

**Meeting**

**HEALTH & WELLBEING BOARD**

**Date and time**

**Thursday 9TH MAY, 2024**

**At 9.30 AM**

**Venue**

**COMMITTEE ROOM 1, 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 Janet Djomba

Sarah Campbell

Chris Munday

Debbie Sanders

Dawn Wakeling

Kathleen Isaac

Natalie Crompton

Simon Wheatley

Fiona Bateman

Dr Joanna Yong

**Substitute Members**

Councillor Anne Clarke

Councillor Zahra Beg

Councillor Barry Rawlings

Michelle Humphrey

Dr Louise Miller

Anita Sheth

Carol Kumar

Sarah McDonnell-Davies

Kelly Poole

Ben Thomas

Jess Baines-Holmes

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[pakeezah.rahman@barnet.gov.uk](mailto:pakeezah.rahman@barnet.gov.uk)

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

**Andrew Charlwood – Head of Governance**

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**Health & Wellbeing Board**

**AGENDA ITEM 1**

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

**Board Members present:**

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

**Others in attendance:**

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

**1. Minutes of the Previous Meeting**

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

**2. Absence of Members**

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

### **3. Declaration of Members' Interests**

None.

### **4. Public Questions and Comments (if any)**

None.

### **5. Report of the Monitoring Officer (if any)**

None.

### **6. Deep Dive: Cardiovascular Disease Prevention in Barnet**

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

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

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

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

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

The June 2023 data on hypertension, atrial fibrillation and lipid lowering therapy was shared with the Board. It showed variations between Barnet Primary Care Networks (PCNs). There was not a consistent pattern of performance between PCNs, with the management of different CVD risk factors.

It was noted that hypertension had been proposed as a priority area by the NCL Integrated Care Partnership for 2024.

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

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

The use of data analysis would help monitor CVD prevention and outcomes in Barnet.

A multi stakeholder task and finish group would continue to be held quarterly to discuss CVD prevention and the action plan. Recommendations from the Board were sought to increase representation.

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

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

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

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

#### Healthy Heart Peer Support Project

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

The multi session programme offers information and support that is culturally competent. Delivery of interventions and monitoring were being undertaken. Full sessions covered the importance of managing blood pressure with the help of nutritionists. Collaboration with Fit and Active Barnet has taken place to increase physical activity.

Central guidance was developed as a resource, which has been translated into other languages to help people with self-management and support.

More individuals than anticipated had been engaged with as part of the Healthy Heart Project. Brief interventions and extended interventions were being delivered for heart health promotion.

Results from post course questionnaires helped identify behaviour changes to further the development of the intensive programme, including addressing language barriers.

Behaviour change methodology, self-monitoring and community engagement enabled joint understanding of how best to support individuals and to continue raising awareness.

### Core20 Connectors

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

It was noted that the project allowed Healthwatch Barnet Champions to challenge residents' and patients' views and to work with service providers to make improvements based on the feedback received.

In relation to Barnet, 967 blood pressure tests were carried out targeting particular populations. Four trained community connectors were recruited on a freelance basis to carry out blood pressure tests and to explain readings. British Heart Foundation leaflets were offered to individuals of concern and signposted to local pharmacies or GPs accordingly.

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

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

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

### CVD Prevention and Management

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

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

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

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

The RFL Strategy outlines education on how CVD impacts health and wellbeing at different levels of intervention from primary to specialist care.

Key developments in the treatment of heart failure, has led to an improvement in quality of life and mortality figures.

Heart failure has been an enormous cost to the healthcare budget and 2% of the entire NHS budget.

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

There has been a problem in the UK with 30% of patients with heart failure dying at year 1 and 10% per year thereafter. Variances between boroughs were an indication of high deprivation within some areas.

The Heart Failure Clinical Practice Group is championing standardisation of care, evidenced based interventions and digitalisation for which general practice groups have been set up.

A pilot study was carried out in in Camden which identified patients who were at risk of heart failure and enabled early intervention through testing.

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

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

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

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

It was noted that a significant number of people who were homeless or whose first language was not English, may not be attending health appointments, reading letters from their GPs or were not being cared for.

Fiona Bateman pointed out that in relation to discharge, patients could be signposted to support services, with a focus on people who were not engaging with primary or secondary care.

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

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

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

#### CVD Prevention in Primary Care

Michelle Humphrey and Collette Wood presented the item.

Opportunities for smoking cessation were available in both healthcare and community settings.

Automatic prompts on electronic records for healthcare staff posed questions about smoking and signposted people to smoking cessation services.

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

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

KPIs would help monitor the numbers of people with heart failure on the register, the use of beta blockers and review of post cardiac treatment.

Initial pilots around neighbourhood working was underway to focus on complex groups of people.

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

### **Resolved that the Health & Wellbeing Board**

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

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

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

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

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

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

### **8. Dementia Friendly Barnet (update)**

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

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

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

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

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

It was noted that 21 venues have signed up to the Dementia Friendly Venues Scheme with significant interest from more venues.

More than 15,000 people have become Dementia Friends in Barnet including Councillors and Council Officers.

The Understanding Dementia training has been commissioned by Public Health and sessions have been successfully delivered throughout the year.

Risk reduction messages have been communicated in collaboration with Age UK Barnet and Barnet Carers. Living Well with Dementia leaflets have been created to help support those living with the condition and where to access key services.

To promote the importance of becoming a dementia friendly borough, information has been circulated to venues using magazines, newsletters and social media. Work

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

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

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

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

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

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

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

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

## **9. Place/Borough Based Partnerships**

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

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

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



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

**Resolved:**

- 1. That the Board reaffirms that both Health and Wellbeing Board and Barnet Borough Partnership are of joint importance at Place (Borough) level in relation to health priorities.**
- 2. That the Board agrees the proposed delivery and enabling priorities, as outlined in section 1.5.**
- 3. That the Board agrees the changes to how the Health and Wellbeing Board will operate, as outlined in Section 1.7.**
- 4. That the Board notes the recommendations for Barnet Borough Partnership's future model of operation, as outlined in Section 1.9.**
- 5. That the Board communicates to North Central London Integrated Care Board the recommendations for system level partners as outlined in Section 1.10.**

**10. Barnet Borough Partnership (verbal update)**

None.

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

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

**12. Forward Work Programme**

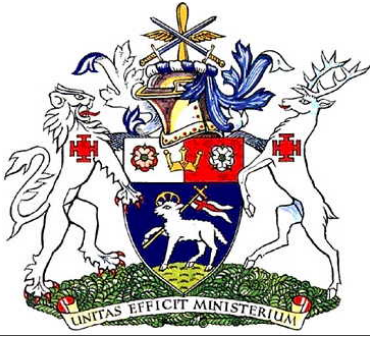
The Board noted the items due to be reported to future HWBB meetings

**13. Any Items the Chair decides are urgent**

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

The meeting finished at 12.05pm

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AGENDA ITEM 6

## Health & Wellbeing Board

<p><b>Title</b></p>	<p>Ageing Well Needs Assessment and Director of Public Health Annual Report 2024/2025</p>
<p><b>Date of meeting</b></p>	<p>9<sup>th</sup> May 2024</p>
<p><b>Report of</b></p>	<p>Janet Djomba, Interim Director of Public Health  <a href="mailto:Janet.djomba@barnet.gov.uk">Janet.djomba@barnet.gov.uk</a></p>
<p><b>Wards</b></p>	<p>All</p>
<p><b>Status</b></p>	<p>Public</p>
<p><b>Urgent</b></p>	<p>No</p>
<p><b>Appendices</b></p>	<p>Appendix A – Ageing Well Health Needs Assessment 2024 (Executive Summary and Recommendations)</p> <p>Appendix B – Ageing Well Health Needs Assessment 2024 (Full Report)</p> <p>Appendix C – Draft Director of Public Health Annual Report 2024/2025</p> <p>Appendix D – Ageing Well Health Needs Assessment and Director of Public Health Annual Report PowerPoint Presentation, London Borough of Barnet Public Health</p> <p>Appendix E – Age Friendly Barnet PowerPoint Presentation, Age UK Barnet</p> <p>Appendix F – Ageing Well Presentation, Ageing Well Clinical Lead, Barnet, North Central London Integrated Care Board</p>
<p><b>Officer Contact Details</b></p>	<p>Madura Nanthakumaran – Public health Specialty Registrar, Live and Age Well <a href="mailto:Madura.Nanthakumaran@barnet.gov.uk">Madura.Nanthakumaran@barnet.gov.uk</a></p> <p>Deborah Jenkins – Public Health Consultant, Live and Age Well  <a href="mailto:Deborah.Jenkins@barnet.gov.uk">Deborah.Jenkins@barnet.gov.uk</a></p>
<p style="text-align: center;"><b>Summary</b></p>	
<p>The report provides an overview and update to the Health and Wellbeing Board on key findings and recommendations of the Ageing Well Health Needs Assessment produced by</p>	

Public Health Directorate (Appendices A and B). It also presents the draft Annual Director of Public Health Report for 2024/25, on Ageing Well (Appendix C).

The Health Needs Assessment uses insights to understand the current and future needs of Barnet's population to age well. It also highlights areas of work supporting ageing well in Barnet, and areas for improvement. Key recommendations from the reports fit into existing workstreams in Barnet. In addition to work delivered by Barnet Public Health, Health and Care System and VCSE organisations, there are also recommendations for consideration for the wider council.

## Recommendations

### That the Health & Wellbeing Board

- 1. Notes the facilitators and barriers around ageing well in Barnet, as identified in the Ageing Well Health Needs Assessment**
- 2. Notes the recommendations from the Ageing Well Health Needs Assessment and Director of Public Health Annual Report 2024/25**
- 3. Endorses the initial progression of work in this area**

### 1. Reasons for the Recommendations

- 1.1 The Ageing Well Health Needs Assessment and Director of Public Health Annual Report set the context locally and nationally for ageing well. The needs assessment reviews data from the last 5 years and 2021 Census and presents analysis of demographics, health outcomes, and disparities seen. It focuses on aspects of ageing well, such as health protection (vaccinations, cancer screening), healthcare services and the broader determinants of health. Special attention is given to population groups with poorer health outcomes or additional support needs. Both reports offer evidence-based recommendations for equitable access to measures which support ageing well. Recommendations in the Director of Public Health Annual Report are based on the longer list of recommendations from the Health Needs Assessment.

### Background – Ageing Well

- 1.2 The World Health Organisation (WHO) define healthy ageing as the 'process of developing and maintaining the functional ability that enables wellbeing in older age'. The WHO define functional ability as the capabilities enabling all people to be and do what they have reason to value: to meet their basic needs; learn, grow, and make decisions; be mobile; build and maintain relationships and contribute to society.
- 1.3 'Ageing Well' goes beyond health, incorporating factors like the environments people live in, housing, employment, and social connections.
- 1.4 Globally people are living longer lives, and this trend is expected to continue in the future. However, it is recognised that whilst people are living longer, healthy life expectancy is not increasing at the same rate<sup>1</sup>. In Barnet, older adults (aged 65+) make up 14% of the population, with Barnet having the 6<sup>th</sup> highest proportion of older adults in London<sup>2</sup>.

<sup>1</sup> Raleigh, V. (2022) What is happening to life expectancy in England, *The King's Fund*. Available at: <https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england> (Accessed 13th October 2023)

<sup>2</sup> Office for health Improvement and disparities (2021) Local Authority Health Profiles. *Fingertips*. Available at: [Local Authority Health Profiles - Data - OHID \(phe.org.uk\)](https://www.localauthorityhealthprofiles.org.uk/) (Accessed 18th October 2023)

## Strategic context of Ageing Well

1.5 **The Chief Medical Officer's (CMO) Annual Report, Health in an Ageing Society (2023)**<sup>3</sup>: This report reflects the need for policy and practice to focus efforts on improving the process for ageing well nationally. The report recognises inequalities seen across society which persist across the life course; whereby some people experience excellent health into later years, and others can spend many years living in poor health. The focus of the report is around improving quality of life in later years and adapting the environment across the themes of urban planning, housing, social care, and aids.

1.6 The current national policies of the NHS including the **Long-Term Plan**<sup>4</sup> acknowledge the importance of anticipatory care planning and 'upstreaming' prevention to improve health and wellbeing. Specific areas of focus include promoting a multidisciplinary team approach, offering more support for informal carers, developing more rapid community response teams and more NHS support in care homes. This is intended to encourage cross-sector working to move towards preventative and anticipatory care models, and shift support from hospital-based services to more care and support being offered closer to or in people's homes.

1.7 **North Central London Integrated Care Board (NCL ICB) Population Health Outcomes Framework (PHOF) and Integrated Care Strategy**<sup>5</sup>: The NCL PHOF has specific indicators to monitor population health across three key areas of start well, grow well and age well. Within ageing well, the identified priorities are to enable people to live as healthy, independent, and fulfilling lives as possible and that people remain connected and thriving in their communities as they age.

1.8 **Barnet Borough Partnership (BBP) Ageing Well Workstream** aims to provide anticipatory care for residents 65 years+ living in Barnet at risk of becoming frail, losing their independence, living with dementia, or requiring support to remain well in their own home. The program strategically aligns with the Age Well NCL ICB Population health outcomes Strategy to:

- Support timely, proactive, and integrated care.
- Support active ageing.
- Reduce social isolation, and support people to remain connected.
- Support early prevention, detection, and management of long-term conditions.
- Support carers.

1.9 **Age-Friendly Barnet, led by Age UK Barnet**: Barnet has committed to becoming an Age-Friendly Community, in line with the WHO framework<sup>11</sup>. This works towards ensuring Barnet is a place that enables people to age well and live a good later life. This work is being led by Age UK Barnet, with input from older adults in Barnet, various teams within the council, colleagues in health and social care and third sector organisations.

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<sup>3</sup> Whitty, C. (2023). *Health in an Ageing Society*. (Online) Department of Health and Social Care. Available at: <https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society> (Accessed 15th November 2023)

<sup>4</sup> NHS England (2019). NHS Long Term Plan. Available at: [NHS Long Term Plan » Areas of work](#) (Accessed 10th October 2023)

<sup>5</sup> NCL ICS (2022) Population Health Outcome indicators: North Central London

## **Ageing Well Health Needs Assessment (see Appendices A and B)**

1.10 The goal of the health needs assessment is to develop an understanding of Barnet's population's health needs as they age, review services and support that is available currently, and make evidence-based recommendations for healthy ageing. While the scope covers diverse topics, areas not detailed are noted for future work. Detailed findings are presented in the full assessment (Appendix B), forming the basis for recommendations (Appendix A), and support for the implementation of national policies for ageing well in Barnet.

1.11 Here below is an overview of key recommendations from the Health Needs Assessment.

- Across these recommendations, ensure the concepts of co-production are used, with groups representative of Barnet's diverse population and its vulnerable population groups. This will increase engagement and support equitable access to measures supporting ageing well across the life course:
  - Enhance access and provision of health promotion and prevention services.
  - Develop appropriate campaigns, information, and advice to promote ageing well.
  - Strengthen Health Protection Programmes.
  - Encourage Proactive and Integrated Health and Social Care.
  - Enhance Falls Prevention and Frailty Support.
  - Promote Social Inclusion and Connectivity.
  - Create environments that promote ageing well.
  - Promote ageing well for people who have additional needs.
  - Support ongoing work to understand and address the needs of Barnet's population to Age Well.

## **Annual Director of Public Health Report 2024/25 (see Appendix C)**

1.12 The theme of the Annual Director of Public Health Report for 2024/25 is 'Ageing Well'. This report serves as a platform to advocate for the health of the diverse population in Barnet and to provide leadership for health improvement and protection within the system. It compiles information, data, and future requirements related to the various factors that impact ageing well. The report is a resource for stakeholders and the public, offering insights into current priorities and recommendations to support ageing well.

## **2. Alternative Options Considered and Not Recommended**

2.1 The board not noting the findings of the health needs assessment and not endorsing future work. This alternative is not recommended, as the Ageing Well Needs Assessment and Recommendations were created with consultation from a range of stakeholders. This report compiles the necessary evidence to inform evidence-based measures which support ageing well across Barnet.

## **3. Post Decision Implementation**

3.1 Recommendations are shared with relevant partners for their consideration and incorporated into existing Ageing Well and Age-Friendly workstreams.

3.2 Where recommendations are outside the scope of existing workstreams, to develop an action plan for progressing this work.

#### **4. Corporate Priorities, Performance and Other Considerations**

##### **Corporate Plan**

4.1 Our plan for Barnet 2023-26 centres around being a council that care for people, our places, and the planet. The Barnet Ageing Well Health Needs Assessment and the Annual Director of Public Health Report fits with caring for people and places which all have an impact on health outcomes. There is also consideration for the planet within recommendations in environments which promote ageing well.

##### **Corporate Performance / Outcome Measures**

4.2 The Ageing Well Health Needs Assessment and Director of Public Health Annual report sit under Key Area 2 of the Health and Wellbeing Strategy (Starting, Living and Ageing Well).

4.3 The Barnet Joint Strategic Needs Assessment (JSNA) includes indicators for 'Age Well' in relation to mortality and health. There are also indicators under 'Live Well' which help understand how well Barnet's population will age in the future. This includes fuel poverty, the proportion of the eligible population receiving NHS health checks and smoking prevalence.

##### **Sustainability**

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

##### **Corporate Parenting**

4.5 The Ageing Well Health Needs Assessment and Director of Public Health Annual Report. focuses on determinants of Ageing Well from the perspective of adult health. However, it is recognised that the factors influencing ageing well can start earlier in life. The Public Health Start and Grow well team incorporate actions which are health promoting and protective, but these are outside of the direct scope of this work.

##### **Risk Management**

4.6 There are not direct risks in relation to the Ageing Well Health Needs Assessment or the Director of Public Health's Annual Report as they are standalone pieces of work.

4.7 Content and recommendations have been produced with engagement of stakeholders, to mitigate the risk of data and health and wellbeing needs being overlooked and content has been adapted in response to feedback.

4.8 Public health report to the Barnet Borough Partnership Ageing Well workstream and form part of the Age Friendly Barnet Steering Group.

##### **Insight**

4.9 Insight and data have been used to create these recommendations to ensure that recommendations are evidence-based. Data was reviewed and the reports considered historical trends where data for this was available, this includes the impact of the COVID-19 pandemic on trends reported.

4.10 The document is extensively referenced to ensure that data sources are clear.

- 4.11 The quality of the data was also considered throughout and known limitations discussed throughout the report. When data was insufficient these informed recommendations to improve the quality of future analysis.
- 4.12 Analysis was completed with the support of the Intelligence and Insight team and Data Analyst.
- 4.13 External benchmarking was used for indicators around health protection – looking at national targets for vaccination coverage. This is highlighted where relevant in the reports.
- 4.14 Data comes from a range of publicly and non-publicly available data sources. All reported data within the document is appropriately aggregated to maintain confidentiality and is in line with data protection guidelines.
- 4.15 Recommendations are made for evaluation of local data. This fits in with the JSNA and also the NCL population health outcomes framework.

### **Social Value**

- 4.16 The recommendations from the Ageing Well Health Needs Assessment and Annual Director of Public Health Report highlight the need to reduce health inequalities and support ageing well across all determinants of health. Cross-cutting themes in the recommendations include safeguarding the natural environmental and its benefits for health outcomes in later life, inclusive employment and housing environments, and benefits of prioritising prevention and early intervention.

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

- 5.1 There are no current financial implications associated with the recommendations of this report 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 improvement of population outcomes and plans to tackle health inequalities. The Joint Health and Wellbeing Strategy (JHWS) should directly inform the development of joint commissioning arrangements in the local area, and the coordination of NHS and local authority commissioning, including Better Care Fund plans.
  - 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 The Ageing Well Health Needs Assessment involved consultation with stakeholders from the wider council, healthcare partners and voluntary and community organisations. This helped guide the content and recommendations for the report. Survey Data from the Age Friendly Barnet Engagement work was also used in the report to understand the views of older adults in Barnet.

7.2 The Director of Public Health Annual Report involved consultation with Age UK Barnet in writing content for Age Friendly Barnet work, and the wider Public Health team.

## **8. Equalities and Diversity**

8.1 The Health Needs Assessment and Director of Public Health Annual report consider a 'whole systems' approach to Ageing Well. Specific needs of vulnerable population groups and populations experiencing poorer health outcomes have been included throughout the Needs Assessment. Recommendations have focus on these groups. There is an overarching recommendation to ensure the concepts of co-production are used, with groups representative of Barnet's diverse population and its vulnerable population groups. This will increase engagement and support equitable access to measures supporting ageing well across the life course.

## **9. Background Papers**

9.1 [Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/115122/Chief-Medical-Officer-Annual-Report-2023-Health-in-an-ageing-society.pdf)

9.2 [NHS Long Term Plan » Cardiovascular disease](https://www.nhs.uk/longtermplan/long-term-plan-cardiovascular-disease/)

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## Executive Summary

*This summary should be read in conjunction with the 'Recommendations' to give an overview of the whole report.*

It is recognised that whilst global life expectancy is rising, healthy life expectancy lags behind – there is a societal need to improve how we can age well. The World Health Organisation defines healthy ageing as “the process of developing and maintaining the functional ability that enables wellbeing in older age.” Functional ability includes meeting basic needs, learning, growing, decision-making, mobility, relationships, and societal contribution. The Barnet Ageing Well Needs Assessment 2023/24 aligns with this perspective.

'Ageing Well' goes beyond health, incorporating factors like the environments people live in, housing, employment, and social connections. The needs assessment reviews data from the last 5 years' and 2021 Census and presents analysis of demographics, health outcomes, and disparities seen. It focuses on aspects of ageing well, such as health protection (vaccinations, cancer screening), healthcare services and the broader determinants of health. Special attention is given to population groups with poorer health outcomes or additional support needs.

The goal of this health needs assessment is to develop an understanding of Barnet's population's health needs as they age, review services and support that is available currently, and make evidence-based recommendations for healthy ageing. While the scope covers diverse topics, areas not detailed are noted for future work. Detailed findings are presented in the full assessment, forming the basis for recommendations, and support for the implementation of national policies for ageing well in Barnet.

## Demographic Profile

In 2021, adults aged 65 and over made up 14.4% of Barnet's population (Figure 1), marking an 18% increase since 2011. While this proportion is below the national average, Barnet ranks sixth among London boroughs for the percentage of people aged 65+. Projections suggest that by 2043, one in five adults in Barnet will be 65 and over, with a declining proportion of younger age groups.

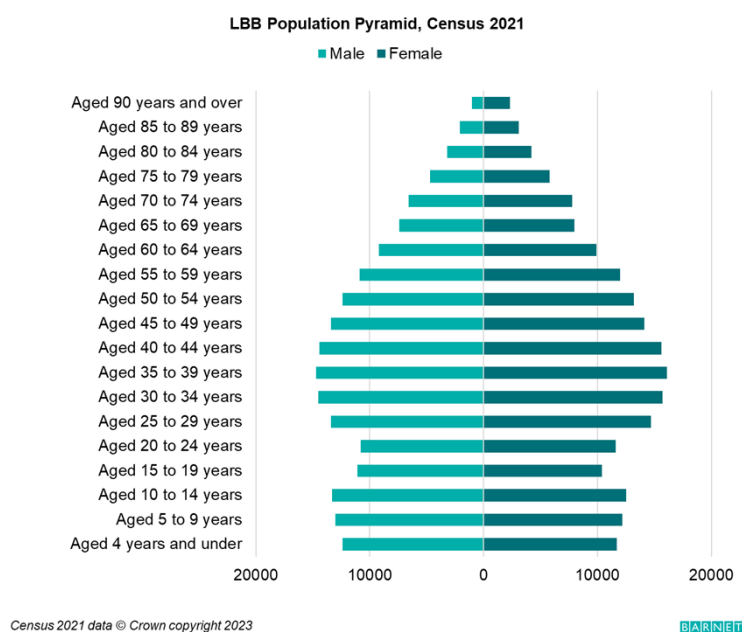


Figure 1 Barnet Population Pyramid, Census 2021

Life expectancy in Barnet exceeds the national average, with females at 85.5 years and males at 80.4 years. Despite overall improvements, the COVID-19 pandemic caused a temporary dip in life expectancy from 2018-2020. Healthy life expectancy estimates indicate that both males and females can expect to spend at least a fifth of their lives in poor health, with variations across locations and with a socioeconomic gradient.

Deprivation levels, measured by the Index of Multiple Deprivation, vary within Barnet. The IMD defines deprivation to encompass a wider range of an individual's living conditions. Higher levels of deprivation are associated with poorer health outcomes, higher levels of disability and an increase of risk-behaviours which further impact health. While the borough's overall deprivation is lower than the national average, specific areas like Colindale North, Cricklewood, Burnt Oak, West Hendon, and Underhill rank among the top 20% deprived areas in England (Figure 2). Income deprivation affecting older people is concentrated in Burnt Oak, Colindale, West Hendon, and East Finchley.

Barnet is a diverse borough, with 42.3% of the population from non-white ethnic groups, including 30% of those aged 65 and over. Language diversity is notable, with over 88 languages spoken, though English remains the primary language for 77.1% of residents aged 3 and over. The top 5 languages after English were Romanian, Persian or Farsi, Polish, Gujarati, and Portuguese. Most older adults (82.7%) in Barnet reported English as their main language in 2021. The most common reported faith for those aged 65+ in Barnet is 'Christian' (42.4%), followed by 'Jewish' (21.0%) and 'No Religion' (13.6%).

## Health Promotion

In later life, health is influenced by behaviours impacted by social, environmental, and economic factors. In Barnet, there is evidence that mortality in 2019 was significantly influenced by behavioural risk factors such as tobacco use, dietary risks, alcohol use, and low physical activity.

Smoking contributes to mortality disparities in England, especially in areas of higher socioeconomic deprivation. It is associated with chronic respiratory disease and loss of functional ability in older age. As of 2023, the prevalence of smoking in Barnet's adult population was 10.5%, equating to about 31,000 people. Data from 2020 to 2023 shows a decreasing trend in the number of people accessing smoking cessation services, with a shift towards accessing them through a wider range of providers, such as pharmacies. The majority of those accessing smoking cessation services are aged 45-64, although national data suggests that the 25-34 age group has the highest smoking rates.

Alcohol use and its impacts on health and wellbeing of populations is well-documented and has been identified as a causal factor in many medical conditions. Susceptibility to the negative effects of alcohol use increases with age, including malnutrition, liver disease and falls. Alcohol-related

**Barnet Index of Multiple Deprivation 2019 Score**

By ward

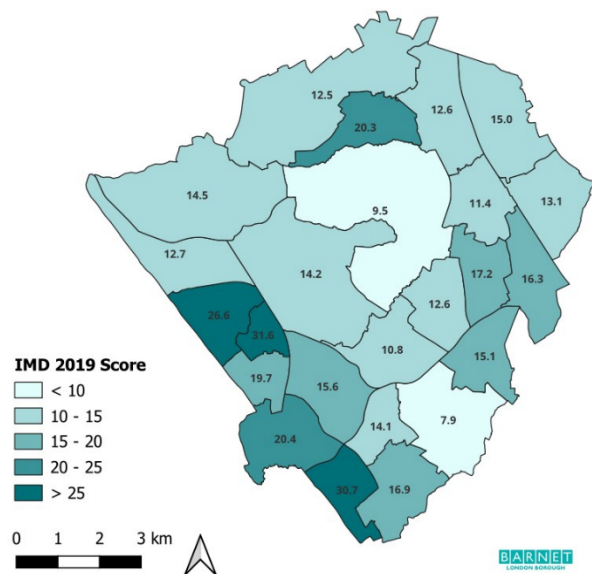
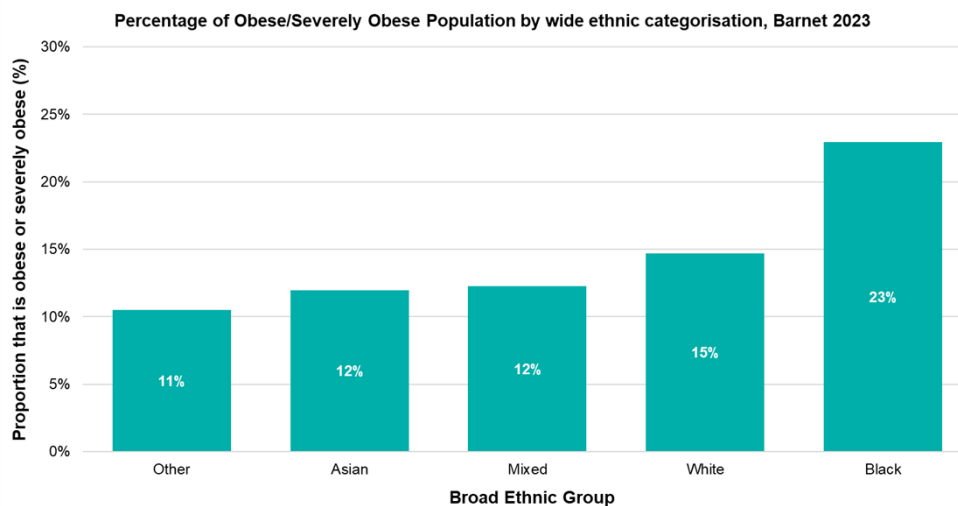


Figure 2 IMD 2019 score by ward represented on heatmap. Darker shades represent higher levels of deprivation. (I&I, LBB)

admissions for those aged 40+ are lower in Barnet compared to national and regional averages. In Barnet, males have a higher admission rate than females, especially those aged over 65. Data shows an increasing trend of adults aged 50+ receiving treatment for alcohol and opiate misuse from 2019/20 to 2021/22. The unmet need for alcohol dependency treatment in Barnet was estimated to be between 71-84%, compared to 76-84% across England. There is an underrepresentation of people aged 65+ in substance misuse treatment as well as females accessing substance misuse services.

Physical inactivity (<30 cumulative minutes/week) Increases chronic disease risk for conditions such as type 2 diabetes and cardiovascular disease. Factors such as physical or mental disability, frailty and co-existing medical conditions can affect a person's activity levels. In Barnet, 22.1% of adults are inactive, comparable to London and England rates.

Obesity, another risk factor for chronic diseases and mental health issues, has increased nationally over the past three decades. In Barnet, 57.5% of adults were overweight or obese in 2021/22, with 15.9% categorised as obese. Obesity rates vary among ethnic groups in Barnet (Figure 3). The highest percentage of obesity in adults was seen in 'Black' ethnic groups (22.94%) and lowest in 'Other' ethnic groups (10.52%) in 2023.



Source: North Central London Integrated Care System, Health Intent. 2023

Figure 3 Percentage of obese, severely obese Barnet Population by Broad ethnic group, Barnet 2023. NCL Health Intent

A balanced and nutritious diet is protective of health, however there is limited data on adults who follow a healthy diet in Barnet. Data from the *Active Lives Survey* showed that 57% of the population aged 16+ in Barnet meet the WHO's '5-a-day' recommendation. Age UK Barnet Survey data from 2023 shows that people from older age groups are less likely to report that they meet this recommendation. Consuming the recommended levels of fruit and vegetables can reduce and delay the risk of conditions such as hypertension, chronic heart disease and stroke in later life. Healthy diets also contribute to a healthy weight, as well as bone health and lower risk of frailty in later life. Malnutrition is another important factor to consider for older adults. Nationally, reports suggest that 1 in 10 people over the age of 65 are malnourished or at risk of malnutrition. It is both cause and consequence of ill health, increasing risk of hospital admission, and long-term health conditions for otherwise independent and healthy people. Risk factors for malnutrition in older adults include other health conditions (particularly dementia and chronic respiratory disease), physical and sensory impairments and social factors. Consideration should be given to how people access food too.

National policies such as regulation and reformulation of high in fat, sugar and salt foods impact the quality of food we can access. At a local level the built environment and the concentration of hot food takeaway can impact the cumulative effect on diet. Food insecurity can also imply a nutritionally inadequate diet, in Barnet there has been an increase in the total number of people accessing foodbanks from 2021 compared to 2023 (increase of 46,000 users).

## Health Protection

Healthcare-seeking behaviours and access to healthcare play a crucial role in successful ageing, and vaccine coverage disparities are highlighted in this assessment. Influenza, pneumococcal, and shingles vaccines are part of routine immunisation schedules for older adults. Uptake and coverage across Barnet, London and England are explored in detail in the full report. Trends showed a reduction in vaccination uptake across these programmes during the first wave of the COVID-19 pandemic (2019/20). Although there has been some improvement since then, Barnet falls short of national targets for the immunisation programmes. COVID-19 vaccination is also explored for adults aged 18+. Data highlights a significant disparity in uptake of the two doses of the vaccine between April 2020- January 2023 between the most and least deprived areas of Barnet (Figure 4). From those who have not received a COVID-19 vaccination, a greater proportion is seen in younger age groups in Barnet, compared to older age groups.

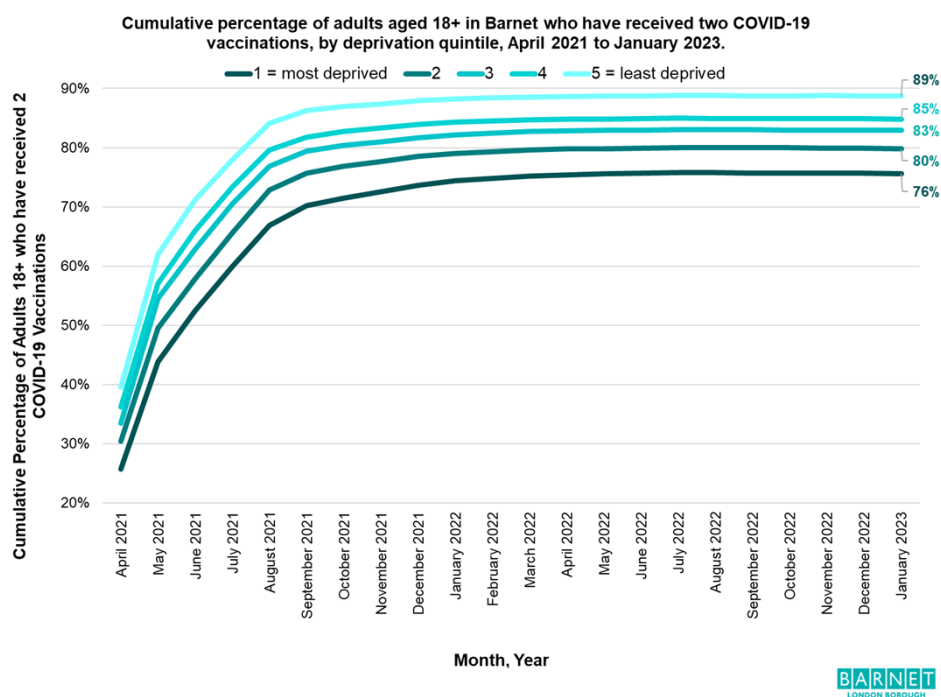


Figure 4 Cumulative percentage of adults aged 18+ in Barnet who have received two COVID-19 vaccinations, by deprivation quintile, April 2021 to January 2023.

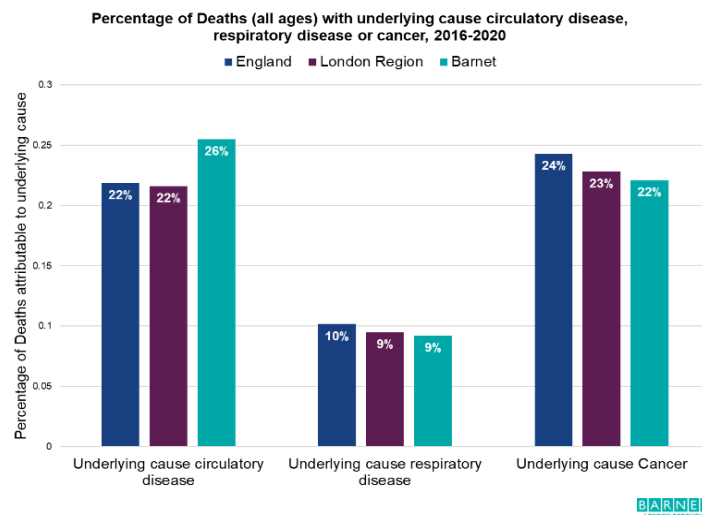
Screening programmes help in the early detection of disease and promote Barnet’s population to age well. The UK has national screening initiatives for breast, cervical, and bowel cancer, as well as targeted lung health checks for those at a higher risk of lung cancer. Additionally, there's a national screening for abdominal aortic aneurysm (AAA) to address associated mortality risks. The full report explores each program's uptake trends among eligible populations, except for targeted lung health checks, which is a newer initiative and data is not available for Barnet currently.

The decrease in screening coverage during the COVID-19 pandemic is noticeable, emphasizing the need for ongoing monitoring to assess long-term effects. There is also a pre-pandemic decline in cervical cancer screening coverage for those aged 50-64, and even lower coverage for younger age groups eligible for screening. Bowel cancer screening coverage has consistently increased since 2011, unaffected by the pandemic. Ongoing monitoring is crucial to assess the long-term effects of the pandemic on screening, early diagnosis and cancer incidence.

## Healthcare and Social Care

Physical and mental ill-health are not an inevitable part of ageing. However, by 2035, it's estimated that two-thirds of adults over 65 will have multiple conditions, leading to complex care needs including long-term and mental health conditions.

For mortality in Barnet, circulatory diseases accounted for 25.5% of deaths from 2016-2020, exceeding national and London averages (Figure 5). The full report presents information about avoidable mortality, revealing disparities across ethnic groups in North Central London.



*Figure 5 Distribution of cause of mortality for circulatory disease, respiratory disease or cancer in Barnet, London and England*

In 2022/23, Barnet residents aged 50+ had 64,885 hospital admissions, marking an increase from 54,890 in 2020/21. The most frequent diagnoses on admission were cataracts and bronchopneumonia when the data excluded planned hospital admissions for regular appointments (Figure 6). Data around hospital admissions and the geographical distribution of this helps identify areas for workforce planning to accommodate an older patient population and the delivery of multidisciplinary care.

Number of Barnet patients admitted to hospital, split by top 10 diagnosis recorded on discharge

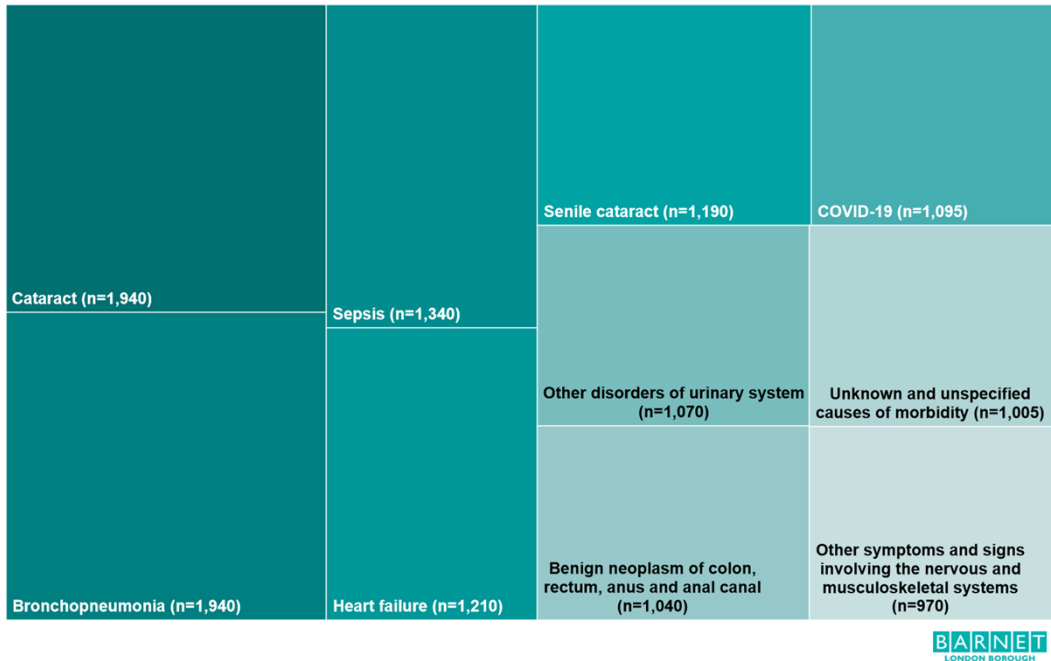


Figure 6 Tree map showing the numbers of admissions to hospitals for Barnet residents, split by top 10 diagnoses on discharge for 2022/23.

### Cardiovascular Disease

About 85% of cardiovascular disease (CVD) is preventable through lifestyle adjustments such as diet and exercise, as well as tobacco and alcohol use reduction (this primary prevention is discussed in the health promotion section). The healthcare system has an important role in early diagnosis and management of clinical risk factors for cardiovascular disease, such as hypertension and raised cholesterol. While the prevalence of CVD-related conditions is lower than the national average, it's higher than the NCL average (Table 1).

QOF Prevalence of CVD for all ages 2021/22, split by condition			
	Barnet	NCL	England
Hypertension	11.40%	10.39%	14.00%
Coronary heart disease	2.40%	1.82%	3.00%
Stroke	1.30%	1.06%	1.80%
Atrial Fibrillation	2.10%	1.13%	2.60%

Table 1 QOF prevalence for CVD in Barnet, NCL and England for 2021/22

The NHS Health Check programme aims to mitigate CVD risk through regular health checks and lifestyle advice. Despite a higher number of invitations in Barnet compared to London, the uptake is lower than the national average. A community health screening program run by GPDQ Ltd in Barnet, aims at supporting underserved population groups. In the first year of delivery, attendees were predominantly from areas of high deprivation such as Colindale and High Barnet.

Heart failure admissions for those aged 50+ in Barnet underscore the importance of early diagnosis, as nationally 80% of cases are diagnosed in hospital despite identifiable early symptoms in the community.

### Diabetes



Diabetes is closely linked to cardiovascular disease (CVD) and overall multimorbidity. Type 2 diabetes, affecting 90% of individuals with diabetes, is linked to CVD risk factors, ethnicity, obesity, and socioeconomic inequalities. In Barnet, there is a rising prevalence of diabetes, with 6.7% of adults aged 17 and older diagnosed. The National Diabetes Prevention Programme aims to identify and assist individuals at risk of developing Type 2 Diabetes Mellitus (DM) through a 9-month lifestyle change programme. In Barnet, less than half of those who attended the initial assessment reached the first milestone of the programme across all Primary Care Networks (PCNs).

### **Respiratory Disease**

Chronic Respiratory Disease (CRD) is prevalent in the UK, affecting 1 in 5 people and disproportionately impacting those in deprived areas. It was the 6th leading cause of preventable mortality in North Central London from 2016 to 2020. Behavioural risks of smoking and obesity contribute to diseases like COPD and asthma respectively. The prevalence of COPD in Barnet was 1% in 2021/22.

### **Mental Health**

There is a higher prevalence of mental health conditions among specific groups of older individuals, such as those in care homes, older carers, and those experiencing life transitions or multimorbidity. These symptoms are less likely to be detected or treated in older people due to barriers like perceived inevitability of poor mental health with age or fear of burdening others. Common conditions include depression and anxiety, and the prevalence of depression has been increasing in Barnet since 2013/14.

### **Frailty**

Frailty is characterised by the gradual loss of body system reserves. It increases the risk of adverse outcomes in older adults, such as physical and mental health decline after minor health events. Although often overlapping with multimorbidity, frailty is distinct, with only a fifth of older adults with multimorbidity being frail. Frailty prevalence is higher and onset earlier in deprived areas. Across Barnet, PCN 2 had the highest number of people aged 65+ determined to be frail using the Hospital Frailty Risk Score.

### **Musculoskeletal Health, Falls and Falls Prevention**

Musculoskeletal (MSK) conditions, impacting bones, joints, muscles, and the spine, can lead to long-term pain and disability. Risk factors include physical inactivity, obesity, vitamin D or calcium-deficient diets, smoking, and genetic factors. MSK conditions limit individuals' ability to work and participate in social activities, with only 59.4% of working-age people with an MSK condition being employed. Prevention, early detection, and treatment are crucial for maintaining health and independence. Osteoporosis, a condition causing bone fragility and increased fracture risk, is more prevalent with age and particularly in post-menopausal women. In 2022/23, the prevalence of osteoporosis in individuals aged 50+ in Barnet was high, ranking in the highest quintile across England. The high prevalence of osteoporosis in Barnet underscores the need for primary and secondary prevention.

In Barnet, the number of emergency admissions for hip fractures among individuals aged 65 and older was 467 per 100,000 of the population. This rate was notably lower than the national average in England (551/100,000) and comparable to the rate observed in London (493/100,000). Barnet has significantly higher rates of admission for hip fractures among individuals aged 80 and over, compared to those aged 65-79 years old (Figure 7).

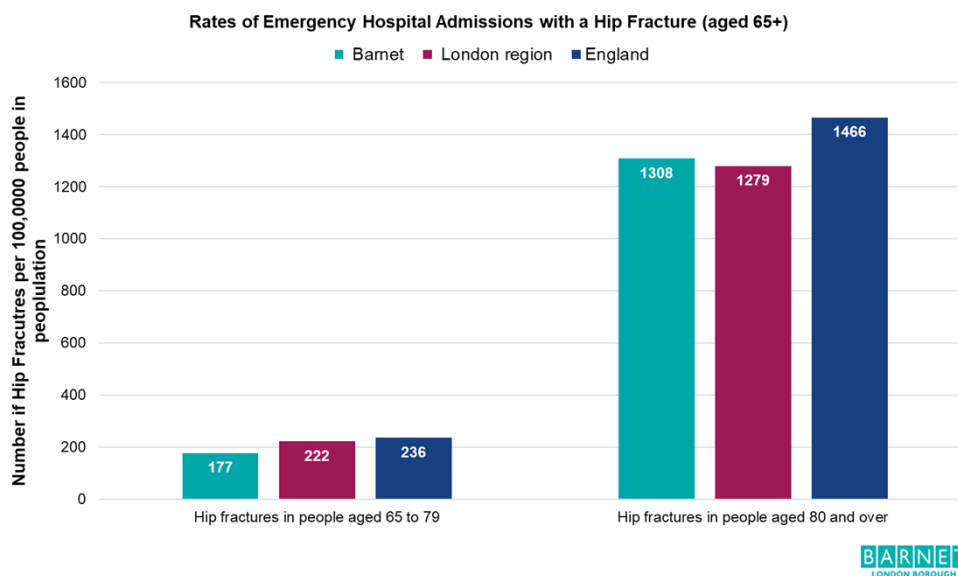


Figure 7 Emergency hospital admissions for fractured neck of femur in persons aged 65+, directly standardised rate per 100,000 for Barnet, London, and England 2021/22

Falls are a major health concern, often leading to long-term care needs for older adults. Data from Barnet suggests a decline in falls presenting to A&E during 2020/21, potentially due to reduced incidents amid the COVID-19 pandemic. Areas like High Barnet, Underhill, Totteridge, and Finchley in Barnet PCN3 show a notably higher fall rate. The multifactorial causes of falls emphasise the need for a comprehensive, multidisciplinary approach to falls prevention. Evidence supports exercise interventions for primary prevention, with specific recommendations for secondary prevention after hip fracture. Falls prevention services should be meaningful, accessible, and include communications to raise awareness and mitigate risks in Barnet.

### Oral Health

An ageing population poses changes in oral health needs, with factors like increased sugar intake and reduced salivary fluid heightening disease risk. Poor oral health is prevalent, especially among those in care homes or living with dementia who face challenges in accessing dental services. Nationally, disparities exist in dental decay, tooth loss, oral cancer, and self-rated oral health, with less impact in fluoridated areas. Promoting good oral health is essential for healthy ageing, with early support and inclusion of oral health in comprehensive assessments being key for vulnerable groups. Local-level data on oral health outcomes will also help identify specific needs for older adults in Barnet.

### Older adults with social care needs

Social care is crucial for individuals with additional needs, addressing longer life expectancy and complex health conditions. Barnet has the highest number of registered care home places for individuals aged 65 and over across NCL. The rate of permanent admissions to care homes has been increasing, with the 2021/22 rate of 543 admissions per 100,000 of the population aged 65+ being significantly higher than the London average. This data, however, excludes self-funded residents, indicating total admission rates would be higher. Future projections suggest an increase in care home residents, especially among those aged 85 and over. Initiatives like the One Care Home Team and Digital Care Home Programme support enhanced and proactive care in these settings. Market

statements in Barnet identify areas for improvement, emphasizing the need for complex care, remodelled residential care, and enhanced workforce training.

Reablement, focusing on post-hospital discharge support, is higher in Barnet (6%) than London and England, but the percentage of individuals remaining at home 91 days after discharge is lower (77.4%). To enhance reablement, factors such as accessibility, cultural needs, and training for complex care are important. Assistive technology, such as fall sensors, can support independent living. Barnet offers various services, which should be complemented with early identification of need for this technology and barrier exploration before crises occur.

Unpaid carers, often older adults, play a vital role in social care support. Self-reported data from the 2021 Census suggested 10% of adults aged 65+ in Barnet were unpaid carers, but actual figures could be higher. Carers often face poorer health outcomes, which could be mitigated by individualised support measures, such as thorough assessments and breaks from caring, aligning with the NHS Long Term Plan. Preventive measures against ill health and support for carers' health should be prioritised, emphasising early identification and engagement in protective health behaviours.

## Wider Determinants of Ageing Well

It is important to consider the wider social, economic, and environmental factors that affect health and wellbeing, such as employment, housing and open space. Age UK Barnet is leading on the Age-Friendly Community Initiative in Barnet, which focusses on aspects of the physical and social environment that influence ageing.

### **Economic Determinants**

The ageing population is vulnerable to economic fluctuations, impacting their health and wellbeing, and increasing demand for services and pensions. This impact can be lessened if older individuals maintain good health and remain economically active.

In the UK, the proportion of adults of pension age has increased significantly from 2018/19 to 2019/20, and 1 in 5 of these people live in relative poverty. Gender inequalities in financial security in later life persist, with family circumstances and working patterns affecting women more than men.

The COVID-19 pandemic saw a reduction in employment among older people, who were more likely to be made redundant and less likely to be reemployed than younger workers. And employment rates among those nearing retirement dropped to their lowest since 2016 in Barnet in 2020/21 (Figure 8).

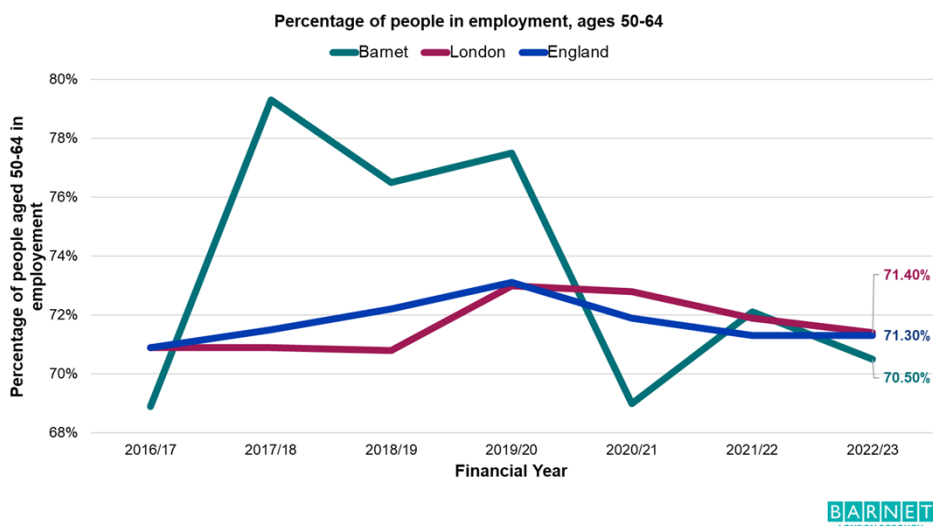


Figure 8 Percentage of people aged 50-64 who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker). Reported for Barnet, London and England

Poor health is a primary reason for unemployment among the 50-64 age group, especially for those in economic deprivation. Access to quality and flexible work, and support in maintaining or returning to such work, is crucial for those aged 50 and over. Financial planning support for later life can help identify needs and access support before reaching crisis points, particularly for those in higher deprivation areas, rented accommodation, or poor health.

### Social Determinants

Social interactions are crucial for overall health and wellbeing, especially for older adults who often experience increased social isolation due to factors such as retirement, bereavement, loss of mobility or sensory impairment. Social isolation and loneliness, whilst different, can both lead to physical and mental health issues, including dementia, heart disease, and depression, and are linked to premature mortality.

Data from the 2021 Census revealed that 22% of Barnet's population aged 50+ lived alone. Age UK's loneliness heat map estimates that the highest risk of loneliness amongst those aged over 65 in Barnet are concentrated in areas towards the West and East of the borough (Figure 9). To reduce inequalities in older age, it's crucial to consider the needs of those most at risk of social isolation when planning communities and designing local services.

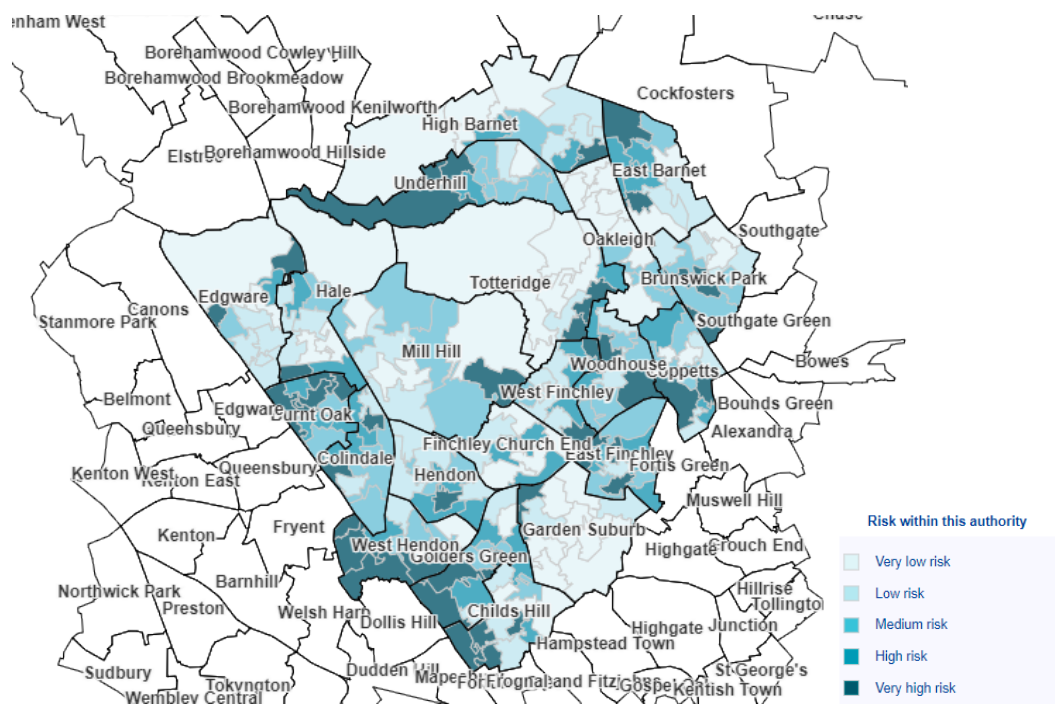


Figure 9 Age UK Risk of Loneliness in England 2016 for people aged 65+ in Barnet. Darker shades indicated higher risk of loneliness.

The Age-friendly Communities model offers a community-led approach to increase the resilience of such initiatives. Barnet’s social prescribing model focuses on reducing social isolation and promoting self-management of health by linking individuals to local community services. It employs a holistic approach, co-creating action plans with patients based on their specific needs.

### Environmental Determinants

The indoor environment significantly impacts aging well, with many older individuals in England residing in homes that result in poorer health outcomes. Issues include cold homes increasing cardiovascular risks, overheating, damp, and mould impacting respiratory health, and unsafe homes leading to falls and injuries. Poor housing quality disproportionately affects those in deprivation and private rentals. Homeowners aged 65+ in Barnet reported better health than those in rented accommodation (Figure 10). National reports suggest that there is a greater concentration of older adult renters in areas of deprivation, and more likely to live in poor-quality homes, which could contribute to poorer health experiences.

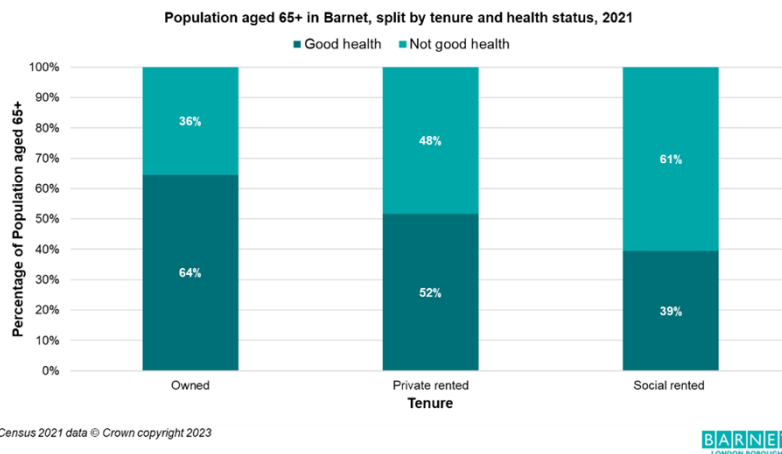


Figure 10 Population aged 65+ in Barnet, split by tenure type and whether they are reporting 'good' or 'not good' health, Census 2021

Air pollution, climate change, and adverse weather impact vulnerable groups, especially older adults. Specific note is made within the full needs assessment of the effect of adverse weather on vulnerable population groups, which includes older adults. These factors increase the demand for social and health care, potentially disrupting support networks. Sustainability considerations for health and social care systems – the system's ability to function during extreme weather, for example - are vital to support Barnet's population to age well.

Barnet is known for its green spaces, but it is important that these spaces, public spaces, and other amenities such as toilets and rest spaces are accessible to people across the life course. Less than 50% of respondents to an Age UK Barnet survey aged above 65 reported that there were enough suitable places to rest and public toilets when out and about. Addressing barriers in access to these spaces will help promote active travel, reduce social isolation, and contribute to healthy ageing.

## Older Adults with Additional Support Needs

### Dementia

Dementia is the leading cause of cognitive decline in older adults, and its prevalence is expected to rise with the aging population. Common types include Alzheimer's disease, vascular dementia, and dementia with Lewy bodies. Young-onset dementia occurs before age 65. Barnet had the 6th highest prevalence of dementia among those aged 65+ compared to other London boroughs in 2020. The estimated dementia diagnosis rate was 65.7% in 2022, highlighting areas where there can be improved recognition and early diagnosis for Barnet's residents.

The Lancet Commission identified 12 modifiable risk factors for dementia which could prevent or delay up to 40% of dementia (Figure 11). A focus on behaviour change in prevention is recommended to help mitigate the risk, including smoking cessation, weight management, diabetes prevention, avoiding excessive alcohol and treating hearing impairments. Work on dementia prevention is supported by existing health promotion measures, and efforts to support these will have positive effects across multiple domains of health, beyond dementia. The 2019 Barnet Dementia Needs Assessment and 2023-2025 Dementia strategy outlines recommendations and actions to support high-quality care for people with dementia and their carers.

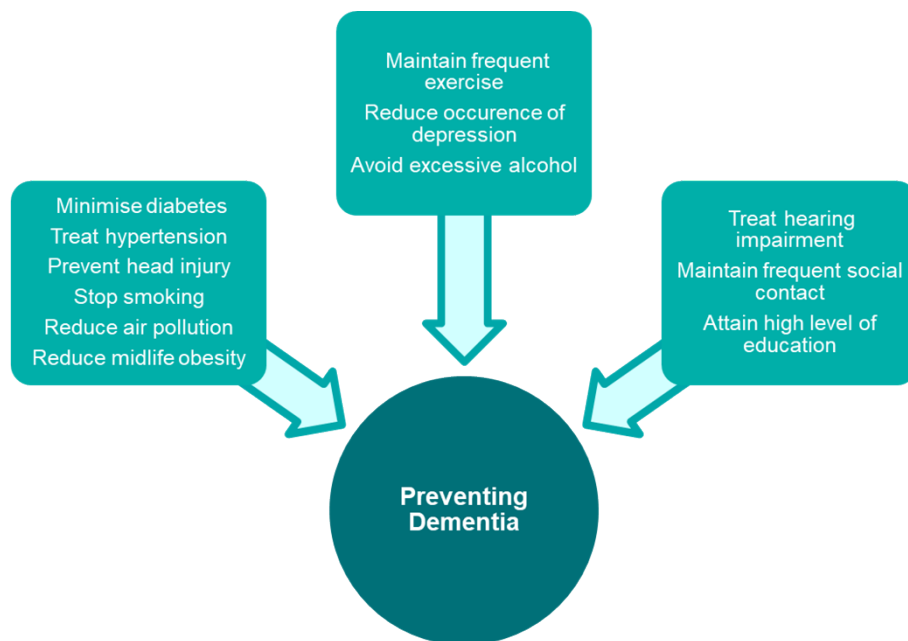


Figure 11 Recommendations for the prevention of dementia, adapted from the 2020 Lancet Commission

### People with Learning Disabilities

Learning disabilities, varying from mild to severe, impact individuals' intellectual ability and social functioning throughout their lives. Aging with these disabilities poses challenges, including premature aging and an elevated risk of Alzheimer's dementia. People with learning disabilities (PWLD) face health inequalities in access to services and with the wider determinants of health, which negatively affect their ability to age well. The Learning Disability and Mortality Review (LeDeR) aims to improve healthcare for PWLD and has reported a decrease in avoidable mortality for PWLD. However, it also identified areas for improvement, including the management of non-communicable diseases and the impact of heatwaves. The report also found an increased risk of premature mortality among PWLD from ethnic minority groups and those living in deprived neighbourhoods.

Annual health checks for PWLD are crucial for proactive medical care and addressing unmet health needs. In 2018/19, 55% of PWLD in Barnet had an annual health check. To address the needs of an ageing PWLD population in Barnet, joint strategies across health, social care and other council services are needed.

### People with Sensory and Physical Impairments

The likelihood of experiencing disability is greater with age, however it is also important to consider how people living with disabilities can be supported proactively to live and age well in Barnet. Without the right support in place, people are more likely to suffer across more domains than their health, this includes employment, social isolation, housing, and physical barriers in the outdoor environment. Active and healthy ageing should acknowledge the value and connection in the lives of those with disabilities. This needs assessment focusses on individuals with sensory (auditory or visual) and physical disabilities.

Hearing and visual impairments significantly impact health and well-being, leading to issues like unemployment, social isolation, depression, and mental health concerns. Sensory impairment increases the risk of specific health conditions, with hearing impairment identified as a risk factor for

dementia. In 2022, an estimated 11,400 people experienced sight loss in Barnet, while 4,544 individuals over 70 had severe or profound hearing loss in 2020.

Barnet residents reported the degree to which their day-to-day activities were limited (or activities of daily living; ADLs), according to if they were disabled under the disability act in Census 2021. The highest number of people reporting significant limitation to ADLs was between the ages of 55-64 for both males and females (Figure 12).

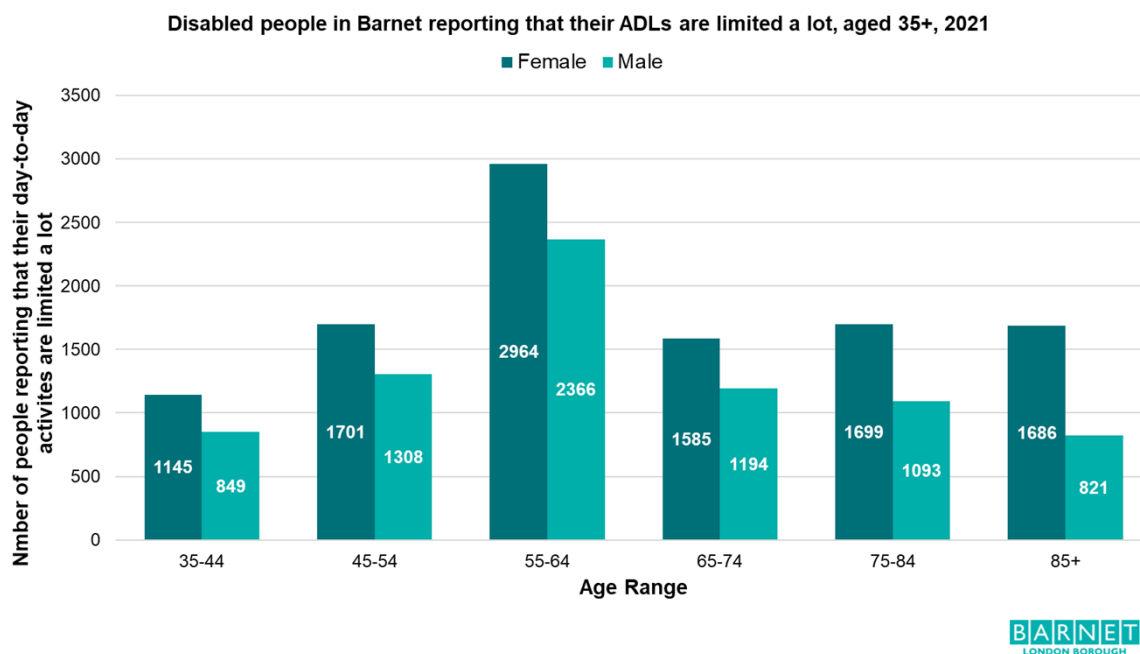


Figure 12 People with disabilities (under the Equality Act) who report that their day-to-day activities are limited a lot. Split by age range and sex, Census 2021

An ethnographic research study in May 2023 highlighted the challenges faced by disabled residents in Barnet, including discrimination, social exclusion, and communication barriers. Recommendations from the study emphasize recognizing intersectional identities, making information more accessible, bridging community organizations, and extending community engagement activities.

Facilitating equipment and home adaptations for disabled people can be made through means-tested Disabled Facilities Grants. The outdoor environment is not consistently accessible for disabled individuals, posing challenges like uneven pavements and a lack of accessible public spaces. Addressing these issues requires a comprehensive understanding and support for day-to-day activities, promoting inclusivity and accessibility in Barnet.

### Severe Mental Illness

Severe mental illness (SMI), encompassing conditions like schizophrenia and bipolar disorder, significantly impairs individuals' functional and occupational activities. SMI is linked with higher premature mortality rates and a 10-20 year reduction in life expectancy compared to the general population, largely due to physical health conditions and elevated suicide risk.

In Barnet, the premature mortality rates for adults with SMI were notably lower than the rates in London and England overall. However, for the fourth quartile of 2021/22 only 30% of people with SMI in Barnet were recorded as having an annual health check. This was the lowest across NCL, and



significantly lower than what was seen in London and England (Figure 13). This highlights the missed opportunities for holistic review of physical and mental healthcare in the community, which contribute to poorer health outcomes seen in people with SMI.

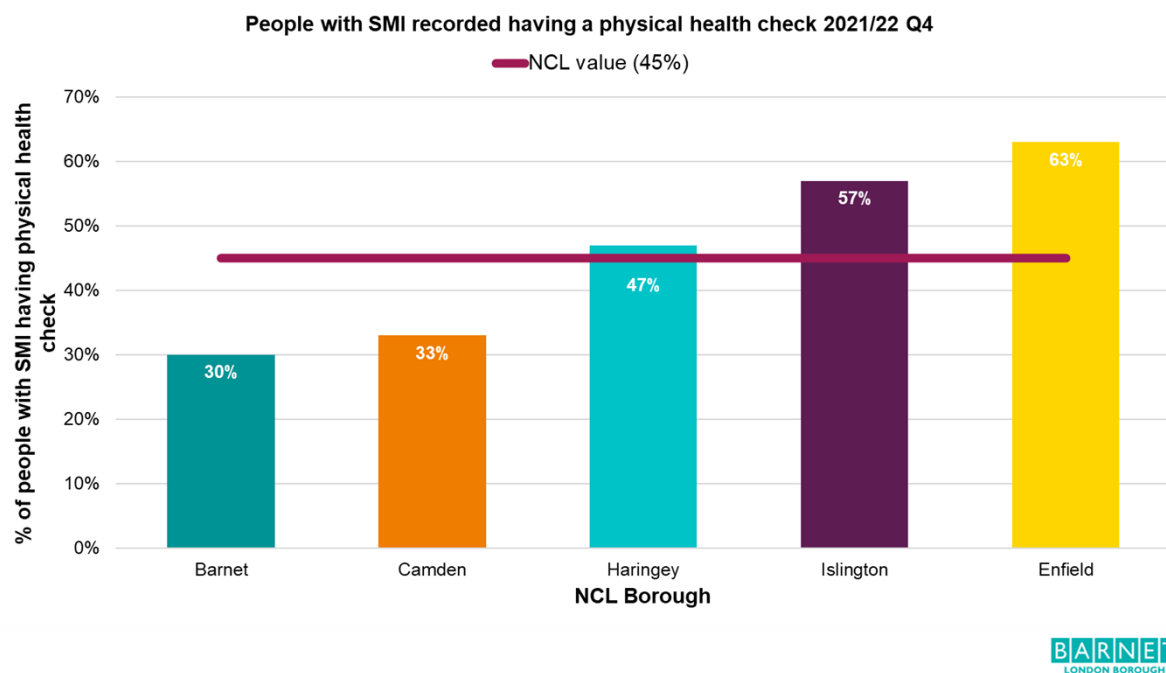


Figure 13 Percentage of people with SMI who received a physical health check in 2021/22 across NCL boroughs, Quartile 4 2021/22

### Inclusion Health Groups

Inclusion health refers to socially excluded individuals who, due to various risks, suffer poor health outcomes and lower life expectancy. Not all inclusion health groups are explored within this needs assessment, however it is recognised that this is an area which has also been addressed in the NCL Inclusion Health Needs Assessment, 2023.

Homelessness extends beyond rough sleeping and includes those without secure or adequate housing. Older homelessness, classified as those aged 55+, is of particular concern due to the accelerated ageing and health conditions associated with long-term homelessness. In Barnet, during 2021/22, the rate of households owed prevention or relief duty under the Homelessness Reduction Act, where the main applicant was aged 55+, was higher than the national average but lower than the London average. The needs assessment also explores the effect of adverse weather for people experiencing homelessness and specific needs for this population. Specific needs identified include addressing complex health needs, access during crises, and health promotion where there may be more acute health needs.

The data on vulnerable migrant populations is limited at a local level. Current information on asylum seekers in contingency accommodation in Barnet is available with broad age ranges. Older asylum seekers (aged 65+) comprise only 1% of this group. The Barnet Migrant Health Needs Assessment was carried out in 2022, resulting in an Asylum Seeker Health Action Plan which incorporates elements of prevention and accessibility of services to this population. This Plan includes comprehensive healthcare checks, cancer screening services and a welcome pack to improve access to healthcare services.

Guidance from the Office for Health Improvement and Disparities recommends actions for frontline workers, managers and senior or strategic leaders to address inclusion health challenges and enhance well-being. Utilising evidence-based initiatives such as this is crucial for meeting the needs of inclusion health groups to ensure all Barnet residents can live and age well.

Health literacy, the ability to access, understand, and use health and social care information, impacts health behaviours such as diet, smoking, and physical activity. Local data on health literacy is limited, but national data from 2015 showed only 43% of the working population could use everyday health information, increasing to 61% when numeracy was involved. Groups at higher risk of low health literacy include older adults, people from areas of higher deprivation, ethnic minority groups, migrants, and disabled people. To address health inequalities, targeted strategies to understand and improve health literacy among vulnerable groups are necessary.

## Recommendations

### Key recommendations for Ageing Well in Barnet

1. Enhance access and provision of Health Promotion and Prevention Services
2. Develop appropriate campaigns, information and advice to promote ageing well
3. Strengthen Health Protection Programmes
4. Encourage Proactive and Integrated Health and Social Care
5. Enhance Falls Prevention and Frailty Support
6. Promote Social Inclusion and Connectivity
7. Create environments that promote ageing well
8. Promote ageing well for people who have additional needs
9. Support ongoing work to understand and address the needs of Barnet’s population to Age Well

### Recommendations

1. Approach to recommendations	Who for?
Across the recommendations below, ensure the concepts of co-production are used, with groups representative of Barnet’s diverse population and its vulnerable population groups. This will increase engagement and support equitable access to measures supporting ageing well across the life course.	All partners
2. Enhance access and provision of health promotion and prevention services	
Recommendation	Who for?
Review provision of health promotion and prevention services associated with disease clusters or conditions identified contributing to highest levels of morbidity and mortality across Barnet.	Public Health NCL ICB Health and social care
Ensure that health promotion and prevention services are accessible to and meeting the needs of older adults in Barnet including Stop Smoking, Drug and Alcohol services and physical activity opportunities. <ul style="list-style-type: none"> <li>- Access to services could be maximised through provision of well-located, and low-cost or no-cost options.</li> <li>- Support efforts to improve screening for health risk behaviours across community, health and social care setting</li> </ul>	Public Health Commissioned Services NCL ICB Health and social care VCSE partners

Provide staff training to support risk behaviour change and include ageing well targets in existing health and social care work.	Public Health NCL ICB Health and social care Wider council
<b>3. Develop appropriate campaigns, information, and advice to promote ageing well</b>	
<b>Recommendation</b>	<b>Who for?</b>
Develop sustainable public health messaging for primary prevention for residents across the life course. <ul style="list-style-type: none"> <li>- Target behaviours associated with highest morbidity and mortality burden in Barnet and NCL.</li> <li>- Improve the cultural competence of campaigns to complement Barnet's diverse ageing population.</li> </ul>	Public Health, Communications team NCL ICB VCSE partner
Improve the provision of information and advice for Barnet residents to enable proactive identification of older adults before reaching financial or housing crisis points. Support them to access the breadth of services already available in Barnet.	Wider council Health and social care VCSE partners
<b>4. Strengthen health protection programmes</b>	
<b>Recommendation</b>	<b>Who for?</b>
Support and develop ongoing vaccination promotion campaigns to increase uptake across Barnet. <ul style="list-style-type: none"> <li>- There should be focus on areas of highest deprivation, and communities where lowest uptake is seen.</li> </ul>	Public Health Healthcare VCSE
Monitor trends in cancer screening uptake following the COVID-19 pandemic. Support delivery of actions to increase uptake and reduce inequalities in uptake, including through work by the NCL Cancer Alliance	Public Health NCL ICB Healthcare
<b>5. Promote proactive and integrated health and social care</b>	
<b>Recommendation</b>	<b>Who for?</b>
Identify areas for workforce development in primary care and hospital settings which older Barnet residents access. <ul style="list-style-type: none"> <li>- This should promote ageing well through primary and secondary prevention where a population may be living with multiple long-term conditions or having increased complex or additional support needs</li> </ul>	Public Health NCL ICB Health and social care
Support early diagnosis and optimal management of conditions identified contributing to higher levels of morbidity and mortality across Barnet, such as cardiovascular disease and diabetes.	Public Health NCL ICB Healthcare
Strengthen understanding of barriers to accessing secondary prevention services such as NHS Health Checks and Community Health Screening, which promote health later in life through disease prevention and early intervention. <ul style="list-style-type: none"> <li>- Once barriers are identified, develop campaigns to increase uptake in underserved population groups.</li> </ul>	Public Health and Communications Healthcare NCL ICB
Develop a better understanding of poor diet, malnutrition, and dehydration in older adults in Barnet in community and healthcare settings.	Public Health with insights and intelligence NCL ICB Health and social care
Support the delivery of Barnet's Carers and Young Carers Strategy, with scope to support older adult carers to be identified earlier, proactive identification of the health needs of carers and opportunities for breaks from caring.	Public Health Health and social care Wider Council NCL ICB

	VCSE partners
Promote and support the development of carer awareness, disability awareness and cultural competence in health and care service delivery and planning as an ongoing endeavour	Public Health Health and social care Wider Council VCSE partners
Place greater emphasis on preventive strategies for older people at risk, or in the early stages of mental ill health. <ul style="list-style-type: none"> <li>- This includes workforce development and training for proactive and early identification of mental ill health in later life.</li> </ul>	Public Health NCL ICB Healthcare
Provide information and tailored advice and services for older adults who need to access mental health support. <ul style="list-style-type: none"> <li>- This should consider additional challenges faced in later life, using accessible language, addressing stigma and attitudinal barriers.</li> </ul>	Public Health Healthcare VCSE partners
Local government strategies for ageing well should recognise and align with, where appropriate local hospital trust and wider NHS strategies. For example, in supporting research inclusive of older adults for both medical and social care.	Public Health NCL ICB Health and social care Academics
<b>6. Enhance Falls Prevention and Frailty Support</b>	
<b>Recommendation</b>	<b>Who for?</b>
Recognise the existing work around frailty support within Barnet and expand provision across Barnet. <ul style="list-style-type: none"> <li>- Encourage use by healthcare providers, supporting multidisciplinary work.</li> </ul>	Health and social care NCL ICB
Adopt a strategic and joined up approach to falls prevention across Barnet and NCL, utilising the strong evidence based behind primary and secondary prevention.	Public Health Health and social care NCL ICB VCSE partners
<b>7. Promote Social Inclusion and Connectivity</b>	
<b>Recommendation</b>	<b>Who for?</b>
Consider the role of public and private employers as part of Age-Friendly Barnet to recognise the needs of older workers and promote flexible working.	Wider council including housing partners. VCSE partners
Map current provision of volunteering opportunities, including those which cater to Barnet's diverse population. <ul style="list-style-type: none"> <li>- This could include a review of evidence for intergenerational activities and its role in reducing social isolation, as well as utilising the skills and experience of older adults in Barnet.</li> </ul>	Social care Wider council VCSE partners
Continue to support the work of voluntary and community organisations in Barnet and encourage cross-collaboration between organisations which reach underserved population groups.	Wider council VCSE partners
Improve understanding of the distribution and trends in social isolation across Barnet's population and geography. This will support a coordinated plan to enable social connectivity in at-risk groups	Public Health with Insights and intelligence Wider council VCSE partners
Promote digital inclusion, with focus on older adults, and those at higher risk of exclusion.	Wider council Health and social care

- Include opportunities to raise awareness of and increase acceptability of the use of digital and remote health and social care provision.	
<b>8. Create environments that promote ageing well</b>	
<b>Recommendation</b>	<b>Who for?</b>
Consider the role of housing, diversification of stock and adaptation in promoting health and independence in later life. <ul style="list-style-type: none"> <li>- This should take account of health inequalities, income deprivation in the older population and additional implications of the projected increase in older adults who live alone and in rented accommodation.</li> </ul>	Wider council Social Care Public Health
Embed an age-friendly approach to Barnet's transport network, public facilities, and active transport routes.	Wider council Public health VCSE partners
Implement frameworks for inclusive planning, to consider the needs of older adults and other vulnerable population groups when identifying system partners' roles in climate change action.	Wider council VCSE partners
Ensure inclusion of accessible and age-friendly environments with regeneration and urban planning across Barnet.	Wider council VCSE partners
<b>9. Promote ageing well for people who have additional needs</b>	
Continue delivery of Barnet's Dementia Strategy to promote ageing well at all stages of life. Include a focus on dementia prevention strategies for where there is an evidence base. For example, smoking cessation, physical activity, addressing hearing impairment and weight management.	Public Health Health and social care NCL ICB VCSE
Consider the implementation of holistic outreach clinics for particularly vulnerable population groups identified in this health needs assessment. <ul style="list-style-type: none"> <li>- Explore approaches to implement joined-up care pathways</li> <li>- Improve uptake where annual health checks are delivered for those at highest risk of poorer health outcomes, an embed opportunities for health promotion and prevention in these</li> <li>- Further work is recommended to explore the needs other inclusion health groups in Barnet</li> </ul>	Public Health Health and social care NCL ICB VCSE
Engage with residents with specific additional needs and their carers to understand their care or supported housing needs and preferences. <ul style="list-style-type: none"> <li>- Areas of focus include location, amenity, acceptability, and affordability</li> </ul>	Housing Social Care VCSE
Understand health literacy levels of adults in Barnet, to ensure health and wellbeing information is accessible across the life course and delivered in culturally competent ways, through the most effective channels. This includes population groups with additional support needs.	Public health with Insights and Intelligence team Health and social care NCL ICB VCSE
Ensure strategies for ageing well around healthcare, social care and the wider determinants of health are inclusive of population groups with additional support needs identified in this needs assessment	All partners
<b>10. Support ongoing work to understand and address the needs of Barnet's population to Age Well</b>	
<b>Recommendation</b>	<b>Who for?</b>

Consider ongoing areas of work to develop Ageing Well in Barnet further, including the needs of other vulnerable population groups not explored in this Health Needs Assessment, and anticipatory care for End-of-Life Care.	Public Health NCL ICB Health and social care
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# LONDON BOROUGH OF BARNET AGEING WELL HEALTH NEEDS ASSESSMENT

2023/24

LONDON BOROUGH OF BARNET PUBLIC HEALTH TEAM

Caring for **people**, our **places** and the **planet**

[www.barnet.gov.uk](http://www.barnet.gov.uk)

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# 1 Executive Summary

**PLACEHOLDER – See accompanying document**

## Recommendations

**PLACEHOLDER - See accompanying document**

## 2 Introduction

Globally people are living longer lives, and this trend is expected to continue in the future. However, it is recognised that whilst people are living longer, healthy life expectancy is not increasing at the same rate<sup>1</sup>. In Barnet, older adults (aged 65+) make up 14% of the population, with Barnet having the 6<sup>th</sup> highest proportion of older adults in London<sup>2</sup>. The proportion of older adults is expected to increase in the future, reflecting the need for an Ageing Well health needs assessment (HNA).

