West Berkshire Health & Wellbeing Board Conference 2024

Presentations will begin at 10:00am

Welcome

Councillor Alan Macro

West Berkshire Health & Wellbeing Board Chairman

‘A View from the Bridge’

Professor John Ashton

Interim Director of Public Health
for Reading and West Berkshire

Health & Wellbeing Board Dashboard

Gayan Perera

Interim Public Health Intelligence Manager

Microsoft | Power BI

Health and Wellbeing (H&WB) Dashboard

View in Power BI ↗

Last data refresh:
4/17/2024 1:42:45 PM UTC

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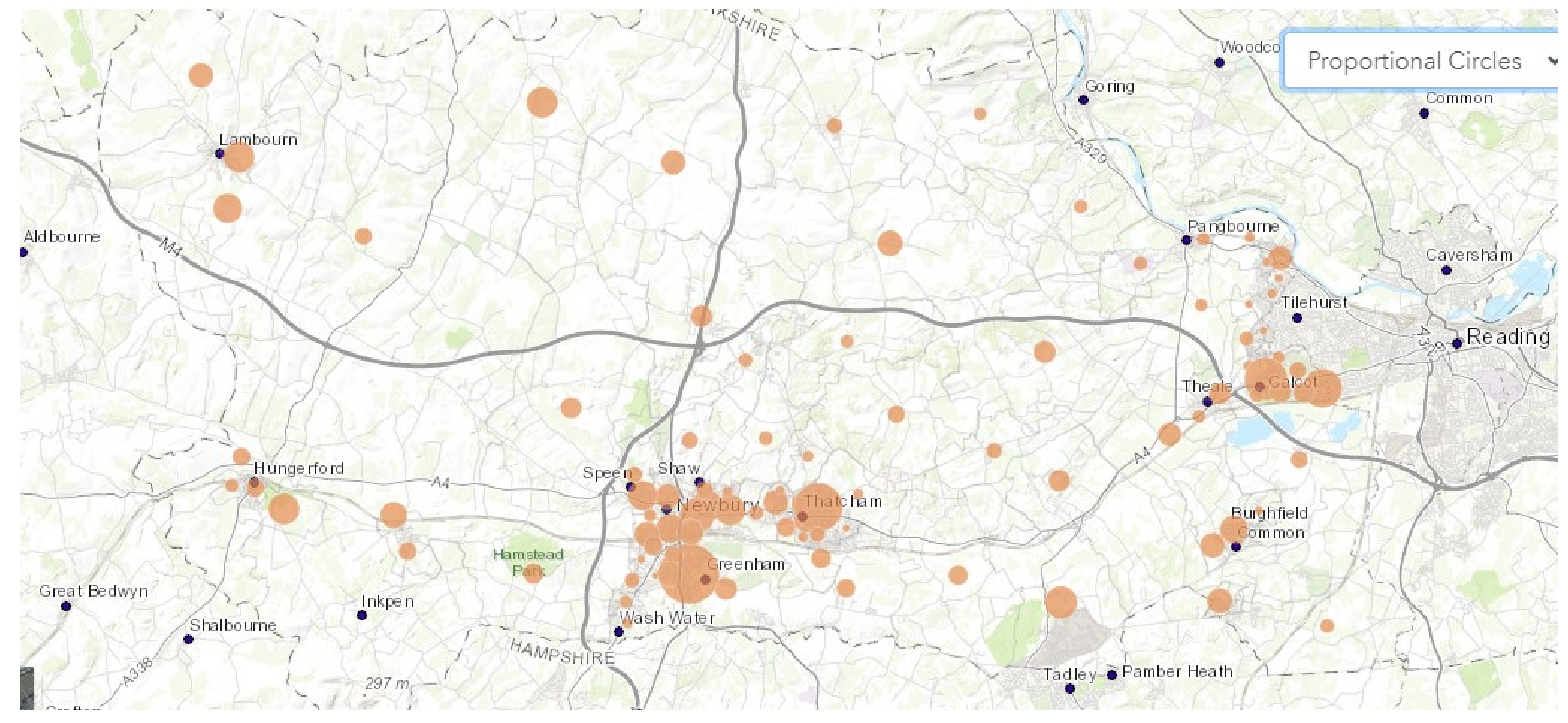
4/17/2024 1:44:32 PM UTC

