Barnet Joint Strategic Needs Assessment, 2011

Navigational summary

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Foreword

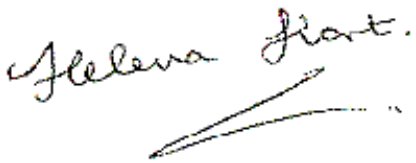
This joint strategic needs assessment (JSNA) is the means by which Barnet Council with NHS partners find out about and describe the current and future health, care and well-being needs of the people of Barnet.

Barnet's second JSNA comes at a time of significant change. Public services face substantial financial challenges whilst demand for public services has risen in recent years and is expected to rise further. As a 'Successful London Suburb' due to regeneration, inward migration, and changes in our population with proportionately more children under the age of 18 years and more people aged over 65 years, Barnet can expect an overall increase in the population of some 20,000 over the coming five years.

This JSNA is therefore not intended as a wish list, but as a compendium of information relevant to the health and well-being of the people of Barnet. It sets out the challenges and opportunities that we face and to which policy makers guided by the 'One Barnet' approach will need to give due consideration to so that our resources can be distributed fairly to enable the greatest benefit for the greatest number. To achieve this we will need to look at what role individuals, communities, employers and public sector bodies need to play as we respond to the public health White Paper 'Healthy Lives, Healthy People'. It is clear from much of the information in this JSNA that many of the health problems that affect people in Barnet, just as they do elsewhere, are related to lifestyle choices.

One such choice is smoking, which is the single most important cause of avoidable illness and death. The second is obesity because it increases the risk of developing a number of conditions (such as diabetes, raised blood cholesterol, high blood pressure) which, in turn, increase the risk of developing – and dying from – heart attack, stroke and some cancers. We know that our lifestyles these days make us less likely to be as physically active as we were. But even moderate physical activity each day, like using the stairs instead of a lift and walking a bit more, can make an important difference to our well-being through reducing the risk of being overweight and increasing the fitness of our hearts and lungs. It is important for public services to make it easier for people to live healthier lifestyles, but they cannot do it for them. People need to play their own part in living healthier lives if they are to reduce their dependency on others and increase their chances of living longer and being in a fitter state to enjoy this longer life.

Nationally, changes are also being proposed for how health and social care services are commissioned. The Government proposals set out in the 'Health and Social Care Bill' for establishing GP commissioning consortia place clinicians in the driving seat of deciding how local NHS resources should be allocated. The future funding for adult social care is also being examined at a national level through the Dilnot Commission due to report in July 2011 followed by a social care White Paper later in the year. To help ensure that these national changes work for Barnet, a Health and Well-Being Board consisting of representatives from the Council, GP consortium and others will identify what services are needed to meet the needs of the people of Barnet and which are the most important ones to concentrate on to improve the health and well-being and thus the quality of life of as many residents of Barnet as possible. The information in this latest JSNA is intended to be a significant guide for this work.



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Introduction

What is the JSNA?

The Joint Strategic Needs Assessment (JSNA) is a statutory document introduced by the Local Government Health and Public Involvement in Health Act (2007). Its purpose is to support the effective commissioning, shaping and delivery of local health and social care services.

This refresh of the JSNA has been co-produced by Barnet Council and NHS Barnet and employs both statistical and qualitative data to set out the current health and social care needs of Barnet's residents. Having established the current state of health and social care, the document attempts to anticipate how those needs may change over the coming years against a background of reduced public spending and changes to the NHS landscape.

This navigational summary highlights the key information from the JSNA – the pressures, trends and areas of greatest need. It is accompanied by online resources that provide a deeper level of analysis and information on each section. The document will be reviewed periodically to ensure that the assessment remains an accurate reflection of the health and social care needs of Barnet's residents.

Planning in a time of change

From population growth to budget cuts, organisational upheaval and rising user expectations, this needs assessment has been written at a time of significant change. The following section highlights the key changes and areas of greatest pressure for local services.

Changes in the NHS

The Government is making major changes to the organisation of healthcare as set out in a series of recent Health White papers aimed at modernising the NHS. These have informed the **Health and Social Care Bill**, which received its first reading in Parliament on 19 January 2011 and is awaiting final approval following the outcome of a 'listening exercise' and recommendations made by the NHS Future Forum. The Bill aims to ensure that patients are at the heart of the NHS, to improve its outcomes, and to give more control to local organisations and professionals. The main proposals are:

- **Primary Care Trusts**, groups of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be **abolished** from 2013.
- **PCTs and SHAs** will 'cluster' into a smaller number of larger organisations (for the Barnet area, North Central London NHS) and will be the **transition vehicles** until April 2013. It is possible that the current PCT clusters will become new 'commissioning support organisations'.
- **GPs will become commissioners** of health services through local **consortium** arrangements, accountable to the new NHS Commissioning Board which will be independent of the Department of Health.
- **The local public health function will transfer to councils**, although the full details of this are not yet available.

The public health white paper, *Healthy Lives, Healthy People* gives more details about the Government's vision for Public Health, including the creation of a national public health service called Public Health England and more dedicated resources for public health.

- **Health and Wellbeing Boards** will be set up under Council leadership and enable democratic legitimacy in health. They will have statutory functions from April 2013, and will have

responsibility for creating and implementing a joint health and wellbeing strategy, and considering any proposed changes to local service delivery.

- Replacement of LINKS with local **Healthwatch** organisations, which will report to a national Healthwatch body forming a part of the Care Quality Commission. These changes offer the Council a greater role in a health service which is democratically accountable and able to be shaped around local communities.

What does this mean for Barnet?

On 14 February 2011, Barnet Council's Cabinet agreed a report on **Partnership working for Health in Barnet**. This set out the vision for Health services in Barnet and the Council's role in leading local partnership working. This was the first major step towards preparing for the changes which will occur once the Health and Social Care Bill has been passed. The report approved some of the arrangements which will need to be put in place within the Council, such as the structure for the new Health and Wellbeing Board. This is due to meet for the first time, in shadow form, in May 2011.

The vision for Health services in Barnet includes:

- Getting people to take more **responsibility** for their own health and that of their families
- **Early identification** of potential problems, and encouraging healthy lifestyles
- A **cost effective**, 'lean' health system – not wasting resources or customer's time and always achieving value for money through GP commissioning
- **Reducing health inequalities**
- A focus on **public engagement** and making sure that the local Healthwatch functions effectively.[1]

To help support the development of integrated care, the government is making available significant monies for social care through the NHS. For Barnet for 2011-12, this is an allocation of £3.9million. Whilst some of this resource will be used to help offset pressures arising from care closer to home, Adult Social Care and Health will be investing in a range of projects to strengthen enablement, rehabilitation and affect early intervention.

This £3.9million has been transferred to the Local Authority and the shadow Health and Wellbeing Board will be overseeing the implementation of a joint investment plan as agreed by Cabinet Resources Committee on 2 March 2011.

A Barnet Health and Wellbeing Board

Barnet is now shaping its shadow Health and Wellbeing board, to set up the foundations for when this board must take on its statutory duties in 2013. We have been accepted to join a national Early Implementation Network for the Health and Wellbeing Board, which will enable us to get this right for Barnet.

This Board is set up in a similar way to our current Partnership Boards, which represent the interests of all the different client groups which use health and social care services. The difference with the Health and Wellbeing Board when fully established will be in its scale, responsibilities and the level of democratic involvement. It will have the role of joining up the commissioning of local NHS services, and will have responsibility for social care and health improvement.

The various Partnership Boards which already exist will report in to this Board, as will the Children's Trust Board in relation to children's health outcomes and the Financial Planning Group, which we have

[1] If you would like to read more about the vision in Barnet, the Cabinet paper from 14 February can be seen on Barnet Online: http://committeepapers.barnet.gov.uk/democracy.

established to join up social care and local NHS financial strategies. The Health and Wellbeing Board will in turn link in to the One Barnet Partnership Board.

The Board's initial work programme will be to put in place the structures and joined up working that are required to implement the Government's White Papers. They will need to ensure that Barnet is as prepared as possible to exploit the opportunities provided by the new health arrangements, and improve health and care outcomes for residents. The Board will also look at money coming into social care from the NHS, and manage the Public Health budget and all other partnerships through Section 75 Agreements (such as the one with the Mental Health Trust).

GP Commissioning Consortium in Barnet

Work has already begun to establish a Barnet GP Commissioning Consortium and Pathfinder status has been awarded. Local GPs are currently discussing:

- What they hope to achieve through commissioning
- Their vision for local health services
- How they will organise themselves into a commissioning consortium.

GPs in Barnet say that they are keen to maintain a local focus: they are currently organised in **three localities** and intend to retain this structure to ensure good clinical involvement and to develop local services to meet local needs. We are now working with these three clusters to make sure that better links with the Council are developed, which will be crucial to the running of the shadow Health and Wellbeing Board.

Once set up and fully operational, the Barnet GP Consortium will report to an overarching NHS Commissioning Board. This new Board is one of the changes in the Health and Social Care Bill, replacing the wider structure of NHS Boards and aiming to cut down the red tape in the NHS and allow for more local freedom.

The economic climate

As well as proposing changes to the NHS, the Coalition has placed an emphasis upon reducing the national debt. The Coalition Agreement of May 2010 paved the way for the **Emergency Budget** in June 2010 and a tranche of spending cuts. Whilst this needs assessment is not primarily concerned with economics, the immediate and emerging impacts of cuts will inevitably inform local health and wellbeing and must therefore be considered.

Part of the Government's response to the deficit has been to reduce the support available to those receiving a range of **welfare benefits**, including caps on housing benefit and stricter tests for incapacity benefit. A reduction in the rate and availability of these benefits will doubtless have a detrimental effect on the health and wellbeing of resident claimants, many of whom will face their cost of living rising while their household income is diminished.

The latest **unemployment** figures (that is to say, people actively but unsuccessfully seeking work) reveal that a greater proportion of Barnet's population are struggling to find work than almost any time in the last half decade. In the year to September 2010, 7.4% of the local population was believed to be unemployed – below the London average (8.9%) but up from the equivalent period in 2005, when local unemployment stood at 6.7%.[i] Meanwhile, the proportion of Barnet residents employed in *elementary occupations* (that is the most basic positions) almost doubled between 2005 and 2010 (3.8% against 6.4%).[ii]

Just as the benefits of employment to **mental health** are clear – in providing purpose and structure, developing relationships, and building confidence and self-esteem – so the link between mental health

problems and unemployment is also well documented. Only 24% of adults with a long-term mental health problem are in work, and people with mental health problems are at more than double the risk of losing their job than those without. The majority of people who spend more than six months out of work after an episode of mental ill health will never work again. The situation is more extreme amongst those receiving social care support – less than 7% of those in Barnet receiving secondary mental health services are in paid employment. This is a systemic problem nationally, but particularly so within London boroughs.

The local policy context

While the Coalition Agreement sets out the policy framework nationally, Barnet's **Sustainable Community Strategy** (SCS) is the blueprint for local public services – a common roadmap for how services should develop over the coming decade. The 2010/11 refresh of Barnet's SCS highlights **Healthy and Independent Living** as one of four local strategic priorities. Several priority objectives are detailed under that heading which are relevant to this needs assessment:

- Better health for all our communities
- Encouraging people to live healthily
- Better access to local health services
- Promote choice and maximise independence of those needing greatest support.

These are ambitious goals even in times of financial plenty; against a backdrop of a shrinking public purse the challenge is even greater. The plan for overcoming this challenge is **One Barnet**. Catalysed in part by the Government's deficit reduction plan, One Barnet is a transformation programme designed to anticipate the challenges ahead by making public services more responsive, effective and efficient, and delivering increased customer satisfaction with fewer resources. Three principles underpin the programme:

- **A new relationship with citizens**: Shaping public services around need and user experience, rather than the processes of individual agencies. Enabling residents to help one another access the information and support they need, providing residents with personalised services and supporting them to change damaging behaviours such as smoking or drug use.

- **A one public sector approach**: Working together in a more linked up way with public sector partners across the borough to deliver better services. Exemplified by development of prototype place-based budgeting.

- **A relentless drive for efficiency**: Delivering more choice for better value. Contributing to public spending cuts without reducing the quality of essential services.

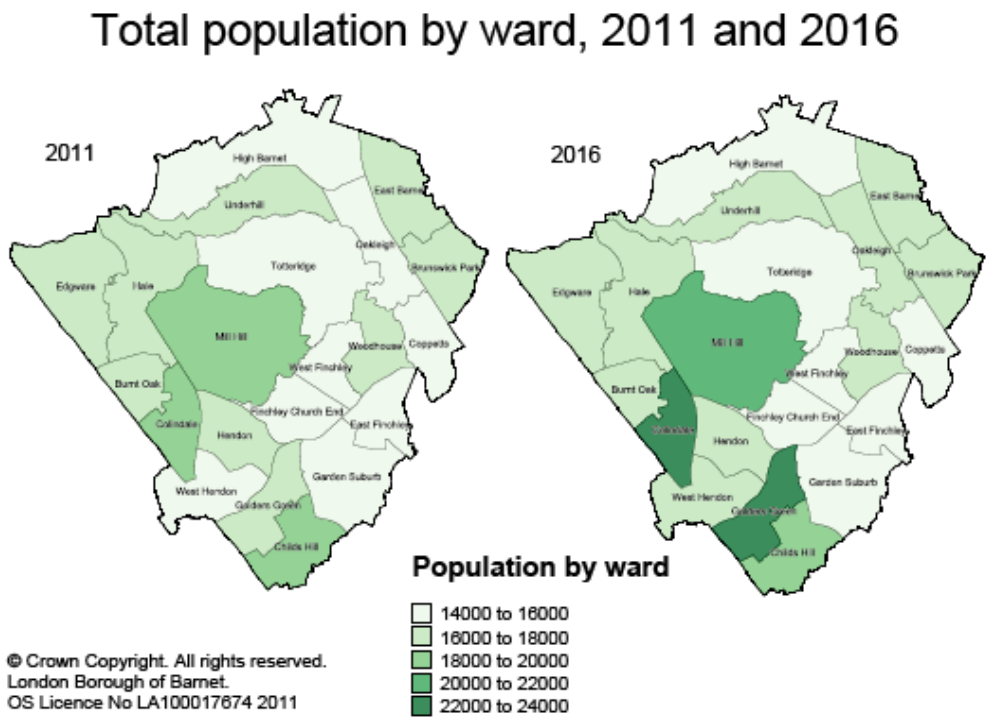
It will be important to consider any needs and priorities identified in this assessment in light of these three One Barnet principles.

