MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 17TH SEPTEMBER, 2015

AT 9.00 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

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Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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Decisions of the Health & Wellbeing Board

30 July 2015

Board Members:-

AGENDA ITEM 1

*Cllr Helena Hart (Chairman)
*Dr Debbie Frost (Vice-Chairman)

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

* denotes Member Present

Substitute Members

*Councillor David Longstaff

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

The Chairman of the Health and Wellbeing Board, Councillor Helena Hart welcomed all attendants to the meeting. Board members were provided with a verbal update on the progress of actions from the previous Minutes of the HWBB on 4th June 2015.

RESOLVED that the minutes of the Health and Wellbeing Board meeting held on 4th June 2015 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from Paul Bennett (NHS England) Councillor Sachin Rajput who was substituted by Councillor David Longstaff.

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. DRAFT JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND EMERGING PRIORITIES FOR THE HEALTH AND WELLBEING STRATEGY (Agenda Item 6):

The Chairman welcomed the report on the draft Joint Strategic Needs Assessment (JSNA) and the emerging priorities as set out in the substantive Report and the appendices to the Report, stating that the successful production of the JSNA and – based on it – the HWBB Strategy were probably the two most important issues currently facing the Board.. The Chairman welcomed Luke Ward, Commissioning Lead Entrepreneurial Barnet, to the table.

The Board noted that producing a JSNA is a legal requirement under the Public Involvement in Health Act 2007. The Chairman thanked Luke Ward and Dr Andrew Howe for all their hard work in producing such a detailed, useful and readable document. The Chairman then went on to thank everyone else - officers and users alike across the Council, CCG and Community Barnet involved in contributing to the draft JSNA as well as the Partnership Boards at their Summit on the 9 July 2015. The Chairman stated that the balance between engagement and analysis had been a critical part of developing a JSNA that had credibility locally as an impartial, high quality, and up-to date evidence base for decision making. She again drew attention to the vital part that prevention and early intervention had to play in delivering better outcomes for Barnet's very large and varied population whilst also meeting the challenges of scarce public resources.

It was noted that the draft JSNA was presented to the Board for comment and that the final version of the JSNA will be reported to the Health and Wellbeing Board at its meeting in September.

Mr Ward briefed the Board about the draft JSNA document and the principles applied to guide the development of the new draft JSNA.

It was noted that a large number of stakeholders have informed the findings of the draft JSNA which is the evidence base for understanding population-level need in the borough.

The Director of Public Health (Harrow and Barnet) Dr Andrew Howe welcomed the new draft JSNA and noted the importance of this comprehensive document which will help to inform up-to-date evidence based decision-making particularly in light of financial challenges.

Mr Ward provided a summary of the key issues and needs emerging from each section of the draft JSNA as set out in Appendix 2 of the report. The Board heard that Barnet is now the largest Borough in London by population and that it is continuing to grow, particularly in light of the planned regeneration work.

It was noted that the population group over-65 is set to grow three times faster than the overall population during the period 2015-2030. Dr Debbie Frost, Chair of the Barnet Clinical Commissioning Group and Vice Chairman of the Health and Wellbeing Board, welcomed the draft JSNA and commended the collation of the material and information as set out in the appendices.

Dr Charlotte Benjamin (Barnet CCG) welcomed the report and noted the importance of developing a model of commissioning and delivery that focuses on longer-term prevention, early intervention and demand management through consideration of the views of residents and stakeholders. Dr Benjamin asked whether the homelessness figures in appendix 1 are correct.

Action: Luke Ward to review homelessness figures.

Michael Rich, Head of Healthwatch Barnet, also welcomed the JSNA and commended its quality. Mr Rich was positive about the inclusion of voluntary and community sector organisation mapping and stated that the resource can be used by organisations to target activity such as to reduce social isolation.

In relation to Chapter 8 of the draft JSNA, Dr Howe informed that the data for child poverty will need to be reviewed following the revision of national definition of child poverty.

It was noted that the findings of the new draft JSNA will inform the development of the new Health and Wellbeing Strategy. The draft of the Health and Wellbeing Strategy will be reported to the Board in September 2015 for approval for consultation. A public consultation will run from 17 September – 28 October 2015.

The Commissioning Director (Adults and Health) Dawn Wakeling introduced the topics and priorities currently being considered for the refreshed Health and Wellbeing Strategy as outlined in the report. Ms Wakeling noted the importance of considering the demand for mental health services across the borough and the need to support all carers, particularly young carers which are two priorities in the updated Strategy.

Following a query from the Board, Dr Andrew Howe noted that the JSNA website is being developed and will be completed by December 2015. The aim is for stakeholders to be able to use the public resource which will be an interactive and transparent tool. Mr Ward also noted that the website will be reviewed and updated as data becomes available.

The Chairman thanked Luke Ward for the presentation and commended all partners for their contribution to the development of the draft JSNA.

RESOLVED that:

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

7. DRAFT SUBSTANCE MISUSE STRATEGY (2015-2020) (Agenda Item 7):

Dr Wazirzada Khan was invited by the Chairman to join the table. The Chairman welcomed the report which sets out the key strategic priorities of the draft Substance Misuse Strategy 2015-2020.

The Board received a presentation from Dr Khan on the draft Substance Misuse Strategy 2015-2020. Dr Khan briefed the Board about the contracts in place to provide substance misuse services in the borough for the period from 1 October 2015 to 31 March 2018 with an option to extend for a further period of up to 2 years.

The Board heard that Barnet and Harrow joint Public Health service is responsible to provide substance misuse services in the borough. It was heard that the aim is to take a whole family approach with organisations working in partnership. Organisations will work together through a Strategy Implementation Group led by Public Health and comprised of representatives from stakeholder organisations, including Police, Fire and voluntary and community sector organisations, Licensing, Community Safety, Education and Primary and Secondary Care Services.

The Strategy implementation group will inform and commit to a detailed implementation plan which will be linked in to other existing strategies in Barnet.

In response to a query from the Board, Dr Howe noted that one of the strategic priorities of the draft Substance Misuse Strategy is the protection of Barnet residents and their families and carers including children and vulnerable adults from indirect harm caused by substance misuse.

Councillor David Longstaff noted the importance of working together with the Fire Brigade to mitigate risks of fires in homes of those misusing substances and work towards further identification of individuals at risk.

Dr Charlotte Benjamin noted the proposed action contained within the draft Substance Misuse Strategy to develop and expand drug and alcohol liaison in hospitals with the aim of encouraging joint working with hospital teams. Dr Benjamin welcomed this action stating that currently the liaison roles are quite isolated.

RESOLVED that:

1. **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. **The Health and Wellbeing Board notes the proposed actions for each strategic priority.**

3. **The Health and Wellbeing Board supports the proposal to set up a strategy implementation group.**

4. **The Health and Wellbeing Board approves the Substance Misuse Strategy as final.**

8. HEALTHWATCH BARNET UPDATE REPORT AND AUTISM SERVICES REPORT (Agenda Item 8):

4

The Chairman commended the Barnet Healthwatch Draft Year 2 report and the work carried out by Barnet Mind, Jewish Care and Advocacy in Barnet which captures the perspectives of service users. The Chairman stated that provision has improved in the Borough following Healthwatch Barnet's enter and views and provision has improved. The Vice Chairman agreed and also thanked Healthwatch Barnet for their continued work. The Chairman welcomed Ray Booth (Barnet Mencap) and Michael Rich (Healthwatch Barnet) to present the report.

Michael Rich provided a summary of the work carried out by Healthwatch Barnet over the past year and the continued partnership work with the local communities.

The Board noted the performance achieved on the contractual targets for Year 2 as set out in the appendix to the report. Furthermore, the Board noted that following the consultation exercise with community organisations through the Partnership Boards, a public meeting is scheduled to take place in September to consult with the public.

Mr Rich informed the Board about the 30 Enter and View visits undertaken by Barnet Healthwatch over the past year and noted that 87% of providers visited carried out at least one recommendation.

Following a query from the Board, Mr Rich explained that the intention is to continue to undertake joint visits to hospital wards. It was noted that the aim is to consult with A&E Managers to inform and plan for future Enter and Visit activities and A&E departments.

Ray Booth introduced the report exploring the experience of people with autism in Barnet (appendix 2). Mr Booth drew the Boards attentions to the findings of the report such as the recommendations for GPs to receive training; general training will be provided by Barnet Mencap.

RESOLVED that:

1. **The Health and Wellbeing Board notes this update report and the reports of Healthwatch and partner organisations and provides comments on their content.**

2. **The Health and Wellbeing Board considers and comments on the recommendations contained within the specific reports (Appendix 1 – 2).**

9. TUBERCULOSIS REPORT - UPDATE FROM TB SITUATIONAL REPORT (Agenda Item 9):

The Chairman welcomed the tuberculosis (TB) situational update report and invited Garrett Turbett to join the table. Mr Turbett presented the report which provides an update to TB rates in Barnet and the work undertaken in relation to the awareness raising campaign.

The Board received an update on the TB rates seen across the Borough with particular focus on areas of high incidence. Mr Turbett went on to explain that there is an opportunity for Barnet CCG to apply to NHS England for funding to develop a latent TB infection screening programme.

The Commissioning Director (Children and Young People) Chris Munday, asked if young people would be able to access the screening programme. Mr Turbett stated that the programme is aimed at people aged 16 – 34 but this is at the GP's discretion.

The Board noted the importance of working towards dispelling the myth about TB and ensuring that all members of the community are aware of their rights to access health services. Dr Charlotte Benjamin commented about the risk of the pathway being confusing for patients and professionals.

RESOLVED that:

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.**

10. MINUTES OF THE HEALTH AND WELL-BEING FINANCIAL PLANNING GROUP (Agenda Item 10):

The Chairman introduced the item which sets out the minutes of the Health and Wellbeing Finance Planning group.

RESOLVED that:

1. **The Health and Well-Being Board notes the minutes of the Financial Planning Sub-Group meeting of 12 June 2015 and 13 July 2015.**

11. FORWARD WORK PROGRAMME (Agenda Item 11):

The Board noted the Forward Work Programme which is a standing item on the agenda.

RESOLVED:

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. **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).**

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12. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 12):

None.

The meeting finished at 11.55 am

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AGENDA ITEM 7

	Health and Wellbeing Board **17 September 2015**
Title	**Joint Strategic Needs Assessment 2015-2020**
Report of	Director of Public Health
Wards	All
Date added to Forward Plan	March 2015
Status	Public
Enclosures	Appendix 1: Barnet's JSNA 2015-2020 Appendix 2: JSNA Executive Summary
Officer Contact Details	Luke Ward, Commissioning Lead, Entrepreneurial Barnet, Email: luke.ward@barnet.gov.uk, Tel: 020 8359 2672

Summary

At its meeting on 30 July 2015 the Health and Wellbeing Board considered and commented on a draft of Barnet's refreshed Joint Strategic Needs Assessment (JSNA) 2015-2020. This report presents the final JSNA 2015-2020 (Appendix 1), incorporating comments provided by the Board then, along with an associated executive summary (Appendix 2). Should it be approved the JSNA will be published on the websites of Health and Wellbeing Board partners.

Recommendations

1. **That the Health and Wellbeing Board approves Barnet's Joint Strategic Needs Assessment 2015-2020.**
2. **That the Health and Wellbeing Board comments on the wider approach being taken to maintaining and embedding the JSNA in Barnet, in particular the JSNA website which is being developed jointly by Barnet CCG and LB Barnet.**

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

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

1.3 Using and maintaining the Barnet JSNA

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

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

1. Focuses on **demand management, prevention and early intervention**
2. **Uses existing data only, with no primary data collection.** Where data we want in the JSNA does not exist or is not accessible this has been logged to be followed up or commissioned at a later date if required.
3. In addition to identifying need over the next 3-5 years, **looking ahead 20-30 years to identify longer-term trends and needs** that will have implications for public sector decision making.
4. Aligns with and **support existing and more specific service-level needs assessments e.g. for mental health**
5. Is **a dynamic way of working, not a static document** e.g. via a new JSNA “micro-site” which will be updated and refreshed on an ongoing basis.
6. **Provides non-political, impartial analysis** with no recommendations about priorities (which is the function of the Health and Well Being Strategy), only identification of need and differential outcomes.

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

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

1.4 **Methodology**

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

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

1.5 **Contents of the JSNA**

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

1. Demography
2. Socio-economic and environmental context
3. Barnet population segments

4. Health
5. Lifestyle
6. Primary and secondary care
7. Children and young people
8. Adult social care
9. Community safety
10. Community assets
11. Residents voice
12. Public sector finances

2. REASONS FOR RECOMMENDATIONS

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

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not producing a JSNA is not an option as it is a legal requirement of the Health and Wellbeing Board and not having one would create a risk of non-alignment across the local system. This 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 and maintain 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.

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

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

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

5.3 **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 Well Being Board, at its meeting on 13 November 2014, recommended that work commence on developing a JSNA to inform the Health and Well Being 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 unnecessary 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 covering the key areas of activity in all these organisations.

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

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

Barnet's Joint Strategic Needs Assessment

2015-2020

CONTENTS

Barnet's JSNA 2015 – 2020

Executive Summary

Structure

1. Demography

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases more in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by natural change in the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% BAME backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a BAME background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less than the average for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth 78.8 years.**
- The west of the Borough has the highest concentration of more deprived LSOAs, with **the highest levels of deprivation in Colindale, West Hendon**

and Burnt Oak. However, the **most deprived LSOA in Barnet is located in East Finchley, specifically the Strawberry Vale estate**, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst both men and women. **As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Some areas, particularly Golders Green, Colindale and Mill Hill, will get younger, bucking the trend of an ageing Borough.

2. Socio-Economic and Environmental Context

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently, the significant majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established community and family networks locally.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.

- **There are shortages of people available to fill vacancies in the caring, leisure and services sector, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.
- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

3: Health

- 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 an 8 year difference in male life expectancy between Burnt Oak and Garden Suburb wards.** Bigger differences exist at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Smoking, diet and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is the case.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **Women in Barnet are significantly less likely to quit smoking in pregnancy** than women on average in London.
- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later**

in life. Particularly HPV, flu and pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.

- **Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate** and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

4: Lifestyle

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost to the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill, and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England,** and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.
- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy**, and **good parenting classes**.

5: Primary and Secondary Care

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in such hospital.
- **There is increasing demand for urgent and emergency care,** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **The 95% national target for Accident and Emergency (A&E) patients waiting no longer than four hours from the time of booking in to either admission to hospital or discharge** was missed in quarter 4 14/15 (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- **Obesity growth in middle-age population** (45-65) year olds places additional risk of them developing long-term conditions.

6: Children and Young People

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and minimise referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably west);** targeted multi-agency, locality based interventions could better support families.
- **The Young Carers Act and Children and Families Act 2014** represent significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**

- The number of post-16 pupils remaining in special schools is placing **pressure on the availability of places for admission of younger pupils.**
- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing.** However, there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years and 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.
- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 14/15, averaging 5 or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

7: Adult Social Care

- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- **Mental disorder** is responsible for the **largest burden of disease in England** – 23% of the total burden. Within Barnet, by far the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently** and **within the community** as possible. This places significant pressure on ensuring that the right services such as **appropriate housing and support needs** are available to **meet their requirements**.
- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, local based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in

elderly women who live alone, especially in **areas of higher affluence and lower population density.**

- **Demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people, 3.3% of the 65 and over population**, which indicates a **deficiency or potential unmet need of around 800 people.**
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average **carers are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.
- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021, the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

8: Community Safety

- **Barnet has the 5th highest rate of Residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to Feb 2014. When considering underreporting the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the 12 months.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to address possible underreporting.
- **Despite constituting just 6.5% of offences, violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs.**
- **Domestic violence is more familiar and bedded down within some services and organisations than other Violence Against Women and**

Girls (VAWG) issues; further work needs to take place to identify if additional VAWG services are needed within the Borough.

9: Community Assets

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with VCS groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is, however, the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).
- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. However, there **is weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- More generally, there are opportunities to:
  - **support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).
  - **rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**

- respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be better engaged with to deliver health and wellbeing outcomes.

10: Resident Voice

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and** '**Repair of roads' as being poor or extremely poor services** provided by the council.
- The **top three concerns** for residents according to the spring 2015 Residents' Perception Survey were '**Conditions of roads and pavements (38%); Lack of affordable housing (33%); and Crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live, whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

1 Introduction

1.1 What is the JSNA?

This refreshed Joint Strategic Needs Assessment (JSNA) is the evidence base for understanding population-level need in Barnet. It has been designed to inform joined up decision making and commissioning by the Barnet Health and Wellbeing Board, Barnet CCG, social care, public health, the wider public and voluntary sectors, and private sector service providers.

The intention is that by having a shared understanding of the size and nature of Barnet's residents in one place that focuses on 1) the needs of the population, irrespective of organisational or service boundaries, 2) areas of common interest and 3) reducing demand for public resources, the JSNA will act as a tool to help partners come together to share expertise and resources to improve the prospects of people living here. It will also ensure that every penny of public money is used as efficiently as possible and with maximum positive impact.

A large number of officers, analysts and service users have been involved with developing the refreshed JSNA across the CCG, the Council and CommUNITY Barnet between January 2015 and July 2015, requiring a significant focus on partner engagement, communications and expectations setting, alongside high quality multi-disciplinary analytical work to actually write the JSNA documentation.

This balance between engagement at a senior level and analysis has been a critical part of developing a successful JSNA because it has:

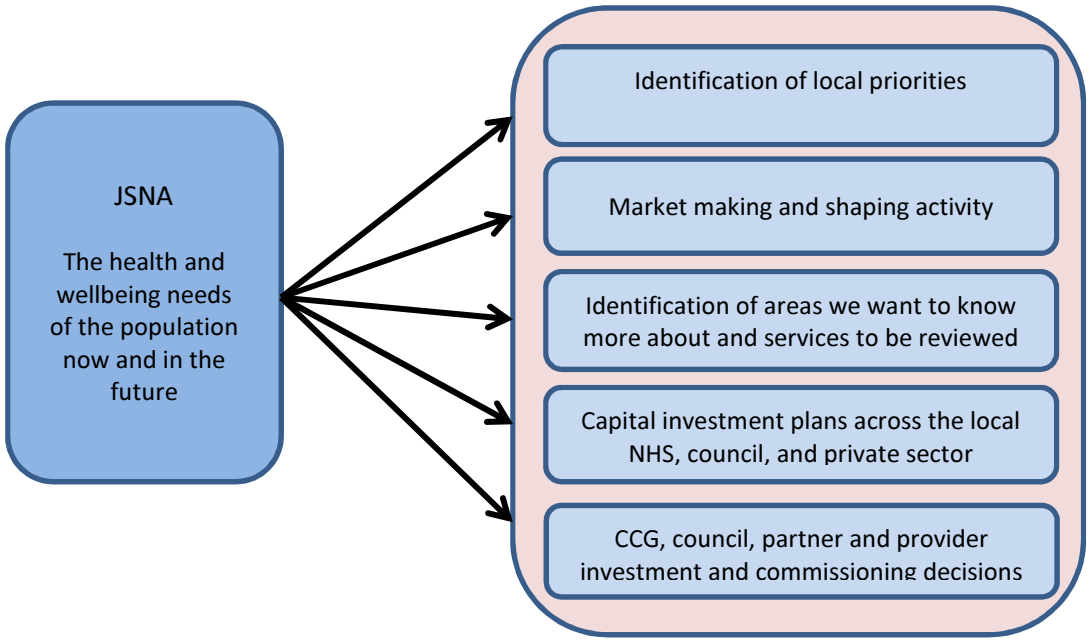
1. allowed the JSNA team to tailor the content to reflect what local partners want, value, and consider important
2. resulted in a JSNA that has credibility locally as an impartial, high quality, and up-to date evidence base for effective and joined up decision making across all sectors.

1.2 Purpose of the JSNA

The purpose of a JSNA is to allow local partners to improve the health and wellbeing of the population and to reduce inequalities for all groups, leading to reduced demand for public services and better lives for people who live in Barnet. It does this by acting as a common, shared evidence base across partners in the Health and Well Being Board and wider public services, enabling alignment of activity and resources around common issues and needs.

There is an opportunity in the JSNA to use it to ensure that public services more broadly are supporting the wellbeing of the population in a more joined up way. For example, to ensure that sports centres, parks and open spaces, employability and apprenticeship schemes, and use of community assets are explicitly targeting their services at those groups in the population who stand to benefit most from using them.

Figure 1: How to use the JSNA



1.3 Principles

It is important that the JSNA does more than just describe statistics and information relating to the Borough's population. To add real value it is important that it aligns with and informs the big strategy decisions that need to be made across the public sector, including health and social care, over the next five years. With this in mind **the following principles have been developed to guide the development of the JSNA**.

This Barnet JSNA will:

1. **Focus on prevention, early intervention and demand management:** Delivering better outcomes for individuals and communities whilst also meeting the challenges of scarce public resources means that it is more important than ever to encourage and support all residents to live longer, healthier, happier lives that are free of long-term conditions and illness. With that in mind, every section of this JSNA is based around understanding the root drivers of need for different services and providing commissioners across the public sector with the intelligence and insight they need to address them and to reduce long term demand for things like hospital beds, social care, and mental health services.
2. **Identify shared agendas across public services:** The nature of JSNA as a joint evidence base means that the issues it focuses on should be cross-cutting "shared" agendas by definition. For example, mental health, carers, and long-term conditions. Crucially though, it also includes any early intervention opportunities that evidence shows can reduce the probability of an individual developing higher needs later on in life such as child immunisations and promoting good dental health in children, good parenting classes, quality housing, improving the effectiveness of smoking cessation activity, and promoting healthy lifestyles. The JSNA supports different agencies to

identify the links between different service areas, keeping the person at the centre of care irrespective of who is providing it.

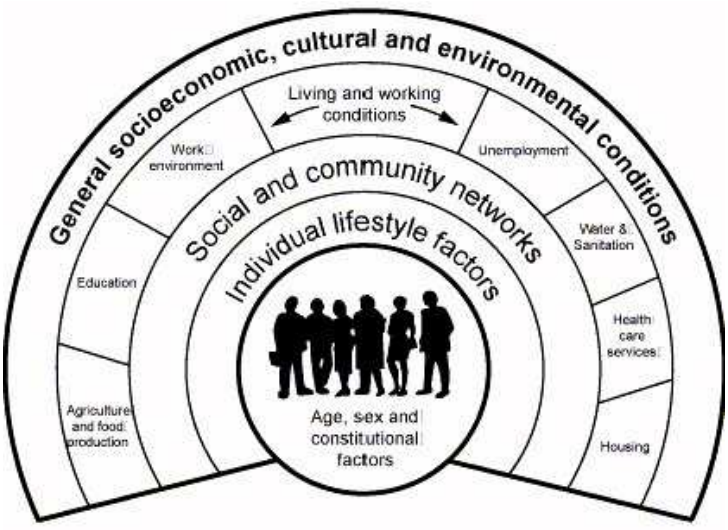
3. **Use existing data only:** There has been no primary data collection associated with this JSNA, which only includes insight and analysis that already exists in the Public Sector. This reflects the fact that analyst time is increasingly valuable and scarce, but also the huge amount of information that already exists in the Barnet public sector and which could be used more effectively to inform decision making than has always been the case in the past.
4. **Look ahead up to 20 years:** As well as looking at the more current needs of the population over the next 3-5 years, this JSNA adopts a more strategic time horizon of up to 20 years, enabling a longer term approach to prevention, early intervention and demand management than has always been the case in the past. This approach is prudent given the long-term increase in population level demand and continued constraints on resources that we know will be a feature of strategy and decision making for the foreseeable future.
5. **Support and align with existing service-level needs assessments:** The JSNA draws on the significant amount of high quality needs assessment that has already been undertaken by the Council and the CCG, for example relating to mental health, special educational needs (SEN) and parks and green spaces. What the JSNA does is contextualise these and draw connections between them at a more strategic level, as well as makes their findings available to a wider audience of commissioners, members, and strategic decision makers.
6. **Be a way of working, not a document or product:** The JSNA will be updated as required over the coming years. In particular, the new Barnet JSNA micro-site will be updated with current analysis as soon as it is available and interpreted for commissioning purposes. This will reduce the risk of the JSNA losing its usefulness as the data within it becomes increasingly out of date.

1.4 Theoretical underpinnings

The focus on prevention, early intervention and demand management embedded across the JSNA requires a broad view of health and wellbeing that accounts for the wider socio-economic factors affecting the health and happiness of individuals and communities now and in the future.

This JSNA uses Dahlgren and Whitehead's Model of Health and Well Being as its theoretical basis, and incorporates not only the important lifestyle and health behaviours of the population, but also wider issues such as employment, volunteering, crime, and housing because all the evidence tells us that these issues are important to engage with if we want to improve health and wellbeing for the population and reduce demand for scarce public resources:

Figure 1: *Dahlgren and Whitehead's model of the wider determinants of health*



1.5 Structure of the JSNA

The JSNA consists of a written document and an interactive, constantly updated website that has been designed to be accessible and useful to residents, elected members, commissioners, and providers. The written JSNA consists of the following sections, with connections made between them in the analysis where relevant:

1. Demography
2. Socio-economic and environmental context
3. Barnet Customer Segments
4. Health of the population
5. Lifestyle
6. Primary and Secondary Care
7. Children and Young People
8. Adult Social Care
9. Community Safety
10. Community Assets
11. Resident voice
12. Public Sector Finance

1.6 Who should use the JSNA?

The JSNA is a public, published document and is available to anyone who wants to understand the local population and its associated needs and trends. There are a number of specific groups who will either need or want to use the JSNA to inform priority setting and strategic commissioning, or to shape the targeting and delivery of front-line services at the areas of highest population need:

- Barnet Health and Well Being Board members
- Elected members
- NHS Clinical Cabinet Board members
- Senior officers
- commissioners
- Providers who want to develop services to be commissioned by the Barnet public sector
- Strategic planners who want to understand and plan for future demand pressures
- Voluntary and Community Sector organisations

1.7 Methodology

The JSNA contains a wide range of data from national and local sources, and where possible this has been benchmarked against other areas and put into time series so that the major trends in Barnet can be understood over time and compared.

The JSNA was developed in four distinct phases:

1. *SCOPING (January-February 2015)*
2. *DATA COLLECTION (February – March 2015)*
3. *ANALYSIS, DRAFTING, VALIDATION, TESTING INTERNALLY (April – June 2015)*
4. *BOARD AND PARTNER ENGAGEMENT AND FINALISATION (July – September 2015)*

1.8 Alignment and Strategic fit

From the outset the JSNA has been designed to support and inform the wider strategic agendas of the Barnet public sector, in particular:

- Barnet's Health and Well Being Strategy
- Barnet CCG's Operational Plan
- Barnet Council Corporate Plan 2015-2020
- Service planning and management agreements across Barnet CCG and Barnet Council
- More holistic, cross-boundary "place-based" commissioning
- A strategic shift to long-term prevention and early intervention across the Barnet public sector
- Acts as the Borough's Child Poverty Needs Assessment
- Development of a wider "ecosystem" approach to developing the Barnet supply chain, in particular making greater use of the large network of established voluntary and community groups in the Borough to deliver improved health and wellbeing outcomes for people in Barnet.

1.9 Caveats

Whilst every effort has been made to ensure that the Barnet JSNA is as accurate and up to date as possible, having undergone an extensive process of validation and proofing with contributors, it remains important to note a number of caveats:

- The project team and contributors have tried hard to ensure high data quality throughout, but where errors or inaccuracies are identified they will be logged and corrected.
- Where there are gaps between what we want to know and what data/insight we have this has been highlighted in section 1.10 below so that work can be commissioned to fill them if identified as a priority by commissioners and decision makers.
- The JSNA is by its nature a broad piece of work; however it can't be everything to all people. It should align with and complement more detailed service-level needs assessments produced by individual service areas across the public sector, but does not replace them because the level of detail they contain will in some cases be more appropriate for detailed service-level planning than the JSNA.

1.10 Further Research

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

- Understanding the specific impacts of reduced home ownership on the long-term financial viability of social care.
- More work is needed to determine the prevalence and needs of young carers within the Borough.
- Further research is needed to understand why Barnet has a significantly higher rate of mental health admissions to hospitals for young people than the national average.
- More work is needed to better understand which areas in the community might be disproportionately affected by Violence Against Women and Girls (VAWG) issues, to establish if there a need for any additional VAWG services within the Borough.
- Understanding the drivers behind the growing income inequality between different wards in the Borough.
- Further research is needed to model the future demand pressures in Barnet associated with increases in the incidence of dementia.
- Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand what is driving this.
- Additional research is needed to develop a better understanding of the level and type of needs of people with learning disabilities and autism.
- More research is needed to understand why there are significantly fewer men aged 65 and over using Adult Social Care services than women.

- Additional work is needed to understand and quantify the impact that different services and support has on a carer's ability to perform their role, achieve their outcomes, and impact their overall health and wellbeing.
- Further research is needed to understand the impacts of educational outcomes for those with learning disabilities on their long-term health and wellbeing outcomes.

2 Demography

2.1 Key Facts

- The most recent population projections indicate that the population of Barnet will be 367,265 by the end of 2015.
- The overall population of Barnet will increase by 13.7% between 2015 and 2030, taking the population to 417,573.
- The number of people aged 65 and over is projected to increase by 34.5% by 2030, over three times greater than other age groups.
- The Barnet population is projected to become increasingly diverse, with the Black, Asian and Minority Ethnic population projected to increase from 38.7 to 43.6% of the total Barnet population.
- By religion, Christianity is the largest religion in Barnet accounting for 41.2% of the total population. The next most common religions are Judaism (15.2%) and Islam (10.3%).
- Barnet is an attractive place for international migrants, with the GLA estimating a net international net migration into Barnet of almost 50,000 over the period 2002 – 2013.

2.2 Strategic Needs

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by growth within the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% Black, Asian and Minority Ethnic backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a Black, Asian and Minority background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth of 78.8 years. For the slightly different measure of life expectancy from 65 years old, Coppetts has the lowest life expectancy of 18.0 years, which equates to 83 years old**.
- The west of the Borough has the highest concentration of more deprived Lowest Super Output Areas (LSOAs)[1], with **the highest levels of deprivation in Colindale, West Hendon**

[1] A Lower Layer Super Output Area (LSOA) is a GEOGRAPHIC AREA. Lower Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

and Burnt Oak. However, the **most deprived LSOA in Barnet is located in East Finchley, specifically the Strawberry Vale estate**, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst men and women. **As male life expectancy continues to converge with women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Driven by regeneration within the Borough, some areas will get younger, bucking the trend of an ageing, different health and wellbeing needs.

2.3 Population Structure

The 2013 round of GLA ward level projections, estimated the population of Barnet to be 367,265 by the end of 2015, making it the most populous Borough within London.

Table 2-1 shows the annual population growth within Barnet since the 2001 Census. The population of Barnet has grown by 14.9% (47,765).

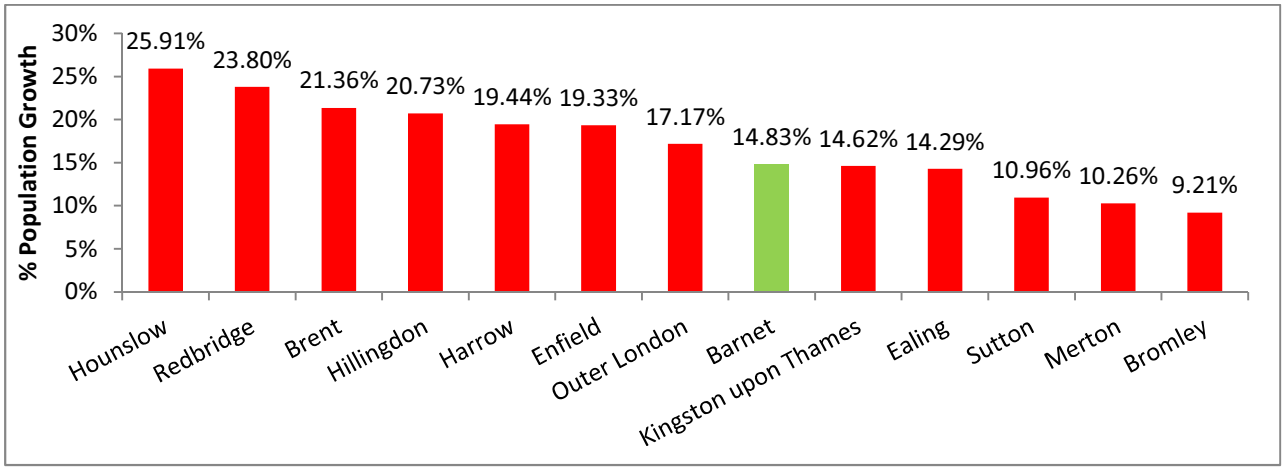
Table 2-1: Barnet Population Growth, 2001 – 2015

Year	Total Population
2001	319,500
2002	320,500
2003	321,800
2004	323,700
2005	327,500
2006	330,800
2007	334,900
2008	339,200
2009	345,800
2010	351,500
2011	357,500
2012	363,958
2013	361,504
2014	364,481
2015	367,265

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

Figure 2-1 shows the population growth for Barnet, compared against statistical neighbours – outlined in the chart - and the Outer London average. Barnet experienced a slower rate of growth compared to the Outer London average which grew by 17.17% between 2001 and 2015. When compared against statistical neighbours, Barnet had the sixth lowest rate of growth, whereas Hounslow had the highest growth of 19.6%.

Figure 2-1: Population Growth, 2001 – 2015 (Barnet, Statistical Neighbours, and Regional)



Source: Census 2001 and GLA Projections 2013 (Preferred Option Projections)

2.4 Population Growth

Table 2-2 shows the 2013 based population projections from the GLA. These projections provide an indication of the future size of the Barnet population, if current trends in fertility, mortality and migration continue.

The projections suggest that between 2015 and 2021, the population of Barnet will continue to grow by 6.6% reaching 391,472[2], an increase of 24,207 people. This is close to the same growth as Outer London, which is projected to see experience a rise of 6.4% in the population. Between 2021 and 2030 the rate of growth will begin to slow, although the population will continue to rise by a further 6.7% to 417,753.

[2] Projections used within this report are taken from the 2013 GLA Borough Preferred Option Projections. These are based on Barnet's actual future development plans that have been provided by LBB to the GLA. The GLA produces a variety of different projections, additional information on these can be found here https://londondatastore-upload.s3.amazonaws.com/jYs%3Dtechnical-note-guide-gla-popproj-variants.pdf

Table 2-2: Population Projections 2015, 2021 & 2030 (Barnet and Outer London)

Year	Barnet		Outer London	
	Total Population	% Growth (Compared to 2015)	Total Population	% Growth (Compared to 2015)
2015	367,265		5,236,869	
2016	369,887	0.7%	5,303,352	1.3%
2017	373,680	1.7%	5,368,535	2.5%
2018	377,316	2.7%	5,421,057	3.5%
2019	382,508	4.2%	5,472,589	4.5%
2020	386,752	5.3%	5,523,280	5.5%
2021	391,472	6.6%	5,573,017	6.4%
2022	394,769	7.5%	5,621,245	7.3%
2023	399,599	8.8%	5,668,045	8.2%
2024	402,814	9.7%	5,713,235	9.1%
2025	406,341	10.6%	5,756,814	9.9%
2026	409,063	11.4%	5,798,827	10.7%
2027	410,596	11.8%	5,839,289	11.5%
2028	412,959	12.4%	5,878,703	12.3%
2029	414,798	12.9%	5,917,139	13.0%
2030	417,573	13.7%	5,954,635	13.7%

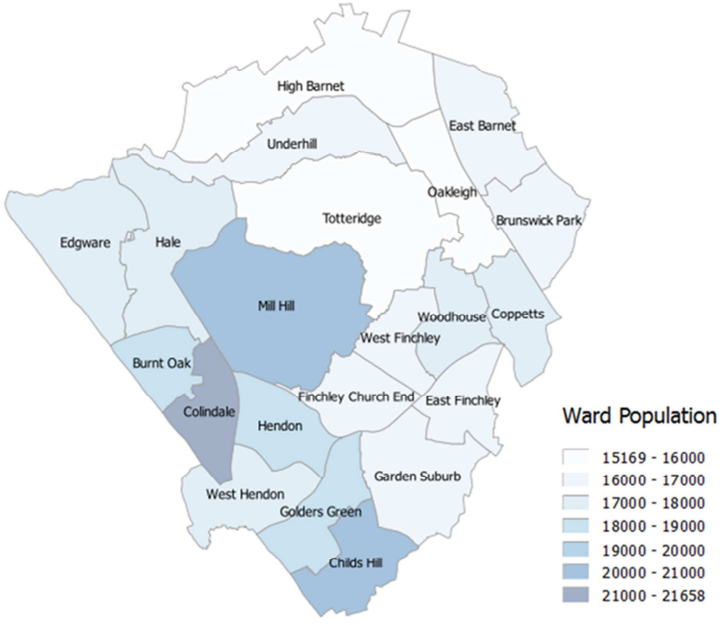
Source: GLA 2013 Projections (Preferred Option Projections)

2.5 Population by Wards

The GLA projections also provide an indication of the population by Ward. In 2015, Colindale was the most populous Ward within the Borough, containing 5.9% (21,658) of the total population. Totteridge is the least populous ward, containing 4.1% of Barnet's total population (15,169).

Figure 2-2: Barnet Population by Ward in 2015

Ward Name	Total Population	% of Population
Brunswick Park	16,402	4.5%
Burnt Oak	18,090	4.9%
Childs Hill	20,695	5.6%
Colindale	21,658	5.9%
Coppetts	17,236	4.7%
East Barnet	16,173	4.4%
East Finchley	16,285	4.4%
Edgware	17,927	4.9%
Finchley Church End	16,015	4.4%
Garden Suburb	16,078	4.4%
Golders Green	18,979	5.2%
Hale	17,353	4.7%
Hendon	18,886	5.1%
High Barnet	15,367	4.2%
Mill Hill	20,187	5.5%
Oakleigh	15,774	4.3%
Totteridge	15,169	4.1%
Underhill	16,153	4.4%
West Finchley	16,959	4.6%
West Hendon	17,961	4.9%
Woodhouse	17,919	4.9%

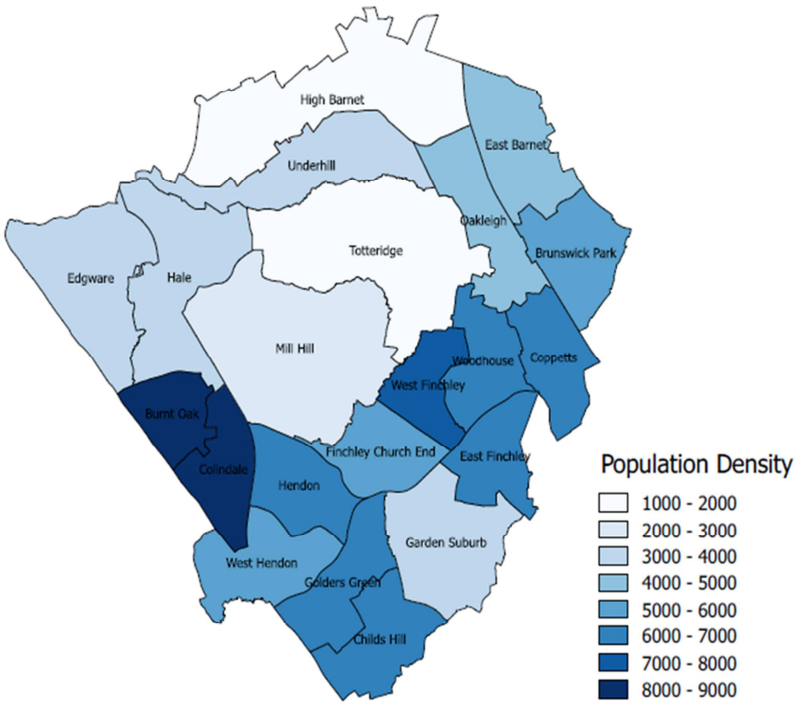


Source: GLA Projections 2013 (Preferred Option Projections)

There is a significant difference in the size of wards within Barnet. Therefore, it is beneficial to view the population density of each ward as this takes into account the population size by area. In 2015, Burnt Oak was the most densely populated ward, with 8,774 residents per square km; whereas, Totteridge was the least densely populated ward with 1,733 residents per square km**.**

Figure 2-3: Barnet Population Density by Ward in 2015

Ward Name	Population by Km²
Brunswick Park	5,179
Burnt Oak	8,774
Childs Hill	6,708
Colindale	8,237
Coppetts	6,352
East Barnet	4,325
East Finchley	6,506
Edgware	3,235
Finchley Church End	5,891
Garden Suburb	3,410
Golders Green	6,401
Hale	3,208
Hendon	6,671
High Barnet	1,855
Mill Hill	2,156
Oakleigh	4,766
Totteridge	1,733
Underhill	3,559
West Finchley	7,860
West Hendon	5,252
Woodhouse	6,854



Source: GLA Projections 2013 (Preferred Option Projections)

Since 2001 Census the population of all Barnet's Wards have increased, with the highest increase in population numbers experienced in Colindale and Mill Hill; which grew by 7,801 and 4,819 respectively. Underhill increased by only 425 people making it the Ward which had the smallest population increase. Colindale and Underhill also experienced the highest and lowest respective percentage population increases (56.3% and 2.7%).

Table 2-3: Population Growth by Ward, 2001-2015

Area name	2001	2015	Change	% Change
Brunswick Park	14,644	16,402	1,758	12.0%
Burnt Oak	15,242	18,090	2,848	18.7%
Childs Hill	17,263	20,695	3,432	19.9%
Colindale	13,857	21,658	7,801	56.3%
Coppetts	14,500	17,236	2,736	18.9%
East Barnet	15,339	16,173	834	5.4%
East Finchley	14,522	16,285	1,763	12.1%
Edgware	14,823	17,927	3,104	20.9%
Finchley Church End	13,804	16,015	2,211	16.0%
Garden Suburb	14,706	16,078	1,372	9.3%
Golders Green	16,272	18,979	2,707	16.6%
Hale	15,661	17,353	1,692	10.8%
Hendon	15,371	18,886	3,515	22.9%
High Barnet	13,846	15,367	1,521	11.0%
Mill Hill	15,368	20,187	4,819	31.4%
Oakleigh	14,739	15,774	1,035	7.0%
Totteridge	14,445	15,169	724	5.0%
Underhill	15,728	16,153	425	2.7%
West Finchley	14,260	16,959	2,699	18.9%
West Hendon	14,593	17,961	3,368	23.1%
Woodhouse	15,544	17,919	2,375	15.3%

Source: 2001 Census and GLA Projections 2013 (Preferred Option Projections)

2.6 Population Projections by Ward

Table 2-4 provides a breakdown of the projected population growth by Ward, for the period 2015 – 2021 and 2015 – 2030.

- Colindale is projected to rise by a further 79.4% (17,917) during the period 2015-2030, whereas Mill Hill will grow by 24.1% (4,875).
- Golders Green is projected to experience the highest rate of growth (113.9%, an additional 21,625 people).
- Not all Wards are projected to increase in population size over this period with the largest proportional decreases projected in Coppetts (-3.1%, a reduction in 541 people) and Hale (-2.3%, a reduction in 402 people).

Table 2-4: Population Growth by Ward 2015, 2021 & 2030

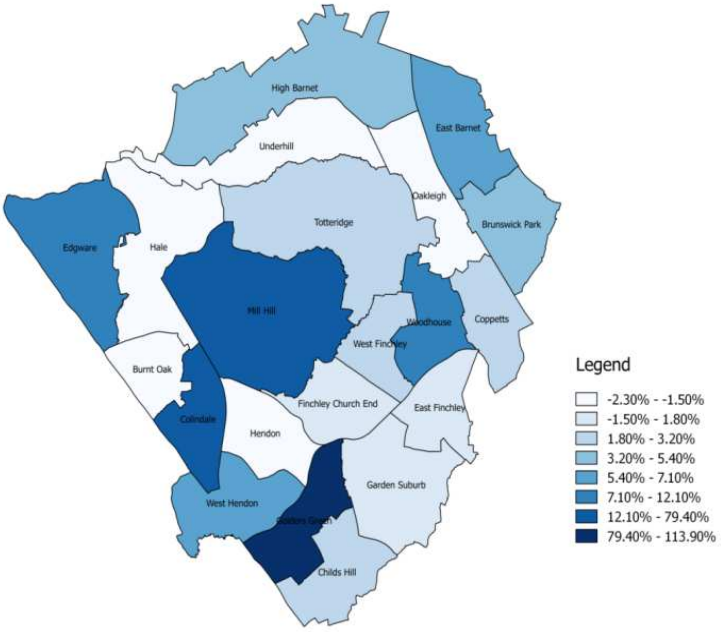
Area name	2015	2021	Change	% Change 2015-2021	2030	Change	% Change 2015-2030
Brunswick Park Ward	16,402	17,093	691	4.2%	17,093	691	4.2%
Burnt Oak Ward	18,090	18,238	148	0.8%	17,814	-276	-1.5%
Childs Hill Ward	20,695	21,251	556	2.7%	21,351	656	3.2%
Colindale Ward	21,658	32,895	11,237	51.9%	38,855	17,197	79.4%
Coppetts Ward	17,236	17,061	-175	-1.0%	16,695	-541	-3.1%
East Barnet Ward	16,173	16,443	270	1.7%	17,238	1,065	6.6%
East Finchley Ward	16,285	16,256	-29	-0.2%	15,985	-300	-1.8%
Edgware Ward	17,927	19,431	1,504	8.4%	20,098	2,171	12.1%
Finchley Church End Ward	16,015	16,273	258	1.6%	16,207	192	1.2%
Garden Suburb Ward	16,078	16,099	21	0.1%	15,974	-104	-0.6%
Golders Green Ward	18,979	24,841	5,862	30.9%	40,605	21,626	113.9%
Hale Ward	17,353	17,245	-108	-0.6%	16,951	-402	-2.3%
Hendon Ward	18,886	18,751	-135	-0.7%	18,483	-403	-2.1%
High Barnet Ward	15,367	15,482	115	0.7%	16,199	832	5.4%
Mill Hill Ward	20,187	22,551	2,364	11.7%	25,062	4,875	24.1%
Oakleigh Ward	15,774	15,682	-92	-0.6%	15,466	-308	-2.0%
Totteridge Ward	15,169	15,750	581	3.8%	15,590	421	2.8%
Underhill Ward	16,153	16,064	-89	-0.6%	15,902	-251	-1.6%
West Finchley Ward	16,959	17,523	564	3.3%	17,358	399	2.4%
West Hendon Ward	17,961	18,247	286	1.6%	19,245	1,284	7.1%
Woodhouse Ward	17,919	18,296	377	2.1%	19,402	1,483	8.3%

Source: GLA Projections 2013 (Preferred Option Projections)

One of the major driving forces of growth in the west of the Borough is the planned development taking place, with the Wards with the greatest projected increases in population, directly correlating with the planned regeneration localities of Colindale and Brent Cross Cricklewood (as shown in Figure 2-4 and 2-5).

Figure 2-4 : Planned Regeneration Works

Figure 2-5: Barnet Population Growth by Ward 2015-2030



Source: GLA Projections 2013 (Preferred Option Projections)

2.7 Age and Gender Structure

This section of the report looks at the population of Barnet by age and gender. Ages are broken up by broad age categories (0-15, 16-64 and 65+); and by five year age bands.

The overall Barnet distribution by age group is displayed is shown in Table 2-5 below. When viewed by broad age band, Barnet has a similar population profile to Outer London. Whereas, when compared to the United Kingdom, Barnet and Outer London have a higher rate of people within the 0-15 category and a lower proportion of people in the 65 and over category. The differences in these age structures is further emphasised when broken down by five year age band, as shown in Table 2-5.

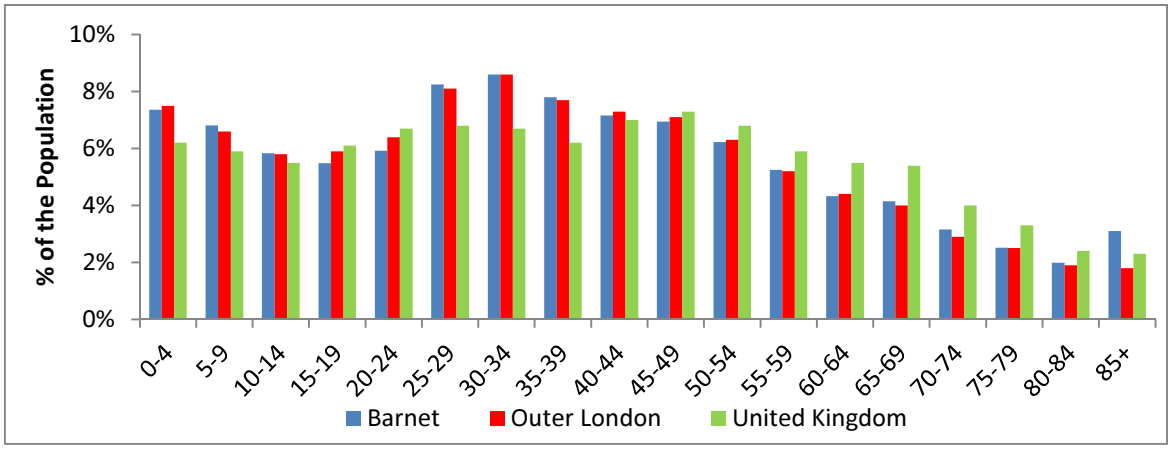
Table 2-5: Population 2015, by Broad Age Group (Barnet, Regional and National)

Age	All Persons		Outer London		United Kingdom	
	No. of People	% of People	No. of People	% of People	No. of People	% of People
0 - 15	77,789	21.2%	1,075,500	21.2%	12,058,700	18.8%
16 - 64	237,901	64.8%	3,340,500	65.7%	40,915,200	63.8%
65 and over	51,575	14.0%	665,100	13.1%	11,131,800	17.4%
Total	367,265	100.0%	5,081,100	100.0%	64,105,700	100.0%

Source: GLA 2013 Projections (Preferred Option Projections) (Barnet and Outer London) and ONS Mid-year Projections 2012 (UK)

- Within Barnet and Outer London, the largest proportion of the population is within the 30-34 and the 25-29 age groups. Whereas, within the UK as a whole, 45-49 and 50-54 are the largest age bands in terms of population size.
- Barnet has a higher proportion of people aged 85 and over (3.1%) compared to Outer London (1.8%) and the UK (2.3%). This is reflective of high life expectancy within the Borough.
- Although, data from the 2011 Census indicates that as a whole, Barnet has a younger population than the average for England as a whole. The average age of people living within Barnet is 36.8, compared to 39.3 for England. This is represented within the age groups, as 40.6% of the UK population is aged between 45 and 84, compared to 34.6% in Barnet.

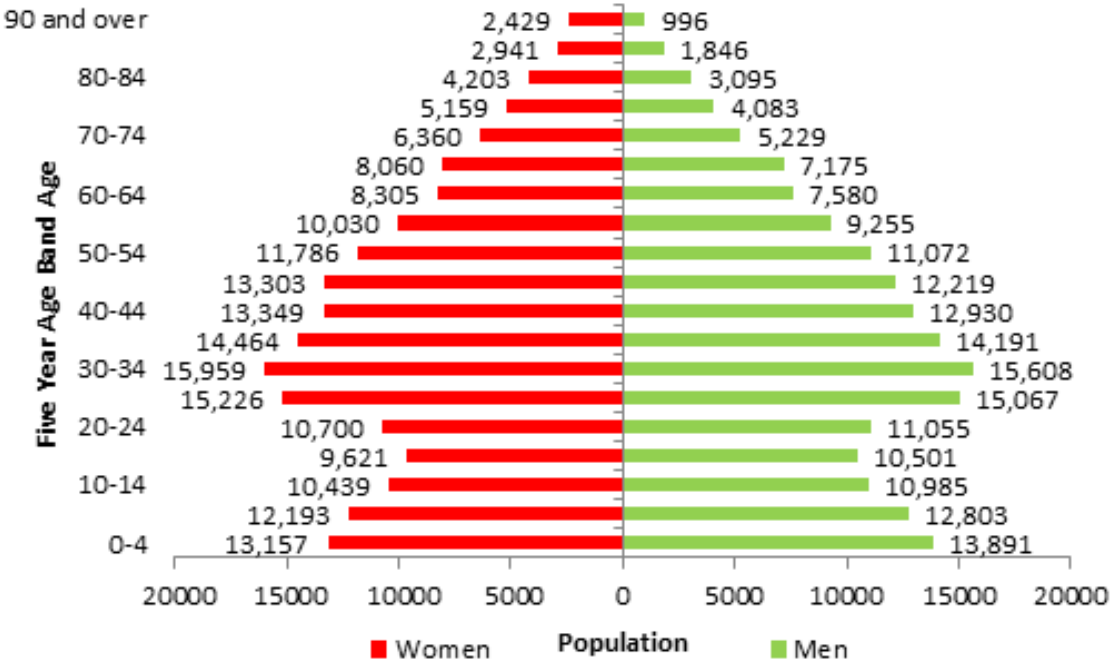
Figure 2-6: Population % by Five Year Age Band in 2015 (Barnet, Regional and National)



Source: GLA 2013 Projections (Preferred Option Projections) (Barnet and Outer London) and ONS Mid-year Projections 2012 (UK)

By gender, women account for a larger proportion of the Barnet population than men. 51.1% (187,685) of the population are women and 48.9% (179,580) of the population are men. As shown in Figure 2-7, the proportion of men to women is roughly equal below 65, whereas above 64, women account for 56.5% of the population (29,152) compared to men who account for 43.5% (22,423). This reflects the longer lifespans of women.

Figure 2-7: Barnet Population by Age Band and Gender in 2015



Source: GLA 2013 Projections (Preferred Option Projections)

2.7.1 Population Projections by Age

Table 2-6 identifies the population projections by broad age structure for the period 2015 – 2021, and 2015 – 2030.

Table 2-6: Population Projections by Broad Age Structure 2015, 2021 & 2030 (Barnet)

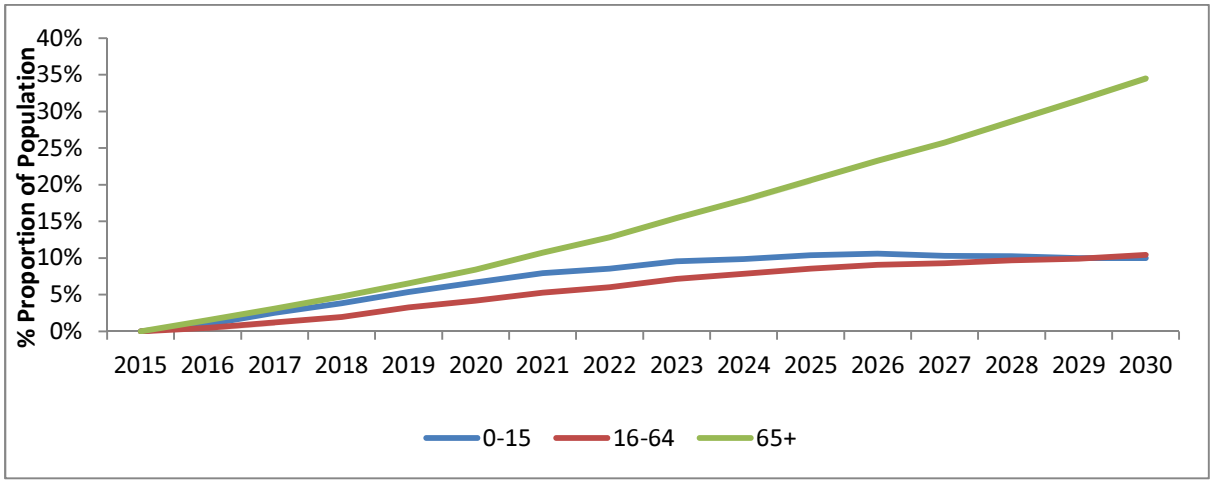
Age Group	2015	2021	Change	% Change 2015-2021	2030	Change	% Change 2015-2030
0-15	77,789	83,966	6,177	7.9%	85,560	7,772	10.0%
16-64	237,901	250,408	12,507	5.3%	262,648	24,747	10.4%
65+	51,576	57,098	5,522	10.7%	69,364	17,789	34.5%

Source: GLA Projections 2013 (Preferred Option Projections)

Growth is projected across all three age groups however; it is not a uniform rise. As with the whole of England, Barnet's population is projected to become proportionally older as the over 65's age group grows at a much faster rate than the 0-15 and 16-64 age bands. This is a significant concern for Barnet as it will likely drive up the dependency ratio within the Borough.

The 0-15 age group shows growth at a greater rate than the 16-64 age group until 2026 after which the child population is expected to slightly decline. The 16-64 population is expected to increase steadily through to 2030. This pattern of growth suggests that families are moving to Barnet with children for school and choosing to stay into older age once children leave for university or begin careers outside Barnet.

Figure 2-8: Barnet Population Growth by Broad Age Structure 2015 –2030



Source: GLA Projections 2013 (Preferred Option Projections)

Table 2-7 below shows the proportion of people aged 65 and over by ward. Currently both Garden Suburb and High Barnet have the largest proportion of people aged 65 and over, 18.1%. By 2030, although Garden Suburb's 65 and over population is projected to have increased to 21.6% of the population; High Barnet's is projected to have increased to 22.9%.

Although, over this period Brunswick Park and Hale are projected to experience the highest levels of growth in the proportion of the population of people aged 65 and over, increasing by 5.8% and 5.5% respectively.

Interestingly, the wards that are projected the highest levels of overall population growth over the period 2015-2030, Golders Green and Colindale are also projected to see the smallest increase in the proportion of the population who are 65 and over. In fact Golders Green is projected to reduce by 2.4%. This is due to growth in these areas is predominantly being driven by development which will bring younger people into the Borough.

Table 2-7: 65 and Over Proportion of Total Population in Barnet by Ward, 2015 –2030

Ward Name	2015	2021	2030	Change from 2015-2030
Brunswick Park	16.5%	17.9%	22.3%	5.8%
Burnt Oak	9.5%	10.3%	13.3%	3.8%
Childs Hill	12.6%	13.3%	15.2%	2.7%
Colindale	8.1%	7.6%	9.0%	0.9%
Coppetts	11.3%	12.8%	16.0%	4.7%
East Barnet	15.2%	16.7%	19.9%	4.7%
East Finchley	13.8%	14.6%	16.9%	3.0%
Edgware	15.2%	16.6%	19.5%	4.3%
Finchley Church End	17.0%	17.7%	19.7%	2.7%
Garden Suburb	18.1%	19.0%	21.6%	3.6%
Golders Green	12.0%	10.7%	9.6%	-2.4%
Hale	14.7%	16.5%	20.2%	5.5%
Hendon	12.0%	12.5%	14.3%	2.2%
High Barnet	18.1%	19.6%	22.9%	4.9%
Mill Hill	13.8%	14.5%	17.2%	3.4%
Oakleigh	17.6%	18.9%	22.0%	4.4%
Totteridge	18.0%	18.8%	21.7%	3.7%
Underhill	17.1%	18.3%	21.3%	4.2%
West Finchley	13.2%	13.9%	16.7%	3.5%
West Hendon	11.6%	12.2%	14.0%	2.4%
Woodhouse	14.0%	14.9%	17.1%	3.2%

Source: GLA Projections 2013 (Preferred Option Projections)

2.8 Ethnicity

Table 2-8 displays the ethnic profile of Barnet in 2015. Compared to the Outer London average, Barnet has a higher proportion of people within the White ethnic group; 57.8% and 61.3% respectively. Barnet also has higher rates of the population within Other; Other Asian and Chinese ethnic groups.

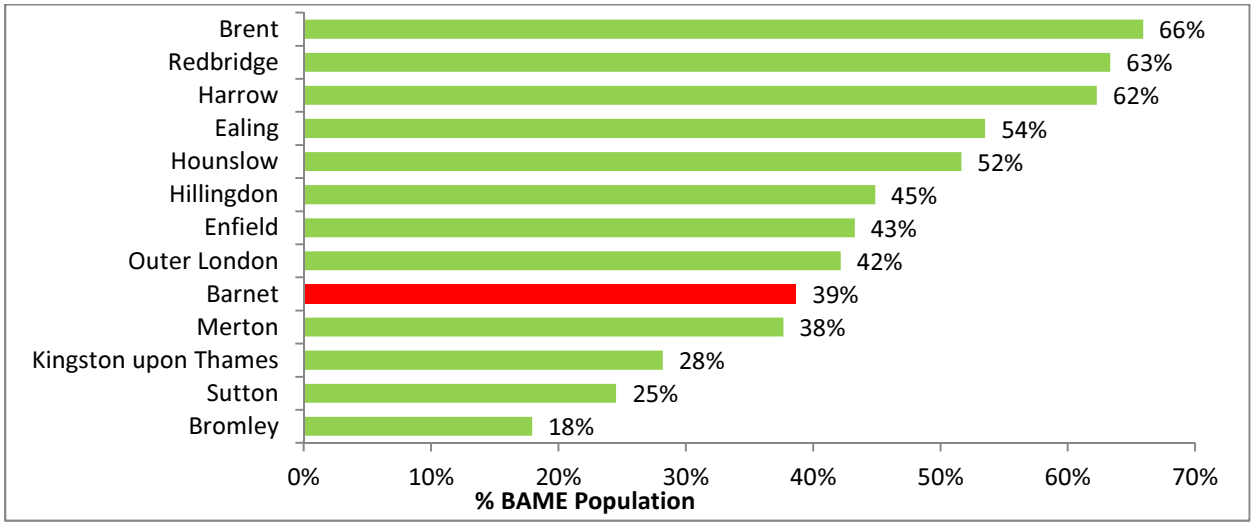
Table 2-8: Population by Ethnicity, 2015 (Barnet and Regional)

Ethnicity	Barnet		Outer London	
	No. of People	% of Population	No. of People	% of Population
All Ethnicities	367,264	100.0%	5,236,869	100.0%
White	225,192	61.3%	3,028,406	57.8%
Black, Asian and Minority	142,076	38.7%	2,208,463	42.2%
Other Asian	34,296	9.3%	420,406	8.0%
Indian	27,530	7.5%	466,540	8.9%
Other	25,916	7.1%	249,337	4.8%
Black African	21,174	5.8%	353,533	6.8%
Black Other	11,588	3.2%	217,968	4.2%
Chinese	8,804	2.4%	65,236	1.2%
Pakistani	5,699	1.6%	187,598	3.6%
Black Caribbean	4,615	1.3%	178,809	3.4%
Bangladeshi	2,454	0.7%	69,036	1.3%

Source: GLA Projections 2013 (Preferred Option Projections)

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

Figure 2-9: Population by Black, Asian and Minority Ethnic Groups, 2015 (Barnet, Regional)

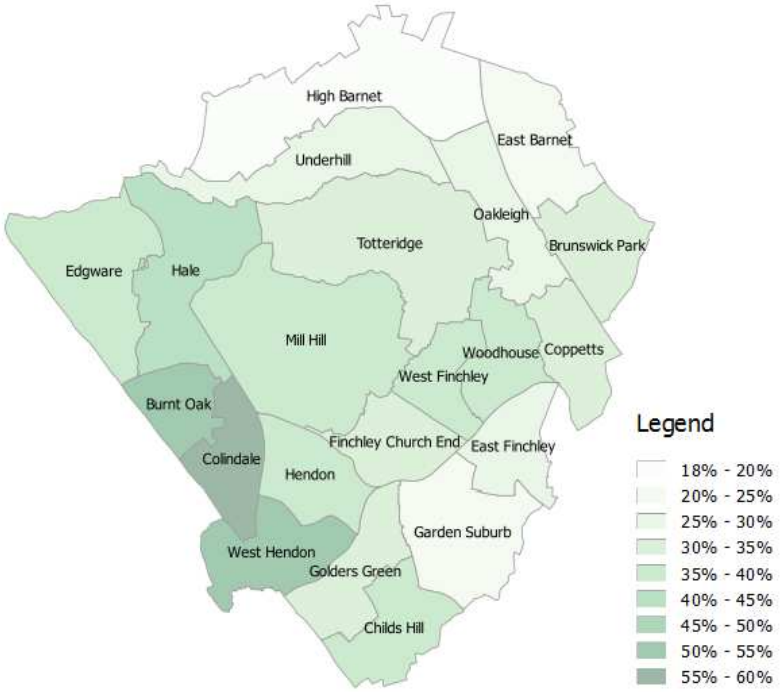


Source: GLA Projections 2013 (Preferred Option Projections)

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

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

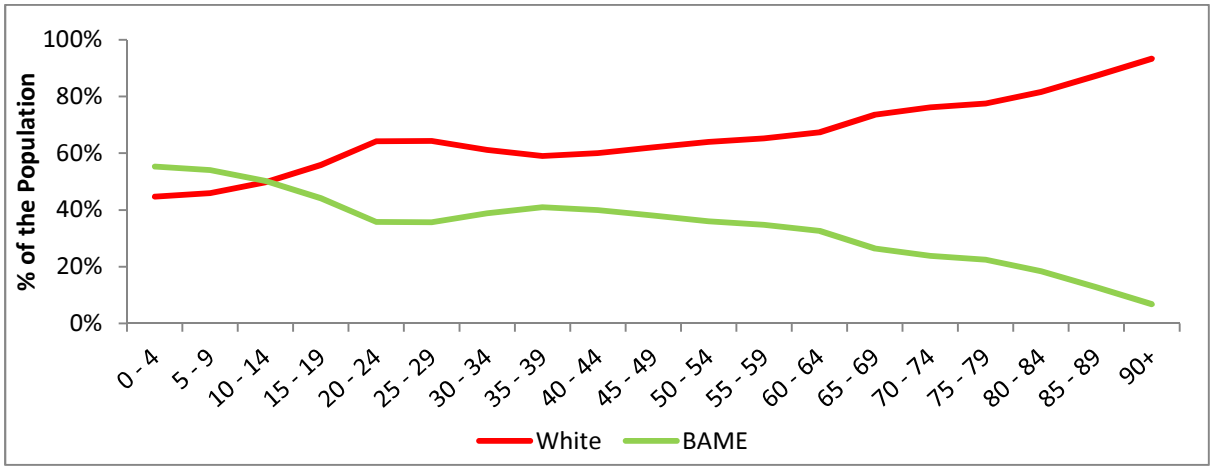
Figure 2-10: Population by Black, Asian and Minority Ethnic Groups by Ward, 2011



Source: 2011 Census

By age, the highest proportion of the population from White ethnic backgrounds are found in the 90 and over age group (93.3%); whereas the highest proportion of people from Black, Asian and Minority Ethnic groups are found in the 0-4 age group (55.4%).

Figure 2-11: Barnet Population by Ethnicity by Age, 2015



Source: 2013 GLA Projections (Preferred Option Projections)

Table 2-9 contains the projected population growth by ethnicity for the period 2015-2021 and 2015-2030. Barnet's population is projected to become increasingly diverse as the White British population is projected to decrease in proportion to the total population (from 61.3% in 2015 to 58.4% in 2021 and 56.4% in 2030).

Whereas, the proportion of the population who are Black, Asian and Minority is projected to increase by 4.9% (40,040), rising from 142,074 to 182,144. This will mean that the Black, Asian and Minority proportion of the total population will rise from 38.7% to 43.6%.

All Black, Asian and Minority Ethnic groups are projected to increase in number during the period 2015 to 2030. Although over this period the proportion of individuals from Indian ethnic groups will reduce from 7.5% of the total population to 7.1%.

Table 2-9: Projections of the population by Ethnicity between 2015-2021 and 2015-2030

Ethnic Group	2015	2021	2030	Ethnic Composition in 2015	Ethnic Composition in 2021	Ethnic Composition in 2030
White	225,193	228,741	235,457	61.3%	58.4%	56.4%
Black Caribbean	4,617	4,781	5,002	1.3%	1.2%	1.2%
Black African	21,174	23,524	25,472	5.8%	6.0%	6.1%
Black Other	11,588	13,978	16,377	3.2%	3.6%	3.9%
Indian	27,530	28,632	29,512	7.5%	7.3%	7.1%
Pakistani	5,698	6,364	6,941	1.6%	1.6%	1.7%
Bangladeshi	2,453	2,814	3,139	0.7%	0.7%	0.8%
Chinese	8,805	9,859	11,015	2.4%	2.5%	2.6%
Other Asian	34,296	41,616	48,638	9.3%	10.6%	11.6%
Other	25,917	31,164	36,012	7.1%	8.0%	8.6%
Black, Asian and Minority	142,074	162,729	182,114	38.7%	41.6%	43.6%

Source: GLA Projections 2013 (Preferred Option Projections)

2.9 Religion

The only reliable data set for religion within the Borough comes from the 2011 Census results. Table 2-10 provides a breakdown of religion in Barnet in the 2001 and the 2011 Census.

Over the ten years between the 2001 and 2011 Census the religious makeup of Barnet has become increasingly diverse, with proportionate growth in most religions except Christianity and Hinduism. The largest increase was in the number of Muslims within the Borough, which increased by 4.2%, although people with no religion had the second highest rate of growth and now accounts for 16.1% of the population.

After Christianity, Judaism was the second most common religion, with Barnet continuing to have the largest Jewish population in the country.

Table 2-10: Population by Religion, 2001 & 2011(Barnet, London and England)

Religion	Barnet					London	England
	2001	%	2011	%	% Change	% in 2011	% in 2011
Christian	148,844	47.3%	146,866	41.2%	-6.1%	48.4%	59.4%
Buddhist	3,422	1.1%	4,521	1.3%	0.2%	1.0%	0.5%
Hindu	21,011	6.7%	21,924	6.2%	-0.5%	5.0%	1.5%
Jewish	46,686	14.8%	54,084	15.2%	0.3%	1.8%	0.5%
Muslim	19,373	6.2%	36,744	10.3%	4.2%	12.4%	5.0%
Sikh	1,113	0.4%	1,269	0.4%	0.0%	1.5%	0.8%
Any other religion	3,215	1.0%	3,764	1.1%	0.0%	0.6%	0.4%
No religion	40,320	12.8%	57,297	16.1%	3.3%	20.7%	24.7%
Religion not stated	30,580	9.7%	29,917	8.4%	-1.3%	8.5%	7.2%

Source: 2001 and 2011 Census

The Jewish and Muslim population make up over a quarter of the total population of Barnet. Figure 2-12 and 2-13 show the population of the Borough by Ward, by Jewish and Muslim.

Figure 2-12: Barnet Jewish Population by Ward

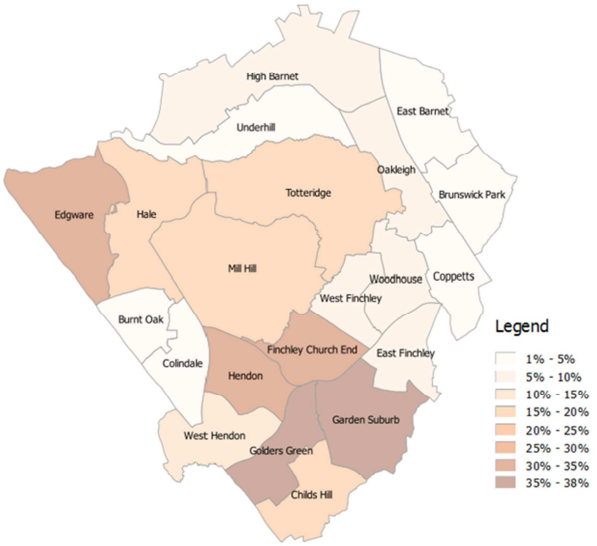
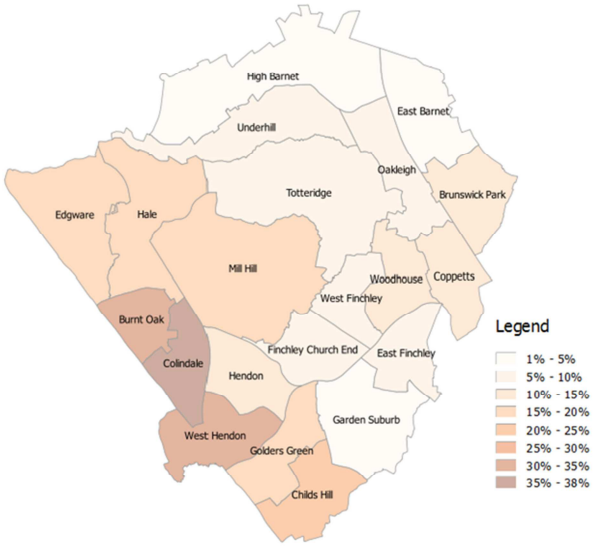


Figure 2-13: Barnet Muslim Population by Ward



Source: 2011 Census

- Wards situated in the North / Eastern areas of Barnet tend to have the highest proportions of Christians compared to other areas of the Borough.
- A large portion of the Jewish community is centred in the south of the Borough, with the largest population in Garden Suburb (38.2% (6,090)), followed by Golders Green (37.1% (6,975)). Although, Edgware has the third largest Jewish community (32.6% (5,447)).
- The largest proportion of the Muslim community is located towards the South West / South of the Borough, with the largest population in Burnt Oak (18.4% (3,356)) followed by Colindale (19.3% (3,301) and West Hendon (17.1% (2,971)).

2.10 Drivers of Population Growth

Population change is determined by the number of births, deaths and migration in and out of the Borough.

2.10.1 Natural Change

Births and deaths are natural causes of population change. The difference between the birth rate and the death rate is called the natural increase, calculated by subtracting the death rate from the birth rate. The 2013 GLA projections provide trend based assumptions around the level of births and deaths within Barnet in the future.

- There are 90,827 live births projected to occur within Barnet during the period 2015-2030.
- Between 2015 and 2021, birth rates are projected to remain relatively stationary, with the number of rates increasing by an average annual rate of only 0.1% (an additional eight births per year).
- After 2021, the number of births is projected to start marginally decreasing by an average 0.1% each year (a decrease of 8 births per year). Therefore, in 2030 there is projected to be 5,635 births in Barnet, 24 less than in 2015.
- There are projected to be 39,354 deaths within Barnet between 2015 and 2030.
- Up until 2020, the downward trend in mortality rates is projected to continue, with the number of deaths projected to reduce by an average -0.5% (12 less) each year.
- In 2021 the number of deaths within the Borough is projected to begin rising by an average 0.9% (an additional nine) each year, all the way up until 2030. This means that in 2030 there is projected to be 2,607 deaths within Barnet, 144 more deaths than in 2015.
- This reduction in births and increased deaths means that there is a projected annual decline of -4.9% (156) in natural change over the period 2015-2030.

2.10.2 Migration

Migration consists of two elements 'internal migration' and 'international migration'. Internal migration refers to people within a country moving to another location within its borders, whereas international migration refers to the act of moving across borders from one country to another.

The GLA publishes historical data for internal and international migration by local authority. Internal migration figures are derived from re-registrations recorded at the National Health Service Central Register. International migration figures are from International Passenger Survey results. This data is not perfect and does not capture all movement in and out of the Borough; however it does provide an indication of the major trends within Barnet.

Table 2-11 shows the internal, international and net migration within Barnet for the period 2002 – 2013.

Table 2-11: International and Internal Migration in Barnet, 2002-2013

Year	Internal Net Migration	International Net Migration	Net Migration
2002	-3,727	4,151	424
2003	-3,527	3,822	295
2004	-2,979	3,917	938
2005	-2,388	4,945	2,557
2006	-1,538	3,183	1,645
2007	-2,096	4,274	2,178
2008	-2,537	4,730	2,193
2009	598	3,886	4,484
2010	-48	3,392	3,344
2011	-1,348	4,982	3,634
2012	-834	3,905	3,071
2013	-1,732	3,912	2,180

Source: GLA, Net Migration and Natural Change, Region and Borough

- Apart from 2009, net internal migration has been negative for every year since 2002. This means that more UK residents have been moving out of the Borough, than into it.
- International migration has been positive throughout this period. With an average annual net migration of 4,092 people into the Borough.
- Throughout the period 2002-2013 net migration has been positive, meaning that migration has been a major driving force of population growth within the Borough.
- Although, since 2009 the total net migration figure has begun to reduce from 4,484 to 2,180 in 2013.

The latest GLA projections provide an indication of the future net migration levels in Barnet[3].

- During 2014-2023, there is a projected net migration of 5,626 people coming into the Borough; this accounts 16.0% of total population growth over this period.
- After 2020, net migration is projected to begin decreasing, with an aggregated net migration of a loss of 4,216 people during 2024-2030.
- Research by the Office for National Statistics (ONS) suggests that during this time, international migration will remain positive; however there will be a higher number of people leaving the Borough through internal migration, making overall net migration negative.
- A 2014 report by the ONS *Internal Migration, England and Wales, Year Ending June 2013* found that as people reach 30 and above, more people move out of London than into it. The report suggests that the drivers of this could be:

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

- The cost of housing - Young couples wishing to buy their first house, or a larger one for a growing family, may find prices in London prohibitively expensive and therefore choose to live outside of London.
- People moving out of London to raise a family. This could be because they are looking for somewhere more rural and quieter, and may also perceive that a less urban neighbourhood offers a better social and educational environment for children.

Table 2-12 displays the population projections for the period 2015-2030, with the drivers of growth (births, deaths and net migration) shown against them.

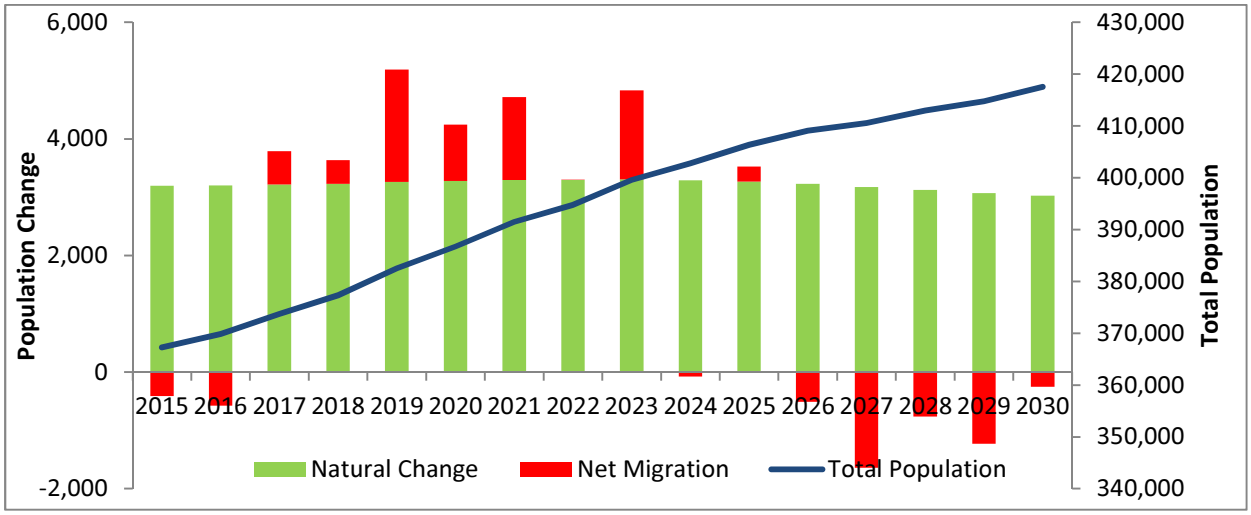
Table 2-12: Population Projections by Drivers of Growth (2015-2030)

Year	Population Projections	Births	Deaths	Natural Change (births - deaths)	Net Migration
2015	367,265	5,659	2,463	3,195	-412
2016	369,887	5,637	2,437	3,200	-578
2017	373,680	5,639	2,420	3,218	574
2018	377,316	5,638	2,406	3,232	405
2019	382,508	5,669	2,405	3,265	1,927
2020	386,752	5,680	2,403	3,277	967
2021	391,472	5,704	2,406	3,298	1,422
2022	394,769	5,701	2,409	3,293	5
2023	399,599	5,731	2,423	3,308	1,523
2024	402,814	5,725	2,436	3,290	-75
2025	406,341	5,725	2,455	3,270	257
2026	409,063	5,710	2,478	3,232	-510
2027	410,596	5,676	2,503	3,174	-1,640
2028	412,959	5,660	2,535	3,125	-763
2029	414,798	5,638	2,568	3,070	-1,231
2030	417,573	5,635	2,607	3,028	-254

Source: GLA Projections 2013 (Preferred Option Projections)

- As can be seen by Figure 2-14, up until 2023, population growth within Barnet is projected to be driven by natural change and net migration. However, after 2023, more people are projected to leave the Borough than enter it, resulting in growth being solely driven by natural change.
- As the natural change remains relatively stable, and net migration becomes negative, the rate of population growth will slow down after 2023.

Figure 2-14: Population Projections by Drivers of Growth (2015-2030)

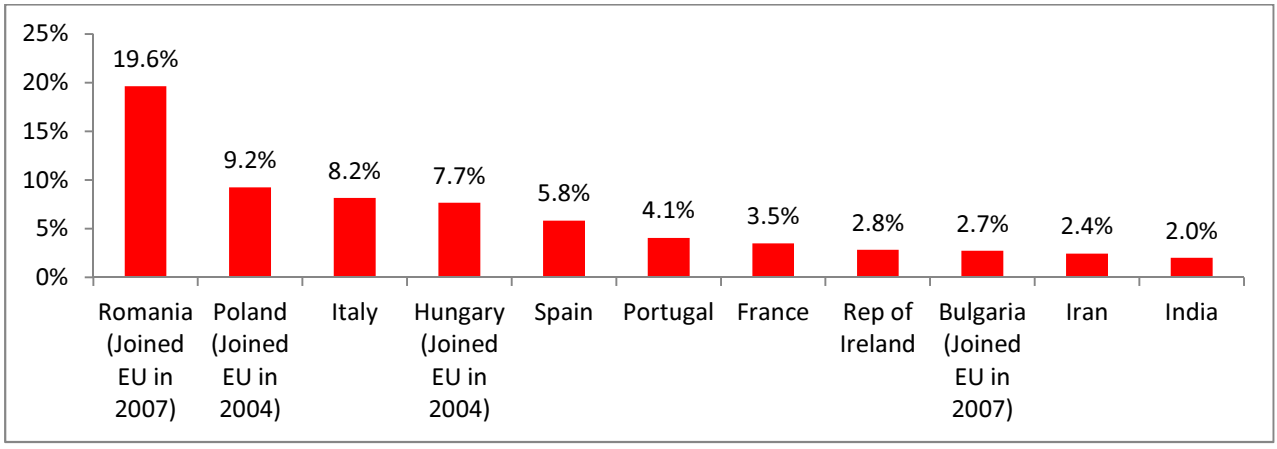


Source: GLA Projections 2013 (Preferred Option Projections)

2.10.3 International Migration

National Insurance registrations of overseas nationals can be used as an indication of the nationality of international migrants. Figure 2-15 displays the National Insurance registrations of overseas nationals into Barnet, for the 2013/14 financial year. In total there were 9,406 national insurance registrations of overseas nationals during this period, which accounted for approximately 4.0% of the Barnet working age group. Romanians accounted for 19.6% of overseas migrations, followed by Polish workers who accounted for 9.2%. All other groups of new migrant overseas workers were relatively small which is why they are not displayed.

Figure 2-15: Number of New Migrant Workers by their Country of Origin, 2013/14

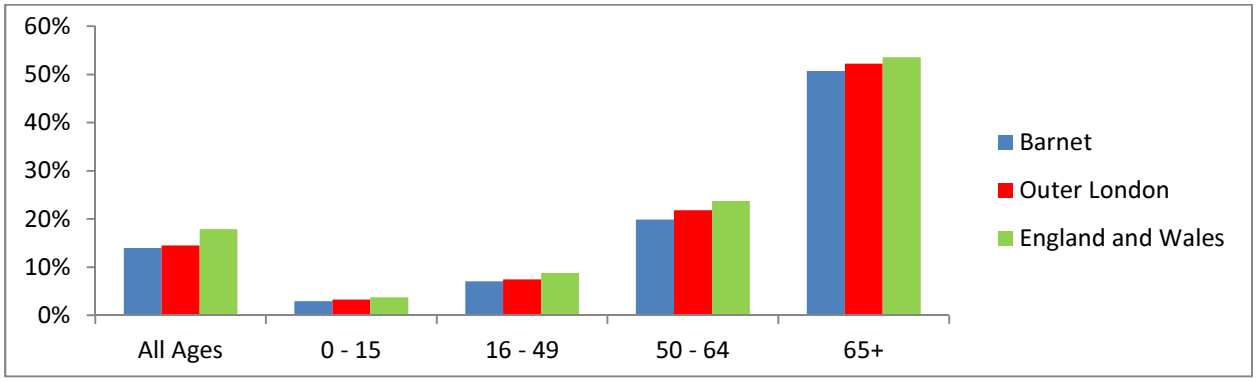


Source: Department for Work and Pensions 2014; National Insurance Number Registrations of Overseas Nationals, Borough

2.11 Disability

In the 2011 Census, residents were asked to assess whether their day-to-day activities were either 'Limited a lot' or 'Limited a little' because of a health problem or disability. These include any problem related to old age, which has lasted, or is expected to last, at least 12 months.

Figure 2-16: Proportion of Population who Self-Reported that their Activity is 'Limited a lot or a little' by Age (Barnet, Regional, and National)



Source: 2011 Census

- As is expected, the proportion of people with disabilities increases as the age range increases.
- Across all ranges, Barnet has a lower proportion of people with disabilities compared to Outer London and England and Wales.

By gender, there were more females aged 16 and above with disabilities than men. For those aged under 16, proportionally more males reported limitations in their day-to-day activities. This was the same across all geographical areas.

Table 2-13: Proportion of Population Whose Activity is 'Limited a lot or a little' by Age and Gender 2011 (Barnet, Regional, and National)

Area	All Ages		0 - 15		16 - 49		50 - 64		65+	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Barnet	12.6%	15.4%	3.6%	2.3%	6.8%	7.3%	18.8%	20.8%	45.9%	54.3%
Outer London	13.1%	15.9%	3.9%	2.6%	7.1%	7.8%	20.5%	23.1%	48.1%	55.5%
England and Wales	16.6%	19.2%	4.6%	2.9%	8.5%	9.0%	22.9%	24.6%	50.3%	56.3%

Source: 2011 Census

- By Ward, Underhill had the largest proportion of residents who reported having their day-to-day activities limited in some way, (17.2%) with 8.2% of these residents assessing themselves as having their day-to-day activities limited a lot.
- Even though Underhill has one of the smallest actual populations within the Borough (15,915 in 2011), it still had the third largest number of people who reporting having their day-to-day activities limited a lot (1,311).
- Burnt Oak and Childs Hill had the highest number of residents who assessed themselves as having their activities limited a lot, 1,499 and 1,390 respectively.

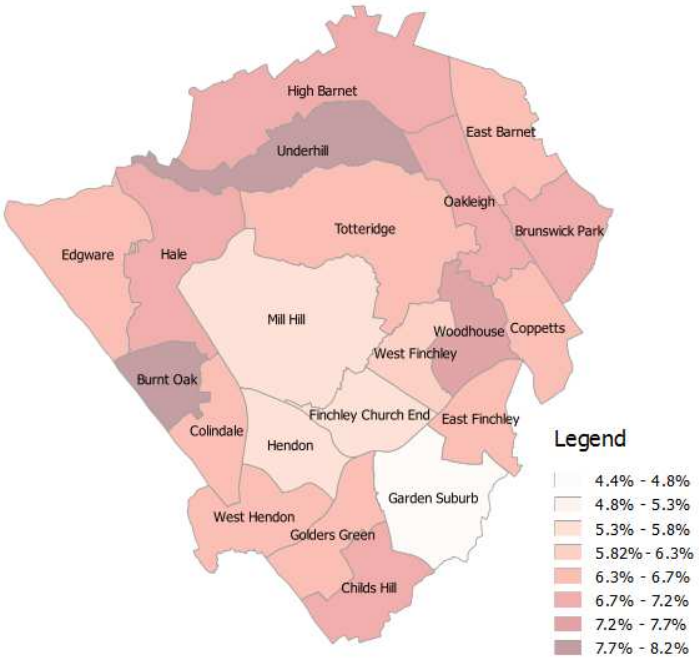
Table 2-14: Proportion of Population Whose Activity is 'Limited a lot or a little' in 2011 (Ward, Barnet, Regional, and National)

Area	Total Population	Number of People with day-to-day activities limited			% of People with day-to-day activities limited		
		Limited a Lot	Limited a Little	Total	Limited a Lot	Limited a Little	Total
Barnet	356,386	23,475	26,428	49,903	6.6%	7.4%	14.0%
Outer London	4,942,040	335,759	382,917	718,676	6.8%	7.7%	14.5%
England and Wales	56,075,912	4,769,712	5,278,729	10,048,441	8.5%	9.4%	17.9%
Brunswick Park	16,394	1,117	1,361	2,478	6.8%	8.3%	15.1%
Burnt Oak	18,217	1,499	1,390	2,889	8.2%	7.6%	15.9%
Childs Hill	20,049	1,429	1,283	2,712	7.1%	6.4%	13.5%
Colindale	17,098	1,079	1,167	2,246	6.3%	6.8%	13.1%
Coppetts	17,250	1,160	1,198	2,358	6.7%	6.9%	13.7%
East Barnet	16,137	1,042	1,301	2,343	6.5%	8.1%	14.5%
East Finchley	15,989	1,074	1,259	2,333	6.7%	7.9%	14.6%
Edgware	16,728	1,075	1,298	2,373	6.4%	7.8%	14.2%
Finchley Church End	15,715	857	1,229	2,086	5.5%	7.8%	13.3%
Garden Suburb	15,929	694	968	1,662	4.4%	6.1%	10.4%
Golders Green	18,818	1,254	1,228	2,482	6.7%	6.5%	13.2%
Hale	17,437	1,182	1,301	2,483	6.8%	7.5%	14.2%
Hendon	18,472	1,078	1,286	2,364	5.8%	7.0%	12.8%
High Barnet	15,307	1,050	1,242	2,292	6.9%	8.1%	15.0%
Mill Hill	18,451	1,047	1,406	2,453	5.7%	7.6%	13.3%
Oakleigh	15,811	1,073	1,172	2,245	6.8%	7.4%	14.2%
Totteridge	15,159	951	1,121	2,072	6.3%	7.4%	13.7%
Underhill	15,915	1,311	1,430	2,741	8.2%	9.0%	17.2%
West Finchley	16,533	1,023	1,136	2,159	6.2%	6.9%	13.1%
West Hendon	17,402	1,172	1,243	2,415	6.7%	7.1%	13.9%
Woodhouse	17,575	1,308	1,409	2,717	7.4%	8.0%	15.5%

Source: 2011 Census

Figure 2-17 provides map of the Barnet population by residents who reported having their day-to-day activities limited a lot. As you can see from the map, this indicator appears less impacted by locality, with a fairly even spread across the whole Borough.

Figure 2-17: Proportion of Population Whose Activity is 'Limited a lot' by Ward, 2011



Source: 2011 Census

2.11.1 Types of Disability

There is no definitive data on the amount of people with disabilities within the Borough, although by applying national prevalence rates to the Barnet population it is possible to get an indication of this. The rates are taken from research undertaken by Oxford Brookes University.

Table 2-15: The Estimated Number of People in Barnet with Moderate or Severe Learning Disabilities, 2015, 2021 & 2030

Age Range	Prevalence Rate	Number of People: 2015	Number of People: 2021	Number of People: 2030
15-19	0.68%	137	143	164
20-24	0.60%	131	128	139
25-29	0.53%	161	158	153
30-34	0.54%	170	174	167
35-39	0.61%	175	191	191
40-44	0.62%	163	177	189
45-49	0.56%	143	144	161
50-54	0.48%	110	120	123
55-59	0.55%	106	122	127
60-64	0.43%	68	79	92
65-69	0.36%	55	53	66
70-74	0.34%	39	47	51
75-79	0.23%	21	25	27
80+	0.18%	28	32	44
Total		1,507	1,591	1,694

Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI)

- The 15-19 age group has the highest proportion of people with moderate or severe learning disabilities (0.68%). However, as the 35-39 has a bigger overall population, the largest number of people with learning disabilities is estimated to be within this age group.
- Due to the projected population increase in the 65 and overs, the number of people aged over 65 with moderate or severe learning difficulties is estimated to rise from 143 in 2015 to 187 in 2030; a rise of over 30%.

Table 2-16: The Estimated Number of People in Barnet Aged 18-64 with Moderate or Severe Physical Disabilities, 2015, 2021 & 2030

			Moderate			Serious		
Age Range	**Prevalence Rates - Moderate Disability**	**Prevalence Rates - Serious Disability**	**2015**	**2021**	**2030**	**2015**	**2021**	**2030**
18-24	4.10%	0.80%	1,188	1,181	1,306	232	230	255
25-34	4.20%	0.40%	2,598	2,604	2,511	247	248	239
35-44	5.60%	1.70%	3,076	3,344	3,456	934	1,015	1,049
45-54	9.70%	2.70%	4,693	4,899	5,279	1,306	1,364	1,470
55-64	14.90%	5.80%	5,240	6,026	6,636	2,040	2,346	2,583
Total			16,795	18,054	19,188	4,759	5,203	5,596

Source: Projecting Adult Needs and Service Information (PANSI)

- Unlike learning disabilities, the prevalence of physical disabilities increases as the population becomes older, with the highest rates of both moderate and serous disabilities located within the 55-64 age group. It is likely that people aged 65 and over will have higher rates of moderate or serious physical disabilities; however POPPI doesn't produce this data.
- Across all age groups, more people have physical disabilities than learning disabilities.

Table 2-17: The Estimated Number of People in Barnet with Mental Health Problems by Gender, 2015, 2021 & 2030

	Prevalence Rates		Males			Females		
	Males	**Females**	**2015**	**2021**	**2030**	**2015**	**2021**	**2030**
Common Mental Disorder	12.50%	19.70%	14,098	14,927	15,680	22,960	24,045	24,993
Borderline personality disorder	0.30%	0.60%	338	358	376	699	732	761
Antisocial personality disorder	0.60%	0.10%	677	717	753	117	122	127
Psychotic disorder	0.30%	0.50%	338	358	376	583	610	634
Two or more psychiatric disorders	6.90%	7.50%	7,782	8,240	8,656	8,741	9,154	9,515

Source: Projecting Adult Needs and Service Information (PANSI)

- Over 10% of men and almost 20% of women aged 18-64 have some form of common mental health disorder. Apart from antisocial personality disorders, women have a higher prevalence across all types of mental health disorder.
- In comparison to learning and physical disabilities, only moderate physical disabilities among the 55 and over age group have a higher prevalence rate within the population.

2.11.2 Disability and Employment

The Office of National Statistics' Annual Population Survey provides data on the working age population (aged 16 – 64) who are disabled. This includes people who are either disabled under the disability discrimination act (DDA) or who have a work-limiting disability, as a percentage of all people aged 16-64 years.

Figure 2-18: % aged 16-64 who are EA core disabled[4] or work-limiting disabled (Barnet and Statistical neighbours)

Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

- In comparison to statistical neighbours, Barnet performs well on the proportion of the people of working age with a disability, with the lowest rate of 12.5%. Barnet also performs well compared to the average Outer London rate of 16.1% and the UK rate of 19.0%.

Figure 2-19: % aged 16-64 who are EA core or work-limiting disabled, by gender (Barnet and Statistical neighbours)

Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

- By gender, Barnet has a higher rate of working age women (16.1%) who are disabled, compared to men (8.80%). Although this is in line with national and regional trends, the difference between genders is significantly higher in Barnet than in many other areas, with 83% more disabled women of working age, than men.

[4] **EA Core disabled** includes those who have a long-term disability which substantially limits their day-to-day activities

Table 2-18: % of Population Aged 16-64 who are EA Core or Work-limiting Disabled

	Men	Women	% Difference
Barnet	**8.8%**	**16.1%**	**83.0%**
Sutton	10.0%	17.7%	77.0%
Ealing	14.3%	21.0%	46.9%
Hounslow	12.3%	17.1%	39.0%
Reading	11.1%	15.2%	36.9%
Redbridge	15.0%	20.4%	36.0%
Outer London	14.1%	18.2%	29.1%
Milton Keynes	15.8%	19.3%	22.2%
United Kingdom	17.6%	20.4%	15.9%
Hillingdon	15.6%	16.6%	6.4%
Kingston upon Thames	13.1%	13.4%	2.3%
Merton	13.0%	12.4%	-4.6%
Bromley	16.2%	14.1%	-13.0%

Source: ONS, Annual Population Survey - Labour Force Survey (October 2013 – September 2014)

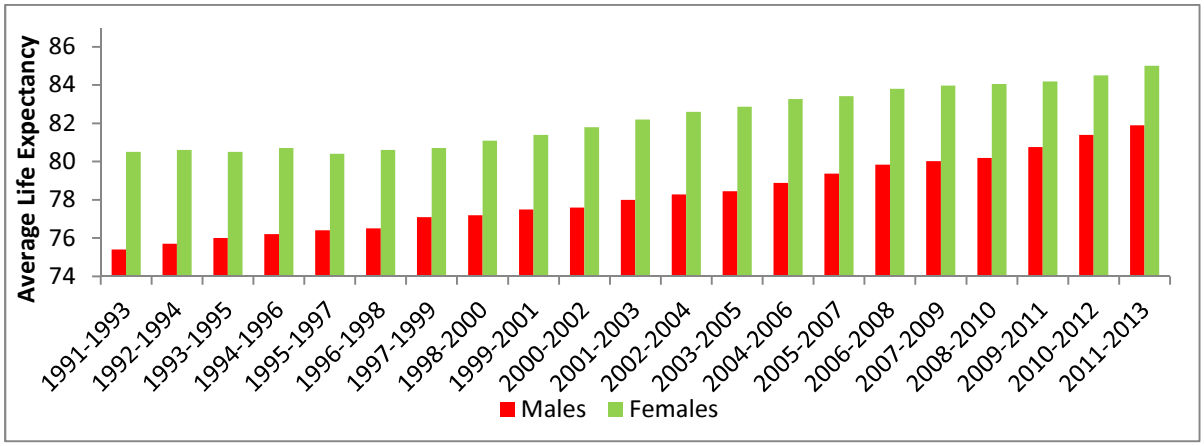
2.12 Life Expectancy

Life expectancy is a good measure of the overall health of a population. People in Barnet continue to enjoy a better health experience than the national average and this is reflected in their life expectancy.

Figure 2-20 displays the life expectancy from birth for men and women within Barnet for the period 1991 – 2013. In Barnet, as in the rest of the country, Women have a higher average life expectancy than. However, as you can see from Figure 2-20, the life expectancy of men has increased at a higher rate than for women, reducing the life expectancy gap between genders from 5.1 years to 3.1 years.

Furthermore, the difference in healthy life expectancy between men and women is much smaller; 68.0 years for men and 68.8 years for women. This indicates that although women are living (on average) longer than men, a larger proportion of their life is spent unhealthy; 19.1% (16.2 years) for women and 17.0% (13.9 years) for men.

Figure 2-20: Life Expectancy at Birth within Barnet by Gender, 1991-2013



Source: ONS 2013, Life Expectancy at Birth

Life expectancy can be measured in two ways; from birth and from age 65. Against regional land national comparators, Barnet is performing well across all these measures of life expectancy.

However, this strong performance in life expectancy when compared to other areas masks the inequalities that exist between areas within Barnet.

From 2009/2010 the London Health Observatory introduced the "Slope Index" of inequality. This is a single score which represents the gap in years of life expectancy between the least deprived and most deprived within a Borough, based on a statistical analysis of the relationship between life expectancy and deprivation scores. The latest data from the London Health Observatory indicates that:

- On average men who live in the 10% most deprived areas live 7.6 years less than those living in the least deprived decile. And for men who are disabled this is even worse, with life expectancies reducing by 9.2 years.
- Whereas, women who live in the 10% most deprived areas most live on average 4.7 years less than those living in the least deprived decile. And disabled women will live 8.1 years, on average, less than a woman who isn't disabled

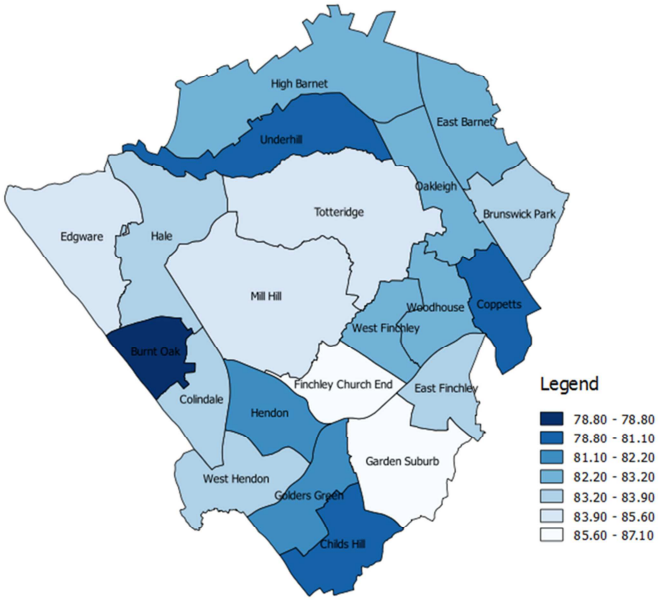
The ONS provides pooled figures on the life expectancy rates by Ward. Table 2-19 and Figure 2-21 display the latest figures for Barnet. Although many of the Wards have life expectancies close to the Borough average, there are some significant outliers.

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

Table 2-19*: Life Expectancy within Barnet by Ward, 2009-2013*

Ward name	Life Expectancy at Birth	Life Expectancy at 65
Garden Suburb	87.1	24.0
Finchley Church End	86.4	23.8
Edgware	85.6	24.3
Mill Hill	85.2	23.8
Totteridge	84.5	22.0
Colindale	83.9	22.6
Hale	83.7	21.9
East Finchley	83.6	21.7
Brunswick Park	83.5	21.3
West Hendon	83.4	21.2
East Barnet	83.2	21.1
High Barnet	83.1	20.9
Woodhouse	83.1	21.0
Barnet	83.0	21.1
West Finchley	83.0	20.9
Oakleigh	82.7	20.8
Hendon	82.2	20.9
Golders Green	81.6	20.3
Childs Hill	81.1	19.1
Underhill	81.0	20.1
Coppetts	80.6	18.0
Burnt Oak	78.8	18.1

Figure 2-21*: Life Expectancy at Birth within Barnet by Ward, 2009-2013*



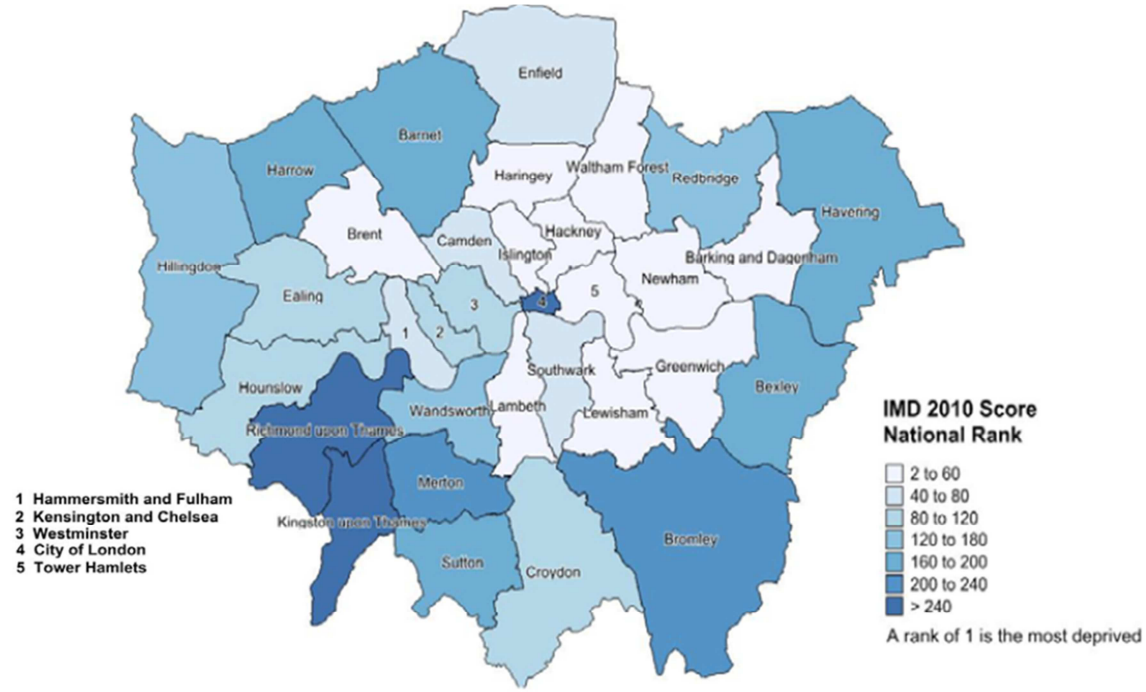
Source: ONS 2013, Life expectancy at birth by ward

2.13 Indices of Deprivation

The Index of Multiple Deprivation (IMD 2010) is the primary source for measuring deprivation in England and Wales. The Index is made up of seven categories known as 'indices', each for a distinct type or 'domain' of deprivation. These domains relate to income, employment, health and disability, education, skills and training, barriers to housing and services, living environment and crime, reflecting the broad range of deprivation that people can experience.

- The 2010 update to the Index of Multiple Deprivation, ranks Barnet 176th out of the 326 local authorities in England and Wales for deprivation – just slightly below the average (163; the authority ranked 1 is the most deprived). This is 48 places higher than 2007 (128th) and 17 places lower than 2004 (193rd).
- Relative to other London Boroughs, Barnet is ranked 25th out of 33 local authorities. This is four places less deprived than 2007 (21st) and one place higher than 2004 (23rd).
- Nearly all of the LSOAs in Barnet have become less deprived relative to the rest of London since 2007.

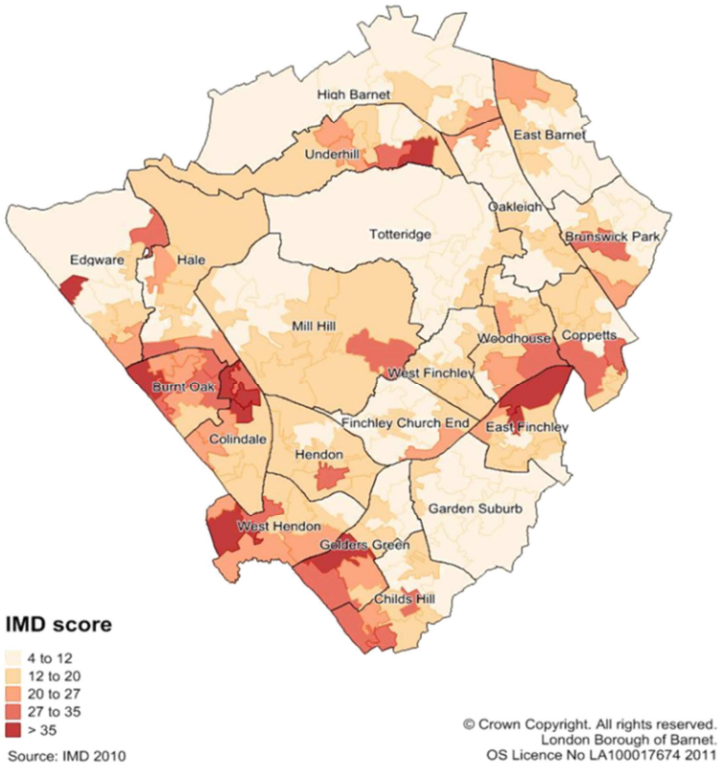
Figure 2-22: National Rank of IMD 2010 Scores for London Local Authorities



Source: ONS LA ID 2010

Within Barnet, the 2010 figures show the west of the Borough has higher levels of deprivation in Colindale, West Hendon and Burnt Oak. These areas also include large scale regeneration projects. Under this index the Strawberry Vale estate in East Finchley is identified as the most deprived area of the Borough and falls within the 11% most deprived in the country.

