

## **Barnet Joint Strategic Needs Assessment**

**2008/09-2011/12**

**- putting people not institutions first**

**Presented to Barnet Adult Strategy Group on 25 March 2009**

# Barnet Joint Strategic Needs Assessment - 2008/11

## Contents

Foreword	3
Introduction	5
<b>Section 1: Creating a health supporting environment</b>	<b>8</b>
Barnet overview	8
Future challenges: A changing Barnet	10
Key population challenges	13
<b>Section 2: Improving health and wellbeing</b>	<b>19</b>
Causes of death	20
Immunisation	21
Smoking and smoking cessation	22
Coronary disease and stroke	23
Cancers and screening	23
Respiratory disease	24
Diabetes	25
Mental Health	25
Obesity	26
Sexual Health	26
Drugs and alcohol	27
<b>Section 3: Experiencing health and social care</b>	<b>28</b>
Surveying the perceptions of health	28
Experiencing adult social care and support services	29
Who might require social care services?	29
Social care and support services in Barnet – activity demand and trends	30
Trends in social care delivery	31
Linking demand and overall spend	33
Pressures on hospital service provision	35
Service prioritisation	36
Key messages	37
<b>Section 4: Investing in independence</b>	<b>39</b>
Overview	39
Community based health programmes	40
Finding the 5000	41
Learning disability - predicting need	44
Mental health - predicting need	46
Physical and sensory Impairment – predicting need	47
Older people – predicting need	48
Key messages	49

# **Barnet's Joint Strategic Needs Assessment - Summary**

**- putting people not institutions first**

**Foreword: Councillor Helena Hart  
Cabinet Member for Public Health – London Borough of Barnet**

**David Riddle  
Chair of Barnet Primary Care Trust**

This is Barnet's first Joint Strategic Needs Assessment (JSNA) written by Barnet Primary Care Trust and Barnet Council. It is an ambitious document which has tried to understand the current health and social care needs of Barnet's residents and anticipate how these may change against a background of a diminishing public purse. In particular we have focused on the importance of lifestyle choices in determining future health and social care outcomes.

Coronary heart disease, cancer and respiratory problems are the three biggest causes of premature death in Barnet. The most common causes of acute ill health in the borough are coronary heart disease, chronic obstructive pulmonary disease, stroke, diabetes and cancer.

In Barnet we know that some of these deaths and ill health are the result of rising obesity, increased alcohol consumption and continued smoking amongst our residents. Given that people can expect to live longer, we want this to be a positive experience. However, we are finding that lifestyles are influencing the quality of these added years and that certain lifestyle choices have a particular adverse impact.

We also know that the current trend of less public money being available to support complex health and social care arrangements in future years will worsen. This brings the challenge of being able to invest in longer term prevention alongside meeting complex needs. Public services need to change the way they work and more importantly work together. This JSNA is one of many illustrations of how the council with its partners can influence the shape of future public services.

Barnet Primary Care Trust and Barnet councils' joint health and social care priorities are to tackle obesity, reduce alcohol consumption and reduce smoking by:

- creating a health supporting environment which encourages well-being
- improving the health interventions on people who suffer ill health
- understanding the experiences of using health and social care services in order to best meet needs and manage demand
- investing in independence by encouraging people to adopt healthier lifestyles to enable them to live longer and healthier lives.

This document is not definitive, but will be regularly reviewed to check that we have correctly assessed the health and social care needs of Barnet's residents so that it can inform future commissioning priorities.

We will expect the JSNA to be considered by all relevant partnership boards so that they take account of the messages it contains in their future policies and plans. We will also expect the JSNA to inform future commissioning by GP clusters and to form the basis of strong locality commissioning, with a focus on community and preventative services

# Barnet Joint Strategic Needs Assessment

- putting people not institutions first

## Introduction

Barnet's Joint Strategic Needs Assessment (JSNA) describes the current and future health, care and well-being needs of our local population and informs the strategic direction of service delivery to meet these needs by Barnet Primary Care Trust (BPCT) and the London Borough of Barnet (LBB) over the next three years.

The document is part of a wider partnership approach to ensure Barnet excels as a successful city-suburb improving quality of life for all, building on Barnet Primary Care Trust's submission to the Department of Health [World Class Commissioning](#) in November 2008. Our JSNA summarises our current analysis of needs and supports the core priorities identified in Barnet's [Sustainable Community Strategy](#) and delivered through our current [Local Area Agreement \(LAA\)](#) which is set against Barnet's story of 'driving success' and tackling disadvantage' and builds on our [Health Profile](#) published in 2007/08.

## Information used to inform Barnet's JSNA

Evidence for our JSNA about local people and health and well being comes from two sources – [statistical data](#) which we collect routinely and forms part of the core dataset based on Department of Health guidance; [perception and satisfaction data](#) collected through active dialogue.

[Statistical data](#) – the data we have used has come from a variety of sources including the core data set advised by the Department of Health, together with data produced for our partnerships boards.

[Perception and engagement data](#) - Both the council and the primary care trust have developed a range of ways of listening to the views of our users and residents. We have been keen to capture the voices of people with complex needs and those experiencing exclusion through discussions as well as using more traditional methods based on surveys, on-line consultations, feedback processes and complaints.

To make the information easier to access we have inserted hyperlinks throughout the document (which are underlined text) and can be clicked on allowing the evidence to be examined in greater detail.

Barnet's JSNA is aligned to the priorities set out in our first [Health and Well-Being Commissioning Framework](#) for Barnet which are:

- **Creating a health supporting environment**

Working together using key plans in the borough we want to identify and address the social and economic factors underpinning local health inequalities such as poor housing, impractical transport links, unemployment and crime and disorder.

- **Improving health and well-being**

In Barnet we believe that public agencies and their partners should work alongside individuals and the wider community to support them to adopt and maintain healthy lifestyles. We have analysed data which enables us to understand the needs of local people so that information can be tailored to encourage them to give up smoking, take up exercise, eat healthily, drink sensibly and access cancer screening.

- **Experiencing health and social care**

This JSNA is about putting people first not institutions. Listening to the voices of users of health and social care services as they share their experiences is vital to promoting health and well-being, but in Barnet we know it is even more important that our residents and users feel listened to. Showing this is hard – but by listing examples of achievements and positive outcomes we hope that everyone who has had contact with our health services is treated with dignity and respect.

### **Investing in independence**

This JSNA will provide evidence of how we can deliver an integrated and well-developed health and social care service for all. At present there are four commissioning strategies developed by BPCT and LBB to promote choice and maximise independence for vulnerable adults. These will be combined into a future health and social care commissioning framework which has been informed by our JSNA.

Barnet's JSNA will provide the necessary information to achieve Barnet's health and well-being vision of '**a healthy city-suburb where all residents can enjoy long, fulfilling and healthy lives**'.

The statutory duty to produce a JSNA has provided an opportunity for BPCT (public health) and LBB (Adult Social Services and Children's Service) to explicitly define the health and well-being aspirations for Barnet's residents and cement the close working relationship between the agencies. There are a several challenges which the borough is facing over the next 10 years which makes the impact of the JSNA even more crucial to our continued success and stability.

We want our population to flourish. But there are huge challenges facing us as one of the fastest growing authorities in London. As a borough that residents believe is a good place to live, we expect another 30,000 households will come and live in our new developments over the next 10 -15 years. We are trying to manage this expansion to our physical infrastructure using the Barnet Financing Plan. This JSNA sets out how we anticipate this population change to impact on the health and well-being of our established and newer residents.

Barnet's economic profile is similarly complex. Whilst perceived to be a prosperous borough, we do have areas of severe economic disadvantage. Approximately 6700 households are believed to have a household income under £10,000 with 5100 households with an annual household income above £100,000 in 2008. Approximately 51,407 in 2005 were in receipt of variety of means tested benefits. This range of household income reveals the extent of the challenge we face in anticipating health and well being needs of our residents.

The inter-relationship of wealth and well-being will influence our residents in how they maintain their health and well-being but also it will shape their future aspirations and expectations and how we as public bodies strategically commission services that support this inter-relationship.

The relationship between deprivation and ill-health is well-documented in the worlds of health and public policy which is further compounded by other conditions including age, fear of crime and diversity.

**Barnet's JSNA illustrates what we know about the current needs of our residents, their expectations in terms of health treatments or other interventions and their aspirations for their quality of life. It aims to support policy makers and commissioners in considering questions and determining priorities by using our demographic profile to assess risk in terms of changing need and resource pressures. It will continue to be updated on an annual basis.**

## Section 1 – Creating a health-supporting environment

**Working together using key plans in the borough we want to identify and address the social and economic factors underpinning local health inequalities such as poor housing, impractical transport links, unemployment and crime and disorder.**

### Barnet: overview

Barnet is a vibrant and diverse city-suburb, playing a major role in London's global competitive success. It is already well ahead of other boroughs in terms of key drivers of economic performance. The borough contributes to the regional economy through its thriving local economy. It is an attractive place to live for the highly skilled workers who are vital to success of the capital, but the current economic downturn is expected to impact on Barnet's residents.

Barnet's effective public services and physical environment make it a desirable place to live. People choose to live here, with 88 percent of residents showing satisfaction with our borough<sup>i</sup>. People who live here can expect excellence from their public services, good schools with good results and low levels of crime. Our residents live healthier and longer lives than average. These achievements are due to strong partnership working. The borough has large areas of protected open space and parkland. It is clean and safe. This, along with our high quality housing, transport links, town centres and amenities is what attracts highly skilled people to live in Barnet.

Fear of crime still remains high. Transport networks are coming under increasing pressure from congestion. Barnet's high house prices mean that it can be difficult for people to buy their own homes. In order to maintain Barnet's distinct appeal, the council with its partners need to focus our efforts on maintaining and improving those aspects – high quality physical environment, transport, housing, education and health services – that contribute to its success.

### Barnet today:

- covers 87 square kilometres and is London's largest borough in geographical size with a population of 334,900 (Office for National Statistics)
- registrations with Barnet General Practitioners (GPs) is 350,000 people (reflecting cross-borough movement)
- 28 percent of the land is green belt (2,466 hectares) and 8 percent is metropolitan open land (690 hectares). There are also 200 parks and open spaces
- is the 2<sup>nd</sup> most religiously diverse borough in the country and with 31.5 percent of its population belonging to a black and minority community, the 20<sup>th</sup> most ethnically diverse

---

<sup>i</sup> Annual Residents' Survey 2008. This survey is replaced by the Place Survey. In March 2009, 79.5 per cent of respondents described their health and well-being as good (National Indicator 5)

- the borough is generally prosperous but there are pockets of deprivation in especially the west of the borough
- results in our primary and secondary schools place us in the top quartile nationally
- over 170 languages were spoken in our primary schools in 2008
- high education attainment is also evident across the adult population; over 37 percent are qualified to at least HND, degree and higher degree level.
- fear of crime remains high, despite crime levels per head of population being lower than the national average
- Barnet residents can expect better than average health and higher than average life expectancy. However, there is a seven-year variation between the deprived and affluent wards
- 71 percent of houses in Barnet are owner-occupied
- 37 percent of Barnet working age residents travel to work by public transport
- Barnet has a large share of knowledge workers – those in managerial, professional and technical jobs – relative to the national average
- Barnet has over 20 town centres, varying in size from Edgware, Chipping Barnet, North Finchley and Finchley Church End to smaller town centres such as Temple Fortune and East Barnet
- It is estimated that 143,000 working days per annum are lost due to work related ill health or injury<sup>ii</sup>.
- Barnet ranked 21<sup>st</sup> highest out of the 376 local authorities in 2005 for international in-migration, and 20th for international out-migration
- In March 2007 295 asylum seekers were receiving subsistence only support from the National Asylum Support Service (NASS) which was down from 415 in 2005 (1<sup>st</sup> quarter)<sup>iii</sup>.