Demographic changes

The challenges facing Barnet are not limited to shrinking public finances or fluid organisational landscape; there is also a significant demographic pressure on local services. Already London's most populous borough, with 349,800 residents in 2011 and a history of integrating diverse migrant communities, Barnet's story is one of growth. This growth is forecast to continue, driven by regeneration and recent high birth rates, bringing increasing pressure on the health and social care system.

Over the next five years, the local population is projected to grow by 5.5% – an increase of 19,400 people. The greatest growth will be concentrated in Colindale (+10,900), Golders Green (+7,300), Mill Hill (+2,000) and West Hendon (+1,900); that is to say, the **regeneration areas**.[2]

As well as population change based on net growth, Barnet (like many London Boroughs) also experiences significant **population churn**; every year, 8% of the resident population moves away and is replaced by new individuals. That's an annual turnover of almost 30,000 people.[3]



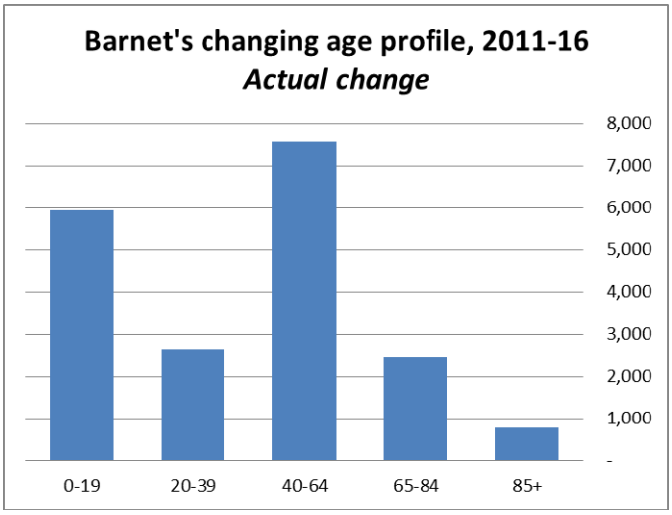
Age profile

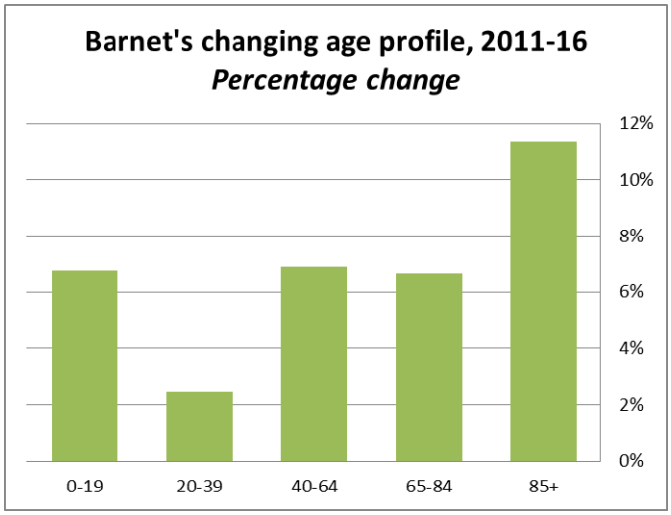
Just as population growth will not be uniform across all parts of the borough, nor will it be uniform across the generations. Between 2011 and 2016, the age profile of Barnet will develop in the following ways:

- There will be a significant increase in **5 to 14 year olds** (+6,600 individuals). This includes an incredible 23% more 5-9 year olds projected by 2016. This young cohort is the fastest growing group in the borough.
- A general decline in **30 to 34 years olds** is anticipated (-1,000 individuals, 3%) and a slower growth in **25 to 29 year olds** (600 individuals, 2%).
- The **40 to 59 year old population** will experience sizable growth, especially the 40-45 (+2,200 individuals, 8%) and 50-54 (2,400 individuals, 11%) cohorts.
- There will also be sizeable growth among **65 to 69 year olds** (+2,100 individuals, 18%) and proportionally significant growth in **90 plus** cohort (17%).

[2] The projections used in this section are based on a hybrid model drawing on elements of the ONS sub-national population projections (2008-based) and the 2010 Round Ward Projections produced by the GLA Intelligence Unit. A fuller discussion of the model can be found in the compendium.

[3] Based on analysis of ONS 2088-based sub-national population projections





Changing ethnic diversity

With regeneration and demographic growth comes a shift in the ethnic profile of the borough. Over the next five years, the local black and minority ethnic (**BME**) population is projected to increase from 33.1% to 35.0% of the total populace. This increase is at a slightly slower rate than other Outer London boroughs (5.6% compared to Outer London average of 7.0%) but faster than London as a whole (4.7%).

- Barnet's fastest growing ethnic group is **Other** (a classification with includes Iranians, Afghans, and Arab peoples) with 19% growth (+4,400 people) over five years against an average growth rate of 5.5%. In 2010, 2.8% of children in Barnet schools speak Farsi as a first language – 1,395 individuals.[iii]
- Although numerically smaller, the **Black Other** community is experiencing the second fastest proportional growth, with 15.1% (1,000) more Black Other Barnet residents expected by 2016. In 2009, there were 250 applications for National Insurance Numbers from Barnet residents of Nigerian nationality, 50 from Ghanaians and another 50 from Somalians. 2010 figures look likely to match or exceed these levels.[4]
- Barnet's largest ethnic group, the **Indian** community, is expected to remain the most populous BME group over the coming half decade, but growth is slower than other groups at just 4.9% (1,600 people). 700 residents of Indian nationality applied for a National Insurance Number in 2009.

Although Barnet continues to attract individuals and families from around the world, the rise in local diversity is predominantly **driven by births** in the existing BME community. The consequence of this is that, aside from a bump in the 30 to 44 cohort, each rising age band is progressively less diverse than the former; just 21.9% of the current 65 to 69 year old population are non-White compared to almost half of all 0 to 4 year olds (49.7%).[iv]

Deprivation

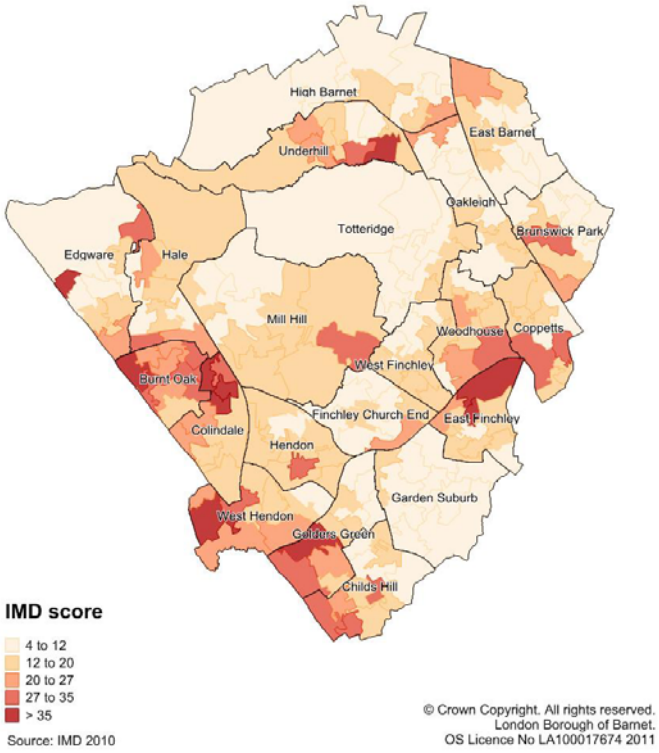
The **English Indices of Deprivation** (sometimes referred to as the Index of Multiple Deprivation, IMD), combines a number of indicators, chosen to cover a range of economic, social and housing issues ('domains'), into a single deprivation score for each small area in England. This allows each area to be **ranked relative to one another** according to their level of deprivation – in other words, Area A might have improved in real terms from the last update, but if Areas B and C have improved more than Area A, then A's ranking will remain the same or even deteriorate.

[4] These figures paint only a partial picture, since they do not take into account non-working individuals or those who have been awarded citizenship from another European country before entering Britain.

Indices are produced at Lower Super Output Area (LSOA) level – a statistical geography containing roughly 1,500 people, of which there are 32,482 in the country and 210 in Barnet.

According to the latest release, **ID2010**, Barnet is **less deprived** than it was three years ago, ranked as the 165th of 326 most deprived Local Authority Area. Barnet is a particularly varied borough however, and although the Barnet average is averagely relatively deprived, there is a wide variance between different domains and different areas. None of Barnet's LSOAs fall within the ten% most deprived nationally, six fewer than 2007. However 35 of 210 (16.67%) rank in the lowest ten% on at least one domain.

Indices of Multiple Deprivation scores 2010, by LSOA[5]



The two domains which have shown the greatest decrease in relative deprivation are **Barriers to Housing and Services** and **Health Deprivation and Disability**. In part the housing domain improvement is likely to be a change in the how data has been defined since the last release.[6] No changes have been made to the methodology for the health domain, however this is a complex weighted measure in part based on prescription data.[7]

The Barnet Local Development Framework (LDF) acknowledges the impact of access to good quality housing on public health and wellbeing. Among the priorities outlined in the document, there is a commitment to **providing quality homes and housing choice**, by developing wider choice in terms of tenures, types, size and affordability and a strategy for intelligent **distribution of growth in meeting housing aspirations**, which sets out the most sustainable locations for housing growth in the west of the borough together with the priority housing estates and town centres to avoid overcrowding.

[5] http://www.communities.gov.uk/documents/statistics/pdf/1871208.pdf
[6] LB Barnet Business Intelligence Team, Deprivation in Barnet: results from the English Indices of Deprivation 2007, http://www.barnet.gov.uk/deprivation-in-barnet.pdf, 6-7
[7] CLG, English Indices of Deprivation 2010: Technical Report, http://www.communities.gov.uk/documents/statistics/pdf/1870718.pdf, 25-31

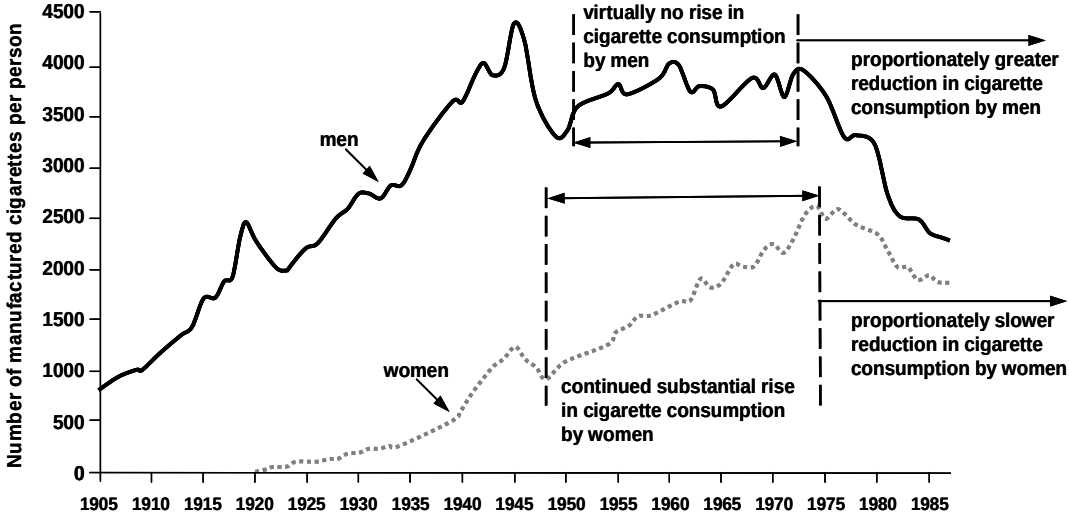
Headline health inequalities

Health inequalities can be thought of as potentially modifiable differences in wellbeing and in access to services of different types. Often, health inequalities are described in the context of deprivation, but avoidable disease is not something that only affects people in deprived areas, it simply occurs more often amongst those living in them.

Health inequalities in smokers (and between men and women)

A very large number of diseases are caused by, or worsened by, smoking and by inhaling second-hand smoke. Smoking-related diseases are more common amongst people living in more deprived areas because such people are, generally, more likely to smoke, but they affect people everywhere. It is noteworthy that deaths from chronic obstructive pulmonary disease in Barnet are dropping in men but have been relatively static in women until the last couple of years.[8] This is probably because men and women have taken up smoking to differing degrees and have had different quit behaviours in past years.

Annual consumption of manufactured cigarettes per person in the UK



Source: Tobacco Advisory Council

Health inequalities in people who are obese

In Barnet, about 54,000 men, women and children are likely to be obese; a further 880 men and 3,100 women are likely to be morbidly obese.[v] Adults who are obese (i.e. who have a body mass index of 30 or greater)[9] are at a greater risk of premature death and are more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders.[vi] Women who are obese are, generally, at greater risk than men of developing certain diseases. For example, obese women are nearly 13 times as likely to develop Type 2 (i.e. non-insulin dependent) diabetes as obese men, who are about five times as likely to do so.

[8] See Mortality from COPD in males and females, Barnet ,1993-2009.

