MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 30TH JULY, 2015

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

TO: MEMBERS OF HEALTH & WELL-BEING BOARD (Quorum 3)

Chairman: Councillor Helena Hart (Chairman)
Vice Chairman: Dr Debbie Frost (Vice-Chairman)

Dr Charlotte Benjamin	Councillor Sachin Rajput	Dawn Wakeling
Paul Bennett	Regina Shakespeare	Michael Rich
Dr Andrew Howe	Dr Clare Stephens	Chris Miller
Chris Munday	Councillor Reuben Thompstone	

Substitute Members

Julie Pal	Dr Ahmer Farooqui	Mathew Kendall
Councillor Wendy Prentice	Dr Barry Subel	Dr Jeffrey Lake
Councillor David Longstaff	Maria O'Dwyer	
Bernadette Conroy	Nicola Francis	

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

Andrew Charlwood – Head of Governance

Governance Services contact: Salar Rida 020 8359 7113, salar.rida@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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1.	Minutes of the Previous Meeting	1 - 8
2.	Absence of Members	
3.	Declaration of Members' Interests	
4.	Report of the Monitoring Officer (if any)	
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Minutes of the Health & Well-Being Board

4 June 2015

Board Members:

AGENDA ITEM 1

Chairman:	*Councillor Helena Hart (Chairman),	
Vice Chairman:	Dr Debbie Frost (Vice-Chairman)	
* Dr Charlotte Benjamin	* Councillor Sachin Rajput	* Dawn Wakeling
* Dr Andrew Howe	* Dr Clare Stephens	* Michael Rich
* Chris Munday	* Councillor Reuben Thompstone	Chris Miller
Paul Bennett	Regina Shakespeare	

* denotes Member Present

Substitute Members:

*Julie Pal	Dr Ahmer Farooqui	Mathew Kendall
Councillor Wendy Prentice	*Dr Barry Subel	Dr Jeffrey Lake
Councillor David Longstaff	Maria O'Dwyer	
Bernadette Conroy	Nicola Francis	

Also in attendance:
Sarah Hellier (HB Public Health)
Matt Powls (CCG)
Hugh McGarel-Groves (CCG)
Dr Tania Misra (NHS England)

1. MINUTES OF THE PREVIOUS MEETING (Agenda Item 1):

The Chairman of the Health and Well-Being Board, Councillor Helena Hart welcomed Michael Rich (Head of Healthwatch Barnet), Chris Munday (Commissioning Director Children and Young People, LBB) and Dr Barry Subel (Barnet CCG) who was substituting for Dr Debbie Frost, to the Health and Well-Being Board (HWBB).

The Chairman noted the departure of Kate Kennally from the Board and placed on record the HWB Board's appreciation and gratitude for everything that she had achieved from its inception. She also noted the departure of Selina Rodrigues and similarly thanked her for all her efforts and contributions to the work of the Health and Well-Being Board.

A correction was made to the minutes of the previous meeting, on page 1, for the last paragraph to read:

The Board heard that in relation to the Healthwatch Update report, a meeting has been arranged between Adults Services and Healthwatch Barnet and that a progress report will be presented by Healthwatch at the ~~June~~ July Health & Well-Being Board which will include information on the progress made by all providers.

Board Members were provided with a verbal update on the progress of actions from the previous minutes of the HWBB on 12 March 2015.

It was noted that in relation to the Strategic Approach to Obesity agenda item, partners have made nominations for representatives on the Obesity Steering Group.

The Board heard that work is underway towards the proposals made at the previous meeting for a pilot, phased GP training programme as part of the IRIS programme.

It was further noted that in relation to the Forward Work Programme, the CCG Delivery Plan was circulated to the HWBB on 31 March 2015.

RESOLVED that the minutes of the Health & Well-Being Board meeting held on 12 March 2015 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

The Board noted the membership list which was updated following the Annual Council meeting on 13th May 2015.

Apologies for absence were received from:

Paul Bennett (NHS England)
Dr Debbie Frost (CCG) - substituted by Dr Barry Subel
Regina Shakespeare (CCG) – Maria O'Dwyer was unable to attend but Matt Powls and Hugh McGarel-Groves (CCG) were in attendance for specific items
Chris Miller (Safeguarding Boards for Adults and Children's)

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

None.

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

None.

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

None were received.

6. BARNET'S HEALTH PROTECTION PROFILE - PUBLIC HEALTH ENGLAND REPORT (Agenda Item 6):

The Chairman invited Dr Tania Misra (Consultant in Communicable Disease Control, Public Health England) to join the meeting to deliver the presentation on the Annual Health Protection Profile for Barnet.

Dr Misra briefed the Board about the Health Protection Profile for Barnet which is prepared on an annual basis and provides a summary of the health protection issues affecting each borough.

The Board was briefed on the health protection related incidents and noted that there were 45 such incidents and outbreaks in Barnet reported to the North East and North Central London Health Protection Team in 2014.

The total number of infectious diseases reported from Barnet was higher in 2014 (773) compared to 2013(676). The Board noted the upward trend in scarlet fever notifications in 2014 (75) compared to 2013 (26). There was also an increase in 2014 in the number of GI infections reported, including Salmonellosis, Shigellosis and VTEC E.coli. compared to 2013 The Board noted the importance of better detection processes and heard that reported coverage has improved.

Following a query from the Board, Dr Misra provided further summary information about Sexually Transmitted Infections (STIs), stating that whilst the prevalence of STIs in older people is increasing, the rate of STIs in young people in Barnet is lower than both the London and England rate. The Director for Public Health, Dr Andrew Howe, stated that consideration is being given to the procurement of a new sexual health service model to ensure health protection and prevention.

Action: For the Board to receive demographic information for Barnet in relation to STIs and HIV from Public Health England.

Action: Public Health England to update the Board about monitoring of the long term effects of scarlet fever and the administration of the BCG in Barnet.

The Chairman thanked Dr Misra for attending the meeting and delivering the presentation to the Board. The Chairman also noted that the Board will receive a Tuberculosis (TB) situational report at its meeting in July.

RESOLVED that the Health and Well-Being Board notes the contents of the report and the appendix as assurance of the Health Protection functions of Public Health.

7. BETTER CARE FUND - POOLED BUDGET PROGRESS (Agenda Item 7):

The Chairman introduced the item on the progress of the Pooled Budget of the Better Care Fund (BCF) which provides an update on the timetable for quarterly reporting of the BCF and the financial risk in the pay for performance element of the fund.

The Chairman welcomed the report and thanked the officers for their contribution to the positive progress that has been made towards the BCF pooled budget.

The Commissioning Director (Adults and Health), Dawn Wakeling, briefed the Board about the contents of the report. Ms Wakeling noted that since the last meeting of the HWBB, both organisations (the Council and Barnet CCG) have received endorsement from their governance bodies namely LBB Policy and Resources Committee and Barnet CCG Audit Committee to enter into a pooled budget. Ms Wakeling noted that there is early evidence of the positive impact of the integrated care services. Ms Wakeling explained that there are plans to roll out the Barnet Integrated Locality Team (BILT) to the west of the borough from the end of September.

It was noted that the HWBB will be required to sign off the quarterly reports prior to formal submission to NHS England and that reporting will be primarily based on the Barnet Part 2 template of the BCF submission. Due to timescales, the reports will be reported to the Board in retrospect having been signed off by Councillor Hart and Dr Debbie Frost. The Chairman asked for the reports to include RAG ratings, the Board endorsed the request for the reports to include RAG ratings.

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Ms Wakeling also informed the Committee about the information pertaining to the key metrics which will be presented to the HWBB on a quarterly basis.

Following queries from the Board, Ms Wakeling informed that in developing the BCF model, several engagement projects have been implemented involving service users and the voluntary sector. Furthermore, BILT will work to ensure that there is better participation across organisations.

The Board also noted the impact of the Government commitment for seven day NHS working - a number of social care services are already available at weekends and in the evening but consultant coverage in hospitals will need to be considered. Dr Charlotte Benjamin explained that GPs are exploring network working to ensure increased quality and good coverage.

The Board discussed the national issue of sustainable funding for social care. Ms Wakeling stated that there is a proportion of the BCF for protecting social care and future arrangements for the BCF will be communicated from Government in due course and communicated to the HWBB.

RESOLVED that:

1. **The Health and Well-Being Board notes the progress in in establishing the pooled budget fund between London Borough of Barnet and Barnet Clinical Commissioning Group.**

2. **The Health and Well-Being Board notes the timetable for Better Care Fund (BCF) quarterly reporting and agrees that the Chairman and Vice-Chairman of the Health and Well-Being Board continue to sign off progress reports, which will include RAG ratings, to NHS England.**

3. **The Health and Well-Being Board endorses the approach to address the identified potential financial risk.**

8. PROGRESS REPORT ON MENTAL HEALTH PROVISION (Agenda Item 8):

Dr Charlotte Benjamin (Barnet Clinical Commissioning Group) introduced the report which updates the Board on the current work undertaken by Barnet CCG and LBB relating to mental health service provision in Barnet.

The Board noted that following the commissioning intentions identified in the 'Redefining Adult Mental Health Social Care Project', the Adults and Safeguarding Committee will consider a detailed report on the proposed service specification later in the month.

Dr Charlotte Benjamin (Barnet CCG) briefed the Committee about the Mental Health Review and Reimagining Mental Health project. Dr Benjamin informed the Board that one of the key recommendations that followed from the review of the mental health care provision is that mental health care and support needs to be much more focused on service users with more support provided in primary care and community settings.

The Board was informed about the key themes which emerged from the Reimagining Mental Health workshop such as the continued involvement of people with mental health

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needs and carers and a provision of social care services through a community-based approach to shape future services. A successful breakfast morning meeting was held in May with residents and voluntary sector organisations to discuss how we take developments forward.

The Chairman welcomed the report and thanked Dr Benjamin for the progress update.

The Board heard about the uncertainty of the sustainability of Barnet Enfield Haringey Mental Health Trust and how mental health services were being looked at across North Central London.

Dr Andrew Howe, Director of Public Health (Barnet and Harrow) briefed the Committee about the positive feedback as a result of the work that was commissioned to employment support and return to work initiatives; the employment pilot supported 1 in 3 people to gain and retain employment.

Dr Howe informed the Board that a further update report will be brought to the HWBB on the results of the delivery of the initiatives to support people with a mental health problem into employment. **(Action)**

The Commissioning Director (Children and Young People) stated that this was an update about adult mental health and that the Board would receive a plan for Children and Adolescent Mental Health services (CAMHs) later in the year.

RESOLVED that the Health and Well-Being Board notes and comments as appropriate on the progress on current interrelated work on mental health service provision within Barnet CCG and LBB.

9. BARNET CCG OPERATIONAL PLAN 2015 - 2016 (Agenda Item 9):

The Chairman introduced the item which sets out the Barnet CCG Operational Plan for 2015-2016 and the Plan's focus on Quality, Access, Innovation and Value for money.

The Chairman invited Mr Matt Powls, Performance and Planning (Interim), Barnet CCG, to join the table.

Mr Powls briefed the Board about the contents of the Operational Plan as set out in Appendix A to the report.

The Board raised the following:

- The Chairman requested that the plan should include more detail on the work undertaken by the CCG in relation to child sexual exploitation, safeguarding, domestic violence and violence against women and girls.
- It was highlighted that CLCH is included but not the Royal Free as they occupy different aspects of the health economy
- Page 15 includes figures from 2012, the Chairman requested that the most up to date data is used.

Mr Powls informed the Board that revisions will be made to the Operational Plan outside of the meeting to address the points raised (**Action).**

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RESOLVED that the Health and Well-Being Board notes the Barnet CCG Operational Plan 2015-2016 Report.

10. CCG ANNUAL REPORT AND ACCOUNTS (Agenda Item 10):

The Chairman introduced the report and noted that the Board is asked to consider the Barnet CCG Annual Reports and Accounts. The Chairman invited Mr Hugh McGarel-Groves (Chief Financial Officer, CCG) to join the meeting.

Mr McGarel-Groves briefed the Board on the contents of the Annual Report and the information as set out in Appendix One of the report which is required to be published prior to 5th June 2015 in line with NHSE requirements.

The Board noted the strategic objectives and goals of the CCG. Mr McGarel-Groves drew attention to the financial overview and informed the Board that the improvement is due to a number of factors including some additional NHS England funding, but principally due to close monitoring and control of expenditure throughout the year. A risk exists for the current year as a number of provider contracts have not been finalised.

The Chairman asked whether the £10 million saving in demand management had caused any negative impacts. Dr Barry Subel informed the Board that there has been no negative impact on patient care and no increase in complaints. Dr Subel went on to describe the improvements that had been made to patient pathways to ensure that patients were referred to the right place, at the right time. Dr Subel did comment that the longer term view was not clear yet.

RESOVED that the Committee considers NHS Barnet CCG's Annual Report and Accounts and comments on the extent to which the CCG has met the priorities set out in the Annual Health and Wellbeing Strategy.

11. PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 11):

The Chairman welcomed the report on the Pharmaceutical Needs Assessment which covers the current need for pharmaceutical services and the future need over the coming three years in Barnet.

The Chairman noted the statutory responsibility of the Health and Well-Being Board to undertake a Pharmaceutical Needs Assessment by virtue of the Health and Social Care Act 2012.

Following a query from the Board, Dr Howe noted the importance of improving access to advanced pharmaceutical services. Dr Andrew Howe informed the Board about the recommendations in the report, mainly for NHS England, which consider the access to pharmaceutical services across the Borough, the location of pharmacies, their opening hours and the services being delivered.

It was also noted that due to the potential increase in local population size and demand over the next three years, there may be a need for up to two further pharmacies

providing essential services and that opening hours could be improved through extended opening hours and weekend opening.

Dr Clare Stephens stated that NHS England has a role to consider pharmacy facilities as part of all building programmes. Dr Howe agreed to raise this at a planning group meeting **(Action).**

RESOLVED that the Health and Well-Being Board notes the report and the appendices and approves the Pharmaceutical Needs Assessment for publication on the Council's website as required by the Health and Social Care Act 2012.

12. WINTERBOURNE VIEW - ASSURING TRANSFORMATION (Agenda Item 12):

The Chairman introduced the item and noted the positive progress made and the ongoing work to improve and adapt services to meet patients' needs. The Chairman informed the Board that the CCG Audit Committee had recently considered a similar report.

In relation to the Care and Treatment Reviews, Ms Wakeling noted that the majority of the reviews undertaken have identified that the care and support needs can be met within an appropriate community setting. Following the reviews, the Board heard that action plans will be implemented to continue to improve engagement with families and carers where possible. Ms Wakeling highlighted that all decisions are taken with the best interest of the person at the centre.

RESOLVED that the Board notes the contents of the report and appendix to the report including the progress made on patient discharges, the update on patients subject to the Winterbourne View Concordat and the current position in delivering the Assuring Transformation programme.

13. MINUTES OF THE FINANCIAL PLANNING SUB-GROUP (Agenda Item 13):

The Board noted the standing item on the agenda, Minutes of the Financial Planning Sub-Group, which included the minutes of the meeting held on 18th March 2015.

It was noted that the changes set out at paragraph 1.6 of the report will be discussed at the next Financial Planning Group and reported to the Board on 30th July 2015.

RESOVED that the Health and Well-Being Board notes the minutes of the Financial Planning Sub-Groups of 18th March 2015.

14. MINUTES OF THE HEALTH AND SOCIAL CARE INTEGRATION PROGRAMME BOARD (Agenda Item 14):

The Board noted the standing item on the agenda, Minutes of the Health and Social Care Integration (HSCI) Board, from the meeting held on 19th March 2015 and the actions points as listed under paragraph 1.8 of the report.

RESOLVED that the Health and Well-Being Board notes the minutes of the Health and Social Care Integration Board of 19th May 2015.

15. FORWARD WORK PROGRAMME (Agenda Item 15):

The Chairman introduced the item which lists the forward work programme of the Health and Well-Being Board.

The Board noted the items listed for the September meeting which includes a report on the Primary Care Strategy and an update report on Opportunities to Align Public Health and Planning teams.

The Chairman welcomed the Board to contribute items to the Forward Plan and align these with their own delivery plans.

RESOLVED that the Health and Well-Being Board notes the Forward Work Programme and proposes any necessary additions and amendments to the forward work programme (see Appendix 1).

16. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 16):

There were none.

The meeting finished at 11.45am

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AGENDA ITEM 6

	Health and Wellbeing Board **30 July 2015**
Title	**Draft Joint Strategic Needs Assessment (JSNA) and emerging priorities for the Health and Wellbeing Strategy**
Report of	Director of Public Health
Wards	All
Date added to Forward Plan	March 2015
Status	Public
Enclosures	Appendix 1: Contents of draft JSNA Appendix 2: Summary of identified needs from the JSNA Appendix 3: Draft JSNA
Officer Contact Details	Luke Ward, Commissioning Lead, Entrepreneurial Barnet, Email: luke.ward@barnet.gov.uk, Tel: 020 8359 2672

Summary

This briefing provides an update on the development of Barnet's Joint Strategic Needs Assessment (JSNA), which is currently at draft stage (appendix 3), and seeks the views of the Health and Wellbeing Board on its content and format before it returns to the Board in final form on 17 September 2015.

Recommendations

1. **That the Health and Wellbeing Board notes the content of the draft JSNA (appendices 1-3) and comments on its findings, including any areas to be developed further.**
2. **That the Health and Wellbeing Board give views about which areas highlighted in the draft JSNA it considers should inform the content and priorities of the Health and Wellbeing Strategy, which will be presented in draft form to the Board on 17 September 2015.**

3. That the Health and Wellbeing Board notes that the final JSNA will return to the Board on 17 September 2015 for sign off.

1. WHY IS THE REPORT 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 Health and Wellbeing Strategy.

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 support joined up, evidence-based decision making and commissioning by the Barnet Health and Wellbeing Board, Barnet CCG, social care, public health, the wider public and voluntary sectors, and providers.

1.2.2 Producing a JSNA is 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 JHWSs, through the Health and Wellbeing Board.

1.3 How can the JSNA be used?

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 help facilitate 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 prevention, early intervention and demand management across organisational boundaries.

1.3.2 The intention is that by having a shared understanding of the size and nature of Barnet's people in one place that focuses on 1) the needs of the population, irrespective of organisational or service boundaries, 2) areas of common or shared interest and 3) reducing demand for scarce resources whilst also improving outcomes, 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.

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

1. Focus on **prevention, early intervention and demand management**
2. **Use 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. Align with and **support existing and more specific service-level needs assessments e.g. for mental health**
5. Be **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. **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.

1.3.4 Alongside the written "paper" JSNA that is out in Appendix 3, **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 LB Barnet and Barnet CCG logos.

1.3.5 The JSNA **may also provide a platform to commission early intervention work using an "ecosystem" approach,** for example in relation to working with the voluntary sector to reduce social isolation whilst increasing volunteering levels and improving the borough's parks and green spaces at the same time.

1.3.6 A detailed content for the JSNA is contained within Appendix 1.

1.4 **Methodology**

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

1. **Focus on developing ownership** at senior level across LBB and the 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 future demand pressures, CCG operational plans etc.
5. **Supporting the Health the Well Being 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 **Key findings**

1.5.1 The findings of the JSNA are divided into two broad sets. **The first relates to generally understood needs and demand pressures**, updating and expanding them to incorporate the most current data and analysis, and to make them more focused and relevant to decision makers.

1.5.2 **The second category relates to significant and cross-cutting issues** that have been identified and which present new opportunities and challenges for the partnership, and may require additional thought and leadership in the period ahead. These new issues tend to be longer-term in nature and connect traditionally different areas of public service.

1.5.3 Demographic demand pressures

- **Barnet's population is continuing to grow**, and we are now the largest borough in London by population. Fastest growth correlates with regeneration areas, with Golders Green, Colindale and Mill Hill being the wards the GLA is projecting to have the fastest rate of population growth over the next 15 years.
- **The >65 population is growing at three times the rate of the total population**. Brunswick Park, Hale and Coppetts Wards are anticipating even faster rates of ageing.
- **Barnet's population is becoming more diverse**, driven predominantly by natural change in the established population. In particular, >50% of the 0-4s are in Barnet are from a BME background.
- **The large majority of referrals to social care are from either primary or secondary care settings**, with only a small minority coming from friends, family and established networks. Could more be done to encourage these groups to do more to refer earlier, before a small health problem becomes a crisis?
- **Smoking, bad diet, and a lack of exercise are main causes of premature death** in Barnet.
- Coronary Heart Disease and Cancer are the main causes of death for men and women in Barnet.
- Barnet has a **lower than average percentage of people** with mental health conditions and learning disabilities in work than other areas.
- The CCG has identified **delayed transfers of care** as an area of growing demand, with an upward trend in numbers.
- Crime in Barnet is relatively low, however burglary rates are higher, and **there is strong evidence to suggest that significant under-reporting of crime amongst young people** who have been victims.
- Resident's tell us that the**ir top concerns are the condition of roads and pavements, and the affordability of housing.** Overall resident satisfaction with Barnet as a place to live is lowest in Burnt Oak, correlating with many other poor outcomes in that area.

- **Growing number of people with mental health conditions** as the population. Mental Health has been identified by the CCG as their number one demand pressure.
- **A need for a different kind of relationship with carers, particularly young carers**, to support them into a successful adult life.

1.5.4 Key longer-term issues, challenges and opportunities for future work

- **There is a long term shift away from home ownership and towards renting. This has implications for the funding of social care when the current cohort of working age adults, who are less likely to own, grows older as they will have less wealth on average to self-fund** using the value in their property. This group may also have lower savings/alternative sources of wealth as a greater proportion of this will have been spent on rent than is currently the case. More work is needed to understand and model the impacts of this change.
- **The JSNA has identified a number of strong proxy indicators that evidence says could be used to target and intervene much earlier to reduce high life-long levels of demand**. The strongest proxy identified is child admissions to hospital with tooth decay. More work is needed to understand the opportunities associated with taking a more joined up and holistic referral and commissioning approach to these children and their families to reduce intergenerational need.
- **Inequality is rising in the borough**. Strong growth in average borough incomes is driven predominantly by the most affluent wards. The poorest (Burnt Oak and Underhill in particular) have experienced no nominal growth over the last 2 years (and a real terms fall).
- **Social isolation is associated with higher wealth, areas of lower population density, and less established social networks**. These areas have been identified and are incorporated into the JSNA and there is an opportunity to reduce demand by working with VCS groups, particularly befriending schemes, dinner clubs etc., to help reduce isolation and associated needs/demand pressures. Could isolated people also be encouraged to volunteer in parks and grounds maintenance, which insight tells us this group likes to do?
- **The JSNA has identified sectors in the economy (care, leisure and retail in particular) where employers tell us they find it difficult to recruit to.** We have also identified work needed to help schools match their offer (in terms of both academic study and wider vocational careers/employability advice) with the local demand for labour. There is an opportunity to bring these issues together and support younger people who may have higher levels of need and unemployed residents into the labour market at a population level using JSNA analysis.
- Male life expectancy is converging with that of females, as men live for longer. **In the future as they live longer. What are the implications of this on need and service design**?
- **The JSNA includes evidence about which interventions and investments are most effective at reducing future demand to health and social care**. Housing is rated as number one, followed by a range of

established public health interventions and more holistic good parenting support. It may be useful to apply some of these interventions to the Barnet population, guided by the HWB Strategy, to understand whether they might have a positive and cost effective impact on outcomes.

1.5.5 The complete set of findings from the JSNA is presented in Appendix 2.

1.6 **Informing the Health and Wellbeing Strategy (2016 – 2020)**

1.6.1 Following a review of the current emerging findings from the JSNA, priorities are being considered for each theme (themes remain from the current HWB Strategy). Ideally there would be one key priority for each theme with other areas of importance highlighted in the section:

1.6.2 **Preparation for healthy life** (Children's Trust / HWBB): This priority is still subject to discussion, the current priority areas being considered include –

- The role of early year's settings in improving and maintaining health and wellbeing – the HWB Strategy would take an active role in promoting early years setting as a place for service delivery (in line with integration) to improve outcomes for children, young people and the wider community.
- Child tooth decay – area of concern highlighted in the JSNA refresh, with links to child poverty and deprivation. Multi agency targeted approaches required.
- Child Sexual exploitation would be included in this section with the HWBB's duty to ensure that this agenda is considered as important by all members and partners.

1.6.3 **Wellbeing in the community** (CCG and LBB): It is recommended that this theme has the priority of mental health in the community. This would build on the HWBB's recent role in reviewing our vision for mental health in the borough and would become the HWB Strategies key priority for year one with the HWBB overseeing and driving the importance of mental health and wellbeing. This would incorporate –

- Maternal mental health
- Toxic trio (domestic violence, mental health and substance misuse) – highlighted in the Early Intervention and Prevention Strategy and the JSNA as a key issue for poor outcomes for Barnet's children
- Undiagnosed mental health problems (including dementia)
- Children and Adolescent Mental Health – key joint priority for the CCG and LBB
- Improved Access to Psychological Therapies
- Reimagining Mental Health work led by the CCG

- Redefining mental health social care
- Progress around supporting people with mental health problems to gain and retain employment (including work with Job Centre Plus)

1.6.3.1 The HWB Strategy would have a role in ensuring a whole family approach to service delivery and intervention, ensuring that services working with vulnerable adults identify children and young people affected (including young carers) and make appropriate, early referrals.

1.6.3.2 This theme will also identify healthy workplace and workforce as a priority. HWBB member organisations to become champions of the healthy workforce agenda. LBB are currently exploring the London Healthy Workplace Charter and in discussions with the CCG about their initiatives.

1.6.4 **How we live** (Public Health): It is recommended that this theme has the priority of healthy lifestyles, for the reduction of obesity and to prevent long term conditions, with the particular focus on - increasing participation in physical activity for all residents to reduce obesity and the prevalence of long term conditions – linked with parks and open spaces and taking into account inequalities in participation highlighted by the JSNA.

1.6.4.1 Substance misuse would be included in this section with the role of HWB Strategy to raise the awareness of substance misuse would be highlighted with the Community Safety Partnership the main driver for this area, reporting to the HWBB as necessary.

1.6.4.2 This section will also discuss the housing needs in the borough including changes in tenure with an increase of people renting (as highlighted by the JSNA), appropriate housing for care leavers, people with disabilities and older people and understanding the causes of homelessness in the borough (linking with the Housing Strategy).

1.6.5 **Care when needed** (LBB and CCG): It is recommended that this theme has the priority of:

- Carers including young carers and identification, championing the needs of carers and the positive role and contribution that they play in the health and social care system

1.6.5.1 This section would give an overview of health conditions in the borough from the updated JSNA and cover areas of concern for example tuberculosis.

1.6.5.2 This section would highlight the integration work and progression needed, stating this as a way of working across the strategy rather than a specific priority – through health and social care services (through the Better Care Fund), work around transitions, pathway reviews as well as with other boroughs and CCGs (particularly in North Central London)

1.6.5.3 Getting the basics right would be included in this section highlighting duties under the Care Act and Children and Families Act as well as the CCG's priority to improve primary care. This section would also champion the increased use of technology within health and social care, service quality and safety as well as the roll out of Personal Health Budgets.

2. REASONS FOR RECOMMENDATIONS

2.1 Producing a JSNA is 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 JHWSs, through the Health and Wellbeing Board

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not producing a JSNA would create a risk of non-alignment across the Health and Well Being Board membership, may result in decisions being made either in silos or based on sub-optimal evidence and intelligence, and increase the likelihood of unnecessary duplication and overlap of public sector spend.

4. POST DECISION IMPLEMENTATION

4.1 Following discussion by the Health and Wellbeing Board the JSNA will be used to inform the content of the Health and Wellbeing Strategy, and to develop the JSNA website that will sit alongside the paper/PDF JSNA.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The JSNA supports evidence-based decision making across the Health and Well Being Board, and informs the priorities set out in the Health and Well Being Strategy and aligns with the aims of the Barnet Council Corporate Plan 2015-2020.

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 Wellbeing 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.

5.3 Legal and Constitutional References

5.3.1 Producing a JSNA is 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 JHWSs, through the Health and Wellbeing Board

5.3.2 The Health and Wellbeing Board, at its meeting on 13 November 2014, recommended that work commence on developing a JSNA to inform the Health and Wellbeing Strategy.

5.3.3 The Council's Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health and Wellbeing Board which 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 agree a Health and Well-Being Strategy for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.
- To consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.
- 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.
- To promote partnership and, as appropriate, integration, across all necessary areas, including the joined-up commissioning plans across the NHS, social care and public health.
- Specific responsibilities include overseeing public health and developing further health and social care integration.

5.4 **Risk Management**

5.4.1 There is a risk that if the JSNA 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.

5.5 **Equalities and Diversity**

5.5.1 The JSNA has equalities embedded at its core, explicitly covering the current and future needs of people in Barnet from every equalities group and socio-economic background. 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.

5.6 **Consultation and Engagement**

5.6.1 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.

5.6.2 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.

6. BACKGROUND PAPERS

6.1 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

Appendix 1: Contents of the draft JSNA

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Appendix 2: Full list of identified needs from the JSNA

Chapter 2 - 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 goes higher 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 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.**
- 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 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.
- Some areas, particularly Golders Green, Colindale and Mill Hill, will get younger, bucking the trend of an ageing Borough.

Chapter 3: 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.

Chapter 5: Health

- 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.**
- **There is 8 Years 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.
- Overall rates of individual mental health problems are lower in Barnet than London and England; however **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.**
- **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 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 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.

Chapter 6: 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 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**.

Chapter 7: CCG

- 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.
- **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**. The 95% national target was missed in quarter 4 (Q4 RFL 94.3%).
- Limited of 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.

Chapter 8: 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 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 in special schools is causing **a 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, 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.

Chapter 9: 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**, **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.**
- **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**.
- **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%.

Chapter 10: 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 increase under reporting.
- **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 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.

Chapter 11: 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. **There is however 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 engaged with better to deliver health and wellbeing outcomes.

Chapter 12: 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 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 less likely to be satisfied with Barnet as a place to live**.

- According to data from the spring 2014 Resident's 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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Barnet's Joint Strategic Needs Assessment

2015-2020

Logos

Logos

CONTENTS

1 Introduction

Executive summary (Appendix 2) to be added here

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.

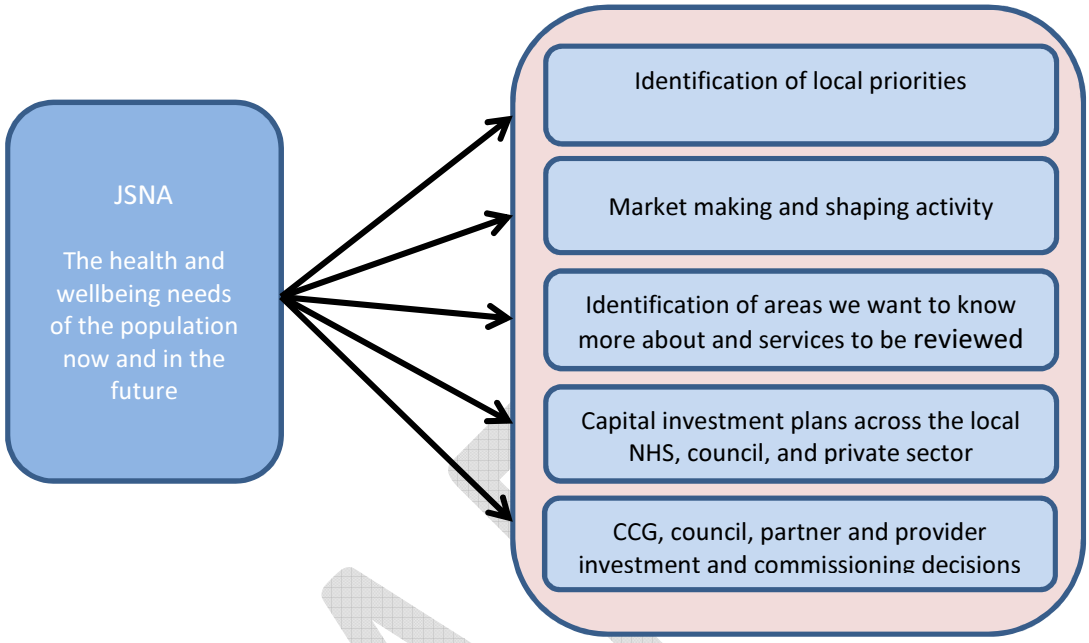
1.2 Purpose of the JSNA

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 our 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, happy 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.

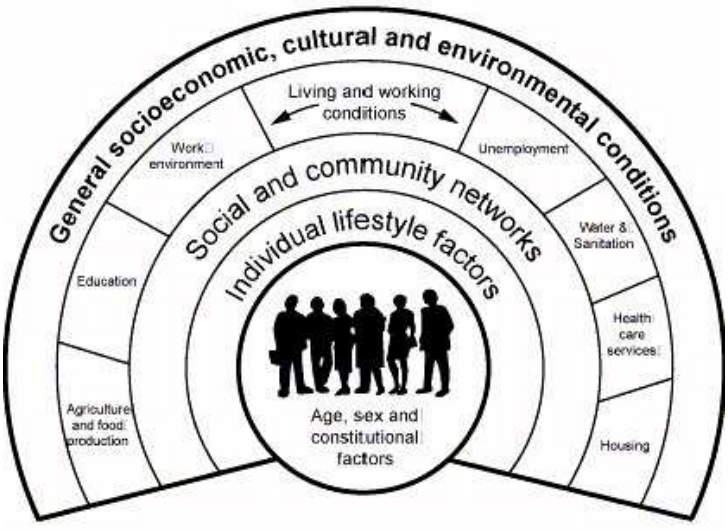
3. **Use existing data only:** There has been no primary data collection associated with this JSNA, which only includes insight and analysis that already exists in the Public Sector. This reflects the fact that analyst time is increasingly valuable and scarce, but also the huge amount of information 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: *Dhalgren 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:

1. Demography
2. Socio-economic context
3. Lifestyles
4. Health of the population
5. Children in Barnet
6. Adult and Community Services
7. Primary and secondary care in Barnet
8. Community Safety
9. Community Assets
10. Resident perceptions and user voice

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 also a number of specific groups who will use the JSNA:

- 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, TESTING INTERNALLY (April – June 2015)***
4. ***ENGAGEMENT AND SIGN OFF (July – September 2015 – not yet delivered)***
    a. Present draft findings at Health and Well Being Board in July 2015 – high level messages drawn out to inform the Health and Well Being Strategy
    b. Signoff Final JSNA at H&WB Board on September (TBC), with the draft H&WBS to follow in November.

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
- Support more holistic "place-based" commissioning and a strategic shift to long-term demand management
- 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 (wording to be developed)

- Worked hard to ensure all data is accurate and the most up to date, but where errors are identified they will be 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, but does not does not replace them because the level of detail they contain is more appropriate for service-level planning than the JSNA, which is higher level and more strategic in nature.

1.10 Further Research

Areas of possible future research have been identified throughout the development process:

- Understanding impact of reduced housing ownership on the financial viability of social care.
- More work is needed to determine the prevalence 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 equality behind wards in the Borough.
- Further research is needed to model the demand pressures in Barnet, caused by the growth in Dementia rates.
- 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.
- In order to respond to the shift in growing community provision, additional work is needed to develop a better understanding of the level and type of needs of people with learning disabilities and Autism.
- Understand if and why, there is a deficiency in the usage of enablement services within Barnet.
- Additional research is needed to understand why there are significantly fewer men aged 65 and over using Adult Social Care services.
- 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.

2 Chapter 2 - Demography

2.1 Key Facts

- The most recent population projections indicate that the population of Barnet will be 367,265[1] 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 BAME population projected to increase from 38.7 to 43.6% of the total Barnet population.
- By religion, Christianity is the largest religion in Barnet with 41.2% (146,866 people). The next most common religions are Judaism (15.2% (54,084)) and Islam (10.3% (36,744)).
- 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 goes higher 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 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**.
- 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.

[1] 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

- 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.
- Regen – some areas will get younger, bucking the trend of an ageing Borough, 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). By gender, the male population increased by 16.3% (25,180) compared to the female population which grew by 13.7% (22,585).

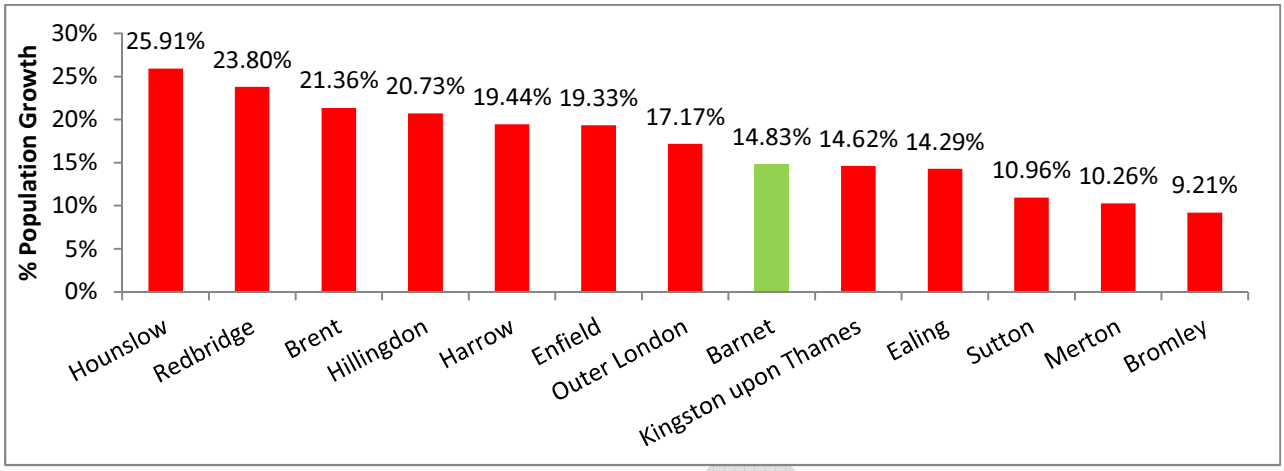
Table 2-1: Barnet Population Growth, 2001 – 2015

Year	Total Population	Male Population	Female Population
2001	319,500	154,400	165,100
2002	320,500	154,900	165,600
2003	321,800	155,000	166,800
2004	323,700	155,800	167,900
2005	327,500	157,300	170,200
2006	330,800	158,800	172,000
2007	334,900	161,100	173,800
2008	339,200	163,600	175,600
2009	345,800	166,900	178,900
2010	351,500	170,000	181,500
2011	357,500	173,400	184,100
2012	363,958	177,038	186,920
2013	361,504	176,272	185,232
2014	364,481	177,998	186,483
2015	367,265	179,580	187,685

Source: ONS Vital Statistics Table 4 and Nomis Labour Market Profile

Figure 2-1 shows the population growth for Barnet, compared against statistical neighbours 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

2.4 Population Growth

Table 2-2 shows the latest 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.

Table 2-2: Population Projections by Broad Age Structure 2015, 2021 & 2030 (Barnet)

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%

[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

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%

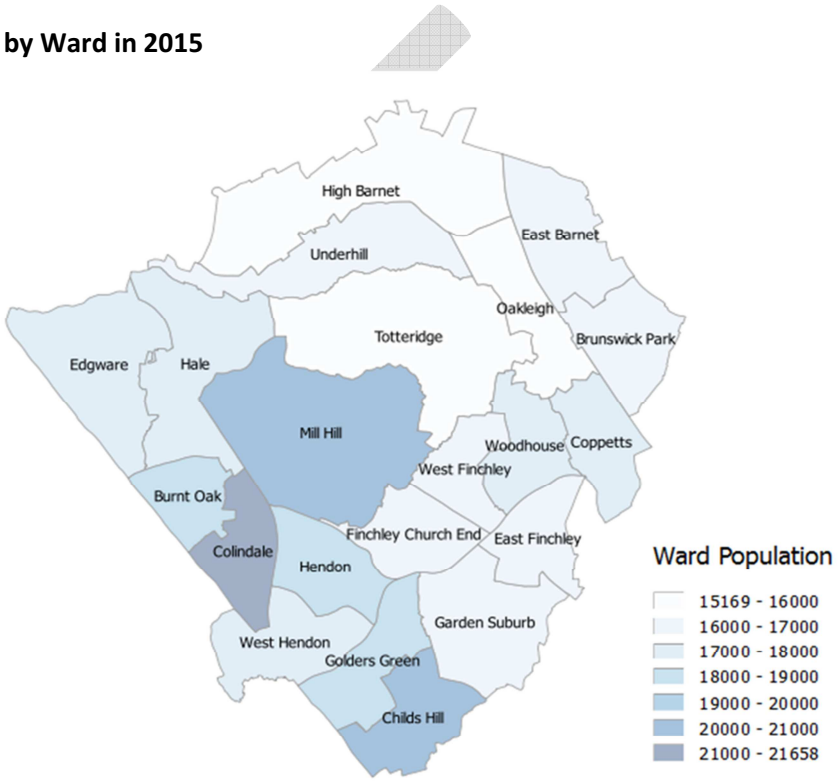
Source: GLA 2013 Projections

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

Since 2001 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

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% (21,625)).
- Not all Wards are projected to increase in population size over this period with the largest proportional decreases projected in Coppetts (-3.1%(-541)) and Hale (-2.3%(-402)).

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

One of the major driving forces of growth in the west of the Borough is the planned development taking place in this area. As can be seen in Figure 2-3 and 2-4, the Wards with the greatest projected increases in population, directly correlate with the planned regeneration localities.

Figure 2-3 : Planned Regeneration Works

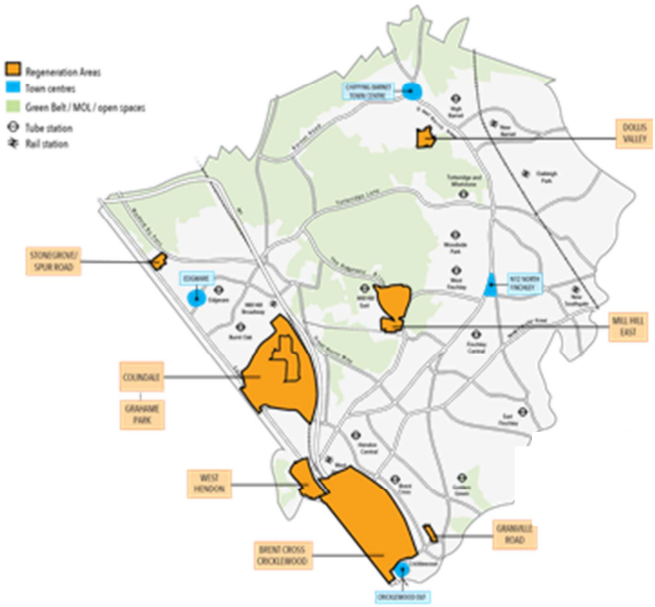
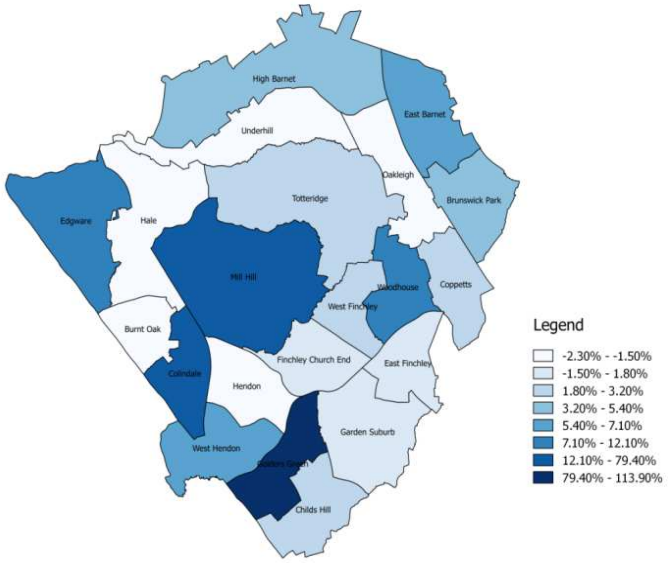


Figure 2-4: Barnet Population Growth by Ward 2015-2030



Source: GLA Projections 2013

2.7 Age 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 Figure 2-5.

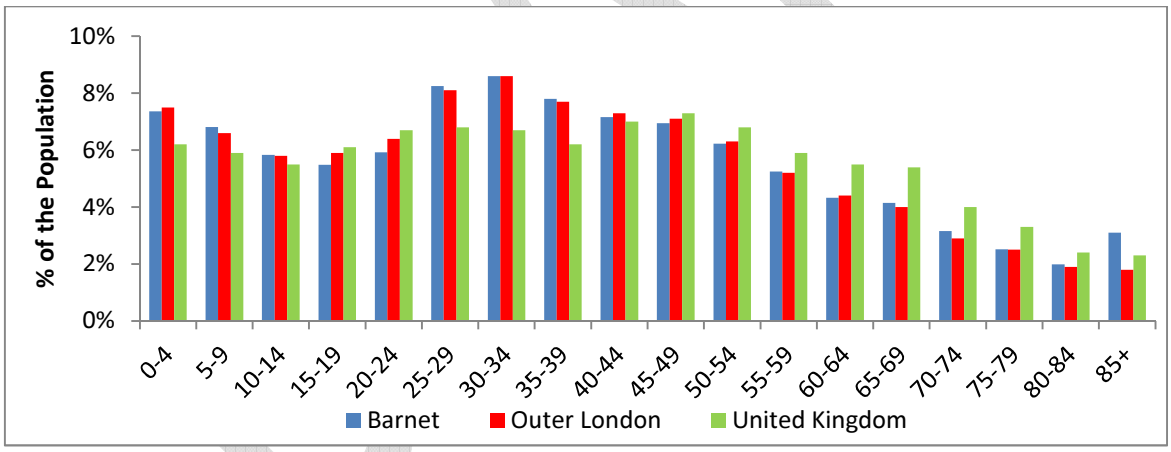
Table 2-5: Population 2015, by Broad Age Group (Barnet, Regional and National)

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 and ONS Mid-year Projections 2012

- 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 likely to be driven by the high life expectancy rates experienced within Barnet.
- 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 mean 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.

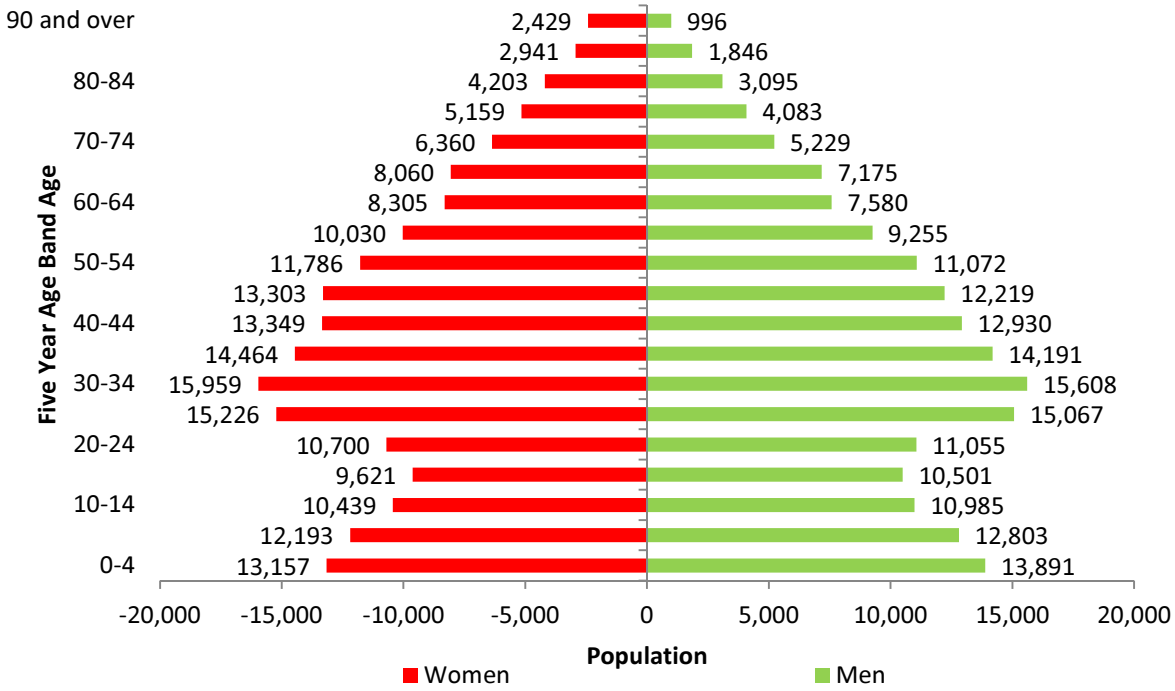
Figure 2-5: Population % by Five Year Age Band in 2015 (Barnet, Regional and National)



Source: GLA 2013 Projections and ONS Mid-year Projections 2012

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 2-6, 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 2-6: Barnet Population by Age Band and Gender in 2015



Source: GLA 2013 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)

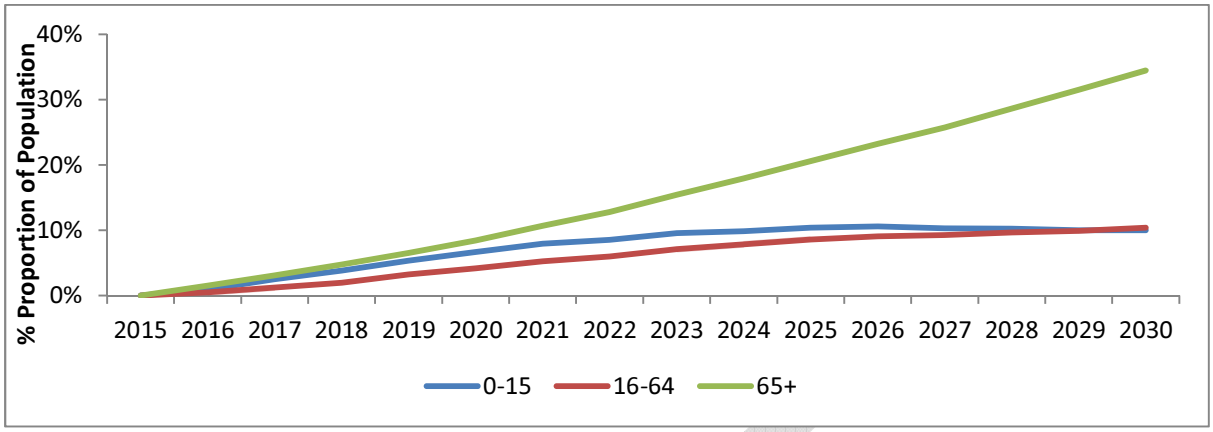
Age Group	2015	2021	Change	% Change 2015-2021	2030	Change	% Change 2015-2030
0-15	77,789	83,966	6,177	7.9%	85,560	7,772	10.0%
16-64	237,901	250,408	12,507	5.3%	262,648	24,747	10.4%
65+	51,576	57,098	5,522	10.7%	69,364	17,789	34.5%

Source: GLA Projections 2013

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 2-7: Barnet Population Growth by Broad Age Structure 2015 –2030



Source: GLA Projections 2013

Table 2-7 below shows the proportion of people aged 65 and over by ward. Currently 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 can be expected, as growth in these areas is likely to be predominantly 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	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

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.

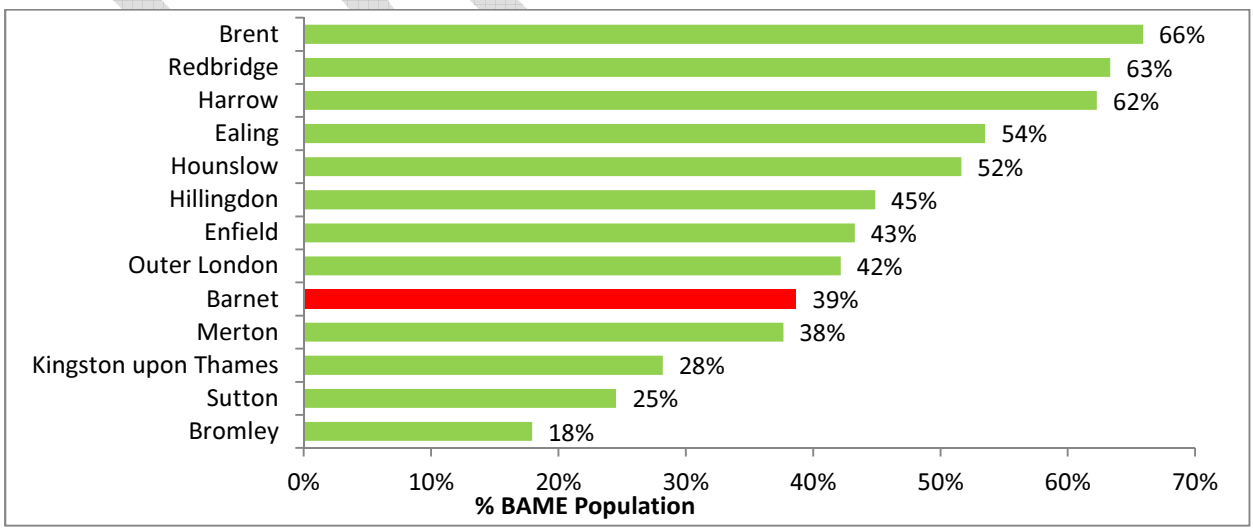
Table 2-8: Population by Ethnicity, 2015 (Barnet and Regional)

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%
BAME	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

In comparison to Barnet's statistical and geographical neighbours, Barnet has a relatively low BAME population (39%); whereas 66% of Brent's population are BAME.

Figure 2-8: Population by BAME Groups, 2015 (Barnet, Regional)

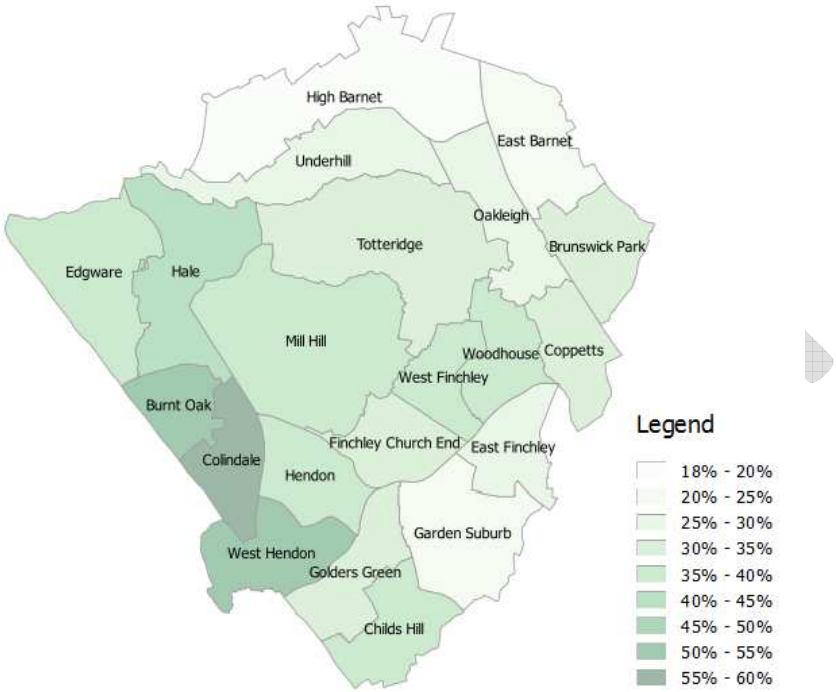


Source: GLA Projections 2013

However, certain areas within the Borough have a higher proportional BAME population than the Borough average. Data from the 2011 Census provides a breakdown of the ethnic profile of Barnet by Ward.

The BAME population in Barnet varies significantly by Ward, with the highest rates of BAME populations generally found to the West of the Borough. Based on the 2011 Census, Colindale, Burnt Oak and West Hendon all have populations where BAME residents make up over half of the population; this is significantly above the Borough wide average of 39%.

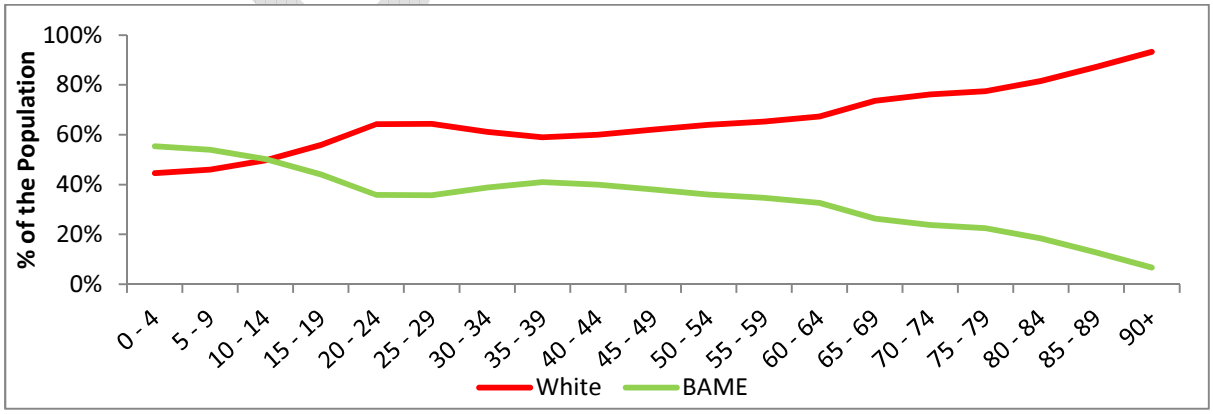
Figure 2-9: Population by BAME Groups by Ward, 2011



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 BAME groups are found in the 0-4 age group (55.4%).

Figure 2-10: Barnet Population by Ethnicity by Age, 2015



Source: 2013 GLA 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 BAME is projected to increase by 4.9% (40,040), rising from 142,074 to 182,144. This will mean that the BAME proportion of the total population will rise from 38.7% to 43.6%.

All BAME groups are projected to increase in number during the period 2015 to 2030, although the Indian ethnicity will reduce in its proportion of the total population (7.5% 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%
BAME	142,074	162,729	182,114	38.7%	41.6%	43.6%

Source: GLA Projections 2013

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 2-11 and 2-12 show the population of the Borough by Ward, by Jewish and Muslim.

Figure 2-11: Barnet Jewish Population by Ward

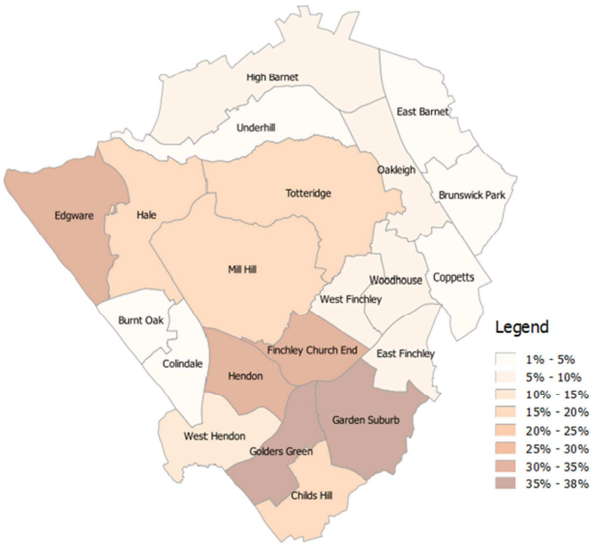
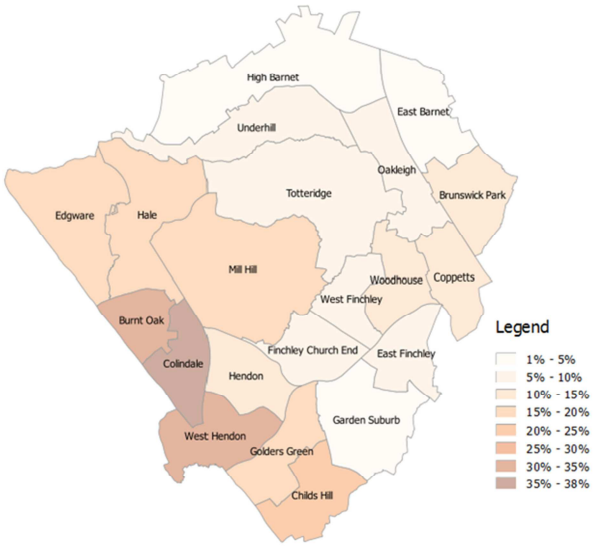


Figure 2-12: Barnet Muslim Population by Ward



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. The natural increase is 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% (8 births per year).
- After 2021, the number of births is projected to start marginally decreasing by an average 0.1% each year (-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) each year.
- In 2021 the number of deaths within the Borough is projected to begin rising by an average 0.9% (9) 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 decline of -4.9% (156) in natural change over the period 2014-2030.

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 -4,216 people during 2024-2030.
- Research by the 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.
- The data suggests that as people become older, a higher proportion of people move out of London. They suggest that drivers of this could be the cost of housing, with people moving outside London to enable them to buy their first house; or environmental factors such as seeking less urban areas to raise children (ONS, 2014).

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

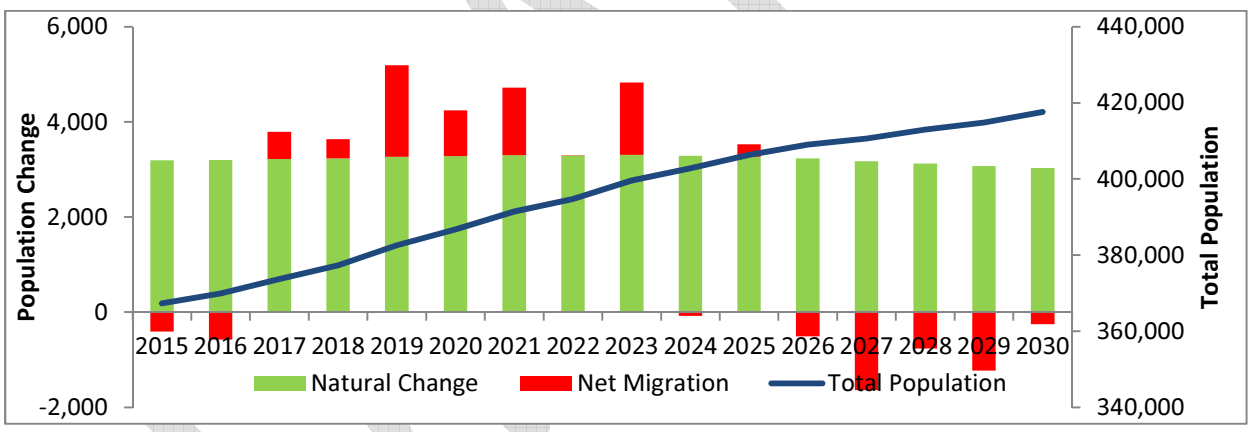
[3] These projections are trend-based, with assumptions made based on recent trends in migration. They give an indication of what future migration levels might be if recent trends continued. They are not forecasts and take no account of policy nor development aims that have not yet had an impact on observed trends and so actual migration levels are likely to be different.

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

- As can be seen by Figure 2-13, 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 2-13: Population Projections by Drivers of Growth (2015-2030)

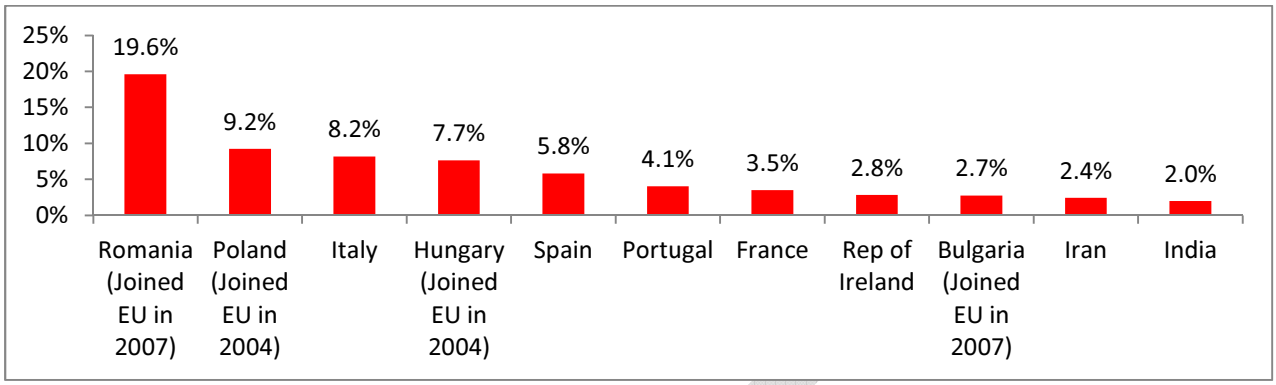


Source: GLA Projections 2013

2.10.3 International Migration

We can use National Insurance registrations of overseas nationals as an indication of the nationality of international migrants. Figure 2-14 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 2-14: Number of New Migrant Workers by their Country of Origin, 2013/14

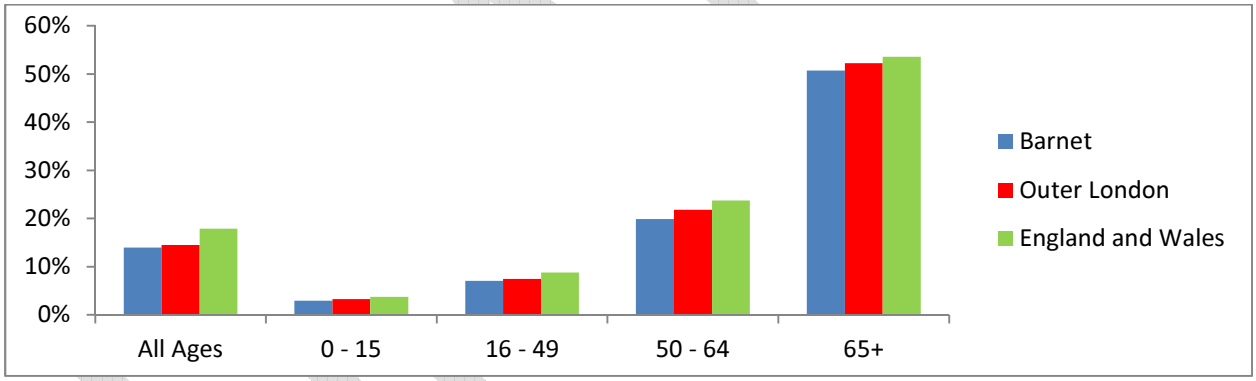


Source: National Insurance Number Registrations of Overseas Nationals, Borough

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 2-15: Proportion of Population Whose 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.

