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Buckinghamshire Joint Health and Wellbeing Board Strategy: Live Well/Cardiovascular Disease Action Plan

Action 1: Increase access to NHS Health Checks in priority risk groups
Rationale: More people will be advised about their cardiovascular disease risk earlier and supported to get the help they need, in particular groups of residents who are at higher risk of poor outcomes.
Health and Wellbeing Board Performance Hub Metric: The number of all NHS Health Checks delivered that were for residents in DQ4 and 5

Ref	Action	Lead	Dates	Baseline	Progress data
	Increase capacity in primary care in priority areas to undertake more NHS Health Checks to detect and manage clinical risk factors in 4 priority primary care networks.	ICB	2023/24 The programme will also run through 2024/25.	1,072 NHS Health Checks Delivered in the 4 priority primary care networks during 2021/22	Number of NHS Health Checks delivered in the 4 priority Primary Care Networks. Target of 2700 checks completed.
	Increase the number of NHS Health Checks delivered by primary care in deprivation quintiles 4 and 5	ICB General Practice	2023 to 2025	1,393 NHS Health Checks delivered in deprived areas of the county in 2021/22	Number of NHS Health Checks delivered by primary care in DQ 4 and 5 practices
	Deliver outreach NHS Health Checks in a variety of community settings.	Public Health Healthy lifestyle service	2023-2025	691 NHS Health Checks conducted in community venues in 2022/23 Venues for 2022/23 included Waste Depots, leisure centres, libraries, and community health settings.	Wider breadth of community venues utilized.

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Action 2: Increase access to tobacco dependency services Rationale: More people will be supported to stop smoking, and this will reduce their risk of cardiovascular disease. Smoking is one of the biggest causes of the gap in life expectancy between residents living in our most and least deprived wards. **Health and Wellbeing Board Performance Hub Metric:** The % of eligible of patients who were referred to NHS inhouse tobacco dependency services who later successfully quit smoking (4 week quit)					
Ref	**Action**	**Lead**	**Dates**	**Baseline**	**Progress data**
	Deliver a fully-functioning in-house tobacco dependency service for acute inpatients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	BHT Acute Inpatients	April 2023	For January 2023 48 Smokers were referred to the in-house Tobacco Dependency advisors 29 smokers were seen by the Tobacco Dependency Advisors 23 referred to community stop smoking support	Increased number of inpatients are referred to the in house service. Increased number of these patients are successfully referred to the community stop smoking service.
	Deliver a fully-functioning in-house tobacco dependency service for mental health inpatients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	OHFT	April 2023	For January 2023 4 Smokers were referred to the in-house Tobacco Dependency advisors 4 smokers were seen by the Tobacco Dependency Advisors 0 referred to community stop smoking support (2 remain as inpatients)	Increased number of inpatients are referred to the in house service. Increased number of these patients are successfully referred to the community stop smoking service.
	Deliver a fully-functioning in-house tobacco dependency service for maternity patients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	BHT Maternity	April 2023	The service has not yet launched due to recruitment challenges.	Increased number of inpatients are referred to the in house service. Increased number of these patients are

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					successfully referred to the community stop smoking service.
	Agree a plan and resources to support patients on surgical waiting lists to 'stop before the op' by stopping smoking and other unhealthy behaviours that increase the patients' risks of poor outcomes following surgery. Start implementation of this plan.	BHT ICB	2023-2024	Currently all patients on waiting lists have their smoking status checked, but not all are actively referred to Stop Smoking Services during the pre-operative process. There are no data for these referrals.	Plan agreed for inclusion of smoking and 'stop before the op' in the pre-operative process/pathway. Number of surgical waiting list patients referred for smoking cessation support in the community. Number of surgical waiting list patients who successfully stop smoking.
	Increase the understanding and skills of the health and social care work force to 'Make Every Contact Count' by having supportive conversations with residents to make healthy behaviour changes.	BHT OHFT ICB Buckinghamshire Council	2022-2025	Health and social care colleagues trained in 2022/23 167 Buckinghamshire Council & voluntary sector colleagues trained. Data for NHS colleagues were not available at the time of submission.	Increase number of health and social care staff trained in MECC by their respective employers and/or other MECC training provision.
	Joint communications campaigns to promote smoking cessation (including regional and national campaigns)	Public Health/ Buckinghamshire Council All NHS partners	2023-2025	1 campaign jointly promoted for Stoptober in October 2022	Number of campaigns delivered each year and the stats that show their 'engagement and

