and the lowest in Burnt Oak ward (77.5). The Coppetts ward had the highest incidence of colorectal cancer (122.8) and lung cancer (117.3) while Hale ward had the lowest incidence of colorectal cancer (69.8) and Garden Suburb ward had the lowest incidence of lung cancer (53.2). The incidence of prostate cancer was the highest in West Finchley ward (115.6) and the lowest in Brunt Oak ward (72.6). Overall, the Underhill ward had the highest incidence of all cancers (103.3) and the Garden suburb ward the lowest incidence of all cancers (86.2) during 2007-2011.

### 5.6.2 Cancer Mortality

Overall cancer related deaths in all persons in Barnet are lower than in London and England. The directly standardised rates (DSR) for all cancer mortality in all persons aged under 75 years in females in Barnet are also less than the average London regional and national rates. The age-standardised mortality rates (ASMR) for cancer in patients aged less than 75 years have decreased in

[43] http://www.localhealth.org.uk/
[44] Public Health England. Cancer Mortality Profiles: Trends spreadsheet
[45] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/

2008-2010 compared to 1995-1997[46]. The highest reduction is in colorectal cancers in females (57%) followed by breast cancer in female (36%), lung cancer in males (36%), prostate cancer (27%) and upper GI cancer in males (20%). The reduction of the ASMR due to upper GI cancer in females was 24% less in 2008-2010 compared to 1995-1997.

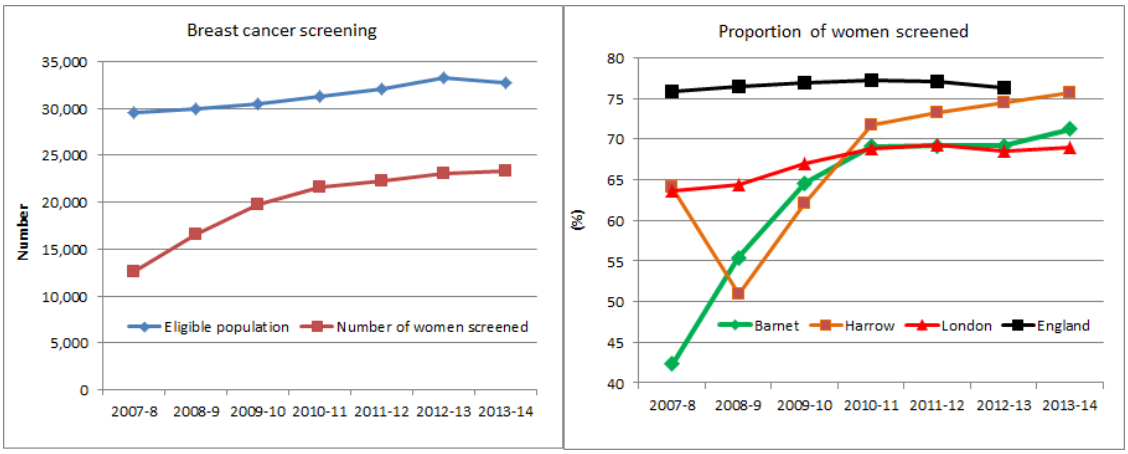
### 5.6.3 Cancer Survival

One-year net survival index for all types of cancers combined in adults (aged 15-99 years) in Barnet is higher (73.5%) than the average for the London region (69.7%) and England (69.3%)[47]. From 1997 to 2012, one year survival index for three cancers combined (breast [women], colorectal and lung) in adults (aged 15-99 years) in Barnet was higher than London and England but lower than in the neighbouring Harrow and Brent CCGs[48].

### 5.6.4 Cancer Screening

Cancer screening coverage for breast cancer (female) in Barnet is better than the average for the London region but worse than the national average (Figure 5-6a and b); while, cervical cancer screening coverage in Barnet is worse than the average rates for London region and England.

**Figure 5-6a&b: Breast (Female) Cancer and screening**




Data for three years prior to March 2014, shows that the rate of cancer screening coverage for breast cancer was 71.2% in Barnet, which is better than the average coverage rate for the London region (68.9%) but worse than the rate for England (75.9%)[49]. For the same period, coverage for cervical cancer screening was 68.8% in Barnet that is lower than the averages for the London region (70.3%) and England (74.2%). These findings suggest a gap between the eligible population and population covered in screening for cervical and breast cancers in females.

### 5.6.5 Cancer Registration

For 2010-2012 period, cancer registration rates (directly standardised rates per 100,000) for cervical (6.8) and lung (58.1) cancers in Barnet were lower compared to the average rates for London region (7.9 and 72.2 respectively) and England (9.2 and 76.0 respectively)[50]. The oral cancer registration

[46] http://www.swpho.nhs.uk/resource/item.aspx?RID=76243
[47] Office of National Statistics. Table 2-4: Index of cancer survival for Clinical Commissioning Groups in England: Adults diagnosed 1997-2012 and followed up to 2013 (Excel sheet 443Kb)
[48] http://www.ons.gov.uk/ons/datasets-and-tables/index.htmlhttp://www.ons.gov.uk/ons/datasets-and-tables/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=Cancer+Incidence+and+Mortality&content-type=Reference+table&content-type=Dataset (Release date: 16 Dec, 2014).
[49] http://www.phoutcomes.info
[50] Public Health England http://fingertips.phe.org.uk/

rate in Barnet (12.4) was higher than the average rates for London region (13.5) and nationally (13.2) during 2010-2012[50]. To encourage the early detection of cancers, the NHS Barnet CCG joined the "Be Clear on Cancer campaign" in July 2013. The campaign is aimed at raising awareness among local people about the early signs of cancers and promoting early diagnosis of cancer.

## 5.7 Respiratory disease

### 5.7.1 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is an airway disease that causes breathing difficulty and it includes several respiratory tract conditions including emphysema and chronic bronchitis[51]. There are 4,247 COPD cases on GP registers (data for 2013/14)[52].

#### *5.7.1.1 COPD Prevalence*

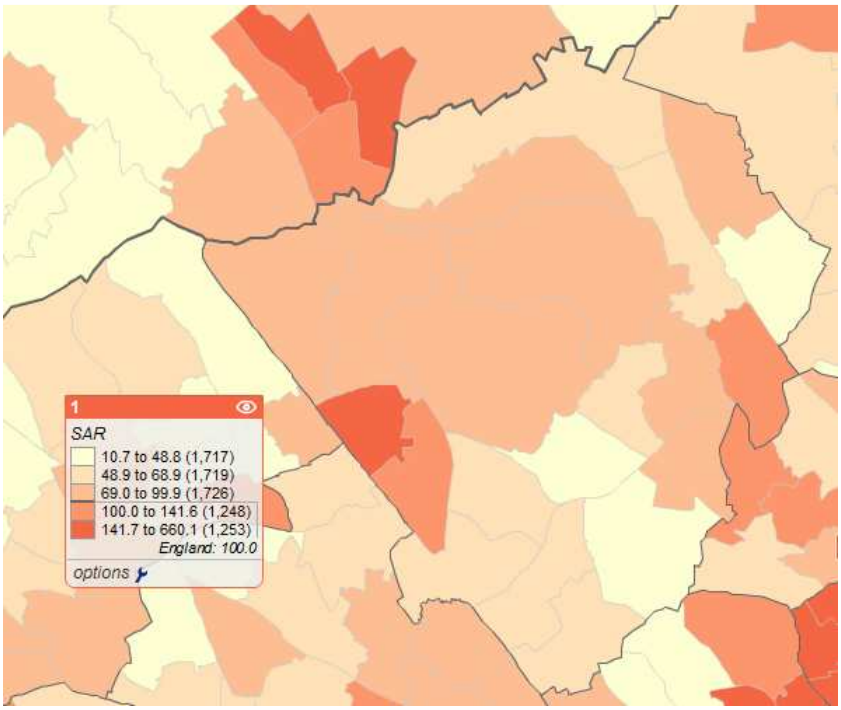
The average COPD prevalence rate for NHS Barnet CCG (1.1%) is lower than the average rate for England (1.8%) and there are wide variations in the COPD prevalence across GPs in Barnet[53]. The COPD prevalence confirmed by spirometry is 88.56% (95% CI: 86.54-90.32) in the NHS Barnet CCG, which is lower than 90.18% (95% CI: 89.83-90.53) in London and 90.74% (95% CI: 90.63-90.85) in England[54]. However, the estimated prevalence of COPD is 2.82% (as of 2011)[2], which suggests a need for increasing the rate of COPD diagnosis.

#### *5.7.1.2 COPD Hospital Admissions*

The total COPD hospital admissions rate (per 1000 patients on the disease register) in Barnet (1.3) is lower than the average national rate (2.2). The standardised admissions ratio of emergency hospital admissions for COPD varies across Barnet (Figure 5-7) with the highest ratio in Burnt Oak ward (141.8) and the lowest ratio in Garden suburb ward (28.3).

[51] http://www.nepho.org.uk/respiratory/index.php
[52] HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14 Date: 28 October 2014. http://www.hscic.gov.uk/catalogue/PUB15751 http://www.hscic.gov.uk/catalogue/PUB15751/qof-1314-prev-ach-exc-ccg.xlsx
[53] http://fingertips.phe.org.uk/profile/general-practice/data
[54] HSCIC. Prevalence: chronic obstructive pulmonary disease confirmed by spirometry: percent, all ages, annual, P ; Period 2013/14: Version 14: Data file 24D_635PC_14_D.xls. Release date: March 2015 [https://indicators.ic.nhs.uk/webview/]

**Figure 5-7: Emergency hospital admissions rates for COPD by wards in Barnet**




### 5.7.2 Asthma

Barnet has 17,609 asthma patients registered with local GPs and the asthma prevalence rate (all ages) is 5.54%, below the average rate (5.9%) for England[52]. The prevalence of asthma widely varies between GPs in the NHS Barnet CCG[52].

### 5.7.3 Risk Factors

Smoking and influenza virus infection of the respiratory system are the two important risk factors for COPD and asthma. Information regarding smoking in Barnet is reported in the section on tobacco use and smoking in the lifestyle chapter while influenza infections related Barnet information is given below. Influenza viruses cause respiratory tract infection that can lead to exacerbations of COPD and asthma, which can be prevented by influenza vaccination[55]. The influenza immunisation rate in Barnet (83%) is slightly higher than the average rate for England (81.9%)[52].

## 5.8 Mental Health

Mental health is a high public health priority area in the country. Addressing mental health problems in all age groups and improving outcomes and relevant services are suggested in the 2011 mental health strategy for England entitled "No health without mental health". Tackling mental health is important because poor mental health not only costs too much for the economy and the health system but also leads to and is associated with inequalities[56].

### 5.8.1 Adult Mental Health

The prevalence of mental health problems including schizophrenia, bipolar affective disorder and other psychoses in all ages recorded on GP disease registers in Barnet is 0.95%, which is higher than the average rate for England (0.84%).[57,58]

[55] Wesseling, G. (2007) Occasional review: Influenza in COPD: pathogenesis, prevention, and treatment. Int J Chron Obstruct Pulmon Dis. 2(1): 5–10.
[56] Department of Health (2011) No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. London.

In Barnet, the prevalence rate of depression (recorded in adults aged 18 and over) is 4.3% (12,921 persons of the total 298,601 GP registered population aged 18+). The Barnet rate is lower than the average rate for England (5.8%).[57,58] There were 2,303 new cases of depression recorded in GP registers during 2013/14 showing the incidence rate of 0.8% for Barnet, which is lower than the average national rate (1.0%)[58,59.]

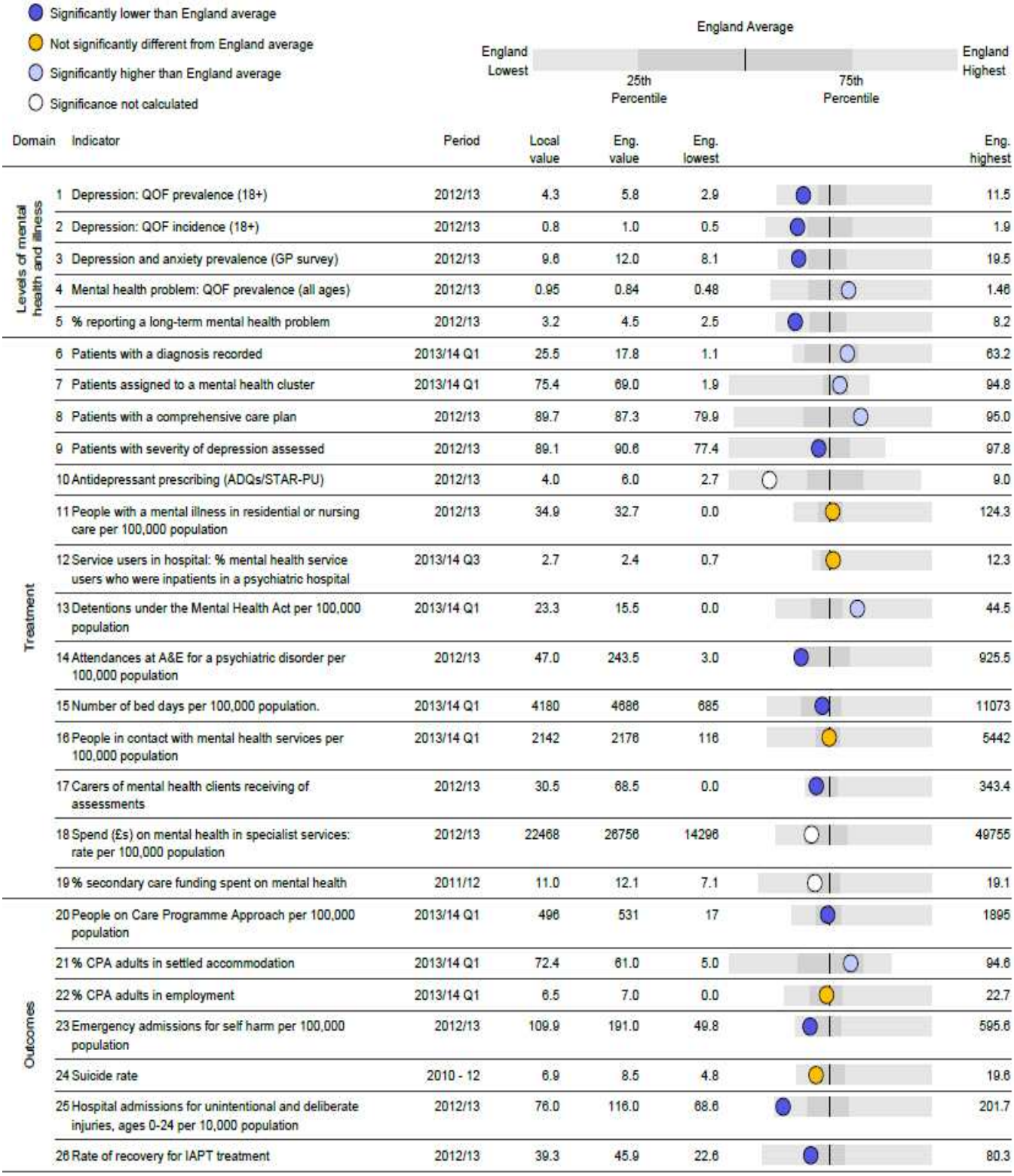
The average rate of people with a mental illness in residential or nursing care per 100,000 of the population in Barnet (34.9) is similar to England (32.7). The percentage of mental health service users who were inpatients in a psychiatric hospital in Barnet (2.7%) is also similar to the national average (2.4%). However, the rate of detentions under the National Mental Health Act per 100,000 population is higher in Barnet (23.3) compared to the average for England (15.5). In addition, Barnet rates for attendances at A&E for a psychiatric disorder (47 per 100,000 population) and number of bed days (4,180 per 100,000 population) are lower than the average national rates (243.5 and 4,686 per 100,000 population, respectively).

Moreover, the rates of emergency admissions for self-harm (109.9 per 100,000 population) and hospital admissions for unintentional and deliberate injuries in aged 0-24 years (76.0 per 10,000 population) in Barnet are lower than the average for England (191.0 / 100,000 and 116.0 / 10,000 population respectively). The suicide rate in Barnet (6.9 per 100,000 population) is similar to the average national rate (8.5 per 100,000 population).

A summary of mental health related indicators for Barnet benchmarked against England are shown in Figure 5-8, which shows that most of Barnet indicators are better than those at the national level.

[57] Public Health England (2014) Community Mental Health Profile data http://fingertips.phe.org.uk/cmhp
[58] Public Health England (2014) Barnet Clinical Commissioning Group. Community Mental Health Profile 2014.
[59] Public Health England (2014) Community Mental Health Profile data

**Figure 5-8: Mental health indicators for Barnet**




| Domain | | Indicator | Period | Local value | Eng. value | Eng. lowest | Eng. highest |
|---|---|---|---|---|---|---|---|
| Levels of mental health and illness | 1 | Depression: QOF prevalence (18+) | 2012/13 | 4.3 | 5.8 | 2.9 | 11.5 |
| | 2 | Depression: QOF incidence (18+) | 2012/13 | 0.8 | 1.0 | 0.5 | 1.9 |
| | 3 | Depression and anxiety prevalence (GP survey) | 2012/13 | 9.6 | 12.0 | 8.1 | 19.5 |
| | 4 | Mental health problem: QOF prevalence (all ages) | 2012/13 | 0.95 | 0.84 | 0.48 | 1.46 |
| | 5 | % reporting a long-term mental health problem | 2012/13 | 3.2 | 4.5 | 2.5 | 8.2 |
| Treatment | 6 | Patients with a diagnosis recorded | 2013/14 Q1 | 25.5 | 17.8 | 1.1 | 63.2 |
| | 7 | Patients assigned to a mental health cluster | 2013/14 Q1 | 75.4 | 69.0 | 1.9 | 94.8 |
| | 8 | Patients with a comprehensive care plan | 2012/13 | 89.7 | 87.3 | 79.9 | 95.0 |
| | 9 | Patients with severity of depression assessed | 2012/13 | 89.1 | 90.6 | 77.4 | 97.8 |
| | 10 | Antidepressant prescribing (ADQs/STAR-PU) | 2012/13 | 4.0 | 6.0 | 2.7 | 9.0 |
| | 11 | People with a mental illness in residential or nursing care per 100,000 population | 2012/13 | 34.9 | 32.7 | 0.0 | 124.3 |
| | 12 | Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital | 2013/14 Q3 | 2.7 | 2.4 | 0.7 | 12.3 |
| | 13 | Detentions under the Mental Health Act per 100,000 population | 2013/14 Q1 | 23.3 | 15.5 | 0.0 | 44.5 |
| | 14 | Attendances at A&E for a psychiatric disorder per 100,000 population | 2012/13 | 47.0 | 243.5 | 3.0 | 925.5 |
| | 15 | Number of bed days per 100,000 population. | 2013/14 Q1 | 4180 | 4686 | 685 | 11073 |
| | 16 | People in contact with mental health services per 100,000 population | 2013/14 Q1 | 2142 | 2178 | 116 | 5442 |
| | 17 | Carers of mental health clients receiving of assessments | 2012/13 | 30.5 | 68.5 | 0.0 | 343.4 |
| | 18 | Spend (£s) on mental health in specialist services: rate per 100,000 population | 2012/13 | 22468 | 26756 | 14296 | 49755 |
| | 19 | % secondary care funding spent on mental health | 2011/12 | 11.0 | 12.1 | 7.1 | 19.1 |
| Outcomes | 20 | People on Care Programme Approach per 100,000 population | 2013/14 Q1 | 496 | 531 | 17 | 1895 |
| | 21 | % CPA adults in settled accommodation | 2013/14 Q1 | 72.4 | 61.0 | 5.0 | 94.6 |
| | 22 | % CPA adults in employment | 2013/14 Q1 | 6.5 | 7.0 | 0.0 | 22.7 |
| | 23 | Emergency admissions for self harm per 100,000 population | 2012/13 | 109.9 | 191.0 | 49.8 | 595.6 |
| | 24 | Suicide rate | 2010 - 12 | 6.9 | 8.5 | 4.8 | 19.6 |
| | 25 | Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population | 2012/13 | 76.0 | 116.0 | 68.6 | 201.7 |
| | 26 | Rate of recovery for IAPT treatment | 2012/13 | 39.3 | 45.9 | 22.6 | 80.3 |

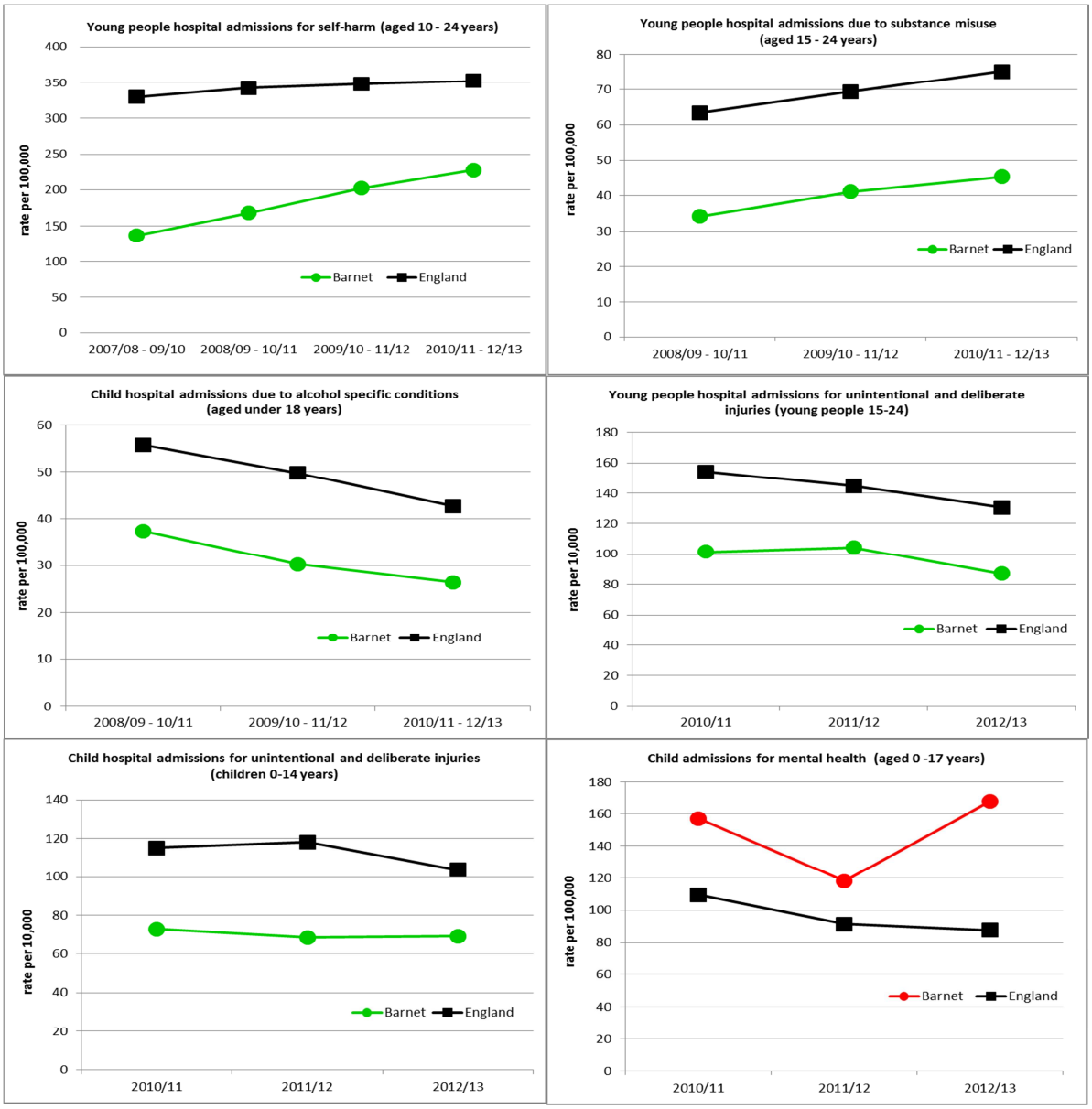
Source: Public Health England. [Barnet Children's and Young People's Mental Health and Wellbeing Profile]

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

In Barnet children aged 5-16 years, the estimated prevalence of any mental disorder (8.3%), emotional disorder (3.2%), conduct disorder (4.99%) and hyperkinetic disorders (1.35%) are all lower than the average rates for England (i.e. 9.6%, 3.7%, 5.8% and 1.5% respectively).

Barnet hospital admissions rates (per 100,000) for self-harm in young people (aged 10-24 years), substance misuse and unintentional and deliberate injuries in young people (15-24 years old), alcohol specific conditions in children (aged less than 18 years) and unintentional and deliberate injuries in children (less than 15 years old) are lower than the average rates for England. However, the hospital admissions rate for mental health in children (aged less than 18 years) in Barnet is higher than the average national rate (Figure 5-9).

**Figure 5-9: Mental health indicators for Barnet vs. England**




Data Source: Public Health England. Children's and Young People's Mental Health and Wellbeing

### 5.8.3 Mental Health Illness Prevention

The National Service Framework for Children, Young People and Maternity Service (2004) suggests providing early and effective services to help children and young people with emotional, behavioural, psychological and mental health problems using the Child and Adolescent Health Services (CAMHS) strategic framework, which comprises 1 to 4 tiers. Providing the CAMHS services at tiers 2-3 is the responsibility of the clinical commissioning groups (CCGs) while commissioning of the tier 4 CAMHS services is the responsibility of NHS England since April 2013[60]. In Barnet, the estimated number of children aged less than 18 years requiring CAMHS services Tier 3 is 1,580 and those requiring the Tier 4 services is 65 (as per estimation of 2012).

The London Borough of Barnet (LBB) has a health and wellbeing strategy "Keeping Well, Keeping Independent" for 2012-2015 that addresses overall health and wellbeing including mental health needs of the local population through a four themes approach. In addition, the LBB and Barnet Clinical Commissioning Group have started a number of initiatives including programmes and services for improving mental health and wellbeing of the local people[61]. For example, the LBB programmes for improving mental health and wellbeing include a schools wellbeing programme, mental health in the community, physical activity programme for older people, a programme to reduce the misuse of alcohol and an outdoor gyms and activator programme. The CCG led initiatives include developing an integrated commissioning health and wellbeing strategy with a multiagency forum mental health partnership board, planning redesigning of CAMHS Tier-4 services, remodelling the primary care mental health team, developing primary care support and liaison teams and re-commissioning mental health day opportunity services.

## 5.9 Diabetes

The rate of recorded (diagnosed) diabetes (in GP registered population aged 17+) in Barnet (6.03%) is similar to London rate (6.00%) but lower than the national rate (6.21%). However, estimated total (diagnosed and undiagnosed) prevalence of diabetes in 2015 in Barnet adults (8.3%) is slightly higher than England (7.6%)[62]. There are an estimated 5,259 (23%) undiagnosed cases of diabetes in Barnet.[63] The prevalence rate of diabetes is forecast to rise at both national and local levels and this increase could be even higher if diabetes risk factors such as obesity are not addressed[64].

There is a wide variation between Barnet GPs (n=67) in terms of both the prevalence of diabetes (from 2.2% to 10.3%)[65] and the clinical management of diabetic patients. However, the Quality and Outcomes Framework (QOF) results for 2013/14 reveal that Barnet GPs have better average diabetes outcomes compared to the national averages[66]. However, some GPs in the Barnet CCGs have diabetes outcomes lower than the local and national averages, which need to be reviewed.

The Barnet indicators of care processes carried out on diabetic patients show that foot checks, urine testing for protein and smoking cessation advice is above the average for England whilst flu vaccination and eye screening are similar to the national average. The BMI recording in diabetic

[60] NHS England (July 2014) Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report. . http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf
[61] Barnet JSNA Refresh 2013-14 - Mental health and wellbeing.
[62] Public Health England. Diabetes Prevalence Model for Local Authorities and CCGs.
[63] http://www.yhpho.org.uk/ncvinintellpacks/pdfs/07M_SlidePack.pdf
[64] Public Health England. Barnet Cardiovascular disease profile. Diabetes. March 2015.
[65] http://www.yhpho.org.uk/ncvincvd/pdfs/Diabetes/07M_Diabetes.pdf
[66] http://fingertips.phe.org.uk/profile/general-practice/data

patients in Barnet is below the average for England, an area which needs to be reviewed. The percentage of diabetic people having all eight check-ups in Barnet (56%) is also below the national average (59.5%), which is an area for improvement in the future.

Complications due to diabetes in Barnet patients are similar to the regional (London) and national averages. However, the National Diabetes Audit 2012-2013 recommended that the Barnet CCG should review its diabetes care providers to reduce the risks associated with diabetes and use different approaches including exercise, diet composition, weight management, smoking, glucose control, blood pressure control and cholesterol control[67]. These recommendations should be taken seriously and implemented through appropriate interventions and services.

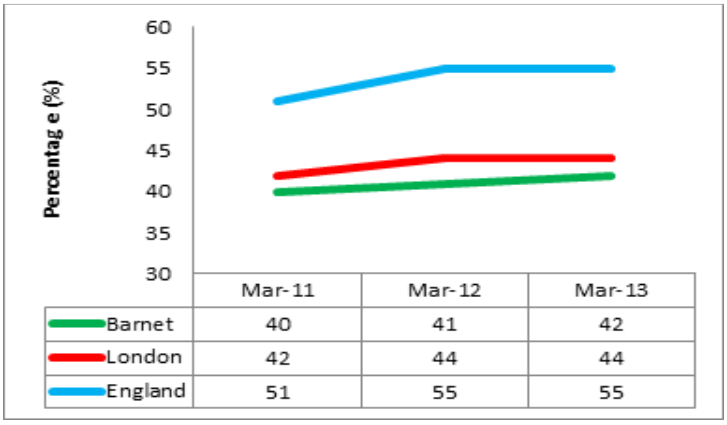
## 5.10 Oral Health

Oral health is integral and essential to general health and an important determinant of the quality of life[68]. Oral diseases limit activity at home and work, and in schools, and there is a strong association between oral diseases and non-communicable chronic diseases (NCDs)[68]. Thus, integration of oral health in to public policy agenda for the prevention and control of NCDs and development agenda has been suggested in the Tokyo Declaration on Dental care and oral health for healthy longevity 2015[69]. In addition, premature mortality can also be reduced by preventing oral diseases[68]. It is however important that oral disease preventative strategies and approaches should address not only the wider and distant socio-economic determinants of oral heath e.g. poor living conditions and low education but also the immediate and modifiable risk behaviours such as sugar consumption (amount, frequency of intake, types), oral hygiene practices, tobacco use and excessive alcohol consumption[70].

### 5.10.1 Adult Oral Health

Data on dental service use shows that the dental access rate in Barnet adults (over 18 years) increased slightly in 2013 compared to 2011 and the Barnet rate (42% for March 2013) followed the average trend for London and England over the reported period (Figure 5-10).

**Figure 5-10: Adult Dental Access Rates 2011-2013**




| | Mar-11 | Mar-12 | Mar-13 |
|---|---|---|---|
| Barnet | 40 | 41 | 42 |
| London | 42 | 44 | 44 |
| England | 51 | 55 | 55 |

Statistics on oral cancers (also known as mouth cancers or cancers of the oral cavity) show that these types of cancers are not very common in the UK (one oral cancer in 50 cases of all types of

[67] HSCIC (2015). National Diabetes Audit 2012-2013. Report 2: Complications and Mortality Summary for NHS Barnet CCG (07M).
[68] World Health Organisation. Oral Health. Policy basis.
[69] World Health Organisation (2015). Tokyo Declaration on Dental care and oral health for healthy longevity.
[70] World Health Organisation. Oral Health. Strategies and approaches in oral disease prevention and health promotion.

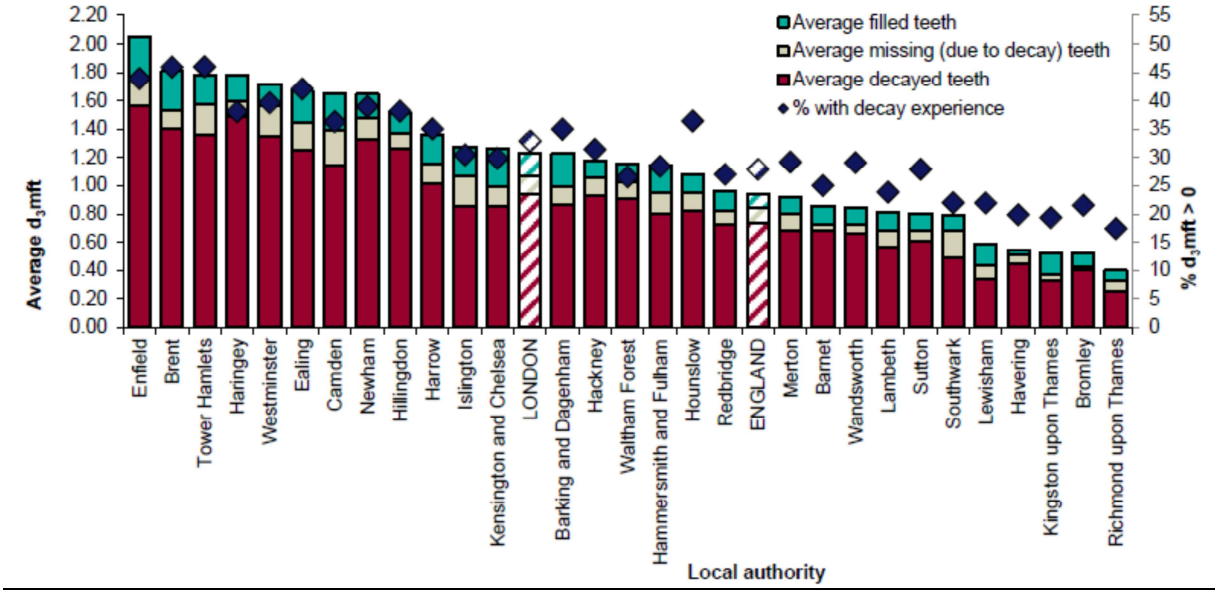
cancers)[71]. Nevertheless, cancers of the oral cavity are the most common cancers of the head and neck region and involve more men than women[72].

In Barnet, the age standardised rate (per 100,000 population) of oral cancer registration is 13.2, which is similar to the national (12.8) and London regional (13.2) averages. Risk factors for mouth cancers include smoking, use of products containing tobacco e.g. chewing of tobacco or *paan* (areca nut/betel leaf), drinking alcohol and infection with the human papilloma virus (HPV).[70,72] Therefore, oral cancer risk could be minimised by avoiding the above risk factors. In addition, the survival rate for oral cancers is higher when treated at the early stage compared to the late stage; therefore, creating awareness especially among communities that are more likely to be at risk is imperative.[72]

### 5.10.2 Child Oral Health

Overall, levels of oral diseases in children in Barnet are low compared to their neighbouring Boroughs. One of the public health outcome framework indicators, overall success of health and wellbeing, is the level of tooth decay in children aged 5 years,[73] which is lower in Barnet compared to the average levels for London and England and several other local authorities in London (Figure 5-11).

**Figure 5-11: The average number of decayed, extracted or filled teeth ($d_3mft$) and the proportion of children affected by dental decay (%$d_3mft$>0) among 5 year old children in Barnet compared to England and other local authorities in the London region**




Source: Public Health England. Barnet Dental Health Profile. October 2014

In addition, the percentage of children with one or more obviously decayed, missing (due to decay) and filled teeth in Barnet (25.0%) is similar to the national average (27.9%) but lower than the London region (32.9%)[74].

[71] NHS Choices (2014) Mouth cancer http://www.nhs.uk/Conditions/Cancer-of-the-mouth/Pages/Introduction.aspx
[72] Public Health England. Oral Cavity Cancer: recent survival trends. The National Cancer Intelligence Network, London.
[73] Public Health England (Oct 2014) Barnet Dental Health Profile. Dental health of five-year-old children 2012.
[74] Public Health England. http://fingertips.phe.org.uk/search/dental

Moreover, the prevalence of early childhood (dental) caries (ECC) involving three year old children in Barnet (6.1%) is higher than the national average (3.9%), which suggests a need for early and targeted oral health improvement interventions to reduce the ECC levels at an early stage[75].

Hospital admissions for extraction of one or more decayed primary or permanent teeth in children aged less than 15 years is lower in Barnet compared to the London region but higher than the national average (Figure 5-12). However, child dental decay is the top cause for non-emergency hospital admissions in Barnet, which involved 349 children aged 0-19 years and the majority (67%) involved 5-14 years olds in 2012/13[76].

Furthermore, statistics about access to the dental service show that the dental access rate in children (under 18 years) in Barnet is slightly above the London regional rate but is below the national rate (Figure 5-13)[77].

**Figure 5-12: Child hospital admissions for extraction of one or more decayed primary or permanent teeth(0-19 years)[76]**

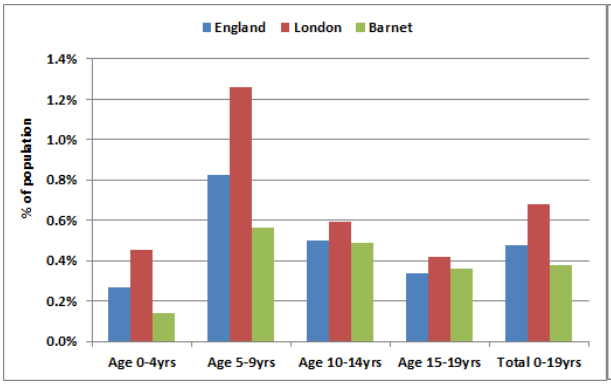
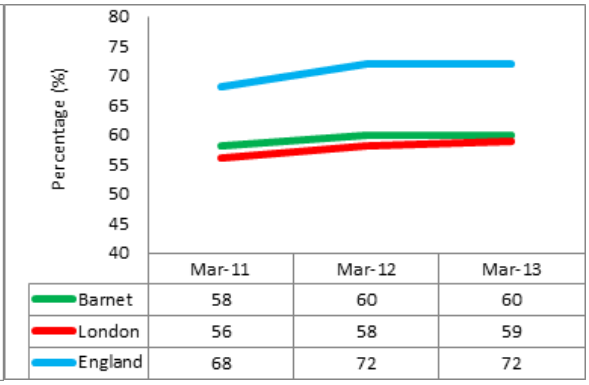



**Figure 5-13: Child Dental Access Rates 2011-2013 (under 18 years)[77]**




| | Mar-11 | Mar-12 | Mar-13 |
|---|---|---|---|
| Barnet | 58 | 60 | 60 |
| London | 56 | 58 | 59 |
| England | 68 | 72 | 72 |

### 5.10.3 Existing Oral Health Interventions in Barnet

The Barnet Child Oral Health Improvement Strategy has three key domains: making oral health everybody's business and every contact count, integrating oral health into Children's Commissioning Plans throughout the life course using the common risk factor approach and increasing the exposure to fluoride e.g. toothpaste and fluoride varnish. The key actions under Barnet's Child Oral Health Improvement Strategic Plan (2014/16) include: training of Health and Social Care Professionals in key messages about oral health, new Healthy Children's Centre Standards developed (covering a range of health priority areas) – identifying and supporting oral health champions in Children's Centres to meet their oral health standards-making sure oral health remains a priority within the centres, distributing toothpaste and brush packs at child development checks (8 months and 21/2 years) alongside brief oral health intervention, and supervised teeth brushing programme in three schools and three children's centres per term.

### 5.10.4 Oral Health Needs

There is no Borough level data on the oral health of adults or older people in Barnet[78]. There could be inequalities in oral health and oral care such as provision of oral care in care homes[79]. A local oral

[75] Public Health Programme (2015) Oral health survey of three-year-old children 2013. A report on the prevalence and severity of dental decay. Dental public health epidemiology programme. (Revised January 2015).
[76] Public Health England. Public Health England Epidemiology Programme: Extraction data
[77] HSCIC. Access by patient London LA region Sept 2013, NHS dental statistics England 2012-2013

health needs assessment could be undertaken in Barnet for identifying oral health inequalities and oral health needs of adults and children.

## 5.11 Maternity and Infant Health

### 5.11.1 Live Births and Rates

There were 5,187 live births (2,699 males and 2,488 females) in Barnet in 2013 (only 1.5% by mothers aged less than 20 years and 37% by mothers aged 30-34 years). The highest birth rate was in women aged 30-34 years (115.6 / 1,000) in Barnet, which was higher than the rates for London (14.7) and England (19.8) in women of the same age group. However, Barnet rates of births by mothers under 18 years (1.8 /1,000) and under 20 years (6.8/1,000) were lower than the average rates for the London region (5.1 and 12.3 respectively) and nationally (7.8 and 12.3 respectively) in 2013.

Data for 2013 show that the crude live birth rate (14.1/ 1,000 population), general fertility rate (63.4/1,000 women aged 15-44 years) and maternity[80] rate (62.4 /1,000 women aged 15-44 years) in Barnet were slightly lower than these rates for London (15.2, 64.0 and 63.2 respectively) but higher than the national rates (15.2, 62.4 and 61.7 respectively).

Whilst the projected trend of women of childbearing age is expected to increase, the number of live births and the fertility rate is decreasing. Data for 2008-2012 show that the highest fertility rate (per 1,000 women aged 15-44 years) is in Golders Green ward (82.9) followed by Hendon (77.3) and Colindale (77.2) wards while the lowest fertility rate is in the Brunswick Park ward (56.8) followed by Woodhouse (57.1) and Underhill (57.2) wards in Barnet.

### 5.11.2 Infant Health and Mortality

The percentage of live births under 2.5 kg in Barnet (7.2%) is similar to England (7.0%) but slightly lower than the London region average (7.5%). Data for 2008-2012 show that the proportion of babies born with a low birth weight (i.e. less than 2500 g) was highest amongst women resident in Finchley Church End ward (9.1%) followed by Burnt Oak (8.5%), Colindale (8.3%) and Edgware (8.3%) wards in Barnet. The lowest proportion of underweight births was in the Hendon (5.9%) followed by Coppetts (6.3%) and East Finchley (6.4) wards in Barnet.

The life expectancy at birth is increasing in Barnet and is higher for females (85.0 years) than males (81.9 years) in Barnet, which are both higher than the averages for the London region (83.8 and 79.7 years for females and males respectively) and England (82.72 and 78.85 years for females and males respectively). However, Barnet life expectancy at birth is lower than in Harrow males (82.0 years) and females (85.6 years).

Barnet rates of infant (under 1 year) mortality (2.3 /1,000 live births), neonatal (under 4 weeks) mortality (1.3/1,000 live births) and perinatal mortality (4.8/ 1,000 stillbirths and deaths under 1 week) are lower than the average rates for London (3.8, 2.6 and 7.3 respectively) and England (3.9, 2.7 and 6.7 respectively).

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[78] JSNA Refresh 2014 Oral Health Barnet

[79] Public Health England (2014) Dental public health intelligence programme. North West oral health survey of services for dependent older people, 2012 to 2013.

[80] A maternity is a pregnancy resulting in the birth of one or more children, including still births

### 5.11.3 Breast Feeding

In 2013/14, breastfeeding initiation in Barnet was the 11th highest among all 326 English LAs and 9th highest among 33 London Boroughs. The proportion of all mothers who breastfeed their babies in the first 48 hours after delivery in Barnet (89.3%) was better than the national average (73.9%) during the same period.

### 5.11.4 Maternal Health

#### *5.11.4.1 Smoking in Pregnancy*

The percentage of women who smoked at the time of delivery in Barnet (4.4%) is lower than the London (5.1%) and national (12.0%) averages for the year 2013/14. However, the percentage of pregnant women who successfully quit is 45% in Barnet, which is lower than the averages for London (53%) and England (47%). The percentage of pregnant women who did not quit and those who were lost to follow up in Barnet (23% and 32% respectively) were higher than the national (29% and 23% respectively) and London regional averages (20% and 28% respectively). Public health funded stop smoking services need to proactively target pregnant women in Barnet.

#### *5.11.4.2 Maternal Mortality*

The maternal mortality rate (Directly age-standardised rate (DSR) per100, 000 of women aged 15-44) in Barnet (0.44) is higher than the average rates for London (0.22) and England (0.31).

#### *5.11.4.3 Service Use*

82.7% of pregnant women in Barnet had an antenatal assessment by the 12th week of pregnancy, which was lower than England average (93.7%) during 2013/14.

## 5.12 Health Protection

### 5.12.1 Immunisation

Immunisation has been described as a process by which a person is made immune or resistant to an infectious disease usually by the administration of a vaccine[81]. Immunisation thus helps in controlling and eliminating life threatening infectious diseases and thereby reducing illness, disability and death from vaccine preventable infectious diseases[82]. Vaccination can be provided from the age of two months onwards and there are specific vaccinations for babies, children, adults, elderly, travellers and people in special groups such as pregnant women, people with long term health conditions as well as healthcare workers[83]. The latest NHS complete routine immunisation schedule from summer 2014 provides a list of vaccines, when to immunise (the age of a person for administering particular vaccines) and the names of diseases protected against[84].

The latest update of the coverage of specific immunisations in Barnet is provided below.

#### *5.12.1.1 Childhood Primary Immunisations*

The NHS routine childhood immunisations provide cover against a number of infectious diseases such as diphtheria, Haemophilus influenza type b (Hib), meningococcal group C disease (MenC)

[81] http://www.who.int/topics/immunization/en/
[82] World Health Organisation (2014) Immunization coverage. Fact sheet N°378. Last reviewed: November 2014.
[83] http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx
[84] Department of Health. (2014) Vaccines for the routine immunisation schedule from summer 2014. Published on 7 May 2014.

pertussis, pneumococcal disease, polio, rotavirus and tetanus. The childhood immunisation in England is evaluated by the cover of vaccination evaluated rapidly (COVER) programme.

The NHS immunisation statistics for 2013/14 (Table 5-2) show that Barnet rates for MenC (12 months), DTap/ IPV/ Hib (24 months) and MMR1 (5 years) are better than the corresponding rates for England; however, other childhood immunisation rates in Barnet are worse than the national rates[85].

**Table 5-2: Coverage of routine childhood immunisations in Barnet compared to England**

| | | Barnet | | | England |
|---|---|---|---|---|---|
| Cohort | Short name | Cohort size CS-2013-14 | Number immunised IM-2013-14 | Rate (%) 2013-14 | Rate (%) 2013-14 |
| 12 months | DTaP/IPV/Hib | 5789 | 4612 | 79.7 | 94.3 |
| | PCV | 5789 | 4767 | 82.3 | 94.1 |
| | MenC | 5786* | 5286 | 91.4 | 93.9 |
| | Hep B | 39 | 19 | 48.7 | - |
| 24 months | DTaP/IPV/Hib primary | 6029 | 5633 | 93.4 | 96.1 |
| | PCV booster | 6029 | 4839 | 80.3 | 92.4 |
| | Hib/MenC booster | 6029 | 4833 | 80.2 | 92.5 |
| | MMR1 (1st dose) | 6029 | 4863 | 80.7 | 92.7 |
| | Hep B | 19 | 11 | 57.9 | - |
| 5 years | DTaP/IPV/Hib (primary) | 5956 | 5478 | 92.0 | 95.6 |
| | DTaP/IPV booster | 5956 | 4497 | 75.5 | 88.8 |
| | MMR1 (1st dose) | 5956 | 5403 | 90.7 | 94.1 |
| | MMR2 (1st and 2nd dose) | 5956 | 4473 | 75.1 | 88.3 |
| | HibMenC booster | 5956 | 5122 | 86.0 | 91.9 |

DTaP = Diphtheria, Tetanus, and acellular Pertussis (whooping cough); IPV = Inactivated Polio Vaccine; HIb = Haemophilus influenzae type b; Men C = Meningitis C; MMR = Measles, Mumps, and Rubella; Hep B = Hepatitis B (given to children of positive mothers only; PCV = Pneumococcal vaccination; *2012-13

Source: HSCIC (2014) NHS Immunisation Statistics, England - 2013-14. Publication date: September 25, 2014

#### *5.12.1.2 Human Papillomavirus (HPV) Immunisation*

The total eligible population (girls aged 12-13 years) for HPV in Barnet was 1,926 of which 1,339 were immunised against HPV in 2013/14. Thus, the HPV vaccination coverage rate (% of girls aged 12-13 who received al three doses of the HPV vaccine) in Barnet was 69.5%, which is worse than the average coverage rate of HPV for London (80.0%) and England (86.7%) during 2013/14.

#### *5.12.1.3 Flu and Pneumococcal (PCV) Immunisation*

In Barnet, the rates of immunisation against influenza (seasonal flu) was 71.8% in the adult population aged 65 and over and 51.7% in those at risk (individuals aged 6 months to 65 years excluding pregnant women) during 2013/14. The Barnet rates were lower than the average rates for England (73.2% and 52.3% respectively).

[85] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/1/par/E12000007/are/E09000003

In Barnet, the total cohort for pneumococcal vaccination (PCV) against pneumococcal disease in children comprised 5,789 persons of whom 4,767 persons were immunised leading to the coverage rate of 82.4% in 2013/14. The PCV coverage rate in Barnet was worse than the average rates for London (89.7%) and England (94.1%).

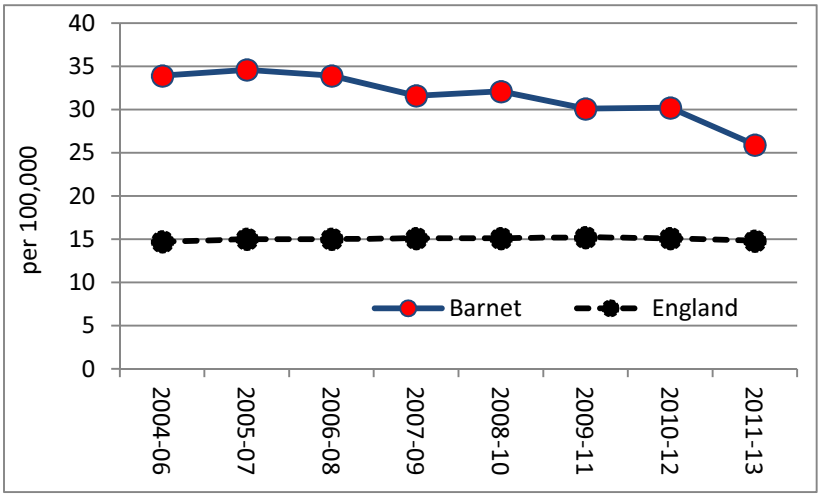
In 2013/14, the total eligible population for immunisation against pneumococcal disease in persons aged 65 years and above was 39,966 persons of whom 26,919 persons received PPV vaccination. The PPV vaccination rate in Barnet (67.5%) was better than the regional London rate (64.2%) but worse than the average rate for England (69.1%) during 2013/14.

### 5.12.2 Tuberculosis

Tuberculosis (TB) is a notifiable infectious disease that is caused by the bacterium Mycobacterium Tuberculosis, which can affect any part of the body such as bones, intestine, brain and skin but it mainly affects the lungs. TB can be either dormant (latent or hidden) or active and it is curable; however, if active TB especially of the lungs is left untreated or treatment is discontinued then it could be fatal and there is a chance of it spreading to other people. Thus, TB is a major cause of concern from the public health perspective.

TB rates in the UK have declined in the last two years; however the rates are still high in London and the Midlands[86]. The incidence of TB (three year average) in Barnet (25.9 per 100,000) is lower than the London regional rate (39.6 per 100,000) but higher than the rate in England (14.8 per 100,000) (Figure 5-14)[87]. The remaining TB indicators for Barnet are similar to England except the proportion of drug sensitive TB cases that completed a full course of treatment by 12 months (91.8%) and the proportion of TB cases offered an HIV test (98.6%), which are better than the average national rates (Figure 5-15)[86].

**Figure 5-14: TB incidence (3 years average) in Barnet compared to England**




Source: Public Health England. Barnet - TB Strategy Monitoring Indicators

TB in Barnet is more common in men in all age groups but it involves more females in the 20-29 years age group. The majority of TB patients were born abroad and about 28 % came to the UK within the previous 4 years. In Barnet, the most common ethnic group having TB is people of Indian origin (35%), which is followed by mixed / other ethnic background (26%) and black Africans (20%).

[86] Public Health England. (2014) Tuberculosis in the UK: 2014 report. London.
[87] Public Health England. TB Strategy Monitoring Indicators.

In addition, Barnet has a higher number of drug resistant TB cases than the average number of these cases in London[88].

**Figure 5-15: Barnet - TB Strategy Monitoring Indicators**

Comparison to England value: Better | Similar | Worse

| | Period | England | Bark & Dag | Barnet | Bexley | Brent |
|---|---|---|---|---|---|---|
| TB incidence (three year average) | 2011 - 13 | 14.8 | 35.1 | **25.9** | 13.2 | 94.9 |
| Proportion of pulmonary TB cases starting treatment within two months of symptom onset | 2013 | 41.3 | 46.4 | **47.6** | 35.7 | 68.3 |
| Proportion of pulmonary TB cases starting treatment within four months of symptom onset | 2013 | 71.6 | 75.0 | **73.8** | 57.1 | 86.6 |
| Proportion of pulmonary TB cases that were culture confirmed | 2013 | 71.3 | 75.0 | **70.5** | 93.8 | 79.8 |
| Proportion of culture confirmed TB cases with drug susceptibility testing reported for the four first line agents | 2013 | 97.5 | 100 | **95.8** | 100 | 100 |
| Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months | 2012 | 83.3 | 91.9 | **91.8** | 90.9 | 87.5 |
| Proportion of drug sensitive TB cases who were lost to follow up at last reported outcome | 2012 | 4.3 | 3.0 | **1.9** | 0.0 | 6.0 |
| Proportion of drug sensitive TB cases who had died at last reported outcome | 2012 | 4.8 | 3.0 | **0.9** | 8.0 | 1.3 |
| Proportion of TB cases offered an HIV test | 2013 | 81.1 | 97.1 | **98.6** | 97.0 | 99.6 |

#### *5.12.2.1 TB and Involvement of Local Communities*

Evidence shows that involvement of local communities helps in creating awareness and successful completion of treatment of latent TB[89]. To raise TB awareness in local communities identified as being most likely to be affected by TB, Barnet and Harrow public health commissioned a number of TB awareness training sessions during January – March 2015. The training sessions were attended by more than 60 local community groups, service managers and interested individuals. In addition, TB workshops and a seminar on the world TB day (24th March) were organised that brought together local advocacy and community groups, national TB and local clinical and public health expertise to discuss TB related issues and local needs. A local TB grant scheme has been developed and opportunities for local community groups and organisations to bid for small sums to support local TB advocacy awareness are now being rolled out.

### 5.12.3 Notifiable Infectious Diseases

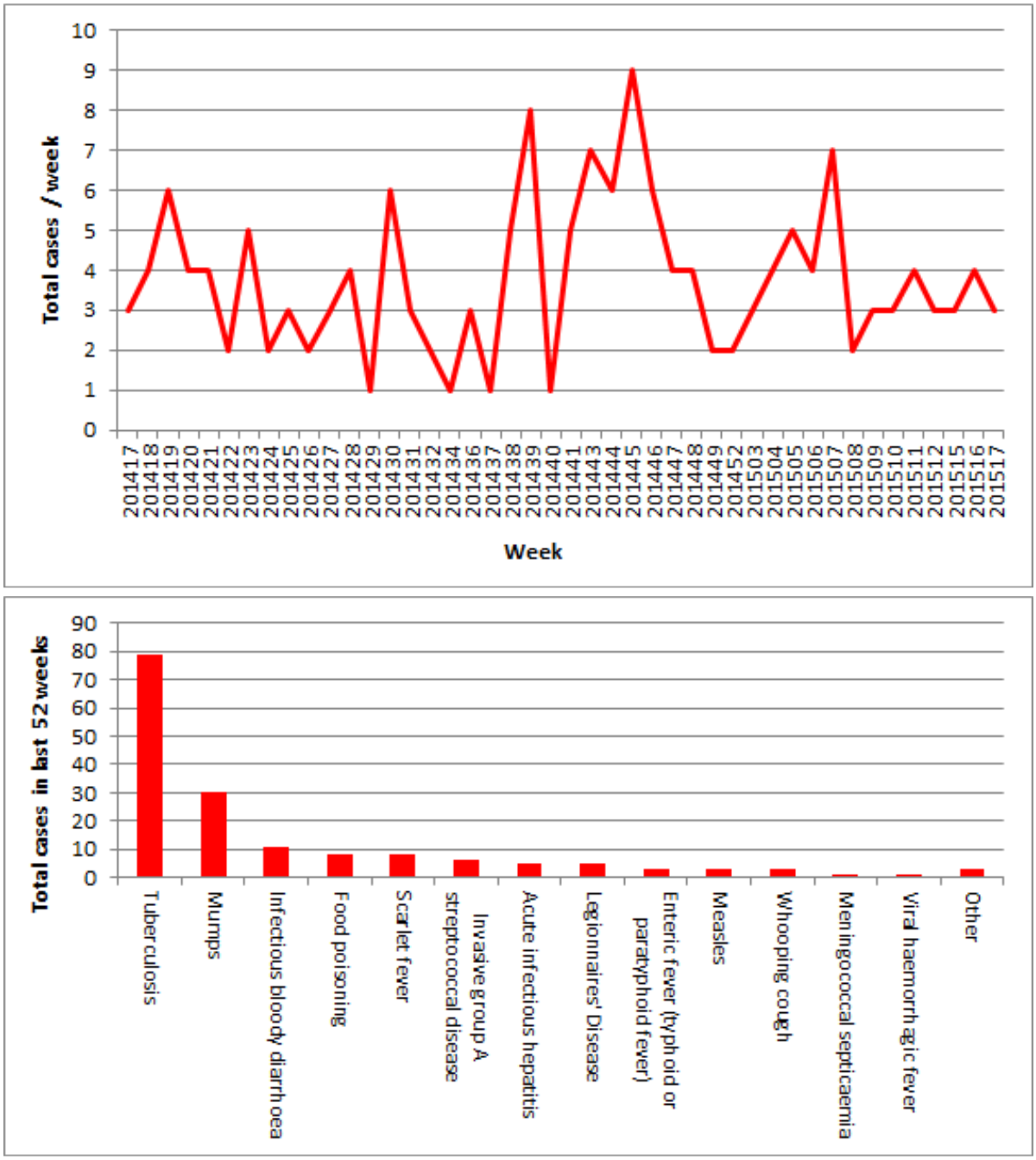
The latest data on notifications of infectious diseases (NOIDs) for the last 52 weeks released by Public Health England on 28th April 2015 show a total of 166 notifications of infectious diseases in Barnet over the last 52 weeks (Figure 16a&b). The weekly trend of NOIDs in Barnet (Figure 5-16a)

[88] Public Health England. (2013) Local authority TB profiles (2012 data).
[89] Gupta et al. (2015) Tuberculosis among the Homeless — Preventing another Outbreak through Community Action. *N. Engl. J. Med.* 372 (16):1483-1485.

shows that the largest number of notifications was reported in the 43rd week (28th October) and the 46th week (18th November) in 2014, which might suggest a seasonal trend.

The highest number of notifications were for TB (n=79) followed by mumps (n=30), infectious bloody diarrhoea (n=11), food poisoning (n=8) and scarlet fever (n=8) during the previous 52 weeks (Figure 5-16b). There is a need to tackle TB in Barnet, which could involve raising awareness about TB through active involvement of local communities such as South Asians in which TB is more prevalent.

**Figure 5-16a&b: Notifications of infectious diseases (NOIDs) in Barnet (in last 52 weeks on 28/04/2015)**




Data Source: Public Health England. Statutory notifiable diseases: cases reported in last 52 weeks (Date: 28 April 2015)

# 6 Lifestyle

## 6.1 Key Facts

- In Barnet, there were 117 cases (31 male and 86 female) of hospital admissions with a primary diagnosis of obesity in 2013/14. This equated to a rate of 32 / 100,000 persons (rate: males = 17, females = 46), which was higher than the average rates for the London region and England.
- Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%). Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates.
- The percentage of residents who abstain from drinking alcohol in Barnet (22.05%) is similar to the average in the London region (22.37%) but higher than the national rate (16.53%). In terms of the number of alcohol abstainers, Barnet ranks 22nd highest among 326 local authorities in England.
- According to the most recent estimates (2011/2012), Barnet has 1,492 opiate and/or crack users (OCU), 1156 opiate users, 857 crack cocaine users and 215 injecting drug users aged 15-64 years.

## 6.2 Strategic Needs

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **Smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England**, and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.

- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy** and **good parenting classes**.

## 6.3 Tobacco and Smoking

Tobacco and smoking are risk factors for a number of chronic health conditions such as cardiovascular disease (CVD), cancer, asthma and chronic obstructive pulmonary disease (COPD). Tobacco use kills over 80,000 people per year in England making it the single greatest cause of preventable death in the country.[90] The tobacco and smoking picture in Barnet is given below.

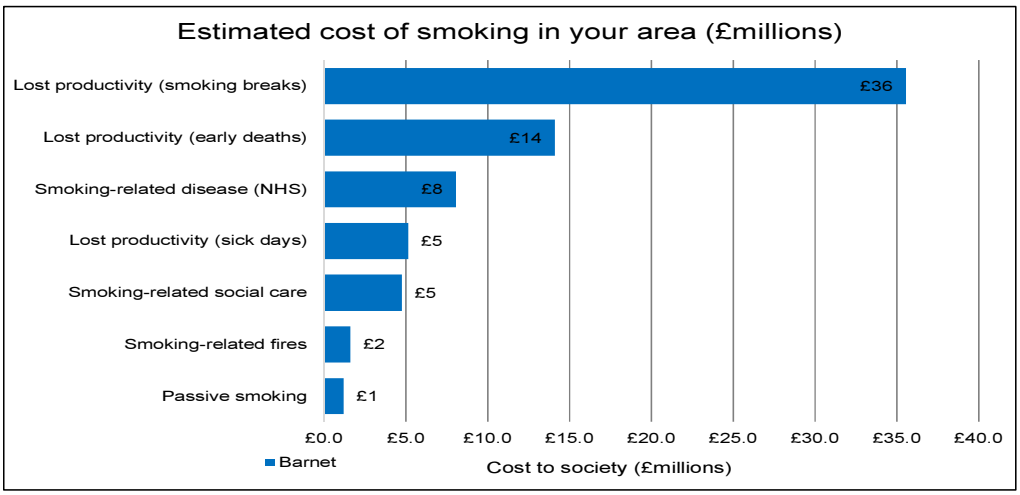
### 6.3.1 Smoking in Adults

Smoking indicators for Barnet are shown in Figure 6-2. Smoking prevalence in adults over 18 years in Barnet is 15% and is lower than the national average (18.4%). Modelled estimates of smoking prevalence in pregnant women and young people aged 15 years are 4.4% and 5.5% respectively.[91] Barnet has lower death rate due to smoking (205 per 100,000) than the average rate for England (289 per 100,000).

Estimated prevalence of synthetic smoking in adults (18 years and above) in Barnet is the highest in Burnt Oak (16.9%), Colindale (16.5%) and West Hendon (16%) wards while the lowest in Garden Suburb (13.5%), Totteridge (14.1%) and Finchley Church End (14.2%) wards.

Smoking is a leading risk factor for COPD while passive smoking triggers asthma[92, 93.] According to an estimate smoking related illnesses in Barnet costs about £8m annually to the local NHS (Figure 6-1).[94] Smoking cessation interventions could help in reducing the burden of COPD and other medical conditions associated with smoking.[95]

**Figure 6-1: Estimated cost of smoking in Barnet Local Authority**




Source: Action on Smoking and Health (ASH). Local cost of smoking (May 2015)

[90] National Institute for Health and Care Excellence (NICE) (2015) Tobacco. NICE advice [LGB24]. Published date: January 2015.
[91] http://www.tobaccoprofiles.info/profile/tobacco-control/data
[92] Deborah et al. (2004) Genetics of Asthma and COPD. Similar results for different phenotypes. *Chest,* 126 (2): 105S-110S.
[93] Hardin et al. (2011) The clinical features of the overlap between COPD and asthma. *Respiratory Research*, 12(1): 127.
[94] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/
[95] Hillas, et al. (2015) Managing comorbidities in COPD. *Int. J. Chron. Obstruct. Pulmon. Dis.* 10: 95–109.

The Barnet public health team commissions smoking cessation programmes in the Borough through NHS GPs. The smoking cessation support and treatment offered rate in Barnet is 96% and this is higher than the average national rate (93.1%).[96]However, Barnet smoking cessation statistics (2013/14) regarding successful quitters at 4 weeks (total count = 916; rate = 2,269 / 100,000 smokers), successful quitters (CO validated) at 4 weeks (total count = 633, rate = 1,568 / 100,000 smokers), and completeness of NS-SEC recording by Stop Smoking Services (total count = 1,430; rate = i.e. 65.1%) are worse compared to the average rates for England (Figure 6-2). However, other smoking related indicators for Barnet are better than in England (Figure 6-2).

**Figure 6-2: Barnet smoking indicators**

| | | Period | Local value | Eng. value | Eng. worst | England Range | Eng. best |
|---|---|---|---|---|---|---|---|
| 1 | Smoking Prevalence (IHS) | 2013 | 15.0 | 18.4 | 29.4 | | 10.5 |
| 2 | Smoking prevalence - routine & manual | 2013 | 28.1 | 28.6 | 47.5 | | 16.5 |
| 3 | Successful quitters at 4 weeks | 2013/14 | 2269 | 3524 | 1251 | | 8946 |
| 4 | Successful quitters (CO validated) at 4 weeks | 2013/14 | 1568 | 2472 | 525 | | 6950 |
| 5 | Completeness of NS-SEC recording by Stop Smoking Services | 2013/14 | 65.1 | 86.2 | 25.2 | | 100 |
| 6 | Smoking status at time of delivery | 2013/14 | 4.4 | 12.0 | 27.5 | | 1.9 |
| 7 | Low birth weight of term babies | 2012 | 2.9 | 2.8 | 5.0 | | 1.5 |
| 10 | Lung cancer registrations | 2009 - 11 | 59.0 | 75.5 | 144.2 | | 42.1 |
| 11 | Oral cancer registrations | 2009 - 11 | 13.2 | 12.8 | 21.1 | | 6.7 |
| 12 | Deaths from lung cancer | 2011 - 13 | 45.6 | 60.2 | 111.6 | | 32.3 |
| 13 | Deaths from chronic obstructive pulmonary disease | 2011 - 13 | 33.7 | 51.5 | 101.0 | | 26.8 |
| 14 | Smoking attributable mortality | 2011 - 13 | 204.9 | 288.7 | 471.6 | | 186.6 |
| 15 | Smoking attributable deaths from heart disease | 2011 - 13 | 22.2 | 32.7 | 65.5 | | 20.6 |
| 16 | Smoking attributable deaths from stroke | 2011 - 13 | 8.0 | 11.0 | 21.5 | | 7.2 |
| 17 | Smoking attributable hospital admissions | 2012/13 | 1280 | 1688 | 2884 | | 906 |
| 18 | Cost per capita of smoking attributable hospital admissions | 2010/11 | 32.4 | 36.9 | 61.7 | | 15.6 |

*Compared with benchmark:* Better Similar Worse

Source: HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14.

### 6.3.2 Smoking in Children

An estimated prevalence of smoking (regular and occasional) in children aged up to 17 years in Barnet is similar to England (Figure 6-3).

[96] HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14. Dated: 28 October 2014.

**Figure 6-3: Barnet smoking prevalence estimates in children (aged 17 years or less)**

| | | Period | Local value | Eng. value | Eng. worst | England Range | Eng. best |
|---|---|---|---|---|---|---|---|
| 22 | Smoking prevalence estimates – regular smokers aged 11-15 years | 2009 - 12 | 2.0 | 3.1 | 4.7 | | 1.1 |
| 23 | Smoking prevalence estimates – regular smokers aged 15 years | 2009 - 12 | 5.5 | 8.7 | 12.7 | | 3.2 |
| 24 | Smoking prevalence estimates – regular smokers aged 16-17 years | 2009 - 12 | 9.7 | 14.7 | 20.7 | | 5.7 |
| 25 | Smoking prevalence estimates – occasional smokers aged 11-15 years | 2009 - 12 | 1.1 | 1.4 | 2.0 | | 0.5 |
| 26 | Smoking prevalence estimates – occasional smokers aged 15 years | 2009 - 12 | 3.1 | 3.9 | 5.3 | | 1.4 |
| 27 | Smoking prevalence estimates – occasional smokers aged 16-17 years | 2009 - 12 | 4.6 | 5.8 | 7.8 | | 2.2 |

*Compared with benchmark:* Better Similar Worse

Source: HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14.

Modelled estimates of smokers under 18 years of age by wards in Barnet (2009-12) are shown in Table 6-1. The percentage of smokers' increases in each ward as the age of smoker increases. Hendon, Under Hill and Mill Hill are the top three wards having the highest percentage of smokers in all three age categories included in Table 6-1 while the Colindale ward has the lowest percentage of smokers in all categories of smokers aged 11 years to 17 years. Therefore protecting Barnet children and young people from tobacco smoke, especially in Hendon, Under Hill and Mill Hill wards, is imperative.[90]

**Table 6-1: Modelled prevalence of regular smoking in children and young people (less than 18 years)**

| | Top three Barnet Wards | |
|---|---|---|
| Smoker's age | Wards with the highest % of smokers | Wards with the Lowest % of smokers |
| 11-15 years | Underhill (5.6%), Hendon (5.5%) and Mill Hill (5.4%) | Colindale (1.1%), Childs Hill (1.2%) and Finchley Church End (1.4%) |
| 15 years | Hendon (14.2%), Underhill (12.4%), and Mill Hill (11.3%) | Colindale (4.2%), West Hendon (4.3%) and Brunswick Park (4.4%) |
| 16-17 years | Hendon (22.6%), Underhill (20.1%), and Mill Hill (18.7%) | Colindale (7.8%), West Hendon (7.9%) and Brunswick Park (8.1%) |

Source: Public Health England. Local Health

### 6.3.3 Local Tobacco and Smoking Needs

Local needs for tackling tobacco use and smoking include protecting children from tobacco use and smoking and stop smoking services targeting of poorer smokers and women smokers, especially those who use smokeless tobacco and chew *paan*.

## 6.4 Obesity

Obesity is a nationwide issue in the UK and the rates of obesity are rising in the country. The prevalence of obesity in some London Boroughs is already high and the rates are rising in the London region.

### 6.4.1 Obesity in Adults

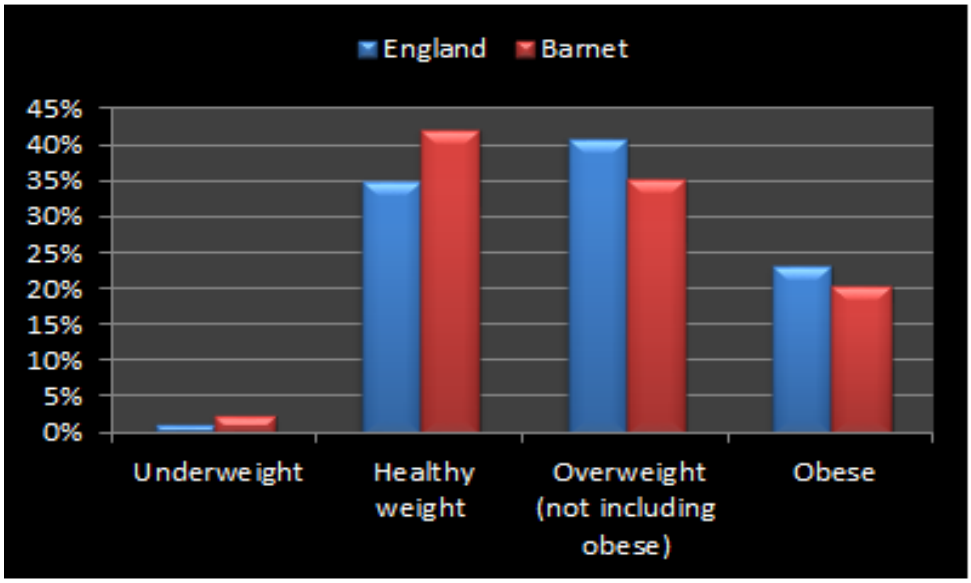
Barnet has a high percentage of the adult population with a healthy weight (42.1%) and a low percentage with excess weight (55.7%) (combined overweight (35.2%) plus obese (20.5%))

compared to the average adult weights nationally (Figure 6-4); however, Barnet has a high percentage of underweight adults (2.3%) compared to the national level (1.2%).

Public Health England's modelled estimate of adult obesity in Barnet shows that the three wards with the highest percentage of adult obesity include Burnt Oak (23.7%), Colindale (22.1%) and Underhill (21.6%) wards while the three wards having the lowest percentage of adult obesity include Garden Suburb (12.8%), Finchley Church End (14.7%) and West Finchley (14.8%) wards in Barnet.

In Barnet, there were 117 cases (31 male and 86 female) of hospital admissions with a primary diagnosis of obesity in 2013/14. This equated to the rate of hospital admissions with primary obesity in Barnet at 32 / 100,000 persons (rate: males = 17, females = 46), which was higher than the average rates for the London region (rates: all persons =25, males = 13, females = 37) and England (rates: all persons = 17, males = 10 and females = 25).[97] In addition, the rates (per 100,000 population) of finished consultant episodes in an inpatient setting with a primary diagnosis of obesity and a main or secondary procedure of 'Bariatric surgery' in Barnet (all persons =25, males = 12 and females =37) were higher than the average rates for the London region (rates: all persons =19, males = 9 and females =28) and nationally (rates: all persons =12, males = 6 and females =18).[97]

**Figure 6-4: Prevalence of underweight, healthy weight, overweight, obesity, and excess weight among adults in Barnet (2012)**




Source: Public Health England Adults: identifying and accessing local area obesity data

### *6.4.1.1 Adult Obesity Needs*

Although overall obesity in the adult population in Barnet is lower than the national level, the high rates of hospital admissions due to obesity in Barnet suggest a need for reducing adult obesity through targeted interventions. These include promotion of healthy lifestyles, physical activity and eating healthy diets as well as meeting the health and care needs of obese adults to avoid hospital emergency admissions.

[97] HSCIC (2015) Statistics on Obesity, Physical Activity and Diet - England 2015 [Publication date: March 03, 2015)

### 6.4.2 Obesity in Children

In Barnet, obesity in children is low compared to the average rates in the London region and nationally. Barnet children's weight profiles based on the latest NCMP data are given below.