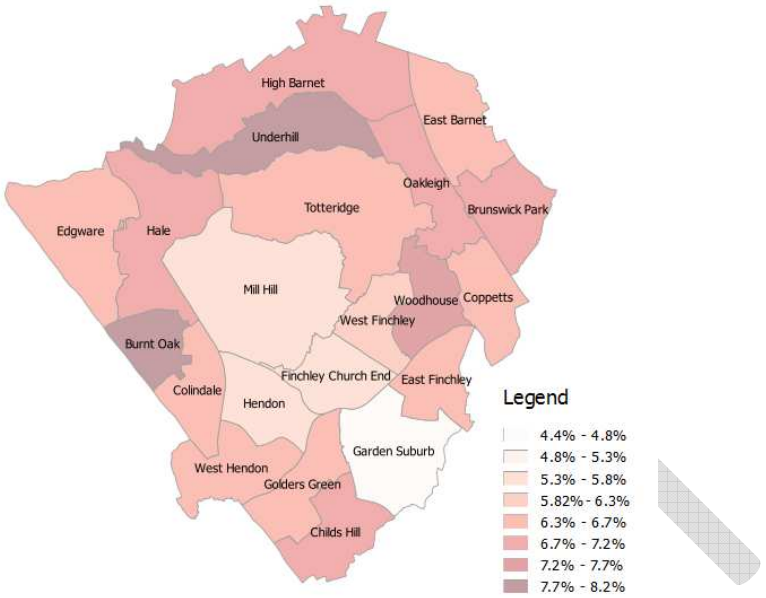
Table 2-14: Proportion of Population Whose Activity is 'Limited a lot or a little' in 2011 (Ward, Barnet, Regional, and National)

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 2-16 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 2-16: Proportion of Population Whose Activity is 'Limited a lot' by Ward, 2011



Source: 2011 Census

2.11.1 Types of Disability

We have no definitive data on the amount of people with disabilities within the Borough, although by applying national prevalence rates to the Barnet population we can 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

- 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

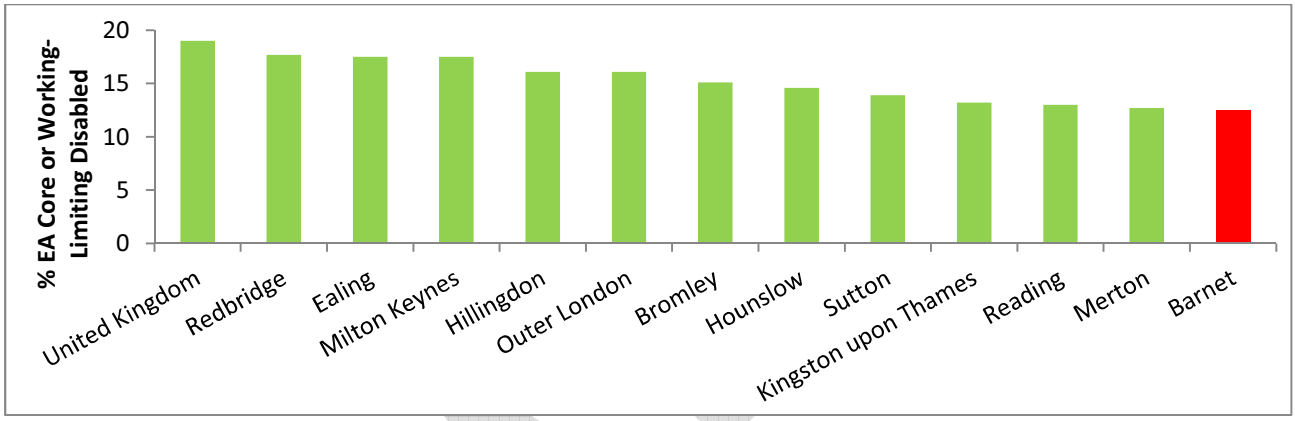
- Over 10% of men and almost 20% of women aged 18-64 have some form of common mental health disorder. Apart from antisocial personality disorders, women have a higher prevalence across all types of mental health disorder.

- 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 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 2-17: % aged 16-64 who are EA core or work-limiting disabled (Barnet and Statistical neighbours)



Source: Annual 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 2-18: % aged 16-64 who are EA core or work-limiting disabled, by gender (Barnet and Statistical neighbours)

Source: Annual 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.

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: Annual Labour Force Survey (October 2013 – September 2014)

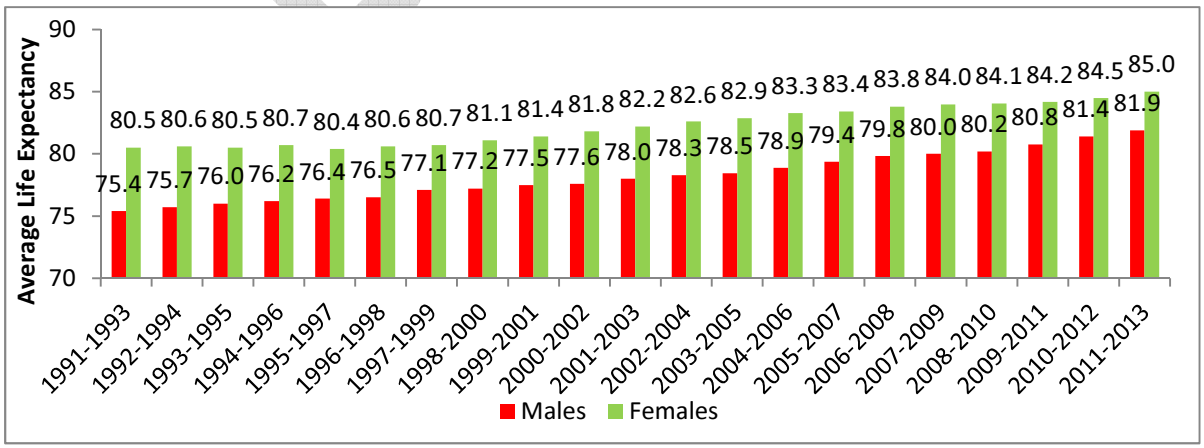
2.12 Life Expectancy

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 2-19 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 2-19, 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 2-19: Life Expectancy at Birth within Barnet by Gender, 1991-2013



Source: ONS 2013

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 most deprived decile will 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 most deprived deciles will 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

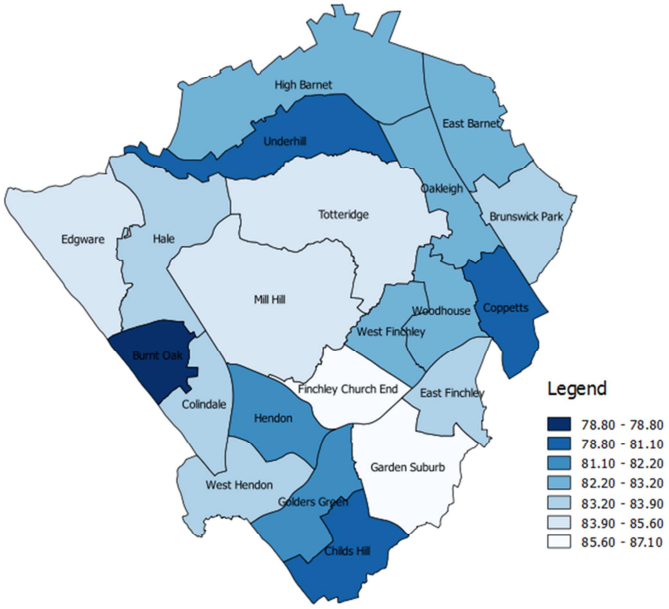
The ONS provides pooled figures on the life expectancy rates by Ward. Table 2-19 and Figure 2-20 display the latest figures for Barnet. Although many of the Wards have life expectancies close to the Borough average, there are some significant outliers.

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

Source: ONS 2013

Figure 2-20*:* Life Expectancy at Birth within Barnet by Ward, 2009-2013



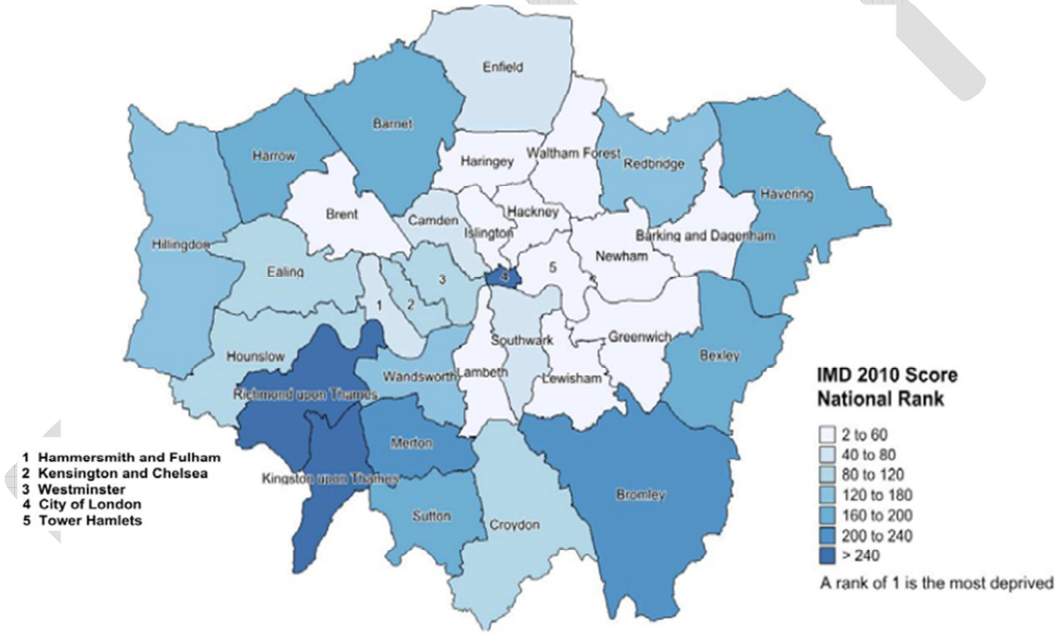
- Burnt Oak has the lowest life expectancy from birth, 78.8. This is 4.2 years behind the Barnet average and 8.3 years behind Garden Suburb, which has the highest age of 87.1.
- Whereas, Coppetts has the lowest life expectancy at 65, 18.0. This is 3.1 years below the Barnet average of 21.1 and 6.3 years below Edgware, which has the highest age of 24.3.

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 higher 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.

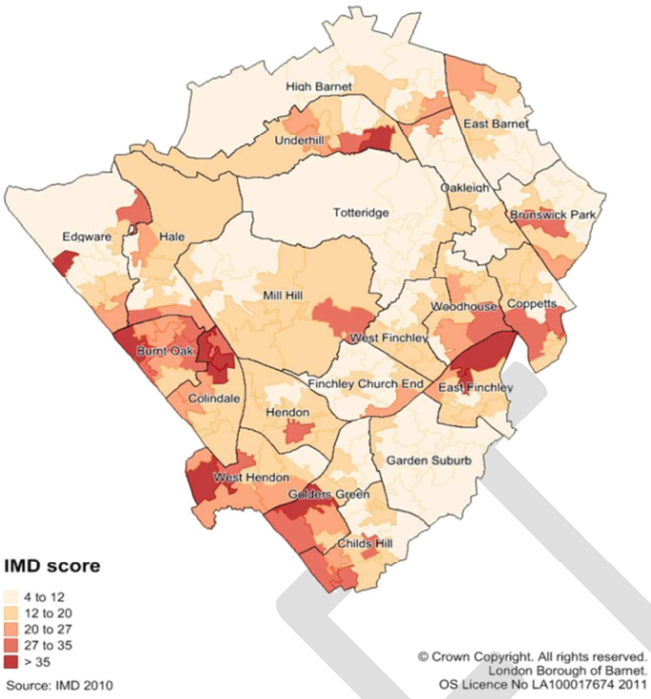
Figure 2-21: National Rank of IMD 2010 Scores for London Local Authorities



Source: ONS LA IN 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 2-22: 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.

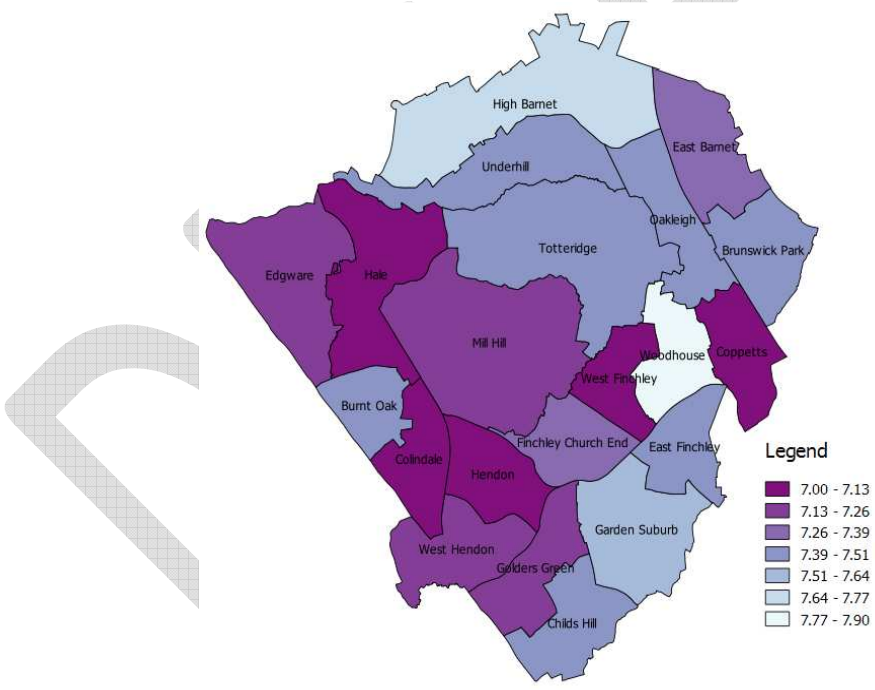
Table 2-20: Wellbeing Scores 2011-2014 (Barnet)

	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

By ward, we don't have the breakdown by each variable however the ONS does provide aggregated score, which is comprised of a combination of all four variables.

Figure 2-23: 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 Chapter 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 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.

3.3 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.

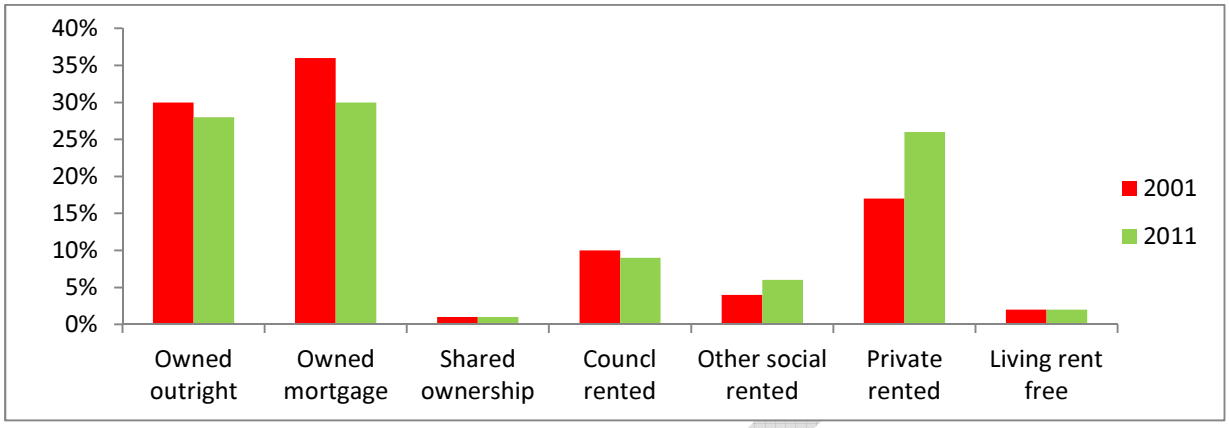
Data from the last census indicates that in 2011 the average household in Barnet consisted of 2.6 persons and 2.7 bedrooms.

Following the 2008 economic downturn, mortgage repossessions 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.

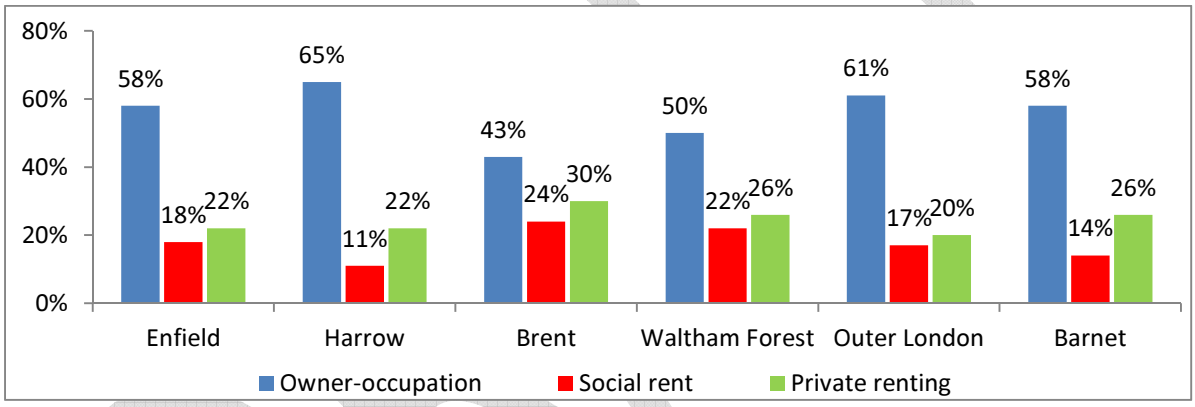
Figure 3-1: Housing Tenure in Barnet, 2001 and 2011



Source: ONS, 2011

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.

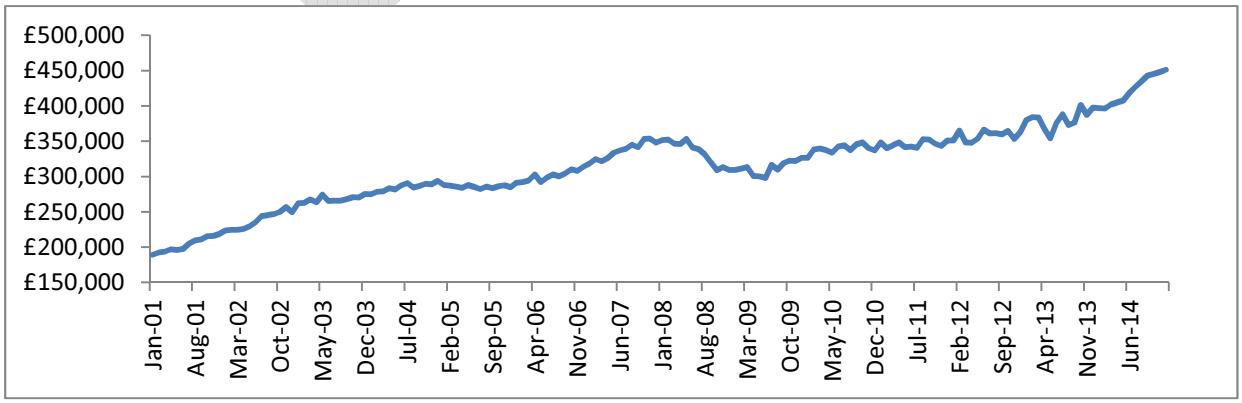
Figure 3-2: Housing Tenure by Borough, 2011



Source: ONS, 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.

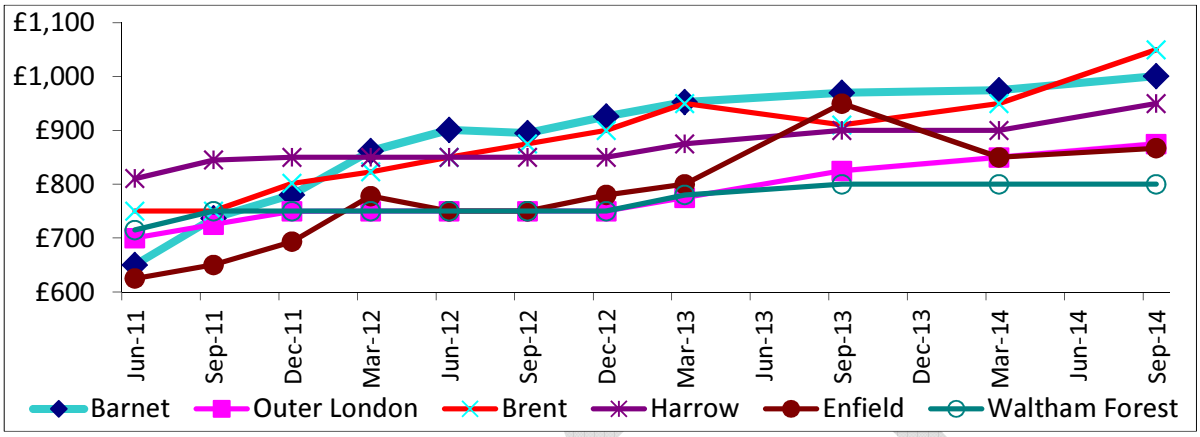
Figure 3-3 Average House Prices in Barnet, January 2001 – December 2014



Source: Land Registry House Price Index

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

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 of 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 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[4] and increasing the housing choices available for the elderly, we expect 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.

[4] Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society– Communities& Local Government Feb 08

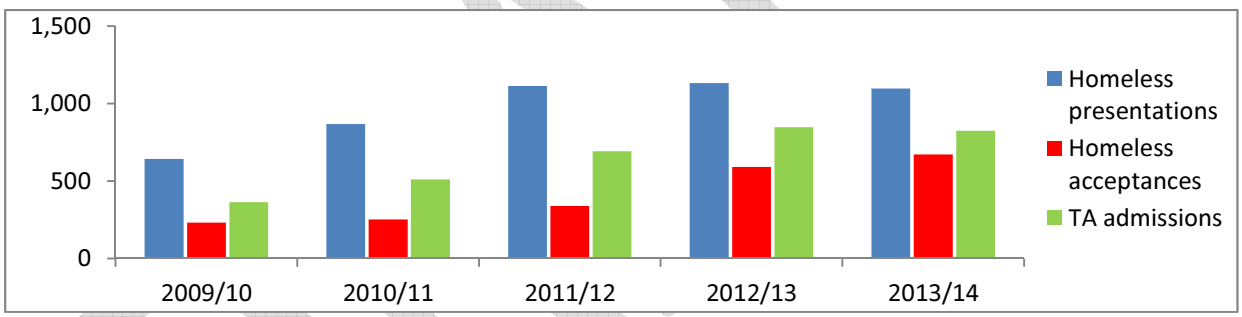
3.3.4 Temporary Accommodation and Reducing Homelessness

The number of households presenting as homeless and the number of households being accepted as homeless has 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.

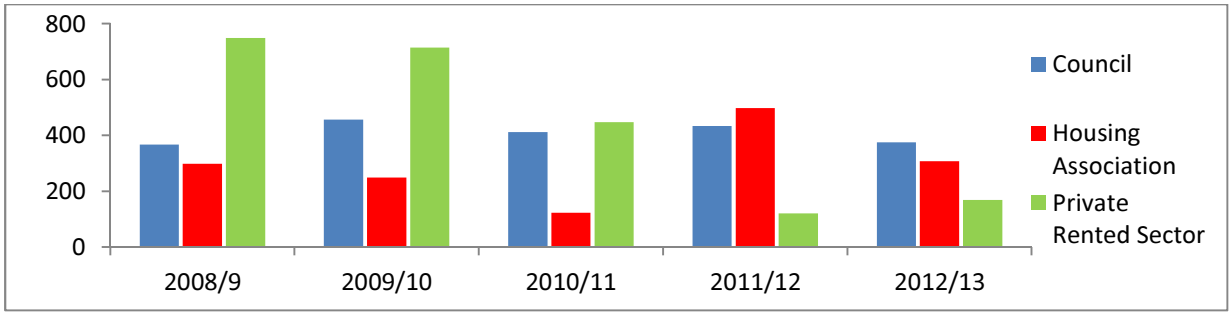
Figure 3-5*:* Increased demand for housing within Barnet, 2009-2014



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 been particularly 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



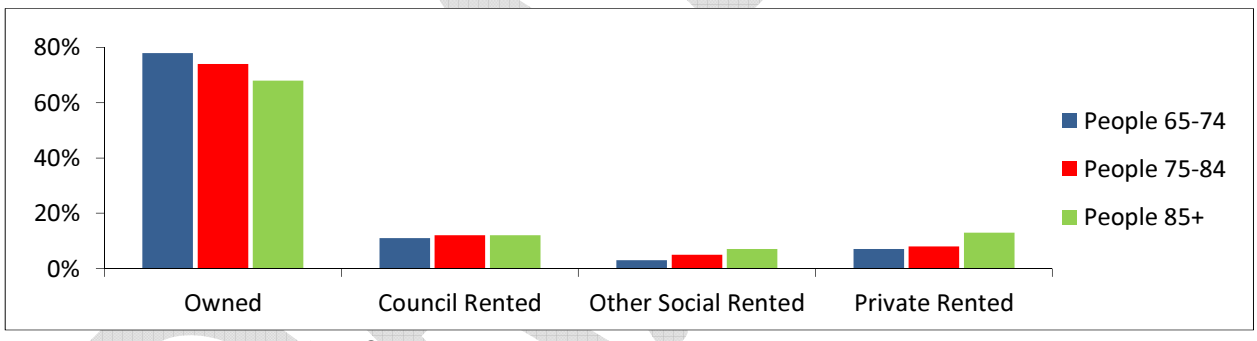
Source: Barnet Council Data

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.

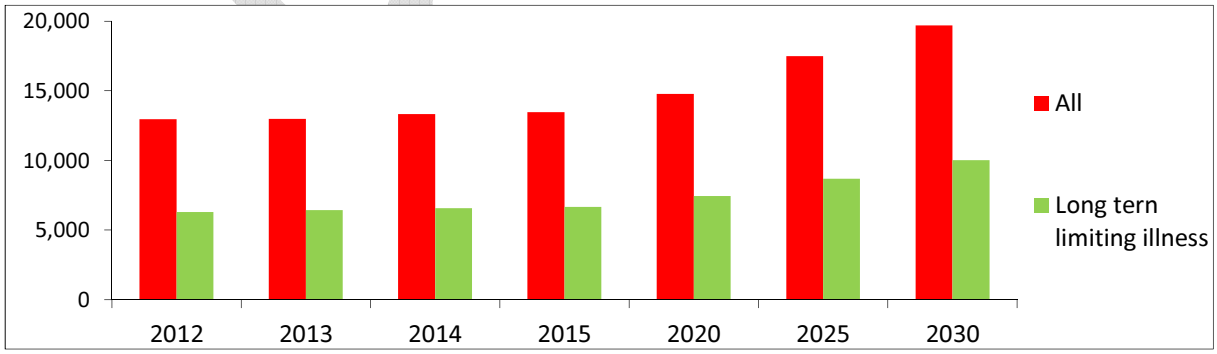
Figure 3-7: Older People and Housing Tenure, 2011



Source: GLA 2013 Projections & 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 & 2011 Census

We know that 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 rises that the number of people requiring care will also increase, particularly amongst those that live beyond the age of 85, and figures from the Department of Health suggest that the number of people over 65 with limiting long term illnesses, including heart conditions, dementia, and diabetes is likely to increase by over 4,000 by 2020.

Table 3-1: Projected Number of Older People with a Limiting Long Term Illness in Barnet, 2012-2020

Age	2012	2020	Change
65-74	8,608	10,288	+1,680/+20%
75-84	7,976	9,241	+1,265/+16%
85+	4,336	5,653	+1,317/+30%
All 65+	20,920	25,182	+4,262/+20%

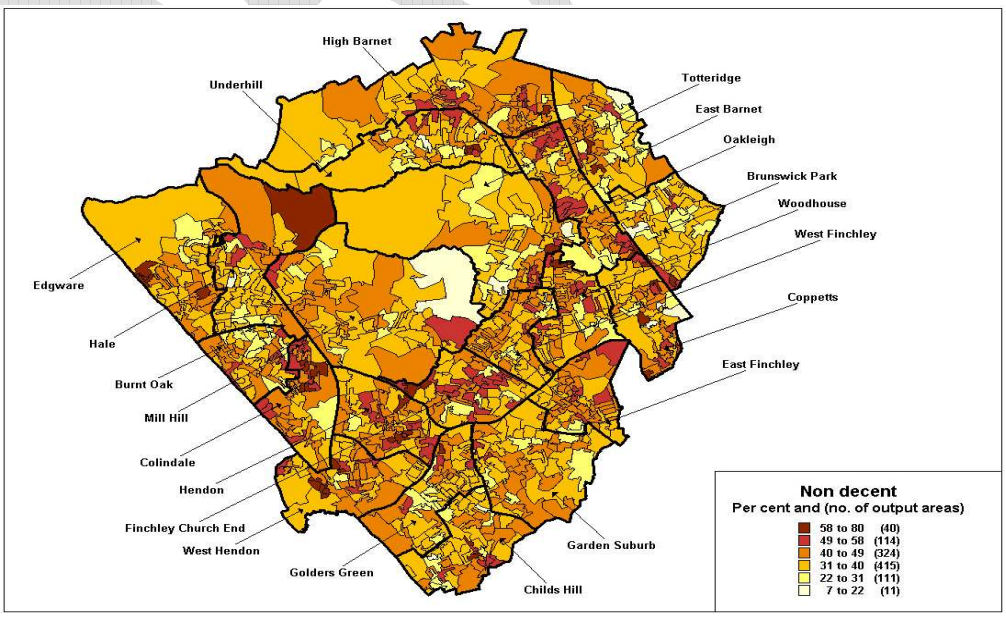
Source: Department of Health

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.

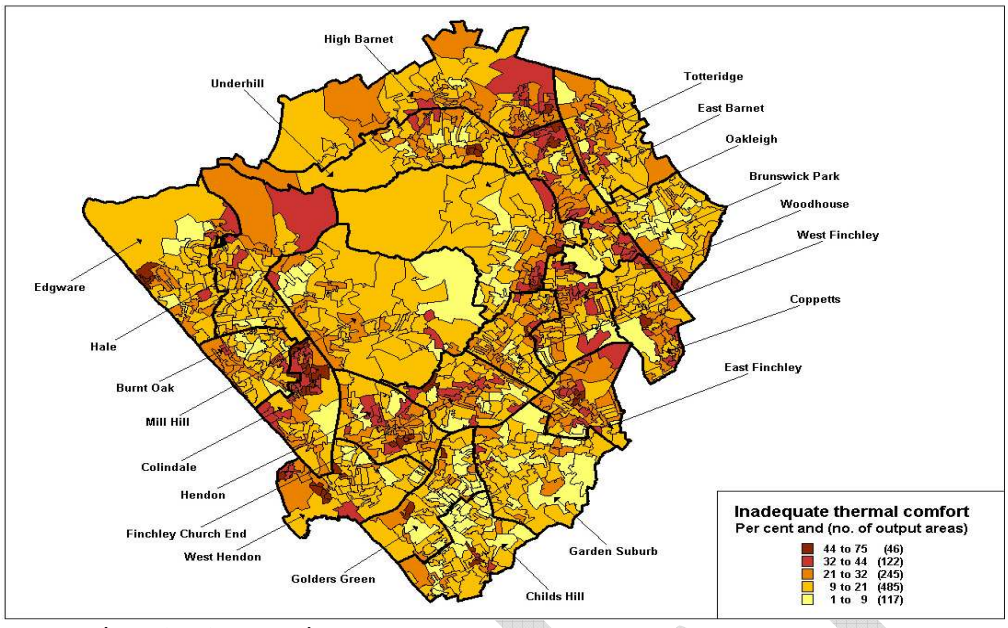
Figure 3-9: Non-decent homes in the private sector within Barnet, 2009



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

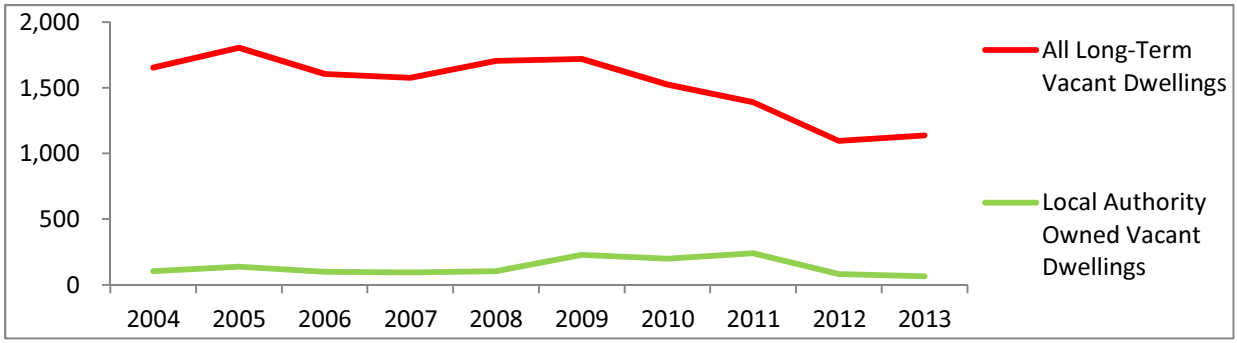
The role of the private rented sector in meeting the housing needs of the Borough has increased significantly over the last decade. Between 2001 and 2011, the number of private rented homes rose from 17% to 26% of homes in the Borough. Our analysis of affordability and housing need going forward suggests 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



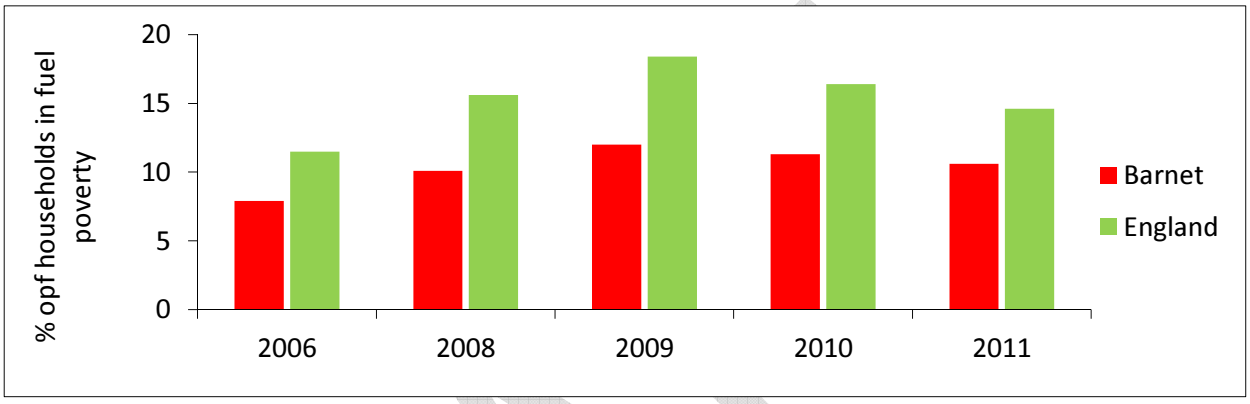
Source: Department for Communities and Local Government

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

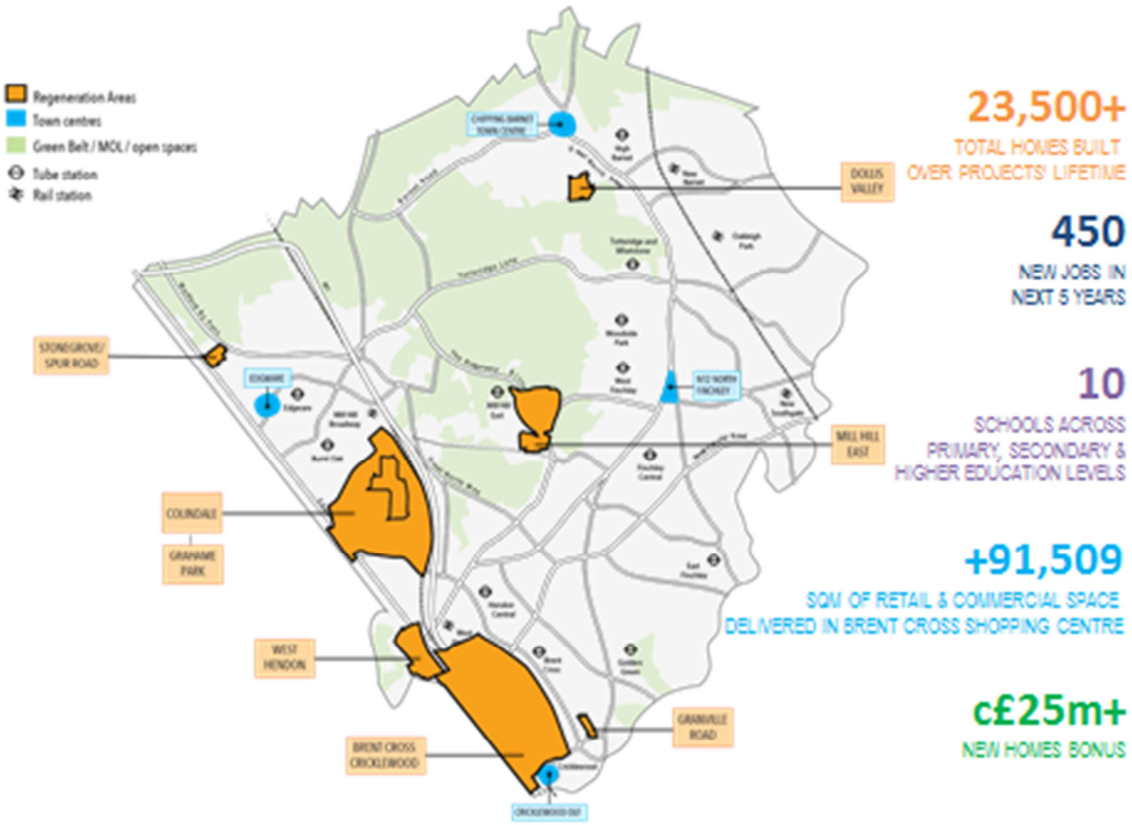
The level of excess cold hazards is considered an issue given the increasing numbers of older residents in Barnet.

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

We 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[5].

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

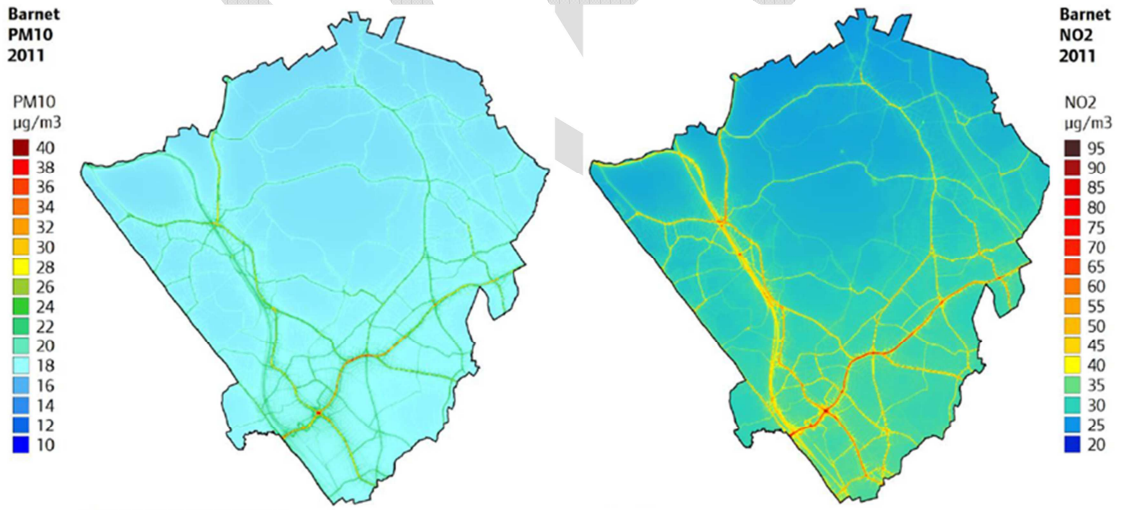
For the majority of the population the health impacts of air pollution are not obvious, however, smaller numbers of the population are more vulnerable to the effects of air pollution, as exposure to pollution can exacerbate existing health conditions including cardiovascular and respiratory disease. This can lead to restricted activity, hospital admissions and even premature mortality[6].

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.

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

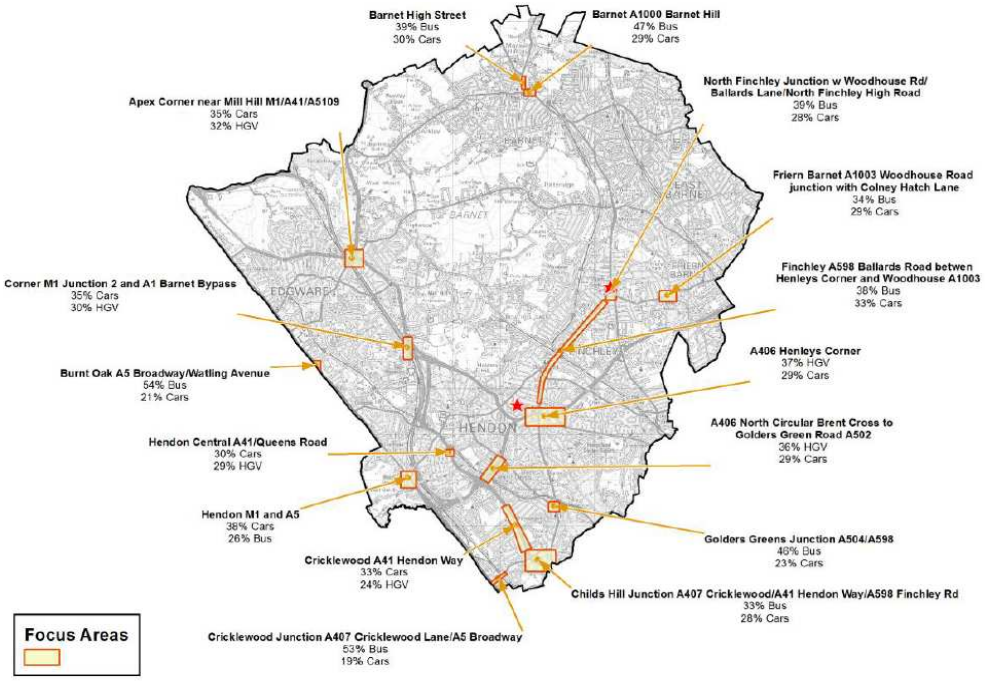
In 2011 air quality focus areas were selected by the GLA as areas where there is the most potential for improvements in air quality within the Capital. These areas have been selected through an analysis of factors such as current and predicted air quality; population and traffic patterns.

[5] AEA for the Department of Energy and Climate Change: Local and regional CO2 Emissions Estimates for 2005-2012

[6] https://www.london.gov.uk/sites/default/files/Air%20Quality%20for%20Public%20Health%20Professionals%20-%20LB%20Barnet.pdf

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[7]. Frequenting a park has also been found to reduce stress-related illness which has a positive effect on mental wellbeing[8].

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%)[9].

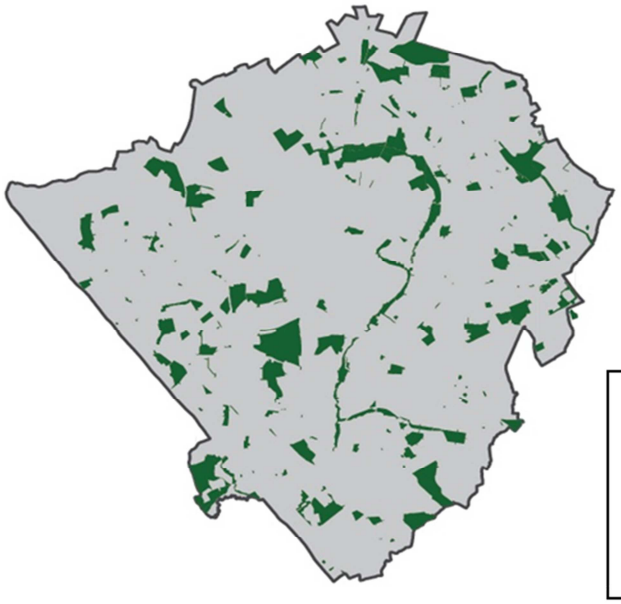
Generally speaking, the west of the Borough had lower satisfaction with parks than the east. With the exception of East Finchley, the wards with the lowest satisfaction were all in the Hendon constituency.

7 SPA Consultation, 2013

8 Grahn, P., and Stigsdotter, U.A. (2003). Landscape planning and stress. Urban Forestry and Urban Greening 2 (1): 1-18.

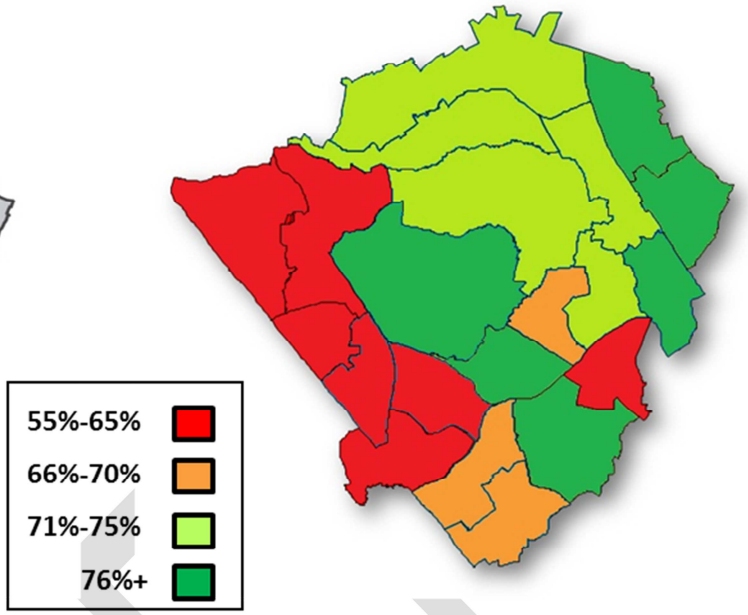
9 Residents' Perception Survey, 2014

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.
- 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.

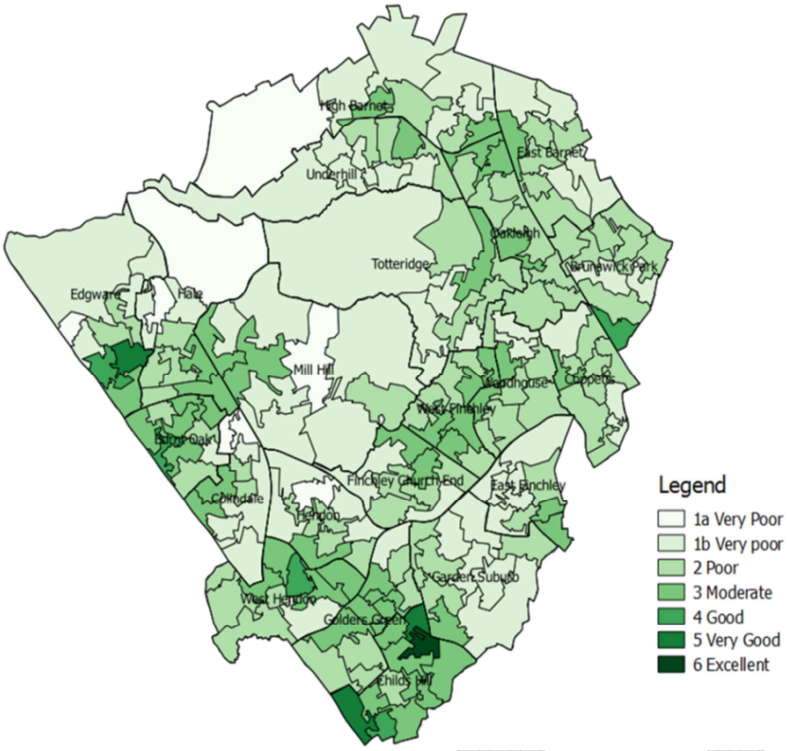
3.4.4 Transport

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[10]. Transport for London (TfL) produces an annual review of accessibility to public transport by for each Borough, broken down by LSOA.

10 Lucas, K. (2012) Transport and social exclusion: Where are we now? Transport Policy, 20, 105-113

Figure 3-19: Public Transport Accessibility Levels in Barnet, 2014



Overall Barnet is rated as having 'poor' access to public transport which is below the 'moderate' rating given to London to 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.

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%[11]. This trend has resulted in high street sales of things 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 do online like restaurants, beauty salons, gyms and other products related to lifestyle, food and leisure. There are opportunities associated with an ageing population too, which 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.[12]
- 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[13].

[11] http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2014/sty-digital-day-2014.html
[12] http://www.londoncouncils.gov.uk/policylobbying/transport/parkinginlondon/parkingurban.htm
[13] IDBR annual data for March 2009 to March 2012

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%), 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.

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 -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[14].
- 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 Ballards Lane access route[15].

'The Economic Outlook for London'[16] 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.

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

- 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[17]. However since this time, the rate has begun to reduce with the unemployment rate at 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%.

[14] NOMIS annual BRES data 2008 to 2011
[15] BRES 2011
[16] Oxford Economics: http://web.oxfordeconomics.com/FREE/PDFS/UKMFEAT3_1012.PDF
[17] ONS Labour Market Profile – based on 16-64 age group

- 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.

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%

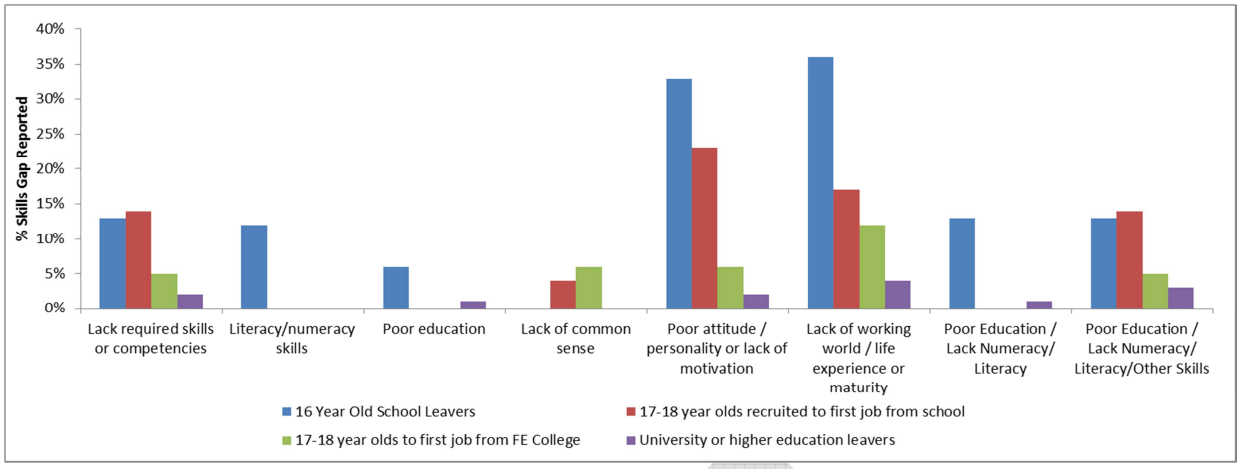
Source: UK Commission Employer Skills Survey 2013

- 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% 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%[18]. And 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[19].

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[1].

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.

Sheffield Hallam University has also done some work looking at 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, the government's Impact Assessment and benefit claimant data.

[18] NOMIS Labour Market Profile: ONS Annual Population Survey Jan 2013 – Dec2013
[19] GLA London Labour Market Projections, 2014
[1] LGA, August 2013

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	540	0.2%	9,070	0.3%	115,410	0.3%

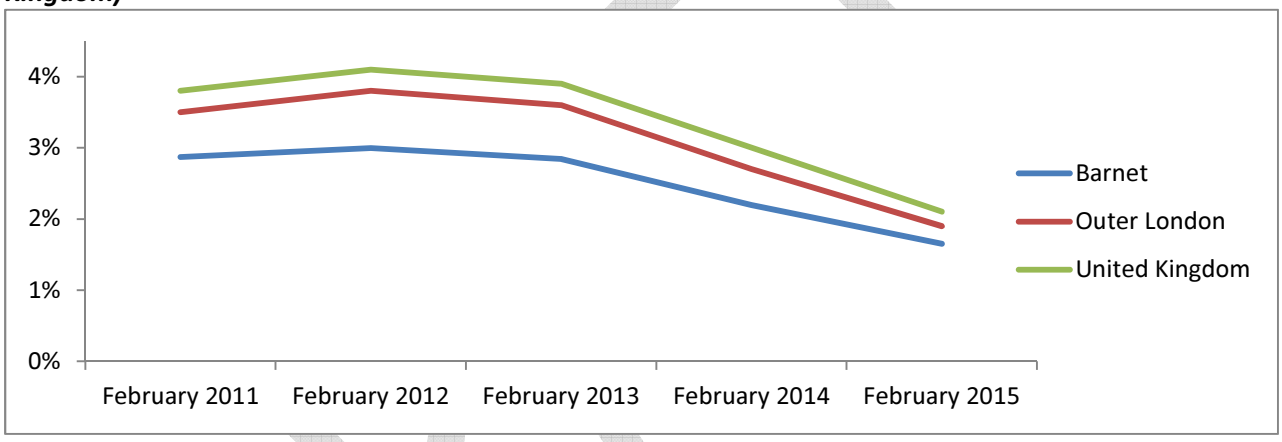
benefit						
Disabled	1,920	0.8%	30,330	0.9%	416,820	1.1%
Bereaved	360	0.2%	5,470	0.2%	64,900	0.2%
Key out-of-work benefits[20]	17,880	7.6%	288,590	8.6%	3,551,610	9.8%

Source: DWP benefit claimants - working age client group

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 Number of People Claiming JSA, 2011-2015 (Barnet, Outer London and United *Kingdom)*

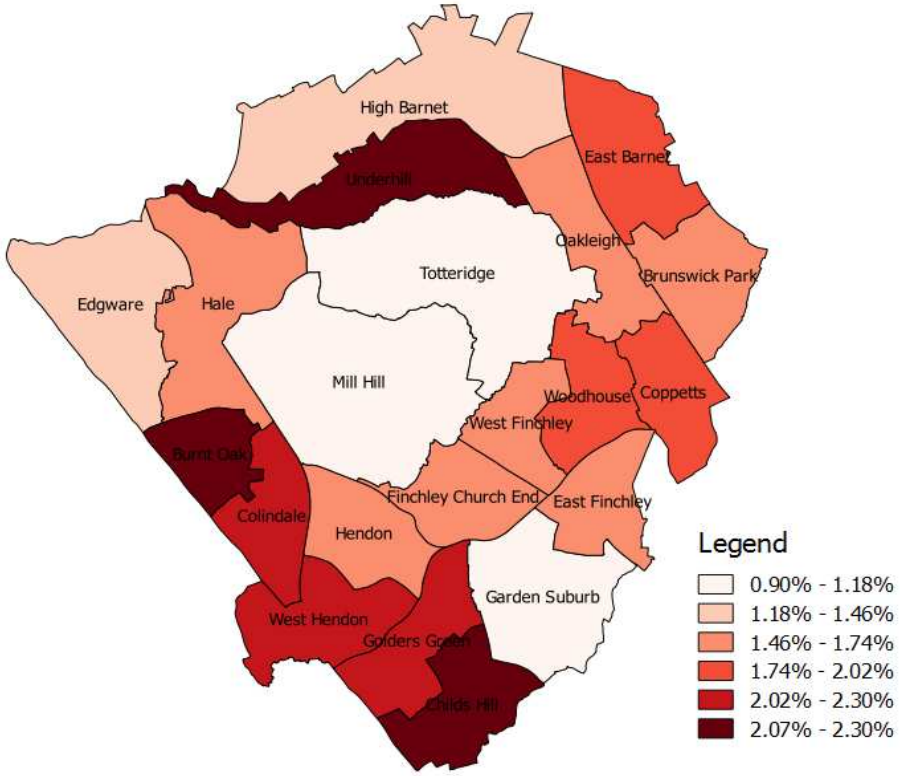


Source: ONS claimant count

[20] 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 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%).

Figure 3-22: Proportion of JSA Claimants by Ward by total 16-64 Population, February 2015



Source: ONS claimant count

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

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[21]. 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)

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[22]. Whereas, the social exclusion that

[21] Nomis Labour Market Profile: DWP benefit claimants - working age client group

[22] Bennett, D. (1970) the value of work in psychiatric rehabilitation. Social Psychiatry 5, 224230

they experience as a result of mental ill health is reduced by work and aggravated by unemployment[23].

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[24], 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.

Table 3-10: Proportion of adults in contact with secondary mental health services in paid employment, February 2015

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[25].

- 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.

23 Social Exclusion Unit (2004) Mental Health and Social Exclusion. London: Office of the Deputy Prime Minister
24 http://ascof.hscic.gov.uk/Outcome/717/1F
25 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.

- According to data from the 2015 CACI PayCheck, Barnet's average raw household income in 2014 was £41,658; this is 44.5% higher than the Great Britain average of 28,696.
- Between 2012 and 2015 Barnet's average household income increased by 17.6%, 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 25 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. This results in higher income inequality between different areas in Barnet.

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

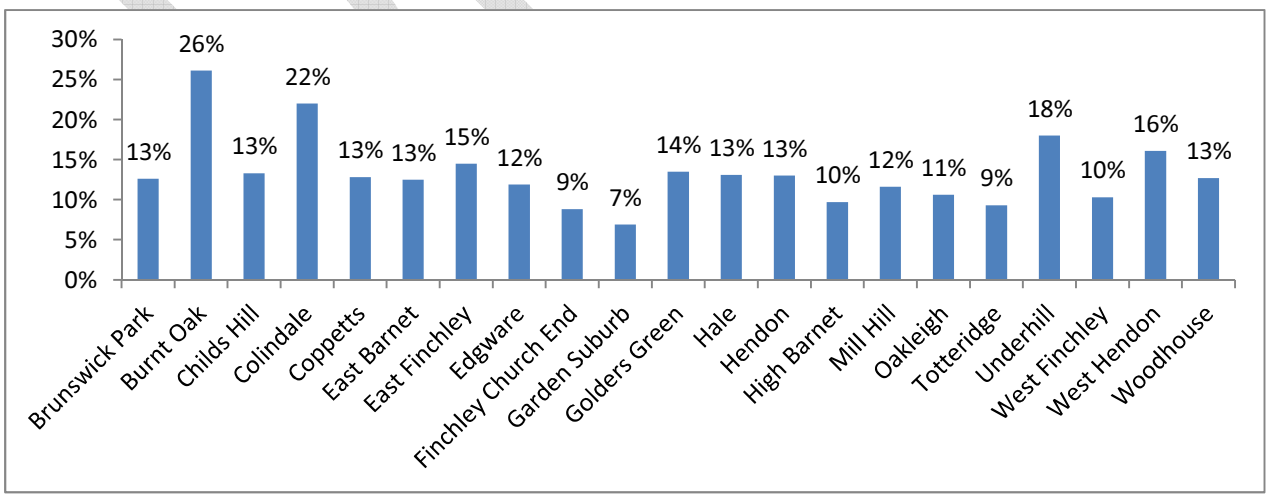
3.12.2 Poverty Measures

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 13.5%. 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 15k. 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 Chapter 4: Barnet Customer Segments – Overview

4.1 Introduction

As a way to easily distil the information covered in the previous two chapters, a customer segmentation approach is used throughout this document. Each person in Barnet has been grouped into one 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[26].

This chapter introduces the 17 Barnet customer segments, describes them by their age, income and 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.

Family Feelgoods (17% of Barnet households)

Households from this segment are highly affluent and educated, with young children. These are residents of all ages (25 to 65), 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.

4.2.1 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 85.6% report very good health, and 10.4 fairly good health, placing them 3rd among the healthiest Barnet segments.

[26] 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+.

4.2.2 Friends Together (13%)

These residents are low income, blue collar or unemployed house sharers. They can be friends, family or same-sex couples living in twosomes, 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 5.27% reporting poor health, which places them in the medium high group of least healthy Barnet segments.

4.2.3 Contemporary Elders (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 aware segment, they mostly report a good (85%) and fairly good health (10.9%), being in the top quartile of healthiest residents.

4.2.4 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.

4.2.5 Accomplished 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.

4.2.6 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.

4.2.7 Proud Parents Coping Alone (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.

4.2.8 Mature and Stable Sedentaries (4%)

These households are comfortably retired, well settled, established couples or widowed singles of mixed 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.

4.2.9 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 enjoy good (84.8%) and fairly good (10.9%) health, placing them in the top quartile of most healthy Barnet residents.

4.2.10 Constrained Solos (3%)

These are households of financially constrained, blue collar or unemployed, unattached solos 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 receive 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.

4.2.11 Maintained 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.

4.2.12 Young Optimists (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.

4.2.13 Go Getting DINKys (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.

4.2.14 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.

4.2.15 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.

4.2.16 Poundstretching Twosomes (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[27], 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 statistical neighbours. Kinston-Upon-Thames can be used as an exemplar approach when it outperforms Barnet at addressing certain health problems.

[27] Local authorities with similar characteristics used for benchmarking and comparing performance.

Table 4-1: Segment composition of Barnet compared to statistical neighbours

Customer Segments	Barnet	Hounslow	Kingston upon Thames	Merton	LONDON
A - Accomplished Singles	7.59%	8.44%	9.44%	8.42%	7.85%
B - Go Getting DINKys	1.59%	1.87%	3.24%	3.73%	2.26%
C - Family Feelgoods	16.53%	9.18%	18.93%	13.61%	10.19%
D - Maintained 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 - Contented Greys	3.55%	3.41%	5.28%	5.23%	3.96%
G - Contemporary Elders	9.58%	5.36%	9.48%	6.05%	5.90%
H - Secure Singles	1.07%	1.03%	1.30%	1.54%	1.31%
J - Poundstretching Twosomes	0.98%	1.42%	0.86%	1.40%	1.80%
K - Friends Together	12.81%	21.59%	10.58%	15.79%	17.65%
L - Comfortable Older Families	8.32%	11.06%	6.81%	10.06%	9.22%
M - Mature and Stable Sedentaries	3.78%	2.59%	4.25%	3.40%	2.88%
N - Young Optimists	2.14%	3.39%	1.39%	1.90%	4.58%
P - Constrained Solos	2.55%	2.75%	1.91%	2.39%	4.42%
Q - Struggling Families	0.98%	1.55%	0.41%	0.93%	1.39%
R - Proud Parents Coping Alone	5.12%	5.42%	3.87%	4.56%	5.50%
S - 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 *Friends Together* 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 *Constrained Solos*, *Struggling Families* and *Poundstretching Twosomes.*

Following the High Road north through the centre of Barnet from Child's Hill to Totteridge, households are mostly comprised of families (*Family Feelgoods, Comfortable Older Families*), professionals (*Accomplished Singles*, *Go Getting DINKYs*, *and Sophisticated Singles*) and affluent retirees (*Contemporary Elders*, *Contented Greys*). 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 (*Mature and Stable Sedentaries* and *Contented Greys*). People in these areas tend to be of mid-level affluence compared to the rest of the Borough.

Table 4-2: Segment composition of each ward

	Brunswick Park	Burnt Oak	Childs Hill	Colindale	Coppetts	East Barnet	East Finchley	Edgware	Finchley Church End	Garden Suburb	Golders Green	Hale	Hendon	High Barnet	Mill Hill	Oakleigh	Totteridge	Underhill	West Finchley	West Hendon	Woodhouse
A - Accomplished singles	4.67%	3.26%	10.00%	5.72%	7.70%	5.54%	10.52%	6.34%	9.08%	10.15%	10.10%	6.21%	12.44%	6.50%	7.91%	6.02%	7.32%	3.93%	12.09%	8.08%	7.03%
B - Go Getting DINKys	0.93%	0.37%	1.79%	1.29%	2.25%	1.62%	3.12%	0.74%	2.20%	1.80%	0.90%	0.77%	1.90%	2.45%	1.12%	1.78%	1.94%	0.80%	2.89%	1.28%	2.17%
C - Family Feelgoods	19.28%	2.91%	14.29%	5.06%	13.81%	18.20%	13.18%	24.02%	19.66%	23.82%	19.73%	18.15%	15.60%	22.02%	21.51%	21.73%	24.11%	12.57%	16.78%	10.96%	13.67%
D - Maintained Single Parents	1.19%	1.16%	3.36%	2.14%	3.30%	2.72%	2.84%	2.21%	2.81%	3.76%	2.71%	1.49%	2.50%	2.29%	2.78%	2.87%	2.72%	1.77%	3.50%	1.66%	2.32%
E - Sophisticated Singles	15.03%	4.67%	18.55%	9.12%	15.52%	12.12%	16.60%	14.07%	18.61%	20.91%	16.69%	13.67%	16.58%	16.15%	17.77%	14.20%	17.77%	10.57%	18.69%	10.79%	15.46%
F - Contended Greys	3.71%	1.82%	3.41%	1.85%	4.39%	4.54%	5.05%	2.67%	4.26%	3.69%	2.16%	2.74%	2.75%	5.97%	3.60%	4.07%	4.03%	3.47%	4.82%	1.97%	4.69%
G - Contemporary Elders	10.04%	2.26%	9.90%	3.60%	6.88%	9.61%	7.54%	13.08%	15.37%	16.83%	8.79%	8.83%	8.45%	12.26%	10.64%	12.41%	14.44%	7.42%	9.89%	6.00%	9.91%
H - Secure Singles	0.49%	0.44%	1.58%	1.40%	1.52%	1.53%	0.91%	0.62%	1.23%	0.80%	0.79%	0.45%	1.48%	1.16%	0.70%	0.93%	0.82%	0.50%	2.25%	1.14%	1.83%
J - Poundstretching Twosomes	0.99%	2.64%	0.93%	2.68%	1.01%	0.64%	1.16%	0.32%	0.14%	0.04%	0.81%	0.96%	0.57%	0.35%	0.62%	0.51%	0.18%	2.62%	0.60%	1.71%	0.55%
K - Friends Together	12.41%	28.46%	11.02%	22.36%	14.63%	12.44%	10.33%	9.45%	7.37%	3.89%	11.67%	16.14%	11.94%	6.95%	9.69%	9.56%	6.13%	15.57%	8.23%	21.24%	13.72%
L - Comfortable Families	10.56%	15.68%	4.95%	11.29%	8.36%	9.72%	6.12%	9.50%	4.46%	2.47%	7.19%	10.86%	5.91%	5.56%	6.19%	7.74%	5.71%	13.51%	5.61%	11.38%	9.33%
M - Mature and Stable Sedentaries	3.26%	1.24%	4.17%	2.15%	4.02%	5.53%	4.26%	2.83%	5.06%	4.75%	3.02%	3.21%	5.15%	5.30%	3.49%	3.83%	3.91%	3.67%	3.97%	2.35%	4.99%
N - Young Optimists	1.70%	7.53%	2.22%	6.94%	2.30%	1.20%	2.83%	1.25%	0.68%	0.33%	1.63%	2.05%	2.69%	0.51%	1.45%	1.20%	0.73%	1.81%	0.44%	2.77%	1.14%
P - Constrained Solos	2.43%	4.55%	3.42%	7.01%	2.79%	1.76%	2.77%	1.46%	1.18%	0.54%	2.18%	1.47%	3.13%	2.00%	1.63%	2.31%	1.83%	3.01%	1.64%	3.53%	1.89%
Q - Struggling Families	0.55%	2.85%	0.48%	2.72%	0.67%	0.50%	1.29%	0.59%	0.28%	0.25%	0.71%	1.30%	0.75%	0.56%	0.74%	0.74%	0.57%	1.28%	0.44%	1.80%	0.95%
R - Proud Parents Coping Alone	5.69%	9.12%	4.85%	6.81%	5.50%	6.35%	4.22%	5.13%	3.08%	2.60%	4.77%	5.57%	4.77%	3.76%	4.99%	4.90%	3.32%	7.28%	2.95%	5.13%	5.05%
S - Penny-Wise Pensioners	7.07%	11.05%	5.07%	7.87%	5.35%	5.99%	7.25%	5.73%	4.54%	3.36%	6.14%	6.12%	3.38%	6.21%	5.16%	5.19%	4.49%	10.23%	5.19%	8.20%	5.30%

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[28]. The five customer segments with the poorest self-reported health are also the segments in Barnet with the lowest household income (*Pound Stretching Twosomes, Young Optimists, Struggling Families, Constrained Solos and Pennywise Pensioners*). Segments comprised of the more affluent older population (*Mature and Stable Sedentaries* and *Contented Greys* and *Contemporary Elders*) do not report their health as being any worse than other younger more affluent segments in the Borough.