### The economic downturn – its impact on Barnet’s health and well-being

The increasing likelihood of a sustained economic downturn and recession in the UK could have adverse consequences for Barnet. The current economic situation has been precipitated primarily by the effects of the credit crunch; the slow down in the housing market and impact on commodity prices. It is difficult to predict the full consequences of an economic downturn in Barnet. However, it will undoubtedly have an adverse impact on some of our residents and businesses including suffering job losses and increasing personal debt. The decline in consumer spending and reluctance of banks to lend money will also have consequences for local business. This is likely to be felt unevenly across the borough - some residents and business will be equipped to weather the storm whilst others may not have the

---

<sup>ii</sup> Labour Force Survey. Estimated from FOD Regional 3 year average rate 2003/4 to 2005/06

<sup>iii</sup> Home Office: Asylum Statistics 1<sup>st</sup> quarter 2007 United Kingdom

means. Priorities identified as driving success such as our regeneration schemes are on track but with deferred timescales. It is too early to predict the impact on health and well-being, however, based on national experience from the last recession there is a strong likelihood of an increase in cases of poor mental ill health.

## **Tackling Disadvantage**

Whilst we will continue to enhance those factors that reinforce the appeal of Barnet, we also recognise that not all residents share in its prosperity and success.

There are some people in Barnet who experience a disproportionately high level of deprivation, particularly in the west of the borough. Barnet has six super output areas within the 10 percent most deprived nationally. We know that some individuals and families in Barnet experience multiple challenges as a result of poor health, lack of family support, unemployment, low educational attainment, poor housing, disability, drug and alcohol problems, mental health issues and criminal or anti-social behaviour. They can not only cause great harm to themselves and their families but also to the wider community.

We believe a truly successful city-suburb is one where all residents have the opportunity to share in its wider success which requires the safeguarding of the quality of life for all residents. Through some targeted work with individuals and their families we are beginning to understand some of the causes and results of multiple disadvantage and are trying to secure a decent quality of life for all.

## **Future challenges: A changing Barnet**

Barnet will continue to change rapidly over the next 10 years. Its attractive suburban nature has made the borough a magnet for development and growth. By 2018, our population is likely to exceed 366,000 making it the fastest growing city-suburb in London. Large-scale [regeneration](#) in the borough will provide about 23,000 new homes, bringing both new households and people to Barnet but also create new opportunities for the people who live here. It will attract business, retail and leisure facilities and ensure new employment opportunities for local residents. We are still confident that the number of local jobs will increase by at least 10 per cent by 2018.

This growth will also change our existing communities, attracting a much younger and diverse population. Over the next ten years there will be a marked increase in the number of children aged between 5-14 years old and number of people over the age of 65. We welcome new communities, who will add to Barnet's diverse and vibrant population, but they will have a significant impact on the demand for public services. In this environment, we need to be proactive in understanding how the needs of our population are changing mindful that traditional models of service delivery will not be fit for the future.

Managing this growth will be a major challenge over the next 10 years. We must preserve the best elements of Barnet – its identity as a popular, successful city-suburb with strong and cohesive communities. We need to build a stronger relationship with our citizens to understand their needs and preferences. Our role is to provide the space for citizens to interact with the council and public agencies, and with one another, about local priorities and

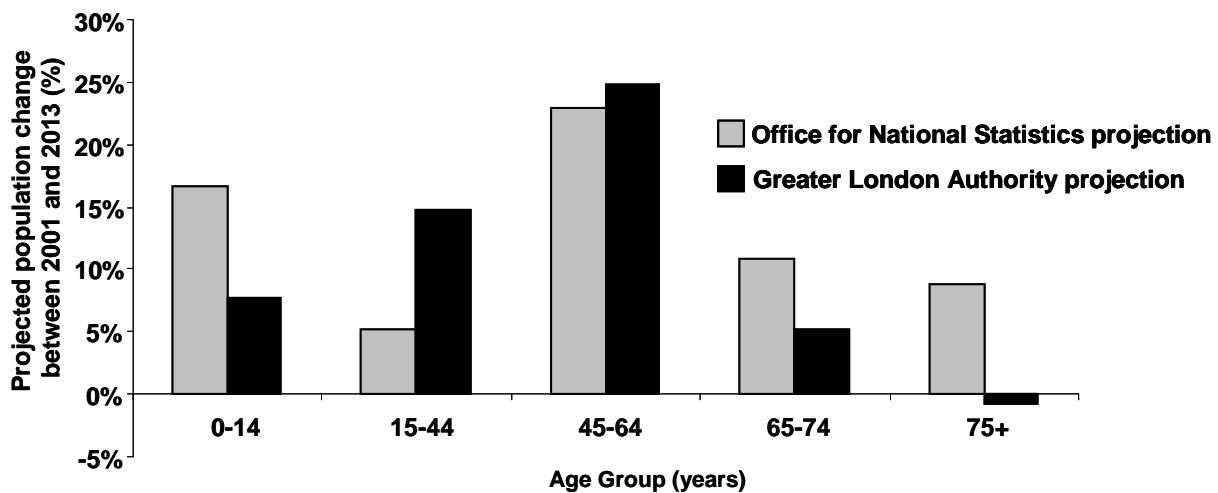
decision-making. We also want to give citizens greater control over their lives and the ability to make informed choices for themselves. We seek to support a culture where Barnet residents do things for themselves, where they define the problems they face and play a role in tackling them where necessary to change their behaviour.

### [Our changing diverse population](#)

Our resident population has a similar age-structure to the rest of London, with a couple of notable exceptions. Firstly, there are proportionately fewer men and women in the 20-44 age band in Barnet compared to London with implications for the resourcing of maternity services; secondly there are greater numbers of women in the 45 plus group and men in the 50 plus group reflecting the rise of the ‘middle-aged spread’ group. This is a group that is emerging throughout the country, which is susceptible to a number of age-related risk triggers to a number of diseases including cardiovascular disease (CVD), increased cholesterol, blood pressure, blood cholesterol and diabetes. Lifestyle risk assessments and interventions will need to be developed to reduce morbidity and mortality amongst this particular age group. The bar chart below compares the population distribution between London and Barnet.

#### **Proportionate growth predicted in Barnet’s population**

Source: Office for National Statistics and Greater London Authority



In addition to the ‘middle-aged spread’ bulge, [Children and young people](#) make up almost a quarter of Barnet’s total population and, in numerical terms, Barnet has the second largest population of children and young people in London, with, in 2008, almost 84,000 children age 0 - 19. Barnet’s younger population is more diverse than the adult population. When ethnic groups are broken down by age, a markedly different age structure emerges between groups. Under 20’s account for 40% of residents with Black African origin and 55% of residents with ‘Black Other’ origin compared to accounting for just under 21.6% of the White population and just over 25% of the population overall. There has been a steady increase in the number of people living to the age of 75 years which will be compounded by the post war-generation reaching 75 by 2020. Associated with this will be an increase in the number of older people



Our **key population challenges** for the next 10 years are:

- More public services will be required to meet the growth in population
- Increasing diversity requires a greater understanding of complex health needs
- The changing profile of child-bearing women will impact on family planning and sexual health services
- Expansion of the 45-64 age group will mean more people at risk of long-term conditions. These people are the most likely to develop obesity, raised cholesterol, high blood pressure, diabetes, stroke and heart disease.

### Creating sustainable communities

While overall Barnet enjoys relative prosperity compared to other parts of the country in spite of the current economic crisis, there are some significant areas of deprivation and need which will compound the health and well-being of some of our residents. Creating a quality local environment must be a key objective of all public bodies in Barnet with their partners. Some of the key influential factors affecting the quality of the local environment include housing tenure, deprivation, diversity, crime, economic profile and education. These factors also play a part in promoting social cohesion by encouraging communities to engage with confidence with each other.

### Deprivation

The updated version of the English Indices of Deprivation 2007<sup>iv</sup> reveals the following:

- Barnet is more deprived in relation to other local authority areas than it was in 2004 and is now close to the top third of most deprived authorities in the country
- Barnet now has six Local Super Output Areas within the 10% most deprived nationally. Within London, Barnet ranks below the middle point, close to the bottom third of least deprived boroughs
- Barnet's rank on most types of deprivation has risen with the exception of the 'education, skills and training' domain which shows an improvement
- Burnt Oak and Colindale remain the most deprived wards in Barnet by a significant margin, as was the case in 2004

Just over 23% of Barnet children and young people live in families claiming means tested benefits. In February 2006 there were 5,355 lone parent families in Barnet receiving Income Support. On this indicator Barnet was ranked thirtieth out of the 413 authorities in Great Britain. In 1999 the equivalent was 4,970 families, giving Barnet a rank of 46th. This increase in the percentage of such families by 7.7% slightly outstripped the 1999-2005 general population increase of 5.2%.

---

<sup>iv</sup> Published by the Department for Communities and Local Government

There is a close relationship between poor health and deprivation. This includes factors such as employment status, the proportion of working age adults with no or low qualifications, household overcrowding, housing without central heating. Where there is a high deprivation score there is a correspondingly higher death rate.

## Diversity

As the second most religiously diverse areas in the country and one of the most ethnically diverse, understanding the diversity of our population is crucial to determining the strategic direction of allocating health and social care resources. But this is only possible through routine diversity monitoring.

Barnet has a large Cypriot community and a growing Eastern European population. Additionally, our faith communities are similarly diverse. We are home to the largest Jewish community in Britain and our Hindu and Muslim communities comprised of six percent each in the 2001 Census. Population projections for our regeneration estates predict that our overall Muslim population will treble over the next 10-15 years. Over 170 languages are spoken in Barnet's primary schools with Somali being the second largest after English. Gujarati is the second most common language spoken in the adult population

The culture and requirement for collecting diversity data differs between the Primary Care Trust and the local authority. However, diversity data needs to be collected to inform and strategic commissioning. Barnet Council has its own bespoke [diversity monitoring tool](#) to support its officers to collect and analyse diversity data and use the findings to influence service improvement. Data collection within the PCT is subject to the contract with GPs. If data collection were regularised and shared between agencies it would enrich our understanding of the needs of local residents.

For instance, data on sexual orientation is not routinely collected yet research published by the Department of Health, Age Concern, Stonewall and the Commission for Social Care Inspection amongst other has identified specific health and social care support needs which are regularly missed due to the absence of data collection. This needs to be improved locally.

Currently our approach to understanding our diverse communities is based on strong anecdotal evidence. We would like this to be supported by empirical evidence. For example, some sections of our large Jewish community are genetically predisposed to experiencing breast cancer. Similarly, type 2 diabetes presents in our South Asian community. In both cases, it would be possible to engage with these communities to work with them to enable them to anticipate and manage these long term conditions. More activity needs to be done with Mosaic data to map out our different communities to gain a greater understanding of their lifestyles and aspirations.

## Economic environment

It is anticipated that the next two decades will see £8bn of market driven and council led redevelopment. Barnet's total population is expected to grow by 1.4% per annum to 2029

compared with 1.1% for London<sup>v</sup>. In terms of population growth this will result in an additional 63,000 people over the next twenty years – equivalent to adding the population of St Albans into the Borough.

## Housing

In the 2001 Census, 7.3% of Barnet residents described their health as ‘not good’ compared to 8.1% in London and 9.2% in England. Barnet’s Housing Needs Assessment in 2006 confirmed that there was a higher correlation between ill-health and social housing.

Resident profiles of our social housing properties reflect national trends. Secure tenants are primarily older, long-established White British whilst non-secure tenants in temporary accommodation are newer arrivals from black and minority ethnic (BME) communities. Our older residents make up 21 percent of our population of which 75 percent own their properties without mortgages making many of them ‘asset rich but cash poor’ which influences their care and well-being choices.

