Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Briefing note for: West Berkshire Health Scrutiny Committee

Subject:	**ICB Place Update - Berkshire West**
Date/Time:	**20th September 2022**
Attendees:	**Belinda Seston – Interim ICB Place Director**
Location:	**Virtual**
Contact:	**Belinda Seston – Interim ICB Place Director**

1. Background Purpose (of meeting)

This briefing note provides an overview of the relevant health related activity undertaken recently within Berkshire West ICB; it provides information relating to dementia diagnosis performance as well as formation of the ICB, and confirmation of the future Berkshire West 'Place' leadership arrangements.

2. Summary Overview

2.1 BOB ICB Update

From 1 July 2022, the new **BOB Integrated Care Board (ICB)** took over the commissioning responsibilities of the area's three Clinical Commissioning Groups (CCGs – which were dissolved from 30 June), together with some current national functions, including pharmacy, optometry, and dentistry.

The **BOB Integrated Care Partnership (ICP)** – whose statutory members are the ICB and the five upper tier local authorities – are developing an overall strategy by the end of 2022. This strategy will be developed through local consultation. It will set out how the ICP aims to improve health and care outcomes for our population through stronger partnership working between the NHS, our local authorities and other providers and it will inform the ICB, local authorities, NHS trusts and NHS England which will fund and deliver health and care services.

Patients and the public will continue to access care and services in the same way as before, but these changes will increase the integration of health and care services, building on the many great examples of partnership working and providing more joined up care.

Across BOB ICS, we will plan and provide joined up health and care services through the NHS, local authorities and third sector organisations to:

- improve the health and wellbeing of people in our area
- tackle health inequalities

- improve productivity
- support broader social and economic development.

The ICB Place Directors lead the ICB place-based teams and are the ICB point person for local authorities, local providers and Healthwatch. They are responsible for the development of partnership working and will be an ICB nominee to serve on their local Health and Wellbeing Board.

Working with the chair of the place-based partnerships, they will develop the health components of the Place-based strategy and work with the Directors of Adults Social Services, Directors of Public Health and Directors of Children's Services on the broader health and care place strategy that will form part of the overall system strategy.

On behalf of the ICB, they will also have a role in overseeing operational performance and development of local health services in Place including urgent and emergency care and primary care. The Place Directors also support joint commissioning arrangements and lead on stakeholder engagement and communications at place on behalf of the ICB.

Sarah Webster is the newly appointed Place Director for Berkshire West and will commence in role October 2022.

3.0 Winter Planning

3.1 Flu Planning

Flu planning has commenced from a BOB wide system approach as in previous years. Assurances are being sought regarding the co-administration where possible and delivery supply across primary care, inpatients, and care/nursing home setting.
Any campaign communications are being coordinated at a BOB wide level.
Fortnightly regional meetings are in progress to ensure messages and issues are received from the region.
As we move further through the season, we will be monitoring uptake within the at risk groups as we do on an annual basis.

3.2 COVID Vaccination Autumn Plan

The Autumn Covid Vaccination Programme commenced on 5th September with PCNs beginning to visit care homes and housebound residents. GP-run and national booking systems will open to over 75s and self-declaring health and social care workers from 12th September. All remaining cohorts will be invited for their vaccination in due course. Overall system capacity to deliver vaccines exceeds the anticipated demand and we are working with our partners across Berkshire West to ensure good access, both geographically and to our communities at risk of inequalities.

3.3 Covid 19 Vaccination take-up

For the West Berkshire local authority area (Source: coronavirus.data.gov.uk 08/09/22)

1st dose (denominator used 12+ although eligible from 5)) 88.6%
2nd dose (denominator used 12+, although eligible from 5) 85.6%
1st Booster Autumn 2021 (denominator used 12+, although eligible from 16) 72.9%
For these metrics, data sources of the denominators for local authority areas and nations are different, so like-for-like comparisons are not possible.

Spring 2022 Booster 75+: 86% (compared with all England 78.6%)

3.4 Demand & Capacity Plans for Winter 2022

BOB ICB has submitted its Demand & Capacity plans for winter 2022 aimed at reducing acute bed occupancy to below 90%. These have now been considered by the SE Regional Team and Berkshire West has secured £2.1m to fund the two key schemes worked up by partners across health & social care.

