

Joint Strategic Needs Assessment:

Barnet 2011-15

Table of Contents

Purpose the JSNA	4
Headline issues	4
A note about population statistics	8
Mapping the GP clusters	9
Creating a health-supporting environment.....	10
Overview	11
The Health and Social Care Bill	11
Barnet's changing population	15
Mosaic Health profile of Barnet.....	17
Deprivation	21
Headline health inequalities	24
Future challenges – Prioritising need, managing demand	30
Improving health and wellbeing	33
Causes of death	34
Physical disability.....	35
Learning disabilities and Autism	40
Smoking cessation	46
Drugs and Alcohol Misuse	53
Mental health	66
Cancers and Screening.....	75
Respiratory disease.....	89
Coronary heart disease and stroke	98
Diabetes	107
Obesity.....	112
Sexual health	115
Children and young people	122
Older people	146
Carers.....	156

Experiencing health and social care	158
Perceptions of health and social care	159
Changes in hospital activity and cost	164
Pressure on social care and support services.....	167
Safeguarding, personal dignity and respect.....	172
Investing in independence – Opportunities for preventative interventions	173
Projected needs.....	174
Personal budgets	177
The voluntary sector and Big Society solutions.....	179

Purpose the JSNA

This document seeks to set out the current health and social care needs of Barnet's residents and anticipate how these may change over the coming years against a background of reduced public spending and changes to the NHS landscape. In particular we have focused on the importance of lifestyle choices in determining future health and social care outcomes. The fundamental purpose of the document is to support the commissioning, shaping and delivery of local services – whether by GP consortia, local authorities or third sector enterprise.

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

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

Headline issues

Barnet residents enjoy better than average health and higher life expectancy. However, this experience is not universal across the borough and there is a seven year difference in life expectancy between the most deprived and most affluent areas. Moreover, with a growing population, limited resources and changes planned in the provision of national health services, there are a number of challenges facing Barnet.

Implications of demographic change

Barnet's rising local population (especially at the youngest and oldest extremes) will place pressure on all health and social care services, with a number of implications for health and wellbeing.

The projected growth in the child population, especially **5 to 9 year olds** will place significant demands on health, social care and education services. In addition to the general increase, improved survival rates also mean that there will be more children with complex needs which need supporting.

45-64 year olds – another expanding age group – are most at risk of developing long-term conditions, including obesity, raised cholesterol, high blood pressure, diabetes, stroke and heart failure. This may in turn lead to a rise in incidences of dementia further down the line.

While many **older people** are living independent lives, many will be dependent on care provided by family or public services. Over the next five years, there will be 3,250 more residents aged over 65 (+7.4%) and 783 more residents aged over 85 (+11.3%). Both of these increases are above the

average growth rate (5.5%). In addition to the traditional health risks of old age, dementia is a particular issue that we can expect to see increase in prevalence as more people live into old age.

Barnet is already a very diverse borough in 2011, with 33.1% of the local population belonging to non-White communities. Different ethnic groups have differing health needs and susceptibilities. Over the coming years, Barnet is forecast to become **increasingly diverse** (35.0% non-White by 2016), creating new and complex health needs. It is vital that the unique health needs of these communities are properly understood and managed.

Increases in the total population and improvement in medical expertise means that the number of residents with **complex needs** is likely to increase over the coming years. There are an estimated 4,600 people ages 18-64 in Barnet with a **serious physical disability**, of which 1,700 are predicted to have a serious personal care disability. By 2015 this group is estimated to increase by around five per cent (in line with total population growth). By contrast, the number of residents over 65 with serious physical disabilities is forecast to increase by ten per cent over the same period – twice the average rate of growth. Additionally, there are an estimated 5,360 residents aged 18-64 with a **learning disability** in Barnet. People with learning disabilities are much more likely to have significant health risks and major health problems, and are more likely to be exposed to poverty, poor housing conditions, unemployment, social disconnectedness and discrimination. Improved survival, rising birth rates and growth among communities at higher risk of learning disabilities (for example, the South Asian community) all mean that this is likely to be an area of growing need locally.

Specific health trends

While medical expertise continues to advance, some health issues remain significant obstacles. These may be exacerbated by changes in lifestyle, the economic climate and the local population profile.

The incidence of **cancers** is showing a downward trend in Barnet. However we should not be complacent as this remains a significant health issue and as life expectancy and the number of older people increases, so the number of cancers diagnosed locally each year is likely to increase. Although mortality 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.

In 2009-10, 3,650 people were registered as having **chronic obstructive pulmonary disease** (COPD) on GP lists in Barnet. Although death rates from COPD are generally falling, it is estimated that there are as many undiagnosed cases as there are diagnosed. A challenge for the coming years is how to identifying more incidences of COPD and sooner, thus reducing the severity on the patient and public services.

Reductions in smoking and improvements treatments for heart attack and stroke mean that death rates from **cardiovascular disease** (CVD) have reduced in recent years and prevalence is lower in Barnet than nationally. However, the '**obesity epidemic**' and the growth in Barnet's middle aged population

mean that we can expect more people to be at risk of CVD than before. Without active steps to help people to reduce lifestyle risks then the downward trend in death rates is likely to reverse.

Almost 25,000 Barnet residents aged 18 plus are **obese**. Although this represents a lower prevalence than nationally (15.4% versus 24.5%) it is still a significant number, especially considering that those who are obese are at 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. Among the younger population, obesity is more of an issue, with 18.3% of Barnet children Year 6 considered obese in 2008/9 and a rising trend. Tackling obesity is an important step towards slowing the rising prevalence of diabetes locally.

Nationally and locally, the prevalence of poor **mental health** is numerically significant but often overlooked; during 2009/10, there were almost 23,000 residents suffering from depression recorded on local GP lists. Even taking suicide into account, people suffering from poor mental health tend to have poor physical health and as a result die young. Poor mental health is also associated with personal and social problems, such as someone's ability to go to work and stay in employment. In Barnet, almost half of all Incapacity Benefit claimants are receiving benefit due to mental health issues (4,040 people). With ongoing economic uncertainty and changes to the benefit system, it is important that mental health is adequately understood and managed.

Independence

With the increased pressures from a burgeoning population and reduced financial resources, it will be essential to **enable more people to manage their own health** responsibly.

Immunisation is second only to a clean drinking water supply as a way of improving and maintaining the health of the population. Take-up of the MMR vaccine has increased in recent years following some ten years of significantly low take-up. Among adults, take-up of the flu vaccine is equally important but has seen a decrease in recent years. Promoting the importance of immunisations through schools, community and faith groups might support improved vaccination rates going forward.

Tobacco use is the most important preventable risk factor for death from cancer and cardiovascular disease, making **smoking cessation** the most significant *secondary* disease prevention measure. Even though Barnet's smoking prevalence is one of the lowest in London, there remain some 62,300 smokers in the borough. Supporting pregnant mothers to stop smoking is especially important, as **smoking during pregnancy** is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intrauterine growth restriction.

With the rate of alcohol related admissions to local hospitals more than doubling between 2004/5 and 2009/10, **alcohol misuse** is an expensive habit for both the misuser and public services. Educating the public about responsible consumption would reduce the burden on the health, social care and criminal justice systems.

Commissioning informed by insight

In addition to helping residents improve their own health, there are several ways that we can ensure that our limited resources are best used. In a time of financial shortage, it will simply not be possible to meet every demand on the health and social care services. In light of this, it will be essential to **prioritise need and manage demand**. Services must be commissioned based on evidence to tackle the areas of greatest need and where the investment is most cost effective – for example the pockets of deprivation. In most cases, **identifying problems early** can reduce the severity and burden of the problem on both the individual and the state. In light of this there should be a continued, reinvigorated emphasis on prevention. Where possible, this preventative action may be delivered through **innovative solutions** which tackle the underlying causes of health and wellbeing problems in partnership with our diverse communities, and the third and faith sectors.

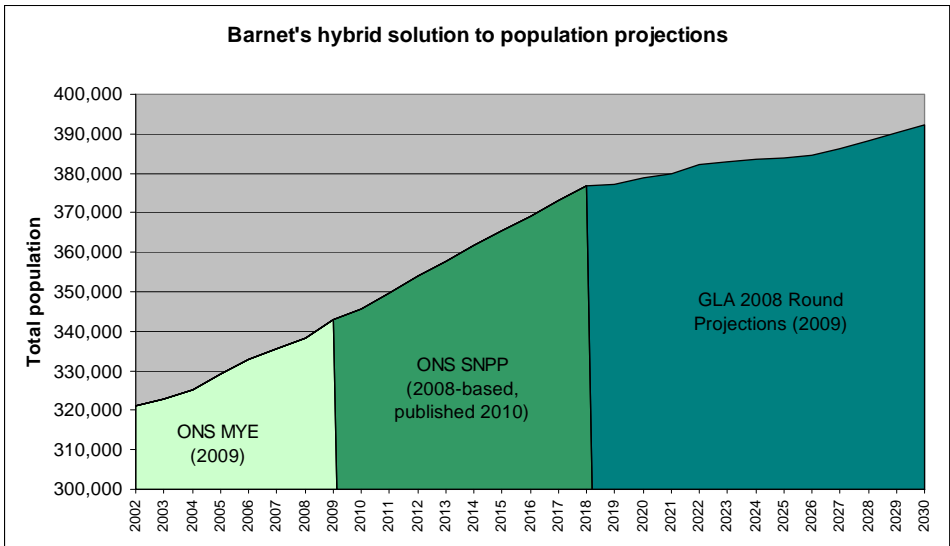
A note about population statistics

Two organisations produce population statistics that may be considered authoritative – the Office for National Statistics (ONS) and the Greater London Authority Intelligence Unit (GLA). While the ONS figures are available for the entire country and are therefore useful in comparing one area to another nationally, they do not take additional housing development into account, as the GLA figures do. Consequently, the ONS population projection for Barnet forecasts a constant rate of growth over the coming decade, irrespective of the changing capacity of the borough due to regeneration. By contrast, the GLA data forecasts periods of steep population growth, followed by shallower increases as the additional capacity created by our large regeneration projects is filled.

To manage the relative merits of each model, the Barnet Insight Unit has developed a hybrid population model which draws on the strengths of each projection. In short, the hybrid is built upon the latest GLA data for ward population adjusted proportionally to reflect the ONS total population figures to 2018. From 2019 onwards, the hybrid adopts the unadulterated GLA figures.

It is this hybrid model which is used to describe the population throughout this document (unless otherwise stated).¹

Figure 1: Barnet Hybrid Solution



Alternative sources of population data do exist, in particular GP lists, the Electoral Register and the School Census. However, while these administrative records are valuable sources of information on particular cohorts, they are not comprehensive and do not reflect the entire population as the ONS and GLA models do. As a result, health professionals reading this document should not be alarmed by

¹ The hybrid population data within this report is based upon the GLA's 2009 Round Ward Population Projections. The GLA has recently released the 2010 Round but there has not been time to integrate these new data with the model before release of this document.

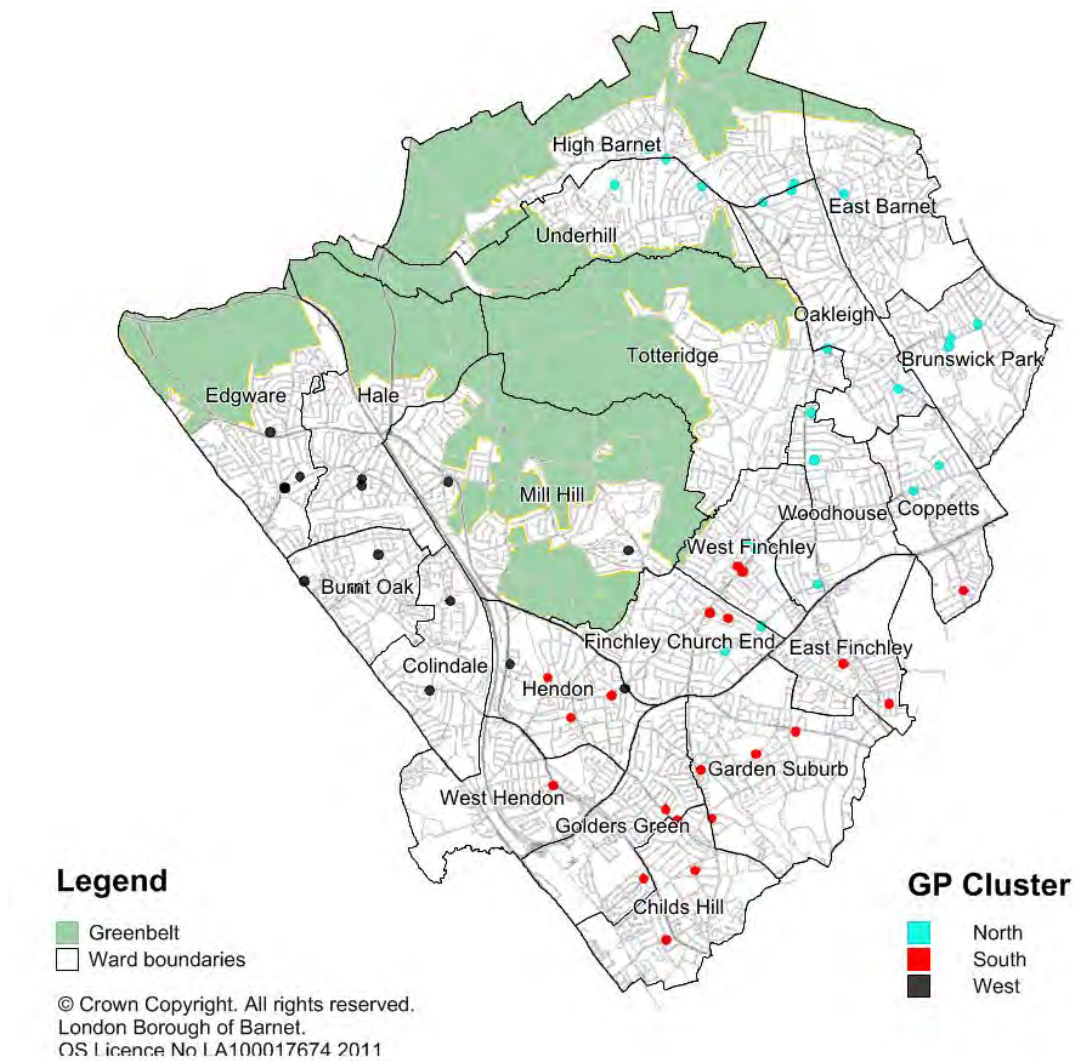
discrepancies between the number of people identified by the hybrid model and the number of people known to the NHS and other services.

Mapping the GP clusters

Where possible, data in this Needs Assessment has been divided into three geographical clusters to reflect the organisation of local NHS services across the borough. The map below is intended as a visual guide to illustrate where the practices in each cluster are located (and the somewhat ill-defined boundaries between each grouping).

It must also be noted that while a practice may be located in one area, their patients may not be drawn exclusively from that same area.

Image 1: Barnet GP clusters



Creating a health-supporting environment

Overview

This JSNA update is written at a time of significant change, not just in the local population, which is expected to expand by an additional 20,000 people over the next five years as a result of regeneration and in-migration, but also in the organisation of NHS services. These changes, discussed in more detail below include the intention to transfer NHS commissioning budget responsibility to general medical practitioner consortia from 2013. We expect to have one such consortium in Barnet divided into three localities: North, South and West. Where the size of the numbers permit, the data in this JSNA update have been presented at locality level. However, it must be remembered that the reorganisation does not affect people's needs, only how they might be met.

The Health and Social Care Bill

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 still awaiting final approval. 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 (Sectors) and Strategic Health Authorities will be **abolished** from 2013.
- **Sectors** (for the Barnet area, North Central London NHS) will be the **transition vehicles** until April 2013.
- **GPs will become commissioners** of health services through **consortia** arrangements, accountable to new NHS Commissioning Board which will be free of political control.
- **Public Health will transfer to Councils**. This will include issues such as obesity, health screening, smoking and disease control.

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.

You can find out more about the modernisation of health and social care services at <http://healthandcare.dh.gov.uk/>.

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 was 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.

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.

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>.

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 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.

Due to its statutory function and importance, the Health and Wellbeing Board will be chaired by a Cabinet Member. The shadow Health and Wellbeing Board being formed at the moment will have as members:

- Three Cabinet Members (from Leader of the Council, and Cabinet Members with responsibility for Public Health, Children and Families, and Adults)
- NHS - Barnet Borough Director
- NHS Board - non executive Director
- GP consortia representatives (x 3)
- Director of Adult Social Care and Health
- Director of Children's Services
- Joint Director of Public Health
- Representative of Barnet LINK

Providers would be invited to attend meetings as and when relevant issues are being discussed by the 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).

For more information about the role of the current Partnership Boards for social care and health, visit their pages on Barnet Online.

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 clusters and want to keep this structure to ensure good clinical involvement and to develop local services to meet local needs

We are now working with these three clusters of GPs 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.

There is the feeling amongst local GPs that it is important to get their Consortium up and running sooner rather than later to make sure structures are in place well in advance of the abolition of Primary Care Trusts in 2013. The local GPs with the support of NHS Barnet were approved as a Pathfinder on 1ST April 2011. This will enable them to form a shadow commissioning board to take forward the GP Consortium development.

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.

You can visit the Commissioning area of the Department of Health website for more information about the plans for GP commissioning and see any new local and national developments:

<http://healthandcare.dh.gov.uk/category/commissioning/>.

Barnet's changing population

The **local population** has been growing consistently over the last ten years and is expected to increase by a further 5.5% (19,400) by 2016. As of 2011 Barnet is London's most populous borough (ahead of Croydon) with 349,800 residents.²

Barnet, like the rest of London, has been experiencing a prolonged flow of **in-migration**, both from overseas and from other parts of the country – which is forecast to continue over the coming decade.

Change will not be uniform across the borough. The population in the **West** is forecast to grow most significantly, with an additional 15,000 residents between 2011 and 2016 (an increase of 12%). This growth is likely to be driven by regeneration and new housing with the most significant growth expected in **Colindale** (36%) and **West Hendon** (11%). These wards will also experience the greatest increases in population density. By comparison, the population of the **South** will increase by 5,000 (6%). In contrast the **North** is forecast to decrease slightly, by 1%.

Age profiles

The changes are not limited to simple growth – they will transform the **age** and **ethnic profile** of the borough too.

- Most significant real growth in 45-49 year old group
- Significant proportional growth in 65-69 year old group
- Proportionally high growth in 75+ age group, especially 90+
- Significant actual growth in 0-15 year olds, especially 5-9 year olds.

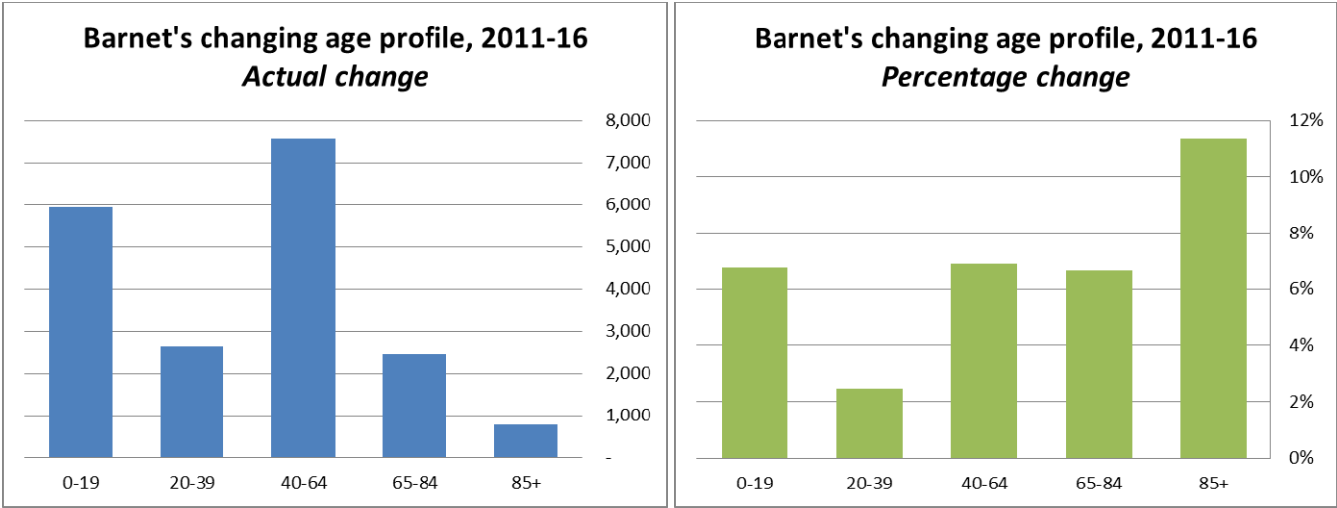
Although the GP cluster areas do not map to recognised boundaries, a simple allocation of population by broad area can be used to paint a picture of the changing age profile of the different clusters.

- The **North** GP Cluster Area is forecast to experience a general decline in 0-4 and 25-34 age groups, while the biggest growth is predicted in the 65-69 and the 90+ age group (19% each)
- The **South** GP Cluster Area should see a 17% decline in 20-24 age group and a 16% rise in both the 65-69 and the 90+ age groups
- The population in the **West** GP Cluster Area is predicted to grow amongst all age groups but most significantly in the 10-14 (18%), 20-44 (20%), 65-69 and 90+ age groups (22% each).³

² ONS sub-national population projections (2008-based), published May 2010

³ CES Insight Team, Population Projections - Hybrid Solution - Updated for MYE09 v5

Figure 2:



Diversity

Barnet's population is growing increasingly **diverse**, especially in the under 19 age group; the attitudes, ethnicity and culture of Barnet are now more reflective of London than previously.⁴

- Over the next five years, the local **non-White** population is projected to increase from 33.1% to 35.0% of the total populace
- Barnet's fastest growing ethnic group is **Other** (a classification which includes Iranians, Afghans, and Arab peoples) with 19% growth (+4,400 people) over five years against an average growth rate of 5.5%.
- 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.
- Barnet's largest ethnic group, the **Indian** community, will 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).

The rise in local diversity is being driven by births in BME community – almost half of all 0-4 year olds (49.7%) are BME. Aside from a bump in the 30-44 cohort, each rising age band is progressively less diverse than the former; just 21.9% of the 65-69 year old population are non-White. Amongst Barnet resident pupils whose first language is not English, the most common languages spoken are Gujarati, Persian-Farsi, Somali, Arabic and Polish.⁵

⁴ GLA Intelligence 2010 Round Ethnic Group Projections adjusted to fit Barnet Hybrid Population Model

⁵ School Census January 2010

Mosaic Health profile of Barnet

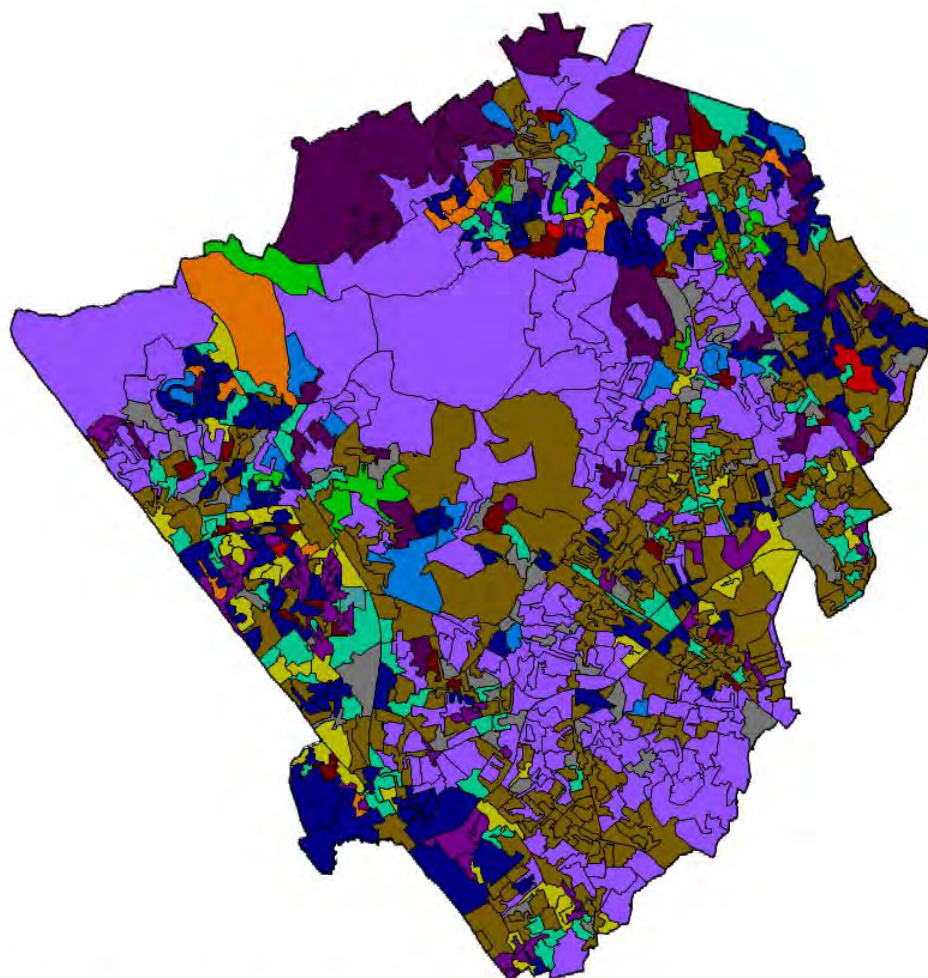
Mosaic Public Sector is a licensed data set produced by Experian which allows us to profile the local community based on *modelled data* from a range of sources. The information contained in the product for profiling health data is relatively limited but the key information is summarised in the following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

While the majority of the borough is in good health, there are some areas with significant proportions of Groups who are typically vulnerable to a number of health issues. For example, 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 far smaller percentage of Barnet's overall population but do have specific health issues that could be improved with better communication and targeted campaigns.

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 through local papers or face to face interactions, and similarly have a negative response rate when information is distributed through the post.

Image 2: Mosaic group by Census Output Area



Experian MOSAIC Public Sector Groups

- B - Residents of small and mid-sized towns with strong local roots
- C - Wealthy people living in the most sought after neighbourhoods
- D - Successful professionals living in suburban or semi-rural homes
- E - Middle income families living in moderate suburban semis
- F - Couples with young children in comfortable modern housing
- G - Young, well-educated city dwellers
- H - Couples and young singles in small modern starter homes
- I - Lower income workers in urban terraces in often diverse areas
- K - Residents with sufficient incomes in right-to-buy social houses
- L - Active elderly people living in pleasant retirement locations
- M - Elderly people reliant on state support
- N - Young people renting flats in high density social housing
- O - Families in low-rise social housing with high levels of benefit need

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Mosaic data 2010 - © Copyright 2004 Experian Ltd

Once again, it should be stressed that Mosaic uses *modelled* data and the following pen portraits are therefore robust generalisations intended to paint a broad picture of the expected health of the borough. Actual administrative data from Barnet services is included in the next chapter. The figures in brackets represent the proportion of the local population which is classified in each Group, followed by the actual number of people for 2011 (rounded to nearest ten).

Group G - Young, well-educated city dwellers (31.1%, 108,790)

Levels of health are good. Residents in this group are well informed enough to recognise the value of regular exercise and in a varied diet. Devotees of extreme sports are found among this community and people are regular users of gyms, squash and tennis courts and swimming pools. An increasing number of residents now cycle to work. This group of people are quick to adopt health fads, and both alternative medicine and psychotherapy have many supporters.

Group C - Wealthy people living in the most sought after neighbourhoods (19.1%, 66,810)

Levels of health are good. However, most people rely on private health providers in preference to the National Health Service. Most likely to be a non-smoker with a good diet and high levels of regular exercise; high number undertake Pilates and Tennis.

Group E - Middle income families living in moderate suburban semis (12.4%, 43,380)

Households have an age profile of between 40-60. Levels of health are very typical of the national average. There is good access to shops and services which offer fresh fruit and vegetables, and this group takes seriously health messages from mass media. Amount of exercise undertaken is similar to the national average.

Group H - Couples and young singles in small modern starter homes (10.3%, 36,030)

Levels of health are good. Most illness reported from; Stress - due to high mortgage and repayments on consumer loans; Binge drinking and associated illnesses; Higher than average risk of health issues associated with pregnancy (Complications of labour and delivery, delivery and pregnancy with abortive outcome are all higher than national averages); Instances of problems relating to sexual health will also be more represented within this group; more likely to be smokers

Group L - Active elderly people living in pleasant retirement locations (6%, 20,990)

High demand on health services, however these residents are still relatively active, mobile and comfortable financially. They have moved away from family home into a smaller residence situated in an older community.

Group I - Lower income workers in urban terraces in often diverse areas (5.8%, 20,290)

Though the population is young, it is vulnerable to a number of health conditions to which immigrant communities are particular susceptible, of which diabetes and sickle cell anaemia are examples. Members of minority groups often have difficulty adapting to the ways of dealing with health services in Britain. Some women for example, will often only visit service providers if accompanied by family members and many South Asians will not expect receptionists to address them by their personal name. Though some aspects of diet are bad, such as their intake of salt and sugar, other aspects are good,

such as the plentiful provision and consumption of fresh fruit and vegetables and of fish. Birth rate is high, and as such pregnancy related issues are more frequent.

N - Young people renting flats in high density social housing (5.5%, 19,240)

Life expectancy is significantly worse than national average; many people's health succumbs to the combination of stress and low incomes. Opportunities to purchase a varied diet are good, however, these are neighbourhoods which have very high levels of smoking. Migrant populations with high levels of salt, sugar. Residents are more likely to attend A&E rather than seek assistance at a GP.

Group M - Elderly people reliant on state support (2.8%, 9,790)

As expected, there is a very heavy demand on Health Services from this group. Aside from medical conditions, mobility is an issue which can manifest in increased risks from trips and falls, and neighbourhood and household hazards such as hypothermia, electric shocks from poorly maintained equipment and fire risk from gas explosions.

Group D - Successful professionals living in suburban or semi-rural homes (2.2%, 7,700)

Most exhibit fairly good general health, few smoke, however some have increased risk of overeating, high levels of alcohol consumption and low consumption of fruit and vegetables.

Group F - Couples with young children in comfortable modern housing (1.8%, 6,300)

Due to the young age profile of both children and parents in this group, demand on health services is generally very low. Most hospital instances are household accidents rather than any medical issues. Good proportion eating fruit and vegetables and will generally be exercising frequently.

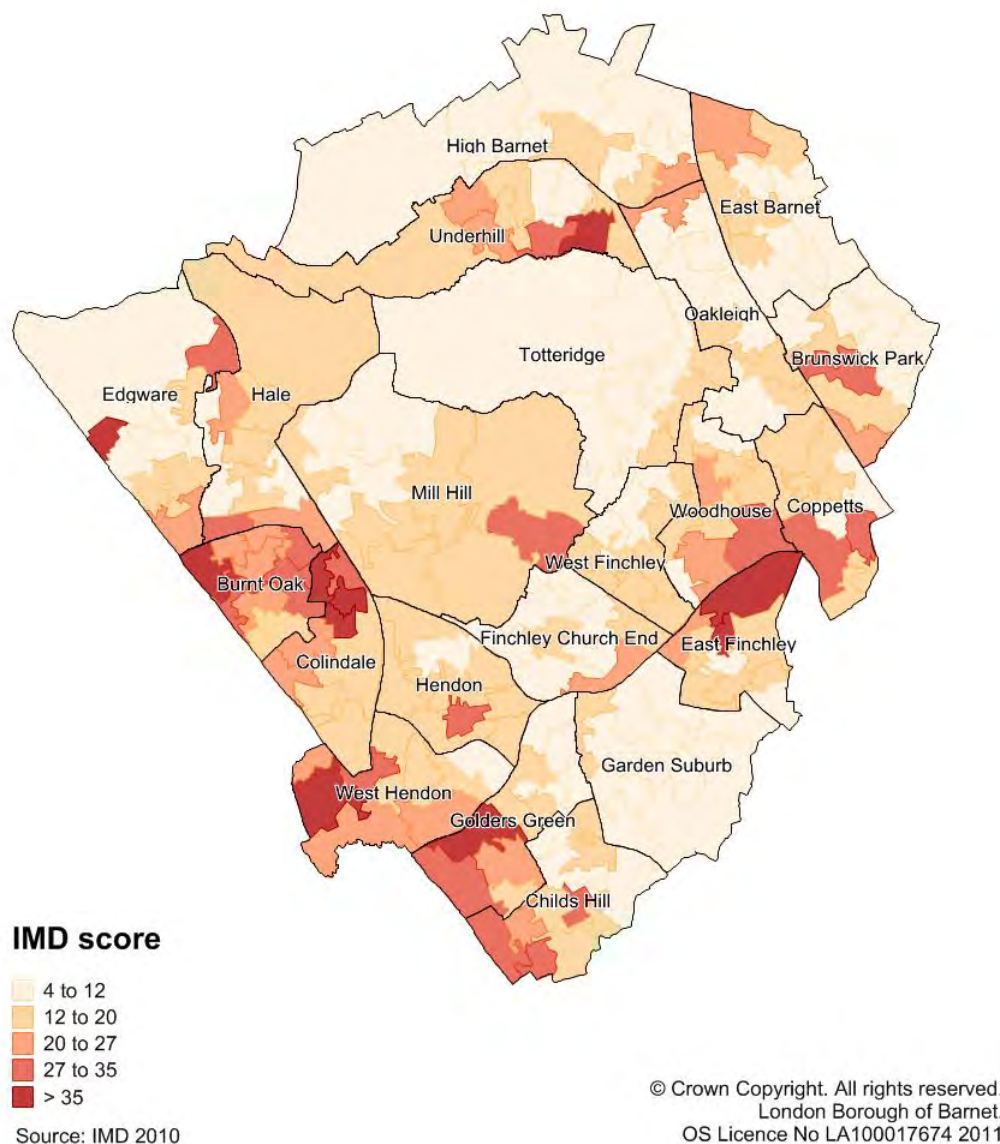
Group K – Residents with sufficient incomes in right-to-buy social houses (1.3%, 4,550)

Levels of health in this group is lower than national average although not markedly so; hospital statistics for this indicate a generally increased risk of all illness (except for mental health) when compared to the national trends. Healthy eating and regular exercise are not high priorities for this group.

Deprivation

According to the latest release of the **English Indices of Deprivation**, 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 diverse borough however, and although the Barnet average is averagely relatively deprived, there is a wide variance between different domains and different areas. No Lower Level Super Output Areas (LSOAs) in Barnet fall within the ten per cent most deprived nationally, six fewer than 2007. However 35 of 210 (16.67%) rank in the lowest ten per cent on at least one domain.

Image 3: Indices of Multiple Deprivation scores 2010, by LSOA



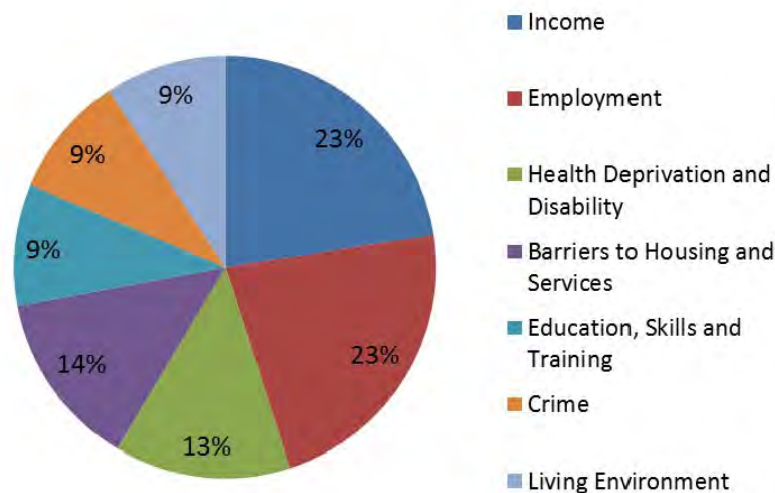
English Indices of Deprivation 2010⁶

The English Indices of Deprivation 2010 are measures of multiple deprivation at the small area level. The model of multiple deprivation which underpins the Indices of Deprivation 2010 is based on the idea of distinct domains of deprivation which can be recognised and measured separately. These domains are experienced by individuals living in an area. People may be counted in one or more of the domains, depending on the number of types of deprivation that they experience.

Each domain was constructed separately, from the component indicators, and each LSOA was assigned a domain score representing the combination of these indicators and then ranked according to this domain score. The domain ranks were then transformed to the exponential distribution and combined into the overall Index of Multiple Deprivation.

The table below sets out the weights used to combine the domains. These are the same as in the ID2007 allowing for comparison over time.

Figure 3: Domain weights for the ID 2010



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.⁷ 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.⁸

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

⁶ <http://www.communities.gov.uk/documents/statistics/pdf/1871208.pdf>

⁷ 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

⁸ CLG, English Indices of Deprivation 2010: Technical Report, <http://www.communities.gov.uk/documents/statistics/pdf/1870718.pdf>, 25-31

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.

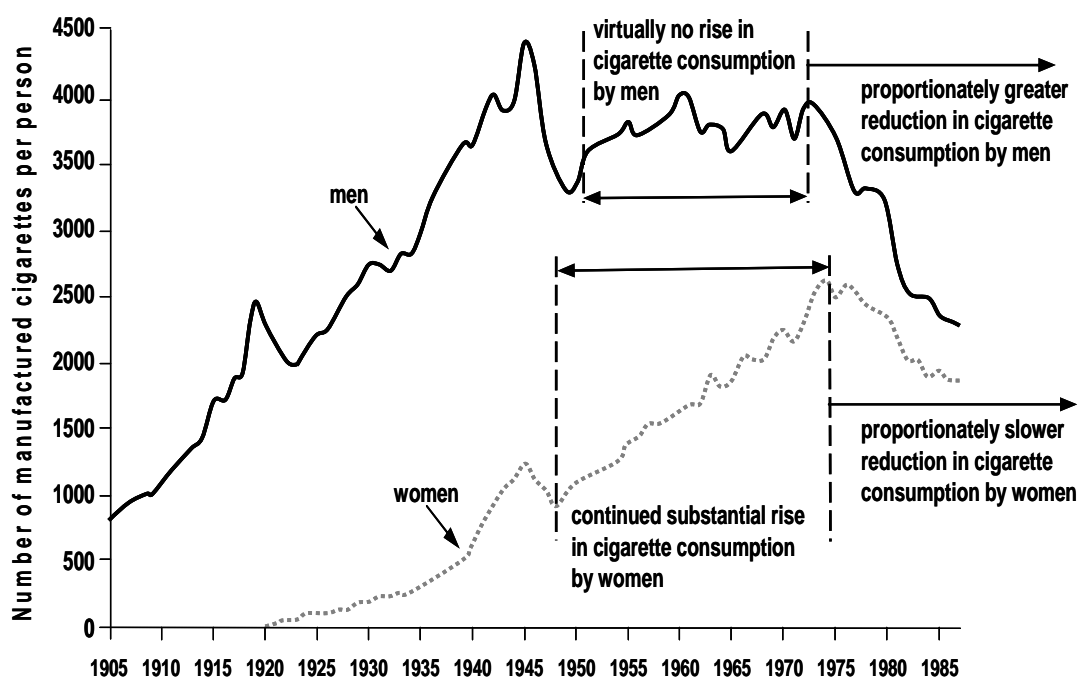
Headline health inequalities

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.⁹ This is probably because men and women have taken up smoking differently and have had different quit behaviours in past years.

Figure 4: 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.¹⁰ Adults who are obese (i.e. who have a body mass index of 30

⁹ See Mortality from COPD, males and females, Barnet, 1993-2009 on page 90

¹⁰ Barnet PCT. *An obesity prevention and weight management strategy for Barnet*. Barnet PCT. London 2007

or greater)¹¹ 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.¹² 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.

Table 1: 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 Officeⁱ

In Barnet in 2010, 10.6% of children in reception and 17.5% in year six were found to be obese. For the reception age, the Barnet figure is slightly lower than the London average of 11.6 but slightly higher than the England average of 9.8. The year six figure was lower than the London and England averages of 21.8% and 18.7% respectively.

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,¹³ the risk of developing diabetes can be reduced by more than 50%, and angina symptoms reduced by over 90%.

¹¹ 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

¹² National Audit Office *Tackling obesity in England* National Audit Office. London, 2001

¹³ 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 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.¹⁴ 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.¹⁵

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.¹⁶ 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.¹⁷

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.¹⁸

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 figure 5 below

¹⁴ Disability Rights Commission. *Equal treatment: closing the gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.* Disability Rights Commission. Stratford-upon-Avon 2006

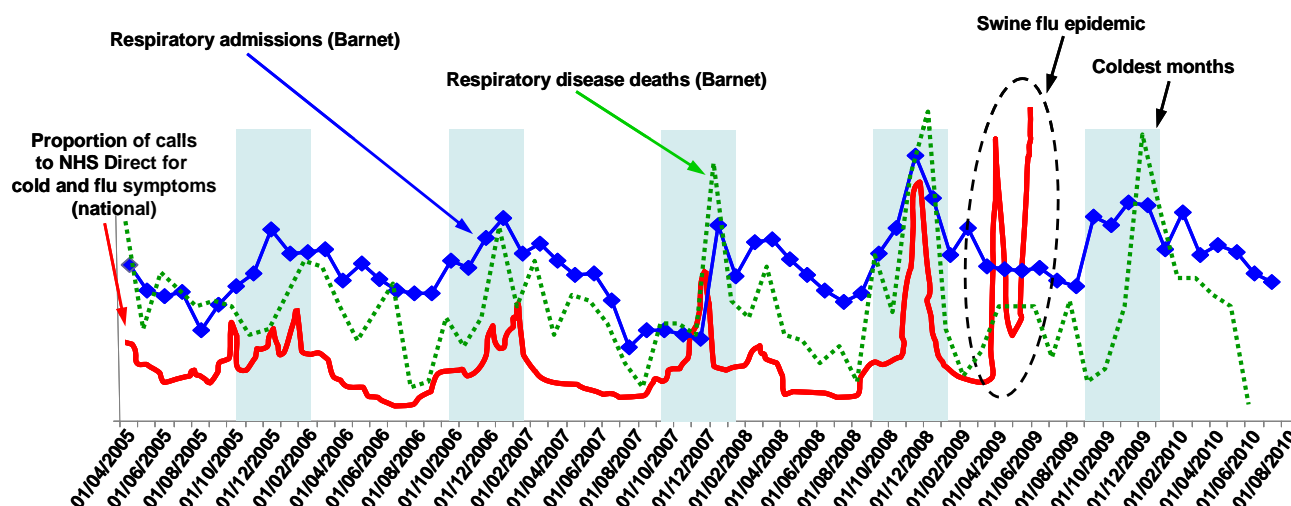
¹⁵ Department of Health. *Choosing Health: Supporting the physical health needs of people with severe mental illness. Commissioning framework* Department of Health. London 2006

¹⁶ Diabetes UK. *Diabetes and the disadvantaged: reducing health inequalities in the UK. A report to the All Parliamentary Group for Diabetes and Diabetes UK.* Diabetes UK. London. 2006

¹⁷ Weng, C., Coppin, D.V. and Sonksen, P.H. Geographic and social factors are related to increased morbidity and mortality rates in diabetic patients. *Diabetic Medicine* 2002; 17: 612-7.

¹⁸ Schizophrenia and Diabetes 2003' Expert Consensus Meeting (2004) Consensus summary. *Br J Psych* 184:s112-S114

Figure 5: 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

Each year in England, 60,000-80,000 people die because of the cold.¹⁹ Over half of these excess winter deaths²⁰ are caused by cardiovascular disease and one third by respiratory disease.²¹ 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). The study showed the death-rate rose more sharply at a given fall of temperature in regions with warm winters, in populations with cooler homes, and among people who wore fewer clothes and were less active outdoors.²²

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.²³ The estimates used in figure 6 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.

¹⁹ Eurowinter Group. Cold exposure and winter mortality from ischaemic heart disease, cerebrovascular disease, respiratory disease and all causes in warm and cold regions of Europe. *Lancet* 1997; 349: 1341-6

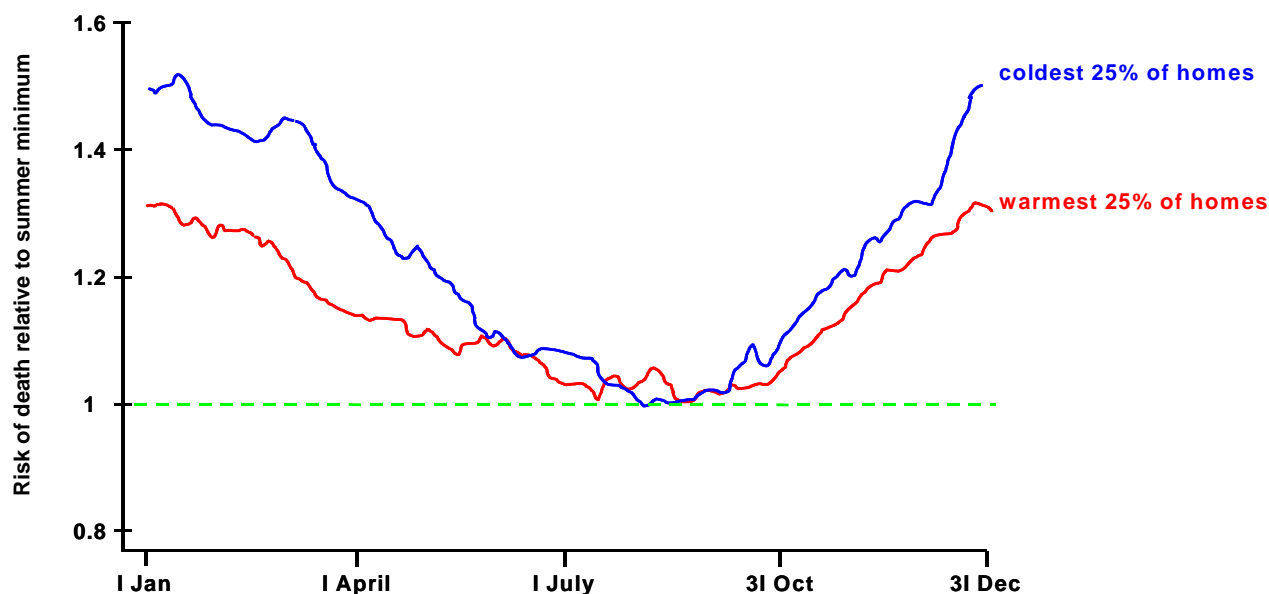
²⁰ Excess winter mortality is calculated by comparing the number of deaths occurring in winter with the number occurring in the a non-winter period

²¹ Donaldson GC et al. Effective protection against moderate cold, with rise in mortality only below 0°C in Yekaterinburg, Russian Federation. *Br Med J* 1998; 316: 514-8

²² Donaldson GC et al. Cold related mortalities and protection against cold in Yakutsk, eastern Siberia: observation and interview study. *Br Med J* 1998; 316: 978-2

²³ Madjid M, Miller CC, Zarubaev VV, Marinich IG, Kiselev OI et al. Influenza epidemics and acute respiratory disease activity are associated with a surge in autopsy-confirmed coronary heart disease death: results from 8 years of autopsies in 34,892 subjects. *Eur Heart J* 2007;28:1205-10. This estimate has been made for the top and bottom quarters of the distribution of predicted indoor (hall) temperatures at standard conditions with an outside temperature of 5oC.

Figure 6: Relative risk of death in relation to indoor temperature



It is also noteworthy that, compared to other countries, at 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) and are more likely to shiver (showing that they are cold).²⁴ 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;²⁵ an increase in deaths in cold weather (leading to health and social care 'winter pressures') are not necessarily inevitable.

It is also important to note that seasonal flu has been shown to increase cardiac mortality²⁶ and flu immunisation has been shown to statistically significantly reduce all-cause mortality throughout the seasonal flu period by 37% in elderly people with chronic heart disease;²⁷ flu immunisation saves lives not just by reducing respiratory disease.

In 2009/10 65% of category 1 hazards (as defined by the Housing Act 2004) reduced were due to Excess Cold e.g. problems with insulation or heating or damp and mould e.g. rising/ penetrating dampness or extreme condensation problems.

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

²⁴ Department of Health. Health Effects of Climate Change in the UK: An Expert Review. Department of Health. London, 2001

²⁵ Khaw K-T. Temperature and cardiovascular mortality. *Lancet* 1995; 345: 337-38. The Eurowinter Group: Cold exposure and winter mortality from ischemic heart disease, cerebrovascular disease, respiratory disease, and all causes in warm and cold regions of Europe. *Lancet* 1997; 349:1341-6

²⁶ Wilkinson P et al. Cold Comfort: The Social and Environmental Determinants of Excess Winter Death in England, 1986-1996. The Policy Press. Bristol 2001

²⁷ de Diego C, Vila-Córcoles A, Ochoa O, Rodriguez-Blanco T, Salsench E et al. Effects of annual influenza vaccination on winter mortality in elderly people with chronic heart disease. *Eur Heart J* 2009; 30:209-16

hazards relating to Excess Cold is £90,400 annually. Using the same calculator the average cost of remedial work has been calculated at £4,993.

Where Category 1 hazards are identified by the Private Sector Housing Team in Environmental Health the Environmental Health Officers try and work with landlords to bring the properties up to a minimum standard. Where this is unsuccessful statutory notices will be 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 are also running a Decent Homes Scheme 2011-2013 which provides 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.

Future challenges – Prioritising need, managing demand

It is important that public resources are used fairly and appropriately. Such resources are finite whilst demand for them continues to rise year-on-year. And 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 5-6% 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.²⁸

This means that it is not possible to fund every type of care for everybody, nor necessarily to do so in the way that they may want it or where they may want it. A balance has to be struck between the needs of an individual and the needs of the population for which public services are responsible.

There are different ways of considering what is ‘ethical’ when making such decisions. One approach is the so-called ‘rule of rescue’ which implies that all resources are made available for a person in need, regardless of cost or impact on others. Another is the ‘utilitarian’ approach which seeks to maximise welfare. Commonly, the utilitarian approach is interpreted as using finite resources for the greatest benefit of the greatest number. The problem with the first approach is that whilst some people may receive a lot of care or help, when the money runs out there is nothing left for anyone else, regardless of their need. The problem with the second approach is that, whilst the majority may benefit to a considerable extent, it is not possible to provide the ‘best possible’ care for all.

Sharing limited resources fairly therefore 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 doing this, it is necessary to take account of the evidence that a proposed intervention is effective in terms of outcomes and cost; that it is affordable; and to consider that funding something is fair and reasonable. One way of considering these latter aspects is to take account of the four principles of medical ethics. These are beneficence, non-maleficence, autonomy and distributive justice.

