Director of Public Health Annual Report 2022: DRAFT Action Plan (version 5) – additional actions to be added

Action plan timescale: July 2022 to June 2023

	Detail of action	Lead Organisation(s)	Timescale		Outcomes	Included in the Buckinghamshire Health and Wellbeing Strategy action plan .
			From	Completed by		
Recommendation 1: **Act on the broader determinants of health** such as income, debt, good quality employment, high quality education and healthy environments to level up outcomes across Buckinghamshire.						
1.2	**The Buckinghamshire Levelling Framework 'Opportunity Bucks' programme is delivered.**	**Levelling Up Board**	**July 2022**	**July 2025**	The levelling up agenda for Buckinghamshire delivered by all the member organisations will improve the broader determinants of health and contribute to reducing cardiovascular disease. Actions as part of this programme, under the 5 priority themes, are well linked to the prevention of cardiovascular disease. The five Opportunity Bucks themes are: • Education and Skills • Jobs and Career Opportunities • Quality of our Public Realm • Standard of Living • Health and Wellbeing	Yes. Some of the work on health and wellbeing that is being and will be done as part of the Opportunity Bucks programme will be included in the Health and Wellbeing Strategy.
Recommendation 2: **Support a systematic large-scale improvement in behavioural risk factors**						
2.1	**All partner organisations to identify a Making Every Contact Count lead and roll out behaviour change training.**	**Public Health All health and wellbeing board partners**	**July 2022**	**April 2023**	Increase in the understanding and the skills required to design effective behaviour change interventions across Buckinghamshire Council, the NHS and partners. This enables people to have "healthy conversations" to support behaviour change in their day-to-day	Yes. Making Every Contact Count is a key approach to delivering the breadth of preventative activity outlined in the Health and Wellbeing Strategy.

					interactions with residents. An increase in these interactions will result in more residents being referred for lifestyle support from the Council's integrated lifestyle service (Live Well Stay Well).	
2.2	**Inpatient (acute and mental health) and maternity NHS trusts to deliver in-house tobacco dependency services by April 2023.**	**Buckinghamshire Healthcare Trust Oxford Health NHS Trust**	**October 2021**	**April 2023**	Deliver in house tobacco dependency services that enable an increase in smoking cessation support to adults who smoke in the county.	Yes. Smoking actions for the NHS are included in the Health and Wellbeing Strategy actions. Metrics are included in the strategy.
2.3	**Continue the development and delivery of a whole systems approach to healthy weight for Buckinghamshire.**	**Public Health**	**2021**	**2024**	Increase the system wide understanding of how to increase healthy weight in Buckinghamshire. Develop and deliver system wide approaches and interventions to achieve the aim of increasing healthy weight. Deliver the agreed actions as set out in the Whole System Healthy Weight Action Plan for the county.	Yes. Obesity in adults and children are key priorities for the Health and Wellbeing Strategy. Metrics are included in the strategy.
2.4	**All partners to support the further development of the annual countywide multiagency physical activity action plan, focusing on encouraging priority groups to start being more active.**	**Public Health**	**2021**	**2023**	Develop an approach to work with communities and partners to reduce sedentary behaviour and increase movement as the social 'norm'. Ensure more social care settings and services develop opportunities for older adults to engage with physical activity to help prevent falls and maintain physical and mental health.	Yes. Physical activity reduces the risk of cardiovascular disease, improves mental health and increases the health and wellbeing of older people.
2.5	**All partners to deliver the Buckinghamshire Tobacco Control Strategy and**	**Public Health**	**2021**	**2024**	Increase tobacco control activities that are joined up and have a larger impact on our residents' health and wellbeing.	Yes. Smoking cessation is a key priority for the Health and Wellbeing Strategy.

	associated action plan				Increase the number of residents accessing smoking cessation services in hospital and in the community.	
Recommendation 3: Increase detection and management of modifiable risk factors in people at higher risk of cardiovascular disease including those living in more deprived areas, ethnic groups at higher risk of cardiovascular disease and those with mental illness						
3.1	**Increase the capacity of Primary Care Networks in deprived areas to increase cardiovascular disease prevention and smoking cessation in general practice.**	**NHS - Integrated Care Board and Primary Care Networks**	**September 2021**	**September 2023**	Increase capacity in primary care in priority areas to undertake NHS Health Checks to detect and manage clinical risk factors such as high blood pressure and diabetes, and refer to appropriate interventions such as smoking cessation. Increase the number of residents aged 15+ who have had their blood pressure checked in the last year. Increase the number of NHS Health Checks delivered in at risk residents.	Yes. This action supports the reduction of the rates of cardiovascular disease and smoking cessation metrics.
3.2	**Co-design a community based blood pressure initiative in a community with an increased risk of cardiovascular disease.**	**Public Health**	**March 2022**	**December 2022**	Communities at increased risk of poor cardiovascular disease outcomes are better able to access the support and advice they require to make behaviour changes. The first faith community is in High Wycombe. The insight phase is complete, so the design phase is beginning. Work with people from ethnic minority groups to design effective, culturally competent approaches to increase detection of cardiovascular disease risk factors and the management of these risk factors.	Yes. This action supports the reduction of the rates of cardiovascular disease.

Recommendation 4: Improve data collection and monitoring to track progress.						
4.1	**Improve data collection in primary and secondary care on risk factors for cardiovascular disease and associated outcomes.**	**NHS**	**2022**	**2024**	Increase ability to monitor cardiovascular outcomes by ethnicity and areas of deprivation and improve the quality, accuracy and completeness of ethnic monitoring data. Increase the number of residents who have their blood pressure recorded in their GP record. Increase the number of people with hypertension who are managed to their clinical target.	Yes. This action supports the reduction of the rates of cardiovascular disease by improving the ability to identify where we need to target interventions and monitor impact.
4.2	**Undertake equity audits to determine access to and uptake of prevention and treatment initiatives of cardiovascular disease by different groups.**	**NHS**	**TBD**		Gain a better understanding of where inequalities are in the full cardiovascular disease pathway and where work should be focused.	