#### *6.4.2.1 Reception-Year Children (aged 4-5 years)*

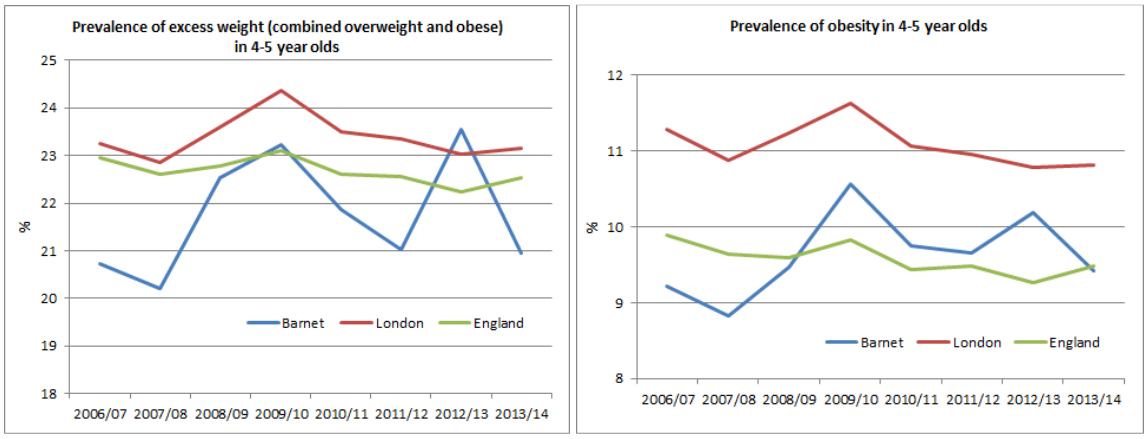
In reception year children (aged 4-5 years) the percentage of excess weight (overweight and obese) was 21% in 2013/14 in Barnet, which was lower than the average rates for the London region (23.1%) and England (22.5%) (Figure 6-5a). In Barnet, the proportion of excess weight children in this age group declined in 2013/14 compared to the previous five years. In addition, the proportion of obese children in 4-5 year olds in Barnet also declined below the average rates in the London region and nationally (Figure 6-5b). However, the proportion of underweight reception children (aged 4-5 years) in Barnet (1.37%) is higher than the average national rate (0.95%).

The prevalence of obesity in reception year children was the highest in Colindale (13.1%), Edgware (13.1%) and Burnt Oak (12.1%) wards while the lowest in Garden Suburb (5.6%), High Barnet (5.8%) and Finchley Church End (6.2%) wards in Barnet.

#### *6.4.2.2 Reception Year Children's Needs*

The data suggests improving diet intake in underweight reception year pupils in Barnet.

**Figure 6-5a&b: Excess weight and obesity in 4-5 year old children**




Source: Health and Social Care Information Centre, National Child Measurement Programme (NCMP)

#### *6.4.2.3 Year 6 Children (aged 10-11 years)*

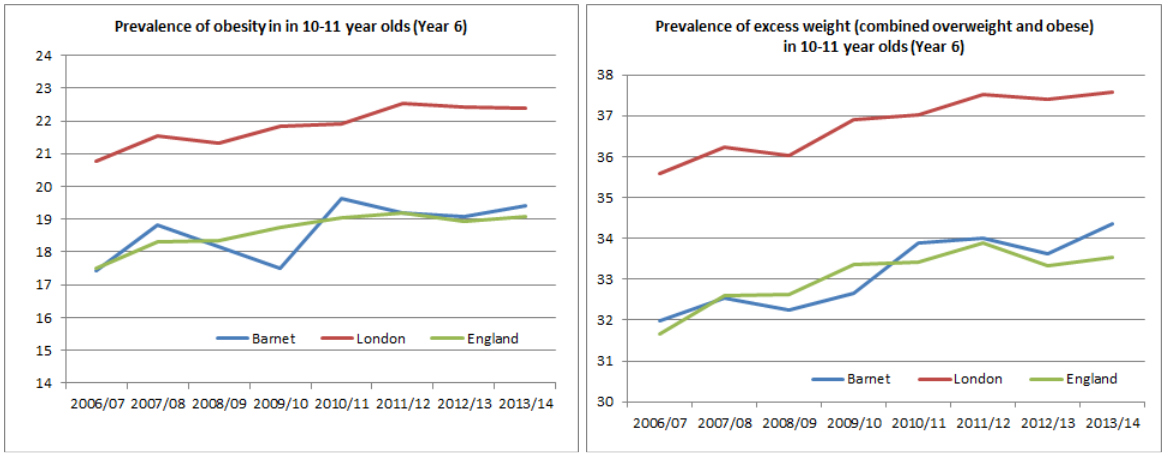
In Barnet, the obesity rate for Year 6 children (10-11 year olds) slightly increased to 19.41% in 2013/14 compared to 19.07% in 2012/13, which was similar to the national rate (19.09%) but lower than the London regional rate (22.39%) for 2013/14 (Figure 6-6a).

The proportion of excess weight in 10-11 years old children in Barnet has also increased to 34.4% in 2013/14 compared to 33.6% in 2012/13. The rate of excess weight in 10-11 year olds in Barnet is similar to the national rate but lower than the rate in the London region (37.59) for 2013/14 (Figure 6-6b).

The prevalence of obesity in Year 6 children was the highest in Colindale (25.1%), Burnt Oak (24.4%) and Hale (22.1%) wards while the lowest in Finchley Church End (13.2%), Garden Suburb (13.4%) and High Barnet (14.5%) wards in Barnet.

Overall, Colindale ward has the highest percentage of obese children in both the reception year and Year 6.

**Figure 6-6 a&b: Prevalence of obesity and excess weight in children aged 10-11 years**




Source: Health and Social Care Information Centre. National Child Measurement Programme

## 6.5 Physical Activity

The UK Chief Medical Officer has recommended physical activity at all ages and for adults has recommended at least 150 minutes of physical activity per week.[98] Based on this criterion, Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%)[99]. Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates.[99]

Barnet residents' participation in sports once a week (Table 6-2) shows that about four in every ten persons aged 14 and above are involved once a week in sports. Participation in sports by males is greater than for females; however, both male and female participation in sports has increased in 2013/14 compared to the previous year. Young persons aged 14-25 years have increased participation in sports as shown in the latest annual physical survey (APA8) compared to the previous survey (APS7). However, children's participation in sports has slightly declined in the 2013/14 survey (APS8) in contrast to the APS7 conducted in 2012/13. Overall, the involvement in sports by people in social grades 1-4 is similar in both surveys. Overall, participation in sports is higher in white British residents than those of black and minority ethnic (BME) origin residents in Barnet. However, the percentage of participation in sports has recently decreased in white British residents but increased in the BME residents of Barnet (Table 6-2).

[98] Chief Medical Officer (2004). At least five a week: Evidence on the impact of physical activity and its relationship to health. London: Department of Health.
[99] Public Health England. Health Improvement in Public Health Outcome Framework

**Table 6-2: Sports participation - At least once a week in Barnet population (aged 14+)**

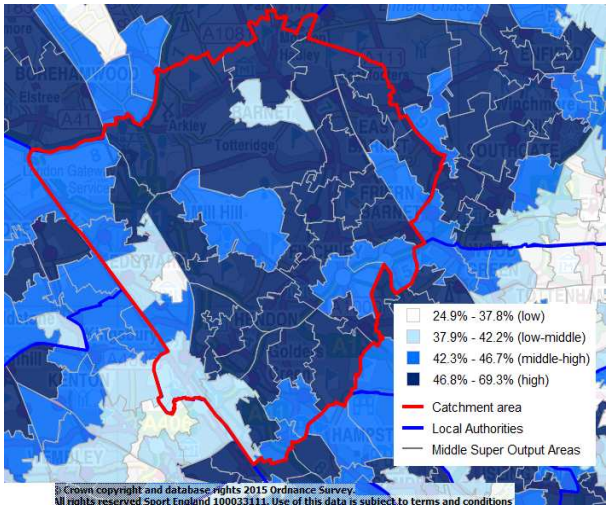
| | | 2012/13 (APS7) | 2013/14 (APS8) |
|---|---|---|---|
| Adult Population | Whole population (14+) | 40.2% | 41.5% |
| Gender | Male | 44.9% | 48.3% |
| | Female | 35.9% | 35.1% |
| Age Range | 14 - 25 | 52.2% | 61.1% |
| | 26 - 34 | * | * |
| | 35 - 44 | 41.9% | * |
| | 45 - 54 | 38.1% | 39.2% |
| | 55 - 64 | * | * |
| | 65 and over | * | * |
| Children | | 47.8% | 44.4% |
| Social grade | NS SEC 1-4 | 42.5% | 42.6% |
| | NS SEC 5-8 | * | * |
| Ethnicity | White British | 47.8% | 45.0% |
| | Black and Minority Ethnic Groups | 42.2% | 44.4% |

* Data unavailable, question not asked or insufficient sample size

Source: Sport England. Active People Interactive (Active People Survey analysis tool)

In addition, the latest physical activity survey (APS8) has revealed that 68% of Barnet 16+ population would like to do more sports (also known as overall latent sport demand), which includes 42.3% of those currently active and 25.7% of currently inactive. Moreover, the same level of sport activity has declined in females compared to males during 2013/14 in comparison to the previous year. This might suggest a need for increasing participation of females in sports in Barnet. In addition, there are inequalities in participation in sports between different localities in the London Borough of Barnet. Data from Sport England's Active People Survey 6 (October 2011 - October 2012) shows that once a week sports participation at the MOSA level in Barnet was the highest in MOSA E02000043 (53.8%), MOSA E02000039 (54.3%) and MOSA E02000046 (54.4%) while the lowest in MSOA E02000049 (36.5%), MSOA E02000047 (38.7%) - both in Burnt Oak ward, and MSOA E02000027 (40.9%) in Under Hill ward (Figure 6-7)[100].

**Figure 6-7: Modelled once a week sports participation estimates for Barnet - MSOA level (Data from APS6 – 2011/2012)[100]**




The CMO recommendation for physical activity in children stresses upon promotion of physical activity at an early age and creation of more opportunities for children and young people to be physically active. The local children centres offer a range of services for babies, children and young people. The London Borough of Barnet supports several interventions and programmes aimed at promotion of physical activity not only for young children and adolescents but also for adults and older people as reported in the Harrow & Barnet on the Move annual report by

[100] Sport England. Small Area Estimates web tool

the Joint Director of Public Health (DPH) at Barnet and Harrow Borough Councils.[101]

In addition, 'Keeping Well, Keeping Independent' – the Barnet Health and Wellbeing Strategy 2012-2015 recognises the need for creating a supportive environment to increase physical activity aimed at the prevention agenda; partnership working is key to identifying and addressing the factors underpinning health inequalities across Barnet communities.

### 6.5.1 Physical Activity Needs

The DPH's annual report Harrow & Barnet on the Move suggests a range of interventions for fulfilling the physical activity needs of local residents. For example the following activities are suggested by the council and healthcare providers:

- Creating safe, age-friendly neighbourhoods and communities
- Ensuring there are convenient and attractive walking and cycling opportunities and access to the natural environment
- Identifying physically inactive older people and encouraging them to take exercise – offering referrals to free programmes if appropriate
- Focusing on ability rather than limitations

## 6.6 Alcohol

The percentage of residents who abstain from drinking alcohol in Barnet (22.05%) is similar to the average in the London region (22.37%) but higher than the national rate (16.53%). In terms of the number of alcohol abstainers, Barnet ranks 22nd highest among 326 local authorities in England.

Among drinking Barnet residents, 6.8% are classified as 'higher risk' drinkers (over 50 units of alcohol per week for men and over 35 units per week for women), which is similar to the averages for the London region (6.9%) and England (6.75%). Thus, for the higher risk drinker population, Barnet ranks 20th lowest among all English local authorities (n=326). Estimates show that 18.87% of Barnet adult residents are 'increasing risk' drinkers (22-50 units per week for men, and 15-35 units per week for women). These are lower than the average estimates for the London region (19.7%) and England (20%).

### 6.6.1 Binge Drinking

In terms of binge drinking, Barnet ranks 9th lowest among 326 total English local authorities. Estimated percentage of 'binge drinkers' (eight or more units of alcohol for men or six or more units of alcohol for women, on at least one day in the previous week) in Barnet (12%) is less than both the London region (14.3%) and national (20.1%) averages.

Public Health England's modelled estimates of binge drinking adults show that the percentage of binge drinkers by wards in Barnet is the highest in Garden Suburb (14.7%), High Barnet (14.4%) and East Barnet (14%) wards while the lowest in Colindale (8.4%), Burnt Oak (9.7%) and West Hendon (10.1%) wards.

[101] London Borough of Barnet (2014) Harrow & Barnet On The Move. The Annual Report of the Director of Public Health of the London Boroughs of Barnet and Harrow 2013-14

### 6.6.2 Alcohol Related PHOF Indicators

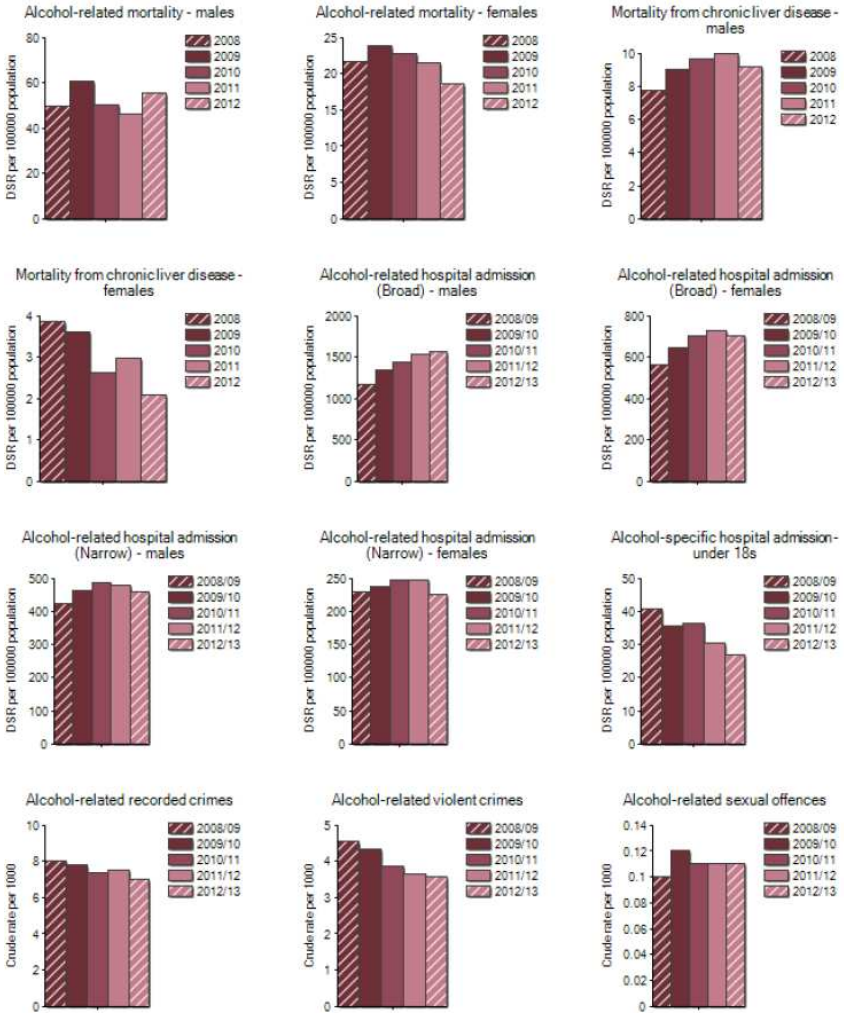
Barnet rates of alcohol related mortality, hospital admissions, crimes, and sexual offences as well as mortality from chronic liver disease are shown in Figure 6-8 below. Most of these rates in Barnet are coming down except the alcohol related mortality and hospital admissions in males, which are increasing and the rate of alcohol related sexual offences has not changed in the last three years.

The ward level standardised admission ratios (SAR) of hospital admissions for alcohol attributable conditions are the highest in Burnt Oak (122.9), Colindale (105.9) and Underhill (102.8) wards while the lowest in Garden Suburb (50.9), Finchley Church End (66.1) and Childs Hill (74.7) wards in Barnet.

### 6.6.3 Alcohol Dependence

The Adult Psychiatric Morbidity Survey (APMS) 2007[102] revealed that 5.9% of Barnet adults may have some form of alcohol dependence, which is higher in men (8.7%) compared to women (3.3%) and white men and women (9.6% and 3.7% respectively) are more likely to be dependent. The number of people in treatment for alcohol dependence has risen by 53% in the last five years. The level of successful completions for alcohol treatment (28.1%) is below the national average (37.5%) for 2013/14. The level of re-presentations for treatment within 6 months is higher.

**Figure 6-8: Barnet alcohol related rates by gender (2008-2012)**




Source: Public Health England. Barnet local alcohol profile. LAPE - Local Alcohol Profiles for England

[102] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

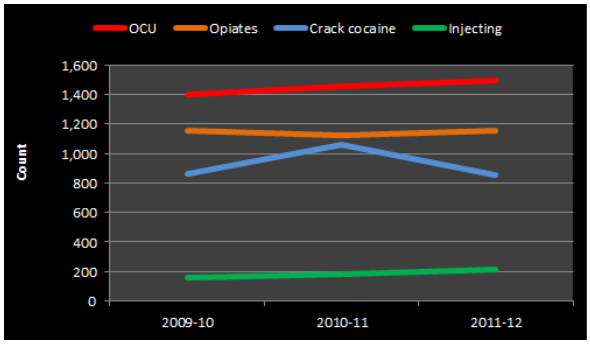
## 6.7 Drugs and Substance Misuse

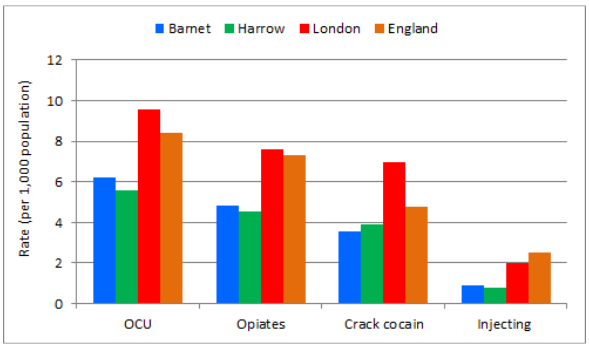
### 6.7.1 Prevalence of Drug Misuse

According to the most recent estimates (2011/2012), Barnet has 1,492 opiate and/or crack users (OCU), 1156 opiate users, 857 crack cocaine users and 215 injecting drug users aged 15-64 years. Barnet rates of OCU and opiates prevalence by age (per 1,000 population) are highest in persons aged 35-64 years (OCU = 6.88, opiates = 5.47) followed by those aged 15-24 years (OCU = 5.73, opiates = 4.04) and persons aged 24-34 years (OCU = 5.16, opiates = 3.99).

In Barnet, total number of users of OCU, opiates, and drug injecting has increased but crack cocaine users number has decreased recently (Figure 6-9a). However, the estimated rates (per 1,000 population) of OCU, opiates, crack cocaine and injecting drug users in Barnet are lower than London regional and national rates (Figure 6-9a). Nevertheless, the total number of OCU, opiates, crack cocaine and injecting drug users are higher in Barnet compared to Harrow, which is a similar and neighbouring local authority (Figure 6-9b). The rates of substance misusers in the two Boroughs are however not very different.

**Figure 6-9a&b: Estimated rates of OCU, opiates, crack cocaine and injecting drug users**




Source: Public Health England. Drugs and Alcohol. Prevalence estimates by Local authority

### 6.7.2 Drug Related Deaths in Barnet

The number of drug-related deaths per year in those aged 16 and over whose usual residence was Barnet is very low i.e. one case in 2012 and two cases in 2011. Deaths in treatment National Drug Treatment Monitoring System (NDTMS), whilst not necessarily drug-related, are reported as an unsuccessful treatment exit reason. The numbers for each year in Barnet treatment providers are shown in Table 6-3 below.

In 2013 details of five deaths in treatment were received by commissioners from treatment providers; however, three of these were alcohol related. There is a disparity between NDTMS and local reporting that needs further investigation and explanation. There is therefore a need for improving the local serious incident and drug/alcohol-related death reporting processes.

**Table 6-3: Deaths in drug treatment – Barnet 2011/12-2013/14 (NDTMS)**

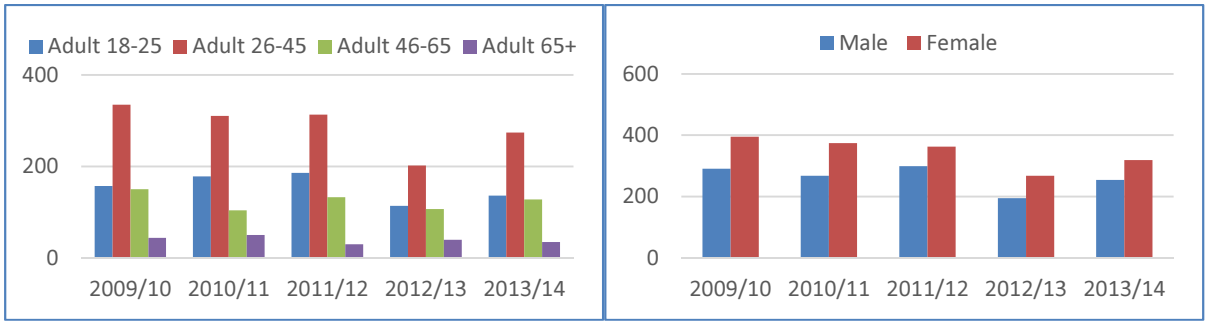
| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Number | 2 | 8 | 7 |
| Treatment provider | (2 BDAS) | (6 BDAS, 2 WDP) | (6 BDAS, 1 WDP) |

BDAS= Barnet Drug and Alcohol Service; WDP = Westminster Drug Project

### 6.7.3 Drug Related Ambulance Data

Drug-related callouts for Barnet adults undertaken in 2013/14 were 573 compared to 463 callouts in the previous year. The number of callouts was highest in 26-45 year olds, followed by 18-25 year olds most years (Figure 6-10a). In adults, drug-related callouts by females was higher than males (Figure 6-10b). Drug-related ambulance callouts were the highest in Colindale ward followed by Burnt Oak ward while the lowest was in Brunswick Park ward.

**Figure 6-10a&b: London Ambulance Service drug-related callouts by Barnet adults by age and gender**




### 6.7.4 Drug Related Crime Data

Drug related crime in the Borough is shown in the panel below that provides a snapshot of drug related crime initially for possession and supply offences for a six month period in 2013 (Figure 6-11).

**Figure 6-11: Drug related crime in Barnet**

**Drug supply and drug possession crimes**

**Data set:**

- Jan – June 2013. (6 months data)
- All Barnet Crime allegations (including those no crimed or resulting in crime related incidents), that are classed as 'Drug Trafficking' or 'Drug Possession' .
- 'Drug Trafficking' refers to drug supply related allegations

**Headline figures:**

Volume in 6 month period between Jan – June 2013

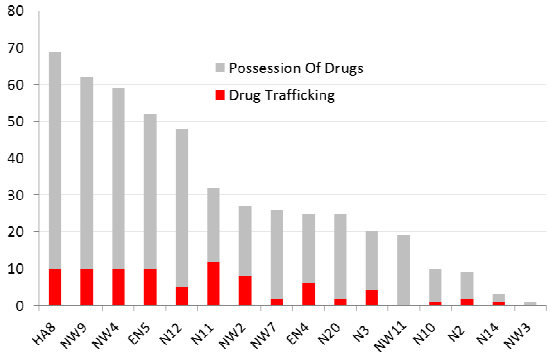
Drug Trafficking (i.e. supply related crime allegations:

**83**

Drug possession allegations:

**72**

**Breakdown by location:**




**Drug related crime allegations**

**Data set:**

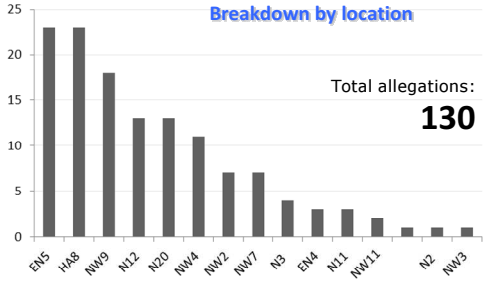
Jan – Dec 2013 (12 months data) All Barnet Crime allegations , that are flagged as drug related (victim/suspect taking prior to or at the incident)

**Drug related crimes**

Break down of crimes in Barnet during 2013, with drug related flag present (victim or suspect taking drugs at or prior to the crime)

| *Crime type* | *Volume* |
|---|---|
| Drugs Possession Of Drugs | 64 |
| Drugs Drug Trafficking | 10 |
| Violence Against the Person Assault with Injury | 10 |
| Other Accepted Crime Others - Other Accepted Crime | 9 |
| Other Notifiable Offences Other Notifiable | 7 |
| Violence Against the Person Common Assault | 5 |
| Sexual Offences Rape | 4 |
| Violence Against the Person Harassment | 4 |
| Violence Against the Person Serious Wounding | 4 |
| Theft and Handling Theft/Taking of M/V | 3 |
| Burglary Burglary in a Dwelling | 2 |
| Violence Against the Person Offensive Weapon | 2 |
| Other | 6 |

**Breakdown by location**




Total allegations:

**130**

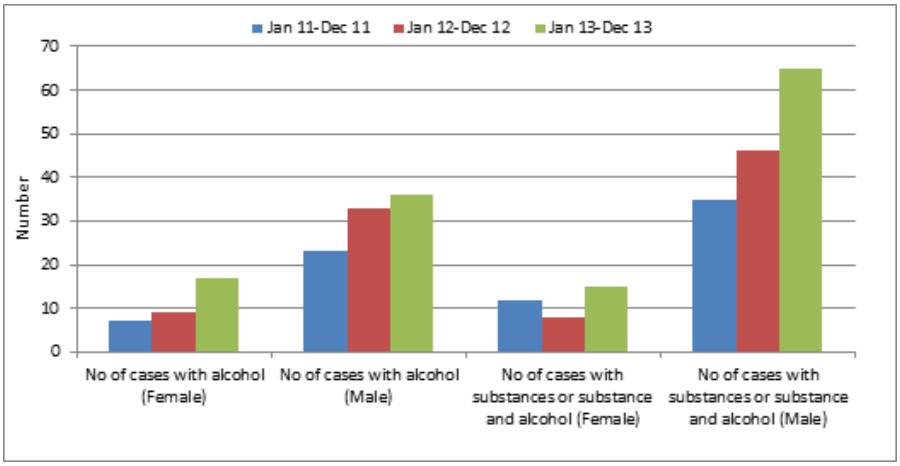
Also shown for all crime flagged as drug related during the whole year 2013. The postcodes HA8 (Edgware), NW9 (Colindale/West Hendon) and NW4 (Hendon) have the highest drug possession offences and N11 (New Southgate/Bounds Green) has the highest level of drug supply offences for the year.

Saturday is the peak day for crimes flagged where perpetrator or victim is thought to have taken drugs prior to the incident. The level of drug related crime increases from midday to a peak at midnight then drops again.

### 6.7.5 Drug or Alcohol Related Domestic Violence

The Multi-Agency Risk Assessment Conference (MARAC) data for Barnet shows that the total number of MARAC high risk domestic violence cases where drug or alcohol issues are present is also increasing year on year (Figure 6-12). The number of referrals to the MARAC from drug and alcohol treatment services remains very low (two referrals in 2011, three referrals in 2012 and one referral in 2013). This may indicate a need to ensure the treatment workforce is aware, trained and confident in identifying and responding to drug related domestic violence.

**Figure 6-12: Barnet MARAC cases involving drugs or alcohol**




### 6.7.6 Housing Support

A Floating Support Service (FSS) is provided to drug/alcohol using tenancy holders. The FSS provides help with budgeting, income maximisation and tenancy maintenance (Outreach Barnet). Data from Supporting People commissioners shows the number of drug and alcohol users supported by the floating support (Table 6-4).

**Table 6-4: Floating support service – substance misuse needs and outcomes**

| | Substance misuse need identified | % of caseload with substance misuse need | positive outcome achieved | % of those with a substance misuse need who had a positive outcome |
|---|---|---|---|---|
| 2011-12 | 92 | 7.76 | 51 | 55.44 |
| 2012-13 | 94 | 8.55 | 60 | 63.83 |
| 2013-14 | 96 | 7.26 | 61 | 63.54 |

Whilst substance misuse represents less than 2% of primary needs identified by Supporting People data at initial referral stage, subsequent assessment shows that up to 8.5% of the caseload have a substance misuse issue. Positive outcomes range between 55% and 64% in the years shown.

Homeless Action Barnet, also deliver support to homeless clients, many of whom have alcohol rather than drug issues. The service can help with breakfast/lunch, showers, laundry, clothing, escorts to appointments and referral to food banks. Public Health funds contribute £35,000 per year towards the service. HAGA (alcohol treatment service) provide satellite sessions (up to 3.5 days a week) and are starting up a SMART group in association with Westminster Drug Project (WDP), which has three shared houses that are supported by one worker. Some tenants have alcohol problems and engagement in treatment is a condition of their tenancy. Tenancies are short-term, six months to a year, pending suitable long term accommodation. However, good quality accommodation has become harder to find due to benefit changes.

### 6.7.7 Drug Treatment Completion Rates

The percentage of opiate drug users that left drug treatment successfully who do not represent to treatment within 6 months in Barnet (8.6%) was similar to the national (7.8%) and London regional (9.0%) averages for 2013. However, the proportion of non-opiate drug users that left drug treatment successfully who do not represent to treatment within six months in Barnet (20.4%) was lower than the London (37.2%) and national (37.7%) averages for 2013. For the same period, the Barnet rates of successful completion of drug treatment for both opiate and non-opiate users were lower than these rates in Harrow (11.5% for opiate users and 41.4% for non-opiate users), which is a neighbouring Borough.

The proportion of OCUs in treatment (estimated penetration rate) in 2013/14 in Barnet (44.3%) is lower than the estimated national penetration rate (52.3%).[103] The 'penetration rate' for OCUs in treatment needs to increase to optimise numbers into treatment.

There is a need to 'segment' the treatment population to ensure that those with more complex needs and longer treatment journeys are targeted with services that help build recovery capital. Furthermore there is a need to improve the effectiveness of treatment for non-opiate users, specifically cannabis and cocaine users which will require better psychosocial interventions and support to maintain treatment gains long term.

## 6.8 Sexual and Reproductive Health

### 6.8.1 Reproductive Health

#### *6.8.1.1 Teenage Pregnancy*

Teenage pregnancy related indicators i.e. the rates of conception in under 16 years and under 18 years and the abortion and birth rates in under 18 years in Barnet are lower than the regional London and national rates. However, percentage of conception to females aged less than 18 years leading to an abortion is higher in Barnet (76.2%) compared to London (64.2%) and England (51.1%). In Barnet, the top three wards with the highest percentage of delivery episodes where the mother was under 18 years of age include West Hendon (1.2%), Hale (1%) and Finchley Church End (1%) wards.

[103] DOMES report Q4 2013-2014

#### 6.8.1.2 Abortions

The total number of legal abortions carried out in Barnet was 1,624 (95% CI: 1,546-1,705). The age standardised rate (ASR) of abortions was 19.9 per 1,000 female population aged 15-44 years. The ASR of abortions (in all ages) in Barnet is lower than the London regional rate (22.8) but higher than the national rate (16.6).[104] The crude rate of abortions in the 20-24 years age group was highest (34 per 1,000 women aged 20-24 years), which was lower than the London regional rate (38 per 1,000 women) but higher than the national rate (28.7 per 1,000 women). The crude rate of abortions in the under 18 years of age was 8 per 1,000 women (aged <18 years) which was lower than the average rates in the London region (14 per 1,000 women aged <18 years) and England (11.7 per 1,000 women aged <18 years). Of abortions, 84% were carried out at less than 10 weeks gestation. 60% of abortions were carried out using surgical methods while the remaining 40% of abortions were carried out using medical methods. The percentage of repeat abortions was 40% in women of all ages, 30% in women aged less than 25 years and 46% in women aged 25 years and above.

Higher percentages of repeat abortions and conceptions leading to abortions might suggest inequalities in regards to advice and access to services concerning contraception.

#### 6.8.1.3 Contraception (provision of advice and services around contraception)

The rate of GP prescribed long acting reversible contraceptives (LARC) per 1,000 in Barnet (19.4) is lower than the average rates for London (25.1) and England (52.7). This suggests a need for increasing the rate of LARC prescription by GPs in Barnet.

#### 6.8.1.4 Sexual Offences

In Barnet, 307 incidences of sexual offences were reported in 2013/14. The rate of sexual offences (per 1,000) in Barnet (0.84) is the fifth lowest across all London Boroughs and it is lower than the average rates for London region (1.22) and England (1.01).

#### 6.8.1.5 Sexually Transmitted Infections (STI)

In Barnet, the diagnosis rates (per 100,000) for syphilis (6.0), gonorrhoea (60.2), genital warts (122.8) and genital herpes (64.0) are similar to average rates in England but lower than the average London rates.

In young people aged 14-24 years, Chlamydia detection rate (1,098 per 100,000) and Chlamydia screening proportion (16.0%) measured separately in genitourinary medicine (GUM) clinics and non-GUM settings, in Barnet are lower than the national rates (2016 /100,000 and 24.9% respectively). The low rates in Barnet suggest a need for increasing detection of and screening for Chlamydia in young people.

In addition, excluding Chlamydia in young people under 25 years, new cases of STI diagnosed (899 per 100,000 population aged 15-64 years) is higher than the average in England (832 /100,000) and the proportion of STI testing positivity (4.7%) in Barnet is lower than the national average. These STI statistics suggest a need to better understand the demography and epidemiology of STIs in Barnet.

#### 6.8.1.6 Human Immunodeficiency Virus (HIV)

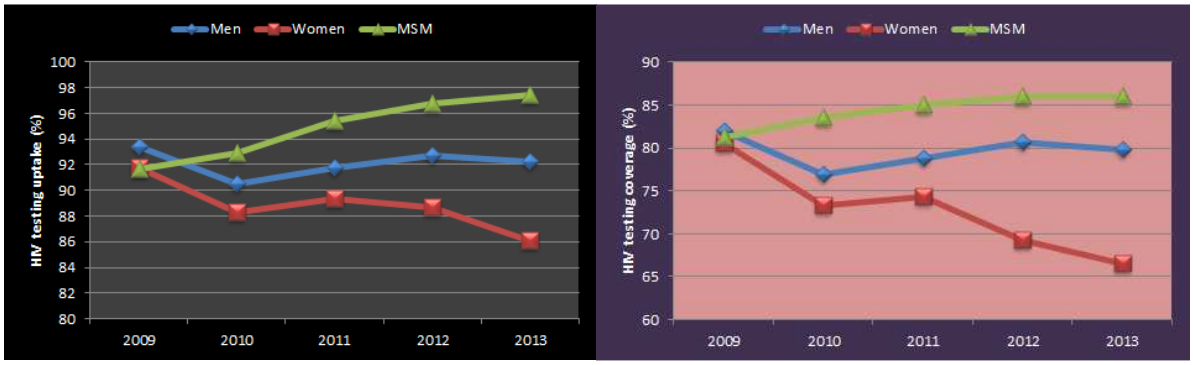
In Barnet, uptake of HIV testing in GUM clinics (86.0 in women, 92.2 in men and 97.4 in men who have sex with men (MSM)) are better than the uptake averages in England. However, within Barnet,

[104] Department of Health (2014) Abortion statistics, England and Wales: 2013. Dated: 12 June 2014.

HIV testing uptake by women is lower than the uptake by men and by those men who have sex with men (Figure 6-13a). Thus, there is a need to increase the uptake of HIV testing in Barnet women.

In addition, coverage of HIV testing in GUM clinics among Barnet women (66.5%), men (79.9%) and MSM (86%) are either better or similar to the average coverage levels for England. However, uptake of HIV testing in Barnet women needs to be increased because it is lower than the uptake by Barnet men and those men who have sex with men in Barnet (Figure 6-13b).

**Figure 6-13: HIV testing uptake and coverage in Barnet**




Source: Public Health England. Sexual and Reproductive Health Profiles. Public Health Outcomes Framework

The rate of diagnosed HIV prevalence (per 1,000 among persons aged 15-59 years) in Barnet (3.00) is higher than the rate in England (2.14) and the proportion of adults (aged 15 years and above) with newly diagnosed HIV in Barnet (51.5%) is worse compared to the average for the London region (40.5%) and England (45%). These statistics suggest a need for improving early diagnosis of HIV with targeted intervention to specific and hard to reach communities such as gays and lesbian people in Barnet.

## 6.9 Preventing Ill Health

The public health outcome framework shows that the majority of Barnet indicators are either better or similar to the national level; however, a few Barnet indicators are either worse or lower than the England average. These worse or lower indicators are mainly under the health protection and health improvement theme indicators (Appendix 1), which can be addressed through public health prevention and health improvement interventions.

### 6.9.1 Primary Prevention

Boyce et al (2010) suggested that primary prevention of ill health could include childhood immunisation against preventable infectious diseases. In Barnet, coverage (uptake) of various immunisations for children, young adults and elderly people is below the national level. It is therefore essential that the rates of immunisation coverage (uptake) are increased in Barnet to the level of average national rates.

For achieving the desired rates with regard to childhood immunisation, motivation of parents and training of GPs are some of the key issues that need to be addressed.[77] In addition, there is a need to target those with transport, language or communication difficulties, and those with physical or learning disabilities.[105] Moreover, appropriate information needs to be provided at the local

[105] National Institute for Health and Care Excellence (2009) Reducing differences in the uptake of immunisations. NICE Public Health guidance 21 London

communities levels, at their premises and in their languages because the language could be a major barrier and source of inequalities for certain types of people. For example, providing information and creating awareness about tuberculosis (TB) through active engagement of local ethnic communities in which TB is more common.

### 6.9.2 Secondary Prevention

Preventing ill health needs addressing the common causes of major diseases that lead to high rates of premature mortality. In Barnet, the top causes of premature mortality include coronary heart disease (CHD), stroke, breast and lung cancers, mental health and respiratory diseases (e.g. pneumonia and COPD), which are more prevalent in specific communities such as people of BME origin and those living in most deprived localities such as Burnt Oak and Colindale wards. There are health and lifestyle inequalities between different wards in Barnet (Table 6-5).

More importantly, the common causes of the above mentioned major killer diseases include smoking, poor diet, alcohol, obesity, physical inactivity, high blood pressure and air pollution, which are mostly lifestyle related health risk factors that could be modified by behavioural change and health promotion interventions such as smoking cessation, stop alcohol, healthy eating and physical and weight reduction activities.

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

**Table 6-5: Health and Lifestyle indicators: ranking of Barnet wards**

| Indicator | Unit | Best ward | Worse ward |
|---|---|---|---|
| Life expectancy | Years | Garden Suburb (males =84.1, females =88.5) | Burnt Oak (males = 75.8, females = 81.6) |
| Stroke mortality | SMR | Finchley (47.9) | Childs Hill (117.7) |
| Emergency hospital admissions for stroke | SMR | Garden Suburb (78.9) | Burnt Oak (173) |
| Breast cancer incidence | SMR | Burnt Oak (77.5) | Mill Hill (118.2) |
| Colorectal cancer incidence | SMR | Hale (69.8) | Coppetts (122.8) |
| Lung cancer incidence | SMR | Garden Suburb (53.2) | Coppetts (117.3) |
| Prostate cancer incidence | SMR | Brunt Oak (72.6) | West Finchley (115.6) |
| All cancers Incidence | SMR | Garden suburb (86.2) | Underhill (103.3) |
| COPD hospital admissions | SAR | Garden suburb (28.3) | Burnt Oak (141.8) |
| Fertility rate (per 1,000 females aged 15-44) | CFR | Golders Green (82.9) | Brunswick Park (56.8) |
| Low birth weight babies(less than 2500 g) | Proportion (%) | Hendon (5.9%) | Finchley Church End (9.1%) |
| Drug-related ambulance callouts | Count | Brunswick Park | Colindale |
| Smoking in adults (estimated prevalence, 18 years and above) | Proportion (%) | Garden Suburb (13.5%) | Burnt Oak (16.9%) |
| Modelled prevalence of regular smoking in children age 11-15 years | Proportion (%) | Colindale (1.1%) | Underhill (5.6%) |
| Modelled prevalence of regular smoking in children age 15 years | Proportion (%) | Colindale (4.2%) | Hendon (14.2%) |
| Modelled prevalence of regular smoking in young people aged16-17 years | Proportion (%) | Colindale (7.8%) | Hendon (22.6%) |
| Obesity in adults (modelled estimates) | Proportion (%) | Garden Suburb (12.8%) | Burnt Oak (23.7%) |
| Obesity in reception year children (prevalence) | Proportion (%) | Garden Suburb (5.6%) | Colindale (13.1%) |
| Obesity in year six children (prevalence) | Proportion (%) | Finchley Church End (13.2%) | Colindale (25.1%) |
| Binge drinking in adults (modelled estimates) | Proportion (%) | Colindale (8.4%) | Garden Suburb (14.7%) |
| Hospital admissions for alcohol attributable conditions | SAR | Garden Suburb (50.9) | Burnt Oak (122.9) |

The likely positive outcomes of reducing inequalities and preventing CHD, stroke, cancers, respiratory diseases and mental health in Barnet include reduction in costs of and demand for health and care services, improvement in life expectancy and reduction in the premature mortality as shown in Table 6-6.

**Table 6-6: Life expectancy years gained if Barnet most deprived quintile had the same mortality rates as Barnet least deprived quintile, by detailed cause of death (2010-2012)**

| Broad cause of death | Number of deaths in most deprived quintile | | Number of excess deaths in most deprived quintile | | Number of years of life expectancy gained* | |
|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female |
| Circulatory diseases | 219 | 240 | 122 | 103 | 2.61 | 1.73 |
| Cancers | 158 | 170 | 39 | 19 | 0.94 | 0.54 |
| Respiratory diseases | 68 | 96 | 23 | 36 | 0.49 | 0.65 |
| Digestive diseases | 31 | 36 | 18 | 21 | 0.41 | 0.36 |
| Mental and behavioural illnesses | 39 | 76 | 24 | 48 | 0.39 | 0.63 |
| * A positive figure indicates that life expectancy years would be gained if the base area (the most deprived area) had the same mortality rate as the comparator area (the least deprived area) (i.e. the mortality rate in the base area for the cause is higher than the comparator) | | | | | | |
| Adapted from: Public Health England. Segment Tool 2015 | | | | | | |

### 6.9.3 Tertiary Prevention

Under the tertiary preventative initiatives, a few selected public health issues such as mental health could be tackled. In Barnet, mental health and behavioural illnesses are among the major causes of premature mortality, especially among women and young children. Mental health and behavioural illnesses are multidimensional issues; therefore, tackling them would require a multi-disciplinary approach involving the key stakeholders such as GPs, local governments / public health agencies, NHS England, Public Health England, third sector organisations and families of patients.

### 6.9.4 Return on Investment in Public Health Prevention Interventions

A report 'Making the case for public health interventions' by the Kings Fund has suggested that little investment in public health prevention interventions such as changing unhealthy lifestyle and behaviour could results in considerable savings by reducing or avoiding some healthcare and care costs and would increase life expectancy. A few examples of investment and return for specific public health interventions are given in Table 6-7.

**Table 6-7: Return on investment in public health prevention interventions**

| Intervention area | Investment (£) | Possible return (£) | Saving in |
|---|---|---|---|
| Housing interventions (warm and safe) | 1 | 70 | NHS costs over 10 years |
| Be active programmes | 1 | 23 | Quality of life, reduced NHS use and other gains |
| School-based public health interventions i.e. smoking prevention programmes and anti-bullying interventions | 1 | 15 | Children's health |
| Preventing teenage pregnancy | 1 | 11 | Healthcare cost |
| Parenting programmes | 1 | 8 | Preventing conduct disorder over six years |
| Supporting people with alcohol or drug addiction | 1 | 5 | Reduced health care, social care and criminal justice costs |
| Providing social support | 1 | 3.75 | Reduced mental health service spending and improvements in health |
| Drug treatment | 1 | 2.50 | Reduced NHS and social care costs and reduced crime |

Source: Adapted from Kings Fund (September 2014) Making the case for public health interventions

# 7 Primary and Secondary Care

## 7.1 Key Facts

- Barnet is ranked 3rd across North Central London (NCL) CCG's in terms of A&E activity usage and yet is the lowest per 1000 population compared to the other NCL CCGs.
- Largest number of nursing home beds in London.
- The total number of GP registered patients in Barnet at the start of 13/14 was 388,895 and is estimated to rise to 402,748 by 2015/16.
- Older people (65+) are three times more likely to be admitted to hospital following attendance at A&E.
- Hip fractures prompt entry to a care home in up to 10% of cases.
- The rate of alcohol related hospital admissions has steadily increased over a six year period.

## 7.2 Strategic Needs

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges, place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in acute care.
- **Increasing demand on urgent and emergency care** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **Accident and Emergency (A&E) patients waiting no longer than four hours from the time from booking in to either admissions to hospital or discharge**. Quarter 3 and Quarter 4 having missed the 95% national target (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- Obesity growth in middle-age population (45-65) year olds places additional risk of them developing long-term conditions.

## 7.3 Barnet Clinical Commissioning Group (BCCG)

Barnet Clinical Commissioning Group was authorised in April 2013 and has completed two years of operation. Barnet Clinical Commissioning Group is responsible for commissioning population-based general health care services for its registered population. It is made up of 67 GP practices. CCG governing body consists of 9 elected members (3 from each locality), 2 lay members, a secondary care consultant, a nurse, the Chief Officer and the Financial Officer.

The healthcare system is facing the challenges of increasing demand and limited resources. Demand for services will continue to grow faster than funding, meaning that there is a need to innovate and transform the way services are delivered, within the resources available, to ensure that patients, and their needs, are always put first.[106]

Barnet's CCG remains committed to improvements in the health and wellbeing of the local population by focusing on preventative services, reducing health inequalities, meeting of NHS Constitutional commitments and enabling the population to take responsibility for their own health.

## 7.4 Health Inequalities in Barnet

Health inequalities refer to the differences in health experiences and outcomes between individuals or groups where they are avoidable and, therefore, not justifiable.

Current evidence indicates that inequalities in health persist and the gap in life expectancy between the most and least deprived people in England has not narrowed over time. In Barnet males in the most deprived areas have a life expectancy 9.1 years less than those in the least deprived areas; for females the equivalent figure is 6.8 years.

Whilst there are limitations in available evidence linking the differences in socio-economic inequalities and survival rates from cancer and disease in general, it is clear from international studies and evidence that people from more deprived groups tend to[107]:

- Have higher incidence of cancer;
- Be diagnosed later; and
- Have less treatment and have poorer outcomes.

### 7.4.1 Health Inequalities in Barnet

Within Barnet, the groups that have been identified as experiencing the health inequalities are:

- Obesity and the related conditions for adults, children and young people;
- Mental health and learning disability;
- Long-term conditions;
- Integrated care;
- Primary care development;
- Diabetes mellitus; and
- Conditions attributable to cold weather.

### 7.4.2 Reducing Health Inequalities

106 Commissioning for Value. NHS England, Public Health England. CCG Barnet
107 Foot C, Harrison T (June 20011).How to improve cancer survival: Explaining England's, poor rates (Catherine Foot)

Fair Society, Healthy Lives proposed an approach of "proportionate universalism by which actions are focused on the needs of the most vulnerable groups. Healthy Lives proposed an approach of "proportionate universalism" [108] by which actions to address health inequalities are universal, but with a scale and intensity proportionate to the level of disadvantage health and healthcare.

## 7.5 Long Term Conditions and Integrated Care

The Health and Social Care Act, 2012 created a duty for Clinical Commissioning Groups, NHS England and Monitor to promote integrated services for patients between the NHS and social care (and other local services) where this would improve quality or reduce inequalities of access and outcome.[109]

The Act further introduced public health and health improvement responsibilities for local authorities, including the responsibilities for promoting partnership working through the Joint Health and Wellbeing Board.

Barnet's Integrated Care model reflects partnership working with the local authority designed to support local population throughout all stages of their lives, with a focus on older people and those with long-term conditions, with a view to the delivery of improved care coordination, supported early discharge from hospital, rapid response and promotion of self-care.

### 7.5.1 Integrated Care

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require on-going care and support. These include diabetes, chronic obstructive pulmonary disease, heart diseases and musculoskeletal disease.

It is projected that by 2018 the number of people in the UK with three or more long-term conditions is expected to rise to 2.9 million, compared to 1.9 million in 2008 (Department of Health 2012). Current evidence suggests that the number of conditions a patient has can be a greater determinant of a patient's use of health services than the specific service (Barnett et al 2012).

With the present levels of obesity and the estimated increases in the size of the population, the number of cases of diabetes is set to rise dramatically. Increasing prevalence of long term conditions, particularly diabetes, chronic cardiac conditions and dementia will severely stretch the emergency and hospital services unless better management in the community is achieved.

Many people with long term conditions are often at risk of deteriorating health, reduced wellbeing and lack of independence. This can lead to an increase in hospital admissions, more extensive involvement of health/social care and reduction in control of their own lives

## 7.6 Hospital and Residential Care

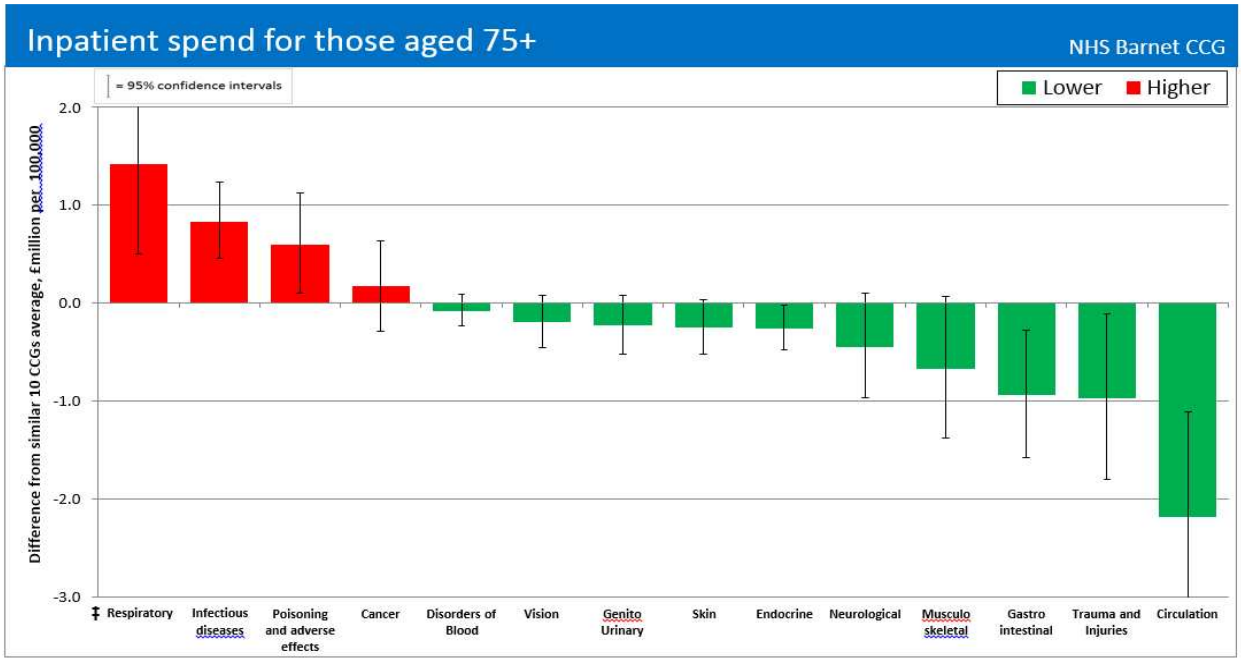
Barnet has the highest number of requests for emergency/urgent ambulance conveyance to hospital out of all London Boroughs from care homes; a total of 1133 ambulance requests for conveyance were made within the first 6 months of 2013 of these calls 12% were not conveyed.

[108] Fair Society Health Lives: Marmot Review Report, Feb 2010)
109 The Integration of Health and Social Care, June 2012: BMA Health Policy & Economic Research Unit

Compared to other Boroughs Barnet has a high proportion of care homes. There are 85 residential and 21 nursing homes in Barnet registered with the Care Quality Commission. In total, these homes provide approximately 2,800 beds for a range of older people and younger people with disabilities.

Barnet Clinical Commissioning Group and the London Borough of Barnet have been working together to give greater numbers of people in Barnet, of all ages, the opportunity to live healthy, active lives; to help prevent avoidable illnesses, and to manage long term conditions more effectively. Barnet's approach focuses on the 65 and over which is set to rise by 21% over the next 10 years.

**Figure 7-1: Inpatient Spend for those Aged 75+**




‡ Only those programmes with the highest inpatient spend are included

Public Health England RightCare NHS England

## 7.7 Emergency Admissions

Emergency admissions account for more than 70% of hospital bed days[110]. Factors that have been associated with increased rates of admissions are age, social deprivation, morbidity levels, living in an urban area, ethnicity and environmental factors[111].

Eighty per cent of emergency admissions, whose length of stay exceeds two weeks, are aged over 65, providing further evidence that maintaining the focus on reducing the length may have the most potential for reducing use and cost of hospital beds[112].

Figure 7-2 shows the number of Emergency Admissions by age group, by hospital in Barnet. As can be seen over the period 2012-2015 the level of emergency admission has remained relatively stable over this period, with the Barnet and Chase Farm hospitals accounting for the largest portion of admissions.

[110] Poteliakhoff and Thompson 2011
[111] Purdy 2010
[112] Poteliakhoff et al 2011

**Figure 7-2: Barnet Emergency admissions Trend by Providers, 2012-2015**

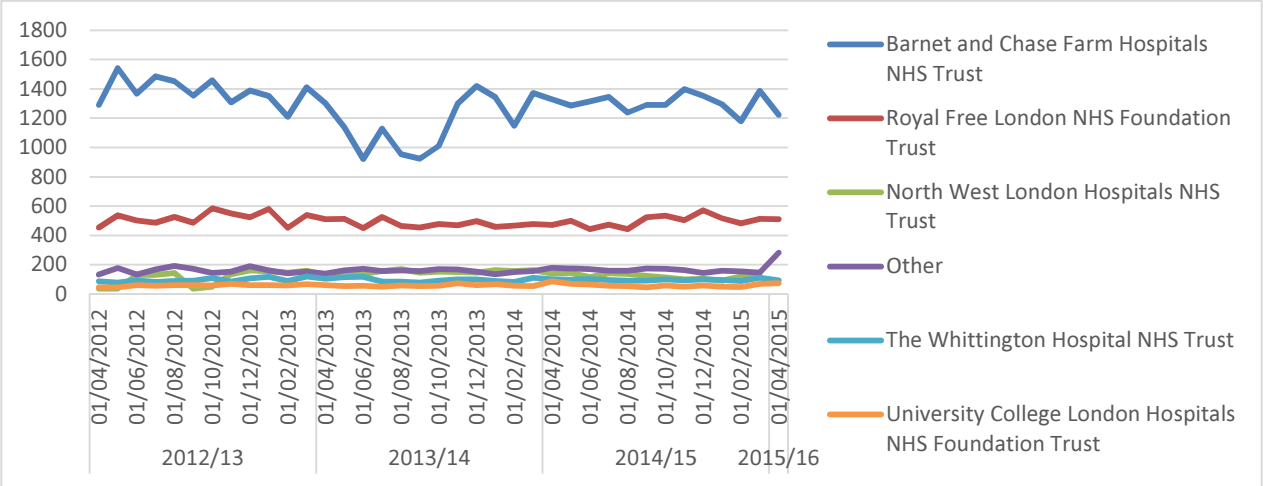
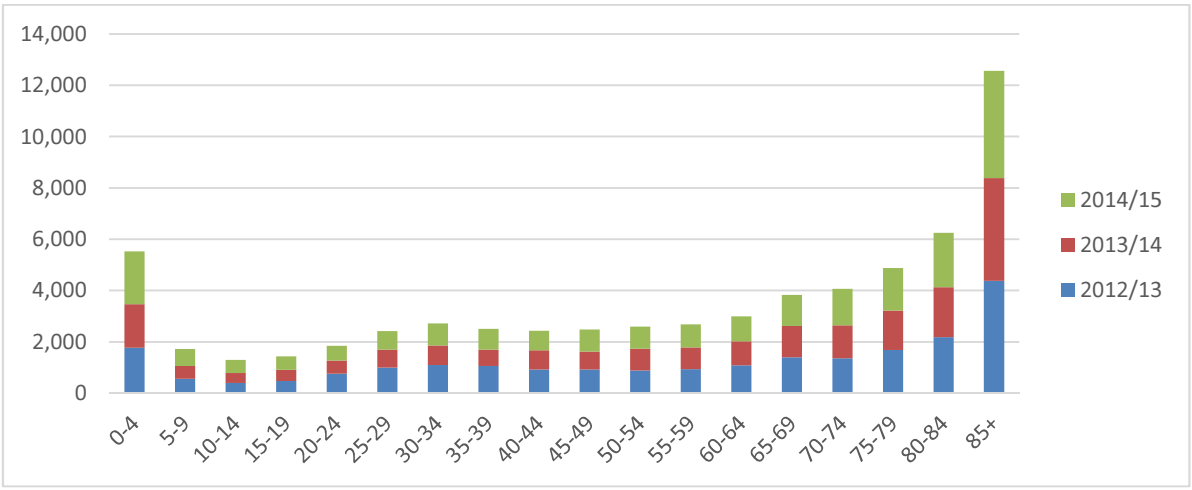



Figure 7-3 provides a breakdown of emergency admissions by age group for this same period. As can be seen, 48.9% of all admissions in 2014/15 were for people aged 65 or over, with people aged 85 or over accounting for 19.3% of admissions. Interestingly, by five year age band, the second highest rate of admissions (9.5%) was for people aged 0-4 year old. This high level of admission amongst young children could identify an area of opportunity to identify and address future demand early on in life.

**Figure 7-3: Barnet Emergency Admissions - Royal Free Total activity by age, 2012-2015**




Reducing avoidable emergency admissions improves the quality of life for people with long term and acute conditions and their families, as well as reducing pressures upon the resources of local hospitals.

### 7.7.1 Key Pointers from Evidence[113] [114]

- Early supported discharge planning has been shown to enable people to return home earlier, remain at home in the long term and regain their independence in activities of daily living

[113] (Fearon and Langhorne 2005)
[114] Avoiding hospital admissions: what does research evidence say? Purdy S (2010)

- An agreed discharge process that includes timescales and protocols for assessment and decision-making for different agencies to work together
- Ensuring patients with existing community services are discharged as soon as possible with care re-started
- Rehabilitation to ensure people do not become dependent or disabled in hospital
- Supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports

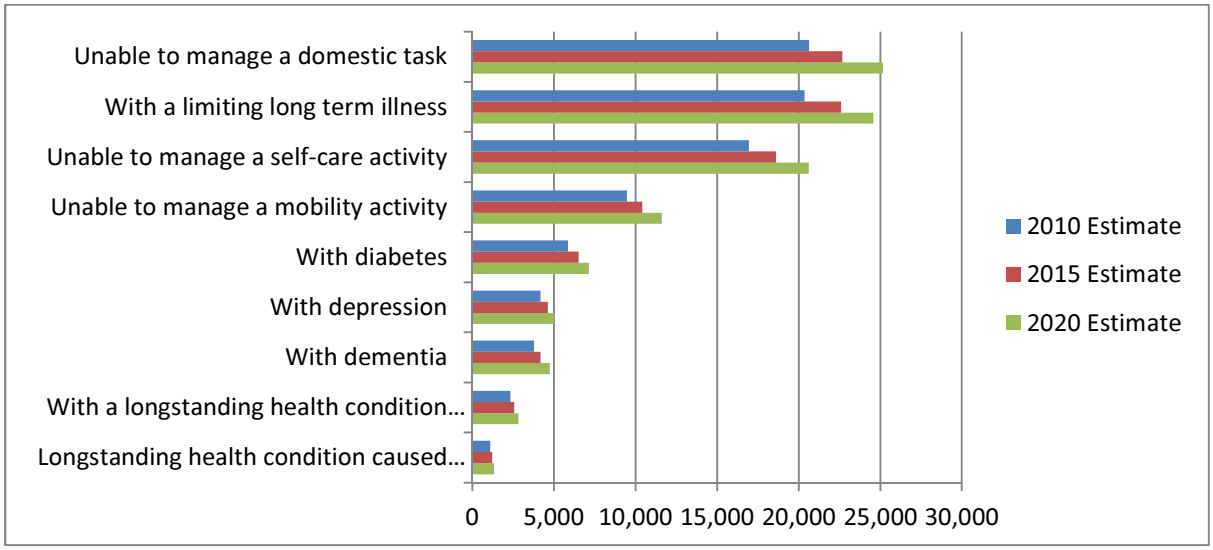
## 7.8 Frail and Elderly

Barnet is projected to have some of the strongest growth in elderly residents out of all the London Boroughs over the next five to ten years. Frail and elderly residents within the Borough are often at risk of deteriorating health, reduced wellbeing and lack of independence.

The older population is more likely to suffer from chronic and long-term conditions and is also more likely to suffer from falls and fractures. At present there are an estimated 20,359 people aged 65 or over with a limiting long term illness. The Projecting Older People Population Information (POPPI) system projects these figures to increase by more than 20% over the next ten years.

Over the next five years, there are predicted to be 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). Both of these increases are above the average growth rate (5.5%).

**Figure 7-4: Projected Increases in the number of people with a Long Term Condition**




Source: Department of Health, Projecting Older People Population Information (POPPI)

### 7.8.1 Key Issues

In the light of the anticipated pressure, there is a greater need to proactively manage the health and social care response as the elderly experience greater difficulties have been identified to allow for development of initiatives that will address the following health and social care needs[115]:

- Not being able to manage a mobility activity on their own
- Unable to manage good self-care activity on their own

[115] NICE Guidance 2014, DOH (2009). Fracture prevention services: An economic evaluation. London: The stationery Office.

- Struggling to manage and or complete a domestic tasks
- Having a known long term condition/ illness
- Having a fall within the last 12 months;

## 7.9 Falls and Fractures

National Institute for Health and Care Excellence (NICE) guidelines (2013) recommend that older people should be asked routinely whether they have fallen in the past year, and those who report recurrent falls to be offered a multifactorial falls risks assessment and individualized intervention.

Identifying older people who are at risk of falls and setting up of fracture prevention services for older people have been found to reduce hospital admissions and the need for social care, including admissions to a care home (Department of Health 2009).

Since 2010, there has been an estimated 13,146 people that have suffered a fall within Barnet's elderly population and this is projected to increase by 22% by 2020 in line with the projected population growth. From this cohort, the number of people that have been admitted to hospital due to a fall is 1,065, which again, is expected to rise by 20% by 2020.

Consequences of falls in this group have a significant impact on health and social care resources. It can lead to required support at home, or even admission to a care home, right through to major hip surgery, in patient care in acute or rehabilitation settings.

Using the London Ambulance Service (LAS) data, to look at the number of attendances for falls, in 2009, there were 3,700 falls in over 65 year olds in Barnet. This represented 24% of LAS incidences which is a 36% increase since 2005.

It is difficult to accurately determine the prevalence of falls in Barnet; however, by using estimates from the number of falls and their consequence, it is possible to put together the following figures in Table 7-1 below.

**Table 7-1: Prevalence of Falls, Barnet**

| | Estimates for Barnet | |
|---|---|---|
| | **No. of people** | **Proportion of those falling** |
| Fall each year | 18,083 | |
| Fall twice a year | 7,817 | 43% |
| Attend A&E | 2,567 | 14% |
| Call an ambulance | 2,567 | 14% |
| Sustain a fracture | 1,283 | 7% |
| Sustain fracture to hip | 420 | 2% |

Source: Falls & fractures: effective interventions in health & social care, Department of Health July 2009.

## 7.10 Better Care Fund (2013)

The Better Care Fund (BCF) comprises a pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

The BCF presents an opportunity to bring resources together in support of health and social care integration, to address immediate pressures on services. Guidance makes clear that the BCF is expected to deliver a substantial shift of activity and resources from hospital to the community, to be measured by 15% reduction in "hospital emergency admission"116.

The BCF Plan provides a framework for targeting investment in a holistic, integrated model, to drive and quicken the pace in shifting the balance of care and activity over time from hospital and long-term residential care to the community.

A comprehensive analysis of risks and mitigating actions / contingency plan has been developed as part of the BCF. The core challenge is the financial position of the Barnet health economy, so significant emphasis will be placed on the delivery of targets related to reducing non-elective emergency admissions. Target progress must be considered in the context of an anticipated funding gap in Health and Social Care which could manifest itself as cost pressures within organisations leading to a risk of potential reduced services.

## 7.11 Minor Ailments Scheme

In addition to General Practice, Primary Care includes pharmacists and a range of other provisions. The scheme enables patients to access minor ailment advice and treatment from eight pharmacies that are part of the scheme. The three most common reasons for people attending the eight pharmacies in connection with the minor ailments scheme were hay fever, threadworm and fever. The pilot is to be extended to the pharmacies at the 3 local hospital sites, with the aim of providing a viable alternative to attending the walk in centre or Urgent Care Centre for minor ailment advice/treatment.

## 7.12 Medicines Management Strategy

It is estimated that between one-third and one-half of medication prescribed for long-term conditions is not taken as recommended [117] and around 7% of hospital admissions have been [118]associated with adverse drug reactions[119] .

### 7.12.1 Referral Management

Referral management is a system by which GP referrals to community or secondary care services are reviewed by a peer in order to ensure that the correct referral pathway is being used. New pathways are being developed to enable care closer to home, to improve the patient experience and to deliver better value for money within the NHS.

The Referral Management Service (RMS) in Barnet is provided by Barndoc Healthcare Limited and was set up in June 2010 against the backdrop of a changing commissioning landscape at a time of growth in community or interface services. The RMS purpose was to provide the then PCT with a greater understanding of referral patterns, the clinical symptoms requiring the referral, as well as acting as a central point from which referrals could be directed to the most appropriate services. The RMS process approximately 7,000 GP initiated referrals each month, the majority of which are triaged by a team of local GPs.

[116] NHSE 2013
[117] Nunes et al 2009
[118] Making best use of the Better Care Fund. Spending to save, January 2014. Kings Fund
[119] Pirmohamed et al 2004

Further work is needed to review the current referral management service to develop the understanding of referral patterns.

## 7.13 Urgent (unscheduled) and Emergency Care

"Unscheduled care can be defined as: health and/or social care which cannot be reasonably foreseen or planned in advance of contact with relevant professional. It follows that such demand can occur any time and that services to meet this demand must be available 24 hours a day, seven days a week."(A guide to good practice: Unscheduled care and Emergency Care Services).

A range of urgent and emergency care services are available through Barnet Urgent & Emergency Care Services and comprise the following:

- Barnet Hospital A&E (24hrs; UCC 8pm to 10pm
- Edgware Walk in Centre (7am – 10pm)
- Cricklewood Walk in Centre (8am – 8pm)
- Royal Free Hospital A&E (24nhs); UCC 8pm to 10 pm
- GP OOH (6:30pm to 8am); Telephone assessment, Base visits, Home visits
- Finchley Walk in Centre 7am – 10pm
- GP OOH base (6:30 to 11pm)
- NHS 111 (24 hours)
- London Ambulance Service (24hrs)

## 7.14 Barnet Accident and Emergency Summary Key facts and figures:

- The A&E waiting times target of 95% of patients waiting no longer than four hours continues to present a challenge
- Barnet A&E activity recorded an increase in 2014/15 compared to 2013/14
- Concurrent increase in activity in Barnet Walk in centres in 2014/15 compared to 2013/14
- In 2014/15 around 48% of the total Barnet A&E activity was at Barnet Hospital, and 23% at the Royal Free London NHS Trust.
- Moorfield Eye hospital saw an increase in Barnet activity in 2014/15

**A&E Treatment: Patient Profile 2014/15**

- 55% of A&E attendances were discharged and 28% admitted
- 50% of admissions related to patients of 60+
- Largest users of A&E were 0-9 and 20-39yrs
- Around 9% of attendances to A&E had no investigation and no significant treatment
- Majority of patients discharged with no treatment and advice and guidance were aged 20-39yrs
- 35% of patients received investigation with category 1 treatment
- 62% from Walk-in-centres received no treatment and advice and guidance only

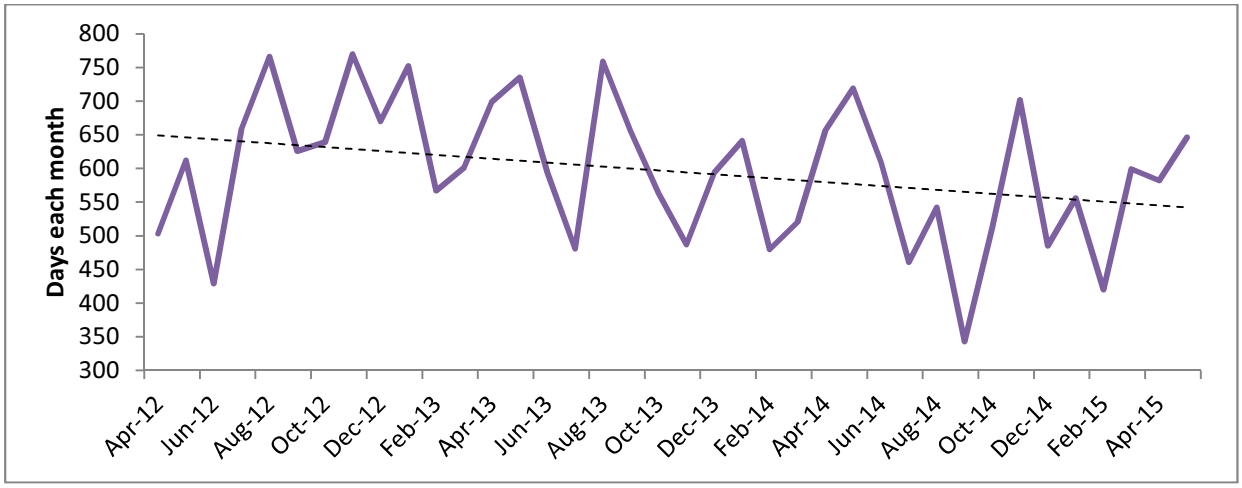
## 7.15 Delayed Transfer of Care (DToC)

A delayed transfer of care is experienced by an inpatient in hospital when they are ready to move on to the next stage of care, but are unable to do because social or health related arrangements are not in place to enable the discharge. Department of Health defines a delayed transfer of care (DToC),

also known as a delayed discharge as "occurring when a patient is ready for transfer from a general and acute hospital bed, but still occupying such a bed."

Figure 7-5 shows the number of DToC within Barnet for the period April 2012 – May 2015. Although there has been some significant fluctuation in the number of DToC days, overall during this 38 month period there has been a downward trend in the number of lost days due to DToC.

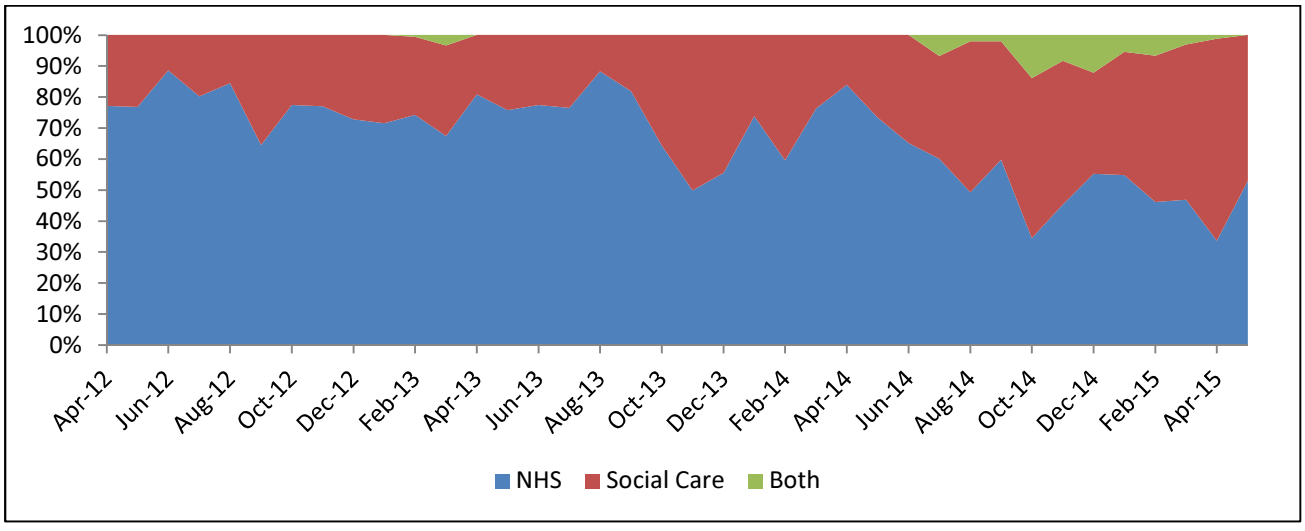
**Figure 7-5: Delayed Transfer of Care in Barnet (Lost Days each month), April 12 – May 15**




Source: NHS England

However, over this 38 month period, the split of the responsibility for delays has shifted away from the NHS towards Adult Social Care. At April 2012 Adult Social Care's portion of delays stood at 22.9%, by May 2015 it had risen to 47.1% of delays, with a high of 65.1% in April 2015. Further research is needed to identify the driving factors behind this change.

**Figure 7-6: % of Barnet Delays by Organisation, April 2012 – May 2015**




Source: NHS England

### 7.15.1 Factors Attributable to Delayed Discharge from Hospital in Barnet

- Increased complexities and needs of ageing population and demands on local urgent, community system;

- Complexity of patients and increased demand for social care and health input and impact on productivity;
- Increased number of frail and elderly patients moving into Barnet from other local authorities and CCGS and impact on hospital admissions;
- Increasing complexity of supporting patients with multiple long-term conditions, to remain at home and increasing quantum of support and provider capacity to meet rising demand;
- Increasing need to provide care to patients who require complex packages of social care and health and related financial pressures;
- Impact on providers having the capacity to support the lower needs and prevention;
- Increasing number of people surviving major trauma and needing lifelong care and support;
- Impact of delayed discharges within the current system of unscheduled care; and
- Care homes capacity issues.

## 7.16 Mental Health

Mental ill health is reported to be the single largest cause of disability in the UK, with at least one in four people predicted to experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time[120]. Mental Health is high on the government's agenda, with a published National Strategy for Mental Health 'No Health without Mental Health', setting out a cross government approach with a focus on better outcomes for people with a mental illness.