Barnet’s 2006 Housing Needs Assessment estimates that 4.14% of all households, or 5294 households, suffer from ill-health due to the condition of their home. 15.3% of households living in council rented accommodation suffer from ill-health because of the condition of their home. 8.88% of households living in RSL rented accommodation and 7.69% of households living in private rentals also suffer from ill-health because of the condition of their home. The data also shows that 9.27% of households living in a non-purpose built flat and 6.93% of household living in a purpose-built flat suffers from ill-health because of house condition. 7.36% of households in Hendon suffer from ill-health because of house condition. The assessment also estimates that these households are more likely to contain no older people and to have support needs.

It is estimated that around 1,127 children live in social housing in Barnet. Of the 2489 households in temporary accommodation on 31st March 08, 74% contained dependent children or pregnant women. 204 of these households (8%) are vulnerable young people living alone.

## Education

Barnet’s resident population is well qualified with 35% of the adult population having a university degree or the equivalent – 4% higher than the London average and 15% higher than the England average. Barnet’s residential employment rate, 70.1%, is above the London average and 13<sup>th</sup> out of 33 boroughs<sup>vi</sup>. It is also significantly below the London average on both the ILO<sup>vii</sup> and claimant count measures of unemployment. The employment numbers

---

<sup>v</sup> Barnet defines a successful city suburb in its corporate plan outlining five key criteria: Growing successfully; Delivering the Three Strands Approach of Protect, Enhance and Grow; Delivering housing growth in a sustainable way; Creating conditions for a vibrant economy; and Improving Transport infrastructure to maximise opportunities.

<sup>2</sup> Source: Subnational Population Projects Unit. ONS. Crown Copyright.

<sup>vi</sup> Office for National Statistics (June 2007) *Labour Market Statistics: London*

<sup>vii</sup> ILO unemployment counts those who are looking for or willing to work and not simply those receiving  
Barnet’s Joint Strategic Needs Assessment – 25.03.09

may be skewed downwards by Barnet's residential character which is likely to lead to higher levels of voluntary inactivity, e.g. women staying at home to raise children.

In 2007, 11.2 percent of Barnet's population had no qualifications, compared to the London average of 12.8 percent and the national average of 13.1 percent<sup>2</sup>. In 2006, 54.4 percent of Barnet's working-age population was qualified to NVQ Level 3 or higher and 39.3 percent to Level 4 or above. Partners in Barnet are committed to increasing this still further and have included this as a target in its current Local Area Agreement.

### **Not in Education, Employment and Training young people**

For all children, the ability to be resilient in the face of challenges is one of the key factors leading to a successful adulthood. Some children in Barnet will grow up experiencing significant problems in their lives or those of their parents. Building resilience means helping children to manage those difficulties when they arise, and to recover better when they have experienced them.

Barnet council aims to assist young people to access a broad range of education, training and employment opportunities through targeted support and improved access in order to develop and broaden their skills<sup>3</sup>. The wards with the biggest NEET populations also have higher rates of youth related crime and disorder. This population experiences a range of disadvantages which are being explored through the targeted work mentioned earlier.

ONS data for economic activity amongst 16-24 year old young people in Barnet shows that between April 2006 and March 2007 Barnet's rate (75.8 per cent) was slightly higher than the rest of London (75.0 per cent), but lower than England (78.6 per cent). There is a similar trend for the overall employment rate in Barnet (71.2 per cent), London (69.3 per cent) and England (78.6 per cent). The unemployment rate in Barnet (6.2 per cent) is therefore lower than London (7.6 per cent), but higher than for England (5.5 per cent) reflecting voluntary economic inactivity.

### **Crime**

Fear of crime and anti-social behaviour is high in Barnet. They are top of residents' list of the greatest areas of local concern, despite Barnet being among the safest boroughs in London, 40% in the most recent residents' survey<sup>viii</sup> highlighted crime as the most important local issue.

Alcohol is the common factor in many of Barnet's crime and disorder problems, including violent crime (where there is a strong correlation with alcohol related incident hotspots), domestic violence and youth disorder, and alcohol misuse leading to a series of other problems including the impact on health.

---

unemployment benefits

<sup>viii</sup> Annual Residents' Survey 2008

People living in the poorest areas suffer more violent crime, burglary and have a greater fear of crime than those in more affluent areas<sup>ix</sup>, although the latter are more likely to report crime and anti-social behaviour. Residents in poor neighbourhoods are nearly twice as likely to experience problematic levels of crime as those in more affluent neighbourhoods.

People with poor health are more likely to be victims of crime. Similarly disabled people are more vulnerable to becoming victims of crime and are:

- three times more likely to be victims of property crime than non-disabled people
- have a higher likelihood to be a repeat victim
- deliberately targeted for car crime
- regarded as easy targets<sup>x</sup>

Mental health is still socially stigmatised. Populist portrayals of people with mental health support needs as violent hides the reality that less than 5 percent of mental health sufferers kill a stranger and that in fact 16 percent of people with psychosis living in inner-city environments are more likely to be victims of crime<sup>xi</sup>.

Reporting of hate crime levels in the borough has steadily reduced over the past three years reflecting a London-wide trend. Work is being undertaken locally to improve reporting mechanisms for a range of hate crimes.

The Police recorded around 2489 domestic incidents and 1460 domestic offences in Barnet in 2007- 08, a considerable number of which are likely to be witnessed by children, with a smaller number of incidents in which children are themselves victims.

Domestic violence reports to the police have reduced steadily since 2005/06. This is not believed to reflect the true level of domestic violence activity in the borough but is reflective of the national trend of reduced reporting of domestic violence. In Britain women in households with an annual income of less than £10,000 are three and a half times more likely to be victims of domestic violence than in households with over £20,000. Reporting patterns in Barnet are sympathetic to this trend.

Bullying both in and outside of school is a concern commonly raised by Barnet children and young people taking part in consultation exercises or activities. Consultation with pupils in Summer 2008 (Tellus3 Survey) suggest that 11% had been bullied in school in the previous four weeks, below the national average of 15%. This is an improvement compared with

---

<sup>ix</sup> Paxton W, Dixon M (2004) *The State of the Nation: An Audit of Injustice in the UK*. Institute for Public Policy Research, London

<sup>x</sup> Cunningham S, Drury S and McManus J (2003) *Disability, neighbourhood stress, fear of crime and health*. Nacro, London

<sup>xi</sup> Social Exclusion Unit (2004) *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister

Summer 2007 where 23% had been bullied and 30% nationally. However, the Children's Service will continue to encourage children, young people and schools to report all incidences of bullying and [racial harassment](#).

The council maintains a statutory register of children who are subject to a child protection plan. In March 2008 there were 155 children on the register in Barnet equating to 20.7 per 10,000 population, compared with a rate of 26.5 nationally, of these 104 (37%) cases were noted to have evidence of domestic violence issues. In 68 (24%) cases there were parental mental health issues, 47 cases (17%) evidence of alcohol abuse issues and 45 (16%) evidence of drug abuse issues.

### **Alcohol and Drug behaviour**

Alcohol and drug taking in Barnet has affected the way Barnet residents feel about their local area. Calls to the ambulance service for alcohol related injuries have increased steadily over the past 3 years. Alcohol consumption has increased in the more affluent wards in the borough and consumption of opiate drugs has also increased across all communities (Barnet Adult Drug and Alcohol Needs Assessment 2009).

Building on the key population challenges listed earlier are some of the key **social and economic factors** which will also influence ensuring how we create our health supporting environment:

- Barnet's complex economic and social profile
- Our physical size both in terms of geography and expanding population
- The link between deprivation and health outcomes reflecting the national picture
- Diversity compounds our understanding of Barnet's different communities
- Disability significantly impacts on health and well-being outcomes
- Regularise data collections across the PCT and Barnet Council
- Domestic violence influences health and well-being of all involved
- Crime affects a range of residents in different ways across generations
- Burnt Oak and Colindale remain the most deprived wards in Barnet by a significant margin
- Effects of multiple deprivation in these wards and other SOAs affect health and well-being

## Section 2 - Improving health and wellbeing: enabling healthy choices for a healthy life, and supporting independence and building resilience

**In Barnet we believe that public agencies and their partners should work alongside individuals and the wider community to support them to adopt and maintain healthy lifestyles. We have analysed data which enables us to understand the needs of local people so that information can be tailored to encourage them to give up smoking, take up exercise, eat healthily, drink sensibly and access cancer screening.**

In this section we look at how we can improve our health and wellbeing by focusing on our own responsibility to keep as fit and well as possible. Things that damage health include lifestyle factors such as smoking, physical inactivity and obesity. Barnet Council and Barnet PCT believe that individuals and the community have a key role to play in improving their own health whilst influencing and encouraging the rest of the community to do so, using local networks.

### Causes of death

Coronary heart disease, cancer and respiratory problems are the three biggest causes of premature death in Barnet, although rates are lower than England as a whole. The most common causes of acute ill health in the borough are coronary heart disease, chronic obstructive pulmonary disease, stroke, diabetes and cancer. However, tackling obesity, reducing alcohol consumption and reducing smoking rates remain priorities for Barnet PCT and Barnet Council.

Health inequalities exist in Barnet. [Life expectancy](#) is influenced by gender and locality. There is significant variation in life expectancy between deprived and affluent wards, with people in affluent wards having a life expectancy of up to seven years longer than those in deprived wards.

	Women		Men	
		Electoral Ward		Electoral Ward
<b>Difference in life expectancy</b>	4.8 years		7.1 years	
<b>Maximum average life expectancy</b>	85.2 years	Garden Suburb	82.7 years	Garden Suburb
<b>Minimum average life expectancy</b>	81.0 years	West Finchley	75.6 years	Colindale

Barnet is divided into three deprivation categories to help understand responses to clinical and long-term conditions.

High deprivation wards	Medium deprivation wards	Low deprivation wards
Woodhouse	Mill Hill	Totteridge
Underhill	Brunswick Park	Garden Suburb
East Finchley	Hendon	Finchley Church End
Coppetts	Hale	High Barnet
Burnt Oak	Golders Green	East Barnet
Colindale	Edgware	West Finchley
West Hendon	Childs Hill	Oakleigh

(London Health Observatory)

The fall in overall death rates from cancer in the most deprived electoral wards (reduction of 8%) has not been as marked as that in the more affluent electoral wards (reduction of 32%). Furthermore, despite an overall reduction in death rates from coronary heart disease, death rates for people aged less than 75 years in medium deprived wards (i.e. West Finchley, Golders Green, Hale, Hendon, Brunswick Park, Child Hill and Edgware) have increased slightly and death rates for people living in the seven most deprived wards are worse than the national average.

Additionally, life expectancy and health well-being is influenced by a number of factors including health, social and economic factors. Life expectancy of people with severe and enduring mental illness is also reduced.

Overall, average life expectancy among people with a learning disability is some twenty years lower than the rest of the population

Mental illness is more prevalent for people with a learning disability, as are chronic illness or disability such as epilepsy, diabetes, circulatory disease, sensory impairments, coronary heart disease and stroke. People with learning disabilities also have higher rates of respiratory disease, and are more likely to be obese, so these are the populations we need to focus on in terms of well-being support.

## Immunisation

Immunisation is second only to a clean drinking water supply as a way of improving and maintaining the health of the population. Whilst smallpox has been eradicated from the world (through immunisation) all other infectious diseases remain; the only way to protect children and adults from avoidable death and serious, often long-term, complications from such diseases is to maintain high levels of immunisation in the population.<sup>xii</sup>

Immunisation levels are lower in all London boroughs than they need to be to ensure adequate protection of our children, as well as adults. This is especially so with MMR

<sup>xii</sup> The main exception to this is TB. Whilst BCG vaccine is an important way to protect people most at risk the way this disease affects the population has changed.

immunisation and we now face a real risk of a resurgence of recurrent measles epidemics. Increasing immunisation rates in Barnet is a key health improvement need. Of particular concern is the low take-up of measles immunisation within our Jewish community which is currently being addressed.