Scheme 1: Development of a fully functioning discharge hub, £1.6m

Building on the current discharge infrastructure to create a fully functioning discharge hub - expanding both the capacity and capability within the hub and widening the focus to include admission avoidance. The enhanced offer will enable triaging at the front door signposting patients onto the most appropriate pathway and support a reduction in LOS across all pathways (including P0). Services will operate extended hours and 7 days a week supporting an increase in week-end discharge rates. Scheme to include: streaming practitioner and social worker in ED to support admission avoidance (signposting into alternative pathways both NHS and social care), opening the Discharge Lounge 7 days a week supporting both week-end discharges and promoting earlier on the day discharges, support to self-funders who have an above average length of wait particularly for P3, P0 safety net team supporting a reduction in re-admissions, enhanced Early Supported Discharge Team providing a bridging role for those needing support at home, additional Patient Flow Co-ordinators to support P0 which make up 60% of the bed days and Care Home liaison practitioner. RBFT and BHFT are leading jointly on mobilisation linking into adult social care as required.

Scheme 2: Commissioning a D2A bedded facility, £0.5m

Building on the successful pilot run by Reading LA during covid commissioning a D2A bedded facility to move patients promptly out of hospital. A team approach with strong therapy leadership enabled over 80% of patients after a short stay to return home independently. Costings based on commissioning 10-11 beds for a 6 month period for use by any BW patient. A meeting is being scheduled early September with the LAs to consider how we best take this forward and ensure it meets the needs of each LA.

3.5 Urgent Care Centre Pilot in Reading

To help address pressures on ED resulting from minor illness attendances and to support local primary care services, the ICB is working to commission a new Urgent Care Centre (UCC) to run on a pilot basis in Reading for the next 18 months. The UCC will be a GP-led service operating seven days a week from 8am to 8pm offering an enhanced walk-in offer for up to 50 people per day. The service will also be able to provide care to patients referred from the RBH Emergency Department, and GP practices, thereby working to support resilience and better manage demand across the system. The UCC will also support GP registration and provide patient education on the appropriate use of health services. It will be funded through savings from the suspended Reading walk in service. As part of an evaluation of the service at the end of the 18-month pilot, we will consider whether there is a need for the Walk in Centre to re-open. If it's felt the Centre is no longer necessary given the provision of the UCC, we will commence the decommissioning procedure and public consultation as required.

We recognise that the UCC will largely see Reading patients and are therefore also working directly with practices across Berkshire West to plan for the Winter, supporting them to maximise recruitment to new roles, co-ordinate closely with community pharmacies to manage minor presentations and work with other practices in their Primary Care Networks to build resilience. Should additional funding be received from NHS England we will consider how this is best allocated to support practices that remain most under pressure from growing demand.

4. Elective Care Recovery

BOB Providers continue to experience larger waiting lists compared to pre-Covid levels with RBFT seeing the largest increase of 48% OUH at 22% and BHT at 18%. The initial focus has been to treat all patients waiting greater than 104 weeks. NHSE are now measuring these according to whether patients are choosing to wait longer, whether they are complex and require significant work-up prior to treatment and a third category which is described as 'capacity' related breaches. Capacity related breaches carry the most intense scrutiny as they should be avoidable. So far, BOB providers have avoided these although there remain circa 20 patients spread across OUH and BHT that are categorised as either patient choice or complex. The next focus is on treating all patients waiting over 78 weeks which represents less than 1% of the overall volume of patients waiting. As at the 14th August, there were 540 BOB patients breaching the 78 week target. However, 11,348 patients on BOB provider waiting lists must be treated by 31st March 2023 in order to meet the NHSE target. BOB is currently ahead of trajectory and is aiming to have no patients waiting greater than 78 weeks by the 31st December 2022.

5. Summary update of Long-Term Conditions management

5.1 BP@Home

As part of a national Trailblazer pilot across BOB, BW GP practices actively participated in the BP@home project. This aimed to address the negative impact that the COVID-19 pandemic had on blood pressure (hypertension) management.
The work led by Dr Heike Veldtman (BOB CVD Lead/GP partner at Thatcham Medical practice) has enabled several practices to adopt a simple, structured process to ensure patients were having their BP reviewed, whilst increasing the number of patients following a locally adapted home -monitoring pathway.
The initial focus was on people aged 65-74 living in the most deprived deciles as a priority. 1370 monitors (circa 5000 across BOB) were received across BW, with all these distributed.