### 7.16.1 Mental Health in Barnet

The prevalence of mental illness in Barnet is higher than the England average and has slightly increased over the past 5 years at a similar rate to that of England Risk factors for poor mental health. There has been a concurrent increase in national and regional prevalence in mental illness reflecting significant increases compared to those observed between the 2008/09 and 2011/12.

Deaths rates from suicide and undetermined injury in Barnet are almost three times higher in men than in women; , although there has been a reported moderate decline in rate of mortality due to suicide and undetermined injury among men and a slight decline in the rate among women[121].

The Barnet rates of people reporting low levels of mental wellbeing or high levels of anxiety are higher than the England average but slightly lower than the average for London.

The evidence-base indicates that people with learning disability demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities[122]. 2014 Barnet Community Mental Health Profiles are now available at: http://fingertips.phe.org.uk/profiles-group/mental-health/profiles/cmhp.

### 7.16.2 Adults Mental Health Services

[120] Community Health Mental Health Profiles 2013:
Public Health Observatories
[121] JSNA Refresh 2013/14 Mental Health & Wellbeing - Barnet
[122] Mental Health Nursing with Learning Disabilities:wwww.rcn.org.uk/_data/assests/pdf/0006/78765/003184.pdf

The Community Mental Health Teams provide an assessment and care planning service to people with serious mental health difficulties. There are multi-disciplinary teams comprising of psychiatrists, nurses, occupational therapists, social workers and administrators working together in the community. Each team has the same functions of care management and assessment.

The Community Mental Health Team (CMHT) refers directly to Children's Services if in the course of their work they have any child protection or safeguarding concerns in connection with. Parental Mental Health issues. Patients are offered a service based on assessed need. This may or may not be under the Care Programme Approach (CPA).

The care plan is managed by a care coordinator, who is usually a nurse or social worker. There is an out of hour's service, accessed through the Emergency Duty Team (EDT). Mental Health Workers routinely record whether there is a child in the family or in contact with the adult.

### 7.16.3 Mental Health and Learning Disabilities

**The Winterbourne Concordat** set a target for registers to be developed, with reviews and personalised care planning to be in place for all clients meeting the Winterbourne View Criteria by 1 June 2014.

The Concordat also required health care commissioners to review all current hospital placements, and to provide appropriate support to everyone inappropriately placed in hospital (assessment & treatment) to move to community-based support as quickly as possible as and no later than 1 June 2014

### 7.16.4 New Service Developments

#### *7.16.4.1 Rapid Assessment, Interface and Discharge (RAID) for Barnet and Chase Farm Hospital*

RAID service became fully operational in 2014 and represents a partnership arrangement between Barnet and Chase Farm Hospital NHS Trust and Barnet, Enfield and Haringey Mental Health NHS Trust.

The Mental Health Trust provides mental health assessments and liaison for A & E and acute wards in Barnet General Hospital.

The service operates between 9am-9pm and expected to improve patient experience and outcomes by reducing A&E waits, ensuring that patients with mental health conditions receive appropriate assessment and support, integrating mental and physical health care and reducing length of stays on acute wards.

The service is subject to a formal evaluation in order to determine options for delivering the service on a long-term basis.

#### *7.16.4.2 Dementia Redesign*

A Memory Assessment Service is currently under development to increase capacity and to work alongside an Alzheimer's Society Dementia Advisor. This will increase access to support for patients and ensure that carers receive comprehensive information and advice at the point of diagnosis, and have on-going support as needed. Four dementia cafes are now operating across the Borough with attendance growing every month.

### 7.16.5 Expected Outcomes:

- Increase in the number of patients receiving psychological therapies to 10% of those assessed as having depression or anxiety disorders
- Early intervention in Psychosis services
- Suicide prevention: 100% of psychiatric in-patients on CPA followed up within 7 days of discharge
- Improving Access to Psychological Therapies: 6000 people receiving IAPT treatment by 2014/15
- Year on year increase based on the 2009/10 baseline of people with a learning disability and those with mental health illness who have received an annual health check
- Increase by 11% the number of people with long term mental health problems and people with a learning disability in regular paid employment by 2014/15.

# 8 Children and Young People

## 8.1 Key Facts

- The Borough's population of 93,590 children and young people aged 0 – 19 remains the second largest in London and this group accounts for one quarter of the overall Borough's population.
- The population of children and young people in Barnet is estimated to grow by 6% between 2015 and 2020 when it will reach 98,914. Barnet will continue to be the Borough with the second highest population of children and young people in London.
- In 2015 Golders Green will have the highest population of children and young people of any ward in Barnet at 6,218, followed by Colindale with 6,055 children. However, projections suggest that by 2025, the population of children and young people in Colindale will be the highest of any ward.
- There are more children from all Black and Minority Ethnic groups in the 0 – 9 age group, than there are White children. Children and young people in the 10 – 19 age groups are predominantly White. This demonstrates a more diverse population shift in terms of ethnicity. Colindale, Burnt Oak, and West Hendon have populations that are more than 50% Black, Asian and Minority ethnic background. Over 50% of all 0-4 year olds in Barnet are from a Black, Asian and Minority ethnic background and this is forecast to increase.

## 8.2 Strategic Needs

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably in the west).**Targeted multi-agency, locality-based interventions could better support families.
- **The Young Carers Act and Children and Families Act 2014** represents a significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**
- The number of post-16 pupils remaining in special schools is causing **pressure on the availability of places for admission of younger pupils.**
- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing** however; there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years, 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics

have been youth violence or gang related activity and, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.

- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 2014/15 averaging five or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

## 8.3 Demography

### 8.3.1 Overview - Population Growth

The children and young people population in Barnet will increase by 2.91% between 2011 and 2015. From 2011 – 2020, the population is projected to increase by 8.76%. The population is also estimated to grow by 6% between 2015 and 2020 when it will be 98,914, with Barnet continuing to have the second highest children and young people's population of all London Boroughs. Year on year growth consistently projects a higher proportion of males than females in the 0-19 age range.

### 8.3.2 Age Bands in Wards for 2015

In 2015, the largest population of children and young people aged 0-19 years are in the wards to the west of the Borough: Golders Green with 6,218; Colindale with 6,055; Burnt Oak with 5,457 and Mill Hill with 5,501. High Barnet has the least number of children with 3,451. The wards with the highest number of 0-4 year olds are Colindale with 2,005; Golders Green with 1,712; Hendon with 1,626 and Childs Hill with 1,499. Golders Green has the highest number of children in the 5 – 14 age groups and Mill Hill has the highest proportion of 15 – 19 year olds.

## 8.4 Early Years

### 8.4.1 Early Years Demographics by locality

### 8.4.2 Deprivation 0-5 years

Whilst Barnet is generally an affluent Borough, approximately 16% of children under five live in the 30% most deprived Local Super Output Areas (LSOAs)[123]. 19% of children under five (5,000 children) live in low income families, defined as those in receipt of Child Tax Credit and either on benefits (Income Support or Jobseekers allowance) or earning less than 60% of median the income[124].

### 8.4.3 Lone parents 0-5 years

Whilst there are high concentrations of lone parents in Barnet's deprived LSOAs, it should be noted that there are also high concentrations of lone parents in the Borough's more affluent LSOAs.

**Central / East Locality:** Within the locality, there are five LSOAs that have a relatively high number of lone parent household (over 80 households per LSOA). Four of the LSOAs are deprived with IMD scores ranging between 19%-26%.

[123] Index of Multiple Deprivation, DCLG, 2010
[124] HMRC, 2011

**Table 8-1: Lone Parent Households by LSOA, Central/East Locality**

| LSOA | Children's Centre Reach | Locality | Ward | IMD score | Lone parent households with dependent children |
|---|---|---|---|---|---|
| E01000163 | Coppetts Wood | Central/East | Coppetts | 26% | 102 |
| E01000315 | Coppetts Wood | Central/East | Woodhouse | 23% | 116 |
| E01000171 | St Margaret's | Central/East | East Barnet | 49% | 121 |
| E01000289 | Underhill | Central/East | Underhill | 19% | 118 |
| E01000291 | Underhill | Central/East | Underhill | 26% | 107 |

**West Locality:** the locality contains the three LSOAs with the highest number of lone parents in the Borough. These are deprived LSOAs with IMD scores of 12%-19%.

**Table 8-2: Lone Parent Households by LSOA, West Locality**

| LSOA | Children's Centre Reach | Locality | Ward | IMD score | Lone parent households with dependent children |
|---|---|---|---|---|---|
| E01000189 | Stonegrove | West | Edgware | 12% | 169 |
| E01000125 | Barnfield | West | Burnt Oak | 18% | 134 |
| E01000152 | Wingfield | West | Colindale | 19% | 153 |

**South locality:** Within the locality, there are six LSOAs that have a relatively high number of lone parent household. With the exception of one LSOA within Childs Hill ward, five LSOAs are deprived with IMD scores ranging between 17% - 27%. The two most deprived LSOAs within the south locality are also LSAOs with high numbers of lone parent households.

**Table 8-3: Lone Parent Households by LSOA, South Locality**

| LSOA | CC Reach | Locality | Ward | IMD score | Lone parent households with dependent children |
|---|---|---|---|---|---|
| E01000245 | Bell Lane | South | Hendon | 23% | 80 |
| E01000137 | Childs Hill | South | Childs Hill | 24% | 93 |
| E01000141 | Childs Hill | South | Childs Hill | 27% | 98 |
| E01000142 | Childs Hill | South | Childs Hill | 42% | 87 |
| E01000221 | Parkfield | South | Golders Green | 17% | 81 |
| E01000308 | The Hyde | South | West Hendon | 17% | 96 |

### 8.4.4 Ethnicity 0-5 years

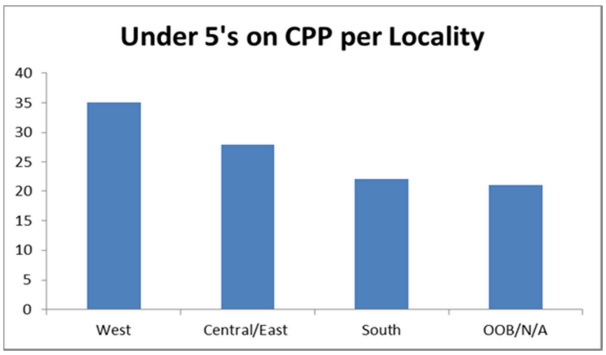
Barnet has 24 LSOAs with relatively high estimated number of Black, Asian and Minority Ethnic children under five (over 90 households per LSOA). The West locality contains 17 of the LSOAs with high concentration of Black, Asian and Minority Ethnic households with children under five. It should be noted that there are high numbers of Black, Asian and Minority Ethnic children in the wards of Burnt Oak and Colindale, which have pockets of deprivation. The Central/East locality has only two LSOAs with high number of Black, Asian and Minority Ethnic households with children under five, however, these are not deprived LSOAs.

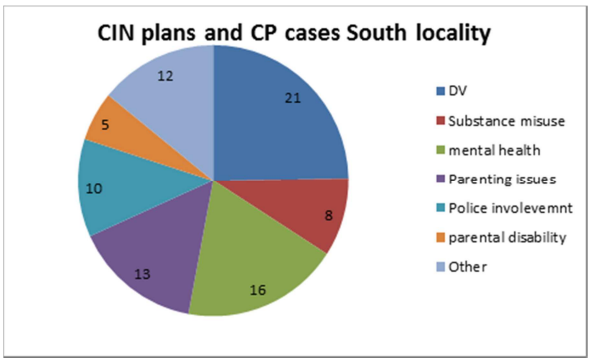
### 8.4.5 Children In Need (CIN) and Children Subject of a Child Protection Plan (CP) aged 0-5 years.

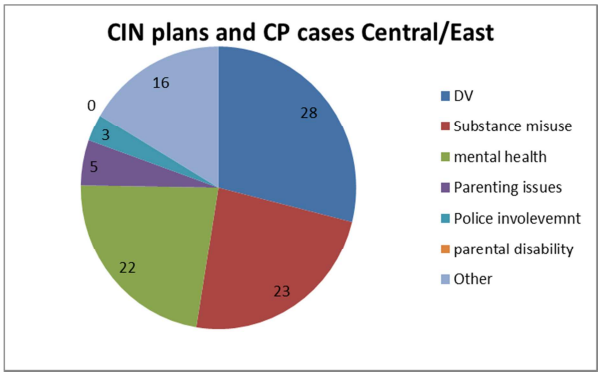
The tables below demonstrate that there is a higher number of under-fives on a child protection plan in the West locality, despite this locality currently containing the smallest number of under-fives overall. CIN plans by locality excluding disability show 160 CIN plans in total (Central/East: 64 CIN

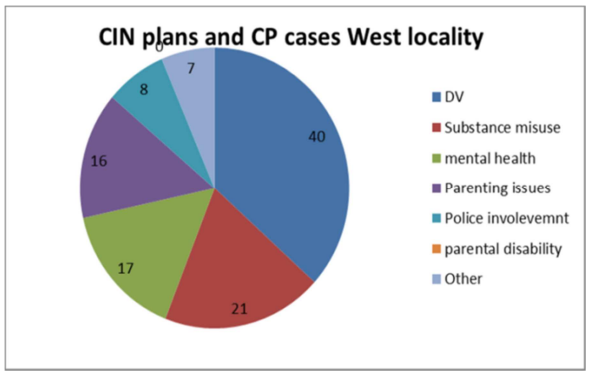
plans South: 33 CIN Plans West: 63 CIN plans). Primary concerns leading to CIN and CP plans are identified in the charts below.

**Figure 8-1a-d: Under 5's on Child Protection Plans**




Source: ICS October 31st 2014, under-fives on a Child Protection Plan

### 8.4.6 School Readiness by Locality

The quality of a child's early experience is vital for their future success. It is shaped by many interrelated factors, notably the effects of socio-economic status, the impact of high-quality early education and care and the influence of 'good parenting'. High-quality early education is crucial in countering the effects of socio-economic disadvantage[125].

Overall, attainment of good level of development (GLD) in Barnet is above the national average, including the development of children in receipt of free school meals (FSM) and SEN pupil attainment. However, attainment varies by locality. A higher percentage of children within the Central/East locality achieved a GLD (68.1%) with 65% attaining above the national average, whilst in the West locality, GLD attainment is lower (60.1%) but is in line with the national average.

The table below sets outs GLD attainment by locality overall, and by the following characteristics:

- Children whose first language is other than English
- Children with Special Educational Needs
- Children eligible for Free School Meals
- Children born in the summer term.

[125] Are You Ready? Good Practice In School Readiness, Ofsted 2014

**Table 8-4: GLD Attainment by Locality**

| | Central/East | South | West | Out of Borough | Barnet | National Average (DfE)[126] |
|---|---|---|---|---|---|---|
| **No of children at EYFS** | 1,775 | 1,273 | 1,225 | 450 | 4,723 | N/A |
| **No of children achieving a GLD** | 1209 **68.1%** | 845 **66.3%** | 737 **60.1%** | 297 **66%** | 3088 65.4% | **60%** |
| **No of children whose first language is English achieving a GLD** | 707 out of 958 **73.8%** | 374 out of 510 **73.3%** | 335 out of 512 **65.4%** | 135 out of 184 **73.3%** | 1551 out of 2164 **71.6%** | **63%** |
| **No of children whose first language is other than English achieving a GLD** | 502 out of 817 **61.4%** | 471 out of 763 **61.7%** | 402 out of 713 **56%** | 162 out of 257 63% | 1537 out of 2550 60.2% | **53%** |
| **No of children with SEN achieving a GLD** | 30 out of 145 **20.7%** | 31 out of 97 **32%** | 24 out of 152 **15.8%** | 7 out of 40 **17.5%** | 92 out of 434 **21.2%** | **19%** |
| **FSM** | 144 out of 273 **52.7%** | 84 out of 156 **54%** | 113 out of 235 **48%** | 38 out of 64 **59.4%** | 379 out of 728 **52%** | **45%** |
| **Term of Birth (summer babies achieving GLD** | 369 out of 621 **59.4%** | 233 out of 426 **54.7%** | 211 out of 419 **50.4%** | 98 out of 184 **53.3%** | 911 out of 1650 **55.2%** | **49%** |

Source: KEPAS 2014

## 8.5 Children's Centres

Children's Centre's aim to improve outcomes for families with children under five, ensuring that all children are properly prepared for school ('School Readiness'). Services are delivered, either by or through Children's Centres and include both Universal and Specialist services for families in greatest need - families living in deprived areas; workless families; those with low levels of English; and those experiencing the 'toxic trio' of domestic violence, mental health issues and/or substance misuse.

### 8.5.1 Gaps in Current / Future Provision or Unmet Need

There appear to be a good range of services targeting children's health and development, although better partnerships would ensure that these are more joined up. Key issues are:

- Development of an integrated service offer delivered through the centres for parents, with a particular focus on the needs of parents with mental health, drug and alcohol problems, and parents without literacy and basic skills required to progress into work. Improved partnerships with health and Jobcentre Plus would help facilitate this.
- Increased engagement with vulnerable families to support family learning: – engaging children and parents learning together, such as family literacy and numeracy, support for teenage parents and housing advice.
- Increase the take-up of adult education including courses leading to qualifications through access to child care at low cost, and a Service Level Agreement with Barnet College, leading to better evaluation and tracking of learners' outcomes.

[126] Early years foundation stage profile attainment by pupil characteristics, England 2014, DfE, Statistical First Release

## 8.6 Education and Skills

### 8.6.1 Primary Education in Barnet

Between 2016/17 and 2020/21, primary school rolls are projected to rise by an estimated seven to nine forms of entry (FE), and these school places will need to be commissioned through a series of temporary or permanent expansions and new provision. Barnet has a higher proportion of pupils on roll in primary schools with special educational needs (both statemented and without statements) compared to statistical neighbours, national and London, and the proportion of pupils on school action and school action plus has gradually declined since 2011 in line with statistical neighbours. Overall absence in Barnet primary schools is ranked in the 3rd quartile, at 94th nationally.

The proportion of Barnet's primary school pupils who speak English as an additional language is below the London average but above that of Barnet's statistical neighbours and the proportion of pupil's eligible for free school meals is above that of statistical neighbours.

### 8.6.2 Secondary Education in Barnet

Between 2010 and 2014, the number of children on roll in mainstream secondary schools increased by 6.1% to 22,853 pupils. Barnet currently has 24 secondary schools: 4% are community schools, 25% are voluntary-aided and 71% are academies. Assuming that a Free School, which is currently subject to planning, is delivered, an estimated 20 FE of additional need is projected between 2016/17 and 2020/21. These school places will need to be commissioned through a series of temporary or permanent expansions and new provision.

Barnet has a higher proportion of pupils on roll with a statement of special educational needs compared to London, England and statistical neighbours. The proportion of pupils on roll with special education needs (without a statement) has decreased for the past three years but remains above that of statistical neighbours. Overall absence in Barnet secondary schools is ranked in the top quartile, at 23rd nationally.

The proportion of pupils with English as an additional language is above statistical neighbours, but below the London average. The proportion has increased at a lower rate than London and statistical neighbours, but more than the national increase. Barnet has a lower proportion of Free School Meal pupils in secondary schools than London, but more than England and statistical neighbours.

At Key Stage 2, attainment and achievement in all subjects is in the top quartile nationally. The attainment and achievement of all pupil groups are in line with national averages, and most pupil groups attain significantly above the national average. Barnet's FSM and disadvantaged pupil attainment gaps have narrowed and the gap is now in line with the London average and smaller than the national average.

There is an 11 percentage point difference in attainment between disadvantaged (those who have been eligible for free school meals in the past six years or are in local authority care) and non-disadvantaged pupils, which is in line with the London average. Disadvantaged pupil attainment is high and is ranked 13th nationally.

Pupil progress in Reading and Mathematics is significantly above national averages, with Barnet ranked 6th and 12th nationally. The proportion of pupils making expected progress in Writing is in the third quartile, ranked 48th nationally.

At Key Stage 4, attainment of 5 A*-C grades including English and Maths and 5 A* - C grades is ranked in the top quartile nationally. Attainment of SEN, EAL and disadvantaged pupils is

significantly above the attainment of their national counterparts. The attainment gap for disadvantaged and non-disadvantaged pupils increased to 28 percentage points in 2014, and is wider than the London attainment gap (21 percentage points).

### 8.6.3 Key Issues

- Teacher and head teacher recruitment is a key issue for primary schools, with a head teacher recruitment and retention working group set up in response to difficulties in securing permanent posts. Key barriers to recruitment in Barnet include: availability and cost of parking, public transport, cost of affordable housing/rentals and increasing pressure and responsibilities on teachers and head teachers.
- The capacity of schools in Barnet struggles to meet demand from the population each year, with temporary and permanent expansions being commissioned as part of a school expansion strategy, and the Council working in partnerships with Free Schools to develop new provision.
- Black pupils perform relatively poorly compared to other ethnic groups in Barnet across all key stages.
- Whilst disadvantaged children perform above disadvantaged children nationally, they continue to perform significantly below their non-disadvantaged counterparts.

### 8.6.4 Looked After Children

In 2014, the attainment of looked after children in Barnet is in line with or above that of looked after children nationally at Key Stage 1 (level 2+), is slightly below that of looked after children nationally at Key Stage 2 (level 4+) in RWM, Mathematics, EGPS, and in line with or above for Reading and Writing. A lower proportion of Barnet's looked after pupils attained the expected standard at GCSE compared to looked after children nationally (12% compared to 15%). However, the attainment of looked after children remains significantly below the attainment of their non-looked after counterparts (both nationally and in Barnet) across all key stages.

Value-added (the amount of progress made) between key stages 1 and 2 for looked after children in Barnet has remained below the progress seen in looked after children nationally since 2012, and remains below the progress of their non-looked after counterparts in al years. Value-added (the amount of progress made) between key stages 2 and 4 for looked after children in Barnet was below the progress seen in looked after children nationally in 2012 and 2014, and remains below the progress of their non-looked after counterparts across the past 3 academic years.

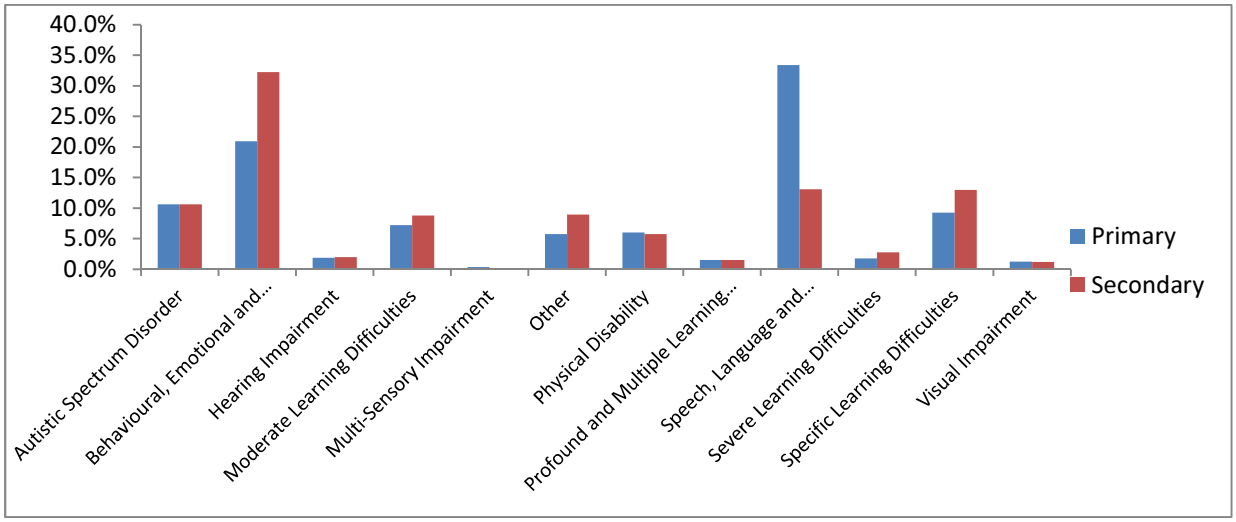
The virtual school has recently been re-located within the Barnet School Improvement Team and a permanent headteacher appointed in order to drive up educational standards within this cohort.

### 8.6.5 Special Educational Needs

Barnet has four State-funded special schools and three Pupil Referral Units. Across all pupils with Special Educational Needs (SEN) in Barnet, the highest proportion of needs in primary schools are Speech, Language and Communication; in secondary the highest proportion of needs are in Behavioural, Emotional and Social Difficulties.

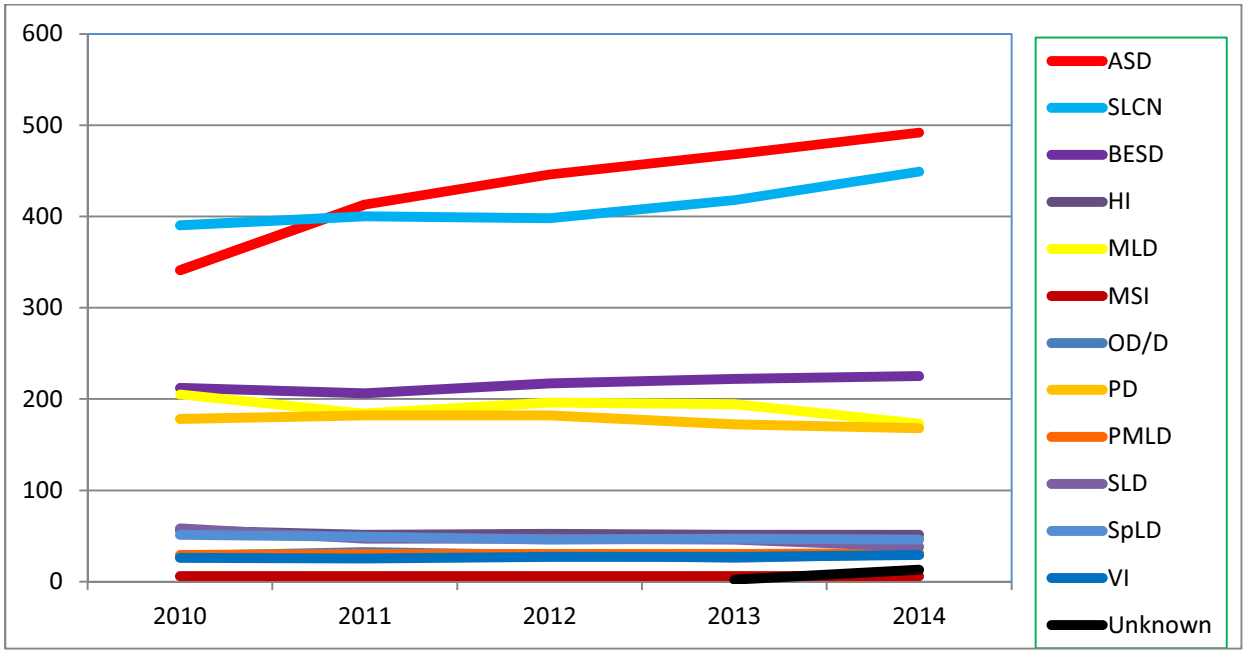
Primary Category of SEN Statement Type is shown in figure 7-2 and trend in the figure below.

**Figure 8-2: Proportion of Total of SEN Need by Type**




Source: January Census 2014

**Figure 8-3: Trend DATA Barnet SEN Statement Numbers by Category of Need; 2010-2014**




Barnet is an inclusive authority, given that 57% of pupils (997 of a total of 1751 in 2014) with a statement of Special Educational Needs maintained by the council are placed in mainstream settings. A level which is significantly higher than statistical neighbours and other Outer London Boroughs, where larger proportions attend specialist provision.

Specialist provision is required to meet the needs of the remaining children and young people. Some of this is offered by Additional Resourced Provisions (ARPs) in mainstream primary and secondary schools, with a greater number of places provided by the council's four special schools. Additionally, a number of pupils with SEN are placed in the special schools of other local authorities, whilst, in 2014, almost 10% (167) of pupils with a statement of SEN issued by the council were placed in a non-maintained or independent provision, including 35 in expensive residential settings.

A detailed assessment of the future needs of Barnet's SEN population established the following needs to be met up to 2019/20. The findings are displayed in Table 8-5.

**Table 8-5: Future Needs of Barnet's SEND Population**

| | Primary ASD/SLCN* | Secondary ASD/SLCN* | Primary BESD** | Secondary MLD*** |
|---|---|---|---|---|
| Demography | 18 | 45 | 2 | 11 |
| Reduce dependency on expensive placements | 10 | 10 | 8 | 5 |
| Total | 28 | 55 | 10 | 16 |

* Autistic Spectrum Difficulties / Speech, Language and Communication Needs

** Behaviour, Emotional and Social Difficulties

*** Moderate Learning Difficulties

#### 8.6.5.1 Attainment of SEN pupils

Key Stage 2 attainment of Barnet pupils with a statement of SEN (at level 4+ in Reading, Writing and Mathematics) is in the top quartile in the country, ranked 13th nationally, whilst attainment of SEN pupils without a statement of SEN (those identified on School Action or School Action plus) is also in the top quartile nationally, ranked 12th.

Key Stage 4 Attainment of Barnet pupils with a statement of SEN (5 A*-C grades including English and Mathematics) is in the top quartile in the country, ranked 20th nationally, whilst attainment of Barnet SEN pupils without a statement is in the top quartile in the country, ranked 33rd nationally.

#### 8.6.5.2 The Review of Future Needs, Key Issues

A review of future needs mapped the current provision against the range of needs of children with SEN in Barnet. It found that:

- The current pattern of provision of specialist places provided through a mix of special schools and resourced provisions within mainstream schools no longer best meets the geographic spread of demand across the Borough. This is resulting in a significant and growing transport cost and for some children, long journeys to school.
- The consistency in the current pattern of provision within the ARPs, particularly for children with Autistic Spectrum Difficulties and Speech, Language and Communication needs could be improved, both in the types of need catered for and the nature of the offer with regard to levels of inclusion within the mainstream setting in which the ARP is located.
- There is some overlap in the nature of needs that are being met within the four special schools and this is an increasingly common feature nationally.
- The number of post-16 pupils remaining in special schools is causing pressure on the availability of places for admission of younger pupils.
- There is an opportunity to improve the offer for children with significant SENs in the area of behavioural, emotional and social difficulties (now described in the new SEN Code of Practice as "social, emotional and mental health difficulties").

#### 8.6.5.3 Key Issues

- Future needs have considered how best to invest in order to both meet the increased demand and the increase in local provision, to meet parental aspirations and reduce transport costs. The review considered the cost, site availability, and range of pupil needs and concluded that future provision should be shaped through:
    - developing a pattern of smaller localised new provision within existing or newly commissioned mainstream schools;

- working with mainstream schools to improve provision within existing resourced provision, whilst sharing expertise across the network of provision;
- re-shaping provision within existing special schools;
- re-shaping the current offer for children with behavioural, emotional and social difficulties;
- developing an increased range of options for young people post-16.

#### 8.6.5.4 Conclusion

Initial engagement with head teachers regarding the findings of the review has established some shared principles so far:

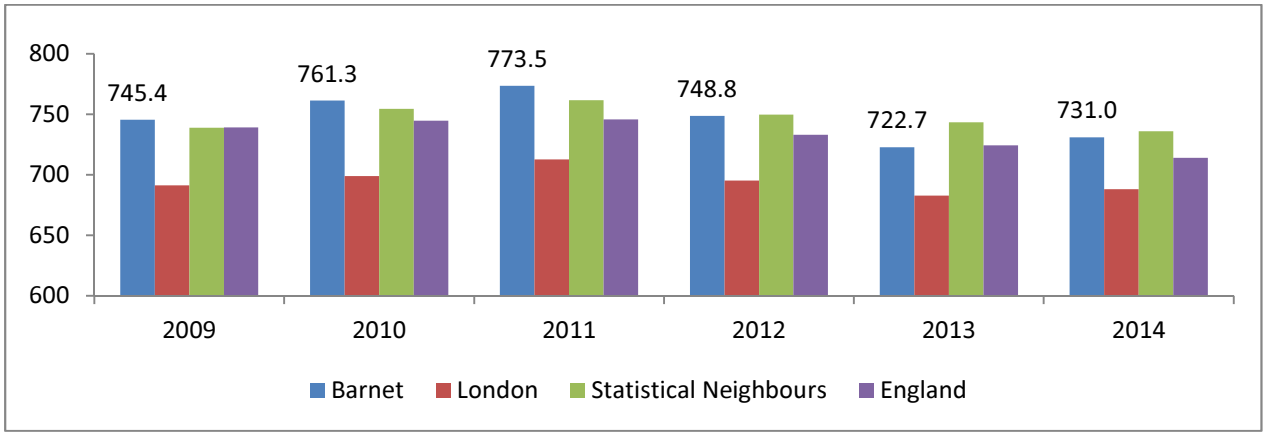
- The strategy for meeting the future needs of children with SEN should focus on the requirement to develop the right type of provision in the right place.
- The objective should be to develop local provision wherever possible.
- Flexible models of delivery should be considered.
- The current balance between mainstream and specialist provision is appropriate and should be maintained.
- Funding mechanisms should be designed to provide stability and enable planning for quality provision.
- The strategy should ensure equity of provision for SEND in and between schools and equity of funding based on outcomes.

It is expected that there will be a continuing programme of support and environmental improvement for mainstream schools and academies, to respond to complex needs of pupils in those schools.

### 8.6.6 Post-16 Education, Employment and Training

Key Stage 5 attainment (average point score per pupil) in Barnet is ranked in the top quartile, 26th nationally. By age 19, 89.3% of pupils attain a level 2 qualification (ranked 13th nationally), and 68.3% attain a level 3 qualification (ranked 11th nationally).

**Figure 8-4: APS per Candidate**

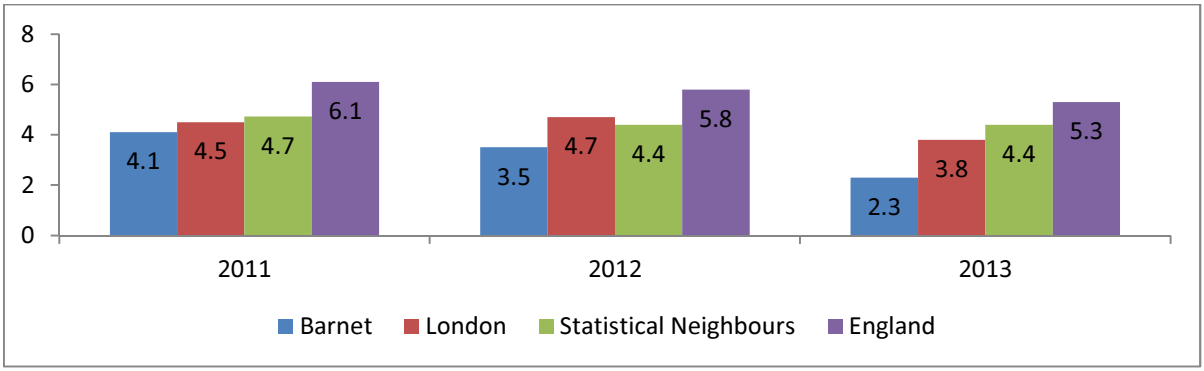



Source: www.gov.uk/government/statistics/a-level-and-other-level-3-results-2013-to-2014-revised

Barnet performs particularly well at ensuring all young people engage in education, employment or training up until age 19 with the proportion of 16 to 18 year olds not in education, employment or

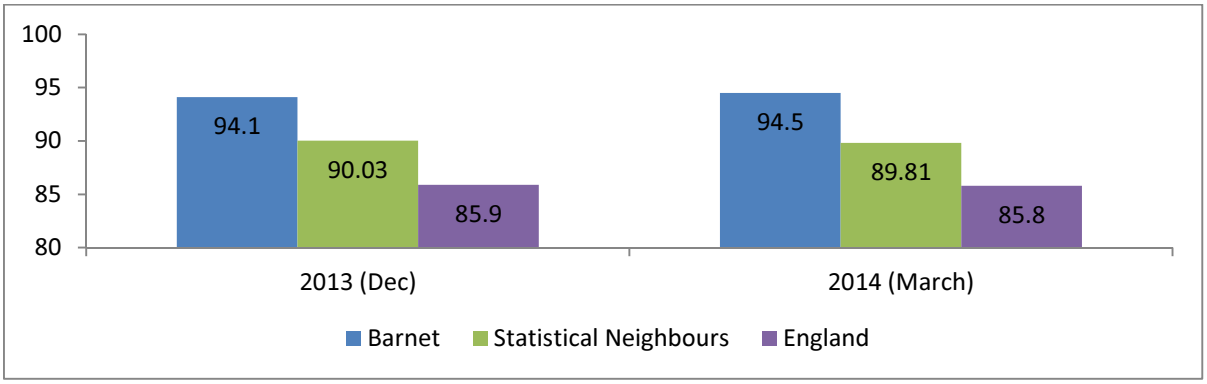
training (NEET) ranked 4th nationally. This success is continued for those pupils with learning difficulties or disabilities, where participation rates are ranked 9th nationally.

**Figure 8-5: % NEET**




**Source:** Local Authority Interactive Tool (LAIT)

**Figure 8-6: % Learning Difficulties and Disabilities (LDD) Recorded in Education and Training Aged 16 – 17 Years**




**Source:** Local Authority Interactive Tool (LAIT)

### 8.6.7 Raising Participation

The Education and Skills Act 2008 places a duty on all young people to participate in education or training until their 18th birthday. The first phase was introduced in 2013; young people are now required to continue in education or training until the end of the academic year in which they turn 17 years. From September 2015 they will be required to continue until their 18th birthday. Participation may be:

- full-time education at school, college, other provider
- an apprenticeship
- employment, self -employment or volunteering for 20 hours or more a week with part-time education or training

The Local authority is required to:

- promote the effective participation in education or training of all 16 and 17 years olds resident in Barnet.
- make arrangements to identify young people resident in Barnet who are not participating.
- provide advice and guidance to young people aged 16-18 who are not on the roll of an institution and who are deemed vulnerable.

- these new duties complement existing duties to:
    - secure sufficient and suitable education and training provision for all 16-19 years olds
    - track young people's participation.

**Participation in Barnet - June 2015**

The figures below demonstrate Barnet's progress towards full participation at June 2015 and the current level of NEET and 'Not Known' (the destination of the person is unknown and no information can be gained from other reliable sources).

**Table 8-6: In Learning**

| Year 12 | | | Year 13 | | | Year 14 | | | Year 12-14 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jun14 | Jun15 | Variation | Jun14 | Jun 15 | Variation | Jun14 | Jun15 | Variation | Jun14 | Jun15 | Variation |
| 97.2% | 97.9% | 0.7% | 94.1% | 97.5% | 3.4% | 80.2% | 83.0% | 2.8% | 90.7% | 93.1% | 2.4% |
| 3404 | 3438 | 34 | 3118 | 3487 | 369 | 2584 | 2677 | 93 | 9106 | 9602 | 496 |

Data Source: West London Partnership Support Unit

**Table 8-7: NEET**

| Year 12 | | | Year 13 | | | Year 14 | | | Year 12-14 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jun14 | Jun15 | Variation | Jun14 | Jun15 | Variation | Jun14 | Jun15 | Variation | Jun 14 | Jun 15 | Variation |
| 2.1% | 1.7% | -0.4% | 2.6% | 2.2% | -0.4% | 4.2% | 4.2% | 0.0% | 2.9% | 2.6% | -0.3% |
| 73 | 60 | -13 | 86 | 77 | -9 | 127 | 129 | 2 | 286 | 266 | -20 |

Data Source: West London Partnership Support Unit

**Table 8-8: Not Known**

| Year 12 | | | Year 13 | | | Year 14 | | | Year 12-14 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jun14 | Jun15 | Variation | Jun14 | Jun15 | Variation | Jun14 | Jun5 | Variation | Jun14 | Jun15 | Variation |
| 0.3% | 0.0% | -0.3% | 1.6% | 0.0% | -1.6% | 6.5% | 3.8% | -2.7% | 2.7% | 1.2% | -1.5% |
| 9 | 0 | -9 | 52 | 0 | -52 | 209 | 121 | -88 | 270 | 121 | -149 |

Data Source: West London Partnership Support Unit

Barnet is performing better in all three categories against statistical neighbours. The mean Indicator for statistical neighbours in May 2015 is 86.2% in year 12-14 in learning, 3.9% NEET and 5.9% Not Known.

## 8.7 Prevention and Early Intervention

Prevention and Early Intervention is about tackling problems experienced by children and families as early as possible to improve outcomes, and to lower costs. Barnet's approach to Prevention and Early Intervention has been organised according to three guiding principles: i) to intervene as early as possible; ii) to take a whole family approach; and iii) to use evidence-based monitoring systems.

A local needs analysis identified eight 'themes' or problems which are most likely to drive poor outcomes for Barnet families:

- Domestic violence
- Alcohol and/or drug misuse
- Mental health
- Parenting and neglect
- Unemployment
- Involvement with police

- Missing from school
- Child sexual exploitation

The needs analysis found that the 'toxic trio' of domestic violence, alcohol/drugs and mental health were significant factors triggering referrals to social care. Aligning early intervention and assessment to these themes will help to counteract projected pressures on social care services and other targeted and specialist resources.

The Barnet Early Help Offer consists of a set of services which deliver a Prevention and Early Intervention approach; it is formed of the following key components:

1. A Front door/triaging service- which assesses and signposts cases to early help services
2. A core set of council early help services including Children's Centres, the Intensive Family Focus Team and Youth Services
3. A set of commissioned services, where the council procures early help services from third parties – for example Child and Adolescent Mental Health Services (CAMHS)
4. Services provided by partners, such as services provided by the voluntary sector which are not commissioned by the council.

The Council is reviewing the above offer to ensure it is line with the eight themes identified in the needs analysis and is better integrated with partner agencies. Children and families fall into four categories of need, identified in the table below. Early identification of problems, assessment and intervention is achieved through the Common Assessment Framework (CAF).

**Table 8-9: Levels of Need**

| Level of need | Definition of this type of Need |
|---|---|
| **Level 1** | No identified additional needs. Response services are universal services |
| **Level 2** | Child's needs are not clear, not known or not being met. This is the threshold for beginning a Common Assessment. Response services are universal support services and/or targeted services |
| **Level 3** | Complex needs likely to require longer term intervention from statutory and/or specialist services. High level additional unmet needs - this will usually require a targeted integrated response, which will usually include a specialist service |
| **Level 4** | Acute needs, requiring statutory intensive support. This in particular includes the threshold for child protection which will require Children's Social Care Intervention |

### 8.7.1 Key Issues

- Strengthen the Barnet integrated offer of services across partner agencies to support children and families.
- Continue to build on work which has already started in remodelling services. Barnet has prioritised early years as part of its prevention and early intervention approach and has completed a comprehensive 18 month 'Early Years Review'. The review has recommended a locality model which is currently being developed. Barnet's 13 children's centres will be grouped into three 'localities' with the aim of focusing on identifying and supporting the most vulnerable and allowing staff and resources to be used more flexibly.

- Development of services to support children on the edge of care, specifically in the 10-15 age group, which support children and their families in the community and prevent the need for children to become looked-after.
- Update and strengthen the monitoring of CAFs and outcomes to ensure more needs are being met via the introduction of e-CAF; this will join up with phase II of the Troubled Families programme.
- Expand the reach of the CAF in some of the most deprived schools. For example, four schools with moderate to high deprivation percentages initiated zero CAFs in 2012/13 and 2013/14. As part of the Early Intervention Strategy a strategic approach to schools and Early Intervention is currently being developed, including considerable use of the pupil premium.
- Improve practice in relation to obtaining the voice of the child and working with diversity
- Increase the percentage of needs met/successful interventions in family support work and ensure plans are purposeful and interventions are focused.
- Improve the quality assurance processes from 'good' to 'best in class', by drawing on best practice in other Boroughs.

### 8.7.2 Multi-Agency Safeguarding Hub

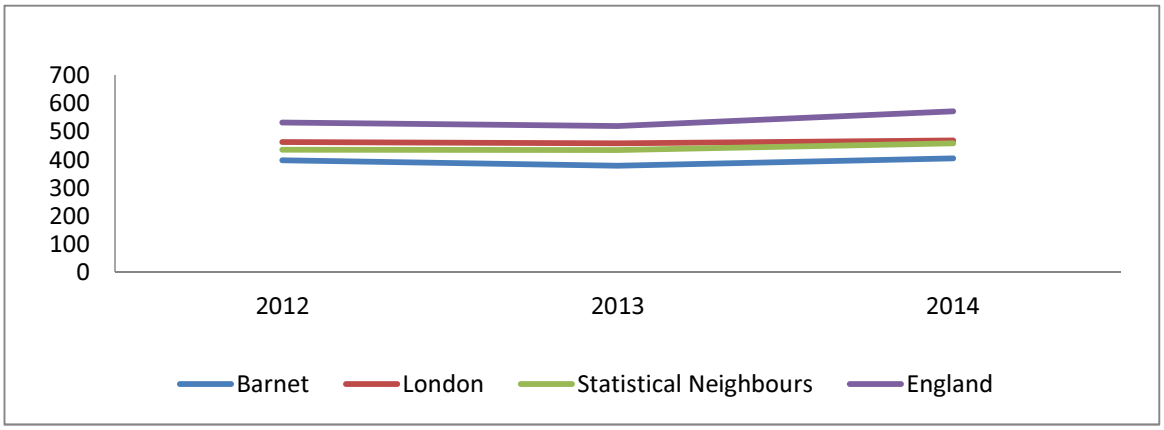
All agencies or individuals contacting Family Services with information, concerns or a query about a child or family are received through the Multi-Agency Safeguarding Hub (MASH). A number of these contacts will meet the threshold for a social care referral. In Barnet, contacts received into the MASH consistently exceed 3,000 per quarter. Contact rates nationally and across London have been increasing since 2013.

### 8.7.3 Children Supported by Social Care - Children in Need (CIN)

Children in Need are assessed as in need of support under Section 17 of the Children Act 1989, and due to challenging family situations or other forms of disadvantage are entitled to a range and level of services appropriate to their needs.

Barnet's Children in Need numbers saw a marked increase in 2010/11, but have remained consistently stable for the past 5 years. The graph below shows the Children in Need rate per 10,000 children.

**Figure 8-7*: Children in Need Rates per 10,000 of Referrals to Children's Social Care***



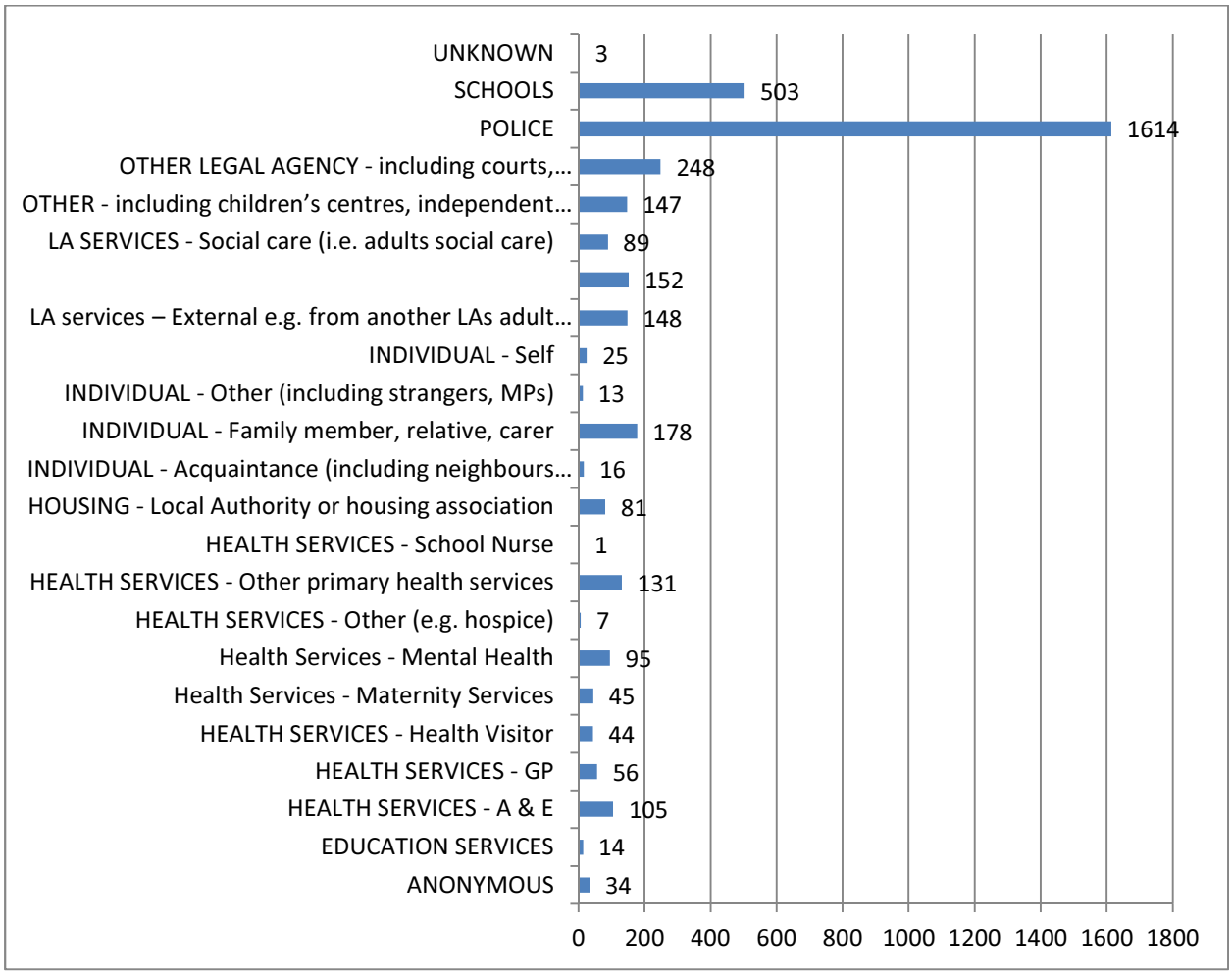

Source: Local Authority Interactive Tool

Since 2009, Barnet's rate of Children in Need, when compared to London, England and its Statistical Neighbours, has remained low. The trend for London, England and statistical neighbours has shown increased rates.

Children aged between 5 - 9 and 10 - 15 are the largest age group within this population, each making up 29% of the total population. This is closely followed by 1 - 4 years, who make up 25%. Overall, the age of Barnet's Children in Need is skewed towards younger age bands.

The figure below shows the number of referrals by referral source for the quarter 1 April – 30 June 2015.

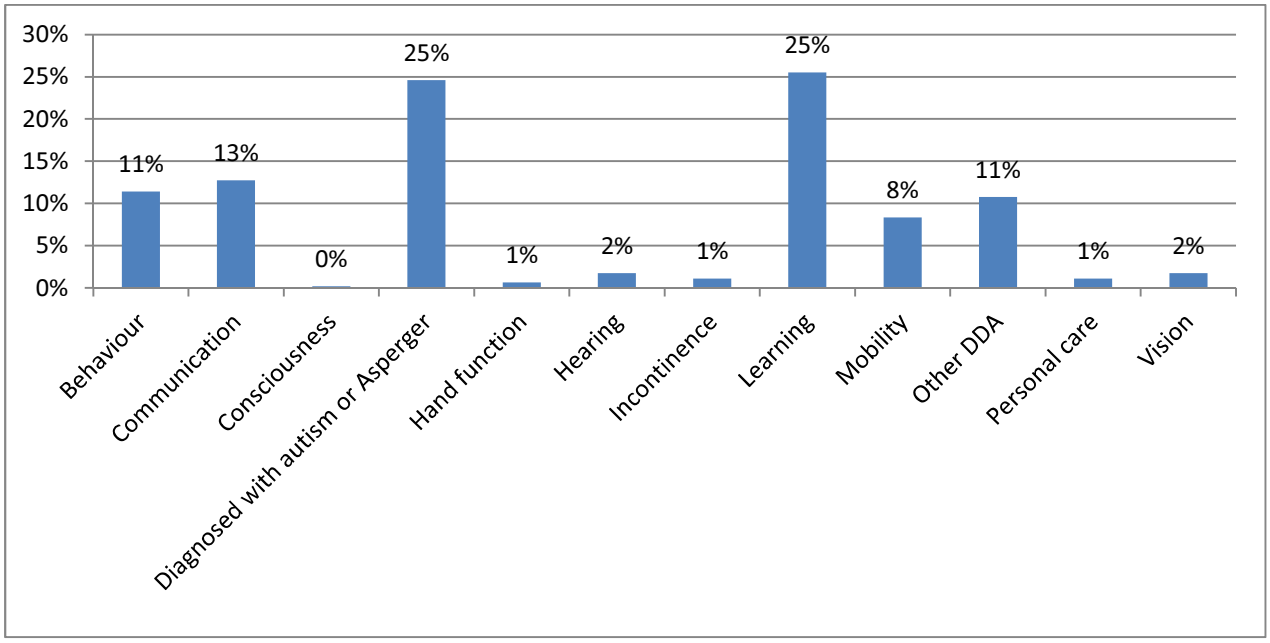
**Figure 8-8: Referrals by referral source, April-June 2015**




There are currently (June 2015) 455 service users aged 0-25[127] who have noted a Disability as an Active Category of Need.

[127] Data source ICS (includes all teams)

**Figure 8-9: CWD - Nature of Disability aged 0-25**




Source: ICS June 2015

Of those Children in Need with a disability, the highest percentage had a learning disability (25%) or autism (25%).

### 8.7.4 Children Supported by Social Care - Children Subject to a Child Protection Plan

A child at risk may be subject to a Child Protection Plan, which is intended to keep the child safe, promote their welfare and support their wider family to care for them. As of February 2015, 234 children in Barnet were subject to a Child Protection Plan. The largest category of abuse is shown to be neglect, at 47%, followed by emotional abuse (30%), physical abuse (19%), and sexual abuse (4%). Neglect has risen at a slightly higher rate than other categories in recent years.

The table below illustrates that the number of children subject to a Child Protection Plan has increased since 2009, with a peak in 2012.

**Table 8-10: Number of Children subject to a Child Protection Plan**

| Year | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | As at 28 February 2015 |
|---|---|---|---|---|---|---|---|
| Number of Children Subject to a Child Protection Plan | 152 | 201 | 210 | 256 | 206 | 208 | 234 |
| **Neglect** | 70 | 76 | 97 | 97 | 81 | 94 | 109 |
| % | **46%** | **38%** | **46%** | **38%** | **39%** | **45%** | |
| **Emotional** | 62 | 86 | 77 | 93 | 66 | 67 | 71 |
| % | **41%** | **43%** | **37%** | **36%** | **32%** | **32%** | |
| **Physical** | 17 | 33 | 28 | 51 | 44 | 42 | 45 |
| % | **11%** | **16%** | **13%** | **20%** | **21%** | **20%** | |
| **Sexual** | 2 | 6 | 6 | 15 | 11 | 4 | 9 |
| % | **1%** | **3%** | **3%** | **6%** | **5%** | **2%** | |

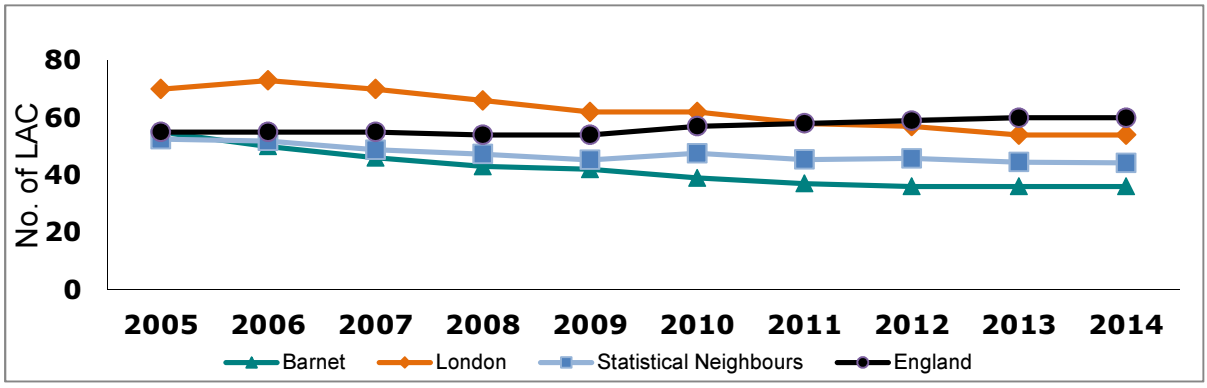
Source: Data extract from ICS data pulled 28 February 2015

### 8.7.5 Looked After Children (LAC)

Barnet's rate of Looked After Children per 10,000 children under 18 is low when compared to London, England, and statistical neighbours. The numbers of LAC over the past seven years has remained relatively stable, with an average of 308 children. In 2014, Barnet had a rate of 36 children in care per 10,000.

The trend over the past ten years shows Barnet's rate gradually reducing year on year, from a rate similar to England to a rate significantly lower. Barnet's rate of Looked After Children (36 children per 10,000 under 18) is low when compared to London, England, and statistical neighbours. This suggests that children in Barnet are supported effectively to remain with their families, where possible. However, in relation to actual number of Looked After Children, as opposed to the rate, Barnet has one of the highest numbers. This is due to the Borough's population size, which is predicted to be the highest in London in 2015.

**Figure 8-10: Looked After Children per 10,000**




Source: LAIT

The most common ethnicity for Barnet's Looked After Children is White (49%), followed by Mixed and Black or Black British ethnicity (18%). Barnet and London both have a much lower proportion of White children in care than across England, shown in Figure 3 below, which reflects the more ethnically diverse population across London. Compared to London, Barnet has a slightly higher proportion of Mixed and White Children in Care, and slightly lower proportions of Black or Asian Children.

**Table 8-11**: **Ethnicity of Barnet's Looked After Children**

| Ethnicity as at 28 February 2015 | Number of Children | % |
|---|---|---|
| White | 148 | 48% |
| Mixed | 56 | 18% |
| Black or Black British | 55 | 18% |
| Any Other | 20 | 6% |
| Asian or Asian British | 15 | 5% |
| Not stated | 13 | 4% |
| Gypsy/Roma | 1 | 0% |

Source: Data extract from ICS data pulled 28 February 2015

The predominant age for children becoming Looked After is 10 – 15 years (38% of the Barnet cohort fall into this age band). Children aged 5 – 9 years make up 25% of the cohort. 60% of children currently in Barnet's care are males, compared to 40% of females. This is reflective of the national picture.

Barnet has a high proportion of Children in Care in residential placement[128] which stands at 22% (March 2014), this is both higher than London and national averages. 25.4% of children and young people are placed out of Borough. Children placed in foster care as at March 2014 was 69%, which is below statistical neighbours (73%) and the England average (75%). There is considerable demand for increased foster placements locally and significant demand pressures relating to the cost of out of Borough placements and specialist placements for children and young people with complex needs. Gaps in the provision of in-house foster placements are identified as: children over the age of 11, sibling groups, and children with complex emotional and behavioural needs.

SEN rates for Barnet Looked After Children are much higher than for Barnet pupils generally and higher than the England rate. At key stage4 (2010-14) attainment of Barnet pupils who are Looked After Children (5 A*- C including English and Maths) is better than the national attainment for Looked After Children, but well below that of all pupils in Barnet and nationally.

### 8.7.6 Care Leavers

A Care Leaver is a young person who has been looked after away from home by a local authority for at least 13 weeks since the age of 14, and who was still in care on their 16th birthday. Barnet's number of Care Leavers has remained relatively unchanged since 2010. As of February 2015 there were 279 Care Leavers in Barnet.

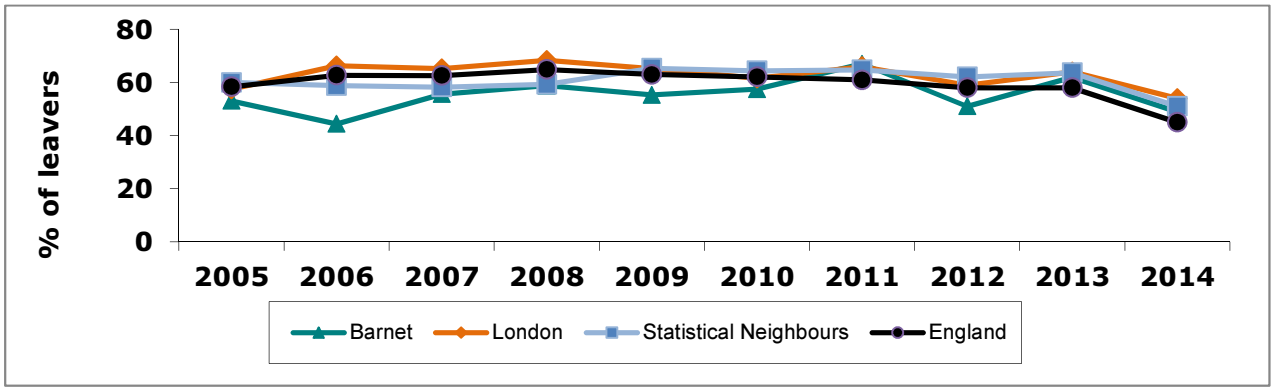
For the past 2 years, Barnet's rate of Care Leavers in Suitable Accommodation has been higher than that of London, England and statistical neighbours.

**Table 8-12: Number of Care Leavers in Barnet**

| Year | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | Feb 2015 |
|---|---|---|---|---|---|---|---|
| Number of Care Leavers | 297 | 278 | 266 | 274 | 267 | 266 | 279 |

The graph below shows that Barnet's Care Leavers in Education, Employment or Training (EET) has fluctuated since 2005. In 2014, Barnet's rate was similar to London and statistical neighbours and higher than England. All comparators have seen a decline in figures, with one of the lowest percentages of Care Leavers in EET when compared to the past nine years.

**Figure 8-11: Care Leavers (aged 19, 20 and 21) – Education, Employment and Training**




Source: LAIT

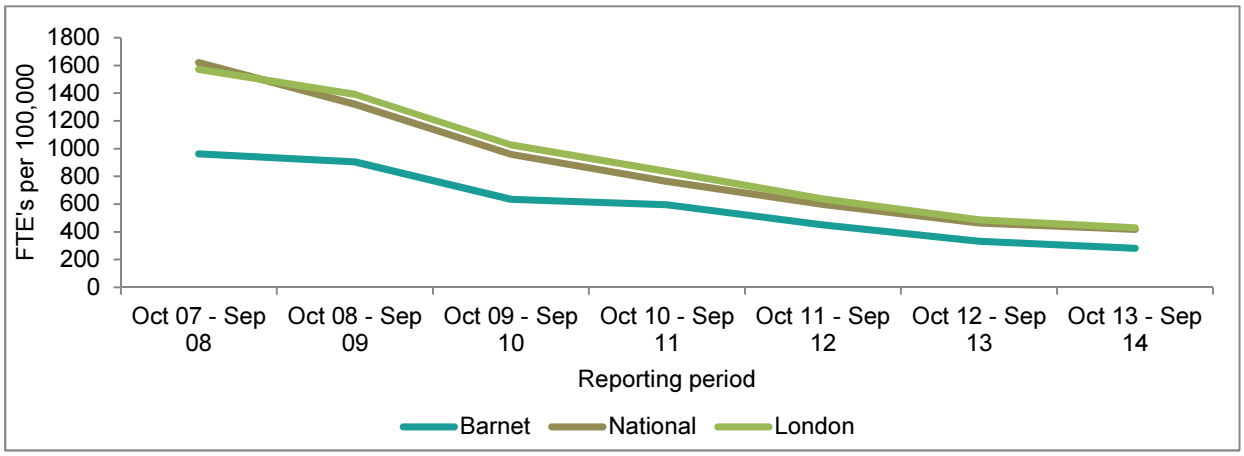
[128] Residential placements as defined in OFSTED social care data 31st March2014

## 8.8 Young People who Offend or Reoffend

### 8.8.1 First Time Entrants (FTE)

A first time entrant is defined as a young person aged under 18 at the time of their offence entering into the justice system for the first time. The data in Figure 8-12 represents the most recently published figures from the Youth Justice Board. Barnet continues to have a lower FTE per 100,000 rate compared to National and London figures.

**Figure 8-12: Rate of First Time Entrants per 100,000**



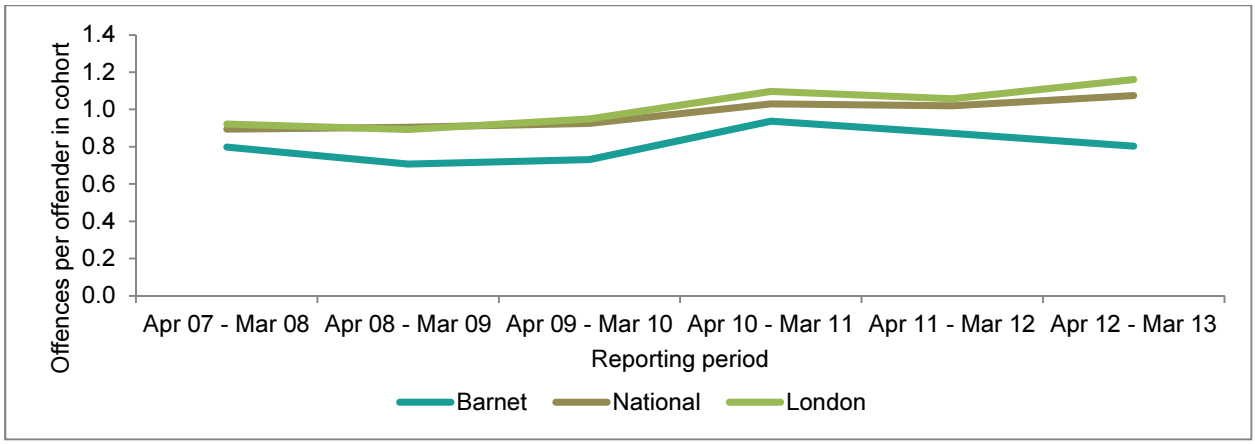

Source: Youth Justice Management information System

There is a need to improve access to Child and Adolescent Mental Health Services, Speech & Language Therapy and school nurse provisions as well as additional access to mentors. If these provision issues were resolved, the service would be better equipped to engage with young people before they enter the justice system and become FTEs. This is likely to have a positive impact on Barnet's already low FTE numbers.

### 8.8.2 Re-Offending

A young person aged 17 or under at the time of their offence, is tracked for 12 months and their re-offending behaviour is reported on. The data in Figure 2 represents the most recently published figures from the Youth Justice Board. Barnet continues to perform well compared to National and London figures, particularly in regard to the number of offences the tracked offender commits in the 12 month period.

**Figure 8-13: Number of offences per offender**




Source: Youth Justice Management information System

An increase in suitable education provision in schools has been identified for hard-to-reach young people which should include the following to improve outcomes:

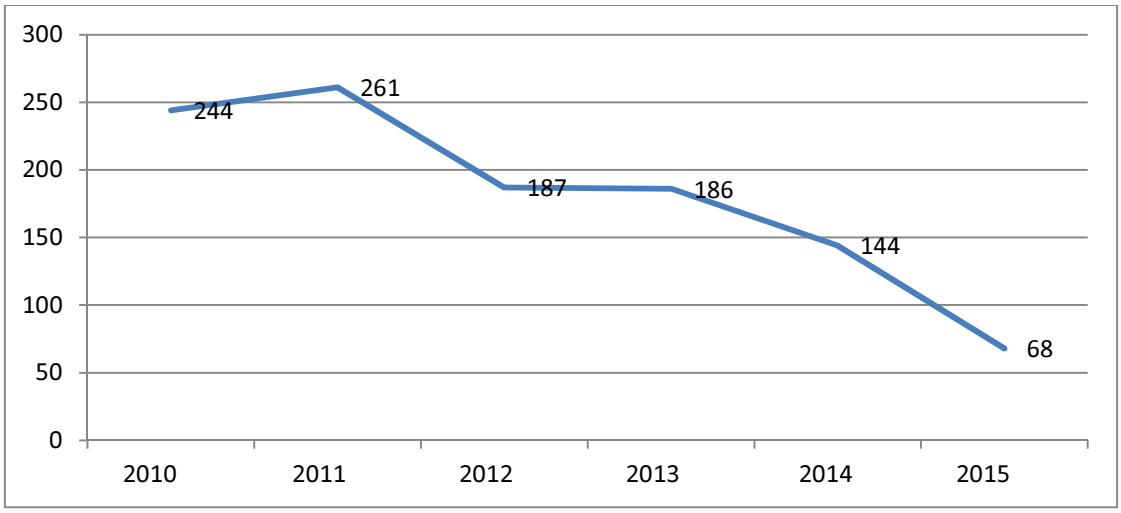
- additional support and mentoring.
- interventions which target the needs of the male BME population.
- physical health provision in the form of a school nurse who can deliver training in first aid/sexual health.
- CSE screening.

The rate of re-offending is decreasing; however, there has been an increase in the seriousness of offending by a small proportion of young people who are associated with gangs. This small cohort of young people has been targeted for support and turnaround through multi –agency interventions and evidence-based intervention.

### 8.8.3 Number of Statutory Programmes

A young person is sentenced to a statutory order at court and their order is overseen by the Youth Offending Team (YOT). Whilst the number of young people supervised by the YOT has fallen over the years due to more preventative work, those young people under supervision are very complex and high risk offenders. This graph refers to the number of statutory programmes started[129], by year of start date (the 2015 figure is as at June 2015).

**Figure 8-14: Number of Statutory Programmes started, 2010-2015**




## 8.9 Child Sexual Exploitation (CSE)

CSE is a type of sexual abuse in which children are sexually exploited for money, power or status. A range of recent reports, national media coverage and recent convictions of perpetrators highlight that this form of child abuse is often hidden from sight and preys on the most vulnerable in the society. CSE is a priority of the Barnet Safeguarding Children Board.

In 2014/15 there were 129 referrals to the MASH (Multi-Agency Safeguarding Hub) reporting concerns about CSE, of these 73% (94) were female. A report from Barnardo's based on evidence from over 9,000 records for CSE in England found that 66% of records belonged to girls, which is broadly in line with the gender split of Barnet MASH contacts. However, the report points out that

[129] Number of programmes started, rather than number of young people

there are a number of barriers to disclosure specific to boys and young men, such as discriminatory social attitudes and expectations of 'masculine' behavior, so the figures may not accurately reflect the realities of CSE locally or nationally. Further analysis of the profile of child at risk of CSE is ongoing.

## 8.10 Gangs

A gang is a 'relatively durable, predominantly street-based group of young people who:

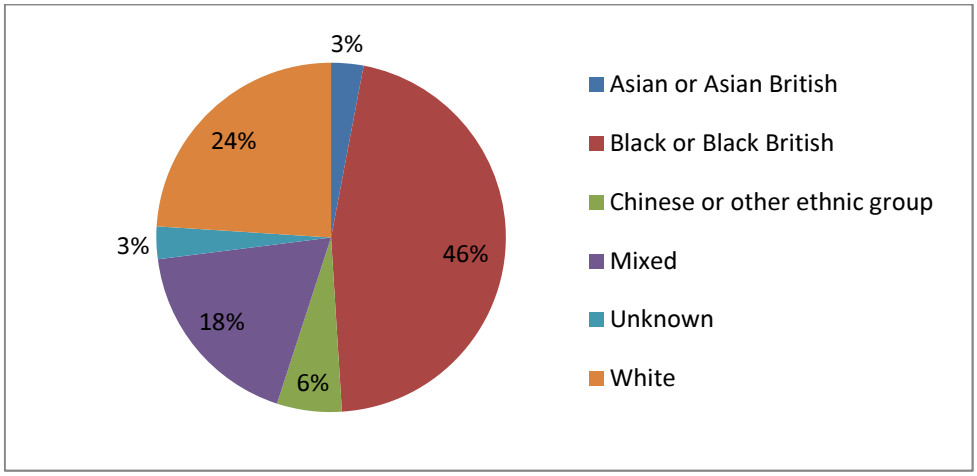
(1) See themselves (and are seen by others) as a discernible group, and
(2) Engage in a range of criminal activity and violence'

In Barnet there are some localised issues of young people affected by serious youth violence and gangs mainly in the west of the Borough.

Evidence has suggested that there is strong correlation with the supply of drugs and gang affiliation in Barnet. However the activities of particular gangs have also generated youth violence.

In Barnet, 59% of the most serious gang offenders rated as Red or Amber (red being the most serious) are aged 19 or younger. 45% of offenders are Black or Black British and all are male.

**Figure 8-15: Ethnicity of known children in Barnet in Gangs**




All young people in Barnet known to be in gangs are male. Although there are no gang members currently known to services who are girls, there is a cohort that is likely to be linked to or associated with gang members. The majority of young people identified as being at risk of entering a gang or being a victim of gang activity are white, although this group is under-represented when compared to the Barnet population. However, black young people in Barnet are over-represented and nearly three times more at risk of being affected by gang activity than young people outside of this cohort.

The following principles underpin the Barnet Youth Crime Prevention Strategy and are based on the Home Office assessment against the national and international experience and learning from working with gangs:

- strong local leadership;
- mapping the problem;
- assessment and referral;

- targeted and effective interventions; enforcement, pathways out and prevention;
- criminal Justice and breaking the cycle;
- mobilising communities.

## 8.11 Missing

Recent research by The National Missing Persons Helpline has revealed that nationally, one child runs away from home or is forced to leave home every five minutes.

Approximately 77% of those children are under 16 years and running away for the first time. Around a third of children in care run away three times or more. Children may run away from a problem (e.g. abuse or neglect at home) or to go somewhere they want to be. They may also have been coerced to run away.

It is thought that approximately 25 per cent of children and young people that go missing are at risk of serious harm. There are particular concerns about the links between children running away and risk of sexual exploitation. Missing children may also be vulnerable to other forms of exploitation such as violent crime, gang exploitation, or drug and alcohol misuse.

In Barnet, known children and young people of all ages go missing, though the likelihood increases when children are in their teenage years. Of the known cohort, missing children are predominantly white and marginally more likely to be female.

