The London Borough of Barnet: Health Needs, Inequalities and ICS Priorities

The Centre for Population Health January 2026

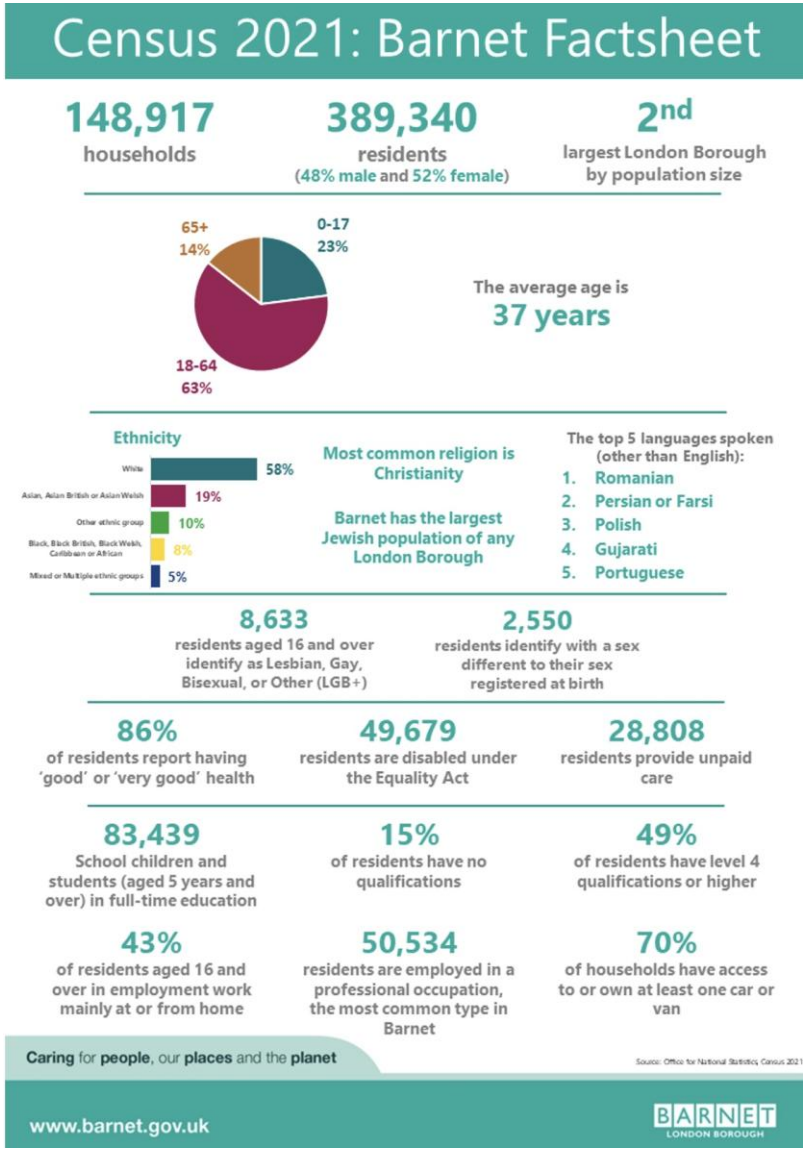
Introduction

This summary provides an integrated overview of The London Borough of Barnet's population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence-based planning across health, social care and community partners.

The pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

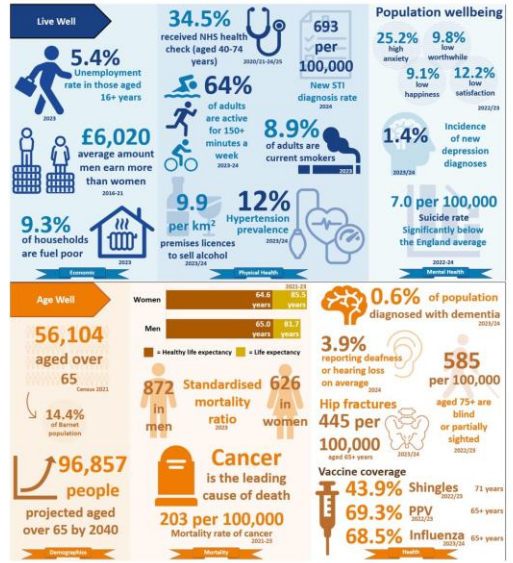
Summary

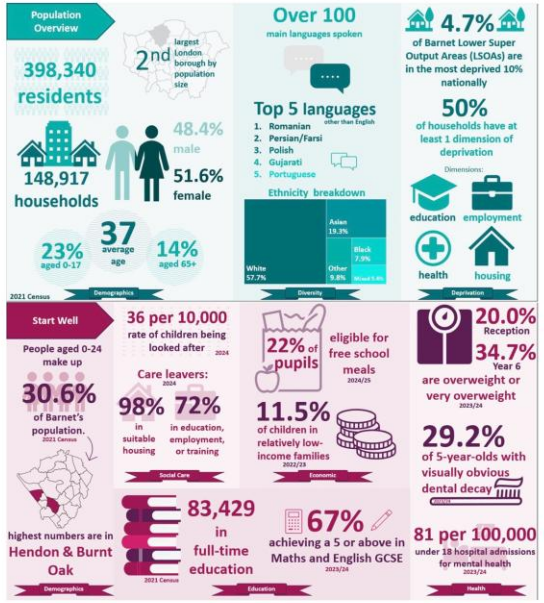
- Barnet is London's second most populous borough, with 389,300 residents and significant demographic diversity.
- Overall health outcomes exceed national averages, yet stark inequalities persist between affluent and deprived neighbourhoods.
- Life expectancy varies by up to nine years between wards, reflecting entrenched socio-economic and ethnic disparities.
- Childhood obesity, mental health needs, and uneven screening uptake highlight widening gaps across the life course.
- Ageing population growth of 55% by 2041 increases demand for long-term conditions management and social care.
- Housing affordability, fuel poverty, and overcrowding remain major determinants driving health inequalities in Barnet.
- ICS priorities focus on prevention, early intervention, and targeted support for high-need communities and vulnerable groups.