Table 4-3: Self-reported ratings of health

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*

[28] Worklessness has strong links to mental illness explored later in this document

Twosomes, Young Optimists, Struggling Families, Constrained Solos 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 will have further reaching societal impact.

Table 4-4: 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 - Accomplished Singles	2.53%	12.57%	6.01%
B - Go Getting DINKys	2.76%	13.40%	6.31%
C - Family Feelgoods	2.08%	12.79%	5.42%
D - Maintained Single Parents	2.69%	12.98%	6.16%
E - Sophisticated Singles	2.44%	12.99%	5.84%
F - Contented Greys	2.73%	13.81%	6.35%
G - Contemporary Elders	2.24%	13.90%	5.62%
H - Secure Singles	3.43%	13.65%	7.25%
J - Poundstretching Twosomes	5.00%	17.00%	8.97%
K - Friends Together	4.00%	15.10%	7.95%
L - Comfortable Older Families	3.67%	14.99%	7.59%
M - Mature and Stable Sedentaries	2.93%	14.91%	6.52%
N - Young Optimists	4.94%	15.71%	8.99%
P - Constrained Solos	4.64%	15.88%	8.55%
Q - Struggling Families	4.63%	15.94%	8.54%
R - Proud Parents Coping Alone	3.80%	14.92%	7.68%
S - Penny-Wise Pensioners	3.96%	16.30%	7.75%

4.5 Conclusion

The top 5 customer segments most likely to require health services are *Poundstretching Twosomes*, *Young Optimists*, *Struggling Families*, *Constrained Solos*, 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.

The 17 Barnet customer segments are used throughout this report as a means describing the types of residents that will be accessing health services in Barnet, their backgrounds and behaviours. Health services in Barnet should be delivered to meet the particular needs of these residents.

5 Chapter 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 during 2010-2012.
- 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.
- In the London Borough of Barnet (LBB), 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 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.
- 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. **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 8 Years 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.
- Overall rates of individual mental health problems are lower in Barnet than London and England; however **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.**
- **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 on in life.** Particularly HPV, flu and

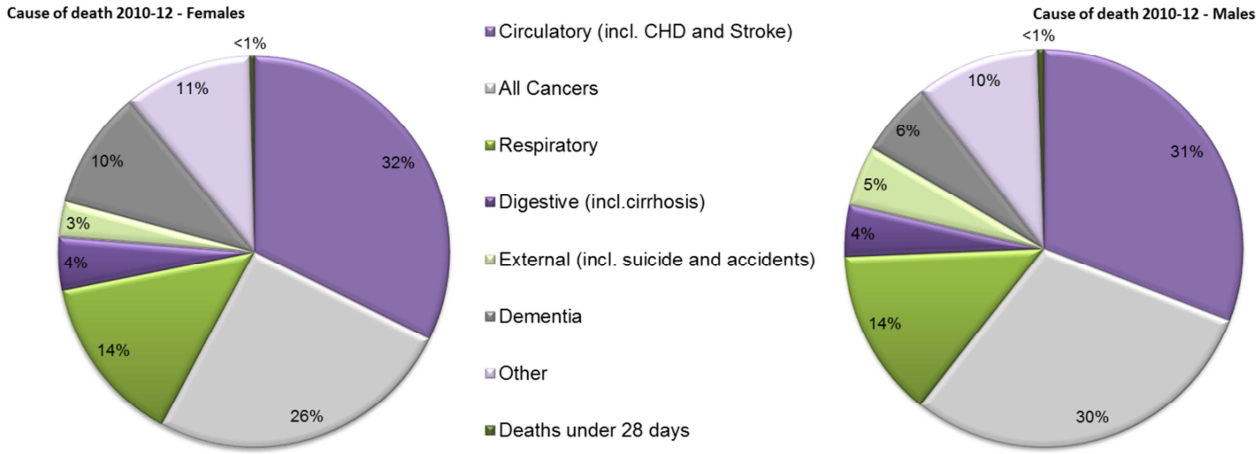
pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.

- **Overall the percentage of diabetic people having all 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.

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. 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.[29] 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).[29]

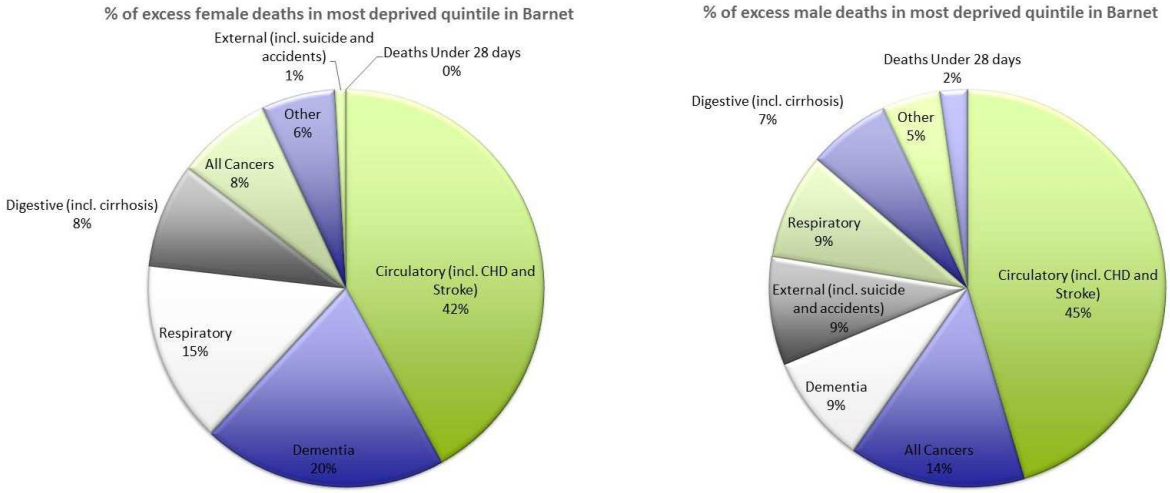
Figure 5-1a & b: Causes of death in females and males in Barnet (2010-2012)



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).[30] 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).

[29] Public Health England. Segment Tool 2015
[30] Public Health England. Barnet indicators. Public Health Outcomes Framework. 3 February 2015 http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E09000003.pdf

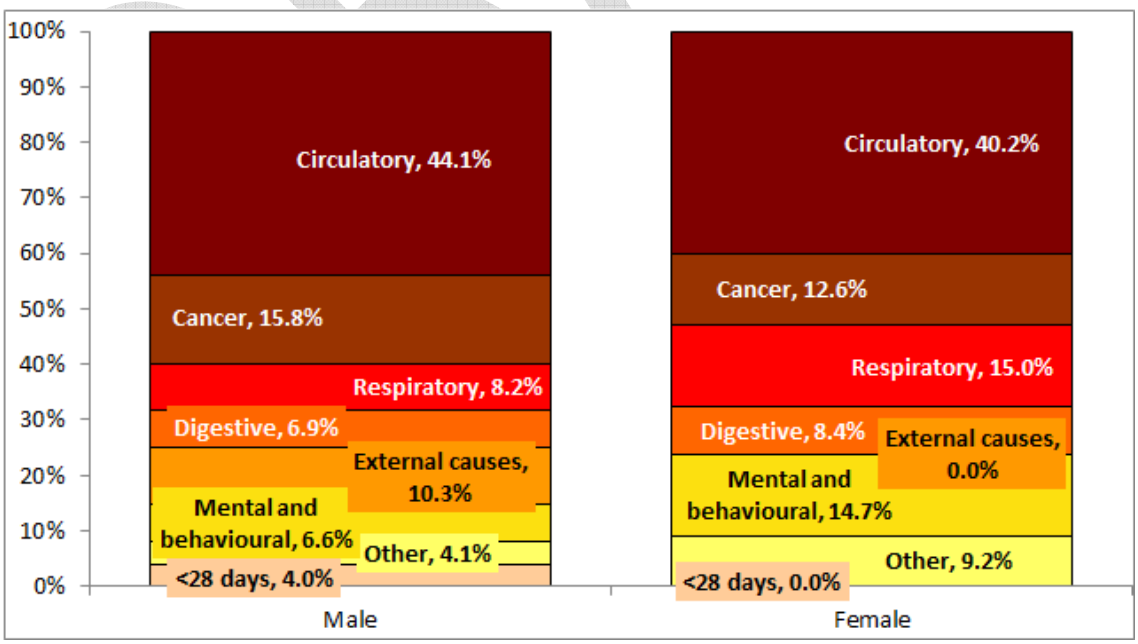
Figure 5-2a&b. Percentage excess deaths in males and females: the most deprived quintile vs. the least deprived quintile in Barnet (2010-2012)



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)



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.[31]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 1 below shows Barnet statistics on common causes of illness, 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

[31] 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 the 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.[32] CVD is the number one killer disease globally and one of the major causes of preventable mortality (WHO, 2011).[32] The global burden of CVD was 17.5 million deaths in 2012.[33] In the UK, CVD caused 160,000 deaths in 2011[34] and there are an estimated 7 million CVD patients in the country.[35]CVD affects men more than 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.[36]

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).

[32] World Health Organisation (2011) Global Atlas on cardiovascular disease prevention and control, Geneva.
[33] World Health Organisation (2015) Cardiovascular diseases (CVDs), Fact sheet N°317 (Updated January 2015), Geneva.
[34] NHS Choices. Cardiovascular disease (Page last reviewed: 15/09/2014)
[35] British Heart Foundation. Cardiovascular Disease Statistics Factsheet (Last reviewed and updated: 13/02/2015)
[36] World Health Organisation (2014) Global status report on noncommunicable diseases 2014. Geneva.

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/

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.[37] For the same period, 10,273 people were diagnosed with CHD, which was lower than the expected 13,400 cases of CHD in Barnet.[37] 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).[38]

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 in Finchley (47.9), Mill Hill (51) and Garden Suburb (53.1) wards for the period 2008-2012.

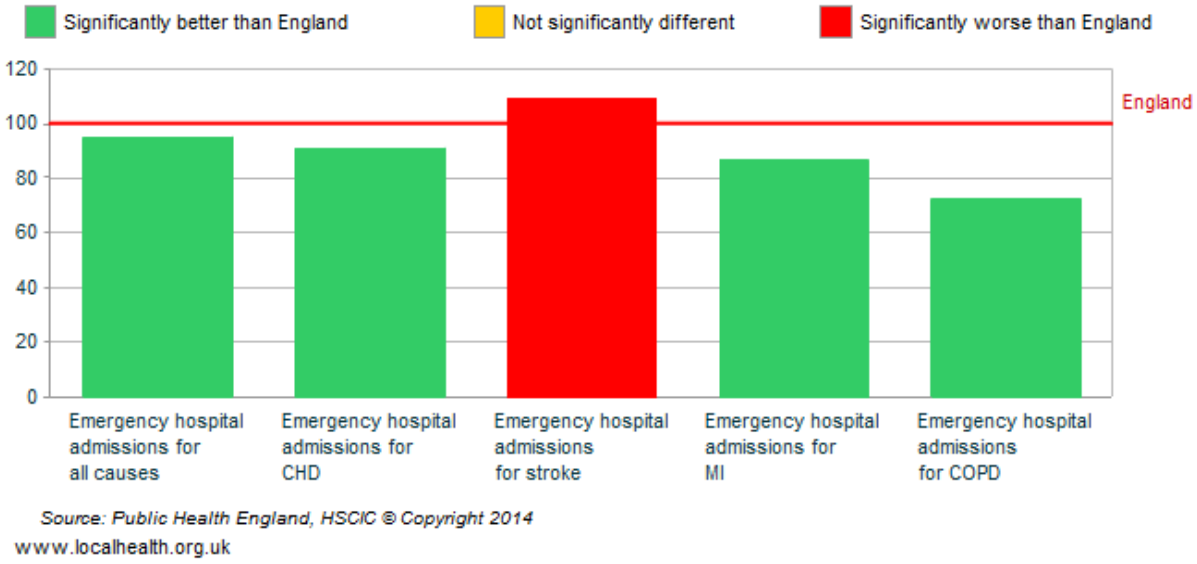
The rate of emergency hospital admissions for stroke in Barnet (235.4 / 100,000 people) was higher than the national rate (174.3 / 100,000 people) (Figure 5).[38] Overall, the emergency hospital admissions rate due to stroke in Barnet increased by 51.9% from 2003-04 to 2013-14.[38]

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

[37] http://www.yhpho.org.uk/ncvincvd/pdfs/Heart/07M_Heart.pdf
[38] http://www.yhpho.org.uk/ncvincvd/pdfs/stroke/07M_Stroke.pdf

(152.3) and Coppetts (132.3) wards while the lowest 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)



5.5.3 CVD prevention

In Barnet, there are variations in the prevalence of CHD and stroke at GP[37, 38] and ward levels.[39] 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 have 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.[33] 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=5469 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). The NHS health checks program in Barnet needs to target eligible people with special attention to specific wards and communities that have a high prevalence of CHD and stoke.

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.[40]

[39] http://www.localhealth.org.uk/
[40] Public Health England. Cancer Mortality Profiles: Trends spreadsheet

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).[41]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).[41] 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).[41]

Data for 2007-2011 shows that the new cases of cancer (standardised incidence ratio) varies by the type of cancer in 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, males and females in Barnet are lower than in London and England. The directly standardised rates (DSR) for all cancer mortality in age under 75 years in females, males and all persons 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 2008-2010 compared to 1995-1997.[42] 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%).[43] 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.[44]

5.6.4 Cancer screening

Cancer screening coverage for breast (female) cancer in Barnet is better than the average for the London region but worse than the national average (Figure 4-5a); while, cervical cancer screening coverage in Barnet is worse than the average rates for London region and England (Figure 5-6b).

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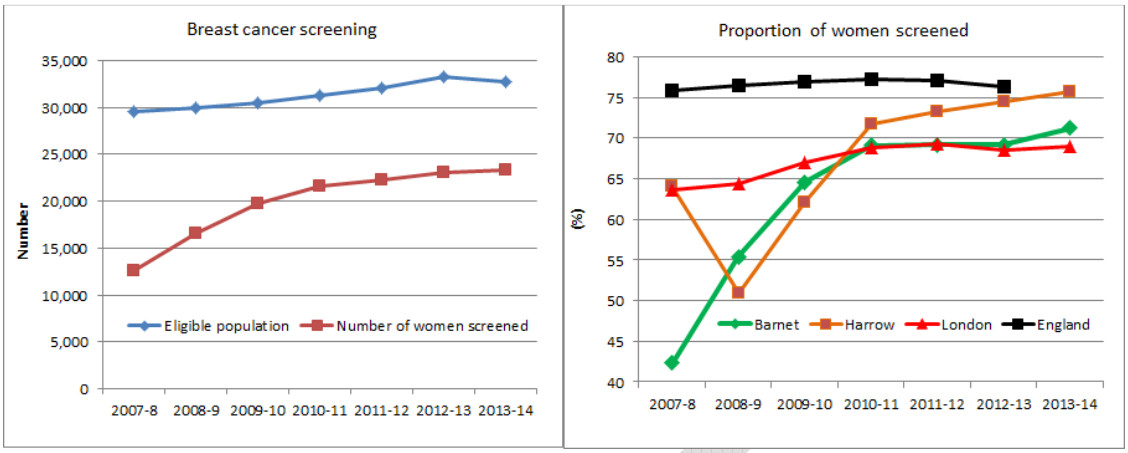
[41] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/
[42] http://www.swpho.nhs.uk/resource/item.aspx?RID=76243
[43] Office of National Statistics. Table 2-4: Index of cancer survival for Clinical Commissioning Groups in England: Adults diagnosed 1997-2012 and followed up to 2013 (Excel sheet 443Kb)
[44] 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).

Figure 5-6a&b: Breast (Female) Cancer and screening



Data for 3 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%).[45] 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, which needs to be reduced.

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). [46] The oral cancer registration rate in Barnet (12.4) was higher than the average rates for London region (13.5) and nationally (13.2) during 2010-2012.[46] 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.[47] There are 4,247 COPD cases on GP registers (data for 2013/14).[48]

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.[49] The COPD prevalence confirmed by spirometry is 88.56% (95% CI: 86.54-90.32) in the NHS Barnet CCG,

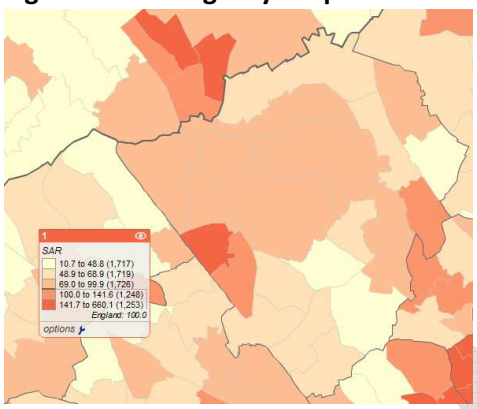
[45] http://www.phoutcomes.info
[46] Public Health England http://fingertips.phe.org.uk/
[47] http://www.nepho.org.uk/respiratory/index.php
[48] HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14 Date: 28 October 2014. http://www.hscic.gov.uk/catalogue/PUB15751 http://www.hscic.gov.uk/catalogue/PUB15751/qof-1314-prev-ach-exc-ccg.xlsx
[49] http://fingertips.phe.org.uk/profile/general-practice/data

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.[50] 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 7) with the highest ratio in Burnt Oak ward (141.8) and the lowest ratio in Garden suburb ward (28.3).

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% that is below the average rate (5.9%) for England.[48] The prevalence of asthma widely varies between GPs in the NHS Barnet CCG.[48]

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.[51] The influenza immunisation rate in Barnet (83%) is slightly higher than the average rate for England (81.9%).[48]

5.8 Mental Health

Mental health is a high public health priority area in the country and addressing mental health problems in all age groups and improving outcomes and relevant services are suggested in the 2011 mental health strategy for England entitled "No health without mental health". Tackling mental health is important because poor mental health not only costs too much for the economy and the health system but also leads to and is associated with inequalities.[52]

5.8.1 Adult Mental Health

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%).[53,54] There were 2,303 new cases of depression recorded in GP

[50] 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/]

[51] Wesseling, G. (2007) Occasional review: Influenza in COPD: pathogenesis, prevention, and treatment. Int J Chron Obstruct Pulmon Dis. 2(1): 5–10.

[52] Department of Health (2011) No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. London.

[53] Public Health England (2014) Community Mental Health Profile data http://fingertips.phe.org.uk/cmhp

[54] Public Health England (2014) Barnet Clinical Commissioning Group. Community Mental Health Profile 2014.

registers during 2013-14 showing the incidence rate of 0.8% for Barnet, which is lower than the average national rate (1%).[54,55] 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%).[53,54]

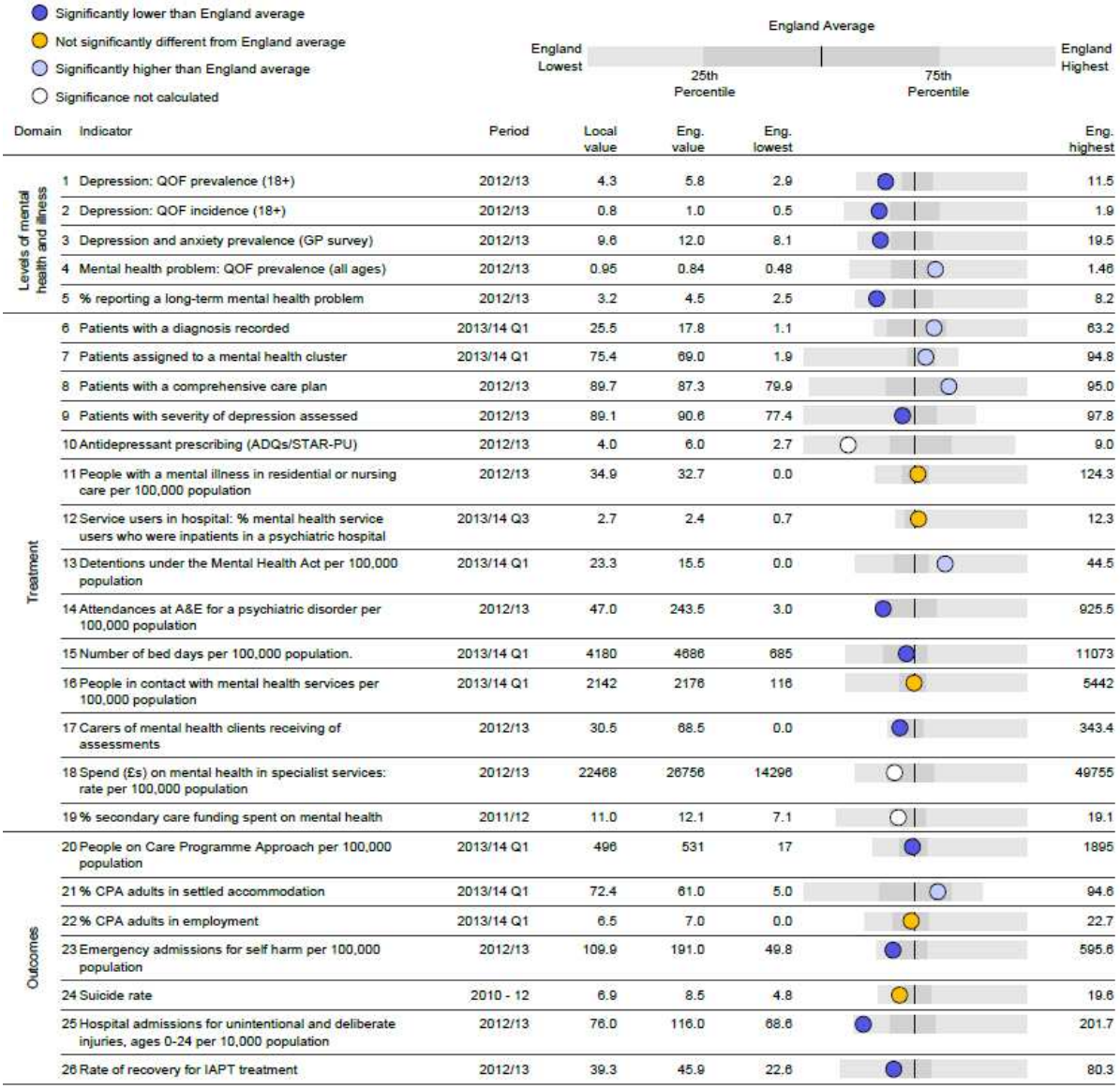
The average rate of people with a mental illness in residential or nursing care per 100,000 of the population in Barnet (34.9) is similar to England (32.7). The percentage of mental health service users who were inpatients in a psychiatric hospital in Barnet (2.7%) is not different from the national 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 4686 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.

[55] 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	2176	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

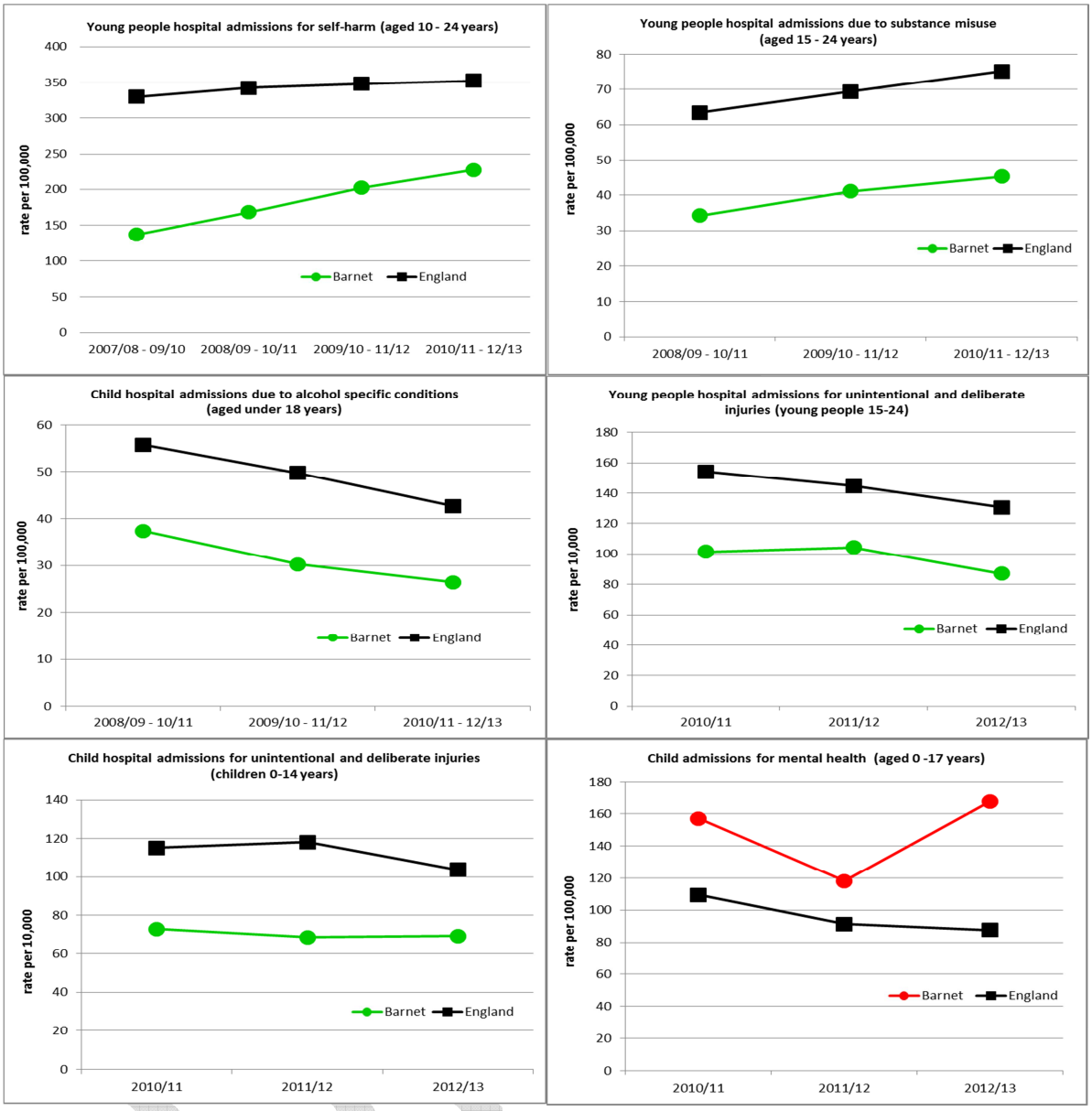
Source: Public Health England. Barnet Children's and Young People's Mental Health and Wellbeing Profile

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 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.[56] 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).

[56] 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

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 CCG have started a number of initiatives including programmes and services for improving mental health and wellbeing of the local people.[57] 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%).[58] There are an estimated 5,259 (23%) undiagnosed cases of diabetes in Barnet.[59] The diabetes rates are forecast to rise at the national and local levels and an increase in the rates could be even higher if diabetes risk factors such as obesity are not addressed.[60]

There is a wide variation between Barnet GPs (n=67) in terms of both the prevalence of diabetes (from 2.2% to 10.3%)[61] 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.[62] However, some GPs in the Barnet CCGs have diabetes outcomes lower than the local and national averages, which need to be improved.

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 and flu vaccination and eye screening are similar to the national average. The BMI recording in diabetic patients in Barnet is below the average for England, which needs to be improved. The percentage of diabetic people having all 8 check-ups in Barnet (56%) is also below the national average (59.5%), which also needs to be improved.

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

[57] Barnet JSNA Refresh 2013-14 - Mental health and wellbeing.
[58] Public Health England. Diabetes Prevalence Model for Local Authorities and CCGs.
[59] http://www.yhpho.org.uk/ncvinintellpacks/pdfs/07M_SlidePack.pdf
[60] Public Health England. Barnet Cardiovascular disease profile. Diabetes. March 2015.
[61] http://www.yhpho.org.uk/ncvincvd/pdfs/Diabetes/07M_Diabetes.pdf
[62] http://fingertips.phe.org.uk/profile/general-practice/data

control, blood pressure control and cholesterol control.[63] These recommendations should be taken seriously and implemented through appropriate interventions and services.

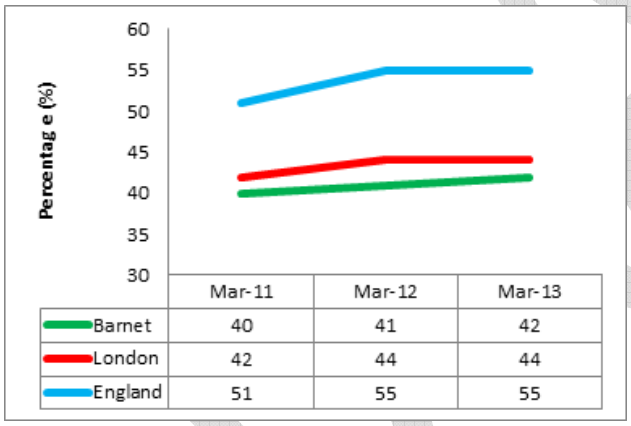
5.10 Oral Health

Oral health is integral and essential to general health and an important determinant of the quality of life.[64]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).[64] 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.[65] In addition, premature mortality can also be reduced by preventing oral diseases.[64]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.[66]

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 (1 oral cancer in 50 cases of all types of cancers).[67] Nevertheless, cancers of the oral cavity are the most common cancers of the head and neck region and involve more men than women.[68]

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).[66,68] Therefore, oral cancer risk could be minimised by avoiding the above risk factors. In addition, the

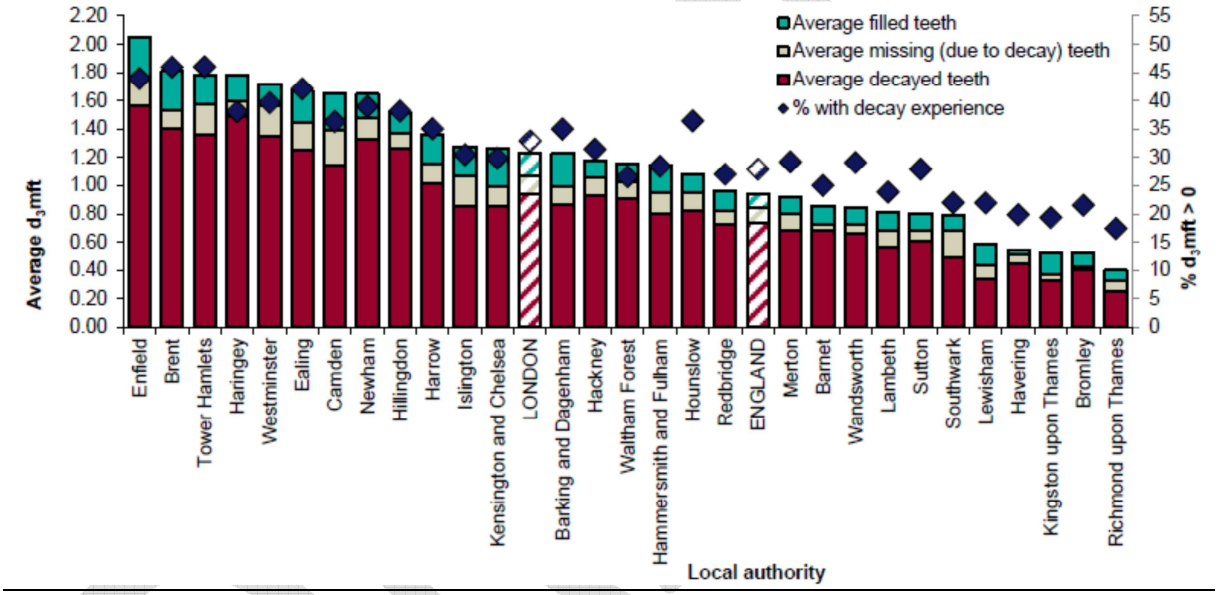
[63] HSCIC (2015). National Diabetes Audit 2012-2013. Report 2: Complications and Mortality Summary for NHS Barnet CCG (07M).
[64] World Health Organisation. Oral Health. Policy basis.
[65] World Health Organisation (2015). Tokyo Declaration on Dental care and oral health for healthy longevity.
[66] World Health Organisation. Oral Health. Strategies and approaches in oral disease prevention and health promotion.
[67] NHS Choices (2014) Mouth cancer http://www.nhs.uk/Conditions/Cancer-of-the-mouth/Pages/Introduction.aspx
[68] Public Health England. Oral Cavity Cancer: recent survival trends. The National Cancer Intelligence Network, London.

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.[68]

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 of overall success of health and wellbeing is the level of tooth decay in children aged 5 years,[69] 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 ($d_3$mft) and the proportion of children affected by dental decay (%$d_3$mft>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%).[70]

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.[71]

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

[69]Public Health England (Oct 2014) Barnet Dental Health Profile. Dental health of five-year-old children 2012.
[70]Public Health England. http://fingertips.phe.org.uk/search/dental
[71]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).

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.[72]

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).[73]

Figure 5-12: Child hospital admissions for extraction of one or more decayed primary or permanent teeth(0-19 years)[72]

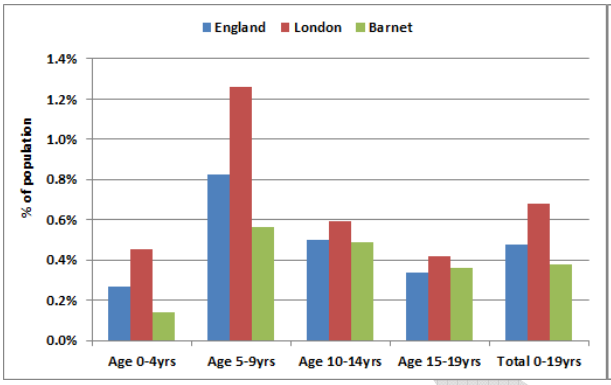
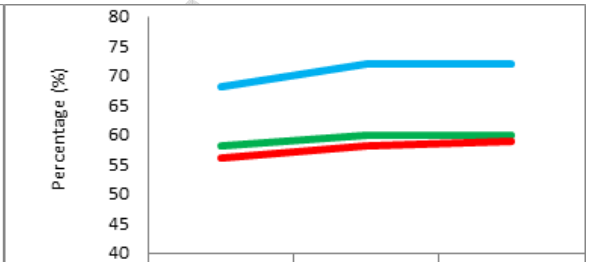


Figure 5-13: Child Dental Access Rates 2011-2013 (under 18 years)[73]



	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 3 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 3 schools and 3 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.[74] There could be inequalities in oral health and oral care such as provision of oral care in care homes.[75] A local oral health needs assessment could be undertaken in Barnet for identifying oral health inequalities and oral health needs of adults and children.

[72] Public Health England. Public Health England Epidemiology Programme: Extraction data
[73] HSCIC. Access by patient London LA region Sept 2013, NHS dental statistics England 2012-2013
[74] JSNA Refresh 2014 Oral Health Barnet
[75] Public Health England (2014) Dental public health intelligence programme. North West oral health survey of services for dependent older people, 2012 to 2013.

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[76] 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 averages rates for London (3.8, 2.6 and 7.3 respectively) and England (3.9, 2.7 and 6.7 respectively).

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.

[76] A maternity is a pregnancy resulting in the birth of one or more children, including stillbirths

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.[77] Immunisation thus helps in controlling and eliminating life threatening infectious diseases and thereby reducing illness, disability and death from vaccine preventable infectious diseases.[78] 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.[79] 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.[80]

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) 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

[77] http://www.who.int/topics/immunization/en/
[78] World Health Organisation (2014) Immunization coverage. Fact sheet N°378. Last reviewed: November 2014.
[79] http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx
[80] Department of Health. (2014) Vaccines for the routine immunisation schedule from summer 2014. Published on 7 May 2014.

for England; however, other childhood immunisation rates in Barnet are worse than the national rates.[81]

Table 5-2: Coverage of routine childhood immunisations in Barnet compared to England

		Barnet			England
		Cohort size	Number immunised	Rate (%)	Rate (%)
Cohort	Short name	CS-2013-14	IM-2013-14	2013-14	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 1926 of which 1339 were immunised against HPV in 2013-14. Thus, the HPV vaccination coverage rate (% of girls aged 12-13 who received al 3 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).

In Barnet, the total cohort for pneumococcal vaccination (PCV) against pneumococcal disease in children comprised 5789 persons of whom 4767 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%).

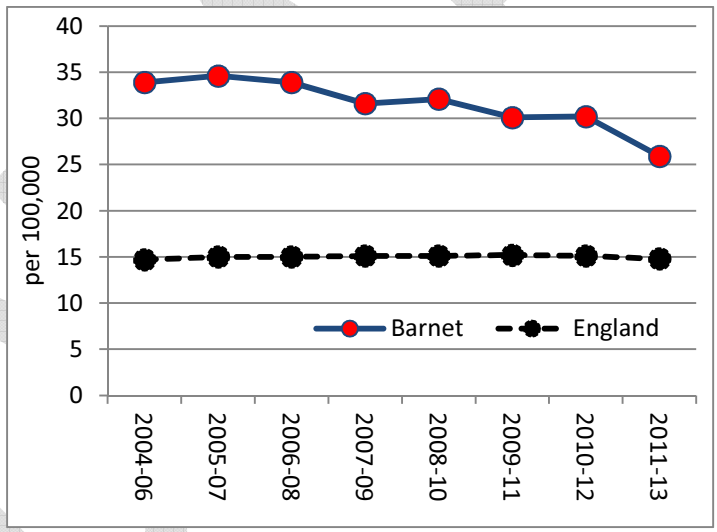
[81] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/1/par/E12000007/are/E09000003

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 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.[82] The incidence of TB (3 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).[83] 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).[82]

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%). In addition, Barnet has a higher number of drug resistant TB cases than the average number of these cases in London.[84]

[82] Public Health England. (2014) Tuberculosis in the UK: 2014 report. London.
[83] Public Health England. TB Strategy Monitoring Indicators.
[84] Public Health England. (2013) Local authority TB profiles (2012 data).

Figure 5-15: Barnet - TB Strategy Monitoring Indicators

	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

Comparison to England value: Better | Similar | Worse

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.[85] To raise TB awareness in local communities identified as being most likely to be affected by TB, the 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.

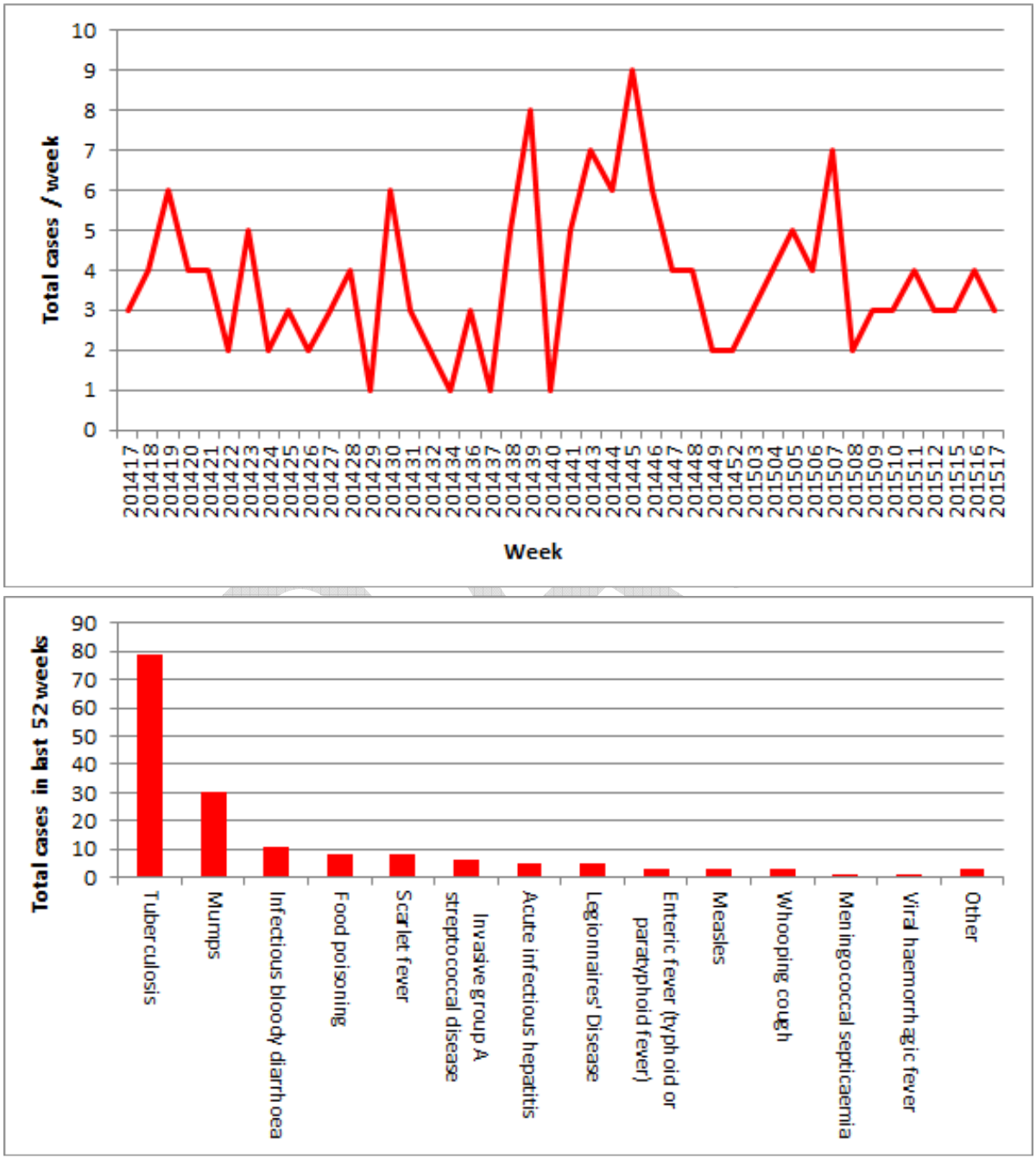
5.12.3 Notifiable Infectious Diseases

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) 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.

[85] Gupta et al. (2015) Tuberculosis among the Homeless — Preventing another Outbreak through Community Action. *N. Engl. J. Med.* 372 (16):1483-1485.

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 Chapter 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 CVD, cancer, asthma and COPD. Tobacco use kills over 80,000 people per year in England making it the single greatest cause of preventable death in the country.[86] The tobacco and smoking picture in Barnet is given below.

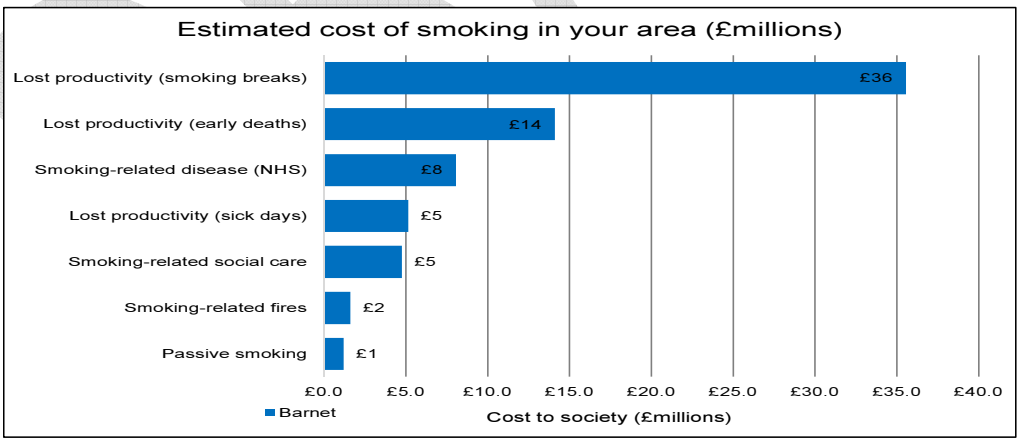
6.3.1 Smoking in Adults

Smoking indicators for Barnet are shown in Figure 5-1. 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.[87] 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.[88, 89]According to an estimate smoking related illnesses in Barnet costs about £8.0m annually to the local NHS (Figure 6-1).[90] Smoking cessation interventions could help in reducing the burden of COPD and other medical conditions associated with smoking.[91]

Figure 6-1: Estimated cost of smoking in Barnet Local Authority



Source: Action on Smoking and Health (ASH). Local cost of smoking (May 2015)

[86] National Institute for Health and Care Excellence (NICE) (2015) Tobacco. NICE advice [LGB24]. Published date: January 2015.
[87] http://www.tobaccoprofiles.info/profile/tobacco-control/data
[88] Deborah et al. (2004) Genetics of Asthma and COPD. Similar results for different phenotypes. *Chest,* 126 (2): 105S-110S.
[89] Hardin et al. (2011) The clinical features of the overlap between COPD and asthma. *Respiratory Research*, 12(1): 127.
[90] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/
[91] 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%).[92]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 18). 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

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).

[92] 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

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.[86]

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%)

Data 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

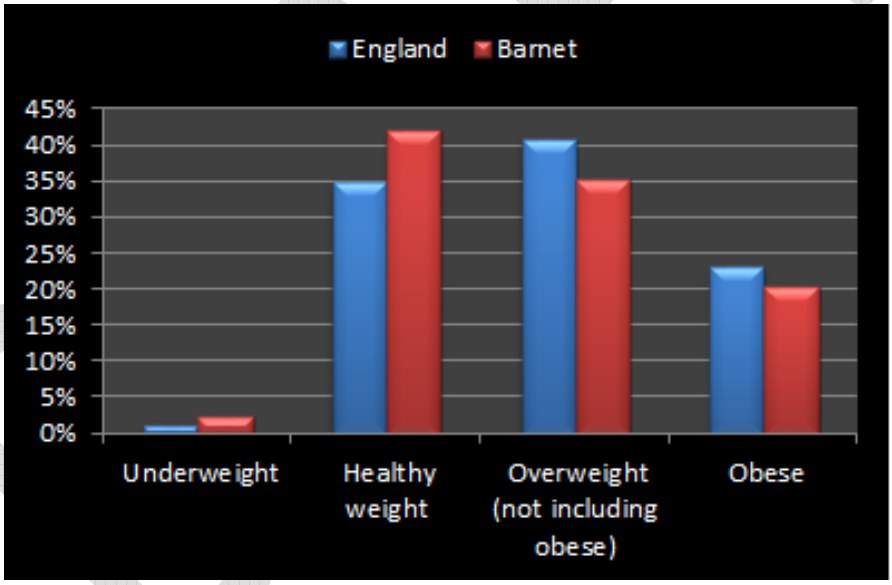
Barnet has a high percentage of the adult population with a healthy weight (42.1%) and a low percentage with excess weight (55.7%) (combined overweight (35.2%) plus obese (20.5%))

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).[93] 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).[93]

Figure 6-4: Prevalence of underweight, healthy weight, overweight, obesity, and excess weight among adults in Barnet (2012)



Data 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.

[93] 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)

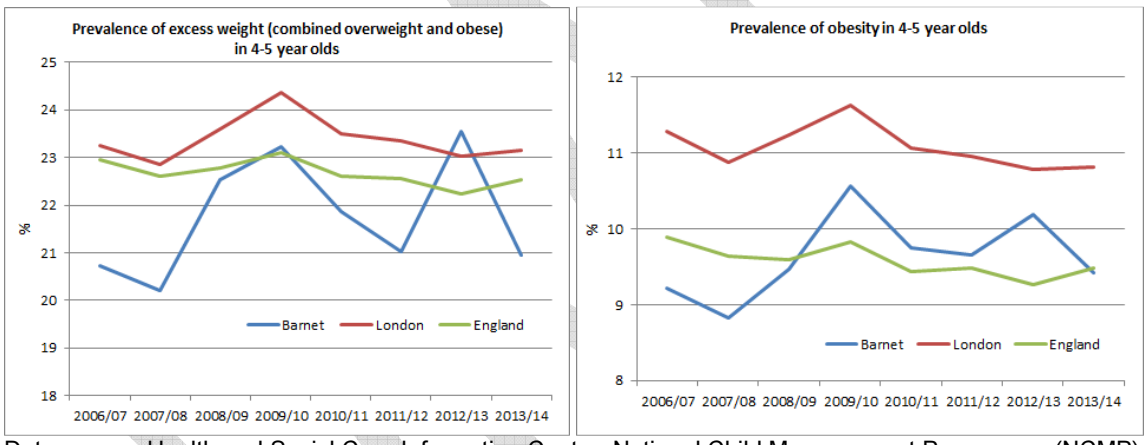
In reception year children (aged 4-5 years) the percentage of excess weight (overweight and obese) was 21% in 2013/14 in Barnet, which was lower than the average rates for the London region (23.1%) and England (22.5%) (Figure 6-5a). In Barnet, the proportion of excess weight children in this age group 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



Data source: Health and Social Care Information Centre, National Child Measurement Programme (NCMP)

6.4.2.3 Year 6 children (aged 10-11 years)

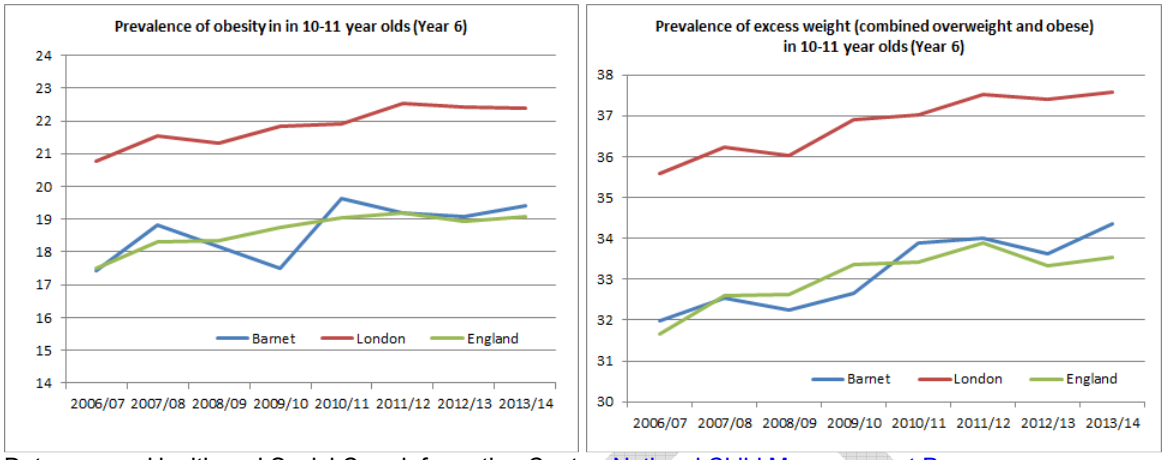
In Barnet, the obesity rate for Year 6 children (10-11 year olds) slightly increased to 19.41 in 2013-14 compared to 19.07% in 2012/13, which was similar to the national rate (19.09%) but lower than the London regional rate (22.39%) for 2013-14 (Figure 6-6a).

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 six 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 the year 6.

Figure 6-6: a&b. Prevalence of obesity and excess weight in children aged 10-11 years



Data 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.[94] 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%)[95]. Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates.[95]

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 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).

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%

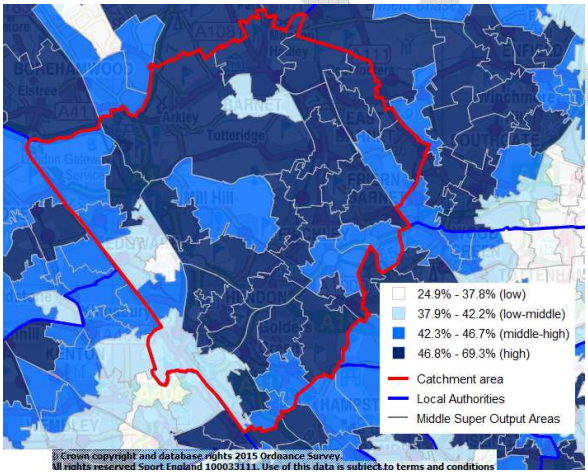
[94] Chief Medical Officer (2004). At least five a week: Evidence on the impact of physical activity and its relationship to health. London: Department of Health.
[95] Public Health England. Health Improvement in Public Health Outcome Framework

	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
Data 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)[96]

Figure 6-7: Modelled once a week sports participation estimates for Barnet - MSOA level (Data from APS6 - 2011-2012)[96]



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 the Joint Director of Public Health (DPH) at Barnet and Harrow Borough Councils.[97]

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

[96] Sport England. Small Area Estimates web tool
[97] 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

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.

6.6.2 Alcohol related PHOF indicators

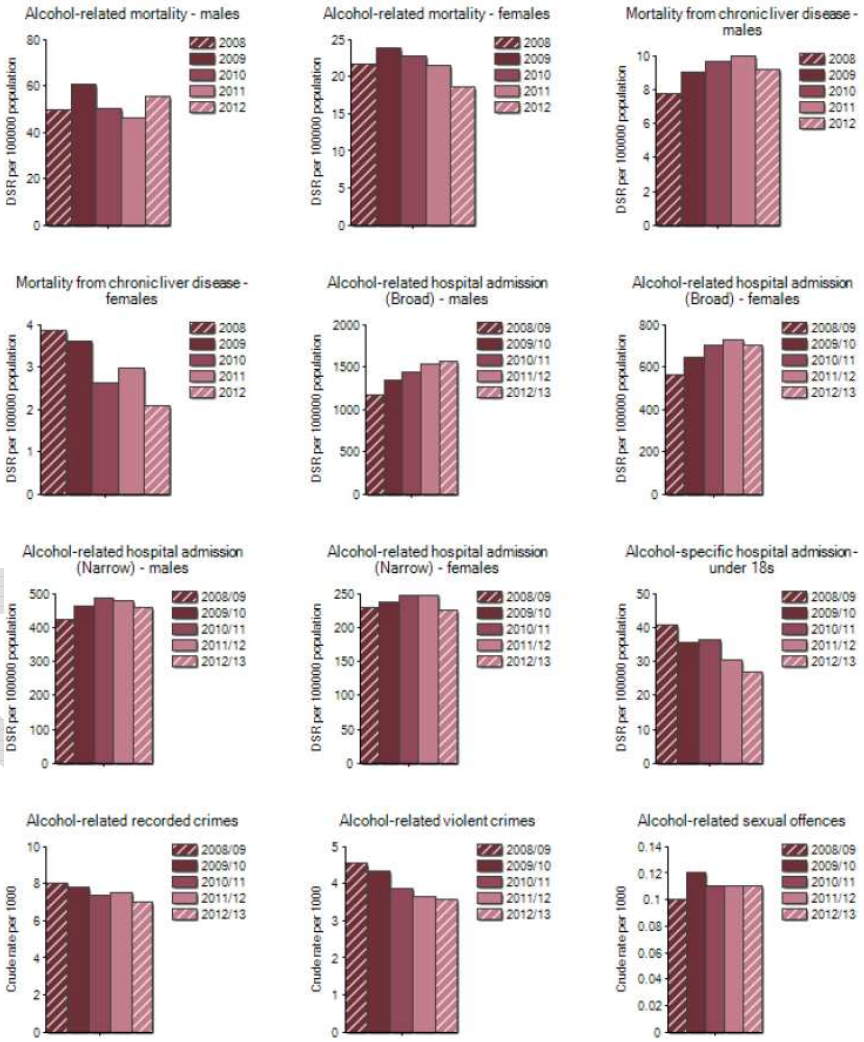
Barnet rates of alcohol related mortality, hospital admissions, crimes, and sexual offences as well as mortality from chronic liver disease are shown in Figure 5-8 below. Most of these rates in Barnet are coming down except the alcohol related mortality and hospital admissions in males, which are increasing 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[98] 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)



Data source: Public Health England. Barnet local alcohol profile. LAPE - Local Alcohol Profiles for England

6.7 Drugs and substance misuse

6.7.1 Prevalence of drug misuse

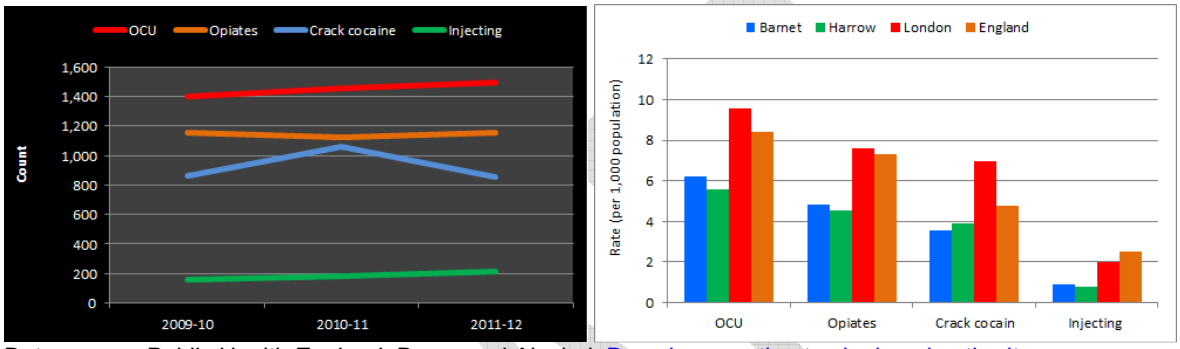
According to the most recent estimates (2011-2012), Barnet has 1,492 opiate and/or crack users (OCU), 1156 opiate users, 857 crack cocaine users and 215 injecting drug users aged 15-64 years.

[98] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

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



Data 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) (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 5 deaths in treatment were received by commissioners from treatment providers; however, 3 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)

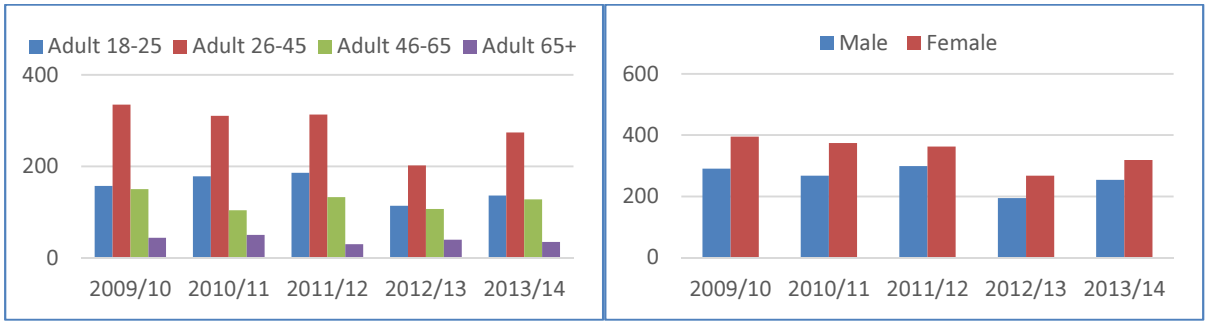
	2011/12	2012/13	2013/14
Number	2	8	7
Treatment provider	(2 BDAS)	(6 BDAS, 2 WDP)	(6 BDAS, 1 WDP)

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 6 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

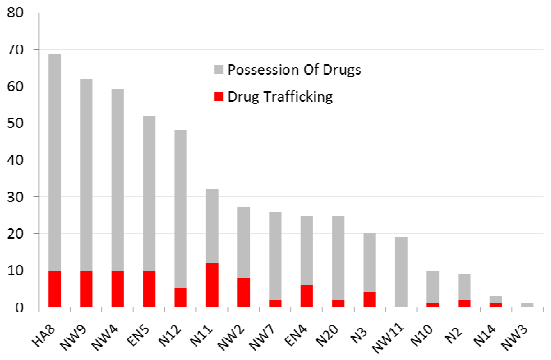
Drug Trafficking (i.e. supply related crime allegations:

83

Drug possession allegations:

72

Breakdown by location:



Drug related crime allegations

Data set:

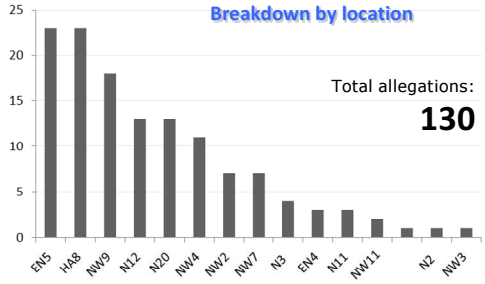
Jan – Dec 2013 (12 months data) All Barnet Crime allegations , that are flagged as drug related (victim/suspect taking prior to or at the incident)

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

www.barnet.gov.uk 2

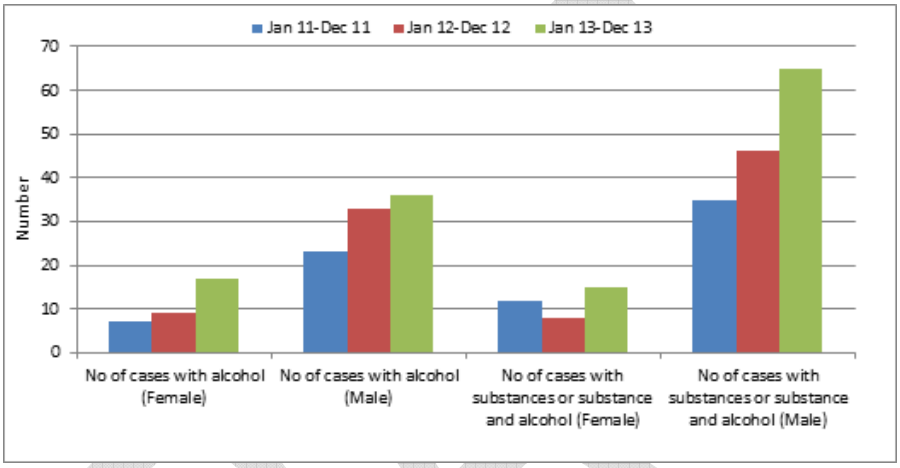
Also shown for all crime flagged as drug related during the whole year 2013. The postcodes HA8 (Edgware), NW9 (Colindale/West Hendon) and NW4 (Hendon) have the highest drug possession offences and N11 (New Southgate/Bounds Green) has the highest level of drug supply offences for the year.

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 (2 referrals in 2011, 3 referrals in 2012 and 1 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, 6 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 6 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%).[99] 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.

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).[100] The crude rate of abortions in the 20-24 years age group was highest (34

[99] DOMES report Q4 2013-2014
[100] Department of Health (2014) Abortion statistics, England and Wales: 2013. Dated: 12 June 2014.

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. Sixty percent 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 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.

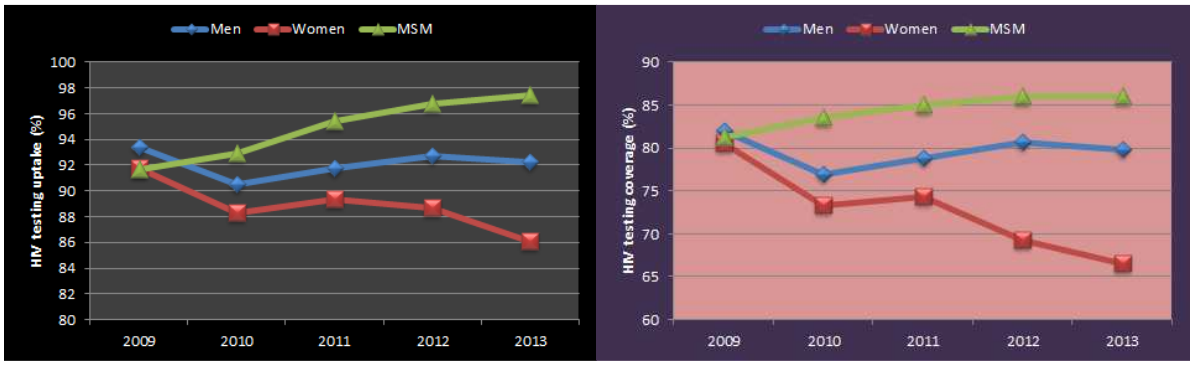
In addition, excluding Chlamydia in young people under 25 years, new cases of STI diagnosed (899 per 100,000 population aged 15-64 years) is higher than the average in England (832 /100,000) and the proportion of STI testing positivity (4.7%) in Barnet is lower than the national average. These STI statistics 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, 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.

6.8.1.7 Domestic Violence and Violence against Women

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.

Violence against women could have different manifestations such as rape, sexual violence, and female genital mutilation, which are reported below.

6.8.1.8 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.[101]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.[101]

6.8.1.9 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".[102] 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

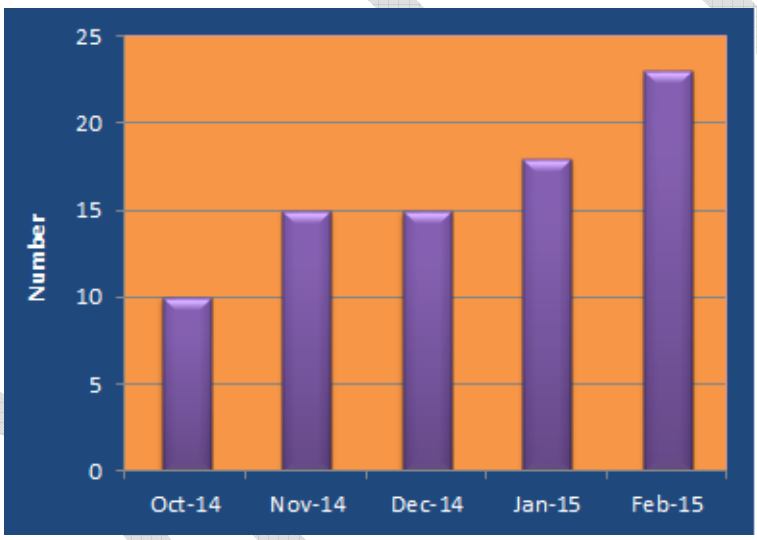
[101] Metropolitan Police. Crime Figures for London
[102] WHO (2014) Female genital mutilation. Fact sheet No. 241. Updated February 2014.

psychological effects on the girls and women and it violates their reproductive health and human rights.[103] 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 is the London Borough of Barnet (LBB). 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 data by the Royal Free London NHS Foundation Trust, which provides healthcare to most of the Barnet population, is shown in Figure 6-14.

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 6-14: Active Caseloads of FGM at Royal Free London NHS Foundation Trust



Data source: HSCIC, FGM Experimental Statistics (Feb 2015)

6.9 Preventing Ill Health

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.

[103]United Nations Population Fund (UNFPA) (2014) Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation. New York.

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.[104] Moreover, appropriate information needs to be provided at the local 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 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 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	CFR	Golders Green (82.9)	Brunswick Park (56.8)

[104] National Institute for Health and Care Excellence (2009) Reducing differences in the uptake of immunisations. NICE Public Health guidance 21 London

aged 15-44)			
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, PHE, 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 5-7.