Figure 2-23: IMD 2010 Scores for 2010 by LSOA



By domain overall Barnet performed well in comparison to other areas. However there are certain areas within the Borough that experience high levels of deprivation.

- 13 of Barnet's LSOAs rank within the 10% most income deprived nationally and eight fall within London's 10% most deprived. These areas are found within Colindale, Edgware, Burnt Oak and East Finchley.
- Stonegrove in Edgware and Grahame Park in Colindale fall into the 10% most deprived nationally for employment.
- Regionally, two LSOAs within the Dollis Valley estate in Underhill fall within the 10% most deprived areas for education, skills and training.
- The area around Cricklewood Station in Childs Hill, the area around Hendon Thameslink Station and the West Hendon estate all fall within the 10% most deprived LSOAs nationally for the living environment domain.
- The area around Cricklewood Station in Childs Hill is the 71st most deprived area in London for crime and disorder. This places it within the 1.5% most deprived across the capital and Barnet's most deprived result on any domain.

2.14 Wellbeing

People with higher levels of wellbeing are likely to live longer, healthier and happier lives. They are also likely to have lower levels of ill health and recover quicker and for longer and have better physical and mental health (HM Government, 2010).

Using data from the Annual Population Survey, the ONS measure personal wellbeing across four variables: life satisfaction; worthwhileness; happiness and anxiety. Each variable is scored out of 10. The highest levels of life satisfaction, worthwhileness and happiness include ratings of 9 or 10 out of

10. For anxiety, ratings of 0 or 1 out of 10 indicate the lowest levels of anxiety and therefore the highest wellbeing.

- In 2013/2014 Barnet residents compared favourably to other London Boroughs in happiness and anxiety. It scored on average 7.53 for happiness (ranked 4th out of all London Boroughs) and 2.61 for anxiety (ranked 2nd).
- The life satisfaction and worthwhileness scores weren't as positive, with Barnet scoring 7.39 for life satisfaction (ranked 16th out of all London Boroughs) and 7.69 for worthwhileness (ranked 14th). Both of these variables 'have experienced declining scores since 2011.

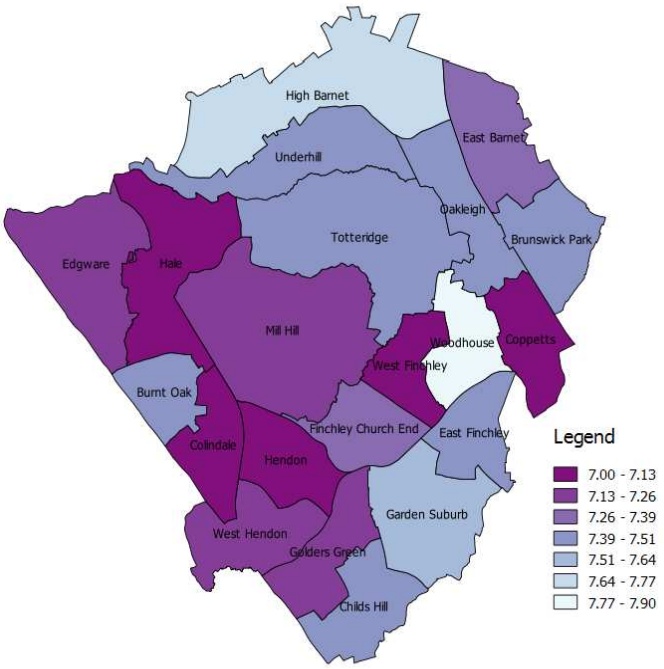
Table 2-20: Wellbeing Scores 2011-2014 (Barnet)

	2011-12	2012-13	2013-14
Life Satisfaction	7.45	7.35	7.39
Worthwhileness	7.72	7.79	7.69
Happiness	7.26	7.27	7.53
Anxiety	3.33	2.63	2.61

Source: ONS Annual Population Survey 2011 - 2014

There isn't a breakdown of each wellbeing variable by ward; however the ONS does provide an aggregated score, which is comprised of a combination of all four variables.

Figure 2-24: Wellbeing Score by Ward



Source: ONS Annual Population Survey

- Within Barnet, the Wards that reported the highest levels of wellbeing are Woodhouse (7.9); High Barnet (7.7); and Garden Suburb (7.6).
- Whereas the lowest rated areas based on wellbeing are found within Hendon (7.0); Hale (7.1); Coppetts (7.1); Colindale (7.1); and West Finchley (7.1).
- Overall, it appears that the areas of low wellbeing appear to be in the similar localities to the areas that had the highest levels of deprivation in the 2010 IMD figures.

3 Socio-Economic and Environmental Context

3.1 Key Facts

- At the time of the 2011 Census there were 135,916 households in Barnet. 58% of households were owner-occupied, 14% socially rented and 26% privately rented. In 2013, the GLA estimated that the number of households had increased to 141,386.
- Barnet is an expensive place in which to live with average house prices in December 2014 at £451,231.
- Between 2009 and 2012 Barnet's business population increased by 5.3%, to a total of 18,920 business units, a greater increase than for Greater London (4.6%).
- In September 2014, Barnet's employment rate was 70.9%, versus 71.5% for Outer London and 72.1% for the UK.
- In August 2014 there were 22,410 people claiming out-of-work benefits in Barnet, 9.5% of the total 16-64 population. This is below the Outer London and UK rates of 10.9% and 12.6% respectively.
- Barnet's average raw household income in 2015 was £41,658; this was 44.5% higher than the Great Britain average of £28,696.
- Between 2012 and 2015 Barnet's average household income increased by 17.6%, compared to the Great Britain average which increased by 1.0%.

3.2 Strategic Needs

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently the large majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established, local community and family networks.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.

- **There are shortages of people available to fill vacancies in the caring, leisure and services sectors, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.
- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

3.3 Housing

3.3.1 Housing Profile

At the time of the 2011 Census there were 135,916 households in Barnet. 58% of households were owner-occupied, 14% socially rented and 26% privately rented. In 2013, the GLA estimated that the number of households had increased to 141,386.

28% are one-person households, 6% contain only people aged 65 or more, 32% contain married or civil partnership couples with or without children, 7% cohabiting couples with or without children, 12% lone parents and 14% other household types.

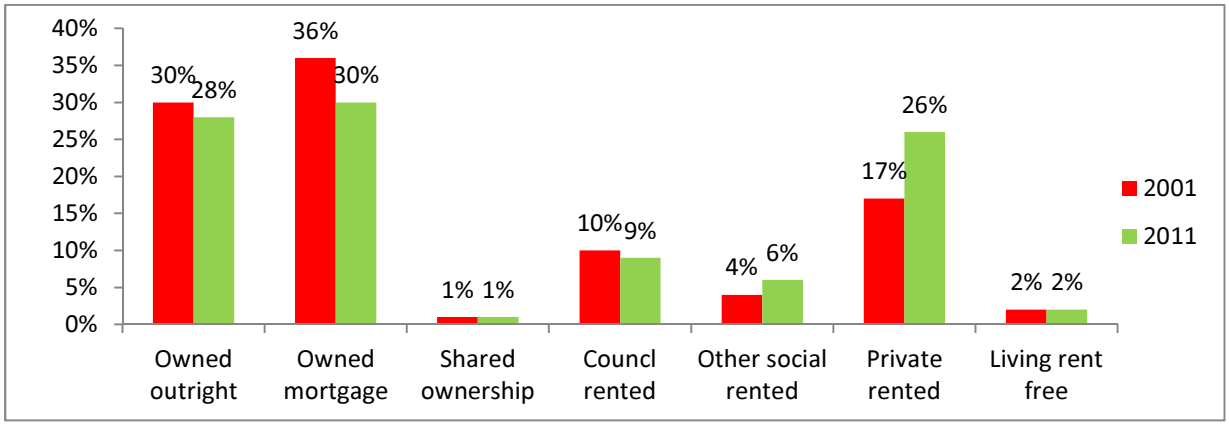
Data from the last census indicates that in 2011 the average household in Barnet consisted of 2.6 persons and 2.7 bedrooms.

Following the 2008 economic downturn, mortgage repossessions in Barnet increased significantly peaking at over 56 repossessions per quarter in 2008. This figure has now significantly reduced, with repossessions per quarter in single figures for the first three quarters of 2014.

3.3.2 Tenure

Over the last 10 years there has been a marked change in the tenure pattern of households living in Barnet as there has been across London. Figure 3-1 below compares the results of the censuses in 2001 and 2011 for Barnet. Owner occupation reduced by 8% between 2001 and 2011, while there was a 9% increase in private renting over the same period. There was only a 1% increase in council or housing association renting.

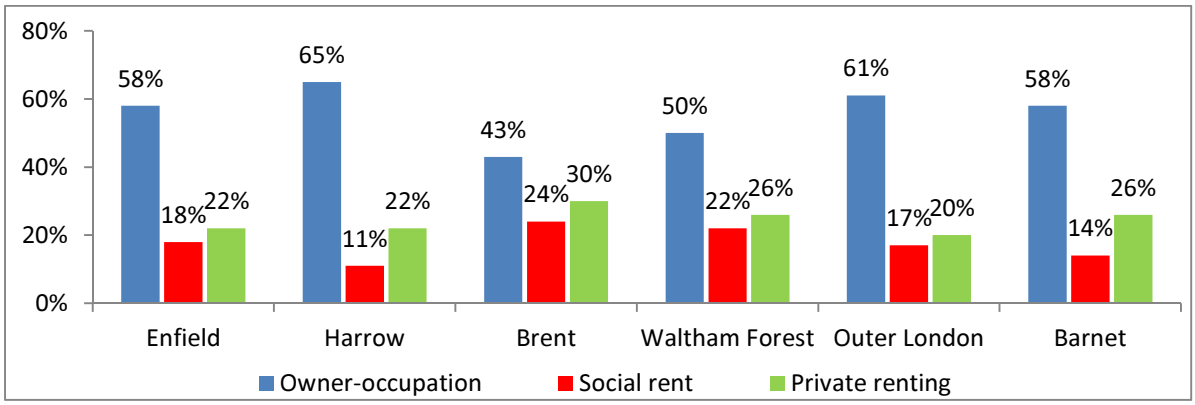
Figure 3-1: Housing Tenure in Barnet, 2001 and 2011



Source: Census 2011 & Census 2001

Barnet now has a lower percentage of owner occupiers than the average for Outer London and more private renters than the average Outer London Borough.

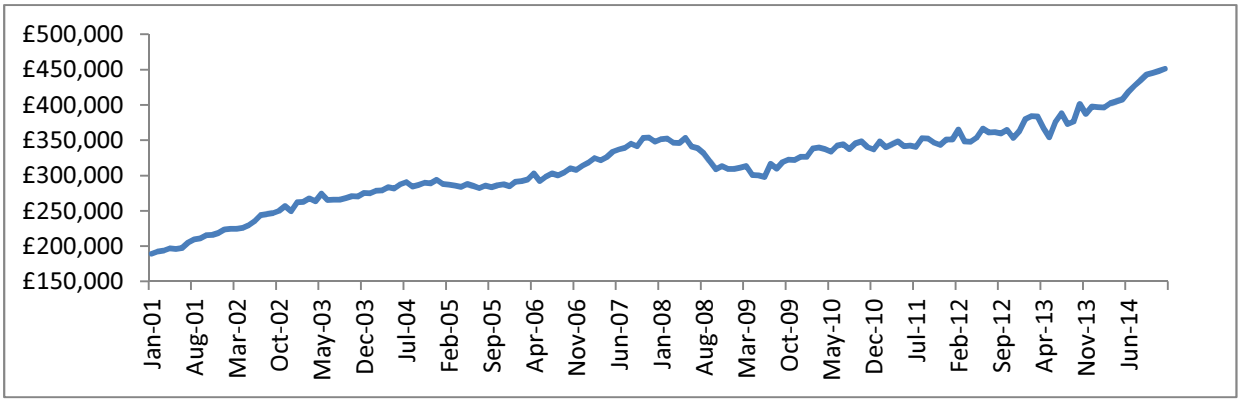
Figure 3-2: Housing Tenure by Borough, 2011



Source: Census 2011

The shift in housing tenure has largely been driven by affordability issues. Home ownership is very expensive in Barnet. Median house prices in Barnet rose by **16%** during the year to December 2014. The Barnet average house price in December 2014, **£451,231** is over **10X** the Barnet average income meaning that for many households home ownership is an unaffordable aspiration.

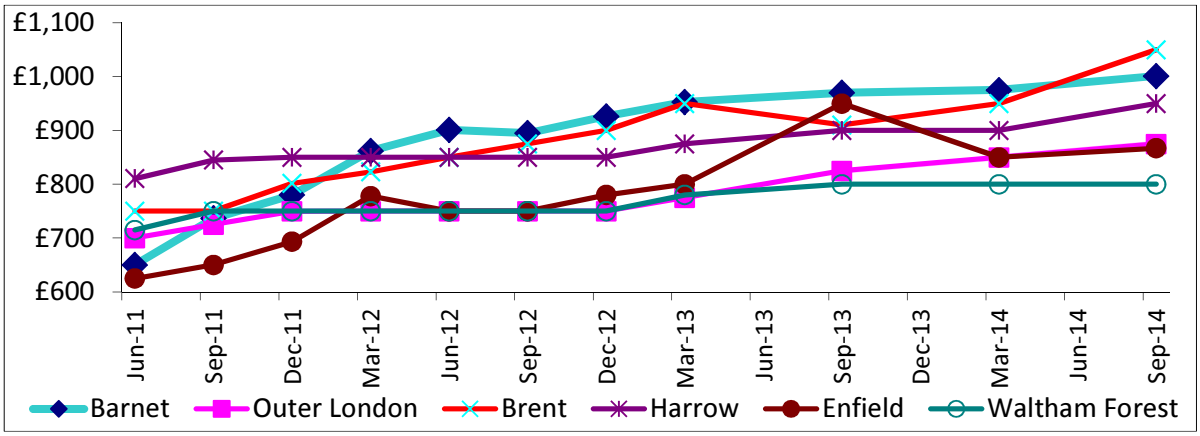
Figure 3-3 Average House Prices in Barnet, January 2001 – December 2014



Source: Land Registry House Price Index 2015

Private renting has also become more expensive in Barnet as can be seen in the chart below. Barnet lower quartile private rents have increased by £351 between June 2011 and September 2014. Barnet was below the average for Outer London and is now the 4th most expensive Outer London Borough.

Figure 3-4: Lower Quartile Monthly Rents, 2011 – 2014 (Regional)



Source: Valuation Office Agency 2015

Given the fact that Barnet is set to become London's most populous Borough in 2015 and that the population is projected to continue to increase, more homes will need to be built across the housing tenures. Most of the new housing will come from small private developments that collectively play a significant contribution to alleviating demand.

3.3.3 Overcrowding

According to the Integrated Household Survey from ONS, in 2010 there were 6.7% overcrowded households in Barnet; this is less than the London average of 7.5%. Given the high demand for housing in the Borough, overcrowding in itself is unlikely to enable a household to be rehoused by the council, unless there is severe overcrowding- at least 3 bedrooms short.

The 2006 Barnet Housing Needs Survey estimated that there are an estimated 38,000 households who are under occupying larger properties – many of whom are older people whose families have grown up. By ensuring that new homes meet the Lifetime Homes standard[5] and increasing the housing choices available for the elderly, it is expected that some older owner occupiers will opt to move into smaller more manageable accommodation, freeing up larger properties. In addition, Barnet Homes operate a successful *trade down* scheme to help council tenants under-occupying larger units move to smaller flats freeing up homes for larger families who need them.

There continues to be a need to work to ensure that the best use is made of council housing by operating a trade down scheme and ensuring that those affected by the under-occupancy charge are given the opportunity to move into homes that meet their bedroom requirements.

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

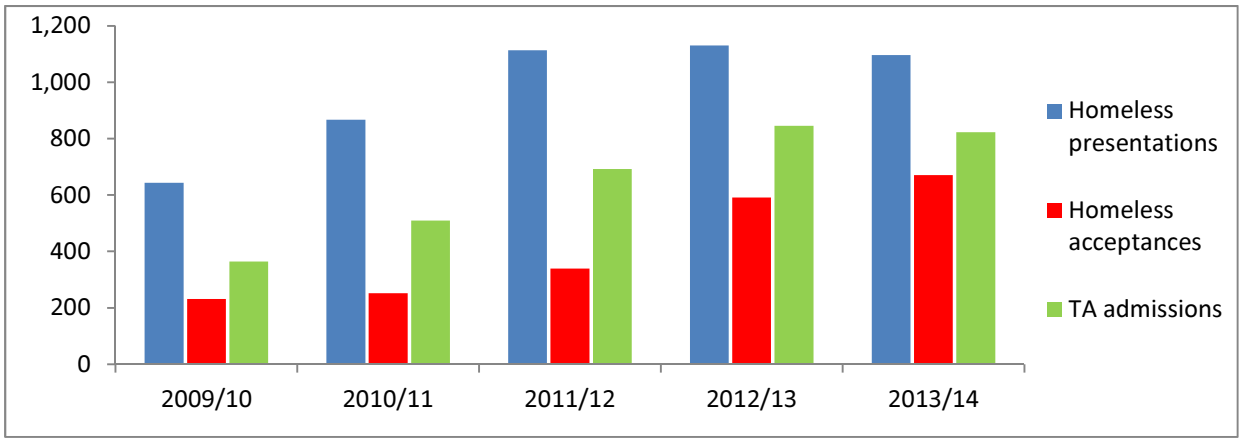
3.3.4 Temporary Accommodation and Reducing Homelessness

The number of households presenting as homeless and the number of households being accepted as homeless have increased significantly over the past five years. The number of new temporary accommodation admissions has also risen.

The key reasons for the increased demand on services include:

- Increased housing costs, combined with restrictions on housing benefit, has resulted in more households moving out of Central London to Outer London Boroughs, including Barnet. This is evidenced by a significant increase in the number of households claiming housing benefit in Barnet and a fall in housing benefit claims in Central London.
- Other welfare reforms, particularly the overall benefit cap, have resulted in the Council and its partners working proactively with affected households living in the private sector to assist them into work or move into more affordable accommodation.
- The number of households seeking help with their housing has been increasing throughout London because of the high cost of owning or renting a home.
- Private sector rents have increased faster in Barnet than in other parts of London and they are the 4th highest out of 16 Outer London Boroughs, meaning that more low-income households may approach the Council for assistance with their housing.

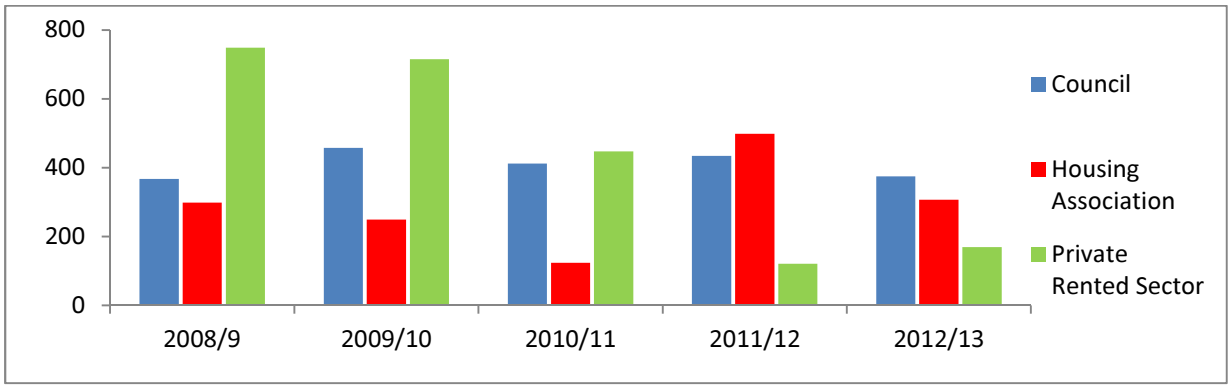
Figure 3-5*:* Increased demand for housing within Barnet, 2009-2014



Source: Barnet Council Data

Housing supply has not kept up with increased demand for housing services. As can be seen from Figure 3-6, below, the number of properties available for the Council to allocate reduced from 2009/10. This has particularly been the case for private rented sector homes. As a result of better services and incentives introduced through the Let2Barnet service at Barnet Homes, the number of private rented properties available has increased significantly since 2012. This has resulted in more households being rehoused in 2013/14 than in the previous two years.

Figure 3-6: Reduced supply of accommodation within Barnet, 2009-2014



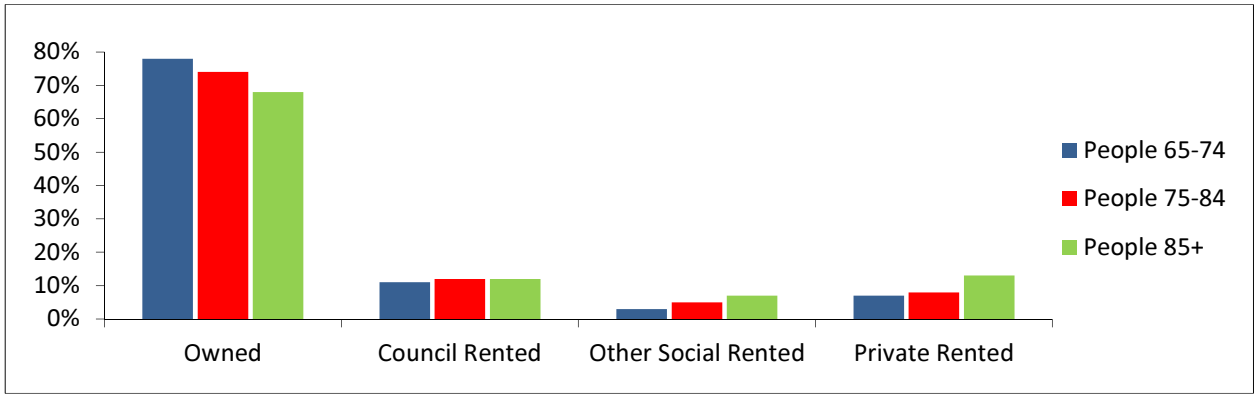
Source: Barnet Council Data

It is likely that there will continue to be a high demand for housing in the Borough as housing costs are expected to remain high. This will mean that the Council and Barnet Homes will need to maximise the supply of accommodation available for housing applicants including in the private rented sector.

3.3.5 Social Isolation

The majority of older people own their own home but 12% of the over 75s live in the private rented sector.

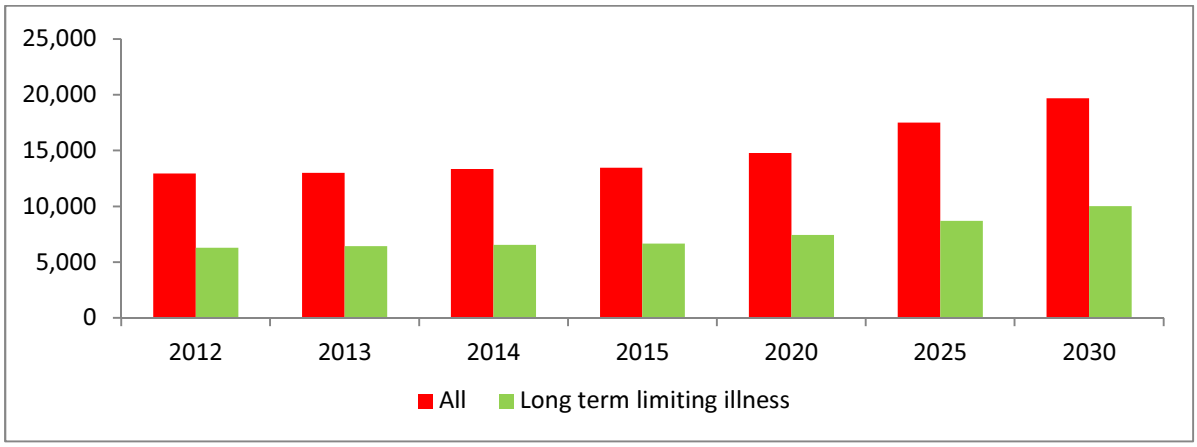
Figure 3-7: Older People and Housing Tenure, 2011



Source: GLA 2013 Projections (Borough Preferred Option) & 2011 Census

The number of older people living alone in the future is projected to increase, including those with a long term limited illness.

Figure 3-8: Number of people aged over 75 projected to be living alone in Barnet, 2012-2030



Source: GLA 2013 Projections (Borough Preferred Option) & 2011 Census

The older population in Barnet is set to increase significantly over the next 30 years. However, older people should not be viewed as a homogenous group and a variety of housing options will be needed to meet their needs and expectations.

Whilst many older people will remain independent for longer, it is inevitable that as the older population grows, the number of people requiring care will also increase, particularly amongst those that live beyond the age of 85.

At present there are an estimated 24,162 people aged 65 or over with a limiting long term illness. The Projecting Older People Population Information (POPPI) system projects these figures to increase by more than 12% by 2020.

Table 3-1: Projected Number of Older People with a Limiting Long Term Illness in Barnet, 2015-2020

Age	2015	2020	Change	
			No.	%
65-74	9,241	10,138	897	9.7%
75-84	9,208	10,346	1,138	12.4%
85+	5,713	6,776	1,063	18.6%
All 65+	24,162	27,260	3,098	12.8%

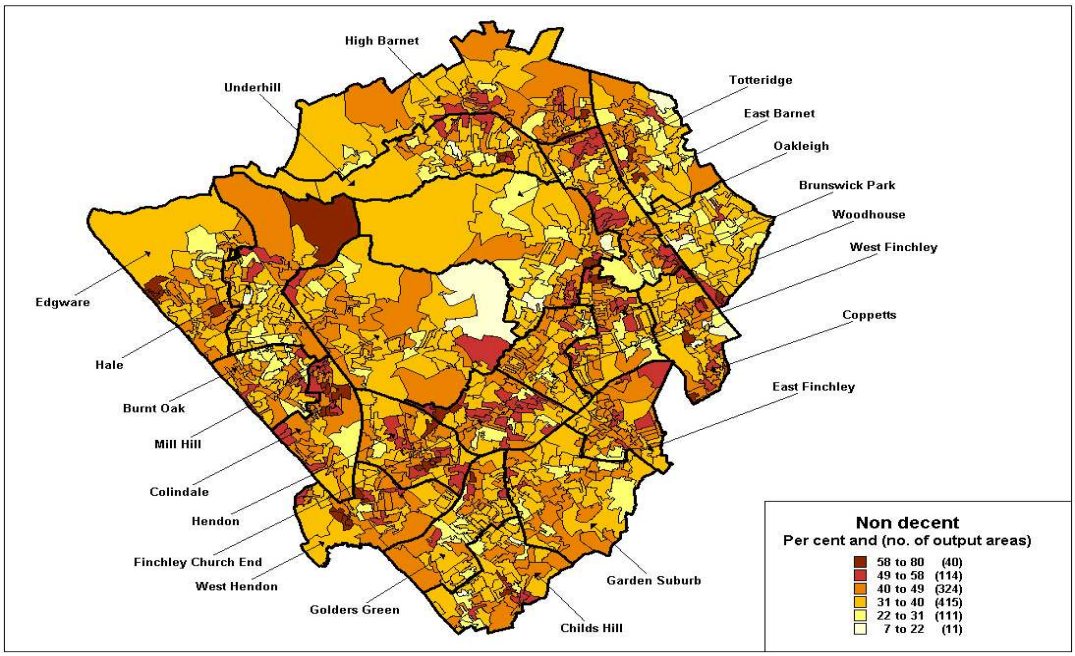
Source: Projecting Older People Population Information System (POPPI) 2015

3.3.6 Existing Housing Stock

Barnet Homes was created to deliver improvements to the condition of the Council's housing stock through the government's Decent Homes programme and to improve services to tenants and leaseholders. Barnet Homes was successful in delivering the Decent Homes programme, in 2011, on homes that were not due for demolition as part of a regeneration scheme.

Estimations of non-decent homes in the private sector (owner occupied and rented) are shown in the map below. They are present across the Borough.

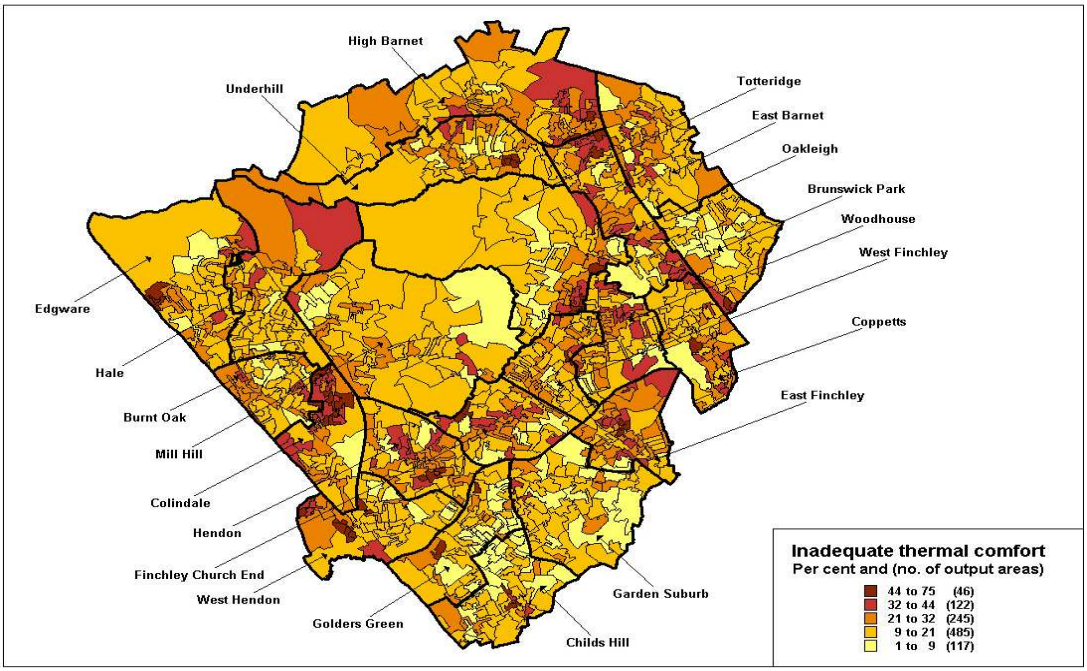
Figure 3-9: Non-decent homes in the private sector within Barnet, 2009



Source: BRE Stock Projections Update 2009

The same data shows that there are relatively few areas of the Borough with high levels of private sector homes with inadequate thermal comfort.

Figure 3-10: Number of homes with inadequate thermal comfort within Barnet, 2009



Source: BRE Stock Projections Update 2009

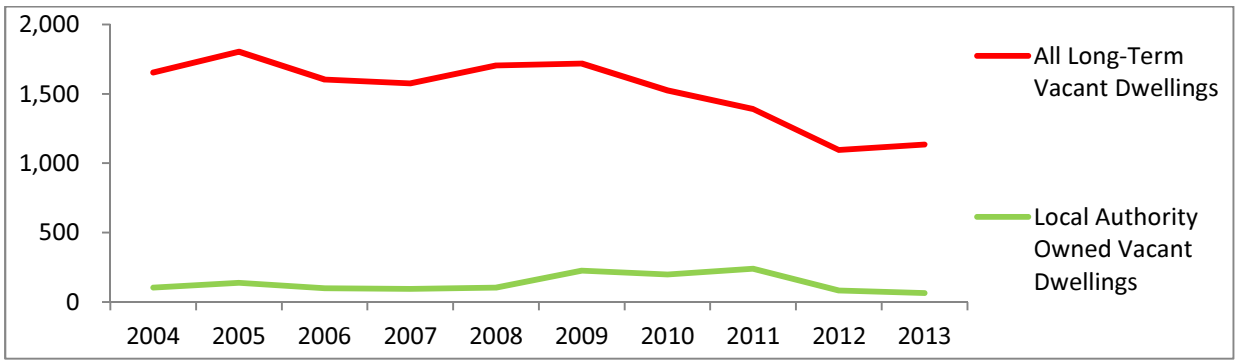
The role of the private rented sector in meeting the housing needs of the Borough has increased significantly over the last decade. Between 2001 and 2011, the number of private rented homes rose from 17% to 26% of homes in the Borough. Analysis of affordability and housing need going forward suggests that the private rented sector will continue to grow over the next ten years by a further 9%, to represent 25% of homes in the Borough.

The private rented sector provides homes for people in a way that provides flexibility and choice. However, the nature of the market means that there are many small scale landlords, often with only one or two properties, which makes it more difficult to ensure a consistent quality across the sector. It is therefore necessary to look at ways to improve the condition of properties in the private rented sector.

3.3.7 Empty Homes

Data published by the Department for Communities and Local Government shows that the number of long-term (at least 6 months) vacant dwellings has declined in the past 10 years. Most vacant dwellings are in the private sector and the council is working with owners of empty properties to bring them back into habitable use.

Figure 3-11: The number of long-term vacant dwellings in Barnet, 2004-2013



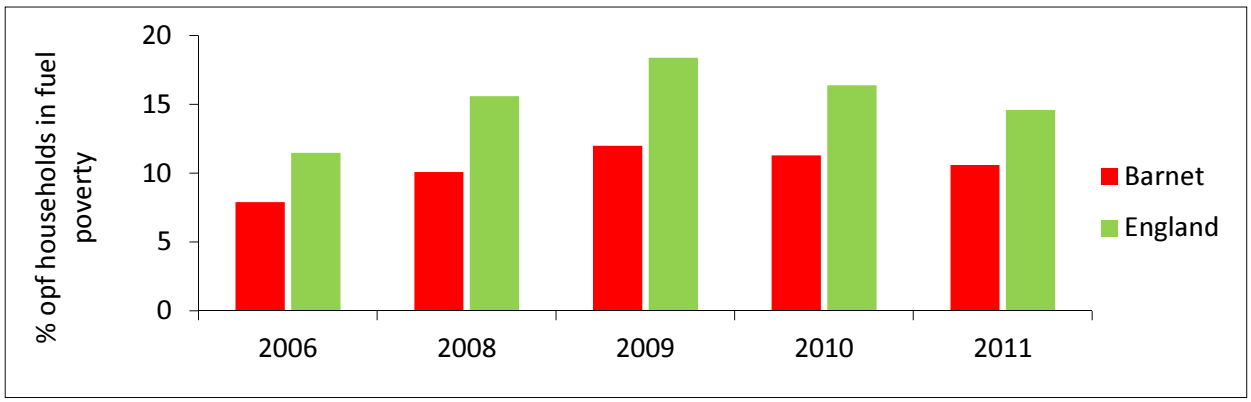
Source: Department for Communities and Local Government, local authority vacant dwellings, England 1989 to 2013

Given the high demand for housing in the Borough, the Council will look at bringing empty properties back into residential use. Currently, there are approximately 1,300 homes in Barnet that have been empty for 6 months or more. Where owners wish to bring properties back into use, the Council will provide financial assistance in the form of Empty Property Grants.

3.3.8 Fuel Poverty and Central Heating

Data produced by the Department for Energy and Climate Change shows that in 2011 10.6% of Barnet's households, or 13,628 homes, were fuel poor.

Figure 3-12: The proportion of households in fuel poverty, 2006-2011



Source: Department for Energy and Climate Change, sub-regional fuel poverty data: low income high costs indicator 2006-2011

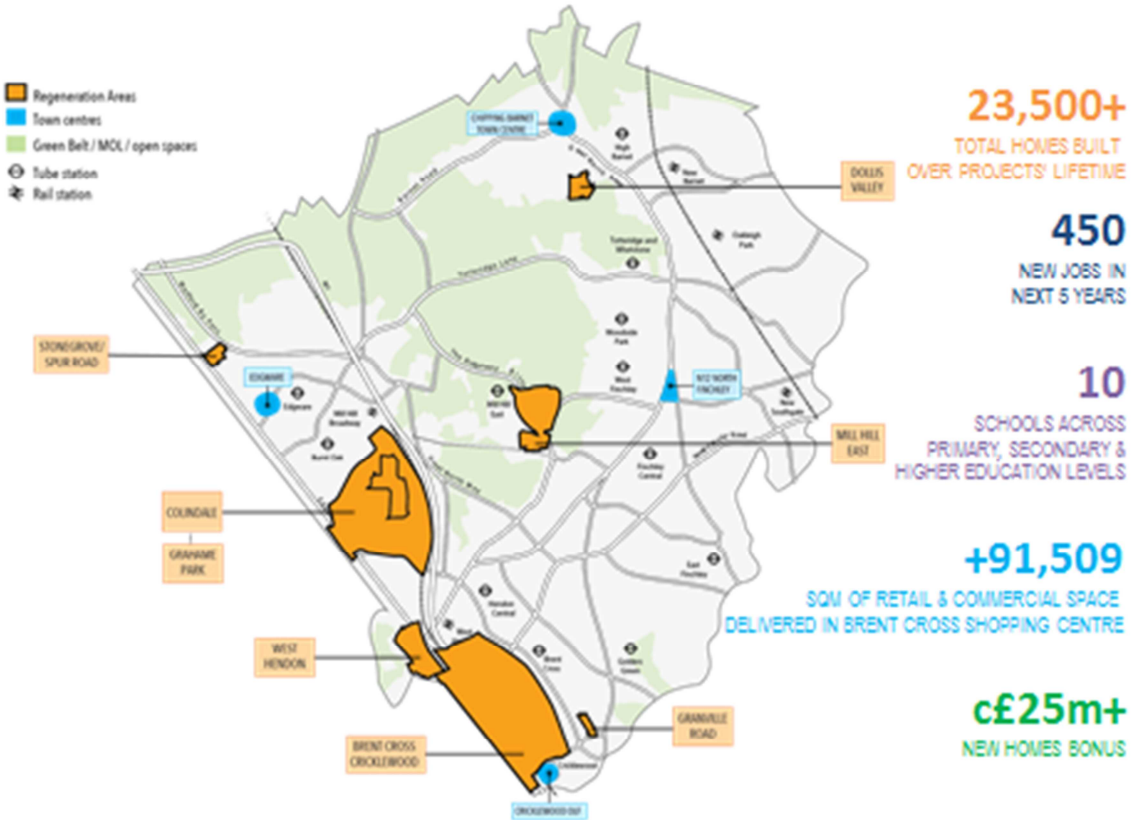
The level of excess cold hazards is considered an issue given the increasing numbers of older residents in Barnet.

3.3.9 Housing Supply

Housing is critical to Barnet's success as a Borough. It plays a key role in the Borough's ambitious plans for growth, providing the catalyst for the major regeneration programmes at Dollis Valley, Stonegrove/Spur Road, West Hendon, Grahame Park and Brent Cross/Cricklewood. Delivering these regeneration programmes will transform the more deprived areas of the Borough and create better places in which to live. There will be more housing tenure choice, increased employment and training opportunities, improved transport infrastructure, better education opportunities and better housing and management services for residents in these areas.

New housing will not only be delivered through the major regeneration programmes. The council is making use of new freedoms arising out of Housing Revenue Account self-financing and the reinvigorated Right to Buy, to build more homes on housing land, including affordable homes. The first three council homes to be built by Barnet Council, in partnership with Barnet Homes, have already been let and there are plans for a further 300 homes over the next 5 years on infill sites across the Borough.

Figure 3-13: Planned Regeneration Works within Barnet



3.3.10 Residents Voice

The Residents Perception Survey 2013 found an increase in concern from residents about lack of affordable housing and homelessness (with Barnet residents more concerned about the former compared to the London average).

Table 3-2: Residents Perception Survey Responses, 2013

Significant increases in concern	% listing this as top concern	Barnet % point change since 2012/13	London % point change since 2012/13	% difference to London 2013/14
Lack of affordable housing	27%	+6%	-3%	+4%
Number of homeless people	8%	+3%	-1%	-1%

Source: London Borough of Barnet, Resident's Perception Survey

In the last four years, overall tenants' satisfaction with the services provided by Barnet Homes has risen by 8.5%. It currently stands at 81.1%. The next challenge is to continue to provide high quality services to ensure that satisfaction rates remain high.

3.4 Environment

3.4.1 Carbon Emissions

The Council recognise the need to reduce carbon dioxide (C02) emissions in the Borough, and that this has to be approached through behavioural change by public services, citizens and businesses.

In 2012, per capita, CO2 emissions in Barnet were 4.4 tonnes per person, down from 5.4 tonnes per person in 2005. This was the fifteenth lowest in London, and below the Greater London rate of 5.2[6].

In 2012, the biggest source of CO2 emissions within Barnet was from homes (51.4%), with industry and commercial activity generating 24.3% of emissions and road transport creating 24.1%. The overall level of carbon emissions in Barnet fell from 1,759,400 tonnes of CO2 in 2005 to 1,600,300 tonnes of CO2 in 2012.

3.4.2 Air Pollution

For the majority of the population the health impacts of air pollution are not obvious, however, smaller numbers of the population are more vulnerable to the effects of air pollution, as exposure to pollution can exacerbate existing health conditions including cardiovascular and respiratory disease. This can lead to restricted activity, hospital admissions and even premature mortality[7].

The UK Air Quality Standards Regulations 2000, updated in 2010, sets standards for a variety of pollutants that are considered harmful to human health and the environment. Despite reductions in the majority of the pollutants, levels of PM10 and Nitrogen Dioxide (NO2) continue to exceed the national air quality standards and objectives in some areas of London.

Figures 3-14 and 3-15, spatially represent the annual mean concentrations of NO2 and PM10 in Barnet in 2011. Generally the levels of NO2 and PM10 are quite low within the Borough, although there are concentrated areas of higher pollution levels around some of the main arterial roads within the Borough.

[6] AEA for the Department of Energy and Climate Change: Local and regional CO2 Emissions Estimates for 2005-2012
[7] https://www.london.gov.uk/sites/default/files/Air%20Quality%20for%20Public%20Health%20Professionals%20-%20LB%20Barnet.pdf

Figure 3-14: Annual Mean Concentrations of PM10 in Barnet, 2011

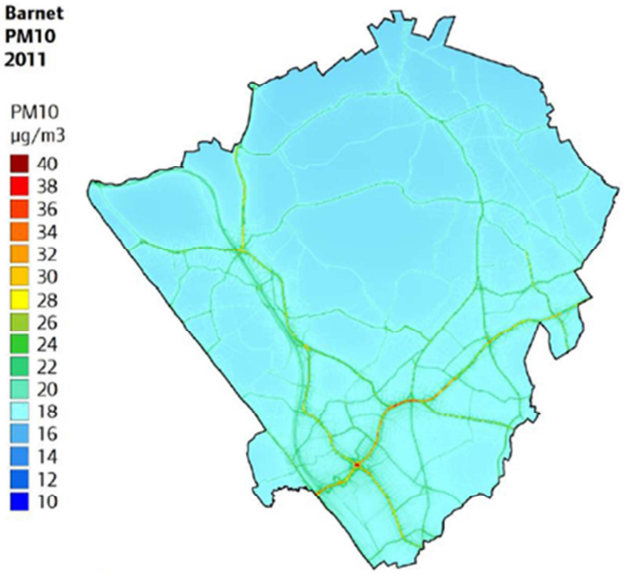
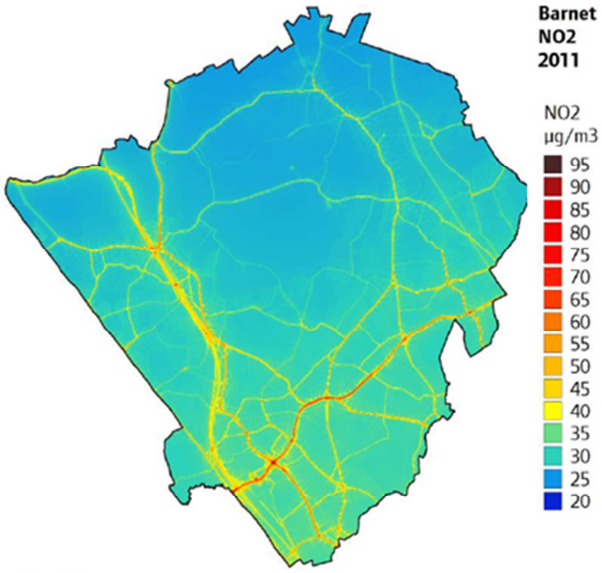


Figure 3-15: Annual Mean Concentrations of NO2 in Barnet, 2011

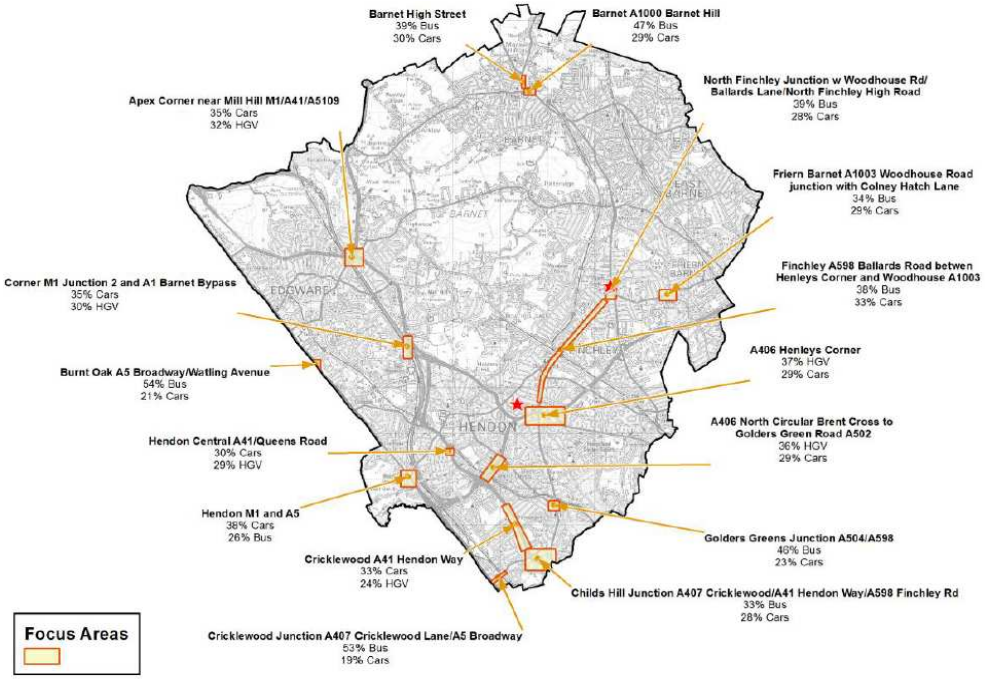


Source: Air Quality in Barnet a Guide for Public Health Professionals, 2013

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

In 2011 the GLA identified eight Air Quality Focus Areas within Barnet, outlined in Figure 3-16 below. The red stars represent the location of the monitoring equipment and the percentages under each location display the primary sources of Nitrogen Oxide emissions for that area.

Figure 3-16: Barnet Focus Areas and Air Quality Monitors



Source: Air Quality in Barnet a Guide for Public Health Professionals, 2013

3.4.3 Green Spaces

Parks are widely recognised for their health benefits as they can be used as a setting for casual or organised exercise. In Barnet, parks and green spaces are the most popular location for exercising, accounting for over 50% of exercise in the Borough[8]. Frequenting a park has also been found to reduce stress-related illness which has a positive effect on mental wellbeing[9].

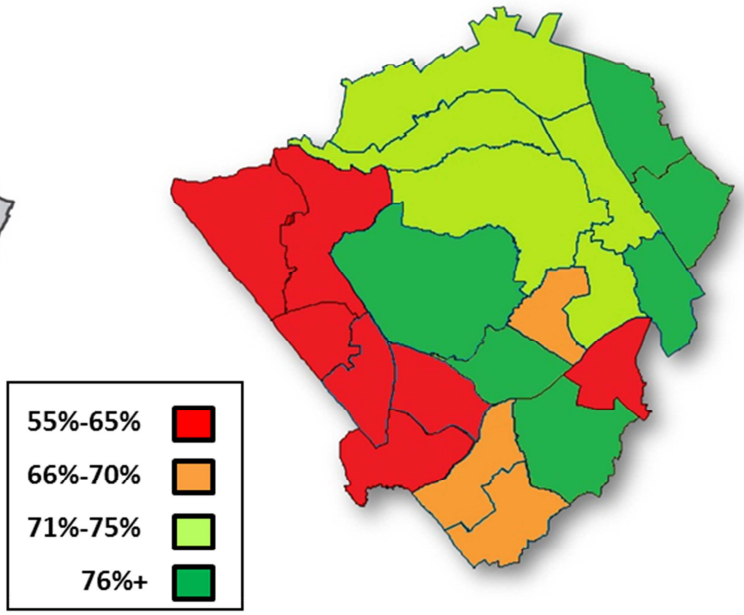
Figure 3-17 shows the location of parks and green spaces in Barnet, and Figure 3-18 shows satisfaction with parks and green spaces by ward. In 2014, the average satisfaction rate for parks and green spaces in Barnet was 70%. Burnt Oak residents had the lowest level of satisfaction (55%) whereas Garden Suburb had the highest (86%)[10].

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

Figure 3-17: Barnet's Parks and Green Spaces

Source: Capita Insight

Figure 3-18: Resident Satisfaction with Parks and Green Spaces



Source: Residents' Perception Survey 2014

A strategic assessment of the parks and green spaces within Barnet was undertaken in 2014. The key findings from the report were:

- Wards that have higher rates of crime that could take place in a park or green space (for example, assault, robbery, and sexual harassment) tend to also have the lowest level of satisfaction with parks.
- Safety and provision have been highlighted as factors that could increase the use of parks. The Leisure Services Survey (2013) notes that park use could be increased if facilities were improved, and if feelings of safety and security were increased.

[8] SPA Consultation, 2013

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

[10] Residents' Perception Survey, 2014

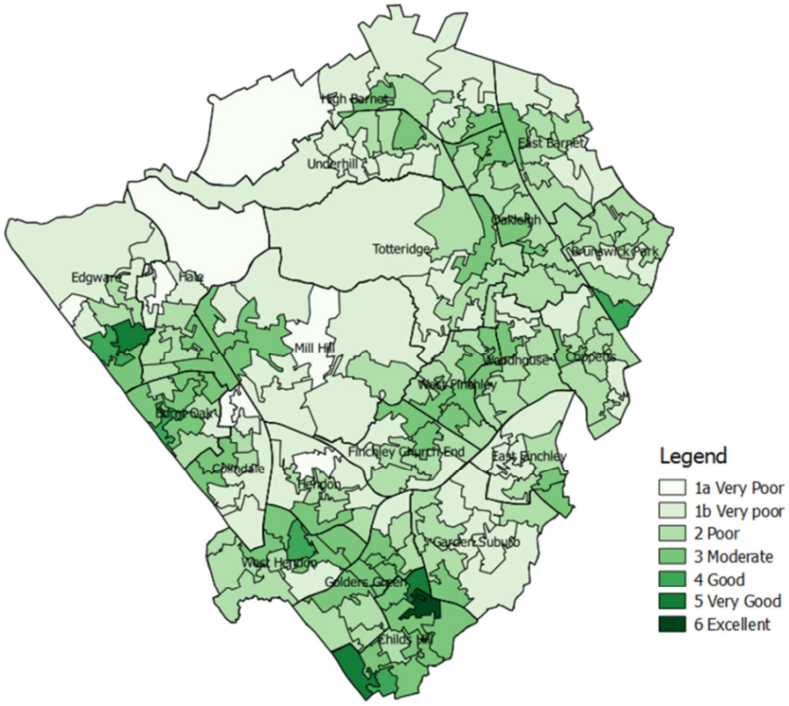
- There are a higher proportion of flats in the west of the Borough, indicating a lack of private open space. This suggests an increased need for public open space within this area.
- Burnt Oak, West Hendon, and Underhill have a higher proportion of residents who are very unlikely to volunteer in parks. This indicates a general disengagement with parks. Higher engagement could be encouraged from these groups by holding events that are targeted to appeal to the population of these wards.

3.4.4 Transport

3.4.4.1 Access to Public Transport

Lack of mobility is viewed as a contributing factor to deprivation, social disadvantage and exclusion as it inhibits people from accessing things such as friends, jobs and education[11]. Transport for London (TfL) produces an annual review of accessibility to public transport for each Borough, broken down by Lowest Super Output Area.

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



Source: Transport for London 2014, Public Transport Accessibility Levels

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

However, when compared against other Outer London Boroughs, only Brent and Waltham Forest have 'Moderate' accessibility; all other Outer London Boroughs are rated as either 'poor' or 'very poor'.

Furthermore, within Barnet the areas with the lowest accessibility scores are primarily located in areas with high levels of green belt land.

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

3.4.4.2 *Trips and Mode of Transport*

Data from the TfL's Travel Demand Survey provides an indication of the amount of trips people within Barnet make each day, and the types of transport they use, for journeys that commence in the Borough.

Table 3-3: Trip Rates and Modes of Transport, 2007/08 to 2009/10 (Barnet and Outer London)

Borough	Trips per Day per Person	Rail	Underground & DLR	Bus / Tram	Taxi / Other	Car & Motorcycle	Cycle	Walk
Barnet	2.9	2%	8%	11%	1%	47%	1%	30%
Outer London	2.5	5%	5%	12%	1%	49%	1%	27%

Source: TfL Travel Demand Survey, 2011

- Compared to the Outer London average, Barnet residents make more trips each day, 2.5 and 2.9 respectively.
- In line with Outer London trends, cars and motorcycles are the primary mode of transport accounting for 47% of journeys.

Although cycle usage currently only makes up 1% of journeys within the Borough, the Local Plan and Local Implementation Plan include targets to increase cycling usage to 4.3% of journeys by 2026. Local Plan policies state "We will seek to make cycling and walking more attractive for leisure, health and short trips."

Barnet has an extensive road network, the second highest length of public road in London, and contained within this are notable barriers to cycling, including the M1, the North Circular Road, A1000 and the Midland Mainline Railway. However, the Borough also contains a number of parks and green field spaces that offer quiet off road cycling opportunities away from traffic.

The London Mayor's Vision for Cycling includes a programme for delivery of Quietways across London. The routes intended to appeal to new and less confident cyclists are envisaged to be mainly on quiet roads. Potential routes in Barnet have been identified for consideration.

A cycle strategy for the Borough is in development and this aims to identify policy influences, a series of objectives, and delivery plans.

3.5 Town Centres

Barnet's high streets are highly valued by the people who use them and the businesses that operate in them; however, the last ten years has seen the most profound change in the way people spend their time and money for half a century.

The biggest change has been the rise of the internet and online shopping, which made up 13.5% of all purchases in 2010 and is projected to reach 23% by 2016. In 2008 53% of adults bought something online. In 2014 this figure had increased to 74%[12]. This trend has resulted in high street sales of items like electronic equipment, clothes, music and shoes all falling sharply.

There are also opportunities. For example, there has actually been some growth in things that consumers can't access online; like restaurants, beauty salons, gyms and other products related to

[12] http://www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2014/sty-digital-day-2014.html

lifestyle, food and leisure. There are opportunities associated with an ageing population too; older adults often have higher disposable incomes, and use the internet less than some other groups.

It is important that people are encouraged to visit and live in town centres and that any barriers to them doing this are minimised. Research by London Councils in 2012 showed that:

- Around 77% of people get to their local town centre by foot, public transport or bicycle rather than by car. These people spend more each month on average in town centres than drivers.
- On average, shoppers say that traffic reduction and environmental improvements would improve the shopping experience most, with cheaper parking being less important.[13]
- Only about 19% of journeys to a town centre in outer London are made by private car.

3.6 Economy

3.6.1 Overview

Between 2009 and 2012 Barnet's business population increased by 5.3%, to a total of 18,920 business units, a greater increase than for Greater London (4.6%). Amongst neighbouring local authorities only Haringey (8.3%), Harrow (9.1%) and Redbridge (13.6%) had higher growth over this period[14].

3.6.2 Key Sectors

Table 3-4 shows the number of business units by sector for Barnet, London and England in March 2012, compared with March 2009.

- In March 2012, the largest business sectors in Barnet were professional scientific/technical; construction; retail; info-communications; and Property.
- Barnet has higher proportions, than for Greater London, of construction property and wholesale.
- Barnet's sectors exhibiting the greatest business unit increase for 2009-2012 were education (22.9%), health (21%), property (15.9%), Professional, Scientific and Technical (PST) (15.8%), information & communication (9.9%) and motor trades (8.8%), with all except information & communication out performing Greater London sector growth.
- The greatest areas of decline were exhibited in public/administrative, production and business/administrative sectors, all performing worse than for London as a whole.

[13] http://www.londoncouncils.gov.uk/policylobbying/transport/parkinginlondon/parkingurban.htm
[14] IDBR annual data for March 2009 to March 2012

Table 3-4: Business Unit by Sector (Broad SIC2007) for March 2012 and change compared with March 2009 for Barnet, London and England

	Barnet			Greater London			England		
	2012	%	% change	2012	%	% change	2012	%	% change
Agriculture, forestry & fishing	35	0%	17%	565	0%	-6%	94,235	4%	0%
Production	540	3%	-6%	13,755	3%	-6%	128,370	6%	-6%
Construction	1,905	10%	-4%	33,775	8%	-2%	232,845	11%	-8%
Motor trades	310	2%	9%	6,215	2%	4%	66,330	3%	0%
Wholesale	1,300	7%	-1%	20,595	5%	-1%	108,845	5%	-2%
Retail	1,860	10%	1%	41,190	10%	3%	240,595	11%	-2%
Transport & storage	325	2%	7%	9,515	2%	1%	70,465	3%	-4%
Accommodation & food services	845	4%	-2%	25,675	6%	1%	139,370	6%	-5%
Information & communication	1,830	10%	10%	47,435	11%	14%	153,575	7%	6%
Finance & insurance	495	3%	7%	14,490	4%	-1%	56,965	3%	-2%
Property	1,640	9%	16%	20,390	5%	5%	80,100	4%	-1%
Professional, scientific & technical	3,475	18%	16%	85,070	20%	11%	329,060	15%	8%
Business administration and support services	1,385	7%	-6%	33,530	8%	-5%	157,510	7%	-9%
Public administration and defence	85	1%	-15%	2,570	1%	6%	20,315	1%	3%
Education	430	2%	23%	8,810	2%	10%	56,555	3%	4%
Health	1,010	5%	21%	21,425	5%	18%	126,690	6%	11%
Arts, entertainment, recreation & other services	1,450	8%	-1%	34,730	8%	2%	156,390	7%	-3%

Source: Annual IDBR data for years ending March 2012 and March 2009

- Between 2008 and 2011 employment in Barnet's businesses decreased by 1.9% to 118,461 (an overall loss of 2,202 jobs), compared to a decrease of 0.9% for Greater London as a whole[15].
- The largest employment wards in Barnet are West Hendon and Colindale, located to the west of the Borough along the A5 corridor, and West Finchley in the centre of the Borough on the Ballard's Lane access route[16].

'The Economic Outlook for London'[17] indicates that between 2012-15 the main employment growth sectors will be professional, scientific/technical, business administration, info-communications and construction, whilst education and health may exhibit some decline. This does not appear entirely in step with Barnet, where there is currently growing demand for health and education services against the context of a growing and ageing population.

[15] NOMIS annual BRES data 2008 to 2011
[16] BRES 2011
[17] Oxford Economics: http://web.oxfordeconomics.com/FREE/PDFS/UKMFEAT3_1012.PDF

3.7 Employment

Table 3-5 shows the employment and unemployment rates within Barnet, compared against Outer London and UK averages. Against both comparators, Barnet has the lower employment rate of 70.9%, compared to 71.5% for Outer London and 72.1% for the UK.

Of people employed, Barnet has a much higher rate of people who are self-employed (19.0%) compared to the Outer London rate of 12.3% and the UK rate of 10.0%. This implies a strong entrepreneurial flair within the Borough.

Table 3-5: Employment Rates for 16-64 Year Olds, (Barnet, Regional and National), October 2013 – September 2014

	Barnet		Outer London		United Kingdom	
All People	**Number**	**%**	**Number**	**%**	**Number**	**%**
Economic activity	176,699	74.6%	2,580,500	77.1%	31,349,500	77.2%
In employment	167,935	70.9%	2,393,800	71.5%	29,261,400	72.1%
Employees	121,510	51.3%	1,967,300	58.8%	25,005,300	61.6%
Self-employed	45,004	19.0%	412,700	12.3%	4,054,500	10.0%

Source: Labour Market Profile Nomis, 2015

- By Ward in 2011, the highest rates of employment were located within East Finchley (74.9%); High Barnet (74.5%) and West Finchley (74.2%).
- Whereas, the lowest employment levels are generally located in the West of the Borough, with Colindale (61.9%) and Burnt Oak (63.7%), having the lowest employment rates.

3.8 Unemployment

Following the recession, unemployment rates for within Barnet raised from 5.0% in 2008 to 9.3% in 2012[18]. However, since this time, the unemployment has begun to reduce with a rate of 5.0% in September 2014. In line with national trends, the highest rate of unemployment (11.9%) is within the 16-24 age group, although this is below the Outer London rate of 20.4% and the UK rate of 17.5%.

- By Ward, the lowest rate of unemployment in 2011 was located in Garden Suburb (3.6%), Totteridge (4.1%) and High Barnet (4.5%).
- The Wards with the highest rates of unemployment were once again located towards the West of the Borough in Colindale (8.4%) and Burnt Oak (8.1%).

3.9 Skills and Qualifications

54% of respondents to the 2014 CBI, Employment Trends Survey, claim that low skill levels will be the biggest threat to the labour market for the next five years. Skills gaps can reflect misalignment between the skills the workforce has and those that employers need, suggesting that the content of qualifications and training may not be fully meeting employer needs.

[18] ONS Labour Market Profile – based on 16-64 age group

Table 3-6: Density of Skills Shortages by Occupation Type in Barnet, 2013

Occupation Type	% Skills Shortage
Managers	1.36%
Professionals	7.13%
Associate professionals	37.61%
Administrative/clerical staff	1.46%
Skilled trades occupations	13.23%
Caring, leisure and other services staff	38.50%
Sales and customer services staff	0.71%
Machine operatives	0.0%
Elementary staff	0.0%
Unclassified staff	0.0%

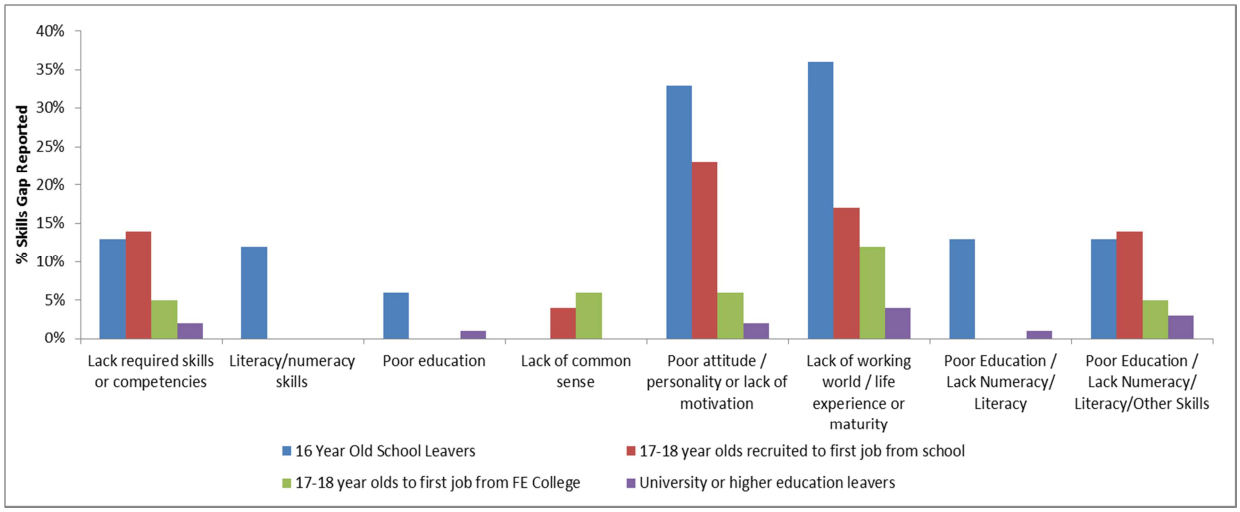
Source: UK Commission Employer Skills Survey 2013

- Caring, leisure and other service occupations have the highest density of skills shortages within Barnet (38.50%). The ageing population is projected to drive up demand for services within this sector and so there could be opportunity for substantial growth within this segment in the future.
- Associate professionals are the third largest occupation type in Barnet, accounting for 13.3% of total jobs; however, it has the second largest level of reported skills shortages. The reported skills shortages within this occupation could be why it is underrepresented when compared to the UK where it accounts for 14.0% of the total jobs market.

Barnet performs well on in job skills shortages, when compared against other regions. 13.0% of Barnet employer's report that Barnet employees did not meet their skills requirement, the lowest in London where the average is 18.0%.

However, as can be seen from Figure 3-20, skills gaps vary significantly depending on the qualification level held by the employee. There is a significant reduction in reported skills shortages for employees who have attended University or Higher Education. This is especially apparent within 'lack of working/life experience or maturity' and 'poor attitude/personality or lack of motivation' which reduce by 32% and 31% respectively.

Figure 3-20: Percentage Skills Gaps within Barnet, by Qualification Type, 2013



Source: UK Commission Employer Skills Survey 2013

Positively, 50.4% of Barnet's working age population hold at least an NVQ level 4 qualifications. This is above the UK rate of 35.1% and the London rate of 48.4%[19]. In line with national and local trends, the proportion of the Barnet population with NVQ level 4 or above qualifications is likely to increase in the future[20].

3.10 Welfare Reform

The current programme of reform to the benefit system, which started in 2011, constitutes the biggest shake up of the welfare state in over 60 years. The reforms that have been rolled out are wide ranging and include changes to some out of work and disability related state benefits, uprating of a wide range of benefits and the locally administered housing benefit and CTS schemes.

As part of these changes, the Government expects reforms to reduce the overall benefits bill. In Barnet, the total reduction in benefits received by eligible residents is expected to be £81.4m in 2015/16 – the 10th highest reduction in the country. The average loss for each claimant household is £2,100[21].

3.10.1 The Impact of Welfare Reform in London

The London Poverty Profile shows that 26% of households in London received housing benefit in 2012, which was higher and has grown faster than the average for England. Average housing benefit values are also much higher in London at £134 per week compared with £92 per week for England.

A quarter of households in London received council tax benefit in 2012, two percentage points higher than the average for England. As a result, the recent changes to Housing Benefit will likely have a wider and deeper impact in London.

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

Sheffield Hallam University has also researched the cumulative impacts of the reforms. Although the findings in the report are estimates, the data is taken from the Treasury's estimates of the financial savings and the government's impact assessment and benefit claimant data.

The findings indicate that the largest impact of welfare reform will be in London. These include not just those areas that have traditionally been identified as 'deprived' but also Boroughs with high benefit receipt and exceptionally high housing costs, which combine to give very large impacts per household, such as Westminster, Kensington and Chelsea and Enfield.

3.10.2 The Impact of Welfare Reform in Barnet

In Barnet, high rents and high levels of benefit receipt have combined to mean that overall welfare reforms can lead to very large financial losses. Research by the Centre for Economic & Social Inclusion commissioned by LGA, estimates that in 2015/16 nearly 40,000 households in Barnet will be affected by at least one of the reforms, the 10th highest in England and the average loss per household will be the 7th highest after Westminster, Kensington & Chelsea, Brent, Wandsworth, Camden and Hackney.

In Barnet 60% of the losses from welfare reforms affect working households and the biggest financial losses are from changes to working tax credits (£26.5 m) and Local Housing Allowance rates (£23.2m). Of the 20,000 affected by the changes to Council Tax support, there are around 3,500 working households claiming Working Tax Credits.

Overall, Welfare Reform means that the 20,000 or so working age claimants of Council Tax support, that will be affected by any changes to Council Tax support, are currently losing nearly £20m already as a result of the locally administered HB and current localised Council Tax Support scheme. In addition to these losses they will also be affected by one or more reductions to Central government administered benefits such as:

- Child Tax Credits
- Working Tax Credits
- DLA replacement with PIP
- 1% up rating (instead of using consumer price index) of all benefits
- ESA

3.10.3 Out of Work Benefits

In August 2014 there were 22,410 people claiming out-of-work benefits in Barnet, 9.5% of the total 16-64 population (table 8). This is below the Outer London and UK rates of 10.9% and 12.6% respectively.

Table 3-7: Benefit Claimants, August 2014 (Barnet, Regional and National)

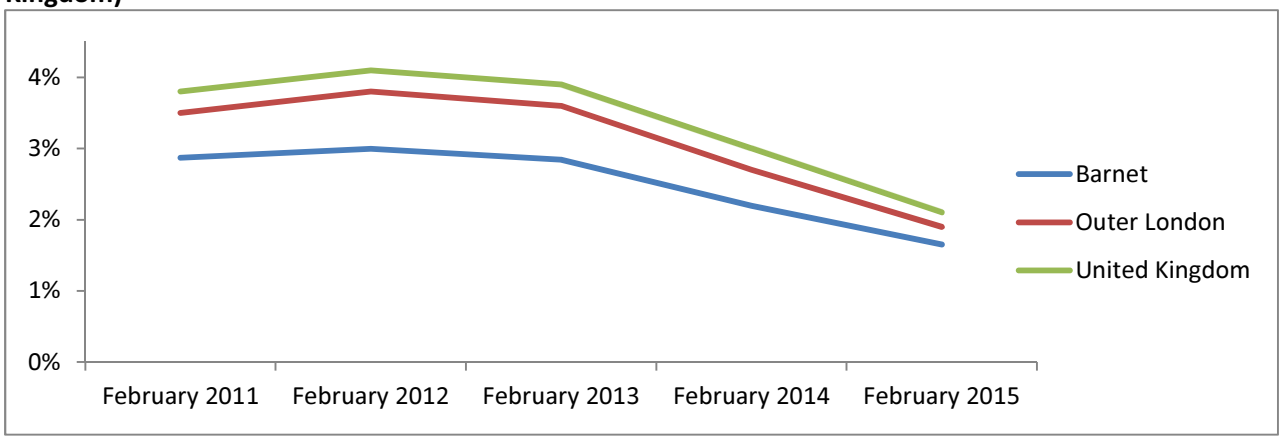
	Barnet		Outer London		England and Wales	
	Number	% of 16-64 Population	Number	% of 16-64 Population	Number	% of 16-64 Population
Total Claimants	22,410	9.5%	361,200	10.8%	4,553,720	12.6%
By Statistical Group						
Job seekers	4,150	1.8%	70,940	2.1%	773,250	2.1%
ESA and incapacity benefits	11,030	4.7%	167,350	5.0%	2,229,760	6.1%
Lone parent	2,160	0.9%	41,220	1.2%	433,190	1.2%
Carer	2,260	1.0%	36,810	1.1%	520,400	1.4%
Others on income related benefit	540	0.2%	9,070	0.3%	115,410	0.3%
Disabled	1,920	0.8%	30,330	0.9%	416,820	1.1%
Bereaved	360	0.2%	5,470	0.2%	64,900	0.2%
Key out-of-work benefits[22]	17,880	7.6%	288,590	8.6%	3,551,610	9.8%

Source: DWP benefit claimants - working age client group 2015

The latest data from the ONS indicates that in February 2015, 3,932 (1.7%) people in Barnet were receiving Job Seekers Allowance (JSA). Of those, 2,327 (59.2%) were male and 1,605 (40.8%) were female. This is below the Outer London and UK rates of 1.9% and 2.1% respectively.

Figure 3-21 shows that, apart from a slight increase in JSA claimants in 2012, there has been an overall downward trend in the amount of JSA claimants within the Borough, this has also occurred with the level of regional and national claimants.

Figure 3-21: The Percentage of People Claiming JSA, 2011-2015 (Barnet, Outer London and United Kingdom)

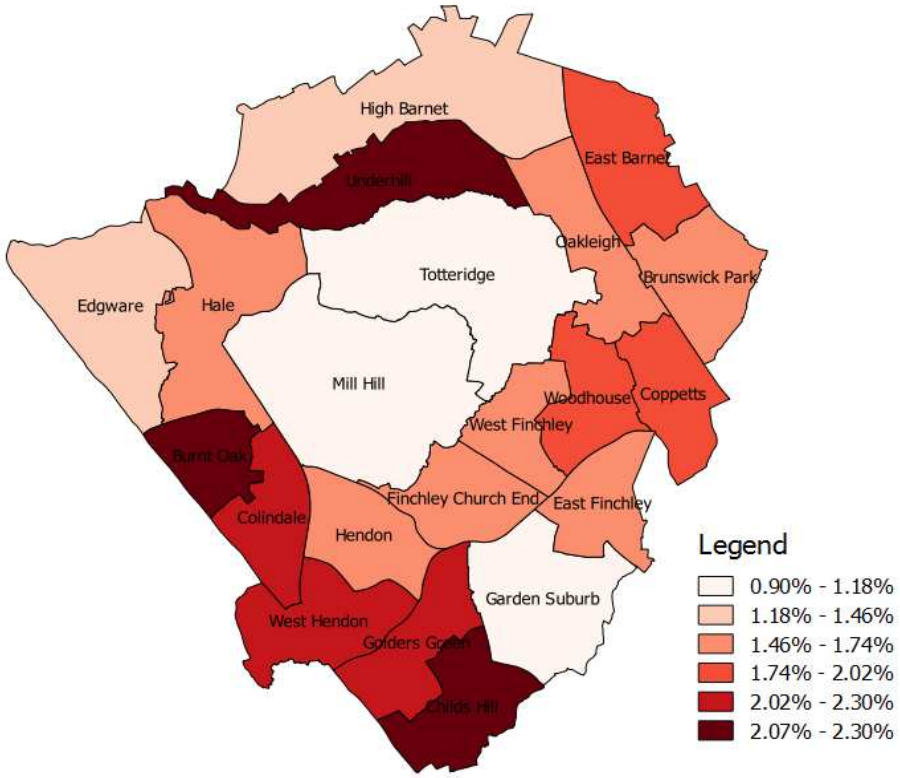


Source: ONS claimant count 2015

Figure 3-22 shows the proportion of JSA claimants by Ward. Many of the areas with high rates of JSA claimants are situated in the West of the Borough, with Child Hills having the largest proportion (2.3%).

[22] Key out-of-work benefits include the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits.

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



Source: ONS claimant count 2015

Table 3-8 breaks down JSA claimants by the average length of time the person has been claiming; less than 6 months; 6-12 months; and over 12 months. Interestingly, although Child's Hill has the largest proportion of claimants who have been claiming for over 6 months (33.8%), over a quarter of High Barnet's and Garden Suburb's claimants have been claiming for over 12 months.

Table 3-8: JSA Claimants by Ward by Length of Time Claiming, February 2015

Ward Name	Number	% of Total Population	Up to 6 Months	6-12 Months	Over 12 Months
Brunswick Park	147	1.4%	63.3%	16.7%	20.0%
Burnt Oak	265	2.2%	62.3%	17.0%	20.8%
Childs Hill	325	2.3%	55.4%	10.8%	33.8%
Colindale	293	2.0%	67.8%	11.9%	20.3%
Coppetts	213	1.8%	61.9%	11.9%	26.2%
East Barnet	190	1.8%	61.5%	15.4%	23.1%
East Finchley	173	1.6%	68.6%	14.3%	17.1%
Edgware	131	1.2%	59.3%	18.5%	22.2%
Finchley Church End	145	1.4%	62.1%	13.8%	24.1%
Garden Suburb	100	1.0%	60.0%	15.0%	25.0%
Golders Green	216	1.9%	51.2%	16.3%	32.6%
Hale	176	1.6%	65.7%	14.3%	20.0%
Hendon	202	1.6%	62.5%	15.0%	22.5%
High Barnet	125	1.3%	60.0%	8.0%	32.0%
Mill Hill	146	1.1%	62.1%	17.2%	20.7%
Oakleigh	149	1.5%	70.0%	10.0%	20.0%
Totteridge	87	0.9%	64.7%	17.6%	17.6%
Underhill	210	2.1%	65.9%	12.2%	22.0%
West Finchley	184	1.6%	65.8%	15.8%	18.4%
West Hendon	234	1.9%	60.4%	16.7%	22.9%
Woodhouse	221	1.8%	66.7%	11.1%	22.2%
Barnet	3,932	1.70%	62.5%	14.1%	23.4%

Source: ONS claimant count 2015

In August 2014 there were just over 11,000 people on a health related benefit within Barnet (ESA & IB), the 15th largest amount in London[23]. Taking population size into account, this only represents 4.7% of the 16-64 population, the 12th lowest across all London Boroughs, and below the Outer London average of 5.0%.

Table 3-9 shows the top five conditions of claimants of either Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) within Barnet in August 2014.

- Across all locations 'mental and behavioural disorders' are the most common condition reported by claimants. Although only small, there is a higher proportion of claimants with these conditions in Barnet (44.9%) compared to London (44.5%) and these are both above the England rate (43.5%).
- In comparison to London, Barnet is also overrepresented with the proportion of 'diseases of the nervous system' 6.8% and 8.0% respectively. Although Barnet is still below the England rate of 9.1%.

Table 3-9: Incapacity Benefit (IB) & Severe Disablement Allowance (SDA) by Claimant Type, August 2014 (Barnet, Regional and National)

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

Condition	Barnet	London	England
Mental and behavioural disorders	44.9%	44.5%	43.5%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	12.8%	13.9%	15.0%
Diseases of the musculoskeletal system and connective tissue	11.8%	12.2%	12.1%
Diseases of the nervous system	8.0%	6.8%	9.1%
Injury, poisoning and certain other consequences of external causes	3.7%	3.5%	3.2%

Source: NOMIS Labour Market Profile: DWP benefit payments - incapacity benefit/severe disablement August 2014

3.11 Disability and Employment

3.11.1 Mental Health

Unemployment can lead to diminished social networks and social functioning, as well as decreased motivation and interest which can lead to apathy. People suffering from mental health problems are especially sensitive to these negative effects of unemployment[24]. Whereas, the social exclusion that they experience as a result of mental ill health is reduced by work and aggravated by unemployment[25].

The Health and Social Care Information Centre measures the number of people by Borough who are in contact with Mental Health Services and in employment[26], the latest data for Barnet is displayed in Table 3-10.

- Within Barnet, for the period 2013/2014, 5.7% of people who were known to mental health services were in employment. In comparison to other regions this is quite low; as only Bromley, Redbridge and Milton Keynes had a lower rate.
- By gender, Barnet is performing better for women where 7.3% of people known to mental health services are known to be in employment. This is above the Outer London average of 7.0%, although it is still below the England average of 8.5%.
- For men, only 4.5% of males known to mental health services in Barnet were in employment in 2013/14. This was the second lowest rate of all statistical neighbours, and below the Outer London and England averages of 5.0% and 5.8% respectively.

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

25 Social Exclusion Unit (2004) Mental Health and Social Exclusion. London: Office of the Deputy Prime Minister

[26] http://ascof.hscic.gov.uk/Outcome/717/1F

Table 3-10: Proportion of adults in contact with secondary mental health services in paid employment, 2013/14

Area	Total	Male	Female
Reading	12.7%	10.6%	15.9%
Sutton	9.7%	8.0%	11.7%
Merton	9.2%	7.1%	11.9%
Kingston upon Thames	8.6%	5.8%	11.7%
Hillingdon	8.3%	7.2%	9.8%
England	7.0%	5.8%	8.5%
Hounslow	6.7%	6.6%	6.8%
Ealing	5.8%	5.2%	6.5%
Outer London	5.8%	5.0%	7.0%
Barnet	**5.7%**	**4.5%**	**7.3%**
Bromley	5.5%	4.7%	6.7%
Redbridge	4.4%	3.7%	5.4%
Milton Keynes	3.7%	4.7%	2.3%

Source: Health and Social Care Information Centre, 2013/14

3.11.2 Learning Disabilities

People with learning difficulties find it much harder to get a job than people without learning difficulties. It is estimated that around 65% of people with learning difficulties would like to work, and with the right support they make highly valued employees[27].

- In February 2015 the proportion of adults known to Social Care with learning disabilities who were paid in employment was 9.4%, compared with the Outer London average of 9.9% and the England average of 6.7% (Table 3-11).
- By gender, across most areas females with learning disabilities tend to have a lower rate of employment than men. This is the case in Barnet, where 10.2% of males with learning disabilities are in paid employment compared to only 8.3% of females.

[27] http://www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187693/

Table 3-11: Proportion of adults with a learning disability in paid employment, February 2015

	Total	Male	Female
Redbridge	15.2%	12.3%	18.8%
Kingston upon Thames	14.3%	17.6%	9.6%
Milton Keynes	11.7%	12.2%	11.0%
Bromley	11.5%	11.8%	11.1%
Merton	11.3%	14.6%	6.1%
Hounslow	10.6%	11.4%	9.5%
Outer London	9.9%	10.6%	8.9%
Barnet	**9.4%**	**10.2%**	**8.3%**
Ealing	9.2%	10.6%	6.9%
Reading	7.8%	9.1%	6.0%
England	6.7%	7.4%	5.8%
Sutton	4.4%	5.4%	3.1%
Hillingdon	1.4%	-	-

Source: Health and Social Care Information Centre, 2013/14

3.12 Incomes

CACI PayCheck is an estimate of household income at postcode level. It is based upon government data sources together with income data for UK homes collected from lifestyle surveys and guarantee card returns. PayCheck models gross income before tax to provide an estimated income for every household within the UK. Income values can be shown as 'nominal values' or 'real values'. The values shown below are 'nominal values'.

- According to data from the 2015 CACI PayCheck, Barnet's average raw household income in 2015 was £41,468; this is 44.5% higher than the Great Britain average of 28,696.
- Between 2012 and 2015 Barnet's average household income increased by 17.1%, compared to the Great Britain average which increased by 1.0%.

3.12.1 Ward Level

Although average incomes are rising in Barnet, there is significant variation in incomes across the Borough. Table 3-12 shows the median household income by ward for 2008, 2012 and 2015.

Growth in incomes is predominantly being driven by more affluent Boroughs, with the wards with the lowest average incomes in 2015; Burnt Oak, Colindale and Underhill stagnating and even falling in real terms[28]. This results in higher income inequality between different areas in Barnet.

[28] Real term values or 'real values' are dereived by adjusting the actual or 'nominal value' by inflation, to take into account the changing value of money ovetime.

Table 3-12: Median Household Income by Ward, 2008, 2012 & 2015

Area Name	2008	2012	2015	Change: 2008-2015%	Change: 2012-2015%
Brunswick Park	£35,249	£35,740	£41,266	17.1%	15.5%
Burnt Oak	£27,274	£25,745	£25,930	-4.9%	0.7%
Childs Hill	£34,924	£36,192	£42,165	20.7%	16.5%
Colindale	£28,028	£27,295	£30,125	7.5%	10.4%
Coppetts	£37,622	£36,402	£41,726	10.9%	14.6%
East Barnet	£35,394	£35,204	£41,491	17.2%	17.9%
East Finchley	£35,199	£35,905	£40,907	16.2%	13.9%
Edgware	£34,596	£35,705	£44,158	27.6%	23.7%
Finchley Church End	£40,359	£39,201	£49,814	23.4%	27.1%
Garden Suburb	£44,220	£44,701	£55,491	25.5%	24.1%
Golders Green	£33,240	£32,625	£40,877	23.0%	25.3%
Hale	£35,070	£34,527	£41,148	17.3%	19.2%
Hendon	£34,022	£33,579	£41,557	22.1%	23.8%
High Barnet	£40,111	£39,765	£48,540	21.0%	22.1%
Mill Hill	£38,146	£38,524	£44,596	16.9%	15.8%
Oakleigh	£37,661	£37,558	£45,919	21.9%	22.3%
Totteridge	£38,946	£39,875	£49,783	27.8%	24.8%
Underhill	£32,336	£31,100	£34,342	6.2%	10.4%
West Finchley	£37,842	£38,348	£47,000	24.2%	22.6%
West Hendon	£31,992	£31,773	£36,642	14.5%	15.3%
Woodhouse	£36,348	£34,946	£41,549	14.3%	18.9%

Source: CACI PayCheck 2008, 2012 and 2015

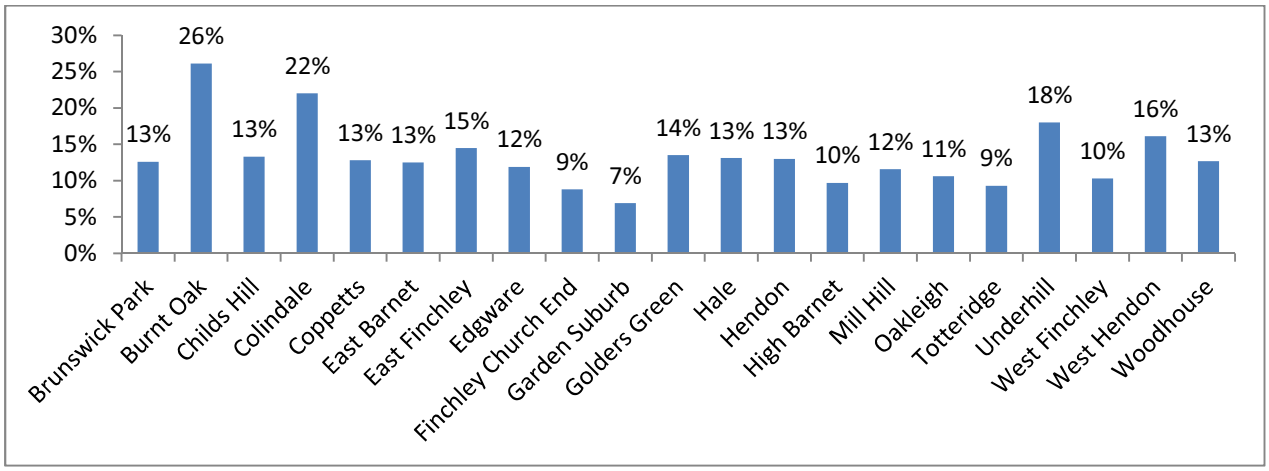
3.12.2 Poverty Measures

The poverty line is defined by the government as 60% of median net income. Using Paycheck 2015 unequivalised Great Britain data, the official poverty line is equivalent to £17,217.

In 2015, 13.5% of households had a household income of below £15,000; this is above the London rate of 18.0% and the Great Britain rate of 24.0%. In comparison to other London Boroughs, Barnet has the sixth lowest rate of households with a total income of less than £15,000 per year. Richmond has the lowest (9.3%) whereas Barking and Dagenham has the highest (27.1%).

Figure 3-23 shows the proportion of households by ward with a household income of below £15,000. More than one in four households in Burnt Oak earn below £15,000 per year and around one in five households in Colindale and Underhill earn below £15,000 per year; this compares to Garden Suburb where fewer than one in ten households earns below £15,000 per year.

Figure 3-23: % 0-15k Household Income by Ward, 2015



Source: CACI PayCheck 2015

4 Barnet Customer Segments – Overview

4.1 Introduction

Each person in Barnet has been grouped into 1 of 17 customer segments which are customer portraits based on CAMEO demographic and lifestyle data produced by Call Credit Information Group. The segments are created at household level and every person in a household belongs to the same customer segment. People in each group broadly have the same characteristics which drive their common needs, interests and behaviours. Understanding the characteristics of the customer segments will help to better deliver services to Barnet residents[29].

This chapter introduces the 17 Barnet customer segments and describes them by their age, income, life-stage and where they live. Self-reported health of each of the segments is detailed along with the effect of limiting long-term illness on peoples' ability to work. This chapter concludes with a section that suggests which customer segments will be the heaviest users of health services in the borough and how addressing their needs will have a wider socio-economic impact.

4.2 Profile of Barnet Customer Segments

To introduce relevant characteristics of the 17 customer segments, a brief description of each is presented below. The CAMEO information that can be used for profiling health data is relatively limited, but the key findings are summarised in the segment description.

4.2.1 Educated, Affluent Families (17% of Barnet households[30])

Households from this segment are highly affluent and educated, with young children. These are residents of all ages, often earning over £50,000, and owning large, expensive homes. They often engage in fun family sports and are active parents. A staggering 86% report good health, and a further 10% fairly good health, making them the healthiest segment in Barnet.

4.2.2 Sophisticated Singles (15%)

They are educated, affluent singles or divorcees who own pricey properties. Their age ranges from 25 to 65 and their earnings are mostly upwards of £30,000. These residents enjoy summer sports and travelling. An impressive 86% report very good health, and 10% fairly good health, placing them 3rd among the healthiest Barnet segments.

4.2.3 Low Income House sharers (13%)

These residents are low income, blue collar or unemployed house sharers. They can be friends, family or same-sex couples living in pairs, who are renting or owning small, low value properties. They can be of all ages and earn in the range of £15,000 - £30,000. The residents in this group often spend their leisure time exercising and are health aware. They enjoy a reasonably good health, with 5% reporting poor health.

4.2.4 Financially Secure Retirees (10%)

The residents in this segment are financially secure, educated pensioners who own expensive properties. They are either couples or widowed singles aged 65 and over, with a household income of £30,000 or more. They enjoy traditional sports and playing with their grandchildren. A health

[29] All analyses in this chapter are based on CAMEO CallCredit data (February, 2015), which comprises individual-level and household-level information about 235,529 Barnet residents aged 16+.
[30] Due to rounding, percentages may not total 100%

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

4.2.5 Comfortable Older Families (8%)

These growing family households are economically active, educated, white collar, owning large average-value properties and are often burdened by large mortgages. They can be of mixed ages, ranging from 20 to 70 and bring home an income between £20,000 and £50,000. They enjoy spending time with their family and playing golf. While their health is generally good, slightly over 5% report poor health, placing them in the second quartile of healthiest residents.

4.2.6 Affluent Singles (8%)

These residents are highly affluent, educated, upwardly mobile, energetic and ambitious singles who share or own high value properties. They are generally aged 25 to 45 and earn over £40,000. The residents in this group often spend their leisure time exercising and are health aware. They are the second healthiest segment in Barnet, with just 4% reporting poor health.

4.2.7 Penny-wise Pensioners (6%)

These are households of minimal income, formerly blue collar, settled elderly couples or widowed singles who own small, low-value properties or live in residential homes. They are aged 65 and over and their income is often below £20,000. A rather high proportion report poor health (5.56%), placing them in the medium high group of least healthy Barnet segments. They are likely to have health problems and spend most of their time in their home.

4.2.8 Financially Restricted Single Parents (5%)

These residents are financially restricted, white collar, part-timers or home-makers, government supported single parents of all ages. They are living in council homes or renting low value properties, and usually have an income of under £30,000. With 5.14% reporting poor health, these residents are in the medium high group of least healthy Barnet segments.

4.2.9 Secure older people (4%)

These households are comfortably retired, well settled, established couples or widowed singles of mixed former occupations who own modest properties. Aged over 55, they have an income between £20,000 and £30,000. They are a health aware group and often spend their time gardening. With 83.7% reporting good health and a further 11.7% fairly good health, they fall into the second quartile of healthiest Barnet residents.

4.2.10 Contended Greys (4%)

These are empty house and full wallet households of educated, settled couples, either reaching or starting to enjoy their retirement years. Aged 45 to 65, they usually have an income of over £40,000 and own large, expensive homes. They like to keep active and often spend their leisure time travelling, gardening and playing golf. An impressive proportion enjoys good (84.8%) and fairly good (10.9%) health, placing them in the top quartile of most healthy Barnet residents.

4.2.11 Low Income Singles (3%)

These are households of financially constrained, blue collar or unemployed, single residents who are renting low quality housing or living in council homes. They are generally aged 40 to 65, mostly living alone, with an income below £20,000 and often in receipt of benefits. Among this non-sporty group

the proportion of residents who report poor health is rather high (5.78%), placing them in the highest group of least healthy Barnet segments.

4.2.12 Well Educated and Employed Single Parents (2%)

The residents in this segment are financially secure, educated, working single parents who share or own high value properties. Their age ranges between 20 and 45 and their income is usually over £30,000. They enjoy spending time with their kids and travelling. A health aware group, they mostly enjoy a good (85.5%) and fairly good (10.3%) health, being among the top quartile of healthiest segments in the borough.

4.2.13 Financially Restricted Single Students and Friends (2%)

These residents are financially limited, young independent singles, students and friends living together in rented low value properties. They are aged 20 to 45 and have an income of less than £20,000. Although they spend a lot of their leisure time exercising, 5.98% report a poor health, which places them among the least healthy segments.

4.2.14 Prosperous Young Couples Without Kids (2%)

These are extremely affluent households of educated young couples with dual incomes and no kids who live in mortgaged medium to high value properties. Aged 25 to 45, they often earn over £50,000. They are a health aware group and enjoy travelling. With 85.1% reporting a good health and 10.7% a fairly good health, this segment is among the healthiest in Barnet.

4.2.15 Financially Secure Singles (1%)

They are financially comfortable, educated singles living alone who rent or own average value properties. They are aged 25 to 45 and earn in the range of £25,000-£30,000. A health aware group, they spend much of their leisure time exercising. With a moderate 4.64% rating their health as poor, they fall into the second quartile of healthiest Barnet segments.

4.2.16 Struggling Families (1%)

These very low income households, of blue collar or unemployed families with children live in council properties or in owned low-priced properties. They can be of mixed ages and usually earn below £20,000.

4.2.17 Low Income Couples (1%)

These are low income households of blue collar or unemployed couples with no children who rent low price properties or live on council estates. They are generally aged over 40 and earn in the range of £20,000-£30,000, often receiving benefits. This non-sporty group is the least healthy segment in Barnet, with 6.36% of residents reporting poor health.

4.3 Profile of Barnet

Barnet is older, has a larger proportion of families and has higher household incomes compared to the rest of London. As would be expected, Barnet has a broad similar distribution of segments when compared to its statistical neighbours[31], though when contrasted against Hounslow and Merton, Barnet's population is again older and more family oriented. Comparing Barnet to Kingston-upon-Thames, the two populations are very similar. Throughout this document, Barnet is compared to

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

statistical neighbours. Kinston-Upon-Thames can be used as an exemplar approach when it outperforms Barnet at addressing certain health problems.

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

Customer Segments	Barnet	Hounslow	Kingston upon Thames	Merton	LONDON
A - Affluent singles	7.59%	8.44%	9.44%	8.42%	7.85%
B - Prosperous young couples without kids	1.59%	1.87%	3.24%	3.73%	2.26%
C - Educated, affluent families	16.53%	9.18%	18.93%	13.61%	10.19%
D - Well educated and employed single parents	2.45%	1.59%	2.44%	2.12%	2.08%
E - Sophisticated singles	14.78%	11.66%	14.69%	11.30%	10.63%
F - Wealthy and nearing retirement	3.55%	3.41%	5.28%	5.23%	3.96%
G - Financially secure retirees	9.58%	5.36%	9.48%	6.05%	5.90%
H - Financially secure singles	1.07%	1.03%	1.30%	1.54%	1.31%
I - Low income couples	0.98%	1.42%	0.86%	1.40%	1.80%
J - Low income house sharers	12.81%	21.59%	10.58%	15.79%	17.65%
K - Comfortable older families	8.32%	11.06%	6.81%	10.06%	9.22%
L - Secure older people	3.78%	2.59%	4.25%	3.40%	2.88%
M - Financially restricted single students and friends	2.14%	3.39%	1.39%	1.90%	4.58%
N - Low income singles	2.55%	2.75%	1.91%	2.39%	4.42%
O - Struggling families	0.98%	1.55%	0.41%	0.93%	1.39%
P - Financially restricted single parents	5.12%	5.42%	3.87%	4.56%	5.50%
Q - Penny-wise pensioners	6.18%	7.68%	5.11%	7.55%	8.38%

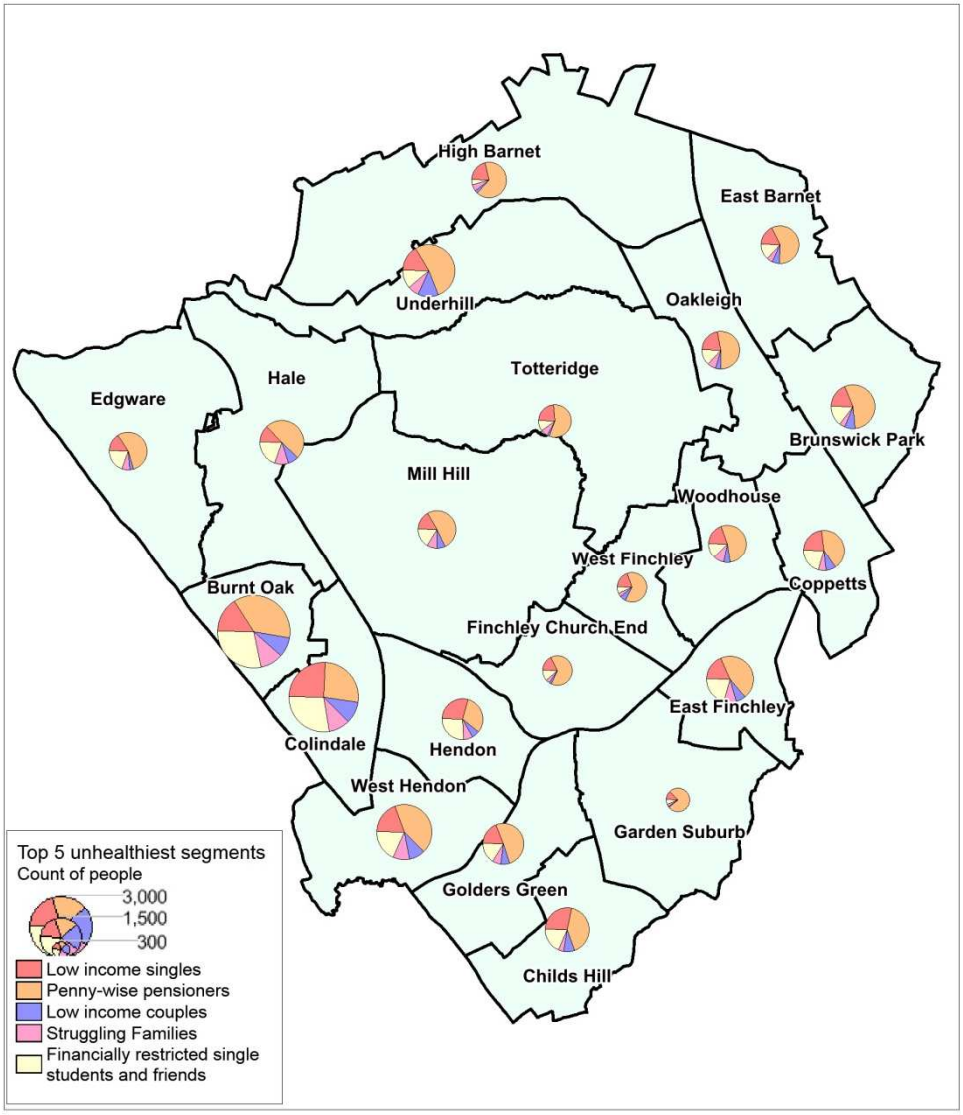
Different areas in Barnet have different profiles, meaning that services should be tailored to best serve their local populations. The east of the borough, along the A5 corridor is home to a younger population dominated by *Low income house sharers* sharing high density living while attending University or working lower paid jobs. It is also the location of Barnet's largest housing estates which account for the higher than average populations of *Low income singles*, *Struggling families* and *Low income couples.*

Following the High Road north through the centre of Barnet from Child's Hill to Totteridge, households are mostly comprised of families (*Educated, affluent families, Comfortable Older Families*), professionals (*Affluent Singles*, *Prosperous young couples without kids*, *Sophisticated Singles*) and affluent retirees (*Financially secure retirees*, *Wealthy and nearing retirement*). These areas are the most affluent parts of the borough with high levels of employment, income and education.

The west and north of Barnet is a mixture of all segments, with larger proportions of families (including the highest proportions of *Comfortable Older Families*) and older households (*Secure older*

people and *Wealthy and nearing retirement*). People in these areas tend to be of mid-level affluence compared to the rest of the borough.

Figure 4-1: Location by ward of the five segments with the worst self reported health



4.4 Data Related to Health in the Segments

While limited, the segments include data on self-reported health, long-term illness and long-term illness affecting worklessness. The five customer segments with the poorest self-reported health are also the segments in Barnet with the lowest household income (*Pound Stretching Twosomes, Financially restricted single students and friends, Struggling families, Low income singles and Pennywise Pensioners*). Segments comprised of the more affluent older population (*Secure older people* and *Wealthy and nearing retirement* and *Financially secure retirees*) do not report their health as being any worse than other younger more affluent segments in the borough.

Economic inactivity, limiting long-term illness and household income are inextricably linked -to Barnet's customer segments. The same five customer segments noted above (*Pound Stretching Twosomes, Financially restricted single students and friends, Struggling families, Low income singles and Pennywise Pensioners*) have the lowest household incomes, poorest self-reported health and

highest occurrences of health affecting their ability to work. Those five groups comprise 13% of Barnet's population; an improvement to their health would have further reaching societal impact.

Table 4-2: Economic inactivity and long-term illness

Customer Segments	Economically inactive residents aged 16-74 permanently sick/disabled	Residents with limiting long-term illness	Residents of working age with limiting long-term illness
A - Affluent Singles	2.53%	12.57%	6.01%
B - Prosperous young couples without kids	2.76%	13.40%	6.31%
C - Educated, affluent families	2.08%	12.79%	5.42%
D - Well educated and employed single parents	2.69%	12.98%	6.16%
E - Sophisticated Singles	2.44%	12.99%	5.84%
F - Wealthy and nearing retirement	2.73%	13.81%	6.35%
G - Financially secure retirees	2.24%	13.90%	5.62%
H - Financially secure singles	3.43%	13.65%	7.25%
I - Low income couples	5.00%	17.00%	8.97%
J - Low income house sharers	4.00%	15.10%	7.95%
K - Comfortable Older Families	3.67%	14.99%	7.59%
L - Secure older people	2.93%	14.91%	6.52%
M - Financially restricted single students and friends	4.94%	15.71%	8.99%
N - Low income singles	4.64%	15.88%	8.55%
O - Struggling families	4.63%	15.94%	8.54%
P - Financially restricted single parents	3.80%	14.92%	7.68%
Q - Penny-wise pensioners	3.96%	16.30%	7.75%

4.5 Conclusion

The top 5 customer *segments most likely to require health services are Low income couples, Financially restricted single students and friends*, *Struggling families*, *Low income singles*, and *Penny-wise pensioners* as they are the residents most likely to report less good health, to have a limiting long-term illness or a disability. They are mostly living in the east of the borough, particularly Burnt Oak and Colindale and represent 13% of Barnet's population (about 30,000 residents). *Penny-wise pensioners* represent the largest of this group (about 14,500 residents) and are likely to have more complex health care needs due to their advanced age.

5 Health

5.1 Key Facts

- In Barnet, the top three broad causes of mortality in both men and women are circulatory diseases, cancers and respiratory diseases. Circulatory diseases led to 2254 deaths, cancers caused 1949 deaths and respiratory diseases resulted in 693 deaths during 2010-2012.
- Smoking, alcohol, air pollution, poor diet, high blood pressure, obesity and hepatitis are the most common causes of ill health leading to premature mortality.
- Cardio Vascular Disease, CVD is the top cause of premature mortality, especially among the population under 75 years of age. In 2011-2013 the Barnet death rate due to preventable CVD in those aged less than 75 years was 39.7 per 100,000 and was higher in males (58.3) compared to females (23.3).
- There were 5,187 live births in Barnet during 2013 (only 1.5% by mothers aged less than 20 years and 37% by mothers aged 30-34 years). The highest live birth rate was in women aged 30-34 years (115.6 / 1,000) in Barnet, which was higher than the rates for London (14.7) and England (19.8) in women of the same age group.
- In 2008-2012 the proportion of babies born with a low birth weight (i.e. less than 2500 g) was highest amongst women resident in Finchley Church End (9.1%); Burnt Oak (8.5%); Colindale (8.3%); and Edgware (8.3%). The lowest proportion of underweight births was in the Hendon (5.9%); Coppetts (6.3%); and East Finchley (6.4%).

5.2 Strategic Needs

- Coronary Heart Disease is the number one cause of death amongst men and women in Barnet. **As male life expectancy continues to converge with women it is likely that dementia will become an increasingly** significant cause of death in the future.
- **There is eight years difference in male life expectancy between Burnt Oak and Garden Suburb wards.** The life expectancy differences are bigger at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Diet, smoking, and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **Child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **On average women in Barnet are significantly less likely to quit smoking in pregnancy** than women in London.
- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later on in life.** Particularly HPV, flu and

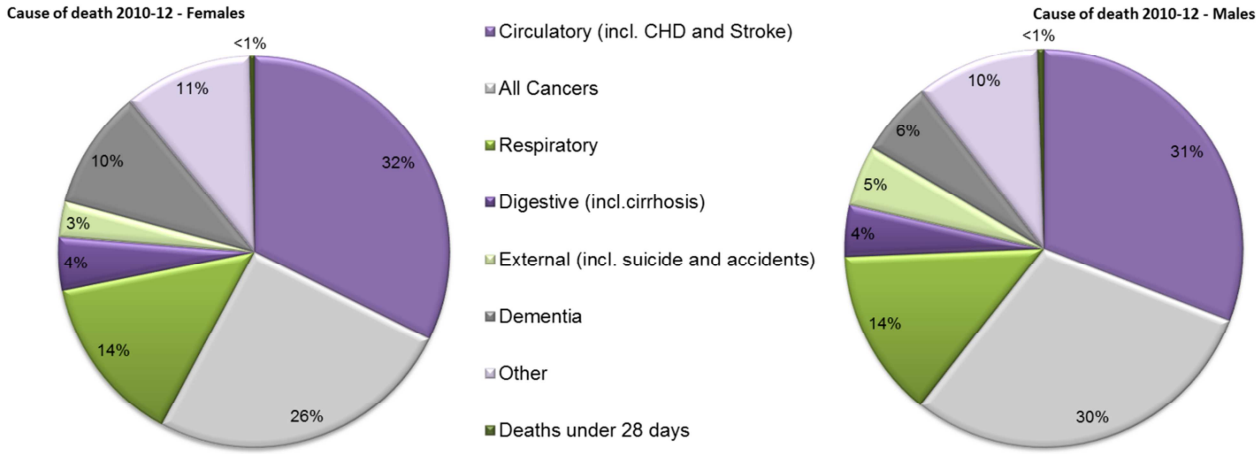
pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.

