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Health & Wellbeing Board

Minutes of the meeting held 9.30 am on 18 January 2024
Committee Room 1, Hendon Town Hall, The Burroughs, London NW4 4BQ

Board Members present:

Councillor Alison Moore	Chair, Health and Wellbeing Board & Cabinet Member - Health & Wellbeing, London Borough of Barnet (LBB)
Councillor Pauline Coakley Webb	Cabinet Member for Family Friendly Barnet, LBB
Councillor Paul Edwards	Cabinet Member for Adult Social Care
Dr Janet Djomba	Deputy Director of Public Health and Prevention, LBB
Dawn Wakeling	Executive Director, Adults, Health and Communities, LBB
Chris Munday	Executive Director, Children & Families LBB
Colette Wood	Director of Integration, North Central London Integrated Care Board (NCL ICB)
Michelle Humphrey	Clinical Lead for Ageing Well, NCL ICB
Dr Louise Miller	Clinical Lead, Barnet Mental Health
Fiona Bateman	Independent Chair, Safeguarding Adults Board
Sarah Campbell	Healthwatch Barnet Manager

Others in attendance:

Claire O'Callaghan	Health and Wellbeing Policy Manager, Public Health, LBB
Dr Deborah Jenkins	Public Health Consultant, LBB
Seher Kayikci	Senior Public Health Strategist, LBB
Gabriel Johns-Mains	National Management Trainee
Judi Dumont-Barter	Healthy Heart Peer Co-Ordinator, Healthwatch Barnet
Dr Tim Lockie	Consultant Cardiologist, Royal Free London NHS Foundation Trust

1. Minutes of the Previous Meeting

RESOLVED that the minutes of the meeting held on 28 September 2023 be agreed as a correct record.

2. Absence of Members

Apologies were received from Dr Nick Dattani who was substituted for by Michelle Humphrey.

3. Declaration of Members' Interests

None.

4. Public Questions and Comments (if any)

None.

5. Report of the Monitoring Officer (if any)

None.

6. Deep Dive: Cardiovascular Disease Prevention in Barnet

Dr Deborah Jenkins presented the Cardiovascular Disease (CVD) Prevention Action Plan for 2024 and Barnet's CVD Prevention Programme 2022-2026.

CVD was noted to be the single largest area where premature mortality could be avoided over the next decade.

Although CVD mortality rate in under 75s in Barnet was lower than the London average, it could be reduced further. Risk factors for CVD vary considerably between borough wards with links to deprivation.

Significantly, CVD was preventable through community and primary care interventions and treatment of high-risk conditions such as hypertension, high cholesterol and atrial fibrillation.

The CVD prevention programme aims to help in the reduction of premature mortality in Barnet by targeting health inequalities across themes relating to geography, deprivation and populations at risk. The 2022-2026 CVD prevention programme has been designed to improve management of risk factors in community settings, primary and secondary care as well as care after discharge.

The June 2023 data on hypertension, atrial fibrillation and lipid lowering therapy was shared with the Board. It showed variations between Barnet Primary Care Networks (PCNs). There was not a consistent pattern of performance between PCNs, with the management of different CVD risk factors.
It was noted that hypertension had been proposed as a priority area by the NCL Integrated Care Partnership for 2024.

The strategic aims of the CVD Action Plan 2024 were divided between actions taken within community settings and healthcare settings. Within community settings, focus was placed on adult weight management services, physical activity, health screening in areas of higher deprivation and delivery of the National Diabetes Prevention Programme. Additionally, peer support to promote heart health to residents in ethnic minority communities as well as combating substance misuse in Barnet are strategic priorities.

Within healthcare settings, strategic aims included optimisation of smoking cessation services in primary and secondary care, increasing blood pressure checks amongst populations at risk and optimising annual health checks for people with learning disabilities and severe mental illness.

The use of data analysis would help monitor CVD prevention and outcomes in Barnet.
A multi stakeholder task and finish group would continue to be held quarterly to discuss CVD prevention and the action plan. Recommendations from the Board were sought to increase representation.

It was noted that a joined-up approach to CVD across the five London Boroughs with ambitions relating to hypertension, could improve overall outcomes within CVD.

Dr Louise Miller suggested that some form of measured targets in Barnet might be useful. It was noted that the available CVD data in relation to mortality rates was slightly outdated.