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

Adapted from: Kings Fund (September 2014) Making the case for public health interventions

7 Chapter 7: CCG

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
- 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 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.
- **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 of 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 Commission Group (BCCG)

Barnet Clinical Commissioning Group was authorised in April 2013 and has completed its 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. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.[105]

Barnet's CCG remains committed to improvements of 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 and they are avoidable and, therefore, not justifiable.

Current evidence base indicate 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. Males in the most deprived areas with a life expectancy 9.1 years shorter than those in the least deprived areas; among 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 prevalence in general, it is clear from international studies and evidence that people from more deprived groups tend to[106]:

- Have higher incidence of cancer;
- Be diagnosed later; and
- Have less treatment and have poorer outcomes.

7.4.1 Health inequalities in Barnet and Summary of Key issues:

- 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

105 Commissioning for Value. NHS England, Public Health England. CCG Barnet
106 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" [107] 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 would improve quality or reduce inequalities of access and outcome.[108]

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 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.

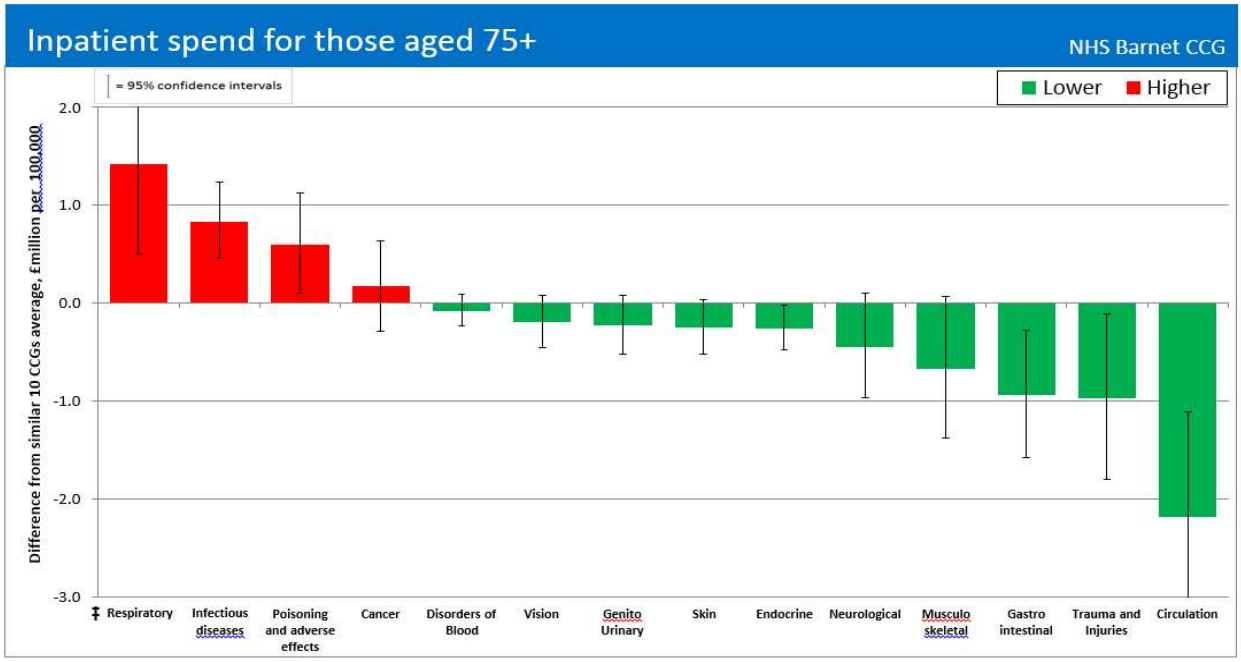
[107] Fair Society Health Lives: Marmot Review Report, Feb 2010)

108 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 is on the elderly population, 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[109]. 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[110].

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[111].

Figure 7-2 shows the number of Emergency Admissions by age group, within 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.

[109] Poteliakhoff and Thompson 2011
[110] Purdy 2010
[111] Poteliakhoff et al 2011

Figure 7-2: Barnet Emergency admissions Trend by Providers, 2012-2015

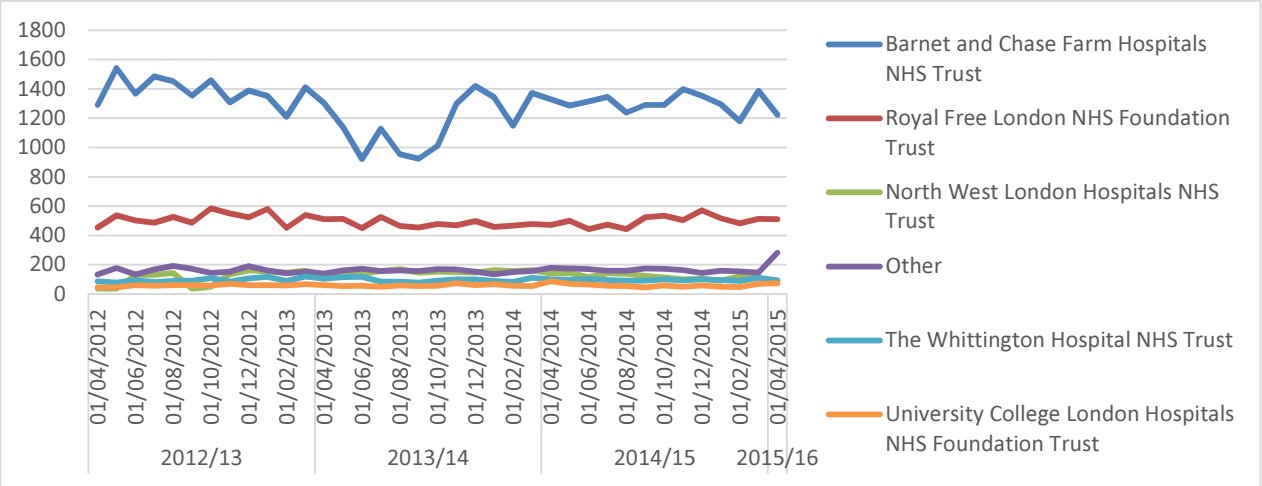
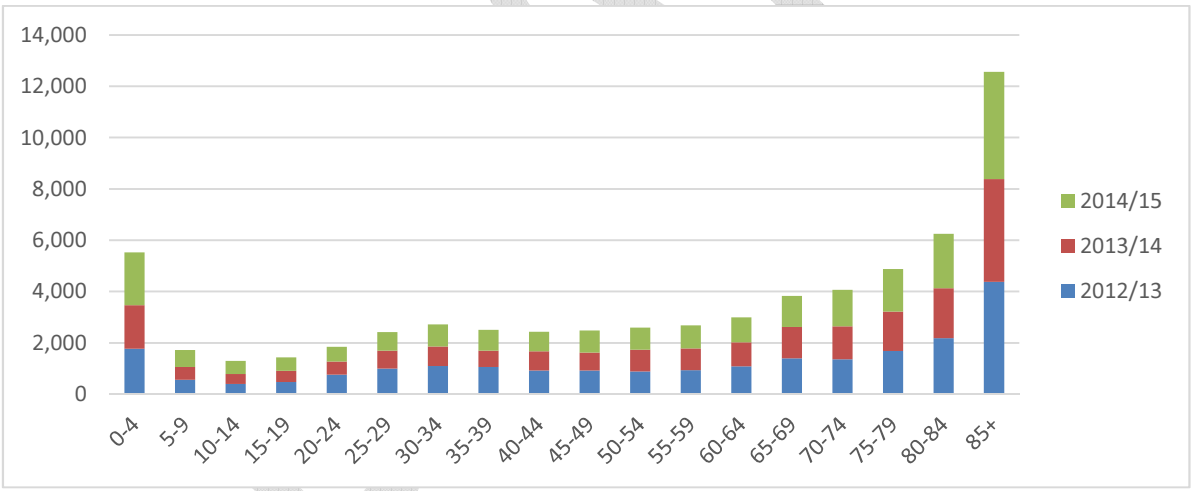


Figure 7-3 provides a breakdown of emergency admissions by age group for this same period. As can be seen, 48.9% of all admissions in 2014/15 were for people aged 65 or over, with people aged 85 or over accounting for 19.3% of admissions. Interestingly, by five year age band, the second highest rate 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:[112] [113]

- 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

[112] (Fearon and Langhorne 2005)
[113] 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

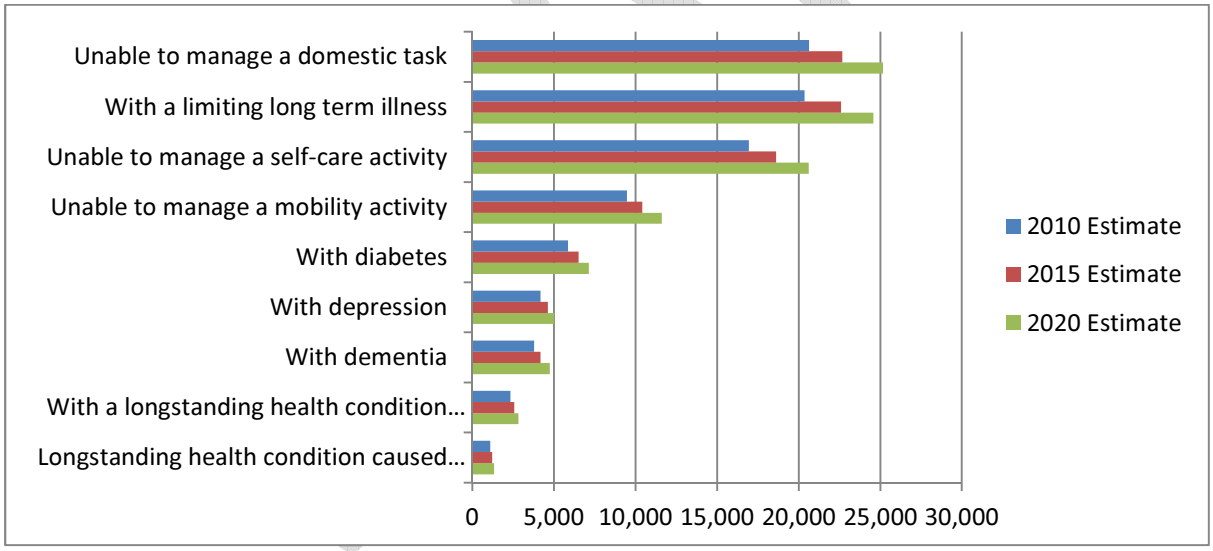
7.8 Frail and Elderly

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: DOH, POPPI

7.8.1 Key Issues

In the light of the anticipated pressure, a greater need to proactively manage our 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 with [114]:

- Not being able to manage a mobility activity on their own

[114] NICE Guidance 2014, DOH (2009). Fracture prevention services: An economic evaluation. London: The stationery Office.

- Unable to manage good self-care activity on their own
- 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. From this cohort, the number of people that have been admitted to hospital due to a fall is 1,065, which again, it is expected to rise by 20% by 2020.

Consequences of falls in this group have a significant impact to 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.

When looking at the number of attendances for falls when using the London Ambulance Service (LAS) data, in 2009, 3,700 Barnet's attendances for falls in over 65 year olds in Barnet. This represented 24% of LAS incidences and is a 36% since 2005.

Whilst it is difficult to accurately determine the prevalence figures of falls, by using estimates from DOH on the number of falls and their consequence, we were able to pull together the following figures in the Table 7-1.

Table 7-1: Prevalence of Falls, Barnet

	Estimates for Barnet (Based on a total population age 65+ of 47,253)	
	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, DOH July 2009.

7.10 Better Care Fund (2013)

The Better Care Fund (BCF) comprises of 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"115.

The BCF Plan provides a framework for targeting investment in a holistic, integrated model, whilst also being one of the drivers accelerating the process of whole system integration, by shifting the balance of care and activity over time from hospital and long-term residential care.

A comprehensive analysis of risks and mitigating actions / contingency plan has been developed as part of the BCF. The core issue relates to the financial position of the Barnet health economy, so significant emphasis will be applied to delivery of targets related to reducing in non-elective emergency admissions. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care and will manifest itself as cost pressures within organisations and potential reduced services.

7.11 Minor Ailments Scheme

Primary Care in addition to General Practice includes pharmacists and a range of other provisions. The scheme enables patients to access minor ailment advice and treatment from pharmacies. Eight pharmacies are part of the scheme. The three most common reasons for people attending the minor ailments scheme in the 8 pharmacies were hay fever, threadworm and fever. The pilot is to be extended to the 3 local hospital sites, with the aim of providing a viable alternative for minor ailment advice/treatment to attending the walking- centre or Urgent Care Centre.

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 [116] and around 7% of hospital admissions have been [117]associated with adverse drug reactions[118] .

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 with the purpose of providing 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, given the changing commissioning landscape at the time and the growth in community or interface services. They

[115] NHSE 2013
[116] Nunes et al 2009
[117] Making best use of the Better Care Fund. Spending to save, January 2014. Kings Fund
[118] Pirmohamed et al 2004

process approximately 7,000 GP initiated referrals each month the majority of which are triaged by a team of local GPs.

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 services urgent and emergency care services are available in Barnet. Barnet Urgent & Emergency Care Services comprise of 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 &E Summary Key facts and figures:

- 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 13/14
- 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.
- Moorefield 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

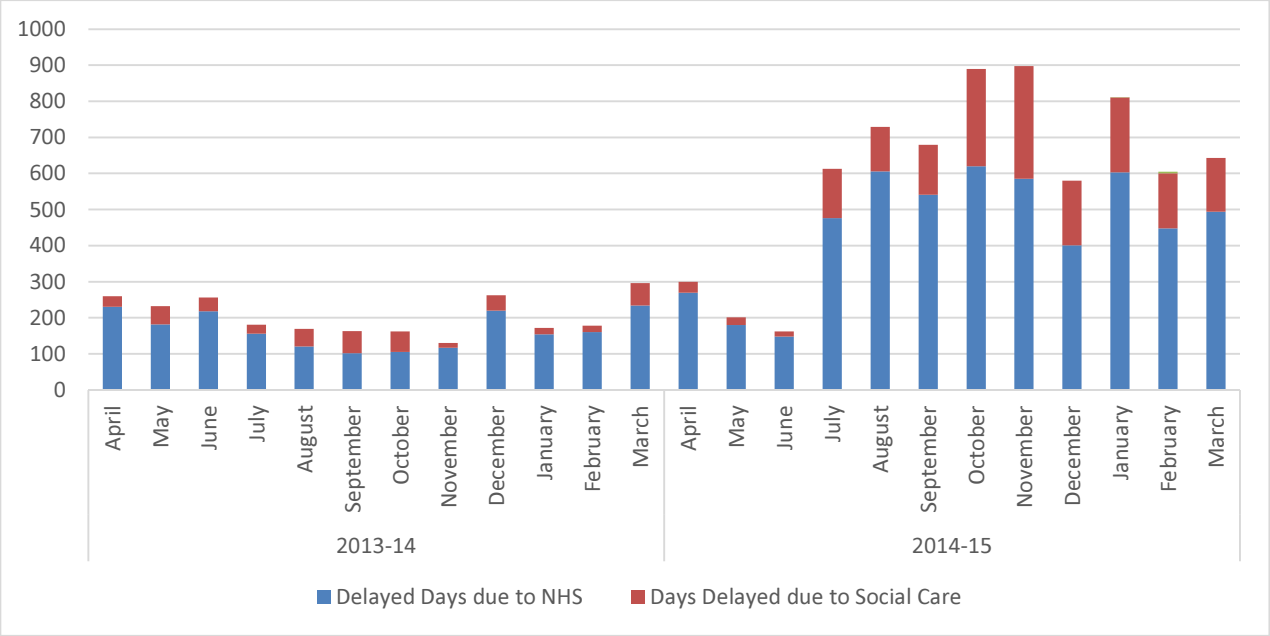
7.15 Barnet Delayed Transfer of Care (DToC)

A delayed transfer of care is experienced by an inpatient in hospital ready to move on to the next stage of care, but unable to do so due to social or health related arrangements not being in place. 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."

Lack of timely transfer and discharge arrangement has a negative impact on patients and availability of beds for others that may need them, adding to pressures on emergency admissions.

- In 2015 the national picture indicated that the total of delayed discharges had increased by 19%, with more than 5,000 patients per day experiencing a delayed discharge.
- The proportion of delayed discharges nationally attributable to the NHS (caused by delays in accessing community or mental health services) has risen from around 60% in 2010/11 to more than 68% in 2014/15.
- The proportion attributable to social care has fallen from around 26% of the total number of delayed transfer.
- Of the proportion attributable to social care, a small proportion are said to be eligible for care funding by the local authority and 4% accounts for waits for public funding accounts.[119]

Figure 7-5: Royal Free London NHS Foundation Trust – Delayed Transfers (Days each Month)



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, with patients likely to come through and potentially into Delayed Transfer of Care (DOTC) period;
- Complexity of patients and increased demand for social care and health input and impact on productivity;

[119] Kings Fund Report: What's going on in A&E

- 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 time120. 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 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 is almost three times higher in men than in women. The rate of mortality due to suicide and undetermined injury in Barnet is 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 rates of people reporting low levels of mental wellbeing or high levels of anxiety is higher than the England average but slightly lower than the average for London.

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.

[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

7.16.2 Adults Mental Health Services

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. Safeguarding Children where there are concerns of Parental Mental Health. 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.

Mental Health Trust provides mental health assessments and liaison A7E 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 receives 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

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 Chapter 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 be 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% BAME background. Over 50% of all 0-4 year olds in Barnet are from a BAME background, 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 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 in special schools is causing **a 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, 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.

8.3 Demography

8.3.1 Overview - Population Growth

The children and young people population in Barnet will increase 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

The largest population of children and young people aged 0-19 years in 2015 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[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 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%.

Table 8-1: Lone Parent Households by LSOA, Central/East Locality

LSOA	CC Reach	Locality	Ward	IMD	Lone parent households

[123] Index of Multiple Deprivation, DCLG, 2010
[124] HMRC, 2011

				score	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	CC 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 6 LSOAs that have a relatively high number of lone parent household. With the exception of 1 LSOA within Childs Hill ward, 5 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

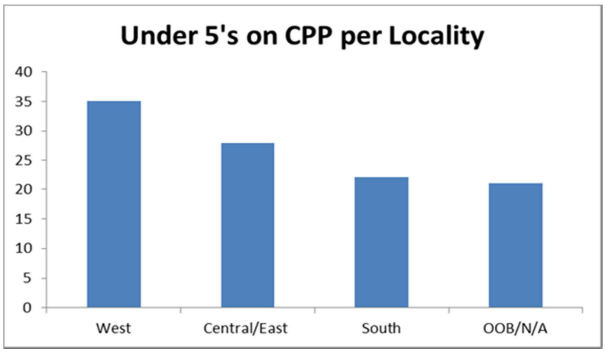
8.4.4 Ethnicity 0-5 years

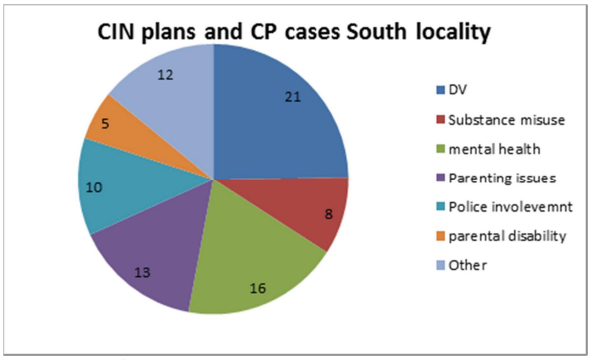
Barnet has 24 LSOAs with relatively high estimated number of BAME children under five (over 90 households per LSOA). The West locality contains 17 of the LSOAs with high concentration of BAME households with children under 5. It should be noted that there are high numbers of BAME children in the wards of Burnt Oak and Colindale, which have pockets of deprivation. The Central/East locality has only 2 LSOAs with high number of BAME households with under 5s, however, these are not deprived LSOAs.

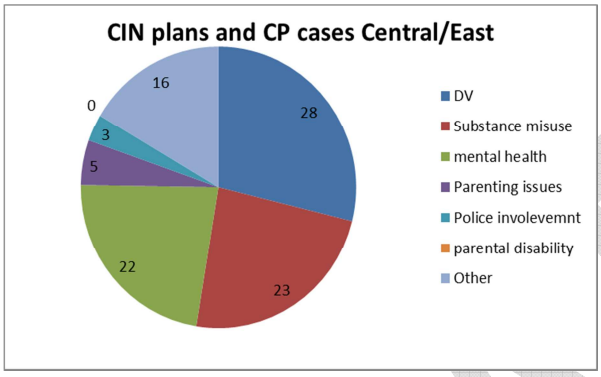
8.4.5 Children In Need (CIN) and Children Subject of a Child Protection Plan (CP) aged 0-5 years.

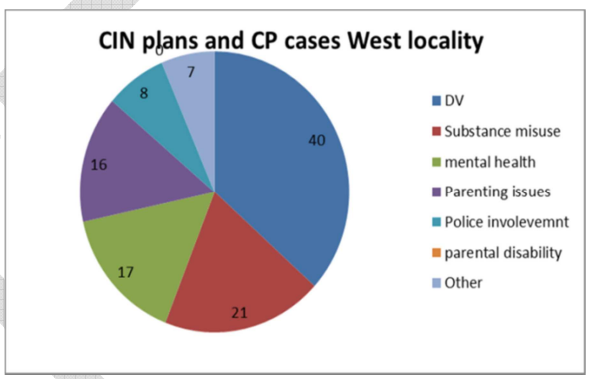
The tables below demonstrate that there is a higher number of under 5s on a child protection plan in the West locality, despite this locality currently containing the smallest number of under 5s overall. CIN plans by locality excluding disability show 160 CIN plans in total (Central/East: 64 CIN plans 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 5s 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%) and above the national average (65%), 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

Table 8-4: GLD Attainment by Locality

[125] Are You Ready? Good Practice In School Readiness, Ofsted 2014

	Central/East	South	West	Out of Borough	Barnet	National Average (DfE)[126]
No of children at EYFS	1775	1273	1225	450	4723	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

- 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 with literacy and basic skills required to progress into work. Improved partnerships with health and Jobcentre Plus.
- 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; 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

8.6 Education and Skills

[126] Early years foundation stage profile attainment by pupil characteristics, England 2014, DfE, Statistical First Release

8.6.1 Primary Education in Barnet

Between 2016/17 and 2020/21, primary school rolls are projected to rise by an estimated 7 to 9 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 3 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 London. 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 above 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. 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 6 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, 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

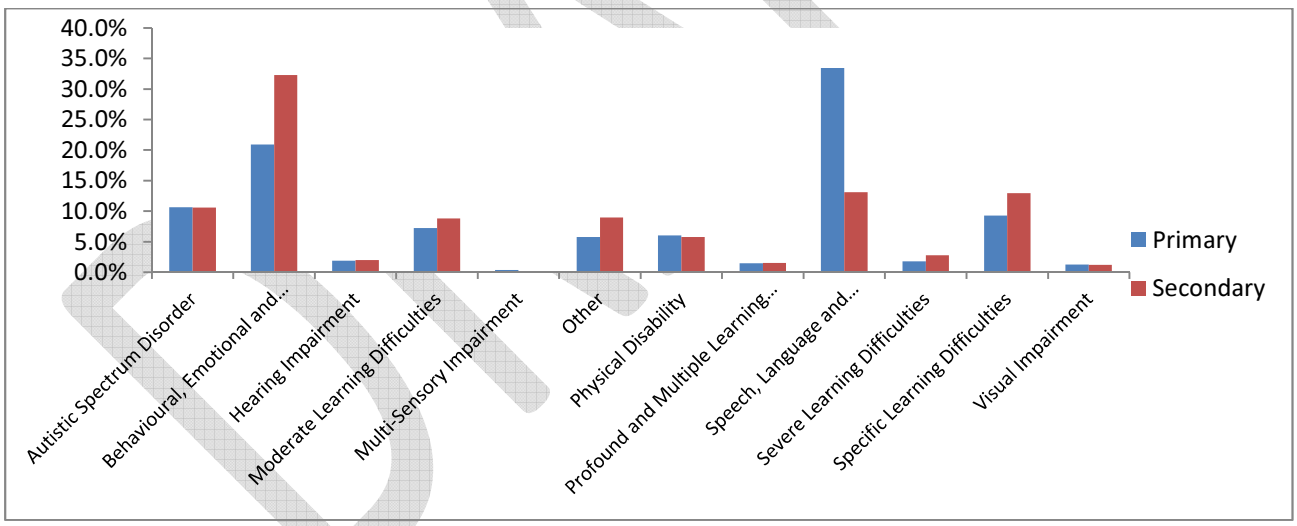
- Teacher and head teacher recruitment is a key issue for primary schools, with a head teacher recruitment and retention working group set up in response to difficulties in securing permanent posts. Key barriers to recruitment in Barnet include: availability and cost of parking, public transport, cost 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 Special Educational Needs

Barnet has 4 State-funded Special schools and 3 Pupil Referral Units. Across all pupils with special education needs 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.

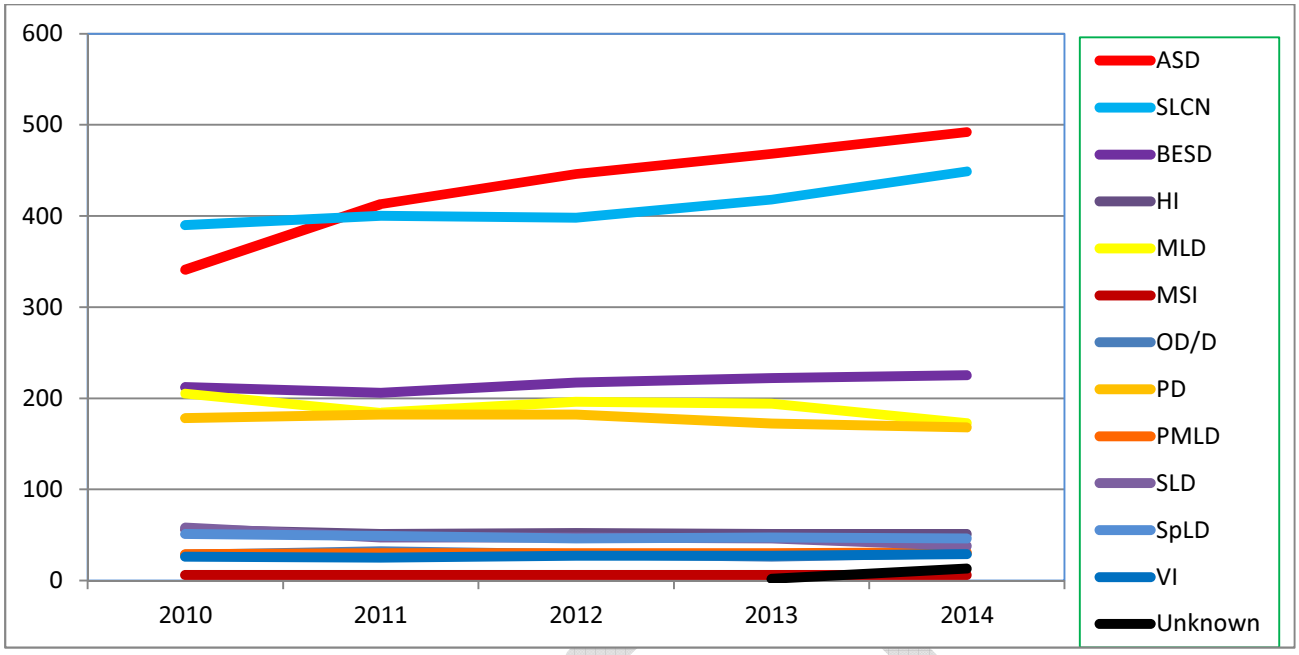
Primary Category of SEN Statement Type is shown in figure 7-2 and trend in the figure below.

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 our 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 SEND are placed in the special schools of other local authorities, whilst, in 2014, almost 10% (167) of pupils with a statement of special educational needs 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 SEND population established the following need 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

8.6.4.1 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.

8.6.4.2 The review of future needs, key issues

A review of future needs mapped the current provision against the range of needs of children with SEND 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 in special schools is causing a pressure on the availability of places for admission of younger pupils.
- There is an opportunity to improve the offer for children with significant SENDs 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").

8.6.4.3 Key Issues

- Future needs have considered how best to invest in order to both meet the increased demand, and 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 our 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.

8.6.4.4 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 SEND should have as its focus 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.

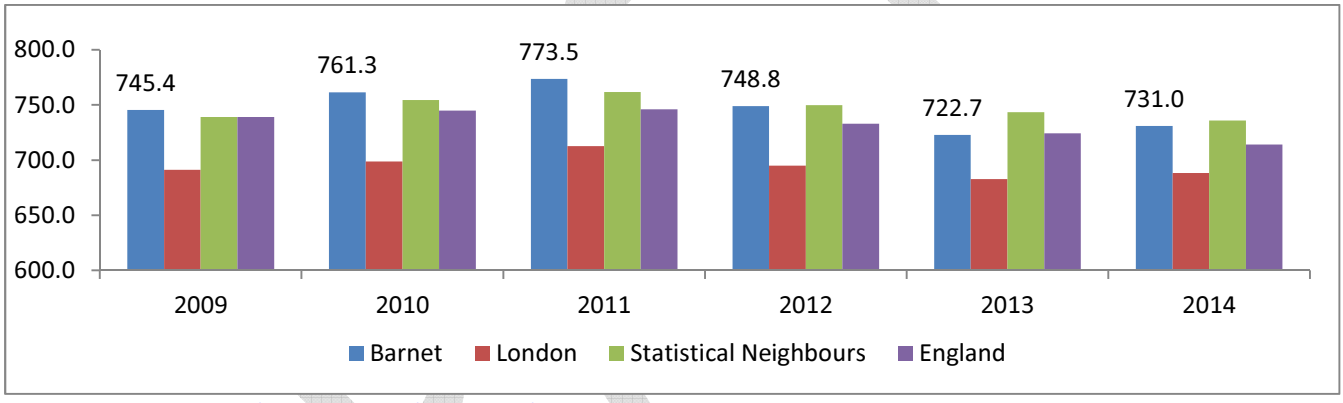
- The current balance between mainstream and specialist provision is appropriate and should be maintained.
- Funding mechanisms should be designed to provide stability and enable planning for quality provision.
- The strategy should ensure equity of provision for SEND in and between schools and equity of funding based on outcomes.

It is expected that there will be a continuing programme of support and environmental improvements for mainstream schools and academies, as now, to respond to complex needs of pupils in those schools.

8.6.5 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).

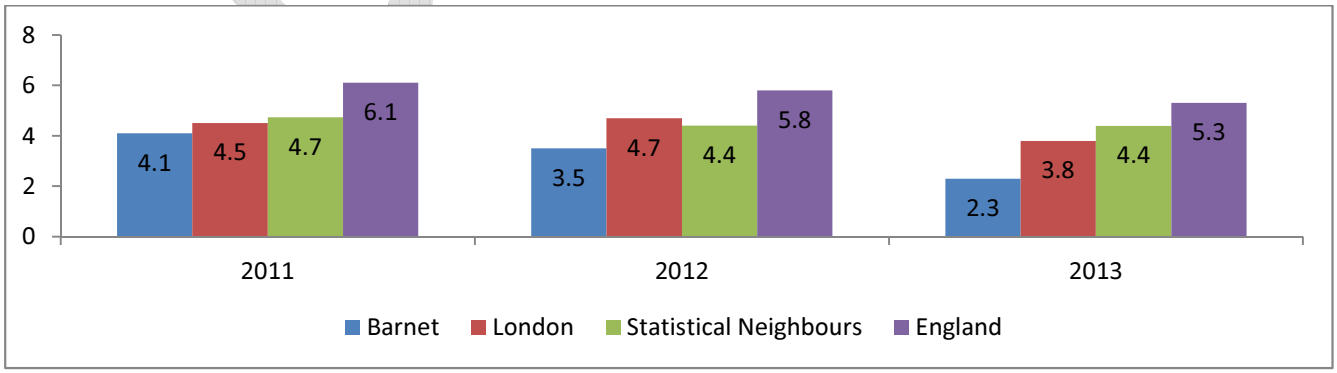
Figure 8-4: APS per Candidate



Source: www.gov.uk/government/statistics/a-level-and-other-level-3-results-2013-to-2014-revised

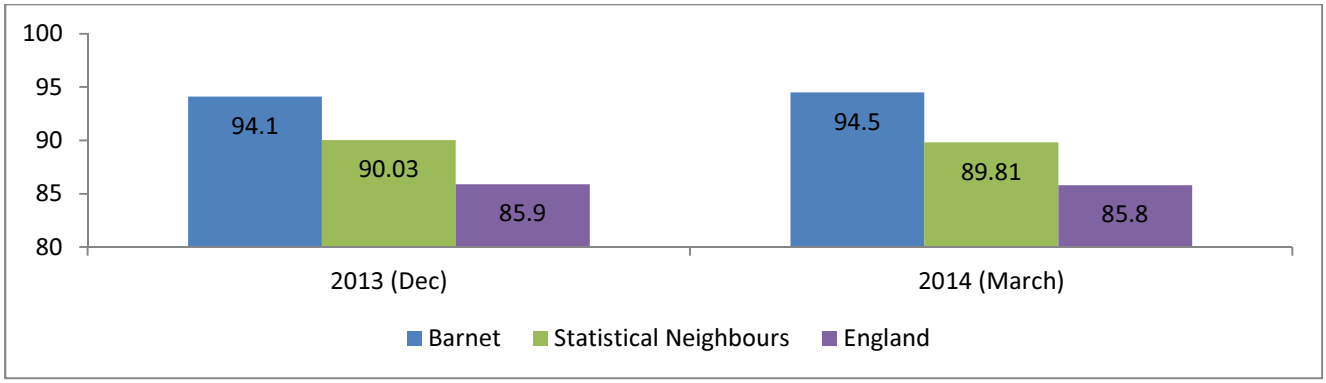
Barnet performs particularly well at ensuring all young people engage in education, employment or training up until age 19 with the proportion of 16 to 18 year olds not in education, employment or training (NEET) ranked 4th nationally. This success is continued for those pupils with learning difficulties or disabilities, where participation rates are ranked 9th nationally.

Figure 8-5: % NEET



Source: Local Authority Interactive Tool (LAIT)

Figure 8-6: % LDD Recorded in Education and Training Aged 16 – 17 Years



Source: Local Authority Interactive Tool (LAIT)

8.6.6 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, 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 our statistical neighbours. The mean Indicator for our statistical neighbours in May 2015 is 86.2% year 12-14 in learning, 3.9% NEET and 5.9% Not Known.

8.7 Prevention and Early Intervention

Prevention and Early Intervention 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) intervene as early as possible; ii) Take a whole family approach; and iii) use evidence based monitoring systems.

A local needs analysis identified 8 '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. Early intervention and assessment early, aligned 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.

We are reviewing the above offer to ensure it is line with the 8 themes identified in our needs analysis and is better integrated with partner agencies. Children and families fall into 4 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 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 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 our most deprived schools. For example 4 schools with moderate to high deprivation percentages initiated 0 CAFs in 2012/13 and 2013/14. As part of the Early Intervention Strategy we are developing a strategic approach to schools and Early Intervention, including considering use of the pupil premium.
- Improve practice in relation to obtaining the voice of the child and working with diversity
- Increase the % of needs met/successful interventions in family support work and ensure plans are purposeful and interventions are focused
- Improve our 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

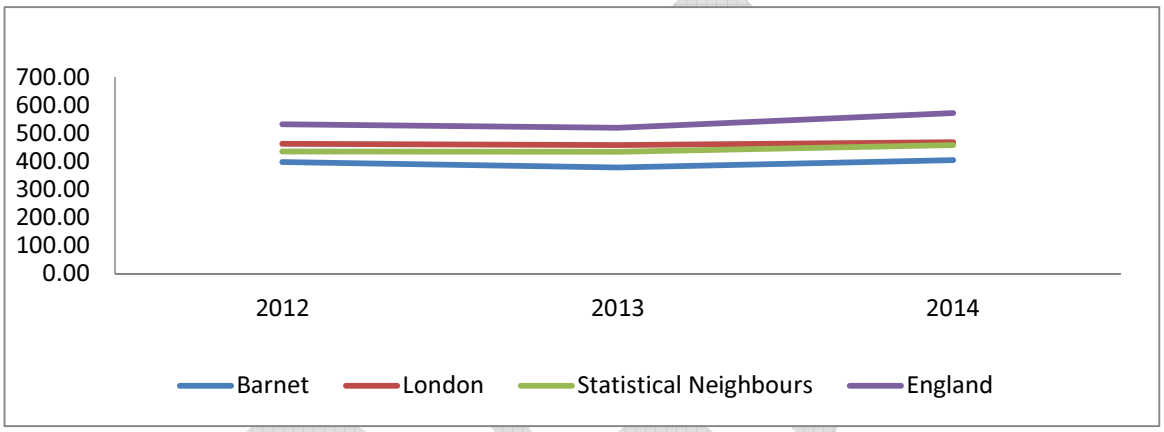
consistently exceed 3,000 per quarter. Contact rates nationally and across London have been increasing since 2013.

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*:* Rates per 10,000 of Referrals to Children's Social Care



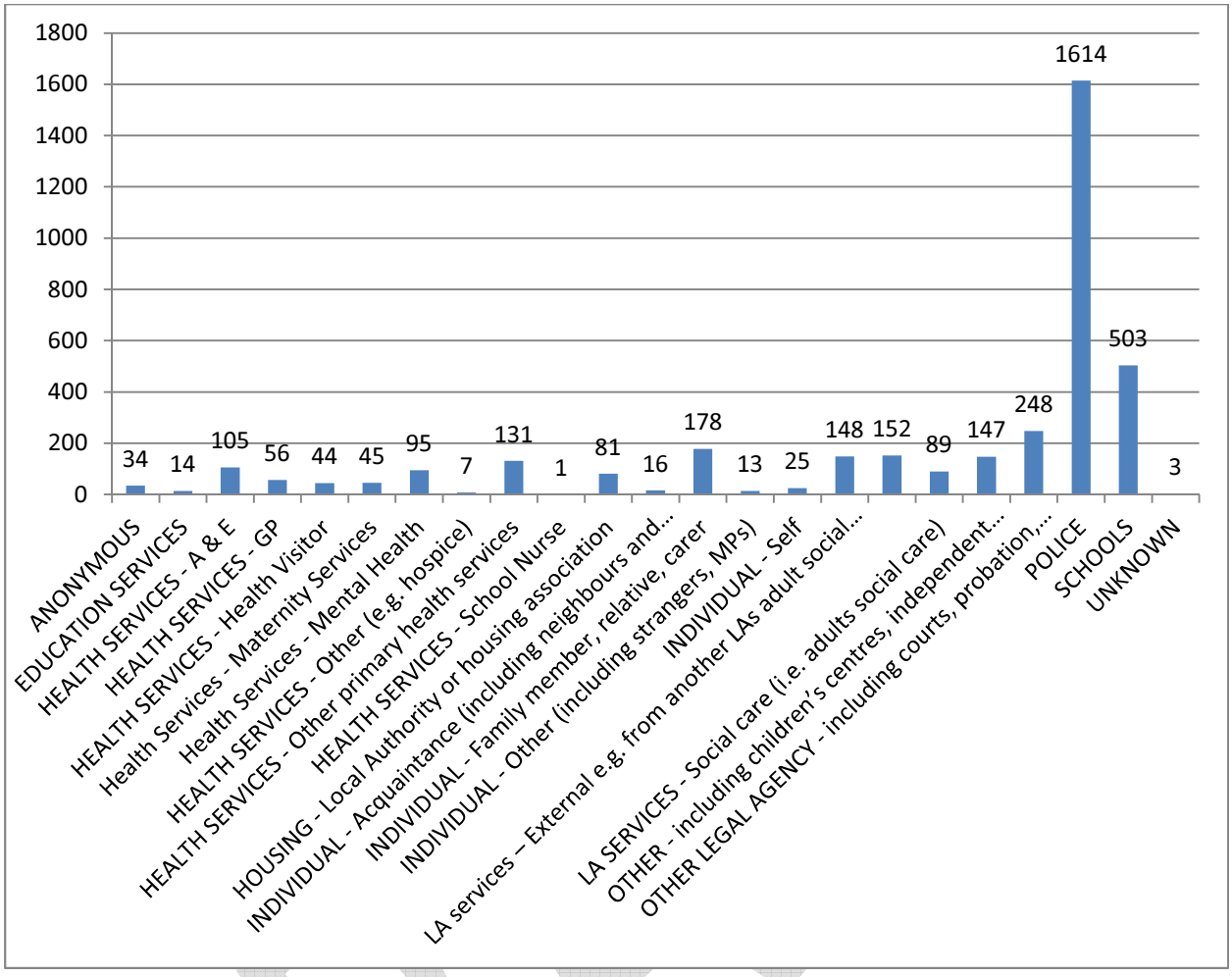
Source: LAIT

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 increases and higher rates.

Children aged between 5 - 9 and 10 - 15 are the largest age group within this population, each making up 29%. 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.

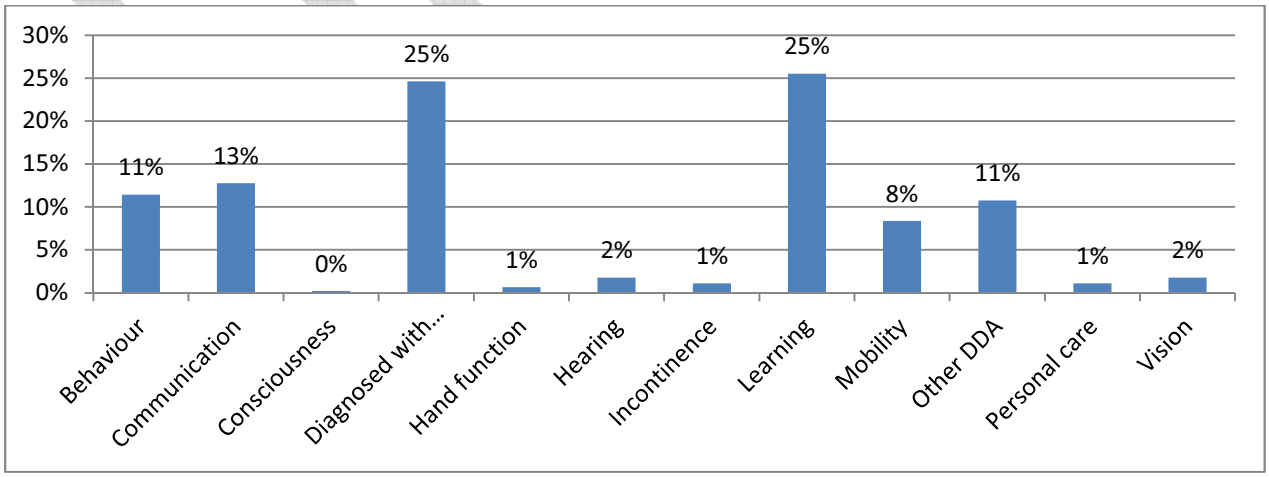
The figure below shows the number of referrals by referral source for the period quarter 1 April – June 2015

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.

Figure 8-9: CWD - Nature of Disability aged 0-25



Source ICS June 2015

[127] Data source ICS (includes all teams)

Of those children in need with disability the highest percentage had a learning disability (25%) and 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%**	

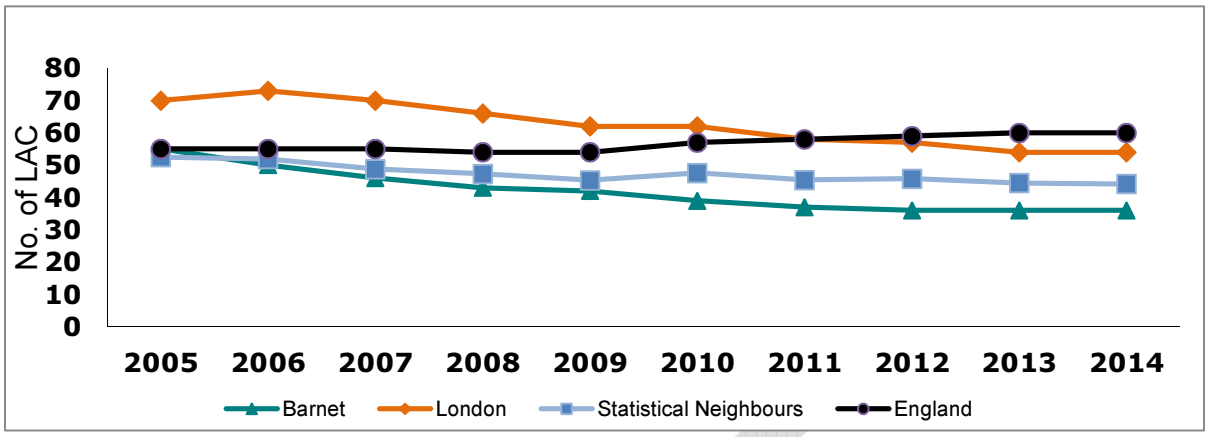
Source: Data extract from ICS data pulled 28 February 2015

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 its statistical neighbours. The numbers of LAC over the past 7 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 Barnet's Statistical Neighbours. This suggests that children in Barnet are supported effectively to remain within 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 of looked after children, due to its 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 with 49%, followed by Mixed and Black or Black British ethnicity at 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 – 15years. (38% of the Barnet cohort falling 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 higher proportion of Children in Care in residential placement[128] which stands at 22% (March 2014) and is higher than both the 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% below statistical neighbours 73% and England average of 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.

[128] Residential placements as defined in OFSTED social care data 31st March2014

SEN rates for Barnet LAC are much higher than for Barnet pupils generally and higher than the LAC in England rate. KS4 2010-14 average performance, Barnet LAC % 5+A*-C inc English & maths is better than national LAC, 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.

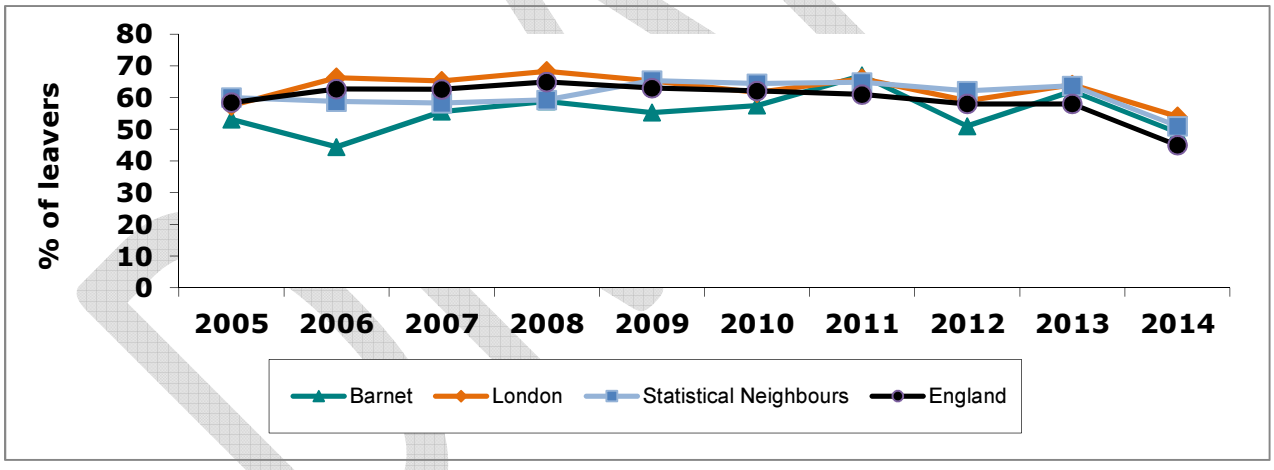
For the past 2 years, Barnet's rate of Care Leavers in Suitable Accommodation has been higher than that of London, England and its statistical neighbours.

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 EET (Education, Employment or Training) has fluctuated since 2005. In 2014, Barnet's rate was similar to London and its 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 9 years.

Figure 8-11: Care Leavers (aged 19, 20 and 21) – Education, Employment and Training



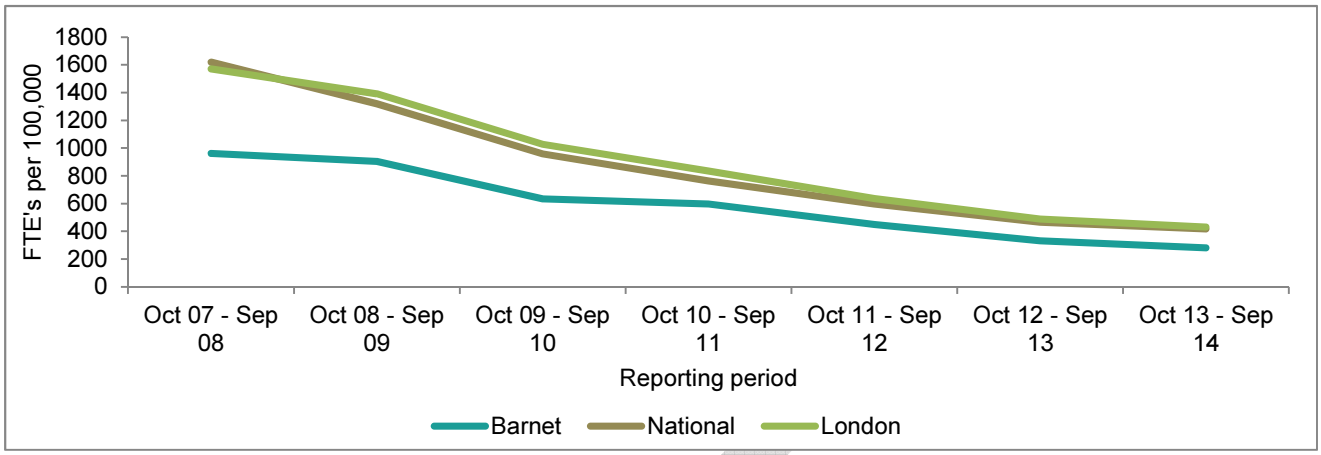
Source: LAIT

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 1 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



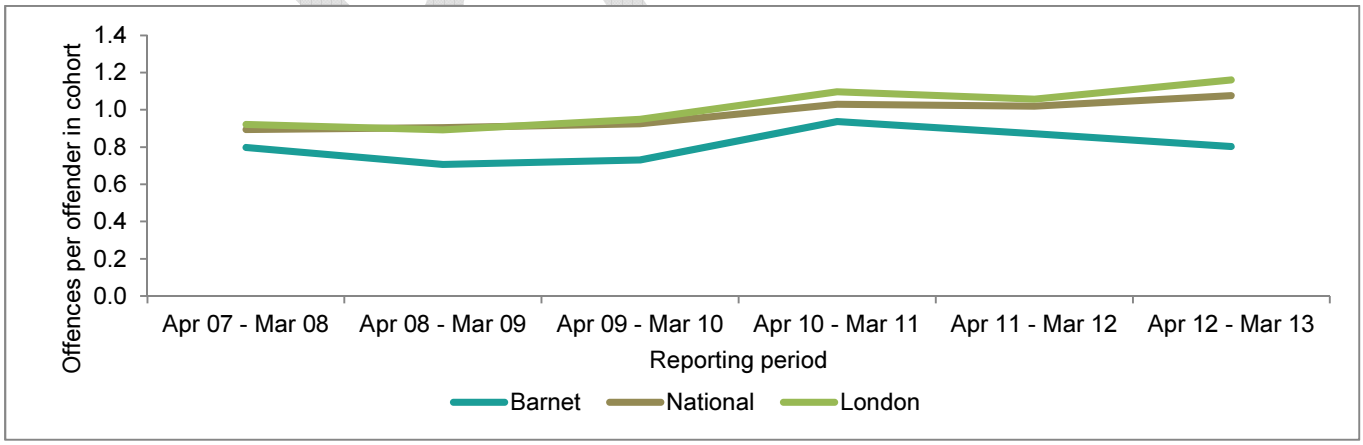
Source: YJMIS

There is a need to improve access to CAMHS, 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 our 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 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: YJMIS

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.

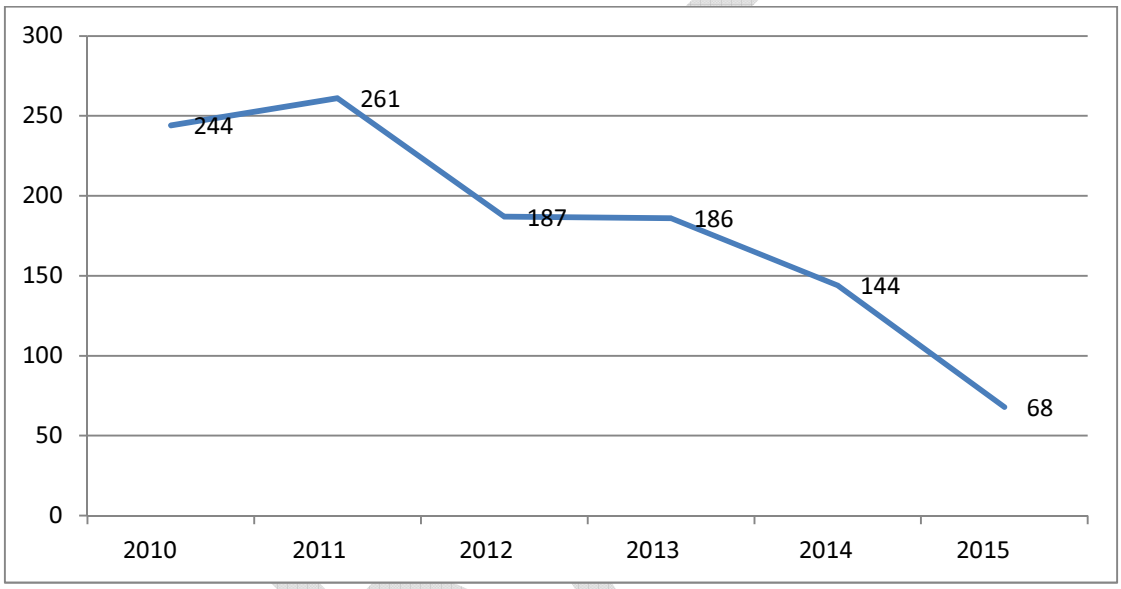
- Additional support and mentoring
- Interventions which target the needs of the male BME population
- Physical health provision in the form of a school nurse who can deliver training in first aid/sexual health
- CSE screening

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. 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

Child sexual exploitation (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 our society. Child Sexual Exploitation is a priority of the Barnet Safeguarding Children Board.

Known cases in Barnet are from predominantly white females in their teenage years, although 35% of children subject to CSE are males. The ages at which the highest numbers of children were sexually exploited in Barnet were between 15 and 16.

[129] Number of programmes started, rather than number of young people

Figure 8-15: Ethnicity of known children in Barnet subject to CSE

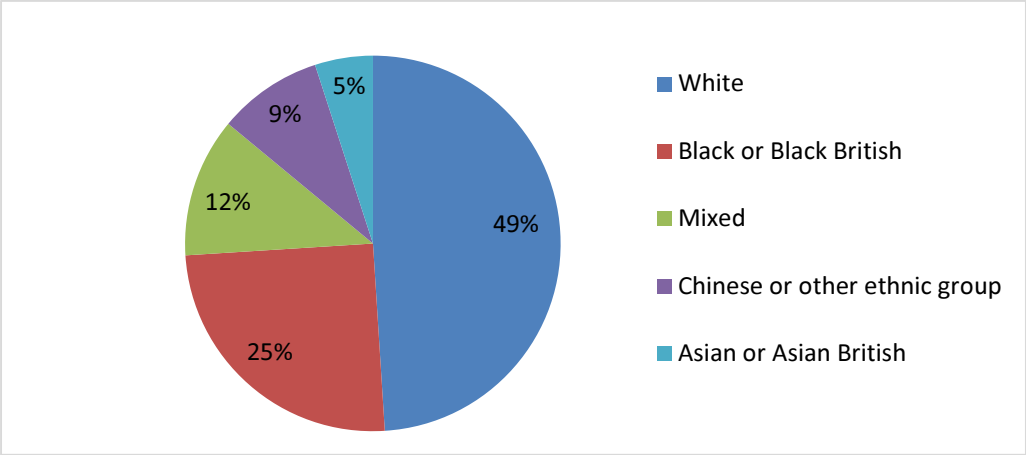
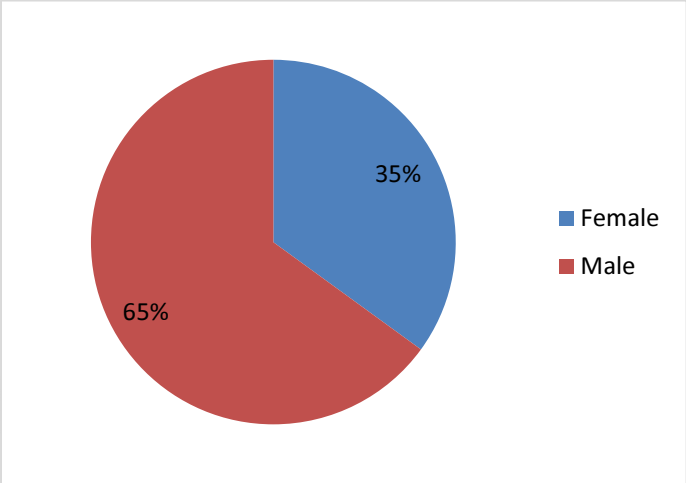


Figure 8-16: Gender of known children in Barnet subject to CSE



The largest number of children deemed at risk of CSE are white (45%), although this group is under-represented when compared to the Barnet population. Young people of mixed or black ethnicity make up 37% of high-risk children, although only make up 13% of the Barnet population, which makes them three times more likely to be at risk of CSE.

8.10 Gangs

A gang is a 'relatively durable, predominantly street-based group of young people who:

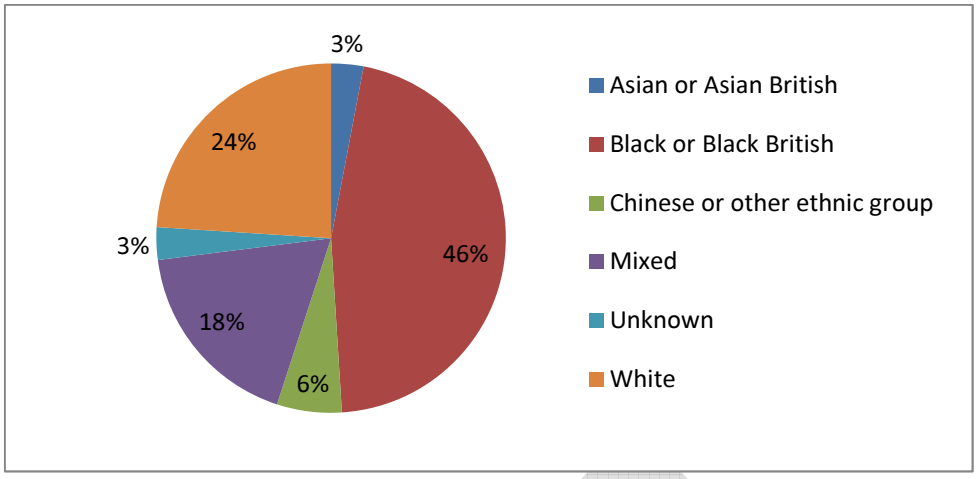
(1) See themselves (and are seen by others) as a discernible group, and
(2) Engage in a range of criminal activity and violence

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 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 8-17: 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 3 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 and running away for the first time. Around a third of children in care run away 3 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 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 8-18: Ethnicity of known children missing from care or home

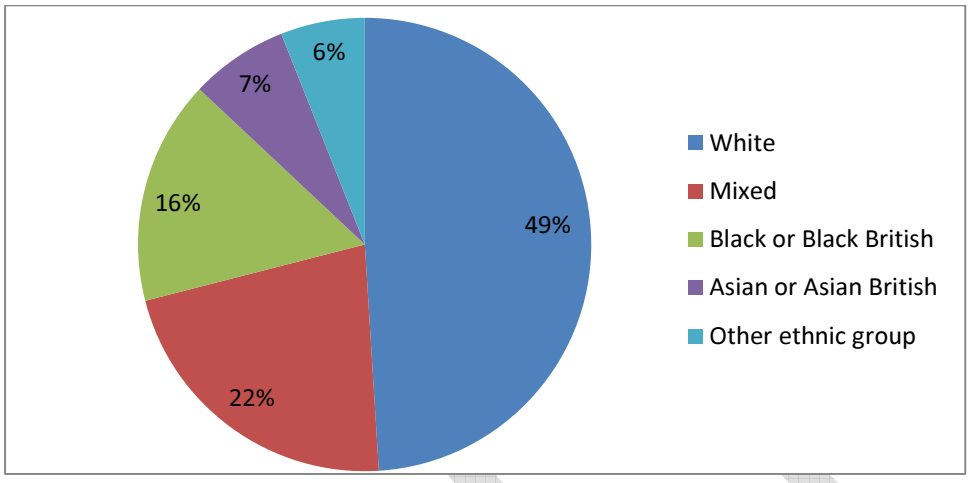
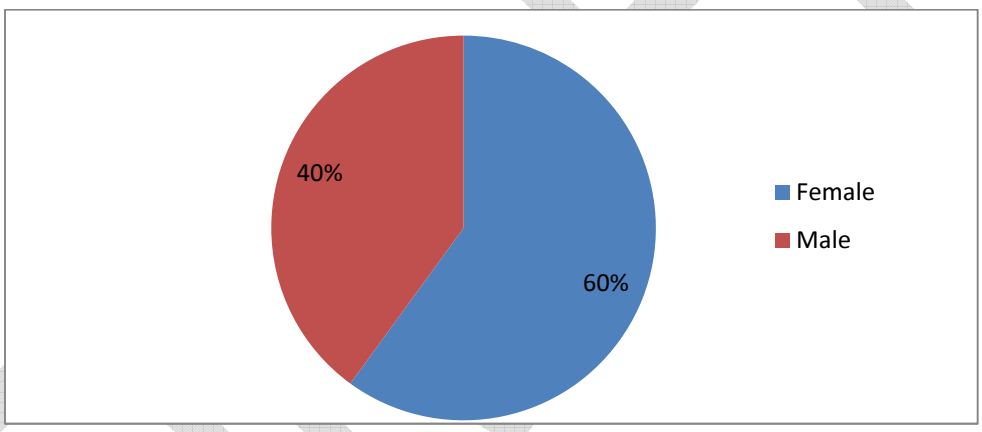


Figure 8-19: Gender of known children missing from care or home



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 6 and 10 and at the age of 16.

8.12 Domestic violence, Parental substance misuse, parental mental ill health (Toxic Trio)

An analysis of random sample of CAFS in Barnet found the 'toxic trio' of domestic violence, mental ill-health and drug and alcohol misuse in families was 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 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 in 38% of cases, followed by those aged between 31–40 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 highlight 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 the 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 3 in 10 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. Dollis Valley estate in Underhill, pockets in Brunswick Park and the A5 corridor from Colindale to Edgware are the worst affected areas.

Barnet commission 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 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 pathway 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/or 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: Barnet primary schools - 21% against 17% in London' 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 is as follows:

[130] Extracted from Children and Adolescent Mental Health Service (CAMHS) – Barnet (26.01.2015) Dr Neel Bhaduri, Draft V2

- 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 disorder 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, spend on CAHMS appears to be reasonable looking at expenditure by deprivation levels.***
- A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 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 3095 5-19 year olds and Mixed anxiety and depressive disorder at an estimated 1405 16 - 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; who are in the youth justice system.

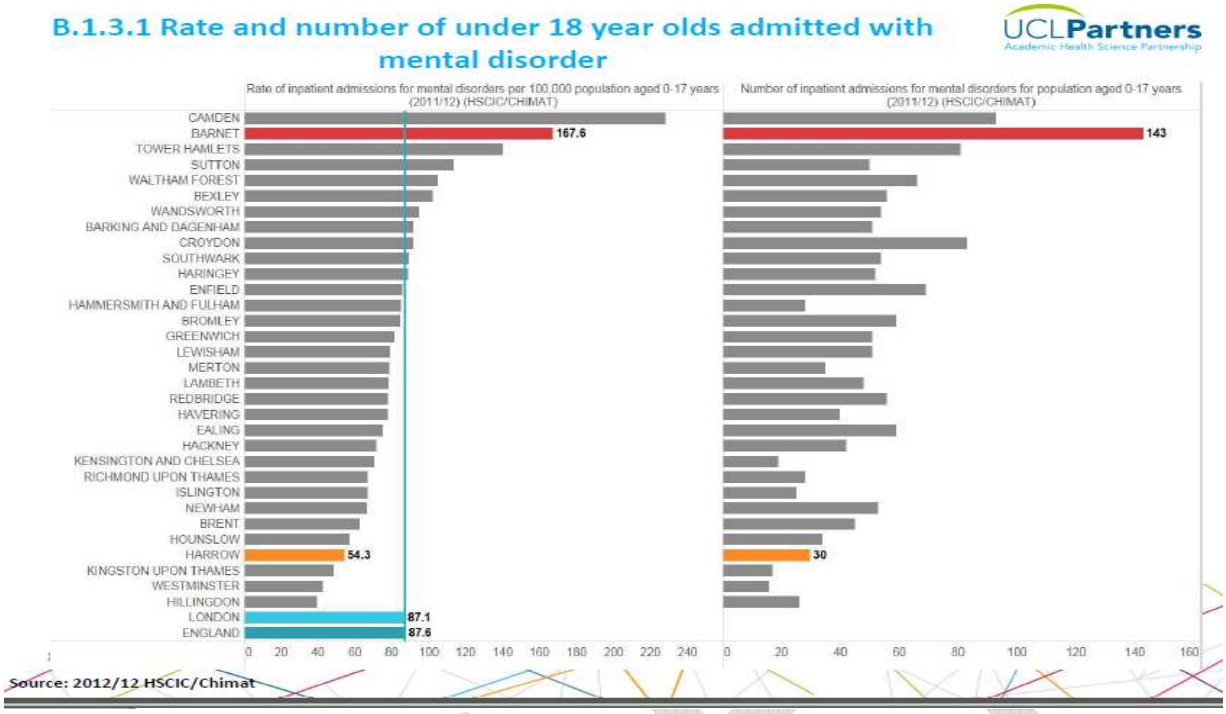
Table 8-14: Estimated number of 16 to 19 year olds with neurotic disorders

	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.

[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 8-20: 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, an increase of 20% from 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, 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 or 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, mental problems or 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 and be black

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 and parent 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 carer's 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 already 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
- Early findings of the young carer's need analysis show.

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 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 10 and between 16 and 24;
    - One in eight are under 10 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.
- Need to ensure sufficient support for young carers under 9 as well as increased identification and support for young carers in transition age. This needs to be addressed in joint commissioning process.

8.14.3 BME;

National research shows young carers are 1.5 times more likely to be BME 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. This confirms the need to ensure sufficient identification and support for children under 10.
- 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 1 in 5 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

- 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 and having low job prospects and educational opportunities. As well as being a young carer at 20/21 and being in lower skilled occupations.

