Meeting
HEALTH & WELLBEING BOARD
Date and time
THURSDAY, 18 JANUARY 2024
At 9.30 AM
Venue
Hendon TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

To: Members of Health & Wellbeing Board (Quorum 3)

Chair: Councillor Alison Moore (Chair),
Vice Chair: Dr Nick Dattani (Vice-Chair)

Councillor Paul Edwards
Councillor Pauline Coakley Webb
Caroline Collier
Dr Tamara Djuretic
Sarah Campbell
Chris Munday
Debbie Sanders
Dawn Wakeling
Kathleen Isaac
Colette Wood
Fiona Bateman
Dr Joanna Yong

Substitute Members

Councillor Anne Clarke
Councillor Zahra Beg
Councillor Barry Rawlings
Michelle Humphrey
Janet Djomba
Anita Sheth
Carol Kumar
Sarah McDonnell-Davies
Kelly Poole
Ben Thomas
Jess Baines-Holmes

In line with the Constitution's Public Participation and Engagement Rules, requests to submit public questions or comments must be submitted by 10AM on the third working day before the date of the committee meeting. Therefore, the deadline for this meeting is Monday 15 January 2024 at 10AM. Requests must be submitted to Pakeezah Rahman, Pakeezah.Rahman@Barnet.gov.uk

You are requested to attend the above meeting for which an agenda is attached.

Andrew Charlwood – Head of Governance

Governance Service contact: Pakeezah Rahman 020 8359 6452
pakeezah.rahman@barnet.gov.uk

Media Relations Contact: Tristan Garrick 020 8359 2454 Tristan.Garrick@Barnet.gov.uk

Assurance Group

Please consider the environment before printing.

Order of Business

Item No	Title of Report	Pages
1.	Minutes of the Previous Meeting	5 - 14
2.	Absence of Members	
3.	Declaration of Members' Interests	
4.	Public Questions and Comments (if any)	
5.	Report of the Monitoring Officer (if any)	
6.	Deep Dive: Cardiovascular Disease Prevention in Barnet	15 - 102
7.	Fit and Active Barnet - Year 1 Progress and Year 2 Action Plan (April 2024)	103 - 112
8.	Dementia Friendly Barnet (update)	113 - 126
9.	Place/Borough Based Partnerships	
10.	Barnet Borough Partnership (verbal update)	
11.	List of Health and Wellbeing Board (HWBB) Acronyms	127 - 130
12.	Forward Work Programme	131 - 136
13.	Any Items the Chair decides are urgent	

Facilities for people with disabilities
Hendon Town Hall has access for wheelchair users including lifts and toilets. If you wish to let us know in advance that you will be attending the meeting, please telephone Pakeezah Rahman, Pakeezah.Rahman@Barnet.gov.uk. People with hearing difficulties who have a text phone, may telephone our minicom number on 020 8203 8942. All of our Committee Rooms also have induction loops.

Fire/emergency evacuation procedure

If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by uniformed custodians. It is vital you follow their instructions.

You should proceed calmly; do not run and do not use the lifts.

Do not stop to collect personal belongings

Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions.

Do not re-enter the building until told to do so.

This page is intentionally left blank

AGENDA ITEM 1

Health & Wellbeing Board

Minutes of the meeting held 9.30 am on 28 September 2023
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 - Family Friendly Barnet, LBB
Dr Tamara Djuretic	Joint Director of Public Health and Prevention, LBB and the Royal Free Group
Dawn Wakeling	Executive Director, Adults, Health and Communities, LBB
Chris Munday	Executive Director, Children & Families LBB
Deborah Sanders	Chief Executive, Barnet Hospital, Royal Free London NHS Foundation Trust
Colette Wood	Director of Integration, North Central London Integrated Care Board (NCL ICB)
Dr Joanna Yong	Clinical Lead for Children and Maternity, NCL ICB
Fiona Bateman	Independent Chair, Safeguarding Adults Board
Sarah Campbell (joined remotely)	Healthwatch Barnet Manager

Others in attendance:

Claire O'Callaghan	Health and Wellbeing Policy Manager, Public Health, (LBB)
Janet Djomba	Deputy Director of Public Health, Public Health (LBB)
Belinda Livesey	Private Sector Housing Manager (LBB)
Susan Curran	Head of Housing & Regeneration (LBB)
Nicola Bird	Housing Development and Regeneration Manager- Customer & Place – Regeneration (LBB)
Louisa Songer	Senior Public Health Strategist, LBB
Ellie Chesterman (joined remotely)	Interim Head of Commissioning: Mental Health and Dementia, LBB and North Central London ICB
Ian Sabini	Estates Managing Consultant, BP Partnerships
Seher Kayikci	Senior Public Health Strategist, LBB
Rachel Wells,	Consultant in Public Health, Public Health, LBB
Jayne Abbott,	Resilience Schools Manager, Public Health LBB
Muyi Adekoya	Head of Joint Commissioning - Older Adults and Integrated Care, LBB and North Central London ICB
Alexis Karamanos	Senior Public Health Intelligence Analyst, Insight and Intelligence, LBB

1. MINUTES OF THE PREVIOUS MEETING

RESOLVED that the minutes of the meeting held on 27 July 2023 be agreed as a correct record.

2. ABSENCE OF MEMBERS

Apologies were received from Councillor Paul Edwards and Dr Nikesh Dattani.

3. DECLARATION OF MEMBERS' INTERESTS

Dr Joanna Yong declared an interest in relation to item 12 by virtue of being a GP and partner at St Andrew's Medical practice.

4. PUBLIC QUESTIONS AND COMMENTS (IF ANY)

None.

5. REPORT OF THE MONITORING OFFICER (IF ANY)

None.

6. LIST OF HEALTH AND WELLBEING BOARD (HWBB) ABBREVIATIONS

RESOLVED that the Board note the standing item on the agenda which lists the frequently used acronyms in Health and Wellbeing Board (HWBB) reports.

7. HOMES AND THE IMPACT ON HEALTH OF RESIDENTS

Jane Djomba, Deputy Director of Public Health, introduced the item and talked about the importance of healthy homes and actions taken to reduce risks to health in relation to damp and mould. It was noted that healthy homes included a range of aspects to be considered such as living standards and air quality.

Kate Laffan, Director of Resident Services for the Barnet Group explained the management of the Council's housing stock and also of unsuitability of private homes in collaboration with the Council's private sector housing team, as well as the delivery of the statutory homelessness service.

It was noted that all aspects of the home environment were considered and strategies such as the Homelessness Health Action Plan were being developed to address the issues of damp and mould as well as unsuitable accommodation. Key initiatives included setting up the Barnet Homes Healthy Homes Team that was responsive and taking a proactive approach following recommendations from the Housing Ombudsman's report, 'It's not Lifestyle.'

It was noted that £2.2m per annum for the next four years to deliver works relating to damp and mould would include the recruitment of specialist contractors and reconfiguration of IT systems to monitor and capture data through the customer care contact team.
Training of all front line and technical staff would be undertaken, pertinent to carrying out their roles in the field. Surveyors with softer skills were vital to picking up nuances in relation to the home, particularly medical issues which could then be flagged up. The Housing Options team would take a holistic approach when inspecting properties affected by damp and mould.

The use of publicity campaigns which have proven to be successful in the past, would help reach tenants and leaseholders whilst providing online opportunities to increase engagement.
Barnet had successfully completed a stock condition survey of 100% of its properties via Savills following which repairs were progressed based on severity.

Belinda Livesey, Private Sector Housing Manager, spoke about the tenanted private sector. A pilot had been set up with Barnet Homes in relation to damp and mould around those who presented as homeless and who required swift responses to serious accommodation issues. The service was expanding audits to ensure standards of temporary homes were met in line with Barnet Homes recommendations.

Supportive conversations with landlords and tenants were being held to eradicate blame-based terminology. In addition, tenants were supported in understanding how their behaviour could help improve safety and living conditions. Due to an increase in complex cases, landlords had to abide by regulations in relation to licensing schemes and inspections to meet the required standards.

Nicola Bird, Housing Development and Regeneration Manager who worked with social landlords, housing associations and registered providers (RPs), said that the majority responded well to the expectations of the regulator by reviewing their policies and activities in relation to damp and mould. In Barnet, information was collated on particular activities and risk assessed. Nicola Bird presented the updated works of the largest RPs in relation to Barnet as part of the Council's performance review.

Louisa Songer, Senior Public Health Strategist, presented the Homelessness Health Action Plan which addressed health issues faced particularly by rough sleepers. It was noted that a homeless needs assessment resulted in the approved delivery plan and tracked progress of actions. Successful events included quarterly screening of vaccinations, TB vans and health checks which resulted in a positive uptake.

The substance misuse rough sleeping project had been successful, utilising grant funding to support those with multiple needs including accessing accommodation. The excellent multi-disciplinary service via the substance misuse provider CGL, in partnership with Barnet Homes and Homeless Action in Barnet has been delivering joint outreach services. Interventions were offered around specific needs including for those without recourse to public funds. The biggest challenges faced were around the delivery of primary care services for rough sleepers due to delays in a Locally Commissioned Service and inadequate care for broader needs such as cardiovascular issues. Another challenge was pending refurbishment works at Homeless Action in Barnet premises.
Despite good collaboration with Barnet Homes, challenges remained in relation to mental health pathways included the disconnect between strategic and operational levels and the need to tie in the dual diagnosis group with adult safeguarding. Lessons learned from the Safeguarding Adult Review showed a need for better collaboration and taking a more proactive approach to prevent deaths at an early stage in the process.

Susan Curran, Head of Housing and Regeneration, addressed the Board and talked about the ongoing progress and implementation plans for the newly approved housing, homelessness and rough sleeping and tenancy strategies.

The priorities of the Housing Strategy relate to the provision of safe and secure affordable homes for all residents to thrive. The strategy addressed a number of

administration commitments as well as challenges faced in the Borough. There was a short supply of social housing to meet the needs of the large population and an increase in homelessness, although this was also a national problem. The London Councils meeting highlighted a 30% increase in homelessness compared to last year. Another challenge was the complex needs of individuals who presented as homeless.
The new Housing Strategy has five themes which were developed in response to the current challenges including promoting healthy homes and preventing homelessness.

Susan Curran highlighted that the Homelessness and Rough Sleeping Strategies were informed by the Homeless Code of guidance. The key points presented was to address challenges in relation to a short supply of housing stock and intervention. Focus was needed on early intervention and implementation by having services spread around the Borough.

Fiona Bateman, Chair of the Adult Safeguarding Board, highlighted that one of the points arising from the Safeguarding Review, was a link between homelessness and domestic abuse. Referring to the statutory safer accommodation strategy, Fiona asked whether a link was made to a risk in homelessness as a result of domestic abuse, taking into account Violence Against Women and Girls (VAWG) and how that would be taken forward.
Kate Laffan said that funding was being sought through their dedicated domestic abuse team and work that was carried out was linked to the VAWG strategy. The highly skilled team was able to capture all data related to the victims. A one stop shop was being run regularly with a range of agencies to support survivors of abuse with suitable accommodation. In addition to Solace, a women's refuge has been set up along with regular training for staff. In relation to the perpetrator, programmes were underway for providing advice on accommodation.

It was noted that lessons learned around perpetrators in that specific case discussed at the Safeguarding Review, would be taken to the Strategic Leader in the Council.

Chris Munday, Executive Director of Children and Family Services, said that additional funding was available for culturally informed perpetrator programmes led by Barnet, details of which could be circulated to the Board. Chris Munday said that having close working networks in the Council on a whole range of issues was positive. Changes in policy meant that Care leavers, who were at risk, could not be made intentionally homeless. Hence it would be good to know about work done around them and young homeless people. It would also be useful to present information regarding damp and mould to the Safeguarding Partnership Board to strengthen links with health.

In relation to Barnet hosting five hotels for homeless people, Chris Munday asked whether there were particular concerns about the accommodation for asylum seekers and whether any more could be done by the Council.

Kate Laffan said that positively, a focus group was held with Care Leavers who were very engaged in shaping strategies with the Onwards and Upwards Team. That helped build better ways to communicate and to implement better pathways for Care Leavers. It was noted that many initiatives were taken for rehousing care leavers including those who had children and supporting their journey out of care. A family mediation role was also implemented to engage with those who excluded their young children particular those who were NEETs. A holistic approach was taken in linking services such as BOOST to help prevent homelessness by working with family members in order to improve their prospects.

Belinda Livesey said that accommodation for asylum seekers, particularly without cooking facilities, was not suitable on a long-term basis, especially for those with health issues and could not afford to travel to take their children to school.

Sexual harassment issues have also been flagged. Comprehensive management and enforcement of safety checks to prevent fire risks, overcrowding and pests or damp and mould were in place.
Louisa Songer added that the migrants' health needs assessment was another avenue to address and such issues could be reported back to the Board.

Dr Tamara Djuretic, Director of Public Health and Prevention suggested that the message on self-care be shared with colleagues in the borough partnership and primary care. The Housing Association route was a good opportunity to target the population at high risk on all health issues. Dr Djuretic asked whether any work been had been done to identify factors causing an increase in homelessness figures and to include other cohorts in supporting prevention.

It was noted that an information resource pack on damp and mould had been developed to be shared with wider partners as well as bespoke training. Although numbers in temporary accommodation had reduced significantly in Barnet, following the pandemic, a surge in demand was anticipated due to cost of living pressures and the consequent risk of evictions. Data was being analysed to understand those presenting as homeless and try to secure an adequate supply of good quality private accommodation. Under 2% of private sector properties were at local housing allowance level, meaning that property is unaffordable for many people. Teams of housing officers' ability to negotiate with private landlords was limited due to the increase of mortgage rates, which lead to higher rents.

Cllr Coakley Webb whether there was available data in relation to no fault evictions and rent increase, where those who presented as homeless was a direct result of actions taken by the landlord.
It was noted that landlords were not always transparent on reasons to evict. However, the data which had been captured relate to affordability and impact on rent levels for landlords. An opportunity to access a specialist resource within environment health would allow to address tenant complaints on condition of properties and to review the conditions within the property to support both the tenant and landlord enabling tenancy sustainability.

Debbie Saunders, Chief Executive Barnet Hospital, Royal Free London NHS Foundation Trust talked about adult respiratory clinics and that the information on damp and mould should be available in clinic to support clinician's in-house referrals when alerted on health issues. It was noted that staff at Barnet and Royal Free ED would be supportive in progressing actions relating to the delay in audit as highlighted in the action plan.

The Chair reiterated the importance of joined up services to minimise harm, supporting residents in giving them the confidence to support themselves with the help provided; the health and wellbeing of care leavers; as well as asylum seeker accommodations and homelessness by holding partners collectively to account on the implementation of the outstanding actions within the plan.

RESOLVED hat the Health and Well-being Board

1. **Notes and comments on the Deep Dive update in Appendix A.**

2. **Comments on how the challenges on the Homeless Health Action Plan can be overcome.**

3. **Discusses and inputs into the implementation plans for the Housing Strategy and Homeless and Rough Sleeping Strategies.**

12. PRIMARY CARE UPDATE: BI-ANNUAL REPORT

It was agreed that the order of business be changed. Therefore, item 12 was considered before item 8.

Colette Wood, Director of Integration, NCL ICB, updated the Board in relation to access to primary care which became a top priority for patients, ICB and all health partners pre and post pandemic. Key focus was on improvement of digital access to general practice including online consultation, cloud telephony and use of the NHS app. A new hybrid model for delivery of primary care needed further development.

Dr Joanna Yong spoke about contractual priorities and mechanisms for improvement namely the Capacity, Access and Improvement Project (CAIP) funded and supported through NHSE. Accelerated programmes were formed to provide practical support to improve access through capacity and workforce, whilst reviewing different ways of working.

Colette Wood explained ongoing work in the ICB alongside PCNs, of gathering data from 48 GP practices to obtain a range of indicators including patient satisfaction which would help identify practices that were doing well, those that required support and those that were struggling. The upcoming Adults and Health Overview and Scrutiny task and finish group would provide the opportunity to invite patients and residents to highlight their experience in order to improve the triage systems. The Barnet wide patient participation group (PPG) also helped communicate how general practice has changed and the range of opportunities to access services within general practice.
Winter challenges meant that current practices had to be built upon collaboratively with partners to deliver better responses such as acute respiratory hubs and ring-fencing appointments around the cohort of patients requiring intensive input.
Dr Yong added that GP survey results were being reviewed to understand what patients wanted and how communications had evolved at a practice and PCN levels.

Ian Sabini, Estates Managing Consultant, NCL Estates, spoke about the importance of infrastructure in providing good quality estates in the right place and increasing access. Infrastructure assessments that were due to be completed by the end of the financial year, would identify priority projects in the borough and North Central London. The Colindale Integrated Hub, Brent Cross Regeneration Scheme and the refurbished health facility in Torrington Park were opportunities to embed general practice, community services and outpatient services into the community.
An annual capital prioritisation process identified priority schemes for the next financial year in relation to population growth and demand. Significant capital was agreed with the ICS to be invested into primary care.

The Chair reiterated the for allocating funds to prevention and early intervention as this would ultimately ease pressure of acute services. The Chair said that challenges around premises structure and facilities and its role in practices, could either help or hinder additional work relating to community and preventative medicine.

RESOLVED that the Health and Wellbeing Board note the primary care and NCL Joint Capital Resource Plan update.

8. BARNET MENTAL HEALTH CHARTER

Ellie Chesterman, Interim Head of Commissioning; Mental Health and Dementia, presented the item. The Chair emphasised the importance of a deep dive on mental health at the previous meeting to help further the aspirations of Councillors and partners in this area within the community.

Ellie Chesterman said that the Charter was an administration commitment to build upon the work already being done during and after the pandemic and having honest conversations on mental health and its impact on wellbeing.
The Charter had been coproduced alongside partners and with residents of all ages. Focus groups were set up including one with young people via Young Barnet Foundation and commissioned by Family Services. Positive feedback was received from young people who felt that they were being listened to, and that the importance of having access to timely support and tackling stigma around mental health was similar to that expressed by older contributors. Over 200 people were involved in the process, half of whom were children. Feedback included the importance of peer support, access to crisis provision, accessibility to services and waiting lists. Using a holistic approach, the Charter was developed to refine the language and there are plans to develop a child friendly version.
Important next steps involved launching the Charter and raising awareness of it, as well as ensuring that organisations have pledged to deliver aspirations of the Charter. In line with coproduction, the monitoring of progress would be assisted by a person with lived experience of mental health and progress would be reported back to the Board and other organisations. Members were invited to the launch of the Barnet Mental Health Charter on the 10th of October during World Mental Health Day.

The Chair said that despite challenges in organisational changes such as the police model on 'right care, right person', a holistic and non-stigmatising approach was needed, supported by the community, especially those with lived experience to ensure that discussions and actions were most meaningful for those facing significant challenges.

Dr Djuretic said that the work on engagement was very positive. Focus should be placed on prevention and early help and the journey should ensure work was built upon preventative work with partners in early years, schools and mental health first aiders.

RESOLVED that the Health and Wellbeing Board

1. **Approves the Mental Health Charter, ahead of its launch and wider circulation**

2. **Notes the range of supplementary versions: a 'pocket' version with headlines on an easy-read version**

3. **Notes the launch event for world mental health day on 10th October. The key elements of the launch are:**

    - **Unveiling the Charter**
    - **Outline of the coproduction activity (Barnet Together Alliance)**

- **Borough-wide organisations signing the Charter and making their pledges**

9. SUICIDE PREVENTION STRATEGY ANNUAL UPDATE 2022-23 AND REFRESHED ACTION PLAN 2023-24

Seher Kayikci, Senior Public Health Strategist, introduced the item. Following the approval of the Barnet Suicide Prevention Strategy in 2021, the annual report outlined collaborative actions across the borough in delivery of the strategy. In addition, a refreshed comprehensive action plan involved 40 local, regional and national organisations and people with lived experience working together to reduce death by suicide in children, young people and adults in Barnet. It was noted that the action plan was developed through workshops, securing the commitment from partners to a borough wide response. The plan was also fully aligned with the priorities and goals in the newly published National Suicide Prevention Strategy.

Dawn Wakeling, Executive Director of Adults, Health and Communities, thanked and commended officers for their dedication to the work produced. The Chair congratulated the team on their effective piece of work around the Barnet Suicide Prevention Campaign and on being shortlisted for the Chamberlain Dunn Award for best digital initiative.

RESOLVED that the Health and Wellbeing Board

1. **Notes the progress on implementation of the Barnet Suicide Prevention Strategy.**
2. **Notes the most recent data for the borough of Barnet.**
3. **Approves the renewed Action Plan 2023-25.**

10. BETTER CARE FUND PLAN

Dawn Wakeling introduced the item, highlighting that the timescales for submission of the Plan had not aligned with the HWBB meetings and therefore had been approved under delegated powers and approved by NHS England.

Muyi Adekoya, Head of Joint Commissioning, Older Adults and Integrated Care, highlighted that the better care fund was in its nineth year of implementation with the primary aim to ensure that those in need could stay well in their homes for as long as possible and to support services in ensuring residents received the right care in the right place at the right time. An increase in funding to £47m has helped develop the two-year care plan in line with the national guidance and metrics. All services in place supported the delivery of the metrics, making Barnet an exemplar of implementing the Better Care Fund Plan.

RESOLVED that the Health and Wellbeing Board

1. **Notes the contents of the Barnet BCF Plan 2023-2025.**

2. **Endorses the BCF Plan submitted to NHSE by the Local Authority on 30th June 2023.**

11. JOINT HEALTH AND WELLBEING STRATEGY - IMPLEMENTATION UPDATE AND PLAN FOR JOINT STRATEGIC NEEDS ASSESSMENT REVIEW

The Chair highlighted the importance of the strategy and the plans around the JSNA that encapsulated data from other services, drawing from external data and linking to key sources which would inform the next Strategy.

Claire O'Callaghan, Health and Wellbeing Policy Manager, spoke on the implementation plan. It was noted that most of the actions had either been completed or were on target with half of the KPIs showing an improvement trend.

Alexis Karamanos, Senior Public Health Intelligence Analyst, presented the development of the JSNA highlighting the organisation of resources based on the Barnet Corporate Plan. The public would be given the opportunity to explore and use the data as a useful tool for topics of interest. It was also a good method of amalgamating existing resources into a central place. The JSNA was set up as a live dashboard that could continually be updated and refreshed.

In reference to the plan, Chris Munday suggested cross referencing information with the borough's partnership to ensure both plans aligned with key strategies.
The Chair commented that the range of strategies should be based on granular data to synthesise plans with intelligence driving the KPIs for the right outcomes to be delivered by the right people in the right places.

Dawn Wakeling suggested consulting NCL colleagues on the challenges around pathways in relation to cardiovascular diseases by the lack of NCL networks and whether more would need to be done at borough partnership level.

Dr Djuretic said that the Healthy Heart Project was very good but it involved a small cohort. Therefore, engaging with primary care in terms of contracts and performance management was needed to deliver indicators in relation to national data.

RESOLVED that the Health & Wellbeing Board

1. **Comments on and notes the progress on the current Implementation Plan, and the Key Performance Indicators.**

2. **Agrees, subject to comment, the updated Implementation Plan for the third period.**

3. **Agrees, subject to comment, the plan to update the Joint Strategic Needs Assessment.**

13. BARNET BOROUGH PARTNERSHIP (VERBAL UPDATE)

Dawn Wakeling provided an update to the Board around the need for further neighbourhood development of neighbourhood working. Funding was available for primary care providers to bid for around project initiatives on neighbourhood models of working, in partnership with other statutory services. A pilot local neighbourhood team was being established on Grahame Park estate in relation to mental health, housing and homelessness and other issues.

Borough partnerships across NCL were expected to deliver the aims and ambitions of the NCL population health and Integrated Care Strategy. In Barnet, the HWBB would feedback on the work carried out on delivering the overlapping strategies.
The Chair said that in terms of partnership neighbourhood working, it was suggested to hold another meeting of the HWB in the future at Grahame Park to have conversations with residents and partners to see what impact significant work by the police on endemic crime and community safety issues (Operation Dakota) had on health, mental health and wellbeing of residents.

14. COMMUNICABLE DISEASES - (VERBAL UPDATE)

Janet Djomba presented the item. Following the return of Covid and its new variants, the autumn booster of vaccinations was brought forward for eligible groups; those 65 and over, those in care homes and those with severe underlying conditions. A separate flu immunisation campaign will also include school children.
It was noted that cases of Covid 19 were increasing but recent hospital data indicated lower hospital admissions.
Nationwide, approximately 3000 patients were admitted to hospital with 79 people on ventilation support. Alongside vaccinations offered in primary care in Barnet, 24 Pharmacies were offering the booster and the Council was organising clinics in asylum seeker and homeless accommodations.
No measles outbreaks were reported in Barnet but work on uptake for immunisations was underway. Focused work had been done with Somali and Romanian communities to identify specific needs and support was provided in Orthodox Jewish communities to increase uptake on immunisations. Reminder letters were circulated to all state schools and private schools that were signed up to Council updates. School immunisation teams were operational to do catch up MMR vaccines in schools with low take up but were waiting on accurate data to be supported by UCLH. Webinars have been scheduled with primary and secondary schools.
The Chair thanked the Vaccine Champions, particularly those working as trusted peers with the most vulnerable. Although measles vaccination levels in Barnet were higher in comparison to NCL partners, continued efforts were needed to push up vaccination level to the threshold to ensure safety in the community especially for the most vulnerable.
The Chair queried whether measle vaccinations had been extended to asylum seeker children.
Janet Djomba said that services were working with GP practices linked to asylum seekers to target accommodations and to cover all essential vaccinations.

15. FORWARD WORK PROGRAMME

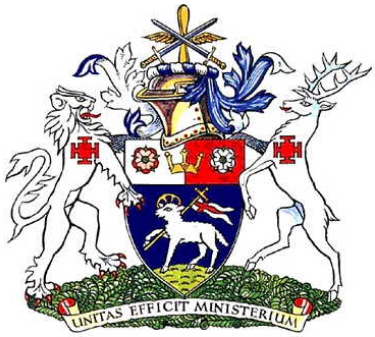
The Board noted the items due to be reported to future HWBB meetings.

RESOLVED that the Board note the Forward Work Programme.

16. ANY ITEMS THE CHAIR DECIDES ARE URGENT

None.

The meeting finished at 12pm

	**Health and Wellbeing Board**
Title	**Long Term Conditions – Cardiovascular Disease Prevention Plan**
Date of meeting	18th January 2024
Report of	Tamara Djuretic, Joint Director Public Health and Prevention, London Borough of Barnet and the Royal Free London Group Tamara.djuretic@barnet.gov.uk Janet Djomba, Deputy Director of Public Health Janet.djomba@barnet.gov.uk
Wards	All
Status	Public
Urgent	No
Appendices	Appendix A – Updated Cardiovascular Disease Prevention Action Plan 2024 Appendix B - Barnet Cardiovascular Disease Prevention Programme 2022-26 Appendix C – Summary slides - CVD Prevention in Barnet Appendix D - CVD Prevention in the community, examples from Healthy Hearts Peer Support Project and the Core20PLUS Community Connectors Project
Officer Contact Details	Deborah Jenkins – Public Health Consultant, Live and Age Well Deborah.Jenkins@barnet.gov.uk 0208 359 7988
Summary	

The Cardiovascular Disease (CVD) Prevention Action Plan has been updated for 2024 (Appendix A) and is intended to work with the existing CVD Prevention Programme 2022-26 (Appendix B). The updated Action Plan includes actions to prevent CVD in community settings and in healthcare settings. Many of the actions refer to current work and several new actions have been introduced for 2024. The updated plan highlights the stakeholders involved, and metrics to measure performance. The Action Plan and Programme aims to add value to the work areas by identifying connections between different programmes and adding actions where there are gaps.

This report introduces the updated CVD Prevention Action Plan 2024 to the Health and Wellbeing Board.

Recommendations

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

Reasons for the Recommendations

1 Reasons for the recommendation

1.1 The CVD Prevention Programme 2022-26 (Appendix B) and the updated Action Plan for 2024 (Appendix A) offer an evidence-based plan for CVD prevention in Barnet. It aims to reduce premature mortality from CVD and reduce inequalities in health outcomes related to CVD. The programme incorporates work in community and healthcare settings for CVD prevention. This is being implemented at sector, borough and neighbourhood level.

1.2 The programme was developed in 2022, in collaboration with multiple stakeholders in Barnet. The updated Action Plan for 2024 was shared for comment during development, with the Barnet CVD Prevention Task and Finish Group, the Barnet Health Inequalities Steering Group and other stakeholders.

Background - cardiovascular disease, risk factors and inequalities

1.3 CVD is a major cause of preventable and treatable premature mortality. Modifiable risk factors include smoking, obesity, physical activity, alcohol and diet. The detection and management of clinical risk factors including hypertension, hypercholesterolaemia, atrial fibrillation and diabetes also reduce the risk of mortality and morbidity from CVD.

1.4 In 2021 in Barnet, the mortality rate from all CVD for people aged under 75 years was 56.6 per 100,000 population.[1] While lower than the London average, this demonstrates that CVD prevention could go further to reduce premature mortality.

1.5 CVD is the one of the biggest contributors to the inequality in life expectancy between people living in the most and least deprived areas of Barnet. Analysis from 2020 estimates that CVD contributed to 14.5% of this inequality in males and 27.2% of this inequality in females. CVD risk factors are also distributed unevenly within the population. In Barnet, analysis shows that the rates of smoking are higher in areas of higher deprivation. There is also variation between Primary Care Networks (PCNs) with the management of clinical risk factors for CVD, such as hypertension.

[1] Public health profiles - OHID (phe.org.uk)

1.6 Nationally, death from CVD is three times higher among people who live in the most deprived communities, compared to those who live in the most affluent.[2] There is higher incidence, prevalence and mortality from CVD in South Asian groups compared with the white group or national average. Black groups have high prevalence of hypertension and diabetes, which are risk factors for heart disease and stroke, but have lower risk of heart disease compared to the majority of the population.[3]

1.7 Data for CVD and inequalities in Barnet is presented in Appendix C.

Strategic context of CVD prevention

1.8 The NHS Long Term Plan[4] states that CVD is the single biggest area where the NHS can save lives over the next 10 years. The policy paper for the forthcoming Major Conditions Strategy includes cardiovascular disease as one of the 6 groups of conditions to focus on.[5] Regionally, the North Central London (NCL) Population Health and Integrated Care Strategy[6] has prioritised heart health as one of its five key health risk areas where the biggest impact can be made. The Royal Free London NHS Foundation Trust Clinical Strategy has cardiovascular as one of its three group priorities over a 10-year horizon.

1.9 Locally, CVD prevention is one of the Barnet Borough Partnership's priorities for reducing health inequalities. The Barnet Health and Wellbeing Strategy 2021 – 2025[7] states that we will develop a CVD prevention programme, supporting residents to avoid developing CVD or better manage existing conditions, addressing inequalities in outcomes from CVD.