- **Overall the percentage of diabetic people having all eight health checks in Barnet is below the national rate** and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

5.3 Causes of Death

In Barnet, the top three broad causes of mortality in both men and women are circulatory diseases, cancers and respiratory diseases[32]. Circulatory diseases led to 2254 deaths (males 1002, females 1252), cancers caused 1949 deaths (males 963, females 986) and respiratory diseases resulted in 693 deaths (males 445, females 248) during 2010-2012. In the same period, dementia, another leading cause of death in Barnet, resulted in 579 deaths, which involved more females (n=383) than males (n=196).**Error! Bookmark not defined.**

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

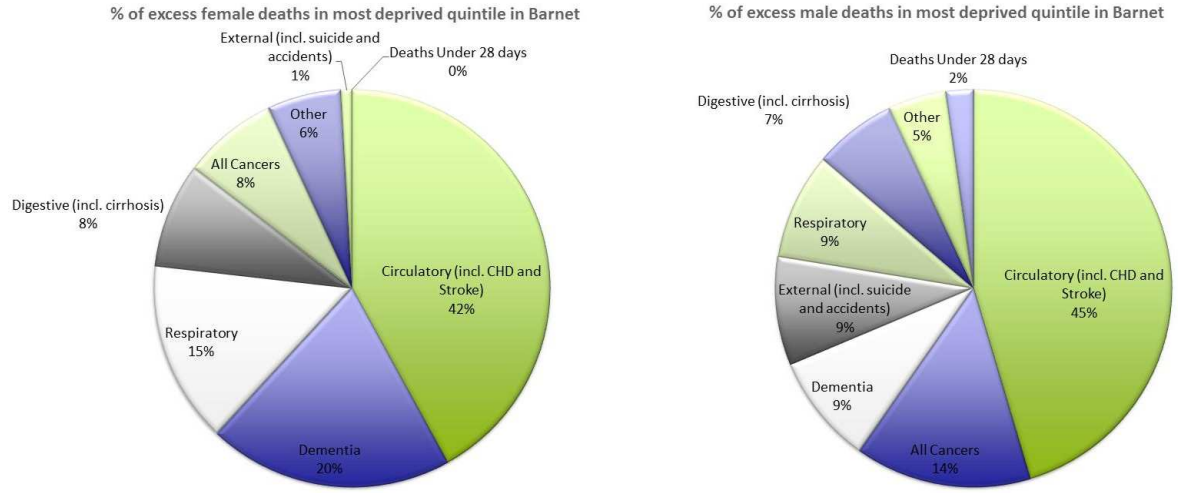


There are inequalities in life expectancy in Barnet by gender, locality / ward and the level of deprivation. Life expectancy at birth in females (85.0 years) is higher than males (81.9 years), and overall life expectancy for both the male and female population in Barnet is higher than the average for England (male =79.4 years, female =83.1 years).[33] The Garden Suburb ward has the highest life expectancy for both males (84.1 years) and females (88.5 years) while the Burnt Oak ward has the lowest life expectancy for both males (75.8 years) and females (81.6 years). In addition, the life expectancy gap is wider and mortality is higher in the most deprived areas compared to the least deprived areas in Barnet (Figure 5-2a&b).

[32] Public Health England. Segment Tool 2015

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

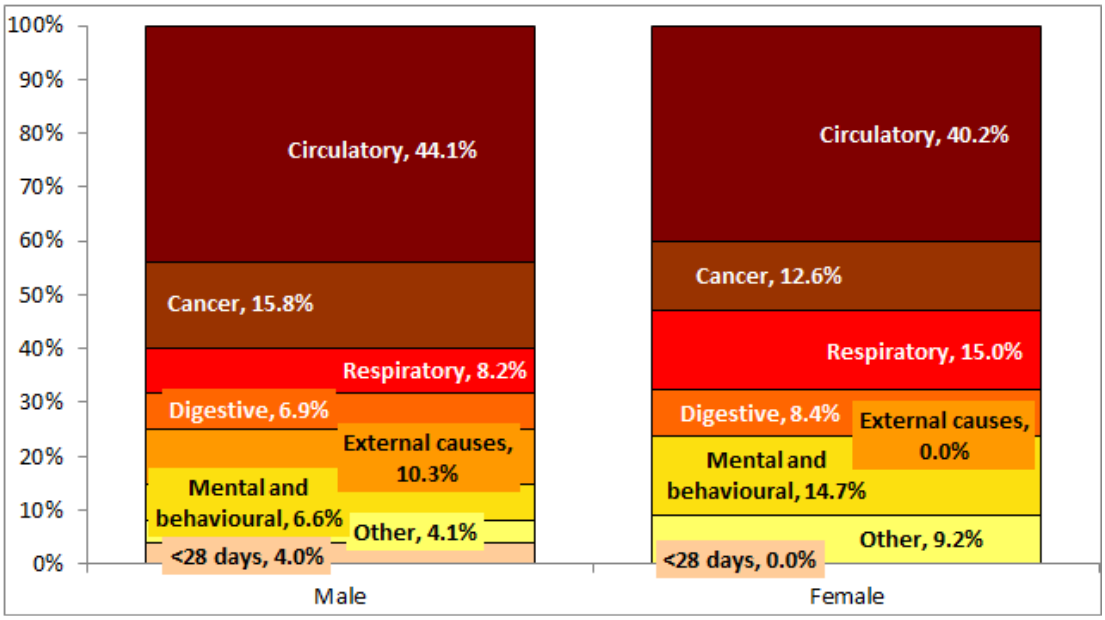
Figure 5-2a&b. Percentage excess deaths[34] in males and females: the most deprived quintile vs. the least deprived quintile in Barnet (2010-2012)



The greatest contributor to the life expectancy gap in the most deprived quintile versus least deprived quintile in Barnet is in circulatory diseases, in both the male and female population. The second and third highest contributors to the life expectancy gap in Barnet are cancers and external causes (i.e. injury, poisoning and suicide) in males and respiratory diseases and mental and behavioural illness in females (Figure 5-3).

In Barnet's most deprived areas, the three leading causes of excess deaths include CHD, stroke and cancer in males and dementia, CHD and COPD in females. These excess deaths can be avoided by reducing inequalities between different areas of Barnet.

Figure 5-3: The breakdown of the life expectancy gap between the most deprived quintile and the least deprived quintile in Barnet by broad cause of death and gender (2010-2012)



[34] Excess mortality is the number of deaths, or mortality, caused by a specific disease or condition. It's a measure of the deaths which occurred over and above those that would be predicted (in the absence of that negative defined circumstance) for a given population.

5.4 Causes of Ill Health

In Barnet, smoking, alcohol, air pollution, poor diet, high blood pressure, obesity and hepatitis are the most common causes of ill health leading to premature mortality[35]. Based on a total 1,981 premature deaths during 2011-13, Barnet ranks the 7th best out of 150 local authorities in England and the 2nd best within 15 similar local authorities. Table 5-1 below shows Barnet statistics on common causes of illness and the major diseases / conditions that are the leading causes of local premature mortality, rates of premature mortality by cause, and the Barnet rank and premature mortality outcomes compared to other local authorities (LAs).

Table 5-1: Common causes of major illness, major diseases leading to premature mortality, premature mortality rates by cause, and premature mortality ranks and outcomes in Barnet

Common causes of major illnesses causing premature mortality	Major diseases / causes of premature mortality	Premature deaths (per 100,000)† for 2011-13	Rank out of 150 local authorities*	Premature mortality outcomes	Rank within 15 similar local authorities*	Premature mortality outcomes
Smoking, poor diet, alcohol	Cancer (all)	118	3		2	
Smoking, poor diet, alcohol	Lung cancer	46	13		2	
Smoking, poor diet, alcohol	Breast cancer	22	70		6	
Smoking, poor diet, alcohol	Colorectal cancer	12	46		6	
High blood pressure, poor diet, smoking, physical inactivity	Heart disease and stroke	63	16		3	
High blood pressure, poor diet, smoking, physical inactivity	Heart disease	35	24		6	
High blood pressure, poor diet, smoking, physical inactivity	Stroke	13	39		7	
Smoking, air pollution	Lung disease	10	23		3	
Alcohol, hepatitis, obesity	Liver disease	12	6		1	
	Injuries	7	14		3	

†Standardised rate of premature deaths (deaths before age of 75 years) per 100,000 population

*The lowest rank number refers to the best outcome

Best Better than average Worse than average

Data source: Public Health England. Healthier Lives: Premature mortality

[35] Public Health England. Healthier Lives: Premature mortality.

The common causes of the major diseases that are leading to premature deaths under 75 years of age (Table 5-1) are lifestyle related factors; these could be modified to reduce and prevent premature mortality in Barnet (as described in lifestyle chapter). The major diseases leading to premature mortality in Barnet are reported below.

5.5 Cardiovascular Disease

Cardiovascular disease (CVD) involves diseases of the heart and blood vessels and vascular diseases of the brain. CVD includes coronary heart disease (CHD) including heart attack and angina, hypertension, stroke and congenital heart disease[36].CVD is the number one killer disease globally and one of the major causes of preventable mortality (WHO, 2011)[36]. The global burden of CVD was 17.5 million deaths in 2012[37]. In the UK, CVD caused 160,000 deaths in 2011[38] and there are an estimated 7 million CVD patients in the country[39]. A higher proportion of men are affected by CVD compared to women. In the UK, the standardised death rate (per 100,000) due to CVD was 140.6 in males and 86.7 in females in 2012[40].

In the London Borough of Barnet (LBB), CVD is the top cause of premature mortality, especially among the population under 75 years of age. Data for 2011-2013 show that the Barnet death rate due to preventable CVD in those aged less than 75 years was 39.7 per 100,000 and was higher in males (58.3) compared to females (23.3). In addition, CVD mortality rate in age under 75 years was also higher in males than in females i.e. 89.6 vs. 39.4 respectively; however, these Barnet rates were lower than the average rates for the London region (males = 113.5, females = 49.6) and England (males =109.5, females = 48.6) (Figure 5-4).

Figure 5-4: CVD mortality rates (under 75) in Barnet

Indicator	Period	England	London	Barking and Dagenham	Barnet	Bexley	Brent	Bromley	Camden
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	50.9	50.2	64.0	39.7	43.6	56.4	39.8	42.0
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	26.5	26.3	32.0	23.3	22.9	31.4	17.7	20.0
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	76.4	76.4	99.7	58.3	66.3	83.3	64.6	66.3
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	48.6	49.6	56.8	39.4	40.6	60.5	37.3	37.3
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	78.2	80.1	97.5	62.9	68.3	93.5	64.4	70.8
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	109.5	113.5	142.4	89.6	98.9	129.1	94.8	107.5

Compared with benchmark: Better | Similar | Worse — Lower | Similar | Higher

Benchmark: England

Source: Public Health England. Public Health Outcomes Framework http://www.phoutcomes.info/

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

5.5.1 Coronary Heart Disease

The prevalence of coronary heart disease (CHD) in Barnet (2.6%) was less than the national prevalence (3.3%) in 2013/14[41]. For the same period, 10,273 people were diagnosed with CHD, which was lower than the expected 13,400 cases of CHD in Barnet[41]. The national general practice profile data show that hospital emergency admissions rate (per 100 patients on the register) due to CHD in Barnet was 6.4% in 2010-2012, which was lower than the national average (7.1%).

5.5.2 Stroke

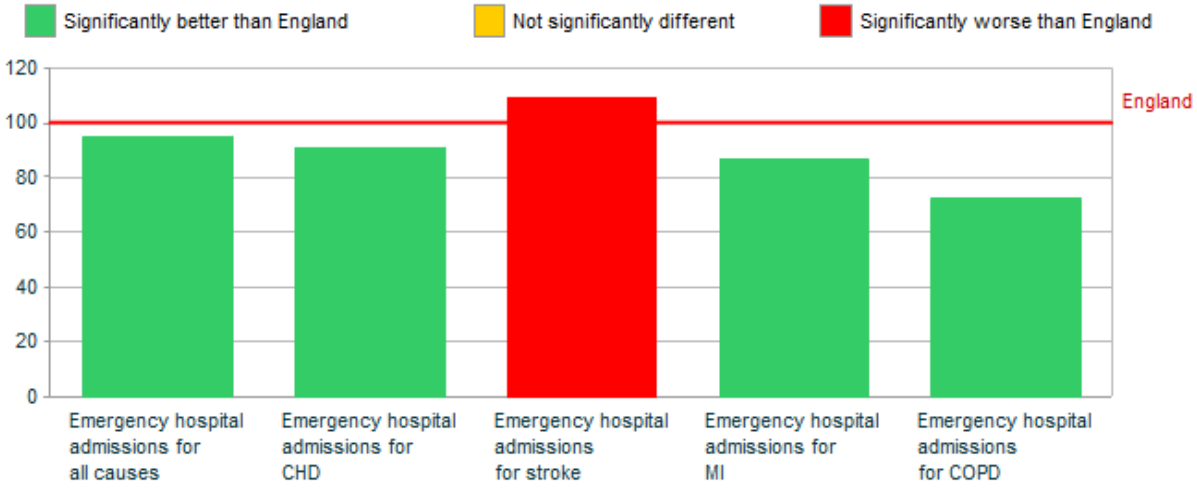
In 2013/14, the prevalence of stroke or transient ischaemic attacks (TIAs) in Barnet was 1.3% compared to 1.7% in England. In the same period, 4,957 people were diagnosed with a stroke and the rate of stroke mortality under 75 years of age was 12.4 / 100,000 people, which was similar to the average rate for England (13.7 / 100,000 people)[42].

In Barnet, the standardised mortality ratio (SMR) for deaths from stroke (at all ages) by ward was the highest in Childs Hill (117.7), Colindale (115.5) and Burnt Oak (110.3) wards while the lowest were in Finchley (47.9), Mill Hill (51) and Garden Suburb (53.1) wards for the period 2008-2012.

The rate of emergency hospital admissions for stroke in Barnet (235.4 / 100,000 people) was higher than the national rate (174.3 / 100,000 people) (Figure 5)[42]. Overall, the emergency hospital admissions rate due to stroke in Barnet increased by 51.9% from 2003-04 to 2013/14[42].

For the period 2008-2012, the standardised admission ratios (SAR) for emergency hospital admissions for stroke (all ages, persons) in Barnet was the highest in Burnt Oak (173), Colindale (152.3) and Coppetts (132.3) wards while the lowest were in Garden Suburb (78.9), Hendon (91.9) and Brunswick (93.7) wards.

Figure 5-5: Emergency hospital admissions in Barnet compared to England (standardised admission ratios) (from 2008-09 to 2012-13)



Source: Public Health England, HSCIC © Copyright 2014
www.localhealth.org.uk

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

5.5.3 CVD Prevention

In Barnet, there are variations in the prevalence of CHD and stroke at GP[41, 42] and ward levels[43]. The higher prevalence in particular Barnet wards and GP registered populations merits further investigation. Barnet people of Black, Asian and Minority Ethnic (BAME) origin are more likely to experience CHD or stroke.

CVD can be prevented by reducing a number of behavioural risk factors such as tobacco use, unhealthy diet, obesity, physical inactivity and use of alcohol by means of population-wide strategies[37]. A number of initiatives aimed at reducing the behavioural risk factors associated with CVD have been initiated, such as the NHS Health Check program, which involves carrying out medical tests including measuring blood cholesterol levels among people aged 40-74 years. In 2013/14, 91,139 persons in Barnet were eligible for an NHS health check; of these 14,657 people (16.1%) were offered a health check but only 37.3% of these (n=5,469 persons) actually received an NHS health check. Overall, NHS Health Check appointments offered and received in Barnet are lower than the average values for England (18% offered and 49% received).

5.6 Cancers

Cancers of the breast, bowel, lung, and prostate are the most common cancers in England. The prevalence rate of these cancers in Barnet is lower than in the London region and England[44].

5.6.1 Cancer Incidence

The incidence rate for all cancers in Barnet (356.7 per 100,000) is lower than the average for England (398.1 per 100,000)[45]. The incidence rates (per 100,000) of breast cancer (126.6), prostate cancer (99.8 per 100,000), cervical cancer (6.7), ovarian cancer (14.9) and stomach cancer (8.1) are similar to the national average rates of these cancers (i.e. 125.7, 105.8, 8.8, 16.7 and 8.4 per 100,000, respectively)[45]. The incidence rate of lung cancer (35.6 per 100,000) and bowel cancer (403 per 100,000) in Barnet are lower than the average rates of these cancers in England (47.7 and 46.5 per 1000,000 respectively)[45].

Data for 2007-2011 shows that new cases of cancer (standardised incidence ratio) vary by the type of cancer across Barnet wards. Breast cancer incidence was the highest in Mill Hill ward (118.2) and the lowest in Burnt Oak ward (77.5). The Coppetts ward had the highest incidence of colorectal cancer (122.8) and lung cancer (117.3) while Hale ward had the lowest incidence of colorectal cancer (69.8) and Garden Suburb ward had the lowest incidence of lung cancer (53.2). The incidence of prostate cancer was the highest in West Finchley ward (115.6) and the lowest in Brunt Oak ward (72.6). Overall, the Underhill ward had the highest incidence of all cancers (103.3) and the Garden suburb ward the lowest incidence of all cancers (86.2) during 2007-2011.

5.6.2 Cancer Mortality

Overall cancer related deaths in all persons in Barnet are lower than in London and England. The directly standardised rates (DSR) for all cancer mortality in all persons aged under 75 years in females in Barnet are also less than the average London regional and national rates. The age-standardised mortality rates (ASMR) for cancer in patients aged less than 75 years have decreased in

[43] http://www.localhealth.org.uk/
[44] Public Health England. Cancer Mortality Profiles: Trends spreadsheet
[45] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/

2008-2010 compared to 1995-1997[46]. The highest reduction is in colorectal cancers in females (57%) followed by breast cancer in female (36%), lung cancer in males (36%), prostate cancer (27%) and upper GI cancer in males (20%). The reduction of the ASMR due to upper GI cancer in females was 24% less in 2008-2010 compared to 1995-1997.

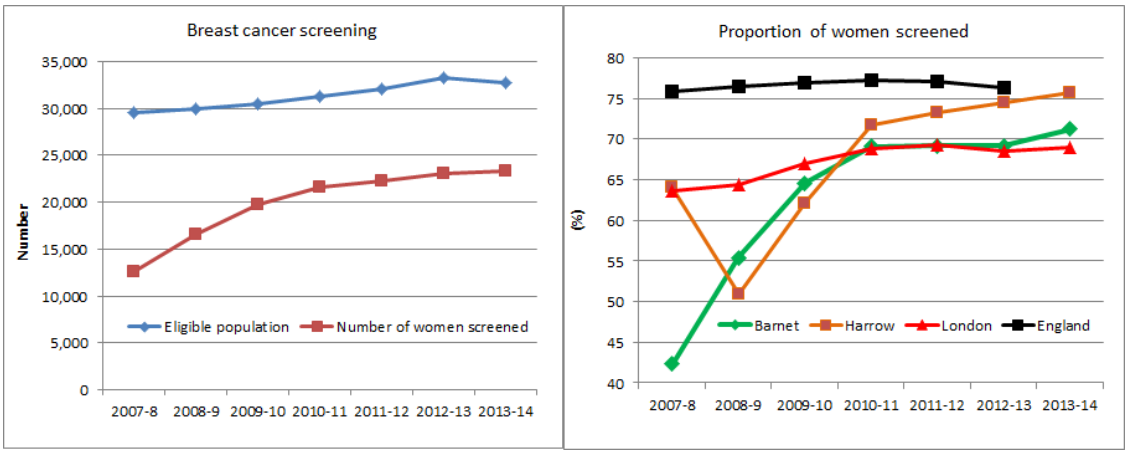
5.6.3 Cancer Survival

One-year net survival index for all types of cancers combined in adults (aged 15-99 years) in Barnet is higher (73.5%) than the average for the London region (69.7%) and England (69.3%)[47]. From 1997 to 2012, one year survival index for three cancers combined (breast [women], colorectal and lung) in adults (aged 15-99 years) in Barnet was higher than London and England but lower than in the neighbouring Harrow and Brent CCGs[48].

5.6.4 Cancer Screening

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

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



Data for three years prior to March 2014, shows that the rate of cancer screening coverage for breast cancer was 71.2% in Barnet, which is better than the average coverage rate for the London region (68.9%) but worse than the rate for England (75.9%)[49]. For the same period, coverage for cervical cancer screening was 68.8% in Barnet that is lower than the averages for the London region (70.3%) and England (74.2%). These findings suggest a gap between the eligible population and population covered in screening for cervical and breast cancers in females.

5.6.5 Cancer Registration

For 2010-2012 period, cancer registration rates (directly standardised rates per 100,000) for cervical (6.8) and lung (58.1) cancers in Barnet were lower compared to the average rates for London region (7.9 and 72.2 respectively) and England (9.2 and 76.0 respectively)[50]. The oral cancer registration

[46] http://www.swpho.nhs.uk/resource/item.aspx?RID=76243
[47] Office of National Statistics. Table 2-4: Index of cancer survival for Clinical Commissioning Groups in England: Adults diagnosed 1997-2012 and followed up to 2013 (Excel sheet 443Kb)
[48] http://www.ons.gov.uk/ons/datasets-and-tables/index.htmlhttp://www.ons.gov.uk/ons/datasets-and-tables/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=Cancer+Incidence+and+Mortality&content-type=Reference+table&content-type=Dataset (Release date: 16 Dec, 2014).
[49] http://www.phoutcomes.info
[50] Public Health England http://fingertips.phe.org.uk/

rate in Barnet (12.4) was higher than the average rates for London region (13.5) and nationally (13.2) during 2010-2012[50]. To encourage the early detection of cancers, the NHS Barnet CCG joined the "Be Clear on Cancer campaign" in July 2013. The campaign is aimed at raising awareness among local people about the early signs of cancers and promoting early diagnosis of cancer.

5.7 Respiratory disease

5.7.1 Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is an airway disease that causes breathing difficulty and it includes several respiratory tract conditions including emphysema and chronic bronchitis[51]. There are 4,247 COPD cases on GP registers (data for 2013/14)[52].

5.7.1.1 COPD Prevalence

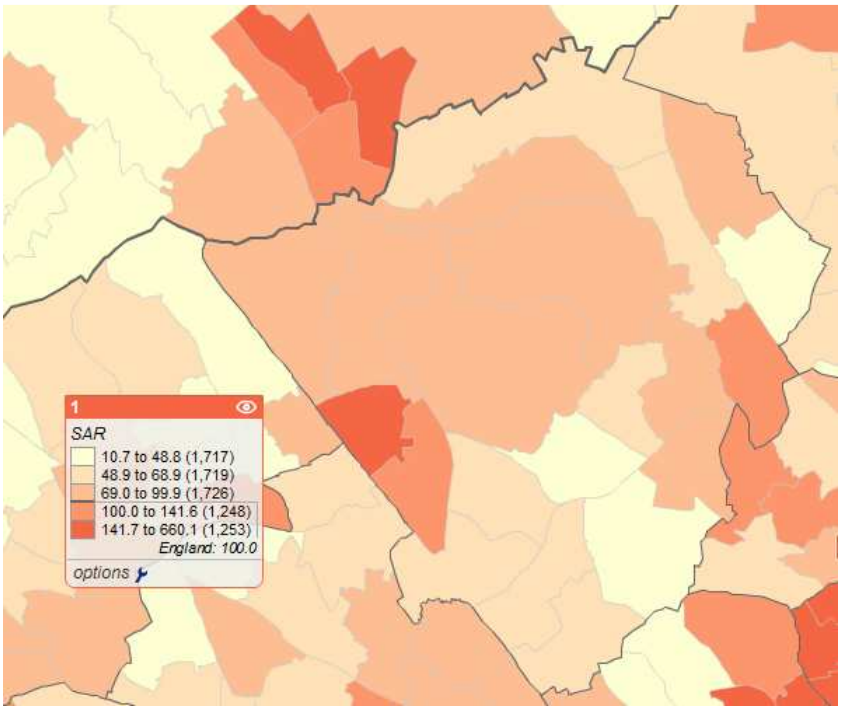
The average COPD prevalence rate for NHS Barnet CCG (1.1%) is lower than the average rate for England (1.8%) and there are wide variations in the COPD prevalence across GPs in Barnet[53]. The COPD prevalence confirmed by spirometry is 88.56% (95% CI: 86.54-90.32) in the NHS Barnet CCG, which is lower than 90.18% (95% CI: 89.83-90.53) in London and 90.74% (95% CI: 90.63-90.85) in England[54]. However, the estimated prevalence of COPD is 2.82% (as of 2011)[2], which suggests a need for increasing the rate of COPD diagnosis.

5.7.1.2 COPD Hospital Admissions

The total COPD hospital admissions rate (per 1000 patients on the disease register) in Barnet (1.3) is lower than the average national rate (2.2). The standardised admissions ratio of emergency hospital admissions for COPD varies across Barnet (Figure 5-7) with the highest ratio in Burnt Oak ward (141.8) and the lowest ratio in Garden suburb ward (28.3).

[51] http://www.nepho.org.uk/respiratory/index.php
[52] HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14 Date: 28 October 2014. http://www.hscic.gov.uk/catalogue/PUB15751 http://www.hscic.gov.uk/catalogue/PUB15751/qof-1314-prev-ach-exc-ccg.xlsx
[53] http://fingertips.phe.org.uk/profile/general-practice/data
[54] HSCIC. Prevalence: chronic obstructive pulmonary disease confirmed by spirometry: percent, all ages, annual, P ; Period 2013/14: Version 14: Data file 24D_635PC_14_D.xls. Release date: March 2015 [https://indicators.ic.nhs.uk/webview/]

Figure 5-7: Emergency hospital admissions rates for COPD by wards in Barnet



5.7.2 Asthma

Barnet has 17,609 asthma patients registered with local GPs and the asthma prevalence rate (all ages) is 5.54%, below the average rate (5.9%) for England[52]. The prevalence of asthma widely varies between GPs in the NHS Barnet CCG[52].

5.7.3 Risk Factors

Smoking and influenza virus infection of the respiratory system are the two important risk factors for COPD and asthma. Information regarding smoking in Barnet is reported in the section on tobacco use and smoking in the lifestyle chapter while influenza infections related Barnet information is given below. Influenza viruses cause respiratory tract infection that can lead to exacerbations of COPD and asthma, which can be prevented by influenza vaccination[55]. The influenza immunisation rate in Barnet (83%) is slightly higher than the average rate for England (81.9%)[52].

5.8 Mental Health

Mental health is a high public health priority area in the country. Addressing mental health problems in all age groups and improving outcomes and relevant services are suggested in the 2011 mental health strategy for England entitled "No health without mental health". Tackling mental health is important because poor mental health not only costs too much for the economy and the health system but also leads to and is associated with inequalities[56].

5.8.1 Adult Mental Health

The prevalence of mental health problems including schizophrenia, bipolar affective disorder and other psychoses in all ages recorded on GP disease registers in Barnet is 0.95%, which is higher than the average rate for England (0.84%).[57,58]

[55] Wesseling, G. (2007) Occasional review: Influenza in COPD: pathogenesis, prevention, and treatment. Int J Chron Obstruct Pulmon Dis. 2(1): 5–10.
[56] Department of Health (2011) No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. London.

In Barnet, the prevalence rate of depression (recorded in adults aged 18 and over) is 4.3% (12,921 persons of the total 298,601 GP registered population aged 18+). The Barnet rate is lower than the average rate for England (5.8%).[57,58] There were 2,303 new cases of depression recorded in GP registers during 2013/14 showing the incidence rate of 0.8% for Barnet, which is lower than the average national rate (1.0%)[58,59.]

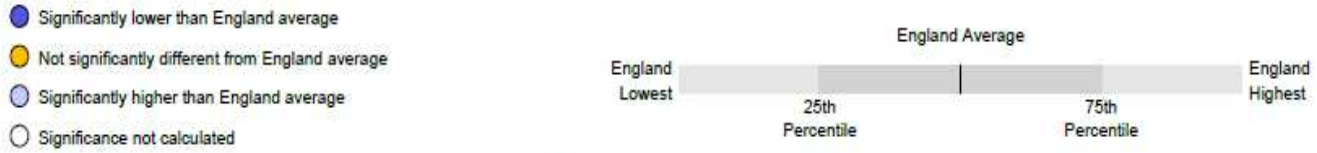
The average rate of people with a mental illness in residential or nursing care per 100,000 of the population in Barnet (34.9) is similar to England (32.7). The percentage of mental health service users who were inpatients in a psychiatric hospital in Barnet (2.7%) is also similar to the national average (2.4%). However, the rate of detentions under the National Mental Health Act per 100,000 population is higher in Barnet (23.3) compared to the average for England (15.5). In addition, Barnet rates for attendances at A&E for a psychiatric disorder (47 per 100,000 population) and number of bed days (4,180 per 100,000 population) are lower than the average national rates (243.5 and 4,686 per 100,000 population, respectively).

Moreover, the rates of emergency admissions for self-harm (109.9 per 100,000 population) and hospital admissions for unintentional and deliberate injuries in aged 0-24 years (76.0 per 10,000 population) in Barnet are lower than the average for England (191.0 / 100,000 and 116.0 / 10,000 population respectively). The suicide rate in Barnet (6.9 per 100,000 population) is similar to the average national rate (8.5 per 100,000 population).

A summary of mental health related indicators for Barnet benchmarked against England are shown in Figure 5-8, which shows that most of Barnet indicators are better than those at the national level.

[57] Public Health England (2014) Community Mental Health Profile data http://fingertips.phe.org.uk/cmhp
[58] Public Health England (2014) Barnet Clinical Commissioning Group. Community Mental Health Profile 2014.
[59] Public Health England (2014) Community Mental Health Profile data

Figure 5-8: Mental health indicators for Barnet



Domain		Indicator	Period	Local value	Eng. value	Eng. lowest	Eng. highest
Levels of mental health and illness	1	Depression: QOF prevalence (18+)	2012/13	4.3	5.8	2.9	11.5
	2	Depression: QOF incidence (18+)	2012/13	0.8	1.0	0.5	1.9
	3	Depression and anxiety prevalence (GP survey)	2012/13	9.6	12.0	8.1	19.5
	4	Mental health problem: QOF prevalence (all ages)	2012/13	0.95	0.84	0.48	1.46
	5	% reporting a long-term mental health problem	2012/13	3.2	4.5	2.5	8.2
Treatment	6	Patients with a diagnosis recorded	2013/14 Q1	25.5	17.8	1.1	63.2
	7	Patients assigned to a mental health cluster	2013/14 Q1	75.4	69.0	1.9	94.8
	8	Patients with a comprehensive care plan	2012/13	89.7	87.3	79.9	95.0
	9	Patients with severity of depression assessed	2012/13	89.1	90.6	77.4	97.8
	10	Antidepressant prescribing (ADQs/STAR-PU)	2012/13	4.0	6.0	2.7	9.0
	11	People with a mental illness in residential or nursing care per 100,000 population	2012/13	34.9	32.7	0.0	124.3
	12	Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	2.7	2.4	0.7	12.3
	13	Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	23.3	15.5	0.0	44.5
	14	Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	47.0	243.5	3.0	925.5
	15	Number of bed days per 100,000 population.	2013/14 Q1	4180	4686	685	11073
	16	People in contact with mental health services per 100,000 population	2013/14 Q1	2142	2178	116	5442
	17	Carers of mental health clients receiving of assessments	2012/13	30.5	68.5	0.0	343.4
	18	Spend (£s) on mental health in specialist services: rate per 100,000 population	2012/13	22468	26756	14296	49755
	19	% secondary care funding spent on mental health	2011/12	11.0	12.1	7.1	19.1
Outcomes	20	People on Care Programme Approach per 100,000 population	2013/14 Q1	496	531	17	1895
	21	% CPA adults in settled accommodation	2013/14 Q1	72.4	61.0	5.0	94.6
	22	% CPA adults in employment	2013/14 Q1	6.5	7.0	0.0	22.7
	23	Emergency admissions for self harm per 100,000 population	2012/13	109.9	191.0	49.8	595.6
	24	Suicide rate	2010 - 12	6.9	8.5	4.8	19.6
	25	Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	76.0	116.0	68.6	201.7
	26	Rate of recovery for IAPT treatment	2012/13	39.3	45.9	22.6	80.3

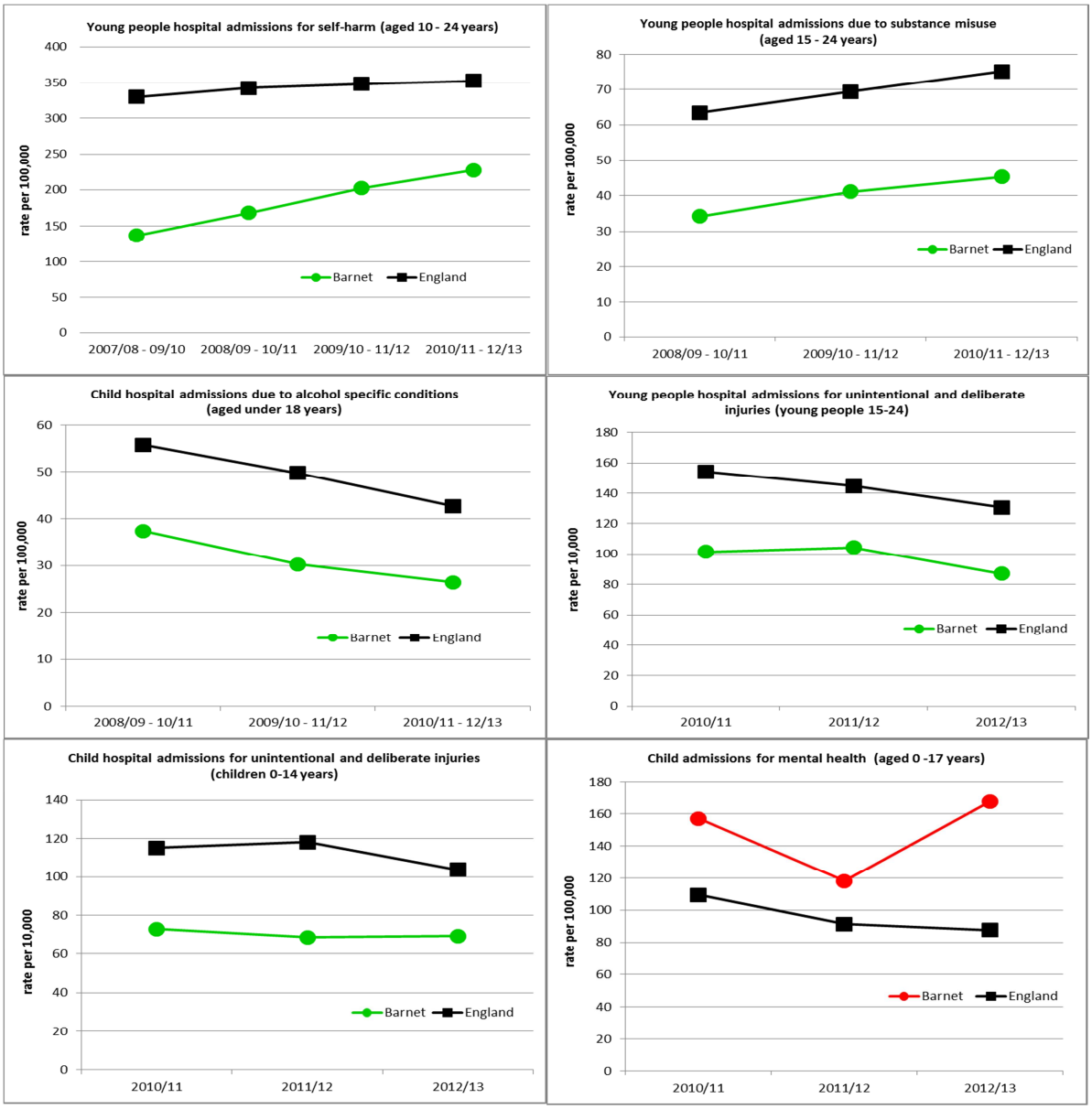
Source: Public Health England. [Barnet Children's and Young People's Mental Health and Wellbeing Profile]

5.8.2 Children's and Young People's Mental Health and Wellbeing

In Barnet children aged 5-16 years, the estimated prevalence of any mental disorder (8.3%), emotional disorder (3.2%), conduct disorder (4.99%) and hyperkinetic disorders (1.35%) are all lower than the average rates for England (i.e. 9.6%, 3.7%, 5.8% and 1.5% respectively).

Barnet hospital admissions rates (per 100,000) for self-harm in young people (aged 10-24 years), substance misuse and unintentional and deliberate injuries in young people (15-24 years old), alcohol specific conditions in children (aged less than 18 years) and unintentional and deliberate injuries in children (less than 15 years old) are lower than the average rates for England. However, the hospital admissions rate for mental health in children (aged less than 18 years) in Barnet is higher than the average national rate (Figure 5-9).

Figure 5-9: Mental health indicators for Barnet vs. England



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

5.8.3 Mental Health Illness Prevention

The National Service Framework for Children, Young People and Maternity Service (2004) suggests providing early and effective services to help children and young people with emotional, behavioural, psychological and mental health problems using the Child and Adolescent Health Services (CAMHS) strategic framework, which comprises 1 to 4 tiers. Providing the CAMHS services at tiers 2-3 is the responsibility of the clinical commissioning groups (CCGs) while commissioning of the tier 4 CAMHS services is the responsibility of NHS England since April 2013[60]. In Barnet, the estimated number of children aged less than 18 years requiring CAMHS services Tier 3 is 1,580 and those requiring the Tier 4 services is 65 (as per estimation of 2012).

The London Borough of Barnet (LBB) has a health and wellbeing strategy "Keeping Well, Keeping Independent" for 2012-2015 that addresses overall health and wellbeing including mental health needs of the local population through a four themes approach. In addition, the LBB and Barnet Clinical Commissioning Group have started a number of initiatives including programmes and services for improving mental health and wellbeing of the local people[61]. For example, the LBB programmes for improving mental health and wellbeing include a schools wellbeing programme, mental health in the community, physical activity programme for older people, a programme to reduce the misuse of alcohol and an outdoor gyms and activator programme. The CCG led initiatives include developing an integrated commissioning health and wellbeing strategy with a multiagency forum mental health partnership board, planning redesigning of CAMHS Tier-4 services, remodelling the primary care mental health team, developing primary care support and liaison teams and re-commissioning mental health day opportunity services.

5.9 Diabetes

The rate of recorded (diagnosed) diabetes (in GP registered population aged 17+) in Barnet (6.03%) is similar to London rate (6.00%) but lower than the national rate (6.21%). However, estimated total (diagnosed and undiagnosed) prevalence of diabetes in 2015 in Barnet adults (8.3%) is slightly higher than England (7.6%)[62]. There are an estimated 5,259 (23%) undiagnosed cases of diabetes in Barnet.[63] The prevalence rate of diabetes is forecast to rise at both national and local levels and this increase could be even higher if diabetes risk factors such as obesity are not addressed[64].

There is a wide variation between Barnet GPs (n=67) in terms of both the prevalence of diabetes (from 2.2% to 10.3%)[65] and the clinical management of diabetic patients. However, the Quality and Outcomes Framework (QOF) results for 2013/14 reveal that Barnet GPs have better average diabetes outcomes compared to the national averages[66]. However, some GPs in the Barnet CCGs have diabetes outcomes lower than the local and national averages, which need to be reviewed.

The Barnet indicators of care processes carried out on diabetic patients show that foot checks, urine testing for protein and smoking cessation advice is above the average for England whilst flu vaccination and eye screening are similar to the national average. The BMI recording in diabetic

[60] NHS England (July 2014) Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report. . http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf
[61] Barnet JSNA Refresh 2013-14 - Mental health and wellbeing.
[62] Public Health England. Diabetes Prevalence Model for Local Authorities and CCGs.
[63] http://www.yhpho.org.uk/ncvinintellpacks/pdfs/07M_SlidePack.pdf
[64] Public Health England. Barnet Cardiovascular disease profile. Diabetes. March 2015.
[65] http://www.yhpho.org.uk/ncvincvd/pdfs/Diabetes/07M_Diabetes.pdf
[66] http://fingertips.phe.org.uk/profile/general-practice/data

patients in Barnet is below the average for England, an area which needs to be reviewed. The percentage of diabetic people having all eight check-ups in Barnet (56%) is also below the national average (59.5%), which is an area for improvement in the future.

Complications due to diabetes in Barnet patients are similar to the regional (London) and national averages. However, the National Diabetes Audit 2012-2013 recommended that the Barnet CCG should review its diabetes care providers to reduce the risks associated with diabetes and use different approaches including exercise, diet composition, weight management, smoking, glucose control, blood pressure control and cholesterol control[67]. These recommendations should be taken seriously and implemented through appropriate interventions and services.

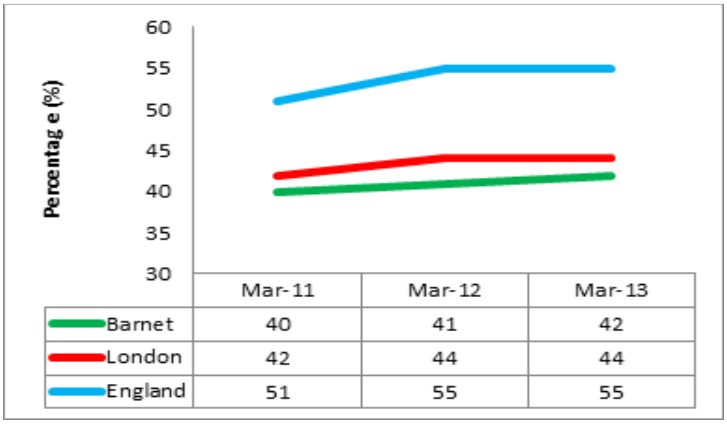
5.10 Oral Health

Oral health is integral and essential to general health and an important determinant of the quality of life[68]. Oral diseases limit activity at home and work, and in schools, and there is a strong association between oral diseases and non-communicable chronic diseases (NCDs)[68]. Thus, integration of oral health in to public policy agenda for the prevention and control of NCDs and development agenda has been suggested in the Tokyo Declaration on Dental care and oral health for healthy longevity 2015[69]. In addition, premature mortality can also be reduced by preventing oral diseases[68]. It is however important that oral disease preventative strategies and approaches should address not only the wider and distant socio-economic determinants of oral heath e.g. poor living conditions and low education but also the immediate and modifiable risk behaviours such as sugar consumption (amount, frequency of intake, types), oral hygiene practices, tobacco use and excessive alcohol consumption[70].

5.10.1 Adult Oral Health

Data on dental service use shows that the dental access rate in Barnet adults (over 18 years) increased slightly in 2013 compared to 2011 and the Barnet rate (42% for March 2013) followed the average trend for London and England over the reported period (Figure 5-10).

Figure 5-10: Adult Dental Access Rates 2011-2013



	Mar-11	Mar-12	Mar-13
Barnet	40	41	42
London	42	44	44
England	51	55	55

Statistics on oral cancers (also known as mouth cancers or cancers of the oral cavity) show that these types of cancers are not very common in the UK (one oral cancer in 50 cases of all types of

[67] HSCIC (2015). National Diabetes Audit 2012-2013. Report 2: Complications and Mortality Summary for NHS Barnet CCG (07M).
[68] World Health Organisation. Oral Health. Policy basis.
[69] World Health Organisation (2015). Tokyo Declaration on Dental care and oral health for healthy longevity.
[70] World Health Organisation. Oral Health. Strategies and approaches in oral disease prevention and health promotion.

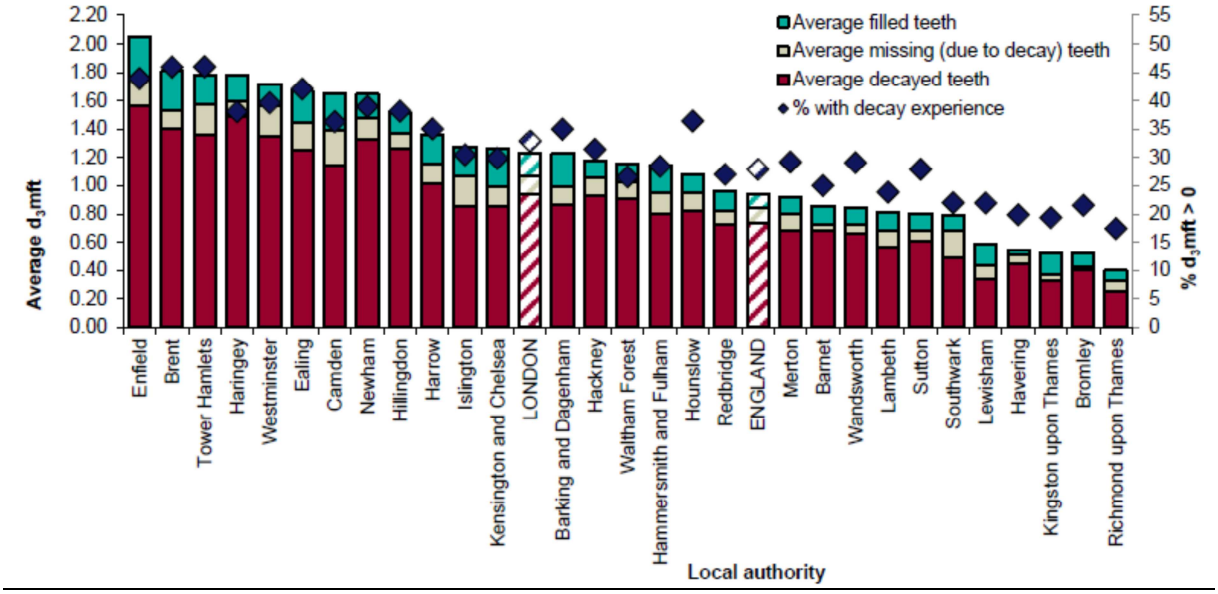
cancers)[71]. Nevertheless, cancers of the oral cavity are the most common cancers of the head and neck region and involve more men than women[72].

In Barnet, the age standardised rate (per 100,000 population) of oral cancer registration is 13.2, which is similar to the national (12.8) and London regional (13.2) averages. Risk factors for mouth cancers include smoking, use of products containing tobacco e.g. chewing of tobacco or *paan* (areca nut/betel leaf), drinking alcohol and infection with the human papilloma virus (HPV).[70,72] Therefore, oral cancer risk could be minimised by avoiding the above risk factors. In addition, the survival rate for oral cancers is higher when treated at the early stage compared to the late stage; therefore, creating awareness especially among communities that are more likely to be at risk is imperative.[72]

5.10.2 Child Oral Health

Overall, levels of oral diseases in children in Barnet are low compared to their neighbouring Boroughs. One of the public health outcome framework indicators, overall success of health and wellbeing, is the level of tooth decay in children aged 5 years,[73] which is lower in Barnet compared to the average levels for London and England and several other local authorities in London (Figure 5-11).

Figure 5-11: The average number of decayed, extracted or filled teeth (d_3mft) and the proportion of children affected by dental decay (%d_3mft>0) among 5 year old children in Barnet compared to England and other local authorities in the London region



Source: Public Health England. Barnet Dental Health Profile. October 2014

In addition, the percentage of children with one or more obviously decayed, missing (due to decay) and filled teeth in Barnet (25.0%) is similar to the national average (27.9%) but lower than the London region (32.9%)[74].

[71] NHS Choices (2014) Mouth cancer http://www.nhs.uk/Conditions/Cancer-of-the-mouth/Pages/Introduction.aspx
[72] Public Health England. Oral Cavity Cancer: recent survival trends. The National Cancer Intelligence Network, London.
[73] Public Health England (Oct 2014) Barnet Dental Health Profile. Dental health of five-year-old children 2012.
[74] Public Health England. http://fingertips.phe.org.uk/search/dental

Moreover, the prevalence of early childhood (dental) caries (ECC) involving three year old children in Barnet (6.1%) is higher than the national average (3.9%), which suggests a need for early and targeted oral health improvement interventions to reduce the ECC levels at an early stage[75].

Hospital admissions for extraction of one or more decayed primary or permanent teeth in children aged less than 15 years is lower in Barnet compared to the London region but higher than the national average (Figure 5-12). However, child dental decay is the top cause for non-emergency hospital admissions in Barnet, which involved 349 children aged 0-19 years and the majority (67%) involved 5-14 years olds in 2012/13[76].

Furthermore, statistics about access to the dental service show that the dental access rate in children (under 18 years) in Barnet is slightly above the London regional rate but is below the national rate (Figure 5-13)[77].

Figure 5-12: Child hospital admissions for extraction of one or more decayed primary or permanent teeth(0-19 years)[76]

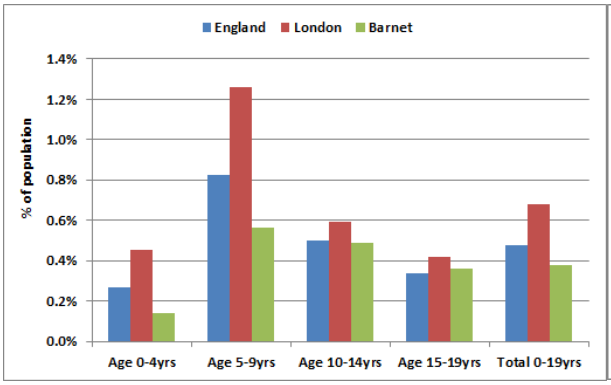
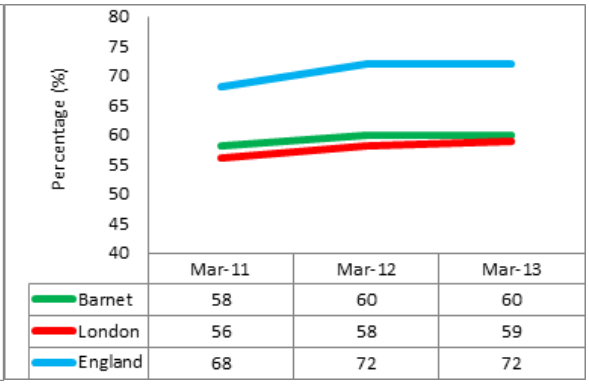


Figure 5-13: Child Dental Access Rates 2011-2013 (under 18 years)[77]



	Mar-11	Mar-12	Mar-13
Barnet	58	60	60
London	56	58	59
England	68	72	72

5.10.3 Existing Oral Health Interventions in Barnet

The Barnet Child Oral Health Improvement Strategy has three key domains: making oral health everybody's business and every contact count, integrating oral health into Children's Commissioning Plans throughout the life course using the common risk factor approach and increasing the exposure to fluoride e.g. toothpaste and fluoride varnish. The key actions under Barnet's Child Oral Health Improvement Strategic Plan (2014/16) include: training of Health and Social Care Professionals in key messages about oral health, new Healthy Children's Centre Standards developed (covering a range of health priority areas) – identifying and supporting oral health champions in Children's Centres to meet their oral health standards-making sure oral health remains a priority within the centres, distributing toothpaste and brush packs at child development checks (8 months and 21/2 years) alongside brief oral health intervention, and supervised teeth brushing programme in three schools and three children's centres per term.

5.10.4 Oral Health Needs

There is no Borough level data on the oral health of adults or older people in Barnet[78]. There could be inequalities in oral health and oral care such as provision of oral care in care homes[79]. A local oral

[75] Public Health Programme (2015) Oral health survey of three-year-old children 2013. A report on the prevalence and severity of dental decay. Dental public health epidemiology programme. (Revised January 2015).
[76] Public Health England. Public Health England Epidemiology Programme: Extraction data
[77] HSCIC. Access by patient London LA region Sept 2013, NHS dental statistics England 2012-2013

health needs assessment could be undertaken in Barnet for identifying oral health inequalities and oral health needs of adults and children.

5.11 Maternity and Infant Health

5.11.1 Live Births and Rates

There were 5,187 live births (2,699 males and 2,488 females) in Barnet in 2013 (only 1.5% by mothers aged less than 20 years and 37% by mothers aged 30-34 years). The highest birth rate was in women aged 30-34 years (115.6 / 1,000) in Barnet, which was higher than the rates for London (14.7) and England (19.8) in women of the same age group. However, Barnet rates of births by mothers under 18 years (1.8 /1,000) and under 20 years (6.8/1,000) were lower than the average rates for the London region (5.1 and 12.3 respectively) and nationally (7.8 and 12.3 respectively) in 2013.

Data for 2013 show that the crude live birth rate (14.1/ 1,000 population), general fertility rate (63.4/1,000 women aged 15-44 years) and maternity[80] rate (62.4 /1,000 women aged 15-44 years) in Barnet were slightly lower than these rates for London (15.2, 64.0 and 63.2 respectively) but higher than the national rates (15.2, 62.4 and 61.7 respectively).

Whilst the projected trend of women of childbearing age is expected to increase, the number of live births and the fertility rate is decreasing. Data for 2008-2012 show that the highest fertility rate (per 1,000 women aged 15-44 years) is in Golders Green ward (82.9) followed by Hendon (77.3) and Colindale (77.2) wards while the lowest fertility rate is in the Brunswick Park ward (56.8) followed by Woodhouse (57.1) and Underhill (57.2) wards in Barnet.

5.11.2 Infant Health and Mortality

The percentage of live births under 2.5 kg in Barnet (7.2%) is similar to England (7.0%) but slightly lower than the London region average (7.5%). Data for 2008-2012 show that the proportion of babies born with a low birth weight (i.e. less than 2500 g) was highest amongst women resident in Finchley Church End ward (9.1%) followed by Burnt Oak (8.5%), Colindale (8.3%) and Edgware (8.3%) wards in Barnet. The lowest proportion of underweight births was in the Hendon (5.9%) followed by Coppetts (6.3%) and East Finchley (6.4) wards in Barnet.

The life expectancy at birth is increasing in Barnet and is higher for females (85.0 years) than males (81.9 years) in Barnet, which are both higher than the averages for the London region (83.8 and 79.7 years for females and males respectively) and England (82.72 and 78.85 years for females and males respectively). However, Barnet life expectancy at birth is lower than in Harrow males (82.0 years) and females (85.6 years).

Barnet rates of infant (under 1 year) mortality (2.3 /1,000 live births), neonatal (under 4 weeks) mortality (1.3/1,000 live births) and perinatal mortality (4.8/ 1,000 stillbirths and deaths under 1 week) are lower than the average rates for London (3.8, 2.6 and 7.3 respectively) and England (3.9, 2.7 and 6.7 respectively).

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[78] JSNA Refresh 2014 Oral Health Barnet

[79] Public Health England (2014) Dental public health intelligence programme. North West oral health survey of services for dependent older people, 2012 to 2013.

[80] A maternity is a pregnancy resulting in the birth of one or more children, including still births

5.11.3 Breast Feeding

In 2013/14, breastfeeding initiation in Barnet was the 11th highest among all 326 English LAs and 9th highest among 33 London Boroughs. The proportion of all mothers who breastfeed their babies in the first 48 hours after delivery in Barnet (89.3%) was better than the national average (73.9%) during the same period.

5.11.4 Maternal Health

5.11.4.1 Smoking in Pregnancy

The percentage of women who smoked at the time of delivery in Barnet (4.4%) is lower than the London (5.1%) and national (12.0%) averages for the year 2013/14. However, the percentage of pregnant women who successfully quit is 45% in Barnet, which is lower than the averages for London (53%) and England (47%). The percentage of pregnant women who did not quit and those who were lost to follow up in Barnet (23% and 32% respectively) were higher than the national (29% and 23% respectively) and London regional averages (20% and 28% respectively). Public health funded stop smoking services need to proactively target pregnant women in Barnet.

5.11.4.2 Maternal Mortality

The maternal mortality rate (Directly age-standardised rate (DSR) per100, 000 of women aged 15-44) in Barnet (0.44) is higher than the average rates for London (0.22) and England (0.31).

5.11.4.3 Service Use

82.7% of pregnant women in Barnet had an antenatal assessment by the 12th week of pregnancy, which was lower than England average (93.7%) during 2013/14.

5.12 Health Protection

5.12.1 Immunisation

Immunisation has been described as a process by which a person is made immune or resistant to an infectious disease usually by the administration of a vaccine[81]. Immunisation thus helps in controlling and eliminating life threatening infectious diseases and thereby reducing illness, disability and death from vaccine preventable infectious diseases[82]. Vaccination can be provided from the age of two months onwards and there are specific vaccinations for babies, children, adults, elderly, travellers and people in special groups such as pregnant women, people with long term health conditions as well as healthcare workers[83]. The latest NHS complete routine immunisation schedule from summer 2014 provides a list of vaccines, when to immunise (the age of a person for administering particular vaccines) and the names of diseases protected against[84].

The latest update of the coverage of specific immunisations in Barnet is provided below.

5.12.1.1 Childhood Primary Immunisations

The NHS routine childhood immunisations provide cover against a number of infectious diseases such as diphtheria, Haemophilus influenza type b (Hib), meningococcal group C disease (MenC)

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

pertussis, pneumococcal disease, polio, rotavirus and tetanus. The childhood immunisation in England is evaluated by the cover of vaccination evaluated rapidly (COVER) programme.

The NHS immunisation statistics for 2013/14 (Table 5-2) show that Barnet rates for MenC (12 months), DTap/ IPV/ Hib (24 months) and MMR1 (5 years) are better than the corresponding rates for England; however, other childhood immunisation rates in Barnet are worse than the national rates[85].

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

		Barnet			England
Cohort	Short name	Cohort size CS-2013-14	Number immunised IM-2013-14	Rate (%) 2013-14	Rate (%) 2013-14
12 months	DTaP/IPV/Hib	5789	4612	79.7	94.3
	PCV	5789	4767	82.3	94.1
	MenC	5786*	5286	91.4	93.9
	Hep B	39	19	48.7	-
24 months	DTaP/IPV/Hib primary	6029	5633	93.4	96.1
	PCV booster	6029	4839	80.3	92.4
	Hib/MenC booster	6029	4833	80.2	92.5
	MMR1 (1st dose)	6029	4863	80.7	92.7
	Hep B	19	11	57.9	-
5 years	DTaP/IPV/Hib (primary)	5956	5478	92.0	95.6
	DTaP/IPV booster	5956	4497	75.5	88.8
	MMR1 (1st dose)	5956	5403	90.7	94.1
	MMR2 (1st and 2nd dose)	5956	4473	75.1	88.3
	HibMenC booster	5956	5122	86.0	91.9

DTaP = Diphtheria, Tetanus, and acellular Pertussis (whooping cough); IPV = Inactivated Polio Vaccine; HIb = Haemophilus influenzae type b; Men C = Meningitis C; MMR = Measles, Mumps, and Rubella; Hep B = Hepatitis B (given to children of positive mothers only; PCV = Pneumococcal vaccination; *2012-13

Source: HSCIC (2014) NHS Immunisation Statistics, England - 2013-14. Publication date: September 25, 2014

5.12.1.2 Human Papillomavirus (HPV) Immunisation

The total eligible population (girls aged 12-13 years) for HPV in Barnet was 1,926 of which 1,339 were immunised against HPV in 2013/14. Thus, the HPV vaccination coverage rate (% of girls aged 12-13 who received al three doses of the HPV vaccine) in Barnet was 69.5%, which is worse than the average coverage rate of HPV for London (80.0%) and England (86.7%) during 2013/14.

5.12.1.3 Flu and Pneumococcal (PCV) Immunisation

In Barnet, the rates of immunisation against influenza (seasonal flu) was 71.8% in the adult population aged 65 and over and 51.7% in those at risk (individuals aged 6 months to 65 years excluding pregnant women) during 2013/14. The Barnet rates were lower than the average rates for England (73.2% and 52.3% respectively).

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

In Barnet, the total cohort for pneumococcal vaccination (PCV) against pneumococcal disease in children comprised 5,789 persons of whom 4,767 persons were immunised leading to the coverage rate of 82.4% in 2013/14. The PCV coverage rate in Barnet was worse than the average rates for London (89.7%) and England (94.1%).

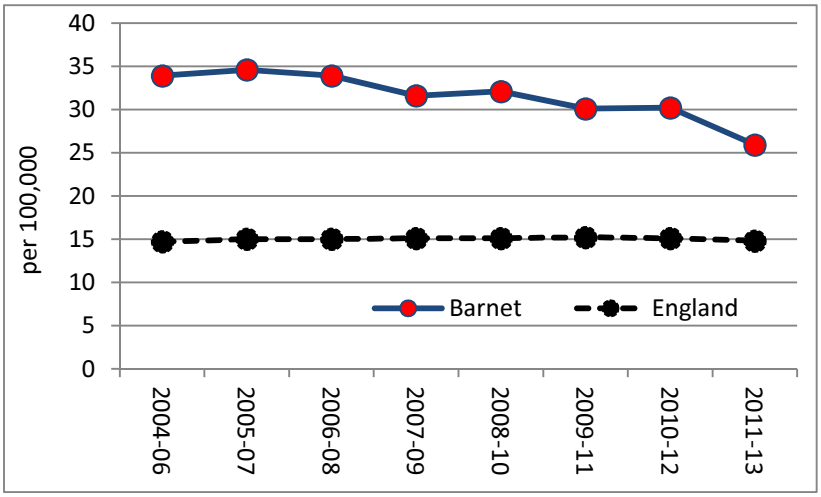
In 2013/14, the total eligible population for immunisation against pneumococcal disease in persons aged 65 years and above was 39,966 persons of whom 26,919 persons received PPV vaccination. The PPV vaccination rate in Barnet (67.5%) was better than the regional London rate (64.2%) but worse than the average rate for England (69.1%) during 2013/14.

5.12.2 Tuberculosis

Tuberculosis (TB) is a notifiable infectious disease that is caused by the bacterium Mycobacterium Tuberculosis, which can affect any part of the body such as bones, intestine, brain and skin but it mainly affects the lungs. TB can be either dormant (latent or hidden) or active and it is curable; however, if active TB especially of the lungs is left untreated or treatment is discontinued then it could be fatal and there is a chance of it spreading to other people. Thus, TB is a major cause of concern from the public health perspective.

TB rates in the UK have declined in the last two years; however the rates are still high in London and the Midlands[86]. The incidence of TB (three year average) in Barnet (25.9 per 100,000) is lower than the London regional rate (39.6 per 100,000) but higher than the rate in England (14.8 per 100,000) (Figure 5-14)[87]. The remaining TB indicators for Barnet are similar to England except the proportion of drug sensitive TB cases that completed a full course of treatment by 12 months (91.8%) and the proportion of TB cases offered an HIV test (98.6%), which are better than the average national rates (Figure 5-15)[86].

Figure 5-14: TB incidence (3 years average) in Barnet compared to England



Source: Public Health England. Barnet - TB Strategy Monitoring Indicators

TB in Barnet is more common in men in all age groups but it involves more females in the 20-29 years age group. The majority of TB patients were born abroad and about 28 % came to the UK within the previous 4 years. In Barnet, the most common ethnic group having TB is people of Indian origin (35%), which is followed by mixed / other ethnic background (26%) and black Africans (20%).

[86] Public Health England. (2014) Tuberculosis in the UK: 2014 report. London.
[87] Public Health England. TB Strategy Monitoring Indicators.

In addition, Barnet has a higher number of drug resistant TB cases than the average number of these cases in London[88].

Figure 5-15: Barnet - TB Strategy Monitoring Indicators

Comparison to England value: Better | Similar | Worse

	Period	England	Bark & Dag	Barnet	Bexley	Brent
TB incidence (three year average)	2011 - 13	14.8	35.1	**25.9**	13.2	94.9
Proportion of pulmonary TB cases starting treatment within two months of symptom onset	2013	41.3	46.4	**47.6**	35.7	68.3
Proportion of pulmonary TB cases starting treatment within four months of symptom onset	2013	71.6	75.0	**73.8**	57.1	86.6
Proportion of pulmonary TB cases that were culture confirmed	2013	71.3	75.0	**70.5**	93.8	79.8
Proportion of culture confirmed TB cases with drug susceptibility testing reported for the four first line agents	2013	97.5	100	**95.8**	100	100
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	2012	83.3	91.9	**91.8**	90.9	87.5
Proportion of drug sensitive TB cases who were lost to follow up at last reported outcome	2012	4.3	3.0	**1.9**	0.0	6.0
Proportion of drug sensitive TB cases who had died at last reported outcome	2012	4.8	3.0	**0.9**	8.0	1.3
Proportion of TB cases offered an HIV test	2013	81.1	97.1	**98.6**	97.0	99.6

5.12.2.1 TB and Involvement of Local Communities

Evidence shows that involvement of local communities helps in creating awareness and successful completion of treatment of latent TB[89]. To raise TB awareness in local communities identified as being most likely to be affected by TB, Barnet and Harrow public health commissioned a number of TB awareness training sessions during January – March 2015. The training sessions were attended by more than 60 local community groups, service managers and interested individuals. In addition, TB workshops and a seminar on the world TB day (24th March) were organised that brought together local advocacy and community groups, national TB and local clinical and public health expertise to discuss TB related issues and local needs. A local TB grant scheme has been developed and opportunities for local community groups and organisations to bid for small sums to support local TB advocacy awareness are now being rolled out.

5.12.3 Notifiable Infectious Diseases

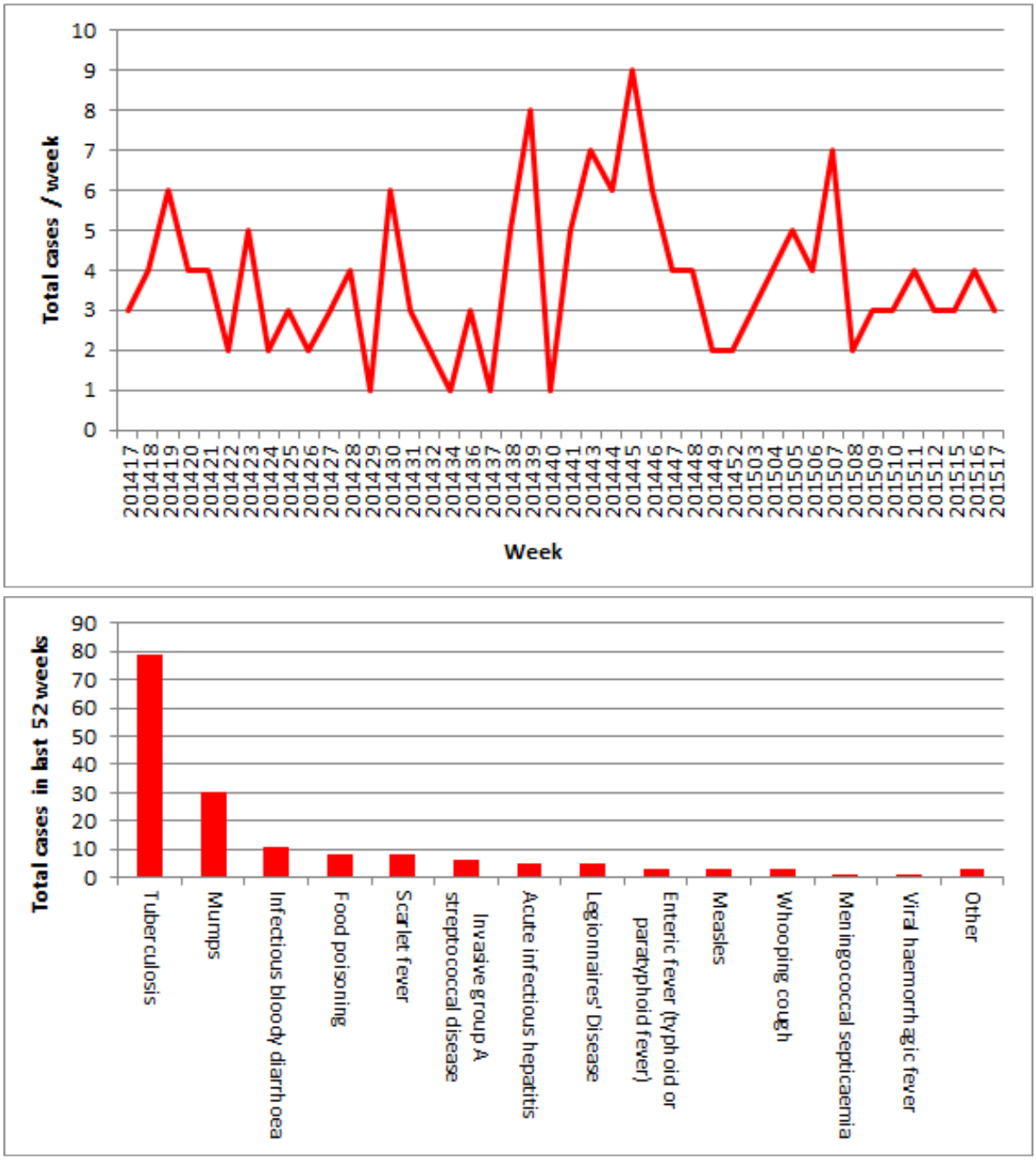
The latest data on notifications of infectious diseases (NOIDs) for the last 52 weeks released by Public Health England on 28th April 2015 show a total of 166 notifications of infectious diseases in Barnet over the last 52 weeks (Figure 16a&b). The weekly trend of NOIDs in Barnet (Figure 5-16a)

[88] Public Health England. (2013) Local authority TB profiles (2012 data).
[89] Gupta et al. (2015) Tuberculosis among the Homeless — Preventing another Outbreak through Community Action. *N. Engl. J. Med.* 372 (16):1483-1485.

shows that the largest number of notifications was reported in the 43rd week (28th October) and the 46th week (18th November) in 2014, which might suggest a seasonal trend.

The highest number of notifications were for TB (n=79) followed by mumps (n=30), infectious bloody diarrhoea (n=11), food poisoning (n=8) and scarlet fever (n=8) during the previous 52 weeks (Figure 5-16b). There is a need to tackle TB in Barnet, which could involve raising awareness about TB through active involvement of local communities such as South Asians in which TB is more prevalent.

Figure 5-16a&b: Notifications of infectious diseases (NOIDs) in Barnet (in last 52 weeks on 28/04/2015)



Data Source: Public Health England. Statutory notifiable diseases: cases reported in last 52 weeks (Date: 28 April 2015)

6 Lifestyle

6.1 Key Facts

- In Barnet, there were 117 cases (31 male and 86 female) of hospital admissions with a primary diagnosis of obesity in 2013/14. This equated to a rate of 32 / 100,000 persons (rate: males = 17, females = 46), which was higher than the average rates for the London region and England.
- Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%). Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates.
- The percentage of residents who abstain from drinking alcohol in Barnet (22.05%) is similar to the average in the London region (22.37%) but higher than the national rate (16.53%). In terms of the number of alcohol abstainers, Barnet ranks 22nd highest among 326 local authorities in England.
- According to the most recent estimates (2011/2012), Barnet has 1,492 opiate and/or crack users (OCU), 1156 opiate users, 857 crack cocaine users and 215 injecting drug users aged 15-64 years.

6.2 Strategic Needs

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **Smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England**, and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.

- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy** and **good parenting classes**.

6.3 Tobacco and Smoking

Tobacco and smoking are risk factors for a number of chronic health conditions such as cardiovascular disease (CVD), cancer, asthma and chronic obstructive pulmonary disease (COPD). Tobacco use kills over 80,000 people per year in England making it the single greatest cause of preventable death in the country.[90] The tobacco and smoking picture in Barnet is given below.

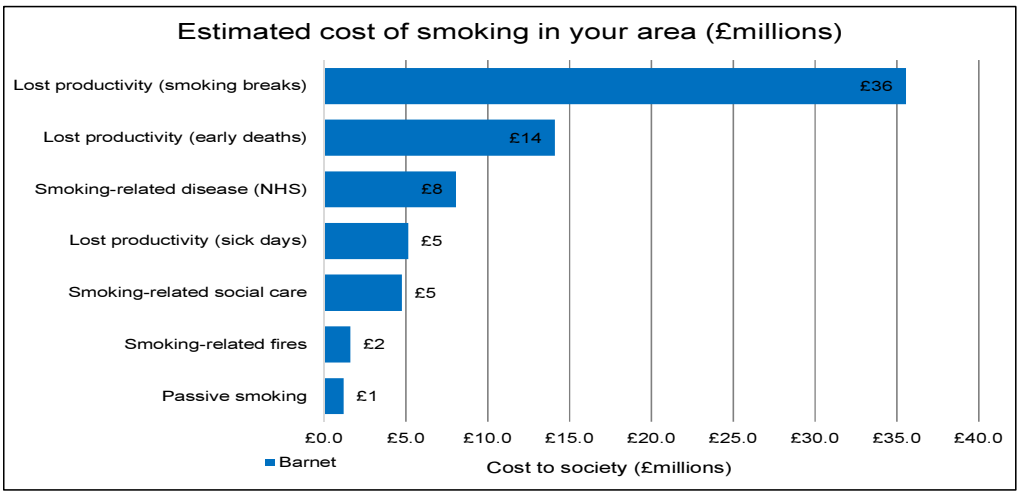
6.3.1 Smoking in Adults

Smoking indicators for Barnet are shown in Figure 6-2. Smoking prevalence in adults over 18 years in Barnet is 15% and is lower than the national average (18.4%). Modelled estimates of smoking prevalence in pregnant women and young people aged 15 years are 4.4% and 5.5% respectively.[91] Barnet has lower death rate due to smoking (205 per 100,000) than the average rate for England (289 per 100,000).

Estimated prevalence of synthetic smoking in adults (18 years and above) in Barnet is the highest in Burnt Oak (16.9%), Colindale (16.5%) and West Hendon (16%) wards while the lowest in Garden Suburb (13.5%), Totteridge (14.1%) and Finchley Church End (14.2%) wards.

Smoking is a leading risk factor for COPD while passive smoking triggers asthma[92, 93.] According to an estimate smoking related illnesses in Barnet costs about £8m annually to the local NHS (Figure 6-1).[94] Smoking cessation interventions could help in reducing the burden of COPD and other medical conditions associated with smoking.[95]

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



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

[90] National Institute for Health and Care Excellence (NICE) (2015) Tobacco. NICE advice [LGB24]. Published date: January 2015.
[91] http://www.tobaccoprofiles.info/profile/tobacco-control/data
[92] Deborah et al. (2004) Genetics of Asthma and COPD. Similar results for different phenotypes. *Chest,* 126 (2): 105S-110S.
[93] Hardin et al. (2011) The clinical features of the overlap between COPD and asthma. *Respiratory Research*, 12(1): 127.
[94] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/
[95] Hillas, et al. (2015) Managing comorbidities in COPD. *Int. J. Chron. Obstruct. Pulmon. Dis.* 10: 95–109.

The Barnet public health team commissions smoking cessation programmes in the Borough through NHS GPs. The smoking cessation support and treatment offered rate in Barnet is 96% and this is higher than the average national rate (93.1%).[96]However, Barnet smoking cessation statistics (2013/14) regarding successful quitters at 4 weeks (total count = 916; rate = 2,269 / 100,000 smokers), successful quitters (CO validated) at 4 weeks (total count = 633, rate = 1,568 / 100,000 smokers), and completeness of NS-SEC recording by Stop Smoking Services (total count = 1,430; rate = i.e. 65.1%) are worse compared to the average rates for England (Figure 6-2). However, other smoking related indicators for Barnet are better than in England (Figure 6-2).

Figure 6-2: Barnet smoking indicators

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	Smoking Prevalence (IHS)	2013	15.0	18.4	29.4		10.5
2	Smoking prevalence - routine & manual	2013	28.1	28.6	47.5		16.5
3	Successful quitters at 4 weeks	2013/14	2269	3524	1251		8946
4	Successful quitters (CO validated) at 4 weeks	2013/14	1568	2472	525		6950
5	Completeness of NS-SEC recording by Stop Smoking Services	2013/14	65.1	86.2	25.2		100
6	Smoking status at time of delivery	2013/14	4.4	12.0	27.5		1.9
7	Low birth weight of term babies	2012	2.9	2.8	5.0		1.5
10	Lung cancer registrations	2009 - 11	59.0	75.5	144.2		42.1
11	Oral cancer registrations	2009 - 11	13.2	12.8	21.1		6.7
12	Deaths from lung cancer	2011 - 13	45.6	60.2	111.6		32.3
13	Deaths from chronic obstructive pulmonary disease	2011 - 13	33.7	51.5	101.0		26.8
14	Smoking attributable mortality	2011 - 13	204.9	288.7	471.6		186.6
15	Smoking attributable deaths from heart disease	2011 - 13	22.2	32.7	65.5		20.6
16	Smoking attributable deaths from stroke	2011 - 13	8.0	11.0	21.5		7.2
17	Smoking attributable hospital admissions	2012/13	1280	1688	2884		906
18	Cost per capita of smoking attributable hospital admissions	2010/11	32.4	36.9	61.7		15.6

Compared with benchmark: Better Similar Worse

Source: HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14.

6.3.2 Smoking in Children

An estimated prevalence of smoking (regular and occasional) in children aged up to 17 years in Barnet is similar to England (Figure 6-3).

[96] HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14. Dated: 28 October 2014.

Figure 6-3: Barnet smoking prevalence estimates in children (aged 17 years or less)

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
22	Smoking prevalence estimates – regular smokers aged 11-15 years	2009 - 12	2.0	3.1	4.7		1.1
23	Smoking prevalence estimates – regular smokers aged 15 years	2009 - 12	5.5	8.7	12.7		3.2
24	Smoking prevalence estimates – regular smokers aged 16-17 years	2009 - 12	9.7	14.7	20.7		5.7
25	Smoking prevalence estimates – occasional smokers aged 11-15 years	2009 - 12	1.1	1.4	2.0		0.5
26	Smoking prevalence estimates – occasional smokers aged 15 years	2009 - 12	3.1	3.9	5.3		1.4
27	Smoking prevalence estimates – occasional smokers aged 16-17 years	2009 - 12	4.6	5.8	7.8		2.2

Compared with benchmark: Better Similar Worse

Source: HSCIC (2014). Quality and Outcomes Framework (QOF) - 2013-14.

Modelled estimates of smokers under 18 years of age by wards in Barnet (2009-12) are shown in Table 6-1. The percentage of smokers' increases in each ward as the age of smoker increases. Hendon, Under Hill and Mill Hill are the top three wards having the highest percentage of smokers in all three age categories included in Table 6-1 while the Colindale ward has the lowest percentage of smokers in all categories of smokers aged 11 years to 17 years. Therefore protecting Barnet children and young people from tobacco smoke, especially in Hendon, Under Hill and Mill Hill wards, is imperative.[90]

Table 6-1: Modelled prevalence of regular smoking in children and young people (less than 18 years)

	Top three Barnet Wards	
Smoker's age	Wards with the highest % of smokers	Wards with the Lowest % of smokers
11-15 years	Underhill (5.6%), Hendon (5.5%) and Mill Hill (5.4%)	Colindale (1.1%), Childs Hill (1.2%) and Finchley Church End (1.4%)
15 years	Hendon (14.2%), Underhill (12.4%), and Mill Hill (11.3%)	Colindale (4.2%), West Hendon (4.3%) and Brunswick Park (4.4%)
16-17 years	Hendon (22.6%), Underhill (20.1%), and Mill Hill (18.7%)	Colindale (7.8%), West Hendon (7.9%) and Brunswick Park (8.1%)

Source: Public Health England. Local Health

6.3.3 Local Tobacco and Smoking Needs

Local needs for tackling tobacco use and smoking include protecting children from tobacco use and smoking and stop smoking services targeting of poorer smokers and women smokers, especially those who use smokeless tobacco and chew *paan*.

6.4 Obesity

Obesity is a nationwide issue in the UK and the rates of obesity are rising in the country. The prevalence of obesity in some London Boroughs is already high and the rates are rising in the London region.

6.4.1 Obesity in Adults

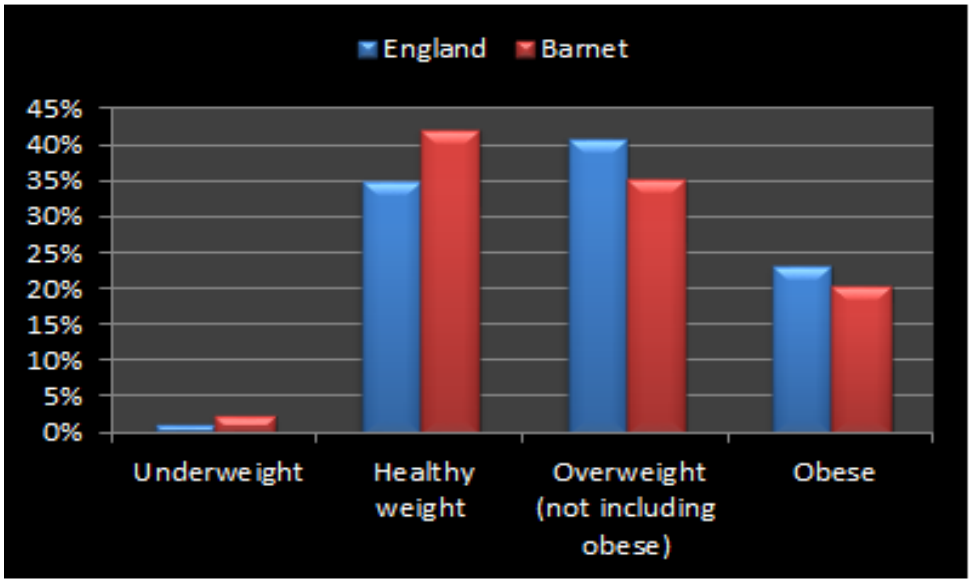
Barnet has a high percentage of the adult population with a healthy weight (42.1%) and a low percentage with excess weight (55.7%) (combined overweight (35.2%) plus obese (20.5%))

compared to the average adult weights nationally (Figure 6-4); however, Barnet has a high percentage of underweight adults (2.3%) compared to the national level (1.2%).

Public Health England's modelled estimate of adult obesity in Barnet shows that the three wards with the highest percentage of adult obesity include Burnt Oak (23.7%), Colindale (22.1%) and Underhill (21.6%) wards while the three wards having the lowest percentage of adult obesity include Garden Suburb (12.8%), Finchley Church End (14.7%) and West Finchley (14.8%) wards in Barnet.

In Barnet, there were 117 cases (31 male and 86 female) of hospital admissions with a primary diagnosis of obesity in 2013/14. This equated to the rate of hospital admissions with primary obesity in Barnet at 32 / 100,000 persons (rate: males = 17, females = 46), which was higher than the average rates for the London region (rates: all persons =25, males = 13, females = 37) and England (rates: all persons = 17, males = 10 and females = 25).[97] In addition, the rates (per 100,000 population) of finished consultant episodes in an inpatient setting with a primary diagnosis of obesity and a main or secondary procedure of 'Bariatric surgery' in Barnet (all persons =25, males = 12 and females =37) were higher than the average rates for the London region (rates: all persons =19, males = 9 and females =28) and nationally (rates: all persons =12, males = 6 and females =18).[97]

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



Source: Public Health England Adults: identifying and accessing local area obesity data

6.4.1.1 Adult Obesity Needs

Although overall obesity in the adult population in Barnet is lower than the national level, the high rates of hospital admissions due to obesity in Barnet suggest a need for reducing adult obesity through targeted interventions. These include promotion of healthy lifestyles, physical activity and eating healthy diets as well as meeting the health and care needs of obese adults to avoid hospital emergency admissions.

[97] HSCIC (2015) Statistics on Obesity, Physical Activity and Diet - England 2015 [Publication date: March 03, 2015)

6.4.2 Obesity in Children

In Barnet, obesity in children is low compared to the average rates in the London region and nationally. Barnet children's weight profiles based on the latest NCMP data are given below.

6.4.2.1 Reception-Year Children (aged 4-5 years)

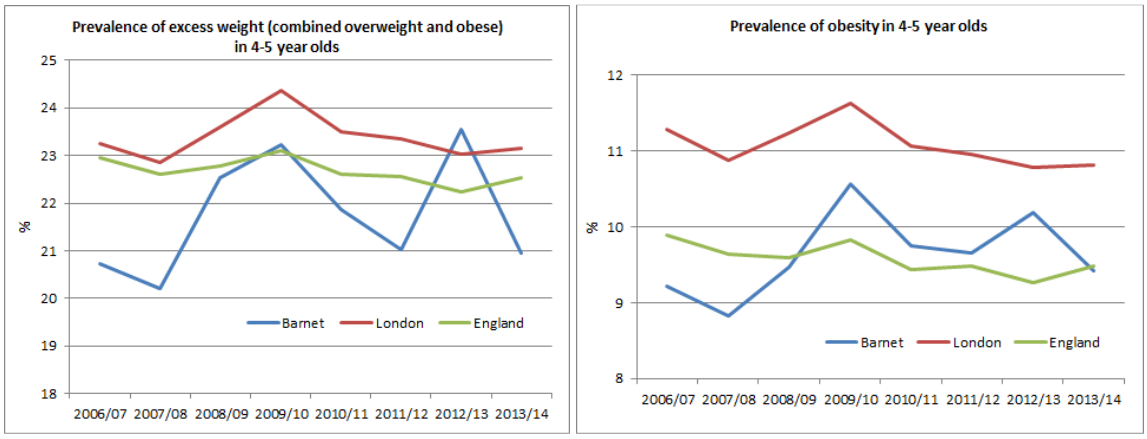
In reception year children (aged 4-5 years) the percentage of excess weight (overweight and obese) was 21% in 2013/14 in Barnet, which was lower than the average rates for the London region (23.1%) and England (22.5%) (Figure 6-5a). In Barnet, the proportion of excess weight children in this age group declined in 2013/14 compared to the previous five years. In addition, the proportion of obese children in 4-5 year olds in Barnet also declined below the average rates in the London region and nationally (Figure 6-5b). However, the proportion of underweight reception children (aged 4-5 years) in Barnet (1.37%) is higher than the average national rate (0.95%).

The prevalence of obesity in reception year children was the highest in Colindale (13.1%), Edgware (13.1%) and Burnt Oak (12.1%) wards while the lowest in Garden Suburb (5.6%), High Barnet (5.8%) and Finchley Church End (6.2%) wards in Barnet.

6.4.2.2 Reception Year Children's Needs

The data suggests improving diet intake in underweight reception year pupils in Barnet.

Figure 6-5a&b: Excess weight and obesity in 4-5 year old children



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

6.4.2.3 Year 6 Children (aged 10-11 years)

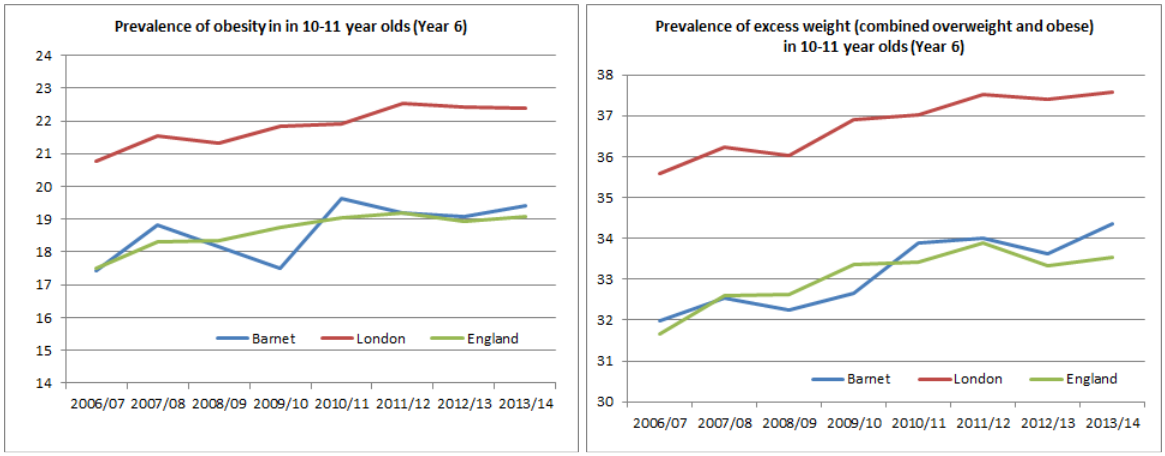
In Barnet, the obesity rate for Year 6 children (10-11 year olds) slightly increased to 19.41% in 2013/14 compared to 19.07% in 2012/13, which was similar to the national rate (19.09%) but lower than the London regional rate (22.39%) for 2013/14 (Figure 6-6a).

The proportion of excess weight in 10-11 years old children in Barnet has also increased to 34.4% in 2013/14 compared to 33.6% in 2012/13. The rate of excess weight in 10-11 year olds in Barnet is similar to the national rate but lower than the rate in the London region (37.59) for 2013/14 (Figure 6-6b).

The prevalence of obesity in Year 6 children was the highest in Colindale (25.1%), Burnt Oak (24.4%) and Hale (22.1%) wards while the lowest in Finchley Church End (13.2%), Garden Suburb (13.4%) and High Barnet (14.5%) wards in Barnet.

Overall, Colindale ward has the highest percentage of obese children in both the reception year and Year 6.

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



Source: Health and Social Care Information Centre. National Child Measurement Programme

6.5 Physical Activity

The UK Chief Medical Officer has recommended physical activity at all ages and for adults has recommended at least 150 minutes of physical activity per week.[98] Based on this criterion, Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%)[99]. Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates.[99]

Barnet residents' participation in sports once a week (Table 6-2) shows that about four in every ten persons aged 14 and above are involved once a week in sports. Participation in sports by males is greater than for females; however, both male and female participation in sports has increased in 2013/14 compared to the previous year. Young persons aged 14-25 years have increased participation in sports as shown in the latest annual physical survey (APA8) compared to the previous survey (APS7). However, children's participation in sports has slightly declined in the 2013/14 survey (APS8) in contrast to the APS7 conducted in 2012/13. Overall, the involvement in sports by people in social grades 1-4 is similar in both surveys. Overall, participation in sports is higher in white British residents than those of black and minority ethnic (BME) origin residents in Barnet. However, the percentage of participation in sports has recently decreased in white British residents but increased in the BME residents of Barnet (Table 6-2).

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

Table 6-2: Sports participation - At least once a week in Barnet population (aged 14+)

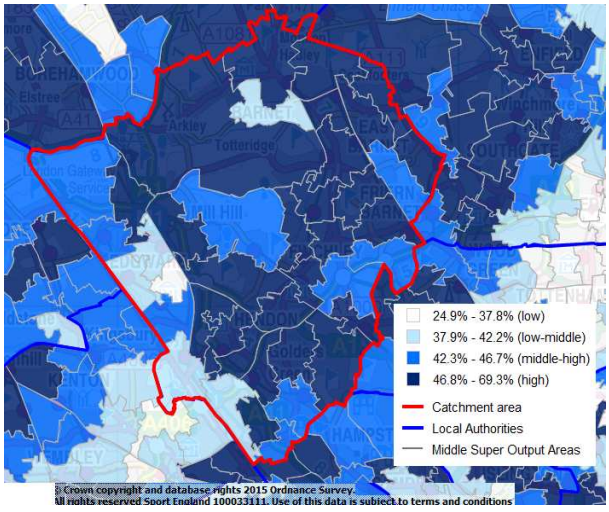
		2012/13 (APS7)	2013/14 (APS8)
Adult Population	Whole population (14+)	40.2%	41.5%
Gender	Male	44.9%	48.3%
	Female	35.9%	35.1%
Age Range	14 - 25	52.2%	61.1%
	26 - 34	*	*
	35 - 44	41.9%	*
	45 - 54	38.1%	39.2%
	55 - 64	*	*
	65 and over	*	*
Children		47.8%	44.4%
Social grade	NS SEC 1-4	42.5%	42.6%
	NS SEC 5-8	*	*
Ethnicity	White British	47.8%	45.0%
	Black and Minority Ethnic Groups	42.2%	44.4%

* Data unavailable, question not asked or insufficient sample size

Source: Sport England. Active People Interactive (Active People Survey analysis tool)

In addition, the latest physical activity survey (APS8) has revealed that 68% of Barnet 16+ population would like to do more sports (also known as overall latent sport demand), which includes 42.3% of those currently active and 25.7% of currently inactive. Moreover, the same level of sport activity has declined in females compared to males during 2013/14 in comparison to the previous year. This might suggest a need for increasing participation of females in sports in Barnet. In addition, there are inequalities in participation in sports between different localities in the London Borough of Barnet. Data from Sport England's Active People Survey 6 (October 2011 - October 2012) shows that once a week sports participation at the MOSA level in Barnet was the highest in MOSA E02000043 (53.8%), MOSA E02000039 (54.3%) and MOSA E02000046 (54.4%) while the lowest in MSOA E02000049 (36.5%), MSOA E02000047 (38.7%) - both in Burnt Oak ward, and MSOA E02000027 (40.9%) in Under Hill ward (Figure 6-7)[100].

Figure 6-7: Modelled once a week sports participation estimates for Barnet - MSOA level (Data from APS6 – 2011/2012)[100]



The CMO recommendation for physical activity in children stresses upon promotion of physical activity at an early age and creation of more opportunities for children and young people to be physically active. The local children centres offer a range of services for babies, children and young people. The London Borough of Barnet supports several interventions and programmes aimed at promotion of physical activity not only for young children and adolescents but also for adults and older people as reported in the Harrow & Barnet on the Move annual report by

[100] Sport England. Small Area Estimates web tool

the Joint Director of Public Health (DPH) at Barnet and Harrow Borough Councils.[101]

In addition, 'Keeping Well, Keeping Independent' – the Barnet Health and Wellbeing Strategy 2012-2015 recognises the need for creating a supportive environment to increase physical activity aimed at the prevention agenda; partnership working is key to identifying and addressing the factors underpinning health inequalities across Barnet communities.

6.5.1 Physical Activity Needs

The DPH's annual report Harrow & Barnet on the Move suggests a range of interventions for fulfilling the physical activity needs of local residents. For example the following activities are suggested by the council and healthcare providers:

- Creating safe, age-friendly neighbourhoods and communities
- Ensuring there are convenient and attractive walking and cycling opportunities and access to the natural environment
- Identifying physically inactive older people and encouraging them to take exercise – offering referrals to free programmes if appropriate
- Focusing on ability rather than limitations

6.6 Alcohol

The percentage of residents who abstain from drinking alcohol in Barnet (22.05%) is similar to the average in the London region (22.37%) but higher than the national rate (16.53%). In terms of the number of alcohol abstainers, Barnet ranks 22nd highest among 326 local authorities in England.

Among drinking Barnet residents, 6.8% are classified as 'higher risk' drinkers (over 50 units of alcohol per week for men and over 35 units per week for women), which is similar to the averages for the London region (6.9%) and England (6.75%). Thus, for the higher risk drinker population, Barnet ranks 20th lowest among all English local authorities (n=326). Estimates show that 18.87% of Barnet adult residents are 'increasing risk' drinkers (22-50 units per week for men, and 15-35 units per week for women). These are lower than the average estimates for the London region (19.7%) and England (20%).

6.6.1 Binge Drinking

In terms of binge drinking, Barnet ranks 9th lowest among 326 total English local authorities. Estimated percentage of 'binge drinkers' (eight or more units of alcohol for men or six or more units of alcohol for women, on at least one day in the previous week) in Barnet (12%) is less than both the London region (14.3%) and national (20.1%) averages.

Public Health England's modelled estimates of binge drinking adults show that the percentage of binge drinkers by wards in Barnet is the highest in Garden Suburb (14.7%), High Barnet (14.4%) and East Barnet (14%) wards while the lowest in Colindale (8.4%), Burnt Oak (9.7%) and West Hendon (10.1%) wards.

[101] London Borough of Barnet (2014) Harrow & Barnet On The Move. The Annual Report of the Director of Public Health of the London Boroughs of Barnet and Harrow 2013-14

6.6.2 Alcohol Related PHOF Indicators

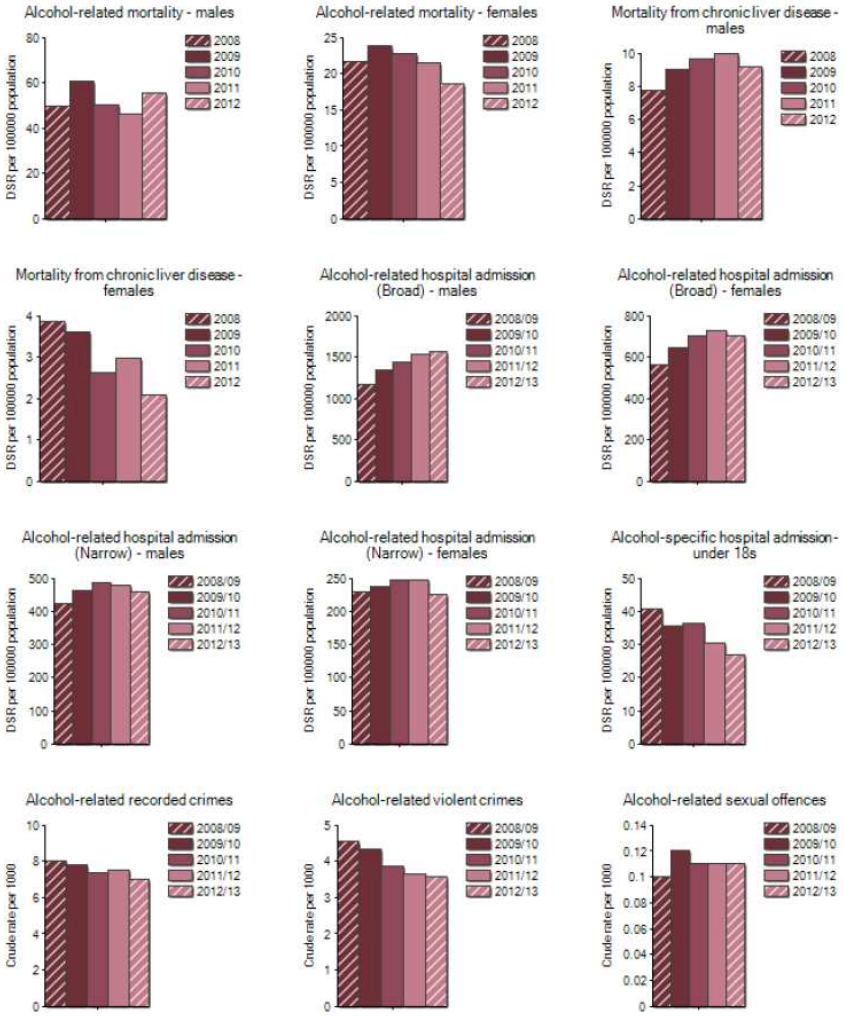
Barnet rates of alcohol related mortality, hospital admissions, crimes, and sexual offences as well as mortality from chronic liver disease are shown in Figure 6-8 below. Most of these rates in Barnet are coming down except the alcohol related mortality and hospital admissions in males, which are increasing and the rate of alcohol related sexual offences has not changed in the last three years.

The ward level standardised admission ratios (SAR) of hospital admissions for alcohol attributable conditions are the highest in Burnt Oak (122.9), Colindale (105.9) and Underhill (102.8) wards while the lowest in Garden Suburb (50.9), Finchley Church End (66.1) and Childs Hill (74.7) wards in Barnet.

6.6.3 Alcohol Dependence

The Adult Psychiatric Morbidity Survey (APMS) 2007[102] revealed that 5.9% of Barnet adults may have some form of alcohol dependence, which is higher in men (8.7%) compared to women (3.3%) and white men and women (9.6% and 3.7% respectively) are more likely to be dependent. The number of people in treatment for alcohol dependence has risen by 53% in the last five years. The level of successful completions for alcohol treatment (28.1%) is below the national average (37.5%) for 2013/14. The level of re-presentations for treatment within 6 months is higher.

Figure 6-8: Barnet alcohol related rates by gender (2008-2012)



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

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

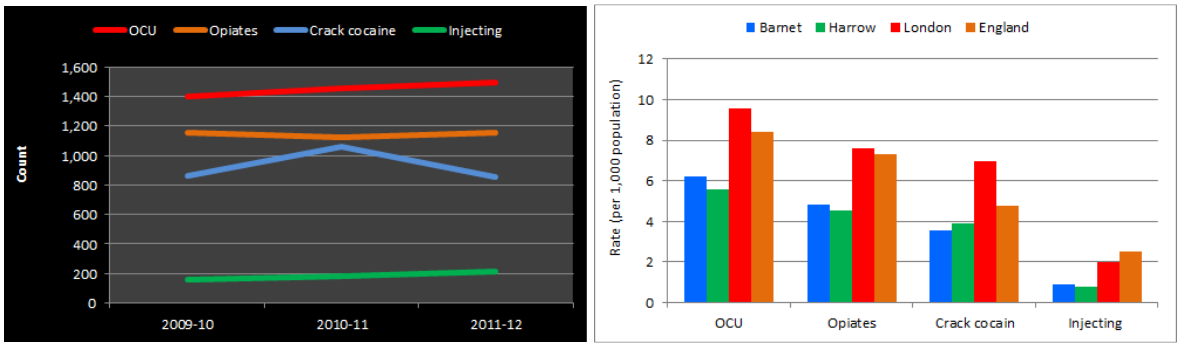
6.7 Drugs and Substance Misuse

6.7.1 Prevalence of Drug Misuse

According to the most recent estimates (2011/2012), Barnet has 1,492 opiate and/or crack users (OCU), 1156 opiate users, 857 crack cocaine users and 215 injecting drug users aged 15-64 years. Barnet rates of OCU and opiates prevalence by age (per 1,000 population) are highest in persons aged 35-64 years (OCU = 6.88, opiates = 5.47) followed by those aged 15-24 years (OCU = 5.73, opiates = 4.04) and persons aged 24-34 years (OCU = 5.16, opiates = 3.99).

In Barnet, total number of users of OCU, opiates, and drug injecting has increased but crack cocaine users number has decreased recently (Figure 6-9a). However, the estimated rates (per 1,000 population) of OCU, opiates, crack cocaine and injecting drug users in Barnet are lower than London regional and national rates (Figure 6-9a). Nevertheless, the total number of OCU, opiates, crack cocaine and injecting drug users are higher in Barnet compared to Harrow, which is a similar and neighbouring local authority (Figure 6-9b). The rates of substance misusers in the two Boroughs are however not very different.

Figure 6-9a&b: Estimated rates of OCU, opiates, crack cocaine and injecting drug users



Source: Public Health England. Drugs and Alcohol. Prevalence estimates by Local authority

6.7.2 Drug Related Deaths in Barnet

The number of drug-related deaths per year in those aged 16 and over whose usual residence was Barnet is very low i.e. one case in 2012 and two cases in 2011. Deaths in treatment National Drug Treatment Monitoring System (NDTMS), whilst not necessarily drug-related, are reported as an unsuccessful treatment exit reason. The numbers for each year in Barnet treatment providers are shown in Table 6-3 below.

In 2013 details of five deaths in treatment were received by commissioners from treatment providers; however, three of these were alcohol related. There is a disparity between NDTMS and local reporting that needs further investigation and explanation. There is therefore a need for improving the local serious incident and drug/alcohol-related death reporting processes.

Table 6-3: Deaths in drug treatment – Barnet 2011/12-2013/14 (NDTMS)

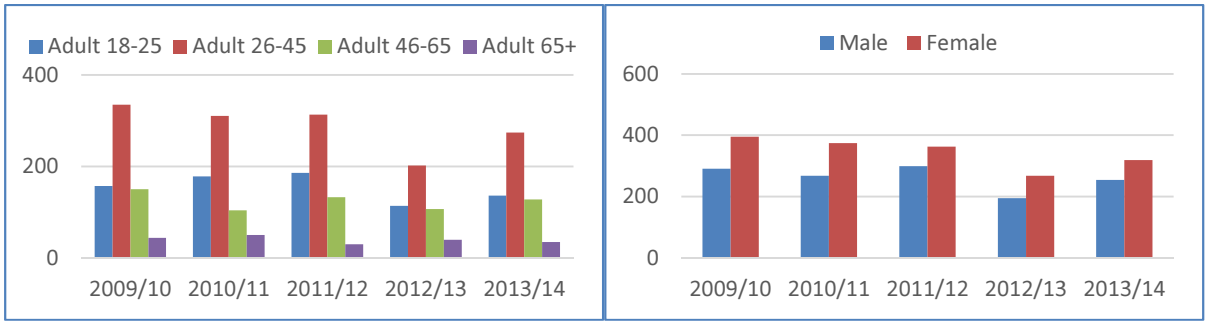
	2011/12	2012/13	2013/14
Number	2	8	7
Treatment provider	(2 BDAS)	(6 BDAS, 2 WDP)	(6 BDAS, 1 WDP)

BDAS= Barnet Drug and Alcohol Service; WDP = Westminster Drug Project

6.7.3 Drug Related Ambulance Data

Drug-related callouts for Barnet adults undertaken in 2013/14 were 573 compared to 463 callouts in the previous year. The number of callouts was highest in 26-45 year olds, followed by 18-25 year olds most years (Figure 6-10a). In adults, drug-related callouts by females was higher than males (Figure 6-10b). Drug-related ambulance callouts were the highest in Colindale ward followed by Burnt Oak ward while the lowest was in Brunswick Park ward.

Figure 6-10a&b: London Ambulance Service drug-related callouts by Barnet adults by age and gender



6.7.4 Drug Related Crime Data

Drug related crime in the Borough is shown in the panel below that provides a snapshot of drug related crime initially for possession and supply offences for a six month period in 2013 (Figure 6-11).

Figure 6-11: Drug related crime in Barnet

Drug supply and drug possession crimes

Data set:

- Jan – June 2013. (6 months data)
- All Barnet Crime allegations (including those no crimed or resulting in crime related incidents), that are classed as 'Drug Trafficking' or 'Drug Possession' .
- 'Drug Trafficking' refers to drug supply related allegations

Headline figures:

Volume in 6 month period between Jan – June 2013

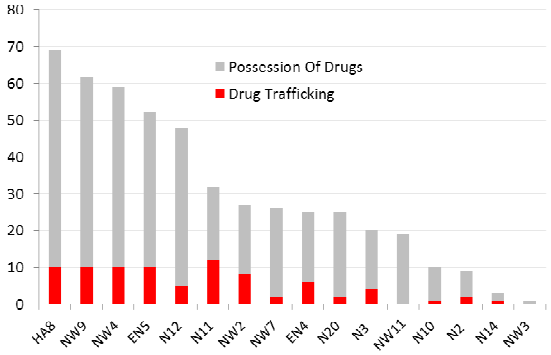
Drug Trafficking (i.e. supply related crime allegations:

83

Drug possession allegations:

72

Breakdown by location:



Drug related crime allegations

Data set:

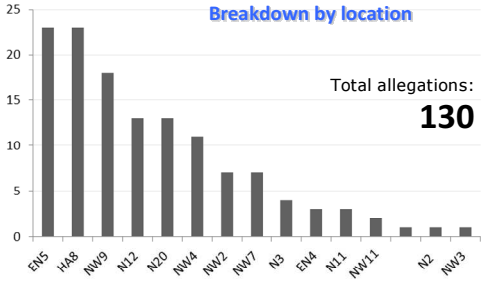
Jan – Dec 2013 (12 months data) All Barnet Crime allegations , that are flagged as drug related (victim/suspect taking prior to or at the incident)

Drug related crimes

Break down of crimes in Barnet during 2013, with drug related flag present (victim or suspect taking drugs at or prior to the crime)

Crime type	*Volume*
Drugs Possession Of Drugs	64
Drugs Drug Trafficking	10
Violence Against the Person Assault with Injury	10
Other Accepted Crime Others - Other Accepted Crime	9
Other Notifiable Offences Other Notifiable	7
Violence Against the Person Common Assault	5
Sexual Offences Rape	4
Violence Against the Person Harassment	4
Violence Against the Person Serious Wounding	4
Theft and Handling Theft/Taking of M/V	3
Burglary Burglary in a Dwelling	2
Violence Against the Person Offensive Weapon	2
Other	6

Breakdown by location



Total allegations:

130

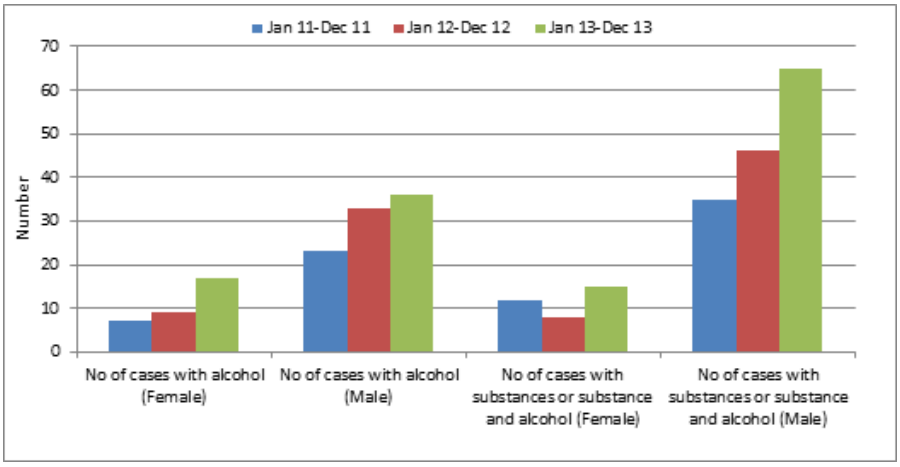
Also shown for all crime flagged as drug related during the whole year 2013. The postcodes HA8 (Edgware), NW9 (Colindale/West Hendon) and NW4 (Hendon) have the highest drug possession offences and N11 (New Southgate/Bounds Green) has the highest level of drug supply offences for the year.