- In Barnet the proportion of 16 to 18 year olds NEET is ranked 4th nationally and 9th nationally for participation rates for pupils with learning difficulties or disabilities.
- Must ensure 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 & the factors that directly & 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.

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 day per person** 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 per cent 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's 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
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.

[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'
[137] http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/child-poverty/disabled-children-and-poverty-0

Black and minority ethnic groups

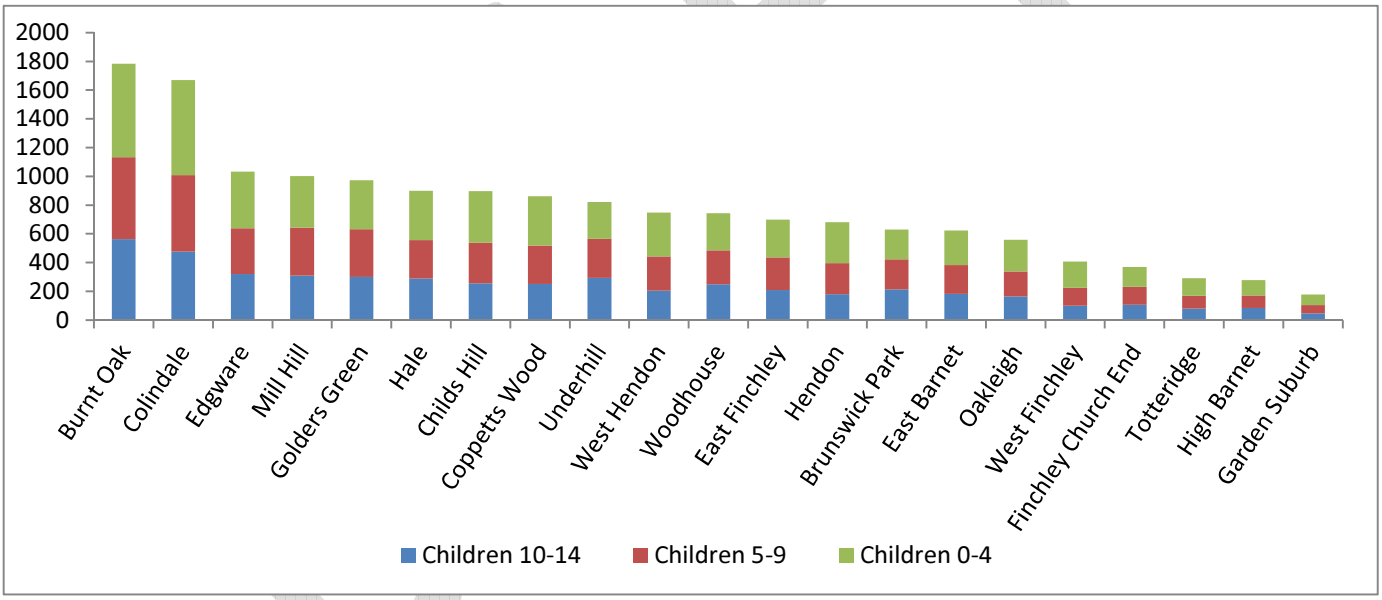
Nationally in 2010, nearly three-quarters of 7-year-old Pakistani and Bangladeshi children and just over half of those black children of the same age were living in poverty. Barnet has a BAME average of 39%; however, in Colindale, Burnt Oak and Hendon, BAME residents make up over half of the population.

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 BAME residents is higher in these areas.

Figure 8-21: Estimated numbers of children living in deprived households by age and ward



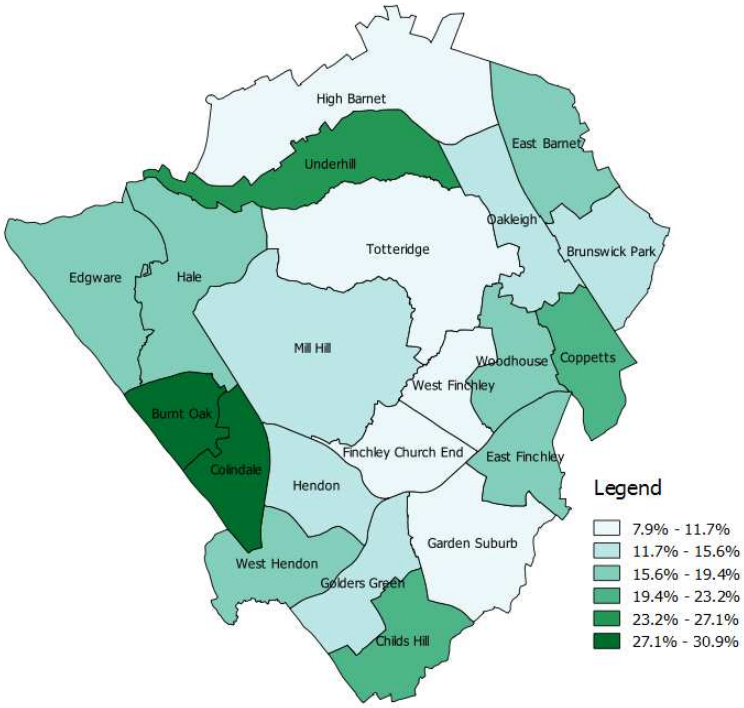
Source: HMRC, 2010

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[140].

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%

[138] 2010 HMRC data
[139] HMRC data 2010

Figure 8-22: Child Poverty by Ward



Child poverty is particularly low in the more central wards running from north to south: 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[141]. 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.

Nationally, only 48 per cent of 5 year olds entitled to free school meals have a good level of development at the end of their reception year, compared to 67 per cent of all other pupils. Less

[141] '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

than half of pupils entitled to free school meals (just 36 per cent) achieve 5 GCSEs at C or above, including English and Maths, which compares to 63 per cent 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 10 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 6 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[142]. 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.

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%

[142] 'Health Consequences of Poverty for Children', End Child Poverty: http://www.endchildpoverty.org.uk/files/Health_consequences_of_Poverty_for_children.pdf

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 2: 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[143], and that the percentage of children in working households has reached 52%, which is the highest level seen in the past 10 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%).

	Barnet	London	England
Children in Workless Households (%)	13%	17%	14%

[143] Labour Force Survey (Household and Labour Market Division) ONS2012

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 & 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 & 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 rich and 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).

In addition a programme of work targeting young people engaged with the YOS team, PRU, and foyer is also under way. Initial feedback from this cohort of young people has told us:

- Young people generally feel safe in Barnet – Believe there is community cohesion – people get along with each other and Barnet does not have the same problems as Tower Hamlets or Rotherham
- The views of statutory/public services by Young people engaged with YOS were often shaped by their experience of the police and youth Justice system.
- Education, Training, Employment- Courses offered is generally too short and or offer limited qualification, if any. The 'churn' in providers is high. Young people are not clear about where they go after doing the courses/ what options are open to them.
- 'Transition from primary to secondary school could have been better' Support network disappeared when young person went to secondary school. Noted that for some of these children their behaviour may deteriorate as a result of limited or no support
- Boys from YOS have said they understand the difference between feeling 'down' and feeling ok, but struggle to understand when feeling down becomes depression. They don't always know where to go for help. In the main they would go to their GP
- Feeling that early intervention mental health services were poor , they had not been told about where to go for help

8.16.1 What other young people have told us and their key/top priorities

- Helping disadvantaged children and young people to do well in school
- Mental health services for children and young people
- 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
- Reducing child poverty
- Young girls have increasingly spoken out about relationships and how they can support each other. They would seek help initially from their GP

- Improved access to, and quality of, mental health provision at the earliest possible opportunity for children and young people
- 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
- CLA to receive a more thorough and considered induction into care and a more flexible approach to their care reviews
- CLA to be able to receive concise information upon their entitlements upon receive CLA 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.

9 Chapter 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 were 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 undertaken to help people to remain at home longer.
- In relation to the total population, Brunswick Park and Underhill has the highest rate of carers (10.5% of the population), whereas Colindale has the lowest (6.90% of the population).
- According to national projections, the most common health conditions/disabilities within Barnet are mental health disorders and hearing impairment in those aged 65 and over.

9.2 Strategic Needs

- 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**, **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.**
- **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**.
- **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 could indicate a **deficiency 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).
- C**arers 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, our 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 our social care teams for full assessment.

Figure 9-1*:* Number of people contacting Adult Social Care during the year

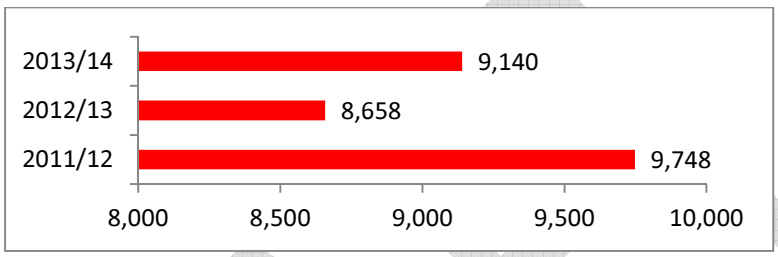


Figure 9-2: Number of people receiving Adult Social Care services during the year

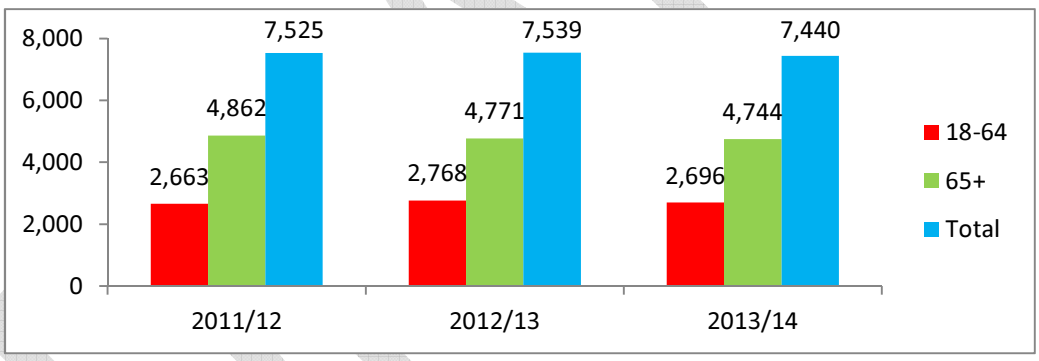
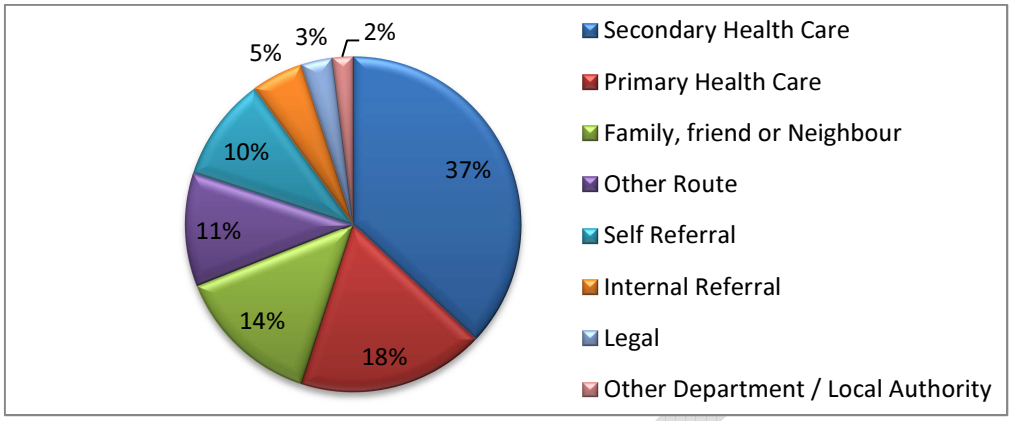


Figure 9-3 shows the proportion of referrals to Adult Social Care by referral source for 2013/14. The largest proportion of referrals to Adult Social Care, were made by secondary health care teams (37%) e.g. hospitals. Whereas, primary health care accounted for less than half of this amount (18%), and family, friends, neighbours and self-referral only accounted for a total of 24% of referrals.

Through effective prevention and early intervention there is an opportunity 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



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. Some elements come into effect in April 2015, others in April 2016.

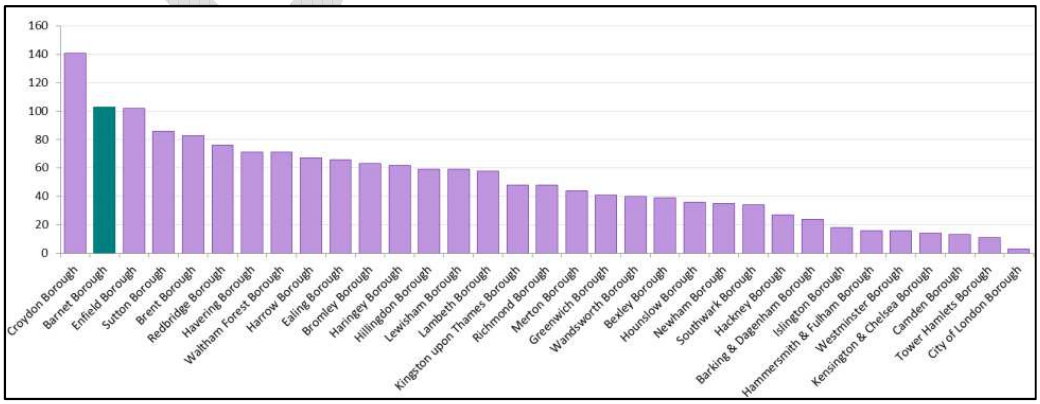
It brings new rights for carers that put them on the same legal footing as the people they care and entitles them to ask for their needs to be assessed. For the first time, the Act will put a limit on the amount anyone will have to pay towards the costs of their care.

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. This is the second largest number of care homes in London.

Figure 9-4: The Number of Care Homes by London Borough



In 2013/14, 75% of residential placements were provided to older adults (65+) and 61% of residential placements were provided to women. The high proportion of women compared to men is unsurprising as women account for 56.5% of the 65 and over population within Barnet, compared to men who account for 43.5% of the population[144].

14% of residents had a learning disability, 6% had a mental health problem and 5% had a physical/sensory impairment.

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 undertaken 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

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

[144] GLA 2013 Projections

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.

Despite the reduction in the number of people living in care, this still remains relatively high within Barnet in comparison to our local authority comparator group. It is important that people are cared for in their homes, if this is what they wish, rather than in residential or nursing homes. This is part of a shift towards enablement and community-based care.

9.6 Enablement

Enablement refers to short-term intensive support which is given to a person to help them regain their independence. It is free of charge, 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 some 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 deficiency of around 800 people.

If the estimates from the CSED are applied to the latest population projections, due 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 Projections

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; we expect this trend 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%

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 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 8-8 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.

Although, 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% adopting 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%

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 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 our understanding of the drivers behind this.

9.8 Community Care

The pattern of social care provision has changed over the years with fewer people wishing to enter long term residential/institutional care and greater variety and number of community provisions. Growth in personal budgets and direct payments has shown the potential for service users to arrange their own care and support, with expectation 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 9-5 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 9-5: Number of Service Users in Receipt of Community Care Services

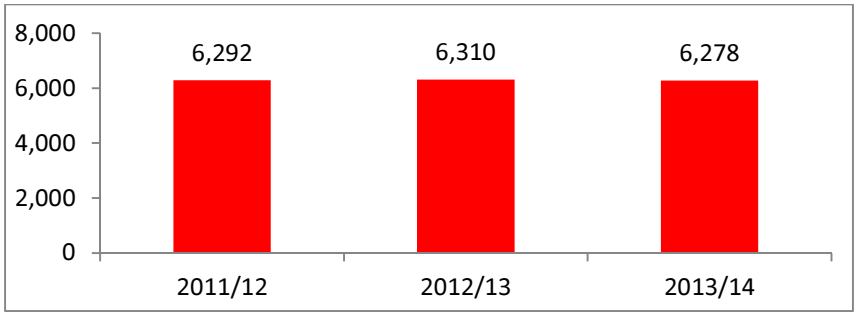


Table 9-9 breaks down the community service users by primary support need, compared against the total number of service users receiving support for these services. In 2013/14, 84.4% of all service users received some form of community care service, with all categories in excess of 70%. Although, there may be an opportunity for clients with learning disabilities as they have a significantly lower take-up rate (74.90% in 2013/14) than other clients.

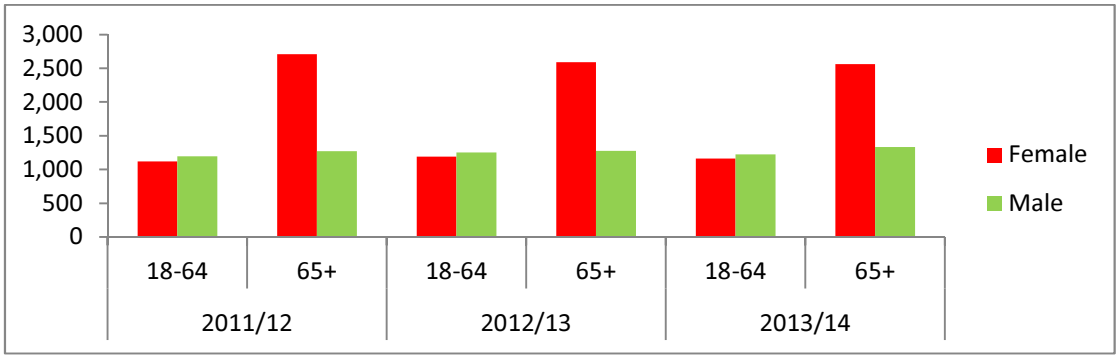
Table 9-9: Number of Service Users by Primary Support Need

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%

Figure 9-6 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 breakdown of Adult Social care clients.

By gender, the rate of 18-64 year olds 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 number of men aged 18-64 receiving community care as those aged 65 and over.

Figure 9-6: Number of Service Users by Age group and Gender



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 and also to people with disabilities or complex needs. It often follows a period of Enablement when 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 Home Care 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) home care 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**

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**

9.8.3 Voluntary services and Social Capital

Those not accessing social services may be purchasing care directly themselves or with 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 to purchase care themselves. 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 are 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 money 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, Day Centre for Tamil Elders. There are also targeted services such as those for people with dementia, or who have suffered from a stroke.

Services such as Home from Hospital and the Handyperson explicitly assist older and vulnerable people to return successfully from a spell in hospital or helping to avoid hospital admissions.

The Barnet Ageing well programme, which together with the Neighbourhood model, stimulates increasing use of social capital through effective use of volunteers and encouraging peer support, and encouraging and supporting local leadership. Projects such as the Barnet Timebank, Mens 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, and 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 is unpaid and 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.

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

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.

Currently nearly 5,500 carers are registered with our commissioned lead provider for carers support services in the Borough.

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 according to 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**

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 we may offer respite care or direct payments
- We have 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
    - 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.

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

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

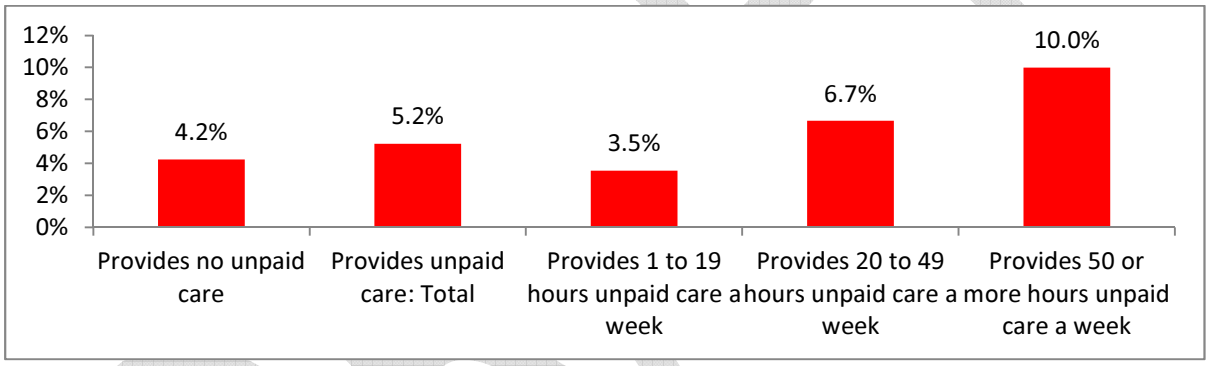
Census, Barnet's informal carers have a potential to save health and social care services, up to £595m per year[145].

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 minimal time for themselves. Being a young carer can impact on a young person's childhood and can have a detrimental impact on their educational attainment, health and emotional wellbeing, and their 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 over two times more likely to report poor health than those providing 1-19 hours of care.

Therefore, it is vital that we 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 9-7: Proportion of Unpaid Carers in Barnet in Poor Health



Source: Census 2011

9.9.3 Gaps in Current Provision

We recognise that we need to:

- Ensure that we 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 our 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;

[145] 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 about.

The demand for carers is projected to increase 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 8-17 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, 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

In Barnet we have adopted the social model of disability. Disability can have significant medical consequences but the difficulties /barriers that face people are encountered in taking part in everyday life arise largely because of attitudes and 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 (where 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: POPPI and PANSI 2015

9.10.1 Mental Health

Mental disorder is 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, all of which create demand on other services.

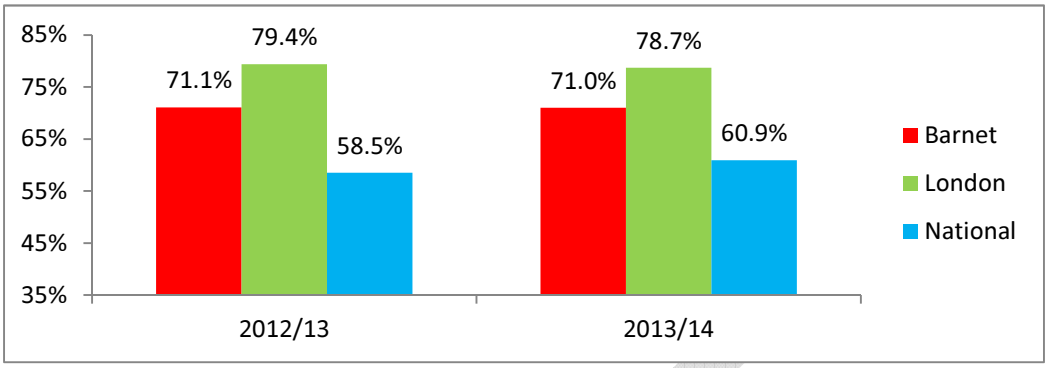
Despite the number of people with mental health conditions expected to rise, over the period 2011-2014 the number of Adult Social Care service users with mental health conditions has marginally reduced. Although, the prevalence rate of service users with mental health conditions remains relatively high, 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%

Where possible, Barnet would like all service users to remain at home for as long as they want 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. Although this is significantly above the National average of 60.9%.

Figure 9-8: 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 of the population will need treatment for mental illness at some time in their lifetime and the majority of these will be managed in primary care. Mental illness forms a large and growing proportion of primary care presentations as one in three GP appointments involve 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 who go on to reside in neighbouring Boroughs.

Adults and older people with mental illness known to the Council total 1,305 and receive social services and 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, 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 along with an increase above national rates in the numbers 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: POPPI and 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[146].

Integral to this model is the development of a 'shared care' or 'collaborative care' that straddles the boundary between primary care and more specialist services, i.e. strategy for integrated care. This service should work closely with GPs and other primary care practitioners to coordinate and deliver care and act as a point of access to more specialist mental health services enabling people to receive 'right care, at the right time, and in the right place'.

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. We are projecting a 14% growth in the number of residents with moderate to severe learning disabilities over the next decade.

[146] The Joint Commissioning Panel for Mental Health, 2012

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 supported by the learning disability nurses and other healthcare professionals within the integrated learning disabilities team.

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**

Table 8-23 shows the number of PWLD who are in receipt of support by adult social care, broken down by a percentage of total 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%

However, we don't expect this current trend 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 we expect more PWLD and complex needs accessing adult services. The majority of these residents will require on-going social care throughout their lives.

Table 9-24: LD Projections for Barnet Population

	2014	2015	2016	2017	2018
People aged 18-24 predicted to have a moderate or severe learning disability	193	192	190	189	191
People aged 25-34 predicted to have a moderate or severe learning disability	343	346	349	351	352
People aged 35-44 predicted to have a moderate or severe learning disability	346	353	362	369	377
People aged 45-54 predicted to have a moderate or severe learning disability	256	262	268	272	276
People aged 55-64 predicted to have a moderate or severe learning disability	176	180	184	189	194
People aged 65-74 predicted to have a moderate or severe learning disability	95	98	101	103	104
People aged 75-84 predicted to have a moderate or severe learning disability	35	35	35	36	37
People aged 85 and over predicted to have a moderate or severe learning disability	15	15	16	17	17

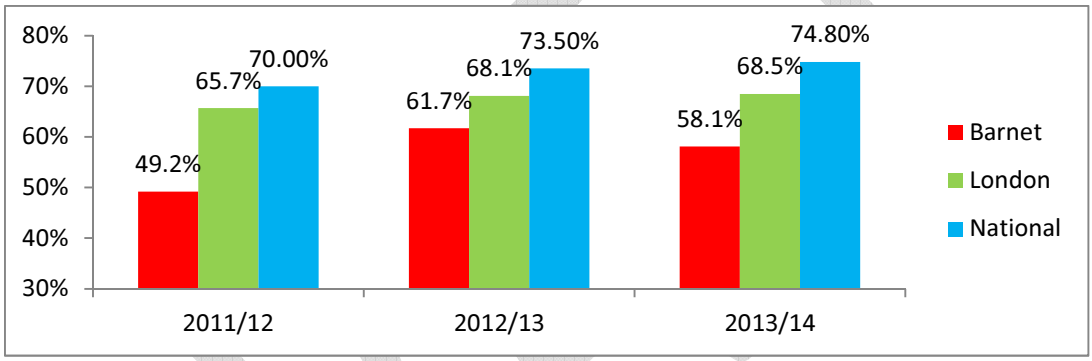
Total population aged 18 and over predicted to have a moderate or severe learning disability	1,459	1,481	1,504	1,526	1,548
* Figures may not sum due to rounding. Crown copyright 2014					

Source: POPPI and 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 stay too long in hospital or residential homes. 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 9-9: Proportion of adults in contact with learning disabilities who live independently, with or without support, 2011-2014 (Barnet, London and National)



The Governments' Green Paper[147] 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 change 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 26, 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

147

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf

In order to respond to the shift in growing community provision, more work is needed to be done to develop a better understanding of the level and type of needs of PWLD and Autism.

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)[148], 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 down 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 DoH 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[149].

Specific comparative data is also required between the health of people with learning disabilities and the non-learning disabled population. We know that 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. For our Learning Disability self-assessment, data is needed on 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 we found that 51 women with LD aged between 25 – 64 years had accessed cervical cancer screening, 6 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, and with the projected population group within this age group, this is likely to result in an increased need for services with more limited resources.

9.10.3.1 Social Isolation

Feelings of social isolation and loneliness are detrimental to a person's health and wellbeing[150]. 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

[148] http://www.bris.ac.uk/cipold/

[149] 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

[150] Rachel Wells PPT http://www.communitybarnet.org.uk/data/files/Rachel_Wells_-_Social_Isolation_and_Public_Health.pdf

isolation. The analysis found that social isolation was most common amongst *women, aged 75 and over* who were *living alone*.

Figure 9-10: Socially Isolated People in Barnet (2014)

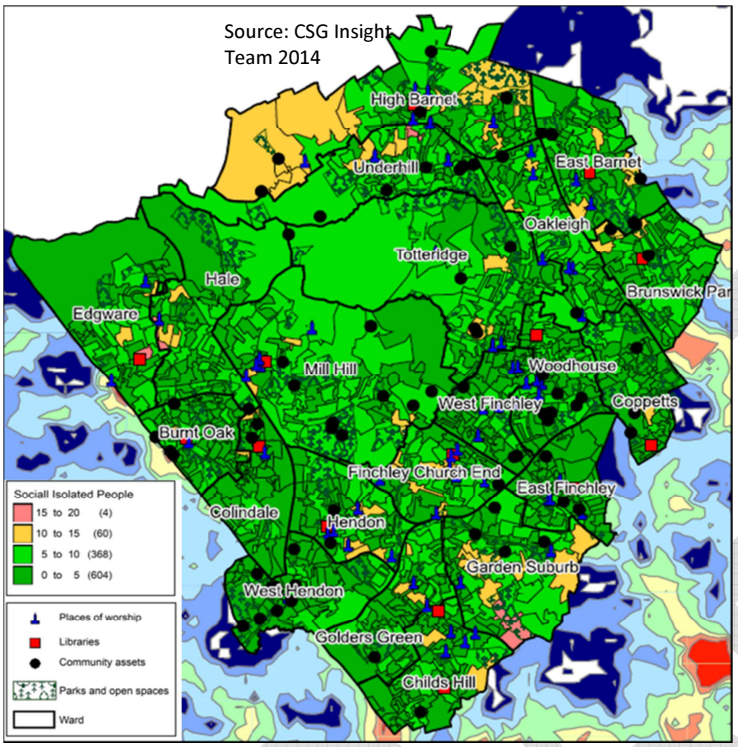


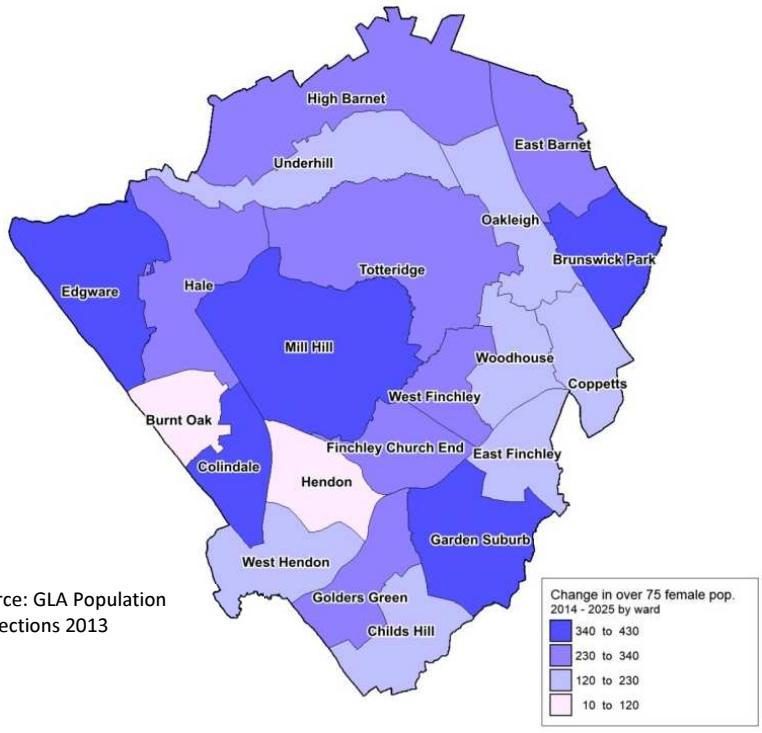
Figure 9-10 shows a map of socially isolated people in Barnet in 2014.

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.

Whereas less densely populated, more affluent areas in the north of the Borough were identified as possible hotspots for social isolation.

9.10.3.1.1 Possible Future Hotspots of Social Isolation

Figure 9-11: Change in over 75 year old female population by ward, 2014 – 2025



Source: GLA Population Projections 2013

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 today.

Colindale has relatively few isolated people today, although as the population grows with regeneration, so will the number of people that is susceptible to isolation.

As more and more older and frail residents 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 which will inform our work 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 a 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

This significant increase in the number of people with dementia will require appropriate support to 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 children and social care adult department 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 to 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 we don't have any robust data on the actual numbers of adults with autism, although estimates indicate that there are an approximately 2,324 people with autism in 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 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

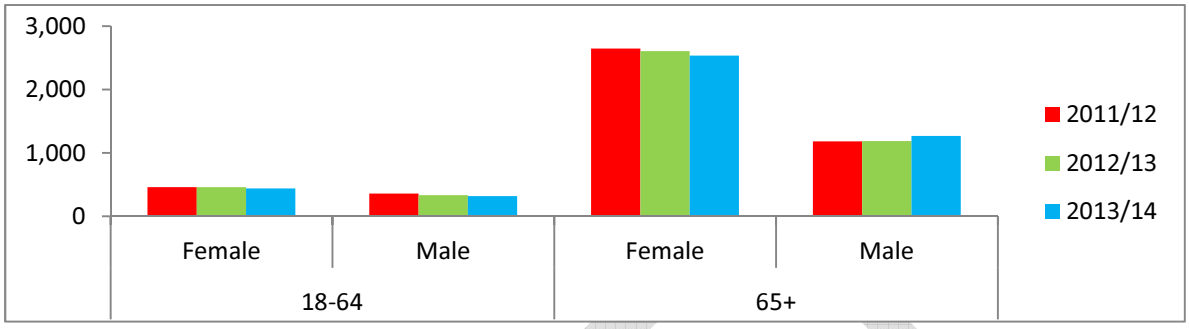
Over 50% of Adult Social Care service users have a physical or learning disability, and for people aged 65 and over this rate this is significantly higher; 72.20% in 2013/14.

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%

As shown in Figure 9-12, 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 over twice as many women with physical or sensory impairments as men. Although 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 9-12: Gender of Physical Disability & Sensory Impaired Service Users



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.

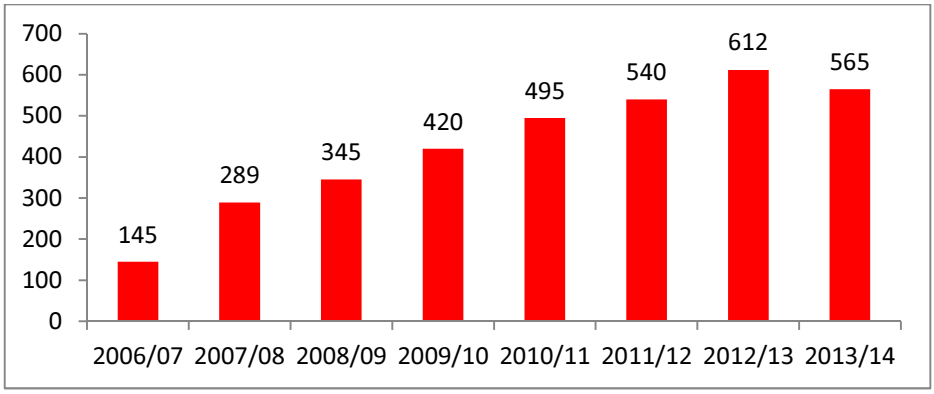
9.11 Safeguarding

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 should occur and encourage people to report it if it happens.
- To ensure that agencies will work effectively together to ensure abuse is investigated and that people are helped to keep 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 on the previous year. This was the first drop in alerts received in 7 years.

Figure 9-13: Safeguarding Alert, 2006-2014



The number of alerts investigated under our 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 we can help people who are affected.

In 2013/14, of the 565 alerts received, 406 (72%) were investigated.

For every case investigated, we decide if the abuse happened (substantiated), part happened (partly substantiated), 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 2014/16:

- 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 we plan 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. As part of ensuring quality and service improvement this is derived through strategic and operational contract management and other data intelligence such as safeguarding information, service user reviews and on-going dialogue with the CQC. A provider experiencing

difficulties to maintain 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 peoples 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 that is

- 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 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's 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.

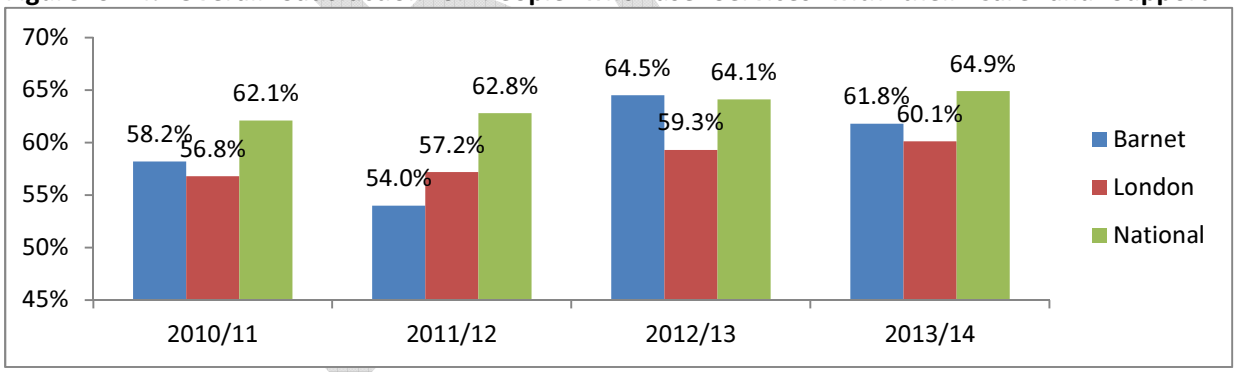
9.13.1 User and Carers experiences of Social Care

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 is 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 9-14: Overall Satisfaction of People who use Services with their Care and Support

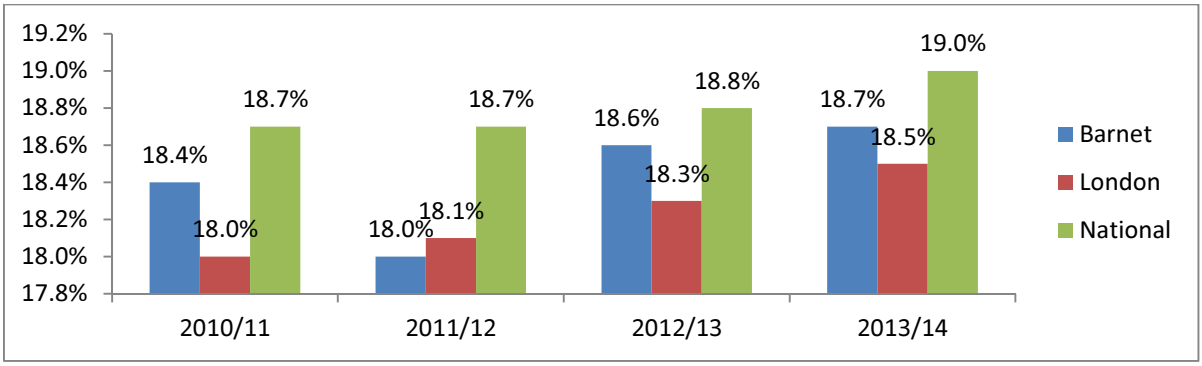


Source: National Adult Social Care Service User Survey 2013/14

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 9-15: Social-Care Related Quality of Life



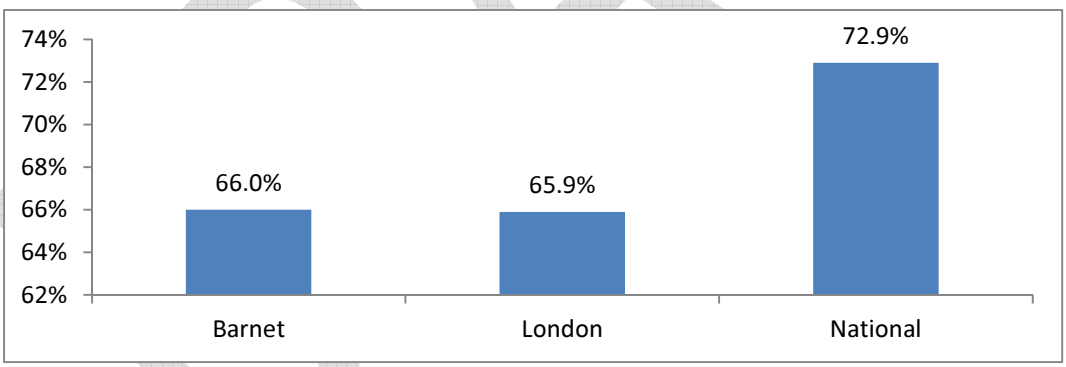
Source: National Adult Social Care Service User Survey 2013/14

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.

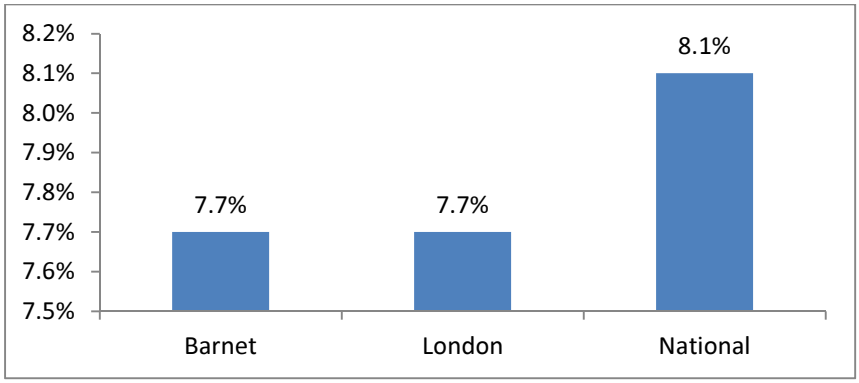
Figure 9-16: Carer's Involvement in Discussions



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 didn't do anything that they valued or enjoyed. These figures were very similar across all comparable local authorities in London.

Figure 9-17: Carer related quality of life



Source: The Carers Survey 2012/13

10 Chapter 10: Community Safety

10.1 Key Facts

- Crime has seen a long term downward trend over the last ten years from a peak in 2005 of over 35,000 crimes a year, 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[151] compared to one year ago.
- There are fewer victims of crime (in the 12 months to 25 Feb 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[152].
- 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 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 increase under reporting.
- **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 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.

10.3 Overview

The statutory duty for Barnet Safer Communities Partnership[153] 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.

[151] Source: Published MPS crime stats (SAroot\data\crime_stats_mps_published_toFeb2014.xlsx)
[152] Source: MPS DOI performance stats (SAroot\data\sx_dash_to25Feb2014.pdf)
[153] 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[154]. 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 on 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.

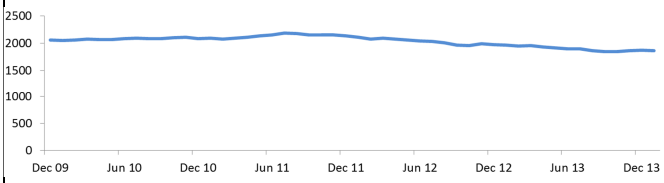
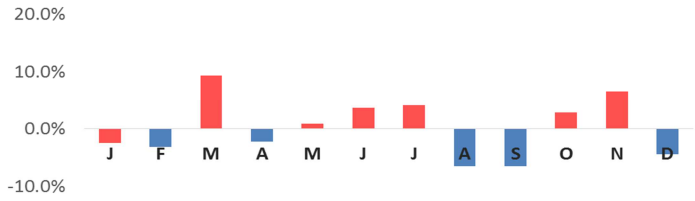
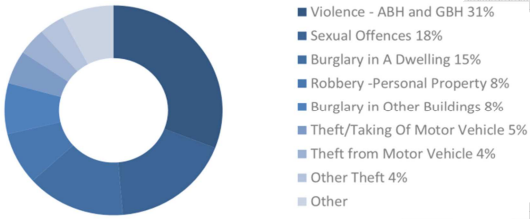
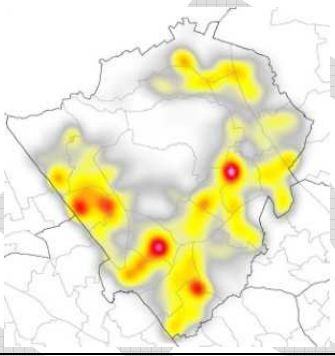
The top three cost contributors are violent crime, Sexual Offences and Residential burglary. Note that for the top two (Violence and Sexual offences) the majority of the victims (though minority of the perpetrators) are women and girls.

10.5 Summary of All Recorded Crime in Barnet

Current Figures refer to the 12 month period ending 31 Jan 2014[155]	
Level of crime	**22,837 crimes** / 62.75 per 1000 residents
Peer comparison	8th/32 in London and 4th/15 in 'Most Similar Group'

154 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118042/IOM-phase2-costs-multipliers.pdf

155 SAroot\data\Crime Data to Feb14 PROTECT.xls

Annual Change	Reduction of 2804 crimes / 10.9% compared to one year ago *(this figure is for 12 months to Feb 2014)*[156]
General Trend	 Falling from late 2011 to late 2013, appears to be levelling off
Seasonality	 March followed by November are the peak months
Breakdown of crime types	 Break down of estimated annual cost of crime on Barnet by crime type
Hotspots	 **Five Wards** (All Crime, to Feb 2014)[157] **West Hendon 1890** **Childs Hill 1775** **Coppetts 1403** **Hendon 1339** **Golders Green 1289** The top 5 account for **34%** of the Borough total
VOL(T) analysis	**Victim**: The top locations where victims of crime live (irrespective of where the offence occurred) in descending order are HA8, NW9, EN5, NW4, NW11 **Offender**: 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 **Location / Time**: The top five areas based on the offence location are (in descending order): HA8, NW4, EN5, NW9 and N12

10.6 Anti-Social Behaviour (ASB)

- Barnet residents made 11,798 ASB related calls to police in the 12 months to 25 Feb 2014; 308 of these were repeat callers[158].

156 Source: SAroot\data\crime_stats_mps_published_toFeb2014.xlsx
157 Source: SAroot\data\mpsBarnet12monthsWardTNOstats.xls

[158] Source: Published MPS crime stats (SAroot\data\crime_stats_mps_published_toFeb2014.xlsx)

- These figures represent a 12.7% reduction in total ASB calls and 13.2% reduction in ASB repeats compared to the previous year.
- According to Barnet's Residents Perception Survey: 70% of residents are very or fairly satisfied that police and council are dealing with crime and ASB in their local area which is up 2% from 2012 RPS, but down from a 75% in 2010.
- The top (and increasing) ASB concern is rubbish and litter lying around[159].
- 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 – 2011 the rate of residential burglary in Barnet increased (in total by around 1000 offences per year), remaining at a high level during 2012 and early 2013. Since April 2013 residential burglary levels on 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 in residential burglary on Barnet.
- Cross border burglary is the most significant contributor to overall burglary levels, during a 12 month sample period 64% of suspects were from off Borough.
- Analysis of the distribution of residential burglaries on the Borough shows that houses in some streets on the Borough face a risk of burglary at least double the 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.

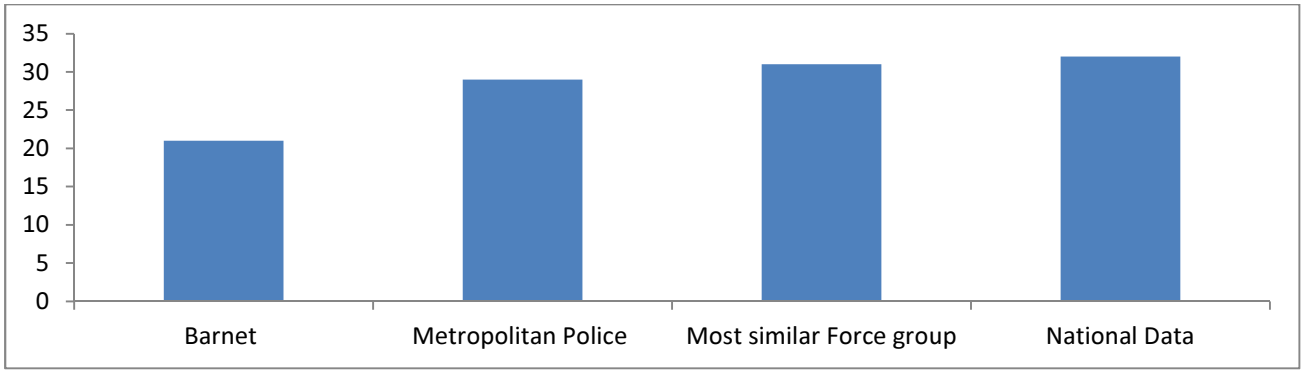
10.8 Domestic Violence and Violence Against Women and Girls (VAWG)

Nationally, it is estimated that 1 in 4 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) are unknown nationally. Some agencies collect data and not all victims refer themselves or are engaged with any support agencies. So there is an assumption of under reporting.

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. .

Figure 10-1: Cases per 10,000 of the adult female population

[159] Flatley, Kershaw, Smith, Chaplin and Moon (2010) BCS - Crime in England and Wales 2009/10



Source: MARAC data, SafeLives

10.9 Key Issues

The current issues are, that domestic violence is more familiar and bedded down 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 men and other communities might be disproportionately affected by these issues. However, more in-depth work needs to take place on all of these areas to establish whether there is a need for any additional VAWG services within the Borough.

10.10 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 Domestic Violence, 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%.

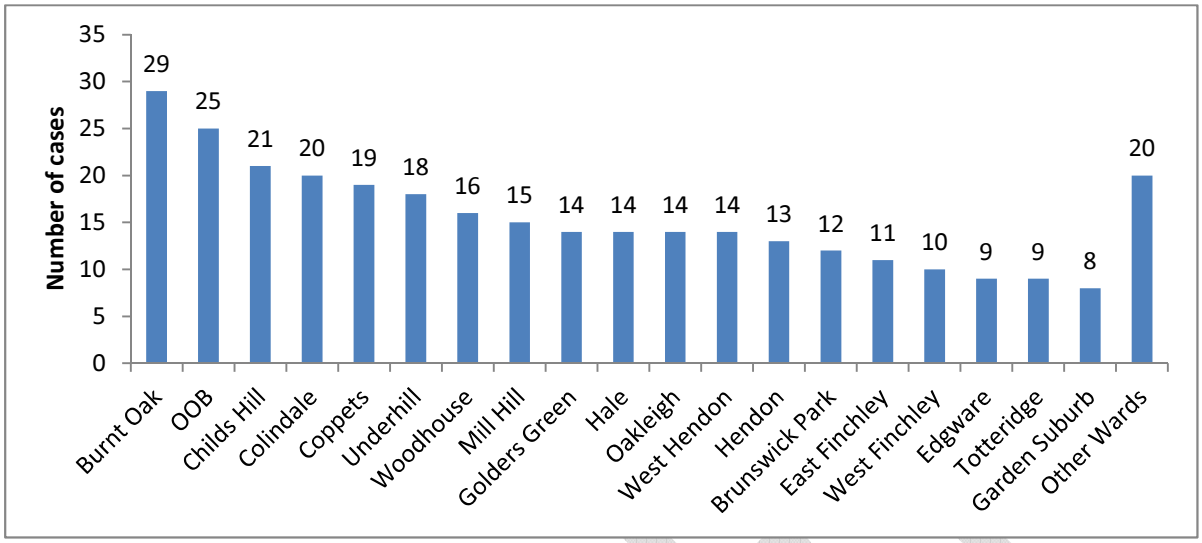
Table 10-2: Age and Ethnicity of Domestic Violence victims

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 of 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, Out of Borough, Childs Hill and Colindale.

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

10.10.1 Domestic Violence Advocacy and Support Services - (which includes support for men)

10.10.1.1 Refuge Provision

We currently provide 18 bed spaces in Barnet. 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 there is no space in the refuge. If the latter is the case, they are still supported by UK Refuges on line to find alternative space. Housing will remain a critical area of work for partners as the refuge requires

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 need to continue. The demand on services by families experiencing domestic violence, if left unsupported will increase and therefore it's important for partners to recognise the collective benefits especially to the statutory organisations. .

The demand for services continues to rise despite national evidence that domestic violence remains an under reporting crime. Women experience an average of 35 incidents of domestic violence before reporting an incident to the police (Yearnshaw 1997).

10.10.2 Domestic Violence and Crime

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 victimisations are common features of domestic violence.

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.

It is shocking that responding to domestic violence alone costs Barnet an estimated £38 million a year. By responding to DV and VAWG early on and preventing it, we can make significant savings across the partnership and, most importantly, reduce the harm it causes to victims, their families and the wider community.

10.10.3 Key facts

The below figures relate to the 2013 calendar year unless otherwise state.

- Sexual crime: 87% of victims are female. There has been a sudden 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, sexual offences has the second highest cost associated with it. 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 on 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 per cent of all DV incidents are repeat (National estimate 2009/10[160]).

10.10.4 Summary

There has been an upward trend in the volumes 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[161]. This is a positive development and reflects some years of 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.

10.11 Youth Crime

Young people have told us, through the consultations we have carried out, that safety is one of their top priorities. Our survey results showed that compared to the population average, people aged 19 year 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 male victims in this range).
- The peak victim age for Sexual crime is: 14 to 22 (= 38% of female victims in this range).
- The Voice of the child consultation exercises seek feedback from young people about the Borough, these have established that: Safety is a priority for many young people, and that some young people don't 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 underreporting and repeat-victimisation, anecdotally (based on a review local intelligence) this appears to be particularly the case where young people are the victims – thus making it more difficult to identify and intervene to reduce the risks associated with on-going victimisation.

[160] Flatley, Kershaw, Smith, Chaplin and Moon (2010) BCS - Crime in England and Wales 2009/10
[161] See 'DV Looking at Underreporting' in section 4 of this document for the assessment of this issue (page 45)

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 1000 population of all 32 London Boroughs. Between April to 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 Graham 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 we set out to create a problem profile analysing existing data. We 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.

- We also saw that HA8 had the highest percentage of offences resulting in injury that were committed by 15-17 year olds over a three year period from October 2010.
- Graham Park – NW9 is the area with the second highest volume of these offences but it 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 HA8 (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 (10 offences); EN5 which includes the Dollis Valley Estate (8 offences); and NW2 (Cricklewood area) 8 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 however 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) The group fighting a rival group (e.g. defending drug dealing zones, or trying to move into another groups zones of control re drugs supply, or fallen out for some other reason
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. We know 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, we have been able to drive down overall crime and so reduce the number of people in Barnet who become victims of crime. We intend 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 - 12 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 can find 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 Domestic violence (DV) trends

More DV offences are being reported. This is likely to be due to an increase in the reporting and recording instances of DV appropriately rather than an underlying increase in the actual prevalence rate.

This is a positive development and reflects some years of concerted effort at the national, London and Borough level to raise awareness and reporting of DV.

10.14.4 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 to 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 our figures, we estimate that the top 200 offenders in the Borough are, between them, committing around 5,000 crimes every two years.

10.15 Resident Voice

10.16 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 our 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.

10.16.1 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.

10.16.2 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 we are doing to tackle crime and ASB
- work together with the community to reduce rubbish and litter concerns.

11 Chapter 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 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.**
- 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 1235 registered charities operating in Barnet. 638 (51.7%) are based in or near Barnet and 597 (48.3%) come from outside the Borough.[162] 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 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

[162] 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.

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 10-3 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%

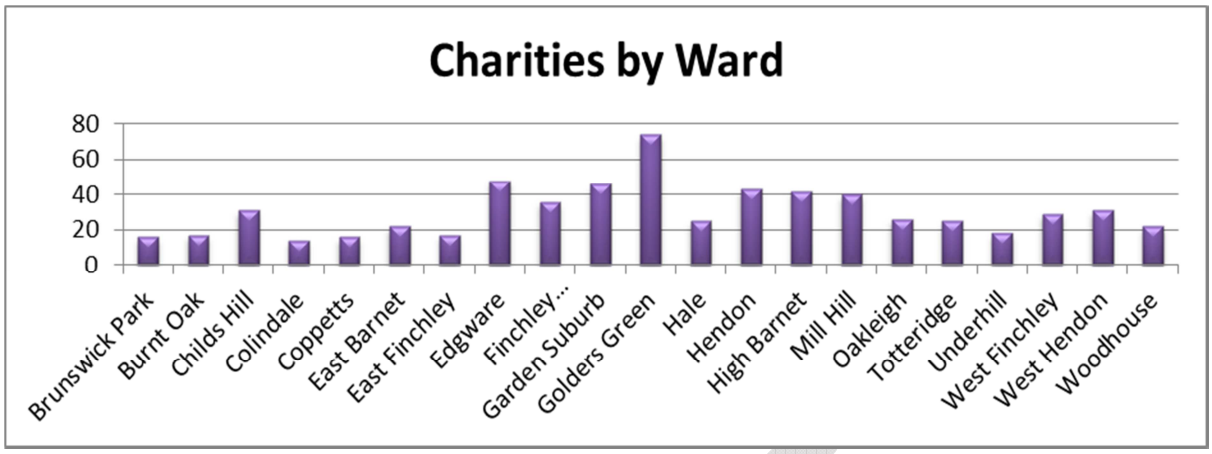
For the 638 charities which are also based in the Borough, it is possible to give a breakdown of the wards in which they are based. The data refers to the registered address of the charity rather than to the address from which it operates services and these may not always be the same. Table 11-4 and 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 – though the latter list is not exhaustive.

11.6 Resources and support

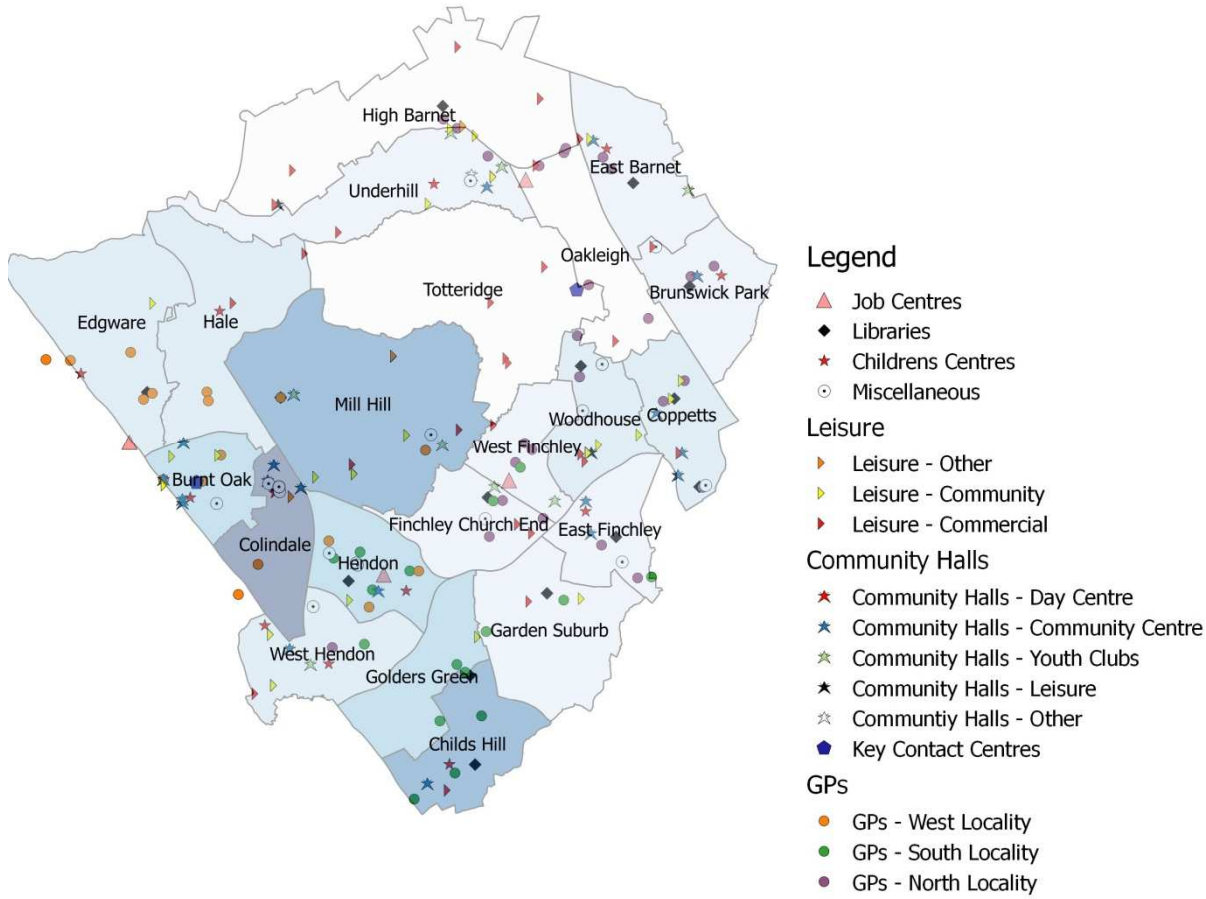
The Council commissions a second Local Infrastructure Organisation partner – as of 2015/16 this is CommUNITY Barnet – to strengthen the local voluntary and community sector, offer expert advice and support, and ensure VCS organisations are represented in Council decisions. This role is a key enabler 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: 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%

Further breakdowns for the Adults and Children's Delivery Units is given 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

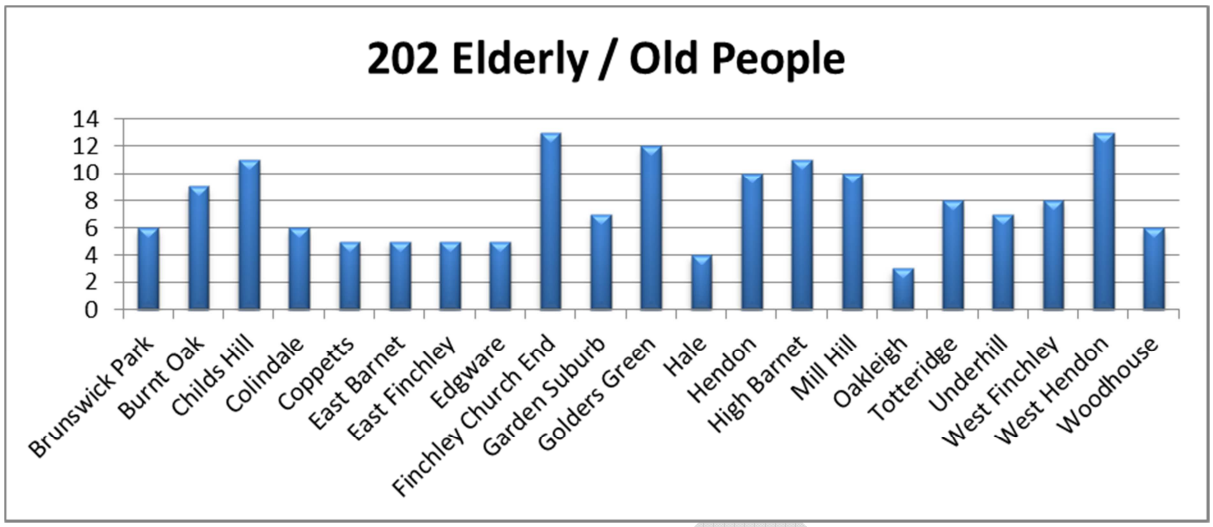
11.7.1 Faith-based activities

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 1255 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

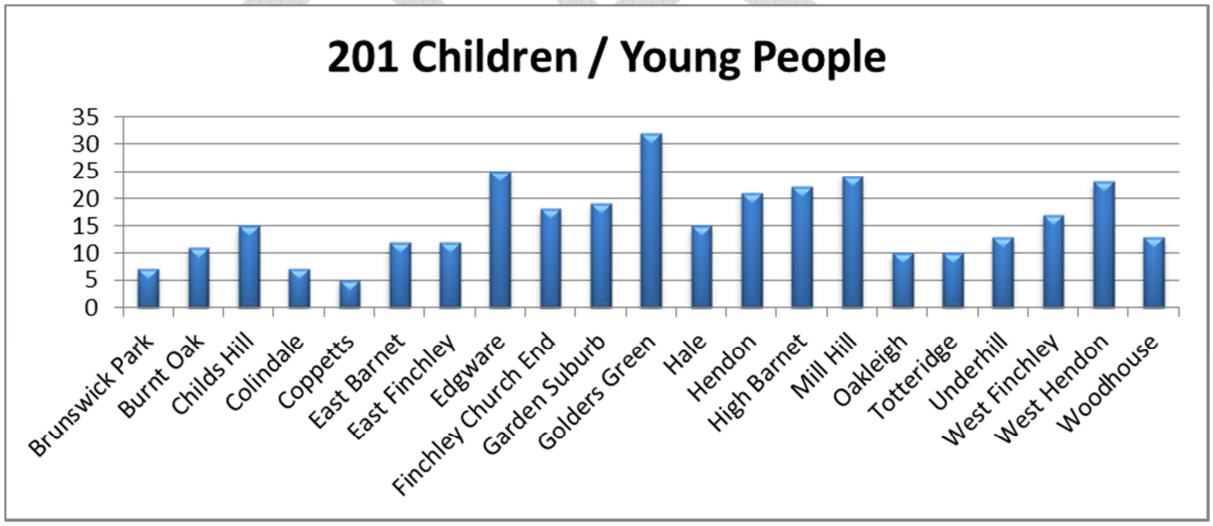


A total of 130 charities (from both inside and outside Barnet) provide services for older people with a health-related benefit – 10.3%. 118 (9.4%) benefit older people and provide a disability-related service.

11.7.3 Services for children

647 of the 1255 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

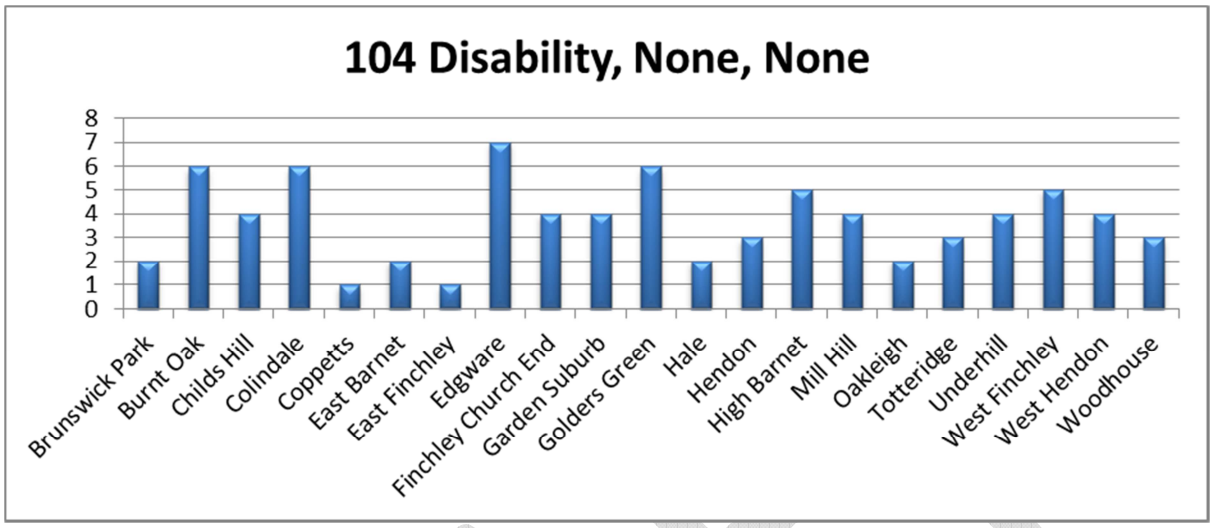


The distribution of children's charities across wards reflects the overall number of charities in each, with particularly high numbers (32) in Golders Green. It's notable that Colindale and Burnt Oak both have relatively low numbers of charities offering services for children and young people (7 of 14 and 11 of 17 respectively).