Borough Overview

- Barnet covers 86.7 km², combining dense urban areas in the south with suburban communities in the north.
- Population reached 389,300 in 2021, making Barnet London's second most populous borough overall.
- Age distribution includes 23% children, 63% working-age adults, and 14% older residents aged 65 and over.
- Barnet hosts the UK's largest Jewish community, representing 14.5% of residents across several neighbourhoods.
- Over 90 languages are spoken locally, with Romanian, Farsi, Polish, Gujarati, and Portuguese widely represented.
- Fuel poverty affects 10% of households, despite Barnet's overall strong socio-economic performance indicators.
- Major roads including the A1, A41, and North Circular contribute to congestion and localised air pollution challenges.



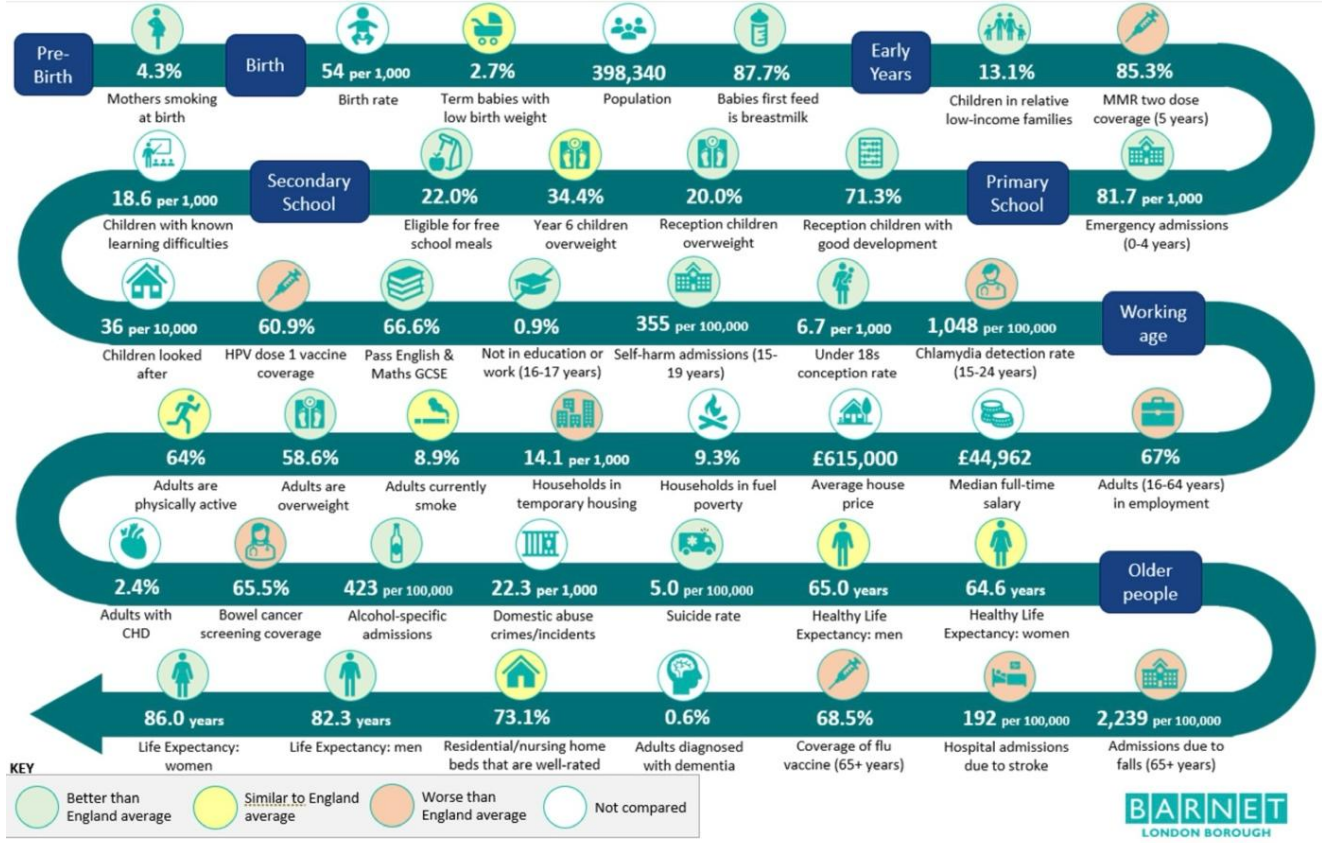


Population Characteristics

- Children and young people increased by 40% since 2011, creating sustained demand for early years services.
- Older residents aged 65+ number 56,000, the second-highest absolute older population among London boroughs.
- Ethnic minorities form 64% of residents, with significant Asian, Black, Eastern European, and Jewish communities.
- Only 57% of residents were UK-born in 2021, reflecting substantial long-term and recent migration flows.
- Half of households experience at least one deprivation dimension, including employment, education, health, or housing.
- Population density ranges from 650/km² in Totteridge to over 13,000/km² in Grahame Park estate.
- Regeneration areas such as Colindale require expanded primary care, community facilities, and preventive infrastructure.