### Definitions

#### Defining Ageing Well

The World Health Organisation (WHO) define healthy ageing as the ‘process of developing and maintaining the functional ability that enables wellbeing in older age’<sup>3</sup>. The WHO define functional ability as the capabilities enabling all people to be and do what they have reason to value: to meet their basic needs; learn, grow, and make decisions; be mobile; build and maintain relationships and contribute to society. This definition will form the foundation of the direction of this needs assessment.

#### Ages in scope for this needs assessment

There is no formal or commonly accepted definition of ‘older age’. The Office for National Statistics (ONS) define older adults as those aged 65 and over, whilst some national data sets look at the health of older adults from 60 and above. It is well-recognised that the conditions which influence one’s health and wellbeing happen before this age, with the cumulative impacts of individual, family, environmental and social factors across the life course affecting one’s ability to age healthily. It could be argued that ageing is a process which starts from conception, however from a pragmatic point of view it would lead to the focus of the HNA being too wide.

For this needs assessment, data sets looking at the demography of the older population will focus on those aged 65+. When considering behaviours across the life-course, smoking prevalence will be considered for all adults aged 18+ due to the significant impact this is shown to have in health outcomes, alcohol will be considered for those aged 40+, physical activity and weight for all adults aged 18+ due to availability of data.

In the report, Health protection will focus on vaccination programmes offered in the older adult population specifically, and the ages at which cancer screening programmes are offered nationally. Healthcare services will focus on ages from which services are offered (for example, NHS health checks from aged 40+) and the ages at which Quality Outcomes Framework data (QOF) is available

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<sup>1</sup> Raleigh, V. (2022) What is happening to life expectancy in England, *The King’s Fund*. Available at: <https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england> (Accessed 13th October 2023)

<sup>2</sup> Office for health Improvement and disparities (2021) Local Authority Health Profiles. *Fingertips*. Available at: [Local Authority Health Profiles - Data - OHID \(phe.org.uk\)](https://www.localauthorityhealthprofiles.org.uk/) (Accessed 18<sup>th</sup> October 2023)

<sup>3</sup> Rudnicka, E. et al. (2020) ‘The World Health Organization (WHO) approach to healthy ageing’, *Maturitas*, 139(139), pp. 6–11. Available at: <https://www.sciencedirect.com/science/article/pii/S0378512220302826>.

from primary care (aged 50+). For consistency this same cut off will be used when looking at secondary care.

When considering the wider determinants of ageing well, this HNA will focus on older adults (65+) where there is national collection of data, and 45+ from where there was survey data collected from Age UK Barnet.

## Aims, Objectives and Scope

The aim of this health needs assessment (HNA) is to examine and describe ageing well in Barnet and the needs of Barnet's older population.

The objectives are to:

- Describe Barnet's population and demographic breakdown by geography.
- Describe the health outcomes of adults in Barnet and how they relate to different demographics and present the health inequalities experienced in Barnet.
- Gather and present information from a range of stakeholders on ageing well in Barnet, with services on offer currently, outcomes and where there may be unmet need.
- Recognise that ageing is not a homogenous process and consider the specific needs for groups of older adults with additional support needs.
- Describe the unmet need and make pragmatic recommendations to enable Barnet's population to age well, considering the sphere of influence of the local authority.

The scope of this HNA includes the national and local strategic context for ageing well and the demographic profile for Barnet. It considers ageing well through the aspects of:

- Health promotion and protection for adults
- Health and social care needs of older adults
- Wider determinants of health
- Specific population groups with additional support needs.

The wide range of topics that affect ageing well are acknowledged and when not covered in detail, they are highlighted as areas that could be considered for future work. At the time of assessment, we did not assess end-of-life care in detail. This is an area with a lot of cross-sector working and broad scope (including advanced care planning, discussion of ceilings of clinical care and palliative care). It is suggested that further needs assessments should be undertaken for this aspect of later life.

Due to the rapid nature of this needs assessment between August to December 2023, this document should be considered as a first step to understand the needs for ageing well in Barnet.

## 3 Methodology

This HNA used a mixed methods systematic approach to understand the population, health outcomes, and current use of services.

The epidemiological approach is used to set the local and national context of Ageing Well. Academic and Grey Literature was reviewed to give a wider understanding of Ageing Well. Epidemiological data has been gathered from a variety of sources both locally (e.g., Barnet Insights and Intelligence, local Service Data) and nationally (e.g., Census 2021, Office for National Statistics). Comparative data was gathered primarily through Fingertips. An informal literature search using a PICO framework

was carried out to identify relevant peer-reviewed papers in relation to ageing well across Medline via PUBMED. Grey literature was reviewed to include reports produced by the Government, Health and Social Care and voluntary sector organisations.

Qualitative methods were used to engage with stakeholders across Barnet within the public health team, wider council, and external partners to understand the current picture in Barnet and the needs of the older population.

## 4 Ageing Well Strategic Context

### 4.1 National Context

#### **The Chief Medical Officer's (CMO) Annual Report, Health in an Ageing Society (2023)<sup>4</sup>**

The CMO for England produced a report on Health in an Ageing Society, reflecting the need for policy and practice to focus efforts on improving the process for ageing well nationally. The report recognises inequalities seen across society which persist across the life course; whereby some people experience excellent health into later years, and others can spend many years living in poor health. The focus of the report is around improving quality of life in later years and adapting the environment across the themes of urban planning, housing, social care, and aids. It also highlights the concentration of older people in coastal and semi-rural areas, and where infrastructure to support this demographic shift needs to be improved.

#### **Healthy Ageing Consensus Statement, Office for Health Improvement and Disparities (OHID)**

The Healthy Ageing Consensus Statement<sup>5</sup>, from OHID and Centre for Ageing Better recognises that whilst we are living longer, too many people are spending a significant proportion of their later life in poor health. 5 principles are outlined in their statement, detailed below:

1. Putting prevention first and ensuring timely access to services and support when needed
2. Removing barriers and creating more opportunities for older adults to contribute to society.
3. Ensuring good homes and communities to help people remain healthy, active, and independent in later life.
4. Narrowing inequalities.
5. Challenging ageist and negative language, culture, and practices wherever they occur, in both policy and practice.

#### **Healthy Ageing Position Statement, Association for Directors of Public Health (ADPH)**

The position statement on Healthy Ageing<sup>6</sup> echoes the OHID principles above. It suggests a renewed focus on prevention across the life course to support people to age healthily and a whole system approach.

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<sup>4</sup> Whitty, C. (2023). *Health in an Ageing Society*. (Online) Department of Health and Social Care. Available at: <https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society> (Accessed 15th November 2023)

<sup>5</sup> OHID (2023). A consensus on healthy ageing. (Online) GOV.UK. Available at: [A consensus on healthy ageing - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/a-consensus-on-healthy-ageing) (Accessed 15th November 2023)

<sup>6</sup> ADPH (2018). The Association of Directors of Public Health Policy Position: Healthy Ageing Key messages. (Online) Available at: [ADPH-Position-Statement-Healthy-Ageing.pdf](https://www.adph.org.uk/wp-content/uploads/2018/07/ADPH-Position-Statement-Healthy-Ageing.pdf) (Accessed 15th November 2023)

### **Long Term Plan, National Health Service (NHS)**

The current national policies of the NHS including the Long-Term Plan<sup>7</sup> acknowledges the importance of anticipatory care planning and ‘upstreaming’ prevention to improve health and wellbeing. Specific areas of focus include promoting a multidisciplinary team approach, offering more support for informal carers, developing more rapid community response teams and more NHS support in care homes. This is intended to encourage cross-sector working to move towards preventative and anticipatory care models, and shift support from hospital-based services to more care and support being offered closer to or in people’s homes.

### **Health in 2040, The Health Foundation**

The Health Foundation predict that by 2040, 9.1 million people in England will be living with a major illness, which equates to 1 in 5 of the adult population<sup>8</sup>. Major illness is defined in this report as having a single condition, or combination of conditions that results in a Cambridge Morbidity Score of greater than 1.5. Conditions which are typically diagnosed and managed in the community are projected to increase at the fastest rates (for example anxiety, chronic pain, and diabetes). It is noted that although prevention will delay the onset of medical conditions and provide benefits to individuals and communities, the effect of living longer may not necessarily reduce pressure on the health and social care system. Therefore, it is important to also consider strategies to allow people to live well with illness.

### **Major Conditions Strategic Framework (MCSF), Department of health and Social Care**

The Department of health and Social Care also released its MCSF<sup>9</sup> in 2023, with an approach to health and care delivery to better meet the needs of a population that is getting older and living with multimorbidity. Six conditions were focussed on, which account for over 60% of ill-health in England, these include: cancers, cardiovascular disease (CVD) (including stroke and diabetes), musculoskeletal disorders (MSK), mental ill health, dementia, and chronic respiratory disease (CRD). In line with this framework, this HNA will focus on these conditions, with attention to primary prevention (to reduce the risk of disease), secondary prevention (halting progression of conditions or risk factors), early diagnosis, and prompt and long-term care. Figure 1 provides definitions across these actions and examples of different types of preventative health care intervention.

Focussing on the older population and the predicted demographic shift in future, it is known that the likelihood of having a long term condition rises significantly for older age groups (Figure 2), with 80% of people ages 85 and over having at least one long-term condition.

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<sup>7</sup> NHS England (2019). NHS Long Term Plan. Available at: [NHS Long Term Plan » Areas of work](#) (Accessed 10<sup>th</sup> October 2023)

<sup>8</sup>The Health Foundation (2023). Health in 2040: projected patterns of illness in England. Available at: [Health in 2040: projected patterns of illness in England - The Health Foundation](#) (Accessed 10<sup>th</sup> October 2023)

<sup>9</sup> Department of Health and Social Care (2023). Major Conditions Strategy: Case for Change and Our Strategic Framework. Available at [Major conditions strategy: case for change and our strategic framework - GOV.UK \(www.gov.uk\)](#) (Accessed 10<sup>th</sup> October 2023)

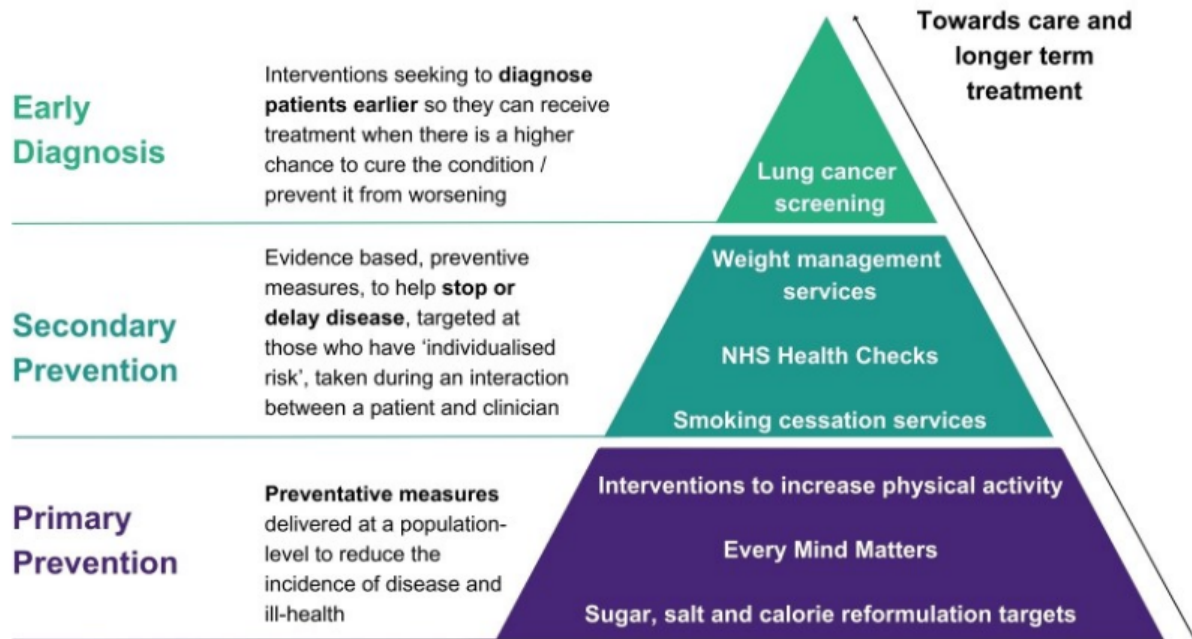


Figure 1 Definitions and examples of different types of preventative healthcare interventions, Major conditions strategic framework, Department of Health and Social Care (2023)

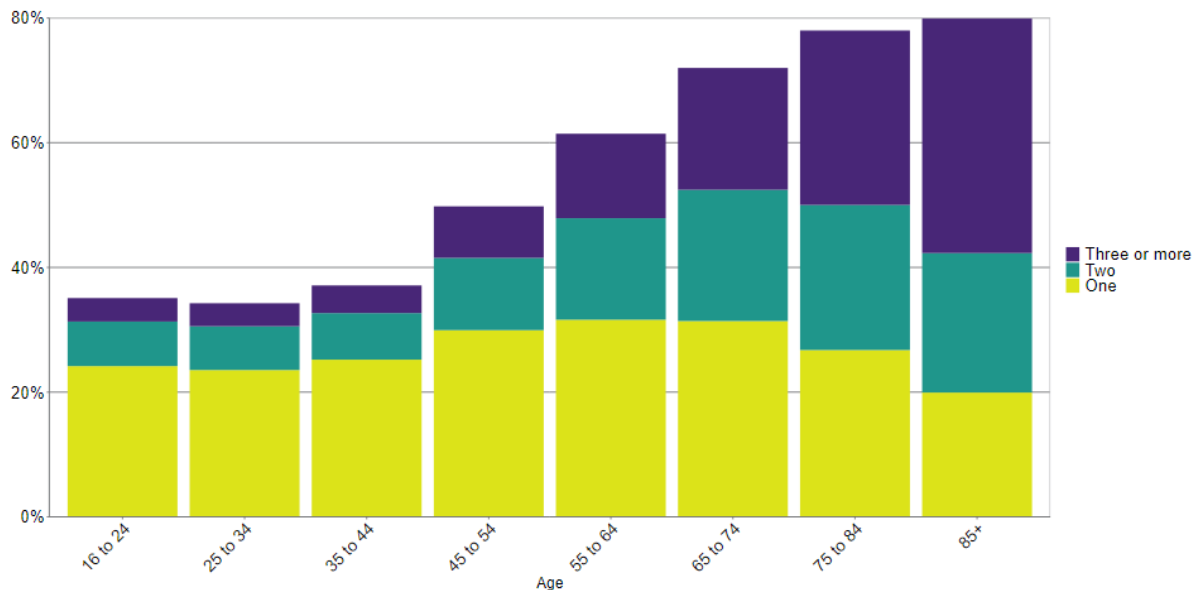


Figure 2 Proportion of age cohorts living with long term conditions in the UK, Major Conditions Strategic Framework, Department of Health and Social Care (2023) - data source GP Patient Survey, 2022

### Core20PLUS5 approach

The CORE20PLUS5 national approach<sup>10</sup> has been created to help reduce inequalities at both national and local levels. The clinical areas that are highlighted in the Core20PLUS5 approach cover aspects of ageing well, including early cancer diagnosis and hypertension case-finding and optimal management. The most deprived 20% of the national population are also identified in this approach, according to the national Index of Multiple Deprivation (IMD). There are 12,000 Barnet residents

<sup>10</sup> Core25PLUS5, NHSE (n.d.). Available at: [NHS England » Core20PLUS5 \(adults\) – an approach to reducing healthcare inequalities](#) (Accessed 10<sup>th</sup> October 2023).

living in the 20% most deprived areas in England<sup>11</sup>. The 'PLUS' populations refer to population groups identified at a local level, these could include ethnic minority communities, people with learning disabilities, long term health conditions or inclusion health groups. This HNA will focus on health inequalities seen in Barnet, with focus on PLUS populations, and recommendations to reduce these health inequalities.

### **World Health Organization (WHO)**

Internationally, the WHO have set out an initiative for 'Age-Friendly Cities'<sup>12</sup>, which cover 8 key domains across health services, wider determinants of health and communication and information. This is also aligned with the United Nations Decade of Healthy Ageing<sup>13</sup> (2021-2030).

## 4.2 Local Context

### **North Central London Integrated Care Board (NCL ICB) Population Health Outcomes Framework (PHOF) and Integrated Care Strategy<sup>14</sup>**

The NCL PHOF has specific indicators to monitor population health across three key areas of start well, grow well and age well. Within ageing well, the identified priorities are to enable people to live as healthy, independent, and fulfilling lives as possible and that people remain connected and thriving in their communities as they age. These indicators were chosen to understand opportunities for improvement and reducing variation in outcomes across NCL.

### **London Borough Barnet (LBB) Dementia HNA 2023 and Strategy<sup>15</sup>**

The Dementia HNA in Barnet identified that 4,387 people aged 65+ were living with diagnosed dementia in 2020, and this is projected to increase by 66% in 2040. It identified the falling estimated diagnosed dementia rate for people aged 65+ since 2017 to 65.7% in 2022, this means out of those predicted to have dementia in the population aged 65+, only 65.7% of these people have a formal diagnosis. The needs across Barnet were identified across the five key elements of preventing well, diagnosing well, supporting well, living well, and dying well.

The Dementia Strategy underpins borough-wide commitments to provide high-quality care and support for people with dementia and their carers. The strategy was co-produced and developed in partnership with people living with dementia and their carers, Adult Social Care, North Central London ICB, Barnet Enfield and Haringey mental Health trusts, commissioned and non-commissioned organisation and voluntary and community sector partners. There is focus on strengthening the current dementia pathway and services and also embedding more proactive dementia support, preventing avoidable crises, and promoting and maximising people's independence, health, and well-being.

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<sup>11</sup> Barnet Council (2023), Barnet Joint Strategic Needs Assessment – People. Available at: [Joint Strategic Needs Assessment | Barnet Open Data](#). (Accessed 10<sup>th</sup> October 2023).

<sup>12</sup> World Health Organisation (2007). Global age-friendly cities: a guide. Available at: <https://iris.who.int/handle/10665/43755>. (Accessed 13<sup>th</sup> October 2023). See also: [The WHO Age-friendly Cities Framework - Age-Friendly World](#)

<sup>13</sup> UN Decade of Healthy Ageing (n.d.). Available at: <https://www.decadeofhealthyageing.org/>. (Accessed 13<sup>th</sup> October 2023).

<sup>14</sup> NCL ICS (2022) Population Health Outcome indicators: North Central London

<sup>15</sup> LBB (2023) Dementia Needs Assessment. Available at: [Dementia Needs Assessment 2023 | Barnet Council](#). Dementia Strategy. Available at: [Dementia Strategy 2023-2028 | Barnet Council](#). (Accessed 10<sup>th</sup> October 2023)



### Barnet Borough Partnership (BBP) Ageing Well Workstream

The BBP ageing well workstream aims to provide anticipatory care for residents 65yrs+ living in Barnet at risk of becoming frail, losing their independence, living with dementia, or requiring support to remain well in their own home. The program strategically aligns with the Age Well NCL ICB Population health outcomes Strategy to:

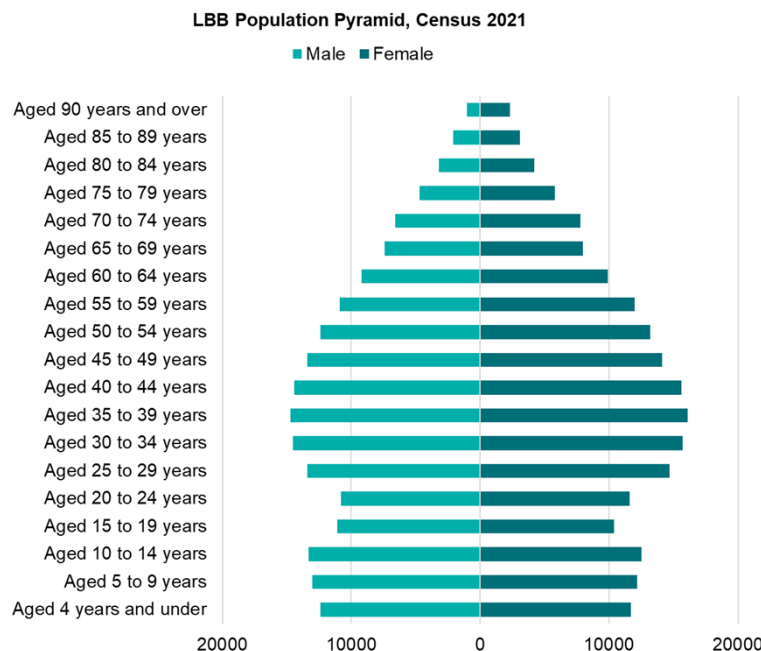
- Support timely, proactive, and integrated care.
- Support active ageing.
- Reduce social isolation, and support people to remain connected.
- Support early prevention, detection and management of long-term conditions.
- Support carers.

### Age-Friendly Barnet, led by Age UK Barnet

Barnet has committed to becoming an Age-Friendly Community, in line with the WHO framework<sup>11</sup>. This works towards ensuring Barnet is a place that enables people to age well and live a good later life. This work is being led by Age UK Barnet, with input from older adults in Barnet, various teams within the council, colleagues in health and social care and third sector organisations. Steps have been taken in the initial parts of the Age-Friendly cycle: Engage and Understand. This includes creating a baseline profile for Barnet using population data, focus groups and survey data. Evidence gathered from older adults in Barnet from this work has been used to inform parts of this HNA, particularly from the perspective of the wider determinants of health. This HNA will also feed into strategic planning for Age-Friendly Barnet.

## 5 Demographic Profile of London Borough of Barnet

### 5.1 Population and Projections



Census 2021 data © Crown copyright 2023



Figure 3 Barnet Population Pyramid based on the Census 2021<sup>16</sup>



The total population of Barnet was estimated at 389, 300 in 2021, which is an increase by 9.2% compared to 2011. Older adults (aged 65 years and older) make up 14.4% (56,100 people) of the Barnet population, which is an 18% increase since 2011 (56,100 older adults in 2021 vs. 47,432 in 2011). Notably the numbers of people aged 70-74 years increased by 40%. The population aged 65+ in Barnet is relatively lower than parts of England, but higher than the average across London (11.6% in London and 18.1% in England). Barnet has the 6<sup>th</sup> highest population aged 65+ across London boroughs<sup>16,17</sup>.

Although on average Barnet has a lower proportion of the population aged 65+ compared to England, areas of Barnet have higher proportions. This is demonstrated in the heatmap on Figure 4. Wards with highest percentage of population aged 65+ include Garden Suburb (21%), High barnet (20.3%) and Finchley Church End (18.2%)<sup>17</sup>, as demonstrated in *Figure 4*.

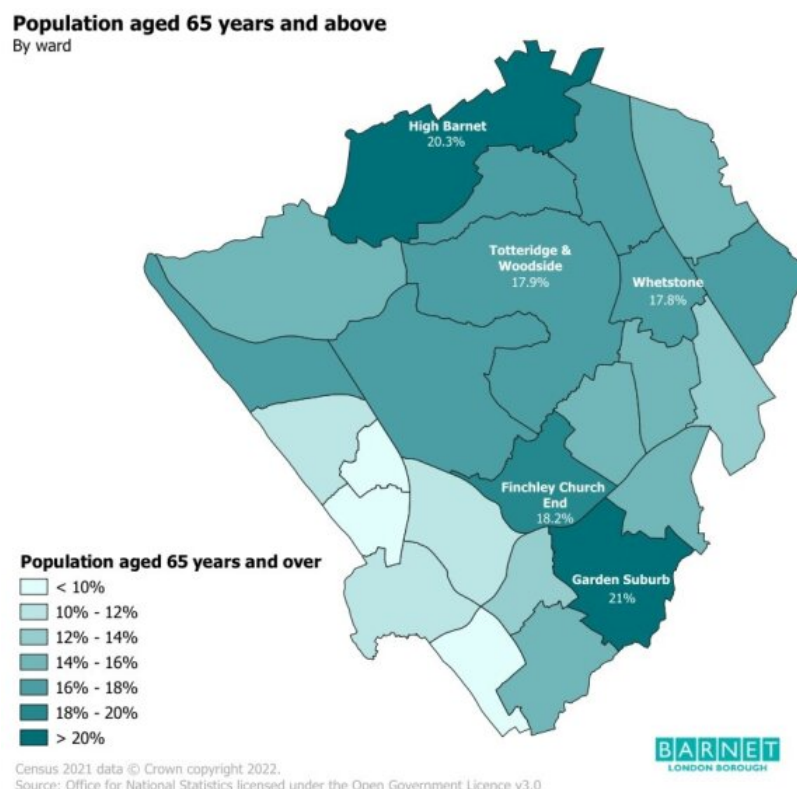


Figure 4: Heat map: % residents aged 65+ by ward in Barnet. Darker shades indicate a higher %. (I&I, LBB, ONS, Census 2021)

## Population Projections

The overall population in Barnet is expected to increase to 447,109 people in 2043<sup>18</sup>. This can be explained by a variety of factors including natural change (the difference between births and deaths) and net migration (the difference in the number of people moving in and out of an area). Over 1 in 5 adults are expected to be 65+ by 2043. The population pyramid also shows a significant change in morphology based on these projections for 2043 (Figure 5), with a lower proportion of people

<sup>16, 17</sup> Office for National Statistics. Population and household estimates, England and Wales: Census 2021 - Office for National Statistics. [Population and household estimates, England and Wales: Census 2021 - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk) (Accessed 28<sup>th</sup> August 2023).

<sup>17</sup> Office for National Statistics (ONS, 2020). Population aged 65+ (%): Small area population estimates, 2020. Available from: <https://www.localhealth.org.uk/#c=indicator&view=map12>. (Accessed 10<sup>th</sup> October 2023)

<sup>18</sup> ONS (2020): Subnational population projections for England: 2018-based. Available from: [Subnational population projections for England - Office for National Statistics](https://www.ons.gov.uk) (Accessed: 18<sup>th</sup> October 2023).

making up the younger populations and increases in the proportions of people aged 55+ in Barnet when compared to 2018. A similar pattern is seen across London, but less pronounced than in Barnet. It is important to note that these projections are limited by the source data and population change over time will be influenced by a variety of factors such as economic development. However, these projections provide some context into the future needs of the population in Barnet when co-ordinating a population-based approach.

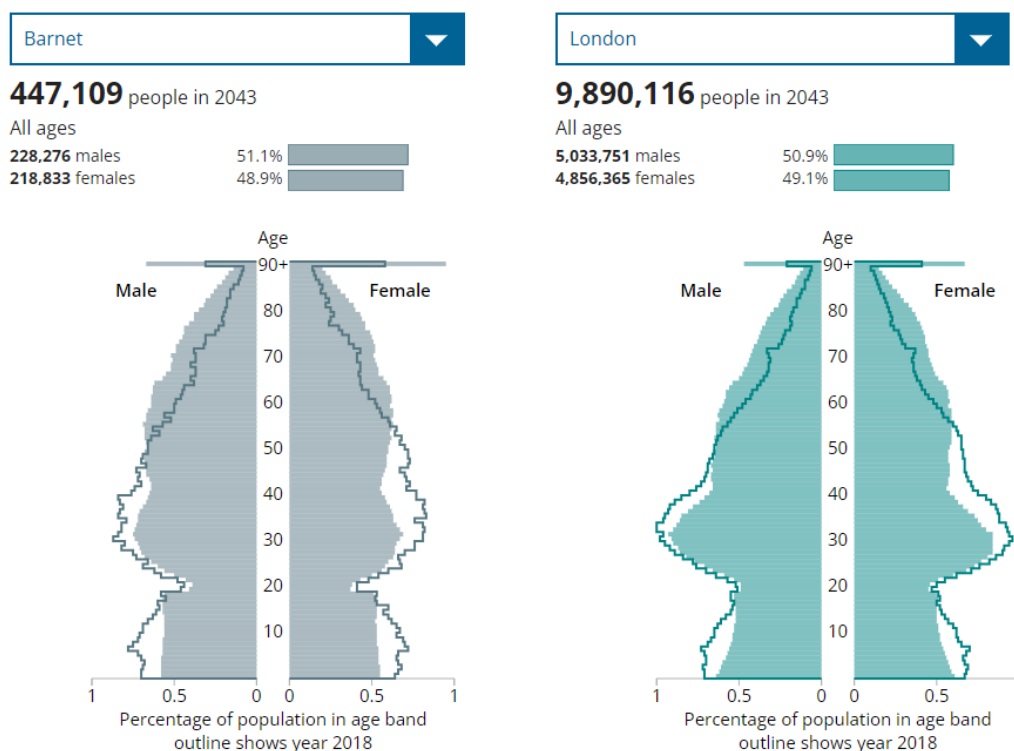


Figure 5 Population Pyramid based on 2018 projections for the year 2043 for Barnet (left) and London (right). 2018 estimates are demonstrated by the outlined population pyramid and 2043 estimates by the shaded region, ONS

## 5.2 Life expectancy

### Life Expectancy

Data from 2021, OHID<sup>19</sup> shows that in Barnet life expectancy at birth in females (85.5) is higher than males (80.4) and this is higher than the averages for England (female 83.1, male 79.4). Life expectancy has been steadily increasing from 2001, however a drop in life expectancy was noted in Barnet, regional and national values following the COVID-19 pandemic for the period 2018-2020. There are inequalities in the borough in relation to life expectancy, the highest life expectancy was in Garden Suburb (86 years for male, for 90.5 females) and the lowest in Burnt Oak (78.6 for males, 81.7 for females). The differences in life expectancy in the borough follows a socio-economic gradient, with shorter life expectancies seen in more deprived areas for both men and women. Disability free life expectancy (DFLE)<sup>20</sup> measures the number of years one can expect to live without illness or a health problem which limits their daily activities. It is measured at birth and from age 65. In Barnet this was measured to be 64.5 years for males and 64.4 years for women at birth.

<sup>19</sup> OHID (2021). Local Authority Health Profiles. Available from: <https://fingertips.phe.org.uk/health-profiles#gid/1938132696/ati/6> (Accessed 10th October 2023)

<sup>20</sup> OHID (2018-2020). Productive Healthy Ageing Profile. Available from: <https://fingertips.phe.org.uk/healthy-ageing#gid/1938133280/ati/6> (Accessed 10th October 2023)

Compared to London and England, the value for males is similar. For females the DFLE at birth was significantly higher than the England average, but similar to the London average. At the age of 65, the DFLE was 10.0 years for males and 9.1 years for females in 2018-2020. This is a similar value to the rest of England and London.

Healthy life expectancy is another important factor to consider in ageing well. It gives an estimate of the amount of life spent in good or very good health and is measured from mortality rates and self-reported measures. Females and males in the London Borough of Barnet can expect to spend at least a fifth of their life in poor health (21.2% for females and greater proportion for men at 23.3%)<sup>20</sup>.

Table 1 summarises data for life expectancy at birth and 65, healthy life expectancy and inequality in life expectancy between the highest and lowest socio-economic groups in Barnet, London, and England.

		Barnet	London	England
Life expectancy at birth (2021)	Male	80.4	78.8	78.7
	Female	85.5	83.4	82.8
Life expectancy at 65 (2021)	Male	19.2	18.2	18.4
	Female	22.5	21.2	21.0
Healthy life expectancy at birth (2018-2020)	Male	62.86	-	-
	Female	67.12	-	-
Healthy life expectancy at 65 (2018-2020)	Male	10.2	10.3	10.5
	Female	11.2	11.2	11.3
Inequality in life expectancy at 65 (2018-2020)	Male	4.8	4.8	5.2
	Female	4.4	3.6	4.8

*Table 1 Life expectancy measure for males and females across Barnet, London and England for 2018-2020*

## 5.3 Deprivation

The Index of Multiple Deprivation (IMD) is a measure of deprivation used on small geographical areas. The heat map (Figure 9) shows differences in deprivation across the borough.

Overall, the London Borough of Barnet has an IMD score of 16.1. This is lower than the London region IMD score of 21.8 and the national average of 12.9. On average, this indicates that Barnet has less deprivation than regional or national averages. However, as with many boroughs, there are areas of Barnet which are more deprived, some of which make up the most 20% deprived areas of England, including Colindale North, Cricklewood, Burnt Oak, West Hendon and Underhill<sup>21</sup>. Note this data was collected in 2019, prior to new ward boundaries defined in 2022.

This doesn't necessarily correlate to data on income deprivation affecting older people (IDAOP) from 2019. This is a measure of the proportion of all those aged 60 and over experiencing deprivation relating to low income (based on people who are not in work, or who are in work but have low incomes). The highest IDAOP scores were seen in Burnt Oak, Colindale (pre-2022 ward boundaries), West Hendon and East Finchley, further information and full breakdown is available from: [Public health profiles - OHID \(phe.org.uk\)](https://publichealthprofiles.org.uk/).

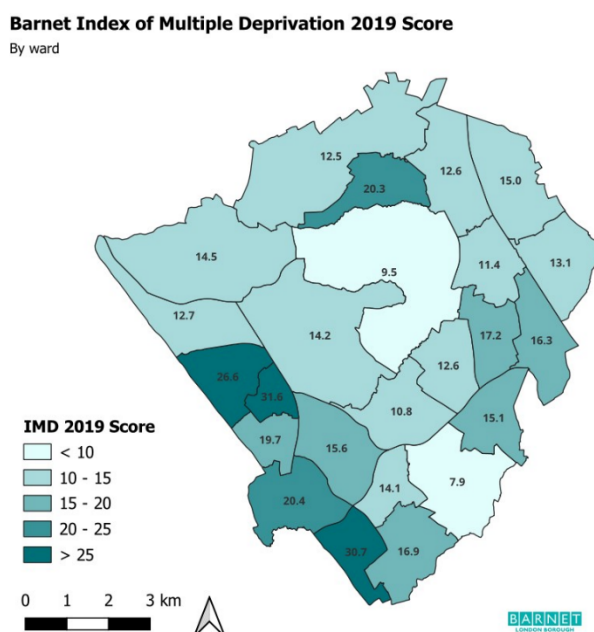


Figure 6 IMD 2019 score by ward represented on heatmap. Darker shades represent higher levels of deprivation. (I&I, LBB)

## 5.4 Ethnic groups and Language

The ethnic profile of Barnet shows there is diverse population. Based on 2021 census data 57.7% (224,766) were white compared to 53.8% across London and 81% across England<sup>22</sup>. The largest ethnic minority group in Barnet was Asian, Asian British or Asian Welsh population at 19.3% (74,970), followed by other ethnic groups at 9.8% (38,075) and Black, Black British, Black Welsh or African background at 5.8% (22,405). For those aged 65 and over, the White (English, Welsh Scottish or Northern Irish) ethnic group makes up the largest proportion (53.4%), followed by Asian, Asian British or Asian Welsh at 17.9%<sup>23</sup>, this is shown in Figure 7.

Although across Barnet the most common ethnicity was White (English, Welsh, Scottish, Northern Irish or British), there are variations between wards seen in the Census 2021 data. Looking

<sup>21</sup> OHID (2022) Indicators: maps, data and charts for IMD/IDAOP, *Local Health*. Available from: [Local Health - Office for Health Improvement and Disparities - Indicators: maps, data and charts](https://publichealthprofiles.org.uk/) Accessed: 13<sup>th</sup> October 2023

<sup>22</sup> Office for National Statistics – Census 2021, Barnet, London and England census population and households (2021). Available from: [Census - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/). (Date of Data Access; 31st July 2021).

<sup>23</sup> Office for National Statistics – Census 2021, Barnet, data by ward (2021). Available from: [Census - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/). (Date of Data Access; 31st July 2021).

specifically at the population aged 65+, certain wards have a different majority ethnic group which does not reflect the overall picture in Barnet. For example, in Colindale South and West Hendon Asian, Asian British or Asian Welsh Ethnic Groups make up 39.8% and 35.9% of the ward population respectively. This is especially important to consider when delivering services and additional risk factors associated with ethnicity in ageing and long-term conditions. Furthermore, the younger population is more diverse in Barnet, so considerations must be made for the future needs of this population as they age. Further information on ethnicity breakdown by ward and age group is available on the ward profile tool at: [Barnet Ward Profile | Barnet Open Data](#).

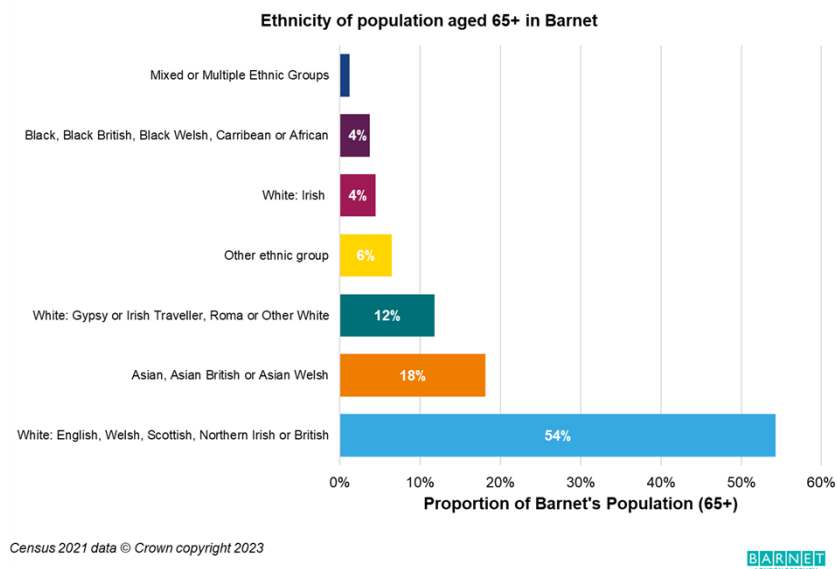


Figure 7 bar chart showing ethnicity of population aged 65+ in Barnet.

Based on 2021 Census data, there are at least 88 languages spoken across Barnet including English. English is the most common main language and is the main language for 77.1% (289,057) for residents aged 3 and over. 22.9% (86,045) did not speak English as their main language. 3.6% reported not speaking English well and 0.5% reported not being able to speak English<sup>24</sup>. In older adults (aged 65+), 82.7% reported English as their main language, 11.44% reported that their main language was not English but spoke it well, and 5.84% reported not being able to speak English or not being able to speak English well (Figure 8)<sup>27</sup>.

<sup>24</sup> Office for National Statistics (2021) – Census 2021, Language Barnet, London and England. Available from: [Language, England and Wales - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/language-england-and-wales). (Date of Data Access; 31st July 2021).

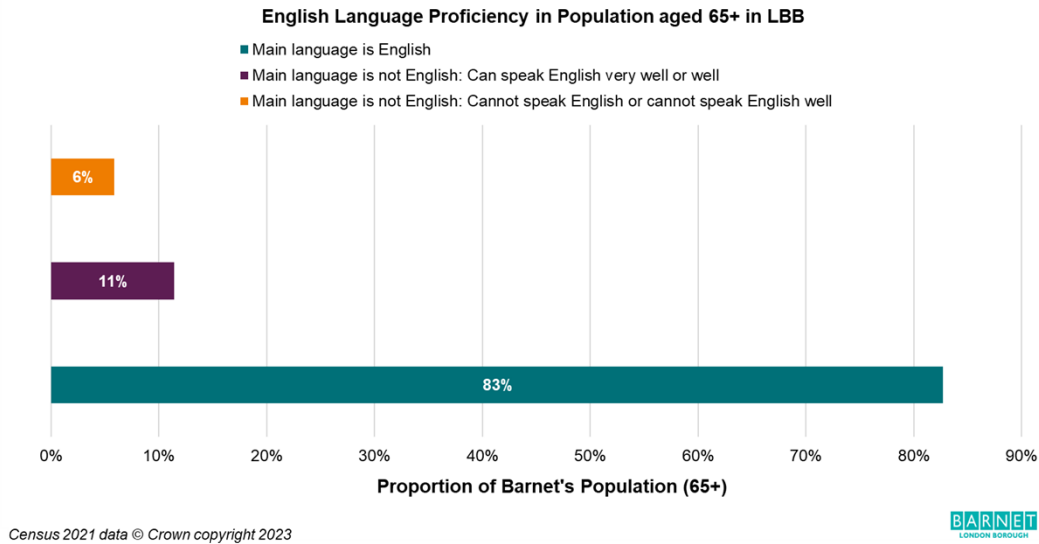


Figure 8 English language proficiency in people aged 65+ in Barnet (Census 2021)

## 5.5 Religion

Religion was included as a voluntary question in Census 2021, the response rate in Barnet was 91.6%. Compared to the 2011 Census there was an increase those describing themselves as having ‘No Religion’ to 20.2% (increase of 4.1% from Census 2011). Those that describe themselves as ‘Jewish’ made up 14.5% of the population in Barnet, this is 12.9% more than the London average of 1.7%. In London, 38.9% (56,616/145,467) of those that described themselves as ‘Jewish’ resided in Barnet and Nationally, 21.7% (56,616 /261,282) of those that described themselves as ‘Jewish’ resided in Barnet<sup>25</sup>. For those aged 65+ in Barnet, the most common religion reported was ‘Christian’ (42.4%), followed by Jewish (21.0%), then ‘No Religion’ (13.6%), the distribution is summarised in Figure 9<sup>26</sup>.

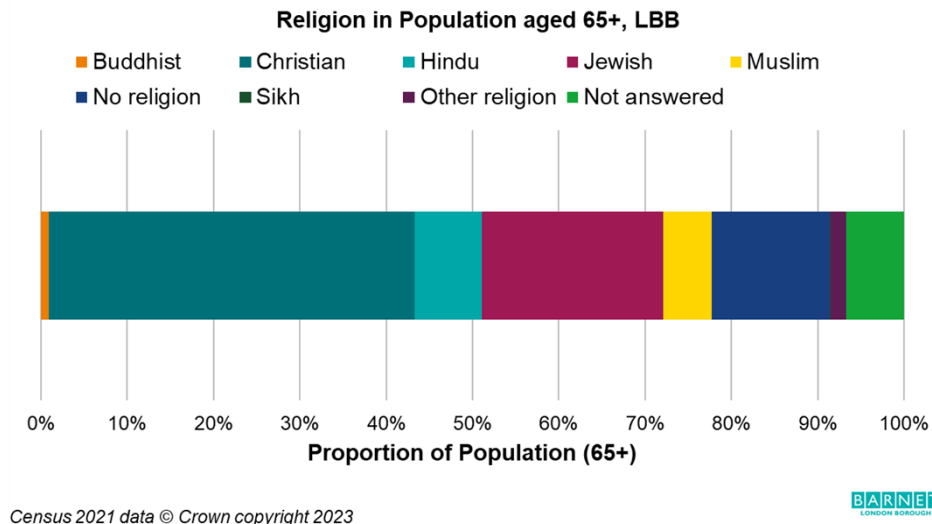


Figure 9 Stacked bar chart to show % of religion recorded by people aged 65+ in Barnet, Census 2021

<sup>25</sup> Insight and Intelligence Hub, LBB (2021) – Ethnicity, Religion and Language Briefing. Available from: [CENSUS 2021 - Ethnicity, Religion & Languages Briefing \(sharepoint.com\)](https://www.sharepoint.com/Census2021-Ethnicity-Religion-Languages-Briefing) (Date of Access: 17<sup>th</sup> October 2023).

<sup>26</sup> Office for National Statistics (2023) – Census 2021, Religion by Age. Available from: [Religion by age and sex, England and Wales - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/religion-by-age-and-sex-england-and-wales). (Date of Data Access; 31st August 2021).

## 5.6 Mortality

### Mortality from Circulatory Disease, Respiratory Disease or Cancer

In Barnet, the percentage of deaths across all ages had circulatory disease as the most common underlying cause (25.5%), followed by cancer (22%) and then respiratory disease (9.2%) between 2016-2020. This is a different picture when compared to England and London region averages – where the most common underlying cause was cancer (24.3% and 22.8% respectively)<sup>27</sup>.

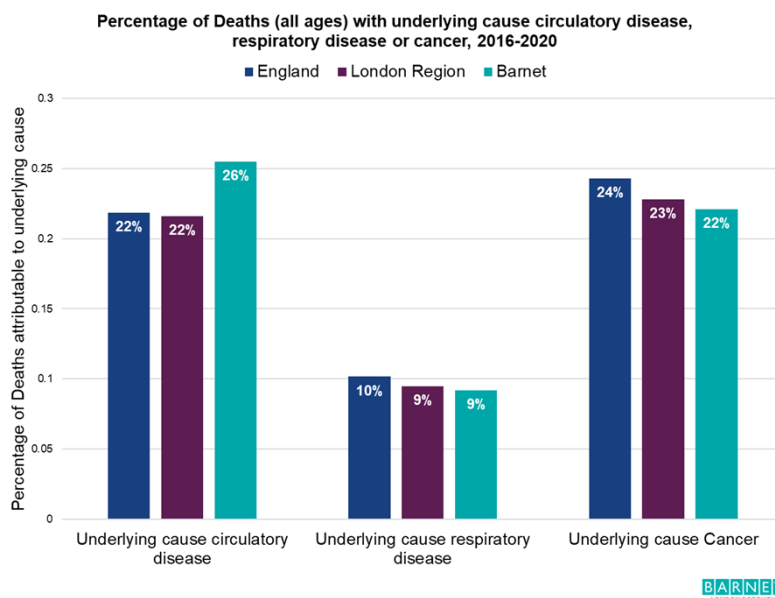


Figure 10 Distribution of cause of mortality for circulatory disease, respiratory disease or cancer in Barnet, London and England

### Avoidable Mortality

Avoidable mortality has been defined in 2020 by the Organisation for Economic Co-operation and Development (OECD)<sup>28</sup>. It can be split as preventable mortality, treatable mortality, or a combination of the two. See Box 1 for definitions. Definitions use the age cut-off of 75 because deaths at older ages are difficult to attribute to a single underlying cause and more likely from coexisting medical conditions and other factors. Note the definition of avoidable mortality does not include mortality from COVID-19. Evidence of avoidable mortality highlight opportunities for improved prevention and management of conditions.

**Avoidable mortality:** causes of deaths that are considered amenable to both medical intervention and health policy.

**Preventable mortality:** deaths in people aged under 75 years that can be mainly avoided through effective public health and primary prevention interventions (that is, before the onset of diseases or injuries, to reduce incidence).

**Treatable mortality** (previously known as amenable mortality): deaths in people aged under 75 years that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment (that is, after the onset of disease, to reduce case fatality).

Box 1: Definitions of avoidable, preventable, and treatable mortality.

<sup>27</sup> OHID (2016-2020). Local health. Public health data for small geographical areas. Available from: <https://fingertips.phe.org.uk/local-health#gid/1938133185/ati/3>. (Accessed 6<sup>th</sup> September 2023).

<sup>28</sup> OECD (2022). Avoidable mortality: OECD/Eurostat lists of preventable and treatable causes of death. Available from: [Avoidable-mortality-2019-Joint-OECD-Eurostat-List-preventable-treatable-causes-of-death.pdf](#). (Accessed 10<sup>th</sup> October 2023)

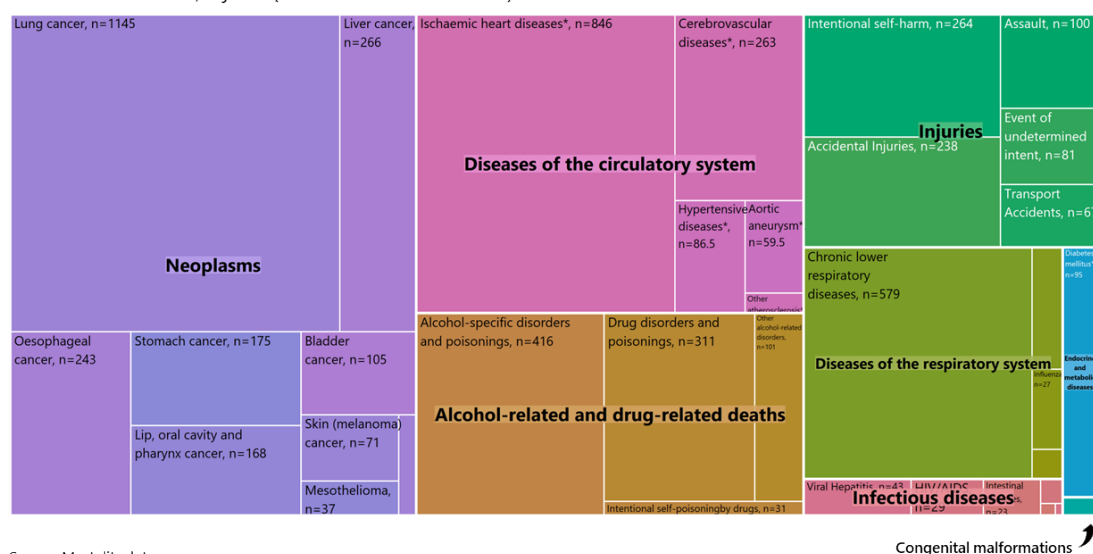


Data across NCL has been collected between 2016-2020. From analysis of this data, preventable mortality rates were lower in Barnet when compared to other NCL boroughs. Across NCL, preventable mortality causes were grouped as shown in Figure 11– with the most common underlying cause being neoplasms (cancer). Treatable mortality rates in Barnet were lower when compared to other NCL boroughs between 2016-2020. Treatable mortality causes were grouped as shown in Figure 12, with the most common being disease of the circulatory system. The analysis investigated across 4 domains: borough, deprivation, ethnic groups, and cause of death<sup>29</sup>. Within each NCL borough there is clear gradient in deprivation. Across NCL, when comparing ethnicity, data shows that Black communities have disproportionality higher death rates when looking at treatable deaths; showing opportunities to improve management of conditions. Disparities in NCL also exist across certain underlying causes when aggregating data across all 5 boroughs. For example, there are higher rates of treatable and preventable mortality from endocrine and metabolic disease in Black and Asian ethnic groups. In NCL, preventable mortality strongly associated with behavioural risk factors (underlying cause is alcohol or drug related) is higher in White communities. Data on ‘other’ ethnic groups suggests misclassification issues when using a broad grouping system and reflects the need for coding of ethnicity to be reviewed in NHS data.

In the context of ageing well, avoidable mortality data reflects the need for further investigation on accessibility and the cultural competence of services involved in primary prevention, access to treatment, and the intersection with deprivation.

#### Grouped cause of preventable mortality

North Central London, 5 years (01 Jan 2016 – 31 Dec 2020)



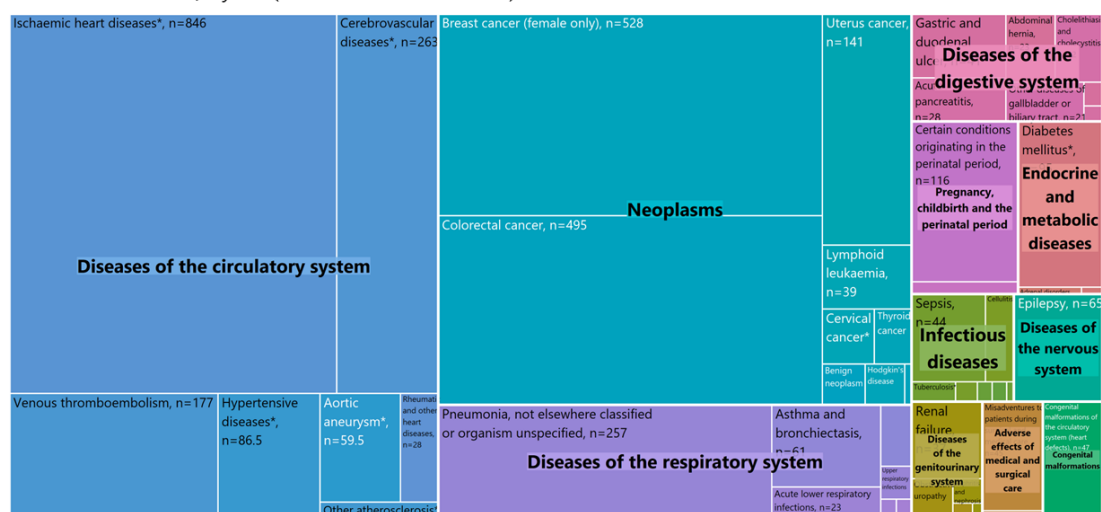
Source: Mortality data  
 \*These underlying causes of death have been 50%-50% allocated between preventable mortality and treatable mortality, as per the OECD definition.

Figure 11. Grouped cause of preventable mortality across NCL (numbers recorded as total for all 5 NCL boroughs)<sup>32</sup>.

<sup>29</sup> North London Partners in Health and Care (25<sup>th</sup> March 2021). Avoidable Mortality by Ethnicity and Deprivation.



**Grouped cause of treatable mortality**  
North Central London, 5 years (01 Jan 2016 – 31 Dec 2020)



Source: Mortality data  
\*These underlying causes of death have been 50%-50% allocated between preventable mortality and treatable mortality, as per the OECD definition.

Figure 12 Grouped cause of treatable mortality across NCL. (Number represents the total cases across all 5 NCL boroughs)<sup>32</sup>

## 6 Health Promotion

### 6.1 Behavioural Risk Factors

The health of people in later life is influenced by behaviours adopted across the life course. These in turn, can be influenced by environments at schools, communities, and workplaces earlier in life. These wider social, environmental, and economic factors are explored further in Section 9. The Institute for Health Metrics and Evaluation (IHME) have developed a tool for assessing the global burden of disease, including from behavioural risk factors. IHME reports that many behavioural and metabolic risks have worsened worldwide in recent years, leading to loss of healthy years of life and therefore impacting the ability to age well<sup>30</sup>. In Barnet, certain behavioural risk factors contributed significantly to mortality in 2019. The most common was tobacco, followed by dietary risks, alcohol use and low physical activity. These risk factors will guide the focus of this section.

#### Smoking

Smoking is a leading cause in inequality in mortality rates between the most and least deprived areas of England. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death<sup>31</sup>. Tobacco is associated with many long-term conditions such as chronic obstructive pulmonary disease and CVD. It is also associated with the loss of functional ability in older adults with accelerating loss of bone density (increasing risk of fractures and poor bone healing), muscular strength and respiratory function<sup>32</sup>.

<sup>30</sup> IHME (2019), Global Burden of Disease Compare tool, IHME Available from: <http://ihmeuw.org/67wm> (Accessed 19th October 2023).

<sup>31</sup> Action on Smoking and Health (ASH, 2019), Health inequalities and Smoking, ASH. Available from: [ASH-Briefing\\_Health-Inequalities.pdf](#) (Accessed 19th October 2023)

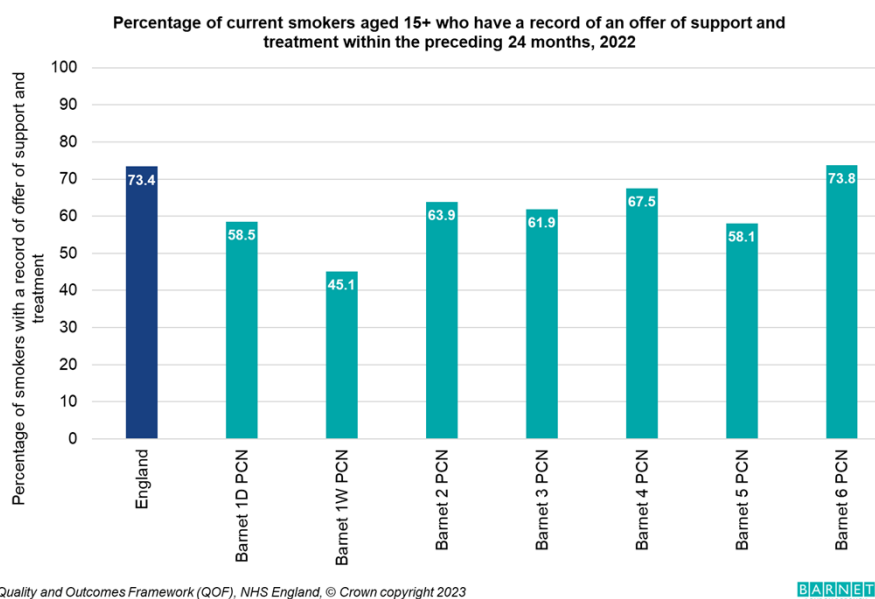
<sup>32</sup> NHS (September 2022), What are the Health Risks of Smoking, NHS. Available from: [What are the health risks of smoking? - NHS \(www.nhs.uk\)](#) (Accessed 19th October 2023)

Data from Action on Smoking and Health (ASH) shows that the currently prevalence of smoking in Barnet’s adult population was 10.5% in 2023, which equates to roughly 31,000 people. Prevalence across NCL ICB is 11.4%<sup>33</sup>.

#### Smoking cessation services in LBB:

Support locally is offered from GP surgeries and pharmacies, and through specialist in-house service. Barnet has partnered with Smoke Free – a mobile phone application which provides advice on stop smoking techniques and communication with accredited advisors. The full range of support, including London-wide Stop Smoking services can be accessed here: [Stop smoking support | Barnet Council](#).

Information is available on the proportion of people offered support and treatment for smokers aged 15+. This data is split by primary care network (PCN) in Barnet and can be compared to the England average (Figure 13)<sup>34</sup>. Note that the denominator in this data set considers all patients recorded as smokers, including those who have already declined treatment, where treatment or support may not be suitable, or where appointments have been cancelled. All but one of the Barnet PCNs (Barnet 6) had significantly lower percentages of smokers aged 15+ being offered support or treatment for smoking cessation in 2022. Note this data uses coded patient record data, which may not reflect services accessed outside of GP, or could be out-of-date (for example, someone incorrectly coded as a smoker but no longer smokes).



Data capturing a wider range of smoking cessation service uptake is available from an internal dashboard and summarised for financial years 2020/21 to 2022/23 (Figure 14)<sup>35</sup>. Note the episodes

<sup>33</sup> ASH (September 2023), Ready Reckoner. Available from: [ASH Ready Reckoner - ASH](#) (Accessed 19<sup>th</sup> October 2023).

<sup>34</sup> OHID (2022), Record of offer of support and treatment in the last 24 months for smokers aged 15+ yrs

(d) *Figure 13 Bar chart showing the proportion of smokers aged 15+ who have a record of an offer of support and treatment within the preceding 24 months. Data is split by England average, and all PCNs in Barnet (2022).*

refer to a single presentation to smoking cessation services, so would count an individual presenting more than once in the financial year as multiple distinct episodes. 'In-house' refers to people referred for specialist support offered within Barnet Council. Since 2021/22, there has been decrease in the number of episodes. There is a significant drop in the number of episodes delivered by GP services. Note the overall trend in smoking prevalence as suggested by OHID from Barnet does not suggest a significant decrease for Barnet since 2020/21<sup>36</sup>, so this could suggest fewer people are accessing smoking cessation services within Barnet.

Episodes are also available by age group (Figure 15). The greatest proportion of episodes are seen in those aged 45-64. There is limited data on smoking prevalence by age group in Barnet, but national data from ONS suggests that those aged 25-34 have the highest proportion of current smokers, compared to those aged 65 years, in 2021<sup>37</sup>. This could be applicable to Barnet's population. Prevalence would not directly correlate to use of smoking cessation services, or factors which contribute to an individual accessing these services. However, it is important to consider whether adults aged 25-34 and older adults are under-represented in-service use.

Ethnicity data has also been summarised for all financial years 2020/21-2022/23<sup>38</sup>. In total, the White British or Irish Ethnic Group had highest smoking cessation episodes compared to other ethnic groups (around 44% of total episodes), followed by White Other (24.3%). This could reflect the demographic make-up of Barnet (the Asian/ Asian British ethnic group is the largest ethnic minority in Barnet and reflected in smoking cessation episodes). 6% of episodes did not have ethnicity recorded or declined reporting. Another consideration is the data from NCL on avoidable mortality (Section 5.6); across NCL preventable mortality from behavioural risk factors (which would include smoking, alcohol or drug related), was highest in White ethnic groups.

Quit rates are available by age group and financial year (Figure 16)<sup>38</sup>. A successful quit is defined as a smoker who has stopped smoking by their 4-week follow-up appointment and has not smoked at all during the 2 weeks leading up to the follow-up. Note, as with the episodes, this could lead to the same individual having multiple 'quits' recorded within the same financial year. Quit rates appear to be similar across age groups for 2020/21-2021/22. There was a slight decline in the quit rate for those aged 75+ in 2022/23 to 37%, from 59% in 2021/22, however as absolute numbers of the cessation episodes are relatively low in this age group, small changes could reflect a larger change in percentage.

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<sup>36</sup> OHID (2022). Smoking prevalence in adults (18+) – current smokers (APS), *Local Tobacco Control Profiles*. Available from: [Local Tobacco Control Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk) (accessed 6<sup>th</sup> November 2023)

<sup>37</sup> ONS (2021), Adult smoking habits in the UK: 2021, *Data and Analysis from Census 2021*, Available from: [Adult smoking habits in the UK - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk) (Accessed: 7<sup>th</sup> November 2023)

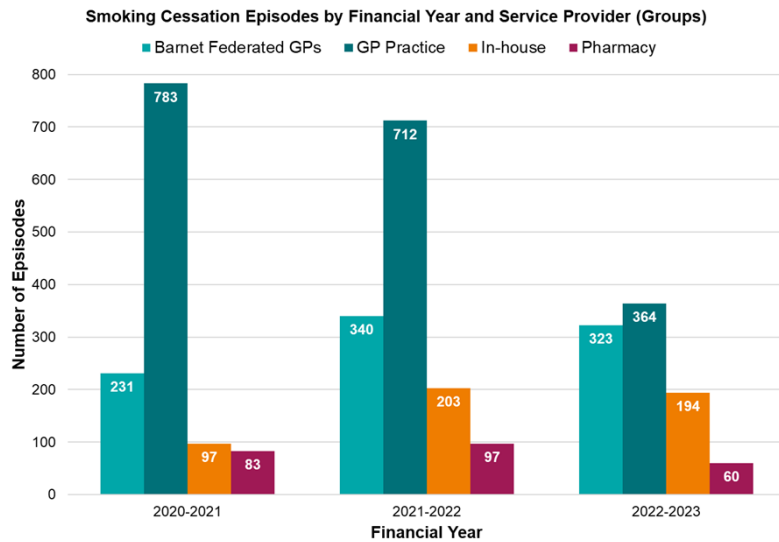


Figure 14 Smoking Cessation, episodes by financial year from 2020-2021 to 2022-2023 for people aged 18+

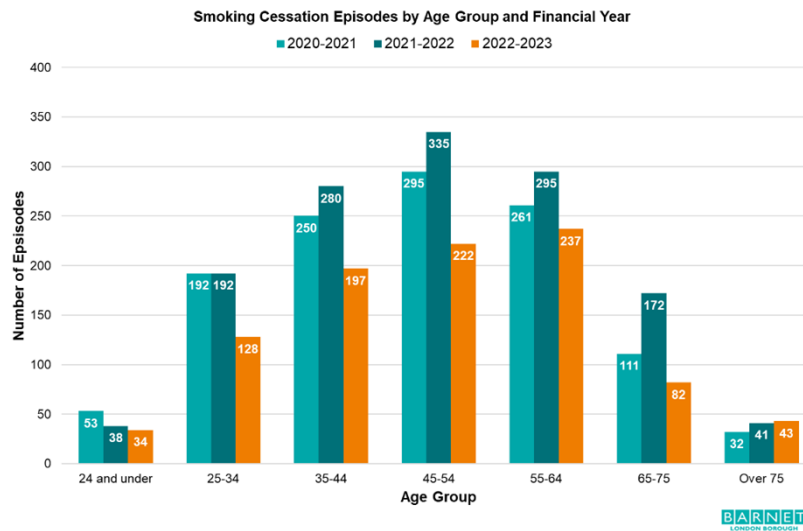


Figure 15 Smoking cessation episodes by age groups and financial year, 2020/21 - 2022/23

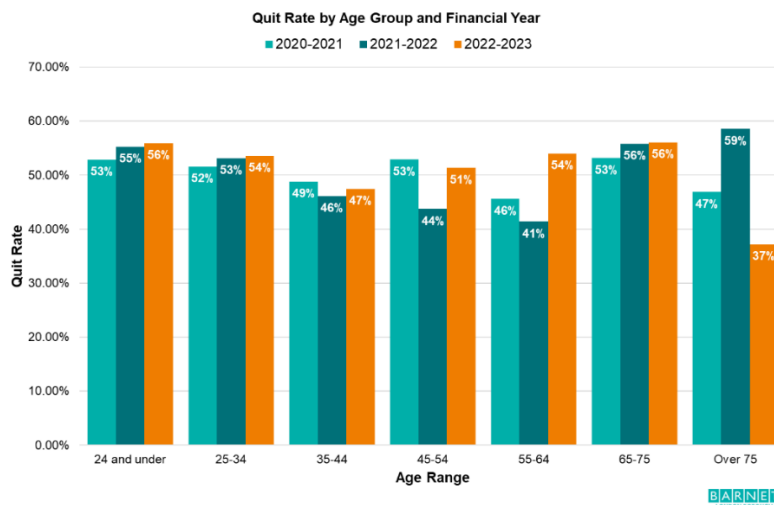


Figure 16 Quit rate split by age group and financial year for 2020/21-2022/23

## Alcohol and Substance Misuse

Alcohol use and its impacts on health and wellbeing of populations is well-documented and has been identified as a causal factor in many medical conditions<sup>38</sup>. Susceptibility to the negative effects of alcohol use increases with age, including malnutrition, liver disease and falls<sup>39</sup>.

Hospital admissions for alcohol-related conditions for those aged 40+ in Barnet is lower compared to London and England averages<sup>40</sup> (Table 2). Barnet had higher rates of admissions for males compared to females, with a significantly higher rate seen in males aged 65+ than females aged 65+.

			Barnet	London region	England
Admissions for alcohol-related conditions 2021-2022 per 100,000	40-64 years old	Males	621	842	954
		Females	397	482	597
	65+ years old	Males	1050	1271	1275
		Females	304	406	425

Table 2 Table summarising the Standardised rates of Admission for Alcohol-Related conditions in people aged 40+, split by sex (admissions per 100,000)

### Drug and Alcohol Services in Barnet

Barnet residents can access a range of services, alongside their family and carers. Support ranges from advice to structured programmes and residential treatment. [Change Grow Live Barnet](#) is a drug and alcohol service commissioned by LBB Public Health to support people with substance misuse issues, in collaboration with primary care and hospital-based services. They are free to access and professionals such as support workers or healthcare professionals and individuals can refer. Other services available in Barnet can be found here: [Drug and alcohol misuse | Barnet Council](#). NCL-wide services which health professionals can signpost or refer to are available here: [Addiction - North Central London GP Website \(icb.nhs.uk\)](#).

Data from the Combating Drugs Partnership (CDP) HNA<sup>41</sup> showed that during 2021/22, 174 people aged 50+ received alcohol misuse treatment in Barnet, representing 40% of the overall alcohol-only treatment population. This is similar to the England average of 39%. During the same period, people aged 50+ made up 27% of adults in drug treatment (n=280). This is above the national average of 20%.

There was an increasing trend seen in adults aged 50+ in structured treatment from 2019/20 to 2021/22 for alcohol only and opiates. Despite the increasing trend, data from local treatment services suggested that there was underrepresentation of people aged 65+ in substance misuse treatment compared to the adult population data from Census 2021. Those aged 35-44 and 45-54 were over-represented in episodes seen, compared to Census 2021 data. The CDP HNA recommended a review of current screening provision, brief intervention and advice provision and referral pathways for older people, to determine whether opportunities for improvement exist.

<sup>38</sup> Age UK (April 2011), Healthy Ageing Evidence Review. Available from:

[rb\\_april11\\_evidence\\_review\\_healthy\\_ageing.pdf \(ageuk.org.uk\)](#) (Accessed 19<sup>th</sup> October 2023)

<sup>39</sup> OHID (2022), Alcohol: applying All Our Health. Available from: [Alcohol: applying All Our Health - GOV.UK \(www.gov.uk\)](#) (Accessed 19<sup>th</sup> October 2023)

<sup>40</sup> OHID (2022) Admission Episodes for alcohol-related conditions. *Productive Healthy Ageing Profile*. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](#). (Accessed: 30<sup>th</sup> August 2023)

<sup>41</sup> LBB PH (2023), *Combating Drugs Partnership Needs Assessment*, Louisa Songer.

NDTMS have estimated the rate of unmet need for treatment of alcohol dependency; this uses the 2021/22 treatment data and prevalence estimates from 2018/19. The unmet need was estimated to be between 71-84% in Barnet, compared to 76-84% in England for 2021/22. Data was also triangulated from GP records, which suggested that the alcohol use was unknown in 76% of GP-registered patients<sup>41</sup>. This data highlights the need for greater identification in healthcare using Identification and Brief Advice (IBA), and supporting non-healthcare professionals to make use of initiatives such as Making Every Contact Count to signpost appropriately.

The CDP needs assessment reported adult (aged 18+) episodes to Tier 3 alcohol and substance misuse services looking at gender, ethnicity and religion<sup>43</sup>. For April 2020- March 2022, males were over-represented in-service use compared to females (68.7% episodes for males, 48.4% for females). Further detail on demographic data and Tier 3 service use is available from the CDP needs assessment<sup>43</sup>. Key conclusions from this data were that overall substance misuse was lower among minority ethnic groups than among the white population, when compared to Census 2021 ethnicity breakdown. It is difficult to draw conclusions from broad categorisation of ethnicity, which could conceal variability within ethnic groups. However, the needs assessment also acknowledged the social stigma associated with alcohol and drug use in some ethnic groups could lead to under-estimation of prevalence and inhibit service provision.

For religion, key findings were that episodes for adults who reported having no religion were substantially higher than the Barnet population from Census 2021 (38.8% and 20.2% respectively). Although Barnet has a higher proportion of Jewish residents compared to England as a whole (14.5% in Barnet, 0.5% in England), only 2.7% of adult episodes were for people who identified themselves as Jewish. The percentage of episodes for Muslim and Hindu residents were also lower than expected from the 2021 Census, as was the percentage of episodes where religion was not stated or not recorded. The percentages of adult episodes for Christians, Buddhists and Sikhs were comparable to the Barnet population.

### **Physical activity**

Inactivity contributes to the risk of conditions such as type 2 diabetes and CVD. Physical activity is also associated with increased functional capacity in older people. Physical inactivity is defined as those engaging in less than 30 minutes of physical activity per week, and targeting those who are inactive will produce the greatest reduction in chronic disease and contribute to healthier ageing<sup>42</sup>. It is important to note that factors such as physical or mental disability, frailty and co-existing medical conditions can contribute to a person's engagement in physical activity. Over 1 in 5 (22.1%) of adults in Barnet are physically inactive, this is similar to the percentages seen across London and England<sup>43</sup>.

### **Weight**

The proportion of adults in England with obesity has been increasing over the last 3 decades<sup>44</sup>. obesity carries significant health risks for a variety of chronic diseases but also mental health. The

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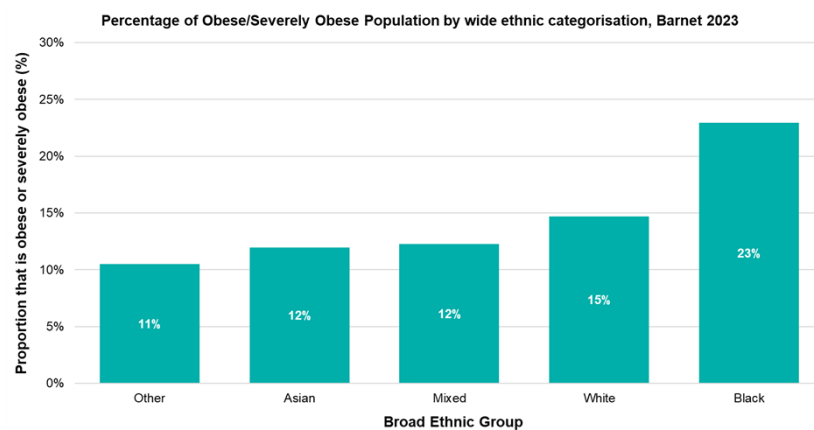
<sup>42</sup> Department of Health and Social Care (2020) 'Physical activity guidelines: UK Chief Medical Officers' report,' GOV.UK Available from: <https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report>. (Accessed 19<sup>th</sup> October 2023)

<sup>43</sup> OHID (2022) Productive Healthy Ageing Profile. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.ohid.org.uk/productive-healthy-ageing-profile). (Accessed: 30<sup>th</sup> August 2023)

<sup>44</sup> Hancock, C. (2021) Patterns and trends in excess weight among adults in England, UK Health Security Agency. Available at: Hancock, C. (2021) Patterns and trends in excess weight among adults in England, UK

risk and severity increase as body mass index (BMI) increases. In Barnet, 57.5% of adults aged 18+ were overweight or obese in 2021/22. 15.9% of adults in Barnet were obese<sup>37</sup>.

There is ethnic variation in the prevalence of obesity and related health risks. Compared with the general population, obesity is lower in men of Bangladeshi and Chinese family origin. For women, obesity is higher for those of African, Caribbean, and Pakistani family origin. The use of lower BMI thresholds (BMI 27.5kg/m<sup>2</sup> or higher) to trigger action to reduce the risk of obesity-related conditions has been recommended for people from South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean backgrounds. This is because of the risk from central adiposity and cardio-metabolic risk occurs at a lower BMI in these groups<sup>45</sup>. The methodology from OHID does not account for ethnicity data, so the reported prevalence of obesity may be underestimated due to the higher cut-off used for ethnic groups other than those listed above, and Barnet having a more diverse population compared to the England average. Data from NCL Health Intent provides comparison of obesity prevalence across broad ethnic groups in Barnet<sup>46</sup> (Figure 17). Note ethnic group is classified in broad categories, so would not account for increased risks within ethnic groups, for example Asian or Mixed ethnic groups. Across all ages, the percentage of obesity and severe obesity was highest for those from 'Black' ethnic groups (22.94%), compared to the lowest percentage seen in 'Other' ethnic groups (10.52%).



Source: North Central London Integrated Care System, Health Intent. 2023

Figure 17 Percentage of obese, severely obese for Barnet Population by Broad ethnic group, 2023

Health Security Agency. Available at: <https://ukhsa.blog.gov.uk/2021/03/04/patterns-and-trends-in-excess-weight-among-adults-in-england/> (Accessed: 19 October 2023)

<sup>45</sup> The National Institute for Health and Care Excellence. (2023). Recommendations: Obesity: Identification, Assessment and Management: Guidance. NICE. Available from: [Recommendations | Obesity: identification, assessment and management | Guidance | NICE](#) (Accessed: 30<sup>th</sup> October 2023)

<sup>46</sup> North Central London ICS, HealthIntent, 2023.



### Active Hospital

The Royal Free Hospital Trust has appointed an [active hospital](#) lead. The aim of the role is to change the physical activity culture within hospitals to encourage patients to engage in activity whilst they are admitted. The focus now is having conversations around physical activity with staff and building their confidence. Once established, there is scope to focus on independent-living frail patients, who are less likely to recover mobility and are at risk of deconditioning during hospital stays. Encouraging mobilisation of medical patients could reduce the average length of stay for older patients and prevent hospital-associated deconditioning, providing the opportunity to maintain independence post-discharge.

### Opportunities for physical activity in Barnet

There are numerous activities on offer currently in LBB, with further information available from: [Move more | Barnet Council](#). Specific activities are also on offer for [older adults](#), via the fit and active Barnet (FAB) scheme which offers a concessionary membership for over 55's, specific classes, videos and walking groups. The distribution of opportunities across Barnet is not equal, with areas having a greater concentration of activities on offer. Other areas within Barnet, particularly some leisure centres are less accessible by public transport, and there is a lack of activities which are completely free of cost for older adults. Some opportunities could be made available virtually for residents, particularly those who may be unable to physically access activities on offer, but it is important to consider accessibility of digital content.

### Adult Weight Management Services

There are tier 1, 2 and 4 weight management services available across Barnet. These include BETTER GLL, services from Central London Community Healthcare (CLCH), , NHS digital wight management programme and bariatric surgery from healthcare trusts. Specific programmes are also available for people with a diagnosis of type 2 diabetes (explored in more detail in Section 8.2). Weight management services set out specific referral criteria, with lower cut offs used for minority ethnic groups, in line with NICE guidance.

## Diet and Nutrition

A balanced and nutritious diet is protective of health during and in later life, however there is limited data on adults who follow a healthy diet in Barnet. The '5-a-day' campaign was based on advice from the WHO to help lower the risk of serious health problems such as heart disease, stroke, and some types of cancers in later life<sup>47</sup>.

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<sup>47</sup> Diet, nutrition, and the prevention of chronic diseases: report of a Joint WHO/FAO Expert Consultation. *WHO Technical Report Series*, No. 916. Geneva: World Health Organization; 2003.



Data from the *Active Lives Survey* showed that in Barnet 57% of the population aged 16+ currently meet this recommendation, which is comparable the levels seen in England (55.4%) and London (57%)<sup>48</sup>.

Age UK Barnet conducted surveys for the older adult population in 2023 as part of the Age-Friendly Barnet engagement phase<sup>49</sup>. A breakdown of the ages and ethnicity of respondents is summarised below:

Age Range	Under 55	55-65	66-75	76-85	85+
Number of respondents	266	394	225	105	38

*Table 3 Numbers of respondents to the Age UK Barnet Survey for Age Friendly Barnet, Split by age range.*

Ethnicity	White, White British, White Irish	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	Other
Respondent number	553	109	51	31	14
Respondent %	72%	14%	7%	4%	2%
Census 2021 %	64%	19%	7%	2%	8%

*Table 4 Numbers and percentage of respondents to the Age UK Barnet Survey for Age Friendly Barnet, split by ethnicity, and compared to Census 2021 Percentages for the Barnet Population (all ages)*

The proportion of respondents aged 85+ make up a small absolute number of those surveyed. Ethnicity data shows that the sample proportions are relatively similar to Census 2021 data, but absolute counts are smaller for some ethnic minority groups, so results in this age range should be interpreted with caution as it could be affected by bias from those who chose to take part in the survey and may not represent views or experience of the entire Barnet population. However, this data provides some insight into the picture for ageing well. Data from this survey is also used later in this report (Section 9). Part of the focus on the health section of the survey was whether people ate at least 5 portions of fruit and vegetables on a usual day. The percentage of people who agreed that they ate at least 5 portions of fruit and vegetables on a 'usual' day was the same as seen in the general adult population for under 55s (57%). A decreasing trend of people agreeing with the statement is seen from age 56 onwards in Figure 18.

<sup>48</sup> OHID (2022) Productive Healthy Ageing Profile. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk) (Accessed: 30<sup>th</sup> August 2023)

<sup>49</sup> Baseline Assessment Report, *Age-friendly Barnet*. AgeUK Barnet; November 2023

Responses to: 'On a 'usual' day, I eat at least 5 portions of fruit and vegetables', 2023

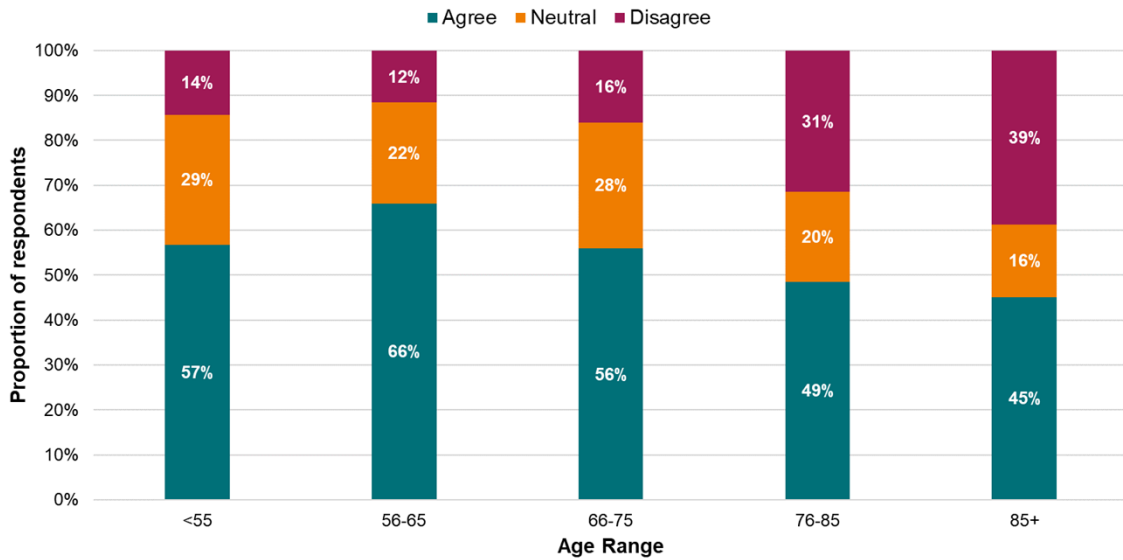


Figure 18 bar chart demonstrating the proportion of people who reported eating 5 portions of fruit and vegetables on a usual day (agreeing with statement, neutral or disagreeing with statement), Age UK Barnet (2023)

Malnutrition is defined by the National Institute for Clinical Excellence<sup>50</sup> (Box 2). Nationally, reports suggest that 1 in 10 people over the age of 65 are malnourished or at risk of malnutrition. It is both cause and consequence of ill health, increasing risk of hospital admission, and long-term health conditions for otherwise independent and healthy people<sup>51</sup>.

