Hampshire County Council

Living Well Theme Focus

Hampshire Health and Wellbeing Board

Living Well Priorities

1. Reduce the proportion of women smoking at the time of delivery
2. Reduce the gap in smoking between people in routine and manual occupations & the general population
3. Implement whole systems approach to childhood obesity in one area of Hampshire
4. Implement the Hampshire Physical Activity Strategy with a specific focus on enabling the workforce to be competent to promote physical activity for life
5. Signpost to and encourage the systematic use of effective tools/initiatives (including digital) that will enable people to improve their self-management and provide peer support for long-term conditions

Reduce the proportion of women smoking at the time of delivery

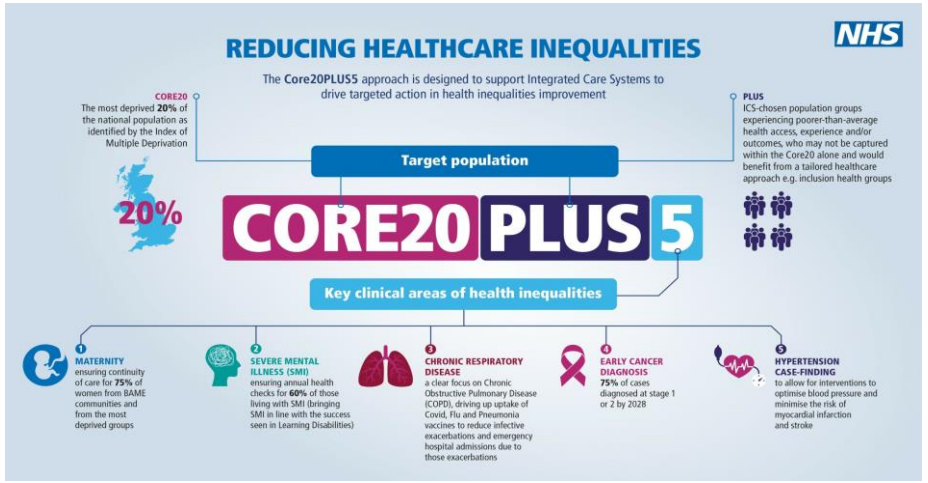
- Smoking at Time of delivery in Hampshire in 20/21 is estimated to be 7.9%. This is a reduction from 19/20 (9.3%) and the lowest prevalence recorded to date.
- Data must be considered within the context of Covid-19 where CO monitoring was paused at midwife appointments for most of the year.
- This will have impacted the identification of women who were both smoking at time of booking (SATOB) and smoking at time of delivery (SATOD). Local variation in trust SATOD data continues, with areas of the highest deprivation having much higher smoker rates.
- Smokefree Hampshire continued to offer a bespoke pathway for pregnant women with 416 setting a quit day in 20/21 and 56% of these achieving a 4 week quit.
- HCC Public Health have worked with Acute, Maternity and Mental Health Trusts to support the implementation of the NHS Long Term Plan for Tobacco Dependency Services and with NHS Trust Tobacco Dependency Steering Groups to develop ‘in-house’ smoking cessation models.

Reduce the gap in smoking between people in routine and manual occupations & the general population

- OHID Fingertips data has updated methodology on smoking prevalence in adults (APS) to account for new local authority and CCG boundaries. It is therefore, no longer directly comparable to previous years.
- In Hampshire the proportion of people who smoke in routine and manual groups is 9.3% compared with 8% of adults overall. (England:12.1%, SE Region:11.1%)
- 40% of people who set a quit date with Smokefree Hampshire were from routine and manual occupations. Of those, 67% went on to successfully quit for 4 weeks.
- In Smokefree Hampshire contract year 2021/22 72% of 4 week quitters were from priority groups, which include routine and manual, among others

- Smokefree Hampshire is available to all smokers in Hampshire, targeting high risk groups. A Health Equity Audit in 2021/22 and ongoing work is supported by 2022/23 insights work with priority groups to enhance service access by these groups.