Saturday is the peak day for crimes flagged where perpetrator or victim is thought to have taken drugs prior to the incident. The level of drug related crime increases from midday to a peak at midnight then drops again.

6.7.5 Drug or Alcohol Related Domestic Violence

The Multi-Agency Risk Assessment Conference (MARAC) data for Barnet shows that the total number of MARAC high risk domestic violence cases where drug or alcohol issues are present is also increasing year on year (Figure 6-12). The number of referrals to the MARAC from drug and alcohol treatment services remains very low (two referrals in 2011, three referrals in 2012 and one referral in 2013). This may indicate a need to ensure the treatment workforce is aware, trained and confident in identifying and responding to drug related domestic violence.

Figure 6-12: Barnet MARAC cases involving drugs or alcohol



6.7.6 Housing Support

A Floating Support Service (FSS) is provided to drug/alcohol using tenancy holders. The FSS provides help with budgeting, income maximisation and tenancy maintenance (Outreach Barnet). Data from Supporting People commissioners shows the number of drug and alcohol users supported by the floating support (Table 6-4).

Table 6-4: Floating support service – substance misuse needs and outcomes

	Substance misuse need identified	% of caseload with substance misuse need	positive outcome achieved	% of those with a substance misuse need who had a positive outcome
2011-12	92	7.76	51	55.44
2012-13	94	8.55	60	63.83
2013-14	96	7.26	61	63.54

Whilst substance misuse represents less than 2% of primary needs identified by Supporting People data at initial referral stage, subsequent assessment shows that up to 8.5% of the caseload have a substance misuse issue. Positive outcomes range between 55% and 64% in the years shown.

Homeless Action Barnet, also deliver support to homeless clients, many of whom have alcohol rather than drug issues. The service can help with breakfast/lunch, showers, laundry, clothing, escorts to appointments and referral to food banks. Public Health funds contribute £35,000 per year towards the service. HAGA (alcohol treatment service) provide satellite sessions (up to 3.5 days a week) and are starting up a SMART group in association with Westminster Drug Project (WDP), which has three shared houses that are supported by one worker. Some tenants have alcohol problems and engagement in treatment is a condition of their tenancy. Tenancies are short-term, six months to a year, pending suitable long term accommodation. However, good quality accommodation has become harder to find due to benefit changes.

6.7.7 Drug Treatment Completion Rates

The percentage of opiate drug users that left drug treatment successfully who do not represent to treatment within 6 months in Barnet (8.6%) was similar to the national (7.8%) and London regional (9.0%) averages for 2013. However, the proportion of non-opiate drug users that left drug treatment successfully who do not represent to treatment within six months in Barnet (20.4%) was lower than the London (37.2%) and national (37.7%) averages for 2013. For the same period, the Barnet rates of successful completion of drug treatment for both opiate and non-opiate users were lower than these rates in Harrow (11.5% for opiate users and 41.4% for non-opiate users), which is a neighbouring Borough.

The proportion of OCUs in treatment (estimated penetration rate) in 2013/14 in Barnet (44.3%) is lower than the estimated national penetration rate (52.3%).[103] The 'penetration rate' for OCUs in treatment needs to increase to optimise numbers into treatment.

There is a need to 'segment' the treatment population to ensure that those with more complex needs and longer treatment journeys are targeted with services that help build recovery capital. Furthermore there is a need to improve the effectiveness of treatment for non-opiate users, specifically cannabis and cocaine users which will require better psychosocial interventions and support to maintain treatment gains long term.

6.8 Sexual and Reproductive Health

6.8.1 Reproductive Health

6.8.1.1 Teenage Pregnancy

Teenage pregnancy related indicators i.e. the rates of conception in under 16 years and under 18 years and the abortion and birth rates in under 18 years in Barnet are lower than the regional London and national rates. However, percentage of conception to females aged less than 18 years leading to an abortion is higher in Barnet (76.2%) compared to London (64.2%) and England (51.1%). In Barnet, the top three wards with the highest percentage of delivery episodes where the mother was under 18 years of age include West Hendon (1.2%), Hale (1%) and Finchley Church End (1%) wards.

[103] DOMES report Q4 2013-2014

6.8.1.2 Abortions

The total number of legal abortions carried out in Barnet was 1,624 (95% CI: 1,546-1,705). The age standardised rate (ASR) of abortions was 19.9 per 1,000 female population aged 15-44 years. The ASR of abortions (in all ages) in Barnet is lower than the London regional rate (22.8) but higher than the national rate (16.6).[104] The crude rate of abortions in the 20-24 years age group was highest (34 per 1,000 women aged 20-24 years), which was lower than the London regional rate (38 per 1,000 women) but higher than the national rate (28.7 per 1,000 women). The crude rate of abortions in the under 18 years of age was 8 per 1,000 women (aged <18 years) which was lower than the average rates in the London region (14 per 1,000 women aged <18 years) and England (11.7 per 1,000 women aged <18 years). Of abortions, 84% were carried out at less than 10 weeks gestation. 60% of abortions were carried out using surgical methods while the remaining 40% of abortions were carried out using medical methods. The percentage of repeat abortions was 40% in women of all ages, 30% in women aged less than 25 years and 46% in women aged 25 years and above.

Higher percentages of repeat abortions and conceptions leading to abortions might suggest inequalities in regards to advice and access to services concerning contraception.

6.8.1.3 Contraception (provision of advice and services around contraception)

The rate of GP prescribed long acting reversible contraceptives (LARC) per 1,000 in Barnet (19.4) is lower than the average rates for London (25.1) and England (52.7). This suggests a need for increasing the rate of LARC prescription by GPs in Barnet.

6.8.1.4 Sexual Offences

In Barnet, 307 incidences of sexual offences were reported in 2013/14. The rate of sexual offences (per 1,000) in Barnet (0.84) is the fifth lowest across all London Boroughs and it is lower than the average rates for London region (1.22) and England (1.01).

6.8.1.5 Sexually Transmitted Infections (STI)

In Barnet, the diagnosis rates (per 100,000) for syphilis (6.0), gonorrhoea (60.2), genital warts (122.8) and genital herpes (64.0) are similar to average rates in England but lower than the average London rates.

In young people aged 14-24 years, Chlamydia detection rate (1,098 per 100,000) and Chlamydia screening proportion (16.0%) measured separately in genitourinary medicine (GUM) clinics and non-GUM settings, in Barnet are lower than the national rates (2016 /100,000 and 24.9% respectively). The low rates in Barnet suggest a need for increasing detection of and screening for Chlamydia in young people.

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

6.8.1.6 Human Immunodeficiency Virus (HIV)

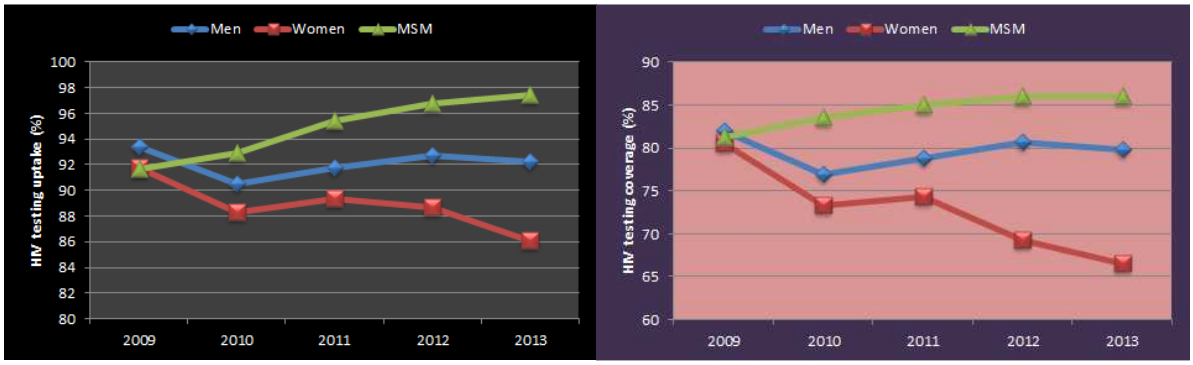
In Barnet, uptake of HIV testing in GUM clinics (86.0 in women, 92.2 in men and 97.4 in men who have sex with men (MSM)) are better than the uptake averages in England. However, within Barnet,

[104] Department of Health (2014) Abortion statistics, England and Wales: 2013. Dated: 12 June 2014.

HIV testing uptake by women is lower than the uptake by men and by those men who have sex with men (Figure 6-13a). Thus, there is a need to increase the uptake of HIV testing in Barnet women.

In addition, coverage of HIV testing in GUM clinics among Barnet women (66.5%), men (79.9%) and MSM (86%) are either better or similar to the average coverage levels for England. However, uptake of HIV testing in Barnet women needs to be increased because it is lower than the uptake by Barnet men and those men who have sex with men in Barnet (Figure 6-13b).

Figure 6-13: HIV testing uptake and coverage in Barnet



Source: Public Health England. Sexual and Reproductive Health Profiles. Public Health Outcomes Framework

The rate of diagnosed HIV prevalence (per 1,000 among persons aged 15-59 years) in Barnet (3.00) is higher than the rate in England (2.14) and the proportion of adults (aged 15 years and above) with newly diagnosed HIV in Barnet (51.5%) is worse compared to the average for the London region (40.5%) and England (45%). These statistics suggest a need for improving early diagnosis of HIV with targeted intervention to specific and hard to reach communities such as gays and lesbian people in Barnet.

6.8.1.7 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.[105]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.[105]

[105] Metropolitan Police. Crime Figures for London

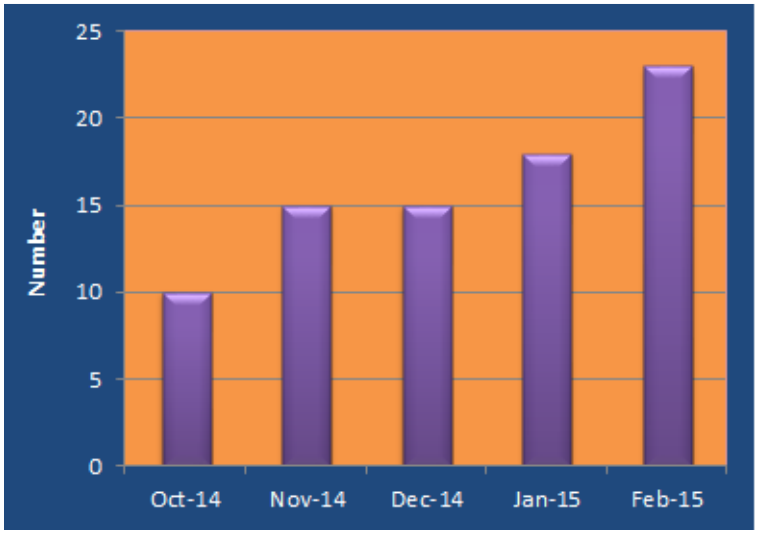
6.8.1.9 Female Genital Mutilation (FGM)

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".[106] Mostly prevalent in some communities of African and Middle Eastern origin, FGM is a harmful practice that has both short term and long term health, social and psychological effects on the girls and women and it violates their reproductive health and human rights.[107] 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. 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



Source: HSCIC, FGM Experimental Statistics (Feb 2015)

6.9 Preventing Ill Health

The public health outcome framework shows that the majority of Barnet indicators are either better or similar to the national level; however, a few Barnet indicators are either worse or lower than the England average. These worse or lower indicators are mainly under the health protection and health

[106] WHO (2014) Female genital mutilation. Fact sheet No. 241. Updated February 2014.
[107] United Nations Population Fund (UNFPA) (2014) Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation. New York.

improvement theme indicators (Appendix 1), which can be addressed through public health prevention and health improvement interventions.

6.9.1 Primary Prevention

Boyce et al (2010) suggested that primary prevention of ill health could include childhood immunisation against preventable infectious diseases. In Barnet, coverage (uptake) of various immunisations for children, young adults and elderly people is below the national level. It is therefore essential that the rates of immunisation coverage (uptake) are increased in Barnet to the level of average national rates.

For achieving the desired rates with regard to childhood immunisation, motivation of parents and training of GPs are some of the key issues that need to be addressed.[77] In addition, there is a need to target those with transport, language or communication difficulties, and those with physical or learning disabilities.[108] 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 tuberculosis (TB) through active engagement of local ethnic communities in which TB is more common.

6.9.2 Secondary Prevention

Preventing ill health needs addressing the common causes of major diseases that lead to high rates of premature mortality. In Barnet, the top causes of premature mortality include coronary heart disease (CHD), stroke, breast and lung cancers, mental health and respiratory diseases (e.g. pneumonia and COPD), which are more prevalent in specific communities such as people of BME origin and those living in most deprived localities such as Burnt Oak and Colindale wards. There are health and lifestyle inequalities between different wards in Barnet (Table 6-5).

More importantly, the common causes of the above mentioned major killer diseases include smoking, poor diet, alcohol, obesity, physical inactivity, high blood pressure and air pollution, which are mostly lifestyle related health risk factors that could be modified by behavioural change and health promotion interventions such as smoking cessation, stop alcohol, healthy eating and physical and weight reduction activities.

However, the services covering these activities would require remodelling and adjustments so that they meet specific needs of the clients and are suitable and accessible to local people, irrespective of their physical (dis)abilities and social, demographic and ethnic background. For example, preventing smoking in people with serious mental illness, during pregnancy, and among young children and women of ethnic minority groups would require programmes that are tailored to the needs of the targeted clients.

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

Table 6-5: Health and Lifestyle indicators: ranking of Barnet wards

Indicator	Unit	Best ward	Worse ward
Life expectancy	Years	Garden Suburb (males =84.1, females =88.5)	Burnt Oak (males = 75.8, females = 81.6)
Stroke mortality	SMR	Finchley (47.9)	Childs Hill (117.7)
Emergency hospital admissions for stroke	SMR	Garden Suburb (78.9)	Burnt Oak (173)
Breast cancer incidence	SMR	Burnt Oak (77.5)	Mill Hill (118.2)
Colorectal cancer incidence	SMR	Hale (69.8)	Coppetts (122.8)
Lung cancer incidence	SMR	Garden Suburb (53.2)	Coppetts (117.3)
Prostate cancer incidence	SMR	Brunt Oak (72.6)	West Finchley (115.6)
All cancers Incidence	SMR	Garden suburb (86.2)	Underhill (103.3)
COPD hospital admissions	SAR	Garden suburb (28.3)	Burnt Oak (141.8)
Fertility rate (per 1,000 females aged 15-44)	CFR	Golders Green (82.9)	Brunswick Park (56.8)
Low birth weight babies(less than 2500 g)	Proportion (%)	Hendon (5.9%)	Finchley Church End (9.1%)
Drug-related ambulance callouts	Count	Brunswick Park	Colindale
Smoking in adults (estimated prevalence, 18 years and above)	Proportion (%)	Garden Suburb (13.5%)	Burnt Oak (16.9%)
Modelled prevalence of regular smoking in children age 11-15 years	Proportion (%)	Colindale (1.1%)	Underhill (5.6%)
Modelled prevalence of regular smoking in children age 15 years	Proportion (%)	Colindale (4.2%)	Hendon (14.2%)
Modelled prevalence of regular smoking in young people aged16-17 years	Proportion (%)	Colindale (7.8%)	Hendon (22.6%)
Obesity in adults (modelled estimates)	Proportion (%)	Garden Suburb (12.8%)	Burnt Oak (23.7%)
Obesity in reception year children (prevalence)	Proportion (%)	Garden Suburb (5.6%)	Colindale (13.1%)
Obesity in year six children (prevalence)	Proportion (%)	Finchley Church End (13.2%)	Colindale (25.1%)
Binge drinking in adults (modelled estimates)	Proportion (%)	Colindale (8.4%)	Garden Suburb (14.7%)
Hospital admissions for alcohol attributable conditions	SAR	Garden Suburb (50.9)	Burnt Oak (122.9)

The likely positive outcomes of reducing inequalities and preventing CHD, stroke, cancers, respiratory diseases and mental health in Barnet include reduction in costs of and demand for health and care services, improvement in life expectancy and reduction in the premature mortality as shown in Table 6-6.

Table 6-6: Life expectancy years gained if Barnet most deprived quintile had the same mortality rates as Barnet least deprived quintile, by detailed cause of death (2010-2012)

Broad cause of death	Number of deaths in most deprived quintile		Number of excess deaths in most deprived quintile		Number of years of life expectancy gained*	
	Male	Female	Male	Female	Male	Female
Circulatory diseases	219	240	122	103	2.61	1.73
Cancers	158	170	39	19	0.94	0.54
Respiratory diseases	68	96	23	36	0.49	0.65
Digestive diseases	31	36	18	21	0.41	0.36
Mental and behavioural illnesses	39	76	24	48	0.39	0.63
* A positive figure indicates that life expectancy years would be gained if the base area (the most deprived area) had the same mortality rate as the comparator area (the least deprived area) (i.e. the mortality rate in the base area for the cause is higher than the comparator)						
Adapted from: Public Health England. Segment Tool 2015						

6.9.3 Tertiary Prevention

Under the tertiary preventative initiatives, a few selected public health issues such as mental health could be tackled. In Barnet, mental health and behavioural illnesses are among the major causes of premature mortality, especially among women and young children. Mental health and behavioural illnesses are multidimensional issues; therefore, tackling them would require a multi-disciplinary approach involving the key stakeholders such as GPs, local governments / public health agencies, NHS England, Public Health England, third sector organisations and families of patients.

6.9.4 Return on Investment in Public Health Prevention Interventions

A report 'Making the case for public health interventions' by the Kings Fund has suggested that little investment in public health prevention interventions such as changing unhealthy lifestyle and behaviour could results in considerable savings by reducing or avoiding some healthcare and care costs and would increase life expectancy. A few examples of investment and return for specific public health interventions are given in Table 6-7.

Table 6-7: Return on investment in public health prevention interventions

Intervention area	Investment (£)	Possible return (£)	Saving in
Housing interventions (warm and safe)	1	70	NHS costs over 10 years
Be active programmes	1	23	Quality of life, reduced NHS use and other gains
School-based public health interventions i.e. smoking prevention programmes and anti-bullying interventions	1	15	Children's health
Preventing teenage pregnancy	1	11	Healthcare cost
Parenting programmes	1	8	Preventing conduct disorder over six years
Supporting people with alcohol or drug addiction	1	5	Reduced health care, social care and criminal justice costs
Providing social support	1	3.75	Reduced mental health service spending and improvements in health
Drug treatment	1	2.50	Reduced NHS and social care costs and reduced crime

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

7 Primary and Secondary Care

7.1 Key Facts

- Barnet is ranked 3rd across North Central London (NCL) CCG's in terms of A&E activity usage and yet is the lowest per 1000 population compared to the other NCL CCGs.
- Largest number of nursing home beds in London.
- The total number of GP registered patients in Barnet at the start of 13/14 was 388,895 and is estimated to rise to 402,748 by 2015/16.
- Older people (65+) are three times more likely to be admitted to hospital following attendance at A&E.
- Hip fractures prompt entry to a care home in up to 10% of cases.
- The rate of alcohol related hospital admissions has steadily increased over a six year period.

7.2 Strategic Needs

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges**, **place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in acute care.
- **Increasing demand on urgent and emergency care** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **Accident and Emergency (A&E) patients waiting no longer than four hours from the time from booking in to either admissions to hospital or discharge**. Quarter 3 and Quarter 4 having missed the 95% national target (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- Obesity growth in middle-age population (45-65) year olds places additional risk of them developing long-term conditions.

7.3 Barnet Clinical Commissioning Group (BCCG)

Barnet Clinical Commissioning Group was authorised in April 2013 and has completed two years of operation. Barnet Clinical Commissioning Group is responsible for commissioning population-based general health care services for its registered population. It is made up of 67 GP practices. CCG governing body consists of 9 elected members (3 from each locality), 2 lay members, a secondary care consultant, a nurse, the Chief Officer and the Financial Officer.

The healthcare system is facing the challenges of increasing demand and limited resources. Demand for services will continue to grow faster than funding, meaning that there is a need to innovate and transform the way services are delivered, within the resources available, to ensure that patients, and their needs, are always put first.[109]

Barnet's CCG remains committed to improvements in the health and wellbeing of the local population by focusing on preventative services, reducing health inequalities, meeting of NHS Constitutional commitments and enabling the population to take responsibility for their own health.

7.4 Health Inequalities in Barnet

Health inequalities refer to the differences in health experiences and outcomes between individuals or groups where they are avoidable and, therefore, not justifiable.

Current evidence indicates that inequalities in health persist and the gap in life expectancy between the most and least deprived people in England has not narrowed over time. In Barnet males in the most deprived areas have a life expectancy 9.1 years less than those in the least deprived areas; for females the equivalent figure is 6.8 years.

Whilst there are limitations in available evidence linking the differences in socio-economic inequalities and survival rates from cancer and disease in general, it is clear from international studies and evidence that people from more deprived groups tend to[110]:

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

7.4.1 Health Inequalities in Barnet

Within Barnet, the groups that have been identified as experiencing the health inequalities are:

- Obesity and the related conditions for adults, children and young people;
- Mental health and learning disability;
- Long-term conditions;
- Integrated care;
- Primary care development;
- Diabetes mellitus; and
- Conditions attributable to cold weather.

7.4.2 Reducing Health Inequalities

109 Commissioning for Value. NHS England, Public Health England. CCG Barnet
110 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" [111] by which actions to address health inequalities are universal, but with a scale and intensity proportionate to the level of disadvantage health and healthcare.

7.5 Long Term Conditions and Integrated Care

The Health and Social Care Act, 2012 created a duty for Clinical Commissioning Groups, NHS England and Monitor to promote integrated services for patients between the NHS and social care (and other local services) where this would improve quality or reduce inequalities of access and outcome.[112]

The Act further introduced public health and health improvement responsibilities for local authorities, including the responsibilities for promoting partnership working through the Joint Health and Wellbeing Board.

Barnet's Integrated Care model reflects partnership working with the local authority designed to support local population throughout all stages of their lives, with a focus on older people and those with long-term conditions, with a view to the delivery of improved care coordination, supported early discharge from hospital, rapid response and promotion of self-care.

7.5.1 Integrated Care

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require on-going care and support. These include diabetes, chronic obstructive pulmonary disease, heart diseases and musculoskeletal disease.

It is projected that by 2018 the number of people in the UK with three or more long-term conditions is expected to rise to 2.9 million, compared to 1.9 million in 2008 (Department of Health 2012). Current evidence suggests that the number of conditions a patient has can be a greater determinant of a patient's use of health services than the specific service (Barnett et al 2012).

With the present levels of obesity and the estimated increases in the size of the population, the number of cases of diabetes is set to rise dramatically. Increasing prevalence of long term conditions, particularly diabetes, chronic cardiac conditions and dementia will severely stretch the emergency and hospital services unless better management in the community is achieved.

Many people with long term conditions are often at risk of deteriorating health, reduced wellbeing and lack of independence. This can lead to an increase in hospital admissions, more extensive involvement of health/social care and reduction in control of their own lives

7.6 Hospital and Residential Care

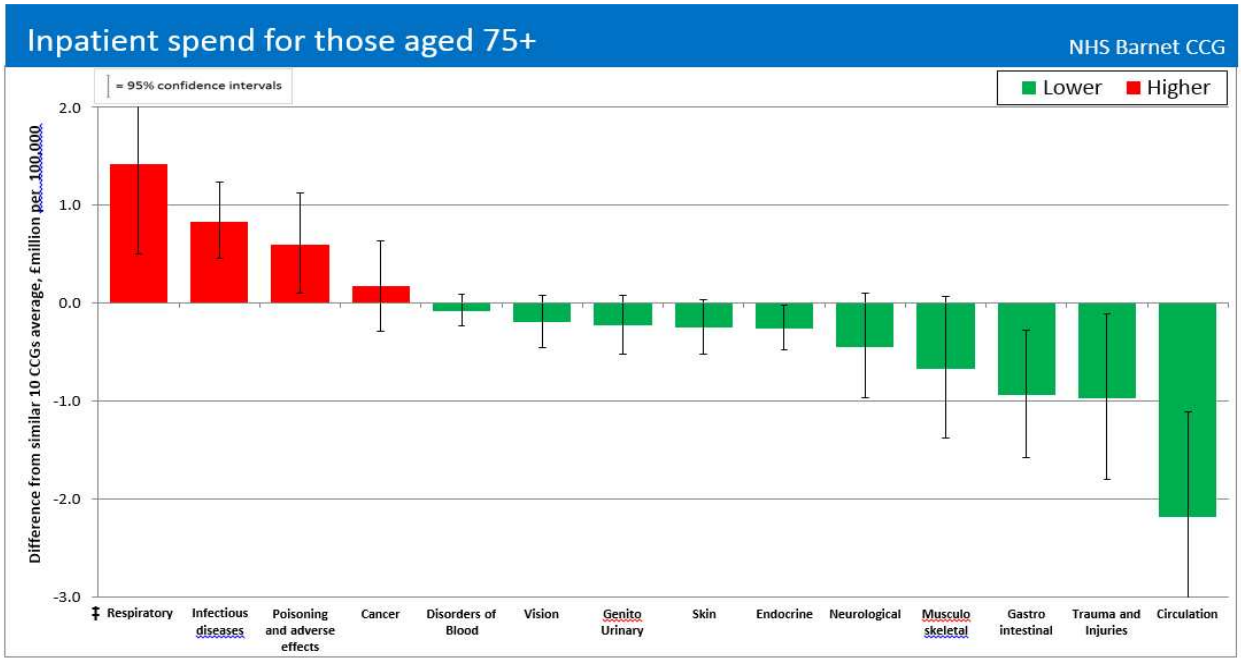
Barnet has the highest number of requests for emergency/urgent ambulance conveyance to hospital out of all London Boroughs from care homes; a total of 1133 ambulance requests for conveyance were made within the first 6 months of 2013 of these calls 12% were not conveyed.

[111] Fair Society Health Lives: Marmot Review Report, Feb 2010)
112 The Integration of Health and Social Care, June 2012: BMA Health Policy & Economic Research Unit

Compared to other Boroughs Barnet has a high proportion of care homes. There are 85 residential and 21 nursing homes in Barnet registered with the Care Quality Commission. In total, these homes provide approximately 2,800 beds for a range of older people and younger people with disabilities.

Barnet Clinical Commissioning Group and the London Borough of Barnet have been working together to give greater numbers of people in Barnet, of all ages, the opportunity to live healthy, active lives; to help prevent avoidable illnesses, and to manage long term conditions more effectively. Barnet's approach focuses on the 65 and over which is set to rise by 21% over the next 10 years.

Figure 7-1: Inpatient Spend for those Aged 75+



‡ Only those programmes with the highest inpatient spend are included

Public Health England RightCare NHS England

7.7 Emergency Admissions

Emergency admissions account for more than 70% of hospital bed days[113]. 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[114].

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[115].

Figure 7-2 shows the number of Emergency Admissions by age group, by hospital in Barnet. As can be seen over the period 2012-2015 the level of emergency admission has remained relatively stable over this period, with the Barnet and Chase Farm hospitals accounting for the largest portion of admissions.

[113] Poteliakhoff and Thompson 2011
[114] Purdy 2010
[115] Poteliakhoff et al 2011

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

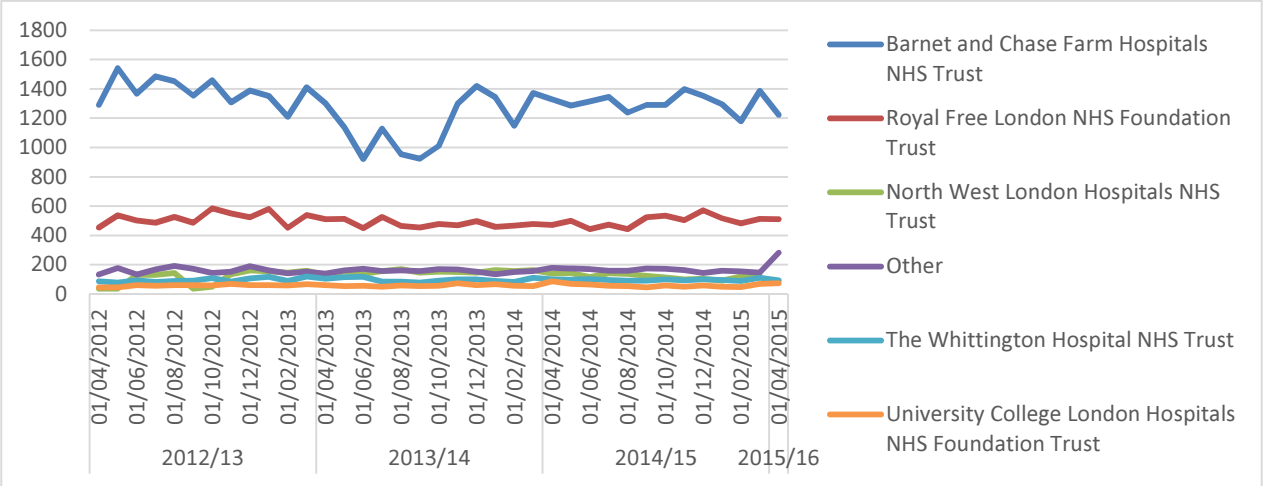
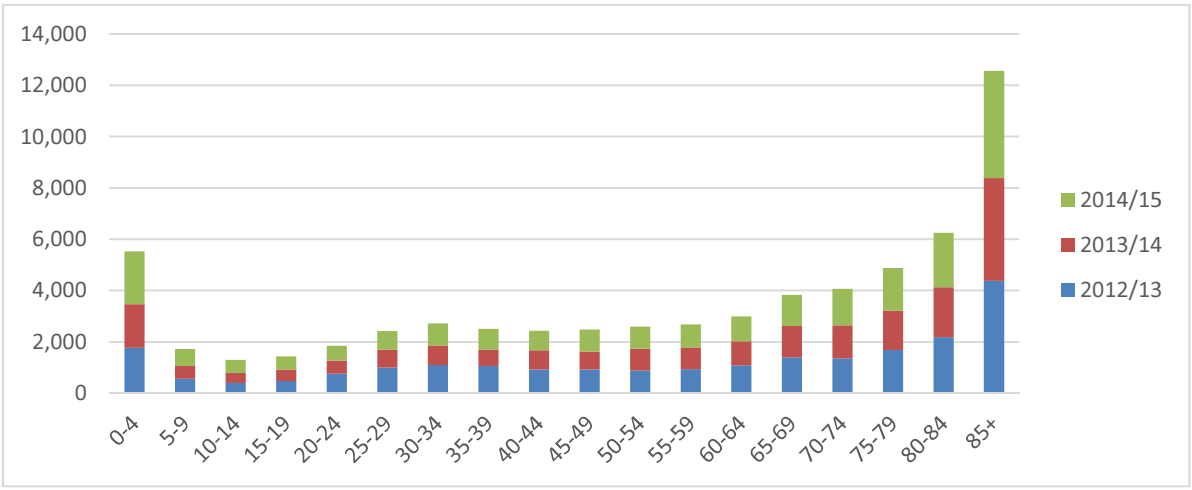


Figure 7-3 provides a breakdown of emergency admissions by age group for this same period. As can be seen, 48.9% of all admissions in 2014/15 were for people aged 65 or over, with people aged 85 or over accounting for 19.3% of admissions. Interestingly, by five year age band, the second highest rate 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[116] [117]

- 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

[116] (Fearon and Langhorne 2005)
[117] Avoiding hospital admissions: what does research evidence say? Purdy S (2010)

- An agreed discharge process that includes timescales and protocols for assessment and decision-making for different agencies to work together
- Ensuring patients with existing community services are discharged as soon as possible with care re-started
- Rehabilitation to ensure people do not become dependent or disabled in hospital
- Supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports

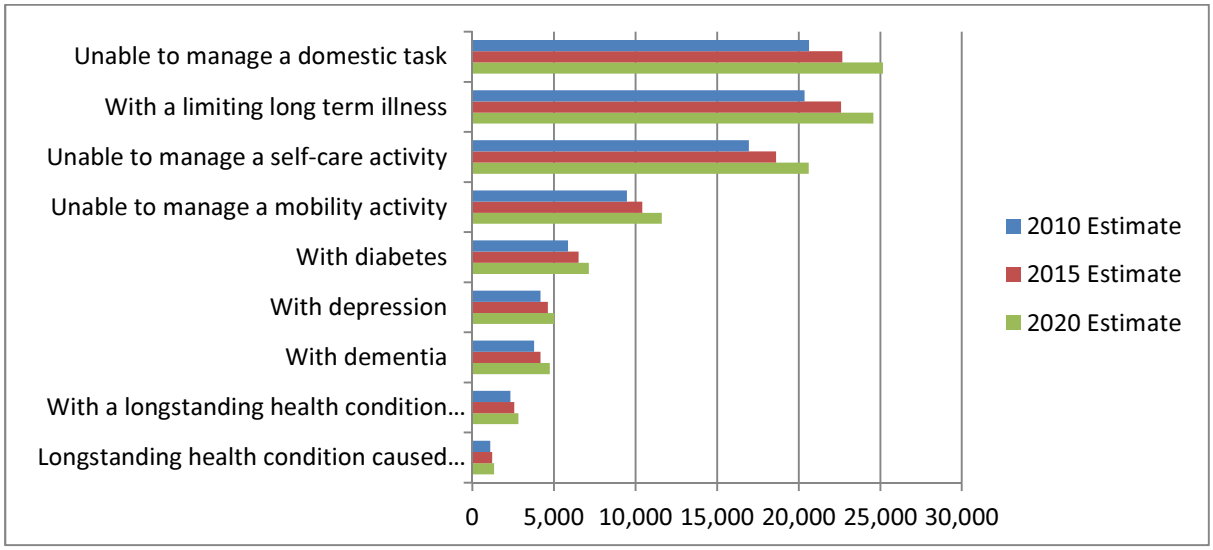
7.8 Frail and Elderly

Barnet is projected to have some of the strongest growth in elderly residents out of all the London Boroughs over the next five to ten years. Frail and elderly residents within the Borough are often at risk of deteriorating health, reduced wellbeing and lack of independence.

The older population is more likely to suffer from chronic and long-term conditions and is also more likely to suffer from falls and fractures. At present there are an estimated 20,359 people aged 65 or over with a limiting long term illness. The Projecting Older People Population Information (POPPI) system projects these figures to increase by more than 20% over the next ten years.

Over the next five years, there are predicted to be 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). Both of these increases are above the average growth rate (5.5%).

Figure 7-4: Projected Increases in the number of people with a Long Term Condition



Source: Department of Health, Projecting Older People Population Information (POPPI)

7.8.1 Key Issues

In the light of the anticipated pressure, there is a greater need to proactively manage the health and social care response as the elderly experience greater difficulties have been identified to allow for development of initiatives that will address the following health and social care needs[118]:

- Not being able to manage a mobility activity on their own
- Unable to manage good self-care activity on their own

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

- Struggling to manage and or complete a domestic tasks
- Having a known long term condition/ illness
- Having a fall within the last 12 months;

7.9 Falls and Fractures

National Institute for Health and Care Excellence (NICE) guidelines (2013) recommend that older people should be asked routinely whether they have fallen in the past year, and those who report recurrent falls to be offered a multifactorial falls risks assessment and individualized intervention.

Identifying older people who are at risk of falls and setting up of fracture prevention services for older people have been found to reduce hospital admissions and the need for social care, including admissions to a care home (Department of Health 2009).

Since 2010, there has been an estimated 13,146 people that have suffered a fall within Barnet's elderly population and this is projected to increase by 22% by 2020. From this cohort, the number of people that have been admitted to hospital due to a fall is 1,065, which again, is expected to rise by 20% by 2020.

Consequences of falls in this group have a significant impact on health and social care resources. It can lead to required support at home, or even admission to a care home, right through to major hip surgery, in patient care in acute or rehabilitation settings.

Using the London Ambulance Service (LAS) data, to look at the number of attendances for falls, in 2009, there were 3,700 falls in over 65 year olds in Barnet. This represented 24% of LAS incidences which is a 36% increase since 2005.

It is difficult to accurately determine the prevalence of falls in Barnet; however, by using estimates from on the number of falls and their consequence, it is possible to put together the following figures in Table 7-1 below.

Table 7-1: Prevalence of Falls, Barnet

	Estimates for Barnet (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, Department of Health July 2009.

7.10 Better Care Fund (2013)

The Better Care Fund (BCF) comprises a pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

The BCF presents an opportunity to bring resources together in support of health and social care integration, to address immediate pressures on services. Guidance makes clear that the BCF is expected to deliver a substantial shift of activity and resources from hospital to the community, to be measured by 15% reduction in "hospital emergency admission"119.

The BCF Plan provides a framework for targeting investment in a holistic, integrated model, to drive and quicken the pace in shifting the balance of care and activity over time from hospital and long-term residential care to the community.

A comprehensive analysis of risks and mitigating actions / contingency plan has been developed as part of the BCF. The core challenge is the financial position of the Barnet health economy, so significant emphasis will be placed on the delivery of targets related to reducing non-elective emergency admissions. Target progress must be considered in the context of an anticipated funding gap in Health and Social Care which could manifest itself as cost pressures within organisations leading to a risk of potential reduced services.

7.11 Minor Ailments Scheme

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

7.12 Medicines Management Strategy

It is estimated that between one-third and one-half of medication prescribed for long-term conditions is not taken as recommended [120] and around 7% of hospital admissions have been [121]associated with adverse drug reactions[122] .

7.12.1 Referral Management

Referral management is a system by which GP referrals to community or secondary care services are reviewed by a peer in order to ensure that the correct referral pathway is being used. New pathways are being developed to enable care closer to home, to improve the patient experience and to deliver better value for money within the NHS.

The Referral Management Service (RMS) in Barnet is provided by Barndoc Healthcare Limited and was set up in June 2010 against the backdrop of a changing commissioning landscape at a time of growth in community or interface services. The RMS purpose was to provide the then PCT with a greater understanding of referral patterns, the clinical symptoms requiring the referral, as well as acting as a central point from which referrals could be directed to the most appropriate services. The RMS process approximately 7,000 GP initiated referrals each month, the majority of which are triaged by a team of local GPs.

[119] NHSE 2013
[120] Nunes et al 2009
[121] Making best use of the Better Care Fund. Spending to save, January 2014. Kings Fund
[122] Pirmohamed et al 2004

Further work is needed to review the current referral management service to develop the understanding of referral patterns.

7.13 Urgent (unscheduled) and Emergency Care

"Unscheduled care can be defined as: health and/or social care which cannot be reasonably foreseen or planned in advance of contact with relevant professional. It follows that such demand can occur any time and that services to meet this demand must be available 24 hours a day, seven days a week."(A guide to good practice: Unscheduled care and Emergency Care Services).

A range of urgent and emergency care services are available through Barnet Urgent & Emergency Care Services and comprise the following:

- Barnet Hospital A&E (24hrs; UCC 8pm to 10pm
- Edgware Walk in Centre (7am – 10pm)
- Cricklewood Walk in Centre (8am – 8pm)
- Royal Free Hospital A&E (24nhs); UCC 8pm to 10 pm
- GP OOH (6:30pm to 8am); Telephone assessment, Base visits, Home visits
- Finchley Walk in Centre 7am – 10pm
- GP OOH base (6:30 to 11pm)
- NHS 111 (24 hours)
- London Ambulance Service (24hrs)

7.14 Barnet Accident and Emergency Summary Key facts and figures:

- The A&E waiting times target of 95% of patients waiting no longer than four hours continues to present a challenge
- Barnet A&E activity recorded an increase in 2014/15 compared to 2013/14
- Concurrent increase in activity in Barnet Walk in centres in 2014/15 compared to 2013/14
- In 2014/15 around 48% of the total Barnet A&E activity was at Barnet Hospital, and 23% at the Royal Free London NHS Trust.
- Moorfield Eye hospital saw an increase in Barnet activity in 2014/15

A&E Treatment: Patient Profile 2014/15

- 55% of A&E attendances were discharged and 28% admitted
- 50% of admissions related to patients of 60+
- Largest users of A&E were 0-9 and 20-39yrs
- Around 9% of attendances to A&E had no investigation and no significant treatment
- Majority of patients discharged with no treatment and advice and guidance were aged 20-39yrs
- 35% of patients received investigation with category 1 treatment
- 62% from Walk-in-centres received no treatment and advice and guidance only

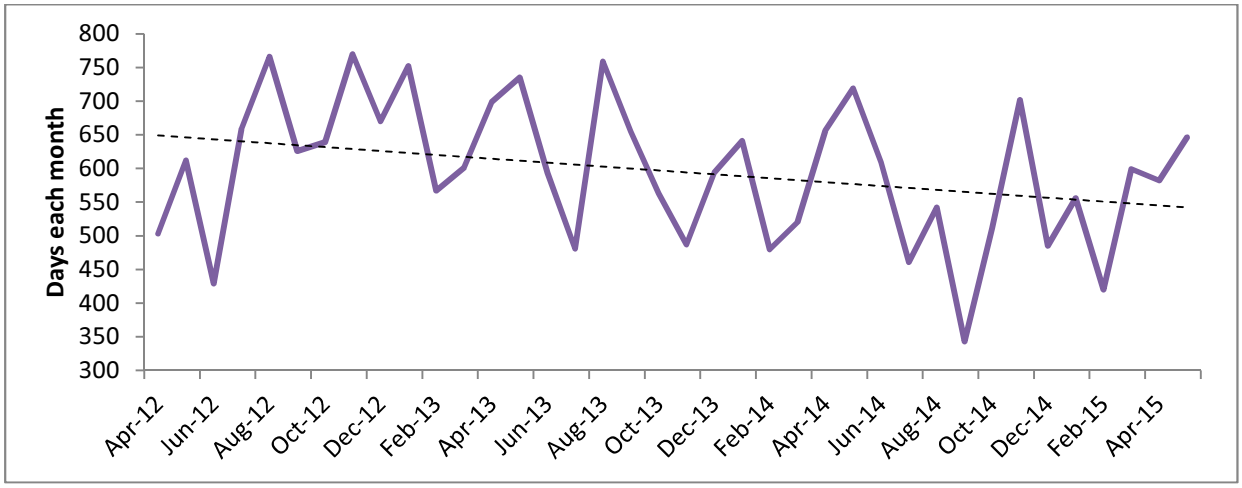
7.15 Delayed Transfer of Care (DToC)

A delayed transfer of care is experienced by an inpatient in hospital when they are ready to move on to the next stage of care, but are unable to do because social or health related arrangements are not in place to enable the discharge. Department of Health defines a delayed transfer of care (DToC),

also known as a delayed discharge as "occurring when a patient is ready for transfer from a general and acute hospital bed, but still occupying such a bed."

Figure 7-5 shows the number of DToC within Barnet for the period April 2012 – May 2015. Although there has been some significant fluctuation in the number of DToC days, overall during this 38 month period there has been a downward trend in the number of lost days due to DToC.

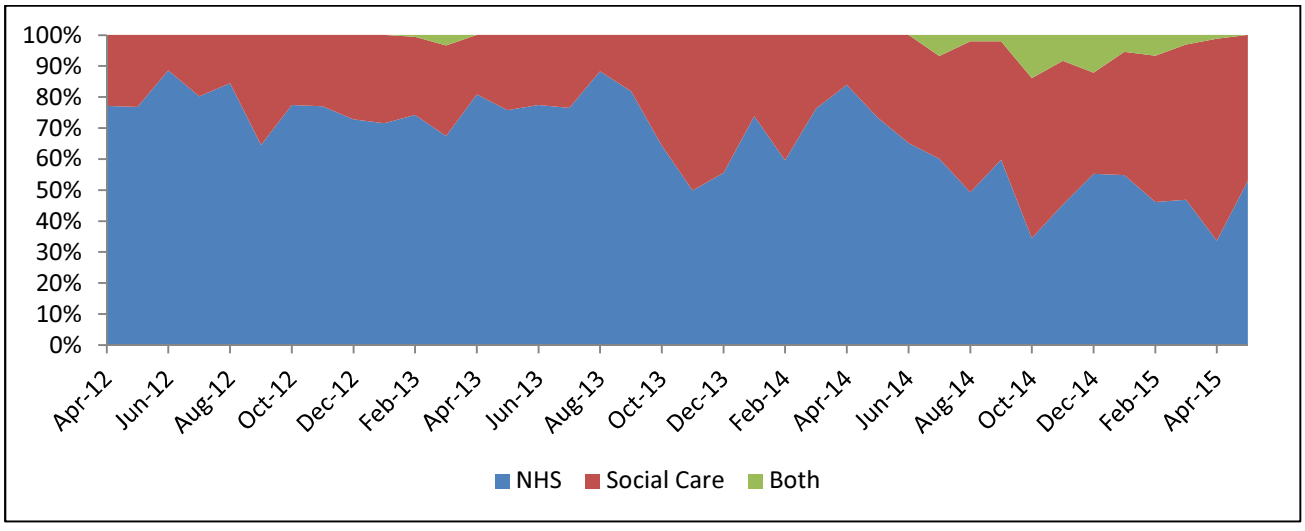
Figure 7-5: Delayed Transfer of Care in Barnet (Lost Days each month), April 12 – May 15



Source: NHS England

However, over this 38 month period, the split of the responsibility for delays has shifted away from the NHS towards Adult Social Care. At April 2012 Adult Social Care's portion of delays stood at 22.9%, by May 2015 it had risen to 47.1% of delays, with a high of 65.1% in April 2015. Further research is needed to identify the driving factors behind this change.

Figure 7-6: % of Barnet Delays by Organisation, April 2012 – May 2015



Source: NHS England

7.15.1 Factors Attributable to Delayed Discharge from Hospital in Barnet

- Increased complexities and needs of ageing population and demands on local urgent, community system;

- Complexity of patients and increased demand for social care and health input and impact on productivity;
- Increased number of frail and elderly patients moving into Barnet from other local authorities and CCGS and impact on hospital admissions;
- Increasing complexity of supporting patients with multiple long-term conditions, to remain at home and increasing quantum of support and provider capacity to meet rising demand;
- Increasing need to provide care to patients who require complex packages of social care and health and related financial pressures;
- Impact on providers having the capacity to support the lower needs and prevention;
- Increasing number of people surviving major trauma and needing lifelong care and support;
- Impact of delayed discharges within the current system of unscheduled care; and
- Care homes capacity issues.

7.16 Mental Health

Mental ill health is reported to be the single largest cause of disability in the UK, with at least one in four people predicted to experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time[123]. Mental Health is high on the government's agenda, with a published National Strategy for Mental Health 'No Health without Mental Health', setting out a cross government approach with a focus on better outcomes for people with a mental illness.

7.16.1 Mental Health in Barnet

The prevalence of mental illness in Barnet is higher than the England average and has slightly increased over the past 5 years at a similar rate to that of England Risk factors for poor mental health. There has been a concurrent increase in national and regional prevalence in mental illness reflecting significant increases compared to those observed between the 2008/09 and 2011/12.

Deaths rates from suicide and undetermined injury in Barnet are almost three times higher in men than in women; , although there has been a reported moderate decline in rate of mortality due to suicide and undetermined injury among men and a slight decline in the rate among women[124].

The Barnet rates of people reporting low levels of mental wellbeing or high levels of anxiety are higher than the England average but slightly lower than the average for London.

The evidence-base indicates that people with learning disability demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities[125]. 2014 Barnet Community Mental Health Profiles are now available at: http://fingertips.phe.org.uk/profiles-group/mental-health/profiles/cmhp.

7.16.2 Adults Mental Health Services

[123] Community Health Mental Health Profiles 2013:
Public Health Observatories
[124] JSNA Refresh 2013/14 Mental Health & Wellbeing - Barnet
[125] Mental Health Nursing with Learning Disabilities:wwww.rcn.org.uk/_data/assests/pdf/0006/78765/003184.pdf

The Community Mental Health Teams provide an assessment and care planning service to people with serious mental health difficulties. There are multi-disciplinary teams comprising of psychiatrists, nurses, occupational therapists, social workers and administrators working together in the community. Each team has the same functions of care management and assessment.

The Community Mental Health Team (CMHT) refers directly to Children's Services if in the course of their work they have any child protection or safeguarding concerns in connection with. Parental Mental Health issues. Patients are offered a service based on assessed need. This may or may not be under the Care Programme Approach (CPA).

The care plan is managed by a care coordinator, who is usually a nurse or social worker. There is an out of hour's service, accessed through the Emergency Duty Team (EDT). Mental Health Workers routinely record whether there is a child in the family or in contact with the adult.

7.16.3 Mental Health and Learning Disabilities

The Winterbourne Concordat set a target for registers to be developed, with reviews and personalised care planning to be in place for all clients meeting the Winterbourne View Criteria by 1 June 2014.

The Concordat also required health care commissioners to review all current hospital placements, and to provide appropriate support to everyone inappropriately placed in hospital (assessment & treatment) to move to community-based support as quickly as possible as and no later than 1 June 2014

7.16.4 New Service Developments

7.16.4.1 Rapid Assessment, Interface and Discharge (RAID) for Barnet and Chase Farm Hospital

RAID service became fully operational in 2014 and represents a partnership arrangement between Barnet and Chase Farm Hospital NHS Trust and Barnet, Enfield and Haringey Mental Health NHS Trust.

The Mental Health Trust provides mental health assessments and liaison for A & E and acute wards in Barnet General Hospital.

The service operates between 9am-9pm and expected to improve patient experience and outcomes by reducing A&E waits, ensuring that patients with mental health conditions receive appropriate assessment and support, integrating mental and physical health care and reducing length of stays on acute wards.

The service is subject to a formal evaluation in order to determine options for delivering the service on a long-term basis.

7.16.4.2 Dementia Redesign

A Memory Assessment Service is currently under development to increase capacity and to work alongside an Alzheimer's Society Dementia Advisor. This will increase access to support for patients and ensure that carers receive comprehensive information and advice at the point of diagnosis, and have on-going support as needed. Four dementia cafes are now operating across the Borough with attendance growing every month.

7.16.5 Expected Outcomes:

- Increase in the number of patients receiving psychological therapies to 10% of those assessed as having depression or anxiety disorders
- Early intervention in Psychosis services
- Suicide prevention: 100% of psychiatric in-patients on CPA followed up within 7 days of discharge
- Improving Access to Psychological Therapies: 6000 people receiving IAPT treatment by 2014/15
- Year on year increase based on the 2009/10 baseline of people with a learning disability and those with mental health illness who have received an annual health check
- Increase by 11% the number of people with long term mental health problems and people with a learning disability in regular paid employment by 2014/15.

8 Children and Young People

8.1 Key Facts

- The Borough's population of 93,590 children and young people aged 0 – 19 remains the second largest in London and this group accounts for one quarter of the overall Borough's population.
- The population of children and young people in Barnet is estimated to grow by 6% between 2015 and 2020 when it will reach 98,914. Barnet will continue to be the Borough with the second highest population of children and young people in London.
- In 2015 Golders Green will have the highest population of children and young people of any ward in Barnet at 6,218, followed by Colindale with 6,055 children. However, projections suggest that by 2025, the population of children and young people in Colindale will be the highest of any ward.
- There are more children from all Black and Minority Ethnic groups in the 0 – 9 age group, than there are White children. Children and young people in the 10 – 19 age groups are predominantly White. This demonstrates a more diverse population shift in terms of ethnicity. Colindale, Burnt Oak, and West Hendon have populations that are more than 50% Black, Asian and Minority ethnic background. Over 50% of all 0-4 year olds in Barnet are from a Black, Asian and Minority ethnic background and this is forecast to increase.

8.2 Strategic Needs

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably in the west).**Targeted multi-agency, locality-based interventions could better support families.
- **The Young Carers Act and Children and Families Act 2014** represents a significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**
- The number of post-16 pupils remaining in special schools is causing **pressure on the availability of places for admission of younger pupils.**
- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing** however; there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years, 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics

have been youth violence or gang related activity and, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.

- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 2014/15 averaging five or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

8.3 Demography

8.3.1 Overview - Population Growth

The children and young people population in Barnet will increase by 2.91% between 2011 and 2015. From 2011 – 2020, the population is projected to increase by 8.76%. The population is also estimated to grow by 6% between 2015 and 2020 when it will be 98,914, with Barnet continuing to have the second highest children and young people's population of all London Boroughs. Year on year growth consistently projects a higher proportion of males than females in the 0-19 age range.

8.3.2 Age Bands in Wards for 2015

In 2015, the largest population of children and young people aged 0-19 years are in the wards to the west of the Borough: Golders Green with 6,218; Colindale with 6,055; Burnt Oak with 5,457 and Mill Hill with 5,501. High Barnet has the least number of children with 3,451. The wards with the highest number of 0-4 year olds are Colindale with 2,005; Golders Green with 1,712; Hendon with 1,626 and Childs Hill with 1,499. Golders Green has the highest number of children in the 5 – 14 age groups and Mill Hill has the highest proportion of 15 – 19 year olds.

8.4 Early Years

8.4.1 Early Years Demographics by locality

8.4.2 Deprivation 0-5 years

Whilst Barnet is generally an affluent Borough, approximately 16% of children under five live in the 30% most deprived Local Super Output Areas (LSOAs)[126]. 19% of children under five (5,000 children) live in low income families, defined as those in receipt of Child Tax Credit and either on benefits (Income Support or Jobseekers allowance) or earning less than 60% of median the income[127].

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%.

[126] Index of Multiple Deprivation, DCLG, 2010
[127] HMRC, 2011

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

LSOA	Children's Centre Reach	Locality	Ward	IMD score	Lone parent households with dependent children
E01000163	Coppetts Wood	Central/East	Coppetts	26%	102
E01000315	Coppetts Wood	Central/East	Woodhouse	23%	116
E01000171	St Margaret's	Central/East	East Barnet	49%	121
E01000289	Underhill	Central/East	Underhill	19%	118
E01000291	Underhill	Central/East	Underhill	26%	107

West Locality: the locality contains the three LSOAs with the highest number of lone parents in the Borough. These are deprived LSOAs with IMD scores of 12%-19%.

Table 8-2: Lone Parent Households by LSOA, West Locality

LSOA	Children's Centre Reach	Locality	Ward	IMD score	Lone parent households with dependent children
E01000189	Stonegrove	West	Edgware	12%	169
E01000125	Barnfield	West	Burnt Oak	18%	134
E01000152	Wingfield	West	Colindale	19%	153

South locality: Within the locality, there are six LSOAs that have a relatively high number of lone parent household. With the exception of one LSOA within Childs Hill ward, five LSOAs are deprived with IMD scores ranging between 17% - 27%. The two most deprived LSOAs within the south locality are also LSAOs with high numbers of lone parent households.

Table 8-3: Lone Parent Households by LSOA, South Locality

LSOA	CC Reach	Locality	Ward	IMD score	Lone parent households with dependent children
E01000245	Bell Lane	South	Hendon	23%	80
E01000137	Childs Hill	South	Childs Hill	24%	93
E01000141	Childs Hill	South	Childs Hill	27%	98
E01000142	Childs Hill	South	Childs Hill	42%	87
E01000221	Parkfield	South	Golders Green	17%	81
E01000308	The Hyde	South	West Hendon	17%	96

8.4.4 Ethnicity 0-5 years

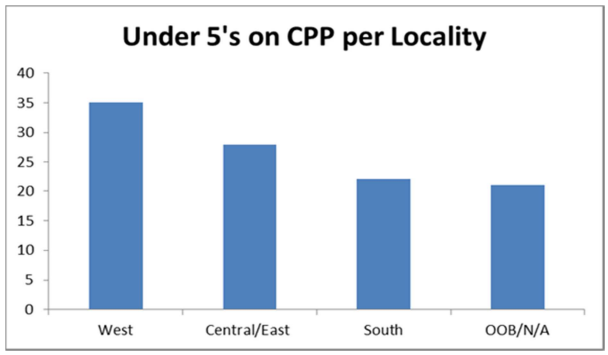
Barnet has 24 LSOAs with relatively high estimated number of Black, Asian and Minority Ethnic children under five (over 90 households per LSOA). The West locality contains 17 of the LSOAs with high concentration of Black, Asian and Minority Ethnic households with children under five. It should be noted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

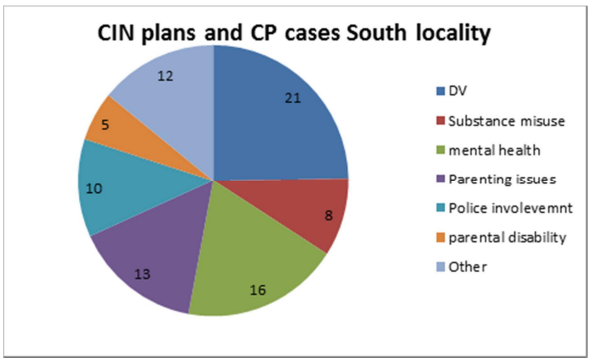
8.4.5 Children In Need (CIN) and Children Subject of a Child Protection Plan (CP) aged 0-5 years.

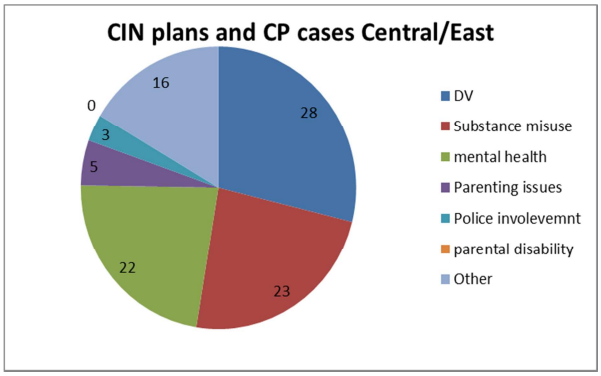
The tables below demonstrate that there is a higher number of under-fives on a child protection plan in the West locality, despite this locality currently containing the smallest number of under-fives overall. CIN plans by locality excluding disability show 160 CIN plans in total (Central/East: 64 CIN

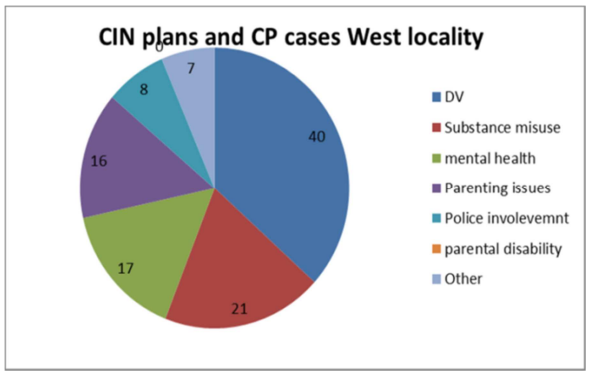
plans South: 33 CIN Plans West: 63 CIN plans). Primary concerns leading to CIN and CP plans are identified in the charts below.

Figure 8-1a-d: Under 5's on Child Protection Plans









Source: ICS October 31st 2014, under-fives on a Child Protection Plan

8.4.6 School Readiness by Locality

The quality of a child's early experience is vital for their future success. It is shaped by many interrelated factors, notably the effects of socio-economic status, the impact of high-quality early education and care and the influence of 'good parenting'. High-quality early education is crucial in countering the effects of socio-economic disadvantage[128].

Overall, attainment of good level of development (GLD) in Barnet is above the national average, including the development of children in receipt of free school meals (FSM) and SEN pupil attainment. However, attainment varies by locality. A higher percentage of children within the Central/East locality achieved a GLD (68.1%) with 65% attaining above the national average, whilst in the West locality, GLD attainment is lower (60.1%) but is in line with the national average.

The table below sets outs GLD attainment by locality overall, and by the following characteristics:

- Children whose first language is other than English
- Children with Special Educational Needs
- Children eligible for Free School Meals
- Children born in the summer term.

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

Table 8-4: GLD Attainment by Locality

	Central/East	South	West	Out of Borough	Barnet	National Average (DfE)[129]
No of children at EYFS	1,775	1,273	1,225	450	4,723	N/A
No of children achieving a GLD	1209 **68.1%**	845 **66.3%**	737 **60.1%**	297 **66%**	3088 65.4%	**60%**
No of children whose first language is English achieving a GLD	707 out of 958 **73.8%**	374 out of 510 **73.3%**	335 out of 512 **65.4%**	135 out of 184 **73.3%**	1551 out of 2164 **71.6%**	**63%**
No of children whose first language is other than English achieving a GLD	502 out of 817 **61.4%**	471 out of 763 **61.7%**	402 out of 713 **56%**	162 out of 257 63%	1537 out of 2550 60.2%	**53%**
No of children with SEN achieving a GLD	30 out of 145 **20.7%**	31 out of 97 **32%**	24 out of 152 **15.8%**	7 out of 40 **17.5%**	92 out of 434 **21.2%**	**19%**
FSM	144 out of 273 **52.7%**	84 out of 156 **54%**	113 out of 235 **48%**	38 out of 64 **59.4%**	379 out of 728 **52%**	**45%**
Term of Birth (summer babies achieving GLD	369 out of 621 **59.4%**	233 out of 426 **54.7%**	211 out of 419 **50.4%**	98 out of 184 **53.3%**	911 out of 1650 **55.2%**	**49%**

Source: KEPAS 2014

8.5 Children's Centres

Children's Centre's aim to improve outcomes for families with children under five, ensuring that all children are properly prepared for school ('School Readiness'). Services are delivered, either by or through Children's Centres and include both Universal and Specialist services for families in greatest need - families living in deprived areas; workless families; those with low levels of English; and those experiencing the 'toxic trio' of domestic violence, mental health issues and/or substance misuse.

8.5.1 Gaps in Current / Future Provision or Unmet Need

There appear to be a good range of services targeting children's health and development, although better partnerships would ensure that these are more joined up. Key issues are:

- Development of an integrated service offer delivered through the centres for parents, with a particular focus on the needs of parents with mental health, drug and alcohol problems, and parents without literacy and basic skills required to progress into work. Improved partnerships with health and Jobcentre Plus would help facilitate this.
- Increased engagement with vulnerable families to support family learning: – engaging children and parents learning together, such as family literacy and numeracy, support for teenage parents and housing advice.
- Increase the take-up of adult education including courses leading to qualifications through access to child care at low cost, and a Service Level Agreement with Barnet College, leading to better evaluation and tracking of learners' outcomes.

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

8.6 Education and Skills

8.6.1 Primary Education in Barnet

Between 2016/17 and 2020/21, primary school rolls are projected to rise by an estimated seven to nine forms of entry (FE), and these school places will need to be commissioned through a series of temporary or permanent expansions and new provision. Barnet has a higher proportion of pupils on roll in primary schools with special educational needs (both statemented and without statements) compared to statistical neighbours, national and London, and the proportion of pupils on school action and school action plus has gradually declined since 2011 in line with statistical neighbours. Overall absence in Barnet primary schools is ranked in the 3rd quartile, at 94th nationally.

The proportion of Barnet's primary school pupils who speak English as an additional language is below the London average but above that of Barnet's statistical neighbours and the proportion of pupil's eligible for free school meals is above that of statistical neighbours.

8.6.2 Secondary Education in Barnet

Between 2010 and 2014, the number of children on roll in mainstream secondary schools increased by 6.1% to 22,853 pupils. Barnet currently has 24 secondary schools: 4% are community schools, 25% are voluntary-aided and 71% are academies. Assuming that a Free School, which is currently subject to planning, is delivered, an estimated 20 FE of additional need is projected between 2016/17 and 2020/21. These school places will need to be commissioned through a series of temporary or permanent expansions and new provision.

Barnet has a higher proportion of pupils on roll with a statement of special educational needs compared to London, England and statistical neighbours. The proportion of pupils on roll with special education needs (without a statement) has decreased for the past three years but remains above that of statistical neighbours. Overall absence in Barnet secondary schools is ranked in the top quartile, at 23rd nationally.

The proportion of pupils with English as an additional language is above statistical neighbours, but below the London average. The proportion has increased at a lower rate than London and statistical neighbours, but more than the national increase. Barnet has a lower proportion of Free School Meal pupils in secondary schools than London, but more than England and statistical neighbours.

At Key Stage 2, attainment and achievement in all subjects is in the top quartile nationally. The attainment and achievement of all pupil groups are in line with national averages, and most pupil groups attain significantly above the national average. Barnet's FSM and disadvantaged pupil attainment gaps have narrowed and the gap is now in line with the London average and smaller than the national average.

There is an 11 percentage point difference in attainment between disadvantaged (those who have been eligible for free school meals in the past six years or are in local authority care) and non-disadvantaged pupils, which is in line with the London average. Disadvantaged pupil attainment is high and is ranked 13th nationally.

Pupil progress in Reading and Mathematics is significantly above national averages, with Barnet ranked 6th and 12th nationally. The proportion of pupils making expected progress in Writing is in the third quartile, ranked 48th nationally.

At Key Stage 4, attainment of 5 A*-C grades including English and Maths and 5 A* - C grades is ranked in the top quartile nationally. Attainment of SEN, EAL and disadvantaged pupils is

significantly above the attainment of their national counterparts. The attainment gap for disadvantaged and non-disadvantaged pupils increased to 28 percentage points in 2014, and is wider than the London attainment gap (21 percentage points).

8.6.3 Key Issues

- Teacher and head teacher recruitment is a key issue for primary schools, with a head teacher recruitment and retention working group set up in response to difficulties in securing permanent posts. Key barriers to recruitment in Barnet include: availability and cost of parking, public transport, cost of affordable housing/rentals and increasing pressure and responsibilities on teachers and head teachers.
- The capacity of schools in Barnet struggles to meet demand from the population each year, with temporary and permanent expansions being commissioned as part of a school expansion strategy, and the Council working in partnerships with Free Schools to develop new provision.
- Black pupils perform relatively poorly compared to other ethnic groups in Barnet across all key stages.
- Whilst disadvantaged children perform above disadvantaged children nationally, they continue to perform significantly below their non-disadvantaged counterparts.

8.6.4 Looked After Children

In 2014, the attainment of looked after children in Barnet is in line with or above that of looked after children nationally at Key Stage 1 (level 2+), is slightly below that of looked after children nationally at Key Stage 2 (level 4+) in RWM, Mathematics, EGPS, and in line with or above for Reading and Writing. A lower proportion of Barnet's looked after pupils attained the expected standard at GCSE compared to looked after children nationally (12% compared to 15%). However, the attainment of looked after children remains significantly below the attainment of their non-looked after counterparts (both nationally and in Barnet) across all key stages.

Value-added (the amount of progress made) between key stages 1 and 2 for looked after children in Barnet has remained below the progress seen in looked after children nationally since 2012, and remains below the progress of their non-looked after counterparts in al years. Value-added (the amount of progress made) between key stages 2 and 4 for looked after children in Barnet was below the progress seen in looked after children nationally in 2012 and 2014, and remains below the progress of their non-looked after counterparts across the past 3 academic years.

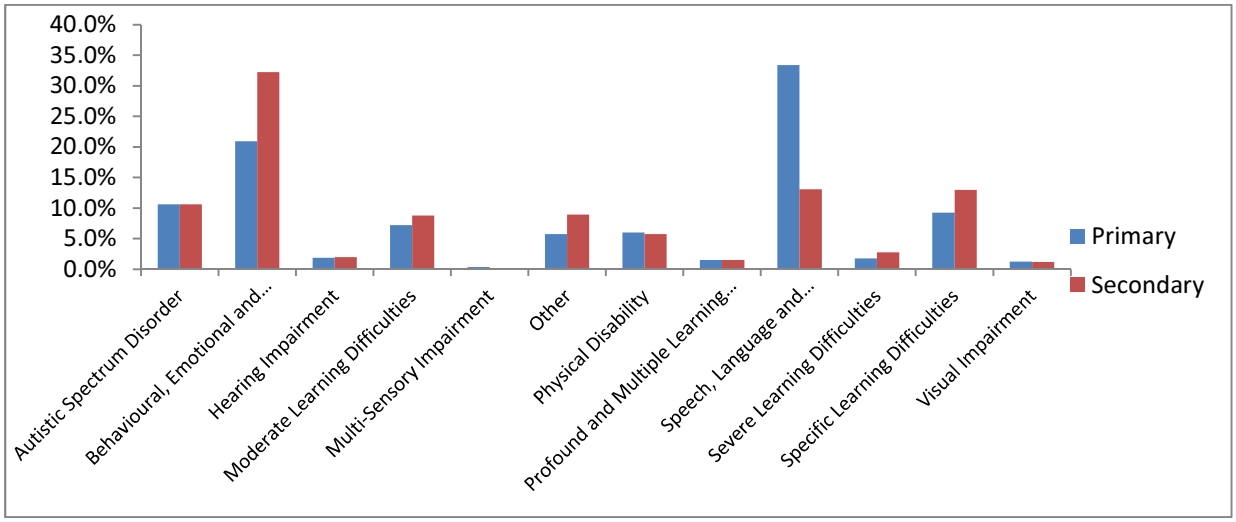
The virtual school has recently been re-located within the Barnet School Improvement Team and a permanent headteacher appointed in order to drive up educational standards within this cohort.

8.6.5 Special Educational Needs

Barnet has four State-funded special schools and three Pupil Referral Units. Across all pupils with Special Educational Needs (SEN) in Barnet, the highest proportion of needs in primary schools are Speech, Language and Communication; in secondary the highest proportion of needs are in Behavioural, Emotional and Social Difficulties.

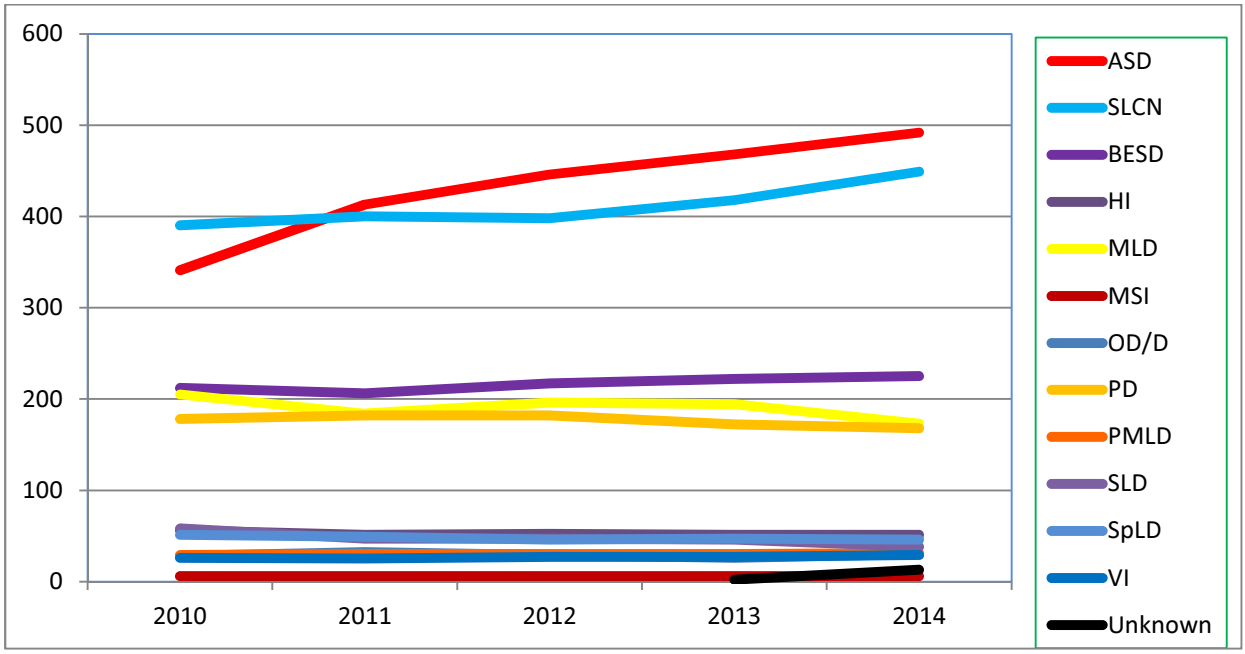
Primary Category of SEN Statement Type is shown in figure 7-2 and trend in the figure below.

Figure 8-2: Proportion of Total of SEN Need by Type



Source: January Census 2014

Figure 8-3: Trend DATA Barnet SEN Statement Numbers by Category of Need; 2010-2014



Barnet is an inclusive authority, given that 57% of pupils (997 of a total of 1751 in 2014) with a statement of Special Educational Needs maintained by the council are placed in mainstream settings. A level which is significantly higher than statistical neighbours and other Outer London Boroughs, where larger proportions attend specialist provision.

Specialist provision is required to meet the needs of the remaining children and young people. Some of this is offered by Additional Resourced Provisions (ARPs) in mainstream primary and secondary schools, with a greater number of places provided by the council's four special schools. Additionally, a number of pupils with SEN are placed in the special schools of other local authorities, whilst, in 2014, almost 10% (167) of pupils with a statement of SEN issued by the council were placed in a non-maintained or independent provision, including 35 in expensive residential settings.

A detailed assessment of the future needs of Barnet's SEN population established the following needs to be met up to 2019/20. The findings are displayed in Table 8-5.

Table 8-5: Future Needs of Barnet's SEND Population

	Primary ASD/SLCN*	Secondary ASD/SLCN*	Primary BESD**	Secondary MLD***
Demography	18	45	2	11
Reduce dependency on expensive placements	10	10	8	5
Total	28	55	10	16

* Autistic Spectrum Difficulties / Speech, Language and Communication Needs

** Behaviour, Emotional and Social Difficulties

*** Moderate Learning Difficulties

8.6.5.1 Attainment of SEN pupils

Key Stage 2 attainment of Barnet pupils with a statement of SEN (at level 4+ in Reading, Writing and Mathematics) is in the top quartile in the country, ranked 13th nationally, whilst attainment of SEN pupils without a statement of SEN (those identified on School Action or School Action plus) is also in the top quartile nationally, ranked 12th.

Key Stage 4 Attainment of Barnet pupils with a statement of SEN (5 A*-C grades including English and Mathematics) is in the top quartile in the country, ranked 20th nationally, whilst attainment of Barnet SEN pupils without a statement is in the top quartile in the country, ranked 33rd nationally.

8.6.5.2 The Review of Future Needs, Key Issues

A review of future needs mapped the current provision against the range of needs of children with SEN in Barnet. It found that:

- The current pattern of provision of specialist places provided through a mix of special schools and resourced provisions within mainstream schools no longer best meets the geographic spread of demand across the Borough. This is resulting in a significant and growing transport cost and for some children, long journeys to school.
- The consistency in the current pattern of provision within the ARPs, particularly for children with Autistic Spectrum Difficulties and Speech, Language and Communication needs could be improved, both in the types of need catered for and the nature of the offer with regard to levels of inclusion within the mainstream setting in which the ARP is located.
- There is some overlap in the nature of needs that are being met within the four special schools and this is an increasingly common feature nationally.
- The number of post-16 pupils remaining in special schools is causing pressure on the availability of places for admission of younger pupils.
- There is an opportunity to improve the offer for children with significant SENs in the area of behavioural, emotional and social difficulties (now described in the new SEN Code of Practice as "social, emotional and mental health difficulties").

8.6.5.3 Key Issues

- Future needs have considered how best to invest in order to both meet the increased demand and the increase in local provision, to meet parental aspirations and reduce transport costs. The review considered the cost, site availability, and range of pupil needs and concluded that future provision should be shaped through:
    - developing a pattern of smaller localised new provision within existing or newly commissioned mainstream schools;

- working with mainstream schools to improve provision within existing resourced provision, whilst sharing expertise across the network of provision;
- re-shaping provision within existing special schools;
- re-shaping the current offer for children with behavioural, emotional and social difficulties;
- developing an increased range of options for young people post-16.

8.6.5.4 Conclusion

Initial engagement with head teachers regarding the findings of the review has established some shared principles so far:

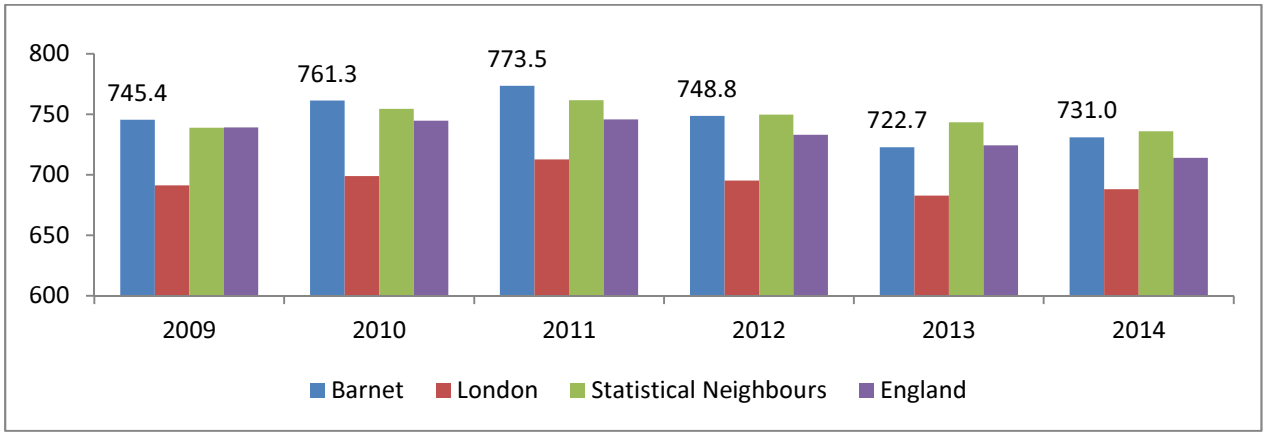
- The strategy for meeting the future needs of children with SEN should focus on the requirement to develop the right type of provision in the right place.
- The objective should be to develop local provision wherever possible.
- Flexible models of delivery should be considered.
- The current balance between mainstream and specialist provision is appropriate and should be maintained.
- Funding mechanisms should be designed to provide stability and enable planning for quality provision.
- The strategy should ensure equity of provision for SEND in and between schools and equity of funding based on outcomes.

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

8.6.6 Post-16 Education, Employment and Training

Key Stage 5 attainment (average point score per pupil) in Barnet is ranked in the top quartile, 26th nationally. By age 19, 89.3% of pupils attain a level 2 qualification (ranked 13th nationally), and 68.3% attain a level 3 qualification (ranked 11th nationally).

Figure 8-4: APS per Candidate

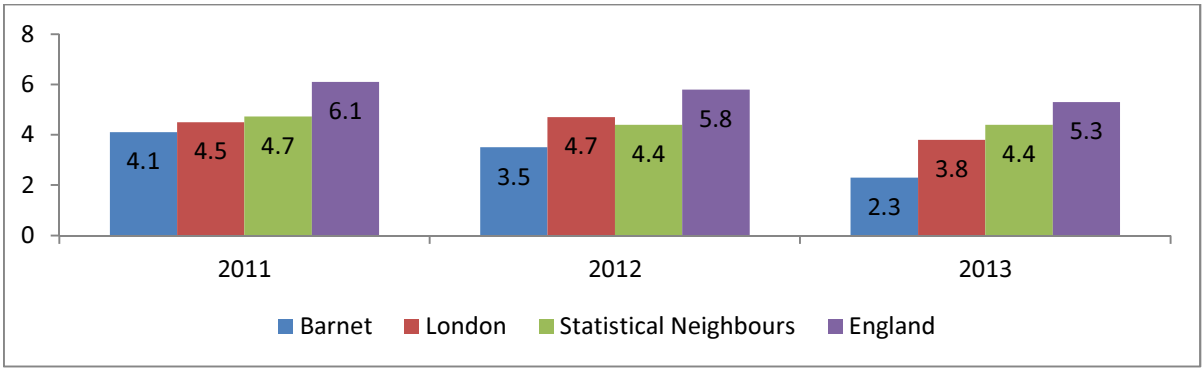


Source: www.gov.uk/government/statistics/a-level-and-other-level-3-results-2013-to-2014-revised

Barnet performs particularly well at ensuring all young people engage in education, employment or training up until age 19 with the proportion of 16 to 18 year olds not in education, employment or

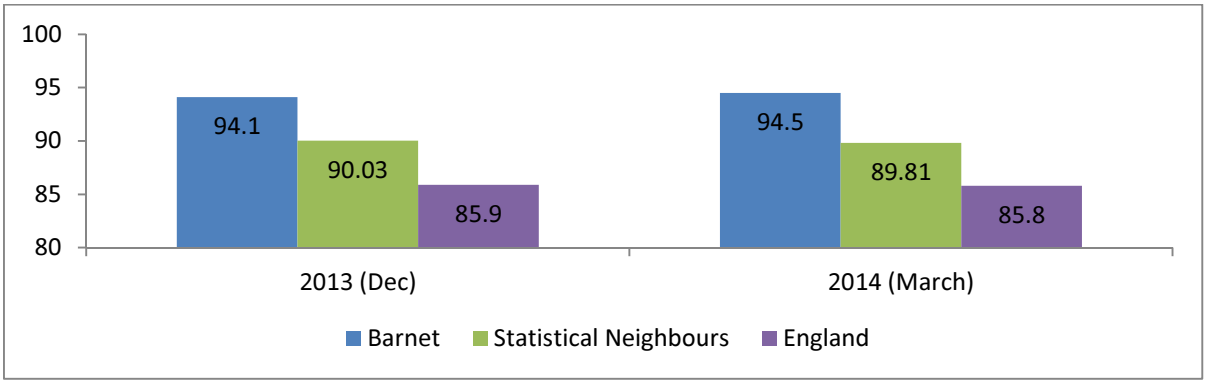
training (NEET) ranked 4th nationally. This success is continued for those pupils with learning difficulties or disabilities, where participation rates are ranked 9th nationally.

Figure 8-5: % NEET



Source: Local Authority Interactive Tool (LAIT)

Figure 8-6: % Learning Difficulties and Disabilities (LDD) Recorded in Education and Training Aged 16 – 17 Years



Source: Local Authority Interactive Tool (LAIT)

8.6.7 Raising Participation

The Education and Skills Act 2008 places a duty on all young people to participate in education or training until their 18th birthday. The first phase was introduced in 2013; young people are now required to continue in education or training until the end of the academic year in which they turn 17 years. From September 2015 they will be required to continue until their 18th birthday. Participation may be:

- full-time education at school, college, other provider
- an apprenticeship
- employment, self -employment or volunteering for 20 hours or more a week with part-time education or training

The Local authority is required to:

- promote the effective participation in education or training of all 16 and 17 years olds resident in Barnet.
- make arrangements to identify young people resident in Barnet who are not participating.
- provide advice and guidance to young people aged 16-18 who are not on the roll of an institution and who are deemed vulnerable.

- these new duties complement existing duties to:
    - secure sufficient and suitable education and training provision for all 16-19 years olds
    - track young people's participation.

Participation in Barnet - June 2015

The figures below demonstrate Barnet's progress towards full participation at June 2015 and the current level of NEET and 'Not Known' (the destination of the person is unknown and no information can be gained from other reliable sources).

Table 8-6: In Learning

Year 12			Year 13			Year 14			Year 12-14		
Jun14	Jun15	Variation	Jun14	Jun 15	Variation	Jun14	Jun15	Variation	Jun14	Jun15	Variation
97.2%	97.9%	0.7%	94.1%	97.5%	3.4%	80.2%	83.0%	2.8%	90.7%	93.1%	2.4%
3404	3438	34	3118	3487	369	2584	2677	93	9106	9602	496

Data Source: West London Partnership Support Unit

Table 8-7: NEET

Year 12			Year 13			Year 14			Year 12-14		
Jun14	Jun15	Variation	Jun14	Jun15	Variation	Jun14	Jun15	Variation	Jun 14	Jun 15	Variation
2.1%	1.7%	-0.4%	2.6%	2.2%	-0.4%	4.2%	4.2%	0.0%	2.9%	2.6%	-0.3%
73	60	-13	86	77	-9	127	129	2	286	266	-20

Data Source: West London Partnership Support Unit

Table 8-8: Not Known

Year 12			Year 13			Year 14			Year 12-14		
Jun14	Jun15	Variation	Jun14	Jun15	Variation	Jun14	Jun5	Variation	Jun14	Jun15	Variation
0.3%	0.0%	-0.3%	1.6%	0.0%	-1.6%	6.5%	3.8%	-2.7%	2.7%	1.2%	-1.5%
9	0	-9	52	0	-52	209	121	-88	270	121	-149

Data Source: West London Partnership Support Unit

Barnet is performing better in all three categories against statistical neighbours. The mean Indicator for statistical neighbours in May 2015 is 86.2% in year 12-14 in learning, 3.9% NEET and 5.9% Not Known.

8.7 Prevention and Early Intervention

Prevention and Early Intervention is about tackling problems experienced by children and families as early as possible to improve outcomes, and to lower costs. Barnet's approach to Prevention and Early Intervention has been organised according to three guiding principles: i) to intervene as early as possible; ii) to take a whole family approach; and iii) to use evidence-based monitoring systems.

A local needs analysis identified eight 'themes' or problems which are most likely to drive poor outcomes for Barnet families:

- Domestic violence
- Alcohol and/or drug misuse
- Mental health
- Parenting and neglect
- Unemployment
- Involvement with police

- Missing from school
- Child sexual exploitation

The needs analysis found that the 'toxic trio' of domestic violence, alcohol/drugs and mental health were significant factors triggering referrals to social care. Aligning early intervention and assessment to these themes will help to counteract projected pressures on social care services and other targeted and specialist resources.

The Barnet Early Help Offer consists of a set of services which deliver a Prevention and Early Intervention approach; it is formed of the following key components:

1. A Front door/triaging service- which assesses and signposts cases to early help services
2. A core set of council early help services including Children's Centres, the Intensive Family Focus Team and Youth Services
3. A set of commissioned services, where the council procures early help services from third parties – for example Child and Adolescent Mental Health Services (CAMHS)
4. Services provided by partners, such as services provided by the voluntary sector which are not commissioned by the council.

The Council is reviewing the above offer to ensure it is line with the eight themes identified in the needs analysis and is better integrated with partner agencies. Children and families fall into four categories of need, identified in the table below. Early identification of problems, assessment and intervention is achieved through the Common Assessment Framework (CAF).

Table 8-9: Levels of Need

Level of need	Definition of this type of Need
Level 1	No identified additional needs. Response services are universal services
Level 2	Child's needs are not clear, not known or not being met. This is the threshold for beginning a Common Assessment. Response services are universal support services and/or targeted services
Level 3	Complex needs likely to require longer term intervention from statutory and/or specialist services. High level additional unmet needs - this will usually require a targeted integrated response, which will usually include a specialist service
Level 4	Acute needs, requiring statutory intensive support. This in particular includes the threshold for child protection which will require Children's Social Care Intervention

8.7.1 Key Issues

- Strengthen the Barnet integrated offer of services across partner agencies to support children and families.
- Continue to build on work which has already started in remodelling services. Barnet has prioritised early years as part of its prevention and early intervention approach and has completed a comprehensive 18 month 'Early Years Review'. The review has recommended a locality model which is currently being developed. Barnet's 13 children's centres will be grouped into three 'localities' with the aim of focusing on identifying and supporting the most vulnerable and allowing staff and resources to be used more flexibly.

- Development of services to support children on the edge of care, specifically in the 10-15 age group, which support children and their families in the community and prevent the need for children to become looked-after.
- Update and strengthen the monitoring of CAFs and outcomes to ensure more needs are being met via the introduction of e-CAF; this will join up with phase II of the Troubled Families programme.
- Expand the reach of the CAF in some of the most deprived schools. For example, four schools with moderate to high deprivation percentages initiated zero CAFs in 2012/13 and 2013/14. As part of the Early Intervention Strategy a strategic approach to schools and Early Intervention is currently being developed, including considerable use of the pupil premium.
- Improve practice in relation to obtaining the voice of the child and working with diversity
- Increase the percentage of needs met/successful interventions in family support work and ensure plans are purposeful and interventions are focused.
- Improve the quality assurance processes from 'good' to 'best in class', by drawing on best practice in other Boroughs.

8.7.2 Multi-Agency Safeguarding Hub

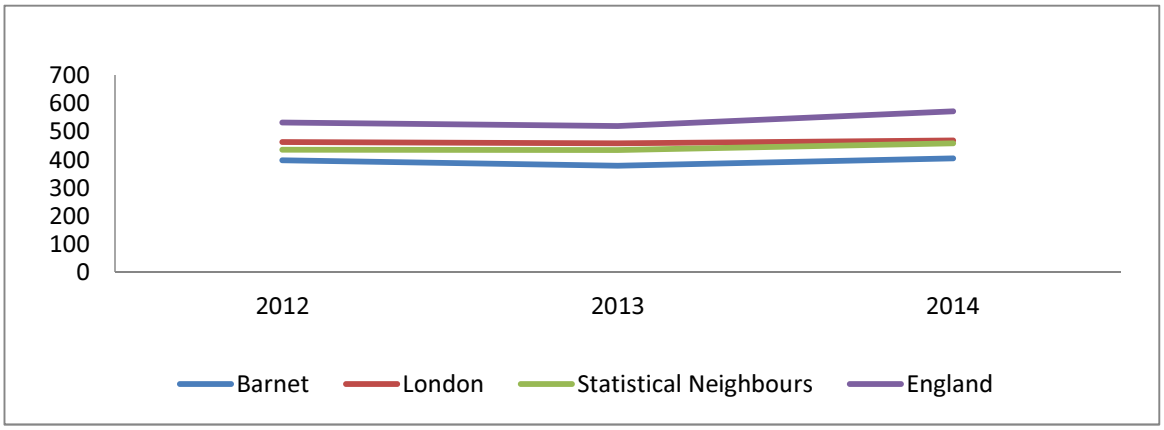
All agencies or individuals contacting Family Services with information, concerns or a query about a child or family are received through the Multi-Agency Safeguarding Hub (MASH). A number of these contacts will meet the threshold for a social care referral. In Barnet, contacts received into the MASH consistently exceed 3,000 per quarter. Contact rates nationally and across London have been increasing since 2013.

8.7.3 Children Supported by Social Care - Children in Need (CIN)

Children in Need are assessed as in need of support under Section 17 of the Children Act 1989, and due to challenging family situations or other forms of disadvantage are entitled to a range and level of services appropriate to their needs.

Barnet's Children in Need numbers saw a marked increase in 2010/11, but have remained consistently stable for the past 5 years. The graph below shows the Children in Need rate per 10,000 children.

Figure 8-7*: Children in Need Rates per 10,000 of Referrals to Children's Social Care*



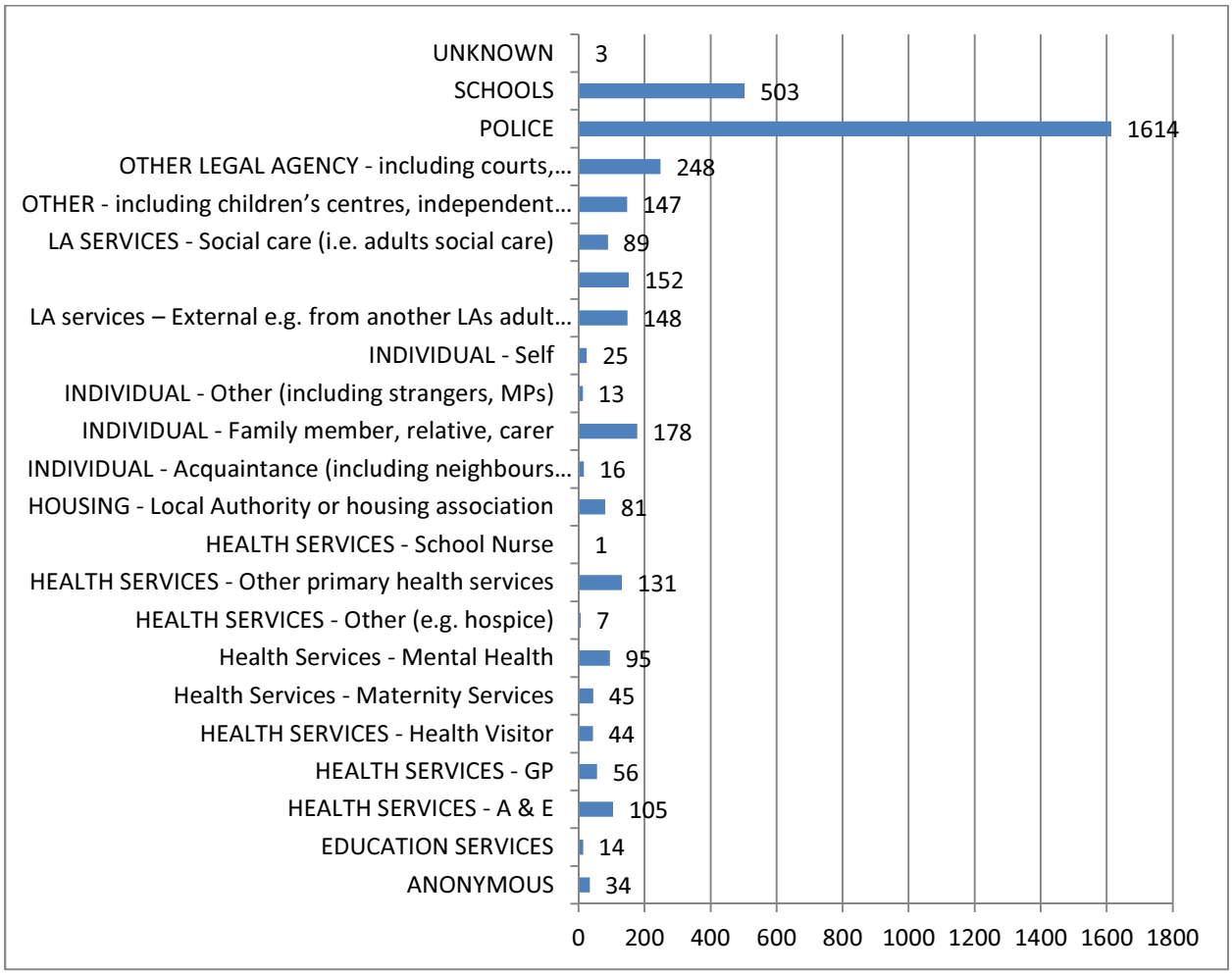
Source: Local Authority Interactive Tool

Since 2009, Barnet's rate of Children in Need, when compared to London, England and its Statistical Neighbours, has remained low. The trend for London, England and statistical neighbours has shown increased rates.

Children aged between 5 - 9 and 10 - 15 are the largest age group within this population, each making up 29% of the total population. This is closely followed by 1 - 4 years, who make up 25%. Overall, the age of Barnet's Children in Need is skewed towards younger age bands.

The figure below shows the number of referrals by referral source for the quarter 1 April – 30 June 2015.

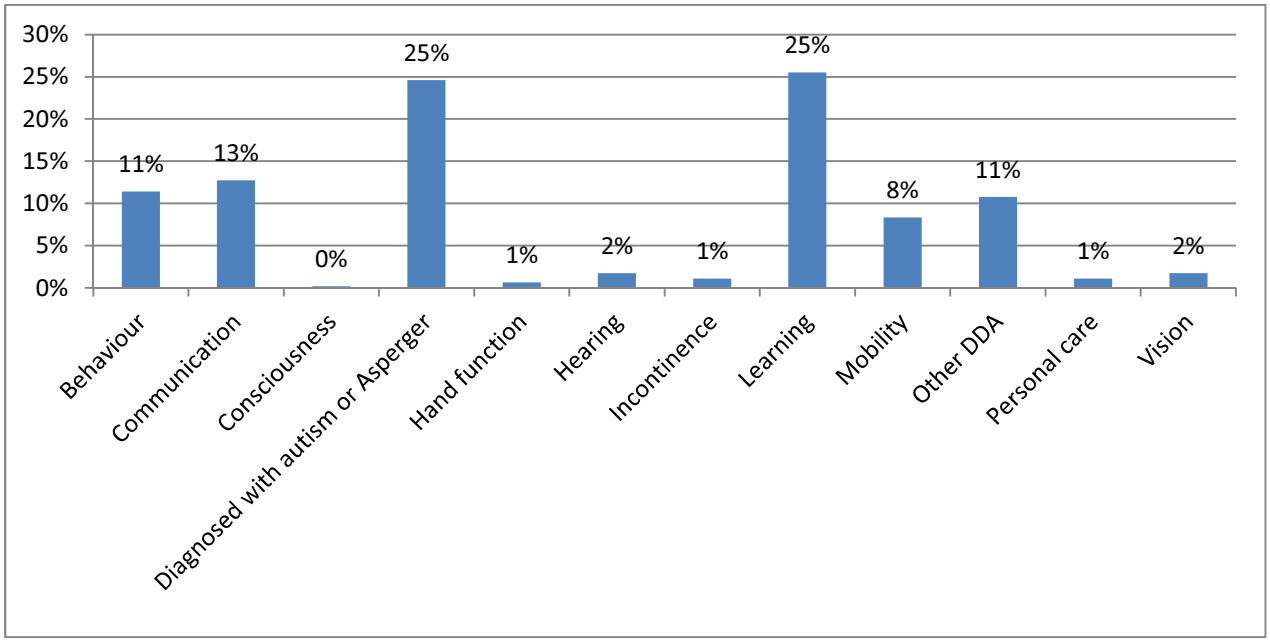
Figure 8-8: Referrals by referral source, April-June 2015



There are currently (June 2015) 455 service users aged 0-25[130] who have noted a Disability as an Active Category of Need.

[130] Data source ICS (includes all teams)

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



Source: ICS June 2015

Of those Children in Need with a disability, the highest percentage had a learning disability (25%) or autism (25%).

8.7.4 Children Supported by Social Care - Children Subject to a Child Protection Plan

A child at risk may be subject to a Child Protection Plan, which is intended to keep the child safe, promote their welfare and support their wider family to care for them. As of February 2015, 234 children in Barnet were subject to a Child Protection Plan. The largest category of abuse is shown to be neglect, at 47%, followed by emotional abuse (30%), physical abuse (19%), and sexual abuse (4%). Neglect has risen at a slightly higher rate than other categories in recent years.

The table below illustrates that the number of children subject to a Child Protection Plan has increased since 2009, with a peak in 2012.

Table 8-10: Number of Children subject to a Child Protection Plan

Year	2009	2010	2011	2012	2013	2014	As at 28 February 2015
Number of Children Subject to a Child Protection Plan	152	201	210	256	206	208	234
Neglect	70	76	97	97	81	94	109
%	**46%**	**38%**	**46%**	**38%**	**39%**	**45%**	
Emotional	62	86	77	93	66	67	71
%	**41%**	**43%**	**37%**	**36%**	**32%**	**32%**	
Physical	17	33	28	51	44	42	45
%	**11%**	**16%**	**13%**	**20%**	**21%**	**20%**	
Sexual	2	6	6	15	11	4	9
%	**1%**	**3%**	**3%**	**6%**	**5%**	**2%**	

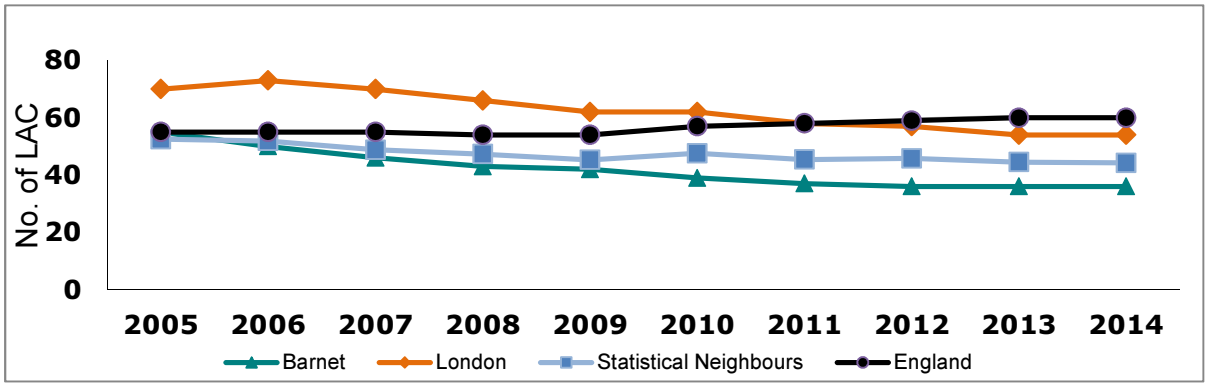
Source: Data extract from ICS data pulled 28 February 2015

8.7.5 Looked After Children (LAC)

Barnet's rate of Looked After Children per 10,000 children under 18 is low when compared to London, England, and statistical neighbours. The numbers of LAC over the past seven years has remained relatively stable, with an average of 308 children. In 2014, Barnet had a rate of 36 children in care per 10,000.

The trend over the past ten years shows Barnet's rate gradually reducing year on year, from a rate similar to England to a rate significantly lower. Barnet's rate of Looked After Children (36 children per 10,000 under 18) is low when compared to London, England, and statistical neighbours. This suggests that children in Barnet are supported effectively to remain with their families, where possible. However, in relation to actual number of Looked After Children, as opposed to the rate, Barnet has one of the highest numbers. This is due to the Borough's population size, which is predicted to be the highest in London in 2015.

Figure 8-10: Looked After Children per 10,000



Source: LAIT

The most common ethnicity for Barnet's Looked After Children is White (49%), followed by Mixed and Black or Black British ethnicity (18%). Barnet and London both have a much lower proportion of White children in care than across England, shown in Figure 3 below, which reflects the more ethnically diverse population across London. Compared to London, Barnet has a slightly higher proportion of Mixed and White Children in Care, and slightly lower proportions of Black or Asian Children.

Table 8-11: **Ethnicity of Barnet's Looked After Children**

Ethnicity as at 28 February 2015	Number of Children	%
White	148	48%
Mixed	56	18%
Black or Black British	55	18%
Any Other	20	6%
Asian or Asian British	15	5%
Not stated	13	4%
Gypsy/Roma	1	0%

Source: Data extract from ICS data pulled 28 February 2015

The predominant age for children becoming Looked After is 10 – 15 years (38% of the Barnet cohort fall into this age band). Children aged 5 – 9 years make up 25% of the cohort. 60% of children currently in Barnet's care are males, compared to 40% of females. This is reflective of the national picture.

Barnet has a high proportion of Children in Care in residential placement[131] which stands at 22% (March 2014), this is both higher than London and national averages. 25.4% of children and young people are placed out of Borough. Children placed in foster care as at March 2014 was 69%, which is below statistical neighbours (73%) and the England average (75%). There is considerable demand for increased foster placements locally and significant demand pressures relating to the cost of out of Borough placements and specialist placements for children and young people with complex needs. Gaps in the provision of in-house foster placements are identified as: children over the age of 11, sibling groups, and children with complex emotional and behavioural needs.

SEN rates for Barnet Looked After Children are much higher than for Barnet pupils generally and higher than the England rate. At key stage4 (2010-14) attainment of Barnet pupils who are Looked After Children (5 A*- C including English and Maths) is better than the national attainment for Looked After Children, but well below that of all pupils in Barnet and nationally.

8.7.6 Care Leavers

A Care Leaver is a young person who has been looked after away from home by a local authority for at least 13 weeks since the age of 14, and who was still in care on their 16th birthday. Barnet's number of Care Leavers has remained relatively unchanged since 2010. As of February 2015 there were 279 Care Leavers in Barnet.

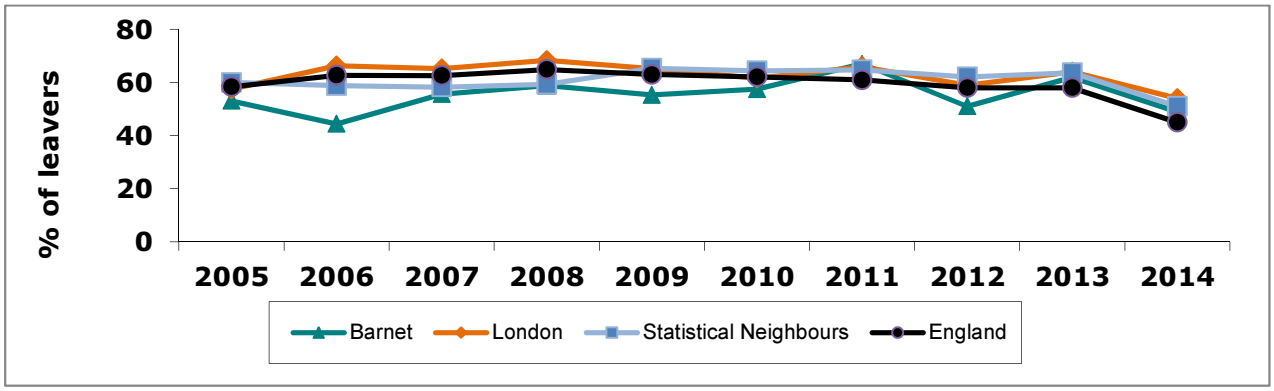
For the past 2 years, Barnet's rate of Care Leavers in Suitable Accommodation has been higher than that of London, England and statistical neighbours.

Table 8-12: Number of Care Leavers in Barnet

Year	2009	2010	2011	2012	2013	2014	Feb 2015
Number of Care Leavers	297	278	266	274	267	266	279

The graph below shows that Barnet's Care Leavers in Education, Employment or Training (EET) has fluctuated since 2005. In 2014, Barnet's rate was similar to London and statistical neighbours and higher than England. All comparators have seen a decline in figures, with one of the lowest percentages of Care Leavers in EET when compared to the past nine years.

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



Source: LAIT

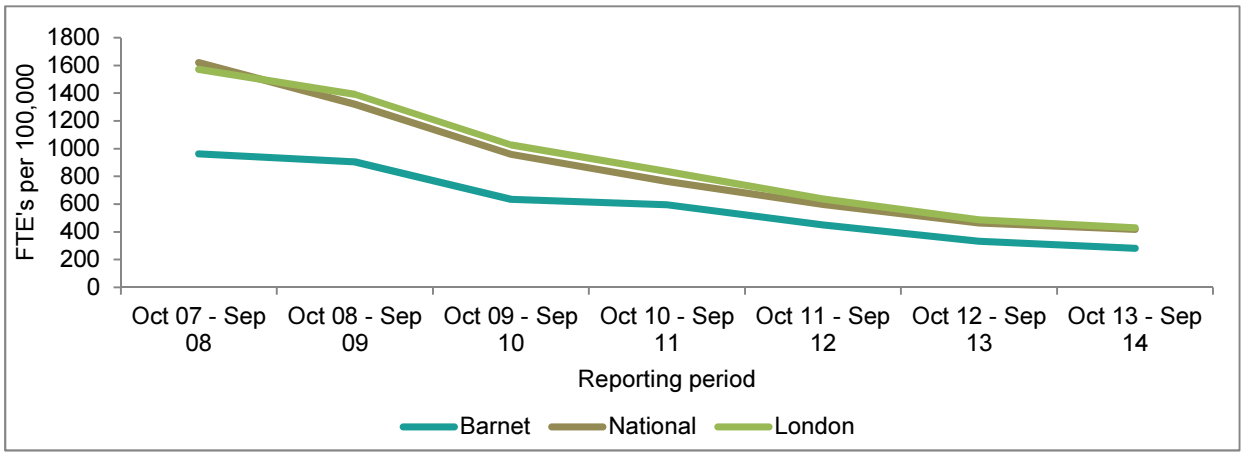
[131] Residential placements as defined in OFSTED social care data 31st March2014

8.8 Young People who Offend or Reoffend

8.8.1 First Time Entrants (FTE)

A first time entrant is defined as a young person aged under 18 at the time of their offence entering into the justice system for the first time. The data in Figure 8-12 represents the most recently published figures from the Youth Justice Board. Barnet continues to have a lower FTE per 100,000 rate compared to National and London figures.