Risk factors for malnutrition in older adults include other health conditions (particularly dementia and chronic respiratory disease), physical and sensory impairments and social factors (loneliness, isolation, and transitions in later life such as bereavement). The Malnutrition Task Force has made recommendations for addressing the disproportionate representation of older adults when considering malnutrition<sup>46</sup>. These include increasing awareness among health professionals, increasing public awareness and addressing the increased incidence and risk of dehydration in older people. In Barnet, there is a community nutrition and dietetics team who take referrals for people meeting the definition of malnutrition. More information on their service can be found here: [Nutrition and dietetics: Central London Community Healthcare NHS Trust \(clch.nhs.uk\)](https://www.clch.nhs.uk).

**NICE defines a person being malnourished if they have:**

- A body mass index (BMI) of <math>< 18.5 \text{ kg/m}^2</math>
- Unintentional weight loss > 10% in the past 3-6 months
- BMI <math>< 20 \text{ kg/m}^2</math> and unintentional weight loss >5% in the past 3-6 months

Box 2 NICE definition of malnutrition

Consuming the recommended levels of fruit and vegetables can reduce and delay the risk of conditions such as hypertension, chronic heart disease and stroke in later life<sup>4</sup>. Healthy diets also

<sup>50</sup> NICE (2006) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Available from: <https://www.nice.org.uk/guidance/CG32> (Accessed 26<sup>th</sup> October 2023)

<sup>51</sup> Malnutrition Task Force (2021) State of the Nation 2021: Older people and malnutrition in the UK today. Available from: <https://www.malnutritiontaskforce.org.uk/sites/default/files/2021-10/State%20of%20the%20Nation%202020%20F%20revise.pdf> (accessed 26<sup>th</sup> October 2023)

contribute to a healthy weight, as well as bone health and lower risk of frailty in later life<sup>52</sup>. Consideration should be given to how people access food too. National policies such as regulation and reformulation of high in fat, sugar and salt foods impact the quality of food we can access<sup>53</sup>. At a local level the built environment and the concentration of hot food takeaway can impact the cumulative effect on diet. Food insecurity can also imply a nutritionally inadequate diet<sup>54</sup>, in Barnet there has been an increase in the total number of people accessing foodbanks from 2021 compared to 2023 (increase of 46,000 users)<sup>55</sup>.

## 7 Health Protection

### 7.1 Vaccination

Healthcare-seeking behaviours and access to healthcare affect our ability to age well, and inequalities in vaccine coverage are important to consider as part of this needs assessment. There are 3 vaccines offered to adults as part of the routine immunisation schedule.

#### Influenza

Adults eligible for an NHS flu vaccine are those with certain long term health conditions and people aged 65 and over. The vaccination is updated to give protection against the main strains of flu every year, so eligible people have an annual flu vaccination.

The proportion of people aged 65+ registered with GP in Barnet receiving the flu vaccine annually has been increasing overall since 2018/19, however the this has remained below the England average and does not meet reach the  $\geq 75\%$  target<sup>56</sup>. In 2022/23 70% of the eligible population aged 65+ received the flu vaccines, compared to the England average of 79.9%, and London average of 68.3%.

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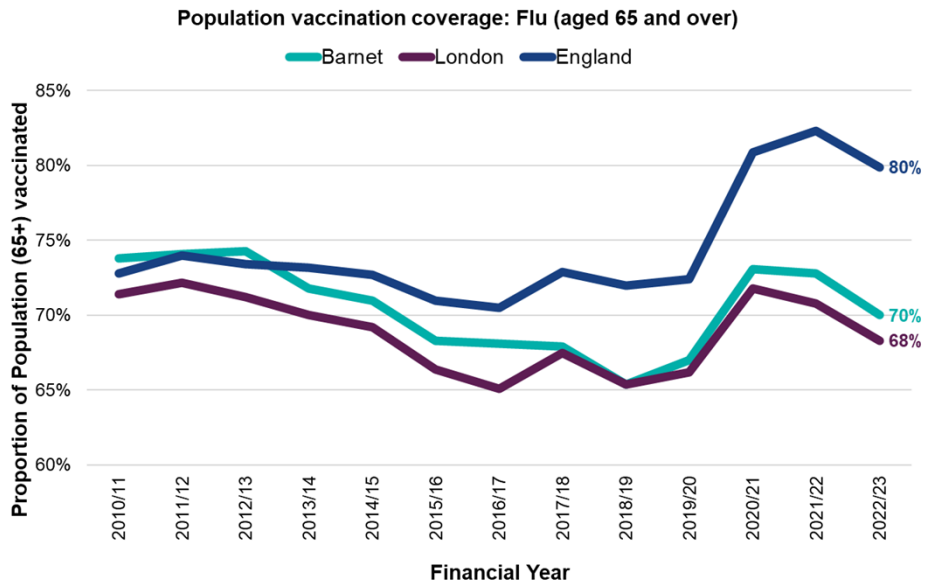
<sup>52</sup> Scientific Advisory Committee on Nutrition (SACN) (2021). *SACN Statement on Nutrition and Older Adults Living in the Community* (Online) Available at: [SACN statement on nutrition and older adults living in the community \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/94442/sacn-statement-on-nutrition-and-older-adults-living-in-the-community.pdf) (Accessed 8<sup>th</sup> April 2024)

<sup>53</sup> Department of health and Social Care (2023). *Restricting Promotions of Products High in fat, Sugar or Salt by Location and by Volume price: Implementation Guidance*. (Online) Available at: [Restricting promotions of products high in fat, sugar or salt by location and by volume price: implementation guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/114442/restricting-promotions-of-products-high-in-fat-sugar-or-salt-by-location-and-by-volume-price-implementation-guidance.pdf) (Accessed 8<sup>th</sup> April 2024)

<sup>54</sup> Sosenko, F., Bramley, G. and Bhattacharjee, A. (2022). *Understanding the post-2010 increase in food bank use in England: new quasi-experimental analysis of the role of welfare policy*. BMC Public Health, (Online) 22(1). doi:https://doi.org/10.1186/s12889-022-13738-0

<sup>55</sup> LBB Insights and Intelligence (2023). *Foodbank Use, Cost of Living Dashboard (2021-2023)*. Available from: [Cost of Living Dashboard \(sharepoint.com\)](https://www.sharepoint.com/~/s/12889-022-13738-0) (Accessed 8<sup>th</sup> April 2024)

<sup>56</sup> OHID (2022) *Productive Healthy Ageing Profile*. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk/publications/productive-healthy-ageing-profile). (Accessed: 4<sup>th</sup> October 2023)

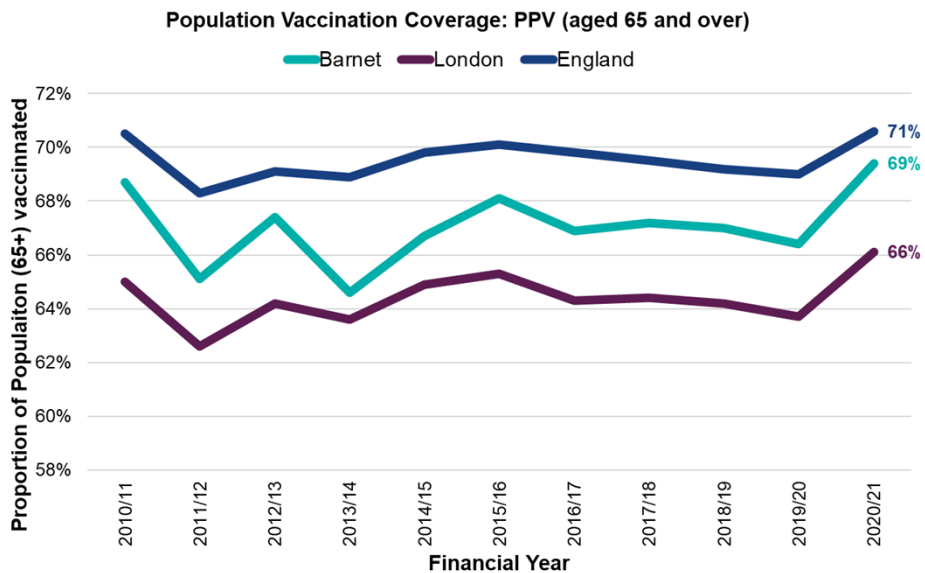


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Figure 19 Graph showing population vaccine coverage for influenza vaccines in the population aged 65+ registered with a GP practice in Barnet, London Region (average) and England (average)<sup>50</sup>

### Pneumococcal

Certain groups are susceptible to severe pneumococcal disease, including young children, older adults, and people from certain clinical groups. Cases increase in the winter and is a significant cause of morbidity and mortality in these at-risk groups. The pneumococcal polysaccharide vaccine (PPV) protects against 23 types of the bacteria. People aged 65+ are offered one dose. For 2020/21 Barnet had 69.4% coverage, which is lower than the England average of 70.6%, but higher than the London average of 66.1%<sup>50</sup>.



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Figure 20 Graph showing population vaccine coverage for influenza vaccines in the population aged 65+ registered with a GP practice in Barnet, London Region (average) and England (average)<sup>50</sup>

## Shingles

The shingles vaccination is offered as a one-off dose for those on their 70<sup>th</sup> birthday, and people remain eligible until their 80<sup>th</sup> birthday. It aims to reduce the incidence and severity by boosting pre-existing immunity. Data is available for coverage of the GP-registered population turning 71 in the financial year who are vaccinated by the end of June. For 2021/22, 46.6% of those offered the vaccine in this age group were vaccinated<sup>50</sup>. Although significantly higher than the London and England average, this does not meet the  $\geq 60\%$  target. It may be that some older adults choose to be vaccinated the following years, which is not captured in this data. From September 2023, delivery of the shingles vaccination programme was changed. The eligible age for immunocompetent individuals will change from 70 years to 60 years (phased over the course of 10 years). In addition to this eligibility will be expanded to all immunocompromised individuals aged 50+. All newly eligible individuals will be offered 2 doses of the non-live shingles vaccine instead of the single dose. The second dose is given 8 weeks to 6 months following the initial dose. Monitoring of vaccination coverage should consider the potential for missed or incomplete vaccination, especially in population groups with poorer uptake of vaccinations.

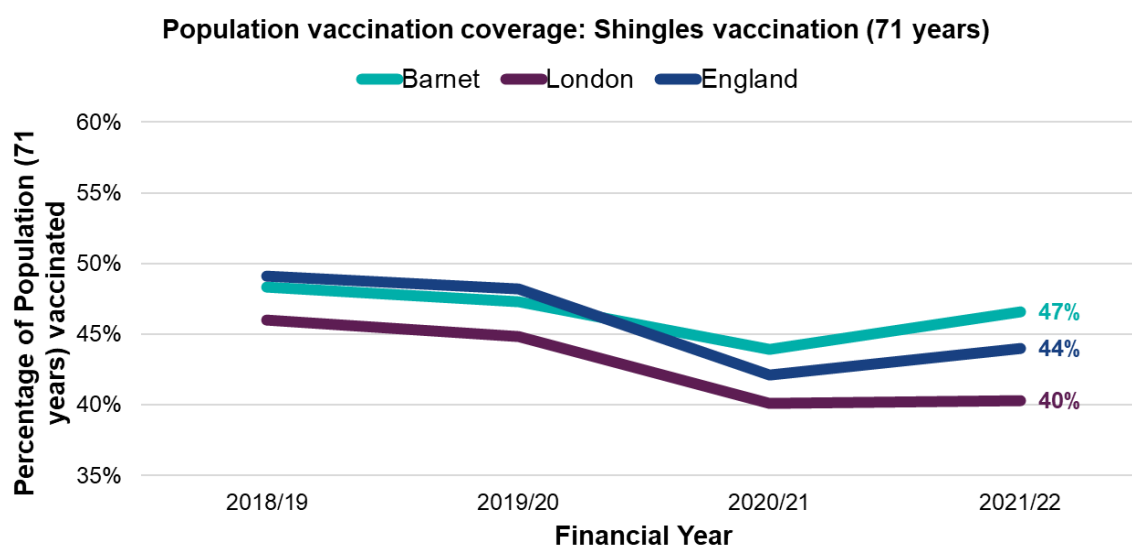


Figure 21 Graph showing population vaccine coverage for shingles vaccine in those aged 71 registered with a GP practice in Barnet, London Region (average) and England (average)<sup>50</sup>

## COVID-19

Data is available from the COVID-19 Health Inequalities Monitoring for England (CHIME) tool on COVID-19 vaccination coverage<sup>57</sup>. The cumulative percentage of people ages 18+ receiving two COVID-19 doses between April 2021 to January 2023 across Barnet is 82.4%, this is compared to 79.4% across London and 87.5% in England. We can further split this data by factors such as age, sex, and deprivation. There is variation in the percentage of adults receiving two doses between the most and least deprived quintiles in Barnet (75.6% in the most deprived versus 88.7% in the least deprived, Figure 22). A similar trend is seen for the third dose (56.6% of people aged 18+ receiving

<sup>57</sup> OHID (2023), CHIME - COVID-19 Health Inequalities. [online]. Available at: [CHIME - COVID-19 Health Inequalities \(phe.gov.uk\)](https://phe.gov.uk) (Accessed 8<sup>th</sup> November 2023)

three vaccines in the most deprived quintile, compared to 79.7% of people in the least deprived quintile).

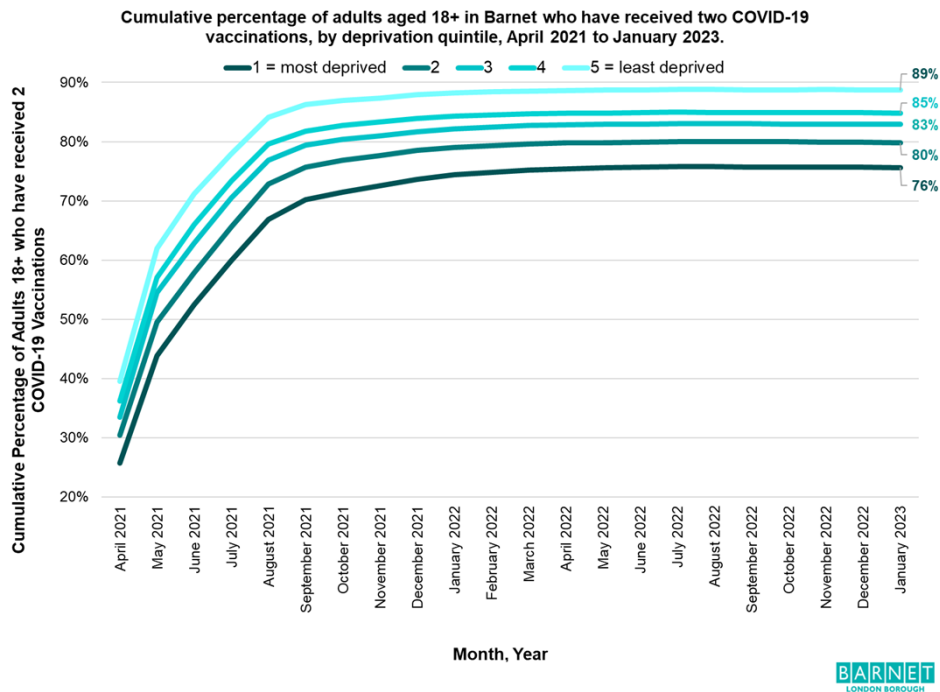


Figure 22 Cumulative percentage of adults aged 18+ in Barnet who have received two COVID-19 vaccinations, by deprivation quintile, April 2021 to January 2023.

The cumulative percentage of people not vaccinated (defined as not receiving any COVID-19 vaccinations) is shown, split by ages is shown in Figure 23. Higher cumulative percentages of people in younger age groups have not received COVID-19 vaccinations from April 2021 to January 2023.

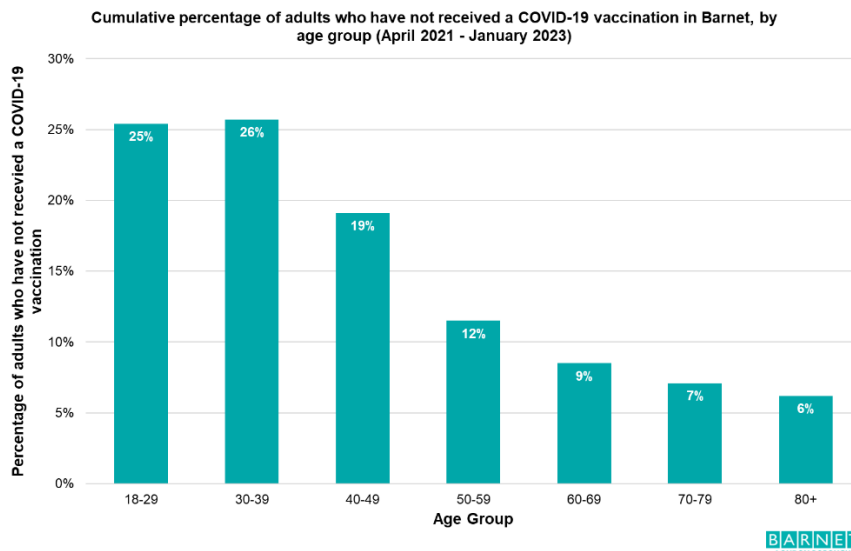


Figure 23 Cumulative percentage of adults (18+) in Barnet who have not received a COVID-19 vaccination, by age group, from April 2021 to January 2023.

## 7.2 National Screening Programmes

Screening programmes help detect early signs of disease in people who may not be experiencing symptoms; early detection is important as treatment is more likely to be successful and chances of survival are better. In the UK there are 3 national screening programmes for cancer: breast, cervical and bowel cancer. Targeted lung health checks (for lung cancer) have also started across NCL. Abdominal aortic aneurysm (AAA) is another condition screened for nationally, with the aim to reduce the risk of significant mortality seen with AAA. Screening coverage data included in this HNA does not include the population who are not registered with a GP, so coverage may be underestimated. Diabetic Eye Screening is covered in Section 8.2.

### Breast Cancer

Females between 50 and 70 years old are invited for regular breast screening every 3 years. Screening coverage is measured as the percentage of the eligible population who have been screened within the last 3 years. In Barnet, the coverage in 2022 was 61.9%, compared to 55.5% across London and 65.2% across England<sup>58</sup>. The trend for breast cancer screening coverage is shown in Figure 25. Across all regions, a significant drop in coverage is seen during the first wave of the COVID-19 pandemic, and coverage is still recovering following this<sup>56</sup>.

### Cervical Cancer

Women between the ages of 25 and 64 are invited for regular cervical screening under the NHS Cervical Screening Programme. Coverage is measured as the percentage of women in the population who are eligible for screening who were screened adequately within the last three and a half years (for women aged 25–49) and five and a half years (for women aged 50–64). In 2022, coverage was 58.7% for people aged 25-49 years old and 70.3% for people aged 50-64 years old. For both ages this was significantly lower than the England value (67.6% and 74.6% respectively) and London averages (59.3% and 70.9% respectively). There is a lower percentage of coverage for the younger cohort seen across all regions, and an overall decreasing trend is also seen over the years for those aged 50-64 years old, but decreasing rates of coverage preceded the first wave of the COVID-19 pandemic (Figure 26)<sup>56</sup>.

### Bowel Cancer Screening Coverage

Bowel cancer screening in the form of a home-testing kit is offered to men and women aged 60 to 74 every two years. From June 2019, the faecal immunochemical test (FIT) replaced the faecal occult blood (FOB) test. An additional one-off bowel scope screening test was introduced in England at the age of 55. In August 2018, it was announced that bowel cancer screening in England would begin at the age of 50, and this would be implemented across four years beginning from April 2021. In 2022 coverage in Barnet was 63.3%, which compares favourably to the London average (62.1%) but is lower than the England average (70.3%). Bowel cancer screening was not officially paused during the COVID-19 pandemic, but services were suspended locally. Contrary to the trends seen in breast and cervical cancer screening, there has been an increasing trend in uptake since 2011 across Barnet, London, and England and a fall in coverage was not seen in 2020 or 2021<sup>56</sup>.

### Targeted Lung Cancer Screening

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<sup>58</sup> OHID (2022) Optimise Health & Reduce Risks Early, *Productive Healthy Ageing Profile*. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://phe.org.uk) (Accessed: 6<sup>th</sup> September 2023)

Targeted Lung Health Checks are currently offered to people between the ages of 55 and 74 in NCL who were previous or current smokers<sup>59</sup>. It entails 2 stages: the first is an assessment with a health professional and the second stage is imaging of the lungs, if eligible. There is no publicly available information yet on screening coverage, but this should be monitored alongside incidence and mortality rates as part of ageing well going forwards.

### AAA Screening Coverage

The NHS Abdominal Aortic Aneurysm Screening Programme is offered to all men aged 65 and over in England. An ultrasound scan is performed to detect an AAA. In 2021/22 screening coverage was 73.7%, which was significantly higher than the London and England average (60.2% and 70.3%). A fall in screening coverage was seen during 2020/21, as in the screening programmes described above. However, in Barnet, coverage has since improved to a similar level seen in 2019/2020 (73.5%)<sup>56</sup>.

### NCL Cancer Alliance: Cancer Prevention, Awareness and Screening Strategy (2023-2028) and Action Plan (2023-2025)

The [NCL Cancer Alliance](#) brings together patients, hospital trusts, GPs, commissioners, and local authorities to improve cancer outcomes and care. They are one of the 21 cancer alliances in England, set up by NHSE. There is a NCL-wide Cancer Prevention, Awareness and Screening [strategy](#), which is underpinned by the ambitions of the NHS Long Term Plan and local priorities. NCL-wide aims include prevention through universal smoking cessation for inpatients and enhancing weight management service provision. There are also aims to increase participation in screening programmes to get closer to national targets as well as reduce inequalities in uptake of screening across NCL. Actions are set out as NCL or borough specific.

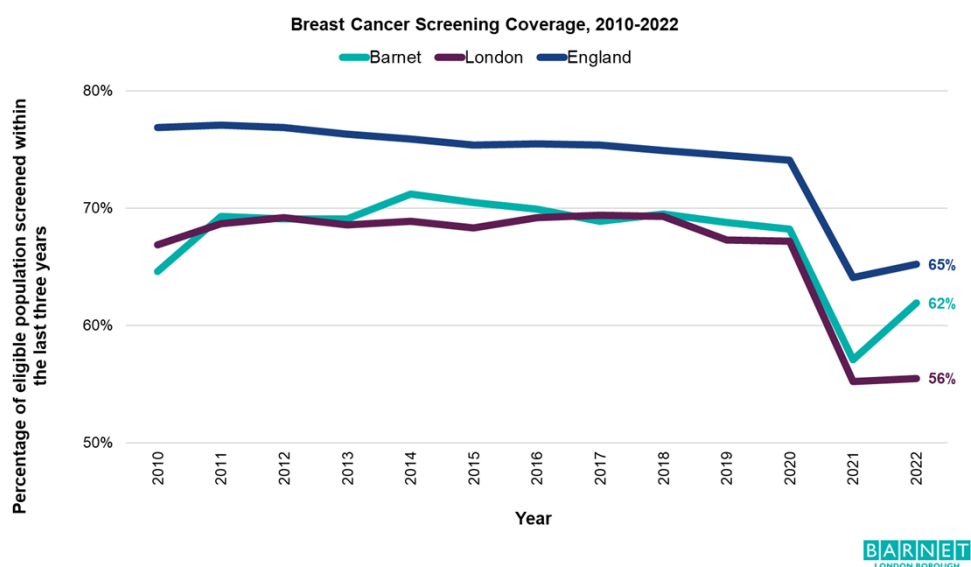


Figure 24 Breast cancer screening coverage in Barnet, London (average) and England (average) from 2010-2022.<sup>56</sup>

<sup>59</sup> UCLH Cancer Collaborative (2023), *What happens at a Lung Health Check? - The 'small c' Campaign* (Online). Available at: [What happens at a Lung Health Check? - The 'small c' Campaign - UCLH Cancer Collaborative \(lungchecklondon.org\)](https://lungchecklondon.org) (Accessed 8<sup>th</sup> November 2023)



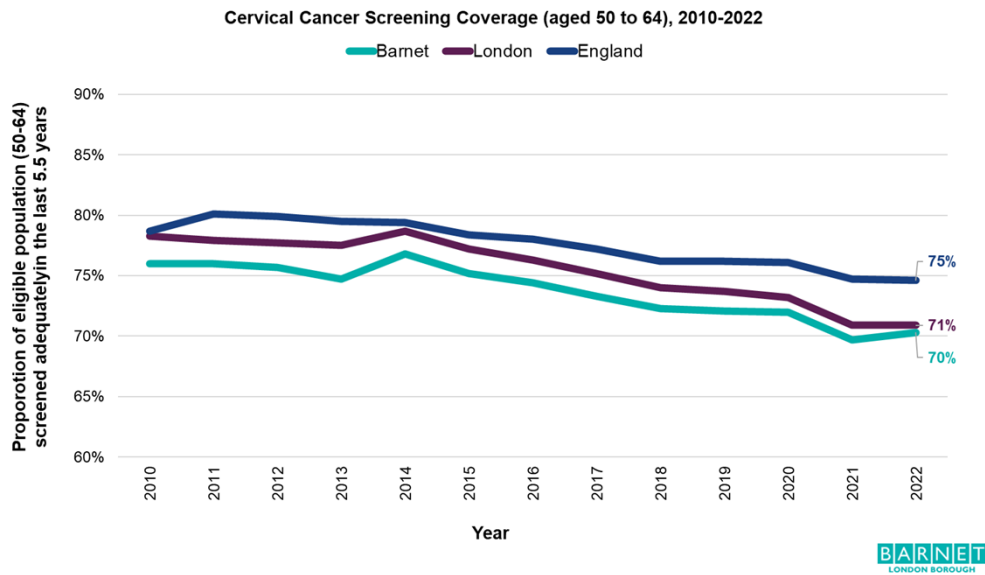


Figure 25 Cervical cancer screening coverage for those aged 50 to 64 in Barnet, London (average) and England (average) from 2010-2022.<sup>56</sup>

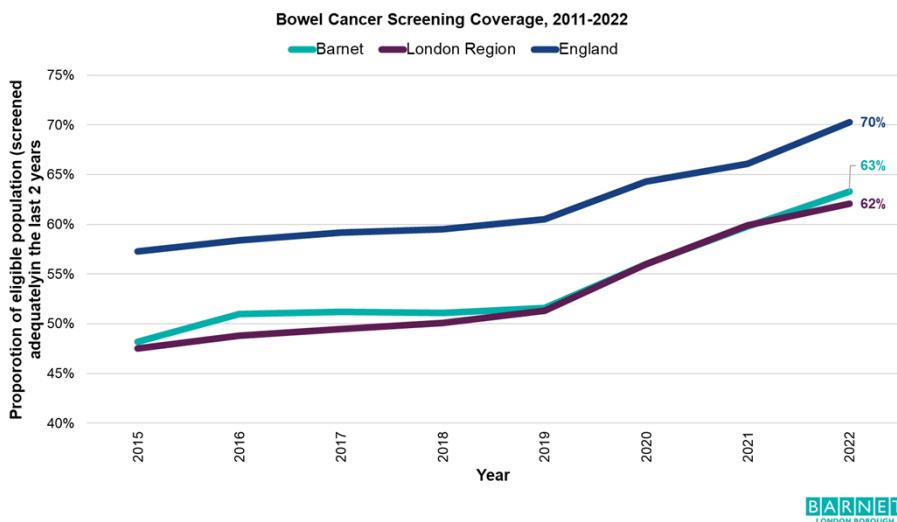


Figure 26 Bowel cancer screening coverage for those in Barnet, London (average) and England (average) from 2015-2022.<sup>56</sup>

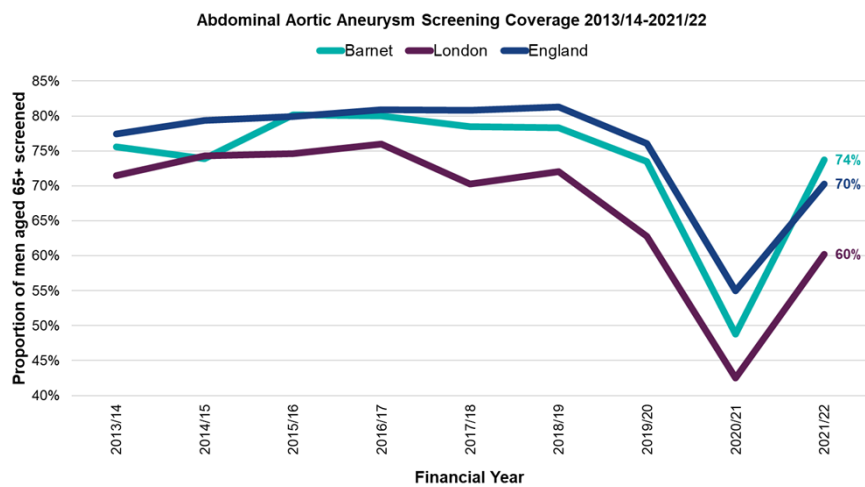


Figure 27 AAA screening coverage in Barnet, London (average) and England (average) from 2013/14-2021/22.<sup>56</sup>

## Summary of cancer incidence

Information on the rate of malignant neoplasms (cancer) per 100,000 people is available for 2018-2020 for NCL and England (Figure 28)<sup>60</sup>. This information would not account for the fall in coverage seen from 2020 onwards, so rates should be monitored to see if there is a significant impact.

NCL incidence could provide an approximation for the incidence seen in Barnet but would not account for the differences in demographics, risk factors and screening coverage across the 5 NCL boroughs.

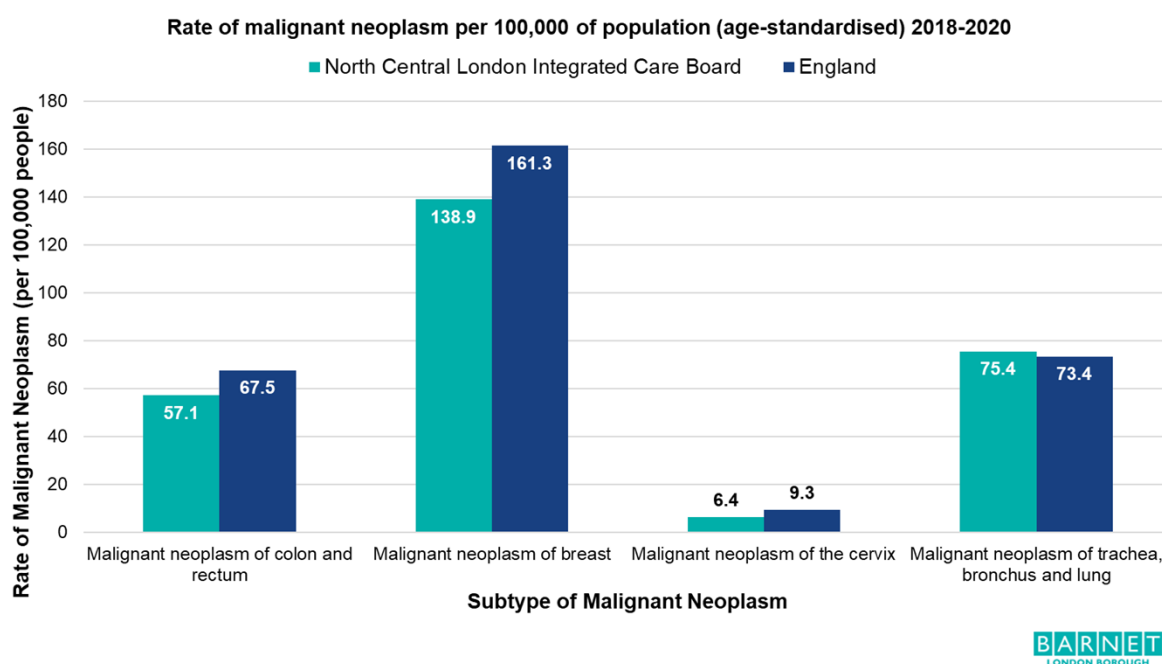


Figure 28 Rate of malignant neoplasms (per 100,000 of population), sub-grouped by type of neoplasm, for NCL and England (2018-2020).

The highest incidence of cancer was from breast cancer in NCL, followed by cancers of the respiratory system (trachea, bronchus, and lung), colon and rectum (bowel) and cervical cancer. The previous section showed that Barnet had lower screening coverage for breast and cervical cancer compared to England. Figure 28 shows the rate of breast cancer and cervical cancer was lower in NCL, compared to England from 2018-2020. This could be due to fewer cancers being detected through national screening programmes. An alternative cause could be a true reduced incidence of these cancers in the NCL population compared to the national population. For bowel cancer, a lower incidence is seen in NCL compared to England and a higher incidence is seen for cancers of respiratory system.

Avoidable mortality data (further information in section 5.6) showed that across NCL, neoplasms were the highest cause of preventable mortality primarily lung cancers), and the second highest cause of treatable mortality (primarily breast cancer). This is in line with the higher incidence seen breast and respiratory cancers across NCL.

<sup>60</sup> National Disease Registration Service, *CancerData* (October 2022), NHS Digital. Available from: [https://www.cancerdata.nhs.uk/incidence\\_and\\_mortality](https://www.cancerdata.nhs.uk/incidence_and_mortality) (Accessed 5th October 2023)

## 8 Healthcare and Social Care

People in Barnet live longer lives on average compared to the national average. Physical and mental ill-health are not an inevitable part of ageing, however the national Major Conditions Strategy estimates that by 2035 2/3rds of adults aged over 65 will have 2 or more conditions<sup>9</sup>. People living longer will also be living longer with complex needs, which include multiple long-term conditions (or MLTCs), mental health conditions and social care needs. Factors which can help prevent ill-health and maintain wellbeing were explored earlier in this HNA. There is a move toward integrated care models, particularly for those in contact with multiple services across health and social care.

### Hospital Admissions

For the period 2022/23, Barnet residents aged 50+ had 64,885 admissions to hospitals (including hospitals outside of Barnet). This number excludes admissions for regular treatment which require admission to hospital. There has been an increasing number of admissions in this group since 2020/21 – where there were 54,890 admissions for those aged 50+<sup>61</sup>. Figure 29 summarises the age breakdown as a percentage for Barnet residents admitted to hospital, compared to NCL for period 2020/21 to 2022/23. A similar picture is seen in Barnet and NCL for percentage of admissions, with the highest proportion of admissions being in those aged 70-79, and lower in those aged 90+.

Breakdown of admissions information is available by the 10 most common coded diagnoses on discharge for those aged 50+ in 2022/23 (Figure 30). The most common diagnoses recorded are for cataracts and bronchopneumonia. Cataracts are usually treated with day-case operation for most patients but reflect the high volume of outpatient surgical care offered to those aged 50+. This is also represented by the ‘Senile Cataract’ diagnosis in the top 10 diagnoses (the two codes represent different patient admissions, so the distribution does not reflect double counting).

Bronchopneumonia is also the most common, followed by sepsis. This provides some insight into the burden of respiratory disease and infection in this age group. Heart failure was the 4<sup>th</sup> most common diagnosis seen in this cohort, and further discussion around CVD disease is included Section 8.1. The high numbers seen in ‘Unknown and unspecified causes of morbidity’ could reflect the lack of accuracy or detail available within hospital coding systems, which cannot map directly to groups of ICD-10 diagnoses.

When including admissions for regular attendance with day or night teams, the top 10 diagnoses changes: the most common being chronic kidney disease (CKD) and malignant neoplasm of the breast for the same period. This is probably explained due to regular attendance for dialysis for CKD, or treatment courses for breast cancer.

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<sup>61</sup> Hospital Episode Statistics (2023), *Admitted Patient Care*, Hospital Admissions in those aged 50+, financial year 2020/21-2022/23 (Accessed 15<sup>th</sup> November 2023).

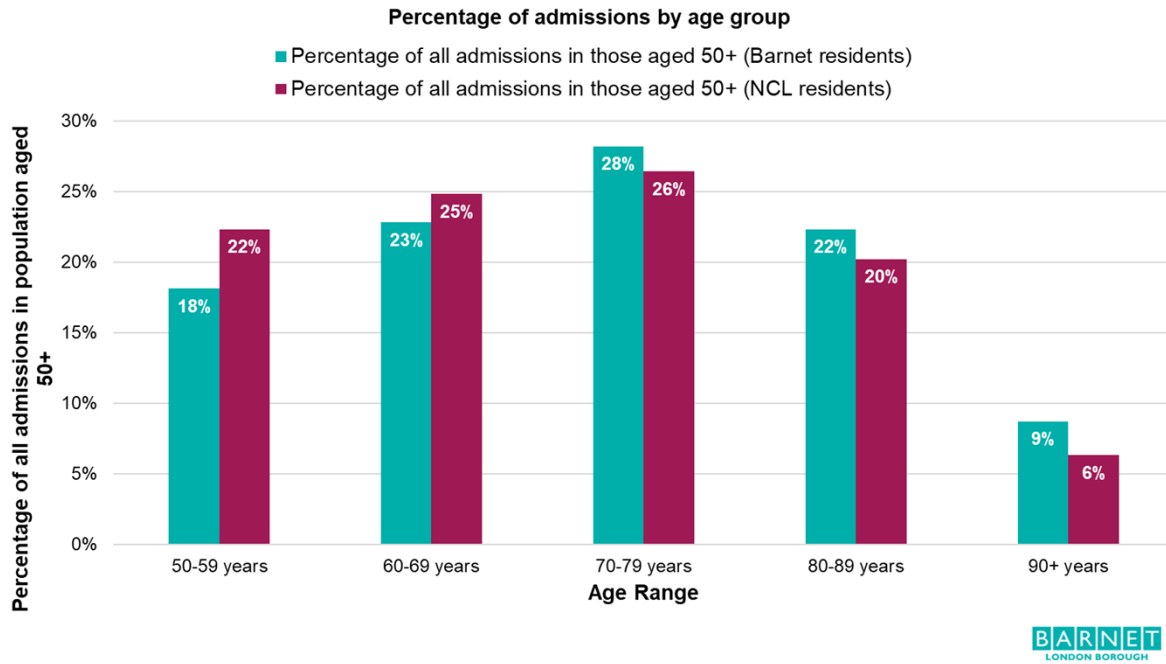


Figure 29 Proportion of admissions to hospitals, split by age group, for Barnet and NCL residents. Financial years 2020/21-2022/23.

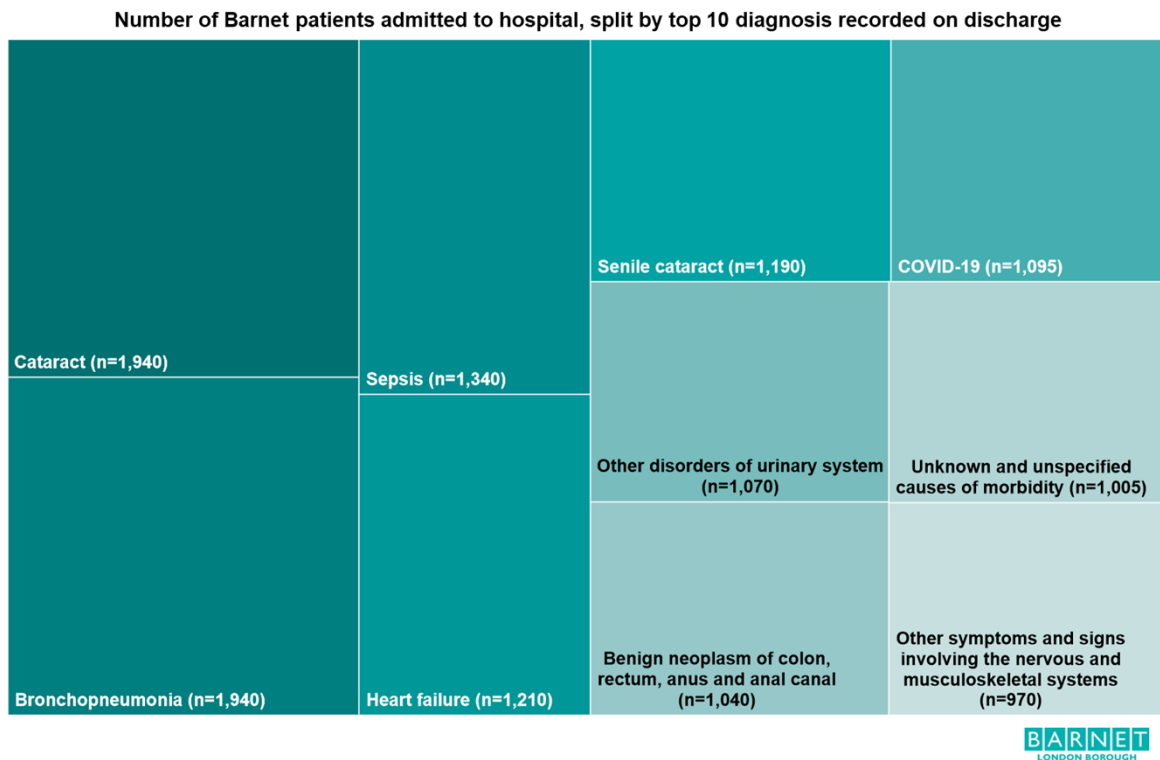


Figure 30 Tree map showing the numbers of admissions to hospitals for Barnet residents, split by top 10 diagnoses on discharge for 2022/23.

A final breakdown of admissions as an inpatient in those aged 50+ who live in Barnet looks at which hospitals residents were admitted to. The data set excludes regular day and regular night attendees. 'Barnet' Hospitals are defined as the following hospitals: Barnet General Hospital, Finchley Memorial Hospital, Hadley Wood Hospital and Edgware Community Hospital. A break down is available for

admissions for people aged 50+ who were admitted to these Barnet Hospitals, split by age group, and compared to the breakdown of people aged 50+ admitted to non-Barnet hospitals (for period 2020/21-2022/23, Figure 31).

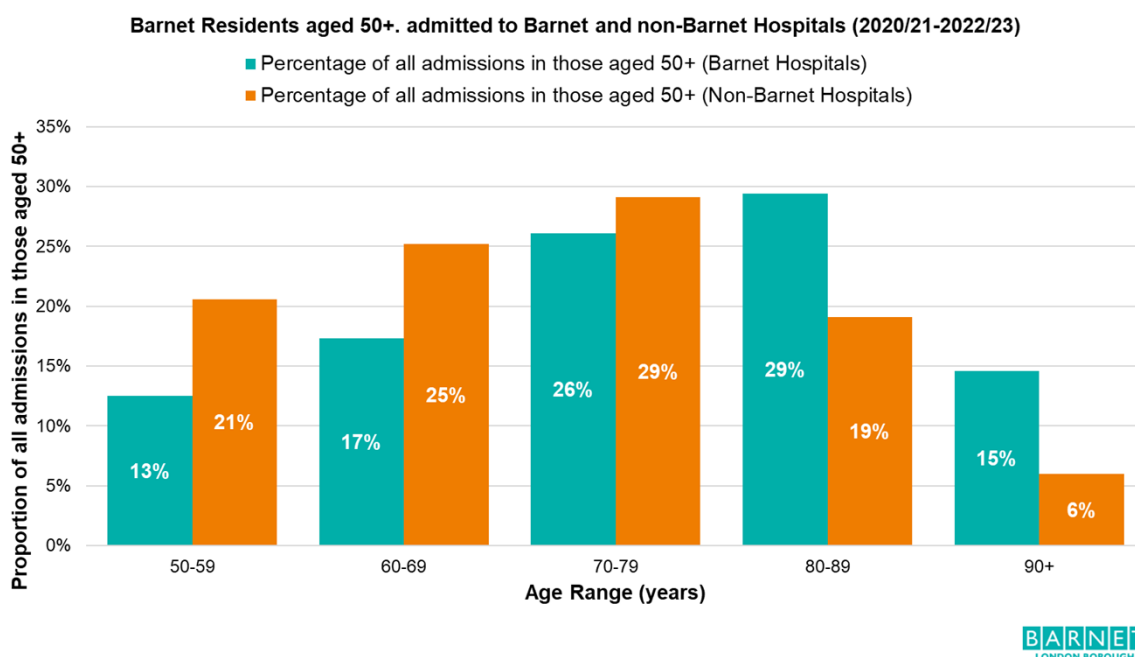


Figure 31 Comparison of proportion of admissions in those aged 50+, split by Age Group, in Barnet and non-Barnet Hospitals, 2020/21-2022/23

The age group where the greatest proportion of admissions were to Barnet hospitals is for those aged 80-89, the lowest proportion is seen in those aged 50-59 years old. The comparison between the two suggests that younger age groups aged 50+ attend non-Barnet hospitals, whereas older residents attend Barnet hospitals<sup>61</sup>. This distribution could be explained by various reasons, including where specialist healthcare is delivered outside of Barnet Hospitals, geographical concentration of older age-groups and proximity to Barnet hospitals, location of work, patient preference, amongst many others. However, this does provide an indication of where workforce planning should account for an older patient population, including delivering care to older adults who may have multiple or complex healthcare needs and delivery of care by other multidisciplinary care teams, with allied health professionals such as podiatrists or occupational therapists.

The top 10 hospitals by admission numbers for Barnet residents are shown in Figure 32<sup>61</sup>. Whilst most residents are admitted Barnet General Hospital, this is followed closely by the Royal Free Hospital (which lies within the same NHS hospital trust as Barnet General Hospital), other hospitals include the Whittington Hospital, UCH Macmillan Cancer Centre and Northwick Park Hospital. Presence of non-Barnet Hospitals could reflect a difference in specialist care offered at these sites, for example with UCH Macmillan cancer Centre, or the Royal National Orthopaedic Hospital. Although these hospitals are not located within Barnet, planning for delivery of services and workforce development should be considered. For example, how services in Barnet maintain communication with and coordinate delivery of care for older adults between hospital and community settings.

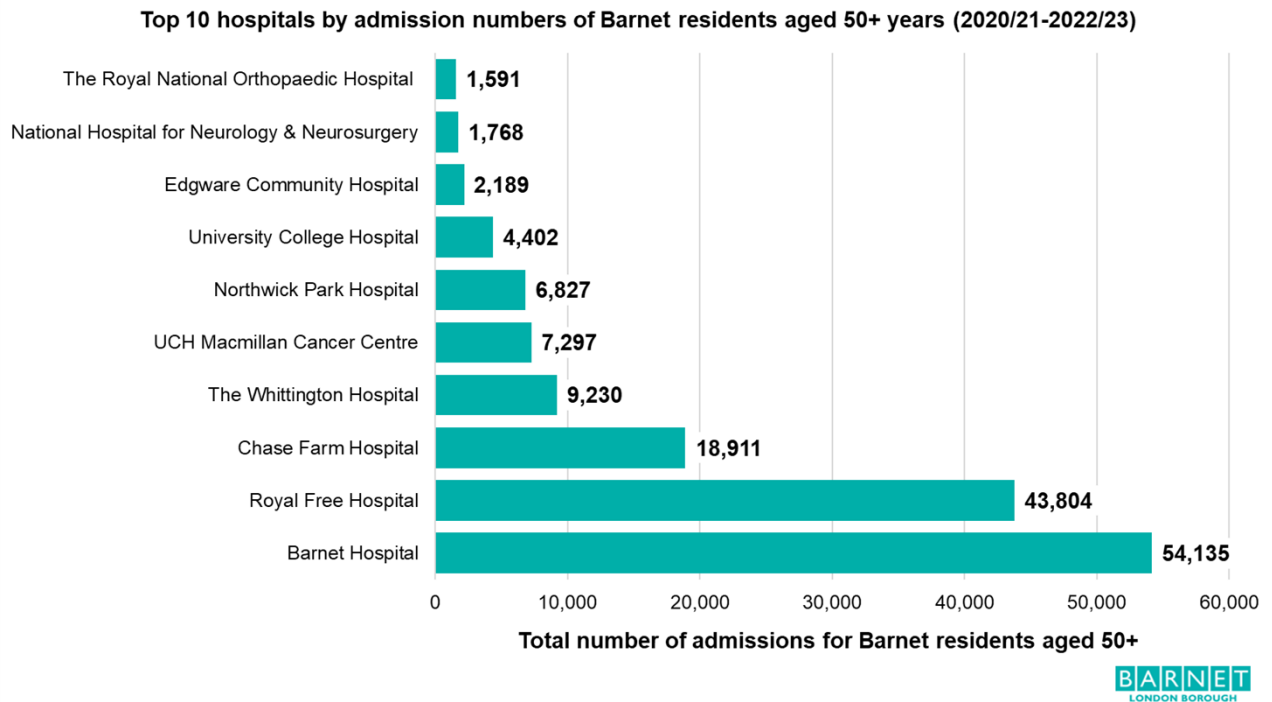


Figure 32 Top 10 hospitals by admission number for Barnet Residents aged 50+, over the period of 2020/21-2022/23.

## 8.1 Cardiovascular Disease, NHS Health Checks and Community Health Screening

### Cardiovascular Disease

CVD is one of the 6 major conditions groups which contribute to 60% of ill-health in the UK. 85% of CVD is thought to be preventable through actions which address physical activity, diet, nutrition, tobacco, and alcohol (explored in more detail in Section 6.1)<sup>4</sup>. Action can also be taken by means of secondary prevention, for earlier diagnosis. Conditions such as atrial fibrillation (an irregular heartbeat), high blood pressure and high cholesterol can go undetected and untreated before more significant events such as heart attacks or strokes occur.

Quality Outcome Framework (QOF) prevalence for conditions classified as CVD for Barnet, NCL and England is summarised in Table 5, for all ages. These values rely on GP patient record data, so would not account for the population with these conditions in the community who are not diagnosed and are not in contact with healthcare providers. The prevalence looks at all ages, however most patients would develop these conditions later in life. Although the prevalence of conditions related to CVD in Barnet is lower than the England average, they are all higher than the NCL average.

Heart failure made up 1210 admissions for people aged 50+ in Barnet for 2022/23 (Figure 30). The CMO's 2023 annual report highlighted the importance of early diagnosis of heart failure; 80% of cases are diagnosed in hospital despite 40% of these individuals experiencing symptoms which should have triggered earlier diagnosis<sup>4</sup>. Early detection will ensure optimal medical and lifestyle management for someone with heart failure, contributing to increased quality of life. Actions to support early diagnosis in the community could include supporting healthcare providers, and health education campaigns for people already living with CVD.

QOF Prevalence of CVD for all ages 2021/22, split by condition			
	Barnet	NCL	England
Hypertension	11.40%	10.39%	14.00%
CHD	2.40%	1.82%	3.00%
Stroke	1.30%	1.06%	1.80%
Atrial Fibrillation	2.10%	1.13%	2.60%

Table 5 QOF prevalence for CVD in Barnet, NCL and England for 2021/22

### Cardiovascular Disease Prevention Programme and Action Plan

LBB Public Health have developed a 4-year CVD prevention programme and 2-year action plan in collaboration with local partners, community groups and clinicians. 4 priority areas were identified which include: population awareness and activation, behavioural risk factor detection and management, clinical risk factor detection and optional treatment and self-care and sustainability. The aims are to reduce prevalence of CVD, improve risk factors management and reduce overall premature mortality and inequalities in outcomes. More information, with links to the full prevention programme and action plan can be found here: [Cardiovascular Disease \(CVD\) Prevention Programme and Action Plan | Barnet Council](#).

### NHS Health Checks

The NHS Health Check<sup>62</sup> is a national risk assessment and prevention programme which aims to reduce risk of CVD. The programme sends an invitation to people aged 40 to 74, who do not have existing CVD, and who are not currently being treated for CVD risk factors. It aims to offer everyone in the target group health checks every 5 years. The assessment addresses the main risk factors for CVD: smoking, lack of physical activity, high alcohol intake and unhealthy diet. The assessment includes a blood pressure test, cholesterol level and blood sugar level. The service then offers lifestyle advice and appropriate referral for help via behaviour change programmes and other interventions, such as medical intervention through treatment of conditions if identified.

The percentage of people who were offered an NHS Health Check from the eligible population, and detail on the proportion who then received one in the financial year is available for Barnet. This value varies between local authorities due to differences in how GPs are incentivised to perform health checks, and how this information is recorded.

For Barnet, the proportion of the eligible population offered a health check in 2022/23 was 15.5%, which is low compared to 22.0% in London and 18.4% in England. However, the total population estimates for the eligible population are based on Census 2011 predictions. Additionally, the health Check programme, as it is offered to an individual every 5 years, aim to cover 20% of the eligible population. Of those invited, 47.9% of people in Barnet took up the offer for an NHS health check in 2022/23, compared to 45.6% in London and 38.9% in England<sup>63</sup>.

<sup>62</sup> NHS. 'NHS Health Check' NHS, Department of Health, 26th November 2019. (Online) Available from: [www.nhs.uk/conditions/nhs-health-check/](http://www.nhs.uk/conditions/nhs-health-check/). Accessed: 15<sup>th</sup> November 2023.

<sup>63</sup> OHID (2022) NHS Health Check (Online) Available from: [NHS Health Check - OHID \(phe.org.uk\)](https://phe.org.uk/nhs-health-check/) (Accessed: 17<sup>th</sup> November 2023)

Although Barnet invites a greater number of people for the health checks compared to London, it is lower than the England average. Additionally, for 2022/23, less than half of the health check invites were taken up. Further work needs to be done into understanding the response to invites and how they vary according to deprivation, geographical areas and gender and ethnicity. Nationally, a review from 2021 has shown that the NHS Health Check Programme has engaged individuals from more deprived non-White ethnic groups, there is further work to be done to ensure that across all ethnic groups and those in the most deprived areas engage with the programme<sup>64</sup>.

### **Community Health Screening**

Complementary community health screening is also offered within Barnet via GPDQ Ltd.<sup>65</sup> It aims to provide health screening within local communities to support underserved population groups. The service is similar to the provision in NHS Health Checks, but it is not linked to primary care and the screening is not counted as NHS Health Checks. Data is available from the providers for its first year (April 2022-2023), small counts  $\leq 10$  have been suppressed for this data<sup>66</sup>. Following the health screening, attendees are signposted onto different services, depending on results, summarised in Figure 31.

In this period, 48 community health screening events were run, reaching 976 people in total (59.32% females and 40.68% males). A breakdown of attendees is also available by ethnicity (Figure 32). The top ward attendees were from Colindale, High Barnet, Mill Hill and East Barnet (Figure 33). Colindale and High Barnet were also identified as areas of high deprivation, however attendees from Cricklewood (another area of high deprivation) had one of the lowest uptakes.

Whilst NHS Health Checks and Community Health screening are aimed at identifying (and then reducing) cardiovascular disease risk factors, opportunistic signposting and advice may be given for other reasons, for example sexual health, substance misuse or accessing healthcare services, resulting in improved health outcomes in different areas. This data should be compared to the uptake of NHS Health Checks in Barnet across demographic data, to review if the service provided does reach underserved population groups, particularly where there is intersectionality. There should also be consideration of where the events take place, and if they are in locations to offer the service to under-served populations in Barnet.

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<sup>64</sup> OHID (2021). *Annex B: Summary of Analyses and Evidence on the Current NHS Health Check Programme*. (Online) NHS Health Check Programme Review. Available at: <https://www.gov.uk/government/publications/nhs-health-check-programme-review>. Accessed 17 November 2023

<sup>65</sup> Community Health Screenings (Online). GPDQ, 2023. Available from: <https://www.gpdq.co.uk/community-health-screenings/>. Accessed 15<sup>th</sup> November 2023

<sup>66</sup> Community Health Screening (2023), *London Borough of Barnet, Dataset from 1 April 2022 – 20<sup>th</sup> April 2023*. GPDQ



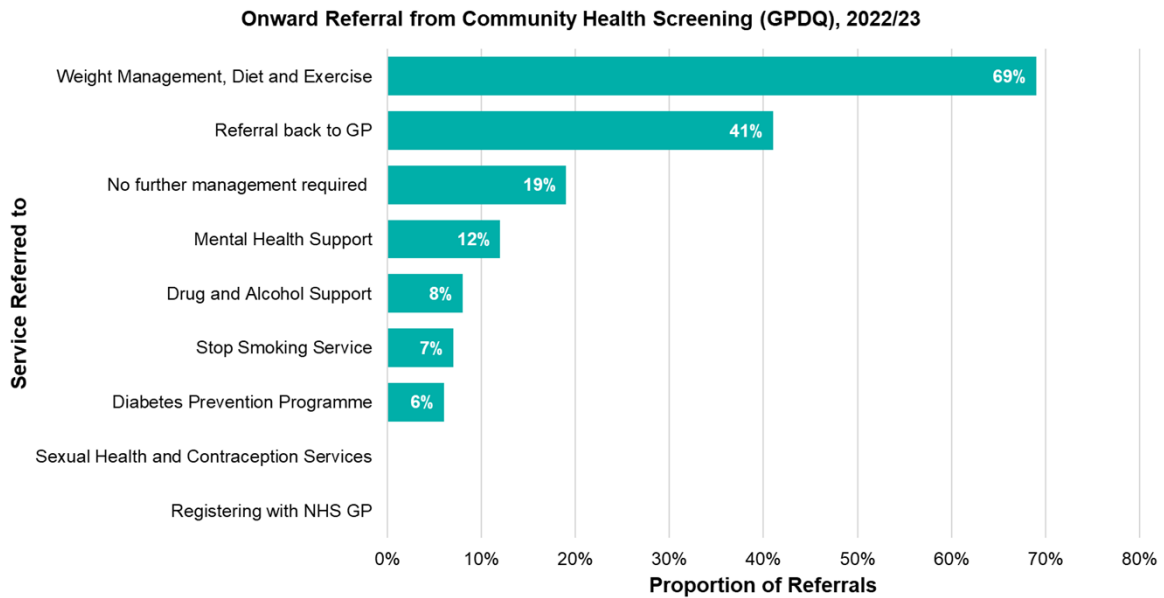


Figure 33 Onward referrals for attendees following GPDQ community health screening, split by service signposted to. Note some attendees would be signposted to multiple services.

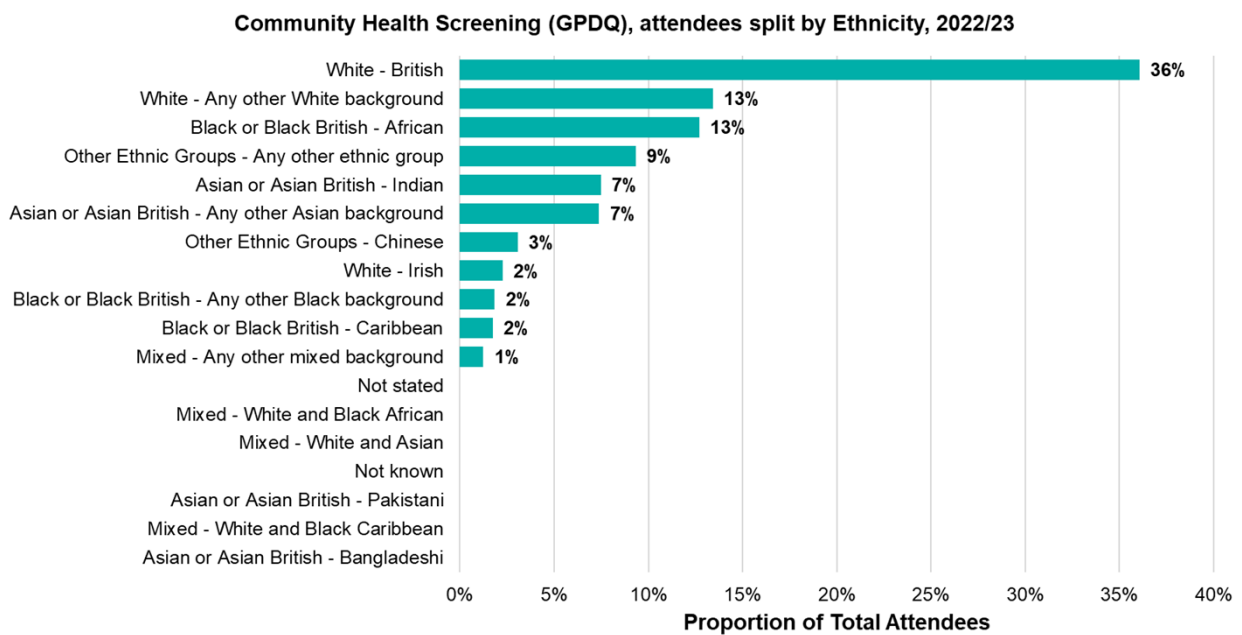


Figure 34 Attendees for GPDQ health screening, split by ethnicity for 2022/23

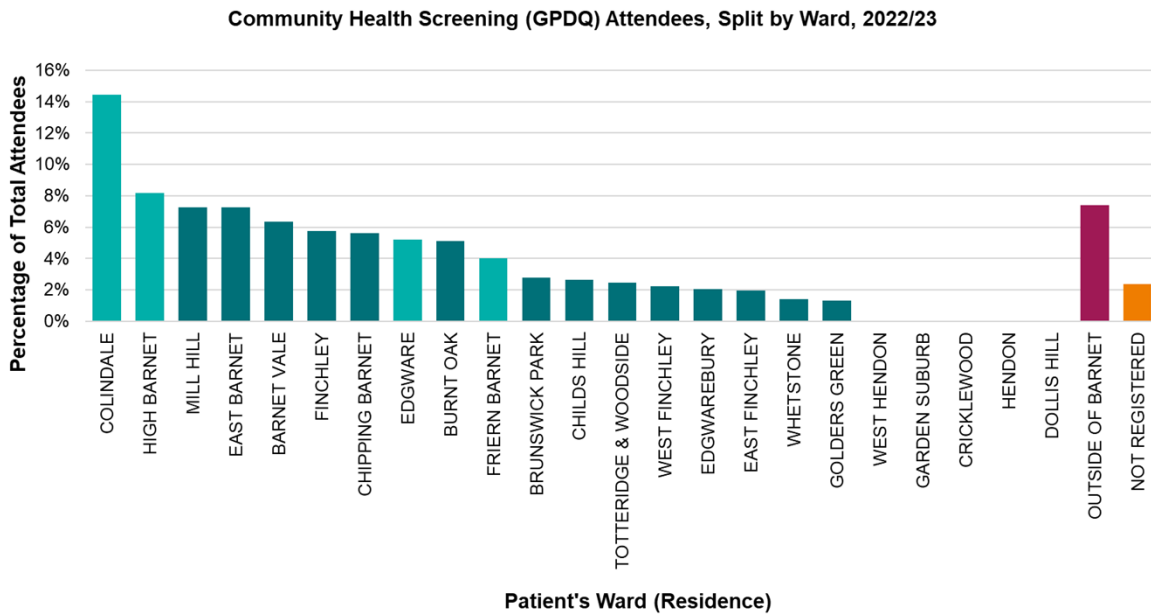


Figure 35 Attendees per ward for GPDQ screening. Highlighted in lighter shades of green were target areas of high deprivation.

## 8.2 Diabetes and the National Diabetes Prevention Programme

### Diabetes Mellitus (DM)

Diabetes is included in the Major Conditions Strategic Framework under CVD, as the two are closely linked. Diabetes overlaps with both CVD specifically and multimorbidity generally: a person with diabetes is twice as likely to have heart disease or a stroke than someone who does not, and at a younger age<sup>9</sup>. Additionally, when not identified or treated appropriately, can lead to multiple complications. One of these is diabetic kidney disease (diabetic nephropathy). Around 40% of people with diabetes could develop diabetic nephropathy and it is the leading cause of kidney failure in the UK with 1/5 people starting dialysis in the UK having the condition<sup>67</sup>. Diabetes is also the leading cause of preventable sight loss in people of working age, and it is estimated the NHS spends 10% of its budget on diabetes<sup>68</sup>. Both Type 1 and Type 2 DM result in high levels of sugar (glucose) in the blood stream. However, there are difference in the onset and mechanism of disease. Type 1 DM affects 8% of people living with DM and usually diagnosed in childhood and is a result of the body not being able to produce insulin (a hormone which helps reduce circulating blood glucose levels). Type 2 DM affects 90% of people living with DM and is linked to the same risk factors as CVD, as well as ethnicity, obesity, and inequalities in socioeconomic status and geography<sup>68</sup>.

<sup>67</sup> Kidney Research UK (2023). *Diabetes*. (Online) Kidney Research UK. Available at: <https://www.kidneyresearchuk.org/conditions-symptoms/diabetes/> (Accessed 13<sup>th</sup> December 2023)

<sup>68</sup> Hex, N., Bartlett, C., Wright, D., Taylor, M. and Varley, D. (2012). Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. *Diabetic Medicine*, (Online) 29(7), pp.855–862. DOI: <https://doi.org/10.1111/j.1464-5491.2012.03698.x>

In Barnet, there has been an increasing trend in prevalence of DM, with 6.7% adults aged 17+ having a diagnosis of DM (either Type 1 or Type 2)<sup>69</sup>. Diabetes prevalence is 3 to 5 times higher in ethnic minority groups compared to the white British population<sup>68</sup>, which is important to consider with Barnet’s more diverse population.

### NHS Diabetes Prevention Programme (NDPP)<sup>70</sup>

The NDPP, or the ‘Healthier You’ programme, identifies people at risk of developing Type 2 DM and refers them to a 9-month evidence-based lifestyle change programme. The service is available face-to-face and digitally and is free at the point of access.

In Barnet, data is available on the number of referrals and split by gender, IMD deprivation quintile, ethnicity, and percentage of service users achieving milestone 1 (split by PCN; milestone 1 refers to where a service user has attended initial assessment and the 1<sup>st</sup> group session) for the financial year period 2019/20 to 2022/23<sup>71</sup>.

In total, 7450 referrals were received with 4320 referrals for females (57%) and 3220 referrals for males (43%). Referral split by deprivation quintile are shown in Figure 34, compared to the Barnet proportions. Most referrals were made for people living in the 2<sup>nd</sup> least deprived quintile (IMD 4), and the fewest from those in the most deprived quintile (IMD 1). When compared to the IMD quintile split of the Barnet population, there was a similar split seen between quintiles. However, this may not account for the relatively higher need for referrals for people from more deprived areas (due to their higher risk).

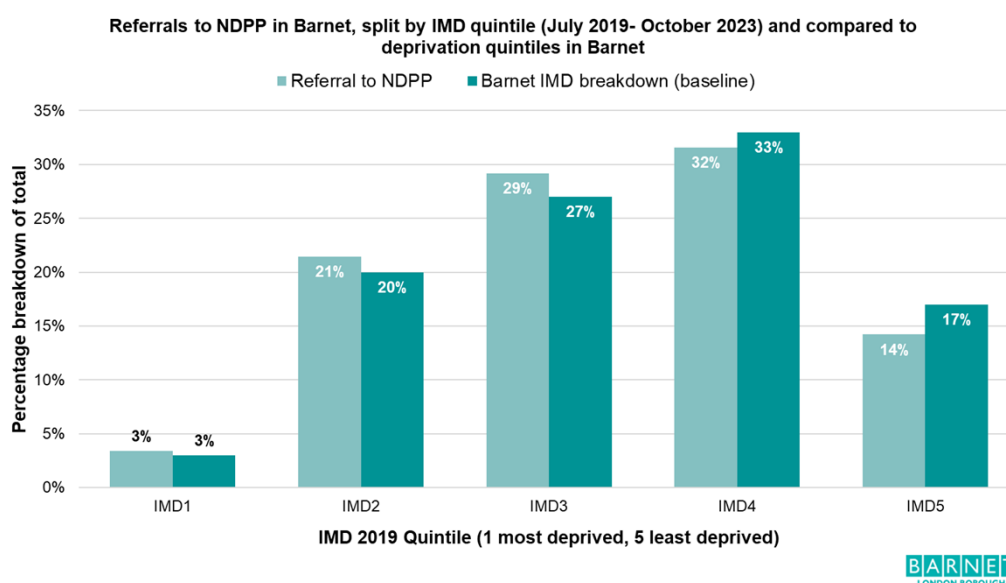


Figure 36 Proportion of referrals to NDPP, split by IMD quintile, where IMD 1 is the most deprived and IMD 5 is the least deprived. Percentages are compared to the IMD quintiles in Barnet.

<sup>69</sup> OHID (2023) Reverse or Live Well with a Long-term Condition, *Productive Healthy Ageing Profile*. (Online). Available from: [Productive Healthy Ageing Profile - OHID \(phe.org.uk\)](https://www.phe.org.uk) (Accessed 17<sup>th</sup> November 2023)

<sup>70</sup> NHS England (2023). *NHS Diabetes Prevention Programme (NHS DPP)*. (Online) NHS England. Available at: <https://www.england.nhs.uk/diabetes/diabetes-prevention/> (Accessed 17 Nov. 2023)

<sup>71</sup> NDPP Dashboard (2023)

Of those referred onto the NDPP who attend the initial assessment, less than 50% reach the first milestone of the programme across all PCNs (Figure 37). Further work into understanding potential reasons for this is needed, exploring the referral process and information given to patients prior, accessibility of the programme (especially in relation to the use of technology and location of sessions) and whether advice given is culturally and age appropriate.

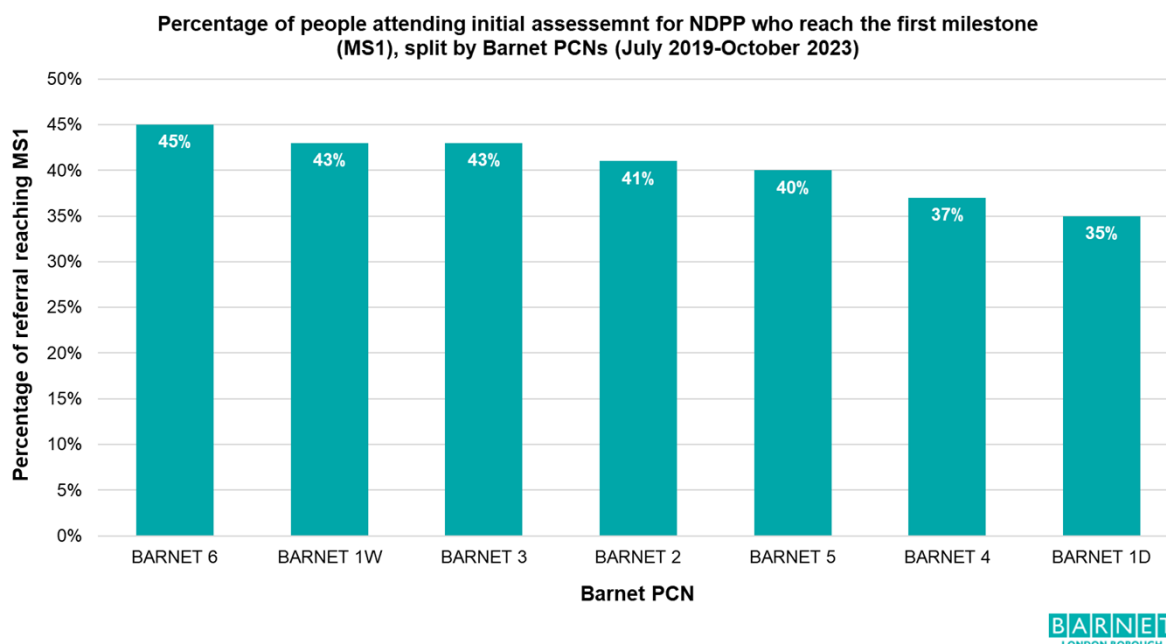


Figure 37 Graph demonstrating the percentage of patients referred to the NDPP in Barnet who attended initial assessment and then achieve milestone 1 (MS1); Service user has attended Initial Assessment and 1st group session). Data is split by PCN for referral from July 2019 – October 2023.

### Diabetic Eye Screening

Complications of Type 1 and Type 2 DM include diabetic retinopathy (diabetic eye disease). The aim is to identify complications early and treat this to reduce sight loss. Data is available for London and England on the proportion of those who are offered routine screening, who attend and complete a screening event where images of the retina are captured (aged 12+). For 2021/22, the value was 78.5% for London and 78.4 for England (statistically similar). Given the impact of significant visual impairment in older age this is an important programme to monitor at a local level<sup>4</sup>. The needs of people living with sensory impairment in Barnet is explored in more detail in Section 10.3.

## 8.3 Chronic Respiratory Disease

Chronic Respiratory Disease (CRD) affects 1 in 5 people of all ages in the UK. It also affects people from more deprived areas within England, with high avoidable mortality rates in females and males seen<sup>9</sup>. Respiratory disease was the 6<sup>th</sup> most common cause of preventable mortality across NCL between 2016-2020<sup>32</sup>. Reducing the risks of CRD can be through behavioural risks; smoking is closely related to chronic obstructive pulmonary disease (COPD) and obesity is attributable to 30% of asthma in the UK<sup>9</sup>.

In Barnet, the QOF prevalence of COPD was 1% in 2021/22, which was significantly lower than the England average (1.9%). In those aged 35+, Barnet had the lowest emergency admission rate to hospitals for COPD in London boroughs in 2019/20 (where values for City of London are combined

with Hackney due to small count). This equated 190 patients per 100,000 of people in Barnet<sup>72</sup>. Data is not available for the same period for smaller areas within Barnet, so there may be variation between wards or PCNs within Barnet where values may be significantly higher. It is important to consider factors such as the environment and deprivation, and how these differ across Barnet and will affect the burden of respiratory disease.

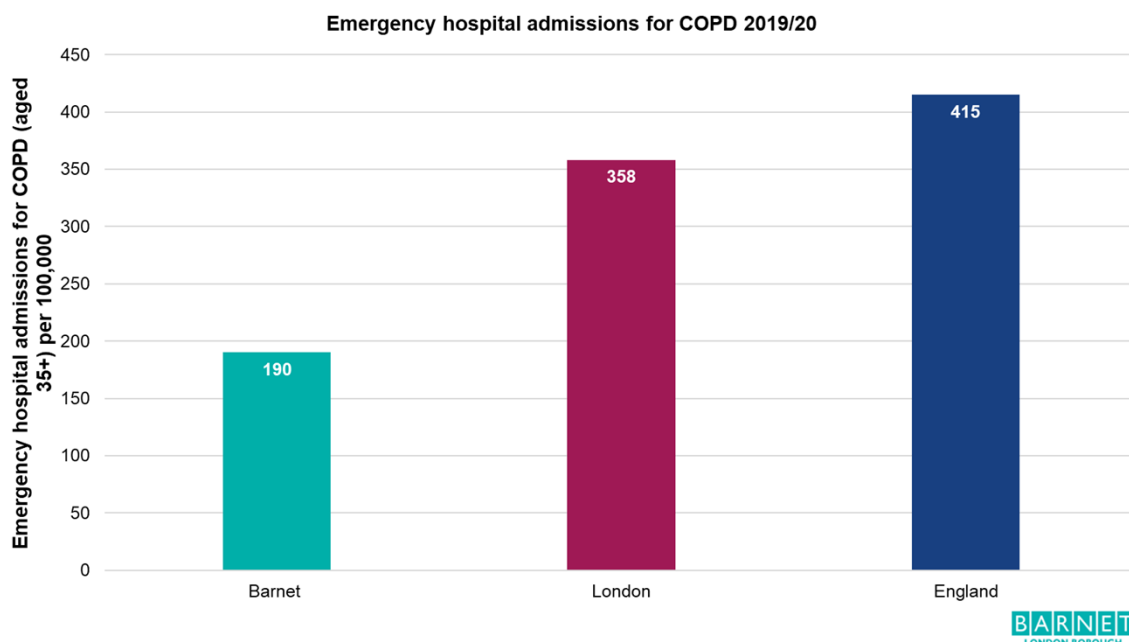


Figure 38 Comparison of rates of emergency hospital admissions for COPD for patients aged 35+ in Barnet, London, and England (2019/20).

Respiratory infections comprised a high number of admissions for patients from Barnet (Figure 30). We can mitigate the risk of some of these infections through vaccination programmes (Section 7.1). Other recommendations from the CMO Annual Report included consideration around national efforts to reduce antimicrobial resistance and recognition of the health protection challenges in health and care setting, where the risk of infection, air pollution, damp and mould and ventilation intersect<sup>4</sup>. Environmental considerations for health outcomes are explored in Section 9.3.

## 8.4 Mental Ill-health

### Common Mental Disorders

The prevalence of mental health conditions is significantly higher in specific groups of older people, such as those living in care homes, older carers (explored further in Section 8.8), those experiencing a transition in life (for example bereavement) or people with multimorbidity<sup>73</sup>.

Mental health symptoms in older people are far less likely to be detected or treated than in younger age groups. Additionally, older adults face barriers to accessing mental health services. There are

<sup>72</sup> OHID (2022), Reverse or Live Well with a Long-Term Condition, *Productive Healthy Ageing Profile*. (Online) Available from: [Public health profiles - OHID \(phe.org.uk\)](https://publichealthprofiles.org.uk) (Accessed 17<sup>th</sup> November 2023).

<sup>73</sup> Age UK (2019). *Mental Health*, Policy Position Paper. (Online). Available at: [ppp\\_mental\\_health\\_england.pdf \(ageuk.org.uk\)](https://ageuk.org.uk/ppp_mental_health_england.pdf) (Accessed 19<sup>th</sup> November 2023)

many reasons for this, including perceiving poor mental health as an inevitable part of ageing, fear of being a burden, and stigma around mental ill health.<sup>74,75</sup>

Common mental disorders include depression and anxiety, which was predicted to affect 16.2% people aged 17+ and 9.8% people aged 65+ in Barnet in 2017<sup>76</sup>. This data is from 2014 survey data, excluding those who were living in institutional settings (who experience higher rates of mental ill health) and using population estimates from this period. Therefore, this prevalence data is likely to be an underestimate.

More recent QOF prevalence of depression was 9.0% in adults aged 18+<sup>77</sup> in Barnet in 2021/22. This was lower than the England average of 12.7% and has shown an increasing prevalence since 2013/14 (Figure 39). This data is reliant on GP patient records and may be an underestimate where people are less likely to present to healthcare services for mental health concerns. Recent data is not available for anxiety prevalence.

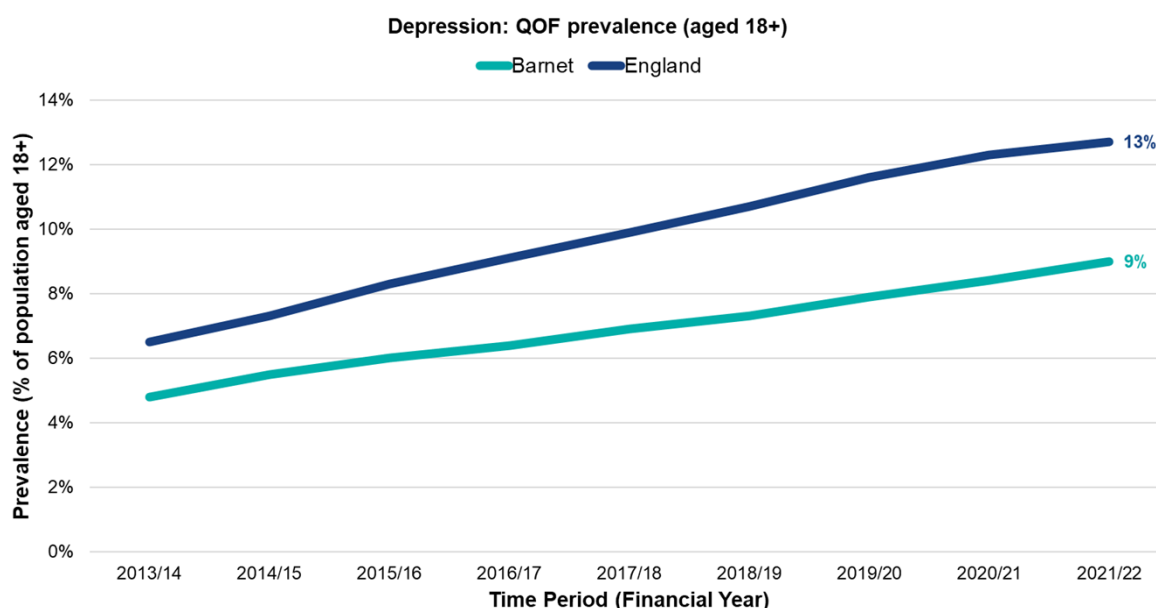


Figure 39 Depression: QOF prevalence for Barnet and England, 2013/14 to 2021/22

The Mental Health Foundation and Independent Age produced a report in 2021, recognising of the mental health needs of older adults, including around loneliness and isolation during the COVID-19 pandemic. It provides recommendations to help address these barriers and inequalities faced in mental health support<sup>78</sup>. Loneliness and Isolation are explored further in Section 9.2.