**Figure 8-16: Ethnicity of known children missing from care or home**

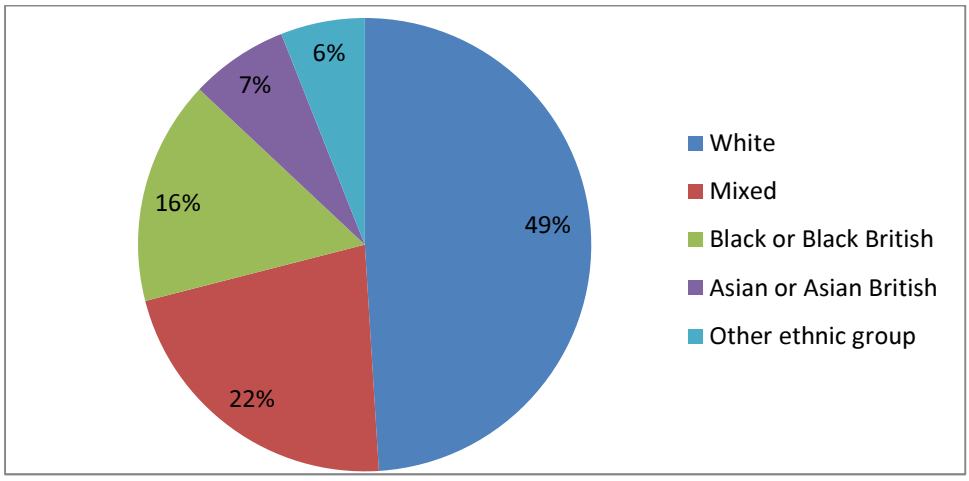
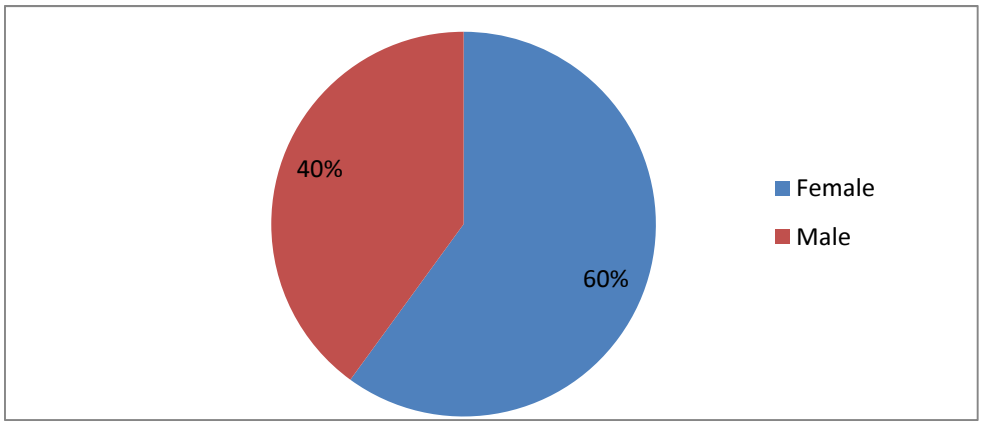



**Figure 8-17: Gender of known children missing from care or home**



Of those children identified as being most at risk of going missing in Barnet, 40% are male and 60% are female. White children are most at risk of going missing from home, care, or school, although this group is under-represented when compared to the Barnet population, as is the Asian cohort of children. The black and mixed populations are over-represented and therefore more at risk.

The age profile of children at risk of going missing is similar to that of known missing cases. A larger number of children are at risk of going missing between the ages of six and ten and at the age of 16.

## 8.12 Domestic Violence, Parental Substance Misuse, Parental Mental Ill Health (Toxic Trio)

An analysis of random samples of CAFS in Barnet found the 'toxic trio' of domestic violence, mental ill-health and drug and alcohol misuse in families amongst the most prevalent causes of poor outcomes for children. From the sampled CAF cases, DV featured in 90% of the cases, substance misuse in 40%, and 20% of cases had significant mental ill-health concerns. Since April 2014 and when MASH started recording presenting issues, nearly a quarter were identified as having domestic violence present in the family. Of these domestic violence cases, 13% progressed under the social care threshold to CAF whereas over double that amount progressed over the threshold to social care (28%).

### 8.12.1 Multi-Agency Risk Assessment Conference (MARAC)

In the last three financial years, there has been a steady increase in the number of referrals of domestic violence to the MARAC (*2012-13* **= 175,** *2013-14***= 234,** *2014-15***= 311**) which is interpreted as the impact of the interventions that have been put in place to heighten the awareness of agencies and the public.

Of the 311 cases discussed by Barnet's MARAC between 1 January and 31 December 2014, 95% were a female victim of domestic violence, and 5% male. The predominant age band of victims of domestic violence in Barnet is between 21–30 years in 38% of cases, followed by those aged between 31–40 years in 25% of cases. The most common ethnicity is White with 58%, followed by any Other and Black with 12%. Police data and referral data highlights Burnt Oak, Colindale and small pockets of Mill Hill to the west and Brunswick Park ward to the east as primary areas for incidences of domestic violence.

Parental alcohol or substance misuse was present in 20% of Child Protection and 40% of Looked After Children cases (for reference Barnet has circa 238 Child Protection cases and circa 300 Looked After Children cases).

Substance misuse among parents of children and young people referred to social care is spread around the Borough, though Grahame Park and surrounding areas have the highest concentration in the Borough. Other areas where parental substance abuse is a problem are pockets in Brunswick Park, East Barnet and Edgware.

A national study found that around three in ten adults will experience mental health problems every year but only three quarters of these will access services. This year (2015) around 16% (58,600) of adults in Barnet have a mental health condition. This is expected to increase by 6% to 62,300 by 2020. Mental health conditions among parents of children referred to care is of particular concern in the more deprived areas of the Borough. The Dollis Valley estate in Underhill, pockets in Brunswick Park and the A5 corridor from Colindale to Edgware are the worst affected areas.

Barnet commissions a number of services to provide support for those affected by domestic violence, mental ill-health and drug and alcohol misuse. Domestic violence support services include refuges, perpetrator and partner programmes and an advocacy service. Barnet Drug and Alcohol Service provide advice and information, drop-in services, psychiatric treatment, psychological therapies, social interventions and complementary therapies. Parenting support services include five Parenting Programmes for hard-to-reach families. The community coaching service recruits and trains community coaches to provide targeted support to vulnerable families in crisis. Since April 2014 there have been increases in the number of MASH contacts for 'toxic trio' cases being referred to Early Intervention services.

### 8.12.2 Key Issues

- The Barnet Early Intervention and Prevention (EIP) strategy identified that CAFs are not identifying or intervening early enough in cases of domestic violence, mental ill-health and drug and alcohol misuse.
- A need to refresh and strengthen referral pathways as the issues of domestic violence, mental ill-health and drug and alcohol misuse are still present in social care referrals
- Increase the numbers of CAFs across the partnership to deliver Barnet's key principles of intervening as early as possible and taking a whole family approach.
- Continue to strengthen the interface between Family and Adult Services to address the issues of domestic violence, mental ill-health and drug and alcohol misuse. This is particularly to ensure children of parents receiving substance misuse treatment are known to Family Service and/are signposted to services appropriately to encourage de–escalation and step down.
- Working alongside the Safeguarding Children's and Adults boards to address the overlap of issues and adapting services and referral pathways.
- Working to bring in more referrals in line with CAADA's Co-ordinated Action Against Domestic Abuse estimation of cases, per Borough population.
- A comprehensive process to conduct Domestic Homicide Reviews

## 8.13 Child and Adolescent Mental Health

### 8.13.1 Prevalence of Mental Health Disorders in Barnet children and young People

Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and gender in Barnet. Note that the numbers in the age groups 5-10 years and 11-16 years do not add up to those in the 5-16 year age group as the rates are different within each age group.

**Table 8-13: Estimated Number of Children with Mental Health Disorders by Age Group and Sex**

| | Aged 5-10 yrs. | Aged 11-16 yrs. | Aged 5-16 yrs. |
|---|---|---|---|
| **All** | 2,155 | 2,965 | **5,160** |
| **Boys** | 1,470 | 1,695 | **3,175** |
| **Girls** | **695** | **1,275** | **2,020** |

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report); Office for National Statistics midyear population estimates for 2012 (local authority report). Green, H. et al (2004)

It is important to note that Barnet has a higher number of children and young people in mainstream school with a special educational need that London; 21% in Barnet primary schools against 17% in London's, and for secondary schools in Barnet 22% against 21% in London. Therefore CAMHS services may be well placed in schools.

### 8.13.2 Prevalence Rates of Mental Health Disorders [130]

The estimated proportion of children and young people to have conduct, emotional and hyperkinetic and less common disorders in Barnet are as follows:

- conduct disorder: 5.8% (3022, 5 – 16 year olds[131])
- emotional disorder: 3.8% (2,014 5- 16 year olds)
- hyperkinetic disorder: 2.2% (1,149, 5 – 16 year olds)
- other less common disorders[132] (730)
- overall admission rate (per 100,000) for mental disorders for under 18 years in Barnet is 167.6, which is 2nd highest in London compared with London at 87.1 and England at 87.6 (see below).
- expenditure rate on child and adolescent mental disorder was £1.1m which was mid-range compared to most other London Boroughs
- ***total spend on child and adolescent mental disorder in 2012/13: £3.7m.***
- a study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 years inclusive, living in private households. The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Barnet.
- the most prevalent conditions are Conduct Disorder at an estimated 3,095 5-16 year olds and Mixed Anxiety and Depressive disorder at an estimated 1,405 16 – 19 year olds.
- greater incidence of Mental Health Problems are found in young people with Learning Disabilities; with Special Educational Needs; who are looked after; homeless or sleeping rough; who attempt suicide or self-harm or; who are in the youth justice system.

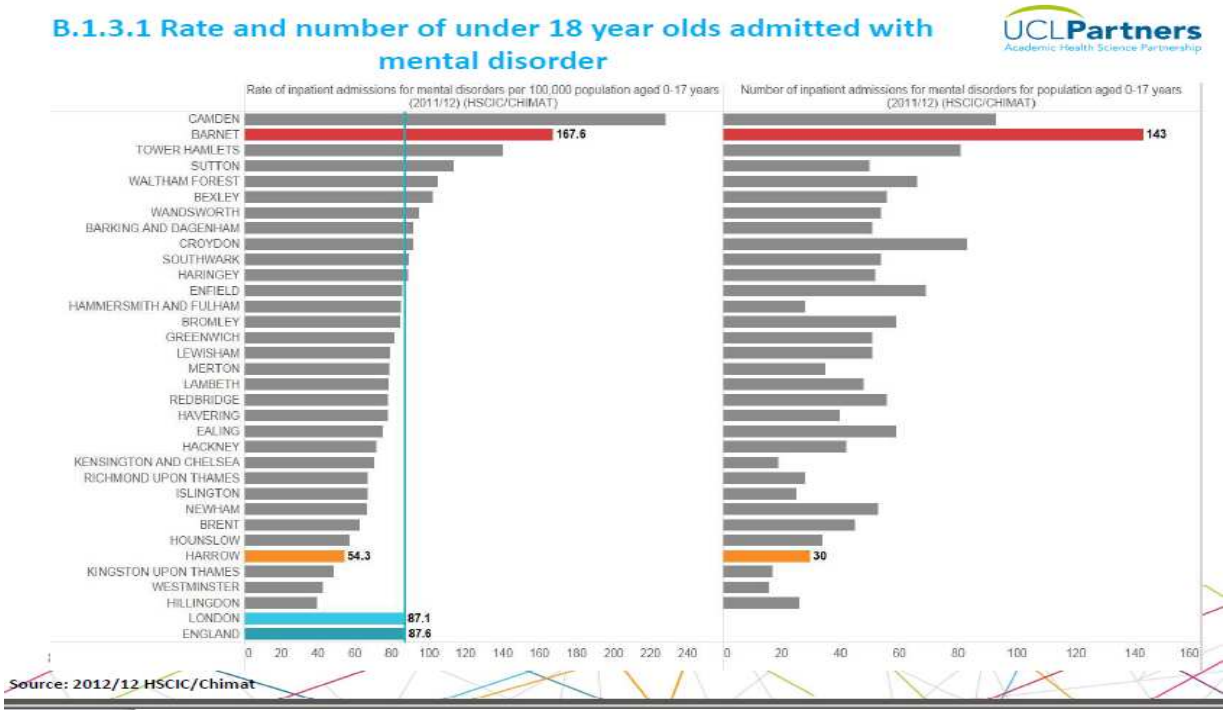
**Table 8-14: Estimated number of 16 to 19 year olds with neurotic disorders**

| | Males | Females |
|---|---|---|
| **Mixed anxiety and depressive disorder** | 435 | 970 |
| **Generalised anxiety disorder** | 135 | 90 |
| **Depressive episode** | 80 | 215 |
| **All phobias** | 55 | 165 |
| **Obsessive compulsive disorder** | 80 | 75 |
| **Panic disorder** | 45 | 50 |
| **Any neurotic disorder** | 730 | 1,500 |

Source: Office for National Statistics mid-year population estimates for 2012.

[130] Extracted from Children and Adolescent Mental Health Service (CAMHS) – Barnet (26.01.2015) Dr Neel Bhaduri, Draft V2
[131] Children and Adolescent Mental Health Services (CAMHS) – Barnet DRAFT (14.01.2015) Dr Neel Bhaduri, Draft V1
[132] Barnet CAMHS NEEDS ASSESSMENT V2

**Figure 8-18: Admission for under 18 year olds in Barnet with mental disorder**




### *8.13.3* Key Issues/Challenges

- young people voted mental health as one of their top service/needs priorities at a Children's Trust Board event.
- implementation of the CAPA and improving Access to Psychological Therapies
- re-modelling of CAMHS through a jointly developed specification with CCG and public health that invests in prevention and early intervention
- transition to adult services is a challenge

Although Barnet appears to be providing a range of good services, there remains considerable challenge to transform the service. The CAMHS core group is working to implement recommendations from previous Barnet reviews and national recommendations

## 8.14 Young Carers

According to the 2011 census there are 166,363 young carers living in Barnet, which is an increase of 20% from the 139,000 in 2001. However this figure does not reflect the scale of young carers in Barnet. Many young carers remain hidden for many reasons including family loyalty, stigma, bullying or not knowing where to go for support. The Children's Society estimates there could be up to four times more young carers, approximately 700,000[133]. This research also suggests 4.5% of children and young people identify themselves as having a caring responsibility. In Barnet this would equate to around 3,900 young carers. Currently the lead provider of support services for young carers in Barnet has a register of approximately 540 children and young people with a caring responsibility.

A young carer is likely to:

- be Black, Asian and Minority Ethnic, have a disability, long-term illness or Special Educational Needs.

[133] The Children's Society (2013), *Hidden from view,* http://www.childrenssociety.org.uk/sites/default/files/tcs/hidden_from_view_-_final.pdf

- care for siblings and adults with physical or mental problems, or a learning difficulty
- care for up to 15 hours per week, but some even up to 30
- miss out on school, have lower GCSE results than peers and be NEET, or if employed be in a lower skilled occupation
- have parents who are not in work, one with a disability and a mother with no educational qualifications
- have a lower family income and more than three children in their family
- not be in contact with support agencies.

The current lead provider in Barnet of support services to young carers provides support through respite clubs, counselling and mentoring. A school liaison service is provided which delivers support using leaflets, 1:1's and group work, as well as presentations to increase the awareness of, and identify young carers. There is also a service to provide help to young carers affected by drug or alcohol misuse by parents or siblings and a service which provides specific assessments and focuses on transitional issues such as education, training and work.

The Care Act 2014 and the Children and Families Act 2014 together provide a framework to ensure inappropriate caring for young people is prevented or reduced and whole family needs are met. The Acts give young carers and parents similar rights to assessment as other carers have under the Care Act. For the first time carers are being recognised by law in the same way as those they care for and are eligible for assessment and support.

In line with recent legislative changes, Barnet will develop a strategy for the vision and future delivery of young carers' services alongside a needs analysis to ensure service delivery is needs led. Barnet will continue to improve outcomes for young carers and their families. Priorities in order to do this include:

- Proactive identification through training and raising awareness amongst key practitioners and partner agencies to ensure young carers do not remain hidden
- Strengthening referral pathways.
- Joint working with Adults and Communities delivery unit to undertake appropriate whole family approach assessments to prevent young carers providing inappropriate levels of care and ensure whole family needs are met.
- Providing individualised, tailored and appropriate support to young carers so each young carer can achieve their potential and have the same opportunities to progress in life as their peers.
- Ensuring young carers are signposted to and access existing mainstream as well as specialist support services.
- Provide transitions assessments and planning to support young carers prepare for adulthood and raise and fulfil their aspirations.

### 8.14.1 Scale

- The number of young carers in the UK has increased by 20% from 2001 to 2011.
- However, in Barnet the numbers of young carers has increased by 30% to 1,191 young carers which is 2% of the under 18 population.
- Research estimates that there could be up to four times more young carers. Using these estimates, young carers as a percentage of the 0 - 18 population in Barnet increases from to

2% to 8%. This would mean nearly 1 in 10 children and young people are providing some level of unpaid care.

- The provider of young carers' services in Barnet has 627 young carers registered (April 2015).

### 8.14.2 Age

- In Barnet there are high proportions of young carers under the age of ten and between 16 and 24:
    - One in eight are under ten years
    - Two thirds of 0 – 24 year olds were aged 18 - 24
- Provider data shows good identification of children and young people under 15 years old. However, there is a large gap in identification of 16 – 17 year olds. Evidence shows a clear association between being a young carer at 16 – 19 and being NEET.
- There is a need to ensure sufficient support for young carers under nine as well as increased identification and support for young carers in transition age. This needs to be addressed in a joint commissioning process.

### 8.14.3 Ethnicity

National research shows young carers are 1.5 times more likely to be Black, or Minority Ethnic and less likely to identify as a young carer. In Barnet younger cohorts are more diverse than older age groups. This confirms the need to ensure sufficient identification and support for children under 10.

### 8.14.4 Disability, long term illness, SEN

- National research shows young carers are 1.5 times more likely to have a disability, long term illness or special educational needs.
- The largest age cohorts on Barnet's Disabled Children's Register and classed as SEN on Barnet's school rolls are 5 – 9 and 10 – 14 years old. This confirms the need to ensure sufficient identification and support for children under ten years old.
- Provider data shows the number of young carers with a disability has been increasing and is now over a third of all young carers registered.
- According to census figures, one in five young carers would describe their health as poor or fairly good.
- This shows the importance of young carers having their own needs assessed and supported.

### 8.14.5 Caring responsibilities

Research shows young carers providing unpaid care who are not in contact with services are likely to be caring for siblings and grandparents. Therefore:

- Identification should focus on services which siblings and grandparents access
- A section on what types of needs young carers are supporting is currently being developed

### 8.14.6 Impact of caring responsibilities

- Evidence shows a clear association between being a young carer at 16 - 19 years old and having low job prospects and educational opportunities. As well as being a young carer at 20 to 21 years and being in lower skilled occupations.

- In Barnet the proportion of 16 to 18 year olds who are NEET is ranked 4th nationally and 9th nationally for participation rates for pupils with learning difficulties or disabilities.
- It is therefore important that the provision of this support is inclusive and accessible for young carers.

## 8.15 Child Poverty

### 8.15.1 Headlines:

- 21.2% of children living in Barnet live in poverty; a total of 17,330 children.
- Barnet has a lower level of child poverty than the London average (36%), but a slightly higher rate than the England average (20.6%). However, there are geographic variations across Barnet, ranging from just 7.7% in Garden Suburb to 37.5% in Colindale.
- In general there is a propensity for a greater number of areas in the west of the Borough to be affected by child poverty and the factors that directly and indirectly influence it.
- The following groups are likely to be more at risk of poverty than others: lone parents, large families, families affected by disability, and black and minority ethnic groups.

According to the 2010 Child Poverty Act, a child is defined as being in poverty when he/she lives in a household with an income below 60% of the UK's average. Although at the time of writing a new national definition of child poverty is currently being developed, throughout this JSNA child poverty will be defined based upon the definition put forward by the 2010 Child Poverty Act.

A third of all children in the UK live in poverty[134]. Child poverty touches all areas of a child's life, from the home they live in to their health, educational attainment, involvement in crime and social exclusion. Indeed, poverty is the most significant general indicator of risk. The Government has a statutory requirement, enshrined in the Child Poverty Act 2010, to end child poverty by 2020.

Families living in poverty can have as little as **£12 per person per day** to buy everything they need such as food, heating, toys, clothes, electricity and transport.

Research at the national level indicates that the following groups are more at risk of poverty than others:

**Lone parents**
In Barnet, there are 10,026 lone parent households[135] with dependent children. Of these lone parents, 46% are not in employment. National statistics show that women accounted for 92% of lone parents with dependent children and these percentages have changed little since 2001.

**Large families**
Around half of Bangladeshi and Pakistani children, and around a third of black African children, are in families of three or more children compared to around a sixth of white British children[136]. A higher proportion of families from ethnic minority groups can be found in Barnet have more deprived wards. Furthermore, there is a minority of ultra-orthodox Jewish families living in Barnet, particularly in and around the Golders Green ward, where family sizes are typically larger.

**Families affected by disability**

[134] Using the measure of household income less than 60 per cent of current median income. Source: HMRC snapshot as at 31 August 2012, IMD 2010, DoE Child Poverty Dataset
[135] 2011 Census
[136] Palmer and Kenway (2007),'Poverty Rates among Ethnic Groups in Great Britain'

Four in every ten disabled children live in poverty[137]. The Children's Society has warned that the new Universal Credit benefit system may have an adverse impact on families affected by disability.

**Black, Asian and minority ethnic groups**

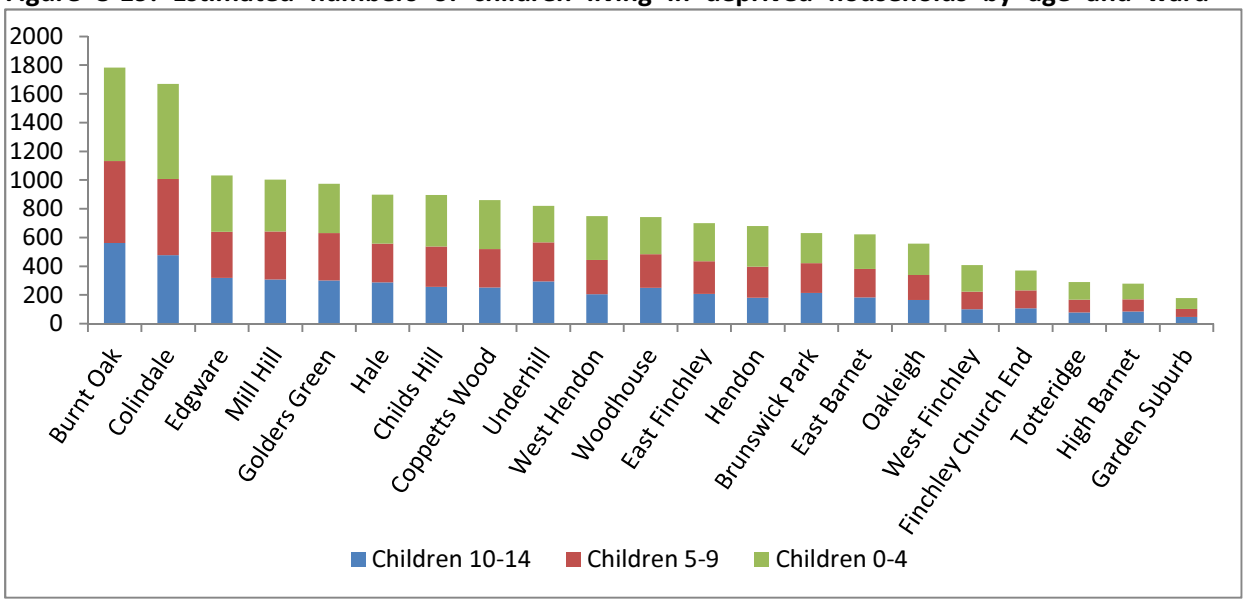
Nationally in 2010, nearly three-quarters of seven-year-old Pakistani and Bangladeshi children and just over half of those black children of the same age were living in poverty. Barnet has a Black, Asian and Minority Ethnic average of 39%. However, in Colindale, Burnt Oak and Hendon, Black Asian and Minority Ethnic residents make up over half of the population.

There is also a strong link between child poverty and unemployment or low levels of income. The percentage of low income families has decreased in Barnet since 2007 to 17.3% in 2012, a trend in line with the London and UK picture.

The number of children living in poverty in Barnet is 21.2%[138] - which is slightly higher than the UK average (20.6%). This makes Barnet the Borough with the 25th highest rate of child poverty of the 33 London Authorities.

Children living in poverty are not distributed equally across the Borough and there is a strong correlation between child poverty and deprived LSOAs in Barnet. In turn, the proportion of Black, Asian and Minority Ethnic residents is higher in these areas.

**Figure 8-19: Estimated numbers of children living in deprived households by age and ward**



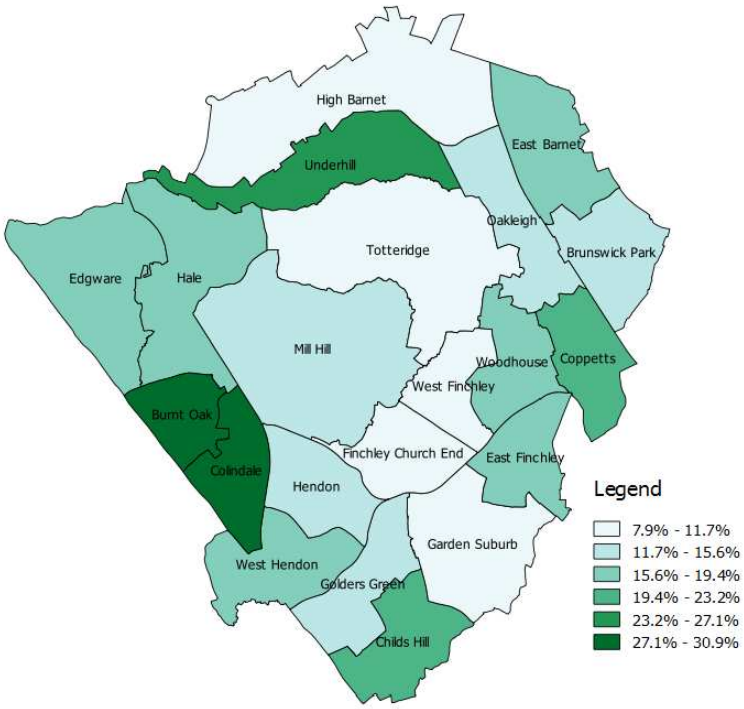

Source: HMRC, 2010

The highest rates of child poverty are in the west of the Borough, in particular Burnt Oak (36%) and Colindale (37.5%)[139], which exceed the national and London averages. Colindale and Burnt Oak also have the highest proportion of children living in low-income families, with just over one third of the children living in low-income families.

Underhill, Child's Hill and Coppetts are the wards with the next highest rates of poverty, with Underhill at 26.2% and the other wards both at 25%

[137] http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/child-poverty/disabled-children-and-poverty-0
[138] 2010 HMRC data
[139] HMRC data 2010

**Figure 8-20: Child Poverty by Ward**




Child poverty is particularly low in the more central wards running from north to south of the Borough: High Barnet, Totteridge, West Finchley, Finchley Church End and Garden Suburb. Garden Suburb has the lowest percentage at only 7.9%. These are also the wards in which the percentage of all children living in a low-income family is at its lowest in the Borough.

There are a number of factors that directly and indirectly influence child poverty, which are set out in more detail below.

### 8.15.2 Housing

Housing costs are a factor which can push families below the poverty line. In turn, bad housing means lower educational attainment and greater likelihood of unemployment for children[140]. Private sector rents have increased faster in Barnet than in other parts of London and they are the 4th highest of 16 Outer London Boroughs.

Increased housing costs can contribute to 'in work poverty', where families who are in work find that housing, bills, childcare costs and living costs mean that there is little leftover from their wages. Income is also depends on the skills and qualifications of the workforce and the level of income.

This means that more low-income households may approach the council for assistance with their housing. 12% of new issues to the Barnet Citizen's Advice Bureau in 2012/13 were related to housing, second to debt (16%) and benefits (35%).

The number of young people being displaced who live within a family unit is increasing. These are young people and children who have to move out of Borough due to homelessness and or the lack of affordable housing. This has implications for school attendance and sustaining family support networks.

### 8.15.3 Education

Children growing up in poverty are less likely to do well at school. This can put them at a disadvantage in later life which, in turn, can affect their children.

[140] 'Chance of a lifetime: The impact of bad housing on children's lives' (Shelter, 2006): https://england.shelter.org.uk/__data/assets/pdf_file/0016/39202/Chance_of_a_Lifetime.pdf

Nationally, only 48% of five year olds entitled to Free School Meals have a good level of development at the end of their reception year, compared to 67% of all other pupils. Less than half of pupils entitled to Free School Meals (just 36%) achieve 5 GCSEs at C or above, including English and Maths, which compares to 63% of pupils who are not eligible.

In Barnet, disadvantaged children continue to perform significantly below their non-disadvantaged counterparts. In 2014, 28 percentage points separated disadvantaged and non-disadvantaged pupils at Key Stage 4. The number of children entitled to Free School Meals progressing to Level Two has increased steadily over the past ten years, in line with London levels.

The percentage of young people in Barnet progressing to higher education exceeds the London average by nine percentage points (58%). However the gap for children on Free School Meals is far smaller, at six percentage points below (43%) the London average.

### 8.15.4 Health

Poverty has been the major determinant of child and adult health and it remains a major cause of ill health with huge public health consequences[141]. A report from End Child Poverty states the following:

- the effects of poverty are passed across generations through pregnancy.
- poor infants are more likely to be born small and/or early.
- acute illnesses are more likely to affect poor children and they are more likely to experience hospital admission.
- child abuse and neglect appear to be more common among poor families, possibly related to the adverse effects of poverty on child rearing.
- breastfeeding is strongly socially patterned.

In Barnet, 7% of live births are under 2.5kg and 1% of children in reception year are underweight, which is largely in line with the London and England averages. Life expectancy for males and females is higher than the London average. However, life expectancy is 7.8 years lower for men and 5.6 years lower for women in the most deprived areas of Barnet than in the least deprived areas.

### 8.15.5 Employment

The government's *Child Poverty Strategy* states that tackling the 'root causes' of child poverty means job creation, labour market programmes helping parents into employment and 'making work pay'. However, benefits and tax credits also play a role.

[141] 'Health Consequences of Poverty for Children', End Child Poverty: http://www.endchildpoverty.org.uk/files/Health_consequences_of_Poverty_for_children.pdf

**Table 8-15*:* The proportion of children living in families in receipt of out-of-work (means-tested) benefits or in families in receipt of tax credits whose reported income is less than 60% of median income**

| Year | Barnet | | London | | England | |
|---|---|---|---|---|---|---|
| | Number | Percentage | Number | Percentage | Number | Percentage |
| 2006 | 17,690 | 23.8% | 531,700 | 31.5% | 2,298,385 | 20.8% |
| 2007 | 18,555 | 24.6% | 552,725 | 32.5% | 2,397,645 | 21.6% |
| 2008 | 18,195 | 23.7% | 534,095 | 30.8% | 2,341,975 | 20.9% |
| 2009 | 18,120 | 22.7% | 531,970 | 29.6% | 2,429,305 | 21.3% |
| 2010 | 17,330 | 21.2% | 512,185 | 28.0% | 2,367,335 | 20.6% |
| 2011 | 16,640 | 20.1% | 495,625 | 26.7% | 2,319,450 | 20.1% |
| 2012 | 14,600 | 17.3% | 442,275 | 23.5% | 2,156,280 | 18.6% |

Source: https://www.gov.uk/government/publications/personal-tax-credits-children-in-low-income-families-local-measure

**Table 8-16: Children living in a low income family**

| Ward | Number of all children living in a low-income family | % of all children living in a low-income family | % of all children living in poverty |
|---|---|---|---|
| Brunswick Park | 565 | 14.1% | 18.0% |
| Burnt Oak | 1595 | 28.5% | 36.0% |
| Childs Hill | 940 | 22.3% | 25.0% |
| Colindale | 1460 | 30.9% | 37.5% |
| Coppetts | 815 | 21.1% | 25.0% |
| East Barnet | 680 | 17.4% | 19.7% |
| East Finchley | 630 | 18.9% | 22.8% |
| Edgware | 725 | 15.9% | 23.7% |
| Finchley Church End | 300 | 9.6% | 12.2% |
| Garden Suburb | 255 | 7.9% | 7.7% |
| Golders Green | 825 | 14.0% | 17.5% |
| Hale | 800 | 17.0% | 21.2% |
| Hendon | 515 | 11.9% | 16.5% |
| High Barnet | 310 | 9.5% | 10.7% |
| Mill Hill | 720 | 15.5% | 21.9% |
| Oakleigh | 555 | 15.5% | 18.0% |
| Totteridge | 355 | 11.3% | 12.8% |
| Underhill | 940 | 24.8% | 26.2% |
| West Finchley | 345 | 11.4% | 15.7% |
| West Hendon | 655 | 16.8% | 21.6% |
| Woodhouse | 640 | 17.3% | 20.9% |

Source: HMRC snapshot as at 31 August 2012

The percentage of children in workless households in Barnet (13%) has decreased to below both the London and England average[142], and the percentage of children in working households has reached 52%, which is the highest level seen in the past ten years. Although employment across Barnet has increased, the highest rates of unemployment are located towards the west of the Borough, in Colindale (8.4%) and Burnt Oak (8.1%).

**Table 8-17: Children in Workless Households**

| | Barnet | London | England |
|---|---|---|---|
| Children in Workless Households (%) | 13% | 17% | 14% |

All services across the partnership share a commitment to improving outcomes for children, young people and families in poverty. However, reduced public sector spending will have a significant implication on the delivery of front line services, in particular the amount of preventative services and early intervention programmes that can make a difference and create efficiencies.
Services need to work together on a whole family basis in order to improve outcomes and wellbeing for children living in poverty. Evidence suggests that single agency responses are unlikely to affect the change a child and family requires to escape deep-rooted poverty.

## 8.16 Voice of the Child

Barnet delivers a diverse range of participation forums which enable children and young people to have their voices heard.

- **Barnet Youth Board** - A representative panel of young people aged 13- 24 years acting as a voice for the wider youth community of Barnet.
- **UK Youth Parliament (UKYP**)
- **Role Model Army (RMA) -** The RMA is Barnet's Children in Care Council.
- **Youth Shield -** Youth Shield is Barnet's Youth Safeguarding Panel for young people aged 14-25 years run by CommUNITY Barnet on behalf of Barnet Safeguarding Children Board (BSCB).
- **Young Commissioners** – A group of children and young people embedded within the commissioning cycle providing their unique voice and insight in to service specification and design.

In addition, a programme of work targeting young people engaged with the YOS team, PRU, and foyer is also under way. Some of the key / top priorities that children and young people have already told us are:

- Mental health services for children and young people.
- Improved access to, and quality of, mental health provision at the earliest possible opportunity for children and young people.
- Reducing child poverty.
- Helping disadvantaged children and young people to do well in school.
- Making sure everyone can read and write at primary school.
- Protecting young people from bullying, violence and sexual exploitation.
- Youth centres and activities for teenagers.
- Young girls have increasingly spoken out about relationships and how they can support each other. They would seek help initially from their GP.

[142] Labour Force Survey (Household and Labour Market Division) ONS2012

- A commitment from all employers to pay the London Living Wage to young people.
- Improved quality of extra-curricular activities with a focus on sport and fitness.
- Improved road safety across Barnet.
- Improvement in young people's participation with politics and local democracy.
- Looked After Children to receive a more thorough and considered induction into care and a more flexible approach to their care reviews.
- Looked After Children to be able to receive concise information upon their entitlements upon receipt of Looked After Children status.
- More effective work experience programmes.
- Wider and more vocal campaigning for votes at 16.
- Improvement to community cohesion and the breaking down of barriers based on gender, race, ethnicity, religion, sexuality and demography.

### 8.16.1 Participation

'The State of the Children's Rights in London' report highlights the importance of ensuring that local authorities place children and young people at the heart of the decision-making process. This highlights the importance of not only listening to the 'voice' of children and young people, but also ensuring that they participate in the planning, delivery and improvement of services that matter to them.

Participation means talking to, listening to and hearing from children and young people whilst encouraging and supporting them to contribute, participate in discussions and have their voices heard. It is then important to act on the views and ideas presented whilst being open, honest and realistic with them on the levels of involvement that they can have.

Barnet has a large population of children and young people and despite the range of engagement forums, there is still an opportunity for improving the way in which they participate with the council.

One area in particular where there is room for improvement is around crime. It is known that children and young people are more likely to be victims of crime, however they are often less likely to report it to the police when they are.

Following the publication of 'The Voice of the Child Strategy Action Plan 2015-17', work is currently underway to identify ways in which the council can enhance its understanding and avenues for engagement with children and young people. This section of the JSNA will be updated in the future to represent this work.

# 9 Adult Social Care

## 9.1 Key Facts

- The most recent population projections indicate that the adult population (18+) of Barnet will be 280,904, 76.5% of the total Borough population, by the end of 2015.
- This population is projected to grow by 14.5% between 2015 and 2030, to 321,677.
- By age group, 4,744 (63.8%) of service users are aged 65+.
- Despite continued growth in the adult population, the number of people in receipt of residential care and nursing care decreased from 1,441 in 2011/12 to 1,367 in 2013/14 (-5.1%), reflecting on-going work to help people remain in their own homes for longer.
- In relation to the total population, Brunswick Park and Underhill have the highest rates of carers (10.5% of the population), and Colindale has the lowest rate (6.90% of the population).
- According to national projections, the most common health conditions/disabilities within Barnet are mental health disorders and hearing impairments in those aged 65 and over.

## 9.2 Strategic Needs

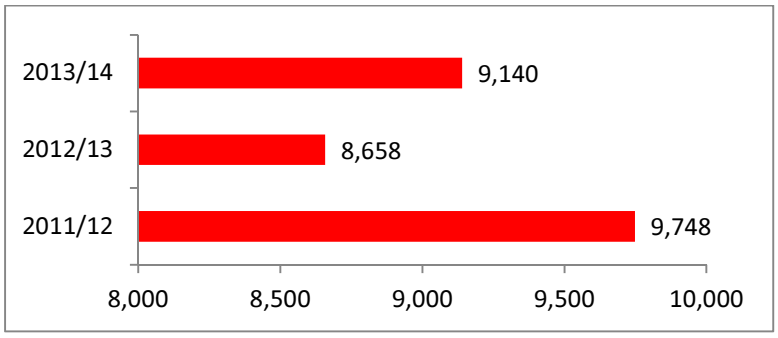
- **Mental disorders** are responsible for the **largest burden of disease in England** at 23% of the total burden. Within Barnet, the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently as possible within the community**. This places significant pressure on ensuring **appropriate housing and support services** are available to **meet their requirements**.
- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, locally based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in **elderly women who live alone**, especially in **areas of higher affluence and lower population density.**
- **The Care Act** represents the most significant reform of care and support in more than 60 years. It is expected to drive **increased demand for adult social care support over and above the increased levels of demand from demographic pressures**.
- **According to national benchmarking information, demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people in Barnet, 3.3% of the 65 and over population**. This could indicate a **lack of take up of around 800 people.**
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average carers **are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.

- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021 the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

## 9.3 Service User Profile

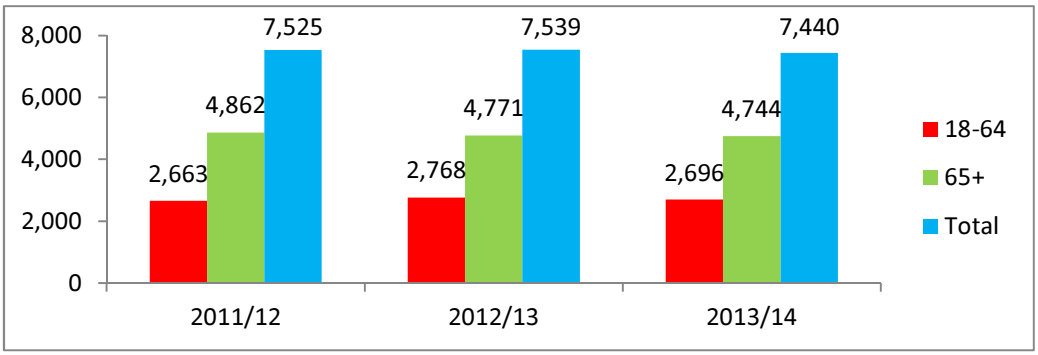
In 2013/14 there was an increase in the number of Adults contacting Barnet for support. Many of these people were provided with advice and information by Social Care Direct, the Council's Front Door service. Some residents were sign posted to services such as Barnet's Carers Centre and the Barnet Centre for Independent Living, whilst others were referred to social care teams for full assessment.

**Figure 9-1*:* Number of people contacting Adult Social Care during the year**




Source: SWIFT – Adult Social Care Database

**Figure 9-2: Number of people receiving Adult Social Care services during the year**



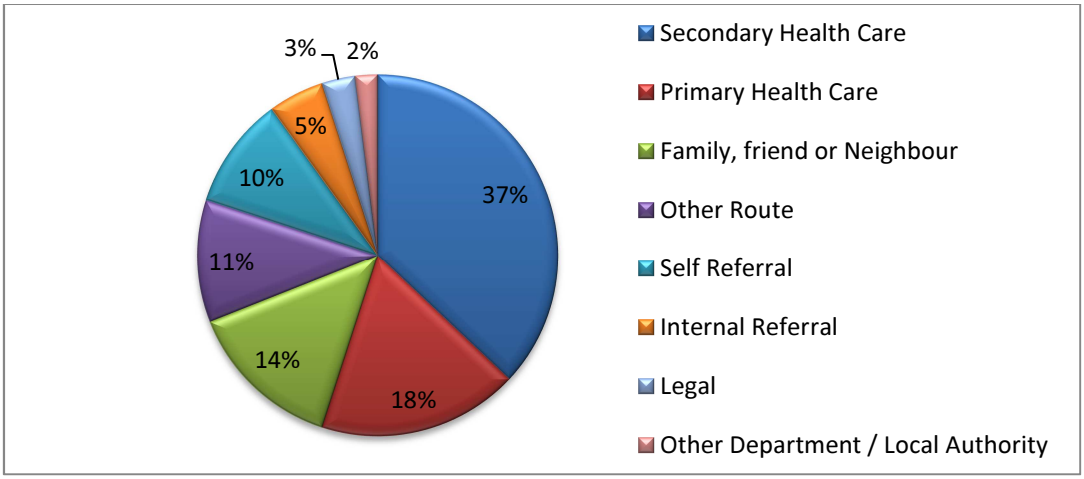

Source: SWIFT – Adult Social Care Database

Figure 9-3 shows the proportion of referrals to Adult Social Care by referral source for 2013/14. The largest proportion of referrals to Adult Social Care, were made by secondary health care teams (37%) e.g. hospitals. Whereas, primary health care accounted for less than half of this amount (18%), and family, friends, neighbours and self-referral only accounted for a total of 24% of referrals.

Effective prevention and early intervention could help to reduce the level of referrals being received from secondary health care and increase those coming from primary health care, self-referrals and friends and family. Not only are hospital admissions often more costly than other forms of care, but

effective prevention and early intervention could have significant impacts on an individual's health and wellbeing.

**Figure 9-3: Origin of referrals to Adult Social Care in 2013/14**




Source: SWIFT – Adult Social Care Database

## 9.4 The Care Act 2014

The Care Act represents the most significant reform of care and support in more than 60 years. It aligns with a central Government commitment to make joined-up health and care the norm by 2018. For an overview of the changes, please refer to the factsheets.

The Care Act promotes wellbeing and aims to prevent or delay people needing social care services. It is built around people's needs and what they want to achieve in their lives.

It brings new rights for carers that put them on the same legal footing as the people they care for and entitles them to ask for their needs to be assessed.

## 9.5 Residential & Nursing Care

In Barnet, care homes are a key area of provision in supporting frail and elderly people who are unable to live in their homes.

There are 80 residential care homes and 23 nursing homes registered with the Care Quality Commission (CQC) in Barnet, which range from small to large.

In 2013/14, 75% of residential placements were provided to older adults (65+) and 61% of these residential placements were provided to women. The high proportion of women compared to men is most likely due to the fact that women account for 56.5% of the 65 and over population within Barnet, compared to men who account for 43.5% of the population[143].

Of the residential placements in 2013/14, 14% of residents had a learning disability, 6% had a mental health problem and 5% had a physical/sensory impairment.

[143] GLA 2013 Population Projections (Borough Preferred Option)

During the period 2011-2014 the number of people in receipt of residential care and nursing care has decreased, despite continued growth in the population, especially within the 65 and over age group. This reflects on-going work to help people to remain at home longer.

**Table 9-1: The number of people in Residential and Nursing Care, 2011-2014**

| Year | Residential Care | Nursing Care | Total |
|---|---|---|---|
| 2011-12 | 1,078 | 363 | 1,441 |
| 2012-13 | 1,076 | 387 | 1,463 |
| 2013-14 | 1,009 | 358 | 1,367 |

Source: SWIFT – Adult Social Care Database

Despite the reduction in the number of people in receipt of residential care and nursing care, in 2013/14 Barnet had a higher permanent admissions rate to care homes, per 100,000 people, than similar local authorities and the overall London average.

**Table 9-2: Permanent Admissions to Care Homes per 100,000 people, 2013-14 (Barnet, Regional, and National)**

| Area | 18-64 | 65+ |
|---|---|---|
| Barnet | 13.4 | 475.1 |
| Similar Local Authorities | 9.6 | 411.8 |
| London | 10.2 | 454 |
| England | 14.4 | 650.6 |

Source: Adult Social Care Outcomes Framework

Residential care and nursing care are high cost services. In 2013/14 14% of all service-users funded by the council accessed residential care and 5% accessed nursing care. The gross expenditure for 2013/14 was £38,364,000 for residential care placements and £7,652,000 for nursing care placements which represents approximately 40% of the total Barnet adult social services spend.

**Table 9-3: Expenditure on Residential & Nursing Care, 2011-2014**

| Year | Gross Expenditure (£000's) | | |
|---|---|---|---|
| | Residential Care Placements | Nursing Care Placements | Total Adult Social Services |
| 2011/12 | £7,680 | £42,170 | £115,940 |
| 2012/13 | £8,188 | £38,767 | £113,888 |
| 2013/14 | £7,652 | £38,364 | £114,340 |

Demographic pressures mean that there are an increasing number of elderly people in Barnet, and an increasing number of people with complex health or social care needs. Residential and nursing homes are a key area of provision for this cohort, especially for people with certain disabilities or conditions.

## 9.6 Enablement

Enablement refers to short-term intensive support which is given to a person to help them regain their independence. It lasts up to six weeks and usually takes place in the person's home. During the

enablement period, the person is assessed to identify if they are likely to require any further services.

Table 9-4 below displays the re-admission rates for both social care services and health referrals up to three months after the end of their enablement package.

- Over 60% of people who have had an enablement package have not been re-admitted to either social care or healthcare within three months of the end of the package.
- 25% of service users who are not in residential or nursing care have gone through the enablement programme.

**Table 9-4: Success rate e.g. re-admissions, good outcomes including people at home 91 days after intervention and 30 days re-admissions**

| Quarter | % not died, been admitted into residential or nursing care, and not receiving homecare or direct payments | | | | | |
|---|---|---|---|---|---|---|
| | Social care referrals | | | Health referrals | | |
| | A week after terminating enablement | A month after terminating enablement | Three months after terminating enablement | A week after terminating enablement | A month after terminating enablement | Three months after terminating enablement |
| 11/12 Qtr 1 | 55% | 56% | 52% | 87% | 87% | 87% |
| 11/12 Qtr 2 | 55% | 55% | 53% | 75% | 80% | 75% |
| 11/12 Qtr 3 | 60% | 56% | 53% | 78% | 76% | 71% |
| 11/12 Qtr 4 | 61% | 60% | 59% | 76% | 69% | 63% |
| 12/13 Qtr 1 | 61% | 60% | 54% | 77% | 75% | 72% |
| 12/13 Qtr 2 | 68% | 68% | 64% | 72% | 72% | 70% |
| 12/13 Qtr 3 | 62% | 58% | 55% | 77% | 73% | 71% |
| 12/13 Qtr 4 | 67% | 65% | 63% | 70% | 65% | 60% |
| 13/14 Qtr 1 | 65% | 60% | 55% | 69% | 70% | 56% |
| 13/14 Qtr 2 | 68% | 64% | 59% | 79% | 75% | 73% |
| 13/14 Qtr 3 | 64% | 61% | 55% | 74% | 77% | 73% |
| 13/14 Qtr 4 | 64% | 62% | 67% | 68% | 67% | 60% |

Although enablement appears to be helping to reduce the level of re-admissions into the healthcare service, the number of new contacts going through the enablement programme has experienced a slight declined from 2011 to 2014.

**Table 9-5: Numbers given an assessment and subsequently given an enablement package**

| Enablement | New Contacts Going Through Enablement (inc. Health Referrals) | % of New Contacts | % of Assessments | % of New Service Provisions |
|---|---|---|---|---|
| 2011/12 | 1,498 | 15.4% | 60.7% | 73.8% |
| 2012/13 | 1,458 | 16.8% | 58.4% | 74.4% |
| 2013/14 | 1,100 | 12.0% | 41.4% | 54.1% |

Source: SWIFT – Adult Social Care Database

A formula developed by the Care Services Efficiency Delivery (CSED) programme indicates that demand for enablement services should be around 5% of the 65 and over population. In 2013/14 the service was used by 1,660 people, 3.3% of the 65 and over population. Based on these projections this could indicate a lack of take up of around 800 people.

If the estimates from the CSED are applied to the latest population projections, due to the projected growth in the older population, demand for enablement services could increase by over 33% from 2015-2030.

**Table 9-6: Projected demand for enablement services, 2015-2030**

| Year | 65+ Population | 5% of Population |
|---|---|---|
| 2015 | 47,705 | 2,385 |
| 2016 | 49,237 | 2,462 |
| 2017 | 49,811 | 2,491 |
| 2018 | 50,691 | 2,535 |
| 2019 | 51,576 | 2,579 |
| 2020 | 52,352 | 2,618 |
| 2021 | 53,173 | 2,659 |
| 2022 | 54,017 | 2,701 |
| 2023 | 54,939 | 2,747 |
| 2024 | 55,918 | 2,796 |
| 2025 | 57,098 | 2,855 |
| 2026 | 58,182 | 2,909 |
| 2027 | 59,531 | 2,977 |
| 2028 | 60,821 | 3,041 |
| 2029 | 62,205 | 3,110 |
| 2030 | 63,575 | 3,179 |

Source: GLA 2013 Population Projections (Borough Preferred Option) and CSED

In addition to this, the changes that are being brought in by the Care Act 2014 are projected to increase demand for these services above demographic pressures alone.

With the high costs attributed to residential and nursing care, enablement provides a way to alleviate some of these costs. Therefore there is significant need over the coming years to ensure that Barnet has suitable capacity in place to meet the possible demand pressures impacting on the enablement service.

Furthermore, with the recent reduction in the number of new contacts goings through enablement, there is a need for greater understanding of the drivers behind this.

## 9.7 Self-Directed Support and Direct Payments

Personal budgets are an allocation of funding given to service users after an assessment, which should be sufficient to meet their assessed needs. They can be taken as a direct payment or the service user/carer can give the council some or all responsibility to commission services on their behalf.

Table 9-7 shows how many council-funded service-users have taken up a personal budget by client category. In 2013/14, 55.3% of all adult social care service users received a personal budget, an increase of 3.9% from 2011. This indicates that an increasing number of people are commissioning their own care; this trend is expected to continue in the future.

**Table 9-7: Number of service-users receiving Self-Directed Support Packages**

| Client Category | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| Physical / Sensory Impairment (18-64) | 498 | 61.0% | 497 | 62.6% | 500 | 65.8% |
| Learning Disability (18-64) | 467 | 61.6% | 509 | 67.7% | 552 | 72.2% |
| Mental Health (18-64) | 593 | 56.0% | 631 | 53.8% | 638 | 56.6% |
| Other (18-64) | 10 | 33.3% | 17 | 34.7% | 22 | 50.0% |
| Older Adults | 2,303 | 47.4% | 2,264 | 47.5% | 2,405 | 50.7% |
| Total Service Users | 3,871 | 51.4% | 3,918 | 52.0% | 4,117 | 55.3% |

Source: SWIFT – Adult Social Care Database

Over the period 2011-2014 there has been an increase in the prevalence of personal budgets in almost every year across all categories. The highest take-up of personal budgets is within clients who experience 'learning disabilities' (72.2%) and 'physical / sensory impairments' (65.8%).

The lowest take-up of personal budgets in 2013/14 was within the 'Other' category (50.7%), although as the numbers of service users within this category are quite low, this shouldn't be viewed as significant. However 'older adults' have the second lowest take-up (50.7%) and this client category accounts for the largest proportion of total service users within adult social care and is projected to experience the highest levels of growth.

Direct payments are cash payments given to service users in place of community care social services to allow them greater flexibility about how their care is delivered. The default position of the council is to offer service-users direct payments, including those people who are currently receiving council-managed services.

Table 9-8 includes all adults in receipt of direct payments, whether or not they are in receipt of a personal budget. As with the take-up rates of personal budgets, over the period 2011-2014 the rate of direct payments has increased from 12.6% in 2011/12 to 17.0% in 2013/14.

However, only 7.5% of clients with 'mental health' conditions had a direct payment in 2013/14, significantly below the level who had personal budgets (56.6%). As with personal budgets 'older adults' continue to have the second lowest take-up of direct payments, with only 13.0% opting for a direct payment in 2013/14; a 0.2% decrease on the previous year.

**Table 9-8: Number of service-users in receipt of Direct Payments**

| Client Category | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| Physical / Sensory Impairment (18-64) | 253 | 31.0% | 288 | 36.3% | 298 | 39.2% |
| Learning Disability (18-64) | 182 | 24.0% | 209 | 27.8% | 258 | 33.7% |
| Mental Health (18-64) | 61 | 5.8% | 67 | 5.7% | 84 | 7.5% |
| Other (18-64) | 2 | 6.7% | 8 | 16.3% | 9 | 20.5% |
| Older Adults | 452 | 9.3% | 632 | 13.2% | 616 | 13.0% |
| Total | 950 | 12.6% | 1,204 | 16.0% | 1,265 | 17.0% |

Source: SWIFT – Adult Social Care Database

Personal budgets and direct payments help residents take control of their own social care budget, manage their own support and choose the services that suit them best. Although the council has experienced a significant increase in their use, some client categories, such as those with mental health issues and older clients, have lower adoption rates than many of the other client categories. In order to maximise the use of these services there is a need to increase the understanding of the drivers behind this.

## 9.8 Community Care

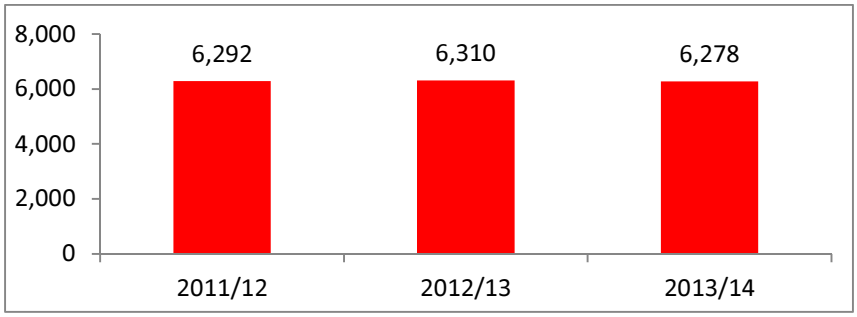
The pattern of social care provision has changed over recent years with fewer people wishing to enter long term residential/institutional care and a greater variety of community provision becoming available. Growth in personal budgets and direct payments has shown the potential for service users to arrange their own care and support, and it is expected that this trend will continue.

**What does Community Care include in Barnet?**

- Home care/Home and Community Support
- Day care
- Community meals
- Short term residential care
- Equipment and adaptations
- Direct payments
- Voluntary sector and local community support

Figure 9-4 shows the number of people in receipt of community care services over the period 2011-2014. Although there has been some slight movement in this figure, generally this has remained fairly constant.

**Figure 9-4: Number of Service Users in Receipt of Community Care Services**




Source: SWIFT – Adult Social Care Database

Table 9-9 breaks down the number of service users accessing community care service users by primary support need, as a proportion of the total number of service users receiving support. In 2013/14, 84.4% of all service users received some form of community care service, with all categories in excess of 70%, although, clients with learning disabilities had a significantly lower take-up rate (74.90% in 2013/14).

**Table 9-9: Number of Service Users Accessing Community Care Services by Primary Support Need**

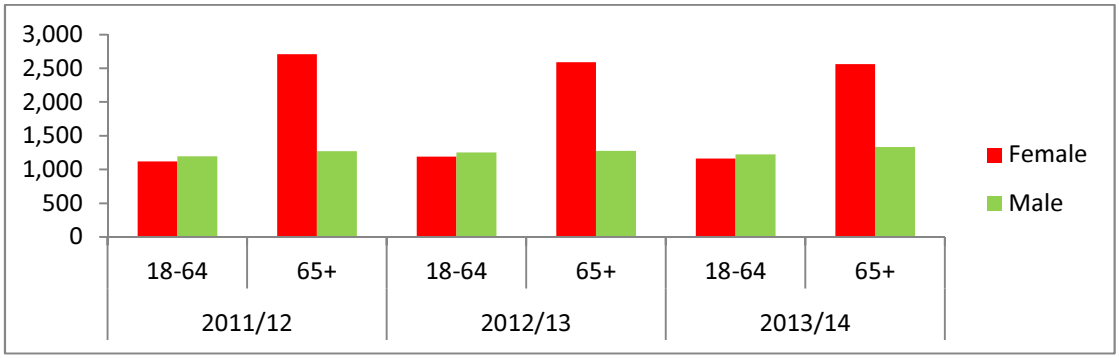
| Client Category | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| Sensory Impairment (18-64) | 752 | 92.16% | 740 | 93.20% | 710 | 93.42% |
| Learning Disability (18-64) | 540 | 71.24% | 551 | 73.27% | 573 | 74.90% |
| Mental Health (18-64) | 993 | 93.77% | 1104 | 94.12% | 1059 | 93.97% |
| Other (18-64) | 28 | 93.33% | 47 | 95.92% | 42 | 95.45% |
| Older Adults | 3,979 | 81.84% | 3,868 | 81.07% | 3,894 | 82.08% |
| Total Service Users | 6,292 | 83.61% | 6,310 | 83.70% | 6,278 | 84.38% |

Source: SWIFT – Adult Social Care Database

Figure 9-5 shows the breakdown of Community Care service users by age and gender. By age, the 18-64 age group accounts for around a third of the total clients, with the 65 and over client group accounting for around two thirds. This is roughly in line with the overall demographic breakdown of Adult Social care clients.

By gender, the proportion of 18-64 year olds accessing Community Care services is roughly the same across both males and females. However, females in the 65 and over category are significantly more likely to use community care services than any other client group. Whereas, there is very little difference between the numbers of men aged 18-64 receiving community care as those aged 65 and over. This could be partially due to women accounting for 56.5% of the 65 and over population (29,152) compared to men who account for 43.5% (22,423).

**Figure 9-5: Number of Service Users by Age group and Gender**




Source: SWIFT – Adult Social Care Database

### 9.8.1 Home and Community Support

Home and Community Support provides support to people in their own home, including older people who are frail or have health needs, as well as to people with disabilities or complex needs. It often follows a period of enablement where it is identified that the individual will require further support.

Currently the council's Home and Community Support service is delivered by three lead providers and a number of other contracted suppliers.

- At present, there are 28 homecare providers on the Barnet contract register.
- In 2013/14, the majority of community care clients received homecare.
- 80% of homecare clients were older adults (65+).
- The majority of younger adult (18-64) homecare recipients were people with a physical / sensory impairment.

**Table 9-10: Number of Home Care Packages offered during the year**

| Number of Unpaid Carers | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Physical / Sensory Impairment (18-64) | 290 | 282 | 271 |
| Learning Disability (18-64) | 173 | 196 | 209 |
| Mental Health (18-64) | 96 | 118 | 110 |
| Other (18-64) | 6 | 11 | 8 |
| Older Adults | 3,046 | 2,982 | 2,948 |
| **Total** | **3,611** | **3,589** | **3,546** |

Source: SWIFT – Adult Social Care Database

The Council has now adopted a 'community offer' approach. The community offer ensures that informal support; telecare, enablement and equipment are considered and offered before traditional care is provided.

Whilst the move towards a 'community offer' approach should help to reduce requirements for Home Care support, demographic projections indicate that the number of people potentially needing a service is due to increase significantly over the next 20 years. The council's modelling also indicates that an increased number of residents will come forward requesting social care support from the council as a result of the enhanced duties on councils arising from the Care Act.

### 9.8.2 Community Meals

The current community meals service provides a lunch time home-delivery service to service users across the Borough 7 days a week. An estimated 50,000 meals are delivered annually and approx. 200 meals per day.

In recent years there has been a decline in the number of people receiving community meals. Nevertheless, there continues to be an on-going demand for this provision across a range of ages and ethnic and cultural backgrounds.

**Table 9-11: Number of Home Meal Packages offered during the year**

| Number of Unpaid Carers | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Physical / Sensory Impairment (18-64) | 18 | 17 | 15 |
| Learning Disability (18-64) | 1 | 1 | 1 |
| Mental Health (18-64) | 8 | 9 | 17 |
| Other (18-64) | 1 | 0 | 2 |
| Older Adults | 513 | 466 | 442 |
| **Total** | **541** | **493** | **477** |

Source: SWIFT – Adult Social Care Database

### 9.8.3 Voluntary Services and Social Capital

Those not accessing social services may be purchasing care directly themselves, relying on the help of family and friends or benefitting from the support of the voluntary sector. Compared to other Boroughs, Barnet provides care to a relatively small proportion of the population indicating a strong voluntary sector as well as a willingness of users to purchase care independently. Many referrals to Adults & Communities are given advice or support at the point of referral and/or referred to an alternative support agency. This helps to ensure that people with moderate and lower level needs have these met in the community.

There are a significant number of charitable and community groups active in Barnet. The sector offers significant value for money by engaging residents as volunteers and bringing external funding into the Borough.

Services offered can be universal such as health promotion, befriending, digital inclusion, information and advice. There are targeted groups such as lunch clubs for Asian Elders and a Day Centre provision for Tamil Elders. There are also targeted services for people with dementia or for those who have suffered from a stroke.

Services such as Home from Hospital and the Handyperson scheme explicitly assist older and vulnerable people to return successfully home from a spell in hospital or help to avoid hospital admissions.

Both the Barnet Ageing Well programme and the Neighbourhood model, stimulates increased use of social capital through effective use of volunteers and encouraging peer support, as well as encouraging and supporting local leadership. Projects such as the Barnet Timebank, Men's Sheds

and Altogether Better Projects are now well established with approximately 1,000 people now involved either as volunteers or beneficiaries.

Feelings of social isolation and loneliness are detrimental to a person's health and wellbeing. As more and more older and frail residents choose to stay at home for longer, there is even more of a need for local social groups and community health care facilities. The initiatives above help to address these issues, as they are user led and promote wellbeing.

## 9.9 Carers

A carer is a person who looks after or supports someone else who needs help with their day-to-day life because of issues such as their age, a long-term illness, disability, mental health or substance misuse. A young carer is anyone under the age of 18 who provides or intends to provide care for another person. Each caring situation is unique and every carer has different needs and priorities.

Data from the 2011 Census indicated that there were 32,256 residents who classified themselves as a carer in Barnet in 2011. By age, the largest number of carers were located within the 25-49 age group. Whereas, only 5,500 carers are registered with the Council's commissioned lead provider for carers support services in the Borough, indicating a significant proportion that remain hidden to the Council.

**Table 9-12: Number of Unpaid Carers in Barnet**

| Number of Unpaid Carers | Total | 0-24 | 25-49 | 50-64 | 65+ |
|---|---|---|---|---|---|
| Provides unpaid care: Total | 32,256 | 2,911 | 12,746 | 10,499 | 6,100 |
| Provides 1 to 19 hours unpaid care a week | 21,448 | 2,249 | 8,394 | 7,432 | 3,373 |
| Provides 20 to 49 hours unpaid care a week | 4,584 | 399 | 1,950 | 1,392 | 843 |
| Provides 50 or more unpaid hours unpaid care a week | 6,224 | 263 | 2,402 | 1,675 | 1,884 |

Source: Census 2011

By ward the areas with the highest level of carers were Mill Hill (1,800); Hale (1,724) and Brunswick Park (1,721). The wards with the lowest number of carers were Colindale (1,176); East Finchley (1,302) and Garden Suburb (1,332).

In proportion to the total population, Brunswick Park and Underhill had the highest rates of carers (10.5%), compared to Colindale which had the lowest (6.90%).

**Table 9-13: Barnet Carers by Ward, 2011**

| Ward | Total (All Ages) | % of Total Population | 0-24 | 25-49 | 50-64 | 65+ |
|---|---|---|---|---|---|---|
| Brunswick Park | 1,721 | 10.5% | 136 | 664 | 606 | 315 |
| Burnt Oak | 1,554 | 8.5% | 190 | 792 | 401 | 171 |
| Childs Hill | 1,623 | 8.1% | 187 | 652 | 500 | 284 |
| Colindale | 1,176 | 6.9% | 144 | 584 | 290 | 158 |
| Coppetts | 1,454 | 8.4% | 138 | 645 | 483 | 188 |
| East Barnet | 1,645 | 10.2% | 129 | 601 | 590 | 325 |
| East Finchley | 1,302 | 8.1% | 93 | 545 | 419 | 245 |
| Edgware | 1,643 | 9.8% | 162 | 593 | 551 | 337 |
| Finchley Church End | 1,452 | 9.2% | 120 | 483 | 478 | 371 |
| Garden Suburb | 1,332 | 8.3% | 61 | 407 | 501 | 363 |
| Golders Green | 1,575 | 8.3% | 203 | 657 | 446 | 269 |
| Hale | 1,724 | 9.9% | 160 | 709 | 557 | 298 |
| Hendon | 1,425 | 7.7% | 152 | 586 | 443 | 244 |
| High Barnet | 1,567 | 10.2% | 105 | 492 | 646 | 324 |
| Mill Hill | 1,800 | 9.7% | 143 | 724 | 581 | 352 |
| Oakleigh | 1,592 | 10.0% | 131 | 553 | 567 | 341 |
| Totteridge | 1,454 | 9.6% | 94 | 495 | 507 | 358 |
| Underhill | 1,671 | 10.5% | 140 | 635 | 560 | 336 |
| West Finchley | 1,363 | 8.2% | 89 | 573 | 443 | 258 |
| West Hendon | 1,502 | 8.6% | 170 | 656 | 406 | 270 |
| Woodhouse | 1,681 | 9.5% | 164 | 700 | 524 | 293 |

Source: Census 2011

Not all carers are offered, or agree to have, an assessment. There are currently eligibility criteria in place for carer assessments but this will change with the introduction of the Care Act 2014.

Table 9-14 shows the number of carers who were assessed in Barnet over the period 2011-2014 by primary support need. As can be seen, there has been a downward trend in the number of carers being assessed over this period reducing from 2,432 in 2011/12 to 1,948 in 2013/14.

**Table 9-14: Number of carers assessed by the primary support need of the cared for adult**

| Client Category | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Physical / Sensory Impairment (18-64) | 226 | 248 | 177 |
| Learning Disability (18-64) | 115 | 171 | 160 |
| Mental Health (18-64) | 164 | 86 | 126 |
| Other (18-64) | 7 | 5 | 5 |
| Older Adults | 1,820 | 1,669 | 1,480 |
| **Total** | **2,432** | **2,179** | **1,948** |

Source: SWIFT – Adult Social Care Database

### 9.9.1 Current Provision

A range of support services are currently in place for carers. These include but are not limited to:

- Accessible information about the many support services available to carers and those they care for within the Borough;
- Carrying out assessments;
- Emergency planning;
- Telecare services for people who need devices to continue to live safely at home e.g. alarms and other equipment to alert support;
- Where a carer has been assessed as eligible for direct support from adult social care, respite care or direct payments may be offered;
- A commissioned a lead provider for carers support services which offers a range of support services including:
    - Individual and group support offering practical help and emotional support
    - Training
    - Short breaks where appropriate
    - Counselling and support service for families of disabled people
    - Benefits advice
    - A Carers forum

**Table 9-15: Number of Carers in receipt of Carer Specific Services**

| Primary Support Need | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Physical / Sensory Impairment (18-64) | 46 | 48 | 45 |
| Learning Disability (18-64) | 80 | 59 | 62 |
| Mental Health (18-64) | 78 | 46 | 63 |
| Other (18-64) | 0 | 0 | 1 |
| Older Adults | 402 | 303 | 369 |
| **Total** | **606** | **456** | **540** |

*Support services include: Training, Support Groups, Short Breaks, Counselling, Benefits Advice
** Respite services may be received in addition to the above; however some respite is recorded against the adult and not the carer, and so will not have been counted.

Source: SWIFT – Adult Social Care Database

**Table 9-16: Number of Carers in receipt of information and advice only**

| Primary Support Need | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Physical / Sensory Impairment (18-64) | 180 | 200 | 132 |
| Learning Disability (18-64) | 135 | 112 | 98 |
| Mental Health (18-64) | 86 | 40 | 63 |
| Other (18-64) | 7 | 5 | 4 |
| Older Adults | 1,418 | 1,366 | 1,111 |
| **Total** | **1,826** | **1,723** | **1,408** |

*Information and Advice includes referral to Carers Centre who then offer support

Source: SWIFT – Adult Social Care Database

### 9.9.2 The Value of Carers

According to Carers UK, there are 6.4 million carers in the UK reducing the national care bill by an estimated £119bn per year, equivalent to £18,594 per carer. Based on these figures and the 2011

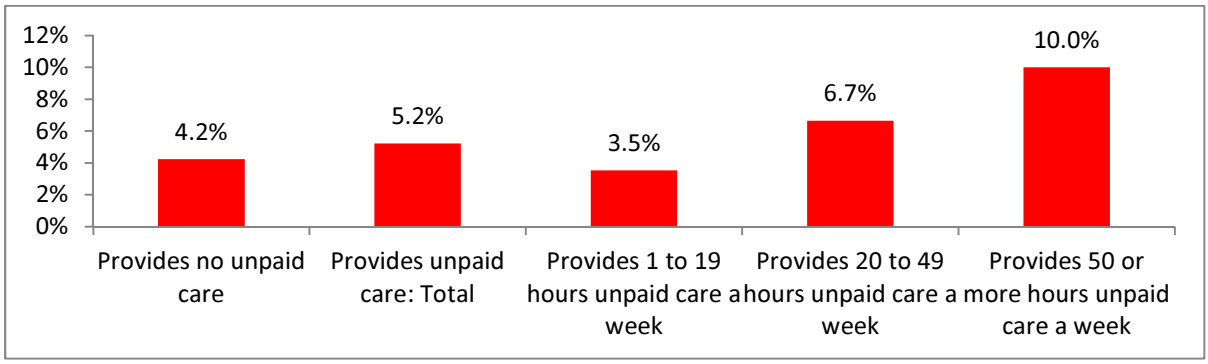
Census, Barnet's informal carers have a potential to save health and social care services, up to £595m per year[144].

While there are positive aspects to being a carer, some carers can experience changes in their health and wellbeing. Carers can suffer from increased stress, social isolation, financial hardship, ill-health and reduced personal time. Being a young carer can impact on a young person's childhood and can have a detrimental impact on educational attainment, health and emotional wellbeing, and the ability to make friends and have a social life.

On average, 5.2% of carers in the 2011 Census reported having poor health, compared to 4.2% of non-carers. There also appeared to be a correlation between the amount of care provided and health, with carers who provided 50 hours or more care a week being over two times more likely to report poor health than those providing 1 to19 hours of care.

Therefore, it is vital that to identify and support carers appropriately to ensure that they can continue with their caring role without it adversely affecting the own health and wellbeing.

**Figure 9-6: Proportion of Unpaid Carers in Barnet in Poor Health**




Source: Census 2011

### 9.9.3 Gaps in Current Provision

The Council recognises the need to:

- Continue to provide co-ordinated information and advice to carers;
- Improve carers access to preventative services which may be of benefit to them;
- Further embed good practise with staff and increase carers awareness throughout the Borough;
- Strengthen partnership working with key stakeholders to ensure that referral pathways are being utilised; and
- Ensure that carers are getting access to the right support when they need it.

There continues to be a real need to understand and quantify the impact that different services and support has on:

- A carers' ability to continue in their role;
- Helping carers to achieve their desired outcomes;

[144] Carers UK & University of Leeds, "Valuing Carers 2011: Calculating the Value of Carer's Support," Carers UK, London, 2011.

- Helping carers to look after their own health and wellbeing; and
- The savings that are achieved through doing this.

There is also a continued need for health and social care professionals to be aware of and take into account the mental and physical implications that caring brings.

The demand for carers is projected to grow with the increase in life expectancy, the increase in people living with a disability needing care, and with the changes to community based support services.

In addition to increased demand from demographic pressures, the new duties being brought in by the Care Act are expected to increase the number of people contacting the council and the number of people needing to be assessed.

Table 9-17 displays the estimated number of self-funders who are currently in residential care and use community services, as well as the number of existing care home and care agencies. This illustrates that, depending on demand, the local authority will have to engage with a significant number of people and providers with whom it does not currently engage.

**Table 9-17: Number of existing self-funding carers and services**

| Type | No. |
|---|---|
| Self-funders in residential care | 750 |
| Self-funders who use community services | 12,000 |
| Residential and nursing homes | 110 |
| Home care agencies | 72 |

Additional demand is also expected from people who live in their own homes, who currently do not receive care, coming forward. Local demand modelling, shown in Table 19-18, indicates that this could have a significant impact on demand.

**Table 9-18: Additional demand from people living at home**

| Type | No. |
|---|---|
| Request a service user assessment | 6,000 |
| Additional support plans | 4,710 |
| Request a carers' assessment | 9,620 |

In addition to the demand pressures discussed above, it should be noted that there will be other pressures relating to infrastructure and support costs.

## 9.10 Primary Support Needs

Barnet has adopted the social model of disability. Disability can have significant medical consequences but the difficulties /barriers that face people or that are often encountered in everyday life largely because of attitudes and existing structures in society. Disability is a social consequence of having impairment.

According to national projections, the most common health conditions/disabilities within Barnet relate to mental health disorders (common mental health conditions are included in this calculation) and hearing impairment in those aged 65 and over. The next largest group of people with disabilities are those with physical impairment aged between 18 and 64.

**Table 9-19: Estimated number of residents by disability, illness or impairment, Barnet**

| Disability, Illness or Impairment | No. |
|---|---|
| Aged 18 and over predicted to have a learning disability | 6,848 |
| Aged 18-64 predicted to have a physical disability (moderate to severe) | 22,024 |
| Aged 65+ predicted to have limited mobility | 10,002 |
| Aged 65+ predicted to have a disabling visual impairment | 4,780 |
| Aged 65+ predicted to have a disabling hearing impairment | 31,292 |
| Aged 18-64 predicted to have a mental health problem | 58,053 |
| Aged 65+ predicted to have Dementia | 3,978 |

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

### 9.10.1 Mental Health

Mental disorders are responsible for the largest burden of disease in England – 23% of the total burden, compared to 16% for cancer and 16% for heart disease.