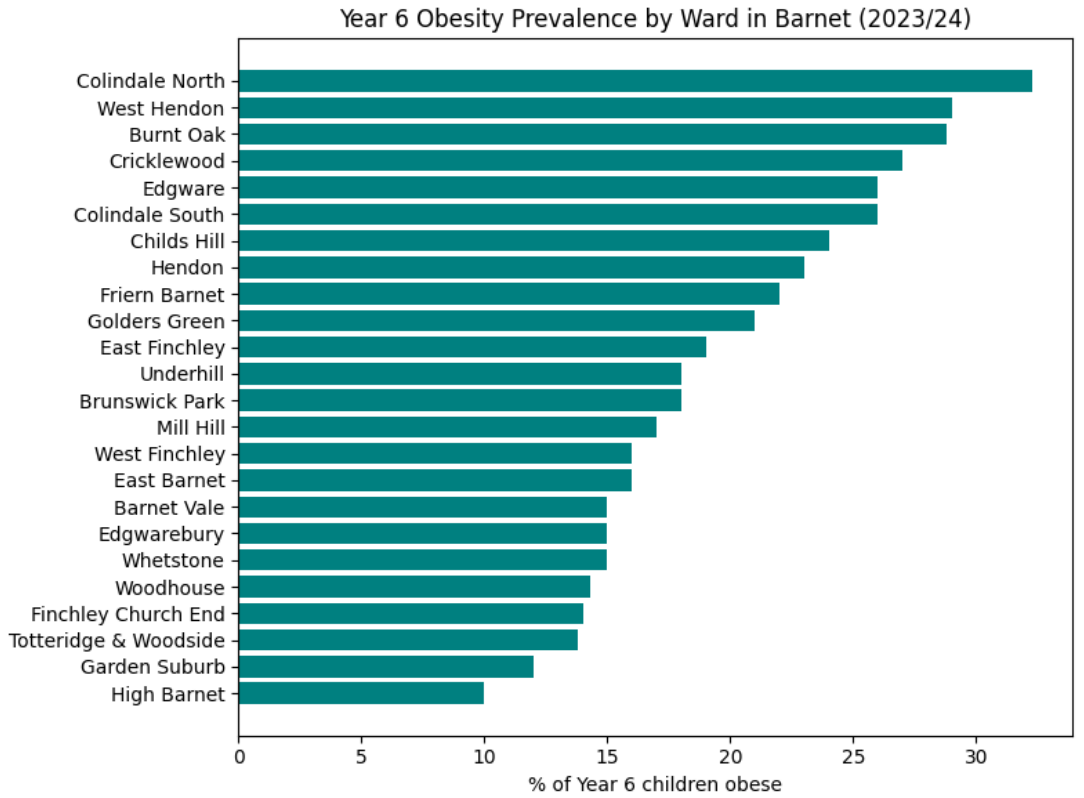
Key Health Inequalities

- Life expectancy differs by up to 8.8 years for women and 7.4 years for men across Barnet wards.
- Burnt Oak and Colindale experience significantly worse outcomes than affluent areas like Garden Suburb and Totteridge.
- Healthy life expectancy for men has declined, indicating more years lived in poor health across the borough.
- Child poverty ranges from 22% in Burnt Oak to just 2% in Garden Suburb, driving early disadvantage.
- School readiness shows major gaps, with only 43% of Black boys meeting expected development in 2021.
- Screening uptake for breast and cervical cancer remains lower in deprived and ethnically diverse communities.
- Childhood immunisation coverage, including MMR, remains below the 95% target in several high-need neighbourhoods.
- COVID-19 disproportionately affected Black, Asian, and deprived communities, widening existing health inequalities.



Key Health Inequalities

- Year 6 obesity reaches 32.3% in Colindale North compared with 10% in more affluent High Barnet.
- Adult overweight and obesity increased from 49.2% in 2015 to 58.6% in 2023/24 across the borough.
- Smoking prevalence is double in Burnt Oak compared with Garden Suburb, reflecting deprivation-linked behaviours.
- Alcohol-related harm is concentrated in deprived areas, increasing hospital admissions and long-term health risks.
- Diabetes prevalence continues rising, particularly among South Asian and Black communities with higher risk profiles.
- Dementia diagnosis rates have fallen despite rising prevalence, indicating potential under-identification in older adults.
- One in three adults aged 65+ experiences a fall annually, increasing demand for community-based prevention services.
- Social isolation disproportionately affects older residents, especially in areas with limited community infrastructure.



Key Health Inequalities

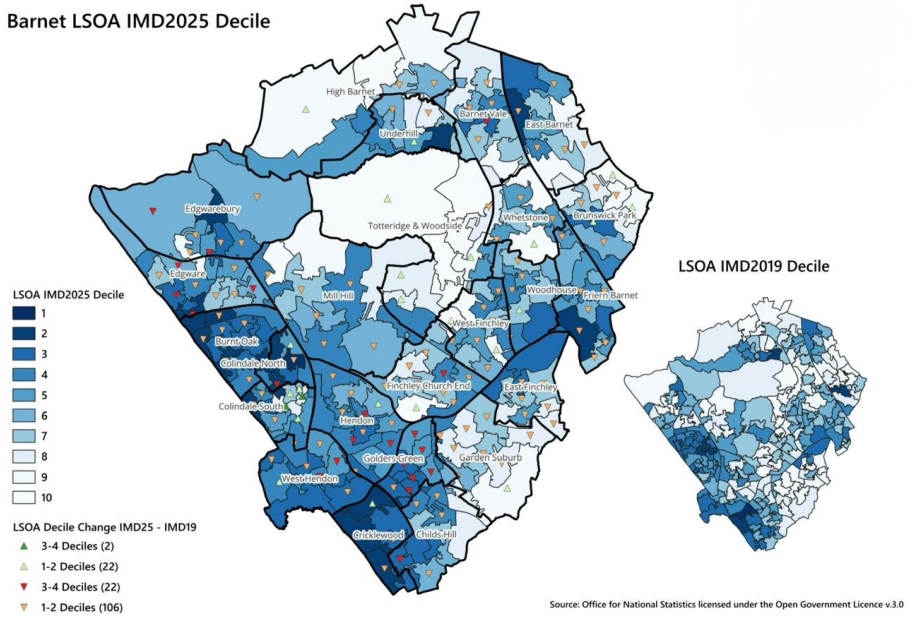
- Cardiovascular mortality is around 20% higher in deprived wards, despite Barnet performing better than England overall.
- Hypertension affects around 16% of adults, rising above 22% in deprived and ethnically diverse communities.
- Cancer incidence is slightly lower than England, yet late-stage diagnosis remains higher in deprived neighbourhoods.
- Depression prevalence is around 10%, with significantly higher rates among young people in deprived wards.
- Severe mental illness affects around 1.2% of adults, higher than London and England averages.
- Suicide rates remain low overall, but middle-aged men show higher risk linked to economic pressures.
- Long-term conditions are 25–30% more common in deprived areas, driving higher emergency hospital admissions.
- Multimorbidity appears 8–10 years earlier in deprived and minority ethnic groups compared with affluent areas.