11.7.4 Services for people with disabilities

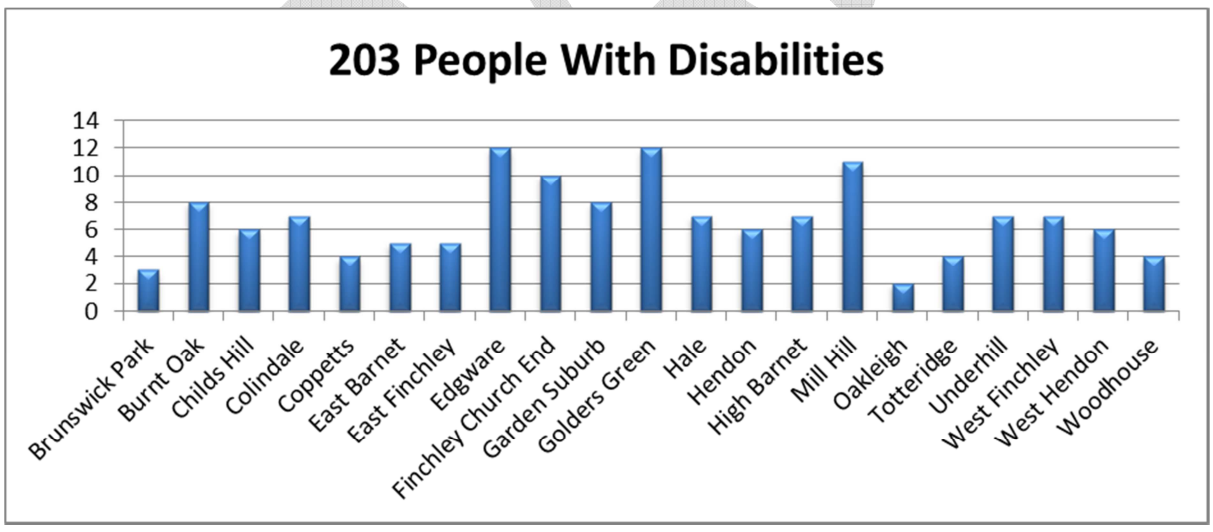
220 charities operating in Barnet (17.5%) identify their charitable benefit as being related to disability and 78 of these are also based in Barnet. The distribution of Barnet-based charities in this group is shown below:

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 is shown below:

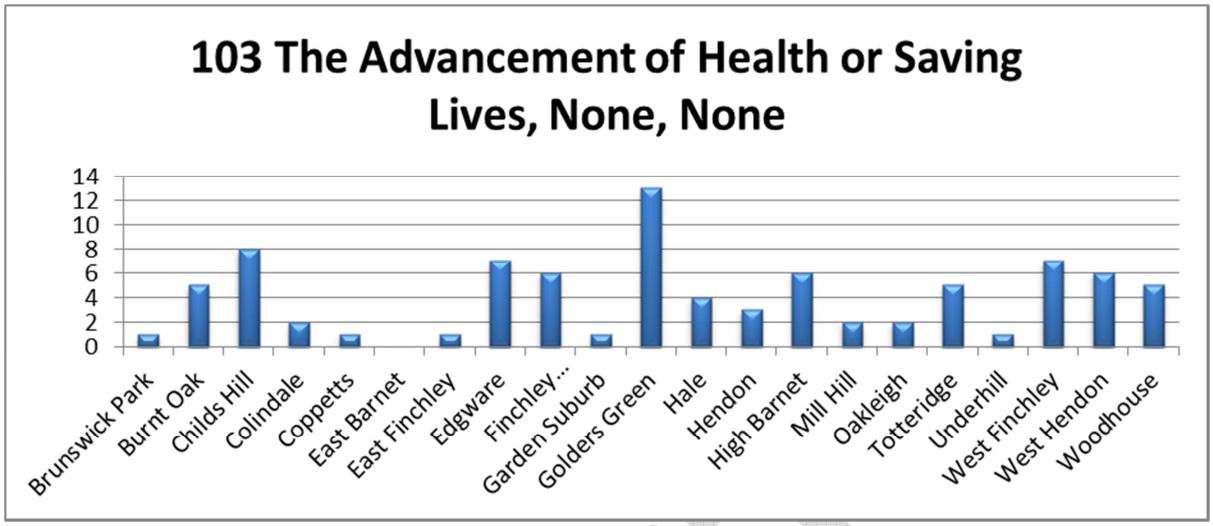
Figure 11-6: Local charities serving people with disabilities, by ward



11.7.5 Services relating to health and physical activity

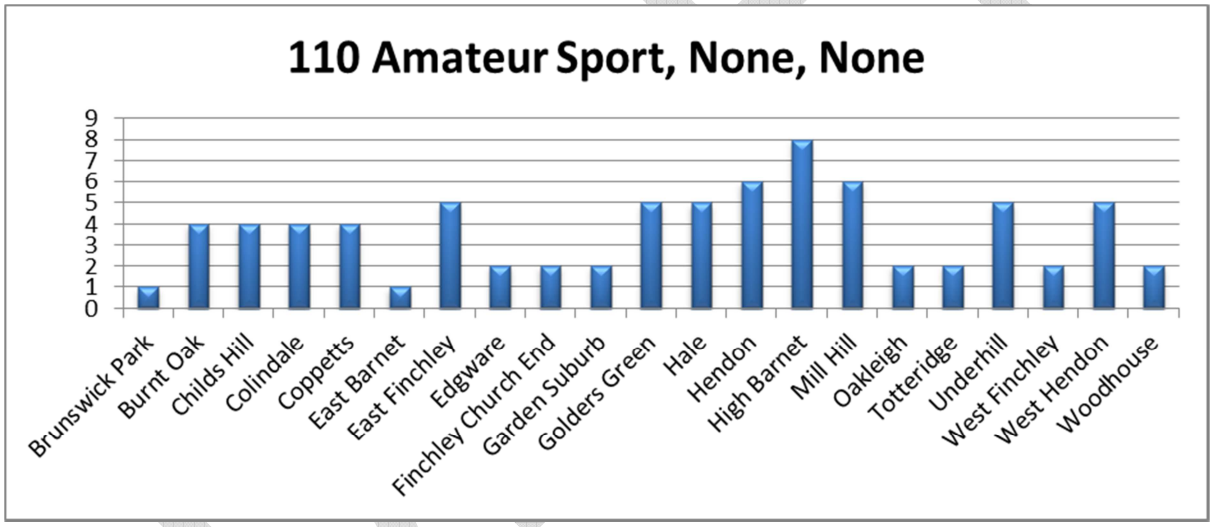
225 charities operating in Barnet (17.9%) identify themselves as providing a health-related benefit. 86 (38.2%) are local and 139 are from outside the Borough. The local charities are shown by ward in the chart below:

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:

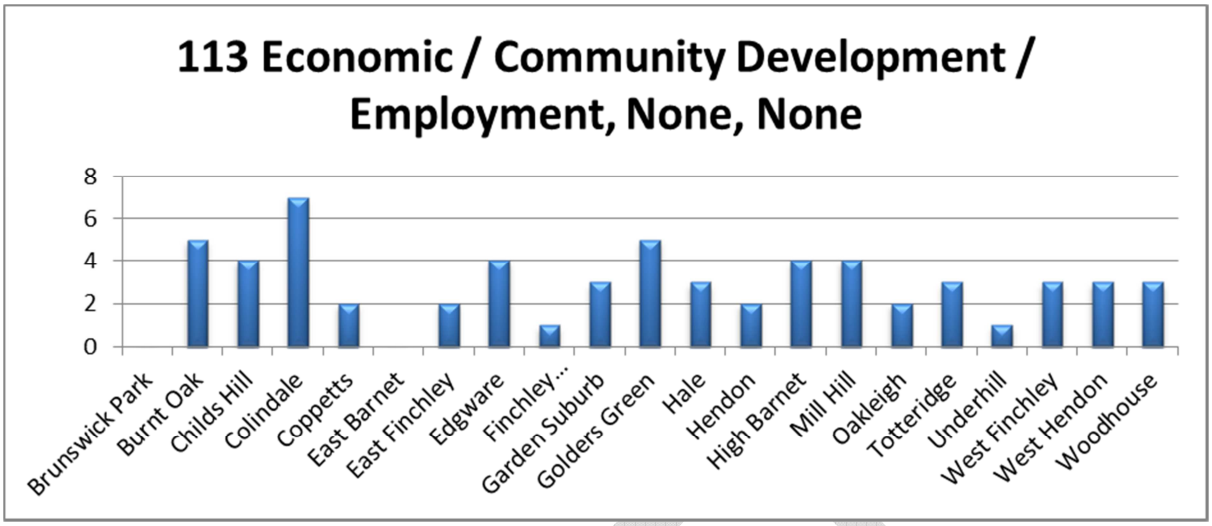
Figure 11-8: Local charities whose purpose or benefit relates to amateur sport, by ward



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 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 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 Chapter 12: Resident 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 less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Resident's 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

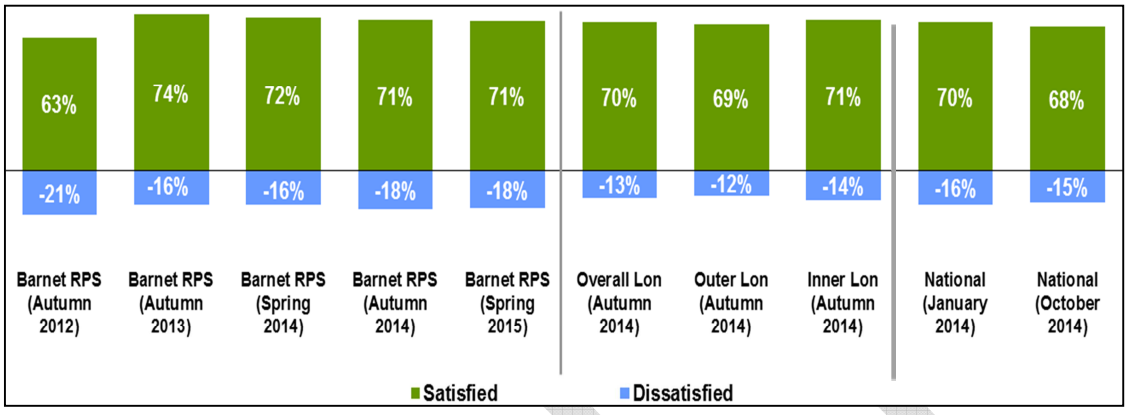
The Residents' Perception Survey captures residents' general views and perceptions towards the Council, the services it provides and the local area and is used to explore changes in these opinions over time on a number of topics. The latest Residents' Perception Survey was conducted in spring 2015; some 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 are dissatisfied with the way Barnet council runs things, has decreased from 21% to 18%.

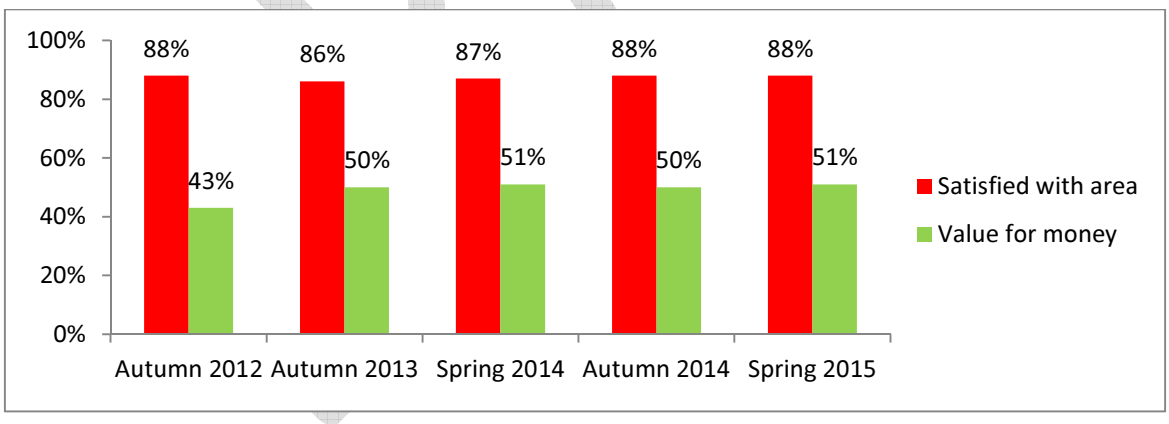
Figure 12-1: Are you satisfied with the way your local council is running things?



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

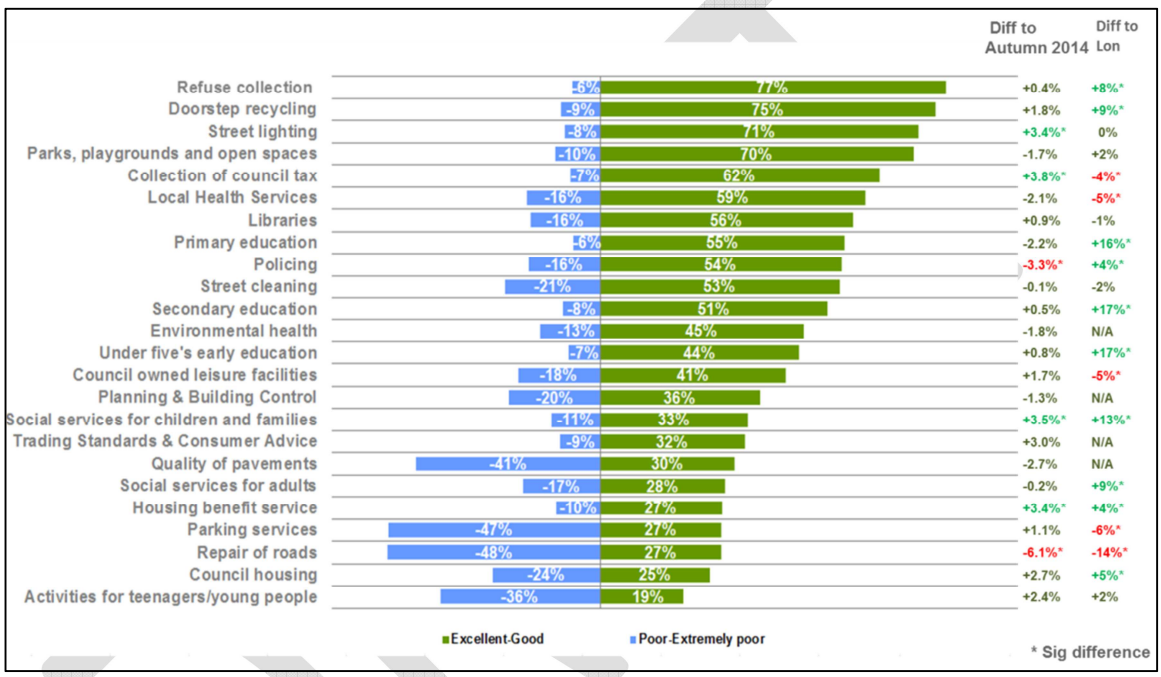
In spring 2015 the services that residents were most happy with were 'Refuse collection', 'Doorstep recycling', 'Street lighting' and 'Parks, playgrounds and open spaces' with 70% or above of respondents rating them as either good or excellent. Whereas, only 25% or less of respondents rated 'Council 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

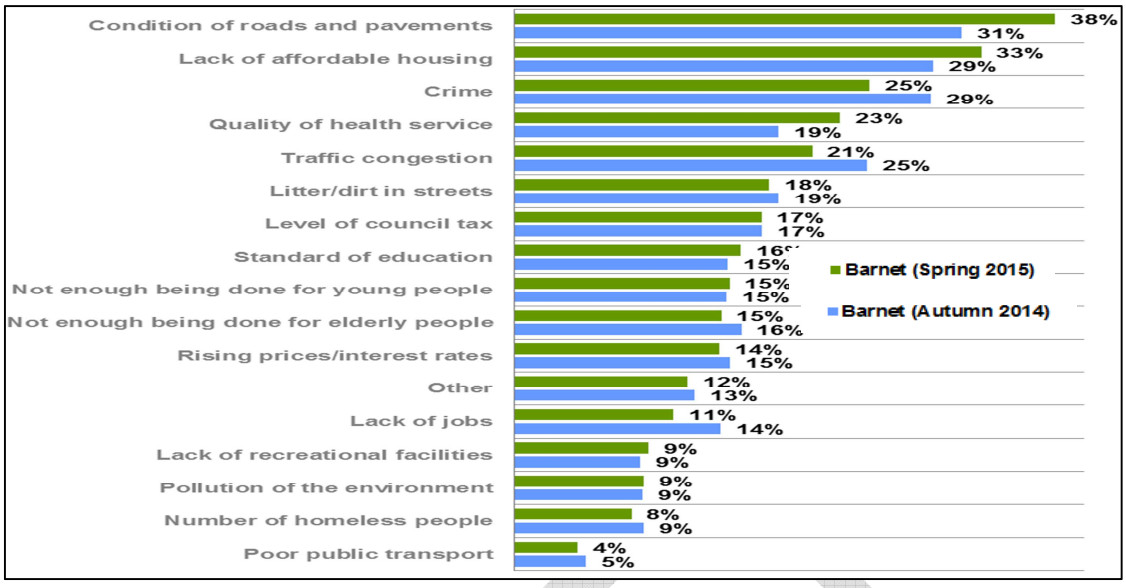
The top three concerns for residents according to the spring 2015 Resident's Perception Survey were:

- Conditions of roads and pavements (38%);
- Lack of affordable housing (33%); and
- Crime (25%)

Since autumn 2014 there has been a significant increase in concern about conditions of roads and pavements, quality of health service and lack of affordable housing. However there has been a significant decrease in crime, traffic congestion and lack of jobs.

In comparison to London the only areas where Barnet residents are significantly more concerned about: lack of affordable housing, quality of health service, not enough being doing 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.

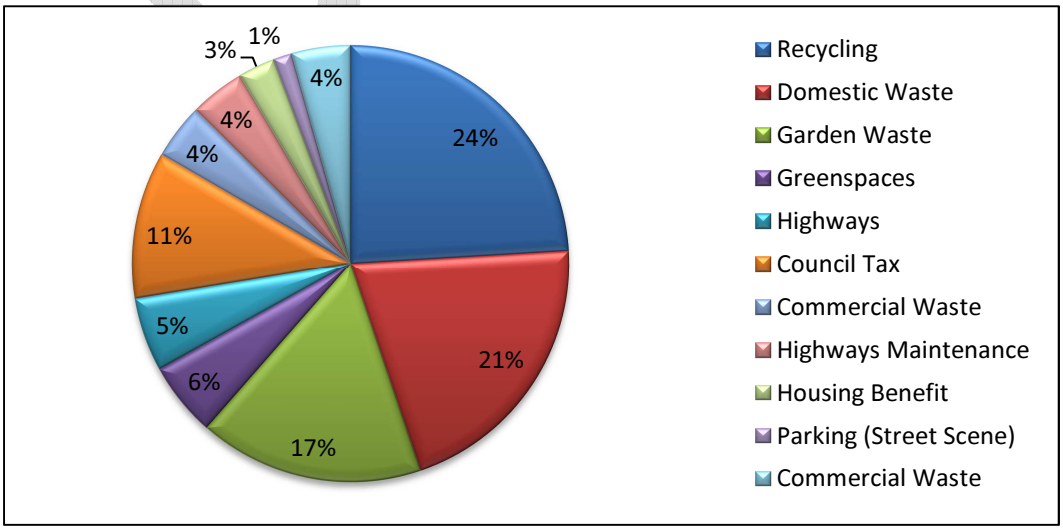
12.8 Community cohesion

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% strong 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.

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	14,657	16.1%	18.4%
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check (persons)	2013/14	5,469	37.3%	49.0%
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check (persons)	2013/14	5,469	6.0%	9.0%
Health Protection				
3.02 - Chlamydia detection rate (15-24 year olds) – CTAD (persons, 15-24 yrs)	2013	485	1098†	2,016†
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)	2013/14	38,244	71.8%	73.2%
3.03xv - Population vaccination coverage - Flu (at risk individuals) (persons, 6 months - 64 yrs)	2013/14	16,206	51.7%	52.3%
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†
Healthcare and Premature Mortality				
4.12i - Preventable sight loss – (New certifications of visual impairment due to) age related macular degeneration (persons, 65+ yrs)	2012/13	44	89.3†	123.1†
4.12iv - Preventable sight loss - sight loss certifications (persons, all ages)	2012/13	122	33.5†	42.3†

†Per 100,000; Data source: Public Health England. Public Health Outcomes Framework (PHOF). Data Release: May 2015

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AGENDA ITEM 7

	Health and Wellbeing Board **30 July 2015**
Title	**Draft – Substance Misuse Strategy 2015-2020**
Report of	Director of Public Health
Wards	All
Date added to Forward Plan	January 2015
Status	Public
Enclosures	Appendix 1: Draft Substance Misuse Strategy Appendix 2: Equality Impact Assessment report
Officer Contact Details	Dr Wazirzada. M. R. Khan Senior Health Improvement Specialist Harrow and Barnet joint Public Health team Wazi.khan@harrow.gov.uk 0208 359 2530

Summary

London Borough of Barnet has a responsibility to provide substance misuse services in the Borough. Barnet and Harrow joint Public Health service has recently recommissioned the contracts for adults and young people for 2.5 years from 1st October 2015 - to 31st March 2018 with an option to extend for a further period of up to 2 years.

However, the actions to address the use of drugs and alcohol are broader than just treatment service provision; and in light of this, the proposed five year strategy outlines what we can do to prevent substance misuse, how we can protect families and the wider community from harm and how to identify those who need treatment early and support them to recover from dependence and lead fulfilling and healthy lives.

Recommendations

1. **That the Health and Wellbeing Board agrees the three key strategic priorities of the draft Substance Misuse Strategy;**

   - **To prevent Barnet residents from harmful use of drugs and alcohol**
   - **To protect Barnet residents and their families/carers including children and vulnerable adults from indirect harm caused by substance misuse.**
   - **To promote and sustain recovery of Barnet residents identified as**

misusing substances.
2. That the Health and Wellbeing Board notes the proposed actions for each strategic priority.
3. That the Health and Wellbeing Board supports the proposal to set up a strategy implementation group.
4. That the Health and Wellbeing Board approves the Substance Misuse Strategy as final.

1. WHY THIS REPORT IS NEEDED

1.1 Substance misuse, in this report, refers to both drug and alcohol misuse. Substance misuse is an important public health issue not just because it causes harm to the individual's health but because it is also associated with indirect harm to families and the wider community. It limits an individual's potential as well as compromising economic development. The adverse impact is marked among young people with regard to their education, health, family and social cohesion and long term opportunities in life. By taking a holistic approach and working in collaboration with key frontline team, we can reduce these harmful impacts. There is good evidence that drug and alcohol treatment is cost effective – for every £1 invested in specialist alcohol treatment £5 is saved on health, welfare and crime costs and for every £1 spent on drug treatment £2.50 is saved in costs to society. Similarly, every £1 spent on young people's drug and alcohol interventions brings a benefit of £5-£8.

1.2 Barnet's Substance Misuse Needs Assessment (2014) identified an estimated 70,000 residents in Barnet who are drinking alcohol above the maximum recommended level and are putting their health at risk. In 2013/14, there were 595 people using alcohol treatment services in Barnet - a rise of 53% compared to 5 years ago. Nearly a third of these patients had been in treatment at least once before.

1.3 With regard to drugs misuse, the most up to date prevalence data (2011/12), estimates around 1,492 problematic opiate and/or crack users (OCU) in Barnet. The proportion of OCU's in treatment in Barnet was 42.6%, which is lower than the estimated national rate (53.4%).

1.4 In addition, substance misuse is also responsible for a significant proportion of hospital admissions, ambulance callouts, crime, disorder and antisocial behaviour and compromising economic development in the borough.

1.5 As Barnet and Harrow joint Public Health service is responsible to provide substance misuse services in the borough, it is essential to have a robust substance misuse strategy that addresses the needs of the local population and encourages multiagency working relationship between health, social care, safeguarding and enforcement agencies. The key actions are listed below and in appendix 1 of this report.

1.5.1 **Prevention from the harmful use of drugs and alcohol by influencing supply and demand;**

- Review the availability of alcohol and location and number of licensed premises
- Consider action on alcohol pricing through a responsible retailer programme or similar schemes (where locally we can have an influence)
- Support action that can be taken to reduce the supply of harmful substances
- Change behaviour in high risk groups through the provision of information and brief advice (IBA)
- Take collaborative action on the social determinants of substance misuse
- Review and recommend action to prevent substance misuse in young people
- Promote healthy behaviours in the general population

1.5.2 **Protection from indirect harm caused by substance misuse** – a whole family approach i.e. children and vulnerable adults

- Refer children at risk of sexual exploitation to appropriate services
- Minimise the potential risk to children with parent who misuse substances by increasing the early identification of children within the family and through increased information sharing
- Consider opportunities to link with the Troubled Families programme
- Ensure appropriate internal and external links are made with Community Safety team and Domestic Violence and Violence against Women and Girls coordinator, Licensing team, Early Intervention and Prevention team, Children and Adults Safeguarding teams, Families services, Primary Care services, Secondary Care services including mental health, sexual health and A&/E teams, Education and Police

1.5.3 **Promote and sustain recovery** – by intervening early and offering comprehensive services which rebuilds lives.

- Improve action on blood borne viruses in injecting drug users
- Partnership working between hospital teams and community substance misuse services
- Data sharing protocols and referral pathways
- Accessible and integrated specialist treatment and recovery services for adults and young people
- Ensure individuals with a mental health and substance misuse problem gain rapid access to the support they require to recover
- Ensure all stakeholders have easy access to up-to-date information which explains the substance misuse services available and the pathways for referral
- Assure that substance misuse services are safe and effective, auditable, continuously improving and evolving to need

1.6 Substance misuse services for both adult and young people have now been recommissioned. The successful providers are Westminster Drug Partnership (WDP) in partnership with Central North West London NHS Trust (CNWL). The new contract will commence on 1st October 2015 however, much work

will be undertaken between now and then to ensure a smooth transition from the current to new service.

1.7 The recent re-procurement of substance misuse services has resulted in efficiencies of £560k over the extended period of the contract due to redesigned pathways and streamlined contract management.

2. REASONS FOR RECOMMENDATIONS

2.1 To ensure that the Public Health Commissioning Plan has the support of members in light of consultation with residents.

2.2 The Health and Wellbeing Board is asked to note that the consultation feedback was overwhelmingly supportive, although in low numbers. Therefore the Health and Wellbeing Board is asked to approve the above actions and strategic priorities attached in appendix 1.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 It would be possible to focus attention solely on treatment services but a broader substance misuse strategy presents significant opportunities for partnership working to deliver improved outcomes for patients, to protect the wider community and contain the costs.

4. POST DECISION IMPLEMENTATION

4.1 We propose the development of strategy implementation group to be led by Public Health and comprised of representatives from stakeholder organisations and service users. The group will be expected to meet on a quarterly basis and jointly propose a detailed implementation plan with attention to other related areas the Council's strategy e.g. in relation to Community Safety, Domestic Violence and Violence against Women and Girls, and Early intervention and Prevention.

4.2 Actions to be taken forward for each strategy priority.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Our strategic priorities for substance misuse closely align with the broader strategic direction set in Barnet's Health and Wellbeing (HWB) Strategy and the London Borough of Barnet's Corporate Plan; the points below cover the key themes highlighted in these documents.

5.1.2 *Healthy communities*: The three key themes from Barnet HWB strategy are; preparation for a healthy life, wellbeing in the community and how we live. Drugs and alcohol misuse has a direct adverse impact on all three of the above themes. Preventing drug and alcohol misuse among our population will support the Council's vision for providing a good start in life to our children and young residents and will also offer our adults and older population to remain healthy and active. Prevention and protection will also mean that our residents live well, age well and stay well and feel safe in their communities.

5.1.3 *Safety of our children and giving them a great start in life:* Children living with

parents with alcohol problems are at risk of physical, psychological and behaviour problems. Prevention and protection activities focused on controlling the sale of alcohol with strict processes for new licensing applications; more collaboration between different agencies along with early intervention and supporting parents and carers during treatment journey will help to ensure children and young people are safe in their homes and in the borough. These activities will also play an essential role in providing every child a best start in life and to enable them to have control over their lives.

5.1.4 *A cleaner and safer place to live:* Litter due to alcohol misuse, particularly, street drinking, is an issue in the borough. Introducing measures that reduce the availability of high strength alcohol and addressing street drinking especially among young people and rough sleepers will help deliver a cleaner borough. Drugs and alcohol misuse is associated with violent assaults, crime, fear of crime and fatalities related to road traffic accidents. Reducing opportunities for harmful substance misuse and treating dependency will provide clients with the opportunities to live healthy lives and will also reduce the crime activities linked with substance misuse. Similarly, it will offer residents with a sense of security and harmony in their communities.

5.1.5 *Better housing and economic prosperity*: Substance misuse can be both a cause and an effect of multiple underlying problems such as unemployment, debt and homelessness. Prevention, protection and effective treatment can help prevent and reverse this vicious cycle. It can help individuals to retain their homes, recover and end their risk of future homelessness by gaining employment and making positive contributions to society.

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

5.2.1 For 2015/16, the Public Health ring-fenced grant allocation for Barnet is £14.335m.

5.2.2 The existing contract spend (for Lot 2: Substance Misuse) if continued over the next 4.5yrs would be approximately £13.197m (see below).

Annual Value	Contract Value 2.5 years	2 year extension	Contract Value 2.5 + 2 years
£ 2,932,667.00	£ 7,331,667.50	£ 5,865,334.00	£ 13,197,001.50

5.2.3 The spend under the new contract following re-procurement (excluding one-off costs 265k for the next 4.5 years (2019-20) will be £12.998m – a reduction of £199k (1.5%) over the full contract term. The bid price amended to include value for money and multi-lot discounts reduces the new contract spend by a

further £33k to £12.965m, a reduction of 1.76% on the existing contract spend.

Public Health (Barnet) - Substance Misuse - Lot 2	Bidders Submitted pricing value for money (vfm) clarification	Bidders Submitted pricing value for money (vfm) clarification excluding one off costs
WDP	£13,229,654.80	£12,965,004.80

5.2.4 The available budget over the full term of the contract (before planned savings of 2.5% per annum) totals £13.790m. This assumes Adults MOPAC external grant funding of £398k (agreed annually) and contributions from the Adult Social Care budget of £715k. This results in a saving of £825k (6% reduction in the budget) over the full term of the contract, excluding the one-off costs.

5.2.5 There are costs of £265k in the first year of the contract relating to the cost of change, such as TUPE, IT and premise set up costs. These costs will reduce the revenue savings that can be delivered from 2016/17, unless these can be funded in year potentially from capital (if this is available and for legitimate elements of these costs such as premises and IT).

5.2.6 The commissioning intentions for Barnet assumed savings of 2.5% per annum, the cumulative effect of which totalled £711k over the four years to 2019/20 from 2016/17. If the costs of change cannot be funded in year or through capital, the phasing of the savings will be delayed until 2017/18 to enable the one-off costs to be recovered and will reduce the cumulative savings to £560k.

5.2.7 This spend is currently contained within the Public Health ring-fenced grant allocation for each council. Whilst the ring-fence is maintained, any efficiencies achieved on public health expenditure enable capacity in the grant, against which expenditure appropriately incurred across the council delivering the wider determinants of health to be charged to the grant. It should be noted that award of this contract results in contractual obligations with the provider for services which are funded by external grant and which cannot be guaranteed in the longer term.

5.2.8 The contract price delivers a reduction in cost of 2.5% per annum. The contract will be open book which may result in additional benefits during the life of the contract and there is no automatic inflation or annual uplift.

5.3 **Legal and Constitutional References**

5.3.1 Under the NHS Act 2006 as amended by the Health and Social Care Act 2012 local authorities are required to take particular steps in exercising public

heath functions, and the (regulations) cover commissioning of services.

5.3.2 The Local Authority's responsibilities for commissioning services are detailed in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

5.3.3 The terms of reference (Responsibility for Functions – Annex A) of the Health and Wellbeing Board are set out in the Council's Constitution and 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 receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
- To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.
- Receive the Annual Report of the Director of Public Health and commission and oversee further work that will improve public health outcomes.
- Specific responsibilities for: Overseeing public health and developing further health and social care integration.

5.3.4 The Local Authority, in respect of the services that it commissions from NHS providers, must have regard to the NHS Constitution in accordance with s2 Health Act 2009.

5.4 **Risk Management**

5.4.1 Treatment service risks are owned by the D&A programme board.

5.4.2 Risks to the broader strategy would be related to engagement, finance (to note that all activity will be within PH's available funding as outlined in the PH commissioning plan etc).

5.4.3 The Substance Misuse Service Procurement has been entered onto H&BJPHS Risk Register which is overseen by the H&BJPHS Substance Misuse Programme Board and Senior Management Team Meeting

5.4.4 The following risks have been identified:

- Breach in delivery of Service during transition to new providers
- Performance - reduction
- Performance - Drop in Activity
- Information Governance
- Environment

5.5 **Equalities and Diversity**

5.5.1 The Council needs to comply with the Equality Act 2010 in the provision of public health services in the area. An initial equalities impact assessment has been carried out on the above recommendations. There is no indication of

adverse effects to local population. It is anticipated that as the new recommendations offer more integration and robust pathways between health, social care, safeguarding and enforcement agencies, they will offer better services and improved outcomes for all residents (appendix 2).

5.6 **Consultation and Engagement**

5.6.1 The draft version of the strategy was sent for consultation and feedback to the following teams and organisations:

- Community safety team with Domestic Violence and Violence against Women and Girls (DV&VAWG) coordinator
- Prevention and Wellbeing team including carers lead
- Trading standards and licensing team
- Family services
- Adults and children safeguarding board members
- Barnet Clinical Commissioning Groups
- Head of Joint Children's Commissioning
- Council's Partnership Boards
- Barnet Healthwatch

6. BACKGROUND PAPERS

6.1 Public Health England Return on Investment from Public Health Interventions: http://www.local.gov.uk/documents/10180/5854661/Making+the+case+for+public+health+interventions/b6e8317e-dd06-492b-a9a3-c7da23edbe43

6.2 Public Health England Alcohol and drugs prevention, treatment and recovery: why invest:
http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf

6.3 Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014 (available on request from author)

6.4 Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014 (available on request from author)

DRAFT - London Borough of Barnet

Substance misuse strategy 2015 – 2020

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Glossary of terms

- Substance misuse – relate to both drugs and alcohol misuse
- DV and VAWG coordinator - Domestic Violence and Violence against Women and Girls coordinator
- CS or Community Safety team – relates to community safety team for the London Borough of Barnet (LBB). The service incorporates the DV & VAWG coordinator.
- LBB – London Borough of Barnet
- D&A services – Drug and Alcohol or substance misuse service
- YP – Young people
- LAPE data – Local Alcohol Profile for England data
- DOMES report – Diagnostic Outcome Monitoring Executive Summary report
- NDTMS data – National Drug Treatment Monitoring System data
- FRANK – Friendly confidential drug advice service
- CAF – Common Assessment Framework
- MASH- Multi-Agency Safeguarding Hub
- MARAC- Multi-Agency Risk Assessment Conference
- NPS – New Psychoactive Substances
- BBV- Blood Borne Virus
- ASB- Anti-social Behaviour
- IBA training – Identification and Brief Advice training

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Executive Summary

Our vision for Barnet	1. **PREVENT** harmful use of substances 2. **PROTECT OTHERS** from indirect harm caused by substance misuse **3. PROMOTE SUSTAINED RECOVERY** from dependence by intervening early and offering comprehensive services which rebuild lives.
The public health importance of substance misuse	• It causes harm to health • It is responsible for a significant proportion of hospital admissions and ambulance callouts • It causes crime, disorder and antisocial behaviour and compromises economic development • There are considerable inequalities associated with substance misuse • It has an indirect impact on children, families and carers of the users • It limits individual's potential • There are tried and tested ways to prevent substance misuse and protect others from harm • Treatment is cost effective saving the public sector money over time
The issue in Barnet	An estimated 70,000 **adults** in Barnet are drinking alcohol above the maximum recommended level and are putting their health at risk. In 2013/14, there were 595 people using alcohol treatment services in Barnet - a rise of 53% compared to 5 years ago. Nearly a third of these patients had been in treatment at least once before. With regard to drugs misuse, the most up to date prevalence data (2011/12), estimates around 1,492 problematic opiate and/or crack users (OCU) in Barnet. The proportion of OCU's in treatment in Barnet was 42.6%, which is lower than the estimated national rate (53.4%). The impact of drugs and alcohol misuse is more pronounced in **young people** with regard to their health, education and prospects of progression in life. Particular groups at risk of substance misuse include children in care, young people with mental health issues, or young people at risk of/or not in education, employment or training, or involved in crime and antisocial behaviour and/or at risk of sexual exploitation. National estimates indicate around 22% of 11-15 year olds drink once a month and the most common drug used by young people is cannabis. An estimated 12% of 11-15 year olds and 19.3% of 16-19 year olds have used any drug in the past 12 months. If we extrapolate these rates to Barnet's population, an estimated 4,400 11-15 year olds drank alcohol in the last month while 2,400 of 11-15 year olds and 2,895 of 16-19 year olds used any drug in the previous year. The transfer of Public Health to local authorities provides an opportunity for us to respond to substance misuse in a joint up and coordinated way. Not only we have a responsibility in managing licensing arrangements, preventing crime and improving community safety, we are now also responsible for substance misuse treatment and recovery services.

What actions will we take?	In the next five years, the broad areas of actions would be around three key areas: **PREVENT harmful use of substances by influencing supply and demand** • Review the availability of alcohol and location and number of licensed premises • Consider action on the local price of alcohol and on cheap alcohol • Support action that can be taken to reduce the supply of harmful substances • Change behaviour in high risk groups through the provision of information and brief advice (IBA) • Take collaborative action on the social determinants of substance misuse • Review and recommend action to prevent substance misuse in young people • Promote healthy behaviours in the general population **PROTECT OTHERS from indirect harm caused by substance misuse** *– a whole family approach i.e. children and vulnerable adults* • Refer children at risk of sexual exploitation to appropriate services • Minimise the potential risk to children with parent who misuse substances by increasing the early identification of children within the family and through increased information sharing. • Consider opportunities to link with the Troubled Families programme • Ensure appropriate internal and external links are made with Community Safety team and Domestic Violence and Violence against Women and Girls coordinator, Licensing team, Early Intervention and Prevention team, Children and Adults Safeguarding teams, Families services, Primary Care services, Secondary Care services including mental health, sexual health and A&/E teams, Education and Police. **PROMOTE SUSTAINED RECOVERY** by intervening early and offering comprehensive services which rebuild lives. • Improve action on blood borne viruses in injecting drug users • Partnership working between hospital teams and community substance misuse services • Data sharing protocols and referral pathways • Accessible and integrated specialist treatment and recovery services for adults and young people • Ensure individuals with a mental health and substance misuse problem gain rapid access to the support they require to recover • Ensure all stakeholders have easy access to up-to-date information which explains the substance misuse services available and the pathways for referral

	• Assure that substance misuse services are safe and effective, auditable, continuously improving and evolving to need.
Substance misuse expenditure and return on investment	The annual Public Health ring-fenced grant allocation for London Borough of Barnet, for 2015-16, is £14.335m while the current spent on substance misuse services is in the region of £2.93m annually. Barnet and Harrow joint Public health service has now recommissioned the contracts for adults and young people for 2.5 years from 1st October 2015 - to 31st March 2018 with an option to extend for a further period of up to 2 years. The re-procurement will improve integrated service provision and has resulted in efficiencies of 2.5% year on year to be delivered through redesigned pathways and streamlined contract management. External grant funding cannot be guaranteed in the longer term, requiring commissioning intentions (and contractual obligations) to be reviewed annually in line with the available financial envelope. There is good evidence that drug and alcohol treatment is cost effective – for every £1 invested in specialist alcohol treatment £5 is saved on health, welfare and crime costs and for every £1 spent on drug treatment £2.50 is saved in costs to society. Similarly, every £1 spent on young people's drug and alcohol interventions brings a benefit of £5-£8.
How will the strategy be implemented	Public Health has started work on a range of proposed actions but partnership is essential for a successful implementation of this strategy over the next five years. We propose the development of strategy implementation group to be led by Public Health and comprised of representatives from stakeholder organisations and service users. The group will be expected to meet on a quarterly basis and jointly propose a detailed implementation plan with attention to other related areas the Council's strategy e.g. in relation to Community Safety, Domestic Violence and Violence against Women and Girls, and Early intervention and Prevention.

Purpose of this document

Barnet and Harrow joint Public Health service has a responsibility to provide substance misuse services in Barnet and is currently finalising the recommissioning of these services. However, actions to address the use of drugs and alcohol are broader than this. This strategy outlines what we can do to prevent substance misuse, how we can protect families and the wider community from harm and how to identify those who need treatment early and support them to recover from dependence and lead fulfilling and healthy lives.

This Strategy has been developed in collaboration with a range of stakeholders and is based on the findings of the substance misuse needs assessment conducted by Fizz Annand, independent consultant. There is a need however for further consultation to ensure annual action plans are developed in partnership with the full range of stakeholders, including service users.

1- Local Picture

1.1- Substance misuse among adults in Barnet[1]

The vast majority of the Barnet residents, who drink alcohol, do so within the recommended level[2] (74.3%; 209,638). However, just over 70,000 adults in Barnet are thought to be drinking alcohol above the maximum recommended level and are putting their health at risk*. Of these, around 19,000 adult residents are drinking to an extent considered to be damaging for health. There are no local estimates for alcohol dependence in Barnet; however, modelling based on national surveys[3] suggests that around 5.9% (8.7% of men, 3.3% of women) of adults in Barnet may have some form of alcohol dependence.

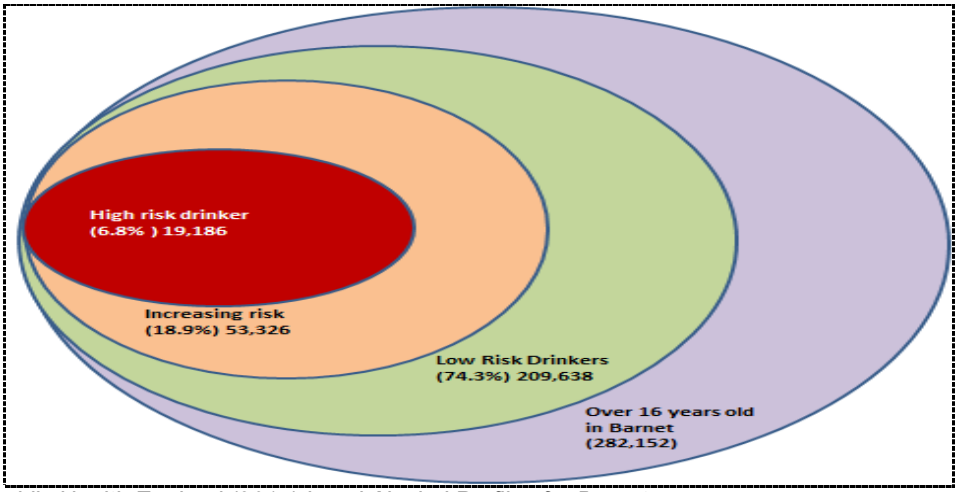

Figure1 – Public Health England (2014) Local Alcohol Profiles for Barnet

[1] Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014
[2] Public Health England (2014) Local Alcohol Profiles for England http://www.lape.org.uk/
[3] Adult psychiatric morbidity in England, 2007- Results of a household survey
http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

In Barnet, there were 595 adults (67% males and 33% females) in **treatment** for alcohol misuse in 2013/14 – a rise of 53% compared to the 5 years ago. The above number includes a third of the clients who had been through one to more previous treatment journeys. The level of successful treatment completions among alcohol clients in 2013/14 was 28.1% which was **below** the national average of 37.5%. There is an even lower completion rate for clients from the Criminal Justice System (20.9%). Furthermore the percentage of repeat presentations to treatment services within 6 months in Barnet was **higher** (15%) compared with the national level (12%).

In Barnet, there were an estimated 1,492 problematic opiate and/or crack users (OCU)[4] with less than half (42.6%) in treatment[5].
Between 2011/12 and 2013/14, the number of **opiates** clients under treatment for went up from 561 to 603. In 2013, the proportion of opiates users who successfully completed treatment was 8.6% which is lower compared to London 9.0% but better than the national rate of 7.8%.
Similarly, the total number of **non-opiates** clients under treatment went up from 143 in 2011/12 to 238 in 2013/14. The proportion of non-opiates users who successful completed treatment in Barnet (2013) was significantly lower (20.4%) compared to London (37.2) and national level 37.7%[6] and the successful treatment completion for clients from the Criminal Justice System (CJS) was even lower at 8.8% (Opiates users)[7].

*** Risk levels**

Lower risk drinking – fewer than 22 units a week for men, fewer than 15 units a week for women.
Increasing risk drinking – between 22-50 units a week for men, between 15-35 units a week for women
Higher risk drinking – more than 50 units a week for men, more than 35 units a week for women.
Binge drinking - drinking double or more the guidelines on a single drinking occasion.
Dependent drinking - refers to having developed alcohol dependence, where the person affected has started to have an excessive desire to drink, or is showing some loss of control over his/her drinking.

1.2 - Substance misuse among young People[8]

The Chief Medical Officer recommends that children should not drink before the age of 15 and older teenagers who do drink alcohol should do so in a supervised environment. The guidance suggested that young people should drink on no more than one day per week and conform to the limits recommended for adults*****. This is due to the association with early drinking and increased health risks, including alcohol-related injuries; truancy, exclusion, and lower educational attainment; involvement in violence; suicidal thoughts and attempts; having more sexual partners; pregnancy and sexually transmitted infections; using drugs; and employment problems[9].

[4] Drugs And Alcohol – Facts and Figures, Prevalence estimates by Local Authority 2011/12 http://www.nta.nhs.uk/facts-prevalence.aspx
[5] DOMES report Q4 2013-2014
[6] Public Health England Outcome Indicators 2.15i and 2.15ii
[7] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014
[8] Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014
[9] Chief Medical Officer for England, Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009. Referenced in http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm

Although, there are no local estimates on the prevalence and levels of alcohol consumption among young people in Barnet, the national rates can be applied to local population to obtain these estimates. According to the national survey[10], in 2013, around two-fifths of pupils (39 per cent) aged 11-15 years had drunk alcohol at least once, while 22% had drunk in the last 4 weeks and 9% had drunk alcohol in the last week. Crudely extrapolating these percentages to Barnet's population of 11-15 years old (an estimated 20,000), we might expect that 7,800 young people tried alcohol, and about, 4,400 have drunk alcohol in the last month and 1,800 in the last week. Boys and girls were equally likely to have drunk alcohol. The above estimate does not necessarily mean the young people are drinking problematically – *please see the section on impact of alcohol for more information.*

With regard to the drug use among young people, nationally the proportion of secondary school pupils (age 11-15) taking drugs decreased from 29% in 2001 to 17% in 2012. According to the national survey[11], an estimated 17% of the pupils aged 11-15 years had taken drugs at some point in the past while 12% of the pupils had taken drugs in the last year and 6% had taken them in the last month. It also concluded that cannabis was the most widely used drugs by pupils in 2012 with 7.5% reporting taking it in the last year. The Crime Survey for England and Wales (CSEW) 2013/14 also found that cannabis was the most commonly used drugs by young adults aged 16-24 years with 15.1% having taken it in the previous year. Translating these figures to a Barnet context, we get the following numbers.

	Barnet					
	11-15 year olds		16-19 year olds		20-24 year olds	
Population	20,000		15,000		24,000	
Any drug in last year	12%	2,400	19.3%	2895	18.7%	4488
Cannabis in last year	7.5%	1,500	15.1%		5889	

Figure 2 - Barnet young people substance misuse needs assessment based on Smoking, Drinking and Drugs use among Young People in England in 2012 - The Crime Survey for England and Wales and ONS and GLA population tools.

Crack cocaine and heroin use is associated with the highest level of harm. There is considerable uncertainty in estimating usage amongst young people in Barnet. The estimates[12] suggest there are between 194 and 386 (best estimate 254) young people between the ages of 15 and 24 using opiates and/or crack and between 121 and 370 opiate users (best estimate 179).

The use and easy availability (over the internet) of New Psychoactive Substances (NPS) (also referred to as legal highs) is rapidly changing the nature of the UK drugs market. The health harms associated with NPS are unknown at present as the chemicals used are not tested for use in humans. Increasing use amongst young people nationally is a big concern. In Barnet we know little about the extent to which

[10] Smoking, drinking & drug use among young people in England 2013; Drinking Tables 4.1b, 4.3b and 4.4 http://www.hscic.gov.uk/catalogue/PUB14579
[11] Ibid 10
[12] Ibid - Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014

legal highs are used as data concerning the use of NPS is not currently collected; however youth workers have reported an anecdotal rise in the use of NPS.

With regard to the demographic characteristics of young people in treatment (2013/14), 64% were male and 36% were females. The majority of the clients were from white UK background and two third of the overall clients were in the 16 and 17 age group. Most (58%) were in mainstream education and an additional 20% were in alternative education.

Based on the National Drugs and Treatment Monitoring System (NDTMS) for Barnet, the number of young people in **treatment** decreased from 103 in 2011/12 to 95 in 2013/14[13]. The mutually agreed care planned exits remained in line with the national benchmark and although the treatment completion rates were initially lower than national levels in 2013/14 these improved in a year to align themselves with national levels. On the other hand, the representations to treatment services within 6 months were much lower in Barnet compared to the national levels.

By examining the referrals to substance misuse services, in 2013/14, Barnet had higher rates of referrals from children and families sources than national levels (Barnet 25% vs. national level 17%), higher rates of referrals from health/mental health sources (13% Barnet vs. 7% nationally), lower rates of referral from youth justice (26% Barnet vs. 33% nationally) and lower levels of self/friends/family referrals (5% Barnet vs. 11% nationally).

The data from Common Assessment Framework (CAF) used by practitioners across children's services to assess a child's needs also identifies drugs or alcohol misuse as a Primary/Secondary or Other reason. In 2013/14, there were a total of 456 assessments initiated including 10 related to either substance misuse in young people or their parents/carers in Barnet[14].

A significant proportion of young people who are in contact with the Youth Offending Team (YOT) have alcohol and /or drugs as one of the risk factors in their offending. Based on the 2013/14 data, 36% (n=46) of all YOT assessments showed moderate or above (ASSET score 2 or over) association with substance misuse.

1.3 - Impact of substance misuse on local health services

Hospital data

Hospital admissions data reflects the general level of health harm from alcohol in the population. Hospital admissions can be a result of casual regular alcohol use above lower-risk levels as well as chronic heavy drinking in the population and is most likely to be found in increasing-risk drinkers, higher-risk drinkers, dependent drinkers and binge drinkers.

The last five year's Local Alcohol Profile for England (LAPE[15]) data for Barnet shows an increasing trend in the rates of alcohol related hospital admissions for both males and females until 2011/12 or 2012/13, when a slight drop occurred in all except the

[13] Ibid – Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014)
[14] Ibid - Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014)
[15] Public Health England – Local Alcohol Profiles for England http://www.lape.org.uk/LAProfile.aspx?reg=X25001AA

broad definition data for males. Although the overall admission rates for both males and females are still lower than regional averages, male admissions in Barnet are double than those for females. As for young people (under 18's), the LAPE data shows a distinct decreasing trend in alcohol related hospital admissions over the last five years.
Data captured on alcohol harm map (Alcohol Concern)[16], estimated 63,557 alcohol related admissions and attendances in Barnet during 2012/13. Of these, 41,421 were visits to A&E and 5,456 were inpatient admissions. An estimated 22.8% (n=1,254) of the inpatient admissions were wholly attributed to alcohol. The overall alcohol-related healthcare costs in Barnet were an estimated £17.6m, equating to £61 per adult - a significant drain on local resources.

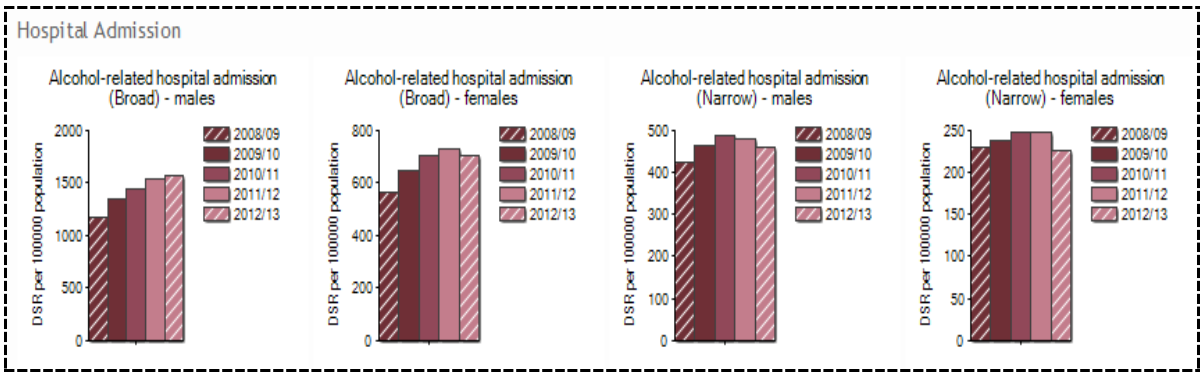

Figure 3 – Alcohol related Hospital admission data for Barnet residents (males and females 2008-2013)

The most up-to-date hospital data related to drug use is for 2012/13 (Barnet Primary Care Trust Data)[17] and based on that there were 332 hospital admissions, with either a primary or secondary diagnosis of drug related mental health and behavioural disorders. An additional 36 hospital admissions were related with a primary diagnosis of poisoning due to illicit drug use. The other impact of drugs on local health services is due to blood borne infections among intravenous drug users. It is also estimated that 73% of those with Hepatitis C in Barnet are either current or have previously injected drugs[18].

Ambulance callouts

A national A&E staff survey estimated that 35% of all visits are related to alcohol consumption, increasing at peak times to 70%[19].
In 2013/14, nearly 1739 London Ambulance callouts for **adults** in Barnet (1182 for males and 555 for females) were registered as "related to alcohol"[20]. The age group with the highest number of alcohol-related callouts was 26-45 years old (740 callouts) followed by 46-65 years old (541) and 18-25 years old (301). The trend in age distribution of these callouts is the same in the last five years. The wards with the highest number of these callouts were Childs Hill, West Hendon and West

[16] Alcohol Concern (2014) Alcohol Harm Map- http://www.alcoholconcern.org.uk/for-professionals/alcohol-harm-map/
[17] Health and Social Care Information Centre (HSCIC) - Statistics on Drugs Misuse - England, 2013 http://www.hscic.gov.uk/catalogue/PUB12994
[18] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014
[19] The cost of alcohol harm to the NHS in England, An update to the Cabinet Office (2003) study, July 2008 Health Improvement Analytical Team, Department of Health
[20] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014

Finchley. Although, the numbers of callouts are related to population density, there is also some indication that the areas identified as the borough hotspots for licensed premises comprise a high volume of alcohol related calls.

The drugs related London Ambulance callouts for adults in Barnet for the same period (2013/14) were 573 (254 for males and 319 for females) with the highest number among 26-45 years old (274).

For the same period (2013/14), the alcohol related London Ambulance callouts for **young people** *(under the age of 18 years)* were 73 (36 males and 37 females). The age group with the highest number of alcohol-related callouts was 15-17 year olds (60 callouts). Based on the local wards, the largest numbers of these callouts were from Edgware and East Barnet, while Oakleigh, Hale and Brunswick Park had the smallest number of callouts.

The drugs related London Ambulance callouts for young people in 2013/14 *(under the age of 18 years)* were 68 (18 for males and 50 for females) with the peak among 15-17 years old.

1.4- Associated and far reaching adverse effects of substance misuse

i. Violence, crime and disorder

Alcohol-related crime, disorder and antisocial behaviour cost an estimated £11bn per year (2010-11 costs, England). In London it is estimated to cost £1.2 billion to police and council resources each year[21]. In almost half (47%) of all violent offences in 2011/12 nationally, alcohol was a contributory factor in the crime[22] and victims believed the offender(s) to be under the influence of alcohol[23]. Binge drinking appears to increase the risk of offending[24] and those who "pre-load" at home before going out for further drinking are more likely to be involved in violent crime[25].

The LAPE for Barnet shows a decreasing trend for alcohol related crimes and violent crimes with the exception of alcohol related sexual offences. Barnet is the second lowest borough in London for alcohol related violent crime, 8th lowest for alcohol related crime generally, and 6th lowest for alcohol related sexual offences[26]. Local data on the alcohol related crimes (provided by Community Safety team) for the period Jan-Dec 2013 showed that 8% (n=1,804) of the overall crimes in Barnet were related to alcohol. Of these 23% (n=72) were classed as violence with injury

[21] Safe Sociable London Partnership (2012) Presentation by Will Tuckley, Senior Responsible Officer for the London Health Improvement Board's Alcohol Priority; 5 Oct 2012. http://www.safesociablelondonpartnership.co.uk/licensing-network/4579962300

[22] Office for National Statistics (2012), Crime Statistics, Nature of Crime tables, 2011/12

[23] Ibid - Alcohol Concern (2014) Alcohol Harm Map. http://www.alcoholconcern.org.uk/for-professionals/alcohol-harm-map/

[24] Matthews S and Richardson A (2005): The 2003 Offending Crime and Justice Survey: alcohol-related crime and disorder. *Home Office Research Findings 261*

[25] Hughes K, Anderson Z, Morleo M and Bellis M A (2008): Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes, *Addiction*, 103(1), 60–65

[26] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014

offences. More recently, Barnet Community Safety MARAC (Multi-Agency Risk Assessment Conference) has observed links between street drinking, rough sleeping, environmental degradation due to litter and a rise in anti-social behaviour in the Borough's hotspots.

On the other hand, dugs are related to crime through the effects they have on the user's behaviour and by generating violence and other illegal activity in connection with drug trafficking. Problem drug users are responsible for a substantial proportion of acquisitive crime, such as shoplifting and burglary and the research claims that young males who take drugs are five times as likely to commit criminal offences[27]. In comparison to alcohol, drugs related crimes in Barnet are fewer. In 2013, there were 130 drugs related allegations in Barnet (local data provided by Barnet Community Safety team on drugs related crimes). An early estimate from drug intervention programme suggests that 25% of Barnet clients have proven* to reoffend which is 1% lower than the Met level.

**Proven Reoffending statistics are based on a conviction for a further offence with limited time period after the initial offence*.

ii. Domestic Violence (DV)

It is estimated that alcohol is a factor in one-third of all incidents of domestic violence nationally, with many perpetrators having consumed alcohol prior to the assault. Victims of domestic violence may also use alcohol as a coping mechanism, which may in turn be used by partners as an excuse for continued violence[28]. In addition, twice as much alcohol is now purchased from the off-licence venues *(data comparison between 2000 and 2009)* than from pubs and bars - potentially magnifying the impact on domestic violence whilst hiding its influence from public view[29].
Domestic violence and alcohol and/or drugs misuse were identified as the three most prevalent causes **"toxic trio"** of poor outcomes for Barnet families[30].

The Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared between professionals about the highest risk domestic violence (DV) cases in the borough. In Barnet, the number of overall referrals to MARAC has increased over the last 3 years from 165 to 230. Similarly, the total number of MARAC cases where drug or alcohol issues are present is also increasing year on year[31].

[27] Barnet Community Safety Strategy 2015/2020
[28] Finney A (2004) Alcohol and intimate partner violence: key findings from the research. Findings 216. London: Home Office
[29] BBPA Statistical Handbook, 2010. Referenced in http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm
[30] Children, Education, Libraries and Safeguarding Barnet Committee Commissioning Plan 2015 - 2020
[31] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014

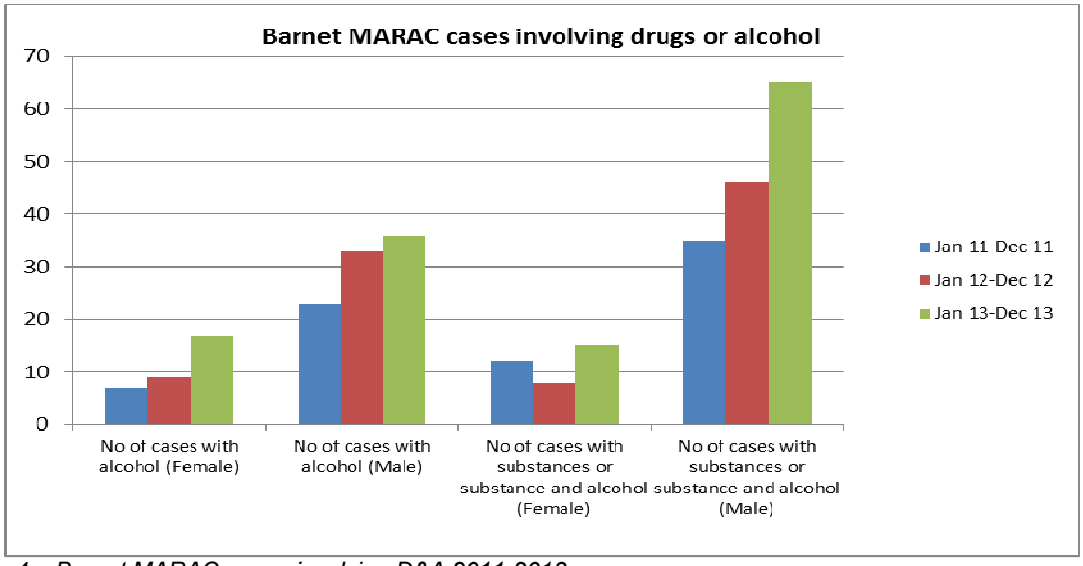

Figure 4 – Barnet MARAC cases involving D&A 2011-2013

iii. Sexual violence

Alcohol consumption is a major factor in sexual violence. Many of those committing sexual assaults had consumed alcohol 6 hours prior to an incident (58% of 142 men imprisoned for rape)[32] and a further 12% had used a combination of alcohol and drugs. Furthermore, many victims of sexual assault have been drinking prior to the event. During 2013, there were 39 sexual offences related to alcohol and four related to drugs in Barnet[33].

iv. Areas with high density of alcohol selling venues

Nationally, a fifth (20%) of all violent incidents in 2010–11 took place in or around a pub or club. There is a good relationship between the number of alcohol premises and the associated harms[34]. Robert Young et al (2013)[35] identified a significant relationship between adolescents and their increased likelihood to drink alcohol based on living close (within 200 m) to an off-sales outlet and or drinking more frequently if living in areas with many nearby off-premises outlets.
In Barnet, there are around 823 premises selling alcohol and although the relationship between levels of crimes, noise, street drinking and callouts to front line services are multifactorial (i.e. dependent on population density, demographics and deprivation), there is an indication that in Barnet, these could be also linked with the concentration of on/off premises selling alcohol[36].

[32] Grubin D and Gunn J (1990): The imprisoned rapist and rape. London: Department of Forensic Psychiatry, Institute of Psychiatry. Cited by Finney A. 2004. Alcohol and sexual violence: key findings from the research. Findings No.216.London: Home office
[33] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014
[34] Full to the Brim: Outlet density and alcohol-related harm - Alcohol Concern Cymru Briefing http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Full-to-the-brim.pdf
[35] Robert Young et al (2013); Associations between proximity and density of local alcohol outlets and alcohol use among Scottish adolescents http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3885793/
[36] London Borough of Barnet, Trading Standards and Licensing, Development and Regulatory Services (2014); Impact of premises licensed the sale and supply of alcohol on crimes; Report on the problems associated with alcohol consumption in London Borough of Barnet.

1.5- Key substance misuse services

Adults

A new service specification has been developed this year with the expectation that the new Drugs and Alcohol service will start from October 2015. At present, the Public Health team commissions the following services;

- Barnet Drugs and Alcohol Services (BDAS)
- Westminster Drugs Project (WDP) Recovery Centre
- Haringey Action Group on Alcohol (HAGA)
- Identification and Brief Advice (IBA) via 17 pharmacies
- A shared care GP service for opiates users via eight GP surgeries

The tier 4 treatment (inpatient detoxification and residential rehabilitation) is funded separately from the main community treatment providers.

In addition to the above, Barnet also has a **Drugs Intervention Programme (DIP)** for clients from criminal justice service. The DIP clients can access a floating support service provided by Outreach Barnet on budgeting, income maximisation and tenancy maintenance. **Homeless Action Barnet** also delivers support to homeless clients, many of whom have alcohol rather than drugs issues.

WDP recovery centre also has a **carers group** that meets every week where carers are reassured that they are not alone and are offered support with understanding addiction better and offered a platform to listen and share common problems and feelings.

Young people

A new service specification for young people is planned to be developed later in this year with the expectation to start in 2016.

At present, Public Health commissions Barnet Young People Drugs and Alcohol Service **(BYPDAS)** which provides community based drugs and alcohol tier 2/3 provision to children and young people who live in Barnet. BYPDAS has a close working relationship with the Youth Offending Team (YOT) to support young people with substance misuse issues identified during assessment. There is also a memoranda of understanding with key agencies who work with children excluded from school, looked after children, young offenders, young people with mental health problems and children from 'troubled families'.

Public Health also commissions a tier 1 substance misuse prevention school programme. The programme is universally offered to all primary and secondary **schools** in Barnet and is delivered by Tavistock and Portman NHS foundation Trust. The programme provides consultancy hours, training for staff and resource development; however, it will finish in July 2015. The Health Education Partnership will continue their work with Barnet schools, providing support for schools working towards the Healthy School London award. Through this schools will be supported to identify areas where they might require more support, one of which could be around alcohol / substances, and then signposted to where such support can be obtained.

In addition to the above, there is a support structure **(Time4us**) for young carers affected by adult drugs or alcohol misuse funded by the early Intervention funds from LBB; and the Mayor's Office for Policing and Crime (MOPAC) also provides grant to LBB that is used to support substance misuse and Youth Offender services.

2- Strategic direction

2A- Our vision is to:

1- **Prevent harmful use of substances**: Reduce dangerous level of alcohol intake and the use of illicit and harmful substances including legal highs.

Prevention measures are aimed at the whole population in general and young people in particular. The key areas of preventive work are to reduce the escalation of substance use and stop people becoming drug or alcohol dependent. It is important to say that, we also need to act on issues like poverty, employment and housing and to create an environment which promotes health and wellbeing and discourages substance misuse. Without such decisive steps, it is likely that the need for treatment will grow in the future.

2- **Protect others from indirect harm caused by substance misuse**

Protection is about reducing the indirect health and social harms suffered by families, communities and society linked to substance misuse. Protection involves a whole family approach and includes children, vulnerable adults and carers of those with substance misuse problem.

3- **Promote sustained recovery**: by intervening early and offering comprehensive services which supports sustained recovery from dependence and rebuild lives.

A much smaller number of Barnet's residents need specialist treatment and support to recover from dependence on substances. Early intervention is paramount which requires pathways that link the entire health and social care system to ensure wherever risk behaviour is noted, be it by a hospital doctor, a social worker or youth offending worker, the staff are knowledgeable and confident about making referrals to their local treatment and support services.
Treatment should focus on offering a package of support – including prescribing, housing and employment support as well as peer support to ensure individuals do not default to substance misuse; and instead can continue to rebuild and progress in their lives making a positive difference for themselves, their families and the wider community.