Beneficence – this consideration emphasises the moral importance of ‘doing good’ to others, entailing doing what is ‘best’ for a patient/client or group of people,²⁹ noting that doing good for one person may

²⁸ Department of Health. *The NHS Constitution: the NHS belongs to us all*. Department of Health. London, 2009

²⁹ The question of who should be the judge of what is ‘best’ is often interpreted as focusing on what an objective assessment by a relevant health professional would determine as in the patient’s best interests, with the patient’s own views being considered through the

prevent us from doing good for another (for example, because spending money on a clinical or social care intervention for one person means that that money is not available for someone else) and that it is not possible to provide benefit for everybody.

Non-maleficence – this consideration requires that we should seek not to harm people, and, because most medical treatments carry some risk of doing some harm as well as doing good, the potential goods and harms and their probabilities must be weighed to decide what, overall, is in a patient's or group of patients' best interests. A similar consideration applies to social care interventions.

But there is a distinction between what many would regard as an absolute duty not to directly harm someone by an act that would physically damage them, and possibly indirectly causing harm by not doing something, such as not funding a proposed clinical or social care intervention or service, which is not an absolute duty to an individual or a group of people because of both our duty to others and the impossibility of preventing all harm coming to all people.

Respect for personal autonomy – this consideration requires that we help people to make their own decisions (e.g. by providing important information), and respect those decisions (even when we may believe that an individual patient's or a group of people's decision may be inappropriate),³⁰ noting that this does not require us to fund a specific clinical or other intervention or service just because someone wants it, but only if it satisfactorily meets sufficient other criteria (such as evidence of the effectiveness of the intervention, its affordability, and the needs of others) and that this does not require us to fund a treatment or a service in a particular place other than as the patient or client may be entitled to under the requirements of NHS and local authority regulations.

Distributive justice – this consideration recognises that time and resources do not allow every person to have the 'best possible' health or social care intervention and that decisions must be made about which types of care can be offered within a health and social care system. This principle of justice emphasises two points:

- People in similar situations should normally have access to similar health care, and
- When determining what level of care should be available for one group, we must take into account the effect of such a use of resources on others (i.e. the 'opportunity costs').

We recognise there are competing moral concerns (for example in providing sufficient health and social care to meet the needs of all, distributing health and social care resources in proportion to the extent of people's needs, providing equal access to health care, enabling as much choice as possible, maximising the benefit produced by available resources), and whilst such factors can be morally justified, not all can be fully met simultaneously³¹ – put another way, it is not possible to provide equal care to everybody, it is not possible to prioritise everybody, and it is not possible for everybody to have free choice in their care when resources are limited.

principle of respect for patient autonomy, the two only conflicting when a competent patient chooses a course of action that might be thought of as not in their best interests.

³⁰ Parker M, Hope T. *Ways of thinking about medical ethics*. In *Ethics*. The Medical Publishing Company Ltd. 2000

³¹ Gillon R. Medical ethics: four principles plus attention to scope. *Br Med J* 1994; 309: 184-8

Thus, in considering the concept of distributive justice, we take the view that we have an obligation to maximise the benefit of the resources made available to us and therefore (as referred to by the judge in the 'Child B case')³² we must allocate a limited budget to enable the maximum advantage of the maximum number of people.

The Child B Case

In determining which services to commission we need to consider whether it is appropriate for us to fund certain services, individual treatments or innovations and service developments rather than whether these are appropriate for individuals or groups of people. A balance therefore has to be struck between what is desirable and what is possible.

This responsibility has been recognised in the courts, most notably in the 'Child B' case, when the judge said:

"I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much the cost, particularly when a life is potentially at stake.

"It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients."³³

³² Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995].

³³ This observation has been quoted with approval in a number of appeal judgments on individual patient treatment funding requests since and remains an accurate statement of the law.

Improving health and wellbeing

Causes of death

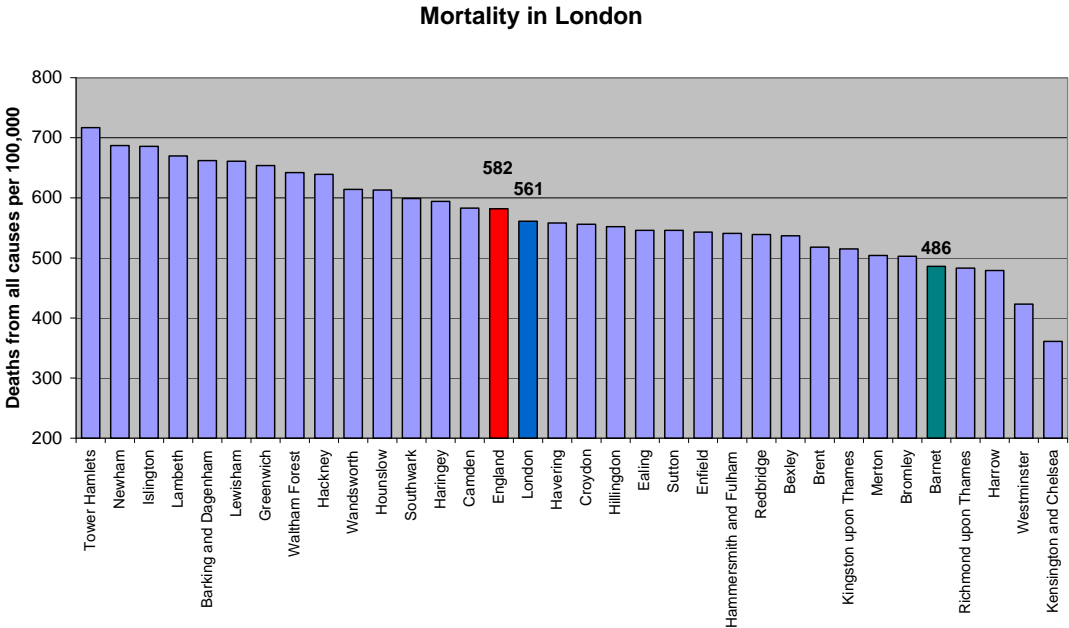
Life expectancy for both men and women in Barnet is greater than the London and national averages. However, this varies from neighbourhood to neighbourhood, with the life expectancy in Garden Suburb, Barnet's most affluent ward some 5.7 years greater than in Burnt Oak, the most deprived.

Table 2: 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

Mortality is significantly lower in Barnet than the London or national averages, with 486 deaths annually per 100,000 residents compared to 561 across the capital – the fifth lowest rate among the London boroughs. Of these local deaths, 96.9 per 100,000 are a consequence of cancers, again the fifth lowest rate in London. For deaths from circulatory disease, Barnet has the third lowest mortality rate, at 56.2 deaths per 100,000 persons compared to a London average of 79.4 per 100,000. For death by suicide, the rate in Barnet is only the thirteenth lowest in London, at 6.6 deaths per 100,000 persons – close to the regional average of 7.3 per 100,000.

Figure 7: Mortality in London



Physical disability

Overview

In Barnet we have adopted the social model of disability. This 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’.

Factors underpinning health and well being for all include poor housing, unemployment, crime and disorder and poor transport links. Disabled people face additional barriers in several areas:

- Physical./access barriers
- Policy barriers
- Empowerment barriers
- Attitudinal barriers

These factors mitigate against an inclusive lifestyle for disabled people, cause stresses which can lead to a worsening of any medical condition that the disabled individual may have. This can lead an individual to be more dependent on outside support than someone with a positive self image of disability. This underlines the importance of a positive, social model of disability and the promotion of an environment which challenges and eradicates as far as possible the barriers listed above.

In the UK it is thought that approximately 15% of the population could be defined as Disabled under the Disability Discrimination Act. If applied to Barnet's population this translates as around 52,000 people. Not all disability will be of a physical nature, but the numbers in question are significant. 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. These numbers are set to increase significantly over the next ten years.

Table 3: Current estimates and projections of physical disabilities in Barnet³⁴

	2010 estimate	2015 estimate	2020 estimate
Barnet residents aged 18-64 with a moderate physical disability	16,126	16,971	17,987
Barnet residents aged 65+ with a moderate physical disability	13,383	14,820	16,284
Barnet residents aged 18-64 with a serious physical disability	4,600	4,839	5,196
Barnet residents aged 65+ with a serious physical disability	7,999	8,855	9,828

³⁴ Incidence rates from General Household Survey 2001 applied to ONS population projections

Neurological conditions

A 'long term neurological condition' results from disease of, 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 be broadly categorised as follows:

- Sudden onset conditions, for example acquired brain injury or spinal cord injury, followed by a partial recovery
- Intermittent and unpredictable conditions, for example epilepsy, certain types of headache or early multiple sclerosis, where relapses and remissions lead to marked variation in the care needed
- Progressive conditions, for example motor neurone disease, Parkinson's disease or later stages of multiple sclerosis, where progressive deterioration in neurological function leads to increasing dependence on help and care from others. For some conditions (e.g. motor neurone disease) deterioration can be rapid.
- Stable neurological conditions, but with changing needs due to development or ageing, for example post polio syndrome or cerebral palsy in adults.

Using national prevalence figures, it is possible to estimate the number of people with a long-term neurological condition in Barnet:

Table 4: 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

Long term neurological conditions can cause a range of different problems for the individual, including:

- Physical or motor problems, such as paralysis, inability to walk, fatigue, incontinence, sexual difficulties and, for some people, impairment of all motor functions
- Sensory problems, such as loss of vision or hearing, pain and altered sensation
- Cognitive/behavioural problems, such as: lapses in memory and attention; difficulties in organisation, planning and problem solving; confusion; apathy; disinhibition and lack of insight into difficulties.

People with these problems may need additional support to make decisions and take responsibility for their own care

- Communication problems, such as difficulties in speaking or using language to communicate and in fully understanding what is said or written. People with these problems may need additional support to access information or to communicate their needs and wishes
- Psychosocial and emotional effects of the condition for the individual, such as potential personality changes after a brain injury and the emotional and psychological effects of living with a long term condition generally on the individual, their carer and family. These can include stress, depression, loss of self image and cognitive/ behavioural issues, which may lead to relationship breakdown if not addressed

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. The table below sets out estimates of the numbers within Barnet with sensory disabilities.

Table 5: Current estimates and projections of disabilities in Barnet³⁵

	2010 estimate	2015 estimate	2020 estimate
18-64 with a serious visual impairment	143	149	155
65+ with a moderate or severe visual impairment	4,337	4,782	5,204
18-64 with a profound hearing impairment	64	68	75
65+ with a profound hearing impairment	591	664	745
18-64 with a moderate or severe hearing impairment	7,498	7,991	8,701
65+ with a moderate or severe hearing impairment	21,529	23,609	26,121

Barnet Social Services keeps records of people who are registered with visual and hearing impairments. As at March 2011, 1,884 people were registered with a visual impairment and 1,390 were registered with a hearing impairment. 107 people were registered with both. The disparity between these registers and the estimated prevalence as presented in the table above 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.

Table 6: People registered with visual or hearing impairment with Barnet Council, March 2011

Visual impairment	Blind	972
	Partially sighted	912
Hearing impairment	Deaf – without speech	166
	Deaf – with speech	221
	Hard of hearing	1,003

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

³⁵ Department of Health's PANSI and POPPI systems

equipment, services and organisations that can help to make deaf or hard of hearing people's lives easier.

The risk we face

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 with 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.³⁶

DLA is a government benefit that helps disabled children and adults under the age of 65 with additional costs that may arise from their disability. Between August 2008 and August 2010 there was an 8% increase in the number of people within Barnet claiming DLA.³⁷ 86% of the 11,470 payments involve a care component; 91% involve a mobility component; some 77% involve elements from both.

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. This is double the rate for working age non-disabled adults.

Linked to the impact of disability on employment is the impact of disability on general health. In the 2006 General Household Survey, only 1.8% of non-disabled adults reported their health as 'not good', compared to 26.3% of disabled adults.

Key things to be done

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 need to be done to focus on how such impacts can be mitigated.

- Learn from the decision making processes introduced in the Right to Control Trailblazer project, which facilitated a holistic, multi disciplinary approach to involving people with disabilities and ensuring they are in the 'driving seat'.
- Involve the people who use support and services in shaping them
- Identify the assistance that people need and choose
- Support self help groups, collective solutions, user led groups to co-ordinate support
- Better long term condition management in the community
- Improve the stroke care pathway, with an emphasis on return to employment for younger disabled people

³⁶ Health Survey for England 2001

³⁷ DLA figures available on DWP's Nomis website

- Review with public health key messages within current and planned health promotion programmes, publicity and events
- Support the work of the Physical Sensory Impairment Partnership Board including the recommendations arising from the work on the Sensory Impairment Sub group, for people with sight loss and deaf/hard of hearing.

Learning disabilities and Autism

Overview

People with learning disabilities in general 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.³⁸

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).³⁹

There are also significant numbers of children with learning disabilities. Although estimation of the population prevalence of learning disability is problematic and should be treated with caution, one study [Emerson & Hatton (2004)] estimated that 2% of the total population has a learning disability. They have further calculated age related prevalence as follows; 5 to 9 years (0.96%), 10 to 14 years (2.26%) and 15 to 19 years (2.67%). In a different study, the Centre for Disability Research have developed the following prevalence rates:

- Moderate learning difficulties - 35.8 per 1,000 children (3.58%)
- Severe learning difficulties - 4.63 (0.46%)
- Profound and multiple learning difficulties - 1.14 (0.11%).⁴⁰

Table 7: Barnet School students with statements of Special Education Need (SEN)

Primary Need of Statement	Female	Male	Total	%
Autistic Spectrum Disorder	60	313	373	23%
Behavioural, Emotional and Social Difficulties	36	211	247	15%
Hearing Impairment	15	28	43	3%
Moderate Learning Difficulty	72	104	176	11%
Multi-Sensory Impairment	1	1	2	0.1%
Other Difficulty/Disability	16	19	35	2%
Physical Disability	67	62	129	8%

³⁸ Emerson and Baines: Health Inequalities & People with Learning Disabilities in the UK: 2010

³⁹ 2010 figures taken from Department of Health's PANSI and POPPI projection models

⁴⁰ http://www.learningdisabilitycoalition.org.uk/download/CeDR_November.pdf

Profound and Multiple Learning Difficulty	26	37	63	4%
Severe Learning Difficulty	38	48	86	5%
Specific Learning Difficulty	30	87	117	7%
Speech, Language and Communication Needs	96	234	330	20%
Visual Impairment	12	12	24	1%
Total	469	1156	1625	100%

The incidence of learning disabilities is likely to increase with increases in maternal age (associated with higher risk factors for some conditions associated with learning disabilities, such as Down's syndrome), improved survival of 'at risk' infants (e.g., very low birth weight or very pre-term infants), and increasing levels of HIV and AIDS in children. Factors likely to reduce incidence include the increasing availability of prenatal screening for Down's syndrome, improving health care and support resulting in fewer 'at risk' infants developing learning disabilities, reductions in child poverty rates and improvements in early years services. Currently the net effect of these competing pressures on the incidence of learning disabilities is not known.

In Barnet the prevalence of learning disabilities does not appear to have increased over recent years, but there has been a substantial increase in the number of births in the borough and the Barnet school population, so that each % of children with a learning disability represents a larger number of children and an increased need for support. The table below shows the number of children in Barnet schools receiving different types of support, from School Action (lower level) to Pupils with Statements of Special Educational Need (higher level), over the past few years.

Table 8: Barnet students receiving support for learning disabilities

	Pupils Receiving School Action					Pupils Receiving School Action Plus					Pupils with Statements of Special Educational Need				
	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010
Primary schools	14%	13%	14%	14%	14%	6%	6%	6%	6%	6%	2%	2%	2%	2%	2%
Secondary schools	11%	10%	11%	12%	12%	5%	5%	6%	5%	7%	2%	2%	2%	2%	2%

The risk we face

People with learning disabilities – especially those with less severe learning disabilities – will more likely be exposed to poverty, poor housing conditions, unemployment, social disconnectedness and discrimination. Bullying within school and overt discrimination in adulthood both contribute to people with learning disabilities having a poorer health status than people without.⁴¹

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

⁴¹ Emerson & Baines: Health Inequalities & People with Learning Disabilities in the UK: 2010

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 for people with learning disabilities. Whilst recording of learning disabilities amongst GP practices has increased significantly over recent years (see table), there still appears to be a shortfall compared to the overall learning disabled population within the borough.

Table 9: Adults (18+) recorded with learning disabilities on GP registers in Barnet⁴²

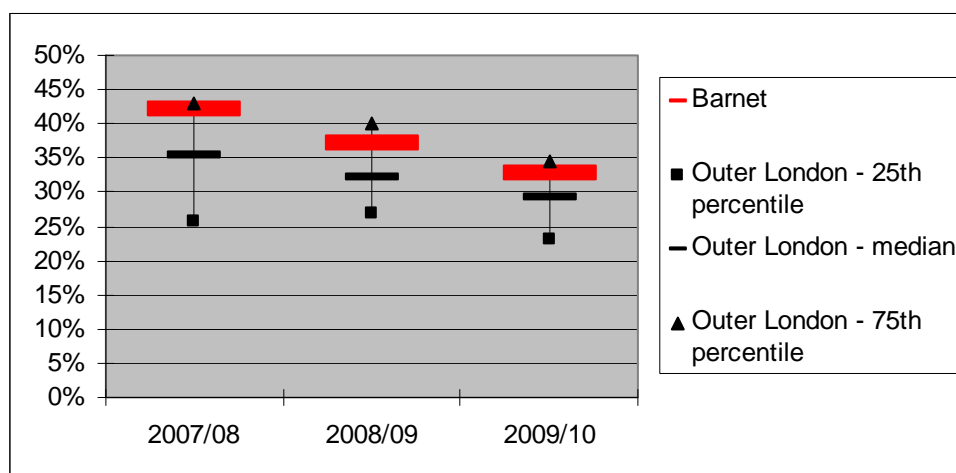
2007/08	2008/09	2009/10
690	857	992

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 this DES. The audit revealed 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. Fifteen of the practices involved had achieved a 100% take-up rate, whereas take-up was less than 50% at some five practices.

A factor affecting the wellbeing of people with learning disabilities within Barnet has historically been a lack of appropriate housing options within the borough. However this is improving along with knowledge and insight into the specific types of accommodation that is required. Among users of social services, those people with the most severe learning disabilities, residential care placements still 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 10% 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.

⁴² Quality and Outcomes Framework data

Figure 7: Percentage of people with learning disabilities receiving services from the council each year that are in residential care.



Source: Referrals, Assessments and Packages of Care returns data held on NASCIS

The independence of people with learning disabilities is also being restricted by the low level of employment among this population. Nationally, the employment rate for disabled people as a whole is just 48%. Among learning disabled people known to social services, this employment rate recorded in 2009/10 was only 6.4% nationally⁴³. Barnet's performance in this regard is better than most, with 10.6% of clients with LD of working age in employment in 2009/10; however, there are still many issues within the borough in finding work placement and employment opportunities for people with learning disabilities. Learning from the 'PSA16' and 'Right 4 Work' projects indicates that 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. However, they often find it more difficult to make use of mainstream Jobcentre Plus or Department of Work and Pensions work programmes as they do not meet the eligibility criteria. Furthermore, they also require reasonable adjustment being made to the way support is offered and in how jobs are packaged to ensure they meet their specific needs. Both issues highlight the need for closer collaboration with JCP and contractors of the DWP work programme to ensure that people with disabilities are able to make use of mainstream provision.

Overall numbers of people with a learning disability are set to increase over and above simple population increases, for a number of reasons:

- 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 particularly pertinent considering projected growth in Barnet's Pakistani and Bangladeshi communities is more than double the overall rate.

⁴³ NI146 for 2009/10 in England taken from NHS Information Centre

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. A key challenge amongst this particular group of people is providing them with the support and structure to allow them to live their lives free from formal care. Out of the 805 adults with learning disabilities receiving a care package from Adult Social Services in 2009/10, only nine per cent had not been receiving services in the previous year, and a similar percentage stopped receiving services. The stability of this population and the difficulties in equipping them to be free from social care raises questions about continuing to meet their needs amid projected population increases and continued budget reductions.

Autism

Approximately one per cent of the adult population is said to have a disorder on the autistic spectrum⁴⁴, equating to around 2,600 in Barnet. This is in addition to an estimated 0.82% of children with autism.⁴⁵ Rates are much higher in men than they are in women (1.8% versus 0.2%).⁴⁶ Studies elsewhere suggest around a quarter of these 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, as found in a recent prevalence study carried out by Barnet Social Services. Estimates of local prevalence relied greatly on applying nationally researched rates to local population statistics, rather than the collection of any reliable local data. Even 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 CYP, including now young adults transferring to college, nationally recognised good practice approaches with outstanding special schools and one accredited by the NAS, some catering for children with autism, 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.

People who are single, with low educational qualifications, with low predicted verbal IQ, or in social housing are more likely to have autism. Nationally it is estimated that around 15% of adults with autism are in full-time employment. There are few specialised employment support services for people with autism, and more training is needed for those delivering employment support and those administering benefits. 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.⁴⁷ 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.⁴⁸

⁴⁴ Emerson & Baines: The Estimated Prevalence of Autism among Adults with Learning Disabilities in England, 2010

⁴⁵ http://www.learningdisabilitycoalition.org.uk/download/CeDR_November.pdf

⁴⁶ Autism Spectrum Disorder in adults living in households throughout England – report from the Adult Psychiatric Morbidity Survey 2007

⁴⁷ Supporting People with Autism through Adulthood – a report by the National Audit Office 2009

⁴⁸ The Economic Consequences of Autism in the UK – a report from the Foundation for People with Learning Disabilities

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, e.g. Asperger syndrome. Approximately half of people with autism will be high-functioning, i.e. 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.

Recommendations

- Increase the take-up of routine health screening including health action planning by people with learning disabilities in order to ensure that their physical health needs are addressed
- Improve our understanding of the health needs of people with learning disabilities and autism, including health promotion.
- Improve information transfer between children's and adult services around the needs of disabled children transitioning into adulthood
- Develop local diagnostic and care pathways for people with autism
- Develop a range of high quality housing options to meet the needs of people with complex and profound learning disabilities and autism to prevent the need for high cost, out of area placements
- Increase targeted support for smoking cessation and weight loss for residents with a learning disability.

Smoking cessation

Overview

Tobacco use is the most important preventable risk factor for death from cancer and cardiovascular disease.⁴⁹ About 2,600 people die in Barnet each year. Of these, about 440 die from smoking-related diseases.⁵⁰ This is more than from any other cause and these deaths are all preventable.

Smoking tobacco causes diseases that affect nearly every part of the body. Smoking is especially damaging to the lining of blood vessels and leads to a reduced blood supply to various parts of the body. It is therefore a leading *and avoidable* cause of heart attack, kidney failure, intermittent claudication and impotence. For the same reason, people who are smokers when they have operations are more likely to suffer from wound breakdown and to have delayed bone healing.

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.

In addition to the unequivocal evidence that smoking damages the smoker's health, there is now substantial evidence that passive exposure to tobacco smoke harms non-smokers.⁵¹ Second-hand smoke causes lung cancer, coronary heart disease, stroke, asthma attacks, reduced growth of babies in the womb and premature birth, and in children it causes cot death, middle ear diseases, respiratory infections, the development of asthma in those previously unaffected and asthma attacks in those already affected.⁵²

It is best not to start smoking, but it is never too late to stop: giving up – at any age⁵³ – will lead to health improvement and reduced risk of disease and premature death.

⁴⁹ Bartecchi CE, MacKenzie TD, Schrier R. The human costs of tobacco use (I). *New NEJM* 1994;330:907-12. Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *Br Med J* 1994;309:901-911

⁵⁰ Callum C, White P. *Tobacco in London: the preventable burden*. London Health Observatory. London. 2004

⁵¹ Eriksen MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. *Am J Hlth Prom* 1998;13:83-104. [xx] Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *Br Med J* 1997;315:980-988. [xxi] Zaridze DG, Peto R, (eds). *IARC Scientific Publications No. 74*. International Agency for Research on Cancer. Lyon, 1986. [xxii] Morris PD. Lifetime excess risk of death from lung cancer for a U. S. Female never-smoker exposed to environmental tobacco smoke. *Environmental Research* 1995;68:3-9. [xxiii] Siegel MS. Involuntary smoking in the restaurant workplace. *JAMA* 1993;270(4):490-493.

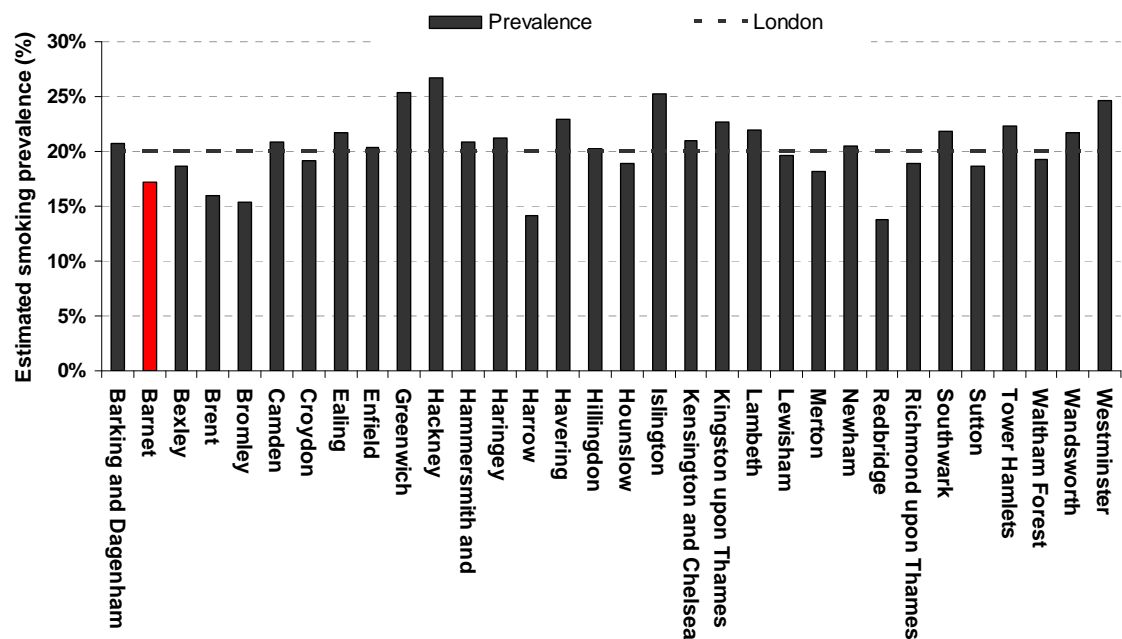
⁵² British Medical Association. *Tobacco – passive smoking* British Medical Association. London, 2003

⁵³ About the only exception to this is that if someone is terminally ill, i.e. they are likely to die in the next three months. In these cases, stopping smoking (always assuming that they are well enough to smoke) will not lead to any significant health gain. In everyone else, it can be expected to do so, if only by reducing the likelihood of a chest infection

The risk we face

The chart below shows the estimated prevalence in different London boroughs. Even though 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.

Figure 9 Smoking Prevalence amongst adults 18+



Source: Health Surveys for England 2006-2009

NHS Barnet Primary Care Trust will be commissioning Stop Smoking Services from Barnet Community Services. The cost effectiveness of this is amongst the lowest available. This is extremely favourable when compared to treatment costs of smoking related diseases.⁵⁴

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.⁵⁵ Stop smoking support can be delivered in a number of ways and it is important that smokers are offered a range of support options so they can choose the type of intervention that is right for them. All interventions share common properties (such as behavioural support, structure and the offer of approved pharmacotherapy) and they all involve multiple sessions.⁵⁶ The local service follows this recommended practice. In addition the service targets areas and groups with the highest smoking prevalence.

⁵⁴ NICE Smoking Cessation Costing Template 2009

⁵⁵ West R, McNeill A and Raw M (2000) 'Smoking cessation guidelines for health professionals: an update.' Thorax; 55(2):987-99

⁵⁶ Roddy E et al (2006) Barriers and Motivators to gaining access to smoking cessation services amongst deprived smokers. BMC HSR 6:147

In 2009/2010 NHS Barnet Stop Smoking Service supported 2220 smokers to stop smoking. This equates to a fall in prevalence of approximately one per cent (taking into account a relapse rate of 80%+ at one year and young people starting to smoke).

Mental Illness

People with mental illnesses are likely to be heavier, more dependent smokers and have smoked longer than smokers in the general population.⁵⁷ In a large population survey of psychiatric morbidity in the UK, 64% of those with probable psychosis were smokers compared with 29% without psychosis.⁵⁸ The highest levels of smoking occur within psychiatric inpatient settings, where up to 70% of patients are smokers and 50% are heavy smokers.⁵⁹

Such high levels of smoking increase the amount of smoking related harm people with mental health disorders suffer. It is responsible for a large proportion of the excess mortality of people with mental health problems.⁶⁰ The death rate from respiratory disease among people with schizophrenia, for example, is tenfold compared with the average.⁶¹ It is therefore crucial that people with mental health problems should have appropriate access to stop smoking support and be encouraged to stop. Making access to smoking cessation services easier for those with disability due to severe mental disorder will also comply with the Equality Act.

Locally the NHS Barnet Stop Smoking Service works with the Barnet, Enfield & Haringey Mental Health Trust to ensure their patients with a mental illness are supported in quitting smoking. To ensure that smoking cessation remains high on the agenda, the Barnet site of the Mental Health Trust has fully implemented the 'Smoke Free' policy and regularly supports the Smoking Service with awareness raising events. To further embed smoking cessation into mental health services a number of clinical staff are now trained to level 2 and are therefore able to provide the required support to inpatients.

Smoking in Pregnancy

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intrauterine growth restriction.⁶² This therefore remains a key public health concern,

⁵⁷ Kumari V and Postma P (2005) 'Nicotine use in schizophrenia: the self medication hypotheses.' *Neuroscience and Biobehavioural Reviews* 29: 1021–34

⁵⁸ Coultard M, Farrell M, Singleton N and Meltzer H (2000) *Tobacco, alcohol and drug use and mental health*. DH. London: Stationery Office

⁵⁹ Jochelson J and Majrowski B (2006) 'Clearing the air: Debating smokefree policies in psychiatric units.' King's Fund

⁶⁰ Brown S, Barraclough B and Inskip H (2000) 'Causes of the excess mortality of schizophrenia.' *British Journal of Psychiatry* 176: 109

⁶¹ Joukamaa M, Heliovaara M, Knekt P et al. (2001) 'Mental disorders and causespecific mortality.' *British Journal of Psychiatry* 179:498–502

⁶² Gardosi J, Beamish N, Francis A, Williams M, Sahota M, Tonks A, McGeown P and Hart M. Stillbirth and infant mortality, West Midlands 1997–2005: Trends, Factors, Inequalities. The West Midlands Perinatal Institute

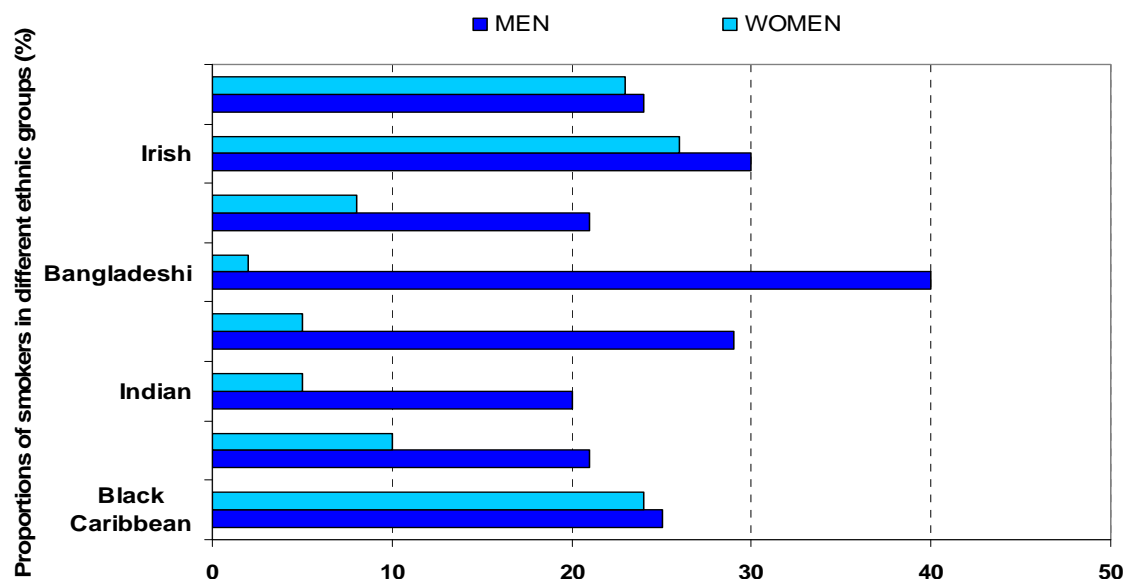
particularly since early intervention (i.e. stopping smoking at three months gestation) significantly improves outcomes.⁶³

The current smoking in pregnancy rate in Barnet where status is known is 10.1 (2008/09). This is slightly higher than the London average of 7.5 and below the England average of 14.6, but remains lower than the national target of 15%. The Stop Smoking Service provides a specialist support service at Barnet & Chase Farm Hospitals, Edgware Birthing Centre and the Royal Free Hospitals maternity service. The service offers pregnant smokers a full range of services following a robust care pathway that allows women to be tracked through their quit attempts. This includes Carbon Monoxide monitoring at the booking appointment and throughout the pregnancy.

The relationship between diversity, deprivation and smoking-related disease

There are differences in smoking habits between the sexes and between people in different ethnic groups; this is shown in Figure 10. 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.

Figure 10: Current smoking by ethnic group and sex in England 2004



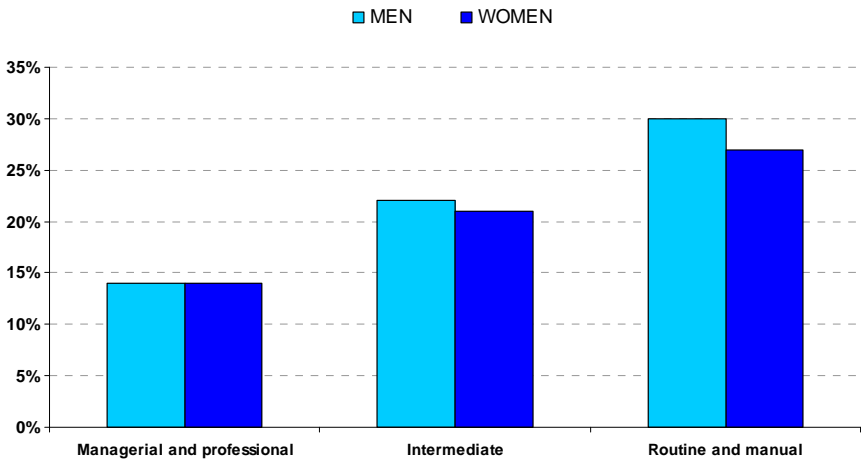
Source: Office for National Statistics⁶⁴

Smoking is more prevalent amongst people who live in deprived areas. Figure11 shows the differences in smoking habits between people from different social classes; people in routine and manual occupations (and those who are unemployed) are more likely to live in deprived areas than those in managerial and professional occupations.

⁶³ West R (2002) 'Smoking and pregnancy' Fetal and Maternal Medicine Review (13)3:181–194

⁶⁴ <http://www.statistics.gov.uk/cci/nugget.asp?id=466> (accessed 14 October 2008)

Figure 11: Cigarette smoking by sex and socio-economic classification, adults aged 16 and over 2009, Great Britain
Source: British Heart Foundation

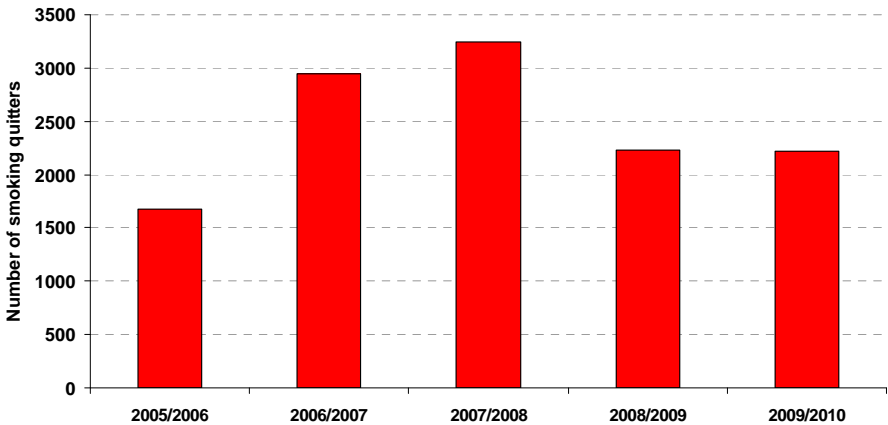


Source: British Heart Foundation

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.

Finally, deaths from COPD – principally a disease caused by smoking – in Barnet are now higher amongst women than men, and deaths from lung cancer in women will soon become more common than deaths from breast cancer. This is simply because an increasing number of women took up smoking in the 1940s and 1950s: they are now reaping the longer-term consequences of this.

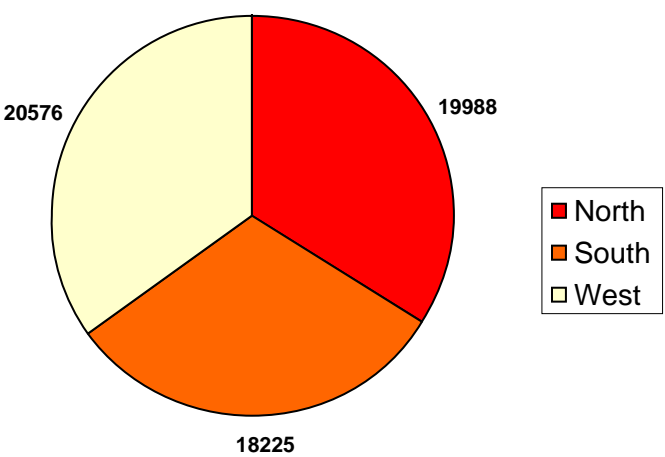
Figure 12: The number of people quitting smoking through NHS Barnet service



Source: Barnet PCT Stop Smoking Service data returns to Department of Health

The number of Barnet residents found to be smokers as a proportion of the Barnet population as a whole is found to be highest in the West locality of the borough where deprivation is known to be the highest. This is followed by the North locality and then more affluent South Locality.

Figure 13: Number of smokers by locality



Source: QOF Data

Tobacco Control Alliance

Tobacco control refers to a coordinated and comprehensive approach to reducing the prevalence of tobacco use. The Department of Health released Smokefree Future on 1st February 2010 in which it outlines the tobacco control approach for England over the next ten years. Reducing the prevalence of tobacco use remains one of the most important interventions in improving and protecting the public’s health. In 2008, over 80,000 people in England died prematurely from a smoking-related disease². PCTs and Local Authorities are expected to work together to deliver the aims of the Department Health Smokefree Future locally.

The core ambitions of a Tobacco Control Alliance (as informed DH strategy) are to:

provide advocacy, communications, monitoring and evaluation thereof; stop the inflow of young people recruited as smokers; reduce underage sales through test purchasing and educating retailers; de-normalise tobacco use and reduce availability by influencing point-of-sale tobacco displays and communications; deliver tobacco control interventions with children and young people by embracing a whole school/college approaches, running PSHE lessons and promoting smokefree schools; offering Stop Smoking Services which draw on best practice and guidance from trained advisors; target priority groups, including routine and manual workers, Black and Minority Ethnic Groups (BME), pregnant and breast feeding

women, prisons, mental health service users; investigate illicit tobacco sales; engaging with users and vendors of niche tobacco products, such as shisha cafes; promote smokefree environments.

Recommendations

- Identify greater numbers of quitters in more deprived areas and enabling them to quit (see also section 3.4.6)
- Introduce techniques, such as measuring 'lung age' to increase quit rates
- Raise awareness amongst health and social care personnel and the public of the risks of being a smoker when a surgical procedure is required to encourage more smokers to quit
- Establish Barnet Tobacco Alliance with high level commitment and linked to the One Barnet Partnership
- Implement the national tobacco strategy 'A Smokefree Future' 2010 locally
- Trading Standards to introduce programmes to identify and prevent sales of counterfeit and 'illegal tobacco' products which can be significantly more harmful to health
- Improve targeting of smoking cessation programmes for people with learning disabilities and with mental problems.

Drugs and Alcohol Misuse

Overview

The UK government has advised that regular consumption of three to four units a day for men, or two to three units a day for women, would not pose significant health risks, but that consistently drinking four or more units a day (men), or three or more units a day (women), is not advisable.⁶⁵ **Binge drinking** is classed as the consumption of more than eight or six units (males and females respectively) in a single session.⁶⁶ By this measure, one in four adults in Britain are binge drinkers.

According to the Office for National Statistics lifestyle survey in 2009, 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.'⁶⁷ This is likely to be because middle class parents introduce their children to alcohol within the family, a continental-style which they believe teaches them to drink responsibly. The children tend also have more money and spare time without parental supervision to experiment.

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. By definition, those requiring drug treatment are drug misusers."⁶⁸ Misuse is defined as "illegal or illicit drug taking or alcohol consumption that leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence."

The annual cost per problematic substance user is estimated to be over £45,000 based on main domains for the estimation including health, work, driving, crime and other economic and social impacts.⁶⁹ In 2009, the estimated number of problem drug (opiate and/or crack cocaine) users aged 15-64 years in England was 321,229. The London region had the highest incidence of problem drug misuse in the country with an estimated number of 62,769.⁷⁰ In Barnet the estimate was 1,275.⁷¹

⁶⁵ <http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/index.htm>

⁶⁶ Prime Minister's Strategy Unit Alcohol harm reduction Strategy for England Cabinet office. London 2004

⁶⁷ <http://www.dailymail.co.uk/health/article-394840/Middle-class-girls-risk-binge-drinkers.html#ixzz1LZHuDuQr>

⁶⁸ NTA Models of Care for treatment of adult drug misusers framework for developing local systems of effective drug misuse treatment in England Part 1 (Oct 2002) p.3

⁶⁹ Home Office Research Study 249. The economic and social costs of Class A drug use in England and Wales, 2000. Christine Godfrey et al.

⁷⁰ Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2008/09: Sweep 5 report. Dr Gordon Hay et al

⁷¹ Ibid

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. This figure covers the Spending Review 2010 Period (2011-12 - 2014-15). During this period, it is estimated £6.9m will be spent on drug treatment locally and this will return an estimated £36.4m in total benefits, broken down into; an estimated £20m in crime cost savings and natural benefits and an estimated £16.4m health cost savings and natural benefits.

TellUs3 data (produced by Ofsted) which compared the frequency of misuse of drugs/volatile substances or alcohol, or both by young people showed that the proportion in Barnet was similar to London average (6.1%) which was lower than national figure of 10.9%.

In 2010, data from the Association of Health Observatories showed Barnet performed significantly better than London and England in terms of substance misuse.⁷²

There is an overall reduction of about 10% in budget allocations to the Barnet Drug and Alcohol treatment system for the financial year 2011-12 compared to 2010/11. These reductions are both local (NHS Barnet, London Borough of Barnet community care and other) and central (Department of Health and Home office). However, the new NTA Value for Money Tool demonstrates that in Barnet for the spending review 2010 period (2011/12 – 2014/2015), for every £1 spent on the local treatment system £5.24 is gained in total benefits.

Drug and alcohol misuse has a negative impact on an individual's health and/or social functioning. This may take the form of drug dependence, or be part of a wider spectrum of problematic or harmful behaviour. Moreover, misuse is associated with a wide range of conditions and complications, both physical and psychological.

Health impact

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. Each year in England and Wales, an estimated 2,000 deaths are caused by illegal drug misuse. Those that use needles to inject drugs have a high risk of catching blood-borne infection, such as HIV or Hepatitis C. The Department of Health estimates that in England, 90% of all cases of Hepatitis C and 6% of all HIV cases are caused by injecting drugs.

It is estimated that 70% of all visits to accident and emergency (A&E) departments, at peak times, are due to alcohol misuse. Health problems from alcohol misuse may affect the brain, liver and pancreas resulting in stroke, liver and heart diseases. Liver diseases resulting from excessive and prolonged alcohol consumption include fatty liver, alcoholic hepatitis and cirrhosis in about 10-15% of clinical alcoholics.⁷³

⁷² Health profiles 2010: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

⁷³ W.Maddrey. ALCOHOL-INDUCED LIVER DISEASE *Clinics in Liver Disease*, Volume 4, Issue 1, Pages 115-131; K A Fleming, J O McGee Alcohol induced liver disease. *J Clin Pathol* 1984;37:721-733.

Sexual problems, infertility and cancers could occur as a result high alcohol consumption. A study in Western Europe showed that assuming causality, 10% (95% confidence interval 7 to 13%) and 3% (1 to 5%) of total cancers in men and women were attributable to alcohol consumption, especially consumption higher than the recommended upper limits.⁷⁴ In terms of selected cancers, the highest proportion was for upper digestive tract with 44% (31 to 56%) and 25% (5 to 46%) in males and females respectively. Other research has also shown that joint exposure to smoking and alcohol consumption increase the risk of development of oral cancer.⁷⁵ These data support the reduction or abstinence from alcohol consumption to reduce the incidence of cancer.

Psychiatric disorders have also been found to be common among alcoholics, with as high as 25 percent suffering severe psychiatric disturbances. The co-occurrence of major depressive disorder and alcoholism is well documented.⁷⁶ Also, a high proportion of problem drug users have experienced mental health problems including for example, depression, anxiety, paranoia, and suicidal thoughts.

Hospital Episodes Statistics showed that there were a total of 606 hospital admissions in 2009/10 which were directly related to drug and alcohol use; less than a third (30%) were females, about 93% of these admissions were due to alcohol use and majority (96.1%) of these admissions were in those 18 years and over.

Table 10: Hospital admissions 2009/10 Directly related to drug use

Mental and behaviour disorders attributed to use of	<18 years Number (%)	>18 years Number (%)	Total Number (%)
Alcohol	23	519	542 (93)
Cannabinoids		15	15 (2.5)
Opoids		24	24 (4)
Sedatives/hypnotics		3	3 (0.5)
Total	23 (3.9)	561 (96.1)	584 (100)

⁷⁴ M. Schutze et al. Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. *BMJ*. 2011 Apr 7;342:d1584

⁷⁵ Kenneth Rothman and Andrew Keller. The effect of joint exposure to alcohol and tobacco on risk of cancer of the mouth and pharynx. *Journal of Chronic Diseases* Volume 25, Issue 12, December 1972, Pages 711-716; Andrew Z. Keller and Milton Terris. THE - ASSOCIATION OF ALCOHOL AND TOBACCO WITH CANCER OF THE MOUTH AND PHARYNX. *American journal of public health*, VOL 5. No. 10; Ronald G. Vincent and Frank Marchetta. The relationship of the use of tobacco and alcohol to cancer of the oral cavity, pharynx or larynx. *The American Journal of Surgery*, Volume 106, Issue 3, September 1963, Pages 501-505.

⁷⁶ Grant BF, Harford TC (October 1995). "[Comorbidity between DSM-IV alcohol use disorders and major depression: results of a national survey](#)". *Drug Alcohol Depend* 39 (3): 197–206; Kandel DB, Huang FY, Davies M (October 2001). "Comorbidity between patterns of substance use dependence and psychiatric syndromes". *Drug Alcohol Depend* 64 (2): 233–41; Cornelius JR, Bukstein O, Salloum I, Clark D (2003). "Alcohol and psychiatric comorbidity". *Recent Dev Alcohol* 16: 361–74.

There were also 72 hospital admissions in 2009/10 which were not directly related to drug use but the secondary and/or tertiary diagnosis for admission was drug related. The majority (87%) of these admissions were due to alcohol use.

Table 11: Hospital admissions 2009/10 where drug use is the secondary/tertiary diagnosis

Mental and behaviour disorders attributed to use of:	<18 years Number (%)	> 18 years Number (%)	Total Number (%)
Alcohol	3	60	63 (87.5)
Cannabinoids	1	3	4 (5.5)
Opoids		2	2 (2.8)
Sedatives/hypnotics		3	3 (4.2)
Total	4 (5.6)	68 (94.4)	72 (100)

Alcohol misuse

Alcohol appears to be the major reason for substance misuse related admissions. Alcohol misuse is when levels of alcohol are drunk to the extent that they can result in physical, psychological, and social problems for the individual - both in the short term and the long term. In 2007, there were 863,000 admissions to hospital in England due to alcohol misuse, and 6,541 deaths directly related to alcohol misuse. The majority of these deaths were due to alcoholic liver disease. The actual number of deaths caused by alcohol misuse is certainly much higher, as alcohol misuse is a major risk factor for a range of life-threatening diseases.

The rate of alcohol related admissions has continued to increase (except in 2007/08, during which period there are anomalies due to data recording and reporting issues at one of the main providers). A new alcohol pilot has recently been launched which will provide useful data on clients alcohol related hospital admissions and their outcomes/plans for 2010/11.