Key Health Inequalities

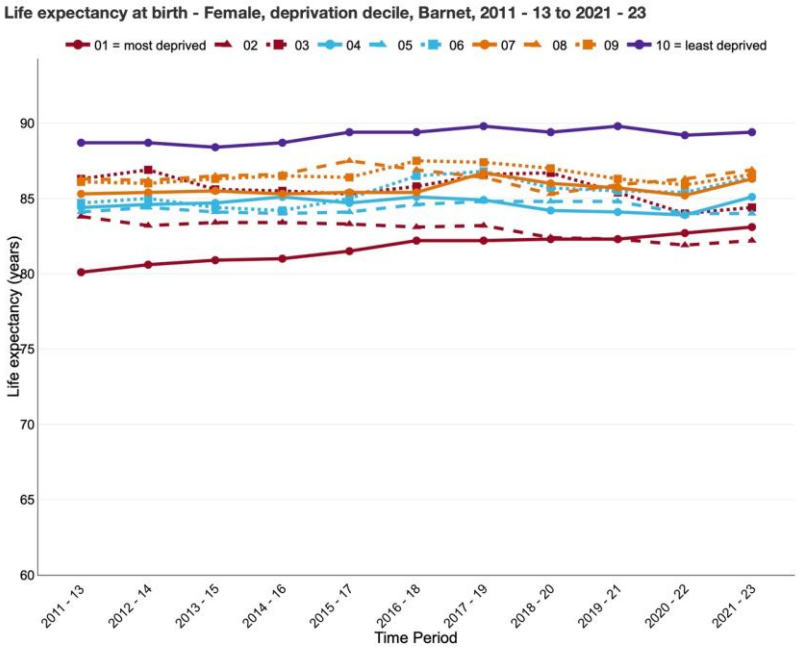
- Overcrowding affects around 12% of households, rising above 25% in Colindale and Burnt Oak.
- Fuel poverty affects around 10% of households, similar to London but above England's 6% average.
- Air pollution exceeds WHO limits along major roads, contributing to higher asthma and respiratory illness rates.
- Unemployment is around 4%, but double in deprived wards with higher ethnic diversity.
- Educational attainment gaps persist, with Black Caribbean pupils achieving 15–20% lower GCSE outcomes.
- Digital exclusion affects around 8% of households, limiting access to online health and care services.
- Transport barriers reduce healthcare access for residents in peripheral or poorly connected neighbourhoods.
- Crime and safety concerns disproportionately affect young people in deprived areas, impacting wellbeing and opportunity.

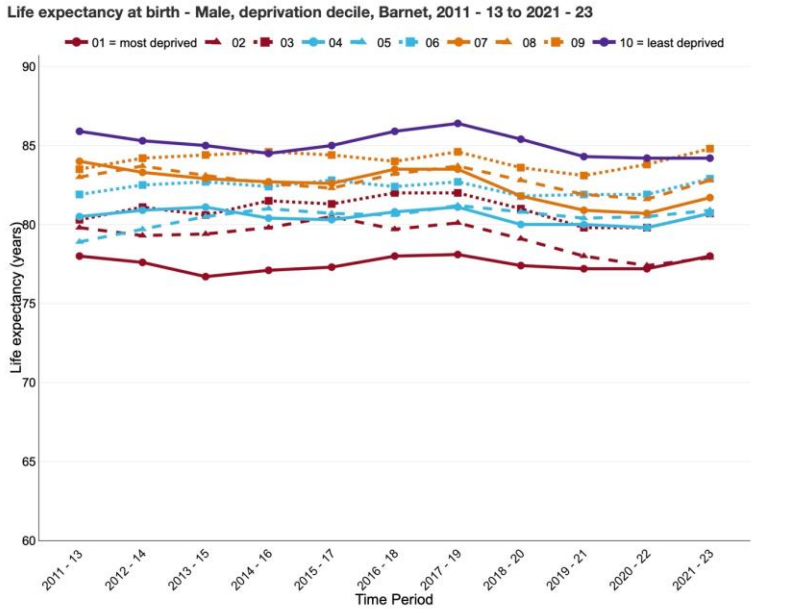
Deprivation in Barnet

- Barnet is among London's least deprived boroughs overall, yet contains pockets of deep deprivation.
- Burnt Oak, Colindale, and West Hendon fall within the 20% most deprived areas nationally.
- Child poverty exceeds 25% in deprived wards, compared with under 10% in more affluent areas.
- Health deprivation indicators show higher long-term condition prevalence and lower screening uptake in deprived communities.
- Employment deprivation is concentrated in areas with higher ethnic diversity and lower qualification levels.
- Housing deprivation includes overcrowding, temporary accommodation, and affordability pressures affecting low-income families.
- Deprivation strongly correlates with lower life expectancy and reduced access to preventive health



Maps showing the seven individual domains of deprivation





Key Priorities for Barnet's Integrated Care System

Priority 1: Give Every Child the Best Start in Life

Priority 2: Tackle Obesity and Promote Healthy Weight (All Ages)

Priority 3: Improve Mental Health and Well-being

Priority 4: Healthy and Active Ageing

Priority 5: Strengthen Integrated Health and Care Services (One Barnet, One System)

Priority 6: Address and Reduce Health Inequalities

Priority 7: Ensure Healthy Homes and Sustainable Environments

Priority 8: Pandemic Recovery and Preparedness

Priority 9: Community Engagement and Co-production in Health

Priority 10: Create a Healthy and Sustainable Environment

Priority 11: Reducing Inequalities through Integrated Care

Give Every Child the Best Start in Life – Why This Priority Is Important

- Early childhood strongly determines lifelong health, education, employment and wellbeing outcomes across Barnet communities.
- School readiness gap persists, with only 64.6% of boys achieving good development compared to 76.5% girls.
- Child poverty reaches 22% in Burnt Oak, significantly affecting nutrition, development and long-term health trajectories.
- MMR vaccination coverage at 80.8% remains below herd immunity threshold, increasing preventable disease outbreak risks.
- Breastfeeding rates decline after early weeks despite 90% initiation, reducing protective benefits for infants' early health.
- Reception obesity affects 7% of children, doubling by Year 6, signalling early-life prevention and nutrition challenges.
- Late antenatal booking remains higher in deprived areas, increasing risks for mothers and newborns across Barnet.