[9] The body mass index (BMI) is calculated by dividing the weight (measured in kilograms) by the square of the height (measured in metres). A healthy BMI is between 19 and 24.9. A person is defined as being 'overweight' if their BMI is between 25 and 29.9 and obese if their BMI is 30 or more. A person with a BMI of 40 or more is defined as being 'morbidly obese'. For example, a person who is 5'9" tall and weighs 12 stones has a BMI of 25, i.e. they are just over the upper limit of having a healthy weight. If they put on two more stones, then their BMI will increase to 29 and they will be on the brink of obesity

Relative risks of health problems associated with obesity in women and men

Disease	Relative risk (women)	Relative risk (men)
Non-insulin dependent diabetes	12.7	5.2
High blood pressure	4.2	2.8
Heart attack	3.2	1.5
Cancer of the bowel	2.7	3.0
Angina	1.8	1.8
Gallbladder disease	1.8	1.8
Cancer of the ovary	1.7	N/A
Osteoarthritis	1.4	1.9
Stroke	1.4	1.3

Source: National Audit Office

The good news is that reducing weight reduces these risks. For example, if an obese person reduces their weight by 10% then their chance of dying prematurely is reduced by 20-25%, their blood pressure is likely to drop by 10-15mmHg,[10] the risk of developing diabetes can be reduced by more than 50%, and angina symptoms reduced by over 90%.

Health inequalities in people with mental health problems and people with learning disability

People with learning disabilities and those with mental health problems are much more likely to have significant health risks and major health problems: for those with learning disability this particularly includes obesity and respiratory disease, and for those with mental health problems obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke.[vii] People with severe and enduring mental illness are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population.[viii]

Health inequalities in people with diabetes mellitus

Whilst about 3% of the general population has Type 2 diabetes mellitus, some 20% of Asians and 17% of Black Africans and African Caribbeans do so.[ix] Diabetes principally damages blood vessels and thus compromises the blood supply to vital organs. It increases the risk of heart attack and death from heart attack, stroke, kidney failure, loss of sensation in the feet, foot ulceration and loss of toes and parts of the feet from dry gangrene. Diabetes is also the most common cause of blindness in people of working age. It is also noteworthy that diabetic complications such as heart attack, stroke and kidney failure are three-and-a-half times more likely to occur in people with diabetes who live in deprived areas.[x]

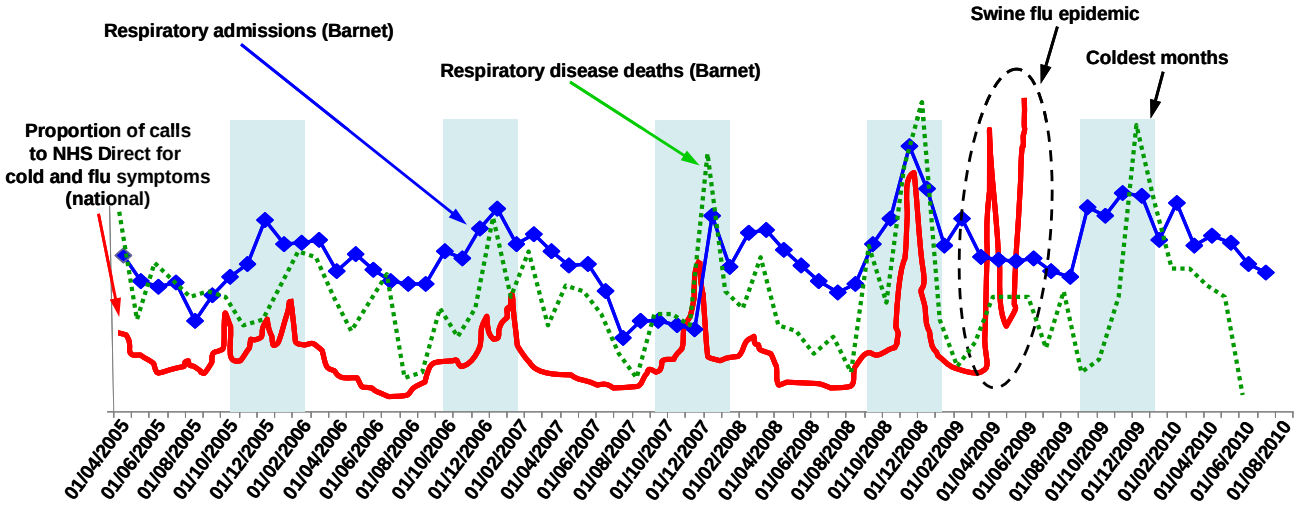
The incidence of Type 2 diabetes is increasing, and the age of onset is decreasing, as more and more people in this country become obese. It is also five times more likely to develop in people with severe mental illness than in the general population.[xi]

[10] Blood pressure is measured in millimetres of mercury (mmHg), i.e. the height that a column of mercury in a sphygmomanometer rises when someone's blood pressure is measured

Health inequalities attributable to cold weather

In Barnet, as elsewhere, hospital admissions for, and mortality rates from, respiratory disease increase in the colder months. There is a correlation between these, and the incidence of influenza-like illness, as shown by the coinciding peaks in the figure below.

The relationship between cold weather, influenza-like illness and respiratory disease and respiratory deaths in Barnet
(not to equal scales)

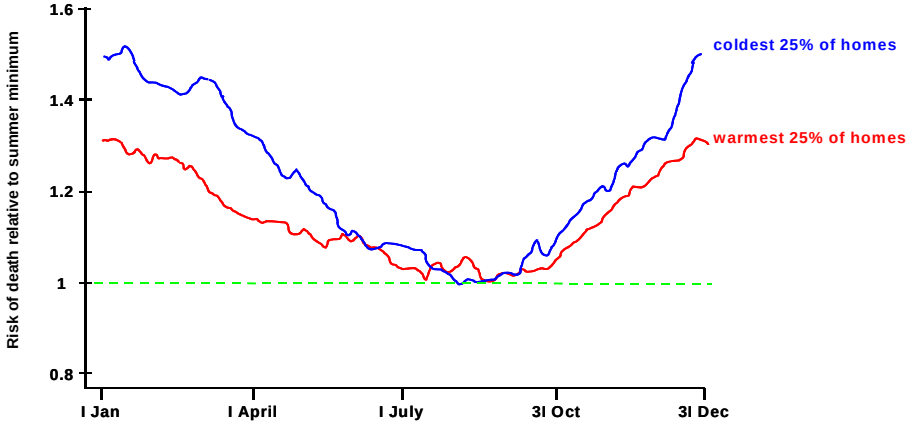


Source: NHS Direct data and HES data

Over half of excess winter deaths in England[11] are caused by cardiovascular disease and one third by respiratory disease.[xii] The 1997 EU Eurowinter study found that cold housing contributes to deaths from respiratory problems in winter, and exposure to outdoor cold contributes to deaths from arterial thrombosis (such as heart attack).[xiii] In Barnet, three to four times as many people die of respiratory disease in winter than during the summer.

The effect of cooler homes on excess winter deaths is shown in the chart below, which depicts the estimated risk of dying at different times of the year compared with the risk when the weather is warmest in mid-summer.[xiv] The estimates show that people living in homes that are amongst the warmest are 1.3 times more likely to die in mid-December to mid-January, whilst those living in the coldest homes are 1.5 times more likely to die.

Relative risk of death in relation to indoor temperature



[11] Excess winter mortality is calculated by comparing the number of deaths occurring in winter with the number occurring in the a non-winter period

An increase in deaths in cold weather (leading to health and social care 'winter pressures') are not necessarily inevitable – compared to other countries with the same outdoor temperature, British living rooms are colder and bedrooms are less likely to be heated, and, when going outside, British people are less likely to wear warm clothes (e.g. anoraks, gloves).[xv] It is also interesting to note that the excess winter death rate in Russia is much lower than in England and that in Yakutsk, Siberia (the coldest city in the world) it is zero;[xvi].

Based on the Chartered Institute of **Environmental Health** Housing Health and Safety rating system calculator, the estimated cost to the NHS of poor health as a result of private sector properties having hazards relating to Excess Cold (that is, problems with insulation, heating, damp or mould) is £90,400 annually. Using the same calculator the average cost of remedial work has been calculated at £4,993. Locally, 65% of Category 1 hazards (as defined by the Housing Act 2004) raised with the Council's Environmental Health team in 2009/10 were due to Excess Cold.

Where Category 1 hazards are identified by the Private Sector Housing Team at Barnet Council, the Environmental Health Officers try to work with landlords to bring the properties up to a minimum standard. Where this is unsuccessful, statutory notices are served. Failure to comply with the notice will result in either the work being undertaken in default by the Council and/or the case being referred for prosecution.

The Private Sector Housing Team also run a **Decent Homes Scheme** (2011-13), providing financial assistance to vulnerable owner occupiers to assist in bringing their properties up to the Decent Homes Standard. One of the criteria for a Decent Home is that it provides a reasonable degree of Thermal Comfort. This requires the dwelling to have both effective insulation and efficient heating. In relation to vulnerable and elderly clients the team works closely with Barnet Care & Repair Agency. The Agency refer clients through to other Agencies e.g. Warm Front and Affordable Warmth Solutions that provide minor grants in relation to thermal efficiency to provide the most comprehensive support for clients in improving their homes.

Approaching the assessment

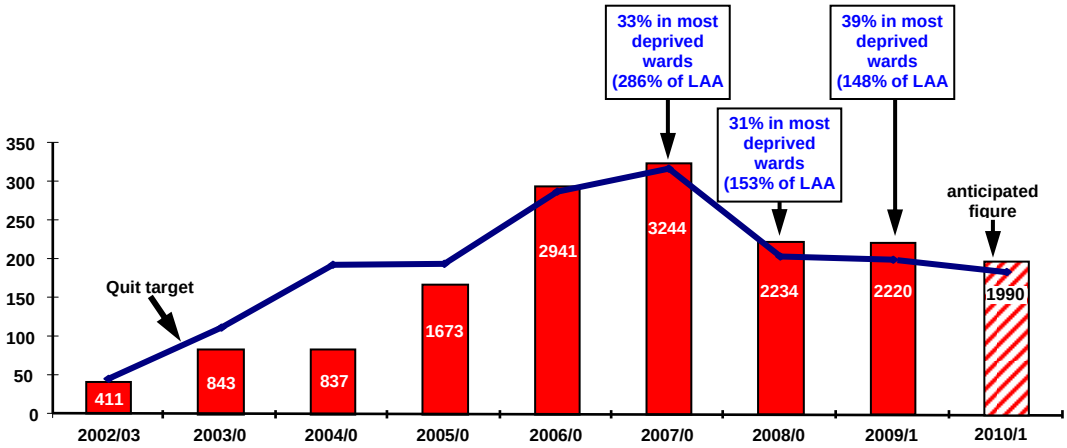
Celebrating success

In understating what the greatest challenges are for local health and wellbeing, it is also important to consider those issues where successful intervention has resulted in improved outcomes and to learn lesson from those successes. The following section briefly outlines three areas of success and highlights key lessons that could be applied to needs which are being less well managed.

Smoking cessation

As outlined in the section above, smoking cessation is the most significant lifestyle area for improving people's health. Since 2006/07, Barnet has consistently seen some of the best performance on smoking cessation in London. This was only achieved by joint working between public health, GP practices, community pharmacies, smoking cessation services and Barnet Council. The key lesson was learning how to broker conversations between frontline staff and patients that enabled signposting to tried and tested support services.

Smoking cessation in Barnet, 2002-11

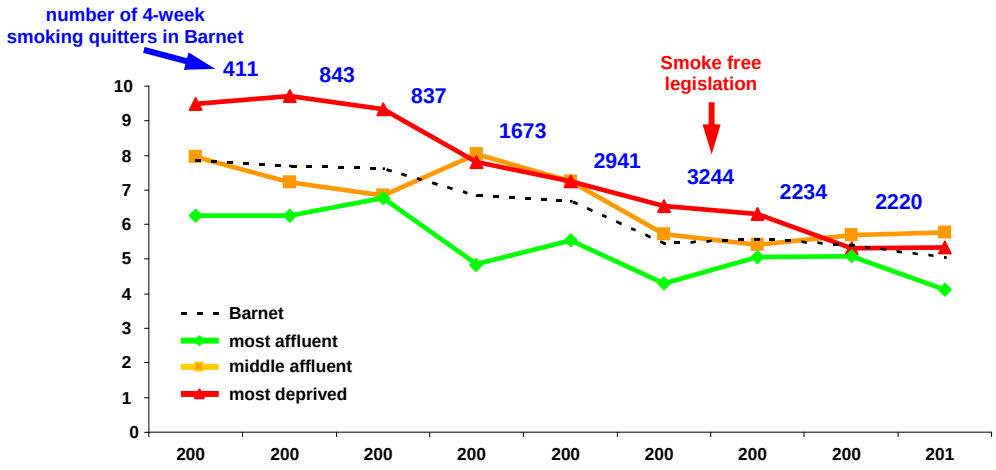


Source: Barnet Public Health team

CVD mortality

Deaths from heart attack and stroke are dropping in Barnet, as elsewhere. What is also happening locally, but less so elsewhere, is that the health inequality for deaths from cardiovascular disease (CVD) between those living in the most deprived areas and those in the most affluent ones has closed. The change has been amongst people in the most deprived areas, where death rates from CVD have dropped more steeply. There are a number of possible causes, but success in smoking cessation, especially with our focus on getting more quitters in the most deprived areas, is a strong contender. It takes about 12 months from quitting to seeing an impact on CVD rates. If so, the key lesson in this incidence is one of preventative interventions that tackle need before they become acute.