#### **Immunisation commissioning priorities:**

- Improve accuracy of immunisation records on the PCT's child health surveillance system
- bolster the immunisation call system to all children requiring immunisation
- increase availability of immunisation clinics

#### **Priority activities:**

- promote immunisation using social marketing techniques
- work with local community and religious leaders to promote immunisation take up

### **Smoking and smoking cessation**

Whilst immunisation is one of the most significant *primary* disease prevention activities, smoking cessation is the most significant *secondary* preventive measure. It is best not to start smoking, but it is never too late to stop: giving up – at any age<sup>xiii</sup> – will lead to health improvement and reduced risk of disease and premature death.

Tobacco use is the most important preventable risk factor for death from cancer and disease causing heart attack and stroke.<sup>4,5</sup> About 2,600 people die in Barnet each year. Of these, about 440 die from smoking-related diseases.<sup>6</sup> This is more than from any other cause and these deaths are all preventable. Smoking cessation is a vital health improvement need and if we are to improve health in the borough, we need to reduce the prevalence of smoking much more by active discouragement of smoking as well as the provision of smoking cessation services.

Deaths from COPD (Chronic Obstructive Pulmonary Disease) – principally a disease caused by smoking – in Barnet are now higher amongst women than men, and deaths from lung cancer in women will soon become more common than deaths from breast cancer.

---

<sup>xiii</sup> About the only exception to this is that if someone is terminally ill, i.e. they are likely to die in the next three months, and then stopping smoking (always assuming that they are well enough to smoke) will not lead to any significant health gain. In everyone else, it can be expected to do so, if only by reducing the likelihood of a chest infection

### **Smoking commissioning priorities:**

- maintain current drive to increase smoking cessation
- continuing to reduce the prevalence of smoking
- increase the number of smoking quitters in deprived wards

### **Activity priorities:**

- introduce techniques such as measuring 'lung age' to increase quit rates
- raise awareness about the added risks of being a smoker during surgical procedures

## **Coronary disease and stroke**

Cardiovascular disease (which causes heart attacks and stroke) is the most common cause of death in Barnet, as elsewhere in the country. It is also a significant cause of health inequality with proportionately more people who live in Barnet's most deprived areas dying in greater numbers from this disease than those living in more affluent areas. A special project to help reduce this health inequality called **Finding the Five Thousand** is described in Section 4. We will only reduce cardiovascular disease deaths more if we reduce the prevalence of both smoking and obesity.

Barnet has been identified as having one of the highest prevalence for stroke in London – particularly in the East Barnet and Cricklewood areas in 'Healthcare for London – A Framework for Action' consultation document which we are examining closely.

People living in the most deprived parts of the borough are most likely to die prematurely from coronary heart disease. Asian people are at higher risk of developing diabetes and consequently have a risk of developing coronary heart disease that is about 40% higher than amongst the White population in the UK,<sup>7</sup> principally because of the damage that diabetes does to the blood vessels. Black Caribbean people are also at higher risk of stroke, because of a genetic predisposition to developing high blood pressure but are less likely to have coronary heart disease than the White population in the UK.

### **Coronary disease and stroke commissioning priorities:**

- Identify and target people at increased risk of CVD who have not self-identified themselves
- work with local employers to support their staff to (i) be healthier at work and (ii) identify the established health risks associated with smoking, obesity, high blood pressure
- work with schools through the Healthy Schools campaign to increase awareness of the long-term benefits of healthy eating and exercise
- establishing ways for GP practices and acute and community sector providers to identify people with obesity and to support them in managing their obesity

### **Activity priorities:**

- maintain the current good performance on smoking cessation
- continue to increase the number of people quitting smoking;
- develop specific services to support people with 'simple' obesity those with obesity and co-morbidity

## Cancers and screening

Overall, cancer is the second most common cause of death in Barnet and across the country. However, unlike CHD (which only affects the heart) and stroke (which only affects the brain) there are many types of cancer and different ones affect different organs, and their causes and effects are different.<sup>xiv</sup>

The most significant way in which death from cancers can be reduced is by increasing the uptake of routine screening for those cancers which are detectable in this way, e.g. breast, colorectal and cervical cancer; and by improving care pathways such that people with suspected cancer can be investigated and treated more quickly.

In addition to the prevalence of breast cancer amongst (Ashkenazi) Jewish women, the appearance of some types of cancer reflect the effect of migration. For example, bowel cancer incidence is very low in India, but numbers are higher amongst the Indians in developed countries. Lung cancer is more prevalent in poorer areas of the borough.

### **Cancer commissioning priorities:**

- Improve the uptake of screening for breast and colorectal cancer screening
- target cancer screening programmes in medium deprived wards
- work with local providers to improve the availability of clinically and cost-effective treatments for cancer

### **Activity priorities:**

- work with local providers to improve access to appropriate and relevant services for people who may have cancer
- continue to encourage people to not to start smoking and support smokers to stop

## Respiratory disease

Excluding cancers of the respiratory tract, respiratory disease is the third most common cause of death in Barnet. Respiratory disease includes infections (such as acute bronchitis and pneumonia), reversible airways obstruction in response to irritation or allergy (asthma), and permanent structural damage (chronic obstructive pulmonary disease (COPD) which includes both chronic bronchitis (repeated chest infections and inflammation) and emphysema). COPD is almost entirely due to smoking.

People living in more deprived areas are more likely to have respiratory disease that is severe enough to require hospital admission and also that smoking is more prevalent in more

---

<sup>xiv</sup> Most cancers have similar characteristics, i.e. they are abnormalities of cell growth causing the affected tissue to grow in a relatively uncontrolled way. The majority of cancers spread locally by infiltrating adjacent tissues and spread distantly by 'metastatic spread' through the blood and lymphatic systems. The rate of growth, the degree of spread and the effect on other parts of the body differs with each type of cancer

deprived areas. There are insufficient data currently available to indicate any relationship between ethnicity or other aspects of diversity and respiratory disease.

#### **Respiratory disease commissioning priority:**

- provision of services to manage acute exacerbations of COPD early and to provide pulmonary rehabilitation services

#### **Activity priorities:**

- continue to reduce smoking prevalence
- continuing to encourage and enable the uptake of influenza and pneumococcal immunisations amongst vulnerable residents

### **Diabetes**

The most significant problem in diabetes is not the symptoms caused by inappropriate amounts of sugar in the blood but the damage that this does to the inner lining of blood vessels and thus to the blood supply to vital organs in the body. Diabetes is a significant cause of morbidity: it increases the risk of death from cardiovascular disease as well as the risk of kidney failure and of blindness. Diabetes is now becoming more common in children and adults because more people are now overweight and obese.

Diabetes is more common amongst Asian and Black Caribbean people with a higher prevalence in women. <sup>xv</sup>

#### **Diabetes commissioning priorities:**

- address lifestyle risk factors that increase their likelihood of developing diabetes
- identify people with diabetes and impaired glucose tolerance ('pre-diabetes')
- increase the proportion of people with diabetes in whom the last HbA1c measurement in the last 15 months is 7.4% or less
- enable people with diabetes to manage their own condition more effectively
- maintain the current high coverage of diabetic retinopathy screening

#### **Priority activities:**

- increase awareness of lifestyle risk factors for developing diabetes
- encourage people at risk of developing diabetes to undergo regular health screenings

---

<sup>xv</sup> Department of Health (1999) *Health Survey for England*

## Mental Health

Mental health problems are common and are the commonest cause of death and years-of-life lost through disability.<sup>8</sup> At any time, one in six of adults can be expected to be experiencing mental health problems<sup>9</sup> and to require medical, psychiatric nursing or other therapist interventions. Nearly one third of GP consultations are related to mental health problems,<sup>10</sup> and over 90% of people with mental health problems will receive care in a primary care setting.<sup>11</sup>

People with mental health problems are also more likely to die prematurely, discounting suicide deaths. This is principally because they are more likely to smoke tobacco. Reducing the stigma of mental health problems and providing support to promote good mental health will benefit a large proportion of Barnet's population.

Schizophrenia is diagnosed more commonly in people of Black Caribbean origin than in people from other ethnic groups.<sup>12</sup> Rates of suicide and deliberate self-harm are higher among young Asian women than in the White population.<sup>13</sup> Dementia rates are expected to rise significantly in Barnet between 2008-2013 if vascular diseases are not managed effectively in the middle-age spread population.

### **Mental health commissioning priorities:**

- prepare for the increased need of dementia related services
- identify common factors for people receiving mental health services who attempt or succeed killing themselves

### **Priority activity:**

- reduce smoking levels amongst people with mental ill health

## Obesity

Obese adults are at a greater risk of premature death and more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders. Overweight is defined as a body mass index (BMI) of 25 and over<sup>xvi</sup> and obesity as a BMI of 30 and over. People with a BMI of 40 or more are referred to as being 'morbidly obese'.

Overweight and obesity is becoming an increasing problem in Barnet, as elsewhere and, as a lifestyle choice that adversely affects health, is second only to smoking as a significant avoidable risk factor for poor health and premature death. Enabling people to avoid becoming

---

<sup>xvi</sup> The body mass index (BMI) is calculated by dividing the weight (measured in kilograms) by the square of the height (measured in metres). Whilst waist circumference and skin-fold thickness are alternative ways of measuring overweight and obesity, the BMI is a simple and consistently reproducible way of doing so and thus is a more appropriate mechanism for screening and monitoring

overweight and obese and supporting those who do to lose weight is a key health improvement need in the borough.

Both men and women in lower socio-economic groups are more likely to be obese than those in professional occupations. In terms of differences between ethnic groups, Asian children more likely to be obese compared to White children, and Black Caribbean women have obesity levels much higher than the national average, as do Pakistani women, albeit to a lesser extent.

#### **Obesity commissioning priorities:**

- Identify and target people at increased risk of CVD who have not been able to self-identify
- work with local employers to support their staff to (i) be healthier at work and (ii) identify the established health risks associated with smoking, obesity, high blood pressure
- work with schools through the Healthy Schools campaign to increase awareness of the long-term benefits of healthy eating and exercise
- establishing ways for GP practices and acute and community sector providers to identify people with obesity and to support them in managing their obesity
- expand services to support families with obese children

#### **Priority activities:**

- target groups more likely to be overweight or obese to identify and manage risk factors for cardiovascular disease
- establish signposting services for health and social care professionals to refer people if they are obese

### **Sexual Health**

Sexual health is an important aspect of physical and mental well-being. Poor sexual health can have a long-lasting and severe impact on people's lives, for example through unintended pregnancies and abortions causing physical disease and curtailing educational, social and economic opportunities; sexually transmitted infections and HIV/AIDS; ectopic pregnancies leading to infertility; cervical and other genital cancers; and hepatitis, chronic liver disease and liver cancer. Practicing 'safe sex' is the simplest and most effective way to maintain good sexual health. Teenage pregnancy rates are very low in Barnet and therefore not regarded as a commissioning priority.

Planning sexual health services is reliant upon an understanding of the cultural and faith beliefs of different communities and how this influences attendance at GUM clinics.<sup>14,15,16</sup>

### **Sexual health commissioning priorities:**

- increase the provision of sexual health services in GP practices
- ensure sexual health services (including sexual health promotion and sexual relationship education) are designed to increase access by people from different ethnic and religious backgrounds

### **Priority activity:**

- increase the number of young people screened for genital Chlamydia infection

## **Drugs and Alcohol**

Garden Suburb (15.5%) and High Barnet (15.8%) record higher rates of alcohol consumption in comparison with Burnt Oak (10.9%) and Colindale (10%). Compared to England and London averages, Barnet has a lower rate of admissions to hospital for alcohol specific conditions for both men and women.