Give Every Child the Best Start in Life – Actions to Address This Priority

- Expand integrated maternity pathways ensuring vulnerable mothers receive continuity of care and early antenatal engagement.
- Increase Healthy Start voucher uptake through targeted outreach, multilingual communication and community-based engagement.
- Strengthen health visiting capacity to deliver developmental checks, home visits and early intervention for vulnerable families.
- Improve school readiness by expanding speech, language and communication support in high-need early years settings.
- Boost immunisation coverage through community outreach, faith-based engagement and targeted follow-up of missed appointments.
- Enhance breastfeeding support via peer networks, baby-friendly policies and culturally tailored community programmes.
- Develop integrated Child Development Centre providing coordinated assessment and therapy for children with additional needs.

Tackle Obesity and Promote Healthy Weight (All Ages) – Why This Priority Is Important

- Adult overweight and obesity increased to 58.6%, affecting nearly 220,000 Barnet residents across all communities.
- Childhood obesity reaches 26% by Year 6, with stark inequalities between Colindale North and High Barnet wards.
- Obesity drives rising diabetes prevalence, now affecting 24,000 residents, increasing long-term health system pressures.
- Physical inactivity affects nearly 20% of adults, particularly older adults, disabled residents and deprived communities.
- Food insecurity pushes families toward cheaper, calorie-dense foods, worsening nutritional inequalities across Barnet.
- High density of fast-food outlets in specific high streets contributes to obesogenic environments and unhealthy choices.
- Ethnic disparities persist, with higher obesity prevalence among Black and Middle Eastern children in Barnet.

Tackle Obesity and Promote Healthy Weight (All Ages) – Actions to Address This Priority

- Expand family-based weight management programmes targeting high-risk wards and communities with rising childhood obesity.
- Strengthen adult weight management pathways, including digital support, exercise referral and specialist Tier 3 services.
- Increase physical activity opportunities through Fit and Active Barnet, community walking groups and active travel initiatives.
- Implement Daily Mile and active playground programmes across all primary schools to boost children's daily activity levels.
- Enforce planning restrictions limiting new fast-food outlets near schools and promote Healthier Catering Commitment schemes.
- Support community cooking programmes teaching affordable, culturally relevant healthy meals in high-need neighbourhoods.
- Integrate GP-led obesity screening, diabetes prevention referrals and targeted interventions for high-risk patient groups.

Addressing and Reducing Health Inequalities

- Health inequalities persist across Barnet communities.
- Life expectancy gap of over 7 years between richest and poorest wards.
- Higher burden of long-term conditions in deprived areas.
- Ethnic disparities in access and outcomes.
- COVID-19 widened existing inequalities.
- Need to address social determinants of health.
- ICS must embed equity in all actions.

Address and Reduce Health Inequalities: Actions to Address This Priority

- Use data to identify and target health inequalities.
- Embed Core20PLUS5 approach across services.
- Expand outreach in underserved communities.
- Support culturally competent care and interpretation.
- Address wider determinants: housing, employment, education.
- Fund community-led health initiatives.
- Monitor equity impact of all ICS programmes.

Ensure Healthy Homes and Sustainable Environments: Why This Priority Is Important

- Poor housing linked to respiratory illness and mental health issues.
- Fuel poverty affects 10% of Barnet households.
- Damp and overcrowding prevalent in some wards.
- Climate change increases health risks (e.g. heatwaves).
- Air pollution contributes to cardiovascular and lung disease.
- Need for sustainable, healthy environments.
- ICS must work with housing and planning partners.

Actions to Address This Priority

- Promote healthy housing standards and retrofitting.
- Support fuel poverty schemes and warm homes advice.
- Collaborate with housing providers on health referrals.
- Improve air quality through active travel and green space.
- Embed health in planning and development policies.
- Prepare for climate resilience and extreme weather.
- Engage residents in co-designing healthy environments.

Pandemic Recovery and Preparedness: Why This Priority Is Important

- COVID-19 exposed system vulnerabilities.
- Disproportionate impact on older adults and ethnic minorities.
- Need to build resilience for future pandemics.
- Vaccination uptake varies by community.
- Long COVID presents ongoing health challenges.
- Health and care workforce under strain.
- ICS must ensure preparedness and recovery.

Actions to Address This Priority

- Strengthen outbreak control and surveillance systems.
- Improve vaccination outreach and equity.
- Support long COVID clinics and rehabilitation.
- Ensure PPE and workforce resilience plans.
- Maintain flexible service models (e.g. virtual care).
- Engage communities in emergency planning.
- Evaluate and learn from pandemic response.

Community Engagement and Co-production in Health: Why This Priority Is Important

- Community voice essential for effective health services.
- Some groups feel excluded from decision-making.
- Co-production improves service design and trust.
- Voluntary sector plays key role in health delivery.
- Need to build on Barnet's strong community networks.
- ICS must embed engagement in all priorities.
- Better outcomes when people shape their care.