Adults with a severe and enduring mental illness face considerable social exclusion. This is evidenced through high rates of unemployment, social isolation, poorer physical health and insecure housing arrangements within this group, all of which create demand on other services.

Despite an expected increase in the number of people with mental health conditions, over the period 2011-2014 the number of Adult Social Care service users with mental health conditions has marginally reduced. However, the prevalence rate of service users with mental health conditions remains relatively high, with 24.2% of all clients having some form of mental health disorder in 2013/14.

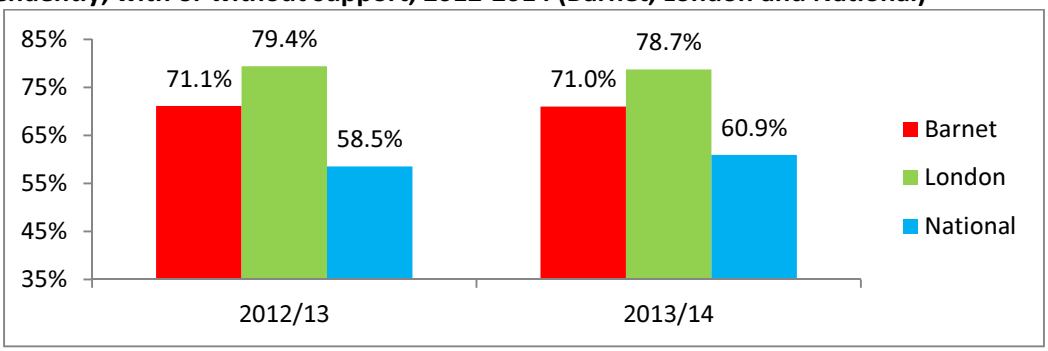
**Table 9-20: Number of mental health service users**

| Age Group | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| 18-64 | 1,059 | 39.8% | 1,173 | 42.4% | 1,127 | 41.8% |
| 65+ | 730 | 15.0% | 702 | 14.7% | 675 | 14.2% |
| Total | 1,789 | 23.8% | 1,875 | 24.9% | 1,802 | 24.2% |

Source: SWIFT – Adult Social Care Database

Where possible, Barnet would like all service users to remain at home and independent for as long as they wish to. In 2013/14 a smaller proportion of Barnet's residents who were in contact with secondary mental health services lived independently than the London average; 71.0% and 78.7% respectively. However, this is significantly above the National average of 60.9%.

**Figure 9-7: Proportion of adults in contact with secondary mental health services who live independently, with or without support, 2012-2014 (Barnet, London and National)**




### *9.10.1.1 Current Provision*

One in four people will need treatment for mental illness at some time in their lifetime and the majority of these treatments will be managed in primary care. Mental illness forms a large and growing proportion of primary care presentations, with one in three GP appointments involving significant mental health issues. This puts GPs and practice nurses at the centre of providing whole person care. Increasingly, this also involves promoting health and engaging with social care and the wider determinants of health.

The CCG spends 8.2% of its overall expenditure on direct mental health services. By far the most significant element of the CCG's mental health expenditure is in secondary mental health (i.e. hospital/residential settings).

Local secondary mental health services are delivered by the Barnet, Enfield and Haringey Mental Health Trust. Other NHS Trusts such as Central North West London Foundation Trust, Camden & Islington Foundation Trust, Tavistock and Portman Foundation Trust and South London & Maudsley Foundation Trust provide a range of secondary and specialist mental health services for Barnet patients, some of whom go on to reside in neighbouring Boroughs.

There are 1,305 adults and older people with mental illness known to the Council receiving social care services. A further 15 people are in receipt of health rehabilitation services funded by the CCG. Third sector and independent organisations such as Richmond Fellowship, MIND in Barnet and Barnet Refugee Service provide a range of support services including residential provision, housing/tenancy support, community inclusion, peer support, employment support etc.

### *9.10.1.2 Key Issues*

The number of people with Mental Health needs in Barnet is expected to continue to increase, especially in the older age patient group due to an above average increase in the number of people in the local older population.

**Table 9-21: Mental Health Projections for Barnet Population, 2014-2018**

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| People aged 18-64 predicted to have a common mental disorder | 38,076 | 38,542 | 39,061 | 39,572 | 40,046 |
| People aged 18-64 predicted to have a borderline personality disorder | 1,066 | 1,079 | 1,093 | 1,107 | 1,120 |
| People aged 18-64 predicted to have an antisocial personality disorder | 815 | 828 | 842 | 856 | 869 |
| People aged 18-64 predicted to have psychotic disorder | 946 | 958 | 971 | 983 | 995 |
| People aged 18-64 predicted to have two or more psychiatric disorders | 16,975 | 17,196 | 17,438 | 17,680 | 17,901 |
| * Figures may not sum due to rounding. Crown copyright 2014 | | | | | |
| ** The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem | | | | | |

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

A CCG commissioned review examined the current mental health services provided by Barnet, Enfield and Haringey Mental Health Trust and advocated modernising the current secondary care services towards a community based model of care (delivery within the community).

The evidence base for mental health disorders overwhelmingly demonstrates the benefits of more upstream investment in primary care and community services and one which focuses on prevention, early intervention and recovery, in improving patient experience, outcomes, quality, cost effectiveness and return on investment. The level of mental health support and training in primary care does not often reflect this level of need and responsibility. Best practice sources recommend that mental health problems should be managed in primary care, with primary care mental health teams working collaboratively with other services to access specialist expertise and skills[145].

### 9.10.2 Learning Disabilities

The proportion of people with learning disabilities (PWLD) is under 0.5% of the overall Barnet population; however over 11%% of Adult Social Care service users are PWLD. A 14% growth in the number of residents with moderate to severe learning disabilities is projected over the next decade.

Table 9-22 below shows the estimated number of PWLD in Barnet (as at 2014). This includes people with a lower level of need who, although unlikely to qualify for social care support, are still supported by the learning disability nurses and other healthcare professionals within the integrated learning disabilities team.

[145] The Joint Commissioning Panel for Mental Health, 2012

**Table 9-22: Estimated number of People with Learning Disability**

| Estimated number of PWLD - 2014 | |
|---|---|
| 18 – 34 years | 2,438 |
| 35 – 64 years | 3,321 |
| 65 + | 1,071 |
| **Total** | **6,830** |

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

Table 9-23 shows the number of PWLD who are in receipt of support by adult social care, as a proportion of the total number of service users. Overall the number and proportion of service users with PWLD has remained relatively stable during the period 2011-2014.

**Table 9-23: No. and % of Service Users with Learning Disability**

| Age Group | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| *18-64* | 758 | 28.5% | 752 | 27.2% | 765 | 28.4% |
| *65+* | 94 | 1.9% | 99 | 2.1% | 105 | 2.2% |

Source: SWIFT – Adult Social Care Database

However, this current trend is not expected to continue in the future. Improved survival rates at birth, increasing life expectancy, and growth among communities at higher risk of learning disabilities (for example, the South Asian community) mean that more PWLD and people with complex needs accessing adult services are expected to access the service in the future. The majority of these residents will require on-going social care throughout their lives.

**Table 9-24: LD Projections for Barnet Population**

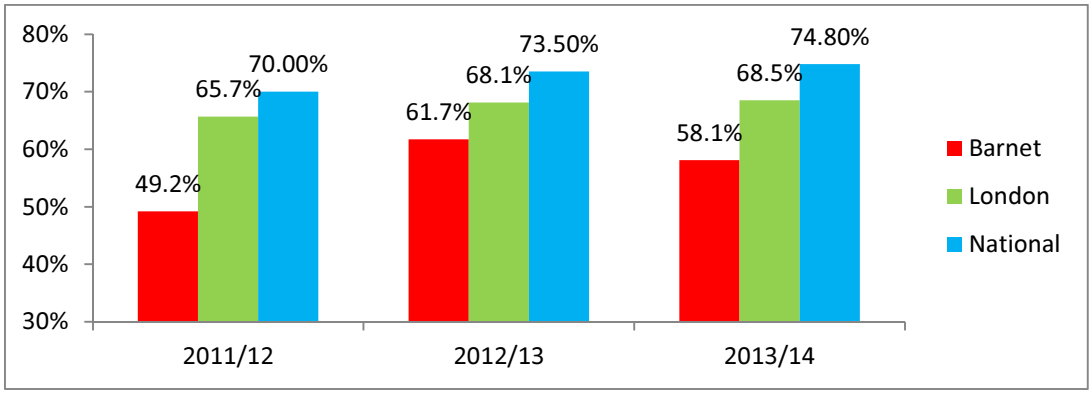
| Predicted to have a moderate or severe learning disability | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| People aged 18-24 | 193 | 192 | 190 | 189 | 191 |
| People aged 25-34 | 343 | 346 | 349 | 351 | 352 |
| People aged 35-44 | 346 | 353 | 362 | 369 | 377 |
| People aged 45-54 | 256 | 262 | 268 | 272 | 276 |
| People aged 55-64 | 176 | 180 | 184 | 189 | 194 |
| People aged 65-74 | 95 | 98 | 101 | 103 | 104 |
| People aged 75-84 | 35 | 35 | 35 | 36 | 37 |
| People aged 85 and over | 15 | 15 | 16 | 17 | 17 |
| Total population aged 18 and over | 1,459 | 1,481 | 1,504 | 1,526 | 1,548 |
| * Figures may not sum due to rounding. Crown copyright 2014 | | | | | |

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

An enquiry into abuse of people with Learning Disabilities and autism at Winterbourne View identified that many people with learning disabilities and/or autism remain in hospital or residential homes for too long. Even though many are receiving good care in these settings, many could lead happier lives living at home in the community.

The proportion of people in 2014 living independently (in their own home or with their family) in Barnet is significantly below the London and National averages. Furthermore, there was a slight decrease between 2012/13 (61.70%) and 2013/14 (58.10%).

**Figure 9-8: Proportion of adults in contact with Adult Social Care with learning disabilities who live independently, with or without support, 2011-2014 (Barnet, London and National)**




Source: SWIFT – Adult Social Care Database

The Government's Green Paper[146] sets out proposals to give people with learning disabilities, autism and mental health conditions more rights around the care they receive. Whilst this is subject to consultation and a programme of legislation, it is a significant policy shift which will mean that PWLD and autism will have a right to be treated near their home and family and wherever possible in community settings. There will also be a reduction in the number of beds available in hospital assessment and treatment units.

This change will be in addition to the increase in numbers of people with complex needs who will be accommodated in community settings. It is therefore expected that the trend shown in Table 9-25, towards increased community based provision and decreasing residential care will continue in the future.

**Table 9-25: People with Learning Disabilities accessing social care**

| Number of Unpaid Carers | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Residential Care | 296 | 272 | 238 |
| Community Care (settings) | 580 | 609 | 632 |

Source: SWIFT – Adult Social Care Database

In order to respond to the shift in growing community provision, more work is needed to develop a better understanding of the level and type of needs of PWLD and autism.

[146] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf

#### 9.10.2.1 Confidential Enquiry into the Premature Deaths of People with Learning Disabilities

The confidential enquiry into the premature deaths of people with learning disabilities (CIPOLD)[147] identified that people with learning disabilities die 16 years sooner on average than the general population and more than a third of these deaths are attributable to people not getting the right healthcare.

The enquiry found that there was not enough routine collection of data to provide information about the age and cause of death of people with learning disabilities. The Department of Health response included a recommendation that systems should be in place to ensure that local learning disability data should be analysed and published with population profiles and within the JSNA[148].

Specific comparative data is also required between the health of people with learning disabilities and the general population. On average, people with learning disabilities have poorer access to healthcare and die younger than their non-learning disabled peers; however there is a lack of robust data from which the JSNA and Health and Wellbeing Strategy can be informed. Additional data is needed around four major long term health conditions (obesity, diabetes, cardiovascular disease and epilepsy) to enable a more effective response to clinical needs and be in better position for future planning of reasonably adjusted health services for people with learning disabilities.

Health screening data will help to develop a better understanding of whether more PWLD are accessing such services, for the annual LD self-assessment it was found that 51 women with LD aged between 25 – 64 years had accessed cervical cancer screening and six PWLD aged 60 – 69 years had received bowel cancer screening.

### 9.10.3 Older Adults

People aged 65 and over account for the largest client group within adult social care. With the projected population within this age group, there is likely to be an increased need for services, during a time of more limited resources.

#### 9.10.3.1 Social Isolation

Feelings of social isolation and loneliness are detrimental to a person's health and wellbeing[149]. In the 2013 Annual User Experience Survey 24% of respondents said they either had some but not enough social contact, or felt socially isolated. In Barnet there are an estimated 18,300 older adults living alone, making up 38% of the elderly population in the Borough.

In 2014, the Barnet Customer Support Group Insight team carried out a piece of analysis to develop a profile of the types of people within Barnet that were likely to experience some level of social isolation. The analysis found that social isolation was most common amongst *women, aged 75 and over* who were *living alone*.

Figure 9-9 shows a map of socially isolated people in Barnet in 2014.

[147] http://www.bris.ac.uk/cipold/

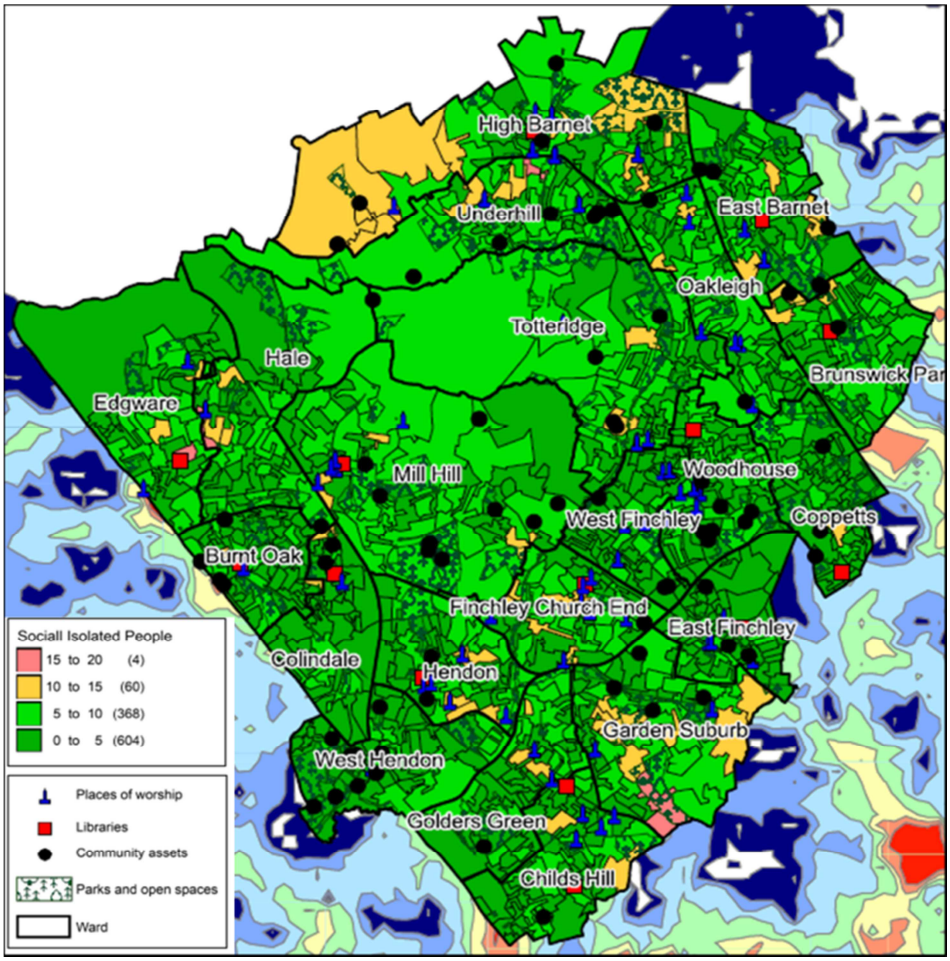
[148] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212077/Government_Response_to_the_Confidential_Inquiry_into_Premature_Deaths_of_People_with_Learning_Disabilities_-_full_report.pdf

[149] Rachel Wells PPT http://www.communitybarnet.org.uk/data/files/Rachel_Wells_-_Social_Isolation_and_Public_Health.pdf

The issue of social isolation is Borough-wide. However, Burnt Oak, Colindale and West Hendon have the lowest number of people likely to be socially isolated. Older people in these areas tend to be long-term residents having strong ties with the community.

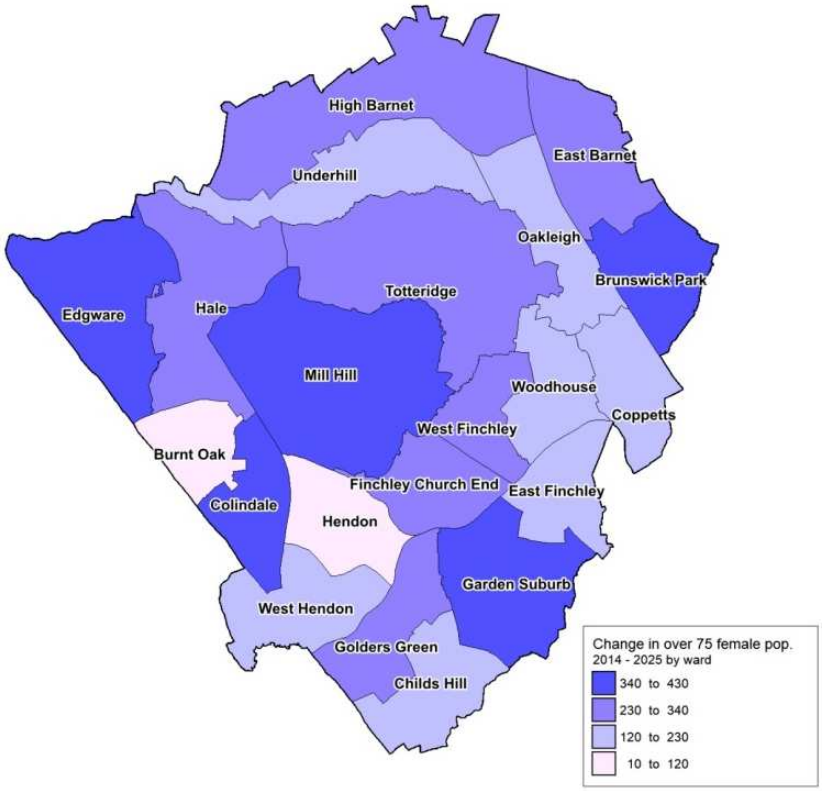
Less densely populated, more affluent areas in the north of the Borough were identified as possible hotspots for social isolation.

**Figure 9-9: Socially Isolated People in Barnet (2014)**



### *9.10.3.1.1 Possible Future Hotspots of Social Isolation*

**Figure 9-10: Change in over 75 year old female population by ward, 2014 – 2025**




Source: GLA 2013 Population Projections (Borough Preferred Option)

There will be an estimated 5,300 more females aged 75 and over by 2025, an increase of 37%.

The largest increases are in Edgware, Mill Hill and Garden Suburb. Garden Suburb and Mill Hill both have large isolated populations at present.

Colindale currently has relatively few isolated people. However, as the population grows with regeneration, the number of people at risk of isolation will also increase.

As more older and frail residents opt to stay at home for longer, there is an increased risk of people becoming socially isolated, driving up the need for local social groups and community health care facilities.

### *9.10.3.2 Dementia*

Barnet Council follows the principles and practice of the National Dementia Strategy and the Prime Minister's Challenge on Dementia and this will inform the Council's approach over the next five years.

Barnet has a higher population of people with dementia than many London Boroughs and the highest number of care home places registered for dementia per 100 population aged 65 and over in London. By 2021 the number of people with dementia in Barnet is expected to increase by 24% compared with the London-wide figure of 19%.

**Table 9-26: Population of people in Barnet over 65 with dementia, 2015-25**

| Year | Projected Population (65+) in Barnet with Dementia | % change from 2015 |
|---|---|---|
| 2015 | 4,044 | |
| 2020 | 4,693 | 16.05% |
| 2025 | 5,536 | 36.89% |

Source: NHSE Data

The significant increase in the number of people with dementia will require appropriate support for people with dementia and their family /carers. Services and communities are seen as key to this, and so there is a need to develop support from dementia friendly communities.

### 9.10.4 Autism

Approximately 1% of the adult population have an Autistic Spectrum Conditions (ASC) which equates to about 2,600 people in Barnet. In 2012/13, autism was recorded as a care need for 170 social care service users. National forecasts indicate that the number of young adults with autism will increase by 2.7% over the next 5 years, in Barnet this will mean a 9% increase. These figures show that there are more cases of ASC being diagnosed.

A comprehensive assessment of the needs of people with autism was undertaken by Public Health (PH) in November 2014. It was completed in collaboration with the with the purpose of informing the Autism Strategy.

**The key areas covered by the needs assessment were:**

- Prevalence of autism in Barnet
- Identifying services available in Barnet
- Comparison of service provision with national guidance

The estimated prevalence of autism amongst children aged 5-9 years old is 300, using the current population. This figure is similar to that produced using the Baron-Cohen et al study in 2012.

Unfortunately there is no robust data on the actual numbers of adults with autism, although estimates indicate that there are an approximately 2,324 people with autism within those aged 18-64. This number is expected to increase to 2,550 by 2020.

The current lack of comprehensive data on the numbers of adults with ASC in Barnet impacts on the ability to accurately plan and deliver the services that are needed for people with ASC and their carers, although prevalence estimates, which give an indication of the total number of people with ASC in the Borough, can be useful.

The study acknowledged the following limitations:

- Services do not routinely collect data on the number of clients with autism.

- "Diagnostic overshadowing" means that some clients with learning disabilities or mental health problems accessing services may also be suspected of having ASC, but are not diagnosed.
- Clients with Asperger's may not be accessing statutory services or be eligible to receive support. It is likely that there are more people with ASC than those known to statutory agencies.
- Individuals can access diagnostic services from a range of private providers and may, therefore, not be known to local NHS providers.

A key priority is to enable the development of the systems to accurately capture and record the numbers of adults with ASC. The focus should be on those areas where data is lacking and where a need has been identified:

- The range of need for support to live independently
- The number of adults with ASC who are likely to need employment support in order to work
- The number living at home on their own or with family members and not receiving health or social care services, and
- The number living with older family carers.

### 9.10.5 Physical and Sensory Impairment

Over 50% of Adult Social Care service users have a physical or learning disability, and for people aged 65 and over this rate this is significantly higher; 72.20% in 2013/14.

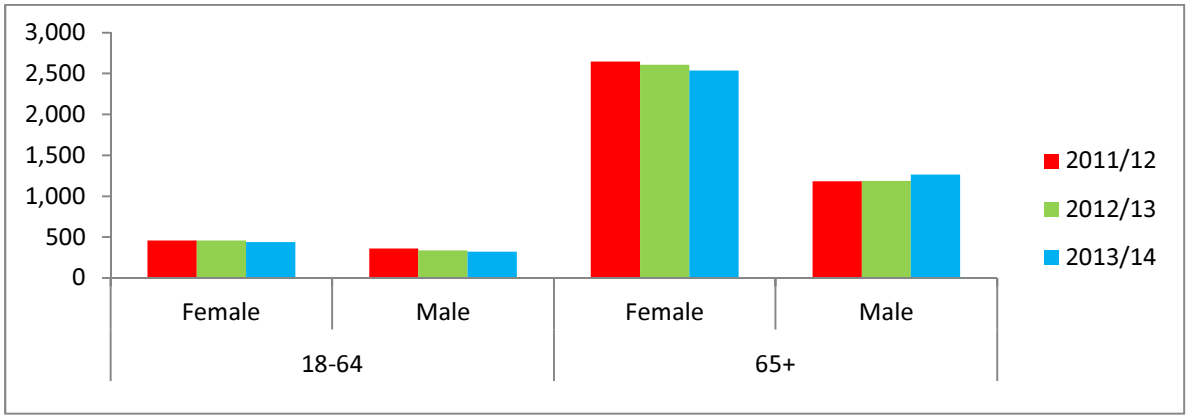
**Table 9-27: No. and % of Adult Social Care categorised as Physical Disability and Sensory Impaired**

| Age Group | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | No. | % of Total Service Users | No. | % of Total Service Users | No. | % of Total Service Users |
| 18-64 | 701 | 26.30% | 689 | 24.90% | 656 | 24.30% |
| 65+ | 3,352 | 68.90% | 3,353 | 70.30% | 3,427 | 72.20% |

Source: SWIFT – Adult Social Care Database

As shown in Figure 9-11, across both age categories there are more females with physical or sensory impairments than male. And within the 65 and over age group, there are more than twice as many women with physical or sensory impairments as men. However, within the 65 and over age group, women account for 56.5% of the population (29,152) compared to men who account for 43.5% (22,423).

**Figure 9-11: Gender of Physical Disability & Sensory Impaired Service Users**




Source: SWIFT – Adult Social Care Database

The high rates of service users with physical or sensory impairments may mean that enabling people to remain in their own home could require them to have access to resources and support from prevention services and / or statutory services.

#### *9.10.5.1 Key Issues*

- The number of people with a Physical and /or sensory impairment is increasing.
- This will have an impact on the demand for services such as appropriate housing /support needs.
- Due to medical improvements people with physical and /or sensory impairment are living longer and therefore resources are required for a longer period of time to support them.
- There is a need for improvements in the provision of health and social care needs.

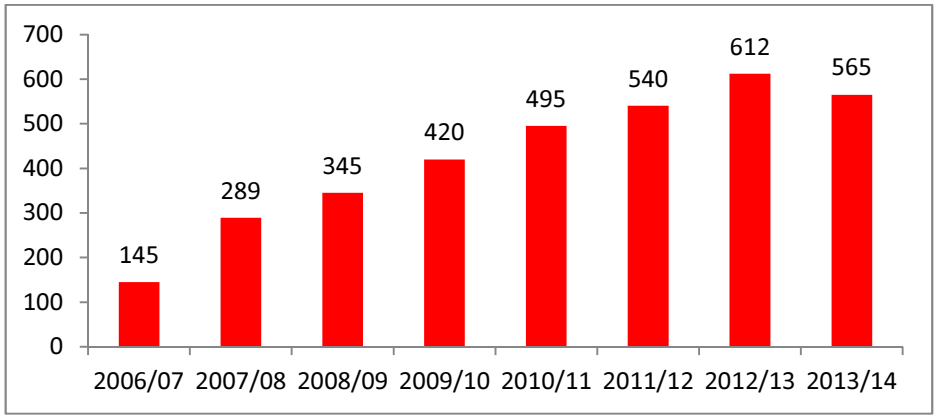
## 9.11 Safeguarding

Barnet's Safeguarding Adults Board was established in July 2001. It is made up of senior officers from the different public services who work with vulnerable adults in Barnet. The
Board has four main aims:-

- To promote the welfare of vulnerable adults and to develop good practice in health and social care services;
- To raise awareness of abuse wherever it occurs and to encourage people to report it if it happens;
- To ensure that agencies work effectively together to ensure abuse is investigated and that people are helped to remain safe;
- To learn lessons where people have not been adequately protected.

In 2013/14 Barnet Council received a total of 565 alerts, an 8% decrease from the previous year. This was the first drop in alerts received in 7 years.

**Figure 9-12: Safeguarding Alerts, 2006-2014**




The number of alerts investigated under the Council's safeguarding procedures in 2013/14 remained very similar to the previous year. This would suggest that there is an improved understanding of what safeguarding is and how the Council can help people who are affected.

In 2013/14, of the 565 alerts received, 406 (72%) were investigated.

For every case investigated, the Council decides if the abuse 'happened' (substantiated), 'part happened' (partly substantiated), or 'did not happen' (not substantiated). In some cases it is not possible to establish what has occurred leading to an outcome of 'not determined'.

**Table 9-28: Concluded Investigations**

| Conclusion | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number of Cases | % of Cases | Number of Cases | % of Cases | Number of Cases | % of Cases |
| Abuse sustained | 148 | 39% | 148 | 39% | 120 | 33% |
| Abuse partly sustained | 40 | 10% | 25 | 7% | 33 | 9% |
| Abuse not sustained | 102 | 27% | 120 | 32% | 134 | 36% |
| Not determined | 92 | 24% | 82 | 22% | 82 | 22% |

The Safeguarding Adults Board has set the following four strategic priorities for 2014/15:

- Improve the standards of care to support the dignity and quality of life of vulnerable people in receipt of health and social care, including effective management of pressure sores.
- Improve the understanding of service providers of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Improve access to justice for vulnerable adults.
- Increase the understanding among the public of what may constitute abuse.

Details of how the Council plans to deliver these priorities can be found in the SAB Business Plan for 2014/16.

## 9.12 Providers and Provider Failure

Care Quality oversees the contract management relationships and compliance with providers across adult social care. To ensure quality and service improvement strategic and operational contract management and other data intelligence such as safeguarding information, service user reviews and on-going dialogue with the CQC are reviewed. A provider experiencing difficulties in maintaining quality or financial sustainability will be managed and supported in a variety of ways to ensure continuity of care.

In a small number of instances, provider failure is unavoidable and in such circumstances, the primary focus is the continuity of care and support for those affected. Alternative care providers will be procured within a managed project to ensure a smooth transition. Table 9-29 displays the current number of contracts held within supply management and is broken down across service areas.

**Table 9-29: Service providers by service type**

| Service | No of Providers |
|---|---|
| Home Care | 28 |
| Day Care | 20 |
| Supported Living (SL) | 52 (31 on SL Framework) |
| Electronic Call Monitoring | 1 |
| Alarm Services | 11 |
| Extra Care | 3 |
| Floating Support Services & Mental Health Services | 1 |
| Housing related support | 6 |
| Meals | 1 |
| Residential & Nursing | 224 |
| Prevention Services | 18 |

### 9.12.1 Care Act 2014 requirements for provider failure

The Care Act 2014 states there is a statutory duty on local authorities when a provider failure occurs and that there is a temporary duty to ensure that people's care is not interrupted. The duty applies temporarily until the local authority is satisfied that the person's needs are met by the new provider. There are specific conditions in which the duty is applied:

- A registered care provider
- Unable to carry out a regulated activity
- This is due to business failure (business failure constitutes appointment of an administrator, appointment of receiver, passing of a resolution for a winding up order)

The Care Act also gives powers to the Care Quality Commission (CQC). The Market Oversight Regime will give CQC powers to monitor the financial sustainability of certain hard to replace providers. This may be due to their size or specialism which would prove difficult to replace if they were to fail.

### 9.12.2 Key learning from previous provider failure

Capacity building to ensure a sustainable market in the medium to long term is acknowledged as a key commissioning and supply management component to ensuring providers deliver quality

services. Understanding and shaping the market will need to be a firm feature in contractual relationships.

A Provider Failure Policy will be implemented as part of implementing the Care Act. A procedure will cover how Barnet will manage a provider failure whether the Care Act duty is enacted or not. The procedure will form part of the business continuity plan.

## 9.13 Voice

Barnet Council and its partners conduct public consultations which seek to understand the opinions and experiences of local residents and service users across a wide range of subjects. The following section details insight lifted from recent consultation related specifically to health and social care.

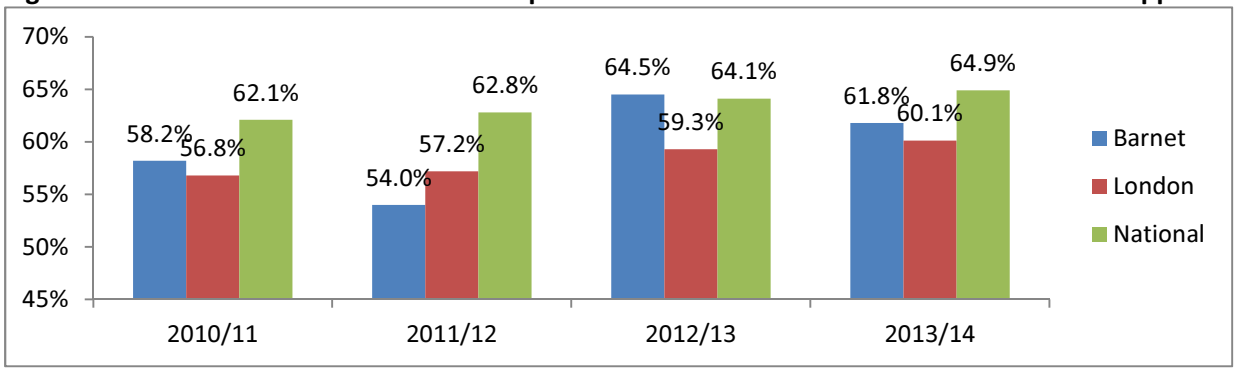
### 9.13.1 User and Carers' experiences of Social Care

Adult Social Care capture information about the service user experience through two surveys:

- The annual National Service User Survey (for service users aged 18 and over), which explores how effectively service users are supported to achieve a good quality of life,
- The National Carers Survey, which highlights how successfully or otherwise carers are supported in their caring role and their life outside of caring. It also captures their perception of the support received by the person they care for. This survey is carried out every two years and was last run in 2012/13.

The last National Adult Social Care Service User Survey was carried out in 2013/14. Responses showed that the level of service user satisfaction had fallen slightly, since 2012/13, with fewer feeling the care and support services they received had helped them with daily activities and their general wellbeing. Fewer service users found it easy to obtain information and advice and less actively sought information.

**Figure 9-13: Overall Satisfaction of People who use Services with their Care and Support**

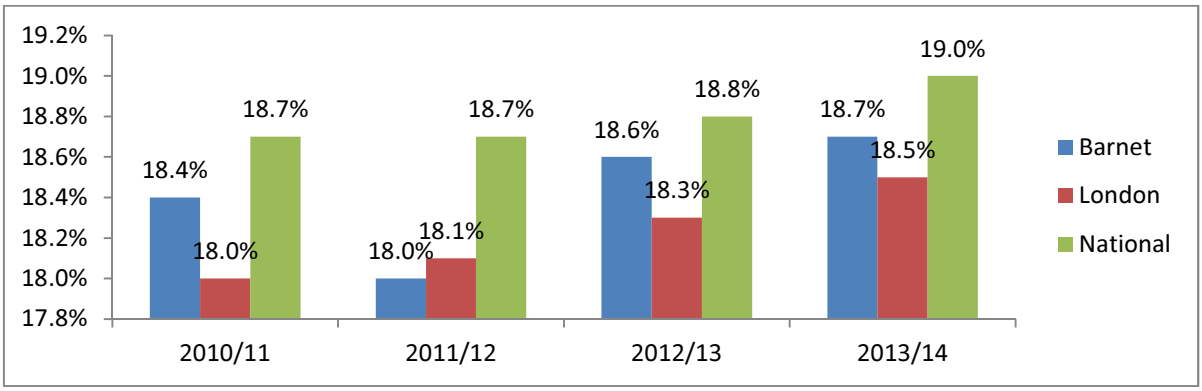



Source: National Adult Social Care Service User Survey 2013/14

Self-reported general health had declined a little since 2012/13 and there had been a significant increase in the proportion of service users experiencing pain or discomfort, with nearly three quarters of service users reporting some level of pain/discomfort.

Despite the above, service users were reporting a similar level of capability with day to day tasks as reported the previous year, along with a significantly improved perception of quality of life.

**Figure 9-14: Social-Care Related Quality of Life**



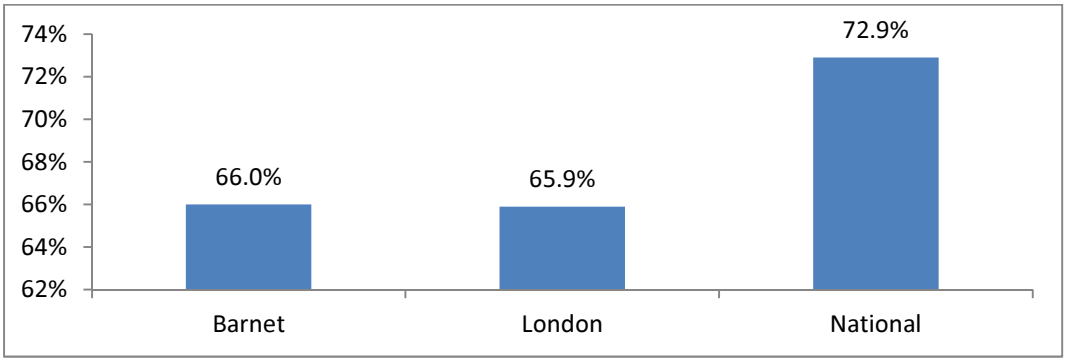

Source: National Adult Social Care Service User Survey 2013/14

The Carers Survey was piloted in 2010/11 and the first national version of the survey was run in 2012/13.

For Barnet, results in 2012/13 showed 34.6% of carers were extremely or very satisfied with the service they received, which was in line with the comparator group average of 35.4%. The proportion of respondents dissatisfied with the service they received had fallen since the pilot survey from 13% to 9%.

66% of carers always or usually felt involved in discussions about support and services for the person(s) they cared for. This was a decrease on the 72% reported in the pilot survey; however Barnet remained in line with its comparator group average.

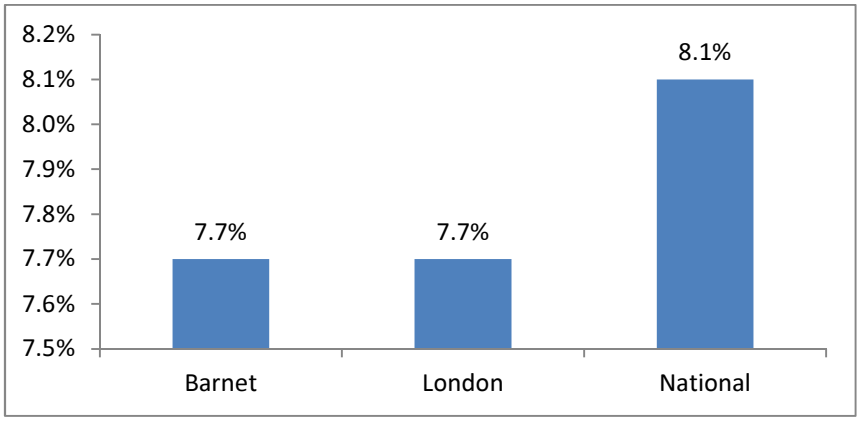
**Figure 9-15: Carer's Involvement in Discussions**




Source: The Carers Survey 2012/13

Between the pilot survey and the first national version in 2012/13, there was a growth in the number of carers receiving information and advice, as well as support for carers to talk in confidence or to stay in employment. Most carers felt that they could do some of the things they enjoyed with their time but not enough (21% in 2012). However; in 2012/13, 15% of carers felt they did not do anything that they valued or enjoyed. These figures were very similar across all comparable local authorities in London.

**Figure 9-16: Carer related quality of life**




Source: The Carers Survey 2012/13

# 10 Community Safety

## 10.1 Key Facts

- Crime has seen a long-term downward trend over the last 10 years from a peak of over 35,000 crimes a year in 2005, to under 25,000 in the 12 months up to February 2014.
- Overall Barnet has experienced 11% less crime in the 12 months between March 2013 and February 2014[150] compared to one year ago.
- There are fewer victims of crime (in the 12 months up to 25 February 2014) compared to one year ago: 747 fewer households being victims of residential burglary, 68 fewer victims of non-residential burglary, and 372 fewer people becoming victims of robbery in the Borough[151].
- In the 12 months up to January 2014 Barnet had the 8th lowest crimes per 1000 population of all 32 London Boroughs.

## 10.2 Strategic Needs

- **Barnet has the 5th highest rate of residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary still remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to February 2014. When considering underreporting, the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the year.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to increase underreporting.
- **Violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs, despite making up just 6.5% of the offences**.
- **Domestic violence is more familiar within some services and organisations than other Violence Against Women and Girls (VAWG) issues**; further work needs to take place to identify if additional VAWG services are needed within the Borough.

## 10.3 Overview

The statutory duty for Barnet Safer Communities Partnership[152] includes producing and considering the findings of an annual strategic crime needs assessment when developing a local community safety strategy. The data in this section is based on Barnet's 2014/2015 Strategic Crime Needs Assessment.

[150] Source: Published MPS crime stats (SAroot\data\crime_stats_mps_published_toFeb2014.xlsx)
[151] Source: MPS DOI performance stats (SAroot\data\sx_dash_to25Feb2014.pdf)
[152] Made up of key agencies Barnet Council, the Metropolitan Police, Fire Service, the Probation Service, Public Health

## 10.4 The Cost of Crime

The Home Office produces unit cost estimates for different crime types[153]. The estimates take into account anticipatory costs (for example security expenditure), consequential costs (e.g. property stolen, emotional or physical impacts), and response costs (e.g. costs to the criminal justice system).

Table 10-1 calculates total cost estimates for different crime types in Barnet by multiplying the Home Office unit cost estimate by the number of offences in the Borough in one year (2013).

**Table 10-1: The Estimated Annual Cost of Crime in Barnet, 2013**

| Type | Estimated Annual Cost (2013) | % of Total Cost |
|---|---|---|
| Violence - ABH and GBH | £22,813,255 | 30.9% |
| Sexual Offences | £13,117,960 | 17.8% |
| Burglary in a Dwelling | £10,817,300 | 14.6% |
| Robbery - Personal Property | £5,937,940 | 8.0% |
| Burglary in Other Buildings | £5,875,200 | 8.0% |
| Theft / taking of Motor Vehicle | £3,772,230 | 5.1% |
| Theft from Motor Vehicle | £3,079,252 | 4.2% |
| Other Theft | £2,759,008 | 3.7% |
| Common Assault | £2,115,750 | 2.9% |
| Criminal Damage Total | £2,016,495 | 2.7% |
| Robbery - Business Property | £693,528 | 0.9% |
| Theft Person | £576,065 | 0.8% |
| Theft / taking of Pedal Cycle | £173,201 | 0.2% |
| Theft from Shops | £146,072 | 0.2% |
| Total Annual Cost (excluding some crime types*) | £73,893,256 | |

This gives an estimated annual total cost of around £73.9M for reported crime in Barnet in one year. Note this estimate does not include costs for the following offences: Drugs; Fraud; Handling; Motor Vehicle Tampering; Harassment; Carrying of Weapons; and Violence other than Common Assault, ABH, GBH. The estimated costs of unreported crime are also not included in this figure.

The top three cost contributors are violent crime, sexual offences and residential burglary. Note that for the top two (violence and sexual offences) the majority of the victims (though minority of the perpetrators) are women and girls.

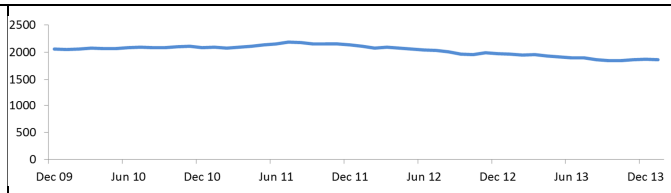
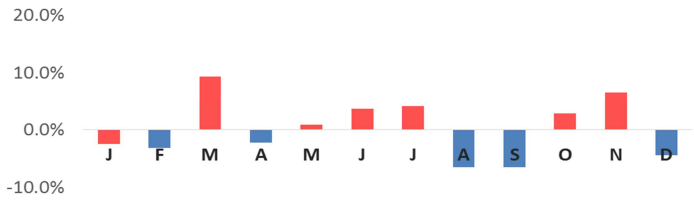
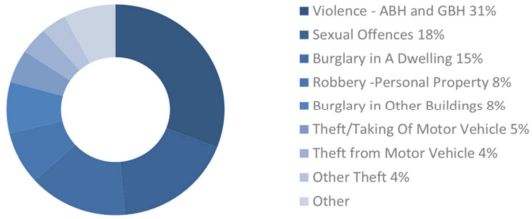
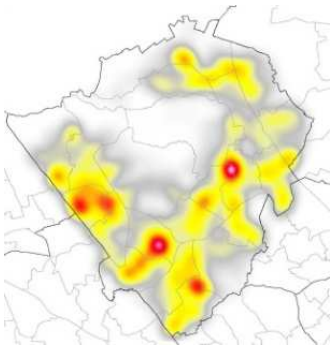
## 10.5 Summary of All Recorded Crime in Barnet

| Current Figures refer to the 12 month period ending 31 Jan 2014[154] | |
|---|---|
| **Level of crime** | **22,837 crimes** / 62.75 per 1000 residents |
| **Peer comparison** | 8th/32 in London and 4th/15 in 'Most Similar Group' |
| **Annual Change** | Reduction of 2804 crimes / 10.9% compared to one year ago *(this figure is for 12 months to Feb 2014)*[155] |

**153** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118042/IOM-phase2-costs-multipliers.pdf

**154** SAroot\data\Crime Data to Feb14 PROTECT.xls

**155** Source: SAroot\data\crime_stats_mps_published_toFeb2014.xlsx

<table>
<tr><td>General Trend</td><td> 
</td><td>Falling from late 2011 to late 2013, appears to be levelling off</td></tr>
<tr><td>Seasonality</td><td> 
</td><td>March followed by November are the peak months</td></tr>
<tr><td>Breakdown of crime types</td><td> 
</td><td>Breakdown of estimated annual cost of crime on Barnet by crime type</td></tr>
<tr><td>Hotspots</td><td>  </td><td>Five Wards (All Crime, to Feb 2014)[156]<br><br>West Hendon 1890<br>Childs Hill 1775<br>Coppetts 1403<br>Hendon 1339<br>Golders Green 1289<br>The top 5 account for 34% of the Borough total</td></tr>
<tr><td>VOL(T) analysis</td><td colspan="2"><table>
<tr><td>Victim</td><td>The top locations where victims of crime live (irrespective of where the offence occurred) in descending order are HA8, NW9, EN5, NW4, NW11</td></tr>
<tr><td>Offender</td><td>Peak age for arrests in Barnet is 16-24 year old (35% of all arrests). Most arrested suspects are male (86.5%). Because of repeat offending a small proportion of offenders are responsible for a disproportionately large amount of crime</td></tr>
<tr><td>Location / Time</td><td>The top five areas based on the offence location are (in descending order): HA8, NW4, EN5, NW9 and N12</td></tr>
</table></td></tr>
</table>

## 10.6 Anti-Social Behaviour (ASB)

- Barnet residents made 11,798 ASB related calls to police in the 12 months to 25 February 2014; 308 of these were repeat callers[157].
- These figures represent a 12.7% reduction in total ASB calls and 13.2% reduction in ASB repeats compared to the previous year.

**156** Source: SAroot\data\mpsBarnet12monthsWardTNOstats.xls

[157] Source: Published MPS crime stats (SAroot\data\crime_stats_mps_published_toFeb2014.xlsx)

- According to Barnet's Residents' Perception Survey: 70% of residents are very or fairly satisfied that police and the Council are dealing with crime and ASB in their local area which is up 2% from 2012 RPS, but down from 75% in 2010.
- The top (and increasing) ASB concern is rubbish and litter lying around[158].
- When asked in the Community Safety Survey 2011 'Imagine you could set local priorities to improve safety in this area', the top response was reducing levels of ASB and disorder (50% of residents said this would be in their top three priorities).

## 10.7 Residential Burglary

- Between 2008 and 2011 the rate of residential burglary in Barnet increased (in total by around 1,000 offences per year), remaining at a high level during 2012 and early 2013. Since April 2013 residential burglary levels in the Borough have fallen.
- Barnet's current sanction detection rate for residential burglary (19.7%) is the highest of all 32 London Boroughs. If Barnet is able to maintain such a high sanction detection rate, this will help contribute towards a sustained long term reduction of residential burglary in Barnet.
- Cross border burglary is the most significant contributor to overall burglary levels; during a 12 month sample period 64% of suspects were from outside of the Borough.
- Analysis of the distribution of residential burglaries in the Borough shows that houses in some streets in Barnet face a risk of burglary of at least double the Borough average. Many such streets back on to open space such as parks, allotments and alley ways.
- Near repeat phenomenon: studies have identified that for a time following a burglary, the homes in the vicinity of the burgled venue face a raised risk of being burgled.

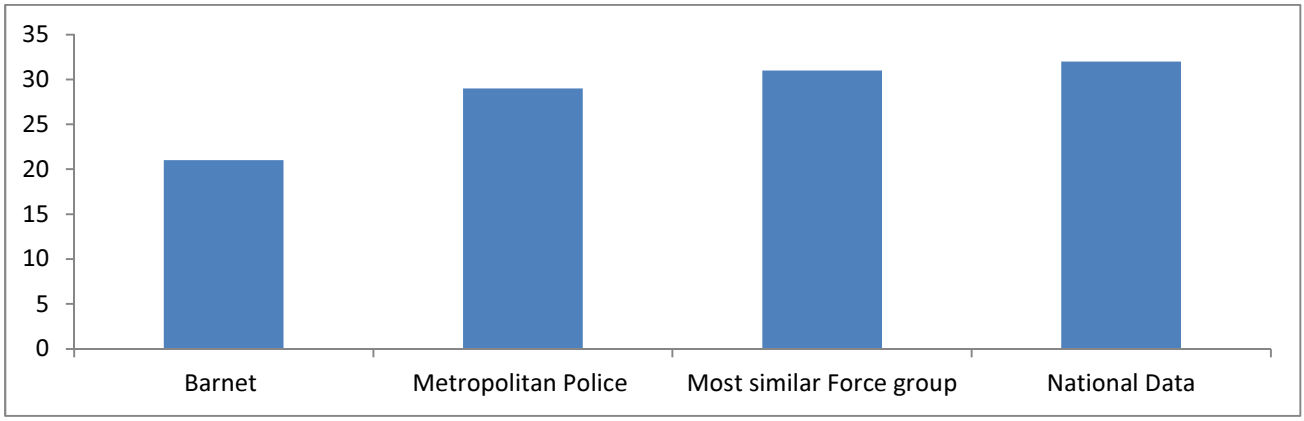
## 10.8 Domestic Violence and Violence Against Women and Girls (VAWG)

Nationally, it is estimated that one in four women experience domestic violence in their lifetime and two women are killed every week due to domestic violence. The exact volume of Domestic Violence (DV) and Violence Against Women and Girls (VAWG) is unknown nationally. Some agencies collect data but not all victims refer themselves or are engaged with any support agencies, meaning there is an assumption of underreporting.

Given this context, Barnet will be seeking support from partners to identify and share their data in order to scope the extent of DV and VAWG issues in the Borough, enabling us to develop a more informed approach that meets local need.

[158] Flatley, Kershaw, Smith, Chaplin and Moon (2010) BCS - Crime in England and Wales 2009/10

**Figure 10-1: Cases per 10,000 of the adult female population**




Source: MARAC data, SafeLives

### 10.8.1 Key Issues

The current issues are that domestic violence is more familiar within some services and organisations; more than the other VAWG issues, so further work needs to take place on this.

- Barnet has a three year Domestic Violence and Violence against Women and Girls Strategy and Action Plan 2013-2016. This is delivered by a whole range of voluntary and statutory partners. This includes domestic violence and abuse, forced marriage, honour based violence, prostitution, trafficking, rape and sexual violence, FGM, peer on peer abuse and sexual exploitation.
- Work has also started on the other areas of VAWG, including a level of understanding of where communities might be disproportionately affected by these issues. However, more in-depth work needs to take place on all areas to establish whether there is a need for any additional VAWG services within the Borough.

### 10.8.2 Multi-Agency Risk Assessment Conference (MARAC)

In the last three financial years, there has been a steady increase in the number of DV referrals to the DV MARAC (*2012-13* **= 175,** *2013-14***= 234,** *2014-15***= 311**) which is interpreted as impact of the interventions that have been put in place to heighten the awareness of agencies and the public to VAWG.

Of the 311 cases discussed by Barnet's DV MARAC between 1 January and 31 December 2014, 95% were female victims of DV, with 5% being male. The predominant age band of victims in Barnet is between 21–30, with 38% of cases, followed by those aged 31–40. The most common ethnicity is White accounting for with 58% of victims, followed by any Other and Black with 12%.

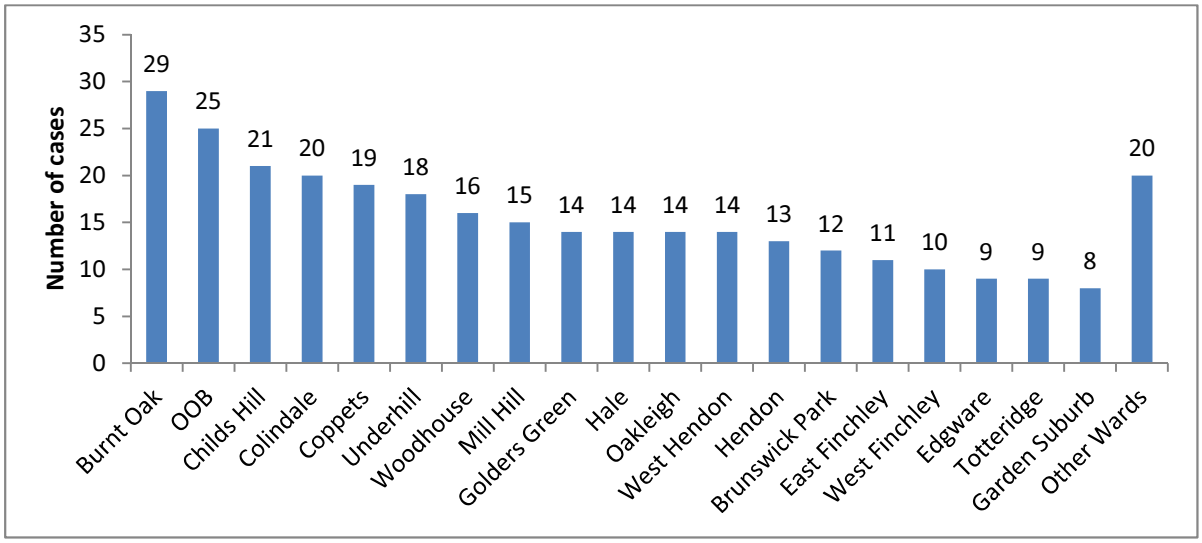
**Table 10-2: Age and Ethnicity of Domestic Violence victims**

| Age of Victim | Number | % | Ethnicity | Number | % |
|---|---|---|---|---|---|
| **15 - 20** | 26 | 8% | **White** | 179 | 58% |
| **21 - 30** | 119 | 38% | **Any Other** | 37 | 12% |
| **31 - 40** | 78 | 25% | **Black** | 36 | 12% |
| **41 - 50** | 56 | 18% | **Not stated** | 28 | 9% |
| **51 - 60** | 20 | 6% | **Asian** | 22 | 7% |
| **61+** | 12 | 4% | **Mixed** | 9 | 3% |
| **Total** | 311 | 100% | **Total** | 311 | 100% |

Source: Extract from MARAC database

The primary addresses for this cohort of cases are spread across the Borough, with the majority of victims residing in some of the areas with the highest levels of deprivation such as Burnt Oak, Childs Hill and Colindale. Also, a large proportion of cases come from Out-of-Borough (OOB).

**Figure 10-2: Primary address of Domestic Violence victims by Barnet Ward**




Source: Extract from MARAC database

Of the 311 cases that were referred, 205 of these had children. The majority of cases involved one child (45%) as shown in Table 3.

**Table 10-3: Number of Children per Family**

| Children per Family | Number | % |
|---|---|---|
| **1 Child** | 93 | 45% |
| **2 Children** | 64 | 31% |
| **3 Children** | 34 | 17% |
| **4+ Children** | 14 | 7% |
| **Total** | 205 | 100% |

Source: Extract from MARAC database

Overall, there were 386 children linked to the 311 referrals made to Barnet's MARAC. The prevalent age bands of these children were the 0-4 (35%) and 5-9 groups (33%).

**Table 10-4: *Age of Children***

| Age of Children | Number | % |
|---|---|---|
| **0-4** | 137 | 35% |
| **5 - 9** | 127 | 33% |
| **10 - 15** | 92 | 24% |
| **16+** | 30 | 8% |
| **Total** | 386 | 100% |

Source: Extract from MARAC database

### 10.8.3 Domestic Violence Advocacy and Support Services

#### *10.8.3.1 Refuge Provision*

The Council currently provides 18 bed spaces in Barnet for women leaving a situation involving domestic violence. Between 2013/2014 and 2014/2015, there has been a 98% occupancy rate of the rooms available. The small percentage of non-occupancy allows for the turnover of referrals.

All the women are Safe Lives (formerly CAADA) DASH risk assessed and they will only be turned away if they are deemed unsuitable in not meeting the criteria or if there is no space in the refuge. If the latter is the case, they are still supported by UK Refuges online to find alternative space. Housing will remain a critical area of work for partners as the refuge requirement increases.

Barnet Community Safety Team continues to co-ordinate the local partnership approach to address violence against women and girls. However, a partnership focus to identify victims, provide interventions to reduce repeat victimisation and ensure the safeguarding needs of vulnerable adults and children experiencing domestic violence needs to continue. The demand placed on services by families experiencing domestic violence will increase if left unsupported; therefore it is important for partners to recognise the collective benefits of prevention especially to statutory organisations.

The demand for services continues to rise despite national evidence that domestic violence remains an under reported crime. Women experience an average of 35 incidents of domestic violence before reporting an incident to the police (Yearnshaw 1997).

### 10.8.4 Domestic Violence and Crime

The rate of domestic abuse incidents (per 1,000 population) recorded by the police in Barnet (18.6) are similar to the national (18.5) and London regional (18.8) rates for the year 2012/13. Overall, the Barnet rate of domestic abuse has decreased from 19.6 in 2010/11 to 18.6 in 2012/13. Domestic violence can be against any member of a household; however, most commonly the victims of domestic abuse are females and young children.

Women account for 13.5% of suspects for crime overall. However, 51.5% of victims of violent offences (violent crime, robbery, sexual) are female. 87% of victims of sexual crimes are female. Even these figures are likely to understate the situation as both under-reporting and repeat victimisation are common features of domestic violence.

VAWG could have different manifestations such as rape, sexual violence, and female genital mutilation, which are reported below.

Nationally, the VAWG agenda is rising in prominence, reflecting national concerns. It is important that Barnet partners both understands the local picture of violence towards women and girls and are able to act to reduce harm towards women and girls who are at risk.

Responding to domestic violence alone costs Barnet an estimated £38 million a year. By responding to DV and VAWG early and seeking to prevent it, there is potential to make significant savings across the partnership and, most importantly, reduce the harm it causes to victims, their families and the wider community.

### 10.8.5 Key Facts

*The figures below relate to the 2013 calendar year unless otherwise stated.*

- Sexual crime: 87% of victims are female. There has been a sharp increase in the number of female victims aged 14 years.
- Violent crime: 52% of victims are female.
- Even these figures are likely to understate the situation as violent crime and hate crime are among the most underreported crime types.

- In Barnet violent crime is the crime type with the single largest cost associated with it, and sexual offences have the second highest associated cost. Both of these crime types have a majority of female victims.
- In fact, reported violent crime and sexual crime against women in Barnet accounts for an estimated 28% of the total cost of crime in the Borough (in contrast residential burglaries account for 14% and robbery around 8%).
- Women experience an average of 35 incidents of domestic violence before reporting an incident to the police (Yearnshaw 1997).
- 76% of all DV incidents are repeat offences (National estimate 2009/10[159]).

### 10.8.6 Summary

There has been an upward trend in the volume of reported domestic violence offences in Barnet. This increase is likely to be due to an increase in willingness to report and record appropriately, rather than an underlying increase in the actual prevalence rate of domestic violence[160]. This is a positive development and reflects concerted effort at the national, London and Borough level to raise awareness and reporting of domestic violence. Efforts to raise awareness amongst practitioners about the importance of making referrals to MARAC has also yielded positive results with the number of cases being risk managed by MARAC increasing significantly in 2013/14.

## 10.9 Rape and Other Sexual Violence

The latest crime figures released by the Metropolitan Police show that in the London Borough of Barnet 150 incidences of rape were reported in the 12 months up to March 2015 (2014/15) compared to 113 rape incidences in the previous 12 months up to March 2014 (2013/14). These statistics reveal that the rape crimes increased by 32.7% in Barnet compared to a 20.4% increase for the whole of London in the last 12 months.[161]The other sexual offences, which include indecent assault and unlawful (under age) sexual intercourse, were also up by about 14% in Barnet in the last 12 months i.e. 277 incidences in 2014/15 vs. 243 incidences in 2013/14.**Error! Bookmark not defined.**

## 10.10 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) has been defined by the WHO as "all procedures that involve the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".[162] Mostly prevalent in some communities of African and Middle Eastern origin, FGM is a harmful practice that has both short term and long term health, social and psychological effects on the girls and women and it violates their reproductive health and human rights.[163] The United Nation passed a resolution in 2012 that calls for elimination of FGM. In the UK, FGM is illegal and the NHS provides specialised FGM health services to women and girls.

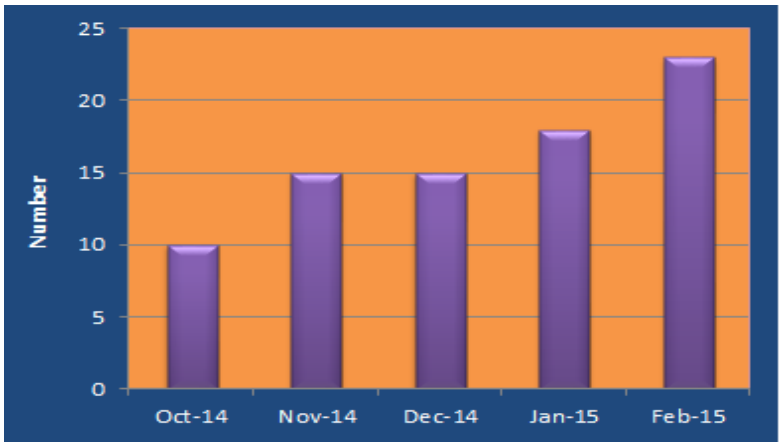
There are no direct statistics with respect to FGM cases in the London Borough of Barnet. However, acute hospital NHS healthcare trusts are required to submit FGM prevalence aggregated data on identified FGM cases on a monthly basis since 1st September 2014. The monthly FGM prevalence

[159] Flatley, Kershaw, Smith, Chaplin and Moon (2010) BCS - Crime in England and Wales 2009/10
[160] See 'DV Looking at Underreporting' in section 4 of this document for the assessment of this issue (page 45)
[161] Metropolitan Police. Crime Figures for London
[162] WHO (2014) Female genital mutilation. Fact sheet No. 241. Updated February 2014.
[163]United Nations Population Fund (UNFPA) (2014) Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation. New York.

data by the Royal Free London NHS Foundation Trust, which provides healthcare to most of the Barnet population, is shown in Figure 10-3.

These data are an indicator but not an actual picture of FGM in Barnet because the FGM patients might be referred to other hospitals. The actual FGM profile in Barnet would take some time to be recognised, especially after the return of FGM enhanced datasets, which began in April 2015. However, to tackle FGM in the Borough, the Barnet Multi-agency Safeguarding Hub (MASH) team has been setup that provides advice to women, girls, parents and carers on FGM and the steps that need to be taken to protect women and girls from FGM and its effects.

**Figure 10-3: Active Caseloads of FGM at Royal Free London NHS Foundation Trust**




Source: HSCIC, FGM Experimental Statistics (Feb 2015)

## 10.11 Youth Crime

Through consultation young people have told the Council that safety is one of their top priorities. Survey results showed that compared to the population average, people aged 19 or under were over 55% more likely to feel 'very worried' about the risk of being physically assaulted.

Barnet is one of the safest Boroughs in London. Barnet's rate of violence with injury rate of 4.2 per 1,000 population in the last 12 months is one of the lowest out of all London Boroughs, and also out of the 15 comparison areas in Barnet's 'Most Similar Group'.

As would be expected, however, violent offences (including violence towards young people) are not distributed uniformly across the Borough.

### 10.11.1 Key Facts

- The peak victim age for offences with violent contact between the victim and offender (robbery, violence, and sexual offences) is: 15 to 33 years (52% of victims are in this range).
- The peak victim age for robbery is: 14 to 18 years old (33% of all male victims in this range).
- The peak victim age for sexual crime is: 14 to 22 (38% of all female victims in this range).
- The 'Voice of the Child' consultation exercises seek feedback from young people about the Borough. This has established that safety is a priority for many young people; that some young people do not feel safe being in some parts of the Borough in the day time and in the evening, and not necessarily always in the areas of deprivation.
- Most arrested suspects are males aged between 15 to 35 years (57% of arrests), peaking between 16 to 24 years old.
- Violent crime is one of the main crime types for both under reporting and repeat-victimisation. Anecdotally (based on a review of local intelligence) this appears to be particularly the case

where young people are the victims. This makes it more difficult to identify and intervene to reduce the risks associated with on-going victimisation.

## 10.12 Gang Activity

Barnet is one of the safest London Boroughs with the overall crime rate falling. From June to August 2013 Barnet had the lowest rate of Violence with Injury per 1,000 population of all 32 London Boroughs. Between April and September 2013 Barnet has seen reductions in most types of violent crime in comparison with the same period in the previous year; Serious Youth Violence, Knife Crime, Gun crime, Robbery, and Non DV Violence with Injury all reduced significantly.

At the same time the SCPB research revealed anecdotal evidence about serious youth violence and gang activity from youth workers, the youth offending service, Intensive Family Focus practitioners, and local community groups such as Barnet Group, 'Get Outta the Gang' and Grahame Park Community Development Group. The practitioners said that they were working with young people affected by serious youth violence and gangs mainly in the west of the Borough, but including other areas such as North Finchley.

### 10.12.1 Problem Profile - offences not evenly distributed –Burnt Oak highlighted

The research began with a hypothesis that suggested offences were not evenly distributed and set out to create a problem profile analysing existing data. Analysis found that offences are not distributed evenly and Burnt Oak (HA8) is highlighted as both the short- and long-term hotspot for violence in Barnet, with data showing an increase in offences resulting in injury in this area, going against the overall downward trend in the Borough. Victims in this area also tend to be younger on average than the rest of the Borough.

- HA8 also has the highest percentage of offences resulting in injury that were committed by 15-17 year olds over a three year period from October 2010.
- Grahame Park (NW9) is the area with the second highest volume of these offences but has seen a gradual downward trend over the same period.

### 10.12.2 Knife Used to Inflict Injury Offences (excluding Domestic Violence offences)

Over the last three years from October 2010 to 2013 there were 23 offences where a knife was used to inflict an injury in the Burnt Oak area, accounting for 25.6% of such incidents across Barnet.

The locations with the highest number of offences over this three year period are: HA8 which corresponds to the Burnt Oak area (23 offences); NW9 which corresponds to the Colindale and Grahame Park Estate area (ten offences); EN5 which includes the Dollis Valley Estate (eight offences); and NW2which corresponds to the Cricklewood area (eight offences).

### 10.12.3 Age of Gang Nominals

Individuals who have been identified by the police as 'gang nominals' are collated in a list referred to as the police Gangs Matrix. Crime and related data is brought together and a score is calculated for each individual indicating their risk of harm. Analysis of the Barnet Gangs Matrix showed that 59% of the most serious offenders rated as Red or Amber (red being the most serious) are aged 19 years or younger.

### 10.12.4 Causal factors: Groups Involved in Street Supply of Drugs – links to violence

Evidence has also suggested that drug supply is the main business related to gangs in Barnet. The activities of particular gangs have also generated youth violence.

The most common offence types that individuals on the Gangs Matrix have been arrested for relate to violence, drugs and weapons, supporting the link between violence and drugs. Violence generated as a result of the drug dealing / supply activity tends to either be:

a) A group fighting a rival group (e.g. defending drug dealing zones, trying to move into another group's zones of control or another dispute.
b) Fighting within a group (e.g. for control, or a falling out over a dispute).

## 10.13 Re-Offending

A reduction in offending has translated into less crime, fewer victims of crime and a reduction in the costs relating to crime. However, it is known that a small proportion of the most prolific offenders are responsible for a disproportionately large amount of crime. National studies and local analysis show that substance misuse (drugs and alcohol) is a significant causal factor for both acquisitive and violent offending.

By focusing on reducing the offending of this prolific cohort, in particular through the work of the Integrated Offender Management (IOM) Programme, the level of overall crime has decreased which has reduced the number of people in Barnet who become victims of crime. The Council intends to continue developing this programme to deliver further reductions in offending and crime.

### 10.13.1 Key Facts

- Approximately 68% of arrested suspects live in the Borough, 32% come from outside the Borough (the proportions vary from crime type to type).
- 86.5% of arrested suspects are male, 13.5% are female.
- Peak age for arrests in Barnet is 16-24 year old (35% of all arrests).
- Barnet IOM has reduced the conviction rate of offenders on the programme by 36%.
- The burglary arrest rate of the IOM cohort has fallen from 2.5 per month to 1.6 per month, equating to an estimated 120 fewer households becoming victims annually, an estimated annual cost saving of around £470,000.

### 10.13.2 Summary

The Integrated Offender Management scheme, introduced in June 2012, has achieved significant reductions in the offending rate of its cohort, a cohort who were selected due to the prolific, repeat and cyclical nature of their offending. These reductions contributed towards overall Borough level reductions in re-offending rates, crime rates, and in particular reducing the number of people becoming victims of burglary in Barnet.

## 10.14 Changing Crime Trends and Changing Environmental Conditions

### 10.14.1 Stolen Property Trends

- The number of crimes where cash or Sat-Navs are stolen has reduced.
- The number of laptops stolen increased over most of the last decade (with a peak in 2011) but has since been falling slightly.
- In 2013 the volume of catalytic convertors stolen increased.
- Over the last three years there has been an upward trend in the volume of power tools stolen.

### 10.14.2 Residential Burglary Trends

Between 2008 and 2012 the market value of gold increased by over 400%. In the same period, demand for vehicles stolen with their own keys increased. As a result, more burglars started travelling to target places where they could locate gold and cars.

These burglars favour areas where they are most likely to find houses (not flats) with gold jewellery inside, expensive cars on the drive and a relatively low concentration of police officers compared to other parts of London. The reversal of the upward trend in the price of gold around April 2013 has helped reduce the cross-border and vehicle-related element of Barnet's burglary problem.

### 10.14.3 Offending Trends

The Integrated Offender Management programme has helped to reduce re-offending among some of the most prolific offenders (the IOM 'cohort'), and this is contributing to crime reductions in Barnet.

Between April and September 2013, around 60 of the 336 fewer residential burglaries in Barnet were likely to have been due to reduced criminal activity by the IOM cohort. Tackling repeat offending successfully will be pivotal to achieving further crime reductions.

Based on the Council's figures, it is estimated that the top 200 offenders in the Borough are, between them, committing around 5,000 crimes every two years.

## 10.15 Feedback from Barnet Residents about Community Safety

During the last two years some 5,100 Barnet residents have taken part in consultation surveys, which either focused specifically on crime and community safety or included a significant section on the subject.

The main surveys which have guided the Council's assessment are the Residents' Perception Survey (RPS) and the Public Attitude Survey (PAS), both have been carried out by separate independent market research companies.

In addition, there have been a number of smaller or one-off consultations that are highly relevant to community safety issues.

### 10.15.1 Key Findings from this Research

- Overall community confidence in the police and local authority in Barnet is strong and most indicators show this improving over the last year.
- Confidence in policing is above the London average.
- Confidence that the police understand community concerns and can be relied upon to be there when you need them is above the London average.
- Community cohesion remains strong.
- Litter and rubbish left around is a top ASB concern.

### 10.15.2 Young People's Perspective

Views of young people about youth crime and safety provide a perspective of the perceptions and circumstances surrounding this peak victim age group.

**Safety is a priority for many young people:**

- Young people said they were particularly less likely to feel safe in some of the more isolated, poorly lit locations in the winter months when it gets dark early.
- Young people can feel the pressure to engage in negative activities for various reasons, which include peer pressure and family circumstances.

**Barnet residents have told us that they want us to:**

- Keep the community informed about what the Council is doing to tackle crime and ASB.
- Work together with the community to reduce rubbish and litter concerns.

# 11 Community Assets

## 11.1 Key Facts

- Barnet has a strong foundation for an asset-based approach with 88% of residents satisfied with their local area and high levels of local capacity.
- 90% of residents agree that they help their neighbours out when needed and 28% volunteer regularly (weekly or monthly).
- Charities Commission and Council data suggests that there were 1235 registered charities operating in Barnet as of February 2015; 51.7% from in or near Barnet and 48.3% from outside the Borough.
- Education and training is the most commonly identified benefit provided (due in part to the number of schools which are registered charities), followed by religious activities, general charitable purposes, and the prevention and relief of poverty.
- The highest numbers of local charities are based in Golders Green (74 organisations), Edgware (48 organisations) and Garden Suburb (46 organisations), likely to reflect high levels of charitable activity among and serving the local Jewish community.
- The resources the Council makes available to local voluntary organisations include grant funding and use of physical assets from the Council's property portfolio – as well as the funds spent with voluntary and community sector (VCS) organisations when commissioning local services.
- 337 charities identify older people as their beneficiaries; 647 identify children and young people; 353 benefit people with disabilities.
- In terms of both health and disability-related charitable activities, less than 20% of charities (225) identify their charitable purpose as the advancement of health.

## 11.2 Strategic Issues

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with voluntary and community (VCS) groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is however the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).

- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. **There is however weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- There is a particular gap around **place-based or environmental VCS groups** and/or the relationships the Council maintains with them. The Council needs to consider how to develop and strengthen this sector, as well as strengthen its own links with other existing relevant organisations such as residents' associations.
- More generally, there are opportunities to:
  - **Support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).
  - **Rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**
  - Respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be engaged with better to deliver health and wellbeing outcomes.

## 11.3 Overview

### 11.3.1 What is a Community Asset?

In a health and wellbeing context, a **community asset** is, broadly speaking, 'any factor or resource which enhances the ability of individuals, communities, and populations to maintain and sustain health and wellbeing' (Morgan, NICE, 2009). Assets could include:

- local residents' skills and knowledge
- voluntary activity by individuals, including friendships and neighbourliness as well as volunteering
- community networks and connections
- local voluntary and community sector (VCS) organisations
- Resources from public and private sector organisations (including assets in the more classic sense, such as money, land and buildings).

### 11.3.2 Evidence for Asset-based Approaches, and the Context in Barnet

Recent thinking on asset based approaches in a health and wellbeing context has tended to focus on a**sset-based community development** (ABCD). This is an approach to improving outcomes for communities which build on the broad definition of a community asset set out above. Rather than focusing on a community's needs (or 'deficits'), ABCD 'starts by focusing on the skills, knowledge, resources, connections and potential within a community; and building on what is working and what it is that people care about' (Developing the power of strong inclusive communities, Think Local Act Personal, 2014). The ability to identify assets – and mobilise them, getting local people participating in their communities and the decisions which affect them – is therefore also key.