Two most deprived quintiles in West Berkshire



Health & Wellbeing Strategy Priorities

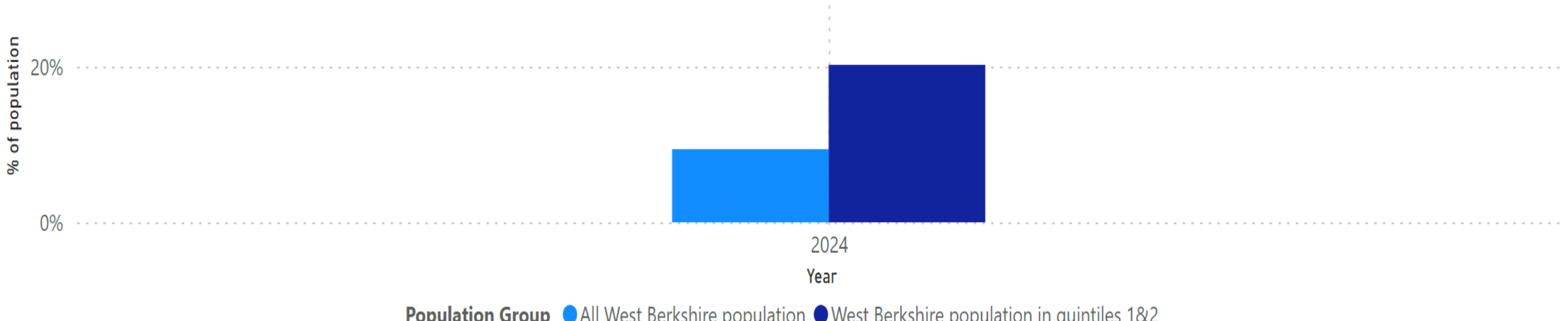
Priority 1 - Reduce the differences in health between different groups of people

1.1 Disease prevalence (number of individuals and percentage of population) of major disease groups in West Berkshire, comparing the GP registered population as a whole to those living in the most deprived areas (IMD quintile 1&2)

Number of individuals
20000
10000
0
20%
10%
0%
Percentage
Hypertension
Obesity
Diabetes
Cancer
CHD
Atrial Fibrillation
Stroke/TIA
COPD
Heart Failure
Mental Health
PAD
Prevalence
#Prevalence (Most deprived quintiles, 1 and 2)
% Prevalence
% Prevalence (Most deprived quintiles, 1 and 2)

The percentage prevalence of obesity, diabetes, mental health conditions, and COPD is higher in the population living in the most deprived quintiles. (Frimley Local Insights)

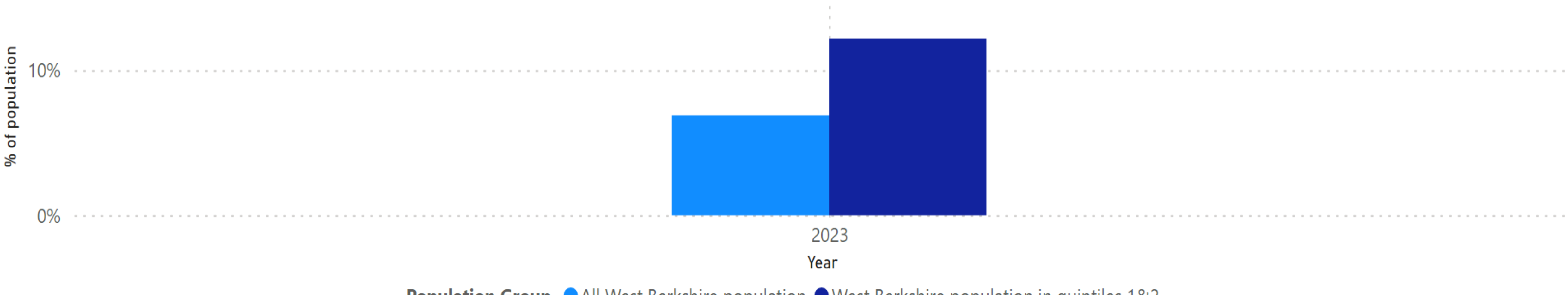
1.3 Proportion of West Berkshire's GP registered population who smoke, compared to the proportion of those living in the most deprived areas of West Berkshire (IMD quintile 1 &2) who smoke