Figure 8-12: Rate of First Time Entrants per 100,000



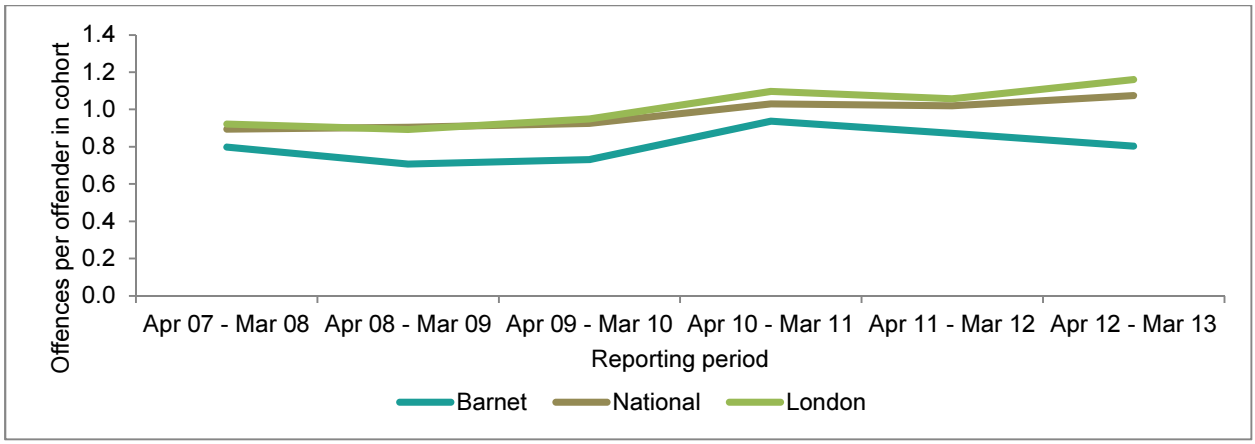
Source: Youth Justice Management information System

There is a need to improve access to Child and Adolescent Mental Health Services, Speech & Language Therapy and school nurse provisions as well as additional access to mentors. If these provision issues were resolved, the service would be better equipped to engage with young people before they enter the justice system and become FTEs. This is likely to have a positive impact on Barnet's already low FTE numbers.

8.8.2 Re-Offending

A young person aged 17 or under at the time of their offence, is tracked for 12 months and their re-offending behaviour is reported on. The data in Figure 2 represents the most recently published figures from the Youth Justice Board. Barnet continues to perform well compared to National and London figures, particularly in regard to the number of offences the tracked offender commits in the 12 month period.

Figure 8-13: Number of offences per offender



Source: Youth Justice Management information System

An increase in suitable education provision in schools has been identified for hard-to-reach young people which should include the following to improve outcomes:

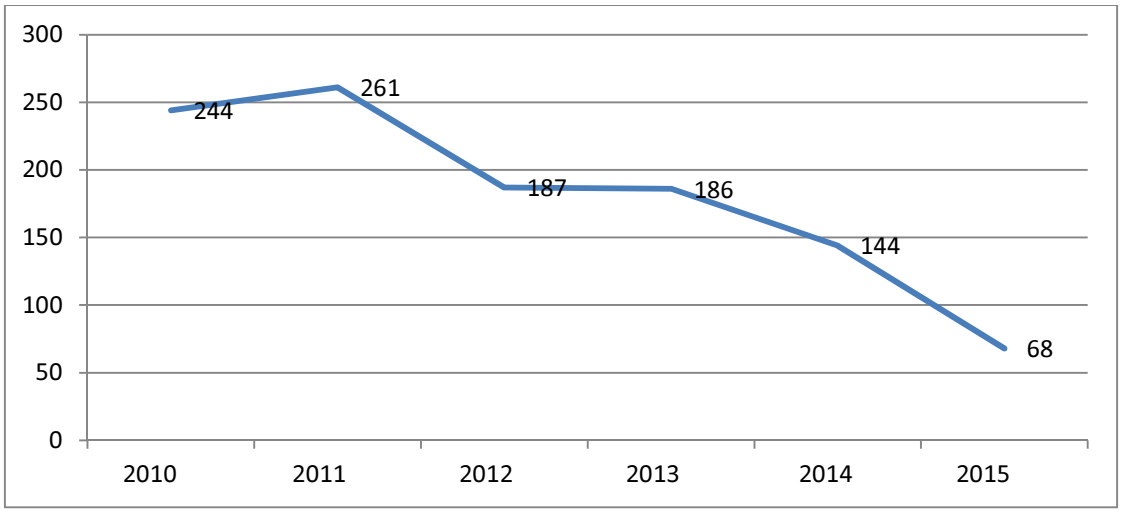
- additional support and mentoring.
- interventions which target the needs of the male BME population.
- physical health provision in the form of a school nurse who can deliver training in first aid/sexual health.
- CSE screening.

The rate of re-offending is decreasing; however, there has been an increase in the seriousness of offending by a small proportion of young people who are associated with gangs. This small cohort of young people has been targeted for support and turnaround through multi –agency interventions and evidence-based intervention.

8.8.3 Number of Statutory Programmes

A young person is sentenced to a statutory order at court and their order is overseen by the Youth Offending Team (YOT). Whilst the number of young people supervised by the YOT has fallen over the years due to more preventative work, those young people under supervision are very complex and high risk offenders. This graph refers to the number of statutory programmes started[132], by year of start date (the 2015 figure is as at June 2015).

Figure 8-14: Number of Statutory Programmes started, 2010-2015



8.9 Child Sexual Exploitation (CSE)

CSE is a type of sexual abuse in which children are sexually exploited for money, power or status. A range of recent reports, national media coverage and recent convictions of perpetrators highlight that this form of child abuse is often hidden from sight and preys on the most vulnerable in the society. CSE is a priority of the Barnet Safeguarding Children Board.

In 2014/15 there were 129 referrals to the MASH (Multi-Agency Safeguarding Hub) reporting concerns about CSE, of these 73% (94) were female. A report from Barnardo's based on evidence from over 9,000 records for CSE in England found that 66% of records belonged to girls, which is broadly in line with the gender split of Barnet MASH contacts. However, the report points out that

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

there are a number of barriers to disclosure specific to boys and young men, such as discriminatory social attitudes and expectations of 'masculine' behavior, so the figures may not accurately reflect the realities of CSE locally or nationally. Further analysis of the profile of child at risk of CSE is ongoing.

8.10 Gangs

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

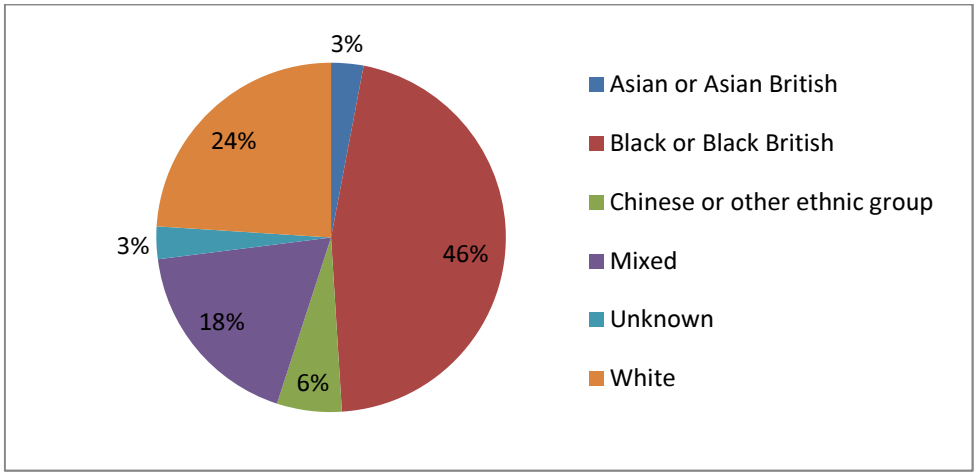
(1) See themselves (and are seen by others) as a discernible group, and
(2) Engage in a range of criminal activity and violence'

In Barnet there are some localised issues of young people affected by serious youth violence and gangs mainly in the west of the Borough.

Evidence has suggested that there is strong correlation with the supply of drugs and gang affiliation in Barnet. However the activities of particular gangs have also generated youth violence.

In Barnet, 59% of the most serious gang offenders rated as Red or Amber (red being the most serious) are aged 19 or younger. 45% of offenders are Black or Black British and all are male.

Figure 8-15: Ethnicity of known children in Barnet in Gangs



All young people in Barnet known to be in gangs are male. Although there are no gang members currently known to services who are girls, there is a cohort that is likely to be linked to or associated with gang members. The majority of young people identified as being at risk of entering a gang or being a victim of gang activity are white, although this group is under-represented when compared to the Barnet population. However, black young people in Barnet are over-represented and nearly three times more at risk of being affected by gang activity than young people outside of this cohort.

The following principles underpin the Barnet Youth Crime Prevention Strategy and are based on the Home Office assessment against the national and international experience and learning from working with gangs:

- strong local leadership;
- mapping the problem;
- assessment and referral;

- targeted and effective interventions; enforcement, pathways out and prevention;
- criminal Justice and breaking the cycle;
- mobilising communities.

8.11 Missing

Recent research by The National Missing Persons Helpline has revealed that nationally, one child runs away from home or is forced to leave home every five minutes.

Approximately 77% of those children are under 16 years and running away for the first time. Around a third of children in care run away three times or more. Children may run away from a problem (e.g. abuse or neglect at home) or to go somewhere they want to be. They may also have been coerced to run away.

It is thought that approximately 25 per cent of children and young people that go missing are at risk of serious harm. There are particular concerns about the links between children running away and risk of sexual exploitation. Missing children may also be vulnerable to other forms of exploitation such as violent crime, gang exploitation, or drug and alcohol misuse.

In Barnet, known children and young people of all ages go missing, though the likelihood increases when children are in their teenage years. Of the known cohort, missing children are predominantly white and marginally more likely to be female.

Figure 8-16: Ethnicity of known children missing from care or home

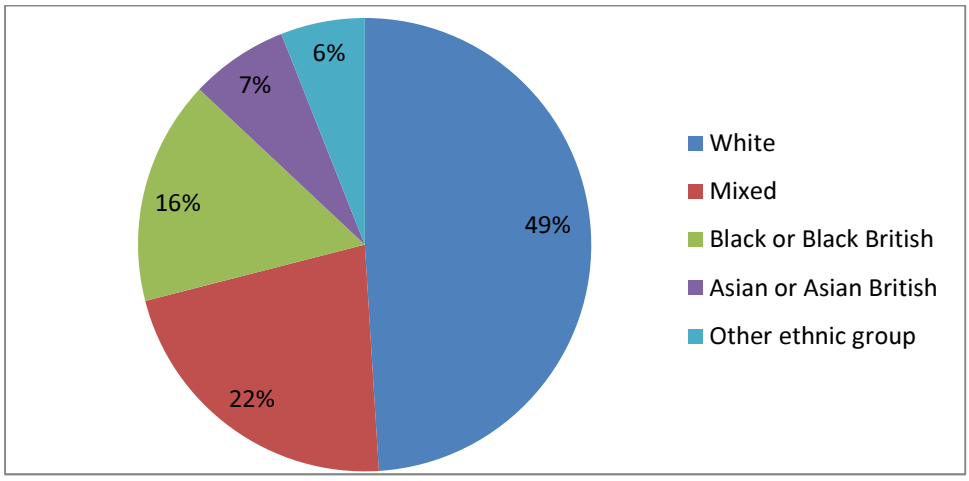
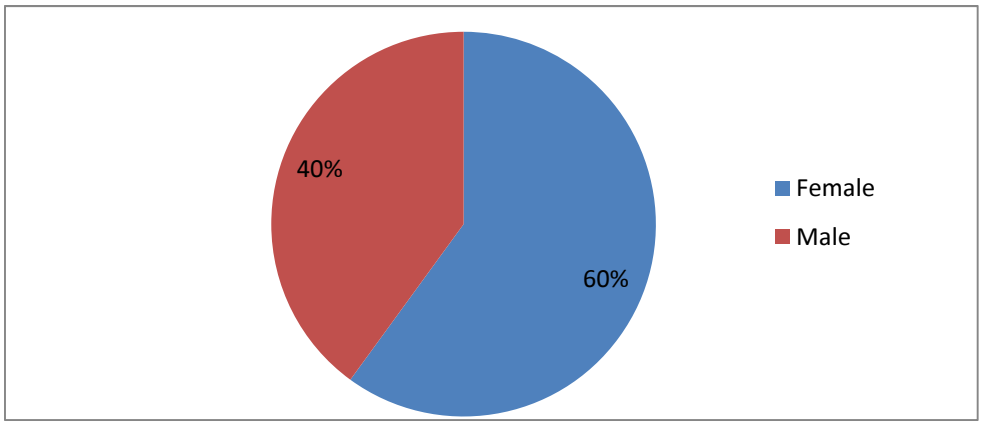


Figure 8-17: Gender of known children missing from care or home



Of those children identified as being most at risk of going missing in Barnet, 40% are male and 60% are female. White children are most at risk of going missing from home, care, or school, although this group is under-represented when compared to the Barnet population, as is the Asian cohort of children. The black and mixed populations are over-represented and therefore more at risk.

The age profile of children at risk of going missing is similar to that of known missing cases. A larger number of children are at risk of going missing between the ages of six and ten and at the age of 16.

8.12 Domestic Violence, Parental Substance Misuse, Parental Mental Ill Health (Toxic Trio)

An analysis of random samples of CAFS in Barnet found the 'toxic trio' of domestic violence, mental ill-health and drug and alcohol misuse in families amongst the most prevalent causes of poor outcomes for children. From the sampled CAF cases, DV featured in 90% of the cases, substance misuse in 40%, and 20% of cases had significant mental ill-health concerns. Since April 2014 and when MASH started recording presenting issues, nearly a quarter were identified as having domestic violence present in the family. Of these domestic violence cases, 13% progressed under the social care threshold to CAF whereas over double that amount progressed over the threshold to social care (28%).

8.12.1 Multi-Agency Risk Assessment Conference (MARAC)

In the last three financial years, there has been a steady increase in the number of referrals of domestic violence to the MARAC (*2012-13* **= 175,** *2013-14***= 234,** *2014-15***= 311**) which is interpreted as the impact of the interventions that have been put in place to heighten the awareness of agencies and the public.

Of the 311 cases discussed by Barnet's MARAC between 1 January and 31 December 2014, 95% were a female victim of domestic violence, and 5% male. The predominant age band of victims of domestic violence in Barnet is between 21–30 years in 38% of cases, followed by those aged between 31–40 years in 25% of cases. The most common ethnicity is White with 58%, followed by any Other and Black with 12%. Police data and referral data highlights Burnt Oak, Colindale and small pockets of Mill Hill to the west and Brunswick Park ward to the east as primary areas for incidences of domestic violence.

Parental alcohol or substance misuse was present in 20% of Child Protection and 40% of Looked After Children cases (for reference Barnet has circa 238 Child Protection cases and circa 300 Looked After Children cases).

Substance misuse among parents of children and young people referred to social care is spread around the Borough, though Grahame Park and surrounding areas have the highest concentration in the Borough. Other areas where parental substance abuse is a problem are pockets in Brunswick Park, East Barnet and Edgware.

A national study found that around three in ten adults will experience mental health problems every year but only three quarters of these will access services. This year (2015) around 16% (58,600) of adults in Barnet have a mental health condition. This is expected to increase by 6% to 62,300 by 2020. Mental health conditions among parents of children referred to care is of particular concern in the more deprived areas of the Borough. The Dollis Valley estate in Underhill, pockets in Brunswick Park and the A5 corridor from Colindale to Edgware are the worst affected areas.

Barnet commissions a number of services to provide support for those affected by domestic violence, mental ill-health and drug and alcohol misuse. Domestic violence support services include refuges, perpetrator and partner programmes and an advocacy service. Barnet Drug and Alcohol Service provide advice and information, drop-in services, psychiatric treatment, psychological therapies, social interventions and complementary therapies. Parenting support services include five Parenting Programmes for hard-to-reach families. The community coaching service recruits and trains community coaches to provide targeted support to vulnerable families in crisis. Since April 2014 there have been increases in the number of MASH contacts for 'toxic trio' cases being referred to Early Intervention services.

8.12.2 Key Issues

- The Barnet Early Intervention and Prevention (EIP) strategy identified that CAFs are not identifying or intervening early enough in cases of domestic violence, mental ill-health and drug and alcohol misuse.
- A need to refresh and strengthen referral pathways as the issues of domestic violence, mental ill-health and drug and alcohol misuse are still present in social care referrals
- Increase the numbers of CAFs across the partnership to deliver Barnet's key principles of intervening as early as possible and taking a whole family approach.
- Continue to strengthen the interface between Family and Adult Services to address the issues of domestic violence, mental ill-health and drug and alcohol misuse. This is particularly to ensure children of parents receiving substance misuse treatment are known to Family Service and/are signposted to services appropriately to encourage de–escalation and step down.
- Working alongside the Safeguarding Children's and Adults boards to address the overlap of issues and adapting services and referral pathways.
- Working to bring in more referrals in line with CAADA's Co-ordinated Action Against Domestic Abuse estimation of cases, per Borough population.
- A comprehensive process to conduct Domestic Homicide Reviews

8.13 Child and Adolescent Mental Health

8.13.1 Prevalence of Mental Health Disorders in Barnet children and young People

Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and gender in Barnet. Note that the numbers in the age groups 5-10 years and 11-16 years do not add up to those in the 5-16 year age group as the rates are different within each age group.

Table 8-13: Estimated Number of Children with Mental Health Disorders by Age Group and Sex

	Aged 5-10 yrs.	Aged 11-16 yrs.	Aged 5-16 yrs.
All	2,155	2,965	**5,160**
Boys	1,470	1,695	**3,175**
Girls	**695**	**1,275**	**2,020**

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report); Office for National Statistics midyear population estimates for 2012 (local authority report). Green, H. et al (2004)

It is important to note that Barnet has a higher number of children and young people in mainstream school with a special educational need that London; 21% in Barnet primary schools against 17% in London's, and for secondary schools in Barnet 22% against 21% in London. Therefore CAMHS services may be well placed in schools.

8.13.2 Prevalence Rates of Mental Health Disorders [133]

The estimated proportion of children and young people to have conduct, emotional and hyperkinetic and less common disorders in Barnet are as follows:

- conduct disorder: 5.8% (3022, 5 – 16 year olds[134])
- emotional disorder: 3.8% (2,014 5- 16 year olds)
- hyperkinetic disorder: 2.2% (1,149, 5 – 16 year olds)
- other less common disorders[135] (730)
- overall admission rate (per 100,000) for mental disorders for under 18 years in Barnet is 167.6, which is 2nd highest in London compared with London at 87.1 and England at 87.6 (see below).
- expenditure rate on child and adolescent mental disorder was £1.1m which was mid-range compared to most other London Boroughs
- ***total spend on child and adolescent mental disorder in 2012/13: £3.7m.***
- a study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 years inclusive, living in private households. The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Barnet.
- the most prevalent conditions are Conduct Disorder at an estimated 3,095 5-16 year olds and Mixed Anxiety and Depressive disorder at an estimated 1,405 16 – 19 year olds.
- greater incidence of Mental Health Problems are found in young people with Learning Disabilities; with Special Educational Needs; who are looked after; homeless or sleeping rough; who attempt suicide or self-harm or; who are in the youth justice system.

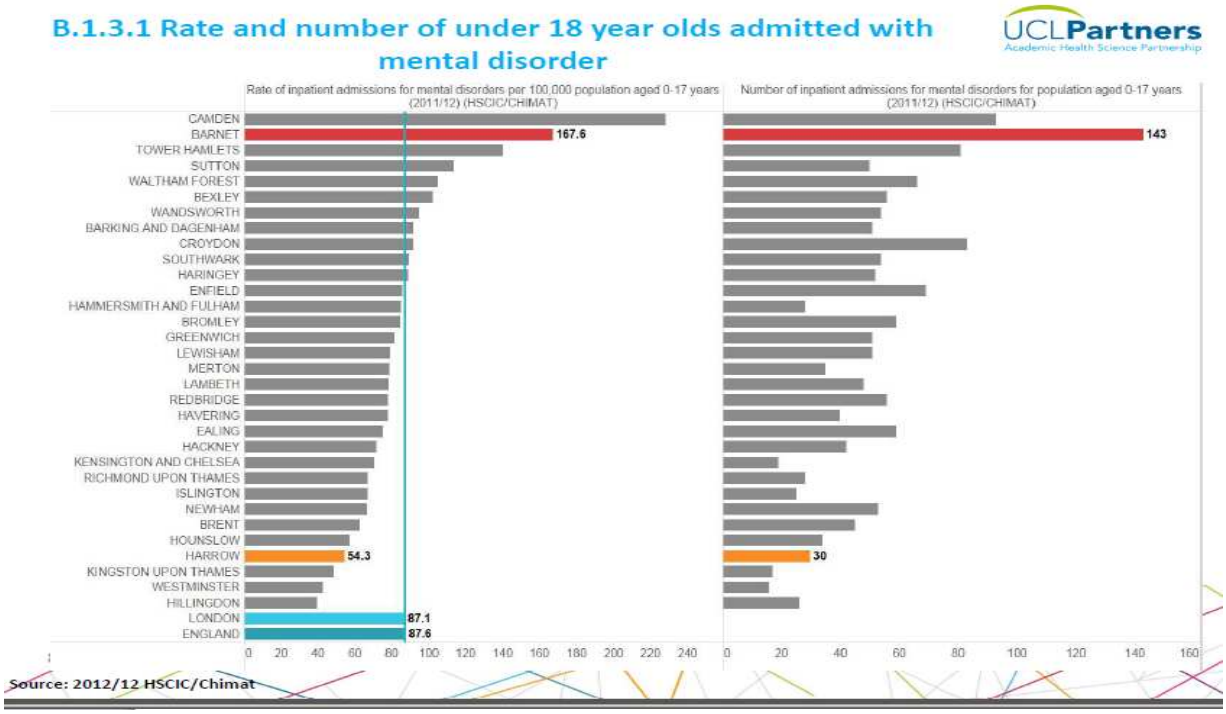
Table 8-14: Estimated number of 16 to 19 year olds with neurotic disorders

	Males	Females
Mixed anxiety and depressive disorder	435	970
Generalised anxiety disorder	135	90
Depressive episode	80	215
All phobias	55	165
Obsessive compulsive disorder	80	75
Panic disorder	45	50
Any neurotic disorder	730	1,500

Source: Office for National Statistics mid-year population estimates for 2012.

[133] Extracted from Children and Adolescent Mental Health Service (CAMHS) – Barnet (26.01.2015) Dr Neel Bhaduri, Draft V2
[134] Children and Adolescent Mental Health Services (CAMHS) – Barnet DRAFT (14.01.2015) Dr Neel Bhaduri, Draft V1
[135] Barnet CAMHS NEEDS ASSESSMENT V2

Figure 8-18: Admission for under 18 year olds in Barnet with mental disorder



8.13.3 Key Issues/Challenges

- young people voted mental health as one of their top service/needs priorities at a Children's Trust Board event.
- implementation of the CAPA and improving Access to Psychological Therapies
- re-modelling of CAMHS through a jointly developed specification with CCG and public health that invests in prevention and early intervention
- transition to adult services is a challenge

Although Barnet appears to be providing a range of good services, there remains considerable challenge to transform the service. The CAMHS core group is working to implement recommendations from previous Barnet reviews and national recommendations

8.14 Young Carers

According to the 2011 census there are 166,363 young carers living in Barnet, which is an increase of 20% from the 139,000 in 2001. However this figure does not reflect the scale of young carers in Barnet. Many young carers remain hidden for many reasons including family loyalty, stigma, bullying or not knowing where to go for support. The Children's Society estimates there could be up to four times more young carers, approximately 700,000[136]. This research also suggests 4.5% of children and young people identify themselves as having a caring responsibility. In Barnet this would equate to around 3,900 young carers. Currently the lead provider of support services for young carers in Barnet has a register of approximately 540 children and young people with a caring responsibility.

A young carer is likely to:

- be Black, Asian and Minority Ethnic, have a disability, long-term illness or Special Educational Needs.

[136] The Children's Society (2013), *Hidden from view,* http://www.childrenssociety.org.uk/sites/default/files/tcs/hidden_from_view_-_final.pdf

- care for siblings and adults with physical or mental problems, or a learning difficulty
- care for up to 15 hours per week, but some even up to 30
- miss out on school, have lower GCSE results than peers and be NEET, or if employed be in a lower skilled occupation
- have parents who are not in work, one with a disability and a mother with no educational qualifications
- have a lower family income and more than three children in their family
- not be in contact with support agencies.

The current lead provider in Barnet of support services to young carers provides support through respite clubs, counselling and mentoring. A school liaison service is provided which delivers support using leaflets, 1:1's and group work, as well as presentations to increase the awareness of, and identify young carers. There is also a service to provide help to young carers affected by drug or alcohol misuse by parents or siblings and a service which provides specific assessments and focuses on transitional issues such as education, training and work.

The Care Act 2014 and the Children and Families Act 2014 together provide a framework to ensure inappropriate caring for young people is prevented or reduced and whole family needs are met. The Acts give young carers and parents similar rights to assessment as other carers have under the Care Act. For the first time carers are being recognised by law in the same way as those they care for and are eligible for assessment and support.

In line with recent legislative changes, Barnet will develop a strategy for the vision and future delivery of young carers' services alongside a needs analysis to ensure service delivery is needs led. Barnet will continue to improve outcomes for young carers and their families. Priorities in order to do this include:

- Proactive identification through training and raising awareness amongst key practitioners and partner agencies to ensure young carers do not remain hidden
- Strengthening referral pathways.
- Joint working with Adults and Communities delivery unit to undertake appropriate whole family approach assessments to prevent young carers providing inappropriate levels of care and ensure whole family needs are met.
- Providing individualised, tailored and appropriate support to young carers so each young carer can achieve their potential and have the same opportunities to progress in life as their peers.
- Ensuring young carers are signposted to and access existing mainstream as well as specialist support services.
- Provide transitions assessments and planning to support young carers prepare for adulthood and raise and fulfil their aspirations.

8.14.1 Scale

- The number of young carers in the UK has increased by 20% from 2001 to 2011.
- However, in Barnet the numbers of young carers has increased by 30% to 1,191 young carers which is 2% of the under 18 population.
- Research estimates that there could be up to four times more young carers. Using these estimates, young carers as a percentage of the 0 - 18 population in Barnet increases from to

2% to 8%. This would mean nearly 1 in 10 children and young people are providing some level of unpaid care.

- The provider of young carers' services in Barnet has 627 young carers registered (April 2015).

8.14.2 Age

- In Barnet there are high proportions of young carers under the age of ten and between 16 and 24:
    - One in eight are under ten years
    - Two thirds of 0 – 24 year olds were aged 18 - 24
- Provider data shows good identification of children and young people under 15 years old. However, there is a large gap in identification of 16 – 17 year olds. Evidence shows a clear association between being a young carer at 16 – 19 and being NEET.
- There is a need to ensure sufficient support for young carers under nine as well as increased identification and support for young carers in transition age. This needs to be addressed in a joint commissioning process.

8.14.3 Ethnicity

National research shows young carers are 1.5 times more likely to be Black, or Minority Ethnic and less likely to identify as a young carer. In Barnet younger cohorts are more diverse than older age groups. This confirms the need to ensure sufficient identification and support for children under 10.

8.14.4 Disability, long term illness, SEN

- National research shows young carers are 1.5 times more likely to have a disability, long term illness or special educational needs.
- The largest age cohorts on Barnet's Disabled Children's Register and classed as SEN on Barnet's school rolls are 5 – 9 and 10 – 14 years old. This confirms the need to ensure sufficient identification and support for children under ten years old.
- Provider data shows the number of young carers with a disability has been increasing and is now over a third of all young carers registered.
- According to census figures, one in five young carers would describe their health as poor or fairly good.
- This shows the importance of young carers having their own needs assessed and supported.

8.14.5 Caring responsibilities

Research shows young carers providing unpaid care who are not in contact with services are likely to be caring for siblings and grandparents. Therefore:

- Identification should focus on services which siblings and grandparents access
- A section on what types of needs young carers are supporting is currently being developed

8.14.6 Impact of caring responsibilities

- Evidence shows a clear association between being a young carer at 16 - 19 years old and having low job prospects and educational opportunities. As well as being a young carer at 20 to 21 years and being in lower skilled occupations.

- In Barnet the proportion of 16 to 18 year olds who are NEET is ranked 4th nationally and 9th nationally for participation rates for pupils with learning difficulties or disabilities.
- It is therefore important that the provision of this support is inclusive and accessible for young carers.

8.15 Child Poverty

8.15.1 Headlines:

- 21.2% of children living in Barnet live in poverty; a total of 17,330 children.
- Barnet has a lower level of child poverty than the London average (36%), but a slightly higher rate than the England average (20.6%). However, there are geographic variations across Barnet, ranging from just 7.7% in Garden Suburb to 37.5% in Colindale.
- In general there is a propensity for a greater number of areas in the west of the Borough to be affected by child poverty and the factors that directly and indirectly influence it.
- The following groups are likely to be more at risk of poverty than others: lone parents, large families, families affected by disability, and black and minority ethnic groups.

According to the 2010 Child Poverty Act, a child is defined as being in poverty when he/she lives in a household with an income below 60% of the UK's average. Although at the time of writing a new national definition of child poverty is currently being developed, throughout this JSNA child poverty will be defined based upon the definition put forward by the 2010 Child Poverty Act.

A third of all children in the UK live in poverty[137]. Child poverty touches all areas of a child's life, from the home they live in to their health, educational attainment, involvement in crime and social exclusion. Indeed, poverty is the most significant general indicator of risk. The Government has a statutory requirement, enshrined in the Child Poverty Act 2010, to end child poverty by 2020.

Families living in poverty can have as little as **£12 per person per day** to buy everything they need such as food, heating, toys, clothes, electricity and transport.

Research at the national level indicates that the following groups are more at risk of poverty than others:

Lone parents
In Barnet, there are 10,026 lone parent households[138] with dependent children. Of these lone parents, 46% are not in employment. National statistics show that women accounted for 92% of lone parents with dependent children and these percentages have changed little since 2001.

Large families
Around half of Bangladeshi and Pakistani children, and around a third of black African children, are in families of three or more children compared to around a sixth of white British children[139]. A higher proportion of families from ethnic minority groups can be found in Barnet have more deprived wards. Furthermore, there is a minority of ultra-orthodox Jewish families living in Barnet, particularly in and around the Golders Green ward, where family sizes are typically larger.

Families affected by disability

[137] 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
[138] 2011 Census
[139] Palmer and Kenway (2007),'Poverty Rates among Ethnic Groups in Great Britain'

Four in every ten disabled children live in poverty[140]. The Children's Society has warned that the new Universal Credit benefit system may have an adverse impact on families affected by disability.

Black, Asian and minority ethnic groups

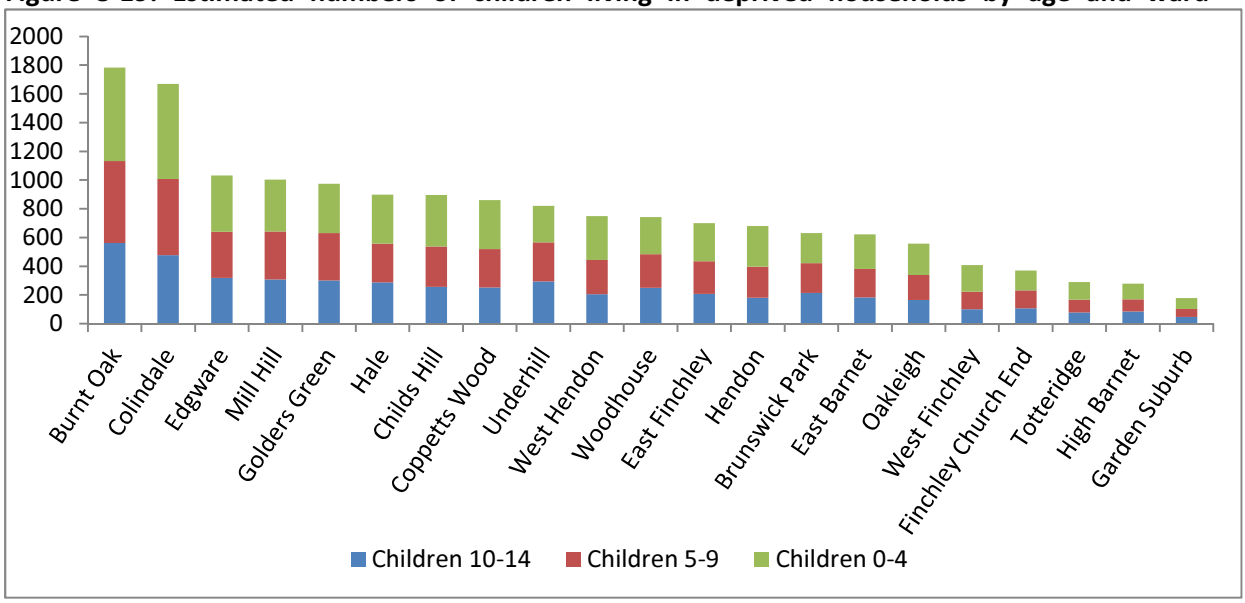
Nationally in 2010, nearly three-quarters of seven-year-old Pakistani and Bangladeshi children and just over half of those black children of the same age were living in poverty. Barnet has a Black, Asian and Minority Ethnic average of 39%. However, in Colindale, Burnt Oak and Hendon, Black Asian and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

There is also a strong link between child poverty and unemployment or low levels of income. The percentage of low income families has decreased in Barnet since 2007 to 17.3% in 2012, a trend in line with the London and UK picture.

The number of children living in poverty in Barnet is 21.2%[141] - which is slightly higher than the UK average (20.6%). This makes Barnet the Borough with the 25th highest rate of child poverty of the 33 London Authorities.

Children living in poverty are not distributed equally across the Borough and there is a strong correlation between child poverty and deprived LSOAs in Barnet. In turn, the proportion of Black, Asian and Minority Ethnic residents is higher in these areas.

Figure 8-19: Estimated numbers of children living in deprived households by age and ward



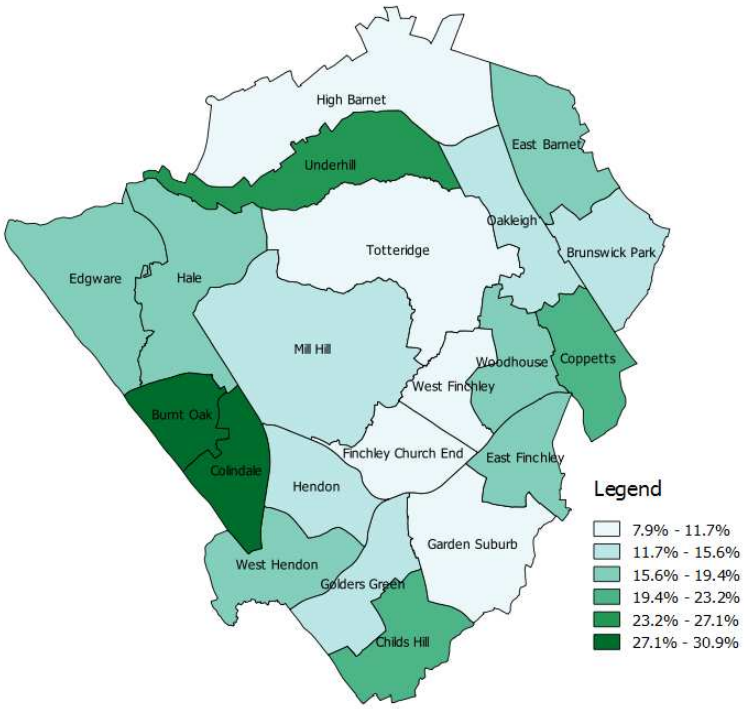
Source: HMRC, 2010

The highest rates of child poverty are in the west of the Borough, in particular Burnt Oak (36%) and Colindale (37.5%)[142], which exceed the national and London averages. Colindale and Burnt Oak also have the highest proportion of children living in low-income families, with just over one third of the children living in low-income families.

Underhill, Child's Hill and Coppetts are the wards with the next highest rates of poverty, with Underhill at 26.2% and the other wards both at 25%

[140] http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/child-poverty/disabled-children-and-poverty-0
[141] 2010 HMRC data
[142] HMRC data 2010

Figure 8-20: Child Poverty by Ward



Child poverty is particularly low in the more central wards running from north to south of the Borough: High Barnet, Totteridge, West Finchley, Finchley Church End and Garden Suburb. Garden Suburb has the lowest percentage at only 7.9%. These are also the wards in which the percentage of all children living in a low-income family is at its lowest in the Borough.

There are a number of factors that directly and indirectly influence child poverty, which are set out in more detail below.

8.15.2 Housing

Housing costs are a factor which can push families below the poverty line. In turn, bad housing means lower educational attainment and greater likelihood of unemployment for children[143]. 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.

[143] 'Chance of a lifetime: The impact of bad housing on children's lives' (Shelter, 2006): https://england.shelter.org.uk/__data/assets/pdf_file/0016/39202/Chance_of_a_Lifetime.pdf

Nationally, only 48% of five year olds entitled to Free School Meals have a good level of development at the end of their reception year, compared to 67% of all other pupils. Less than half of pupils entitled to Free School Meals (just 36%) achieve 5 GCSEs at C or above, including English and Maths, which compares to 63% of pupils who are not eligible.

In Barnet, disadvantaged children continue to perform significantly below their non-disadvantaged counterparts. In 2014, 28 percentage points separated disadvantaged and non-disadvantaged pupils at Key Stage 4. The number of children entitled to Free School Meals progressing to Level Two has increased steadily over the past ten years, in line with London levels.

The percentage of young people in Barnet progressing to higher education exceeds the London average by nine percentage points (58%). However the gap for children on Free School Meals is far smaller, at six percentage points below (43%) the London average.

8.15.4 Health

Poverty has been the major determinant of child and adult health and it remains a major cause of ill health with huge public health consequences[144]. 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.

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

Table 8-15*:* The proportion of children living in families in receipt of out-of-work (means-tested) benefits or in families in receipt of tax credits whose reported income is less than 60% of median income

Year	Barnet		London		England	
	Number	Percentage	Number	Percentage	Number	Percentage
2006	17,690	23.8%	531,700	31.5%	2,298,385	20.8%
2007	18,555	24.6%	552,725	32.5%	2,397,645	21.6%
2008	18,195	23.7%	534,095	30.8%	2,341,975	20.9%
2009	18,120	22.7%	531,970	29.6%	2,429,305	21.3%
2010	17,330	21.2%	512,185	28.0%	2,367,335	20.6%
2011	16,640	20.1%	495,625	26.7%	2,319,450	20.1%
2012	14,600	17.3%	442,275	23.5%	2,156,280	18.6%

Source: https://www.gov.uk/government/publications/personal-tax-credits-children-in-low-income-families-local-measure

Table 8-16: Children living in a low income family

Ward	Number of all children living in a low-income family	% of all children living in a low-income family	% of all children living in poverty
Brunswick Park	565	14.1%	18.0%
Burnt Oak	1595	28.5%	36.0%
Childs Hill	940	22.3%	25.0%
Colindale	1460	30.9%	37.5%
Coppetts	815	21.1%	25.0%
East Barnet	680	17.4%	19.7%
East Finchley	630	18.9%	22.8%
Edgware	725	15.9%	23.7%
Finchley Church End	300	9.6%	12.2%
Garden Suburb	255	7.9%	7.7%
Golders Green	825	14.0%	17.5%
Hale	800	17.0%	21.2%
Hendon	515	11.9%	16.5%
High Barnet	310	9.5%	10.7%
Mill Hill	720	15.5%	21.9%
Oakleigh	555	15.5%	18.0%
Totteridge	355	11.3%	12.8%
Underhill	940	24.8%	26.2%
West Finchley	345	11.4%	15.7%
West Hendon	655	16.8%	21.6%
Woodhouse	640	17.3%	20.9%

Source: HMRC snapshot as at 31 August 2012

The percentage of children in workless households in Barnet (13%) has decreased to below both the London and England average[145], and the percentage of children in working households has reached 52%, which is the highest level seen in the past ten years. Although employment across Barnet has increased, the highest rates of unemployment are located towards the west of the Borough, in Colindale (8.4%) and Burnt Oak (8.1%).

Table 8-17: Children in Workless Households

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

All services across the partnership share a commitment to improving outcomes for children, young people and families in poverty. However, reduced public sector spending will have a significant implication on the delivery of front line services, in particular the amount of preventative services and early intervention programmes that can make a difference and create efficiencies.
Services need to work together on a whole family basis in order to improve outcomes and wellbeing for children living in poverty. Evidence suggests that single agency responses are unlikely to affect the change a child and family requires to escape deep-rooted poverty.

8.16 Voice of the Child

Barnet delivers a diverse range of participation forums which enable children and young people to have their voices heard.

- **Barnet Youth Board** - A representative panel of young people aged 13- 24 years acting as a voice for the wider youth community of Barnet.
- **UK Youth Parliament (UKYP**)
- **Role Model Army (RMA) -** The RMA is Barnet's Children in Care Council.
- **Youth Shield -** Youth Shield is Barnet's Youth Safeguarding Panel for young people aged 14-25 years run by CommUNITY Barnet on behalf of Barnet Safeguarding Children Board (BSCB).
- **Young Commissioners** – A group of children and young people embedded within the commissioning cycle providing their unique voice and insight in to service specification and design.

In addition, a programme of work targeting young people engaged with the YOS team, PRU, and foyer is also under way. Some of the key / top priorities that children and young people have already told us are:

- Mental health services for children and young people.
- Improved access to, and quality of, mental health provision at the earliest possible opportunity for children and young people.
- Reducing child poverty.
- Helping disadvantaged children and young people to do well in school.
- Making sure everyone can read and write at primary school.
- Protecting young people from bullying, violence and sexual exploitation.
- Youth centres and activities for teenagers.
- Young girls have increasingly spoken out about relationships and how they can support each other. They would seek help initially from their GP.

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

- A commitment from all employers to pay the London Living Wage to young people.
- Improved quality of extra-curricular activities with a focus on sport and fitness.
- Improved road safety across Barnet.
- Improvement in young people's participation with politics and local democracy.
- Looked After Children to receive a more thorough and considered induction into care and a more flexible approach to their care reviews.
- Looked After Children to be able to receive concise information upon their entitlements upon receipt of Looked After Children status.
- More effective work experience programmes.
- Wider and more vocal campaigning for votes at 16.
- Improvement to community cohesion and the breaking down of barriers based on gender, race, ethnicity, religion, sexuality and demography.

8.16.1 Participation

'The State of the Children's Rights in London' report highlights the importance of ensuring that local authorities place children and young people at the heart of the decision-making process. This highlights the importance of not only listening to the 'voice' of children and young people, but also ensuring that they participate in the planning, delivery and improvement of services that matter to them.

Participation means talking to, listening to and hearing from children and young people whilst encouraging and supporting them to contribute, participate in discussions and have their voices heard. It is then important to act on the views and ideas presented whilst being open, honest and realistic with them on the levels of involvement that they can have.

Barnet has a large population of children and young people and despite the range of engagement forums, there is still an opportunity for improving the way in which they participate with the council.

One area in particular where there is room for improvement is around crime. It is known that children and young people are more likely to be victims of crime, however they are often less likely to report it to the police when they are.

Following the publication of 'The Voice of the Child Strategy Action Plan 2015-17', work is currently underway to identify ways in which the council can enhance its understanding and avenues for engagement with children and young people. This section of the JSNA will be updated in the future to represent this work.

9 Adult Social Care

9.1 Key Facts

- The most recent population projections indicate that the adult population (18+) of Barnet will be 280,904, 76.5% of the total Borough population, by the end of 2015.
- This population is projected to grow by 14.5% between 2015 and 2030, to 321,677.
- By age group, 4,744 (63.8%) of service users are aged 65+.
- Despite continued growth in the adult population, the number of people in receipt of residential care and nursing care decreased from 1,441 in 2011/12 to 1,367 in 2013/14 (-5.1%), reflecting on-going work to help people remain in their own homes for longer.
- In relation to the total population, Brunswick Park and Underhill have the highest rates of carers (10.5% of the population), and Colindale has the lowest rate (6.90% of the population).
- According to national projections, the most common health conditions/disabilities within Barnet are mental health disorders and hearing impairments in those aged 65 and over.

9.2 Strategic Needs

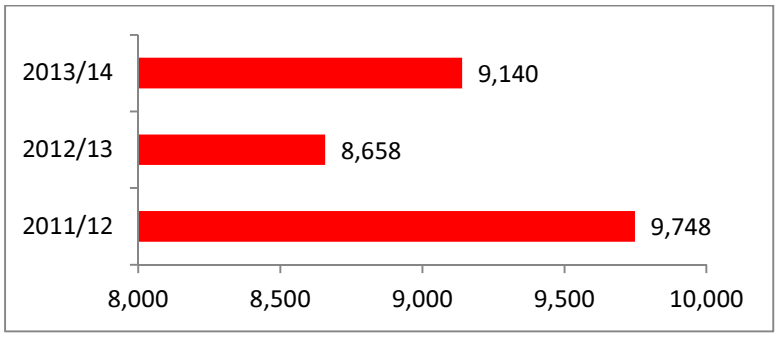
- **Mental disorders** are responsible for the **largest burden of disease in England** at 23% of the total burden. Within Barnet, the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently as possible within the community**. This places significant pressure on ensuring **appropriate housing and support services** are available to **meet their requirements**.
- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, locally based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in **elderly women who live alone**, especially in **areas of higher affluence and lower population density.**
- **The Care Act** represents the most significant reform of care and support in more than 60 years. It is expected to drive **increased demand for adult social care support over and above the increased levels of demand from demographic pressures**.
- **According to national benchmarking information, demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people in Barnet, 3.3% of the 65 and over population**. This could indicate a **lack of take up of around 800 people.**
- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average carers **are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.

- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021 the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

9.3 Service User Profile

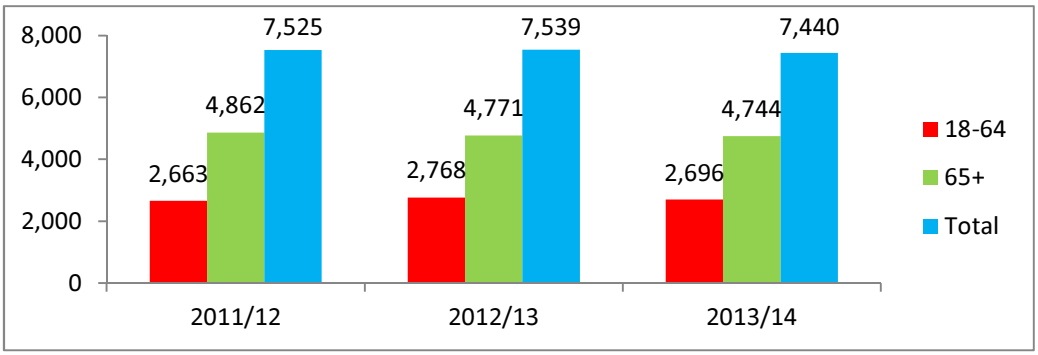
In 2013/14 there was an increase in the number of Adults contacting Barnet for support. Many of these people were provided with advice and information by Social Care Direct, the Council's Front Door service. Some residents were sign posted to services such as Barnet's Carers Centre and the Barnet Centre for Independent Living, whilst others were referred to social care teams for full assessment.

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



Source: SWIFT – Adult Social Care Database

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



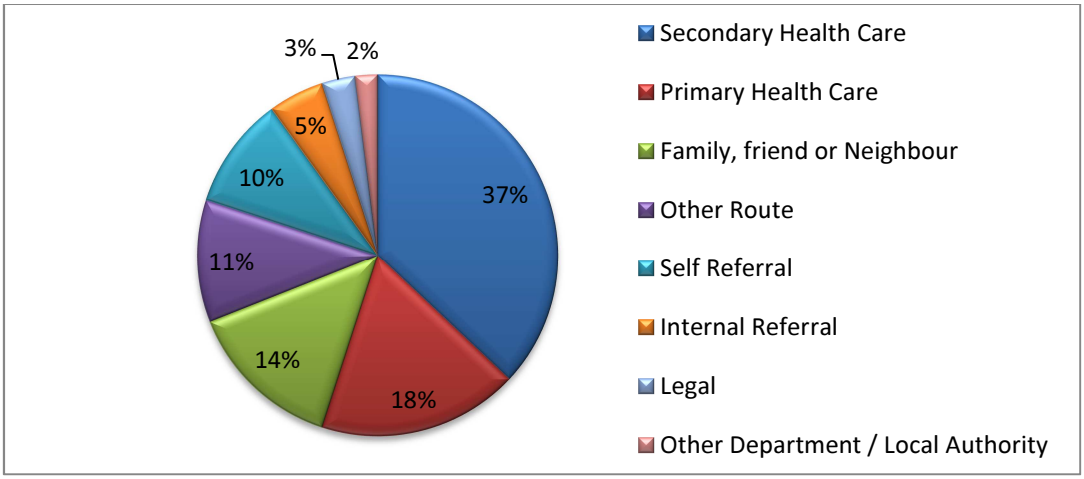
Source: SWIFT – Adult Social Care Database

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

Effective prevention and early intervention could help to reduce the level of referrals being received from secondary health care and increase those coming from primary health care, self-referrals and friends and family. Not only are hospital admissions often more costly than other forms of care, but

effective prevention and early intervention could have significant impacts on an individual's health and wellbeing.

Figure 9-3: Origin of referrals to Adult Social Care in 2013/14



Source: SWIFT – Adult Social Care Database

9.4 The Care Act 2014

The Care Act represents the most significant reform of care and support in more than 60 years. It aligns with a central Government commitment to make joined-up health and care the norm by 2018. For an overview of the changes, please refer to the factsheets.

The Care Act promotes wellbeing and aims to prevent or delay people needing social care services. It is built around people's needs and what they want to achieve in their lives.

It brings new rights for carers that put them on the same legal footing as the people they care for and entitles them to ask for their needs to be assessed.

9.5 Residential & Nursing Care

In Barnet, care homes are a key area of provision in supporting frail and elderly people who are unable to live in their homes.

There are 80 residential care homes and 23 nursing homes registered with the Care Quality Commission (CQC) in Barnet, which range from small to large.

In 2013/14, 75% of residential placements were provided to older adults (65+) and 61% of these residential placements were provided to women. The high proportion of women compared to men is most likely due to the fact that women account for 56.5% of the 65 and over population within Barnet, compared to men who account for 43.5% of the population[146].

Of the residential placements in 2013/14, 14% of residents had a learning disability, 6% had a mental health problem and 5% had a physical/sensory impairment.

[146] GLA 2013 Population Projections (Borough Preferred Option)

During the period 2011-2014 the number of people in receipt of residential care and nursing care has decreased, despite continued growth in the population, especially within the 65 and over age group. This reflects on-going work to help people to remain at home longer.

Table 9-1: The number of people in Residential and Nursing Care, 2011-2014

Year	Residential Care	Nursing Care	Total
2011-12	1,078	363	1,441
2012-13	1,076	387	1,463
2013-14	1,009	358	1,367

Source: SWIFT – Adult Social Care Database

Despite the reduction in the number of people in receipt of residential care and nursing care, in 2013/14 Barnet had a higher permanent admissions rate to care homes, per 100,000 people, than similar local authorities and the overall London average.

Table 9-2: Permanent Admissions to Care Homes per 100,000 people, 2013-14 (Barnet, Regional, and National)

Area	18-64	65+
Barnet	13.4	475.1
Similar Local Authorities	9.6	411.8
London	10.2	454
England	14.4	650.6

Source: Adult Social Care Outcomes Framework

Residential care and nursing care are high cost services. In 2013/14 14% of all service-users funded by the council accessed residential care and 5% accessed nursing care. The gross expenditure for 2013/14 was £38,364,000 for residential care placements and £7,652,000 for nursing care placements which represents approximately 40% of the total Barnet adult social services spend.

Table 9-3: Expenditure on Residential & Nursing Care, 2011-2014

Year	Gross Expenditure (£000's)		
	Residential Care Placements	Nursing Care Placements	Total Adult Social Services
2011/12	£7,680	£42,170	£115,940
2012/13	£8,188	£38,767	£113,888
2013/14	£7,652	£38,364	£114,340

Demographic pressures mean that there are an increasing number of elderly people in Barnet, and an increasing number of people with complex health or social care needs. Residential and nursing homes are a key area of provision for this cohort, especially for people with certain disabilities or conditions.

9.6 Enablement

Enablement refers to short-term intensive support which is given to a person to help them regain their independence. It lasts up to six weeks and usually takes place in the person's home. During the

enablement period, the person is assessed to identify if they are likely to require any further services.

Table 9-4 below displays the re-admission rates for both social care services and health referrals up to three months after the end of their enablement package.

- Over 60% of people who have had an enablement package have not been re-admitted to either social care or healthcare within three months of the end of the package.
- 25% of service users who are not in residential or nursing care have gone through the enablement programme.

Table 9-4: Success rate e.g. re-admissions, good outcomes including people at home 91 days after intervention and 30 days re-admissions

Quarter	% not died, been admitted into residential or nursing care, and not receiving homecare or direct payments					
	Social care referrals			Health referrals		
	A week after terminating enablement	A month after terminating enablement	Three months after terminating enablement	A week after terminating enablement	A month after terminating enablement	Three months after terminating enablement
11/12 Qtr 1	55%	56%	52%	87%	87%	87%
11/12 Qtr 2	55%	55%	53%	75%	80%	75%
11/12 Qtr 3	60%	56%	53%	78%	76%	71%
11/12 Qtr 4	61%	60%	59%	76%	69%	63%
12/13 Qtr 1	61%	60%	54%	77%	75%	72%
12/13 Qtr 2	68%	68%	64%	72%	72%	70%
12/13 Qtr 3	62%	58%	55%	77%	73%	71%
12/13 Qtr 4	67%	65%	63%	70%	65%	60%
13/14 Qtr 1	65%	60%	55%	69%	70%	56%
13/14 Qtr 2	68%	64%	59%	79%	75%	73%
13/14 Qtr 3	64%	61%	55%	74%	77%	73%
13/14 Qtr 4	64%	62%	67%	68%	67%	60%

Although enablement appears to be helping to reduce the level of re-admissions into the healthcare service, the number of new contacts going through the enablement programme has experienced a slight declined from 2011 to 2014.

Table 9-5: Numbers given an assessment and subsequently given an enablement package

Enablement	New Contacts Going Through Enablement (inc. Health Referrals)	% of New Contacts	% of Assessments	% of New Service Provisions
2011/12	1,498	15.4%	60.7%	73.8%
2012/13	1,458	16.8%	58.4%	74.4%
2013/14	1,100	12.0%	41.4%	54.1%

Source: SWIFT – Adult Social Care Database

A formula developed by the Care Services Efficiency Delivery (CSED) programme indicates that demand for enablement services should be around 5% of the 65 and over population. In 2013/14 the service was used by 1,660 people, 3.3% of the 65 and over population. Based on these projections this could indicate a lack of take up of around 800 people.

If the estimates from the CSED are applied to the latest population projections, due to the projected growth in the older population, demand for enablement services could increase by over 33% from 2015-2030.

Table 9-6: Projected demand for enablement services, 2015-2030

Year	65+ Population	5% of Population
2015	47,705	2,385
2016	49,237	2,462
2017	49,811	2,491
2018	50,691	2,535
2019	51,576	2,579
2020	52,352	2,618
2021	53,173	2,659
2022	54,017	2,701
2023	54,939	2,747
2024	55,918	2,796
2025	57,098	2,855
2026	58,182	2,909
2027	59,531	2,977
2028	60,821	3,041
2029	62,205	3,110
2030	63,575	3,179

Source: GLA 2013 Population Projections (Borough Preferred Option) and CSED

In addition to this, the changes that are being brought in by the Care Act 2014 are projected to increase demand for these services above demographic pressures alone.

With the high costs attributed to residential and nursing care, enablement provides a way to alleviate some of these costs. Therefore there is significant need over the coming years to ensure that Barnet has suitable capacity in place to meet the possible demand pressures impacting on the enablement service.

Furthermore, with the recent reduction in the number of new contacts goings through enablement, there is a need for greater understanding of the drivers behind this.

9.7 Self-Directed Support and Direct Payments

Personal budgets are an allocation of funding given to service users after an assessment, which should be sufficient to meet their assessed needs. They can be taken as a direct payment or the service user/carer can give the council some or all responsibility to commission services on their behalf.

Table 9-7 shows how many council-funded service-users have taken up a personal budget by client category. In 2013/14, 55.3% of all adult social care service users received a personal budget, an increase of 3.9% from 2011. This indicates that an increasing number of people are commissioning their own care; this trend is expected to continue in the future.

Table 9-7: Number of service-users receiving Self-Directed Support Packages

Client Category	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
Physical / Sensory Impairment (18-64)	498	61.0%	497	62.6%	500	65.8%
Learning Disability (18-64)	467	61.6%	509	67.7%	552	72.2%
Mental Health (18-64)	593	56.0%	631	53.8%	638	56.6%
Other (18-64)	10	33.3%	17	34.7%	22	50.0%
Older Adults	2,303	47.4%	2,264	47.5%	2,405	50.7%
Total Service Users	3,871	51.4%	3,918	52.0%	4,117	55.3%

Source: SWIFT – Adult Social Care Database

Over the period 2011-2014 there has been an increase in the prevalence of personal budgets in almost every year across all categories. The highest take-up of personal budgets is within clients who experience 'learning disabilities' (72.2%) and 'physical / sensory impairments' (65.8%).

The lowest take-up of personal budgets in 2013/14 was within the 'Other' category (50.7%), although as the numbers of service users within this category are quite low, this shouldn't be viewed as significant. However 'older adults' have the second lowest take-up (50.7%) and this client category accounts for the largest proportion of total service users within adult social care and is projected to experience the highest levels of growth.

Direct payments are cash payments given to service users in place of community care social services to allow them greater flexibility about how their care is delivered. The default position of the council is to offer service-users direct payments, including those people who are currently receiving council-managed services.

Table 9-8 includes all adults in receipt of direct payments, whether or not they are in receipt of a personal budget. As with the take-up rates of personal budgets, over the period 2011-2014 the rate of direct payments has increased from 12.6% in 2011/12 to 17.0% in 2013/14.

However, only 7.5% of clients with 'mental health' conditions had a direct payment in 2013/14, significantly below the level who had personal budgets (56.6%). As with personal budgets 'older adults' continue to have the second lowest take-up of direct payments, with only 13.0% opting for a direct payment in 2013/14; a 0.2% decrease on the previous year.

Table 9-8: Number of service-users in receipt of Direct Payments

Client Category	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
Physical / Sensory Impairment (18-64)	253	31.0%	288	36.3%	298	39.2%
Learning Disability (18-64)	182	24.0%	209	27.8%	258	33.7%
Mental Health (18-64)	61	5.8%	67	5.7%	84	7.5%
Other (18-64)	2	6.7%	8	16.3%	9	20.5%
Older Adults	452	9.3%	632	13.2%	616	13.0%
Total	950	12.6%	1,204	16.0%	1,265	17.0%

Source: SWIFT – Adult Social Care Database

Personal budgets and direct payments help residents take control of their own social care budget, manage their own support and choose the services that suit them best. Although the council has experienced a significant increase in their use, some client categories, such as those with mental health issues and older clients, have lower adoption rates than many of the other client categories. In order to maximise the use of these services there is a need to increase the understanding of the drivers behind this.

9.8 Community Care

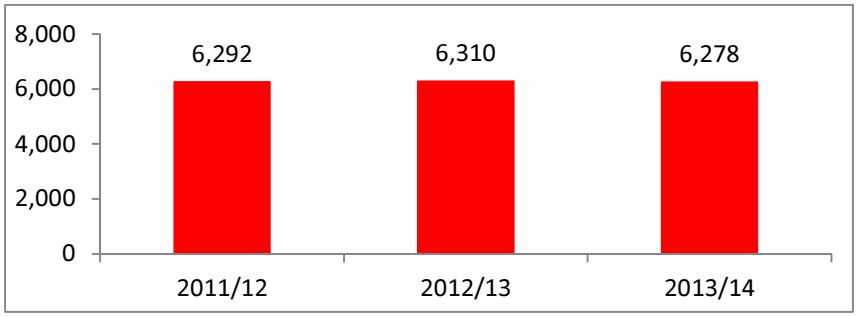
The pattern of social care provision has changed over recent years with fewer people wishing to enter long term residential/institutional care and a greater variety of community provision becoming available. Growth in personal budgets and direct payments has shown the potential for service users to arrange their own care and support, and it is expected that this trend will continue.

What does Community Care include in Barnet?

- Home care/Home and Community Support
- Day care
- Community meals
- Short term residential care
- Equipment and adaptations
- Direct payments
- Voluntary sector and local community support

Figure 9-4 shows the number of people in receipt of community care services over the period 2011-2014. Although there has been some slight movement in this figure, generally this has remained fairly constant.

Figure 9-4: Number of Service Users in Receipt of Community Care Services



Source: SWIFT – Adult Social Care Database

Table 9-9 breaks down the number of service users accessing community care service users by primary support need, as a proportion of the total number of service users receiving support. In 2013/14, 84.4% of all service users received some form of community care service, with all categories in excess of 70%, although, clients with learning disabilities had a significantly lower take-up rate (74.90% in 2013/14).

Table 9-9: Number of Service Users Accessing Community Care Services by Primary Support Need

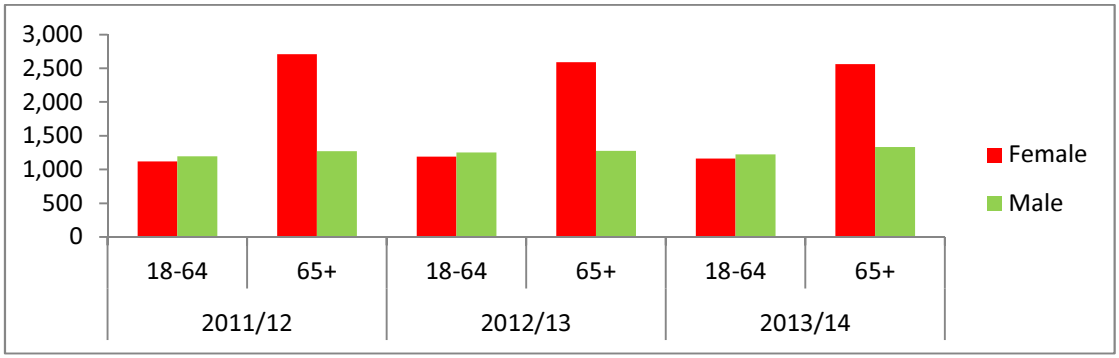
Client Category	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
Sensory Impairment (18-64)	752	92.16%	740	93.20%	710	93.42%
Learning Disability (18-64)	540	71.24%	551	73.27%	573	74.90%
Mental Health (18-64)	993	93.77%	1104	94.12%	1059	93.97%
Other (18-64)	28	93.33%	47	95.92%	42	95.45%
Older Adults	3,979	81.84%	3,868	81.07%	3,894	82.08%
Total Service Users	6,292	83.61%	6,310	83.70%	6,278	84.38%

Source: SWIFT – Adult Social Care Database

Figure 9-5 shows the breakdown of Community Care service users by age and gender. By age, the 18-64 age group accounts for around a third of the total clients, with the 65 and over client group accounting for around two thirds. This is roughly in line with the overall demographic breakdown of Adult Social care clients.

By gender, the proportion of 18-64 year olds accessing Community Care services is roughly the same across both males and females. However, females in the 65 and over category are significantly more likely to use community care services than any other client group. Whereas, there is very little difference between the numbers of men aged 18-64 receiving community care as those aged 65 and over. This could be partially due to women accounting for 56.5% of the 65 and over population (29,152) compared to men who account for 43.5% (22,423).

Figure 9-5: Number of Service Users by Age group and Gender



Source: SWIFT – Adult Social Care Database

9.8.1 Home and Community Support

Home and Community Support provides support to people in their own home, including older people who are frail or have health needs, as well as to people with disabilities or complex needs. It often follows a period of enablement where it is identified that the individual will require further support.

Currently the council's Home and Community Support service is delivered by three lead providers and a number of other contracted suppliers.

- At present, there are 28 homecare providers on the Barnet contract register.
- In 2013/14, the majority of community care clients received homecare.
- 80% of homecare clients were older adults (65+).
- The majority of younger adult (18-64) homecare recipients were people with a physical / sensory impairment.

Table 9-10: Number of Home Care Packages offered during the year

Number of Unpaid Carers	2011/12	2012/13	2013/14
Physical / Sensory Impairment (18-64)	290	282	271
Learning Disability (18-64)	173	196	209
Mental Health (18-64)	96	118	110
Other (18-64)	6	11	8
Older Adults	3,046	2,982	2,948
Total	**3,611**	**3,589**	**3,546**

Source: SWIFT – Adult Social Care Database

The Council has now adopted a 'community offer' approach. The community offer ensures that informal support; telecare, enablement and equipment are considered and offered before traditional care is provided.

Whilst the move towards a 'community offer' approach should help to reduce requirements for Home Care support, demographic projections indicate that the number of people potentially needing a service is due to increase significantly over the next 20 years. The council's modelling also indicates that an increased number of residents will come forward requesting social care support from the council as a result of the enhanced duties on councils arising from the Care Act.

9.8.2 Community Meals

The current community meals service provides a lunch time home-delivery service to service users across the Borough 7 days a week. An estimated 50,000 meals are delivered annually and approx. 200 meals per day.

In recent years there has been a decline in the number of people receiving community meals. Nevertheless, there continues to be an on-going demand for this provision across a range of ages and ethnic and cultural backgrounds.

Table 9-11: Number of Home Meal Packages offered during the year

Number of Unpaid Carers	2011/12	2012/13	2013/14
Physical / Sensory Impairment (18-64)	18	17	15
Learning Disability (18-64)	1	1	1
Mental Health (18-64)	8	9	17
Other (18-64)	1	0	2
Older Adults	513	466	442
Total	**541**	**493**	**477**

Source: SWIFT – Adult Social Care Database

9.8.3 Voluntary Services and Social Capital

Those not accessing social services may be purchasing care directly themselves, relying on the help of family and friends or benefitting from the support of the voluntary sector. Compared to other Boroughs, Barnet provides care to a relatively small proportion of the population indicating a strong voluntary sector as well as a willingness of users to purchase care independently. Many referrals to Adults & Communities are given advice or support at the point of referral and/or referred to an alternative support agency. This helps to ensure that people with moderate and lower level needs have these met in the community.

There are a significant number of charitable and community groups active in Barnet. The sector offers significant value for money by engaging residents as volunteers and bringing external funding into the Borough.

Services offered can be universal such as health promotion, befriending, digital inclusion, information and advice. There are targeted groups such as lunch clubs for Asian Elders and a Day Centre provision for Tamil Elders. There are also targeted services for people with dementia or for those who have suffered from a stroke.

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

Both the Barnet Ageing Well programme and the Neighbourhood model, stimulates increased use of social capital through effective use of volunteers and encouraging peer support, as well as encouraging and supporting local leadership. Projects such as the Barnet Timebank, Men's Sheds

and Altogether Better Projects are now well established with approximately 1,000 people now involved either as volunteers or beneficiaries.

Feelings of social isolation and loneliness are detrimental to a person's health and wellbeing. As more and more older and frail residents choose to stay at home for longer, there is even more of a need for local social groups and community health care facilities. The initiatives above help to address these issues, as they are user led and promote wellbeing.

9.9 Carers

A carer is a person who looks after or supports someone else who needs help with their day-to-day life because of issues such as their age, a long-term illness, disability, mental health or substance misuse. A young carer is anyone under the age of 18 who provides or intends to provide care for another person. Each caring situation is unique and every carer has different needs and priorities.

Data from the 2011 Census indicated that there were 32,256 residents who classified themselves as a carer in Barnet in 2011. By age, the largest number of carers were located within the 25-49 age group. Whereas, only 5,500 carers are registered with the Council's commissioned lead provider for carers support services in the Borough, indicating a significant proportion that remain hidden to the Council.

Table 9-12: Number of Unpaid Carers in Barnet

Number of Unpaid Carers	Total	0-24	25-49	50-64	65+
Provides unpaid care: Total	32,256	2,911	12,746	10,499	6,100
Provides 1 to 19 hours unpaid care a week	21,448	2,249	8,394	7,432	3,373
Provides 20 to 49 hours unpaid care a week	4,584	399	1,950	1,392	843
Provides 50 or more unpaid hours unpaid care a week	6,224	263	2,402	1,675	1,884

Source: Census 2011

By ward the areas with the highest level of carers were Mill Hill (1,800); Hale (1,724) and Brunswick Park (1,721). The wards with the lowest number of carers were Colindale (1,176); East Finchley (1,302) and Garden Suburb (1,332).

In proportion to the total population, Brunswick Park and Underhill had the highest rates of carers (10.5%), compared to Colindale which had the lowest (6.90%).

Table 9-13: Barnet Carers by Ward, 2011

Ward	Total (All Ages)	% of Total Population	0-24	25-49	50-64	65+
Brunswick Park	1,721	10.5%	136	664	606	315
Burnt Oak	1,554	8.5%	190	792	401	171
Childs Hill	1,623	8.1%	187	652	500	284
Colindale	1,176	6.9%	144	584	290	158
Coppetts	1,454	8.4%	138	645	483	188
East Barnet	1,645	10.2%	129	601	590	325
East Finchley	1,302	8.1%	93	545	419	245
Edgware	1,643	9.8%	162	593	551	337
Finchley Church End	1,452	9.2%	120	483	478	371
Garden Suburb	1,332	8.3%	61	407	501	363
Golders Green	1,575	8.3%	203	657	446	269
Hale	1,724	9.9%	160	709	557	298
Hendon	1,425	7.7%	152	586	443	244
High Barnet	1,567	10.2%	105	492	646	324
Mill Hill	1,800	9.7%	143	724	581	352
Oakleigh	1,592	10.0%	131	553	567	341
Totteridge	1,454	9.6%	94	495	507	358
Underhill	1,671	10.5%	140	635	560	336
West Finchley	1,363	8.2%	89	573	443	258
West Hendon	1,502	8.6%	170	656	406	270
Woodhouse	1,681	9.5%	164	700	524	293

Source: Census 2011

Not all carers are offered, or agree to have, an assessment. There are currently eligibility criteria in place for carer assessments but this will change with the introduction of the Care Act 2014.

Table 9-14 shows the number of carers who were assessed in Barnet over the period 2011-2014 by primary support need. As can be seen, there has been a downward trend in the number of carers being assessed over this period reducing from 2,432 in 2011/12 to 1,948 in 2013/14.

Table 9-14: Number of carers assessed by the primary support need of the cared for adult

Client Category	2011/12	2012/13	2013/14
Physical / Sensory Impairment (18-64)	226	248	177
Learning Disability (18-64)	115	171	160
Mental Health (18-64)	164	86	126
Other (18-64)	7	5	5
Older Adults	1,820	1,669	1,480
Total	**2,432**	**2,179**	**1,948**

Source: SWIFT – Adult Social Care Database

9.9.1 Current Provision

A range of support services are currently in place for carers. These include but are not limited to:

- Accessible information about the many support services available to carers and those they care for within the Borough;
- Carrying out assessments;
- Emergency planning;
- Telecare services for people who need devices to continue to live safely at home e.g. alarms and other equipment to alert support;
- Where a carer has been assessed as eligible for direct support from adult social care, respite care or direct payments may be offered;
- A commissioned a lead provider for carers support services which offers a range of support services including:
    - Individual and group support offering practical help and emotional support
    - Training
    - Short breaks where appropriate
    - Counselling and support service for families of disabled people
    - Benefits advice
    - A Carers forum

Table 9-15: Number of Carers in receipt of Carer Specific Services

Primary Support Need	2011/12	2012/13	2013/14
Physical / Sensory Impairment (18-64)	46	48	45
Learning Disability (18-64)	80	59	62
Mental Health (18-64)	78	46	63
Other (18-64)	0	0	1
Older Adults	402	303	369
Total	**606**	**456**	**540**

*Support services include: Training, Support Groups, Short Breaks, Counselling, Benefits Advice
** Respite services may be received in addition to the above; however some respite is recorded against the adult and not the carer, and so will not have been counted.

Source: SWIFT – Adult Social Care Database

Table 9-16: Number of Carers in receipt of information and advice only

Primary Support Need	2011/12	2012/13	2013/14
Physical / Sensory Impairment (18-64)	180	200	132
Learning Disability (18-64)	135	112	98
Mental Health (18-64)	86	40	63
Other (18-64)	7	5	4
Older Adults	1,418	1,366	1,111
Total	**1,826**	**1,723**	**1,408**

*Information and Advice includes referral to Carers Centre who then offer support

Source: SWIFT – Adult Social Care Database

9.9.2 The Value of Carers

According to Carers UK, there are 6.4 million carers in the UK reducing the national care bill by an estimated £119bn per year, equivalent to £18,594 per carer. Based on these figures and the 2011

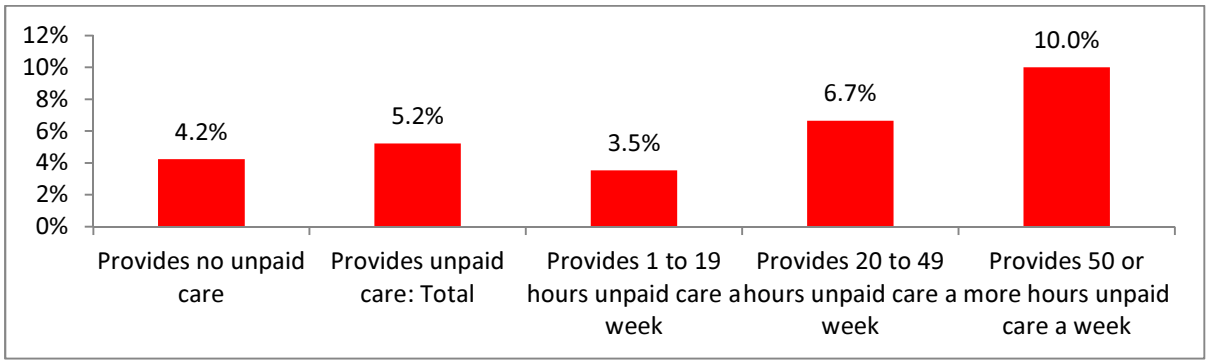
Census, Barnet's informal carers have a potential to save health and social care services, up to £595m per year[147].

While there are positive aspects to being a carer, some carers can experience changes in their health and wellbeing. Carers can suffer from increased stress, social isolation, financial hardship, ill-health and reduced personal time. Being a young carer can impact on a young person's childhood and can have a detrimental impact on educational attainment, health and emotional wellbeing, and the ability to make friends and have a social life.

On average, 5.2% of carers in the 2011 Census reported having poor health, compared to 4.2% of non-carers. There also appeared to be a correlation between the amount of care provided and health, with carers who provided 50 hours or more care a week being over two times more likely to report poor health than those providing 1 to19 hours of care.

Therefore, it is vital that to identify and support carers appropriately to ensure that they can continue with their caring role without it adversely affecting the own health and wellbeing.

Figure 9-6: Proportion of Unpaid Carers in Barnet in Poor Health



Source: Census 2011

9.9.3 Gaps in Current Provision

The Council recognises the need to:

- Continue to provide co-ordinated information and advice to carers;
- Improve carers access to preventative services which may be of benefit to them;
- Further embed good practise with staff and increase carers awareness throughout the Borough;
- Strengthen partnership working with key stakeholders to ensure that referral pathways are being utilised; and
- Ensure that carers are getting access to the right support when they need it.

There continues to be a real need to understand and quantify the impact that different services and support has on:

- A carers' ability to continue in their role;
- Helping carers to achieve their desired outcomes;

[147] Carers UK & University of Leeds, "Valuing Carers 2011: Calculating the Value of Carer's Support," Carers UK, London, 2011.

- Helping carers to look after their own health and wellbeing; and
- The savings that are achieved through doing this.

There is also a continued need for health and social care professionals to be aware of and take into account the mental and physical implications that caring brings.

The demand for carers is projected to grow with the increase in life expectancy, the increase in people living with a disability needing care, and with the changes to community based support services.

In addition to increased demand from demographic pressures, the new duties being brought in by the Care Act are expected to increase the number of people contacting the council and the number of people needing to be assessed.

Table 9-17 displays the estimated number of self-funders who are currently in residential care and use community services, as well as the number of existing care home and care agencies. This illustrates that, depending on demand, the local authority will have to engage with a significant number of people and providers with whom it does not currently engage.

Table 9-17: Number of existing self-funding carers and services

Type	No.
Self-funders in residential care	750
Self-funders who use community services	12,000
Residential and nursing homes	110
Home care agencies	72

Additional demand is also expected from people who live in their own homes, who currently do not receive care, coming forward. Local demand modelling, shown in Table 19-18, indicates that this could have a significant impact on demand.

Table 9-18: Additional demand from people living at home

Type	No.
Request a service user assessment	6,000
Additional support plans	4,710
Request a carers' assessment	9,620

In addition to the demand pressures discussed above, it should be noted that there will be other pressures relating to infrastructure and support costs.

9.10 Primary Support Needs

Barnet has adopted the social model of disability. Disability can have significant medical consequences but the difficulties /barriers that face people or that are often encountered in everyday life largely because of attitudes and existing structures in society. Disability is a social consequence of having impairment.

According to national projections, the most common health conditions/disabilities within Barnet relate to mental health disorders (common mental health conditions are included in this calculation) and hearing impairment in those aged 65 and over. The next largest group of people with disabilities are those with physical impairment aged between 18 and 64.

Table 9-19: Estimated number of residents by disability, illness or impairment, Barnet

Disability, Illness or Impairment	No.
Aged 18 and over predicted to have a learning disability	6,848
Aged 18-64 predicted to have a physical disability (moderate to severe)	22,024
Aged 65+ predicted to have limited mobility	10,002
Aged 65+ predicted to have a disabling visual impairment	4,780
Aged 65+ predicted to have a disabling hearing impairment	31,292
Aged 18-64 predicted to have a mental health problem	58,053
Aged 65+ predicted to have Dementia	3,978

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

9.10.1 Mental Health

Mental disorders are responsible for the largest burden of disease in England – 23% of the total burden, compared to 16% for cancer and 16% for heart disease.

Adults with a severe and enduring mental illness face considerable social exclusion. This is evidenced through high rates of unemployment, social isolation, poorer physical health and insecure housing arrangements within this group, all of which create demand on other services.

Despite an expected increase in the number of people with mental health conditions, over the period 2011-2014 the number of Adult Social Care service users with mental health conditions has marginally reduced. However, the prevalence rate of service users with mental health conditions remains relatively high, with 24.2% of all clients having some form of mental health disorder in 2013/14.

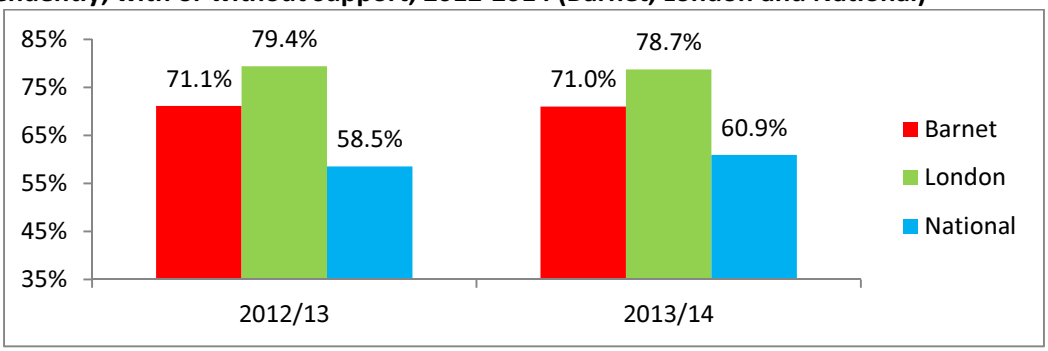
Table 9-20: Number of mental health service users

Age Group	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
18-64	1,059	39.8%	1,173	42.4%	1,127	41.8%
65+	730	15.0%	702	14.7%	675	14.2%
Total	1,789	23.8%	1,875	24.9%	1,802	24.2%

Source: SWIFT – Adult Social Care Database

Where possible, Barnet would like all service users to remain at home and independent for as long as they wish to. In 2013/14 a smaller proportion of Barnet's residents who were in contact with secondary mental health services lived independently than the London average; 71.0% and 78.7% respectively. However, this is significantly above the National average of 60.9%.

Figure 9-7: Proportion of adults in contact with secondary mental health services who live independently, with or without support, 2012-2014 (Barnet, London and National)



9.10.1.1 Current Provision

One in four people will need treatment for mental illness at some time in their lifetime and the majority of these treatments will be managed in primary care. Mental illness forms a large and growing proportion of primary care presentations, with one in three GP appointments involving significant mental health issues. This puts GPs and practice nurses at the centre of providing whole person care. Increasingly, this also involves promoting health and engaging with social care and the wider determinants of health.

The CCG spends 8.2% of its overall expenditure on direct mental health services. By far the most significant element of the CCG's mental health expenditure is in secondary mental health (i.e. hospital/residential settings).

Local secondary mental health services are delivered by the Barnet, Enfield and Haringey Mental Health Trust. Other NHS Trusts such as Central North West London Foundation Trust, Camden & Islington Foundation Trust, Tavistock and Portman Foundation Trust and South London & Maudsley Foundation Trust provide a range of secondary and specialist mental health services for Barnet patients, some of whom go on to reside in neighbouring Boroughs.

There are 1,305 adults and older people with mental illness known to the Council receiving social care services. A further 15 people are in receipt of health rehabilitation services funded by the CCG. Third sector and independent organisations such as Richmond Fellowship, MIND in Barnet and Barnet Refugee Service provide a range of support services including residential provision, housing/tenancy support, community inclusion, peer support, employment support etc.

9.10.1.2 Key Issues

The number of people with Mental Health needs in Barnet is expected to continue to increase, especially in the older age patient group due to an above average increase in the number of people in the local older population.

Table 9-21: Mental Health Projections for Barnet Population, 2014-2018

	2014	2015	2016	2017	2018
People aged 18-64 predicted to have a common mental disorder	38,076	38,542	39,061	39,572	40,046
People aged 18-64 predicted to have a borderline personality disorder	1,066	1,079	1,093	1,107	1,120
People aged 18-64 predicted to have an antisocial personality disorder	815	828	842	856	869
People aged 18-64 predicted to have psychotic disorder	946	958	971	983	995
People aged 18-64 predicted to have two or more psychiatric disorders	16,975	17,196	17,438	17,680	17,901
* Figures may not sum due to rounding. Crown copyright 2014					
** The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem					

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

A CCG commissioned review examined the current mental health services provided by Barnet, Enfield and Haringey Mental Health Trust and advocated modernising the current secondary care services towards a community based model of care (delivery within the community).

The evidence base for mental health disorders overwhelmingly demonstrates the benefits of more upstream investment in primary care and community services and one which focuses on prevention, early intervention and recovery, in improving patient experience, outcomes, quality, cost effectiveness and return on investment. The level of mental health support and training in primary care does not often reflect this level of need and responsibility. Best practice sources recommend that mental health problems should be managed in primary care, with primary care mental health teams working collaboratively with other services to access specialist expertise and skills[148].

9.10.2 Learning Disabilities

The proportion of people with learning disabilities (PWLD) is under 0.5% of the overall Barnet population; however over 11%% of Adult Social Care service users are PWLD. A 14% growth in the number of residents with moderate to severe learning disabilities is projected over the next decade.

Table 9-22 below shows the estimated number of PWLD in Barnet (as at 2014). This includes people with a lower level of need who, although unlikely to qualify for social care support, are still supported by the learning disability nurses and other healthcare professionals within the integrated learning disabilities team.

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

Table 9-22: Estimated number of People with Learning Disability

Estimated number of PWLD - 2014	
18 – 34 years	2,438
35 – 64 years	3,321
65 +	1,071
Total	**6,830**

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

Table 9-23 shows the number of PWLD who are in receipt of support by adult social care, as a proportion of the total number of service users. Overall the number and proportion of service users with PWLD has remained relatively stable during the period 2011-2014.

Table 9-23: No. and % of Service Users with Learning Disability

Age Group	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
18-64	758	28.5%	752	27.2%	765	28.4%
65+	94	1.9%	99	2.1%	105	2.2%

Source: SWIFT – Adult Social Care Database

However, this current trend is not expected to continue in the future. Improved survival rates at birth, increasing life expectancy, and growth among communities at higher risk of learning disabilities (for example, the South Asian community) mean that more PWLD and people with complex needs accessing adult services are expected to access the service in the future. The majority of these residents will require on-going social care throughout their lives.

Table 9-24: LD Projections for Barnet Population

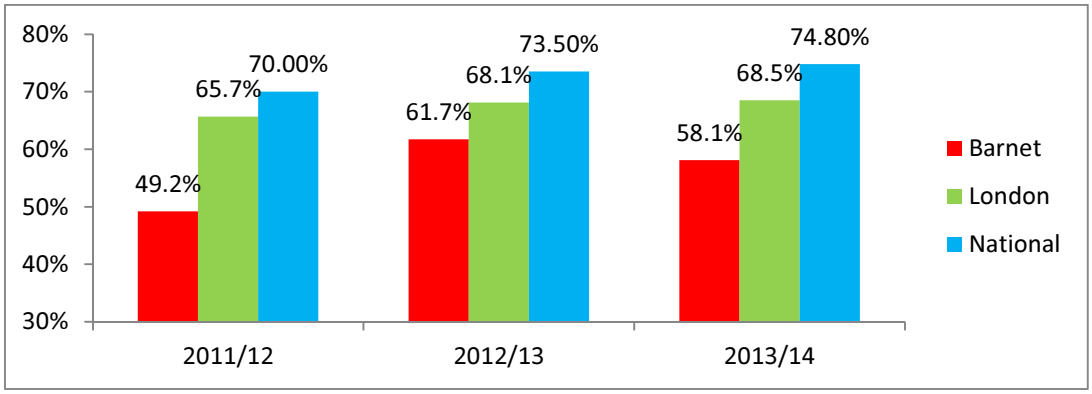
Predicted to have a moderate or severe learning disability	2014	2015	2016	2017	2018
People aged 18-24	193	192	190	189	191
People aged 25-34	343	346	349	351	352
People aged 35-44	346	353	362	369	377
People aged 45-54	256	262	268	272	276
People aged 55-64	176	180	184	189	194
People aged 65-74	95	98	101	103	104
People aged 75-84	35	35	35	36	37
People aged 85 and over	15	15	16	17	17
Total population aged 18 and over	1,459	1,481	1,504	1,526	1,548
* Figures may not sum due to rounding. Crown copyright 2014					

Source: Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) 2015

An enquiry into abuse of people with Learning Disabilities and autism at Winterbourne View identified that many people with learning disabilities and/or autism remain in hospital or residential homes for too long. Even though many are receiving good care in these settings, many could lead happier lives living at home in the community.

The proportion of people in 2014 living independently (in their own home or with their family) in Barnet is significantly below the London and National averages. Furthermore, there was a slight decrease between 2012/13 (61.70%) and 2013/14 (58.10%).

Figure 9-8: Proportion of adults in contact with Adult Social Care with learning disabilities who live independently, with or without support, 2011-2014 (Barnet, London and National)



Source: SWIFT – Adult Social Care Database

The Government's Green Paper[149] sets out proposals to give people with learning disabilities, autism and mental health conditions more rights around the care they receive. Whilst this is subject to consultation and a programme of legislation, it is a significant policy shift which will mean that PWLD and autism will have a right to be treated near their home and family and wherever possible in community settings. There will also be a reduction in the number of beds available in hospital assessment and treatment units.

This change will be in addition to the increase in numbers of people with complex needs who will be accommodated in community settings. It is therefore expected that the trend shown in Table 9-25, towards increased community based provision and decreasing residential care will continue in the future.

Table 9-25: People with Learning Disabilities accessing social care

Number of Unpaid Carers	2011/12	2012/13	2013/14
Residential Care	296	272	238
Community Care (settings)	580	609	632

Source: SWIFT – Adult Social Care Database

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

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

9.10.2.1 Confidential Enquiry into the Premature Deaths of People with Learning Disabilities

The confidential enquiry into the premature deaths of people with learning disabilities (CIPOLD)[150] identified that people with learning disabilities die 16 years sooner on average than the general population and more than a third of these deaths are attributable to people not getting the right healthcare.

The enquiry found that there was not enough routine collection of data to provide information about the age and cause of death of people with learning disabilities. The Department of Health response included a recommendation that systems should be in place to ensure that local learning disability data should be analysed and published with population profiles and within the JSNA[151].

Specific comparative data is also required between the health of people with learning disabilities and the general population. On average, people with learning disabilities have poorer access to healthcare and die younger than their non-learning disabled peers; however there is a lack of robust data from which the JSNA and Health and Wellbeing Strategy can be informed. Additional data is needed around four major long term health conditions (obesity, diabetes, cardiovascular disease and epilepsy) to enable a more effective response to clinical needs and be in better position for future planning of reasonably adjusted health services for people with learning disabilities.

Health screening data will help to develop a better understanding of whether more PWLD are accessing such services, for the annual LD self-assessment it was found that 51 women with LD aged between 25 – 64 years had accessed cervical cancer screening and six PWLD aged 60 – 69 years had received bowel cancer screening.

9.10.3 Older Adults

People aged 65 and over account for the largest client group within adult social care. With the projected population within this age group, there is likely to be an increased need for services, during a time of more limited resources.

9.10.3.1 Social Isolation

Feelings of social isolation and loneliness are detrimental to a person's health and wellbeing[152]. In the 2013 Annual User Experience Survey 24% of respondents said they either had some but not enough social contact, or felt socially isolated. In Barnet there are an estimated 18,300 older adults living alone, making up 38% of the elderly population in the Borough.

In 2014, the Barnet Customer Support Group Insight team carried out a piece of analysis to develop a profile of the types of people within Barnet that were likely to experience some level of social isolation. The analysis found that social isolation was most common amongst *women, aged 75 and over* who were *living alone*.

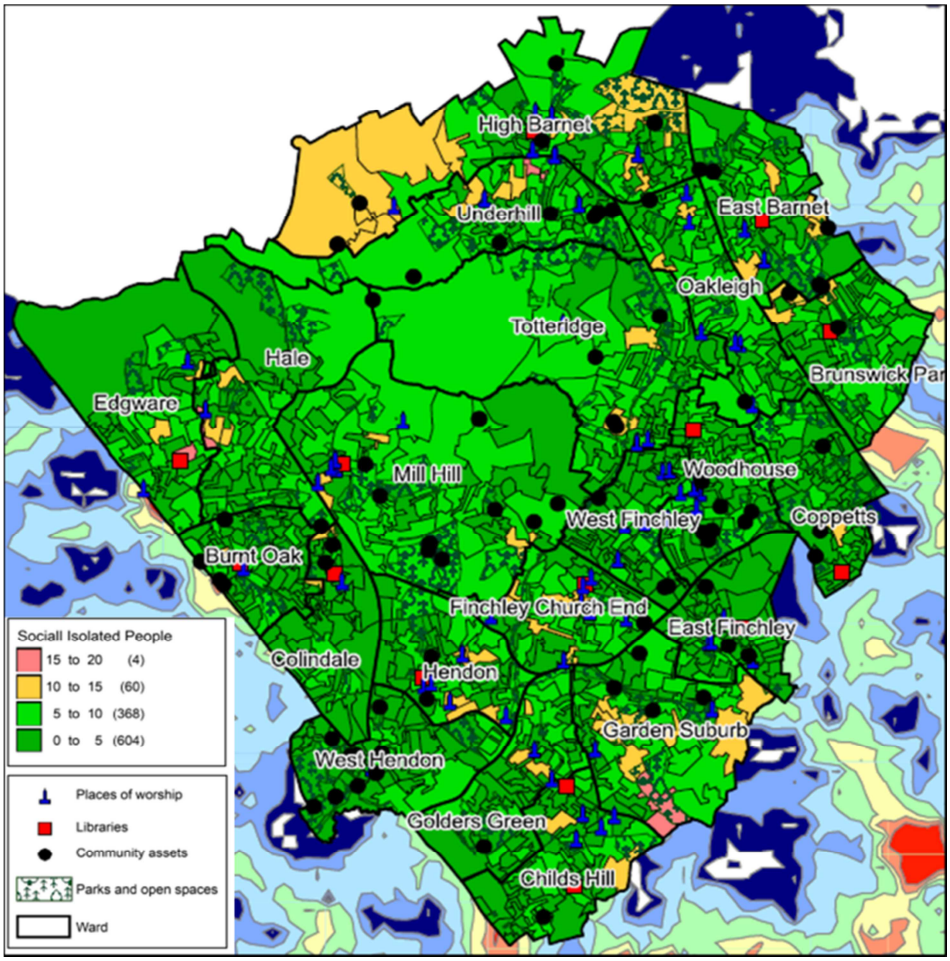
Figure 9-9 shows a map of socially isolated people in Barnet in 2014.

[150] http://www.bris.ac.uk/cipold/
[151] 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
[152] Rachel Wells PPT http://www.communitybarnet.org.uk/data/files/Rachel_Wells_-_Social_Isolation_and_Public_Health.pdf

The issue of social isolation is Borough-wide. However, Burnt Oak, Colindale and West Hendon have the lowest number of people likely to be socially isolated. Older people in these areas tend to be long-term residents having strong ties with the community.

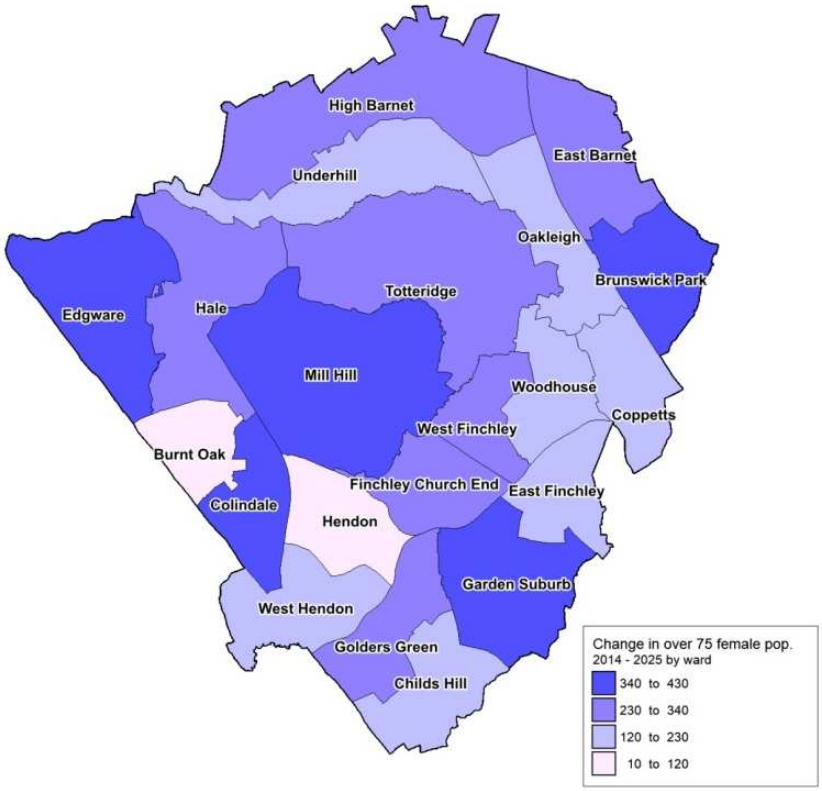
Less densely populated, more affluent areas in the north of the Borough were identified as possible hotspots for social isolation.

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



9.10.3.1.1 Possible Future Hotspots of Social Isolation

Figure 9-10: Change in over 75 year old female population by ward, 2014 – 2025



Source: GLA 2013 Population Projections (Borough Preferred Option)

There will be an estimated 5,300 more females aged 75 and over by 2025, an increase of 37%.

The largest increases are in Edgware, Mill Hill and Garden Suburb. Garden Suburb and Mill Hill both have large isolated populations at present.

Colindale currently has relatively few isolated people. However, as the population grows with regeneration, the number of people at risk of isolation will also increase.

As more older and frail residents opt to stay at home for longer, there is an increased risk of people becoming socially isolated, driving up the need for local social groups and community health care facilities.

9.10.3.2 Dementia

Barnet Council follows the principles and practice of the National Dementia Strategy and the Prime Minister's Challenge on Dementia and this will inform the Council's approach over the next five years.

Barnet has a higher population of people with dementia than many London Boroughs and the highest number of care home places registered for dementia per 100 population aged 65 and over in London. By 2021 the number of people with dementia in Barnet is expected to increase by 24% compared with the London-wide figure of 19%.

Table 9-26: Population of people in Barnet over 65 with dementia, 2015-25

Year	Projected Population (65+) in Barnet with Dementia	% change from 2015
2015	4,044	
2020	4,693	16.05%
2025	5,536	36.89%

Source: NHSE Data

The significant increase in the number of people with dementia will require appropriate support for people with dementia and their family /carers. Services and communities are seen as key to this, and so there is a need to develop support from dementia friendly communities.

9.10.4 Autism

Approximately 1% of the adult population have an Autistic Spectrum Conditions (ASC) which equates to about 2,600 people in Barnet. In 2012/13, autism was recorded as a care need for 170 social care service users. National forecasts indicate that the number of young adults with autism will increase by 2.7% over the next 5 years, in Barnet this will mean a 9% increase. These figures show that there are more cases of ASC being diagnosed.

A comprehensive assessment of the needs of people with autism was undertaken by Public Health (PH) in November 2014. It was completed in collaboration with the with the purpose of informing the Autism Strategy.

The key areas covered by the needs assessment were:

- Prevalence of autism in Barnet
- Identifying services available in Barnet
- Comparison of service provision with national guidance

The estimated prevalence of autism amongst children aged 5-9 years old is 300, using the current population. This figure is similar to that produced using the Baron-Cohen et al study in 2012.

Unfortunately there is no robust data on the actual numbers of adults with autism, although estimates indicate that there are an approximately 2,324 people with autism within those aged 18-64. This number is expected to increase to 2,550 by 2020.

The current lack of comprehensive data on the numbers of adults with ASC in Barnet impacts on the ability to accurately plan and deliver the services that are needed for people with ASC and their carers, although prevalence estimates, which give an indication of the total number of people with ASC in the Borough, can be useful.

The study acknowledged the following limitations:

- Services do not routinely collect data on the number of clients with autism.

- "Diagnostic overshadowing" means that some clients with learning disabilities or mental health problems accessing services may also be suspected of having ASC, but are not diagnosed.
- Clients with Asperger's may not be accessing statutory services or be eligible to receive support. It is likely that there are more people with ASC than those known to statutory agencies.
- Individuals can access diagnostic services from a range of private providers and may, therefore, not be known to local NHS providers.

A key priority is to enable the development of the systems to accurately capture and record the numbers of adults with ASC. The focus should be on those areas where data is lacking and where a need has been identified:

- The range of need for support to live independently
- The number of adults with ASC who are likely to need employment support in order to work
- The number living at home on their own or with family members and not receiving health or social care services, and
- The number living with older family carers.

9.10.5 Physical and Sensory Impairment

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

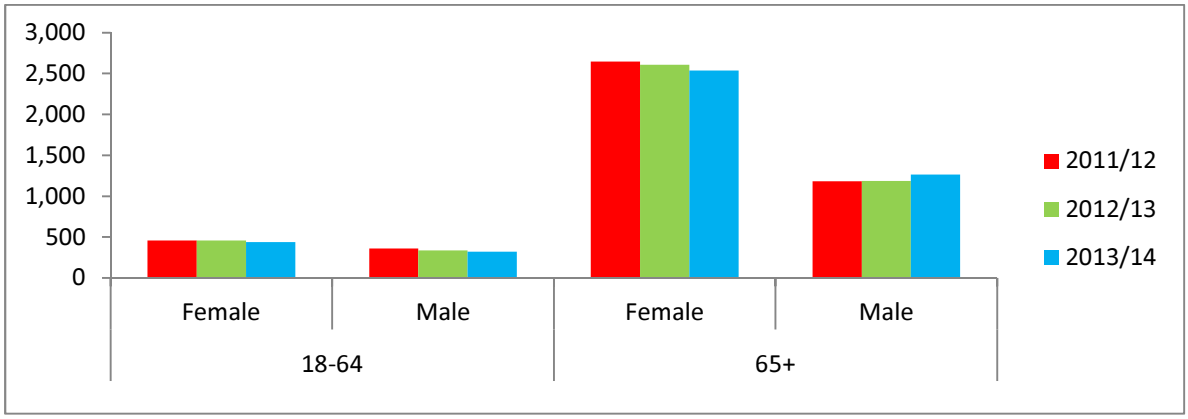
Table 9-27: No. and % of Adult Social Care categorised as Physical Disability and Sensory Impaired

Age Group	2011/12		2012/13		2013/14	
	No.	% of Total Service Users	No.	% of Total Service Users	No.	% of Total Service Users
18-64	701	26.30%	689	24.90%	656	24.30%
65+	3,352	68.90%	3,353	70.30%	3,427	72.20%

Source: SWIFT – Adult Social Care Database

As shown in Figure 9-11, across both age categories there are more females with physical or sensory impairments than male. And within the 65 and over age group, there are more than twice as many women with physical or sensory impairments as men. However, within the 65 and over age group, women account for 56.5% of the population (29,152) compared to men who account for 43.5% (22,423).

Figure 9-11: Gender of Physical Disability & Sensory Impaired Service Users



Source: SWIFT – Adult Social Care Database

The high rates of service users with physical or sensory impairments may mean that enabling people to remain in their own home could require them to have access to resources and support from prevention services and / or statutory services.

9.10.5.1 Key Issues

- The number of people with a Physical and /or sensory impairment is increasing.
- This will have an impact on the demand for services such as appropriate housing /support needs.
- Due to medical improvements people with physical and /or sensory impairment are living longer and therefore resources are required for a longer period of time to support them.
- There is a need for improvements in the provision of health and social care needs.

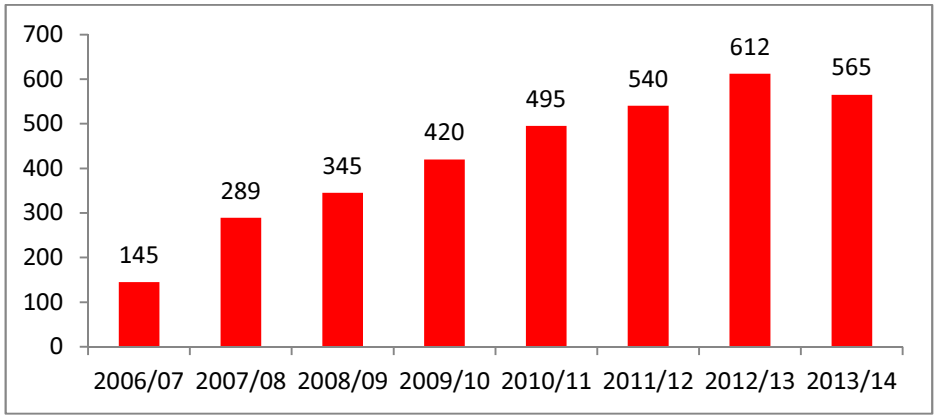
9.11 Safeguarding

Barnet's Safeguarding Adults Board was established in July 2001. It is made up of senior officers from the different public services who work with vulnerable adults in Barnet. The
Board has four main aims:-

- To promote the welfare of vulnerable adults and to develop good practice in health and social care services;
- To raise awareness of abuse wherever it occurs and to encourage people to report it if it happens;
- To ensure that agencies work effectively together to ensure abuse is investigated and that people are helped to remain safe;
- To learn lessons where people have not been adequately protected.

In 2013/14 Barnet Council received a total of 565 alerts, an 8% decrease from the previous year. This was the first drop in alerts received in 7 years.

Figure 9-12: Safeguarding Alerts, 2006-2014



The number of alerts investigated under the Council's safeguarding procedures in 2013/14 remained very similar to the previous year. This would suggest that there is an improved understanding of what safeguarding is and how the Council can help people who are affected.

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

For every case investigated, the Council decides if the abuse 'happened' (substantiated), 'part happened' (partly substantiated), or 'did not happen' (not substantiated). In some cases it is not possible to establish what has occurred leading to an outcome of 'not determined'.

Table 9-28: Concluded Investigations

Conclusion	2011/12		2012/13		2013/14	
	Number of Cases	% of Cases	Number of Cases	% of Cases	Number of Cases	% of Cases
Abuse sustained	148	39%	148	39%	120	33%
Abuse partly sustained	40	10%	25	7%	33	9%
Abuse not sustained	102	27%	120	32%	134	36%
Not determined	92	24%	82	22%	82	22%

The Safeguarding Adults Board has set the following four strategic priorities for 2014/15:

- Improve the standards of care to support the dignity and quality of life of vulnerable people in receipt of health and social care, including effective management of pressure sores.
- Improve the understanding of service providers of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Improve access to justice for vulnerable adults.
- Increase the understanding among the public of what may constitute abuse.

Details of how the Council plans to deliver these priorities can be found in the SAB Business Plan for 2014/16.

9.12 Providers and Provider Failure

Care Quality oversees the contract management relationships and compliance with providers across adult social care. To ensure quality and service improvement strategic and operational contract management and other data intelligence such as safeguarding information, service user reviews and on-going dialogue with the CQC are reviewed. A provider experiencing difficulties in maintaining quality or financial sustainability will be managed and supported in a variety of ways to ensure continuity of care.

In a small number of instances, provider failure is unavoidable and in such circumstances, the primary focus is the continuity of care and support for those affected. Alternative care providers will be procured within a managed project to ensure a smooth transition. Table 9-29 displays the current number of contracts held within supply management and is broken down across service areas.

Table 9-29: Service providers by service type

Service	No of Providers
Home Care	28
Day Care	20
Supported Living (SL)	52 (31 on SL Framework)
Electronic Call Monitoring	1
Alarm Services	11
Extra Care	3
Floating Support Services & Mental Health Services	1
Housing related support	6
Meals	1
Residential & Nursing	224
Prevention Services	18

9.12.1 Care Act 2014 requirements for provider failure

The Care Act 2014 states there is a statutory duty on local authorities when a provider failure occurs and that there is a temporary duty to ensure that people's care is not interrupted. The duty applies temporarily until the local authority is satisfied that the person's needs are met by the new provider. There are specific conditions in which the duty is applied:

- A registered care provider
- Unable to carry out a regulated activity
- This is due to business failure (business failure constitutes appointment of an administrator, appointment of receiver, passing of a resolution for a winding up order)

The Care Act also gives powers to the Care Quality Commission (CQC). The Market Oversight Regime will give CQC powers to monitor the financial sustainability of certain hard to replace providers. This may be due to their size or specialism which would prove difficult to replace if they were to fail.

9.12.2 Key learning from previous provider failure

Capacity building to ensure a sustainable market in the medium to long term is acknowledged as a key commissioning and supply management component to ensuring providers deliver quality

services. Understanding and shaping the market will need to be a firm feature in contractual relationships.