In Barnet, residents already tend to indicate that they have positive feelings about their local area. In autumn 2014, 88% of residents indicated that they were satisfied with their local area as a place to live; significantly higher than the national average (Residents' Perception Survey, autumn 2014). This is a strong foundation for an asset based approach.

Linked to community assets is the concept of **social capital** - 'the connections that are made between people who live in the same area or are part of the same community, and who are able to do things with and for each other. Strong neighbourhoods, clubs and groups help create a sense of community, enabling people to trust each other, work together and look out for each other' (Think Local Act Personal, 2009). Social networks and social capital are consistently linked with better health outcomes – associated with reduced illness and death rates (Berkman & Kawachi, 2000), for example – and is also linked with improvements to other outcomes, such as decreases in crime (Sampson et al, 1997) and increased educational attainment (Ripfa, 2012). In Barnet, social networks are reasonably strong; 84% of residents feeling that people from different backgrounds get on well together as of spring 2014. This is in line with the national average (Residents' Perception Survey, spring 2014).

The level of **participation in civic life**, such as neighbourly activity, peer to peer support, and volunteering, is also considered a community asset. Participation has qualitative benefits – promoting wellbeing for people of all ages (New Economics Foundation, 2008) – as well as providing quantitative benefits in terms of the extra capacity contributed by individuals who are involved in voluntary activity.

Voluntary and community activity also helps to **manage people's need for public services** by preventing individuals from reaching a point where they need funded support. Such activity can involve help with the activities of daily living (such as shopping or cooking) or of maintaining living environments (such as housework or gardening), this can be carried out by organised groups or by informal social networks including friends or neighbours. Voluntary and community groups often provide social activities which **promote inclusion and reduce isolation**, which can also help prevent people from getting to the point where they need more intensive services.

Residents of Barnet perceive themselves as neighbourly – as of spring 2014, 90% of residents agreed that they help their neighbours out when needed, with 57% strongly agreeing. The proportion of residents who agree that their neighbours help each other out when needed is slightly lower at 80%, with 44% strongly agreeing. (Residents' Perception Survey, spring 2014).

## 11.4 Barnet's Community Assets

### 11.4.1 Volunteering in Barnet

28% of Barnet residents report that they give unpaid help to groups, clubs or organisations at least once a week or once a month, as of spring 2014. This is comparable to the most recent national benchmarking data (the Cabinet Office Community Life Survey 2013/14), in which 27% of people reported regular formal volunteering of this kind. Regular volunteering saw a large rise both locally and nationally in 2012/13, generally attributed to the knock-on effect of the London Olympics, and declined slightly in subsequent years. Levels of infrequent volunteering tend to be much higher, with national data suggesting that the proportion of people who volunteer annually exceeds 40%.

The Council commissions a volunteering brokerage service, which matches potential volunteers to volunteering opportunities. As of 2015/16 this was provided by Groundwork London. Some specialist volunteer services run alongside this, including, in 2015/16, Active Volunteering by Disabled People, a project supporting people with disabilities to volunteer.

In Barnet, faith-based communities have a number of specialist volunteering structures such as the Jewish Volunteering Network, which promotes volunteering opportunities to the Jewish community.

Formal volunteer brokerage services are complemented by initiatives such as timebanking, a service which helps individual residents exchange time and skills. In 2015/16 there were two Timebank networks in Barnet, one run by CommUNITY Barnet, covering Burnt Oak, Colindale, Edgware and West Hendon, and the other covering the rest of the Borough, run by Timebank UK. In its first year of operation the Borough-wide Timebank registered 138 members and exchanged 400 hours of activities. Timebank runs on a hub and spoke model with the potential for other organisations to host timebank facilities in the future and plans to roll out an additional three hubs in the next five years.

### 11.4.2 Council-initiated VCS Activity

As well as its mechanisms for involving residents and service users in decision making, the Council commissions a number of specific community development programmes. In 2015/16 these included a public health programme, known as Ageing Well or Altogether Better, which works with people in a number of localities across the Borough to increase community capacity, reduce isolation and help older people live longer as part of their communities. Each locality has a steering group which devises a range of activities appropriate to that community and its needs. In 2015/16 there were four localities – Burnt Oak, East Finchley, Edgware & Stonegrove and High Barnet & Underhill.

There were also a number of small-scale place-based schemes – six 'Adopt-a-Place' schemes (as of November 2014) in which volunteers were working with the Council to maintain a local environmental feature – for example, litter picking in a street, or watering a flowerbed.

### 11.4.3 The Broader VCS in Barnet

There is also a broad range of voluntary and community organisations operating in Barnet and which have come into being independently of the Council. The largest available dataset is drawn from the Charities Commission register of charities, and suggests that there are 1,235 registered charities operating in Barnet. 638 (51.7%) are based in or near Barnet and 597 (48.3%) come from outside the Borough[164]. Local and national research estimates the number of less formal, 'below the radar', organisations may be much larger. These are organisations such as grassroots or neighbourhood groups, including residents' and community associations. In 2015, local research by the Young Foundation found over 300 different 'below the radar' groups operating within one square mile of Golders Green tube station (Young Foundation, 2015). National research estimates 3.66 'below the radar' organisations per 1,000 population (NCVO, 2010, cited in CommUNITY Barnet, 2013).

The registered charities that operate in Barnet serve different client groups. Table 11-1 shows the breakdown of client groups. (Each charity can select more than one client group; percentages are

[164] Data in this section has been compiled from the Charities Commission's register of charities who state that they operate in Barnet, as of February 2015, combined with Charities Commission data on VCS organisations who have contracts with Barnet Council to provide services, either directly to the Council or to residents.

given to show the proportion of the total number of charities in Barnet which serves this client group.)

**Table 11-1: Client groups served by charities operating in Barnet**

| Service Users | Number | Percentage |
|---|---|---|
| Children / Young People | 647 | 52.4% |
| Elderly / Old People | 337 | 27.3% |
| People With Disabilities | 353 | 28.6% |
| People of a Particular Ethnic or Racial Origin | 280 | 22.7% |
| Other Charities or Voluntary Bodies | 267 | 21.6% |
| Other Defined Groups | 165 | 13.4% |
| The General Public / Mankind | 416 | 33.7% |

The Charities Commission register also gives information on the types of social and community benefit the charities operating in Barnet provide, shown in Table 11-2 below. (Again, each charity can select more than one purpose or benefit; percentages are given to show the proportion of the total number of charities in Barnet which offer this purpose or benefit.) The high proportion of charities aimed at children and young people (in Table 11-1) and at providing education and training (in Table 11-2) is in part due to the number of schools which are also registered charities.

**Table 11-2: Social and community benefit provided by charities operating in Barnet**

| Type of benefit | Number | Percentage |
|---|---|---|
| Education / Training | 689 | 55.8% |
| Religious Activities | 364 | 29.5% |
| General Charitable Purposes | 358 | 29.0% |
| The Prevention or Relief of Poverty | 302 | 24.5% |
| The Advancement of Health or Saving Lives | 225 | 18.2% |
| Disability | 220 | 17.8% |
| Arts/ Culture/ Heritage / Science | 188 | 15.2% |
| Amateur Sport | 164 | 13.3% |
| Economic/Community Development / Employment | 152 | 12.3% |
| Accommodation / Housing | 92 | 7.4% |
| Overseas Aid/ Famine Relief | 86 | 7.0% |
| Environment / Conservation / Heritage | 75 | 6.1% |
| Other Charitable Purposes | 70 | 5.7% |
| Recreation | 69 | 5.6% |
| Human Rights / Religious or Racial Harmony / Equality or Diversity | 31 | 2.5% |
| Animals | 13 | 1.1% |
| Armed Forces / Emergency Service Efficiency | 3 | 0.2% |

Charities are also asked to register the types of activity they undertake – again, charities can select more than one activity. These are shown in Table 11-3 below:

**Table 11-3: Types of activities undertaken by charities operating in Barnet**

| Activities provided | Number | Percentage |
|---|---|---|
| Makes Grants to Individuals | 215 | 17.4% |
| Makes Grants to Organisations | 369 | 29.9% |
| Provides Other Finance | 60 | 4.9% |
| Provides Other Human Resources | 253 | 20.5% |
| Provides Buildings / Facilities / Open Space | 342 | 27.7% |
| Provides Services | 572 | 46.3% |
| Provides Advocacy / Advice / Information | 338 | 27.4% |
| Sponsors or Undertakes Research | 100 | 8.1% |
| Acts as an Umbrella or Resource Body | 122 | 9.9% |
| Other Charitable Activities | 132 | 10.7% |

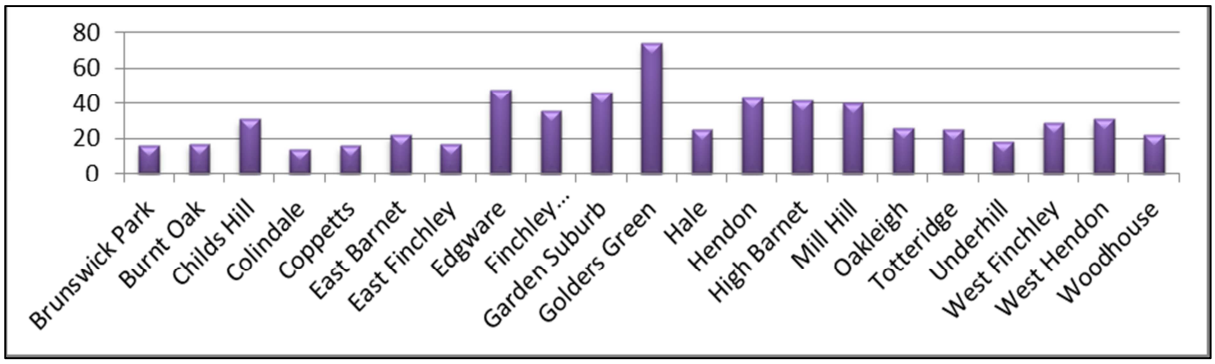
For the 638 charities which are also based in the Borough, it is possible to give a breakdown of the wards in which they are based. The data refers to the registered address of the charity rather than to the address from which it operates services and these may not always be the same. Table 11-4 and Figure 11-1, below, give this breakdown at ward level.

**Table 11-4: Geographical breakdown of charities based in and operating in Barnet, by ward**

| Ward | Number | Percentage* |
|---|---|---|
| Brunswick Park | 16 | 2.51% |
| Burnt Oak | 17 | 2.66% |
| Childs Hill | 31 | 4.86% |
| Colindale | 14 | 2.19% |
| Coppetts | 16 | 2.51% |
| East Barnet | 22 | 3.45% |
| East Finchley | 17 | 2.66% |
| Edgware | 48 | 7.52% |
| Finchley Church End | 36 | 5.64% |
| Garden Suburb | 46 | 7.21% |
| Golders Green | 74 | 11.60% |
| Hale | 25 | 3.92% |
| Hendon | 43 | 6.74% |
| High Barnet | 42 | 6.58% |
| Mill Hill | 40 | 6.27% |
| Oakleigh | 26 | 4.08% |
| Totteridge | 25 | 3.92% |
| Underhill | 18 | 2.82% |
| West Finchley | 29 | 4.55% |
| West Hendon | 31 | 4.86% |
| Woodhouse | 22 | 3.45% |

**Percentage of all Barnet-based charities which are in this ward*

**Figure 11-1*:* Distribution of local charities operating in Barnet, at ward level**




## 11.5 Other Community Groups

In addition to registered charities, there are also a number of less formally constituted community groups across the Borough. These include seven 'Friends of…' groups involved in maintenance or governance of parks and open spaces groups across the Borough; four 'Town Teams', coalitions of local businesses and organisations who look after and are involved in developing town centres; and 23 residents' and community associations.

## 11.6 Resources and Support

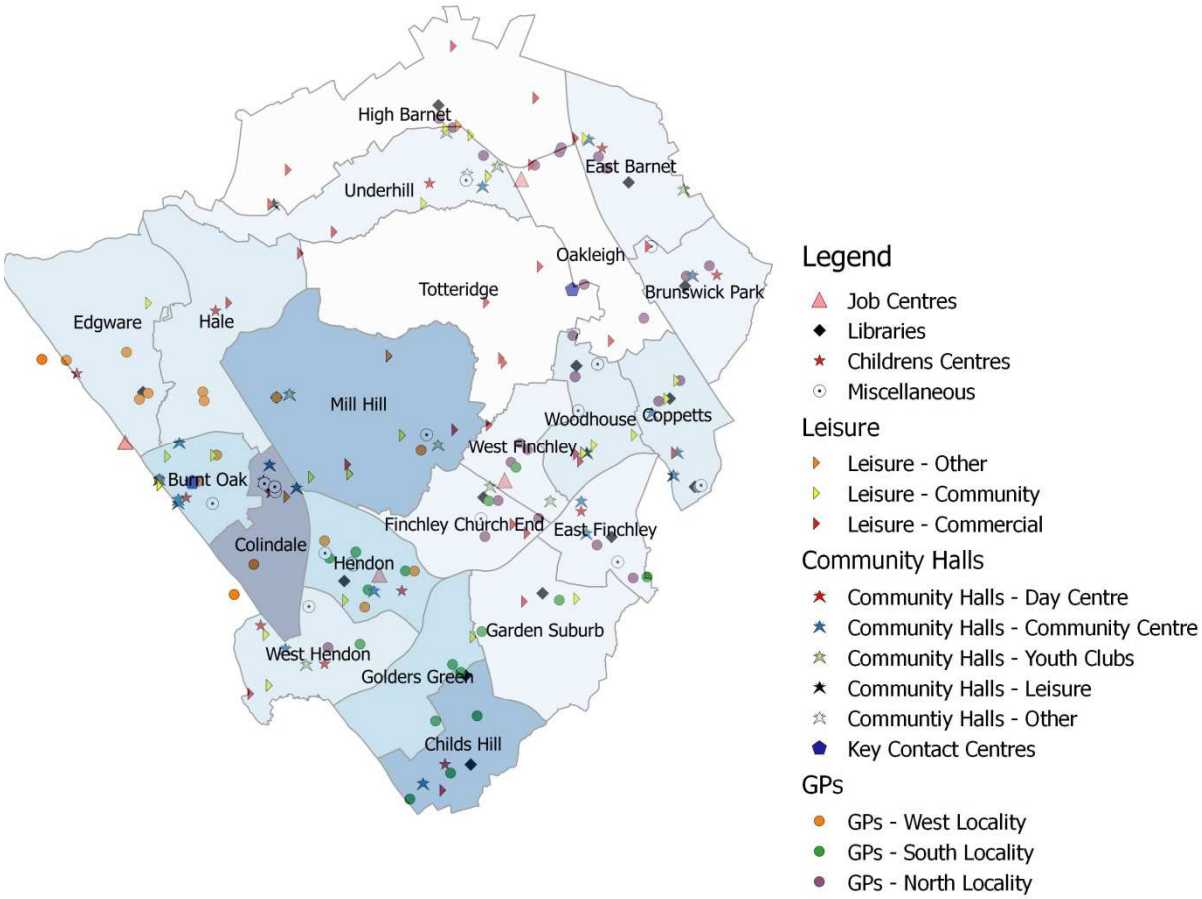
The Council commissions a second Local Infrastructure Organisation Partner – as of 2015/16 this is CommUNITY Barnet – to strengthen the local voluntary and community sector, offer expert advice and support, and ensure VCS organisations are represented in Council decisions. This role is a key enabler for the local VCS.

The Council also makes grant funding available to the voluntary sector. In 2014/15 the total funding available through the Council's Corporate Grants Programme was £104,390.

Physical assets – land and property – which are being used for community benefit are also considered community assets. Some of these are Council buildings primarily used by voluntary and community groups, but others have Council services provided from them or are owned by other public sector stakeholders. A map of these physical assets, as of November 2014, is shown at Figure 11-2 below.

The map shows that these assets are clustered around town centres. The numbers are sparser in the North West of the Borough and in parts of some central Barnet wards (Mill Hill, Totteridge). There may be a case to review the distribution of some facilities which might be well located in more residential areas, such as day centres and community centres, in these parts of the Borough.

**Figure 11-2: Map of community assets in Barnet**




The Council also puts some resource into the voluntary and community sector through services it commissions from VCS groups. A breakdown of spend by location (charities based in Barnet; charities based in central London or charities based elsewhere in London or the UK) is given in table 11-5 below.

**Table 11-5: Total Council spend with charities in 2014/15, by location**

| Spend by Location (2014/15) | | |
|---|---|---|
| **Locality** | **Total Spend** | **%** |
| Barnet | £10,718,331.26 | 35.3% |
| Central London | £3,000,154.48 | 9.9% |
| Other | £16,669,799.23 | 54.9% |
| Grand Total | £30,388,284.97 | 100.0% |

A further breakdown of spend with charities is given for the Adults and Children's Delivery Units in tables 11-6 and 11-7 below.

**Table 11-6: Council spend by location – Adults and Communities (2014/15)**

| Spend by Location and Delivery Unit - Adults and Communities (2014/15) | | |
|---|---|---|
| **Locality** | **Total Spend** | **%** |
| Barnet | £2,148,630.39 | 20.4% |
| Central London | £1,364,400.35 | 13.0% |
| Other | £7,019,283.43 | 66.6% |
| Grand Total | £10,532,314.17 | 100.0% |

**Table 11-7: Council spend by location – Children's services (2014/15)**

| Spend by Location and Delivery Unit - Children's Services (2014/15) | | |
|---|---|---|
| **Locality** | **Total Spend** | **%** |
| Barnet | £2,756,023.80 | 54.9% |
| Central London | £558,134.35 | 11.1% |
| Other | £1,706,069.46 | 34.0% |
| Grand Total | £5,020,227.61 | 100.0% |

The Barnet-based spend on children's services is much higher than the spend from Adults – once again, this is in part due to the inclusion of schools as registered charities.

## 11.7 Type of Provision

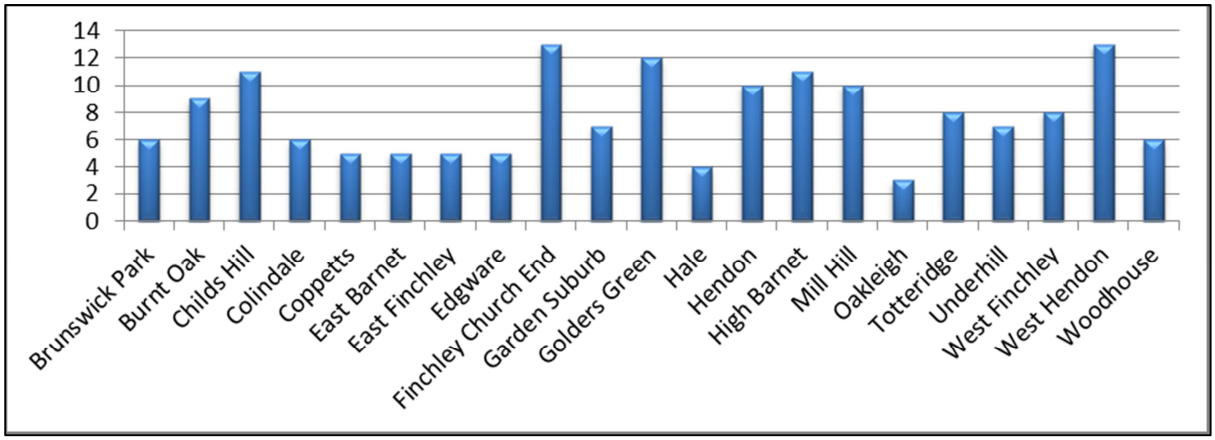
### 11.7.1 Faith-based Activities

A high number of the charities which both operate in and are based in Barnet are located in Golders Green (74 of 638), followed by Edgware (48) and Garden Suburb (46). In each case, a relatively high proportion identifies its beneficiaries as being from particular ethnic or racial groups (67 of the total 166; 40.3%). Considering the demographics of these wards, this suggests that philanthropy within Barnet's Jewish community may account for a high proportion of locally focused charitable activity.

### 11.7.2 Services for Older Adults

337 of the 1,255 charities operating in Barnet (27.3%) identify older people as beneficiaries. Just under half of these (164 or 48.7%) are Barnet-based and 173 are from outside the Borough. Figure 11-3 shows a breakdown of the local charities by ward:

**Figure 11-3: Local charities serving elderly people, by ward**

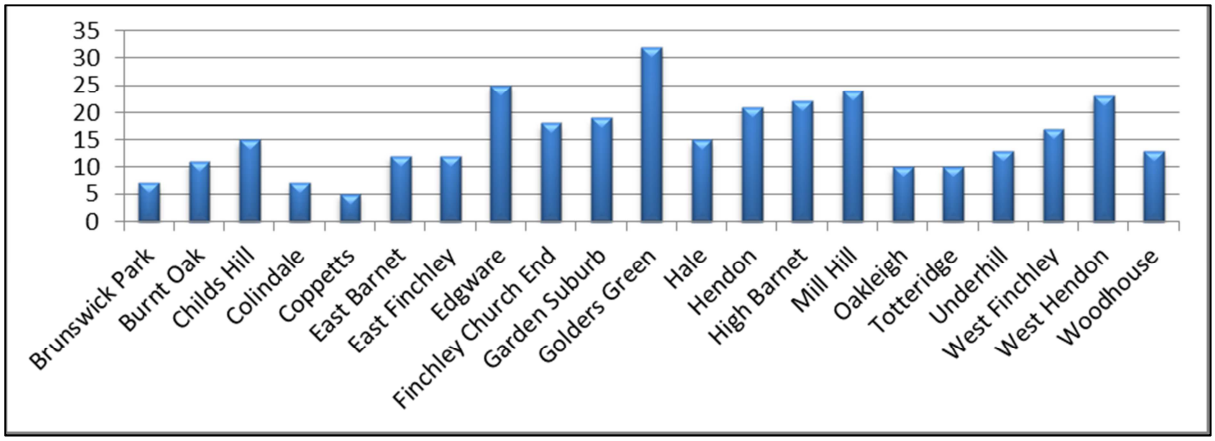


A total of 130 charities (from both inside and outside Barnet) provide services for older people with a health-related benefit – 10.3%. 118 (9.4%) benefit older people and provide a disability-related service.

### 11.7.3 Services for Children

647 of the 1,255 charities operating in Barnet identify children and young people as beneficiaries – more than half (52.5%) of all the charities in the Borough. Just over half of these (331, 51.2%) are Barnet-based and 316 are from outside the Borough. A breakdown of the local charities by ward is shown below.

**Figure 11-4: Local charities serving children and young people, by ward**

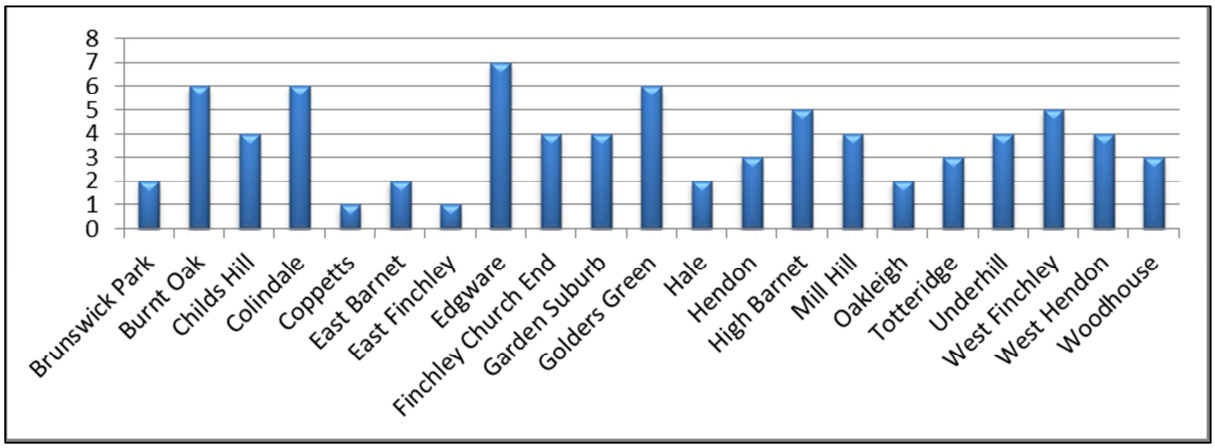



The distribution of children's charities across wards reflects the overall number of charities in each, with particularly high numbers (32) in Golders Green. It is notable that Colindale and Burnt Oak both have relatively low numbers of charities offering services for children and young people (7 of 14 and 11 of 17 respectively).

### 11.7.4 Services for People with Disabilities

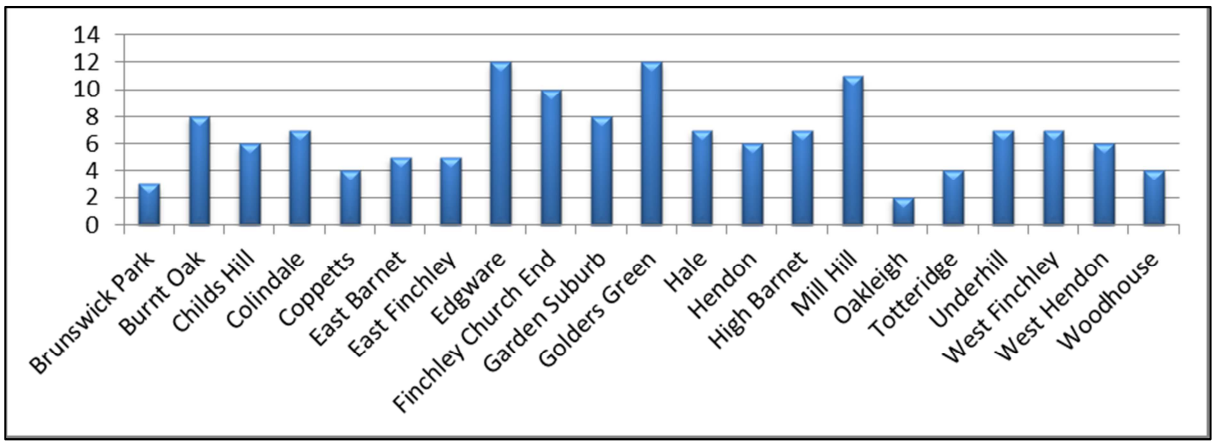
220 charities operating in Barnet (17.5%) identify their charitable benefit as being related to disability and 78 of these are also based in Barnet. The distribution of Barnet-based charities in this group is shown by ward below:

**Figure 11-5: Local charities whose purpose or benefit relates to disability, by ward**



353 charities operating in Barnet (28.1%) identify people with disabilities as service users and 141 of these are also based in Barnet. Their distribution by ward is shown below:

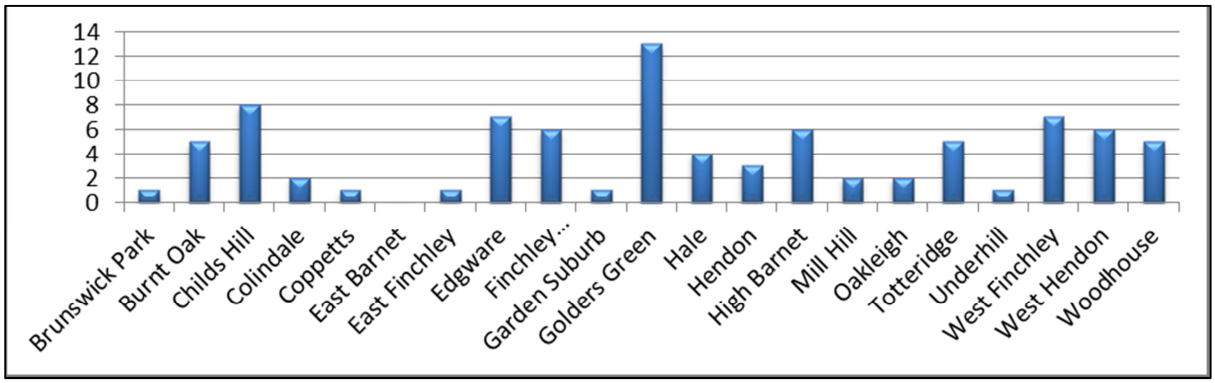
**Figure 11-6: Local charities serving people with disabilities, by ward**




### 11.7.5 Services Relating to Health and Physical Activity

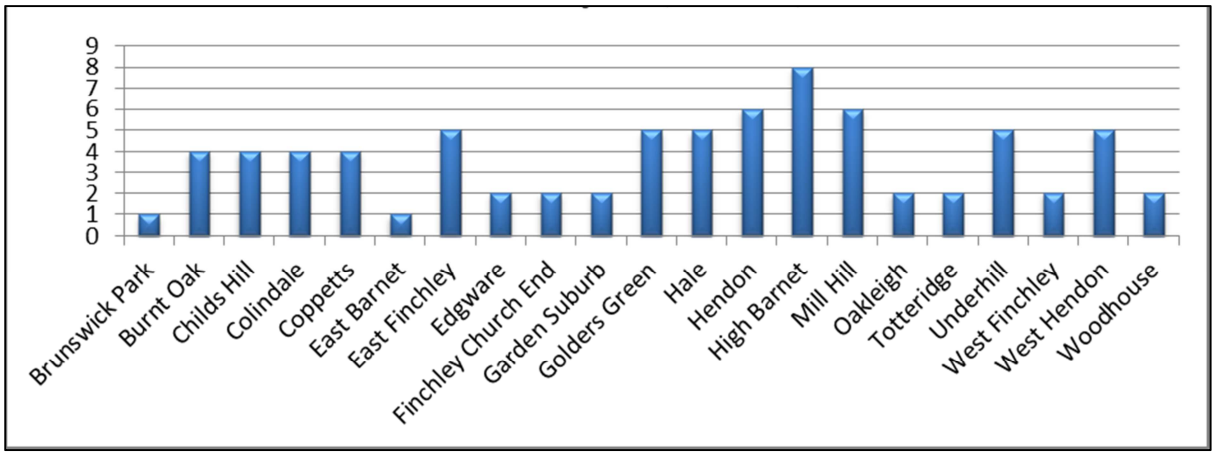
225 charities operating in Barnet (17.9%) identify themselves as providing a health-related benefit. 86 (38.2%) are local and 139 are from outside the Borough. The local charities are shown by ward in the chart below:

**Figure 11-7: Local charities purpose or benefit relates to advancing health or saving lives, by ward**




164 charities carry out amateur sports-related activities; 77 (46.9%) of these are from Barnet. The locations of those based in Barnet are shown in the chart below:

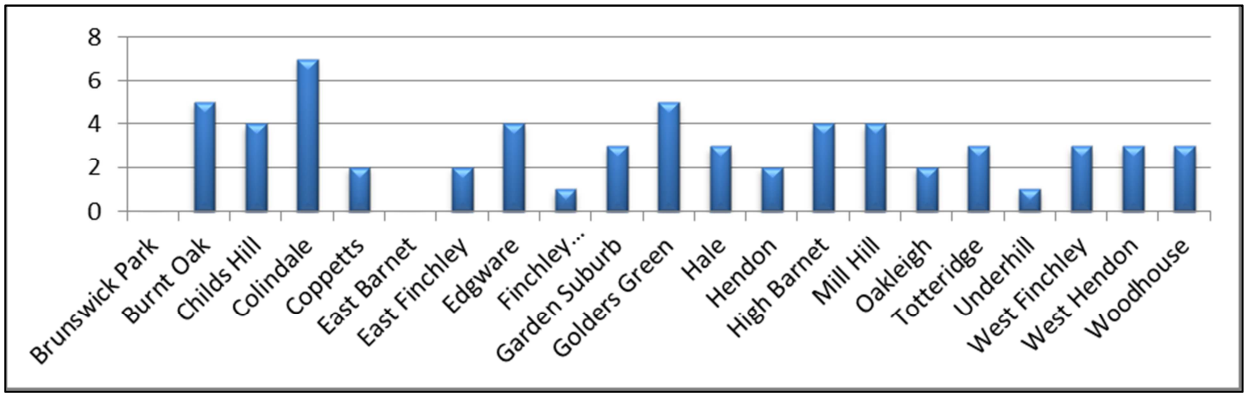
**Figure 11-8: Local charities whose purpose or benefit relates to amateur sport, by ward**




### 11.7.6 Economic and Community Development Services

152 charities provide services relating to community or economic development or employment. 61 (40.1%) are from Barnet and 91 are from outside the Borough. The local charities are distributed by ward as follows:

**Figure 11-9: Local charities whose purpose or benefit relates to economic or community development and employment, by ward**




## 11.8 Key Issues

Voluntary and community sector activity will be essential in meeting a number of needs already identified through the Council's commissioning plans. Key areas which require VCS provision include the following:

### 11.8.1 Adults and Health

In **adult social care and health**, work to reduce the need for services and provide more community care, particularly for older people, people with learning disabilities and mental health/ autism needs. In part, this will involve providing services or activities which help people go about their daily lives – shopping, cooking, housework or gardening – but there will also be an important preventative component, providing activities to promote inclusion and reduce isolation.

The distribution of local charities meeting the needs of older adults in Barnet is relatively well matched to the current and projected older adults' population. It is, however, noticeable that the number of charities operating in Barnet who identify a health or disability-related benefit to the work they do is less than 20%, suggesting that there is room either for provision to grow in this area

or to develop more understanding among community groups of how their activities impact on health and wellbeing.

In terms of sport and physical activity, local community sports provision is reasonably well matched to need, with the wards with the highest rates of childhood obesity (Colindale, Burnt Oak and Underhill) all having numbers of community sport charities slightly above average for the Borough. Again, there is potential room to develop further provision in this area.

### 11.8.2 Children's Services

In **provision for children**, as well as the preventative services identified above there will be a need to increase the availability of childcare in community settings to meet need, development of community provision to enable more holistic delivery models for mental health services, and to build strong relationships with community groups who may be able to improve services such as children's centres by getting more involved in how these are managed and governed.

The Barnet evidence base shows that overall, both the highest numbers of children and young people in Barnet in absolute terms, and the greatest growth in the numbers of children and young people, will be in the west of the Borough, corresponding with Barnet's regeneration programmes. The distribution of services aimed at children is reasonably high in more affluent parts of west Barnet but much lower in those deprived areas – particularly Colindale and Burnt Oak which are also the focus of the regeneration and the areas where the population of children and young people will be largest. This suggests that market shaping activity should consider how to increase local voluntary sector service provision for children and young people in Burnt Oak and Colindale to reflect the likely increase in future need in those areas.

### 11.8.3 Housing and Economic Development

In areas relating to **housing and economic development**, there will be continuing pressure to support people affected by welfare reforms and/or on-going poverty, reducing the negative impacts of living in poverty. VCS groups' knowledge of, and trusted relationship with, their local communities is vital in reaching people who may otherwise struggle to access services.

VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. There are, however, noticeably low levels of provision in East Finchley and Underhill, two wards with significant areas of deprivation.

### 11.8.4 Environment

Finally, opportunities to promote a better **environment** across the Borough will in part be reliant on getting people more involved in developing and maintaining their local areas. Environmental VCS provision in Barnet is relatively low compared to other sectors – only 75 charities, just under 6% of those operating in the Borough, identify themselves as providing an environmental or heritage benefit. This is underpinned by relatively underdeveloped links between the Council and place-based community groups such as residents' associations with clear opportunities to take a more proactive and coordinated approach to its relationship with such groups in future.

### 11.8.5 General Capacity

In terms of the general **capacity and physical assets** which underpin these priorities, Barnet has high levels of local VCS activity but this is not evenly distributed across the Borough. This is in part because a significant proportion local charitable activity is strongly focused around faith communities. The Council should think about using its engagement with faith groups and networks to respond to this, gaining a better understanding of how this capacity is currently deployed and learning any lessons about how similar capacity could be leveraged in other parts of the sector.

There are opportunities to support and develop the broader volunteering base through diversifying the offer to volunteers: presenting a broad range of volunteering opportunities (including Timebanking, community development activities, employer supported volunteering and corporate social responsibility), consolidated and coordinated through the core volunteer offer.

The Council's Community Asset Strategy – though it relates only to physical community assets such as land and property – provides an opportunity to rethink physical asset provision including the potential gaps in provision in the North West and centre of the Borough.

## 11.9 Conclusion and Recommendations

The evidence base for asset-based community development approaches is strong and will be a key part of the approach Barnet needs to take to address the challenges facing health and social care in the coming years.

Barnet has a **strong community asset base** on which to build, with high levels of existing capacity and a wealth of voluntary and community groups. There are opportunities to **work with faith groups** in particular, where community capacity in Barnet is particularly high, to promote stronger relationships between them and other groups in the Borough and to learn lessons about how higher levels of volunteering can be mobilised.

In terms of the overall VCS market, **levels of health-related VCS provision** in Barnet could be further developed, along with charitable activity around community sports. More localised analysis suggests that there may be a current need for **more employment and economic development-related VCS activity in some wards**, and that there will be a need for **more provision of services and activities for children and young people in the west of the Borough** to match the needs of the growing population.

There is a particular gap around **place-based or environmental VCS groups** and/or the relationships the Council maintains with them. The Council needs to consider how to develop and strengthen this sector, as well as strengthen its own links with other existing relevant organisations such as residents' associations.

# 12 Residents' Voice

## 12.1 Key Facts

- In spring 2015, 71% of respondents were satisfied with the way the Council runs things. This is broadly in line with both the average overall London (70%) and outer London (69%) scores, and 3% higher than the national average.
- In spring 2015 88% of Barnet residents were satisfied with their local area as a place to live. This is significantly higher than the national average of 82% (as of October 2014).
- In spring 2015 the services that residents were most happy with were 'Refuse collection', 'Doorstep recycling', 'Street lighting' and 'Parks, playgrounds and open spaces'.
- 26% of residents give unpaid help to groups, clubs, or organisations at least once a week or once a month (spring 2015). This is a significant increase since 2010/11 (21%).
- The largest area for complaints, constituting almost a quarter of top ten complaints is recycling (24%), followed by domestic waste (21%), and garden waste (17%). Together, household waste and recycling constitute 62% of the top ten complaints.

## 12.2 Key Issues

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and 'Repair of roads' as being poor or extremely poor services** provided by the Council.
- The **top three concerns** for residents according to the spring 2015 Resident's Perception Survey were '**conditions of roads and pavements (38%); lack of affordable housing (33%); and crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

## 12.3 Introduction

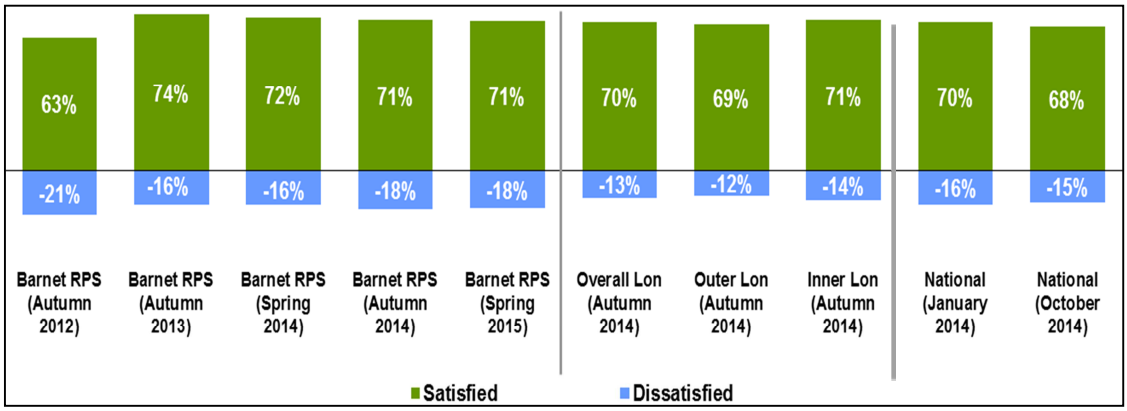
The Residents' Perception Survey captures residents' general views and perceptions towards the Council, the services it provides and the local area and is used to explore changes in these opinions over time on a number of topics. The latest Residents' Perception Survey was conducted in spring 2015; some of the key headlines are presented within this chapter.

## 12.4 Resident Satisfaction and Opinion of the Council

Figure 12-1 shows the responses for the residence perception question '*are you satisfied with the way the Council runs things'*, for Barnet, compared to local and national regions.

- In spring 2015, 71% of respondents were satisfied with the way the Council runs things. This is broadly in line with both the average overall London (70%) and outer London (69%) scores, and 3% higher than the national average.
- During the period autumn 2012 to spring 2015, the proportion of people who were dissatisfied with the way Barnet Council runs things, has decreased from 21% to 18%.

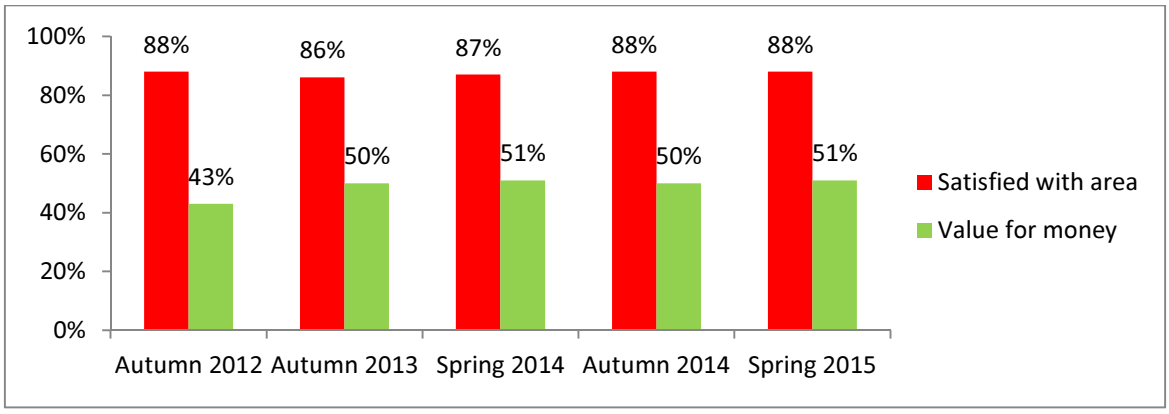
**Figure 12-1: Are you satisfied with the way your local Council is running things?**




Source: (London data from Survey of Londoners, national data from LGA public poll on resident satisfaction) (Barnet Resident Perception Survey Spring 2015)

The spring 2015 RPS shows that 88% of Barnet residents are satisfied with their local area as a place to live. This is significantly higher than the national average (82% as of October 2014). 51% of residents felt that Barnet Council provides value for money (+8% since autumn 2012). The national average for autumn 2014 was 51%, meaning Barnet is performing roughly at the national level.

**Figure 12-2: Resident responses to key RPS questions over time**




By ward, those living in Finchley Church End, Garden Suburb, or Totteridge were significantly more likely to be satisfied with Barnet as a place to live whereas those living in Burnt Oak were significantly less likely to be satisfied with Barnet as a place to live.

## 12.5 Local Services

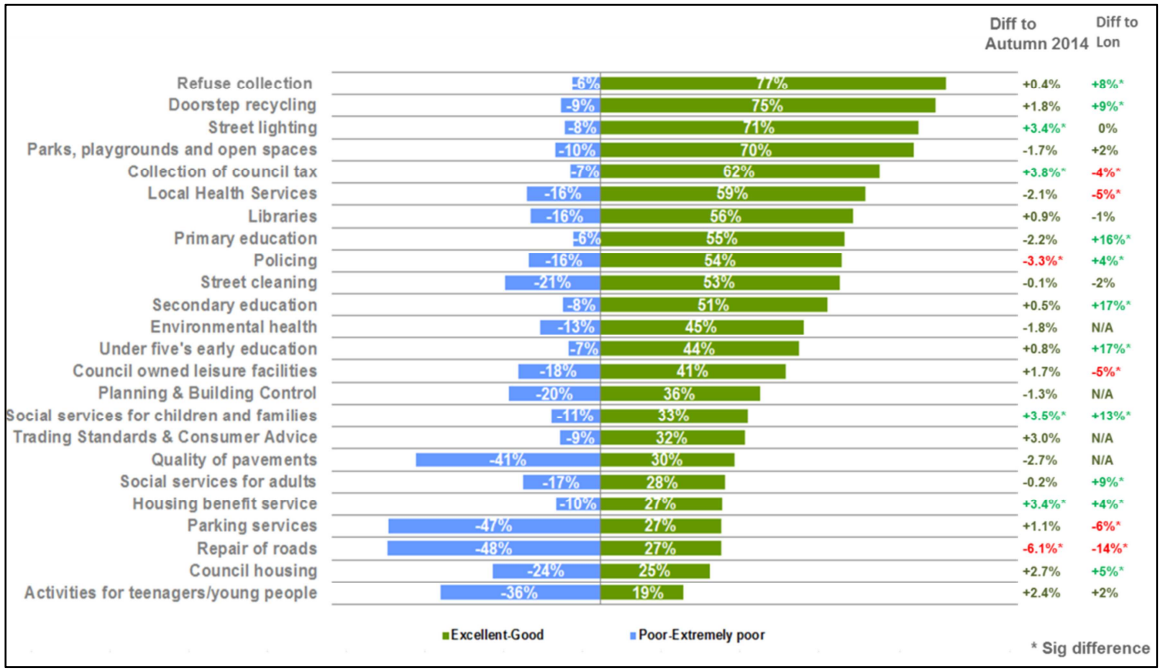
In spring 2015 the services that residents were most happy with were 'Refuse collection', 'Doorstep recycling', 'Street lighting' and 'Parks, playgrounds and open spaces' with 70% or above of respondents rating them as either good or excellent. Whereas, only 25% or less of respondents rated 'Council housing' and 'Activities for teenagers/ young people' as either good or excellent.

Over 40% of respondents rated 'Quality of payments', 'Parking services' and 'Repair of roads' as being poor or extremely poor.

Residents' satisfaction with local services has been maintained since autumn 2014 for thirteen council services and many remain higher than 2013 and 2012 levels. Furthermore, four services have seen significant increases in satisfaction since autumn 2014: 'Street lighting'; 'Collection of Council tax'; 'Social services for children and families'; and 'Housing benefit service'.

However, two services ('Repair of roads' and 'Policing') have experienced decreases in satisfaction; and while 'Policing' is above 2012 levels, 'Repair of roads' is significantly lower than both 2012 and 2013 levels.

**Figure 12-3: % Services Rated Excellent-Good or Poor-Extremely Poor, spring 2015**




## 12.6 Top Concerns for Residents

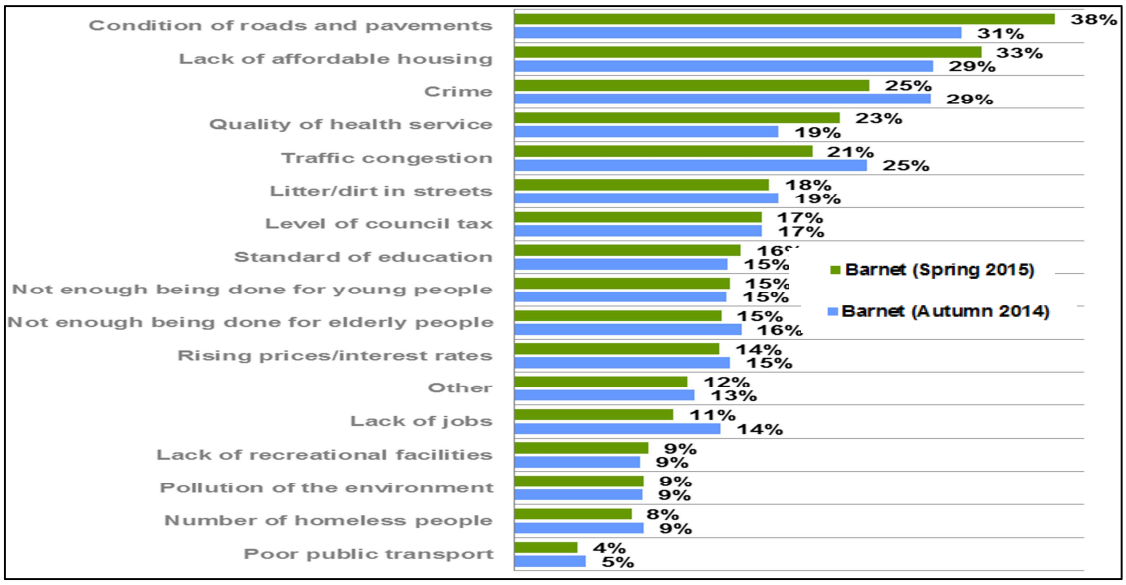
The top three concerns for residents according to the spring 2015 Residents' Perception Survey were:

- Conditions of roads and pavements (38%);
- Lack of affordable housing (33%); and
- Crime (25%)

Since autumn 2014 there have been significant increases in concern regarding the conditions of roads and pavements, quality of health service and lack of affordable housing. However there has been a significant decrease in concern related to crime, traffic congestion and lack of jobs.

In comparison to London the only areas where Barnet residents are significantly more concerned are: lack of affordable housing, quality of health service, not enough being done for elderly people, and standard of education.

**Figure 12-4: "Which three things are you personally most concerned about?"**




## 12.7 Volunteering

26% of residents give unpaid help to groups, clubs, or organisations at least once a week or once a month (spring 2015). This is in line with autumn 2012 (27%), and is a significant increase since 2010/11 (21%). There is no up-to-date national or regional data concerning volunteering, however, the national average for 2010/11 was 24%; Barnet's current result is in line with this.

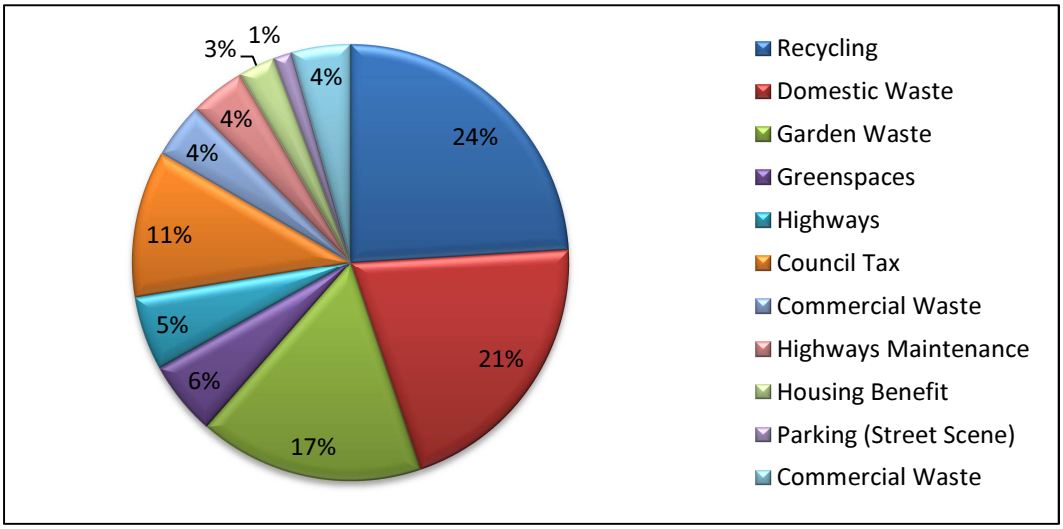
## 12.8 Community Cohesion

As of spring 2015, 84% of residents agree that people from different backgrounds get on well together in Barnet. This is in line with the results from autumn 2014 (84%) and the 2013/14 national average (85%). Of the 84% of respondents that agreed with this statement, 47% strongly agreed. According to the full report from spring 2014 RPS, those living in Burnt Oak or West Hendon were significantly more likely to feel that those from different backgrounds do not get on well together.

## 12.9 Complaints

Figure 12-5 shows the top ten areas of complaint received by the Council in quarter 4 of 2013/14.

**Figure 12-5: Top Ten Areas of Complaint**



The largest area for complaints, constituting almost a quarter of top ten complaints is recycling (24%), followed by domestic waste (21%), and garden waste (17%). Together, household waste and recycling constitute 62% of the top ten complaints.

# 13 Public Sector Finance

## 13.1 Purpose

This section summarises the overall spend of different partners in Barnet including the Council, Barnet Clinical Commissioning Group, Adults and Communities, Children's Service, and Public Health spending.

The intention in setting out Council and NHS finances is so that they can be viewed and understood against the context of the needs in the population identified in this JSNA.

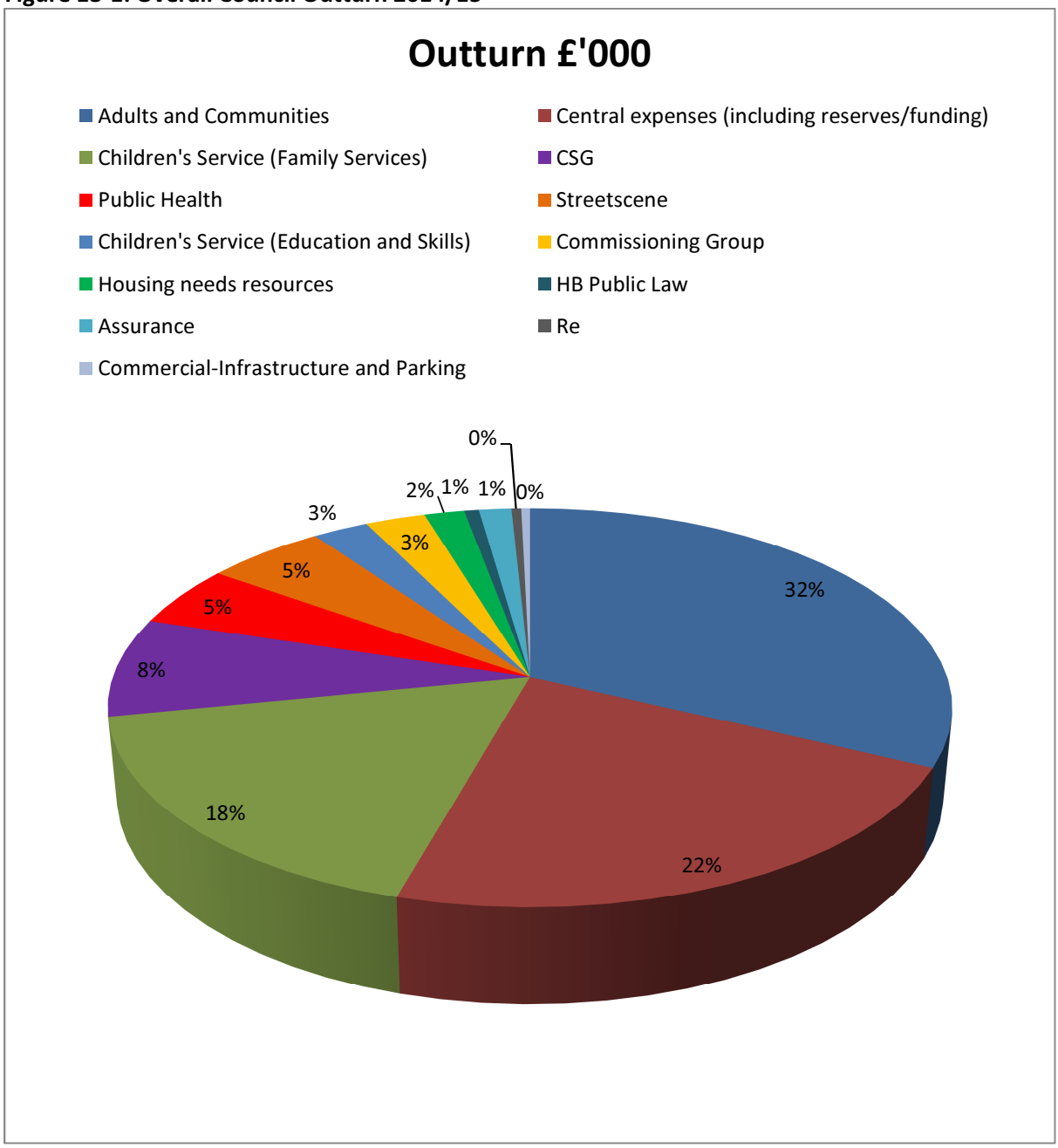
## 13.2 Overall Council Spend 2014/15

**Table 13-1: Overall Council Budget and Outturn 2014/15**

| Delivery Unit | Original Net Budget | Current Net Budget | Outturn |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Adults and Communities | 89,669 | 90,746 | 93,218 |
| Central expenses | 74,323 | 66,220 | 64,352 |
| Children's Service (Family Services ) | 48,342 | 50,436 | 50,505 |
| CSG | 22,153 | 23,341 | 23,341 |
| Public Health | 14,302 | 14,335 | 14,335 |
| Streetscene | 15,650 | 15,357 | 15,399 |
| Children's Service (Education and Skills) | 7,069 | 7,211 | 7,211 |
| Commissioning Group | 6,668 | 7,760 | 7,760 |
| Housing needs resources | 3,338 | 4,833 | 5,170 |
| HB Public Law | 1,782 | 1,952 | 1,883 |
| Assurance | 4,005 | 4,060 | 4,186 |
| Re | 767 | 1,039 | 1,257 |
| Commercial-Infrastructure and Parking | -1,657 | -878 | -1,126 |
| **Total** | **286,411** | **286,412** | **287,491** |

**Note:** the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

**Figure 13-1: Overall Council Outturn 2014/15**




**Biggest areas of net spend:** The biggest areas of net spend of the Council are **Adults and Communities** and **Children's Service (Family Services)**.

**Pressures:** The Council's budget is expected to decrease by **11.7%** over the five years to 2020.

## 13.3 Adults and Communities 2014-15

**Table 13-2: Adults and Communities Budget and Outturn 2014-15**

| Adults and Communities | Original Net Budget | Current Net Budget | Outturn |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Births, Deaths & Marriages | -161 | -160 | -12 |
| Care Quality | 1,363 | 1,353 | 1,227 |
| Community Safety | 1,965 | 1,911 | 1,623 |
| Community Well-being | -289 | 212 | -135 |
| Director Adults Social Service & Health | 185 | 187 | 178 |
| Integrated Care – Learning Disability & Mental Health | 38,923 | 40,845 | 42,711 |
| Integrated Care – Older people & Physical Disability | 38,403 | 38,595 | 41,145 |
| Prevention & Well-being | 6,967 | 6,471 | 5,175 |
| Social Care Commissioning | 918 | 936 | 987 |
| Social Care Management | 1,396 | 396 | 319 |
| **Total** | **89,670** | **90,746** | **93,218** |

**Note:** the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

**Biggest areas of net spend:** The biggest areas of net spend within Adults are towards **Integrated Care for Learning Disability and Mental Health** and **Integrated Care for Older People and Physical Disability**.

## 13.4 Children's Service 2014/15

**Table 13-3: Children's Service (Family Services) Budget and Outturn 2014/15**

| Children's Services (Family Services) | Original Net Budget | Current Net Budget | Outturn |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Assessment & Children in Need | 6,807 | 7,214 | 7,781 |
| Children in Care - Provider Service | 20,829 | 22,010 | 22,796 |
| Commissioning & Business Improvement | 3,006 | 3,285 | 2,476 |
| Early Years | 5,027 | 4,697 | 5,039 |
| Family Services Management | 660 | 899 | 324 |
| Family Support & Early Intervention | 776 | 740 | 761 |
| Safeguarding & Quality Assurance | 1,857 | 1,937 | 2,092 |
| Social Care Management | 1,694 | 1,716 | 1,678 |
| Youth & Community | 7,687 | 7,939 | 7,559 |
| **Total** | **48,343** | **50,437** | **50,506** |

**Note:** the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

**Table 13-4: Children's Service (Education and Skills) Budget and Outturn 2014/15**

| Children's Service (Education and Skills) | Original Net Budget | Current Net Budget | Outturn |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Edu Partnership & Commercial | 1,056 | 949 | 740 |
| Education Management Team | 195 | 196 | -97 |
| High Needs Support | 5,806 | 6,067 | 6,569 |
| **Total** | **7,057** | **7,212** | **7,212** |

**Note:** the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

**Biggest areas of net spend:** Within Family services the biggest areas of net spend are around **Children in Care-Provider Service** and **Assessment & Children in Need**. Within Education and Skills the biggest area of net spend is around **High Needs Support.**

## 13.5 Public Health 2014-15

**Table 13-5: Public Health Expenditure of £14,335,000 grant 2014/15**

| Public Health | Original Net Budget £'000 | Current Net Budget £'000 | Outturn £'000 |
|---|---|---|---|
| **Mandatory Services** | | | |
| Sexual health | 4,368 | 4,368 | 4,555 |
| Health Checks | 573 | 573 | 328 |
| School Nursing | 1,084 | 1,084 | 1,109 |
| **Total** | **6,025** | **6,025** | **5,992** |
| **Discretionary Services** | | | |
| Tobacco control | 707 | 707 | 345 |
| Drugs and Alcohol misuse | 2,887 | 2,887 | 2,910 |
| Physical Activity | 680 | 680 | 611 |
| **Total** | **4,274** | **4,274** | **3,866** |
| **Barnet Public Health** | **2,129** | **2,129** | **1,049** |
| **Contribution to Public Health Team** | **1,962** | **1,962** | **2,392** |
| **Total Barnet Public Health** | **14,390** | **14,390** | **13,299** |
| Direct Barnet expenditure | | **33** | **33** |
| MOPAC | **-88** | **-88** | **-88** |
| Wider Determinants | | | **800** |
| **Total Grant** | **14,302** | **14,335** | **14,044** |
| **Contribution to Reserves** | | | **291** |
| **Total Grant** | | | **14,335** |

**Note:** the increase in the Original Net Budget figures and Current Net Budget figures is due to the Policy Officer post contribution.

**Biggest areas of net spend:** The biggest areas of net spend are towards **Sexual Health** and **Drugs and Alcohol Misuse**.

## 13.6 Barnet Clinical Commissioning Group 2014-15

**Table 13-6: Barnet CCG Budget and Outturn 2014/15**

| CCG | Original Budget | Current Budget | Outturn |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| **Income** | **408,734** | **428,473** | **428,473** |
| **Expenditure** | | | |
| Acute | 254,577 | 271,586 | 263,476 |
| Mental Health | 37,573 | 37,754 | 37,691 |
| Community | 70,506 | 71,717 | 69,113 |
| Primary Care | 51,207 | 52,270 | 52,946 |
| Other | 18,821 | 19,091 | 16,267 |
| **Total** | **432,684** | **452,418** | **439,493** |
| **Net deficit** | **23,950** | **23,945** | **11,020** |

**Note:** the increase from the Original Net Budget to Current Net Budget figures is due to additional non-recurrent funding received in year from NHS England for specific initiatives (e.g. additional patient services over the winter period) or from local North Central London CCGs for specific across CCG projects (e.g. impact of Barnet, Enfield and Haringey Clinical Strategy)

**Biggest areas of net spend:** the biggest areas of net spend are around **Acute** spending and **Community.**

# 14 Appendix-1 Barnet (PHOF) Indicators that are worse or lower than England

(Benchmark: England)

| Compared with benchmark: | Better | Similar | Worse | Lower | Similar | Higher | Not compared |
|---|---|---|---|---|---|---|---|

| Indicator Name | Year | Barnet | | England |
|---|---|---|---|---|
| **Wider Determinants of Health** | | **Count** | **Value** | **Value** |
| 1.15ii - Statutory homelessness - households in temporary accommodation (persons, all ages) | 2013/14 | 2,401 | 16.9 / 1,000 | 2.6 / 1,000 |
| 1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like (persons, all ages) | 2012/13 | No data | 35.8% | 41.3% |
| **Health Improvement** | | | | |
| 2.15ii - Successful completion of drug treatment - non-opiate users (persons, 18-75 yrs) | 2013 | 74 | 20.4% | 37.7% |
| 2.16 - People entering prison with substance dependence issues who are previously not known to community treatment (persons, 18+ yrs) | 2012/13 | 112 | 55.4% | 46.9% |
| 2.17 - Recorded diabetes (persons, 17+ yrs) | 2013/14 | 17,970 | 6.0% | 6.2% |
| 2.20i - Cancer screening coverage - breast cancer (Female, 53-70 yrs) | 2014 | 23,337 | 71.2% | 75.9% |
| 2.20ii - Cancer screening coverage - cervical cancer (Female, 25-64 yrs) | 2014 | 72,574 | 68.8% | 74.2% |
| 2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check (persons) | 2013/14 – 14/15 | 31,104 | 33.4% | 37.9% |
| 2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check (persons) | 2013/14 – 14/15 | 13,687 | 44.0% | 48.9% |
| 2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check (persons) | 2013/14 – 14/15 | 13,687 | 14.7% | 18.6% |
| **Health Protection** | | | | |
| 3.02 - Chlamydia detection rate (15-24 year olds) – CTAD (persons, 15-24 yrs) | 2014 | 600 | 1376† | 2,012† |
| 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 yr old, persons) | 2013/14 | 4,612 | 79.7% | 94.3% |
| 3.03v - Population vaccination coverage - PCV | 2013/14 | 4,767 | 82.3% | 94.1% |
| 3.03vi - Population vaccination coverage - Hib / MenC booster (2 yrs old, persons) | 2013/14 | 4,833 | 80.2% | 92.5% |
| 3.03vi - Population vaccination coverage - Hib / Men C booster (5 yrs old, persons) | 2013/14 | 5,122 | 86.0% | 91.9% |
| 3.03vii - Population vaccination coverage - PCV booster (2 yrs old, persons) | 2013/14 | 4,839 | 80.3% | 92.4% |
| 3.03viii - Population vaccination coverage - MMR for one dose (2 yrs old, persons) | 2013/14 | 4,863 | 80.7% | 92.7% |
| 3.03x - Population vaccination coverage - MMR for two doses (5 yrs old, persons) | 2013/14 | 4,473 | 75.1% | 88.3% |
| 3.03xii - Population vaccination coverage – HPV (Female, 12-13 yrs) | 2013/14 | 1,339 | 69.5% | 86.7% |
| 3.03xiii - Population vaccination coverage – PPV CTAD (persons, 65+ yrs) | 2013/14 | 30,921 | 64.6% | 68.9% |
| 3.03xiv - Population vaccination coverage - Flu (persons, 65+ yrs) | 2014/15 | 38,821 | 71.0% | 72.7% |
| 3.03xv - Population vaccination coverage - Flu (at risk individuals) (persons, 6 months - 64 yrs) | 2014/15 | 16,855 | 48.4% | 50.3% |
| 3.04 - People presenting with HIV at a late stage of infection (persons, 15 yrs) | 2011-13 | 68 | 51.5% | 45.0% |
| 3.05ii - Incidence of TB (persons, all ages) | 2011-13 | 283 | 25.9† | 14.8† |

†Per 100,000; Data source: Public Health England. Public Health Outcomes Framework (PHOF). Data Release: 4th Aug. 2015

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# Barnet's JSNA 2015 – 2020

# Executive Summary

## Structure



## 1. Demography

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases more in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by natural change in the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% BAME backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a BAME background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less than the average for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth 78.8 years.**
- The west of the Borough has the highest concentration of more deprived LSOAs, with **the highest levels of deprivation in Colindale, West Hendon and Burnt Oak**. However, the **most deprived LSOA in Barnet is located in**

**East Finchley, specifically the Strawberry Vale estate**, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst both men and women. **As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Some areas, particularly Golders Green, Colindale and Mill Hill, will get younger, bucking the trend of an ageing Borough.

## 2. Socio-Economic and Environmental Context

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently, the significant majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established community and family networks locally.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.
- **There are shortages of people available to fill vacancies in the caring, leisure and services sector, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.

- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

## 3: Health

- Barnet is healthy borough overall. Coronary Heart Disease is the number one cause of death amongst men and women. **As male life expectancy continues to catch up on and converge with women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- **There is an 8 year difference in male life expectancy between Burnt Oak and Garden Suburb wards.** Bigger differences exist at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Smoking, diet and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is the case.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **Smoking is less prevalent in the Borough than the national average. However, women in Barnet are significantly less likely to quit smoking in pregnancy** than women on average in London.
- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later in life.** Particularly HPV, flu and pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.
- **Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate** and the risk of complication and additional

demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

## 4: Lifestyle

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost to the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill, and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet, although the Borough is the 20$^{th}$ lowest borough in England in terms of the rate of high-risk drinkers.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England,** and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.
- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy**, and **good parenting classes**.

## 5: Primary and Secondary Care

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in such hospital.
- **There is increasing demand for urgent and emergency care,** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **The 95% national target for Accident and Emergency (A&E) patients waiting no longer than four hours from the time of booking in to either admission to hospital or discharge** was missed in quarter 4 14/15 (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- **Obesity growth in middle-age population** (45-65) year olds places additional risk of them developing long-term conditions.

## 6: Children and Young People

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and minimise referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably west);** targeted multi-agency, locality based interventions could better support families.
- **The Young Carers Act and Children and Families Act 2014** represent significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is

expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**

- The number of post-16 pupils remaining in special schools is placing **pressure on the availability of places for admission of younger pupils.**
- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing.** However, there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years and 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.
- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 14/15, averaging 5 or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

## 7: Adult Social Care

- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- **Mental disorder** is responsible for the **largest burden of disease in England** – 23% of the total burden. Within Barnet, by far the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently** and **within the community** as possible. This places significant pressure on ensuring that the right services such as **appropriate housing and support needs** are available to **meet their requirements**.
- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, local based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in

**elderly women who live alone**, especially in **areas of higher affluence and lower population density.**

- **Demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people, 3.3% of the 65 and over population**, which indicates a **deficiency or potential unmet need of around 800 people.**
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average **carers are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.
- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021, the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

## 8: Community Safety

- **Barnet has the 5th highest rate of Residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to Feb 2014. When considering underreporting the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the 12 months.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to address possible underreporting.
- **Despite constituting just 6.5% of offences, violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs.**
- **Domestic violence is more familiar and bedded down within some services and organisations than other Violence Against Women and Girls (VAWG) issues**; further work needs to take place to identify if additional VAWG services are needed within the Borough.

## 9: Community Assets

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with VCS groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is, however, the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).
- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. However, there **is weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- More generally, there are opportunities to:
  - **support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).
  - **rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**
  - respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be better engaged with to deliver health and wellbeing outcomes.

## 10: Resident Voice

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and** '**Repair of roads' as being poor or extremely poor services** provided by the council.
- The **top three concerns** for residents according to the spring 2015 Residents' Perception Survey were '**Conditions of roads and pavements (38%); Lack of affordable housing (33%); and Crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live, whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

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# Keeping Well, Promoting Independence

## A Joint Health and Wellbeing Strategy for Barnet 2016 – 2020

*LOGOS (of HWBB members to be added)*

## Contents

# 1. Councillor Helena Hart / Dr Debbie Frost foreword – to be added

# 2. What we are trying to achieve

Barnet is a great place to live and is now the largest borough in London by population. People in Barnet can expect to live longer and in better health than in many parts of London and England as a whole. This is not by chance but is linked to a range of factors including levels of family support, lifestyle, wealth, access to healthcare and green spaces, as well as the ability to access the right support when needed.

While the overall picture is positive, the current Barnet Joint Strategic Needs Assessment (JSNA) has shown that there are marked differences in health and wellbeing outcomes, between places and different demographic groups, within Barnet. With less and less public money available, this Joint Health and Wellbeing Strategy aims to align and combine our efforts on a focused list of priorities where together we can make the largest impact to reduce health inequalities.

This strategy focuses on health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of addressing wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing.

We hope to inspire and encourage both individuals and partners with this strategy and our vision for health and wellbeing in Barnet; we will do this through the following approach:

- Providing a shared vision and strategic direction across partners
- Continuing the emphasis on prevention and early intervention including secondary prevention (slowing the progression of disease)
- Making health and wellbeing a personal agenda as well as increasing individual responsibility and building resilience
- Joining up services so residents have a better experience
- Developing greater community capacity; increasing community responsibility and opportunities for residents to design services with us
- Strengthening partnerships to effect change and improvement
- Putting emphasis on working holistically to reduce health inequalities.

It is our vision for Barnet residents, where appropriate, to be able to far better manage their own health and wellbeing. Barnet has a strong foundation for using resources within local communities with 88% of residents satisfied with their local

area and 90% of residents saying that they help their neighbours out when needed. 28% of residents volunteer regularly (weekly or monthly) and over 1,400 voluntary and community sector organisations are active in the borough.

The Joint Health and Wellbeing Strategy reflects Barnet's Strategic Equalities Objective that *"Citizens will be treated equally, with understanding and respect, and will have equal access to quality services which provide value to the taxpayer."*

The Health and Wellbeing Board and its partners are well placed to seek to improve wellbeing and tackle inequalities locally. Organisations and partners and residents tell us that they all want the same thing – to keep well and promote independence. This strategy is a guide as to how, together, we can have the biggest impact.

We have consulted widely on this strategy not only to ensure that people feel it is appropriate but also to embed our vision across the public sector and to develop joint services to make the biggest difference.

## Aims

The Joint Health and Wellbeing Strategy has two overarching aims consistent with the aims of the previous strategy:

**Keeping Well** – Based upon a strong belief that 'prevention is better than cure', this strategy aims to begin at the very earliest opportunity by giving every child in Barnet the best possible start to live a healthy life. It aims to create more opportunities to develop healthy and flourishing neighbourhoods and communities as well as to support people to adopt healthy lifestyles in order to prevent avoidable disease and illness.

**Promoting Independence** – This strategy aims to support residents and communities to become equal partners, with public services, to improve health and wellbeing. It also aims to ensure that when extra care is needed, this is delivered in a way which enables everyone (children, young people, adults and older people) to regain as much independence as possible, as soon as possible, and as ever supported by health and social care services working together.

It is our aim that this strategy should be used to inform service planning and service development across the public, private and voluntary and community sectors in the borough. Barnet's Health and Wellbeing Board is responsible for the development of this strategy and for overseeing its implementation. Further information about the Barnet Health and Wellbeing Board, its membership, subgroups and associated groups can be found at appendix one.