Smoking prevalence is significantly higher in the most deprived population. (Frimley Local Insights)

Health & Wellbeing Strategy Priorities

Priority 1 - Reduce the differences in health between different groups of people



Registered prevalence of obesity is higher in the most deprived population. (Frimley Local Insights)

2.1 Difference in life expectancy at birth between the most deprived and least deprived areas in west Berkshire and England, by Gender

Difference in life expectancy in years

10
9
8
7
6
5
4
3

2010 - 12
2011 - 13
2012 - 14
2013 - 15
2014 - 16
2015 - 17
2016 - 18
2017 - 19
2018 - 20

Year

England (Male)
West Berkshire (Male)
England (Female)
West Berkshire (Female)

- Life expectancy at birth is calculated for each deprivation decile of lower super output areas within each area and then the slope index of inequality (SII) is calculated based on these figures.
- The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within each area and summarises this in a single number.
- This represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles.
- In West Berkshire the difference in life expectancy at birth for **females (4.1 years)** is lower to England (7.9 years), and is also lower for **males (3.5 years)** compared to England (9.7 years). (Fingertips/PHE)

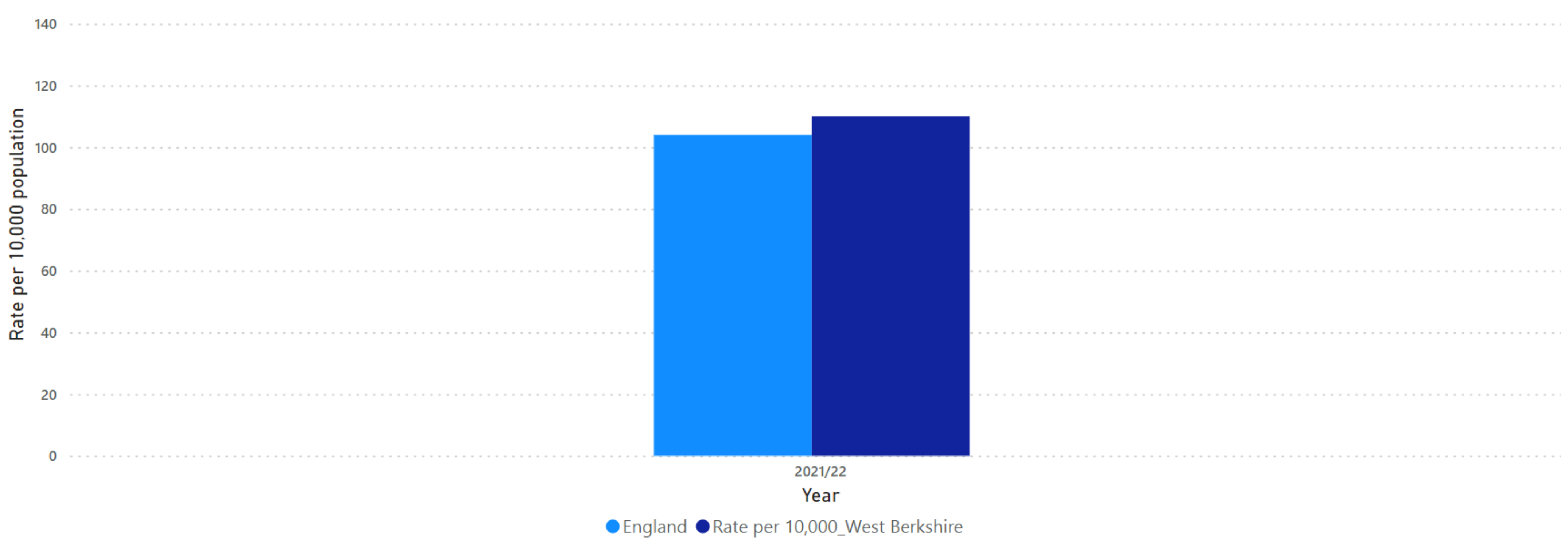
2.2 Percentage of those aged 65 years+ who are estimated to have dementia who have received a diagnosis, in West Berkshire and England