An initial cohort of 21 practices in BW participated based on the criteria above. For participants enrolled in the programme, the recording of blood pressure has increased considerably during the programme (77 to 97%). This also drove overall improvement in achievement at participating practices for the eligible cohort (62% to 76%), compared to relatively flat levels at nonparticipating practices (72% to 77%).

Overall, across BOB more than 7000 people in the target cohort are now actively monitoring their blood pressure at home, with 74% of these achieving their target.

Blood pressure monitors have also been used in West Berkshire and across BW to help support the work around health inequalities for people with significant mental illness (SMI) and LDs, led by Dr Heather Howells. Examples include:

- Several monitors provided to patients identified through the SMI physical health checks as having borderline or raised BP to support treatment.
- Drop in events held e.g. a Health day held at 8 Bells for Mental Health (a Newbury based MH support group and charity) to discuss BP control and checked BP and weight at this event. 30 people with SMIs were supplied with a BP monitor to enable them to check their BP.

The BP@Home approach has now been extended to optimising BP control building the momentum for home blood pressure monitoring to all age groups and moving to a position where home monitoring will be embedded across each practice, to support increased individual understanding of blood pressure, as part of optimising BP control.

Work is also ongoing working with the Local Pharmacy Committee (LPC) to align with the roll out of the Community Hypertension Case Finding service and optimise the benefits of this locally.

Know your Numbers

Education around blood pressure at patient and population level is continuing, working with a range of colleagues from both Public Health and Community Pharmacy. A current focus is on the national “Know your Numbers” campaign running throughout September and supported by a range of communication messages and local events.

Educational events

Several webinars have been held to support practices in the roll out of BP@Home, Heart Failure management (in collaboration with MOT/RBH and BHFT).
A BW TIPS (Time for Improving Patient Service) event is being held on 28 September, for all practices across BW, focused specifically on CVD prevention, including a range of national and local speakers. This is the first TIPS face to face event bringing primary care colleagues together post COVID to focus on this key area.

5.2 Heart Failure Enhanced Service

Additional national funding has successfully been secured as an exemplar site (across BOB), enabling the targeted funding for an Enhanced Service for GP practices. This focuses specifically on earlier detection and case finding of people with Heart Failure, and optimisation of their treatment. Across BW two thirds of practices (43) are already participating with outcomes anticipated in mid-October, and work to support further uptake is underway.

5.3 Diabetes recovery and restoration

National and regional funding of specific schemes will support practices across BW to focus on people with both Type 1 and Type 2 diabetes. The main aim of this funding is to focus on addressing the impact from COVID (including specifically focusing on the impact of inequalities), and support practices to restore pre-pandemic levels in relation to the NICE recommended 8 Care processes and 3 Treatment Targets, whilst also recognising the additional impact that deprivation has had on population groups.
Across West Berkshire this means that *all* practices will receive additional funding (based on a set of indices) to support a more targeted approach to reviewing patients and improving outcomes

5.4 Reducing practice variation

This is aimed at offering practices the opportunity to review a Best Practice Toolkit, led by Dr Aparna Balaji and Dr Richard Bishop (BW Diabetes GP clinical leads), to offer insight into how practices can continue to improve against the national 8 care processes and all 3 treatment targets, and where there is shared learning across practices. To date over 22 virtual visits have been completed with practices.

6.0 Dementia Overview Summary

Improvement in the rate of dementia diagnosis and the increase in the range of support to people post-diagnosis remains one of the most important elements of the NHS national mental health strategy. This programme of work rests on increasing the rates of referral from primary care, identification of people at risk of suffering from dementia at home and in care homes and the prompt provision of appropriate support.
Success in improving the quality of life for people with dementia rests on effective multi agency working and therefore the links between statutory services (NHS and local authority) and the commercial and third sector care providers is vital.

6.1 Dementia Diagnosis Action Plan

The multi-agency Dementia Diagnosis Group meets monthly to bring together stakeholders from primary care, commissioning, and provider organisations to assure progress on a range of measures to improve diagnostic rates, and to improve post-diagnostic support.