CVD mortality rate by deprivation tertiles in people aged under 75 years (standardised death rate per 100,000 population)

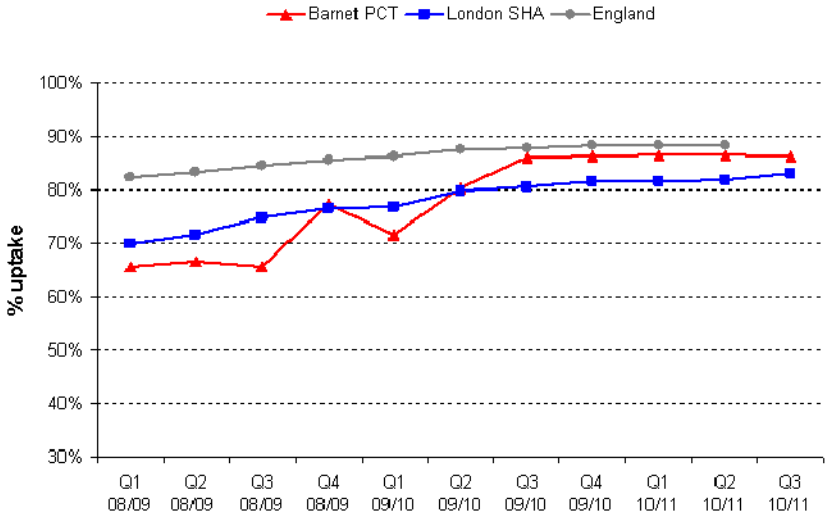


Source: Barnet Public Health team

Immunisations

Health professionals in Barnet have improved childhood immunisation rates considerably in the last two to three years. The biggest success area has been with MMR. In this instance, the key to success was strong partnership working between the NHS and the council – particularly through schools – and effective communications to debunk the MMR-autism myth and encourage more parents to have their children immunised.

MMR take up at two years



Source: NHS London

Prioritising need, managing demand

Another consideration in undertaking this revised assessment is the need to balance demand against both need and capacity. It is important that public resources are used fairly and appropriately. Such resources are finite but demand continues to rise. In the current economic situation this gap has become bigger. Local authorities have had significant cuts to their funding and the NHS, having previously experienced annual income increases of five to 6% for several years will now have an annual increase of just 0.1% for the next four years.

It is also important to differentiate between **'equality'** – when everyone is treated the same way regardless of need – and **'equity'** – when people with equal need are each treated in the same way but those in greater need are given priority over others. This latter point is made in the NHS Constitution which notes that whilst the NHS seeks to provide a comprehensive service to all, it has a wider social duty to promote equality through its services 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.[xvii] A balance has to be struck between the needs of an individual and the needs of the population for which public services are responsible.

Sharing limited resources fairly usually means (i) giving resources preferentially to those who are in greatest need and who can benefit the most from them, and (ii) settling for what is adequate and not necessarily for what may be the 'absolute best'.

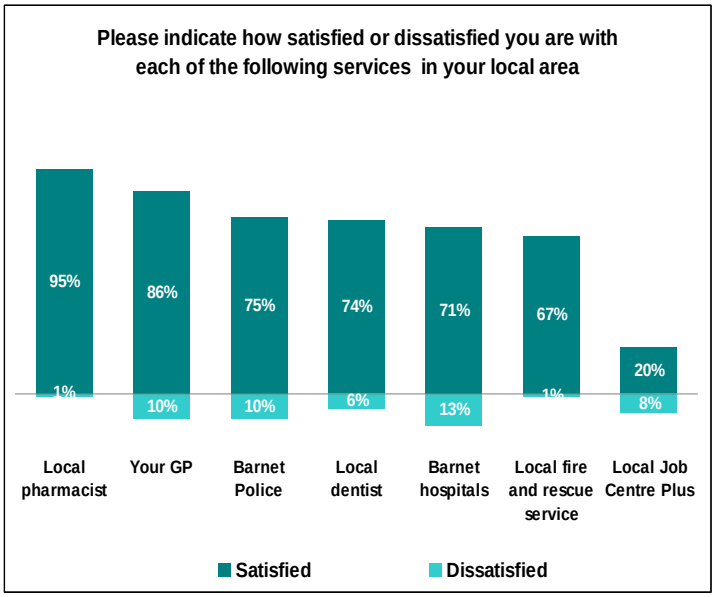
In any decision of this kind, there are competing moral concerns and whilst such factors can be morally justified, not all can be fully met simultaneously.[xviii] Put another way, it is not possible to provide equal care to all, it is not possible to prioritise every need, and it is not possible for everybody to have free choice in their care when resources are limited. In light of this reality, this needs assessment ought to be a vital tool in helping decision makers maximise the benefit of available resources by allocating it in a fashion that enables the maximum advantage to the maximum number of people.

Perceptions of health and social care

A needs assessment should not rely exclusively on quantitative data. During the course of the year, Barnet Council and its partners conduct public consultations which seek to understand the opinions and experiences of local residents and service users across a wide range of subjects. The following section details insight lifted from recent consultation related specifically to health and social care. In the future, it is hoped that there will also be contributions from Barnet LINk / Healthwatch opinion research. Further information about local consultations (past, present and forthcoming) can be found at http://engage.barnet.gov.uk.

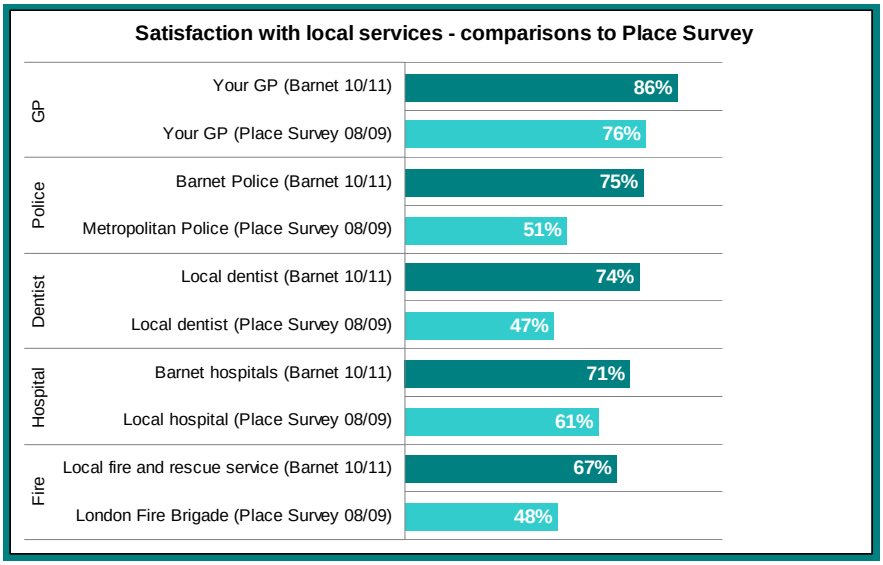
Residents Perception Survey

The 2010-11 Residents Perception Survey was conducted during February and April 2011 and included telephone interviews with more than 2,400 residents. The results reveal that Barnet residents are **very satisfied** with the service they receive from local health services. The most popular service according to the survey is local pharmacists, with whom 95% of respondents said they were satisfied (and just 1% dissatisfied). 86% of people said they were satisfied with their local GP (and 10% were not) – a rise of ten% satisfaction since the 2008/9 Place Survey.



Source: Residents Perception Survey, 2010-11

The former Place Survey asked about satisfaction with 'local hospitals' but it was felt the term 'local' did not reflect how hospitals deliver their services in Barnet, so this language was changed to 'Barnet Hospitals' in the 2010/11 Survey and resulted in a ten% improvement in satisfaction. Local pharmacies and local JobCentrePlus were not included in the former Place survey.

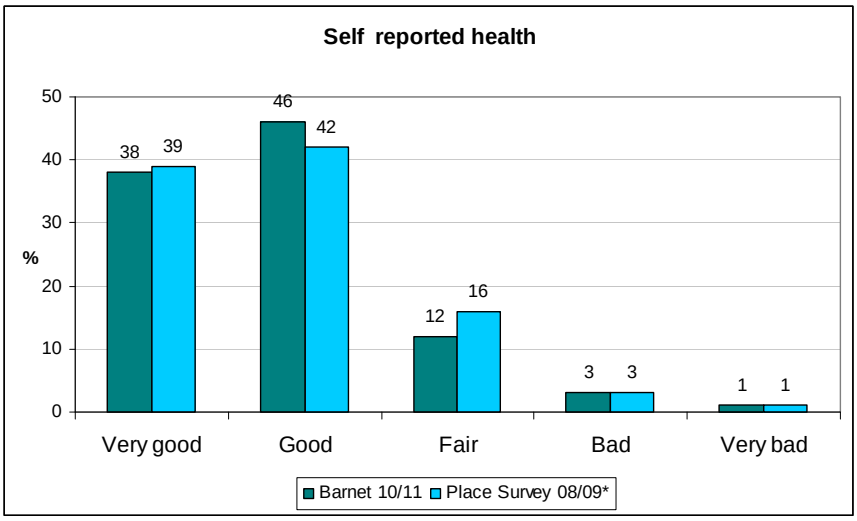


Source: Residents Perception Survey, 2010-11 and Barnet Place Survey, 2008/09

Barnet residents are now **more concerned** with the quality of health services (22%) compared to 2007/08 (+3%), although it is still the sixth concern. Barnet residents are now more concerned about the quality of heath services than the average Londoner (+8%). In 2007/08 Barnet was in line with London average and London is now showing a downward trend in concern.

Self-reported health

Respondents were asked to say how good they consider their health to be. **85% of respondents say their health is very good** (38%) or good (46%). A minority (12%) say their health is fair and even fewer say their health is bad (3%) or very bad (1%). Compared to the last Place Survey (2008/09) there has been a 4% increase in residents saying their health is good. Respondents were slightly more like to say their health is fair.[12]



Source: Residents Perception Survey, 2010-11 and Barnet Place Survey, 2008/09

User experiences of social care

Adult Social Services conducts a number of statutory surveys amongst its users to assess satisfaction with services and identify key areas for improvement. Some key themes emerging from these surveys include:

- Levels of **satisfaction** with social services are generally high, although there is room for improvement, with difficulties and delays in accessing services raising particular concern

[12] Caution should be applied when making direct comparisons to the former Place Survey due to the different methodologies.

- Despite improvements, **quality of life** is still being affected by a lack of control over daily lives, worries about personal safety, and feelings of loneliness and social isolation. For **carers** in particular, health is being affected by a lack of sleep, increased levels of stress, and physical strain and injury
- Professional and friendly **staff** that take the time to listen to users and treat them with respect helps build trust and confidence in the service and ultimately maximise satisfaction. Barnet in particular scores highly regards the punctuality and consistency of care workers when compared to other boroughs
- Barnet also scores well on **keeping users informed** about changes to their care. Clear and accurate information can be seen as vital in ensuring users can make informed and appropriate choices about care and support services
- Most users receive regular **practical help** from friends, neighbours or family neighbours. However, in Barnet there are particularly high numbers of users receiving no help compared to other boroughs, specifically a lack of help from people living outside of their household.

In addition to these surveys, Adult Social Services has also been conducting a programme of user and public consultations to help inform changes to policies and services. The Adult Social Services **Budget Conversations** in November 2010 highlighted the following themes:

- Budget reductions should be set against the need for fairness, safeguarding, protecting those with the most complex needs, and maintaining quality of service
- More responsibility being given to families and communities could translate into an increased strain on carers, where those relationships currently exist
- Significant reductions in the amount spent on prevention mean that the costs could manifest and increase further down the line
- The use of volunteers was stressed as a key component of the services provided through preventive budgets and resulted in good value for money
- Social care should adopt a more integrated approach to working with health and housing support.

Barnet LINk

Another way that service users and their families can share their experiences of local health and social are is through the Barnet Local Involvement Network (LINk). This is an independent network of local people, organisations and groups established by law to work together to:

- Encourage and support more local people to get involved in shaping local health and care services by helping to decide what services should be commissioned and influence the way they are run
- Actively seek to find out the views of people from every part of the local community on their experience of local health and care services, especially of those who may not often get their point of view across
- Provide the local community with a way to monitor and review local health and care services and hold commissioners and providers to account
- Tell those who commission, run and scrutinise local health and care services what local people have recommended to help improve services.

Further information about the Barnet LINk can be found through CommUNITY Barnet:
http://www.communitybarnet.org.uk/pages/link.html

Providers

A key consideration when investigating need is the capacity of the wider health and social care sector to meet local needs – it is no use signposting more people to a service or recommending a particular support group if those providers cannot match demand. This section briefly reviews the local care market and highlights some innovative solutions which are in development.

The care market in Barnet

The 'care market' is used to describe the framework in which individuals, local authorities and the NHS buy care services supplied by public, voluntary and private sector bodies. There is no doubt that the local authority and the NHS are seen as key facilitators in the development of this market both locally, regionally and to some extent nationally. The influence of private wealth in an area clearly has an impact on the range of choices available which has been stimulated through individual demand rather than purely statutory demand. The overall market has continued to respond to greater level of complex need being catered for outside institutional settings. This also potentially places greater responsibilities on families and informal networks which provide the great majority of care and support through their families and households.

The care market then is a mix of well-established and immature markets and is shaped by commissioners, independent and voluntary sector providers, regulators, services users and their carers.

It can be estimated that the 28,000 **informal carers** identified locally during the 2001 census is likely to be well over 30,000 today. Whether this will be sufficient to meet the swell of demand is yet to be seen. Well over a quarter of these provide care for over 20 hours a week. Carers, particularly those with long-term caring commitments, are especially vulnerable to poor physical and mental ill health (such as stress and fatigue). This can in turn threaten any paid employment or education the carer may have, impacting other life chances (especially among young carers). If not carefully managed and supported, the individual personal burden of caring could ultimately increase demands on health and social care services and undermine the viability of informal care arrangements.

The care market in Barnet is dominated by **residential care**, with 121 care homes within Barnet offering 3,082 places. Barnet social services purchases just over a quarter of these beds, as well as buying a third of its provision from homes outside the borough. With NHS purchasing included, this proportion rises to around 50%. The remaining half of the market is made up of people funding their own care and people placed here by other local authorities.

In line with its policy to support people within their own home for as long as possible, admissions to residential care of social services users dropped from 231 in 2006/07 to 171 in 2009/10. Nursing care admissions have gone the other way in recent years though, rising 42% from 2007/08 to 94 in 2009/10, possibly indicating rising levels of severe dementia cases. However the trend for overall admissions to care homes remains on a downward trend in Barnet – in 2010/11 there were only 40 net new placements of older people by Adult Social Services, reflecting increasing confidence in some of the alternatives which are gradually replacing this as a main menu option. In addition, many care homes operate with a level of vacancies except in periods of extreme pressure in other parts of the system.