Barnet CVD Prevention Programme 2022 – 2026

1.10 At the Health and Wellbeing Board on 14th July 2022, the Barnet Cardiovascular Disease Prevention Programme 2022-26 and Action Plan 2022-24 was presented and approved.[8] The Action Plan presented at the Health and Wellbeing Board on 18th January 2024 (Appendix A) is a refresh of the earlier action plan, and the CVD Prevention Programme 2022-26 (Appendix B) is proposed to remain in place.

1.11 Since the launch of the CVD Prevention Programme 2022-26 and Action Plan 2022-24, work has continued across Barnet to reduce and prevent CVD. Examples from 2023 include the Healthy Hearts Peer Support project, provided by Inclusion Barnet (Appendix D), and Community Health Screening, provided by GPDQ Ltd, which provided 48 screening sessions to a total of 976 people in Barnet in the first year of the project. Both projects are now in Year 2 of delivery. A pilot project launched in 2023 aims to increase the uptake of the NHS England Community Pharmacy blood pressure check service, and patients have been followed up in primary care through this work.

Updated Barnet CVD Prevention Action Plan 2024

1.12 The purpose of updating the Barnet CVD Prevention Action Plan for 2024 (Appendix A) is to group the actions into those that prevent CVD through actions in community settings,

[2] Risk factors for CVD | Background information | CVD risk assessment and management | CKS | NICE
[3] https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#cvd
[4] NHS Long Term Plan » Cardiovascular disease
[5] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)
[6] Population health and integrated care - North Central London Integrated Care System (nclhealthandcare.org.uk)
[7] Joint Health and Wellbeing Strategy 2021 to 2025 | Barnet Council
[8] Agenda for Health & Wellbeing Board on Thursday 14th July, 2022, 9.30 am (moderngov.co.uk)

and those that act through healthcare settings, and to identify stakeholders responsible for the different actions more clearly.

1.13 For actions delivered in community settings, the strategic aims include promotion of adult weight management and physical activity to those who would most benefit, delivery of community health screening in areas of higher deprivation in the borough, optimising local delivery of the National Diabetes Prevention Programme, offering Peer Support to promote heart health to residents in African, Caribbean and South Asian Communities, and the reduction of substance misuse in Barnet.

1.14 For actions delivered in healthcare settings, the strategic aims include optimising smoking cessation services in primary and secondary care, increasing delivery of the NHS England community pharmacy blood pressure check service, increasing the delivery of NHS Health Checks in areas of higher deprivation, optimising annual health checks for people with learning disabilities and severe mental illness to promote cardiovascular health, using the upcoming Long-term Conditions Locally Commissioned Service to support CVD prevention, analysing primary and secondary care demographic data for patient with CVD, and more broadly using available data to monitor CVD prevention in Barnet.

1.15 Enablers of the actions include communications and engagement with residents and community groups in Barnet, adopting a Making Every Contact Count (MECC) approach and promoting cardiovascular health in workplace settings, including within the council's workforce. Broader actions to create environments that promote heart health in the borough include reducing people's exposure to air pollution, promoting healthy weight through the food environment, enabling active travel and Fit and Active Barnet opportunities.

1.16 The importance of system leadership for CVD Prevention is highlighted in the recent Kings Fund report.[9] It notes that everyone in a local public health, health and care system has a role to play in preventing CVD and delivering timely, co-ordinated care to those who develop it.

1.17 A multi-stakeholder CVD Prevention Task and Finish Group meets quarterly, to discuss and share updates on the action plan. The membership of this group has been reviewed recently, and the group intends to continue meeting in 2024.

2 Alternative Options Considered and Not Recommended

2.1 To keep the existing CVD Prevention Action Plan 2022-24 (without the proposed updates)

3 Post Decision Implementation

3.1 Following the Board meeting, the updated Cardiovascular Disease Prevention Action Plan 2024 is published on the Barnet website.

3.2 Oversight of delivery of the action plan will be through the Barnet Borough Partnership CVD Prevention Task and Finish Group. This Task and Finish Group forms part of the Health Inequalities workstream, which reports regularly to the Barnet Borough Partnership Delivery Board.

[9] Cardiovascular disease in England | The King's Fund (kingsfund.org.uk)

3.3 For the duration of this programme and action plan delivery, annual updates will be provided to the Health and Wellbeing Board. These updates will give the Board oversight of the progress being made against the action plan and outcome measures.

4 Corporate Priorities, Performance and Other Considerations

Corporate Plan

4.1 Our Plan for Barnet 2023-26 is centred around being a council that cares for people, our places, and the planet. CVD Prevention fits within caring for people and preventing long-term conditions such as CVD is mentioned in the section which discusses tackling inequalities.

Corporate Performance / Outcome Measures

4.2 CVD Prevention sits under Key Area 2 of the Health and Wellbeing Strategy (Starting, Living and Ageing Well). The Barnet Joint Strategic Needs Assessment (JSNA) includes the outcome measure of under 75-years mortality for CVD. The JSNA also includes CVD risk factors of obesity, physical activity, smoking, hospital admissions due to alcohol and drug misuse mortality.

Sustainability

4.3 There are no direct sustainability implications from noting the recommendations.

Corporate Parenting

4.4 The Barnet CVD Prevention Programme and Action Plan focuses on adult health improvement while recognising that some of the roots of cardiovascular disease start in childhood. The Public Health Children and Young People's team are taking actions to reduce risk factors for the development of CVD, but that work is outside the scope of this programme.

Risk Management

4.5 The Barnet CVD Prevention Programme 2022-2026 and Action Plan 2024 requires collective effort across the multi-agency Barnet Borough Partnership (BBP) and wider stakeholder to reduce the rate of premature mortality from CVD in Barnet. If the council or partners do not engage with the programme and progress the actions, it may lead to poor overall delivery of the Action Plan 2024. This could reduce the effectiveness of CVD prevention work in Barnet.

The following controls and mitigations are in place:

The multiagency Barnet CVD Prevention Task & Finish Group and Barnet Borough Partnership Delivery Board were consulted during development of the initial programme. The CVD Prevention Task and Finish Group, Health Inequalities Steering Group and wider stakeholders have been engaged during development of the CVD Prevention Action Plan for 2024, and the Action Plan has been adapted in response to feedback.

The Barnet CVD Prevention Task & Finish Group meet quarterly to report on actions, engage partners, align activities, and implement changes based on new insights.

Insight

4.6 The Joint Strategic Needs Assessment identifies the under 75 (premature) circulatory mortality rate and compares this with the national and London rate.

The Barnet CVD Prevention Programme 2022-2026 is included in Barnet's Health and Wellbeing Strategy. Partners' progress against the action plan can be reported annually to the Health and Wellbeing Board if requested.

The CVD Prevention Programme will monitor and evaluate local data on rates of CVD mortality, behavioural and clinical risk factors using datasets that are available.

Social Value

4.7 The aims of the CVD Prevention Programme and action plan are to reduce premature mortality from CVD in Barnet and reduce inequalities in outcomes relating to CVD. The cross-cutting strategic actions fall within the prevention and healthy themes of the social value framework.

5 Resource Implications (Finance and Value for Money, Procurement, Staffing, IT and Property)

5.1 The recommendations to the Board have no resource implications over and above existing financial commitments.

6 Legal Implications and Constitution References

6.1 Under the Council's constitution, Part 2B of the Terms of Reference & Delegation of Duties to Committees and Sub-Committees, the Health and Wellbeing Board has the following responsibilities:

- To agree a Health and Wellbeing Strategy (HWBS) for Barnet taking into account the findings of the JSNA and strategically oversee its implementation to ensure that improved population outcomes are being delivered.
- To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental, and social wellbeing.
- Specific responsibilities for overseeing public health and promoting prevention agenda across the partnership.

Consideration of the Cardiovascular Disease Prevention Action Plan falls within these terms.

7 Consultation

7.1 The CVD Prevention Programme was co-produced with voluntary and statutory organisations. The Action Plan 2024 was shared with stakeholders from voluntary and statutory organisations. Individual elements of the programme are being further developed in consultation with local residents. Formal consultation is therefore not planned for this programme.

8 Equalities and Diversity

8.1 A whole systems approach to prevention has been taken. Vulnerable groups have been identified through national evidence and local insight. Actions have been put in place to focus on certain communities and individuals with protected characteristics or who may be at a higher risk of CVD. These include specific ethnic groups at increased risk of developing CVD, people living with learning disabilities and severe mental illness.

9 Background Papers

9.1 NHS Long Term Plan » Cardiovascular disease

9.2 The health of people from ethnic minority groups in England | The King's Fund (kingsfund.org.uk)

9.3 Cardiovascular disease in England | The King's Fund (kingsfund.org.uk)

APPENDIX A - Updated Barnet Cardiovascular Disease (CVD) Prevention Action Plan 2024

This Action Plan for 2024 is intended to work with the Barnet CVD Prevention Programme 2022 – 2026, and replace the Barnet CVD Prevention Action Plan 2022 – 2024.

The CVD Prevention work in Barnet involves stakeholders from healthcare, the voluntary and community sector, public health, the wider council and the Barnet Borough Partnership. It also aligns with the North Central London Integrated Care System Population Heath and Integrated Care Strategy and national priorities to prevent and reduce cardiovascular disease.

CVD prevention and early intervention in community settings

Strategic aim	Actions	Key Performance Indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
1. **Adult weight management services (AWMS) tier 2** available to people who would most benefit	AWMS needs assessment and options appraisal Ongoing public health input to FAB and GLL AWMS GLL and Public Health work with primary care to optimise the quality and quantity of referrals to available AWM services	Completion of needs assessment and options appraisal GLL AWMS – % of referrals to starters, completers, and weight loss Improvement in AWM referral pathways	Decide if to commission further AWMS in 2024 Reduced percentage of adults (18+ years) classified as overweight or obese, and in population groups within Barnet	Annual	Public health, Live and Age Well Team Fit and Active Barnet (FAB) and GLL	PCNs BBP Neighbourhoods Team

2. **Physical activity** promotion to people who would most benefit for cardiovascular health	Promote physical activity to people in Barnet with low levels of activity	Number of people taking up GLL physical activity offers Number of people attending other physical activity groups in Barnet	Increased levels of physical activity in Barnet Increase physical activity in areas of higher deprivation and where there are lower levels of physical activity	Annual	Public health, Live and Age Well Team Fit and Active Barnet (FAB) Partnership - LBB and GLL	Primary care BBP Neighbourhoods Team
3. Community health screening – to compliment NHS Health Checks in areas where people are more likely to be living in poor health	Focus delivery in areas of high deprivation and offer to population groups at higher risk of CVD to reduce health inequalities. Ensure culturally competent promotion of service.	Complete mapping of community health screening locations Communications and promotion activity with VCS organisations to promote screening sessions Demographics of people attending screening sessions, percentage of attendees from population groups of focus	Evidence of community health screening delivery in geographical areas of focus Evidence of community health screening provided to population groups at higher risk of CVD and who are less likely to access healthcare Evidence of signposting to local preventative services and awareness of self-help resources	30.04.24 (end of Year 2 contract)	Public health, Live and Age Well Team GPDQ Ltd	LBB Insight and Intelligence team VCS networks in Barnet
4. **National Diabetes Prevention programme** to increase delivery in Barnet (provider is Live Well Take Control (LWTC))	Service improvement to reduce waiting times to start programme and increase completers LWTC and PH work with primary care to optimise the quality	Number of group sessions offered in Barnet Waiting times for initial assessment. Conversion rate from referral to initial assessment and from referral to milestone 1	Service improvements in NDPP in Barnet (reduced waiting times, increase conversion rates from referral to initial assessment and milestone 1, completers with >5% weight loss) Evidence of people joining NDPP following community	Annual	Live Well Take Control (LWTC) Primary Care	NCL NDPP Steering Group Public Health, Live and Age Well Team

	and quantity of referrals Deliver community events for diabetes awareness days & months, align with PH communications	Number of participants with >5% weight loss Community events delivered for Diabetes Week & World Diabetes Day	testing event and increased equity of access through these events Reduced type 2 diabetes prevalence in Barnet			
5. **Community Peer Support** to promote heart health and reduce hypertension for population groups at higher risk of CVD	Healthy Hearts Peer Support promote heart health, working with African, Caribbean and South Asian communities Translate learning from recent Barnet Healthwatch Core20PLUS5 connectors project to Healthy Hearts project	Number of very brief, brief, and extended brief interventions and multi-session courses delivered. Percentage of overall attendees from populations and areas of focus.	At least 400 residents from population groups of focus engaged in Year 2 Self-reported increased knowledge and behaviour changes that promote cardiovascular health Increased awareness of and confidence in accessing local health, care and other support services available	May 2024 (end of Year 2 of project)	Healthy Hearts Peer Support Team, Inclusion Barnet and Healthwatch Barnet	Public health, Live and Age Well Team BBP Primary Care Community pharmacies
6. **Reduction of substance misuse in Barnet**	Promotion of healthy choices information and support/treatment options for alcohol and drug users	Number of referrals to CGL and number of people in treatment. Number of completed audits via the Drinkcoach website.	Reduced number of hospital admissions from alcohol related conditions. Increased number of people in treatment. Set up alcohol treatment clinics based in GP surgeries.	Annual	Public health, Substance Misuse Team	Primary Care Homeless Healthcare CGL Drinkcoach

		Borough wide GP recording of alcohol use and GP referral into treatment.				

CVD prevention and early intervention – healthcare settings

Primary Care and Pharmacy

Strategic action	Actions	Key Performance Indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
7. **Smoking cessation services –** increased delivery in healthcare settings and community	Re-commission smoking cessation services and agree delivery model with GP Federation Promote uptake of smoking cessation services in population groups with higher prevalence and greater risk of harm	Agree smoking cessation services commission from LBB Public Health to GP Federation Uptake of vaping offer as smoking cessation aid (this is means tested and available across the borough)	Reduced smoking prevalence in Barnet Reduced inequality in smoking prevalence between general population and people with SMI / PWLD / routine and manual workers / people living in areas of highest deprivation Use evaluation of vaping offer as smoking cessation aid to inform decision on further use	Annual	LBB Public health - Smoking Cessation Team GP Federation	Primary Care Community pharmacies Acute trust (pre-op, inpatient and maternal smoking cessation)
8. **NHS England Community Pharmacy blood pressure (BP) check service** - increased awareness and delivery in Barnet	BBP Health Inequalities project to support increased delivery of NHSE Community Pharmacy blood pressure check service in two PCNs	BBP Health Inequalities project to support increased delivery in two PCNs – working with GP surgeries and local pharmacies, improve feedback of results from pharmacy to GP practice	Increased delivery of NHS E Community Pharmacy Blood Pressure Check Service Increased feedback of BP results from pharmacies to GP practices	April 2024 (end of pilot)	BBP Health Inequalities Team Community pharmacies	Primary Care Public Health, Live and Age Well team Local Pharmaceutical Committee

	Promote awareness of available services in the community	Promote awareness of services with VCS organisations				Medicines Management
9. **NHS Health Checks (HC) –** increase delivery in areas with high deprivation, to identify people with high risk of CVD and start risk reduction	Re-commission NHS HC and agree delivery model with GP Federation Work with PCNs / GP surgeries to increase delivery in populations more likely to have high risk of CVD	Agree NHS HC commission from LBB Public Health to GP Federation Analyse pattern of NHS HC delivery and identify areas to increase activity.	Increased delivery of NHS HC Increased uptake of NHS HC in patients living in areas of high deprivation, minority ethnic groups	Annual	Public Health, Live and Age Well team Primary Care GP Federation BBP Primary Care Team	BBP Neighbourhoods team
10. **Annual health checks for people with learning disabilities and severe mental illness** – optimise and support actions for CVD prevention	CVD prevention during and following annual health checks	Develop annual health checks further, to optimise CVD prevention	Evidence that annual health checks promote CVD prevention – including behavioural interventions and management of clinical risk factors	Annual	BBP primary care team Primary Care GP Fed BEH Barnet Learning Disabilities Service and Mental Health Commissioners	Barnet Mencap MIND in Barnet Public health
11. **Long term conditions locally commissioned service (LTC LCS)** to support CVD prevention	Development and delivery of LTC LCS	Sharing of best practice and improvement mechanisms between PCNs Engagement between primary care and VCSs to promote uptake of LTC LCS in Core20PLUS populations	Increased case finding – hypertension, hypercholesterolaemia, atrial fibrillation Improved management of hypertension (incentivised 2024/5 LTC LCS outcomes)	Annual	Primary care PCNs BBP primary care team	Public Health, Live and Age Well team NCL central team VCS orgs

			Delivery of LTC LCS in Core20PLUS populations			
12. Heart failure management	Improved management of patients with heart failure in primary care (incentivised 2024/5 LTC LCS outcomes) Review provision of cardiac rehabilitation, including counselling	LTC LCS incentivised outcome for 24/25 - % of people on HF register (with LVSD) and without contraindications on: a) ACEi or equivalent AND b) Betablocker	Improved management of heart failure	Annual	Primary care PCNs BBP primary care team Cardiology, secondary care	Public Health, Live and Age Well team NCL central team VCS orgs
13. Data analysis to monitor CVD prevention in Barnet	Monitor data regularly	See data table below in this document for healthcare measures	Monitoring identifies areas of change / where further action is required	Annual	Primary care, BBP Public Health	VCS orgs

Secondary Care

Strategic action	Actions	Key performance indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
14. Demographic data analysis for people accessing secondary care and primary care for CVD	Review demographic data for Royal Free Trust cardiology services. Compare with primary care demographic data for CVD risk factors.	Analysis of data for Royal Free Trust cardiology services, by patient demographics Analysis of data from primary care for CVD and	Further understanding of local populations at highest risk of CVD and populations accessing primary and secondary care for CVD	Annual	BBP Royal Free Primary Care Barnet Public Health Live and Age Well Team	

		CVD risk factors, by patient demographics				
15. Smoking cessation services – secondary care	Promote uptake of smoking cessation services in population groups with higher prevalence and greater risk of harm	Maternal health programmes roll out Pre op / Acute services roll out	Reduced number of pregnant people smoking at delivery Reduce number of people smoking pre-operatively	Annual	Royal Free Barnet Public Health Smoking Cessation Team	BBP

Facilitators for CVD prevention and early intervention

- **Communications and engagement** activity from VCS organisations, the council, primary care, secondary care and pharmacies
- **Making Every Contact Count (MECC)** approach across the council, VCS partners and healthcare system
- **Workplace health promotion** to detect and reduce CVD risk factors
- **Wider work to create environments that promote CVD prevention**, such as through reducing air pollution, promoting healthy weight through the food environment and facilitating active travel

Also discuss at CVD T&F Group meetings

- Primary care-led work to identify and manage clinical CVD risk factors, including hypertension, atrial fibrillation, hypercholesterolaemia, diabetes
- Secondary care and cardiac rehabilitation

Data to monitor CVD prevention in healthcare settings Barnet (in addition to KPIs and outcome measures in this action plan)

Indicator	Level	Source	Most recent data
MORTALITY			
Under 75 mortality from all CVD	Barnet GP surgery	I&I Hub, Fingertips NCL pop health OF	2021/22
PREVALENCE			
Increase in prevalence compared to RightCare PCN similar 10 - Hypertension - Atrial fibrillation		Future LTC LCS dashboard	
BLOOD PRESSURE			
Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months	GP surgery	CVDPrevent	June 2023
Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold	GP Surgery	CVDPrevent Future plan for NCL pop health outcomes framework	June 2023
ATRIAL FIBRILLATION			
Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy	GP surgery	CVDPrevent Future LTC LCS dashboard	June 2023
HYPERCHOLESTEROLAEMIA			
Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy	GP Surgery	CVDPrevent	June 2023

North Central London Integrated Care System

BARNET LONDON BOROUGH

Barnet Cardiovascular Disease Prevention Programme

2022 – 2026

Data last updated: 27th June 2022
Published: October 2022

About this programme

Why?

Although health has improved over the last 30 years, over the last 10 years improvements in mortality rates have slowed.

Cardiovascular disease (CVD) is the one of the largest causes of premature mortality in deprived areas. It is one of the major causes of deaths in under 75s in Barnet (55.0 per 100,000 population) and is the single largest cause of inequality in premature mortality between the most and least deprived areas. **There remain significant opportunities for the prevention of CVD** through both primary prevention, early detection, public health action, and secondary prevention - clinical care (especially primary care) to reduce the burden of risk factors and maximise the uptake of known effective care.

We need to respond to a changing landscape brought by COVID-19 which has highlighted persisting health inequalities in our society, including in Barnet. CVD and the risk factors for CVD (which are themselves unequal), increase the chance of severe illness or death from COVID-19. In 2019, The National CVD Prevention System Leadership Forum (CVDSLF) set out 7 x 10-year ambitions for CVD, underpinned by an aim to reduce inequality in CVD deaths.

Areas of focus for CVD Prevention in Barnet need to be agreed, in line with both national ambitions and local priorities.

What?

4 year programme
2022-2026

Aim: to develop a CVD prevention programme to reduce prevalence of CVD, improve management of risk factors, reduce premature mortality and inequalities in outcomes.

The programme aims to be complementary to and not replace what is being planned and done locally.

The programme will be guided by:

- Local needs
- Evidence from existing and planned interventions
- Knowledge of what has worked in other areas partnership working
- Innovation
- Regional and national drivers

2 year action plan
2022-2024

Aim: to detail proposed outcomes and activities to meet those outcomes to be carried out over a two year period, and longer where it effective or requires and extended length of time to embed properly.

We want the action plan to be further refined and validated through engagement with the CVD Prevention Task & Finish Group and the wider Barnet Borough Partnership (BBP).

The agreed CVD Prevention Programme Action Plan will be taken forward through the CVD Prevention Task & Finish Group with periodic update to BBP Delivery Board and the Health and Wellbeing Board.

Development

This programme and action plan has been co-produced with system partners across the Barnet Borough Partnership (BBP) through the CVD Prevention Task & Finish Group, as part of the BBP inequalities workstream.

Input has been sought through a series of task & finish group meetings, a detailed mapping exercise and system wide partnership workshops, involving representatives from primary and secondary care, community providers, voluntary and community sector, faith groups and local authority officers, who have collectively driven the priorities and actions presented.

Cross cutting themes

- **Health inequalities: geographical, deprivation; populations at risk; inc. people with learning disabilities and serious mental illness**
- **Integration, transformation and partnership work**

Contents

List of abbreviations

- ABC - AF, blood pressure & cholesterol
- AF – Atrial fibrillation
- AWM – adult weight management
- BBP - Barnet Borough Partnership
- HBP – High Blood pressure
- CCG – Clinical Commissioning Group
- CHD – Coronary Heart Disease
- COPD – Chronic Obstructive Pulmonary Disease
- CVD – Cardiovascular Disease
- CVDSLF - CVD Prevention System Leadership Forum
- DSR – Directly Standardised Rate
- FAB – Fit and Active Barnet
- GP – General Practice/Practitioner
- HbA1c – blood sugar
- HCA – Health care assistant
- HENRY – Health, Exercise and Nutrition for the Really Young
- LBB – London Borough of Barnet
- LDL – low-density lipo-protein
- LTC – Long Term Condition
- LTC LCS – Long Term Condition Locally Commissioned Service
- MDT – multi-disciplinary team
- MECC – Making Every Contact Count
- NCL – North Central London
- NDPP – National Diabetes Prevention Programme
- NHS – National Health Service
- NHSE & I – NHS England & Improvement
- NICE – National Institute for Health and Care Excellence
- OHID – Office for Health Improvement & Disparities
- PAM – Patient Activation Measure
- PCN – Primary Care Network
- PH – public health
- PHE - Public Health England
- PWLD – people with learning disabilities
- QOF – Quality and Outcomes Framework
- RF – risk factor
- SATOB - smoking at time of booking
- SATOD - smoking at time of delivery
- SMI – serious mental illness
- TIA – transient ischemic attack
- UCLP – UCLPartners
- VCS – Voluntary & Community Sector

Background

Prevention is at the heart of the NHS Long Term Plan. In addition to substantial commitments to tackle obesity, alcohol and smoking, the Plan includes a major ambition to prevent 150,000 strokes and heart attacks over the next ten years by improving the treatment of the high-risk conditions – hypertension (high blood pressure), high cholesterol and atrial fibrillation (AF).

National NHS context: premature mortality & risk factors

The NHS Long Term Plan (2019) & Global Burden of Disease Study (2017) set out the current position and areas of focus:

- Top 5 causes of early death for the people of England include:
  - Heart disease
  - Stroke
  - Dementias
- Top risk factors that cause early death in England include:
  - Smoking
  - High blood pressure
  - Obesity
  - Poor diet
  - Alcohol & drug misuse
  - Air pollution
- Life expectancy stalled or fallen for most deprived 10%
- Some parts of population are at substantially higher risk of poor health and early death:
  - Black, asian & minoritised ethnic communities
  - adults with a learning disability
  - people with serious mental illness (SMI)
- CVD is the largest cause of premature mortality in deprived areas
- CVD is the single biggest area where the NHS can save lives in the next 10 years
- Preventable through action on:

1. **Early detection and optimal treatment of CVD**. People routinely knowing their 'ABC' (atrial fibrillation (AF), blood pressure, cholesterol) through use of digital technology and VCS, public sector and NHS staff.
2. **Improving the effectiveness of the NHS Health Check** – working with VCS, community pharmacy and GPs
3. **Better support for heart failure patients through increased access to testing in primary care & multi-disciplinary teams (MDTs)**
4. **Fast and effective action for people suffering cardiac arrest –** building a national network of community first responders and defibrillator
5. **Increase access to cardiac rehabilitation**

Background

There are a number of CVD prevention programmes underway at a national, regional and local level.

National NHS context: CVDPREVENT & BP@Home

CVDPREVENT is a national primary care audit that automatically extracts routinely held GP data, covering diagnosis and management of six high-risk conditions that cause stroke, heart attack and dementia:

- atrial fibrillation (AF)
- high blood pressure
- high cholesterol
- diabetes
- non-diabetic hyperglycaemia
- chronic kidney disease

It will provide a foundation for professionally led quality improvement in individual GP practices across Primary Care Networks (PCNs). It will support primary care in understanding how many patients with the high-risk conditions are potentially undiagnosed, undertreated or over treated.

The first collection (for the year 2019-20) was at the end of December 2020. Data collection is now a quarterly extract.

BP@Home Service

Home blood pressure monitoring has been identified as a priority for CVD management as the NHS recovers from the COVID-19 pandemic to ensure that patients can manage their hypertension well and remotely, reducing the need to attend GP appointments.

NHS England & Improvement have distributed BP monitors around England so that patients can record their BP and send their reading to their GP for review remotely through the BP@Home initiative.

UCLPartners Proactive Care Frameworks

UCLPartners (UCLP) have developed real world frameworks to support proactive care of long term conditions in a post COVID-19 primary care.

The programme looks to identify patients at varying levels of risk by condition, using risk stratification tools. Then, utilising the breadth of the primary care workforce (e.g. health care assistants (HCAs), practice pharmacists) patients are contacted and proactively managed; given health & wellbeing advice, signposted to local support services and digital support tools to support remote and self management.

There are currently 6 (soon to be 8) high impact condition frameworks, of which 4 relate to CVD prevention: atrial fibrillation (AF), blood pressure, cholesterol and type 2 diabetes.

North Central London context

NCL Long Term Conditions Locally Commissioned Service

NCL CCG are designing a more consistent NCL approach to long term conditions care, via a pan-NCL LCS for patients and practices (the NCL LTCLCS). Initial focus will be on metabolic and respiratory conditions due to be introduced in early 22/23 with a preparatory period of up to one year.

NCL CVD and Stroke Network

Established, February 2022 - championing, commissioning and overseeing Proactive Care programmes and transformation initiatives across CVD & stroke prevention pathways and working to reduce health inequalities.

BP@Home

NCL were part of the pilot BP@Home programme: 3 PCNs in Barnet took part: PCNs 1W, 1D and 5.

Background

COVID-19 has brought a sharper focus on persisting health inequalities in our society, including in Barnet. CVD and the risk factors for CVD (which are themselves unequal), increase the chance of severe illness or death from COVID-19.

The National CVD Prevention System Leadership Forum set out 7x 10-year ambitions for CVD, underpinned by an aim to reduce inequality in CVD deaths.

National OHID context: CVD ambition

In 2019, the National CVD Prevention System Leadership Forum (CVDSLF) - made up of 40 organisations and convened by Public Health England (PHE) now Office for Health Improvement & Disparities (OHID) - set out 7x 10-year ambitions for CVD. These are:

- ✓ 85% of people with AF are detected and 90% are adequately treated.
- ✓ 80% of people with hypertension are detected and 80% are adequately treated.
- ✓ 75% of 40-74 year olds have had a CVD risk assessment and cholesterol check in the past 5 years and 45% of those identified as high risk are treated with statins.
- ✓ 25% of people with familial hypercholesterolaemia are diagnosed and treated.

These ambitions are underpinned by an overall aim to reduce significantly the gap in amenable CVD deaths between the most and least deprived by 2029.

COVID-19 and CVD

Those in **more deprived areas have higher likelihood of contracting and dying from COVID-19.**

CVD: 3.9x higher odds of severe COVID-19 disease and 2.7x higher odds of mortality.

Hypertension: 2.6x higher odds of severe COVID-19 disease and 2.5x higher odds of mortality.

Diabetes: 2.5x higher odds of severe COVID- 19 disease and 2.1x higher odds of mortality.

Current smoking: 1.8x higher odds of severe COVID-19 disease, but not mortality.

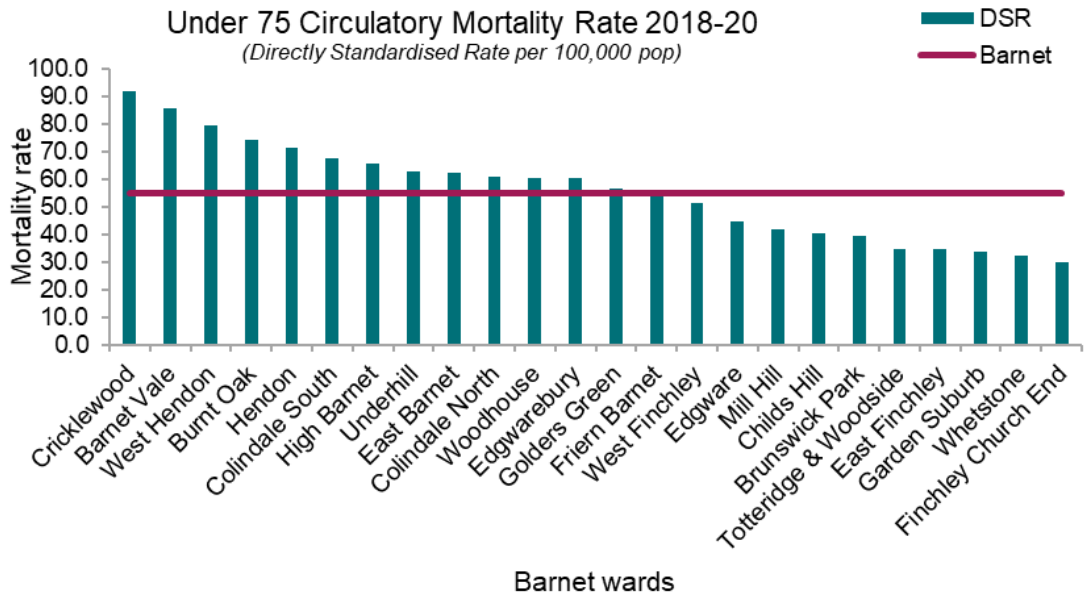
Obesity: significantly associated with severe COVID-19 disease and 2.2% higher odds of mortality.

