Health & Wellbeing Board Buckinghamshire

Action Plan to Reduce the Rates of Cardiovascular Disease

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Consideration: ☐ **Information** ☒ **Discussion**

☐ **Decision** ☒ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☒ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

Not applicable.

Health & Wellbeing Board
Buckinghamshire

1. Purpose of report

1.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan include a priority to reduce the rates of cardiovascular disease and tackle inequalities in cardiovascular disease. This requires addressing the risk factors for cardiovascular disease particularly in people at higher risk including those living in more deprived areas, people from certain ethnic groups and those with serious mental illness (see Director of Public Health Annual Report). Cardiovascular disease has serious consequences and causes heart attacks, stroke and dementia. This report provides the action plan for this theme of the health and wellbeing strategy and updates the board on progress and proposed way forward for the measures, targets and actions by partners.

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board are asked to note the measures, targets and actions set out within the report and in appendix A.

2.2. The Health and Wellbeing Board are asked to commit their respective organisations to deliver their actions.

3. Content of report

3.1 Reducing the rates of cardiovascular disease is a priority under the Joint Local Health and Wellbeing Strategy's Live Well theme. Cardiovascular disease causes 1 in 5 of all deaths in Buckinghamshire and is the major contributor to the gap in life expectancy between people living in our most deprived and least deprived areas. Whilst cardiovascular disease can affect anyone, residents living in our most deprived areas and people from certain ethnic groups are at a higher risk of cardiovascular disease than the Buckinghamshire average.

3.2 The aims and the reasoning for these aims are as follows:

- Over the last 5 years, residents in more deprived areas have received fewer NHS Health Checks compared to residents in less deprived areas. NHS health checks screen for risk factors for cardiovascular disease and give patients advice and treatment where necessary to help reduce their risk. To improve the outcomes of residents at increased risk of cardiovascular disease, there should be an increase in their access and experience of preventative services like the NHS Health Check and referrals to services such as smoking cessation, alcohol misuse services diabetes prevention and weight management services.
- NHS inpatients (acute and mental health) and maternity patients who smoke should be offered the opportunity to quit smoking while under the care of the NHS. This approach has been shown to be successful is increasing the number of residents who stop smoking. Smoking is a major contributor to the gap in life expectancy between those living in the least and most deprived areas and the lower life expectancy of people with a serious mental illness. Smoking during pregnancy results in worse outcomes for babies.

- Residents in the more deprived areas of the county are more like to develop high blood pressure earlier than residents in other areas. However, they are less likely to be identified early and have their blood pressure adequately controlled at an early stage. Therefore, increasing the numbers of higher risk residents who check their blood pressure regularly will increase the numbers receiving support. Increasing the number of patients with hypertension whose blood pressure is controlled will also result in better long-term cardiovascular health for these patients.

3.3 The CVD Prevention and Inequalities Working Group for Buckinghamshire is working together to deliver on this theme. Members include representatives from primary care networks, local GPs, Integrated Care Board, Public Health, Healthwatch Bucks, Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Foundation Trust.

3.4 The four priority targets for this theme are as follows:

- The number of eligible people in priority risk groups (in the 40% most deprived areas in Bucks) who have an NHS Health Check each year.
- The proportion (%) of eligible of patients who were referred to NHS tobacco dependency services (acute inpatients, maternity and mental health inpatients) who later successfully quit smoking (four week quit).
- Proportion of patients (15+) who have had their blood pressure checked in the last year in the four most deprived Primary Care Networks
- Proportion of patients who have their blood pressure treated to target in the 4 most deprived Primary Care Networks Proportion of patients under 80 years old with hypertension whose last blood pressure reading (in the last 12 months) was <= 140/90 mmHg for the four most deprived Primary Care Networks.

3.5 The action plan for the Working Group is included as Appendix A. This plan sets out how the group is working to achieve the collectively agreed targets outlined above.

3.6 Over the last 12 months a variety of actions have been delivered by partners on this priority. Below is a brief summary of some of the key actions:

- Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Foundation Trust have made progress on developing their ‘In-house’ tobacco dependency teams and services. These are for acute inpatients, mental health inpatients and maternity patients as set out in the Long Term Plan.
- The Public Health team alongside Community Boards and Parish Councils have delivered 13 SmokeFree Parks and Playgrounds in priority areas of the county. This project aims to reduce smoking around children and young people.
- A successful pilot looking at whether faith communities can become ‘health promoting’ communities was led by Public Health. This pilot used behavioural science to co-create a

community-based blood pressure initiative with a faith community located in an area with increased cardiovascular disease risks.

- A scheme to increase capacity for the NHS Health Check in primary care was designed by Public Health and resourced by the Clinical Commissioning Group (now the Integrated Care Board). This scheme has launched in two of the four priority Primary Care Networks.
- NHS Health Checks were successfully delivered to employee groups who are unable to access preventative services due to the nature and hours of their jobs. For example, the Council's waste operatives were able to access these at their depot over a number of days. This received exceedingly positive feedback and identified a number of individuals with increased CVD risks.

3.7 Over the next 12 months a large number of initiatives will be continuing and new ones will be starting. Below is a selection of work for this priority:

- Additional faith communities will be trained in how to be health promoting communities. Several of these communities will co-create bespoke projects for their members.
- Two health kiosks will be installed in targeted libraries in Opportunity Bucks areas to allow residents to keep an eye on their overall health status.
- The current pre-operative pilot (for patients on surgical waiting lists) will be expanded to include smoking cessation and healthy behaviours advice and referrals to get residents to 'stop before the op'.
- A plan to increase access to Electrocardiograms (ECGs) to check for signs of heart disease for patients moving through the hypertension diagnosis pathway will be agreed and delivered.
- Seven additional SmokeFree Parks and Playgrounds will be launched in Opportunity Bucks areas.
- An equity audit for the access, experience and outcomes of cardiovascular disease in Buckinghamshire should be conducted to better understand the impacts of a wide range of factors on cardiovascular disease inequalities.

4. Next steps and review

4.1. Partners will continue to work together to deliver the action plan for this priority, and updates will be provided to the Health and Wellbeing Board as appropriate.

4.2. This priority is also a priority for the Opportunity Bucks programme at Buckinghamshire Council which aims to promote opportunities to level up health in Buckinghamshire. This provides a way to work with communities to identify what would work for them to improve their health and quality of life. These relationships are important for delivering the action plan in a sustainable way.

5. Background papers

5.1. Director of Public Health Annual Report on Cardiovascular Disease

5.2. Appendix A – Buckinghamshire Joint Health and Wellbeing Board Strategy: Live Well/Cardiovascular Disease Action Plan