The care homes market in Barnet consists of a relatively high proportion of small homes with sole owners, many of whom are nearing retiring age and we will gradually see a contracting of this type of provision in the borough. There has been new investment into larger high specification care homes with generous space dimensions which attract the older person who does not wish to retain the burden of managing and paying for their own property, and may also be reluctant to take on any further housing tenure very late in life. Registered provisions for domiciliary care continue to remain stable although with some mergers over the last two years.

Market Sustainability

The provider landscape nationally in health and social care continues to be affected by mergers, closures and debt particularly as they are affected by rising costs, the general economic downturn and lower levels of public funding in some cases. In addition the commissioning arrangements are increasingly based on individual or short term arrangements rather than long term or block commissions from social services. Costs for care and support continue to be disaggregated as preparation for more **personalised menu** based services for all citizens who need these services including those with social services funding. In Barnet due to the levels of personal finance of many of the residents, there has been a long tradition of care services not reliant on public subsidy however and capacity in community home and community support type services remains relatively stable. There is evidence that many providers are starting to diversify from their traditional style provisions with care homes offering day care and drop in services and domiciliary type services moving into personal assistant type roles.

The voluntary sector and Big Society solutions

CommUNITY Barnet have identified at least 850 local charities and community groups active and operating in Barnet. Many of these groups are either disability focussed or offer a range of services for disabled people – 37% of those that CommUNITY Barnet surveyed work with people affected by disabilities and 14% specifically work with visually impaired people. Evidence shows that this civil society offers exceptional value for money by engaging residents in volunteering and bringing funds into the borough. The following case studies are included to raise awareness of projects already underway but also to encourage the development of other innovative solutions to local needs.

Community Coaches

Between September 2010 and February 2011, Barnet Council partnered with the Police, NHS, JobCentre Plus and the voluntary sector to prototype a Community Coach Service. This prototype involved local volunteers receiving training and resources to support members of their community without recourse to public services. The coaches themselves were recruited because of their own set of experiences and resilience, which could over time replace the plethora of professionals from different services with whom those facing disadvantage currently have contact. They would help to move people through a personal development process toward achieving their goals and aspirations, improving their sense of wellbeing and in time reducing their dependency on public services. The professional role would continue to exist in respect of gate-keeping public resources and safeguarding.

Although some questions remain to be answered, the prototype of community coaching was successful in evidencing that the service can benefit both the coaches and the people they support; in developing a tool set and training approach for coaches and in capturing a wide range of learning about how to successfully roll out a community coaching service. The next step it to further develop the model of community coaches to the point where it could stand alone as a sustainable commissioned service.

Family Intervention Project

Barnet is one of the first 16 areas to develop a Community Budget, bringing together a range of local agencies to pool resources to address the issue of families with complex needs. This budget is being used to expand the Family Intervention Programme (FIP), which is relatively new in Barnet but which is already achieving spectacular results, through using a trusted worker to engage intensively with a family and smooth their engagement with the many agencies they encounter.

By expanding the scheme we plan to cover a wider cohort of families, collectively identified by partners. We also wish partners to contribute to expanding the FIP in proportion to the costs expected to be saved by effective intervention: these cover a range of positive outcomes from reduced crime and anti-social behaviour and reduced court costs, better school attendance and fewer referrals to a Pupil Referral Unit, to no longer requiring mental health and/or drug treatment services, and moving off benefits.

Health and Wellbeing

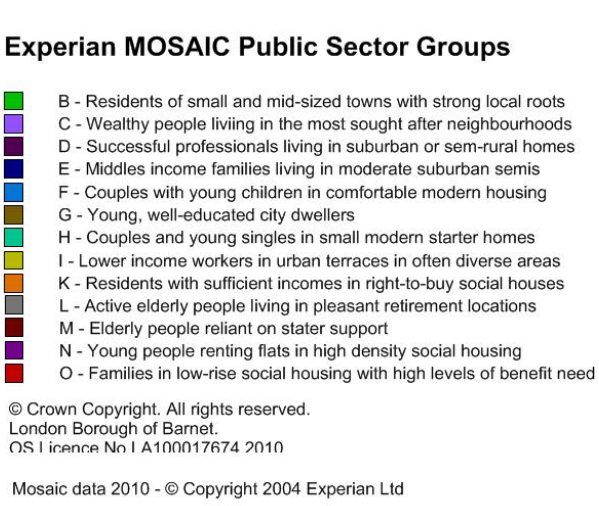
This section begins with a look at the health needs and characteristics that might be expected locally, based on *modelled* data. This can be useful in identifying where Barnet is bucking wider trends, either due to underreporting of problems or as a result of successful local programmes. Thereafter follows a summary of *real* data on a range of health needs in Barnet, against which the expected needs can be measured.

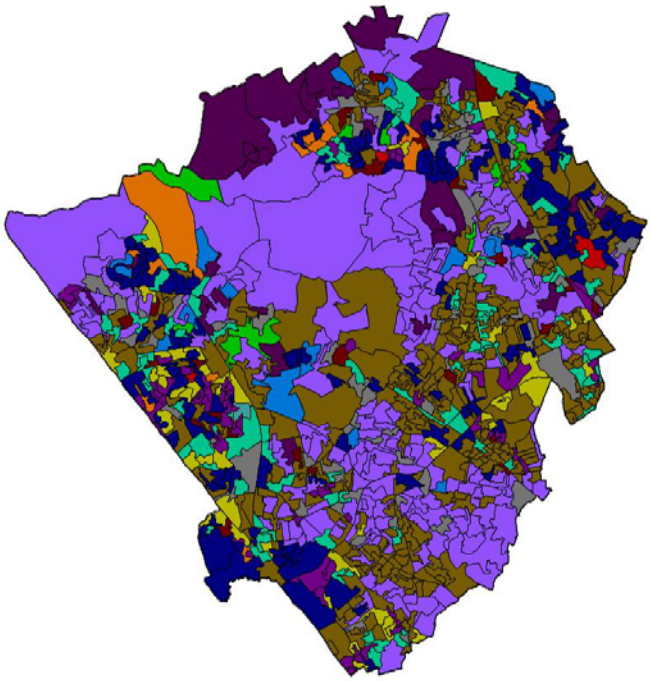
Mosaic Health profile of Barnet

Mosaic Public Sector is a licensed data set produced by Experian which allows us to profile the local community based on *modelled data* from a range of sources. The information contained in the product for profiling health data is relatively limited but the key information is summarised in the following paragraphs.

According to Mosaic Public Sector, Barnet's health is generally very good. Of the four most frequently encountered Mosaic Groups within the borough (comprising 73% of all households) there is no indication that obvious health concerns are not being addressed.[13] The majority of residents have good levels of health, eat a balanced diet and exhibit levels of exercise on a similar level to the national average. Hospital admissions for these four main Groups are similar to national trends.

However, there are some areas with significant concentrations of households who are typically vulnerable to a number of health issues. Three Mosaic Groups - 'Lower income workers in urban terraces in often diverse area', 'Residents with sufficient incomes in right-to-buy social houses', and 'Elderly people reliant on state support' – tend to be found close to each other within Barnet, such as along the A5 corridor. These Groups make up a small percentage of Barnet's overall population but do have specific health issues that could be improved with better communication and targeted campaigns.





[13] Young, well-educated city dwellers (31.1%, 108,790; Wealthy people living in the most sought after neighbourhoods (19.1%, 66,810); Middle income families living in moderate suburban semis (12.4%, 43,380): Couples and young singles in small modern starter homes (10.3%, 36,030).

These Groups have high levels of smoking and poorer diets than the Barnet average. They are also typically more diverse and consequently have unique health needs. Communication with these Groups generally appear to be most positive when information is provided though local papers or face to face interactions, and similarly have a negative response rate when information is distributed though the post.

Causes of death

Life expectancy for both men and women in Barnet is greater than the London and national averages. However, this varies from neighbourhood to neighbourhood, with the life expectancy in Garden Suburb, Barnet's most affluent ward some 5.7 years greater than in Burnt Oak, the most deprived.

Life Expectancy (2007-09) and Key Mortality Indicators (2006-08), London boroughs

	Life expectancy at birth (years)		Deaths from all causes per 100,000	Cancer deaths per 100,000 people	Circulatory disease deaths per 100,000 people	Suicides per 100,00 people	Infant deaths per 1,000 live births 4
	Male	*Female*					
Barnet	80.2	84.3	486	96.9	56.2	6.6	3.6
London	78.6	83.1	561	109.8	79.4	7.3	4.6
England	78.3	82.3	582	114.0	74.8	7.8	4.8

Physical disability

The social model of disability, adopted in Barnet, recognises that whilst disability can have a significant medical aspect, particularly at the onset of any impairment, the difficulties/barriers people encounter in taking part in every day life arise largely because of attitudes and structures in society. As a result, disabled people experience **limited access to everyday life** especially in relation to education, employment, leisure, transport, social life and other aspects of daily life. Disability is therefore 'the social consequences of having an impairment'.

If not managed and supported effectively, the strain that physical disabilities can have on personal lives, as well as the wider system, is enormous. It is estimated that 46% of those with a physical disability have difficulty carrying out personal care tasks, such as getting in and out of bed, dressing, washing and feeding; 8% of people with a physical disability need to get someone else to help with these tasks.[xix]

A disabled person is twice as likely as a non-disabled person of the same age to be **unemployed** and claiming benefits. Although most disabled people are in employment, at any given level of qualification a disabled person is more likely than a non-disabled person to be low-paid and almost a third of working-age disabled adults live in income poverty – double the rate for working age non-disabled adults.

It is estimated there are approximately 12,600 adults in Barnet with a **serious physical disability**, and a further 29,500 with a **moderate physical disability**. With population increase and improve survival rates, these numbers are set to increase significantly over the coming years. The following sections look closer at two specific types of physical disability.

Neurological conditions

A long term neurological condition is the result of disease, injury or damage to the body's nervous system (i.e. the brain, spinal cord and/or their peripheral nerve connections) which will affect the individual and their family in one way or another for the rest of their life. Long term neurological conditions can cause a range of different problems for the individual, including:

- Physical or motor problems
- Sensory problems
- Cognitive/behavioural problems
- Communication problems
- Psychosocial and emotional effects of the condition for the individual.

Exact figures for the number of individuals with neurological conditions locally are not available, though the following table details the estimated prevalence of several conditions based on national rates.

Estimates of prevalence of neurological conditions in Barnet

Common neurological condition	National prevalence – rate per 100,000	2010 estimate for Barnet	2020 estimate for Barnet
Stroke	500	1,729	1,920
Epilepsy	500	1,729	1,920
ME	300 - 500	1,037 - 1,729	1,152 - 1,920
Brain injury	228	788	876
Parkinson's disease	200	692	768
Cerebral palsy	186	643	714
Post polio syndrome	100 - 300	346 - 1,037	384 – 1,152
Multiple sclerosis	144	498	553
Muscular dystrophy	50	173	192
Spina bifida	24	83	92
Motor neurone disease	7	24	27
Traumatic spinal injury	2	7	8

Source: National prevalence rates taken from Neuro numbers – a brief review of the numbers of people in the UK with a neurological condition, The Neurological Alliance (April 2003) and applied to Barnet population

Sensory Impairment

The loss of sight and hearing can present many practical, emotional and social problems, creating a range of needs, which varies between individuals. Barnet Social Services keeps records of people who are registered with visual and hearing impairments. As at March 2011, the records identify 1,884 people with a visual impairment and 1,390 with a hearing impairment. 107 people were registered with both. There is a disparity between those people registered with an impairment and the estimated prevalence. This may indicate large numbers of people within the borough living independent lives without the need for support from statutory services; it could also indicate a particular level of unmet need within the borough.

A user consultation held in 2009 amongst people with hearing impairment, *See Me! Hear Me!* identified some problems with accessing and using interpreting services, particularly when used for health-related appointments. The consultation also highlighted the need to provide better information about equipment, services and organisations that can help to make deaf or hard of hearing people's lives easier.

Learning disabilities

In general, people with learning disabilities have much poorer health, shorter life expectancy and a greater risk of early death. Problems are caused by a high incidence of congenital defects, respiratory disease, and epilepsy, but people with learning disabilities also suffer from high levels of incidence of schizophrenia, psychiatric disorders and dementia. In addition, adults with learning disabilities are more likely to be exposed to poverty, unemployment and social disconnectedness. There are also widely reported issues surrounding poor diets and nutrition, obesity and a lack of physical activity.[xx]

There are an estimated 6,336 adults in Barnet with a learning disability (IQ less than 70). Around 6% of these have a **severe or profound learning disability** (IQ less than 35), and another 15% have a **moderate learning disability** (IQ between 35 and 49).[14] There are also significant numbers of children with learning disabilities. A total of 805 adults received a care package from Adult Social Services during 2009/10. This user population tends to be fairly stable – only 9% of users that year had not received services in the previous year. A similar proportion stopped receiving services. The stability of this population raises questions about continuing to meet their social care needs amid projected population increases and continued budget reductions.

Overall numbers of people with a learning disability are set to increase over and above simple population increases because of:

- increased survival rates for young people with severe and complex disabilities
- increased life expectancy for people with a learning disability, in particular for people with Down's syndrome
- increased diagnosis of autistic spectrum disorders
- higher prevalence rates among South Asian ethnic groups.

With this increase comes a potentially sharp increase in the numbers requiring and accessing health and social care services, and work must be done to ensure that people with learning disabilities are supported to live independent and healthy lives out in the community.

National research shows that, despite their increased chances of health problems and issues, people with learning disabilities are less likely to receive regular **health checks**, and are less likely to take up health promotion or screening activities such as routine dental care or cervical smear tests. Greater collaboration is needed between GPs, primary health care teams and specialist services to support people with learning disabilities. Whilst recording of learning disabilities amongst GP practices has increased significantly over recent years, there still appears to be a shortfall compared to the overall learning disabled population within the borough.