Background

Improvements in treatment for CVD and behaviour change has seen overall death rates from CVD decrease year on year but inequalities persist. To ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.

Barnet context: premature mortality

- There is a life expectancy gap in Barnet:
  - Women in the most deprived areas live just over 6 years less than those in the least deprived areas.
  - Men in the most deprived areas live just under 7 years less than those in the least deprived areas.
- CVD is one of the major causes of deaths in under 75s in Barnet (55.0 per 100,000 population)
- Although the under 75 CVD mortality rate in Barnet continues to decrease and is in fact lower than that seen in London (69.1 per 100,000 population) or England (70.4 per 100,000 population), it varies considerably between the borough's wards, with clear links to deprivation
- The rate of under 75 CVD mortality in the Cricklewood (91.9 per 100,000 population), is more than triple that of Finchley Church End (30.1 per 100,000 population).

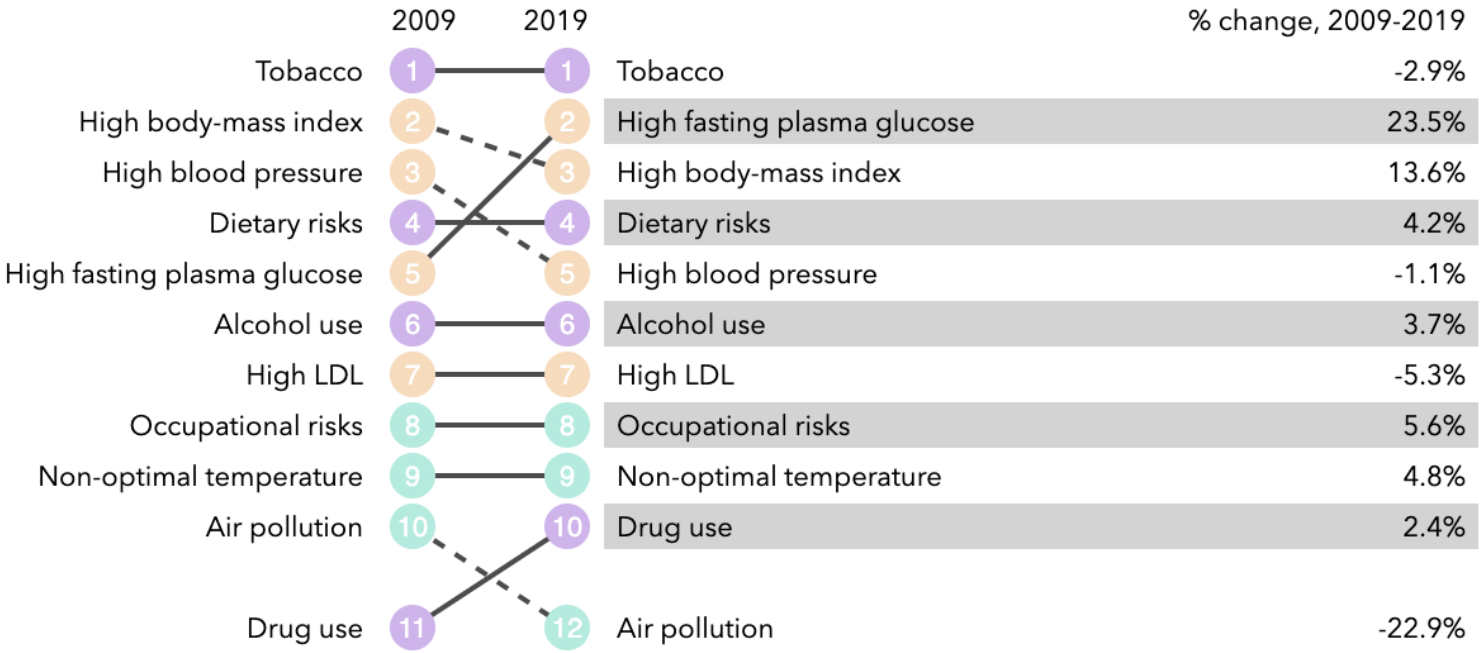


Return to contents

Background

There are many risk factors (RFs) for CVD, including metabolic, environmental and behavioural risks. The risks are not evenly distributed in society. Tackling these RFs can prevent CVD or reduce the risk of poorer outcomes in those already with CVD. In this programme, we are focusing on the top 3 behavioural risk factors.

The **risk factors that drive the most death and disability in the UK** are:



	% change, 2009-2019
Tobacco	-2.9%
High fasting plasma glucose	23.5%
High body-mass index	13.6%
Dietary risks	4.2%
High blood pressure	-1.1%
Alcohol use	3.7%
High LDL	-5.3%
Occupational risks	5.6%
Non-optimal temperature	4.8%
Drug use	2.4%
Air pollution	-22.9%

Source: Global Burden of Disease study, UK profile

Examples of CVD risk factors in Barnet:

In 2019, **11.1% of the Barnet population were estimated to be smokers** (similar to London average). This hides variation, however. Higher rates of smoking were recorded in those with serious mental illnesses, routine & manual occupations, and (across NCL) living in more deprived communities.

Over half (57.7%) of adults aged 18+ in Barnet are overweight or obese (2019). The wards with highest prevalence of adult obesity are Burnt Oak, Colindale and Underhill.

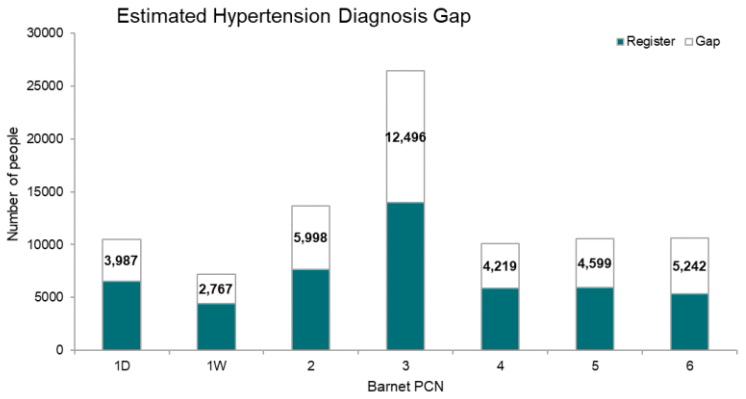
Obese adults are 2.5 times more likely to develop high blood pressure and are 5 times more likely to develop type 2 diabetes, significant risk factors for CVD.

Background

National ambitions (CVDSLF) by 2029:
- ✓ **85% of people with AF are detected**
- ✓ **80% of people with hypertension are detected**

There is a large degree of variability by PCN and GP practice. We need to look to reduce this variation.

Barnet hypertension diagnosis gap

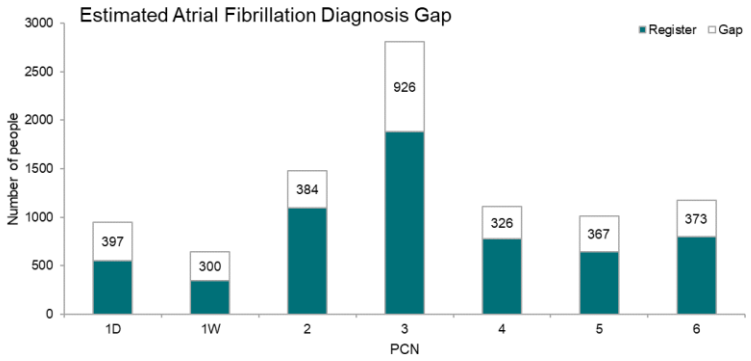


There are nearly 50,000 patients diagnosed with hypertension on the GP QOF Registers in Barnet (2020-21), and the estimated number of people living with hypertension for Barnet registered population is around 89,059.

This suggests around 39,000 people in Barnet may have undiagnosed hypertension.

Range of variation at practice level is 36% to 74% diagnosed

Barnet atrial fibrillation diagnosis gap

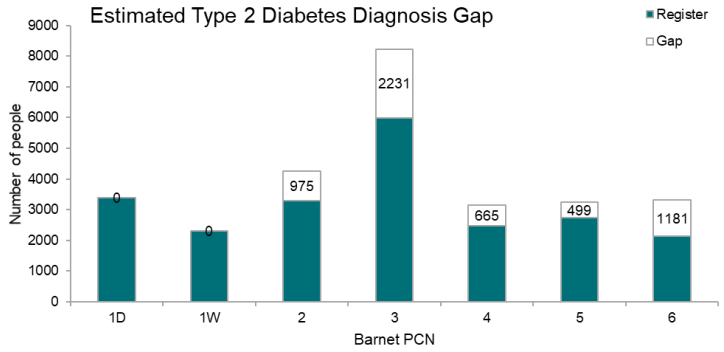


There are around 6,102 patients on the QOF AF register in Barnet.

It is estimated that only 67% of AF has been detected in the population (2020-21), suggesting around 3000 people in Barnet may have undiagnosed atrial fibrillation.

Range of variation at practice level is 32% to 100% diagnosed

Barnet diabetes diagnosis gap



The estimated total prevalence of type 2 diabetes in Barnet is 27,599 (diagnosed and undiagnosed) and there are around 22,336 patients with type 2 diabetes on the GP QOF register in Barnet (2020-21). This suggests nearly 5,550 people in Barnet may have undiagnosed type 2 diabetes.
Range of variation at practice level is 43% to 100% diagnosed.

There are an estimated 34,084 people in Barnet with non-diabetic hyperglycaemia or pre-diabetes (2015). While only 19,042 are on the QOF register (2020-21). Suggesting 15,000 people in Barnet have undiagnosed pre-diabetes and are at increased risk of going on to develop type 2 diabetes.

Source: QOF 202021, diagnosed figures. Estimated prevalence from the NCVIN, 2020. No. rounded to nearest 10.

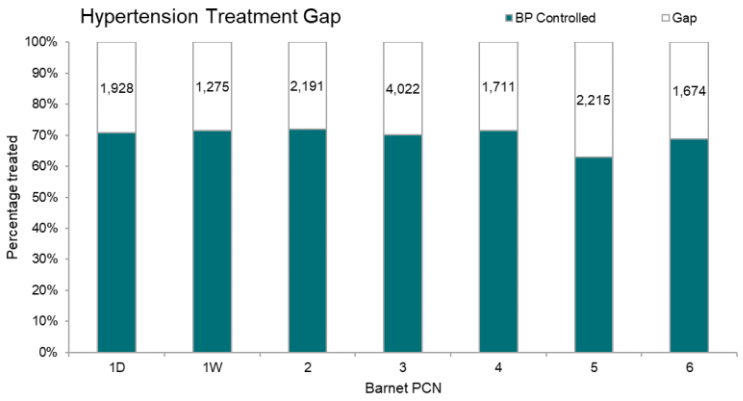
Source: QOF 2020/21, diagnosed figures. **Return to contents**

Background

National ambitions (CVDSLF) by 2029:
- ✓ **80% of people with hypertension are adequately treated**
- ✓ **90% of people with AF are adequately treated**

There is a large degree of variability by PCN and GP practice. We need to look to reduce this variation.

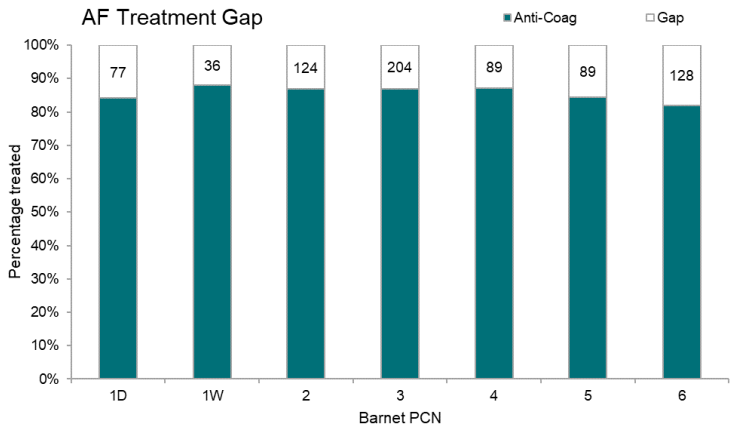
Barnet hypertension treatment gap



Around 15,000 of the patients registered with hypertension in Barnet do not have their blood pressured controlled to the QOF suggested level (2019-20)

Range of variation at practice level is 50.2% and 85% treated to NICE guidance

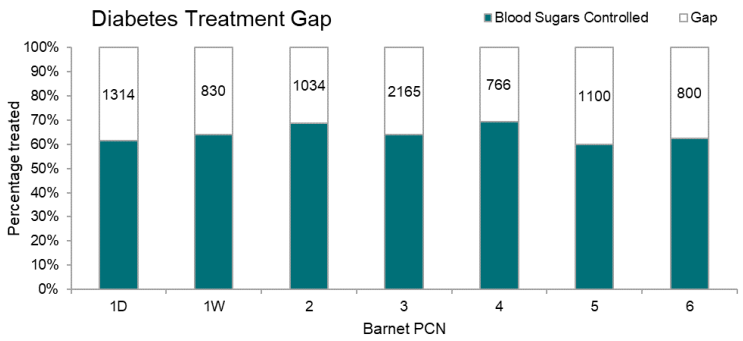
Barnet atrial fibrillation treatment gap



Around 747 of the patients registered with atrial fibrillation in Barnet are not anticoagulated (2019-20)

Range of variation at practice level is 70.7% and 96.7% treated to NICE guidance

Barnet type 2 diabetes treatment gap



Around 8,000 patients on the diabetic register do not have their blood sugars controlled to the level suggested in the QOF contract (2019-20).

This is only 1 of 3 treatment targets for diabetes in adults: HbA1c (blood sugar), cholesterol and blood pressure set by NICE.

39

Source: QOF 2019/20, treatment figures

Return to contents

Background

We will incorporate neighbourhood working into the CVD Prevention Programme by focusing some of the activities on Grahame Park Estate; a population in Barnet who are disproportionately affected by CVD and related risk factors.

CVD, Grahame Park & the Neighbourhood Model

CVD Prevention & Grahame Park

We know cardiovascular diseases (CVD) are a major cause of preventable illness and premature mortality in Grahame Park and this population are disproportionately impacted by certain risk factors, i.e. smoking and alcohol consumption.

The Healthy Heart Peer Support Project will have an initial focus on delivery in Burnt Oak and Colindale, in which Grahame Park is part. This will be in collaboration with local voluntary organisations and community groups.

What is the Neighbourhood Model?

The Neighbourhood Model is, first and foremost, a place-based approach. There is an emphasis on using local insight, and making use of local assets, to meet the unique needs of residents. It will also be coproduced with residents - they will be involved in the conception, design, steering, and management of interventions, rather than only being consulted occasionally.

High blood pressure is the most prevalent condition (11.6%) amongst residents.

Smoking prevalence is higher in Grahame Park (19.1%) than London (14.9%).

Cardiovascular diseases are the leading cause of excess deaths.

Hospital admissions for alcohol-attributable harm are some of the highest in Barnet.

Over 6 in 10 children aged 10-11 are overweight or very overweight.

Return to contents

Background

Intervention decay shows that there are inequalities at every stage of CVD prevention. From an individual recognising they are at risk of CVD, to them being able to sustain the optimal treatment plan.

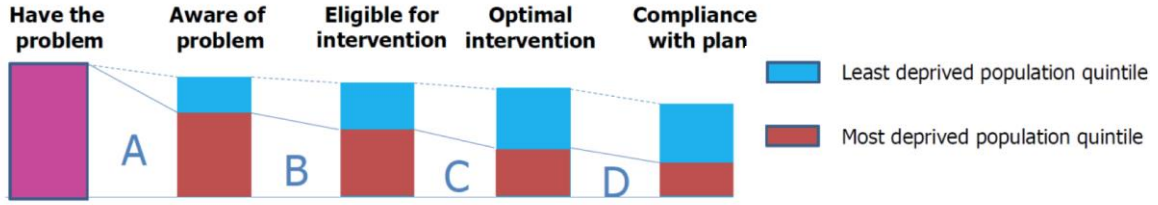
Addressing inequalities

- Some groups are more likely than others to die prematurely (under the age of 75 years) from CVD. They are also more likely to have some key risk factors:
  - Men
  - People with serious mental illness
  - People from Black Caribbean and Black African ethnic backgrounds
- Not everyone who has a long-term condition (LTC) will be aware that they have it, and of those who are aware, not all will sustain optimal treatment - 'intervention decay'
- There is widening inequality between most and least deprived as progress through the different stages of intervention decay
- This CVD Prevention Programme aims to identify and tackle the drivers of inequality at each of these levels, with the goal of both reducing the intervention decay slope and decreasing disparity.
- The programme will consider both individual prevention programmes and overall risk of CVD, recognising that many who are at high risk of CVD will benefit from more than one preventative activity, and therefore successful integration and coordination of these different programmes will impact upon overall compliance.
- The programme is aligned with the NHS Core20PLUS5 approach to support the reduction of health inequalities at both national and system level.

41

Addressing Intervention Decay in heart disease for rapid impact

A	B		C	D
	Partnership	GP		
Social marketing programmes Community based focus to awareness raising Community Champions and Ambassadors	Frontline Making Every Contact Count (MECC) Enhanced focus on target communities: Share No Man's Land Health Check 'No wrong door' for health queries Single point of access/helpline Peer support: • Champions • Navigators • Advocates	Patient register search Flag: opportunistic review Health Check 'Hidden' CHD: • Diabetes • COPD • Severe Mental Illness • Learning Disabled	↑ consistency of clinical outcomes: • CHD • Hypertension • AF Upgrade TIA and stroke pathways	Structured self-management education Support ↑ completion of cardiac and stroke rehab Peer support to self-managed care Wrap-around socio-economic support Social prescribing



Intervention decay, Chris Bentley 2012

CVD prevention in children & young people: Background

Many adults with risk factors for CVD will live in families so improving their outcomes will impact on children's health.

Preventing children and young people from taking up smoking, minimising alcohol consumption and healthy weight in children will shape the health outcomes of the adults of the future.

Young people in Barnet

- Almost a quarter of Barnet's population is 0-19 years old (approximately 99,000 young people)
- Over half (52%) of children and young people in Barnet are from Black, Asian and other ethnic backgrounds, compared with 30% across England.

Healthy weight

- Nationally there is concern at the continuing rise of childhood obesity and the implications of excess weight persisting into adulthood.
- Key findings within 2019/20 National Child Measurement Programme report for Barnet:
  - Levels of excess weight in Reception Children in Barnet has remained around 19%, which is slightly lower than London (21.6%) and England (23.0%).
  - Levels of excess weight in Year 6 Children in Barnet has remained around 34%, which is slightly lower than London (38.2%) and England (35.2%).
  - 1244 children in the Borough over the 91st percentile that would benefit from public health support.
  - Reports from young people and from teachers have highlighted the impact of COVID-19 on weight and physical activity.

Physical activity

Active Lives Children and Young People Survey for Barnet (academic year 2018/19) tells us that for 5 – 16-year-olds:

- 43.5% are active for an average of 60+ minutes a day
- 35.2% are active for less than an average of 30 minutes a day
- In a recent survey reflecting the impact of COVID measures in 2021:
- 87% of teachers believe children's physical fitness is worse and 78% of teachers believe children returned to school following COVID measures with excessive weight.

Smoking activity

- Of those young people that are smoking regularly at 16 years of age, 40% will remain lifelong smokers.
- 2.6% of Barnet's 15 year olds are regular smokers (nationally 5.5%)
- 21.8% had tried Shisha or other tobacco products
- 62% exposed to tobacco smoke in car and home 57% of this in the home.

CVD prevention in children & young people: Action

- Promote the importance of healthy body weight and a good diet before and during pregnancy.
- We will support parents and carers to establish a healthy lifestyle (diet and physical activity) for their children from a very early age.
- Support early year settings achieve the Healthy Early Year London awards
- Supportive programmes like Healthy start vouchers, Sugar Smart, HENRY

Healthy start

- Support schools to achieve Healthy Schools London, whole school approach to food
- We will support children to develop skills and confidence in their physical ability and nutrition knowledge and ability to make informed decisions about their diet and activity.
- Supporting physical activity through programmes like the Golden KM
- Supporting programmes such as Sugar Smart, SMILE, Sugar Transfat, Great Junk Food debate etc.

School age

- We will support adolescents to maintain and deepen their skills, knowledge and confidence in their physical ability, nutrition knowledge and ability to make informed healthy choices.
- We will work with youth organisations to support them to promote access to a range of healthy food choices, lunch boxes and vending
- Supporting confidence building and skills programmes such as Ministry of Food

Adolescent/ teenage

There is ongoing work to address these issues relating to children & young people in other programmes, therefore it is not being addresses within the scope of this programme.

However, as part of the CVD Prevention Programme we should consider what a family approach might mean, especially for obesity.

- When children, adolescents and families are identified as needing support to achieve a healthy weight we will enable them to access relevant and appropriate support.

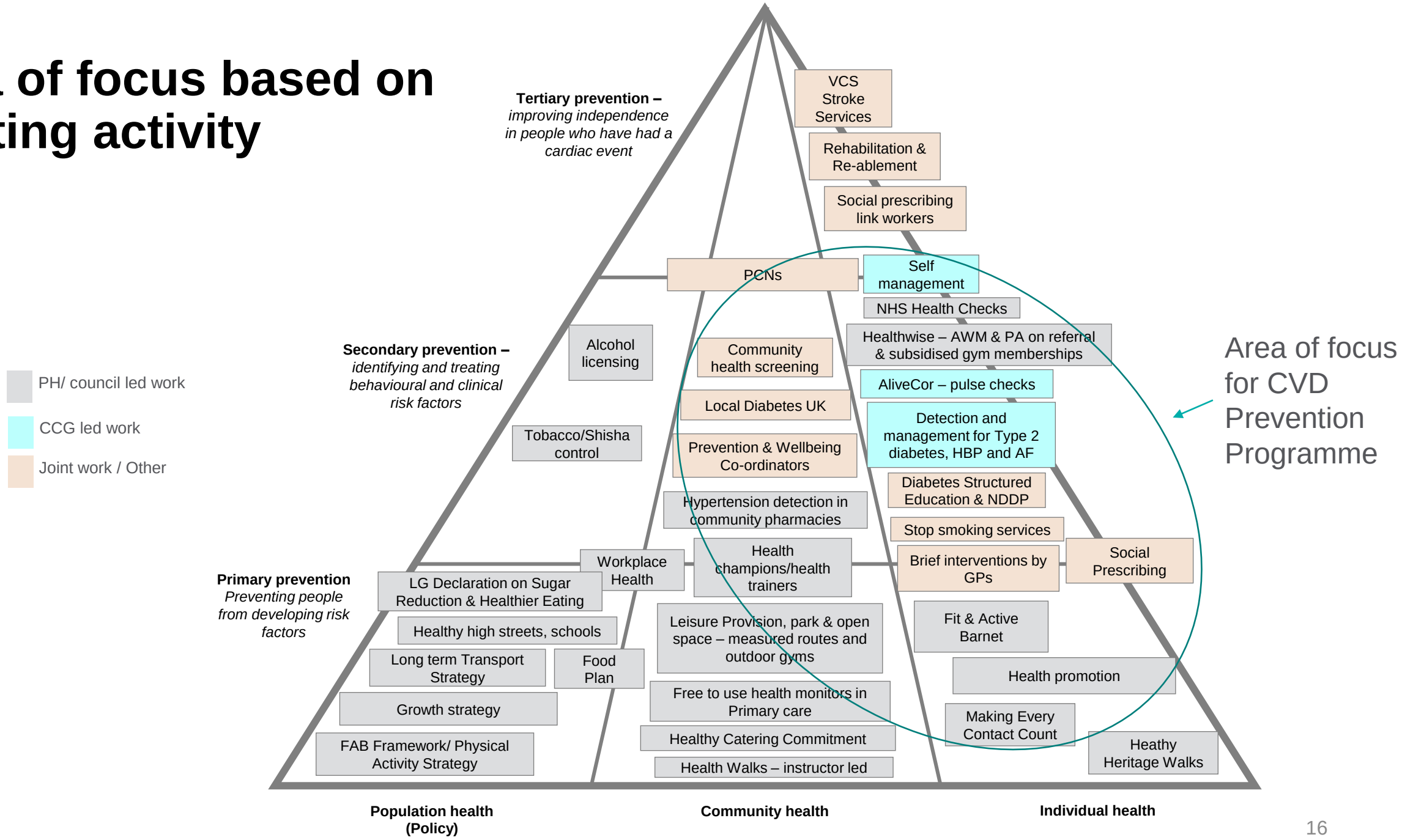
Support when needed

- We will use education and campaigns to support healthier choices being the easier choices.
- We will champion health promoting environments, communities and settings
- We will support health promotion and improvement initiatives in places where children and young people are

Smoking and other risky behaviours

Return to contents

Area of focus based on existing activity



Adapted from a previous draft NCL CVD Prevention Strategy

Return to contents

Areas of priority

The overall aims of this programme is to:

1. **Reduce the rate of premature mortality from CVD in Barnet**
2. **Reduce inequalities in premature mortality relating to geography, ethnicity, deprivation, people living with learning disabilities or severe mental illness**

Population awareness & patient activation

Behavioural risk factor management

Clinical risk factor detection & optimal intervention

Self care & sustaining change

Reduce racial, geographical and social inequalities in CVD outcomes

Priority outcomes: Population awareness & activation

Barnet residents aware of risks of CVD and how to help themselves

Increased awareness of behavioural & clinical CVD risk factors through national and local campaigns

Increased awareness of types of CVD and its consequences

Increased awareness of the importance of early identification & checks available – *NHS health checks, community health checks, annual reviews, self assessment*

Increased awareness of health behaviours that impact CVD risk – *diet, physical activity, weight management*

Barnet residents at increased risk feel empowered to take action

Increased number of residents who know their ABC – AF, blood pressure & cholesterol

Increased MECC conversations and very brief advice given by health champions and front line staff to inform of benefits of healthy behaviours and signpost to services

Increased visits and click-through rates on LBB public health microsite

Underserved communities are supported to understand risks and take action

Increased awareness in target communities of their increased risk relating to ethnicity, age & family history

Improved resident health literacy so people have the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services

Increased tailored communications to communities at higher risk of CVD e.g. multiple languages, easy read

Increased number of local workforce & volunteers trained in MECC, very brief advice & motivational interviewing

Return to contents

Stakeholders involved: Population awareness & activation

- **LBB Public Health**
  - Targeted awareness campaigns
  - Development of public health microsite
  - MECC training dissemination
  - Community health checks promotion
  - NHS Health checks promotion
- **VCS & community leaders**
  - Feedback resident voice/concerns/barriers
  - Disseminate key messaging to target communities
  - Co-design and support targeted awareness campaigns
  - MECC – very brief advice
- **Health services**
  - NHS health checks
  - MECC – very brief advice/opportunistic patient education
  - Motivational interviewing – patient activation measure

Population awareness & patient activation

47

Return to contents

Priority outcomes: Behavioural risk factor detection & management

Reduced prevalence of smoking in deprived communities

Reduced number of residents drinking to harmful levels

Reduced prevalence of obesity in adults

Increased invitations to and uptake of NHS health checks, community screening & utilisation of practice searches

Increased number of routine and manual workers accessing Barnet Stop Smoking Service

Increased number of pregnant women identified as smoking at time of booking (SATOB) during early pregnancy are accessing Barnet Stop Smoking Service

Decreased number of women smoking at time of delivery (SATOD)

Increased number of hospital inpatients offered advice and support regarding smoking cessation if identified to smoke

Increased number of residents assessing their alcohol consumption through Drink Coach

Increased number of patients offered advice through brief intervention or a referral to drug and alcohol services in all health based settings if identified to drink to harmful levels or have alcohol dependence

Targeted interventions to population groups at risk of alcohol misuse delivered

Increased referral & uptake of both local and national adult weight management programmes, particularly from areas of deprivation

Approach to self and supported weight management for people with learning disabilities (PWLD) and severe mental illness (SMI) developed

Increased proportion of residents engaging in physical activity

Improved wrap-around support offer to build resilience around food budgeting and cooking

Return to contents

Stakeholders involved: Behavioural risk factor detection & management

- **LBB Public Health**
  - NHS Health checks
  - Community health screening
  - Stop Smoking Service
  - Drink coach provision
  - Adult Weight Management (with LBB Greenspaces & Leisure)
  - Healthy eating
  - Targeted interventions
- **Health services**
  - Brief advice & interventions for smoking, alcohol, weight management
  - Referral to services: stop smoking, alcohol misuse, adult weight management
- **VCS & community leaders**
  - Awareness raising of risk factors & impact
  - Signposting to services

Behavioural risk factor management

Priority outcomes: Clinical risk factor detection & management

Detection and optimal treatment of hypertension

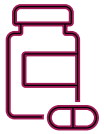
Detection and optimal treatment of atrial fibrillation

Detection and optimal treatment of pre- & type 2 diabetes

Detection and optimal treatment of raised cholesterol

Increased uptake of NHS Health Checks

Increased detection of 4 key clinical risk factors in general practice & community pharmacy



Increased proportion of patients with any of these clinical risk factors optimally treated

Increased referral to and uptake of the National Diabetes Prevention Programme (NDPP) by high risk populations

NB: General practice aspect to be delivered through the NCL Long Term Condition LCS

Stakeholders involved: Clinical risk factor detection & management

- **General practice**
  - NCL LTC LCS delivery including:
    - NHS Health Checks
    - Increased detection of clinical risk factors
    - Brief advice & referral to lifestyle services e.g. NDPP, AWM, Stop Smoking, Alcohol misuse services, diabetes structured education programmes
    - Optimal treatment
- **Community Pharmacy**
  - Detection and management of clinical risk factors e.g. hypertension
- **LBB Public Health**
  - NHS Health checks commissioning
  - Community health screening
- **VCS & community leaders**
  - Support/host community screening events
  - MECC – signposting to services

Clinical risk factor detection & optimal intervention

Proposed outcomes: Self care & sustainability

People with behavioural risk factors empowered to sustain behaviour changes

People with clinical risk factors feel empowered to manage their condition

Increased use of evidence based digital technology and health applications (e.g. NHS Apps) to support residents to manage both behavioural and clinical risk factors

Increased referrals into local behaviour change programmes:

- Weight management, nutrition & dietetic services
- Physical activity on referral
- Health walks
- Stop smoking services
- Drink Coach & substance misuse services
- VCS programmes
- LBB Public Health microsite

Increased referral and uptake of structured education programmes for type 2 diabetes

Residents have access to support from peers who share the condition and are from similar backgrounds

Stakeholders involved: Self care & sustainability

- **LBB Public Health**
  - Stop Smoking Service
  - Alcohol misuse services
  - Drink coach provision
  - Adult Weight Management services (with LBB Greenspaces & Leisure)
  - Healthy eating promotion & education
  - Digital tools – scoping & pilots
  - Peer support projects
  - Public health microsite
- **General Practice**
  - Referral to above programmes and others including structured education, social prescribing, BP@Home
- **VCS & community leaders**
  - Peer support projects
  - Signposting

Self care & sustaining change

Return to contents

Accompanying CVD Prevention Programme Action Plan 2022-24 in separate document.