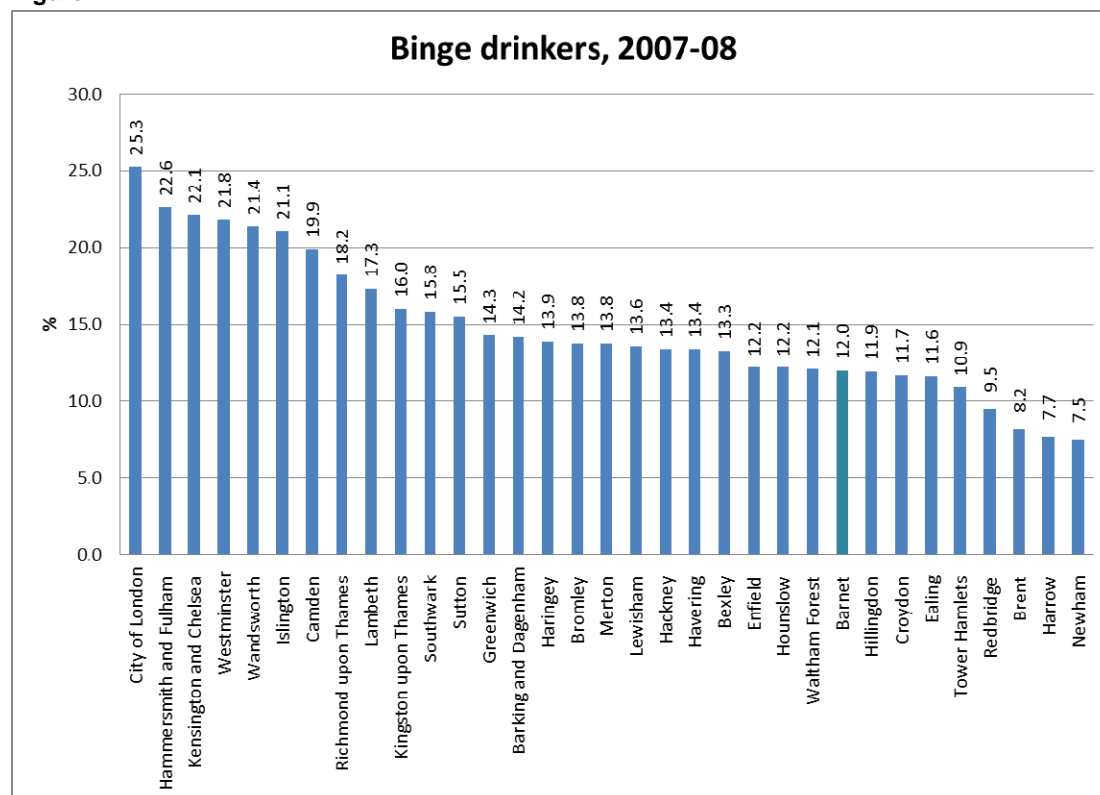
Table 12: Alcohol-related admissions per 100,000 population, 2004-10

Financial year	Rate of alcohol-related admissions per 100,000	% change
2004/05	696	-
2005/06	896	29
2006/07	1,024	14
2007/08	825	-19
2008/09	1,220	48
2009/10	1,444	18

Source: Local Alcohol Profiles for England

While alcohol related hospital admissions are increasing, they remain below the regional and national averages. Likewise, binge drinking is significantly lower in Barnet than for England and London.⁷⁷

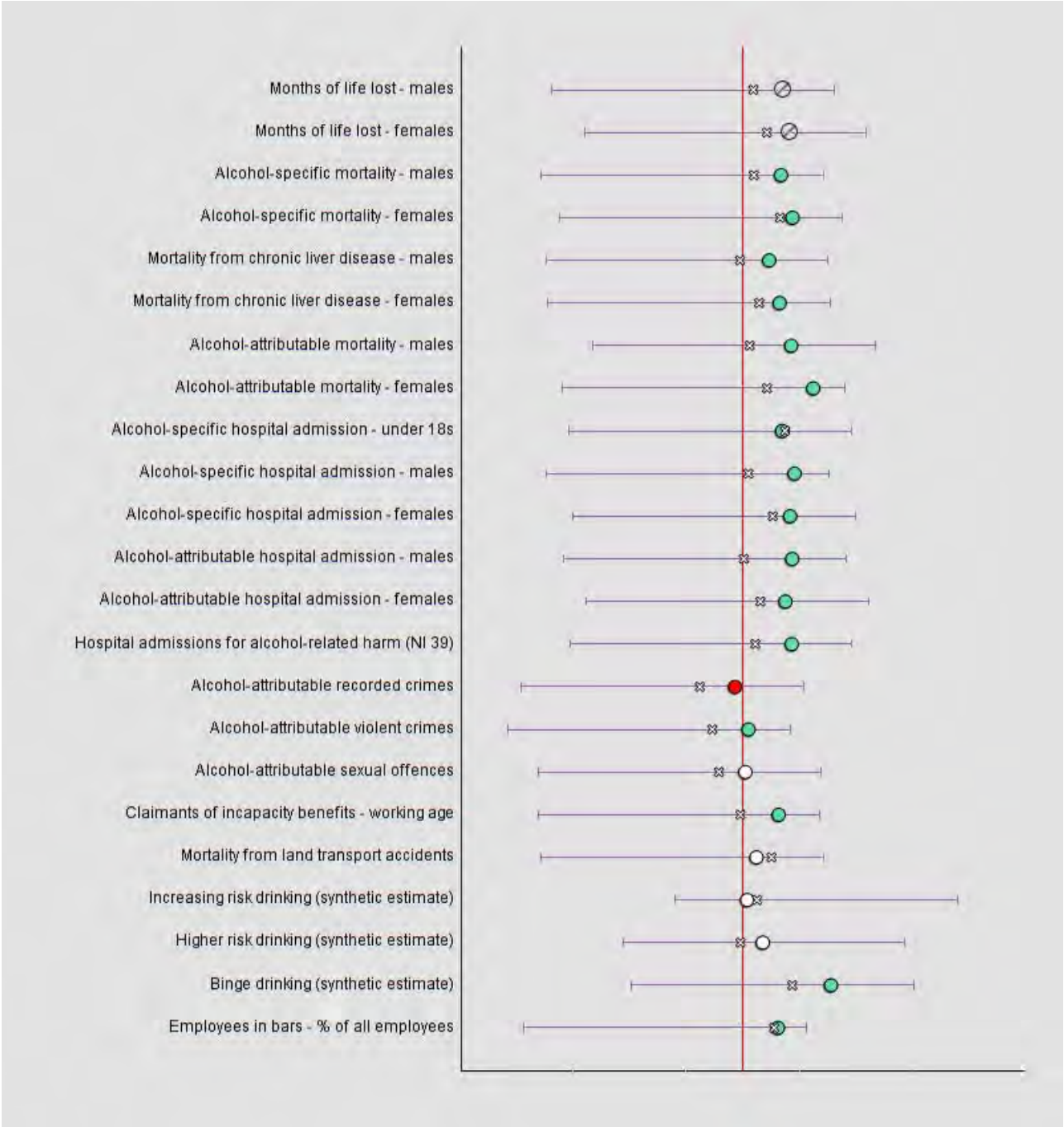
Figure 14:



⁷⁷ Health profiles 2010- <http://www.apho.org.uk/resource/view.aspx?RID=71961>

The figure below shows Barnet's measure for each of the 24 indicators for alcohol related harm, as well as the regional and England averages and range of all local authority values for comparison purposes. Barnet appears to be performing well except for alcohol attributable recorded crimes.

Figure 15: Comparison of Barnet to the regional, England averages and range of all local authority for each of the 24 indicators for alcohol related harm



Source: Local Alcohol Profiles for England

Social impact

Drug misuse and alcohol misuse may result in relationship problems, financial difficulties, unemployment and homelessness. During 2009/10, there were no presentations to Barnet Housing citing drug and alcohol as the reason for presenting as homeless. Neither were there any clients evicted or at risk of eviction due to drug and alcohol issues. However data from the database for those in specialist treatment shows that during 2009/10 there were three referrals from housing services to specialist drug treatment services and 14 referrals from drug treatment services to housing services. Although the Local Authority Housing team were unable to provide any data, they do recognise the need for questions around substance misuse to be included in their housing assessment.

Another concern is that due to altered consciousness, unsafe sex may be practiced leading to unplanned pregnancies and sexually transmitted infections (STIs). Also younger people may expose themselves to higher risks of sexually exploitative relationships.

Criminal justice implications

The relationship between problem drug use and crime is complex. As a direct consequence of the crimes committed, problem drug users are highly likely to end up in the criminal justice system at some point. Some serve community sentences while others will be sent to prison. In either case, the criminal justice system now compels them to confront their drug problems.

Drugs are related to crime through the effects they have on the user's behaviour and by generating violence and other illegal activity in connection with drug trafficking. During 2009/10 there were eight young people convicted of offences in relation to supply, cultivation and possession with intent to supply. From data obtained from Barnet police, in a six month snapshot from October 2009 – March 2010, there were a total of 1428 individuals arrested for possession or supply of which young people under 18 accounted for 22% (31% 2008/09).

Evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary. Other research claims that boys who take drugs are five times as likely to commit criminal offences and that the use of drugs is the strongest predictor of serious and/or persistent offending.⁷⁸ Within Barnet there are a number of teams and initiatives in place delivered through E-nable the prevention team part of the Youth Offending Service and the Targeted Youth Support Crime prevention.

Studies reveal that young drinkers are more likely to admit to being involved in violent incidents.⁷⁹ Alcohol misuse may also result in violence. In England, each year, around 1.2 million violent incidents are linked to alcohol misuse. Police data shows there were a total of eighteen Antisocial Behaviour Orders (ASBOs) issued during 2009/10. 11 of these Antisocial Behaviour Order ASBOs were issued to young people, of which eight (73%) were known to Barnet Impact. Just one of the ASBOs issued included a condition that was alcohol related. The young person to whom this was issued was in targeted provision.

⁷⁸ Flood-Page, C; Campbell, C; Harrington, V and Miller, J (2000) *Youth crime: Findings from the 1998/99 Youth Lifestyles Survey*. London: Home Office.

⁷⁹ Richardson, A and Budd, T (2003) *Alcohol, crime and disorder: A study of young adults*. London: The Home Office.

The risks we face

Health

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.

National Drug Treatment Monitoring System (NDTMS) data as at Quarter 3 2010/11, shows that whilst Barnet has made great progress in reaching targets for service users receiving Hepatitis C testing, those who have had a Hepatitis B vaccinations remains below target, although the borough compares favourably to comparator boroughs.

Treatment

The provision of effective drug treatment reduces individual harm, increases public health and contributes significantly to community safety and is therefore an integral part of the harm reduction strategy.

Early intervention is vital in work aiming to prevent involvement in crime and/or drug misuse for all vulnerable young people. YPDAS is a specialist substance misuse treatment provision which aims to empower young people to live free from drugs and alcohol and minimise the harm of substance misuse on young people, their families and the community. The service works with young people aged under 18 and their families.

NDTMS data shows that in 2009/10, there was a total of 45 young people engaged specialist treatment (35 in 08/09). The numbers in treatment in Barnet appear to be very low when compared amongst our comparator boroughs (table 13).

Table 13: Number of young people engaged in specialist treatment by Borough

	08/09	09/10
Barnet	35	45
Bromley	152	225
Enfield	153	123
Hillingdon	37	37
Kingston Upon Thames	54	49
Redbridge	71	69
Sutton	179	201

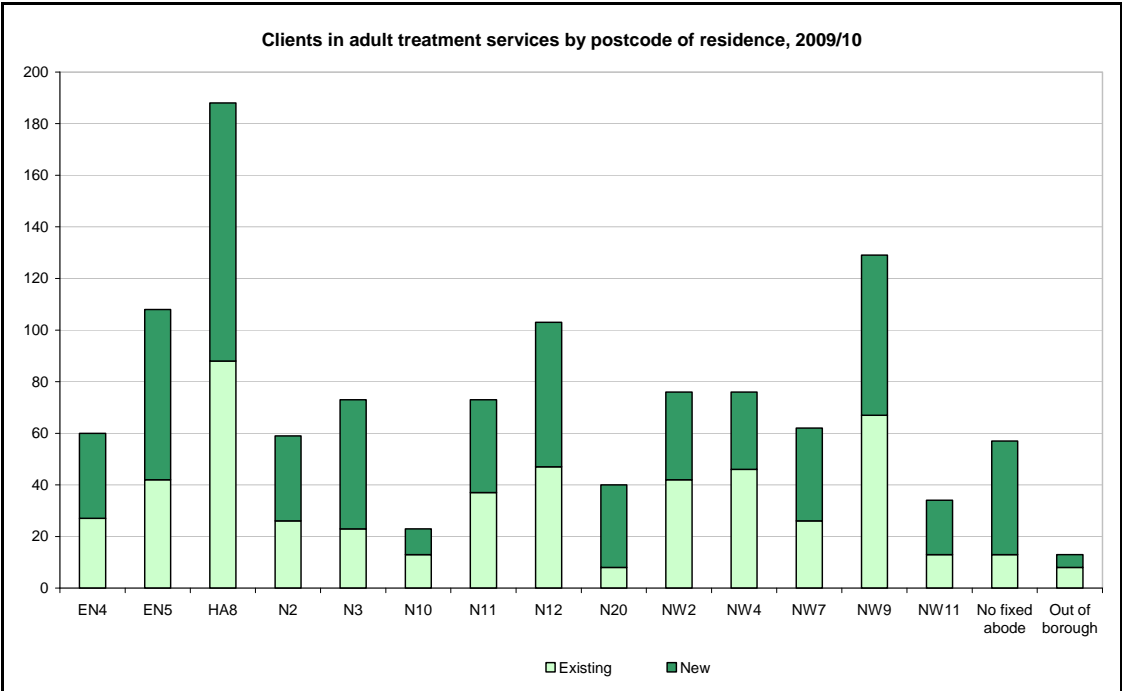
In 2009/10, 56% of discharges of young people from specialist treatment were in a care-planned way, which is a positive increase on the 41% in 2008/09. However NTA good practice expectations are for 70% of young people to leave specialist treatment on a care planned way with discharge destinations in place.

The needs assessment makes six key recommendations which are focused on the delivery of targeted prevention; improvements to the health and educational settings care pathways. There is a need for an improved understanding of drugs and alcohol as a safeguarding issue within social care. Work with families underpinning the work of substance misusing young people alongside removing barriers which impede on the entry, engagement and exiting of provision on the grounds of gender, race, ethnicity, sexual orientation and disability.

In 2009-10, the proportion of adults in need of substance abuse treatment who received treatment from the specialist service in Barnet was 59%. This was an increase from 45% in 2008-09 and compared favourably with other comparator London boroughs (it should be noted that this improvement is partly due to a decrease in prevalence estimates). Direct referrals into the treatment system from GPs are low, further work is being undertaken to determine the number of indirect GP referrals. The Shared Care scheme covers the requisite number of practices. The revised Community Engagement Team is targeted at expanding access to services for the treatment naïve population.

Figure 16 shows that a large proportion of service users as with previous years reside in HA8 postcode which covers Edgware and Burnt Oak and also hosts BDAS. The other high points are Friern Barnet (N12), North Finchley and Colindale (NW9). These high points of activity are all relatively close to existing treatment services.

Figure 16: Residence of clients in Adult Treatment services by postcode



There has been a decrease in the rate (35%) of planned treatment exits for those under 25 (against 49% regionally and 47% nationally) but this is countered by very low numbers of those aged 25 – 34 exiting treatment. Though slightly improved from 08/09 data, Barnet continues to struggle to effectively meet the needs of people who misuse Crack Cocaine; planned exits for those using opiates and crack (29%) and only Crack (31%) compare poorly with only opiates (40%) and cocaine (40%).

The outcomes for service users are improving and within a reconfiguration of the treatment system, they will continue to improve. The partnership's new Aftercare service has been operational since January 2009. In line with the National Drugs Strategy, 2011/12 will see a shift towards 'commissioning for recovery' in order to maximise the range of positive outcomes.

Accommodation

The provision of appropriate housing and integrated housing services is important in the planning and delivery of effective drug treatment. Inappropriate housing provision can impede treatment gains by substance misusers in treatment.⁸⁰

The recording of accommodation type is not a mandatory requirement; however service providers have been actively encouraged to collect this data. According to DAAT families tool, the clients in treatment who are of no fixed abode (NFA) decreased quite markedly from 14.2% in 2008/09 to 9.9% during 2009/10.

The biggest deficit in housing need for drug users in Barnet is the provision of emergency accommodation.⁸¹ The Foundation project and floating support, are able to cater to some of these needs, there is insufficient breadth in current provision to meet the full range of need. The housing advice and rent deposit scheme has also been useful but the higher levels of private sector rent can often act as a disincentive for individuals to return to work.

Employment

These include need for training in basic skills, counselling to increase motivation, confidence and self-esteem, and the need for access to employability services and employment opportunities. Data from the substance misuse database suggests that 45% of all individuals in treatment during 2009/10 were unemployed. The recording of income source is not a mandatory requirement; however service providers have been actively encouraged to collect this data. Data was unavailable from the prescribing service. However, for the individuals in specialist treatment during 2009/10 36% were in receipt of Income Support and 10% reported their source of income as wages. 17% were in receipt of Job Seekers Allowance and this appears relatively high as The Office of National Statistics reports that the proportion of all residents in Barnet receiving JSA as at November 2010 was 2.8%.

The commencement of the Aftercare service will improve access into training and employment. This is now being complemented by the enhanced partnership work with Job Centre plus, however, it is evident that the current range of need within a recovery framework needs to be further expanded.

⁸⁰ DIP Housing briefing-November 2004

⁸¹ The Housing Services for Drug & Alcohol Users in the London Borough of Barnet, an analysis of Need. Landscape Substance Misuse Training and Consultancy Services. May 2006

The relationship between diversity, deprivation and drug and alcohol misuse

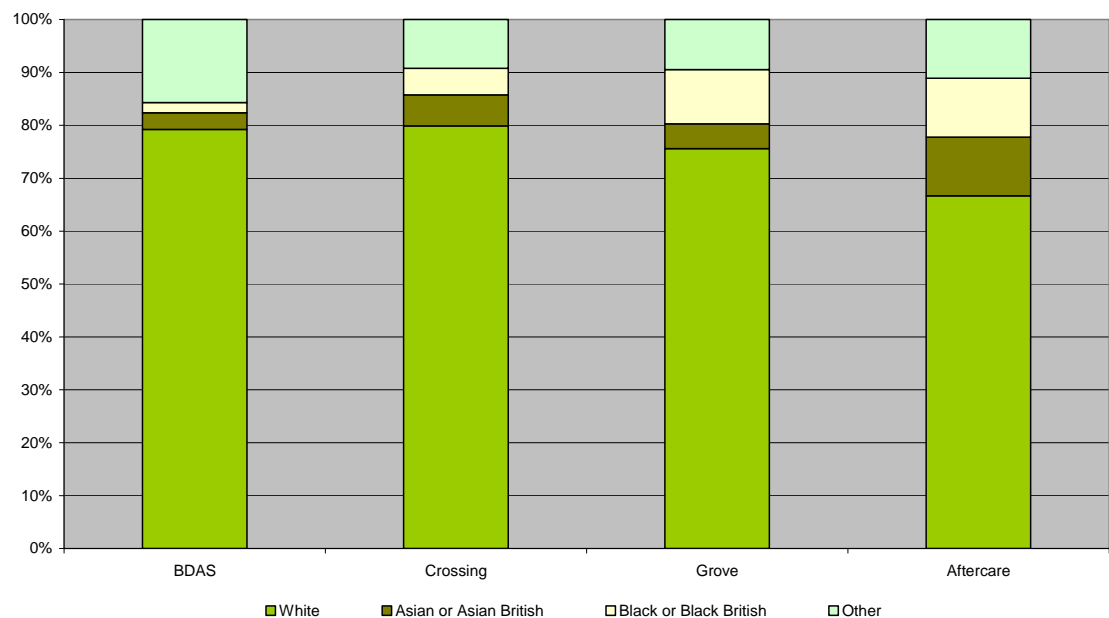
There are a number of risk factors which affect the likelihood of someone misusing drugs, including experiences in the family, home, neighbourhood, school, work, and other settings. Among vulnerable or disadvantaged children and young people aged under 25, the risk of misusing substances increases if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

Ethnicity

National Drug Treatment Misuse System (NDTMS) data showing all those in treatment during 2009/10 has been used for the chart below. White are the largest represented comprising 79% of all clients in treatment. The percentage of Asian or Black ethnic clients in treatment at BDAS is smaller than percentages seen at The Crossing, The Grove and Aftercare. The large percentage of ‘other’ ethnic category at BDAS relates to the growing group of Iranian nationals, seen within the nationality details below.

Figure 17: Ethnicity of clients in treatment in Barnet, 30 September 2009



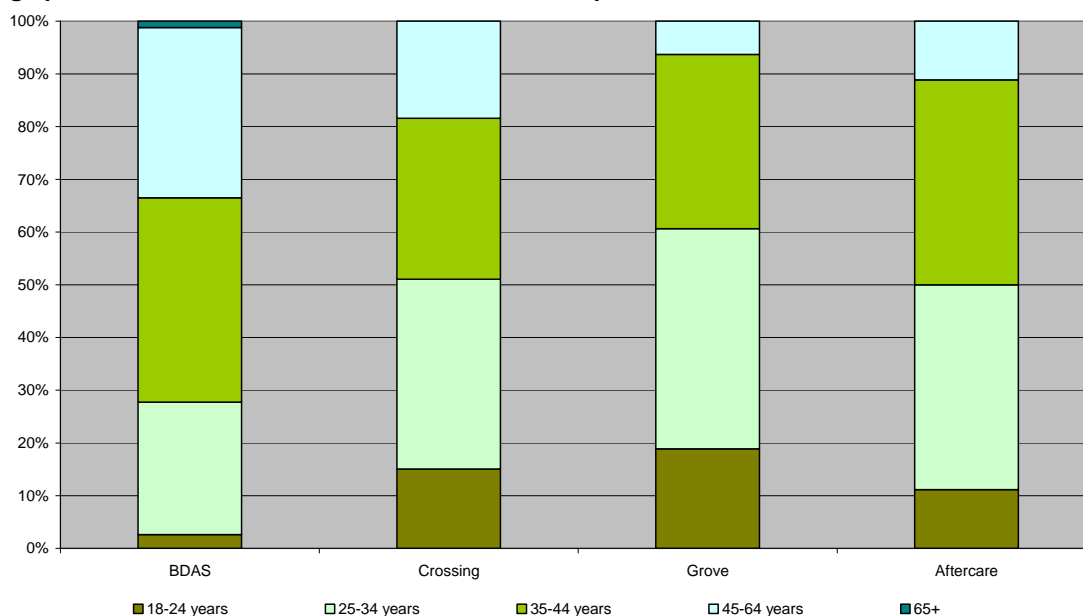
Nationality

NDTMS data during 2009/10 shows that 86% of all those in treatment were UK Nationals. As in previous years, there is a large percentage of nationals from The Islamic Republic of Iran, whilst they represented 3.9% of all those in treatment during 09/10, they represented 5.6% of all new presentations. The largest growth amongst this group is at BDAS where they represent 12% of all new presentations during 2009/10.

Age

The chart below shows that the younger client group are seen in its largest percentages at The Grove (18-24 and 25-34) whilst the older age groups represents greater percentages in treatment at BDAS. There were 4 people aged 18-24 representing 11% of all those in aftercare, along with 11% of the 45-64 age group.

Figure 18: Age profile of Barnet treatment service clients, 30 September 2009



Recommendations

The drug and alcohol treatment system is already jointly commissioned between NHS Barnet and LBB. There are three key areas where improvements can be made:

- A more integrated approach to commissioning across health, social services, housing and wider partners, including Probation and Job Centre Plus to maximise the benefit of the reducing pool of resources.
- Improved support for Barnet Service User Group to establish a larger resource of volunteers and peer mentors to actively develop user-led support and additional resource to engage and retain service users in treatment and improve outcomes
- Increased resource for community treatment options to reduce the requirement for residential services.

In practise, these improvements may be delivered through:

- Identification and targeting of those at risk through Community based interventions thereby preventing people from falling into offending behaviour; supporting young people to stay in education and training all to work
- Ensuring that the configuration of the drug treatment services is designed to meet the needs of the harder-to-reach groups with a particular emphasis on younger crack users
- Establishing improved arrangements for managing the treatment and care of young drug users
- Revising care co-ordination models so that they enable a clearer focus on prioritising those users most at risk of dropping out of the treatment system, while also ensuring that modalities are not defined by provider but by treatment journey needs
- Reviewing the breadth of accommodation options available to drug and alcohol users and ensure that they meet the differential needs of the client group at different stages of their treatment journey
- Enhancing the GP Shared Care so that more service users receive treatment locally.
- Continue Trading Standards under-age alcohol sales test purchasing programme.
- Enforcement of Licensed premises licence conditions in relation to sales of alcohol to people who are drunk.

Mental health

Overview

Mental health problems are common and are the commonest cause of death and years-of-life lost through disability.⁸² At any time, one in six adults can be expected to be experiencing mental health problems⁸³ and require medical, psychiatric nursing or other therapist interventions. Nearly one third of GP consultations are related to some sort of mental health problems,⁸⁴ and over 90% of people with mental health problems will receive care in a primary care setting.⁸⁵

The government's 'No Health Without Mental Health' strategy, launched in February 2011, sets out plans to ensure mental health awareness and treatment is given the same prominence as the nation's physical health, for children as well as adults. The framework aims to emphasize the close links between physical health and mental health and how they influence each other.

Common mental health problems and severe mental illness

The following table provides an estimate of the number of people experiencing common mental health problems (in a given week) and severe mental illness (in a given year) in Barnet. This is estimated from national prevalence weighted by the common mental health illness needs index (NPMS index). The majority of these experienced mixed anxiety and depressive disorder and generalised anxiety disorder.

Table 14: Estimated number of adults in Barnet suffering from mental health problems in Barnet

Mental health problem	Prevalence PCT (%)	London average (%)	Estimated number of adults affected in Barnet
Mixed anxiety and depressive disorder	7.7	8.4	18,395
Generalised anxiety disorder	4.9	5.3	11,644
Depressive episode	3.2	3.5	7,718
All phobias	2.0	2.2	4,745
Obsessive compulsive disorder	1.4	1.5	3,348
Panic disorder	0.8	0.8	1,868
Any neurotic disorder	16.7	18.2	39,761
Psychotic disorders (severe mental illness)*	0.5	0.9	789

Source: Mental Health scorecard, London Health Observatory, 2006 data (2008 data)

Overall Barnet appears relatively low in terms of prevalence of severe mental illness. The MINI2K indicates a ten per cent lower need for inpatient services for schizophrenia in Barnet compared to the England average, and around a 60% lower need than across London⁸⁶. In addition, the age-

⁸² WHO. *The World Health Report*. WHO, Geneva, Switzerland, 1999.

⁸³ Office for National Statistics. *Psychiatric morbidity of adults living in private households*. Office for National Statistics, London, 2000.

⁸⁴ Social Exclusion Unit. *Social exclusion and mental health*. Office of the Deputy Prime Minister. London, 2004

⁸⁵ Hague J, Cohen A. *The neglected majority. Developing intermediate mental health care in primary care*. The Sainsbury Centre for Mental Health. London, 2005

⁸⁶ Mental Health scorecard, London Health Observatory, 2001 data

standardised admission rate for schizophrenia, schizotypal and delusional disorders is 32.3 per 100,000 in Barnet, compared to a rate of 80 per 100,000 for London. However, what these figures disguise is the variation in need and prevalence across the borough. The MINI2K figures show that there are some wards within Barnet that have a 60% lower need for inpatient services than the England average, but other wards where need is 40% higher. The table below reiterates this disparity in need, with GP patients in the West of the borough apparently supported more effectively to stay out of hospital.

Table 14: GP registrations and hospital admissions for schizophrenia and bipolar disorder by GP cluster in Barnet

	North cluster	South cluster	West cluster
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%

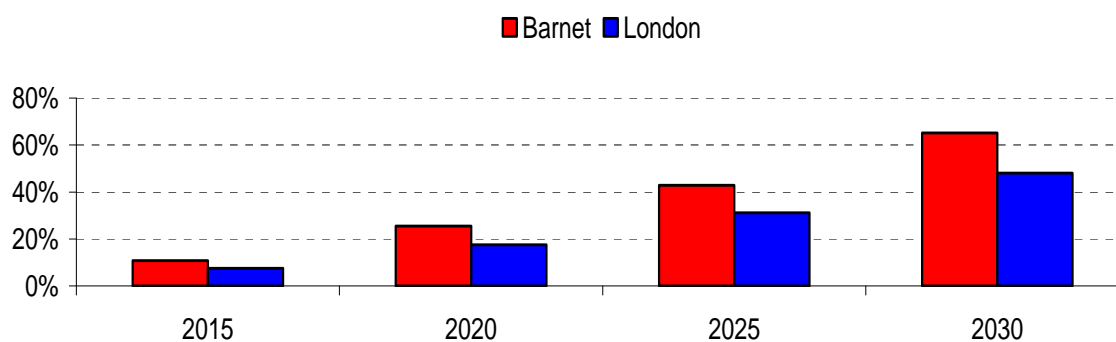
Source: PUMA and QOF data 2009/10

Older people and dementia

Dementia becomes more prevalent as people get older. Estimates of prevalence do vary, but all predict the risk of dementia to significantly increase with age. Age is the main risk factor, but others include cardiovascular disease and learning disability such as Downs Syndrome.

Prevalence rates calculated by London School of Economics and King's College for the Alzheimer's Society predict that dementia will have affected some 8% of people aged 65 years and over within Barnet and 24% of people aged over 85 years. Thus in 2010 it is estimated that the number of people over 65 in Barnet with dementia is 3,778; by 2020 this figure is projected to increase to 4,743.⁸⁷ This represents a 26% increase over 10 years, compared to only 17% across London.

Figure 19: Projected percentage increases from 2010 in number of people aged 65+ with dementia



Source: Department of Health's POPPI system, 2010 estimates and projections

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

⁸⁷ Figures taken from Department of Health's POPPI system, based on prevalence rates from Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

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 – indeed in London only 37% of people with dementia are recorded on registers – but they do help illustrate both the upward trend in recent years 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.

Table 15: Counts of dementia register for Barnet PCT and unadjusted prevalence rates

	2007/08	2008/09	2009/10
Barnet PCT dementia register	1,761	1,884	2,038
Barnet PCT prevalence	0.48%	0.53%	0.56%
London SHA prevalence	0.28%	0.29%	0.31%

Source: QOF prevalence tables, NHS Information Centre

A similar upward trend has been seen amongst people with dementia accessing social care services, although there are similar concerns around a lack of recording. Expenditure on dementia users overall has also increased, although spend per head appears to have dropped. This is partly explained by new cheaper homecare contracts, but lower average costs in other service types, particularly nursing care, may be explained by later admission dates facilitated by greater support out in the community.

Table 16: Adult social care users recorded with dementia

	2007/08	2008/09	2009/10
Number of users	265	318	379
Average committed expenditure per user	£18,048	£17,219	£15,339

Source: Barnet Adult Social Services' Swift database

It would appear that residents in all geographical areas are at risk of dementia, although GP registrations suggest that those in the South cluster are at greater risk than in other areas, particularly those in the West of the borough. However, hospital admission rates suggest that patients in the South are treated more effectively to stay out of hospital, potentially because of early identification and treatment via primary care, albeit that these figures might be distorted by recording issues surrounding dementia at both GP and hospital level.

Table 14: GP registrations and hospital admissions for dementia by GP cluster in Barnet

	North cluster	South cluster	West cluster
per 100,000 people admitted into hospital because of dementia in 2009/10	18	14	18
% of GP patients aged 65+ registered with dementia in 2009/10 ⁸⁸	4.2%	4.8%	3.4%

Source: PUMA and QOF data 2009/10

⁸⁸ For comparison purposes, this calculation assumes that all GP patients registered with dementia are aged 65 or over

There is now a national drive to improve the management of people with dementia. The National Dementia Strategy 2009 sets out the standards and care pathway for dementia care which is based around raising awareness, early diagnosis and improving the quality of care. The Dementia Services Guide rated Barnet amongst five London boroughs with the largest prevalence of dementia in 2007.

Locally, the Barnet, Enfield and Haringey NHS Mental Health 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. However, it should be noted that two-thirds of people with dementia live out in the community, so the strategy also identifies the need for memory assessment services for early diagnosis, dementia home treatment teams to prevent admissions into hospital or registered care, and personalised services to help enable individuals to regain lost skills or retain existing capabilities.

Barnet's Dementia Action plan has mapped our 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.

Further work will be undertaken during 2011/12 on the Dementia care pathway

Depression

An estimated 7,718 people within Barnet will experience a depressive episode in any one week, and 22,924 Barnet residents were recorded on GP registers with depression in 2009/10. 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 Department of Health's POPPI system estimates that there will be 4,179 people in Barnet over the age of 65 with depression, 32% of whom will have severe depression. Deterioration in physical health and capacity, together with feelings of isolation and loneliness, means that the risks of depression can increase quite significantly with age. Two thirds of NHS beds are occupied by older people, and up to 60% 'have or will develop a mental disorder during their admission', with dementia, depression and delirium being most common.⁸⁹ 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.

Yet these problems often go unnoticed and untreated. Studies show that only one out of six older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment. As well as the impact on quality of life, untreated depression in older people can increase need for other services, including residential care. Older people can and do respond very well to psychological and medical treatments and it is crucial that people remain healthy into older age if

⁸⁹ Who Cares Wins: Improving the outcome for older people admitted to the general hospital, 2005, Royal College of Nursing

they are to continue in employment if they wish, participate actively in communities, and carry on with important caring roles at home.⁹⁰

The risk we face

Common mental illnesses are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. For common mental health problems, it is estimated that about 50 per cent may require treatment⁹¹, but not all may be detected or will present to primary care. For people with Severe Mental Illness (SMI) it is expected that most people should be known to primary care and / or social services. In addition, a small minority of people with mental health problems, particularly those with severe mental illness, may need inpatient care and treatment.

There are differences in the rates of mental illness between men and women. Women experience rates of depression and anxiety between one and a half and two times higher than men, and rates of deliberate self-injury two to three times higher than men. Other factors such as child sexual abuse and sexual violence also place women at a higher risk of mental health problems.⁹²

People with mental health problems tend to die earlier than others, even taking suicide into account, and complications related to physical health conditions are likely to be exacerbated. The reasons for this link are various, and include:

- 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.⁹³ As well as a greater risk of developing respiratory disease, tobacco smoke also induces certain enzymes (i.e. makes them more active) and increases the metabolism of a large number of drugs used in the treatment of mental health problems. This can reduce their benefit and – if this effect is recognised – require higher doses
- People with schizophrenia are 90 per cent more likely to develop bowel cancer and women with the condition are 42 per cent more likely to develop breast cancer⁹⁴
- Patients with depressive disorder are twice as likely to use emergency department services as those without depression. Major depression can double one's lifetime risk of developing type 2 diabetes, and depression has also been proven to be a risk factor for the development of heart disease⁹⁵

⁹⁰Management of Depression in Older People, published under the **forum for mental health in primary care**
<http://www.nmhd.org.uk/silo/files/management-of-depression-in-older-people.pdf>

⁹¹ Psychiatric Morbidity Survey, 2000

⁹²National Mental Health Development Unit Factfile 5 Equalities in Mental health <http://www.nmhd.org.uk/silo/files/nmhd-factfile-5.pdf>

⁹³ Seymour L. Not all in the mind: the physical health of mental health service users. Mentality 2003, referenced in the British Medical association, http://www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qof06.jsp?page=25

⁹⁴ Disability Rights Commission, Equal Treatment: Closing The Gap, September 2006, referenced in NHS Confederation, In Sickness and in health: How the NHS can help tackle health inequalities

⁹⁵ Royal College of Psychiatrists, No Health Without Mental Health

- Within diabetes, total health expenditure is 4.5 times higher for individuals with depression than for those without depression.⁹⁶ In chronic heart disease, depressed patients have higher rates of complications and are more likely to undergo invasive procedures⁹⁷
- Approximately a quarter of people with physical illness develop mental health problems as stress causes depression, anxiety and panic. Mental health and physical health are not always tackled jointly, so for example, over half of all cases of depression in the general hospital setting go unrecognised by physicians and nursing staff⁹⁸
- 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 services⁹⁹
- People with mental health problems are much less likely to be offered, for example, blood pressure checks and cholesterol checks and cervical screening¹⁰⁰
- Strong connection between having a mental health condition and committing acts of self harm and mortality due to suicide or intended harm.

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. An important tactic to improving general health and wellbeing is for GPs to keep accurate registers of patients with mental health issues and make appropriate interventions. The numbers recorded on the mental health register have increased from 3,011 in 2007/08 to 3,297 in 2009/10, and it is important that needs are identified at this point. 90.2% of patients on the register in 2009/10 had a comprehensive care plan documented in their records, and 91.1% of patients with schizophrenia, bipolar affective disorder or another psychosis had a review recorded in the preceding 15 months.¹⁰¹

As well as health, mental health is associated with other personal and social problems. Mental health issues can result in social isolation, loneliness or disrupted relationships, or can be the catalyst for these problems. Mental health can widely affect someone's ability to go to work and stay in employment, and mental health problems can often result from unemployment, as a loss of meaningful activity and financial security can impact on a person's wellbeing. Recent problems in the economy and labour market may well have contributed to increased mental health problems in the borough.

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 seven per cent of those in Barnet receiving secondary mental health services are in paid employment. This is a

⁹⁶ Egede, L. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. *Diabetes Care* 2002; 25(3): 464-70' in Royal College of Psychiatrists, *No Health Without Mental Health*

⁹⁷ Royal College of Psychiatrists, *No Health Without Mental Health*

⁹⁸ Royal College of Psychiatrists, *No Health Without Mental Health*

⁹⁹ No health without mental health: A cross-government mental health outcomes strategy for people of all ages

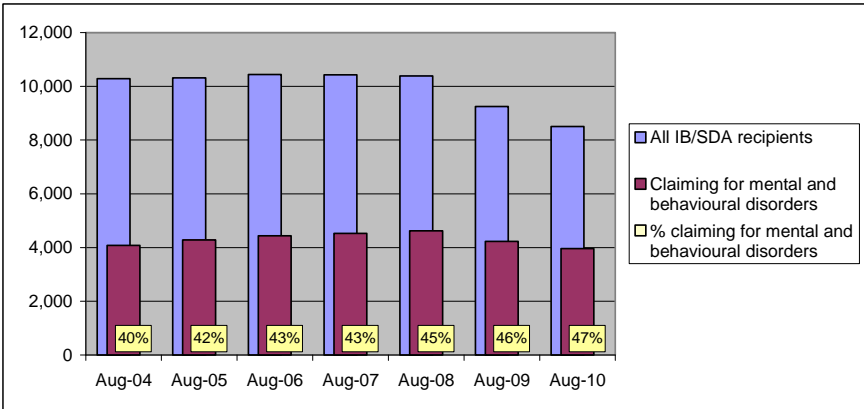
¹⁰⁰ Mentality (2003) 'Promoting Healthy living for People with mental health problems' in Social Exclusion Unit, *Mental Health and Social Exclusion*

¹⁰¹ QOF data

systemic problem nationally, but particularly so within London boroughs. The benefits of employment to general mental health are clear – in providing purpose and structure, developing relationships, and building confidence and self-esteem. Thus the public sector should be working better to improve education, employment and training prospects for people with mental health issues.

As at May 2010, 4,040 people in Barnet were on incapacity benefits related to mental health issues, constituting 46% of the total number of claimants of incapacity benefits. Of these, 98% have been claiming benefits for at least 12 months, and nearly two-thirds have been claiming for at least five years. The proportion of people claiming due to mental health reasons has actually increased year-on-year for the last ten years, even though numbers of claimants both for mental health and overall has dropped quite sharply over recent years.

Figure 20: Numbers receiving Incapacity Benefit or Severe Disablement Allowance in Barnet



Source: Department of Work and Pensions, NOMIS

Mental health problems can be caused by or exacerbated by an unsettled living situation. In 2009/10, only 53% of people in Barnet in contact with secondary mental health services were living in settled accommodation.

The Incapacity Benefit (IB) and Severe Disablement Allowance (SDA) reassessment, in progress since March 2011, is expected to have an impact on the nature of unemployment rates, as a significant proportion of clients will be found to be fit for work and will migrate onto either Job Seekers Allowance (JSA) or Employment Support Allowance (ESA). The profile of JSA and ESA customers is therefore likely to change, with a new cohort with higher support needs and a rise in clients with mental health issues. This will have significant implications for Barnet’s support services, who will need to work closely with Jobcentre Plus (JCP)/Department of Work and Pensions (DWP) partners to ensure work programmes are more adapted to the needs of people with mental health problems.

The relationship between diversity, deprivation and mental health

Various different factors influence the development and course of mental illness, including deprivation, homelessness, unemployment, poor educational attainment, being a member of a Black and minority ethnic group and being a lone parent or teenage mother.

The risk of mental health problems is considerably higher in deprived areas. Residents from the most deprived areas in Barnet will be at increased risk of mental health problems, which could lead to increased need for services. Whilst the needs of those living in deprived neighbourhoods are complex and multiple, there is some evidence that poor quality living environments – such as limited access to green space or light – can contribute to poor mental health. Local authority planners should therefore be designing new spaces and communities with mental health in mind. In Barnet, the Local Development Framework affirms a commitment to high quality design and the importance of protecting and enhancing what makes Barnet distinctive, in particular its suburban family houses and gardens. Likewise, the Making Barnet a Safer Place policy ensures that streets, town centres and open spaces feel safer – countering the fear of crime which can contribute to poor mental health.

The link between mental health problems and ethnicity is complex. Amongst certain groups, the risk of mental health disorders is particularly high: schizophrenia is diagnosed more commonly in people of African Caribbean origin than in people from other ethnic groups; rates of suicide and deliberate self-harm are higher among young Asian women than in the White population; the Somali community may have as high as 90% undiagnosed PTSD issues; and the Afghani community is reported by support agencies as having a significant level of depression and anxiety related illness, with sufferers possibly making up as high as 95% of the community.¹⁰²

But alongside differences in prevalence are issues around awareness, recognition and access. There are often feelings of shame and embarrassment associated with ill mental health, and these can be exacerbated in certain BME communities, with a large number of BME service users fearful of their community becoming aware of their use of mental health services.¹⁰³ In particular within Barnet there is an over-representation of Black service users within inpatient services and an under-representation of this group within outpatient services, suggesting limited engagement with preventative services and access of services only at crisis point. Furthermore, a survey among local GPs carried out in 2010 highlighted very strong support amongst professionals for both a bilingual advocacy service and a multilingual counselling service.¹⁰⁴ Alongside these issues are other problems relating to BME groups, including language and communication problems, a lack of knowledge of the system, a history of migration, and problems around the use of interpreters.

Health and social services have a huge challenge to engage and interact with the wide range of diverse groups within Barnet and promote early identification and treatment of mental health issues. The last couple of years have seen a rise in Afghani, Iranian and Somali residents living within the borough and specifically engaging with MHT services, although there is very little culturally specific mental health service provision for these communities.¹⁰⁵ There is also awareness within the borough of an increase in Eastern European communities which may be becoming isolated.

¹⁰² <http://www.cmha.org.uk/doc/CDW-AnnualReport2009.pdf>

¹⁰³ Barnet Community Development Worker Report <http://www.cmha.org.uk/doc/CDW-AnnualReport2009.pdf>

¹⁰⁴ Multilingual Wellbeing Services, results of GP survey 2010

¹⁰⁵ COWEN, T. (2003) *Suffering Alone: An Examination of the Mental Health Needs of Asylum*

A census amongst in-patients in mental health services – Count Me In 2009¹⁰⁶ – found that across England and Wales the NHS, councils and wider community bodies should be doing more to get people from BME groups linked to mental health services much earlier, including promoting wellbeing, health promotion and anti-stigma campaigns. In particular, the census highlights particularly high rates of admission into inpatient services amongst Black and mixed race populations, with no evidence of a decline in admission rates among black and minority ethnic groups. The census also reported low levels of referrals from GPs and crisis teams but high levels from criminal justice routes amongst many ethnic minority groups, particularly Black African and Black Caribbean groups. And overall rates of patients subject to the Mental Health Act (including Community Treatment Orders) were higher than average among the Black Caribbean, Black African, and mixed Black groupings.

Recommendations

- Improve identification and treatment of the physical health needs of people with severe mental illness
- Improve access to and availability of evidence based psychological therapies in the community
- Undertake local health initiatives aimed at engaging with the wide range of diverse groups, in particular those from BME groups, to promote early identification and treatment of mental health conditions
- Undertake local initiatives to increase awareness, early identification of dementia and include “healthy heart healthy mind” message in our health promotion activities
- Support more people with mental health problems to give up smoking
- Address vascular risk factors in expanding middle-age population to reduce the prevalence of dementia in the future
- Improve understanding of the mental health needs of older people in general hospitals and adequately addressing them
- Promote better access to work and other mainstream vocational opportunities.

¹⁰⁶ Count Me In results for 2009, available at

<http://www.cqc.org.uk/guidanceforprofessionals/mentalhealth/countmeincensus/countmeincensus2009.cfm>

Cancers and Screening

Overview

Incidence, mortality and survival are three ways of describing cancer statistics to give a fuller picture of what is happening to the population in Barnet. Incidence is the number of new cases that occur in a given time period, mortality – the number of people who die from a given condition or in this case a particular cancer. One year survival is used as a proxy indicator for early (or late) diagnosis. It is these three areas of measurement which describe in further detail the cancer profile of Barnet.

The Local Awareness and Early Diagnosis Initiative (LAEDI) baseline has produced a comprehensive set of key cancer metrics (incidence, premature mortality, one and five year survival, staging data) providing an unprecedented level of cancer health intelligence with which to understand the cancer landscape for PCTs within the North London Cancer Network, benchmarked against London, England and the best in Europe, key challenges include:

- Although Barnet has a lower mortality rate from breast cancer compared to England, one-year survival is lower
- Barnet has a lower one-year survival from colorectal cancer than England
- Prostate cancer is one of the top causes of cancer death in men
- Lung cancer survival is difficult to achieve.

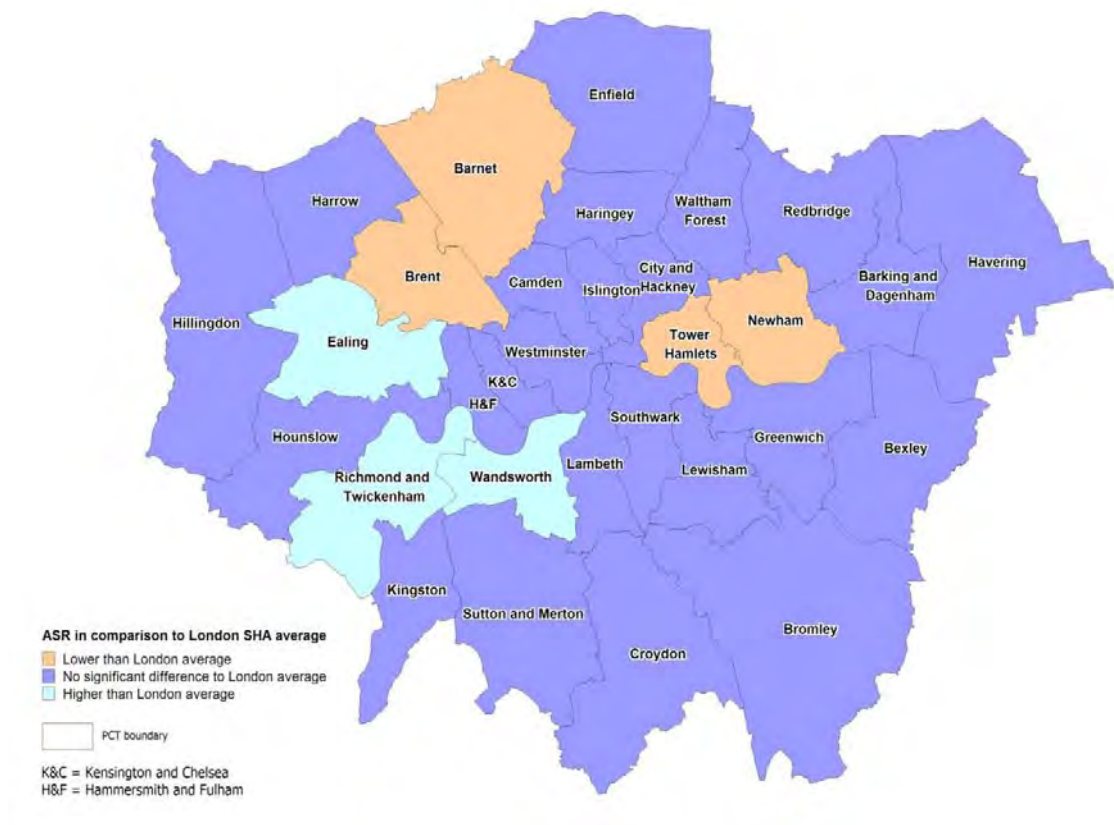
Cancer incidence

It is estimated that more than one in three people will develop some form of cancer during their lifetime. Cancer occurs predominantly in older people, and therefore as life expectancy increases so the number of cancers diagnosed each year will also increase.

Incidence is the measure of the number of new cases of, in this case, cancer that occur in a given time period. In general the incidence for all cancers is rising nationally and in London. Barnet has a downward trend for cancers (LAEDI 1985-2006 pooled data) and has the lowest rate of the North London Cancer Network, this continues into 2005-2007.

The map below shows the comparison of PCTs with the London average (2005-2007 pooled data) using the final year of data from the LAEDI baseline. In this year incidence of all cancers (excluding malignant melanoma) was 362 per 100,000 for the network compared to a national rate of 360 per 100,000 and a London rate of 365 per 100,000.

Image 4: Comparison of directly age standardised incidence rates of breast cancer among women by London PCT against the London average: 2005-07 (LAEDI Baseline pooled data)

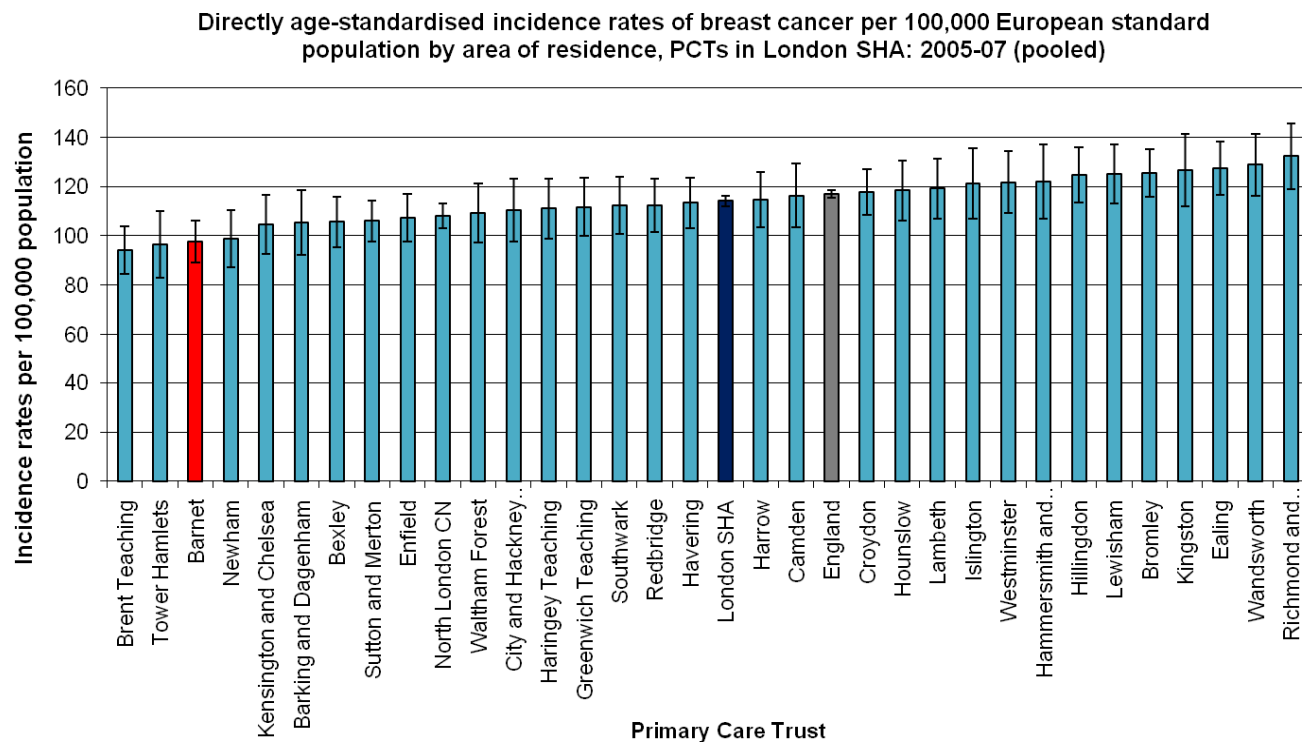


This following section looks at breast, colorectal, prostate and lung cancers which are the most significant in terms of incidence, mortality and survival.