An audit of GP practices carried out in 2010 showed that 436 patients with learning disabilities had received an annual health check during 2009/10. Annual health checks were introduced in 2008 as part of a Directed Enhanced Service (DES) to overcome health inequalities faced by people with learning disabilities. However, in 2009/10 only 56 of 68 practices had signed up to the DES. The audit revealed that even amongst those practices signed up to target learning disabled patients with health checks, there was great disparity in service, with only 59% of patients receiving an annual health check.

Among users of social services, those people with the most severe learning disabilities, **residential care** placements feature heavily, with around a third of service users in a care home setting – much higher than users within other care groups. Not only is this detrimental to the achievement of independence for these particular people, but it also contributes to very high care costs generally within this care group; in 2009/10 people with learning disabilities made up just ten% of the Adult Social Services client-base but accounted for 30% of spending. Over half of these service users are actually placed in residential settings **outside of the borough**, again highlighting the historically limited options for accommodation and the relatively low level of aspirations for this group.

The independence of people with learning disabilities is also being restricted by the low level of employment among this population. People with disabilities, in particular those with mental health problems and a learning disability, require intensive 1:1 support to prepare for, find and keep work. As such they find it difficult to make use of mainstream Jobcentre Plus or Department of Work and Pensions work programmes, or often do not meet the eligibility criteria.

[14] 2010 figures taken from Department of Health's PANSI and POPPI projection models

Autism

Approximately one% of the adult population is said to have a disorder on the autistic spectrum, equating to around 2,600 in Barnet.[xxi] This is in addition to an estimated 0.82% of children with autism.[xxii] Rates are much higher in men than they are in women (1.8% versus 0.2%).[xxiii] Studies elsewhere suggest around a quarter of those with an Autistic Spectrum Disorder (ASD) will have a learning disability, and around a quarter of learning disabled social care clients will have an ASD, but locally there is a lack of data to assess the numbers and level of autism across service usage.

Amongst children, where local data is collected, the number with autism recorded as a Special Educational Need is much lower than we would expect from national prevalence rates. Barnet has a **leading edge group on autism** able to advise on policy and practice in autism at all levels for children and young people (including young adults transferring to college), **nationally recognised good practice** approaches and outstanding special schools, so awareness across early years providers and school settings is strong. In light of this, the difference between the anticipated prevalence and the actual incidences is unclear.

Within health and social care, GPs and social care staff report **low awareness of autism** and how to diagnose it, with 80% of GPs surveyed reporting that they need additional guidance and training in order to identify and treat patients with autism more effectively.[xxiv] A shortage of suitable interventions or support, particularly around early identification and intervention of autism, is prolonging the strain put on families and potentially increasing the long-term care costs associated with autism.[xxv]

Barnet Council and NHS Barnet have recently developed an **Autism Action Plan** that will attempt to plug the gaps in local data, develop a system for identifying and diagnosing autism and assessing needs, ensure young people with autism are supported into adulthood and employment, and deliver appropriate training and communication to front-line staff. A key element of the Action Plan is ensuring early-stage support is available for people with high-functioning autism, such as Asperger syndrome. Approximately half of people with autism will be high-functioning (that is, with an IQ above 70). Although these people may not qualify for social care services because of a learning disability, they are likely to experience **stigma and isolation** because of a lack of public awareness and understanding, and may find it difficult to contact and engage with local health and social services.

Mental Health

Mental health problems are the commonest cause of death and years-of-life lost through disability because of the close link between physical health and mental health. This relationship informs the framework for the government's **No Health Without Mental Health** strategy released in February 2011.

Generally Barnet has low levels of severe mental illness when compared with national rates, though there is a disparity in prevalence between different parts of the borough; some wards within Barnet have a 60% lower need for inpatient services than the England average, but in others the need is 40% higher. The table below reiterates this disparity, with GP patients in the west of the borough apparently supported more effectively to stay out of hospital.

GP registrations and hospital admissions for schizophrenia and bipolar disorder by GP cluster in Barnet

	North	South	West
per 100,000 people admitted into hospital because of schizophrenia or bipolar disorder in 2009/10	48	53	36
% of GP patients registered with schizophrenia, bipolar disorder or other psychosis in 2009/10	0.95%	0.82%	0.95%

Source: QOF data 2009/10

People with mental health issues tend to die earlier due to higher rates of physical health problems:

- Higher rates of smoking amongst people with serious mental illness – 61% of people with schizophrenia and 46% of people with bipolar disorder compared to 33% of the general population.[xxvi]
- Patients with depressive disorder are twice as likely to use emergency department services as those without depression.
- Approximately a quarter of people with physical illness develop mental health problems as stress causes depression, anxiety and panic.
- Untreated depression can lead to a mortality rate of two to three times higher than normal, due to factors including social deprivation, adverse effects of medication increasing the risk of developing the metabolic syndrome, and poor access to services.[xxvii]
- People with mental health problems are much less likely to be offered, for example, blood pressure checks and cholesterol checks and cervical screening.[xxviii]

Despite these strong links between physical and mental health, people with mental health problems often do not get the input and support they need through primary care services.

Mental health is also associated with other personal and social variables:

- Those with mental health issues are more likely to be unemployed and the majority that are out of work for more that six moths will never work again. Employment provides clear benefits to general mental health.
- The risk of mental health problems is considerably higher in deprived areas.
- The risk certain of mental health problems is high amongst particular ethnic groups. For example, schizophrenia is diagnosed amongst African Caribbean people that other ethnic groups.

Dementia

Dementia becomes more prevalent as people get older. Estimates suggest that dementia affects 8% of people aged 65 and over in Barnet (3,778 individuals) and 24% of people aged 85 and over. Thus the number of people affected by dementia is expected to grow by 26% (approximately 1,000 people) over the next ten years.[xxix]

Local GPs receive incentives for recording details of their patients diagnosed with dementia on a register, in order to encourage early identification and early treatment of the symptoms of dementia. In 2009/10, 2,038 people within Barnet were recorded on the **dementia register**, providing a crude prevalence rate of 0.56%. These figures are likely to be grossly understated due to a lack of recording and diagnosis, but they help illustrate the upward trend in people presenting at GPs with dementia, as well as the particularly high incidence of dementia on Barnet registers compared to the London average. Of those on the register in Barnet at the end of 2009/10, 90% had had their care reviewed in the past 15 months.

Locally, the Barnet, Enfield and Haringey NHS Mental Heath Trust's 2010 **Dementia Strategy** sets out a strategic vision which includes reducing the use of antipsychotic medication in people with dementia and improving end of life care for people with dementia. Barnet's **Dementia Action Plan** has mapped local services against the National Dementia strategy and identified gaps. A number of actions have been agreed including:

- Improving public and professional awareness
- Provision of good quality information
- Good quality early diagnosis and intervention.

Depression

22,924 Barnet residents were recorded on GP registers with depression in 2009/10 and an estimated 7,718 people within Barnet will experience a depressive episode in any one week. Of patients newly diagnosed in that year, over 90% had an assessment of severity at the outset of treatment, but only 70.5% of these received a further assessment of severity 5-12 weeks afterwards.

The incidence of depression increases quite significantly with age; depression is the most common mental health problem in **older people**, with around 25% of older people in the community needing intervention. Older people with physical ill health, those living in residential care and socially isolated older people are at particularly high risk. Regardless of the high prevalence in older people, as few as one in six discuss their depression with their GP and, when untreated, often have an increased need for other services.

Cancer

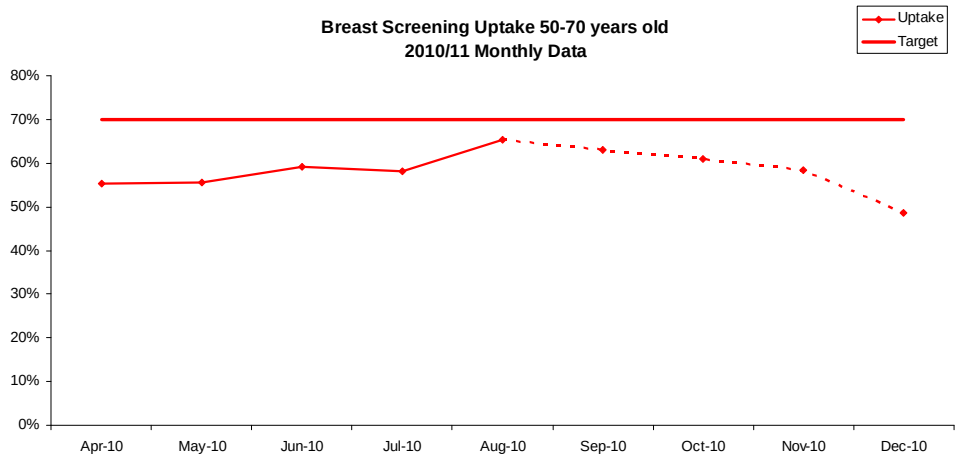
It is estimated that more than one in three people will develop some form of cancer during their lifetime. The incidence of cancers is showing a **downward trend** in Barnet which contrasts to the trends seen in London and nationally. However we should not be complacent as this remains a significant health issue and as population grows and life expectancy increases, so the number of cancers diagnosed locally each year is likely to increase.

The most significant cancers in terms of incidence in Barnet are breast cancer, colorectal cancer, prostate cancer and lung cancer. Incidences of breast cancer are increasing though remain lower than the London and national averages. Incidences of prostate cancer are also increasing and are already equivalent to the incidence rates seen in London and nationally. Colorectal cancer incidences have been consistent in recent years and are equal to those in London and nationally.

Mortality for all cancer types remains relatively low. Improving take-up of **screening** could ensure that more cancers are identified and treated earlier, increasing the likelihood of survival and decreasing the need for more radical treatment. Breast cancer is an example where the relative mortality for Barnet is low but we cannot be complacent because the incidence trend is rising and the one year survival after diagnosis is low.

Cancer screening

Screening is the single most effective way to detect **breast cancer** at an early, curable stage. Incidences of breast cancer are lower than both the London and national rates however the latest available figures show that there is a continual low uptake of screening in the Barnet PCT.



Note: Dotted line represents unconfirmed uptake figures

Bowel cancer is the second most common cause of cancer deaths in the UK, and has the fourth highest incidence of cancer in Barnet PCT. It is predicted that deaths from bowel cancer could drop by as much as 15% as a result of screening. Overall, deaths from bowel cancer in Barnet are declining and this is likely to be due to early diagnoses being made and to treatment being more effective. Full implementation of the bowel screening programme in Barnet began in October 2007 and, as a consequence, bowel cancer's contribution to the overall cancer mortality rate should start to reduce further.

Respiratory Disease

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 caused by **smoking** and is the most significant risk that we face.

During 2009/10, the majority of respiratory related hospital admissions were due to Pneumonia followed by COPD and Asthma. Admissions due to Asthma were highest from the West cluster, whereas residents from the North cluster had higher admissions for COPD and Pneumonia. The lowest number of admissions from all of these conditions was from the South cluster.

Number of inpatient admission by Barnet localities, 2009/10

	Asthma	COPD	Pneumonia	Total
North	145	203	407	755
South	65	108	273	446
West	158	155	289	602
Total	368	466	969	1803

Source: Information centre QOF data[15]

There are 3,649 individuals registered with GPs in Barnet with **COPD**. However, since COPD is largely undiagnosed, the true prevalence of this condition is unknown. Estimates suggest that the true rate could be ten times higher.[xxx] Rates are higher in men, although this is now beginning to equalise as more women reach an age when smoking earlier in life is taking its toll.[xxxi]

Stopping smoking is important whatever the degree of disability someone has because of COPD. This has two important effects: it prevents the damage getting worse and it reduces the risk of hospitalisation. Research has shown that stopping smoking more than halved the likelihood of hospital admission, but merely reducing smoking does not make any significant difference.[xxxii] The risk of people suffering and dying from other respiratory diseases can also be reduced by **quitting smoking** (since smoking increases one's likelihood of developing acute bronchitis) and, for those in at-risk groups, of having an annual **influenza immunisation**.

Rates of **tuberculosis (TB)** are steadily increasing, particularly in the North Central London region. Analysis of the characteristics of local cases suggest that in most instances patients are first exposed to TB bacteria in other parts of the world, only developing the disease up to ten years after their arrival in the UK.[xxxiii] If untreated, an active TB infection can be potentially fatal because it can damage the lungs to such an extent that a person becomes unable to breathe properly and needs admission to hospital.

[15] Note that Pneumonia is not a QOF indicator as it is an acute illness rather than chronic. Thus prevalence figures not provided for pneumonia in the table

There is insufficient data currently available to indicate any relationship between ethnicity or other aspects of diversity and respiratory disease. However, it is likely that different smoking habits in men and women in different ethnic groups are likely to have an effect on this. Since smoking is more prevalent in deprived communities, and these areas are also more likely to be polluted (from traffic and industrial emissions), residents of these neighbourhoods are at greater risk of respiratory disease. The Council's Local Development Framework outlines several priorities which promise to **improve air quality**.

Coronary heart disease and stroke

Death rates from CVD have been dropping in recent years both in Barnet and nationally. There have been two main reasons for this: nationally, the prevalence of smoking has been dropping and treatment for both heart attack and stroke (especially for heart attack) is more effective now than it was. However, given the estimated population projections we should expect 18% more people to be suffering from CHD and 16% more people to suffer a stroke by 2020. Unless we take active steps to help people to reduce lifestyle risks such as smoking and obesity, and identify more people with established problems such as raised blood pressure, raised blood cholesterol and diabetes, then this downward trend in death rates is likely to reverse. The slightly higher death rate from stroke in 2009 may signify the start of this reversal but it is too early to say.