If you wish to collaborate on aspects of the programme or need further information contact:

publichealth@barnet.gov.uk

Health and Wellbeing Board Meeting

18th January 2024

APPENDIX C

Cardiovascular disease prevention in Barnet

Cardiovascular disease and risk factors in Barnet

London – Global Burden of Disease 2019 – top ten disease burdens

The top ten causes shown below account for 35.5% of total disability adjusted life years (DALYs) in the London region.

DALYs for a disease or health condition are the sum of the years of life lost due to premature mortality (YLL) and the years lived with a disability (YLD). One DALY represents the loss of the equivalent of one year of full health

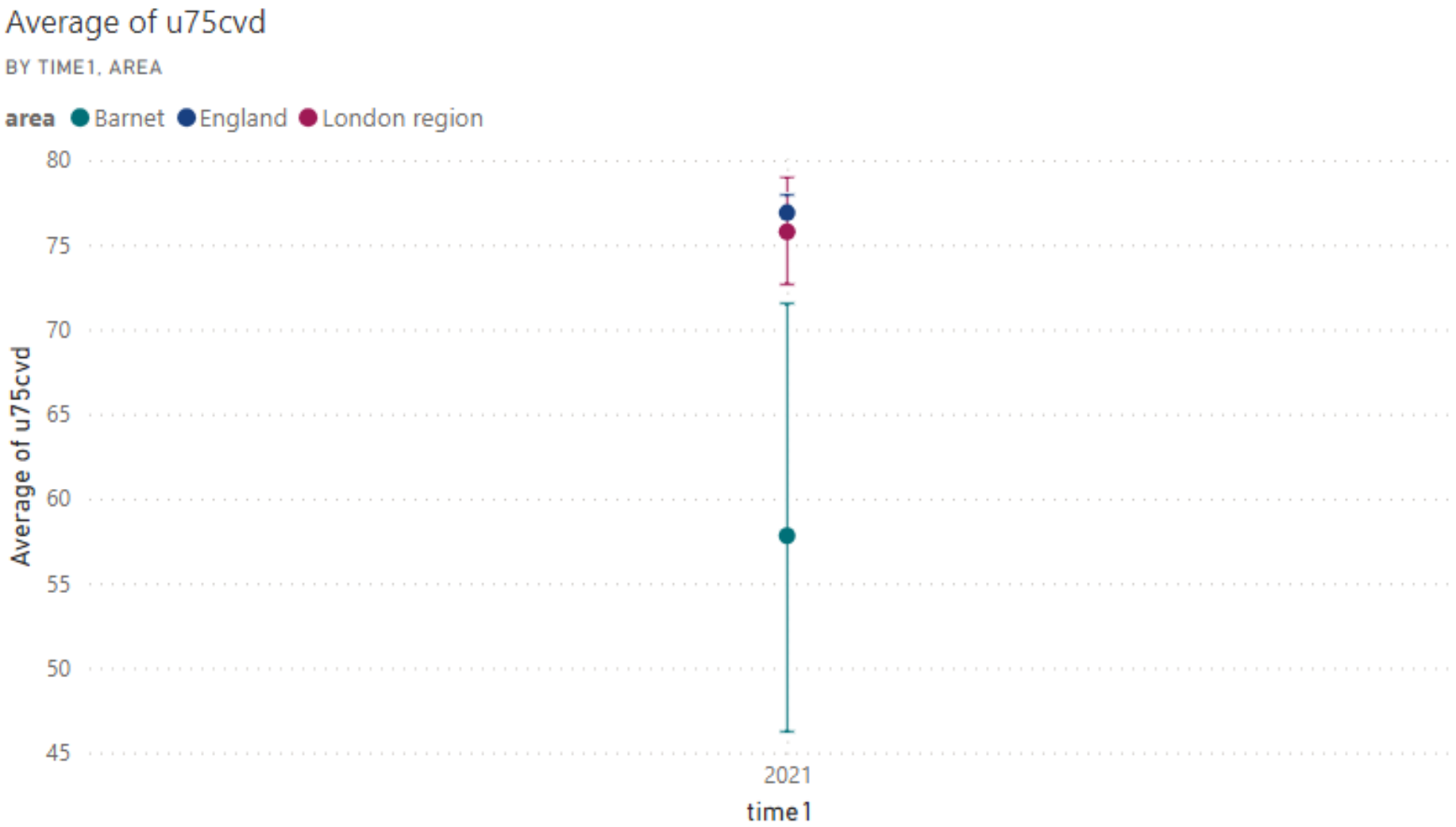
Cause name	Percentage of total DALYs in London (%)
Ischaemic heart disease	**5.52**
Low back pain	5.47
Diabetes mellitus	**3.61**
Chronic obstructive pulmonary disease	3.54
Depressive disorders	3.51
Headache disorders	3.29
Tracheal, bronchus and lung cancer	3.17
Stroke	**2.61**
Falls	2.47
Neck pain	2.28

Cardiovascular disease and associated conditions highlighted in bold red

Reference: Office for Health Improvement and Disparities. Local Inequalities Explorer Tool. ©Crown copyright 2023. Microsoft Power BI
Data source: Global Burden of Disease 2019. Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2020. Available from VizHub - GBD Compare (healthdata.org)

Cardiovascular disease mortality in people aged under 75

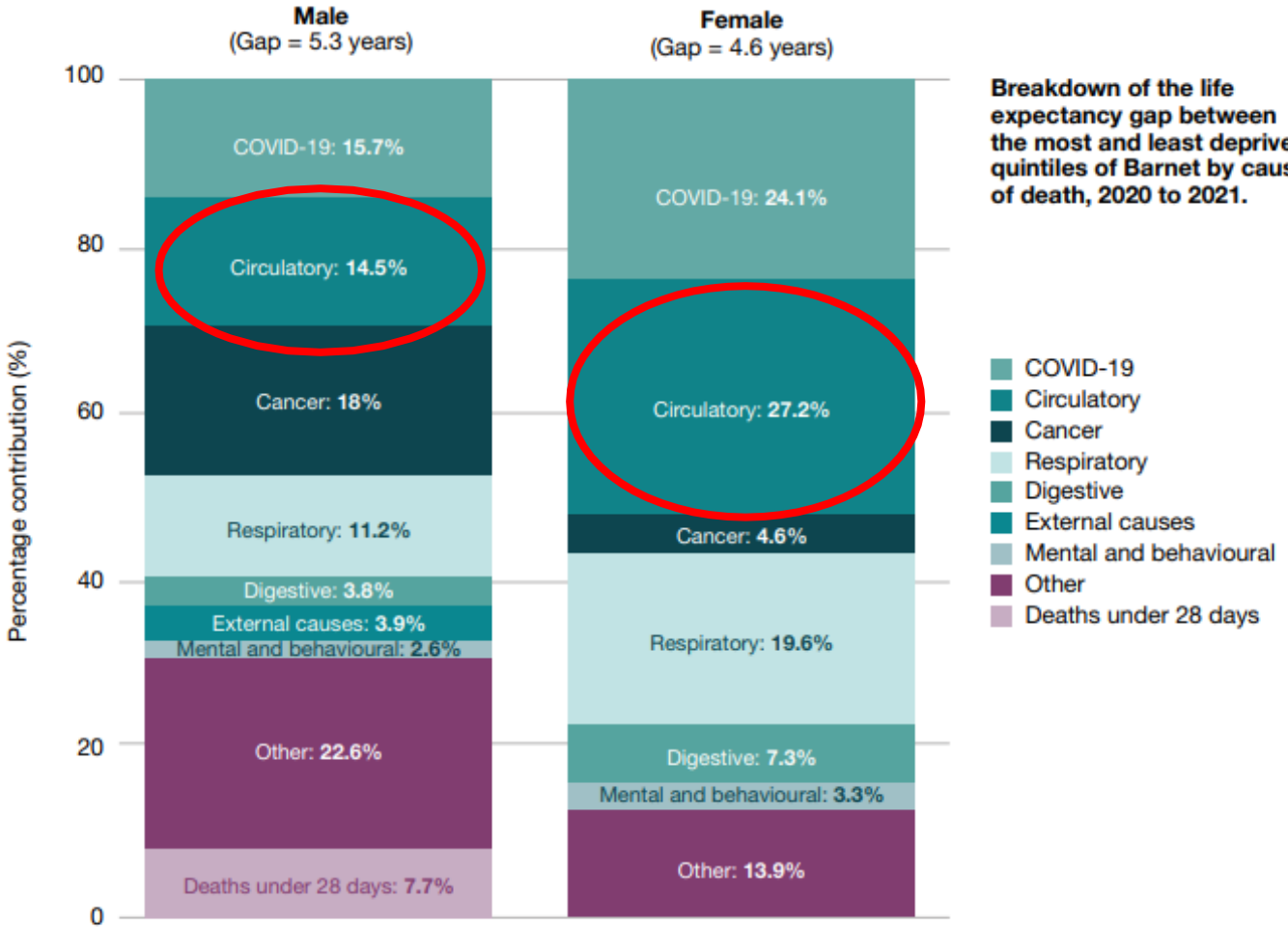
(Directly age standardised mortality per 100,000 population)



Open in Power BI Public_Health_Dashboard_Barnet, Data as of 02/11/23, 15:39

Diseases that contribute to the life expectancy difference between people living in the most and least deprived areas of Barnet

Figure 6: Percentage contribution to the life expectancy gap between those living in the most and least deprived areas, by causes of death



Source: Office for Health Improvement and Disparities based on ONS death registration data and 2020 mid-year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019.

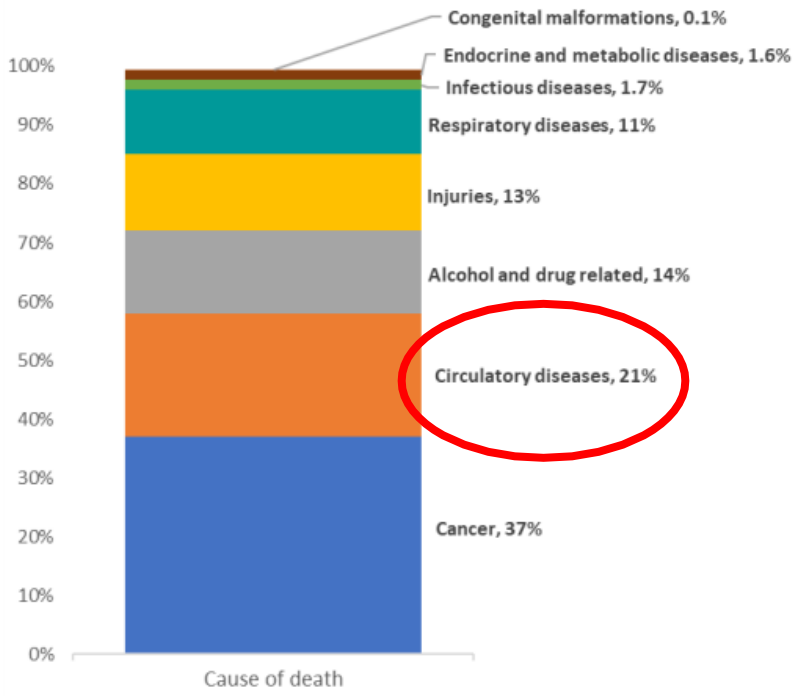
Avoidable mortality in NCL (slide from NCL ICS)

24% deaths <75 years are from causes that could have been prevented or treated – avoidable deaths

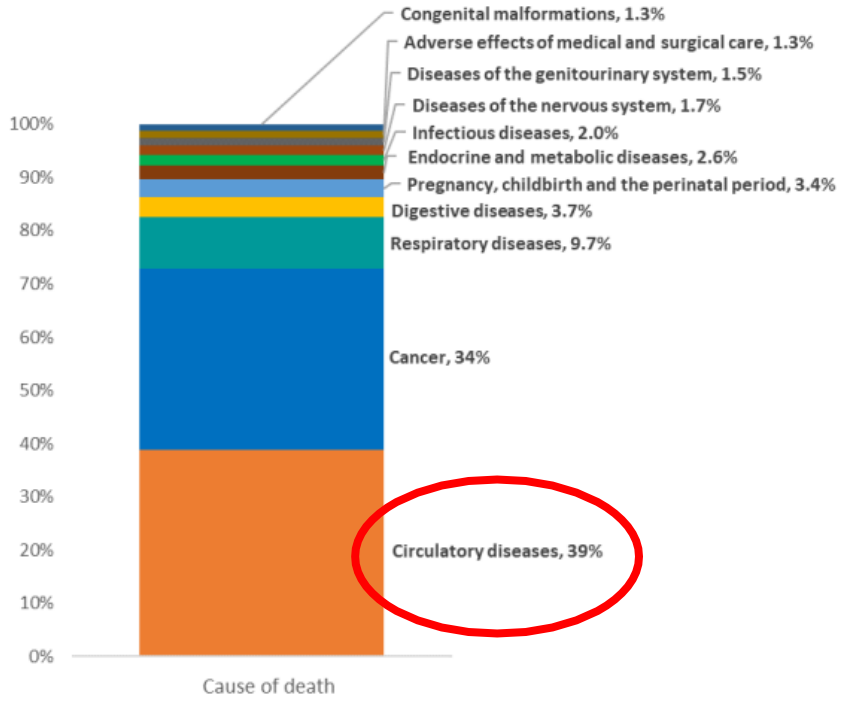
Preventable deaths – deaths <75 years which could have been prevented through public health interventions and primary prevention – approximately 15% deaths in NCL

Treatable deaths – deaths <75 years which could have been prevented through secondary prevention and treatment – approximately 9% deaths in NCL

Underlying causes of preventable mortality, NCL, 1 Jan 2016- 31 Dec 2020



Underlying causes of treatable mortality, NCL, 1 Jan 2016- 31 Dec 2020

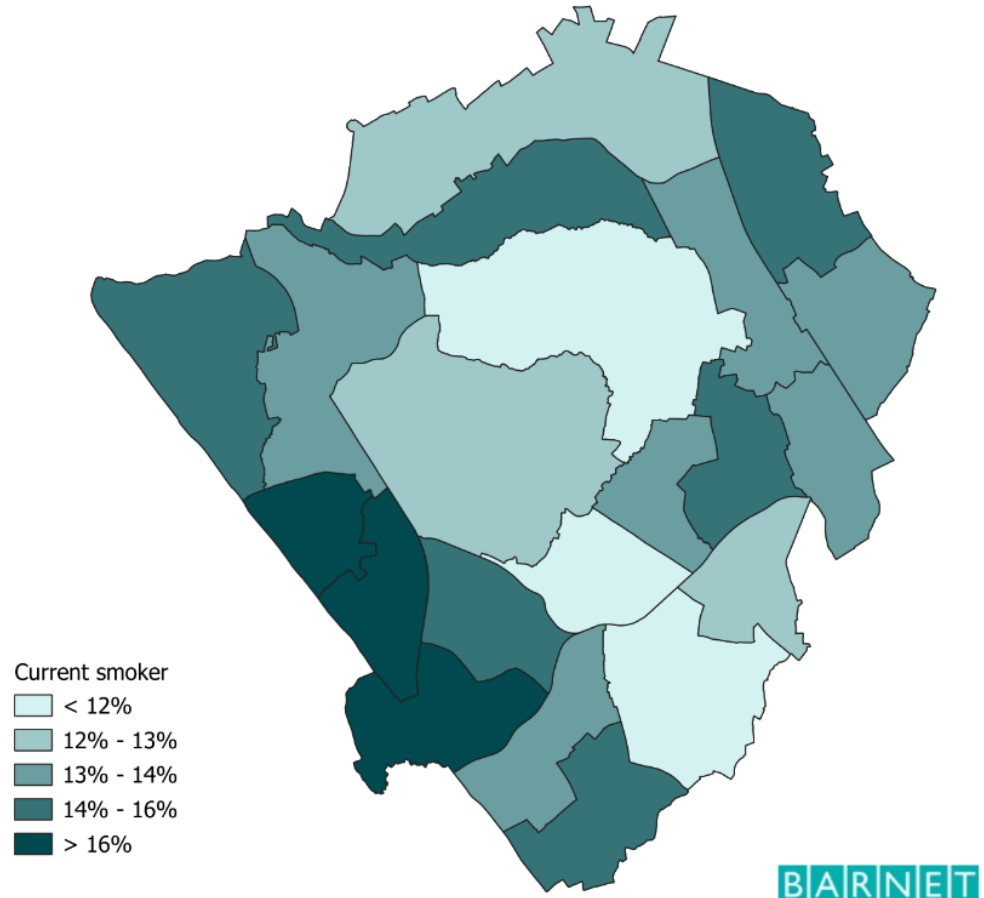


Note: Where causes of death are both preventable and treatable they have been allocated 50%-50% between preventable and treatable mortality.

CVD behavioural risk factors - distribution across Barnet

Smoking Prevalence in Barnet

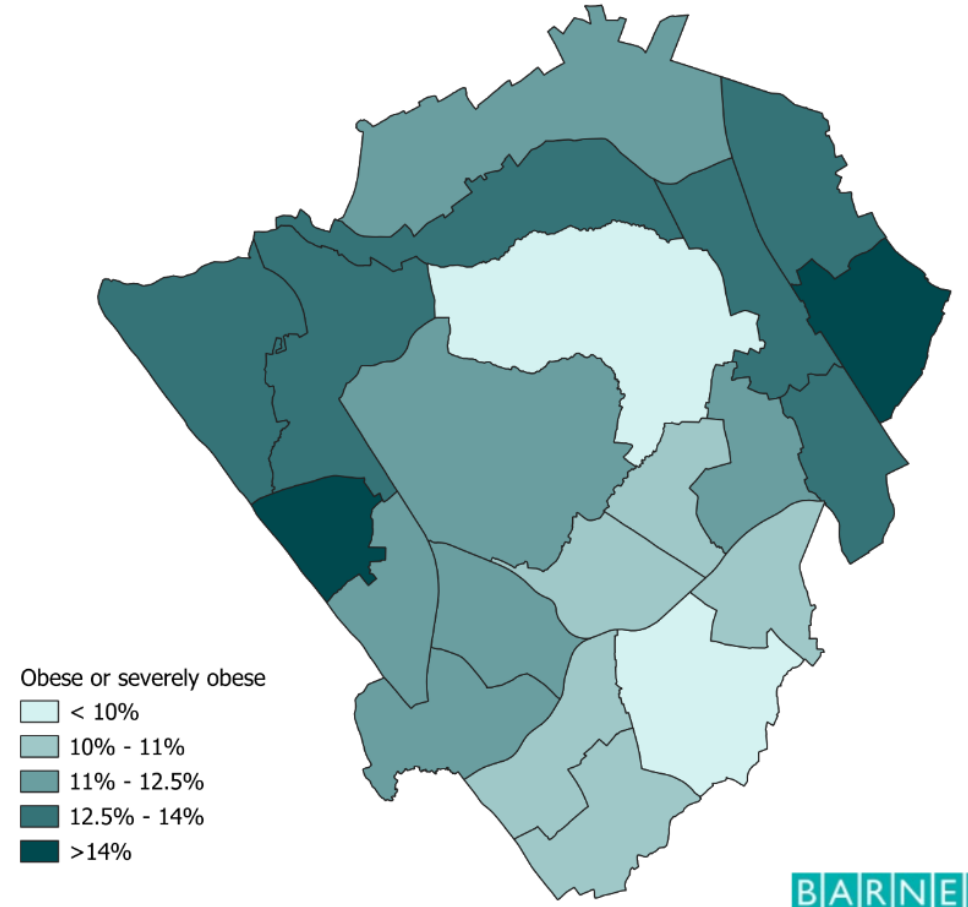
Based on registered GP population by ward



Source: North Central London Integrated Care System, HealtheIntent. 2023 © Crown copyright 2023

Obesity or Severe Obesity Prevalence in Barnet

Based on registered GP population by ward



Source: North Central London Integrated Care System, HealtheIntent. 2023 © Crown copyright 2023

Cardiovascular disease prevention in Barnet

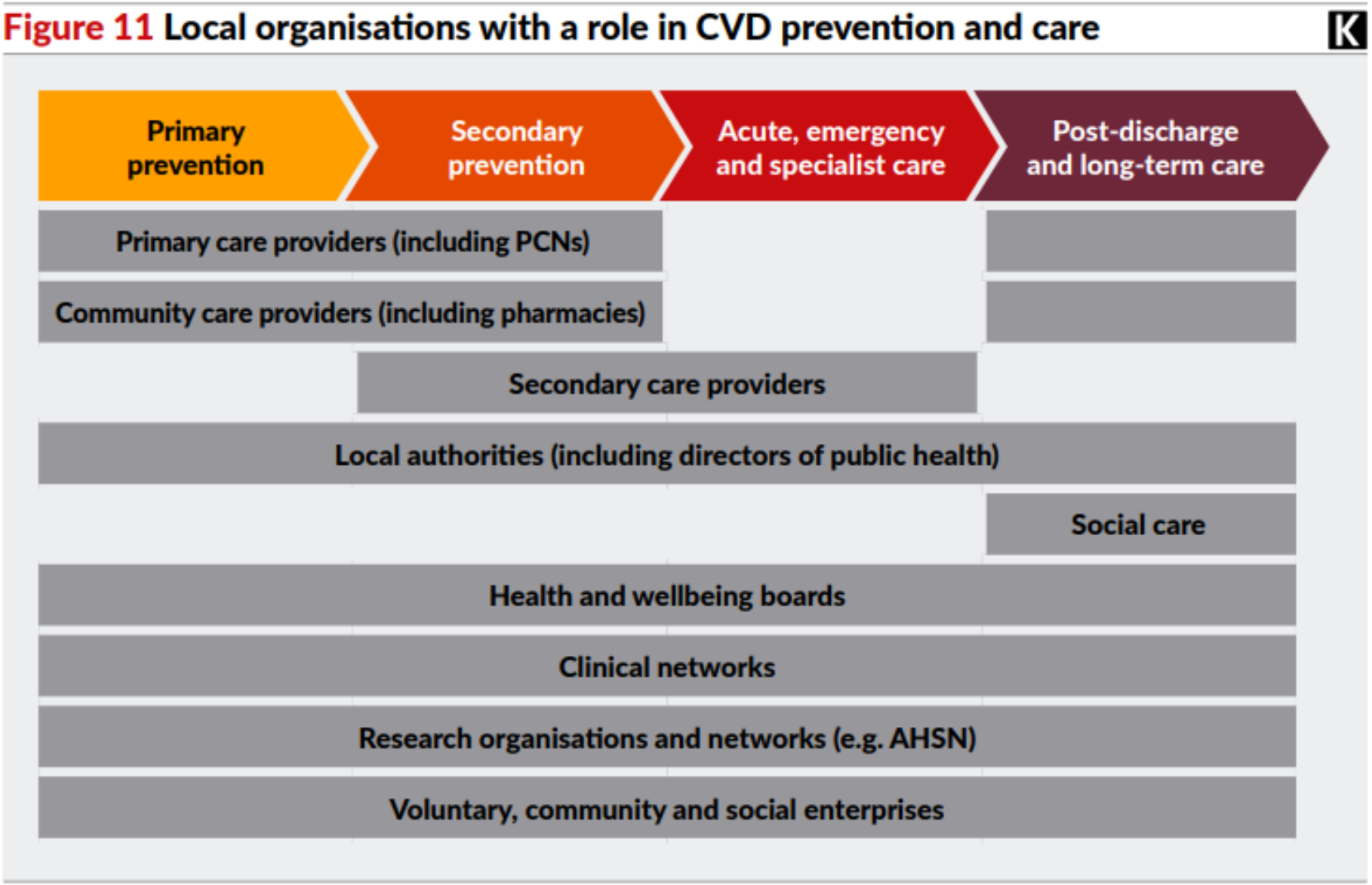
Policy and strategy levers for CVD Prevention

National
NHS Long Term Plan
Major conditions strategy
Core20PLUS5 approach

Regional
NCL Population Health and Integrated Care Strategy
NCL ICS – Heart Health is a priority for 2024
Royal Free London Foundation Trust Clinical Strategy – Cardiovascular is one of three priorities

Local
Barnet Borough Partnership priority for reducing health inequalities – CVD prevention
Barnet Joint Health and Wellbeing Strategy 2021 to 2025 | Barnet Council
Barnet Cardiovascular Disease (CVD) Prevention Programme and Action Plan | Barnet Council

Cardiovascular disease prevention – system approach



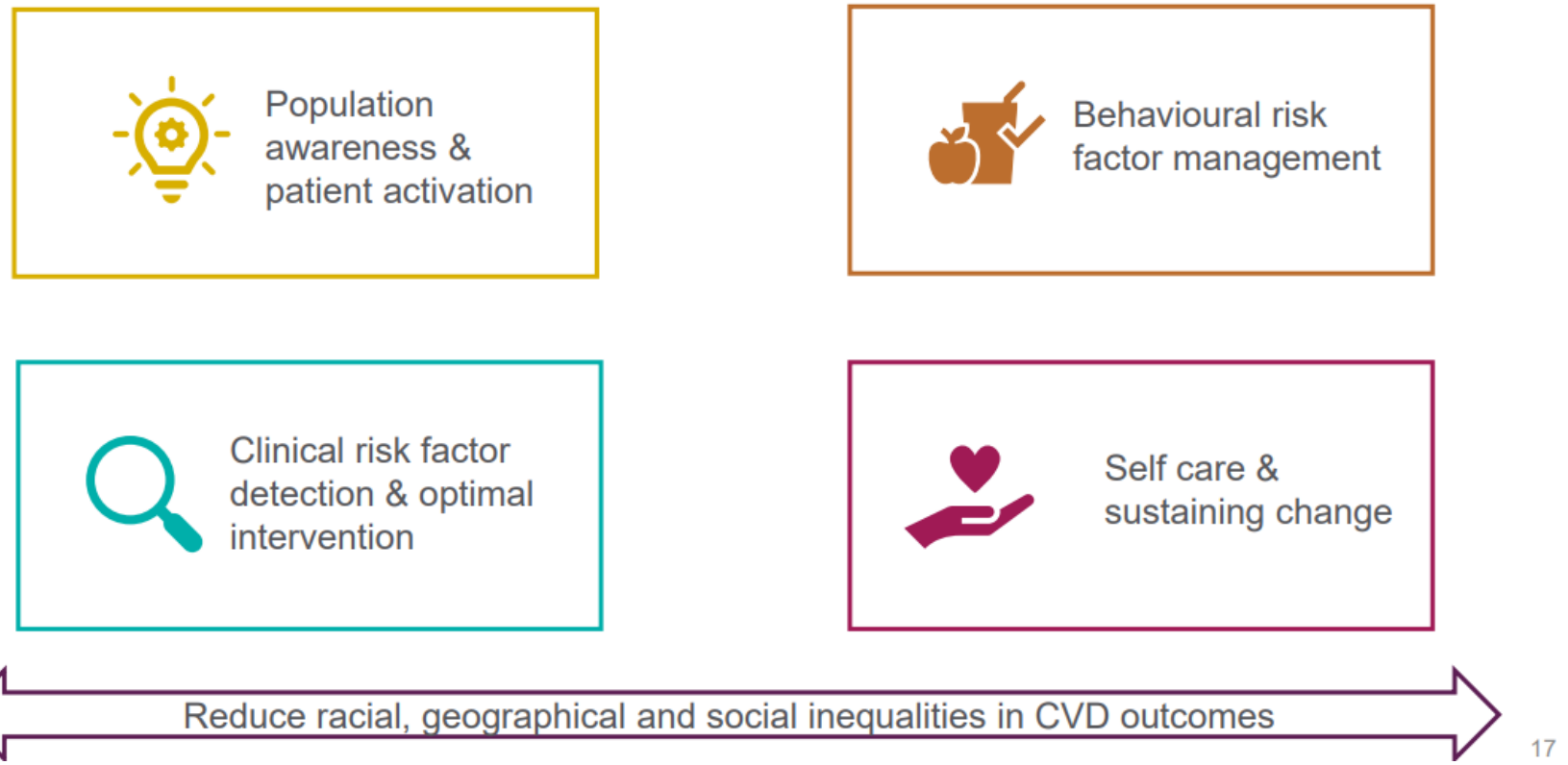
Source: https://www.kingsfund.org.uk/publications/cardiovascular-disease-england

Barnet Cardiovascular Disease Prevention Programme, 2022 - 2026

Areas of priority

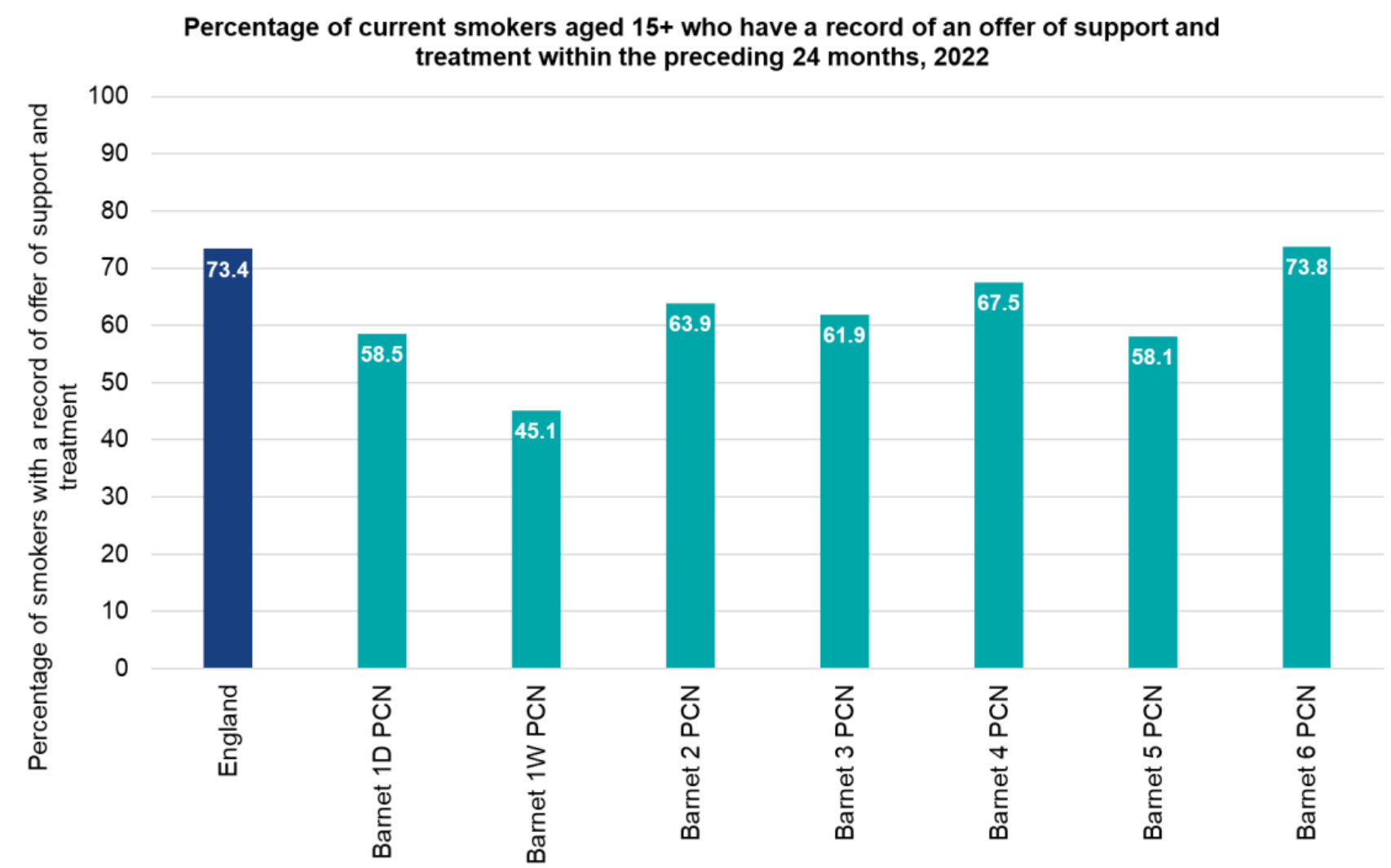
The overall aims of this programme is to:

1. **Reduce the rate of premature mortality from CVD in Barnet**
2. **Reduce inequalities in premature mortality relating to geography, ethnicity, deprivation, people living with learning disabilities or severe mental illness**



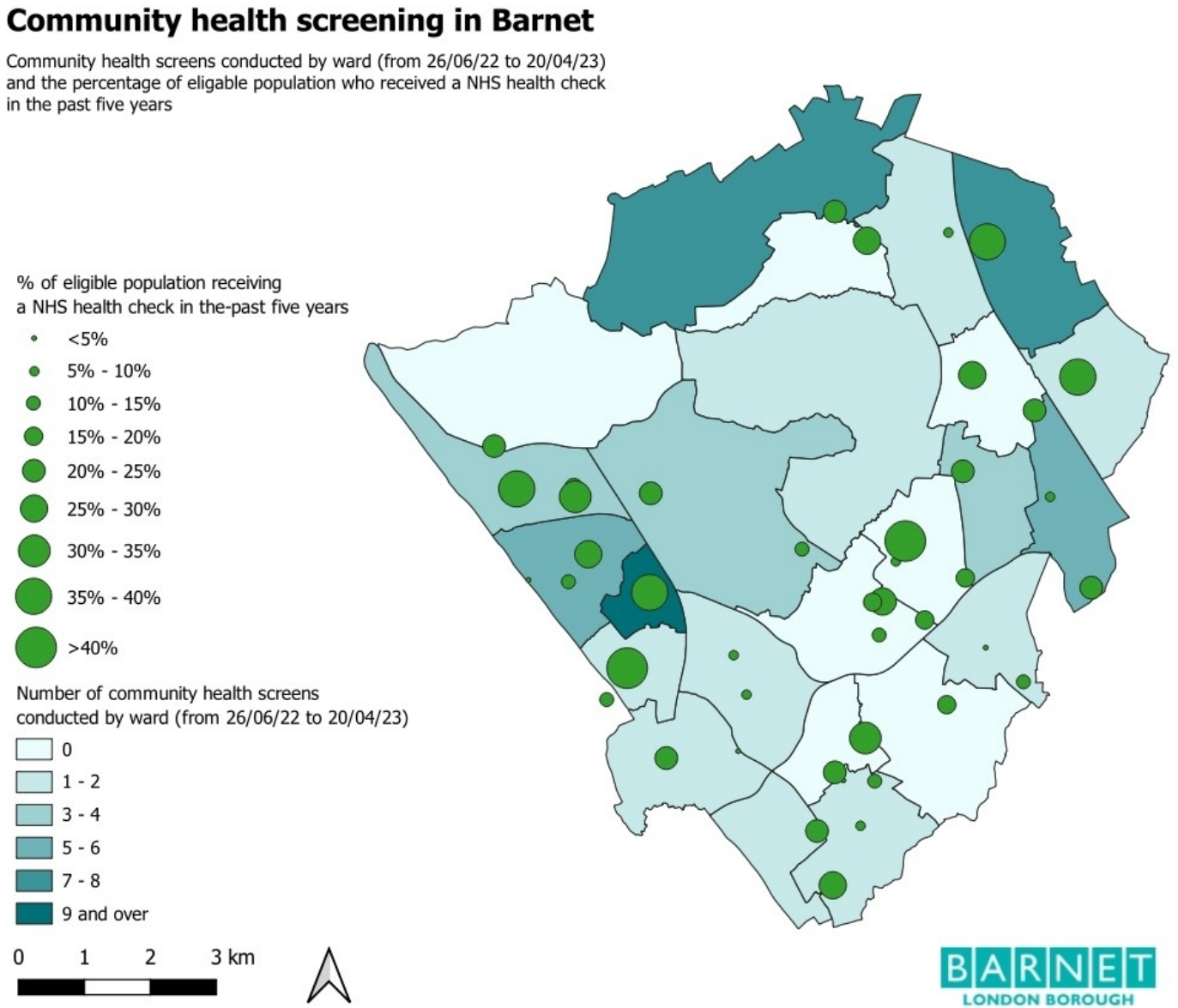
https://www.barnet.gov.uk/health-and-wellbeing/health-and-wellbeing-key-documents/cardiovascular-disease-cvd-prevention

Smoking cessation

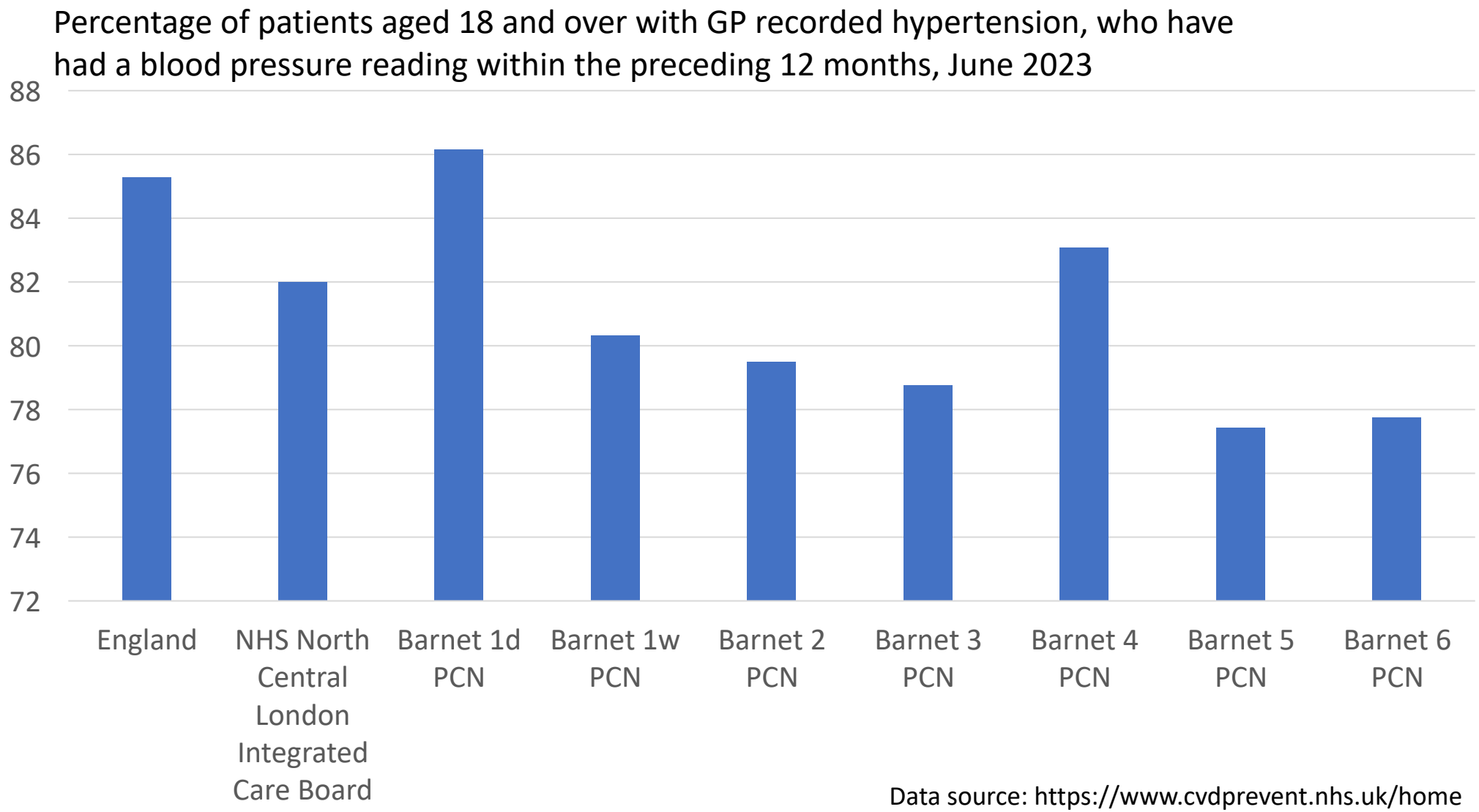


Quality and Outcomes Framework (QOF), NHS England, © Crown copyright 2023

Community health screening and NHS Health Checks across Barnet



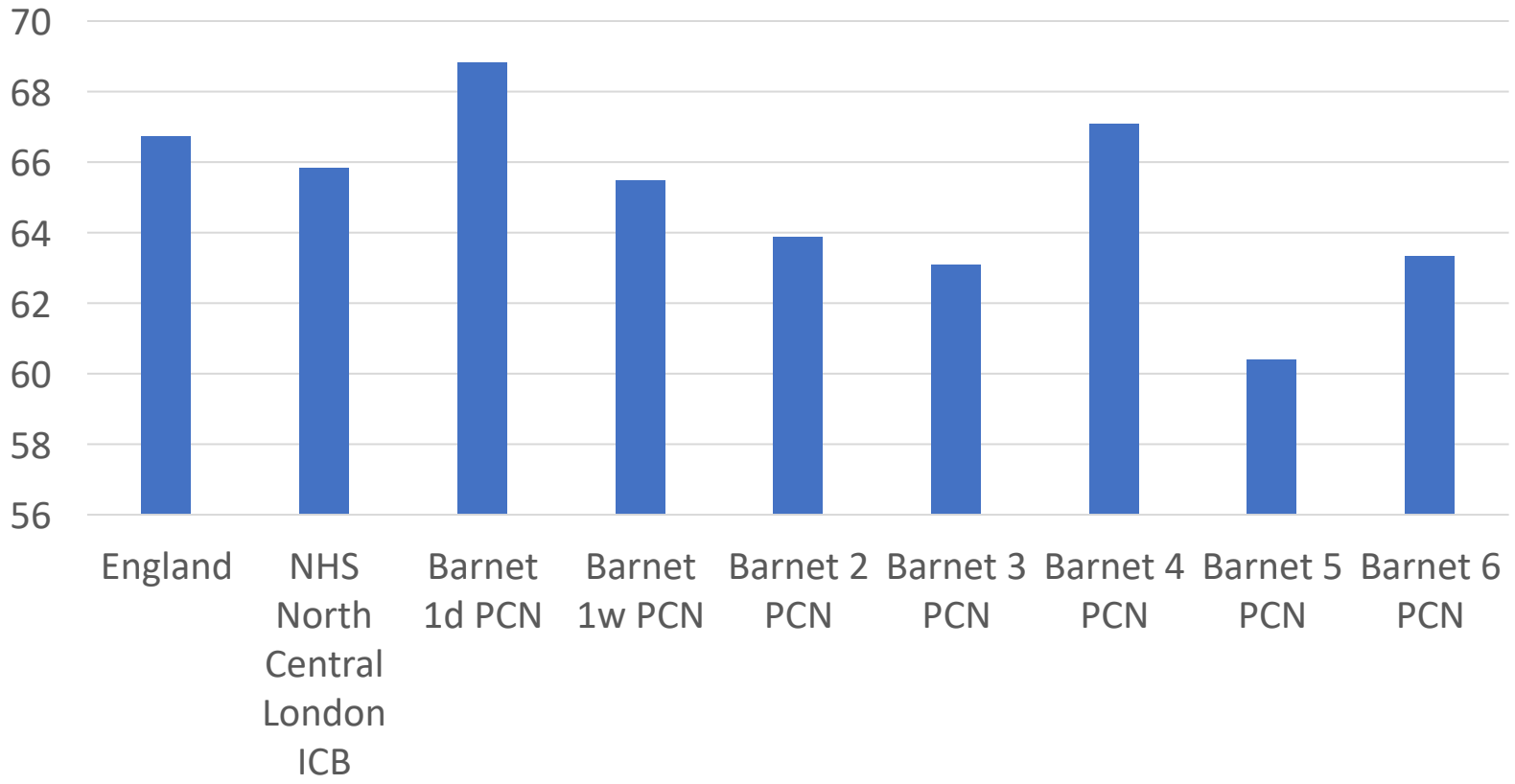
CVD clinical risk factor - Hypertension and blood pressure measurement



Data source: https://www.cvdprevent.nhs.uk/home

CVD clinical risk factor - Hypertension management

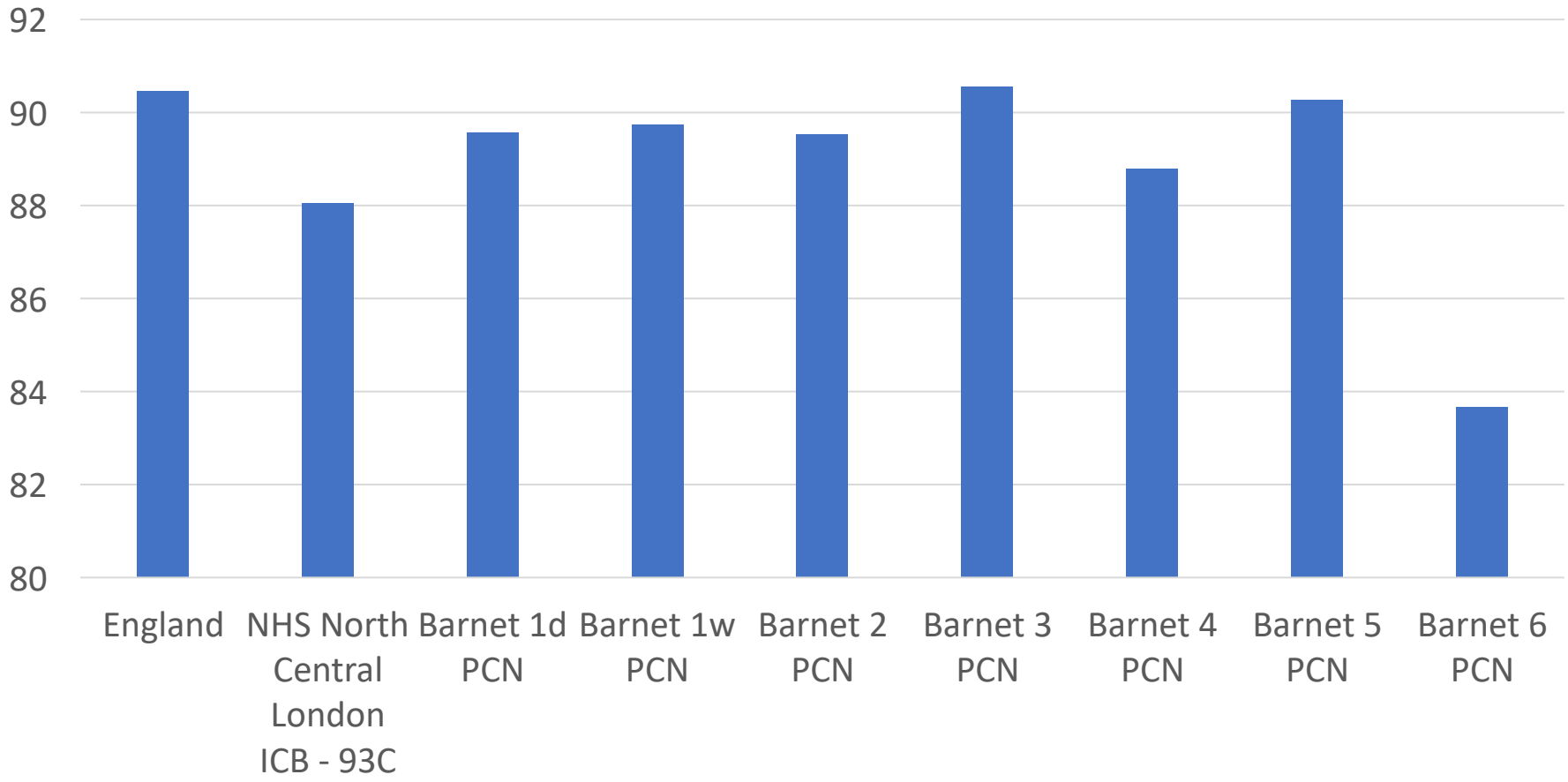
Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold, June 2023



Data source: https://www.cvdprevent.nhs.uk/home

CVD clinical risk factor – anti-coagulation for atrial fibrillation

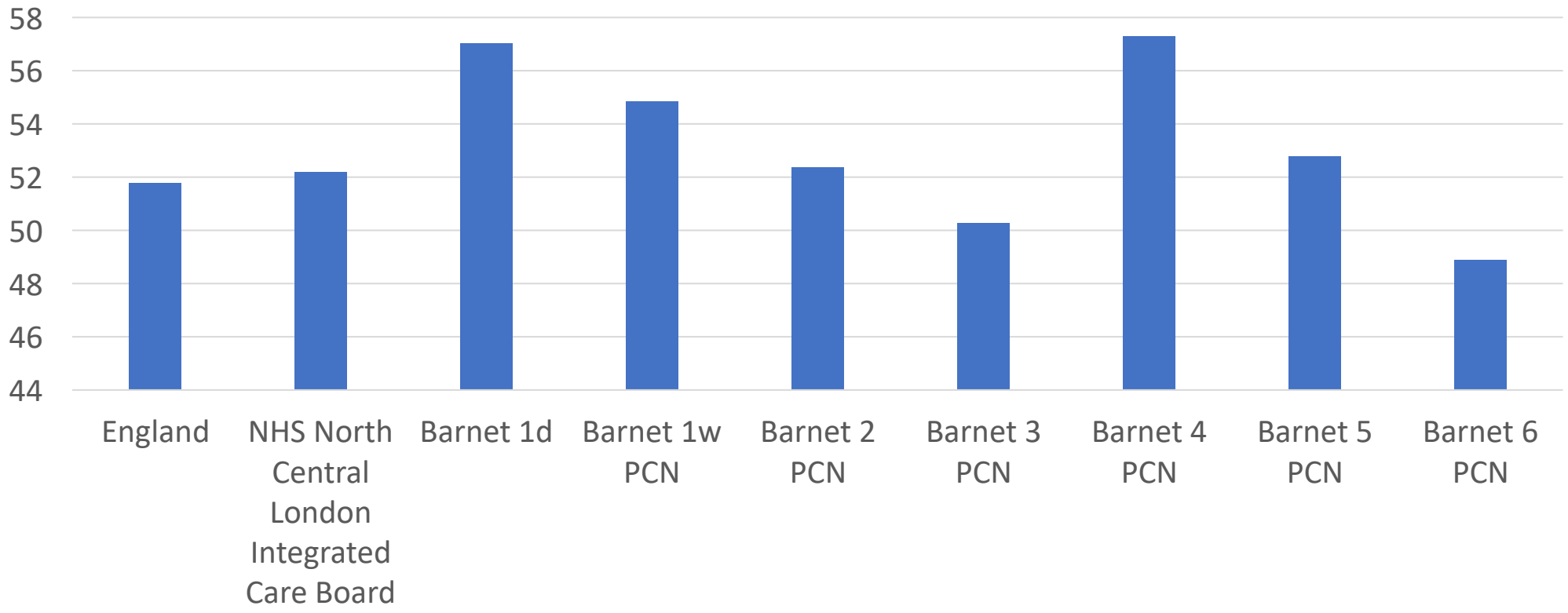
Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy, June 2023



Data source: https://www.cvdprevent.nhs.uk/home

CVD clinical risk factor – lipid lowering therapy

Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy, June 202



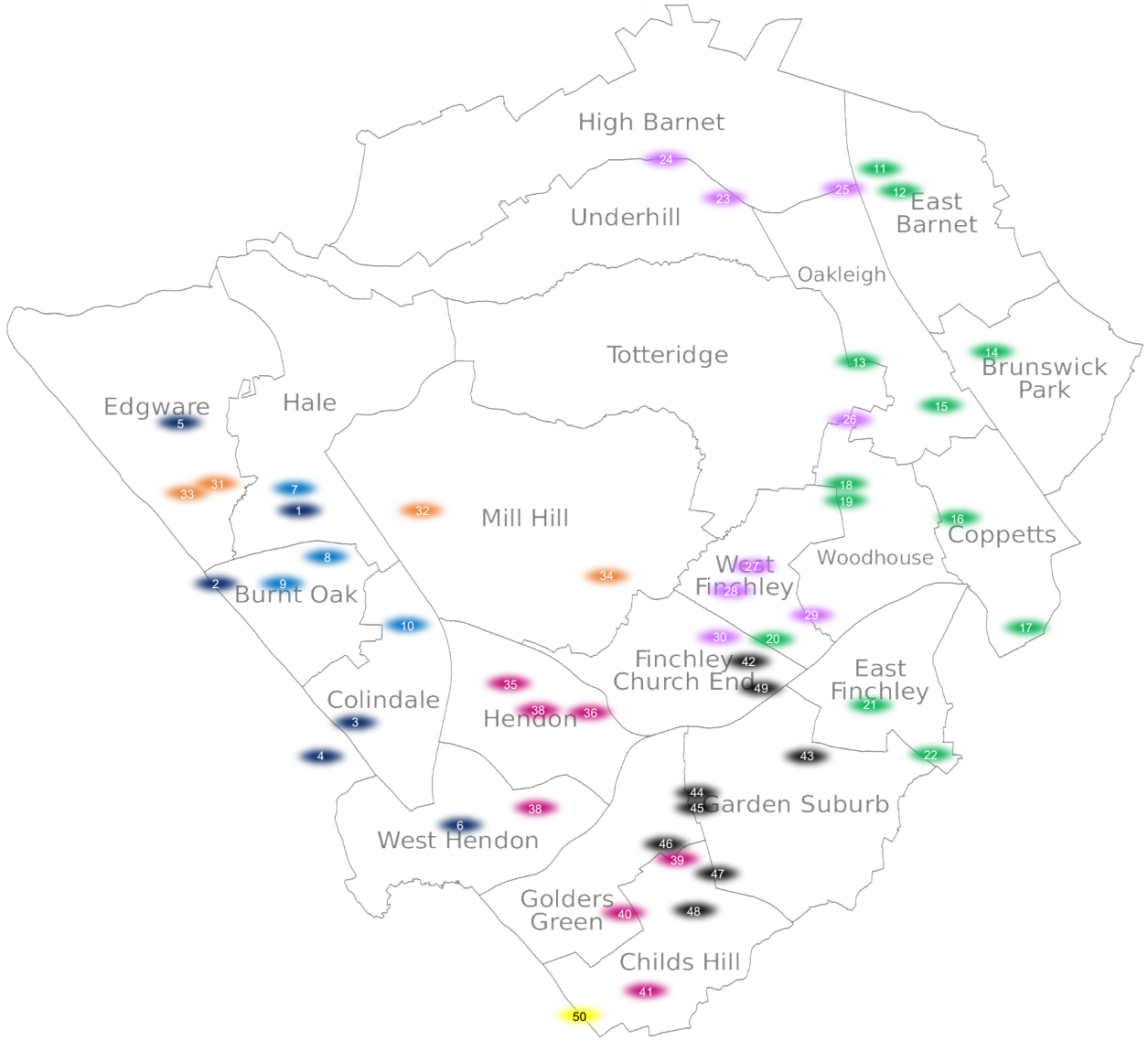
Data source: https://www.cvdprevent.nhs.uk/home

CVD Prevention Action Plan for 2024 – Strategic aims

Community settings
Adult weight management services (AWMS) tier 2 available to people who would most benefit, and resulting in weight loss
Physical activity promotion to people who would most benefit for cardiovascular health
Community health screening to compliment NHS Health Checks in areas where people are more likely to be living in poor health
National Diabetes Prevention programme to increase delivery in Barnet
Community Peer Support to promote heart health and reduce hypertension for population groups at higher risk of CVD
Reduction of substance misuse in Barnet

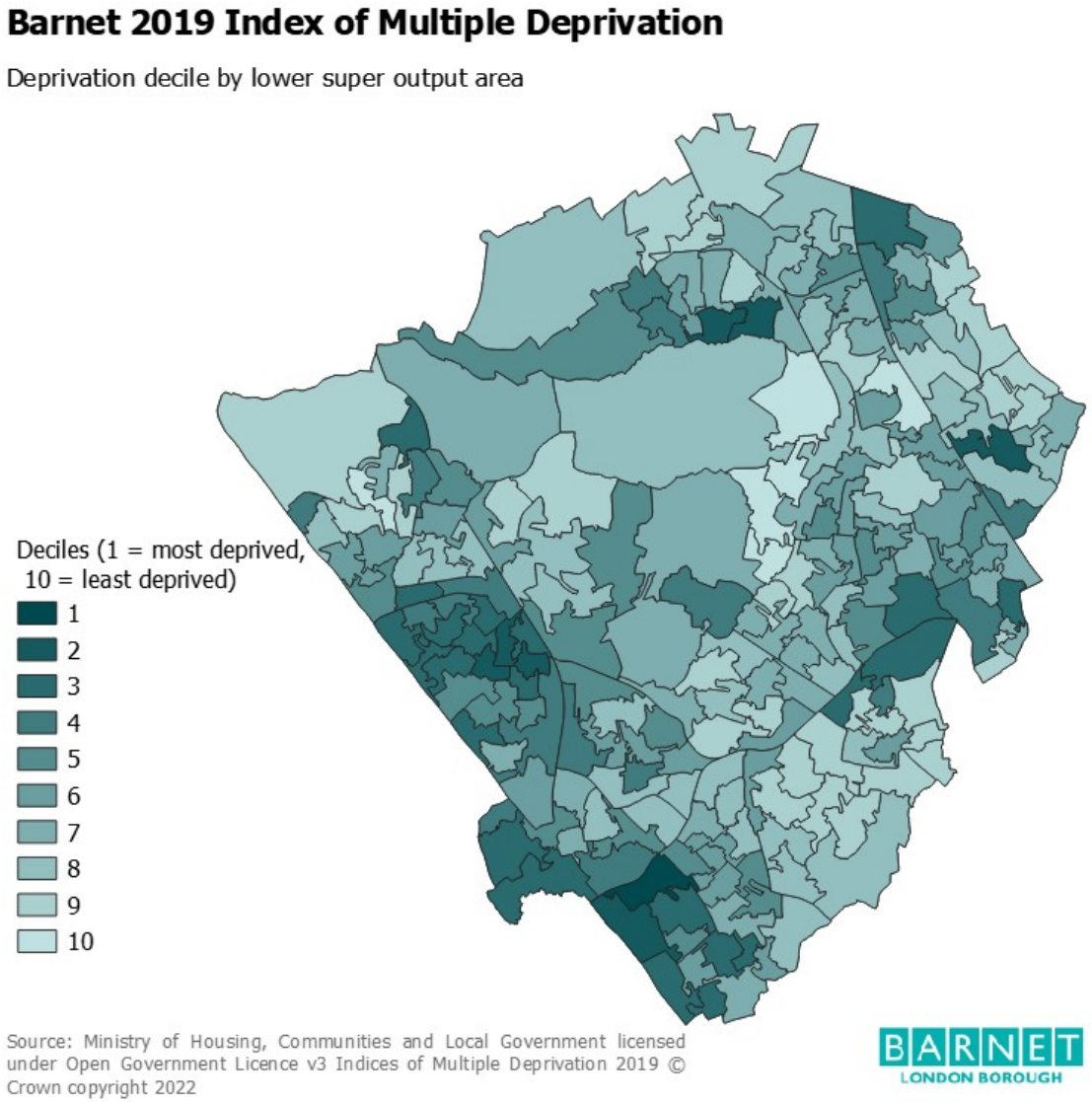
Healthcare settings
Smoking cessation services to increase delivery in primary and secondary healthcare and community
NHSE Community Pharmacy blood pressure check service - increased awareness and delivery in Barnet
NHS Health Checks – increase delivery in areas with high deprivation, to identify people with high risk of CVD and start risk reduction
Annual health checks for PWLD and SMI – optimise and support actions for CVD prevention
Long term conditions locally commissioned service (LTC LCS) to support CVD prevention – hypertension and heart failure management
Secondary care - Demographic data analysis for people accessing secondary care and primary care for CVD
Data analysis to monitor CVD prevention in Barnet

Appendix 1 – Barnet PCN map



Key	Practice Name	PCN
1	Mulberry Medical Practice	PCN 1D
2	Oak Lodge Medical Centre	PCN 1D
3	Colindale Medical Centre	PCN 1D
4	Wakeman's Hill Surgery	PCN 1D
5	Jai Medical Centre	PCN 1D
6	Hendon Way Surgery	PCN 1D
7	Deans Lane Medical Centre	PCN 1W
8	Parkview Surgery	PCN 1W
9	Watling Medical Centre	PCN 1W
10	The Everglade Medical Practice	PCN 1W
11	The Village Surgery	PCN 2
12	East Barnet Health Centre	PCN 2
13	St Andrews Medical Practice	PCN 2
14	Brunswick Park Medical Practice	PCN 2
15	The Clinic (Oakleigh Rd North)	PCN 2
16	Friern Barnet Medical Centre	PCN 2
17	Colney Hatch Lane surgery	PCN 2
18	The Speedwell Practice	PCN 2
19	Torrington Park Group Practice	PCN 2
20	Rosemary Surgery	PCN 2
21	Woodlands Medical Practice	PCN 2
22	East Finchley Medical Practice	PCN 2
23	Longrove Surgery	PCN 3
24	The Old Courthouse Surgery	PCN 3
25	Addington Medical Centre	PCN 3
26	Derwent Medical Centre	PCN 3
27	Wentworth Medical Practice	PCN 3
28	Cornwall House Surgery	PCN 3
29	Squires Lane Medical Practice	PCN 3
30	Lichfield Grove Surgery	PCN 3
31	Penshurst Gardens	PCN 4
33	Millway Medical Practice	PCN 4
33	Lane End Medical Group	PCN 4
34	Langstone Way Surgery	PCN 4
35	St George's Medical Centre	PCN 5
36	Hillview Surgery	PCN 5
37	The Phoenix Practice	PCN 5
38	Dr Azim & Partners	PCN 5
39	Ravenscroft Medical Centre	PCN 5
40	Pennine Drive Surgery	PCN 5
41	Greenfield Medical Centre	PCN 5
42	Supreme Medical Centre	PCN 6
43	Heathfielde	PCN 6
44	PHGH Doctors	PCN 6
45	Temple Fortune Medical Group	PCN 6
46	The Practice @ 188	PCN 6
47	Drs Adler & Rosenberg	PCN 6
48	Hodford Road Surgery	PCN 6
49	Mountfield Surgery	PCN 6
50	Cricklewood Health centre	TBC

Appendix 2 – Barnet Index of Multiple Deprivation map



Health and Wellbeing Board Meeting

18th January 2024

APPENDIX D

Healthy Heart Peer Support Project

THE TEAM

Judi Dumont-Barter

Riffat Ahmed

Salna Abdallah

<u>Contact information:</u>

- **Webpage:** Healthy Heart Project - Inclusion Barnet
- **Email:** healthyheart@inclusionbarnet.org.uk
- **Telephone:** 020 3475 1316
- **Text us:** (Mon-Thurs 9am-5pm): 07719105534

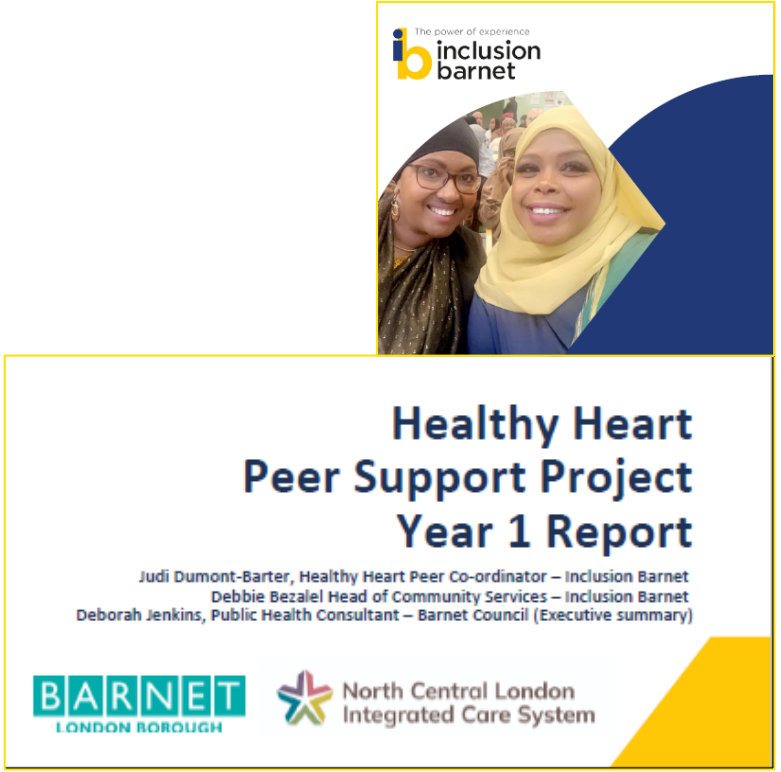
The power of experience
inclusion barnet

BARNET
LONDON BOROUGH

North Central London
Integrated Care System

Project purpose | Year 1 report | Areas of operation | Governance

- The Healthy Heart (HH) Peer Support Project aims to empower Barnet residents from **South Asian, African, or Caribbean** heritage to better manage their cardiovascular health, through community outreach, **peer support and culturally competent resources.**
- **Inclusion Barnet**, in partnership with Barnet Public Health, delivered the first year of the programme from May 2022 to May 2023, and the programme has been extended for a second year.
- **Link to the report:** HH-Year-1-Executive-Report-updated-Oct-23.pdf (inclusionbarnet.org.uk)
- Healthy Heart **ward focus:** Burnt Oak, Colindale, Edgware and West Hendon.
- Healthy Heart is underpinned by a **Clinical Reference Group** made up of local GPs, Public Health representatives, plus a Cardiologist, Pharmacy Lead, Renal Nurse, Dietician, and Social Prescribing Lead. This group have supported the development of the Healthy Heart intensive programme.