Breast Cancer

Breast cancer is the most common cancer in women, particularly affecting those in the more affluent social groups, but risk factors include obesity, family history and use of Hormone Replacement Therapy (HRT). In Barnet there is trend of increasing incidence of breast cancer.

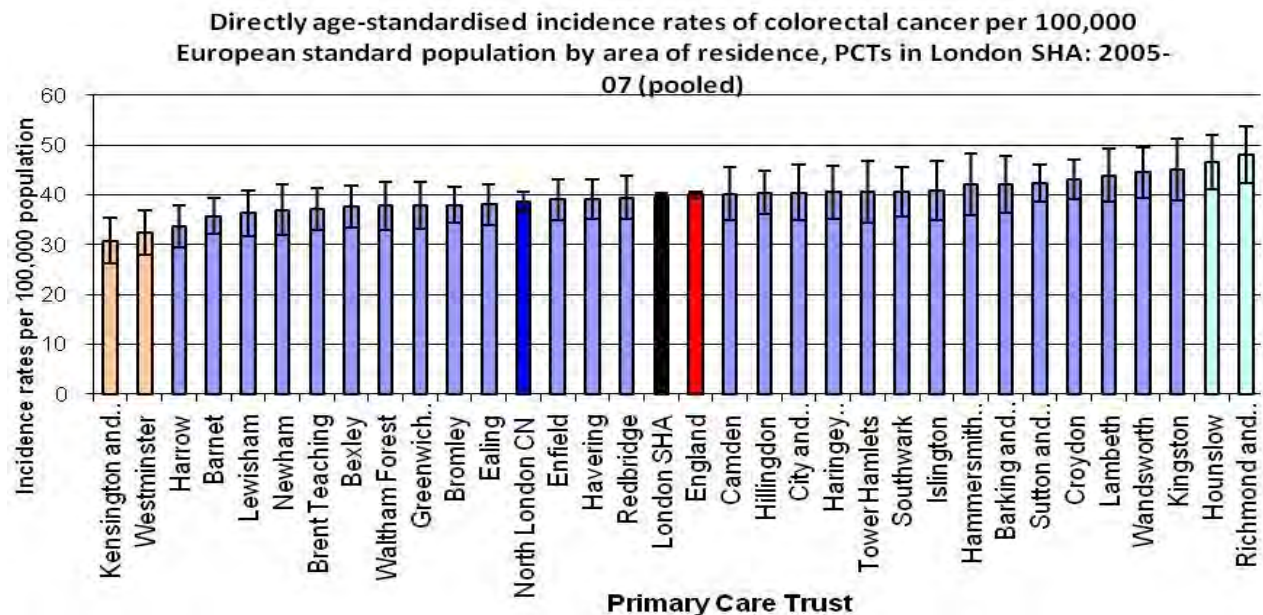
Figure 21:



Colorectal cancer

Barnet incidence is stable at 35.67(CI 32.09- 39.24) per 100,000 (LAEDI baseline 2005-2007). There are no significant differences between Barnet and the London or the national incidence for colorectal cancer.

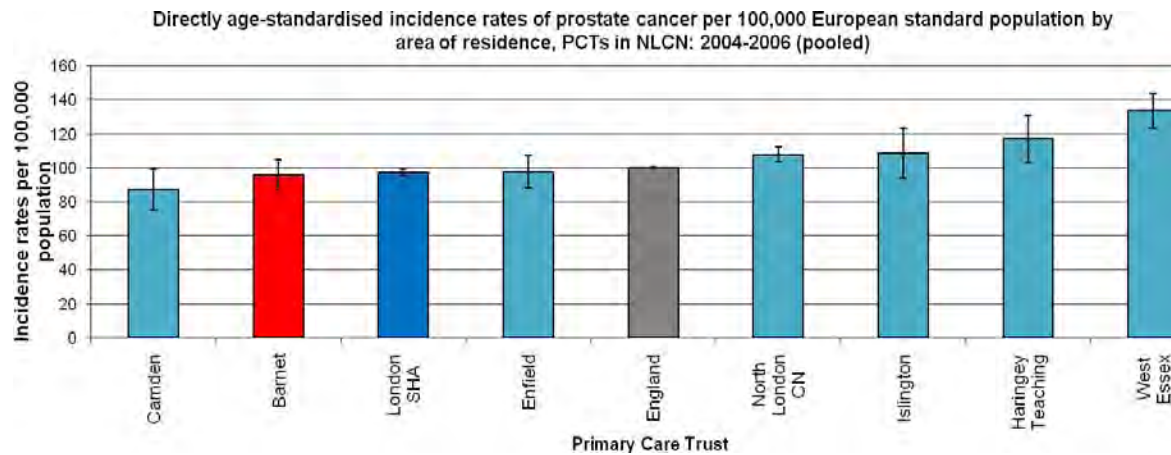
Figure 22:



Prostate cancer

This is on the rise in Barnet in common with London and England rates. These have more than doubled across all organisations in North London, except in Camden. Prostate cancer is the most common cancer in men and much of the increases in incidence may be attributable to more improved detection through Prostate Specific Antigen (PSA) testing.

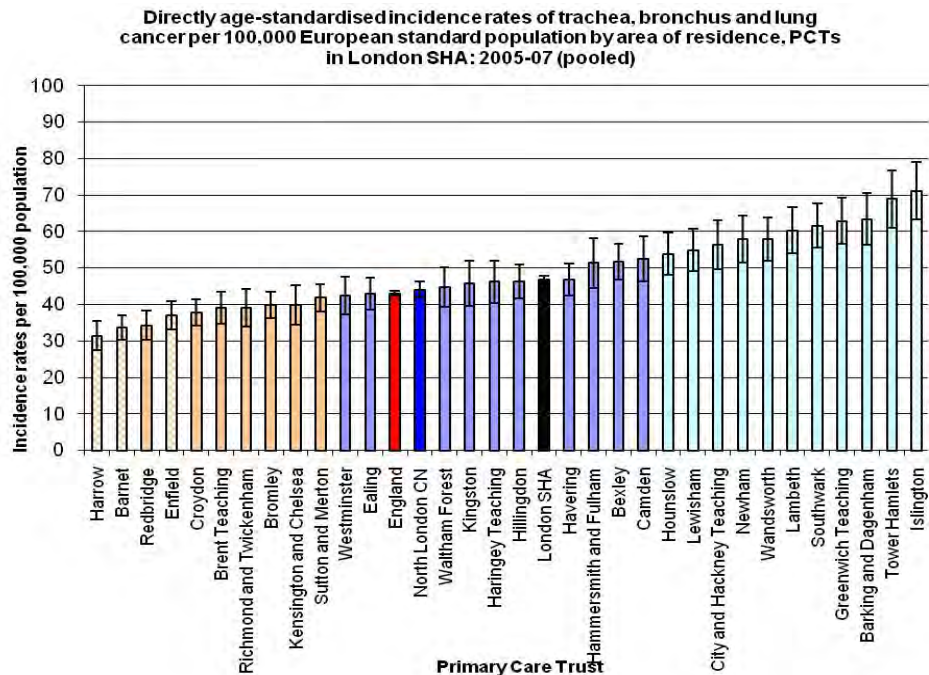
Figure 23



Lung cancer

Barnet's incidence was significantly lower at 33.7 (30.2 - 37.1) per 100,000 compared to the London, England and Network rates at 46.8 (45.9-47.8) per 100,000 and 43 (42.3-43.6) and 44 (41.8-46.2).

Figure 24



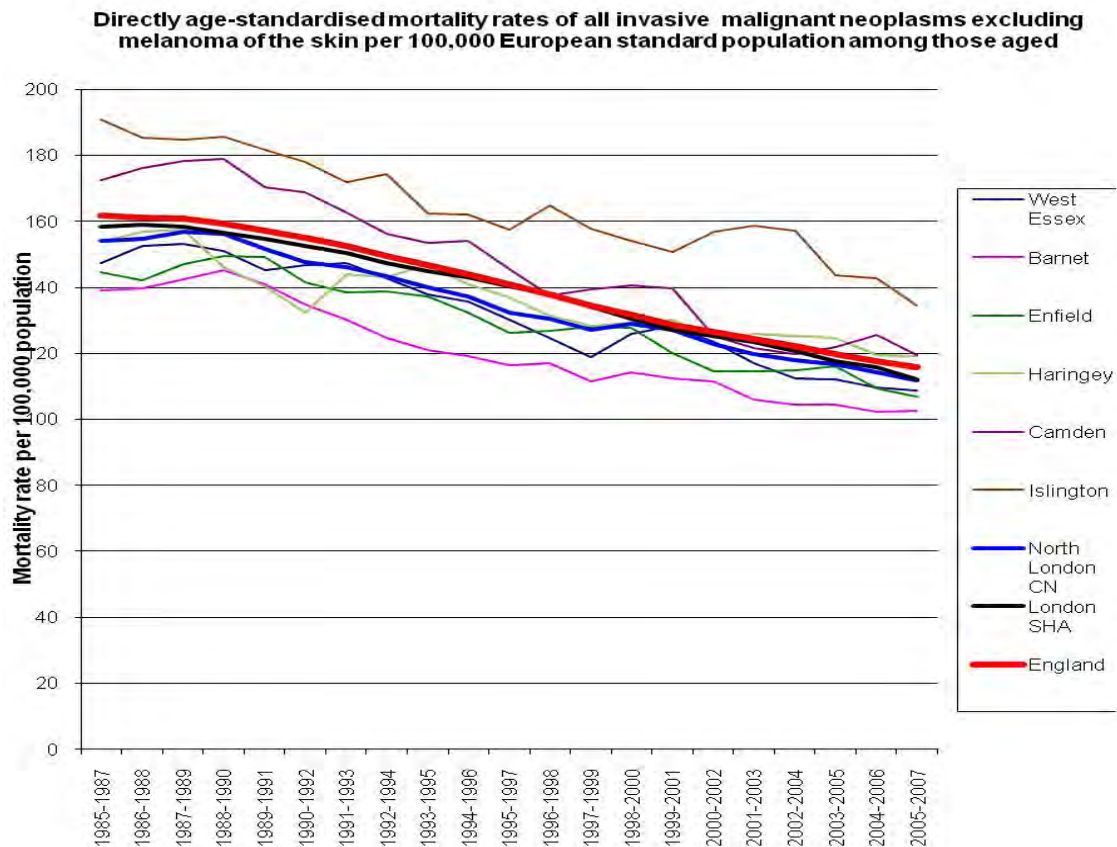
Mortality and Survival

Mortality statistics are the number of people who die from a particular type of cancer in a year. In isolation, these figures can be misleading. The incidence figures and other statistics should be considered at the same time as changes in mortality figures over time are difficult to interpret. The incidence of a cancer may be decreasing or treatment may be improving so more people are cured. Treatment improvement may mean more people are living longer after they are diagnosed and this will also make the mortality figures fall in the short

Therefore it is also helpful to consider one and five year survival alongside mortality. One year survival refers to the number of people alive after one year of diagnosis and can be used as a proxy measure for early (or late) diagnosis. Five year survival refers to the number of people alive five years after diagnosis and can be used as a proxy for treatment outcomes.

The LAEDI baseline data shows that there is a downward trend for mortality when all cancers are considered together across our cancer network. This pattern is in common with the England and London rates. Barnet is significantly lower.

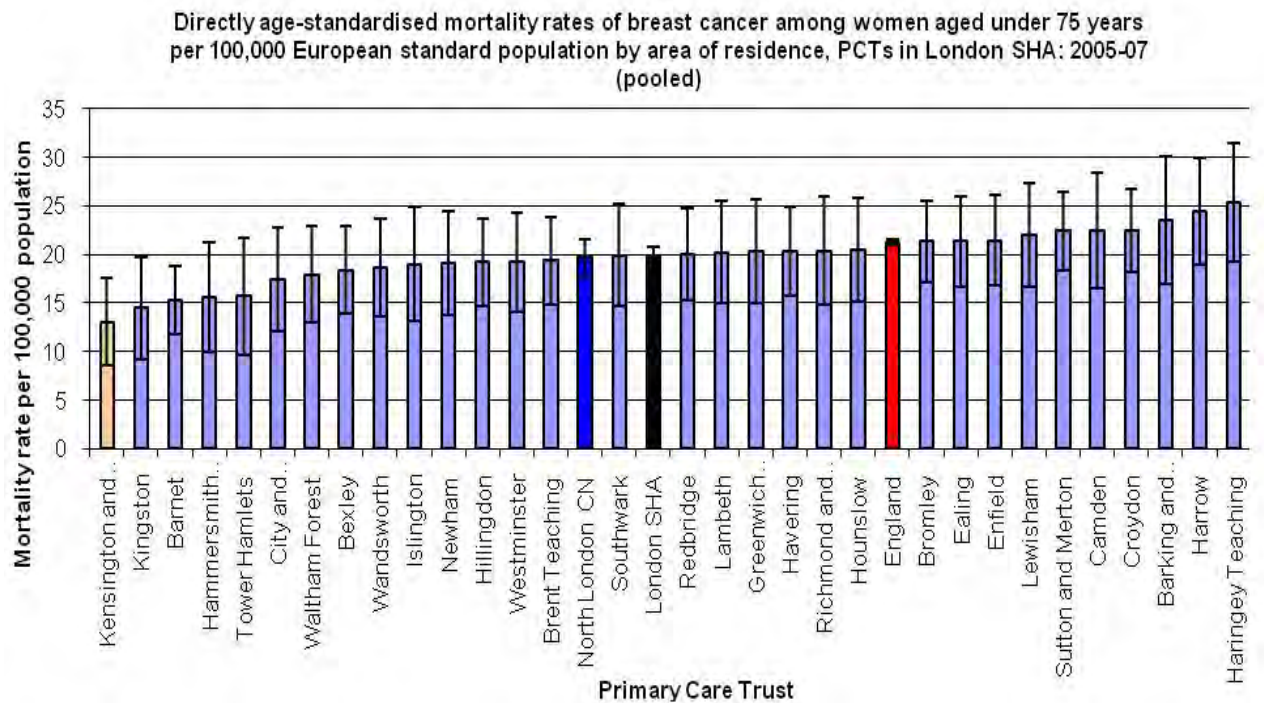
Figure 25:



Breast cancer

Barnet has a mortality rate of 21.26 (CI17.56 -24.96) lower than the London and England averages. This rate is also the lowest in the North London Cancer Network.

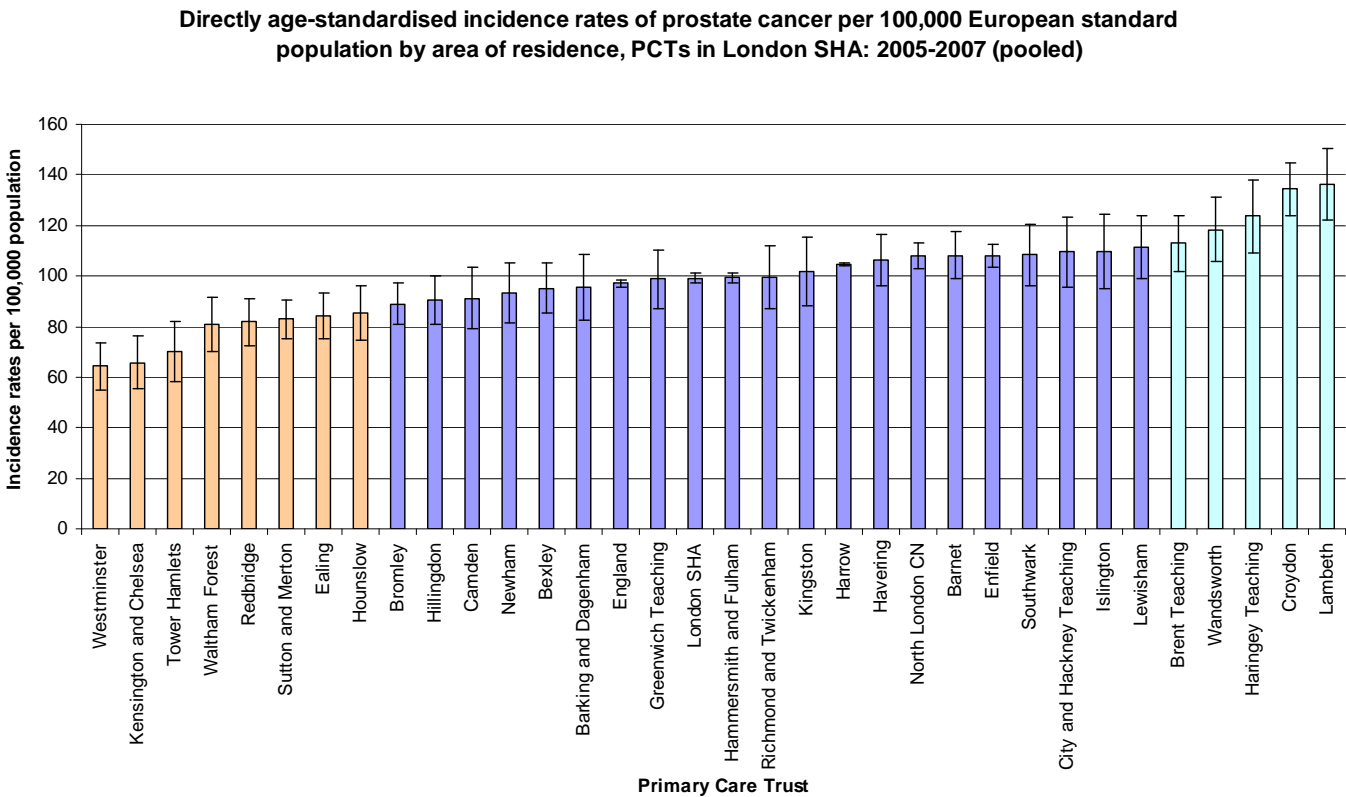
Figure 26:



Prostate Cancer

Prostate cancer is the third most common cause of cancer death in Barnet at a rate of 21.4 per 100,000 (ONS 2009) and the second cause of cancer death nationally after lung cancer. Despite a high rise in incidence, the mortality rates for prostate cancer show a downward trend, in common with the England and London rates (under 75s). Increases in incidence are attributed to improved screening and more widespread use of PSA testing which will also contribute to lower rates of mortality since changes in the prostate can be detected earlier and treatment started sooner.

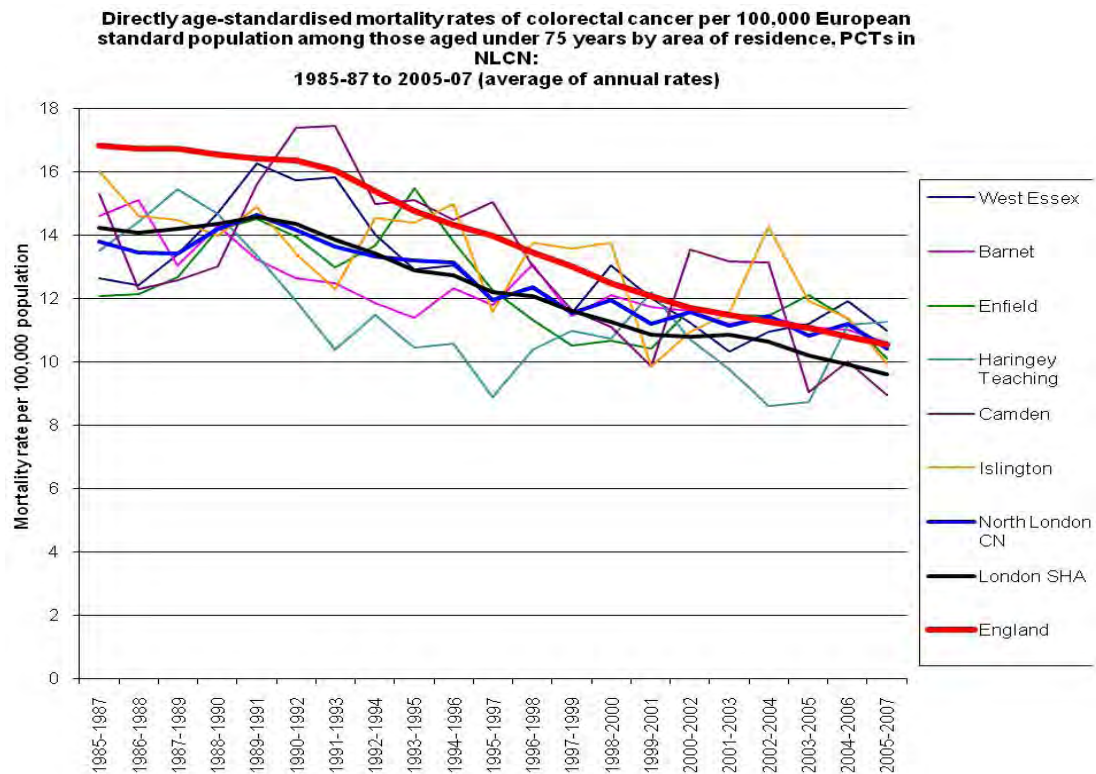
Figure 27:



Colorectal Cancer

Colorectal cancer remains the second most common cancer death after lung cancer nationally and is the fourth most common cancer death in Barnet (15.9 per 100,000 ONS 2009). Mortality from colorectal cancer is declining across all NCL organisations reflecting the national, London and network mortality rates, with no outlying PCTs.

Figure 28:



Lung, Trachea and Bronchus Cancers

In terms of the sector, mortality rates are significantly lower in Barnet at 18.5 per 100,000(15.6-21.3) when compared to the rates for London 26.5 per 100,000 (25.7-27.2), in the North London Cancer Network 24.2 per 100,000 (22.6-25.8) and England 26.6 per 100,000(26.3-26.9) rates.

The mortality for lung, trachea and bronchus cancers is declining across the network, in London and nationally. Lung cancer is the most common cause of cancer death in the UK. The decline in mortality is related to declining smoking rates and although it is still the most common cause of deaths for both genders it still kills more men than women and has a distinct relationship with deprivation.

Figure 29:

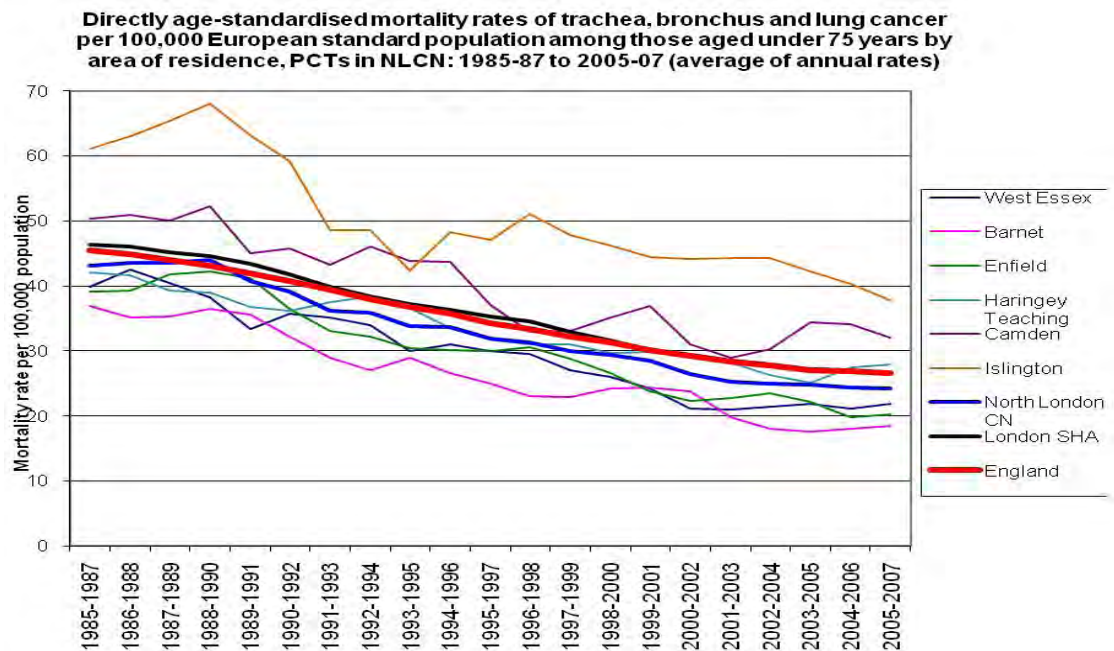
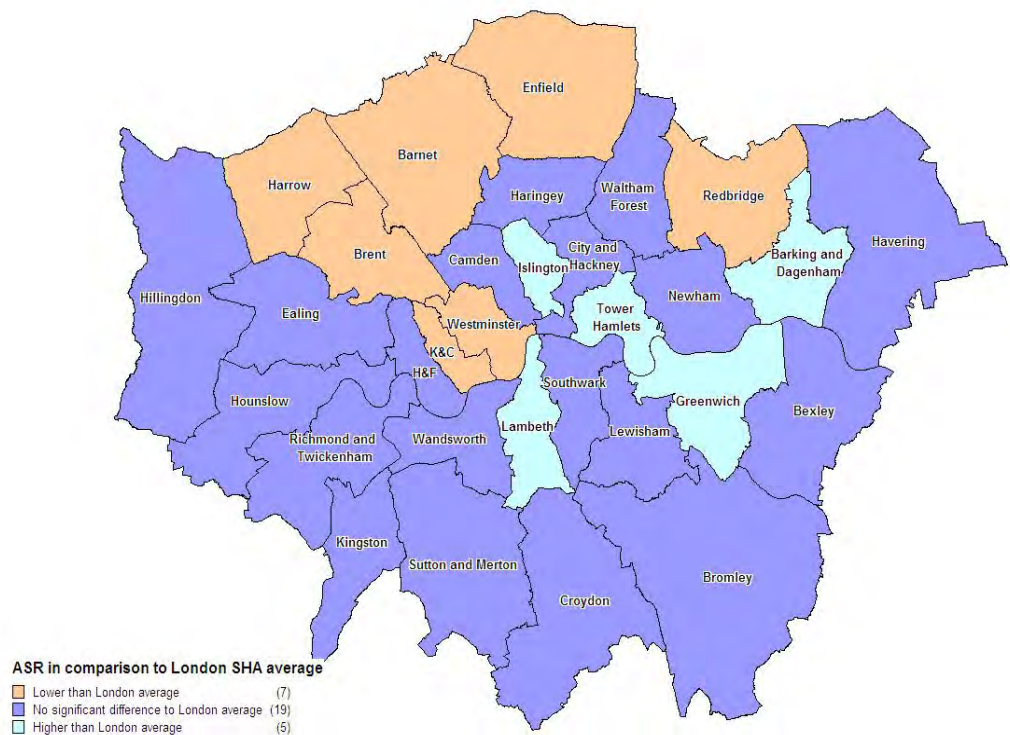


Image 5: Comparison of directly age standardised mortality rates of lung cancer by London PCT against the London average: 2005-07 (pooled)



One and five year survival

One year survival refers to the number of people alive after one year of diagnosis and can be used as a proxy measure for early (or late) diagnosis. Five year survival refers to the number of people alive five years after diagnosis and can be used as a proxy for treatment outcomes.

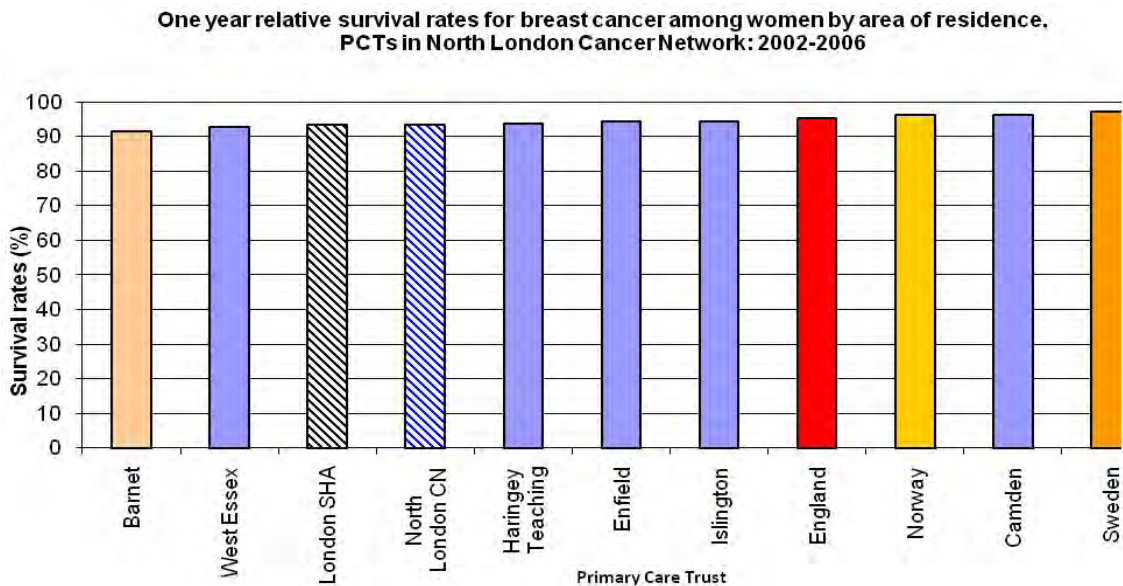
One year survival is a proxy for late/early diagnosis and can be particularly useful when staging data is not sufficiently complete. Data for England is most often compared to other European countries where there is 100% cancer registration (known as EUROCARE-4) such as those in Scandinavia.

One year survival across all cancers in Barnet is slightly better than the London rate, though not significantly and is lower than the England rate. Although this is significant statistically the difference is still very small.

Breast Cancer One year survival

In England one year survival for breast cancer is around 95-96%. Barnet has a significantly lower one year survival than England at around 91.5%. This means that of every 100 women with breast cancer 91.5 of them will live for one year or more after diagnosis (LAEDI baseline data 2004-2006). More investigation is required to understand more fully why Barnet has a low one year survival rate for breast cancer.

Figure 30:



Lung Cancer

Lung cancer has one of the lowest survival outcomes of any cancer because over two-thirds of patients are diagnosed at a late stage when curative treatment is not possible.¹⁰⁷ Latest figures (England and

¹⁰⁷ Cancer Research UK 2010

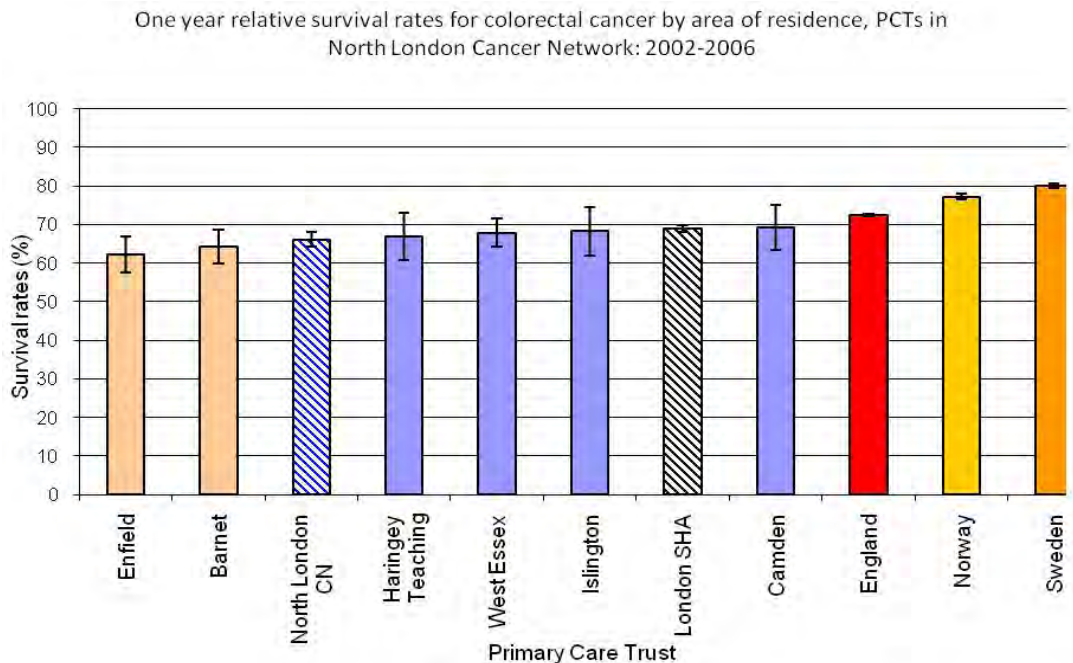
Wales) show around 27% of male and 30% of female lung cancer patients are alive one year after diagnosis falling to 7% and 9% respectively at five years.¹⁰⁸

In Barnet, one year survival is 29.44 (CI 25.40 -33.47), this compares with the North London Cancer Network PCTs one year survival ranges from 28.16 (CI 23.29-33.03) in Haringey to 34.134 (CI 29.38-38.88) in Islington where one year survival is better than the England average (LAEDI baseline).

Colorectal Cancer

The graph shows the position of North London Cancer network PCTs compared to Norway, Sweden and England rates with Barnet (64.310 CI 59.94- 68.67) significantly lower. This may be due to reluctance of patients to report changes which could be identified as early symptoms and signs of cancer thus causing later presentation of the disease.

Figure 31:



The relationship between diversity, deprivation and cancer

Various factors have been reported that increase the risk of developing breast cancer. Some like gender (being female), age (being older), genes (having the BRCA 1 and 2 genes), ethnicity (being White), and having a family history of breast cancer all increase the risk but cannot be changed. However, lifestyle factors like never given birth, having the first child after the age of 30 years, which are commoner features amongst women living in more affluent areas, obesity, high fat diets and inactivity, also increase the risk of breast cancer but can be changed in many instances.

Analysis of cancer incidence and survival by major ethnic group showed that across both age groups and for all ages, people from the Asian, Chinese and mixed ethnic groups were between 20% and 60%

¹⁰⁸ Cancer Research UK 2010

less likely to get cancer than those from the White ethnic group. This report however highlights the increased risk of liver, mouth and cervical cancers in the Asian and Black ethnic groups. Furthermore, the Asian and Black women were found to have lower survival than the White ethnic group for females diagnosed with breast cancer aged 65 years and under.¹⁰⁹

Research shows that cervical cancer and death from the disease is commoner amongst women living in more deprived areas. There is also evidence that women from deprived backgrounds are less likely to attend for cervical screening, and this may be connected with reduced self-esteem, lower educational attainment and poorer literacy skills.¹¹⁰ Women who smoke (smoking is also more prevalent amongst people in lower socio-economic groups) are less likely to attend for cervical screening.

Thus, the picture with cancer in terms of deprivation, ethnicity and other factors is complex and not easy to unravel. It is further complicated when examined at a local level because the numbers of people with different cancers (even the common ones) are relatively small. This means that year-to-year variations in the number of people developing cancer are not necessarily significant: it is the overall trend over several years that is more important.

Screening

Breast cancer screening

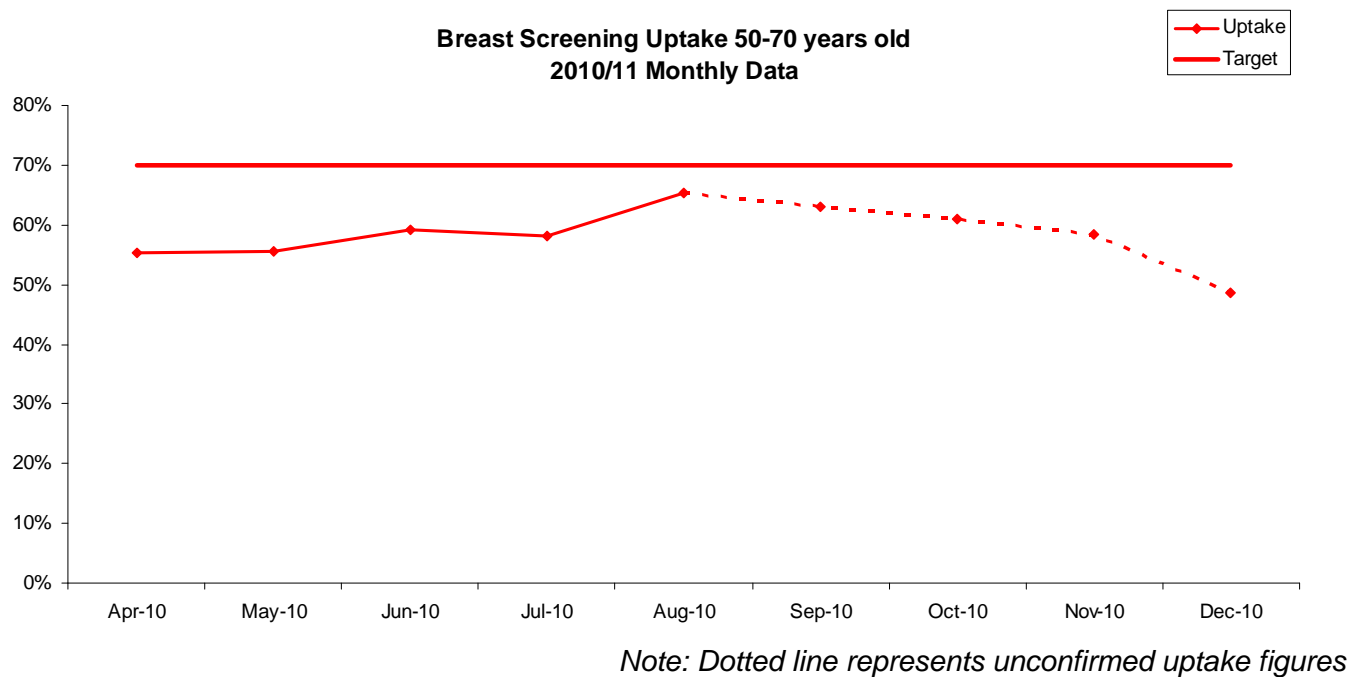
Nearly all breast cancers can be treated successfully if detected early and regular breast screening with mammography, an x-ray examination of the breast, is reported as the single most effective way to detect breast cancer at an early, curable stage. There has been a dramatic reduction in mortality since the late 1980s when over 15,000 women were dying each year and the data shows that this has occurred in Barnet as well.

However, the latest available figures show that breast screening for Barnet PCT show that there is a continuing low uptake of screening in Barnet.

¹⁰⁹ National Cancer Intelligence Network and Cancer Research UK (2009). Cancer Incidence and Survival by Major Ethnic Group, England 2002-2006

¹¹⁰ Lightwood et al. PEDIATRICS Vol. 104 No. 6 December 1999

Figure 32:



Increasing uptake of breast screening in Barnet should be tackled alongside measures to increase awareness of cancer signs and symptoms. This will maximise the opportunities for cancers of all types to be identified earlier when treatment can be more successful, and survival is more likely. There are a number of reasons why uptake of breast screening in particular is low in Barnet. These include the perceptions that women may have about the way in which screens are undertaken, cultural influences, the use of other non NHS services in preference to the NHS programme and reluctance to attend for other reasons. The activity undertaken will aim to delve deeper into the specifics of these for Barnet and identify where the greatest gains can be made to address them.

Colorectal cancer screening

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 (see also Figure 38) 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.

The bowel cancer screening programme invites men and women aged 60-69 (people aged 70 or over are provided with a testing kit on request) to be screened for bowel cancer every two years. Testing kits are sent direct to individuals to be used in their homes.

Recommendations

- Improve the uptake of screening for breast and colorectal cancer screening – the two biggest cancer killers for which population screening is available;
- Increase awareness of the signs and symptoms of cancer to enable people to visit their GP earlier and improve their chances of early diagnosis
- Work with local providers to improve access to services to ensure that people who may have cancer are investigated and, as necessary, treated, as soon as possible; and
- Work with local providers to try to improve the availability of clinically and cost-effective treatments for cancer.

Respiratory disease

Overview

Excluding cancers of the respiratory tract, respiratory disease is the third most common cause of death in Barnet. Respiratory disease includes infections (such as acute bronchitis and pneumonia), reversible airways obstruction in response to irritation or allergy (asthma), and permanent structural damage (chronic obstructive pulmonary disease (COPD) which includes both chronic bronchitis (repeated chest infections and inflammation) and emphysema). COPD is almost entirely due to smoking. In 2009-10 the prevalence of COPD in Barnet was 1% same as that of London average. Whereas Barnet had slighter higher prevalence (4.9%) compare to London average prevalence of 4.8%. (Please see Table 17)

In the UK, pneumonia affects up to 11 in 1,000 adults each year and it is more common during autumn and winter.

Table 17: Prevalence of respiratory diseases, Barnet, London, 2009-10

	Number on GP register		Prevalence	
	<i>Barnet</i>	<i>London</i>	<i>Barnet</i>	<i>London</i>
COPD	3,649	86,643	1.0%	1.0%
Asthma	17,846	413,972	4.9%	4.8%

Source: Information centre QOF data¹¹¹

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

Table 18: 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 data¹¹²

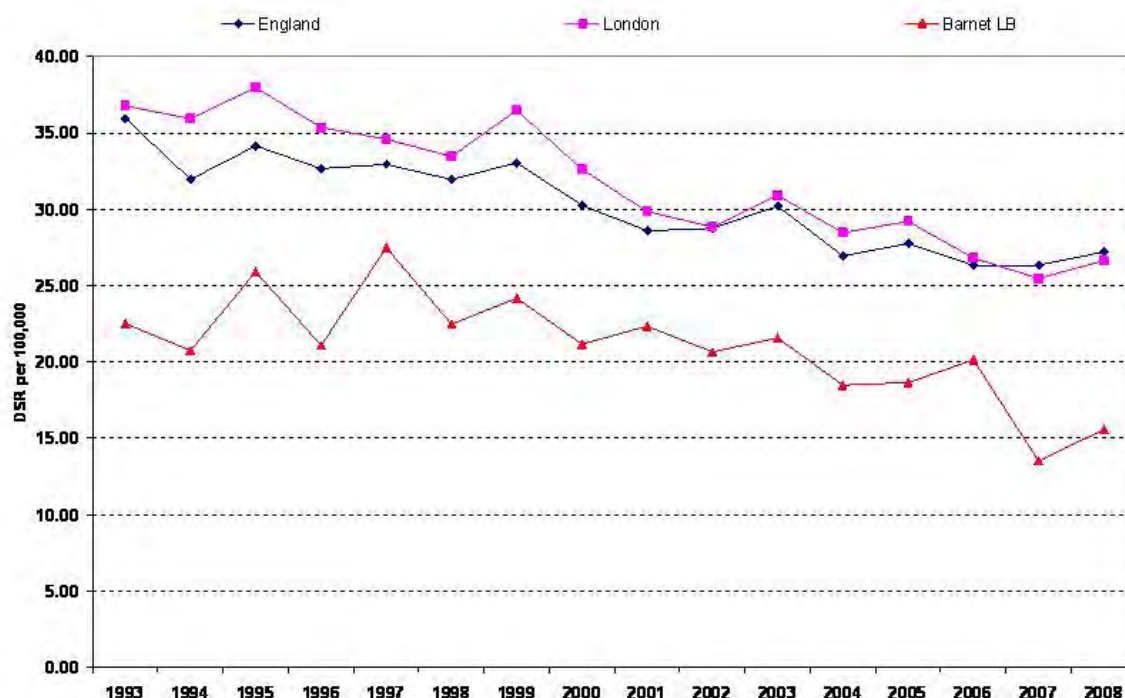
¹¹¹ Note that Pneumonia is not a QOF indicator as it is an acute illness rather than chronic. Thus prevalence figures not provided for pneumonia in the table

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Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease is a long term condition and covers a group of illnesses: chronic bronchitis, emphysema and bronchiolitis or small airways disease. It is caused primarily by smoking but other factors such as occupational exposure have also been implicated. COPD is more common in males and increases with age, largely due to the higher levels of smoking in men and the accumulative effect of smoking on lungs.

Figure 33: Mortality from COPD, all ages, all persons, 1993-2008

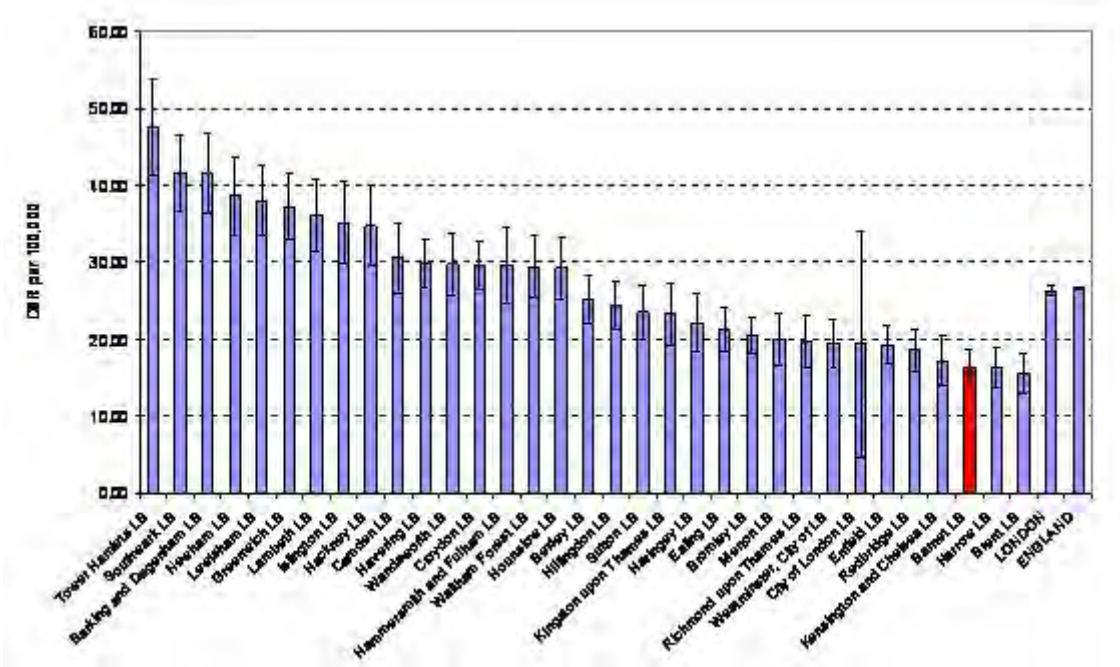


Source: NCHOD Compendium of Clinical and Health Indicators

Death rates from COPD are generally falling, although there was an increase in 2008. However, the trend is that death rates in Barnet have been consistently below the London and England average.

Looking at the most recent mortality dataset (2006-2008), Barnet death rates from COPD are significantly lower than the London and England averages also lower death rates compared to majority of boroughs in London.

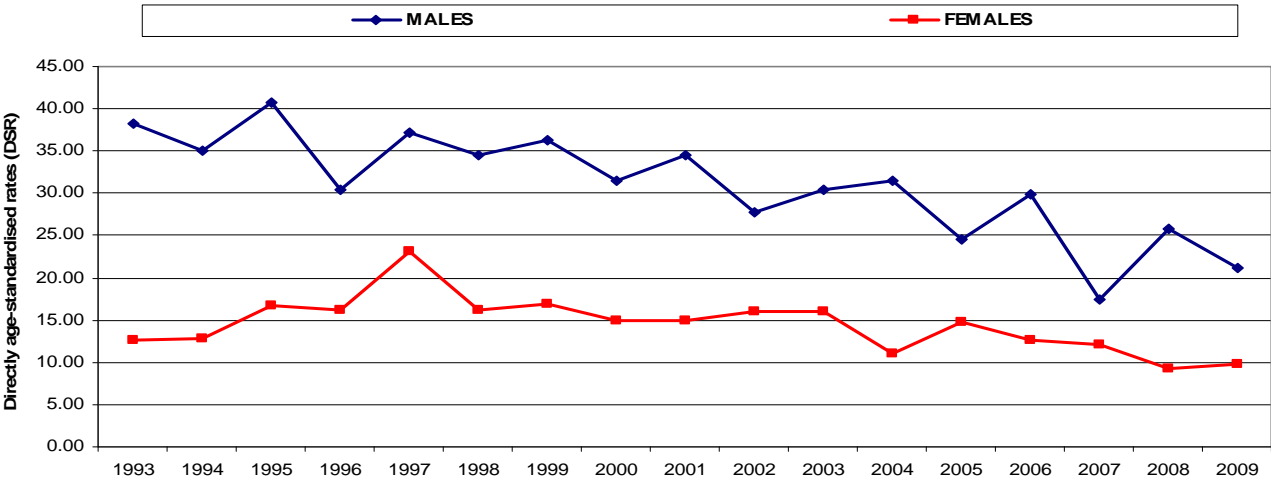
Figure 34: Mortality from COPD, Standardised Mortality Ratio, all persons, 2006-2008



Source: NCHOD Compendium of Clinical and Health Indicators

In Barnet, death rates from COPD are reducing faster in men than they are in women, as shown in Figure 35 and we can expect this gender difference to continue for some time. This reflects smoking habits over the last 30-40 years when proportionately fewer women were giving up smoking thus causing problems in years to come.

Figure 35 Mortality from COPD for males and females in Barnet, 1993-2009

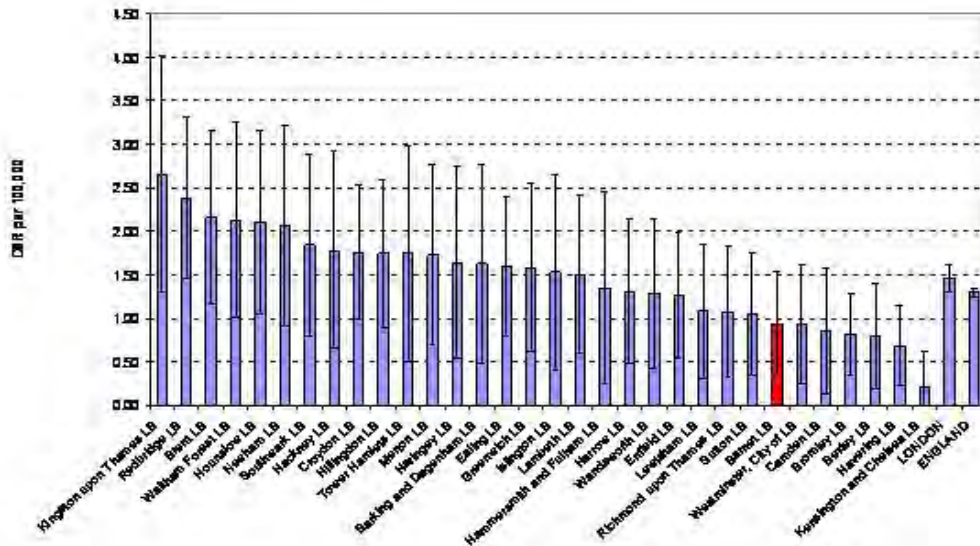


Source: NCHOD Compendium of Clinical and Health Indicators

Asthma

Asthma is a chronic inflammation of the airways, with symptoms of wheezing. It can be made worse by allergens (e.g. the house dust mite), exercise, cold dry air, traffic pollutants (e.g. fine particles and nitrogen dioxide), viruses and occupational chemicals. Asthma is more common in children than in adults, with the peak prevalence of asthma being between the ages of five and ten years of age. Whilst there are treatments available, left untreated it can lead to hospital admissions to control the illness and death, although this is a rare event.