The current action plan includes the following:

Date	Area of Concern	Action Agreed	Lead	Update
08/06/2022	Data & Performance figures	Record number of those people with dementia diagnosis instead of %. Annual Review figures to be checked. Waiting time: review formulae for calculating waiting times to ensure they are accurate.	JC	Work ongoing.
08/06/2022	SE Dementia Diagnosis Rate PCN (primary care network) report	VM to share the SE Dementia Diagnosis Rate PCN report with the group that compares all regions and can be filtered by CCG, PCN and GP Practice.	VM	Work ongoing.
11/05/2022	Conversion rate for DDR - Waiting list	Check the waiting list and conversion rate for Dementia diagnosis.	VM	08/06/22 - Data Production post has been offered, waiting on a start date. July onwards reports can start going out.
11/05/2022	Standard Work	Review standard work across the localities.	VM, SJ	08/06/22 - Standard Work for reporting purposes - VM to discuss with SJ.
11/05/2022	Standard Letter	RC to check standard letters from Services to Primary Care are being sent.	VM	08/06/22 - Discussed at last meeting, variations across all localities - one standard letter across all? VM to check localities are using same type of

				presentation of letter with diagnosis letter.
11/05/2022	Diagnostic Tools	HH, LJ and VM to review different diagnostic tools available and share best practice.	HH, LJ, VM	08/06/22 - Diadem and other tools looked at any new changes will wait until BOB changes are in place. Developing a new Dementia Strategy in BOB, led by Sian Roberts across BOB. Post diagnostic service needs to be in place a+F11nd clear pathway in place.
11/05/2022	Percentage of referrals from Care Homes	Informatics may be able to provide this data.	JC	08/06/22 - Looking at introducing a Care Home Flag on RiO but may be able to collate this information manually in the meantime. Something more user friendly needs to be in place - source of referral - care home - mapped nationally in the background. GP referral and resident in care home could be a source. Want to make it as simple as possible from front end.
11/05/2022	Review of activity across BOB	LJ to review what is taking place across BOB.	LJ/AM	08/06/22 - carry over to next meeting.

*Names: VM (Vicky Mathews), SJ. HH (Heather Howells), LJ (Lajla Jonassen), AM (Andy Moody), JC (Jo Cook), HH (Heather Howells).

6.2 Data reporting

Using Connected Care, BHFT's Information Team has developed a process identifying when a dementia diagnosis recorded on Rio but is not showing on Primary Care records. They have recruited a Data Production Worker to produce monthly reports by practice listing the NHS numbers for patients whose Primary Care records need updating to show their dementia diagnosis. To increase practice QOF dementia numbers and improve performance against the DDR target of 66.7%, Primary Care will need to enter the dementia diagnoses listed in the report onto their system. This will improve the level of recorded diagnosis.

6.3 Stakeholder involvement

The commissioning lead for adults is developing, with the support of the mental health clinical lead, a programme to increase engagement with stakeholders in local community, this will be co-ordinated across BOB ICS and will be consistent with the priorities identified in each of the three local authorities. This will include, for example, how health services, including primary care, are able to support dementia friendly communities.
A programme of engagement with stakeholders is taking place to increase visibility of post-diagnostic support including dementia friends, Admiral Nurses and third sector organisations to ensure that from the point of diagnosis, people are able to access the support they need.
A monthly task and finish group will be set up with a focus on continuing to support and work with the Dementia Diagnosis Rate working group. This will ensure that the actions taking place in primary care, specialist and community settings are co-ordinated.

6.4 Training and education

A programme of training and education is being developed for GP practices which will increase knowledge and awareness of signs and symptoms of dementia and the current best practice in ensuring diagnosis and referral to treatment and support becomes more consistent and that people have access to the support they need.
The opportunity to establish a service providing in-reach into care homes for people with dementia is being developed using a model which has been successfully established by Black Country Healthcare. The aim is to develop a business plan to support a similar model in BOB ICS, with benefits on reduced uptake of emergency services as well as improved quality of care.
Work is ongoing with primary care in supporting the increased use of the Diadem tool to improve diagnosis.

The dementia diagnosis rates for BOB ICB are summarised in the tables below and indicate a steady level of performance across the area with a small degree of improvement. However, this compares favourably with other ICBs and improvements in diagnosis rates are, as indicated in the figures, not subject to dramatic improvements.