Dr Janet Djomba reiterated that numerical and KPI targets were essential even though difficult to set in relation to complex issues. Therefore, collaboration amongst partners around target setting would help to achieve desired outcomes. Dr Djomba welcomed suggestions from partners on how to work together to approach target setting.

Chris Munday queried whether outcomes included the younger population to prevent long term CVD. Dr Jenkins said that work was being done with children and young people around weight management and smoking cessation support for pregnant women and could be strengthened further. It was agreed to add children and young people health promotion action to the CVD Prevention Action Plan 2024. Kathleen Isaac also offered to work with Dr Jenkins on what CLCH NHS Trust could do to support.

Healthy Heart Peer Support Project
Judi Dumont-Barter presented the item highlighting the Healthy Heart Peer Support project, which works to offer peer support for high blood pressure and heart health, particularly amongst African, Caribbean and South Asian communities.

The multi session programme offers information and support that is culturally competent. Delivery of interventions and monitoring were being undertaken. Full sessions covered the importance of managing blood pressure with the help of nutritionists. Collaboration with Fit and Active Barnet has taken place to increase physical activity.
Central guidance was developed as a resource, which has been translated into other languages to help people with self-management and support.
More individuals than anticipated had been engaged with as part of the Healthy Heart Project. Brief interventions and extended interventions were being delivered for heart health promotion.

Results from post course questionnaires helped identify behaviour changes to further the development of the intensive programme, including addressing language barriers.
Behaviour change methodology, self-monitoring and community engagement enabled joint understanding of how best to support individuals and to continue raising awareness.

Core20 Connectors
Sarah Campbell (Healthwatch) presented the Core20 Connectors outreach project which aimed to raise awareness of high blood pressure.

It was noted that the project allowed Healthwatch Barnet Champions to challenge residents' and patients' views and to work with service providers to make improvements based on the feedback received.
In relation to Barnet, 967 blood pressure tests were carried out targeting particular populations. Four trained community connectors were recruited on a freelance basis to carry out blood pressure tests and to explain readings. British Heart Foundation leaflets were offered to individuals of concern and signposted to local pharmacies or GPs accordingly.

Events were held for those who were identified as being marginalised. In terms of demographics, outreach work was done to increase participation at affordable gyms.

Some people with higher blood pressure readings fed back that they would take recommended actions either through more exercise or seeing a health professional. Barriers to behavioural change included factors such as the cost of living and stress.
It was highlighted that there was a lack of awareness of the NHS Health Check service available to anyone over the age of 40. The touch point service advocated on behalf of those who required translator services. Without that support, people would not be accessing the service due to a lack of awareness. More publicity around the provision would prove to be valuable.

Those who participated in these community projects were able to build connections and trust with those they were supported by. It was suggested that the programme could be improved by following up with groups of people to ensure that individuals were carrying out the actions identified. However, checking up on behaviour without support would be a challenge. Patient Participation Groups that should be part of all GP practices would be able to encourage their respective practice to promote checks.

CVD Prevention and Management
Dr Tim Lockie, Consultant Cardiologist, presented the item on CVD Prevention and Management in secondary and tertiary care.

Cardiology at the Royal Free London comprises of five sites across NCL including Barnet Hospital, and receives over 30,000 referrals to Cardiology, over 2000 inpatient admissions and has the busiest 24/7 Heart Attack Centre in London.

Prevalence figures for CVD at the Royal Free Trust and surrounding areas remained higher than the national data. Therefore, consolidating cardiology and vascular

services into a single Cardiovascular division at the Royal Free London (RFL) allowed for scale and resilience as part of its long-term strategy.

The RFL Strategy outlines education on how CVD impacts health and wellbeing at different levels of intervention from primary to specialist care.
Key developments in the treatment of heart failure, has led to an improvement in quality of life and mortality figures.

Heart failure has been an enormous cost to the healthcare budget and 2% of the entire NHS budget.
Statistics show that approximately 80% of new heart failure diagnosis has taken place in secondary or tertiary care which highlights opportunities of early identification at the primary care stage. Medications have proven to make a huge difference in reducing mortality and demonstrable impact on preventing hospital admissions.