Figure 36: Mortality from Asthma, all persons, London Boroughs, 2006-2008



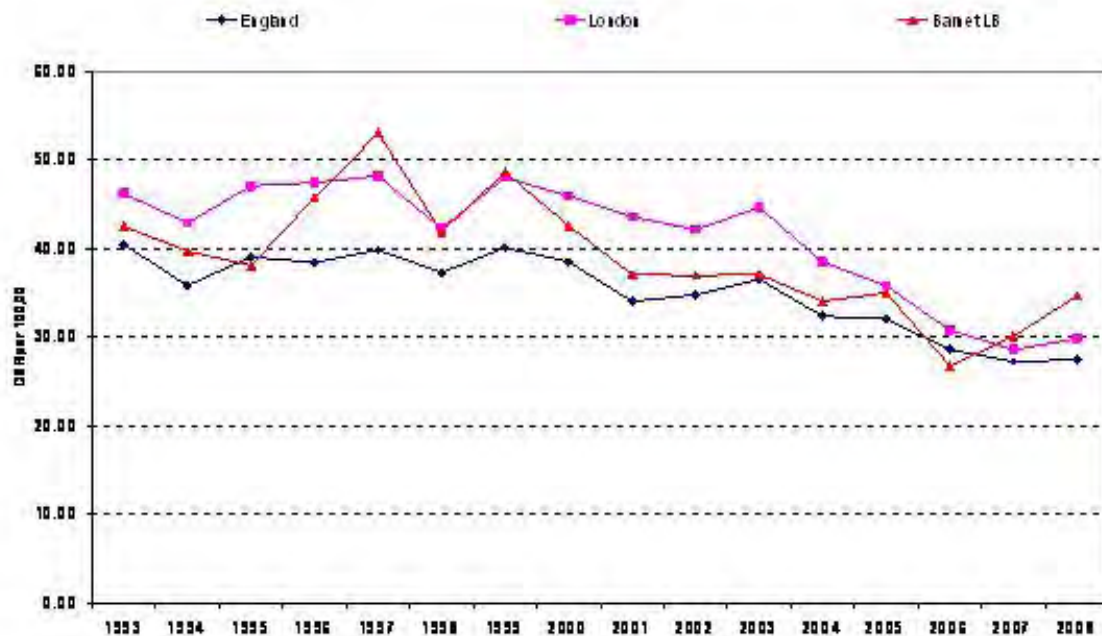
Source: NCHOD Compendium of Clinical and Health Indicators

In comparison to other London boroughs, Barnet has the sixth lowest death rates from asthma. However the rates are not significantly different from that of London and England average.

Pneumonia

Pneumonia is a localised infection of the lungs. It is characterised by cough and sometimes a fever. A person is more likely to get pneumonia if they have a weak immune system, and it is more common in older people. It is often a complication of asthma, COPD, flu or HIV/AIDS.

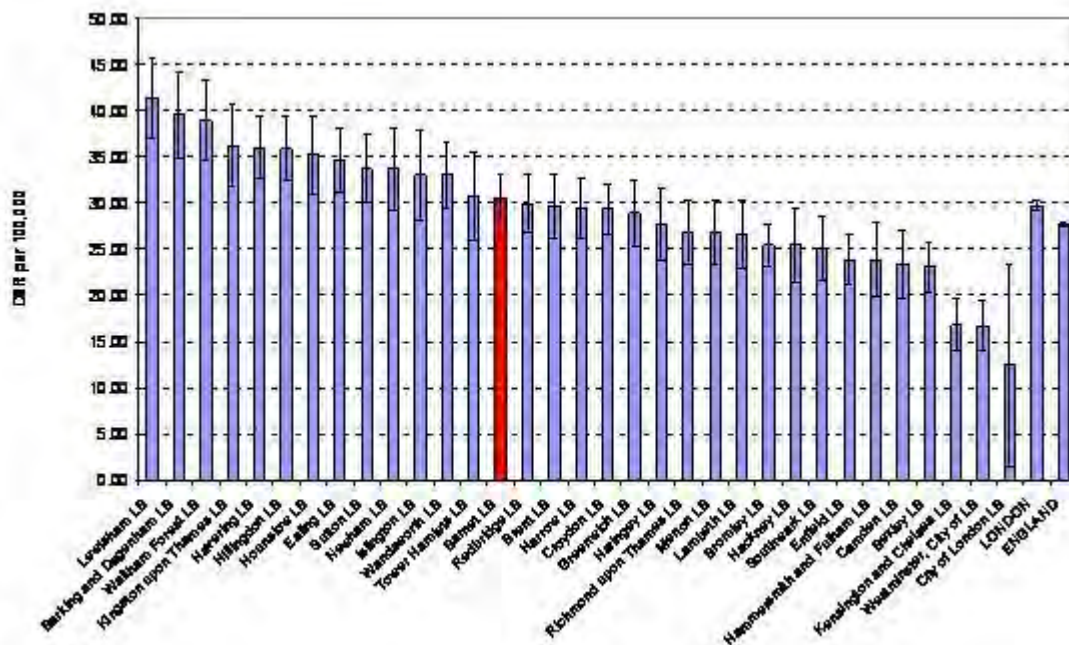
Figure 37: Mortality from Pneumonia, all ages, all persons, 1993-2008



Source: NCHOD Compendium of Clinical and Health Indicators

In general Barnet death rates from pneumonia follow the London and England trends, but rates in Barnet have increased between 2006 and 2008.

Figure 38: Mortality from Pneumonia, all persons, London Boroughs, 2006-2008



Source: NCHOD Compendium of Clinical and Health Indicators

The death rate from pneumonia in Barnet is comparable to the London and England averages. However, several London boroughs – including two of our immediate neighbours (Camden and Enfield) – have significantly lower mortality rates than Barnet.

Tuberculosis (TB)

TB is caused by bacteria (a type of germ) called *Mycobacterium tuberculosis* (*M. tuberculosis*). A person who has TB disease in his or her lungs or larynx (throat) can release tiny particles called droplet nuclei into the air by coughing, sneezing, singing, shouting, talking, or breathing.

These particles are invisible to the naked eye and are approximately 1 to 5 microns in size. (A micron is approximately one-hundredth the width of a human hair.) Droplet nuclei can remain airborne in room air for a long period of time, until they are removed by natural or mechanical ventilation.

In order for TB to spread, there must be a source patient who has infectious TB disease and a susceptible host (a person to inhale droplet nuclei containing *M. tuberculosis*). Anyone who shares air with a person with infectious TB disease of the lungs or larynx is at risk, although TB is not usually spread by brief contact. TB is spread when another person inhales one or more of these particles and becomes infected with TB.¹¹³

During the year ending 30th September 2010 the rate of new TB notifications per 100,000 population amongst London residents was 47.4, ranging from 28.0 in south west London to 65.4 in north west London

Table 17: London TB rate per 100,000 population* by sector of residence - reported to the London TB Register during year ending 30/09/2010

London	North Central	North East	North West	South East	South West
47.48	40.41	63.95	65.48	32.12	28.04

Source: HPA

The aim of TB control is to reduce local transmission of the disease. TB rates in Barnet fluctuated year to year. Between 2005 and year ending 30th September 2010 the number and percentage of new TB notifications amongst Barnet residents was ranging from 104 in 2007 to 123 in 2006.

¹¹³ Francis J. Curry National Tuberculosis Center, 2007: Tuberculosis Infection Control: A Practical Manual for Preventing TB

Table 18: Number of new TB notifications in London residents by PCT of residence and year of notification - reported to the London TB Register

PCT	2005		2006		2007		2008		2009		Qtr 1, 2 & 3 2010	
North Central												
Barnet	117	62%	123	50%	104	60%	114	53%	105	59%	84	52%
Camden	101	65%	97	53%	89	53%	85	49%	100	60%	55	58%
Enfield	104	49%	100	52%	73	51%	100	61%	117	49%	76	47%
Haringey	132	57%	153	56%	93	62%	103	59%	131	60%	73	67%
Islington	87	67%	97	65%	93	63%	93	66%	91	63%	49	67%
North Central Total	541	60%	570	55%	452	58%	495	58%	544	58%	337	58%
North East												
Barking & Dagenham	60	48%	49	51%	62	45%	69	49%	73	37%	50	58%
City & Hackney	132	55%	137	65%	143	48%	124	47%	118	51%	77	45%
Havering	30	47%	23	57%	16	44%	20	55%	30	27%	13	23%
Newham	257	43%	261	45%	277	41%	287	41%	310	42%	249	38%
Redbridge	120	39%	144	37%	135	39%	163	37%	147	47%	111	47%
Tower Hamlets	129	46%	133	47%	153	41%	133	45%	144	47%	115	44%
Waltham Forest	114	48%	121	58%	92	39%	129	40%	93	54%	96	57%
North East Total	842	46%	868	50%	878	42%	925	43%	915	45%	711	45%
North West												
Brent	286	40%	240	45%	274	42%	307	48%	299	48%	234	37%
Ealing	239	43%	235	45%	236	44%	199	43%	221	43%	157	41%
Hammersmith & Fulham	90	53%	80	56%	68	50%	68	54%	74	61%	42	50%
Harrow	133	45%	124	49%	122	50%	128	44%	137	38%	108	47%
Hillingdon	143	61%	126	56%	127	46%	152	60%	123	49%	99	40%
Hounslow	167	42%	138	35%	136	36%	134	32%	172	41%	152	30%
Kensington & Chelsea	49	51%	53	55%	32	72%	53	58%	50	66%	33	64%
Westminster	96	56%	85	61%	86	55%	69	67%	82	41%	48	48%
North West Total	1203	46%	1081	48%	1081	46%	1110	48%	1158	46%	873	40%
South East												
Bexley	23	61%	19	47%	26	46%	21	52%	17	58%	14	57%
Bromley	29	48%	41	51%	35	46%	19	26%	32	50%	24	58%
Greenwich	88	56%	98	59%	105	59%	138	53%	122	52%	97	48%
Lambeth	146	55%	134	53%	104	45%	127	44%	116	59%	84	51%
Lewisham	99	54%	85	53%	100	48%	84	55%	76	59%	63	43%
Southwark	137	49%	125	54%	104	52%	117	40%	95	40%	74	43%
South East Total	521	53%	502	54%	474	50%	506	47%	458	52%	356	48%
South West												
Croydon	113	48%	102	39%	117	42%	112	44%	124	46%	88	40%
Kingston	29	45%	25	64%	29	59%	29	69%	31	55%	24	75%
Richmond & Twickenham	19	47%	20	55%	14	50%	13	62%	21	43%	13	31%
Sutton & Merton	86	56%	93	54%	90	54%	81	58%	93	66%	70	46%
Wandsworth	125	64%	82	60%	115	53%	110	56%	85	42%	72	47%
South West Total	372	55%	322	52%	365	50%	345	54%	354	51%	267	46%
London Totals	3479	50%	3343	51%	3250	48%	3381	49%	3429	49%	2544	46%

Source: HPA

The risk we face

COPD is the most significant risk that we face. There are over 900,000 people in the UK, diagnosed with COPD and half as many again are thought to be living with undiagnosed COPD.¹¹⁴ The true prevalence of COPD both nationally and locally is unknown, but it has been estimated at 1-10%.¹¹⁵ Rates are higher in men, although this is now beginning to equalise¹¹⁶ as more women reach an age when smoking earlier in life is taking its toll. Stopping smoking is important whatever the degree of

¹¹⁴ Godtfredsen NS, Vestbo J, Prescott E Risk of hospital admission for COPD following smoking cessation and reduction: a Danish population study' *Thorax* 2002; 57:967-972

¹¹⁵ British Thoracic Society Standards of Care Subcommittee on Pulmonary Rehabilitation. Pulmonary Rehabilitation. *Thorax* 2001;56:827-834

¹¹⁶ Calverley P. COPD: early detection and intervention. *Chest* 2000; 117:S365-S371

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.¹¹⁷

The risk of people suffering and dying from other respiratory diseases can also be reduced by quitting smoking – it increases one's likelihood of developing acute bronchitis – and, for those in at-risk groups, of having an annual influenza immunisation.

Asthma is predominantly a cause of intermittent breathing difficulty and a relatively unusual cause of death. For most people, it can be wholly managed in a primary care setting with only a small number requiring hospital admission for severe attacks.

Pneumonia can affect people of any age, although it is more common and can be more serious in groups such as: babies, young children and elderly people, people who smoke and people with other health conditions, such as a lung condition or a weakened immune system. People in these groups are more likely to need treatment in hospital.¹¹⁸

Rates of TB in London are steadily increasing particularly in 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.¹¹⁹ 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.

The relationship between diversity, deprivation and respiratory disease

Most respiratory disease is related to smoking and a polluted environment (NO₂). It's known that smoking is more prevalent in deprived areas which are also more likely to be polluted so increasing the risk of respiratory illness including TB.

The Council's Local Development Framework outlines several priorities which promise to improve air quality, including one to provide safe, effective and efficient travel, which highlights the need for more environmentally friendly transport networks, another which outlines a commitment to enabling inclusive and integrates community facilities, ensuring that community buildings including schools, libraries and meeting spaces are located where they are easily accessible (by foot or public transport) and a plan for ensuring the efficient use of natural resources, outlining a local commitment to reduce carbon emissions, energy and water waste, noise and air pollution.

¹¹⁷ Soriano JB, Maier WC, Eager P, et al. Recent trends in physician diagnosed COPD in women and men in the UK. Thorax 2000;55:789-94

¹¹⁸ NHS Choice

¹¹⁹ HPA, TB Surveillance, London, Nov 2010

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.

Recommendations

- Improve the provision of services to manage acute exacerbations of COPD early and to provide pulmonary rehabilitation services
- Explore the possibility of spirometry being available in all GP practices to improve diagnosis
- Ensure that COPD is diagnosed early so that treatment can control the illness and prevent admissions
- Ensure that people diagnosed with asthma have a regular review of their condition and improve the measures for the detection of asthma in those at risk groups e.g. children
- Ensure that guidelines are followed for these conditions in the community and that once diagnosed with pneumonia, acute guidelines are followed
- As most TB responds rapidly to treatment, the key aspects of TB control should be early case finding and disease treatment.
- Participate in 'Airtex' scheme to enable asthma sufferers to be alerted when air quality is poor.
- Improve the knowledge of health professionals of the work undertaken by the Private Sector Housing Team and the Handy Person Scheme to try and prevent the reoccurrence of respiratory illness due to poor housing.

Coronary heart disease and stroke

Overview

Coronary heart disease (CHD) is caused by the progressive narrowing or by the blockage of one or more of the small arteries that supply the muscle of the heart. As less blood gets through these arteries the oxygen supply to the heart muscle is reduced. This causes pain on exertion (angina) and reduces the amount of work that the heart can do. If the narrowing gets too great or there is a sudden blockage caused by a small blood clot the blood supply to a portion of the heart is stopped completely. This is a 'heart attack' and, together with stroke, is still the most common cause of death in this country and in Barnet.

Stroke is caused by either a blockage of one of the blood vessels supplying the brain or, less commonly, by one of these blood vessels bursting and bleeding. In either event, the blood supply to a portion of the brain is suddenly stopped. This is a 'stroke' (also called a cerebro-vascular accident or 'CVA') and leads to a permanent loss of function of the part of the brain affected.

These two diseases have similar origins: they are usually caused by progressive damage to the lining of blood vessels. This damage occurs in many parts of the body but the heart and the brain are more susceptible to a loss of blood supply than most other organs. CHD and stroke are often combined into one condition – cardio-vascular disease (CVD) for this reason.

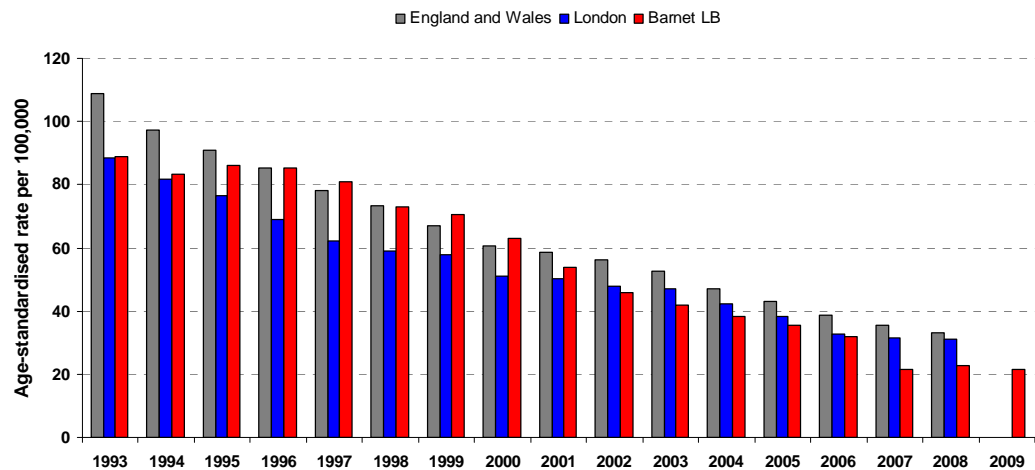
The most common causes of CVD are smoking, high blood pressure, raised blood cholesterol levels and diabetes. These last three risk factors are much more common amongst people who are obese. Put another way, the most common cause of death in Barnet is mainly caused by two things: smoking and obesity. If we wish to reduce the number of people who die each year from *avoidable* disease then we need to help people – in various different ways – to stop smoking and, if they are overweight or obese, to lose weight.

The risk we face

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.

Figure 38 shows comparative rates and trends in deaths from heart attack in England and Wales, London and Barnet. The rate is lower and is decreasing in Barnet at a slightly higher rate compared to London, England and Wales. The inequality gap is narrower in 2009.

Figure 38: Age-standardised death rate from CHD all ages, all persons, Barnet, London and England and Wales*

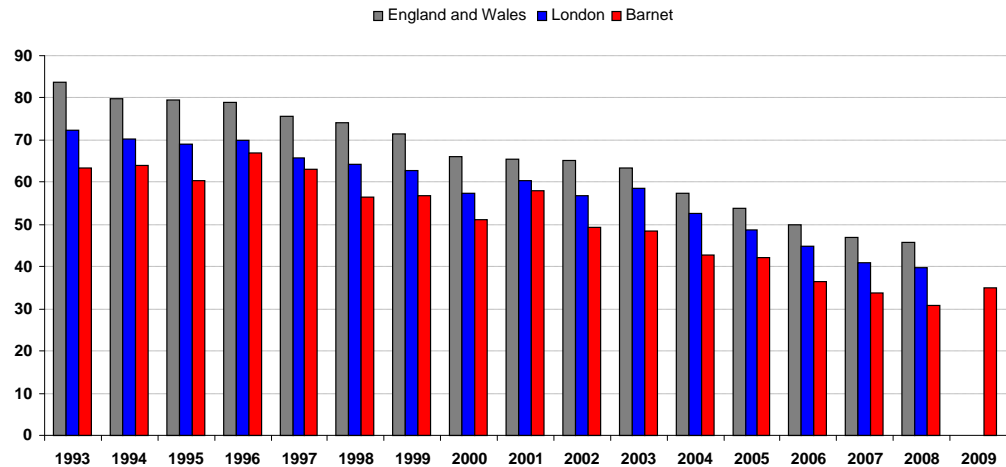


Source: Office for National Statistics

*2009 comparative figures for London and England and Wales are not yet available

Figure 39 shows comparative rates and trends in deaths from stroke in England and Wales, London and Barnet. Like heart attack, the rates have been decreasing in Barnet although the latest available figure shows the rate has increased slightly in 2009.

Figure 39: Age-standardised death rate from stroke, all ages, all persons, Barnet, London and England and Wales*



Source: Office for National Statistics

*2009 comparative figures for London and England are not yet available

The modelled CHD prevalence for Barnet in 2010 is 4.6% for all adults compared to England 5.7%. The prevalence of CHD is greater in those 75 years and above (20.2%). The modelled prevalence for stroke is 2.1% in Barnet compared to England which is 2.5%.

Table 19 compares the modelled CHD prevalence and stroke prevalence (expected) to that recorded in General practice (observed). This gives an indication of the number of cases that have not been

diagnosed. For both stroke and CHD, the data suggests approximately twenty per cent of cases are undiagnosed

Table 19: Comparison of reported cases of CHD and stroke compared to that expected in Barnet in 2010

	Number of cases Expected (a)	Expected Prevalence (b)	Number of cases Observed (c)	Observed Prevalence (d)	Observed compared to expected (e=c/a)%
CHD	12,605	4.6%	10,352	2.8%	82.1%
Stroke	5567	2.1%	4,689	1.3%	84.2%

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

The 'obesity epidemic' and the projected change in Barnet's population (see section 2.1 concerning Barnet's impending 'middle age spread') mean that we can expect more people to be at risk of CVD than before.

Estimated projections suggest 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 take active steps to 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 (figure 39) may signify the start of this reversal but it is too early to say.

Table 20: 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

Hospital stroke admission rates in Barnet are significantly lower than the national average, and this is coupled with a significantly lower number of early and overall deaths from stroke compared to the national average. However, it is likely that these low rates are related to low levels of stroke risk factors in Barnet, such as hypertension, atrial fibrillation, smoking, binge drinking and obesity, rather than exceptional levels of treatment and care. A Care Quality Commission review of stroke services in Barnet in 2010 found that Barnet had a mixed performance in dealing with stroke, with room for improvement in a number of aspects of care. In particular, Barnet performs poorly in terms of GPs recording cholesterol and blood pressure, and those that survive stroke receive only an average standard of primary care. The review also outlined weaknesses in providing sufficient 'stroke-specific

services', such as information, training to care homes, home adaptations, and a stroke-specific helpline and named worker.

Low hospital admission and death rates for stroke in Barnet also disguise great disparity in these rates between different parts of the borough. Admission rates in the North cluster are nearly twice the rate found in the West cluster; death rates follow a similar, if less pronounced, pattern.

Table 14: Hospital admissions and death rates for stroke by GP cluster in Barnet

	North cluster	South cluster	West cluster
Hospital admissions because of strokes, per 100,000 people, 2009/10	171	112	89
Directly standardised mortality rate for stroke or CHD, per 100,000 people, 2005-07	104	99	77

Source: PUMA 2009/10 and ONS 2005/07 data

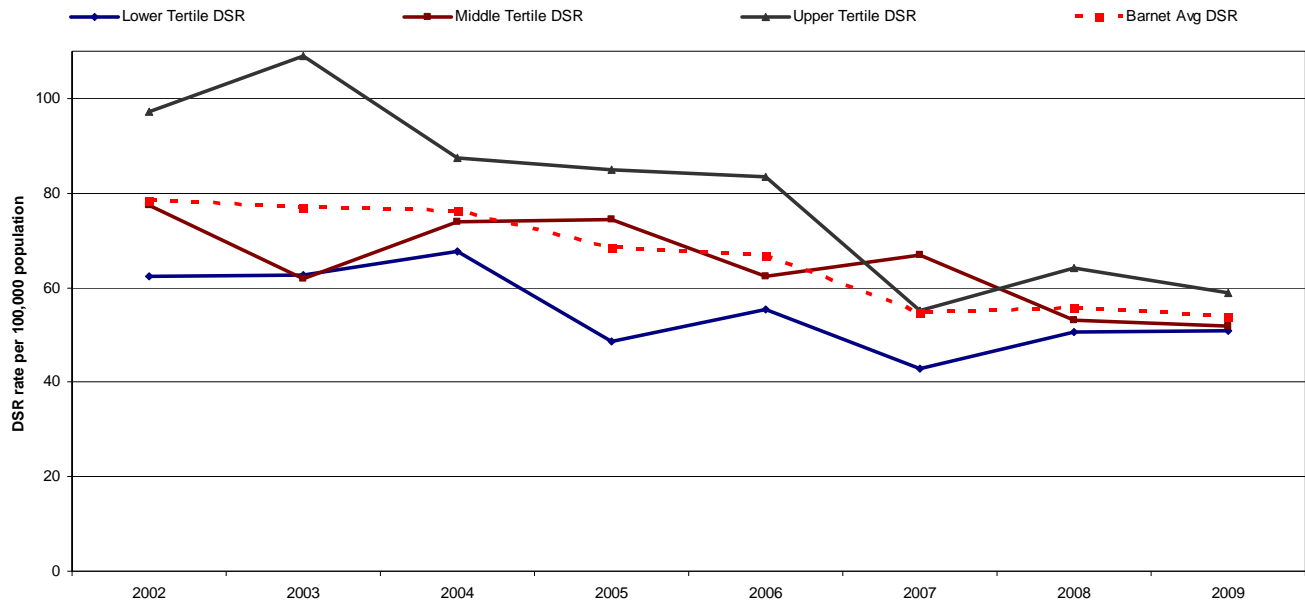
The relationship between diversity and deprivation and CVD

The impact of deprivation on health is shown most starkly in terms of deaths from coronary heart disease, which, together with stroke, is the most common cause of death. Everyone will die of something, so we tend to look at 'premature' deaths and this is defined as death occurring under the age of 75 years (see Figure 41 below).

Figure 40 shows the trend in deaths in Barnet from coronary heart disease in recent years. This has been constructed by ranking super output areas in order of deprivation and then dividing these into three groups of lowest, middle and highest deprivation.

Figure 40 clearly shows that, in terms of coronary heart disease, people living in the most deprived parts of the borough are most likely to die prematurely.

Figure 40: Age-standardized death rates from coronary heart disease in people aged under 75 years grouped by super-output areas ranked in order of deprivation



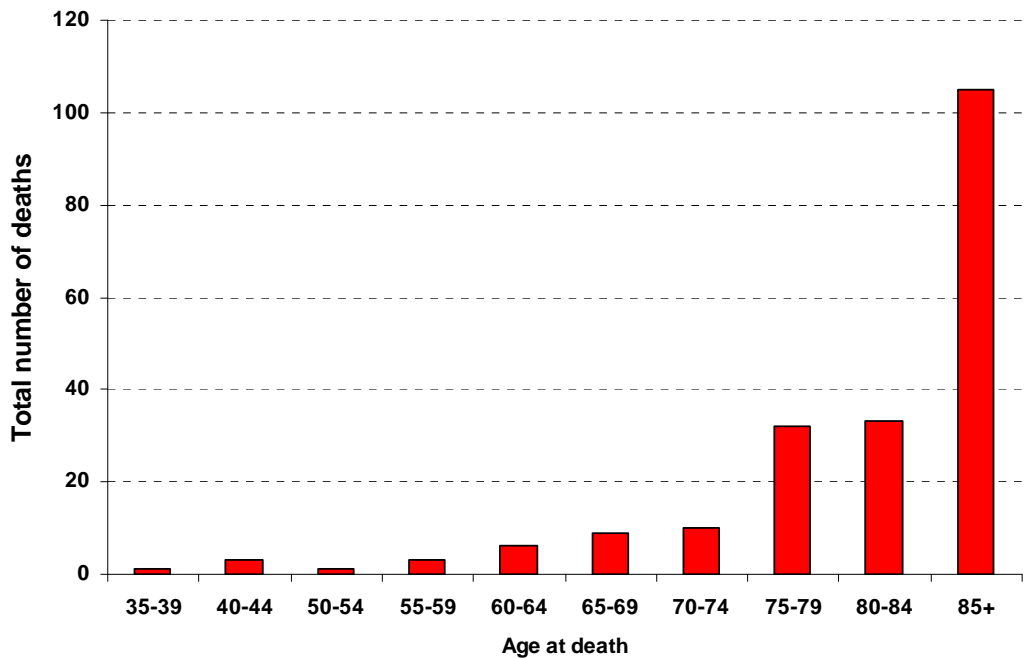
Source: Office for National Statistics, Index of multiple deprivation 2008

Asian people are at higher risk of developing diabetes and consequently have a risk of developing coronary heart disease that is about 40% higher than amongst the White population in the UK,¹²⁰[i] principally because of the damage that diabetes does to the blood vessels. People from Black, and especially African-Caribbean, ethnic groups are also at higher risk of stroke, principally because of a genetic predisposition to developing high blood pressure. However, for reasons that are not clear, Black people are between 25% and 50% less likely to have coronary heart disease than the White population in the UK

Age is also a factor in death from CVD: death from a heart attack or a stroke is more likely to occur in an older person than a younger one. This may seem obvious, but the important point is that an increasing number of people live to old age before dying of a CVD-related event, as shown in Figure 41.

¹²⁰ Department of Health. *Coronary Heart Disease National Service Framework. Chapter two: Preventing coronary heart disease in high risk patients*. Department of Health. London. 2000

Figure 41: The total number of deaths from stroke in Barnet in 2009 by age group



Source: Office for National Statistics Annual District Mortality Data

‘Finding the 5000’

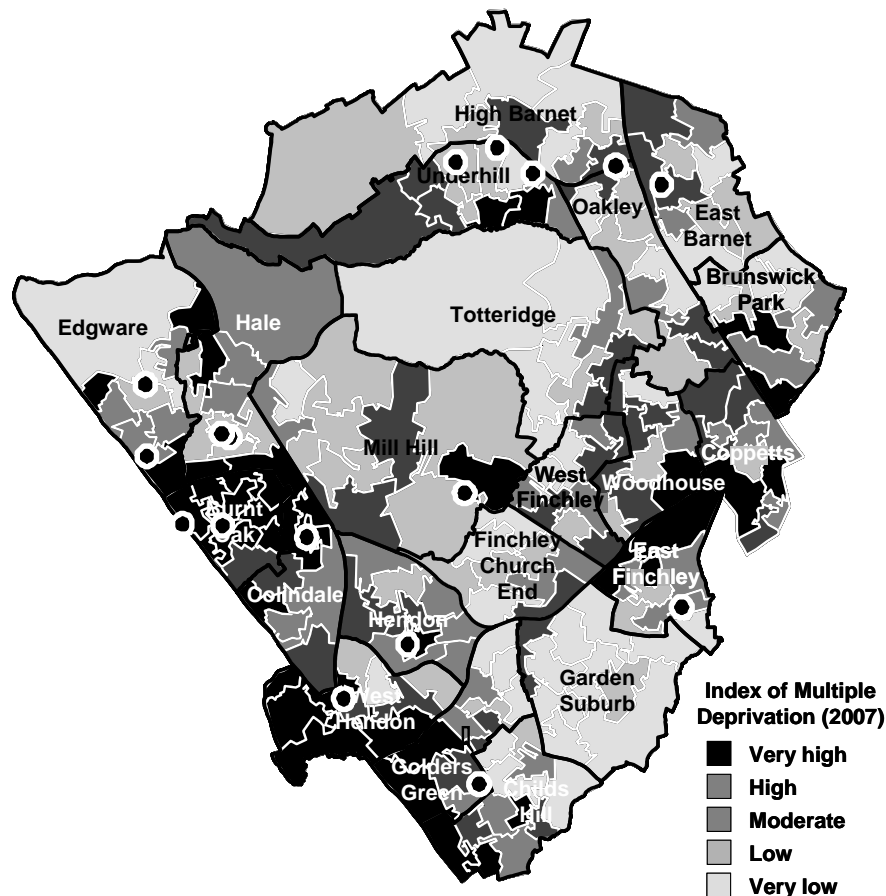
Mortality data for Coronary Vascular Disease (CVD) indicates that death rates, for those under 75 years, are higher in people who live in social housing. It was found that 87% of such households were registered with a GP close to a high deprivation area and that 21 GP practices have between 10 - 48%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

Quality and Outcomes Framework (QoF) data in these GP practices show that most are providing good quality care for all those patients with an established disease that increases the risk of heart attack or stroke. It is thus most likely that higher CHD death rates amongst those living in more deprived areas reflect higher levels of unrecognised and/or unmanaged CHD and stroke risk factors.

Modelling data suggests that there are many more people in these practices who are smokers and/or who are obese than is currently recognised. Put another way, in these practices there is likely to be a large number of people with unidentified and thus currently unmodified risk factors for CHD and stroke, such as smoking, hyperlipidaemia, pre-diabetes, diabetes and hypertension.

Using this data, we have developed 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

Image 6: The location of GP practices with the highest proportion of registered patients living in social housing in relation to deprivation levels



21,821 (20 %) of those registered in the surgeries were eligible for screening over a period of five years. From the initial modelling work, screening of this eligible population would enable us to identify and manage at least 5,000 people at risk of developing CVD over a five year period.

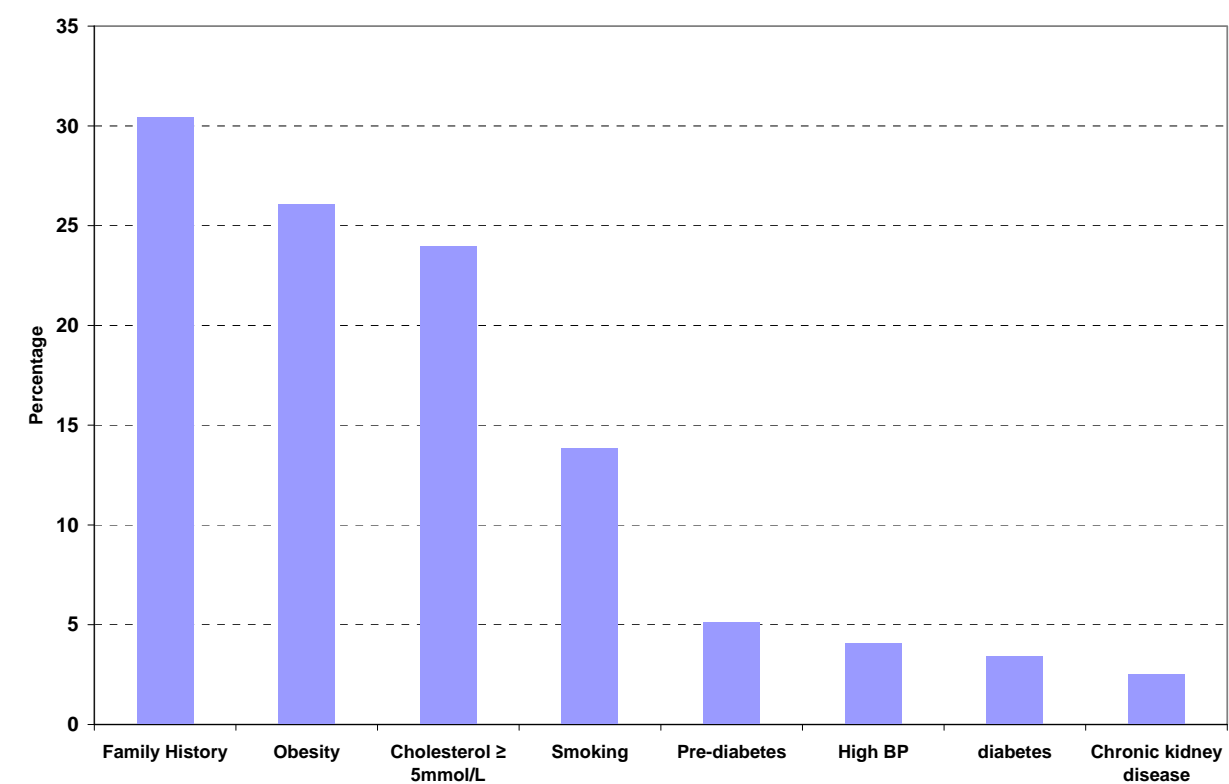
Eighteen practices eventually participated in the programme and more than twice the number of patients expected to attend in the first year, attended for screening (2,939) and 2,511 completed the screening.

One of the aims was to identify people early on with CVD risk factors - , most of those screened were between 45 and 50 years of age and were mostly females. The results showed that 76% of those who completed the screening had at least one cardiovascular disease risk factor including a positive history in first degree relatives and 71% had at least one modifiable risk factor. About a third of the patients expected to be identified over the 5 year period with CVD risk factors were picked up in the first year.

The other identified risk factors were smoking in 14%, obesity (BMI >30Kg/M2) in 26%, high cholesterol (>5Mmol/L) in 53%, fasting blood sugar above 7mmol/L in 3.4% (with 30 (1.2%) confirmed to be diabetic), high blood pressure (Systolic >140mmHg and or diastolic >90mmHg) in 4% and Chronic kidney disease (eGFR <60ml/min/1.73M2).

The screening programme also provided an opportunity to identify other non CVD conditions like liver cirrhosis in one patient. More of these non CVD conditions might have been identified but not reported.

Figure 43: CVD risk factors identified as a proportion of those that completed the screening¹²¹



Source: Finding the five thousand report, Barnet BCT

All those identified with the modifiable risk factors received advice such as healthy eating, exercise, less alcohol and other lifestyle changes. Most smokers were supported to quit in their own surgeries with 10% referred to the stop smoking community based clinics. Specific treatments were given to those found to have significant levels of cholesterol, confirmed diabetes and hypertension.

To explore ways of working with and involving others organisations and community based services, a ‘nested pilot study’ on the participation of community pharmacies and use of call centre was carried out from March to June 2010 with very positive outcomes. An additional 513 Patients were screened. Findings were similar to the GP based screening and made us better informed on how to work with the community pharmacies which we hope to explore in the future.

121

Recommendations

- Establish ways for GP practices and acute and community sector providers to identify people with obesity and to refer them to specific services to enable them to lose weight which need to be of two types:
 - For people with 'simple' obesity and no other established medical problems
 - For people with obesity and co-morbidity, e.g. conditions such as high blood pressure, raised blood cholesterol, diabetes, as helping these people to lose weight requires careful monitoring of the treatment they have for their other conditions
- Work with employers to make it easier for their staff to (i) be healthier at work and (ii) identify any established health risks such as smoking, obesity, high blood pressure and for these risks to be properly dealt with
- Work with schools to increase opportunities for healthy eating and taking exercise and to increase understanding amongst younger people of the importance of healthier lifestyles
- Work with local food businesses to promote healthier catering and alternative menu specifications
- The transfer of social care allocations from NHS Barnet to the council through additional funding available to all PCT's from 2010/11 to 2012/2013 will present an opportunity to increase the connection between health and social care services, to improve outcomes and deliver efficiencies. Work streams will focus on older people in particular, and a major work stream will be to improve the stroke care pathway and address weaknesses highlighted in the CQC review.

Diabetes

Overview

Diabetes is a chronic and progressive disease in which the amount of glucose in the blood is too high. It affects both children and adults and there are two main types. Type 1 diabetes develops if the body is unable to produce any insulin, affects about one per cent of the population and requires lifelong treatment while Type 2 develops mainly in people older than 40, is non-insulin dependent and occurs when the body does not respond properly to insulin and therefore cannot keep blood sugar levels within a normal range (<100mg/dl for FPG and <140mg/dl for GOTT).

If diabetes is untreated or poorly controlled, the build-up of glucose in the blood over time impacts on many organs of the body, including the heart, kidneys, neurological system and eyes. This results in serious complications such as increased risk of heart attack, kidney failure, blindness, inadequate blood supply to the extremities (especially the feet) can lead to ulceration and gangrene, and inadequate blood supply to nerves, especially in the extremities, leading to loss of touch and pain sensation. Diabetic retinopathy is a complication of diabetes and the leading cause of blindness in people of working age in the United Kingdom. It is estimated that there were about 3.35 million people living with diabetes in England in 2010 and this is anticipated to increase to over 3.4 million by 2015.¹²²

Prevalence of diabetes

In October 2010, the Association of Public Health Observatories (APHO) diabetes prevalence model estimated the prevalence of diabetes in people aged 16 years or older that have diabetes (diagnosed and undiagnosed). These estimates were adjusted for age, sex, ethnic group and deprivation¹²³. The forecast of the prevalence of diabetes is that it continues to rise and also remains highest in Barnet compared to London and England. As with all estimates there is a degree of uncertainty around the data however, the lower and upper uncertainty limits define the range of values in which it is plausible that the true prevalence of diabetes in Barnet for 2010 lies.

Forecast prevalence (%) of diabetes in England, London & Barnet 2010-25

Year	England %	London %	Barnet %
2010	7.40	7.50	8.1 (5.3-12.9)
2015	8	8.1	8.8 (5.7-14.1)
2020	8.5	8.7	9.6 (6.1-15.4)
2025	9.0	9.3	10.3 (6.4-16.7)

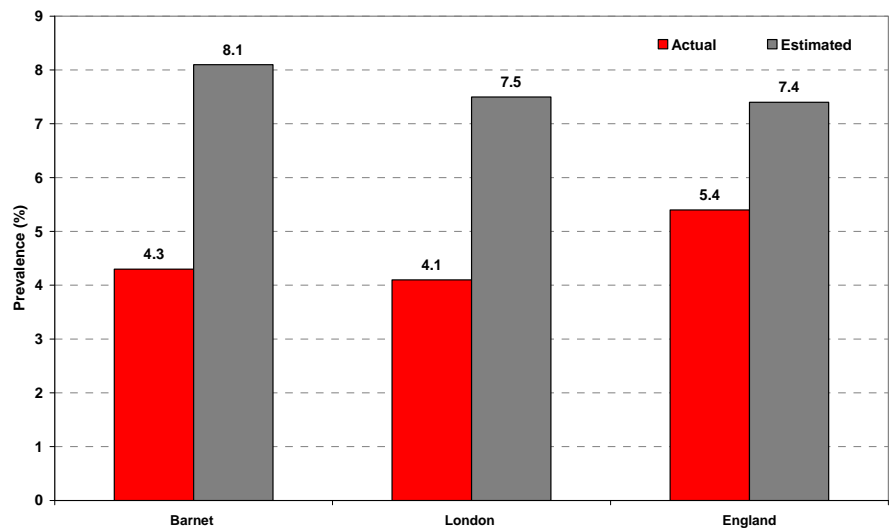
¹²² <http://www.yhpho.org.uk/default.aspx?RID=81090>

¹²³ Yorkshire and Humber Public Health Observatory APHO Diabetes Prevalence Model (1st Oct. 2010)

Source: APHO diabetes prevalence model

National GP registers showed that the actual prevalence of diabetes in people aged 17 and over in 2009-10 was highest in England (5.4%) and lowest in London (4.1%) – much lower than the forecasts made by the APHO. The prevalence in Barnet was 4.3% in people over 17 years and in addition there were about 200 others living with diabetes 16 years and under.

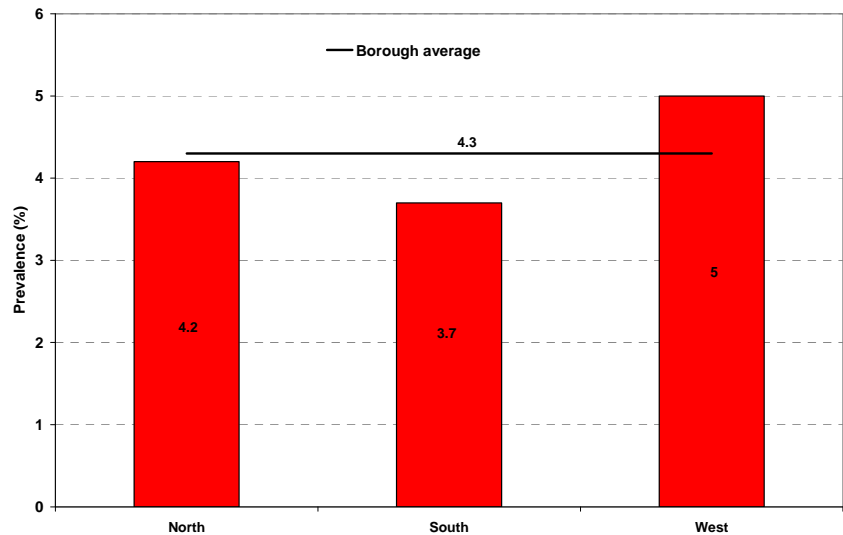
Estimated & actual prevalence (%) of diabetes in England, London & Barnet 2009-10



Sources: APHO diabetes prevalence model & NHS Information centre

The borough prevalence of diabetes determined from the GP registered population is 4.3%. However, prevalence was highest in the West cluster (5%) and lowest in the South (3.7%). It should be noted that this may not be a true picture of the disease pattern as a number of cases may remain undiagnosed.

Prevalence (%) of diabetes by clusters in Barnet based on GP registers 2009-10



The risks we face

Barnet GPs have identified that there are over 15,000 individuals (4.3% of the registered population) living with diabetes. 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 YHPHO estimates).

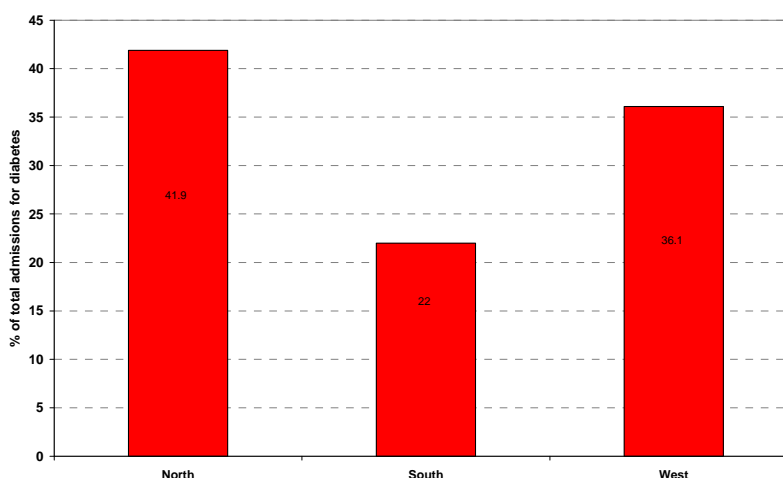
Social deprivation and ethnicity are major risk factors for developing Type 2 diabetes. Incidence and prevalence of diabetes is higher in areas of greater deprivation, as are mortality rates and as a result, there is considerable variation in the prevalence and burden of diabetes. A report by Diabetes UK to the All Parliamentary Group for Diabetes in 2006 stated that the highest observed prevalence is in Asians (20%) and Black Africans and African Caribbeans (17%) compared to an overall prevalence in the general population of three per cent. 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; as these groups are also susceptible to the cardiovascular and renal complications of diabetes.¹²⁴

Barnet has the 20th (13.88%) highest number of **excess deaths attributable to diabetes in 20-79 year olds** when compared to all 152 PCTs in England, with Newham being the highest (17.08%) and Oxfordshire lowest (9.25%). Although it is known that people with diabetes have higher mortality rates than those without the disease, when diabetes or diabetes related complications are a contributory factor to death they are not necessarily recorded on the death certificate. Clinical coding practice means that only a minority of deaths among people with diabetes from causes that can be associated with the disease have diabetes identified as the primary cause of death. As a result it is not possible to get an accurate picture of the number of deaths attributable to diabetes from routine data sources.

The proportion of **total admissions for diabetes and its complications** is lowest in the south which is to be expected (if clinical management is similar across all clusters) due to the fact that prevalence is lowest in the cluster. However, the highest proportion of admissions is in the North cluster and not the West where prevalence is highest.

¹²⁴ Diabetes UK – full reference required

Proportion (%) of total admissions for diabetes and its complications by registered cluster populations, 2009-10¹²⁵



Source: QOF data

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 per cent of those at risk.¹²⁶ A report entitled 'The Cost of Blindness' calculated that lifetime costs of dealing with retinopathy can be up to £237,000 per person.¹²⁷ For every case of diabetic retinopathy avoided the Government could be making a potential savings of £237,000.

The increase in risk for diabetes with each kilogram weight gain has been estimated to be between 4.5-9%.¹²⁸ Thus, a major risk factor for Type 2 diabetes is **obesity**:¹²⁹ 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.¹³⁰ Unless we can curb the year-on-year rise in obesity in Barnet 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.

A condition called '**pre-diabetes**' (which is also referred to as 'impaired glucose tolerance' and 'impaired fasting glucose' is an asymptomatic condition characterised by higher than normal blood glucose levels and insulin resistance. Without intervention and appropriate treatment, people with pre-diabetes are at risk of developing Type 2 diabetes within ten years.¹³¹ The risk factors for pre-diabetes

¹²⁵ This chart must be interpreted with caution as diagnosis and reason for admission of patients may be related to diabetes but that may not be noted as the primary or secondary reason the patient has presented to the hospital

¹²⁶ http://www.diabetes.org.uk/About_us/Our_Views/Position_statements/Retinal_screening/

¹²⁷ <http://www.healthyeeyes.org.uk/index.php?id=35#714>

¹²⁸ Kumar S. Introduction: What are the main drivers of the increase in numbers in adults? National Library for Health. March 2007

¹²⁹ Hartemink et al., *Combining risk estimates from observational studies with different exposure cutpoints: A meta-analysis on body mass index and diabetes Type 2*. American Journal of Epidemiology 2006;163(11): 1042-1052

¹³⁰ National Audit Office, *Tackling obesity in England*. National Audit Office. London, 2001

¹³¹ Prediabetes, *Prevention and treatment for your diabetes* (Accessed 8 August 2006)

<http://www.dlife.com/dlife.com/dLife/do/ShowContent/prediabetes/treatment.html>

are similar to those for Type 2 diabetes and there is evidence that by identifying and treating pre-diabetes with lifestyle change and – as necessary – drugs, Type 2 diabetes can be prevented or delayed and the risk of complications associated with the condition, such as cardiovascular disease, can be reduced.¹³²

Recommendations

Improvement in diabetes care is clear as evidenced by the Quality and Outcomes Framework. More people are getting the tests and measurements they need and their outcomes are improving. However, there are areas that need further work such as prevention, early identification, and care for children.

- A Diabetes Prevention Strategy for Barnet should be developed
- Opportunistic screening in practices and community should be encouraged to identify people with diabetes and impaired glucose tolerance ('pre-diabetes') and also to manage this effectively
- Outreach service within the community targeting different ethnic and socioeconomic groups to raise awareness of diabetes and address lifestyle risk factors.
- Training of people with diabetes should continued and encouraged to enable people manage their own condition more effectively
- To increase uptake of diabetic retinopathy screening
- The training needs of ward nurses in the care of patients admitted with diabetes should be reviewed.

¹³² Tuomilehto J, Lindstrom J, Eriksson JG et al.: *Prevention of Type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance*. N Eng J Med, 2001; 344:1343-1350. The Diabetes Prevention Research Group: *Reduction in the incidence of Type 2 diabetes with lifestyle intervention or metformin*. N Eng J Med, 2002; 346:393-403. Buanan TA, Xiang AH, Peters RK et al: *Preservation of pancreatic (beta) cell function and prevention of Type 2 diabetes by pharmacological treatment of insulin resistance in high-risk Hispanic women*. Diabetes, 2002; 51:2796-2803.

Obesity

Overview

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.¹³³ People with a BMI of 40 or more are referred to as being 'morbidly obese'.

In Barnet, 24,988 adults aged 18 years and above are registered as obese giving a crude prevalence of 6.8% amongst the registered population.¹³⁴ Most are from Edgware and Burnt Oak areas of the West locality and the Finchley area of the North locality.

The risk we face

In 2008, almost a quarter of adults (24% of men and 25% of women aged 16 or over) in England were classified as obese (BMI 30kg/m² or over).¹³⁵ The upward trend of obesity is seen as the result of a combination of factors such as less active lifestyle and changes in eating patterns.