Table 1 Dementia Diagnosis rates 65yeras +

ICS/STP	Organisation	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Sparkline	Last Mth DoT	Variance
	England	62.1	62.0	62.0	61.9	62.0	61.8	61.6	61.7	62.0	61.8	61.9	62.0		↑	0.05
	South East	60.4	60.4	60.2	60.2	60.2	60.2	60.0	60.2	60.5	60.5	60.4	60.5		↑	0.06
	BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST STP	59.4	59.5	59.4	59.4	59.6	59.3	59.2	59.0	59.0	58.8	58.8	58.8		↑	0.06
	FRIMLEY HEALTH & CARE ICS (STP)	63.4	63.2	63.3	63.4	63.5	63.6	63.3	63.6	64.0	63.6	63.6	63.4		↓	-0.17
	HAMPSHIRE AND THE ISLE OF WIGHT STP	61.1	60.8	61.1	60.6	60.5	60.4	60.3	60.5	61.2	61.6	60.9	60.9		↑	0.08
	KENT AND MEDWAY STP	57.0	57.3	57.2	57.3	57.3	57.3	57.1	57.5	57.5	57.5	57.7	57.7		↑	0.02
	SURREY HEARTLANDS HEALTH & CARE PARTNERSHIP (STP)	62.2	62.1	62.4	62.8	63.1	63.1	62.9	63.2	63.6	63.5	63.6	63.7		↑	0.11
	SUSSEX HEALTH AND CARE PARTNERSHIP ICS	61.6	61.6	60.4	60.6	60.6	60.6	60.3	60.7	60.9	60.7	61.0	61.1		↑	0.14
BOB STP	NHS Berkshire West CCG	58.3	59.3	59.2	59.0	59.0	59.2	58.9	58.5	58.5	58.2	58.5	58.4		↓	-0.11
BOB STP	NHS Buckinghamshire CCG	57.6	57.6	57.6	57.4	57.5	57.4	57.2	56.9	56.9	56.8	56.7	56.8		↑	0.17
BOB STP	NHS Oxfordshire CCG	61.4	61.0	60.9	61.2	61.5	60.9	61.0	60.9	60.9	60.6	60.7	60.8		↑	0.08

Table 2. Monthly Diagnosis rates

ICS/STP	Organisation	Dementia diagnosis per 100,000 patients aged 65 and over						Trend changes	Dementia Registers (65 + only) latest available Numerator	Dementia Registers : Changes from previous month		Patients registered at a GP practice - Aged 65 and over	Estimated Dementia Prevalence (65 + only) CFAS II Denominator
		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		Jun-22				
	SOUTH EAST	8,658.7	8,693.4	8,738.0	8,737.9	8,740.0	8,757.0		73,990	↑	296	844,927	122,381
	BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST STP	8,401.7	8,374.4	8,378.7	8,355.0	8,370.2	8,384.7		12,926	↑	57	154,161	21,967
	FRIMLEY HEALTH & CARE ICS (STP)	8,895.7	8,951.4	9,014.9	8,962.0	8,950.3	8,931.4		5,335	↑	1	59,733	8,411
	HAMPSHIRE AND THE ISLE OF WIGHT STP	8,632.3	8,660.0	8,762.1	8,828.3	8,732.3	8,751.5		15,929	↑	65	182,015	26,136
	KENT AND MEDWAY STP	7,947.6	8,003.3	8,020.5	8,023.8	8,061.5	8,074.6		14,101	↑	49	174,635	24,430
	SURREY HEARTLANDS HEALTH & CARE PARTNERSHIP (STP)	9,566.7	9,616.1	9,674.1	9,660.6	9,699.6	9,726.9		9,228	↑	41	94,871	14,482
	SUSSEX HEALTH AND CARE PARTNERSHIP ICS	9,039.2	9,098.9	9,133.1	9,107.2	9,148.2	9,175.4		16,471	↑	83	179,512	26,956
BOB STP	NHS Berkshire West CCG	8,122.4	8,071.4	8,087.1	8,049.4	8,090.0	8,076.2		3,343	↑	4	41,393	5,728
BOB STP	NHS Buckinghamshire CCG	8,236.6	8,213.9	8,206.7	8,203.2	8,202.4	8,237.5		4,104	↑	28	49,821	7,220
BOB STP	NHS Oxfordshire CCG	8,716.9	8,701.4	8,706.9	8,676.3	8,687.2	8,704.1		5,479	↑	25	62,947	9,018

Table 3 Dementia registers 65years+