HH offer a range of interventions to support participants

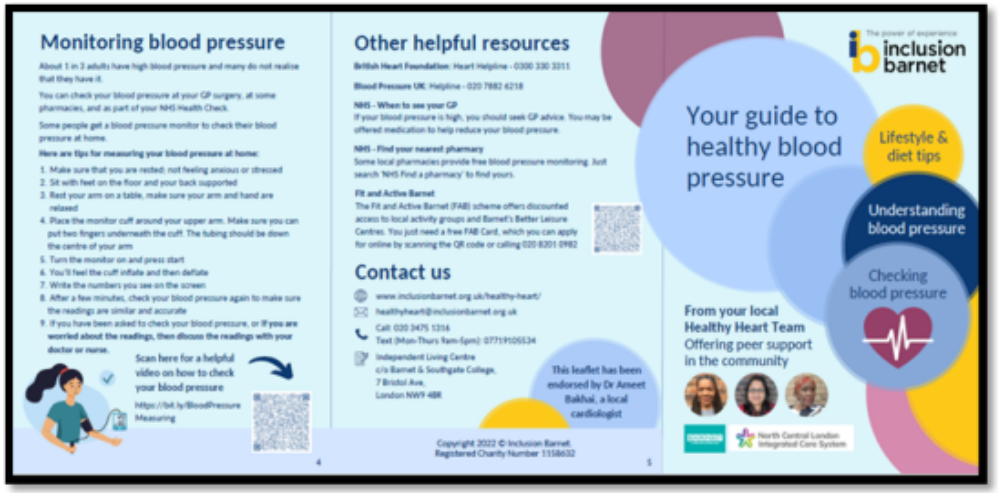
- Very brief / brief interventions:
  - **30 seconds to 2 minutes** – information giving, signposting, awareness raising, encouragement; probably doesn't include goal setting – eg. conversations at outreach events, sharing leaflets or posters in person.
  - **5-10 minutes** - includes discussion, encouragement, signposting, potentially goal-setting and multiple themes.
  - Examples: International Women's Day and Black History Month events.
- Extended brief interventions:
  - 10-15 minutes – specific information provision, goal setting, supporting participants to identify capability, opportunity & motivation for behaviour change; monitoring could include demographics.
  - Example: Healthy Heart weekly drop-in sessions at the West Hendon Hub (Housing Association).
- Workshops and multi-session interventions (see next slide):
  - Can be over multiple sessions, enabling and supporting participants to identify capability, opportunity & motivation for behaviour change, includes goal setting and review of goals, multiple discussion topics.
  - Example: intensive 4 session programme that covers High Blood Pressure (HBP) awareness, correct monitoring, managing HBP through changes to diet / nutrition and increasing activity.

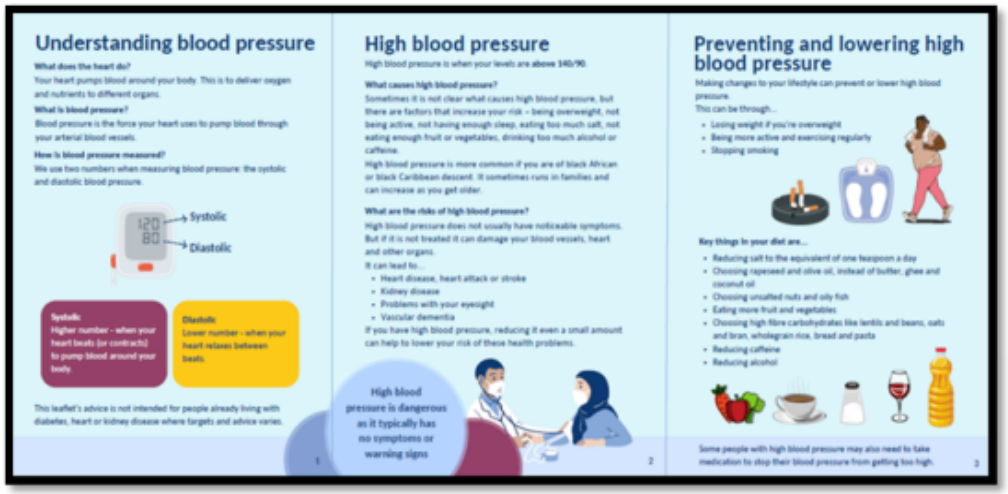
HH intensive course breakdown | Supporting documentation

Session 1	HH team	• Healthy Heart project introduction • What is high blood pressure? • Why is it important? • What does it mean to you personally?
Session 2	**Medical Perspective** Dr Amit Shah (video)	• Medical advice (via video) • Risks of having high blood pressure • Familial Risks • Medication
Session 3	**Nutrition** Nourhan Barakat (video)	• Nutrition advice (via video) • What does healthy eating look like? • Q&A from participants • Aids from YouTube on healthy diet | Salt video
Session 4	**Fit & Active in Barnet**	• Fit & Active in Barnet provide activity session • Course recap

Healthy Heart Resources

- Healthy Heart (HH) are particularly proud of our jointly developed **Resource Pack** for the community. Following requests from participants, we have been able to create versions in Somali and Gujarati.
- Additionally, **video usage** has proved very successful within the intensive programme. Most recently, Public Health have supported HH to add subtitles to each video. Eventually the videos will be available via YouTube.

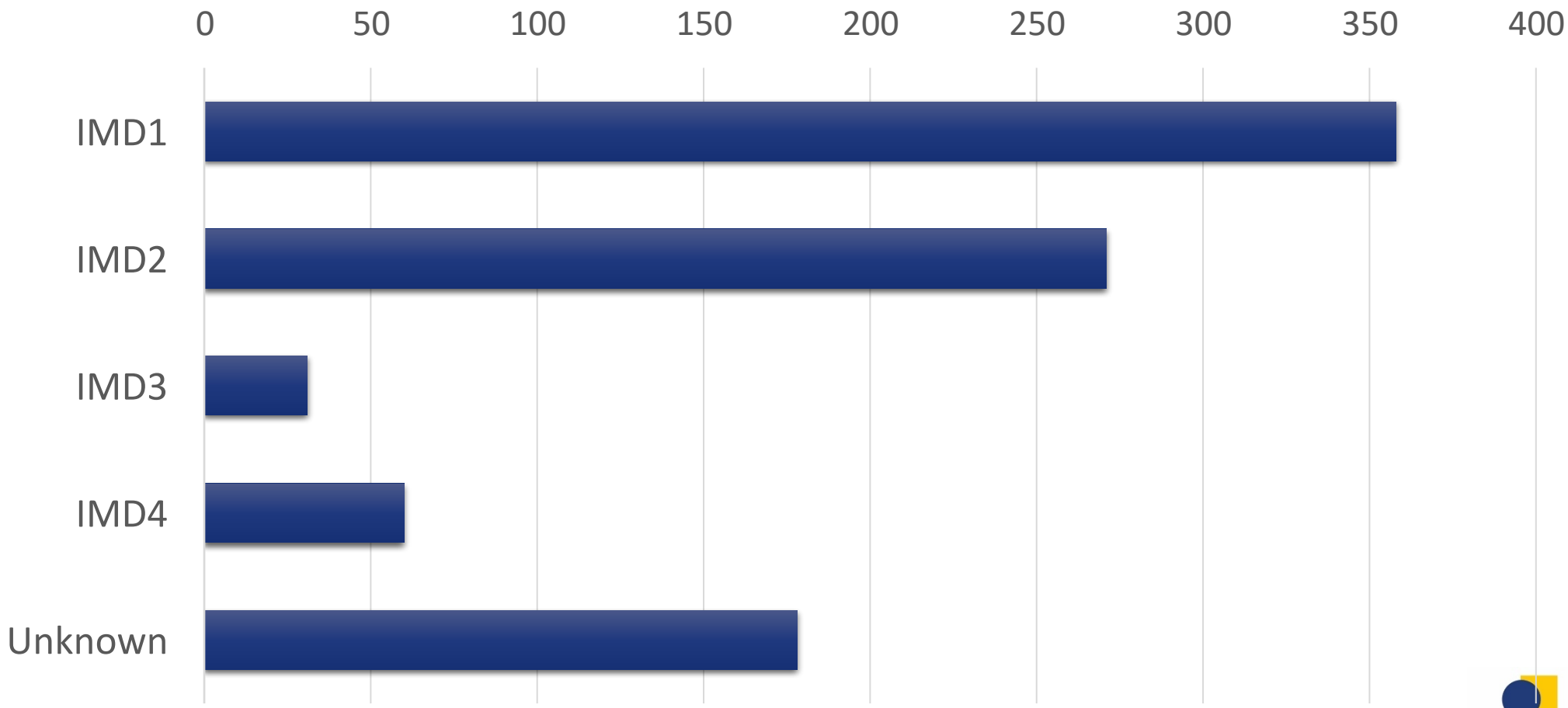




Highlights from Year 2 of the Healthy Heart project

- Total **number of contacts** from May – Nov 2023 **= 898** (Target 400)
- Number of very **brief / brief interventions = 447**
- Number of **extended brief interventions = 268**
- Number of **multi-session interventions = 183**
- **One course attendee said:** ***'It had great information to take and act on. How to take care of yourself and manage your high blood pressure. Food intake and quality, activities on daily basis. Managing stress and worries. The importance of eating less salt. See your GP if medication isn't working'.***
- September | **Everglades GP Practice**, Hypertension & Diabetes Educational event – invited to present to 40+ patients from the Colindale area
- September | **NCL Inequalities Workshop**, presentation on Healthy Heart year 1 results
- **VCS organisations** engaged **= 15+**
- October | presented at **Black History Month events** | Centre of Excellence, LBB, African Cultural Association **= 140+ attendees.** Fed back learning from HH participants re: health inequalities including: access to interpreters, digital exclusion and access to primary care.

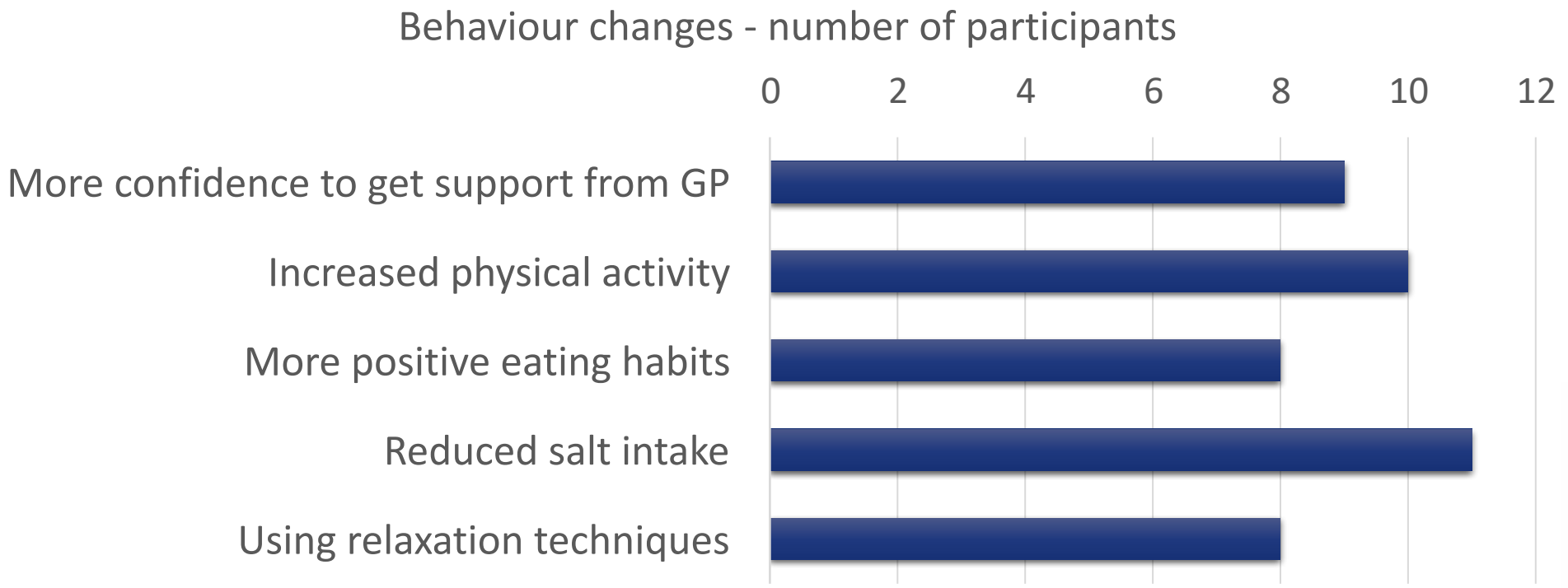
Participants by IMD



Please note: in most cases IMD is based on the postcode of the venue where the event took place, not the participant's home address.

Post-course questionnaires

- To date, 23 intensive course participants have completed post-course questionnaires
- After doing the course, 17 out of 23 people said that if their blood pressure goes above 140/90, they would know they should go to see their GP
- A number of participants found out they had high blood pressure as a result of HH, and accessed primary care - 8 out of 23 people went see their GP, and 5 out of 23 visited their local pharmacy



Post-course feedback

What was the most important thing you learned during the Healthy Heart course / session?

- 'Start with the small steps, more activity, less salt'.
- 'The difference between good/bad nutrition.. and to always get my blood pressure checked'.
- ‘This also taught me that just because you are on medication not all is fine. I have learned to keep an eye on [my blood pressure] on regular basis and started doing more exercise'.
- 'I learnt what is blood pressure and what happens when it is high. How to prevent and control it. If blood pressure is higher than 140/90 then get help and do your exercise and healthy eating'.

Case Study – Barnet Asian Women’s Association (BAWA)

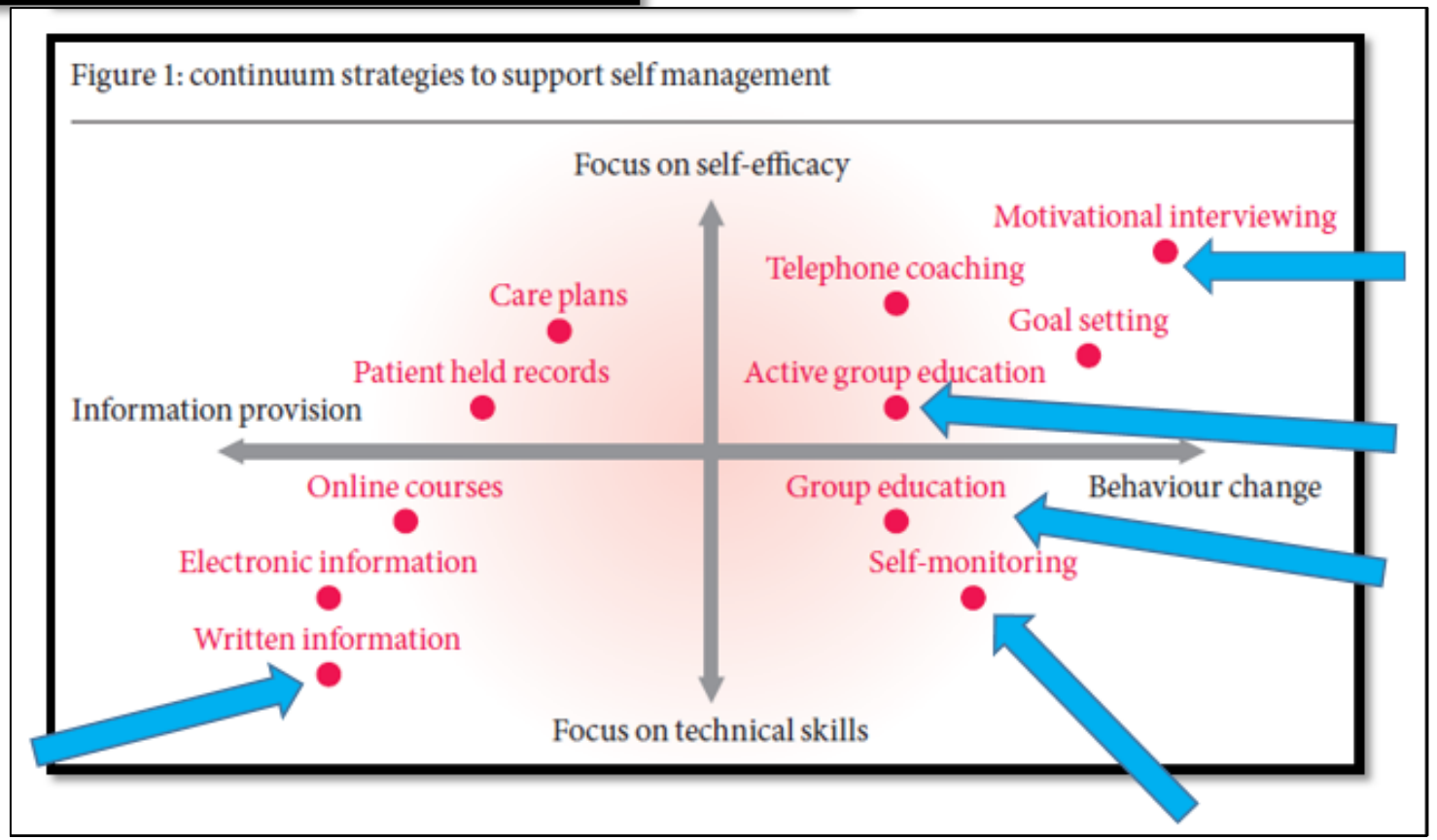
One BAWA staff member said: ‘The ladies expressed that they feel cut off because of their ethnicity and excluded from education or self-help programmes, preventing them from managing their blood pressure.’

Another employee told us: ‘The women at BAWA felt really comfortable with the Healthy Heart peer worker. Being spoken to in the Hindi / Urdu language and provided with examples linked to their cultural lifestyle and values made them believe in what was being said.

Food is a problem in social gatherings, some ladies expressed concern at the difficulty in cooking separate meals for high blood pressure in the family. You educated them on how it is to talk to the family members about healthy eating and making some small healthy choices to implement into day to day eating, and how to manage and cope with food and stress during social gatherings.’

Report informing HH intensive programme development

Arrows denote the focus of the Healthy Heart project, to support self-management and behaviour change when working with the targeted communities.



Healthy Heart - Community Engagement | Y1 & Y2

At the start of the Healthy Heart project (May 2022), self-registration eventbrite pages were created to advertise our events; this approach was not effective. **Partnerships with local providers** have been the key route to reaching our target communities. Here are just some of the organisations / events we have engaged with, to build relationships of trust and shared knowledge:

- Centre of Excellence
- Grahame Park Community Centre
- Barnet African Caribbean Association (BACA)
- West Hendon Hub
- Barnet Asian Older People's Association (BAOPA)
- Barnet Asian Women's Association (BAWA)
- Living Ways Ministries
- Jain community
- International Women's Day
- Black History Month events
- Islamic Centres
- Unitas
- Yaran Project
- Diabetes & hypertension awareness week
- Burnt Oak & Colindale Foodbanks
- New Citizens Gateway
- Everglades surgery | Diabetes & hypertension event

Peer Support & Partnership Working

- The 3 Healthy Heart staff are people with lived experience of long-term health conditions.
- This shared awareness makes a difference to the delivery of the programme and provides a platform to build trust and mutuality.
- Inclusion Barnet has over a decade's experience of working in this way, which we believe leads to more effective service delivery.
- Staff have been trained in: **Motivational Interviewing** (Healthy Dialogues), **Understanding Behavioural Change** (British Association of Cardiovascular Prevention and Rehabilitation) and **Making Every Contact Count** (LBB).
- HH works with VCS staff to develop a joint understanding of how to best support their customers. Information from the HH Clinical Reference Group has been key to empowering the VCS to raise awareness.
- HH provides follow-up visits to VCS organisations, to meet new customers, reinforce the initial message and address emerging issues.

Thank you

The power of experience

inclusion barnet

APPENDIX D
Core20 Connectors

Introduction

- Core20 Connectors was a community outreach project to raise awareness of hypertension

- Summary – Healthwatch & Core20 project
- Demographics
- Numbers with high blood pressure
- Planned actions
- Learnings

Summary

Healthwatch Barnet:

- We gather residents' views on local health and social care services & work with service providers to make improvements
- We also do outreach projects in the community

Core 20 Project:

- Funded by NHS England – all five NCL Healthwatch took part
- Data in this presentation are only from Barnet
- Barnet events ran from February to October 2023
- 967 blood pressure checks
- We targeted groups at greater risk – black & minority ethnic community, disabled people, people in financial hardship
- Project was smaller scale than Healthy Heart

Core20 Project

- Recruited four Community Connectors who worked for us freelance
- Management included fortnightly meetings
- Training sessions from clinicians included Dr Katie Coleman (City Road Medical Centre)

Stalls at events:

- Took blood pressure
- Explained chart
- Blood pressure card
- British Heart Foundation leaflet
- If high blood pressure, signposted to GP, pharmacy or A&E

Background - locations

Smaller events:

- Food banks
- Community garden
- Romanian Hub

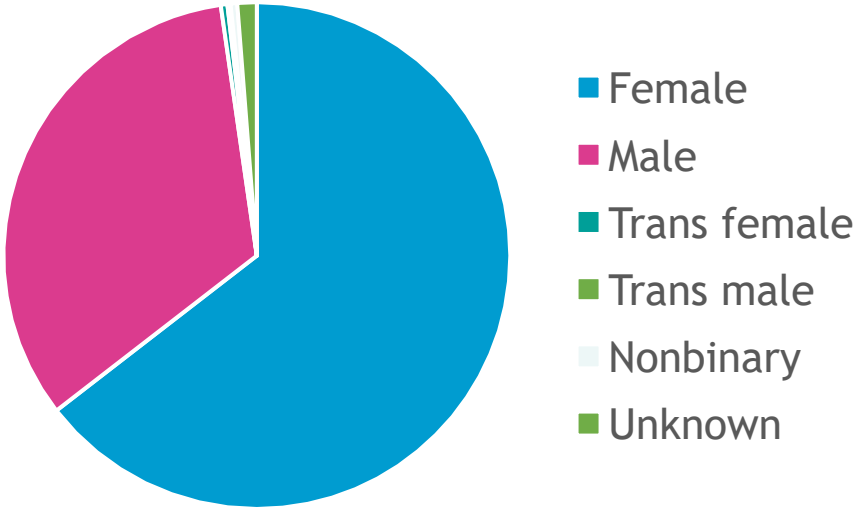
Larger events:

- Community & Religious Centres
- Age UK Barnet events
- Clitterhouse Farm
- Edgware Shopping Centre
- GLL Leisure Centres

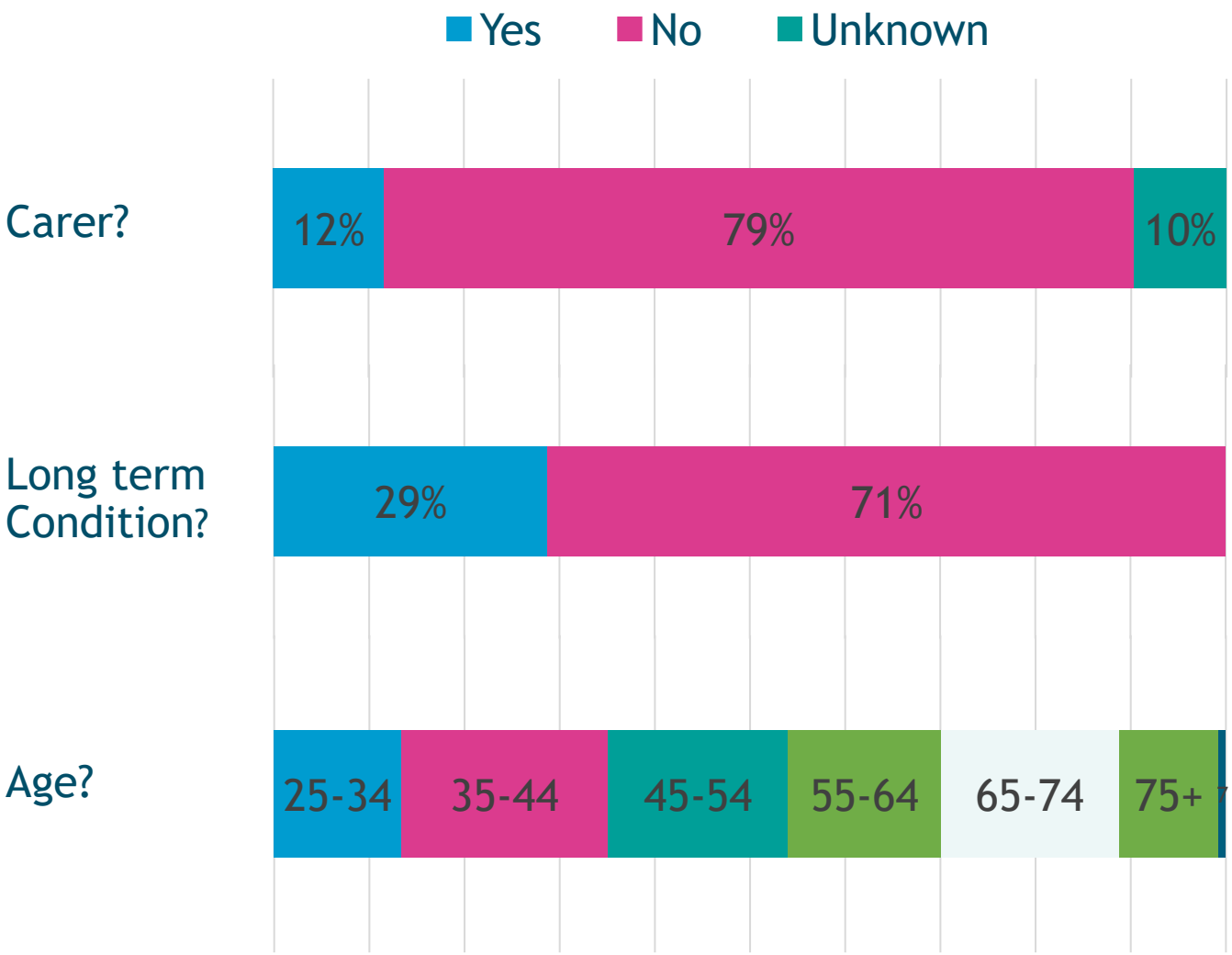
Demographics - Gender

- Female – 65% (n=624)
- Male – 33% (n= 321)
- Trans & Non-binary – 1% (n=10)

- Increasing male participants:
  - Diversity in team
  - Choice of venues – GLL gyms, Edgware Shopping Centre, Romanian Hub