In West Berkshire, 60.2% of those aged 65 or over, estimated to have dementia have a coded diagnosis of dementia as of July 2023, which is lower than England (64.5%). (NHS Digital)

2.3 Rate of people sleeping rough in West Berkshire and England (per 100,000 population)

The rate of people sleeping rough in West Berkshire has increased between 2021 and 2022 from 0.62 per 100,000 to 4.94 per 100,000. This is similar to England with 5.4 per 100,000. (Department for levelling Up, Housing and Communities)

3.2 Number of hospital admissions, per 10,000 children aged 0-4 years, caused by unintentional and deliberate injuries in West Berkshire and England



West Berkshire has a statistically similar rate (109.7 per 10,000) of hospital admissions for unintentional and deliberate injuries in children aged 0-4 to England with 103.6 per 10,000. Note: there is no historic data for this indicator. (OHID/Child and Maternal Health)

4.2 Rate of children in care per 10,000 under 18 population in West Berkshire and England

The indicator shows the rate of children in care on 31 March for each year (rate per 10,000 population aged under 18 years). West Berkshire has a similar rate of children in need compared with England, with 24.0 per 10,000 and 25.2 per 10,000, respectively. (OHID/Public Health Profiles)

4.5 Percentage of children and young people engaged with MHST who have moved toward their goals

RCADs is the Revised Children's Anxiety and Depression Scale.

Source: Mental Health Support Team

5.1 Number and proportion of the population diagnosed with Serious Mental Illness in West Berkshire

The prevalence of Serious Mental Illness is currently at 0.9% in West Berkshire. (Frimley Local Insights)

5.2 Number and % of the population diagnosed with Depression in West Berkshire

% of England residents ● % of West Berkshire residents

Prevalence of diagnosed depression in West Berkshire is less than England until 2018/19

Prevalence of diagnosed depression in West Berkshire more than England from 2019/20

% of residents

14%
12%
10%
8%
6%
4%
2%
0%

2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23

Year

The prevalence of depression is currently 13.9%. Quality and Outcomes Framework (QOF), NHS England

5.5 Percentage of people who feel lonely often, always, or some of the time in West Berkshire

This indicator comes from the Active Lives Adult Survey, Sport England. It shows the percentage of adults (aged 16 and over) that responded to the question "How often do you feel lonely?" with "Always or often" or "Some of the time". (OHID/Public Health Profiles)

Health Inequalities Hot Focus Update

April Peberdy

Interim Service Director Communities and Wellbeing

Purpose of the Hot Focus Session

Create a shared understanding of health inequalities and how they show up in West Berkshire.

Establish a common vision for improving the building blocks to improve health and wellbeing.

Inspire individuals, groups, and organisations to take ownership in addressing and reducing health inequalities within their respective spheres of influence.

Introduce tools to help structure conversations such as the Place Standard Tool.

What are health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health.

Joint Health and Wellbeing Strategy

REDUCE THE DIFFERENCES IN HEALTH BETWEEN DIFFERENT GROUPS OF PEOPLE

To Make a Difference We Will….