There has been a problem in the UK with 30% of patients with heart failure dying at year 1 and 10% per year thereafter. Variances between boroughs were an indication of high deprivation within some areas.
The Heart Failure Clinical Practice Group is championing standardisation of care, evidenced based interventions and digitalisation for which general practice groups have been set up.

A pilot study was carried out in in Camden which identified patients who were at risk of heart failure and enabled early intervention through testing.
Mega-clinics have been set up through community connected care comprising of a variety of health professionals to carry out blood testing, electrocardiograms (ECGs) and echocardiograms (echos), the data from which would be collated centrally and escalated further when necessary. The pilot was successful in improving outcomes for 30 patients and in reducing the number of referrals. Patient feedback showed that anxious individuals felt informed and reassured.

The top priorities identified as chronic cardiac conditions were heart failure, atrial fibrillation and cardiovascular secondary prevention risk factors. The multistep process could be adopted to include screening and optimisation, leading to improved outcomes.

Future work plans, led by the RF, include bringing together pilots in Barnet, Camden and Haringey by developing common pathways. They have received £600,000 from the NCL ICB for this. The work aims to provide excellent care which has scalability and implementation through community screening and digitalisation.

Dawn Wakeling suggested that the Royal Free joined up with Fit and Active Barnet services via community and public health initiatives. Dr Lockie said that part of community care was to engage patients by joining up services to create opportunities particularly in relation to understanding those of different cultural backgrounds so as to make connections.

It was noted that a significant number of people who were homeless or whose first language was not English, may not be attending health appointments, reading letters from their GPs or were not being cared for.
Fiona Bateman pointed out that in relation to discharge, patients could be signposted to support services, with a focus on people who were not engaging with primary or secondary care.

It was noted that the steering group led by Dr Jenkins on CVD prevention would be a good place to start to make necessary connections.

The Chair said there were many different levels of activity in our community and health economy so the more these were joined up to increase impact, the better it would be for the population and more effective from a health perspective.

It was highlighted that there was a lack of awareness of heart failure and other CVD and that provision of more information about CVD and related services to reach the wider public was needed. The Chair agreed that more thought could be given to promotion and communications.

<u>CVD Prevention in Primary Care</u>
Michelle Humphrey and Collette Wood presented the item.
Opportunities for smoking cessation were available in both healthcare and community settings.
Automatic prompts on electronic records for healthcare staff posed questions about smoking and signposted people to smoking cessation services.

Interactions with community pharmacies were also available to support screening or interventions. In primary care, high risk patients are invited annually for monitoring as part of early intervention when needed.

The Long Term Conditions Locally Commissioned Service (LTC LCS), recently introduced by NCL, includes case finding and management. It aims to reduce variation, to provide consistency of practice across NCL. A targeted approach to treatment of long-term conditions and a universal offer cover a wide range of conditions. The LTC LCS could be a key enabler in sharing best practice, improvement in PCNs and engaging primary care in collaboration with the voluntary sector.

KPIs would help monitor the numbers of people with heart failure on the register, the use of beta blockers and review of post cardiac treatment.
Initial pilots around neighbourhood working was underway to focus on complex groups of people.

The Chair thanked all the speakers for a meaningful deep dive discussion.

Resolved that the Health & Wellbeing Board

1. Notes the report and appendices B, C and D

2. Approves the updated Cardiovascular Disease Prevention Action Plan 2024 as outlined in Appendix A

7. Fit and Active Barnet - Year 1 Progress and Year 2 Action Plan (April 2024)

David Walton presented the item on the Fit and Active Barnet framework. The strategy involved creating a more healthy and active Borough and was split into health, education, faith, voluntary and sport sections facilitated by Barnet Council.

With the continually changing landscape, the FAB framework was refreshed to incorporate connections with the emerging Culture Strategy and development of a new Parks and Open Spaces Strategy.

Resolved that the Health & Wellbeing Board note the contents of the report and the achievements to date of the Fit & Active Barnet Framework.

8. Dementia Friendly Barnet (update)

Seher Kayikci highlighted that becoming a dementia friendly Borough meant that people living with dementia were understood, respected and supported as well as included in community life and their contributions recognised. Key action areas adopted from the Alzheimer's Society, included dementia friendly values.

The 2022 action plan received formal recognition from the Alzheimer's Society as a Borough working towards becoming dementia friendly.