## Themes and priorities

Annually the Health and Wellbeing Board has reviewed the progress made against the previous Health and Wellbeing Strategy (2012 – 2015) and, based on the progress made, has identified a number of priorities. Using the updated JSNA we are now able to review the progress made and redefine our approach for the lifetime of this refreshed Joint Health and Wellbeing (JHWB) Strategy (2016 – 2020). Our current Health and Wellbeing Strategy focuses on priorities across four theme areas and these priorities have been retained for the refreshed strategy. The table below gives an overview of the theme areas and the priorities we will focus on within each theme area:

| **Vision** | To help everyone to keep well and to promote independence | | | |
|---|---|---|---|---|
| **Themes** | *Preparation for a healthy life* | *Wellbeing in the community* | *How we live* | *Care when needed* |
| **Objectives** | Improving outcomes for babies, young children and their families | Creating circumstances that enable people to have greater life opportunities | Encouraging healthier lifestyles | Providing care and support to facilitate good outcomes and improve user experience |
| **What we will do to achieve our objectives** | Focus on early years settings and supporting parents especially older and first time mothers | Focus on improving mental health and wellbeing for all | Focus on reducing obesity through promoting physical activity | Focus on identifying unknown carers and improving the health of carers (especially young carers) |
| | | Support people to gain and retain employment and promote healthy workplaces | Assure promotion and uptake of screening (for cervical and breast cancer) and the early identification of disease | Work to integrate health and social care services |

Our efforts across the priorities will have a cumulative positive impact. Our aspiration for all children, young people, adults and older people are embedded across the theme areas.

# 3. Where we are now

## Barnet at a glance

The latest Barnet JSNA, formulated in 2015, is an impartial and up-to-date evidence base to be used as an effective means for joined up decision making across all sectors. The JSNA provides the data and information from which we can determine our priorities. The key headlines from the JSNA are:

- Barnet is now the **largest borough in London by population (projected to be 367,265 by the end of 2015) and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the borough, with over 113% growth in Golders Green and 56% in Colindale by 2030
- **The west of the borough has generally the highest levels of deprivation in the wards of Colindale, West Hendon and Burnt Oak.** Although, the **Strawberry Vale estate in East Finchley ward is actually the most deprived area** in the borough
- **Barnet's population is becoming more diverse**, driven predominantly by natural change in the established population. The highest proportion of the population from white ethnic backgrounds are found in the 90 years and over age group (93.3%) whereas the highest proportion of people from black, Asian and minority ethnic (BAME) groups are found in the 0-4 age group (55.4%). The wards of Colindale, Burnt Oak and West Hendon have populations of whom more than 50% are from BAME backgrounds
- In Barnet, as in the rest of the country, **women have a higher average life expectancy (85 years) than men (81.9 years).** The life expectancy of men has increased at a higher rate than that of women, reducing the life expectancy gap between genders from 5.1 years (1991/93) to 3.1 years
- The life expectancy of individuals living in the most deprived areas of the borough are on average 7.6 years less for men and 4.7 years less for women than those in the most affluent areas. By ward, **Burnt Oak has the lowest average life expectancy from birth of 78.8 years,** 4.2 years behind the Barnet average and 8.3 years behind Garden Suburb, which has the highest life expectancy of 87.1 from birth
- Gains in life expectancy have outstripped gains in **healthy life expectancy.** This indicates that although women are living (on average) longer than men, **a larger proportion of women's lives is spent in poor health**; 19.1% (16.2 years) for women and 17.0% (13.9 years) for men
- **Coronary Heart Disease is the number one cause of death amongst men and women, followed by Cancer**

- Due to the projected population increase in those 65 and over, **the number of people aged over 65 living with moderate or severe learning disabilities is estimated to rise** from 143 in 2015 to 187 in 2030
- It is estimated that over **4,000 people in Barnet are living with dementia** and even greater numbers of families and friends are adversely impacted by the condition. By 2021 the number of **people with dementia in Barnet is expected to increase** by 24% compared with a London-wide figure of 19%
- During 2013/14, **4,957 people were diagnosed as having had a stroke**. The rate of emergency hospital admissions for stroke in Barnet (235.4 / 100,000) was higher than the national rate (174.3 / 100,000)
- In 2013-14, **breastfeeding initiation in Barnet was the 11th highest among all 326 English local authorities** and 9th highest among the 33 London boroughs.
- Barnet has a **relatively low level of smoking prevalence compared with other areas** (15% of adults over 18 years, compared to 18.4% nationally).
- Barnet has a relatively **high percentage of the adult population with a healthy weight** (42.1%). Although the percentage of adults with excess weight (55.7%) (combined overweight 35.2%, plus obese 20.5%) is low compared to the national average it nonetheless covers a large proportion of the adult population. Barnet also has a **high percentage of underweight adults** (2.3%) compared to the national level (1.2%)
- For children aged 4 - 5 years, the percentage of excess weight (overweight and obese) of 21% in 2013/14 was lower than London (23.1%) and England (22.5%) averages and has declined over the past five years. However, the proportion of **excess weight for children** aged 10 – 11 years has increased to 34.4% in 2013/14 compared to 33.6% in 2012/13 this is similar to the national rate but still lower than the London region (37.59%)
- Barnet is ranked 16th and 14th out of all London boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores out of the 33 London boroughs. Both of these indicators have experienced a decline in Barnet since 2011. **Satisfaction levels of Barnet vary throughout the borough** peaking in Finchley Church End, Garden Suburb and Totteridge with satisfaction being lowest in Burnt Oak.

The full JSNA can be accessed here – *Add website link when available*

## Policy context

Although it has only been three years since the last JHWB Strategy the policy context has moved on greatly with a number of major legislative changes and policy developments.

Locally, the council approved it its **Corporate Plan** (2015 – 2020)[1] in April 2015 which strives to ensure that Barnet is the place of opportunity, where people are helped to help themselves, where responsibility is shared and where high quality services are delivered effectively and at low cost to the taxpayer. The council's Corporate Plan sets the framework for each of the commissioning committees' five year commissioning plans. Whether the plans are covering social care services or concern universal services such as the environment and waste, there are a number of core and shared principles which underpin the commissioning outcomes – the principles of fairness, responsibility and opportunity. With the Corporate Plan, this strategy will provide strategic direction to council strategies and action plans, including those on housing, regeneration, transport, employment and business.

The Barnet Clinical Commissioning Group's (BCCG) **Five Year Strategic Plan** (2014 – 2019) outlines its strategic vision to work with local people to develop seamless, accessible care for a healthier Barnet. BCCG goals are to promote health and wellbeing; transform primary care; ensure the right care, first time and develop joined up care.

**Nationally** it is proposed that GPs provide services on a seven-day a week, 8am – 8pm basis by 2020. BCCG had submitted a collaborative bid with Enfield CCG in partnership with Barnet constituent GP federated networks regarding the Prime Minister's Fund – Wave Two. Although the bid was unsuccessful the proposals explored networks delivering extended access (8am to 8pm, seven days a week) and digital primary care.

The continuing financial pressures across the health and social care economy underlies the importance of changing the way in which we work for example crossing organisational boundaries and providing services in a more collaborative and effective way.

NHS England approved the council and Barnet Clinical Commissioning Group (CCG) joint **Better Care Fund** bid in January 2015 which laid out how they plan to better care for people with complex needs. Barnet Better Care Fund represented a single pooled budget of £23,312,00 for 2015/16, to support health and social care services to work more closely together. The council and BCCG are working together, within the Health and Social Care Integration model, to deliver a robust programme of work including Healthy Living Pharmacies and Barnet's Integrated Locality Team (BILT).

[1] https://www.barnet.gov.uk/citizen-home/council-and-democracy/policy-and-performance/corporate-plan-and-performance.html

The **Five Year Forward View**, published in October 2014 by NHS England, set out a radical increase in emphasis on prevention and public health focusing on greater individual and community control and responsibility through a new relationship with patients and communities. Four new models of care are identified in the NHS England planning guidance for the Five Year Forward View including multispecialty community providers, integrated primary and acute care system, additional approaches to creating smaller viable hospital and models of enhanced health in care homes. Relevant here is the shift to local determination of how resources are most effectively deployed, one example is the Great Manchester devolution deal with NHS England, this would enable decisions to be made closer to the population being served.

In 2014, NHS England asked for CCGs to put forward their bids for **co-commissioning (with NHS England)** of primary care. The North Central London (NCL) CCGs' Co-Commissioning application to be involved at Level 2 decision making only has been approved. Following changes to their constitutions, the CCGs in NCL (Barnet, Enfield, Haringey, Camden, Islington) will be able to collaborate to decision-making within the Joint Co-Committee arrangements set out by NHS England.

The **Care Act 2014**, the most comprehensive overhaul of social care since 1948, provided an opportunity to build on and improve the care and support that we deliver. The Care Act called for care to be focused on the individual, their needs and their wellbeing, including increasing the importance of individuals choosing who they buy their care from. The Care Act has also put carers on an equal platform as their cared for in terms of eligibility for support. The Care Act came into force on 1 April 2015 and is therefore a key driver in refreshing the JHWB Strategy alongside challenges of increased demand for adult social care support.

The **Children and Families Act**, another major piece of legalisation, was implemented in September 2014. In particular, the Act introduced a single assessment process, Special Educational Needs (SEN) reforms (including Education, Health and Care plans replacing statements) and a comprehensive local offer of services available to children, young people and their families. The council and BCCG have been working together to implement changes including cross-over with the Care Act.

In December 2012, the Department of Health published the **Winterbourne View Concordat**. This has developed into the Transforming Care programme of action designed to transform services for people with learning disabilities, autism and mental health conditions. There is ongoing work in Barnet to improve and adapt current services, such as a new model for community learning disability services, embedding new care and treatment review processes to include people at risk of admission and a new Learning Disability Skills and Competency Framework for staff.

We are aware that the policy context is likely to change in the lifetime of this strategy and while we will be as flexible as possible in order to meet these demands, our ambition and priorities are unlikely to change.

# 4. Preparing for a healthy life

## Highlights

The council, BCCG and voluntary and community sector organisations have been working hard to implement the reforms from the **Children and Families Act** (2014) in order to be compliant to deliver a system designed around the needs of children and will support them until they are 25.

We have developed our commitment to improving the life experiences of children and young people with complex disabilities into a vision for a new and improved 0-25 disability service which aims to foster resilience and independence. The new service intends to reduce the 'cliff-edge' of care our young people and their families often report during the transition from children's services to adults. The council is working to align with BCCG as the same service challenges are experienced by young people and their families accessing health services.

New models of **health visiting** and school nursing have been completed in time for the transfer of the responsibility of services from NHS England to the local authority in October 2015.

The **Healthy Children's Centre Project** supports Children's Centre staff and health professionals to work together to provide high quality services to support young children and families' health and wellbeing. Taking a whole family approach the project has focused on a range of health and wellbeing outcomes such as involving families in healthy eating, reducing obesity through healthy lifestyles, promoting successful breastfeeding and children's oral health. An Oral Health Co-ordinator, started in 2014 and has trained staff to deliver the Brushing for Life Programme (promoting effective tooth brushing and fluoride's indisputable role in preventing tooth decay). Oral Health Champions in Children's Centres have also been identified. Schools in areas of high deprivation or with a high number of overweight children have been prioritised.

At centres for children, baby clinics (or self-service weighing services at centres without baby clinics) are providing a valuable opportunity for centre staff to engage with new families about services and support available.

## What does Barnet's JSNA tell us?

### Population growth

- The 0-15 age group shows growth at a greater rate than the 16-64 age group until 2026, after which the child population is expected to decline slightly. This pattern of growth suggests that families are moving to Barnet with children. The high rates of population growth for children and young people (CYP) is expected to largely occur in wards with planned regeneration works and are predominantly in the west of the borough

### Deprivation

- Overall, in comparison with the national picture, children in Barnet have above average good health, educational attainment and life chances. However, this is not uniform for all children across the borough
- Although the number of children living in poverty[2] has reduced slightly from the last Health and Wellbeing Strategy, from 18,000 to 17,330, this remains a significant proportion of children in the borough (21.2%), located notably in the western areas of Barnet. The poor outcomes for children in poverty are well documented especially poor educational attainment and ill health

### Health

- Childhood immunisations rates seem to remain a problem in Barnet with rates worse than the national rates although we will continue to work with NHS England to ensure accurate data is collected. Barnet's Public Health team is looking at immunisation uptake with partners, overseen by the Health Overview and Scrutiny Committee
- Poor dental health is associated with poor health outcomes in later life. Child dental decay is the top cause for non-emergency hospital admissions in Barnet for children
- The number of post-16 pupils remaining in special schools is placing pressure on the availability of places for admission of younger pupils.

### Safety

- Keeping people safe is a key component of health and wellbeing. The safety of children in Barnet is overseen by a partnership of colleagues on the

[2] According to the 2010 Child Poverty Act, a child is defined as being in poverty when he/she lives in a household with an income below 60% of the UK's average. Throughout the refreshed JSNA and JHWB Strategy child poverty will be defined based upon the definition put forward by the 2010 Child Poverty Act.

Safeguarding Children Board and the Children, Education, Libraries and Safeguarding Committee

- Over half of children and young people with a child protection plan have suffered neglect. 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years. The pattern of CSE in Barnet is wide and varied. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet.

## What we plan to do

### Improve oral health for children

We will seek to improve access to dental services for children and young people. In June 2015, Healthwatch reported problems with NHS dentists accepting new patients (including children) and have commissioned Homestart Barnet to explore the dentistry experiences of families with young (pre-school children). This study will look at the impact of accessibility to dental services for young children, availability of NHS dental services, family attitudes and opinions to dental care and the availability of clear information on how to access dental services.

For Oral Health Champions, we will increase stakeholder networking and increase community activity, outside of the classroom and centres for children to ensure that good oral health practices are embedded.

### Provide effective services for children, young people and their families

Poor oral health is an indicator of wider difficulties including neglect; we are committed to supporting parents and families to create positive and supportive environments for children. The best chance for intervention with lasting positive impact is during the first 1001 critical days[3] of a child's life which is a critical period for brain development. We aim to improve outcomes for our children and young people through developing a supportive environment so children can thrive in their early years. We will provide a variety of support for parents especially older and first time mothers. All of our centres for children are working towards **Healthy Children's Centre** Status anticipating five centres will be awarded this status in late 2015. We will continue to support all of our Children's Centres to become registered as Healthy Children's Centres by late 2016.

Our partners are key to ensuring centres for children are able to make a positive impact on the health and wellbeing of children and their families. For this reason, we hope by 2020 that the Healthy Children's Centre Project is embedded as a priority amongst all the partners. This will improve working partner relationships as well as

[3] http://www.1001criticaldays.co.uk/UserFiles/files/1001_days_jan28_15_final.pdf

improve the quality and holistic approach to the health services received throughout Barnet.

From mapping of **voluntary and community sector services** documented in the JSNA, local voluntary and community sector provision for children is relatively low in the areas where the population of children and young people is forecast to be highest (Colindale and Burnt Oak). Targeted social action, volunteering and employment projects, delivered by our local infrastructure partners, aim to rectify this.

Pregnancy and the birth of a baby are a critical 'window of opportunity' when parents are especially receptive to offers of advice and support. Promotion of support and linking new parents with early years provision is vital and effective. The Early Years Service provides brokerage and outreach across the borough to seek to ensure all parents of targeted two year olds and universal three and four year olds access their **free entitlement offer**. Currently 42% of eligible two year olds and 86% of eligible three and four year olds access their offer. Therefore there is a targeted approach to see an increase in these numbers. There are opportunities to link employment opportunities with the take up of the free two year child care offer.

The JSNA identifies Burnt Oak and Colindale as areas of particular need given the levels of deprivation. Just over one third of the children in Burnt Oak and in Colindale are living in low-income families. Burnt Oak is the only ward where the average household income in 2015 – at £25,000 per year – was lower than in 2008. Targeted, multi-agency, place based commissioning programmes have been developed including a GP-led well-being pilot, Love Burnt Oak's Health Coaches funded by the Area Forums, a town centre regeneration project and a multi-agency employment service (Burnt Oak Opportunity Support Team, BOOST).

A thorough **Early Years review** has been undertaken and a locality model for centres for children has been developed which supports integrated working with partners with an early years offer being led jointly by BCCG and the council. The model will deliver a broader offer of services which incorporates external provision and builds on community capacity; it will also consider co-location and integration of health services. The offer will aim to improve outcomes and reduce inequalities for children. The locality model focuses on three areas (east/central, south and west) of the borough aiming to improve flexibility, effectiveness and also join up services to create a clear, identifiable Early Years offer which is trusted by residents and facilitates strong support networks.

We will seek to support more of our looked after children locally, especially those with a range of complex needs, enabling them to benefit from the quality of local schools and other local services. We are committed to increasing the number of Barnet children fostered by Barnet foster carers.

The Health and Wellbeing Board recognises and supports the priorities of the Safeguarding Children Board including CSE and Female Genital Mutilation (FGM). The Health and Wellbeing Board has a role to ensure CSE issues are championed across partners.

## How will we know we have made a difference?

*Draft targets (not in a table, for consultation purposes)*

| Measure | Baseline – 14/15 | Target – 15/16 | Target - 19/20 |
|---|---|---|---|
| Number of Healthy Children's Centres | 0 | 5 | All |
| Percentage of families with child/ren under 5 registered and accessing services at centres for children | New indicator | 85% (65% from vulnerable groups) | 96% (65% from vulnerable groups) |
| Percentage of children in care in LBB foster care as a percentage of all children in care | 35% (q3 2014/15) | 39% | 53% |
| The percentage of free entitlement early years places taken up by parents/carers that are eligible for a place. | 41% | 50% | 85% |
| Satisfaction of children and parents with services for disabled children and their families | To be set with the development of the 0-25 disabilities service (2015/16 baseline) | | |
| Prevalence of early childhood (dental) caries | 6.1% (2013) | Decrease | At national average (3.9%) |
| School readiness: the percentage of children achieving a good level of development at the end of reception | TBC | TBC | TBC |
| Increase uptake of childhood immunisations (six vaccinations) | 75.1% - 86% | At or above England average (88.3% – 94.3% | Maintain at or above England average |
| Increased number of voluntary and community sector organisations in deprived areas | New indicator – target to be set in 2016 | | |
| Increased social action (resulting in volunteering opportunities) in deprived areas | New indicator – target to be set in 2016 | | |

# 5. Wellbeing in the Community

## Highlights

The previous Health and Wellbeing Strategy identified excess cold hazards (such as cold homes, the cost of energy bills, social isolation, access to services and risk of falls) as a priority. The **Winter Well scheme**, led by Regional Enterprise Ltd. (Re), working in partnership with the council, BCCG and voluntary and community sector partners, was successfully delivered in 2014. The scheme aims to reduce negative health outcomes and excess winter deaths by providing practical assistance to the most vulnerable and eligible residents.

To date the scheme has included training and advice to over 110 professionals and 210 residents on energy matters to prevent and reduce fuel poverty. The scheme includes a Winter Well helpline and has also provided emergency supplies and services such as heaters, damp proofing and boiler repairs. To date energy switches have saved borough residents a total of £24,004 (total for 97 residents). Warm places have been set up across the borough for people who had difficulty heating their homes and/or found themselves isolated over the colder months, with a particular focus on older people and people with long term conditions. Seventy new Community Friends (part of Altogether Better) were recruited during the scheme showing the community's response to help others in the event of cold weather.

**Altogether Better**

Altogether Better projects are a way of providing opportunities to address an individual's needs, facilitate mutual support mechanisms, build resilience, unlock community resources and bring people and communities together.

Altogether Better officers work in small geographical localities, have an open door, access to information and small amounts of funding, but most importantly a remit to nurture local solutions and keep people independent. They help people to access services where they are the only option, as a last resort.

Currently there are four Altogether Better sites covering the following the areas:

- Burnt Oak
- East Finchley
- Edgware and Stonegrove
- High Barnet, Arkley and Underhill.

Activities include Talkie Walkies (walking groups), Wellbeing Cafés and Men in Shed projects.

In addition to Altogether Better Barnet has some borough wide projects. The Barnet Timebank in its second year; 121 exchanges have included CV help, gardening, befriending, fitness advice and language lessons. There are also a

number of volunteer led intergenerational reading groups including for people with dementia and their carers.

The condition of and access to local **housing** has an important role in the quality of life and health of both individuals and communities. The council has developed a new Housing Strategy (2015 – 2020) which sets out how the council and partners will deliver the additional housing that is required in the borough due to the growing population. The strategy also details how more affordable housing will be provided as well as promoting independence through the provision of wheelchair accessible housing. In Barnet, there are also a number of plans in place to improve housing such as re-locating and improving the quality of an in-house children's home, increasing the number of fostering placements through recruitment of foster carers as well as work to better understand the causes of homelessness and how to prevent it as part of the Housing Strategy. We are also working with private landlords to ensure good quality private sector housing.

Improving **mental health and wellbeing** is a key priority. In 2014, BCCG and Barnet Council signed up to the Crisis Care Concordat and the Government emphasised the importance of achieving parity of esteem between physical and mental health; valuing mental health equally with physical health.

Action already taking place includes:

- Barnet Council's Network Enablement Service
- BCCG and council working with Barnet, Enfield and Haringey Mental Health Trust to improve and modernise the current secondary care services towards a community based model of care delivery within the community
- BCCG South Locality Primary Care Liaison Pilot which is reporting early reductions in hospital admissions through step-up functions
- The Burnt Oak and Colindale Wellness Service Pilot involving a navigator role to support people through their health and wellbeing journey
- Improving access to services such as the BCCG implementing a locally enhanced service to improve access to primary care for people with mental health problems who are homeless and reducing the waiting list for IAPT as well as encouraging self-referrals to IAPT
- Public Health has developed a Suicide Prevention Strategy, Working Group and action plan. Self-harm and suicide prevention workshops have been held for professionals and volunteers who work with vulnerable groups
- Two public health commissioned employment support services - Motivational and Psychological Support based in local Job Centres and an Individual Placement and Support (IPS) scheme for people with severe and enduring mental health needs and based in community mental health teams
- Barnet is leading a West London Alliance (WLA) programme looking at developing IPS for people with common mental health conditions. Learning

from other similar schemes suggests that we should expect to see between a third and a half of people supported gain and retain employment.

A Barnet Schools Health and Wellbeing programme has been in place since 2013, and is both established and performing well. The emotional health and well-being element of this programme offers consultancy support, development of schemes of work and a directory for signposting as well as training to build capacity within schools. Health, Education and Care partners have been engaged to develop a smoother treatment pathway that effectively meets needs. We seek to build on existing work in schools which will promote early identification of Tier Two (CAMH specialists working in community and primary care settings) needs and offer appropriate interventions and referrals access for CYP. A pilot project of an evidence based manualised treatment group is already underway, for managing severe anxiety which impacts on school attendance.

There are a number of befriending schemes running in Barnet such as Alzheimer's Society supporting people with dementia and their carers, Mind supporting people at risk of social isolation due to a mental health problem and Homestart supporting families.

## What does Barnet's JSNA tell us?

**Mental health, mental wellbeing and social isolation**

- Barnet has lower prevalence of depression (4.3%) in adults than the national average (5.8%) however the prevalence of schizophrenic, bipolar affective disorder and other psychoses (0.95%) are higher than the national average (0.84%)
- Emergency admissions for self-harm (109.9 per 100,000) are lower than the average for England (191 / 100,000) and the suicide rate (6.9 / 100,000) is lower than the national rate (8.5 / 100,000)
- According to national projections, the most common health conditions within Barnet are mental health disorders
- The hospital admissions rate for poor mental health in children (aged less than 18 years) in Barnet is higher (167.6 / 100,000) than the average national rate (87.6 / 100,000)
- Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

### Domestic violence and violence against women and girls

- Domestic violence along with parental mental ill health and substance abuse are the most common causes for referrals into social care and result in the poorest outcomes for children and young people
- The number of Multi Agency Risk Assessment Conference (MARAC) cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013.

### Employment

- Barnet has a lower than average percentage of people with mental health conditions and learning disabilities in work than other areas
- There are significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.

## What we plan to do

### Mental health and wellbeing

The number of people with mental health conditions is predicted to increase as the population grows. In November 2014, the Health and Wellbeing Board identified prevention of and early intervention in mental health problems as a priority. Mental health is our **key priority in year one of this strategy** with partners coming together to make a positive impact for our residents.

We will continue to implement national guidance including the recommendations that will come from the NHS England established taskforce to develop a five year forward view for mental health. We are hoping, through this strategy, to build **prevention and early identification** into all we can to prevent and reduce mental health problems for the borough's residents. Many Public Health and community initiatives contribute to mental wellbeing across the lifespan such as pregnancy and parenting support, physical activity and self –care.

Barnet will run a **wellbeing campaign** focusing on taking responsibility for and improving mental wellbeing as well as tackling stigma. The campaign will embed wellbeing into current activity, share success stories and celebrate World Mental Health Day. We will also:

- Develop a health champion programme in primary care focused on improving mental health and wellbeing
- Review local pathways for antenatal and postnatal depression including promoting peer support
- Be part of the pan London digital mental health support service.

All services and activities working with residents have a responsibility to identify where someone could benefit from support. Barnet Healthwatch Youth has been working with teachers to find out if they feel equipped to identify and support students suffering from mental health problems.

Early mortality for people with severe mental health problems is widely documented. Treatment services are required to make changes at scale to re-focus on recovery, social inclusion and enablement. The **Reimagining Mental Health** project, led by BCCG, is putting residents at the centre of mental health service delivery. The co-designed and co-produced model aims to deliver better, more targeted health services through a community–based approach.

BCCG has committed to the following commissioning intentions to:

- Work with Enfield and Haringey CCGs to review Psychiatric Liaison Service provision
- Continue to work with Enfield and Haringey CCGs on the Crisis Concordat implementation plan
- Review each 2015/16 contract for services for older people relating to multidisciplinary care in patient's own homes that link with primary, secondary, social and voluntary care sectors, and including access to Rapid Care, Triage Rapid Elderly Assessment Team, Post-Acute Care Enablement Service, Integrated Care Team and the Barnet Integrated Locality Team
- Undertake, collaboratively across North Central London, an end-to-end pathway redesign of existing Child and Adolescent Mental Health Services (CAMHS) as our response to the national CAMHS Transformation agenda
- Produce CAMHS out of hour's service, working with North Central London partners.

A new specification for **mental health social work** has been developed by the council to re-focus social work and care on recovery, social inclusion and enablement. Work is now underway to embed the model which includes Consultant Social Workers and integrated pathways as well as improving employment and accommodation.

**Social isolation**

Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. We will seek to improve the identification of people (children, young people, adults and older people) at risk of or experiencing social isolation through our Healthy Living Pharmacies, hospital discharge teams and substance misuse treatment services.

In Barnet, social isolation is especially prevalent in elderly women who live alone, notably in areas of higher affluence and lower population density. We will develop

targeted initiatives, building on current good practice and working with the voluntary and community sector, to encourage greater social contact. We will engage volunteers through befriending schemes (particularly as a respite offer for carers) and promote ways for people to get involved locally such as in the borough's parks and green spaces and libraries.

> **The Barnet Provider Group** has expanded its programme of activities which include lunch clubs and befriending activities, tea dances and games afternoons. They reached close to 2,500 new people over the last 12 months and in total more than 5,600 older people have enjoyed a range of activities. Many of these activities are delivered by in excess of 500 volunteers. The benefits of volunteering are well documented and the majority of volunteers are older people themselves. The Barnet Provider Group plans to expand its befriending services during 2015/16 so that it can continue its work to prevent loneliness and isolation.

The Altogether Better programme continues to expand, supporting access to and increasing the range of community activities to help tackle social isolation and loneliness. Examples include the Silver Service, restaurants offering discounted meals for older people and the opportunity for older people to eat together, set up in two localities.

**Employment and healthy workplaces**

There has been growing recognition that the relationship between health and work has a significant effect on the lives of individuals and on wider society[4]. When out of work, an individual's health is more likely to deteriorate and they risk falling into poverty. Nationally, for too long it was assumed that people with health conditions should be protected from work but in recent years evidence has shown how detrimental this approach can be to individuals and their families.

Barnet has been responding to the Welfare Reform agenda with a **Welfare Reform** Task Force. The Task Force brought together the council's housing officers, Jobcentre staff and health advisers into a single team to work with those impacted by Welfare Reform. This integrated team has engaged with 96% of residents affected by the Benefit Cap and helped over a third of them into work.

> In the past, local authorities, Jobcentre Plus, Work Programme providers, and the local voluntary and community sector have generally operated in silos to help people into work. While this has produced some positive results, there remain pockets of disadvantage where communities are missing out on the opportunities that growth brings.

[4] Fitness for Work, Department for Work and Pensions (2013) - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

**Burnt Oak Opportunity Support Team (BOOST)**, launched in April 2015 and based in the library, helps people find work through holistic support in their local area. The project is part of a West London Alliance approach called 'Working People, Working Places' and puts all relevant services together under one roof so all residents (whether they claim benefits or not) can access the targeted support they need to help them develop new skills and overcome any obstacles to employment that stand in their way. Key to the success of the model is the involvement of the local community facilitated by Love Burnt Oak who will help the service engage with more isolated residents. The service is also supported by a commissioned service called Future Path that supports people with their mental health, physical health and employability side by side. The aim of the two year project is to boost incomes in the area, supporting people into work as well as supporting a measurable increase in the wellbeing of those supported.

There are opportunities for more partners to get involved in the BOOST project and work together to increase incomes and improve wellbeing.

The JSNA has identified sectors in the economy where employers tell us they find it difficult to recruit to care, leisure and retail. There is an opportunity to bring these issues together and support younger people and unemployed residents into the labour market. Engaging with sports and physical activity will not only have positive health and social outcomes for young people, volunteering in this sector will open up employment opportunities.

When residents **gain employment** (including a return to employment following a period of ill-health) we want them to be healthy and we need to create healthy workplaces that support this. Around 300,000 people across the country fall out of work a year and into the welfare system because of health-related issues. The state spends £13 billion a year on health-related benefits, with employers facing an annual bill of around £9 billion for sick pay and associated costs. Costs to individuals are around £4 billion in lost income. A healthy and happy workforce also improves the experience of our customers.

As we ask residents to take more responsibility for their own health, **employers** also need to take responsibility for the health and wellbeing of their staff, creating healthy environments and modelling healthy behaviours. The council and BCCG are two of the largest employers in the borough. The council is looking to achieve an excellence level for the London Healthy Workplace Charter and BCCG is implementing its Health and Wellbeing Policy. HWBB member organisations are committed to supporting their staff to be healthy at work and will promote and champion this agenda to partners such as Re and the NHS Trust providers as well as via Entrepreneurial Barnet which is Barnet's public sector approach to making the best place in London to be a small business.

As not all of our residents will actually work in the borough, the Health and Wellbeing Board (HWBB) will share its learning and experience across London, through the London Healthy Workplace Charter, to promote to other boroughs and partners.

> The **London Healthy Workplace Charter**, a Greater London Authority programme, asks employers to review the support they offer their employees in a number of areas including stress prevention, the promotion of mental wellbeing, smoke free spaces, active travel, healthy eating, a reduction of excess alcohol consumption and the prevention of substance misuse.

## How will we know we have made a difference?

*Draft targets (not in a table, for consultation purposes)*

| Measure | Baseline – 14/15 | Target – 15/16 | Target - 19/20 |
|---|---|---|---|
| Health champions programmes | N/A (new programme 2016) | 2016/2017 – 50 recruited | Roll out (outcomes) |
| Proportion of adults in contact with secondary mental health services in paid employment | 5.7% (2013/14) | 7% | To be established following definition review |
| Proportion of adults with mental health needs who live in stable accommodation | 70.90% | 75% | Top 25% of comparable boroughs |
| Design, delivery and commissioning of a THRIVE or similar Outcomes model to support the Children and Young Peoples IAPT and CAMHS Transformation programmes | Introduce into the CAMHS commissioned system | >70% recording of the outcomes model in appropriate contacts | 100% recording of the outcomes model in appropriate contacts |
| Support people into work (BOOST) | N/A (New programme) | Support 240 people into work | 2016/17 - Support further 240 people into work |
| Barnet Council achieve (by 2016) and maintain London Healthy Workplace Charter excellence status | | | |
| Sickness absence – percentage of employees who had at least one day off in the previous week | 1.3% (2010 – 2012) | Maintain/reduce | Maintain/reduce |
| Social Isolation: % of adult social care users who have as much social contact as they would like | 41.4% | Top 25% of comparable London boroughs | Top 25% in England |

# 6. How we live

## Highlights

Barnet has embraced the **transition of public health** from the NHS to the local authority using this as a key way to address the wider aspects critical to health and wellbeing. Some successes include the commission of substance misuse services which will address fragmentation of services, school nursing, health visitors transfer preparation and increase in NHS Health Checks.

Public Health has also developed a **Substance Misuse** Strategy which coordinates activities to prevent and protect residents from harmful substance misuse as well as promote and sustain recovery through collaboration, training, social marketing and reviewing local licensing. An Implementation Group, led by Public Health, has been established to take forward key areas of action overseen by the Health and Wellbeing Board as well as the Community Safety Partnership. Further to this, enhanced training of Barnet GPs in health promotion for patients with mental illness is part of the Reimagining Mental Health plan.

Barnet and Harrow joint Public Health service is working in collaboration with the West London Alliance (WLA) and the majority of boroughs across London as part of collaborative **sexual health** (genitourinary medicine, GUM) service commissioning arrangements. The major new service tendering, expected in 2017, will reduce service fragmentation, improve access and early intervention which in turn will reduce unwanted pregnancies and onward transmission of sexually transmitted infections (STIs) as well as aiming to tackle escalating costs.

Taking action locally, we have organised a number of pop up screening events to increase the **early identification of disease**. The pop up shops and health promotion events have provided information on healthy lifestyles and their contribution to cancer prevention, symptoms and the importance of early presentation and diagnosis and screening.

The **Obesity** Pathway group, with a membership of BCCG, schools, leisure and providers, has been exploring improvements to the child weight management pathway. Healthy Weight Nurses were appointed in January 2015 and after being in place for six months, the nurses had engaged with 25 children on a 1:1 basis, reporting that almost all had shown positive behaviour change and, as a consequence, six had already lost weight. The team has also noticed behaviour changes in the families of the children they have engaged with. Another aspect of our Child Weight Management programme is Alive and Kicking which, through information on nutrition and physical activities, is successfully supporting weight loss. Alive and Kicking is also engaging with schools and parents to embed healthy weight principles.

The council has worked with its contracted leisure provider, GLL, to increase membership of disabled people. The total number of "Better Inclusive" members peaked in 2015.

## What does Barnet's JSNA tell us?

### Healthy Lifestyles

- Smoking, bad diet, and a lack of exercise are the main causes of premature death in Barnet
- Rates of sexually transmitted infections are lower than London rates. However, there are lower detection rates of chlamydia (16%) than England (24.9%)
- Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%). Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates
- However, inequalities are apparent as men's activity levels (at least 1x30 minutes a week) are higher (44%) than women's (28.4%)
- In Barnet, only 1% of all trips between 2007/08 – 2009/10 (baseline figures) were made by bike
- Pollution levels are higher along arterial routes, particularly the North Circular, M1, A1 and A5.

### Long-term conditions

- The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England
- The prevalence rate of diabetes is forecast to rise at both national and local levels and this increase could be even higher if diabetes risk factors such as obesity are not addressed.

### Screening

- Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average (23.3 per 100,000 vs. 15.5 per 100,000).

## What we plan to do

### Sport and physical activity

Barnet Sport and Physical Activity Needs Assessment (2012) highlighted that while health behaviours and outcomes are more favourable in Barnet than in England as a whole, sport and physical activity rates and the use of outdoor spaces are below the national average.

Regular physical activity helps to reduce the risk of stroke, type II diabetes, development of dementia, incidences of heart disease, cancers and high blood pressure. Physical activity supports the prevention and management of long term conditions as well as being a key component of achieving and maintaining a healthy weight and positive mental wellbeing.

Physical inactivity costs the NHS approximately £4.1 million per year nationally. It also creates costs for the wider economy, through sickness absence and through the premature death of productive individuals, and increases costs for individuals and their carers. Importantly, in Barnet, a quarter of people who are inactive would like to do more physical activity.

To make it easier for people to **access and engage with sport and physical activity**, we will:

- Build **two new leisure** centres at Copthall, and another at either Victoria Recreation Ground or Danegrove (public consultation will determine the location) to improve access to facilities
- Take sport and physical activity **outside of the leisure centre**, improving access and reducing cost for residents through:
    - Making healthy choices the easiest and first in the built environment such as consideration of the placement of stairs in new buildings
    - Promoting and normalising active travel
    - Delivering Community Sport and Health Activation projects in Burnt Oak and Colindale, targeting young people 11-19yrs, supported by Sport England and other local partners
    - Promoting the use of green spaces for sport and physical activity including the use of outdoor gyms
    - Assessing the supply, demand, accessibility and quality of playing pitches
    - Promoting free activities such as local Parkrun
    - Working with local and national partners
    - We will work with our Volunteer Centre to build physical activity into volunteering opportunities.
- **Target those who do not traditionally engage**:
    - Maintain the current level of leisure centre memberships for women ( 48%), but also introduce women only sessions at Hendon and Burnt Oak
    - Provide reduced price leisure offers for people aged over 55, build physical activity into signposting as part of the NHS Health Check programme and build on current activity (such as Altogether Better Talkie Walkies) and Fitness for Life walks in parks
    - Increase the offer for physical activity for people referred via post Health Checks interventions and diabetes programmes

- Build positive experiences of sport and physical activity through schools, Community Sport and Health Activation Project in Burnt Oak and Colindale, Positive Activities, Youth and Family Services, the London Youth Games, School Nurses will be well informed of local clubs and activities and build on the success of school travel plans
- Improve the obesity pathway for children and young people – developing tier 3 services and support for young people in secondary school
- Engage families through fun days and special offers i.e free summer membership and £1 per activity
- Engage community and faith leaders
- Hold a series of Inclusive Open days for people with disabilities, working alongside Barnet Mencap. We will retain Inclusive Fitness Initiative Accreditation at Burnt Oak and seek accreditation for Finchley Lido
- Continue to develop Fit and Active Barnet (FAB) as an umbrella brand, recognised by residents, and as a network for partnership engagement and collaboration.

Through local infrastructure organisations, we will support individuals and communities to take **ownership and responsibility** for sustainable sports and physical activity options, particularly in areas where childhood obesity rates are high (Colindale, Burnt Oak and Underhill). This will be supported by an increase in the quality and number of volunteers.

We need to support people to make better choices and led healthier lifestyles. The council's commitment to this agenda is reflected in the establishment of a Sports and Physical Activity team which, alongside the Public Health team, will work to embed physical activity across all work of the council and partners. The Obesity Strategy Group has expanded following a commitment to develop a Healthy Weight (Obesity) Strategy and action plan. Weight Management Service development is underway.

**Wider public health workforce**

The definition of the Public Health workforce is changing to highlight how public health is everyone's business. To make the biggest impact we need to utilise the wider public health workforce which consists of individuals who are not specialists in Public Health but who have the opportunity to improve the public's health and to create inclusive communities and places. A training resource will be developed to upskill staff who interact with residents (from all sectors) to maximise the opportunities for face-to-face contact to promote good health, social care and wellbeing information, messages and signposting. The training will also support the identification of hidden carers. Specific training is also available such as Raising the

Issue of Weight training to support professionals to discuss weight issues with residents.

To intervene early we will increase the offer of NHS Health Checks in the borough through improved promotion and access. We will also improve the post Health Check service offer and pathway to ensure that people engage in services and lifestyle changes where necessary.

**Regeneration**

The borough's ambitious regeneration and growth programme provides an opportunity to develop new lifetime neighbourhoods that promote independence and wellbeing. Being aware that the environment and where people live impacts their health, we will build public health into all our regeneration and transport projects and programmes including the provision of new health facilities. The high street, at the heart of local community, offers an ideal platform for health promotion. Where possible, we will create healthy high streets including health champions and stores making healthy options easier. We will also consider the proximity of fast food outlets to schools, colleges, leisure centres and other places children gather. We will also link regeneration programmes with child friendly and dementia friendly community developments. We will drive this through our Entrepreneurial Barnet Board supported by national programmes such as NHS England's Healthy New Towns. We will also look at the role Health Impact Assessments play in planning.

Where comprehensive development and regeneration is taking place across the borough (particularly at Colindale and Brent Cross), a wide range of investment programmes are planned to secure improvements to health outcomes for those populations already living in and new residents moving to those areas. Research projects will be set up to monitor impact. These include:

- Expanded or new integrated use local primary care facilities
- New high quality and energy efficient housing to replace existing non-decent housing stock
- Travel planning, public transport, parking measures and highways improvements to enable travel choices
- New schools that can help improve educational and family lifestyle outcomes
- New community and youth facilities to promote social engagement and support positive local community activities.

**Screening**

Increasing screening uptake remains a priority. NHS England has lead responsibility for screening performance. Public Health will work with NHS England to explore appropriate service delivery in line with best practice.

## How will we know we have made a difference?

Monitor –

- Life expectancy and healthy life expectancy including decreasing inequalities (between wards and genders)
- Reduce prevalence of CHD and cancers
- Increase the uptake of screening.

*Draft targets (not in a table, for consultation purposes)*

| Measure | Baseline – 14/15 | Target – 15/16 | Target – 19/20 |
|---|---|---|---|
| Excess weight in adults | 55.7% | Decrease | Decrease |
| Percentage of active adults | 53.9% (2013) | Increase | Exceed national average (56%) |
| Prevalence of 4 – 5 year olds classified as overweight | 11.6% | Decrease | 11.1% |
| Prevalence of 4 – 5 year olds classified as overweight | 9.4% | Decrease | 8.90% |
| Prevalence of 10 – 11 year olds classified as overweight | 15% | Decrease | 14.5% |
| Prevalence of 10 – 11 year olds classified as overweight | 19.40% | Decrease | 18.9% |
| Cumulative % of the eligible population aged 40-74 offered/take up an NHS Health Check | 33.4% / 8% of the eligible population | Become more targeted | Become more targeted |
| Increase the number of people with disabilities with leisure memberships | | | 2% |
| Increase usage of our leisure centres for people from BAME communities | | | 2% |
| Maintain women leisure centre usage | 48% | | 48% |
| Number of older people who take up leisure services – participation over 45 | 18.4% (October 2014) | 20.4% | Top 25% in England |
| Completion of new leisure facilities | | | Two new centres by 2018 |
| Prevention and Wellbeing Programme training (local mental every contact count) | | TBC | TBC |

# 7. Care when needed

## Highlights

Barnet has improved **access to care and support** by:

- Launching a new universal deferred payments scheme
- Providing prevention services, promoting wellbeing and focusing on delaying or preventing the need for social care services
- Improving information and advice services, enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how to fund it
- Implementing a service to support self-funders to arrange and manage their community care; users pay a fee to cover costs
- Promoting Information and Advice providers including Social Care Direct
- Changes to support services for carers as well as establishing an assessment for carers own needs and implementing changes of eligibility for carers.

**Carers** can access mainstream and prevention services to promote their health and wellbeing for example; they can receive health checks for themselves and obtain information and advice about benefits. There are specialist support services for carers delivered through a lead provider, who work with voluntary and community sector partners, to provide short breaks so carers can have time off from caring; peer and group support; training in manual handling and help with emergency planning. Following a carers assessment and development of a personalised Support Plan, the council offers further support options including obtaining a direct payment to meet their identified and eligible needs and outcomes; and respite given to the person they look after.

With support from the council, a Parent Carer Forum has been established in Barnet with a membership of over 100 parent carers. The forum will be a resource for consultation, vital at a time of service development alongside the wider Carer's Forum.

**Integrated care and encouraging self-care** were identified as priority areas by the Health and Wellbeing Board in November 2014 and since then a key focus of the board has been to deliver the Better Care Fund objective of better care for people with complex health care needs. The council, BCCG, voluntary and community sector as well as providers are working together to create an environment which allows people to remain in their own homes for longer.

In line with our prevention aims and to reduce the pressure on accident and emergency departments, we have been developing community models of care. The borough has established a Healthy Living Pharmacy (HLP) model with 21

pharmacies (of the 78 in Barnet) already signed up to providing a health and wellbeing support service to patients.

Our commitment to support people to live **meaningful, fulfilling lives** whatever their ability or disability is also evident in our Winterbourne View Concordat progress. There are active discharge plans in place for many of the remaining patients. Commissioners and care co-ordinators are working closely with existing and new providers to develop solutions which are in the patients' best interests.

Barnet achieved the 67% **dementia diagnosis** national target for 2014/15 with a 67.7% result. The re-configured Memory Assessment Service provided by Barnet, Enfield and Haringey Mental Health Trust became fully operational since July 2014. The service provides a holistic assessment for people with memory problems, and has the capacity to meet the needs of a growing population of older people with dementia. Located with this service, is Barnet's Dementia Advisor service which provides specialist information and advice at the point of diagnosis and a point of contact on an ongoing basis. Four Dementia café's provide opportunities for people with dementia and their carers to gain information and advice and take part in a range of activities.

On leaving hospital the Early **Stroke** Discharge team, which provides specialist stroke rehabilitation care, offer a seamless transfer from hospital to home for stroke survivors. Barnet's post-acute services such as stroke review and specialist information and advice ensure that the recovery potential for people following a stroke is maximised. The stroke review service re-assesses an individual's health, social care and therapy needs at six months post stroke, improving their recovery potential. The review can pick up the need for further prevention services so reducing the likelihood of a second stroke.

## What does Barnet's JSNA tell us?

### Our population

- Barnet has a higher proportion of people aged 85 and over (3.1%) compared to Outer London (1.8%) and the UK (2.3%). This is likely to be driven by the high life expectancy rates
- Currently, Garden Suburb and High Barnet have the largest proportion of people who are over 65, both at 18.1% of the population within the ward. Over this period, Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over, increasing by 5.8% and 5.5% respectively
- The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030, and the rate goes higher in successive age bands; over-65 population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.

### Health and social care

- Despite continued growth in the adult population, the number of people in receipt of residential care and nursing care has decreased from 1,441 in 2011/12 to 1,367 in 2013/14 (a decrease of 5.1%)
- Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes
- Increasing demand on urgent and emergency care with Barnet Accident and Emergency activity recording an increase in 14/15 compared to 2013/14
- Barnet has a higher population of people with dementia than many London boroughs and the highest number of care home places registered for dementia per 100 population aged 65 and over in London
- The incidence of tuberculosis (TB) in Barnet (25.9 per 100,000, three year average) is lower than the London regional rate (39.6 per 100,000) but higher than the rate in England (14.8 per 100,000). Barnet has a higher number of drug resistant TB cases than the average number of these cases in London.

### Carers

- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746)
- In relation to the total population, Brunswick Park and Underhill have the highest rate of carers (10.5% of the population), whereas Colindale has the lowest (6.90% of the population)
- Young carers are at particular risk of remaining hidden from services, in Barnet we have identified 2% of under 18s to be carers but there is a large gap in identification of 16 – 17 year olds with a caring responsibility
- On average carers are more likely to report having poor health (5.2%) than non-carers (4.2%), especially among carers who deliver in excess of 50 hours of care per week. One in 5 young carers describe their health as being only fairly good or even poor
- Young carers are also 1.5 times more likely to have a disability, long term condition and special educational needs than non-young carers
- Young carers are twice as likely not to speak English as their first language.

## What we plan to do

### Carers

Carers are being recognised nationally for their contribution. Carers are being prioritised in this strategy due to their crucial role and **their own health and wellbeing** needs. This will increase as more people choose and are supported to

remain at home for longer. According to Carers UK, there are 6.4 million carers in the UK reducing the national care bill by an estimated £119bn per year, equivalent to £18,594 per carer. Each caring situation is unique and every carer has different needs and priorities. It is important to identify carers, and where needed, support them to carry out their caring role whilst protecting their own health and wellbeing.

A caring role can develop and change gradually overtime or an individual (parent, partner and sibling) may not regard what they do as caring which means that identifying carers is difficult. Awareness needs to be raised with residents to understand what caring is and that it is ok to ask for help. To increase the **identification of unknown carers** we will:

- Develop campaigns for the following:
    - Areas with a high population of older people such as Garden Suburb
    - Work with schools and colleges to develop effective outreach to identify carers who are aged 16 -17
    - People from BAME communities to ensure literature and information is accessible
    - With pharmacies, when a carer collects a prescription for their cared for to interact
- Work with businesses, through Entrepreneurial Barnet, to ensure that businesses understand their responsibility, as employers and in interactions with residents, to identity and provide carers with the flexibility they require to work and care
- Ensure services working with adults identify children and young people (and where they have caring responsibility) at an early stage and make referrals as necessary such as drug and alcohol services and enablement services as well as voluntary and community sector providers.

To support carers to have a life of their own and **positive health and wellbeing** we will embed the needs of carers across the priorities of the JHWB Strategy as well as:

- Providing specific training for young carers in the areas of learning disability, physical disability and mental health (including dementia) so they are better equipped in their caring role
- Developing the respite offer for carers, through our local volunteering service and through the council's contracted lead provider
- Ensuring that services are developed with carers and their cared for in mind particularly prevention provision and services for people with long term conditions such as dementia and stroke
- Actively involving carers in at all stages of strategic and service commissioning. The council and BCCG are committed to making sure that the voice of carers shapes the services available to them, and monitor the effectiveness and standards of what is available.

**Dementia**

Our aim has been to focus on early and timely diagnosis, improving information and supporting people with dementia and their carers in the early stages.

Our **Barnet Dementia Manifesto** sets out what we aim to do next, for example, increase public and professional awareness and understanding of dementia. Recognising particular housing needs, the council will increase the supported housing options for people with dementia and their carers, accommodation will be linked to health and care support and other community facilities by 2025.

**Health and social care integration**

The Health and Wellbeing Board has a clear vision for the integration of health and social care for frail elderly people and people with long-term conditions in Barnet and has set up an ongoing programme of work to deliver it which includes:

- Encouraging residents to be involved in and take responsibility for their health and wellbeing in order to support independence. Programmes which develop social capital are achieving great outcomes such as the Altogether Better neighbourhood development programmes and voluntary and community sector initiatives
- Building teams across primary and community health and social care to support people with complex long term conditions
    - Barnet Integrated Locality Team – to improve the coordination and quality of care
    - Develop the Health Living Pharmacy model to support patients experiencing social isolation and to improve the public health service offer (smoking cessation, sexual health services) across the borough
    - Produce a local dementia manifesto
    - Looking at where integration of commissioning can be explored with neighbouring boroughs.
- Encouraging friends and families to refer to social care services, earlier as currently a large majority of referrals to social care are from either primary or secondary care settings
- Embedding prevention through system transformation including changing the patient-professional conversation which our Heath Champion pilot in 2016 aims to achieve with roll out from 2017
- Taking a whole life perspective to health and wellbeing including end of life care.

The council and BCCG are also committed to working with voluntary and community sector groups, such as Barnet Senior Assembly, to improve the quality of and access to information and advice for older people.

In terms of the Winterbourne View Concordat (Assuring Transformation), there have been no new in or out of borough hospital admissions since September 2014. The BCCG's Continuing Health Care team continues to work closely with the Integrated Community Learning Disabilities service to identify and plan appropriate support for those at risk of admission. A whole system approach is required to achieve better outcomes for our residents. When someone needs care and support, they need services that are joined up around individual needs, including those of carers. Personal Budgets and Personal Health Budgets are central to this approach.

Gearing Up is a partnership programme led by Barnet Mencap alongside Barnet BCCG (Continuing Healthcare Staff), the council and parent carers piloting Personal Health Budgets for people with learning disabilities. **Personal Health Budgets** aim to develop innovative, personalised accommodation, care and wellbeing solutions for individuals and presents a huge opportunity for the health and social care market to diversify and personalise their service offer to creatively meet the needs of residents. There are also opportunities to explore this with neighbouring boroughs.

**Primary care**

The success of the Health and Social Care Integration model relies on significant changes in primary care delivery. Improving access, quality and outcomes in primary care will reduce hospital admissions. Improving primary care is a key strategic goal of BCCG and across North Central London to:

- Jointly co-commission primary care with NHS England
- Coordinate care around the needs of the patient
- Building on existing Primary Care Networks, support the continued development of Networks, across the borough, to deliver a wider range of enhanced services, delivered at scale, within a primary or community setting, that allows for improved access to seven days a week
- Promote health and wellbeing (improve uptake of Health Checks for people aged 40 – 74)
- Recruit and retain the best staff
- Provide high quality and safe premise and practice.

Primary care services are keen to work with partners to improve service quality such as voluntary and community organisations highlighting the experiences of residents such as Barnet Mencap detailing the experiences of people with learning disabilities and autism.

**Tuberculosis** (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. In January 2015, Public Health England and Department of Health released the Collaborative TB Strategy for England, 2015-2020. In July 2015, the Health and Wellbeing discussed a new approach to control TB in the borough which includes developing a Latent TB Infection screening

programme for new registrants targeted a people aged 16 – 34 and from countries of high prevalence. This will require a local programme network to develop and an application for available funding.

## How will we know we have made a difference?

*Draft targets (not in a table, for consultation purposes)*

| Measure | Baseline – 14/15 | Target – 15/16 | Target – 19/20 |
|---|---|---|---|
| Increase identification of unknown carers | Adult Social Care (ASC) assessed 1626<br><br>Registered with the Carers Centre – 5950 | Increase by 10% (TBC) | Increase |
| Carer assessments resulting in information, advice and services being provided | 1160 carers received direct support following ASC assessment (ASCOF) | Increase | Top 25% of comparable boroughs |
| Social Isolation: % of adult carers who have as much social contact as they would like | 35.8% (2012/13) | Increase | Increase |
| Proportion of carers satisfied with social services | Note: bi-annual survey | 35.7% | Top 25% of comparable boroughs. |
| Dementia diagnosis rate | 67.7% | Increase | 75% (2017) |
| Proportion of people who feel in control of their own lives | 73.3% | Top 25% of comparable boroughs | Top 25% in England |
| Successful implementation of Personal Health Budgets | 0 (new programme) | 9 | Increase (Roll out TBC) |
| Latent TB screening programme | 0 (new programme) | Target TBC | |
| Permanent admissions to residential and nursing care homes, per 100,000 population age 18 - 64 | 13.5 | 13.5 | Upper quartile |
| Proportion of older people still at home 91 days after discharge (reablement). | 73.8% | 81.5% | Top 10% in the country |
| Reducing the proportion of people reporting very poor experience of primary care, this is the responsibility of NHS England. Locally, building on the work of Healthwatch Barnet, we need to be encouraging service user feedback and improve the collection of patient experience information. | | | |

# 8. Target setting, monitoring and governance

The targets chosen in this strategy are considered most relevant to the strategic priorities. Most of the data which will be used to monitor achievement against targets is already being collected and monitored by one of more of the agencies on the Health and Wellbeing Board, which avoids duplication.

The targets will be regularly monitored and reported to the Health and Wellbeing Board to assess progress.

While this is a four year strategy, the targets will be reviewed annually, taking on board the latest intelligence and recommendations. The results will be published so that the public are easily able to track our progress in achieving our priorities set out in our Joint Health and Wellbeing Strategy.

# Appendix 1 Barnet's Health and Wellbeing Board

The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where key leaders from the health and care system work together to improve the health and wellbeing of local communities.

The Health and Wellbeing Board plays a key role in the local commissioning of health care, social care and public health through development and implementation of Barnet's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy.

The membership of the HWBB (November 2015)

**Chairman**: Councillor Helena Hart

**Vice-Chairman**: Dr Debbie Frost (Barnet Clinical Commissioning Group Chair)

**London Borough of Barnet**

Two Councillors –

- Chairman of Adults Safeguarding Committee
- Chairman of Children, Education, Libraries and Safeguarding Committee

Director of Adults Social Services

Director of Children's Services

Director of Public Health

**Barnet Clinical Commissioning group (BCCG)**

Two BCCG Board Members

Chief Operating Officer

**NHS England**

One representative

**Observer member**
(Speaking, non-voting rights)

Independent Chair of the Safeguarding Adults and Children Boards

**Healthwatch Barnet**

Head of Healthwatch Barnet

Barnet's Health and Wellbeing Board has been functioning in shadow form since 2012 and functioning a statutory body in April 2013 and has achieved the following:

- Agreed the final plans for Barnet's Better Care Fund
- Supported Barnet CCG's proposal to joint co-commission (with NHS England) primary care alongside the North Central London CCGs
- Approved Public Health 5-year Commissioning Plan

- Agreed for Public Health to commission the Fit and Active Partnership Board to be set up
- Supported the commissioning of a Tier 2 adult weight management service
- Reviewed our progress against the Disability Charter
- Identified the need for a local Dementia Manifesto
- Received Healthwatch Barnet reports highlighting issues on:
    - meals in hospitals
    - the hospital discharge process
    - improving awareness of local services.
- Took responsibility for health and wellbeing issues in the Children and Young People Plan.

Barnet's Health and Wellbeing Board has three subgroups: Early Years Subgroup, Finance Group and the Health and Social Care Integration Board.

The Health and Wellbeing Board works closely with Barnet's five Partnership Boards (Older People's Partnership Board; Mental Health Partnership Board; Learning Disabilities Partnership Board; Carers Strategy Partnership Board; Physical and Sensory Impairments Partnership Board). Members of the Health and Wellbeing Board and the Partnership Boards are bought together at twice yearly summits which are a forum for collaborative working.

To access more information about the Board including the Board's work programme, agenda and papers visit:
https://barnet.moderngov.co.uk/ieListMeetings.aspx?CId=177&Year=0

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AGENDA ITEM 11

# Health Overview and Scrutiny Committee

## 13 October 2015

| | |
|---|---|
| **Title** | **GP Provision in Barnet** |
| **Report of** | Governance Service |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | *No* |
| **Enclosures** | Appendix A – Update Report from NHS England and Barnet Clinical Commissioning Group |
| **Officer Contact Details** | Anita O'Malley – Governance Team Leader<br>anita.vukomanovic@barnet.gov.uk 0208 359 7034 |

## Summary

At their meeting on 6 July 2015, the Committee received a Member's Item in the name of Councillor Barry Rawlings. The Committee resolved to request a report providing information and forecasting on GP provision within the Borough.

The Committee have requested that the report includes figures on the number of GPs expected to retire, regeneration programmes and the management of future seven day GP services.

The Committee have requested that NHS England who have responsibility for this provision be provide the report and have asked that NHS England liaise with the Barnet Clinical Commissioning Group in order to prepare the report. The report attached at Appendix A is the submission from NHS England.

Representatives from both NHS England and Barnet Clinical Commissioning Group have been invited to attend the meeting.

# Recommendations

1. **That the Committee note the update from NHS England and ask appropriate questions.**

## 1. WHY THIS REPORT IS NEEDED

1.1 At their meeting 6 July 2015, the Health Overview and Scrutiny Committee received a Member's Item in the name of Councillor Barry Rawlings on GP Provision in Barnet.

1.2 Following consideration of the item, the Committee resolved to request a report providing information and forecasting on GP provision within the Borough at their October meeting. The report attached at Appendix A is the response from NHS England to this request.

## 2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on the site issues which have previously affected GPs moving into the premises, and be kept abreast of the future plans for healthcare at Finchley Memorial Hospital.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

## 4. POST DECISION IMPLEMENTATION

4.1 Following consideration of this item, the Committee will be able to determine any further actions that they wish to pursue.

## 5. IMPLICATIONS OF DECISION

### 5.1 Corporate Priorities and Performance

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 There are no financial implications for the council.

5.3 **Social Value**

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

5.4 **Legal and Constitutional References**

5.71 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

5.7.11 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

*"To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas."*

5.5 **Risk Management**

5.5.1 Not receiving this report would present a risk to the Committee in that they would not be kept up to date on issues surrounding GP provision in the London Borough of Barnet.

5.6 **Equalities and Diversity**

5.9.1 Equality and Diversity issues are a mandatory consideration in decision making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must fulfil its equality duty when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

5.9.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

*Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

*Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

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5.7 **Consultation and Engagement**

5.7.1 None in the context of this report.

5.8 **Insight**

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

## 6. BACKGROUND PAPERS

6.1 None.

# General Practice Clinical Capacity in Barnet

Jill Webb
Head of Primary Care

23rd September 2015

# The Brief

- Review of GP service provision available within Barnet specifically in relation to access and clinical capacity
- Future plans to ensure sufficient GPs to provide comprehensive coverage within the growing population
- GP provision for the predicted increase in the elderly population
- Plans to provide adequate services in areas of regeneration

# Content

1. National context - Funding in primary care (2015/16) to improve capacity and access
2. GP Contracts and Workforce in Barnet
3. Current clinical capacity and provisions of access across Barnet
4. Patient views on access
5. Future prediction for clinical capacity (population growth and elderly population)
6. Future plans, what are the priorities to address capacity and access
7. Summary / Conclusion

## National Context – Funding in primary care (2015/16) to improve capacity and access

- Primary Care budgets have increased by 4.1% compared to CCGs at 3.4%
- £1 billion - Primary Care Infrastructure Fund is a new four-year investment programme in workforce, technology and infrastructure
- £125 million - PM Challenge Fund – improving access to general practice wave two schemes will further improve access to and build on £50m wave one funding 2014/15. It includes £6m programme to support digital transformation
- £250 million budget for primary care IT – improving access to online booking, click and collect service for repeat prescriptions and full medical records
- £10 million for measures to tackle recruitment and retention – the GP Workforce 10-Point Plan
- £10 million programme of support for struggling practices to be developed between NHS England and NHS Clinical Commissioners.

# GP Contracts and Workforce in Barnet

| CCG Name | APMS | GMS | PMS | Grand total | Estimate Population size ONS 2014 | Proportion of Single Hander contracts |
|---|---|---|---|---|---|---|
| NHS Barnet CCG | 1 | 36 | 26 | 63 | 367,265 | 30% |
| NHS Camden CCG | 3 | 17 | 16 | 36 | 225,140 | 22% |
| NHS Enfield CCG | 1 | 21 | 27 | 49 | 320,524 | 33% |
| NHS Haringey CCG | 1 | 21 | 25 | 47 | 265,900 | 32% |
| NHS Islington CCG | 1 | 31 | 2 | 34 | 206,100 | 21% |

The above table provides an overview of the range of Primary Care Contracts that are commissioned across North Central London and the proportion of single hander practices. **There are 284 GP Performers across Barnet of which 3 % (8) are locums and 17% (48) are more than 60 years.**

Barnet has a similar proportion of single hander contracts compared to Enfield and Haringey. **NHS England has seen a change in the number of small practices that wish to merge. In 2015, there have been 3 mergers with 1 pending in Barnet. This has not impacted on GP clinical capacity.**

# Clinical Capacity across Barnet
# Comparison of GPs per 1000 patients in London and Nationally

| Ranking GP-patient ratio | NHS England Region | CCG | Average Number of Registered Patients | GPs (exc. Registrars and Retainers) per 1,000 Patients - FTE |
|---|---|---|---|---|
| **Average across London and England** | NHS England London | NHS Barnet | 5771 | 0.56 |
| **Highest in London** | NHS England London | NHS Islington | 6047 | 0.69 |
| **Highest in England** | NHS England North (Cumbria and North East) | NHS Northumberland | 7151 | 0.77 |
| **Lowest in London and England** | NHS England London | NHS Bexley | 8531 | 0.40 |

The average GP FTE per 1000 patients Nationally and across London is 0.57 and 0.55, therefore Barnet falls within the average.

**This indicates that Barnet meets the national average for FTE GPs employed per 1000 patients.**

*Office of National Statistics (ONS) September 2014*

# Clinical Capacity across Barnet
# Comparison of GPs & Nurses WTE per 1000 patients in London and North Central London

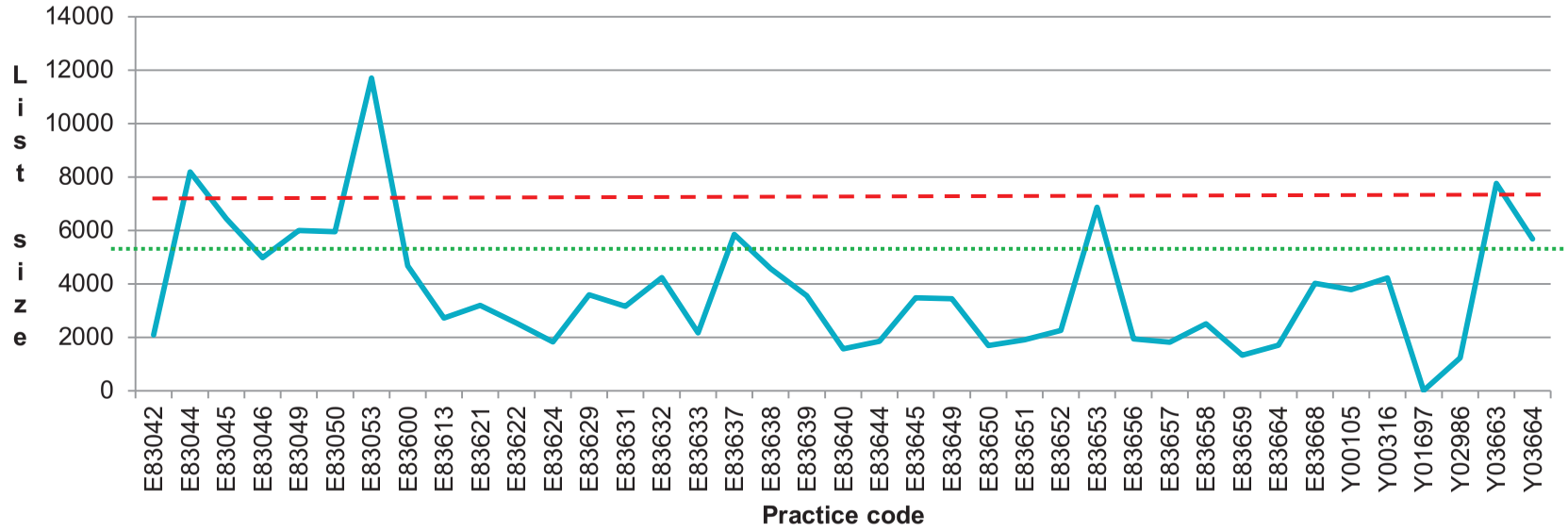
| Ranking GP-patient ratio | NHS England Region | CCG | Average Number of Registered Patients | GPs (exc. Registrars and Retainers) per 1,000 Patients - FTE | Nurses per 1000 patients | GPs/Nurse combined per 1,000 patients |
|---|---|---|---|---|---|---|
| **Average across London** | NHS England London | NHS Barnet | 5771 | 0.56 | 0.16 | 0.72 |
| **Lowest in London** | NHS England London | NHS Redbridge | 6385 | 0.45 | 0.14 | 0.59 |
| **Highest in London** | NHS England London | NHS Tower Hamlets | 7989 | 0.68 | 0.27 | 0.96 |
| **Lowest in North Central London** | NHS England London | NHS Enfield | 6458 | 0.55 | 0.16 | 0.71 |
| **Highest in North Central London** | NHS England London | NHS Islington | 6047 | 0.69 | 0.20 | 0.89 |

The average GP & Nurse FTE per 1000 patients combined across London is 0.75. Barnet is just above the average across London, the Borough is 19th out of 32 CCG areas in London.

**This indicates that Barnet provides sufficient clinical capacity for GP and Nurse FTE per 1000 patients**

*Office of National Statistics (ONS) September 2014*

## Provision of access
## Comparison between practice list sizes in Barnet and the National average list size (1)

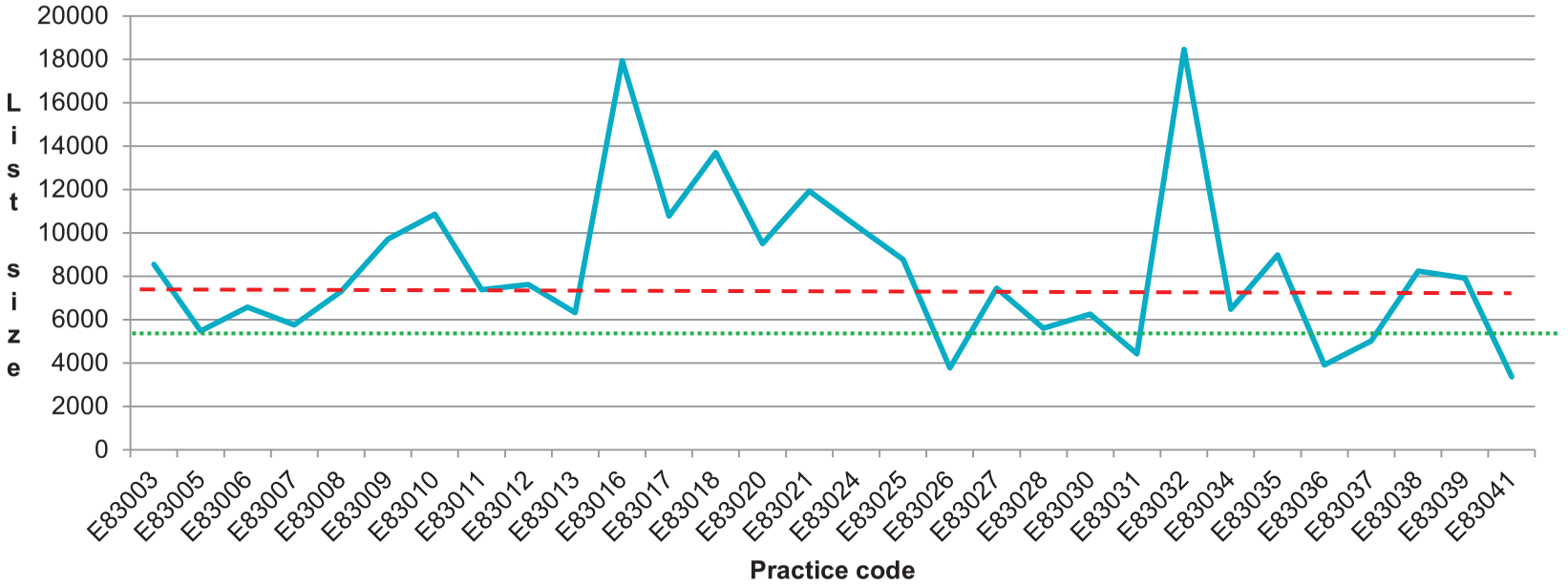



80% of the practices in Barnet are below the National average list sizes (7,518) and 60% are below the Barnet CCG average (5,721). Barnet also has the highest number of practices across North Central London.

This indicates that **Barnet has a high number of small practices but is within the London average for GP FTE. Therefore, on average, patients should have reasonable access to clinical services.**

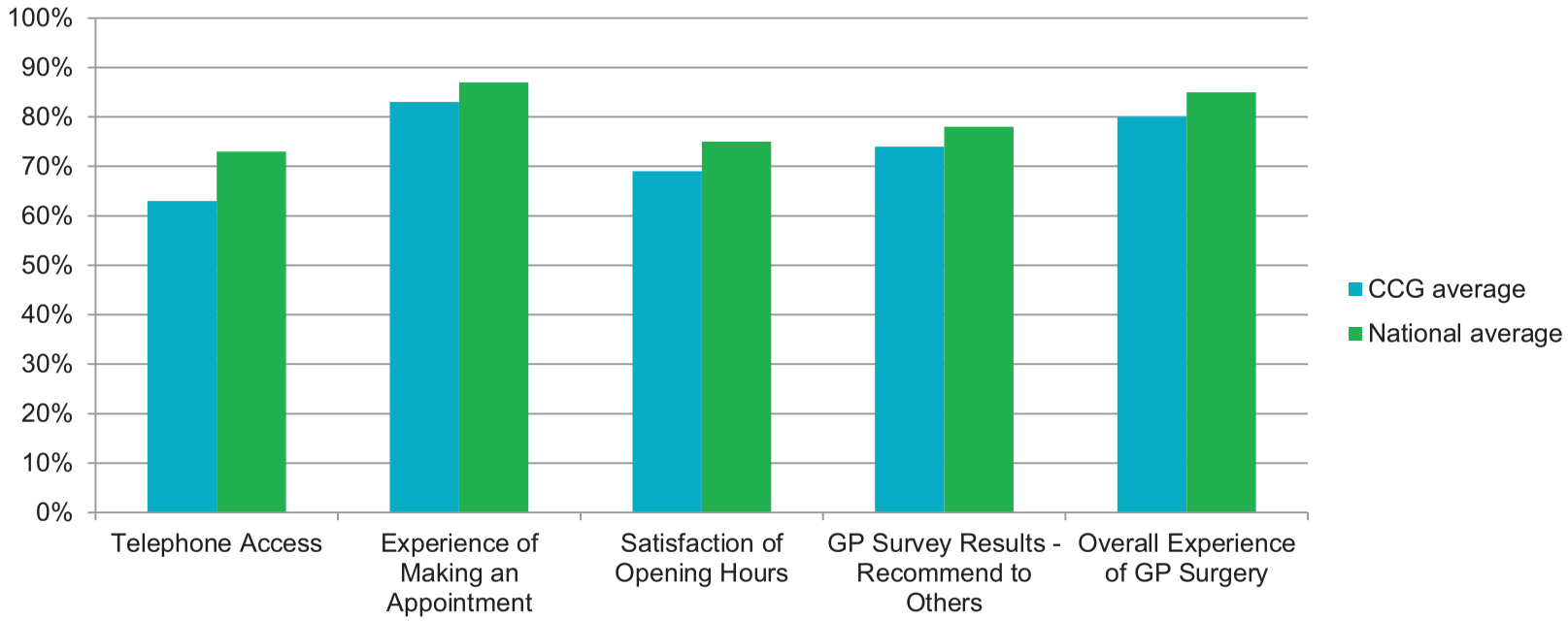
**Barnet average raw list size October 2014**
**National raw list size ,Office of National Statistics September 2014 GP Census**

# Provision of access across Barnet
# Comparison between practice list sizes in Barnet and the National average list size (2)




*Barnet average raw list size October 2014*
*National raw list size ,Office of National Statistics September 2014 GP Census*

## Patient views on access




When we compare patients views of access (Core and Extended Hours provision) across Barnet against the National average, it shows that **patients are most satisfied with their experience of making an appointment** with a only a 4% difference between the Barnet (83%) and National average (87%).