<sup>74</sup> Public Health England (2018). *Health matters: reducing health inequalities in mental illness*. (Online) Public Health England. Available at: [Health matters: reducing health inequalities in mental illness - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/684842/Health_matters_reducing_health_inequalities_in_mental_illness_GOV.UK.pdf) (Accessed 18th November 2023)

<sup>75</sup> Royal College of Psychiatrists (2018). *Suffering in silence: age inequality in older people's mental health care*. (Online) RCPsych. Available at: [college-report-cr221.pdf \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/docs/default-source/press-releases/college-report-cr221.pdf) (Accessed 18th November 2023)

<sup>76</sup> OHID (2022) CMHD pathway, *Common Mental Disorders*. (Online). Available at: <https://fingertips.phe.org.uk/profile/common-mental-disorders/data> (Accessed 19th November 2023)

<sup>77</sup> OHID (2022). Preventing Well, *Dementia*. (Online) Available at: [Dementia Profile - OHID \(phe.org.uk\)](https://www.phe.org.uk/publications/dementia-profile) (Accessed 18th November 2023)

<sup>78</sup> The Mental Health Foundation, Independent Age (2021). *The Mental Health Experiences of Older People During the Pandemic*. (Online). Available at: [The Mental Health Experiences of Older People During the Pandemic | Mental Health Foundation](https://www.mentalhealth.org.uk/publications/the-mental-health-experiences-of-older-people-during-the-pandemic) (Accessed 23rd November 2023)

People with a longstanding mental health problem are more likely to smoke, and when compared to the general patient population have a substantially higher risk of obesity, asthma diabetes, COPD and CVD. Severe mental illness (SMI) refers to people with mental ill-health that is so debilitating that it affects their ability to engage in functional and occupational activities<sup>79</sup>. People with SMI experience stark inequalities in their health outcomes, this is explored in more detail in Section 10.4

### **Mental Health Support and Services in Barnet**

Various community services are on offer within Barnet for Mental Health and Wellbeing, this list is not exhaustive but covers areas of support available to residents. When evaluating these services, it is important to consider their reach to Barnet's diverse population, for example across older age, ethnicity, deprivation, and religion. Ensuring services are well-connected and tailored to the local demographic will increase engagement of the service, as well as support in reducing barriers to access services supporting mental health and wellbeing.

North London Mental Health Partnership have community mental health pathways encompassing mental health practitioners in GP, wellbeing pathways and other services. Barnet's Older People's Community Mental health team offer a service to people aged 65+ who present with mental health problems, and younger people with cognitive impairment or dementia. There is collaboration between the mental health trust and voluntary care sector (VCS), including local communities, Inclusion Barnet, Mind (Enfield and Barnet) and meridian wellbeing. Talking therapies which are compliant with NICE IAPT stepped care services are embedded in local VCS BAME organisations. This includes interventions in languages other than English. Further information on the range of services can be found at: [Mental Health Services \(beh-mht.nhs.uk\)](http://beh-mht.nhs.uk)

[The Network](#) is an adult mental health enablement social care service for residents in Barnet. This service provides short-term mental health enablement interventions for people who are experiencing mental health challenges and want to set goals, strategies and acquire skills to move forward independently.

The integrated Barnet Wellbeing Service comprises work within the wellbeing hub, community interventions and clinical support. Through this service, individuals receive an emotional health-check, following onto a personalised plan to help navigate services across Barnet including activities, financial support, mental health support and housing. This service is available to Barnet residents aged 16+, experiencing mild to moderate mental health needs and psychosocial issues. Further information on the range of support can be found at: [Wellbeing | Barnet Wellbeing Service | England](#)

[Age UK Barnet Befriending service](#): this is available to Barnet residents aged 55 and over who are isolated and lonely due to frailty, physical disability, or other circumstances.

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<sup>79</sup> OHID (2018). *Severe mental illness (SMI) and physical health inequalities: briefing*. (Online) GOV.UK. Available at: [Severe mental illness \(SMI\) and physical health inequalities: briefing - GOV.UK \(www.gov.uk\)](http://www.gov.uk) (Accessed 18th November 2023)

## 8.5 Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication<sup>80</sup>. Frail older adults experience an increased risk of adverse outcomes such as falls, fractures, comorbidity, disability, dependency, hospitalisation, need for long-term care and mortality<sup>81</sup>.

Frailty is not the same as multimorbidity, but there is often overlap. It is estimated that around 70% of adults living with frailty have multimorbidity, but less than a fifth of older adults with multimorbidity are living with frailty. There are inequalities in frailty prevalence, with higher rates and earlier onset in areas of deprivation<sup>4</sup>.

### Frailty Prevalence

The prevalence of frailty, split by PCN is available for Barnet for 2022/23 for people aged 65+. This indicator uses the Hospital Frailty Risk Score<sup>82</sup>, applied to inpatient records. A numerical score is calculated, stratifying patients into low, intermediate, or high risk.

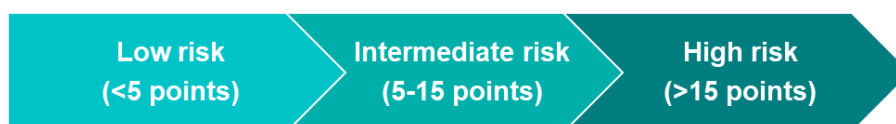


Figure 40 HFRS stratification, adapted from Gilbert T et al<sup>81</sup>

Although this provides a standardised approach to determining if a patient is frail, it does not capture factors such as disease severity, polypharmacy (taking multiple medications) or support required for activities of daily living (ADLs). It will also not capture the people who have frailty living in the community. This means that frailty prevalence may be underestimated. Additionally, it does not account for people who are frail and are under the age of 65. Figure 41 summarises the prevalence of frailty in Barnet in 2022/23, as absolute numbers in PCNs<sup>83</sup>. Anyone who had a HFRS was deemed to have frailty.

<sup>80</sup> British Geriatric Society (2014). *Fit for frailty. Consensus best practice statement for the care of older people living in the community and outpatient settings*. A report by the British Geriatric Society in association with the Royal College of General Practitioners and Age UK. London

<sup>81</sup> Collard et al 2012 *Prevalence of Frailty in Community-Dwelling Older Persons: A Systematic Review*. *J Am Geriatric Soc* 60:1487–1492, 2012

<sup>82</sup> Gilbert, Thomas, et al. *Development and Validation of a Hospital Frailty Risk Score Focusing on Older People in Acute Care Settings Using Electronic Hospital Records: An Observational Study*. *The Lancet*, vol. 391, no. 10132, May 2018, pp. 1775–1782, [https://doi.org/10.1016/s0140-6736\(18\)30668-8](https://doi.org/10.1016/s0140-6736(18)30668-8)

<sup>83</sup> NCL (2023). *Frailty- Barnet*. NCL providers, SUS+ IP. Date of access: 15<sup>th</sup> September 2023.



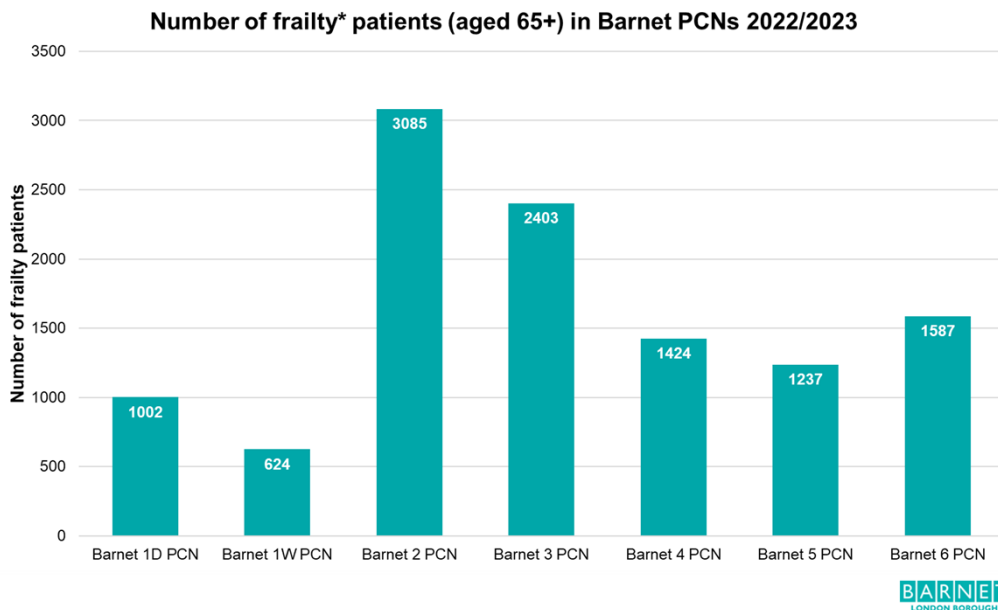


Figure 41 Number of frailty patients in Barnet in 2022/23. \*Where a patient has a HFRS score, they are determined to be frail.

The overall numbers of frail patients over 65 were highest in Barnet PCN 2 –this is also the PCN with the largest population. Understanding the need across PCNs through the number of patients who are frail is important when considering the design of frailty services which are hyperlocal and meet the needs of the population.

### Frailty Multi-Disciplinary Team (MDT)

The frailty MDT focuses on supporting Barnet patients aged 65+ with frailty and provide anticipatory care. It is split into localities across Barnet, with weekly MDT meetings. A specific locally commissioned service (LCS) has been designed to support GPs and PCNs to identify, refer to and participate in meetings.

The aim of the frailty MDT service is to provide a comprehensive borough-wide frailty service with GP practices, community providers, voluntary care sector and communities working collaboratively. This will in turn provide a holistic, proactive, and preventative model to managing frailty.

Core members of the MDT include a frailty clinical lead nurse, frailty nurse, consultant geriatrician, psychiatrist (once a month), GP, physiotherapist, occupational therapist, and an Age UK nurse. Other members include dieticians, speech and language therapists and support workers.

The Barnet Frailty MDT has been put in place to support GP practices and primary care networks in identifying, referring, and participating in Barnet Frailty MDT meetings. The purpose of this is to enable collaborative case discussions with acute and community healthcare professionals to enhance coordinated care of the frail population in Barnet.

## 8.6 Musculoskeletal Health and Falls Prevention

### Musculoskeletal (MSK) Health

MSK conditions affect the bones, joints, muscles and spine and cause significant long-term pain and physical disability. There are multiple risk factors that can heighten someone's susceptibility to MSK problems such as physical inactivity, being overweight or obese, diets deficient in vitamin D or calcium, smoking and genetic predisposition. The effects limit independence and the ability to participate in family, social and working life. It's estimated that only 59.4% of people of working age who have an MSK condition are in work. In 2020, it was the second most common cause of sickness absence (surpassed by absence due to minor illness such as coughs and colds).<sup>84</sup>

Prevention, early detection, and treatment can enable people to live in good health, remain independent and connected to the community. Considerations must also be made to support people with MSK conditions to thrive in work.

Osteoporosis is a condition which weakens bones, making them fragile. This increases the risk of fracture of most bones: hip, wrist, and spine. The prevalence of osteoporosis increases with age, with particularly higher prevalence in females following menopause due to the loss of the protective effects of oestrogen on bone health. Other risk factors include being on certain medications, having a low body mass index (BMI), smoking and not exercising regularly.

In 2022/23, the QOF prevalence of osteoporosis among individuals aged 50+ in Barnet was high (1.1%, equivalent to 1,512 people). Barnet ranks in the highest quintile across England for osteoporosis prevalence. Furthermore, within London Boroughs, Barnet has the second-highest prevalence, following Harrow<sup>85</sup>.

Barnet 4 PCN had the highest prevalence of osteoporosis from all NCL PCNs in 2022/23, it also had the highest prevalence across all NCL PCNs, with Barnet 6 PCN having the third highest prevalence<sup>86</sup>. Prevalence data for osteoporosis highlights the need for primary and secondary prevention across Barnet. In terms of mitigating future needs, factors around health promotion earlier on in the life course should be considered (Section 6.1).

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<sup>84</sup> Public Health England (2019) *Musculoskeletal Health: Applying All Our Health*. GOV.UK. (Online) Available at: [Musculoskeletal health: applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/musculoskeletal-health-applying-all-our-health) (Accessed 21<sup>st</sup> November 2023)

<sup>85</sup> OHID (2022) Enhancing Care and Support, *Productive Healthy Ageing Profile* (Online). Available at: [Productive Healthy Ageing Profile - OHID \(phe.org.uk\)](https://phe.org.uk/producing-healthy-ageing-profile) (Accessed 15<sup>th</sup> September 2023)

<sup>86</sup> OHID (2022) Musculoskeletal Conditions, *National General Practice Profiles* (Online). Available at: [National General Practice Profiles - Data - OHID \(phe.org.uk\)](https://phe.org.uk/national-general-practice-profiles) (Accessed 15<sup>th</sup> September 2023)

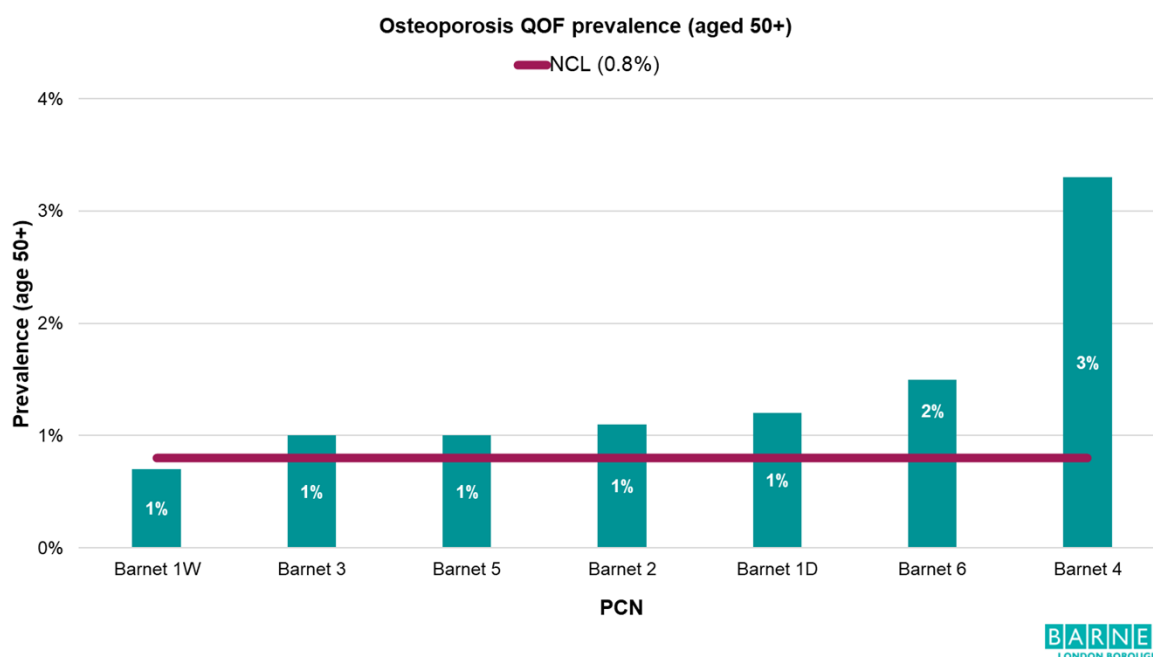


Figure 42 Osteoporosis QOF prevalence for people aged 50+ for Barnet PCNs, compared to NCL value (2021/22).

Other musculoskeletal conditions are not explored in depth in this HNA. However, conditions such as osteoarthritis, back pain, fibromyalgia, and inflammatory conditions such as rheumatoid arthritis are important to consider enabling a population to age well. Many conditions have gradual onset and progression, providing opportunities for early identification and secondary prevention. There should be further work into understanding of the impact of timely referrals and supported self-management in Barnet. Some considerations for delivering change are highlighted in the Major Conditions Strategy<sup>9</sup>.

## Falls and Fractures

Falls and fall-related injuries are a significant challenge to health and care systems and to the older people who suffer them. In addition to fractures, falls may lead to prolonged lies on the floor, with resulting complications. Falls frequently serve as a catalyst for individuals requiring transition into long-term care or requiring additional support at home<sup>87</sup>.

In Barnet, data is available for people presenting to Accident and Emergency (A&E) with a fall. This is split by PCN for the period 2019/20, with predictions to 2023/24 (Figure 43)<sup>88</sup>. This data is collected from patient record data, with primary complaints related to a fall (this means a presentation being recorded as a fall, or other proxy complaints for example a 'broken arm', 'unsteady gait' or 'at risk of injury due to fall'). Because this data is reliant on how well information is coded on systems, the perceived increase in the number of falls could be due to improved coding of falls over time. Additionally, the criteria used to identify falls may overestimate prevalence.

<sup>87</sup> Oliver, D. (2013) *What are the real costs of falls and fractures?* (Online) The King's Fund. Available at: [What are the real costs of falls and fractures? | The King's Fund \(kingsfund.org.uk\)](https://www.kingsfund.org.uk/publications/what-are-the-real-costs-of-falls-and-fractures) (Accessed: 21<sup>st</sup> November 2023)

<sup>88</sup> NCL (2023) *Falls Activity for Barnet Registered Patients*. A&E Data, SUS (Accessed 15<sup>th</sup> September 2023).

Across all PCNs, a reduction in the number of falls presenting to A&E was seen during 2020/21. This could be due to a variety of reasons: a true reduced incidence, due to fewer falls during the COVID-19 pandemic; reduced presentation to A&E due to falls during the pandemic; or from other diagnoses being coded as the primary reason for admission to A&E (for example, COVID-19 infection). A predicted increase is seen for 2023/24 FOT (Forecast over time). Note that these estimates are a straight line forecast from 2023, so would not account for month-to-month differences we usually see across a year. In 2022/23, the highest number of falls per 100 of the GP-registered population was seen in Barnet 3 PCN. This covers the areas such as High Barnet, Underhill, Totteridge, and Finchley.

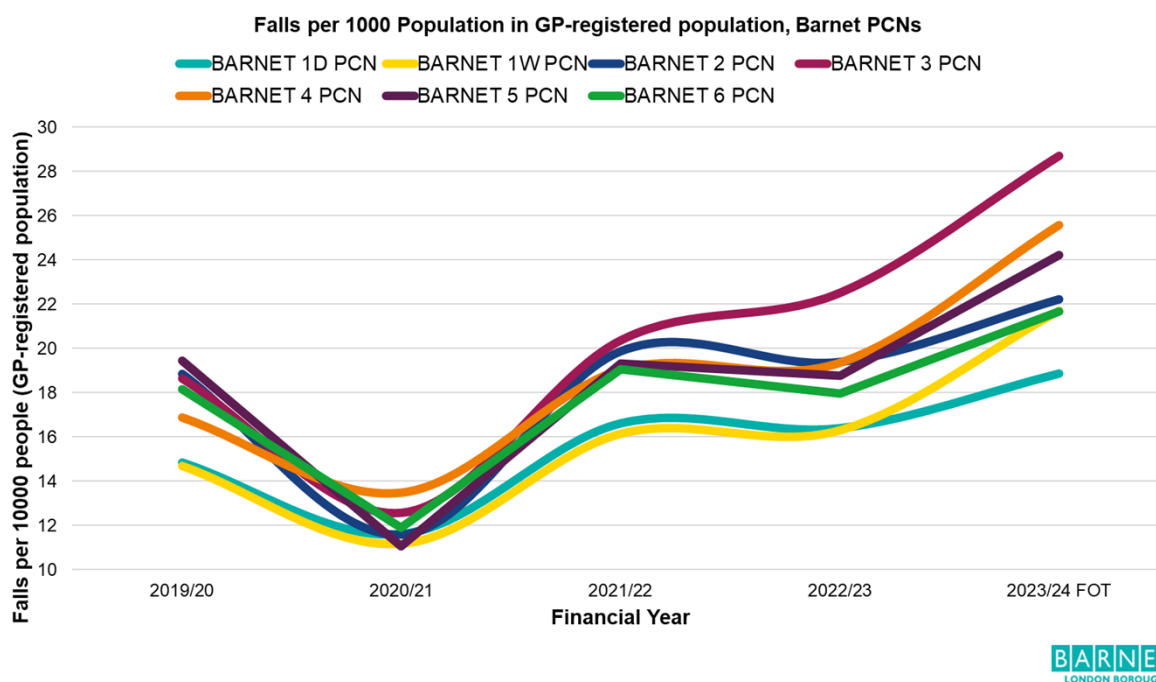


Figure 43 Falls per 1000 of the population in Barnet from 2019/20 to FOT for 2023/24, split by PCN.

Hip fractures, resulting from trauma such as falls, contribute to a significant loss of productive years amongst older adults. Changing modifiable risk factors such as smoking and physical inactivity can help in reducing disability-adjusted life years lost after a hip fracture.

In Barnet, the number of emergency admissions for hip fractures among individuals aged 65 and older was 467 per 100,000 of the population. This rate was notably lower than the national average in England (551/100,000) and comparable to the rate observed in London (493/100,000). However, when breaking down the age groups into 65-79 and 80 and over, it becomes apparent that Barnet has significantly higher rates of admission for hip fractures among individuals aged 80 and over. This pattern is consistent with the age distribution observed in both London and England (Figure 43)<sup>89</sup>.

The higher prevalence of hip fractures in older adults suggest that opportunities for primary prevention should be employed for the ageing population in Barnet. It also points towards a focus on post-operative recovery being accessible to this population group. Secondary prevention is particularly important; ¼ of people with a hip fracture will have another fracture within 5 years, and

<sup>89</sup> OHID (2022) Enhancing Care and Support, *Productive Healthy Ageing Profile* (Online). Available at: [Productive Healthy Ageing Profile - OHID \(phe.org.uk\)](https://www.phe.org.uk) (Accessed 21<sup>st</sup> November 2023)

half of these will occur within 18 months. Therefore, ongoing bone-strengthening treatment is an important consideration for these people. In 2022, national data suggested that only 35% of people received bone protection treatment following a hip fracture<sup>90</sup>.

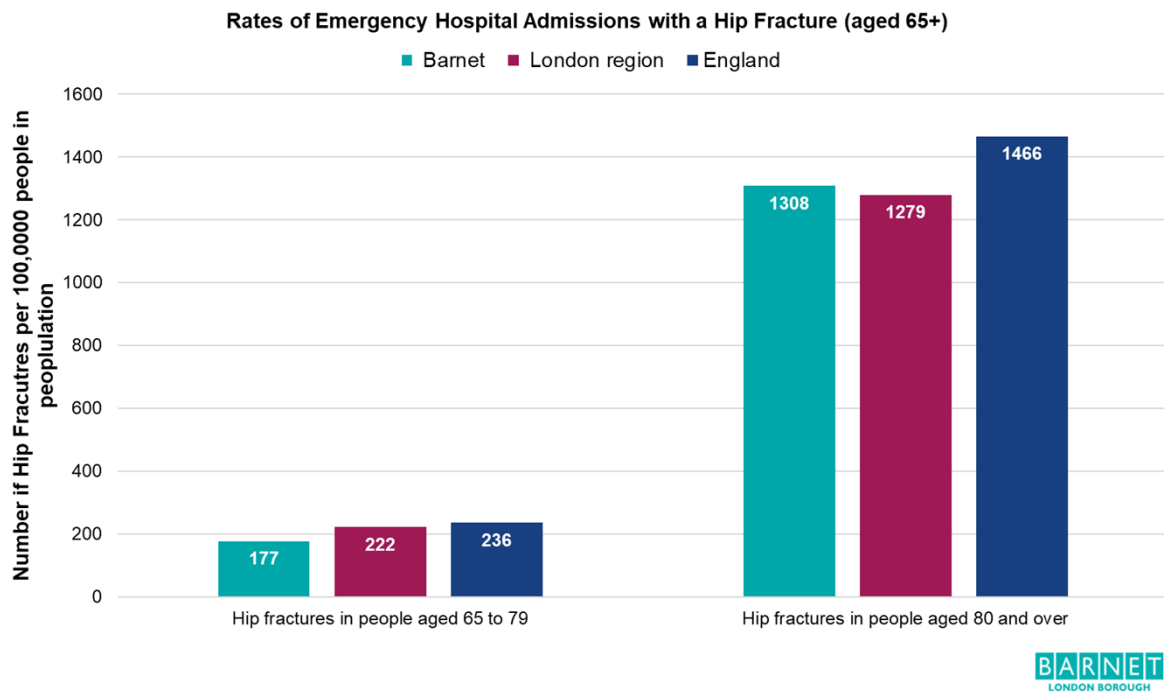


Figure 44 Emergency hospital admissions for fractured neck of femur in persons aged 65+, directly standardised rate per 100,000 for Barnet, London, and England 2021/22

<sup>90</sup> The National Hip Fracture Database (NHFD, 2023), NHFD Annual Report, 2023 (Online). Available at: [NHFD 2023 Annual Report v1a.pdf](#) (Accessed 21<sup>st</sup> November 2023).

## Falls Prevention

The causes of falls can be multifactorial, so prevention requires involvement from different sectors and organisations. There are medical, environmental, behavioural, and human factors, which impact across health and social care, housing and the built environment<sup>4</sup>.

NICE guidelines from 2013 cover assessment of fall risk and interventions to prevent falls in people aged 65 and over<sup>91</sup>. It aims to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality. This guidance is undergoing an update with a publication date to be confirmed. Public Health England (now OHID) also released a consensus statement around falls and fractures, which supported commissioning around prevention, using a whole system approach<sup>92</sup>.

More recently, work was done around the wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults (aged 65+)<sup>93</sup>. It found that inequalities in inactivity persisted during the pandemic, with older people in the most deprived group (from IMD 2019 criteria), more likely to be inactive than those in least deprived groups. As a result of inactivity, modelling predicted that without mitigation, this would result in increased falls. Key recommendations focussed on older adults, who have deconditioned following the COVID-19 pandemic, to increase levels of strength

### Better Balance Falls Prevention Programme - Healthwise

The Better Balance programme is a weekly class where participants attend for 8 weeks. Participants are referred by their GP if criteria are met. The programme uses evidence-based strength and balance exercises from an OTAGO-qualified instructor. The aim is to reduce the risk of fall for people who are mobile with or without walking aids. Although the classes are free, participants need to purchase a subsidised membership to participate in the programme. Further information is available from: [Healthwise Physical Activity Referral | Better UK](#).

Currently, referrals are received in varying numbers across Barnet PCNs. There is a limitation to the number of people who can be on the course at one time and a maintenance programme is not currently on offer.

### Barnet Falls Prevention Service (CLCH – Central London Community Healthcare)

The falls prevention service offers an assessment of a person's risk of falling and support they may need. It is offered to all adults (18+) registered with a GP practice. Following an assessment, individuals are enrolled onto a 12-week programme which is free of charge with information, group sessions for balance, flexibility and stamina and a review of the home to identify environmental hazards. On completion of the programme, participants will be signposted to other groups and activities in the area to maintain wellbeing.

<sup>91</sup> NICE. *Clinical Guideline [CG161], Falls in Older People: Assessing Risk and Prevention*. 12 June 2013 (Online). Available at: [www.nice.org.uk/guidance/cg161](http://www.nice.org.uk/guidance/cg161) (Accessed 21st November 2023)

<sup>92</sup> Public Health England (2017). *Falls and fracture consensus statement Supporting commissioning for prevention*. (Online) GOV.UK. Available at: [Falls and fractures: consensus statement and resources pack - GOV.UK \(www.gov.uk\)](#) (Accessed 21st November 2023)

<sup>93</sup> Public Health England (2021). *Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults*. (Online) Available at: [Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults \(publishing.service.gov.uk\)](#) (Accessed 22<sup>nd</sup> November 2023)

and balance activities to safely resume activities they had engaged in before the pandemic. The benefits extend beyond increased physical activity to social activities, accessing healthcare and work.

Key evidence and areas for focus on falls prevention are explored in the *World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative*<sup>94</sup>. It highlights the need for multidisciplinary management, and how managing risk factors for falls can have wider benefits beyond fall prevention with improved intrinsic capacity, functioning and quality of life.

For primary prevention, exercise interventions had a strong evidence base. This included balance-challenging and functional exercises and progressive resistance strength training. There were conditional recommendations around the use of wearables for falls prevention, and expert recommendation around the use of telehealth or smart home systems in combination with exercise training, primarily due to their scalability in low- and middle-income countries (LMICs).

In addition, there is specific evidence linked to the secondary prevention of falls following a hip fracture. The strength of evidence for tailored exercise in preventing falls in older adults after hip fracture is moderate<sup>95</sup>. Recommendations for this group focus on mobility rehabilitation after hip fracture and include balance training and adequate pain control. The guidelines provide additional recommendations around people with other health conditions (cognitive impairment dementia and Parkinson's disease) and sensory impairment.

It is important that preventative activity is carried out in a way that is meaningful to and appropriate for the people it is designed for. Barnet's diverse ageing population provide additional factors to consider in terms of accessibility. Barnet is also a large borough, so it is crucial to ensure that current provision has adequate capacity and distributed appropriately across the borough. Communication is also important to consider when raising awareness amongst the public, particular with the preference of use of some phrases such as 'staying steady' or 'remaining active' over 'falls'<sup>96</sup>. Proactive falls and fracture prevention will support older adults to remain mobile and connected, and in turn contribute to healthy ageing.

## 8.7 Oral health

Poor oral health can lead to pain and discomfort, loss of function and self-esteem. Experiencing tooth decay or having missing teeth or ill-fitting dentures can lead to an individual becoming socially isolated. Health behaviours such as toothbrushing, diet (specifically consumption of sugar-containing food and drinks), smoking and alcohol have effects on the risk of gum disease, infection, tooth loss and oral cancer<sup>97</sup>. Poor oral health also has an impact on general health including poor diabetic control, pneumonia (especially those who are frail or older and living in community care facilities)

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<sup>94</sup> Montero-Odasso M, van der Velde N, Martin FC and others. *World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative, Age and Ageing* (2022), Volume 51, Issue 9.

<sup>95</sup> Fairhall NJ, Dyer SM, Mak JCS, Diong J, Kwok WS, Sherrington C. Interventions for improving mobility after hip fracture surgery in adults. *Cochrane Database of Systematic Reviews* 2022, Issue 9. Article. No.: CD001704

<sup>96</sup> Age UK (2012). Don't mention the F-Word: advice to practitioners on communicating messages to older people (Online). Available at: [rb 2012 falls prevention dont mention the f word.pdf \(ageuk.org.uk\)](https://www.ageuk.org.uk/resources/older-adults/2012-falls-prevention-dont-mention-the-f-word/) (Accessed 22<sup>nd</sup> November 2023)

<sup>97</sup> Public Health England (2017). *Adult oral health: applying All Our Health*. (Online) GOV.UK. Available at: <https://www.gov.uk/government/publications/adult-oral-health-applying-all-our-health/adult-oral-health-applying-all-our-health>. (Accessed 22<sup>nd</sup> November 2023)

and there has been some reported association with CVD (although there is uncertainty of the mechanism that causes this)<sup>96</sup>.

With an ageing population, oral health needs will change, including factors increasing the risk of dental disease (higher frequency of sugar intake, reduced salivary fluid). Other considerations are the increased levels of disease in older people in nursing or care homes, people living with dementia and barriers to accessing services (for example need for a chaperone if coming from a nursing home, transport, and cost).

Accessibility of dental services is important to consider when looking at health outcomes. Currently NHS dental treatment is free for those aged under 19 in full time education, pregnant women (or have had a baby in the previous year) and those on low-income benefits.

Across NCL, 32.4% adults (18+) were seen by an NHS dentist in the last 24 months in July 2023. NCL is in the lowest quintile nationally, with the average across England being 38.7% and London being 36.4%<sup>98</sup>. For Barnet, the value was 30.4% for the period 2022-2023<sup>99</sup>.

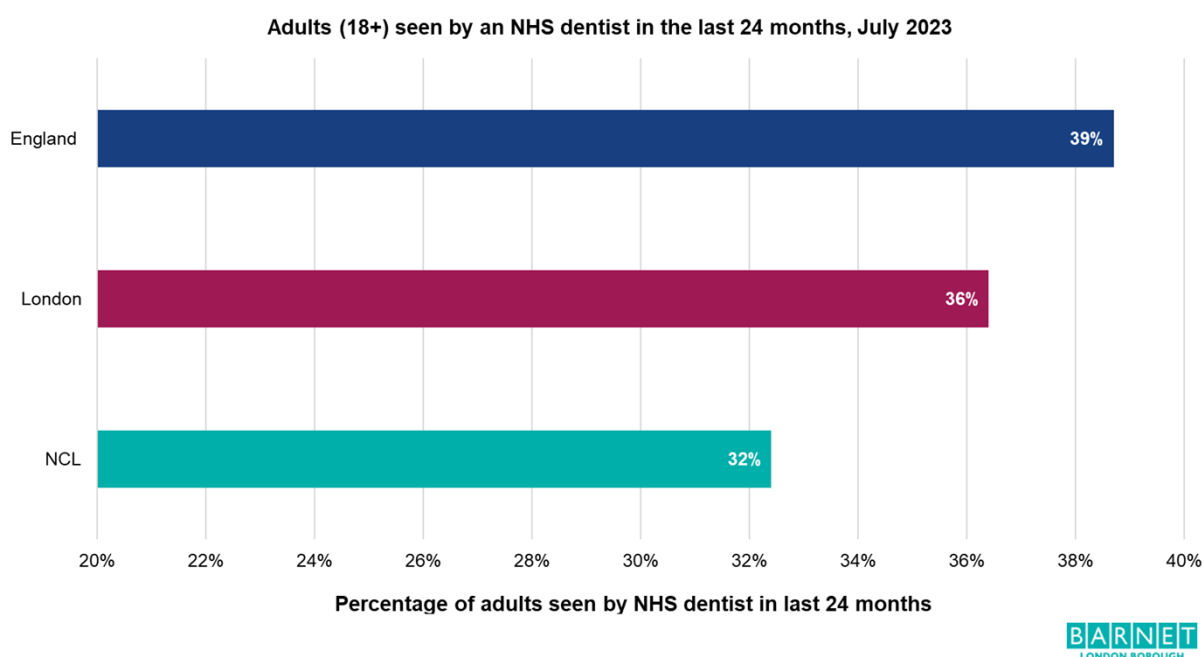


Figure 45 Percentage of Adults (aged 18+) who were seen by an NHS dentist in the last 24 months (NCL ICB, London, England) July 2023. NHS digital.

24 months is the longest interval between oral reviews recommended for adults. Note this data will give insight into most of NHS dentistry, it will not cover separate services commissioned by ICBs or private dental services. Additionally, the data includes patients seen by a dentist who is not necessarily resident in that area.

<sup>98</sup> OHID (2023), Proportion of adults seen by an NHS dentist in last 24 months (18+ yrs), *Dental Services*. Available at: [Dental services - Data - OHID \(phe.org.uk\)](https://phe.org.uk) (Accessed 23<sup>rd</sup> November 2023).

<sup>99</sup> NHS Digital (2023). Annex 2- Geographical breakdown of dental data, *NHS Dental Statistics: 2022-2022* (Online). Available at: [NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital](https://nhs.uk) (Accessed 23<sup>rd</sup> November 2023).



## Inequalities in Oral Health<sup>100</sup>

Nationally, there are inequalities seen in oral health across all stages of life, summarised in a 2021 report from OHID. This is both in prevalence and in the availability and utilisation of dental services across ages, sex, geography, and deprivation. However, the report recognised the paucity of data across many of these characteristics, limiting a full understanding of oral health in England. Data for Barnet is limited across these areas.

For national data, there was clear and consistent data for social gradients in the prevalence of dental decay, tooth loss, oral cancer, and self-rated oral health. This was less pronounced in fluoridated areas. Access to services partly explained social inequalities in dental decay, whilst smoking was an important factor in periodontal (gum) disease.

No conclusions could be drawn from this report around inequalities by ethnic group, religion, and sexual orientation on oral health. Associations between disability and oral health varied by type of disability. Vulnerable population groups including those experiencing homelessness, prisoners, looked after children and migrants have poorer oral health, although data to support this is limited, with conclusions based on studies.

### Opportunities for Ageing Well

Functional oral health supports people to age well, it should also include identified populations who experience poorer health outcomes. For example, for people with frailty and ensuring oral health forms part of a comprehensive assessment where there are concerns around nutrition or identifying how to support people living with dementia to access oral care and support through accessible channels. Local-level data on oral health outcomes will help identify where the needs lie within an ageing population. Guidance is available from NICE on for oral health for local authorities and partners, and specifically on oral health for adults in care homes<sup>101, 102</sup>.

## 8.8 Older adults with social care needs

Social care allows people with additional needs to live independent lives, or where they cannot, they are supported. LBB can provide social care services to those who require it, following an assessment of needs and finances. They can support all or some of the care and support an individual may need. In some situations, social care and support is provided by the NHS, including reablement (care after illness for hospital discharge) or care for complex and serious health conditions<sup>103</sup>. Some people need support throughout their life, whereas others have needs which develop gradually later in life, or suddenly. Social care is closely related to the health outcomes an individual may experience; with people living longer, and with more complex needs and more long-term conditions, the number of people requiring short or long-term social care is expected to rise.

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<sup>100</sup> OHID (2021). *Inequalities in oral health in England*. (Online) GOV.UK. Available at: [Inequalities in oral health in England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97444/inequalities-in-oral-health-in-england-2021.pdf) (Accessed 22<sup>nd</sup> November 2023)

<sup>101</sup> NICE (2014). *Overview | Oral health: local authorities and partners | Guidance | NICE*. (Online) Available at: <https://www.nice.org.uk/guidance/ph55> (Accessed 22<sup>nd</sup> November 2023)

<sup>102</sup> NICE (2016). *Overview | Oral health for adults in care homes | Guidance | NICE*. (Online) Available at: <https://www.nice.org.uk/guidance/ng48> (Accessed 22<sup>nd</sup> November 2023)

<sup>103</sup> NHS (2018). *Introduction to care and support*. (Online) NHS. Available at: [Introduction to care and support - Social care and support guide - NHS \(www.nhs.uk\)](https://www.nhs.uk/publications/introduction-to-care-and-support-social-care-and-support-guide) (Accessed 24<sup>th</sup> November 2023)

A snapshot of social care services used by older adults (aged 65+) from Barnet Council is shown in Figure 46.

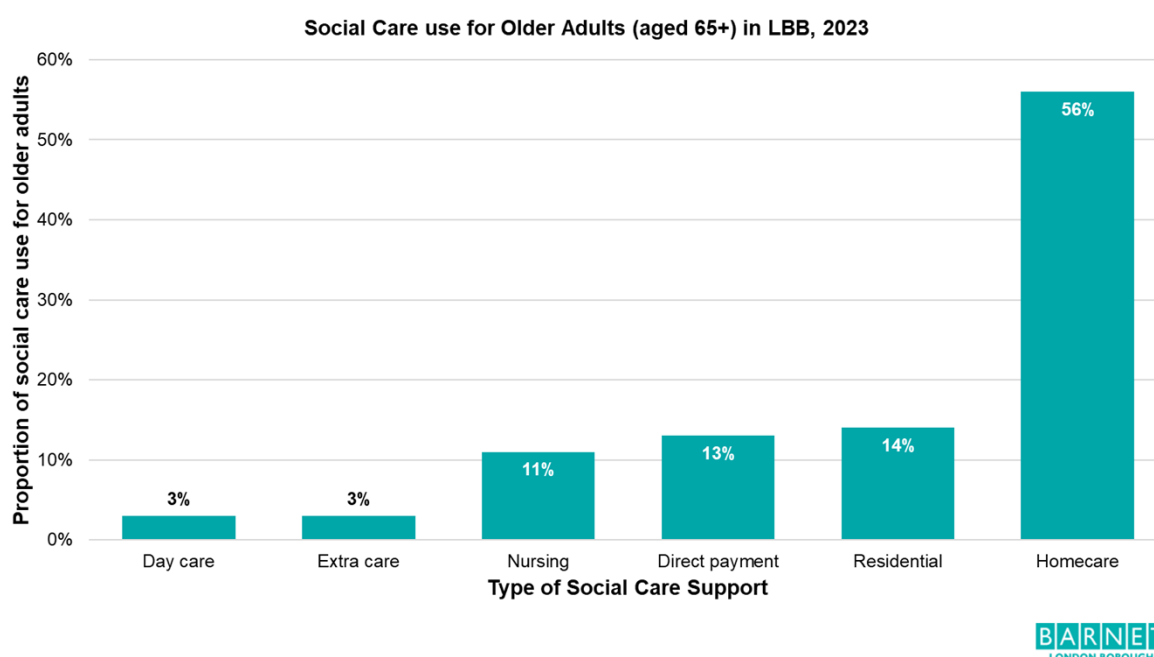


Figure 46 Older People Purchased Services for LBB, 2023. LBB Adult Social Care

### Residential and Nursing Care

Barnet has the largest number of registered care home places for people aged 65+ in North Central London. As of August 2023, there were 21 older adult care homes providing nursing care, or which were dual registered (accepting residents who need both personal and nursing care). This is a total of 1354 beds. 12 of the care homes were solely older adult nursing homes, providing 661 beds. The Dementia Needs Assessment<sup>15</sup> also highlighted data from Dementia UK, that around 69% of people living in older adult care homes have a dementia diagnosis<sup>104</sup>.

Trends from previous years show increasing rates of permanent admissions to residential and nursing care homes in Barnet (Figure 47)<sup>105</sup>. In 2021/22 the rate was 543 admissions per 100,000 of the population aged 65+, which was significantly higher than the rate seen in London, but comparable to the national average. This rate included admissions where Barnet council made any contribution to the costs of care, so includes local authority staffed, independent and registered care home for nursing care. Residents are classified as permanent residents if the care home is regarded as their normal place of residence. People who fund their own residence in a care home, with no support from Barnet council are excluded from this data, so the total rate of admissions are likely to be higher.

<sup>104</sup> Prince, M et al (2014) Dementia UK: Update (Online). Available at: [Dementia UK: Update \(kcl.ac.uk\)](https://www.kcl.ac.uk/dementia-uk/) (Accessed 30th January 2024)

<sup>105</sup> OHID (2023) Enhanced Care and Support, *Productive Healthy Ageing Profile*. (Online) Available at: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk/productive-healthy-ageing-profile-data). (Accessed 25<sup>th</sup> September 2023)

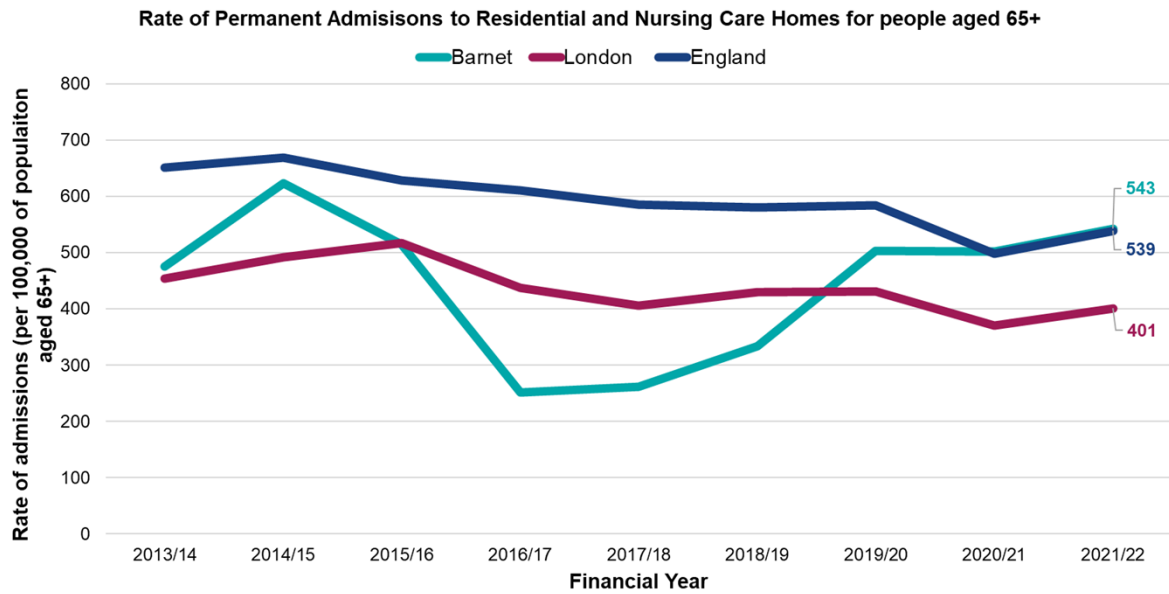


Figure 47 Permanent admissions to residential and nursing care homes per 100,000 aged 65+ for Barnet, London, and England (2013/14-2021/22)

Data from POPPI (Projecting Older People Population Information) provides projections for people in Barnet aged 65+, who will be living in a care home with or without nursing to 2040<sup>106</sup> (Figure 48). There is expected to be an increase in the number of people who will be living in a care home, with the greatest proportion from those aged 85+. These projections use Census 2011 data so would not provide accurate projections from Barnet’s current population and their needs so this could be an under or overestimation of future need. Additionally, projections would not account for other factors affecting the need for residential or nursing care, with changes in public health interventions, demographic changes or other.

<sup>106</sup> POPPI (2023). *Barnet Living Status*. (Online) Oxford Brookes University and Institute of Public Care. Available at: [Projecting Older People Population Information System \(poppi.org.uk\)](https://poppi.org.uk) (Accessed 24<sup>th</sup> November 2023)

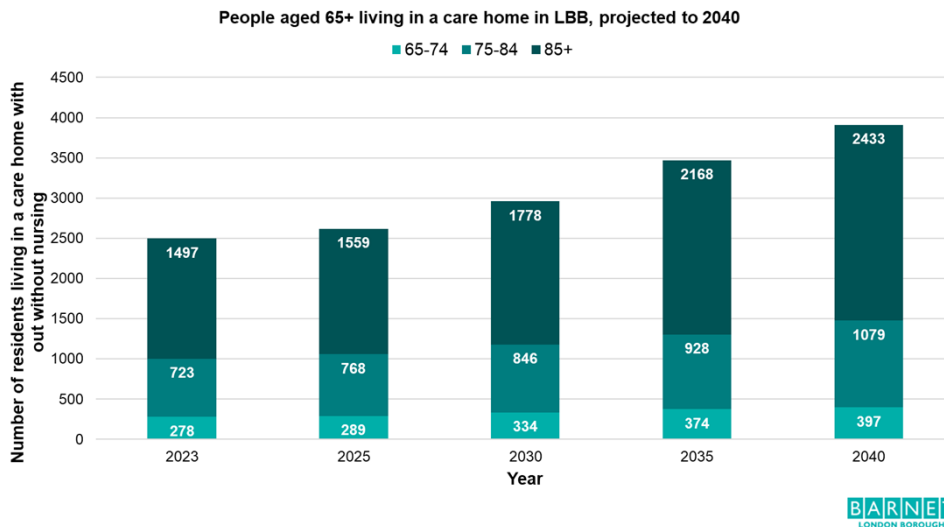


Figure 48 People aged 65 and over living in a care home with or without nursing by local authority / non-local authority, by age, projected to 2040 for Barnet. From POPPI, figures may not sum due to rounding. Crown Copyright 2020

### One Care Home Team (OCHT)

The OCHT supports 68 care homes with 2499 beds across Barnet. They are an MDT including Community Matrons, Geriatricians, Psychiatrists, Occupational Therapist, Rehab Support Worker, Technical Instructor and Trusted Assessors. This model fits within the [Enhanced Health in Care Home model](#), moving towards more proactive care centred on the needs of residents, families and care home staff.

The team also work closely with [Silver Triage](#), across NCL. This enables geriatricians to advise and guide ambulance paramedics in assessing older adults in care homes. They are also able to access and coordinate community services to provide care at home, or within an outpatient clinic if the person does not need to go to A&E.

### Digital Care Home Programme

This is a programme established with NCL ICB, aiming to improve digital maturity of care homes. Primary projects include:

- **Digital social care records (DSCR):** this aims to meet NHSE target for 80% adult social care registered providers to have a DSCR by March 2024.
- **Falls prevention (using acoustic monitoring technology):** this aims to monitor residents via sounds to alert care home staff if a resident is at high risk of falling, enabling proactive care.
- **Data Security protection Toolkit (DSPT):** this will allow use of remote monitoring within information governance rules.
- **Whzan remote monitoring:** the Whzan blue box allow clinicians to remotely view patient observations in care homes, with appropriate escalation pathways. The aim is for early identification of deterioration, and to develop the skills and support wellbeing of staff in care homes. Remote monitoring could also support early discharge and management in the community.

Specific areas for improvement in the current social care provision are described through Barnet’s market position statements<sup>107</sup>. These are around the increasing need to provide more complex care for residents and nursing services. Opportunities to remodel services such as mainstream residential care have been identified, with opportunities to provide a range of services. Additionally, workforce training to provide carers with appropriate skills to manage more complex needs can help in supporting residents as well as reducing hospital admissions.

### Reablement

Reablement refers to short-term support to maintain and improve peoples’ independence. This is typically following discharge from hospital and aims to reduce readmission to hospital or permanent admissions to residential and nursing care homes. This can be through support for personal care, home equipment or emergency personal monitoring.

In 2021/22 6% of people aged 65+ in Barnet were offered reablement services following discharge from hospital (439 people), compared to 4.3% in London, and 2.8% in England<sup>108</sup>. This proportion covers reablement services from adult social care, health services and joint teams.

Of these people, 77.4% were still at home 91 days after discharge from hospital into reablement services in Barnet (Figure 49). This was significantly lower than the proportions seen in London (85.1%) and England (81.8%)<sup>109</sup>. The definition of ‘at home’ included within the individual’s own home, extra care housing or an adult placement scheme setting. However, note the relatively higher proportions of people aged 65+ being offered reablement in Barnet, compared to London and England.

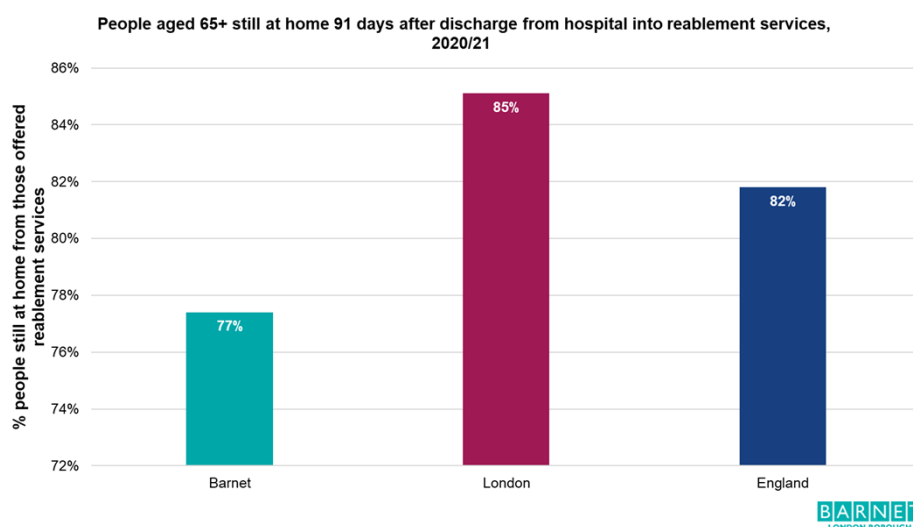


Figure 49 Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services for Barnet, London and England. 2020/21

To support older adults better with reablement services, it is important to consider the accessibility of these services. This spans social, cultural, spiritual or religious need within care and support, with

<sup>107</sup> Barnet Council. (2023). *Market position statement key messages for 2020/2024 – what we need*. (Online) Available at: [Market position statement key messages for 2020/2024 – what we need | Barnet Council](#) (Accessed 24<sup>th</sup> November 2023)

<sup>108</sup> OHID (2023) Enhanced Care and Support, *Productive Healthy Ageing Profile*. (Online) Available at: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](#). (Accessed 24<sup>th</sup> November 2023)

<sup>109</sup> OHID (2023) Enhanced Care and Support, *Productive Healthy Ageing Profile*. (Online) Available at: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](#). (Accessed 24<sup>th</sup> November 2023)

Barnet's diverse older population, as well the training to provide care people with more complex needs.

### Home Care

Domiciliary care refers to care provided within someone's home. Overall, in England, the number of social care establishments has changed over time, with a decrease of around 9% in the number of residential establishments, and an increase of around 47% in non-residential establishments<sup>4</sup>. Residential care establishments refer to care homes with or without nursing (where care and accommodation are provided together). Non-residential establishments refer to services where care is regulated by the care quality commission, but not the housing. For example, care can be delivered within someone's own home (domiciliary care), or purpose-built accommodation where varying amounts of care and support can be offered, and where some services and facilities are shared (extra care), and supported living services. The shift to continue to support people to live longer in their homes is reflected in current national policy<sup>110</sup> and Barnet's Housing Strategy<sup>111</sup>.

Other services commissioned by LBB include extra care developments. There is a dementia-friendly extra care home in Mill Hill, and work is going into two additional extra care schemes in Burnt Oak and Fosters Estate. There are also commissioned sheltered housing schemes and overnight care services available at some of these (sheltered plus).

Assistive care technology and equipment also enable people to live well within their own homes and stay connected with the community. Assistive technology can increase confidence and provide an assurance mechanism for carers, family, or friend that someone is safe. This can be through mechanisms such as fall sensors, monitors to check for gas leaks or prompts for medication. Further information is available from: [Medequip Connect care technology | Barnet Council](#). Whilst there is a wide range on offer, it is important to ensure people can access this support before a crisis point is reached for a more proactive service. This could be through improved communications and exploring potential barriers to requesting this support. Additionally, whilst someone may not be eligible for social care funding, they may not have the financial ability to invest in these services themselves.

### Carers

A Carer is a person over the age of five who provides unpaid care and support to a parent, partner, child, relative, friend, or neighbour who is unable to manage on their own because of a disability or impairment, poor health, frailty, or use of drugs or alcohol. They can have a role in the support of older adults and are often older adults themselves. The State of Caring Report (2022) found that 28% of unpaid carers in the UK were aged 65+, with recipients of care usually being older relatives or partner<sup>112</sup>.

In Barnet, data from Census 2021 found that 1 in 10 of adults aged 65+ were providing some form of unpaid care (Figure 50)<sup>23</sup>. Over half of those providing unpaid care, were providing 20+ hours of care per week.

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<sup>110</sup> GOV.UK (2022). *Build Back Better: Our Plan for Health and Social Care*. (Online). Available at: [Build Back Better: Our Plan for Health and Social Care - GOV.UK \(www.gov.uk\)](#) (Accessed 24<sup>th</sup> November 2023)

<sup>111</sup> Barnet Council, Housing (2019). *Barnet Housing Strategy 2019-2024*. (Online) Available at: [housing\\_strategy\\_final1.pdf \(barnet.gov.uk\)](#) (Accessed 23<sup>rd</sup> November 2023)

<sup>112</sup> Carers UK(2022), *State of Caring 2022 – A snapshot of unpaid care in the UK* (Online) Available from: <https://www.carersuk.org/reports/state-of-caring-2022-report> (Accessed 24<sup>th</sup> November 2023)

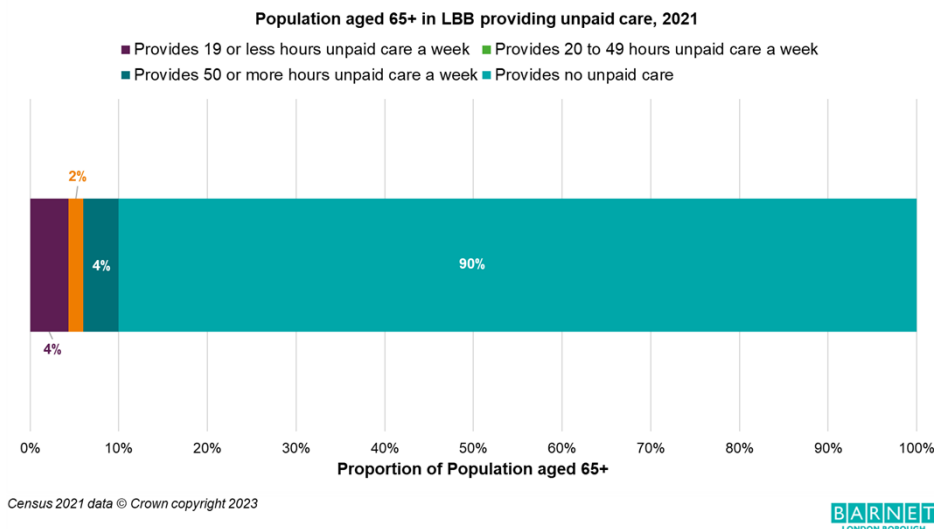


Figure 50 Population aged 65+ in Barnet, split by breakdown of number of hours of unpaid care provided., Census 2021

This data is self-reported, so the proportions of adults providing unpaid care may be higher; people may view their caring responsibilities as part of another role. Carers have the right to a statutory [Carers Assessment](#) under the Care Act 2014. This is a discussion to understand the physical, emotional, and practical impact of caring, and to ensure access to appropriate services. People with caring responsibilities often experience poorer health outcomes, with negative impacts on mental and physical health<sup>113</sup>. Investing in support for informal caregivers, from relief from caregiving tasks or through support groups (for example through the work of [Barnet Carers](#)). Can reduce the negative impacts seen. There should be more work to better understand the effect of caring responsibilities between population groups at a local level, which will allow for more targeted intervention.

In January 2020, NICE published guidelines on supporting adult carers<sup>114</sup>. The guidance aims to help identify people who are caring for someone and give them the right information and support. This should be achieved through carer assessments, practical, emotional, and social support, and training. The NHS long term plan<sup>7</sup> underscores the contribution of carers and the need for more integrated and personalised support.

<sup>113</sup> Bom, J. *et al* (2018). The Impact of Informal Caregiving for Older Adults on the Health of Various Types of Caregivers: A Systematic Review. *The Gerontologist*, 59(5). doi: <https://doi.org/10.1093/geront/gny137>

<sup>114</sup> NICE (2020). Overview | Supporting adult carers | Guidance | NICE. (Online) [www.nice.org.uk](http://www.nice.org.uk). Available at: <https://www.nice.org.uk/guidance/NG150> (Accessed 11th December 2023)

### Barnet Carers and Young Carers Strategy

Barnet council developed [the Barnet Carers and Young Carers Strategy](#), with recognition of the need for support for carers and the diverse group of people who are carers and young carers. Although from Census 2021, 7.9% Barnet's population were carers (28,808 people), the strategy acknowledged that census data is likely to underreport the number of carers due to many viewing their caring responsibilities as part of another role. In production of the strategy, various focus groups were held as well as surveys conducted. These explored views on the strengths and weaknesses in the range of services, support, and resources available to carers and how this allowed them to sustain their own caring roles with having a life of their own. The focus groups also explored where opportunities may lie to improve the quality of life of carers in Barnet. The strategy highlights support available to carers within Barnet, and through the commissioned lead provider (Barnet Carers). Outcomes the strategy aims to achieve include:

- Proactive and early identification of carers and young carers, so they can get support they need and are entitled to.
- Supporting them to fulfil education, training, and employment activities, and being aware of resources available to them.
- Support to access financial information and advice.
- Time for positive and recreational activities, with an aim to improve mental health and wellbeing.

The projected rise in the number of older adults with ill health and disability is expected to place additional pressure on the social care sector and in turn, unpaid and informal carers, families, and communities. To mitigate this, efforts to prevent and delay ill health are crucial in reducing the reliance on long-term social care and will support the broader health and social care system. Strategic planning, backed by data insight, is essential for ensuring effective support for the growing ageing population. Additionally, interventions to improve carers' physical and mental health should be prioritised, with an effort to understand which groups experiencing more negative effects on their wellbeing, and efforts to implement early identification of health needs through primary and secondary prevention measures. Carers should also be supported within their role to access these interventions and engage in protective health behaviours through breaks in their caring roles.

## 9 Wider Determinants of Ageing Well

The WHO Age-Friendly Cities Framework sets out 8 priority themes to ageing well. These are:

1. Information and Advice
2. Transport
3. Respect and Social Isolation
4. Social participation
5. Housing and neighbourhoods
6. Outdoor spaces and buildings
7. Economic activity and civil engagement



## 8. Health and wellbeing

Beyond health and wellbeing, the focus of these themes is across the wider and social determinants of health. These are the diverse range of social, economic, and environmental factors which affect people's mental and physical health.

These wider influences on our health and wellbeing may impact directly, for example poor air quality, or indirectly, for example low quality open space, discouraging physical activity and social interaction.

This section focuses on a few key aspects of the physical and social environment that strongly influence ageing, drawing on the results from engagement work completed by Age UK Barnet who are leading on the Age-Friendly Community Initiative<sup>115, 12</sup>.

## 9.1 Economic Activity

Older people may be more vulnerable to economic fluctuations, which can have a huge impact upon their health and wellbeing. In addition to this, an increase in the older population has implications on the economy in terms of service and pension provision demand. The effect of this impact can be mitigated by people living healthier lives for longer and continuing to be economically active at older ages<sup>116</sup>.

In a period where the state pension age has risen to 66, employment rates among people approaching retirement age have reached their lowest levels since 2016. The proportion of adults in the UK who were of pension age had sharply risen from 2018/19 to 2019/20, with 1 in 5 people living in relative poverty in this group<sup>116</sup>.

There is also evidence demonstrating gender inequalities in financial insecurity in later life<sup>117</sup>. It remains the case that family circumstances affect the life course and working patterns (and therefore workplace-based pensions) for women more than men, for the current generation of people aged over 50.

Experiences of poverty and disadvantage across the life course, including unemployment, low-paid, or insecure work. These accumulate and have a strong influence over people's financial security in later life. The relationship between employment and health are well-documented<sup>118</sup>. Local authorities with lower economic inactivity, or higher employment rates have higher healthy life expectancy<sup>119</sup>.

Data is available from Barnet on the percentage of people ages 50-64 who are in employment. In 2022/23 the value was 70.5% in Barnet compared to 71.4% in London and 71.3% in England. Values were statistically comparable across all three areas. These figures, with a trend from 2016/17 are

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<sup>115</sup> Age UK Barnet (2023). *Age Friendly Barnet*. (Online) Barnet. Available at: [Age Friendly Barnet \(ageuk.org.uk\)](https://ageuk.org.uk) (Accessed 20<sup>th</sup> December 2023)

<sup>116</sup> Centre for Ageing Better (2022). *The State of Ageing 2022 | Centre for Ageing Better*. (Online) ageing-better.org.uk. Available at: [The State of Ageing 2022 | Centre for Ageing Better \(ageing-better.org.uk\)](https://ageing-better.org.uk) (Accessed 4<sup>th</sup> December 2023)

<sup>117</sup> Centre for Ageing Better (2017). *Inequalities in later life: The issue and the implications for policy and practice | Centre for Ageing Better*. (Online) ageing-better.org.uk. Available at: [Inequalities in later life: The issue and the implications for policy and practice | Centre for Ageing Better \(ageing-better.org.uk\)](https://ageing-better.org.uk) (Accessed 4<sup>th</sup> December 2023)

<sup>118</sup> Williams, R. (2018). *How is work good for our health? | The Health Foundation*. (Online) The Health Foundation. Available at: [How is work good for our health? \(Accessed 18<sup>th</sup> December 2023\)](https://www.healthfoundation.org.uk)

<sup>119</sup> The Health Foundation, *Relationship between employment and health* (October 2022). Available from: [Relationship between employment and health - The Health Foundation](https://www.healthfoundation.org.uk) (Accessed 4<sup>th</sup> December 2023).

shown in Figure 51. This percentage is taken from annual population survey data, so may not be representative of the entire Barnet population.

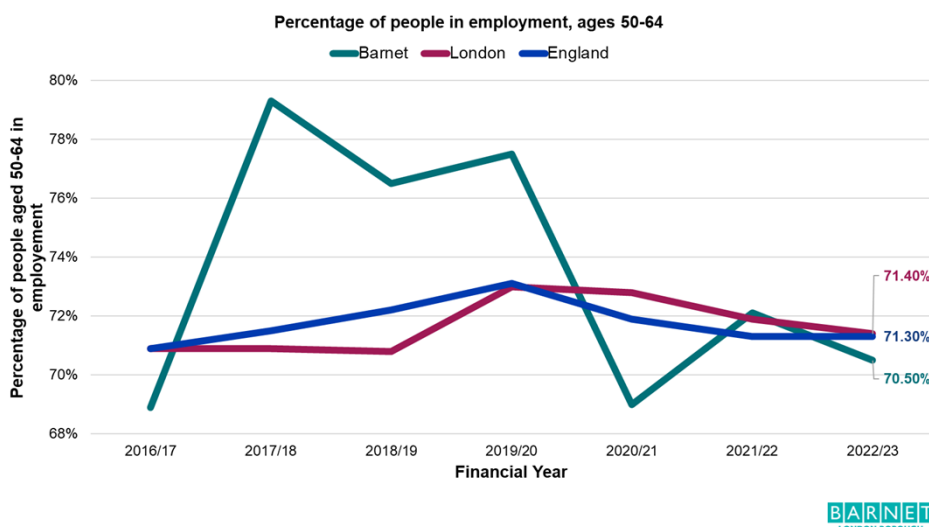


Figure 51 Percentage of people aged 50-64 who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker). Reported for Barnet, London and England

It is important to consider the need for those aged 50 and over to be able to access good quality work, and to be supported in remaining or returning to such work, is a key aspect of ageing well. Figure 49 shows a reduction in the proportion of people in employment in Barnet over 2020/21, which coincides with the COVID-19 pandemic.

This trend was also noted nationally in the Centre for Ageing Better’s State of Ageing Report 2022<sup>116</sup>: older workers were more likely to be made redundant during the pandemic and less likely to be re-employed compared to younger workers. They also report that poor health is the main reason people aged 50-64 are out of work. Having good enough health or being supported in the workplace is key to longer working lives. This is particularly crucial for those experiencing economic deprivation; the proportion of males who are working but for whom their health condition limits their ability to do their job is seven times higher for the poorest compared with the wealthiest<sup>114</sup>. The last state of ageing report (2023) found that those on with higher incomes were more likely to leave paid work earlier by choice, and those on lower incomes were more likely to leave due to health issues<sup>120</sup>. Additionally, those who would like to return to work in their 50s and 60s were often limited by caring responsibilities, lack of flexibility, age discrimination and employment support services which do not meet their needs.

Recommendations from the 2022 and 2023 report include targeted, individualised back to work support for people aged 50+ to address ageism and the barriers faced in employment. Recommendations for employers include addressing people’s health at work, flexible working and encouraging career development at all ages<sup>116</sup>. Other recommendations included increasing the uptake of pension credit, so people are not missing out on benefits to which they are entitled<sup>120</sup>. Supporting residents to engage in financial planning for later life can help identify needs and access support before reaching crisis points. These services should also consider the greater need for input

<sup>120</sup> Centre for Ageing Better (2023) State of Ageing 2023. (Online) Available at: <https://ageing-better.org.uk/summary-state-ageing-2023-4> (Accessed 11th December 2023)

where people are more likely to plan reactively, than proactively for example living in areas of higher deprivation., living in rented accommodation or in some cases poor health<sup>121</sup>.

### Later Life Planning Service

The Later Life Planning Service is a service commissioned by LBB and provided by Age UK Barnet. They cover a range of advice on topics such as social care, home adaptations, legal issues, and support in relation to income advice (for example benefit maximisation and pension advice) and small grant funding. The service is run via telephone advice and aims to support older adults in Barnet to manage and plan across multiple aspects of their life, whilst retaining independence, choice and control.

## 9.2 Social

Social interactions are important for overall health and wellbeing for everyone. As people age, they are more likely to live alone or to find themselves having fewer social interactions. For example, due to retirement taking away workplace interactions.

Social isolation does not always have to mean loneliness and vice versa. Loneliness describes the negative subjective feeling that arises from a discrepancy between the amount of social contact a person has and the amount they desire. Social isolation is a more objective state of having a small social circle resulting in few or infrequent interactions with others<sup>122</sup>.

Social isolation has been linked to an increased risk of both physical and mental health issues including dementia, high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, and cognitive decline. It also influences longevity and quality of life. Social isolation and loneliness have been shown to predict premature mortality and were associated with a 29% and 26% increased risk of mortality respectively<sup>123</sup>. These risks are particularly high for those who find themselves alone unexpectedly, whether due to bereavement, loss of family or friends, retirement or loss of mobility and transportation. Older people with life limiting illnesses and sensory impairments are at increased risk of social isolation and loneliness. There is also evidence to suggested that LGBTQ+ older people are often more isolated<sup>124</sup>.

Data from Census 2021 showed that 22% of Barnet's population aged 50+ lived alone. This is compared to 24% in London and 23% in England. Other factors contributing to the risk of loneliness include being a carer (See Section 8.8).

Age UK produced loneliness heat maps in 2016, using data from the English Longitudinal Study of Ageing (ELSA) survey to obtain and test predictors of loneliness. The results were then applied to Census 2011 data to predict loneliness at small geographical area (LSOA, lower super output area)

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<sup>121</sup> Preston, C. (2018) *Planning and preparing for later life* - Centre for Ageing Better. Available at: [Planning-and-preparing-for-later-life-research-report.pdf \(ageing-better.org.uk\)](https://www.ageing-better.org.uk/planning-and-preparing-for-later-life-research-report.pdf) (Accessed: 18<sup>th</sup> December 2023).

<sup>122</sup> World Health Organisation (2021). *Social isolation and loneliness among older people: advocacy brief*. (Online) [www.who.int](https://www.who.int/publications/i/item/9789240030749). Available at: <https://www.who.int/publications/i/item/9789240030749>. (Accessed 4<sup>th</sup> December 2023)

<sup>123</sup> Rico-Urbe, L.A., *et al* (2018). Association of loneliness with all-cause mortality: A meta-analysis. *PLoS One*, (Online) 13(1), p.e0190033. doi: <https://doi.org/10.1371/journal.pone.0190033>.

<sup>124</sup> Maes, M., *et al* (2019). Gender Differences in Loneliness Across the Lifespan: A Meta-Analysis. *European Journal of Personality*, 33(6), pp.642–654. doi: <https://doi.org/10.1002/per.2220>.

level across England<sup>125</sup>. There are limitations to the validity of the Age UK model: only 6 factors were considered when calculating a risk: health status, marital status, household size, housing ownership, ADLs and multiple eye conditions. Other factors which could contribute to loneliness include ethnicity, income, sex and sexual orientation<sup>126</sup>. Despite these limitations, the risk index could reasonably be used as a starting point to identify areas with high risks of loneliness. The model estimates that the highest risk of loneliness amongst those aged over 65 in Barnet are concentrated in areas towards the west of Borough, and areas towards the North and East of the borough.

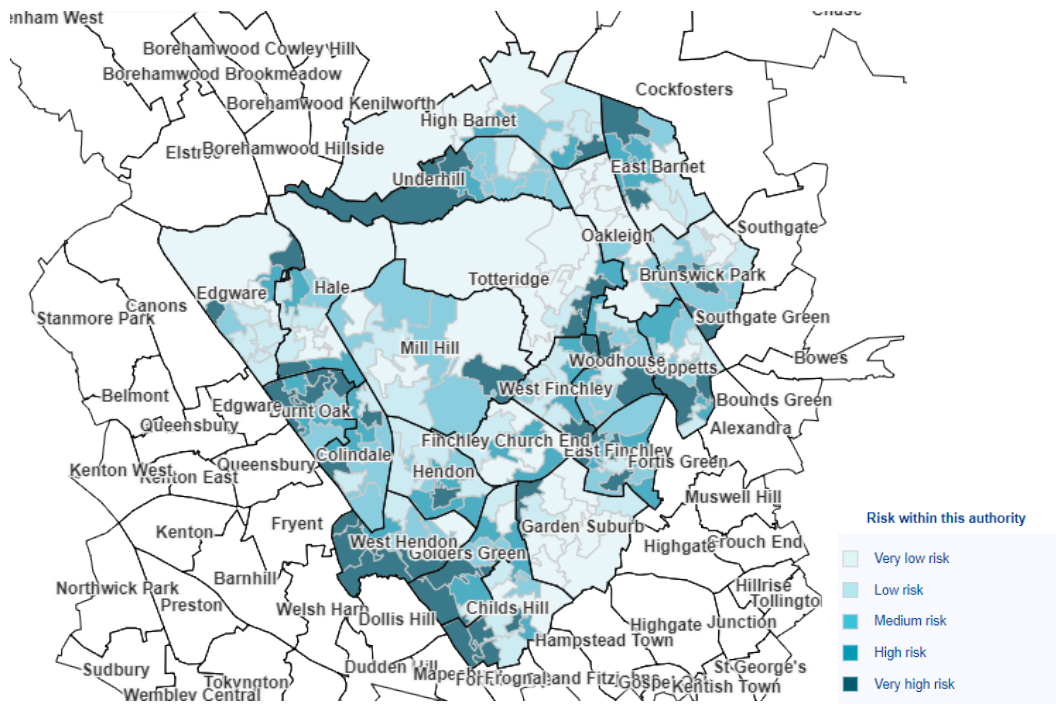


Figure 52 Age UK Risk of Loneliness in England 2016 for people aged 65+ in Barnet. Darker shades indicated higher risk of loneliness.

Existing evidence supports that interventions which promote social interaction, such as volunteering or enhancing community engagement, may improve wellbeing and reduce depression. Services which could signpost clients to other services were also found to be effective to reduce social isolation and loneliness in older people<sup>127</sup>.

<sup>125</sup> Age UK (2016). Barnet Local Authority Loneliness Map. (Online) data.ageuk.org.uk. Available at: <https://data.ageuk.org.uk/loneliness-maps/england-2016/barnet/> (Accessed 4<sup>th</sup> December 2023)

<sup>126</sup> Department for Digital, Culture, Media & Sport (June 2022). *Investigating factors associated with loneliness in adults in England*. (Online) GOV.UK. Available at: [Investigating factors associated with loneliness in adults in England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/research-data-and-analysis/publications/investigating-factors-associated-with-loneliness-in-adults-in-england) (Accessed 18<sup>th</sup> December 2023)

<sup>127</sup> NICE (2015). *Overview | Older people: independence and mental wellbeing | Guidance | NICE*. (Online) Nice.org.uk. Available at: [Overview | Older people: independence and mental wellbeing | Guidance | NICE](https://www.nice.org.uk/guidance/NG117) (Accessed 4<sup>th</sup> December 2023)

### **Making Every Contact Count**

LBB have developed a [Making Every Contact Count Sheet for Loneliness](#), highlighting key facts and figures, and signposting to appropriate help, advice and services. Services run within Barnet include the Befriending Service from Age UK Barnet.

### **Social prescribing**

Barnet's social prescribing model aims to reduce social isolation and support people taking control of their health by signposting and connecting people to local community activities and services. Social prescribers take a holistic approach and give time to their patients to identify what matters most to them and what they feel they require to improve their circumstances and their wellbeing. From these conversations, social prescribers co-create an action plan with the patient to help them self-manage their concerns and signpost to appropriate services. However, note the service can only be accessed by people registered to a GP practice. Read more here: [Barnet Social Prescribing Link Worker Service - North Central London GP Website \(icb.nhs.uk\)](#)

Participating in leisure, social, cultural, and spiritual activities in the community fosters older people's continued integration with society and helps them stay engaged and informed. Participation in such activities, however, is affected by access to transport and facilities, their awareness of such activities and their affordability. Accessible and affordable activities should account for a broad range of interests, convenient locations, and appropriate communications. Intergenerational activities are also noted to be mutually enriching and fulfilling for all ages, presenting opportunities to share knowledge and experience<sup>128</sup>.

The Centre for Ageing Better reported that the awareness of support available from voluntary groups was low amongst certain populations following the COVID-19 pandemic<sup>116</sup>. This included those from non-white ethnic groups, people facing financial difficulties, and those with long term conditions that significantly affect their lives. In their 2023 report, the Centre for Ageing Better also recognises the presence and value of active civil society and faith infrastructure led by minority ethnic communities in areas where these populations live. However, these groups are also generally chronically underfunded<sup>120</sup>.

Unless older adults who are at the greatest risk of social isolation are considered when planning communities and designing local services, inequalities in older age will persist. The Age-friendly Communities model provides an approach to community-led organising that increases resilience of community initiatives. This can be through face to face or digital interventions and improving infrastructure such as transport.

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<sup>128</sup> World Health Organisation (n.d.). *Social Participation*. (Online) Age-Friendly World. Available at: [Social Participation - Age-Friendly World \(who.int\)](#) (Accessed 4<sup>th</sup> December 2023)

## 9.3 Environments

### Indoor Environment

#### Housing

Where a person lives is fundamental to ensuring that they can remain healthy, active, and independent in later life. Older adults often spend a higher proportion of their time in homes than at other times in life. In England, millions of older people are living in homes that are cold, damp, prone to overheating, unsafe, or unsuitable for their needs, putting their health at risk<sup>4, 129</sup>.

Some of the specific challenges encountered by older adults in unsuitable housing are listed below<sup>4</sup>:

- **Cold Homes:** cold conditions increase the risk of cardiovascular events such as heart attacks, chest infections and can worsen chronic MSK or mental ill health.
- **Overheating Homes:** older adults are more likely to live in homes which can overheat compared to younger people, and they are vulnerable to heat-related illness and heat exacerbating existing conditions. The risk is predicted to increase with climate change in the summer months. It is important to consider how homes can be kept cool.
- **Damp and Mould:** Older adults with pre-existing respiratory conditions are particularly vulnerable to the effects of damp and mould. The risk of damp and mould increases with low temperatures (cold homes) and poor ventilation.
- **Unsafe and Inaccessible Homes:** falls and injuries from hazards in the home are a major cause of disability in older adults and can lead to decline in physical and mental health.

The risk of living in poor quality housing is increased for those living in deprivation<sup>130</sup>. People in private rented homes are also at high risk of living in poor-quality homes, with 1/5<sup>th</sup> of the housing stock being classified as non-decent<sup>129</sup>. This is particularly important to consider with ongoing shortages of social housing options and with increasing numbers of older renters in the private sector<sup>131,120</sup>.

Census 2021 collected data on tenure of residents. This is shown for residents aged 65+ in Figure 53<sup>132</sup>. Most people aged 65+ in Barnet owned their house in 2021 (owned outright or with a mortgage, loan, or shared ownership). This is followed by social rented accommodation, then private rented (private rented or lives rent free) accommodation.

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<sup>129</sup> Centre for Ageing Better (2020). *Homes, health and COVID-19 | Centre for Ageing Better*. (Online) ageing-better.org.uk. Available at: [Homes, health and COVID-19 | Centre for Ageing Better \(ageing-better.org.uk\)](https://ageing-better.org.uk/homes-health-and-covid-19) (Accessed 20<sup>th</sup> December 2023)

<sup>130</sup> Centre for Ageing Better (2020). *Home and dry: The need for decent homes in later life | Centre for Ageing Better*. (Online) ageing-better.org.uk. Available at: [Home-and-dry-decent-homes-later-life.pdf \(ageing-better.org.uk\)](https://ageing-better.org.uk/home-and-dry-decent-homes-later-life.pdf) (Accessed 4<sup>th</sup> December 2023)

<sup>131</sup> Age UK (2022). *Why older private renters need more security*. (Online). Available at: [Security for older private renters | Campaigns | Age UK](https://ageuk.org.uk/campaigns/older-private-renters) (Accessed 4<sup>th</sup> December 2023)

<sup>132</sup> LBB Insights and Intelligence Team, *Age-Related Census Data, broken down by age and other demographic or census topics*. Data from Office for National Statistics - Census 2021. Date of access: 31<sup>st</sup> July 2021.

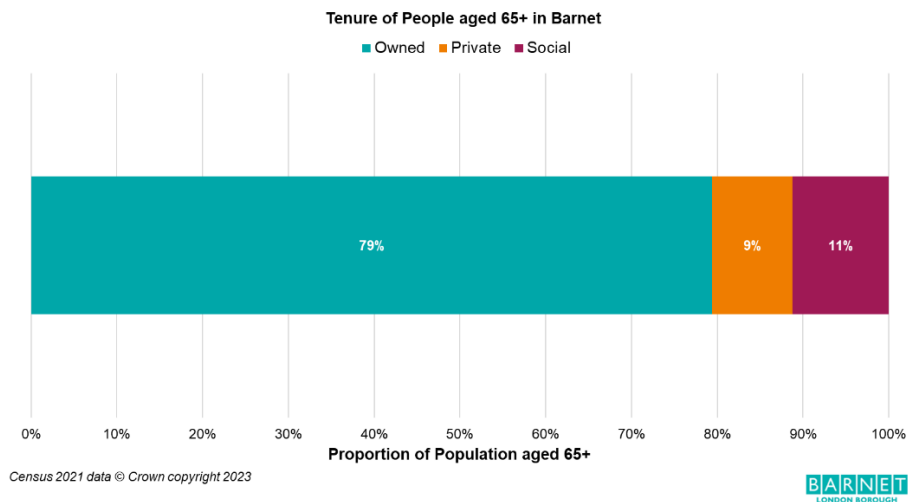


Figure 53 Tenure of people aged 65+ in Barnet, Census 2021

Figure 54 combines tenure status with reporting on whether they reported experienced ‘good’ or ‘not good’ health in Figure 53. Those who owned their house had higher levels of people reporting good health (64%), when compared to those in private rented (52%) or social rented accommodation (39%)<sup>132</sup>. It is difficult to attribute the experience of health to tenure alone but provides an indicator of where interventions to improve the quality of homes should be targeted in Barnet, especially for those with pre-existing health conditions.