Drug use in Barnet is varied across different communities with a range of substances used. Barnet Drug and Alcohol Team have identified a number of commissioning and activity priorities to support drug users and their families. A significant proportion of current treatment users are from Farsi speaking communities

### **Drug and Alcohol commissioning priorities:**

- Establish clear pathways for accessing service users into employment, education and training
- Use the Community Peer Education Plan to support different communities manage substance misuse within their communities
- To improve retention/effective engagement rates for under 25 year olds who require adult drug treatment.

### Section 3 – Experiencing health and social care

**This JSNA is about putting people first not institutions. Listening to the voices of users of health and social care services as they share their experiences is vital to promoting health and well-being, but in Barnet we know it is even more important that our residents and users feel listened to. Showing this is hard – but by listing examples of achievements and positive outcomes we hope that everyone who has contact with our health and social care services is treated with dignity and respect.**

In this section we have summarised some of the feedback received from residents and patients on their experience of using health and social care public services. Set against this feedback are the challenges facing the borough in supporting people to manage a range of long term conditions.

#### Surveying the perceptions of health

We have used a broad range of information to help us understand the perceptions and experiences of service users. Eight survey sources were used to capture the perceptions and experiences of users and receivers of health services:

- Barnet Citizens' Panel – Public Health Report (London Borough of Barnet 2006)
- TellUs2 Survey (London Borough of Barnet 2007)
- A report on the Health Related Behaviour of Young People in Barnet (School health Education Unit 2007)
- 'You're Welcome' Young People's Participation Pilot<sup>xvii</sup> (DCLG 2008)
- Better Health in Barnet (Barnet PCT 2008)
- Healthcare in London (Ipsos Mori 2008)
- Delivering Better Health in Barnet – "Your NHS, Your Money, YOU help Decide" (Barnet Primary Care Trust 2008)
- Barnet Citizens' Panel – Private Healthcare (London Borough of Barnet 2008)

#### **Emerging trends from the data revealed the following perceptions:**

A belief across all communities that health had deteriorated significantly since the previous survey in 2000

- 35-44 year olds were most likely to rate their own health as (very) good (85%) compared to 63% for those aged 18-24 years and 59% for those aged 55+. None of those aged 18-24 years rated their own health as being (very) poor

---

<sup>xvii</sup> DCLG – Department for Communities and Local Government

- Respondents of “White” overall ethnicity (73%) were more likely than respondents of “Non White” origin (59%) to rate their own health as (very) good
- Respondents without a disability (76%) were almost twice as likely to say their health was (very) good, as compared to respondents with a disability (39%)
- Of those respondents (31%) who said they would like to mention any specific health problems they have, the top five health problems were:
  - Arthritis (19%); High blood pressure (18%); Asthma/Hayfever (14%); Back Problems (12%) and Mobility (11%)
- The top five issues were believed to have the most beneficial impact on health conditions were:
  - amount of exercise (59%); Food you eat (54%); Fresh air (43%); Making it easier to get healthcare (32%) and Situation at job and Standard of living (both 28%)
- Explanations for deteriorating health included:
  - Taking less exercise; increased pressure at work, increase in stress levels generally; weight increase/eating too much/wrong foods eaten; onset of old age

### Experiencing Adult Social Care and Support Services

Health and social care needs of the adults identified within these sections cost approximately 70% of the total health and social care spend in England.

Longer term estimates indicate that this figure is set to rise dramatically. By 2022 public expenditure on social care alone will rise by 94% to £15.9 billion. Such is the financial pressure of the changing demographic of need for the groups of people identified in this section, the government has called for a review of how long term care is funded, as the current arrangements will not be sufficient to respond to the significant increase in need.

### Who might require social care services?

We have already established that Barnet’s population is healthier and living longer than the national average. We expect this trend to be reflected in the disabled population. Using the Projecting Adult Needs and Service Information System (PANSI) prevalence model, we estimate an 11% increase in prevalence for learning disability and mental health client groups and an increase of 17% of people with a moderate of physical disability in Barnet.

Prevalence levels are increasing nationally. Barnet Adult Social Services predicts an increase in the number of disabled people known to health and social care, as more young disabled individuals with complex health needs survive childhood and complete their transition from the Children Service to Adult Social Services. In addition, prevalence rates of learning disability are higher amongst the south east Asian community which is set to increase within Barnet.

Currently Barnet has the second largest population over 65 and over 85 in greater London. Older people are more likely to suffer from chronic and long term conditions and are also more likely to suffer from falls / fractures bringing them into contact with health services, but continuing their rehabilitation and convalescence elsewhere. It is vital these episodes of acute/ medical treatment are used as opportunities for people to improve their ability to look after themselves and therefore return home safely.

**Cancer** continues to be the second biggest cause of death and the biggest cause of premature death (i.e. deaths in persons aged under 75 years) in Barnet. Deaths from cancers account for almost 40% of all premature deaths (under 75 years) in the borough. Overall, lung cancer is still the most common cause of premature deaths from cancer in Barnet, although rates are still lower than the England average. Nevertheless, prostate cancer has now overtaken lung cancer as the most frequently reported cancer among men. Breast cancer remains the most commonly reported malignancy among women.

The fall in overall death rates from cancer in the most deprived electoral wards (reduction of 8%) has not been as marked as that in the more affluent electoral wards (reduction of 32%). Furthermore, despite an overall reduction in death rates from coronary heart disease, death rates for people aged under 75 years in medium deprived wards (i.e. West Finchley, Golders Green, Hale, Hendon, Brunswick Park, Child Hill and Edgware) have increased slightly and death rates for people living in the seven most deprived wards are worse than the national average.

<b>Organ</b>	<b>Total number of deaths over 4-year period 2004-2007</b>	<b>Average number of deaths/year (rounded)</b>
<b>Lung</b>	575	144
<b>Colon or rectum</b>	293	73
<b>Breast</b>	234	59
<b>Prostate</b>	169	42
<b>Bladder</b>	49	12
<b>Cervix</b>	16	4

Source: Office for National Statistics Annual District Mortality Data

### **Social care and support services in Barnet –activity, demand and trends**

During 2007/08, Barnet Adult Social Services dealt with 6119 referrals for adults of which over 3400 resulted in assessments of individual need. This activity has increased steadily over the last 5 years for each of the care groups, however with a decrease in 2007/8.

In common with the national picture for local councils, Barnet Adult Social Services has developed filtering mechanisms for screening people at the point of referral to ensure that the most vulnerable are eligible for social care. There has been greater reliance on the voluntary sector to offer low level support and interventions where direct referral by the council is not necessary. What is not fully known is how people with ‘low or moderate needs’ are able to get their needs met and what level of unmet need there is in the general population. It is important that more is known about the consequences of unmet need both in terms of assessing the outcomes for those individuals and their families, and in terms of predicting the

numbers of adults who may develop care needs which are 'substantial and critical' over the next 10 to 20 years and where an earlier intervention may have prevented referral to social services, acute or specialist care for longer.

### Housing care and support

The traditional definition of care services is changing. Referrals from housing services to Adult Social Services is rising, reflecting the need for suitable accommodation for disabled and vulnerable adults as highlighted by the Housing Needs Survey 2006 mentioned in Section 1.

21.4% of all households in Barnet with older people tend to have one or two persons only. This number is expected to rise through the 'Choice and Independence' programme with older adults being supported to remain in their homes with aids and adaptations provided through a range of public service providers.

Housing related support funded through the Supporting People programme is focused on maintaining independence and supporting stable accommodation arrangements for adults in the community who experience a range of difficulties including disability, mental health problems, domestic violence, substance misuse and homelessness. There has been a recent rise in the numbers of people supported through these arrangements. The Supporting People activity data reveals total of 1446 new client record forms were received for 2007-08, an increase of 479 on last year's figure of 970, and an improvement of 49%. The overall number of new service entrants in Barnet was 55% higher than the London borough average although Barnet receives 20% less SP grant than average. These figures reflect increasing volumes of people from a range of groups receiving short term support; where 79.5% of the client record forms were for floating support (the support goes to where the need is) in Barnet compared to a London average of 45.6%, however this should be set against 4.2% for supported housing (support is linked to specific housing options) in Barnet against a London average of 31.4%.

### Trends in Social Care Service Delivery

Volumes of service provision are only one indicator of level of needs and of the costs of meeting that need. There has been a general rise in the complexity of need for individuals who are referred to social services and living at home. This is due in part to people with long term conditions living longer and general increases in life expectancy. This has a knock on effect to the care homes who are now meeting much higher levels of need.

The pattern and delivery of community provisions has changed significantly in Barnet and reflects an increase in professional support, Direct Payments, community equipment and breaks for carers. More data is required about patterns and use of services including changes in the lengths of stay in care homes and particularly about the impact of changes in health provisions and the impact on demand for social care services.

### Care Market in Barnet

Most people receive care and support through informal arrangements through their families and households. Long-term cares are especially vulnerable to physical and mental ill health which creates an individual personal burden, increases demands on health and social care services and undermines the viability of informal care arrangements. In addition to informal care, the care market in Barnet is dominated by residential care, much of which is accessed by people originally resident outside the borough.

The latest demand analysis for residential care purchased by the Local Authority and local Primary Care Trust combined is under 50 per cent of the total available for older people. The proportions are higher for younger adults.

There is a need for more self contained accessible housing with 24 hour support and access to good quality homecare services which can support younger and older people with complex care needs. This has been reflected within the Barnet LAA in respect of people with mental health needs known to secondary mental health services.

### Personal Dignity and Respect

The experience of abuse and neglect is likely to have a significant impact on a person's health and well being. By its very nature, abuse – the misuse of power by one person over another – has a large impact on a person's independence. We know that neglect can prevent a person dependent on others for their basic needs exercise choice and control over the fundamental aspects of their life and experience humiliation and loss of dignity.

Vulnerable adults in receipt of social care services experience a higher prevalence of abuse and neglect than the general population, however referrals to our Safeguarding Team have been lower than expected for the population of Barnet. During 2007/08 there were 258 people referred under the Barnet safeguarding arrangements with the majority of referrals made in regard to older people – almost 14 times higher than for learning disabled people which were the next highest referral group.

Levels of referrals into the Safeguarding Team have been lower than expected for the population of Barnet. In 2007/08 with targeted focus to improve Safeguarding arrangements levels of referrals are moving more in line with what would be expected. During 2007/08 there were 258 people referred under the Barnet safeguarding arrangements. The following table sets out the source of the referrals and the types of alleged abuse.

## Safeguarding referrals per client group for 2007/08 per 10,000 18-64

	Older People	Learning Disability	Physical and Sensory Impairment	Mental Health	HIV/AIDS	Drug service users	Carers
Barnet	28.59	2.97	1.58	1.48	0.00	0.10	0.00
IPF	41.36	3.32	1.24	1.46	0.02	0.05	0.06
England	47.34	4.80	1.94	1.96	0.01	0.11	0.10

## Total Number of safeguarding referrals were made by 'No Secrets' MAPP partners in the NHS, Police, Housing, Probation, Criminal Justice services and CSCI in 2007-08

	Barnet	IPF Data	England (Average)
NHS	52	32	50
Police	2	5	21
Housing agencies.	8	5	10
Probation and criminal justice.	0	0	6
CSCI.	2	4	10

### Linking Demand and Overall spend

The gross expenditure for Barnet Adult Social Services has increased above inflation levels reflecting the Council's commitment to the corporate plan priority of 'Supporting the Vulnerable.' The gross spend on Barnet Adult Social Services has increased by 25% over the five year period 2003/04 to 2007/08, an actual gross spend increase of over £22 million. The actual increase on demand for a social care service in the same period was a 32.5% increase.