Projected increase in prevalence of CHD and stroke, all persons 2010-2020, Barnet

Condition	2010		2020		Projected increase in cases	
	Prevalence	***Number***	***Prevalence***	***Number***	***Percentage***	***Number***
CHD	4.6%	12,605	5.0%	14818	18	2,213
Stroke	2.1%	5567	2.2%	6479	16	912

Source: ERPHO modelled estimates and projections for Local Authorities in England for CHD and stroke respectively

There is a clear correlation between **deprivation** and the incidence of CVD. Additionally Asian people are at a 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.[xxxiv] A growing Asian population coupled with higher deprivation would lead one to expect that there will be the greatest increase of CVD incidences in the western corridor of the borough. The **Finding the 5,000** initiative supports this and has led to the creation of a 'local enhanced service' (a local addition to GPs' NHS contracts) in order to identify individuals who have CVD risk factors, manage these risk factors to pre-determined levels and plan appropriate social marketing packages to target information appropriately and effectively.

Diabetes

Diabetes is a chronic and progressive disease in which the amount of glucose in the blood is too high. The prevalence of diabetes in Barnet is estimated at 8.1% of people aged 16 and over in 2010, though Barnet GPs have only identified around 15,000 individuals (4.3% of the registered population) living with diabetes.[xxxv] The discrepancy in the estimated (21,608) and actual number (15,595) of patients diagnosed by GPs locally suggests that it is likely that there are a considerable number of **undiagnosed cases** (though perhaps not as many as suggested by the estimates). Incidence rates are higher in more **deprived** areas and among some **ethnicities**. The highest incidence rates are found amongst Asians (20%) and Black Africans and Black Caribbeans (17%). The average age at diagnosis is also lower in these groups and the risk of death from diabetes is between three and six times higher than the general population.[xxxvi]

Diabetic retinopathy is a leading cause of **blindness** in people of working age in the UK. Research shows that if retinopathy is identified early, through retinal screening, and treated appropriately, blindness can be prevented in 90% of those at risk.[xxxvii] A report entitled *The Cost of Blindness* calculated that lifetime costs of dealing with retinopathy can be up to £237,000 per person. [xxxviii]

The increase in risk for diabetes with each kilogram weight gain has been estimated to be between 4.5-9%.[xxxix] Thus, a major risk factor for Type 2 diabetes is **obesity**.[xl] An obese woman is 12.7 times as likely to develop diabetes as a woman who is not obese and an obese man is 5.2 times as likely to do so as a man who is not.[xli] Unless the year-on-year rise in obesity in Barnet is curbed then the number of people with diabetes (and thus the number of people at risk of complications and death as a consequence) will continue to rise. Diabetes is also **more common with age** and is more likely to occur in someone if one or more of their close family has diabetes, and in women who developed glucose intolerance during pregnancy.

Obesity

In Barnet, 24,988 adults aged 18 years and above are registered as obese giving a crude prevalence of 9.2% amongst the registered population.[xlii] Obese adults are at a greater risk of **premature death** and are 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 and obesity as a BMI of 30 and over. [16] People with a BMI of 40 or more are referred to as being 'morbidly obese'.

Between 2007 and 2009, just 9.76% of residents over 16 in Barnet participated in moderate intensity sport and **active recreation** on 20 or more days in a month, slightly below the London average of 11.25%. However modelled data suggests that Barnet eating habits are fairly good, with 42.0% of over 16s eating five or more portions of **fruit and vegetables** a day. However, the rate of eating healthily is not uniform across the borough; 56.1% and 54.3% of adults eat healthily in Garden Suburb and Totteridge respectively, whilst in Dollis Valley only 32.7% do, a difference of more than 23%.[xliii]

People in lower socio-economic groups are more likely to be obese and people from certain ethic groups are likely to be obese; **Asian** individuals and **Black Caribbean** women are more likely to be obese than White residents. More men are overweight than women but the proportion of obese men and women is much the same. It is unclear why this should be so and it may simply be a statistical artefact. However, the relative risk of developing a number of diseases is greater in obese women than it is in obese men. In terms of geographical distribution, most obese people are found in the west locality.

Obesity has been called 'the new epidemic'. Whilst currently fewer people die in Barnet due to the direct and indirect effects of obesity, it is clear that without adequate action, morbidity and mortality will rise considerably over the coming years and will probably reverse the current downward trend in death rates.

Smoking cessation

Tobacco use is the most important preventable risk factor for death from cancer and cardiovascular disease.[xliv] Of the 2,600 people that die in Barnet each year, about 440 die from smoking-related diseases – more than from any other cause and these deaths are all **preventable**.[xlv] Although Barnet's smoking prevalence overall is estimated to be only 17% and is one of the lowest in London, this still means that there are some **62,300 smokers** in the borough of Barnet.

[16] 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

Among many other conditions caused by smoking are chronic obstructive pulmonary disease (COPD), coronary heart disease, osteoporosis, insulin resistance in diabetes, infertility, age-related macular degeneration (the most common cause of blindness in older people), premature menopause, Crohn's disease, gastro-oesophageal reflux and peptic ulcers, bone resorption and tooth loss, multiple sclerosis, thyroid disease, hearing loss, and liver disease. Women who smoke when pregnant damage the placenta and this leads to a reduced blood supply to their baby. Smoking is also a cause of premature hair loss and premature skin ageing. It is not only smokers that are susceptible to these conditions but substantial evidence suggests that many afflict those exposed to **passive exposure** of tobacco smoke by non-smokers.

NHS Barnet Primary Care Trust is commissioning **Stop Smoking Services** from Barnet Community Services. The cost effectiveness of this is amongst the lowest available and is extremely favourable when compared to treatment costs of smoking related diseases.[xlvi] Evidence has shown that a combination of behavioural support from a stop smoking adviser plus pharmacotherapy can increase a smoker's chances of stopping by up to four times.[xlvii]

There are differences in smoking habits between the sexes and between people in different ethnic groups. Principally, this is important when planning smoking cessation services. It is important that promotion and provision of such services are culturally appropriate and that smokers see them as relevant to them and not just to others.

Smoking is also more prevalent among people who live in **deprived areas** and markedly higher among people with **mental illness**.[xlviii] As smoking is the cause of so many deaths, and it is more common amongst people living in more deprived areas, an important cause of the differences in death rates between affluent and deprived areas is likely to be smoking. Seeking to increase the proportion and the absolute number of smoking quitters in deprived areas will thus contribute to reducing health inequalities.

Misuse of alcohol and other drugs

The National Treatment Agency (NTA) Models of Care document defines **drug misuse** as "drug taking that causes harm to the individual, their significant others or the wider community".[xlix] The UK government has advised that consistently drinking four or more units a day (for men), or three or more units a day (for women) is not advisable.[l] **Binge drinking** is classed as the consumption of more than eight or six units (males and females respectively) in a single session.[li] By this measure, one in four adults in Britain is a binge drinker.

Physical health problems due to **drug misuse** include thrombosis, abscesses, overdose, Hepatitis B and C, HIV, and respiratory and cardiac problems. These result in high levels of morbidity and mortality. Health problems from **alcohol misuse** may affect the brain, liver and pancreas resulting in stroke, liver and heart diseases. It also causes cancer, sexual problems and could result in infertility. It is estimated that 70% of all visits to accident and emergency (A&E) departments at peak times are due to alcohol misuse. A high proportion of drug and alcohol problem uses have experienced mental health problems.

Alcoholism

According to the Office for National Statistics, **middle class drinkers** are more likely to indulge in heavy drinking – this equates to drinking double the recommended daily limit on a given evening. Middle class professionals are much bigger drinkers than blue collar workers. Middle-class children, especially **teenage girls** living in affluent areas or rural communities with two working parents, are significantly more likely to have tried alcohol than any other group. They are bigger binge-drinkers and drug-takers than peers in the inner-cities.[lii]

With the rate of alcohol related **admissions to local hospitals** more than doubling between 2004/5 and 2009/10 (564 in 2009/10), alcohol misuse is an expensive habit for both the misuser and public services (not to mention the secondary social and environmental costs, such as drink driving and domestic violence). Educating the public about responsible consumption would reduce the burden on the health, social care and criminal justice systems.

Drug misuse

The **annual cost** per problematic substance user is estimated to be over £45,000 (including health, work, driving, crime and other economic and social impacts).[liii] The National Treatment Agency value for money tool, demonstrates that for every £1 spent on the local treatment system, £5.24 is gained in total benefits. In 2009, the estimated number of problem drug (opiate and/or crack cocaine) users aged 15-64 years in Barnet was 1,275, making the estimated burden on local public services £57.4m.

There are a number of **risk factors** which affect the likelihood of someone misusing drugs, including experiences in the family, home, neighbourhood, school, work, and other settings. Among vulnerable or disadvantaged children and young people aged under 25, the risk of misusing substances increases if they fall into any of the following categories:

- Those whose family members misuse substances
- Those with behavioural, mental health or social problems
- Those excluded from school, and truants
- Young offenders
- Looked after children
- Those who are homeless
- Those involved in commercial sex work
- Those from some black and minority ethnic groups.

A lot of work had been done in Barnet to address harm associated with drug and alcohol use through the Barnet **Harm Reduction strategy** and **Drug Related Death strategy**. The Barnet Drug & Alcohol partnership delivers a broad range of harm reduction services including Needle Exchange services at pharmacies and all specialist drug treatment services in Barnet, Hepatitis B vaccinations and Hepatitis C testing, substitute prescribing, brief interventions and general healthcare assessments in line with the Harm Reduction strategy.

Sexual Health

Sexual health is an important aspect of physical and mental wellbeing. 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 poor educational, social and economic opportunities; sexually transmitted infections (STIs) and HIV/AIDS; ectopic pregnancies leading to infertility; cervical and other genital cancers; and hepatitis, chronic liver disease and liver cancer.

Nationally, the number of new cases of STIs rose in 2009. This was due to increase diagnoses of genital **Chlamydia, gonorrhoea and genital herpes**. The true incidence of STIs in Barnet is not known since figures on the numbers of people with a STI are rarely presented on the basis of a person's residence. Most data are reported at GUM clinic level, but since these clinics see people regardless of their place of residence, figures from clinics include diagnoses made on people living outside of the 'host' PCT area where the clinic is situated.

There is a clear relationship between rates of sexual ill-health, poverty and social exclusion. Certain groups are particularly at risk of poor sexual health, including:

- young people, especially those in, or leaving, care
- people from Black and ethnic minority groups
- gay and bisexual men
- injecting-drug users
- adults and children living with HIV and other people affected by HIV
- sex workers
- people in prisons and youth offending establishment.

People in these groups are not only more likely to engage in sexually risky behaviour, but will often make only poor use of existing services and are therefore hard to reach.[liv] In light of this, those planning sexual health services should be consider issues of ethnicity and diversity, for example:

- Certain communities are more likely to experience a high incidence of specific STIs. HIV is more common amongst the Black African community.
- Services may need to be modified to be made religiously and/or culturally acceptable to certain communities, for example sex and relationships education (SRE) programmes for young people from certain orthodox Jewish and Islamic communities.
- Cultural values and ethnicity may affect health beliefs and behaviours and health-seeking activities.

HIV/AIDS

In 2009, there were 640 people known to have HIV infection living in Barnet – 367 males and 273 females. This equates to a prevalence rate of 2.7 per 1,000 population aged 15-59. These rates are lower than the London average of 5.0 per 1,000 people. The highest rates are found in the south-western tip of the borough. The rate of HIV infection has increased by 25% since 2005, though this is lower than the rate nationally.

Two areas of particular pressure

This section concentrates on the two extremes of Barnet's population, where the most significant growth is expected and where dependence on public services is greatest.

Children and young people

Barnet has the second largest population of children and young people in London (estimated in 2010 at 88,560). Over the next five years it is estimated that the 0-19 cohort in Barnet will grow by 6.8%, with 22.8% more children aged 5-9 by 2016. In real terms, this equates to an increase of almost 6,000, with 4,700 more 5-9 year olds alone.[lv]

The Barnet **Children and Young People Plan** 2010-2013 includes several priorities related to health. The actions under these are refreshed annually to reflect action planned for the coming year. The current priorities are to:

- Improve emotional health and wellbeing
- Increase choice and access to maternity services
- Increase take-up of immunisations
- Reduce obesity in children and young people
- Improve adolescent health.

Overall, and in comparison with the national picture, children in Barnet have above average health, educational attainment and life chances. However this experience is not uniform for children across the borough. As part of funding reductions, services are likely to become more targeted to those children, young people and families considered to be **most in need**, and in communities where need is highest. Recent national policy guidance also stresses the importance of the **early years** and providing a good start in life, together with prevention, early intervention and well integrated services to reduce both duplication and gaps in service provision.

Childhood Mortality

Low birth weight is a known risk factor for infant deaths. Babies of low birth weight (less than 2,500 grams) are more likely to die. In comparison, very low birth weight babies (less than 1,500 grams) are much more likely to die within the first year of life. The Child Death Overview Panel (CDOP)[17] in Barnet found that of 46 babies reviewed in the period 2008 to first quarter 2011, 17 were categorised as premature and had birth weights which were found to be less than 2500 or 1,500 grams. Nine were due to **still births**.

Breastfeeding

Breastfeeding brings significant health benefits for both mother and child. Infants who are not breastfed appear more likely to suffer with conditions such as **gastroenteritis** and **respiratory disease**, requiring hospitalisation. In the longer term the child could be a greater risk of having higher levels of blood pressure and blood cholesterol in adulthood at a greater risk of Type 2 diabetes. In addition, breastfeeding is associated with a reduction in the risk of **breast and ovarian cancers** for mothers. [lvi]

Increasing rates of breastfeeding is considered to be a vital component of improving the health of the population, and in particular that of children and young people. For this reason the Department of Health monitors rates of breastfeeding initiation and rates of breastfeeding at six to eight weeks after birth.[lvii] Breastfeeding initiation rates in Barnet are one the **highest** of any of London's PCTs.

[17] This panel has responsibility for reviewing all deaths in children up to 18 years with priority given to unexpected and unexplained deaths.