Cardiovascular Disease Prevention



- ❖ Cardiovascular disease (CVD) kills 160,000 people a year (COVID has killed 150,000 since the start of the pandemic)
- ❖ Modifying risk factors will reduce mortality and morbidity
- ❖ There are significant health inequalities across Hampshire and the Isle of Wight
- ❖ HIOW has identified CVD as a key priority area

- The ’Healthy Hearts’ programme has been developed with primary care and public health
- Management and treatment of hypertension is one of the first focus areas of the programme because:
  a) Hypertension is a key risk factor for a number of clinical conditions
  b) Hampshire and Isle of Wight does not perform well in the management of hypertension compared to other areas
  c) We will significantly improve outcomes over the next few years
  d) It aligns with a number of national and local policies
  e) Covid has severely impacted the management of hypertension
- The ‘Healthy Hearts’ programme has been structured based on successful pilots across our system

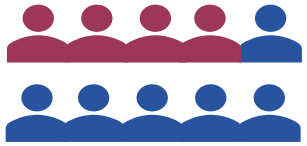
CVDPREVENT

Using the CVDPREVENT data

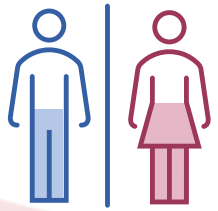
First Annual Audit Report – Key messages

For the baseline audit period up to March 2020

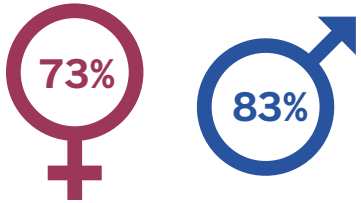
1 **Hypertension:** About 4 in 10 people with recorded hypertension also had obesity, increasing to 5 in 10 in the working age population



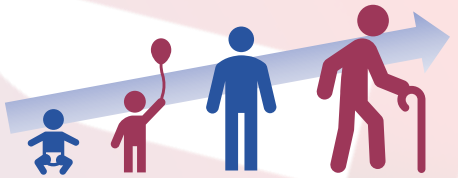
2 **Hypertension:** In people aged 18 – 79 years **69%** of females and **66%** of males were treated to target



3 **Atrial Fibrillation:** Females, with high stroke risk, aged **40 – 59** years, less likely to be prescribed an anticoagulant



4 **Familial Hypercholesterolaemia (FH):** The audit results suggest under recording of FH, highlighting opportunities to identify people with this genetic condition at a younger age



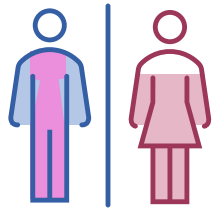
5 **Cholesterol:** Prescription for lipid lowering therapy was 93% for patients with CVD and 74% for those with CKD

93% Patients with CVD

74% Patients with CKD

6 **Cholesterol:** Females with CVD aged **40 to 59** years were less likely to have a prescription for a lipid lowering therapy