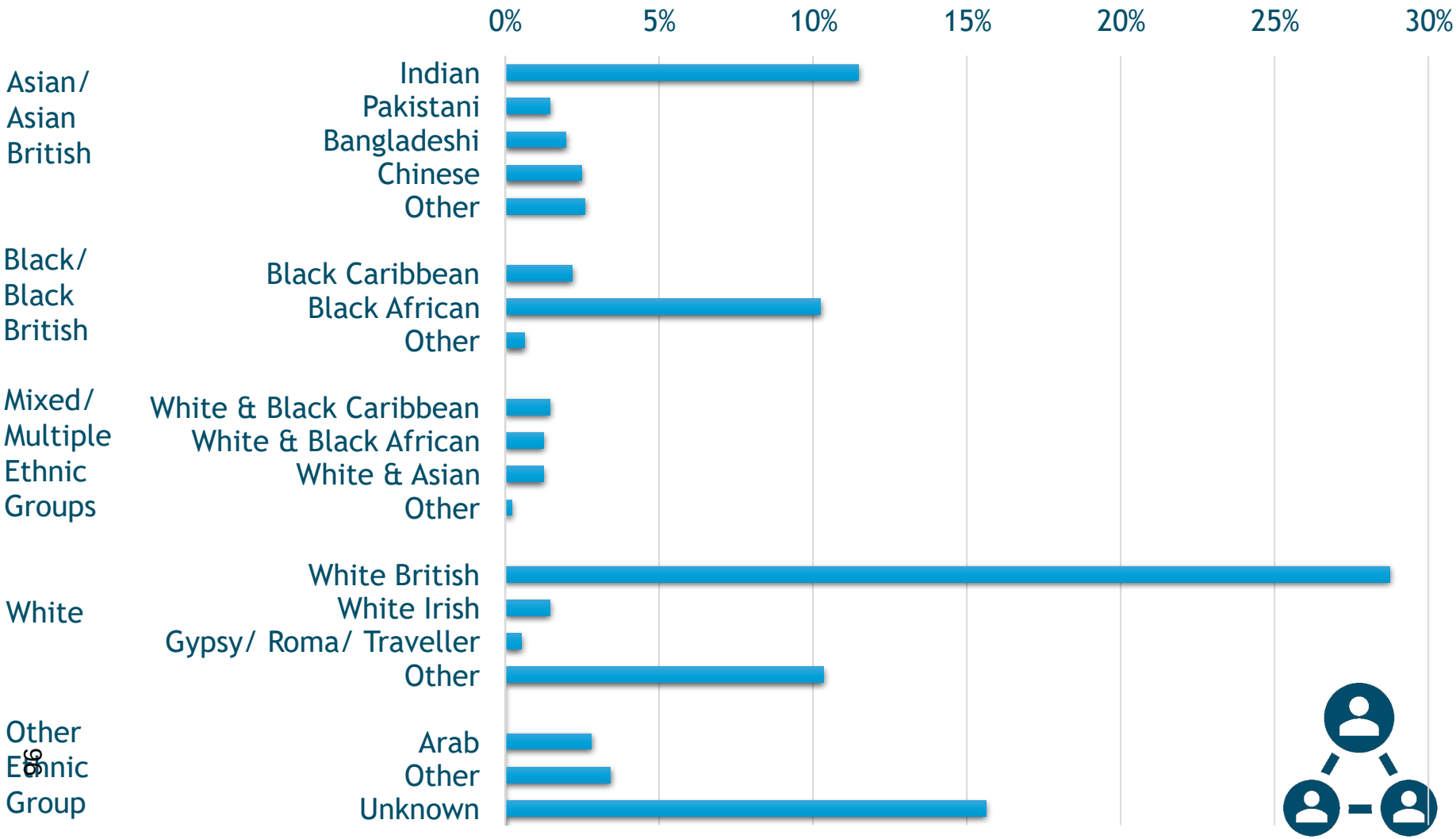


Carers/ LTCs/ Age



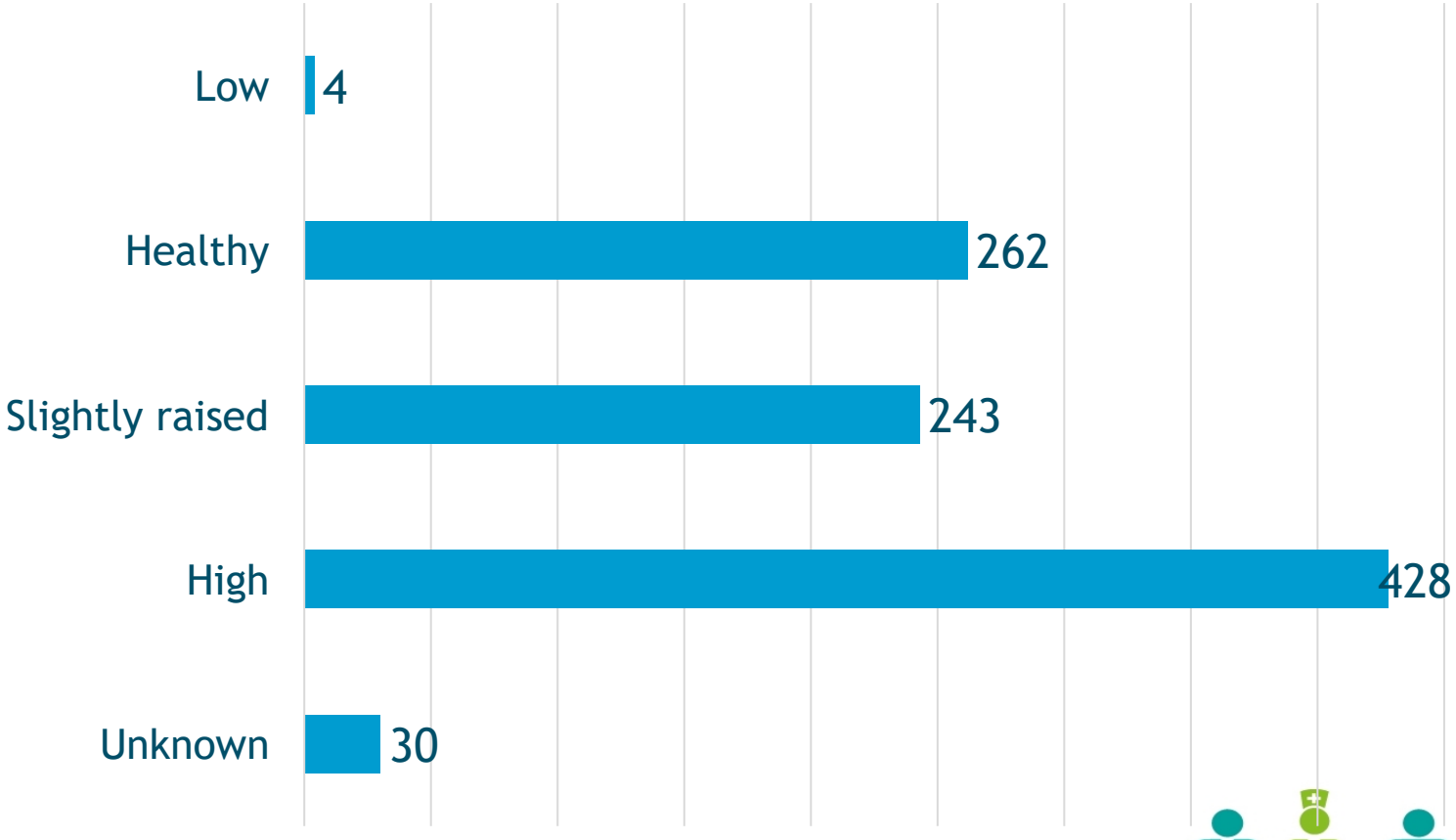
Ethnicities

Languages: 39% (n=378) of participants said English was not their first language.

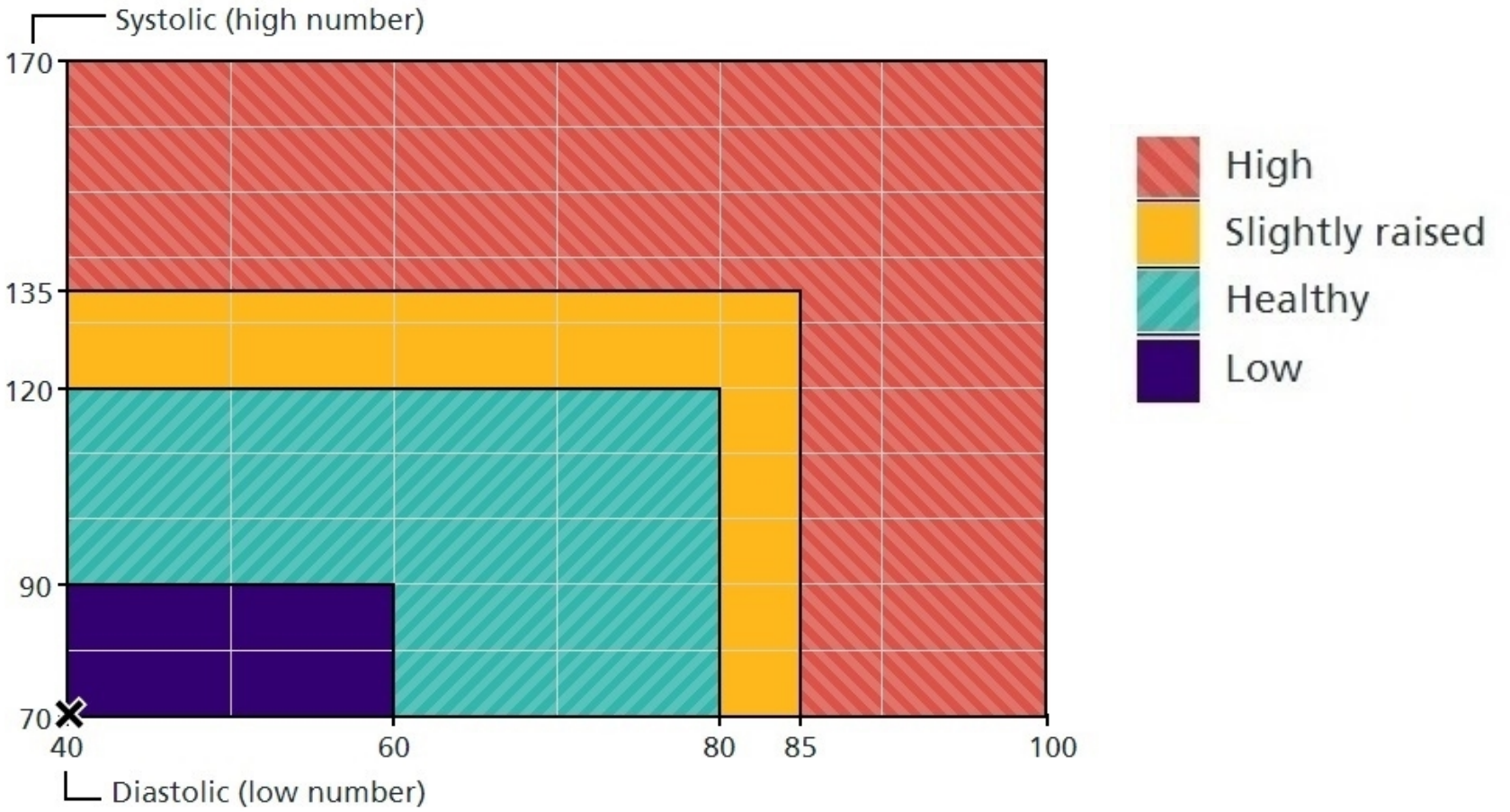


Numbers - high blood pressure

967 - categorised using NHS online ‘Check your blood pressure reading’ tool



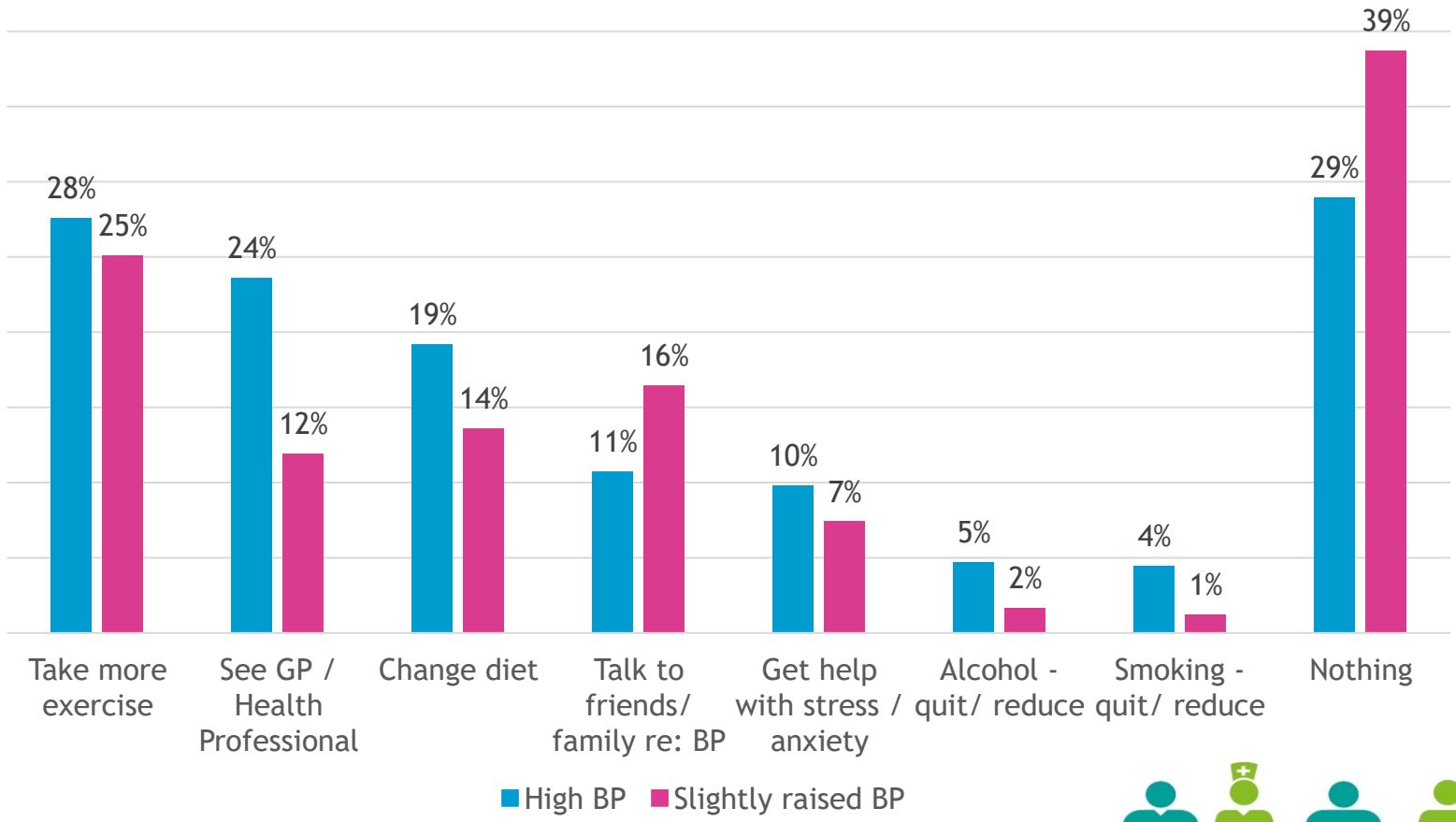
NHS online ‘Check your blood pressure reading’ tool



nhs.uk/health-assessment-tools/check-your-blood-pressure-reading

Planned actions

Participants could tick multiple options re: any action they planned to take as a result of the Core20 intervention. Per cent responses for the 428 with high blood pressure, and 243 with slightly raised blood pressure are set out below.



Feedback from participants

Awareness:

- ‘It was very helpful for me to know that I have very high blood pressure, staff serving were friendly and helpful’

Learning:

- ‘Absolutely fantastic – explained the numbers - I understand this now (for the first time in my life), thanks’
- ‘Wonderful idea – has made me ask questions about the BP measurements & I’m going to look into it. It’s all about educating ourselves.’

Community outreach:

- ‘Thankyou for making me feel comfortable’
- ‘Good idea to have this in common places where people go every day (rather than healthcare settings)’
- ‘[The connector] was very approachable & friendly, shared personal detail that I can also relate to my health journey, especially around keeping doing what I know & increase & make changes.’

Key points

Behaviour change:

- Primary care – access challenges including re: interpreters
- Lack of awareness re: Hypertension Case-Finding Service
- Impact of cost of living crisis, particularly on diet
- Exercise was perceived as a more accessible change

Reaching communities:

- Recruiting diverse staff and utilising their community links
- Small, targeted events can reach vulnerable groups
- Using Smart Survey to review demographics at different venues
- Spreading awareness through family and community links

Contact:
sarahcam@healthwatchbarnet.co.uk

General enquiries:
info@healthwatchbarnet.co.uk
0203 475 1308

AGENDA ITEM 7

Health & Wellbeing Board

Title	Fit and Active Barnet (FAB) Framework update
Date of meeting	18th January 2024
Report of	Executive Director for Adults, Communities and Health, London Borough of Barnet
Wards	All
Status	Public
Urgent	No
Appendices	None
Officer Contact Details	Dawn Wakeling, Executive Director, Adults and Health dawn.wakeling@barnet.gov.uk Cassie Bridger; Assistant Director – Greenspaces & Leisure cassie.bridger@barnet.gov.uk David Walton; Service Manager – Sport & Physical Activity david.walton@barnet.gov.uk

Summary

The Fit & Active Barnet (FAB) Framework (2022-2026), Barnet's physical activity strategy, sets out a vision to 'create a more active and healthy borough', achieved through three priority aims: People, Place and Partnerships.

This report highlights the progress in delivering the Fit & Active Barnet Implementation Plans which have led to an increase in participation levels across the borough. It also details a need to refresh the FAB Framework in the context of delivering Our Plan for Barnet, recognising the connections with the emerging Culture Strategy and the development of a new Parks and Open Spaces Strategy.

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

1. Reasons for the Recommendations

1.1. The Fit & Active Barnet Partnership Board was established to drive forward the FAB vision and includes a range of organisations from the sport and physical activity, health, education and the voluntary, community and faith sectors. The partnership has adopted the following principles:

- Making physical activity not just the business of 'sports' agencies but integrated within all relevant services that support residents.
- Make Barnet a place where everyone can lead more active and healthier lifestyles.
- Work collaboratively to co-produce and support delivery of sustainable interventions across a life course.
- Invest time to understand and reduce barriers to participation by engaging with diverse communities and using a robust evidence base to inform and guide decisions.
- Explore sustainable innovative approaches, whilst attracting investment into the borough.

1.2. Board members include Better, Saracens Foundation, Young Barnet Foundation, Barnet Partnership for School Sports, Barnet Homes, Age UK Barnet, Barnet Mencap, Inclusion Barnet, Sense and New Citizens Gateway, as well as council services.

1.3. London Sport has also joined the Partnership to give the wider London-wide perspective. Their involvement has already paid dividends since they have been able to alert local agencies to funding opportunities and share examples of good practice elsewhere.

Fit and Active Barnet- Summary Highlights 2022-23

Get Active, Give it a Go! Campaign

1.4. The Council and the Fit and Active Barnet Partnership has collaborated on a series of initiatives to promote and improve levels of physical activity. This included the Fit & Active Barnet Campaign; ‘Get Active. Give it a Go!’ delivered in 2022/23.

1.5. The campaign was delivered across a series of digital and print channels encouraging residents to get active by trying something new or getting back to an old pastime.

1.6. Working with a range of partners and activity providers across the borough (including the VCS and sports clubs) over 40 free of charge or low-cost activities were offered such as swimming, gym, netball, rugby, football, dance, cheerleading, walking etc.

1.7. Some of the headline results include:

- Over 4,000 participants engaged in free and low-cost activities
- 49% male participation and 51% female participation
- 37% participation from BAME residents and 38% White
- 74% participants aged 16 – 64 years, 23% aged 0-16 years and 3.5% 65+ years
- 1,226 new Fit & Active Barnet Card memberships registered during September
- 100 Give it a Go (free 3 month all-inclusive Better memberships) issued
- 117,480 digital reach with 3,698 engaged – engagement rate 3% (based on industry standards, a good engagement rate is generally agreed to be between 1% to 5%).

Facility improvements

1.8. £37,610 was secured from Department for Levelling Up, Housing and Communities to install a Changing Places Facility (fully accessible toilet and change facilities for people with complex needs) at Finchley Lido Leisure Centre. Meanwhile Barnet Copthall Leisure Centre became an accredited Dementia Friendly facility.

Targeted interventions

1.9. Throughout 2022-23 a range of targeted interventions were delivered.

- Healthwise: child weight management (124 completers), adult weight management (195 completers) physical activity on referral (300 completers).
- Collaborated with Inclusion Barnet to deliver the Healthy Heart project in Grahame Park
- Barnet Mencap physical activity sessions in partnership with Better and Barnet Lawn Tennis Club
- Over **6,000** CYP engaged in the Holiday Activities and Food programme delivered via Young Barnet Foundation and 0-19 Early Help Service
- Over **5,500** under 8's swam for free and almost **33,000** 8-15 year olds swam for £1
- Collaboration between Age UK Barnet and Barnet Homes to deliver physical activity in sheltered accommodation services.

Fit and Active Barnet – 2023-24

1.10. The FAB action plan for the year 2023/24 was developed in collaboration with partners across the Borough. Once again, the strength of the Partnership has enabled innovative and creative solutions designed to increasing physical activity levels within Barnet.

1.11. Our leisure centre portfolio continues to recover in a post Covid era with community confidence growing. Participation levels are increasing with an attendance of 372,750 in the Quarter to September 2023 (up 16,064 from the same Quarter last year). Timetabling and programming of activities is continually adjusted to meet the changing demands from residents. Better achieved either *excellent* or *very good* in its most recent 'Quest' independent quality assurance assessments, matching their scores from the previous round of assessments. (QUEST is the Sport England accredited quality assurance assessment which utilises a number of techniques to assign a rating).

1.12. Last summer saw an investment programme across the parks and greenspaces which resulted in 21 tennis court venues being improved in a scheme valued at £1.2m (£688,000 coming from either the Government or the Lawn Tennis Association). Resurfacing of tennis courts brought them back to life, with gate access technology and a new booking system. Further investment into the parks resulted in 5 playground improvements valued at £0.75m.

1.13. Cabinet on 14 November 2023 agreed the outline business case for the redevelopment of Finchley Lido Leisure Centre. Officers are continuing to work up the detail of the new facility, building upon the two rounds of public consultation. Option B was supported by Members, offering a family friendly attraction, delivering an increased and diverse range of facilities GNLP and Finchley Cabinet Report.pdf (moderngov.co.uk)

1.14. Targeted initiatives continued under the FAB banner with ongoing schemes designed around (adult and child) weight management, physical activity referral service, coronary heart disease, falls prevention and healthy schools. Those at risk are generally referred by health professionals into supported activity helping people in vulnerable groups follow healthier lifestyles.

1.15. FAB staff have also hosted a series of events for targeted groups. These include a women and girls football tournament (250 women and girls attended and the event included screening of the world cup final), legacy sessions (3 clubs supported to expand their women and girls provision) and funding opportunities (awards of up to £2000 with an application deadline of 31st January 2024).

1.16. London Youth Games participation is increasing with energy focussed on entering teams where none was possible last year (195 participants and 26th place in 2023) and seeking to create sustainable activity through partnership working with the voluntary sports sector. Home - London Youth Games

2024

1.17. The Paris Olympic Games will take place in summer 2024. Partners across FAB want to take advantage of the excitement that the Olympics bring to encourage people to become more

physically active. Early discussions are underway with partners and stakeholders to deliver local activities and opportunities for residents take up an activity for the first time.

1.18. Over the past year the Council has also developed its Culture Strategy, a Borough of Culture bid 2027 and creating a 'Borough of Fun'. In addition, work has commenced on creating a new Parks and Open Spaces Strategy for Barnet. These workstreams, along with others have signalled the need to refresh the FAB Framework to ensure that strategic connections are captured, and that the Framework supports the delivery of Our Plan for Barnet. Work to refresh the FAB framework will start during Q4 2023/24, with workshops for FAB partners and other organisations.

Physical Activity Levels – Update

1.19. A national measurement of the number of people taking part in sport and physical activity is undertaken via the Sport England Active Lives Survey which focuses on people aged 16 and over. A separate survey, the Active Lives Children and Young People Survey looks at the activity levels of children aged 5-16 years.

1.20. The activity levels (of at least 150 minutes activity per week) in Barnet adults aged 16 and over has been consistently and incrementally increasing since the first data point in November 2015-16 (Sport England, Active Lives Survey).

1.21. The Active Lives dataset released in April 2023 indicates a 1% increase to 63.7% (of at least 150 minutes activity per week for the period Nov 21-22). When comparing this dataset against the neighbouring London Boroughs of Enfield and Harrow, Barnet has continued to maintain a higher percentage of adults aged 16+ active for at least 150 minutes per week over the last three years.

1.22. The Active Lives Children and Young People Survey highlighted that 43.5% of 5–16 year-olds were active for an average of 60+ minutes a day (2018-19). Due to a limited sample size this is the latest dataset made available for this indicator. We will continue to encourage schools to participate in this survey.

1.23. Whilst the Active Lives Survey is a useful benchmark, it is a snapshot of the local picture, given the sample size. The Council's Resident Perception Survey (RPS) is also used as further analysis to understand the local picture. The questions included in the RPS reflected those included in the Active Lives Survey.

1.24. The results of the RPS, based on a controlled sample of 2,000 participants (interviewed October 21 – March 22), indicated that 51% of residents aged 18 and over were active for at least 150 minutes per week however only 11% were inactive.

1.25. Both sets of results (Active Lives Survey and the Council RPS) demonstrate that our targeted approach to engaging residents and community groups who are most disproportionately

impacted in respect of their access to, and experience of physical activity opportunities and facilities has proven successful. These include children and young people (particularly those from deprived communities), older people, minoritised communities, disabled people and those living with long-term health conditions, and women and girls.

2. Alternative Options Considered and Not Recommended

2.1 None

3. Post Decision Implementation

3.1 The Council and Fit & Active Barnet Partnership Board captures data on a quarterly basis.

3.2 During Q4 2023/24 a review of the existing FAB Framework will commence with partners to support a refresh of the strategy. This will include dedicated workshops to identify any areas of further opportunity or improvement.

4. Corporate Priorities, Performance and Other Considerations

Corporate Plan

4.1 Our Plan for Barnet 2023-26 contains cross cutting themes that are fundamental to quality of life in a healthy environment. Sport and Physical activity can contribute in many ways to supporting the mission to care for people, places, and the planet.

Corporate Performance / Outcome Measures

4.2 GLL conduct a wide-ranging annual user satisfaction survey with a target of achieving 4 out of a score of 5 (1772 responses in 2023). The most recent survey scored 3.82. Car park charges were introduced at the time of the survey and had a noticeable impact upon the score. Last year the equivalent score was 3.43 so the direction of travel is very positive.

Sustainability

4.3 Delivery of the priority aims and commitments set out within the Fit & Active Barnet Framework (2022-2026) have demonstrated synergy and supported priorities identified within the Barnet Sustainability Strategy Framework and the Long-Term Transport Strategy (2020-2041) e.g., delivery of events making Clean Air Day (June 2022) and World Car Free (September 2022) and interventions that promote active forms of travel such as Health Walks, Healthy Heritage Walks and Active Trails.

Corporate Parenting

4.4 Implementation of the FAB Framework has continued to support the councils Corporate Parenting Commitment through the delivery of interventions such as the FAB Card and its additional benefits to carers (including foster carers), looked after children, and those who are care experienced.

Risk Management

4.5 The Council has an established approach to risk management, which is set out in the Risk Management Framework. Risks are reviewed quarterly (as a minimum), and any high level

(scoring 15+) risks are reported to the relevant Theme Committee and Policy and Resources Committee.

4.6 The FAB Partnership and the Greenspaces and Leisure service continue to ensure

4.7 that appropriate risk management is in place to mitigate risks associated with delivery

4.8 of interventions that support implementation of the Framework.

Insight

4.9 Data and insight were carefully reviewed and considered in development of the Fit & Active Barnet Framework (2022-2026) and development of its accompanying implementation plan (2022-2023).

4.10 Data and insight have continued to be aligned with in delivery of interventions and actions within the implementation plan which includes considering outcomes of the Resident Perception Survey(s) and that shared amongst the Fit & Active Barnet Partnership and subsequent networks.

Social Value

4.11 A report by the Sport Industry Research at Sheffield Hallam University concluded that every £1 spent on community sport and physical activity generates nearly £4 for the English economy. The report concluded that investment into physical activity creates a return across health and social care, improves wellbeing, builds stronger communities, and develops skills in the economy.

4.12 Better continue to utilise the social value calculator (developed by 4Global, Experian & Sheffield Hallam University) to measure social value based on regular participation within Better leisure facilities. Between April 22 and March 23, the leisure management contract indicated a social value of £6,155,421. This is measured across a range of outcomes including improved health, improved subjective wellbeing, increased educational attainment, and reduced crime.

5. Resource Implications (Finance and Value for Money, Procurement, Staffing, IT and Property)

5.1 External funding has been secured from a variety of sources in the year. Most noticeable has been the capital investment into the parks and greenspaces (Government and LTA Tennis court improvement £1.2m, playground improvement £0.75m jointly funded by Barnet Council and the Seneca Trust).

5.2 Leisure centre improvement has resulted in a sensory facility at the teaching swimming pool in New Barnet Leisure Centre which will sit alongside the, first in the country, £0.5m playground in Victoria Rec (for children and adults with disabilities).

6. Legal Implications and Constitution References

6.1 In accordance with the Council's Constitution, Part 2B the Terms of Reference and Delegation of Duties to the Health and Wellbeing Board include:

4.2.2.1 - To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental, and social wellbeing.

4.2.2.5 - To provide collective leadership and enable shared decision making, ownership and accountability

4.2.2.6 - To promote partnership and, as appropriate, integration, across all necessary areas, including joined-up commissioning plans and joined-up approach to securing external funding across the NHS, social care, voluntary and community sector and public health.

4.2.2.8 - Specific responsibilities for:

- Overseeing public health and promoting prevention agenda across the partnership
- Developing further health and social care integration.
- Receiving regular reports on the North Central London Integrated Care Board and their partner NHS trusts and NHS foundation trusts, including joint capital resource use plans, ICB Annual reports, Forward Plans and Performance Assessments

7. Consultation

7.1 Quarterly meetings are held with the FAB Partnership. In refreshing strategy and implementation plan partners will be engaged.

8. Equalities and Diversity

8.1 An Equalities Impact Assessment was conducted on the Fit & Active Barnet Framework (2022 - 2026) and equalities, diversity and inclusion continues to be adopted in all forms of implementation. Decision makers should have due regard to the public sector equality duty in making their decisions. The equalities duties are continuing duties they are not duties to secure a particular outcome. The equalities impact assessment will be revisited on each of the proposals as they are developed. Consideration of the duties should precede the decision. It is important that Cabinet has regard to the statutory grounds in the light of all available material such as consultation responses. The statutory grounds of the public sector equality duty are found at section 149 of the Equality Act 2010 and are as follows:

8.2 S149(1) A public authority must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3 (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b) Take steps to meet the needs of persons who share a relevant protected

characteristic that are different from the needs of persons who do not share it;
c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

8.4 (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

8.5 (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a) Tackle prejudice, and
b) Promote understanding.