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. This is below (though not significantly) the national average of 11.25% of adults and close to the London average – fourteenth best in the capital. By contrast, modelled data based on the Health Survey for England 2006-08 would suggest that eating habits in Barnet 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%.¹³⁶

Being obese increases the risk of developing a number of conditions, such as diabetes, high blood pressure and high blood cholesterol that, in turn, increase the risk of life-threatening conditions such as heart disease and stroke. Obesity also increases the risk of developing some types of cancer, musculoskeletal disease, infertility and respiratory problems.¹³⁷ Regardless of age, a person with a BMI of 30 or greater has a higher risk of premature death than someone with a healthy BMI (i.e. 19-25).

The chart below illustrates the effect that unchecked obesity has on the incidence of three key conditions: diabetes, stroke and coronary heart disease. Obesity has been called 'the new epidemic'

¹³³ 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

¹³⁴ QOF prevalence data 2010

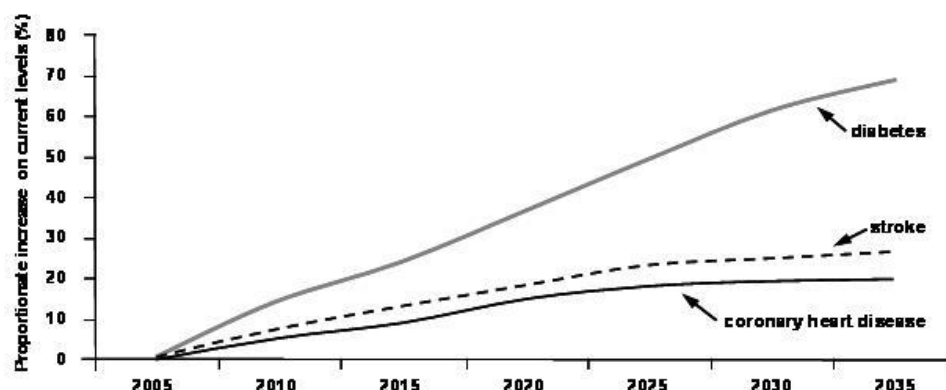
¹³⁵ http://www.ic.nhs.uk/webfiles/publications/opad10/Statistics_on_Obesity_Physical_Activity_and_Diet_England_2010.pdf

¹³⁶ Association of Public Health Observatories, <http://www.apho.org.uk/resource/view.aspx?RID=71961>

¹³⁷ National Audit Office *Tackling obesity in England*. London. 2001

and likened in its risks to health to smoking. 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.

Proportionate increase expected in diabetes, stroke and coronary heart disease due to obesity (age and sex standardized)¹³⁸



Maternal Obesity

Maternal obesity adversely impacts pregnancy outcome primarily through increased rates of hypertensive disease (chronic hypertension and pre-eclampsia), diabetes (pre-gestational and gestational), caesarean section and infections. It is associated with a higher rate of venous thromboembolic disease and respiratory complications, and may be an independent risk factor for neural tube defects, foetal mortality and preterm delivery. Maternal obesity also increases the risk of delivering a large for gestational age or macrosomic neonate, who is in turn at an increased risk of subsequent childhood obesity and its associated morbidity.¹³⁹

These complications pose particular challenges to aspects of our maternity services with increased need for appropriate facilities, resources to reduce, minimise and manage the higher frequency of complications and greater demands on midwives, obstetricians and anaesthetists who manage the complications. Of course the cost of this places an increased burden on our limited resources for maternity service.¹⁴⁰

The relationship between diversity, deprivation and obesity

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

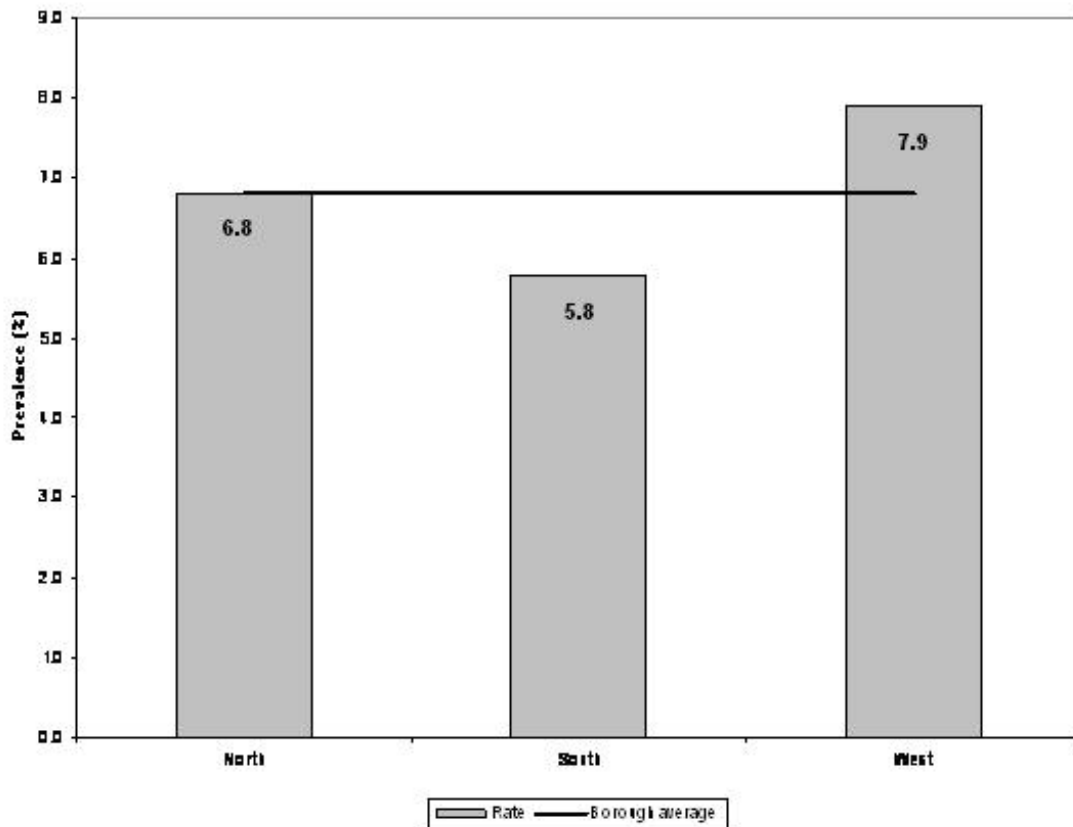
¹³⁸ http://www.foresight.gov.uk/Obesity/Obesity_final/Index.html (accessed 20 March 2008)

¹³⁹ *Journal Obstet Gynaecol Can.* Feb 2010; 32(2):165-73)

¹⁴⁰ Maternal Obesity in the UK: Findings from a national project 2010 <http://www.cemach.org.uk/getattachment/be192f8b-d942-47f0-90eb-dcff4cc6ca16/Maternal-obesity-in-the-UK--findings-from-a-nation.aspx>

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.

Figure: Prevalence of obesity, all ages in the three localities in Barnet



Source: QOF data, 2011

Recommendations

- Target groups more likely to be overweight or obese to identify and manage risk factors for cardiovascular disease
- Establish services for GPs, practice nurses, community pharmacists, hospital doctors, nurses and allied health professionals, and social care workers can signpost and/or refer people to if they are obese
- Work with local food businesses to promote healthier catering and alternative menu specifications.

Sexual health

Overview

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.

The risk we face

Sexually transmitted infections

Nationally, the latest data indicate that numbers of new cases of sexually transmitted infections (STIs) rose in 2009. The total number of new cases of STIs diagnosed in genitourinary medicine (GUM) clinics and in community-based settings screening for Chlamydia, rose by three per cent last year (470,701 to 482,696), while other STI diagnoses (such as recurrent presentations) rose by two per cent (243,423 to 249,377) over the same 12 month period.

The rise in total numbers of new STI diagnoses between 2008 and 2009 was primarily associated with increased diagnoses of genital Chlamydia (+7%, 203,773 to 217,570), gonorrhoea (+6%, 16,451 to 17,385), and genital herpes (+5%, 28,807 to 30,126). During the same period, new diagnoses of genital warts were relatively unchanged 0.3% (-1%, 91,503 to 91,257) while those of syphilis fell slightly (-1%, 3,309 to 3,273).

Over the past ten years there has been a substantial increase in diagnoses of many STIs, although diagnoses of gonorrhoea had been in decline. It is likely that increased transmission through unsafe sexual behaviour, especially among men who have sex with men (MSM), has contributed to the overall rise in STI diagnoses. However, to some extent, the rise in diagnoses of gonorrhoea and genital herpes may be associated with increasing use of more sensitive molecular diagnostic tests.¹⁴¹ Likewise, improved availability of community-based Chlamydia testing for young adults through the National Chlamydia Screening Programme (NCSP) has resulted in more Chlamydia diagnoses.¹⁴²

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. Data can also be distorted when the place of residence of a patient attending a clinic is unknown and this varies between GUM clinics, as shown below.

¹⁴¹ Ison C. GC NAATs: is the time right? *Sex Transm Infect* 2006; 82:515. HPA. Data from UK GUM clinics up to 2007 indicates continued increase in diagnoses of sexually transmitted infections. *Health Protection Report* [serial online] 2008; 2(29): HIV/STIs.

¹⁴² HPA. Major step forward in chlamydia screening in 2009/10. *Health Protection Report* Vol 4 No. 23 - 11 June 2010.

“Unassigned PCT” from Unify data, selected GUM clinics (2007)

GUM clinic	Proportion of attendances recorded as “Unknown PCT” (%)
Claire Simpson Clinic (Barnet Hospital)	30.4
The Marlborough Clinic (Royal Free Hospital)	16.8
The Archway Sexual Health Clinic	14.6
Mortimer Market Centre	11.4
Jefferiss Wing St Mary's Hospital	3.8
Northwick Park Hospital	12.4
Central Middlesex Hospital	2.1

The potentially distorting effect of clinic-based data and under-recording of PCT of residence is demonstrated in the table below, which shows the number of cases of different infections that would be expected at the Claire Simpson Clinic (Barnet's main GUM provider) based on the extrapolation of national data and the number of cases actually reported.

Diagnoses of STIs in Barnet residents, 2006

	Syphilis	Gonorrhoea	Genital Herpes	Genital warts	Chlamydia
Number expected annually: Unify data	25	136	166	343	476
Number of diagnoses reported	0 ¹⁴³	43	128	218	222

Source: Claire Simpson Clinic and Health Protection Agency

It is also important to note that data from different GUM clinics may not be equally accurate, complete or representative of attendance by Barnet residents. Also, it is assumed that the rates of STIs in Barnet residents visiting a GUM clinic are equal to those attending who live in other boroughs. However, people from inner city boroughs may be more likely to have a STI or, conversely, people from Barnet attending inner city GUM clinics may be more likely than local residents to have a STI; there is no

¹⁴³ The Claire Simpson Clinic believes that this number should be 6-9, i.e. that reported incidence is erroneous

obvious method for correcting for this limitation. Therefore, GUM clinic data can only provide an approximation of the numbers of STIs in Barnet residents.

That said, whilst local GUM clinic data are a poor indication of the local incidence and prevalence of STI, they do give a reasonable idea of trends and these continue to rise in Barnet, as elsewhere.

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, compared to the London rate of 5.0 per 1,000. More than half of all Middle Super Output Areas (MSOAs) in Barnet have HIV prevalence rates higher than the UK average of 1.3 per 1,000. The highest rates are found in the southern tip and towards the western part of the borough.

The number of people in Barnet known to have HIV infection has increased by 25% since 2005. This growth is slower than the national rate of 45% increase over the same period, but slightly above the national change in recent years. The largest proportion of patients who were resident in Barnet were infected through heterosexual sex (n= 382, 63%). Infection via sex between men (SBM) accounted for the next largest group (n= 169, 28%) of residents receiving HIV care.¹⁴⁴

HIV positive people in Barnet

	Males	Females	Total
2005	276	225	501
2006	279	234	513
2007	316	232	548
2008	345	259	604
2009	367	273	640

Residents most commonly seeking HIV-related care are aged 35-44, although there were also 18 children under 15 years old with HIV in 2009. The greatest numbers of patients accessing care were Black Africans (n=286, 47%) and White (n =210, 35%).

¹⁴⁴ HPA HIV in North Central London – PCT Profiles

The ethnic groups of Barnet residents with HIV infection

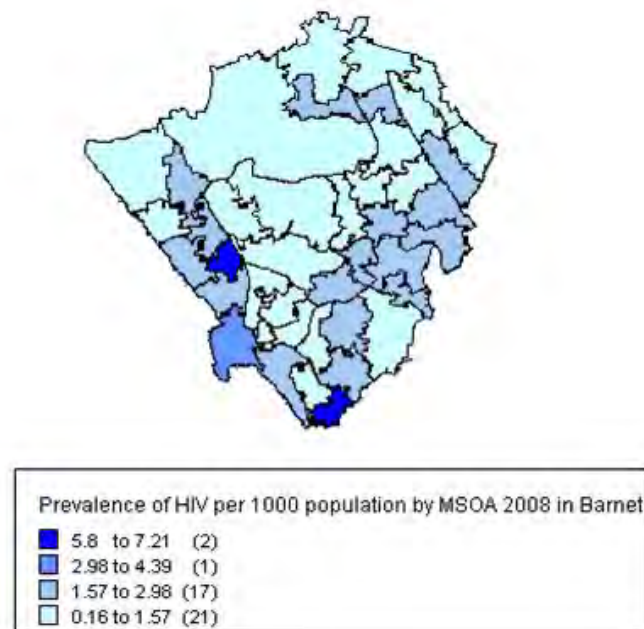
	White	Black African / Caribbean	Indian / Pakistan / Bangladesh	Other	Not known	Total
2005	153	276	6	61	5	501
2006	167	277	6	57	6	513
2007	193	280	7	62	6	548
2008	210	303	9	72	10	604
2009	218	322	11	77	12	640

The age distribution of Barnet residents with HIV infection

Age band (years)	0-15	16-24	25-34	35-44	45-54	55+
Number of people with HIV	15	20	97	264	174	70

However, unlike most of the other PCTs in the north central part of London, especially the inner-city ones, HIV infection is becoming increasingly common in Black women in Barnet rather than in the Black MSM group. It is possible that the male partners of many of these women contract the infection abroad. But the important point is that it is heterosexual transmission of HIV that is becoming a larger issue than in MSM in Barnet.

Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA in Barnet, 2008



Source HPA HIV in North Central London – PCT Profiles

The relationship between diversity, deprivation and sexual health

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.¹⁴⁵

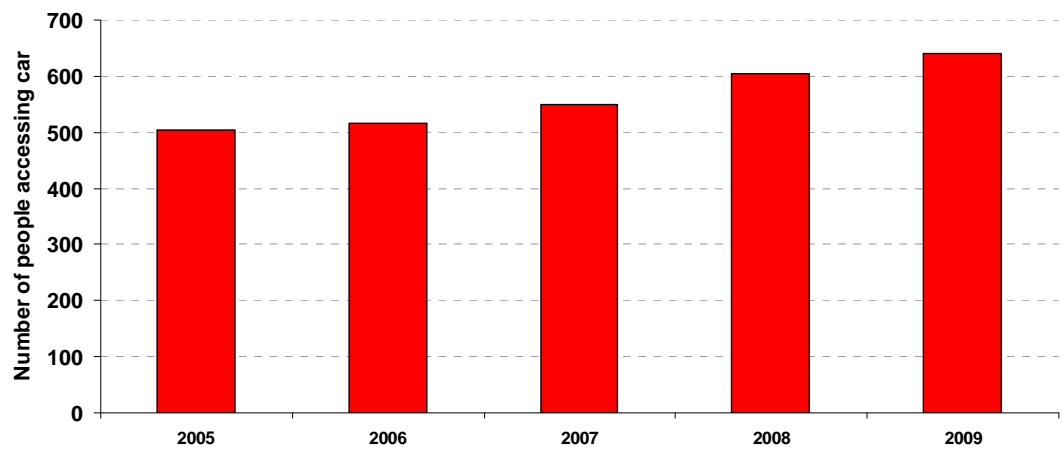
Ethnicity is relevant to the planning of sexual health services in several ways. First, certain communities are more likely to experience a high incidence of specific STIs, for example HIV is much more common in the Black African community, and the majority of women with HIV in Barnet are from this community. Secondly, services may need to be modified so that that can be made religiously and/or culturally acceptable to certain communities, for example sex and relationships education (SRE) programmes for

¹⁴⁵ Downing J, Jones L, Cook PA et al (2006) Prevention of sexually transmitted infections (STIs): a review of reviews into the effectiveness of non-clinical interventions. Evidence Briefing Update. London: National Institute for Health and Clinical Evidence.

young people from certain orthodox Jewish and Islamic communities. Thirdly, cultural values and ethnicity may affect health beliefs and behaviours and health-seeking activities and can be important influences on health and wellbeing. There is limited evidence on this issue, but for instance there is some indication that men from the Black African community are less likely to attend GUM clinics.¹⁴⁶

An increasing number of women are becoming infected with HIV in Barnet, although the numbers involved remain relatively small. Whilst there is a year-on-year increase in the number of HIV-infected people accessing services, the proportion of men doing so is increasing faster than that of women.

The number of HIV-infected Barnet residents accessing care

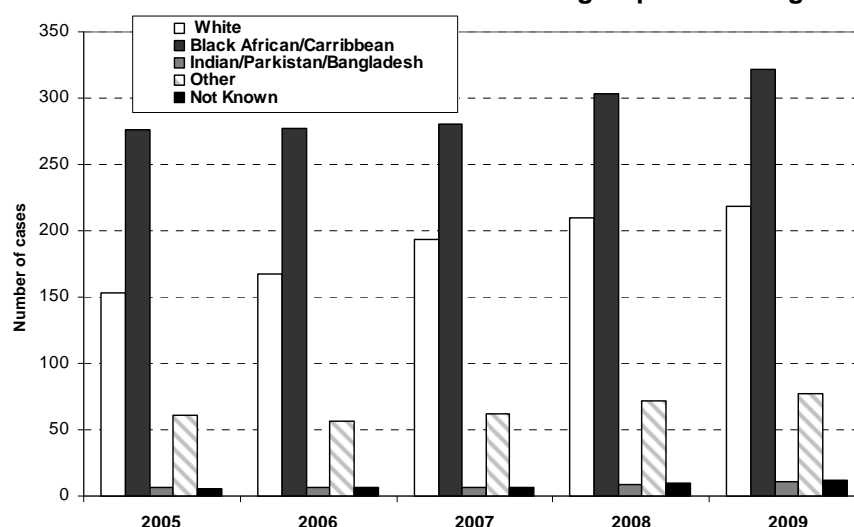


Source: Health Protection Agency

The chart below shows the number of HIV-infected people accessing services by ethnic group. A small part of the year-on-year increase shown here may be attributed to a reduction in the number of people for whom their ethnic group is unknown. However, there is a clear picture: the groups most affected by HIV/AIDS in Barnet are the Black and African Caribbean and the White, and the numbers of people infected is increasing.

¹⁴⁶ National Survey of Sexual Attitudes and Lifestyles II, National Centre for Social Research. Sadler KE, McGarrigle CA, Elam G et al (2007) Sexual behaviour and HIV infection in black-Africans in England: results from the Mayisha II survey of sexual attitudes and lifestyles. Sexually Transmitted Infections 2007; 83:523-529. Fenton KA et al. Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey. The Lancet 365: 1246 - 1255, 2005.

The number of HIV-infected Barnet residents in different ethnic groups accessing care



Source: Health Protection Agency

Understanding Barnet's changing ethnicity is also important in terms of designing services. There is evidence that many people from the African community are uncomfortable visiting GUM clinics, and that in this community a different approach is needed. Since in general, sexually active women of all communities are more likely to attend health services, increasing testing in these settings is an important method for increasing uptake of HIV screening in women, for example in antenatal or family planning clinics. For men, however, a more community-orientated approach is most likely to achieve results.

In terms of age and general sexual health services, the greatest numbers of people seen in the main GUM clinics serving Barnet's population are aged 15-35 years (77% of attendees) and 60% of attendees are women.

Recommendations

- Continue to maintain and increase the provision of local enhanced sexual health services in GP practices and pharmacists
- Implement the five standards set out in the *London sexual health strategic framework* (2009) in Croydon.¹⁴⁷
- Deliver targeted HIV promotion/testing through outreach and integration into core services.

¹⁴⁷ London Sexual Health Programme. *London sexual health strategic framework*. London: London Specialised Commissioning Group; 2009. Available from <http://www.londonsexualhealth.org/>

Children and young people

Overview

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.

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:

- 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.

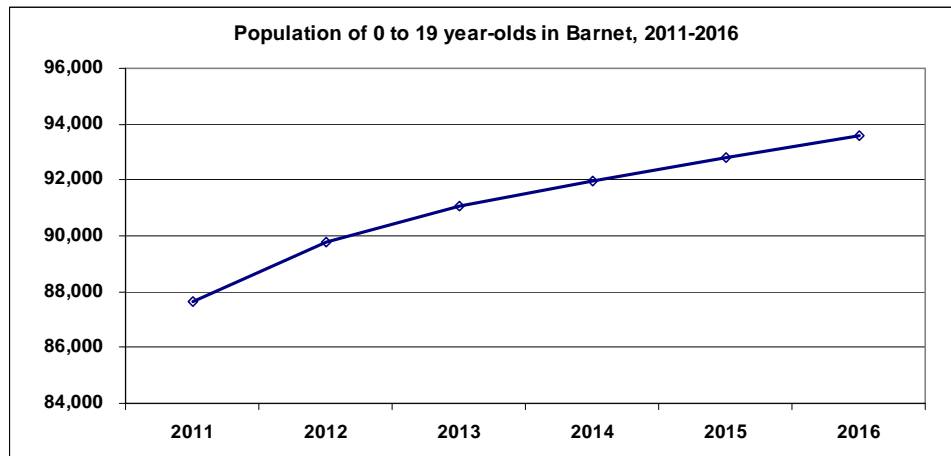
The current financial pressures provide powerful drivers for fundamental review and redesign of children's services. As part of overall reductions, services are likely to become more targeted to those children, young people and families considered to be most in need, and in communities where need is 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.

The risk we face

Barnet has the second largest population of children and young people in London (estimated in 2010 at 88,560). This group accounts for a quarter of Barnet's total population. 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.¹⁴⁸

¹⁴⁸ Barnet Hybrid Population Model, 2010

Population projections 0-19 year olds in Barnet 2011-16



Broadly speaking, the younger population is spread equally between age bands, with approximately 20,000 children in each of the four five year cohorts. However, the 0-5 year olds account for the largest proportion of young people across all the wards in Barnet. Males account for a slightly higher proportion of the younger population than females, with an estimated 45,386 males, compared to approximately 43,195 females. This is in contrast to the overall population, in which females outnumber males by approximately 10,000.

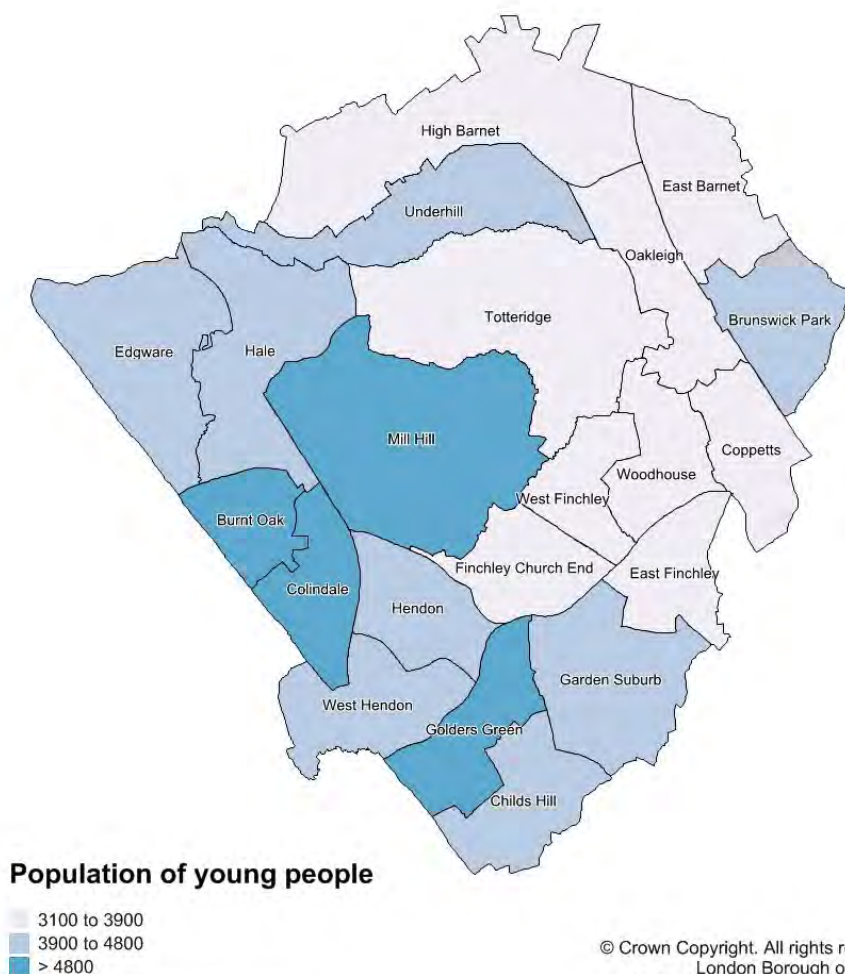
Single year of age by gender, 2011

Single year of age	2011 Population	Males	Females	
0	5,335	2,689	2,647	Under 5 = 26,449
1	5,345	2,717	2,630	
2	5,291	2,686	2,606	
3	5,315	2,736	2,581	
4	5,164	2,635	2,530	
5	4,696	2,402	2,296	Age 5 to 9 = 20,514
6	4,416	2,259	2,159	
7	4,013	2,063	1,952	
8	3,889	2,002	1,888	
9	3,500	1,804	1,697	
10	3,620	1,863	1,759	Age 10 to 14 = 20,116
11	3,982	2,043	1,941	
12	4,157	2,118	2,041	
13	4,176	2,126	2,052	
14	4,181	2,133	2,049	

15	4,069	2,097	1,975	Age 15 to 19 = 20,563
16	4,116	2,140	1,978	
17	4,198	2,157	2,043	
18	4,102	2,072	2,031	
19	4,077	2,053	2,026	
Total	87,641	44,796	42,881	

Source: Barnet Insight Unit, Hybrid Population Model

Population of Young people aged 0-19 by ward, 2011



Source: Barnet Hybrid Solution 2011

Source: Insight Unit, London Borough of Barnet

Child Poverty

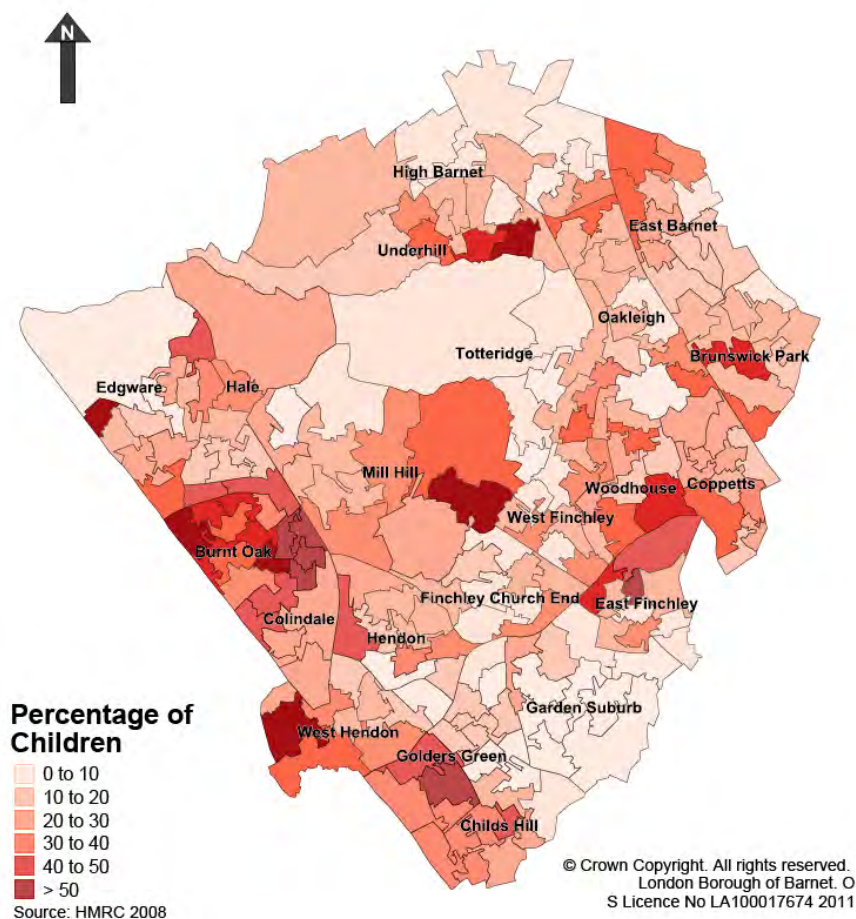
The Income Deprivation Affecting Children Index (IDACI) is a sub-set of Income Deprivation Domain of the Indices of Deprivation (ID) 2010 and combines statistics on the number of children under sixteen

who are living in households receiving a range of benefits including Income Support, Working Families Tax Credit, Disabled Person's Tax Credit and Income Based Job Seekers Allowance.

Barnet has 210 super output areas, 56 of which rank within the most deprived for Income Deprivation Affecting Children and 14 fall within the ten per cent most deprived on this indicator nationally. Those areas within the ten per cent most deprived can be found in along the A5 corridor in Burnt Oak, Colindale, West Hendon and Edgware, but are also scattered in pockets of Mill Hill, Coppetts and East Finchley.¹⁴⁹

Data on Working Families Tax Credit¹⁵⁰ can also be used for assessing the proportion of children under 16 living in poverty. This shows that in April 2010 there were 8,200 out of work families receiving Child or Working Tax Credit in Barnet. There were 15,900 children within these families. In total there were 27,300 families receiving Child or Working Tax Credit of which 2,300 had no children.¹⁵¹

Percentage of children in poverty 2008, Barnet LSOAs



¹⁴⁹ Additional analysis on deprivation in Barnet will be published by the Insight Unit shortly

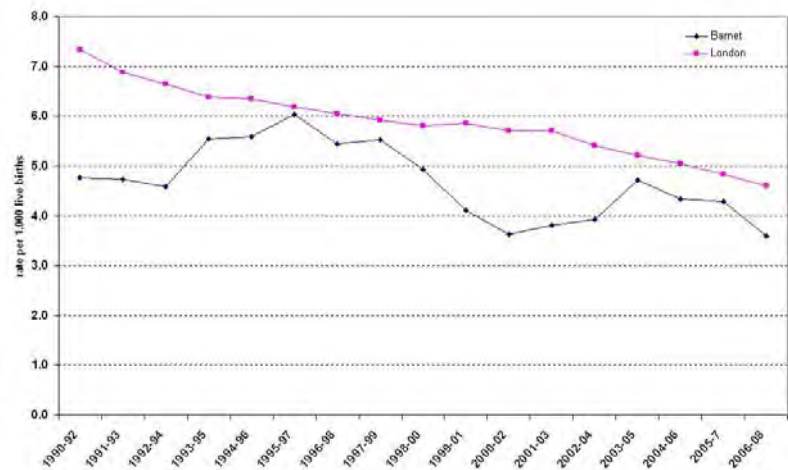
¹⁵⁰ At present this is a family income of £360 per week for family of 2 adults 2 children

¹⁵¹ HMRC Child and Working Tax Credits Statistics Geographical Analyses, April 2010

Infant mortality

Infant mortality rate is defined as number of deaths within the first year of life per 1,000 live births. It is used as a sensitive measure of the overall health of a population, providing an important measure of the wellbeing of infants, children and pregnant women. Although infant mortality in England is at an all-time low and falling, significant inequalities persist. The charts below show that the infant mortality rate in Barnet has remained constantly below that of the London average since 1990.

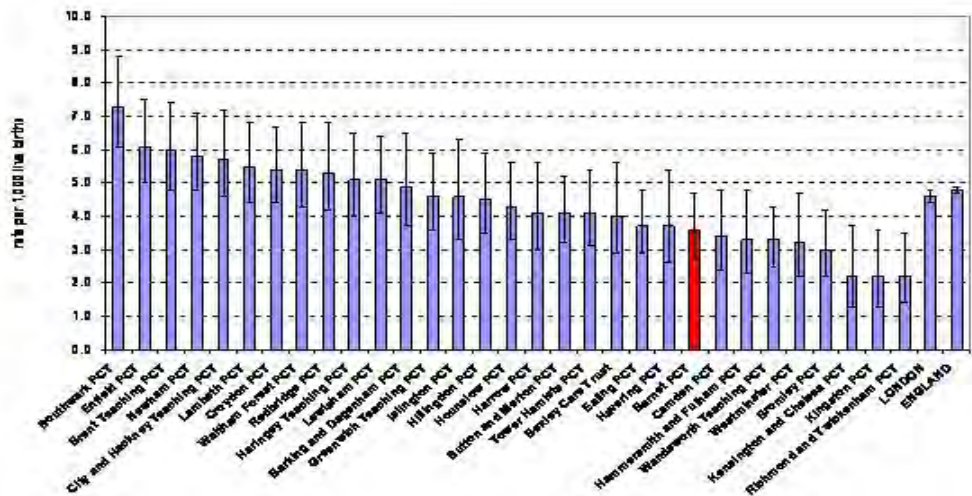
Infant Mortality, 1990-2008



Source: London Health Observatory

Between 2006 and 2008, the Infant Mortality Rate (IMR) in Barnet (3.6 per 1,000 live births) was significantly lower than the England’s average (4.8 per 1,000 live births). However when compared to the London average (4.6 per 1,000 live births) the Barnet IMR is found to be lower.

Infant mortality by boroughs, 2006-2008



Source: NCHOD

Over the last three years, infant mortality has improved in both London and England. London experienced a greater decrease in its IMR than England as a whole and fell from above the national

average to below during that time. Decrease in infant mortality can also be seen for Inner and Outer London areas. However, in every year Inner London had higher infant mortality compared with Outer London. This is consistent with Inner London having higher levels of deprivation than Outer London.

When Infant Mortality Rates are analysed at ward level, they show that some wards have relatively poor infant mortality rates even within areas with apparently better rates.¹⁵² Colindale has the highest IMR in the borough of Barnet – 9.5 (n14), and is closely followed by Woodhouse which has an IMR of 9.1 (n10).

Infant Mortality Rate by Ward 2005-09

	Total Deaths 2005-2009	Rate per 1000
Brunswick Park	1	1.1
Burnt Oak	7	4.6
Childs Hill	8	6.0
Colindale	14	9.5
Coppetts	2	1.5
East Barnet	5	4.3
East Finchley	3	2.5
Edgware	5	4.2
Finchley Church End	3	3.0
Garden Suburb	5	4.6
Golders Green	8	5.1
Hale	2	1.6
Hendon	6	3.8
High Barnet	5	5.6
Mill Hill	7	5.6
Oakleigh	4	4.4
Totteridge	5	5.4
Underhill	4	4.1
West Finchley	5	4.3
West Hendon	5	3.8
Woodhouse	10	9.1
Total	114	4.5

Source: National Centre for Health Outcomes Development and London Health Observatory

Known factors that contribute to IMR include smoking in pregnancy, maternal obesity, failure to initiate breastfeeding, teenage pregnancy and poverty. All of these can lead to or have a direct impact on the birth weight of the infant and thus the mortality and morbidity of the infant.

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. In Barnet, 7.5% of all births (2009) were babies weighing less than 2.5kg – slightly higher than the England average of 7.4%. That same year, 1.6% of babies born in Barnet were below 1.5kg.

¹⁵² GLA Intelligence Update 09-2009- May 2010, Infant Mortality 2002-2010 web:
<http://www.lho.org.uk/Download/Public/16433/1/Update%20092010%20Infant%20Mortlty%202002-08.pdf>

The Child Death Overview Panel (CDOP) in Barnet has responsibility for reviewing all deaths in children up to 18 years with priority given to unexpected and unexplained deaths. The Barnet CDOP 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.

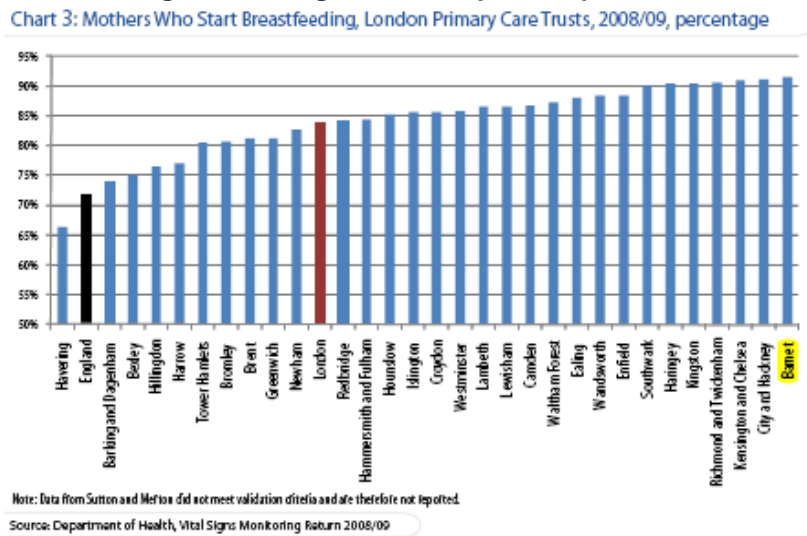
Breastfeeding

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.¹⁵³

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 6-8 weeks after birth.¹⁵⁴

Breastfeeding, especially in the first six months, is widely known as having health benefits for the child. The Barnet breastfeeding initiation rates are better than average and remain high. In 2009/10, 92.7% of women initiated breastfeeding in NHS Barnet, which was higher than the England and London average.

Breastfeeding status for Babies aged six to eight weeks, April – September 2010



Smoking in Pregnancy

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is estimated to contribute to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intrauterine growth restriction.¹⁵⁵ This therefore remains a key public health concern,

¹⁵³ Department of Health & Department for Children, Schools and Families (2009) Commissioning Local Breastfeeding Support Services

¹⁵⁴ Vital signs target VSB11_05

¹⁵⁵ Gardosi J, Beamish N, Francis A, Williams M, Sahota M, Tonks A, McGeown P and Hart M. Stillbirth and infant mortality, West Midlands 1997–2005: Trends, Factors, Inequalities. The West Midlands Perinatal Institute

particularly since early intervention (i.e. stopping smoking at three months gestation) significantly improves outcomes.¹⁵⁶

The current smoking in pregnancy rate in Barnet where status is known is 10.1 (2008/09). This is slightly higher than the London average of 7.5 and below the England average of 14.6, but remains lower than the national target of 15%. The Stop Smoking Service provides a specialist midwifery service at Barnet & Chase Farm Hospitals, Edgware Birthing Centre and the Royal Free Hospitals maternity service. The service offers pregnant smokers a full range of services following a robust care pathway that allows women to be tracked through their quit attempts. This includes Carbon Monoxide monitoring at the booking appointment and throughout the pregnancy

Children with disabilities

The national Family Resources Survey carried out by the Department for Work and Pensions estimates that around five per cent of under 16s have a disability and the Department for Children, Schools and Families (now the Department for Education) estimated around seven per cent 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. Estimates for the number of children with a disability vary depending on the definition of disability and the method of calculation.

In August 2010, 1,720 children in Barnet under the age of 18 were claiming Disability Living Allowance. This is an increase of 90 claimants from the same point two years earlier. The strongest percentage growth was for children under 5 and those aged 11 to 15. There has also been strong growth in the number of younger adults aged 18 to 24 receiving this benefit.¹⁵⁷

There are various factors which may explain the rising number of children born with disabilities, though the picture is not clear.¹⁵⁸

- Trends towards greater obesity among women and an increasing number of births to older mothers may be contributing to an increased incidence of disability in children
- Low weight births and births to teenage mothers can increase the likelihood of childhood disability, although these rates have remained fairly consistent in England and Wales, and the incidence of low weight births is slightly declining in London
- Fewer women are smoking at delivery, which could lead to a lower incidence of disability in children
- More low birth weight babies (among whom there is a higher incidence of disability) are surviving. The improved survival of low birth weight babies is leading to an increased prevalence of cerebral palsy, the commonest cause of severe physical disability in children.¹⁵⁹

The burden of chronic conditions in adolescence is increasing as larger numbers of chronically ill children survive beyond the age of ten. 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

¹⁵⁶ West R (2002) 'Smoking and pregnancy' Fetal and Maternal Medicine Review (13)3:181–194

¹⁵⁷ DLA figures for Barnet taken from DWP's Nomis website

¹⁵⁸ http://www.kcl.ac.uk/news/news_details.php?news_id=1005&year=2009 and

<http://ukpmc.ac.uk/articles/PMC27324.jsessionid=13B7A00CE146C142DB476F557AEE912E.jvm1>

¹⁵⁹ http://adc.bmj.com/content/62/4/379.abstract?ijkey=99b8e131c17edb64529698908886ed67a6c07fa4&keytype2=tf_ipsecsha

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.¹⁶⁰

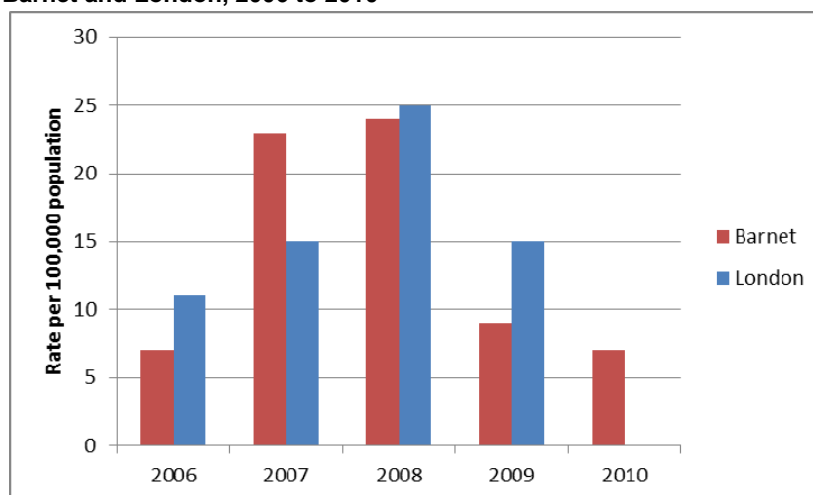
The prevalence of confirmed permanent childhood hearing impairment (>40 dB HL) in the United Kingdom has risen with age to at least 1.65/1000 live births (and may be as high as 2.05/1000 live births) among children 9 years of age and older. If the current yield from screening is sustained, then an additional 50-90% of children will remain to be detected in the postnatal years.¹⁶¹

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.¹⁶²

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.

Measles notifications, Barnet and London, 2006 to 2010



Source: North East North Central Health Protection Unit

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.

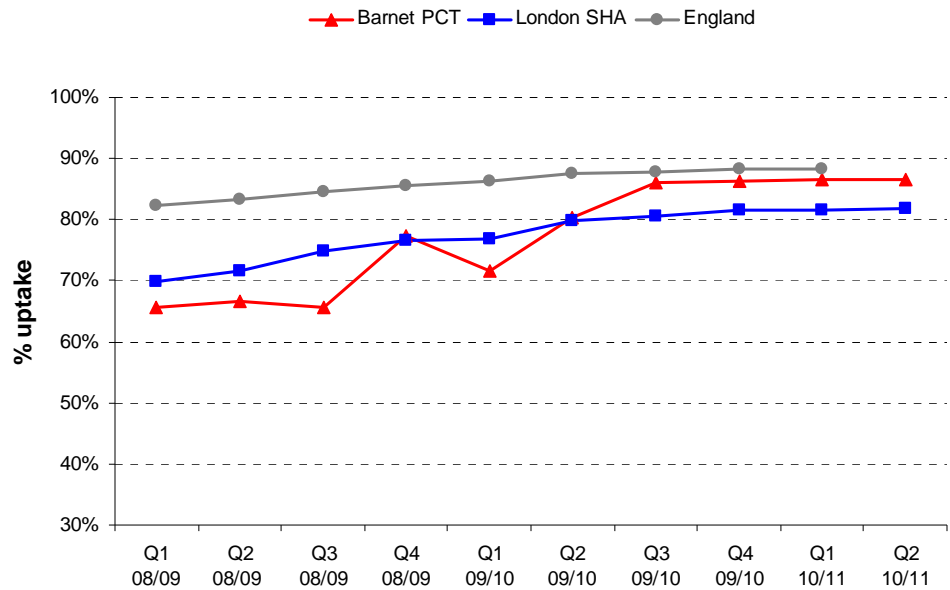
Considerable more work still needs to be done to ensure uptake rates reach a level (95%) that will prevent future measles outbreaks or a measles epidemic. In Barnet, the MMR rates have improved considerably since 2007/08, however the levels are starting to plateau and we are still at risk of an outbreak.

¹⁶⁰ <http://www.bmj.com/content/330/7493/721.extract>

¹⁶¹ <http://www.bmj.com/content/323/7312/536.full?sid=8b5cd345-ec0f-4741-89be-e3e8a3dbeba7>

¹⁶² 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.

MMR1 at 2 years old by quarter, April 2008 to December 2010

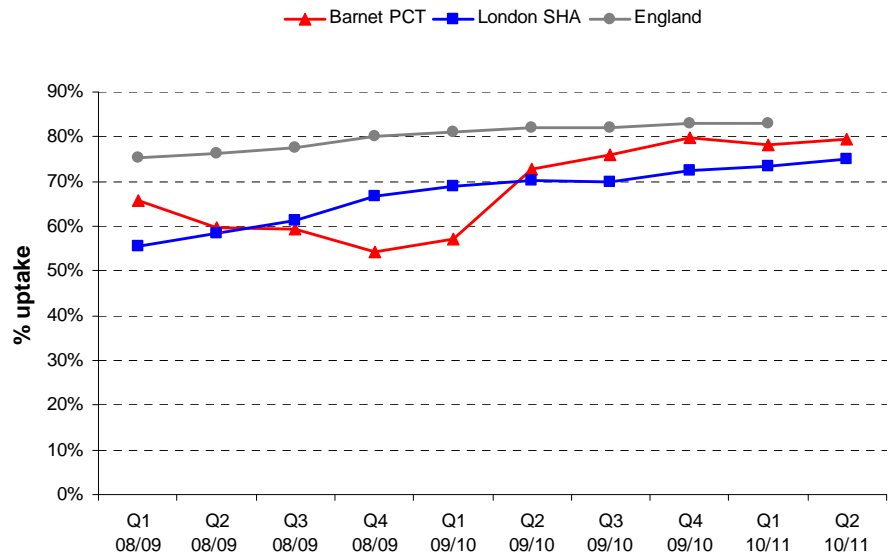


Source: North Central London SHA

MMR is given as two doses, one at 13 months (MMR1) and the other between the ages of three and five years (MMR2 or preschool dose).

The uptake of the preschool dose is lower. It is important this is received as two to five per cent of the population do not respond to measles component of the first dose and also to ensure protection against mumps. There is evidence in Barnet that some parents are opting to give their children single measles vaccines instead of MMR. This is not recommended as there is lack of evidence about the level of protection from single injections and also children will not be protected from mumps or rubella.

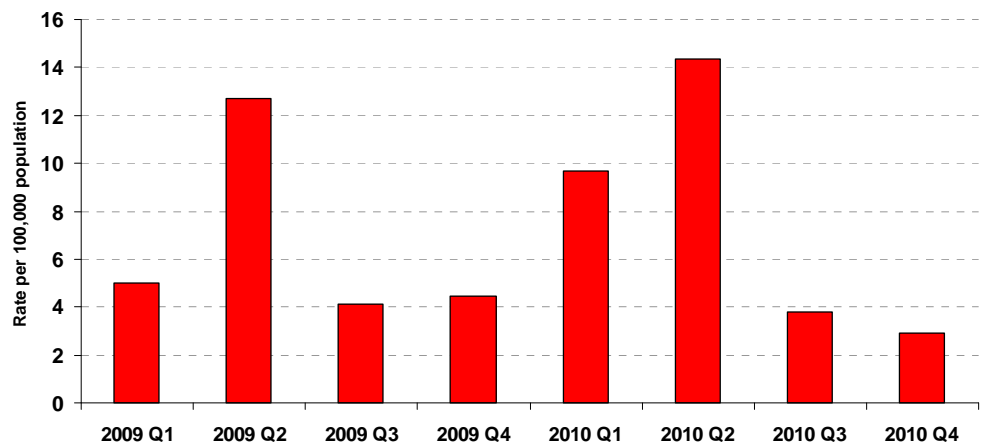
MMR1 at 5 years old by quarter, April 2008 to December 2010



Source: North Central London SHA

The chart below shows mumps cases peaking in the summer months (Q2) when you would normally expect activity to be low. This is probably as a result of the low uptake of the second dose MMR so more people are susceptible to mumps infection. Mumps is usually a mild illness but it can cause inflammation of the ovaries or testes which can affect future fertility. Outbreaks are common in academic institutions and it is important college students are aware they should be protected with two doses of MMR.

Mumps notifications in Barnet by quarter, January 2009 to December 2010

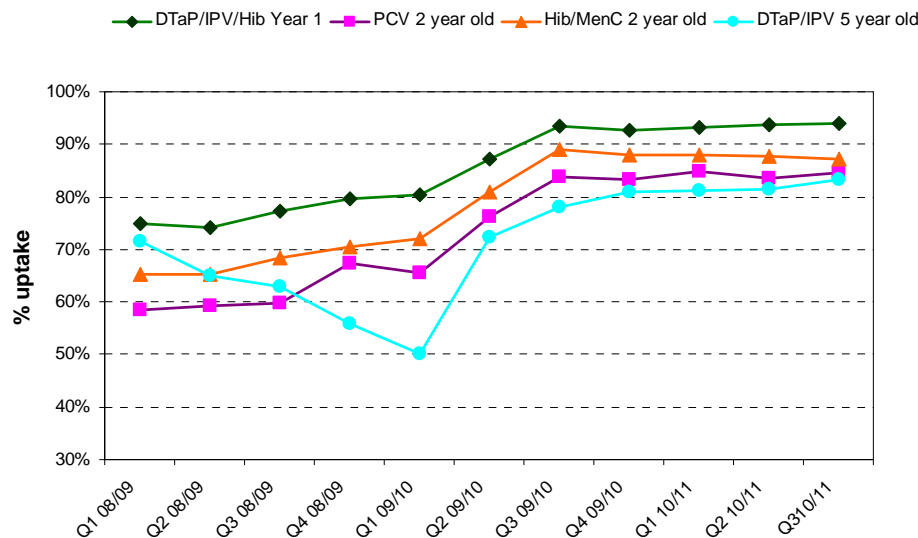


Source: North East North Central Health Protection Unit

The following chart shows the current relative achievement in immunising children in Barnet against a range of other diseases.