Children with disabilities

The national Family Resources Survey estimates that around 5% of under 16s have a disability and the Department for Children, Schools and Families (now the Department for Education) estimated around 7% of children have a disability as defined by the Disability Discrimination Act (DDA). In Barnet, this would equate to around 3,600 – 5,100 children from 0-15 or 4,400 – 6,200 from 0-19.

Those children born with **chronic conditions** are now living longer than previously. Over 85% of children with congenital or chronic conditions now survive into adolescence, and conditions once seen only in young children are now seen beyond childhood and adolescence. In addition, the prevalence of certain chronic illnesses in adolescence, such as diabetes (Types 1 and 2) and asthma, has increased, as has survival from cancer.[lviii]

Childhood infectious diseases

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, by 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.[18]

The number of cases of **measles** in Barnet increased during 2007/08 and 2008/09 because there were many children whose parents refused consent for them to be immunised with measles, mumps and rubella (MMR) vaccine and 'herd immunity' of the population fell. **MMR immunisation** rates are now starting to increase in London, although they remain lower than the rest of the country. Sporadic measles outbreaks have occurred in parts of London in 2010. Considerable more work still needs to be done to ensure uptake rates reach a level (95%) that will prevent future measles outbreaks or a measles epidemic. In Barnet, the MMR rates have improved considerably since 2007/08, however the levels are starting to plateau and we are still at risk of an outbreak.

Childhood obesity

Every year since 2005, as part of the National Child Measurement Programme (NCMP), children in Reception and Year 6 are weighed and measured during the school year to inform local planning and delivery of services for children. The last verified data pool (2009) identifies obesity in 10.4% of Barnet boys and 8.8% of Barnet girls ahead of the England average 9.8% in Reception year (aged 4-5 years) and 20% of boys and 16.6% of girls, which is behind the England average 18.7% in Year 6 (aged 10-11 years).

Oral Health

The need to reduce oral health inequalities remains high. The main measure of children's oral health is an estimate of the average number of decayed, missing or filled teeth that each child has. This is the 'dmft' index. For deciduous ('milk') teeth, this is denoted as the dmft index and for permanent ('adult') teeth as the DMFT index – the higher the index, the worse the dental health.

The NHS Dental Epidemiology Programme for England Oral Health survey of 12 year olds in 2008/09 showed that Barnet's dmft index (0.51) is better than the London average (0.57).[lix]

Child and Adolescent Mental Health (CAMHS)

Mental health problems are not restricted to adults. Among Barnet children aged 5-16, 5.3% have a conduct disorder, 4.3% have an emotional disorder, 1.4% are hyperactive, and 1.3% have a less common mental disorder. Children with medical conditions have a higher incidence of mental health problems, learning disabilities, developmental disorders and autistic spectrum disorders. Children that

[18] 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.

are looked after by the local authority are at much higher risk of developing certain behavioural disruptions than the general population, a trend particularly evident in children in residential care. Children with mental health problems are more likely to commit crimes or self-harm.

Sexual Health

Sexual health is a major issue for young people, especially **sexually transmitted infections** (STI), which are on the increase in the UK and are disproportionately affecting young people. Research shows that young people are more likely to have higher numbers of sexual partners, use barrier contraception inconsistently and are more likely to become re-infected after being diagnosed with and treated for an initial STI. The incidence of sexually transmitted infections (STIs) in Barnet is in line with the national average, although diagnosed with **Chlamydia** is increasing. The decommissioning of Chlamydia services in Barnet increases the risk of young people in Barnet with Chlamydia being left untreated, which can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility.

Teenage pregnancy

Teenage pregnancy is an important issue in public health as teenage parents are prone to access antenatal care late (if at all), have lower birth weight babies and high infant mortality rates. Barnet has one of the **lowest rates** of teenage pregnancy in London, and this is also lower than similar boroughs (including those matched for deprivation) such as Merton, Hounslow and Enfield. The rate of teen pregnancies increased from the first quarter 2001 until the second quarter of 2004 but has since returned to 2001 levels. Approximately 17% of teenagers who conceived in Barnet in 2009 had a termination of pregnancy.

Teenage mothers are three times more likely to **smoke** throughout their pregnancy, and half as likely to **breastfeed**, than older mothers – both of which have negative health consequences for the child. Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties and are more likely to have accidents and behavioural problems. Moreover, falling pregnant can result in **low educational attainment** and disengagement from school for the mother, increasing the chances that they leave school at 16 with no qualifications, consolidating the cycle of deprivation.

Child Protection Services

Between July and September 2010, Barnet Children's Service received 842 referrals, carried out 107 initial assessments and 183 core assessments. This was almost twice the number of **referrals** and **initial assessments**, and six and half times as many **core assessments** as during that same quarter in 2006; below both the London and national averages.[lx] In March 2010 there were 311 **children in care** in Barnet, the majority of whom were boys aged 10-15. The number of children in care fluctuates during the year depending on the number of children entering and leaving care, and as at February 2011 there were 307 children in care.

Children in Need

As at 1 March 2011, there were 1,905 children considered 'in need' by Barnet Children's Social Care, compared with 2,028 at the end of March 2010. The majority of these children were boys. They were particularly concentrated along the A5 corridor and others areas with relatively high levels of socio-economic **deprivation**. Due to challenging family situations or other forms of disadvantage, children in need are often more likely to be at risk of negative health outcomes, including negative mental health outcomes.

Transitions

'Transitions' is a term used to describe the move into adulthood for those young people accessing social care services. Becoming an adult can be a difficult and challenging time for a young disabled due to the difference in support services available to adults from those that are offered for children. To help manage these changes, a dedicated Transitions team works with children with needs from the age of 16,

sometimes right through into their 20s. The transitions teams work with those with both physical and mental disabilities, learning disabilities and those with dual diagnoses.

Older People

There are an estimated 44,900 people aged 65 or over living in Barnet.[lxi] According to projections, this elderly population is set to rise by 21% over the next decade. Within this older population, the comparatively small 90+ age group is set to increase by 1,600 (55%).

The higher incidence among older age groups of many health conditions, disabilities and incapacities, as set out in the chart below, means that our ageing population poses a great challenge to the health and social care systems in terms of managing demand for services with increasingly tight resources. It is older people who are the main users of health and social care services. Older people are three times more likely to be admitted to hospital following attendance at an emergency department. Once there older people are more likely to stay and suffer life-threatening infections, falls and delirium.[lxii] Increased **life expectancy** in Barnet implies longer periods for individuals where health, social care and support are required.

In addition, the forthcoming **welfare reforms**, particularly those related to housing benefit and disability benefits, will impact on a number of groups, but especially older people and those with disabilities. With the projected increase in people living with long-term conditions and increasing shortage of **affordable housing**, more work needs to be done to focus on how such impacts can be mitigated.

Current estimates and projections of disabilities and health problems amongst older adults in Barnet

	2010 estimate	2015 estimate	2020 estimate	% increase 2010–20
With a limiting long-term illness	20,359	22,593	24,583	21%
With longstanding health condition caused by a stroke	1,101	1,219	1,345	22%
With longstanding health condition caused by a heart attack	2,329	2,576	2,831	22%
With diabetes	5,861	6,514	7,144	22%
With dementia	3,778	4,185	4,743	26%
With depression	4,179	4,624	5,025	20%
Unable to manage a mobility activity on own	9,466	10,409	11,617	23%
Unable to manage a self-care activity on own	16,943	18,608	20,618	22%
Unable to manage a domestic task on own	20,644	22,679	25,159	22%

Source: Department of Health, POPPI

Chronic and long-term illnesses

At present there are an estimated 20,359 people aged 65 or over with a limiting long-term illness, as well as 13,146 who are expected to have a fall. By 2020, many chronic and long term illnesses are projected to increase by more than 20%.

The conditions most commonly associated with ageing are: coronary heart disease and stroke, diabetes, cancer, chronic pulmonary obstructive disease, incontinence, Alzheimer's disease, osteoporosis and osteoarthritis. There is also some decline in hearing, vision, physical strength and balance and there may be some loss in mental acuity. However, many of the diseases experienced in old age are **preventable**. For example, obesity increases the risk of Type 2 diabetes twenty-fold and doubles or

triples the risk of other chronic conditions including high blood, pressure, heart disease, and colon cancer. Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease. Men who smoke increase their risk of dying from lung cancer by 22 times, and women by nearly 12 times.

Falls and fractures

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious In Barnet, the total number of older people predicted to have a fall in 2010 is estimated at 13,146.[lxiii] This is projected to increase by 22% by 2020 and a further 26% by 2030, so that in 2030 the number of older people having a fall is estimated at 20,239. Similarly, the number of people admitted to hospital as a result of a fall is expected to increase by 20% between 2010 and 2020, from 1,065 to 1,275.

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate **loss of confidence**, the need for regular social **care support** at home, or even admission to a **care home**. Fractures of the hip require **major surgery** and inpatient care in acute and often rehabilitation settings, ongoing recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind can require a care package for most older people to support them at home.

The Department of Health has recommended that patients at risk of a future hip fracture should be **proactively identified** and managed through a systematic approach such as a fracture liaison service, thereby reducing cost in terms of bed days, rehabilitation and home support.

Social care

The ageing population in Barnet poses major challenges to the health and social care sector, in particular how we continue to allocate resources to meet needs. Nearly two-thirds of Adult Social Services users are aged 65 or over; a majority of these need help or support in their own home, and nearly half of these become eligible for help after a spell in hospital. It is important that these people are supported to regain their **independence** as soon as possible.

Out of the 4,770 older people receiving a social care package during 2009/10, 73% went on to receive services the following year. However, over half of the remaining 27% not going on to receive services the following year had actually died. Thus the actual numbers of older people **enabled out of care** remains low; this is an area that social care services, in collaboration with the health system, will need to tackle if we are to meet the challenge of an ever ageing population with less resources.

Detrimental to the wellbeing of older people is a loss of control and independence over their lives, but also feelings of **social isolation** and **loneliness**. Tied to this issue is an increased risk of social disconnectedness and isolation. In Barnet there are an estimated 18,300 older adults in living alone, making up 38% of the elderly population in the borough.[lxiv] As more and more older and frail residents elect to stay at home for longer, the need for local social groups, community health services, and preventative care facilities increases even further.

One way independence is being promoted is through **enablement services**. Adult Social Services recently changed the way that adults come into their service. All referrals now assessed as requiring home and community support are required to have a short intensive session of homecare, normally lasting six weeks. This enablement service is delivered by specially trained care-workers and focuses on people learning or re-learning particular self-care skills. The service focuses on users regaining their independence, or at least gaining enough independence to require less formal care at home. Since its launch in 2009 it has been very successful, with the majority of people not needing ongoing care after enablement.

Influenza

Influenza is a highly infectious viral illness. A **seasonal flu vaccine** is made available each year according to the circulating influenza strains. It is recommended for certain **target groups** including over 65s and those with chronic conditions such as asthma, diabetes and heart conditions.

There is an annual seasonal flu campaign to promote uptake to the target groups. The **national target** is 70% although PCTs are encouraged to aim for the WHO target of 75%. The uptake in Barnet for those aged 65 years and above during the 2010/11 flu season was 73.8%. This is slightly lower than in recent years. Further work will need to be done with practices which were unable to achieve the national target and with all practices to encourage them to reach the WHO target.

Headline recommendations

The full assessment contains a long list of recommendations against each need. However, the priority areas are as follows:

- Improve uptake of breast screening in Barnet to increase early identification and improve outcomes
- Tackle the obesity epidemic by promoting the benefits of healthy lifestyles, including physical activity and healthy eating
- Reduce admissions and readmissions to hospital among older people
- Develop more effective campaign to ensure individuals with mental health problems and those with learning disabilities receive appropriate health checks and advice in primary care
- Support residents to take greater responsibility for their own health and that of their families
- Undertake a short investigation into the issues concerning oral health of children locally.

Delivering on these priorities will require significant and ongoing cooperation between the local NHS, Council and third sector.

Next steps: Measuring progress

The JSNA represents a live evidence base and forms part of an ongoing dialogue between the NHS, local authority and thirds sector. Having been approved by the new Health and Wellbeing Board, it will be important that we are able to monitor our progress against the priorities and targets identified and outlined within this needs assessment. We need to be able to assess what impact our various projects, initiatives, programmes and interventions have had on the health and wellbeing of residents within Barnet, both individually and collectively. This evaluation and assessment is important because, although all our public health and social care projects have the aim of reducing health inequalities within the community, we need to understand which projects have worked, and what have been their impact on different groups within the borough. Impact assessment also allows us to judge whether value for money was achieved, and how well we have deployed resources.

To evaluate our health improvement programme and the projects within it, we will utilise the impact assessment framework developed by Local Government Improvement and Development's Healthy Communities programme,[lxv] which sets out four key stages:

Step 1: Understanding the project
Ideally, planning the evaluation should be done at the start of a project. Thought needs to be put into what is already known about the project and the key issues it raises; what activities will be delivered by the project and what will be its immediate results; and what will be the intermediate and long-term outcomes of the project.

Step 2: Planning the impact assessment
The impacts and outcomes identified in Step 1 can now be used to select some key impact assessment indicators to be monitored. Understanding what change we want to measure, and thinking through the best ways of measuring that change is key to success in this step. It is important that we set baselines from which to measure, and hopefully this JSNA goes a long way to defining much of that baseline position.

Step 3: Analysing the data
Once we have recorded and collected the information, we need to make sense of it in order to identify changes, trends or key themes. This should allow us to assess whether the project had its intended impact upon residents' wellbeing and health inequalities, or even whether the range of projects that we have jointly commissioned has collectively met needs and reduced inequalities within the borough.

Step 4: Sharing the findings
Once we have assessed the impact of the project, we will share findings with relevant stakeholders, including practitioners, commissioners, and user and patient groups, as well as the public through mechanisms such as the JSNA. The impact assessment will allow us to decide whether to continue investing in that particular project, or might flag up the need for alternative projects to tackle those particular health needs or inequalities.

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