Gabriel Johns-Mains summarised the key action areas of the plan. The Mayor's Dementia Friendly Venues Charter was adopted to support the arts, culture, and leisure with 21 venues signing up to the scheme.

Linking with Faith communities helped combat individuals in isolation brought about by dementia. In connection with Faith Action and the Barnet Multi Faith Forum, the Dementia Friendly Faith Communities self-assessment framework was created.

Four businesses on the high street have signed up to the dementia friendly initiative. A more targeted approach would be used to prioritise areas with ageing populations.

It was noted that 21 venues have signed up to the Dementia Friendly Venues Scheme with significant interest from more venues.
More than 15,000 people have become Dementia Friends in Barnet including Councillors and Council Officers.
The Understanding Dementia training has been commissioned by Public Health and sessions have been successfully delivered throughout the year.

Risk reduction messages have been communicated in collaboration with Age UK Barnet and Barnet Carers. Living Well with Dementia leaflets have been created to help support those living with the condition and where to access key services.
To promote the importance of becoming a dementia friendly borough, information has been circulated to venues using magazines, newsletters and social media. Work

was underway on creating a new Dementia Friendly brand for Barnet by joining up work done by Barnet Council and its partners.

In terms of strategic developments, recommendations to improve quality of life for older adults, taken from the Chief Medical Officer's Annual Report 2023 included reduction of disease, prevention of degenerative disease and change of environments.

The NCL ICB has welcomed ongoing collaboration with the five NCL boroughs to strengthen dementia friendly initiatives and by creating an NCL-wide Dementia Friendly Accreditation scheme to be launched in April 2024.

Future planned projects involve the Dementia Friendly Fire Service and Dementia Friendly Transport.

It was noted that training and links should be established with the local police to help manage distressed individuals with dementia.

Fiona Bateman suggested tapping into the Herbert Protocol introduced by the police in partnership with other agencies to encourage carers to compile useful information which could be used to help locate a vulnerable person if they go missing.

Councillor Edwards raised the issue around transport for older people especially those with dementia travelling with a freedom pass. Interesting work had been done in Doncaster involving working with bus companies and their drivers to improve awareness and develop good practice in transporting older people.
The Councillor enquired about progress data around early diagnosis which was found to be crucial in helping affected people.

Resolved that the Board notes and comments on progress towards making Barnet a Dementia Friendly borough.

9. Place/Borough Based Partnerships

Claire O'Callaghan presented the recommendations arising out of the discussion held with members of the Health and Wellbeing Board and the Barnet Borough Partnership.

Chris Munday highlighted that the delivery groups needed to be updated, to reflect the priorities. Chris Munday also suggested that the Healthy Child Programme be added to the Board's priorities, either as a standalone priority, or as part of the Children and Young People priority. The Chair confirmed that further discussion was required on this ask.

Fiona Bateman queried the role of the two different partnerships in relation to patient safety issues and how they would be monitored as well as delivery and oversight for improvement of services. It was confirmed that patient safety responsibility remained with statutory agencies and would not transfer to these partnerships.

The Chair said that the joined-up actions of the partnerships was crucial to maximising the impact across individuals and communities.

Resolved:

1. **That the Board reaffirms that both Health and Wellbeing Board and Barnet Borough Partnership are of joint importance at Place (Borough) level in relation to health priorities.**

2. **That the Board agrees the proposed delivery and enabling priorities, as outlined in section 1.5.**

3. **That the Board agrees the changes to how the Health and Wellbeing Board will operate, as outlined in Section 1.7.**

4. **That the Board notes the recommendations for Barnet Borough Partnership's future model of operation, as outlined in Section 1.9.**

5. **That the Board communicates to North Central London Integrated Care Board the recommendations for system level partners as outlined in Section 1.10.**

10. Barnet Borough Partnership (verbal update)

None.

11. List of Health and Wellbeing Board (HWBB) Acronyms

The Board noted the list of frequently used acronyms in HWBB reports.

12. Forward Work Programme

The Board noted the items due to be reported to future HWBB meetings

13. Any Items the Chair decides are urgent

The Chair notified Board Members the meeting scheduled for the 14th of March has been cancelled and the next scheduled meeting will take place on the 9th of May 2024.

The meeting finished at 12.05pm