The breakdown of this total spend for Adult Social Services over the last 5 years reflects the changes to the pattern of care provisions. There is a significant decrease in the proportion of expenditure on residential care and increased spend on community based services. This increased spend is partially explained through increased number of community packages, but is also linked to the costs of meeting more complex needs in the community. This trend of increased costs of community packages has been influenced further through personalisation as older people are receiving more intensive home care packages as an alternative to residential care.

Work has been undertaken to project the future costs for adult social care based on current patterns of demand and spend and population growth. This has been estimated as being £43

million over the next 10 year period over and above standard increases for inflation if patterns of service delivery remain unchanged. In the context of a difficult economic climate across the United Kingdom and the challenge for social care funding given the worsening dependency ratio as set out in the Government's consultation on the future of social care, this level of funding increase cannot be sustained. The responsibility between the state, citizen and family in the provision of social care over the next 10 years will need to be fundamentally redefined.

### User Experience of Social Care

If the future delivery model for social care needs to be set in the context of redefining the roles of the individual, family and state, it is important to understand the views of the local people in Barnet who are in receipt of social care services or potential customers in order to inform future plans.

On an annual basis, Adult Social Services conducts a user satisfaction survey to examine the experience of service users in a particular area of service. Consistent themes emerging included:

- People wanted to be kept informed about their care at different stages of service delivery
- Once a service had started, people didn't want delays or interruptions
- Recognition that people receiving social care feel more isolation and need support in gaining greater control over their lives
- Improved signposting about the range of services and opportunities available
- Better support for accessing different employment entry levels

Between September and November 2008, the London Borough of Barnet facilitated a public discussion on the strategic proposals to change assessment and care management practice to give people more choice and control through personal budgets.

- People appeared to see the benefit of introducing short-term 'enablement' packages of care
- People had a balanced view of the advantages and disadvantages of personal budgets.
- There was support for the Council's proposal to support people to plan their own care using a range of support mechanisms including family, friends, 3<sup>rd</sup> sector organisations, and health professionals.

## Hospital Acquired Infections

The Healthcare Commission (HC) is the independent watchdog for healthcare in England. HC assess and report on the quality and safety of services provided by the NHS and the independent healthcare sector. Infection control is one of the core assessed standards.<sup>xviii</sup>

The HCC monitors trusts on [Methicillin Resistant Staphylococcus Aureus \(MRSA\)](#) infections and [Clostridium Difficile \(C.Diff\)](#).

In Barnet there has been an annual decrease in hospital acquired infections by patients.

### Pressures on hospital service provision

A key element of ensuring robust financial planning in the medium and long term is to shift the focus to prevention rather than cure. The PCT needs to ensure that it spends its limited resources in those areas which demonstrate the best outcomes to ensure maximum value for money. Again there is a clear synergy with the PCT's focus on health improvement and reducing inequalities. Value for money is therefore defined in terms of economy, efficiency and effectiveness.

A key financial risk is the acute activity growth which has often exceeded the growth in resources. This has been exacerbated by the need to invest in the achievement of the 18 weeks target, the additional activity that has been seen due to higher referrals that are the consequence of the reduction in waiting times, and the increasing expectations of the population which can be managed through community based health programmes.

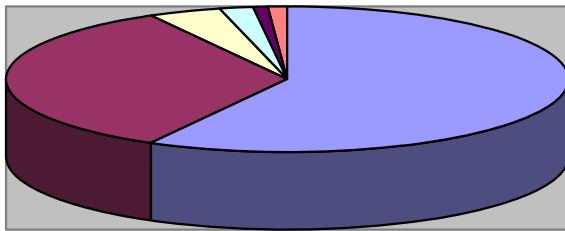
The demand for emergency and unscheduled care has risen considerably nationally. This has been recognised by Government who are exploring new models of delivery.<sup>xix</sup> The proportional activity flow in Accident and Emergency departments, where Barnet residents have received such care and then been admitted to a ward are Barnet & Chase Farm Hospitals and then the Royal Free Hospital.

---

<sup>xviii</sup> **Core Standard 4a:**

“Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).”

<sup>xix</sup> Department of Health (2004) NHS Modernisation Agency- *Right Skill, Right Time, Right Place* COI Communications Department



The proportional activity flow in A+E departments, where Barnet residents have received A+E care and then been admitted to a ward

### Financial implications for targeting health improvements

Financing the targeted health improvements set out in this JSNA is expected to cost Barnet public services on average £1.8m per year over the next three years with the most significant increases for immunisations, Chlamydia screening and smoking cessation. Investment in Adult Social Services will also increase significantly as set out in the next section.

It is important to recognise that many of the new drugs developed to treat cancer do not cure but can, in some instances, prolong survival times. However, not all prolong survival by much, and many are very expensive. A balance has to be struck between the wants of individual patients and their relatives and the needs of the wider population: sometimes the needs of the wider population conflict with the needs of individuals, and the NHS has a duty to use public money to the maximum advantage of the maximum number of patients.

### Service Prioritisation

The experience of local authorities and the NHS is that the demand for services, and the potential to provide them, has always exceeded the resources available to provide them. (e.g. money, staff time, buildings, equipment, supplies) Furthermore, advancing technology brings new expensive drugs and equipment to the market, which competes on budgets which are already stretched. It has thus always been necessary to restrict service provision, and thus to determine which services are most important, to enable the greatest good for the greatest number<sup>xx</sup> Put another way, sometimes the needs of the wider population conflict with the needs of individuals.

---

<sup>xx</sup> "The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. *At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*" [Emphasis added]

A similar situation can arise when an expensive treatment or service may possibly produce some benefit but only for a relatively limited time or at very high cost. However, more people may gain greater benefit if the same money or other resources were used for other purposes, even if that may not be in the best interests of an individual or smaller group of people. This concept has been tested in [cases within English law courts](#).<sup>xxi, xxii</sup>

Barnet PCT uses a [Framework of Principles](#) to balance the principles against each other, when determining what are the most appropriate health services and treatments that it gives priority to for both the populations we serve and for individual patient treatment requests.

An example of where a [commissioning and decommissioning](#) decision has been made using the framework of principles was when there was an increase to access “level 4” community based cardiac rehabilitation services, by people who had a heart attack, so that it would reduce their risk of having another one. However, a decision was made to stop certain NHS funded exercise schemes where there was significantly less evidence of benefit of using the service.

With a likely worsening of the national and international economic situation, Government funding for health and other local services will become more restricted and thus necessitate the further limiting of treatments and services to ensure that the greatest benefit can be had by the greatest number within the resources available.

## Key Messages

- More people will be living with long term conditions presenting a range of challenges in terms of delivering care and support needs within limited resources
- The health and social care system is transforming from providing institutional care towards care closer to home with new options emerging.
- This service transformation will test traditional investment practices requiring a shift towards being able to develop choices for people with care needs to remain independent yet prevent excessive demand on acute and specialist services.
- There is a central challenge in how to manage wider population needs against local needs
- Decisions must be taken more regularly about complex and often initially costly (but perhaps also more cost effective) treatments and care opportunities.
- Investment in wellness as a prevention strategy requires good local intelligence which links across health needs and social care and support needs.
- Improving data quality and using data intelligence to inform resource allocation must remain a priority

---

<sup>xxi</sup> Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995]

<sup>xxii</sup> *R v NW Lancashire Health Authority, ex parte A, D&G* [1999]

- The traditional definition of care is being expanded through systematic links to housing and accommodation with increasing recognition of the impact of design on supporting health and well-being.
- Progress being made in housing strategies in Barnet, particularly on improving quality, increasing capacity in the private rented sector for those on low incomes, reducing the use of temporary accommodation and linking housing with health promotion strategies has a beneficial impact on health and therefore on demand for social care.
- Future prevention strategies will need to 'reach out' to wider sections of the different communities in Barnet if more equality in health outcomes is to be achieved.
- The picture of future demand presents an ever growing financial burden both to the health and social care system as well as individuals, carers and families.
- Barnet PCT and Barnet Council must prioritise services to provide proportionately more services to those in greater need in order to reduce inequality.

## Section 4 - Investing in independence

**This JSNA will provide evidence of how we can deliver an integrated and well-developed health and social care service for all. At present there are four commissioning strategies developed by BPCT and LBB to promote choice and maximise independence for vulnerable adults. These will be combined into a future health and social care commissioning framework which has been informed by our JSNA.**

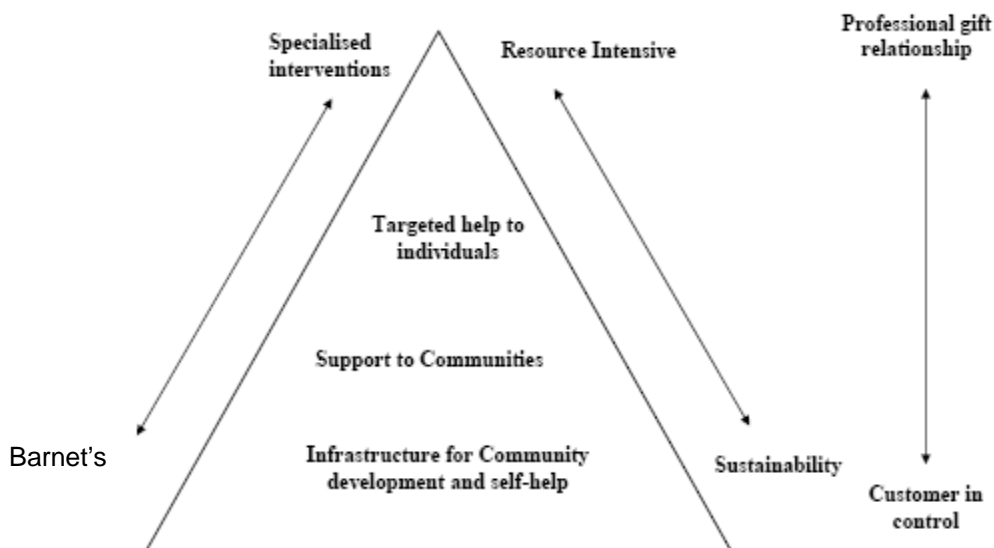
Our ideal society is one where Barnet residents are doing things for themselves, where they define the problems they face and play a role in tackling them. As public authorities we want to have minimal interference in peoples' lives and respect their private autonomy as citizens by building resilience and responsiveness to unexpected challenges through our role as commissioners committed to delivering the best possible outcomes for all.

### Overview

Managing public resources to improve accessibility and quality of care will become an ever greater challenge as the population in Barnet continues to expand and change. National policy is geared to ensure individuals and communities can support their own care as much as possible and stay free from illness for as long as possible. Local agencies are required to use what we know about what keeps people well as a basis for future investment, in particular to make a shift to a more collaborative model where people and communities can become empowered to become active participants in their own well being.

The challenge in Barnet is reflected nationally and led to the Government publishing a paper to set out the future direction of social care for all adults of all age groups in England in 2009 building on the concordat 'Putting People First' which has provided the framework for the personalization of adult social services.

Barnet Council and Barnet PCT need to work with local communities to develop support through easily accessible networks which will help promote health and well being and prevent isolation and loss of independence. Using the model below taken from 'All our Tomorrows' Empowering individuals and communities to maximize wellness, prevent ill-health and to make the best use of health and social care services through:



## The invaluable contribution of informal carers to meet needs

Carers provide a great deal of unpaid care in the community. The 2001 Census 2001 identified 28,000 (self-reported) carers in Barnet, of which approximately 1,000 are aged under 18 years. Nearly 60% of all carers are women, with 78.4% being of working age. In addition, almost 2,000 are above 75 years of age, providing over 20 hours of care per week. The wards with the highest number and proportion of carers are Edgware, East Barnet, Hale and Oakleigh.