A Provider Failure Policy will be implemented as part of implementing the Care Act. A procedure will cover how Barnet will manage a provider failure whether the Care Act duty is enacted or not. The procedure will form part of the business continuity plan.

9.13 Voice

Barnet Council and its partners conduct public consultations which seek to understand the opinions and experiences of local residents and service users across a wide range of subjects. The following section details insight lifted from recent consultation related specifically to health and social care.

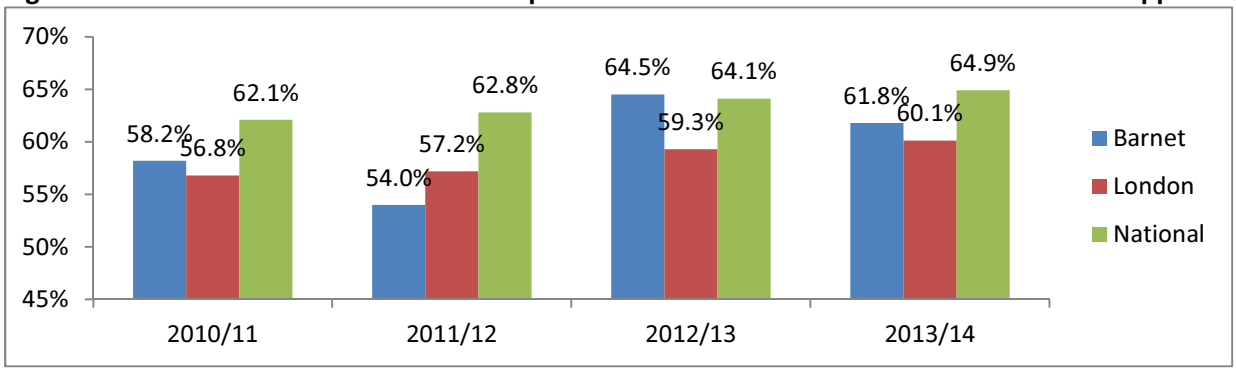
9.13.1 User and Carers' experiences of Social Care

Adult Social Care capture information about the service user experience through two surveys:

- The annual National Service User Survey (for service users aged 18 and over), which explores how effectively service users are supported to achieve a good quality of life,
- The National Carers Survey, which highlights how successfully or otherwise carers are supported in their caring role and their life outside of caring. It also captures their perception of the support received by the person they care for. This survey is carried out every two years and was last run in 2012/13.

The last National Adult Social Care Service User Survey was carried out in 2013/14. Responses showed that the level of service user satisfaction had fallen slightly, since 2012/13, with fewer feeling the care and support services they received had helped them with daily activities and their general wellbeing. Fewer service users found it easy to obtain information and advice and less actively sought information.

Figure 9-13: Overall Satisfaction of People who use Services with their Care and Support

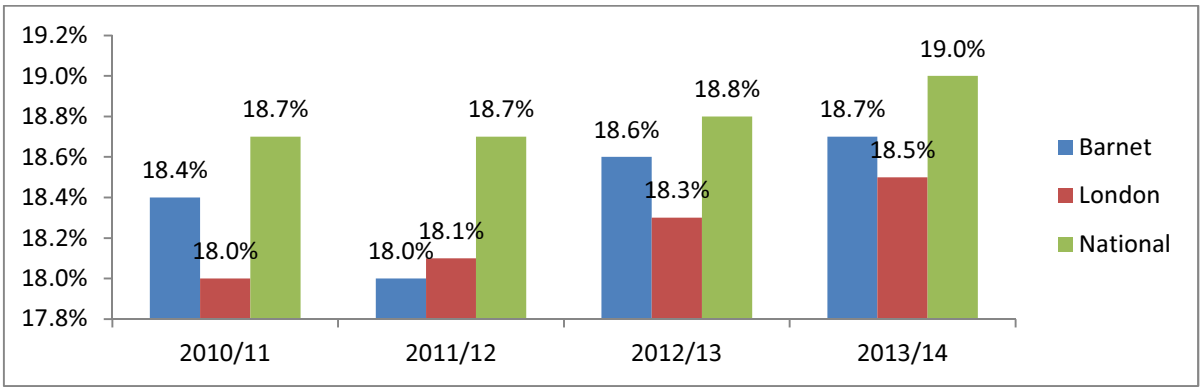


Source: National Adult Social Care Service User Survey 2013/14

Self-reported general health had declined a little since 2012/13 and there had been a significant increase in the proportion of service users experiencing pain or discomfort, with nearly three quarters of service users reporting some level of pain/discomfort.

Despite the above, service users were reporting a similar level of capability with day to day tasks as reported the previous year, along with a significantly improved perception of quality of life.

Figure 9-14: Social-Care Related Quality of Life



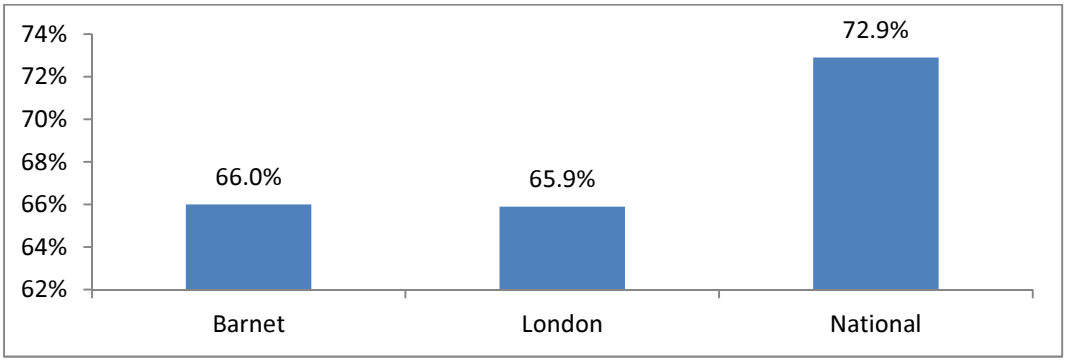
Source: National Adult Social Care Service User Survey 2013/14

The Carers Survey was piloted in 2010/11 and the first national version of the survey was run in 2012/13.

For Barnet, results in 2012/13 showed 34.6% of carers were extremely or very satisfied with the service they received, which was in line with the comparator group average of 35.4%. The proportion of respondents dissatisfied with the service they received had fallen since the pilot survey from 13% to 9%.

66% of carers always or usually felt involved in discussions about support and services for the person(s) they cared for. This was a decrease on the 72% reported in the pilot survey; however Barnet remained in line with its comparator group average.

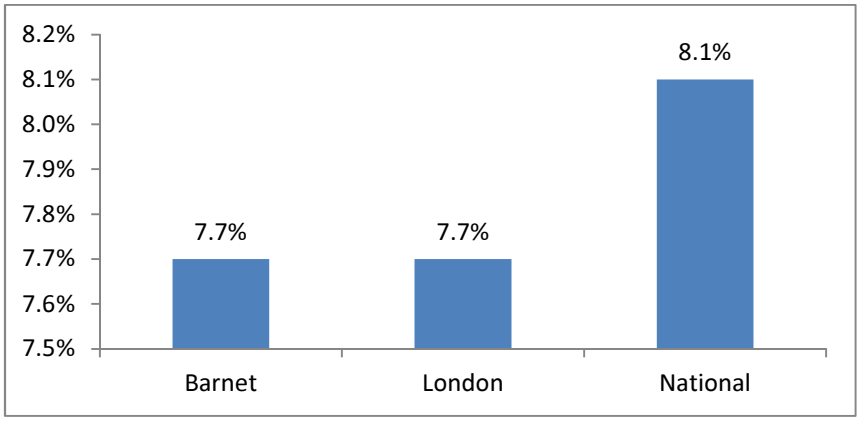
Figure 9-15: Carer's Involvement in Discussions



Source: The Carers Survey 2012/13

Between the pilot survey and the first national version in 2012/13, there was a growth in the number of carers receiving information and advice, as well as support for carers to talk in confidence or to stay in employment. Most carers felt that they could do some of the things they enjoyed with their time but not enough (21% in 2012). However; in 2012/13, 15% of carers felt they did not do anything that they valued or enjoyed. These figures were very similar across all comparable local authorities in London.

Figure 9-16: Carer related quality of life



Source: The Carers Survey 2012/13

10 Community Safety

10.1 Key Facts

- Crime has seen a long-term downward trend over the last 10 years from a peak of over 35,000 crimes a year in 2005, to under 25,000 in the 12 months up to February 2014.
- Overall Barnet has experienced 11% less crime in the 12 months between March 2013 and February 2014[153] compared to one year ago.
- There are fewer victims of crime (in the 12 months up to 25 February 2014) compared to one year ago: 747 fewer households being victims of residential burglary, 68 fewer victims of non-residential burglary, and 372 fewer people becoming victims of robbery in the Borough[154].
- In the 12 months up to January 2014 Barnet had the 8th lowest crimes per 1000 population of all 32 London Boroughs.

10.2 Strategic Needs

- **Barnet has the 5th highest rate of residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary still remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to February 2014. When considering underreporting, the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the year.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to increase underreporting.
- **Violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs, despite making up just 6.5% of the offences**.
- **Domestic violence is more familiar within some services and organisations than other Violence Against Women and Girls (VAWG) issues**; further work needs to take place to identify if additional VAWG services are needed within the Borough.

10.3 Overview

The statutory duty for Barnet Safer Communities Partnership[155] 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.

[153] Source: Published MPS crime stats (SAroot\data\crime_stats_mps_published_toFeb2014.xlsx)
[154] Source: MPS DOI performance stats (SAroot\data\sx_dash_to25Feb2014.pdf)
[155] 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[156]. The estimates take into account anticipatory costs (for example security expenditure), consequential costs (e.g. property stolen, emotional or physical impacts), and response costs (e.g. costs to the criminal justice system).

Table 10-1 calculates total cost estimates for different crime types in Barnet by multiplying the Home Office unit cost estimate by the number of offences in the Borough in one year (2013).

Table 10-1: The Estimated Annual Cost of Crime in Barnet, 2013

Type	Estimated Annual Cost (2013)	% of Total Cost
Violence - ABH and GBH	£22,813,255	30.9%
Sexual Offences	£13,117,960	17.8%
Burglary in a Dwelling	£10,817,300	14.6%
Robbery - Personal Property	£5,937,940	8.0%
Burglary in Other Buildings	£5,875,200	8.0%
Theft / taking of Motor Vehicle	£3,772,230	5.1%
Theft from Motor Vehicle	£3,079,252	4.2%
Other Theft	£2,759,008	3.7%
Common Assault	£2,115,750	2.9%
Criminal Damage Total	£2,016,495	2.7%
Robbery - Business Property	£693,528	0.9%
Theft Person	£576,065	0.8%
Theft / taking of Pedal Cycle	£173,201	0.2%
Theft from Shops	£146,072	0.2%
Total Annual Cost (excluding some crime types*)	£73,893,256	

This gives an estimated annual total cost of around £73.9M for reported crime in Barnet in one year. Note this estimate does not include costs for the following offences: Drugs; Fraud; Handling; Motor Vehicle Tampering; Harassment; Carrying of Weapons; and Violence other than Common Assault, ABH, GBH. The estimated costs of unreported crime are also not included in this figure.

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

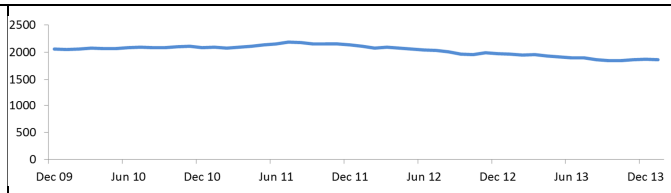
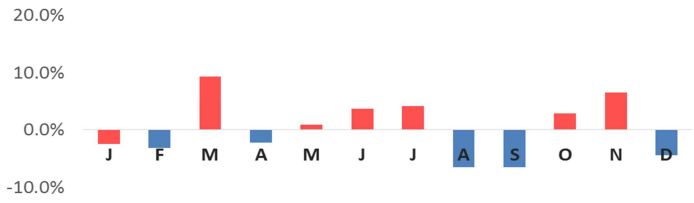
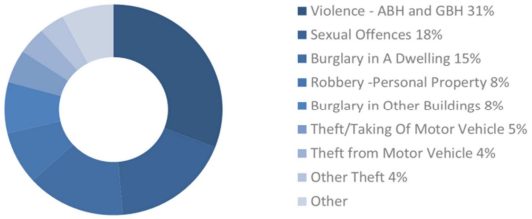
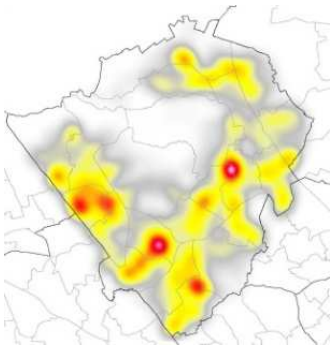
10.5 Summary of All Recorded Crime in Barnet

Current Figures refer to the 12 month period ending 31 Jan 2014[157]	
Level of crime	**22,837 crimes** / 62.75 per 1000 residents
Peer comparison	8th/32 in London and 4th/15 in 'Most Similar Group'
Annual Change	Reduction of 2804 crimes / 10.9% compared to one year ago *(this figure is for 12 months to Feb 2014)*[158]

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

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

158 Source: SAroot\data\crime_stats_mps_published_toFeb2014.xlsx

<table>
<tr><td>General Trend</td><td> 
</td><td>Falling from late 2011 to late 2013, appears to be levelling off</td></tr>
<tr><td>Seasonality</td><td> 
</td><td>March followed by November are the peak months</td></tr>
<tr><td>Breakdown of crime types</td><td> 
</td><td>Breakdown of estimated annual cost of crime on Barnet by crime type</td></tr>
<tr><td>Hotspots</td><td>  </td><td>Five Wards (All Crime, to Feb 2014)[159]

West Hendon 1890
Childs Hill 1775
Coppetts 1403
Hendon 1339
Golders Green 1289
The top 5 account for 34% of the Borough total</td></tr>
<tr><td>VOL(T) analysis</td><td colspan="2"><table>
<tr><td>Victim</td><td>The top locations where victims of crime live (irrespective of where the offence occurred) in descending order are HA8, NW9, EN5, NW4, NW11</td></tr>
<tr><td>Offender</td><td>Peak age for arrests in Barnet is 16-24 year old (35% of all arrests). Most arrested suspects are male (86.5%). Because of repeat offending a small proportion of offenders are responsible for a disproportionately large amount of crime</td></tr>
<tr><td>Location / Time</td><td>The top five areas based on the offence location are (in descending order): HA8, NW4, EN5, NW9 and N12</td></tr>
</table></td></tr>
</table>

10.6 Anti-Social Behaviour (ASB)

- Barnet residents made 11,798 ASB related calls to police in the 12 months to 25 February 2014; 308 of these were repeat callers[160].
- These figures represent a 12.7% reduction in total ASB calls and 13.2% reduction in ASB repeats compared to the previous year.

159 Source: SAroot\data\mpsBarnet12monthsWardTNOstats.xls

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

- According to Barnet's Residents' Perception Survey: 70% of residents are very or fairly satisfied that police and the Council are dealing with crime and ASB in their local area which is up 2% from 2012 RPS, but down from 75% in 2010.
- The top (and increasing) ASB concern is rubbish and litter lying around[161].
- When asked in the Community Safety Survey 2011 'Imagine you could set local priorities to improve safety in this area', the top response was reducing levels of ASB and disorder (50% of residents said this would be in their top three priorities).

10.7 Residential Burglary

- Between 2008 and 2011 the rate of residential burglary in Barnet increased (in total by around 1,000 offences per year), remaining at a high level during 2012 and early 2013. Since April 2013 residential burglary levels in the Borough have fallen.
- Barnet's current sanction detection rate for residential burglary (19.7%) is the highest of all 32 London Boroughs. If Barnet is able to maintain such a high sanction detection rate, this will help contribute towards a sustained long term reduction of residential burglary in Barnet.
- Cross border burglary is the most significant contributor to overall burglary levels; during a 12 month sample period 64% of suspects were from outside of the Borough.
- Analysis of the distribution of residential burglaries in the Borough shows that houses in some streets in Barnet face a risk of burglary of at least double the Borough average. Many such streets back on to open space such as parks, allotments and alley ways.
- Near repeat phenomenon: studies have identified that for a time following a burglary, the homes in the vicinity of the burgled venue face a raised risk of being burgled.

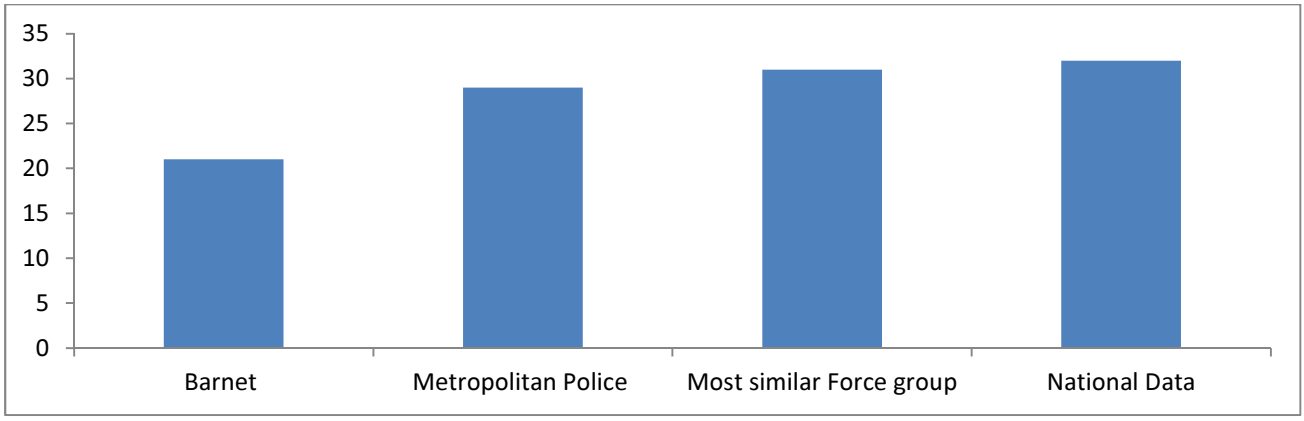
10.8 Domestic Violence and Violence Against Women and Girls (VAWG)

Nationally, it is estimated that one in four women experience domestic violence in their lifetime and two women are killed every week due to domestic violence. The exact volume of Domestic Violence (DV) and Violence Against Women and Girls (VAWG) is unknown nationally. Some agencies collect data but not all victims refer themselves or are engaged with any support agencies, meaning there is an assumption of underreporting.

Given this context, Barnet will be seeking support from partners to identify and share their data in order to scope the extent of DV and VAWG issues in the Borough, enabling us to develop a more informed approach that meets local need.

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

[161] 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 within some services and organisations; more than the other VAWG issues, so further work needs to take place on this.

- Barnet has a three year Domestic Violence and Violence against Women and Girls Strategy and Action Plan 2013-2016. This is delivered by a whole range of voluntary and statutory partners. This includes domestic violence and abuse, forced marriage, honour based violence, prostitution, trafficking, rape and sexual violence, FGM, peer on peer abuse and sexual exploitation.
- Work has also started on the other areas of VAWG, including a level of understanding of where communities might be disproportionately affected by these issues. However, more in-depth work needs to take place on all areas to establish whether there is a need for any additional VAWG services within the Borough.

10.10 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 DV, with 5% being male. The predominant age band of victims in Barnet is between 21–30, with 38% of cases, followed by those aged 31–40. The most common ethnicity is White accounting for with 58% of victims, followed by any Other and Black with 12%.

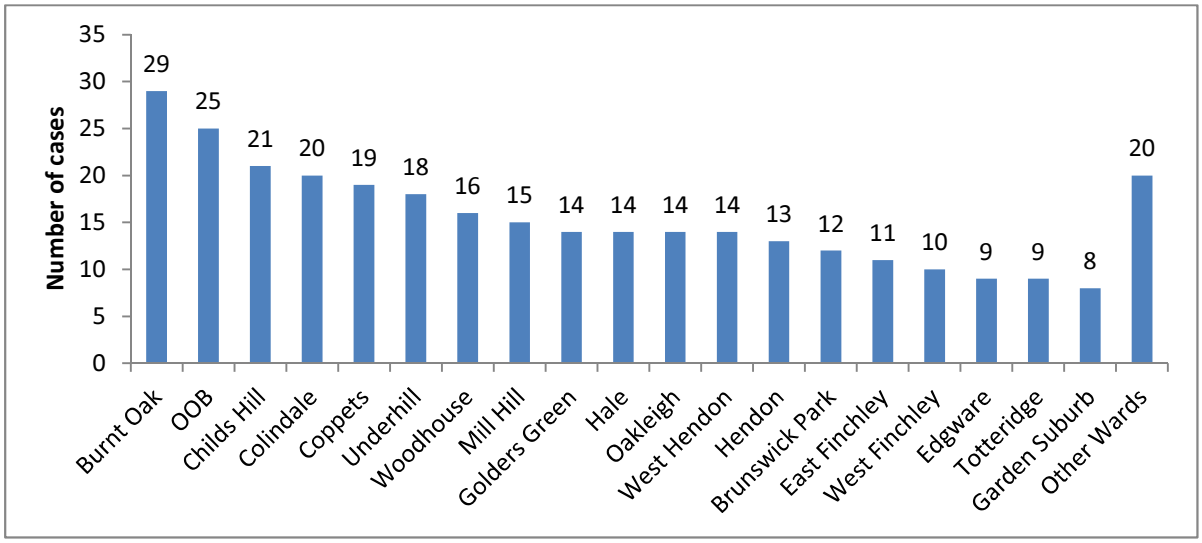
Table 10-2: Age and Ethnicity of Domestic Violence victims

Age of Victim	Number	%	Ethnicity	Number	%
15 - 20	26	8%	**White**	179	58%
21 - 30	119	38%	**Any Other**	37	12%
31 - 40	78	25%	**Black**	36	12%
41 - 50	56	18%	**Not stated**	28	9%
51 - 60	20	6%	**Asian**	22	7%
61+	12	4%	**Mixed**	9	3%
Total	311	100%	**Total**	311	100%

Source: Extract from MARAC database

The primary addresses for this cohort of cases are spread across the Borough, with the majority of victims residing in some of the areas with the highest levels of deprivation such as Burnt Oak, Childs Hill and Colindale. Also, a large proportion of cases come from Out-of-Borough (OOB).

Figure 10-2: Primary address of Domestic Violence victims by Barnet Ward



Source: Extract from MARAC database

Of the 311 cases that were referred, 205 of these had children. The majority of cases involved one child (45%) as shown in Table 3.

Table 10-3: Number of Children per Family

Children per Family	Number	%
1 Child	93	45%
2 Children	64	31%
3 Children	34	17%
4+ Children	14	7%
Total	205	100%

Source: Extract from MARAC database

Overall, there were 386 children linked to the 311 referrals made to Barnet's MARAC. The prevalent age bands of these children were the 0-4 (35%) and 5-9 groups (33%).

Table 10-4: *Age of Children*

Age of Children	Number	%
0-4	137	35%
5 - 9	127	33%
10 - 15	92	24%
16+	30	8%
Total	386	100%

Source: Extract from MARAC database

10.10.1 Domestic Violence Advocacy and Support Services

10.10.1.1 Refuge Provision

The Council currently provides 18 bed spaces in Barnet for women leaving a situation involving domestic violence. Between 2013/2014 and 2014/2015, there has been a 98% occupancy rate of the rooms available. The small percentage of non-occupancy allows for the turnover of referrals.

All the women are Safe Lives (formerly CAADA) DASH risk assessed and they will only be turned away if they are deemed unsuitable in not meeting the criteria or if there is no space in the refuge. If the latter is the case, they are still supported by UK Refuges online to find alternative space. Housing will remain a critical area of work for partners as the refuge requirement increases.

Barnet Community Safety Team continues to co-ordinate the local partnership approach to address violence against women and girls. However, a partnership focus to identify victims, provide interventions to reduce repeat victimisation and ensure the safeguarding needs of vulnerable adults and children experiencing domestic violence needs to continue. The demand placed on services by families experiencing domestic violence will increase if left unsupported; therefore it is important for partners to recognise the collective benefits of prevention especially to statutory organisations.

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

10.10.2 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 victimisation 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.

Responding to domestic violence alone costs Barnet an estimated £38 million a year. By responding to DV and VAWG early and seeking to prevent it, there is potential to make significant savings across the partnership and, most importantly, reduce the harm it causes to victims, their families and the wider community.

10.10.3 Key Facts

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

- Sexual crime: 87% of victims are female. There has been a sharp increase in the number of female victims aged 14 years.
- Violent crime: 52% of victims are female.
- Even these figures are likely to understate the situation as violent crime and hate crime are among the most underreported crime types.
- In Barnet violent crime is the crime type with the single largest cost associated with it, and sexual offences have the second highest associated cost. Both of these crime types have a majority of female victims.
- In fact, reported violent crime and sexual crime against women in Barnet accounts for an estimated 28% of the total cost of crime in the Borough (in contrast residential burglaries account for 14% and robbery around 8%).
- Women experience an average of 35 incidents of domestic violence before reporting an incident to the police (Yearnshaw 1997).
- 76% of all DV incidents are repeat offences (National estimate 2009/10[162]).

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

10.10.4 Summary

There has been an upward trend in the volume of reported domestic violence offences in Barnet. This increase is likely to be due to an increase in willingness to report and record appropriately, rather than an underlying increase in the actual prevalence rate of domestic violence[163]. This is a positive development and reflects concerted effort at the national, London and Borough level to raise awareness and reporting of domestic violence. Efforts to raise awareness amongst practitioners about the importance of making referrals to MARAC has also yielded positive results with the number of cases being risk managed by MARAC increasing significantly in 2013/14.

10.11 Youth Crime

Through consultation young people have told the Council that safety is one of their top priorities. Survey results showed that compared to the population average, people aged 19 or under were over 55% more likely to feel 'very worried' about the risk of being physically assaulted.

Barnet is one of the safest Boroughs in London. Barnet's rate of violence with injury rate of 4.2 per 1,000 population in the last 12 months is one of the lowest out of all London Boroughs, and also out of the 15 comparison areas in Barnet's 'Most Similar Group'.

As would be expected, however, violent offences (including violence towards young people) are not distributed uniformly across the Borough.

10.11.1 Key Facts

- The peak victim age for offences with violent contact between the victim and offender (robbery, violence, and sexual offences) is: 15 to 33 years (52% of victims are in this range).
- The peak victim age for robbery is: 14 to 18 years old (33% of all male victims in this range).
- The peak victim age for sexual crime is: 14 to 22 (38% of all female victims in this range).
- The 'Voice of the Child' consultation exercises seek feedback from young people about the Borough. This has established that safety is a priority for many young people; that some young people do not feel safe being in some parts of the Borough in the day time and in the evening, and not necessarily always in the areas of deprivation.
- Most arrested suspects are males aged between 15 to 35 years (57% of arrests), peaking between 16 to 24 years old.
- Violent crime is one of the main crime types for both under reporting and repeat-victimisation. Anecdotally (based on a review of local intelligence) this appears to be particularly the case where young people are the victims. This makes it more difficult to identify and intervene to reduce the risks associated with on-going victimisation.

10.12 Gang Activity

Barnet is one of the safest London Boroughs with the overall crime rate falling. From June to August 2013 Barnet had the lowest rate of Violence with Injury per 1,000 population of all 32 London Boroughs. Between April and September 2013 Barnet has seen reductions in most types of violent crime in comparison with the same period in the previous year; Serious Youth Violence, Knife Crime, Gun crime, Robbery, and Non DV Violence with Injury all reduced significantly.

At the same time the SCPB research revealed anecdotal evidence about serious youth violence and gang activity from youth workers, the youth offending service, Intensive Family Focus practitioners, and local community groups such as Barnet Group, 'Get Outta the Gang' and Grahame Park Community Development Group. The practitioners said that they were working with young people

[163] See 'DV Looking at Underreporting' in section 4 of this document for the assessment of this issue (page 45)

affected by serious youth violence and gangs mainly in the west of the Borough, but including other areas such as North Finchley.

10.12.1 Problem Profile - offences not evenly distributed –Burnt Oak highlighted

The research began with a hypothesis that suggested offences were not evenly distributed and set out to create a problem profile analysing existing data. Analysis found that offences are not distributed evenly and Burnt Oak (HA8) is highlighted as both the short- and long-term hotspot for violence in Barnet, with data showing an increase in offences resulting in injury in this area, going against the overall downward trend in the Borough. Victims in this area also tend to be younger on average than the rest of the Borough.

- HA8 also has the highest percentage of offences resulting in injury that were committed by 15-17 year olds over a three year period from October 2010.
- Grahame Park (NW9) is the area with the second highest volume of these offences but has seen a gradual downward trend over the same period.

10.12.2 Knife Used to Inflict Injury Offences (excluding Domestic Violence offences)

Over the last three years from October 2010 to 2013 there were 23 offences where a knife was used to inflict an injury in the Burnt Oak area, accounting for 25.6% of such incidents across Barnet.

The locations with the highest number of offences over this three year period are: HA8 which corresponds to the Burnt Oak area (23 offences); NW9 which corresponds to the Colindale and Grahame Park Estate area (ten offences); EN5 which includes the Dollis Valley Estate (eight offences); and NW2which corresponds to the Cricklewood area (eight offences).

10.12.3 Age of Gang Nominals

Individuals who have been identified by the police as 'gang nominals' are collated in a list referred to as the police Gangs Matrix. Crime and related data is brought together and a score is calculated for each individual indicating their risk of harm. Analysis of the Barnet Gangs Matrix showed that 59% of the most serious offenders rated as Red or Amber (red being the most serious) are aged 19 years or younger.

10.12.4 Causal factors: Groups Involved in Street Supply of Drugs – links to violence

Evidence has also suggested that drug supply is the main business related to gangs in Barnet. The activities of particular gangs have also generated youth violence.

The most common offence types that individuals on the Gangs Matrix have been arrested for relate to violence, drugs and weapons, supporting the link between violence and drugs. Violence generated as a result of the drug dealing / supply activity tends to either be:

a) A group fighting a rival group (e.g. defending drug dealing zones, trying to move into another group's zones of control or another dispute.
b) Fighting within a group (e.g. for control, or a falling out over a dispute).

10.13 Re-Offending

A reduction in offending has translated into less crime, fewer victims of crime and a reduction in the costs relating to crime. However, it is known that a small proportion of the most prolific offenders are responsible for a disproportionately large amount of crime. National studies and local analysis

show that substance misuse (drugs and alcohol) is a significant causal factor for both acquisitive and violent offending.

By focusing on reducing the offending of this prolific cohort, in particular through the work of the Integrated Offender Management (IOM) Programme, the level of overall crime has decreased which has reduced the number of people in Barnet who become victims of crime. The Council intends to continue developing this programme to deliver further reductions in offending and crime.

10.13.1 Key Facts

- Approximately 68% of arrested suspects live in the Borough, 32% come from outside the Borough (the proportions vary from crime type to type).
- 86.5% of arrested suspects are male, 13.5% are female.
- Peak age for arrests in Barnet is 16-24 year old (35% of all arrests).
- Barnet IOM has reduced the conviction rate of offenders on the programme by 36%.
- The burglary arrest rate of the IOM cohort has fallen from 2.5 per month to 1.6 per month, equating to an estimated 120 fewer households becoming victims annually, an estimated annual cost saving of around £470,000.

10.13.2 Summary

The Integrated Offender Management scheme, introduced in June 2012, has achieved significant reductions in the offending rate of its cohort, a cohort who were selected due to the prolific, repeat and cyclical nature of their offending. These reductions contributed towards overall Borough level reductions in re-offending rates, crime rates, and in particular reducing the number of people becoming victims of burglary in Barnet.

10.14 Changing Crime Trends and Changing Environmental Conditions

10.14.1 Stolen Property Trends

- The number of crimes where cash or Sat-Navs are stolen has reduced.
- The number of laptops stolen increased over most of the last decade (with a peak in 2011) but has since been falling slightly.
- In 2013 the volume of catalytic convertors stolen increased.
- Over the last three years there has been an upward trend in the volume of power tools stolen.

10.14.2 Residential Burglary Trends

Between 2008 and 2012 the market value of gold increased by over 400%. In the same period, demand for vehicles stolen with their own keys increased. As a result, more burglars started travelling to target places where they could locate gold and cars.

These burglars favour areas where they are most likely to find houses (not flats) with gold jewellery inside, expensive cars on the drive and a relatively low concentration of police officers compared to other parts of London. The reversal of the upward trend in the price of gold around April 2013 has helped reduce the cross-border and vehicle-related element of Barnet's burglary problem.

10.14.3 Offending Trends

The Integrated Offender Management programme has helped to reduce re-offending among some of the most prolific offenders (the IOM 'cohort'), and this is contributing to crime reductions in Barnet.

Between April and September 2013, around 60 of the 336 fewer residential burglaries in Barnet were likely to have been due to reduced criminal activity by the IOM cohort. Tackling repeat offending successfully will be pivotal to achieving further crime reductions.

Based on the Council's figures, it is estimated that the top 200 offenders in the Borough are, between them, committing around 5,000 crimes every two years.

10.15 Feedback from Barnet Residents about Community Safety

During the last two years some 5,100 Barnet residents have taken part in consultation surveys, which either focused specifically on crime and community safety or included a significant section on the subject.

The main surveys which have guided the Council's assessment are the Residents' Perception Survey (RPS) and the Public Attitude Survey (PAS), both have been carried out by separate independent market research companies.

In addition, there have been a number of smaller or one-off consultations that are highly relevant to community safety issues.

10.15.1 Key Findings from this Research

- Overall community confidence in the police and local authority in Barnet is strong and most indicators show this improving over the last year.
- Confidence in policing is above the London average.
- Confidence that the police understand community concerns and can be relied upon to be there when you need them is above the London average.
- Community cohesion remains strong.
- Litter and rubbish left around is a top ASB concern.

10.15.2 Young People's Perspective

Views of young people about youth crime and safety provide a perspective of the perceptions and circumstances surrounding this peak victim age group.

Safety is a priority for many young people:

- Young people said they were particularly less likely to feel safe in some of the more isolated, poorly lit locations in the winter months when it gets dark early.
- Young people can feel the pressure to engage in negative activities for various reasons, which include peer pressure and family circumstances.

Barnet residents have told us that they want us to:

- Keep the community informed about what the Council is doing to tackle crime and ASB.
- Work together with the community to reduce rubbish and litter concerns.

11 Community Assets

11.1 Key Facts

- Barnet has a strong foundation for an asset-based approach with 88% of residents satisfied with their local area and high levels of local capacity.
- 90% of residents agree that they help their neighbours out when needed and 28% volunteer regularly (weekly or monthly).
- Charities Commission and Council data suggests that there were 1235 registered charities operating in Barnet as of February 2015; 51.7% from in or near Barnet and 48.3% from outside the Borough.
- Education and training is the most commonly identified benefit provided (due in part to the number of schools which are registered charities), followed by religious activities, general charitable purposes, and the prevention and relief of poverty.
- The highest numbers of local charities are based in Golders Green (74 organisations), Edgware (48 organisations) and Garden Suburb (46 organisations), likely to reflect high levels of charitable activity among and serving the local Jewish community.
- The resources the Council makes available to local voluntary organisations include grant funding and use of physical assets from the Council's property portfolio – as well as the funds spent with voluntary and community sector (VCS) organisations when commissioning local services.
- 337 charities identify older people as their beneficiaries; 647 identify children and young people; 353 benefit people with disabilities.
- In terms of both health and disability-related charitable activities, less than 20% of charities (225) identify their charitable purpose as the advancement of health.

11.2 Strategic Issues

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with voluntary and community (VCS) groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is however the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).

- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. **There is however weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- There is a particular gap around **place-based or environmental VCS groups** and/or the relationships the Council maintains with them. The Council needs to consider how to develop and strengthen this sector, as well as strengthen its own links with other existing relevant organisations such as residents' associations.
- More generally, there are opportunities to:
  - **Support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).
  - **Rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**
  - Respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be engaged with better to deliver health and wellbeing outcomes.

11.3 Overview

11.3.1 What is a Community Asset?

In a health and wellbeing context, a **community asset** is, broadly speaking, 'any factor or resource which enhances the ability of individuals, communities, and populations to maintain and sustain health and wellbeing' (Morgan, NICE, 2009). Assets could include:

- local residents' skills and knowledge
- voluntary activity by individuals, including friendships and neighbourliness as well as volunteering
- community networks and connections
- local voluntary and community sector (VCS) organisations
- Resources from public and private sector organisations (including assets in the more classic sense, such as money, land and buildings).

11.3.2 Evidence for Asset-based Approaches, and the Context in Barnet

Recent thinking on asset based approaches in a health and wellbeing context has tended to focus on a**sset-based community development** (ABCD). This is an approach to improving outcomes for communities which build on the broad definition of a community asset set out above. Rather than focusing on a community's needs (or 'deficits'), ABCD 'starts by focusing on the skills, knowledge, resources, connections and potential within a community; and building on what is working and what it is that people care about' (Developing the power of strong inclusive communities, Think Local Act Personal, 2014). The ability to identify assets – and mobilise them, getting local people participating in their communities and the decisions which affect them – is therefore also key.

In Barnet, residents already tend to indicate that they have positive feelings about their local area. In autumn 2014, 88% of residents indicated that they were satisfied with their local area as a place to live; significantly higher than the national average (Residents' Perception Survey, autumn 2014). This is a strong foundation for an asset based approach.

Linked to community assets is the concept of **social capital** - 'the connections that are made between people who live in the same area or are part of the same community, and who are able to do things with and for each other. Strong neighbourhoods, clubs and groups help create a sense of community, enabling people to trust each other, work together and look out for each other' (Think Local Act Personal, 2009). Social networks and social capital are consistently linked with better health outcomes – associated with reduced illness and death rates (Berkman & Kawachi, 2000), for example – and is also linked with improvements to other outcomes, such as decreases in crime (Sampson et al, 1997) and increased educational attainment (Ripfa, 2012). In Barnet, social networks are reasonably strong; 84% of residents feeling that people from different backgrounds get on well together as of spring 2014. This is in line with the national average (Residents' Perception Survey, spring 2014).

The level of **participation in civic life**, such as neighbourly activity, peer to peer support, and volunteering, is also considered a community asset. Participation has qualitative benefits – promoting wellbeing for people of all ages (New Economics Foundation, 2008) – as well as providing quantitative benefits in terms of the extra capacity contributed by individuals who are involved in voluntary activity.

Voluntary and community activity also helps to **manage people's need for public services** by preventing individuals from reaching a point where they need funded support. Such activity can involve help with the activities of daily living (such as shopping or cooking) or of maintaining living environments (such as housework or gardening), this can be carried out by organised groups or by informal social networks including friends or neighbours. Voluntary and community groups often provide social activities which **promote inclusion and reduce isolation**, which can also help prevent people from getting to the point where they need more intensive services.

Residents of Barnet perceive themselves as neighbourly – as of spring 2014, 90% of residents agreed that they help their neighbours out when needed, with 57% strongly agreeing. The proportion of residents who agree that their neighbours help each other out when needed is slightly lower at 80%, with 44% strongly agreeing. (Residents' Perception Survey, spring 2014).

11.4 Barnet's Community Assets

11.4.1 Volunteering in Barnet

28% of Barnet residents report that they give unpaid help to groups, clubs or organisations at least once a week or once a month, as of spring 2014. This is comparable to the most recent national benchmarking data (the Cabinet Office Community Life Survey 2013/14), in which 27% of people reported regular formal volunteering of this kind. Regular volunteering saw a large rise both locally and nationally in 2012/13, generally attributed to the knock-on effect of the London Olympics, and declined slightly in subsequent years. Levels of infrequent volunteering tend to be much higher, with national data suggesting that the proportion of people who volunteer annually exceeds 40%.

The Council commissions a volunteering brokerage service, which matches potential volunteers to volunteering opportunities. As of 2015/16 this was provided by Groundwork London. Some specialist volunteer services run alongside this, including, in 2015/16, Active Volunteering by Disabled People, a project supporting people with disabilities to volunteer.

In Barnet, faith-based communities have a number of specialist volunteering structures such as the Jewish Volunteering Network, which promotes volunteering opportunities to the Jewish community.

Formal volunteer brokerage services are complemented by initiatives such as timebanking, a service which helps individual residents exchange time and skills. In 2015/16 there were two Timebank networks in Barnet, one run by CommUNITY Barnet, covering Burnt Oak, Colindale, Edgware and West Hendon, and the other covering the rest of the Borough, run by Timebank UK. In its first year of operation the Borough-wide Timebank registered 138 members and exchanged 400 hours of activities. Timebank runs on a hub and spoke model with the potential for other organisations to host timebank facilities in the future and plans to roll out an additional three hubs in the next five years.

11.4.2 Council-initiated VCS Activity

As well as its mechanisms for involving residents and service users in decision making, the Council commissions a number of specific community development programmes. In 2015/16 these included a public health programme, known as Ageing Well or Altogether Better, which works with people in a number of localities across the Borough to increase community capacity, reduce isolation and help older people live longer as part of their communities. Each locality has a steering group which devises a range of activities appropriate to that community and its needs. In 2015/16 there were four localities – Burnt Oak, East Finchley, Edgware & Stonegrove and High Barnet & Underhill.

There were also a number of small-scale place-based schemes – six 'Adopt-a-Place' schemes (as of November 2014) in which volunteers were working with the Council to maintain a local environmental feature – for example, litter picking in a street, or watering a flowerbed.

11.4.3 The Broader VCS in Barnet

There is also a broad range of voluntary and community organisations operating in Barnet and which have come into being independently of the Council. The largest available dataset is drawn from the Charities Commission register of charities, and suggests that there are 1,235 registered charities operating in Barnet. 638 (51.7%) are based in or near Barnet and 597 (48.3%) come from outside the Borough[164]. Local and national research estimates the number of less formal, 'below the radar', organisations may be much larger. These are organisations such as grassroots or neighbourhood groups, including residents' and community associations. In 2015, local research by the Young Foundation found over 300 different 'below the radar' groups operating within one square mile of Golders Green tube station (Young Foundation, 2015). National research estimates 3.66 'below the radar' organisations per 1,000 population (NCVO, 2010, cited in CommUNITY Barnet, 2013).

The registered charities that operate in Barnet serve different client groups. Table 11-1 shows the breakdown of client groups. (Each charity can select more than one client group; percentages are

[164] Data in this section has been compiled from the Charities Commission's register of charities who state that they operate in Barnet, as of February 2015, combined with Charities Commission data on VCS organisations who have contracts with Barnet Council to provide services, either directly to the Council or to residents.

given to show the proportion of the total number of charities in Barnet which serves this client group.)

Table 11-1: Client groups served by charities operating in Barnet

Service Users	Number	Percentage
Children / Young People	647	52.4%
Elderly / Old People	337	27.3%
People With Disabilities	353	28.6%
People of a Particular Ethnic or Racial Origin	280	22.7%
Other Charities or Voluntary Bodies	267	21.6%
Other Defined Groups	165	13.4%
The General Public / Mankind	416	33.7%

The Charities Commission register also gives information on the types of social and community benefit the charities operating in Barnet provide, shown in Table 11-2 below. (Again, each charity can select more than one purpose or benefit; percentages are given to show the proportion of the total number of charities in Barnet which offer this purpose or benefit.) The high proportion of charities aimed at children and young people (in Table 11-1) and at providing education and training (in Table 11-2) is in part due to the number of schools which are also registered charities.

Table 11-2: Social and community benefit provided by charities operating in Barnet

Type of benefit	Number	Percentage
Education / Training	689	55.8%
Religious Activities	364	29.5%
General Charitable Purposes	358	29.0%
The Prevention or Relief of Poverty	302	24.5%
The Advancement of Health or Saving Lives	225	18.2%
Disability	220	17.8%
Arts/ Culture/ Heritage / Science	188	15.2%
Amateur Sport	164	13.3%
Economic/Community Development / Employment	152	12.3%
Accommodation / Housing	92	7.4%
Overseas Aid/ Famine Relief	86	7.0%
Environment / Conservation / Heritage	75	6.1%
Other Charitable Purposes	70	5.7%
Recreation	69	5.6%
Human Rights / Religious or Racial Harmony / Equality or Diversity	31	2.5%
Animals	13	1.1%
Armed Forces / Emergency Service Efficiency	3	0.2%

Charities are also asked to register the types of activity they undertake – again, charities can select more than one activity. These are shown in Table 11-3 below:

Table 11-3: Types of activities undertaken by charities operating in Barnet

Activities provided	Number	Percentage
Makes Grants to Individuals	215	17.4%
Makes Grants to Organisations	369	29.9%
Provides Other Finance	60	4.9%
Provides Other Human Resources	253	20.5%
Provides Buildings / Facilities / Open Space	342	27.7%
Provides Services	572	46.3%
Provides Advocacy / Advice / Information	338	27.4%
Sponsors or Undertakes Research	100	8.1%
Acts as an Umbrella or Resource Body	122	9.9%
Other Charitable Activities	132	10.7%

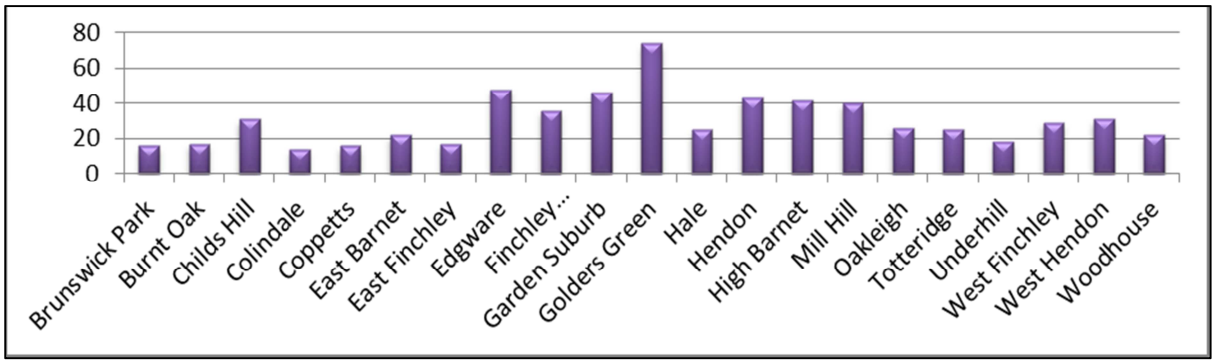
For the 638 charities which are also based in the Borough, it is possible to give a breakdown of the wards in which they are based. The data refers to the registered address of the charity rather than to the address from which it operates services and these may not always be the same. Table 11-4 and Figure 11-1, below, give this breakdown at ward level.

Table 11-4: Geographical breakdown of charities based in and operating in Barnet, by ward

Ward	Number	Percentage*
Brunswick Park	16	2.51%
Burnt Oak	17	2.66%
Childs Hill	31	4.86%
Colindale	14	2.19%
Coppetts	16	2.51%
East Barnet	22	3.45%
East Finchley	17	2.66%
Edgware	48	7.52%
Finchley Church End	36	5.64%
Garden Suburb	46	7.21%
Golders Green	74	11.60%
Hale	25	3.92%
Hendon	43	6.74%
High Barnet	42	6.58%
Mill Hill	40	6.27%
Oakleigh	26	4.08%
Totteridge	25	3.92%
Underhill	18	2.82%
West Finchley	29	4.55%
West Hendon	31	4.86%
Woodhouse	22	3.45%

**Percentage of all Barnet-based charities which are in this ward*

Figure 11-1*:* Distribution of local charities operating in Barnet, at ward level



11.5 Other Community Groups

In addition to registered charities, there are also a number of less formally constituted community groups across the Borough. These include seven 'Friends of…' groups involved in maintenance or governance of parks and open spaces groups across the Borough; four 'Town Teams', coalitions of local businesses and organisations who look after and are involved in developing town centres; and 23 residents' and community associations.

11.6 Resources and Support

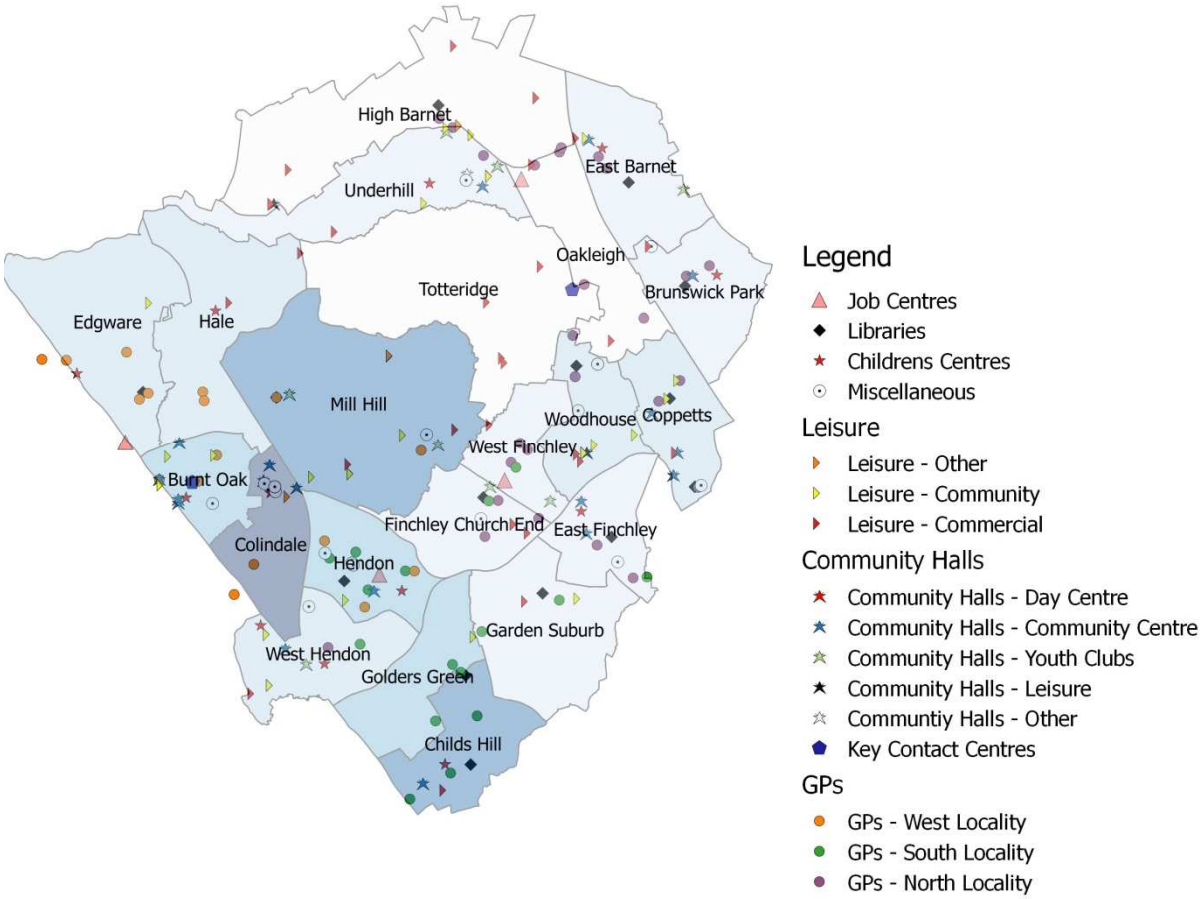
The Council commissions a second Local Infrastructure Organisation Partner – as of 2015/16 this is CommUNITY Barnet – to strengthen the local voluntary and community sector, offer expert advice and support, and ensure VCS organisations are represented in Council decisions. This role is a key enabler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

The Council also makes grant funding available to the voluntary sector. In 2014/15 the total funding available through the Council's Corporate Grants Programme was £104,390.

Physical assets – land and property – which are being used for community benefit are also considered community assets. Some of these are Council buildings primarily used by voluntary and community groups, but others have Council services provided from them or are owned by other public sector stakeholders. A map of these physical assets, as of November 2014, is shown at Figure 11-2 below.

The map shows that these assets are clustered around town centres. The numbers are sparser in the North West of the Borough and in parts of some central Barnet wards (Mill Hill, Totteridge). There may be a case to review the distribution of some facilities which might be well located in more residential areas, such as day centres and community centres, in these parts of the Borough.

Figure 11-2: Map of community assets in Barnet



The Council also puts some resource into the voluntary and community sector through services it commissions from VCS groups. A breakdown of spend by location (charities based in Barnet; charities based in central London or charities based elsewhere in London or the UK) is given in table 11-5 below.

Table 11-5: Total Council spend with charities in 2014/15, by location

Spend by Location (2014/15)		
Locality	**Total Spend**	**%**
Barnet	£10,718,331.26	35.3%
Central London	£3,000,154.48	9.9%
Other	£16,669,799.23	54.9%
Grand Total	£30,388,284.97	100.0%

A further breakdown of spend with charities is given for the Adults and Children's Delivery Units in tables 11-6 and 11-7 below.

Table 11-6: Council spend by location – Adults and Communities (2014/15)

Spend by Location and Delivery Unit - Adults and Communities (2014/15)		
Locality	**Total Spend**	**%**
Barnet	£2,148,630.39	20.4%
Central London	£1,364,400.35	13.0%
Other	£7,019,283.43	66.6%
Grand Total	£10,532,314.17	100.0%

Table 11-7: Council spend by location – Children's services (2014/15)

Spend by Location and Delivery Unit - Children's Services (2014/15)		
Locality	**Total Spend**	**%**
Barnet	£2,756,023.80	54.9%
Central London	£558,134.35	11.1%
Other	£1,706,069.46	34.0%
Grand Total	£5,020,227.61	100.0%

The Barnet-based spend on children's services is much higher than the spend from Adults – once again, this is in part due to the inclusion of schools as registered charities.

11.7 Type of Provision

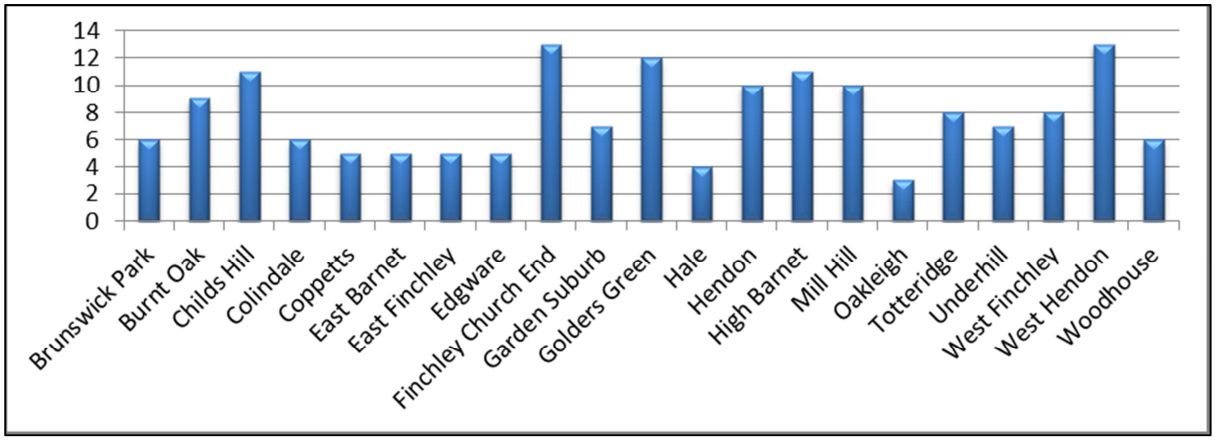
11.7.1 Faith-based Activities

A high number of the charities which both operate in and are based in Barnet are located in Golders Green (74 of 638), followed by Edgware (48) and Garden Suburb (46). In each case, a relatively high proportion identifies its beneficiaries as being from particular ethnic or racial groups (67 of the total 166; 40.3%). Considering the demographics of these wards, this suggests that philanthropy within Barnet's Jewish community may account for a high proportion of locally focused charitable activity.

11.7.2 Services for Older Adults

337 of the 1,255 charities operating in Barnet (27.3%) identify older people as beneficiaries. Just under half of these (164 or 48.7%) are Barnet-based and 173 are from outside the Borough. Figure 11-3 shows a breakdown of the local charities by ward:

Figure 11-3: Local charities serving elderly people, by ward

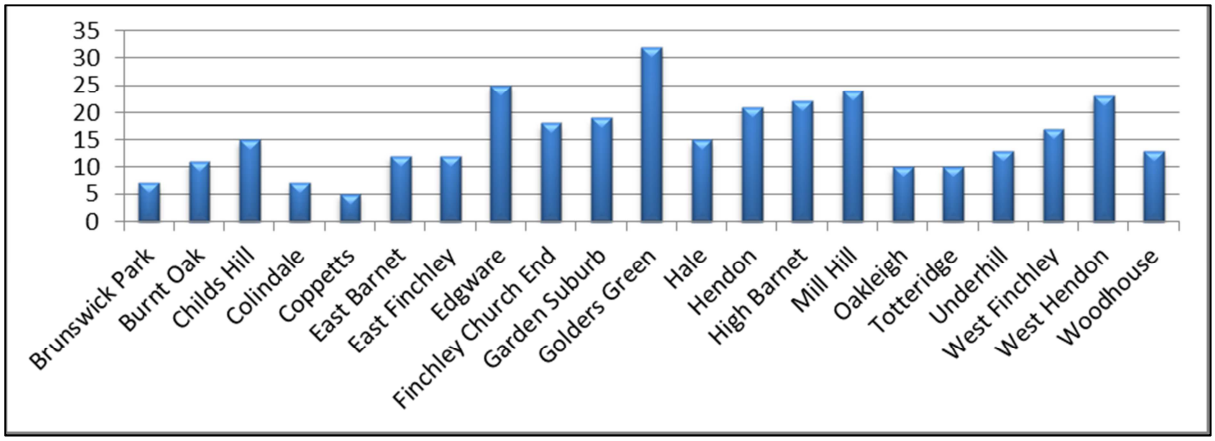


A total of 130 charities (from both inside and outside Barnet) provide services for older people with a health-related benefit – 10.3%. 118 (9.4%) benefit older people and provide a disability-related service.

11.7.3 Services for Children

647 of the 1,255 charities operating in Barnet identify children and young people as beneficiaries – more than half (52.5%) of all the charities in the Borough. Just over half of these (331, 51.2%) are Barnet-based and 316 are from outside the Borough. A breakdown of the local charities by ward is shown below.

Figure 11-4: Local charities serving children and young people, by ward

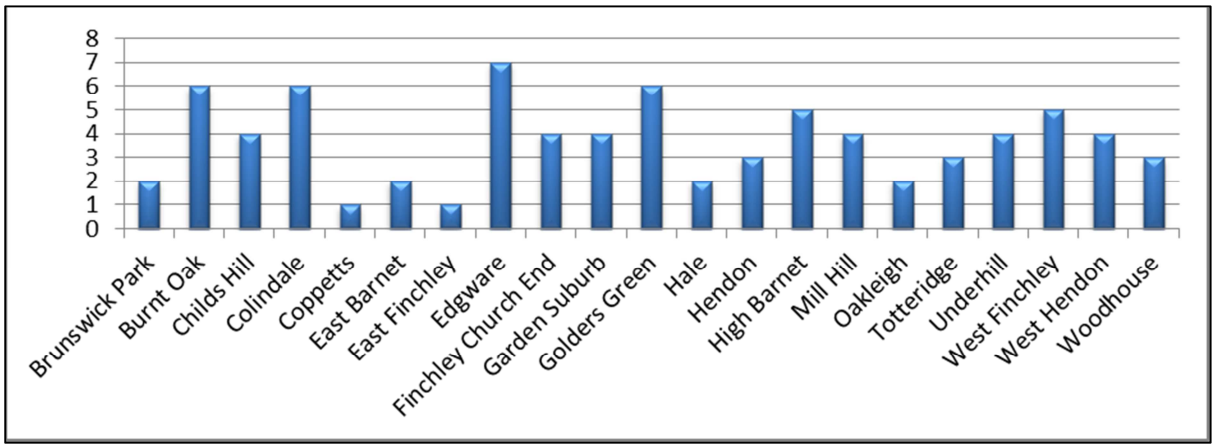


The distribution of children's charities across wards reflects the overall number of charities in each, with particularly high numbers (32) in Golders Green. It is notable that Colindale and Burnt Oak both have relatively low numbers of charities offering services for children and young people (7 of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

11.7.4 Services for People with Disabilities

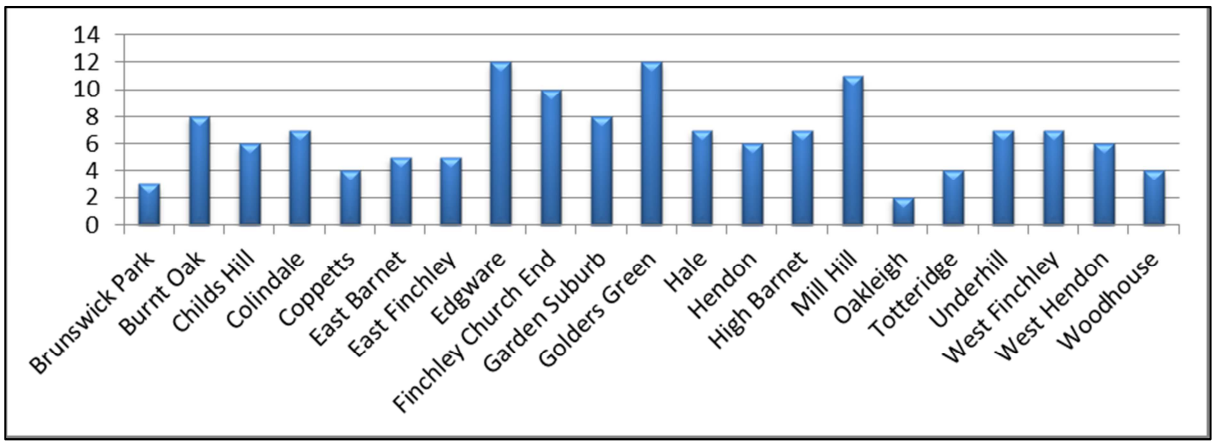
220 charities operating in Barnet (17.5%) identify their charitable benefit as being related to disability and 78 of these are also based in Barnet. The distribution of Barnet-based charities in this group is shown by ward below:

Figure 11-5: Local charities whose purpose or benefit relates to disability, by ward



353 charities operating in Barnet (28.1%) identify people with disabilities as service users and 141 of these are also based in Barnet. Their distribution by ward is shown below:

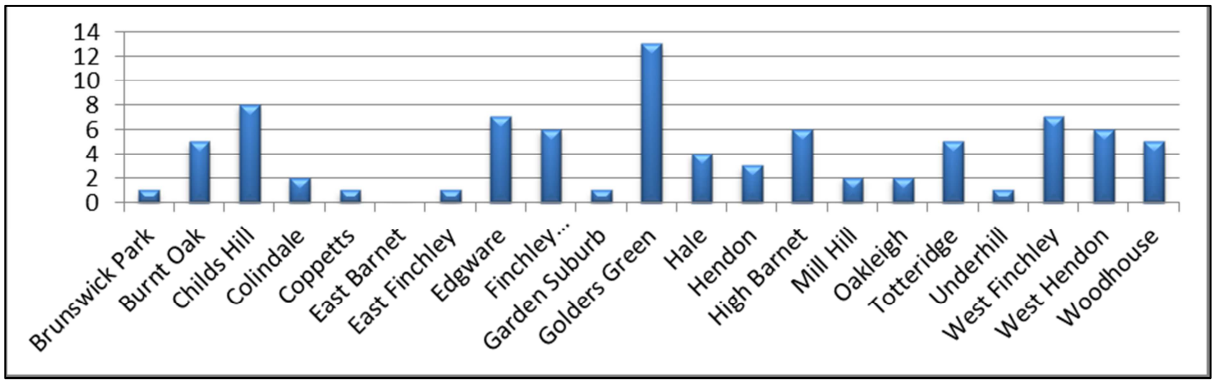
Figure 11-6: Local charities serving people with disabilities, by ward



11.7.5 Services Relating to Health and Physical Activity

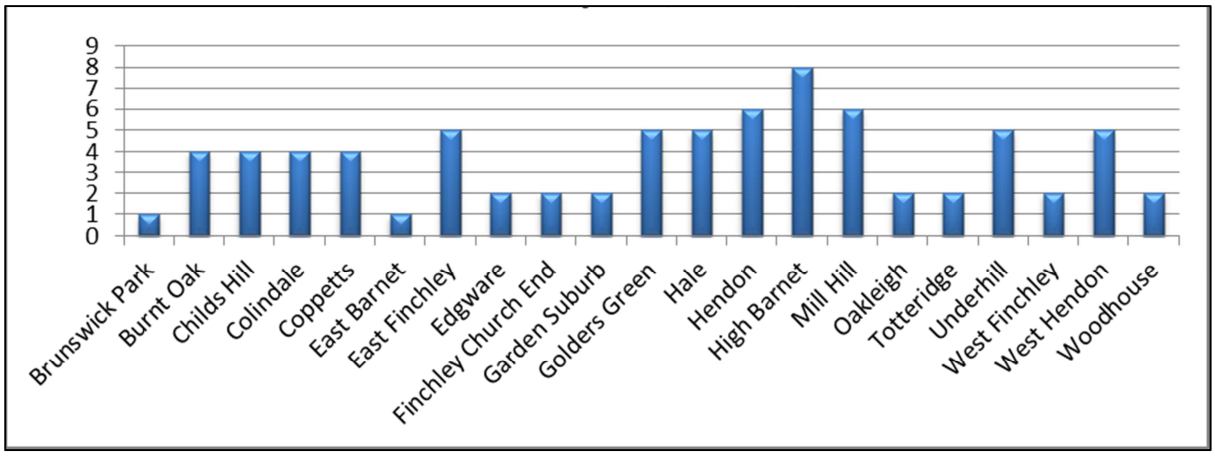
225 charities operating in Barnet (17.9%) identify themselves as providing a health-related benefit. 86 (38.2%) are local and 139 are from outside the Borough. The local charities are shown by ward in the chart below:

Figure 11-7: Local charities purpose or benefit relates to advancing health or saving lives, by ward



164 charities carry out amateur sports-related activities; 77 (46.9%) of these are from Barnet. The locations of those based in Barnet are shown in the chart below:

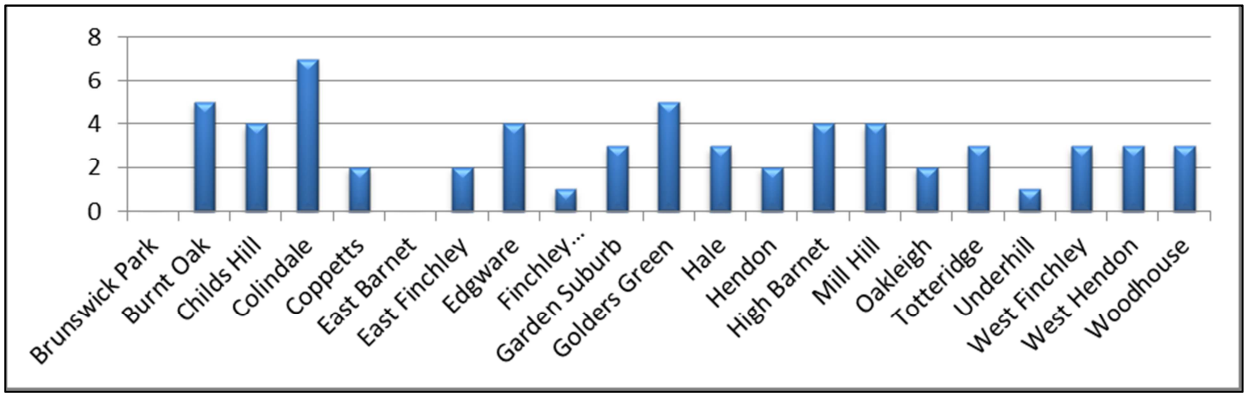
Figure 11-8: Local charities whose purpose or benefit relates to amateur sport, by ward



11.7.6 Economic and Community Development Services

152 charities provide services relating to community or economic development or employment. 61 (40.1%) are from Barnet and 91 are from outside the Borough. The local charities are distributed by ward as follows:

Figure 11-9: Local charities whose purpose or benefit relates to economic or community development and employment, by ward



11.8 Key Issues

Voluntary and community sector activity will be essential in meeting a number of needs already identified through the Council's commissioning plans. Key areas which require VCS provision include the following:

11.8.1 Adults and Health

In **adult social care and health**, work to reduce the need for services and provide more community care, particularly for older people, people with learning disabilities and mental health/ autism needs. In part, this will involve providing services or activities which help people go about their daily lives – shopping, cooking, housework or gardening – but there will also be an important preventative component, providing activities to promote inclusion and reduce isolation.

The distribution of local charities meeting the needs of older adults in Barnet is relatively well matched to the current and projected older adults' population. It is, however, noticeable that the number of charities operating in Barnet who identify a health or disability-related benefit to the work they do is less than 20%, suggesting that there is room either for provision to grow in this area

or to develop more understanding among community groups of how their activities impact on health and wellbeing.

In terms of sport and physical activity, local community sports provision is reasonably well matched to need, with the wards with the highest rates of childhood obesity (Colindale, Burnt Oak and Underhill) all having numbers of community sport charities slightly above average for the Borough. Again, there is potential room to develop further provision in this area.

11.8.2 Children's Services

In **provision for children**, as well as the preventative services identified above there will be a need to increase the availability of childcare in community settings to meet need, development of community provision to enable more holistic delivery models for mental health services, and to build strong relationships with community groups who may be able to improve services such as children's centres by getting more involved in how these are managed and governed.

The Barnet evidence base shows that overall, both the highest numbers of children and young people in Barnet in absolute terms, and the greatest growth in the numbers of children and young people, will be in the west of the Borough, corresponding with Barnet's regeneration programmes. The distribution of services aimed at children is reasonably high in more affluent parts of west Barnet but much lower in those deprived areas – particularly Colindale and Burnt Oak which are also the focus of the regeneration and the areas where the population of children and young people will be largest. This suggests that market shaping activity should consider how to increase local voluntary sector service provision for children and young people in Burnt Oak and Colindale to reflect the likely increase in future need in those areas.

11.8.3 Housing and Economic Development

In areas relating to **housing and economic development**, there will be continuing pressure to support people affected by welfare reforms and/or on-going poverty, reducing the negative impacts of living in poverty. VCS groups' knowledge of, and trusted relationship with, their local communities is vital in reaching people who may otherwise struggle to access services.

VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. There are, however, noticeably low levels of provision in East Finchley and Underhill, two wards with significant areas of deprivation.

11.8.4 Environment

Finally, opportunities to promote a better **environment** across the Borough will in part be reliant on getting people more involved in developing and maintaining their local areas. Environmental VCS provision in Barnet is relatively low compared to other sectors – only 75 charities, just under 6% of those operating in the Borough, identify themselves as providing an environmental or heritage benefit. This is underpinned by relatively underdeveloped links between the Council and place-based community groups such as residents' associations with clear opportunities to take a more proactive and coordinated approach to its relationship with such groups in future.

11.8.5 General Capacity

In terms of the general **capacity and physical assets** which underpin these priorities, Barnet has high levels of local VCS activity but this is not evenly distributed across the Borough. This is in part because a significant proportion local charitable activity is strongly focused around faith communities. The Council should think about using its engagement with faith groups and networks to respond to this, gaining a better understanding of how this capacity is currently deployed and learning any lessons about how similar capacity could be leveraged in other parts of the sector.

There are opportunities to support and develop the broader volunteering base through diversifying the offer to volunteers: presenting a broad range of volunteering opportunities (including Timebanking, community development activities, employer supported volunteering and corporate social responsibility), consolidated and coordinated through the core volunteer offer.

The Council's Community Asset Strategy – though it relates only to physical community assets such as land and property – provides an opportunity to rethink physical asset provision including the potential gaps in provision in the North West and centre of the Borough.

11.9 Conclusion and Recommendations

The evidence base for asset-based community development approaches is strong and will be a key part of the approach Barnet needs to take to address the challenges facing health and social care in the coming years.

Barnet has a **strong community asset base** on which to build, with high levels of existing capacity and a wealth of voluntary and community groups. There are opportunities to **work with faith groups** in particular, where community capacity in Barnet is particularly high, to promote stronger relationships between them and other groups in the Borough and to learn lessons about how higher levels of volunteering can be mobilised.

In terms of the overall VCS market, **levels of health-related VCS provision** in Barnet could be further developed, along with charitable activity around community sports. More localised analysis suggests that there may be a current need for **more employment and economic development-related VCS activity in some wards**, and that there will be a need for **more provision of services and activities for children and young people in the west of the Borough** to match the needs of the growing population.

There is a particular gap around **place-based or environmental VCS groups** and/or the relationships the Council maintains with them. The Council needs to consider how to develop and strengthen this sector, as well as strengthen its own links with other existing relevant organisations such as residents' associations.

12 Residents' Voice

12.1 Key Facts

- In spring 2015, 71% of respondents were satisfied with the way the Council runs things. This is broadly in line with both the average overall London (70%) and outer London (69%) scores, and 3% higher than the national average.
- In spring 2015 88% of Barnet residents were satisfied with their local area as a place to live. This is significantly higher than the national average of 82% (as of October 2014).
- In spring 2015 the services that residents were most happy with were 'Refuse collection', 'Doorstep recycling', 'Street lighting' and 'Parks, playgrounds and open spaces'.
- 26% of residents give unpaid help to groups, clubs, or organisations at least once a week or once a month (spring 2015). This is a significant increase since 2010/11 (21%).
- The largest area for complaints, constituting almost a quarter of top ten complaints is recycling (24%), followed by domestic waste (21%), and garden waste (17%). Together, household waste and recycling constitute 62% of the top ten complaints.

12.2 Key Issues

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and 'Repair of roads' as being poor or extremely poor services** provided by the Council.
- The **top three concerns** for residents according to the spring 2015 Resident's Perception Survey were '**conditions of roads and pavements (38%); lack of affordable housing (33%); and crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

12.3 Introduction

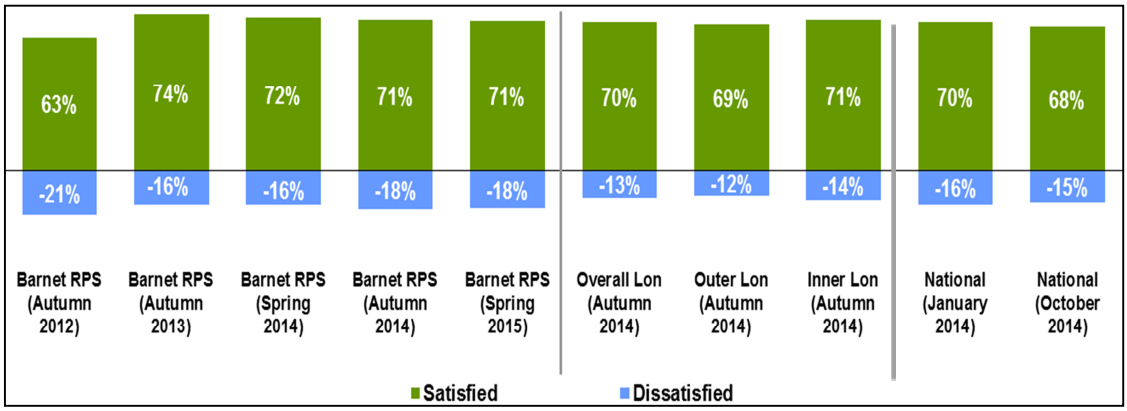
The Residents' Perception Survey captures residents' general views and perceptions towards the Council, the services it provides and the local area and is used to explore changes in these opinions over time on a number of topics. The latest Residents' Perception Survey was conducted in spring 2015; some of the key headlines are presented within this chapter.

12.4 Resident Satisfaction and Opinion of the Council

Figure 12-1 shows the responses for the residence perception question '*are you satisfied with the way the Council runs things*', for Barnet, compared to local and national regions.

- In spring 2015, 71% of respondents were satisfied with the way the Council runs things. This is broadly in line with both the average overall London (70%) and outer London (69%) scores, and 3% higher than the national average.
- During the period autumn 2012 to spring 2015, the proportion of people who were dissatisfied with the way Barnet Council runs things, has decreased from 21% to 18%.

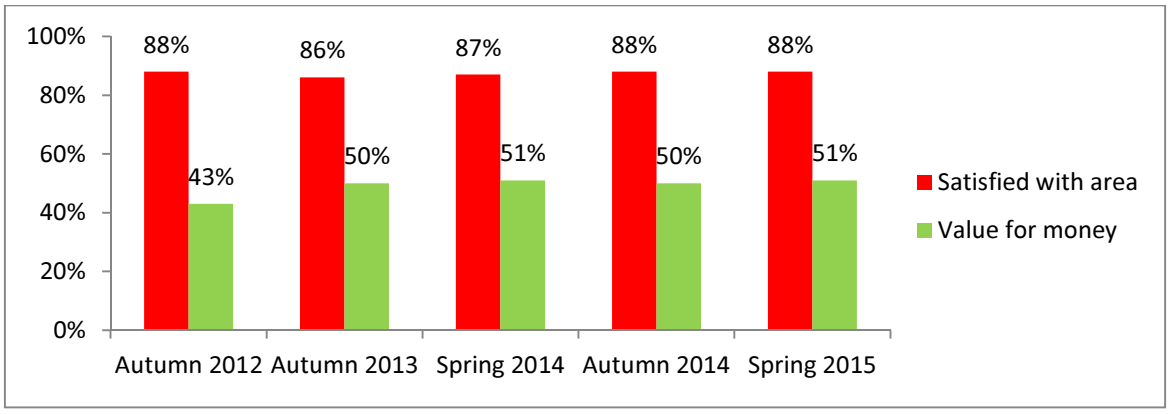
Figure 12-1: Are you satisfied with the way your local Council is running things?



Source: (London data from Survey of Londoners, national data from LGA public poll on resident satisfaction) (Barnet Resident Perception Survey Spring 2015)

The spring 2015 RPS shows that 88% of Barnet residents are satisfied with their local area as a place to live. This is significantly higher than the national average (82% as of October 2014). 51% of residents felt that Barnet Council provides value for money (+8% since autumn 2012). The national average for autumn 2014 was 51%, meaning Barnet is performing roughly at the national level.

Figure 12-2: Resident responses to key RPS questions over time



By ward, those living in Finchley Church End, Garden Suburb, or Totteridge were significantly more likely to be satisfied with Barnet as a place to live whereas those living in Burnt Oak were significantly less likely to be satisfied with Barnet as a place to live.

12.5 Local Services

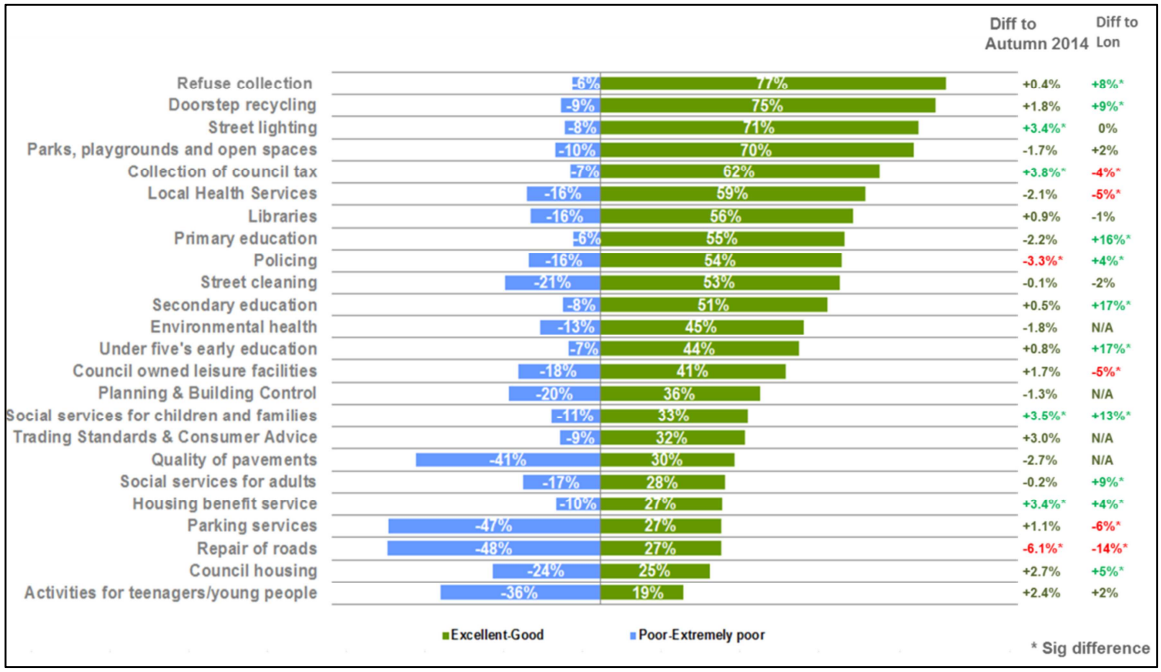
In spring 2015 the services that residents were most happy with were 'Refuse collection', 'Doorstep recycling', 'Street lighting' and 'Parks, playgrounds and open spaces' with 70% or above of respondents rating them as either good or excellent. Whereas, only 25% or less of respondents rated 'Council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

Over 40% of respondents rated 'Quality of payments', 'Parking services' and 'Repair of roads' as being poor or extremely poor.

Residents' satisfaction with local services has been maintained since autumn 2014 for thirteen council services and many remain higher than 2013 and 2012 levels. Furthermore, four services have seen significant increases in satisfaction since autumn 2014: 'Street lighting'; 'Collection of Council tax'; 'Social services for children and families'; and 'Housing benefit service'.

However, two services ('Repair of roads' and 'Policing') have experienced decreases in satisfaction; and while 'Policing' is above 2012 levels, 'Repair of roads' is significantly lower than both 2012 and 2013 levels.

Figure 12-3: % Services Rated Excellent-Good or Poor-Extremely Poor, spring 2015



12.6 Top Concerns for Residents

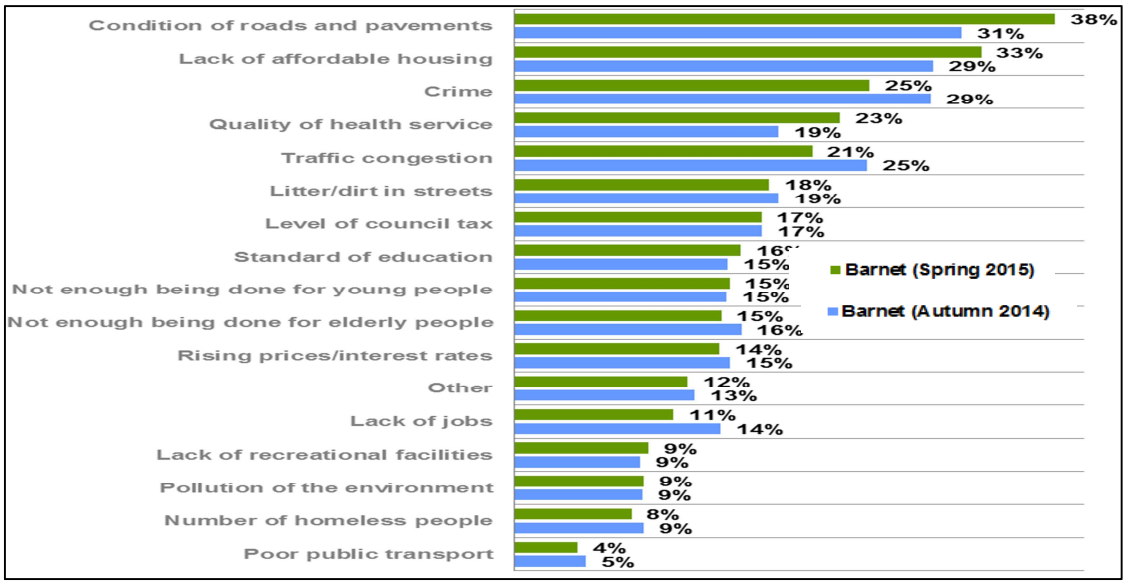
The top three concerns for residents according to the spring 2015 Residents' Perception Survey were:

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

Since autumn 2014 there have been significant increases in concern regarding the conditions of roads and pavements, quality of health service and lack of affordable housing. However there has been a significant decrease in concern related to crime, traffic congestion and lack of jobs.

In comparison to London the only areas where Barnet residents are significantly more concerned are: lack of affordable housing, quality of health service, not enough being done for elderly people, and standard of education.

Figure 12-4: "Which three things are you personally most concerned about?"



12.7 Volunteering

26% of residents give unpaid help to groups, clubs, or organisations at least once a week or once a month (spring 2015). This is in line with autumn 2012 (27%), and is a significant increase since 2010/11 (21%). There is no up-to-date national or regional data concerning volunteering, however, the national average for 2010/11 was 24%; Barnet's current result is in line with this.

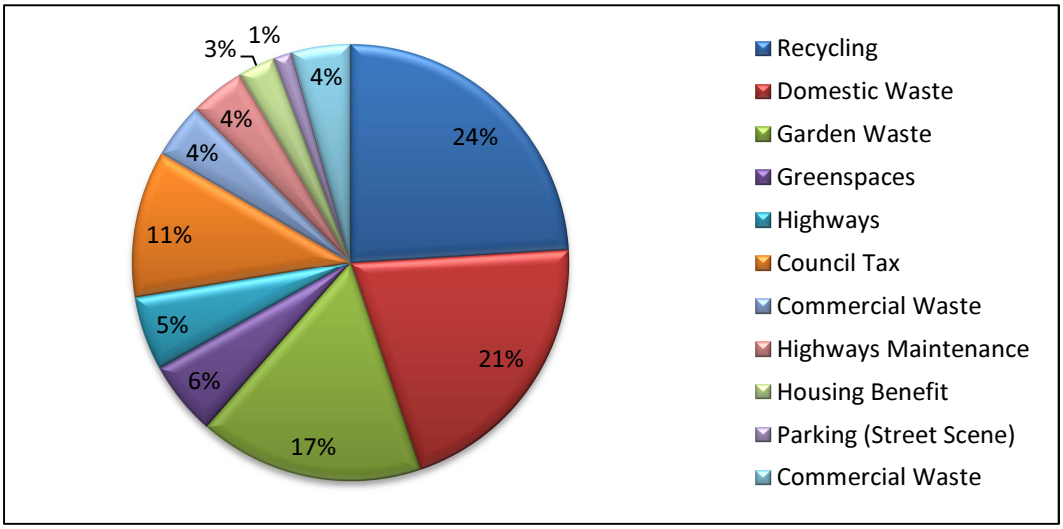
12.8 Community Cohesion

As of spring 2015, 84% of residents agree that people from different backgrounds get on well together in Barnet. This is in line with the results from autumn 2014 (84%) and the 2013/14 national average (85%). Of the 84% of respondents that agreed with this statement, 47% strongly agreed. According to the full report from spring 2014 RPS, those living in Burnt Oak or West Hendon were significantly more likely to feel that those from different backgrounds do not get on well together.

12.9 Complaints

Figure 12-5 shows the top ten areas of complaint received by the Council in quarter 4 of 2013/14.

Figure 12-5: Top Ten Areas of Complaint



The largest area for complaints, constituting almost a quarter of top ten complaints is recycling (24%), followed by domestic waste (21%), and garden waste (17%). Together, household waste and recycling constitute 62% of the top ten complaints.

13 Public Sector Finance

13.1 Purpose

This section summarises the overall spend of different partners in Barnet including the Council, Barnet Clinical Commissioning Group, Adults and Communities, Children's Service, and Public Health spending.

The intention in setting out Council and NHS finances is so that they can be viewed and understood against the context of the needs in the population identified in this JSNA.

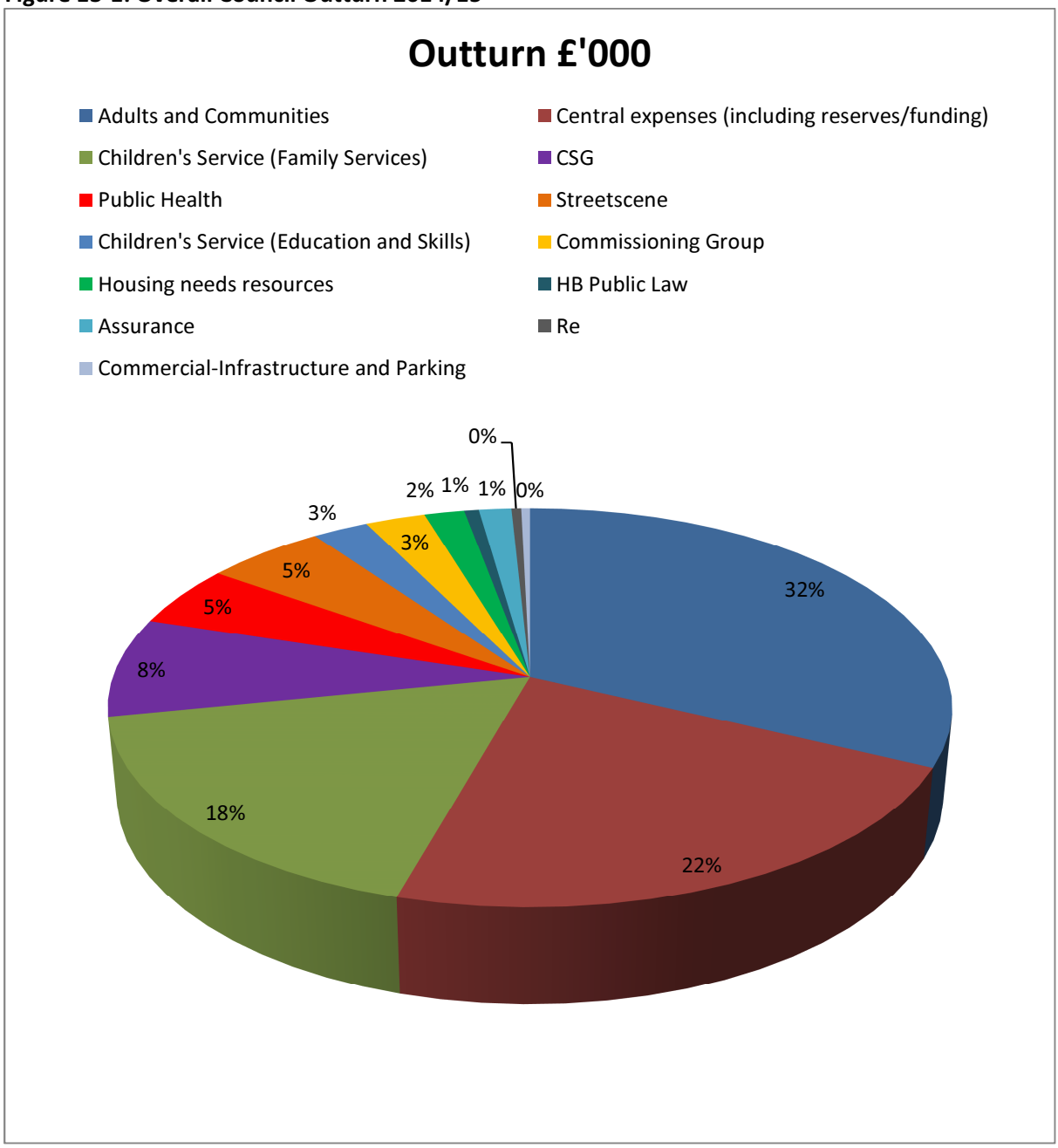
13.2 Overall Council Spend 2014/15

Table 13-1: Overall Council Budget and Outturn 2014/15

Delivery Unit	Original Net Budget	Current Net Budget	Outturn
	£'000	£'000	£'000
Adults and Communities	89,669	90,746	93,218
Central expenses	74,323	66,220	64,352
Children's Service (Family Services)	48,342	50,436	50,505
CSG	22,153	23,341	23,341
Public Health	14,302	14,335	14,335
Streetscene	15,650	15,357	15,399
Children's Service (Education and Skills)	7,069	7,211	7,211
Commissioning Group	6,668	7,760	7,760
Housing needs resources	3,338	4,833	5,170
HB Public Law	1,782	1,952	1,883
Assurance	4,005	4,060	4,186
Re	767	1,039	1,257
Commercial-Infrastructure and Parking	-1,657	-878	-1,126
Total	**286,411**	**286,412**	**287,491**

Note: the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

Figure 13-1: Overall Council Outturn 2014/15



Biggest areas of net spend: The biggest areas of net spend of the Council are **Adults and Communities** and **Children's Service (Family Services)**.

Pressures: The Council's budget is expected to decrease by **11.7%** over the five years to 2020.

13.3 Adults and Communities 2014-15

Table 13-2: Adults and Communities Budget and Outturn 2014-15

Adults and Communities	Original Net Budget	Current Net Budget	Outturn
	£'000	£'000	£'000
Births, Deaths & Marriages	-161	-160	-12
Care Quality	1,363	1,353	1,227
Community Safety	1,965	1,911	1,623
Community Well-being	-289	212	-135
Director Adults Social Service & Health	185	187	178
Integrated Care – Learning Disability & Mental Health	38,923	40,845	42,711
Integrated Care – Older people & Physical Disability	38,403	38,595	41,145
Prevention & Well-being	6,967	6,471	5,175
Social Care Commissioning	918	936	987
Social Care Management	1,396	396	319
Total	**89,670**	**90,746**	**93,218**

Note: the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

Biggest areas of net spend: The biggest areas of net spend within Adults are towards **Integrated Care for Learning Disability and Mental Health** and **Integrated Care for Older People and Physical Disability**.

13.4 Children's Service 2014/15

Table 13-3: Children's Service (Family Services) Budget and Outturn 2014/15

Children's Services (Family Services)	Original Net Budget	Current Net Budget	Outturn
	£'000	£'000	£'000
Assessment & Children in Need	6,807	7,214	7,781
Children in Care - Provider Service	20,829	22,010	22,796
Commissioning & Business Improvement	3,006	3,285	2,476
Early Years	5,027	4,697	5,039
Family Services Management	660	899	324
Family Support & Early Intervention	776	740	761
Safeguarding & Quality Assurance	1,857	1,937	2,092
Social Care Management	1,694	1,716	1,678
Youth & Community	7,687	7,939	7,559
Total	**48,343**	**50,437**	**50,506**

Note: the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

Table 13-4: Children's Service (Education and Skills) Budget and Outturn 2014/15

Children's Service (Education and Skills)	Original Net Budget	Current Net Budget	Outturn
	£'000	£'000	£'000
Edu Partnership & Commercial	1,056	949	740
Education Management Team	195	196	-97
High Needs Support	5,806	6,067	6,569
Total	**7,057**	**7,212**	**7,212**

Note: the difference in the Original Net Budget figures and Current Net Budget figures is due to budget movements within the financial year. These can include a transfer of services from another delivery unit, inflationary bids or pressures agreed from Contingency.

Biggest areas of net spend: Within Family services the biggest areas of net spend are around **Children in Care-Provider Service** and **Assessment & Children in Need**. Within Education and Skills the biggest area of net spend is around **High Needs Support.**

13.5 Public Health 2014-15

Table 13-5: Public Health Expenditure of £14,335,000 grant 2014/15

Public Health	Original Net Budget £'000	Current Net Budget £'000	Outturn £'000
Mandatory Services			
Sexual health	4,368	4,368	4,555
Health Checks	573	573	328
School Nursing	1,084	1,084	1,109
Total	**6,025**	**6,025**	**5,992**
Discretionary Services			
Tobacco control	707	707	345
Drugs and Alcohol misuse	2,887	2,887	2,910
Physical Activity	680	680	611
Total	**4,274**	**4,274**	**3,866**
Barnet Public Health	**2,129**	**2,129**	**1,049**
Contribution to Public Health Team	**1,962**	**1,962**	**2,392**
Total Barnet Public Health	**14,390**	**14,390**	**13,299**
Direct Barnet expenditure		**33**	**33**
MOPAC	**-88**	**-88**	**-88**
Wider Determinants			**800**
Total Grant	**14,302**	**14,335**	**14,044**
Contribution to Reserves			**291**
Total Grant			**14,335**

Note: the increase in the Original Net Budget figures and Current Net Budget figures is due to the Policy Officer post contribution.

Biggest areas of net spend: The biggest areas of net spend are towards **Sexual Health** and **Drugs and Alcohol Misuse**.

13.6 Barnet Clinical Commissioning Group 2014-15

Table 13-6: Barnet CCG Budget and Outturn 2014/15

CCG	Original Budget	Current Budget	Outturn
	£'000	£'000	£'000
Income	**408,734**	**428,473**	**428,473**
Expenditure			
Acute	254,577	271,586	263,476
Mental Health	37,573	37,754	37,691
Community	70,506	71,717	69,113
Primary Care	51,207	52,270	52,946
Other	18,821	19,091	16,267
Total	**432,684**	**452,418**	**439,493**
Net deficit	**23,950**	**23,945**	**11,020**

Note: the increase from the Original Net Budget to Current Net Budget figures is due to additional non-recurrent funding received in year from NHS England for specific initiatives (e.g. additional patient services over the winter period) or from local North Central London CCGs for specific across CCG projects (e.g. impact of Barnet, Enfield and Haringey Clinical Strategy)

Biggest areas of net spend: the biggest areas of net spend are around **Acute** spending and **Community.**

14 Appendix-1 Barnet (PHOF) Indicators that are worse or lower than England

(Benchmark: England)

Compared with benchmark:	Better	Similar	Worse	Lower	Similar	Higher	Not compared

Indicator Name	Year	Barnet		England
Wider Determinants of Health		**Count**	**Value**	**Value**
1.15ii - Statutory homelessness - households in temporary accommodation (persons, all ages)	2013/14	2,401	16.9 / 1,000	2.6 / 1,000
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like (persons, all ages)	2012/13	No data	35.8%	41.3%
Health Improvement				
2.15ii - Successful completion of drug treatment - non-opiate users (persons, 18-75 yrs)	2013	74	20.4%	37.7%
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment (persons, 18+ yrs)	2012/13	112	55.4%	46.9%
2.17 - Recorded diabetes (persons, 17+ yrs)	2013/14	17,970	6.0%	6.2%
2.20i - Cancer screening coverage - breast cancer (Female, 53-70 yrs)	2014	23,337	71.2%	75.9%
2.20ii - Cancer screening coverage - cervical cancer (Female, 25-64 yrs)	2014	72,574	68.8%	74.2%
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check (persons)	2013/14 – 14/15	31,104	33.4%	37.9%
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check (persons)	2013/14 – 14/15	13,687	44.0%	48.9%
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check (persons)	2013/14 – 14/15	13,687	14.7%	18.6%
Health Protection				
3.02 - Chlamydia detection rate (15-24 year olds) – CTAD (persons, 15-24 yrs)	2014	600	1376†	2,012†
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 yr old, persons)	2013/14	4,612	79.7%	94.3%
3.03v - Population vaccination coverage - PCV	2013/14	4,767	82.3%	94.1%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 yrs old, persons)	2013/14	4,833	80.2%	92.5%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 yrs old, persons)	2013/14	5,122	86.0%	91.9%
3.03vii - Population vaccination coverage - PCV booster (2 yrs old, persons)	2013/14	4,839	80.3%	92.4%
3.03viii - Population vaccination coverage - MMR for one dose (2 yrs old, persons)	2013/14	4,863	80.7%	92.7%
3.03x - Population vaccination coverage - MMR for two doses (5 yrs old, persons)	2013/14	4,473	75.1%	88.3%
3.03xii - Population vaccination coverage – HPV (Female, 12-13 yrs)	2013/14	1,339	69.5%	86.7%
3.03xiii - Population vaccination coverage – PPV CTAD (persons, 65+ yrs)	2013/14	30,921	64.6%	68.9%
3.03xiv - Population vaccination coverage - Flu (persons, 65+ yrs)	2014/15	38,821	71.0%	72.7%
3.03xv - Population vaccination coverage - Flu (at risk individuals) (persons, 6 months - 64 yrs)	2014/15	16,855	48.4%	50.3%
3.04 - People presenting with HIV at a late stage of infection (persons, 15 yrs)	2011-13	68	51.5%	45.0%
3.05ii - Incidence of TB (persons, all ages)	2011-13	283	25.9†	14.8†

†Per 100,000; Data source: Public Health England. Public Health Outcomes Framework (PHOF). Data Release: 4th Aug. 2015

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Barnet's JSNA 2015 – 2020

Executive Summary

Structure

1. Demography

- Barnet is the **largest Borough in London by population and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with **over 113% growth in Golders Green and 56% in Colindale** by 2030.
- **The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030,** and the rate increases more in successive age bands. For instance, the 65+ population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%.
- **Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over**, increasing by 5.8% and 5.5% respectively during the period 2015-2030.
- **The Borough will become increasingly diverse, driven predominantly by natural change in the existing population**. One of the key challenges will be meeting the diverse needs of these different and growing communities. **Colindale, Burnt Oak and West Hendon have populations that are more than 50% BAME backgrounds**. Over 50% of all 0-4 year olds in Barnet are from a BAME background in 2015 and this is forecast to continue to increase.
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less than the average for men and 4.7 years less for women. By Ward, **Burnt Oak has the lowest average life expectancy from birth 78.8 years.**
- The west of the Borough has the highest concentration of more deprived LSOAs, with **the highest levels of deprivation in Colindale, West Hendon and Burnt Oak**. However, the **most deprived LSOA in Barnet is located in**

East Finchley, specifically the Strawberry Vale estate, and falls within the 11% most deprived LSOAs in the country.

- Coronary Heart Disease is the number one cause of death amongst both men and women. **As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women.**
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores. Both of these indicators have experienced a decline since 2011.
- Some areas, particularly Golders Green, Colindale and Mill Hill, will get younger, bucking the trend of an ageing Borough.

2. Socio-Economic and Environmental Context

- There is a long term **shift in housing tenure towards renting and away from owner occupancy** (either outright or with a mortgage) reflecting a sustained reduction in housing affordability and an imbalance between housing demand and supply.
- **Housing affordability is the second highest concern for residents** according to the 2015 Residents' Perception Survey. Only the condition of roads and pavements is a higher concern.
- Currently, the significant majority of older residents own their own home and use the equity they have built up to fund the care they may need later in life. **Over the coming years a declining proportion of the growing older population will own their own home**, having important implications for how the health and care system works and is paid for in the Borough.
- Social isolation is an important driver of demand for health and care services. In Barnet **social isolation is associated with areas of higher affluence and lower population density,** as people in these areas tend to have weaker, less established community and family networks locally.
- **Average income is rising in Barnet, however this growth is driven predominantly by more affluent wards, with wage growth in other areas stagnating and even falling in real terms,** resulting in higher income inequality between different areas in Barnet. More work is needed to understand what is driving this divide and its implications.
- There are **significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards**, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill.
- Employers in Barnet say **they can find it difficult to find people with the right employability skills,** particularly in relation to having the right attitude, motivation and numeracy/literacy amongst candidates.
- **There are shortages of people available to fill vacancies in the caring, leisure and services sector, associate professionals sectors, and skilled trades sector in Barnet**. Future careers advice and education/training offers could focus on filling these.

- Barnet has a very low proportion of people with learning disabilities and mental health conditions in employment compared with similar Boroughs.
- **Pollution levels are higher along arterial routes,** particularly the North Circular, M1, A1 and A5.
- The majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services.

3: Health

- 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 an 8 year difference in male life expectancy between Burnt Oak and Garden Suburb wards.** Bigger differences exist at lower geographical levels. **Circulatory diseases are the main contributors to differences in life expectancy between different areas**.
- Smoking, diet and alcohol are the main contributors to premature death in Barnet.
- **The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England.** The wards with the highest rates of mortality from stroke are Burnt Oak, Childs Hill and Colindale.
- **Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average** (23.3 per 100,000 vs. 15.5 per 100,000). More work is needed to understand why this is the case.
- Overall rates of individual mental health problems are higher in Barnet than London and England; **the rate of detention for a mental health condition is significantly higher than the London or England averages.**
- Poor dental health is associated with poor health outcomes in later life. With this in mind, **child dental decay is the top cause for non-emergency hospital admissions in Barnet.**
- **Women in Barnet are significantly less likely to quit smoking in pregnancy** than women on average in London.
- **Barnet performs poorly for some immunisations that are strongly associated with poor outcomes and additional demand pressures later in life.** Particularly HPV, flu and pneumococcal (PCV) immunisation and childhood immunisations are lower than the average national rates.
- **Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate** and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes.

4: Lifestyle

- Barnet has a relatively low level of smoking prevalence compared with other areas, however **smoking cessation programmes in Barnet are significantly less effective than in England on average**, indicating that the current £8m cost to the NHS of smoking in Barnet could be reduced.
- The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill, and Underhill.
- **Barnet has a higher rate of underweight adults and children** than London or England.
- **The wards with the highest rates of child obesity are Colindale, Burnt Oak and Underhill.** These are also the wards with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering.
- The rates for alcohol related mortality and hospital admissions in males are rising in Barnet.
- **The wards with the highest rates of admission to hospital with alcohol-related conditions are Burnt Oak, West Hendon and Colindale.**
- **Treatment for alcohol dependency in Barnet is less effective than in the rest of the country.** Specifically, completion rates for treatment for alcohol dependency are below the national average, and the rate of re-presentations after treatment are higher.
- The number of MARAC **cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013**.
- **For non-opiate drug users successful completion rates are lower than in England,** and the proportion of those who successfully complete a programme and do not re-present for treatment within 6 months has decreased below the baseline and is also lower than the average for England.
- **The rate of GP prescribed long acting reversible contraceptives in Barnet is lower than the average rates for the London region and England**.
- The evidence-based public health interventions with the highest "return on investment" according to the respected Kings Fund are: **housing interventions** (e.g. warm homes), **school programmes** (e.g. to reduce child obesity and smoking), **education to reduce teenage pregnancy**, and **good parenting classes**.

5: Primary and Secondary Care

- Barnet has more than 100 care homes, with the highest number of residential beds in London, leading to **a significant net import of residents with health needs moving to Barnet** from other areas.
- **Increasing levels of delayed discharges place added pressure on bed capacity and emergency admissions**.
- Need for the **development of high standard integrated out-of-hospital community services**, with the appropriate skills mix/capacity, available 24/7 to halt rising use of hospital care.
- An **insufficient level of capacity outside of acute hospitals** is resulting in some patients having extended stays in such hospital.
- **There is increasing demand for urgent and emergency care,** with Barnet A&E activity recording an increase in 14/15 compared to 13/14.
- **The 95% national target for Accident and Emergency (A&E) patients waiting no longer than four hours from the time of booking in to either admission to hospital or discharge** was missed in quarter 4 14/15 (Q4 RFL 94.3%).
- Limited capacity/inability to move patients onto rehabilitation pathways.
- **Obesity growth in middle-age population** (45-65) year olds places additional risk of them developing long-term conditions.