92%



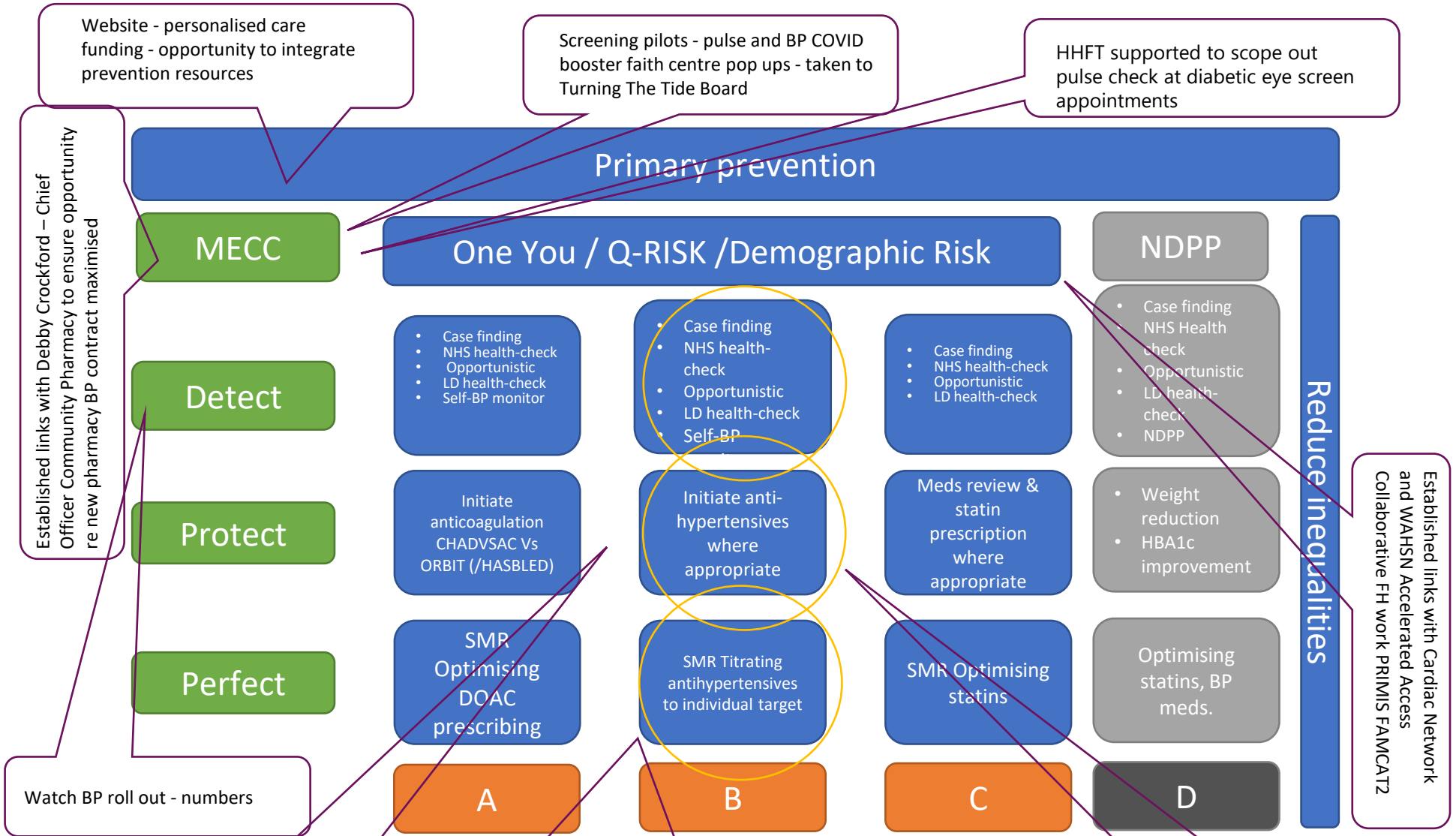
83%

7 **Cholesterol:** People with CKD in Black ethnic groups are least likely to have a prescription for a lipid lowering therapy, Asian ethnic groups are most likely

Black ethnicity

Asian ethnicity

LC H&IOW CVD Prevention Plan on a page



Implement Whole Systems Approach to obesity in an area of Hampshire

- Rushmoor's overweight & obesity prevalence is 64.3%, above England and Hampshire averages. A Whole Systems Approach (WSA) pilot to obesity was initiated in 2029/20 and continues in Rushmoor (and since piloted in Havant) bringing together partners to map the whole picture. There are links between:
    - ***Obesity and Income***
    - ***Obesity & the Built Environment***
    - ***Obesity & Inactivity***
    - ***Obesity & Food Poverty***
- An opportunity to trial place focused multi-agency interventions informed by community and system partners, for long-term change. Once tested, the approach can be applied elsewhere.
- Actions so far include: strengthening schemes such as the Healthy Start Scheme, working closely with Rushmoor Borough Council planning dept to ensure health is built into planning decisions, and working with schools.
- The success of bringing Rushmoor partners together in a WSA was extended in 2021/22 to Havant. Both are ongoing. Another district will be identified in 2022/23. WSA recognises that no single agency can tackle overweight and obesity alone. The WSA by district also builds-in the place based approach.

Hampshire Physical Activity Strategy

- We Can Be Active was created by over 800 individuals and organisations across Hampshire and the Isle of Wight.