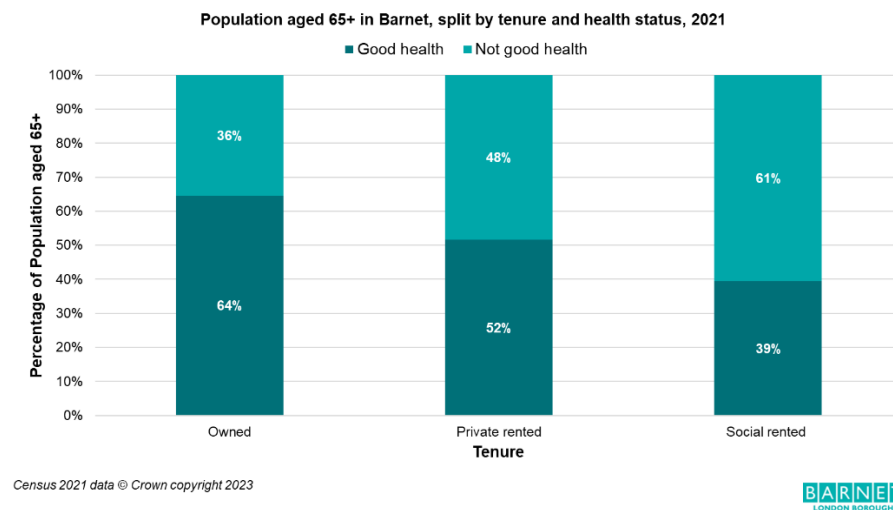


Figure 54 Population aged 65+ in Barnet, split by tenure type and whether they are reporting ‘good’ or ‘not good’ health, Census 2021

The council’s [Housing Strategy 2019-2024](#) recognises the need for access to affordable and accessible housing. This includes extra care housing as an alternative to residential care. Links should also be made with private and social landlords to help support tenants to age well, for example through adaptations and improving standards of homes in the private rented sector. Recommendations from the centre for Ageing Better’s state of ageing report included support for older adults in finding trusted tradespeople, how to finance repairs and improve energy efficiency of homes. Support like this would build on existing home improvement services available and help in sharing best practice. National recommendations account for the increased likelihood of older adults living in a house that is not energy efficient, so are harder to keep warm. It calls for a national



strategy to improve poor quality homes of all tenure types, and making all new homes accessible to disabled and older people, so they can live in homes which enable them to live fulfilling lives<sup>120</sup>.

### Fuel Poverty

Drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to cold homes<sup>133</sup>. This in turn is associated with excess winter mortality, with 1 in 5 if these being attributable to the coldest quarter of housing in England and Wales<sup>134</sup>. Modelled estimates of fuel poverty are available for Barnet across old ward boundaries in 2020<sup>135</sup>. The 5 wards with the highest proportion of estimated households in fuel poverty are shown in Figure 55. This can help identify target areas to improve quality of homes, and support residents.

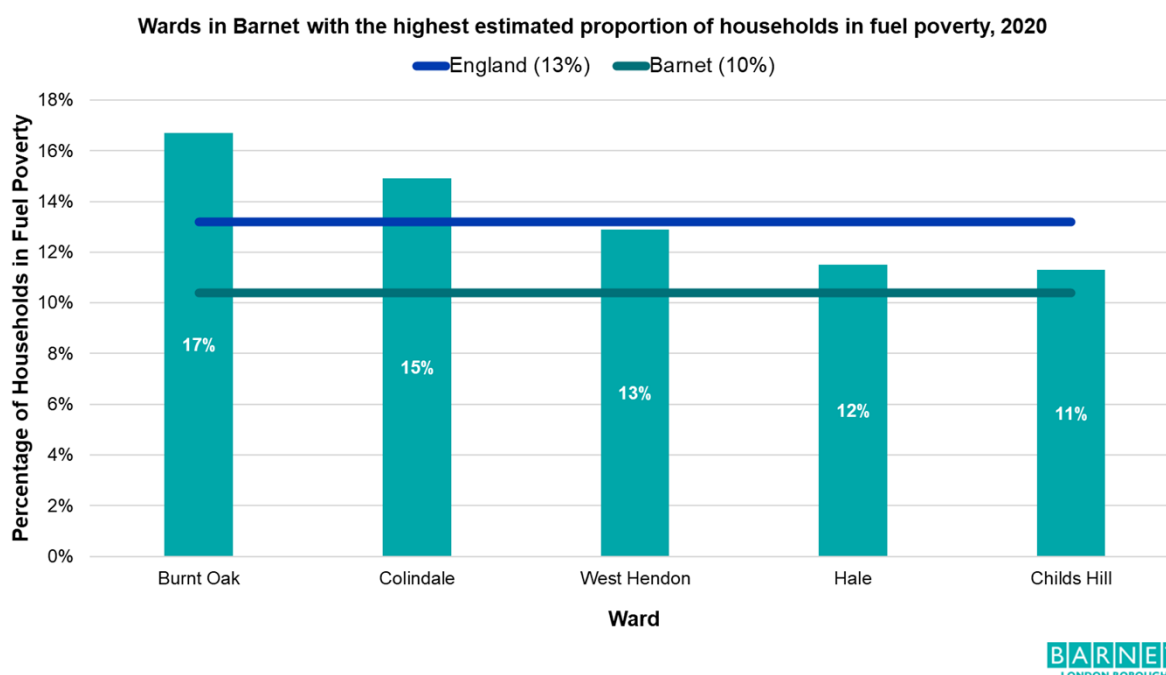


Figure 55 Graph showing the five wards with the highest estimated proportion of households in fuel poverty in Barnet in 2020 (old electoral ward boundaries), compared to the Barnet average and England average. OHID 2020

### Digital Exclusion

Digital exclusion is where a section of the population does not have access to the use of digital communications to help them fully participate in society. It is a complex challenge and includes three components: access to digital infrastructure (devices and internet etc), digital literacy and skills and engagement with digital platforms<sup>136</sup>.

<sup>133</sup> Wilkinson P, Landon M, Armstrong B, Stevenson S, Pattenden S, McKee M and Fletcher T (2001) *Cold Comfort: The Social and Environmental Determinants of Excess Winter Deaths in England, 1986–96*. Bristol: The Policy Press.

<sup>134</sup> UCL Institute of Health Equity (2011). *The Health Impacts of Cold Homes and Fuel Poverty*. (Online) Available from: [the-health-impacts-of-cold-homes-and-fuel-poverty.pdf \(instituteofhealthequity.org\)](https://www.instituteofhealthequity.org/publications/the-health-impacts-of-cold-homes-and-fuel-poverty) (Accessed 4<sup>th</sup> December 2023)

<sup>135</sup> OHID (2021). *Our Community Local Health, Public Health Data for small geographical areas*. (Online). Available at: [Local Health. Public Health Data for small geographical areas - OHID \(phe.org.uk\)](https://www.phe.org.uk/local-health-public-health-data-for-small-geographical-areas) (Accessed 4<sup>th</sup> December 2023)

<sup>136</sup> Sanders, R. (2020). *Digital inclusion, exclusion and participation*. (Online) Iriss. Available at: [Digital inclusion, exclusion and participation | Iriss](https://www.iriss.org.uk/digital-inclusion-exclusion-and-participation) (Accessed 4<sup>th</sup> December 2023).



The generational gap is narrowing with continued growth in internet use amongst older adults, however there is still a large difference between the generations and over 75s were the largest group not to have used the internet in the last three months in 2019<sup>137</sup>.

Maps of digital exclusion are available from the London Office for Technology and Innovation (LOTI, Figure 56)<sup>138</sup>. It shows that clusters of postcode areas where there are slower broadband speeds. Lack of access to fast internet can hinder internet use and digital connection. Passive and uncommitted users and e-withdrawn users (according to [Internet User Classification](#)) were observed in Burnt Oak, Colindale and Underhill. Underhill was also noted to have lower proportions of people responding to the Census 2021 online, along with Mill Hill and East Barnet.

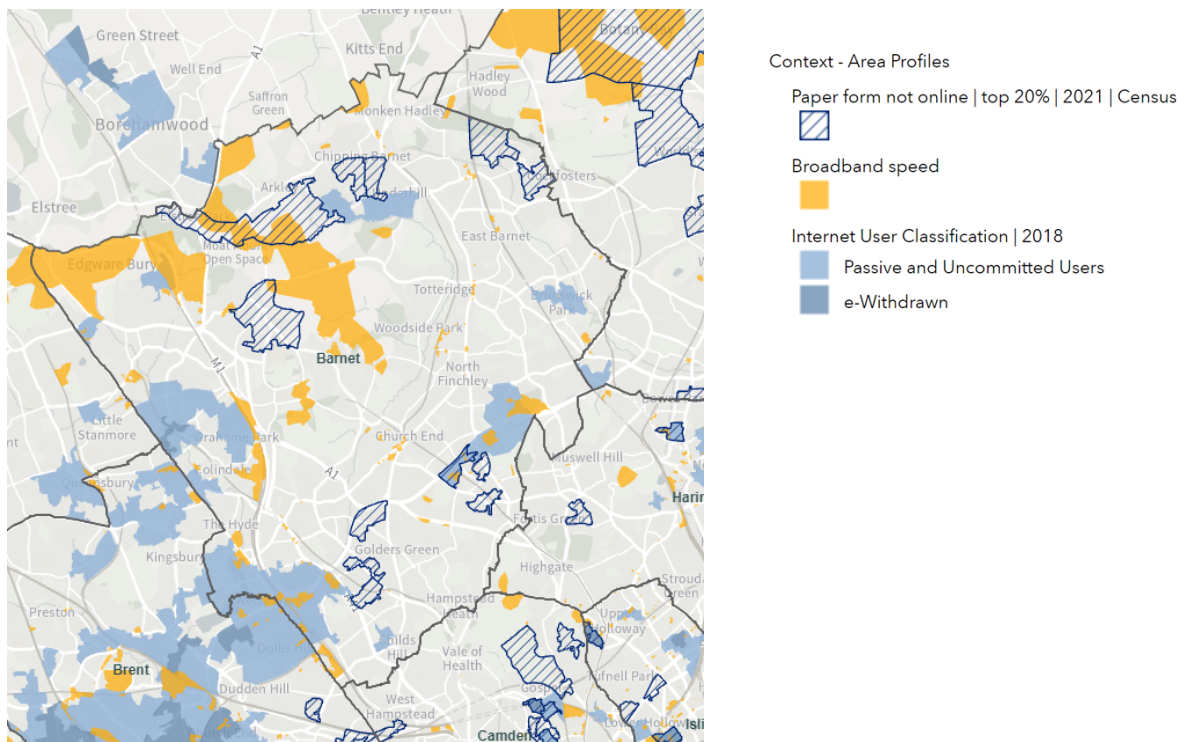


Figure 56 Barnet digital exclusion map, identifying areas of slower broadband speed, people completing Census 2021 on paper and Internet User Classification, LOTI 2023.

Age UK Barnet conducted surveys for the older adult population in 2023 as part of the Age-Friendly Barnet engagement phase<sup>49</sup>. This included how confident people were with using digital technology such as phones, tablets, and the internet. Responses, split by age band are shown in Figure 57. A notable increase is seen with age for people who disagree with the statement that they are confident with digital technology.

<sup>137</sup> Office for National Statistics (ONS, 2019), *Internet users, UK: 2019* (Online). Available from: [Internet users, UK - Office for National Statistics \(ons.gov.uk\)](#) (Accessed 4th December 2023).

<sup>138</sup> LOTI (2023). *London Digital Exclusion Map*. (Online). LOTI. Available at: [London Digital Exclusion Map - LOTI](#) (Accessed 4th December 2023).

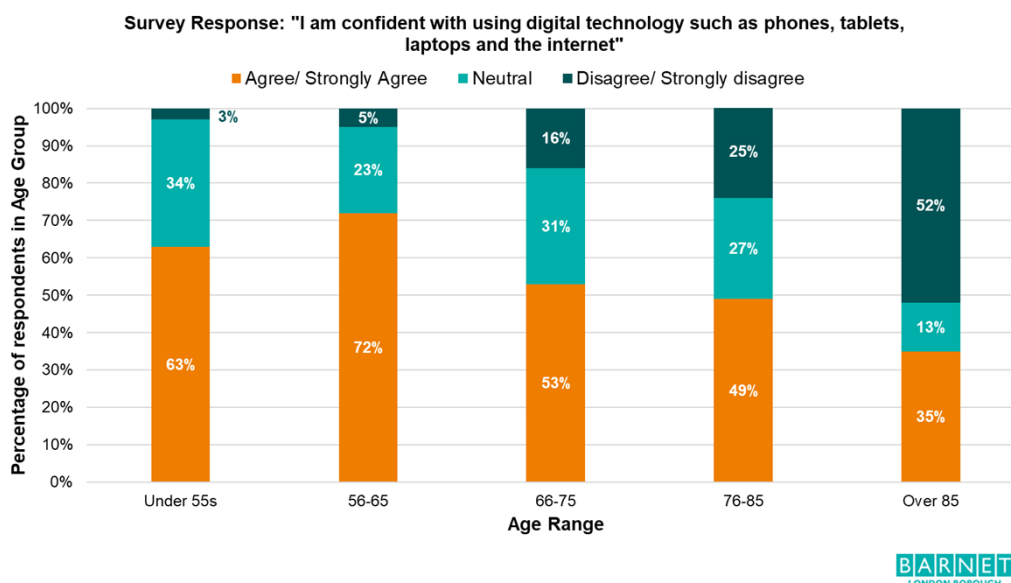


Figure 57 Responses to Age UK Barnet Survey: Confidence with digital equipment and technology, Age UK Barnet 2023.

Some groups face additional disadvantages in low digital access, for example older adults from minority ethnic groups, those with English as their second language or living in areas of high deprivation. The triple disadvantage of low digital access, low digital literacy, and low socioeconomic group seen in some population groups results in a higher risk of digital exclusion<sup>139</sup>.

Data from the Lloyds 2022 consumer digital index report showed that 53% of respondents to a survey reported difficulties accessing services as a result of not being online. The most common service reported was healthcare (1/3 of respondents)<sup>120, 140</sup>.

The NHS has developed a framework for NHS action on digital inclusion. It recognises that certain population groups, including older adults, face a higher risk of being both digitally excluded and experiencing health inequalities<sup>141</sup>. Digital exclusion can compound health inequalities by exacerbating challenges with access to healthcare, skills, and capability to navigate and use services, and the general resources needed to lead a healthy life. The framework sets out actions, informed by barriers to digital participation. These actions should be reviewed alongside data available for Barnet, to ensure it has a positive impact on those experiencing greater risks of digital exclusion. Using a co-production approach will enable a better understanding the barriers and enablers, along with the direct and indirect effects on health and wellbeing outcomes.

## Outdoor Environment

The nature and quality of the wider environment beyond people's homes has a major impact on independence, health, wellbeing, and quality of life of older people.

<sup>139</sup> Poole, L., Ramasawmy, M. and Banerjee, A. (2021). Digital first during the COVID-19 pandemic: does ethnicity matter? *The Lancet Public Health*, 6(9). doi: [https://doi.org/10.1016/s2468-2667\(21\)00186-9](https://doi.org/10.1016/s2468-2667(21)00186-9)

<sup>140</sup> Lloyds Bank plc. (2022). *UK Consumer Digital Index 2022*. (Online) [www.lloydsbank.com](http://www.lloydsbank.com). Available at: [lb-consumer-digital-index-2022-report \(lloydsbank.com\)](https://www.lloydsbank.com/uk-consumer-digital-index-2022-report) (Accessed 11<sup>th</sup> December 2023)

<sup>141</sup> NHS England (2023). *NHS England» Inclusive digital healthcare: a framework for NHS action on digital inclusion*. (Online) [www.england.nhs.uk](http://www.england.nhs.uk). Available at: [NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion](https://www.england.nhs.uk/digital-inclusion/framework-for-nhs-action-on-digital-inclusion) (Accessed 4<sup>th</sup> December 2023)

## **Air Pollution, Climate Change and Adverse Weather Events**

Air pollution has negative effects on health throughout the life course, from pre-birth to older age. Effects in older adults include asthma, poor lung function, increased risk of lung cancer, diabetes, dementia, and CVD<sup>142</sup>. Although air pollution can be harmful to everyone, it particularly affects people living in areas where there are higher concentrations of pollutants, those who are exposed to higher levels of air pollution in their day to day lives, and those who are more susceptible to health problems caused by air pollution, widening health inequalities<sup>143</sup>.

Climate change and an increasing older population are occurring together. Many older people are disproportionately affected by the effects of climate change due to their greater physiological susceptibility, and pre-existing health conditions. This is exacerbated further with factors such as deprivation and living alone<sup>144</sup>. Climate sensitive health risks include illness and mortality related to temperature extremes (heat and cold), respiratory illness and CVD.

UKHSA have developed an Adverse Weather and Health Plan guidance to protect individuals and communities from the health effects of adverse weather<sup>145</sup>. This has been produced alongside [Cold](#) and [Heat](#) Health Alert action cards. These recommend actions to be taken by professional organisations, with focus on those at higher risk of adverse health outcomes during weather alerts.

Initiatives that offer opportunities for synergistic action and mutual benefit for the outdoor environment and healthy ageing, such as the Age-Friendly Cities<sup>10</sup>, present a range of approaches<sup>146</sup>. Air pollution, climate change and adverse weather increase the need for social and health care, while also potentially disrupting care and support networks and systems. It is also important to consider the sustainability of the care and support systems that many people need as they age. National and local policy to help build resilience and tailor this to the requirements of Barnet's older population is needed.

## **Built Environment and Green Spaces**

Accessibility of the urban environment is important for older adults, encompassing features like seating, public toilets, and secure pedestrian crossings<sup>147</sup>. Pavements that promote walking, cycling and wheelchair use, while giving priority to pedestrians and cyclists over cars contribute to inclusiveness. Such environments provide opportunities for social interaction, reduce social isolation, and promote increased physical activity. Establishing spaces that facilitate and motivate older

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<sup>142</sup> Whitty, CJM. Chief Medical Officer's Annual Report 2022: Air Pollution (December 2022). Available from: [Chief Medical Officer's Annual Report 2022 \(publishing.service.gov.uk\)](#) (Accessed 4th December 2023)

<sup>143</sup> Public Health England (2018a). *Health matters: air pollution*. (Online) GOV.UK. Available at: <https://www.gov.uk/government/publications/health-matters-air-pollution> (Accessed 4th December 2023)

<sup>144</sup> World Health Organisation (2022). *The UN Decade of Healthy Ageing 2021-2030 in a Climate-changing World*. [online] Available at: [The 2030 Agenda for Sustainable Development and the UN Decade of Healthy Ageing 2021-2030 \(who.int\)](#) (Accessed 4th December 2023)

<sup>145</sup> UKHSA (2023). *Adverse Weather and Health Plan*. (Online) GOV.UK. Available at: [Adverse Weather and Health Plan - GOV.UK \(www.gov.uk\)](#) (Accessed 4th December 2023)

<sup>146</sup> Mavrodaris, A., Mattocks, C. and Brayne, C.E. (2021). Healthy ageing for a healthy planet: Do sustainable solutions exist? *The Lancet Healthy Longevity*, 2(1), pp. e10–e11. doi: [https://doi.org/10.1016/s2666-7568\(20\)30067-2](https://doi.org/10.1016/s2666-7568(20)30067-2)

<sup>147</sup> Newton R. Et al. Increasing independence for older people through good street design. *Journal of Integrated Care* 2010;18(3):24-2

individuals to walk is a vital element in promoting healthy aging, especially considering the observed decline in physical activity, particularly walking, with age<sup>148</sup>.

Residents engaging with the Age UK Barnet surveys responded with the extent to which they agree with the following statements<sup>49</sup>:

- There are enough places (warm venues and benches) to rest when out and about.
- There are enough public toilets in Barnet.
- I am able to access greenspace/ a park at least once a day

Responses are summarised in Figure 58-60. A similar trend is seen in answers across all questions, with a lower percentage of people in older age groups agreeing with the statements.

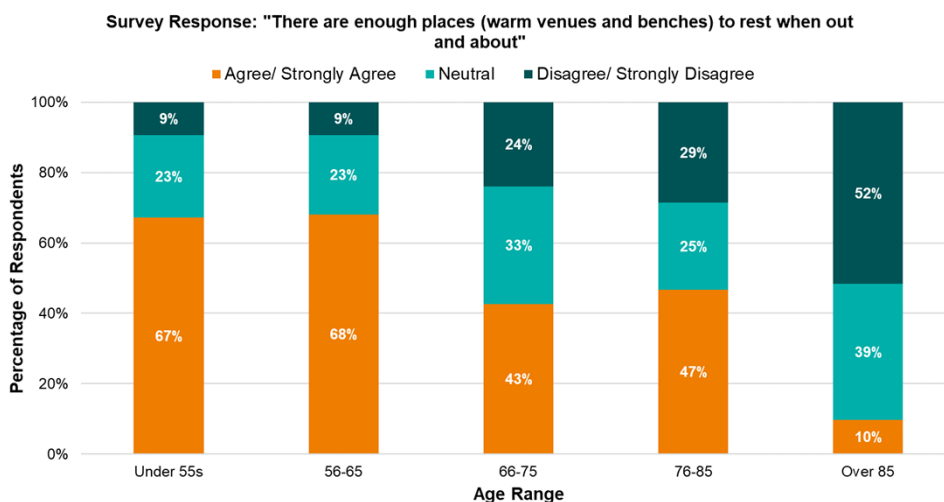


Figure 58 Survey Response: "There are enough places (warm venues and benches) to rest when out and about", Age UK Barnet 2023

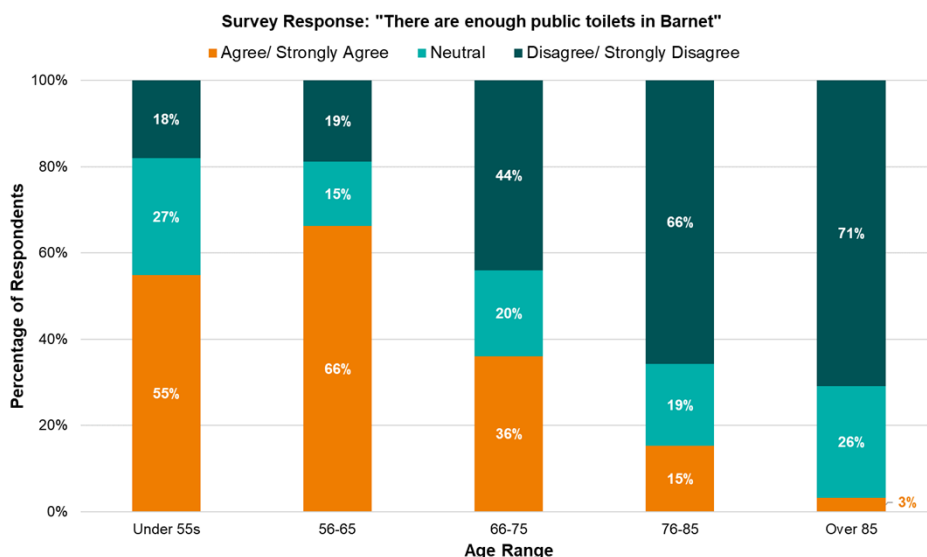


Figure 59 Survey Response: "There are enough public toilets in Barnet", Age UK Barnet 2023

<sup>148</sup> Department for Transport. National Travel Survey: England 2016. DfT, July 2017

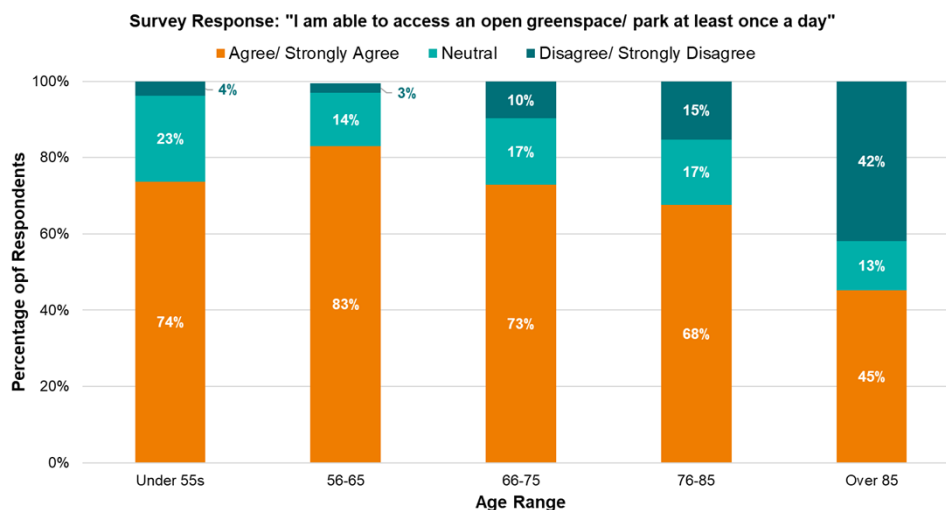


Figure 60 Survey response: "I am able to access an open greenspace/ Park at least once a day, Age UK Barnet 2023

Barnet [Healthier High Streets](#) Initiative encourages businesses to provide healthier living for residents. It brings together five schemes to help improve health and wellbeing: Healthier Catering, Breastfeeding Welcome, Dementia Friendly and Community Toilets. Incontinence in older age, disabled people or people with sensory impairment face barriers accessing facilities which are not available nor accessible. For example, some older adults with incontinence report more restricted daily lives, avoiding unfamiliar social spaces, or restricting fluid intake as a result<sup>149,150</sup>. Initiatives such as Healthier High Streets can improve the experience of older adults in Barnet, addressing barriers they may face to going out in public.

Barnet is known for being a green and leafy borough in London<sup>49</sup>, which is reflected in the survey response where a high proportion of residents reported they were able to access greenspace daily. However older adults were less likely to report this, with less than 50% of people over the age of 85 agreeing with the statement.

Other factors to consider are the neighbourhoods in which older adults live. Homes in places where people can easily and safely reach the everyday shops and services that they need, preferably by active transport (walking or cycling) to help maintain physical health. Older adults' experience of their neighbourhood is moderated by access to, and the accessibility of, of green space, other public spaces, and walking infrastructure. Public and green spaces should be designed to meet the needs of older people, including those with sensory and physical impairments (Section 10.3). This is key to enabling older people to participate in their communities, stay active, enjoy life, and reduce the incidence of loneliness and social isolation<sup>4</sup>.

### Transport and Mobility

Supporting and maintaining active transport (walking and cycling) has positive effects on physical and mental health. As the people grow older, they may lose the ability to drive safely. Therefore,

<sup>149</sup> Tinker, A. and Ginn, J. (2015). *An Age Friendly City - how far has London come?* (Online) Kings College London. Available at: [age-friendly-london-report.pdf \(kcl.ac.uk\)](#) (Accessed 9<sup>th</sup> February 2024).

<sup>150</sup> Horrocks S, Somerset M, Stoddart H et al. (2004) What prevents older people from seeking treatment for urinary incontinence? A qualitative exploration of barriers to the use of community continence services. *Family Practice* 21(6): 689-96

having a public transport system which meets the needs of older people is important for independence. In addition to this, transport should be reliable and convenient, so older adults can continue to do things which matter to them<sup>4,151</sup>.

Frequent public transport use in older people (who can use public transport) is associated with a decrease in age-related decline in physical capability and an increase in leg muscle strength<sup>152</sup>. Affordability is another consideration, concessionary schemes in London enable residents to have reduced reliance on car travel, whilst maintaining independence.

The [WebCAT Tool](#) from Transport for London provides a way to measure connectivity through public transport networks in Barnet. It uses the PTAL measure (Public Transport Access Level), which rates a selected place based on how close it is to public transport and how frequent services are in the area. This provides an overall access index which can be allocated to nine accessibility levels between 0 (worst) and 6b (best). In Barnet, areas in the periphery of greater London have lower scores (1a and 1b), particularly to the north of the borough. Promoting sustainable active travel in areas like this could be more challenging<sup>153</sup>.

Survey data from Age UK Barnet<sup>49</sup> shows a significant decline in the proportion of people who find it easy to navigate public transport at ages 85+ (Figure 61).

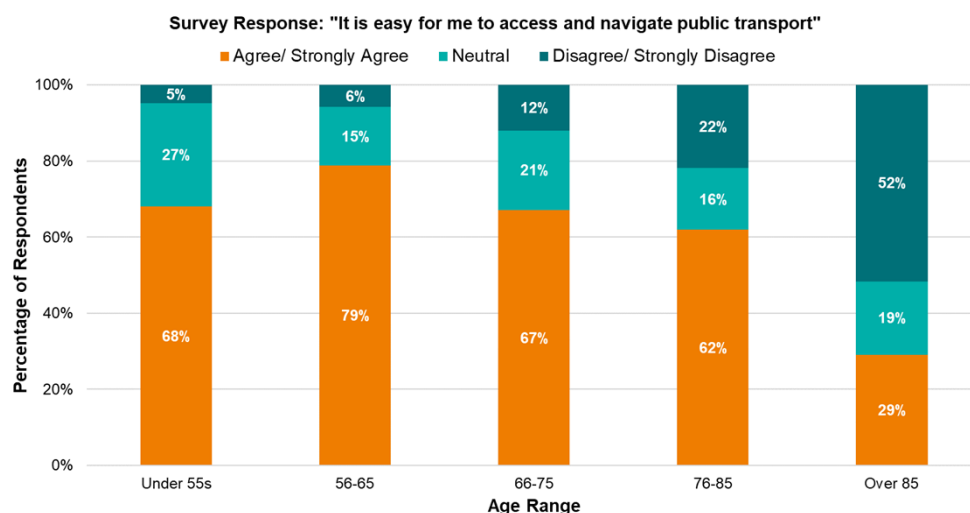


Figure 61 Survey Response: "It is easy for me to access and navigate public transport", Age UK Barnet

It is important to consider wider factors such as comfort (being able to sit) and overcrowding as potential deterrents for older adults. From their focus groups, Age UK Barnet also identified barriers such as drivers parking too far away from the kerb and not giving passengers enough time to sit down before driving away from the bus stop. Other considerations should be around the provision of step-free access, ramps and transport driver training.

<sup>151</sup> Shrestha BP. et al. Review of Public Transport Needs of Older People in European Context. *J Popul Ageing*. 2017; 10(4): 343–361

<sup>152</sup> Rouxel P., Webb E. and Chandola T. Does public transport use prevent declines in walking speed among older adults living in England? A prospective cohort studies. *BMJ Open* 2017;7: e017702

<sup>153</sup> National Institute for Health and Care Research (NIHR, 2023). Evaluating coastal rural communities' active and sustainable travel (COAST) (Online). Available from: [Evaluating coastal rural communities' active and sustainable travel \(COAST\) - NIHR School for Public Health Research](#) (Accessed 4<sup>th</sup> December 2023)

Recent data is not available on active travel in older adults. This is important to collect to identify the unmet need and consider the needs of the older population in planning cycling and walking routes. High-quality and accessible transport plays a crucial role in facilitating the engagement of older adults in society. Collaborating with transport providers to enhance accessibility, encompassing step-free access at stations, and ensuring safe bus stops equipped with reliable information, will encourage the use of public transport by older adults.

## 10 Older Adults with Additional Support Needs

### 10.1 Dementia

Cognitive health refers to one's ability to think, learn and remember. Mental health refers to psychological and emotional health. Cognitive function covers aspects of perception, memory, learning, decision making and language. Mild cognitive impairment (MCI) refers to when someone has a slight decline in their cognitive ability.

Some changes are normal with older age for example slower reaction times. However, as with physical health, age related changes in cognition are not uniform across individuals or domains of cognitive function<sup>154</sup>.

Dementia is the predominant cause of poor cognitive health in older adults and the overall number of people living with dementia is expected to increase as the number of older adults rises<sup>4</sup>. The most common types of dementia seen in older adults are Alzheimer's disease, vascular dementia and dementia with Lewy bodies. Young-onset dementia refers to when an individual develops dementia before the age of 65. The age cut-off has no biological significance and is based on the previous age at which people traditionally retired. People with young-onset dementia have different needs, and often follow a different clinical pathway, compared with those diagnosed with dementia over the age of 65<sup>155</sup>. The needs of Barnet's population in relation to people living with a diagnosis of dementia are explored in the 2022 Dementia Needs Assessment<sup>15</sup>.

In 2020, the recorded prevalence of dementia in those aged 65+ was 4.59% in Barnet, compared to 4.17% in London and 3.97% in England (using QOF data). Barnet had the 6<sup>th</sup> highest prevalence of dementia in those aged 65+ compared to all London boroughs<sup>156</sup>. There has been a decrease prevalence compared to previous years, however the indicator value was recorded during the COVID-19 pandemic, so the trend should be monitored in the future to assess changes to prevalence (Figure 62).

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<sup>154</sup> Glisky EL. Changes in Cognitive Function in Human Aging. In: Riddle DR, editor. *Brain Aging: Models, Methods, and Mechanisms*. Boca Raton (FL): CRC Press/Taylor & Francis; 2007. Chapter 1

<sup>155</sup> Alzheimer's Society (2023). *Alzheimer's Society says 19,000 people in England could be living with undiagnosed young-onset dementia* | Alzheimer's Society. (Online) [www.alzheimers.org.uk](http://www.alzheimers.org.uk). Available at: [Alzheimer's Society says 19,000 people in England could be living with undiagnosed young-onset dementia | Alzheimer's Society \(alzheimers.org.uk\)](https://www.alzheimers.org.uk/news/19000-people-in-england-could-be-living-with-undiagnosed-young-onset-dementia) (20<sup>th</sup> December 2023)

<sup>156</sup> OHID (2020), Reverse or Live Well with a Long-term Condition, *Productive Health Ageing Profile*. Available from: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk/products/healthy-ageing-profile) (Accessed 28<sup>th</sup> November 2023).



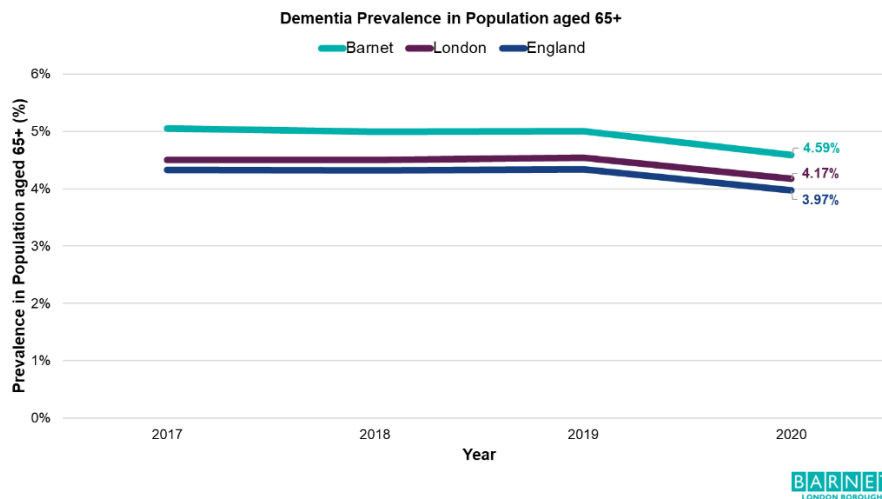


Figure 62 Dementia prevalence in population aged 65+ in Barnet, London and England 2017-2020

The estimated diagnosis rate for dementia in those aged 65+ was 65.7% in Barnet for 2022, this is compared to 73.1% at the time of the dementia needs assessment (2018). This proportion suggests that out of the population living with dementia in 2022 (predicted by prevalence rates from the Cognitive Function and Ageing Study II), 65.7% have a recorded diagnosis<sup>157</sup>. The 2022 value for Barnet is statistically comparable to that in 2018, and to the values seen for London and England. As the diagnosis rate is based off predictions from a study, the true diagnosis rate for Barnet may be higher or lower. However, monitoring of this value will provide some insight into the undiagnosed population in Barnet and help review the impact of actions from the strategy to support early identification and diagnosis.

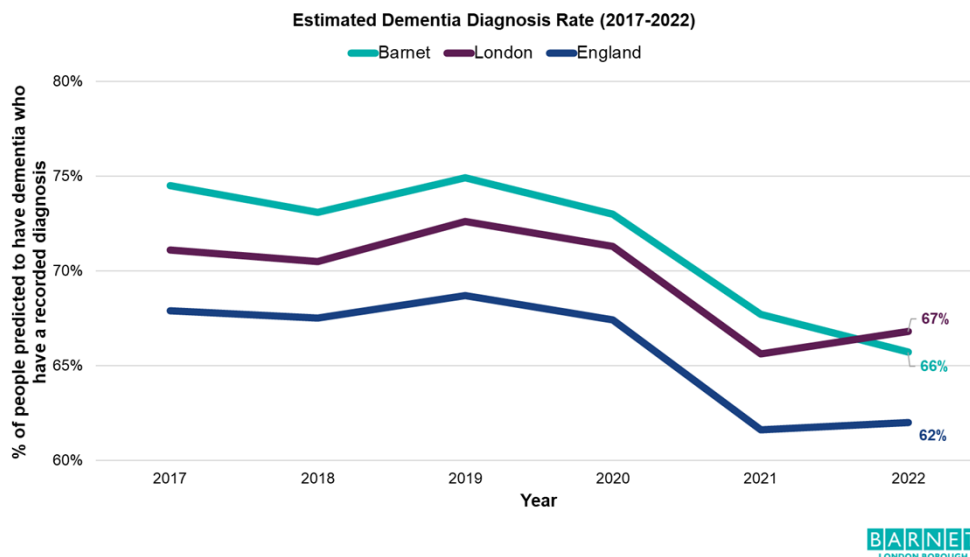


Figure 63 Estimated dementia diagnosis rate for Barnet, London, and England for 2017-2022

The numbers of people living with dementia is predicted to increase to 7477 in 2035<sup>15</sup>; this also includes those diagnosed with young-onset dementia (diagnosed under the age of 65) and people with learning disabilities, who are more likely to develop Alzheimer’s disease between the ages of 50-65.

<sup>157</sup> OHID (2022), Reverse or Live Well with a Long-term condition, *Productive healthy Ageing Profile*. (Online) Available at: [Productive Healthy Ageing Profile - Data - OHID \(phe.org.uk\)](https://www.phe.org.uk/products/production/healthy-ageing-profile) (Accessed 28<sup>th</sup> November 2023),



Actions to support high quality care and support for people with dementia and their carers are outlined in the [2023-2023 Dementia strategy](#)<sup>15</sup>, not all aspects of the strategy are explored within this HNA but a summary is provided in the context of aging well .

In 2020, a Lancet Commission on dementia prevention, intervention and care identified 12 modifiable risk factors which could prevent or delay up to 40% of dementias<sup>158</sup>, these are summarised in Figure 64.

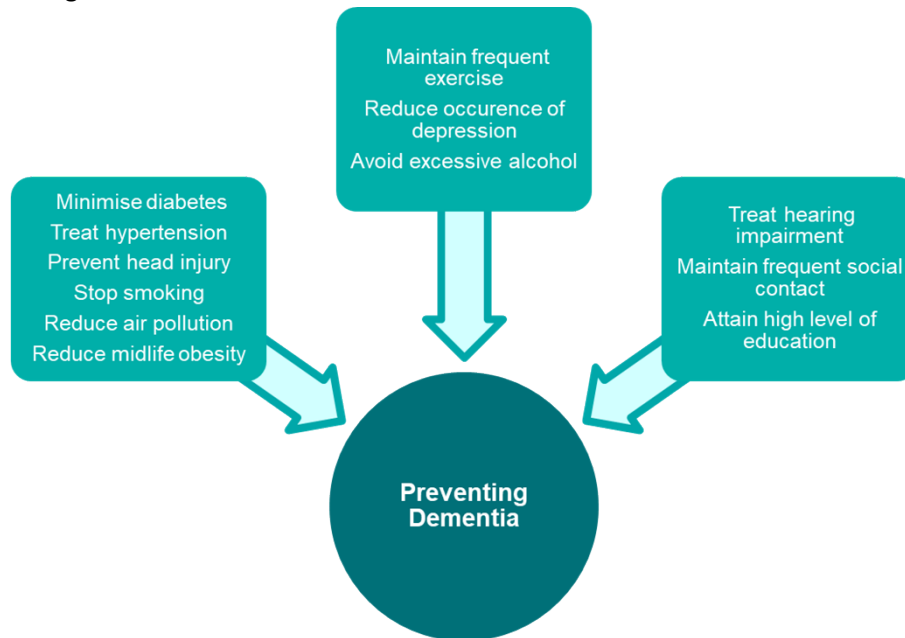


Figure 64 Recommendations for the prevention of dementia, adapted from the 2020 Lancet Commission<sup>115</sup>

The dementia strategy has a focus on of behaviour change in prevention including services such as smoking cessation, weight management, diabetes prevention and substance misuse services. Other factors prioritised within prevention are included: information being given early on, supporting minoritised groups to access services, local and accessible services and access to fitness programmes which appeal to those aged over 55. Nationally, there has been recognition to support minority ethnic groups with dementia care, with tools developed such as the ADAPT toolkit<sup>159</sup>, and work to address the gaps in knowledge and support for underserved and minoritised groups<sup>160</sup>.

Work on dementia prevention is supported by existing health promotion measures, and efforts to support these will have positive effects across multiple domains of health, beyond dementia. As outlined in Figure 62, the wider determinants of health are also important to consider, including the outdoor environment, social contact, and level of education. These are explored in more detail in Section 9.

Following diagnosis, GPs should perform an annual review of patients and their carers. This is an opportunity for a physical and mental health review, an understanding of the patient’s health and

<sup>158</sup> Livingston G, Huntley J, Sommerlad A, Ames D, Ballard C, Banerjee, S, and Mukadam N. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet* (2020), 396(10248), 413-446

<sup>159</sup> ADAPT (2022). *The toolkit*. (Online) ADAPT South Asian Dementia Pathway. Available at: <https://raceequalityfoundation.org.uk/adapt/the-toolkit/> (Accessed 28<sup>th</sup> November 2023)

<sup>160</sup> Race Equality Foundation (2022). *Dementia and BAME Communities*. (Online) Available at: <https://raceequalityfoundation.org.uk/projects/dementia-and-bame-communities/> (Accessed 30<sup>th</sup> November 2023)

social care, as well as the impact of care on the care giver. In 2020/21, 45.9% of patients with dementia had their care plan reviewed face-to-face in the last 12 months in Barnet, as recorded on GP records. Note this was during the time of the COVID-19 pandemic, with a noticeable drop seen compared to the previous year for Barnet, London, and England (Figure 65). Prior to this, the proportion was 76.5% in Barnet. Since then, Barnet PCNs have had an increase in the proportion of patients with a care plan review in the last 12 months – with an average of 77% across PCNs in 2022/23, similar to pre-pandemic levels.

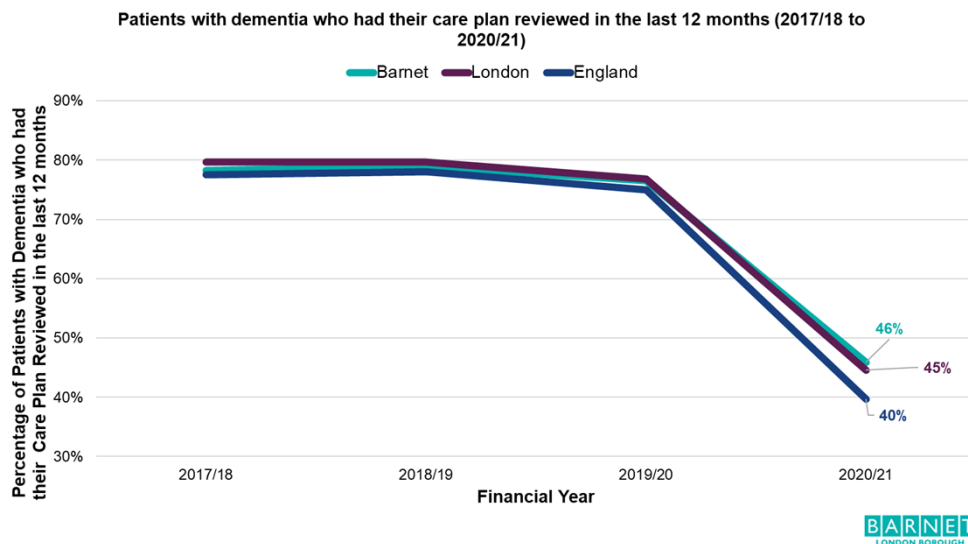


Figure 65 Patients who are recorded as having a diagnosis of dementia, whose dementia care plan was reviewed in the last 12 months between 2017/18-2020/21. For Barnet, London and England

The strategy sets out how to transform dementia care and support in Barnet, which aligns to the 2020 NHS England *Well Pathway for Dementia*<sup>161</sup> –across preventing well, diagnosing well, supporting well, living well, and dying well. Further information and context can be accessed through the Dementia Strategy. Plans to improve ageing well in Barnet will work closely with existing partnerships and projects set up in Barnet.

### Dementia Friendly Barnet

The Dementia Friendly Barnet Partnership was established in 2019 by Public Health to work collaboratively and support those living with dementia so that they are empowered, understood, and supported to live well. Barnet gained recognition as a dementia friendly borough in 2022. Ongoing work supports recognition of culture and leisure venues to be dementia friendly, creating a dementia friendly faith framework and encouraging businesses to support people living with dementia. As a result, 21 venues are currently accredited as ‘Dementia Friendly’, and over 15,000 residents and colleagues have undertaken training to become Dementia Friends. More information on Dementia Friendly Barnet can be found here: [Dementia | Barnet Council](#)

<sup>161</sup> NHS England (2020). *The Well Pathway for Dementia*. (Online) NHS. Available at: [NHS England » Dementia](#) (Accessed 28<sup>th</sup> November 2023)

## 10.2 People with Learning Disabilities

A learning disability refers to a group of conditions which affect intellectual ability and social functioning. This presents before adulthood and affect someone for their whole life. Learning disabilities can be mild, moderate, or severe, with some people with learning disabilities (PWLD) living independently, whilst others require high-level and complex support<sup>162</sup>.

When considering aging well for PWLD, it is important to appreciate that PWLD are a highly heterogeneous group of people, in relation to the severity of the learning disability, or the cause of it. For example, for people with a diagnosis of Down's syndrome (Trisomy 21), the genetic effect results in affected development of a child, but also apparent premature ageing, with the propensity to develop Alzheimer's dementia much earlier on in life<sup>163</sup>.

However, it is important to recognise that the life expectancy of PWLD has been increasing; and those who live into their third decade of life are likely to live into older age<sup>164</sup>. PWLD also experience specific health inequalities, this includes barriers to accessing cancer screening programmes (including levels of literacy as well as physical barriers from lack of suitable transport), higher prevalence of mental ill health and poor recognition of certain conditions due to diagnostic overshadowing (inadvertently attributing a person's additional mental health or physical health problems to their learning disabilities). The range health inequalities experienced by PWLD in turn negatively affect their ability to age well. Therefore, interventions for health promotion and services should account for the additional needs of this population. The broad range of health inequalities, split by condition is available from the OHID (Health Inequalities: [Learning Disability Profiles - OHID \(phe.org.uk\)](https://phe.org.uk)).

In Barnet, the QOF prevalence of PWLD across PCNs in 2021/22 was 1991 people (Figure 66)<sup>165</sup>. This compared to service user data from LBB Adult Social Care, where in March 2023 there were 3411 clients with a learning disability aged 18-64 and 466 aged 65+ (a total of 3877)<sup>166</sup>. The discrepancies in numbers could be because many PWLD, especially those with milder disability, are not known to health services<sup>167</sup>.

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<sup>162</sup> NHS (2022). *Overview - Learning Disabilities*. (Online) NHS. Available at: [Learning disabilities - NHS \(www.nhs.uk\)](https://www.nhs.uk) (Accessed 28<sup>th</sup> November 2023).

<sup>163</sup> Holland, A.J. (2000). Ageing and learning disability. *British Journal of Psychiatry*, 176(1), pp.26–31. doi: <https://doi.org/10.1192/bjp.176.1.26>

<sup>164</sup> Foundation for People with Learning Disabilities (2023). *Ageing*. (Online) Learning Disabilities. Available at: [Ageing | Foundation for People with Learning Disabilities](https://www.fpld.org.uk) (Accessed 28<sup>th</sup> November 2023)

<sup>165</sup> OHID (2023). Learning disability: QOF prevalence (all ages) *Public Health Profiles*. (Online) Available from: [Public health profiles - OHID \(phe.org.uk\)](https://phe.org.uk) (Accessed 30<sup>th</sup> November 2023)

<sup>166</sup> LBB Adults and Health (2023), Demographics: Clients with a Learning Disability, broken down by age bands, *Learning Disability Visualisations*.

<sup>167</sup> OHID (2022). *Learning disability Profiles* (Online) Available from: <https://fingertips.phe.org.uk/profile/learning-disabilities> (Accessed 30<sup>th</sup> November 2023)

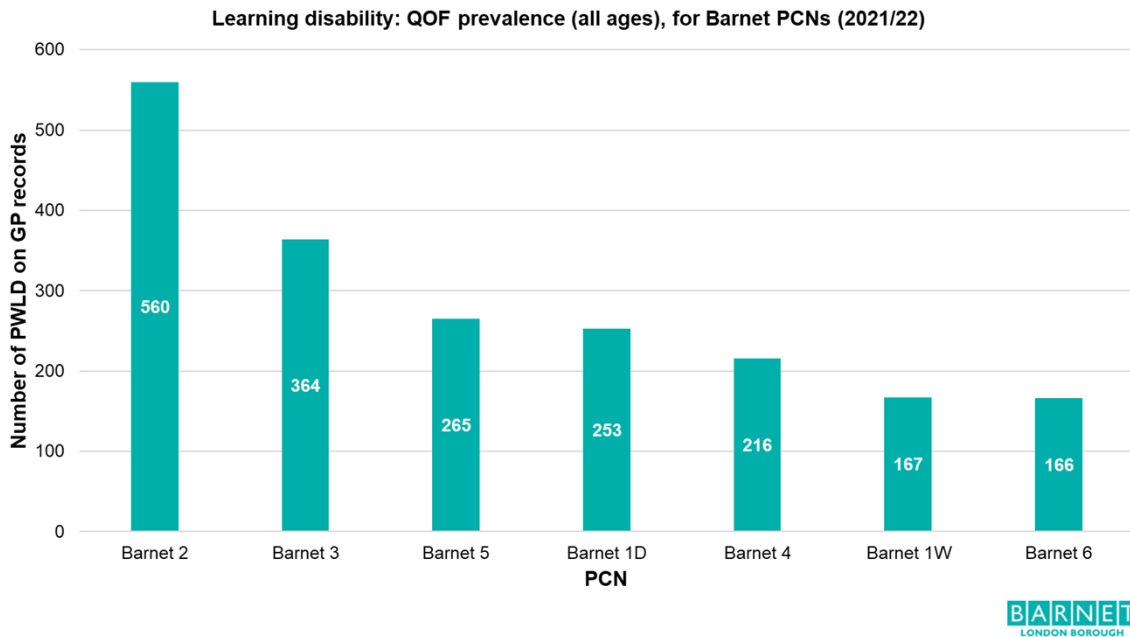


Figure 66 Prevalence of Learning Disabilities across Barnet PCNs 2021/2022 (total numbers with 'Learning Disability' coded on GP records)

Projecting Adults Needs and Service Information (PANSI), have estimated the numbers of PWLD with projections to 2040, split by age group (Figure 67)<sup>168</sup>. Of note, there is a predicted increase in the numbers of PWLD, and a larger proportion of PWLD are expected to be aged 65+ in 2040, compared to 2023.

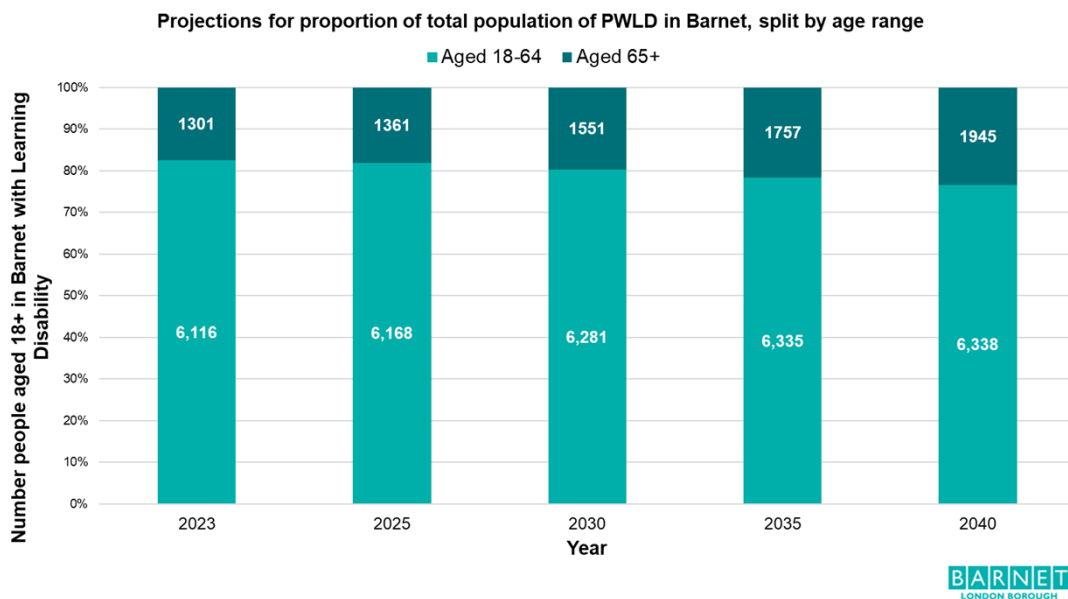


Figure 67 Projections to 2040 for the total number of PWLD aged 18+ in Barnet, split by proportion aged 18-64 and 65+. Data labels to highlights crude prevalence as the number of PWLD within the age band, PANSI 2023

NICE have developed quality standards on the care and support of people growing older (2019)<sup>169</sup>. A specific age limit was not used to define the older population of PWLD as age-related difficulties are

<sup>168</sup> OHID (2023). *Learning Disability Profiles*. (Online) Available at: [Public health profiles - OHID \(phe.org.uk\)](https://publichealthprofiles.org.uk/) (Accessed 30<sup>th</sup> November 2023)

<sup>169</sup> NICE (2019). *Overview | Learning disability: care and support of people growing older | Quality standards*. (Online) [www.nice.org.uk](https://www.nice.org.uk/guidance/QS187). Available at: <https://www.nice.org.uk/guidance/QS187> (Accessed 28<sup>th</sup> November 2023)

experienced at different ages and typically at a younger age to the general population. The needs of an older population of PWLD will overlap across health and social care services, so joint strategies to address these are important.

The same principles of maintaining physical and mental health for PWLD should be adopted, including national programmes such as NHS health checks for early detection and cancer screening programmes. Targeted programmes will need to be delivered, where adjustment of mainstream services cannot be made accessible to PWLD.

The annual report of the Learning Disability and Mortality Review (LeDeR) was established to improve healthcare for PWLD and people with autism nationally. In the most recent report<sup>170</sup> (2022) it was identified that avoidable mortality continues to decrease. Whilst there were positive messages, it identified where further work needs to be done in improving prevention pathways, improved management of non-communicable disease such as circulatory conditions and the impact of heatwaves, resulting in excess deaths.

Other key findings included:

- An increased risk of premature mortality in PWLD who were from ethnic minority groups, compared to white ethnic groups, when adjusting for other demographic factors (sex, region, deprivation, and accommodation)
- An increased rate of mortality in those living in the most deprived neighbourhoods.

A summary of findings from the national report is available from: [Master LeDeR 2023 \(2022 report\) \(kcl.ac.uk\)](#)

PWLD over the age of 14 and on the GP register should have an annual health check. This is different from the NHS health check programme and designed to pick a wider range of unmet health needs. It enables more proactive medical care, providing time for PWLD to communicate symptoms or concerns, and to help identify and address health needs such as vaccinations, dental review and hearing or vision assessment<sup>171</sup>. Data from 2018/19 showed that the proportion of eligible PWLD having an annual GP health check was 55% for Barnet. This compared to 58.2% in London and 52.3% in England in 2018/19<sup>172</sup>. More recent data from NCL ICB showed an improvement in the proportion of PWLD aged 14+ who had a health check. For the financial year 2022/23 this was 91.3% in Barnet, compared against the national target of 75%.

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<sup>170</sup> Kings College London (2023). *LeDeR Annual Report Learning from Lives and Deaths: People with a Learning Disability and Autistic People*. (Online) Available at: [Master LeDeR 2023 \(2022 report\) \(kcl.ac.uk\)](#) (Accessed 30<sup>th</sup> November 2023)

<sup>171</sup> NHS England (2021). *Annual Health Checks*. (Online) Learning Disability and Autism, Improving Health. Available at: [NHS England » Annual health checks](#) (Accessed 30<sup>th</sup> November 2023)

<sup>172</sup> OHID (2020). *Learning Disability Profiles*. (Online) Available at: [Public health profiles - OHID \(phe.org.uk\)](#) (Accessed 30<sup>th</sup> November 2023)

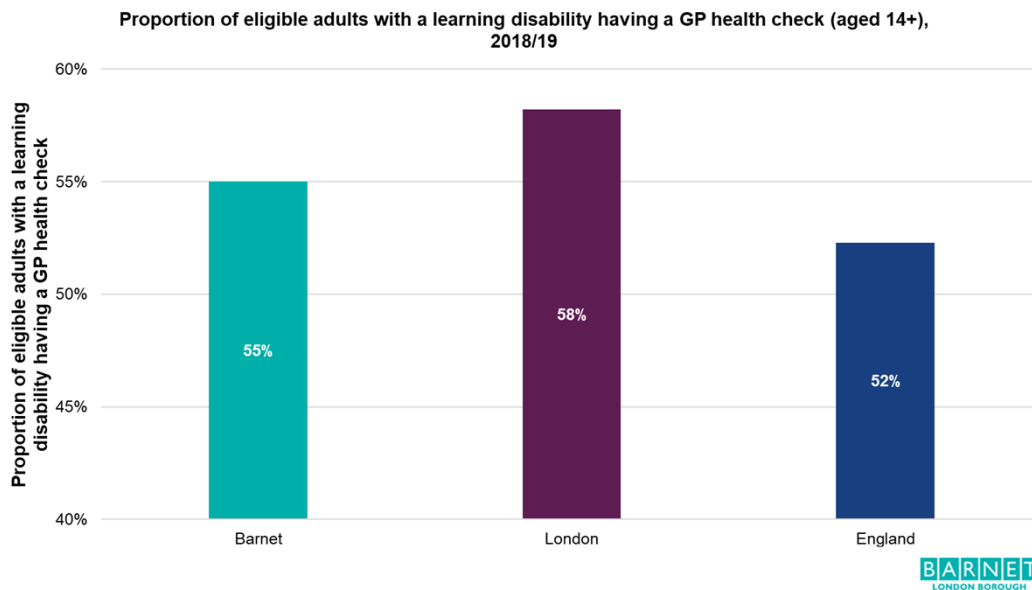


Figure 68 Proportion of eligible adults with a learning disability having a GP health check in Barnet, London, and England for 2018/2019

### Barnet Mencap

Access to services should also be considered across the wider determinants of health, including opportunities to engage in social activities, education, and employment. Barnet Mencap offer a range of support and events for PWLD, autistic people and their families. A full range of their services is available from: [Home - Barnet Mencap](#).

The Working for You service is one example of the work done. It is a free information and guidance service supporting PWLD with support for housing, money and benefits, letters and keeping safe. In the most recent quarter of the 2023/24 financial year, the most common reason for referral was for support with benefits, freedom pass and general advice.

## 10.3 People with Sensory and Physical Impairments

The World Health Organization sets out the three dimensions of disability<sup>173</sup>:

1. Impairment in a person's body structure or function, or mental functioning; examples of impairments include loss of a limb, loss of vision or memory loss.
2. Activity limitation, such as difficulty seeing, hearing, walking, or problem solving.
3. Participation restrictions in normal daily activities, such as working, engaging in social and recreational activities, and obtaining health care and preventive services.

The likelihood of experiencing disability is greater with age, however it is also important to consider how people living with disabilities can be supported proactively to live and age well in Barnet. Without the right support in place, people are more likely to suffer across more domains than their health, this includes employment, social isolation, housing, and physical barriers in the outdoor environment<sup>174</sup>.

<sup>173</sup> World Health Organization, [International Classification of Functioning, Disability and Health \(ICF\) \(who.int\)](#). Geneva: 2001, WHO.

<sup>174</sup> United Nations (2018). Persons with Disabilities: Breaking Down Barriers, in: *Promoting Inclusion through Social Protection: Report on the World Social Situation*. New York: United Nations, pp.63–76. Available at: [1-1.pdf \(un.org\)](#) (Accessed 1<sup>st</sup> December 2023)

Whilst some aspects of active and healthy ageing focus on delaying ill-health and prevention, it is important to acknowledge lives of value and connection for those living with disabilities in later life. Ageing well should also encompass ageing well with disability, regardless of the onset during the life course. This HNA will focus on people who have sensory (auditory or visual) and physical impairments.

Both hearing and visual impairment can have a profound effect on health and wellbeing and the ageing process. Without the right support in place people with sensory loss are more likely to suffer from unemployment, social isolation, depression, and mental ill health<sup>175</sup>. The presence of a sensory impairment also increases the risk of certain health conditions. For example, hearing impairment is an identified risk factor for dementia (See [Dementia](#)) and dual sensory impairment (both hearing and vision impairment) increases the risk of falls compared to vision impairment alone<sup>176</sup>.

### Sight Impairment

A data tool is available from the Royal National Institute of Blind People (RNIB) to provide information about blind and partially sighted people and those at risk of sight loss at a local level throughout the UK<sup>177</sup>.

The main causes of sight loss in the UK are<sup>136</sup>:

- Uncorrected refracted error (39%). This refers to short and long sightedness.
- Age-related macular degeneration (AMD, 23%). This is a condition which leads to problems with central vision it can be sudden or slow onset depending on the subtype.
- Cataracts (19%). This is common in older people, where the lens becomes cloudy over time and usually treated with an operation.
- Glaucoma (7%). This can damage vision due to changes in pressure in the eye.
- Diabetic eye disease (5%). Diabetes can affect the blood vessels in eye, leading to permanent sight loss if not monitored and treated early on. Efforts to prevent or delay the onset of diabetes can therefore reduce the risk of visual impairment.

Some of these causes of sight loss can be slowed, prevented, reduced or in some cases reversed. These include refractive errors, cataracts, glaucoma, macular degeneration and diabetic eye disease<sup>4</sup>. Regular attendance to eye tests allows changes to vision to be detected and risk to be managed appropriately.

Estimates for prevalence are taken from varying sources including Census data, ONS predictions and prevalence modelling from a 2017 study<sup>178</sup>. There were an estimated 11,400 people living with sight loss in Barnet in 2022, this is split by severity in Figure 67. These estimates include people whose vision is better than levels qualifying for registration, but still has a significant impact on their daily

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<sup>175</sup> Steinman, B.A. and Allen, S.M. (2011). Self-Reported Vision Impairment and Its Contribution to Disability Among Older Adults. *Journal of Aging and Health*, 24(2), pp.307–322. doi:

<https://doi.org/10.1177/0898264311422600>

<sup>176</sup> Crews, J.E. and Campbell, V.A. (2004). Vision Impairment and Hearing Loss Among Community-Dwelling Older Americans: Implications for Health and Functioning. *American Journal of Public Health*, 94(5), pp.823–829. doi: <https://doi.org/10.2105/ajph.94.5.823>

<sup>177</sup> RNIB (March 2023). *Sight Loss Data Tool*. (Online) RNIB. Available at: [RNIB Sight Loss Data Tool - statistics on sight loss | RNIB | RNIB](#) (Accessed 1<sup>st</sup> December 2023)

<sup>178</sup> Pezzullo, L., et al (2017). The economic impact of sight loss and blindness in the UK adult population. *BMC Health Services Research*. 18(1). doi: <https://doi.org/10.1186/s12913-018-2836-0>.

life. This equates to a prevalence across all ages of 2.8%, which is lower than the average for England of 3.3%, but higher than the average for London (2.2%).

Future projections expect 14,200 people in Barnet to be living with sight loss in 2032, which is an increase of 25% over the course of 10 years.

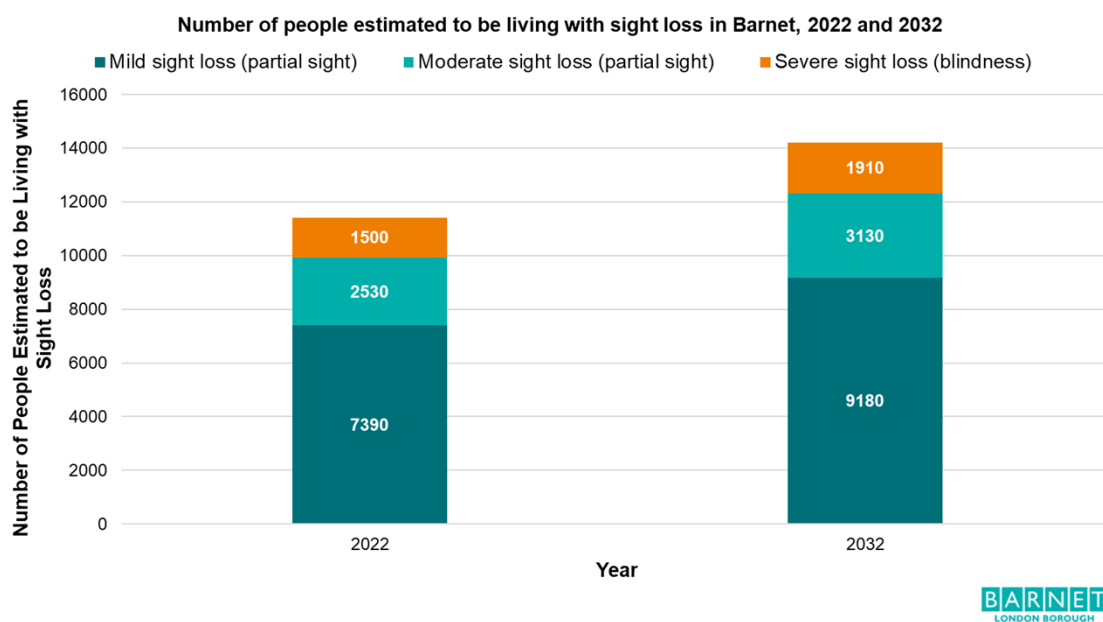


Figure 69 Estimates for number of people living with sight loss in Barnet, split by severity. Includes projections to 2032, RNIB.

A Certificate of Vision Impairment (CVI) certifies a person as either sight impaired (partially sighted) or severely sight impaired (blind). The purpose of the CVI is to provide a formal referral route for someone with sight loss to social care services; they can then offer registration and other relevant advice and services.

Registration as blind or partially sighted is voluntary, however it can support with tax allowance, access to loan equipment, and help with the cost of travel. If the individual agrees to be registered, social services will contact them to discuss carrying out a needs assessment. Even if registration is declined, social services should still provide support to promote independence.

A break down by type of registration (blind or partially sighted) and age group for those aged 18+ is shown in Figure 70. A significant proportion of those who are registered blind or partially sighted are aged 75+. This age group are also likely to have other long-term conditions, further impacting the barriers those with visual impairment already face. This includes lower employment rates, and engagement with volunteering opportunities and social connectedness. Additionally, access to digital technology is noted to be a lot lower in older people with visual impairment, compared to younger people with visual impairment<sup>136</sup>.



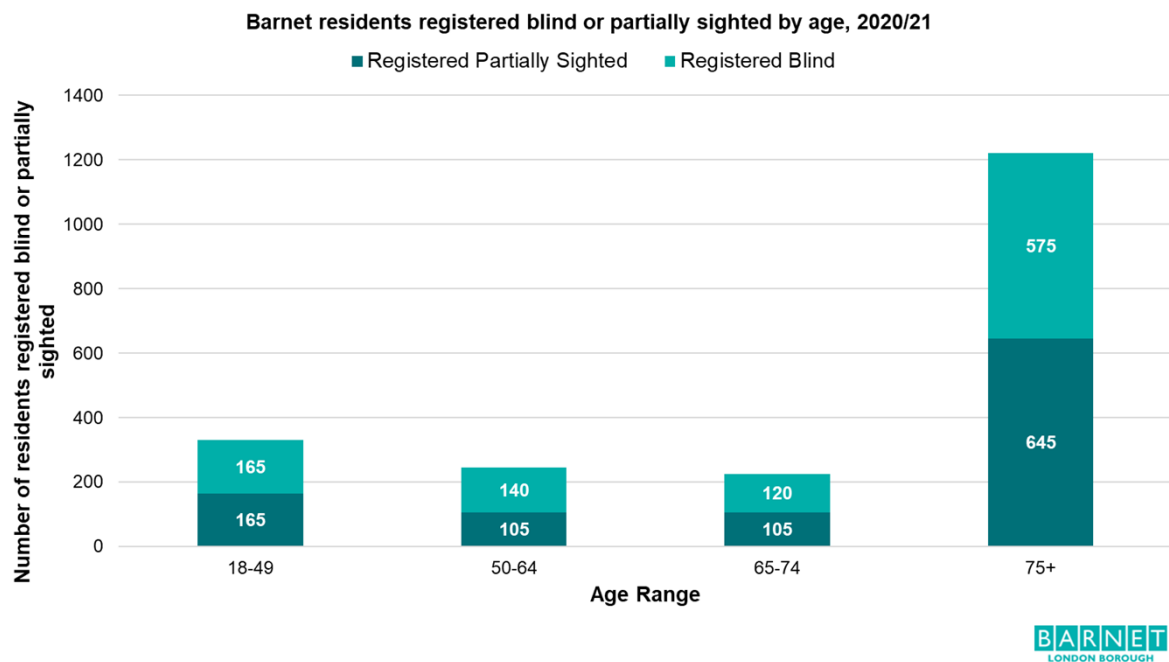


Figure 70 Numbers of Barnet residents who were registers as blind or partially sighted in 2020/21, split by age band.

A more detailed analysis of visual impairment in Barnet, including eye health and social care landscape is available from the [Sight Loss Data Tool](#).

#### **Middlesex Association for the Blind (MAB)**

MAB is a registered charity which aims to support those with visual impairment to lead independent lives. They have local provision of services such as home visiting, rapid response counselling, employment support, Braille, and IT training. They also have a Mobile Resource Unity which visits various venues and providing information, advice, and an opportunity to try specialist equipment for those living with a visual impairment. More information can be found on their website: [Middlesex Association for the Blind – supporting people with sight loss since 1922 \(aftb.org.uk\)](http://Middlesex Association for the Blind – supporting people with sight loss since 1922 (aftb.org.uk))

## Hearing Impairment

Hearing loss can be congenital (from birth or shortly after) or acquired (can occur at any age). Acquired hearing loss can be due to injury, excessive noise (including occupational exposure), infectious diseases and age-related degeneration of sensory cells<sup>179</sup>.

The risk of hearing loss increases sharply with age, with around 71% of people aged 70+ living with hearing loss. Unassisted hearing loss has significant impacts in the process of ageing well, leading to isolation, depression and loss of independence and mobility<sup>180</sup>.

Data around hearing loss beyond childhood screening programmes is limited. However, NHS estimates based on prevalence of hearing loss by age indicate that as of 2020 there were 58,850 people in Barnet with clinically significant hearing loss (with a level of 25dBHL or more<sup>181</sup>), and over half of were aged 60+ (Figure 71)<sup>182</sup>. The same estimates suggest that there were potentially 4544 people aged over 70 who have severe or profound hearing loss in 2020 (with a level of 65dBHL or more). These figures are expected to continue to increase over the next decade.

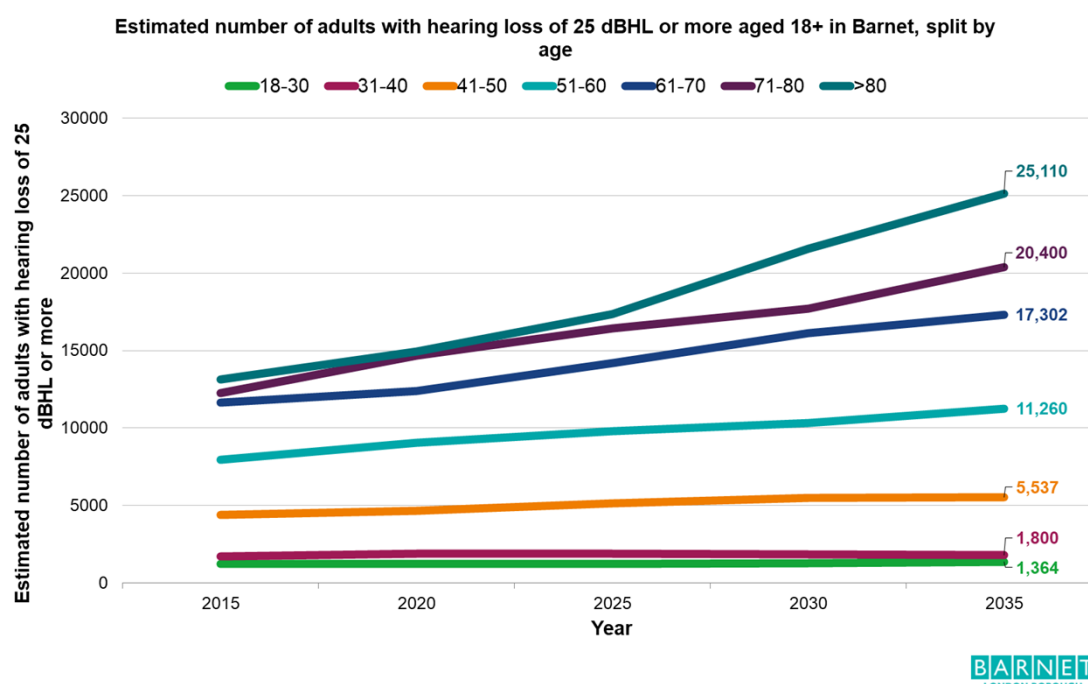


Figure 71 Estimated number of adults with hearing loss of 25 dBHL or more aged 18 and over from 2020 - 2035, split by age group, NHS.

The WHO suggest that half of hearing loss globally can be prevented with public health measures earlier in the life course. This includes reducing exposure to loud sounds (both occupational and recreational), rational use of medications which can cause hearing loss, screening for early signs and campaigns to raise awareness<sup>138</sup>.

<sup>179</sup> World Health Organization (2023). *Deafness and hearing loss*. (Online) Available at: [Deafness and hearing loss \(who.int\)](https://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss) (Accessed 1<sup>st</sup> December 2023)

<sup>180</sup> Hearing Link (2016). *Facts about deafness & hearing loss - Hearing Link*. (Online) Hearing Link. Available at: [Deafness & hearing loss facts - Hearing Link Services](https://www.hearinglink.org.uk/facts-about-deafness-and-hearing-loss) (Accessed 1<sup>st</sup> December 2023)

<sup>181</sup> World Health Organization (2008). *World Health Organisation Grades of Hearing Impairment*. (Online) [ec.europa.eu](https://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&plugin=1). Available at: [Table 4: World Health Organisation Grades of Hearing Impairment - Figures and Tables \(europa.eu\)](https://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&plugin=1) (Accessed 1<sup>st</sup> December 2023)

<sup>182</sup> NHS (2019). *NHS England» Hearing Loss Data Tool*. (Online). Available at: [NHS England » Hearing Loss Data Tool](https://www.hearingloss.org.uk/hearing-loss-data-tool) (Accessed 1<sup>st</sup> December 2023)

NHS England published a guide for commissioners and providers of social and medical care in relation to hearing loss and healthy ageing<sup>183</sup>. It can be read in full here: [NHS England Healthy Ageing 'What Works' Guide](#). It outlines the impact of hearing loss across physical and mental health, access to services, economic impact and the responsibilities of commissioners and providers.

Recommendations include early detection of hearing loss (for example with screening services) and adhering to accessible information standards.

Hearing tests are available on the NHS following a GP assessment and referral. Some causes of hearing loss in older age such as build-up of wax in the ear canal are reversible. Technology such as hearing aids and cochlear implants enable people who are deaf or hard of hearing to stay socially active, reduce the risk of depression and may reduce the risk of dementia.<sup>184,185</sup>

### **Barnet Council: Deaf and Hard of Hearing Engagement Project, 2023**

Working with research and findings from a [2021 Healthwatch report](#), LBB conducted solutions focused engagement sessions based on tools, processes, partnerships and training which can be implemented to make public services more accessible to deaf and hard of hearing residents.

As part of the council's [digital inclusion strategy](#) and accessibility initiatives, the team procured a [BSL online tool](#) which enables deaf and hard of hearing residents to dial in a BSL interpreter when accessing council services. Throughout the implementation of this tool LBB worked with the supplier, Interpreters Live, and community organisation Jewish Deaf Association (JDA), to test the tool with residents and receive feedback about their experience with the product.

Through these discussion groups, a solution-focussed approach was used to where residents have seen examples of how recommendations are implemented in the borough, and where they have, the impact this measure has had in making public services more accessible. The information will be incorporated into a report due to be finalised in March 2024. An engagement programme is being developed to provide tailored information sessions to residents who are deaf and hard of hearing, building trust in council services and understanding how better to keep residents informed on topics that are important to them, enabling them to thrive in Barnet.

### **Limitation of day-to-day activities**

Barnet residents reported the degree to which their day-to-day activities were limited (or activities of daily living; ADLs), according to if they were disabled under the disability act in Census 2021<sup>186</sup>. This is summarised in Figure 70. The highest number of people reporting significant to ADLs was between the ages of 55-64 for both males and females. Across all ages from 35 to 85+, there were a greater number of females reporting limitation of activities compared to males. The distribution

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<sup>183</sup> NHS England (2019). *What Works: Hearing Loss and Healthy Ageing*. (Online) Available at: [NHS England Healthy Ageing 'What Works' Guide](#) (Accessed 1<sup>st</sup> December 2023)

<sup>184</sup> Royal National Institute for Deaf People (RNID). *Get your hearing tested* (Online). Available from: [Get your hearing tested - RNID](#). (Accessed 1<sup>st</sup> December 2023)

<sup>185</sup> Wolff A, Houmøller SS, Tsai LT, Hougaard DD, Gaihede M, Hammershøi D and Schmidt JH. The effect of hearing aid treatment on health-related quality of life in older adults with hearing loss. *International Journal of Audiology* (2023), pp.1-10.

<sup>186</sup> LBB Insights and Intelligence Team, *Age-Related Census Data, broken down by age and other demographic or census topics*. Data from Office for National Statistics - Census 2021. Date of access: 31<sup>st</sup> July 2021.

seen could be explained by the higher numbers of females in Barnet’s population across these age ranges (Section 5.1). Additionally, the life expectancy for females is higher than males in Barnet, which could explain the decline in numbers seen after the age of 65-74 for males but increase for females.

Due to the nature of how the census is recorded, this data would not capture the entire Barnet population who report that their ADLs are limited a lot. People may also underreport the degree to which activities are limited; where two people have the same limitation to ADLs, one might perceive this as ADLs being limited ‘a little’ and another may report this a ‘a lot’.

For the population aged 55-64, people may still be in employment, or may not be able to work because of the barriers they face living with their disabilities. The higher numbers seen across this age range prompts consideration of the level of support and reasonable adjustments for work that is received. Further work should be done to understand how better we can meet the needs of this population with support to undertake day-to-day activities where appropriate.

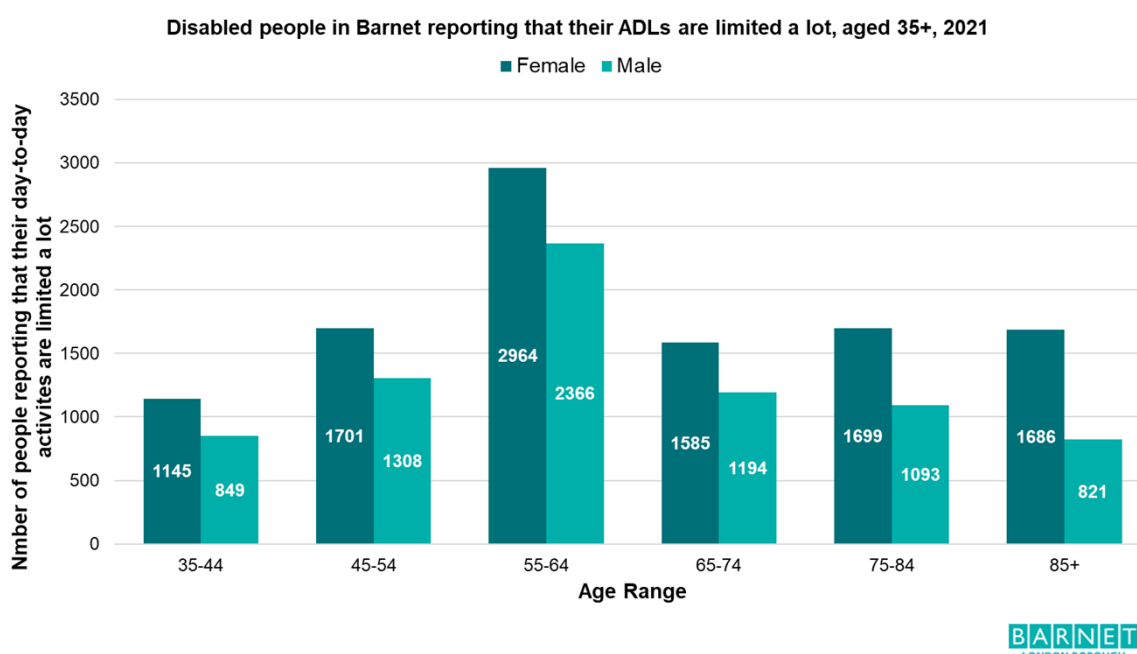


Figure 72 Data from Census 2021. People with disabilities (under the Equality Act) who report that their day-to-day activities are limited a lot. Split by age range and sex.