6: Children and Young People

- **The high rates of population growth for children and young people (CYP)** will occur in wards with planned development works and **are predominantly in the west** of the Borough. The growth of CYP combined with **benefit cuts will place significant pressure on the demand for services** from children's social care and specialist resources from other agencies (notably health).
- Domestic violence, parental mental ill health and parental substance abuse (toxic trio) are the most common and consistent contributory factors in referrals into social care**. Effective prevention and early intervention could help to reduce impact on CYP and their families** and minimise referrals to children's social care and other specialist services within health and criminal justice system.
- **Child poverty is entrenched in specific areas of Barnet (notably west);** targeted multi-agency, locality based interventions could better support families.
- **The Young Carers Act and Children and Families Act 2014** represent significant reform of care and support to children and young people with special educational needs and disabilities, and those caring for others. It is expected to raise the expectations of parents and carers. This **will represent a challenge to the Local Authority and partner agencies.**
- The number of post-16 pupils remaining in special schools is placing **pressure on the availability of places for admission of younger pupils.**

- Overall, all **children in Barnet achieve good levels of educational attainment** against statistical neighbours and national averages. However, **the attainment for disadvantaged groups against their peers in Barnet has widened** compared to the London gap. Data shows the gap is wider for black boys in Barnet.
- **Neglect** is the primary reason for children and young people to have a child protection plan.
- The **rate of re-offending is decreasing.** However, there has been **an increase in the seriousness** of offending by a small proportion of young people who are **associated with gangs.**
- 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years and 35% are male. **The pattern of CSE in Barnet is wide and varied**. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet. There is a strong correlation between children who go missing and those known to be victims and or at risk of CSE.
- The **numbers of children in Barnet that go missing have remained fairly consistent** throughout 14/15, averaging 5 or less children per month. This requires resources which can assess, collate and analyse information provided by the young people who go missing to determine what interventions are required to mitigate against this.

7: Adult Social Care

- The **highest proportion of referrals** into Adult Social Care **are from secondary health care teams**.
- **Mental disorder** is responsible for the **largest burden of disease in England** – 23% of the total burden. Within Barnet, by far the **most significant element of the CCG's mental health expenditure is in secondary mental health** (i.e. hospital/residential settings).
- As more young people with complex needs survive into adulthood, there is a national and local drive to help them to **live as independently** and **within the community** as possible. This places significant pressure on ensuring that the right services such as **appropriate housing and support needs** are available to **meet their requirements**.
- There is a significant shift in the way in which support is delivered with more **people choosing to remain at home** for a longer period of time. This requires **effective, targeted, local based provision.**
- Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. In Barnet, social isolation is especially prominent in **elderly women who live alone**, especially in **areas of higher affluence and lower population density.**
- **Demand for enablement services** should be around **5% of the 65 and over population**. In **2013/14** the service was used by **1,660 people, 3.3% of the**

65 and over population, which indicates a **deficiency or potential unmet need of around 800 people.**

- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746).
- **Carers have the potential** to make **significant savings to health and social care services** each year. However, on average **carers are more likely to report having poor health than non-carers**, especially amongst carers who deliver in excess of 50 hours of care per week.
- **Demand for carers is projected to grow** with the increase in life expectancy, the increase in people living with a disability needing care and with the changes to community based support services.
- **Barnet** has a **higher population of people with dementia than many London Boroughs** and the **highest number of care home places** registered **for dementia per 100 population** aged 65 and over in London. **By 2021, the number of people with dementia** in Barnet is expected to **increase by 24%** compared with a London-wide figure of 19%.

8: Community Safety

- **Barnet has the 5th highest rate of Residential burglary out of the 32 London Boroughs** (per 1000 households). The rate of residential burglary climbed substantially between 2008 and 2012; despite a sharp fall since April 2013 burglary remains above the London average and is still a prominent issue of community concern.
- Across the Borough **the cost of recorded crime is estimated at over £73.9 million** in the 12 months up to Feb 2014. When considering underreporting the **true cost could be nearer £169 million.** The reduction in crime achieved in the last 12 months equates to an estimated saving of £1.7 million over the 12 months.
- There is evidence that young people are significantly more likely to be a victim of crime, **and also that they are less likely to report that they have been a victim of crime**. More work is needed to understand this phenomenon and to address possible underreporting.
- **Despite constituting just 6.5% of offences, violent assaults** (ABH and GBH) **have the greatest associated costs, accounting for 29% of the total costs.**
- **Domestic violence is more familiar and bedded down within some services and organisations than other Violence Against Women and Girls (VAWG) issues**; further work needs to take place to identify if additional VAWG services are needed within the Borough.

9: Community Assets

- Key areas of activity in relation to the voluntary and community sector over the next five years include:
  - In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
  - In children's services, as well as preventative activity, **increased childcare in community settings;** more diverse community provision particularly around mental health, and increased community involvement in the governance of services such as children's centres or libraries.
  - **Working with VCS groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities, particularly in the Borough's parks and green spaces.
  - In housing, growth and regeneration, **supporting people affected by welfare reforms and/or on-going poverty.**
  - In environmental services, **getting more people proactively engaged in developing and maintaining their local areas.**
- **Local community sports provision is reasonably well matched to need. There is, however, the potential to develop this further in areas where childhood obesity rates are high** (Colindale, Burnt Oak and Underhill).
- **Local VCS provision for children is relatively low in the areas where the population of children and young people is forecast to be amongst the highest in the future** (Colindale).
- VCS activity relating to economic development and unemployment is well developed in Colindale and Burnt Oak, the wards with the highest unemployment rates in Barnet. However, there **is weaker VCS provision in East Finchley and Underhill, wards which also have significant levels of deprivation.**
- More generally, there are opportunities to:
  - **support and develop the broader volunteering base through diversifying the offer to volunteers**, promoting opportunities such as timebanking, employer supported volunteering, corporate social responsibility and community action (coordinated through the core volunteer offer).
  - **rethink physical asset provision, including the lower levels of physical community assets present in the North West and centre of the Borough.**
  - respond to the fact that a significant proportion of local charitable activity in Barnet is focused within faith communities, and this capacity could be better engaged with to deliver health and wellbeing outcomes.

10: Resident Voice

- Over 40% of respondents rated **'Quality of payments'**, '**Parking services' and** '**Repair of roads' as being poor or extremely poor services** provided by the council.
- The **top three concerns** for residents according to the spring 2015 Residents' Perception Survey were '**Conditions of roads and pavements (38%); Lack of affordable housing (33%); and Crime (25%)**.
- Since autumn 2014 there has been a **significant increase in residents' concerns** about the **conditions of roads and pavements**, **quality of health service and lack of affordable housing.**
- **Satisfaction levels of Barnet vary throughout the Borough**, with residents living in Finchley Church End, Garden Suburb, or Totteridge significantly more likely to be satisfied with Barnet as a place to live, whereas **those living in Burnt Oak are less likely to be satisfied with Barnet as a place to live**.
- According to data from the spring 2014 Residents' Perception Survey, **those living in Burnt Oak or West Hendon** were significantly **more likely to feel that those from different backgrounds do not get on well together**.

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AGENDA ITEM 8

	Health and Wellbeing Board **17 September 2015**
Title	**Draft Joint Health and Wellbeing Strategy (2016 – 2020)**
Report of	Commissioning Director – Adults and Health Director of Public Health
Wards	All
Date added to Forward Plan	March 2015
Status	Public
Enclosures	Appendix 1: Draft Joint Health and Wellbeing Strategy (2016 – 2020)
Officer Contact Details	Zoë Garbett, Commissioning Lead, Health and Wellbeing Email: zoe.garbett@barnet.gov.uk, Tel: 020 8359 3478

Summary

This briefing provides an update on the development of Barnet's Joint Health and Wellbeing Strategy, which is currently at draft stage (appendix 1), and seeks the views of the Health and Wellbeing Board on its content and format prior to consultation and before it returns to the Board in final form on 12 November 2015.

Recommendations

1. **That the Health and Wellbeing Board notes the draft Joint Health and Wellbeing Strategy (2016-2020) and comments on its content, including any areas to be developed further.**
2. **That the Health and Wellbeing Board approves the draft Joint Health and Wellbeing Strategy for public consultation from 17 September to 25 October 2015.**
3. **That the Health and Wellbeing Board notes that the final Joint Health and Wellbeing Strategy will return to the Board on 12 November 2015 for sign off.**

1. WHY IS THE REPORT NEEDED

1.1 Background

1.1.1 At its meeting in November 2014 the Health and Well-Being Board (HWBB) requested work to commence on refreshing the current Barnet Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing (JHWB) Strategy, which were originally produced in 2011/2012 and expire in 2015.

1.1.2 The JHWB Strategy refresh offers an opportunity to review and improve the focus of the HWBB and its partners.

1.1.3 Key features of the JHWB Strategy refresh -

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

1.2 Work to date

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

1.2.2 The aims of the updated are Strategy –

- Keeping well
- Promoting independence

1.2.3 The current Strategy has four themes; the four themes have been retained with updated priorities. Each section of the Strategy (appendix 1) highlights activity since the last Strategy, key data from the updated JSNA, planned activity to meet our objectives in the area as well as targets. The table below gives an overview of each section –

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

1.3 **Consultation**

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

1.3.2 A public consultation is planned from 17 September – 25 October to gain the views of partners, colleagues and residents on the draft JHWB Strategy. The consultation will include an online feedback form promoted through a number of channels including CommUNITY Barnet, Healthwatch, Patient Participation Groups, Barnet's Communication team, local events and organised visits and meetings to specific groups such as schools and the Practitioner's Forum.

1.3.3 Feedback from the consultation will inform the final JHWB Strategy 2016-

2020 and will be reported to the Health and Wellbeing in November with the final Strategy.

2. REASONS FOR RECOMMENDATIONS

2.1 Producing a Joint Health and Wellbeing Strategy 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 JHWB Strategy, through the Health and Wellbeing Board.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is a legal requirement to draft a Health and Wellbeing Strategy. Not producing a JHWB Strategy would create a risk of non-alignment across the Health and Wellbeing 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 JHWB Strategy will go out to public consultation. Comments from the Health and Wellbeing Board and the consultation will inform the content of the final JHWB Strategy.

4.2 The final JHWB Strategy will return to the Health and Wellbeing Board for approval in November 2015. The JHWB Strategy will be presented with the Public Health report on activity 2014/15, the dementia manifesto and Carers Strategy to show our position and progress on these pieces of work.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

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

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

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

5.3 Legal and Constitutional References

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

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

5.5 **Equalities and Diversity**

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

5.5.2 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010, advance equality of opportunity

between people from different groups and foster good relations between people from different groups. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.6 **Consultation and Engagement**

5.6.1 See point 1.3. A number of partners have been involved in the development of the JHWB Strategy and a public consultation is planned ahead of the final JHWB Strategy being produced in November.

6. BACKGROUND PAPERS

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

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

Keeping Well, Promoting Independence

A Joint Health and Wellbeing Strategy for Barnet 2016 – 2020

LOGOS (of HWBB members to be added)

Contents

DRAFT

1. Councillor Helena Hart / Dr Debbie Frost foreword – to be added

2. What we are trying to achieve

Barnet is a great place to live and is now the largest Borough in London by population. People in Barnet can expect to live longer and in better health than in many parts of London and England as a whole. This is not by chance but is linked to a range of factors including levels of family support, lifestyle, wealth, access to healthcare and green spaces as well as the ability to access the right support when needed.

While the overall picture is positive, the current Barnet Joint Strategic Needs Assessment (JSNA) has shown that there are marked differences in health and wellbeing outcomes, between places and different demographic groups within Barnet. With less and less public money available, this Joint Health and Wellbeing Strategy aims to align and combine our efforts on a focused list of priorities where together we can make the largest impact to reduce health inequalities.

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

We hope to inspire and encourage both individuals and Partners with this Strategy and our vision for health and wellbeing in Barnet; we will do this through the following approach -

- Providing a shared vision and strategic direction across partners
- Continuing the emphasis on prevention and early intervention including secondary prevention (slowing the progression of disease)
- Making health and wellbeing a personal agenda as well as increasing individual responsibility and building resilience
- Joining up services so residents have a better experience
- Developing greater community capacity; increasing community responsibility and opportunities for residents to design services with us
- Strengthening partnerships to effect change and improvement
- Putting emphasis on working holistically to reduce health inequalities

It is our vision for Barnet residents, where appropriate, to be able to far better manage their own health and wellbeing. Barnet has a strong foundation for using resources within local communities with 88% of residents satisfied with their local

area and 90% of residents saying that they help their neighbours out when needed. 28% of residents volunteer regularly (weekly or monthly) and over 1,400 voluntary and community sector organisations are active in the Borough.

The Joint Health and Wellbeing Strategy reflects Barnet's Strategic Equalities Objective that *"Citizens will be treated equally, with understanding and respect, and will have equal access to quality services which provide value to the taxpayer."*

The Health and Wellbeing Board and its partners are well placed to seek to improve wellbeing and tackle inequalities locally. Organisations and partners and residents, tell us that they all want the same thing – to keep well and promote independence. This Strategy is a guide as to how, together, we can have the biggest impact.

We have consulted widely on this Strategy not only to ensure that people feel it is appropriate but also to embed our vision across the public sector and to develop joint services to make the biggest difference.

Aims

The Joint Health and Wellbeing Strategy has two overarching aims consistent with the aims of the previous strategy –

Keeping Well – Based upon a strong belief that 'prevention is better than cure', this Strategy aims to begin at the very earliest opportunity by giving every child in Barnet the best possible start to live a healthy life. It aims to create more opportunities to develop healthy and flourishing neighbourhoods and communities as well as to support people to adopt healthy lifestyles in order to prevent avoidable disease and illness.

Promoting Independence – This Strategy aims to support residents and communities to become equal partners, with public services, to improve health and wellbeing. It also aims to ensure that when extra care is needed, this is delivered in a way which enables everyone (children, young people, adults and older people) to regain as much independence as possible, as soon as possible, and as ever supported by health and social care services working together.

It is our aim that this Strategy should be used to inform service planning and service development across the public, private and voluntary and community sectors in the Borough. Barnet's Health and Wellbeing Board is responsible for the development of this Strategy and for overseeing its implementation. Further information about the Barnet Health and Wellbeing Board; its membership, subgroups and associated groups can be found at appendix one.

Themes and priorities

Annually the Health and Wellbeing Board has reviewed the progress made against the previous Health and Wellbeing Strategy (2012 – 2015) and, based on the progress made, has identified a number of priorities. Using the updated JSNA we are now able to review the progress made and redefine our approach for the lifetime of this refreshed Joint Health and Wellbeing (JHWB) Strategy (2016 – 2020). Our current Health and Wellbeing Strategy focuses on priorities across four theme areas and these priorities have been retained for the refreshed Strategy. The table below gives an overview of the theme areas and the priorities we will focus on within each theme area –

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

Our efforts across the priorities will have a cumulative positive impact. Our aspiration for all children, young people, adults and older people are embedded across the theme areas.

3. Where we are now

Barnet at a glance

The latest Barnet JSNA, formulated in 2015, is an impartial and up-to-date evidence base to be used as an effective means for joined up decision making across all sectors. The JSNA provides the data and information from which we can determine our priorities. The key headlines from the JSNA are -

- Barnet is now the **largest Borough in London by population (projected to be 367,265 by the end of 2015) and is continuing to grow**. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with over 113% growth in Golders Green and 56% in Colindale by 2030
- **The west of the Borough has generally the highest levels of deprivation in the wards of Colindale, West Hendon and Burnt Oak.** Although, the **Strawberry Vale estate in East Finchley ward is actually the most deprived area** in the Borough
- **Barnet's population is becoming more diverse**, driven predominantly by natural change in the established population. The highest proportion of the population from White ethnic backgrounds are found in the 90 years and over age group (93.3%); whereas the highest proportion of people from Black, Asian and minority ethnic (BAME) groups are found in the 0-4 age group (55.4%). The wards of Colindale, Burnt Oak and West Hendon have populations of whom more than 50% are from BAME backgrounds
- In Barnet, as in the rest of the Country, **women have a higher average life expectancy (85 years) than men (81.9 years).** The life expectancy of men has increased at a higher rate than that of women, reducing the life expectancy gap between genders from 5.1 years (1991/93) to 3.1 years
- The life expectancy of individuals living in the most deprived areas of the Borough are on average 7.6 years less for men and 4.7 years less for women than those in the most affluent areas. By ward, **Burnt Oak has the lowest average life expectancy from birth of 78.8 years,** 4.2 years behind the Barnet average and 8.3 years behind Garden Suburb, which has the highest life expectancy of 87.1 from birth
- Gains in life expectancy have outstripped gains in **healthy life expectancy.** This indicates that although women are living (on average) longer than men, **a larger proportion of women's lives is spent in poor health**; 19.1% (16.2 years) for women and 17.0% (13.9 years) for men
- **Coronary Heart Disease is the number one cause of death amongst men and women, followed by Cancer**

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- Due to the projected population increase in those 65 and over, **the number of people aged over 65 living with moderate or severe learning disabilities is estimated to rise** from 143 in 2015 to 187 in 2030
- It is estimated that over **4,000 people in Barnet are living with dementia** and even greater numbers of families and friends are adversely impacted by the condition. By 2021 the number of **people with dementia in Barnet is expected to increase** by 24% compared with a London-wide figure of 19%
- During 2013/14, **4,957 people were diagnosed as having had a stroke**. The rate of emergency hospital admissions for stroke in Barnet (235.4 / 100,000) was higher than the national rate (174.3 / 100,000)
- In 2013-14, **breastfeeding initiation in Barnet was the 11th highest among all 326 English Local Authorities** and 9th highest among the 33 London Boroughs.
- Barnet has a **relatively low level of smoking prevalence compared with other areas** (15% of adults over 18 years, compared to 18.4% nationally).
- Barnet has a relatively **high percentage of the adult population with a healthy weight** (42.1%). Although the percentage of adults with excess weight (55.7%) (combined overweight 35.2%, plus obese 20.5%) is low compared to the national average it nonetheless covers a large proportion of the adult population. Barnet also has a **high percentage of underweight adults** (2.3%) compared to the national level (1.2%)
- For children aged 4 - 5 years, the percentage of excess weight (overweight and obese) of 21% in 2013/14 was lower than London (23.1%) and England (22.5%) averages and has declined over the past five years. However, the proportion of **excess weight for children** aged 10 – 11 years has increased to 34.4% in 2013/14 compared to 33.6% in 2012/13; this is similar to the national rate but still lower than the London region (37.59%)
- Barnet is ranked 16th and 14th out of all London Boroughs in relation to 'life-satisfaction' and 'worthwhileness' wellbeing scores out of the 33 London Boroughs. Both of these indicators have experienced a decline in Barnet since 2011. **Satisfaction levels of Barnet vary throughout the Borough** peaking in Finchley Church End, Garden Suburb and Totteridge with satisfaction being lowest in Burnt Oak

The full JSNA can be accessed here – *Add website link when available*

Policy context

Although it has only been three years since the last JHWB Strategy the policy context has moved on greatly with a number of major legislative changes and policy developments.

Locally, the Council approved it its **Corporate Plan** (2015 – 2020)[1] in April 2015 which strives to ensure that Barnet is the place of opportunity, where people are helped to help themselves, where responsibility is shared and where high quality services are delivered effectively and at low cost to the taxpayer. The Council's Corporate Plan sets the framework for each of the Commissioning Committees' five year commissioning plans. Whether the plans are covering social care services or concern universal services such as the environment and waste, there are a number of core and shared principles which underpin the commissioning outcomes – the principles of fairness, responsibility and opportunity. With the Corporate Plan, this Strategy will provide strategic direction to council Strategies and action plans, including those on housing, regeneration, transport, employment and business.

The Barnet Clinical Commissioning Group's (BCCG) **Five Year Strategic Plan** (2014 – 2019) outlines its strategic vision to work with local people to develop seamless, accessible care for a healthier Barnet. BCCG goals are to promote health and wellbeing; transform Primary Care; ensure the right care, first time and develop joined up care.

Nationally it is proposed that GPs provide services on a seven-day a week, 8am – 8pm basis by 2020. BCCG had submitted a collaborative bid with Enfield CCG in partnership with Barnet constituent GP federated networks regarding the Prime Minister's Fund – Wave Two. Although the bid was unsuccessful the proposals explored networks delivering extended access (8am to 8pm, seven days a week) and digital primary care.

The continuing financial pressures across the health and social care economy underlies the importance of changing the way in which we work for example crossing organisational boundaries and providing services in a more collaborative and effective way.

NHS England approved the Council and Barnet Clinical Commissioning Group (CCG) joint **Better Care Fund** bid in January 2015 which laid out how they plan to better care for people with complex needs. Barnet Better Care Fund represented a single pooled budget of £23,312,00 for 2015/16, to support health and social care services to work more closely together. The Council and BCCG are working together, within the Health and Social Care Integration model, to deliver a robust programme of work including Healthy Living Pharmacies and Barnet's Integrated Locality Team (BILT).

The **Five Year Forward View**, published in October 2014 by NHS England, set out a radical increase in emphasis on prevention and public health focusing on greater individual and community control and responsibility through a new relationship with patients and communities. Four new models of care are identified in the NHS

[1] https://www.barnet.gov.uk/citizen-home/council-and-democracy/policy-and-performance/corporate-plan-and-performance.html

England planning guidance for the Five Year Forward View including multispecialty community providers, integrated primary and acute care system, additional approaches to creating smaller viable hospital and models of enhanced health in care homes. Relevant here, is the shift to local determination of how resources are most effectively deployed, one example is the Great Manchester devolution deal with NHS England, this would enable decisions to be made closer to the population being served.

In 2014, NHS England asked for CCGs to put forward their bids for **co-commissioning (with NHS England)** of primary care and locally this is being taken forward at a North Central London level across the five CCGs.

The **Care Act 2014**, the most comprehensive overhaul of social care since 1948, provided an opportunity to build on and improve the care and support that we deliver. The Care Act called for care to be focused on the individual, their needs and their wellbeing including increasing the importance of individuals choosing who they buy their care from. The Care Act has also put carers on an equal platform as their cared for in terms of eligibility for support. The Care Act came into force on 1 April 2015 and is therefore a key driver in refreshing the JHWB Strategy alongside challenges of increased demand for adult social care support.

The **Children and Families Act**, another major piece of legalisation, was implemented in September 2014. In particular, the Act introduced a single assessment process, Special Educational Needs (SEN) reforms (including Education, Health and Care plans replacing statements) and a comprehensive local offer of services available to children, young people and their families. The Council and BCCG have been working together to implement changes including cross-over with the Care Act.

In December 2012, the Department of Health published the **Winterbourne View Concordat**. This has developed into the Transforming Care programme of action designed to transform services for people with learning disabilities, autism and mental health conditions. There is ongoing work in Barnet to improve and adapt current services, such as a new model for community learning disability services, embedding new Care and Treatment review processes to include people at risk of admission and a new Learning Disability Skills and Competency Framework for staff.

We are aware that the policy context is likely to change in the lifetime of this Strategy and whilst we will be as flexible as possible in order to meet these demands, our ambition and priorities are unlikely to change.

4. Preparing for a healthy life

Highlights

The Council, BCCG and voluntary and community sector organisations have been working hard to implement the reforms from the **Children and Families Act** (2014) in order to be compliant to deliver a system designed around the needs of children and will support them until they are 25.

We have developed our commitment to improving the life experiences of children and young people with complex disabilities into a vision for a new and improved 0-25 disability service which aims to foster resilience and independence. The new service intends to reduce the 'cliff-edge' of care our young people and their families often report during the transition from children's services to adults. The Council is working to align with BCCG as the same service challenges are experienced by young people and their families accessing health services.

New models of **health visiting** and school nursing have been completed in time for the transfer of the responsibility of services from NHS England to the Local Authority in October 2015.

The **Healthy Children's Centre Project** supports Children Centre staff and health professionals to work together to provide high quality services to support young children and families' health and wellbeing. Taking a whole family approach the project has focused on a range of health and wellbeing outcomes such as involving families in healthy eating, reducing obesity through healthy lifestyles, promoting successful breastfeeding and children's oral health. An Oral Health Co-ordinator, started in 2014 and has trained staff to deliver the Brushing for Life Programme (promoting effective tooth brushing and fluoride's indisputable role in preventing tooth decay). Oral Health Champions in Children's Centres have also been identified. Schools in areas of high deprivation or with a high number of overweight children have been prioritised.

At centres for children, baby clinics (or self-service weighing services at centres without baby clinics) are providing a valuable opportunity for Centre staff to engage with new families about services and support available.

What does Barnet's JSNA tell us?

Population growth

- The 0-15 age group shows growth at a greater rate than the 16-64 age group until 2026, after which the child population is expected to decline slightly. This pattern of growth suggests that families are moving to Barnet with children. The high rates of population growth for children and young people (CYP) is

expected to largely occur in wards with planned regeneration works and are predominantly in the west of the Borough

Deprivation

- Overall, in comparison with the national picture, children in Barnet have above average good health, educational attainment and life chances. However, this is not uniform for all children across the Borough
- Although the number of children living in poverty[2] has reduced slightly from the last Health and Wellbeing Strategy, from 18,000 to 17,330, this remains a significant proportion of children in the Borough (21.2%), located notably in the western areas of Barnet. The poor outcomes for children in poverty are well documented especially poor educational attainment and ill health

Health

- Childhood immunisations rates remain a problem in Barnet with rates worse than the national rates. Barnet's Public Health team is addressing this with partners, overseen by the Health Overview and Scrutiny Committee
- Poor dental health is associated with poor health outcomes in later life. Child dental decay is the top cause for non-emergency hospital admissions in Barnet for children
- The number of post-16 pupils remaining in special schools is placing pressure on the availability of places for admission of younger pupils

Safety

- Keeping people safe is a key component of health and wellbeing. The safety of children in Barnet is overseen by a partnership of colleagues on the Safeguarding Children Board and the Children, Education, Libraries and Safeguarding Committee
- Over half of children and young people are subject to a child protection plan because of neglect. 65% of known cases of child sexual exploitation (CSE) in Barnet are females in their teenage years. The pattern of CSE in Barnet is wide and varied. Key characteristics have been youth violence or gang related activity, male adults 'talking' to young females and boys through the internet

[2] According to the 2010 Child Poverty Act, a child is defined as being in poverty when he/she lives in a household with an income below 60% of the UK's average. Throughout the refreshed JSNA and JHWB Strategy child poverty will be defined based upon the definition put forward by the 2010 Child Poverty Act.

What we plan to do

Improve oral health for children

We will seek to improve access to dental services for children and young people. In June 2015, Healthwatch reported problems with NHS dentists accepting new patients (including children) and have commissioned Homestart Barnet to explore the dentistry experiences of families with young (pre-school children). This study will look at the impact of accessibility to dental services for young children, availability of NHS dental services, family attitudes and opinions to dental care and the availability of clear information on how to access dental services.

For Oral Health Champions, we will increase stakeholder networking and increase community activity, outside of the classroom and centres for children to ensure that good oral health practices are embedded.

Poor oral health is an indicator of wider difficulties; we are committed to supporting families to create positive and supportive environments for children. The JSNA identifies Burnt Oak and Colindale as areas of particular need given the levels of deprivation. Burnt Oak is the only ward where the average household income in 2015 – at £25,000 per year – was lower than in 2008. Just over one third of the children in Burnt Oak and in Colindale are living in low-income families. Targeted, multi-agency, place based commissioning programmes have been developed including a GP led Well-Being pilot, Love Burnt Oak's Health Coaches funded by the Area Forums, a town centre regeneration project and a multi-agency employment service (Burnt Oak Opportunity Support Team, BOOST).

Provide effective services for children, young people and their families

The best chance for intervention with lasting positive impact is during the first 1001 critical days[3] of a child's life which is a critical period for brain development. We aim to improve outcomes for our children and young people through developing a supportive environment so children can thrive in their early years. We will provide a variety of support for parents especially older and first time mothers. All of our centres for children are working towards **Healthy Children's Centre** Status anticipating five Centres will be awarded this status in late 2015. We will continue to support all of our Children's Centres to become registered as Healthy Children's Centres by late 2016.

Our partners are key to ensuring centres for children are able to make a positive impact on the health and wellbeing of children and their families. For this reason, we hope by 2020 that the Healthy Children's Centre Project is embedded as a priority

[3] http://www.1001criticaldays.co.uk/UserFiles/files/1001_days_jan28_15_final.pdf

amongst all the partners. This will improve working partner relationships as well as improve the quality and holistic approach to the health services received throughout Barnet.

From mapping of **voluntary and community sector services** documented in the JSNA, local voluntary and community sector provision for children is relatively low in the areas where the population of children and young people is forecast to be highest (Colindale and Burnt Oak). Targeted social action, volunteering and employment projects, delivered by our local infrastructure partners, aim to rectify this.

Pregnancy and the birth of a baby are a critical 'window of opportunity' when parents are especially receptive to offers of advice and support. Promotion of support and linking new parents with early years provision is vital and effective. The Early Years Service provides brokerage and outreach across the Borough to seek to ensure all parents of targeted two year olds and universal three and four year olds access their **free entitlement offer**. Currently 42% of eligible two year olds and 86% of eligible three and four year olds access their offer. Therefore there is a targeted approach to see an increase in these numbers. There are opportunities to link employment opportunities with the take up of the free two year child care offer.

A thorough **Early Years review** has been undertaken and a locality model for centres for children has been developed which supports integrated working with partners with an early years offer being led jointly by BCCG and the Council. The model will deliver a broader offer of services which incorporates external provision and builds on community capacity; it will also consider co-location and integration of health services. The offer will aim to improve outcomes and reduce inequalities for children. The locality model focuses on three areas (East/Central, South and West) of the Borough aiming to improve flexibility, effectiveness and also join up services to create a clear, identifiable Early Years offer which is trusted by residents and facilitates strong support networks.

The Health and Wellbeing Board recognises and supports the priorities of the Safeguarding Children Board including CSE and Female Genital Mutilation (FGM). The Health and Wellbeing Board has a role to ensure CSE issues are championed across partners.

How will we know we have made a difference?

Draft targets (not in a table, for consultation purposes)

Measure	Baseline – 14/15	Target – 15/16	Target - 19/20
Number of Healthy Children's Centres	0	5	All
Percentage of families with child/ren under 5 registered and accessing services at	New indicator	85%	96%

centres for children			
Percentage of children in care in LBB foster care as a percentage of all children in care	35% (q3 2014/15)	39%	53%
The percentage of free entitlement early years places taken up by parents/carers that are eligible for a place.	41%	50%	85%
Satisfaction of children and parents with services for disabled children and their families	To be set with the development of the 0-25 disabilities service (2015/16 baseline)		
Prevalence of early childhood (dental) caries	6.1% (2013)	Decrease	At national average (3.9%)
School readiness: the percentage of children achieving a good level of development at the end of reception	TBC	TBC	TBC
Increase uptake of childhood immunisations (six vaccinations)	75.1% - 86%	At or above England average (88.3% – 94.3%	Maintain at or above England average
Increased number of voluntary and community sector organisations in deprived areas	New indicator – target to be set in 2016		
Increased social action (resulting in volunteering opportunities) in deprived areas	New indicator – target to be set in 2016		

5. Wellbeing in the Community

Highlights

The previous Health and Wellbeing Strategy identified excess cold hazards (such as cold homes, the cost of energy bills, social isolation, access to services and risk of falls) as a priority. The **Winter Well scheme**, led by Regional Enterprise Ltd. (Re), working in partnership with the Council, BCCG and voluntary and community sector partners, was successfully delivered in 2014. The scheme aims to reduce negative health outcomes and excess winter deaths by providing practical assistance to the most vulnerable and eligible residents.

To date the scheme has included training and advice to over 110 professionals and 210 residents on energy matters to prevent and reduce fuel poverty. The scheme

includes a Winter Well helpline and has also provided emergency supplies and services such as heaters, damp proofing and boiler repairs. To date energy switches have saved Borough residents a total of £24,004 (total for 97 residents). Warm places have been set up, across the Borough, for people who had difficulty heating their homes and/or found themselves isolated over the colder months, with a particular focus on older people and people with long term conditions. 70 new Community Friends (part of Altogether Better) were recruited during the scheme showing the communities response to assist others in the event of cold weather.

Altogether Better

Altogether Better projects are a way of providing opportunities to address an individual's needs, facilitate mutual support mechanisms, build resilience, unlock community resources and bring people and communities together.

Altogether Better Officers work in small geographical localities, have an open door, access to information and small amounts of funding, but most importantly a remit to nurture local solutions and keep people independent. They help people to access services where they are the only option, as a last resort.

Currently there are four Altogether Better sites covering the following the areas –

- Burnt Oak
- East Finchley
- Edgware and Stonegrove
- High Barnet, Arkley and Underhill

Activities include Talkie Walkies (walking groups), Wellbeing Cafés and Men in Shed projects.

In addition to Altogether Better Barnet has some borough wide projects. The Barnet Timebank in its second year; 121 exchanges have included CV help, gardening, befriending, fitness advice and language lessons. There are also a number of volunteer led intergenerational reading groups including for people with dementia and their carers.

The condition of and access to local **housing** has an important role in the quality of life and health of both individuals and communities. The Council has developed a new Housing Strategy (2015 – 2020) which sets out how the council and partners will deliver the additional housing that is required in the Borough due to the growing population. The Strategy also details how more affordable housing will be provided as well as promoting independence through the provision of wheelchair accessible housing. In Barnet, there are also a number of plans in place to improve housing such as re-locating and improving the quality of an in-house Children's Home, increasing the number of fostering placements through recruitment of foster carers as well as work to better understand the causes of homelessness and how to

prevent it as part of the Housing Strategy. We are also working with private landlords to ensure good quality private sector housing.

Improving **mental health and wellbeing** is a key priority. In 2014, BCCG and Barnet Council signed up to the Crisis Care Concordat and the Government emphasised the importance of achieving parity of esteem between physical and mental health; valuing mental health equally with physical health.

Action already taking place includes -

- Barnet Council's Network Enablement Service
- BCCG and Council working with Barnet, Enfield and Haringey Mental Health Trust to improve and modernise the current secondary care services towards a community based model of care delivery within the community
- BCCG South Locality Primary Care Liaison Pilot which is reporting early reductions in hospital admissions through step-up functions
- The Burnt Oak and Colindale Wellness Service Pilot involving a navigator role to support people through their health and wellbeing journey
- Improving access to services such as the BCCG implementing a locally enhanced service to improve access to primary care for people with mental health problems who are homeless and reducing the waiting list for IAPT as well as encouraging self-referrals to IAPT
- Public Health has developed a Suicide Prevention Strategy, Working Group and action plan. Self-harm and suicide prevention workshops have been held for professionals and volunteers who work with vulnerable groups
- Two public health commissioned employment support services - Motivational and Psychological Support based in local Job Centres and an Individual Placement and Support (IPS) scheme for people with severe and enduring mental health needs and based in community mental health teams
- Barnet is leading a West London Alliance (WLA) programme looking at developing IPS for people with common mental health conditions. Learning from other similar schemes suggests that we should expect to see between a third and a half of people supported gain and retain employment

A Barnet Schools Health and Wellbeing programme has been in place since 2013, and is both established and performing well. The emotional health and well-being element of this programme offers consultancy support, development of schemes of work and a directory for signposting as well as training to build capacity within schools. Health, Education and Care partners have been engaged to develop a smoother treatment pathway that effectively meets needs. We seek to build on existing work in schools which will promote early identification of Tier Two (CAMH specialists working in community and primary care settings) needs and offer appropriate interventions and referrals access for CYP. A pilot project of an evidence based manualised treatment group is already underway, for managing severe anxiety which impacts on school attendance.

There are a number of befriending schemes running in Barnet such as Alzheimer's Society supporting people with dementia and their carers, Mind supporting people at risk of social isolation due to a mental health problem and Homestart supporting families.

What does Barnet's JSNA tell us?

Mental health, mental wellbeing and social isolation

- Barnet has lower prevalence of depression (4.3%) in adults than the national average (5.8%) however the prevalence of schizophrenic, bipolar affective disorder and other psychoses (0.95%) are higher than the national average (0.84%)
- Emergency admissions for self-harm (109.9 per 100,000) are lower than the average for England (191 / 100,000) and the suicide rate (6.9 / 100,000) is lower than the national rate (8.5 / 100,000)
- According to national projections, the most common health conditions within Barnet are mental health disorders
- The hospital admissions rate for poor mental health in children (aged less than 18 years) in Barnet is higher (167.6 / 100,000) than the average national rate (87.6 / 100,000)
- Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems

Domestic Violence and Violence Against Women and Girls

- Domestic violence along with parental mental ill health and substance abuse are the most common causes for referrals into social care and result in the poorest outcomes for children and young people
- The number of Multi Agency Risk Assessment Conference (MARAC) cases of domestic abuse associated with drug and alcohol use in Barnet nearly doubled between 2011 and 2013.

Employment

- Barnet has a lower than average percentage of people with mental health conditions and learning disabilities in work than other areas
- There are significant differences in the proportion of working-age people receiving Job Seekers Allowance in different wards, the areas with the highest proportions being in Burnt Oak, Childs Hill and Underhill

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What we plan to do

Mental health and wellbeing

The number of people with mental health conditions is predicted to increase as the population grows. In November 2014, the Health and Wellbeing Board identified prevention of and early intervention in mental health problems as a priority. Mental health is our **key priority in year one of this Strategy** with partners coming together to make a positive impact for our residents.

We will continue to implement national guidance including the recommendations that will come from the NHS England established taskforce to develop a five year forward view for mental health. We are hoping, through this Strategy, to build **prevention and early identification** into all we can to prevent and reduce mental health problems for the Borough's residents. Many Public Health and community initiatives contribute to mental wellbeing across the lifespan such as pregnancy and parenting support, physical activity and self –care.

Barnet will run a **wellbeing campaign** focusing on taking responsibility for and improving mental wellbeing as well as tackling stigma. The campaign will embed wellbeing into current activity, share success stories and celebrate World Mental Health Day. We will also –

- Develop a health champion programme in primary care focused on improving mental health and wellbeing
- Review local pathways for antenatal and postnatal depression including promoting peer support
- Be part of the pan London digital mental health support service

All services and activities working with residents have a responsibility to identify where someone could benefit from support. Youth Healthwatch has been working with teachers to find out if they feel equipped to identify and support students suffering from mental health problems.

Early mortality for people with severe mental health problems is widely documented. Treatment services are required to make changes at scale to re-focus on recovery, social inclusion and enablement. The **Reimagining Mental Health** project, led by BCCG, is putting residents at the centre of mental health service delivery. The co-designed and co-produced model aims to deliver better, more targeted health services through a community–based approach.

BCCG has committed to the following commissioning intentions to -

- Work with Enfield and Haringey CCGs to review Psychiatric Liaison Service provision

- Continue to work with Enfield and Haringey CCGs on the Crisis Concordat implementation plan
- Review each 2015/16 contract for services for older people relating to multidisciplinary care in patient's own homes that link with primary, secondary, social and voluntary care sectors, and including access to Rapid Care, Triage Rapid Elderly Assessment Team, Post-Acute Care Enablement Service, Integrated Care Team and the Barnet Integrated Locality Team
- Undertake, collaboratively across North Central London, an end-to-end pathway redesign of existing Child and Adolescent Mental Health Services (CAMHS) as our response to the national CAMHS Transformation agenda
- Produce CAMHS out of hour's service, working with North Central London partners

A new specification for **mental health social work** has been developed by the Local Authority to re-focus social work and care on recovery, social inclusion and enablement. Work is now underway to embed the model which includes Consultant Social Workers and integrated pathways as well as improving employment and accommodation.

Social isolation

Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. We will seek to improve the identification of people (children, young people, adults and older people) at risk of or experiencing social isolation through our Healthy Living Pharmacies, hospital discharge teams and substance misuse treatment services.

In Barnet, social isolation is especially prevalent in elderly women who live alone, notably in areas of higher affluence and lower population density. We will develop targeted initiatives, building on current good practice and working with the voluntary and community sector, to encourage greater social contact. We will engage volunteers through befriending schemes (particularly as a respite offer for carers) and promote ways for people to get involved locally such as in the Borough's parks and green spaces and libraries.

> **The Barnet Provider Group** have expanded their programme of activities which include lunch clubs and befriending activities, tea dances and games afternoons. They reached close to 2,500 new people over the last 12 months and in total more than 5,600 older people have enjoyed a range of activities. Many of these activities are delivered by in excess of 500 volunteers. The benefits of volunteering are well documented and the majority of volunteers are older people themselves. The Barnet Provider Group plan to expand their befriending services during 2015/16 so that they can continue their work to prevent loneliness and isolation.

The Altogether Better programme continues to expand, which supports access to and increases the range of community activities to help tackle social isolation and loneliness examples include the Silver Service set up in 2 localities.

Employment and healthy workplaces

There has been growing recognition that the relationship between health and work has a significant effect on the lives of individuals and on wider society[4]. When out of work, an individual's health is more likely to deteriorate and they risk falling into poverty. Nationally, for too long it was assumed that people with health conditions should be protected from work but in recent years evidence has shown how detrimental this approach can be to individuals and their families.

Barnet has been responding to the Welfare Reform agenda with a **Welfare Reform** Task Force. The Task Force brought together the Council's housing officers, Jobcentre staff and health advisers into a single team to work with those impacted by Welfare Reform. This integrated team has engaged with 96% of residents affected by the Benefit Cap and helped over a third of them into work.

> In the past, Local Authorities, Jobcentre Plus, Work Programme providers, and the local Voluntary and Community sector have generally operated in silos to help people into work. While this has produced some positive results, there remain pockets of disadvantage where communities are missing out on the opportunities that growth brings.
>
> **Burnt Oak Opportunity Support Team (BOOST)**, launched in April 2015 and based in the library, helps people find work through holistic support in their local area. The project is part of a West London Alliance approach called 'Working People, Working Places' and puts all relevant services together under one roof so all residents (whether they claim benefits or not) can access the targeted support they need to help them develop new skills and overcome any obstacles to employment that stand in their way. Key to the success of the model is the involvement of the local community facilitated by Love Burnt Oak who will help the service engage with more isolated residents. The service is also supported by a commissioned service called Future Path that supports people with their mental health, physical health and employability side by side. The aim of the two year project is to boost incomes in the area; supporting people into work as well as supporting a measurable increase in the wellbeing of those supported.

[4] Fitness for Work, Department for Work and Pensions (2013) - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181072/health-at-work-gov-response.pdf

There are opportunities for more partners to get involved in the BOOST project and work together to increase incomes and improve wellbeing.

The JSNA has identified sectors in the economy where employers tell us they find it difficult to recruit to; care, leisure and retail. There is an opportunity to bring these issues together and support younger people and unemployed residents into the labour market. Engaging with sports and physical activity will not only have positive health and social outcomes for young people, volunteering in this sector will open up employment opportunities.

When residents **gain employment** (including a return to employment following a period of ill-health) we want them to be healthy and we need to create healthy workplaces that support this. Around 300,000 people across the country fall out of work a year and into the welfare system because of health-related issues. The State spends £13 billion a year on health-related benefits, with employers facing an annual bill of around £9 billion for sick pay and associated costs. Costs to individuals are around £4 billion in lost income. A healthy and happy workforce also improves the experience of our customers.

As we ask residents to take more responsibility for their own health, **employers** also need to take responsibility for the health and wellbeing of their staff, creating healthy environments and modelling healthy behaviours. The Council and BCCG are two of the largest employers in the Borough. The Council is looking to achieve an excellence level for the London Healthy Workplace Charter and BCCG is implementing its Health and Wellbeing Policy. HWBB member organisations are committed to supporting their staff to be healthy at work and will promote and champion this agenda to partners such as Re and the NHS Trust providers as well as via Entrepreneurial Barnet which is Barnet's public sector approach to making the best place in London to be a small business.

As not all of our residents will actually work in the Borough, the Health and Wellbeing Board (HWBB) will share its learning and experience across London, through the London Healthy Workplace Charter, to promote to other Boroughs and partners.

The **London Healthy Workplace Charter**, a Greater London Authority programmes, asks employers to review the support they offer their employees in a number of areas including stress prevention, the promotion of mental wellbeing, smoke free spaces, active travel, healthy eating, a reduction of excess alcohol consumption and the prevention of substance misuse.

How will we know we have made a difference?

Draft targets (not in a table, for consultation purposes)

Measure	Baseline – 14/15	Target – 15/16	Target - 19/20
Health champions	N/A (new	2016/2017 – 50	Roll out

programmes	programme 2016)	recruited	(outcomes)
Proportion of adults in contact with secondary mental health services in paid employment	5.7% (2013/14)	7%	To be established following definition review
Proportion of adults with mental health needs who live in stable accommodation	70.90%	75%	Top 25% of comparable Boroughs
Design, delivery and commissioning of a THRIVE or similar Outcomes model to support the Children and Young Peoples IAPT and CAMHS Transformation programmes	Introduce into the CAMHS commissioned system	>70% recording of the outcomes model in appropriate contacts	100% recording of the outcomes model in appropriate contacts
Support people into work (BOOST)	N/A (New programme)	Support 240 people into work	2016/17 - Support further 240 people into work
Barnet Council achieve (by 2016) and maintain London Healthy Workplace Charter excellence status			
Sickness absence – percentage of employees who had at least one day off in the previous week	1.3% (2010 – 2012)	Maintain/reduce	Maintain/reduce
Social Isolation: % of adult social care users who have as much social contact as they would like	41.4%	Top 25% of comparable London Boroughs	Top 25% in England

6. How we live

Highlights

Barnet has embraced the **transition of public health** from the NHS to the Local Authority using this as a key way to address the wider aspects critical to health and wellbeing. Some successes include the commission of substance misuse services which will address fragmentation of services, school nursing, health visitors transfer preparation and increase in NHS Health Checks.

Public Health have also developed a **Substance Misuse** Strategy which coordinates activities to prevent and protect residents from harmful substance misuse as well as promote and sustain recovery through collaboration, training, social marketing and reviewing local licensing. An Implementation Group, led by Public Health, has been established to take forward key areas of action overseen by the Health and Wellbeing Board as well as the Community Safety Partnership. Further to this,

enhanced training of Barnet GPs in health promotion for patients with mental illness is part of the Reimagining Mental Health plan.

Barnet and Harrow joint Public Health service is working in collaboration with the West London Alliance (WLA) and the majority of Borough across London as part of collaborative **sexual health** (genitourinary medicine, GUM) service commissioning arrangements. The major new service tendering, expected in 2017, will reduce service fragmentation; improve access and early intervention which in turn will reduce unwanted pregnancies and onward transmission of sexually transmitted infections (STIs) as well as aiming to tackle escalating costs.

Taking action locally, we have organised a number of pop up screening events to increase the **early identification of disease**. The pop up shops and health promotion events have provided information on healthy lifestyles and their contribution to cancer prevention, symptoms and the importance of early presentation and diagnosis and screening.

The **Obesity** Pathway group, with a membership of BCCG, schools, leisure and providers, has been exploring improvements to the child weight management pathway. Healthy Weight Nurses were appointed in January 2015; after being in place for six months, the nurses had engaged with 25 children on a 1:1 basis, reporting that almost all had shown positive behaviour change and, as a consequence, six had already lost weight. The team has also noticed behaviour changes in the families of the children they have engaged with. Another aspect of our Child Weight Management programme is Alive and Kicking which, through information on nutrition and physical activities, is successfully supporting weight loss. Alive and Kicking is also engaging with schools and parents to embed healthy weight principles.

The Council has worked with its contracted leisure provider, *Better*, to increase membership of disabled people. We now have the highest disabled membership in *Better* leisure centres in London.

What does Barnet's JSNA tell us?

Healthy Lifestyles

- Smoking, bad diet, and a lack of exercise are the main causes of premature death in Barnet
- Rates of sexually transmitted infections are lower than London rates. However, there are lower detection rates of chlamydia (16%) than England (24.9%)
- Barnet has 55.1% physically active adults, similar to the average rate in the London region (56.2%) and nationally (56%). Similarly, the Barnet rate of physically inactive adults (26.1%) is similar to the London region and national average rates

- However, inequalities are apparent as men's activity levels (at least 1x30 minutes a week) are higher (44%) than women's (28.4%)
- In Barnet, only 1% of all trips between 2007/08 – 2009/10 (baseline figures) were made by bike
- Pollution levels are higher along arterial routes, particularly the North Circular, M1, A1 and A5

Long term conditions

- The rate of emergency hospital admissions due to stroke is significantly higher in Barnet than London or England
- The prevalence rate of diabetes is forecast to rise at both national and local levels and this increase could be even higher if diabetes risk factors such as obesity are not addressed

Screening

- Screening rates for cervical and breast cancer are significantly lower in Barnet than the England average (23.3 per 100,000 vs. 15.5 per 100,000).

What we plan to do

Sport and Physical Activity

Barnet Sport and Physical Activity Needs Assessment (2012) highlighted that whilst health behaviours and outcomes are more favourable in Barnet than in England as a whole, sport and physical activity rates and the use of outdoor spaces are below the national average.

Regular physical activity helps to reduce the risk of stroke, type II diabetes, development of dementia, incidences of heart disease, cancers and high blood pressure. Physical activity supports the prevention and management of long term conditions as well as being a key component of achieving and maintaining a healthy weight and positive mental wellbeing.

Physical inactivity costs the NHS approximately £4.1 million per year nationally. It also creates costs for the wider economy, through sickness absence and through the premature death of productive individuals, and increases costs for individuals and their carers. Importantly, in Barnet, a quarter of people who are inactive would like to do more physical activity.

To make it easier for people to **access and engage with sport and physical activity**, we will -

- Build **two new leisure** centres at Copthall, and another at either Victoria Recreation Ground or Danegrove (public consultation will determine the location) to improve access to facilities

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- Take sport and physical activity **outside of the leisure centre**, improving access and reducing cost for residents through –
    - Making healthy choices the easiest and first in the built environment such as consideration of the placement of stairs in new buildings
    - Promoting and normalising active travel
    - Delivering Community Sport and Health Activation projects in Burnt Oak and Colindale, targeting young people 11- 19yrs, supported by Sport England and other local partners
    - Promoting the use of green spaces for sport and physical activity including the use of outdoor gyms
    - Assessing the supply, demand, accessibility and quality of Playing Pitches
    - Promoting free activities such as local Parkrun
    - Working with local and national partners
    - We will work with our Volunteer Centre to build physical activity into volunteering opportunities
- **Target those who do not traditionally engage** –
    - Maintain the current level of leisure centre memberships for women (48%), but also introduce women only sessions at Hendon and Burnt Oak
    - Provide reduced price leisure offers for people over 55, build physical activity into signposting as part of the NHS Health Check programme and build on current activity (such as Altogether Better Talkie Walkies) and Fitness for Life walks in Parks
    - Increase the offer for physical activity for people referred via post Health Checks interventions and diabetes programmes
    - Build positive experiences of sport and physical activity through schools, Community Sport and Health Activation Project in Burnt Oak and Colindale, Positive Activities, Youth and Family Services, the London Youth Games, School Nurses will be well informed of local clubs and activities and build on the success of school travel plans
    - Improve the obesity pathway for children and young people – developing tier 3 services and support for young people in secondary school
    - Engage families through fun days and special offers i.e free summer membership and £1 per activity
    - Engage community and faith leaders
    - Hold a series of Inclusive Open days for people with disabilities, working alongside Barnet Mencap. We will retain Inclusive Fitness Initiative Accreditation at Burnt Oak and seek accreditation for Finchley Lido
    - Continue to develop Fit and Active Barnet (FAB) as an umbrella brand, recognised by residents, and as a network for partnership engagement and collaboration

Through local infrastructure organisations, we will support individuals and communities to take **ownership and responsibility** for sustainable sports and physical activity options, particularly in areas where childhood obesity rates are high (Colindale, Burnt Oak and Underhill). This will be supported by an increase in the quality and number of volunteers.

We need to support people to make better choices and led healthier lifestyles. The Council's commitment to this agenda is reflected in the establishment of a Sports and Physical Activity team which, alongside the Public Health team, will work to embed physical activity across all work of the Council and partners. The Obesity Strategy Group has expanded following a commitment to develop a Healthy Weight (Obesity) Strategy and action plan. Weight Management Service development is underway.

Screening

Increasing screening uptake remains a priority. NHS England have lead responsibility for screening performance. Public Health will work with NHS England to explore appropriate service delivery in line with best practice.

Wider public health workforce

The definition of the Public Health workforce is changing to highlight how public health is everyone's business. To make the biggest impact we need to utilise the wider public health workforce which consists of individuals who are not specialists in Public Health but who have the opportunity to improve the public's health and to create inclusive communities and places. A training resource will be developed to upskill staff who interact with residents (from all sectors) to maximise the opportunities for face-to-face contact to promote good health, social care and wellbeing information, messages and signposting. The training will also support the identification of hidden carers. Specific training is also available such as Raising the Issue of Weight training to support professionals to discuss weight issues with residents.

To intervene early we will increase the offer of NHS Health Checks in the Borough through improved promotion and access. We will also improve the post Health Check service offer and pathway to ensure that people engage in services and lifestyle changes where necessary.

Regeneration

The borough's ambitious regeneration and growth programme provides an opportunity to develop new lifetime neighbourhoods that promote independence and wellbeing. Being aware that the environment and where people live impacts their health, we will build public health into all our regeneration and transport projects and

programmes including the provision of new health facilities. The high street, at the heart of local community, offers an ideal platform for health promotion. Where possible, we will create healthy high streets including health champions and stores making healthy options easier. We will also consider the proximity of fast food outlets to schools, colleges, leisure centres and other places children gather. We will also link regeneration programmes with child friendly and dementia friendly community developments. We will drive this through our Entrepreneurial Barnet Board supported by national programmes such as NHS England's Healthy New Towns. We will also look at the role Health Impact Assessments play in planning.

Where comprehensive development and regeneration is taking place across the borough (particularly at Colindale and Brent Cross), a wide range of investment programmes are planned to secure improvements to health outcomes for those populations already living in and new residents moving to those areas. Research projects will be set up to monitor impact. These include:

- Expanded or new integrated use local primary care facilities
- New high quality and energy efficient housing to replace existing non-decent housing stock
- Travel planning, public transport, parking measures and highways improvements to enable travel choices
- New schools that can help improve educational and family lifestyle outcomes
- New community and youth facilities to promote social engagement and support positive local community activities

How will we know we have made a difference?

Monitor –

- Life expectancy and healthy life expectancy including decreasing inequalities (between wards and genders)
- Reduce prevalence of CHD and cancers
- Increase the uptake of screening

Draft targets (not in a table, for consultation purposes)

Measure	Baseline – 14/15	Target – 15/16	Target – 19/20
Excess weight in adults	55.7%	Decrease	Decrease
Percentage of active adults	53.9% (2013)	Increase	Exceed national average (56%)
Prevalence of 4 – 5 year olds classified as overweight	11.6%	Decrease	11.1%
Prevalence of 4 – 5 year olds classified as overweight	9.4%	Decrease	8.90%
Prevalence of 10 – 11 year olds classified as overweight	15%	Decrease	14.5%

Prevalence of 10 – 11 year olds classified as overweight	19.40%	Decrease	18.9%
Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	33.4% / 8% of the eligible population	Become more targeted	Become more targeted
Increase the number of people with disabilities with leisure memberships			2%
Increase usage of our leisure centres for people from BAME communities			2%
Maintain women leisure centre usage	48%		48%
Number of older people who take up leisure services – participation over 45	18.4% (October 2014)	20.4%	Top 25% in England
Completion of new leisure facilities			Two new centres by 2018
Prevention and Wellbeing Programme training (local mental every contact count)		TBC	TBC

7. Care when needed

Highlights

Barnet has improved **access to care and support** by:

- Launching a new universal deferred payments scheme
- Providing prevention services, promoting wellbeing and focusing on delaying or preventing the need for social care services
- Improving information and advice services, enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how to fund it
- Implementing a service to support self-funders to arrange and manage their community care; users pay a fee to cover costs
- Promoting Information and Advice providers including Social Care Direct
- Changes to support services for carers as well as establishing an assessment for carers own needs and implementing changes of eligibility for carers

Carers can access mainstream and prevention services to promote their health and wellbeing for example; they can receive health checks for themselves and obtain information and advice about benefits. There are specialist support services for carers delivered through a Lead Provider, who work with voluntary and community sector partners, to provide short breaks so carers can have time off from caring; peer and group support; training in manual handling and help with emergency

planning. Following a carers assessment and development of a personalised Support Plan, the council offers further support options including obtaining a Direct Payment to meet their identified and eligible needs and outcomes; and respite given to the person they look after.

With support from the Council, a Parent Carer Forum has been established in Barnet with a membership of over 100 parent carers. The Forum will be a resource for consultation, vital at a time of service development alongside the wider Carer's Forum.

Integrated care and encouraging self-care were identified as priority areas by the Health and Wellbeing Board in November 2014 and since then a key focus of the Board has been to deliver the Better Care Fund objective of better care for people with complex health care needs. The Council, BCCG, voluntary and community sector as well as providers are working together to create an environment which allows people to remain in their own homes for longer.

In line with our prevention aims and to reduce the pressure on accident and emergency departments, we have been developing community models of care. The Borough has established a Healthy Living Pharmacy (HLP) model with 21 pharmacies (of the 78 in Barnet) already signed up to providing a health and wellbeing support service to patients.

Our commitment to support people to live **meaningful, fulfilling lives** whatever their ability or disability is also evident in our Winterbourne View Concordat progress. There are active discharge plans in place for many of the remaining patients. Commissioners and care co-ordinators are working closely with existing and new providers to develop solutions which are in the patients' best interests.

Barnet achieved the 67% **dementia diagnosis** national target for 2014/15 with a 67.7% result. The re-configured Memory Assessment Service provided by Barnet, Enfield and Haringey Mental Health Trust became fully operational since July 2014. The service provides a holistic assessment for people with memory problems, and has the capacity to meet the needs of a growing population of older people with dementia. Located with this service, is Barnet's Dementia Advisor service which provides specialist information and advice at the point of diagnosis and a point of contact on an ongoing basis. 4 Dementia café's provide opportunities for people with dementia and their carers to gain information and advice and take part in a range of activities.

On leaving hospital the Early **Stroke** Discharge team, who provides specialist stroke rehabilitation care, offer a seamless transfer from hospital to home for stroke survivors. Barnet's post-acute services such as stroke review and specialist information and advice ensure that the recovery potential for people following a stroke is maximised. A recent addition is the stroke review service is a re-

assessment of an individual's health, social care and therapy needs at six months post stroke, improving their recovery potential. The review can pick up the need for further prevention services so reducing the likelihood of a second stroke.

What does Barnet's JSNA tell us?

Our population

- Barnet has a higher proportion of people aged 85 and over (3.1%) compared to Outer London (1.8%) and the UK (2.3%). This is likely to be driven by the high life expectancy rates
- Currently, Garden Suburb and High Barnet have the largest proportion of people who are over 65, both at 18.1% of the population within the ward. Over this period, Brunswick Park and Hale are projected to experience relatively higher levels of growth in the proportion of the population aged 65 and over, increasing by 5.8% and 5.5% respectively
- The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030, and the rate goes higher in successive age bands; over-65 population will grow by 34.5% by 2030, whereas the 85 and over population will increase by 66.6%

Health and social care

- Despite continued growth in the adult population, the number of people in receipt of residential care and nursing care has decreased from 1,441 in 2011/12 to 1,367 in 2013/14 (a decrease of 5.1%)
- Overall the percentage of diabetic people having all 8 health checks in Barnet is below the national rate and the risk of complication and additional demand pressures from people with diabetes in Barnet is higher compared to those without diabetes
- Increasing demand on urgent and emergency care with Barnet A&E activity recording an increase in 14/15 compared to 2013/14
- Barnet has a higher population of people with dementia than many London Boroughs and the highest number of care home places registered for dementia per 100 population aged 65 and over in London
- The incidence of tuberculosis (TB) in Barnet (25.9 per 100,000, 3 year average) is lower than the London regional rate (39.6 per 100,000) but higher than the rate in England (14.8 per 100,000). Barnet has a higher number of drug resistant TB cases than the average number of these cases in London

Carers

- In 2011 there were 32,256 residents who classified themselves as a carer in Barnet. The 25-49 year old age group had the largest number of carers (12,746)

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- 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)
- Young carers are at particular risk of remaining hidden from services, in Barnet we have identified 2% of under 18s to be carers but there is a large gap in identification of 16 – 17 year olds with a caring responsibility
- On average carers are more likely to report having poor health (5.2%) than non-carers (4.2%), especially amongst carers who deliver in excess of 50 hours of care per week. 1 in 5 young carers describe their health as being only fairly good or even poor.
- Young carers are also 1.5 times more likely to have a disability, long term condition and special educational needs than non-young carers
- Young carers are twice as likely not to speak English as their first language

What we plan to do

Carers

Carers are being recognised nationally for their contribution. Carers are being prioritised in this Strategy due to their crucial role and **their own health and wellbeing** needs. This will increase as more people choose and are supported to remain at home for longer. According to Carers UK, there are 6.4 million carers in the UK reducing the national care bill by an estimated £119bn per year, equivalent to £18,594 per carer. Each caring situation is unique and every carer has different needs and priorities. It is important to identify carers, and where needed, support them to carry out their caring role whilst protecting their own health and wellbeing.

A caring role can develop and change gradually overtime or an individual (parent, partner and sibling) may not regard what they do as caring which means that identifying carers is difficult. Awareness needs to be raised with residents to understand what caring is and that it is ok to ask for help. To increase the **identification of unknown carers** we will –

- Develop campaigns for the following -
    - Areas with a high population of older people such as Garden Suburb
    - Work with schools and colleges to develop effective outreach to identify carers who are aged 16 -17
    - People from BAME communities to ensure literature and information is accessible
    - With pharmacies, when a carer collects a prescription for their cared for to interact
- Work with businesses, through Entrepreneurial Barnet, to ensure that businesses understand their responsibility, as employers and in interactions

with residents, to identity and provide carers with the flexibility they require to work and care
- Ensure services working with adults identify children and young people (and where they have caring responsibility) at an early stage and make referrals as necessary such as drug and alcohol services and enablement services as well as voluntary and community sector providers

To support carers to have a life of their own and positive health and wellbeing we will embed the needs of carers across the priorities of the JHWB Strategy as well as –

- Providing specific training for young carers in the areas of learning disability, physical disability and mental health (including dementia) so they are better equipped in their caring role
- Developing the respite offer for carers, through our local volunteering service and through the Council's contracted lead provider
- Ensuring that services are developed with carers and their cared for in mind particularly prevention provision and services for people with long term conditions such as dementia and stroke
- Actively involving carers in at all stages of strategic and service commissioning. The council and BCCG are committed to making sure that the voice of carers shapes the services available to them, and monitor the effectiveness and standards of what is available

Dementia

Our aim has been to focus on early and timely diagnosis, improving information and supporting people with dementia and their carers in the early stages.

Our **Barnet Dementia Manifesto** sets out what we aim to do next, for example, increase public and professional awareness and understanding of dementia. Recognising particular housing needs, the Council will increase the supported housing options for people with dementia and their carers, accommodation will be linked to health and care support and other community facilities by 2025.

Health and social care integration

The Health and Wellbeing Board has a clear vision for the integration of health and social care for frail elderly people and people with long-term conditions in Barnet and has set up an ongoing programme of work to deliver it which includes -

- Encouraging residents to be involved in and take responsibility for their health and wellbeing in order to support independence. Programmes which develop social capital are achieving great outcomes such as the Altogether Better neighbourhood development programmes and voluntary and community sector initiatives

- Building teams across primary and community health and social care to support people with complex long term conditions
    - Barnet Integrated Locality Team – to improve the coordination and quality of care
    - Develop the Health Living Pharmacy model to support patients experiencing social isolation and to improve the public health service offer (smoking cessation, sexual health services) across the Borough.
    - Produce a local dementia manifesto
    - Looking at where integration of commissioning can be explored with neighbouring Boroughs
- Encouraging friends and families to refer to social care services, earlier as currently a large majority of referrals to social care are from either primary or secondary care settings
- Embedding prevention through system transformation including changing the patient-professional conversation which our Heath Champion pilot in 2016 aims to achieve with roll out from 2017
- Taking a whole life perspective to health and wellbeing including end of life care

The Council and BCCG are also committed to working with voluntary and community sector groups, such as Barnet Senior Assembly, to improve the quality of and access to information and advice for older people.

In terms of the Winterbourne View Concordat (Assuring Transformation), there have been no new in or out of borough hospital admissions since September 2014. The BCCG's Continuing Health Care team continues to work closely with the Integrated Community Learning Disabilities service to identify and plan appropriate support for those at risk of admission. A whole system approach is required to achieve better outcomes for our residents. When someone needs care and support, they need services that are joined up around individual needs, including those of carers. Personal Budgets and Personal Health Budgets are central to this approach.

Gearing Up is a partnership programme led by Barnet Mencap alongside Barnet BCCG (Continuing Healthcare Staff), the Council and parent carers piloting Personal Health Budgets for people with learning disabilities. **Personal Health Budgets** aim to develop innovative, personalised accommodation, care and wellbeing solutions for individuals and presents a huge opportunity for the health and social care market to diversify and personalise their service offer to creatively meet the needs of residents. There are also opportunities to explore this with neighbouring Boroughs.

Primary care

The success of the Health and Social Care Integration model relies on significant changes in primary care delivery. Improving access, quality and outcomes in primary

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care will reduce hospital admissions. Improving primary care is a key strategic goal of BCCG and across North Central London to –

- Jointly co-commission primary care with NHS England
- Coordinate care around the needs of the patient
- Building on existing Primary Care Networks, support the continued development of Networks, across the Borough, to deliver a wider range of enhanced services, delivered at scale, within a primary or community setting, that allows for improved access to 7 days a week
- Promote health and wellbeing (improve uptake of Health Checks for people aged 40 – 74)
- Recruit and retain the best staff
- Provide high quality and safe premise and practice

Primary care services are keen to work with partners to improve service quality such as voluntary and community organisations highlighting the experiences of residents such as Barnet Mencap detailing the experiences of people with learning disabilities and autism.

Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. In January 2015, Public Health England and Department of Health released the Collaborative TB Strategy for England, 2015-2020. In July 2015, the Health and Wellbeing discussed a new approach to control TB in the Borough which includes developing a Latent TB Infection screening programme for new registrants targeted a people aged 16 – 34 and from countries of high prevalence. This will require a local programme network to develop and an application for available funding.

How will we know we have made a difference?

Draft targets (not in a table, for consultation purposes)

Measure	Baseline – 14/15	Target – 15/16	Target – 19/20
Increase identification of unknown carers	Adult Social Care (ASC) assessed 1626 Registered with the Carers Centre – 5950	Increase by 10% (TBC)	Increase
Carer assessments resulting in information, advice and services being provided	1160 carers received direct support following ASC assessment (ASCOF)	Increase	Top 25% of comparable Boroughs
Social Isolation: % of adult carers who have as much social contact as they would	35.8% (2012/13)	Increase	Increase

like			
Proportion of carers satisfied with social services	Note: bi-annual survey	35.7%	Top 25% of comparable Boroughs.
Dementia diagnosis rate	67.7%	Increase	75% (2017)
Proportion of people who feel in control of their own lives	73.3%	Top 25% of comparable Boroughs	Top 25% in England
Successful implementation of Personal Health Budgets	0 (new programme)	9	Increase (Roll out TBC)
Latent TB screening programme	0 (new programme)	Target TBC	
Permanent admissions to residential and nursing care homes, per 100,000 population age 18 - 64	13.5	13.5	Top 10% in the country
Proportion of older people still at home 91 days after discharge (reablement).	73.8%	81.5%	Top 10% in the country
Reducing the proportion of people reporting very poor experience of primary care			

8. Target setting, monitoring and governance

The targets chosen in this Strategy are considered most relevant to the strategic priorities. Most of the data which will be used to monitor achievement against targets is already being collected and monitored by one of more of the agencies on the Health and Wellbeing Board, which avoids duplication.

The targets will be regularly monitored and reported to the Health and Wellbeing Board to assess progress.

While this is a four year Strategy, the targets will be reviewed annually; taking on board the latest intelligence and recommendations. The results will be published so that the public are easily able to track our progress in achieving our priorities set out in our Joint Health and Wellbeing Strategy.

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Appendix 1 Barnet's Health and Wellbeing Board

The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where key leaders from the health and care system work together to improve the health and wellbeing of local communities.

The Health and Wellbeing Board plays a key role in the local commissioning of health care, social care and public health through development and implementation of Barnet's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy.

The membership of the HWBB (November 2015)

Chairman: Councillor Helena Hart

Vice-Chairman: Dr Debbie Frost (Barnet Clinical Commissioning Group Chair)

London Borough of Barnet

Two Councillors –

- Chairman of Adults Safeguarding Committee
- Chairman of Children, Education, Libraries & Safeguarding Committee

Director of Adults Social Services

Director of Children's Services

Director of Public Health

Barnet Clinical Commissioning group (BCCG)

Two BCCG Board Members

Chief Operating Officer

NHS England

One representative

Observer member
(Speaking, non-voting rights)

Independent Chair of the Safeguarding Adults and Children Boards

Healthwatch Barnet

Head of Healthwatch Barnet

Barnet's Health and Wellbeing Board has been functioning in shadow form since 2012 and functioning a statutory body in April 2013 and has achieved the following –

- Agreed the final plans for Barnet's Better Care Fund
- Supported Barnet CCG's proposal to joint co-commission (with NHS England) primary care alongside the North Central London CCGs
- Approved Public Health 5-year Commissioning Plan

- Agreed for Public Health to commission the Fit and Active Partnership Board to be set up
- Supported the commissioning of a Tier 2 adult weight management service
- Reviewed our progress against the Disability Charter
- Identified the need for a local Dementia Manifesto
- Received Healthwatch Barnet reports highlighting issues on:
    - meals in hospitals
    - the hospital discharge process
    - improving awareness of local services
- Took responsibility for health and wellbeing issues in the Children and Young People Plan

Barnet's Health and Wellbeing Board has three subgroups: Early Years Subgroup, Finance Group and the Health and Social Care Integration Board.

The Health and Wellbeing Board works closely with Barnet's five Partnership Boards (Older People's Partnership Board; Mental Health Partnership Board; Learning Disabilities Partnership Board; Carers Strategy Partnership Board; Physical and Sensory Impairments Partnership Board). Members of the Health and Wellbeing Board and the Partnership Boards are bought together at twice yearly summits which are a forum for collaborative working.

To access more information about the Board including the Board's work programme, agenda and papers visit - https://barnet.moderngov.co.uk/ieListMeetings.aspx?CId=177&Year=0

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AGENDA ITEM 9

	Health and Wellbeing Board **17 September 2015**
Title	**Health and Wellbeing Board and Partnership Boards Summit Report**
Report of	Adults and Communities Director
Wards	All
Date added to Forward Plan	July 2015
Status	Public
Enclosures	Appendix One - Health and Wellbeing Board and Partnership Boards Summit Report
Officer Contact Details	Hannah Ufland, Partnership Boards Officer, Adults and Communities hannah.ufland@barnet.gov.uk 020 8359 4712 Zoe Garbett, Commissioning Lead-Health and Wellbeing Zoe.garbett@barnet.gov.uk 020 8359 3478

Summary

This report provides an overview of the Health and Wellbeing Board and Partnership Boards Summit held on Thursday 9 July 2015.

The report gives key details about the main agenda items discussed at the Summit -

- The information presented on the Joint Strategic Needs Assessment (JSNA) and the engagement work completed following this.
- The Joint Health and Wellbeing Strategy consultation including the participant vote on the priorities for the Strategy and suggestions of additional priorities participants would like to see.
- Designing the future of partnership engagement and the feedback from participants about what they would like to see included in a future model design.

Recommendations

1. **That the Health and Wellbeing Board agrees the Summit report (appendix 1) for publication on London Borough of Barnet website and for circulation to all**

members of the Health and Wellbeing Board and Partnership Boards.
2. That the Health and Wellbeing Board notes that a report on the proposals for future partnership engagement will be presented to the Health and Wellbeing Board on the 28 January 2016.

1. WHY THIS REPORT IS NEEDED

1.1 This report provides an overview of the Health and Wellbeing Board and Partnership Boards Summit held on Thursday 9 July 2015.

1.2 The event was a vibrant day with 88 people attending representing:

- Service Users
- Carers
- Third Sector
- London Borough of Barnet
- Health and Wellbeing Board
- Barnet Enfield and Haringey Mental Health Trust
- Public Health
- Barnet Clinical Commissioning Group (CCG)

1.3 During the Summit engagement was carried out on three key areas of work that will impact on further work to be reported to the board at a later date (see the report at appendix 1). Areas covered were:

- The Joint Strategic Needs Assessment (JSNA)
- The Joint Health and Wellbeing Strategy
- Designing the future of partnership working

1.4 The Summit attendees heard a presentation about the JSNA which was in draft form at the time of the Summit. The presentation highlighted to the participants the key data that would influence the service planning across the borough. Participants were asked to comment on the data, input if they felt this was representative and if they felt anything was missing. Responses have been incorporated into the final draft of the JSNA.

1.5 The Summit attendees also heard about the refresh of the Boroughs Joint Health and Wellbeing Strategy (2016 – 2020. The Strategy uses data from the updated JSNA to outline the Borough's priorities to improve health and wellbeing for residents and reduce health inequalities. Participants were given the opportunity to vote on the current priorities and highlight anything else they feel should be considered. Mental health, carers and early years settings were the top three priorities. This information is being incorporated in the development of the Joint Health and Wellbeing Strategy.

1.6 Participants were given information about the engagement and the purpose of engaging with residents. Participants were advised that it was a priority for the Borough to ensure that the people using services were able to contribute in a meaningful way to the development of health and social care in Barnet. Participants were given the opportunity to advise what they would like to see

in the future to ensure that we have good partnership engagement. The outcome of this will be used to create a model design in co-production with members of the partnership boards.

1.7 Alongside the three agenda items above, participants enjoyed a Tai Chi session, information on engagement at the Info Hub and a performance from HFT's Unlimited choir.

2. REASONS FOR RECOMMENDATIONS

2.1 The recommendation is to approve the report for publication on the website and to members of the Health and Wellbeing Board and Partnership Boards in a timely way.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable in the context of this report as this report is for information and update.

4. POST DECISION IMPLEMENTATION

4.1 Further papers will be brought to the Health and Wellbeing Board on the Joint Strategic Needs Assessment (September), Health and Wellbeing Strategy (final strategy in November) and Partnership Boards model design (November) that will include the engagement work documented within this report.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Partnership Boards are currently tasked with supporting the delivery of the Health and Wellbeing Strategy and the report highlights how the Summit works to ensure the responsibility of this work is shared.

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

5.2.1 Not applicable to this report.

5.3 Legal and Constitutional References

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

(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.

5.4 Risk Management

5.4.1 None within the context of this report.

5.5 Equalities and Diversity

5.5.1 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 persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

5.5.2 The protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services.

5.5.3 To ensure that all participants wishing to attend the Summit were able to partake in the event the following measures were put in place.

- Pre meet and post meet for members of the Learning Disability Partnership Board to aid understanding of the work
- Communication cards on all the tables to aid individuals to ask a question or make a comment
- BSL interpreters to support members who need this to partake in the event
- Provision of a hearing loop to aid those who are Deaf or Hard of Hearing.

5.5.4 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.

5.6 **Consultation and Engagement**

5.6.1 This report highlights the consultation work undertaken during the Health and Wellbeing Board and Partnership Board Summit.

6. BACKGROUND PAPERs

6.1 Health and Wellbeing Strategy Year 2 Performance Report (appendix B Barnet Health and Well-being Board & Partnership Board Summit) item 6, 13 November 2014 https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7783&Ver=4

Report on

Health and Well-Being Board and Partnership Boards

Summit

Thursday 9 July 2015

Contents

1. Introduction

The 3rd full day Health and Wellbeing and Partnership Boards Summit was held on 9 July 2015.

The Summit event brings together the Health and Wellbeing Board and members of the 5 Partnership Boards.

88 people attended this years summit and the key topics covered were:

- Joint Strategic Needs Assessment
- Designing the Future of Partnership Working.

2. Introduction and Welcome

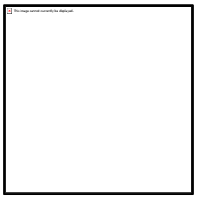
Mathew Kendal, Adults and Communities Director welcomed everyone to the event.

Councillor Helena Hart, Chairman of the Health and Wellbeing Board welcomed everyone to the event.

Points that Councillor Hart made included:

- The importance of the Joint Strategic Needs Assessment in planning for the future
- The benefits of having the opportunity to work together to influence the future priorities for the health and wellbeing of the residents of Barnet
- The importance of partnership working
- The benefits of the opportunity to work together to design a partnership working structure.

3. Joint Strategic Needs Assessment



Luke Ward, Commissioning Lead, presented the Joint Strategic Needs Assessment.

Key points of the presentation included:

- That we have a Joint Strategic Needs Assessment to understand how people in Barnet live their lives and to make sure that the services we deliver are the ones people need.
- Key pieces of data including information on:
  - The ageing population
  - Life expectancy variations
  - Housing
  - Employment
  - Mental Health
  - Carers.

The workshop was an opportunity to feedback on:

- If there were any surprises in the data?
- If any of the data particularly important to you?
- If there anything you think is missing from the data?

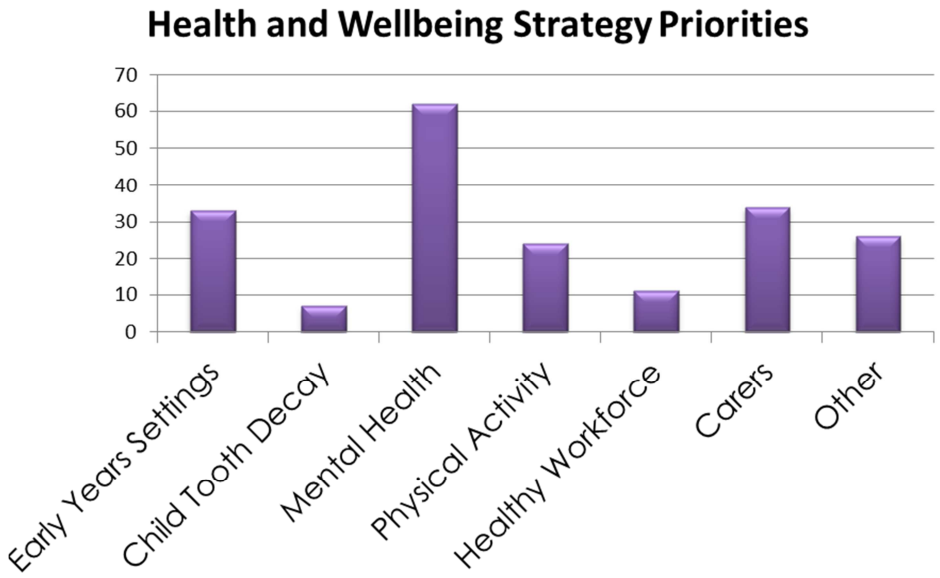
The key themes of the things you told us were:

- To better co-ordinate the voluntary sector
- To look at how to meet the needs of the diverse population of Barnet
- Mental health, carers and the ageing population are important to you
- To ensure that everyone has equal access to all services through improved transport options and localised services.

Zoë Garbett, Commissioning Lead – Health and Wellbeing Commissioning Group, introduced the Health and Wellbeing Strategy

Key points of the presentation included:

- The Health and Wellbeing Strategy is a key document of the Health and Wellbeing Board and highlights areas of work that we can tackle together
- The current Health and Wellbeing Strategy is being updated to run from 2016-2020
- The key priorities that had already been identified were presented to the room which included:
    - Early years settings
    - Child tooth decay
    - Mental Health
    - Physical Activity
    - Healthy Workforce
    - Carers
    - Other
- You voted for the priorities important to you -



Some of the suggestions for other priorities included:

- Learning Disabilities, older adults and physical and sensory impairment
- Improving access to services
- Improved community living
- Ensuring quality of services.

4. Designing the future of partnership working

Ben Lee, Independent Facilitator introduced the workshop on designing the future of partnership working.

Key points of the presentation included:

- There are currently 5 Partnership Boards who aim to undertake strategic partnership working between the key public, voluntary and community organisations
- People who use public services are experts in the services they use and that during times of increased financial challenges it is vital that the decisions that are made include the people they effect
- The participants were asked to consider the following points whilst designing any changes
    - There would be no new resources
    - If changes were made Partnership Boards would not be able to continue in the way they currently do
    - We want everyone who is currently a member to continue to be able to engage with us.

During the workshop participants were asked

- Top 3 things that make engagement work well
- Top 3 things that stop engagement working well.

The key themes that came out of the feedback were:

- Communication
- Membership
- Strong facilitation
- Feedback
- Location.

Ben Lee presented the second part of designing the future of partnership engagement.

Key points of the presentation included:

- Feedback had currently been that having somewhere to have your voice heard and having a variety of people in the same room was working well
- Some of the things people would like to see changed were to have earlier engagement and improved feedback.
- Some initial ideas we think may work included:
    - We could set-up time limited groups on key issues, as and when issues arise
    - We could allow any current Partnership Board member to join a group looking at an issue
    - We could set clearer objectives and timescales for discussing issues and monitor progress on resolving them
    - We could identify subject areas as a group at the annual Summits and review at autumn catch ups.

During the workshop participants were asked:

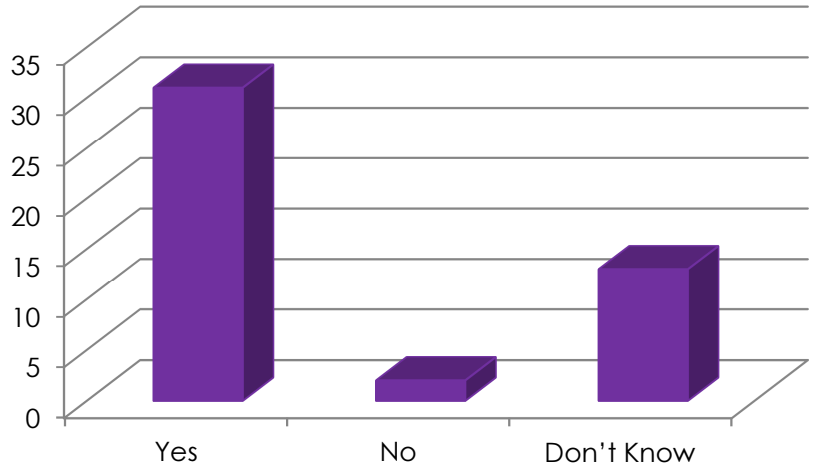
- What do you think of our ideas?
- Do they tackle the right problems?
- How might they work in practice?
- Are there better ways to improve how we engage?

The key themes that came out of the feedback were:

- In principle the ideas suggested are good
- Having people from different Boards together is good
- Concern that the ideas will be difficult to implement in practice
- Boards are used to pass on information and not to consult and influence decisions
- Need to know the objectives of both the Partnership Boards and engagement
- Meetings should be more joined up
- Having Partnership Boards is better than having nothing.

Participants were asked at the end of the session to vote if they felt the discussions during this session had taken us in the right direction.

Below are the results.



5. Other Activities on the Day

Info Hub


Participants were able to find out about opportunities to have their voice heard by:

- London Borough of Barnet
- Barnet Enfield and Haringey Mental Health Trust
- Barnet Seniors Assembly
- Barnet Clinical Commissioning Group.

Tai Chi


Debra Cura, Age UK Barnet lead a short Tai Chi Session

HFT's Unlimited choir



HFT's Unlimited choir sang some of their favourite songs during lunch.

6. Feedback

88 people attended the day

- 46 people returned a feedback form
- 100% of people found the day to be good or very good
- 93% of people felt able to say what they wanted
- 76% found the Joint Strategic Needs Assessment to be good or very good
- 78% found the designing the future of partnership working workshop to be good or very good.

Some of the comments that were given in the feedback included:

- Would like to see the outcomes of previous meetings at the next meeting
- I liked having active contributions from Councillors
- I liked listening to different peoples views and finding out other people from other boards have similar views
- Tai Chi was great
- It worked well sitting with a mixed group and not individual Partnership Boards
- Would like more time for individual feedback
- I would like to see more diversity at the meetings
- I would like to have more dialogue with the Health and Wellbeing board members during the meeting.

7. Appendix 1 - Joint Strategic Needs Assessment Feedback

Workshop 1 –Joint Strategic Needs Assessment what do the group think of what they have heard?

Any surprises?	• Number of voluntary sector organisations in the borough – this led to a discussion on difficulty of understanding what organisations are out there (and what they do) and how we need to improve engagement
	• Care leavers have not been addressed
	• Increase of the Black and Minority Ethnic population – need to be more diverse in delivery
	• Population growth –
	  ○ Numbers of older people
	  ○ Transport
	  ○ Population in Brent Cross
	  ○ Impact of expansion on GPs?
	  ○ Biggest borough!
	  ○ Cope with growth over 5- 10 years – education and health
	• Jobs for young people
	• Social isolation east / west parallel and in an affluent borough - no early help for better off people, family support not there, young people can't afford to live near their parents – multi generational living?
	• "empathetic living" – more from individual to communal thinking
	• More people at home and a skills gap – able to care for people at home?

Anything that is important to you?	• Mental health was seen as a priority –
	  ○ especially early intervention and lower level mental health (e.g. does not meet threshold)
	  ○ link up with other conditions / outcomes e.g. smoking, pregnancy
	• Young Carers – stigma attached, lots of 'hidden' young carers' and need to support young carers better
	• Life expectancy – difference across borough
	• New homes but social care budget reducing to cope with more
	• Social isolation
	• Housing –
	  ○ Needs to address health challenges

	through planning, use available land for council housing o re-mortgaging, paying for support, real issue for Learning Disabilities, right to buy • Dementia increasing – will services be there • Making sure that those who are not able to access help – those on benefits, can't use taxis, are able to access support • Extra money to promote 111 • Promote things that are good • Local health centres – focal point for communities • Dentistry – need quicker shorter checks
Anything missing?	• Mental health – why is our rate higher than other boroughs? How do we compare to statistical neighbours? o focus should be placed on ensuring that people aren't categorised into boxes leading to people being stigmatised • Residential care – do we only have 1400 in resident care and what is the definition of 'residential care' in the statistics? • Sexual health – especially around the impact on Black and Minority Ethnic groups and how different groups may have different issues. • Transition, 0-25 (Care Act) • Care leavers support group is needed • No additional resources • Get direct payments • Cost of caring from home • Transport - social isolation black spots caused by lack of transport • "it takes a village to raise a child and it takes a village to look after an elderly person" • Access – e.g. if older people don't have a car • Physical disabilities/Sensory Impairment can affect mental health in the future • Supporting victims of crime / abuse especially young people • Young people accepting to be victims of crime – this needs to change • Some detail on pollution / road networks / transport within the presentation • Bigger focus on employability and especially the positive impacts that this could have upon people's health and wellbeing • End of life care

Other	• 1 in 4 have mental health issues, it does not matter if you are BME / affluent • Worry mental health services are moving towards Edgware • Finchley Memorial Hospital – hard to access • No respect for volunteers • Family presence might not equal support • Want individuals / self / families to refer but sometimes this can't be done (process) • Local authority prioritising mental health but cutting Children and Adolescents Mental Health Services budget? • Locally available services needed

Workshop 2 – Health and Wellbeing strategy what does the group think of the updated priorities?

Priority	Comments
The role of early year's settings in improving and maintaining health and wellbeing	• This area was seen as a key priority to most groups • Important to start from pregnancy (e.g. advice on diet / smoking / alcohol) • Maternal mental health is a priority • Need to improve engagement with fathers • Important to educate parents in how to live a 'healthy life' – such as importance of diet / nutrition /exercise • Parenting support / parental attachment is very important • Support needs to not only be in children's centres but all early years settings • Healthy Schools programme (they didn't know if it was still running) and how good this had been. Especially as it took a holistic approach to health, focusing on Education, Diet, Exercise, Wellbeing etc. • In order for schools to effectively provide support, they need to manage their own budgets • A few people highlighted the importance of educating both children and parents on the dangers of the internet – especially around young girls putting themselves in vulnerable positions • Overall everyone agreed that it was important for all children to be given a good initial foundation around health and wellbeing • Not as much health promotion in EY settings as there used to be • Parenting classes in secondary schools (pre early years provision) • Child – to – child health care programmes – a few children

	teaching younger (Werner)
	• Building resilience and coping capacity- better habits
	• Inherent, in built now – support for emotional problems
	• Health and wellbeing starts here
	• Low level unsupported can lead to significant difficulties
	• Important
	• Invest in young people, help them prepare for their adult life
	• Not got an extended family can be difficult for children to develop
	• Picking things up early
	• Not forgetting the quieter children
	• More investment in education and training
	  o For mums to be and important in nursery
	  o More motivated in their role as a parent
	  o Understanding learning disabilities and mental health

Child tooth decay	• Seen as a very good identifier of need • Discussed how to make it easier for families to access dental care + could dentists come to schools to discuss issues? • Need to involve dental care more in early years health and wellbeing work • Felt this could potentially fall into the early years category • Useful indicator – access to multiple related issues • Need to look at how unhealthy food is being retailed • School dentist programme (need to be reimbursed differently) • Improve access to dentistry for disadvantaged • Not just a problem for young people • Should be part of early years above
Mental Health	• National growth in young people's mental health problem – more stresses on children today? • Importance of particular groups – looked after children and young carers? • Two key issues – stigma (e.g. getting people to understand they need support) and thresholds (very high) - How do we support people with low level mental health issues • Importance of early intervention and building awareness (de-stigmatising) • Biggest priorities surrounding mental health should be the removal of any 'stigma' associated with it. And in order to do this, a better understanding of Mental Health is needed. • People didn't feel that there is a holistic approach to Mental Health currently within the healthcare system. Mental Health is impacted by a variety of things and they wanted to emphasis (from personal experience) the importance of physical health within treatment. However, when they had gone through the system, the focus had always been on

	psychological issues rather than physical activity and the benefit that this could have. • They identified issues around the referral system – In regards of the length of time taken to be referred and not always being referred to the correct services. Importance of receiving treatment as soon as possible, as any delays can have a significant negative effect on the person's health. • Importance of ensuring clear defined outcomes are built into any treatment as it should always be the aim for people to be aiming to leave the service. • Multigenerational living • Third sector support • Earlier interventions are cheaper / less specialised • Hard to access Children and Adolescents Mental Health Services • Mental health provision hard to get into schools • Stigma • "Choice is expensive" – look at different ways to deliver services e.g. web based (could cause isolation) • Integrated care needs to look across all needs • Mental health services are not working – o Hospital welcome pack but no farewell pack (discharge pack) o No care worker /social worker o Support group found same problems o You do not want to ask people • No condition exists in isolation • Sensory impairments / physical disabilities – there is no link • Rio – computer system – does not cater to accessible details on patients • Clients are being assessed by different people • There is no single point of contact – caring and mental health should not be separate • Difficult to find out what is available – if you are a person with various problems, getting an understanding of all of your needs • Neighbours should talk to each other – street parties • Childhood trauma – personality difficulties later o Supporting the victims e.g. of Child Sexual Exploitation • Recognise better • Wellness/wellbeing – biologically predisposed to mental health problem – identify , advise • Smoking – increasing anxiety, misconception of smoking • Join up services – one person for support, links to Reimaging Mental Health • Ready to change • Encourage self-care rather than learned dependency

	• Co-production – reflect service users in service delivery (valuing diversity) • Better rather than good – recovery rhetoric • Social isolation missing as a key theme • Safe relationships, safe places • Only at 6th form at the moment. Jewish Care and JAMI are doing a schools course • Talk about it more • Disability equality training • Growing problem • Important of a sympathetic ear • Having some support to pick up issues early • Panic attacks – having a safe place • 40% increase in under 20s • Consequences of mental ill health – losing job, house • Need to keep the things that keep them well • Keep the door open • Need support that is available earlier • Having a variety of support, not putting people in a box • Training and education • Mental Health First Aid – asking the right questions • Want to do a course – accreditation
Increasing participation in physical activity	• Cycling – road safety through planning • Cycle to school week – no road safety arrangements! • Guidance on school bags to make cycling safer • Funding for bikes – Barnet Bikes • Healthy lifestyles is key – good for depression, link with mental health • What legislation to stop fast food? • Do you teach people to cook? • Keep people healthy in childhood • Prevention better than cure • Explain benefits of physical activity – how can we tie it up with daily activities e.g. walk can be tied to meeting friends / people • For over 55 – large range and often they go with friends (reduce isolation) • Broad theme, needs to be more specialist • Vested interest / self-preservation management
Healthy workforce	• Feed through from early intervention and through to next generation • Muscular – skeletal issues good indicator for other things • Important • Flexible working – working from home • Hand in hand with mental health • Declaring mental health in application form (illegal) • Moving to a place where people don't have to declare that

	they have a mental health problem when they call in sick (equality with physical illness) • Talk to boroughs residents / employees – what they want • People with disabilities employed at all levels of management (Barnet Centre for Independent Living) • Positive employment practices • Good communication and observation in the work place is needed • Mental health – employee issue, ability to adapt to work • Identifying needs to employees
Carers	• Professionals need to engage / appreciate the important role that carers play and ensure that they are seen as the gateway to the patient – this currently doesn't always happen • Some people felt that in recent years there has been a change to services – especially around social workers. Whereas, at one time social workers were the key source of information, this has changed somewhat and they can no longer be relied on in the same way. For example, one person's social worker went on holiday, the only number they had to contact was for a central helpdesk in Birmingham. The people in Birmingham didn't know where Barnet was. • Overall the general feel was that the service had lost the personalisation that it once had. • The issues around hidden carers sounded very familiar to everyone at the table. They all spoke about the 'obligation' that they felt to caring and that they hadn't even realised they were carers for a significant period of time; one person had been a carer for 3 years before they realised they were a carer. • In order to better identify carer and ensure they receive the necessary support – they spoke about the need for all professionals to be better at identifying / signposting carers to relevant services and support • Older people is a big issue – major funding issues • Carers with mental health issues • Young carers – link to tooth decay / diet • Children need to get to a good quality of life / attainment
Other	• Charities do work health can't afford • Places where people can meet • Prioritise people with hearing difficulties and other access issues • Messages that resonate – work with the person where they are, short – medium – long term view • Doing the wrong things for the right reasons – e.g. cannabis and smoking

	• Interlinks, bring themes together • Partnership boards – service user voice, need to link to committee priorities / commissioning strategies

8. Appendix 2 - Designing the future of partnership engagement workshop feedback

Workshop 1

Top three things that make engagement work well.	• To celebrate people's differences and experiences • To learn from the past and be optimistic and open minded about the future • Trust • Good communication • Plan ahead • Prioritise and do a few things well • Take account of different needs • Really listen and be able to hear and see each others views • Clarity about expectations • Bring the right people together at the right time • Report back to contributors how they made a difference • Cross-cutting issues, do not work in silos • Greater use of technology • Good engagement with a diverse community • Exchange ideas and networking • Speed, feedback quickly • Follow up on actions that have been agreed • Engage with service users on their terms in familiar and convinient locations • Interaction between different Partnership Boards • Good representation of the community • Sharing power and responsibility.
Top three things that stop engagement working well.	• Not genuine, just a tickbox exercise • Poor chairing • Individuals dominating conversations • Papers coming out too late • Accessibility and transparency of information • Lack of vision and focus • Use of jargon • Lack of empowerment • Not being clear about what is and isnt possible • Cynicism that nothing will change • Bad planning • Lack of representation • Broken promises • Duplication and wasting resources • Poor accessibility • Not enough time for the agenda • People not wanting to change • Not following up an action

	• Need to involve a more diverse group of people • Not agreeing shared objectives • Not resulting in change • No real shared power • Not learning lessons.

Workshop 2

What do you think of our ideas?	• Could be difficult to achieve in practice • More focussed groups meeting more often could be beneficial • Have we got the right Partnership Boards • We could have more meetings focused on themes • Not sure that crossing over to other Partnership Board meetings would work, your specialism is with one area. • Acknowledge overlaps but each Partnership Board works on the issues most important to it • Task and finish groups are a good idea • Learning Disabilities Partnership Board needs to continue as a standalone board. • How will priorities be decided • There needs to be a balance in the topics discussed between individual issues and things that seem too big • We could have task and finish groups instead of Partnership Board on specific issues • Most do not feel that they will make enough difference • Like the idea of time limited working groups such as the carers care act working group, this worked well
Do they tackle the right problems?	• Agendas too full • Needs to be genuine co-production • Strategic subjects not always welcome, more real subjects need tackling • Partnership Boards need to collect the issues • Time limited groups are a good idea to address paticular issues • Resources available should be an issue for each Partnership Board meeting. • Need to have papers in advance • Need to be told what happens following consultation • It is a challenge for the Partnership Boards to not just be a reporting point • Need to influence the Health and Wellbeing Board • Messages for other Partnership Boards is useful • Democracy doesn't always work, need some priorities from professionals • Need to have the right people there to discuss each issue

	• Need improved health representation • Bring in the Partnership Boards at the commissioning intentions stage • Do not reduce the number of professionals at the meetings • Wider issues need to be tackled which affect the wider community • Need to build improved relationships between all sectors.
How might they work in practice?	• Officers from the council needs to attend each meeting • There is a pressure to produce reports, minutes and information for each board, focus on one subject with no minutes and general discussion • Start with a subject, have a group discussion and share information • Who is deciding the issues if we go to an issues based idea? • People giving up time between each meeting is an issue • Need to manage expectations • Do outreach surgeries to hear peoples views and to listen • Do some community Based events with the Public so they unserstand what the issues are • Lets not just talk about meetings lets think about events, meeting the public, some board members might be really good at speaking and engaging with people. • Representative from the Partnership Boards to sit on the Health and Wellbeing Boards • An hour before the Partnership Boards fpr service users to discuss what has happened and any actions/issues from the board • Need to be clear about actions, purpouse of the meetings and relationships between the Health and Wellbeing Board and other Partnership Boards • Workshops are good but not good if there is not nough time • Same amount of recourses – needs to be a trade off, more themed issue meetings and less of the current partnership board meetings • Need a good balance between meetings and follow up actions • Use a combination of commissioning plans and what is important to you and prioritise • When we try to provide something different need to find out if it works and is it doesn't learn lessons from this.
Are there better ways to improve how we engage?	• Sub groups to form under each partnership board • Have Partnership Board meetings every 2 months • Have more frequent task and finish groups • Sub-groups have worked well in the past • Need to plan to address issues in advance • Need to make attendence at Partnership Boards

	mandatory for key people • As a principle support Partnership Boards to go to other Partnership Board meetings • Partnership Board chairs need to do more to keep individuals engaged • Set tasks for members outside of Partnership Board meetings • Each Partnership Board to decide its own terms of refrence • Keep different membership in balance • Service users need to be central to the group • Use tennant groups, ward meetings, notice boards in shops. • You cannot always fix an issue in the meeting but need to work on it outside of the meeting • Partnership Boards to be shorter and more intimate and have working groups to deal with the themes • Re-imagining mental health- a group of people from every walk of life sitting down with a free agenda, real work gets done. • Clearer purpouse and aims for the Partnership Boards • Improve interactions between Partnership Boards • Use different forms of communication • Make better use of days and weeks related to a paticular issue ie World Mental Health day, Carers week etc • Make Partnership Boards open to more people • More co-production • Make meetings fun • Learning disabilities parliament is important • There needs to be better mechanisms for influence.

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AGENDA ITEM 10

	Health and Wellbeing Board **17 September 2015**
Title	**Barnet CCG: 2016/17 Draft Commissioning Intentions**
Report of	Director of Integrated Commissioning (Interim)
Wards	All
Date added to Forward Plan	May 2015
Status	Public
Enclosures	Appendix 1 – Barnet CCG: 2016/17 Draft Commissioning Intentions
Officer Contact Details	Elizabeth James – Director of Integrated Commissioning (Interim), Barnet CCG Elizabeth.james@barnetccg.nhs.uk Maria O'Dwyer – Director of Integrated Commissioning, Barnet CCG Maria.O'Dwyer@barnetccg.nhs.uk

Summary

Under the terms of the NHS Act 2006 all CCGs are required to prepare commissioning intentions for each financial year. The commissioning intentions plan must set out how the CCG proposes to exercise its functions in that period. Each CCG is required to provide a copy of the commissioning plan to the local authority's Health and Wellbeing Board, to ensure that commissioning intentions are kept up to date, and to ensure that they are routinely discussed by the Health and Wellbeing Board.

The purpose of this paper is to present draft 2016/17 commissioning intentions to members of the Barnet Health and Wellbeing Board following a process of active engagement with Barnet CCG Governing Body Members, the public and patients of Barnet, and providers of services to patients. These engagement events have included representatives from Barnet Council.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the content of the draft Barnet CCG 2016/17 Commissioning Intentions (see Appendix 1).**

1. WHY THIS REPORT IS NEEDED

1.1 Under the terms of the NHS Act 2006 all CCGs are required to prepare commissioning intentions for each financial year. The commissioning intentions plan must set out how the CCG proposes to exercise its functions in that period (Appendix 1). Each CCG is required to provide a copy of the commissioning plan to the Borough's Health and Wellbeing Board, to ensure that commissioning intentions are kept up to date, and to ensure that they are routinely discussed by the Health and Wellbeing Board.

2. REASONS FOR RECOMMENDATIONS

2.1 The recommendation to members of the Health and Wellbeing Board is in line with the NHS Act 2006.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There are no alternative options that comply with the terms of the NHS Act 2006.

4. POST DECISION IMPLEMENTATION

4.1 Following consideration by the Health and Wellbeing Board, Barnet CCG Governing Body will receive the final draft 2016/17 Commissioning Intentions for sign off at their meeting on 24th September 2015. Responsibility for sign off is held by Barnet CCG. After this meeting, the intentions will be published on the Barnet CCG website and issued through lead commissioner arrangements to all providers of services to the people of Barnet.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Barnet CCG 2016/17 Commissioning Intentions are required as part of the Barnet CCG 5 Year Strategic Plan and will be used as the basis of the 2016/17 Delivery Plan.

5.1.2 The report aligns with the strategies and commissioning intentions of Barnet Council's Corporate Plan 2015-2020, reflect Barnet's Joint Strategic Needs Assessment (JSNA) and contribute to the aims of Barnet's Joint and the Health and Wellbeing Strategy, particularly the overarching aim of 'Keeping Well'.

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

5.2.1 Section 6 of the document (Appendix 1) details Barnet CCG's current expenditure by services and by main healthcare providers. All areas are required to deliver efficiencies of at least 3.5% in 2016/17, which may be through increased throughput, for the same inputs, removing costs from the system by fewer steps in the delivery of care; decommissioning clinically ineffective procedures, treatments and therapies; and price re-negotiation. An overall summary of 2015/16 Quality, Innovation, Productivity and Prevention (QIPP) schemes is detailed.

5.3 Legal and Constitutional References

5.3.1 Barnet CCG is legally required to discuss with all key stakeholders - that

includes: the public and patients of Barnet, the Health and Wellbeing Board and key providers of healthcare – the compilation of the commissioning intentions document.

5.3.2 Section 14Z11 of the National Health Service Act 2006 requires the CCG to present its commissioning plans to the Health and Wellbeing Board as set out in paragraph 1 above.

5.3.3 The Council Constitution – Responsibility for Functions (Annex A) sets out the Terms of Reference of the Health and Wellbeing Board which includes:

- To consider all relevant commissioning strategies from the CCG and the NHS England and its regional structures to ensure that they are in accordance with the JSNA and the Health and Wellbeing Strategy and refer them back for reconsideration
- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients
- Specific responsibilities for:
    - Overseeing public health
    - Developing further health and social care integration

5.4 **Risk Management**

5.4.1 The draft commissioning intentions have been compiled with close attention to the patient's right of access to defined quality, and safe, healthcare that is affordable. Each individual intention is supported by a piece of work that will define the risks of taking it forward in greater detail.

5.5 **Equalities and Diversity**

5.5.1 In the same way as for risk management in section 5.4, each individual intention will be developed and if an equalities impact assessment is required then this will be undertaken as part of the supporting work. The aim of the plan is to continue to reduce the inequalities faced by the population of Barnet and this will be a key part of the criteria in progressing each of the commissioning intentions.

5.6 **Consultation and Engagement**

5.6.1 Barnet CCG is required by statute to discuss with all key stakeholders - that includes: the public and patients of Barnet, the Health and Wellbeing Board and key providers of healthcare – the compilation of the commissioning intentions document. Section 14Z2 of the NHS Act states:

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) —

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the

manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

5.6.2 As part of the process of developing this paper, widespread engagement and consultation has been undertaken with key stakeholders.

5.6.3 Some individual intentions will also require separate engagement such as the procurement of the GP Out of Hours and access to 111 services across the North Central London CCG's.

5.6.3 Further engagement will be carried out and comments will be compiled by the Director of Integrated Commissioning, Barnet CCG.

6. BACKGROUND PAPERS

6.1 Not applicable.

NHS Barnet Clinical Commissioning Group

Commissioning Intentions 2016-2017

Date: 15th July 2015

Document Revision History

Creation date	Author(s)	Summary	Version
15/07/15	Katie Quigley Turner Sarah Thompson	• Creation of 16/17 Commissioning Intentions	v1
Revision date	**Author(s)**	**Change Summary**	**Version**
20/07/15	Katie Quigley Turner Sarah Thompson	• Addition of: Planned Care, Urgent Care, Medicines Management, Primary Care, Integrated Care, Contracting Approach, and Foreword.	v2
21/07/15	Katie Quigley Turner Sarah Thompson	• Amendments to Planned Care, Urgent Care and Medicines Management • Addition of Health Needs of Barnet's Population Section	v3
23/07/15	Katie Quigley Turner Sarah Thompson	• Added third paragraph to section 3 • Updated section 3 'NHS England' • Updated section 8.2 Primary Care • Updated section 8.3 Medicines Management • Updated section 8.4 Planned Care • Added section 6 Financial Position and QIPP Programme	v4
24/07/15	Katie Quigley Turner Sarah Thompson	• Updated 'Enabler' titles • Added paragraphs on 7 day working and Finchley Memorial to section 3 • Added CSU commissioning intentions to section 7 • Updated Planned and Urgent Care commissioning intentions in section 8 • Formatted Integrated Care commissioning intentions in section 8 • Changed 'Medicine Management' to 'Medicine Optimisation' • Added Finances commissioning intentions to section 7	v5
27/07/15	Katie Quigley Turner Sarah Thompson	• Updated figures to Primary Care section 8 • Added section on Quality to section 9 • Updated following comments from Buz	v6

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		Dodd	
27/07/15	Rita Shah	• Formatted for Executive Team Meeting • Pages added to content list	v7
28/07/15	Katie Quigley Turner	• Comments from Regina Shakespeare • Accepted track changes from Regina Shakespeare • Removed 'Prevention' section	v8
29/07/15	Katie Quigley Turner Sarah Thompson	• Updated sections following comments from GS and Executive Team	v9
30/07/15	Katie Quigley Turner	• Updated Integrated Care, Childrens and Maternity Care and Mental Health Care sections • Updated CSU sections	v10
4/08/15	Buz Dodd	• Updated cancer pan London intentions • Updated Integrated care –inserted FMH	v11
5/08/15	Bhavini Shah Sarah Thompson	• Updated section 4.1 - the population registered with Barnet GP's • Amended Goal 3, 'GOs' to 'GPs' • Care pathways and interface between Barnet Hospital and Chase Farm Hospital section removed from section 8.5 and reinserted in section 7	v12
11/0815	Katie Quigley Turner	• Updated section 4 to include information on Care Homes • Updated section 6 with Simon Mendy's amendments • Updated below sections following internal engagement event on 6th August: 8.1 8.2 8.3 8.4 8.5 8.6 8.7 • Removed cancer section 8.3.1 following internal commissioning intentions steering group meeting on 11/08/15	v13

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21/08/15 24/08/15	Katie Quigley Turner	• Updated sections 8.6 and 8.7 following provider event on 13th August • Updated number of GP practices in Barnet from 65 to 64 in section 3 • Updated UCC commissioning intention in section 8.5 following feedback from Simon Mendy • Updated section 8.6 and 8.7 following discussion with Muyi Adekoya and Maria O'Dwyer. • Added draft executive summary	v14
25/0815	Katie Quigley Turner Katie Quigley Turner Regina Shakespeare	• Updated Planned Care section with Teresa Callum • Updated Urgent Care section with Buz Dodd • Review of resilience approach; references to Finchley Memorial Hospital; public feedback from engagement event on 20th August.	v15

Approvals

This document requires the following approvals before finalisation.