**Patients are least satisfied with telephone access and opening hours.**

***GP Patient Survey 2014***

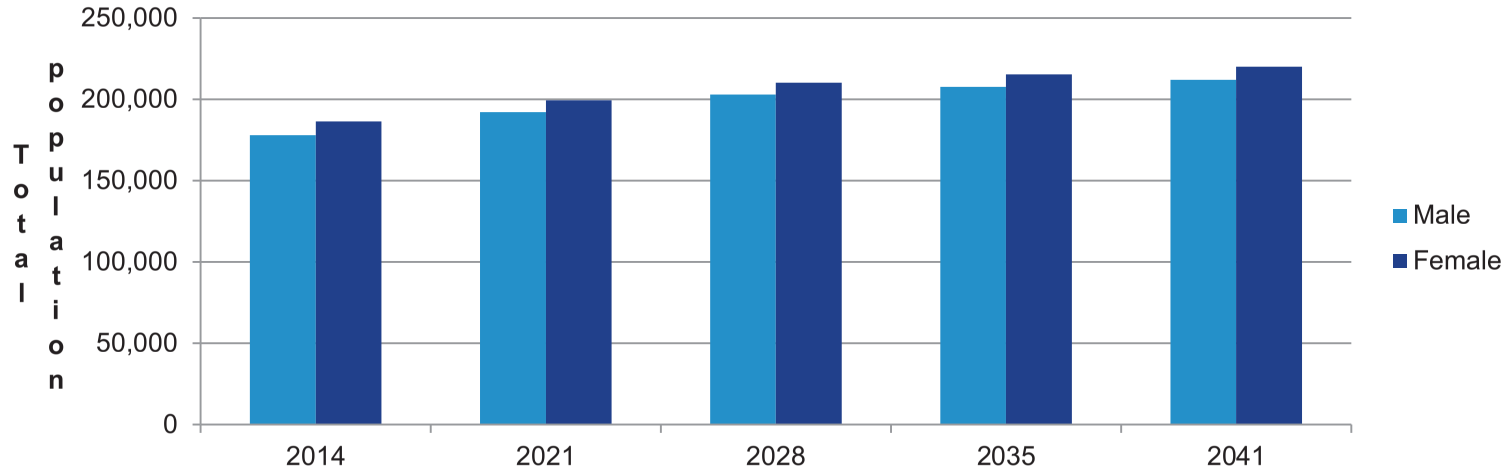
## Patient views of access

| % of Core hours provided | No. of practices | % of practices |
|---|---|---|
| Practice 's providing 100% | 8 | 13% |
| Practice's providing 80-99% | 30 | 48% |
| Practice's providing 60-79% | 21 | 33% |
| Practices providing less than 60% | 4 | 6.3 |

- Patient views may be reflective of the opening hours of practice's
- Only 13% (8) of practices across Barnet are open 100% of Core Hours (8am to 6.30pm)
- 48% (30) are open between 80-100% of core hours
- 8 / 30 practice's are delivering 80% (+/- 2%) of core hours per week. They are closed for 10.5 hours per week (equates to 2 hours closure per day)
- 4 practice's are delivering less than 60% of core hours. They are closed for more than 21 hours per week (equates to 4 hours closure per day)

**NHS England and the CCG are currently considering how the arrangements for 8am -8pm and weekend opening hours will work. We are also working with the Care Quality Commission (CQC) to address the variation in quality and performance.**

## Future prediction for Clinical Capacity – population growth



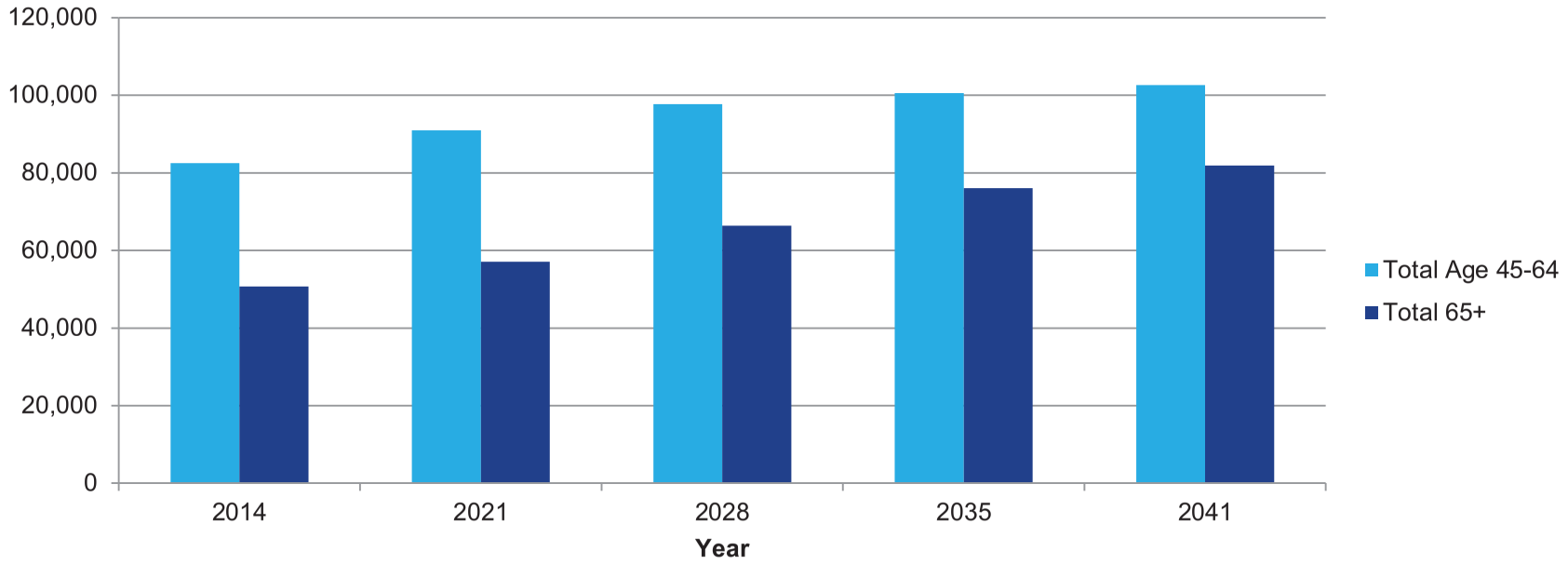

The largest increase in the population is between 2014 – 2021 with 6.89% increase in the total population ( 26,991 residents). Post 2021 there is a predicted decline in the population at a rate of about 2% over the 20 years.

Based on Barnet's current GP capacity of 0.56 FTE, which is line with the London and National average, **this equates to an additional 15 GP FTE over the next 7 years**.

Barnet's existing GP and Nurse combined is 0.72 FTE which is above the London average, the increase in population over the next 7 years will **equate to an additional 19 GP and Nurse FTE over the next 7 years.**

*Office of National Statistics September 2014*

## Will the additional GP and Nurse capacity meet the growth in the elderly population?



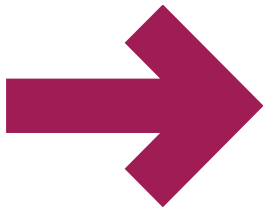

- The rate of growth for the elderly population over the next 7 years (2014-2021) is above the rate of the total population growth (6.89%).
- For ages 45-64, the rate of growth is 9.24% (8,412 residents) and over 65 is 11.24% (7,000 residents) which are both above the total population rate of growth
- The change in the population demographics is reflected in practices budgets

*Office of National Statistics September 2014*

## Will the additional GP and Nurse capacity meet the growth in the elderly population?

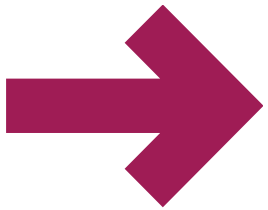
- The Weighted Carr–Hill formula is used to compensate GP practices for any additional workload associated with different factors. GP budgets are adjustment to include the:
  - Age and sex
  - Additional needs of the population, relating to morbidity and mortality
  - List turnover
  - Nursing and residential homes index
  - Market forces factor and rurality index

- **The increase of 7,000 patients for the age groups 45-64 and 65+ across Barnet within the next 7 years will be adjusted in practice budgets using the Carr-Hill formula which will allow practices to review resources to meet demand.**



## Ways that commissioners can maximise capacity and access to GP services for registered patients

- **FTE GP and Nurse** - Bench mark British Medical Association 1 GP FTE : 1800 patients. Comparing Barnet's existing 0.56WTE per 1000 patients indicates that Barnet existing capacity is in line with the BMA recommendation
- **Access** – Ensuring Core hours provision (8am – 6.30pm) and Extended hours provision through contract management
- **Health Care Assistants/skill mix** – Barnet currently has 40 HCA employed across 63 practices, which provides additional clinical capacity
- **Open list** – No practice in Barnet currently has a closed list
- **Number of appointments available** – 72 GP and 33 Nursing appointments per 1000 population per week in PMS practices
- **PMS Contracts and access** – 26 / 36 practices are PMS across Barnet .Existing KPIs deliver a range of access indicators
  - open at least 52.5 hours per week (core hours 8am – 6.30pm)
  - practice offers 15 minute appointments for routine booked appointments



## Future Plans, what are the priorities to address capacity and access Development Area – Grahame Park

Planned population change near Grahame Park Estate

- Existing health centre at Grahame Park due for demolition in 2017/18 when the 'Plot 11' area of Grahame Park Concourse is redeveloped
- Site currently houses Everglade Practice and Park View MC (branch).
- New facility planned with two suitable sites in the vicinity identified.
- The new health centre will appear as a single practice, and will have space for patient growth to meet the housing growth in the vicinity.
- Although unlikely, there may be a need to provide a temporary facility if the new centre is incomplete by the time existing centre is demolished.
- New centre planned opening 2018-2020 (subject to land availability).

## Future Plans, what are the priorities to address capacity and access Development Area – Central Colindale

- Population change near Colindale Station / Aerodrome Road:
  - To respond to the population growth in the Aerodrome Road/Colindale Avenue area, a new health centre and GP service is being planned to over time serve 15,000 patients
  - Health centre (approx. 1,000 sqm) being negotiated with Redrow, developer of Peel Centre. Site adjacent to Colindale tube station will be available from approximately 2022
  - A temporary health centre is being discussed with St George (landlord) to be located at Beaufort Park, to house services until the new Peel Centre site becomes available.
  - Aim is to have temporary site in place by early 2017

## Future Plans, what are the priorities to address capacity and access Development Area – Brent Cross

- Significant regeneration area, developing a new town centre and up to 27,000 new jobs and 7,500 new homes by 2020
- 3 new schools and new parks and community facilities, indicating an anticipation of an influx of young families with children to the area.
- Significant developments in the immediate and surrounding area of Brent Cross and Colindale will put additional pressure on the capacity of the surrounding GP practices as more people move into the area.
- **Part of the re-development of the Brent Cross locality should incorporate a new health facility**
- There is also capacity for further growth in the Cricklewood HC in the south of the borough

## Future Plans, what are the priorities to address capacity and access

- **Primary Medical Services Contract Review 2015/16** – "Premium Services" and renegotiated Key Performance Indicators (KPIs) aim to deliver improvements in clinical services, access and clinical capacity through increased appointments to meet patient need and access

- **Primary Care Infrastructure fund (PCIF)** – Nationally, 721 practices PCIF applications have been approved in principle (spring 2015). The applications range from facility expansions / improvements which will provide short term capacity within the wider GP network of practices

- **Performance** – NHS England, Barnet CCG & the CQC continue to identify and address variations in performance

- **Access** – NHS England & Barnet CCG are currently considering how the arrangements for 8am – 8pm and weekend opening hours will work

- **Primary Care Co- Commissioning** – From 1st October, NHS England and North Central London CCGs are 'co-commissioning' GP services

## Summary of Findings

- Existing FTE GP and Nurse per 1000 patients is sufficient to meet the existing population
- Based on the predicted population growth of 26,991 residents over the next 7 years in Barnet it is estimated that Barnet will need an additional 15 GP FTE and 19 GP and Nurse FTE combined
- Carr-Hill weighted formula will provide an age adjustment to practice budgets which will meet the growth in the elderly population of 7,000 residents over the next 7 years. There are also a significant number of factors that can be deployed by commissioners to maximise access and clinical capacity to GP services
- NHS England has commenced work with the London Borough of Barnet and the CCG to address the housing developments specifically in the Grahame Park Area of Barnet where a new health centre is planned. A new GP practice is also planned for the Peel Centre site
- The CCG is also working jointly with NHS England to review the provision of services for Elderly patients delivered from Finchley Memorial Hospital
- Nationally there are several initiatives to improve access
- NHS England are also implementing key priorities to address the variation in quality and access

# Questions

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AGENDA ITEM 12

# Health Overview and Scrutiny Committee

## 13 October 2015

| | |
|---|---|
| **Title** | **Dentistry in Barnet** |
| **Report of** | Governance Service |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | *No* |
| **Enclosures** | Appendix A –Dentistry Report from NHS England<br>Appendix B – Report from Healthwatch Barnet<br>Appendix C – Dentistry in Barnet – A Dental Investigation in Barnet in 2014/15 |
| **Officer Contact Details** | Anita O'Malley – Governance Team Leader<br>anita.vukomanovic@barnet.gov.uk 0208 359 7034 |

**Summary**

At their meeting on 6 July 2015, the Committee received a Member's Item in the name of Councillor Mittra. The Committee resolved to request a report providing information on Dentistry in Barnet.

After considering the Member's Item, the Committee resolved to receive a report from NHS England at their October meeting which addresses the issue of dentistry in Barnet as well as the recommendations made in the recent Healthwatch Barnet report as referred to in the Member's Item.

The Committee also requested that the future report to Committee also contains an appendix from Healthwatch Barnet which sets out what actions Healthwatch have taken since their report.

Representatives from both NHS England Healthwatch Barnet have been invited to attend the meeting.

| Recommendations |
| --- |
| **1. That the Committee note the update from NHS England and ask appropriate questions.** |

## 1. WHY THIS REPORT IS NEEDED

1.1 At their meeting 6 July 2015, the Health Overview and Scrutiny Committee received a Member's Item in the name of Councillor Mittra on Dentistry in Barnet.

1.2 Following consideration of the item, the Committee resolved to request a report providing information on the issue of dentistry in Barnet as well as the recommendations made in the recent Healthwatch Barnet report. The report attached at Appendix A is the response from NHS England to this request. The report at Appendix B is the response from Healthwatch Barnet, and the erport at Appendix C is the original report which outlines the investigation in dentistry in Barnet which was undertaken by Healthwatch Barnet.

## 2. REASONS FOR RECOMMENDATIONS

2.1 By receiving this update, the Committee will be kept up to date on issues surrounding the provision of Dentistry in Barnet.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

## 4. POST DECISION IMPLEMENTATION

4.1 Following consideration of this item, the Committee will be able to determine any further actions that they wish to pursue.

## 5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 None in the context of this report.

5.3 **Social Value**

The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits.

5.4 **Legal and Constitutional References**

5.71 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

5.7.11 The Council's Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities:

*"To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas."*

5.5 **Risk Management**

5.5.1 Not receiving this report would present a risk to the Committee in that they would not be kept up to date on issues surrounding dental provision in the London Borough of Barnet.

5.6 **Equalities and Diversity**

5.9.1 Equality and Diversity issues are a mandatory consideration in decision making in the Council pursuant to the Equality Act 2010. This means the Council and all other organisations acting on its behalf must fulfil its equality duty when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

5.9.2 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

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The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

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5.7 **Consultation and Engagement**

5.7.1 None in the context of this report.

5.8 **Insight**

5.8.1 None in the context of this report. Upon considering the report, the Committee will determine if they require further information or future updates.

## 6. BACKGROUND PAPERS

6.1 None.

| | |
|---|---|
| **Report to:** | Barnet Health Overview & Scrutiny Committee |
| **Report from:** | Alice Benton, Regional Lead (London) Dental, Optometry & Pharmacy Commissioning, NHS England |
| **Subject:** | Healthwatch: Barnet – Report of Access to Dental Services 2014/15 |
| **Date:** | 17 September 2015 |

## 1. Background

Following the presentation of a Barnet Healthwatch report by Cllr Arjun Mittra at the Barnet Health Overview & Scrutiny Committee on 6 July 2015 on the subject of dentistry in Barnet, NHS England were requested to provide a corresponding report in September 2015 to address the issues and recommendations outlined in the said report.

## 2. NHS England, London Region response

A report was received by NHS England, London Region in July 2015 from Healthwatch Barnet outlining the findings of a survey undertaken by them between December 2014 and January 2015.

NHS England, London Region provided a comprehensive response to Healthwatch Barnet on 18 August 2015 addressing the issues and recommendations outlined in their report.

## 3. Access / Availability of NHS Dental Services in Barnet

The following points were highlighted to Healthwatch Barnet:

3.1 Currently there are 62 practices providing NHS dental services in Barnet. It was not clear from the Healthwatch report whether *all* of the practices selected for the research were NHS providers or some purely private.

Healthwatch Barnet subsequently clarified that their research was not restricted to practices providing NHS Dentistry. The 50 practices selected in the Borough were from the Care Quality Commission website as opposed to from the NHS Choices website which would have provided the list of all NHS dental providers.

As the findings of the survey were not separated into NHS and private providers, it is not clear what actual percentage of *NHS providers* were complying with their contractual obligations by:

- accepting all patient groups
- providing NHS services
- displaying patient charges information
- providing treatment plans

3.2 The level of dental activity commissioned and delivered in Barnet since 2006 is as follows:

| Year | Units of Dental Activity Commissioned | Units of Dental Activity Delivered | % of Delivery |
|---|---|---|---|
| 2006/07 | 364,463.00 | 353,463.40 | 96.98% |
| 2007/08 | 364,407.75 | 345,967.85 | 94.94% |
| 2008/09 | 380,377.62 | 356,559.15 | 93.74% |
| 2009/10 | 384,080.00 | 381,860.00 | 99.42% |
| 2010/11 | 411,297.00 | 399,547.75 | 97.14% |
| 2011/12 | 405,764.00 | 376,874.00 | 92.88% |
| 2012/13 | 393,772.00 | 386,297.85 | 92.88% |
| 2013/14 | 399,554.00 | 394,248.60 | 98.67% |
| 2014/15 | 398,136.00 | 392,346.25 | 98.54% |
| 2015/15 | 398,136.00 | | |

It can be noted that contracted activity has not remained static as suggested in the report, but there has been an incremental increase since 2006. Any decrease is likely due to in year adjustments either because of rebasing contracts which have persistently underperformed or because there were decreased or no non-recurrent investments.

In years where there were considerable increases it should be noted that this was as a result of non-recurrent dental allocations. It can be seen that in 2010/11 where the level of investment increased substantially, resulted in a high level of under-performance.

The level of investment in dental services has been variable and based on historical priorities in any given borough.

It is important to note that increased investment does not always necessarily correlate to an increase in access, as there are instances where practices may use additional activity to recall the same patients unnecessarily. This is monitored on an ongoing basis by NHS England.

3.3 Up until 2013/14, the commissioning organisations received non-recurrent allocations from the Department of Health in the last quarter of the financial year which was required to be invested and delivered in that quarter. This non-recurrent funding is no longer available, and the only available resource currently is from contracts that are rebased or terminated which would then be reinvested back into services, usually through a procurement process.

3.4 When drawing conclusions from the data relating to access to dental services it should be noted that unlike doctors, people who wish to visit a dentist do not need to register with that dentist and people are free to use any dentist in the country. Additionally, uptake of services can be an issue whereby, people only attend when they need to rather than as a regular preventative measure.

Approximately a third of Barnet residents who access NHS dental services, receive dental treatment from outside the borough of Borough, either in neighbouring boroughs or counties such as Enfield, Hertfordshire, Harrow or other non- neighbouring areas.

Some graphs showing dental service use are included in Appendix 1.

**4. Specific issues arising from the report**:

4.1 Children not being accepted for treatment – this is unusual as most practices are more likely to accept child patients on the NHS with a view to offering private treatment for their parents. In order for NHS England to address this issue with the relevant practices, we would require information from Healthwatch Barnet as to which practices the findings relate to.

As the survey was undertaken by Healthwatch Barnet by way of a mystery shopping exercise, they feel unable to share this information so as not to compromise their relationship with practices.

4.2 Charges information not being provided or displayed – as NHS England is not party to the information on which practices this relates to and given that some practices were private practices, it is difficult to address contractually with individual practices. However, for NHS providers, this is a contractual requirement and NHS England will follow this up with all providers to ensure that they are complying with their contract in this way.

4.3 Provision of treatment plans – as above, NHS England can only follow up as a general point with all NHS dental providers as a contractual requirement whereby patients receiving Band 2 and Band 3 treatments specifically, must receive a treatment plan.

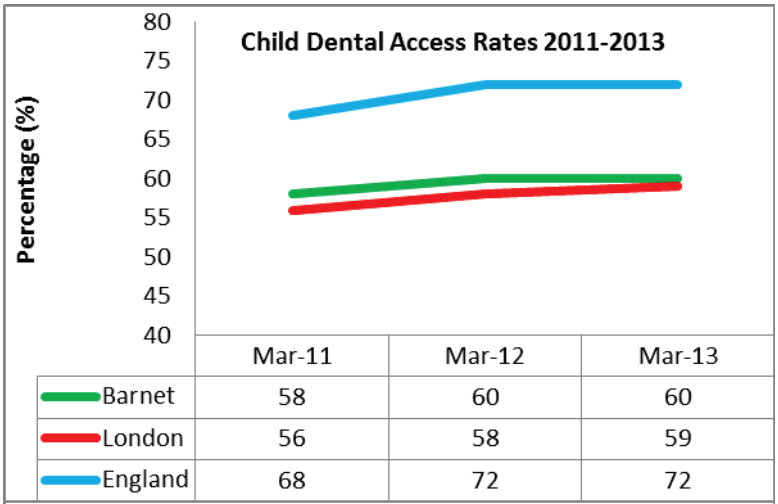
**5. Conclusion**

It was unfortunate that Healthwatch Barnet were unable to obtain input from NHS England in time for the publication of their report due to the lack of appropriate contact being established, however we have agreed to work together on any future projects.

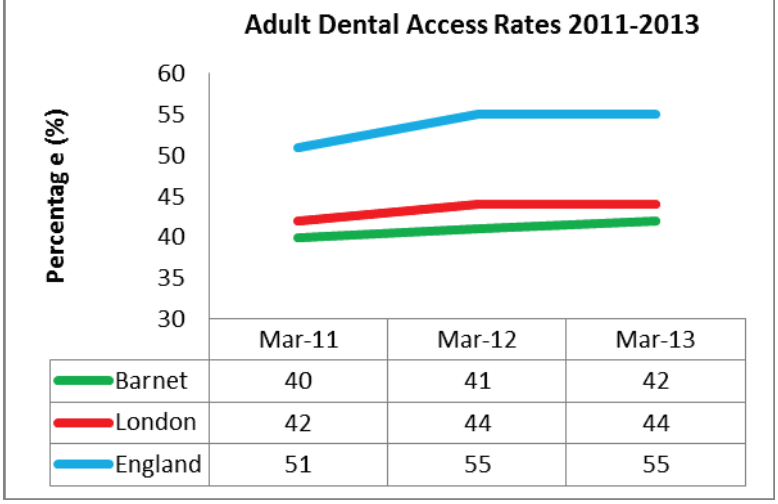
Whilst it was important to obtain the views of the Local Dental Committee, contribution from NHS England would have been beneficial in understanding the commissioning perspective, thereby enabling a balanced view of service provision.

NHS England will be sharing the findings of the report with all Barnet providers with a view to ensuring that the concerns are addressed albeit on a general level.

# Appendix 1 - Dental Service Use




| | Mar-11 | Mar-12 | Mar-13 |
|---|---|---|---|
| Barnet | 58 | 60 | 60 |
| London | 56 | 58 | 59 |
| England | 68 | 72 | 72 |




| | Mar-11 | Mar-12 | Mar-13 |
|---|---|---|---|
| Barnet | 40 | 41 | 42 |
| London | 42 | 44 | 44 |
| England | 51 | 55 | 55 |

- The first figure shows trend data for the 24 months preceding March 2013 for the % of children living in Barnet aged 17 or under who have visited a dentist.
- The second figure shows trend data for the 24 months preceding March 2013 for the % of adults living in Barnet who have visited a dentist.
- In Barnet, **58%** of children aged 0-17 years visited the dentist in March 2011, **60%** in March 2012 and **60%** in March 2013.
- In Barnet, **40%** of adults (over 18 years) visited the dentist in March 2011, **41%** in March 2012 and **42%** in March 2013.
- This has followed the London and England trend with moderate increase or flat line in access between 2011 and 2013.
- Data source Access by patient London LA region Sept 2013, FOI, NHS dental statistics England 2012-2013 http://hscic.gov.uk/catalogue/PUB11625

## Appendix 2 – NHS Dental Providers in Barnet

| Dental Practice Name | Practice Address 1 | Practice Address 2 | Practice Address 3 | Postcode | Telephone Number |
|---|---|---|---|---|---|
| East Barnet Village Practice | 19 Longmore Avenue | East Barnet | London | EN4 8AE | 020 8441 4213 |
| Cat Hill Dental Practice | 108 Cat Hill | East Barnet | London | EN4 8HX | 020 8440 2204 |
| East Barnet Dental Practice | 37-39 East Barnet Road | E. Barnet | London | EN4 8RN | 020 8441 8000 |
| York Road Dental Practice | 7 York Road | New Barnet | London | EN5 1LJ | 020 8449 0235 |
| Mona Lisa Smiles | 83 STATION ROAD | New Barnet | London | EN5 1PX | 020 8449 2798 |
| Barnet Smiles Dental Care | 87 Cedar Lawn Avenue | Barnet | London | EN5 2LP | 020 8441 6201 |
| Barnet Orthodontic Practice | 27 Wood Street | Barnet | London | EN5 4BE | 020 8449 3022 |
| Wood Street Dental Surgery | 28, Wood Street | Barnet | London | EN5 4BW | 020 8449 4378 |
| A Langdon | 177 High Street | Barnet | London | EN5 5SU | 020 8440 9828 |
| Grove Dental Practice | 236 High Street | Barnet | London | EN5 5TD | 020 8449 5931 |
| High Barnet Dental Care | 59 High Street | Barnet | London | EN5 5UR | 020 8275 2980 |
| Finchley Dental Care Practice Partnership | 200 BALLARDS LANE | Barnet | London | N3 2NA | 020 8343 0480 |
| Broadway Dental Surgery | 198 Burnt Oak Broadway | Edgware | London | HA8 0AS | 020 8952 3323 |
| Angle House Orthodontics | Elizabeth House, 54-58 High Street | Edgware | London | HA8 7EJ | 020 8952 4596 |
| Promenade Dental Prac. | 11a The Promenade | Edgware | London | HA8 7JZ | 020 8958 9966 |
| Edgwarebury Surgery | 66 Edgwarebury Lane | Edgware | London | HA8 8LX | 020 8905 4849 |
| Kandlers Practice | 150 Broadfields Avenue | Edgware | London | HA8 8SS | 020 8958 7056 |
| Deansbrook Dental Care | 107 Deansbrook Road | Edgware | London | HA8 9BP | 020 8959 2069 |
| Katz & Madhok Orthodontist | 165 Hale Lane | Edgware | London | HA8 9QN | 020 8906 8660 |
| Friern Barnet Dental Clinic | 21 Queens Parade | Friern Barnet | London | N11 3DA | 020 8368 7676 |
| The Green Dental Practice | 701 High Road | North Finchley | London | N12 0BT | 020 8446 6694 |
| G W Cooper | 80 Southover | Woodside Park | London | N12 7HB | 020 8446 4943 |
| Dental Care Centre | 787a High Road | North Finchley | London | N12 8JT | 0208 445 5954 |
| N12 Dental Care | 753 High Road | Finchley | London | N12 8LG | 020 8492 9710 |
| The Smile Team | 831a High Road | Finchley | London | N12 8PR | 020 8445 2994 |
| London Day Surgery Centre | Gloucester House | 150 Woodside Lane | London | N12 8TP | 020 8445 1199 |
| A. Stellman | 126 Ashurst Road | Finchley | London | N12 9AB | 020 8446 0550 |
| Woodhouse Dental Practice | 229a Woodhouse Road | Friern Barnet | London | N12 9BD | 020 8368 9229 |
| Hampden Square Clinic | 3 Onslow Parade | Southgate | London | N14 5JN | 020 8368 1782 |
| Prais Dental Care | Suite 2, Lyttelton House | 2 Lyttelton Road | London | N2 0EF | 020 8201 8877 |
| Cavendish House Dental Surgery | 240 East End Road | East Finchley | London | N2 8AX | 020 8883 1182 |
| East Finchley Smiles | 144 High Road | East Finchley | London | N2 9ED | 020 8444 3436<br>07737 921129 |
| Aron Marcus & Associates | 19 Oakleigh Road | Whetstone | London | N20 9HE | 020 8445 6353 |
| Toebridge House | 1279 High Road | Whetstone | London | N20 9HS | 020 8446 9878 |
| Church End Dental Clinic | 313 Regents Park Road | Finchley | London | N3 1DP | 020 8346 3826 |
| Nether St Dental Practice | 393 Nether Street | Finchley | London | N3 1QG | 020 8346 5397 |
| The Dental Practice | 113a Ballards Lane | Finchley | London | N3 1XY | 020 8346 0983 |
| Bliss Dental Practice | 3 Temple Fortune Parade | Bridge Lane | London | NW11 0QN | 020 8455 1171 |
| Dental Surgery | 1005A Finchley Road | Golders Green | London | NW11 7HB | 0208 458 1611 |
| G I Gilbert | 710 Finchley Road | Golders Green | London | NW11 7ND | 020 8455 3224 |
| The Clock Tower Dental Practice | 9 North End Road | | London | NW11 7RJ | 020 8455 6800 |
| The Garden<br>Dental Practice | 610 Finchley Road | Golders Green | London | NW11 7RX | 0208 455 3310 |
| Family Dental Practice | 103a Golders Green Road | Golders Green | London | NW11 8EN | 020 8458 2311 |
| Gental Dental Care | 2B Golders Green Road | Golders Green | London | NW11 8LH | 020 8455 9580 |
| A.M. Cohen | 20 Armitage Road | Golders Green | London | NW11 8RA | 020 8455 5705 |
| Golders Green Dental Care | 192 Golders Green Road | Golders Green | London | NW11 9AL | 020 8455 8202 |
| Excel Dental Care | 289 Cricklewood Lane | Barnet | London | NW2 2JL | 020 8458 3330 |
| Bell Lane Dental practice | 19 Bell lane | Hendon | London | NW4 2BP | 020 203 3155 |
| Brace Place | 65A Brent Street | Hendon | London | NW4 2EA | 020 8201 5111 |
| Approach Dentistry | 5 The Approach | Hendon | London | NW4 2HS | 020 8202 9767 |
| Elite Dental Care | 86 Audley Road | Hendon | London | NW4 3HB | 020 8202 7216 |
| Dental Art Studio | 41-43 Vivian Avenue | Hendon | London | NW4 3UX | 020 8202 7038 |
| Hendon Dental Practice | 125 Station Road | Hendon | London | NW4 4NL | 0208 202 9910 |
| Apex Dental Care | 647 Watford Way | Mill Hill | London | NW7 3JR | 020 8959 2299 |
| Broadway Dental Studio | Broadway Dental Surgery | 1 Broadway House, The Broadway | London | NW7 3LJ | 020 8959 2497 |
| Mill Hill Dental Practice | 8 Millway | Mill Hill | London | NW7 3RE | 0208 8959 1208 |
| Balcombe Practice | 51 Goodwyn Avenue | Mill Hill | London | NW7 3RJ | 020 8959 1908 |
| Colindal Dental Pratice | 49 Colindale Avenue | Colindale | London | NW9 5EP | 020 8205 0337 |
| The Gainsborough Centre | The Concourse | Colindale | London | NW9 5UN | 0208 205 0090 |
| Corner House Dental Practice | 2 Colin Park Road | Colindale | London | NW9 6HS | 020 8205 8300 |
| Kamlesh Shah Dental Practice | 3a Sheaveshill Avenue | Colindale | London | NW9 6SH | 020 8205 6690 |
| The Ivory Dental Practice | 158 West Hendon Broadway | West Hendon | London | NW9 7AA | 0208 202 5346 |

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Appendix B

**Report to Health Overview and Scrutiny Committee**
**Healthwatch Barnet Dental Report**

28/09/2015

Since the publication of the Healthwatch Barnet Dental Report we have decided to action the following activity:

- Refresh the current report in February 2016 to provide an update. For this refresh we will use the same methodology but also carry out some mapping of access to NHS and private dentistry services;

- We have commissioned Homestart Barnet to carry out some work looking at access to dentistry for pre-school children which will also include work on experience and attitudes to dentistry services for this important age group.

**Purpose of activity**

**Refreshing the current report**
Following on from data provided to us by NHS England we have decided to refresh the dental report in February 2016. In this refresh we will cover the following:

- A mapping of NHS providers in the Borough – taking into account especially the availability of dental services to areas of recognised need;

- A data review to ascertain the % of patients that come from out of Borough against Barnet residents – if this is not available we will survey dentists in the Borough.

**Early Years Oral Health Project**
This commissioned project will capture the oral health and experiences of parents with young children in Barnet by using a combination of questionnaires and focus groups to target hard to reach families supported by Home-Start Barnet.

We will be carrying out 50 one-to-one interviews and one focus group (on the Grahame Park Estate in Colindale). The interviews and focus group will cover the following areas:

- The quality of the service offered by dentists
- Any barriers to take up of local dental health services (e.g. lack of understanding of the benefits, cultural issues, unaware that the service is available, or how to access it;
- Ease/difficulty of location of services
- Perception of the effectiveness of good oral health
- Impact of lifestyle on children's oral health

The project will also train 3 volunteer oral health champions to disseminate information and support hard to reach parents on importance of early years oral health by promoting, and encouraging increased take-up of dental health services in Barnet.

**Feedback from NHS England**

With regard to feedback from NHS England, we were disappointed that it took so long for NHS England to come back to us with comments on our report. They were first approached on 28th April 2015 and we sent a number of requests for feedback after that so we could include these in our report. Unfortunately, our only response came after publication. We have noted the comments and the figures that they sent with regard to Units of Dental Activity in Barnet. We do not feel that the comments make any difference to the Dental Report as it stands.

**Michael Rich**
Head of Healthwatch
Community Barnet

healthwatch Barnet

# Dentistry in Barnet

## A dental investigation in Barnet 2014/15

# Introduction

Healthwatch Barnet was contacted by local residents who had experienced difficulty with dental services in the Barnet Area. These individuals had concerns in the following three areas:

1) Difficulty in being able to find a dentist offering NHS services;

2) Not being advised of the potential full cost of dental services at the start of treatment;

3) Feeling unconvinced that dental treatments recommended by their dentist were necessary.

To investigate these situations further, we focussed on the first two areas, and undertook Mystery Shopping of Barnet Dental Surgeries. We decided to ask 40% of surgeries a set of standard questions to explore:

1) Availability of NHS dentists in the Borough;

2) The approach taken by dental surgery staff to ensure patients were made aware of the potential costs of their treatment.

We considered that we had to look into the first two areas before we could consider the third. Consequently we advised those patients who contacted us that they could arrange to have a second opinion about treatment, by visiting another dentist and seeking their opinion. Many patients did not understand that if they were not 'registered' with a dentist they were free to go elsewhere for any treatment should they wish to do so.

However, by seeking a second opinion in this way these patients were likely to incur the cost of a second check-up. Having discussed this issue with individuals affected, we concluded that the lack of access to dental records and medical and other lifelong history was a significant barrier in building up trust between dentists and their patients and ensuring the correct treatment was offered. Patients distinctly thought that the dentist stood to financially gain from recommending treatment, and they did not therefore always trust the dentist's recommendation.

# Approach and Methodology

We recruited a team of six Healthwatch Barnet volunteers who helped to design a short questionnaire exploring the issues relevant to this investigation. The questionnaire can be seen in appendix 1.

The list of dental practices registered in Barnet with the CQC was extracted from the CQC website and those practices that dealt with only specialist services were removed from the list (Care Quality Commission, 2015). The rest of the practices were geographically plotted on a map of the Borough and a range of practices from all geographic areas of Barnet were randomly selected to be contacted.

We trained the volunteers in the principles of mystery shopping and provided them with the details of a number of dental practices across the Borough.

Each of the volunteers undertook a number of phone calls asking the standard agreed questions, and they each recorded the responses using Survey Monkey. This was then analysed.

A copy of the final report was sent to the Local Dental Committee who made some helpful comments and supported our conclusions and recommendations. A copy was also sent to NHS England but no response has been received from them to date.

# Background Research

This was the first time the Healthwatch Barnet team had worked in the field of dentistry – it was very exciting!

We spoke to a number of patients and professionals to make sure we understood the process and any key issues. In addition, we spoke to a 'Friend of Healthwatch Barnet' who is a dentist and who has worked in a number of different areas of the country. He explained how the dental practices operate and the contracts that are in place with NHS England and provided expert knowledge. We also explored NHS Choices in depth and found the information section of the website to be very clear and informative about how charges work and what is covered (National Health Service, 2015).

We met with the Barnet Local Dental Committee who were very helpful in explaining the local dental services and contractual processes.

We also reviewed NHS England's GP Patient Survey, which was conducted from July to September 2014 (National Health Service England, 2015). 3,626 adults across Barnet were asked about their views on NHS dentistry as part of NHS England's national dentist survey. The Barnet specific data revealed:

1) In response to, *'Were you successful in getting an NHS dental appointment?'*, 89% of people who tried to get an NHS dental appointment were successful in Barnet in the last two years

2) In response to *'Last time you tried to get an NHS dental appointment, was it with a dental practice you had been to before for NHS dental care?'*, national results show that those respondents who had not been to the practice before were 20% less successful (76% compared to 96%) than who had made an appointment at a practice which they had previously visited in the last two years.

3) In response to the *'Overall, how would you describe your experience of NHS dental services?*, 82% of people had a very good/fairly good experience of NHS dental services in Barnet, 7% had a fairly poor/very poor experience and 11% judged it has neither good nor poor.

4) The reasons most often given for people not trying to obtain a NHS dental appointment were: prefer to go to a private dentist (25%); haven't needed a visit (21%); didn't think could get an NHS appointment (20%).

Concurrently HWB were contacted by Which? (the consumer champion organisation, which undertakes regular research and reviews into services and products) who were undertaking a national survey of the public to ascertain their understanding of dental costs and charges. We contributed to the preparations for this, by discussing the local dental issues that had been raised with us and promoted the survey with Barnet residents.

Which? surveyed 1,001 dental patients about their experiences and found the following:

1) 22% of the people surveyed who had dental treatment didn't feel completely clear about what it would cost before starting.

2) 43% of people surveyed felt well informed about NHS and private treatments, and how they differ.

3) 15% did not have the benefits and drawbacks of different options explained.

4) 52% of people surveyed who should have got a treatment plan (for complex treatment such as fillings or crowns) were given one, although 87% think it's important.

5) 43% of people surveyed saw a price list in the reception or waiting area, although 88% think this is important.

Furthermore, Which? sent five undercover researchers to dentist practices nationally at 25 mixed (NHS/private) practices. They asked a panel of experts – including two experienced dentists/practice owners and an expert in patient-focused dental research – to assess the visits. They looked at everything from the communication of NHS and private options, to clarity of pricing. The Which? undercover investigation has found that people could be paying more than they need to for treatment because some dentists aren't explaining dental prices upfront, or being clear about what NHS treatment patients

are entitled to. The investigation (Dentists unclear about costs and treatment options, finds Which?) recommends that all dentists should:

1) Comply with existing rules and make information on prices clearly available:

2) Explain the dental treatment options properly;

3) Make sure patients know whether or not their treatment is available on the NHS (Which? 2015).

# Profile of Barnet Dentists

According to the CQC website there are 122 dentists registered within the Borough of Barnet, though a number of these are providing specialist services only. The general dental practices are geographically spread throughout the Borough with significant groupings of services following the main population density of the area (Care Quality Commission, 2015).

Since the new dental contracts were introduced in 2006 there has apparently been no change in the number of UDAs available in the Borough of Barnet. (A UDA is a Unit of Dental Activity which represents a single unit of dental work such as a check-up.) Each dental practice which was in existence in 2006 was allocated a level of UDAs which was determined by their work level in 2005, and these amounts have not altered in the last 10 years. The population of the Borough has been estimated to have grown from 329,100 in 2005 to 364,000 in 2012, (Public Health England, 2014; The Guardian, 2015) so the level of funding per head of population has therefore fallen.

The Local Dental Committee (LDC) is very aware of this situation, and knows that many of their members would very much like to be able to offer much higher levels of NHS treatments, but due to the very tight contracts they are unable to do so. If dentists undertake NHS work above the level they are allocated to do, they are not reimbursed for this work and are therefore out of pocket. They consider themselves powerless to influence the decision-makers in this area, despite the fact that the need for additional resources for NHS dentistry appears to be generally acknowledged.

As part of the Secretary of State for Health's 2014/15 determination for dental contracts and agreements the Department of Health has decided to:

1) Uplift (increase in funds) to all General Dentistry Services contracts and Personal Dentistry Services by 1.6%. The LDC informed us that the uplift does not mean an increase in UDAs and would be swallowed up by increased practice expenses.

2) Develop strategic aims for NHS dentistry:

a. To improve the oral health of the population, especially children, hard to reach and vulnerable groups, and to reduce inequalities of outcomes;
b. To move to a more preventative approach based on the needs of the individual patient and the population.
c. Increased integration of care across primary, community and hospital settings.
d. Ensuring good and equitable access to NHS dentistry.

3) Develop an efficacy package that can deliver savings across, national and local, in line with the rest of the NHS (National Health Service England, 2015).

# Findings

We spoke to 50 dental practices in the Borough of Barnet as mystery shoppers and asked them all the same questions, posing as someone who was looking for a new dentist in their local area, and wanting to find out what services were available. The calls all took place during December 2014 and January 2015.

## Findings:

## New Patients:

We found that:

1) 53% of the practices we spoke to were not, at that point, accepting new NHS adult patients;

2) 47% were not accepting new children as patients.

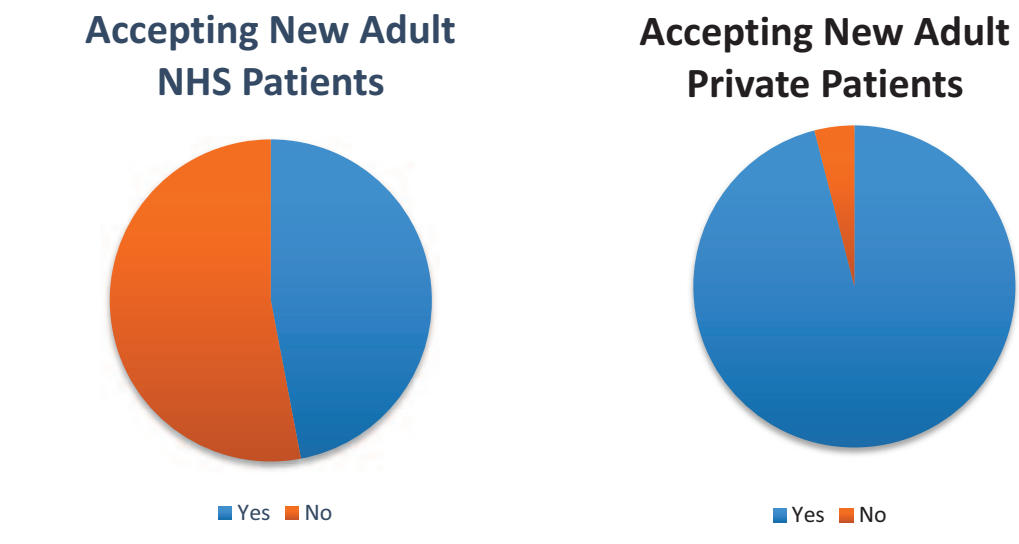
A small number of surgeries (6) told us they would be able to take NHS again when the new financial year started and to contact them again in February/March when they would start making NHS appointments again. We understand that this is because they have used up the full allocation of Units of Dental Activity. Some practices told us they would offer NHS charges to patients who did not require significant dental work.

96% of practices were taking on new private adult patients (and 92% for children). This would lead us to believe that there is not an issue with capacity for dentists.

This information concurs with the feedback that Healthwatch Barnet has received from the local residents that it is very difficult to access NHS dentistry services in the Borough, though they can easily be offered private treatment which is often out of financial reach

of patients. As is the case nationally, Barnet residents are not restricted to using dental services within the Borough itself.

Our findings do not support the results from NHS England's GP Patient Survey (July to September 2014) in Barnet. The NHS England results indicate that very high percentage of patients are successful in getting an NHS appointment in Barnet within the last two years. We found that more than half of practices we spoke to did not accept new NHS patients. The inconsistency could be explained by the time of the year that the NHS survey was undertaken or the phrasing of their question. Our findings in Barnet are also replicated by findings of Which?'s investigations.

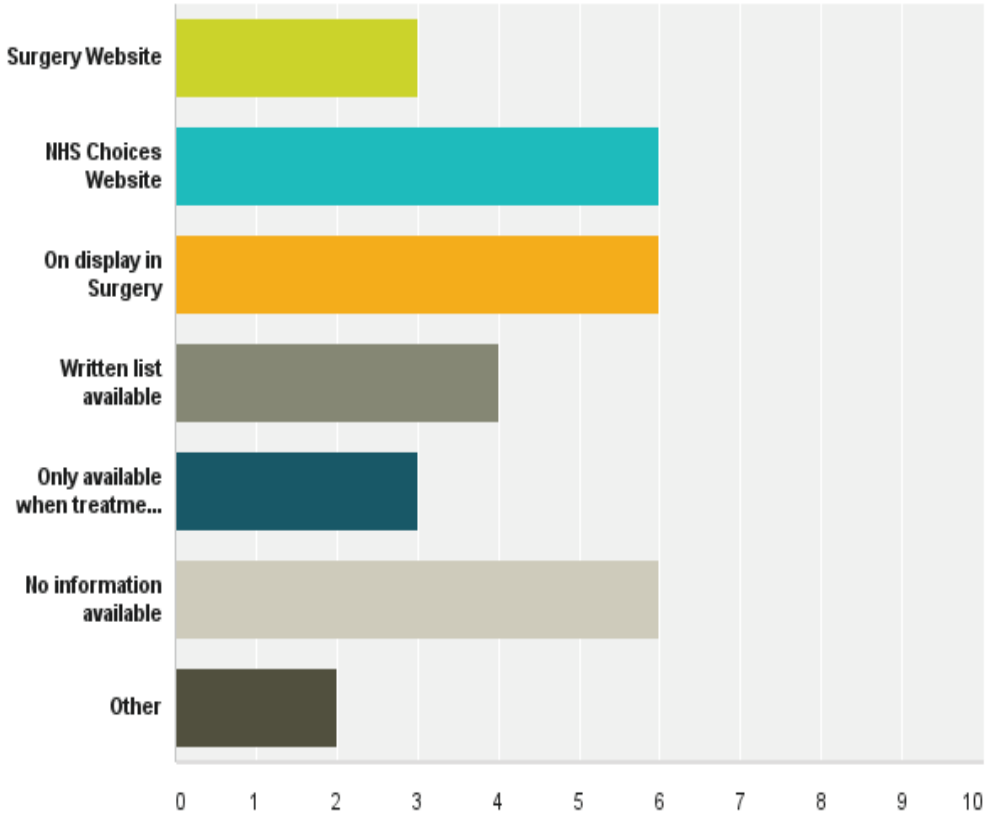



## Findings:
## Transparency of Cost

We wished to investigate if information is provided to patients clearly about how much their treatment will cost. The General Dental Council advises that 'before a dental professional carries out any work, they should check your mouth and then give you a treatment plan and an estimate of how much any work will cost' (Smile - Your dental team have check-ups too GDC 2014).

NHS England (via NHS Choices) also advise that all NHS patients should be given a treatment plan and estimate of how much any work will cost. Therefore, we asked the practices who offered NHS services, if NHS patients were given information about the cost of their treatment, and 69% told us that an explanation of NHS charges was provided. The chart below shows where practices said the information was available.

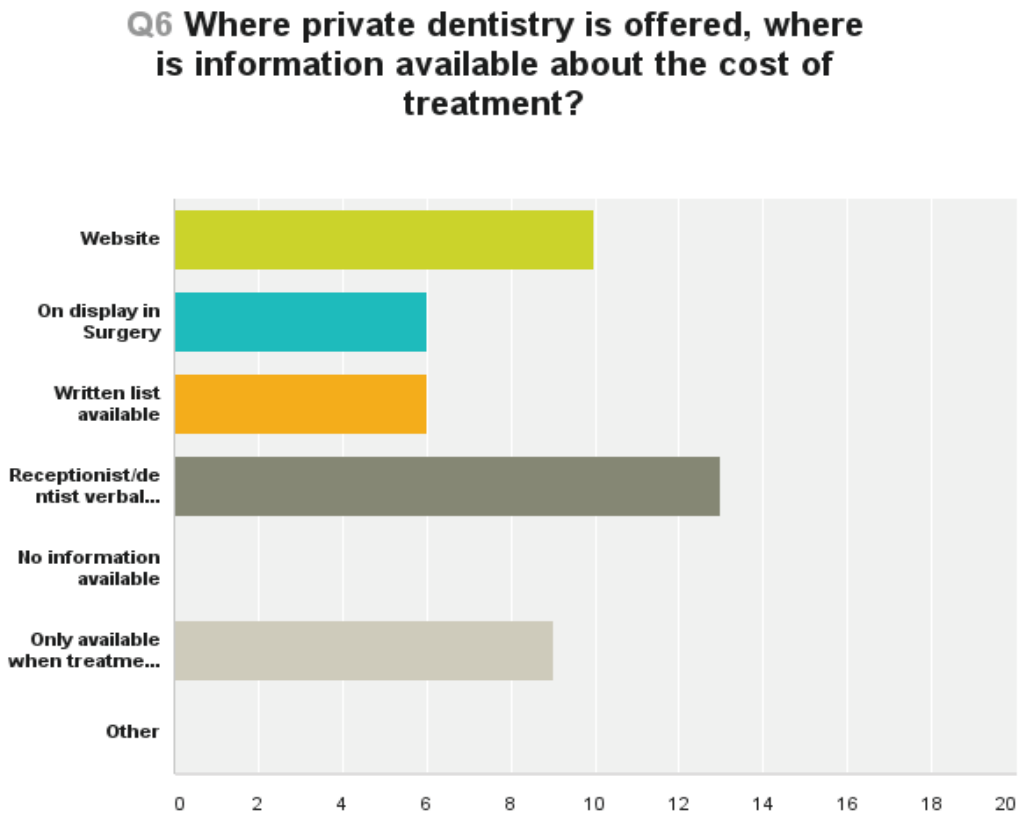
## Q5 How can information about the cost of NHS treatment be accessed?




Only 6 practices said the information relating to cost was on display. Of the remainder:

- 5 said a written list was available
- 9 would refer to either the practice website or the NHS Choices website
- 3 said they would explain the costs if treatment was needed.

We also asked practices offering private charges for dentistry, if private patients were able to access information about the cost of treatments. The graph below summarises the responses.




Only 6 of the 44 practices who offer private treatment had a list on display in the surgery. Of those remaining:

- 10 said it was available on the surgery website, (we checked and found this was the case for 9)
- 6 that a written list was available on request
- 22 said that either the dentist would discuss it when treatment was needed or the information was explained verbally.

**Findings:**

## Treatment Plans

We asked if treatment plans were available to all patients as a matter of routine before any treatment was offered - 85% of practices told us they were, though 15% (7 practices) said they were not.

We had received anecdotal evidence from patients that they felt under pressure to agree to treatment when it was recommended even though it would them financial hardship.

Patients felt vulnerable at the time of attending the appointment and did not feel comfortable explaining their financial considerations, and felt under pressure to continue with the treatment recommended. Some also felt that this was discussed in an area that was not private enough. We believe it would be beneficial to patients if they could have some time to reflect on their options before agreeing to continue with their treatment including being able to research further options that may be available to them. Some individuals told us that once they had made the appointment they felt unable to retract from the agreement, and others felt they would have been fined for changing the arrangement. Whilst we did not at this point research this point further we accept that this situation could commonly occur and could easily be rectified.

# Recommendations

Consideration should be given by NHS England to increase the number of UDAs that are available in Barnet.

We have clear evidence that NHS dentistry is not available in Barnet due to the lack of funding. This is particularly an issue in the last 4/5 months of the financial year, when practices have used their full allocation of UDAs.

1) Clear information about NHS dentistry costs should be readily available to all patients when they attend a dental appointment. The Department of Health leaflet 'NHS dental services in England' explains the full situation in clear language and should be readily available. NHS Choices also provides very straightforward advice. These sources should be easily available and patients should be referred to them, or other-up-to-date advice and information either before or at the start of their visit to the dentist. It is suggested that when a patient books an appointment they should be given some information or referred to a web resource at that point to ensure they understand the situation.

2) Details of private dental costs should be available to all private patients at the time they attend an appointment. We recommend that all practices make their prices clearly available to all patients, on their website, on display in the practice or in leaflets available to patients. This information should be available to patients before they attend appointments so that they are aware of potential costs and can make informed decisions.

3) All patients should receive a clear written treatment plan, including costs, before any treatment is started.

   Practices should ensure that patients have a clear period of time to consider their treatment plan, especially if it involves significant financial outlay, to ensure they

are comfortable with going ahead with the treatment. They should also ensure the patient understands any disadvantages of delaying the treatment. We recommend that ideally, there should be a private area where patients can ask questions and explain their situation to the receptionist or dentist, away from other patients/the main waiting area. However, we do not know how many practices have a private area, as this was not a specific question on our survey.

# Conclusions

We found that there is clearly a shortfall in the amount of NHS dentistry being funded in Barnet, resulting in patchy availability both geographically and also according to the time of year

However our recommendations would ensure that patients are more aware of the cost of treatment, and thus be able to make measured decisions about what treatment they wish to undertake. In particular, there is a definite need for dentists offering private treatment to be more transparent about their costs.

# Acknowledgements

We would like to thank the team of Healthwatch Barnet volunteers who generously assisted with this research. They are: Asmina Remtulla, Amlan Ghosal, Stewart Block, Sue Blain, Lyn Tobin and Ellie Chamberlain.

We also extend out thanks to the Barnet Local Dental Committee members who met with us and provided much information about the local situation.

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## Appendix 1

# Dentistry Questionnaire

**1. General Information**

Your Name:

Date of contact:

Name and address of Dental Surgery:

**2. Are you currently accepting new NHS patients?**

| | | |
|---|---|---|
| **Adults** | Adults Yes | Adults No |
| **Children** | Children Yes | Children No |

Any Comments

**3. Are you accepting new Private Patients?**

| | | |
|---|---|---|
| **Adults** | Adults Yes | Adults No |
| **Children** | Children Yes | Children No |

Any Comments

**4. If you are accepting new NHS patients, is there a list of charges for different treatments available?**

☐ Yes
☐ No

**5. How can this information be accessed?**

☐ Surgery Website
☐ NHS Choices Website
☐ On display in Surgery
☐ Written list available
☐ Only available when treatment needed
☐ No information available
☐ Other (please explain)
Any Comments ☐

**6. If you are accepting new private patients is there a list of charges for different treatments under private care?**

☐ Website
☐ On display in Surgery
☐ Written list available
☐ Receptionist/dentist verbally explains
☐ No information available
☐ Only available when treatment needed
☐ Other (please explain)
Any comments ☐

**7. Are written Treatment Plans automatically produced for all treatment recommended? Are these issued before treatment starts in all cases?**

☐ Yes
☐ No
Other (please specify) ☐

**8. Please add any other general information you gathered that may be interest.**

## Contact us:

**Healthwatch Barnet**
Barnet House
1255 High Road
London N20 0EJ

www.healthwatchbarnet.co.uk

AGENDA ITEM 13

# Barnet Health Overview and Scrutiny Committee

# 13 October 2015

| | |
|---|---|
| **Title** | North West London, Barnet & Brent Wheelchairs Service Redesign |
| **Report of** | Lizzy Bovill<br>Programme Director<br>NHS West London Clinical Commissioning Group<br>15 Marylebone Road<br>London NW1 5JD<br>07500 815339 |
| **Wards** | **All** |
| **Status** | Public |
| **Urgent** | No |
| **Key** | No |
| **Enclosures** | None |
| **Officer Contact Details** | Mona Hayat<br>Associate Director of Service Transformation & Pathways<br>NHS West London Clinical Commissioning Group<br>15 Marylebone Road<br>London NW1 5JD<br>Tel: 0203 350 4284 |

## Summary

West London, Central London, Hammersmith & Fulham, Brent, Barnet, Ealing and Hounslow NHS Clinical Commissioning Groups (CCGs) are nearing the completion of a re-design programme for community wheelchair services for people of all ages who have a long-term need for mobility assistance. The aim will be to procure a new service from February 2016 which will go live 1st July. West London CCG is hosting the re-design and procurement programme.

# Recommendations

That the Committee note the contents of the report, the proposed direction of travel in relation to the re-design of the programme, and the required timescales for the project.

## 1. WHY THIS REPORT IS NEEDED

1.1 In November 2014 Central London, West London, Hammersmith & Fulham, Brent, Barnet, Ealing and Hounslow NHS Clinical Commissioning Groups (CCGs) agreed to undertake a full service redesign of community wheelchair services for people of all ages who have a long-term need for mobility assistance. The priority was to ensure those with complex, long term conditions, are able to access the right wheelchair, quickly, and with appropriate support. The full service redesign of all wheelchair services covered:

- Assessment and prescribing of powered and non-powered wheelchairs
- Rehabilitation engineering facilities (RE)
- Special seating
- Wheelchair cushions and accessories
- Service and maintenance packages (AR)

### 1.2 Current delivery of wheelchair services

Wheelchair Services in North West London are commissioned collaboratively by the 7 NHS CCGs. The services are provided by four separate NHS Trusts and one private sector provider:

- **Wheelchair services:**

The Wheelchair Services provide the clinical mobility, postural assessment and special seating services to child and adult clients who have a long term condition affecting their mobility. Once provision of service is established, the Wheelchair Service will continue to support and reassess clients. Central London Community Healthcare NHS Trust (CLCH), London North West Hospitals NHS Trust (LNWH) and Hounslow & Richmond Community Healthcare NHS Trust (HRCH) provide these services.

- **Rehabilitation engineering**

The rehabilitation engineer (RE) service provides information and advice on adaptations and modifications and technical advice on the use and maintenance of equipment. It monitors and assists in the quality management of the repair refurbishment service and ensures that technical and safety standards of the work are of a good quality. The service provides information and advice to health professionals and the on the range of

available wheelchairs, special seating and associated items the technical specifications and suitability, it also advises on the procurement of service equipment. Kings College Hospital NHS Foundation Trust provides Rehabilitation Engineering services.

- **Approved repairer:**

The approved repairer is responsible for the procurement, storage, delivery, collection, refurbishment, decontamination, repair and maintenance of manual and powered wheelchairs, cushions, accessories and spares. NRS Healthcare provides the approved repairer service.

**1.3 Rationale for new service**

In April 2014 Healthwatch undertook two key user engagement exercises; Healthwatch Central West London was commissioned by Hammersmith and Fulham Clinical Commissioning Group (H&FCCG), West London Clinical Commissioning Group (WLCCG) and Central London Clinical Commissioning Group (CLCCG) to produce a piece of patient engagement around local service users experiences of the wheelchair hardware and repair service and how they would like the service improved. Healthwatch Ealing undertook the same process on behalf of Ealing CCG (ECCG). Three key themes arose as outcomes from both engagements:

i. Service users would like a more personalised service that reflects their needs and allows for choice.
ii. Service users would like a fast and reliable service.
iii. Service users would like excellent customer service from the hardware and repair service.

1.3.1 A number of engagement activities were carried in Barnet, including a survey went out on Barnet CCG and Council websites, and a paper was presented at the PSI board to solicit their views on this programme. Also the Patient Reference Group and Healthwatch Barnet promoted engagement events for this programme by publicising information on their website and sending out to their database of members.

1.3.2 Since the Healthwatch reports, 3 further wheelchair service user events took place across North West London, inclusive of one young service user and carer event in Brent (between September - March 2015). These endorsed the three key themes above, but also served to advocate for revised consideration of an integrated wheelchairs service across the 7 CCGs. They have expressed the need for the procurement to be combined with assessment and prescription services in order for services to be robust and seamless. Service user feedback suggested that by procuring an integrated service, delays between the assessment and the issue of wheelchairs could be resolved as would the inconsistent communication between the assessment and maintenance services. Users particularly cited the need for improving the waiting times for repairs.

The service redesign and procurement has also taken into account changes in national guidance in terms of tariff and healthcare standard, specific to wheelchair services. We also want to improve quality and efficiency of the service. Two critical areas are:

1.3.2.1 **Changes in classification**

New guidance is to impact definitions of levels of complexity of our service users: low, medium, high, complex. Once more, classifications will be required to be altered within the specification to represent the new definitions. Changes in disease categories over the next 10 years means our trajectory of service users that have static and progressive conditions is on the increase. It is likely that we will need to increase the amount of provision to account for these changes.

#### 1.3.2.2 Alignment to new models of care

A critical aim of the service redesign of wheelchair provision has been to ensure the new services are adaptable to changing need and new initiatives such as the models of care developed under the Better Care Fund and Whole Systems Integrated Care. These schemes will have a significant interface and impact on the future provision of wheelchair services within the next 5 years.

### 1.4 The Wheelchair Alliance

Commissioners have also met Baroness Tanni Grey Thompson who leads the Wheelchair Leadership Alliance and sought to ensure that proposals reflect the ambitions of the organisation which was set up to help transform the quality and effectiveness of services for wheelchair users. The organisation has published a charter of principles for wheelchair services which includes the following principles.

a. A person centred service that works in partnership with service users and their carers and make the user/carer voice central to any design, innovation and service change
b. Equality of access and provision for all, irrespective of age or postcode and including essential user-skills training as standard
c. Entry to the service via referral from an appropriately skilled profession. The time from referral to delivery will be at least within the constitutional right of 18 weeks with substantial improvements for urgent referrals immediately and by 2016/17 for everyone using the service
d. Assessment for all wheelchair and associated postural support within nationally mandated timescales and priorities taking into account all aspects of individual needs including those of carers
e. Establishing regular reviews with the user/carer according to their individual needs
f. Prescriptions which take into account the current and future needs for all adults including those of carers
g. Delivery, maintenance and emergency backup providing to nationally mandated timescales
h. Innovative and flexible budgeting working with key partnerships to strengthen integration across health, social care, work and education, enabling the accommodation of individual needs, independence health and wellbeing
i. Recruitment of qualified staff in respect of numbers and skills, with support for on-going development and training
j. Supporting clinicians, manufacturers and independent organisations working together to develop innovating, affordable products and solutions.

These principles underpin the new service specification. Baroness Grey Thompson is due to visit Barnet CCG in November to discuss existing services for wheelchair users in the borough and plans for future developments.

## 1.5 Current update on service redesign to September 2015

**Governance**

NWL CCGs, Barnet and Brent CCGs are committed to ensuring that service users and other stakeholders are involved in all stages of the service redesign including, planning, development and consideration of proposals for changes. To this end we invited a cross section of current service users from across the relevant geographical areas to be members of the following groups:

- Service redesign wheelchairs group
- Wheelchairs finance task and finish group
- NWL, Brent and Barnet wheelchair strategy board

The service user members who attend the above groups have also agreed to be members of a virtual user group that assist WL CCG in scrutinising documents to ensure they are fit for purpose.

### 1.6 Stakeholder engagement to date

As stated above, there were 3 service user events since October 2014. One was based in Westminster, one in Ealing and Brent and one young people's event in Brent. These events were advertised on the CCG websites. A service user survey is in circulation to all service users via our providers to gain feedback on their views of current provision. This is in the public domain for 6 weeks.

One provider event took place and 2 process-mapping events (with a range of stakeholders, including service users) which have provided a wealth of information regarding current pathways management. These events have enabled commissioners to identify areas of good practice and gaps in the current system.

WLCCG appointed 2 external clinical leads to support the engagement process. The GP Lead developed GP surveys to understand the level of primary care input into wheelchair provision.

The other clinical lead supported the service redesign by undertaking clinical audits of the current services across the 7 CCGs. She is a senior manager with specialist clinical background in NHS wheelchair provision.

## 1.7 What we have learnt so far

- We have benchmarked with other areas who have commissioned innovative services i.e. the Torbay Local Authority and partner's social enterprise model and the Northern Ireland integrative model. Engagement has informed us of the need.

- For a better understanding of the relationship between wheelchair services, effectiveness evidence, service user perspectives and policy intentions.
- Current NWL, Barnet and Brent wheelchair services have not been commissioned to take into account all factors influencing wheelchair mobility, including the user's physical, social and environmental needs.

We need to take into account the increasing number and proportion of older people living in their own homes with limitations in mobility, dexterity and mental capacity. This has been reflected in the draft service specification.

## 2. REASONS FOR RECOMMENDATIONS

The service redesign and procurement has also taken into account changes in national guidance in terms of tariff and healthcare standard, specific to wheelchair services and also reflects the strong desire to improve quality and efficiency of the service. The Committee are being asked to consider and note the report so that they have the opportunity to scrutinise provision of this health related projected.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

There is one alternative option that has been considered:

**Alternative option 1:** Continue service as currently provided. This option would not be feasible as the existing contract for the approved repairer expires on the 30th March 2016 (although will be extended until 30th June 2016).

## 4. POST DECISION IMPLEMENTATION

The Business Case will be signed off through the most appropriate governance mechanisms at each CCG during November. The procurement is due to commence from January 2016 with service inception commencing on 1st July 2016.

Following the consideration of this report, the Health Overview and Scrutiny can determine if they wish to receive any future reports on this matter.

## 5. IMPLICATIONS OF DECISION

### 5.1 Corporate Priorities and Performance

5.1.1 The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020.

The strategic objectives set out in the 2015 – 2020 Corporate Plan are: –

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

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

5.2.1 There are no financial implications arising as a result of this report.

5.2.2 A Business Case to be signed through the most appropriate governance mechanisms at each CCG during November, will comprise details of financial modelling and required investment.

5.2.3 The benefits of this procurement are generated through 7 CCG's joining together to procure a wheelchairs service:

- Facilitate economies of scale, redirecting current monies to facilitate benefits
- Address equality issues between CCG's, providing that all CCG's follow the same model
- The new contract will look for Value for Money (VFM) and sustainability in the short and long term.

## 5.3 Legal and Constitutional References

5.3.1 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

5.3.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

5.3.3 The Health Overview and Scrutiny (Responsibility for Functions, Council's Constitution) has the following responsibilities:

- To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.
- To make reports and recommendations to Council, Health and Well Being Board, the Secretary of State for Health and/or other relevant authorities on health issues which affect or may affect the borough and its residents.
- To receive, consider and respond to reports, matters of concern, and consultations from the NHS Barnet, Health and Wellbeing Board, HealthWatch and/or other health bodies.

## 5.4 Risk Management

West London CCG is hosting the re-design and procurement programme and maintains the programme risk log, under the aegis of the Collaborative Performance Committee for NWL CCGs and Brent and Barnet Governing Bodies. The Senior Responsible Officer is Lizzy Bovill, Director of Programmes for the NWL Collaborative of CCGs.

In the instance that a significant change is required of the programme, this will need to be approved by each CCG as an individual sovereign entity. The Collaborative Performance Committee will make a recommendation to the Governing Bodies.

## 5.5 Equalities and Diversity

An Equality Impact Assessment will be undertaken as a necessary part of the service redesign/ business case.

The development of a wheelchairs service would ensure that services are accessible to all who need them on a fair basis.

And ensure compliance with the public sector equality duty in s149 Equality Act 2010 to 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.

The protected characteristics are:

age;
disability;
gender reassignment;
pregnancy and maternity;
race;
religion or belief;
sex;
sexual orientation

and

No human rights or privacy issues have been identified.

## 5.6 Consultation and Engagement

5.7.1 Significant engagement has taken place to date outlined under section one.

## 5.8 Insight

5.8.1 As above.

## 6. BACKGROUND PAPERS

AGENDA ITEM 14

# Health Overview and Scrutiny Committee

# 13 October 2015

| | |
|---|---|
| **Title** | **Health Overview and Scrutiny Committee Work Programme** |
| **Report of** | Governance Service |
| **Wards** | All |
| **Status** | Public |
| **Urgent** | No |
| **Key** | No |
| **Enclosures** | Appendix A – Committee Forward Work Programme |
| **Officer Contact Details** | Anita O'Malley, Governance Team Leader<br>Email: anita.vukomanovic@barnet.gov.uk<br>Tel: 020 8359 7034 |

## Summary

The Committee is requested to consider and comment on the items included in the 2015/16 work programme

## Recommendations

1. **That the Committee consider and comment on the items included in the 2015/16 work programme**

## 1. WHY THIS REPORT IS NEEDED

1.1 The Health Overview and Scrutiny Committee Work Programme 2015/16 indicates forthcoming items of business.

1.2 The work programme of this Committee is intended to be a responsive tool, which will be updated on a rolling basis following each meeting, for the inclusion of areas which may arise through the course of the year.

1.3 The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

## 2. REASONS FOR RECOMMENDATIONS

2.1 This approach allows the Committee to respond to Health related matters of interest in the Borough.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There are no specific recommendations in the report. The Committee is empowered to agree its priorities and determine its own schedule of work within the programme.

## 4. POST DECISION IMPLEMENTATION

4.1 Any alterations made by the Committee to its Work Programme will be published on the Council's website.

## 5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Committee Work Programme is in accordance with the Council's strategic objectives and priorities as stated in the Corporate Plan 2013-16.

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

5.2.1 None in the context of this report.

5.3 **Social Value**

5.3.1 N/A

5.4 **Legal and Constitutional References**

5.4.1 The Terms of Reference of the Health Overview and Scrutiny Committee is included in the Constitution, Responsibility for Functions, Annex A.

5.5 **Risk Management**

5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**

5.6.1 None in the context of this report.

5.7 **Consultation and Engagement**

5.8 **Insight**

5.8.1 N/A

## 6. BACKGROUND PAPERS

6.1 None.

# London Borough of Barnet Health Overview and Scrutiny Committee Forward Work Programme October 2015 - May 2016

Contact: Anita Vukomanovic 020 8359 7034 anita.vukomanovic@barnet.gov.uk

| Title of Report | Overview of decision | Report Of *(officer)* | Issue Type (Non key/Key/Urgent) |
|---|---|---|---|
| 13 October 2015 | | | |
| Tuberculosis | Following the consideration of the Annual Report of the Director of Public Health, Committee have requested to receive a report on Tuberculosis. | Director of Public Health (Barnet and Harrow) | **Non Key** |
| Sexual Health | Following the consideration of the Annual Report from the Director for Public Health, Committee have requested to receive a report on the issue of sexual health. The report is to include provision for older people and the under 25s in Barnet. | Director of Public Health (Barnet and Harrow) | **Non Key** |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| Finchley Memorial Hospital | At their meeting on 30 March 2015, the Committee considered a report which provided an update from NHS England and Barnet CCG on the provision of GP Services or a primary care facility at the Finchley Memorial Hospital site.<br><br>The Committee noted that the project was scheduled to develop a series of initial options for review in April 2015, which would then need appraisal and planning in order to work through the commissioning and costing consequences. The Committee noted that the intention was to identify agreed options by the summer of 2015, with a view to commencing work on implementing the new models of service. The Committee have requested to consider a further update report to capture the agreed options which are due for agreement in the summer of 2015. | NHS England and Barnet CCG | **Non Key** |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| Joint Strategic Needs Assessment (JSNA) and Joint Health and Well-being Strategy | Committee to receive the Joint Strategic Needs Assessment (JSNA) following it being considered by the Health and Wellbeing Board, and also to consider the Joint Health and Well-being Strategy. | Director of Public Health (Barnet and Harrow) | **Non Key** |
| GP Provision: Update Report from NHS England | At their meeting on 6 July 2015, the Committee received a Member's Item in the name of Councillor Barry Rawlings. The Committee resolved to request a report providing information and forecasting on GP provision within the Borough.<br><br>The Committee have requested that the report includes figures on the number of GPs expected to retire, regeneration programmes and the management of future seven day GP services.<br><br>The Committee have requested that NHS England who have responsibility for this provision be provide the report and have asked that NHS England liaise with the Barnet Clinical Commissioning Group in order to prepare the report. | NHS England | **Non Key** |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| Dentistry in Barnet | At their meeting on 6 July 2015, the Committee received a Member's Item in the name of Councillor Arjun Mittra.<br><br>Committee resolved to receive a report from NHS England at their October meeting which addresses the issue of dentistry in Barnet as well as the recommendations made in the recent Healthwatch Barnet report as referred to in the Member's Item.<br><br>The Chairman requested that the future report to Committee also contains an appendix from Healthwatch Barnet which sets out what actions Healthwatch have taken since their report. | NHS England | **Non Key** |
| North West London, Barnet & Brent Wheelchairs Service Redesign | Central London, West London, Hammersmith & Fulham, Brent, Barnet, Ealing and Hounslow NHS Clinical Commissioning Groups (CCGs) are redesigning community wheelchair services for people of all ages who have a long-term need for mobility assistance. Following a period of pre-consultation engagement, there will be a six week consultation starting mid-August 2015 to obtain views and achieve a mandate for the change. | NHS West London Clinical Commissioning Group | **Non Key** |
| 7 December 2015 | | | |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| Annual Report of the Director of Public Health | Committee to receive the Annual Report of the Director of Public Health. | Director of Public Health (Barnet and Harrow) | **Non Key** |
| Update report on the East Barnet Health Centre from NHS England and NHS Property Service at their meeting in December 2015 | At their meeting on 6 July 2015, the Committee considered a report which was submitted by NHS Property Services and NHS England in relation to the East Barnet Health Centre.<br><br>The Committee noted the report, and resolved to request that NHS England and NHS Property Services attend the meeting of the Committee in December 2015 to provide an additional update on the matter. | NHS England and NHS Property Service | **Non Key** |
| Update Report: Cricklewood GP Health Centre | At their meeting on 6 July 2015, the Committee received a report from Barnet Clinical Commissioning Group which outlined options for the continuation of services at Cricklewood GP Health Centre.<br><br>The Committee resolved to request a further report from the Clinical Commissioning Group at their meeting on 7 December 2015. | Barnet Clinical Commissioning Group | **Non Key** |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| Quality Accounts - Mid Year Review | At their meeting on 11 May 2015, the Committee reviewed the Quality Accounts for 2014-15 for the Following NHS Trusts:<br><br>• The Royal Free London NHS Foundation Trust<br>• Central London Community Healthcare NHS Trust<br>• The North London Hospice.<br><br>As is usual practice, the Committee formally commented on the draft Quality Accounts, and submitted their comments for inclusion within the final reports.<br><br>The Committee have requested to scrutinise the progress made over the last six months against the comments submitted to each NHS Trust. | NHS Trusts | **Non Key** |
| Adult Audiology, Wax Removal and Community ENT Service | Committee to receive a report from Barnet Clinical Commissioning Group on Adult Audiology, Wax Removal and Community Ear, Nose and Throat Service. | Barnet Clinical Commissioning Group | **Non Key** |
| 8 February 2016 | | | |
| 16 May 2016 | | | |

| Subject | Decision requested | Report Of | Contributing Officer(s) |
|---|---|---|---|
| NHS Trust Quality Accounts | Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16. | NHS Trusts | **Non Key** |
| Items to be Allocated | | | |
| Dehydration in Patients Admitted to Hospitals from Care Homes | Committee to receive a report on the admission of patients with dehydration to hospital. | | **Non Key** |