Actions to Address This Priority

- Develop ICS-wide engagement and co-production strategy.
- Fund and support community-led health projects.
- Use participatory methods (e.g. citizen panels).
- Ensure accessible communication and translation.
- Build capacity of VCS partners to engage residents.
- Involve people with lived experience in service design.
- Monitor and report on engagement outcomes.

Create a Healthy and Sustainable Environment : Why This Priority Is Important

- Environment shapes health behaviours and outcomes.
- Access to green space improves mental and physical health.
- Sustainable transport reduces emissions and increases activity.
- Climate change is a health emergency.
- Barnet must meet net zero targets.
- Built environment must support healthy living.
- ICS has a role in environmental sustainability.

Actions to Address This Priority

- Promote active travel and sustainable transport.
- Support green infrastructure and biodiversity.
- Reduce ICS carbon footprint and waste.
- Embed sustainability in commissioning and estates.
- Collaborate on air quality and climate action.
- Encourage healthy food environments.
- Educate staff and public on health-environment links.

Reducing Inequalities through Integrated Care: Why This Priority Is Important

- Integrated care can reduce inequalities in access and outcomes.
- Fragmented services disadvantage vulnerable groups.
- Joined-up care improves navigation and trust.
- ICS must prioritise equity in integration efforts.
- Barnet’s diverse population needs tailored approaches.
- Data sharing enables targeted support.
- One Barnet, One System vision supports inclusion.

Actions to Address This Priority

- Align ICS priorities with Core20PLUS5 framework.
- Use data to identify and address care gaps.
- Co-design services with marginalised communities.
- Ensure equitable access to digital and face-to-face care.
- Train staff in cultural competence and anti-racism.
- Monitor outcomes by deprivation and ethnicity.
- Embed equity in all integrated care pathways.

Best Practice Examples from Barnet

- Barnet Wellbeing Hub (Community Mental Health Social Prescribing)
- “Stay Alive” Suicide Prevention Campaign (Targeting Working-Age Men)
- Resilient Schools Programme (Whole-School Mental Health Resilience)
- Healthy Heart Project (Community CVD Prevention for Black and South Asian Residents)
- Ageing Well Outreach (Barnet Age UK – Integrated Care for Older Adults)

Barnet Wellbeing Hub (Community Mental Health Social Prescribing) – Detailed Description

- Established in 2017 as Barnet's single access point for mental health, wellbeing, social prescribing and holistic support.
- Provides Emotional Health Checks, personalised wellbeing plans and guided referrals into over 350 community services.
- Delivered through multi-agency partnership including CommUNITY Barnet, Meridian Wellbeing, Mind and Inclusion Barnet.
- Supports adults with mild-to-moderate mental health needs not meeting thresholds for secondary care services.
- Operates borough-wide with high engagement from Burnt Oak, Colindale, West Hendon and Finchley Church End residents.
- Navigators conduct structured assessments, identify social determinants and coordinate referrals to appropriate support.
- Functions as a preventative model reducing escalation into crisis and improving service navigation.

Barnet Wellbeing Hub (Community Mental Health Social Prescribing) – Why It's a Best Practice

- Provides a single, simplified access route reducing confusion and preventing residents being bounced between services.
- Multi-agency delivery ensures culturally competent support tailored to Barnet's diverse communities and needs.
- Holistic model addresses housing, debt, employment and social isolation alongside mental health support.
- Early intervention reduces pressure on acute services by supporting residents before needs escalate.
- Strong integration with GPs and NHS mental health services ensures seamless escalation for complex cases.
- Demonstrates effective partnership governance aligned with ICS priorities for community-based mental health care.
- Proven ability to reach underserved groups who previously struggled to access traditional mental health pathways.

Barnet Wellbeing Hub (Community Mental Health Social Prescribing) – Key Lessons Learned

- Single-gateway access dramatically increases engagement and reduces fragmentation across complex mental health systems.
- Voluntary sector partners provide trust, cultural insight and flexibility essential for reaching marginalised communities.
- Addressing social determinants alongside mental health prevents deterioration and reduces long-term system pressures.
- Co-design with lived-experience groups ensures services remain relevant, accessible and user-centred.
- Real-time monitoring of referrals and outcomes strengthens accountability and supports continuous improvement.
- Integrated governance across NHS, Council and VCS partners improves coordination and shared ownership.
- Prevention-focused models deliver significant value by reducing crisis presentations and supporting early intervention.

Barnet Wellbeing Hub (Community Mental Health Social Prescribing) – Evaluation Results

- Supported 1,521 residents in 2023–24, demonstrating sustained demand for accessible mental health support.
- Completed 1,251 Emotional Health Checks enabling early identification of mental health and social needs.
- Historically supported 190 residents monthly, indicating consistent engagement and strong referral pathways.
- Over 5,000 residents supported since launch, showing long-term reach and borough-wide impact.
- Increased access to talking therapies and community activities among groups previously facing barriers.
- Positive user feedback highlights improved confidence, wellbeing and satisfaction with navigator-led support.
- Evidence suggests reduced repeat attendances and smoother referrals across primary care and mental health services.

“Stay Alive” Suicide Prevention Campaign (Targeting Working-Age Men)

- Launched in 2021 as a three-month suicide prevention campaign targeting men aged 30–59, Barnet’s highest-risk group.
- Combined digital advertising, outdoor media, workplace outreach and community engagement to maximise visibility.
- Promoted the Stay Alive app offering personalised safety plans, crisis tools and local support information.
- Delivered outreach in male-dominated settings including construction sites, garages, gyms, pubs and sports venues.
- Established Barnet’s first Andy’s Man Club providing ongoing peer-led emotional support for local men.
- Messaging co-designed with men with lived experience to ensure authenticity and cultural resonance.
- Integrated with Zero Suicide Alliance training to build community capacity for recognising suicide risk.