The above vision closely aligns with the broader strategic direction set in Barnet's Health and Wellbeing (HWB) strategy and the London Borough of Barnet's Corporate Plan.

Healthy communities: The three key themes from Barnet HWB strategy are; preparation for a healthy life, wellbeing in the community and how we live. Drugs and

alcohol misuse has a direct adverse impact on all three of the above themes. Preventing drug and alcohol misuse among our population will support the Council's vision for providing a good start in life to our children and young residents and will also offer our adults and older population to remain healthy and active. Prevention and protection will also mean that our residents live well, age well and stay well and feel safe in their communities.

Safety of our children and giving them a great start in life: Children living with parents with alcohol problems are at risk of physical, psychological and behaviour problems. Prevention and protection activities focused on controlling the sale of alcohol with strict processes for new licensing applications; more collaboration between different agencies along with early intervention and supporting parents and carers during treatment journey will help to ensure children and young people are safe in their homes and in the Borough. These activities will also play an essential role in providing every child a best start in life and to enable them to have control over their lives.

A cleaner and safer place to live: Litter due to alcohol misuse, particularly, street drinking, is an issue in the Borough. Introducing measures that reduce the availability of high strength alcohol and addressing street drinking especially among young people and rough sleepers will help deliver a cleaner Borough.

Drugs and alcohol misuse is associated with violent assaults, crime, fear of crime and fatalities related to road traffic accidents. Reducing opportunities for harmful substance misuse and treating dependency will provide clients with the opportunities to live healthy lives and will also reduce the crime activities linked with substance misuse. Similarly, it will offer residents with a sense of security and harmony in their communities.

Better housing and economic prosperity: Substance misuse can be both a cause and an effect of multiple underlying problems such as unemployment, debt and homelessness. Prevention, protection and effective treatment can help prevent and reverse this vicious cycle. It can help individuals to retain their homes, recover and end their risk of future homelessness by gaining employment and making positive contributions to society.

2B- Our values and principles[37,38]

Equality and accessibility: As Barnet and Harrow joint Public Health service, we believe that Barnet residents should have equal access to services, which are appropriate to their needs and which take account of their age, gender, disability, sexuality, race and religious and cultural beliefs. We will ensure our services are easily accessible and our service users and their families are at the heart of our work to tackle drug and alcohol misuse. Similarly, we will support the delivery of safe and high-quality health and social care services.

[37] Keeping Well, Keeping Independent – A Health and Wellbeing Strategy for Barnet (2012-2015)
[38] London Borough of Barnet, Corporate Plan 2015-2020

Effective multi-agency and collaborative working: We will ensure there is a holistic approach in reducing the harmful effects of substance misuse and, to achieve this, we will work in collaboration with both internal and external partners and promote data sharing and evidence of best practice at a multi-agency level.

Evidence based practice: We will ensure that we use research evidence of what is effective when making recommendations and developing services. We will also ensure that service users' experiences are good across the range of services.

2C- Strategic priorities in action

Substance misuse has multiple underlying causes and to have a real and lasting impact on the health and wellbeing of the people of Barnet, there is a need for **collaboration at multi-agency level.** Teams from different departments, such as Local Public Health, Substance misuse services for adults and young people, Primary Care, Secondary Care including A&E, Maternity and Mental Health services, Adult Social Care services, Children and Family services, Housing, Community Safety team with Domestic Violence and Violence against Women and Girls representative, Prevention and Wellbeing services, Youth Justice, Police, Education and Employment services need to work in partnership to address the range of vulnerabilities. In essence, all professionals need to improve communication and actively seek opportunities for collaborative work in order to prevent substance misuse alongside sustaining recovery from dependence.

The key strategic priorities are illustrated in the figure below followed by three main sections.

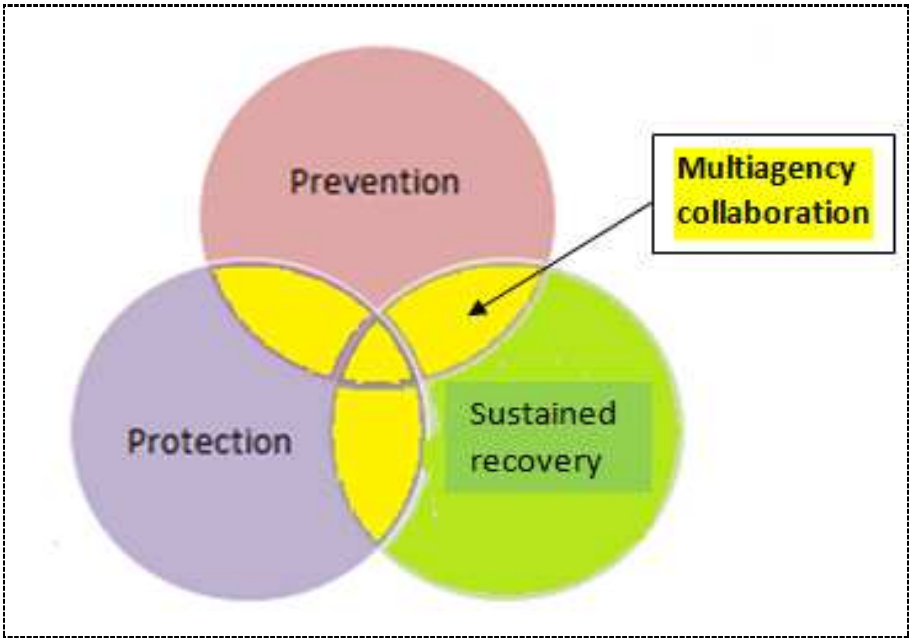

Figure 5 – Strategic priorities and levels of action

2.1 – Our actions to **PREVENT** harmful use of substances by influencing supply and demand

By 2020 in Barnet we will have:

- Reduced drug and alcohol use in the borough.
- Reduced numbers of young people drinking before aged 15.
- Reduced numbers of adults and young people drinking above the NHS guidelines including binge drinking.
- Improved public awareness around harms related to substance misuse and improved resilience, particularly in young people, to make healthy choices.
- Increased alcohol screening and brief advice in primary care and A&E in Barnet.

Key areas of work include

2.1.1 Review the availability of alcohol and location and number of licensed premises

Easy availability of alcohol has a direct relationship with increased consumption and the associated harm. The relationship between the number of licensed premises and increased consumption of alcohol and also alcohol-related violence is mentioned previously and a recent review commissioned by the Barnet's licensing team have also concluded this link. International evidence suggests that making it less easy to buy alcohol, by reducing the number or density of outlets selling it and conditions under which it can be sold, is an effective way of reducing alcohol-related harm[39], specifically binge drinking and alcohol related crime[40] and drinking in young people[41].
The local authority is responsible for granting licenses to premises selling and supplying alcohol through the Licensing Act 2003. The Director of Public Health is one of the responsible authorities who are entitled to comment on applications and make representations to the licensing authority within 28 days if they think the application threatens one of the statutory licensing objectives.

The objectives are as follows:

- The prevention of crime and disorder
- Public safety
- The prevention of public nuisance
- The protection of children from harm

In light of the above, it is essential to work more closely and provide Public Health support to the Council's licensing and trading standards team.

[39] NICE public health guidance 24. Alcohol-use disorders: preventing harmful drinking. June 2010
[40] Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People, University of Sheffield review for the NICE Public Health Programme Development Group, 2009.
[41] Anderson P, Baumberg B. Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006.

2.1.2 Consider action on the local price of alcohol and on cheap alcohol

It is currently possible to buy a can of lager for as little as 20p and a two-liter bottle of cider for £1.69 because there is **no minimum price** for alcohol[42]. The practice of "pre-loading" at home prior to a night out has resulted from cheap alcohol being available in supermarkets and off-licenses[43]. In a recent study, 66% of 17–30 years old arrested in a city in England claimed to have "pre-loaded"[44] before a night out, with pre-loaders two and half times more likely to be involved in violence than other drinkers. This has contributed to a fifth of all violent incidents occurring in, or around, a pub or club.

Those who consume the most alcohol are known to "shop around" for the cheapest form of alcohol[45]. Research suggests that **increasing the price of alcohol** is the best way to reduce consumption at a population level[46] and there is evidence that setting the minimum unit price at 40p per unit would affect the heaviest drinkers the most without a substantial impact on moderate drinker's consumption and spend[47]. Nationally, the plan to introduce minimum unit price for alcohol has stalled and in Barnet the proposal to set a minimum unit price has been postponed at present. However, we can explore the practicality of a responsible retailer programme, like that which has been introduced in Haringey and Camden and Islington. These voluntary agreements stop the sale of super strength alcohol, single cans and sales to street drinkers, particularly in areas associated with street drinking and alcohol related harm. There are also opportunities to work with retailers around price promotions on alcohol given research indicates such offers encourage customers to buy more[48] and subsequently drink more[49].

2.1.3 Support action that can be taken to reduce the supply of harmful substances

There is an opportunity to support action by Police and Trading Standards Officers to reduce the supply of illegal substances. It is important to establish what action is currently being taken and what collaborative actions could helpfully:

- reduce the sale of New Psychoactive Substances (legal highs) over the internet and in 'head shops'
- reduce the sale of counterfeit alcohol

[42] Health Committee (2012). Third report. Government's Alcohol Strategy. Written evidence from the Department of Health http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm
[43] HM Government 2012. The Government's alcohol strategy. https://www.gov.uk/government/publications/alcohol-strategy
[44] Barton, A and Husk, K. Controlling pre-loaders: alcohol related violence in an English night time economy. Drugs and alcohol today - Referenced in
[45] Ibid - Health Committee (2012)…..
[46] The likely impacts of increasing alcohol price: a summary review of the evidence base (2011). Home Office
[47] The Government's Alcohol Strategy (2012); HM Government https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf
[48] Blattberg, R C & Neslin, S A (1990). *Sales Promotion: Concepts, Methods, and Strategies*. Englewood Cliffs, NJ: Prentice-Hall, Inc
[49] Ibid - Independent Review of the Effects of Alcohol Pricing and Promotion, Part B, University of Sheffield, 2008.

- break the link between drugs and gang activity in the borough

2.1.4 Raise awareness in high risk groups

Use of alcohol scratch cards which enable individuals to review their drinking habits is a simple concept. Subject to the scratch card results, a trained professional can provide a brief advice (5-10 mins) and refer on to specialist services if appropriate. There is good evidence that the provision of **information and brief advice (IBA**) by a trained professional at a key moment in time, such as at a time of concern about the individual's health can change attitudes and reduce risk taking behaviour. At least one in eight at risk drinkers reduce their drinking and experience improved health as a result of IBA[50].

In Barnet[51], 17 pharmacies are delivering IBA programme as part of the pilot, but there is lack of information on the level and extent of IBA in primary care settings. There is a need to review and expand the current IBA programme with its integration into broader substance misuse service provision that would support monitoring, on-going training requirement and evaluation. **Training** in IBA would enable staff to work with low risk individuals themselves and without the need to refer on to specialist service providers. There is a wide range of stakeholder who may benefit from training including pharmacists, GPs, health visitors, school nurses, teachers, adult social care, children's social care services, safeguarding specialists, community safety team, mental health teams, housing support workers, police/teams working with clients in the criminal justice system, fire services and hospital staff in A&E and on inpatient wards. Specialist substance misuse providers are best placed to run regular training sessions which relevant professionals in Barnet should be encouraged to attend. However, given turnover of staff and the need for regular prompts to ensure the training is used, it may be advantageous to adopt a 'train the trainer' model.

It is important to ensure all training covers new psychoactive substances (NPS) as we know that nationally this is a growing area of use – the workforce needs to be aware of the substances, impacts and potential issues as well as usual pathway and referral routes. The new treatment provider will be expected to provide "Club Drug Clinics" in the Borough to address stimulants and NPS use.

2.1.5 Raise awareness in general population

The evidence from research commissioned by Department of Health (DH) suggests that the impact of campaigns centred on the health risks of alcohol is greater for "less entrenched drinkers and those more motivated by long term health, such as people aged 35–54, those in ABC1 social groups, and many women". Younger adults tend not to see long term health risks as compelling[52]. Research suggests information alone does not motivate most heavy drinkers to change their behaviour.

[50] Health Committee (2012). Third report. Government's Alcohol Strategy. Written evidence from the Department of Health http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm
[51] Ibid - Barnet drug and alcohol needs assessment & treatment system review (Adults) 2014
[52] 2CV (2008) Insight and action to help reduce levels of hazardous and harmful drinking, Qualitative research debrief. http://www.aim-digest.com/digest/members%20over%20yr/harmfulnhs.pdf

It is recommended that when our future campaigns are commissioned, they are based on the learning from rigorously evaluated campaigns such as those published in the Alcohol Learning Centre[53] and preferably run in conjunction with national awareness weeks and campaigns such as 'Dry January'. Similarly, any workplace health programmes should incorporate messages around substance use, particularly alcohol.

2.1.5 Preventing drug and alcohol misuse among young people

A range of research has been carried out on what influences drinking behaviour among children and young people. For younger children, parents and other family members play the key role in forming their initial understanding of alcohol, but as children grow older and begin to socialise more, peers start to have an increasing impact on their attitudes, choices and behaviour.

All young people should have access to information, advice and effective drug/alcohol education in mainstream settings such as schools. Schools understand the connections between pupils' physical and mental health, their safety, and their educational achievement, and are well placed to provide good pastoral care and early intervention for problems which may arise from, or lead to, substance misuse. There is good evidence for the use of drug and alcohol education programmes in schools[54]. Fear based approaches are not effective in reducing substance use. Neither are programmes which rely only on providing information or only aim to boost self-esteem. An interactive approach to teaching is essential.

The Barnet needs assessment highlighted that referrals from schools in Barnet to Barnet Young People's specialist substance misuse services are currently low and some schools are reluctant to allow drug and alcohol specific services access to undertake prevention work or take up the offer of support to develop appropriate policies. There is a need to evaluate the extent to which schools, including independent schools, are aware of local sources of support and have relevant policies in place. There is value in recruiting 'champions' (Head Teachers) from within schools and colleges to help promote prevention services, highlight successful outcomes and raise awareness at a strategic level. This could be facilitated by engagement from education representatives in the strategy group proposed.

2.1.6 Collaborative action on the social determinants of substance misuse

In our efforts to prevent substance misuse, it is important not only to concentrate attention on the issues resulting from substance misuse but also on the factors which may lead to substance misuse in the first place. For instance, socioeconomic situation, being rich or poor plays a part – women in the lowest income bracket (lowest 20% of household income) are 33 times more likely to be dependent on

[53] *Alcohol Social Marketing for England: Working together to tackle higher risk drinking* http://www.alcohollearningcentre.org.uk/_library/Resources/SocialMarketing/Alcohol_SM_Toolkit.pdf

[54] Drug prevention programmes in schools: what's the evidence? Mentor UK www.mentoruk.org/wp-content/uploads/2011/11/Prevention-Evidence-Paper-Nov-11-Final.pdf

drugs than women in the top income bracket (highest 20% of household income)[55]. Similarly, unmanageable debt, unemployment, housing problems and social deprivation can lead to or exacerbate substance misuse[56]. As mentioned previously, the individuals with a history of alcohol and drug misuse require a holistic approach in order to sustain recovery. Without such efforts, treatment success can be short-lived.

It is of paramount importance that the substance misuse strategy implementation group includes representatives from all services from all these directorates within Barnet Council and that opportunities for collaborative action are scoped and acted upon. In this context, the key groups include both adult and young people drug and alcohol services, education, housing, welfare, police, communication, children and family services, community safety team with DV&VAWG coordinator, mental health, youth offending and social care teams work in collaboration and have robust referral mechanisms. Staff from these services should be able to identify drug and alcohol needs early on (including those of children and young people affected by parental drug and alcohol misuse), offer screening and brief intervention at the earliest opportunity and/or make timely referrals to appropriate service for further support.

[55] Green et al 2005, McManus et al 2009 quoted in Public Mental Health: risk factors and protective factors. Dr Jonathan Campion. Director of Population Mental Health, UCL Partners

[56] Annual Report of the Chief Medical Officer 2013 - Public Mental Health Priorities: Investing in the evidence

2.2 – Our actions to **PROTECT OTHERS** from indirect harm caused by substance misuse'

By 2020, in Barnet we will have:

- Increased identification of parental substance misuse and early referrals of children and young people to appropriate support services.
- Reduced substance misuse related death and other serious incidents related to clients accessing substance misuse services.
- Improved pathways between domestic violence and substance misuse services.
- Improved identification of victims and perpetrators of domestic violence with substance misuse problems.
- Improved identification and support for those with mental health and substance misuse problems.
- Reduced street drinking in the borough, substance related anti-social behaviour and offending.
- Improved substance misuse focused collaboration between the NHS, Voluntary Sector, Police and Council (including Education, Housing, Welfare, Children's Services, Adult Services, Community Safety team with DV&VAWG coordinator, Domestic Violence, Licensing and Trading standards, Mental Health and Youth Offending teams) to prevent, protect from and treat substance misuse.

Key areas of work

2.2.1 Protection of vulnerable children and families/carers from drugs and alcohol related harm

The harmful effects of substance misuse are not just limited to the individual users but extend to their children, families and carers as well. The analysis of local data carried out for Barnet's **Early Intervention and Prevention strategy**[57] identified alcohol and/or drug misuse as one of the eight themes most likely to have a poor outcome for Barnet families. Alcohol misuse by parents is more widespread than drug misuse and affects a significant number of children[58].

Substance misuse was highlighted throughout the Rotherham report regarding child sexual exploitation **(CSE)**[59]. Almost 50% of children who were sexually exploited or at risk were found to have misused alcohol or other substances. The use of substances is reported to have been part of the grooming process, provided for free by those involved in the exploitation. Years after the abuse suffered by the individuals in Rotherham, a disproportionate number had developed drug and alcohol addiction. Although LBB is different to other boroughs in terms of its demography, the importance of safeguarding vulnerable and young children against child sexual exploitation is the same.

[57] London Borough of Barnet - Early Intervention and Prevention Strategy (2014)
[58] Office of the Children's Commissioner (2012) Silent Voices: Supporting Children and Young People Affected by Parental Alcohol Misuse http://www.childrenscommissioner.gov.uk/content/publications/content_619
[59] Independent Inquiry into Child Sexual Exploitation in Rotherham (1997-2013)

In order to protect the vulnerable children, young adults and victims of domestic abuse, it is vital to have systems in place that can identify at risk individuals **early** and offer appropriate intervention to support their protection from harm.

In Barnet, the **Multi-Agency Safeguarding Hub (MASH)** acts as a single point of contact for all referrals where a child may have additional needs for services or be at risk of harm. It provides an intelligence hub where integrated multi-agency teams share information about vulnerable children, families and adults in order to risk assess and make decisions on further actions/referrals to appropriate teams. Specialist substance misuse treatment providers are part of the MASH. If a child needs are at a lower level or if a case is being 'stepped-down' from Children's social care then the practitioner complete a **Common Assessment Framework**.

Whilst substance misuse may be a presenting factor in many social care cases, it is not picked up until further assessment or work is done with the young person and/or family. For instance, in 2013/14, there were a total of 456 CAF assessments including 10 related to either substance misuse in young people or their parents/carers in Barnet[60]. In order to provide early intervention, there is a need to consider more CAF assessments in all frontline services including drug and alcohol services. Similarly, there is a need for more clarity and robust pathways for adult patients under substance misuse treatment who are found to have/live with children.

At a family level, Barnet has a **Troubled Families** programme. Troubled families are identified as those with complex issues, who are more likely to access services and require intensive support. The programme is focused on getting children back into school, reducing youth crime and anti-social behaviour, getting adults back into work and reducing the need for services. One of the key areas for future exploration is around appropriate mechanisms for information sharing between substance misuse providers and Troubled Families team. In order to protect the vulnerable and provide early intervention, there is a need to consider the role of **Hidden Harm Specialist** – to enable joint assessments and improve information sharing/communications between different teams (including troubled families) and treatment services. The Hidden Harm coordinator can also identify and support parents who are involved in problematic drug and/or alcohol misuse in order to minimise the impact of this on their children or carers.

WDP recovery programme offers support to carers on a weekly basis at present. Barnet's adult needs assessment captured the suggestions from carers on expanding the service to more than once a week. Barnet Council also provides support to young carers affected by adult drug or alcohol misuse through a support service – **Time 4 us.** The service offers support for young people, who may be isolated, let down and in need of resilience building as a result of their parents' drug/alcohol use. Young people receive help to raise their awareness about drugs and alcohol and reassurance that they are not to blame, this improves their understanding and allow explanation of what is happening. The number of referrals from substance misuse services is low and there is a need to improve this by

[60] Ibid - Barnet Young People & Substance Misuse Needs Assessment & Specialist Services Review 2014)

promoting available services and confidence building among staff for making prompt referrals.

Substance misuse is regarded as a contributory factor for domestic violence and Barnet has a joint protocol to address the complicated cases around mental health, substance misuse and domestic violence (toxic-trio) to ensure the agencies have a coordinated response to the needs of the these clients. The new Domestic Violence and Violence against Women and Girls Strategy (DV/VAWG)[61] for Barnet also advocates joint working between DV and the Public Health team. Similarly, the latest business plan for Barnet's Safeguarding Children Board[62] identifies effective working with D&A services, mental health, police and social work services to assess and agree plans for children who experience neglect.

In Barnet, the **Multi-agency risk assessment conference (MARAC)** aims to review and co-ordinate service provision in high risk cases with an aim to reduce repeat victimisation and to prevent DV related homicides. Although the total number of MARAC cases including those involving substance misuse have gone up in the past three years (between 2011 and 2013), the number of referrals from substance misuse service to the MARAC remains very low (2011, 2 referrals; 2012, 3 referrals; 2013, 1 referral). There is a need for a clear pathway and protocol to improve the number of referrals from substance misuse services to the MARAC along with the regular representation by their team in the MARAC meetings.

Barnet and Harrow joint Public Health service has recently commissioned a cross-agency training package for DV/VAWG and CSE which incorporates a substance misuse element. The training intends to ensure that all frontline professionals, including substance misuse staff working with young people in the Borough are better informed and equipped to recognise the signs of child sexual exploitation and take action.

From the above discussion, it is clear that protection of vulnerable individuals requires a holistic and multi-agency approach with agreed referral pathways between the **teams** and **safeguarding boards**; coupled with an effective communication and branding of services in a way that are perceived supportive and non-threatening to the service users.

2.2.2 Protecting communities

Substance misuse can lead to crime and violence in the community. There is good evidence that areas associated with higher density of premises selling alcohol also has a higher number of crimes, ambulance callouts related to substance misuse and street litter. In 2013/14, one of the top three areas of personal concern among individuals in Barnet[63] was crime with a fifth (20%) saying that they felt unsafe outside in their local area after dark (Residents' Perception Survey 2014). In the

[61] Domestic violence and violence against women and girls Strategy 2013 – 2016
[62] Barnet Safeguarding Children Board Business Plan 2014-2016
[63] Barnet Council (2014). Residents' Perception Survey Quarter 2/3, 2013/14 http://engage.barnet.gov.uk/consultation-team/residents-perception-survey-2013/user_uploads/residents--perception-survey-report-qtr-2-3-2013-14-final.pdf

same survey, Barnet residents' perceived rubbish or litter lying around and people being drunk or rowdy in public places as becoming more of a concern – (38% of residents saying rubbish or litter lying around was a very or fairly big problem and with teenagers hanging around the streets (28%) while people using or dealing drugs (26%) as the second and third biggest problems in the local area.

The clients in the criminal justice system (CJS) are some of the most complex clients using services and may have multiple health and social needs and hence the requisite to offer a holistic approach to these individuals in order to break the vicious cycle of harm and disorder in the community. Barnet has a **Drugs Intervention Programme (DIP)** which exists to support and encourage CJS clients into drug treatment with an aim to reduce drug-related reoffending. Barnet's **Integrated Offender Management (IOM)** programme lead by the Community Safety team, also works in collaboration with D&A services to address substance misuse as one of the factors driving repeat offences by the prolific offenders. One of the key priority outcomes in the new Barnet Community Safety Strategy[64] is a "sustained reduction in reoffending" and a vision for partnership working between voluntary and community teams including substance misuse, employment, education and training, mental health and housing.

There are opportunities for collaborative work with the **police, community safety and licensing and trading standards teams** in the Borough to address the issues to substance misuse related anti-social behaviour and street litter i.e. broken glass and empty cans. Triangulating local data – for example, anonymised A&E data linked to alcohol-related incidents can provide a profile of the most problematic premises or streets in the Borough. Similarly, sharing data on methanol poisoning is another example as this could provide information about the illicit or counterfeit alcohol being sold in specific premises and help support trading standards and police action on illegal sales. Any such efforts would strengthen our relationship with the partners and would also support them in targeting resources where most appropriately required.

Many accidental fires result from reduced awareness (e.g. falling asleep, distraction and carelessness), which is compounded when alcohol has been consumed. In 2011/12, an estimated 8% of the fires in England were linked with suspected drug or alcohol use[65]. There is an opportunity to link with Barnet Fire Service to reduce risk of fire in homes of those misusing substances and ensure adequate means of escape in case of fire. The Fire brigade can supply leaflets and smoke alarms as well as fire proof bedding. The Fire Service could also be trained in the use of information and brief advice where there identify individuals at risk.

[64] Barnet Community Safety Strategy 2015/2020

[65] The effect of alcohol or drugs on casualty rates in accidental dwelling fires, England, 2011-12

2.3. Our actions to **PROMOTE** sustained recovery from dependence by intervening early and offering comprehensive services which rebuild lives.

By 2020 in Barnet we will have:

- Reduced hospital admissions and attendances relating to substance misuse
- Reduced Hepatitis B through increased testing, treatment and vaccine completion in clients accessing substance misuse services.
- Reduced Hepatitis C through increased testing and treatment in clients accessing substance misuse services.
- Increased HIV testing in clients accessing substance misuse services.
- Reduced risk of blood borne virus transmission through increased access to needle exchange
- Reduced waiting times to first treatment intervention.
- Better understanding of drug type used, particularly amongst vulnerable groups
- Increased proportion of all clients and specifically, criminal justice clients, successfully completing treatment.
- Reduced number of people dependent on drugs in the borough.
- Reduced re-presentations (people who complete treatment but represent within 6 months) in all clients and specifically, criminal justice clients.
- Increased number of clients in 'effective treatment'
- Reduced time in treatment (not at the expense of re-presenting).
- Increased abstinence from substances amongst clients in treatment at 6 months follow up.
- Increased the proportion of clients no longer injecting at 6 month follow up.
- Increased the proportion of clients successfully completing treatment with no reported housing need.
- Increased proportion of clients successfully completing treatment working more than 10 days in last 28 at exit.
- Improved mental wellbeing and physical health including smoking status and weight for those exiting treatment.

Key areas of work include:

2.3.1 - Improve action on blood borne viruses in substance misusers

Individuals taking injecting drugs carry a high risk of transmission of a number of blood-borne viruses (BBV). Most common among these are Hepatitis B, C and HIV. More than 70% of those infected with Hepatitis B and C have no symptoms at the time of becoming infected and 40% of those infected in England remain undiagnosed[66]. Chronic liver disease may also lie silent and go undetected for many years meaning when a patient does present with symptoms the prognosis is poor. Hepatitis C related hospital admissions, registrations for liver transplants and deaths from end stage liver disease and liver cancer are rising in England. A good proportion of those infected with hepatitis B and C, if treated early with anti-viral

[66] Hepatitis B and C. Local Government Association briefing for councillors

therapy as recommended by NICE will clear the infection, however, very few people are accessing services[67].

There are an estimated 1686 people infected with Hepatitis C in Barnet. Around 73% of these are thought to be either current or had previously used injectable drugs.

Although, hepatitis B can be prevented through a course of vaccinations, the rates of those who completed the full course of Hepatitis B vaccination is 29.8% which is below the national average rate of 35%. On the other hand, the rates for Hepatitis C testing along clients in treatment in Barnet are currently at 87.5% which is better than the current national average of 81.1% - DOMES report quarter 2, 2014/15[68].

Testing for BBV infections, prompt referral to positive patients and vaccination for Hepatitis B presents an excellent opportunity to reduce health harms to individuals in the high-risk group. The new Sexual Health Strategy[69] for Barnet places an expectation on substance misuse services to offer HIV testing to all clients as part of screening for blood borne viruses and to record this data. There are opportunities for substance misuse services to **work closely** with local sexual health and family planning services to review and update data sharing and patient referral pathways between the two services.

For Hepatitis, **clear pathways** from substance misuse services to local liver services should be established in collaboration with Barnet CCG. Similarly, the use of peer support for clients accessing hepatitis treatment has been found to be useful in some boroughs to help adherence to treatment. It is also recommended that substance misuse service staffs are familiar with hepatitis B and C and the online course organized by Royal College of General Practitioners may assist in the development of this.

Finally, it is important to emphasise the need for an expanded needle exchange service in Barnet in order to supply injecting drug users with clean needles and syringes to facilitate safer injecting and reduce the chance of transmission of blood borne viruses. Clearly emphasis should be placed on reducing injecting behaviour but whilst it continues, needle exchange is an important action to reduce the prevalence of blood borne viruses.

2.3.2. Partnership working between hospital teams and community substance misuse services

A large number of patients arrive in hospitals with a substance misuse related problem. The hospital A&E departments and wards are seeing a significant number of people misusing or at risk of misusing drugs or alcohol. Some of these individuals frequently return back to hospital services due to a lack of engagement with community drug and alcohol treatment services.

[67] PHE Hepatitis C in London's drug using population. Emma Burke, PHE Programme Manager
[68] DOMES report quarter 2, 2014/15
[69] Barnet Sexual Health Strategy 2015-2020

Barnet young people substance misuse needs assessment identified no referrals from A&E services from local hospital (except Royal Free hospital). The needs assessment also highlighted the need for a systematic follow-up for those young people who are residents in Barnet and attend A&E for alcohol or drug related issues. Barnet substance misuse needs assessment for adults also identified the need to develop and expand alcohol liaison in hospitals. It is also important that robust pathways are put in place to ensure Barnet residents attending hospitals receive timely and specialist care at an earlier stage, thereby reducing the associated harm.

Similarly, individuals with a dual diagnosis of mental health and substance misuse often have multiple and complex needs which require a comprehensive, coordinated, seamless, multi-agency response.

The new service specifications for Barnet's adult substance misuse service encourages joint working relationship with hospital teams and requires the provider to deliver **drug and alcohol liaison** and **dual diagnosis workers**. The new dual diagnosis service will aim to provide advice and support to mental health agencies that are responsible for co-ordinating care delivery for service users with severe and enduring mental illness while drug and alcohol liaison service will provide advice, information and support to emergency department workforce and liaison with ward staff where relevant.

Both dual diagnosis and D&A liaison service will also incorporate the training, screening and brief interventions and facilitation of rapid access to community drug and alcohol treatment including detoxification.

2.3.3 Accessible and integrated specialist treatment and recovery services

A successful service relies on being easily accessible, matched with local needs and has an extension into community as outreach; while a successful outcome relies on offering holistic care to ensure both health and social needs of the patients are met so help them complete their recommended treatment and stay off the substance misuse in the future. In light of this, the new service specification for adult's D&A services includes the following key elements;

- Increase access with suitable opening times and developing a new outreach service.
- Increase the level of shared care by more primary care based prescribing, and/or nurse prescribing where appropriate.
- Incorporate the requirements of clients in the Criminal Justice System (DIP/CJIT) by swift access to prescribing and the quality, content and management of Psycho-Social Interventions (PSI).
- Develop stronger links with children and families' services (early intervention as well as safeguarding) and community resources to sustain recovery, health and wellbeing.
- Integrate with and benefit from, other external services such as mutual aid, employment support (Job Centre Plus), housing support, and abstinence based residential programmes.

Keeping the same principles and objectives, a service specification for children D&A services will be developed later in the year.

All commissioned services will be high quality, safe, effective, auditable, continuously improving and evolving to the changing needs of the population. To facilitate this, adequate clinical, financial and information governance will be a key priority which will monitored through contract performance processes. This will include identification, reporting, investigation and learning from serious incidents. There should be clear channels for investigation and escalation.

In order that services continue to meet current and future need, it is important that a substance misuse data dashboard is developed and monitored. This will enable the outcomes desired from the implementation of this strategy to be monitored and for all stakeholders to agree what data can be measured.

In addition to the above there is a need for a comprehensive local communication plan to raise awareness and signpost both individuals to the specialist treatment services. The communication plan should also include information on referral pathways and any upcoming training programmes/events for the professionals.

2.3.4. Data sharing protocols and referral pathways

Early identification needs to be followed up by agreed data sharing and referral pathways between all relevant services. For instance, hospital A/E department, maternity services, mental health and social services come across a significant number of people misusing or at risk of misusing drugs or alcohol. Some of these individuals visit/contact the services more frequently due to a lack of engagement with specialist drugs and alcohol treatment services. There is evidence of fragmented services and a lack of communication between health and social care services in Barnet - reflected as infrequent identification of vulnerable children in families with substance misuse problem.

An ideal service model is one where all relevant parties know about their partners' details, roles and have a regular to and fro communication. There is a need to review the existing protocols and pathways including consultation with partners to make them even more robust. In addition, we will encourage a multi-agency approach to improve data sharing and referrals via a local data sharing strategy. We envisage this as an immediate but on-going activity which will take shape over time with evidence of what works best at the local level.

2.3.5 Sustain recovery by addressing underlying factors

Underlying mental health problem, unemployment, homelessness, poor education, deprivation and victimisation are some of risks that can jeopardise treatment and recovery journey of the individuals. Public Health England has stated that 94% of dependent drinkers are not in treatment at any one time. Research evidence suggests that those who drop out are likely to be among the more risky or vulnerable individuals - the frequent hospital attenders, the repeated offenders and the person

committing anti-social behaviour[70]. The National Drug Strategy 2010[71] acknowledges the complex underlying causes and personal drivers of drug and alcohol misuse and suggests tailored packages of care and support to ensure the recovery is sustained.

Homeless Action Barnet delivers support to homeless clients, many of whom have alcohol rather than drugs issues while a **Floating Support** is available to clients from criminal justice system.
Carers of people with substance misuse problem play an essential role in helping them get the right treatment and support in successful recovery and providing a holistic approach is the key to sustained recovery. The new service specifications for adults drug and alcohol services acknowledge this by ensuring the services are available to families and carers.

In addition it expects the provider to;

- have good integration with other external services such as mutual aid, employment support (Job Centre Plus), housing support, and abstinence based residential programmes.
- have a dual diagnosis service to support staff in addressing the needs of those with mental health issues alongside substance misuse, and to ensure clients receive appropriate care from both substance misuse and mental health services.
- provide specialist advice/joint working to Child and Adolescent Mental Health Team (CAMHS)

Public Health team also piloted a successful employment support work (2014) to give people with common mental health conditions the support they need to get into paid employment. The success of the pilot has been translated into two new services in Barnet i.e. Individual Placement and Support **(IPS)** service for severe and endurance mental conditions and Motivational and Psychological Support **(MaPS)** for common mental health problems. This programme is also a good example of joint working between Public Health and Council's teams including Adult Social Care, the local Clinical Commissioning Group, Barnet, Enfield and Haringey Mental Health Trust, Jobcentre Plus, Department for Work and Pensions and local service users. However, there is a need for more collaboration between employment support team and D&A services to ensure all clients are screened at the beginning of the programme for their dependency on substance misuse and then linked with the D&A services for support and treatment as appropriate.

[70] Alcohol Concern – Blue Light Project, Working with change resistant drinkers – The Project Manual 2014 http://www.alcoholconcern.org.uk/wp-content/uploads/2015/02/Alcohol-Concern-Blue-Light-Project-Manual-Final.pdf
[71] Drug Strategy (2010); HM Government; Reducing Demand, Restricting Supply, Building Recovery : Supporting People to Live a Drug Free Life https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

3- Strategy Implementation

3.1- Implementation process

As demonstrated in figure 6 below, partnership is the key to successful implementation of this strategy.

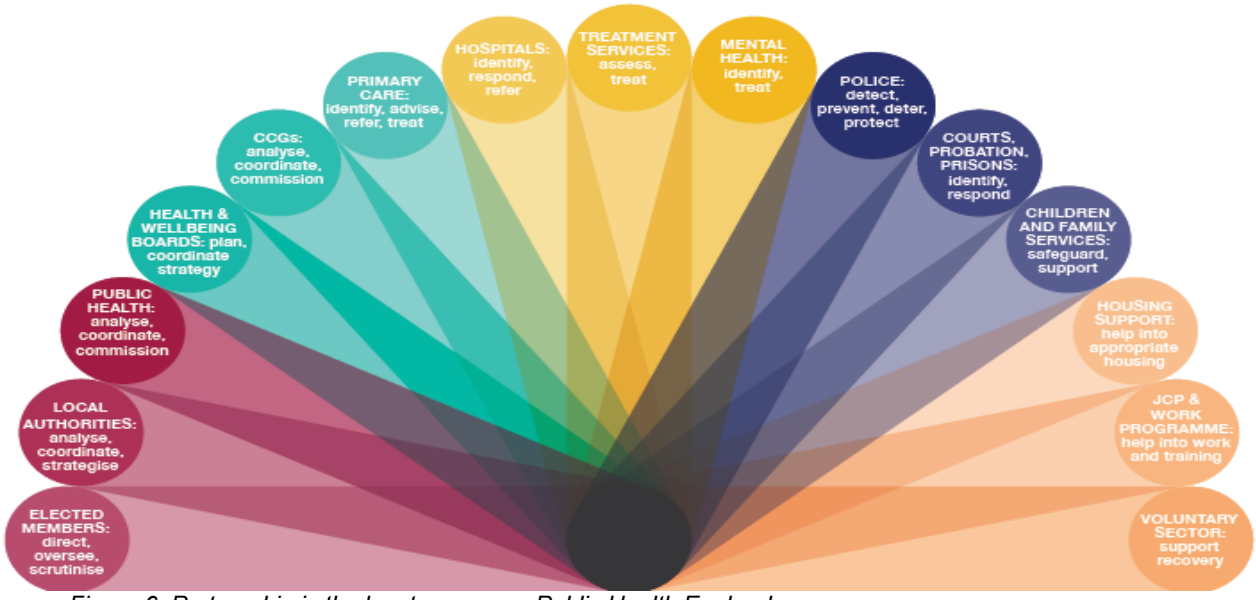

Figure 6: Partnership is the key to success, Public Health England

It is therefore recommended that a strategy implementation group is set up that oversees the delivery of strategic actions. It is suggested that the following stakeholders sit on the strategy implementation group (although not all attendees would be required to attend each meeting and participation will be required according to the relevance of the agenda).

- Substance misuse commissioners
- Public Health
- Community safety team with Domestic Violence and Violence against Women and Girls (DV&VAWG) coordinator
- Adult Social Care representative including representation from Prevention and Wellbeing team
- Environment (licensing)
- Providers
- CCG and secondary care (hospital) services
- Voluntary sector representatives
- Family services
- Safeguarding team
- Housing team
- User involvement

3.2 - Key actions for 2015/16 *(Please note the table below is a list of both agreed and proposed actions that will be reviewed on a yearly basis by strategy implementation group with additions of new actions as appropriate)*

Key area	Proposed and agreed action	Proposed responsibility by team/s	Proposed timeframe
Recommissioning of new integrated substance misuse services	Development of new service specifications based on the needs assessment and ensure the new integrated service is accessible, promotes equality and takes account of users' age, gender, disability, sexuality, race and religious and cultural beliefs.	Public Health	October 2015 for adults and March 2016 for children
Collaborative multi-agency team working to offer holistic approach	Setup a strategy implementation group with membership from local Public Health, Primary care, Secondary care, Housing, Welfare support, Children's and Family services, Adult Social services, Community Safety team with DV and VAWG coordinator, Licensing and Trading standards team, Youth Offending teams, Mental Health, Police, Fire, Education, and Voluntary sector. Implementation group to agree and commit to the strategic actions. Using the above group, ensure this strategy is aligned with other strategies in the borough. Provide Public Health intelligence input as appropriately required and to map hotspot areas in the borough on a regular basis.	Public Health to lead the setup with support from all teams. Strategy implementation group Public Health Public Health	September – October 2015 Ongoing
Raising awareness about drug and alcohol misuse and signposting to appropriate support services.	We **propose** engagement with young people for an insight to their attitudes and perception of drugs and alcohol misuse in order to develop key awareness messages.	Public Health in collaboration with Children's team	September – November 2015
	Raise awareness using social marketing principles that target individuals in all age groups especially young people, parents/carers in schools and non-school settings.	Public Health and substance misuse service.	November – December 2015

Key area	Proposed and agreed action	Proposed responsibility by team/s	Proposed timeframe
	Signpost residents to local carers group, local substance misuse services and online resources (such as FRANK and Alcohol Concern) for advice, support, treatment and recovery. Promote services within older people's services and vulnerable adult's teams.	Public Health Substance misuse services	 Ongoing
	We **propose** the continuation of the current alcohol scratch cards programme with wider provision in the borough's hotspot areas of alcohol related crime and highest number of premises selling alcohol.	Public Health	Ongoing
	We **propose** an exercise/programme for door and bar staff working at the licensed premises which raises awareness around; 1) the links between substance misuse and sexual offences 2) what to do in the event of a sexual assault 3) how to respond to and support victims and 4) how to preserve evidence.	Jointly between Public Health, Community Safety team, Licensing team and Police.	TBC
	Collaborative community awareness raising work in association with Drinkaware team	Public Health and Road Safety team	November – December 2015
Data sharing and referral pathways	Strategy implementation group to identify the main data streams for monitoring activities and effectiveness of the strategic recommendations. We **propose** that all frontline teams identify known gaps in their communication plans around health (primary and secondary care such as A&E and maternity services), social care and community services.	Strategy implementation group All via strategy implementation group.	December 2015
	We **propose** that all frontline teams agree on data sharing and referral pathways (between substance misuse and relevant key health, social care and community services).	Substance misuse team via strategy implementation group.	December 2015
Collaboration with	We **propose** Public Health's input to licensing applications	Public Health and Licensing	Ongoing

Key area	Proposed and agreed action	Proposed responsibility by team/s	Proposed timeframe
licensing and trading standards team	especially in hotspot areas of the borough and explore a responsible retailer programme to stop the sale of super strength alcohol, single cans.	team	
	We **propose** the test purchasing for the underage sale of alcohol and the assurance that licensees understand the responsibilities they have associated with selling or supplying alcohol to intoxicated persons.	Licensing team and Police	TBC
Collaboration with community safety team	We **propose** partnership work with community safety team of the LBB around a range of new legislative provisions such as drinking ban and criminal behaviour order	Public Health and Community Safety team	Ongoing
	We **propose** a reduction in alcohol-related harm and ASB (including street drinking) through consulting and involving local communities in developing local actions and facilitating multi-agency/multi-component approaches to identified problems.	Substance misuse services, Police and Community Safety team. Support from Healthwatch team.	September 2015 and then on on-going basis
	Identify and address the treatment and recovery needs of clients from Criminal Justice Service in police custody suites, prison, court and the community settings.	Substance misuse service and Community Safety team and Police	September 2015 and then on on-going basis
	We **propose** close working with enforcement partners to ensure street drinkers, including rough sleepers, receive outreach and support to access substance misuse services to help them cut down or stop drinking.	Substance misuse services to provide outreach Community Safety team to provide intelligence	October 2015 and then on on-going basis
Collaboration with safeguarding teams	We **propose** the development of pathways that lead to timely identification and action to protect children from sexual exploitation	Children safeguarding team, Early Intervention team, Substance misuse services, Children and Families services	TBC
	Establish mechanisms to expose hidden harm associated with substance misuse and take actions to minimise the impact of substance misuse on children and carers of those with substance		

Key area	Proposed and agreed action	Proposed responsibility by team/s	Proposed timeframe
	misuse problem.		
Collaboration with early intervention, children and families teams	Early identification and protection of vulnerable children and families via 1) Ensure drug and alcohol issues are identified as part of CAF and other relevant assessments and that appropriate actions and referrals are made via MASH. 2) Develop the role of hidden harm specialist to identify and support parents/carers who are involved in problematic drug and/or alcohol misuse and to minimise the impact of this substance misuse on their children. 3) Train frontline staff in CAF assessment to identify vulnerable children of those with substance misuse issues.	Public Health and Early Intervention team Substance misuse services, Children and Families services Children and Families services CAF team	November 2015 and on-going as per local needs September 2015 TBC
Collaboration with domestic violence team	Provide holistic approach to victims of domestic violence having substance misuse problem 1) Explore the feasibility for Alcohol Concern 'Blue Light' project for novel ways to support alcohol treatment-resistant perpetrators of DV into treatment. 2) Health coaching (one to one) for families that are affected by domestic violence, mental health and substance misuse **"toxic trio"**.	Public Health Public Health, Families service and Domestic Violence teams	September 2015 November 2015 - March 2016
Collaboration with health partners	Integrated substance misuse service to support hospital focused services via; 1) Drug and alcohol liaison work in A/E, hospital wards and sexual health service. 2) Collaboration with existing **alcohol liaison services** provided by secondary care services. 3) Establishing **dual diagnosis** link between mental health and substance misuse service.	Substance misuse service	October 2015 and then on on-going basis

Key area	Proposed and agreed action	Proposed responsibility by team/s	Proposed timeframe
	We **propose** the development of clear pathways from substance misuse services to local liver services in collaboration with Barnet CCG.	Substance misuse service and Barnet CCG	
Training of frontline staff	Rolling programme of training (e-learning) on identification and brief advice **(IBA)** for all frontline staff from health and social care including carers of those with substance misuse problem.	Public Health	Ongoing
	We **propose** housing and welfare support teams to provide IBA to all clients requiring support with referral to treatment services where required.	Housing and Welfare support team?	Ongoing
	We **propose** screening and provision of IBA to all clients assessing Public Health's employment support work with referral to treatment services where required.	Public Health via employment support providers	Ongoing
	We **propose** training programme for frontline professionals to ensure that are confident to provide assessment and support to those directly or indirectly affected by substance misuse.	Substance misuse provider	Yearly
Miscellaneous/Others	London Fire Brigade staffs to provide Home Fire Safety Visits (HFSV) in Barnet for residents and areas that are considered high risk from fire. This includes those residents identified with substance misuse problems.	London Fire Brigade	Ongoing
	Substance misuse services to be represented in MARAC meetings	Substance misuse service	Ongoing

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Equality Analysis (EqA)

Questionnaire

Please refer to the guidance before completing this form.

1. Details of function, policy, procedure or service:	
Title of what is being assessed: Barnet Substance misuse Strategy 2015-2020	
Is it a new or revised function, policy, procedure or service? New and revised services	
Department and Section: Local Authority Public Health Team	
Date assessment completed: 02 - 07 -2015	
2. Names and roles of officers completing this assessment:	
Lead officer	Jeffrey Lake - Consultant in Public Health – Barnet and Harrow Public Health Team Jeff.lake@harrow.gov.uk Wazirzada M.R. Khan – Senior Health Improvement Specialist – Barnet and Harrow Public Health Team wazi.khan@harrow.gov.uk
Stakeholder groups	• Community safety team with Domestic Violence and Violence against Women and Girls (DV&VAWG) coordinator • Prevention and Wellbeing team including carers lead • Trading standards and licensing team • Family services • Adults and children safeguarding board members • Barnet Clinical Commissioning Groups • Head of Joint Children's Commissioning • Council's Partnership Boards • Barnet Healthwatch
Representative from internal stakeholders	None at this stage
Representative from external stakeholders	None at this stage
Delivery Unit Equalities Network rep	
Performance Management rep	
HR rep (for employment related issues)	Not required
3. Full description of function, policy, procedure or service:	

Please describe the aims and objectives of the function, policy, procedure or service
Please include - why is it needed, what are the outcomes to be achieved, who is it aimed at? Who is likely to benefit? How have needs based on age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, marriage and civil partnership and carers been taken account of? Identify the ways people can find out about and benefit from the proposals. Consider any processes they need to go through or criteria that we apply to determine eligibility.

Background

Substance misuse* is an important public health issue not just because it causes harm to the individual's health but because it is also associated with indirect harm to families and the wider community. Some of these harms and Public Health importance of substance misuse are mentioned below;

- It causes harm to health
- It is responsible for a significant proportion of hospital admissions and ambulance callouts
- It causes crime, disorder and antisocial behaviour and compromises economic development
- It has an indirect impact on children, families and carers of the users
- It limits individual's potential
- There are considerable inequalities associated with their use
- There are tried and tested ways to prevent substance misuse and protect others from harm
- Treatment is cost effective saving the public sector money over time.

** Substance misuse, in this report, refers to both drug and alcohol misuse*

Barnet and Harrow joint Public Health service has a responsibility to provide substance misuse services in Barnet and is currently in the process of recommissioning these. However, actions to address the misuse of drugs and alcohol are broader than this. Barnet substance misuse strategy (2015-2020) outlines what we can do to prevent substance misuse, how we can protect families and the wider community from harm and how to identify those who need treatment early and support them to recover from dependence and lead fulfilling and healthy lives.

Why is it needed?

Alcohol related hospital admissions are growing every year. Barnet's substance misuse needs assessment (2014) identified an estimated 70,000 **adult** residents in Barnet who are drinking alcohol above the maximum recommended level and are putting their health at risk. In 2013/14, there were 595 people using alcohol treatment services in Barnet - a rise of 53% compared to 5 years ago. Nearly a third of these patients had been in treatment at least once before.
Analysis of 2013/14 data from treatment services shows that there were more males (67%) than females (33%) in treatment. Men aged 40-49 and women aged 45-49, were the top two **age groups** in treatment. In relation to the **ethnicity** of those under treatment, the group with the largest proportion of individuals was White (67% White British, 9% other White and 7% White Irish). Individuals from African, Indian and other Asians ethnic background were 4%,

3% and 2% respectively. An additional 8% belonged to Other ethnic groups.

In Barnet, there are around 1,492 problematic opiate and/or crack users (OCU). Analysis of 2012/13 data from treatment services in Barnet shows that individuals from White ethnic background were the largest group (72.2%) in treatment followed by individuals from Other (9.5%) and Black and Black British (6.7%). Individuals from Asian and Asian British and Mixed ethnic background had the smallest proportion in treatment. Between 2005/06 and 2012/13, the proportion of White drug users in treatment decreased from 80% to 70% while all other ethnic groups showed a slight increasing trend. The consultation process for the needs assessment also identified a noticeable increase in Iranians presenting with opiate dependency year on year. In addition, there has been a distinct increase (drug treatment) in the number of individuals in older age groups 45 – 60 years plus (figures based on 2012/13 data)

The impact of drugs and alcohol misuse is more pronounced in **young people** with regard to their health, education and prospects of progression in life. Particular groups at risk of substance misuse include children in care, young people with mental health issues, or young people at risk of/or not in education, employment or training, or involved in crime and antisocial behaviour and/or at risk of sexual exploitation. With regard to the demographic characteristics of young people in treatment (2013/14), 64% were male and 36% were females. The majority of the clients were from white UK background and two third of the overall clients were in the 16 and 17 age group.

It is estimated that alcohol is a factor in one-third of all incidents of domestic violence nationally, with many perpetrators having consumed alcohol prior to the assault. In Barnet, the number of overall referrals to Multi-Agency Risk Assessment Conference (MARAC) has increased over the last 3 years from 165 to 230. Similarly, the total number of (MARAC) cases where drug or alcohol issues are present is also increasing year on year. Children of parents with alcohol problems have an increased risk of experiencing physical, psychological and behavioural problems.

No data is systematically collected across the treatment system to identify levels of Lesbian, Gay and Bisexual (LGB) people accessing services or to evaluate outcomes for these groups. A study and project by the Lesbian & Gay Foundation (The LGF) into drug and alcohol use among LGB people in England found significant substance dependency problems in the community. 'Binge drinking' is high across all LGB groups. Available comparable data suggests that LGB people are approximately twice as likely to binge drink at least once a week, compared with the general population, and have a higher likelihood of being substance dependent.

In Barnet a lower proportion of service users starting treatment are unemployed but a higher proportion are categorised as long term sick or disabled than national levels. Unemployment levels of people in drug treatment do not vary much according to length of time in treatment. For example opiate users in treatment between 12 to 48+ months, unemployment levels vary only slightly between 75% -78%, non-opiate users in treatment after 6 months have a rate of 63% unemployed (2013/13 figures). This further underlines the need to increase the focus on recovery and reintegration, and building links with education, training and employment resources into the treatment process.

Our aims and objectives are to;

- To prevent Barnet residents from harmful use of drugs and alcohol
- To protect Barnet residents and their families/carers including children and vulnerable adults from indirect harm caused by substance misuse.
- To promote and sustain recovery of Barnet residents identified as misusing substances.

To achieve the above aims and objectives, following broad actions are proposed for each strategic priority;

For prevention;

- Review the availability of alcohol and density of licensed premises
- Review the local price of alcohol and consider action on cheap alcohol
- Support action to reduce the supply of harmful substances
- Change behaviour in high risk groups through the provision of information and brief advice (IBA)
- Take collaborative action on the social determinants of substance misuse
- Review action to prevent substance misuse in young people
- Promote healthy behaviours in the general population

For protection - – *a whole family approach i.e. children and vulnerable adults*

- Refer children at risk of sexual exploitation to appropriate services
- Minimise the potential risk to children with parent who misuse substances by increasing the early identification of children within the family and through increased information sharing.
- Consider opportunities to link with the Troubled Families programme
- Ensure appropriate internal and external links are made with Community Safety team and Domestic Violence and Violence against Women and Girls coordinator, Licensing team, Early Intervention and Prevention team, Children and Adults Safeguarding teams, Families services, Primary Care services, Secondary Care services including mental health, sexual health and A&/E teams, Education and Police.

To promote and sustain recovery- by intervening early and offering comprehensive services which rebuilds lives.

- Improve action on blood borne viruses in injecting drug users
- Partnership working between hospital teams and community substance misuse services
- Data sharing protocols and referral pathways
- Accessible and integrated specialist treatment and recovery services for adults and young people
- Ensure individuals with a mental health and substance misuse problem gain rapid access to the support they require to recover
- Ensure all stakeholders have easy access to up-to-date information which explains the substance misuse services available and the pathways for referral
- Assure that substance misuse services are safe and effective, auditable, continuously improving and evolving to need.

Who is it aimed at and who is likely to benefit?

Barnet substance misuse strategy is aimed at the whole population with wide spread benefits especially for groups with highest needs.

Service specification for the newly recommissioned substance misuse services in Barnet also makes the following expectations from the new providers;

- Complete an EqIA as per request from the commissioners.
- Collect and submit equalities monitoring information on a quarterly basis. This will be used to ensure that all clients regardless of protective characteristics are accessing the service.

The following EqIA is carried out to identify the impacts of our proposed actions on the protected characteristics of our population.

4. How are the equality strands affected? *Please detail the effects on each equality strand, and any mitigating action you have taken so far. Please include any relevant data. If you do not have relevant data please explain why.*

Equality Strand	Affected?	Explain how affected	What action has been taken already to mitigate this? What action do you plan to take to mitigate this?
1. Age	Yes ☒ / No ☐	<u>Positive impact</u> Although our strategic proposals address the needs of individuals in all age groups, two groups will benefit most i.e. young people aged 16 and 17, older adults aged 45 – 60+ (due to their increased numbers in drug treatment). The new treatment pathway will include Hidden Harm specialist who will be expected to work closely with Children & Families Service. The role will identify, encourage and support parents during treatment and assist in reducing the associated risks to their children.	Development of new service specifications that incorporate these points and ensure the provider respond positively to the needs of all groups who have a protected characteristic within the Equality Act 2010.
2. Disability	Yes ☒ / No ☐	<u>Positive impact</u> Strategic recommendations promote collaborative working relationship with Welfare support,	The new substance misuse provider will ensure appropriate and effective disability access to services and relevant

		Prevention and Wellbeing and Safeguarding teams to ensure individuals with disability are offered a holistic support. The new substance misuse provider will ensure appropriate and effective disability access to services and relevant support resources.	support resources. Similarly, the services are expected to complete an EqIA and collect equality monitoring information to identify under-served groups.
3. Gender reassignment	Yes ☒ / No ☐	<u>Positive impact</u> At present, there is lack of systematic data collection to identify levels of transgender people accessing treatment services. The strategy makes clear expectations from the substance misuse treatment provider to promote equality in service provision and respond positively to the needs of all groups who have protected characteristics including gender reassignment.	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics.
4. Pregnancy and maternity	Yes ☒ / No ☐	<u>Positive impact</u> Substance misuse strategy promotes joint working and robust pathways between A/E, mental health services, midwifery and maternal health services. Such efforts will have a positive impact in identifying and supporting at risk drinkers during pregnancy and after birth.	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics including pregnancy and maternity.
5. Race / Ethnicity	Yes ☒ / No ☐	<u>Positive impact</u> Certain communities may experience additional difficulties and barriers in accessing relevant support due to cultural/religious practices where alcohol and drug use is forbidden. This lack of access can lead to escalation of issues and poor outcome. Substance misuse strategy recognises this and makes recommendations for the	The new substance misuse provider will ensure it can appropriately address the needs of specific ethnic/cultural groups.

		treatment provider to ensure there is capacity for ethnic counselling specialists to provide relevant information, appropriate resources and access to BME groups.	
6. Religion or belief	Yes ☒ / No ☐	Positive impact Although substance misuse strategy will not have any direct impact on individuals from different religions or believes, it makes clear recommendations for the treatment provider to ensure services are accessible, welcoming and take into account these religious and cultural differences.	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics.
7. Gender / sex	Yes ☒ / No ☐	Positive impact Analysis of treatment data shows higher alcohol dependence among men compared to women. Substance misuse treatment provider is expected to provide gender specific interventions and include gender specific groups to ensure safe space for women who have suffered domestic abuse or sexual exploitation.	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics.
8. Sexual orientation	Yes ☒ / No ☐	Positive impact At present, there is lack of systematic data collection on sexual orientation. Strategy makes clear recommendation for the treatment provider to respond positively to the needs of all groups who have a protected characteristic and engage with these groups through all necessary means to ensure inclusion is in a positive and meaningful way. In addition the provider will monitor the sexual orientation of patients and clients in order to understand the experiences of Lesbian, Gay and Bisexual (LGB) people and offer	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics.

		LGB-specific services, such as peer support groups and counselling.	
9. Marital Status	Yes ☒ / No ☐	<u>Positive impact</u> At present, there is lack of systematic data collection collected by treatment providers to identify people within a marriage/civil partnership. The strategy makes clear expectations from the substance misuse treatment provider to promote equality in service provision and respond positively to the needs of all users regardless of their marital status.	Substance misuse treatment provider to complete an EqIA and collect and monitor treatment uptake against all protected characteristics.
10. Other key groups?	Yes ☐ / No ☐		

5. What will be the impact of delivery of any proposals on satisfaction ratings amongst different groups of residents?
Barnet substance misuse strategy takes into account the relationship between health and social care needs of the individuals and emphasises the importance of joint working between different teams to offer a holistic approach. It is anticipated that the suggested options would have a positive impact on the satisfaction ratings amongst different groups of residents in the borough.
6. How does the proposal enhance Barnet's reputation as a good place to work and live?
It is anticipated that the suggested options in the strategy will have a positive effect on Barnet's reputation as a good place to live. Recommendations will be consulted at an implementation and delivery stage (as appropriate) to ensure the positive impact of our plans is maintained.
7. How will members of Barnet's diverse communities feel more confident about the council and the manner in which it conducts its business?
The strategic recommendations take into account the needs of the broad diversity of Barnet residents. The substance misuse treatment provider is expected to take account of the different needs within the communities and tailor the services wherever possible e.g. by improving access to groups who may not be using the service. In addition, we will monitor the referral and take up rates to ensure the service is being used by all diverse communities in Barnet and that we are providing equal access.
8. What measures and methods have been designed to monitor the application of the policy or service, the achievement of intended outcomes and the identification of any unintended or adverse impact? *Include information about the groups of people affected by this proposal. Include how frequently will the monitoring be conducted and who will be made aware of the analysis and outcomes? Include these measures in the Equality Improvement Plan (section 15)*
Substance misuse treatment provider will carry out an additional EqIA and will also monitor treatment uptake against the 9 protected characteristics.
9. How will the new proposals enable the council to promote good relations between different communities? *Include whether proposals bring different groups of people together, does the proposal have the potential to lead to resentment between different groups of people and how might you be able to compensate for perceptions of*

differential treatment or whether implications are explained.
There will be dedicated webpage on the Council website and a web link will be circulated to Healthwatch and partnership boards for circulation among community groups.
10. How have residents with different needs been consulted on the anticipated impact of this proposal? How have any comments influenced the final proposal? *Please include information about any prior consultation on the proposal been undertaken, and any dissatisfaction with it from a particular section of the community.*
At present the strategy makes recommendations based on the local needs and gaps in the existing services. The EqIA will be updated further post consultation as appropriate.

Overall Assessment

11. Overall impact		
Positive Impact ☒	Negative Impact or Impact Not Known[1] ☐	No Impact ☐
12. Scale of Impact		
Positive impact: Minimal ☐ Significant ☒	Negative Impact or Impact Not Known Minimal ☐ Significant ☐	

13. Outcome			
No change to decision ☒	Adjustment needed to decision ☐	Continue with decision *(despite adverse impact / missed opportunity)* ☐	If significant negative impact - Stop / rethink ☐

14. Please give full explanation for how the overall assessment and outcome was decided
The above assessment is based on Barnet's substance misuse need assessments and evidence of best practice. There is lack of information on some of the protected characteristics, however, the new recommendations offer more integration and robust pathways between health, social care, safeguarding and enforcement agencies, that will offer better services to all residents. The current EqIA will remain a live document and further updates will be made to it at an implementation stage.

[1] 'Impact Not Known' – tick this box if there is no up-to-date data or information to show the effects or outcomes of the function, policy, procedure or service on all of the equality strands.

15. Equality Improvement Plan

Please list all the equality objectives, actions and targets that result from the Equality Analysis (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Objective	Action	Target	Officer responsible	By when

1st Authorised signature (Lead Officer)	2nd Authorised Signature (Delivery Unit management team member)
Date:	**Date:**

AGENDA ITEM 8

	Health and Wellbeing Board **30 July 2015**
Title	**Healthwatch Barnet Update report and Autism Services report.**
Report of	Head of Healthwatch Barnet
Wards	All
Date added to Forward Plan	January 2015
Status	Public
Enclosures	Appendix 1 - Healthwatch Barnet Y2 Report Appendix 2 - Healthwatch Barnet Report – Autism Services
Officer Contact Details	Michael Rich michael.rich@healthwatchbarnet.co.uk 020 8364 8400

Summary

This paper provides the Board with Healthwatch Barnet's Draft Report for Year 2 and a summary of research and engagement carried out by Barnet Mind, Jewish Care, Advocacy in Barnet and Healthwatch Barnet.

Recommendations

1. **That the Health and Wellbeing Board notes this update report and the reports of Healthwatch and partner organisations and provides comments on their content.**
2. **That the Health and Wellbeing Board considers and comments on the recommendations contained within the specific reports (Appendix 1 – 2).**

1. WHY THIS REPORT IS NEEDED

1.1 The report (appendix 1) provides the Health and Wellbeing Board with a summary of Healthwatch Barnet activity for Year 2, and shows how it is meeting its contractual targets. It also includes a report on Autism in Barnet and a report on Dental Services in Barnet.

2. REASONS FOR RECOMMENDATIONS

2.1 Healthwatch Barnet welcomes any comments from the Board.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

4.1 N/A

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 Through its representation on statutory bodies and its ongoing relationship with health and social care fora and residents, Healthwatch Barnet will contribute to the development and delivery of the Health and Well-Being Strategy and other relevant strategies and initiatives.

5.1.2 The update report aligns with the strategies and commissioning intentions of partner organisations in particular the 2012-15 Health and Wellbeing Strategy's twin overarching aims (Keeping Well; and Keeping Independent); the Barnet Council Corporate Plan, the Barnet Core Strategy; Barnet Housing strategy 2015-25; the Growth and Regeneration Programme and Barnet CCG's strategic plans.

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

5.2.1 The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet. The Healthwatch contract value is £197,361 per annum. The contract commenced on 1 April 2013 and expires on 31 March 2016; the contract sum received is £592,083. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

5.3 **Legal and Constitutional References**

5.3.1 Section 182 to 184 of the Health and Social Care Act, 2012, in amending the Health and Social Care Act 2008 and The Local Government and Public Involvement in Health Act 2007, and regulations subsequently issued under these sections, govern the establishment of Healthwatch, its functions and the responsibility of local authorities to commission a local Healthwatch.

5.3.2 The Terms of Reference of the Health and Wellbeing Board are set out in the Council's Constitution (Responsibility for Functions, Annex A), The Health and Wellbeing Board is required:

(1) 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.

(5) To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients

(6) 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.

5.4 **Risk Management**

5.4.1 A risk register was submitted as part of the tender documents and issues are identified through Healthwatch Barnet's monthly workplan reviews.

5.5 **Equalities and Diversity**

5.5.1 One of the core aims of Healthwatch Barnet is to ensure the views and experiences are heard and represented of those group with protected characteristics under the Equality Act, and with under-represented communities and individuals. Healthwatch Barnet runs targeted activities with people from protected groups (as defined in the Equality Act 2010) and its work is further enriched by our developing engagement programme with children and young people and older adults.

5.6 **Consultation and Engagement**

5.6.1 Healthwatch Barnet has distributed its Communications Strategy, which is also publicly available on the Healthwatch Barnet website.

6. BACKGROUND PAPERS

6.1.1 Healthwatch Update Report, Health and Wellbeing Board 29 January 2015, item 11:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7784&Ver=4

6.1.2 Annual Report from Healthwatch Barnet, Health and Wellbeing Board 12 June 2014, item 12:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7784&Ver=4

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Appendix 1

Report on the activity of Healthwatch Barnet to July 2015

It has been an exceptionally busy year for Healthwatch Barnet. We have managed to successfully build upon the platform of our previous work and have proved the success of our partnership model through the amount of activity that we have been able to achieve. Throughout the year we have seen some great examples of how the model for Healthwatch that we have developed in the Borough provides opportunities to create much, much more.

More engagement with our many and varied local communities. **More influential briefings and reports** that have made a real impact on the health and social care services in the Borough. **More Enter and View visits** with another 30 covered in the year. **More volunteers, more awareness, more calls and more visits to our website**.

A massive effort has been put in by our partners who have not only helped promote Healthwatch across the Borough through their own networks, but have also undertaken significant pieces of work covering mental health, hospital discharge, take up of vaccinations and more that you will find outlined in this report.

Of course, nothing could be achieved without the support and work of our volunteers. At Healthwatch Barnet they have a very special place and effectively direct much of the work of the organisation through our different groups. The Engagement Group, the Primary Care Group, the Enter & View Group, amongst others take a full role in directing the work of Healthwatch Barnet and in the work that makes it all happen. Whether writing reports, carrying out surveys, running engagement events or being part of an Enter & View Team, our volunteers make it happen and we are very grateful to them.

We have been formulating our priorities for next year following on from a consultation exercise with our community partners and the information that we have collected through our many listening events across the Borough.