For the increasing number of people living longer in their own homes, with shorter hospital admission times, we can expect for there to be a greater impact on families and informal carers in respect of caring responsibilities. In addition as Barnet is a diverse borough, black and minority ethnic carers are among the 'hidden' carers and this brings the requirement to ensure that carers support is culturally sensitive and competent in order to 'reach out' across all sections of the community

## **Community based health programmes**

Community based health programmes can target those in greatest need and reach out to all sections of the community.

These can be supported and enhanced by continuing to improve universal access to advice and information by continuing to modernise access points and using local intelligence to map the different ways people approach services for help.

For those who need long term care or support due to age or disability:

- Implement self care initiatives which support people to manage their own conditions and live independently
- Continue to increase the capacity of local housing stock to deliver suitable accommodation for people with long term conditions
- Changing models of investment by changing existing services to promote and strengthen independent living.

Whilst the issues identified above equally apply to all care groups, these need to be applied with understanding of the specific needs and issues relating to the different groups of people with long term health and social needs. The following sections set this out in more detail and should be read alongside the four integrated commissioning strategies. These documents set out how health and social care will invest and disinvest in services to meet the needs of the people of Barnet.

## **Long term conditions**

The number of people in Barnet with long-term conditions is likely to increase. If this is not managed effectively, it will put an increasingly strain on health and social care services.

Long term conditions are health problems that require ongoing management over a period of years or decades. This includes a wide range of conditions including non-communicable diseases such as cancer and cardiovascular disease, communicable diseases (e.g. HIV/AIDS), certain mental disorders (e.g. schizophrenia, depression), and ongoing impairments in structure (e.g. blindness, joint disorders).

On average, 80% of GP consultations in Barnet are with people suffering from long-term conditions. Furthermore, about two thirds of patients admitted to an acute hospital with a medical emergency are admitted because of a long-term condition and 60% of hospital bed days relate to long term conditions.

Long term conditions generally develop in people aged 45–64. Therefore with the projected increase of people in this age group in the coming years in Barnet, it is expected that there will be also an increase in the number of people with long-term conditions. For example, it is estimated that just under 59,000 people over 60 years of age are affected by a mental health disorder in Barnet, a number which is projected to increase to just under 65,000 by 2016.

Furthermore, Barnet already has an over-supply of care home beds, based on a national comparison. This means that more people over the age of 65 than average move into the borough to take up care home placements. If this continues it will have a potential impact on social services and PCT health revenue budgets. Support to people with long-term conditions in Barnet's care homes could be at the expense of more investment into primary and community based services for local residents.

### **Palliative Care**

In 2007/08, there were 2,417 people who died in Barnet of which 59% die in hospital, higher than the national average. Research commissioned by Marie Curie Cancer Care found that most people would like to be cared for, and die, at home if they had a terminal illness.

#### **Palliative care commissioning priorities:**

- Barnet citizens to experience a dignified death, in the place they choose, including their home.
- Patients diagnosed with chronic conditions, not related to cancer, such as respiratory diseases are less likely to receive palliative care. This is because the terminal phase is difficult to identify.
- Provision of palliative services in Barnet can be fragmented and lack coordination. The palliative care service needs to be improved.

### **Finding the 5000**

Mortality data for Coronary Vascular Disease (CVD) indicates that death rates, for those under 75 years, are higher in people who live in social housing. It was found that 87% of such households were registered with a GP close to a high deprivation area and that 21 GP practices have between 10 - 48% of their patients living in these households.

Quality and Outcomes Framework (QoF) data in these GP practices show that most are achieving above-maximum threshold performance in terms of controlling, for example, blood pressure. Put another way, QoF data suggest that these practices are providing good quality care for all those patients with an established disease that increases the risk of heart attack or stroke. It is thus most likely that higher CHD death rates amongst those living in more deprived areas reflect higher levels of unrecognised and/or unmanaged CHD and stroke risk factors.

With help from Pfizer Ltd, we have obtained *Health Acorn* data and used this to model various characteristics of the populations in these areas. Modelling with these data suggests that there are many more people in these practices who are smokers and/or who are obese than is currently recognised. Put another way, in these practices there is likely to be a large number of people with unidentified and thus currently unmodified risk factors for CHD and stroke, such as smoking, hyperlipidaemia, pre-diabetes, diabetes and hypertension.

The ethnic makeup of the people registered in these practices also differs from the Barnet average. This is relevant because (i) people in different ethnic groups can have different likelihoods of developing certain conditions, such as diabetes and high blood pressure, and (ii) people in different ethnic groups have different beliefs and cultural values and behaviours that require different approaches if we are to engage them effectively in reducing vascular disease risk factors.

It is important to note that the expected prevalences of risk factors are modelled; they do not represent actual data for individual people. However, they tend to corroborate our hypothesis that higher CHD death rates amongst people living in the more deprived parts of the borough are probably due to unrecognised and/or unmanaged CHD and stroke risk factors.

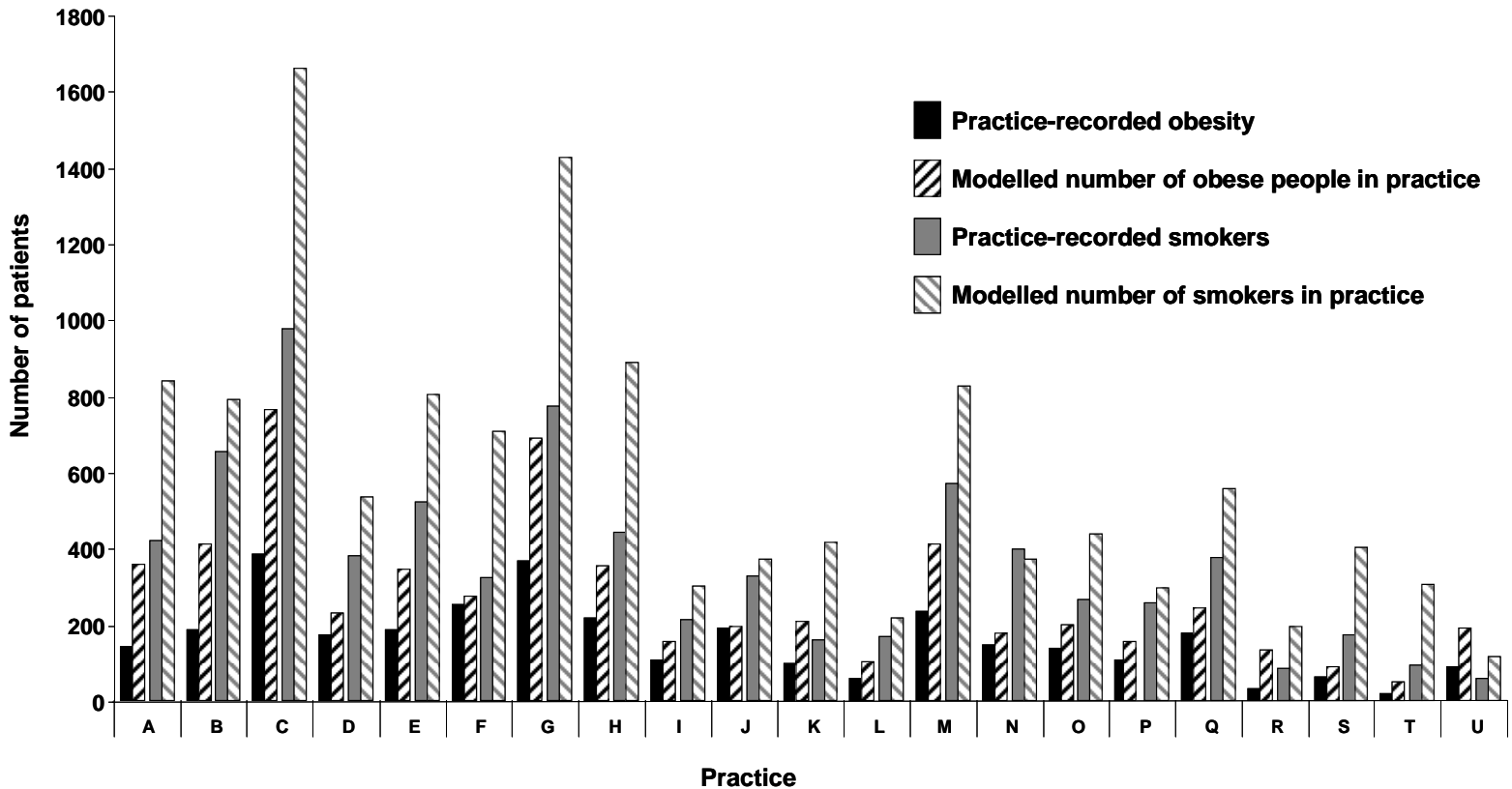
We also think it likely that the majority of these people do not visit their GP surgery. We therefore need to find ways to engage them individually in the community identify those at risk (e.g. by measuring their blood pressure and body mass index and identifying smokers) and encourage and enable them to attend their GP surgery for management. We therefore also think it likely that many of these people will not yet have identifiable disease, such as diabetes or a history of heart attack or stroke.

Barnet has been selected as a pilot site by the London Social Marketing Group (engaged by NHS London). In collaboration with Pfizer Ltd and Barnet Council, we are currently undertaking a social marketing research exercise with two companies, TNS and *thinkpublic*.

The TNS work is concentrating on issues such as:

- do people recognise health risks? What is important? What is not? What matters to them in health terms?
- what might influence them to see health as an important issue (especially in terms of heart disease and stroke and in relation to smoking and problems like raised blood cholesterol, diabetes and high blood pressure)?
- what might influence them to have aspects of their health checked? and
- where might they go for such checks?

## Comparison of practice-recorded and modelled number of patients with obesity and who smoke



The **thinkpublic** work is looking to:

- explore the lives of people at risk from vascular problems in relation to accessing support services;
- identify the reasons why these people do not access the vascular check service;
- aim to identify how people internalise Barnet’s existing messages and the drivers behind the target audiences’ behaviours;
- explore different approaches to communicating with the target audience; and
- produce a clear set of recommendations for Barnet’s social marketing campaign.

*What needs to be done do next?*

This market research will be used to inform pilot work with the London Social Marketing Group and the PCT working collaboratively with Barnet Council. This will probably include activities such as:

- leaflet drops in specific streets targeted at the population segments most likely to be living there;
- letters to individuals, probably through or on behalf of their GP surgery, inviting them for a health check;

- posters at bus stops, on the back of public toilet doors (e.g. in pubs and shopping centres) and elsewhere, targeted at the population segments most likely to be living/working/going there, publicising the issue;
- publicity in public places, e.g. supermarkets, shopping malls, targeted at the population segments most likely to be going there, publicising the issue;
- posters in GP surgeries and community pharmacies, targeted at the population segments most likely to be attending there, publicising the issue;
- publicity in work places, e.g. Barnet PCT, Barnet Council, public transport depots, targeted at the population segments most likely to be working there, publicising the issue; and
- advertorial in local papers and, as may be possible, items on local radio, publicising the issue.

This will be a long-term project and, depending on the outcomes of working with those in the most deprived areas in Barnet, will need to be extended across the whole borough.

Understanding our population is the first step to being able to improve health and well-being and promote healthy choices for individuals to make healthy choices to lead healthy lives.

#### **Next steps:**

We need to undertake more data analysis to identify the number of smokers known in each practice. From this, and each practice's current stop smoking activity, we can estimate how many additional people might be enabled to quit. This work should enable us to develop individual practice profiles of registered patients with CVD risk factors.