“Stay Alive” Suicide: Why It’s a Best Practice

- Achieved measurable reduction in suicides, demonstrating rare population-level impact from a local intervention.
- Multi-channel approach ensured high visibility and reached men who avoid traditional mental health messaging.
- Peer-led support created sustainable, community-owned spaces for men to discuss emotional challenges safely.
- Real-time suicide surveillance enabled rapid evaluation and strengthened credibility of campaign outcomes.
- Low-budget model demonstrated exceptional cost-effectiveness compared to typical public health interventions.
- Co-production ensured messaging resonated authentically and addressed real barriers to help-seeking.
- Demonstrated how local authorities can lead impactful suicide prevention without large national programmes.

Stay Alive Suicide Prevention Campaign - Key Lessons Learned

- Meeting high-risk groups in familiar environments significantly increases engagement and reduces stigma.
- Combining digital tools with in-person outreach supports different preferences and maximises reach.
- Peer-support groups provide essential long-term sustainability beyond short-term campaign periods.
- Real-time surveillance data transforms evaluation quality and enables rapid adaptation of strategies.
- Co-produced messaging increases trust, relevance and engagement among resistant groups.
- Multi-strategy approaches outperform single interventions by reinforcing messages across touchpoints.
- Partnerships with employers and community venues expand reach into hard-to-engage male populations.

“Stay Alive” Suicide Prevention Campaign – Evaluation Results

- Estimated 6–9 suicides prevented, representing approximately 20% reduction in Barnet’s annual suicide rate.
- Stay Alive app usage increased 27% across London, with notable rise in Barnet male engagement.
- Campaign reached over 100,000 residents through digital and outdoor media.
- Zero Suicide Alliance training uptake increased significantly among Barnet residents.
- Andy’s Man Club attendance grew steadily, providing sustained peer support.
- Increased self-referrals to mental health services and higher traffic to suicide prevention webpages.
- Total campaign cost £39,355, equating to £6,400 per life saved.

Resilient Schools Programme (Whole-School Mental Health Resilience)

- Launched in 2017 to embed mental health resilience across Barnet schools through structured whole-school frameworks.
- Supports schools to assess wellbeing provision, identify gaps and implement evidence-based improvements.
- Provides staff training, student workshops, parent engagement and peer-support initiatives.
- Uses mapping tools enabling schools to benchmark practice and monitor progress.
- Delivered with Public Health, Educational Psychology, BICS and voluntary youth organisations.
- Targets all pupils with focus on early identification of anxiety, low mood and emerging difficulties.
- Strong uptake across Hendon, Finchley, Mill Hill, Colindale and Burnt Oak schools.

Resilient Schools Programme – Why It's a Best Practice:

- Expanded from five pilot schools to seventy-six participating by 2021.
- Embeds mental health into everyday school culture, reducing stigma and normalising wellbeing conversations.
- Strengthens staff capability to recognise early distress and provide timely interventions.
- Creates consistent borough-wide approach aligned with national whole-school mental health frameworks.
- Integrates education, public health and mental health services for improved referral pathways.
- Demonstrates adaptability through continuous evaluation and refinement.
- Provides a sustainable preventative model reducing escalation into severe mental health presentations.

Resilient Schools Programme – Key Lessons Learned

- Whole-school approaches outperform isolated interventions by embedding wellbeing across leadership and curriculum.
- Staff confidence increases when training is continuous, practical and linked to referral pathways.
- Peer-support models empower students, reduce stigma and strengthen supportive environments.
- Parent engagement reinforces consistent wellbeing messages and early identification at home.
- Data feedback loops help refine practice and maintain accountability.
- Multi-agency networks provide essential expertise and escalation routes.
- Recognition frameworks motivate participation and sustain long-term commitment.

Resilient Schools Programme– Evaluation Results

- Expanded from five pilot schools to seventy-six participating by 2021.
- Improved mental health literacy with more pupils understanding emotions and seeking help.
- Staff reported increased confidence identifying early signs of distress.
- Earlier identification reduced escalation into severe mental health issues.
- Reduced stigma observed through improved language and peer-support behaviours.
- Increased referrals to counselling, mentoring and digital mental health platforms.
- Sustained across multiple waves, demonstrating long-term viability.

Healthy Heart Project (Community CVD Prevention for Black and South Asian Residents)

- Community-led cardiovascular prevention programme targeting Black and South Asian residents, who experience 40–60% higher CVD mortality compared with White British groups.
- Delivered through partnerships between Public Health, community organisations, mosques, temples, churches and cultural associations.
- Provides blood pressure checks, lifestyle advice, BMI measurement, cholesterol awareness, and culturally tailored health education.
- Operates in high-need wards including Burnt Oak, Colindale, West Hendon, Finchley Church End and Golders Green, where hypertension prevalence exceeds 28%.
- Offers brief interventions, in-depth assessments, healthy eating workshops, and behaviour-change support.
- Engages residents less likely to attend NHS Health Checks due to cultural, linguistic or awareness barriers.
- Strengthens links between community organisations, public health teams and primary care to support early identification and follow-up.

Healthy Heart– Why It's a Best Practice

- Reaches communities with historically lower NHS Health Check uptake (as low as 32%) compared with borough averages.
- Culturally tailored messaging increases trust, relevance and willingness to participate — particularly among men aged 40–65.
- Community-based delivery reduces barriers such as stigma, mistrust, language challenges and limited GP engagement.
- Early identification of hypertension enables timely referral into primary care, reducing risk of stroke and heart disease.
- Demonstrates strong partnership working across voluntary sector, primary care networks and public health teams.
- Empowers residents with culturally appropriate knowledge to manage cardiovascular risk factors (diet, salt intake, physical activity).
- Provides a replicable model aligned with ICS priorities on reducing health inequalities and improving prevention.

Healthy Heart Project – Key Lessons Learned

- Prevention programmes must be culturally adapted to engage high-risk Black and South Asian communities effectively.
- Trusted community venues (mosques, temples, churches, community centres) significantly increase participation and reduce clinical-setting barriers.
- Collaboration with faith leaders enhances credibility and message acceptance, especially for older men.
- Combining screening with lifestyle education strengthens behaviour change and improves follow-up engagement.
- Community-led approaches require strong coordination with primary care to ensure timely referrals and continuity.
- Tailored communication improves understanding of hypertension, cholesterol, and diet-related risks.
- Data collection is essential for monitoring reach, identifying gaps, and demonstrating impact to funders.