8.6 (6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

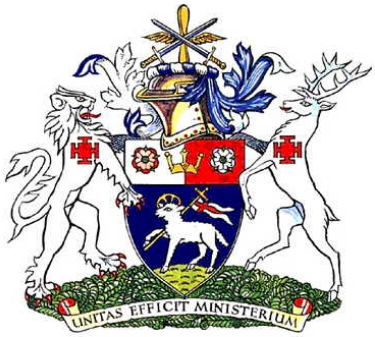
8.7 (7) The relevant protected characteristics are:

a) Age
b) Disability
c) Gender reassignment
d) Pregnancy and maternity
e) Race
f) Religion or belief
g) Sex
h) Sexual orientation

9. Background Papers

None.

This page is intentionally left blank



Health and Wellbeing Board

Title	Dementia Friendly Barnet Progress Report 2022-23
Date of meeting	18th January 2023
Report of	Tamara Djuretic, Director of Public Health and Prevention tamara.djuretic@barnet.gov.uk
Wards	All
Status	Public
Urgent	No
Appendices	Appendix 1. Dementia Friendly Barnet Progress Report 2022-23
Officer Contact Details	Tamara Djuretic, Director of Public Health and Prevention tamara.djuretic@barnet.gov.uk Seher Kayikci, Senior Public Health Strategist Seher.Kayikci@barnet.gov.uk Gabriel John-Mains, National Graduate Management Trainee Gabriel.Johns-Main@Barnet.gov.uk Rachel Wells, Consultant in Public Health Rachel.Wells@barnet.gov.uk

Summary

The Dementia Friendly Barnet Partnership was established in 2019 by Barnet Council Public Health. The main purpose of the partnership is to collaboratively work towards becoming a dementia friendly borough where people living with dementia (PLWD) are understood, respected and supported.

Following a successful submission to Alzheimer's Society, London Borough of Barnet has gained formal accreditation as working to become a Dementia Friendly Community.

The partnership agreed to three key action areas. These are:

1. Dementia Friendly Venues
2. Dementia Friendly Faith Communities
3. Dementia Friendly High Streets

This report provides an update on the recent strategic developments linked to Dementia Friendly Barnet, progress on key action areas, updates on activities to communicate the Dementia Friendly messages across the borough, training and examples of future action.

Recommendations

The Board notes and comments on progress towards making Barnet a Dementia Friendly borough.

1. Reasons for the Recommendations

The full progress report is added as Appendix 1. Below are the main highlights:

1.1 Recently, there have been several strategic developments to improve the lives of PLWD and their carers. These include:

1.2 Chief Medical Officer Annual Report 2023 - The CMO's annual report[1] recommends two complementary approaches to improve the quality of life for older adults. The first is to reduce disease, including degenerative disease, to prevent, delay or minimise disability and frailty. The second is to change the environment so that, for a given level of disability, people can maintain their independence longer. Dementia Friendly Barnet contributes to this by not only promoting risk reduction and prevention messages and healthier lifestyle choices, but also by addressing the environment by promoting Dementia Friendly Venues.

1.3 New Ageing Well Workstream – The North Central London (NCL) Integrated Care Board (ICB) has launched the Ageing Well workstream to provide anticipatory care for residents 65yrs+ living in the Borough of Barnet at risk of becoming frail, losing their independence, living with dementia, or requiring support to remain in their own home. Dementia Friendly Barnet is an essential part of this workstream.

1.4 Dementia Strategy - Barnet has launched its first Dementia Strategy as it prepares for a large increase in the number of residents living with the condition. Since 2011, Barnet has seen a 9% increase in population size, but an 18.3% increase in the over 65 population[2]. The strategy is designed to help the Council and its partners in the health and voluntary sectors provide more proactive support, maximising people's independence, health, and wellbeing. Dementia Friendly is an integral part of the new strategy.

1.5 Age-Friendly Barnet - Age UK Barnet has launched Age-Friendly Barnet to address the structural and social barriers to ageing well in Barnet by using the World Health Organization's framework for Age-Friendly Communities. There are significant overlaps between the dementia and age-friendly work. We are in the process of aligning action plans to strengthen action and avoid duplication.

[1] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

[2] Barnet population change, Census 2021 – ONS

1.6 The NCL ICB accreditation scheme - The NCL ICB has invited dementia friendly leads from all five NCL boroughs to improve collaboration and strengthen dementia friendly initiatives. Sadly, the Alzheimer's Society's Dementia Friendly Communities recognition scheme will come to an end on 31 December 2023. The group has therefore agreed to create an NCL-wide Dementia Friendly Accreditation scheme with a view to launch in April 2024.

1.7 As the number of people living with dementia in Barnet increases, we have a responsibility to ensure that our communities are accepting and supportive; and ensure that people feel included and valued. People affected by dementia still have an incredible amount to offer to their community. Dementia Friendly Barnet in collaboration with the Age Friendly Agenda will continue to address environmental factors which can help in reducing the risk of dementia as well as creating an environment conducive to living well with dementia. By doing so, PLWD can continue to play an active and valuable role even years after diagnosis and stay independent.

1.8 We therefore ask the Board to note progress and continue to support the work towards becoming a dementia friendly borough.

2. Alternative Options Considered and Not Recommended

2.1 This is a progress report on a project previously agreed by HWBB, therefore no alternative recommendations were considered.

3. Post Decision Implementation

3.1 The Dementia Friendly Barnet Partnership will develop a refreshed action plan to be implemented.

4. Corporate Priorities, Performance and Other Considerations

Corporate Plan

4.1 The Corporate Plan priorities supporting Dementia Friendly include *"Living Well"* under the key area *"Caring for People".* This area suggests *"increasing the inclusion of older and disabled residents and celebrating their contributions".*

4.2 Dementia Friendly sits under Key Area 2 of the Health and Wellbeing Strategy (Starting, Living and Ageing Well).

Corporate Performance / Outcome Measures

4.3 The nature of the work is such that we are working towards making Barnet a dementia friendly borough and therefore there are no set KPIs in place. However, we are monitoring the number of dementia friends in the borough, the number of people who attended the training programme, and the number of venues accredited as Dementia Friendly.

Sustainability

4.4 Actions to implement the Dementia Friendly agenda are currently funded within existing budgets and staffing of the public health department, other council departments, and

partner agencies such as Voluntary and Community sector organisations who are funded from diverse sources.

Corporate Parenting

4.5 Not applicable

Risk Management

4.6 Work towards becoming a dementia friendly borough requires a collaborative approach and effort across the multi-agency Dementia Friendly Barnet Partnership to improve the lives of PLWD in Barnet. If the council or partners do not engage with this work, it may lead to poor overall delivery of the Action Plan 24-25. This could have a negative impact on the lives of PLWD and their carers as well as an increased demand on care services.

The following controls and mitigations are in place:

4.5.1 The Action Plan will be co-produced and co-owned by the multi-agency Dementia Friendly Barnet Partnership. Each partner has committed actions to strengthen dementia awareness and support within their organisations as well as offering their expertise and specialist knowledge to the partnership.

4.5.2 Continuous engagement with people affected by dementia to ensure that their views, needs and wants are reflected in the plans going forward.

4.5.3 The Dementia Friendly Barnet Partnership meets regularly to re-engage partners, align activities, and implement changes based on new insights.

4.5.4 Regular monitoring against agreed actions will be built into the process by collecting regular updates from partners.

4.5.5 Annual progress reports to the Health and Wellbeing Board.

Insight

4.7 Public Health conducted a needs assessment for dementia which has informed the Dementia Strategy. However, the main insight came from the engagement with people affected by dementia, their carers and people who provide care. The insight gathered from listening to individuals is embedded within the Dementia Friendly Action Plan.

Social Value

4.8 The Dementia Friendly Action Plan fully supports the Joint Health and Wellbeing Strategy social value framework.

5. Resource Implications (Finance and Value for Money, Procurement, Staffing, IT and Property)

5.1 Actions to implement the Dementia Friendly agenda are funded within existing budgets and staffing of the public health department, other council departments, and partner agencies such as Voluntary and Community sector organisations who are funded from diverse sources and for a wide range of purposes.

6. Legal Implications and Constitution References

6.1 Under the Council's constitution, Part 2B of the Terms of Reference & Delegation of Duties to Committees and Sub-Committees, the Health and Wellbeing Board has the following responsibilities:

- To jointly assess the health and social care needs of the population with NHS commissioners and use the findings of a Barnet Joint Strategic Needs Assessment (JSNA) to inform all relevant local strategies and policies across partnership including North Central London Integrated Care Strategy.
- To agree a Health and Wellbeing Strategy (HWBS) for Barnet taking into account the findings of the JSNA and strategically oversee its implementation to ensure that improved population outcomes are being delivered.
- To work together to ensure the best fit between available resources to meet the health and social care needs of the whole population of Barnet, by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental, and social wellbeing.
- Specific responsibilities for overseeing public health and promoting prevention agenda across the partnership.

7. Consultation

7.1 Not applicable for this report.

8. Equalities and Diversity

8.1 The diversity of the Dementia Friendly Partnership ensured focus on certain communities who may be underserved.

9. Background Papers

None.

This page is intentionally left blank

Dementia Friendly Barnet Progress Report 2022-23

Figure 1 – Dementia Friendly Communities

Introduction

It is estimated that 4,387 people are living with dementia in Barnet and this figure is expected to increase to 6,402 by 2035[1]. The Dementia Friendly Barnet Partnership was established in 2019 by Public Health to respond to this challenge by working collaboratively to adapt environments and enable people living with dementia (PLWD) to live as independent and enjoyable a life as possible.

[1] Dementia Strategy 2023-2028.pdf (barnet.gov.uk)

Author:
Seher Kayikci – Senior Public Health Strategist
December 2023

Too many people affected by dementia feel society does not understand the condition they live with. This is why people with dementia sometimes feel they need to withdraw from their community as their condition progresses.

Alzheimer's Society defines a dementia-friendly community as a city, town or village where people with dementia are understood, respected and supported[2]. We have adopted Alzheimer's Society's evidence-based framework for Dementia Friendly Communities (see Figure 1) and started to shape the action plan to guide the work towards becoming a dementia friendly borough where people living with dementia are understood, respected, and supported.

The views and experiences of people living with dementia are at the heart of Barnet's Dementia Friendly movement. We have used appreciative enquiry techniques to get the views of PLWD and their carers to create an action plan. Over 200 people affected by dementia from a diverse group of community venues and activities were engaged. This allowed us to understand the needs of those living with dementia, what they wanted, and where they felt the greatest areas of improvement are required in Barnet. The Partnership also includes significant carer representation. In addition, a person living with dementia as a core member provides regular input into the work of the partnership.

Last year we agreed to three key action areas. These are:

1. **Dementia Friendly Venues**
2. **Dementia Friendly Faith Communities**
3. **Dementia Friendly High Streets**

This report will provide an update on the recent strategic developments linked to Dementia Friendly, progress on key action areas, updates on activities to communicate the Dementia Friendly messages across the borough, training and examples of future action.

1.Strategic Developments

Recently, there have been several strategic developments to improve the lives of PLWD and their carers. These include:

- **Chief Medical Officer's Annual Report 2023**
  The CMO's annual report[3] recommends two complementary approaches to improve the quality of life for older adults. The first is to reduce disease, including degenerative disease, to prevent, delay or minimise disability and frailty. The second is to change the environment so that, for a given level of disability, people can maintain their independence longer. Dementia Friendly Barnet contributes to this by not only promoting risk reduction and

[2] What is a dementia-friendly community? | Alzheimer's Society (alzheimers.org.uk)
[3] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

prevention messages and healthier lifestyle choices, but also by addressing the environment by promoting Dementia Friendly Venues.

- **Ageing Well Workstream**
  The North Central London (NCL) Integrated Care Board (ICB) has launched the Ageing Well workstream to provide anticipatory care for residents 65yrs+ living in the Borough of Barnet at risk of becoming frail, losing their independence, living with dementia, or requiring support to remain in their own home. Dementia Friendly Barnet is an essential part of this workstream.

- **Dementia Strategy**
  Barnet has launched its first Dementia Strategy as it prepares for a large increase in the number of residents living with the condition. The strategy is designed to help the Council and its partners in the health and voluntary sectors provide more proactive support, maximising people's independence, health, and wellbeing. Dementia Friendly is an integral part of the new strategy.

- **Age-Friendly Barnet**
  Age UK Barnet has launched Age-Friendly Barnet to address the structural and social barriers to ageing well in Barnet by using the World Health Organization's framework for Age-Friendly Communities. There are significant overlaps between the dementia and age-friendly work. We are in the process of aligning action plans to strengthen action and avoid duplication.

- **End of Alzheimer's Society's Dementia Friendly Communities**
  Sadly, the Alzheimer's Society's Dementia Friendly Communities recognition scheme will come to an end on 31 December 2023. Whilst we are looking into creating an alternative accreditation scheme, we will continue to promote London Mayor's Dementia Friendly Venues.

- **NCL ICB Dementia Friendly Accreditation**
  The NCL ICB has invited dementia friendly leads from all five NCL boroughs to improve collaboration and strengthen dementia friendly initiatives. Creating an NCL-wide Dementia Friendly Accreditation scheme was agreed and will be launched in April 2024.

2. Dementia Friendly Venues (arts, culture and leisure)

The Mayor's Dementia Friendly Venues Charter provides support for arts, culture, and leisure venues to become dementia friendly, and then awards them with an official accreditation. One of the borough's priorities is supporting as many venues as possible to sign on to the scheme.

We have established a Working Group in order to provide peer support to those arts, culture venues, leisure centres and libraries interested in joining the scheme.

Author:
Seher Kayikci – Senior Public Health Strategist
December 2023

The members of the group were also responsible for engaging with residents with lived experience and incorporating their views on cultural spaces, i.e., inviting a carer to do a venue walk-through. These meetings were highly valued by the members, as a support system and check-in points for progress.

The RAF Museum was the first accredited venue in Barnet. They have been instrumental in supporting other venues and providing valuable advice for the application process during working group meetings.

This year has seen 21 venues sign up for the Dementia Friendly Venues scheme. There are also several venues with significant interest in completing their accreditation in the new year. (See Appendix 1 for the list of accredited venues in Barnet).

3. Dementia Friendly Faith Communities

Faith can play a vital role in the lives and wellbeing of people affected by dementia. As we didn't have a blueprint of what Dementia Friendly Faith entails we worked with Faith Action (National Faith Charity), local faith leaders, residents with lived experience, and the Barnet Multi Faith Forum to develop the Dementia Friendly Faith Communities self-assessment framework.

The framework includes a series of actions that are specific to faith communities and respect the diversity of religious and spiritual practices.

So far, we have two faith communities that have been accredited via the Mayor's scheme. (See Appendix 1 for the list of accredited venues in Barnet).

4. Dementia Friendly High Streets

As part of the Healthier High Street Programme, local businesses were invited to help support people with dementia to remain independent for as long as possible. So far, four businesses have signed up to become dementia friendly.

Some businesses have raised concerns about crime and vandalism and expressed that becoming dementia friendly therefore is not their priority. One option to go forward is to take a more targeted approach and prioritise the areas with an ageing population where this scheme may be more relevant.

Greater collaboration with the Town Centres team and utilisation of their network would also likely be beneficial.

5. Dementia Training

Adapting the environment, changing the perceptions, challenging stigma and improving awareness and understanding of what it means to live with dementia take time and also require training.

We therefore promote Alzheimer's Society's *"Dementia Friends"* scheme. A Dementia Friend is somebody who learns about dementia so they can help their community. We encourage residents, businesses, and local organisations to become Dementia Friends by watching a short video on the Alzheimer's Society's website. In September 2023, there were 15,808 Dementia Friends in the borough.

In addition, the DCUK's *"Understanding Dementia"* training has been commissioned by Public Health and sessions have been successfully delivered throughout the year. This training provides information on reducing the risks of dementia, understanding the effects it has on people and families, and how we can all be more dementia friendly. The training provides individuals with a CPD qualification and accredits businesses and other organisations as working toward being dementia friendly. Up to November end of 2023, 1,400 people have undergone the training. This has included councillors, a growing number of whom are now Dementia Friends.

Furthermore, the MECC Factsheet for Dementia has also been produced and regularly circulated, providing information on dementia and support services for frontline health and care professionals.

6. Raising awareness of dementia and dementia support in Barnet

We have a three-pronged approach to our comms plans. They are:

1. Communicating risk reduction messages:

Dementia is not an inevitable part of ageing, there is often an assumption that dementia is part of being old, for example, around nine out of ten 80- to 84-year-olds do not have dementia; in those aged 90 to 94 years, around seven out of ten will not have dementia[4]. It is possible to reduce the risk and delay the onset of dementia partially.

Around 40% of dementia cases might be attributable to potentially modifiable risk factors. The NICE guidance[5] recommends reducing the risk of or delaying the onset of disability, dementia, and frailty by helping people stop smoking, be more active, drink alcohol in moderation and maintain a healthy weight [6],[7].

[4] Prince M, Knapp M, Guerchet M, McCrone P, Prina M, Comas-Herrera A, Wittenberg R, Adelaja B, Hu B, King D, Rehill A and Salimkumar D. Dementia UK: Update, Second edition [Internet] (November 2014) Available from: https://www.alzheimers.org.uk/about-us/policy-and-influencing/dementia-uk-report (Accessed 25/10/2023).

[5] Overview | Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset | Guidance | NICE

[6] Health matters: midlife approaches to reduce dementia risk - GOV.UK (www.gov.uk)

[7] Dementia prevention, intervention, and care: 2020 report of the Lancet Commission - The Lancet

In collaboration with Age UK Barnet and other key partners, we are regularly developing and posting the key risk reduction messages.

2. Awareness of living well with dementia after diagnosis:

A new "Living Well with Dementia" information leaflet has been produced with the help of key stakeholders. The leaflet outlines key information about dementia, where to go for diagnosis, how to support those living with it, and signposts to key support services. 4,000 leaflets have been distributed to libraries, faith organisations, key partners and councillors. An 'easy read' version is currently in development.

Barnet Carers and Age UK Barnet have hosted/participated in several events including an information event at St Barnabas Church, a Living Well Event, a Pan-Barnet GP Event, multiple Dementia Cafes, a Health Champions Lunch and Learn, new elected members training, and the Age UK Dementia Action Week Sing-a-long.

During the Dementia Action Week, May 2023, we created six videos and shared a comms toolkit that signposts activities through the month.

In collaboration with key partners, a number of video case studies about dementia have been released marking the launch of the Dementia Strategy. These case studies highlighted the importance of early diagnosis, the support available, preventative measures, and the stories of individuals:

- Living well with dementia in Barnet
- The importance of prevention and diagnosis
- Launching Barnet's dementia strategy

3. Promoting the importance of becoming Dementia Friendly:

The importance of becoming dementia friendly and the Dementia Friendly Venues and High Streets have been promoted in magazines, social media, and newsletters as well as at in-person networking events (as above).

Work is underway on creating a new Dementia Friendly brand for Barnet. This would replace the old Alzheimer's Society branding and be used by the council and key partners to signify they are dementia friendly.

7. Future Plans

We are working towards refreshing the Dementia Friendly Action Plan 2024-25 in line with recent strategic developments. The engagement with PLWD and their carers will continue to ensure that their views, needs and wants are reflected in the plans going forward.

Author:
Seher Kayikci – Senior Public Health Strategist
December 2023

The refreshed plan will maintain current priorities as well as include new areas of work. Examples include:

- New NCL Dementia Friendly accreditation at the ICB level – Alzheimer's Society announced that they can no longer continue with the Dementia Friendly Communities accreditation, therefore, we are working across the five NCL boroughs to develop our own accreditation to sit alongside the Mayor's accreditation as this is only designed for arts and cultural venues. Once we have completed our own accreditation scheme, we can include GP surgeries, businesses and all manner of venues and spread the dementia friendly mission further.

- Dementia Friendly Fire Service – We have successfully reached out to the fire service and trained one quarter of the fire staff in Barnet. Training was conducted in partnership with Age-Friendly Barnet to ensure that not just PLWD, but all older people are supported. The training was very positively received, and plans are underway to train the remaining staff next year.

- Dementia Friendly Transport – Following concerns raised through the Age Friendly Barnet survey we have made the bus network an area of focus for both work streams. We have had positive dialogue with representatives of the bus network, and plan to hold training sessions for bus managers and key personnel as well as information sessions for drivers.

8. Conclusions

People affected by dementia still have an incredible amount to offer to their community. Dementia Friendly Barnet in collaboration with the Age Friendly agenda will continue to address environmental factors which can help in reducing the risk of dementia as well as creating environments conducive to living well with dementia. By doing so, PLWD can continue to play an active and valuable role even years after diagnosis.

Author:
Seher Kayikci – Senior Public Health Strategist
December 2023

APPENDIX 1
DEMENTIA FRIENDLY VENUES IN BARNET

1	Ann Owens Centre - Age UK Barnet
2	Arts Depot
3	Brunswick Park Medical Practice
4	Burnt Oak Leisure Centre
5	Candlewood House Care Home
6	Chickenshed Theatre
7	Chipping Barnet Library
8	Colindale Community Trust
9	Copthall Leisure Centre
10	Dell Field Court Care Home
11	Finchley Church End Library
12	Finchley Reform Synagogue
13	Goodwin Court
14	Meadowside Care Home
15	Michael Sobell Day Centre (Jewish Care)
16	New Barnet Leisure Centre
17	Phoenix Cinema
18	RAF Museum
19	Samuel Beckman Day Centre (Jewish Care)
20	Station Road - Age UK Barnet
21	St Barnabas Church

Author:
Seher Kayikci – Senior Public Health Strategist
December 2023

Acronym	Long title	Description
AVA	Association for Vascular Access	
BACE	Barnet Active, Creative Engaging	The council have worked with the Young Barnet Foundation to provide the Barnet Active, Creative Engaging (BACE) holidaying scheme which is DfE funded for all free school meal children and vulnerable children to access fun activities with a hot meal, activities include learning about healthy eating and exercise.
BCU	Borough Command Unit (Check)	Policing
BEA	Barnet Equalities Allies	
BECC	Borough Emergency Control Centre	
BEHMHT	Barnet Enfield and Haringey Mental Health Trust	
BELS	Barnet Education & Learning Service	Barnet Education & Learning Service (BELS) is a local authority controlled company which is responsible for providing the Council's Education & Skills service to Barnet schools.
BING	Barnet Inclusive Next Generation	Barnet Inclusive Next Generation (formerly Barnet Development Team Youth) is our SEND Youth Voice Forum.
BOOST	Burnt Oak Opportunity Support Team	Multiagency team with staff from Jobcentre Plus, Barnet Homes, Councils Benefit Service, Education and Skills Team. We are an employment, benefit advice, skills and wellbeing project helping Barnet residents.
BPSI	Barnet Partnership for School Improvement	BPSI is a school improvement traded service to pool funding for training, consultancy and support.
BSPP	Barnet Suicide Prevention Partnership	
BYOD	Bring Your Own Device	Use of personal devices for limited business use.
CAMHS	Children and Adolescent Mental Health Services	
CAW	Case Assistant Worker	Used in a health and wellbeing context.
CDOP	Child Death Overview Panels	Used in a health and wellbeing context.
CEAM	Child exploitation and missing tool	Used in a health and wellbeing context.
CESC	Children, Education & Safeguarding Committee	Barnet Committee
CETR	Care, Education and Treatment Reviews	Used in a health and wellbeing context.
CIL	Community Infrastructure Levy	Planning obligation to raise funds for local infrastructure. Also see S106
CSC	Crisis Standards of Care	
CWFS	Covid Winter Fund Scheme	
CWP	Children's Wellbeing Practitioners	Used in a health and wellbeing context.
CYP	Children & Young People	
CYPP	Children & Young People's Plan	
DCT	Disabled Children's Team	Used in a health and wellbeing context.
DPR	Delegated Powers Report	Report on a decision made at Officer level.
EHCPS	Education, Health and Care Plans	Used for children with specific needs.
FPC	Financial Performance and Contracts Committee	Barnet Committee

Acronym	Long title	Description
HEP	Health Education Partnership	
HEYL	Healthy Early Years London award programme	Healthy Early Years London (HEYL) is an awards scheme funded by the Mayor of London which supports and recognises achievements in child health, wellbeing and development in early years settings.
HOSC	Health Overview & Scrutiny Committee	(Pronounced Hosk)
HSL	Healthy Schools London award programme	Taking part in Healthy Schools London (HSL), and working successfully through the tiered awards, will enable schools to directly support the health and wellbeing of their pupils and staff.
ICP	(Borough Based) Integrated Care Partnerships	Health reference to joined up services.
ICS	Integrated Care System	Health reference to joined up services delivered by an ICP.
IRIS	Identification and Referral to Improve Safety	
MARAC	Multi Agency Risk Assessment Conference	
MASH	Multi-Agency Safeguarding Hub	
MHFA	Mental Health First Aiders	
MHST	Mental Health Support Teams	
MOPAC	Mayors Office for Policing and Crime	
NCIL	Neighbourhood Community Infrastructure Levy	Planning obligation to raise funds for local infrastructure. Also see S106
NEET	Not in Education, Employment and Training	
NRPF	No Recourse to Public Funds	Asylum/refuge status
P&R	Policy & Resources Committee	Barnet Committee
PRU	Pupil Referral Unit	Specialist educational support unit supporting schools with pupils with additional needs.
PVIs		
RON	Risk of NEET	Educational at risk group.
RRR	Recovery, Reset and Renaissance Project	Recovery, Reset and Renaissance (RRR) Project - part of schools related COVID-19 recovery.
S106	Section 106	Legal agreement for planning obligations in a local area (also see CIL)
SARG	Safeguarding Adolescents at Risk Group	Used in a health and wellbeing context.
SCAN	Service for children and adolescents with neurodevelopmental difficulties	Used in a health and wellbeing context.
SEF	Self-Evaluation	"The Local Area Special Educational Needs and Disabilities (SEND inspection and Self-Evaluation (SEF)" Educational reference.
SEMH	Social, Emotional and Mental Health	Education related.
SENCO	Special Educational Needs Coordinator	Used in a health and wellbeing context.
SEND	Special Educational Needs & Disability	School and educational terms for those with additional support requirements
SEND	Special Educational Needs and Therapy	Used in a health and wellbeing context.
SFSC		
SMI		Health reference
STP	Sustainability and Transformation Plan	Health reference

Acronym	Long title	Description
UASC	Unaccompanied Asylum-Seeking Children and Young People	
UASC	Unaccompanied Asylum-Seeking Children and Young People	Used in a health and wellbeing context.
VARP	Vulnerable Adolescents at Risk Panel	Used in a health and wellbeing context.
VAWG	Violence Against Women and Girls	Used in a health and wellbeing context.
YOT	Youth Offending Team	Used in a health and wellbeing context.

This page is intentionally left blank

London Borough of Barnet
Health and Wellbeing Board
Forward Work Programme
2023 / 2024

Contact: Pakeezah Rahman (Governance) pakeezah.rahman@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
18 JANUARY 2024			
Deep Dive			
Long Term Conditions – Cardiovascular Disease Prevention Plan *Part of Key Area 2 – Starting, Living and Aging Well*	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Joint Director of Public Health and Prevention, LBB and the Royal Free	Public Health Consultant (Live and Age Well), London Borough of Barnet (Deborah Jenkins) Barnet Borough Partnership team
DISCUSSION items			
Dementia Friendly Barnet	The Board notes and comments on progress on making Barnet a Dementia Friendly borough.	Joint Director of Public Health and Prevention, LBB and the Royal Free	Senior Public Health Strategist, London Borough of Barnet (Seher Kayikci)
Fit and Active Barnet – Year 1 Progress and Year 2 Action Plan	The Board to note and comment on progress, and put forward ideas for future action	Executive Director for Adults, Communities and Health, London Borough of Barnet	Assistant Director, Greenspace and Leisure, London Borough of Barnet (Cassie Bridger)
Barnet Borough Partnership Update	The Board notes the verbal update	Executive Director for Adults, Communities and Health. London Borough of Barnet Chief Executive, Barnet Hospital	
9 MAY 2024			
Deep Dive			

**A key decision is one which: a key decision is one which will result in the council incurring expenditure or savings of £500,000 or more, or is significant in terms of its effects on communities living or working in an area comprising two or more Wards*

Subject	Decision requested	Report Of	Contributing Officer(s)
Aging Well *Part of Key Area 2 – Starting, Living and Aging Well*	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Joint Director of PH and Prevention, LBB and the RF Executive Director for Adults, Communities and Health, London Borough of Barnet	
DISCUSSION items			
Annual Director of Public Health Report 2023/24	The Board notes the report and its recommendations.	Director of Public Health and Prevention, London Borough of Barnet	
Joint Strategic Needs Assessment	The Board to approve – subject to comments – the final version of the Joint Strategic Needs Assessment 2023-24.	Chair and Vice Chair of the HWB	
NOTING items			
North Central London Population and Integrated Health Strategy – Year 1 Performance	The Board to note and comment on the performance of the first year of the strategy.	Director of Integration, North Central London Integrated Care Board	
Health and Wellbeing Strategy – 6-month progress report and proposal for development of new Health and Wellbeing Strategy	The Board to note and comment on progress	Chair and Vice Chair of Health and Wellbeing Board	Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O'Callaghan)

Subject	Decision requested	Report Of	Contributing Officer(s)
Pharmaceutical Needs Assessment Update	The Board approves – subject to comment – any updates to the assessment.	Director of Public Health and Prevention, London Borough of Barnet	Public Health Consultant (Live and Age Well), Public Health, London Borough of Barnet (Deborah Jenkins) Head of Insight and Intelligence, London Borough of Barnet (James Rapkin)
Communicable Diseases Update	The Board notes the verbal update	Director of Public Health and Prevention, London Borough of Barnet	Deputy Director of Public Health, London Borough of Barnet (Janet Djomba)
11 JULY 2024			
Deep Dive			
Improving children's life chances *Part of Key Area 2 – Starting, Living and Aging Well*	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Chair and Vice Chair of the HWB	
DISCUSSION items			
ICB Joint Capital Resource Strategy	The Board to comment on and note the annual update of the strategy.	Director of Integration, North Central London Integrated Care Board	Capital Programmes Team, ICB
NOTING items			
Communicable Diseases Update	The Board notes the verbal update	Director of Public Health and Prevention, London Borough of Barnet	Deputy Director of Public Health, London Borough of Barnet (Janet Djomba)
SEPTEMBER 2024 (TBC)			

Subject	Decision requested	Report Of	Contributing Officer(s)
Deep Dive			
Grahame Park and Burnt Oak *Part of Key Area 3 – Ensuring delivery of co-ordinated and holistic care, when we need it*	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Chair and Vice Chair of the HWB	Public Health Consultant, (Neighbourhoods and Communities) London Borough of Barnet (Rachel Wells)
DISCUSSION items			
NOTING items			
Health and Wellbeing Strategy – 6-month progress report and update on development of new Health and Wellbeing Strategy	The Board to note and comment on progress	Chair and Vice Chair of Health and Wellbeing Board	Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O'Callaghan)
Pharmaceutical Needs Assessment Update	The Board approves – subject to comment – any updates to the assessment.	Director of Public Health and Prevention, London Borough of Barnet	Public Health Consultant (Live and Age Well), Public Health, London Borough of Barnet (Deborah Jenkins) Head of Insight and Intelligence, London Borough of Barnet (James Rapkin)

This page is intentionally left blank