- It began with an online conversation and focus groups to find out what would make it easier for local people to be active. The experiences and ideas shared in that conversation became the focus of a big planning session. And from there we developed 5 broad goals that summarise what local people need to be active:
  - Positive early experiences for our children and young people
  - Opportunities that meet our needs and interests and are accessible and easy to find
  - Places and travel routes where we all feel safe and are encouraged to be active
  - Support to help us get started or keep moving when we feel like we can't do it alone
  - Bold leaders working together to create happier and healthier communities
- Alongside the strategy Energise Me will continue to support active lifestyles for all by promoting local options (Parkrun, Zumba, Yoga) as well as tips to get active at home. Reducing inequalities in physical activity and sport is a top priority.

- Ongoing work with physical activity, health and community partners to embed movement into healthcare, education, planning and transport systems and providing training to professionals.

- The Prevention and Inequalities Board continues to promote physical activity programmes

tools/initiatives (including digital) that will enable people to improve self-management

- Video & Telephone Consultation – secondary care procurement in progress. Primary care has just completed procurement for practices

- A number of PCN's are acting as self-care demonstrators for particular conditions, reviewing and evaluating self-care apps. Includes diabetes & weight management, low-level MH/anxiety issues, BP at Home. The Healthier Together app provides advice for parents, young people and pregnant women.

- Virtual wards/social care – Use of remote monitoring technologies including wearables and bio sensors to enable patients who would otherwise be in hospital to remain at home, including supporting the prevention of avoidable admissions and facilitating early discharge.

- Primary Care Pods – SE Hants enables patients to self-provide clinical data (measurements, readings and self-rated scores) without the usual requirement of a face-to-face appointment.

- ICS Digital Team working with social care have deployed 400 iPads to care homes to support ward rounds with GP's. A digital maturity survey is planned to horizon scan ICS requirements and prioritise less digitally mature care homes

tools/initiatives (including digital) that will enable people to improve self-management

- Portsmouth & South East Digital Inclusion Community Network promoting collaborative working , sharing of best practice and awareness raising. CCG providing financial support to colleagues within the voluntary sector in PSEH to:
    - access online digital champions training support
    - purchase and/or refurbish devices for loan
    - provide short-term access to free mobile data for use with loaned devices
- HIVE and Community First are recruiting digital champions, working with Age UK, Citizens Advice and You Trust to support citizens including those with learning disabilities. Working with libraries to create digital learning hubs.
- Community First provide IT support with 6 tablets and 6 Chromebook available to loan and provide training to develop a positive mindset and employment related skills. 1 in 3 participants have a disability and 50% of referrals are from mental health service with others from DWP etc. In addition they are in the process of applying for further sim cards from Vodafone and have recently been able to help a referral from a social prescriber to support a patient with mental health needs to have a phone to access health support.
- ICS Digital Empowered Citizens workshop held attended by health & care colleagues, voluntary sector organisations and patient representatives to understand what is needed to support people using digital approaches such as self-monitoring equipment, online appointments, etc so that those who would like to use tools are able to.
- Creation of an ICS Digital Empowered Citizens Working Group to develop a costed plan to support digital inclusion as part of the wider 3 year ICS Digital Transformation Plan

Recommendations to the Board

1. **Reduce the proportion of women smoking at the time of delivery**
   The Board are asked to note the reduction in the numbers smoking at delivery but the need to keep focus on this area

2. **Reduce the gap in smoking between people in routine and manual occupations & the general population**
   Although two thirds of people set a quit date after 4 weeks there is always more that could be done and more targeted interventions are being employed

3. **Implement whole systems approach to childhood obesity in one area of Hampshire**
   The Board is asked to support and promote the Healthy Weight strategy within their organisations including working collaboratively through a whole system approach

4. **Implement the Hampshire Physical Activity Strategy with a specific focus on enabling the workforce to be competent to promote physical activity for life**
   The Board is asked to ensure their organisations are sighted on and contribute to the Strategy implementation

5. **Signpost to and encourage the systematic use of effective tools/initiatives (including digital) that will enable people to improve their self-management and provide peer support for long-term conditions**
   The Board is asked to note and promote the various tools open to clinicians and the public to support them in their conditions

Discussion