The government published the UK National Disability Strategy in July 2021<sup>187</sup>. It recognises the inequalities and disadvantage experienced by people living with a lifetime disability. This includes reduced access to transport and essential services, lower likelihood of having a job or owning their own home, increased exposure to harassment or prejudice, and becoming the victim of crime. The aim of the strategy is to increase opportunity in all areas of disabled people’s lives and change the public’s perceptions.

<sup>187</sup> HM Government (2021). *National Disability Strategy*. (Online) Available at: [National Disability Strategy - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/national-disability-strategy) (Accessed 1<sup>st</sup> December 2023)

## Habitus Report<sup>188</sup>

An ethnographic research study was conducted in May 2023 with Barnet Council and Habitus, to understand the lived experience of disabled residents living in Barnet. A survey was conducted, as well as deep engagement with 26 disabled residents, parents, and carers across Barnet. Their experiences of disability ranged across sensory impairment, neurodiversity, mobility issues, mental ill health and other medical conditions.

Participants reported that discrimination and social exclusions accumulates over time. Barriers experienced included inaccessible communication, lack of coordinated service provision. Negative experiences often led to disengagement with the council or external service providers inevitably leading to isolation and poorer health outcomes.

People with disabilities including carers are reliant on social networks to engage in community life, and information sharing is often within these social networks. They also reported the value of co-production, and the importance of participation being through a range of forums (in-person, online, social media) for inclusion.

Recommendations from the report are summarised below:

1. **Understanding:** recognising intersectional identities can be useful in better understanding the lived experience of people with disabilities and their carers. Opportunities to engage with community-based initiatives and seek preventative support enable people engage in community life more meaningfully.
2. **Making information accessible:** using different routes to spread information in online and community spaces. Communications should be in everyday language.
3. **Community matters:** bridge community sector organisations across Barnet. This bringing together people from different age groups, communities, and backgrounds together
4. **Opportunities for Engagement and Co-production:** extended community engagement activities to reach a wider pool of people. Closing the feedback loop will maintain trust and buy-in following engagement. Opportunities for solution-focussed discussions are important, particularly with challenges or barriers that speak to lived experiences.

## Environment

Age UK released a Factsheet in March 2023 around equipment and home adaptation for people with disabilities<sup>189</sup>. It covers the process of a needs assessment being carried out by the local authority and examples of equipment and adaptations. The fact sheet also covers the means-tested disabled facilities grant (DFG), it can support in work such as access, moving between floors, transfers, and accessible kitchen facilities. In England, the maximum entitlement of the grant under DFG is currently £30,000 however local authorities have power to give additional discretionary assistance for adaptation or support a move to alternative accommodation. More information on the process in Barnet is available from the council website: [Apply for a Disabled Facilities Grant | Barnet Council](#).

The outdoor environment also presents many challenges to people with sensory and physical impairments. For example, through uneven pavements or footpaths, lack of accessible public spaces or toilets. Advisory access standards for outdoor spaces are available from the Sensory Trust<sup>190</sup>.

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<sup>188</sup> Habitus and LBB (2023). *Ethnographic Research Study to Understand the Lived Experience of Disabled Residents Living in Barnet. Summary of the Final Report May 2023*. Habitus.

<sup>189</sup> Age UK (2023). Factsheet 42: *Disability equipment and home adaptations*. (Online) Available at: [Disability equipment and home adaptations \(ageuk.org.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

<sup>190</sup> The Sensory Trust (2023). *Access Standards*. (Online) [www.sensorytrust.org.uk](#). Available at: [Access standards and recommendations for outdoor spaces \(sensorytrust.org.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

These help with benchmarks to identify where improvements should be made and identifying areas of best practice.

National initiatives such as [Euan's Guide](#) aim to tackle the lack of trusted, up to date disabled access information. An annual access survey is also undertaken. In 2022 72% people reported accessibility

### Inclusion Barnet

Inclusion Barnet is a deaf and Disabled People's Organisation, using lived experience for social change. They aim to advocate for services which meet the needs of disabled people, and support disabled people to raise awareness of the barriers they face. Inclusion Barnet also offer peer support, benefits advice, and work with the health heart peer support project in Barnet. Further information on their work can be found online: [Inclusion Barnet | We Believe in the Power of Experience](#).

information on websites misleading, confusing or inaccurate and over half of people reported avoiding going somewhere because it had not shared disabled access information. Top accessible facilities needed to improve confidence were accessible parking and toilets<sup>191</sup>. Similar local initiatives could help improve accessibility of public spaces in Barnet and have a positive impact across the wider determinants of health.

## 10.4 Severe Mental Illness

Severe mental illness (SMI) refers to psychological problems which are debilitating to the extent where it affects people's ability to engage in functional and occupational activities. People with SMI often have a diagnosis of schizophrenia or bipolar disorder. People with SMI have significantly higher levels of premature mortality than the general population. They also have a lower life expectancy by 10 to 20 years and the major causes of mortality in people with SMI include physical medical conditions such as CVD, CRD, DM or hypertension<sup>79</sup>. Suicide risk is also high following acute psychotic episodes and psychiatric hospitalisation. The NHS Five Year Forward View for Mental Health highlighted the need for action to address the physical health needs of people with SMI to reduce this inequality when compared to the general population<sup>192</sup>.

In Barnet, the premature mortality rates (mortality under the age of 75) for adults with SMI for 2018-2020 per 100,000 people was 68.5, this was the lowest mortality seen across NCL mortality, and significantly lower than mortality rates seen in London (102.5 per 100,000) and England (103.6 per 100,000)<sup>193</sup>.

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<sup>191</sup> Euan's Guide (2023). *Euan's Guide Access Survey 2022 Supported by Motability Operation*. (Online) Available at: [2022-euansguideaccesssurvey.pdf](#) (Accessed 4<sup>th</sup> December 2023)

<sup>192</sup> The Mental Health Taskforce (2016), NHS England. (Online) Available at: ['Five Year Forward View for Mental Health'](#) (Accessed 17<sup>th</sup> November 2023)

<sup>193</sup> North London Partners (June 2022). *Live Well (2)*, NCL population health outcomes framework.

Rates of preventative screening such as physical health check and cancer screening are lower amongst people with SMI<sup>194,195</sup>. An annual physical healthcare check offers opportunities for improving health outcomes for people with SMI.

In Barnet, for the fourth quartile of 2021/22 only 30% of people with SMI were recorded as having an annual health check (Figure 73). This was the lowest across NCL, and significantly lower than what was seen in London (45%) and England (43%). Furthermore, only 41% of people with SMI had a comprehensive care plan in Barnet in 2020/21<sup>193</sup>. This highlights the missed opportunities for holistic review of physical and mental healthcare in the community, which contribute to poorer health outcomes seen in people with SMI. The National Institute for health and Care Research set out recommendations in 2023 to help support the physical health of people with SMI<sup>78</sup>. These included methods to increase uptake of physical health checks through telephone invitations, earlier intervention for clusters of multiple health conditions and longer consultations to combine management of both physical and mental health conditions.

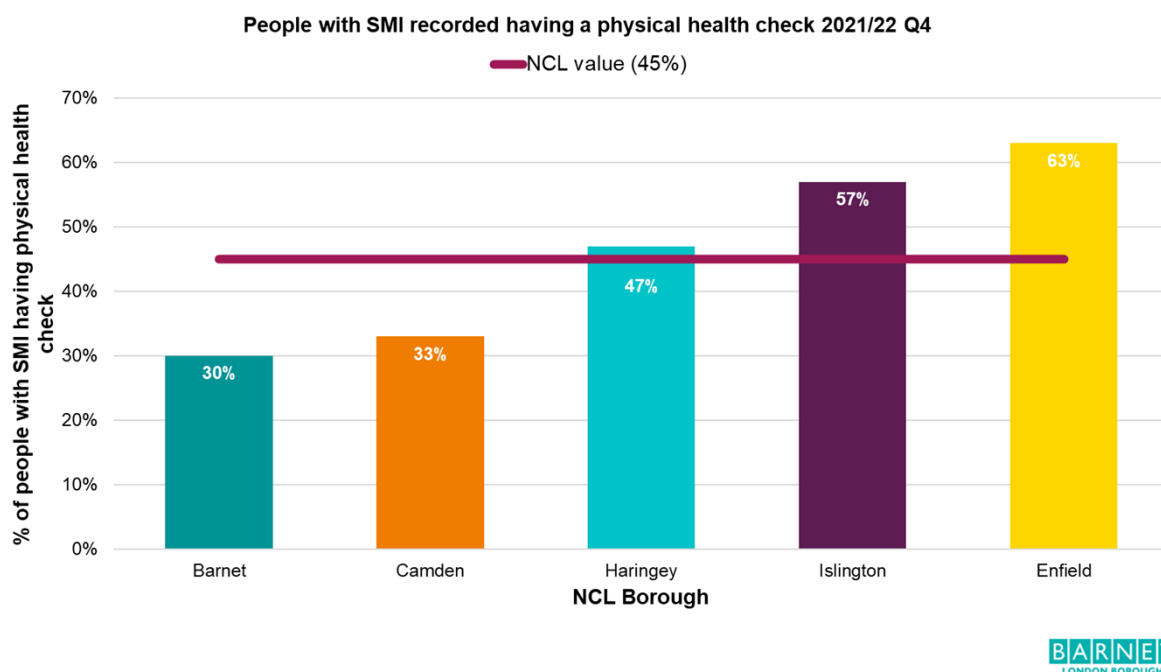


Figure 73 Percentage of people with SMI who received a physical health check in 2021/22 across NCL boroughs

## 10.5 Inclusion Health Groups

Inclusion health is an umbrella term to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. People belonging to inclusion groups, tend to have

<sup>194</sup> Powell, M. (2023). *Supporting the physical health of people with severe mental illness*. (Online) National Institute for health and Care Research (NIHR). Available at: <https://evidence.nihr.ac.uk/collection/supporting-the-physical-health-of-people-with-severe-mental-illness/> (Accessed 24<sup>th</sup> November 2023)

<sup>195</sup> Lamontagne-Godwin, F *et al.* (2018). Interventions to increase access to or uptake of physical health screening in people with severe mental illness: a realist review. *BMJ Open*, 8(2), p.e019412. DOI: <https://doi.org/10.1136/bmjopen-2017-019412>



very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities<sup>196</sup>.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered. This in turn will negatively impact the process of healthy ageing.

The NCL Population health and Care Strategy<sup>197</sup> has highlighted inclusion health as a key component of its strategy, as well as one of its locally nominated PLUS groups from the Core20PLUS5 framework<sup>10</sup>. NCL completed an inclusion health needs assessment<sup>198</sup> to better understand the demographics, health needs, experiences, and service provision for inclusion health groups. Two population groups are explored within this needs assessment but a more detailed understanding of other inclusion health groups across NCL can be found within the NCL Inclusion HNA.

### **People Experiencing Homelessness**

The legal definition of homelessness is that a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough. It includes people who are roofless, houseless (temporary places to sleep), live in insecure housing or living in inadequate housing. The causes of homelessness are typically described as either structural or individual and can be interrelated and reinforced by one another. Causes and their relationship vary across the life course<sup>199</sup>.

Older homelessness is identified as those who are aged 55+. This is because homelessness and long periods of rough sleeping can accelerate the ageing process and health conditions associated with ageing<sup>200</sup>. Nearly half of the street homeless population in London were found to have some form of mental ill health, and higher levels of prevalence in the older homeless population is recorded globally<sup>152</sup>.

LBB completed a Health Needs Assessment of Rough Sleepers in 2021<sup>201</sup>. A multiagency partnership task and finish group was established during the COVID-19 pandemic. They developed the needs assessment to understand the support and needs for the people who are homeless in Barnet. Key findings report on the wider determinants of health, experiences of health services, health related behaviours, mental health and substance misuse. The HNA also explores multiple exclusion homelessness, highlighting the importance of integrated working across health and social care for people to access and navigate the range of physical and mental health and substance misuse services they require to sustain stable accommodation. Key recommendations from this report included addressing barriers to accessing suitable health care, addressing substance misuse, and

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<sup>196</sup> NHS (2022). *NHS England» Inclusion health groups*. (Online) [www.england.nhs.uk](http://www.england.nhs.uk). Available at: [NHS England » Inclusion health groups](#) (Accessed 4<sup>th</sup> December 2023)

<sup>197</sup> NCL ICS (2023). *North Central London Population Health and Integrated Care Strategy*. (Online) Available at: [PowerPoint Presentation \(nclhealthandcare.org.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

<sup>198</sup> Camden and Islington Public Health on Behalf of NCL ICB (2021). *NCL Inclusion Health Needs Assessment*. [democracy.islington.gov.uk](http://democracy.islington.gov.uk). Available at: <https://democracy.islington.gov.uk/documents/s33383/2a%20-%20NCL%20IHNA%20Islington.pdf> (Accessed 4<sup>th</sup> December 2023)

<sup>199</sup> Public Health England (2019). *Homelessness: applying All Our Health*. (Online) GOV.UK. Available at: [Homelessness: applying All Our Health - GOV.UK \(www.gov.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

<sup>200</sup> Centre for Policy on Ageing (2017). *Diversity in older age – Older homelessness*. (Online) Available at: [CPA- Rapid-Review-Diversity-in-Older-Age-Older-Homeless-People.pdf](#) (Accessed 4<sup>th</sup> December 2023)

<sup>201</sup> Songer, L (2021). *Health and Wellbeing Needs Assessment of Rough Sleepers in Barnet*. Available at: [Barnet rough sleeper HNA 2021 Final 050721.pdf \(moderngov.co.uk\)](#) (Accessed 7<sup>th</sup> February 2024)



improving migrant health. It was identified through the HNA that many non-UK rough sleepers do not engage with local services.

In Barnet, for the period 2021/22, 4.5 households per 1000 households were owed prevention or relief duty under the Homelessness Reduction Act (HRA), where the main applicant was aged 55+ (Figure 74). This was significantly higher than the England average (2.8/1000), but lower than the London average (5.2/1000)<sup>202</sup>. This is an important to measure to consider as over recent years there has been a significant increase in homelessness experienced by older adults. People are increasingly living in the private rented sector and older households are also living in poverty. Note a reduction in number of households during the COVID-19 pandemic, which may reflect a reduction in services and fewer people presenting for housing support. More recent data following the pandemic should be monitored to see if there is a projected increase.

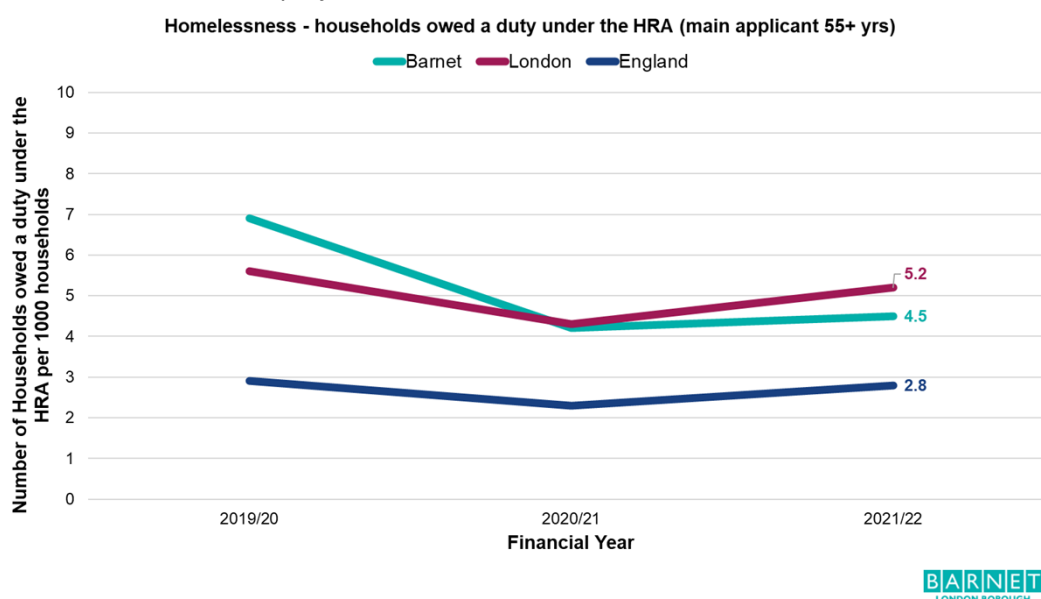


Figure 74 Households owed a duty under the HRA (where the main applicant is aged 55+), for Barnet, London, and England between 2019/20-2021/22. Value provided as a crude rate of the number of households per 1000 households.

Data is available on the number of people reported to be rough sleeping in Barnet via the CHAIN annual reports. In 2022/23 it was reported that 166 people were rough sleeping in Barnet<sup>203</sup>. This value is likely an underestimate as people are recorded as having been seen rough sleeping if they have been encountered by a commissioned outreach worker bedded down on the street, or in other open spaces or locations not designed for habitation (for example doorways, stairwells, parks or derelict buildings).

People who are rough sleeping are likely to experience poorer health outcomes when we consider the effect of adverse weather, such as extreme heat and cold. Older people experiencing homelessness have additional factors which compound this further. The UK Health Security Agency

<sup>202</sup> OHID (2022), Improve Wellbeing and Wider Determinants of Health, *Productive Healthy Ageing Profile*. (Online). Available at: [Productive Healthy Ageing Profile](#). (Accessed 4<sup>th</sup> December 2023)

<sup>203</sup> Greater London Authority (2022). *Rough sleeping in London (CHAIN reports) – London Datastore*. (Online) Available at: [Rough sleeping in London \(CHAIN reports\) - London Datastore](#) (Accessed 4<sup>th</sup> December 2023).

(UKHSA) have provided guidance to support people who are homeless and sleeping rough<sup>204</sup>. Recommendations include having individual care plans where possible, engaging with people who have lived experience to understand the local context and where people are likely to go in the hot weather and increasing public information on available water sources and access to shade. Similar guidance is also available for supporting people during cold weather<sup>205</sup>. Night shelters are available within Barnet for the winter months, and recommendations within this guidance include the implementation of public health principles, for example single-room accommodation to prevent the spread of respiratory infections, especially for older adults, and appropriate ventilation.

The Centre for Policy on Ageing set out some measures which could help prevent homelessness in older age<sup>152</sup>. Particularly avoidable areas were where there were housing support for administrative problems, monitoring rent arrears for signs of exception risk or vulnerability, identification in healthcare settings and collaborative working between professional agencies. Many older people in temporary accommodation are ready to move out but unable to do so because of lack of suitable or affordable accommodation. Age UK published a policy position paper on Older Homelessness in 2019<sup>206</sup>. Proposals are set out on a national and local level. At a local level, a variety of recommendations are made. These include proactive advice and assistance for older people facing arrears and debt, long term secure tenancies linked to ongoing care and support, and specialist worked to work with older people experiencing homelessness to ensure access to appropriate support.

The 2021 HNA of Rough Sleepers provided a summary of health conditions in the GP-registered population, where people were identified as experiencing homelessness. In July 2020, 663 people were identified as registered to a GP, with 2/3 of them being male, and 1/3 female. The most prevalent health conditions identified in this group included mental health (54%, n=356), musculoskeletal and physical trauma (23%), skins and subcutaneous tissue disease (23%) and respiratory conditions (16%). National data supports that the homeless population have higher incidence of these conditions when compared to an entire local population. Other conditions identified nationally include cardiovascular disease and hepatitis C<sup>201</sup>. Other challenges related to health outcomes include those with complex needs (for example substance misuse and high-level mental health needs), accessing services when at crisis point and trying to address prevention (for example through screening programmes) where people have more acute health needs.

NICE have developed thorough guidelines on providing integrated health and social care services for people experiencing homelessness, which is also supported in the recommendations through the

### **Homeless Action in Barnet (HAB)**

HAB support Barnet's vulnerable population to gain access to housing, health, and other services. In doing so they support people to make their own effective choices, and to express themselves as fully independent members of society. They offer practical services such as Wi-Fi connectivity, showers, food, and laundry facilities. However, they also work with people experiencing homelessness and help advocate in accessing services related to housing, emotional wellbeing and tenancy support. A specialist GP service running within HAB was identified as an effective intervention in the NCL Inclusion Health Needs Assessment. More information of HAB's work can be found here: [Homeless Action in Barnet \(habcentre.org\)](http://habcentre.org).

Barnet Homeless HNA<sup>207</sup>. Recommendations for planning and commissioning include creation of integrated multidisciplinary health and social care services, recognising the need for additional resources and targeted service delivery to account for the level need and address health inequalities experienced. Recommendations also identify support aimed at groups of people experiencing homelessness, in which it includes older people, disabled people, LGBT+ people and people from minority ethnic or religious backgrounds.

### Vulnerable Migrants

Data collected on the vulnerable migrant population is limited to a local authority level. Data from OHID fingertip profiles are only available from 2017, recording the rate of migrant GP registration per 1000 people. In Barnet this value was 24.7 registrations per 1000, which was significantly higher than the England average (12.6/1000), but lower than the London average (27.9/1000)<sup>208</sup>. More recent data is available on the numbers of asylum seekers who reside in contingency accommodation sites in Barnet. Breakdown by age is in broad ranges, splitting adults into ages 18-64 and 65+. This breakdown is shown in Figure 75. Older adult asylum seekers only make up 1% of this population. However, a more detailed breakdown is not available for those approaching this age. It is important to acknowledge that lack of data available which would help ensure that preventative and health promotion initiatives are accessible to this population.

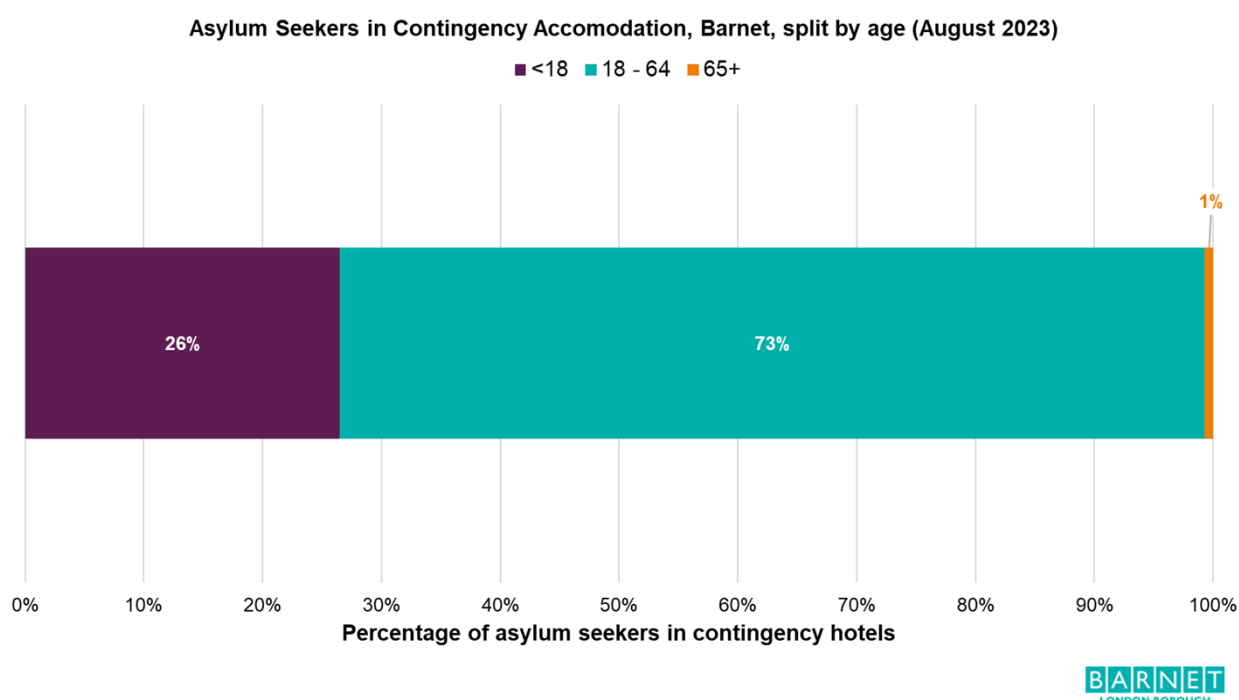


Figure 75 Age Breakdown of Asylum Seekers in Barnet living in contingency hotels, August 2023

OHID have developed a Migrant health Guide<sup>209</sup> to support primary care practitioners in delivering healthcare services. Other organisations such as Doctors of the World Safe Surgeries support GPs to tackle barriers faced by excluded groups with resources, translated posters and training. In Barnet a

<sup>207</sup> NICE (2022). *Integrated health and social care for people experiencing homelessness*, NG214 (Online) Available at: [Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE](#) (Accessed 4<sup>th</sup> December 2023).

<sup>208</sup> OHID (2019). *Migrant GP registration: rate per 1000 population*. (Online) Available at: [Migrant GP Registrations](#) (Accessed 4<sup>th</sup> December 2023).

<sup>209</sup> OHID (2021). *Migrant Health Guide*. (Online) GOV.UK. Available at: [Migrant health guide - GOV.UK \(www.gov.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

Migrant Health Needs Assessment was carried out in 2022, resulting in an Asylum Seeker Health Action Plan. This incorporates elements of prevention and accessibility of services to this population; including cancer screening services; translated materials development of a welcome pack to help with access to healthcare services; and other support such as smoking cessation or opportunities for physical activity.

### **Low Health Literacy Levels**

Health literacy refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluation, use and navigate health and social care information and services. Levels of health literacy are also influenced by the provision of clearer and provision of clear and accessible health and social care services and information for all (service responsiveness)<sup>210</sup>. Limited functional health literacy predicts poor diet, smoking, and lack of physical activity. This is independent of risk factors associated with age, ethnicity, and other social determinants of health.

Little data is available on the level of health literacy in the population locally. Nationally data is only available from 2015, when it was reported that only 43% of the working age population at this time were able to make use of everyday health information, rising to 61% when numeracy skills were required for comprehension<sup>211</sup>.

Populations at higher risk of health literacy include older adults, those experiencing socioeconomic deprivation, people from ethnic minority groups, migrant populations and disabled people. Adults over the age of 65 years have the lowest levels of health literacy compared with younger age groups and health literacy skills have been found to decline rapidly from age 55. Older adults (over 50 years) with inadequate health literacy are also less likely to participate in cancer screening than those with adequate health literacy.

Where health primary and secondary preventative measures are used, efforts must be taken to understand the health literacy levels, to ensure reach to these vulnerable population groups and increasing their engagement. At the local level, a targeted approach, to improve the health literacy of disadvantaged or vulnerable groups within a broader strategy to improve health literacy and the conditions in which people are born, grow, live, work and age, can contribute to strategies to reduce health inequalities<sup>162</sup>.

The National Institute for health and Care Research (NIHR) also set out evidence-based recommendations in 2022, to help people understand health information better. This includes stressing benefits, providing only relevant online information or the effective use of pictures and guidelines<sup>212</sup>.

### **Ageing Well for Inclusion Health Groups**

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<sup>210</sup> Public Health England (2015). *Improving health literacy to reduce health inequalities*. (Online) Available at: [4a Health Literacy-Full.pdf \(publishing.service.gov.uk\)](#) (Accessed 4<sup>th</sup> December 2023)

<sup>211</sup> Rowlands, G. *et al.* (2015). A mismatch between population health literacy and the complexity of health information: an observational study. *British Journal of General Practice*. (Online) 65(635), pp. e379–e386. doi: <https://doi.org/10.3399/bjgp15x685285>.

<sup>212</sup> NIHR (2022). Health information: are you getting your message across? *NIHR Health and Social Care Services Research*. doi: [https://doi.org/10.3310/nihrevidence\\_51109](https://doi.org/10.3310/nihrevidence_51109).

OHID has written guidance<sup>213</sup> on the challenges faced by inclusion health groups, and strategies to include and support these populations. The guidance recommends actions for frontline workers, managers and senior or strategic leaders to address inclusion health challenges and enhance well-being. Examples include appropriate professional development and training opportunities for frontline workers, or pathways which support timely referrals to services and integrated approaches to improve health and wellbeing. A systematic review from 2018<sup>214</sup> also outlines effective interventions for marginalised and excluded populations. These should be considered within the context of ageing well in Barnet, to ensure strategies incorporate the needs of inclusion health groups.

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<sup>213</sup> OHID (2021). *Inclusion Health: applying All Our Health*. (Online) GOV.UK. Available at: [Inclusion Health: applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/94422/inclusion-health-applying-all-our-health.pdf) (Accessed 4<sup>th</sup> December 2023)

<sup>214</sup> Luchenski, S. et al. (2018). What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The Lancet*, 391(10117), pp.266–280. doi: [https://doi.org/10.1016/s0140-6736\(17\)31959-1](https://doi.org/10.1016/s0140-6736(17)31959-1)

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Health and Wellbeing Board

# Ageing Well Health Needs Assessment and Annual DPH Report 2024/25

Dr Madura Nanthakumaran

London Borough of Barnet Public Health

Caring for people, our places and the planet

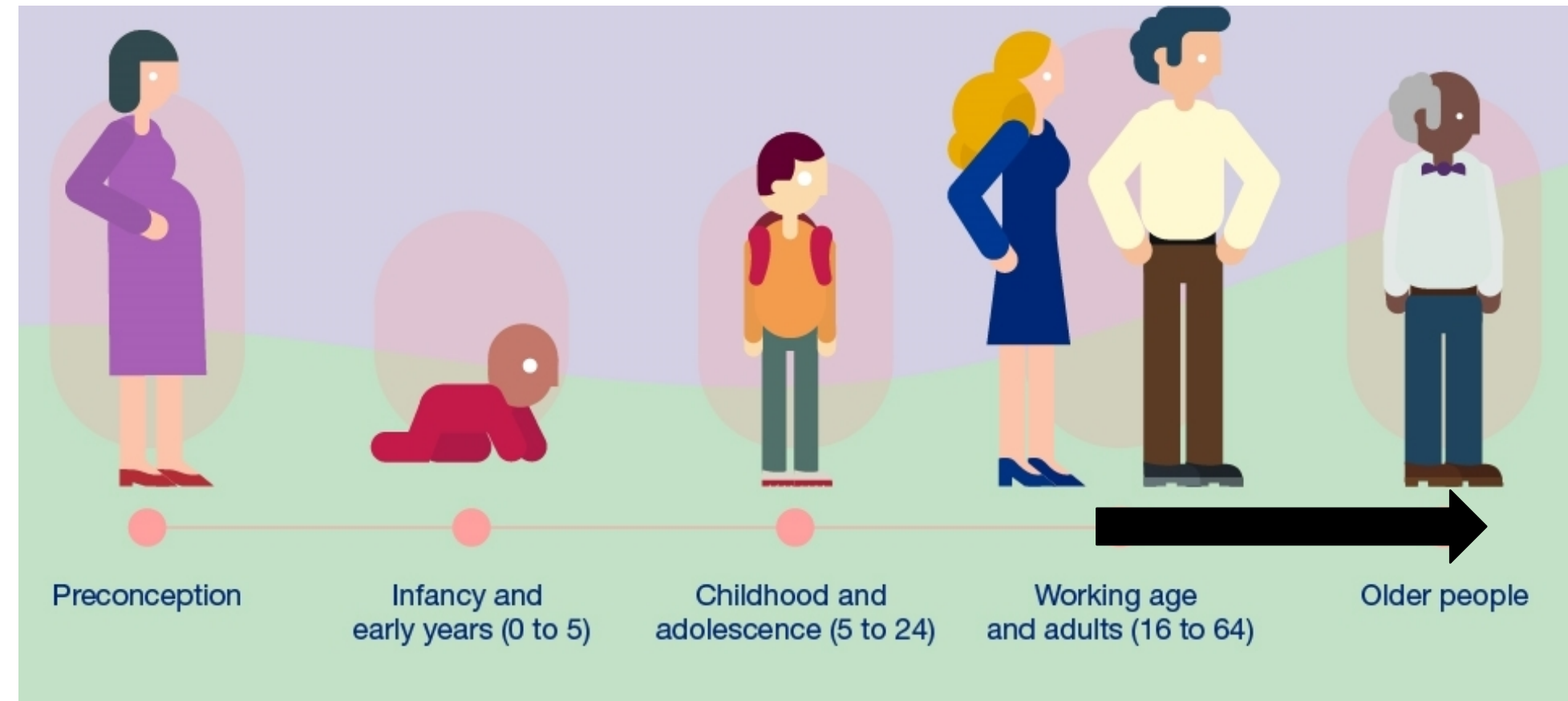
# How and Why

- The Ageing Well Health Needs Assessment (HNA) was written to develop the work in the Live and Age Well Team in LBB Public Health
  - Describe health outcomes of adults in Barnet and present health inequalities experienced.
  - Describe unmet need and make informed recommendations to enable Barnet's population to age well.
- Consulted a range of stakeholders
- Data from various sources



# Scope

- Recognise the life-course approach to ageing well
  - Health behaviours from adulthood
  - National health protection programmes offered to adults
  - Healthcare – secondary prevention and early diagnosis
  - Social care – older adults
  - Wider determinants – older adults



*Health matters: Prevention - a life course approach - GOV.UK ([www.gov.uk](http://www.gov.uk))*

# What do we mean by Ageing Well?

‘Healthy ageing is the process of **developing and maintaining the functional ability** that **enables wellbeing** in older age’

*World Health Organisation, 2020*

Health promotion  
and protection for  
adults

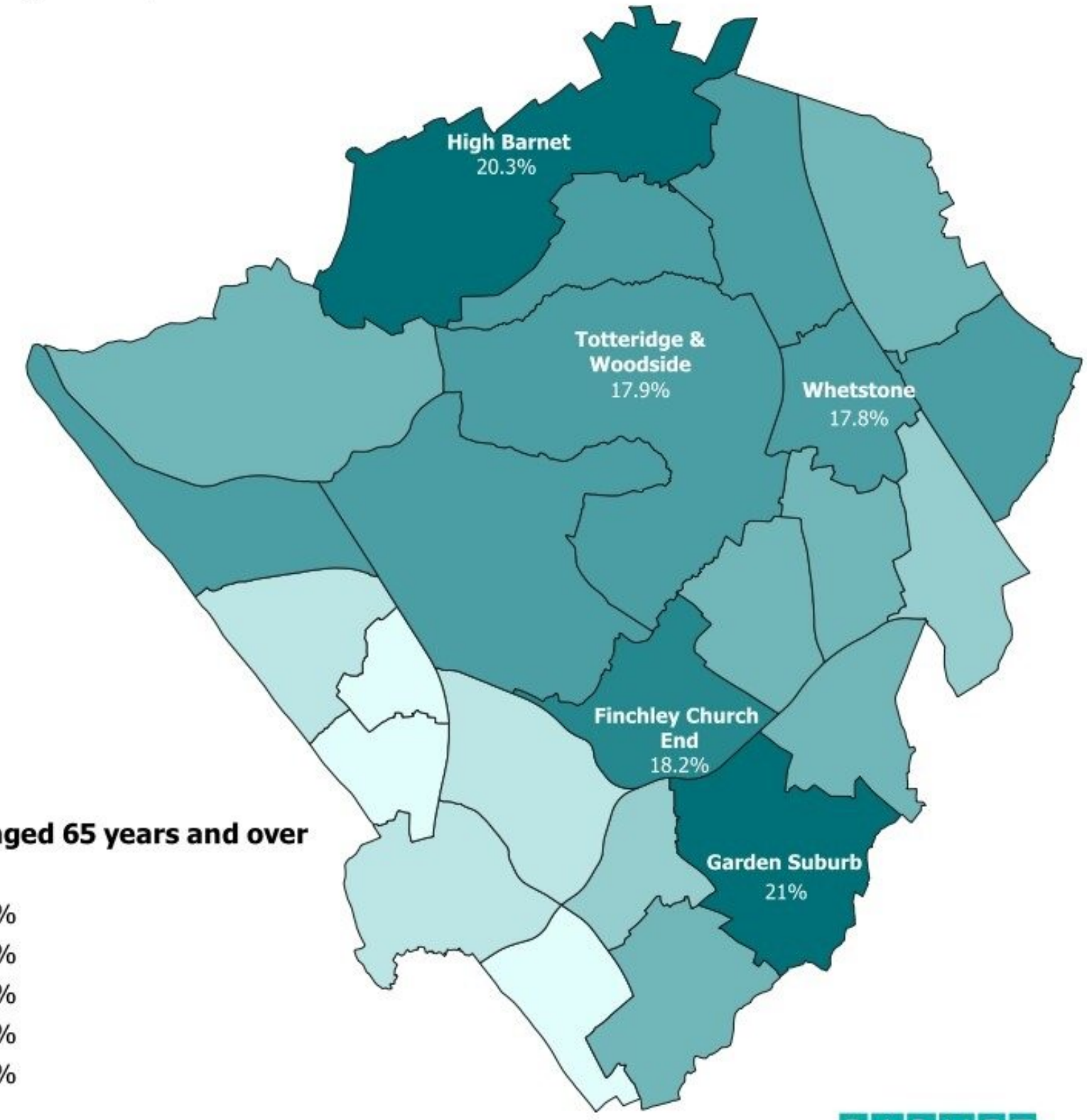
Health and social  
care needs

Wider  
determinants of  
health

Older adults with  
additional support  
needs

# Proportion of Population aged 65+ in Barnet

**Population aged 65 years and above**  
By ward



**Population aged 65 years and over**

- < 10%
- 10% - 12%
- 12% - 14%
- 14% - 16%
- 16% - 18%
- 18% - 20%
- > 20%

Census 2021 data © Crown copyright 2022.  
Source: Office for National Statistics licensed under the Open Government Licence v3.0



# Barnet Population Projections to 2043



Source: Office for National Statistics licensed under the Open Government Licence v3  
Population projections – local authorities: SNPP Z1 © Crown copyright 2020

# Healthy Life Expectancy

Life expectancy and healthy life expectancy at birth, males and females in Barnet, 2021



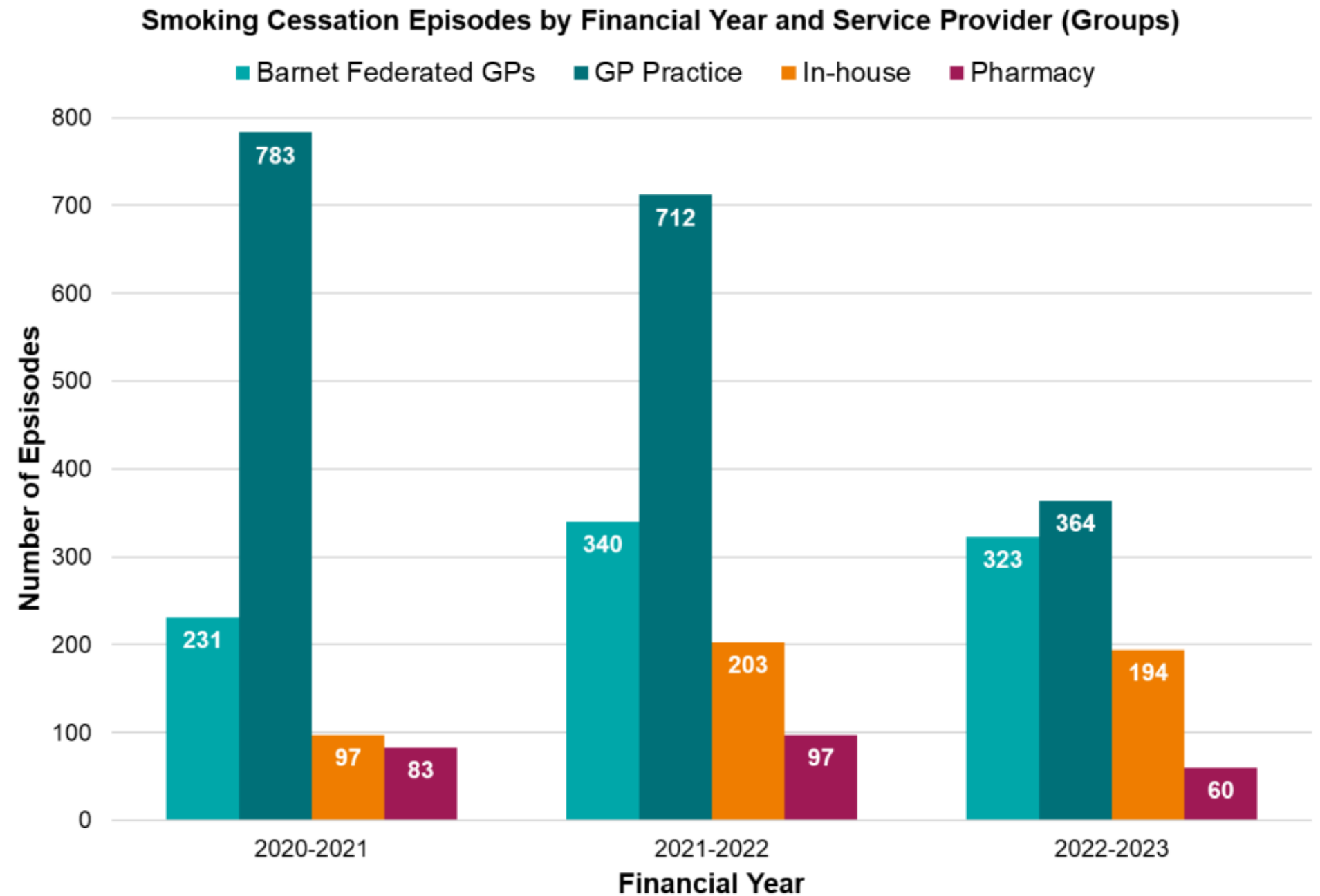
LBB PH (2024). JSNA Age Well

# Health Promotion - Behavioural Risk Factors

Morbidity in Barnet was significantly influenced by behavioural factors such as **tobacco, alcohol** use, **dietary** risks and low **physical activity** (GBD, 2019)

# Behavioural Risk Factors - Smoking

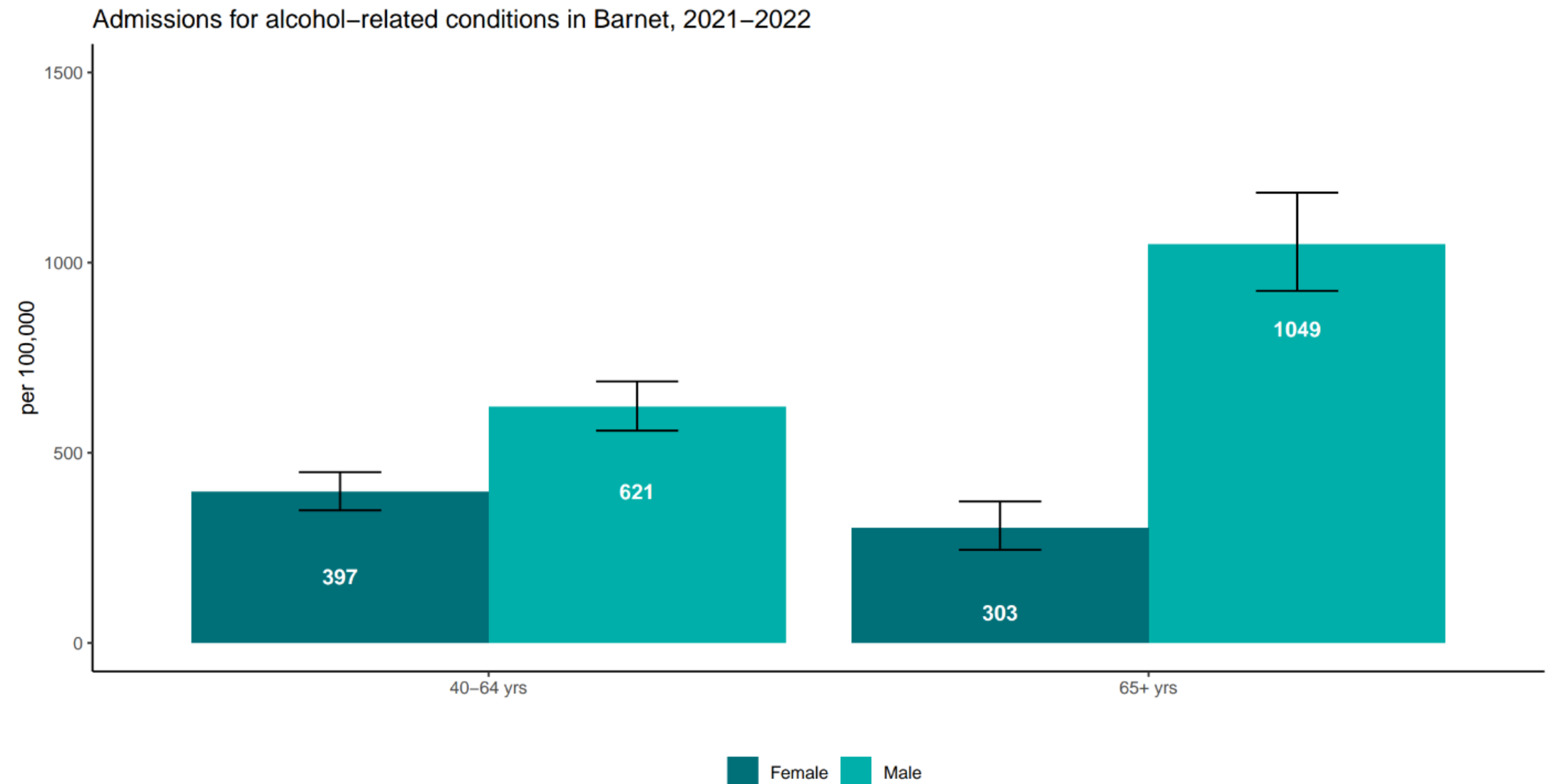
- Smoking prevalence – 10.5% (ASH, 2023)
- Higher prevalence and risk of tobacco-related morbidity for someone from area of higher deprivation (ASH, 2023)
- Decrease in total number of cessation episodes from 2018/19 to 2022/23





# Behavioural Risk Factors - Alcohol

- Hospital admissions for alcohol-related conditions in Barnet is lower compared to London and England
- Males aged 65+ had significantly higher rates of admission compared to females aged 65+
- Underrepresentation of older adults in substance misuse services



Source: OHID Fingertips © Crown Copyright Under the terms of the Open Government licence (OGL)

[JSNA – People – Ageing Well | Barnet Open Data](#)



# Behavioural Risk Factors

## Physical Activity

- Over 1 in 5 of adults (18+) in Barnet are physically inactive
- **Targeting those who are inactive** will produce the greatest reduction in chronic disease and contribute to healthier ageing

## Excess Weight

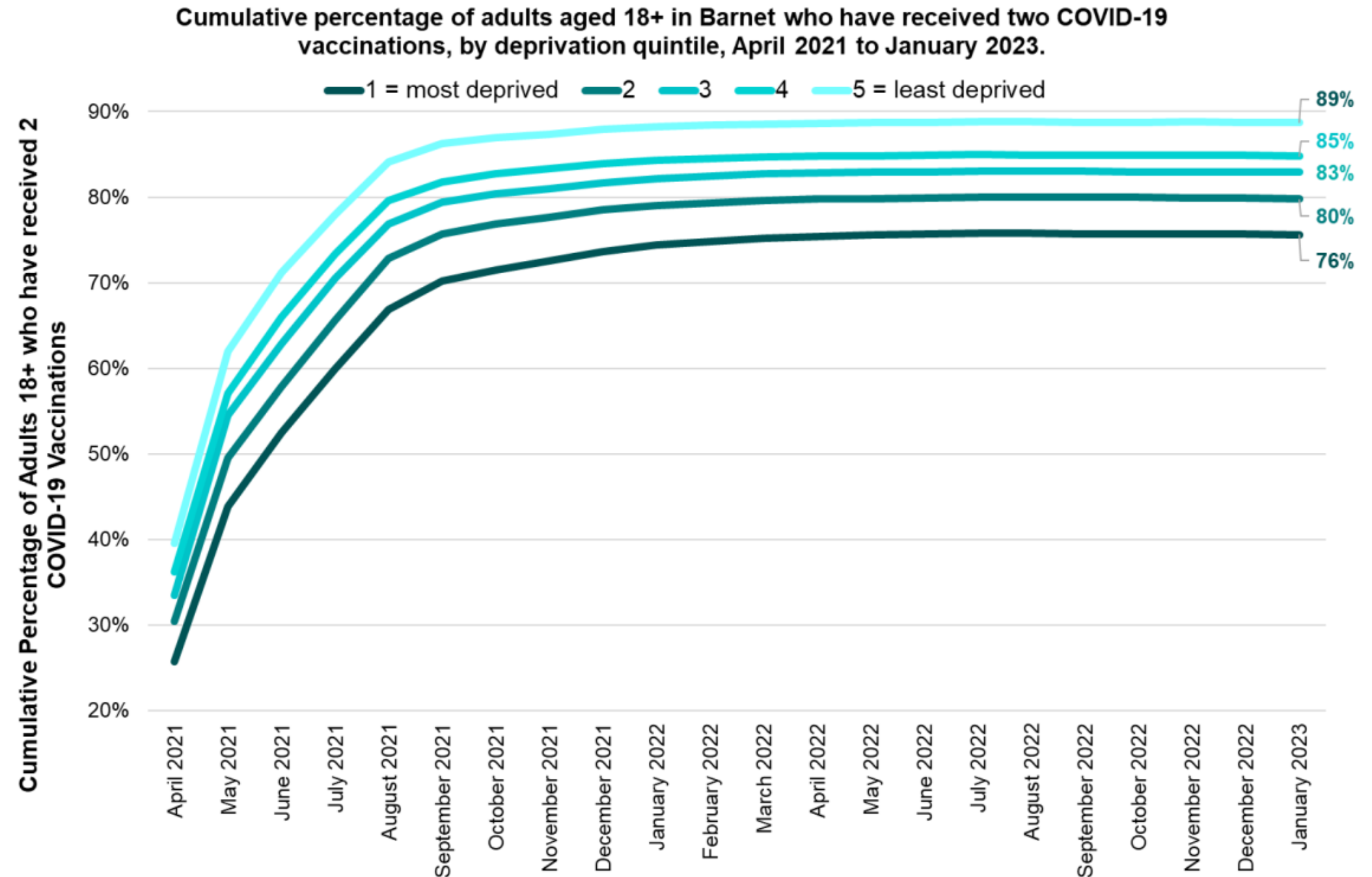
- **57.5%** of adults aged 18+ were overweight or obese in 2021/22
- **Obesity rates vary among ethnic groups** in Barnet. The highest percentage of obesity in adults was seen in 'Black' ethnic groups (22.94%).

## Diet

- Age UK Barnet Survey data shows that people from **older age groups are less likely to report that they meet the recommended '5-a-day'** (2023)
- Nationally, reports suggest that 1 in 10 people aged 65+ are **malnourished** or at risk of malnutrition

# Adult Vaccination Coverage

- Reduction in vaccination uptake across adult vaccination programmes during the first wave of the COVID-19 pandemic (2019/20).
- COVID-19 vaccination (April 2021-January 2023)  
variation in the percentage of adults receiving two doses between the **most and least deprived quintiles** in Barnet



CHIME, 2023

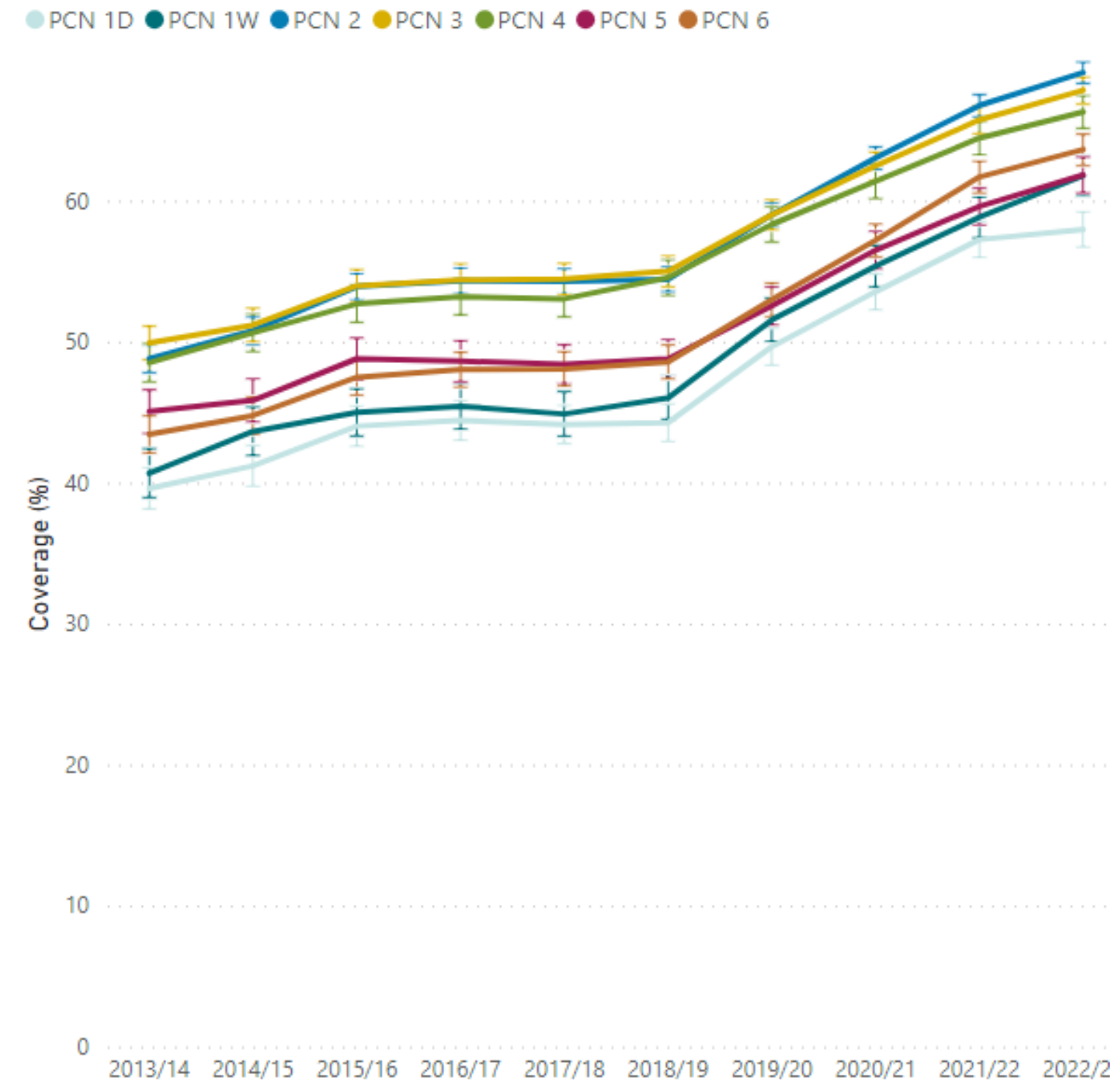
# National Screening Programmes

- Reduction in screening coverage for breast cancer, cervical cancer and AAA during pandemic

Decline in cervical screening coverage for people aged 50-64 preceded pandemic

- Improving coverage for bowel cancer across Barnet, London and England
- Neoplasms were the main cause of preventable mortality and second highest cause of treatable mortality across NCL (2016-2020)

Bowel cancer screening coverage in those aged 60-74 years...



*JSNA – People – Cancer Screening | Barnet Open Data*

# Health and Healthcare



# Health and Healthcare

## Cardiovascular Disease and Diabetes

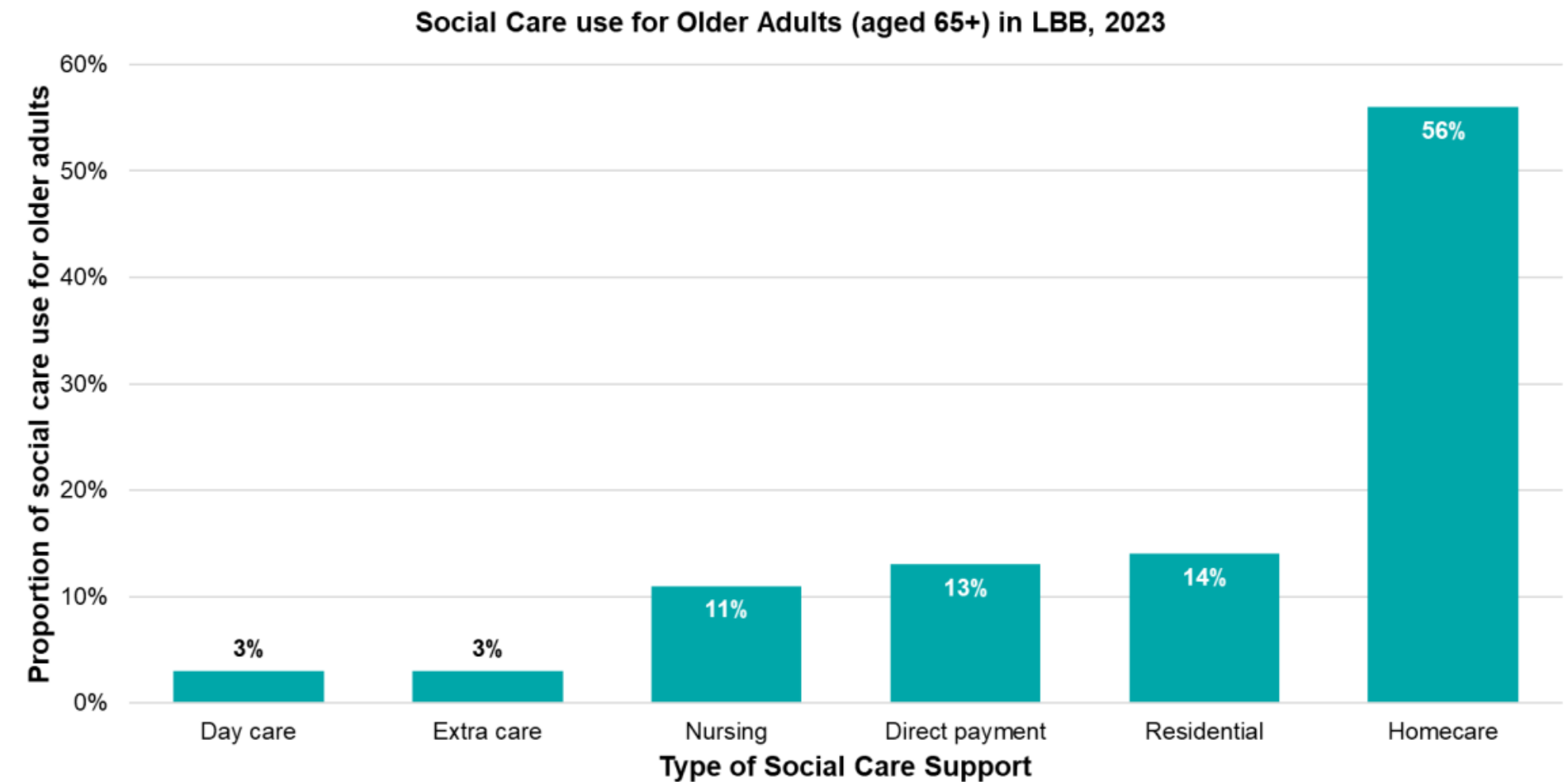
- **Higher prevalence of cardiovascular diseases in Barnet**, compared to NCL average
- Lower uptake of NHS health checks in Barnet compared to national average, improving trend
- Increasing prevalence of Diabetes in those aged 17+
- Less than 50% of people referred to NDPP in Barnet reach the first milestone of the programme. Seeing increasing conversion rate

## Frailty and Falls

- Evidence demonstrates that **frailty prevalence is higher and earlier in onset in more deprived areas**
- Increasing trend of numbers of admissions to hospitals with falls from 2019/20 to 2022/23
- Significantly **higher rates of admission for hip fractures among individuals aged 80 and over**, compared to those aged 65-79 years old
- Inequalities in inactivity which increased the risk of falls worsened during the pandemic.

# Social Care

- Barnet has the highest number of registered care home places for individuals aged 65+ across NCL
- 10% people aged 65+ in Barnet are unpaid carers (Census 2021)
- Projected rise in the number of older adults with ill health and disability is expected to place additional pressure



LBB ASC, 2023

# Wider Determinants of Health

Economic Activity

Social Connections

Housing

Digital Exclusion

Air Pollution,  
Climate Change and  
Adverse Weather  
Events

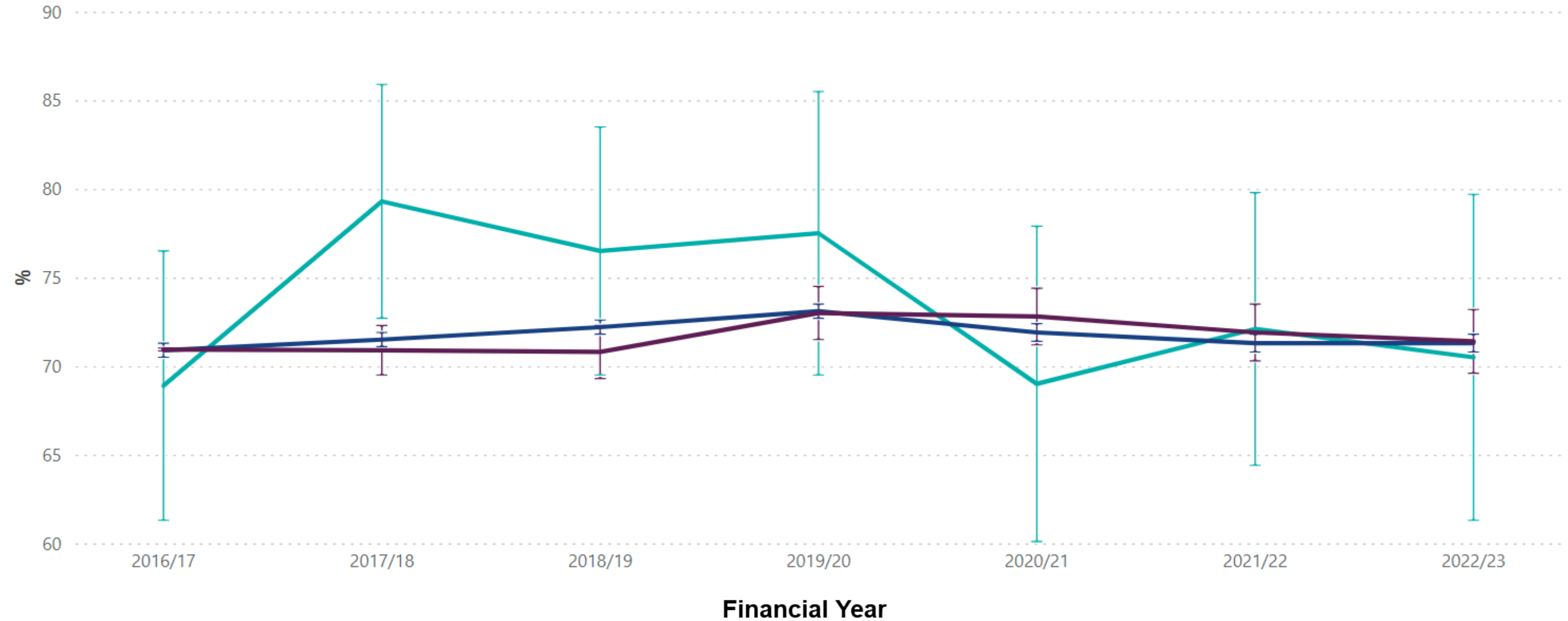
Built Environment  
and Green Spaces

Transport

# Employment

Percentage of people in employment (50-64 years)

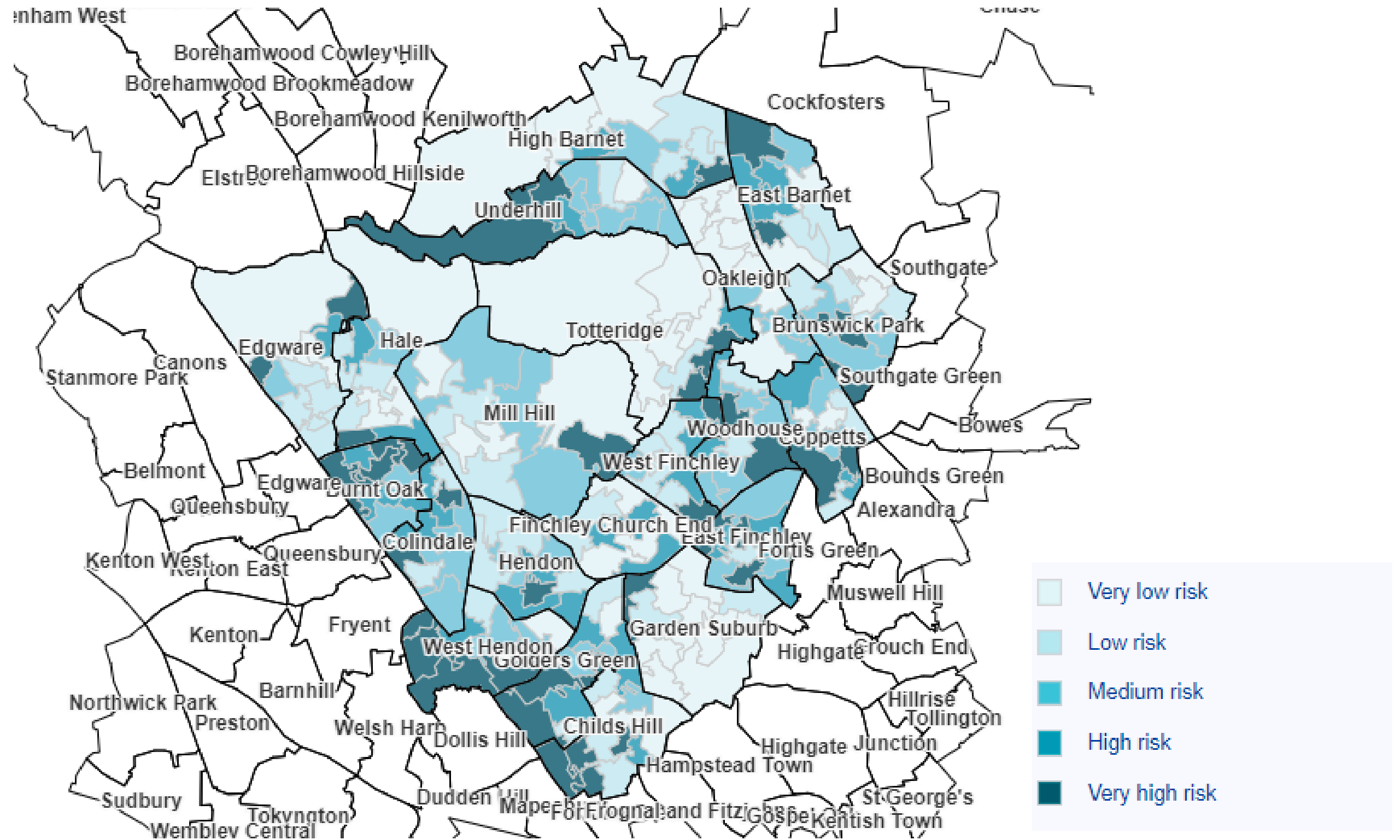
● Barnet ● England ● London region



OHID, 2023

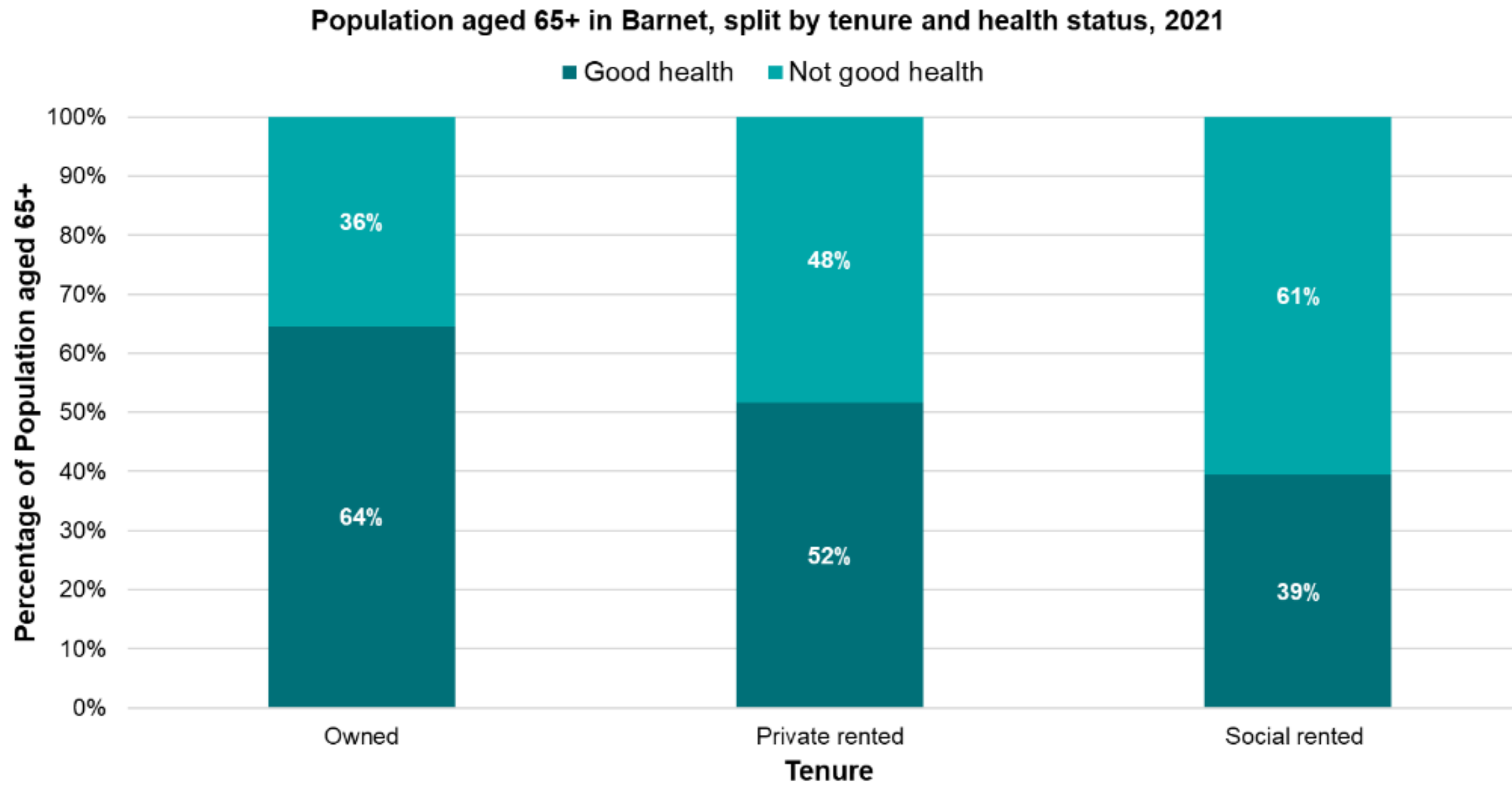


# Social



Age UK Risk of Loneliness in England 2016 for people aged 65+ in Barnet. Darker shades indicated higher risk of loneliness.

# Housing



Census 2021 data © Crown copyright 2023



# Older Adults with Additional Support Needs

Dementia

People with Learning  
Disabilities

People with Sensory and  
Physical Impairments

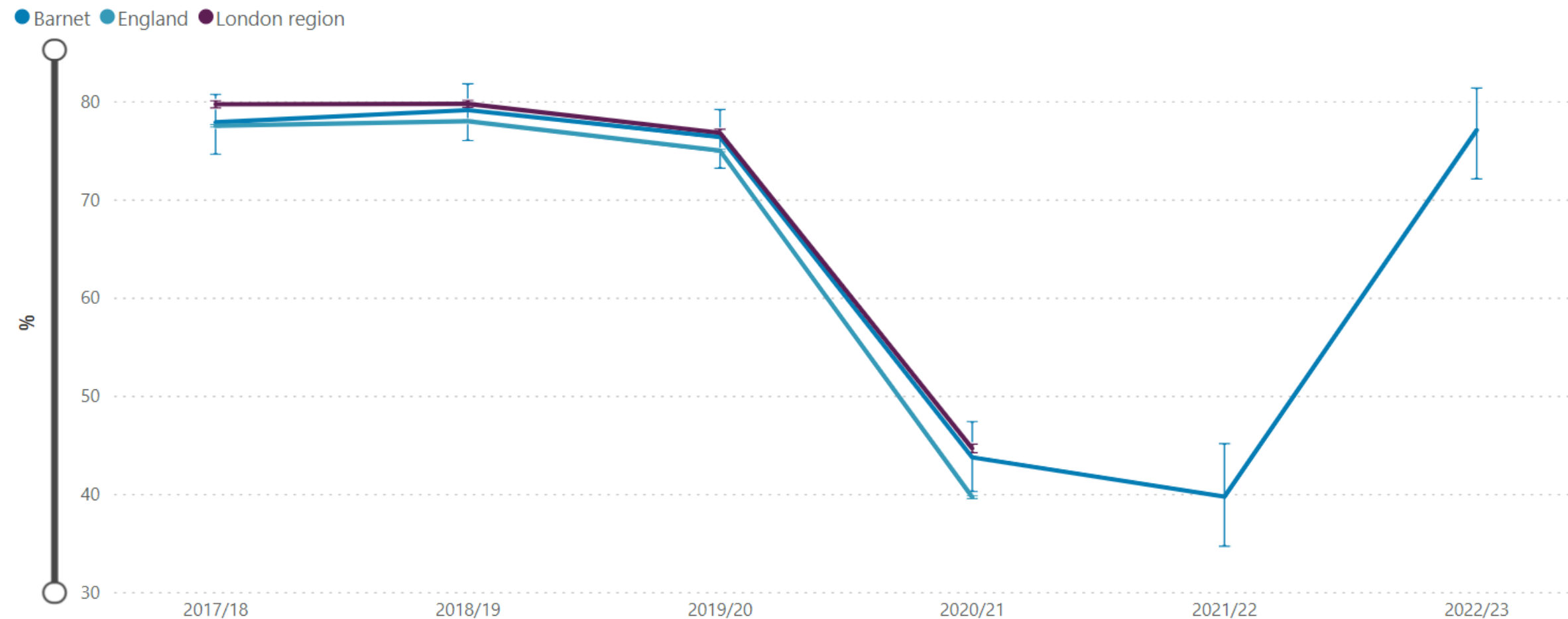
Severe Mental Illness

Inclusion Health Groups

# Dementia

- Barnet had the 6th highest prevalence of dementia (aged 65+) compared to other London boroughs (2020)
- Prevention –modifiable risk factors prevent or delaying up to 40% dementias (2020 Lancet Commission)
- Living well with dementia - Dementia friendly Barnet and associated action plan

Dementia care plan has been reviewed in the last 12 months

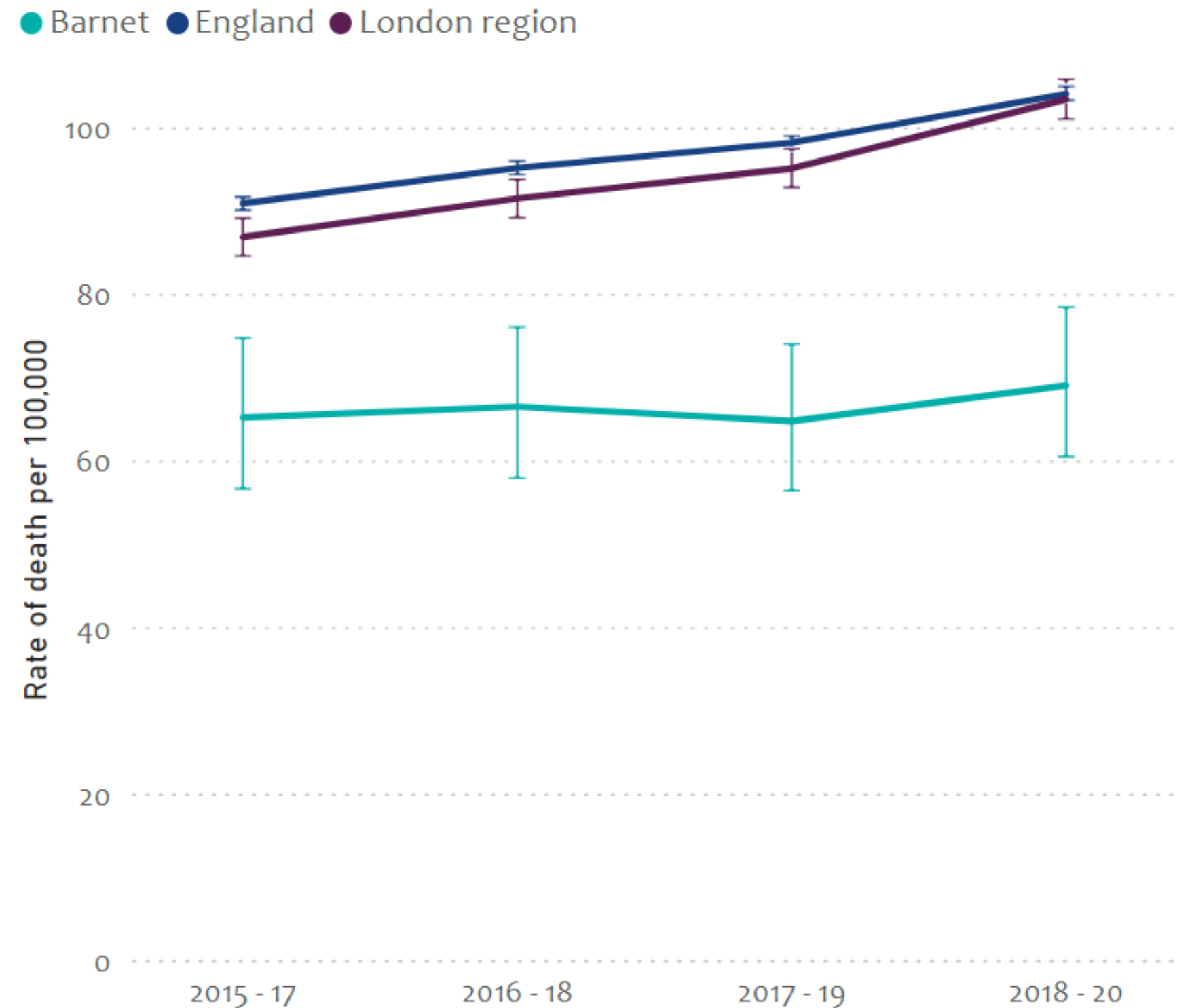


*JSNA – People – Ageing Well | Barnet Open Data*

# SMI

- Higher levels of premature mortality compared to the general population
- Premature mortality in Barnet for people with SMI was 68.5/100,000 deaths (lowest across NCL in 2018-2020)
- Decreasing number of people recorded with SMI in Barnet GPs having a comprehensive plan

Premature mortality in adults with severe mental illness - aged 18-74



*JSNA – People – Mental Health | Barnet Open Data*

# Ageing Well for Inclusion Health Groups

- Older homelessness is identified as those who are aged 55+: 4.5/1000 households owed duty under HRA where main applicant aged 55+ (2021/22)
- Older adults (65+) make up 1% of the Asylum Seeker population in Barnet
- Limited functional health literacy predicts poor diet, smoking, and lack of physical activity
  - Increased risk for older adults, deprivation, ethnic minority groups, migrant populations and disabled people.

# Key Recommendations

Enhance access and provision of health promotion and prevention services

Develop appropriate campaigns, information and advice to promote ageing well

Strengthen health protection programmes

Encourage proactive and integrated health and social care

Enhance falls prevention and frailty support

Promote social inclusion and connectivity

Create environments that promote ageing well

Promote ageing well for people who have additional needs

Support ongoing work to understand and address the needs of Barnet's population to age well

Ensure the concepts of co-production are used, with groups representative of Barnet's diverse population and its vulnerable population groups.

# Thank you

Any questions?