Consultation on Year 3 activities

After a successful first two years, in which Healthwatch Barnet was recognised in the Healthwatch England national awards, the staff team undertook consultation with local communities on the Year 3 priorities.

Through a series of community engagement events, Healthwatch Barnet consulted with local residents on its key priorities and activities for Year 3.

Consultation events were held throughout the year and some are listed below.

- Care Act Event
- Knit & Natter at Hendon Library
- Pensioners Voice Meeting
- Underhill Parenting Group
- TB Awareness Workshop
- LGBT Engagement Event
- Patient Participation Group Event (in conjunction with Barnet CCG)
- Dementia Event
- Parenting Consortium Afghani Group
- Parenting Consortium Café Church Meeting
- Parenting Consortium Living Way Ministries Meeting
- Parenting Consortium at Grahame Park

Consultation also took place with community organisations, through the LBB Partnership Boards and through our charity partners.

A public meeting is planned for September 2015 to further consult with the public.

We are currently working to align the Healthwatch Barnet priorities with those of the Health and Wellbeing Board and the JSNA and Barnet CCG in order that we can have impact and add value to the health and social care system locally.

Performance on contractual targets (year 2)

Reach: (promotion of health and social care issues and raising awareness of Healthwatch Barnet to local residents.)
Target: 12,000.
Achieved: 108,398.

Engage (residents are provided with the opportunity to actively express their views on an individual basis.)
Target: 1200.
Achieved: 1409.

New contacts
Target:180
Achieved: 574

Volunteer Roles
Target: 105.
Achieved: 136

IAS
Target: 240
Achieved: 145

Enter & View Visits
Target: 30
Achieved: 30

Summary details of Healthwatch Barnet activity
The following section provides some highlights of activity throughout the year.

Enter & View

- We have carried out 30 visits
- 87% of providers we visited carried out at least one recommendation
- 33% of providers adopted 5 or more recommendations
- We contributed to a review of meal time procedures at Barnet and Chase Farm Hospitals

Consultation and engagement

- We consulted 150 people around hospital discharge and as a result hospital staff are now increasingly involving carers and making sure that cultural requirements are met;
- 50 people attended an LGBT flagship event which fed into a public health consultation on sexual health services;
- Over 80 people attended a PPG summit ran in conjunction with the CCG to discuss the role of patient involvement and Patient Participation Groups;
- Established the Barnet Youth Health Forum and as a direct result young people are now consulting about mental health support services in schools.

Reaching out to the public and volunteering

- 108,398 contacts through our 11 delivery partners;
- 45 active volunteers covering 136 different volunteer roles.
- Face-to-face consultation and engagement with **1,409 residents**, including 547 contacts new to Healthwatch Barnet.

Reports, interventions and influence

We have produced a range of reports and led interventions over the past year, summaries of which are below:

Dentistry
In a mystery shopping survey of 50 dental practices, Healthwatch Barnet found that over half of practices (53%) were not accepting new NHS adult patients and just under half (47%) were not accepting new children as patients. This contrasts sharply with the fact that over 90% of the practices were accepting both adult and children as new private patients.

Podiatry Services
A Healthwatch Barnet volunteer raised concerns about the waiting times for podiatry services in Barnet. He raised this with the provider, Central London Community Healthcare (CLCH), through his involvement with their Quality Stakeholder Reference Group. CLCH held a specific discussion to understand the issues and are now reviewing the service to make improvements.

Phlebotomy Services
A Healthwatch Barnet volunteer received feedback that there were long queues for blood tests at the Hampstead site of Royal Free London. Healthwatch staff raised this with the Director of Nursing at Royal Free and the Head of Clinical Quality at Barnet Clinical Commissioning Group. The Director of Nursing said that this would be improved for patients by changes to the staff processes.

District nursing provided by CLCH
Healthwatch Barnet volunteers noticed that there were delays with appointments and waiting times for district nursing. Healthwatch staff raised this with the CCG Head of Clinical Quality and CLCH. A review is now taking place to see how changes can be made to improve the service for patients.

Hospital Discharge
Alerted to local and national concerns about hospital discharge, Healthwatch Barnet approached its charity partners, Advocacy in Barnet and Jewish Care, to undertake research into patients' and their carers' experiences. Advocacy in Barnet's extensive contacts and experience with patients, particularly older and frail adults, and their knowledge of hospital and discharge processes was considered valuable in liaising with a range of patients, some of whom would have experienced distressing or difficult experiences. There are plans to review the changes providers have made following this work and an update will be presented to the Health and Wellbeing Board later in the year. Healthwatch England is undertaking a Special Inquiry into hospital discharge and this report has been sent as a submission of evidence of people's experiences.

Health and social care experiences of young people
CommUNITY Barnet's dedicated Children and Young People's Team were commissioned to listen to the views of local children and young people and to learn what they had to say about their health and social care experiences. The methodology used for this research supports CommUNITY Barnet's principles around engagement.

Mental Health Services – Complaints and Feedback
Barnet Centre for Independent Living carried out a commissioned report on mental health services. For a small but significant number of people BCIL interacted with, there was real distress around experiences of mental health services, and more specifically around experiences of using the complaints processes for mental health services. As a charity partner to Healthwatch Barnet, BCIL carried out a survey of people's experiences of using the mental health complaints services in Barnet.

Autism Services in Barnet (Appendix 2)
This report carried out by Barnet Mind looks at the issues faced by people with autism within the Borough and makes recommendations as to future work to improve both experience and outcomes.

Information and signposting
Following a review, the information and signposting service that had been contracted to Barnet CAB was brought in house. We are currently carrying out a root and branch review of our whole approach in this area with a view to considerably extend our reach.

Representation and Influence
Healthwatch Barnet continues to play an active role on and with:

- Health and Wellbeing Board
- Health Oversight and Scrutiny Committee
- Adult Safeguarding
- Barnet CCG Board
- Partnership Boards

- We also have excellent relationships with the local acute provider (Royal Free Trust) and other key organisations such as BEH Mental Health NHS Trust and the CQC – all of whom we meet on a regular basis.
- We work in collaboration with other Healthwatch's in the central north London areas a work closely with Healthwatch Enfield, Healthwatch Camden and Healthwatch Haringey.

Highlighting specific areas of activity

Enter & View
The Enter and View team have continued to work across a number of areas in the Borough and have carried out 30 visits in 2014/15. The team has taken on 8 new volunteers and now have a pool of 25 Authorised Representatives. They have undertaken visits in a number of different areas which are outlined below and the details are contained in the table at the end of this report:-

Care Home Visits
The Enter and View team have continued with their programme of visits to care homes for older people in Barnet and have been to 15 different homes across the Borough. The planning group (which is made up of 7 volunteers and a staff member) meets regularly and decide on the homes that they feel should be visited. These decisions are based on information from the public, discussions with the CQC, IQICH and the Quality and Purchasing Team at Barnet. Over the period, the teams saw some very good care homes offering very appropriate and compassionate care to residents. Many had good meaningful activities on offer and residents and their relatives were very happy with the care received. Some were not at as good standard and several recommendations were made in these cases.

The main areas where recommendations were made were:

- Lack of meaningful activities;
- Food and menus (often not displayed or residents not involved in food planning);
- Engagement (residents and relatives not involved in meetings or not aware of meetings):
- Complaints (policies not easily available);
- Staff levels (low levels of staff meaning not enough engagement with residents)

During the year we introduced questionnaires for relatives/friends of residents to tell us about their experiences of care at their care home. These are distributed to relatives/friends by the home manager and are returned directly to Healthwatch. This has been very helpful and has enabled us to reach a much wider range of opinions and feedback about services.

Hospital Mealtime Visits
A team of Enter and View volunteers undertook a series of visits to Barnet Hospital to observe the food and mealtime support. We visited 6 wards on two separate occasions, each at different times or the day and week. The wards and times of each visit were not known to the staff. The visits took place in April/May 2014. We liaised with Barnet Hospital about our findings and they have developed a Mealtimes Matter Action Plan which our findings fed into. Several changes such as changing the time of lunch, introducing nutrition nurses on each ward, more closely managed mealtimes and the introduction of hand wipes have resulted. Many patients /relatives that we spoke to were happy with the food and support given, but this varied between wards. Some of the other suggestions made were around reinforcing the protected mealtime principles; exploring a wider range of options for breakfast; improve the quality of Kosher and halal food; and more support for patients not able to use the menu/ordering system.

During June 2015 the team has returned to Barnet Hospital and are undertaking 12 more visits to see how the food and support is now being delivered and will report back on this when the visits are completed.

Joint Mental Health Visits with Healthwatch Enfield
As some mental health services provided by Barnet Enfield and Haringey Mental Health Trust cover all three Boroughs we worked jointly with our neighbouring Healthwatch's to visit some wards. Healthwatch Barnet led a visit to The Oaks ward at Chase Farm which is for older adults with mental health conditions. This has been published and we are currently working on a report from another joint visit led by Healthwatch Enfield to Suffolk Ward which supports female adults with mental health conditions. Our colleagues at Enfield and Haringey also visited Downhills ward at St Ann's Hospital in Haringey.

Hospital Visits	
14 April 2014	Willow Ward, Barnet Hospital (lunch)
14 April 2014	Spruce Ward, Barnet Hospital (lunch)
22 April 2014	Spruce Ward, Barnet Hospital (evening)
22 April 2014	Walnut Ward, Barnet Hospital (lunch)
08 May 2014	Olive Ward, Barnet Hospital (breakfast)
13 May 2014	Willow Ward, Barnet Hospital (evening)
14 May 2014	Walnut Ward, Barnet Hospital (evening)
17 May 2014	Juniper Ward, Barnet Hospital (lunch)
Care Home Visits	
29 April 2014	Clovelly House, (follow-up visit with manager who was not able to be present at original visit)
21 May 2014	Rosa Freedman
21 May 2014	Hadley Lawns Nursing Home
31 May 2014	Athenaeum Care Home
28 August 2014	Paulmay Dementia Care Home
04 September 2014	Cedars Care Centre, Richmond Road.
30 September 2014	Friary Lodge
14 October 2014	Elmhurst Residential Home
14 October 2014	Meadowside 1 (large home – two teams of volunteers attended)
14 October 2014	Meadowside 2 (large home – two teams of volunteers attended)
25 November 2014	Seaforth Lodge
26 November 2014	Roseview Care Home
27 January 2015	Baxendale
04 February 2015	Hilton Lodge

30 January 2015	Hadley Lawns (unannounced revisit)
24 February 2015	Clara Nehab House
9 April 2015	Eastside House
Joint Visits with Enfield Healthwatch to Mental Health Wards	
2 December 2015	The Oaks Ward, BEHMHT, Chase Farm Hospital
17 March 2015	Suffolk Ward, BEHMHT, Chase Farm Hospital
Mental Health Care Homes	
19 January 2015	Woodfield House (unannounced revisit)
18 March 2015	Oakleigh House
Mental Health Ward Revisit	
02 October 2014	Thames Ward, BEHMHT, Edgware Community Hospital (unannounced revisit)

Mental Health Care Homes
We undertook a final revisit to Woodfield House which is a care home for a small number of adults being supported back into the community after a hospital stay for a mental health condition. We also visited Oakleigh House which has a similar remit and were very impressed by the care and support provided there.

Mental Health Ward Visit
We undertook a re-visit to Thames Ward at Edgware Community Hospital (run by Barnet, Enfield and Haringey Mental Health Trust) We found some aspects had improved and we were reassured that recommendations we made would be followed up by via the Action Plan produced by the ward, particularly about discharge support, complaints procedures and quality of food

The team are continuing to develop their skills and the way they undertake visits and are planning more observations in a number of areas in the coming year.

healthwatch Barnet

Achievements

Enter & View

30 VISITS **87%** ADOPTED AT LEAST ONE RECOMMENDATION **33%** ADOPTED FIVE RECOMMENDATIONS

Contributed to a review of hospital mealtimes and the launch of the Mealtime Matters Action Plan

Consultation and Engagement

150 People around hospital discharge ✓ Hospital staff now involve carers and ensure cultural requirements are met

50 People attended an LGBT flagship event ✓ Public Health consultation on sexual health services.

Established Barnet Youth Health Forum for and by young people ✓ 8 young people between 14 and 24 are consulting about mental health support services in schools

Impact

Creating Change

Supporting patients to choose the right service with a new GP supported leaflet ✓ Changing the delivery of mental health services after commended focus group

Getting there

Reaching Out

108,398 CONTACTS through **11** CHARITY partners **45** ACTIVE volunteers **136** VOLUNTEER roles

Face-to-face consultation and engagement with **1,409**, including **547** contacts new to Healthwatch

Listening to local people

"You must do something about dementia" ✓

"Check local hospitals - that's what I am concerned about" ✓

"Volunteers are mainly older people. Get young people involved" ✓

Sharing

Working with other Healthwatch

Enter & View training and support to Healthwatch Brent

Joint Enter & View programmes with Healthwatch Enfield

Working in partnership through the North West London Healthwatch Consortium, Healthwatch England and other pan London consortia ✓

healthwatchbarnet.co.uk

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Appendix 2

Autism Services in Barnet

Healthwatch Barnet has collaborated with eleven charity partners to help co-ordinate and devise activities and events that can be used to provide experiences for and gather opinions from members of the community. Barnet Mencap is a well-established local voluntary organisation for Barnet residents with learning disabilities and/or autism and their families. In 2013 Barnet Mencap, as part of Healthwatch Barnet, conducted research on the healthcare experiences of people with learning disabilities and autism, and in February 2014 published the Healthwatch report 'Talk to Me'.

In this report Barnet Mencap conducts additional research with the focus on adults with autism spectrum condition only.

Recommendations

1. People with autism should routinely be given additional time for their medical appointments, preferably early or end-of-day slots to reduce their waiting time.
2. Raise autism awareness in primary care staff and look into the viability of some Borough wide training sessions for primary care professionals. We would suggest approaching the BEHMHT for funding for 2 Borough wide training days.
3. It should not be assumed that people with high-functioning autism/Asperger syndrome or with high IQs are able to cope better while receiving medical consultation/treatment or are able to communicate their health concerns and symptoms.
4. Many people with autism are unable to talk about their health problems and symptoms. Any unusual behaviour should not be automatically attributed to psychological causes, as it may signal underlying physical condition/symptoms/pain.
5. People with ASC should be encouraged to attend their medical consultation/treatment with their carer or advocate. Medical staff should always address patients with ASC directly and avoid talking to their carers only but ensure that there is joint understanding of what is being discussed.
6. Adopt recommendations of the National Autistic Society for medical professionals.
7. Whenever possible, patients with ASC should be seen by the same allocated staff member, ie GP, nurse, etc, each time. This would reduce the patient's stress around attachment to their routine and enable better communication.

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AGENDA ITEM 9

	Health and Wellbeing Board **30 July 2015**
Title	**Tuberculosis Report – 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 Appendix 2: TB Awareness Evaluation Report (June 2015)
Officer Contact Details	Dr Laura Fabunmi, Consultant in Public Health (Medicine) Laura.fabunmi@harrow.gov.uk Garrett Turbett, Public Health Specialist 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.

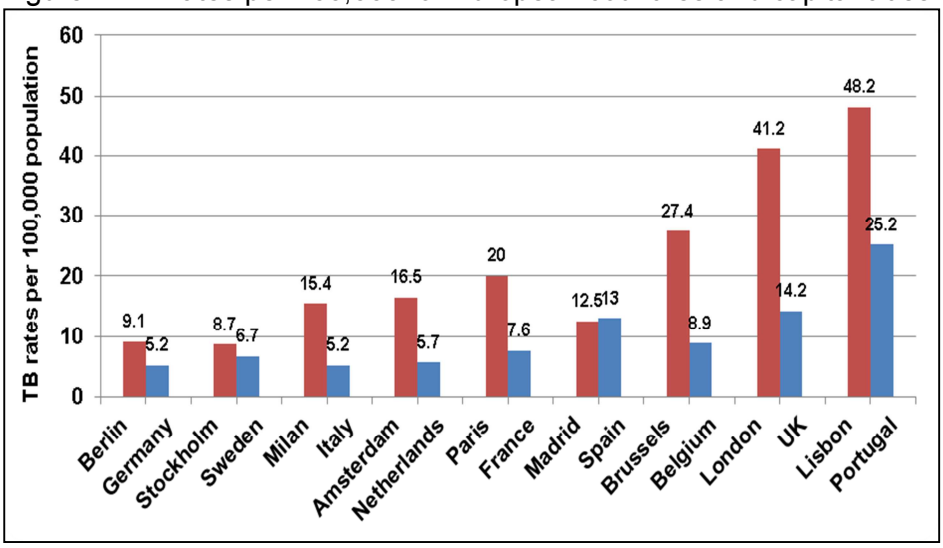
Recommendations
1. **The Health and Wellbeing Board is asked to consider the information provided following the 2014/15 TB awareness campaign and ask partners to support continued awareness raising programmes of work.**
2. **The Health and Wellbeing Board is asked to consider the information provided 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

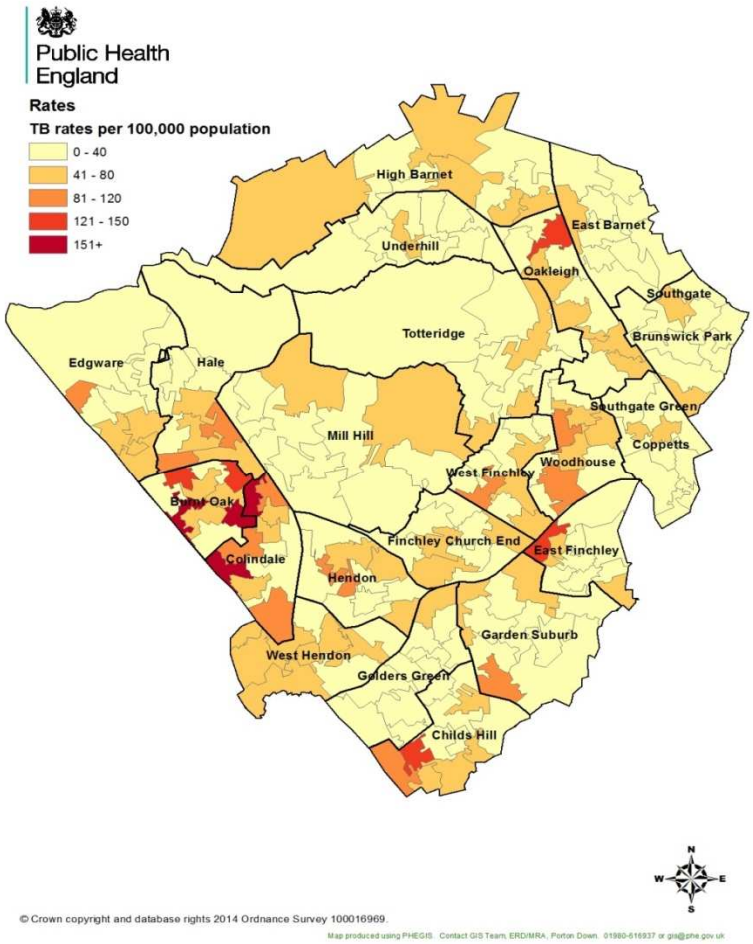
1.1.4 TB rates remain highest in northwest and northeast London.[3] North London has one of the highest rates of TB in the capital, and although Barnet does not rank as one of the boroughs with the highest rates, overall rates can mask smaller areas of very high incidence.

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

DRAFT

Local Plan for new migrant LTBI testing and treatment services

We encourage you to seek advice as required from the national LTBI team as you complete this template. Please email queries jointly to england.reducingprematuremortality@nhs.net and to tbscreening@phe.gov.uk.

The completed form should be submitted to the local TB Control Board with a copy to the above email addresses.

1. TB Control Board area
2. CCG area(s) covered by this plan
3. Proposed start date for LTBI testing and treatment service
4. TB epidemiology of the (CCG) area(s) covered by the plan and evidence of need for LTBI testing and treatment services
5. Service description and proposed service / care pathway (please be succinct)
a) Target population for LTBI testing
b) Mode of identification for eligible screening recipients
c) Method of invitation to new migrants (by whom and how)
d) Setting and pathway for testing
e) Testing arrangements (including test, transport and laboratory processing)
f) Setting and pathway for LTBI treatment
g) Referral criteria for active and LTBI treatment
h) Treatment arrangements
i) Proposed additional activities (e.g. awareness raising)
j) Proposed additional tests (e.g. BBVs)
k) Other important information

6. Has agreement has been reached with local GPs/LMC on a local GP incentive scheme for LTBI testing? If so, please set out the arrangements agreed. If not, please set out the timescale for doing so, any key risk factors and how these are being addressed.
7. Has agreement been reached with the local TB secondary care providers for any additional capacity with respect to the treatment of LTBI positive patients? If so, please set out the arrangements agreed. If not, please set out the timescale for doing so, any key risk factors and how these are being addressed.
8. Are appropriate arrangements in place with respect to laboratory capacity for the LTBI tests, including interim arrangements whilst the conclusion of specific procurement arrangements is awaited? If so, please set out the details. If not, please set out the timescale for doing so, any key risk factors and how these are being addressed.
9. In what ways will existing services and other resources be used to support delivery of LTBI testing and treatment?
10. Expected local outcomes e.g. the expected number of patients to be tested and treated in 2015/16, wider community awareness of LTBI
11. Outline of the proposed evaluation and monitoring arrangements
a) Data collection and collation mechanism and interface to PHE LTBI surveillance system
b) Monitoring and reporting arrangements
12. Are all CCGs affected by the above proposals supportive of them?
13. Estimated funding requirements
a) Number and costs of expected tests
b) Cost of GP incentives
c) Number of patients expected to need LTBI treatment and agreed additional costs for local TB services
d) Number of patients expected to need full TB treatment and agreed additional costs for local TB services
e) Other (including set up costs)
f) Total amount required

Key stakeholders involved in the development and delivery of this plan

(Please adapt as relevant locally but should include as a minimum CCG, NHS England and provider representation)

Stakeholder	Name	Role	Email / telephone number
Local LTBI Plan development lead (i.e. lead who has coordinated development of this plan)			
CCG TB Lead			
Secondary care LTBI lead			
Lead TB nurse			
CCG GP representative for LTBI			
NHS England team representative			
PHE TB lead			

Date plan prepared:

Confirmation of lead CCG support for the plan by the CCG Chief Officer

I confirm CCG support for the above plan and the financial implications and funding requirements therein.

Name _____ Signature_____

Date _____

Confirmation by the relevant TB Control Board director that the Control Board supports the above plan

I confirm that the TB Control Board gave its support to the above plan and funding requirements on (insert date)

Name _____ Signature _____

Date _____

When a Control Board has supported a plan, it should be sent to england.reducingprematuremortality@nhs.net and to tbscreening@phe.gov.uk.

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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).

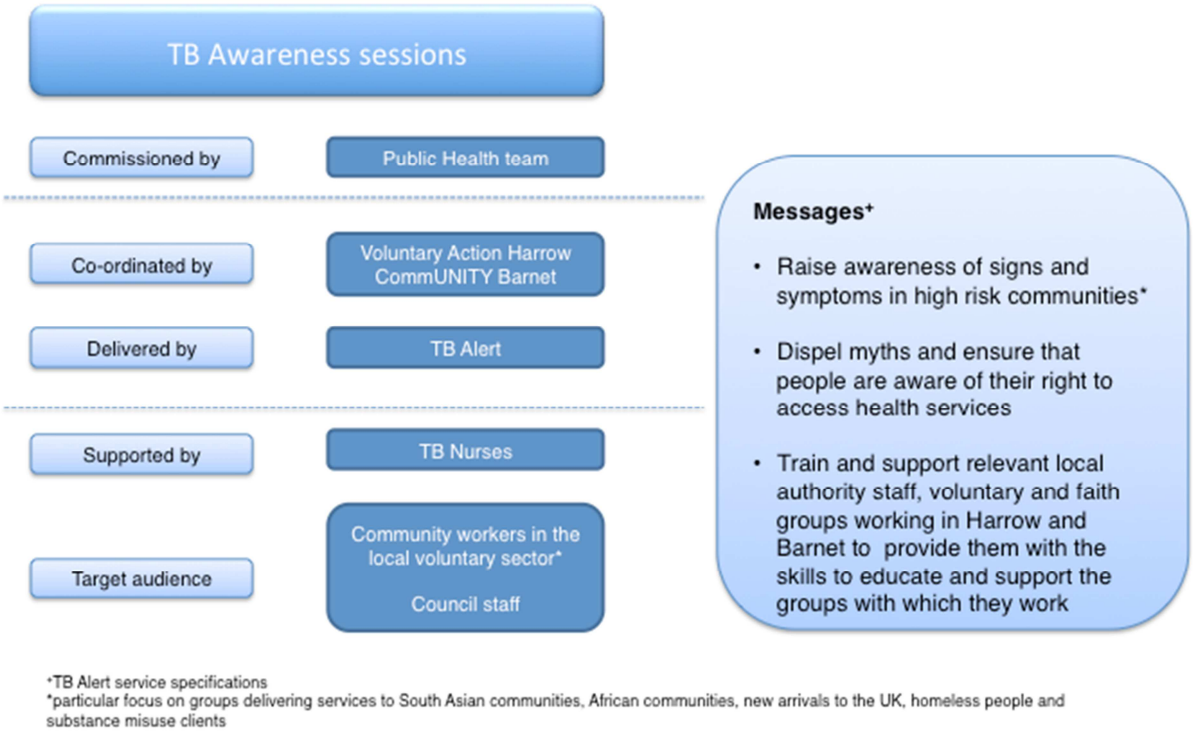


Figure 1: Model of delivery for the awareness project

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 • Sourcing promotional material from TB Alert for information packs • Organise staff awareness sessions for council staff • Encouraging GP uptake of RCGP online training for TB • Organising TB seminar on World TB Day
TB Alert[3]	• Deliver workshops to awareness sessions to community groups and council staff • Facilitate a monthly teleconference for attendees where information can be shared and questions answered • Provide all training and promotional material • Provide a resource pack for attendees, including recommendations on how they can increase TB awareness in their organisations • Promotional material to be disseminated to GPs • Provide advice to commissioner regarding a grants scheme • 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 • Arrange venues • Co-ordinate awareness sessions • Publicise sessions to the target audience using mailing list, social media, direct contact and newsletter items • End of project report • 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.

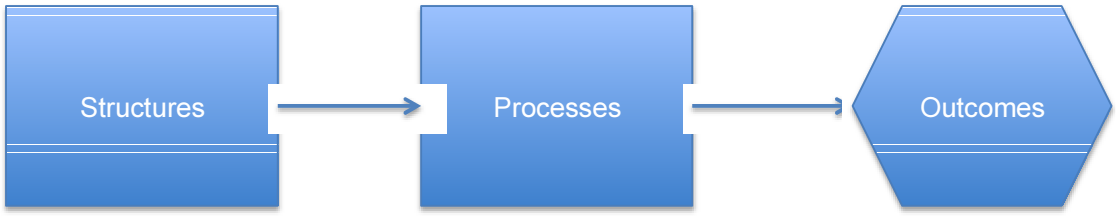
£10,000 has been committed for phase 2 of this project (small grants) with £3,000 available to organisations in Barnet and £7,000 available to organisations in Harrow based on the interest in both areas to the community workshop and relative burden of disease.

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.



- How many sessions were arranged?
- Were the right audience targeted?
- Did those invited attend?
- Were the venues appropriate?
- Were those delivering the workshops adequately trained?

- Were the attendees given sufficient notice of training?
- Was the objective of the training clear to those targeted?
- Was the content of the training appropriate for the aims?
- Were the sessions evaluated?

- Self-reported increase in awareness by attendees
- Self-reported intention to act on new information

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 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).

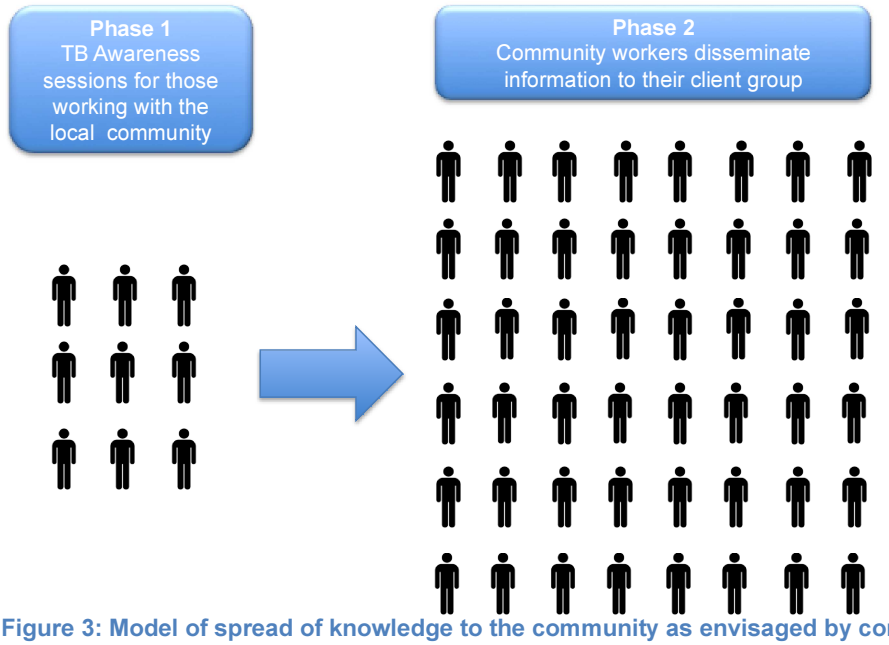


Figure 3: Model of spread of knowledge to the community as envisaged by commissioners

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 (attendance list for each event not available)	Organisations working with • Black and Minority Ethnic community • Refugees/asylum seekers • People with specific health issues • Substance misusers • Homeless people • Prisoners/ex-prisoners • Students in further education • School and children's centre • People with Mental health issues • Elderly • Healthwatch Barnet • 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 Event 2 – 5 people	• Children's Centre • Older Person's charity • Community resource centre • Somali organization • Pre-school/nursery • Charity providing health and social care • Substance misuse charity • Women's Centre • Young people's charity • Harrow resident
February 2015	One community event	Community event- 5 people	• Asian Support group • Substance misuse provider/charity • Pre-school/primary school
March 2015	One community event	Event 1- 8 people Event 2- 10 people	• Afghan charity • Health charities/providers/health champions • Children's services • Deaf Club • Harrow resident • Learning disability charity • Older persons charity • Substance misuse charity/provider • 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 • 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

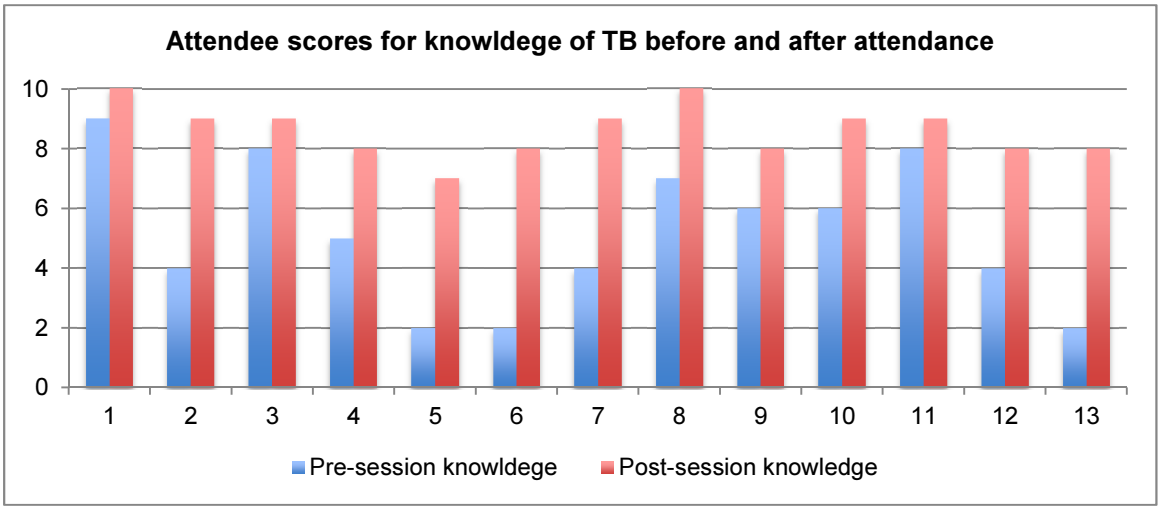


Figure 4: Chart showing pre- and post session self reported knowledge by those who attended session in Barnet (n=13)

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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AGENDA ITEM 10

	Health and Wellbeing Board **30 July 2015**
Title	**Minutes of the Financial Planning Sub-Group**
Report of	Commissioning Director – Adults and Health
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1- Minutes of the Financial Planning Group – 12 June 2015 Appendix 2- Minutes of the Financial Planning Group – 13 July 2015
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report is a standing item which presents the minutes of the Financial Planning Sub-group and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan. The Sub-groups key areas of work include the Better Care Fund and Section 75 agreements.

Recommendations

1. **That the Health and Well-Being Board notes the minutes of the Financial Planning Sub-Group meeting of 12 June 2015 and 13 July 2015.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health and Wellbeing Board on the 26th May 2011 agreed to establish a Financial Planning sub-group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial planning sub-group meets bi-monthly and is required to report back to the Health and Wellbeing Board (HWBB).

1.2 In 2015/16, the section 256 allocation for Barnet Council is £6,634,000 to deliver the main social care services which also have a health benefit. In 15/16, this funding is no longer received from NHS England but included within CCG allocations as part of the total Better Care Fund allocation of £23.4M for Barnet, which includes the NHS Barnet CCG minimum contribution to the Better Care Fund of £14,060,000. The Health and Wellbeing Board Financial Planning Sub-Group has in its terms of reference the approval of plans for S256/BCF funds on behalf of the HWBB.

1.3 The budgets will be used to continue to support the delivery of existing initiatives, as well as any such new initiatives identified to support the delivery of Better Care Fund (BCF) outcomes and the appropriate protection of social care services.

1.4 Minutes of the meeting of the Financial Planning sub-group held on the 12 June 2015 are presented in appendix 1 and minutes from the sub-group held on the 13 July 2015 are presented in appendix 2.

1.5 In March the Financial Planning sub-group reviewed the operating context for the CCG and LBB given the changes that both organisations have experienced over the past nine months and therefore the relevance of the Financial Planning Sub-group and it was agreed to –

- Focus on areas of strategic joint work between the CCG and LBB which includes the section 75 agreements, the operation of the Joint Commissioning Unit and the Better Care Fund
- Change the name of the group to the Joint Commissioning Executive Group
- Review the Terms of Reference including updating the membership given personnel changes in both organisations
- Shape the Health and Wellbeing Board work programme with the Health and Well-Being Board Chairman and Vice Chairman
- Support the development of the Health and Wellbeing Strategy

1.6 The Terms of Reference will be updated and finalised following a governance review of the Health and Wellbeing Board and sub-group structures.

1.7 In June the Group –

- Agreed to review all Section 75 agreements held between LBB and the CCG to ensure that these are fit for purpose, appropriately governed and schedules are bought in line with the overarching agreement

- Reviewed joint priorities and areas of joint working to inform the sub-groups work programme
- Reviewed the adult and children Joint Commissioning Unit work programmes
- Discussed and agreed the financial reporting required for the Better Care Fund

1.8 In July the Group –

- Agreed a revised Terms of Reference to be bought to a later meeting of the HWBB
- Agreed financial reports for the Better Care Fund and Section 75 agreements
- Considered adult social care budget pressures

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Wellbeing Board established the Health and Wellbeing Financial Planning Sub-Group to support it to deliver on its Terms of Reference; namely that the Health and Wellbeing Board is required:

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.

2.2 Through review of the minutes of the Health and Well-Being Financial Planning Sub-Group, the Health and Well-Being Board can assure itself that the work taking place to ensure that resources are used to best meet the health and social care needs of the population of Barnet is fair, transparent, stretching and timely.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided the Health and Wellbeing Board is satisfied by the progress being made by the Financial Planning Sub-Group to take forward its programme of work, the sub-group will progress its work as scheduled in the areas of the Better Care Fund, Section 75 agreements and financial reporting.

4.2 The Health and Wellbeing Board is able to propose future agenda items of forthcoming sub-group meetings that it would like to see prioritised if it is not satisfied with the work that the sub-group is taking forward on its behalf.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Integrating care to achieve better outcomes for vulnerable population groups, including older people, those with mental health issues, and children and

young people with special needs and disabilities, is a key ambition of Barnet's Health and Wellbeing Strategy.

5.1.2 Integrating health and social care offers opportunities to deliver the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and the CCG's Quality, Innovation, Productivity and Prevention Plan (QIPP) and Financial Recovery Plan.

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

5.2.1 The Health and Wellbeing Financial Planning Sub-Group acts as the senior joint commissioning group for integrated health and social care in Barnet. it has the following functions that relate to the management of local resources (subject to approval of the revised terms of reference in September):

a) *To oversee the development and implementation of plans for an improved and integrated health and social care system for children, adults with disabilities, frail elderly, those with long term conditions, and people experiencing mental health problems.*
b) *To govern the implementation and delivery of the Better Care Fund including the implementation of the 5 tier model for frail elderly, holding the Joint Commissioning Unit and partners to account for its delivery.*
c) *To approve the work programme of the Joint Commissioning Unit.*
d) *To agree any business cases arising from the Joint Commissioning Unit including in relation to the integrated care model*
e) *To recommend to the Health and Well-Being Board, Council Committees and the CCG Board how budgets should be spent to further integration between health and social care.*
f) *To ensure appropriate governance and management of additional budgets delegated to the Health and Well-Being Board.*

5.2.2 Projects and enablement schemes linked to Section 256 funding are reviewed by the Financial Planning sub-group as well as the Section75 agreements between LBB Barnet and CCG to ensure that the projects have a clear programme of work and that approved business cases are adequately resourced to deliver the agreed outcomes.

5.3 **Legal and Constitutional References**

5.3.1 The Health and Wellbeing Board has the following responsibility within its Terms of Reference:

To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet.

5.3.2 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of

staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended). This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

5.3.3 Under the Health and Social Care Act 2012, a new s2B is inserted into the National Health Service Act 2006 introducing a duty that each Local Authority must take such steps as it considers appropriate for improving the health of the people in its area. The 2012 Act also amends the Local Government and Public Involvement in Health Act 2007 and requires local authorities in conjunction with their partner CCG to prepare a strategy for meeting the needs of their local population. This strategy must consider the extent to which local needs can be more effectively met by partnering arrangements between CCGs and local authorities, and at 195 of the Health and Social Care Act there is a new duty-- Duty to encourage integrated working:

> *s195 (1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.*
>
> *s195 (2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.*

5.3.4 As yet, there is no express provision in statute or regulations which sets out new integrated health budgets arrangements, and so the s75 power remains.

5.3.5 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

5.4 **Risk Management**

5.4.1 There is a risk, without aligned financial strategies across health and social care, of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The Financial Planning sub-group has identified this as a key priority risk to mitigate, and the group works to align timescales and leadership of relevant work plans which affect

both health and social care.

5.5 **Equalities and Diversity**

5.5.1 All public sector organisations and their partners are required under s149 of the 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.*

5.5.2 The protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

5.5.3 The MTFS has been subject to an equality impact assessment considered by Cabinet, as will the specific plans within the Priorities and Spending Review as these are developed. The QIPP plan has been subject to an equality impact assessment considered by NHS North Central London Board.

5.6 **Consultation and Engagement**

5.6.1 The Financial Planning sub-group will factor in engagement with users and stakeholders to shape its decision-making in support of the Priorities and Spending Review, and Barnet CCG's financial recovery plan.

5.6.2 The Financial Planning sub-group will also seek assurance from group members that there is adequate and timely consultation and engagement planned with providers as the integrated care model is implemented.

6. BACKGROUND PAPERS

6.1 None.

DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Friday 12th June 2015
North London Business Park, Reynolds Room
11am – 12.30pm

Present:
(AH) Andrew Howe Director of Public Health, Barnet and Harrow Public Health Team
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director – Adults and Health, LBB
(HMG) Hugh McGarel-Groves, Chief Finance Officer, Barnet CCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG (Chair)
(RH) Ruth Hodson, Assistant Director of Finance, Barnet CCG

(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies: None

	ITEM	ACTION
1.	**Welcome / Apologies** MOD (Chair) introduced herself as Chair and welcomed those present. MOD welcomed CM to the meeting as the recently appointed Commissioning Director – Children and Young People. With CM's appointment Kate Kennally (KK) will no longer be a member of this Group. The Group acknowledged KK's valuable contribution to the Group and thanked her for the work she has done.	
2.	**Minutes of the last meeting** The Group made no amendments to the minutes and noted that they were presented to the HWBB on the 4 June 2015.	
3	**Action log** The action log was reviewed and updated (see action log).	
4.	**Agreeing –** **4.1 ToR** HMG stated that the CCG need to review the governance arrangements for the HWBB and Finance Group in relation to CCG processes and suggested that the minutes of the Finance Group will need to go to the Finance, Performance and QUIPP (FPQ) Committee. **HMG to check delegated authorities to ensure CCG members can make decisions at the Finance Group meetings.**	**HMG**

	The Group reviewed the ToR, the ToR will be updated. **ZG to update ToR**	**ZG**
	AH asked about the need for Heath Visiting to be governed. It was agreed for this to be added to the work programme of the Group.	
	With the amendments above the Group agreed the ToR as draft subject to HWBB audit review. It was noted that the Group are still working to the current ToR.	
	ZG, Andrew Charlwood (LBB Governance), Andy Nuckcheddee (CCG Governance) to take forward the audit of HWBB and subgroup ToR (including a review of delegated authorities).	**ZG, AC, AN**
	ZG to invite Sarah Thompstone (Director of Clinical Commissioning) to future meetings.	**ZG**
	The Group discussed the purpose of the meetings. The Group membership, of key commissioners and finance officers, allows for oversight of the joint arrangements, commissioning projects and finances. The Group is the platform for integration work discussion, making decisions about how this is done and making recommendations to other Boards as to how the CCG and LBB work together. The Group is to have financial oversight of any papers going to the HWBB with financial implications.	
	RH stated that that the Group needed to receive more finance reports, performance, how things are working	
	RH and HMG to look at a draft financial report that should be coming to this Group and present this at the meeting in July to include - • **Reviewing and approving finances for integrated care** • **Programme of Financial Plan for critical finance reports**	**RH / HMG**
	4.2 S75	
	DW presented the paper, the aim is to extend the overarching Section 75 agreement (with no end date) and bring the existing Section 75 agreements for specific activity under the overarching agreement as schedules. All agreements will also need to be reviewed and updated.	
	For adults, this has already been done for the Voluntary services prevention commissioning and the Health and Social Care Integration schedule is currently being developed and will be added to the overarching Section 75 through a Deed of Variation.	
	ZG to look at adding the Campus Reprovision Section 75 to the overarching 75 as part of the same Deed of Variation.	**ZG**
	The Integrated Learning Disability Service Section 75 will be reviewed and added to the overarching Section 75 later in the year.	

	MOD and Mathew Kendal to discuss Lead Commissioning for an Integrated Community Equipment Service. The overarching Section 75 will be reviewed, the updated Section 75s added as schedules and presented to the CCG and LBB to agree as final. **DW and MOD to check powers to agree/process for Section 75 sign off within their organisations. Progress to be reported at the next meeting.** **The process of tracking outcomes and spend and the mechanism of reporting to this Group needs to be agreed.** **ZG, MOD and CM to explore a similar activity for childrens Section 75s.** The Group reiterated that Section 75s are not contracts but agreements. Also, contracts with providers will still have end dates **4.3 MoUS** DW has commented on the adult MoU. MOD updated that factual changes have been made to the adults MoU. **MOD to update and take to Audit Committee** **MOD and CM to review the childrens MoU.**	**MOD** **DW/MOD** **DW/MOD** **CM/MOD/ZG** **MOD** **MOD/CM**
5.	**Joint priorities** LBB had developed a list of priorities (including associated reported structures) which had been presented to the CCG in May. MOD, DW and Matt Powls (Interim Director of Planning and Performance, CCG) reviewed the documents and Debbie Frost (CCG Chair) sent a final, agreed version to KK. The document presented to the Group was not considered to be the most up to date document. The Group commented and recommendations were made. CM clarified that the 0 – 25 disability service is not just for people with learning disabilities, as listed, but for people with learning disabilities, physical disabilities, sensory impairments, mental health issues and complex needs. DW explained that the inclusion of this in the priorities related to the activity that needs to happy around updated the Section 75 agreement and service development which needs to consider the 0 – 25 service. **MOD to update and send a word version to ZG.** **CM to review and comment.** **AH, CM, DW and MOD to agree and send updated agreed version to KK and DF.** The agreed priorities will form the work programme for the Finance Group. **ZG to add completion dates and reporting deadlines.**	**MOD** **CM** **AH/CM/DW/MOD** **ZG**

12pm – HMG left the meeting		
6.	**JCU Work Programmes – Adult and Children** The Group reviewed the draft work programmes for the Joint Commissioning Units (JCUs) for adults and childrens. The Group noted that the work programmes are currently being revised. The adults work programme just includes the work of the JCU (not the entire commissioning group), the childrens plan is wider than the JCU. **JCU work plans to be bought back to the Finance Group in September priorities and work plan to be discussed with teams**	**DW/MOD/CM**
7.	**BCF – timescales** DW presented the BCF paper and asked the Group to note the timescales that need to be adhered to in order to sign off the Deed of Variation and financial procedures. MOD updated that she is speaking to Capsticks in the next couple of days to clarify the process for the CCG. This will be taken to the next Audit Committee. **Updated and final schedule to be circulated to the Finance Group.** The first quarterly report was submitted to NHS England at the end of May. **Financial procedures to be reviewed, clarified and managed by Paul Thorogood, Richard Hammond and Ruth Hodson and present this to the Finance Group (8 July)** The Group agreed that the pooled budget lead manager should be RH as the Council hosts the BCF.	**DW/MOD** **RH**
8.	**CCG Co- commissioning update** Sarah Thompstone – Director of Clinical Commissioning is now the lead for this programme and will report to the Finance Group in September. Public Health to be involved going forward. **ZG to add Co-commissioning update to agenda of this Group for September**	**ZG**
9.	**JSNA / HWB Strategy Update** AH explained that the JSNA refresh is going well and on track. There is an outstanding issue with regards to the data from the CCG which AH has been discussing with Debbie Frost. AH is aware that Matt Powls is working with Luke Ward (LBB) but the data needs to be provided. **MOD to discuss with Matt Powls.** ZG presented an overview of the HWB Strategy. ZG is currently discussing the priorities with senior officers. The HWB Strategy is going to the CCG executive in June. The JSNA and HWB Strategy will be discussed at the Partnership Board and Health and Well-Being Board Summit on 9 July.	**MOD**

	CM asked for this to be aligned with the update of the Children and Young People's Plan.	**ZG**
10.	**Health and Well-Being Board work programme and actions** The Group reviewed the HWBB Work Programme and made the following changes • Learning disability service paper to move from July to November • Co-commissioning update to move from July to September • CAMHS to be taken to the HWBB in November **ZG to update and discuss with Councillor Hart and Debbie Frost.**	**ZG**
11.	**Work Programme** Covered in 5. **ZG to update following discussions.**	**ZG**
12.	**AOB** Next meeting – 8 July 2015, 1pm – 3pm.	

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DRAFT Minutes from the Health and Well-Being Board – Financial Planning Group
Monday 13th July 2015
North London Business Park, Reynolds Room
1pm – 2pm

Present:
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director – Adults and Health, LBB (Chair)
(HMG) Hugh McGarel-Groves, Chief Finance Officer, Barnet CCG
(JL) Jeff Lake, Consultant in Public Health, Barnet and Harrow Public Health Team
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(MB) Melanie Brooks, Programme Director Health and Social Care Integration, Barnet CCG/LBB
(RH) Ruth Hodson, Assistant Director of Finance, Barnet CCG
(RoH) Roger Hammond, Deputy Chief Finance Officer, Barnet CCG

(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies: None
(AH) Andrew Howe Director of Public Health, Barnet and Harrow Public Health Team

	ITEM	ACTION
1.	**Welcome / Apologies** Apologies received from Andrew Howe.	
2.	**Minutes of the last meeting** No changes were made to the minutes, agreed as final. The minutes will be taken to the HWBB on 30th July 2015.	
3.	**Action log** The action log was reviewed and updated (see action log).	
4.	**Financial Report template** Templates for Better Care Fund (BCF, covering item 7.2) and Section 75 agreement reporting were circulated and considered by the group. MB explained that income and expenditure information is needed for NHS England reporting for the BCF. The template from NHS England is delayed and therefore the degree of detail is unknown this is needed before the 27 August NHS England deadline. RoH outlined the information he would expect to see in this report such as whether	

	we are on track or not, under / over spends and how the year is unfolding. DW was happy with the template but asked for the committed / uncommitted column to be completed throughout the report. RH explained that the report details the timings for LBB requirement and to take on to the Health and Wellbeing Board (HWBB). RH discussed the report with CCG prior to the meeting. **CCG Finance, Performance and Quality meetings need to be added.** The Group agreed with the timescale and template but requested that the Finance Group receive the most up to date monthly report as well as the quarterly report. Quarterly reports will go to the HWBB. **S75 report to be moved to a template more similar to BCF report with quarterly spends and detail (e.g. what the money is being spent on).**	**RH** **RH**
5.	**Five Borough meeting (7th July)** DW attended a meeting of the 5 NCL Chief Executives and either their CCG Chair, Chief Officer or Chief Finance Officer. Gina Shakespeare (Chief Officer) and Debbie Frost (CCG Chair) attended on behalf of Barnet CCG. The group agreed in principle to work across the NCL footprint (Local Authorities and CCGs) but further discussions are required, including a discussion to identify priorities. The next discussion will take place at the NCL collaboration board in September which will be attended by the Chief Executives and Directors of Adult Social Services from each borough. DW to keep the group updated.	
6.	**6.1 ToR** Final comments were made and agreed as final draft with the addition of governance work in relation to CCG internal scheme of delegation and delegation from the Health and Wellbeing Board. Once this is complete the revised ToR will go to the HWB for approval. Delegation of powers is being discussed by the CCG at a meeting on 28 August 2015. Final, agreed ToR to go to the HWBB 17 September 2015. **ZG to update minutes and send to Andy Nuckcheddee (CCG) for comment.** **6.2 S75 –** Finance template included in point 4. **ZG to meet with MOD, CM and DW to discuss way forward.**	**ZG** **ZG**

	MOD stated the CCG Audit Committee asked if there were other ways (not Section 75s) to pool budgets. **ZG to look at with Andy Nuckcheddee.** CM explained that there are Section 10 agreements in children's. **6.3 MoUS** Returning to Audit Committee in September.	**ZG**
7.	**7.1 BCF - S75 Deed** MOD updated the group following the S75 being considered at Audit Committee. One line change from the Audit Committee to be agreed on both sides. The schedule was accepted as a way of working subject to confirmation from DW and MD that all required changes have been made and to include a caveat around governance as the CCG does not currently recognise the Finance Group (which is the JC executive in the schedule) in its scheme of delegation. RH clarified that budgets are being aligned and not pooled. MB stated that this needs to be in line with what is required for NHS England (BCF guidance) CM asked if both organisations could withdraw their funding. MOD stated that this is possible but not what we would like to do. **7.2 BCF Financial Procedures** In point 4.	
8.	**Social Care Finances** DW tabled a presentation and a discussion about the borough's adult social care budget forecast took place. DW drew the group's attention to the budget pressures this year (2015/16) and the increase in referrals to social care from hospitals. This shows an increase of c. 20% per year since 2012 in referrals along with a decrease in funding from system resilience funding (from just under £1M in 2012 to 3120K in 14/15). The council Resilience funding bids are being considered on Friday (17 July). MOD asked for more detail about the outcomes of the people supported through resilience funding. As the meeting was coming to the end of the allotted time, it was agreed that **DW, MOD, HMG and RH would meet to continue the discussion.**	**DW**
9.	**JSNA / HWB Strategy Update** The Group were asked to consider the paper and send comments to ZG.	

10.	**Health and Well-Being Board work programme and actions** The Group were asked to consider the paper and send comments to ZG.	
11.	**Work Programme** The group noted the work programme. The work programme will be further updated.	
12.	**AOB** None.	
Next meeting – 2 September 2015, 1pm – 3pm		

AGENDA ITEM 11

	Health and Wellbeing Board **30 July 2015**
Title	**Forward Work Programme**
Report of	Commissioning Director Adults and Health
Wards	All
Date added to Forward Plan	January 2014
Status	Public
Enclosures	Appendix 1- Forward work programme of the Health and Well-Being Board Appendix 2- Forward work programme of Council Committees and Barnet CCG's Board
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 359 3478

Summary

This report introduces the forward work programme for the Health and Wellbeing Board and outlines a series of considerations that will support the Board to manage and update its forward work programme effectively. These considerations are:

- The statutory responsibilities and key priorities of the Health and Wellbeing Board
- The work programmes of other Strategic Boards in the Borough, thematic Committees and Health Overview and Scrutiny Committee
- The significant programmes of work being delivered in Barnet in 2015/16 that the Board should be aware of
- The nature of agenda items that are discussed at the Board

Recommendations

1. **That the Health and Wellbeing Board notes the Forward Work Programme and proposes any necessary additions and amendments to the forward work programme (see Appendix 1).**

2. That Health and Wellbeing Board Members agree to propose updates to the forward work programme before the first day in each calendar month, so that the work programme can be published on the Council's website more efficiently, with the most up to date information available.
3. That the Health and Wellbeing Board agrees to align its work programme with the work programmes of the Council Committees (namely the Adults and Safeguarding Committee, and the Children's, Education, Libraries and Safeguarding Committee), Health Overview and Scrutiny Committee, and Barnet CCG's Board (see Appendix 2).

1. WHY THIS REPORT IS NEEDED

1.1 At the Health and Wellbeing Board meeting on 13th November 2014 the Board committed to monthly updates of the forward work programme in alignment with other council committees.

1.2 The current forward work programme has been designed to cover both the statutory responsibilities of the Health and Wellbeing Board and the key projects that have been identified as priorities by the Board at its various meetings and development sessions. The current work programme covers a 8 month period until the end of March 2016.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented to the Board on 4 June 2015 and suggests a refreshed schedule of reports and items for the following 8 months, reflecting the Board's statutory requirements, new responsibilities as the Commissioning Committee for public health (see below), agreed priorities, and objectives set out in the Health and Wellbeing Strategy. Key items to note include a report on the Partnership Boards/ Health and Well-Being July Summit (September), a review of services for people with learning disabilities (November), CCG Co-Commissioning update (September) and Opportunities to align the Public Health and Planning Teams (November).

1.4 The Health and Wellbeing Board must ensure that it's forward work programme is compatible with the forward work programmes of the Adults and Safeguarding and Children's, Education, Libraries and Safeguarding Committees. The Board also needs to seek alignment with the work programmes of the Council's Health Overview and Scrutiny Committee, and Barnet CCG's Governing Body, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate. Updated forward work programmes (August 2015 – May 2016) for each of these Boards are attached at Appendix 2 to support the Board in planning its work programme effectively.

1.5 There are a number of work programmes being delivered in 2015/16 that will be of interest to the Health and Wellbeing Board, and should be reflected in the Board's forward plan. These work programmes include, but are not limited to, the Mental Health Community Model, Child and Adolescent Mental Health services, early years alternative delivery model and Care Act implementation.

2. REASONS FOR RECOMMENDATIONS

2.1 To maintain a programme of agenda items that will aid the Board in fulfilling its remit.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Following approval of the recommendations in this report, Board Members will be asked to update the forward work programme.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Health and Wellbeing Board needs a robust forward work programme to ensure it can deliver on the key objectives of the Health and Wellbeing Strategy, including the annual priorities within the Strategy that were agreed at the November 2014 Board meeting.

5.1.2 Successful forward planning will enable the Board to meet strategic local and national deadlines for each organisation represented at the Board and transformational changes required to meet the savings targets for both the Council and the CCG.

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

5.2.1 Currently, all items on the forward work programme of the Health and Wellbeing Board will be managed within existing budgets.

5.3 **Legal and Constitutional References**

5.3.1 Health and Wellbeing Boards have a number of statutory duties designated through the Health and Social Care Act (2012) that will inform what items should be taken to the Health and Well-Being Board meetings.

5.3.2 The work programme should ensure that the Health and Well-Being Board is able to deliver on its terms of reference as set out in the Council's Constitution Responsibility for Functions- Annex A, which are set out below:

*(1) 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.*

*(2) To **agree a Health and Well-Being Strategy** for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.*

*(3) To work together to **ensure the best fit between available resources to meet the health and social care needs of the 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.

*(4) To **consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures** to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.*

*(5) To **receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services** for users and patients.*

*(6) 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.*

*(7) To **promote partnership and, as appropriate, integration, across all necessary areas**, including the use of joined-up commissioning plans across the NHS, social care and public health.*

*(8) **Receive the Annual Report of the Director of Public Health** and commission and oversee further work that will improve public health outcomes.*

(9) Specific responsibilities for:
- ***Overseeing public health***
- ***Developing further health and social care integration.***

5.4 **Risk Management**

5.4.1 A forward work programme reduces the risks that the Health and Wellbeing Board acts as a talking shop for the rubber stamping of decisions made elsewhere, or does not focus on priorities. It ensures that all decisions formally within the Board's statutory duties, Terms of Reference and other key issues relating to local health and care services are considered.

5.5 **Equalities and Diversity**

5.5.1 All items of business listed in the forward programme and presented at the Health and Wellbeing Board will be expected to bear in mind the health inequalities across different parts of the Borough and will aim to reduce these inequalities. Individual and integrated service work plans sitting within the remit of the Health and Wellbeing Board's work will need to demonstrate how the needs analysis contained in the Joint Strategic Needs Assessment (JSNA) has influenced the delivery options chosen, including differential outcomes between different communities.

5.5.2 The Public Sector Equality Duty at s149 of the Equality Act 2010 will apply to CCGs and local authorities who as public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the 2010 Act and advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and 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.

5.5.3 This is essential when addressing 5.3.2. (6) above regarding health inequalities.

5.6 **Consultation and Engagement**

5.6.1 The forward work programme will be set by the Members of the Health and Well-Being Board but the Health Overview and Scrutiny Committee also has the opportunity to refer matters to the Board.

5.6.2 The bi-annual Partnership Board Summits, and the meetings of the Partnership Board co-chairs, will provide opportunity for the Board to engage with each of the Partnership Boards on the forward work programme.

6. BACKGROUND PAPERS

6.1 None.

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Health and Well-Being Board Work Programme

July 2015 – March 2016

Contact: Zoë Garbett
Commissioning Lead – Health and Wellbeing (LBB)
zoe.garbett@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
30 July 2015			
Draft JSNA refresh and emerging priorities for the Health and Well-Being Strategy	**The Board is asked to comment on the draft JSNA and the implications for the Health and Well-Being Strategy refresh**	Director of Public Health	**Consultant in Public Health Commissioning Lead, LBB Commissioning Lead – Health and Wellbeing, LBB**
Draft substance misuse strategy	**The Board is asked to comment on the draft substance misuse strategy**	Director of Public Health	**Consultant in Public Health**
Healthwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**
Update- implementing recommendations from the TB situational report	**The Board is asked to comment on the progress made**	Director of Public Health	**Consultant in Public Health Public Health Specialist**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Commissioning Director – Adults and Health CCG Chair	**Associate Consultant – Health & Social Care Integration Programme**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
17 September 2015			
JSNA refresh	**The Board is asked to approve the refresh of the JSNA**	Director of Public Health	**Consultant in Public Health Commissioning Lead, LBB**
Draft Health and Wellbeing Strategy refresh	**The Board is asked to comment on the draft Health and Well-Being Strategy**	Director of Public Health Commissioning Director – Adults and Health	**Consultant in Public Health Commissioning Lead – Health and Wellbeing, LBB**

Subject	Decision requested	Report Of	Contributing Officer(s)
CCG Commissioning Intentions 16/17	**The Board is asked to comment on the report.**	CCG Chair	**Director of Clinical Commissioning, CCG**
CCG Co-commissioning update	**The Board is asked to note the progress that has been made locally towards co-commissioning with NHS England**	CCG Chair	**Director of Clinical Commissioning, CCG**
Commissioning NHS 111 and Out-of-Hours Service	**The Board is asked to note the progress made to date and support the CCGs' proposed approach for the programme**	Director of Clinical Commissioning (CCG)	**BCCG GP Clinical Lead Commissioning Manager Head of Service Redesign**
Report on the Partnership Boards/ Health and Well-Being July Summit	**The Board is asked to comment on the report and take forward any delegated actions that arise out of the report**	Commissioning Director – Adults and Health	**Customer Care Service Manager, LBB Commissioning Lead – Health and Wellbeing, LBB Partnership Boards Officer, LBB**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	CCG Chair Commissioning Director – Adults and Health	**Associate Consultant – Health & Social Care Integration Programme**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
12 November 2015			
Health and Wellbeing Strategy (2015-20) including Public Health report on activity 2014/15	**The Board is asked to approve the Health and Well-Being Strategy**	Commissioning Director – Adults and Health	**Consultant in Public Health Commissioning Lead – Health and Wellbeing, LBB**
Primary Care Strategy	**The Board is asked to note the CCG progress to develop Primary Care services and pathways**	CCG Chair	**Director of Clinical Commissioning, CCG**

Subject	Decision requested	Report Of	Contributing Officer(s)
Procurement of sexual health services	**The Board is asked to note the specification and plans for the sexual health service procurement**	Director of Public Health	**Consultant in Public Health**
Director of Public Health's Annual Report	**The Board is asked to note the report**	Director of Public Health	**Consultant in Public Health**
Child and Adolescent Mental Health Services (CAMHs)	**The Board to review and comment on the proposal for Barnet's Child and Adolescent Mental Health services**	Commissioning Director – Children and Young People	**Head of Joint Children's Commissioning**
Opportunities to align the Public Health and Planning teams – progress report	**The Board is asked to note the progress that has been made locally to align the work of the public health and planning teams**	Director of Public Health	**Consultant in Public Health**
Services for people with learning disabilities	**The Board is asked to review commissioning plans for services for people with learning disabilities**	Commissioning Director – Adults and Health	**Head of Joint Commissioning**
Barnet Safeguarding Children Board annual report	**The Board to comment on the report.**	Barnet Safeguarding Children Board Chair	**Barnet Safeguarding Children Board Manager**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Integration Programme Board**	CCG Chair Commissioning Director – Adults and Health	**Associate Consultant – Health & Social Care Integration Programme**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
28 January 2016			
Healthwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**

Subject	Decision requested	Report Of	Contributing Officer(s)
Health visiting and integration of health services	**The Board is asked to comment on the progress made in developing the Boroughs health visiting and integration of health services.**	Commissioning Director – Children and Young People	**Head of Joint Children's Commissioning**
Barnet School Wellbeing Programme	**The Board is asked review progress to date and comment on future plans**	Director of Public Health	**Consultant in Public Health**
Winterbourne View – Assuring Transformation	**The Board is asked to note the contents of the paper, the progress made with regards to the Winterbourne View Concordat and the current position.**	Commissioning Director – Adults and Health	**Joint Commissioning Manager**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chair	**Associate Consultant – Health & Social Care Integration Programme**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
10 March 2016			
Stop Smoking Service and Tobacco Alliance update	**The Board is asked to review and comment on the report.**	Director of Public Health	**Consultant in Public Health**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chair	**Associate Consultant – Health & Social Care Integration Programme**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing, LBB**

Subject	Decision requested	Report Of	Contributing Officer(s)
Unallocated			
Public Health report on activity 2015/16	**The Board is asked to comment on the progress Public Health made in 2015/16**	Director of Public Health	**Consultant in Public Health**

Appendix 2 - Forward Work Programmes of Strategic Boards (August 2015 - May 2016)			
Calendar month	Strategic Board	Agenda Item	Nature of item (if known)
August			
27 August 2015	CCG Governing Body	Urgent items only	
September			
16 September 2015	Adults and Safeguarding Committee	Barnet Multi-Agency Safeguarding Adults Board Annual Report 2014/15	Committee to receive the Barnet Multi-Agency Safeguarding Adults Board Annual Report 2014/15
		Mental Health Community Model Full Business Case	Committee to receive the Mental Health Community Model Full Business Case
21 September 2015	Children, Education, Libraries & Safeguarding Committee	Library review	To approve the future shape of library provision in Barnet
		Child and Adolescent Mental Health Services	To approve a revised commission for CAMHS services
24 September	CCG Governing Body	Report to the Chair	
		Report of the Accountable Officer	
		Clinical Quality & Risk Report	
		Governing Body Assurance Framework	
		Update Report on Patient & Public Engagement/Patient Reference Group	
		Finance Report	
		Performance Exception Report	
		Referral to Treatment Update	
		Commissioning Intentions 2016/17	
		Ratification of Decision: Community Gynaecology Service	
October			
13 October 2015	Health Overview and Scrutiny Committee	Tuberculosis	Following the consideration of the Annual Report of the Director of Public Health, Committee have requested to receive a report on Tuberculosis.
		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.
		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. 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.
		Joint Strategic Needs Assessment (JSNA)	Committee to receive the Joint Strategic Needs Assessment (JSNA) following it being considered by the Health and Wellbeing Board.
November			
	Adults and Safeguarding	Report on Adult Social Care ADM project - consultation and early findings/SOC	Committee to receive a report on Adult Social Care ADM project, including consultation and early findings/SOC.

12 November 2015	Adults and Safeguarding Committee	Approach to Concerns Within the Regulated Care Market - Update Report	At their meeting on 8 June 2015, the Committee received a report on the London Borough of Barnet's approach to concerns with providers in the regulated care market. The Committee requested to be provided with an update report in six months' time.
18 November 2015	Children, Education, Libraries & Safeguarding Committee	Early years alternative delivery model	To consider options for the future delivery of early years services in Barnet.
		Education and Skills Alternative Delivery Model	Selection of partner for the creation of a joint venture to deliver education services in Barnet
December			
7 December 2015	Health Overview and Scrutiny Committee	Annual Report of the Director of Public Health	Committee to receive the Annual Report of the Director of Public Health.
January			
19 January 2016	Adults and Safeguarding Committee	Report on Adult Social Care ADM project Outline Business Case	Committee to receive a report on Adult Social Care ADM project OBC.
		Implementing the Care Act: Implementation of Carers Support	Committee to receive a report on implementing the Care Act: Implementation of Carers Support
May			
16 May 2016	Adults and Safeguarding Committee	NHS Trust Quality Report	Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16.
Unallocated item			
	Health Overview and Scrutiny Committee	Dehydration in Patients Admitted to Hospitals from Care Homes	
Unallocated item		Health and Welbeing Strategy	
Unallocated item	Children, Education, Libraries & Safeguarding Committee	Noam Conversion to Voluntary Aided Sector	
	Adults and Safeguarding Committee	Commissioning strategy for enablement	
		Home care commissioning - outcomes based approach	
		Commissioning strategy for supported living	
		Implementation of Better Care Fund: development of integrated locality teams	
Unallocated item		Care Act implementation: market sustainability and oversight	