Name and Position/Group	Date	Version
Health and Wellbeing Board	17th September 2015	v15
BCCG Governing Body	To be approved - 24th September 2015	v tbc

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NHS Barnet Clinical Commissioning Group

DRAFT Commissioning Intentions 2016-2017

Contents

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1. Foreword

NHS Barnet Clinical Commissioning Group (Barnet CCG) is a clinically led organisation. We have worked with providers of health services to the people of Barnet, the London Borough of Barnet, the voluntary sector, and with our patients and public, to look at how best to shape services that meet the needs of our population. As a result we have made commissioning decisions based on key clinical priorities within the resources available and taking full account of what our patients have told us.

In 2016/17 Barnet CCG intends to continue the work that has been started in 2015/16. We will continue to ensure that we work collaboratively with all partners across the health and social care spectrum, and to deliver safe and affordable services for all of our residents in line with the Barnet Five Year Strategic Plan and Delivery Plan 2014-19 and North Central London (including Haringey, Enfield, Islington and Camden CCG's) strategic direction.

The North Central London (NCL) health system faces significant financial challenges that require a different approach by the NCL Clinical Commissioning Groups and providers going forward if we are all to build sustainable services in the future. A considerable amount of work designed to address this is already underway across the NCL system, supported by external advisors, but it is important that we set out Barnet CCG's financial context for 2016/17 and how we expect this to impact on our contracts.

This document sets out our commissioning intentions for the year commencing 1 April 2016 and aims to give providers of health services with whom we work a clear indication of where we are planning to make changes next year. These intentions have been compiled with contributions from the member GP practices that make up Barnet CCG, with providers, with the London Borough of Barnet (LBB) and with our public and patients, and we look forward to working with you all to deliver healthcare to service users in Barnet.

Signature

Dr Debbie Frost

Chair, Barnet Clinical Commissioning Group

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2. Executive Summary

All CCG's are required under the terms of the NHS Act 2006 to prepare a commissioning intentions plan for each financial year. This is to ensure that the providers with whom we work have a clear understanding of what is expected of them.

The Barnet CCG 2016/17 Commissioning Intentions have been written to reflect the full range of services commissioned by Barnet CCG; what is currently known about the health needs of the population, and the associated financial position, as we look forward into 2016/17 in the context of the strategic goals.

The commissioning priorities for Barnet CCG include primary care services, medicine optimisation, planned care and cancer services, urgent care, adult integrated care, children and maternity care and adult mental health. These priorities are supported by three enablers that are: co-design with public and patients, ensuring quality of services and innovating with technology.

The NHS and Barnet CCG face large challenges in the coming years due to the increasing demands for health and social care provision. Challenges such as how to deliver better for less; how to empower citizens with more control over their own care; and how to create a culture which is open to innovation and new ideas.

Barnet CCG is looking to change some ways in which it works so that it can provide quality services in the most productive and cost-effective way possible, ensuring better outcomes for patients. Barnet CCG will continue working on the QIPP agenda to ensure that reviews and re-structuring of services take account of Quality, Innovation, Productivity and Prevention (QIPP).

The CCG will be embarking on a number of ambitious work streams including the re-design of community and out of hospital services in areas such as Cardiology and Dermatology and the 'Reimagining Mental Health' work, which is looking to redesign mental health services.

This document sets out Barnet CCG's commissioning requirements by areas of care and illustrates the providers who will be impacted by these proposals. We will work closely with providers and other key stakeholders over the coming months to agree and deliver our commissioning and operational plans for 2016/17.

This document does not contain a complete list of all initiatives, projects and service changes that are either already underway or are in the pipeline, but instead summaries the key priorities for the year ahead.

3. NHS Barnet CCG

Barnet CCG is a membership organisation made up of GPs from the 64 GP practices which work within the borough to plan and buy (commission) health services for the local population.

Barnet CCG is responsible for planning and buying most of the local healthcare services, including:

- Planned hospital care
- Urgent and emergency care (including out-of-hours services)
- Rehabilitative care
- Maternity services
- Most community health services
- Mental health and learning disability services
- Prescribing by member practices

In 2016/17 there will be an established NCL Primary Care Joint Co-Commissioning Committee routinely operating that Barnet CCG will be a member of, in partnership with NHS England, giving oversight to a range of primary care functions that include: GP practice mergers/moves and premises plans.

Our role is to ensure that residents and those registered with GPs in Barnet have access to healthcare. We want to work with the people of Barnet to commission services which achieve the best health for all. The CCG has an important role to play in providing clinical leadership, ensuring quality and effectiveness of health care and value for money within Barnet.

Commissioning in Barnet is a complex process ensuring health and social care services meet the needs of a large and varied population effectively. It involves assessing population needs, prioritising local health outcomes, commissioning appropriate products and services, and managing numerous service providers. Clinical commissioning is central to the success of the NHS in Barnet as it allows doctors and nurses to draw on their medical expertise to lead the buying of healthcare services.

3.1 Our Partners

Barnet CCG works with many partner agencies and organisations to ensure local NHS services are integrated, safe and designed around the needs of the local population.

Our key partners include:

3.1.1 NHS North and East London Commissioning Support Unit

To support us to deliver our vision and achieve our goals for the NHS in Barnet, we commission the North and East London Commissioning Support Unit (NELCSU). Its role is to support business functions, such as contract negotiation and monitoring, procurement and analytics.

3.1.2 London Borough of Barnet

Local authorities commission care and support services and have a new responsibility to protect and improve health and wellbeing. They use their knowledge

of their communities to tackle challenges such as smoking, alcohol and drug misuse and obesity. We work in partnership with the local authority on joint commissioning such as services for older people, children and mental health services and the implementation of the recent Better Care Fund initiative in April 2015. This initiative will create a single pooled budget between Barnet CCG and the London Borough of Barnet to support working closely together, placing people's well-being at the focus of health and social care.

3.1.3 Barnet Health and Wellbeing Board

Barnet's Health and Wellbeing Board plays a key role in the local commissioning of health care, social care and public health through development and implementation of Barnet's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing (JHWB) Strategy. The JSNA and JHWB Strategy inform the CCG, Local Authority and wider partners in the commissioning and developing services which aim to respond to the local community's needs and priorities.

3.1.4 Barnet Healthwatch

Barnet Healthwatch, which is represented on the Barnet Health and Wellbeing Board and on the CCG Governing Body, gives patients and communities a voice in decisions that affect them. Barnet Healthwatch reports its views and concerns to Healthwatch England so that pervading issues can also be raised at a national level.

3.1.5 NHS England

Nationally, NHS England commissions specialist services, primary care, offender healthcare and some services for the armed forces. The specialist services commissioning intentions will be produced in September 2015.
NHS England hold a range of responsibilities for primary care services and works collaboratively with Barnet CCG, and all NCL CCG's, on the Joint Co-Commissioning agenda for primary care.

4. Health Needs of Barnet's Population

Barnet CCG uses Barnet's Joint Strategic Needs Assessment (JSNA) to understand the health and wellbeing of the residents of Barnet.

4.1 Population Growth

In 2015 Barnet was home to 367,265 residents and Barnet's population is expected to rise by around 0.7% in 2016 to 369,887. The population registered with Barnet GP's as of 1 July 2015 was estimated at 365,355. The borough has a higher proportion of its total population who are aged over 65 when compared to London. 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. Barnet's rising population will place pressure on all health and social care services, with a number of implications for health and wellbeing. Key issues include:

- 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.

The borough of Barnet also has one of the largest numbers of care and residential homes in Greater London. Currently, there are 79 residential and 23 nursing homes registered with CQC in Barnet (CQC, June 2015). In total, these homes provide 2,921 beds for a range of older people and younger people with disabilities. Projections show that the number of residential placements within Barnet will increase by around 30% to over 2,800 placements by 2020. By 2030 the total population aged over 65 years and over living in a care home will be over 3,500 (POPPI, 2014).

4.2 Ethnicity

Barnet is a very diverse borough with around 38% of the local population belonging to non-white communities. Different ethnic groups will have differing health needs and susceptibilities and Barnet is forecast to become increasingly diverse, creating new and complex health needs.

4.3 Deprivation

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 (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.

4.4 Mortality

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. 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).

4.5 Health inequalities

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).

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. It is clear from international studies and evidence that people from more deprived groups tend to

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

5. Barnet CCG's Strategic Goals

BCCG's 5 Year Strategic Plan and Delivery Plan 2014-19 outlines the CCG's approach to delivering transformational change in health and social care, to improve health and social outcomes over the course of the next five years. The strategic goals are:

- **Strategic Goal 1**: Promote health and wellbeing, enabling Barnet's population to be as healthy as they can be and make informed choices about their health and lifestyle;
- **Strategic Goal 2**: Utilise the knowledge and skills of our GP membership, ensuring patient centered, consistent primary care for the people of Barnet; develop proactive and innovative Primary Care networks? to provide more local and joined up care;
- **Strategic Goal 3**: Ensure Right Care First Time. - Working with patients, the public, GPs, the London Borough of Barnet, service providers and other stakeholders, BCCG will develop new service models and pathways to meet the health and social care needs of our population; and
- **Strategic Goal 4**: Develop local and joined up care – working with primary care, the London Borough of Barnet and other health and social care partners, to streamline and join up complex care and support for the frail and elderly and those with complex long term conditions, with care provided at home or as close to home as possible.

We have used the above strategic goals as the basis of our 16/17 commissioning intentions.

5.1 Barnet CCG's Vision

To achieve these goals:

Barnet CCG will work in partnership with local people to improve the health and wellbeing of the local population of Barnet, find solutions to challenges, and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

Barnet CCG Values

- Treat everyone with compassion, dignity and respect

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- Person-centred care that supports people to be as healthy as they can be
- Work in partnership and collaborate with all
- Reduce dependency and promote self-care

Refer to **Appendix 1** for a pictorial example of Barnet CCG's Vision and Enablers.

6. Financial Position and QIPP Programme

As outlined in the Foreword, the NCL health system faces significant financial challenges, which requires a different approach by all NCL clinical commissioning groups and providers to build sustainable services in the future.

The CCG's financial allocation has for some years been below its 'fair shares' target and this has placed a significant amount of tension on the system. We expect to see some growth in funding over the next few years taking us closer to target 'fair shares' by 2018/19. Increased funding for 2015/16 provided only a marginal improvement on 2014/15, leaving the CCG 2.47% below its 'fair shares' target (a funding gap of £10.953m per annum).

It is estimated that the CCG will be at least 2.0% beneath its target allocation by 18/19. A range of +/- 2% is regarded as tolerable by the Department of Health due to the limitations of the data used. However, this still leaves the CCG with a rising population and allocations increasing in a delayed way.

Our Financial Recovery Plan suggests that if no improvement action is taken, the CCG could be faced with an ever-growing accumulated deficit in the region of £25m to £30m by 2018/19.

Barnet CCG needs to change the way services are delivered so that we can provide better quality services in the most productive and cost-effective way possible, making best use of the potential for innovation. This is call QIPP – Quality, Innovation, Productivity and Prevention. QIPP is the umbrella term used to describe the approach that the CCG is taking to redesign services in light of operational and financial requirements.

QIPP savings in the order of £12m to £15m will be required recurrently to pay off the current accumulated deficit of £11m and achieve a surplus financial position by 2016/17, with all cumulative deficits repaid, and to achieve the aim of fully meeting NHSE business rules by 2017/18.

The annual QIPP savings required represent on average 3.5% of Barnet CCG's annual resource allocations over the same period. This level of annual efficiencies is only achievable if Barnet CCG and its associate commissioners in NCL, together with all providers in the system, work collaboratively.

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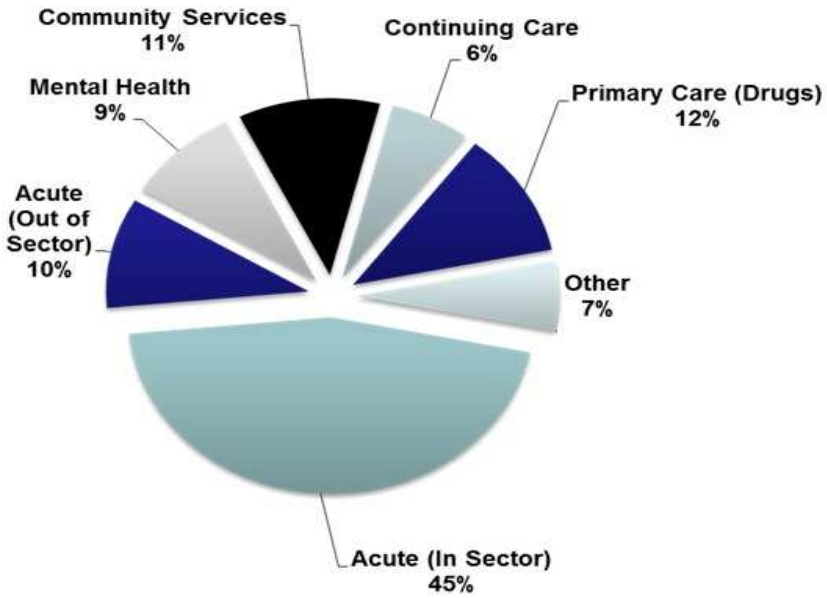
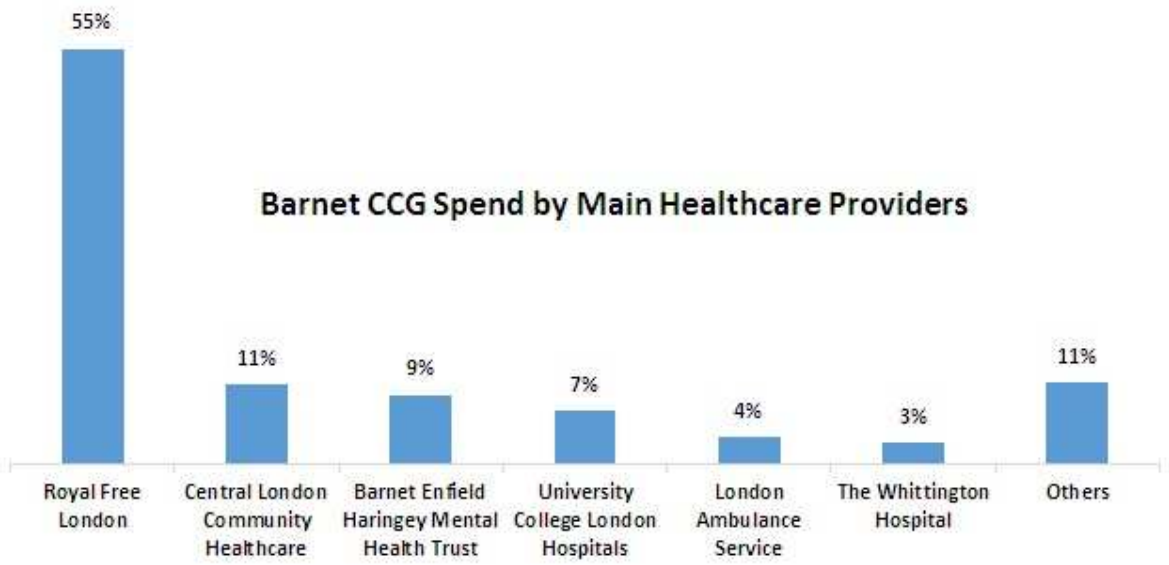
The following charts show Barnet CCG's expenditure by services and by main healthcare providers.





All areas are required to deliver efficiencies of at least 3.5% in 2016/17, which may be through increased throughput, for the same inputs, removing costs from the system by fewer steps in the delivery of care; decommissioning clinically ineffective procedures, treatments and therapies; and price re-negotiation.

An overall summary of 2015/16 QIPP schemes is shown in **Appendices 2 and 3**, with indicative amounts for the following years.

7. Approach to Contracting

As stated in section 6, the financial challenge for CCG commissioners and provider organisations in NCL over the next five years means that existing ways of working together through contracts are not sustainable. With forecast financial deficit positions in 2015/16 for Barnet CCG, the Royal Free London NHS Foundation Trust (RFL) Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), our objective is to take costs out of the system and not to continue to pass risk around the system.

We believe this can be achieved through mutual agreement of a financial approach with underpinning contractual terms in 2016/17 that share gain and risk equitably. There are a number of clinical services that lend themselves to this, which could include access to: Endoscopy, MRI and Urology services as three examples.

Agreement of a financial approach would also include the following elements:

- Aligning commissioner QIPP and provider Cost Improvement Plans (CIP) schemes with agreed outcomes;
- Commissioning end to end clinical pathways for planned care with a view to securing best in market value for money;
- Ensuring that hospital beds are accessed in line with the agreed Barnet, Enfield & Haringey Clinical Strategy;
- Designing new integrated clinical services at locations such as Finchley Memorial Hospital;
- Using new methods of procurement of clinical services where this adds real value, for example value based or outcomes based contracting over longer durations.
- Barnet CCG is fully committed to using its contractual powers alongside clinically based dialogue to secure high quality care for patients, including access to care within the NHS Constitution stipulated waiting times. It will, as a matter of course, agree contracts and contract variations using the NHS standard contract.

Barnet CCG is fully committed to delivering fully integrated services that will support a range of borough based care pathways in accordance with our key strategic goal of '*Ensure Right care, First time'.*

In line with the Barnet, Enfield & Haringey Clinical Strategy, RFL Integrated Business Case for the Acquisition of Barnet and Chase Farm Hospitals NHS Trust (January 2014) and Transaction Agreement (June 2014) there is agreement to use the beds at Barnet and Chase Farm Hospitals in more clinically effective ways.

All borough based care pathways will have the single priority in supporting a timely and safe discharge directly from Barnet Hospital and there will be no clinical commissioning agreement for any internal hospital transfer to Chase Farm Hospital. This extends to all patients admitted following an un-planned episode of care and

includes all wards operational at any point throughout the year such as escalation, re-enablement and rehabilitation.

Barnet CCG is working to transform the local role and capability of services at Finchley Memorial Hospital through enhanced integration across health and social care to include primary care.

This will increase the local capacity which will underpin borough based care pathway delivery to support both admission avoidance and early supported discharge from Barnet Hospital.

Work on utilisation of the facilities at Finchley Memorial Hospital has commenced with agreement by Barnet CCG commissioners to undertake detailed service design work on:

- Filling the empty inpatient beds.
- New GP primary care services/closer working with the Walk in Centre.
- An older people's assessment service.
- Dementia services

Barnet CCG has a commissioning intention to develop an agreed financial approach to underpin contracts in 2016/17 that will be progressed through the following business arrangements:

- Negotiations for the 16/17 contracts will run from January 2016 until the end of March 2016.
- Governance arrangements for decision making and escalation of issues in dispute will be agreed before the negotiations commence.
- Contracts not agreed and signed by the end of March will go to NHS mediation/arbitration (non FTs) or a mediation/arbitration process agreed between Barnet CCG as lead commissioner and the provider.
- Any contract not agreed by 1st April 2016 will be paid monthly 1/2th of the first contract offer made by the commissioners until the contract is agreed and signed. Any required adjustments will be made retrospectively.
- Financial sanctions for breaches of national and locally agreed contract, quality, information and other standards will be applied without exception

Contracting Intentions for 2016/17 include the following:

- Notice is given that reporting of key services and indicators must be by hospital site and GP practice where required by commissioners. Services that are failing to meet national or local access or other quality indicators must always be reported by hospital site
- 6 months' notice is given to CLCH, RFL and North Middlesex University Hospital (NMUH) that Barnet CCG will undertake a review of readmission avoidance thresholds in line with the Barnet, Enfield and Haringey Clinical Strategy. This work will be undertaken by relevant CCGs across NCL in line with national technical guidance.

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- 6 months' notice is given to RFL that following a benchmarking review of local pricing led by Barnet CCG that local prices will need to demonstrate comparative value for money and any that do not, will need to be reduced from 1st April 2016.
- 6 months' notice is given to RFL that Barnet CCG will undertake a review of pricing for regular day attenders with a view to a reduction in prices with effect from 1st April 2016.
- 6 months' notice is given to RFL that following a review of pricing of critical care bed days the price charged by RFL may need to be reduced to ensure that equitable pricing is in place that stands scrutiny.

  6 months' notice is given to RFL that following reviews of pricing in relation to the following block agreements, prices for these services may need to be reduced to demonstrate value for money. It should be noted that this list is not exhaustive:
  - Stroke rehabilitation
  - Community Paediatrics
  - Cystic Fibrosis
  - Diabetes development
  - Eating Disorders
  - Pain management
- 6 months' notice is given to RFL that Barnet CCG will undertake a review of pricing for patient transport services to ensure that pricing is appropriate and stands scrutiny following the transfer of the service to a new provider.
- 6 months' notice is given to RFL that Barnet CCG will undertake a review of high cost drug prices to ensure that pricing is appropriate in relation to acquisition cost and stands scrutiny.
- 6 months' notice is given to RFL that Barnet CCG will undertake a review of SLA exclusions to the main contract, and associated service lines, with a view to following national guidance and having no exclusions.
- 6 months' notice is given to RFL that Barnet CCG will base the market forces factor used in the contract on national guidance.
- Notice has previously been given to RFL that Barnet CCG will not contract for any outpatient or support services in relation to TB from 1st November 2015, therefore this will continue to be excluded from the 16/17 contract with RFL
- 6 months' notice is given that Barnet CCG will establish contracts with providers in 2016/17 where there is sufficient volume and value of non-contracted clinical activity flows in 2015/16, normally £200,000 and above.
- 6 months' notice is given to all secondary care acute and any other relevant providers that Barnet CCG intends to commission PbR related activity based on any revised national PbR tariffs for 2016/17 thus eliminating Enhanced Tariff Option (ETO) / Default Tariff Rollover (DTR) tariffs used in 2015/16.
- 6 months' notice is given to all providers that Barnet CCG expects to re-introduce the Commissioning for Quality and Innovation (CQUIN) payment for the achievement of stretch targets and innovative measurable schemes in line with national guidance and best practice.
- 6 months' notice is given to providers of mental health services of the possible requirement to move to (or shadow) mental health PbR

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arrangements. To do so will require improved confidence in activity recording by mental health providers.

- 6 months' notice is given to mental health providers that Barnet CCG will be introducing access targets and waiting time targets to mental health services.
- 6 months' notice is given to mental health providers that Barnet, Enfield and Haringey CCG's will be exploring a move to a consistent priced contract across the boroughs. Such a move would be price neutral to providers overall and will require CCGs to also ensure movement of resources between them to ensure cost neutrality.
- Barnet CCG will continue to monitor activity baselines in the CLCH contract, with the view to develop sound baseline activity in 2016/17 to identify areas of increased activity that may need to move to a cost and volume contract in 2017/18.
- 6 months' notice is given that Barnet CCG requires improved data quality and timeliness for activity reporting**.**
- Barnet CCG will work to ensure robust benchmarking of activity, costs and securing clinical efficiencies with 2016/17 contracts.

8. Commissioning Priorities

8.1 Overview

We have identified the following seven commissioning priorities that we will focus on to transform services, aligned to our four strategic goals.

Strategic Goal	Commissioning Priority
1. Promote health and wellbeing	
2. Utilise the knowledge of skills of GP membership	1. Primary Care 2. Medicine Optimisation
3. Ensure right care first time	3. Planned Care and Cancer Care 4. Urgent Care 5. Children and Maternity Care
4. Develop local and joined up care	6. Adult Integrated Care 7. Adult Mental Health Care

For each commissioning priority we have set out:

- A brief description of the service area(s) covered; and
- Details of Barnet CCG's Commissioning Intentions for 2016/17.

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8.2 Primary Care

What do we mean by Primary Care?

Primary care is usually a patient's first point of contact with the NHS. This involves contact with community based services such as GPs, Community Nurses, Allied Health Professionals such as Physiotherapists and Occupational Therapists, Midwives and Pharmacists.

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What action will Barnet CCG take in 2016/17?

Barnet CCG is responsible for improving the quality of local primary care services, working closely with NHS England with joint responsibility for commissioning primary medical care commencing from 1 October 2015. As the CCG is a membership organisation it has a unique working relationship with the local GPs and nominated clinical leads sharing management responsibilities for designated programmes of work.

The strategic context for primary care in Barnet is currently defined by the Transforming Primary Care in London: A Strategic Commissioning Framework and from October 2015 arrangements for the Joint Co-commissioning of primary care across the NCL CCG's and NHS England will be in place. This Framework also aligns to the challenges set out in the Five Year Forward View and to the vision to a seamless seven day health service.

Commissioning intentions for 2016/17 include the following:

- Barnet CCG will produce a Barnet CCG Primary Care Strategy that supports patient and out of hospital care, that builds on the direction of travel for primary care development, agreed at the NCL workshops and complements the London and NCL-wide strategic approaches for implementation during 2016/17.
- Barnet CCG will undertake a review of all local commissioned services with a view to commissioning one new Local Commissioned Service (LCS) that supports the delivery, and management of long term conditions within primary care from 1 April 2016. A requirement of the new LCS will be for practices to sign up to information sharing agreements that promote and supports integrated care across health and social care provision. The NHS Standard contract will be used as the contracting vehicle for the new local commissioned service.
- Barnet CCG will work with primary care providers to implement and deliver an equitable 7 day service in primary care that can be accessed in at least one of the CCG's Localities extended to other Localities in future years.
- Barnet CCG will support estates planning as part of it co-commissioning role with NHSE, including Primary Care Improvement funded projects that support the strategic direction of travel for further development of out of hospital care.
- Barnet CCG will support the development of all providers including Barnet GP Networks, to ensure there is a robust, sustainable market of providers within Barnet.
- Barnet CCG will actively contribute to the joint Co-Commissioning of primary care across NCL so that there are real benefits to delivering primary care at scale in Barnet while addressing local needs.
- Barnet CCG will define the education programme with CEPN to deliver multi-professional learning events that support the commissioning priorities of the CCG and development needs of the Barnet workforce, encouraging recruitment and retention of both GPs and practice nurses across the Barnet area.

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8.3 Medicine Optimisation

What do we mean by Medicine Optimisation?
Barnet CCG's aspiration for medicines optimisation going forward into 2016/17 is to improve the quality of medicines management through evidenced based prescribing.

The new term 'Medicines Optimisation' is broadly defined as the approach by which the NHS optimises the use of medicines and ensures evidence based medication prescribing protocols based on shared decision making, informed consent, and the principle of 'do no harm' in all care settings. This is targeted at a multi professional approach inclusive of patients and carers. Self-care must be at the heart of the approach and decisions about medicines should be made jointly with patients.

What action will Barnet CCG take?
Barnet CCG aims to support effective medicines optimisation, helping people to get the most out of their medicines.

The medicines optimisation commissioning intentions and QIPP plans for 2016/17 build on existing work to drive improvements in quality and efficiency through effective medicines use. These include:

- 6 months' notice is given to RFL that Barnet CCG will reduce handling charges for certain groups of PbR exclusion drugs, such as the anti-TNF drugs Adalimumab and Etanercept, to bring costs in line with the Bart's Health NHS Trust charges of £50 per year. This will be an NCL CCG wide change.
- Barnet CCG will expect the RFL to monitor out-patient pharmacy waiting times on a 3 monthly basis and report back to the CCG on mean waiting times and the percentage of patients that had to wait one hour or above for their prescription to be dispensed.
- 6 months' notice is given to Moorfields Eye Hospital NHS Foundation Trust that Barnet CCG will agree a reduction to the overall cost of the medication and administration of anti-vascular endothelial growth factor (Anti-VEG) drugs. The current overall cost of this treatment is more than other local secondary care providers therefore costs will be aligned across NCL.
- Barnet CCG will reduce medication waste, promote cost effective evidence-based prescribing, and reduce the risks of Residential and Nursing Home residents experiencing medication adverse effects and possibly being admitted to hospital. To support this work the CCG will be recruiting an additional Pharmacist to support the Barnet CCG's Medicine Management Team in 2015. Barnet CCG is working with the RFL on this initiative.
- 6 months' notice is given to all secondary care providers that Barnet CCG requires 30% of the intravenous anti-TNF drug infliximab to be the biologic product.

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- Barnet CCG with other NCL associate commissioners will review the treatment of wet AMD with a view to delivering the most cost effective treatment options for patients.
- Following the introduction of the biosimilar Follitropin Alfa drug (Bemfola®), 6 months' notice is given to Guys and St Thomas' NHS Foundation Trust of a 25% reduction in any costs associated with IVF treatment.

8.4 Planned Care and Cancer Care

What do we mean by Planned Care?

Planned Care can be defined as the provision of routine services with planned appointments or interventions within community settings such as GP surgeries, health centres and other community facilities. This term can also encompass routine surgical and medical interventions provided in a secondary care setting and in some instances long term conditions such as diabetes and musculoskeletal conditions. Simply put, planned care refers to those services and treatments which are not carried out in an emergency.

For Barnet residents, Planned Care is usually carried out by Barnet's Community service provider CLCH or from secondary care providers, such as the RFL.

The CCG will focus on planned care by ensuring that member practices refer the right patients for a specialist opinion and/or treatment in an outpatients setting, based on clinical effectiveness protocols, through the effective use of the Barnet Referral Management Service (RMS). This should result in a reduction in a number of hospital based outpatients appointments.

A key part of Barnet CCGs strategy is to manage and streamline activity through a single point of access into the system and the Barnet RMS is the central point through which referrals should be routed. This will ensure that:

- All agreed pathways have been followed prior to referral to acute trust
- All relevant diagnostics are attached
- The purpose of the referral is clear
- Any lack of clarity can be clarified with the referring GP in advance
- The patient is referred into the correct service according to their clinical need
- Patients are not required for unnecessary follow ups and can be seen and treated/diagnosed in one appointment where possible.
- Any sudden changes in referral activity can be identified early, and where appropriate, mitigating actions are put in place

It is essential, and in the best interests of the patient, the provider and the commissioner that this initiative is fully supported.

As part of the planned care agenda, Barnet CCG will need to work with providers on considering when it would be appropriate to spread local services over 7 days using existing resources. Nationally there is evidence that many patients are not discharged from hospital at weekends when they are clinically fit, because the supporting services are not available to facilitate it.

Barnet CCG is also working on optimising the use of Finchley Memorial Hospital (FMH) to ensure that the venue is utilised to its maximum capacity. Making more effective use of FMH is also a local driver along with tackling the cost pressure resulting from the current under-utilisation. A number of options have been shortlisted to optimise the space available and Barnet CCG will be considering the options in 2015/16. It is intended that plans to progress advances to the venue will begin to take place in 2016/17, with patients benefitting from improved, accessible services in a community setting.

What action will Barnet CCG take in 2016/17?

- 6 months' notice is given to all NHS and private providers of Procedures of Limited Clinical Effectiveness (PoLCE) treatments that Barnet CCG and Enfield CCG will not fund any procedures undertaken without the relevant prior approval form. The current PoLCE policy, 2015-2016, outlines these procedures and HRG codes and is available as part of providers 2015/16 contract. This includes all procedures irrespective of the referrer. Applications for approval should be directed to either the Barnet RMS (Barnet Patients) or the Enfield Referral Service (Enfield Patients).
  The consequence of non-compliance with the prior approval procedure will be the cost of the PoLCE treatment, plus the MFF; any associated new and follow up appointments; and prescribing costs. This will be validated by requesting the approval forms for a random number of PoLCE treatments each month. Any treatment carried out without the relevant prior approval, will not be funded, whether or not the criteria has been met.
- 6 months' notice is given to all NHS and private providers of PoLCE procedures that the NCL PoLCE Policy covering Barnet, Enfield, Haringey, Camden and Islington will undertake a rolling programme of content review and updates to ensure that it is up to date in terms of NICE guidance, best practice and evidence based medicine. One month's notice will be given to providers of any changes to any sections of the Policy.
- Six months' notice is given to all providers that, with effect from 1st April 2016, all referrals listed below that are received by providers from Barnet GPs must have been assessed and triaged by the Barnet RMS. An electronic stamp will be visible on each referral to indicate that this has happened. Where this is not present, the referral should be returned to the RMS for processing.
  The referrals that must be assessed and triaged by the RMS are:
  - Routine referrals to acute trusts
  - Routine referrals to community interface services e.g.
    - Community Ophthalmology Service
    - Community ENT Service
    - Community Cardiology Service
    - Community Dermatology Service
    - Community MSK
    - Community COPD Service
  - Referrals for Direct Access Endoscopy
  - Referrals for Direct Access MRI

  Referrals currently excluded are:

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  - Mental Health referrals
  - Referrals to the provider of community services, CLCH
  - Urgent Referrals
  - Suspected Cancer referrals (2 week waits)
  - Direct Access Diagnostics (excluding Endoscopy and MRI as stated above)
- New to follow up ratios will be inserted into 16/17 contracts in priority areas which will be identified following a review of 15/16 performance and benchmarking with peers to ensure effective services. Activity relating to these ratios will be removed from the 16/17 contract in April 16 and any excess activity over and above this will be managed by the provider with support from the commissioner.
- 21 months' notice is given to UCLH, RFL, In Health Limited, Scrivens the Opticians and Hearing Group, Specsavers Healthcare Limited and The Outside Clinic that their service in relation to AQP Audiology is decommissioned with effect from 1st July 2017. A new service combining Adult Audiology, Wax Removal and Community ENT will be procured effective from that date.
- 21 months' notice is given to UCLH, UCLH Community ENT Service and RFH London and Barndoc (Cricklewood Walk In Centre) that their service in relation to primary care/GP referred Ear Wax Removal is decommissioned with effect from 1st July 2017. A new service combining Adult Audiology, Wax Removal and Community ENT Service will be procured effective from that date.
- 21 months' notice is given to UCLH Community ENT that their Community ENT service is decommissioned for BARNET patients with effect from 1st July 2017. A combined Adult Audiology, Wax Removal and Community ENT Service will be procured effective from that date.
- Barnet CCG will undertake a review of the RFL Community Ophthalmology Service with a view to widening and enhancing the current service specification in order to carry out a procurement exercise.
- Barnet CCG is undertaking an end-to-end pathway review of Cardiology in 2015-16, which will result in a new updated service specification for the provision of a community cardiology service, including the provision of a new heart failure service. Procurement of a community cardiology service is to be commenced in 2016. A new acute cardiology specification is currently in development and will require contract variation to 15/16 and alignment to new procured service in 16/17.
- Barnet CCG will be undertaking an end-to-end pathway review of the Dermatology speciality in 2016-17, the outcome of which will be a revised new service specification for the provision of dermatology services provided within the community improving the quality of services and access in terms of waiting times. The service review will consider commissioning arrangements for the provision of a primary care tele-dermatology service as a means of supporting early identification of conditions that will support a reduction in secondary care outpatient appointments. Consideration will be given to procurement options and lead provider arrangements during 2016/17.

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- Barnet CCG will be undertaking an end-to-end pathway review of the Musculoskeletal (MSK) speciality and a new service specification is expected to be available from April 2016.This will include;
    - Orthopaedics
    - Rheumatology
    - Physiotherapy
    - Pain management
    - Biomechanics as part of podiatry

  Consideration will be given to procurement and lead provider arrangements during 2016/17.
- 6 months' notice is given that Barnet CCG will be extending the AQP contracts for the provision of the Termination of Pregnancy services for one year from 1st April 2016. The service will be reviewed and a re-procurement process will be undertaken. We would welcome interest from providers for the new service, which will start 1st April 2017. Barnet CCG is currently in discussion with North Central London CCGs about whether this service should be provided following the AQP contracting approach, and a patient engagement event in July 2015 will inform the decision. Current providers of the service are: British Pregnancy Advisory Service, Pregnancy Advisory Service (Frater Drive), Marie Stopes, Royal Free London NHS Foundation Trust, St Georges and Homerton.
- Barnet CCG will work collaboratively with the Royal Free London NHS Foundation Trust and Central London Community Healthcare to enhance the current community respiratory service to include a pathway for patients with Bronchiectasis. The outcome of this work will result in service specification changes to the current community service, provided by CLCH. Consideration will be given to lead provider arrangements.
- Barnet CCG is currently working with providers to further develop an integrated end to end diabetes service model based upon the NCL model. The new service will see the vast majority of diabetes patients of the most common conditions managed within an out of hospital setting. It will build upon allied health care disciplines providing intermediate services to bridge from primary care to in-hospital care. This transformational programme will ensure that the system makes focused use of secondary care capacity and skills. NCL wide services specifications are currently under review by NCL local clinicians and formal procurement is expected in 2016/17.
- For 2016-17 at least 50% full year effect of current follow-up appointments, will be followed up within a community multidisciplinary team with consultant supervision. The will be de-commissioned in 2016-17.
- Any diagnostic undertaken at the request of a GP shall be reported back to the GP within five working days of the diagnostic being undertaken.
- Any diagnostic undertaken at the request of a GP in relation to a patient with suspected cancer shall be reported back to the GP within 24 hours of the diagnostic being undertaken.

Cancer Care

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Cancer services will be commissioned in line with the requirements of NICE Improving Outcomes Guidance and NICE quality standards (QS), the London Model of Care for cancer services and the National Cancer Survivorship Initiative (NCSI).

Currently there are draft London wide cancer commissioning intentions in development, which will be ready to be published in October 2015.

8.5 Urgent Care

What do we mean by Urgent Care?
Urgent care services are those health services which patients use in an emergency or when they require urgent advice, support or care. This includes advice from the NHS 111 phone line, Out of Hour's services provided by local GPs, phoning 999 for the London Ambulance Service (LAS), the Walk in Centres (WiCs) at Edgware Community Hospital, Finchley Memorial Hospital and Cricklewood Health Centre and the Accident and Emergency departments (A&E) including the Urgent Care Centres (UCC) based at the RFL.

What action will Barnet CCG take in 2016/17?
Barnet CCG aims to support local people to receive the right care in the right place, at the right time. It is not always possible to plan healthcare in advance so when emergency or urgent treatment is needed, Barnet CCG is planning to make it simpler to access the services required.

The number of patients accessing urgent care services has increased across Barnet and neighbouring CCGs, and Barnet, Enfield and Haringey CCG will be working together, alongside local people and providers, to review local urgent care services to ensure that they are accessed appropriately and provide the right care to patients.

The need to review Urgent Care services locally has arisen from a number of changes in the local and national landscape. These include the changing needs of an ageing population, rising demand from a number of local regeneration developments, and changing expectations of patients as a result of a 24/7 culture. National guidance outlines the need for urgent and emergency care services to be redesigned to integrate between A&E departments, GP out-of-hours services, Urgent Care Services, NHS 111, and ambulance services (5 Year Forward View, NHS England 2014). A local urgent care review has been undertaken in 2015, which will determine changes in 2016/17. The local review will include looking into developing:

- 8am-8pm provision of diagnostics, including weekends, at local WiCs
- Equity of access and consistency of provision across all sites
- Review and gap analysis of current services and walk in facilities to minimise emergency admissions
- The possibility of having direct access appointment booking in GP practices available at local WiCs and UCCs
- Reviewing mental health support availability in local urgent care services

Specific commissioning intentions for urgent care are outlined below.

- Barnet CCG is working in collaboration with the 5 NCL CCGs on the re-procurement of an integrated NHS 111 and GP Out-of-Hours service and the new service will go live in October 2016. Current contracts with the service providers, Barndoc Ltd and London Central & West Unscheduled Care Collaborative**,** will be extended to September 2016.
- Barnet CCG will be undertaking a consultation and re-procurement process of the Cricklewood Walk-in-Centre service, provided by Barndoc Healthcare Ltd in 2016-17, to ensure that a new contract is awarded from 1 April 2017. The re-procurement of this service will be considered in the context of the CCG's local urgent care review. The CCG will work in collaboration with NHSE who have responsible for contact arrangements of the GP practice service of the integrated service provided by Barndoc Health Care Ltd.
- 6 months' notice is given to RFL that Barnet CCG expects that a minimum of 50% of all A&E Activity is seen within the Urgent Care Centre and charged under urgent care centre national tariff during opening hours, resulting in less activity going through the A&E departments. UCCs are classed as Type 3 departments according to the PbR rules and as such will attract the Type 3 tariff.

Barnet's System Resilience Group (SRG) formed in 2014/15 and has provided the opportunity for all parts of the local health and social care system to work closely together to develop strategies and plan safe and efficient services for the local population.

In 2016/17, Barnet System Resilience Group will continue to focus on:

- Developing and implementing demand and capacity plans in urgent and planned care;
- Initiating local changes to manage pressures and surge in demand across the local system;
- Building effective system working;
- Reviewing existing communication processes to ensure that patients and the public are aware of what services they can access in times of urgent need, as alternatives to A&E departments.
- Barnet CCG has evaluated the individual provider bidding process, moderated by the SRG, which took place in 2015/16 and resulted in advising it on additional services it might purchase to improve resilience in planned and unplanned care. Its intention in 2016/17 is proactively to invite suitable and capable providers and groups of providers to submit proposals for evidence based services for commissioning by Barnet CCG within its affordable envelope. This will be a more streamlined and purposeful approach, within which whole system interdependence will be support and demonstrated.

North Central London System Resilience Groups will be forming an Urgent and Emergency Care Network, which will build on existing System Resilience Group work in the area. This will ensure a consistent approach to the delivery of services and formally link the community and hospital components of the urgent and

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emergency care system. They are a key recommendation of the national Urgent and Emergency Care Review Phase 1 Report and will be implemented in 2015 with work programmes going into 2016/17.

8.6 Adult Integrated Care

What do we mean by Integrated Care?

Integrated care is working to ensure that the people of Barnet receive targeted and more personalised care appropriate to their needs, as the result of systems that proactively work together to identify and support patients before a crisis.

The development of integrated care, alongside primary care, will enable the shifting activity from acute settings of care. Clear themes relating to integrated care include: self-help for supporting those patients managing more than one long term condition; proactive management of those most at risk of A&E admission in primary care; consistent models of integrated care focusing on patient access, empowerment, wellbeing and prevention, and admission avoidance schemes to reduce inappropriate admissions. Barnet CCG will review each 2015/16 contract for services for older people relating to multidisciplinary care in patient's own homes that link with primary, secondary, social and voluntary care sectors, and including access to Rapid Care, Triage Rapid Elderly Assessment Team, Post-Acute Care Enablement Service, Integrated Care Teams and the Barnet Integrated Locality Teams. Barnet CCG will act on the outcomes in year (2016/17) in order to deliver a further integrated service.

Barnet CCG will work with LBB as lead commissioner on arrangements to extend the existing contract for integrated learning disability services with CLCH and BEHMHT by one year until February 2017. During this time a re-procurement options appraisal will be undertaken.

Integrated care includes services to both children and adults, the commissioning intentions for adults health care services are as follows.

What action will Barnet CCG take in 2016/17?

- Barnet CCG will be reviewing the current annual contract for learning disability specialist residential services, which is provided by the Hertfordshire Partnership University NHS Foundation Trust (HPFT), with a view to moving to a 2 year contract from April 2016 to allow patients to be repatriated to the community.
- Barnet CCG will work with the local health community to develop a strategy for increasing services in end of life care in 2016/17. Barnet CCG will be giving notice in April 2016 to the North London Hospice, Marie Curie, and CLCH while considering future service development and re-procurement options.

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- Early notice is given to CLCH and RFL that Barnet CCG will be decommissioning the Parkinson's Disease Service and the Neuro Rehab service in 2016/17 with a view to develop a single integrated pathway.
- Early notice is given that Barnet CCG will commence a formal procurement exercise from January 2016 for the procurement of an independent brokerage service to support the delivery of personal health budgets for patients accessing continuing healthcare. The current contract with MySupportBroker will be extended while procurement options are considered.
- Early notice is given to CLCH that Barnet CCG will decommission the assessment element of the Wheelchair service and this service will be re-procured in 2016/17 as part of the wider North West London Collaborative. Notice will be given in line with procurement requirements.

8.7 Children and Maternity Care

What do we mean by Children and Maternity Care?
The standard definition of children and young people is those aged from 0 to 19 years, and up to 25 for those with a disability meeting health care criteria. Barnet provides a number of services to manage and treat children's health and mental health conditions.

Maternity care covers a wide range of services that provide women and their partners with advice, support and care from preconception, during pregnancy (antenatal care), child birth and after care (postnatal care).

Context
Children's services are developed by a range of organisations, which include providers, the CCG, the LBB and NHS England. Current responsibilities are outlined below:

- Barnet CCG commissions community services such as therapies, continuing and complex care, maternity and acute services.
- NHS England commissions immunisation services, screening and specialist services such as those provided by Great Ormond Street Hospital.
- The LBB commissions' public health services, health visiting services, breast feeding services, oral health and the national weight management programme.

Barnet CCG and Local Authority work in partnership to integrate services and ensure safe and seamless services for families in Barnet. Barnet CCG is currently reviewing children's services to better understand where existing service strands can be aligned for efficiency.

The key themes and challenges facing children's services in 2015/16 are:

- Building and maintaining a sufficiently skilled workforce;
- An increase in the local child population; and

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- The need for a systematic approach to delivering services, including integrated information sharing across the local system.

The CCG wishes to review the reasons for children's unplanned visits to A&E and resultant admissions and to develop an integrated care pathway for the most common reasons for attendances. It is intended that this work will inform the wider work being undertaken to review local emergency and urgent care services.

We will also work with the London Borough of Barnet to consider the benefits of integrating the children's 0-25 services with the CCG's Children Complex and Continuing Care service provided by CLCH. This will also include working with NHS England as necessary on pathways for life limiting conditions. The outcome of this work may result in a new service specification in 2016/17, with new commissioning and contract arrangements for implementation in 2017/18.

Another area of focus will be on implementing the Children and Family Act 2014, which involves transforming children's health services, such as mental health, Health Visiting and School Health functions. Particular emphasis will be on early identification, intervention and prevention. This will also include safeguarding vulnerable children.

Barnet CCG will also focus on strengthening transition planning, to ensure that clear pathways are outlined for children who require transfer to adult services, for example in relation to an acute episode or for children with physical, emotional and/or learning difficulties.

Following the publication in November 2015 of the Obesity National Strategy, the CCG will review national requirements with a view to implementing appropriate procurement strategy in 2016-17.

The five NCL CCGs are working together to develop a specialist perinatal mental health pathway of care, which meets national requirements, including NICE guidance, and to commission specialist perinatal mental health services that are consistent across the sector. This is linked to mental health commissioning.

What action will Barnet CCG take in 2016/17?

Maternity

- Barnet CCG and the maternity sector lead will work with NHSE to ensure that new immunisation requirements are embedded in all relevant provider practice, for example baby BCG.

Children's Services

- Barnet CCG will work with the London Borough of Barnet in 2015/16 to consider the benefits of the integrated provision of the CLCH children's OT/Physiotherapy and orthotics services with social care and education.
- Current work on the enuresis pathway will result in a new pathway and service specification with the procurement of this service being undertaken in 2016/17.

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- Barnet CCG will undertake a review of children's paediatric eye (orthoptics) services provided by CLCH and the RFL with a view to service consolidation and consideration being given to re-procurement of a new service in 2016.
- Barnet CCG is undertaking an end to end pathway redesign, collaboratively across NCL, of the existing CAMHS services during 2015/16. This could result in the decommissioning of the current service, with a re-procurement process being undertaken in 2016/17.
- Barnet CCG expects all providers to work with the CCG and other relevant providers to ensure a transition plan is agreed with the child and their families/carers from the age of 14 years, working towards adult services and independence where possible.
- Barnet CCG will procure a CAMHS out of hour's service in 2016/17, which will involve working with NCL boroughs on a co-ordinated response.

8.8 Adult Mental Health Care

What do we mean by Mental Health Care?
Mental health is about physical, emotional and social wellbeing. Themes relating to integrated care covering mental health include: the opportunity to scale up integrated services across NCL; outcomes based commissioning to prioritise those people with the most acute need and who also account for the majority of costs; consistent models of care for mental health that deliver consistently high quality care across NCL and productivity opportunities.

Barnet CCG has been undertaking a programme of work called 'Reimagining Mental Health' in collaboration with the LBB in 2015/16. Reimagining Mental Health encompasses a range of directions to improve the outcomes for people with mental health needs. Within constraints, there is opportunity to review the range and breadth of current services to find new ways of maximising delivery of good mental health support. The programme so far has provided organisations, individuals and the wider community to take part in the early co-production of the high level principles governing the approach through workshop-style collaboration. The Reimagining Mental Health work could result in the decommissioning of some existing adult mental health services and the procurement of new services in 2015/16 and 2016/17, with an aim to reduce avoidable admissions to acute services. Barnet CCG anticipates strong engagement of the voluntary sector and potentially a lead provider model that may be voluntary sector led.

Barnet CCG will continue the work with Enfield and Haringey CCGs on the implementation of the Mental Health Crisis Care Concordat plan. The Mental Health Crisis Care Concordat is a national agreement between services, commissioners and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance and current service provision will continue while the plan is being implemented.

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Barnet CCG will also develop a new Autism diagnostic pathway in line with national guidelines. This will align with other pathways, including the ADHD pathway, and a procurement options appraisal will be undertaken.

What action will Barnet CCG take in 2016/17?

- Barnet CCG will work with Enfield and Haringey CCGs to review the Recovery House provision with a view to improving discharge pathways by April 2017. The outcome of this review will be enhanced service specifications and the re-commissioning of some services following a process of procurement. This could mean that some services may be subject to decommissioning that will be subject to contractual notice.
- Barnet CCG will work with Enfield and Haringey CCGs to review the Psychiatric Liaison Service provision to make better use of resources. The impact on existing providers, BEHMHT and Camden and Islington NHS Foundation Trust, will be enhanced service specifications and the re-commissioning of some services following a process of procurement. This will mean that some services may be subject to decommissioning that will be subject to contractual notice.
- Barnet CCG will work to support BEHMHT to review and redesign Springwell Day Hospital, which supports the healthcare needs of older people's mental health. This will result in an updated service specification for the service in 2016/17.
- Barnet CCG is supporting BEHMHT to undertake a review of the patients on Ken Porter ward and will be considering the needs of the patients on the ward. This will include an updated service specification and re-procurement options in 2016/17.
- 6 months' notice is given to BEHMHT that Barnet CCG will be decommissioning the Personality Disorder service in 2016/17 and will be undertaking a re-procurement process for this service.

9. Enablers

9.1 Co-design with public and partners

Barnet CCG will work in partnership with local organisations and local people to meet the following objectives:

- To improve the health and wellbeing of the population of Barnet by commissioning new and improved collaborative pathways of care which address the health needs of the Barnet population;
- To ensure that Barnet residents are put at the centre of the CCG's decision-making process and are able to influence commissioning decisions and the design of local health services;
- To commission high quality, responsive services working in partnership with the patient public to make best use of the available resources.

We will work closely with Healthwatch Barnet, the independent organisation responsible for representing the views of local residents with community Barnet and the voluntary sector and the Partnership Boards and networks at Barnet Council

In relation to involving people, our commitments are:

- To involve the public early in our decision making about commissioning new services and re-designing existing ones
- To listen to what people tell us and ensure so far as is possible that public views are acted upon
- To feedback what we have done to take account of patient's views, and where we have not made any changes to explain why.
- Make sure that the organisations we commission services from have effective public engagement and systems in place to gather patient views and patient experience information
- Make sure that everyone who works with us will share our views about the importance of involving the public.

9.2 Ensure the quality of services

Clinical quality is defined by three elements; patient safety, clinical effectiveness and patient experience. Issues with clinical quality were exposed by reviews such as 'The Mid Staffordshire NHS Foundation Trust Public Inquiry' in 2013. The service delivery described in this report has led to the development of processes to effectively measure clinical quality as part of the contract management process applied to all healthcare providers through monthly Clinical Qualify Review Groups (CQRGs).
Since the creation of this mechanism, it has been constantly evolving through review and reflection by the provider and commissioning organisations to monitor the three elements. Currently, Barnet CCG is reviewing and updating its Clinical Quality Strategy, to be finalised in the autumn 2015, which will define the organisation's processes to develop quality over the next three years. The process of strategic definition will be collaborative and will include the local health providers and patients groups. The aims are to reference the organisation's own strategies, and where appropriate, to align the CCG's strategies to these and also to give patient groups and providers an opportunity to feed into the CCG's strategy.

In addition to the development of the strategy, three areas of quality are included in the 2016/17 Commissioning Intentions which address patient safety, clinical effectiveness and patient experience (inclusive of dementia friendly hospitals):

9.2.1 NHS Serious Incidents Framework

Patient safety is inherent to clinical quality and the serious incident framework is vital to its management. It was reissued in April 2015 and its impact will be monitored and managed throughout the financial year 2015/16. During this time, the CCG aims to work collaboratively with providers to ensure that the SI framework is embedded and that providers are adhering to the policy.
In 2015/16 and 2016/17 the CCG will address any deficiencies in serious incident reporting that have been impacted by the adoption of the new framework and will develop Key Performance Indicators (KPIs) to monitor these. This will ensure that there are no gaps in serious incident monitoring, and therefore patent safety, as a result of the changes to the policy.

9.2.2 NICE technology appraisals

One measure of clinical effectiveness is through the National Institute for Health and Care Excellence (NICE) technology appraisals which 'assess the clinical and cost effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, to ensure that all NHS patients have equitable access to the most clinically and cost-effective treatments that are available.
Regulations require clinical commissioning groups, NHS England and local authorities to comply with recommendations in a technology appraisal within 3 three months of its date of publication'.
The CSU will continue to work with the CCG and providers to ensure that providers evidence their compliance with and implementation of NICE directives through the CQRGs, to fully develop the review of these new technologies in the individual healthcare settings and ensure these are visible to all parties.

9.2.3 Patient stories and patient involvement
This will be an area of strategic development for the CCG and healthcare providers. The CCG requests that, where programmes of patient stories have not been developed, these are added to providers existing patient experience methodologies in 2016/17 and report on the progress of this will be through the CQRG.
For providers that have developed patient experience programmes, the CCG asks that the provider works collaboratively to share and learn their stories through the patient involvement teams so that organisations can gain further understanding of the views of the Barnet population.

We would also request that organisations utilise patient surveys to ensure that patient experience and patient reported outcomes can be measured when undertaking service review or improvement projects. Service reviews may address areas of review or concern highlighted through any route including contractual, clinical quality and patient or carer concerns. These should be both responsive to patient experience and effective in ensuring patient safety and clinical effectiveness.

9.3 Innovate with technology
Barnet CCG's Information Management and Technology (IM&T) vision is "better to exploit information and technology; both within the CCG and across the whole of health and social care".

9.3.1 Key components of Barnet's IM&T vision are:

- Ensuring access to the right information, in the right place at the right time;
- Use of technology and information to drive towards paperless working across the entire health and social care sector;
- Use of technology to support patient access, patient choice and reduce health inequalities;
- Harness technology and information to improve and reduce health inequalities;
- Development of a digital healthcare environment that supports and enables the integrated care model.

9.3.2 Nine delivery themes of the Barnet IM&T Strategy:

- **IT Management & Governance** – development of IMT integrated governance structures/IT portfolio management structure;
- **Information Governance & Security** – Review of current Information governance and review of CCG's "Safe Haven Status;
- **Service management** – Appointment of the CCT IM&T Strategy Coordinator to oversee strategy implementation, establish local service management regime and KPIs and undertaking the review of current IT Service provision and re-tender of contracts;
- **Infrastructure** – Complete infrastructure review
- **Information &knowledge Management** – Develop information management strategy
- **Digital by 2018** – Leverage existing investments in Docman EDI hub and work with providers to develop a join plan to become paperless, including strategy for funding
- **Shared Care Records** – work with LBB to evaluate options for shared care records and aligning IG arrangements to support sharing of information across care pathways
- **Patient Access & Enablement** – Increase digital access for patients
- **Referral management** – Development of the e-Referral Strategy and implementation of the e-referral solution

9.3.3 IMT& Priority Priorities for 2016/17

- Complete Infrastructure review and Information governance needs
- Conduct a review of IT Service provision and re-tender of contracts, where they are in place
- Develop an infrastructure improvement programme and full implementation of mobile working
- Enable service delivery in additional care settings;
- Development of the Information Management Strategy and work with providers to develop a joint plan to become paperless, including strategy for funding
- Leverage funding solution to support GP IT (EMIS MIG and SCR)
- Develop a traffic light system on quality indicators for GP practices for use in 2016-2017
- Continue to develop and embed referral forms in EMIS directly linked to either RMS or to the provider
- Develop a plan for use of EMIS by GP's in care homes, by using laptops
- Produce an online directory of all services available to patients, that can be referred to by GP's, with a PC and phone app, with the ability to refer direct from the app.
- Develop a Pan CCG Patient Access Strategy and Communications Plan; and
- Develop e-Referral Strategy and commence the implementation of National e-Referral Solution

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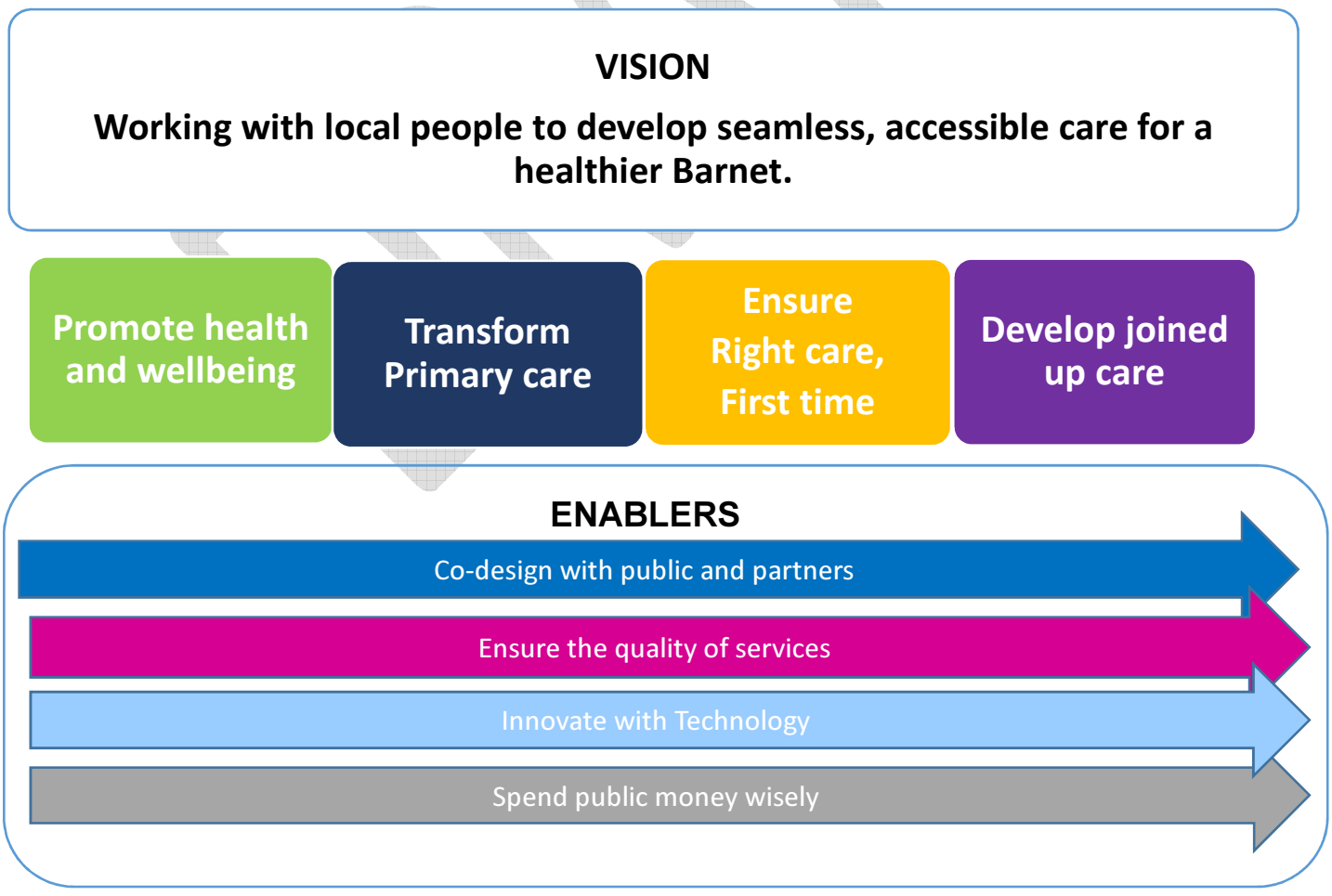
10. Appendices

10.1 Appendix 1: Barnet CCG's Vision and Enablers



10.2 Appendix 2: Overview of draft QIPP Schemes 2016/17 – 2018/19

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Area	Scheme Name	15-16 Planned '£000s	16-17 Draft Plan '£000s	17-18 Draft Plan '£000s	18-19 Draft Plan '£000s
Children, Young People and Maternity		-	-	-	-
Extended Primary Care Services		-	-	-	-
Quality Premium		-	-	-	-
Community Health Services	Community Services Efficiencies	£795	£750	£750	£750
	Continuing Healthcare	£745	£500	£500	£500
	Decommissioning Stand Alone Services	£175	-	-	-
Community Health Service		**£1,715**	**£1,250**	**£1,250**	**£1,250**
Corporate	Estates	£1,500	-	£500	£500
	CCG Running Costs				
Corporate		**£1,500**	**-**	**£500**	**£500**
Elective Care	Contract Metrics	£4,830	-	-	-
	Demand Management - Outpatients (inc direct access and MRI)	£3,480	£700	-	-
	Pathway Redesign	-	£3,000	£3,000	£3,000
	Prescribing Medicines Management (Acute)	£224	£500	£500	£500
	Prescribing Primary Care	£1,140	£750	£750	£750
	Regular and Frequent Flyers	-	-	-	-
Elective Care		**£9,674**	**£4,950**	**£4,250**	**£4,250**
Emergency and Urgent Care	Ambulatory Care	£523	£500	-	-
	Barnet Hospital Urgent Care Centre - Tariff and	-	-	-	-
	Hampstead Urgent Care Centre - Tariff and	-	-	-	-
	Regular and Frequent Flyers	-	-	-	-
Emergency and Urgent Care		**£523**	**£500**	**-**	**-**
Integrated Care	Integrated Care - Managing Crisis Better (Better Care Fund)	£1,098	£3,000	£3,000	£3,000
	Integrated Care - Mental Health	-	£600	£600	£600
Integrated Care		**£1,098**	**£3,600**	**£3,600**	**£3,600**
Mental Health and Learning Disabilities	CAMHS	-	-	-	-
	LD\MH CHC High Cost Placements	£200	-	-	-
	Mental Health Transformation	-	-	-	-
Mental Health and Learning Disabilities		**£200**	**-**	**-**	**-**
Reprovision	Reprovision	-£66	-£800	-£600	-£600
Subtotal of Current QIPP Ideas		**£14,644**	**£9,500**	**£9,000**	**£9,000**
QIPP GAP (QIPP Schemes to quantified)		**-**	**£5,100**	**£5,900**	**£6,400**
QIPP PLANNING REQUIREMENT		**£14,644**	**£14,600**	**£14,900**	**£15,400**

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Appendix 3: 2016/17 Draft QIPP Profile and Themes

Workstream	Main Aims	Key Areas of Focus	Expected Outcomes
1. Planned Care	To review expenditure on elective care (outpatients, day cases and elective inpatients)	Data quality (cost of pathways)	Fewer acute new/ follow-up outpatient attendances/ elective admissions per head of population
	To determine short, medium and longer term QIPP schemes to deliver savings	Treatment in the 'right place'	Reduced overall cost of delivering acute elective activity across the system
	To provide the most productive quality service within the funding available.	Referral Management & clinical thresholds	Delivery of Efficiencies
	Health and Lifestyle Promotion	Use of single provider for specific elective work	Appropriate management of hernias, haemorrhoids, cataracts, bunions and pathways leading to hysteroctomies.
		Discharge planning	Weight Management Service
2. Mental Health Care	To develop an integrated physical/mental health approach to patient care which will focus on improved patient outcomes, experience and whole system savings	Data quality and Service Line Reporting	Delivery of a sustainable mental health service
	To increase partnership working with local authority commissioners, housing providers, the voluntary sector, community services and primary care	What can be learnt from cost effective models in use elsewhere	Delivery of efficiencies
	To continue to address the current health and access inequalities experienced by our patients	Place of care (community vs inpatient)	Improved integration/ alignment between physical and mental health care and clinical outcomes
	Collaborate with current Mental Health service providers and make sure system is resilient.	Opportunities for greater use of voluntary sector and community resources to support patients	Improved patient satisfaction of service delivery
		Impact of mental health on physical health and vice versa.	Equality of Access CCG-wide

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Workstream	Main Aims	Key Areas of Focus	Expected Outcomes
3. Urgent Care	To review expenditure on urgent care	Delayed transfers of care	Reduced delayed transfers of care
	A&E and non-elective admissions	Treatment in the 'right place'	Decrease in inappropriate use of A&E/ increase in number of patients treated in 'right' location
	To determine short, medium and longer term QIPP schemes to deliver savings	Front end A&E model. Explore GP presence at A&E.	Greater coordination between services
	To provide the most productive quality service within the funding available.	Urgent Care Centres: Service and Tariff harmonisation	Right PbR Tariff for each Emergency Department Type
		Links between GPs & ambulance service	Delivery of efficiencies
		Single points of access for patients and professionals	
4. Integrated Care (Incl Frail Elderly and Vulnerable Adults)	To improve outcomes and patients' experiences of older people services	Unplanned acute hospital care for older people	To drive improvement in quality and outcomes by:
	For older people's services to be organised around the needs of the patient	Improved community health services for older people & adults	Ensuring people have an excellent & equitable experience of care and support, with care organised around the patient
	To make sure older patients have the right support to stay healthy, to maintain their independence and receive care in their home or local community whenever possible with hospitalisation as a last resort	Older People Mental Health Services Enhanced primary care, voluntary sector input	Treating and caring for people in safe environment and protecting them from avoidable harm
	Manage frail elderly crisis better		Developing an organisational culture of joined-up working , patient-centred care, empowered staff and effective information sharing
	Deliver Better Care Fund Ambitions (the Intergrated Care Programme aligns with BCF)		Early intervention to promote health, well-being and independence
			Long term recovery and sustainability of health
			Care and support for people at the end of their lives.

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Workstream	Main Aims	Key Areas of Focus	Expected Outcomes
5. Children & Maternity	To review and redesign children and maternity services across Barnet	Maternity and newborn	Increased integration with London Borough of Barnet services
	To develop a new service models	Acute care, especially A&E attendances	Increased integration across the pathway (primary care to acute)
	To determine how to implement new services to fit the agreed model	Long term conditions and Complex Continuing Care	Reduction in hospital attendances and admissions
		Caesaereans without medical grounds	Increase in community based service delivery
			Reduced caesaereans without medical grounds

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AGENDA ITEM 11

	Health and Wellbeing Board **17 September 2015**
Title	**Joint Co-Commissioning Arrangements for Primary Care Services within Barnet and North Central London CCGS from 1 October 2015**
Report of	Director of Clinical Commissioning (Interim)
Wards	All
Date added to Forward Plan	July 2015
Status	Public
Enclosures	Appendix 1: Barnet CCG Governing Body Report, February – North Central London CCGs Joint Primary Care Co-Commissioning Proposal and Strategy
Officer Contact Details	Beverley Wilding, Head of Primary Care Commissioning, Barnet CCG. Beverley.wilding@barnetccg.nhs.uk

Summary

This report provides an update regarding the arrangements for the development of Joint Co-Commissioning of Primary Medical Services at Level 2, within Barnet and North Central London CCGs. The Joint Committee will comprise NHS England - London and the North Central London CCGs which are Barnet CCG, Camden CCG, Enfield CCG, Haringey CCG and Islington CCG ('NCL CCGs').

Co-commissioning for primary care refers to the increased role of CCGs in the commissioning, procurement, management and monitoring of primary medical services contracts, alongside a continued role for NHS England.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the contents of this report.**

1. WHY THIS REPORT IS NEEDED

1.1 This report provides Members with an overview of the current work within Barnet Clinical Commissioning Group (Barnet CCG) and North Central London (NCL) CCGs (Camden, Islington, Enfield, Haringey) to develop Level 2 Joint Co-Commissioning arrangements for Primary Care with NHS England – London from 1 October 2015.

1.2 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. Co-commissioning for primary care refers to the increased role of CCGs in the commissioning, procurement, management and monitoring of primary medical services contracts, alongside a continued role for NHS England.

1.3 There are three levels of co-commissioning:

- Level 1: where CCGs have involvement in primary care decision making,
- Level 2: which is where the CCG (or CCGs) participate in decision making with NHS England in a Joint Committee
- Level 3: delegates decision making regarding certain functions entirely to the CCG (or CCGs)

1.4 Following the submission of the North Central London CCGs' Co-Commissioning application in January 2015 (see Appendix 1 for background information) to be involved at Level 2 decision making only, the CCGs in NCL have been working to sign off changes to their constitution. The changes allow the CCGs to collaborate within the Joint Co-Committee arrangements set out by NHS England.

1.5 The Barnet CCG's Governing Body approved the submission of an updated proposal to NHS England on 24th June 2015 to establish Joint Co-Commissioning of Primary Care services with NHSE from 1st October 2015. The Terms of Reference for the NCL Primary Care Joint Committee, Standing Orders and the Scheme of Delegation have been developed and are due to be approved by NCL CCG Governing Bodies in September 2015.

1.6 The Joint Committee's membership will meet the requirements of each of the NCL CCGs' constitutions and shall consist of the following voting members:

- A GP representative from Barnet CCG;
- A GP representative from Camden CCG;
- A GP representative from Enfield CCG;
- A GP representative from Haringey CCG;

- A GP representative from Islington CG;
- An officer representative from Barnet CCG;
- An officer representative from Camden CCG;
- An officer representative from Enfield CCG;
- An officer representative from Haringey CCG;
- An officer representative from Islington CCG;
- A practice nurse representative from an NCL CCG;
- Three lay member representatives from the NCL CCGs;
- Three representatives from NHS England.

1.7 The Chair of the Joint Committee shall be a lay member of an NCL CCG.

1.8 The Vice Chair of the Joint Committee shall be a lay member of an NCL CCG.

1.9 Non-voting attendees shall include:

- Health and Wellbeing Board representative(s);
- Healthwatch representative(s);
- A Local Medical Committee representative

1.10 It has been agreed that the NCL Joint Co-Committee will include within its remit the following activities in which all members of the Joint Committee will participate and be joint decision makers:

- Oversight of General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Personal Medical Service (APMS) contracts (including the design of PMS and APMS contracts, sharing contract monitoring information);
- Development of newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services);
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF)
- Informing decision making on whether to establish new GP practices in an area:
- Informing decision making on approving of practice mergers, retirements, resignations; and
- Ratifying of decisions made by the NHSE England Contracting Team with regards to 'discretionary' payments.

1.11 The Joint Committee will not have delegated Authority from NCL CCGs to:

- Pool Budgets
- Make all of the CCGs primary care commissioning decisions
- Make decisions on the CCG's statutory functions

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Wellbeing Board are asked to note and comment on the report.

2.2 The recommendation to members of the Health and Wellbeing Board is in line with the NHS Act 2006.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None.

4. POST DECISION IMPLEMENTATION

4.1 The commencement of joint co-commissioning will become business as usual for Barnet and NCL CCGs from 1 October 2015.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 In line with the London Transforming Primary Care Strategic Commissioning Framework, the NHS Five Year Forward View and BCCG's 2015/16 Operating Plan

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

5.2.1 None in the context of this report.

5.3 Legal and Constitutional References

5.3.1 Barnet CCG is required by statute to discuss with all key stakeholders - that includes: the public and patients of Barnet, the Health and Wellbeing Board and key providers of healthcare. Section 14Z2 of the NHS Act states:

> (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) —
> (a) in the planning of the commissioning arrangements by the group,
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
> (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

5.3.2 Section 15 of the Constitution Responsibility for Functions Annex A requires the Health and Wellbeing Board 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

5.3.3 The HWBB must also 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.

5.4 **Risk Management**

5.4.1 Risks relating to conflicts of interest will need to be managed as a result of co-commissioning. This is being addressed via the new NCL CCG's Conflicts of Interest Policy

5.5 **Equalities and Diversity**

5.5.1 Ensures that BCCG meets its Equalities Duties and due regard will be given to ensure that all relevant aspects of Equalities and Diversity are considered by virtue of the Public Sector Equality Duty at s149 of the Equality Act 2010, in order to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- The protected characteristics are - age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.5.2 The Terms of Reference, Standing Orders and Scheme of Delegation for the new North Central London Joint Committee have been drafted in accordance with the Equality Act 2010.

5.5.3 It is anticipated that monitoring and actively improving the performance and quality of Primary Care service provision will have a beneficial impact for all patients in Barnet.

5.6 **Consultation and Engagement**

5.5.4 All North Central London CCGs agreed to apply to become Joint Co-Commissioners of Primary Care with NHSE from 1 October 2015.

6. BACKGROUND PAPERS

6.1.1 See attached Documents: 1. North Central London Primary Care Co-Commissioning Submission and 2. North Central London CCGs Strategy Refresh (Draft) which were presented to the Barnet CCG Governing Body on 26 February 2015.

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Paper 10.0

MEETING	NHS Barnet CCG Board Governing Body Meeting- Part I
DATE	26th February 2015
REPORT	North Central London CCGs Joint Primary Care Co-Commissioning Proposal and Strategy
LEAD DIRECTOR	Maria O'Dwyer, BCCG Director Integrated Commissioning David Riddle, BCCG lay Vice- Chair
AUTHOR	Alison Blair, Chief Officer Islington CCG Tony Hoolaghan, Director of Delivery Improvement and Transformational Change North and East London CSU
CONTACT DETAILS	Tony.Hoolaghan@nelcsu.nhs.uk

EXECUTIVE SUMMARY

NHS Barnet, Camden, Enfield, Haringey and Islington CCGs North Central London (NCL) have applied to take on joint commissioning responsibility for Primary Care (GP Services) with NHS England.

The purpose of this report is to update the Governing Body on the proposal that was submitted to NHS England on 30th January and for the Governing Body members to approve all of the draft governance documents which were used as supporting documentation as part of the submission, which were developed in consultation with constituents and stakeholders.

The NCL CCGs have received feedback from NHS England's Regional Moderation Panel on the application for joint commissioning on 16th February 2015:

- The Regional Panel recognises and appreciates the progress which has been made in terms of NCL CCGs working together and with NHS England and endorses the direction of travel;
- The Panel has approved the application for NCL CCGs to start Joint Commissioning on the 1st of October 2015 in principal, based on the following:

  I. The Panel has asked that NCL continue their plans to gain the necessary sign offs by the 1st of April 2015;
  II. Rather than using the term 'shadow joint commissioning' which might be confusing in terms of decision-making, NHS England (London) suggest that the term 'development period' is used for the period up to October 2015.
  III. NCL CCGs would then need to re-submit a Joint Commissioning application on the **24th June 2015** in order to be reviewed by the Panel on the **1st July**, as per the process for mid-year co-commissioning changes. This is also an opportunity to further strengthen the application with learnings from the development process.

In Barnet we have always strived to develop and support a sustainable primary care system that contributes to our plans to improve health outcomes and develop an integrated healthcare system. In July 2014 we submitted an expression of interest outlining our intention to become Primary Care Co-commissioners. In November 2014 further guidance was released by NHS England, inviting CCGs to submit proposals for co-commissioning. CCGs were allowed to choose between three types of co-commissioning arrangements, which were as follows:

- **Level 1 – Greater involvement in Primary Care decision making:** CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks
- **Level 2 – Joint Commissioning:** A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations.
- **Level 3 – Delegated Commissioning:** Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

In Barnet we submitted proposals related to joint commissioning. The opportunity to become primary care joint commissioners will provide us with greater strategic oversight and the opportunity to shape the way in which primary care develops. Our intention is to act collaboratively across Barnet, Camden, Enfield, Haringey and Islington (NCL), and work towards the aims set out in the *Strategic Commissioning Framework for Primary Care Transformation in London*.

The deadline for submitting our proposal to become primary care joint commissioners in North Central London to NHS England was 30th January 2015. Our proposal set out plans to operate as primary care joint commissioners (in shadow form) from April 2015 – October 2015. In order to become primary care joint commissioners, we will need to make some changes to our constitution and also establish a Primary Care Committee to enable us to jointly commission services with NHS England. This will enable NCL CCGs to assume responsibility for primary medical services with the NHS England area team, through a joint committee or "committees in common".

We have been provided with some model wording for the constitution, and the terms of reference for the Primary Care Committee, which have been developed by solicitors on behalf of NHS England. The model wording enables us to act as primary care joint commissioners. This model wording has been reviewed internally by all of the NCL CCGs and our view is that, subject to minor amendments, the model wording should be adopted as it stands to ensure that we are in line with national changes relating to co-commissioning.

In addition, in preparation for our new role, we have been asked to update our Conflicts of Interest policy to reflect statutory guidance produced by NHS England on 18th December 2014 and to include the Primary Care Committee in the CCG scheme of delegation, reflecting that we will need to update our constitution in preparation for our new

responsibility.

Therefore, the Governing Body are asked to approve the NCL Primary Care Committee;

- Appendix A –North Central London CCGs Primary Care Strategy Refresh;
- Appendix B –Draft Terms of Reference for the Primary Care Committee; and
- Appendix C -Proposed Amendment to Barnet CCG's Constitution.

Following the approval of these documents, we will establish the Joint NCL Primary Care Committee so that it the first meeting is April 2015. We will put in place the structures for the Committee, along with carrying out further transfer due diligence from NHS England.

Conflicts of Interest

The CCGs proposals relating to co-commissioning include an amended Conflicts of Interest Policy, which reflects statutory guidance released by NHS England in December 2014. Taking joint commissioning responsibilities will mean that the Primary Care Committee will make decisions that will impact the CCGs' member constituents as providers of services. Therefore, the proposed makeup of the Primary Care Committee is a Lay and Executive majority. The NCL CCGs are currently working together to establish the arrangements for this and are commissioning Baker Tilly to develop a Conflicts of Interest Policy for NCL CCGs. This will be shared with the Governing Body once finalised.

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It is anticipated that monitoring and actively improving the performance and quality of Primary Care service provision will have a beneficial impact for all patients in Barnet.

RECOMMENDED ACTION

Governing Body members are asked to:

1. Approve the primary care joint commissioning proposal including the governance documents provided as appendices to this report; and
2. Approve the proposed changes to the CCG's Constitution highlighted in Appendix C, subject to agreement by NHS England.

Objective(s) / Plans supported by this paper: *(How does this report help to deliver the objectives plans and strategies of the CCG?)*
Strengthens CCG decision making with NHS England on commissioning primary care, enabling more joined up commissioning of services outside hospital.

Outcomes Expected:
Strengthens CCG decision making with NHS England on commissioning primary care, enabling more joined up commissioning of services outside hospital.

Audit Trail: *(Details of the groups or committees that have received the paper including dates)*
Considered at Governing Body 18 December 2014
Considered at Clinical Cabinet 5 Feb and 19 Feb 2015
Report to Health & Welbeing Board 29 Jan 2015
Other key stakeholders engaged with include LMC and Network Leads.

Patient & Public Involvement (PPI):
Discussed at latest Patient Engagement Group.

Equality Impact Assessment: N/A

Risks: See conflicts of interests above.

Resource Implications: None directly. Provides opportunity for joint decisions on use of existing budgets held by CCG and NHS England.

Next Steps: *(This section will set out what will happen next, including when the item may next be reported to a committee or the Board. It should include explicitly any communication plan)*

Engagement with member practices.
Approval to constitution changes by NHS England.
Finalise governance documents.
Establish joint committee for developmental period to October 2015.
Submit formal application by 24 June 2015.
Commence joint commissioning in October 2015.

AGENDA ITEM 12

	Health and Wellbeing Board **17 September 2015**
Title	**Planned procurement of an integrated NHS 111/out-of-hours service across North Central London**
Report of	Director of Clinical Commissioning, Barnet CCG
Wards	All
Date added to Forward Plan	July 2015
Status	Public
Enclosures	Appendix 1 – Engagement activity log for NHS 111 OOHS
Officer Contact Details	Barry Subel: Clinical lead for Urgent Care barry.subel@nhs.net Buzz Dodd, Head of Service Redesign and Urgent Care, buzz.dodd@barnetccg.nhs.uk, 020 3688 1786

Summary

Barnet CCG is working with the other four CCGs in north central London (Camden, Enfield, Haringey and Islington) to improve the local NHS 111 and GP out-of-hours services (OOH). This includes bringing together the NHS 111 service and the GP out-of-hours service to enable them to work better together. The contract for the current NHS 111 service needs to be renewed in 2016, which means that there is a real opportunity to learn from experience and make NHS 111 work better for patients. The objective is to improve patients' experience of using and accessing urgent care services, making sure they receive the best care, from the best person, in the right place, at the right time.

Combining NHS 111 and GP out-of-hours services under a single contract helps patients get to the right service quicker, with less time spent being passed from one call handler to another. Nurse, GP or pharmacist input at an early stage may help patients get the right advice or treatment more quickly. Over the past eight months NCL CCGs have held a large number of events and have heard from a wide range of members of the local community on the 111/OOH procurement proposals. The evidence gathered so far from stakeholders, along with clinical evidence, shows that bringing the two services together across the five boroughs will both meet local need for the service and provide a sustainable service. The options for commissioning this service were debated by the CCG at its Governing Body

meetings. BCCG Governing Body received an options appraisal paper at its meeting on 28 November 2014.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the proposal to procure an integrated NHS 111/GP out-of-hours service (OOH) across Barnet, Camden, Enfield, Haringey and Islington.**

1. WHY THIS REPORT IS NEEDED

1.1 This report provides the Health and Wellbeing Board with an update on the planned procurement of an integrated NHS 111/Out-of-hours (OOH) service across Barnet, Camden, Enfield, Haringey and Islington.

1.2 NHS 111 and the out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111. It is vital to make sure they work in a co-ordinated way to support the patient's journey and deliver high quality, safe patient care.

1.3 Currently the CCGs in north central London commission three different organisations to deliver separate NHS 111 and out-of-hours services to patients in north central London.

- The NHS 111 service is provided by one provider for all five CCGs in north central London – *London Central and West Unscheduled Care Collaborative (LCW),* a GP-led not for profit organisation.
- The GP out-of-hours service for Barnet, Enfield and Haringey is provided by *Barndoc Healthcare* Ltd. and the service for Camden and Islington is provided by *Care UK*.

1.4 The contracts for both of these services were set to expire in March 2015, but these have been extended to allow the Clinical Commissioning groups (CCGs) to refresh and improve the service and consider commissioning a combined NHS 111 and out-of-hours (OOH) service across the five boroughs.

1.5 Barnet CCG, along with the other CCGs in north central London consider it more viable to commission NHS 111 and OOH as a single contract, with a single specification, so that patients would receive a more joined-up service with fewer transfers between medical staff and better information-sharing.

1.6 A single contract, does not, however, mean that a single provider would be commissioned to provide the service. Our proposal is to develop a single contract, where a lead provider(s) would coordinate the work with all the local providers (which could include NHS trusts, GP collaboratives or private and voluntary sector providers), making sure they are working together to deliver the best possible outcomes and care for patients – they would be held accountable by CCGs for delivering those outcomes and care, with a detailed and clear specification for the service. The NCL CCGs believe this would be the right model because it matches how patients actually access these services.

1.7 The current services have all demonstrated excellent performance over the years of their current contracts – north central London residents have access to NHS 111 and out-of-hours services that are as good as, or better than, any in London. This is demonstrated from the evidence seen at the monthly clinical quality review meetings. Also, evidence published on the NHS England website1 shows that 86% of our patients said they were fairly or very satisfied with their NHS 111 experience.

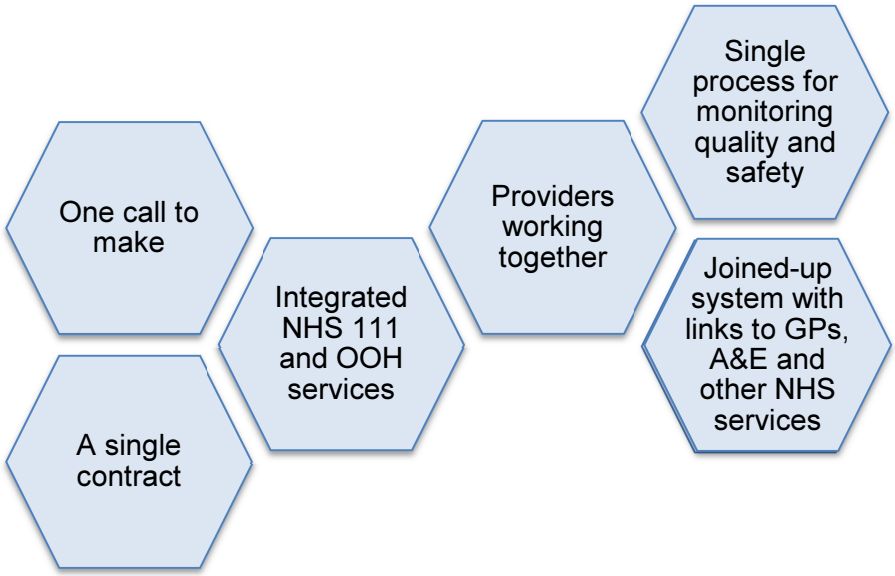
1.8 However, we also know from complaints, incidents and feedback that some patients have had a poor experience, and this needs to be improved.

1.9 As the current contracts for these services are all drawing to an end, the CCGs are legally required to undertake a formal procurement process.

1.10 This is also an opportunity to redevelop the NHS 111 and OOH service as an integral part of the health system across north central London, and ensure that it works intuitively with other aspects of primary care and emergency care.

1.11 In developing our proposals NCL CCGs have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. The CCG's preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers.

1.12 The proposed model is outlined below:



[1] [1] http://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

1.13 Callers to NHS 111 are often not near their registered GP practice when they call, but are usually somewhere within the NCL area, so it makes sense for NHS 111 to be able to refer them to healthcare services near to where they actually are at the time of their call. Combining the two services would make this easier.

1.14 By commissioning a service across NCL, doctors believe it would mean the NHS could develop better systems and infrastructure which would be more flexible and reactive to patients' needs; for example, NCL CCGs want the service to employ a skills-mix of health professionals – including pharmacists and paramedics as well as GPs and nurses – so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111 – and this would be the same for our patients, wherever they live.

1.15 Deaf service users and those with learning difficulties also sometimes experience a poor service, and NCL CCGs want to develop systems to improve this. This is achievable if NCL CCGs commission at a five borough scale, and would be much less viable if NCL CCGs commissioned separate services.

1.16 Current model vs proposed model:

	Current model	Proposed model
Contract	One organisation providing NHS 111 for all of north central London (Barnet, Camden, Enfield, Haringey and Islington). Two organisations providing OOH services for north central London (one in Barnet, Enfield and Haringey; one in Camden and Islington)	A single contract with responsibility for all NHS 111 and OOH services in north central London. This may be delivered by a single organisation or (more likely) by a group of organisations working together. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.
Clinical support	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what

	Current model	Proposed model
		they need.
Assessment	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
Appointments	Some direct bookings – but patients usually need to hang up and call a different number to make an appointment with the appropriate service	Direct bookings for OOH appointments, including home visits. Direct bookings available for most other services.
Medical history	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS 111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
Equity of access	Access to OOH services is different depending on where people live in north central London	Access to OOH services would be the same, regardless of where people live in north central London – and patients would have more choice

1.17 The CCGs believe that investing in an integrated NHS 111/out-of-hours service would provide numerous benefits for patients and residents of north central London:

- Patients would be more likely to be seen by the right clinician, earlier in the process
- There would be fewer transfers as the patient progresses through the system – you should only have to give your information once
- Patients would no longer be bound by administrative barriers (eg residents in West Haringey could be directed to the OOH base at the urgent care centre at the Whittington hospital, rather than travel across the borough to the North Middlesex hospital) – you would be able to choose the services most convenient to you
- The skills mix model, combined with more timely access to a GP, would help support the urgent care system – you would be directed to the most appropriate service that meets your medical needs and this should mean you are less likely to have to wait around at a busy A&E

- The integrated service would have flexibility to redeploy staff to where they are most needed to meet changes in patient use throughout the day and year
- Clinicians would be able to prescribe without the need for duplication or unnecessary referral
- All contracts would be rigorously monitored, as is the case today; providing assurance that the service is safe and of a high quality. Providers would be accountable for delivering the outcomes and care that patients need
- NHS 111 call advisers would be able to book patients directly to appointments with OOH and other services. This works very well and improves patients' experience. NHS 111 services could make much better use of local community services. NHS 111 services need to develop better online access. Commissioning at this scale would allow the development of systems and infrastructure that are more flexible and reactive to patients' needs – for example online tools to enable you to assess your own health needs, and systems for deaf service users.
- Commissioning at this scale would allow the development of systems and infrastructure that are more flexible and reactive to patients' needs – for example online tools to enable you to assess your own health needs, and systems for deaf service users.

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Wellbeing Board are asked to note the report and the information contained in the appendix to the report. The report is an update on the planned procurement of an integrated NHS 111/OOH service across Barnet, Camden, Enfield, Haringey and Islington.

2.2 The recommendation to members of the Health and Wellbeing Board is in line with the NHS Act 2006.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 In further developing the proposals NCL CCGs have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. Our preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers. The following table outlines the advantages of each option:

✓ = the option partially offers this advantage

✓✓ = the option fully offers this advantage

	Patients get clinical advice quickly from the right person, without calling a	Reduces pressure on A&E by making sure patients get treatment	Equal access to services wherever you live in north central London	Fewer transfers from one adviser to another	Can adapt to deal with pressure at peak times	Service provided by local clinicians	Contracts can be rigorously monitored	Could develop new systems – e.g. for deaf service users –

	different number	early on						that are better at meeting patients' needs
Option 1 – Commission one NHS 111 and two GP OOH providers – No change	✓	✓			✓	✓[2]	✓✓	✓
Option 2 – Each CCG to commission its own NHS 111 and GP OOH providers	✓	✓				✓[2]	✓✓	
Option 3 – Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – (our preferred option)	✓✓	✓✓	✓✓	✓✓	✓✓	✓[2]	✓✓	✓✓

3.2 The initial idea to commission NHS 111 and OOH services as a single service across NCL was developed based on extensive feedback from service users and clinicians. In particular, the Review of Urgent Care carried out in Camden and Islington in 2013/4, in which the CCGs spoke to hundreds of patients, which recommended a more joined-up approach to commissioning urgent care and specifically NHS 111 and OOH services.

3.3 There was also an independent review by the Primary Care Foundation which showed how reducing transfers between NHS 111 and OOH would speed up the clinical care patients received and improve their experience.

4. POST DECISION IMPLEMENTATION

4.1 Following presentation to the Health and Wellbeing Board, the final draft service specification for an integrated NHS 111/OOH service will be submitted to Barnet CCG's Clinical Cabinet for approval at its meeting on 8 October 2015 and subsequently to the Barnet CCG Governing Body meeting. The other NCL CCGs will be processing approval through their own governance arrangements. The intention will then be to begin the procurement process by issuing the PQQ in October 2015.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The key projects described in this report are closely aligned to the remit of the HWBB as it relates to key leaders from the health and care system working together to improve the health and well-being of local communities through local commissioning of health care, social care and public health; informed by the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing

[2] * The current national shortage of GPs means it can be difficult for OOH services to recruit local doctors. We couldn't guarantee, regardless of how we commission these services; that they would employ local doctors – but we do want to make sure that the local service is an attractive career option that good local clinicians would want to take part in.

Strategy. There is also close alignment with the strategic aims of the other four CCGs for the delivery of high-quality health and health care services for the residents of north central London.

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

5.2.1 This has financial implications for the CCGs but should have no negative impact on service provision. The plans for procuring an integrated NHS 111 and out-of-hours service include investment to fund additional clinical support – doctors, nurses and paramedics working closely with the call advisers to make sure that those service users who need clinical advice are put through to the most suitable clinician.

5.3 **Legal and Constitutional References**

5.3.1 Barnet CCG is legally required to discuss with all key stakeholders - that includes the public and patients of Barnet, the Health and Wellbeing Board and key providers of healthcare. Section 14Z2 of the NHS Act 2006 states:

(a) in the planning of the commissioning arrangements by the group,
(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

5.3.2 The Council Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health and Wellbeing Board which includes:

- To consider all relevant commissioning strategies from the CCG and the NHS England and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.
- 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. To explore partnership work across north central London where appropriate.
- Specific responsibilities include overseeing public health and developing further health and social care integration.

5.4 **Risk Management**

5.4.1 There are no additional risks to the service, patients or the CCG if the procurement proceeds. However of it does not proceed, then the risks of patients receiving an uncoordinated service or poor experience will continue.

5.5 **Equalities and Diversity**

5.5.1 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 persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

5.5.2 The protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services.

5.5.3 Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports. Proposals are therefore assessed for their impact on equality and diversity in line with the Barnet CCG Equality Delivery System that the CCG will ensure that all the policies and practices carried out by the CCG, or on behalf of the CCG, have made informed decisions based on equality Impact analysis (EQIA) of outcome that has identified if there are any effects on people; specifically with protected characteristics; within our community who may use our services or on the people we employ in line with the Equality Act 2010.

5.5.4 The current service configuration results in an access inequality between boroughs. See section 1.16 Equity of Access. The new service will mean there will be greater choice of GP OOH base across NCL for face to face appointments. The proposed service will reduce this inequality by offering consistent access and availability of services across NCL. The NHS 111 and OOH Patient and Public Reference Group has been involved in the service development which informed the equality analysis. A number of engagement events have been held with patient groups such as those with hearing difficulties or learning difficulties with useful feedback on current services.

5.5.5 Work is underway in finalising the Equality Impact Assessment which will be published on the CCG website once it has received CCG approval. It is not anticipated that any group will be negatively impacted. Commissioning the NHS 111/OOH integrated service across the NCL represents an opportunity for investment in developing systems and infrastructure that are more flexible and reactive to patients' needs–for example online tools to enable patients to assess themselves, and systems for deaf service users.

5.6 **Consultation and Engagement**

5.6.1 In line with 5.3.1, The CCGs have undertaken a substantial engagement programme across NCL over the past eight months (see Appendix 1), which has included:

- Individual CCGs discussing NHS 111 and OOH proposals at local events, including discussions with hundreds of individual service users and meetings with community and voluntary groups
- Presentations at the regular meetings with GPs across NCL to ensure local doctors understand what is proposed and how they could be involved
- Two phases of focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which were attended by hundreds of interested service users and encouraged in-depth discussion of the proposals. In Barnet, these took place in March, April, May and August.
- An online survey to find out the views of stakeholders and service users on our commissioning proposals.
- The setting-up of a Patient and Public Reference Group, involving service users from all five boroughs and Healthwatch representation – this is looking in detail at the proposed service specification and has had a fact-finding visit to the current NHS 111 provider. Members who have expressed an interest are being invited to participate in the Procurement Panel when it goes ahead.
- Market events with local and national providers, letting them know what NCL CCGs are proposing so they can decide whether to bid for the new contract.
- Presentations to the joint health overview and scrutiny committees.

5.6.2 NCL CCGs have had very useful feedback from many service users and local campaign groups, with considerable support for joining up NHS 111 with the GP out-of-hours service to improve patients' experience. That a future service would mean fewer handoffs between services has been particularly welcomed, as have the improvements proposed in the clinical model such as the opportunity to talk to other NHS services (dentists, pharmacists, mental health workers) and earlier access to clinicians including pharmacy, repeat prescriptions and direct access into GP appointments.

5.6.3 There were concerns and anxieties too, so in July, a focused piece of engagement took place, sharing further with residents and service users, exactly why the CCGs are proposing to commission an integrated NHS 111/OOH service. Despite wide communications highlighting the engagement document and its survey, there was a very small response to the engagement, of those that did respond Option 3 was the most favoured option.

5.6.4 The draft service specification for the proposed integrated service has been under development since Spring 2015, with input from the programme's clinical sub-group, whose members are clinical leads from Barnet, Camden, Enfield, Haringey and Islington CCGs. The Patient and Public Reference Group and Healthwatch organisations have had the opportunity to discuss the specification and make line-by-line comments. Additionally, the draft specification was published on the websites of all five CCGs from 21 July to 19 August, and circulated to same stakeholder list as the engagement

document, inviting comments which will be fed back to the drafting team before the final specification is produced for discussion by CCGs in September.

5.6.5 In July, CCG Chief Officers, with other NHS leads, received a letter from Dame Barbara Hakin, National Director of Commissioning Operations for NHS England, informing of proposals for 'commissioning a functionally integrated urgent care access, treatment and clinical advice service.' This letter notes that NHS England is developing new commissioning standards for an integrated NHS 111 and OOH service, and asks commissioners to suspend procurements of these services until the end of September 2015. This is already in line with the timetable to which CCGs in north central London (NCL) are working – our procurement is planned to start in October, allowing time for a further period of engagement and communication with our local communities.

6. BACKGROUND PAPERS

6.1 Public engagement events summary report - http://www.barnetccg.nhs.uk/Downloads/Get%20Involved/NCL-NHS-111-and-OOH-patient-engagement-event-feedback-8-June-2015.pdf

6.2 July engagement document - http://www.barnetccg.nhs.uk/Downloads/Get%20Involved/150702_Proposal_NCL_NHS111-OOH_model.pdf

6.3 Draft service specification engagement - http://www.barnetccg.nhs.uk/service-specification.htm

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Barnet CCG's Engagement Activity Log for NHS 111/OOHS

Engagement Activity for Barnet CCG on NHS 111/OOHs					
Date of activity or dates activity ran from and to	**Type of activity e.g. Meeting, focus group, deliberative event, online discussion, online**	**Target audiences e.g. Local patient groups, public, stakeholders, public, disease specific groups**	**How were participants informed (invited, media release, advertisements, flyers, online)**	**Key themes identified/ areas covered**	**Number of attendees / number of hits or users**
4th December 2014	Clinical Cabinet	GPs	Invited	Programme timelines Proposed clinical model Update on pilots (verbal presentation)	
4th December 2014	Barnet Urgent Care Programme Board	Commissioning/clinical leads from primary care, integrated care and unscheduled/urgent care	Invited	Programme timelines Proposed clinical model (Meeting)	6
16th January 2015	JHOSC	All NCL local authority JHOSC members	Added to agenda	Update on NHS 111/OOH programme	10
21st January 2015	NCL workshop	Clinical and commissioning leads	Invited	Programme timelines Proposed clinical model Update on pilots	

				Data on 111/OOH patient usage by CCG (Presentation)	
12th February 2015	Barnet Urgent Care Programme Board	Commissioning/clinical leads from primary care, integrated care and unscheduled/urgent care	Invited	Programme timelines Proposed clinical model Data on 111/OOH patient usage by CCG (Meeting)	5
19th February 2015	Clinical Cabinet	GPs	Invited	Programme update (verbal presentation)	
24th February 2015	GP network event	GPs		Programme update (by Beverley Wilding ad Dr Barry Subel)	
3rd March 2015	Public meeting (Green Towers Community Ctr)	Patients and public	Advert in local press and through Healthwatch website	Programme timelines Proposed clinical model Update on pilots Data on 111/OOH patient usage by CCG (Presentation)	
4th March 2015	Meeting	Healthwatch Barnet	Invited	Programme update	
6th March 2015	Public meeting (Education Centre, Barnet Hospital)	Patients and public	Advert in local press and through Healthwatch website	Programme timelines Proposed clinical model Update on pilots	4 x public 2 x CCG reps

				Data on 111/OOH patient usage by CCG (Presentation)	
25th March 2015	South Locality meeting	GPs (south)	Bi-monthly meeting for members of the South Locality	Update on 111/OOH (verbal presentation)	26
26th March 2015	Online	Patients and public	• Barnet CCG website • Email directly to PRG members and local organisations • Healthwatch newsletter and website	11/OOH survey	Approx. 400
End March	NHS 111/OOH update presentation	Barnet GP practices	emailed		
30 April 2015	Patient Reference Group (School in Brent)	Members of the Barnet CCGs PRG	Invited	Interactive session around urgent/unscheduled care incl. 111/OOH	Approx 25,
14th May	North Locality meeting	GPs (north)	Bi-monthly meeting for members of the North Locality	Update on 111/OOH (presentation)	
19 May 2015	Public meeting (Stephens House and Gardens)	Patients and public	Advert in local press and through Healthwatch website Practice Managers Weekly news Bulletin	Programme timelines Proposed clinical model Update on pilots	8

			Posters to display in GP practices	Data on 111/OOH patient usage by CCG (Presentation)	
21.May 2015	West Locality Meeting	GPs (West)	Bi-monthly meeting for members of the West Locality	Update on 111/OOH (presentation)	15
27 May 2015	NHS 111/OOH Procurement Update Letter	Stakeholders Practice Managers PPG Members	Emailed letters	NHS 111/OOH Procurement Update	150
28 May	Update letter	Barnet Council LB of Barnet Barnet MPs Barnet 55 Plus Barnet Carers Barnet Voice for Mental Health CommUNITY Barnet Healthwatch Barnet Barnet Local Dental Committee Barnet Local Medical Committee Barnet, Enfield and Haringey Local Optical Committee Barnet, Enfield and Haringey Local Pharmaceutical Committee Barnet Youth Parliament Multilingual Wellbeing Service Barnet Deaf Association Barnet Learning Disability Service	By letter/email	Programme update Key themes identified from engagement events Opportunity to feedback	25
28 May	Update letter	Barnet GP Practice Managers to cascade to PPGs	By letter/email	Programme update Key themes identified from engagement events	68

				Opportunity to feedback	
29 May	Handwritten Correspondence received after 18 May meeting	Member of the public - David Shepherd		Concern about democratic deficit – provided list of organisations that we could engage/consult with.	1
2 June	Patient and Public Reference Group	Members of the PPRG from the five boroughs	Email	ToR Confidentiality Service Spec input	20
24 June	PPRG visit to LCW	Members of the PPRG	Email	Visit to LCW	6
26 June 2015	NHS 111/OOH Update paper	HOSC			15
2 July 2015	NHS 111/OOH Procurement Update Letter and engagement plan sent by BCCG Chair/CO	List Stakeholders Barnet Council LB of Barnet Barnet MPs Barnet 55 Plus Barnet Carers Barnet Voice for Mental Health Community Barnet Healthwatch Barnet Barnet Local Dental Committee Barnet Local Medical Committee Barnet, Enfield and Haringey Local Optical Committee Barnet, Enfield and Haringey Local Pharmaceutical Committee Barnet Youth Parliament	Letter and Engagement Plan on the future model for NHS 111 and GP OOH's in NCL 3.7.15 engagement plan posted on website GP Bulletin w/c 13/7 with link to the Barnet CCG website		150

		Multilingual Wellbeing Service Barnet Deaf Association Barnet Learning Disability Service Barnet GP members Barnet PPG Barnet GP Networks			
23 July 2015	Service Specification post on internet	Commissioner stakeholders Providers Patients and public	Posted on intranet 23 July 2015		150
August 2015	Draft Commissioning Intentions engagement events	3 events held; • Commissioner stakeholders • Providers • Patients and public	Invitation email to stakeholders Advert in local press and through Healthwatch website	NHS 111/OOH covered within context of urgent care table discussions	
4 August	Patient and Public Reference Group	Members of the PPRG from the five boroughs	Email	NHS England update Standard contract and contract monitoring Directory of Servcies	15
5 August 2015	Market testing event	Barnet GPs Barnet GP Networks Barndoc	Invitation email to stakeholders Adverts in contract finder 14.7.15 BCCG website		22

12th August 2015	Meeting	Healthwatch Barnet Engagement Group			20
2 September	Patient and Public Reference Group	Members of the PPRG from the five boroughs	Email	Programme update Draft JHOSC paper Contract management and KPIs	16
17 September 2015	Health & Wellbeing Board Update on the procurement				

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AGENDA ITEM 13

	Health and Wellbeing Board **17 September 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 seven 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 30 July 2015 and suggests a refreshed schedule of reports and items for the following 7 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 Proposed future structure of the Partnership Boards and Child and Adolescent Mental Health Services (CAMHs) update and transformation plan (November). The final Health and Wellbeing Strategy will also be presented in November.

1.4 The Health and Wellbeing Board must ensure that its 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 (September 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, Adult Social Care ADM project, 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

September 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)
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 Joint Health and Wellbeing Strategy (2016 - 2020)	**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**
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 and 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 – meeting held 15 September	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– meeting held 8 September	The Board is asked to approve the minutes	CCG Chair Commissioning Director – Adults and Health	Associate Consultant – Health & Social Care Integration Programme

Subject	Decision requested	Report Of	Contributing Officer(s)
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 dementia manifesto and Carers Strategy	**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**
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**
Child and Adolescent Mental Health Services (CAMHs) update and transformation plan	**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**
Barnet Safeguarding Children Board and Safeguarding Annuals Board annual reports	**The Board to comment on the reports**	Barnet Safeguarding Children and Safeguarding Adult Board Chair	**Barnet Safeguarding Children Board Manager Head of Safeguarding Adults**
Better Care Fund and Health and Social Care Integration - Quarter 1 2015/2016 report and minutes of the Health and Social Care Integration Programme Board	**The Board is asked to note the report.**	Commissioning Director – Adults and Health CCG Chair	**Programme Director Health and Social Care Integration**
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**

Subject	Decision requested	Report Of	Contributing Officer(s)
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**
Director of Public Health's Annual Report	**The Board is asked to note the report**	Director of Public Health	**Consultant in Public Health**
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**
Proposed future structure of the Partnership Boards	**The Board is asked to comment on and agree with the implementation of the proposed model**	Commissioning Director – Adults and Health	**Customer Care Service Manager, LBB Commissioning Lead – Health and Wellbeing, LBB Partnership Boards Officer**
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**
Services for people with learning disabilities including 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**

Subject	Decision requested	Report Of	Contributing Officer(s)
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**
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**

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Appendix 2 - Forward Work Programmes of Strategic Boards (September 2015 - March 2016)			
Calendar month	Strategic Board	Agenda Item	Nature of item (if known)
September			
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
		Annual report of Barnet Safeguarding Children's Board	To receive and annual report on progress in delivering the priorities of the Barnet Safeguarding Ch
		Early Highlights of Attainment Results	
		Business Planning: Annual Report 2014/15	To receive an annual performance report on progress in delivering the commissioning priorities of
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			
		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 and Care Act implementation: Market Sustainability and Oversight	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.
		Commissioning strategy for supported living	Committee to receive a commissioning strategy for supported living.
18 November 2015	Children, Education, Libraries & Safeguarding Committee	Key Performance Indicators	Report regarding key performance indicators that relate to the work of the Committee.
		Education and Skills Alternative Delivery Model	Selection of partner for the creation of a joint venture to deliver education services in Barnet
		Promoting British Values and Citizenship amongst Children and Young People in Barnet	To consider options for the future delivery of early years 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.
		Implementation of Better Care Fund: development of integrated locality teams	Implementation of Better Care Fund: development of integrated locality teams.
		Implementing the Care Act: Implementation of Carers Support	Committee to receive a report on implementing the Care Act: Implementation of Carers Support
March			
7 May 2016	Adults and Safeguarding Committee	Implementing the Care Act: Adult Social Care and Support Contributions Policy	Committee to receive a report on implementing the Care Act: Adult Social Care and Support Contributions Policy
May			
16 May 2016	Health Overview and Scrutiny Committee	NHS Trust Quality Accounts	Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16.
Unallocated item			
Unallocated item	Health Overview and Scrutiny Committee	Dehydration in Patients Admitted to Hospitals from Care Homes	
		Health and Welbeing Strategy	
Unallocated item	Children, Education, Libraries & Safeguarding Committee	Noam Conversion to Voluntary Aided Sector	
		Early years alternative delivery model	