Caring for **people**, our **places** and the **planet**



# AGE-FRIENDLY BARNET

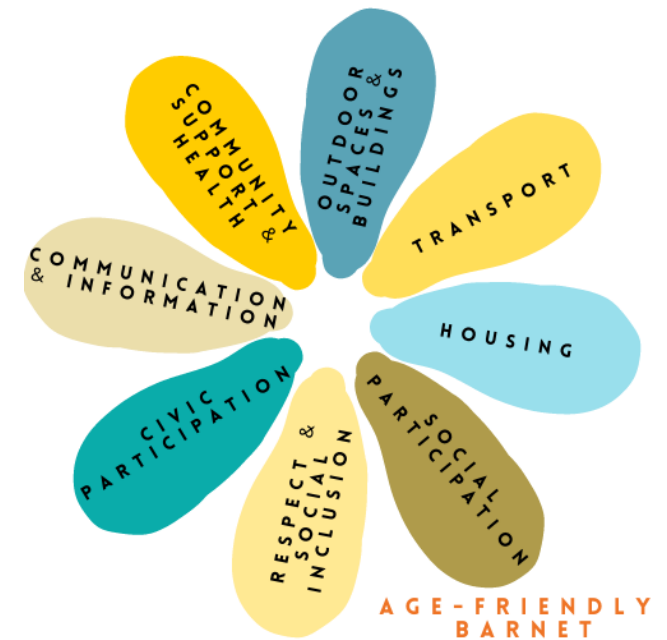
09.05.2024



# What does being an “age-friendly” community mean?



- It marks a commitment to improve parts of the social and physical environment to make sure that age is not a barrier to living well and engaging in all aspects of community life.
- Age-friendly Communities commit to following the World Health Organisation’s Age-friendly Communities framework.
- Older voices are at the heart of the project.

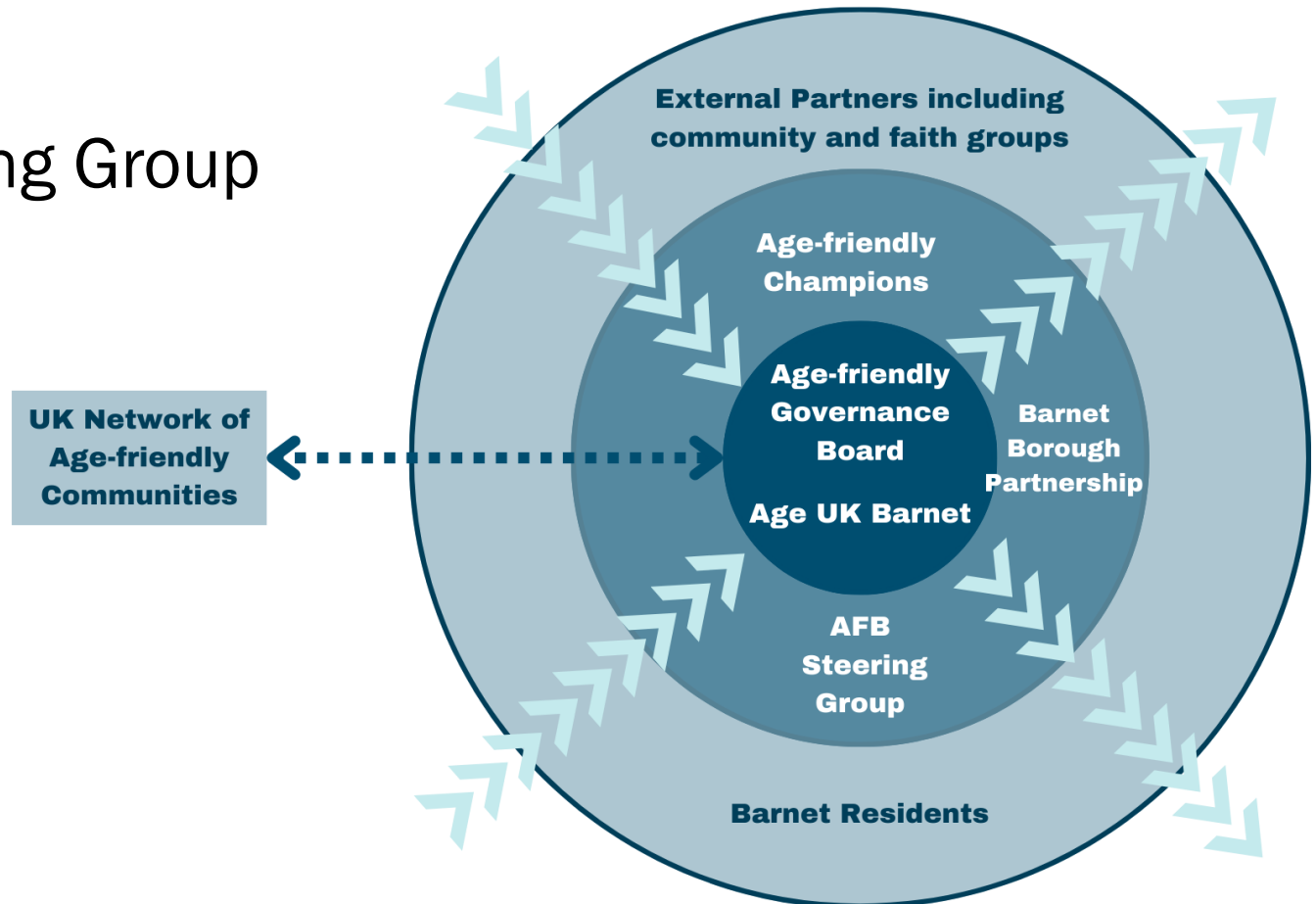


Nothing ~~about us~~, without us

# Age-friendly Barnet: Who is involved?



- Barnet Council
- Age UK Barnet
- Age-friendly Barnet Steering Group
- Age-friendly Champions



*Through utilising and increasing our connections, we intend to make age-friendly a movement rather than a standalone project*



# Progress to date

- **January 2023:** Political Commitment to join the UK Network of Age-friendly Communities.
- **May 2023:** Coordinator in Post
- **July 2023:** Age-friendly Barnet Survey – 1024 responses received.
- **July/ August 2023:** Focus Groups (7 across borough).
- **October 2023:** Official launch of Age-friendly Barnet on Silver Sunday.
- **November 2023:** Baseline Assessment Published.
- **March 2024:** Call for Action Published.







# Age-friendly Barnet Call for Action

## Seven areas which should support active ageing:

1. Challenging Ageism: Intergenerational Respect & Inclusion.
2. Public Spaces & Safety
3. Transport & Active Travel
4. Activities & Socialisation
5. Housing & Home Support
6. Work & Volunteering
7. Community Information & Digital Inclusion





# Projects (2024-2025)

The Call for Action lists eight projects which will be undertaken over the next two years. Our priorities for the rest of this year include:

1. Establishing our Mobile Information Service (Age-friendly Pop-Up).
2. Gathering a Digital Taskforce to create more opportunities for older adults to improve their digital skills.
3. Growing our group of 'Age-friendly Champions'.
4. Continue to develop our baseline assessment to ensure that we are engaging with Barnet's diverse communities, community and faith organisations to promote equality and inclusion for all.
5. Silver Sunday – 6<sup>th</sup> October 2024






# Any Questions?



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	<h2>Health and Wellbeing Board</h2>
<p><b>Title</b></p>	<p><b>Joint Strategic Needs Assessment (JSNA)</b></p>
<p><b>Date of meeting</b></p>	<p>Thursday 9<sup>th</sup> May 2024</p>
<p><b>Report of</b></p>	<p>Interim Director of Public Health and Prevention, London Borough of Barnet</p>
<p><b>Wards</b></p>	<p>All</p>
<p><b>Status</b></p>	<p>Public</p>
<p><b>Urgent</b></p>	<p>No</p>
<p><b>Appendices</b></p>	<p>Appendix A – JSNA Refresh Draft Plan Appendix B – JSNA Update Static Overview</p>
<p><b>Officer Contact Details</b></p>	<p>Dr. Janet Djomba - Interim Director of Public Health &amp; Prevention - <a href="mailto:janet.djomba@barnet.gov.uk">janet.djomba@barnet.gov.uk</a></p> <p>James Rapkin – Head of Insight &amp; Intelligence – London Borough of Barnet - <a href="mailto:james.rapkin@barnet.gov.uk">james.rapkin@barnet.gov.uk</a></p> <p>Alexis Karamanos – Senior Public Health Analyst – London Borough of Barnet - <a href="mailto:alexis.karamanos@barnet.gov.uk">alexis.karamanos@barnet.gov.uk</a></p>
<h3>Summary</h3>	
<p>The plan for updating the Joint Strategic Needs Assessment was agreed by Board in September 2023.</p> <p>This report provides to Board Members:</p> <ul style="list-style-type: none"> <li>• An overview of the progress made in updating the Joint Strategic Needs Assessment</li> <li>• An overview of the future development plan for the Joint Strategic Needs Assessment so that it continues to remain a useful and relevant insight tool</li> </ul>	

## Recommendations

1. That the Board approves, subject to any amendments it may wish to make, the publication of the updated Joint Strategic Needs Assessment to Barnet Council's open data portal, OpenBarnet.

### 1. Reasons for the Recommendations

- 1.1 The Joint Strategic Needs Assessment (JSNA) is a statutory document for each Local Authority. The Health and Wellbeing Board must develop and maintain a Joint Strategic Needs Assessment.
- 1.2 A JSNA is used to identify the health and wellbeing needs of the local community. It is important to maintain a JSNA to provide an evidence base that can inform the priorities of future Joint Health and Wellbeing Strategies (which is planned to be reviewed in 2024-25), as well as update the analysis to present the fullest, most granular picture of the health and wellbeing needs of our diverse and evolving population, and help identify and address health inequalities.
- 1.3 Barnet's current JSNA was last fully updated in 2019/20. Since then, new data sources have become available and the original data sources have new information available about Barnet and the changes to the local population and their needs.
- 1.4 A plan to update and restructure the JSNA was presented to and agreed by Board in September 2023. The update would allow a range of analyses to be presented, as well as providing access to summaries which create a rich picture of the current (and future) health and wellbeing of Barnet's residents. The original proposal for the JSNA update is attached to this report as Appendix A.
- 1.5 An updated JSNA has now been completed and is ready, subject to any requested amendments, to be made live on OpenBarnet where it will be publicly available. A link to the updated JSNA is available here: [Joint Strategic Needs Assessment 2024 | Barnet Open Data](#) and a static overview of the updated JSNA, covering layout, topics and infographics is attached to this report as Appendix B.
- 1.6 The updated JSNA has been structured around the three main pillars of the Barnet Plan; People, Place and Planet.
- 1.7 The updated JSNA is a resource and source of information for everyone. The data and analyses contained within the updated JSNA can be used by any council service/department, any council partner, any external organisation/charity as well as by Barnet residents and other members of the public.
- 1.8 The updated JSNA will continue to be developed and expanded with new data and new topics added over time and as priorities change. This will provide all council services/departments and council partners such as the North Central London Integrated Care Board, the opportunity to contribute and feed into the growing resource of data and information.
- 1.9 The updated JSNA uses PowerBI dashboards, embedded into narrative pages on OpenBarnet, as a base to organise analysis and provide a more easily updated JSNA with built-in interactivity to allow users to pick which area(s) they want to explore. The use of PowerBI dashboards allows for underlying data to be updated regularly so that the latest data is always presented while also allowing us to show historic trends and benchmarking information where this data is available. Embedding PowerBI dashboards within narrative pages means that a complete data analysis is

always available to users while headline figures and contextual narrative are included alongside the data to provide essential context.

- 1.10 Updated JSNA chapters focus on current and emerging challenges around health and wellbeing, as well as the diversity of experience within Barnet. Analysis includes information on changes over time and comparisons with other areas particularly around the increased diversity of our residents.
- 1.11 As well as challenges around health and wellbeing, the updated JSNA also incorporates analyses that look at the wider determinants of health such as employment and the environment. This is to demonstrate the impact that these wider determinants have on residents' health and mental health as well as the impact residents' health and mental health can have on these wider determinants.
- 1.12 The updated JSNA also includes smaller geographies such as Lower Super Output Areas (LSOAs – which are around the size of 1,000 – 3,000 residents), where this data is available.
- 1.13 The structure of the updated JSNA and the use of PowerBI embedded within narrative webpages, will ensure that the JSNA can be regularly updated and continue to remain relevant. This will prevent the JSNA from going out of date and reduce the need for major updates and refreshes in the future.
- 1.14 Furthermore, the updated JSNA has a 'Feedback' section which will allow users to provide feedback on the content and functionality and help to improve the JSNA as a collaborative project.
- 1.15 The open nature of the updated JSNA will also enable all council services/departments and external council partners to contribute content to Barnet's JSNA as part of a collaborative project to identify the health and wellbeing needs of the local community and to better tell our story as a borough.
- 1.16 While the updated JSNA is a digital product, there is provision to support users to access the available data and narrative in alternative formats. Contact details are available on the JSNA along with the option to provide feedback. Users can request data in alternative formats or be supported to access the JSNA.

## **2. Alternative Options Considered and Not Recommended**

- 2.1 To not publish the updated Joint Strategic Needs Assessment and continue to use the existing Joint Strategic Needs Assessment.
- 2.2 This is not recommended as the existing Joint Strategic Needs Assessment is out of date and does not fully reflect the changing nature of the borough, its population, or its corporate priorities and will not provide any useful insight for future strategies including the refresh of the Joint Health and Wellbeing Strategy.

## **3. Post Decision Implementation**

- 3.1 The updated Joint Strategic Needs Assessment will be made live and fully available on OpenBarnet.
- 3.2 Once the Joint Strategic Needs Assessment has gone live, work will start on developing the refreshed Joint Health and Wellbeing Strategy for Barnet, with a view to having an updated strategy in place in May 2025.

## 4. Corporate Priorities, Performance and Other Considerations

### Corporate Plan

- 4.1 Supporting the health and wellbeing of residents is the core aim of the Health and Wellbeing Board. The Joint Strategic Needs Assessment brings together quantitative and qualitative insight from various sources to help inform future strategies. This includes the Joint Health and Wellbeing Strategy which will articulate how the Health and Wellbeing Board will support the health and wellbeing of Barnet residents.

### Corporate Performance / Outcome Measures

- 4.2 Whilst there are no direct performance or outcome measures related to the Joint Strategic Needs Assessment, the insights generated by the needs assessment will be used to inform strategies such as the Joint Health and Wellbeing Strategy. This Strategy will have performance outcome measures to track its impact. The headline measures – including Life Expectancy – are also referenced in the Barnet Plan.

### Sustainability

- 4.3 Whilst there is no direct impact on sustainability, the Joint Strategic Needs Assessment contains data related to Air Quality and Pollution under the 'Planet' section of the needs assessment. It is expected that this will expand to include new data sets and insights when they become available. It is anticipated that this will have a positive impact on the Council's carbon and ecological impact and as such contribute to BarnetNetZero.

### Corporate Parenting

- 4.4 Whilst there is no direct impact on the council's corporate parenting role, the insights from the Joint Strategic Needs Assessment will be used in the development of the Joint Health and Wellbeing Strategy. The actions that will be set out in this strategy will provide opportunities to support the council's role as corporate parents through the health, mental health and wellbeing improvement interventions of children and young people residing in the borough including children in care.

### Risk Management

- 4.5 To remain a relevant and useful resource, the Joint Strategic Needs Assessment will require regular maintenance and updates. Furthermore, it is expected that as new priorities and topics emerge, these will also be incorporated into the JSNA. With such a broad range of topics already included, there is a risk that maintaining and updating the JSNA will become more difficult and time consuming. To mitigate some of this risk, the update of underlying data will be automated as much as is possible with a regularly scheduled 6-month review of data to ensure it remains relevant. Any changes to the underlying data will also trigger a request to subject matter experts to review and update any subject narratives as required. This will require the engagement of subject matter experts from different areas and partners to support the maintenance of the JSNA.

### Insight

- 4.6 The Joint Strategic Needs Assessment brings together quantitative and qualitative insight from various sources to provide the latest information on the needs of the local population. The JSNA is the insight product which will help inform future strategies including the Joint Health and Wellbeing Strategy.

<b>Social Value</b>	
4.7	Not applicable to this report.
<b>5. Resource Implications (Finance and Value for Money, Procurement, Staffing, IT and Property)</b>	
5.1	There are no resource implications because of the proposals.
<b>6. Legal Implications and Constitution References</b>	
6.1	Under section 116A of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012), there is a statutory duty to produce a Joint Strategic Needs Assessment.
6.2	Under Part 2B of the Council’s Constitution, the Terms of Reference of the Health and Wellbeing Board include:  (1) 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.  (2) To agree a Health and Wellbeing Strategy for Barnet taking into account the findings of the JSNA and strategically oversee its implementation to ensure improvement in population outcomes and plans to tackle health inequalities. The Joint Health and Wellbeing Strategy (JHWS) should directly inform the development of joint commissioning arrangements in the local area, and the coordination of NHS and local authority commissioning, including Better Care Fund plans.
<b>7. Consultation</b>	
7.1	Health and Wellbeing Board members have been asked to contribute to the development of the Joint Strategic Needs Assessment and have had opportunity to provide input and feedback.
7.2	Collaboration within London Borough of Barnet and with external partners has shaped the content of the Joint Strategic Needs Assessment.
7.3	The update of the Joint Strategic Needs Assessment will make future additions easier to manage and produce while the new structure will allow multiple sources of information and analysis to be included. This will ensure the Joint Strategic Needs Assessment continues to provide the latest and best data available.
<b>8. Equalities and Diversity</b>	
8.1	The Joint Strategic Needs Assessment supports and informs a whole systems approach to prevention and health and care integration on health inequalities in groups with protected characteristics.
8.2	The Joint Strategic Needs Assessment provides the latest and best data available, which often includes nationally collected datasets which are not routinely – at Local Authority level – broken down by protected characteristics.
8.3	Where possible, the Joint Strategic Needs Assessment provides data below the borough and ward level to the more granular Middle Super Output Area (MSOA) and Lower Super Output Area

(LSOA). By providing data at a more granular geographic level, it is hoped that the JSNA will describe and evidence the diversity of needs of our residents.

- 8.4 The evidence provided by the Joint Strategic Needs Assessment will help to inform the refresh of the Joint Health and Wellbeing Strategy for Barnet as well as informing and being informed by the work on disproportionality and Tackling the Gaps being undertaken by the Council.
- 8.5 While the updated JSNA is a digital product, there is provision to support users to access the available data and narrative in alternative formats. Contact details are available on the JSNA along with the option to provide feedback. Users can request data in alternative formats or be supported to access the JSNA.

## **9. Background Papers**

- 9.1 Approval of the update plan for the Joint Strategic Needs Assessment – Item 11 on agenda for 28 September 2023 [Agenda for Health & Wellbeing Board on Thursday 28th September, 2023, 9.30 am \(moderngov.co.uk\)](#)
- 9.2 Barnet Joint Strategic Needs Assessment (JSNA), 2019 - [Joint Strategic Needs Assessment | Barnet Open Data](#)
- 9.3 Barnet Joint Strategic Needs Assessment (JSNA), 2024 - [Joint Strategic Needs Assessment 2024 | Barnet Open Data](#)

# JSNA Refresh Plan

Version 1.1



# Plan

- JSNA would be an interactive PowerBI dashboard that functions to sort reports, needs assessments, dashboards, and external resources into sections based on the Barnet Corporate Plan: People, Places, Planet.
  - Choosing one of these themes would take you to a second page with further sub-sections e.g., Start Well, Live Well, Age Well.
  - This would lead to a list of resources that fit the chosen theme.
- This would allow:
  - Users to see reports and tools on the specific topic that they are interested in, increasing accessibility of the JSNA.
  - For already existing resources to be incorporated and brought together in one place
  - For the JSNA to be continually updated and refreshed as new resources get produced and new data becomes available for existing JSNA chapters
  - Insights to be easily accessed and extracted for use in other documents
- Chapters would focus on current and emerging challenges as well as the diversity and change in Barnet over time and compared to other areas
- Analysis will include low-level geographies such as LSOA (when this data is available). This will improve the identification of current and emerging challenges in small areas that traditionally are hidden by a larger geographical area



# Example of dashboard layout

# Barnet Joint Strategic Needs Assessment



People



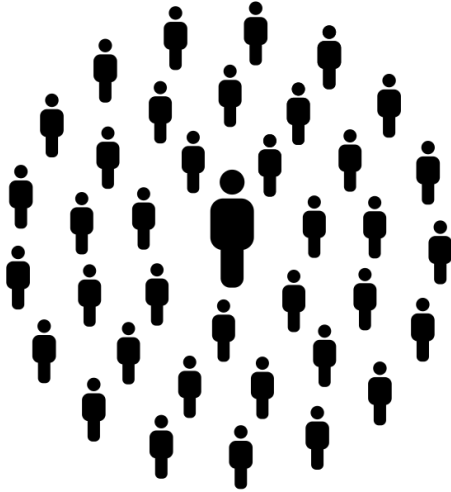
Places



Planet

This home page will include a narrative to explain why we are using the themes of People, Places and Planet and link to Our Plan for Barnet

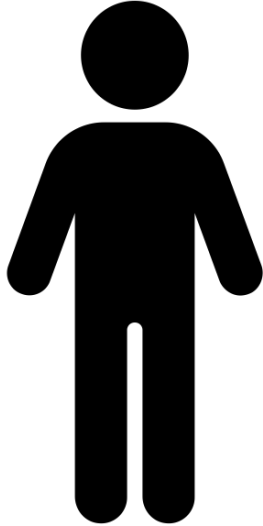
# People



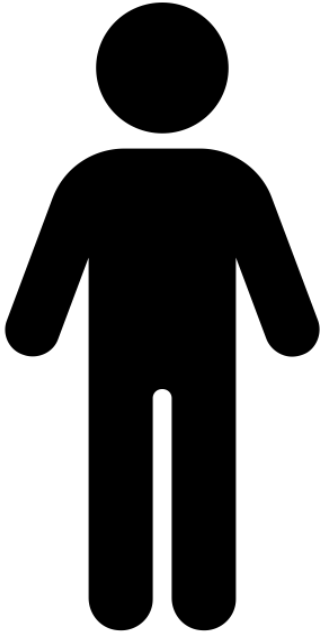
Population Overview



Start Well



Live Well



Age Well



# Live well

Public  
Health  
dashboard

Mental Health and  
Wellbeing  
dashboard

Employment  
Dashboard

Social  
Loneliness  
Report

Sexual Health  
Needs  
Assessment

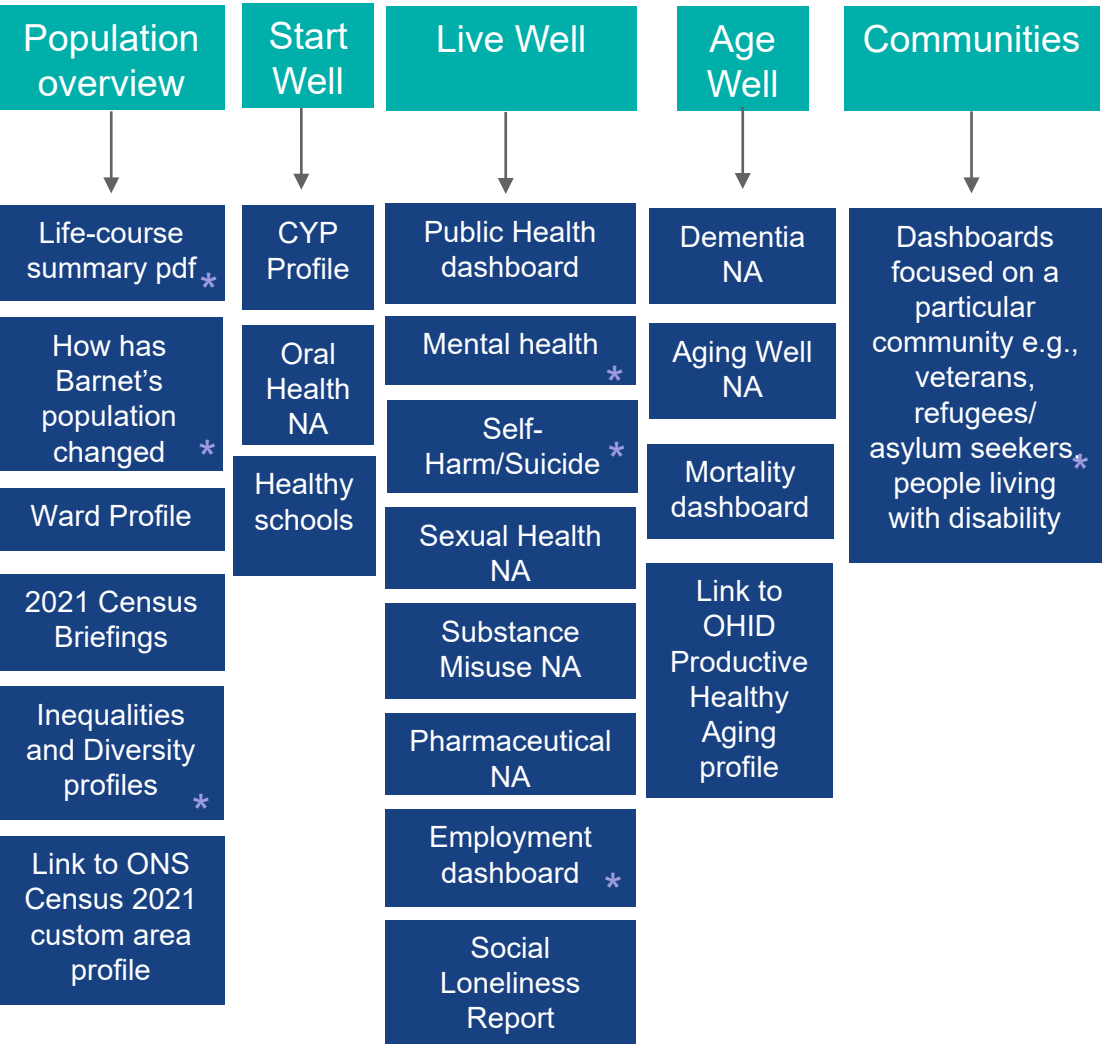
Substance Misuse  
Needs  
Assessment

Pharmaceutical  
Needs  
Assessment

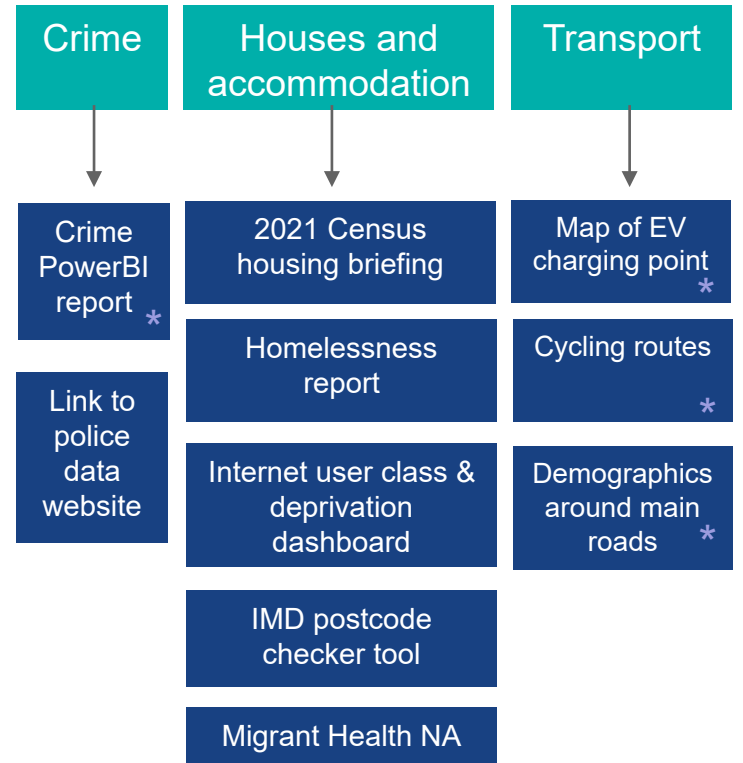


# Overall layout plan and example chapter content

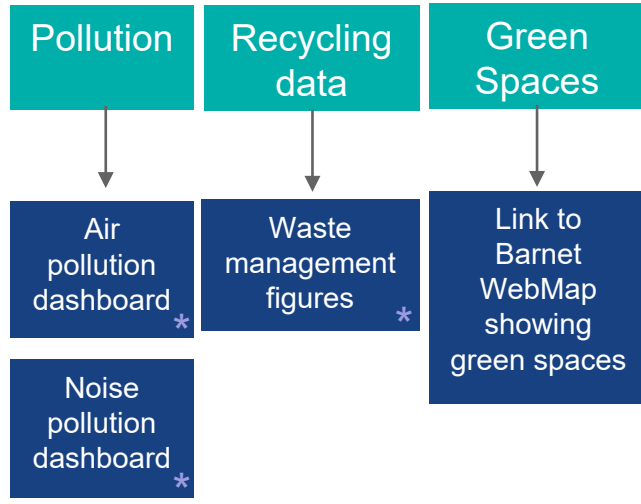
## People



## Places



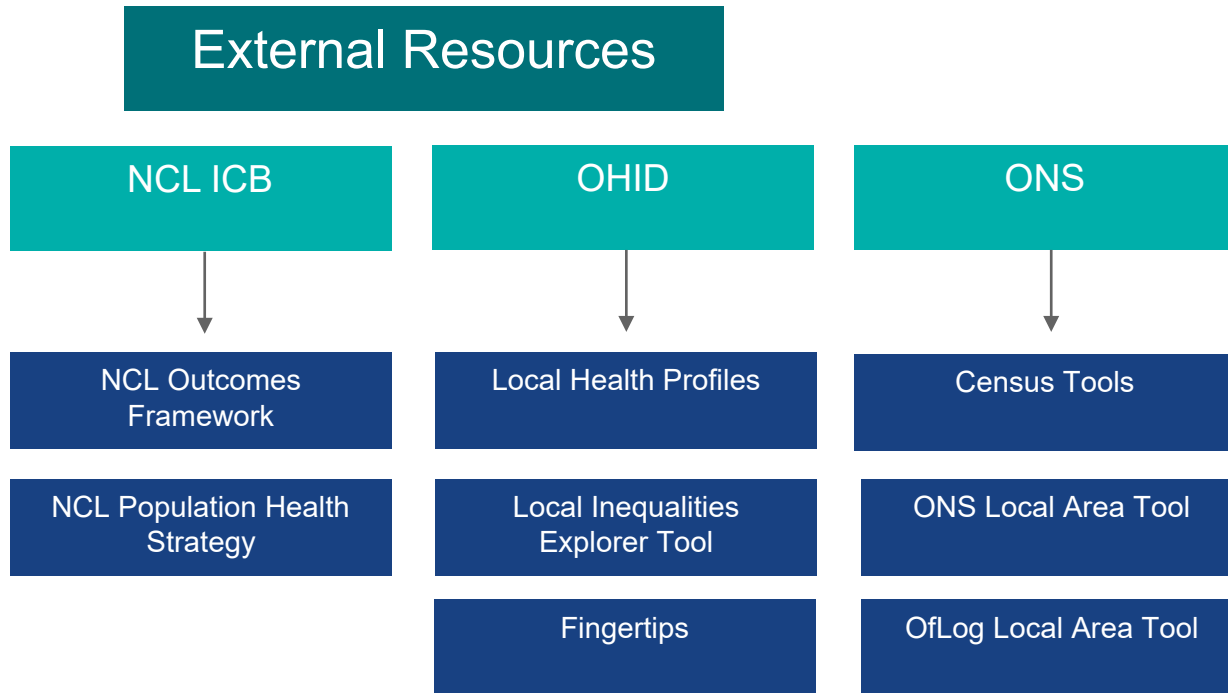
## Planet



\* = resource to be made

Note: These are examples of resources to include. As new resources become available, they will be incorporated into the JSNA product.

# Overall layout plan and example chapter content



\* = resource to be made

101  
Note: These are examples of resources to include. As new resources become available, they will be incorporated into the JSNA product.

# Timeline

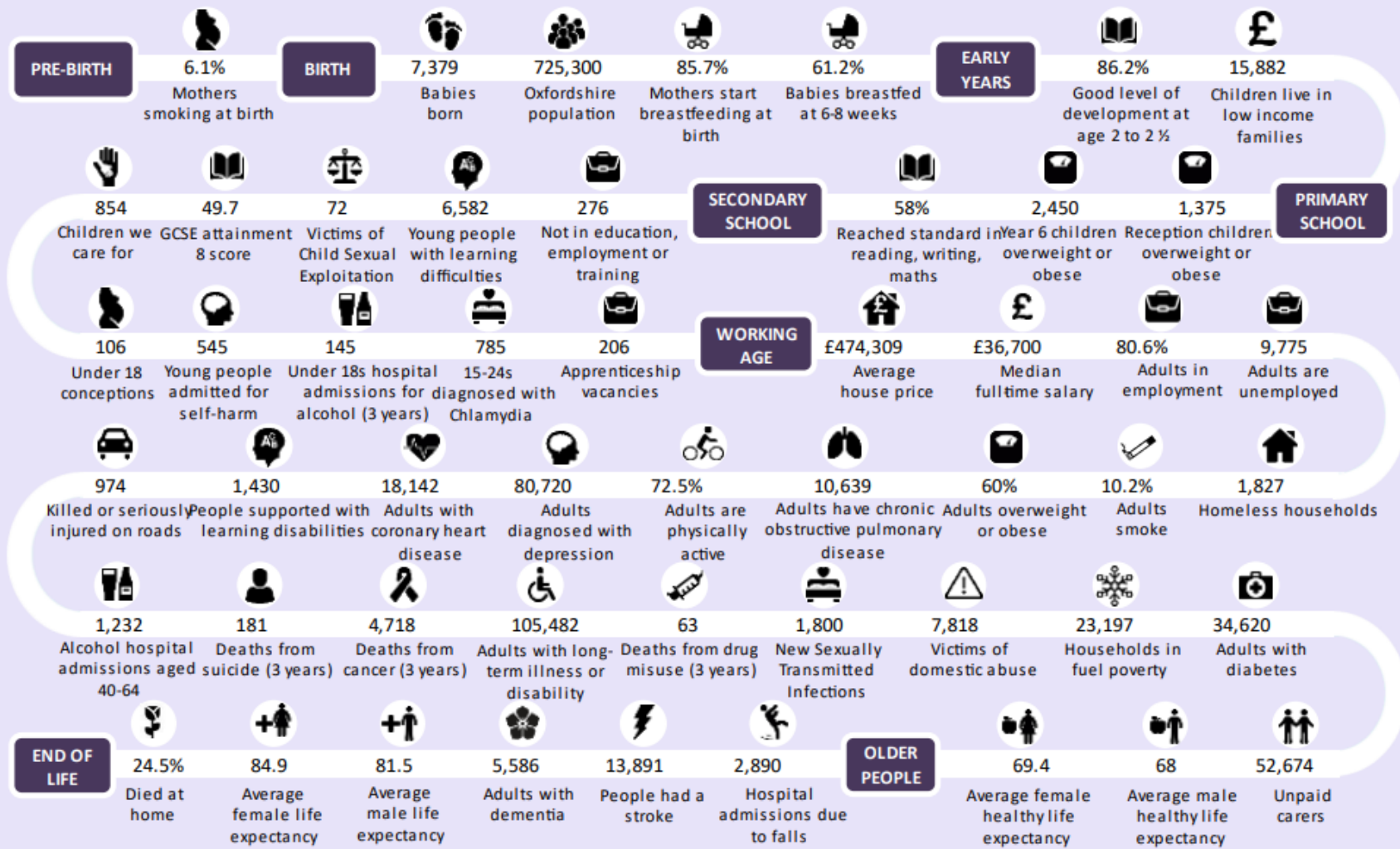
- **September/October 2023:** Present JSNA plan to members of PH SMT and the Health and Wellbeing Board for review and approval.
- **October 2023 – December 2023:** Create the overall JSNA PowerBI report to add all existing dashboards, reports, tools and needs assessments into.
- **January – February 2024:** Start to create PowerBI dashboards for topics that do not have an existing tool:
  - Planned topics: Mental Health and Wellbeing; Employment; Pollution; Crime.
  - Time: approx. one month each
- **February 2024:** Release a draft of new JSNA product for feedback
- **February – April 2024:** Continue developing dashboards for topics that do not have an existing tool
- **April – May 2024:** Create JSNA summary documents and infographics (e.g., life course summary)
- **May 2024:** Deadline to release a live version of JSNA for public consumption (note that JSNA will continue to develop after this date).
- **May – June 2024:** Training and demonstration session for the updated JSNA product will be held

# Examples from other LAs

- Buckinghamshire: [Microsoft Power BI](#)
  - Example of how this JSNA interactive layout could function
- Brent: [Microsoft Power BI](#)
  - Another example of an interactive JSNA report sorted into sections
  
- Oxfordshire: [PowerPoint Presentation \(oxfordshire.gov.uk\)](#)
  - Example of a life-course summary to possibly function as a “JSNA in a page” document



# Oxfordshire JSNA, health and wellbeing facts and figures 2023




An example from Oxfordshire of a life-cycle infographic.

A similar infographic can be produced for Barnet JSNA alongside smaller infographics that focus on specific chapters or communities such as refugees and asylum seekers, people living with disability and veterans.

# Needs Assessment Styling

To ensure a consistency with the styling of needs assessments we propose to introduce the following as guidance to staff with a dedicated 'how to' page on the staff intranet.

A needs assessment requires the following:

- A main document which always uses the Barnet letterhead template: [BARNET-Corporate-Letterhead-Template\\_MASTER.docx \(sharepoint.com\)](#)
- A short executive summary which uses the Barnet powerpoint template:  Needs-Assessmen  
Summary-Templa
- All charts, tables and figures should follow the Barnet brand guidelines: [Customer and Place - Barnet-Corporate-Brand-Guidelines-2023-\[v4\].pdf - All Documents \(sharepoint.com\)](#)
- Each needs assessment should be accompanied by an interactive data dashboard that sits within the wider JSNA product and links to the summary and main document.
- All needs assessments should be uploaded to the Health and Wellbeing website: [Health and Wellbeing key documents | Barnet Council](#)

# Joint Strategic Needs Assessment (JSNA) Update - Static Overview

Version 1.0



# Introduction

- In September 2023, the Health and Wellbeing Board approved the plan to refresh Barnet's Joint Strategic Needs Assessment (JSNA)
- The updated JSNA is a digital product and is available here: [Joint Strategic Needs Assessment 2024 | Barnet Open Data](#)
- This document provides a high-level, static overview of the refreshed JSNA, covering the layout, topics included and infographics.

## Joint Strategic Needs Assessment (JSNA)

The Barnet Joint Strategic Needs Assessment (JSNA) presents data to support the local authority, local NHS organisations and other public and private organisations including the voluntary sector, assess the current and future health, care and wellbeing needs of the borough and our community to inform local decision making.

A comprehensive picture of the borough is presented through a range of data and intelligence relating to demography, and factors that influence our health, wellbeing, and behaviours.

The JSNA is based on [Our Plan for Barnet](#)'s three pillars of Caring for People, our Places and the Planet. The different JSNA chapters can be viewed below by selecting the relevant pillar.

[About the JSNA](#)[External Resources](#)

## JSNA Landing Page

- The JSNA is hosted on Barnet's open data platform: [OpenBarnet](#)
- The JSNA landing page provides background information about the JSNA as well as links to external resources.
- The JSNA is structured around the three main pillars of the Barnet Plan; People, Places and Planet.



People



Places



Planet

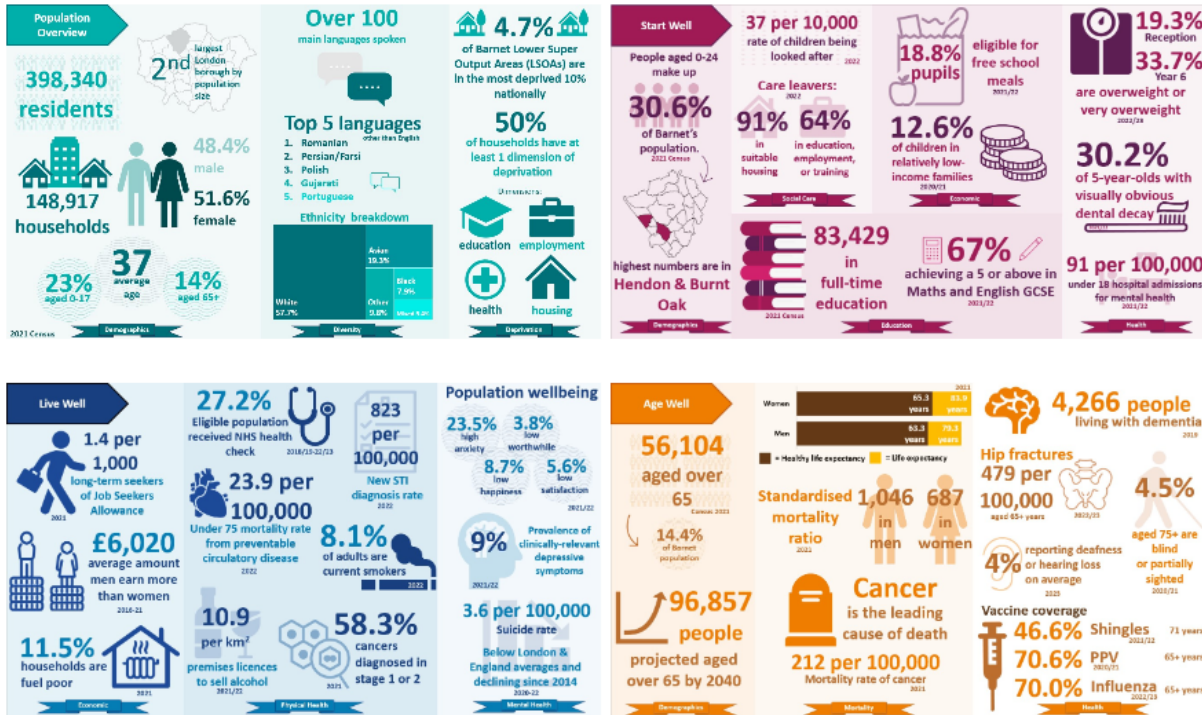
# People

Barnet is located in North London. It is the second largest London borough by population with 398,344 residents as of the 2021 Census.

This chapter discusses Barnet's population structure, life expectancy including healthy life expectancy, mortality, and education and employment in Barnet.



[Back to JSNA menu](#)



# People Landing Page

- The landing pages of People, Places and Planet all follow a consistent layout.
- A brief introduction to the subject, in this example, People.
- This introduction is followed by summary infographics which are available to view and download.
- This is then followed by links to the individual topic pages. For People, these topics are grouped into:
  - Population Overview
  - Start Well
  - Live Well
  - Age Well
  - Communities and Neighbourhoods



# Employment

[Back to People](#)

The Employment Dashboard details employment data in Barnet benchmarked against London and England with demographic breakdowns included. The dashboard is organised into two sections:

- **Labour Supply and Demand:** indicators for (un)employment rate, employees by industry, and wages.
- **Benefits and Financial Support:** indicators for universal credit, employment and support allowance, carers allowance, attendance allowance, and personal independence payment.

## Headline Figures

- Between October 2022 and September 2023, **28.8%** of residents aged 16-64 years in Barnet were economically inactive – this is **higher** than both the London and England average.
- Specific demographic groups that have shown an increase in economic inactivity are males and ethnic minority groups.
- The predominant employment sector in Barnet is **healthcare**, representing a higher proportion of workers than both London and England.
- Residents who are aged 35 to 49 years, females and unemployed residents in Barnet were most likely to claim Universal Credit.



# Employment Topic Page

- Individual topic pages also follow a consistent format.
- At the top of the page is a brief introduction to the topic, in this example, Employment. This includes headline figures and trend comparisons.
- This introduction is followed by data dashboard which allows a user to self-serve and explore the available data.
- This is then followed by an analytical narrative which includes content provided by a subject matter expert.

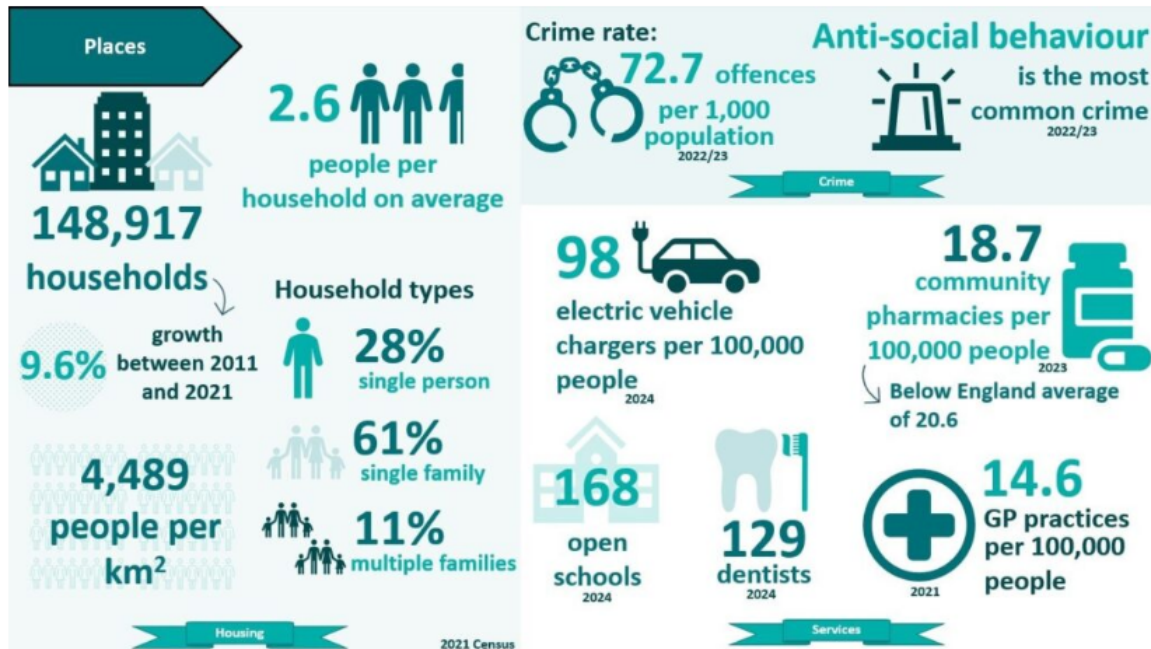
# Places

Barnet is an ambitious London suburb – a vibrant and fun place to live, work and visit. There are many different towns, neighbourhoods, and communities within Barnet.

This chapter discusses these places throughout Barnet, focusing on houses & accommodation, crime, and transport.



[Back to JSNA menu](#)



# Places Landing Page

- This is the landing page for Places.
- It follows the same layout as the People and Planet pages. There is an introduction followed by a summary infographic.
- This is then followed by links to the individual topic pages. For Places, these topics are grouped into:
  - Housing and Accommodation
  - Transport
  - Crime
  - Services



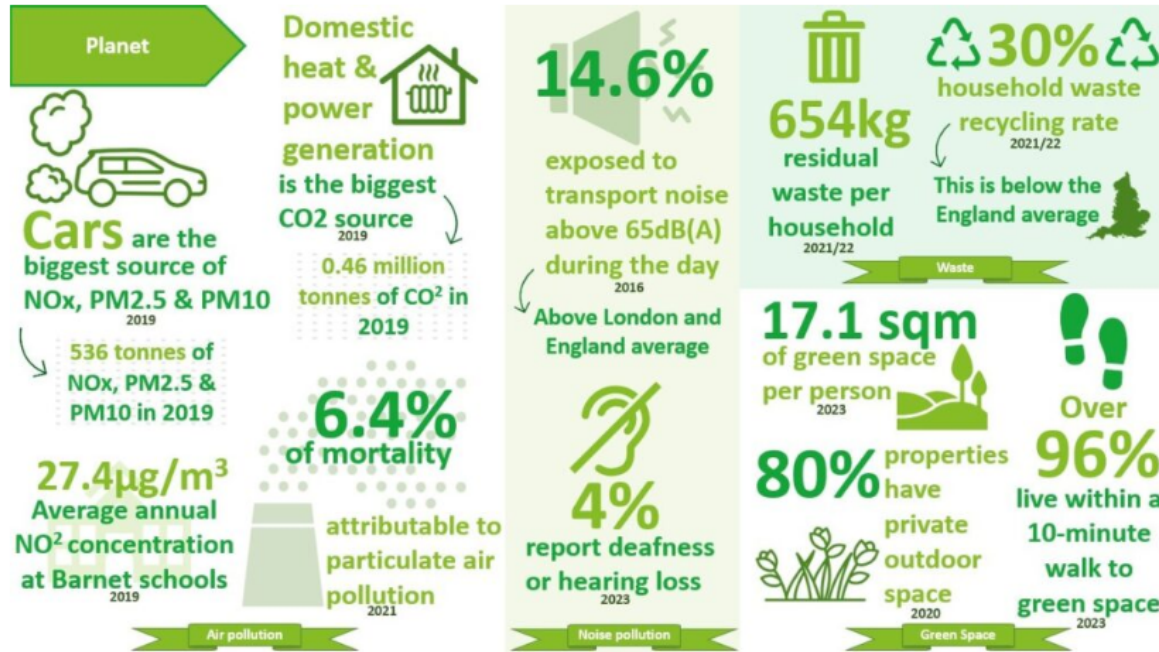
# Planet

Barnet is working together with local people, local communities, and local businesses on a Journey to Net Zero, with an ambitious target to be a net zero council by 2030 and a net zero borough by 2042.

This chapter discusses pollution, waste management, and green spaces.



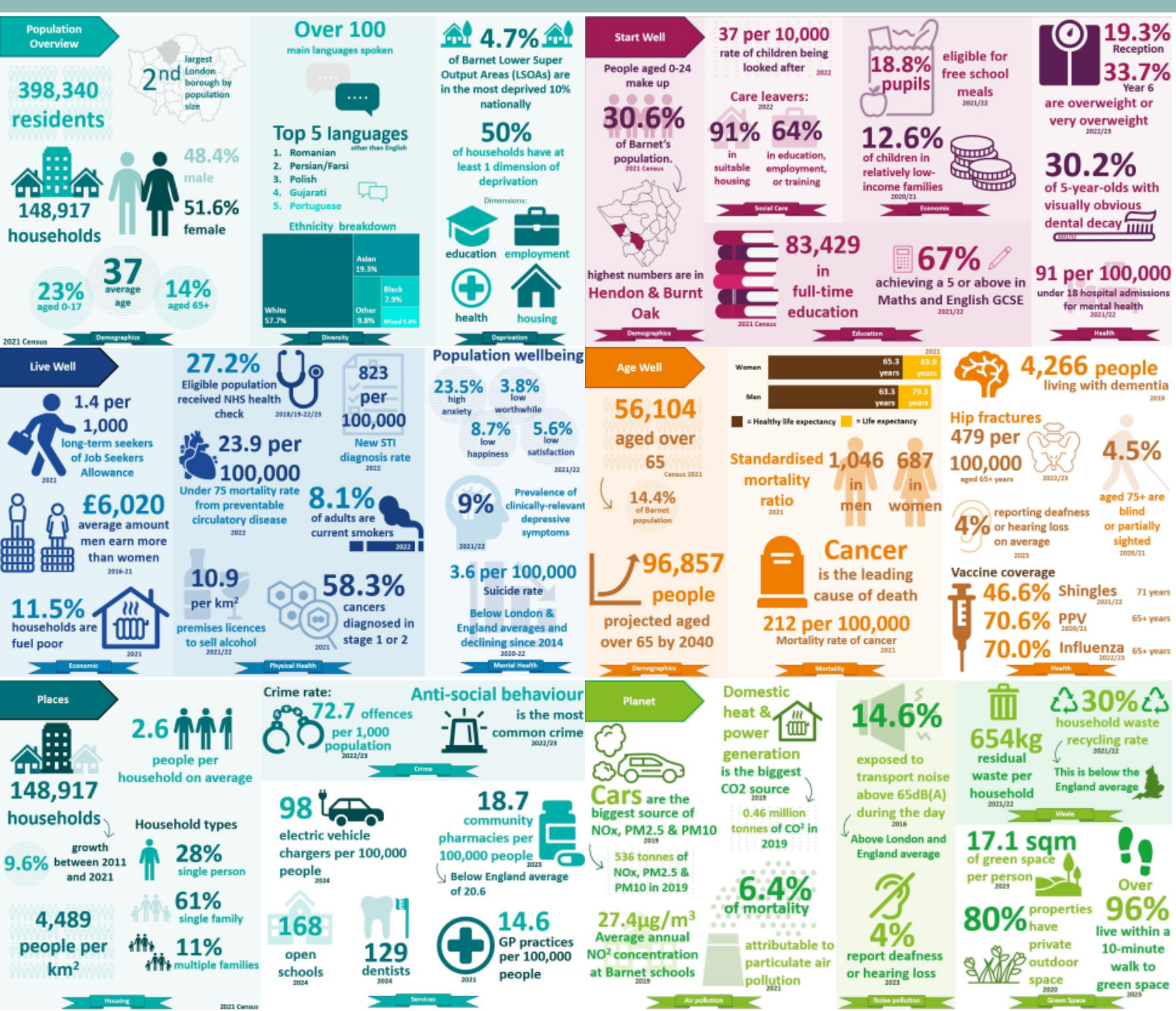
[Back to JSNA menu](#)



- This is the landing page for Planet.
- It follows the same layout as the People and Planet pages. There is an introduction followed by a summary infographic.
- This is then followed by links to the individual topic pages. For Places, these topics are grouped into:
  - Pollution and Waste
  - Green Spaces

# Infographics

- A series of infographics have been created for each of the subject areas of the JSNA.
- These infographics provide a high-level figures about a subject and topic in an easy to absorb format.
- These infographics can be downloaded and included in any strategy and/or report as required.



# Topics

The following topics are included in the updated JSNA:

## People

- Population Overview
  - Population Tool
  - Ward Profile
  - 2021 Census Briefings
- Start Well
  - Children and Young People
  - Family Friendly Index
  - National Childhood Measurement Programme
  - Oral Health
- Live Well
  - Cost of Living
  - Communities Dashboard
  - Inequalities Dashboard
  - Employment
  - Cancer Screening
  - Mental Health
  - Sexual Health
  - Social Loneliness
  - Substance Misuse
  - Suicide and Self-Harm
- Age Well
  - Ageing Well
  - Dementia Needs Assessment
  - Mortality


## Places

- Housing and Accommodation
  - 2021 Census Housing Briefing
  - IMD Postcode Checker
  - Deprivation Data Tool
- Transport
  - Cycling Routes
  - Electric Vehicle Charging Points
  - Road Maintenance
- Crime
  - Crime Dashboard
  - Police Open Data
- Services
  - Local Insight – Services Map
  - Pharmaceutical Needs Assessment

## Planet

- Pollution and Waste
  - Air and Noise Pollution
  - Waste Management Data
- Green Spaces
  - Green Spaces Index 2023
  - Mayor of London – Green Infrastructure Map
  - Natural England – Green Spaces Map

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	<h2>Health and Wellbeing Board</h2>
<p><b>Title</b></p>	<p><b>Joint Health and Wellbeing Strategy Implementation Plan Update and Timeline for Renewal</b></p>
<p><b>Date of Meeting</b></p>	<p>Thursday 9<sup>th</sup> May 2024</p>
<p><b>Report of</b></p>	<p>Interim Director of Public Health, London Borough of Barnet</p>
<p><b>Wards</b></p>	<p>All</p>
<p><b>Status</b></p>	<p>Public</p>
<p><b>Urgent</b></p>	<p>No</p>
<p><b>Enclosures</b></p>	<p>Appendix A – Phase 3 Implementation Plan (2023-2025) Appendix B – Key Performance Indicators</p>
<p><b>Officer Contact Details</b></p>	<p>Claire O’Callaghan, Health and Wellbeing Policy Manager, London Borough of Barnet <a href="mailto:claire.o’callaghan@barnet.gov.uk">claire.o’callaghan@barnet.gov.uk</a></p>

### Summary

For this period, this report will cover two items:

- 1) The regular six-monthly update on the current Implementation Plan, and Key Performance Indicators.
- 2) A draft plan and timescale for the renewal of the current Joint Health and Wellbeing Strategy, which will read the end of its current lifespan in 2025.

### Recommendations

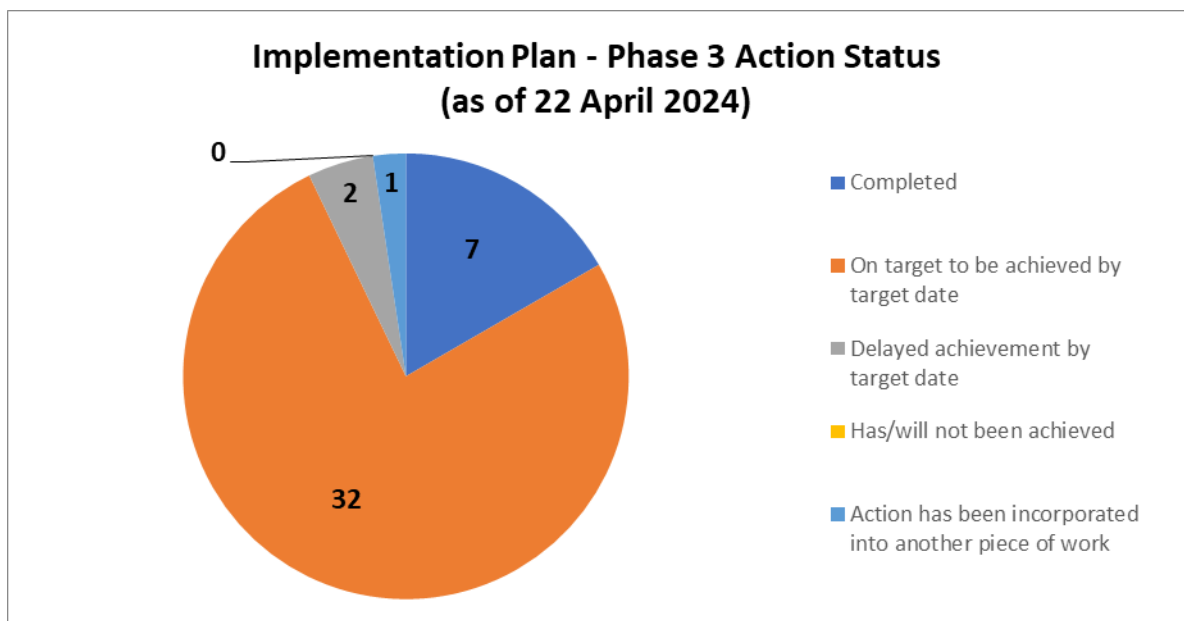
1. That the Board comments on and notes the progress on the current Implementation Plan, and the Key Performance Indicators.



**2. That the Board agrees, subject to comment, the draft plan for the renewal of the current Barnet Health and Wellbeing Strategy.**

**1. Reasons for the Recommendations**

- 1.1 The Joint Health and Wellbeing Strategy (JHWBS) is a statutory document for each Local Authority area. The Health and Wellbeing Board must develop and agree the Strategy.
- 1.2 Barnet’s current JHWBS was signed off in July 2021, with the Implementation Plan and Key Performance Indicators signed off by Health and Wellbeing Board in September 2021.
- 1.3 We have instituted an approximately six-monthly reporting cycle to Health and Wellbeing Board on progress on the Implementation Plan and Key Performance Indicators. The last update was in September 2023.
- 1.4 This report focusses on an update of all the Phase 3 Implementation Plan since September 2023, and presents updated Key Performance Indicator figures (where available) since September 2023.
- 1.5 Phase 3 Implementation Plan
  - 1.5.1 Of the 42 actions in the Phase 3 Implementation Plan, 92.9% of actions are either completed or on target.



- 1.5.2 The full Phase 3 Implementation Plan is appended to this report as Appendix A. The following actions have been delayed from their original completion date.

HWBS Key Area	Project Activity	Start Date	Finish Date	Progress Report - What has been achieved, and what still needs to be achieved?
Key Area 1	Review the Healthy High Street approach, and develop next stage of the programme	Sep-23	Sep-24	Evaluation of the programme in its previous form has been undertaken and demonstrates that a different approach is required to ensure that programme has an impact within current resources. However, different parts of the programme continue. Community Toilets have been handed to the Network and Infrastructure Team (LBB), and Breastfeeding Welcome and Dementia Friendly still continue as Public Health led programmes.
Key Area 2	Recommissioning of borough level smoking cessation services and NHS Health checks	Aug-23	Mar-24	This is delayed compared to the original timescale but is progressing. Legal is currently drafting a contract for the new service model for 2024/25 onwards. Service specifications for both service areas have been amended to reflect additional funding for smoking cessation activity, with information governance processes updated for Health Checks. It is expected that the new service will be in place by Summer 2024.

1.5.3 It is proposed to drop the following action, as North Central London work on Heart Health is planned, and may overtake this action.

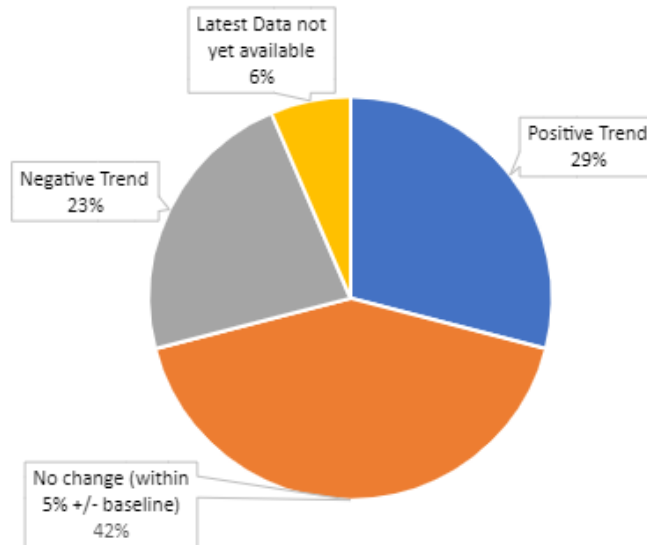
HWBS Key Area	Project Activity	Start Date	Finish Date	Progress Report - What has been achieved, and what still needs to be achieved?
Key Area 3	Develop integrated pathways around CVD	Sep-21	Sep-23	This work is likely to be incorporated into the North Central London wide Heart Health programme, working with the Barnet CVD Task and Finish Group.

## 1.6 Key Performance Indicators

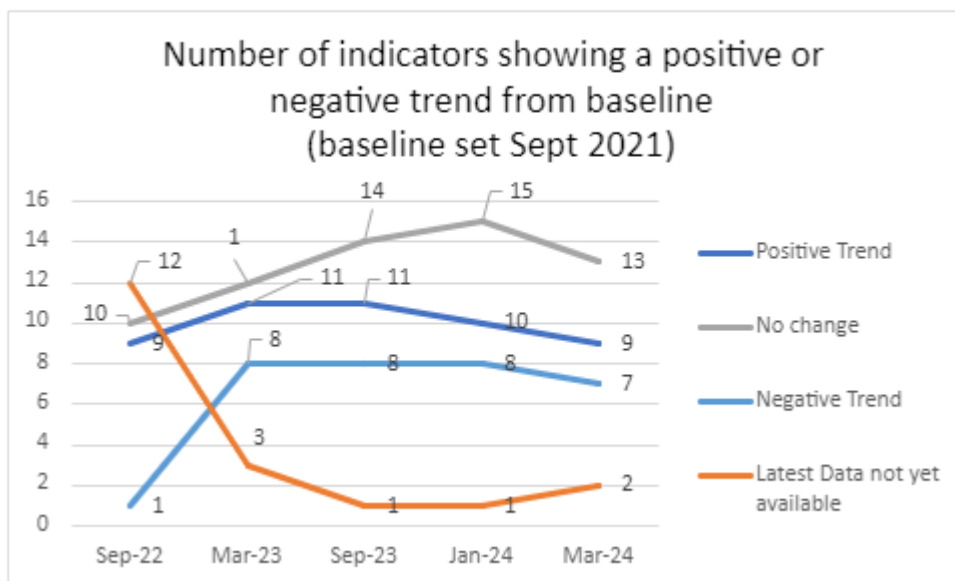
1.6.1 There are 31 Key Performance Indicators aligned to the Barnet JHWBS. This is a reduction of three indicators compared to September 2023, as we have temporarily paused the indicators related to the Healthy High Streets programme until the future delivery of the programme is clear. The full list of indicators is presented in this report as Appendix B.

1.6.2 Of these, 9 indicators (29%) have a positive trend from the baseline, 13 indicators (42%) are +/- 5% of the baseline, and 7 indicators (23%) have a negative trend. Two indicators are missing the latest data. Benchmark data was set in September 2021.

**JHWBS Key Performance Indicators- January 2024  
Trend compared to baseline**



1.6.3 Compared to September 2023, two fewer indicators show positive direction of travel compared to the baseline, one fewer shows a trend of +/- 5%, and one fewer indicator shows a negative direction of travel.











1.6.4 One indicator - Emergency admissions from ambulatory care sensitive conditions – is listed on NHS Digital as being delayed, but no timescale is provided for its update.

1.6.5 Below is a list of the indicators that are below their baseline level at the end of this period. The full list of indicators is listed in Appendix B.

Measure	Baseline Date	Baseline Data	Time period/date of latest data	Data (as of 31st August 2023)	Direction of Travel from baseline
<b>KEY AREA 1</b>					



Total number of foodbank beneficiaries per month	<b>Jan-22</b>	7,268	<b>Dec-23</b>	14,310	
<b>KEY AREA 2</b>					
Proportion of 5 year olds who have received MMR first and second doses	<b>As of 01/02/2022</b>	76%	<b>As of 15/04/2024</b>	68%	
Proportion of infants known to be partially/totally breastfed at their 6-8 week health visitor review	<b>2021-22 Q1</b>	56%	<b>2023-24 Q1</b>	18%	
	<b>2021-22 Q2</b>	57%	<b>2023-24 Q2</b>	11%	
	<b>2021-22 Q3 (data collection affected due to short term prioritising due to staffing issues/Cov id19)</b>	16%	<b>2023-24 Q3</b>	26%	
	<b>2021-22 Q4 (data collection affected due to short-term prioritising due to staffing issues/Cov id19)</b>	13%	<b>2023/24 Q4</b>	Not available	
<b>KEY AREA 3</b>					
Number of carers registered with their GP	<b>As of 30 September 2021</b>	12,125	<b>As of 1 January 2024</b>	11,240	
<b>OVERALL STRATEGY</b>					
Life Expectancy at 65 - Female	<b>2017-19</b>	23.10	<b>2020-22</b>	20.90	
Life Expectancy at 65 - Male	<b>2017-19</b>	20.93	<b>2020-22</b>	18.40	
1.6.6 The following indicators which have seen a fall have explanations to give context behind the indicator:					

Indicator Title	Explanation
Proportion of infants known to be partially/totally breastfed at their 6-8 week health visitor review	Only 15.4% of 6-8 weeks reviews for those eligible were completed in 2023/4 and of those 20.8% were recorded as breastfed, anecdotal reporting indicates that breastfeeding levels in the borough may be higher than reported as between 10-12% are still breastfeeding at 12 months. However, as denominator for this indicator is the total eligible infant population, and we can only collect data for the 15.4% of whom received a review on time, our total reported breastfeeding number remains extremely low. We are working with the new healthy child programme provider to urgently improve the delivery of the 6-8 week and other mandatory reviews.

1.7 Review of the current Barnet Health and Wellbeing Strategy

1.7.1 The current timespan of the Barnet JHWBS is due to come to an end in 2025.

1.7.2 As reported earlier in the agenda, we have done a comprehensive update of the Joint Strategic Needs Assessment (JSNA), as part of the preparation for the strategy refresh.

1.7.3 Therefore, we are proposing to the Board that we start the process of reviewing the Barnet JHWBS. The proposed timescale and activities are below:

Date/Time Period	Activity
<b>May – September 2024</b>	<ul style="list-style-type: none"> <li>• Develop narrative on Barnet based on JSNA work</li> <li>• Desktop review of partners strategies</li> <li>• Desktop review of resident engagement on health issues</li> <li>• Conversations with key partners</li> <li>• Formalise input from VCS and residents on developing draft</li> <li>• Workshop with HWBB partners to develop priorities</li> </ul>
<b>September 2024</b>	<ul style="list-style-type: none"> <li>• Update to HWBB on work so far</li> </ul>
<b>September – December 2024</b>	<ul style="list-style-type: none"> <li>• Testing and development of priorities with residents, partners, and key stakeholders</li> </ul>

	<ul style="list-style-type: none"> <li>• Develop draft document and Equalities Impact Assessment and Health Impact Assessment</li> <li>• Workshop with HWBB partners to test draft document</li> </ul>
<b>January 2025</b>	<ul style="list-style-type: none"> <li>• HWBB approve draft for formal public and partner consultation</li> </ul>
<b>January – May 2025</b>	<ul style="list-style-type: none"> <li>• Formal public consultation to open for six weeks</li> <li>• Review and amend draft document</li> <li>• Update Equalities Impact Assessment and Health Impact Assessment</li> <li>• Develop implementation plan and Key Performance Indicators</li> </ul>
<b>May 2025</b>	<ul style="list-style-type: none"> <li>• HWBB agrees JHWBS, Implementation Plan and Key Performance Indicators</li> </ul>

1.7.4 As significant amounts of analysis, and consultation has already been undertaken around the subject of health and wellbeing, we are proposing that we use as much recent work as possible to review the current Health and Wellbeing Strategy, in order to cut down duplication, and work within current budgetary constraints.

1.7.5 This timeline also aligns well with the work by the Barnet Borough Partnership to review its priorities for the coming year, and it is planned that its work programme in future years would form an important of delivering the new JHWBS.

## 2 Alternative Options Considered and Not Recommended

2.1 There are alternative options for the timeline for the Health and Wellbeing Strategy, these include:

2.1.1 Rolling over the current Health and Wellbeing Strategy – this is discounted, as the last strategy was written in 2020-21, and significant changes have happened to society after Covid, and to the health system.

2.1.2 Starting the review process later and condensing over a shorter period of time – this is judged to be not as good an option, as the preferred proposal will spread out the work required to ensure that there is public and partner consultation undertaken in line with Council priorities, and that this can be managed within existing capacity.

## 3 Post decision implementation

3.1 Actions and indicators will continue to be tracked throughout the year, with key items for decision or consultation brought to Board as required.

- 3.2 Following the decision on the timetable for the JHWBS refresh, we will start work on the next stage of the process as outlined in the timeline.

## **4 Corporate Priorities, Performance and Other Considerations**

### **Corporate Plan**

- 4.1 Tackling health inequalities to ensure that all residents have good health and wellbeing is the core aim of the Health and Wellbeing Board, and the Joint Health and Wellbeing Strategy is the articulation of how we will achieve this aim.

### **Corporate Performance / Outcome Measures**

- 4.2 Appendices A and B outlines the performance and outcome measures which track the impact of the Joint Health and Wellbeing Strategy. The headline measures – including Life Expectancy – are also in the Barnet Plan.

### **Sustainability**

- 4.3 The Implementation Plan contains actions around improving Air Quality, promoting Active Travel and the Food Plan has actions around improving access to locally grown food, as well as reducing food waste. It is anticipated that this will have a positive impact on the Council's carbon and ecological impact.

### **Corporate Parenting**

- 4.4 Whilst there is no direct impact on the council's corporate parenting role because of the Health and Wellbeing Strategy development, the actions set out in the current plan do provide opportunities to support the council's role as corporate parent through the health and wellbeing improvement interventions for children and young people residing in the borough including children in care.

### **Risk Management**

- 4.5 Each area of work has its own risk management schedule and protocol.

### **Insight**

- 4.6 The JHWBS was developed using the Joint Strategic Needs Analysis and other quantitative and qualitative work during 2020-21.
- 4.7 For the JHWBS review, we will develop this using the refreshed JSNA, results of work with partners and residents, and we will conduct an Equalities Impact Assessment and Health Impact Assessment on the draft and final documents.

### **Social Value**

- 4.8 Not applicable to this report.

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

5.1 There are no additional resource implications because of the proposals.

## **6 Legal Implications and Constitution References**

6.1 Under section 116A of the Local Government and Public Involvement in Health Act 2007 (as amended), there is a statutory duty to produce a Joint Health and Wellbeing Strategy to meet the needs identified in the joint strategic needs assessment

6.2 Under Part 2B of the Council's Constitution, the Terms of Reference of the Health and Well Being Board include

(1) 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.

(2) 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.

## **7 Consultation**

7.1 The current JHWBS underwent a consultation on the draft strategy between 29 January 2021 and 12 March 2021. This consultation consisted primarily of an online questionnaire with an engagement session taking place with Barnet MENCAP users. The option of alternative questionnaire formats was advertised but not taken up by respondents. 72 responses were received for the questionnaire.

7.2 From the consultation with the public and engagement across the organisation and health bodies, actions and key performance indicators have been identified in order to achieve the overarching goals of the JHWBS.

7.3 For the JHWBS review, we will develop this using the refreshed JSNA, results of work with partners and residents, and we will conduct an Equalities Impact Assessment and Health Impact Assessment on the draft and final documents.

## **8 Equalities and Diversity**

8.1 A whole systems approach to prevention and health and care integration focus on health inequalities which persist amongst groups with protected characteristics. To do this, we use the best data available, which often includes nationally collected datasets which are not routinely – at Local Authority level - broken down by protected characteristics. However, by consulting and engaging with appropriate communities and stakeholders, it is expected that a whole systems approach to prevention will prevent unintended harms against marginalised groups and promote health equity. As the COVID-19 pandemic has shone a further light on disproportionality of the health outcomes amongst various groups, reviewed Health

and Wellbeing Strategy process will include an engagement with diverse communities with a particular focus on Black, Asian and Minority Ethnic Groups.

- 8.2 For the current strategy, the Implementation Plan is also informed by the emerging work on disproportionality and Closing the Gap being undertaken by the Council.
- 8.3 Any evidence that demonstrates a disproportionate impact will be reviewed within the Actions and, if necessary, edited to ensure that the goal of equality within health is as tangible as possible.
- 8.4 For the JHWBS review, we will develop this using the refreshed JSNA, results of work with partners and residents, and we will conduct an Equalities Impact Assessment and Health Impact Assessment on the draft and final documents.

## **9 Background papers**

- 9.1 Approval of the Joint Health and Wellbeing Strategy - Item 9 on agenda for 15 July 2021 [Agenda for Health & Wellbeing Board on Thursday 15th July, 2021, 9.30 am | Barnet Council \(moderngov.co.uk\)](#)
- 9.2 Barnet Joint Health and Wellbeing Strategy, 2021-2025, [Barnet Joint Health and Wellbeing Strategy 2021 to 2025 - full document.pdf](#)
- 9.3 Last Joint Health and Wellbeing Strategy Performance Report – Health and Wellbeing Board, 28 September 2023 – [Agenda for Health & Wellbeing Board on Thursday 28th September, 2023, 9.30 am \(moderngov.co.uk\)](#)
- 9.4 Barnet Joint Strategic Needs Assessment (JSNA), 2019 - [Joint Strategic Needs Assessment | Barnet Open Data](#)

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 1	Implement and promote the new Health Impact Assessment guidance across all policies and strategies	Deputy Director of Public Health Public Health Officer LBB	Sep-23	Mar-24	Completed	Health Impact Assessment (HIA) guidance note has been finalised, with the next step is for it to be formally approved at cabinet in March 2024. Current focus will be on gambling policy, particularly contributing to the Local Area Plan for Gambling Statement of Principles and other pieces of work on gambling.
Key Area 1	Further develop the Dementia Friendly Partnership, and increase the number of organisations who are Dementia Friendly accredited	Senior Public Health Strategist, LBB	Sep-21	Mar-24	Completed	<ul style="list-style-type: none"> <li>Barnet has successfully maintained “Working to become Dementia Friendly Community” status until the end of Alzheimer’s Society’s scheme at the end of December 2023.</li> <li>The members of Dementia Friendly Barnet Partnership have increased from ~40 to 57.</li> <li>27 venues accredited through the Mayor’s Dementia Friendly Venues Charter encompassing a wide range of venues, including theatres, sports centres, care homes and faith venues. Barnet has by far the highest number of venues accredited in London. The next highest borough is Kensington and Chelsea, with six venues.</li> <li>1,598 people have completed DCUK’s “Understanding Dementia” training.</li> <li>Co-produced “Living Well with Dementia” leaflet. Over 4,000 copies distributed to libraries, faith organisations, councillors, and other key partners, as well as hosted/participated in several events, produced case studies and videos</li> <li>New Dementia Friendly Barnet Action Plan (2024-26) has been co-produced. We are continually engaging with people affected by dementia to find out what services matter to them most, as well as reaching out to local service providers to espouse the benefits of becoming dementia friendly. However, we have carried out additional engagement to inform the development of this action plan. The results of this engagement were included within the refreshed action plan.</li> </ul>
Key Area 1	Work with partners like 'Drink Coach' to embed preventative services for higher risk drinkers	Senior Public Health Strategist, LBB	Sep-22	Aug-24	On target to be achieved by target date	<p>Drink Coach Barnet offers a bespoke online site where Barnet residents can complete an ‘alcohol test’ in order to learn more about their alcohol use, how risky it may be and receive signposting and advice. Additionally, DrinkCoach also provides online individual coaching for those looking for support with their alcohol use.</p> <p>We have seen an increase quarter on quarter over 2023/24 for the number of people viewing the test site with some months clearly much higher than others such as November 2023 and January 2024. This increase is likely due to higher levels of marketing and promotion of the alcohol test, and additionally in January the national ‘Dry January’ campaign.</p> <p>Individuals starting and completing the test (or Audit) is much lower than the test views and has less fluctuation with the exception of January. Public Health is working with the DrinkCoach provider to review what marketing is taking place and how we can use it most effectively to reach individuals who will go on to complete the test and receive tailored advice dependent on their audit scores.</p> <p>On average across the year 38% of people completing the audit are scoring in the ‘possible dependence’ category. With this in mind we have improved the process for self referral into Change Grow Live (CGL) from the DrinkCoach site as CGL is the most suitable service for dependent and higher risk drinkers to seek support.</p>
Key Area 1	Review the Healthy High Street approach, and develop next stage of the programme	Deputy Director of Public Health, LBB	Sep-23	Sep-24	Delayed achievement by target date	Evaluation of the programme in its previous form has been undertaken, and demonstrates that a different approach is required to ensure that programme has an impact within current resources. However, different parts of the programme continue. Community Toilets have been handed to the Network and Infrastructure Team (LBB), and Breastfeeding Welcome and Dementia Friendly still continue as Public Health led programmes.

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 1	Identify and bid for different funding opportunities available	All	Sep-21	Sep-25	On target to be achieved by target date	The partnership continues to identify different funding streams, with funding to voluntary sector organisations from NCL Cancer Alliance and potential funding from the Royal Free Charity identified for cancer screening. Further opportunities are being scoped as they arise.
Key Area 1	Deliver action plan for Make Every Contact Count (MECC)	Public Health Officer	Sep-22	Sep-24	On target to be achieved by target date	<ul style="list-style-type: none"> <li>- Barnet MECC Steering Group continues to meet on a quarterly basis.</li> <li>- The reviewing &amp; updating of MECC factsheets is an ongoing piece of work. 27/28 MECC factsheets have been updated &amp; uploaded onto the Barnet webpage - <a href="https://www.barnet.gov.uk/MECC">https://www.barnet.gov.uk/MECC</a>.</li> <li>- Social Marketing Gateway (SMG) have delivered 12/12 MECC bespoke training sessions (Phase 1).</li> <li>- SMG have been recommissioned to deliver MECC bespoke training sessions (Phase 2). Currently, SMG have delivered 1/10 sessions (Health Champions, Parent Champions &amp; GPDQ were trained in January 2024).</li> <li>- Project initiation meetings to deliver training sessions for CGL, Early Help, Children's Service, community pharmacies have been held. The aim is to deliver training sessions to these teams &amp; services during the first half of 2024.</li> <li>- The evaluation report of Barnet's MECC programme is an ongoing piece of work. This will be finalised in March 2024. The MECC communications plan has been initiated (Presentation delivered to the Barnet Combatting Drug Partnership Board in January 2024).</li> </ul>
Key Area 1	Agree and Deliver Food Plan for Barnet	Deputy Director of Public Health, LBB	Sep-22	Jul-24	On target to be achieved by target date	Work on the Food Partnership continues with monthly meetings which are well-attended. Three working groups have been established within the partnership (food economy, food education and food insecurity) which meet separately. Food charter has been finalised, and the partnership are working on Terms of Reference and a website. Close, collaborative working relationship with the Food Hub continues via regular meetings. Projects started for delivery in 2024 are 1) a piece of work on healthy food environment in Edgware with town centre team, 2) healthy eating campaign, and 3) Community Food Growing Project.
Key Area 1	Ensure that the two Superzones in Grahame Park and Edgware are delivered, and the impact is tracked	Public Health Strategist	Aug-22	Dec-23	Completed	The Superzones projects are completed, with the final reports submitted to the Greater London Authority in December 2023. However, some activities continue as developed in the plan developed as part of the Superzone work.
Key Area 1	Deliver Healthy Homes campaign, targeted at all tenures of property	Head of Strategy and Compliance, Barnet Homes Senior Communications and Campaigns Manager, LBB Public Health Consultant, LBB	Apr-23	May-25	On target to be achieved by target date	Healthy Homes campaign, including advice and outreach about Damp and Mould was run again during Winter 2023-24, as part of the Winter Well campaign. We are currently evaluating the reach of the campaign, and which areas were more popular.
Key Area 1	Improve Air Quality through delivering the Air Quality Action Plan, including Air Quality Audits, anti-idling campaigns, and promotion of Active Travel	Public Health Officer, LBB / EH Lead [partnership AQ Steering Group under review]	Mar-23	Sep-28	On target to be achieved by target date	The Air Quality steering group has been reviewed and re-established. Roles and responsibilities are being confirmed, and programme of activities to be developed to build on current activity around promoting Active Travel, and anti-idling campaigns.



## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 1	Work between Anchor Institutions to explore ambition to introduce the London Living Wage (LLW)	London Borough of Barnet, North Central London Integrated Care Board	Sep-23	May-25	On target to be achieved by target date	<p>North Central London Integrated Care System has committed to work towards becoming recognised as a London Living Wage system. This includes work with the supply chain and the Primary Care Anchor Network. Barnet Council agreed to sign up to the London Living Wage in 2022. All directly employed staff are paid the LLW, which included uplifting the salaries of some staff who were insourced during that time from contracts previously run by third parties. We have updated our procurement portal to request that wherever possible, any new contracts are compliant with LLW. 70% of all non-adult social care contracts are compliant with LLW. However, the greatest challenge with meeting LLW criteria is with adult social care contracts, where a large number of private care providers in the sector do not pay LLW. Especially with 'spot purchase' contracts, which is used for the majority of residential and nursing placements, unless a council is commissioning the totality of that provider's business, it is almost impossible to influence that provider's terms and conditions. Following further discussion with the Living Wage Foundation (LWF), they have agreed to consider spot purchasing separately to the rest of our application for accreditation. Discussions are ongoing about the capacity for the council to bring the remaining contracts into line with LLW, which would cost just under £1m for all corporate contracts and in excess of £10m including all adult social care contracts. At this stage, it is not possible to commit to finding this money within the next three years, but the Council commits to working to maximise the number of contracts that are compliant with LLW, and continue to hold the long-term ambition for LWF accreditation.</p>
Key Area 1	Deliver the BOOST three year plan, which aims to improve the financial resilience of all Barnet residents	BOOST, The Barnet Group	Feb-23	Feb-26	On target to be achieved by target date	<p>BOOST three year plan has been approved, and is being delivered. Annual report 2023/24 is being developed currently. Initial highlights for the past year include:</p> <ul style="list-style-type: none"> <li>- 305 residents helped into employment, including 51 into Care or Health jobs and 73 Ukranian refugees through the STEP programme</li> <li>- 85% of people helped into work are still in work after three months</li> <li>- 585 people registered with BOOST for support</li> </ul> <p>In addition to this, BOOST now operates from more venues across the borough, including regular slots at three foodbanks and Chipping Barnet library, and a new employment support project funded through the UK Shared Prosperity Fund, and delivered with West London Alliance started in Quarter 4.</p>

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 1	Work with Anchor institutions to deliver the Barnet Sustainability Strategy	Assistant Director - Sustainability, LBB Inequalities Team, NCL ICB	Sep-23	May-25	On target to be achieved by target date	The Barnet Sustainability Strategy is currently being developed, based on the Framework which has previously been approved by the Council. However, action has been undertaken including: replaced our street lights with LED lighting, reducing our energy consumption and our carbon footprint; supported walking and cycling to school initiatives; provided 150 electric vehicle charge points to help in the transition to electric vehicles; completed the RE:FIT project, which installed energy saving measures on the Council corporate estate, such as libraries and council offices; started to fund heat decarbonisation and energy efficiency measures on our land and buildings, through the Public Sector Decarbonisation Scheme; secured over £1m of funding to retrofit Barnet social housing through the Green Homes Grant scheme, making it more energy efficient trialled a new road surface using recycled tyres helping to reduce landfill waste; supported the North London Heat and Power Project, which will convert up to 700,000 tonnes of waste to energy from the 7 North London boroughs; and started the new Brent Cross Town development, which will be a net zero town. This is part of wider sustainability initiatives as part of the North Central London Integrated Care System, which also includes wider activity to decarbonise the NHS estate and operations as well as council activity.
Key Area 1	Renew and agree the Barnet Transport Strategy, which will explore more active and low emission transport options and delivery	Director of Highways and Transportation, London Borough of Barnet	Oct-23	Dec-24	On target to be achieved by target date	The Barnet Long Term Transport Strategy has been agreed and runs until 2041. It includes proposals around walking, cycling, use of public transport, car use, freight usage and behaviour change. Achieved work since September 2023 (not mentioned in the action on the Sustainability Strategy above) include opening of new Brent Cross West station; start of works to upgrade facilities and capacity at Colindale Underground Station; 4 trial school streets schemes are live; Superloop network extended to include Barnet destinations; and a first cycleway (51) opened between Burnt Oak and Colindale.
Key Area 2	Reduce the risk of vaccine preventable diseases	Barnet Flu and Immunisation Steering Group	Sep-21	Sep-25	On target to be achieved by target date	This continues to be on target, and is a priority programme under the Population Health and Integrated Care Strategy. Current focus is increasing vaccination rates around Measles and Whooping Cough.
Key Area 2	Agree and implement the Corporate Parenting Strategy for 2023-25	Director - Children's Social Care, Family Services	Oct-23	Oct-25	On target to be achieved by target date	The Corporate Parenting Strategy is due to be updated. In the current time, we are working to the current strategy.
Key Area 2	Deliver the Cardiovascular Disease (CVD) Prevention Programme, and track its impact	Barnet Borough Partnership - CVD Task and Finish Group	Sep-22	Jul-26	On target to be achieved by target date	The CVD Prevention Programme was updated, presented and agreed by Health and Wellbeing Board in January 2024. The Task and Finish Group continues to review progress on the plan, and track impact in this area.
Key Area 2	Work with partners and ICP on increasing the number of residents accessing social prescribing as well as increasing the range of organisations and sectors that can make referrals	Senior Public Health Strategist, LBB	Jul-22	Sep-25	On target to be achieved by target date	Data for 2023-24 shows that the number of people accessing social prescribing has increased from 7,122 in 2022/23 to 8,452 in 2023/24 (an increase of 18.7%). Work continues to connect residents via social prescribing to the range of activity and support available in Barnet.

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 2	Improving children's oral hygiene across the borough through the Oral Health Action Plan	Barnet Oral Health Partnership Working Group	Sep-23	May-24	On target to be achieved by target date	Oral health action plan is finalised and updated at quarterly partnership meetings by all. Meetings with Oral Health team have taken place to clarify support for Healthy Early Years London/Healthy Schools London programmes in Barnet. Toothpaste packs to be stored at children centres for Oral Health Teams to use and for health visitors to have access during health checks. Toothpaste packs handed out at hotels during an event for families residing in the hotels. Dental epidemiology survey to be carried out in the 2023/24 academic year. We are currently liaising with epidemiology team and there is good uptake among schools. Sugar Smart Webinar to take place in March 2024 for Early Years and schools to attend.
Key Area 2	Develop the Healthy Start programme – ensuring access to adequate and healthy food	Health Improvement Officer, LBB	Mar-22	May-25	On target to be achieved by target date	Continued promotion of healthy start via professionals continues. Food Roots funding toward digital champions at food banks has meant extra support for families eligible to sign up. A Barnet Healthy Start Toolkit has been developed for use at food banks and circulated to early years teams and health professional staff members. A 'before you start' screen is now available when applicants start the online application detailing what information they need to hand. You tube short videos now available with animations about how to apply and Barnet comms have used these to promote the scheme. New translated materials on the healthy start website have been circulated too. An extended vitamin programme for refugee and asylum seeker families is in place with promotion and signposting to local children centres. Unfortunately, a national error with Healthy Start data meant all uptake figures from July 2023 to February 2024 are incorrect. This has affected all London Boroughs. Currently we can only take data from back in June 2023 where uptake was 51% and March 2024 where it is now 53%. On the NHS healthy start website they have put. <i>"We were made aware that the eligibility data that we receive and use to calculate the uptake of the NHS Healthy Start scheme was incorrect. This issue affected the eligibility number from July 2023 to February 2024. We have therefore removed the eligibility data and the uptake percentage for those months from the datasets. The DWP is not able to provide accurate historical eligibility data, so there is a gap in the eligibility data and the uptake percentage from July 2023 to February 2024."</i>
Key Area 2	Implement Resilient Schools Plan for 2023-24, to improve children's mental health	Resilient Schools Manager, LBB	Sep-23	Aug-24	On target to be achieved by target date	The plan continues to be delivered. In March 2024, 85 schools are on the Resilient Schools network with 30 schools achieving the Resilient Schools kitemark through the Barnet programme or Healthy Schools London. Peer Champion Scheme is progressing with 3 schools completing the training and co production workshop and four more booked on in Spring Term. 285 (+61 peer champions) have been trained in Youth Mental Health First Aid and 81 people in suicide prevention. Commissioning of on line counselling service and been completed and Qwell has been awarded the contract.

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 2	Deliver the Suicide Prevention Plan, led by the Suicide Prevention Partnership, for children, young people and adults for 2023-24	Senior Public Health Strategist, LBB	Sep-23	Sep-24	On target to be achieved by target date	Annual report on progress on the Suicide Prevention Plan was presented to Health and Wellbeing Board in September 2023, with a refreshed and co-produced plan agreed to run from 2023 to 2025. There are nearing 40 organisations working together to support the mental health of children, young people and adults and making a commitment to reduce suicide deaths in Barnet. Progress has been made across the eight key action areas of the strategy despite cost-of-living pressures on both residents and staff. The current three-year average suicide rate in Barnet of 4.8 per 100,000 (2019 -2021), remained the second lowest in London. The total number of suspected suicides from the Real Time Surveillance System (RTSS) for 2022-23 was 20, this is lower than in 2021-22 of 25. However, this needs to be interpreted with caution as under reporting may be an issue.
Key Area 2	Ongoing implementation of Champion role to focus on developing priority areas	Senior Public Health Programme Manager, LBB	Apr-23	Mar-25	On target to be achieved by target date	Health Champions has continued to be delivered by Groundwork in Barnet, with a focus in 2023/24 of developing Public Mental Health approaches. As of the end of March 2024, 308 people are on the Barnet Health Champion network, with 9 Health Champions having Specialist Mental Health training.
Key Area 2	Deliver the Barnet Fit and Active Barnet (FAB) Annual Plan	Assistant Director - Greenspaces and Leisure, LBB	Apr-23	Mar-24	Completed	Development of the annual plan for 2024-25 is currently underway, with the period of the 2023-24 annual plan now finished.
Key Area 2	Update the Sexual Health Strategy, and implementation plan, which will include the recommissioning of Sexual Health Services	Head of Healthy Behaviours Commissioning, LBB	Aug-23	Jun-25	On target to be achieved by target date	Sexual health draft strategy has almost been completed, with the KPIs to be finalised as part of a NCL collaboration. Recommissioning of this service will be led by Camden in collaboration with Barnet and Islington. We are now in the process of appointing a Project Manager to oversee the recommissioning process. A new Contract is expected to be awarded by end of May 2025.
Key Area 2	Finalise Substance Misuse Delivery Plan, which will include recommissioning of Substance Misuse Services	Combatting Drugs Partnership - Delivery Plan Head of Healthy Behaviours Commissioning, LBB	Aug-23	Mar-25	On target to be achieved by target date	The current substance misuse service contract delivered by Change Grow Live comes to an end in March 2025. Currently Public Health are reviewing the specification in accordance with the 2021 drug strategy and local needs assessment which was completed in 2023. Work is taking place with procurement to determine which provider selection process is most appropriate in line with the Provider Selection Regime (which came into force in January 2024). We are on track for the new contract to be in place by the end of March 2025.
Key Area 2	Complete the Public Health Aging Well Needs Assessment	Consultant - Live and Age Well, LBB	Aug-23	Jan-24	Completed	The Needs Assessment and recommendations form the basis of the Annual Director of Public Health report for 2024, and will be presented to Health and Wellbeing Board in May 2024.
Key Area 2	To develop and implement the response to health needs of the Migrant Health population	BBP, Borough of Sanctuary, Barnet Public Health	Sep-23	Sep-24	On target to be achieved by target date	Asylum Seeker Health Action Plan has been developed, with 19 areas of action. The work on the plan is supported by investment from North Central London ICB and from the Council.
Key Area 2	Recommissioning of borough level smoking cessation services and NHS Health checks	Head of Healthy Behaviours Commissioning, LBB	Aug-23	Mar-24	Delayed achievement by target date	This is delayed compared to the original timescale, but is progressing. Legal is currently drafting a contract for the new service model for 2024/25 onwards. Service specifications for both service areas have been amended to reflect additional funding for smoking cessation activity, with information governance processes updated for Health Checks. It is expected that the new service will be in place by Summer 2024.
Key Area 2	Commission the Health and Wellbeing Service for teenagers	Consultant - Start and Grow Well, LBB	Sep-23	Dec-23	Completed	Contract has been awarded, and is being rolled out across the borough.
Key Area 2	To develop a programme of Public Mental Health responses for implementation in Barnet	Senior Public Health Programme Manager, LBB	Sep-23	Sep-24	On target to be achieved by target date	As well as the work around Suicide Prevention, Resilient Schools and Health Champions (as outlined above), Barnet continues to be an active partner in Thrive LDN, which supports London wide activity to improve Mental Health.



## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 3	Deliver the Integrated Care Strategy for North Central London	Health and Wellbeing Board / Barnet Borough Partnership	Oct-22	Mar-23	Completed	The Population Health and Integrated Care Strategy was signed off in Quarter 1 2023-24. The current focus is on developing the Joint Forward Plan.
Key Area 3	Develop aligned intervention pathways with the ICP for CYP	Assistant Director of Commissioning - Family Services, LBB	Sep-21	Sep-25	On target to be achieved by target date	<p>The CYP Mental Health and Wellbeing Board is now fully established with members from all provider trusts. Work is ongoing to enhance join up across the system and on pathways. Things being worked on include:</p> <ul style="list-style-type: none"> <li>•Sharing of performance data between services to establish the gaps and challenges</li> <li>•A task and finish group led by the Royal Free London and Barnet, Enfield and Haringey to begin exploring a joint pathway for ADHD and autism diagnosis for under 7s</li> <li>•Parent carer involvement to enhance the Waiting Room developed by T&amp;P</li> </ul> <p>The Community Services Delivery Group has now been established. An dedicated Asthma Nurse for Barnet will start in post in April 2024, and their work will build on the annual #AskAboutAsthma campaign.</p> <p>Barnet has been selected to be the lead Local Authority for the London Challenge Programme Partnership (CPP). Pilots are taking place across the 9 Department for Education's (DfE) regions and are focused on delivering the improvements set out in the DfEs Special Education Needs and Disability (SEND) and Alternative Provision (AP). This is a joint piece of work with the system and the community and is a true partnership piece. Barnet will also be trialling an innovative, earlier intervention approach to Speech and Language Therapy.</p>
Key Area 3	Collaborate to develop a Healthy Aging pilot in one neighbourhood of BBP as demonstration of whole system approach to healthy aging.	Barnet Borough Partnership - Aging Well Working Group	Sep-22	Sep-24	On target to be achieved by target date	<p>Work has focussed on the borough wide Age Friendly Barnet, which uses the World Health Organisation Age Friendly 7 key domains:</p> <ol style="list-style-type: none"> <li>1. Challenging Ageism: Intergenerational Respect &amp; Inclusion.</li> <li>2. Public Spaces &amp; Safety</li> <li>3. Transport &amp; Active Travel</li> <li>4. Activities &amp; Socialisation</li> <li>5. Housing &amp; Home Support</li> <li>6. Work &amp; Volunteering</li> <li>7. Community Information &amp; Digital Inclusion</li> </ol> <p>Age UK Barnet led resident engagement methods, in partnership with wider organisations, to seek the views of residents to ensure diverse reach of views to undertake a baseline assessment for Age Friendly domains, with Action Plan and Charter developed using the information.</p>
Key Area 3	Integrate our data to provide longitudinal view of the patient to support direct patient care and population health management	North Central London Integrated Care Board - Analytics Team	Sep-21	Sep-25	On target to be achieved by target date	<p>The focus in this area over the last six months has development of the outcome framework for the Population Health and Integrated Care Strategy, which has now been launched - <a href="https://nclhealthandcare.org.uk/our-working-areas/population-health/ncl-outcomes-framework/">https://nclhealthandcare.org.uk/our-working-areas/population-health/ncl-outcomes-framework/</a></p> <p>HealthIntent continues to be used, with a Childhood Vaccinations, NHS Diabetes Prevention Programme and Long Term Condition case finding dashboards being developed and rolled out across the North Central London area.</p>

## Barnet Health and Wellbeing Strategy - Phase 3 Implementation Plan (September 2023 - May 2025)

HWBS Key Area	Project Activity	Lead	Start Date	Finish Date	Status as of April 2024	April 2024 Progress Report
Key Area 3	Address inequalities in access to digital services	Head Of Customer Services & Digital, LBB	Sep-21	Sep-25	On target to be achieved by target date	A range of programmes continue to be delivered in 2023-24, including Libraries Digital Inclusion Programme; BOOST Drop in Clinics; Make It Click; Age UK Digital Skills training; Gifted Devices from Age UK; BOOST call back service; Digital Champions; BOOST SIM card and Gifted Devices; 2econd Chance Device Scheme and Community Fibre. 549 residents have been reached with gifted devices/SIM cards, and 622 residents reached with training.
Key Area 3	Develop integrated pathways around CVD	North Central London ICB - Clinical CVD and Stroke prevention network	Sep-21	Sep-23	Action has been incorporated into another piece of work	This work is likely to be incorporated into the North Central London wide Heart Health programme, working with the Barnet CVD Task and Finish Group.
Key Area 3	Increase range of services participating in Multi Disciplinary Teams (MDTs) and rolling out model across all areas	Barnet Borough Partnership - Aging Well Working Group, Children and Young People Working Group	Sep-21	Sep-25	On target to be achieved by target date	Two types of multi disciplinary teams are now being rolled out across the borough - Community Aging Well Service (formerly known as Frailty) MDT and Paediatric Multi Disciplinary Meetings (MDMs). The Community Aging Well Service continues to deliver across the borough, and impact of the service continues to be monitored. Paediatric MDMs are operational in 4 out of 6 Primary Care Networks (same as September 2023). Positive feedback has been received from clinicians and there is excellent engagement from acute Paediatric Consultants and Start Well leads. CAMHS consultants are engaged with PCN2 for mental health focussed MDMs. Once condition prevalence data has been collected for each MDMs, MDM leads will be encouraged to access professionals from across the system to discuss high prevalence cases. Data collection has been variable this year, largely linked to contractual variances. However, overall clinician feedback received from those participating in the MDMs has been 100% positive with feedback that 100% of the young people discussed have benefitted from the MDT discussion. A short term contracting and financing solution has been found to continue the work of the current MDM system, with work being undertaken at a North Central London level on a long term model of contracting and funding.
Key Area 3	Embed prevention in PCN work through use of population health management on Long Term Conditions	North Central London ICB/BBP	Sep-21	Sep-25	On target to be achieved by target date	The Long Term Conditions Locally Commissioned Service was rolled out across North Central London in the second half of 2023/24. The service is in the early stages of delivery, and further data and information is expected in 2024/25.
Key Area 3	Implement a strategic framework and action plan to respond to the needs of the homeless population	Public Health Strategist, LBB	Sep-23	May-25	On target to be achieved by target date	Homeless Health Work Plan continues to be delivered, and the steering group in place to ensure progress is made. Homeless Locally Commissioned Service was due to launch in April 2024, however one bid was received and service was not awarded. We are working around this gap to see what progress can be made in the meantime.
Key Area 3	Devise and implement the Neighbourhood Model for Barnet based on PCN and/or hyper local geographies	Barnet Borough Partnership - Neighbourhood Working Group	Apr-23	Jul-24	On target to be achieved by target date	Four neighbourhood pilot projects have been agreed, funded and have started delivery. The projects cover a range of health and healthcare support measures, including digital inclusion, holistic reviews of housebound patients, one stop shops for patients with Learning Disabilities, and community level work to reduce health inequalities and improve patient education. Further information on delivery is expected in early 2024/25.
Key Area 3	Work with the Grahame Park Pathfinder Project to lead the Adults, Health and Wellbeing sub group	Barnet Borough Partnership - Grahame Park Adults, Health and Wellbeing sub group	Sep-23	May-25	On target to be achieved by target date	Adults, Health and Wellbeing sub group continues to meet, with successful conversations being had with Housing and Central London Community Healthcare (CLCH) on improving access to services for residents. Co-chair of group has now passed to CLCH.

**Appendix B - Key Performance Indicators - Key Area 1**

Measure	Unit of Measurement	Baseline Date	Baseline Data	Time period/date of latest data	Data (as of 26th January 2024)	Direction of Travel from baseline	Target
The proportion of overweight or obese children at Year 6 (ages 10-11).	% of Year 6 children	2019/20	34.4%	2022-23	34.20%	↔	No increase.
Proportion of deaths attributable to air pollution. * methodology change for 2021 onwards data	Percentage of overall deaths	2019	8.6%	2022	7.2%	↓	No increase.
Proportion of residents who walk or cycle for travel (at least once a week). *2022 Cycling statistics has been provided for Outer London only	Proportion Cycling	2018/19	5.5%	2022	6.1%	↔	7%
	Proportion Walking	2018/19	49.1%	2022	41.5%	↔	60%
Number of people in contact with Social Prescribers/Prevention and Wellbeing Co-ordinators	Number of people	2020/21	3,224	2023-24	8,452	↑	5,000
Rate of domestic abuse incidents	Rate per 1,000/population	1 October 2020 - 30 September 2021	8.2	1 April 2023 - 31 January 2024	6.9	↓	Barnet to become lowest rate of all 32 London Boroughs.
Number of GP surgeries fully trained under IRIS	Number of GP Surgeries	September 2020 - August 2021	0	Mar-24	23	↑	50
Total number of foodbank beneficiaries per month	Number of beneficiaries	Jan-22	7,268	Dec-23	14,310	↑	Decrease

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## Health and Wellbeing Board

<b>Title</b>	North Central London (NCL) Joint Forward Plan
<b>Date of meeting</b>	9 <sup>th</sup> May 2024
<b>Report of</b>	Director of Place (West), NCL Integrated Care Board (ICB)
<b>Wards</b>	All
<b>Status</b>	Public
<b>Urgent</b>	No
<b>Appendices</b>	Appendix 1 – NCL Joint Forward Plan Delivery Plan
<b>Officer Contact Details</b>	Simon Wheatley, Director of Place (West) NCL ICB <a href="mailto:simon.wheatley2@nhs.net">simon.wheatley2@nhs.net</a>

### Summary

The NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners at the Integrated Care Partnership (ICP) Committee in April 2023 following a significant programme of engagement and co-production.

Since April, significant work has been undertaken:

- Engaging and socialising
- Building the action plans for system transformation programmes
- Developing and mapping local priorities in Borough Partnerships
- Developing the NCL Outcomes Framework

Population health improvement is embedded in everything we will do so this Delivery Plan sets out our critical path to achieve this. This document will serve as our Joint Forward Plan submission to NHS England.

As focus shifts to monitoring and delivery of our plan, we ask the Health and Wellbeing Boards to consider implications for local plans and strategies and how to remain closely linked as delivery progresses.

### Recommendations

1. That the Board note the implementation of the Joint Forward Plan (JFP) 2023-2024.
2. That the Board consider whether there are specific areas of the JFP that are particularly important to the population in Barnet.
3. That the Board consider how they see the Health and Wellbeing Strategy and the Joint Forward Plan (JFP) together delivering improved health outcomes for people in Barnet.
4. That the Board consider how can we ensure our common and coherent ambitions are reflected in joint strategies and plans, and that delivery is overseen in partnership.

## 1. Reasons for the Recommendations

- 1.1 Our NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. It outlines our ambition to tackle health inequalities by a shared emphasis on early intervention, prevention and proactive care.
- 1.2 Since April 2023, significant socialising, and planning work across the Integrated Care Partnership (ICP) has culminated in the development of our NCL Joint Forward Plan (JFP) which outlines our critical path to deliver against our PH & IC Strategy. This has recently been endorsed at the ICB Board of Members.
- 1.3 Our JFP (appendix 1) summarises plans to tackle inequalities among our 'key communities', who we have identified as facing the poorest outcomes in NCL.
- 1.4 As delivery against our strategy continues, we are also building on the lessons learned from system and place work on vaccinations, a small number of areas have been identified by the ICP to "super-charge" - making the best use of the collective weight of the ICP to accelerate and deepen impact. Areas identified are childhood immunisations, SEND, Family Help in Early Years, Mental Health, Heart Health, and Admissions Avoidance.
- 1.5 Work is ongoing to socialise the JFP with the ICP and Health and Wellbeing Boards with the ask of colleagues to consider how to best remain involved in delivery moving forward and any implications for local footprint plans and strategies.

## 2. Alternative Options Considered and Not Recommended

- 2.1 N/A

## 3. Post Decision Implementation

- 3.1 Work across system, place and neighbourhood will continue to deliver the JFP as well as provide a yearly refresh in line with NHSE guidance.
- 3.2 This work should remain closely linked to the NCL Outcomes Framework which will monitor our progress against tackling health inequalities.

## 4. Corporate Priorities, Performance and Other Considerations

### Corporate Plan

- 4.1 Supports tackling health inequalities, living well and working in partnership with our communities

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

5.1 There are no specific cost implications or proposals at this point, this is more about a commitment to a Population Health approach, which will align with a cost-effective use of resource.

## **6. Legal Implications and Constitution References**

6.1 Under Part 2B - Terms of Reference & Delegation of Duties to Committees and Sub-Committees of the Council's Constitution, the main functions of the Health and Wellbeing Board include:

- To work (together with Barnet Borough Partnership) with Integrated Care Partnership (ICP) and Integrated Care Board (ICB) to determine the integrated approach that will best deliver holistic and streamlined care and prevention activities, including action on wider determinants in their communities.
- 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 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.
- 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 In line with the system-ownership of the strategy, engagement has been central to progressing strategy development and subsequent delivery planning. This includes engaging with:

- Integrated Care Partnership Committee
- Health and Wellbeing Boards
- Borough Partnership Boards
- Provider Boards
- VCSE Alliance
- Programme leads across NCL (E.g. Cancer Alliance, Inequalities Fund, Start Well)
- Community Partnership Forum

7.2 The strategy was taken to the Barnet HWBB on 13<sup>th</sup> March 2023 in draft form. The purpose of engaging the HWBB was to ensure the draft Strategy had strong Barnet stakeholder input before being finalised and to also consider next steps in developing the JFP.

## **8. Equalities and Diversity**

8.1 As the system develops plans for delivery of the Strategy in each local area, each project will develop a robust Equalities Impact Assessment.

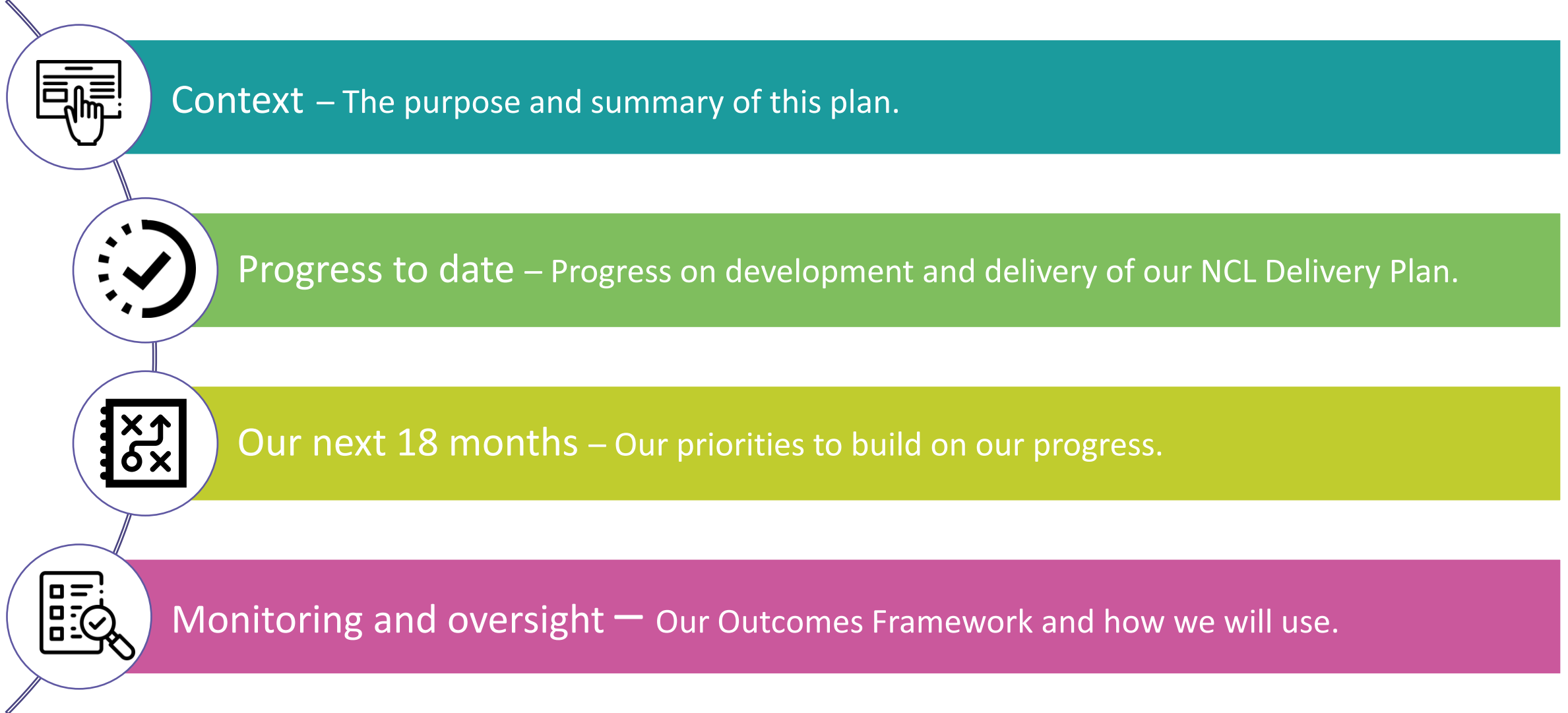
## **9. Background Papers**

9.1 North Central London Population Health and Integrated Care Strategy: [Agenda for Health & Wellbeing Board on Thursday 16th March, 2023, 9.30 am \(moderngov.co.uk\)](#)

# North Central London Delivery Plan – implementing the NCL Population Health & Integrated Care Strategy

Reflecting on the last 12 months and looking 18 months ahead

*March 2024*



# Context

About this document

**‘Our ambition is to work with residents of all ages of North Central London so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death.’**

Photo to be added by  
designer



## About this document

- The NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found [here](#).
- Since April, significant work has been undertaken:
  - **Engaging and socialising**
  - **Building the action plans for system transformation programmes**
  - **Developing and mapping local priorities in Borough Partnerships**
  - **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring – *the dashboard can be found [here](#)*.**
- Population health improvement is embedded in everything we will do so – this document sets out our critical path to achieve this. It is a live document that will change over time as we refine our ambitions.

# Strategy Delivery Areas

Our five key health risk areas where we can create the biggest impact in NCL.

Our child and young people (CYP) NCL communities who experience greater health inequalities and poorest outcomes.

The 20% most deprived communities in NCL.



Our adult NCL communities who experience greater health inequalities and poorest outcomes.

Focusing on the root causes of poor health.

- Inclusion Health Groups
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness and adults with learning disabilities
- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

- Children with Special Educational Needs and Disabilities (SEND)
- Children Looked After (CLA) and care leavers.
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Continuing Care for Children and Young People
- Safeguarding arrangements for designated doctors and nurses for Children and Young

- Childhood immunisations
- Heart Health
- Cancer
- Lung Health
- Mental Health and Wellbeing across all ages

# Progress to date

Delivery since April 2023

# Key Communities Progress – Adults and Children



- £5m investment to address inequalities experienced by 20% most **deprived communities** working with communities and VCSE focused on areas of greatest disparity in outcomes
- £1m system investment in multi-agency, integrated support for people experiencing **homelessness**
- **Inclusion Health** needs assessment completed which has been identified as an example of good practice in national guidance
- 14,000 adults with **Severe Mental Illness** will have a specified physical health check in 23/24
- Equitable expansion of community **chronic kidney disease** service now offered by all practices in NCL
- Supporting care home staff through **staff wellbeing bus** where high levels of hypertension and diabetes risk identified and navigated to right care setting.

240



- Improved **vaccination** uptake (1 year) by 5% between January 22 and January 24
- Free prescriptions for NCL **care leavers** launching in spring 2024.
- Inequalities funding directed to **Children & Young People in most deprived areas** for empowerment, mentoring and reduction in serious youth violence schemes.
- Additional **Mental Health Support** Teams - 257 schools supported by 14 teams in 2024/25.
- Invested in capacity in **eating disorders** services to meet an increase in demand improving performance significantly.
- Over £1m invested in **Children's Therapies** backlog so that 5,591 initial assessments provided in SLT and OT, reducing the number waiting for initial assessment
- **Parentcraft** courses contributing to a 24% reduction in ED attendances for under 5s in one local hospital.



- **Tobacco** dependence teams established in all acute and mental health trusts leading to an increase in number of staff members in the trust trained regarding having conversations on smoking cessation and an increase in referrals to the community stop smoking services
- Improved the uptake of Targeted **Lung Health** Checks from 30% to 55%. Over 20,000 people have now had a lung health check
- Across three NCL trusts in Q3 2023/24, 942 people were identified as being at high risk of **liver cancer** and of those, 397 received a routine ultrasound
- Worked with the Voluntary, Community and Social Enterprise (VCSE) sector, including those representing the Bangladeshi, Jewish and Somali populations to improve uptake of **childhood immunisations** in those groups.
- Invested in a range of hyperlocal schemes to encourage **healthy weight** informed by Community Participatory Research [\[insert link to EVA film\]](#)

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designer

# System Transformation Programmes Progress

NCL has a number of system transformation programmes, which have a strong focus on population health improvement and which use core population health approaches. This includes risk stratification and targeting support using our population health management platform HealthEintent, co-production with most impacted communities, alignment with **Core20plus5** priorities and ensuring services are equitable.

- **Long Term Conditions Locally Commissioned Service** rolled out with resource aligned to need through additional deprivation weighting
- **Community Services** – shifted resource to areas of highest need – including recruitment of 60 additional front-line staff and 48% increase in virtual ward capacity
- **Mental Health** - increased workforce by 6.4% in 22/23 with a further 4% increase in 2023/24. Over 21,000 people will access our transformed adult community mental health services in 2023/24
- **Diagnostics** – established two Community Diagnostic Hubs in areas of high need, with best diagnostic waiting times in the country in Dec 2023
- **Start Well** – clinically developed proposals to improve access, experience and outcomes associated with maternity and neonatal care as well as emergency surgical pathways for very small babies that has benefited from a comprehensive consultation programme with >150 community events

We are also working across our wider system programmes to ensure that a population health approach is embedded within each and maximising impact on health, inequalities, integration and the shift toward prevention. This includes **Digital Strategy** focus on digital inclusion, **Urgent and Emergency Care** utilisation linked to deprivation, improving end to end pathway outcomes through **Specialist Commissioning**, equitable **Elective Recovery**, hyperlocal care through **Primary Care Transformation**, and addressing outcomes, our work on the **Women's health strategy** and considering in reports such as **Child Death Oversight**.



# Levers for Change Progress

**Making population health everyone's business**

**Strengthening integrated delivery**

**Collaborating to tackle the root causes of poor health**

**Aligning resources to need**

**Becoming a learning system**

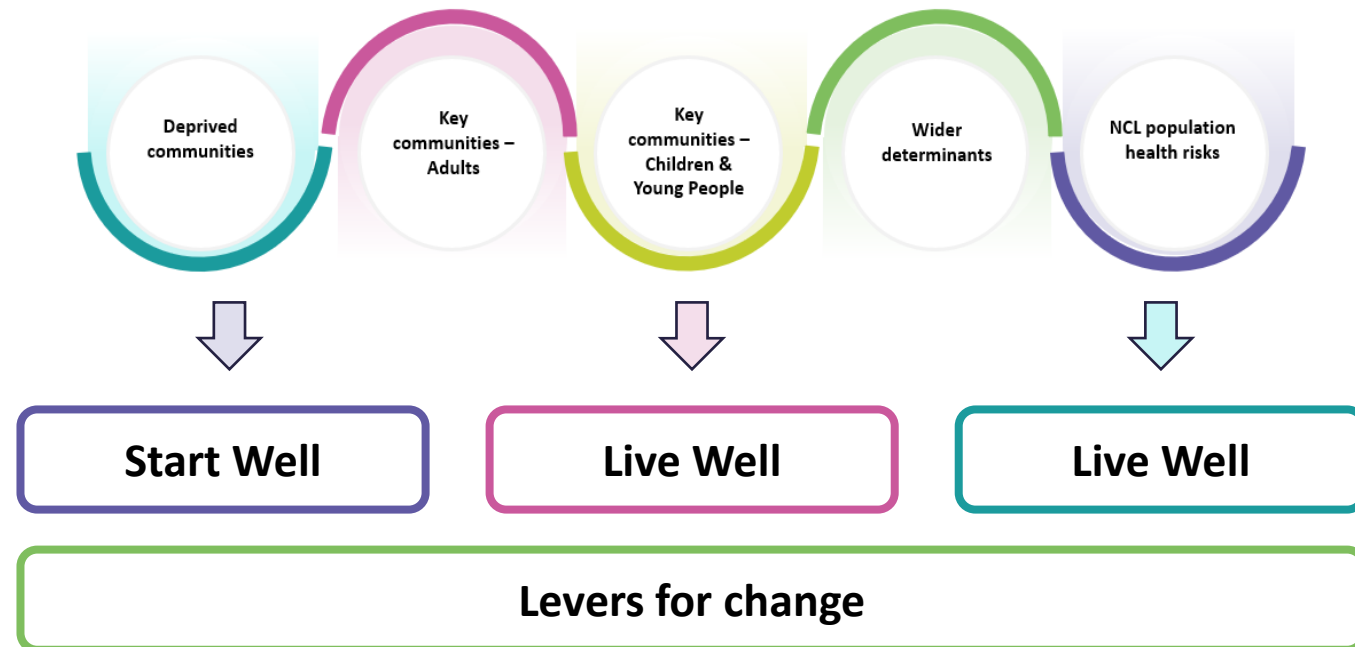
**Creating 'one workforce'**

- Supported system partners to launch the **NCL Health and Social Care Academy**, supporting over 150 residents into work with a focus on supporting those with barriers to employment.
- Secured national funding to establish a **Research Engagement Network (REN)** which has developed relationships between the ICB and academic and VCSE partners. Delivered 20 community engagement events working with our black and Gypsy Roma Traveller communities to co-ordinate research and improve diversity in research.
- Launched the **ethnicity dashboard** and refined data system to focus on most underserved communities.
- Met the reduction target in **inhaler emissions** in Q3 as part of our Green NHS plan.
- Delivered our **Communities and VCSE strategies** – community voice now key part of governance structures and service delivery
- Began implementing the year 1 delivery plan of our **People Strategy**, 'Laying the foundations'
- Collaboration across system to address impact of **cost of living** through provision of advice and support to staff, patients and residents.
- Development of the Outcomes Framework and launching the online dashboard to support monitoring

# Our next 18 months

## Headline plans for further progress

In our delivery plan we have combined our focus on key communities and population health risks with improving health outcomes across the life course. Levers for change are enablers which underpin our programme of work over the coming months





# Next Steps – Start Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks



Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
<b>Start Well</b>	<ul style="list-style-type: none"> <li>Challenges associated with outcomes for deprived populations, location, declining birthrate and increasing complexity &amp; specialist staffing in maternity and neonatal care</li> </ul>	<ul style="list-style-type: none"> <li>Finalising the proposals for maternity and neonatal services, and children’s surgical services following public consultation</li> <li>Delivery of maternity and neonatal equity and equality plan via LMNS and key focus on service use experience</li> </ul>	<ul style="list-style-type: none"> <li>Ensure equity in access and outcomes from hospital based maternity, neonatal and CYP care.</li> </ul>
<b>Children Looked After (CLA) and care leavers.</b>	<ul style="list-style-type: none"> <li>Care leavers experience poorer health outcomes than other young people.</li> <li>The homeless population has significant levels of people with experience of care.</li> </ul>	<ul style="list-style-type: none"> <li>Understanding delivery of key areas identified through the London Care Leavers Compact.</li> <li>Work with NCL Directors of Children’s services to improve access to effective emotional, psychological, and physical health and wellbeing support for care leavers</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of free prescriptions programme</li> <li>Scoping further support to address health needs such as dental care</li> <li>Internship opportunities</li> </ul>
<b>Special Educational Needs and Disabilities (SEND)*</b>	<ul style="list-style-type: none"> <li>High levels of need and delays on assessments</li> <li>CYP wait much longer than NICE guidance for CYP Autism diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>Develop a network of learning across Special Educational Needs &amp; Disability and Alternative Provision programme</li> <li>Improvement of care pathway for Children &amp; Young People with neuro-developmental needs</li> </ul>	<ul style="list-style-type: none"> <li>Significant reduction in waiting times for therapy and NDD assessments</li> </ul>
<b>Childhood immunisations*</b>	<ul style="list-style-type: none"> <li>Entrenched health inequalities, and impact of post-pandemic on immunisation rates in NCL. Particular challenges re MMR uptake.</li> </ul>	<ul style="list-style-type: none"> <li>Increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.</li> </ul>	<ul style="list-style-type: none"> <li>Target 3-5% increase in childhood vaccination by focusing on areas of greatest disparity.</li> </ul>
<b>Family help in early years*</b>	<ul style="list-style-type: none"> <li>Identified as an ICP priority</li> </ul>	<ul style="list-style-type: none"> <li>ICP consideration of priorities in April 2024</li> </ul>	<ul style="list-style-type: none"> <li>Aspiration in line with ICP recommendations</li> </ul>
<b>Children’s Mental Health</b>	<ul style="list-style-type: none"> <li>Significant differences in early help and prevention in NCL for CYP MH</li> <li>High levels of need and delays in assessments</li> </ul>	<ul style="list-style-type: none"> <li>Serious Youth Violence Vanguard</li> <li>Implementing the THRIVE model</li> <li>Enhancing support for Children &amp; Young People by development of our online CAMHS waiting room</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in variation of provision between boroughs</li> <li>Improvements in waiting times for assessment</li> </ul>

# Next Steps – Live Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks

Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
<b>Inclusion Health</b>	<ul style="list-style-type: none"> <li>Differential community health services, lack of integration with wider services and lack of skills in mainstream</li> </ul>	<ul style="list-style-type: none"> <li>Develop equitable integrated MDT physical and mental health community offer for people experiencing homelessness in all boroughs in line with needs.</li> <li>Improve mainstream offer that is trauma informed</li> </ul>	<ul style="list-style-type: none"> <li>Improve healthcare equity, access, experience and outcomes for people in inclusion health groups across boroughs.</li> </ul>
<b>Community Services</b>	<ul style="list-style-type: none"> <li>Limited access to diagnostics in some geographies/some conditions</li> <li>Inequitable community service offer across boroughs.</li> </ul>	<ul style="list-style-type: none"> <li>Community Services Review implementation 2024/25</li> <li>Reduce growth of liver disease diagnosis through Community Diagnostics Centres</li> <li>Increased capacity of diagnostics at Wood Green</li> </ul>	<ul style="list-style-type: none"> <li>Increased investment according to need</li> <li>Increased Diagnostic Capacity whilst tackling health inequalities including through rapid cancer diagnostics and new Fibroscan</li> </ul>
<b>Prevention and wider determinants</b>	<ul style="list-style-type: none"> <li>Differential prevention offer across NCL</li> <li>Lack of employment impacting health</li> </ul>	<ul style="list-style-type: none"> <li>Develop sustainable and equitable core offer across smoking cessation, alcohol and weight management services.</li> <li>Implement work well programme</li> </ul>	<ul style="list-style-type: none"> <li>Long Term Plan tobacco offer fully implemented</li> <li>Enhanced employment opportunities</li> </ul>
<b>Heart Health*</b>	<ul style="list-style-type: none"> <li>Challenges in case-finding, treatment and management of lifestyle risk factors for high blood pressure, but also from an inequalities lens when looking across communities.</li> </ul>	<ul style="list-style-type: none"> <li>Develop borough-based action plans to support identification and management of high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>Close our high blood pressure prevalence gap and to treat people with high blood pressure to target, while tackling inequalities in NCL.</li> </ul>
<b>Mental Health/Learning Disability &amp; Autism*</b>	<ul style="list-style-type: none"> <li>Residents who have an SMI die on average 14.9 years earlier if they are female, 18.4 years if they are male.</li> <li>Inequitable community mental health service offer</li> </ul>	<ul style="list-style-type: none"> <li>Longer Lives – supporting better physical health for residents with SMI</li> <li>Improving home treatment for people in crisis and strengthening proactive community support at home</li> <li>Strengthen diagnostic and support services for residents with LD &amp; Autism</li> </ul>	<ul style="list-style-type: none"> <li>Reduce premature death of NCL residents with SMI due to preventable conditions.</li> <li>Ensure there is an equitable, consistent and high-quality service offer available to all NCL residents.</li> <li>Further reduce reliance on inpatient care for LD &amp; A residents</li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>Participation in screening varies across boroughs and communities</li> </ul>	<ul style="list-style-type: none"> <li>Promote and enable engagement with primary care, focussing on actions that support earlier diagnosis plan</li> </ul>	<ul style="list-style-type: none"> <li>Contribute towards achieving the diagnosis of 75% of cancers at stage 1 and 2.</li> </ul>
<b>MSK Live Well Review</b>	<ul style="list-style-type: none"> <li>Rising demand that outstrips current capacity alongside increasingly complex patient needs and inequity in funding across our services.</li> </ul>	<ul style="list-style-type: none"> <li>A minimum MSK community services offer, including digital self-management and self-referral</li> </ul>	<ul style="list-style-type: none"> <li>Ensure quality MSK care for all, best possible MSK outcomes for all, and sustainable, continuously improving care</li> </ul>

\*ICP Priority Area

# Next Steps – Age Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks



Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
<b>Long Term Conditions</b>	<ul style="list-style-type: none"> <li>Launched with 100% of GP Practices signed up</li> </ul>	<ul style="list-style-type: none"> <li>Embedding outcomes incentivisation and case finding to reduce prevalence gap</li> </ul>	<ul style="list-style-type: none"> <li>A single Locally Commissioned Service for Long Term Conditions focussed on proactive and personalised care.</li> </ul>
<b>Proactive Care</b>	<ul style="list-style-type: none"> <li>Commitment to developing the ICB’s approach to and functionality around Proactive Care and LTCs</li> </ul>	<ul style="list-style-type: none"> <li>Develop the vision, aims and case for a proactive care function and design an approach to this function that optimises resources, skills and assets in NCL</li> </ul>	<ul style="list-style-type: none"> <li>Patients and Residents diagnosed earlier, treated to target in a biopsychosocial model with coordination, continuity and digital support to be more empowered and active in their care</li> </ul>
<b>Carers</b>	<ul style="list-style-type: none"> <li>Family carers have poorer health and wellbeing outcomes and are disproportionately impacted by the cost of living crisis</li> </ul>	<ul style="list-style-type: none"> <li>Borough based development and delivery of carer strategies.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure carers receive proportional support required to improve outcomes</li> </ul>
<b>Older adults with care and support needs</b>	<ul style="list-style-type: none"> <li>Reducing numbers of care providers, variations in care and the need to support digital and tech infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>Continue to implement Enhanced Health in Care Homes programme</li> <li>Progress joint market management arrangements for care homes, drawing on the particular strengths the NHS and Councils can bring.</li> </ul>	<ul style="list-style-type: none"> <li>Equitable offer across care provision</li> <li>Joint working to stabilise and develop care market offer in NCL</li> </ul>
<b>Supporting residents at risk of hospital admission*</b>	<ul style="list-style-type: none"> <li>Significant challenges on hospital flow with focus on downstream activities</li> <li>Our most deprived communities experience increased admission levels of 20-30% than the general population</li> </ul>	<ul style="list-style-type: none"> <li>Further develop the admissions avoidance framework and utilise as tool to develop system and place plans/build admission avoidance approaches across key programmes</li> </ul>	<ul style="list-style-type: none"> <li>Improve join up and effectiveness of downstream activities whilst shifting focus upstream and on prevention</li> </ul>
<b>Supporting residents to recover following hospital admissions</b>	<ul style="list-style-type: none"> <li>Broad range of services in NCL ICS which help people to recover from hospital admission</li> <li>Opportunities for further integration and consistency across the ICS</li> </ul>	<ul style="list-style-type: none"> <li>Embedding a shared core offer of discharge services and pathways between partners</li> <li>Improved understanding of outcomes, with particular focus on population health</li> <li>Focus on ‘home first’ – helping people recover at home</li> </ul>	<ul style="list-style-type: none"> <li>Proactive, recovery oriented, services between partners, aligned to need</li> <li>Shared evidence of improving long term outcomes</li> <li>Helping more people get ‘home first’</li> </ul>

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\*ICP Priority Area

## Next steps – Levers for Change

Making population health everyone's business

Strengthening integrated delivery

Collaborating to tackle the root causes of poor health

Aligning resources to need

Becoming a learning system

Creating 'one workforce'

- Incorporate plans into ICB business planning processes and those of wider system partners so this is a **golden thread** throughout all that we do.
- Develop and implement **population health and health inequalities training programme**, building on training already delivered and hold system wide Equity Summit.
- Develop **Neighbourhood Teams** as core integrated population health management delivery vehicles.
- Extend the impact of **Inequalities Fund** schemes in areas of greatest deprivation using this as a vehicle for attracting shared investment funding and building evidence base.
- Embed approach to **aligning resource to need** across investment activity and decision making.
- Implement **VCSE Strategy** developing a shared approach to investment in this sector across Council and ICB commissioning, supporting **prevention** agenda.
- Strong and ongoing engagement of Borough Partnerships in the identification of local gaps against the **Community and Mental Health Services core offer** and design and prioritisation of investment recommendations to address these.
- Develop **NCL Research Strategy** with the aim of increasing quality, quantity and depth of research undertaken across NCL. Evaluate **Research Engagement Network (REN)**
- Take forward **People Strategy** and **Work Well programme** (subject to outcome of bid)
- Revise **Population Health governance** to reflect focus on delivery phase.

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\*As outlined in slide 36 of our PH & IC Strategy, in order to drive progress on our delivery areas, we have identified ICS levers for change which will create the context and conditions for sustainable delivery.

# Next Steps – Borough Partnerships

Borough Partnerships and integrated working are core to the successful implementation of our delivery plan. Significant focus will be on supporting and enabling that delivery building on significant work to date.

Next steps for Borough Partnerships include:

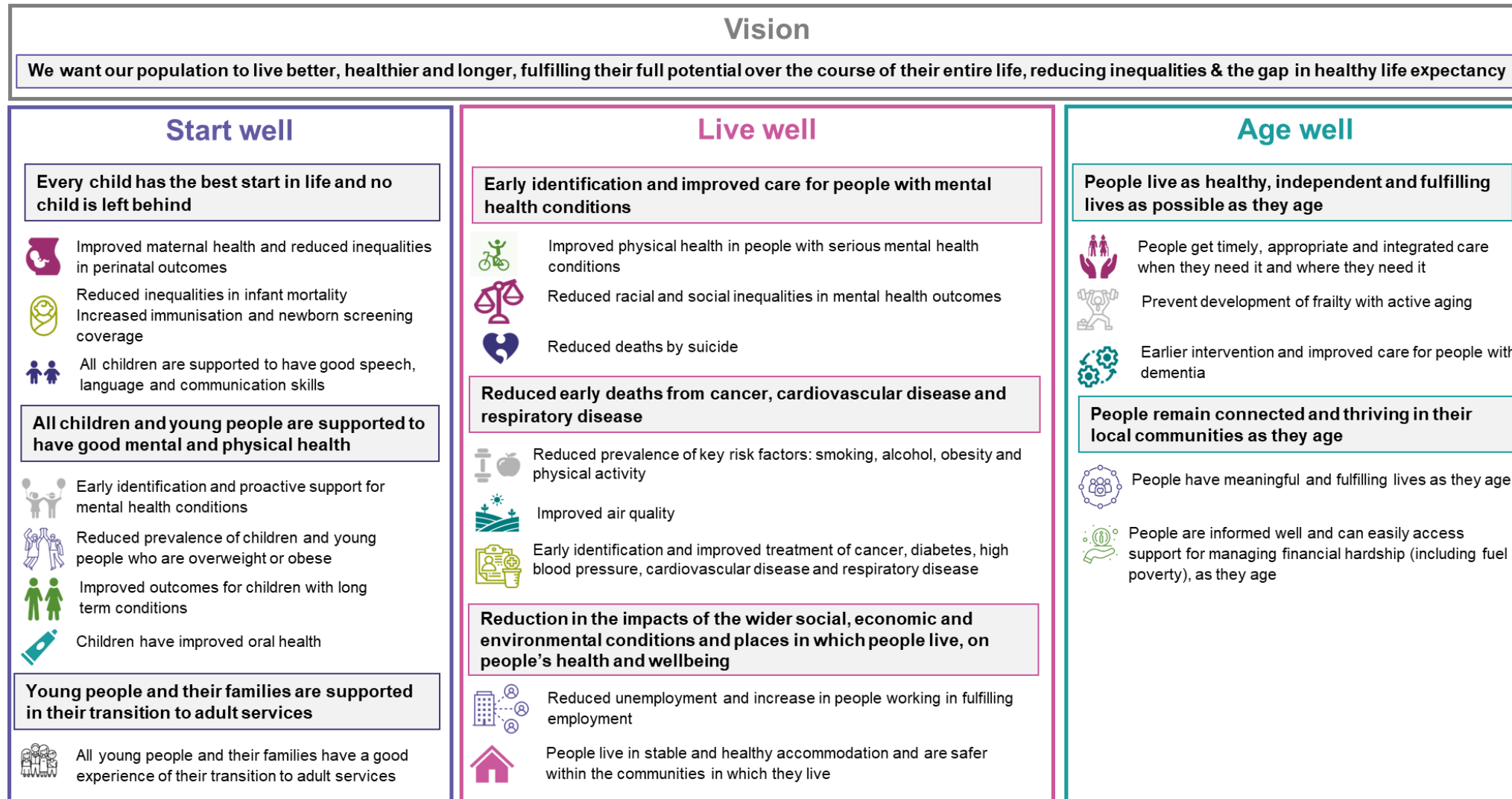
- Refine plans and priorities for the coming 18 months so that each borough has a **clear focused local programme of work** aligned with the Delivery Plan.
- Align project monitoring to indicators and outcomes in the NCL Outcomes Framework and develop and embed use of **borough dashboards**.
- Agree how to drive systematic **cross-borough learning**.
- Deepen work to drive impact and align resources to ‘supercharge’ on a **tighter set of priorities**.



# Monitoring and oversight

## *Our Outcomes Framework*





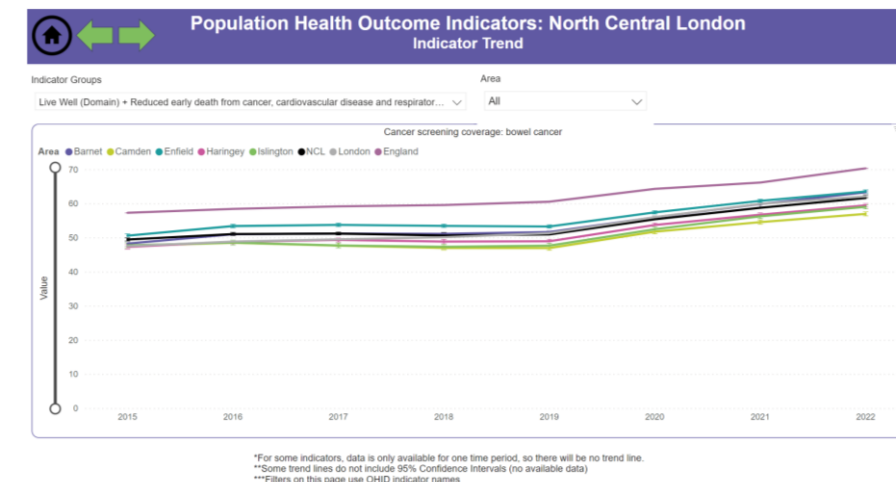
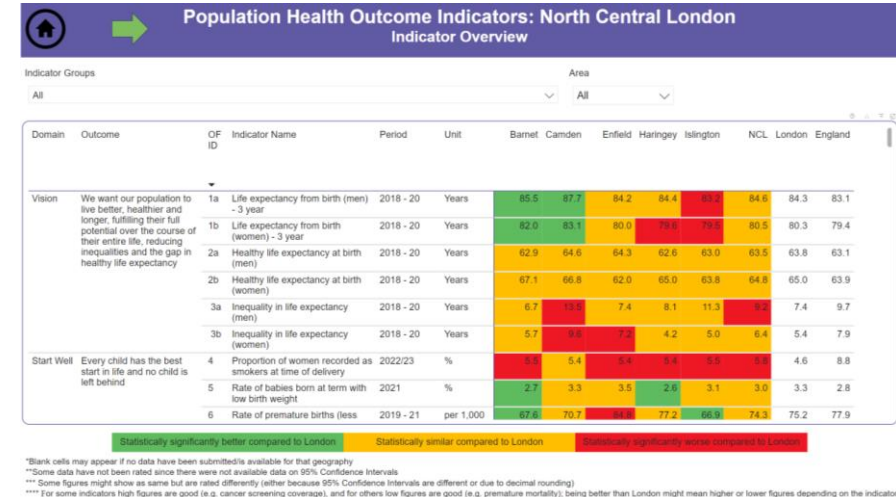
\*Slide 16 of the PH & IC Strategy outlines that we have developed a population health outcomes framework that reflects where we have significant local disparities across the life course.

# Developing the NCL Outcomes Framework

## Views of the NCL Outcomes Framework online dashboard

### Further development of the NCL Outcomes Framework planned for the next 18 months:

- Review and refresh the full data across all indicators in the Outcomes Framework on an annual basis and produce an insight report to go alongside this
- Update data in the dashboard at more regular intervals (where available)
- Work with Borough Partnerships to design and develop borough-level outcome and performance dashboards
- Embed awareness and use of the framework across teams within the ICB, and the wider system, through training and communications
- Continue to review the range of indicators to ensure it remains relevant and aligned to emerging priorities
- **Ensure improving equity remains at the heart of everything we do**





# Appendices

- Financial monitoring
- Glossary

# Work is ongoing to ensure we are discharging NHS financial duties

- We are currently working on the NHS system financial plan for 24/25 and we are aiming to set a plan that meets all the financial standards expected of us.
- With regard to the revenue plan, we are working towards a system break-even plan for 24/25, but we know that this will be challenging to agree and to deliver.
- We will set a 24/25 capital expenditure plan within the capital resource limit. This will also be a challenge to agree with NHS system partners, as the local requirement will exceed the available funding.
- We also recognise there are financial challenges for non-NHS partners such as Local Authorities and VCSE, therefore working together will be important.

NHS Rule	Meaning for our NHS system	23/24	24/25
Duties to break even / achieve financial balance	Objective to breakeven - i.e. duty to seek to achieve objective of system financial balance.	We are expecting to achieve all of these financial targets in 2023/24.	Work in progress towards a break-even plan for revenue.
Capital resource limit	Collective duty to act with a view to ensuring that the capital resource use limit set by NHS England is not exceeded.		We are expecting to achieve all of these financial targets in 2024/25.
Mental Health Investment Standard	Comply with standard as set out in relevant planning guidance.		
Better Care Fund	Comply with minimum contribution as set out in relevant planning guidance.		

**To be added at end**

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# Update on delivery of our Population Health & Integrated Care Strategy and development of our Joint Forward Plan

Barnet Health and Wellbeing Board

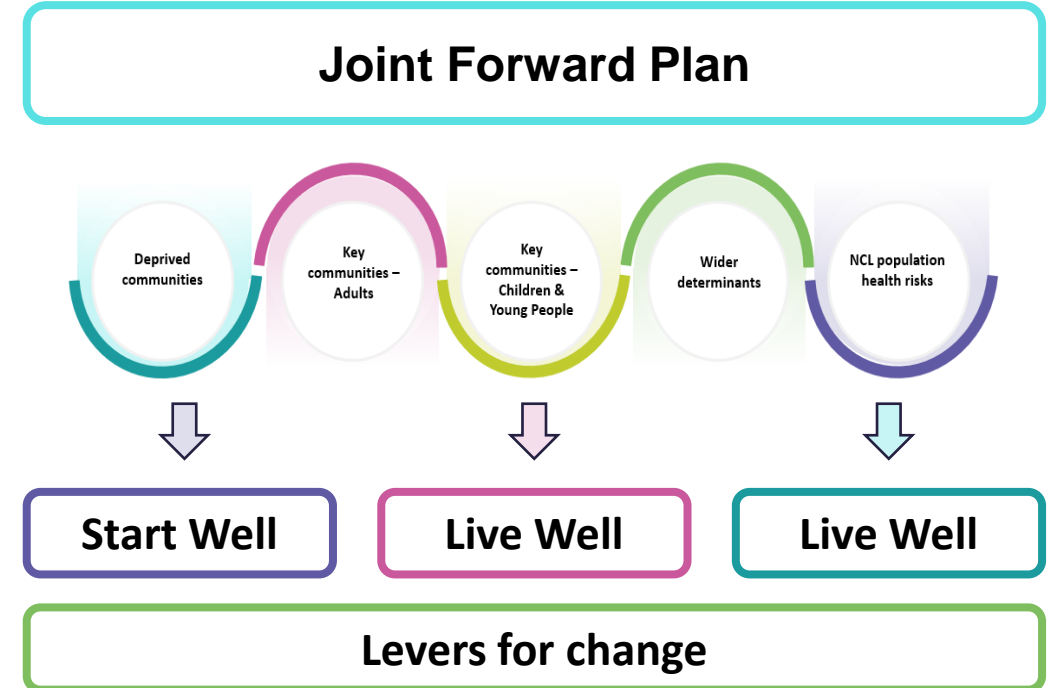
*9<sup>th</sup> May 2024*

Our NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found [here](#). It outlines our ambition to **tackle health inequalities** by a **shared emphasis** on **early intervention, prevention and proactive care**.

Since April 2023, significant socialising and planning work across the ICP has culminated in the development of our **NCL Joint Forward Plan (JFP)** which outlines our critical path to **deliver against our PH & IC Strategy**. The JFP appears in full in the appendix.

The JFP describes progress in implementing the strategy over the last 12 months, our plans for the coming 18 months and how we will monitor delivery using the NCL Outcomes Framework. The plans are aligned to a life course approach and incorporate:

- NCL communities experiencing the poorest outcomes, wider determinants of poor health and 5 key health risk areas
- NCL system transformation programmes, which are aligned to delivering our population health ambitions
- System levers which will create the conditions for population health improvement
- A number of areas within the plan have been identified by the ICP to "**super-charge**" - making the **best use of the collective weight** of the ICP to **accelerate and deepen impact**.



## Work undertaken since strategy endorsement in April 2023

Since April, significant work has been undertaken:

- **Engaging and socialising** with Health & Wellbeing Boards, Trust Boards, Borough Partnerships, forums involving the VCSE and patient representatives.
- **Building the action plans for system transformation programmes** setting out the changes that will be delivered in the next 18 months, as well as stock-taking delivery to date.
- **Developing and mapping local priorities in Borough Partnerships** to gain a better understanding of the range of work that speaks to the Delivery Areas of the PH & IC Strategy. This mapping was completed in Autumn 2023 and taken through the ICP Committee.
- **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring – *the dashboard can be found [here](#)***. Work over the last 12 months has focused on confirming indicators across the outcome and sub-outcomes, developing a dashboard for NCL and borough level, developing an annual insight report and establishing links between borough and programme outcomes framework with the NCL outcomes framework – helping understand impact of delivery.
- **Setting the context and conditions for sustainable delivery** via action planning and delivery against our levers for change in the strategy. This work is happening in parallel to what is being delivered by Borough Partnerships and our System Transformation Programmes and ownership of delivery against the levers varies.
- Progress in delivering against our strategy ambitions is set out in more detail in the JFP but headlines include:
  - Supporting care home staff through **staff wellbeing bus** where high levels of hypertension and diabetes risk identified and navigated to right care setting.
  - **Long Term Conditions Locally Commissioned Service** rolled out with resource aligned to need through additional deprivation weighting
  - Increased mental health workforce by 6.4% in 22/23 with a further 4% increase in 2023/24. Over 21,000 people will access our transformed adult community mental health services in 2023/24

## Highlights

### Start Well

- **Childhood immunisations and vaccinations**-partnership approach to enhancing both equity in uptake and increase in uptake, with rates of completed childhood immunisations rate at 1, 2 and 5 years all highlighting consistent increases over the last 12 months (HI data)
- **Integrated Paediatric Service-Multi-Disciplinary Meetings** providing early Consultant Paediatrician advice in the community/ primary care continue to receive highly positive feedback engagement from primary care and local Paediatric Consultants and early positive subjective outcomes regarding reducing need for onward referrals.
- Successful **partner approach to Asthma** including cross partner asthma friendly schools campaign and locally developed tier 2 and tier 3 training to support community approaches to asthma.
- Wider CYP transformation program including transformational approaches to autism diagnostic pathways and Barnet has been selected to be the lead Local Authority for the London Challenge Programme Partnership (CPP). Pilots are taking place across the 9 Department for Education's (DfE) regions and are focused on delivering the improvements set out in the DfEs Special Education Needs and Disability (SEND) and Alternative Provision (AP). This is a joint piece of work with the system and the community and is a true partnership piece. Barnet will also be trialling an innovative, earlier intervention approach to Speech and Language Therapy.



## Highlights

### Live Well

- Key communities-Innovative, integrated, community-based programmes co-created and mobilised by the Barnet Borough Partnership and positively making impact in community. For example, **Healthy Hearts-Provision of BAME Peer Educator roles** to enable delivery and co-production of **culturally appropriate outreach activities to support HTN** awareness and readings in the community to support reduction in diagnosis gap. Over 1000 touchpoint interventions have been completed.
  - **Art Against Knives-** enabled paid employment for peer support workers within young black male community, project to provide support to young black and co-produced piece of work to understand barriers in accessing mental health services in attempt to reduce disparity in outcomes and production of young black males co-produced feedback report on delivery of mental health services for young black males in the community.
  - **Health Inequalities-endorsement and mobilisation of cross partner Cardiovascular disease** prevention program and implementation of primary care led proactive hypertension case finding in Core20 areas, showcasing early promising results in supporting HTN diagnosis and treatment.
  - **Community Innovation Fund-**3 rounds of funding totalling £820k has been provided supporting 47 community projects reaching circa 15 thousand residents largely in Core20 areas with a strong prevention and wider determinants support focus. Work is underway to align this strategically to BBP to further support the impact of this program and co-ordination with our community and VCSE.
  - **Neighbourhood Model Working-**cross partner workshops were held in Barnet and enabled the development and delivery of innovative hyper-local, primary care and partner led pilots across Barnet, tailored to local neighbourhood level need.
- 2021 These include proactive care at home, digital inclusion support and outreach health checks for those with LD.

## Highlights

### Age Well

- Continued development of Community Ageing Well Service, supporting integrated care for our ageing population including specialist dementia and Carer support and education plus complex frailty case management plus therapies and broad community VCSE led offer to support residents to age well. Key highlights this year VCSE broadening of the model to include a fully recruited cross specialism team including therapies, dementia nurses, VCSE led advisory and support roles and the support of social workers.
- A further highlight is the commencement and embedding of **Admiral Dementia Nurses** in Barnet, specialist educational and clinical Dementia Nurses supporting **Carers** and those with Dementia and embedded within Community Ageing Well Service. The service has received highly positive feedback so far with positive feedback from Carers and from clinicians and broader system on support for co-ordination of care, for holistic support to residents with dementia and their carers and for reduction in need for wider system including urgent care due to the whole person approach and specialist and integrated approach.
- **Dementia Strategy**-an action plan was produced with partners across the system following the co-produced Dementia strategy. The action plan is successfully underway utilising a cross partner approach and planned further engagement with residents and Carers to seek feedback on action plan implementation to date.
- **Age Friendly Barnet**-working with Age UK Barnet and LBB towards World Health Organisation Age-Friendly cities framework to ensure Barnet is an Age Friendly borough, to ensure the environment and community enables supported, active ageing. BBP worked in partnership with Age UK Barnet to undertake a baseline assessment across a range of domains which has now been developed into a cross partner action plan across the range of wider determinant domains to support active ageing, for delivery in 24/25.

# What have we delivered in Barnet in the last twelve months

## Wider determinants-Working with our Communities and embedding the VCSE.

Provision of pooled funding direct to a partner VCSE organisation to enable the **direct employment of a dedicated BBP Peer Engagement and Co-Production Lead**

**Inclusion health groups**-work to support asylum seeker and homeless health in partnership with wider community groups

**VCSE led user experience research project** completed in 2023 incorporated into neighbourhood model development and Grahame Park development

BBP led development of a cross **partner co-production community of practice** to support co-production in practice, maximise impact and support cross partner learning across Barnet.



Age UK Barnet led **resident engagement methods, in partnership with wider partner organisations**, to seek the views of residents to ensure diverse reach of views to undertake a baseline assessment for Age Friendly cities framework, achieving over 1000 resident responses and completing 8 focus groups.

**Grahame Park** cross partner work with housing services and residents to support approaches to support health and wellbeing

Focusing on the root causes of poor health.

Art Against Knives **co-produced report with young black males on MH service provision** for young black males fed back to partner system

**Community Innovation Fund**-continues to support community projects and support to encourage a strong and resilient vcse sector.

**Healthy Hearts**- VCSE led community outreach peer support program, empowering our local community and building connections

Outreach feedback and engagement sessions for Community Ageing Well Service (formerly Frailty MDT) and co-produced and rename of the model to Community Ageing Well Service

# What next for Barnet?



## Early Priority Areas for Barnet Borough Partnership

DRAFT IN DEVELOPMENT

*To be worked through with partners  
and strategically aligned*

### Borough Partnership draft Aims

**Start Well** – Develop work to embed focus on **childhood immunisations, looked after children** and children with SEND transformation and community approaches to asthma.

**Live Well** - Enhance and join up working with our communities across the Borough to enhance **engagement and co-production** approach and **tackle inequality in outcomes, for example, in CVD** and MH. Build upon the **whole system approach to Cardiovascular Disease** including CVD prevention plan and proactive hypertension case finding

**Age Well** - Develop strategic, aligned, cross-partner approach to ageing and pathway with enhanced local prevention offer and link with urgent care, building upon community ageing well service and neighbourhood model foundations.

### Key stakeholders

- Barnet Borough of NCL Integrated Care Board;
- London Borough of Barnet;
- Royal Free London NHS Foundation Trust;
- Central London Community Healthcare NHS Trust;
- Barnet, Enfield and Haringey Mental Health Trust; and
- Barnet GP Federation
- The Barnet voluntary and community sector represented by the Barnet Together Partnership, Inclusion Barnet and the Young Barnet Foundation
- Barnet Primary Care Networks

### Borough Partnership early priorities for the next 18 months

- Build upon **Neighbourhood Model Working** - building upon foundations of integrated MDTs, Grahame Park and primary care led, integrated neighbourhood model approaches and develop CYP neighbourhood model approaches.
- Enhance **focus on prevention** with an aim **to develop scope and impact of key priorities/ 'supercharge'** a tighter set of key priorities for example with Ageing Well and Cardiovascular Disease, through joint-up, co-ordinated, strategic approaches.
- Enhance **close working and alignment with Health and Wellbeing Board to maximise impact** and reduce duplication of effort.
- Deliver improved outcomes through **strategically aligning outcomes** with clear delivery plans and **outcome measures** with defined data to support monitoring of impact.

### Strategically align and enhance close working with HWBB and wider BBP partner strategies

Early review of HWBB/ BBP priorities, wider partner strategies and priorities and initial discussion with partners have highlighted synergies and early priority areas incorporated into the NCL Population health draft priority areas) and to be incorporated into the BBP and joint forward plan. Review priority areas and opportunities within priority areas with Senior Responsible Officers and BBP Partners on alignment of approaches and how delivery may work best. Draft areas include:

- Ageing Well
- Looked After Children, and Children with Special Educational Needs and Disabilities – Delivery led by wider CYP/SEND group
- Mental Health – Children and Adults-workplans and areas to be finalised with borough partnerships and link to opportunities within community services
- Review, work already underway in these areas
- Enabled by neighbourhood model delivery, engagement and co-production, data and metrics and a health inequalities lens/ population health approach.

# What next for Barnet ?

## Barnet – NCL Population Health and Care Framework



DRAFT IN DEVELOPMENT

### A selection of metrics from the Outcomes Framework that align to our priorities for consideration and further discussion

	Metric	Date	Unit	Barnet	NCL	London
Start well	% uptake of MMR (for 1 dose) aged 2	22/23	%	80.6	77.5	82.4
	% uptake of MMR (for 2 doses) aged 5	22/23	%	70.6	66.8	74.0
	% children with complete immunisations by age 5	2023	%	72.5	69.2	
Live well	Cancer screening coverage - cervical cancer (25-49 yrs)	2023	%	57.3	55.1	58.0
	Cancer screening coverage - cervical cancer (50-64 year olds)	2023	%	69.7	69.9	70.7

Borough and NCL figures in table RAG-rated to London

	Metric	Date	Unit	Barnet	NCL	London
Live Well	Cumulative % of eligible population 40-74 who received an NHS Health Check	18/19 - 22/23	%	27.2	27.2	34.1
	Proportion of patients with hypertension, treated to age-specific blood pressure target, in last 12 months	22/23	%	70.3	72.7	69.6
	Under 75 mortality rate from all cardiovascular diseases	2022	Per 100,000	61.5	74.2	75.0
Age Well	Estimated dementia diagnosis rate (age 65 over)	2023	Per 100,000	61.8	66.3	65.6
	Dementia care plan has been reviewed in the last 12 months	22/23	%	78.1	78.5	77.7
	Carer-reported quality of life score	21/22	Out of 12	6.6	6.9	7.1

Barnet performs higher than the NCL average on several metrics although worse than the London average.

A key next step will be to understand these indicators from a lens of communities and hyperlocal inequalities.

To note: Cancer screening is also a draft priority area for improvement for Camden and Haringey. Child immunisations a priority metric for improvement for Camden, Enfield and Haringey. Dementia diagnosis rate also a priority area for improvement for Camden and Enfield.

This is a selection of metrics that align to our draft priority areas. Further work is planned with partners and SROs to review broader datasets to review wider deprivation data and inequalities and system narrative, for example inequity in outcomes in CVD and inequity in uptake in childhood immunisations and cancer screening.

This will be reviewed alongside the above and from areas within our key communities and real time data to build into borough dashboards to support monitoring progress and impact.

Borough Partnerships and integrated working are core to the successful implementation of our delivery plan. Significant focus will be on supporting and enabling that delivery building on work to date.

Next steps for Borough Partnerships include:

- Refine plans and priorities for the coming 18 months so that each borough has a **clear focused local programme of work** aligned with the Joint Forward Plan.
- Align project monitoring to indicators and outcomes in the NCL Outcomes Framework and develop and embed use of **borough dashboards**.
- Agree how to enable systematic **cross-borough learning**.
- Deepen work to drive impact and align resources to ‘supercharge’ on a **tighter set of priorities**.

- Are there specific areas of the JFP that are particularly important to the population in Barnet?
- How does the Health and Wellbeing Board see the Health and Wellbeing Strategy and the Joint Forward Plan (JFP) together delivering improved health outcomes for people in Barnet?
- How can we ensure our common and coherent ambitions are reflected in joint strategies and plans, and that delivery is overseen in partnership?

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**London Borough of Barnet  
Health and Wellbeing Board  
Forward Work Programme  
2024 / 2025**

Contact: Pakeezah Rahman (Governance Service) [pakeezah.rahman@barnet.gov.uk](mailto:pakeezah.rahman@barnet.gov.uk)

Subject	Decision requested	Report Of	Contributing Officer(s)
<b>09 MAY 2024</b>			
<b>Deep Dive</b>			
<p>Aging Well Needs Assessment and Annual Director of Public Health Report 2023/24</p> <p><i>Part of Key Area 2 – Starting, Living and Aging Well</i></p>	<p>The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area</p>	<p>Interim Director of Public Health, London Borough of Barnet</p> <p>Executive Director for Adults, Communities and Health, London Borough of Barnet</p>	<p>Public Health Consultant (Live and Age Well), Public Health, London Borough of Barnet (Deborah Jenkins)</p> <p>Public Health Registrar, Public Health, London Borough of Barnet (Madura Nanthakumaran)</p>
<b>DISCUSSION items</b>			
<p>Joint Strategic Needs Assessment</p>	<p>The Board to Approve – subject to comments – the final version of the Joint Strategic Needs Assessment 2023-24, and the plan for reviewing the Joint Health and Wellbeing Strategy</p>	<p>Interim Director of Public Health, London Borough of Barnet</p>	
<p>Health and Wellbeing Strategy: 6-month progress report and proposal for Strategy review process</p>	<p>The Board to Note and comment on progress and agrees on the HWBS review process</p>	<p>Interim Director of Public Health, London Borough of Barnet</p>	<p>Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O’Callaghan)</p>
<p>North Central London Population and Integrated Health Strategy: Performance &amp; Joint Forward Plan 2023-2024</p>	<p>The Board to Note and Comment on the joint forward plan</p>	<p>Director of Integration, North Central London Integrated Care Board</p>	

\*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)
<b>NOTING items</b>			
Communicable Diseases Update	The Board Note the verbal update	Interim Director of Public Health, London Borough of Barnet	<i>Interim Director of Public Health, London Borough of Barnet</i>
<b>04 JULY 2024</b>			
<b>Deep Dive</b>			
Improving children's life chances <i>Part of Key Area 2 – Starting, Living and Aging Well</i>	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Executive Director, Children's & Family Services	
<b>DISCUSSION items</b>			
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
<b>NOTING items</b>			
Communicable Diseases Update	The Board to Note the verbal update	Interim Director of Public Health, London Borough of Barnet	Interim Director of Public Health, London Borough of Barnet (Janet Djomba)
<b>19 SEPTEMBER 2024</b>			
<b>Deep Dive</b>			

Subject	Decision requested	Report Of	Contributing Officer(s)
Grahame Park and Burnt Oak  <i>Part of Key Area 3 – Ensuring delivery of coordinated and holistic care, when we need it</i>	The Board listens to the experience of residents, and the work currently underway to improve health and wellbeing in the area	Interim Director of Public Health, London Borough of Barnet	Public Health Consultant, (Neighbourhoods and Communities) London Borough of Barnet (Rachel Wells)  Muyi Adekoya
<b>DISCUSSION items</b>			
Deaths of Despair	The Board to Note the report.	Interim Director of Public Health, 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)
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	Interim Director of Public Health, London Borough of Barnet	Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O’Callaghan)
Pharmaceutical Needs Assessment Update	The Board to Approve – subject to comment – any updates to the assessment.	Interim Director of Public Health, 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)

Subject	Decision requested	Report Of	Contributing Officer(s)
<b>NOTING items</b>			
Suicide Prevention Plan Annual Report and Work Plan	The Board to Note the annual report and work plan.	Interim Director of Public Health, London Borough of Barnet	
Barnet Food Plan	The Board to Note the Plan.	Interim Director of Public Health, London Borough of Barnet	
Communicable Diseases Update	The Board to Note the verbal update	Interim Director of Public Health, London Borough of Barnet	
<b>23 JANUARY 2025</b>			
<b>Deep Dive</b>			
Draft Health and Wellbeing Strategy	The Board to sign off the draft Health and Wellbeing Strategy for Barnet ahead of formal public consultation	Interim Director of Public Health, London Borough of Barnet	Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O'Callaghan)
<b>DISCUSSION items</b>			
Better Care Fund Plan	The Board agrees the sign off process for the Better Care Fund Plan	Executive Director for Adults, Communities and Health, London Borough of Barnet	<p>Head Of Commissioning Older Adults and Integrated Care, Adults &amp; Health, London Borough of Barnet (Muyi Adekoya)</p> <p>Royal Free London NHS Foundation Trust (Gauri Mohan)</p>

Subject	Decision requested	Report Of	Contributing Officer(s)
<b>NOTING items</b>			
Communicable Diseases Update	The Board to Note the verbal update	Interim Director of Public Health, London Borough of Barnet	
<b>15 MAY 2025</b>			
<b>Deep Dive</b>			
Final Health and Wellbeing Strategy	The Board to sign off the draft Health and Wellbeing Strategy for Barnet ahead of formal public consultation	Interim Director of Public Health, London Borough of Barnet	Health and Wellbeing Policy Manager, London Borough of Barnet (Claire O'Callaghan)
<b>DISCUSSION items</b>			
Draft Pharmaceutical Needs Assessment	The Board approves the draft assessment ahead of formal public consultation.	Interim Director of Public Health, 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)
<b>NOTING items</b>			
North Central London Population and Integrated Health Strategy – Year 2 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	

<b>Subject</b>	<b>Decision requested</b>	<b>Report Of</b>	<b>Contributing Officer(s)</b>
North Central London Integrated Care Board Forward Plan Refresh	The Board to note the Forward Plan.	Director of Integration, North Central London Integrated Care Board	
Communicable Diseases Update	The Board to Note the verbal update	Interim Director of Public Health, London Borough of Barnet	Communicable Diseases Update

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Acronym	Long title	Description
AVA		
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		
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.

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