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		Healthy Lifestyle Service		Stats of reach and engagement from joint Stoptober campaign* Facebook: 11 posts that reached 10,404 people Twitter: 7 tweets that reached 5,532 people Instagram: 8 posts that reached 1,856people Nextdoor: 6 posts that reached 15,393 impressions LinkedIn: 8 posts that reached 1,733 people **Some of the people may be duplicates. We are unable to say how many times a single person interacted with the various posts.*	reach' via social media to our residents.
	SmokeFree Parks and Playgrounds to promote smokefree areas for children to play	BC Public Health Community Boards Ward Partnerships	2023-2024	13 smoke free parks and playgrounds	Install at least 1 SmokeFree Park and Playground in every Opportunity Bucks ward.

Action 3: Increase numbers of residents aged 15 years and older who have their blood pressure checked at least once a year in the 4 most deprived Primary Care Networks **Health and Wellbeing Board Performance Hub Metric:** Proportion of patients (15+) who have had their blood pressure checked in the last year in the 4 most deprived Primary Care Networks					
Ref	Action	Lead	Dates	Baseline	Progress data
	Equity audit of cardiovascular disease access, experience and outcomes to be conducted	ICB	By the end of 2023/24	No equity audit in place	Completion of the equity audit.
	Collaborate with faith communities at risk of cardiovascular disease to create community based blood pressure	BC Public Health Ward Partnerships Community Boards	2023-2025	1 faith community participating	Number of communities increases

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	initiatives across Aylesbury, High Wycombe and Chesham.	Primary Care Networks			
	Co-design a blood pressure prevention initiative with taxi drivers across the county.	BC Public Health and Taxi Licensing	2023-2025	No initiative in place.	Initiative co-designed with taxi driver representatives and firms. Number of taxi drivers checking their blood pressure increases
	General practice to increase the proportion of hypertensive patients who are treated to target in the priority areas. *Quality and Outcomes Framework metric HYP003 - Hypertension aged 79 or under BP 140/90 mmHg or less*	ICB Primary Care Networks	2023/24	2021/22 data* • 52.1% Central Maple PCN (range 45-63%) • 61.5% Central Aylesbury (range 47-66%) • 61.2% Cygnet (range 43-68%) • 57.5% Dashwood (range 44-75%) **These averages mask some of the practices who are poorly performing on this metric.*	Increase the proportion treated to target in 4 priority PCNs increases
	Health Kiosks installed in libraries in key levelling up areas to allow residents to keep an eye on various health assessments, including blood pressure.	BC Public Health and Libraries	2023-2025	No health kiosks currently in place	2 kiosks installed Number of residents accessing these machines and checking their blood pressure
	Blood pressure loan kits will be available for residents to 'check out' from local libraries in Aylesbury, High Wycombe and Chesham.	BC Public Health and Libraries	2023-2025	No loan kits currently in place	Loan kits installed Number of residents accessing these kits

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	ICB to deliver a plan to increase access to ECGs for patients moving through the high blood pressure diagnosis pathway.	ICB	2023/24	Currently not enough ECG appointments available.	Increase the number of ECG appointments available, in particular for patients in the 4 most deprived PCNs.
	Pharmacies to deliver more blood pressure checks to residents who fit set criteria as part of the NHS agenda to increase blood pressure checks.	Local Pharmaceutical Committee NHSE/DHSC	2023-2025	Data for November 2021 to December 2022 43 pharmacies provided the service 3,411 blood pressures were checked 109 patients with high blood pressure were given a 24-hour blood pressure monitor by a pharmacy	Increase in the number of pharmacies participating Number of residents who have checked their BP at their local pharmacy