- first course of diphtheria, tetanus, pertussis and polio (Dtap/IPV)
- first dose of Haemophilus influenzae B (Hib)
- pneumococcal booster (PCV)
- Haemophilus influenzae and meningococcus C booster (Hib/Men C)
- Diphtheria, tetanus and pertussis and inactivated polio booster (Dtap/IPV).

Immunisation rates by children's second and fifth birthdays in Barnet April 2008 to December 2010



Source: North Central London SHA

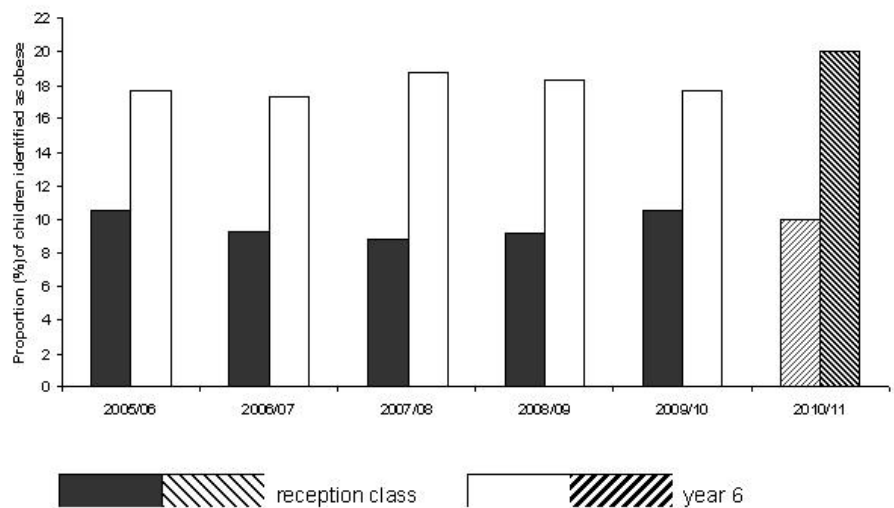
Childhood obesity

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 population-level surveillance data gathered allows analysis of trends in growth patterns and obesity (National Obesity Observatory, 2010).

Nationally, there has been a rapid increase in the prevalence of overweight and obesity. In children this is considered a primary predictor of obesity in adulthood. The health outcomes of sustained obesity are numerous and include increased incidence of Type 2 Diabetes, CHD, stroke, depression, some cancers and back pain. Obesity throughout adulthood decreases life expectancy by up to nine years.

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).

Obesity levels in Barnet Reception and Year 6 classes from 2006 to 2010 with 2010-11 trajectory

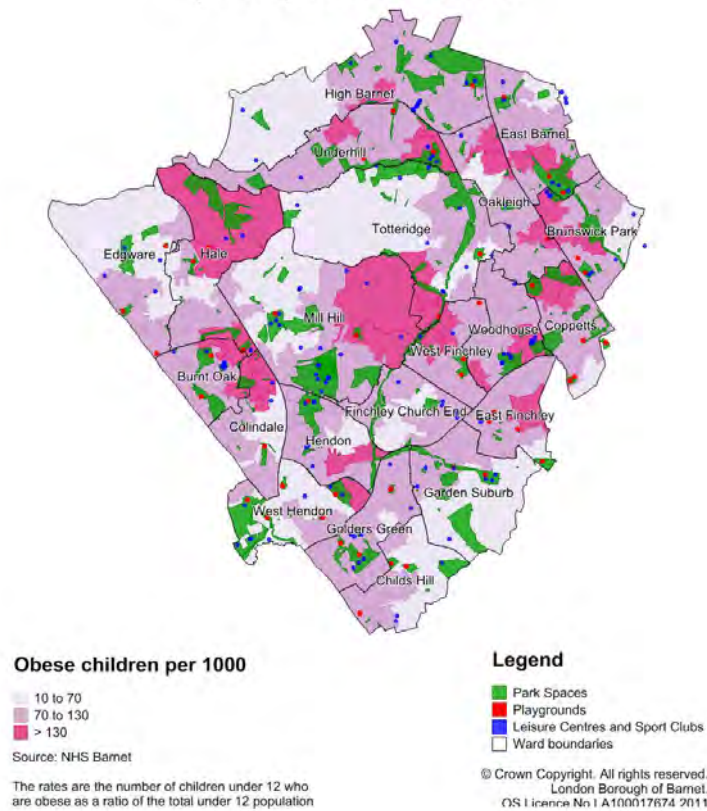


Childhood overweight and obesity is a special problem. It is difficult for an adult to lose weight, as shown by the plethora of diet books and services available commercially. Childhood overweight and obesity is a family issue since, young children have no real sense of overeating or taking insufficient exercise and are dependent upon adult family members and carers to help them make healthy food choices and exercise. Consequently, evidence supports whole family and population level interventions aimed at modifying behaviours from towards more healthy choices, with specific interventions based in identified geographical and ethnic communities at highest risk.¹⁶³

One of the ways that local authorities can support healthy lifestyles is by making planning decisions that safeguard local parks and open spaces. Barnet Council has outlined commitments to protect and enhance Barnet's open spaces in its planning policies, ensuring that access to open spaces is improved and that they become more attractive as places to a wider range of users. This is especially important for encouraging active lifestyles among children.

¹⁶³ Nationally, whilst 30% of children in the general population are overweight or obese, about 42% of Black Africans and 40% of Black Caribbeans are overweight or obese and obesity is four times as common amongst Asian children as it is amongst Whites. Department of Health *Annual report of the Chief Medical Officer 2002. Health check: On the state of the public health*. Department of Health. London 2003

Child obesity rate by LSOA and park spaces in Barnet



The table below shows that uptake to weekly physical activity in line with curriculum requirement for pupils aged 5 – 16 has only recently reached the national level.

Table: Percentage of pupils participating in at least 120 minutes of curriculum PE (Years 1-11)

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Barnet	59	72	67	71	73	81
National	-	-	-	-	81	
Statistical Neighbours	47.6	59.3	70.1	78.7	83.4	

Source: Barnet PE Strategy & Sports Development Team.¹⁶⁴

Oral Health

The need to reduce oral health inequalities remains high. Severe tooth decay carries the burden of pain, distress and disfigurement. There are other risks too. For example in Barnet, high levels of

¹⁶⁴ National figures for 2009/10 are not yet available.

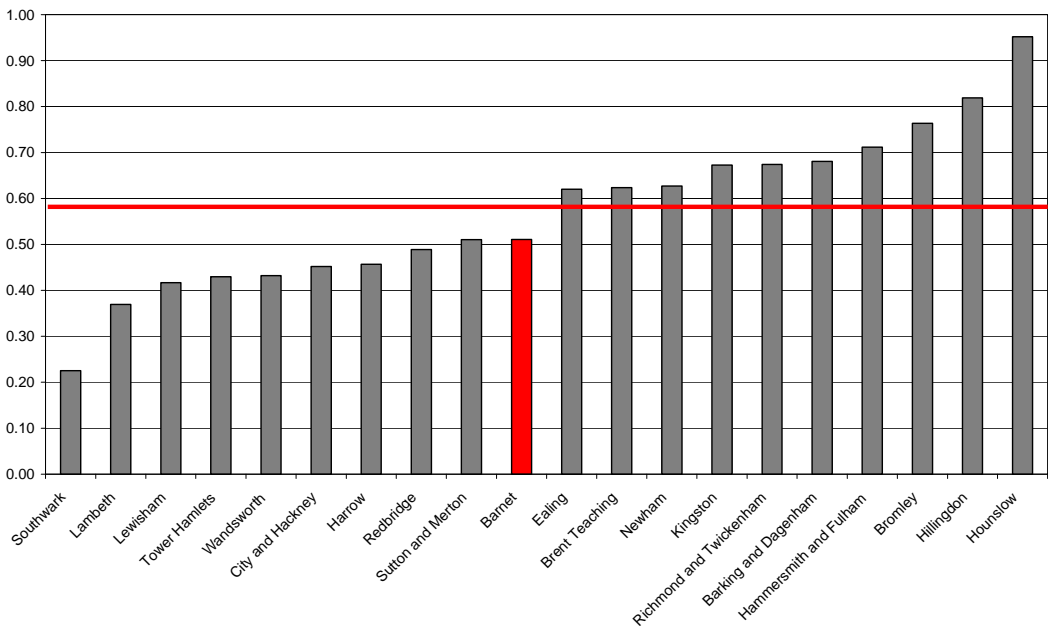
untreated dental disease in a significant proportion of children, many under five, may require general anaesthetic to remove decayed “milk” or deciduous teeth. Although small, such procedures do bear a certain amount of risk.

Dentistry is one area of the NHS where patient charges are levied. However it is free for children and exemptions apply to people on income support, certain tax credits and maternity benefits. Also part or full exemption may apply to certain people who must undergo a process of means testing which may create an obstacle to accessing dental care and very likely these are people from the more deprived areas. The prevalence of exemptions as reported by many practices is high in the more deprived parts of Barnet as would be expected. However we do not have detailed data on this yet. Action is required to improve information for patients on dental charges and exemptions.

Access to and the provision of dental services in Barnet has improved and local commissioners have promote dental health as priority not only in the deprived areas but across Barnet. NHS Barnet currently has a contract with 67 local dental practices to provide general dental services to the residents. A detailed oral health needs assessment is required to be able to identify gaps in the service and for future planning,

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 index (0.51) is better than the London average (0.57). See fig.? below.

Fig: Average Number of obviously decayed, missing (due to decay) & filled teeth per child (D₃MFT)



Source: <http://www.nwph.net/dentalhealth/>

Oral health does have significant impact on the quality of life. Good oral health allows people to enjoy food and drink, to speak, to smile, to socialise, even can affect employment. The effects of poor oral health can be very profound, causing misery, limiting food choices, inhibiting communication, lowering self-esteem and possibly impacting on life chances.

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 than the average population, as well as a higher incidence of learning disabilities, developmental disorders and autistic spectrum disorders. Children with developmental delay and learning disabilities have much higher mental health morbidity than children without, and are more likely to be admitted to paediatric wards because of a higher prevalence of physical problems.¹⁶⁵ Children that 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.

Prevalence of mental disorders observed in looked after children and children living in private households

	5 to 10 year olds		11 to 15 year olds	
	Looked after children	Children in private households	Looked after children	Children in private households
Emotional disorders	11%	3%	12%	6%
Conduct disorders	36%	5%	40%	6%
Hyperkinetic disorders	11%	2%	7%	1%
Any childhood mental disorder	42%	8%	49%	11%

Source: *The mental health of young children looked after by local authorities in England*, ONS, 2003

Research has shown that 25% of juvenile offenders aged ten to 17 years appearing before a Youth Court had had recent contact with psychology or psychiatric services. . In Barnet there are 609 young people on the caseload of the Youth Offending Service (YOS). If this data is applied to the same age range on the YOS caseload, the following estimates are obtained

Estimates of young offenders who have a mental health disorder, 2006

Condition	Count	%
Conduct disorders	323	53%
Hyperkinetic disorders	116	19%
Substance abuse	146	24%
Depression	85	14%
Psychotic symptoms	24	4%

Children and young people with emotional disorders are almost five times more likely to report self-harm or suicide attempts.

¹⁶⁵ Barnet CAMHS needs assessment accessed from <http://ias6.chimat.org.uk/IAS/profiles/profile?profileId=4>

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. Chlamydia is the most common STI and left untreated can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility. The group considered to be at greatest risk of the long-term consequences of Chlamydia infection is young people, in this context defined as those aged 15-24 years old.

The incidence of sexually transmitted infections (STIs) in Barnet is in line with the national average, although infection with Chlamydia (diagnosed in clinics of genitourinary medicine) is increasing. Some of this increase is due to increased testing but the high proportion of positive tests is of concern. By the end of December 2010 (Quarter 3) around 12.2% of 15-24 year olds in Barnet had been tested for Chlamydia, 5.2% of these tested positive for Chlamydia. Gonorrhoea, Syphilis and Herpes infections across Barnet have mirrored the increase seen nationally.¹⁶⁶

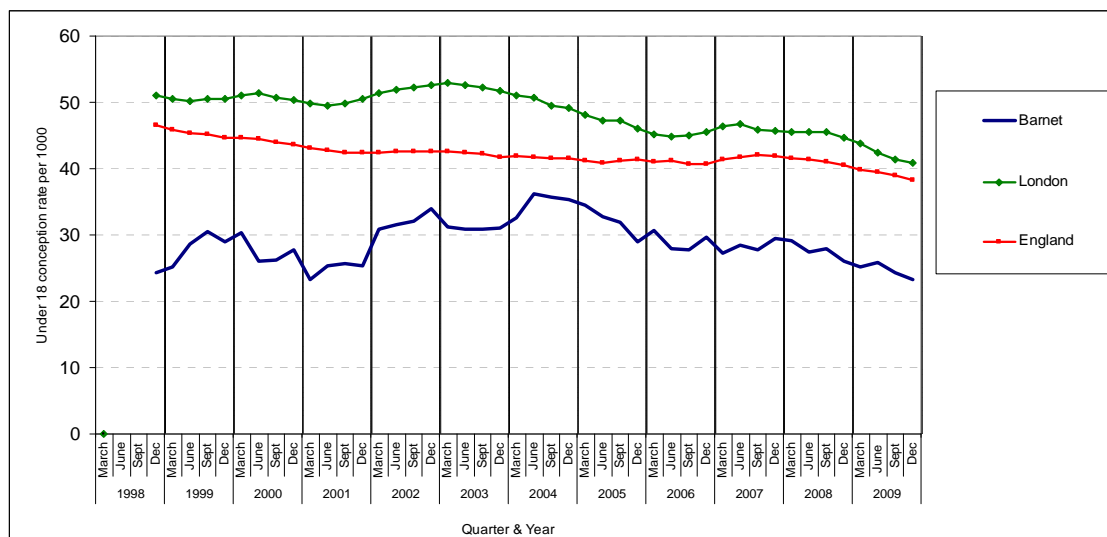
The decommissioning of Chlamydia services in Barnet increases the risk of young people in Barnet having STI's particularly Chlamydia being left untreated which can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility.

Teenage pregnancy

Teenage pregnancy is an important issue in public health as teenage parents are prone to access antenatal care late (if at all), lower birth weight babies and high infant mortality rates.

Barnet has one of the lowest rates of teenage pregnancy (TP) in London, and this is also lower than similar boroughs (including those matched for deprivation) such as Merton, Hounslow and Enfield. Not only is it lower than the London average, but it is also lower than the national average.

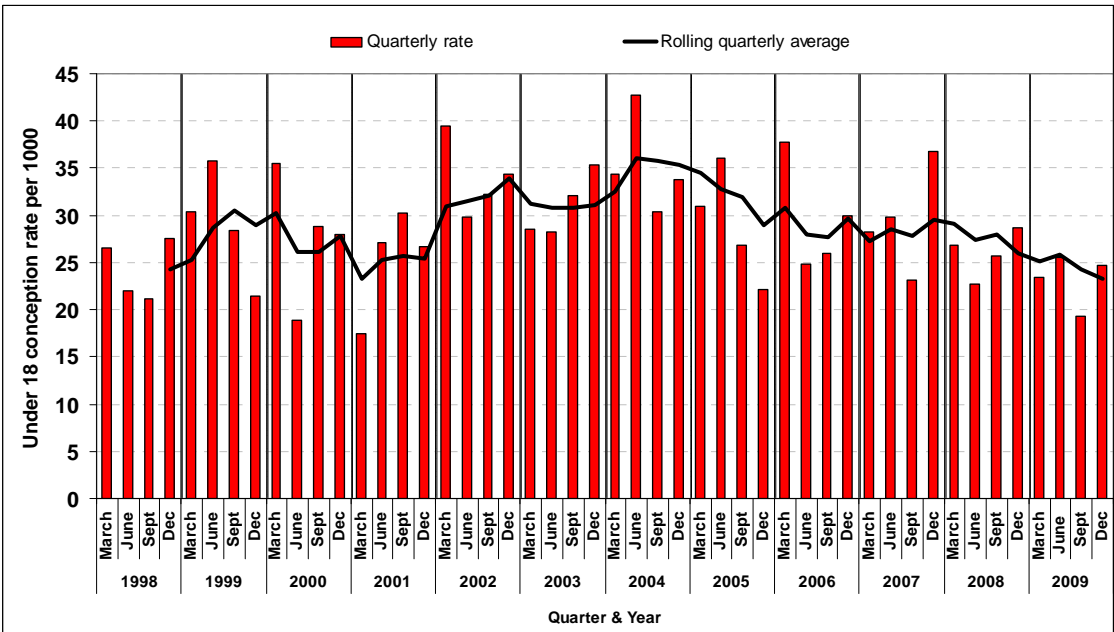
The trend in teenage pregnancy in Barnet, London and England



Source: Office for National Statistics

¹⁶⁶ National Chlamydia Screening Programme, <http://www.chlamydia-screening.nhs.uk/ps/index.html>.

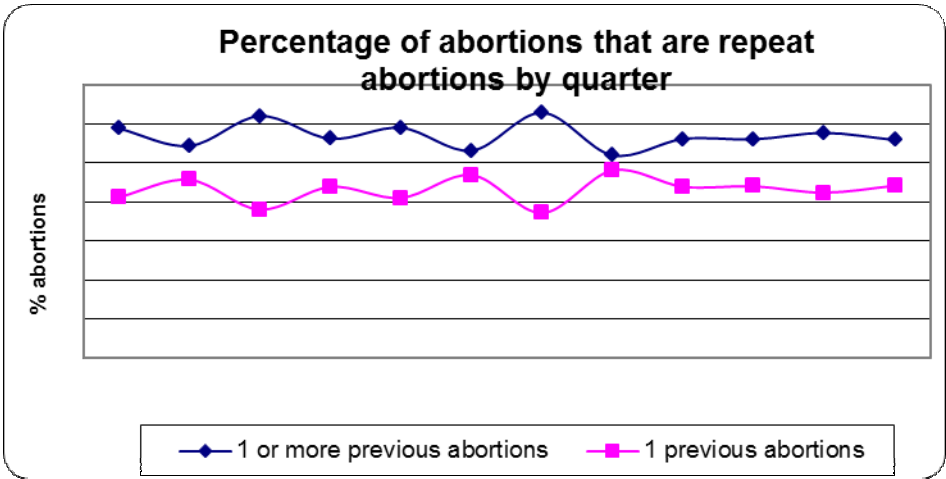
The trend in teenage pregnancy in Barnet



Source: Office for National Statistics

The trend in teenage pregnancy in Barnet was increasing until the second quarter of 2004 but has since decreased.

There are a number of negative outcomes associated with teenage pregnancy that make it a key concern for health and social care. Firstly, the infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers. 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.



Termination of pregnancy

In the UK, a pregnancy can be legally terminated where two doctors agree that the circumstances of the pregnancy match one of the criteria specified in the 1967 Abortion Act (as amended by the 1990 Human Fertilisation and Embryology Act).

A termination may be performed because of medical reasons but may also be performed because; 'the continuation of the pregnancy constitutes a greater threat to the physical or mental health of the pregnant woman than does its termination'. Terminations can be legally performed under these grounds up to 24 weeks, and it is under this ground that the majority of terminations at all ages are provided in Britain.

Approximately 17 per cent of teenagers who conceived in Barnet in 2009 had a termination of pregnancy (TOP). 15.2% of teenage abortions were performed on young women who had had at least one previous TOP. This could be seen as an indication of young women either having better access to termination services or a lack of access to contraception services. As Barnet has such a low number of teenage conceptions (which include abortions as well as births) relative to most other PCTs in London, this latter possible explanation is unlikely.

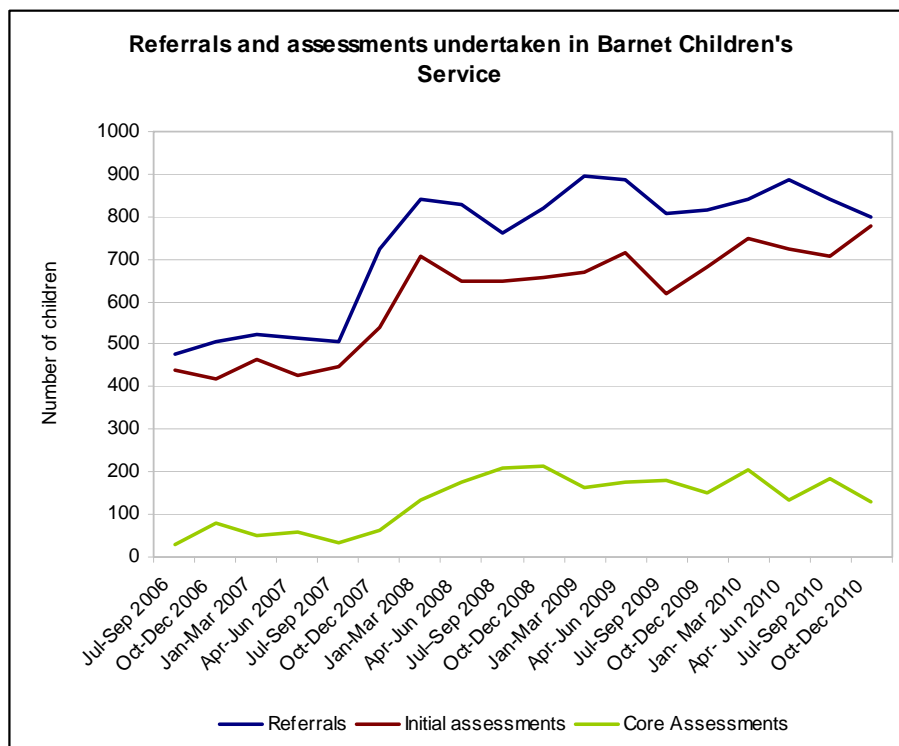
Following a slight rise, the incidence of repeat terminations has remained fairly static since Quarter 1 2009. However, the coordination of teenage pregnancy prevention and support to young people in Barnet has been decommissioned. There is still much that could be done to further reduce the number of Barnet teenagers whose lives are changed by an often unwanted pregnancy. Teenage parents and their children are more likely to suffer from poor health, unemployment and poor achievement at school than their peers and as such continued coordinated efforts between health, local authority and voluntary sector around the prevention agenda must continue.

Child Protection Services

A growing number of children are being brought to the attention of children's social services and are subsequently being assessed to determine if they are in need or at risk and the services they may require. 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 2006.¹⁶⁷ However, despite this increase in referrals and assessments, the proportion of children subject to a protection plan in Barnet remains below London and national averages at 25.9 per 10,000 children compared with 35.5 in England.¹⁶⁸

¹⁶⁷ Barnet Children and Young People Profile 2010

¹⁶⁸ DCSF Statistical Returns



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

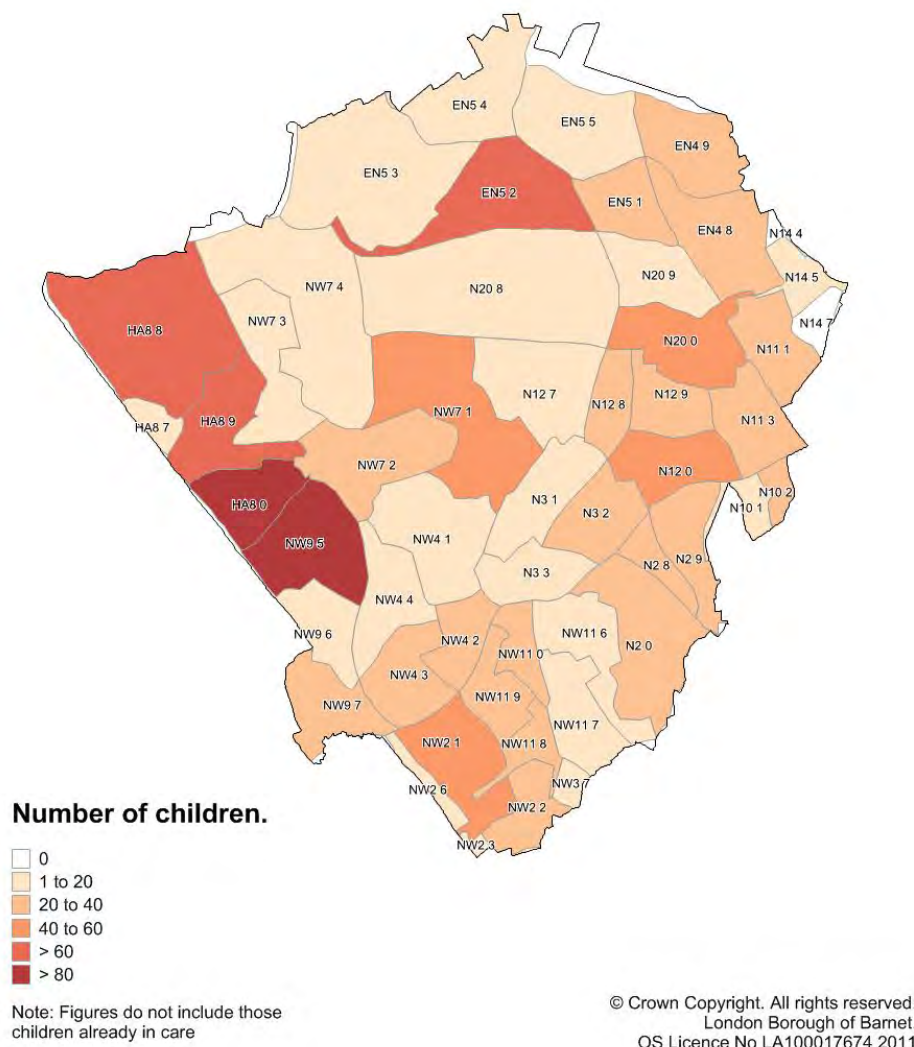
Children and young people are considered 'children in need' if they require services under section 17 of the Children Act 1989. This is usually because they have additional needs requiring integrated targeted support. There are many reasons why a child may be considered in need, some of them include:

- They are living in an environment that poses a risk to their safety or well being
- They have a high level of special needs requiring constant supervision, which results in a high risk of family breakdown
- They have challenging behaviour that results in serious risk to the child or others, which parents are unable to manage resulting in a high risk of family breakdown
- They have parents whose criminal and / or anti-social behaviour threatens the welfare of the child.

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.

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.

Children in Need in Barnet by postal district, March 2011¹⁶⁹



The Common Assessment Framework

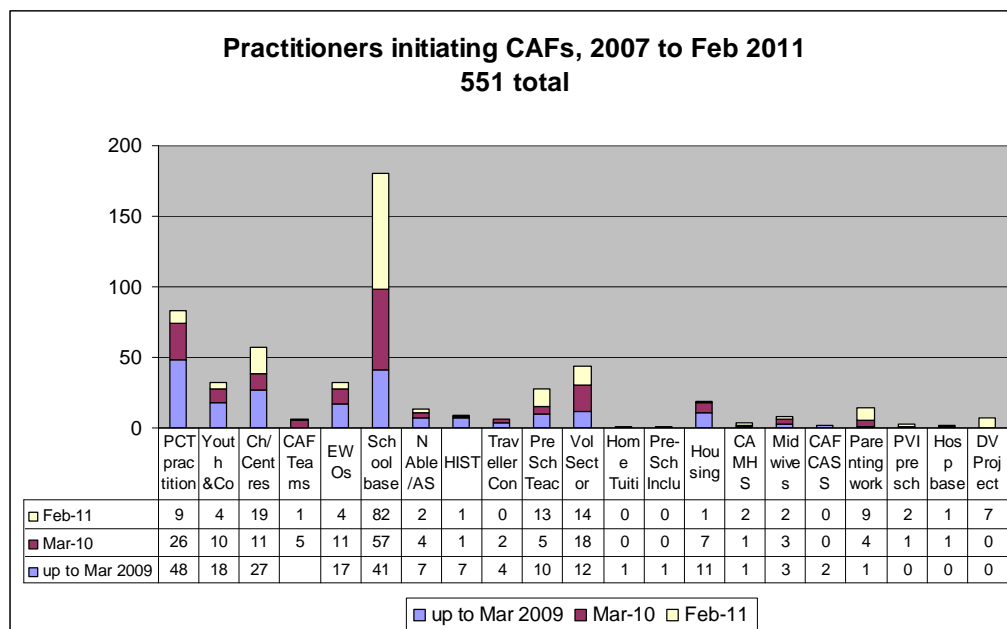
The Common Assessment Framework (CAF) is a standardised assessment process to gather information about a child's life from the different professionals it is in contact with, and to assess the child's strengths and weaknesses, including those related to health. It supports multi-agency working and information sharing; helping everyone to plan together what support is required so the child's needs can be met quickly and effectively.¹⁷⁰

A high proportion of CAFs are initiated by school-based staff would be expected, since they are in close day-to-day contact with children and young people.

¹⁶⁹ Children in care not included.

¹⁷⁰ More information on the process can be found on the Barnet Council website at <http://www.barnet.gov.uk/caf> and <http://www.barnet.gov.uk/chypf/chypf-multi-agency-working/caf-practitioner-info.htm>

GPs are well placed to be able to signpost for a CAF, and there have been a small number of cases where GPs have asked Health Visitors to follow up a case with a CAF. Also School Nurses are becoming more frequently involved as part of the Team Around the Child process (which follows on from a CAF), and they have been able to access info from GPs in order to contribute towards the CAF with the patient's consent.



Health visitors have been using the Pre-Assessment CAF checklist (the stage before a CAF) since 2008 for all new birth visits and new arrivals to the borough, to help them profile their caseloads and identify when a CAF is required. Health Visitors' main use of the CAF is to evidence the need for a funded Children's Centre Place via the Early Years Panel.

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 life-changing events such as potentially moving out of the family home, leaving school or getting a job for the first time, but also because the support and services available as an adult are quite different from those available to 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.

Not all children receiving social care will have learning difficulties, but the majority of children needing support with transitioning from Children's Services to Adult Services will be learning disabled, often with profound and multiple needs. For such people, it is important that there are services available in the borough to deal with their complex needs, but also to assist them in their move into adulthood. In particular, there are issues with young people returning to Barnet aged 18 or 19 after several years spent living away in residential schools and colleges, and often finding that suitable accommodation, employment and further education opportunities are not available locally. This shortfall in local options

and opportunities means that many disabled young people remain in out of borough residential settings for much longer than necessary.

The Transitions team also works with children with mental health issues, particularly associated with young people leaving care. As evidenced in the Mental Health section, mental and behavioural disorders are much more prevalent in certain groups of children, with two-thirds of children placed in residential care having a mental disorder. It is imperative that these young people are supported effectively when they leave residential care so that their disorders can be appropriately monitored and managed.

Another group of young people that the Transitions team works with where needs are often high and unmet, are children with dual diagnoses, be that learning and physical disability, learning disability and a mental health need, or mental health and physical disability. As these children do not easily slot into a particular care group, they can often find themselves shunted between social work teams, or find that services and providers are insufficiently adapted to their needs. Children and young people with autistic spectrum disorder often experience this as well.

The number of young people aged 14 to 17 receiving support from Barnet's Disabled Children's Team (as at March 2011) is given in the table below. When young people turn 18 they are funded by Adult Social Services, if they are eligible for services.

Age	14	15	16	17	Total
Number	33	34	31	25	123

There are also a significant number of children in Barnet schools with learning disabilities and difficulties – approximately two per cent of Barnet secondary school pupils (excluding those who attend special schools) have a Statement of Special Educational Need. The actual number who will go on to receive adult social care will be fairly small (see table below), although the complexity of their needs means that the cost of their care will be relatively very large.

The number of young people receiving support from Barnet Adult Social Services (as at March 2011)

Age	18	19	20	21	22	23	24	25
Number	19	34	23	31	36	40	38	39

Most children with identified educational needs will either not be eligible for funded social care support as an adult, or can be supported to live independently without the need for formal support. Such people, with lower level but still significant needs, may still require assistance with gaining independence from families and carers, and / or help finding suitable accommodation, employment or training, or further education. They are also likely to require support via housing support floating support staff, Supporting People, or local charity and help groups.

It is recognised that not enough is known about the needs of disabled children transitioning into adulthood, and there is a particular problem in connecting information from Children's Services with

information from Adult's Services. A project is currently underway that will result in better use of the wealth of data held on young people across both departments.

National analysis conducted by the Centre for Disability Research suggests that in an 'average' area in England with a population of 250,000 the number of adults with people with Profound and Multiple Learning Disabilities (PMLD) receiving health and social care services will rise from 78 in 2009 to 105 in 2026. It also indicates that the number of young people with PMLD becoming adults in any given year will rise from three in 2009 to five in 2026.¹⁷¹ Barnet is currently contributing to a project run by a team of researchers at Lancaster University that will help project the need for adult services among children with Special Educational Needs.

Recommendations

- Provide peer support – especially during the early weeks – to establish and continue breastfeeding. Routinely inform fathers about the health benefits of breastfeeding, giving them advice and encouraging them to be supportive about breastfeeding – the father's involvement is a key predictor of breastfeeding initiation and maintenance
- Use children's centres to make antenatal and postnatal services more accessible to hard-to-reach groups
- Improve public awareness of health issues associated with childhood obesity; engage community groups and provide support for healthy living initiatives
- Undertake a comprehensive Oral Health Needs Assessment with a view to improving access to local dental services
- Ensure all sexual health services (including sexual health promotion and sexual relationship education) are designed to enable access by young people and people from different ethnic and religious backgrounds at times and places that suit them
- Develop integrated health and social care packages, which include sexual health, for key vulnerable groups of young people, for example looked after children, and young people not in employment, education or training.
- Raise the profile of CAFs among GPs, increasing their role in signposting other health professionals to initiate a CAF; improve the transfer of CAFs between health visitors and Children's Centres
- Improve information transfer between children's and adult services around the needs of disabled children transitioning into adulthood
- Develop a range of high quality housing options to meet the needs of people with complex and profound learning disabilities and autism to prevent the need for high cost, out of area placements.

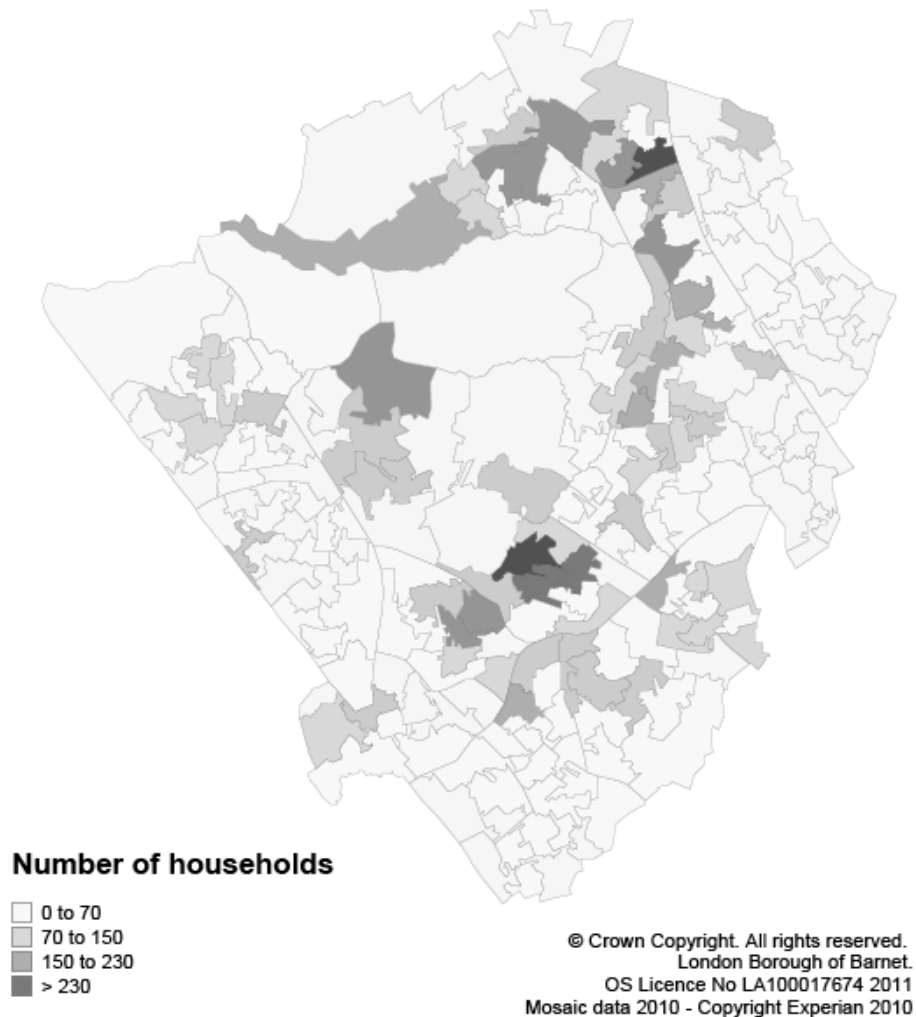
¹⁷¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103200.pdf

Older people

Overview

There are an estimated 44,900 people aged 65 or over living in Barnet.¹⁷² According to forecasts, 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%). According to the Mosaic customer profiling tool two areas that have high numbers of older people are Totteridge and in the centre of the borough near Finchley Church End and Mill Hill.

Concentrations of households with older people based on Mosaic, by LSOA¹⁷³

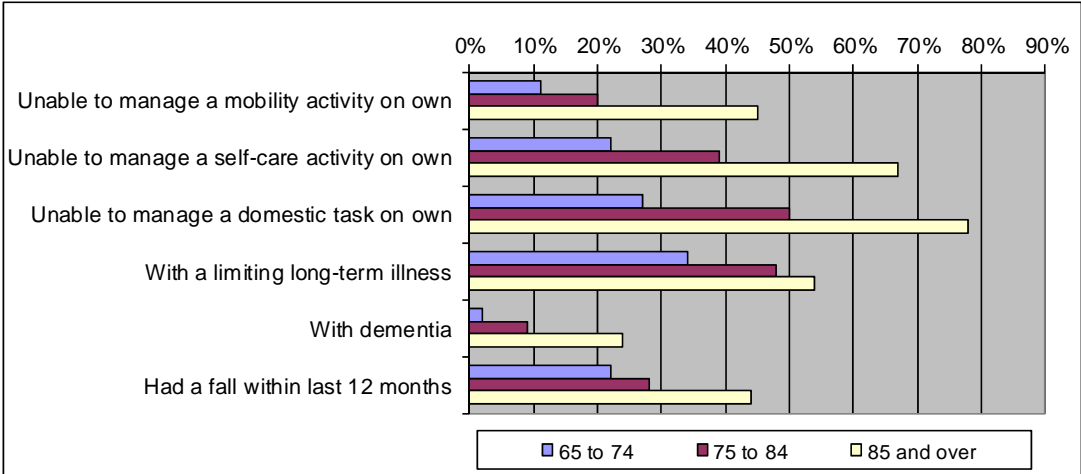


¹⁷² Barnet Hybrid Population Solution 2011

¹⁷³ This figure was created by counting the number of households in each LSOA that fall into either group particularly applicable to older people; Active elderly people living in pleasant retirement locations and Elderly people reliant on state support

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 tighter resources. Increased life expectancy in Barnet implies longer periods for individuals where health, social care and support are required.

Incidence of illness and conditions amongst older adult age groups



Source: Incidence rates taken from Department of Health’s POPPI system, applied to Barnet’s age profile

The risk we face

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.¹⁷⁴

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.

Barnet is projected to have some of the strongest growth in elderly residents out of all London boroughs over the next five to ten years. Older people are more likely to suffer from chronic and long-term conditions, mental health issues, and are also more likely to suffer from falls and fractures. It is important that episodes of medical treatment are used as opportunities for people to improve their ability to look after themselves and therefore return home safely. Table x illustrates the current estimates for some of these conditions and disabilities and the projections for the next ten years.

¹⁷⁴ Prof Ian Philip 2007

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%.

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

	2010 estimate	2015 estimate	2020 estimate	% increase 2010 – 2020
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

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 injury.

In Barnet, the total number of older people predicted to have a fall in 2010 is estimated at 13,146.¹⁷⁵ This is projected to increase by 22% by 2020 and a further 26% by 2030, so that in 2030 the number of

¹⁷⁵ Department of Health's POPPI system

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.

It is difficult to determine accurate prevalence of falls because many falls go unreported and there is poor recording of falls as the cause of an injury. Using estimates produced by Department of Health on the number of falls and their consequences for a typical PCT, the following figures were extrapolated for Barnet.

Estimated numbers of people aged over 65 years experiencing falls and fractures in Barnet

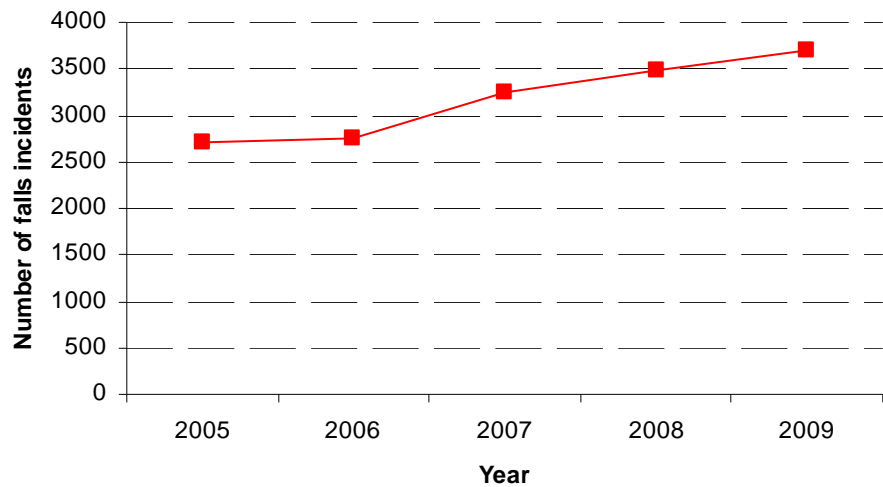
	Estimates for Barnet <i>(Based on a total population of 34,3088 and a population aged 65+ of 47,253)</i>	
	Number of people	As proportion of those falling each year
fall each year	18,083	-
fall twice or more	7,817	43%
attend A/E	2,567	14%
call an ambulance	2,567	14%
sustain a fracture	1,283	7%
sustain fracture to hip	420	2%

Source: Falls and fractures: effective interventions in health and social care, Department of health, July 2009

Another source of data is the number of attendances for falls by the London Ambulance Service (LAS). In 2009, there were 3,700 attendances for falls in over 65 year olds in Barnet, representing 24% of all incidents attended by the LAS in Barnet.¹⁷⁶ This data demonstrates an upward trend in the number of falls incidents since 2005 and reveals a 36% increase in ambulance attendances for falls between 2005 and 2009.

¹⁷⁶ Note, these are attendances for all falls occurring in Barnet and will therefore include non Barnet residents

Number of ambulance attendances for falls incidents in over 65 year olds, Barnet, 2005-2009

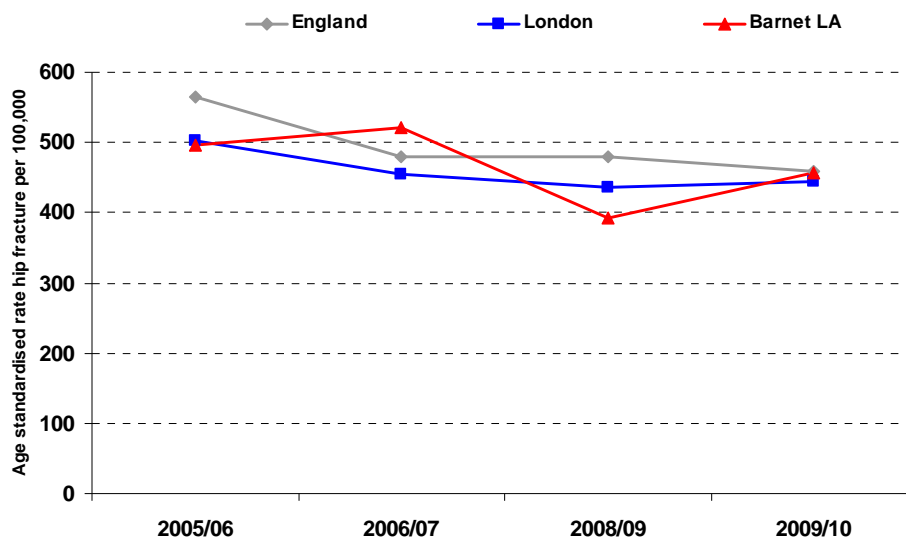


Source: London Ambulance Service

Not all older people injure themselves in a fall, but many have great difficulty getting up again after the fall. Out of the 3,700 ambulance attendances for falls amongst over 65 year olds, 2,535 (69%) were not admitted into hospital. This is an area where joint working could be developed between the ambulance service, health and social services to assist this vulnerable group.

Hip fractures remain the most serious consequence of a fall and the commonest cause of accident-related death in older people – 20% die within four months and 30% within a year. More than 95% of hip fractures are the result of a fall. Monitoring the rates of hip fractures can provide an indirect measure for the trends in incidence of falls and underlying bone health. The incidence of hip fracture in older people can be obtained by looking at hospital admissions for fractured neck of femur. In 2009/10, the age-sex standardised hip fracture rate in over-65s was 457 per 100,000 in Barnet, similar to the England rate (458 per 100,000) and higher than though not statistically different from London (444 per 100,000). These hip fracture rates in Barnet have not reduced significantly since 2005/06 apart from a dip between 2007/08 and 2008/09 when data quality was affected as a result of some providers being unable to submit data.

Age standardised rates, emergency admissions for hip fracture in over 65 year olds, 2005/06-2009/10, Barnet, London and England¹⁷⁷



Source: Hospital Episode Statistics, Department of Health

Most older people who suffer a fracture following a fall have reduced bone strength or a condition known as osteoporosis. Its onset is asymptomatic and it is often only recognised after an older person falls and sustains a fragility fracture. There is evidence that treatment of an individual presenting with a current or previous fragility fracture with osteoporosis medication reduces the risk of hip fracture in the future by half. Systematic identification and treatment of these patients has been shown to be poor across the country by several national audits. A recent audit conducted in 12 GP practices in Barnet showed that only 51% of patients with a prior fragility fracture had been treated.

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. Reducing the incidence of hip fractures will have significant cost savings to the NHS and social services in terms of bed days, rehabilitation and support at home.

There is strong evidence that physical activity is important in preserving adequate to good skeletal health and in preventing fractures. Exercise, even at advanced ages and in people of varying physical activities, can improve balance, strength and other risk factors for falls and injury. Multi-component exercise programmes which include strength and balance training and Tai chi are most effective

Dementia

A key pressure on services for older people and their carers is the impact of dementia. The section on Mental Health detailed the increase in dementia seen in both the health and social care systems; it is a challenge for the entire system to think about how better support can be provided to dementia sufferers

¹⁷⁷ For the period 2009/10 the data was standardised by Age and Sex whereas for the previous years the data was only standardised by Age

and their carers and families. Barnet, Enfield and Haringey NHS Mental Health Trust's 2010 Dementia Strategy set out a strategic vision which included reducing the use of antipsychotic medication in people with dementia and improving end of life care for people with dementia. However, it should be noted that two-thirds of people with dementia live out in the community, so the strategy also identifies the need for memory assessment services for early diagnosis, dementia home treatment teams to prevent admissions into hospital or registered care, and personalised services to help enable individuals to regain lost skills or retain existing capabilities. A key area affecting the ability of people with dementia being able to remain living in their own home is the availability and quality of informal care, specific support to family carers and the understanding, the attitudes and tolerance of the wider community.

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. Adult Social Services have for a number of years tried to restrict admissions into care homes for older people, responding to users' and the public's feedback that where possible people would like to remain in their own homes receiving community- and home-based support. Performance figures suggest a lot of success with this policy – 19.5% of service users aged 65 or over received residential care services in 2006/07; this figure had dropped to 15.1% in 2009/10. However, Barnet social services purchases only a quarter of care home beds within the borough, the rest of the market is made up of people funding their own care and people not originally from Barnet placed here by other local authorities. Adult social services, working with health services and the voluntary sector, need to do more to build the confidence and capability of older people to remain in their own homes.

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.¹⁷⁸ Over two-thirds of these single pensioner households will be aged 75 or over. 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.

¹⁷⁸ Department of Health's POPPI model

Where older people do not live alone, they are quite often looking after an elderly partner within their home, or indeed being looked after themselves. Within Barnet, it is estimated that there are 5,334 people over the age of 65 providing unpaid care to a partner, family member or other person.¹⁷⁹ This represents 11% of older people in the borough, and by 2020 this number is set to increase by over 1,000. Nearly 40% of these carers are aged 75 or over; there is also a small but significant number of carers aged 85 or over (estimate of 356 in 2010).

Seasonal pressures

There are periods when there is an increased demand for health and social care services. Common causes of increase demand which can lead to pressures are illnesses related to colder weather, to seasonal flu, and heat wave, which can increase the number of people having heart attacks and strokes as well as substantially increase the number of people affected by acute respiratory disease. It is mainly older and vulnerable people that are affected by this.

The Barnet capacity plan brings together our local organisational plans for dealing with a period of increased demand for unplanned Health and Social Care. It sets out procedures to ensure that the system is able to manage any increase in demand for health and social care services across community and acute services, including the period of time patients have to wait for treatment in A&E Departments, or to be admitted to a hospital ward in periods of severe pressures and still meet National targets.

Coupled with the capacity plan, Barnet Social Services has a multi-agency plan that outlines the approach to the protection of vulnerable adults during a cold spell. It contains details of:

- Actions to be taken by all agencies in a combined effort to prevent the incidence of hypothermia
- The importance of early intervention.

Key to this is the identification of people at risk. Frontline staff across the local authority, health services and voluntary sector have a key role in working together to identify vulnerable service users.

Influenza

Influenza is a highly infectious viral illness. It can be a very serious illness for certain groups, particularly the elderly and the very young and those with chronic conditions who are particularly vulnerable to complications such as pneumonia.