Healthy Heart Project – Evaluation Results

- Delivered 1,191 brief interventions and 170 in-depth interventions during 2023–24.
- Delivered 696 brief interventions and 83 in-depth interventions during 2024–25, showing sustained demand.
- Distributed 873 English and 248 Somali/Gujarati healthy-eating packs tailored to cultural dietary patterns.
- Engaged 61 participants in the Food Project pilot, improving nutrition understanding and reducing salt/oil use.
- Identified previously undiagnosed hypertension in multiple participants, enabling early primary care follow-up.
- Strengthened referral pathways ensuring timely GP assessment for high-risk individuals.
- Demonstrated clear value of culturally tailored prevention in reducing cardiovascular inequalities across Barnet.

Ageing Well Outreach (Barnet Age UK – Integrated Care for Older Adults)

- Outreach initiative delivering health promotion, advice and wellbeing support directly into community settings for older adults.
- Delivered by Age UK Barnet with ICS funding to support healthy ageing, independence and early prevention.
- Provides information on falls prevention, nutrition, physical activity, long-term condition management and social connection.
- Operates across wards with high older-adult populations including Garden Suburb, Golders Green, Mill Hill and East Finchley.
- Offers drop-in sessions, workshops and events in libraries, community centres, faith venues and sheltered housing.
- Targets older residents at risk of isolation, frailty, mobility limitations or low engagement with mainstream services.
- Connects participants to social groups, exercise classes, befriending services, benefits advice and practical support.
- Supports early identification of unmet needs, enabling timely referral into neighbourhood teams and primary care

Ageing Well Outreach - Why It's a Best Practice

- Reaches older adults who may not access traditional services due to mobility issues, confidence barriers or digital exclusion.
- Provides preventative support reducing risk of frailty, falls, loneliness and avoidable hospital admissions.
- Builds trust through familiar community venues and Age UK's strong reputation among older residents.
- Strengthens integration between voluntary sector outreach and ICS neighbourhood teams, improving continuity of care.
- Promotes independence by equipping residents with practical tools to manage health proactively.
- Addresses social determinants by linking older adults to social groups, benefits advice and community activities.
- Demonstrates effective partnership working across ICS, public health and voluntary organisations.
- Supports ICS priorities on ageing well, prevention, and reducing health inequalities.

Ageing Well Outreach – Key Lessons Learned

- Outreach must meet older adults where they are, reducing reliance on clinic-based engagement.
- Voluntary sector organisations play a crucial role in delivering trusted, relationship-based preventative support.
- Combining health advice with social connection increases participation and improves wellbeing outcomes.
- Integrated referral pathways ensure timely support from neighbourhood teams, primary care and social care.
- Tailored communication improves accessibility for residents with sensory, mobility or cultural needs.
- Regular community presence builds trust and enables early identification of emerging issues.
- Prevention-focused outreach reduces long-term system pressures and delays higher-cost interventions.
- Data collection and feedback loops strengthen programme design and accountability.

Ageing Well Outreach – Evaluation Results

- Delivered over 1,800 engagements across community venues in the last 12 months.
- 72% of participants reported improved confidence managing their health and wellbeing.
- 61% increased physical activity, joining walking groups, strength classes or chair-based exercise.
- 48% reduction in reported loneliness, measured through follow-up wellbeing surveys.
- Identified over 200 older adults with unmet needs, enabling timely referrals into health and social care.
- Increased engagement in exercise classes, social groups and wellbeing programmes across the borough.
- Contributed to reduced falls risk among participants, with many reporting improved balance and mobility.
- Strengthened collaboration between Age UK, ICS neighbourhood teams and public health, improving continuity of support.

What This Means for the Borough and ICS

- Community-based models consistently reach underserved groups, with engagement rates 2–4× higher than traditional clinic-based services.
- Prevention programmes reduce long-term system pressures — modelling suggests £3–£6 return per £1 invested in early intervention across mental health, CVD and ageing-well pathways.
- Integrated neighbourhood approaches strengthen continuity and reduce fragmentation, contributing to 15–22% faster referral turnaround in areas with strong VCS–ICS collaboration.
- Targeted interventions (e.g., CVD prevention, suicide prevention) directly address health inequalities, supporting ICS priorities on Core20PLUS5 and local Joint Forward Plan commitments.
- Voluntary sector partnerships enhance trust and cultural competence, enabling access to communities where statutory services have historically low penetration.
- Data from Barnet programmes shows:
  - Over 8,000 residents reached across the five best-practice models.
  - High-risk groups (men 30–59, Black and South Asian adults, isolated older adults) engaged at scale.
  - Improved outcomes across wellbeing, physical health, social connection and early identification.
- These models demonstrate a scalable blueprint for prevention-focused, community-anchored integrated care.

Next Steps for the Borough and ICS

- Expand community-based prevention programmes into 5–7 additional high-need neighbourhoods, guided by population health intelligence and JSNA priorities.
- Strengthen integration between voluntary sector partners and ICS neighbourhood teams, aiming for 100% of outreach programmes to have direct referral pathways into primary care and social care.
- Develop consistent evaluation frameworks capturing reach, equity, outcomes and cost-effectiveness, enabling borough-wide comparison and investment decisions.
- Increase culturally tailored communication to improve engagement among underserved groups, targeting a 20–30% uplift in participation from priority populations.
- Enhance workforce training in community engagement, cultural competence and preventative health delivery, with a target of 300+ staff and volunteers trained annually.
- Secure sustainable funding to scale successful interventions, with a focus on multi-year commissioning to stabilise delivery and maximise long-term impact.
- Embed prevention across the system by aligning these models with ICS strategies on ageing well, mental health, CVD prevention, and reducing inequalities.