Develop a 'local enhanced service' (a local addition to GPs' NHS contracts) to:

- Identify individuals who have CVD risk factors
- manage these risk factors to pre-determined levels
- develop appropriate social marketing packages to target information appropriately and effectively

#### **Learning Disability - Predicting Need**

We know that the number of people with a learning disability in Barnet is set to increase over and above simple population increases and with that the number of people who will need health and social care services. Demographic trends on their own do not account for the anticipated significant increase in demand for Learning Disability Services.

Other factors include:

- A higher prevalence rate among some immigrant population groups, such as those originating in South Asia where rates of learning disability are significantly higher. Rates of learning disability amongst South Asians aged between 5 and 32 are up to three times higher than in other communities. Of the South Asian families caring for family members with a learning difficulty, 19% had more than one member with a learning difficulty.
- Increasing diagnosis of autistic spectrum disorders
- Increases in foetal alcohol syndrome linked to an increasing use of alcohol in the UK
- People with a learning disability are living longer - between 2001 and 2011, there will be an increase of between 10% (aged 50-59) 34% (aged 70-79).
- Increased survival rates among young people with severe and complex disabilities

Chronic illness or disability such as epilepsy, diabetes, circulatory disease, sensory problems and coronary heart disease and stroke as well as the other age related disabilities are 2.5% more common than in the general population. Lack of early intervention/detection results in deterioration of health problems and contributes towards shortened life expectancy.

### **Responding to changing needs**

Over the last six years since the publication of Valuing People, Valuing People - A New Strategy for Learning Disability for the 21st Century, 2001 we have made significant improvements to supporting people to live well in their community. The outcomes of this can be seen in people living longer, living more independently and having increased choice and control. However needs continue to outstrip resources despite as care costs have risen.

The biggest challenge is how to provide for increasing demand whilst making services person centred and keeping them within the resources available and on a path of steady performance improvement. We believe this can be achieved through personal budgets across the learning disability service and other public sector areas.

### **Delivering Learning Disability Services**

- Health as well as social care services will need to ensure access to preventive health services is available so that chronic health problems, associated with learning disabilities, can be reduced and or treated effectively.
- Move away from a traditional model of using registered care to one of providing self-contained accommodation particularly for young people coming through transition within Borough.
- There needs to be an expectation of that people with a learning disability will move into employment and schools.
- Health and social services need to work together to develop appropriate joint packages of support for people especially for people with challenging behaviours and complex needs and as people age. High cost out of Borough residential placements are no longer the answer.

- Health facilitation offers people from all care groups to have equitable access to healthcare services.
- The increased levels of demand in the absence of significant growth in budgets will require alternative patterns of service delivery to be established.

### Mental Health – predicting need

People with good mental health are more likely to be, and remain, in work and be financially independent. In Barnet there are 4,650 people on incapacity benefits related to mental health issues which constitutes 44% of the total number of claimants of incapacity benefits. There is little support when people fall out of employment and people with mental health difficulties are at more than double the risk of losing their jobs. The majority of people who spend more than six months out of work after an episode of mental ill health will never work again. Loss of self esteem and aspiration stops people from continuing their education, getting jobs, making friends and establishing relationships. Often it is the expectation of stigma that stops people leading fulfilling lives and enjoying themselves. People with mental health difficulties often experience discrimination in everyday life. 44% of people with mental health problems surveyed for the Government's Social Exclusion Unit felt that they had experienced discrimination from GPs, while 18% said they would not disclose their condition to a GP. Fewer than 40% of employers say that they would consider employing someone with a history of mental health problems.

### **Delivering Mental Health Services**

The issues that need to be addressed over the lifetime of this Joint Strategic Needs

Assessment in respect of the changes in demand and models of Adult Mental Health

Services include:-

- Support the development of healthier communities and address the causes of poor mental health.
- Increasing choice and control for people with common mental illnesses through Primary Care Based Mental Health Services that can be accessed directly by individuals.
- Increase Choice and Control for people with Severe and Enduring Mental Health difficulties through the delivery of Self Directed Care to promote social inclusion
- Continue expanding early intervention and detection for people with severe mental health conditions, through the delivery of a recovery based model.
- Ensure people have access to a range of mainstream community services which include the development of high quality accommodation and support in people's own homes.

## Physical and Sensory Disability - Predicting Need

Disabled people in Barnet are a significant proportion of the population in Barnet who we know experience poorer life chances and outcomes than non-disabled people. The definition of 'disability' here is taken from the Disability Discrimination Act 1995:

“A physical or mental impairment that has a substantial and long term impact on the ability of a person to carry out normal day to day activities. Included within this definition in Barnet are adults aged 18 plus affected by physical disability, long term illness/ conditions and sensory impairment.”

In Barnet we can expect:-

- 13,785 households in Barnet that have support needs due to a physical disability
- 1890 people with a neurological condition requiring help with daily living
- 4590 carers of people with a neurological condition
- 745 people with acquired brain injury
- 820 registered blind and 730 partially sighted people
- 1485 people who are registered deaf or hard of hearing
- 40% of people with a learning disability also have a hearing impairment

## **Responding to changing demand**

Barnet has adopted the social model of disability. This recognises that many of the difficulties / barriers that arise for disabled people, notwithstanding the fact of their disability, are largely attributable to attitudes and structures in society. The six priorities for action identified in the commissioning strategy are focused on an agenda for change which focuses on inclusion, rights and choice, moving away from specialised service provision towards facilitating access to mainstream services with a strong focus on addressing inequalities. A cornerstone of this is the development of individualized budgets. Another is partnership with housing agencies.

Currently Barnet has the highest number of service users overall receiving Direct Payments. The most recent review of the Direct Payments Advisory Service highlights improved performance and the relatively high number of people from black and minority ethnic backgrounds in receipt of direct payments. The report also shows that the Direct Payments Advisory Service is highly valued by service users evidenced by 98% customer satisfaction. The service has targets including increasing service user involvement in the management and implementation of direct payments and facilitating change and delivery of individual budgets as part of the Delivering Choice and Independence Programme. The outcomes for people using this increased flexibility of care arrangements are clearly demonstrated in the user survey. The high level of Direct Payments and the high value placed on this method by service users are helping to promote the cultural and organisation change required to deliver the overall vision.

## Delivering services for people physical and sensory impairments

- That disability is predominantly a whole community agenda, focused on rights inclusion and choice and moving away from specialist provisions and with a strong focus on addressing inequalities
- Health and social care organisations are developing a commissioning system which supports personalised care
- Access to suitable housing and opportunities for paid employment is key areas for continued development

## Older people - predicting need

According to GLA projections the borough's 80+ population will rise by 13% over the next decade. Within this, the comparatively small 90+ age group is set to increase by 1,100 (46%). Those aged 75 to 79 will decrease by 400. The 40-54 age group will increase by 17,000 (25%).

Accepting that there is a link between income and deprivation which impacts on a range of health outcomes will in turn affect demand for social care. The range of claimants for means tested benefit ranges from a low of three percent in one area to a high of 43 percent in another area together with factors affecting personal wealth including decreases in average savings as a result of changes in pension arrangements and changes in house values that more peoples' working lives will extend beyond the age of 65 which will also affect health outcomes and well-being for older people.

Targeted work needs to be undertaken to ensure supplementary pension benefits are claimed to help reduce depression, poor nutrition, hypothermia and social isolation.

Equality issues are a major theme for older people because as a group their experience of societal discrimination is compounded by other identities including, ethnicity, gender, mental well-being and sexual orientation.

One of our key priorities in the commissioning strategy of older people is to tackle inequalities and social exclusion that lead to poor health and improve access to services for vulnerable people.

The direction of travel over the next ten years needs to ensure a robust continuum of care is developed for older people and to better support them at an earlier stage based on the principle that early intervention leads to better prevention, enabling a much higher level of self managed care. This builds on the lesson learnt from the Expert Patient Programme and research on the benefits of better management of people with long term chronic health conditions.

## Delivering older people services

- Adopting positive approaches to mental health in older people will increase personal independence and reduce reliance on specialist and acute services later on

- The local authority and the PCT have a clear community leadership role in championing older people's positive contributions to society and reduce the stigma and discrimination attached to people becoming older
- Develop inclusive initiatives around health and well being which promote better inclusion for older people
- Promote intergenerational integration which uses the wisdom and experience of older people,
- Ensure episodes of acute/ medical treatment of older people are used as opportunities for people to optimise their functioning and return home safely.
- Develop a carer's strategy and build a better infrastructure to respond to carers' needs
- Encourage older people to access practical help to maintain their homes through the Care and Repair or Handyman services which are critical factors in supporting older people to live in their own homes and promote peace of mind.
- The use of telecare initiatives is growing and needs more research on the impact and in how to use technology to greater effect to empower older citizens. There are still challenges of linking up customer information across different agencies and this challenge will become greater as wider choice involves a greater number of agencies.

### Key messages for investing in independence

- Helping people stay at home for as long as they want to.
- Providing people with good information and advice on how to manage their condition, increasing investment in active rehabilitation and prevention and improving the way that services are delivered
- Improving availability of good quality housing for those on low incomes and those with long term support needs.
- Providing more support for people in short term need to help them maintain their accommodation.
- Improving support for carers

- 
- <sup>1</sup> ONS Revised Pop. Projections 27 Sep 2007
  - <sup>2</sup> Office for National Statistics. <https://www.nomisweb.co.uk/reports/lmp/la/2038431875/report.aspx#tabquals> (accessed 17 November 2008)
  - <sup>3</sup> Office for National Statistics. <https://www.nomisweb.co.uk/reports/lmp/la/2038431875/report.aspx> (accessed 17 November 2008)
  - <sup>4</sup> Bartecchi CE, MacKenzie TD, Schrier R. The human costs of tobacco use (I). *New NEJM* 1994;330:907-12
  - <sup>5</sup> Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *Br Med J* 1994;309:901-911
  - <sup>6</sup> Callum C, White P. *Tobacco in London: the preventable burden*. London Health Observatory. London. 2004
  - <sup>7</sup> Department of Health. *Coronary Heart Disease National Service Framework. Chapter two: Preventing coronary heart disease in high risk patients*. Department of Health. London. 2000
  - <sup>8</sup> WHO. *The World Health Report*. WHO, Geneva, Switzerland, 1999.
  - <sup>9</sup> Office for National Statistics. *Psychiatric morbidity of adults living in private households*. Office for National Statistics, London, 2000.
  - <sup>10</sup> Social Exclusion Unit. *Social exclusion and mental health*. Office of the Deputy Prime Minister. London, 2004
  - <sup>11</sup> Hague J, Cohen A. *The neglected majority. Developing intermediate mental health care in primary care*. The Sainsbury Centre for Mental Health. London, 2005
  - <sup>12</sup> Cochrane R & Sashidharan. *Mental health and ethnic minorities: A review of literature and implications for services in Ahmad W, Sheldon T, Stuart O; Ethnicity and Health*. NHS Centre for Review and Dissemination, Social Policy Unit. Leeds, 1996
  - <sup>13</sup> Bahl, V. *Mental illness: a national perspective*. In *Ethnicity: an Agenda for Mental Health*. Bhugra, D and Bahl, V. Gaskell, London, 1999.
  - <sup>14</sup> National Survey of Sexual Attitudes and Lifestyles II, National Centre for Social Research
  - <sup>15</sup> Sadler KE, McGarrigle CA, Elam G et al (2007) Sexual behaviour and HIV infection in black-Africans in England: results from the Mayisha II survey of sexual attitudes and lifestyles. *Sexually Transmitted Infections* 2007; 83:523-529.
  - <sup>16</sup> Fenton KA et al. Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey. *The Lancet* 365: 1246 - 1255, 2005.