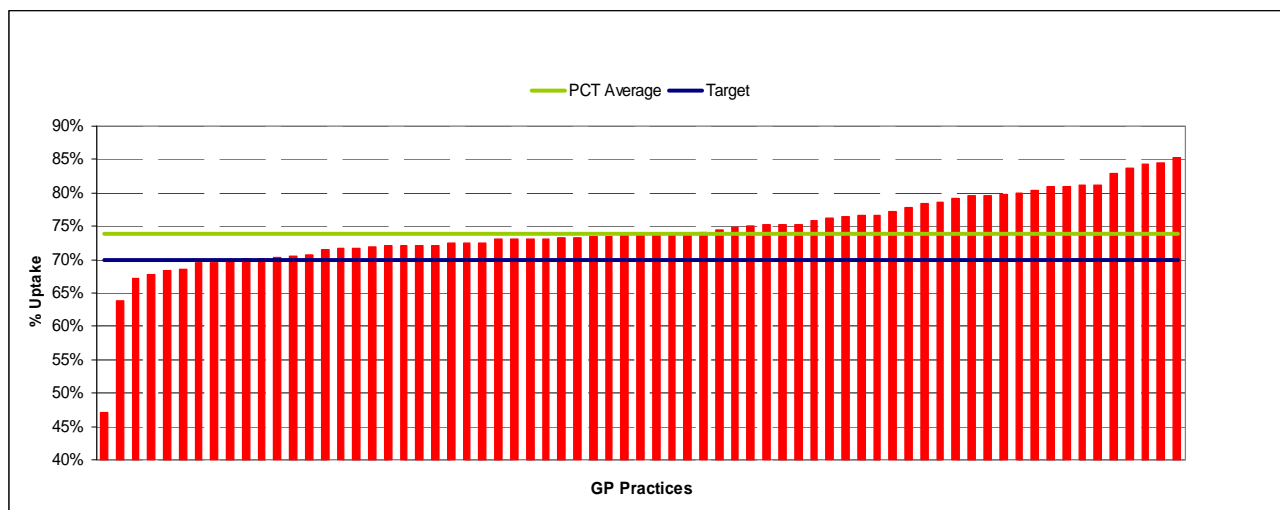
The seasonal flu vaccine is made available each year according to the circulating influenza strains. It is recommended for certain target groups including over 65's and those with chronic conditions such as asthma, diabetes and heart conditions. Pregnant women were included in the target groups for the first time in 2010/11 because the predominant strain was the swine flu virus.

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

¹⁷⁹ Department of Health's POPPI model

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. The uptake in clinical risk groups aged under 65 years was 48.1% which has fallen from a previous persistent steady increase.

Seasonal flu uptake in people aged 65 years and above, Barnet 2010/11



Source: Department of health, Immform website

Recommendations

Key elements of older people's care include:

- Early intervention and assessment of old age conditions
- Long-term condition management in the community
- Early supported discharge whenever possible delivering care closer to home
- General acute hospital care when needed, combined with quick access to new specialist centres
- Partnerships (acute, community services, health and social services and the voluntary sector) built around the needs and wishes of older people
- Support to family carers
- Working more closely with GP practices that were unable to reach the national seasonal flu immunisation target.

The transfer of social care allocations from NHS Barnet to the council through additional funding available to all PCTs from 2010/11 to 2012/2013 will present an opportunity to increase the connection between health and social care services, to improve outcomes and deliver efficiencies. Work streams will focus on older people, in particular supporting avoidable hospital admissions and reducing hospital re-admissions. Specific work will include

- Ensuring pathway in place to tackle prevention of falls, reduce risk of future fragility fractures and promote bone health

- Extending the enablement offer for Barnet residents
- Improving the stroke care pathway
- Developing the offer for supporting Barnet residents in care homes including continence management, medicine reviews and assessments
- Planning for increased spend on community equipment and telecare
- Piloting a number of initiatives connected to improving intermediate care
- Improving the dementia care pathway in terms of improved public and professional awareness, providing good quality information, and early diagnosis and intervention.

Carers

Overview

Carers have a vital role in supporting people who are ill, disabled, frail or who have mental health problems or learning disabilities so they can remain living in the home. It is estimated that 60% of the population will care for someone at some point during their lives, and this informal care makes an enormous contribution to society. In Barnet, around 9% of the population are currently carers, of which at least 2,000 are 75 years or older, with nearly 5,000 providing 50 hours or more of care per week. These rates are relatively higher in the North and West clusters. Many carers do not identify themselves as carers and therefore, these 'hidden carers' may not be accessing the support and advice available to them.

Carers recorded in 2001 Census

Hours of care per week	Number of carers, Barnet	% of population, Barnet	% of population, London	% of population, England
Total	28,171	9.0%	8.5%	9.9%
0-19 hours	20,440	6.5%	5.8%	6.8%
20-49 hours	3,128	1.0%	1.0%	1.1%
50+ hours	4,603	1.5%	1.7%	2.0%

Source: 2001 Census, ONS

During 2009/10, Adult Social Services in Barnet assessed the needs of 2,138 carers.¹⁸⁰ The council and NHS Barnet work jointly with Barnet Carers Centre and other carer support organisations to support carers in the borough, and BCC currently hold a register of 4,855 carers.¹⁸¹ Joining this support up with appropriate and timely interventions has improved, but there remains a real need to understand and quantify the impact that different services and support have on carers' ability to continue in their role, and the savings that this brings to the system. There is also a continued need for health and social care professionals to be aware of and take into account the mental and physical implications that caring brings about.

The risk we face

The demand for carers is projected to increase with the increase in life expectancy, with the increase in people living with a disability needing care and with the changes to service provisions in community settings away from institutions. In particular there will be a sharp increase in the demand for carers of older people and of people with dementia. With this comes a risk of increased social isolation, particularly where carers are experiencing declining health themselves.

Caring can have a strong negative impact on physical, mental and emotional health. It has been found that over a half of all carers have developed a caring related health condition. A link also exists between the length of time carers have spent caring and carers' poor health. The results of a carers survey in Barnet in 2009 noted that carers and the people they care for receive support and services from a mix of local authority, private agencies and voluntary organisations. This support makes things easier for carers, and it is important that this range of support is sustained going forward. Reported delays and difficulties in accessing services is an area that needs attention, particularly considering the fragile nature of many caring

¹⁸⁰ Survey of Carers in Households in England 2009/10, Department of Health

¹⁸¹ Barnet Carers Centre register as at 25th March 2011

situations. The impact of the caring role on carers' health is undeniable, having a negative effect on levels of sleep and stress as well as depression and physical problems.

Caring can also affect relationships, career prospects, income and expectations for the future. Many carers provide long-term caring for example for people with learning disabilities or long term conditions (for up to 40- 50 years). From national data it is estimated that up to 20% of employees are likely to have caring responsibilities. Balancing employment and caring can cause great difficulties for employees and their employers. This has resulted in many carers deciding to work part-time, take early retirement, or give up work altogether, with both an economic and skill loss to the local economy. Nationally, carers lose an average of £11,050 p.a. by taking on significant caring responsibilities. Within Barnet, 2,390 carers receive a Carers Allowance to help alleviate some of the financial problems caused by caring responsibilities.¹⁸²

A young carer is anyone under the age of 18 who cares for or helps to care for a family member. They may be looking after someone because they have a physical disability, a sensory impairment, mental health support needs, a learning disability, they misuse drugs or alcohol, or they have any combination of the above. According to the 2001 Census there were 1,000 young carers in Barnet, but is an area that is likely to under-estimated. Being a young carer can impact on young person's childhood in many ways and can have a detrimental impact on their educational attainment, health and emotional wellbeing, and their ability to make friends and have a social life. It is important that young carers get respite from their caring responsibilities at home in order to improve their emotional wellbeing and reduce their social isolation.

Recommendations

The multi-agency strategy produced in 2009, Barnet Carers Strategy 2009-2012, identified a wealth of successful initiatives and good practice operating in the borough to support carers. But it also outlined a number of gaps and priorities for the council, the PCT and voluntary sector partners to tackle, including:

- Whole area approach to supporting carers, and clear support pathway clearly joining up with mainstream support, targeted preventative support, and support for carers in high need
- Improved understanding, appreciation and support of carers by professional staff and employers which recognises the increasing demands on carers as more people with support needs are cared for in their homes
- The need for more comprehensive and accessible information for carers which reflects the often transient and changing role of caring as well as the diversity of backgrounds of carers
- Continuing to improve partnership working across agencies with signposting to additional support options and in recognition that many carers are themselves vulnerable adults
- Improved options for emergencies/contingencies to help prevent inappropriate need for residential or hospital care and which maintain continuity for the cared for person
- The need for a wider variety of 'carers' break' options which support the diversity of individual lifestyles.

¹⁸² August 2010 figure from DWP's Nomis website

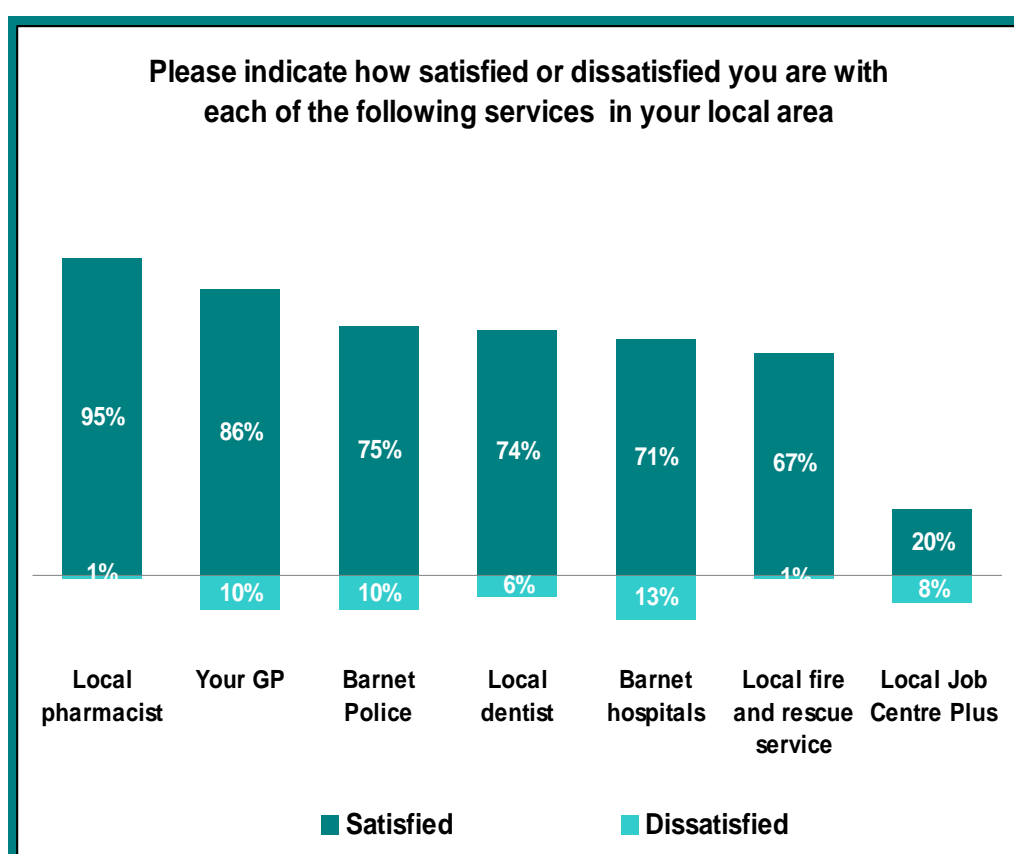
Experiencing health and social care

Perceptions of health and social care

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>.

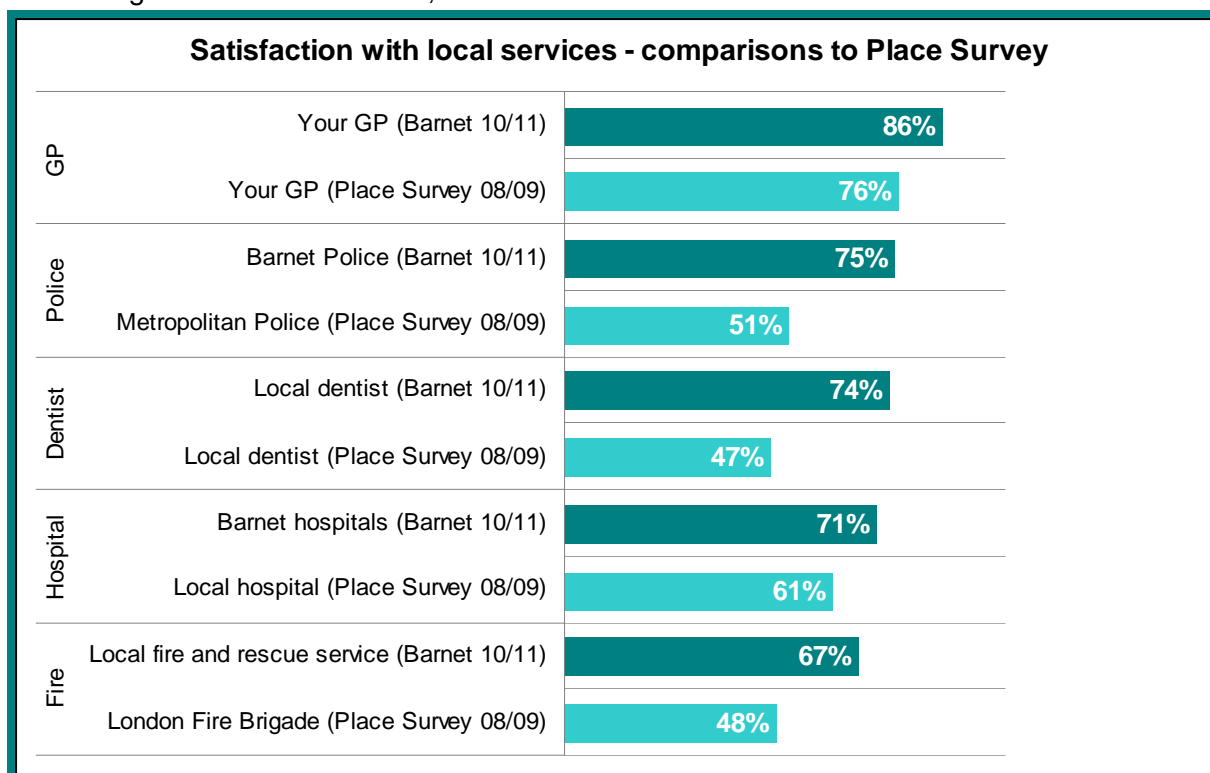
Residents Perception Survey

The 2010-11 Residents Perception Survey was conducted during February and April 2011 and included telephone interviews with more than 2,100 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 10% 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 10% improvement in satisfaction. Local pharmacies and local JobCentre Plus were not included in the former Place survey.



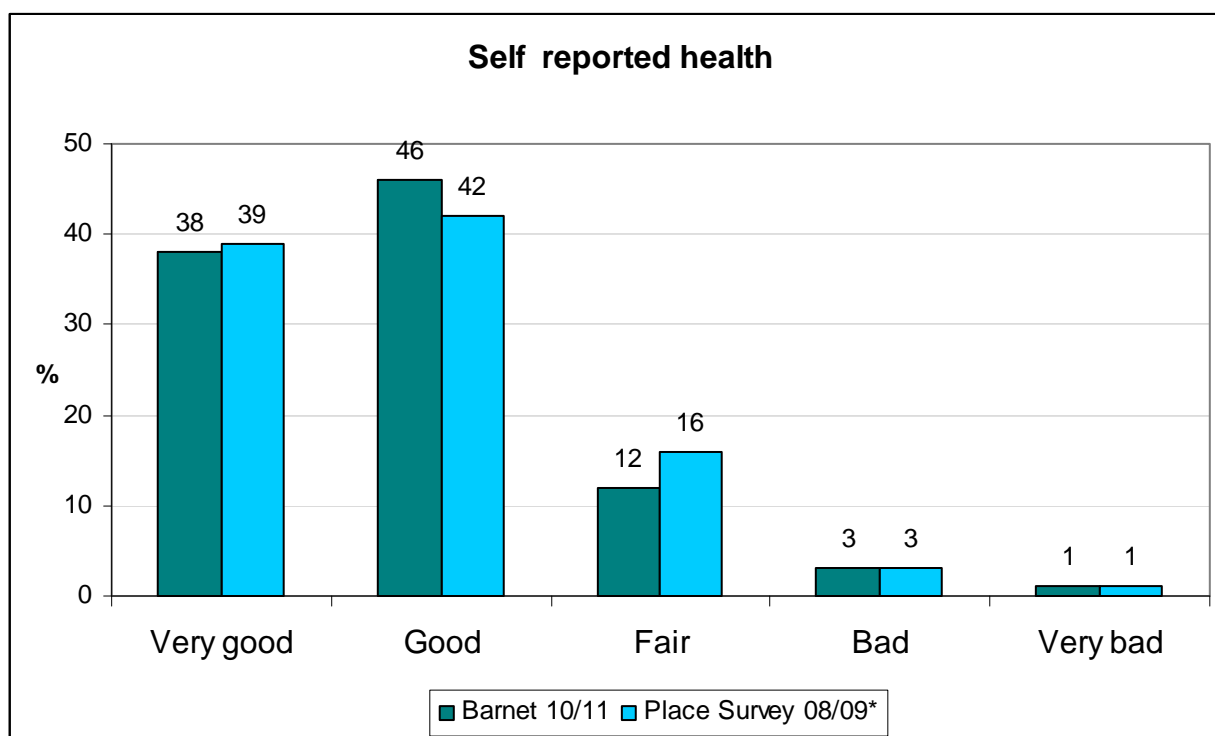
Source: Residents Perception Survey, 2010-11 and Barnet Place Survey, 2008/09

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 health 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.¹⁸³

¹⁸³ Caution should be applied when making direct comparisons to the former Place Survey due to the different methodologies.



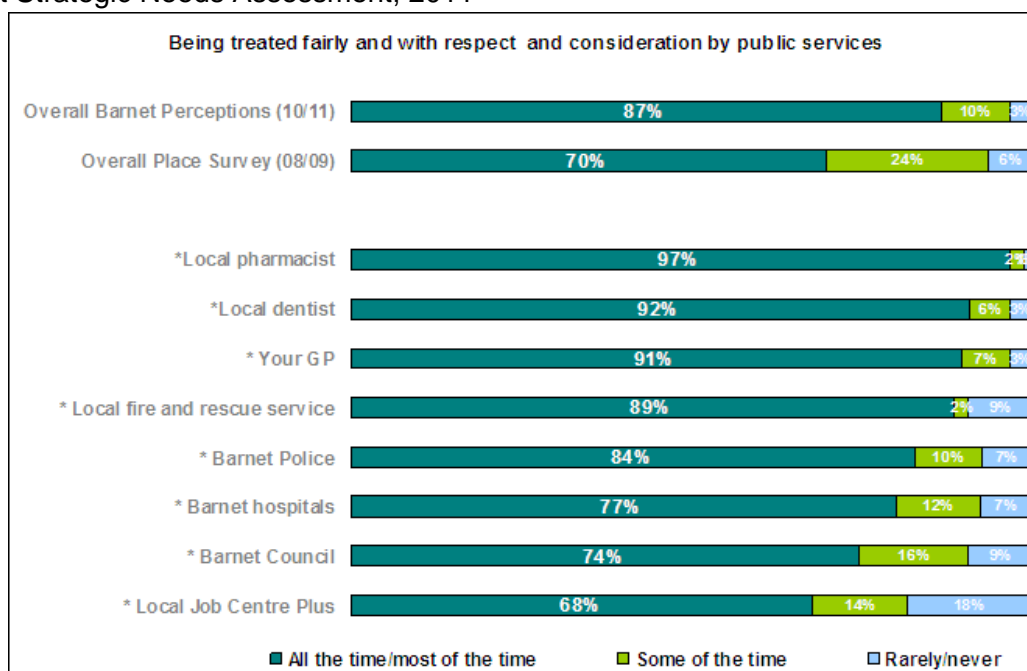
Source: Residents Perception Survey, 2010-11 and Barnet Place Survey, 2008/09

Being treated fairly and with respect and consideration by local public services

The former Place Survey asked if residents felt they were treated fairly and with respect and consideration by local public services. This indicator has been identified as one of a basket of indicators that will measure performance on the council's corporate equalities dashboard. In order to gain a deeper insight on how public services are performing on this indicator, this year's survey also included a series of questions that asked residents for their views on individual public services in terms of being treated fairly and with respect and consideration by local public services.

- The chart below shows that respondents are overall significantly more likely to say they have been treated fairly and with respect and consideration, all the time or most of the time, compared to when this question was last asked on the Place Survey¹⁸⁴ (87%, +17%).
- In terms of individual services those services that scored significantly above this overall score are local pharmacists (97%, +10%), local dentist (92%, +5%) and, GPs (91%, + 4%).
- Those services that scored significantly below the overall score (in terms of being treated fairly and with respect and consideration all of the time or most of the time) are Barnet Hospitals (77%, -10%), Barnet Council (74%, - 13%) and Job Centre Plus (68%, -19%).

¹⁸⁴ Caution should be applied when making direct comparisons to the former Place Survey due to the different methodologies



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. Recent surveys have included:

- Home Care User Experience Questionnaire 2009
- Carers Experience Survey 2009
- Adult Social Services User Outcomes Survey 2010
- Equipment and Minor Adaptations: Quality and Outcomes Questionnaire 2010

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
- Our services and support can help users and their carers in a number of ways - improving health and wellbeing, improving mobility and encouraging exercise, improving diet and tackling obesity, reducing stress and smoking, maintaining independence and increasing confidence
- 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. Recent consultations include:

Adult Social Services Budget Conversations, Nov 2010

- 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

Fair Contributions Policy Consultation 2010

- General agreement that users should be assessed to pay a contribution towards the cost of their care
- Work needs to be done to ensure benefits are maximised for users

Further information about each of these consultations can be found at <http://engage.barnet.gov.uk>.

Barnet LINK

Another way that service users and their families can share their experiences of local health and social care 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>

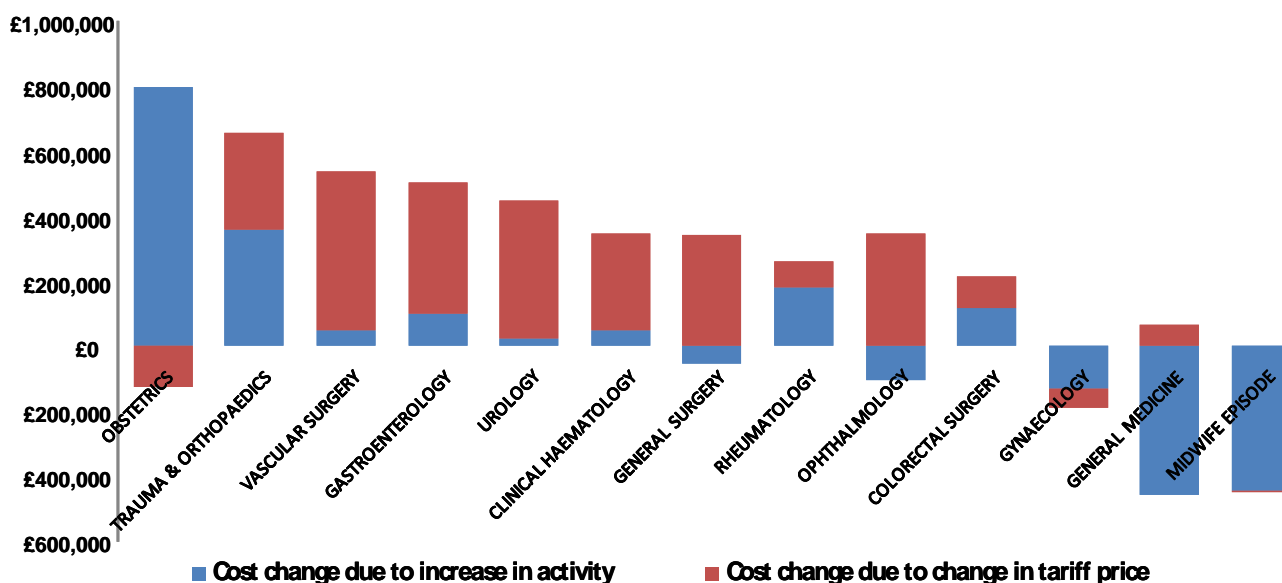
Changes in hospital activity and cost

Everything has to be paid for and the budgets available for both health and social care are finite. Public bodies are statutorily required to break even at the end of the financial year, i.e. not to spend more money than is available, and thus services have to be commissioned to provide the greatest benefit for the greatest number within available resources.

Most acute hospital services are charged at a national 'tariff' rate. Whilst this standardises the cost to commissioners for each activity there are still differences between hospitals because of (i) defining services differently, e.g. one hospital defining a procedure as an outpatient one and another as a day case one (the latter costing more), and (ii) differences due to a 'market forces factor', whereby hospitals sited closer to the centre of London uplift their prices because staff receive Inner London Weighting as part of their salaries. This latter difference means that the same procedure, which should be provided with the same quality, will cost commissioners more if a patient is treated in an inner London hospital than an outer London one. In addition, there have been increases in the national tariff prices for a number of acute hospital services.

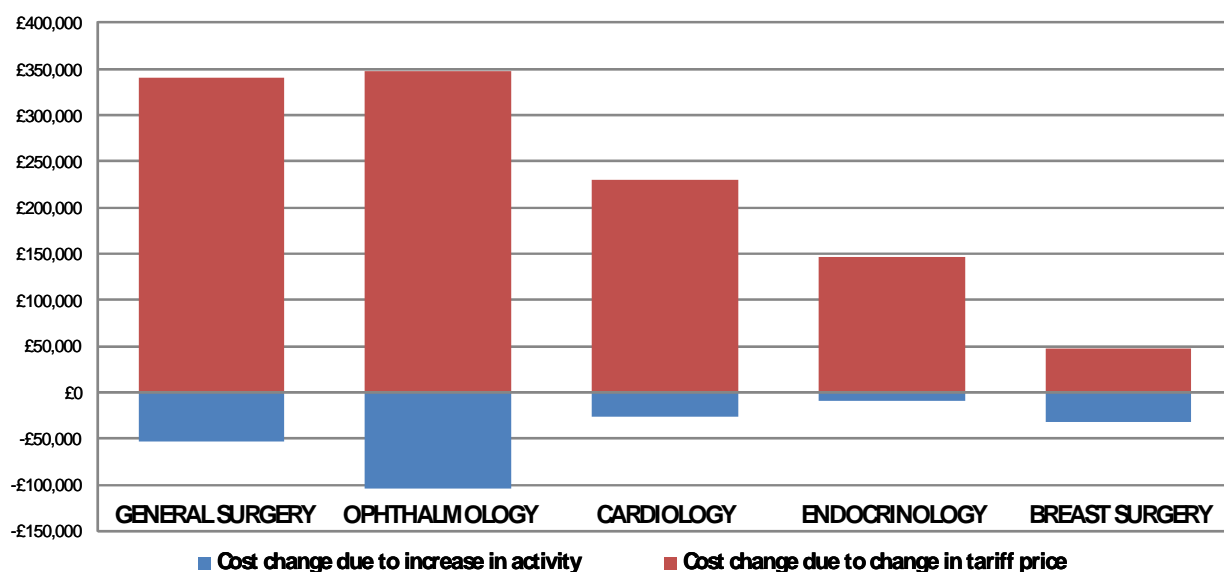
A review by NHS Barnet of activity at Barnet & Chase Farm Hospitals NHS Trust, the Royal Free Hampstead NHS Trust and University College London Hospitals NHS Foundation Trust from April 2009 to February 2010 and the same period in 2010/11 shows a 17% increase in cost to commissioners but only a 4% increase in outpatient attendances. Price increases accounted for three-quarters of the increased cost to commissioners and predominantly reflected changes to the national tariff.

Most significant cost changes in outpatient activities in the main acute hospitals serving the Barnet population, comparing April 2009 - February 2010 and the same period in 2010/11



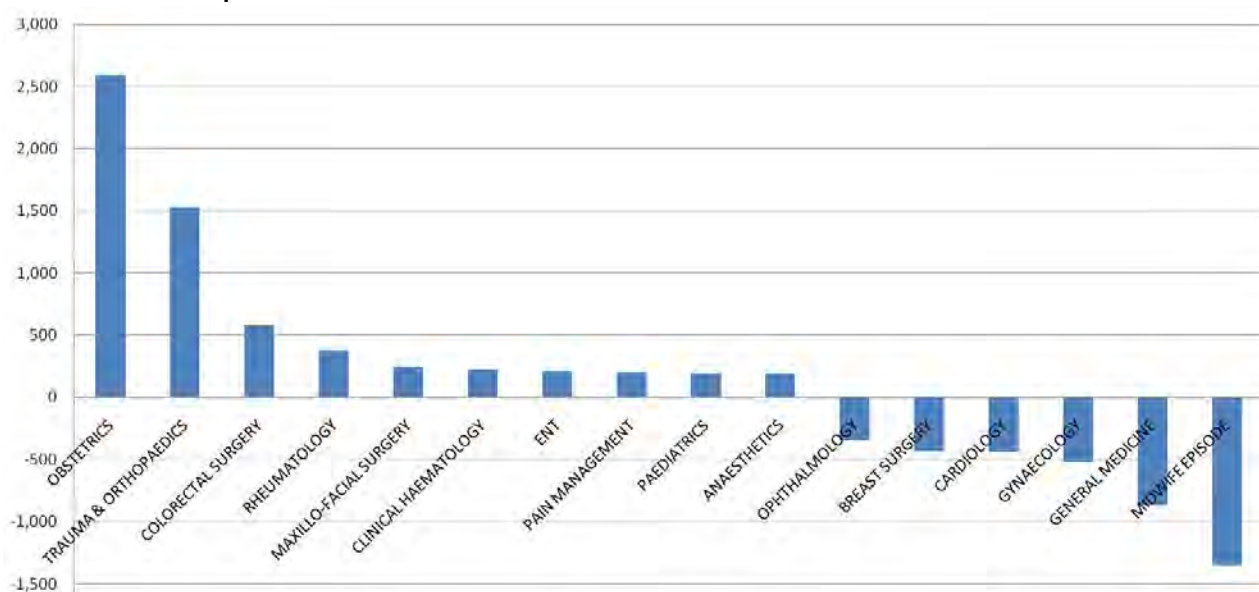
Another way of looking at this is where, in certain specialties, reductions in activity have been outweighed by increases in price.

Main specialties where reductions in activity have been outweighed by increases in tariff prices, comparing April 2009 - February 2010 and the same period in 2010/11



It is also noteworthy that in some specialties there have been significant changes in the number of people recorded as attending for a first appointment.

Changes in the number of people recorded as attending a first outpatient appointment, comparing April 2009 - February 2010 and the same period in 2010/11



For two reasons, obstetrics stand out. The first is an apparent shift in care from midwives to doctors. The second is that it seems that a disproportionately large number of attendances are defined as being first attendances. As this exceeds the number of births, it seems possible that there is a mis-coding of follow-up appointments (which have a lower tariff price) and that many of these are being mistakenly defined as being first attendances (which have a higher tariff price). It is also unclear what the clinical basis may be for an apparent switch of midwife activity to doctor activity (which also has price implications). These apparent anomalies do not seem to be occurring at all hospitals.

In order to ensure that care is provided in the most clinically and cost effective way, it is important that these changes in activity are understood more fully. Similarly, to ensure best value for money, it is also important to identify how safe and effective services can be provided in the most cost-effective way, which

Barnet Joint Strategic Needs Assessment, 2011

may necessitate shifts from acute hospitals to community-based care, including the provision of more services in a primary care setting, and changes in the pathway of care.

Pressure on social care and support services

Social care services meet the needs of people with disabilities, experiencing mental health problems, or struggling to cope with old age. Indicators of the some of the people who could potentially require social care services are given in the table below:

People aged 18 to 64 estimated to have a moderate or serious physical disability	20,726
People aged 18 to 64 estimated to have a learning disability	5,355
People aged 18 to 64 estimated to have two or more psychiatric disorders	15,824
People claiming Disability Living Allowance as at May 2010	11,360
People claiming Incapacity Benefit as at May 2010	8,700
People aged 65 or over estimated to have a limiting long-term illness	20,359
People aged 65 or over estimated to have a fall	13,146

Out of the numbers identified above with disabilities or potential social care needs, a relatively small proportion actually access care and support from Barnet social services. During 2009/10, 7,365 adults within Barnet received a package of care. Those not accessing social services may be purchasing their own care themselves, coping with their needs either by themselves or with the help of friends or family, or benefitting from the support of Barnet's voluntary sector. Indeed, compared to other boroughs, Barnet Adult Social Services provides care to a relatively small proportion of the population, indicating both a strong and cohesive voluntary sector operating in Barnet but also perhaps a greater ability and willingness for people to purchase care themselves.

Disability and incapacity benefits can support people to stay out of formal social care services, or can help individuals with the costs related to their condition that exist outside of the social care package they may be receiving. Analysis shows that greater proportions of the population receive Disability Living Allowance and Incapacity Benefit in the North and West clusters.¹⁸⁵ To a lesser extent, this trend is reflected in the proportions of the population receiving social care from Barnet Council, indicating relatively high levels of wellbeing and support structures in the South of the borough.

Adult Social Services

During 2009/10, Barnet Adult Social Services dealt with 9,774 referrals, of which 2,918 resulted in assessments of individual need. Despite a 5% increase from the year before in the level of referrals, there was actually a 12% decrease in the number of assessments, and reflects the filtering mechanisms that are used to screen people at the point of referral to ensure that the most vulnerable are eligible for social care. The remaining 6,856 referrals were either given advice or information at the point of referral, or referred onto an alternative support organisation for help. This screening process makes it imperative that Adult Social Services works effectively with partner organisations and a range of voluntary organisations to ensure that moderate to lower-level needs are met in the community.

Referrals to and assessments of Adult Social Services users

	Referrals to Adult	Number that led to an	Number that were dealt

¹⁸⁵ Benefits data from Nomis website

	Social Services	assessment of need	with at point of referral
2006/07	10,443	5,310	5,133
2007/08	9,525	3,406	6,119
2008/09	9,347	3,316	6,031
2009/10	9,774	2,918	6,856

Of those actually receiving a service in 2009/10, nearly two-thirds were aged 65 or over. As opposed to the trend in the general population, this proportion has been steadily decreasing over the last five years, primarily because it is amongst this demographic where this screening mechanism has been most effective. The chance of someone requiring adult social care still massively increases in the older age groups, as shown in the table below, with over 30% of Barnet residents aged 85 or over receiving care in the last year.

Numbers receiving a care package from Barnet Adult Social Services, 2009/10

	18-24	25-44	45-64	65-74	75-84	85+
Number receiving social care package during 2009/10	245	981	1,369	808	1,592	2,370
<i>Per 10,000 population</i>	<i>87</i>	<i>88</i>	<i>172</i>	<i>348</i>	<i>953</i>	<i>3,038</i>

Amongst those service users aged under 65, numbers are split roughly evenly between those with a physical or sensory impairment, those with a learning disability, and those with a mental health problem. Within Barnet, we provide services to proportionally more adults with learning disabilities than found in other boroughs, with a particular concentration in the North cluster – the reason for these high numbers is unclear, but may relate to the supply of high-quality learning disability services within the borough. There are also a proportionally higher number of older people with dementia or mental health problems accessing services in Barnet.

The department works hard to engage the broad range of ethnic and cultural groups found in Barnet, to ensure that all residents have access to effective advice and information, and support and services if and when required. On the whole, the people receiving services are reflective of Barnet's diverse population, and amongst some services or care groups Black and minority groups are indeed over-represented. However, there is evidence to suggest that Chinese residents resist accessing social care services until points of critical emergency, which could be detrimental to long-term health and wellbeing, as well as costs. Data also highlights higher than average proportions of white service users in residential and care home settings, potentially explained by the strong family support structures traditionally associated with BME communities.

The spread of social care users across the borough broadly reflects the spread of wealth in Barnet – many residents who do not qualify for funded support from Barnet choose to bypass the council completely and purchase their own care privately. The exception to this trend is in Colindale and West Hendon, where deprivation is quite high but social care numbers are broadly in line with the rest of the borough.

The services provided to users has shifted in recent years from residential and nursing care services to providing people with services in their own home and in their own community. This is as a response to people's desires to remain independent for as long as possible, but also to protect against the risk of

people becoming institutionalised in long-term care. The embodiment of this policy is the use of direct payments and personal budgets so that service users can decide themselves how best to spend a particular allocation of money. Within Barnet, the take-up of direct payments has been particularly high, especially among ethnic minority groups, , including Chinese residents.

Despite this trend towards home and community provision, residential care placements remain a significant part of Adult Social Services' expenditure. In 2009/10, 15% of Barnet's users aged 65+ were in a residential care home, compared to an average amongst our borough's comparator group of only 10%. These placements accounted for over a third of spending on services for older people, and nursing care accounted for another 13% of spending. Whilst this indicates relatively high admission rates in Barnet, it does also suggest that Barnet's work and resources are focused on those residents with the greatest need.

The residents that access support from Barnet social services have tended to remain fairly consistent, with the majority of users receiving long-term care packages rather than short interventions of care as and when needed. Indeed, amongst users aged 65 or over, the majority of users only stop receiving services when they die. Compounding this issue, social care data reveals that people coming into the system account for just a small proportion of the department's budget each year, and that the vast majority of spend (over 95%) is involved in providing care packages to those already in the system. Amid a rapidly ageing population and tighter budgeting, Adult Social Services thus faces a real challenge on how to support users to help themselves and make full use of the support services and facilities available out in the community.

One way we are helping people to help themselves and be more independent is through enablement services. Although some people go from receiving no social care support straight into residential or nursing care, the majority of people enter social care requiring some form of support within their own home. Adult Social Services thus recently changed the way that adults come into the 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 re-gaining 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.

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 and public, voluntary and private sector bodies supply them. 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 market overall 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 2011 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 physical and mental ill health. This creates an individual personal burden, increases demands on health and social care services and undermines 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, around a half of which are registered as 'dementia beds'. Barnet social services purchases just over a quarter of available beds in Barnet, 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. Nearly a half of residential homes and beds within Barnet are located in the North cluster, although homes and beds with nursing facilities are concentrated in the South cluster.

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 option as a main menu option. We also know that 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.

Housing care and support

Housing is now a crucial component of the care system as accommodation, care and support continues to be disaggregated. Housing related support funded through the Supporting People programme is focused on maintaining independence and supporting stable accommodation arrangements for adults in the community who experience a range of difficulties including disability, mental health problems, domestic violence, substance misuse and homelessness. After a consistent year-on-year rise in the numbers of people supported through these arrangements, 2009/10 saw a fall for the first time in the programme's history, with the number of new client forms received dropping 23% to 1,559. In that year, 81% of new clients in Barnet received floating support (the support goes to where the need is), whereas in London an average across boroughs was only 42%. The other key difference is that only 14% of Barnet's new clients

received supported housing (where support is linked to specific housing options), compared to a London average of 31%.

One of the fundamental elements of good Public Health is effective management of waste – a particular problem in (sub)urban environments. To meet this need, Barnet Council has outlined a policy for **dealing with our waste** which promotes waste minimisation and links to the North London Waste Plan.

Barnet Council's **Private Sector Housing Team** (PSH) plays a key role in helping residents to remain safely in their homes and live independently by the provision of adaptations through **Disabled Facilities Grants**. These adaptations enable freedom of movement in and around the home as well as the provision of essential facilities. Examples of adaptations provided include stair lifts, level access shower, widening doorways and ramps. In 2010/11, a total of one hundred and sixty seven disabled residents were provided with an adaptation and this has seen an increase of thirty nine since the previous year. This work is closely linked to the prevention of slips, trips and falls in the home as well as seeking to prevent admissions to residential/nursing care or hospitals. The team also has an in-house Home Improvement Agency Barnet Care & Repair partly funded by Supporting People to help applicants to undertake necessary adaptations or to complete work so that they can live safely at home. In 2010/11 four hundred clients received significant assistance from this service.

PSH regulates private sector accommodation, including Houses in Multiple Occupation, and ensures a safe, decent, adequate and accessible standard of housing. Accommodation is assessed in terms of any health and safety hazards, serious disrepair or nuisances which are present. The service received one thousand and twenty eight complaints regarding private sector housing conditions 2010/11. In 2010/11, PSH reduced eighty nine category 1 hazards (the most serious hazards) in relation to excess cold e.g. no heating and twenty six in relation to damp and mould e.g. extensive penetrating dampness (closely linked with excess cold). The statistical evidence shows that there is a continuous relationship between indoor temperature and vulnerability to cold related death – the colder the dwelling, the greater the risk. In 2010/11 one hundred and fifteen private sector properties occupied by vulnerable persons were assisted through Decent Homes grant assistance.

PSH run a **Handy Person Scheme** with Age UK Barnet. This service assists clients with small jobs around the home. The work carried out by handyperson schemes can help local authorities to reach vulnerable clients much faster. These schemes can also assist health service providers to reduce hospital admissions of older people having accidents. Carrying out minor repairs prevents hospital admission from falls and accidents in the home. In 2010/11 this assisted one thousand three hundred and fifty eight clients.

Safeguarding, personal dignity and respect

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

Vulnerable adults

Vulnerable adults in receipt of social care services experience a higher prevalence of abuse and neglect than the general population, which is why the safeguarding service provided by the council is so important for protecting social services users. Referrals into the Adults Safeguarding Team have increased steadily over the last few years, from 289 in 2007/08 to 420 in 2009/10, reflecting focused efforts to raise awareness of the service and improve procedures. During 2009/10, 41% of alleged abuses were committed by friends or relatives of the vulnerable adult and 32% were committed by care workers.

Referrals to Adult Safeguarding Team, 2009/10

Older People	Learning Disability	Mental Health	Physical and Sensory Impairment	Combination
166	95	83	41	35
40%	23%	20%	10%	8%

Source: Barnet Council Adult Social Services

Investing in independence – Opportunities for preventative interventions

Projected needs

The JSNA is as an opportunity to explore and understand the needs of users of the health and social care system and to understand and map key health trends locally. We also need to understand what keeps users well and functioning and use this information to support strategic prevention.

Although health and social care overlap in many ways, and many people interact with health and social care services (either consecutively or at the same time), assessing and projecting need across the entire health and social care sector can be very difficult. Entirely separate information systems, and different processes for recording in and managing those systems, means that it can be challenging or even impossible to identify the same person on different systems, let alone consider their needs holistically to make predictions for the future.

Early work has been started though to map people across both systems, and a feasibility study carried out by the Nuffield Trust outlines both the capability of such an approach, as well as some key outputs:

- a predictive model to assess an individual's future need for health and social care
- early identification of high-risk individuals and targeting of preventative care
- more accurate forecasting of future care needs and costs.¹⁸⁶

An analysis of hospital admissions data between April 2009 and June 2010 showed that 5,510 admissions related to one of 18 health conditions identified as potentially not requiring inpatient care. Of the patients involved, 19% overall and 36% of those aged 75 or over were found to have received an adult social care package during the same 15 month period. This piece of work will be extended to look at patient journeys through the two systems, but clearly with such a degree of overlap it is vital that we start looking at needs, outcomes and costs across the entire system of care.

Within Barnet there are large numbers of people that might class themselves as being disabled. Using the Projecting Adult Needs and Service Information (PANSI) prevalence model, we estimate there to be 20,726 adults in 2010 aged 18 to 64 with a moderate or serious physical disability, 5,355 with a learning disability, and 15,824 with two or more psychiatric disorders. In the next ten years, these numbers are projected to increase by 11.9%, 8.4% and 8.3% respectively.

On the whole, these projected increases assume prevalence rates to remain constant, with projections tied to generic population growth only. There is however some evidence to suggest that prevalence rates are increasing. A greater proportion of young disabled individuals with complex health needs are surviving childhood and moving into adulthood. In addition, prevalence rates of learning disability are higher among certain South Asian ethnicities, perhaps as much as three times higher than for non-Asian groups. This is particular pertinent if we consider that projected growth in the Pakistani and Bangladeshi communities is more than double that for Barnet's population overall.

Older people

As examined in Chapter Two, Barnet is projected to have some of the strongest growth in elderly residents out of all London boroughs over the next five to ten years. This older population are more likely to suffer from chronic and long-term conditions and are also more likely to suffer from falls and fractures. It is important that episodes of medical treatment are used as opportunities for people to improve their ability to

¹⁸⁶ Predicting social care costs: a feasibility study, The Nuffield Trust, 2011

look after themselves and therefore return home safely. 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. An ageing population in Barnet means that the Projecting Older People Population Information (POPPI) system projects these figures to increase by more than 20% over the next ten years.

One way we are promoting independence 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 re-gaining 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.

Learning disabilities

Out of an estimated 6,366 adults in Barnet with a learning disability (1,302 moderate or severe), a total of 805 received a care package from Adult Social Services during 2009/10. This user population tends to be fairly stable - only nine per cent 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, for a number of reasons:

- 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.

Mental health

In Barnet, 4,040 people are on incapacity benefits related to mental health issues, constituting 46% of the total number of claimants of incapacity benefits (May 2010 figures). Of these 4,040 people, 98% have been claiming benefits for at least 12 months, and nearly two-thirds have been claiming for at least five years. The proportion of people claiming due to mental health reasons has actually increased year-on-year for the last ten years, even though numbers of claimants both for mental health and overall has dropped quite sharply over recent years.

The link between mental health problems and unemployment is 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 seven per cent 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 benefits of employment to general mental health are clear – in providing purpose and structure, developing relationships, and building confidence and self-esteem. Thus

the public sector should be working better to improve education, employment and training prospects for people with mental health issues.

Despite concerns over data accuracy and recording, there appear to have been large increases in recent years in numbers of people with dementia accessing social care support from the council. Expenditure on dementia users overall has also increased, although spend per head appears to have dropped. This is partly explained by new cheaper homecare contracts, but lower average costs in other service types, particularly nursing care, may be explained by later admission dates facilitated by greater support out in the community.

Numbers and costs of people with dementia accessing social services

	2007/08	2008/09	2009/10
Number of users	265	319	379
Average committed expenditure per user	£18,048	£17,219	£15,339

Source: Barnet Council Adult Social Services

Preventable hospital admissions

Work was recently carried out in Barnet to examine the profile of emergency hospital admissions for a number of conditions identified as potentially preventable, in terms of being treatable at home or in the community, or a preventable episode in the first place. Conditions included were dehydration and gastroenteritis, influenza and pneumonia, and urinary tract infections, or combinations of these.¹⁸⁷ The study identified 2,605 potentially preventable hospital admissions for Barnet residents in a 15-month period (April 2009 to June 2010), with each admission leading to an average stay in hospital of ten days. Older people make up nearly two-thirds of these admissions, and remain in hospital on average for much longer than younger patients.

The study found that 27% of the patients overall, and 42% of those aged 75 or over, had received an adult social care package during the same 15-month period. The majority of these received community packages such as home care, attendance at a day centre, meals at home, or assistive technology and equipment. The study raises questions about the timeliness of social care interventions, health and wellbeing training amongst social care providers, and the use of community and voluntary services to promote wellbeing amongst older people.

Significant numbers of admissions also came from care homes, particularly if we include those care home placements either funded privately or by other local authorities. Around a half of these come from residential care homes without nursing, where there is a stronger element of providing social care support. Perhaps more is needed to promote healthy living and wellbeing in these settings, and staff at these homes might need additional support or guidance on how to deal with particular health-related problems within the care home.

Preventable hospital admissions in Barnet and relationship to social care provisions

Age	65-74	75-84	85+
Preventable hospital admissions in 15-month period	282	671	743
% receiving a Barnet social care package in same period	22%	39%	45%

¹⁸⁷ Any admissions involving any health condition in addition to the three detailed were excluded from the analysis

% in Barnet-funded residential or nursing care in same period	1%	9%	12%
% admitted from care home placement not funded by Barnet Council	6% to 12%	10% to 16%	14% to 25%

Source: Hospital admissions data from PUMA, matched against Barnet care data

This data helps illustrate some of the ways in which the health and social care sectors are intrinsically linked, but it is often difficult to assess needs and activity across this entire system of care.

Health and Safety

Nearly 30 million working days are lost each year in the UK due to workplace ill health and injury. The estimated economic cost of health and safety ill health incidents in Barnet is between £32.7 million and £50.1 million. The estimated cost for work place accidents in Barnet is between £18.9 million and £34.3 million. The workplace injury rate per year in Barnet was estimated by the Health and Safety Executive to be 357.8 per 100,000 employees in 2009/10. Many of these will require hospital attendance.

Working to improve the health of working age people by ensuring healthier and safer workplaces and promoting healthier lifestyles is a key strand of improving public and environmental health. The Council's **Environmental Health Team** has a major role to play in ensuring that everyone is protected from ill health and accidents arising from work activities. This involves a programme of inspections, accident investigations and advisory interventions aimed at:

- Sensible risk management of health and safety
- The improvement of health, safety and welfare standards
- A higher profile for health and safety.

Personal budgets

Personal Budgets help residents take control of their own social care budget, manage their own support and choose the services that suit them best. The model works by providing a clear, up-front idea about how much money there is for support, letting clients use the money in a way that best suits their own needs and situation, and provides support to help clients plan what they want and how to organise it.

The Department for Health's 2010 Vision for Adult Social Care outlines the government's ambition for personalisation as follows: "Individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care."¹⁸⁸

The move towards personal budgets frees users from a limited menu of options by making it easier for them to access services from a wider range of providers. Where personalisation has taken root, it works and is popular with users and carers. A report from the Office of Fair Trading showed that direct payments made people happier with the service they receive.¹⁸⁹ Two reports on individual budgets said people, including carers, enjoyed the enhanced control over their care.¹⁹⁰

¹⁸⁸ Department of Health, A Vision for Adult Social Services: Capable Communities and Active Citizens, November 2010, www.dh.gov.uk/publications

¹⁸⁹ Choice and Competition in Public Services: A Guide for Policy Makers (Office of Fair Trading/Frontier Economics, 2010)

¹⁹⁰ The National Evaluation of the Individual Budgets Pilot Programme (Social Policy Research Unit, University of York, 2008); Individual Budgets: Impacts and Outcomes for Carers (Social Policy Research Unit, University of York, 2009).

Locally, during 2010/11, 2,185 social services users benefited from personalisation, including:

- 117 direct payments to carers
- 395 direct payments to clients
- 1,673 client personal budgets.

This represents slightly more than 30% of Barnet social care clients receiving self-directed support, meeting the national target.

By giving clients control over where they spend their money, Personal Budgets create new opportunities for both providers and commissioners. For existing providers, this opportunity will be to expand or consolidate their offer. Small-scale voluntary and independent sector “microproviders” and social enterprises can offer community-based, affordable and niche support to individuals or small groups. Larger providers should be encouraged to offer more flexible community options, and care homes will see themselves increasingly as community facilities. All of this will support the development of a wider menu of quality options for clients.

In addition, there is an opportunity to grow the existing stock of providers, which local public services can support by promoting unmet areas of need and assisting entry to the market for new providers. Ongoing and open communication between all stakeholders is essential to ensure effective, sustained and responsive service delivery, investment in innovation, development of workforce skills and value for money. The introduction of more business development expertise would benefit the process of local market improvement. The following section highlights a number of innovative new models which have been prototyped locally.

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. Part of an effort to develop new and innovative ways of delivering services at a time when community need is growing in scale and complexity but resources are increasingly limited, this prototype involved local volunteers receiving training and resources to support members of their community without recourse to public services. The prototype took place in Grahame Park and was designed to tackle disadvantage by seeking to understand problems facing people and families on the estate, the connection between those problems and how they might be overcome.

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 is 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.

We are using our budget to expand a 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.

Barnet Joint Strategic Needs Assessment, 2011

We have estimated these using the Department for Education costing tool and work other authorities have already done, but are in the process of identifying actual families and we will run the model on their data. Participating partners then share in the rewards that accrue (or indeed bear the risk) and make a collective decision on how these are reinvested.

ⁱ National Audit Office. *Tackling Obesity in England*. National Audit Office, London. 2001