- Use information and intelligence to understand our communities, identify those who are in greatest need……….
- Assess how Covid-19 has differentially impacted our local populations.
- Take a Health in All Policies approach that embeds health across policies and various services.
- Address the variation in the experience of the wider social, economic and environmental determinants of health.
- Continue to engage and collaborate with diverse communities, voluntary organisations, unpaid caregivers, and self-help groups, prioritising inclusivity and amplifying their voices.
- Ensure services and support are accessible to those most in need.

What works to address inequalities?

The Labonte model is a simple but effective tool:

- Understands health inequalities and guides solutions.
- Identifies factors affecting health and their interactions.
- Emphasises addressing place alongside people.

Health and Wellbeing

Physiological impacts
- High blood pressure
- High cholesterol
- Anxiety/depression

Health behaviours
- Smoking
- Diet
- Alcohol

Wider determinants of health
- Income and debt
- Employment/quality of work
- Housing
- Education and skills
- Natural and built environment
- Access to goods/services
- Power and discrimination

Psycho-social factors
- Isolation
- Social support
- Social networks
- Self-esteem and self-worth
- Perceived level of control
- Meaning/purpose of life

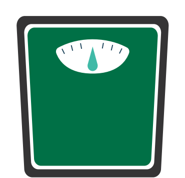
Health Behaviours

Smoking Prevalence

Least deprived 10%	9.9%
Average	14.4%
Most deprived 10%	21.6%

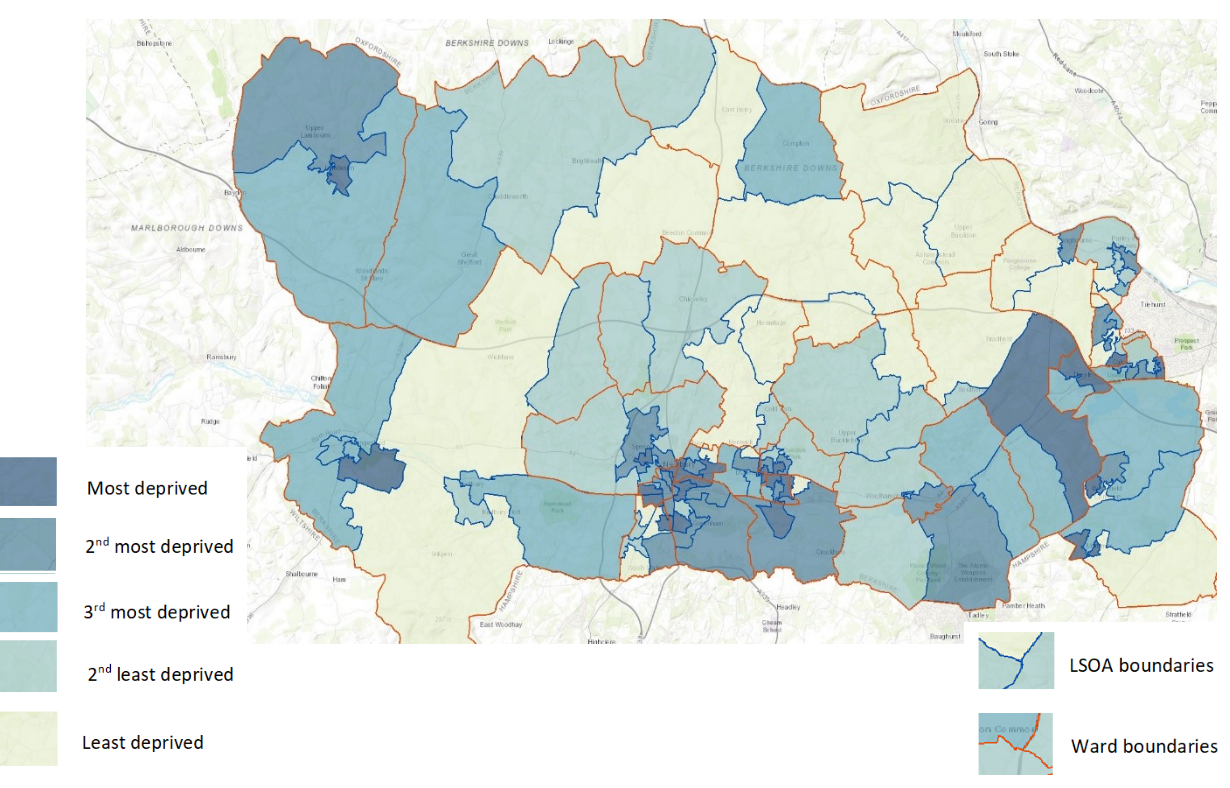
Obesity Prevalence

Least deprived 10%	34%
Average	35%
Most deprived 10%	41%



Harmful and hazardous drinking prevalence

Least deprived 10%	11.5%
Average	13.2%
Most deprived 10%	12%



Wider Determinants of Health

% of children in low-income households

Least deprived 10%	7%
Average	10%
Most deprived 10%	22%

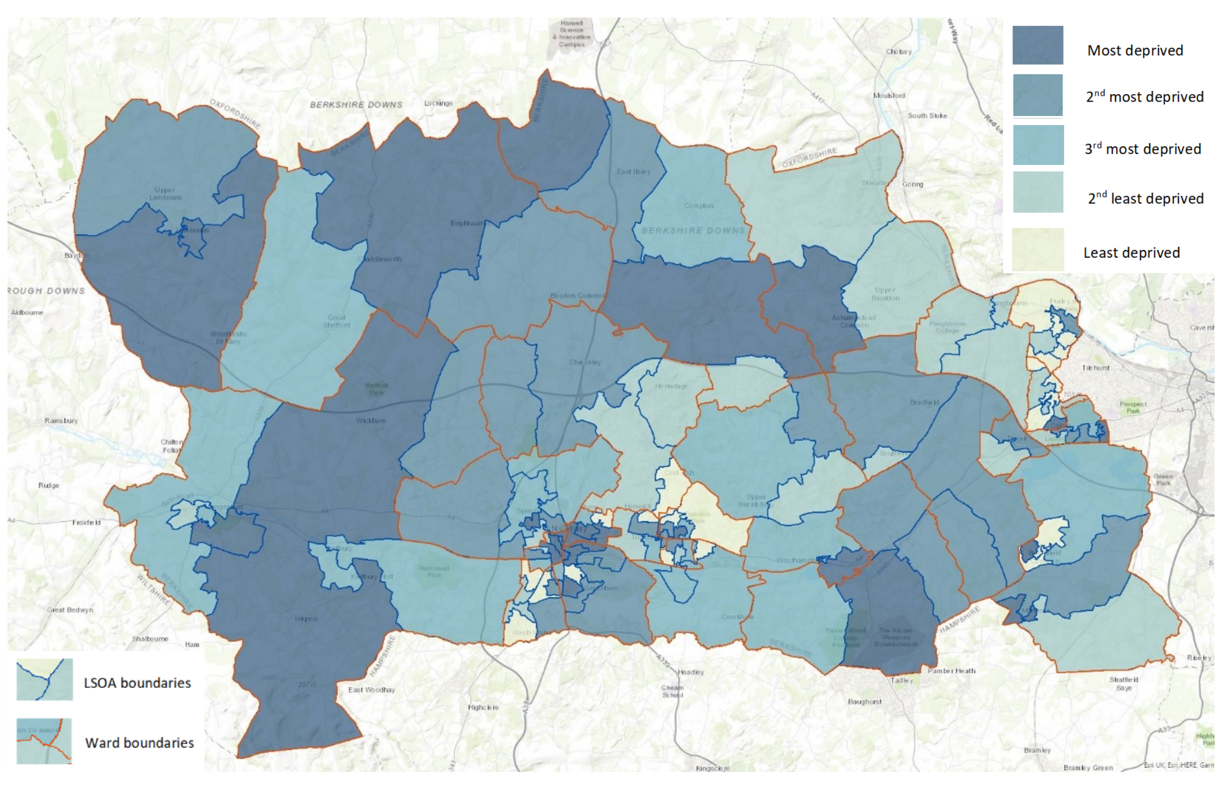
Total Crime Rate per 1,000 persons

Least deprived 10%	35
Average	68
Most deprived 10%	124

Anti-social Behaviour Rate per 1,000 persons

Least deprived 10%	5
Average	8
Most deprived 10%	20

Overall Deprivation in West Berkshire



Building Blocks to Health…

- Lower educational attainment
- Poor housing quality

Example:

- Lower education and poor housing can lead to health risks like smoking or poor nutrition.
- Health problems can affect job opportunities, leading to financial instability and stress.
- Inadequate housing may expose individuals to environmental hazards, worsening health conditions.
- Over time, these factors can compound, resulting in deteriorating health and increased reliance on support services.

Feedback from the Workshops

- Closing Early Years Education Gaps
- Improving Outcomes for Adults with Learning Disabilities

Next Steps Empowering Sub-Groups

West Berkshire Health & Wellbeing Board

West Berkshire Health & Wellbeing Steering Group

Pharmaceutical Needs Assessment Sub-Group

Building Communities Together Partnership

Substance Misuse Harm Reduction Partnership

Homelessness Strategy Group

Health Inequalities Task Force

Skills & Enterprise Partnership

SEND Strategic Partnership Board

Locality Integration Board

Suicide Prevention Action Group

Mental Health Action Group

Ageing Well Task Group

Children's Prevention and Early Help Partnership

Community Wellness Outreach Service

A collaborative programme across Berkshire West

Heike Veldtman (CVD Lead, BOB ICB)
Kate Toone (Project Manager, West Berkshire Council)
Wendy Tafi (Engagement Lead, Solutions4Health)

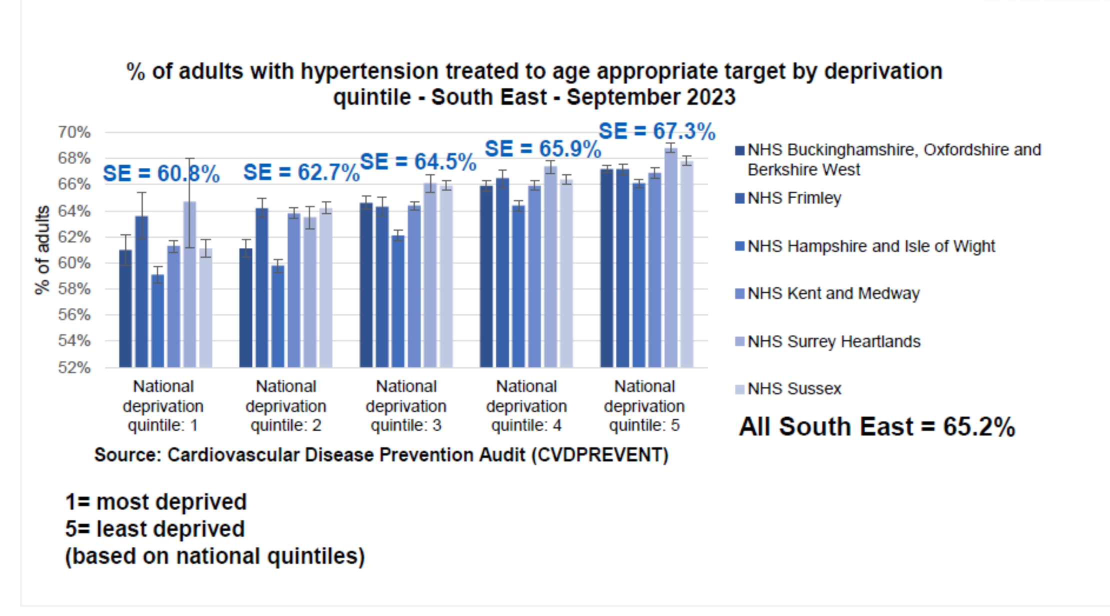
Introduction and overview

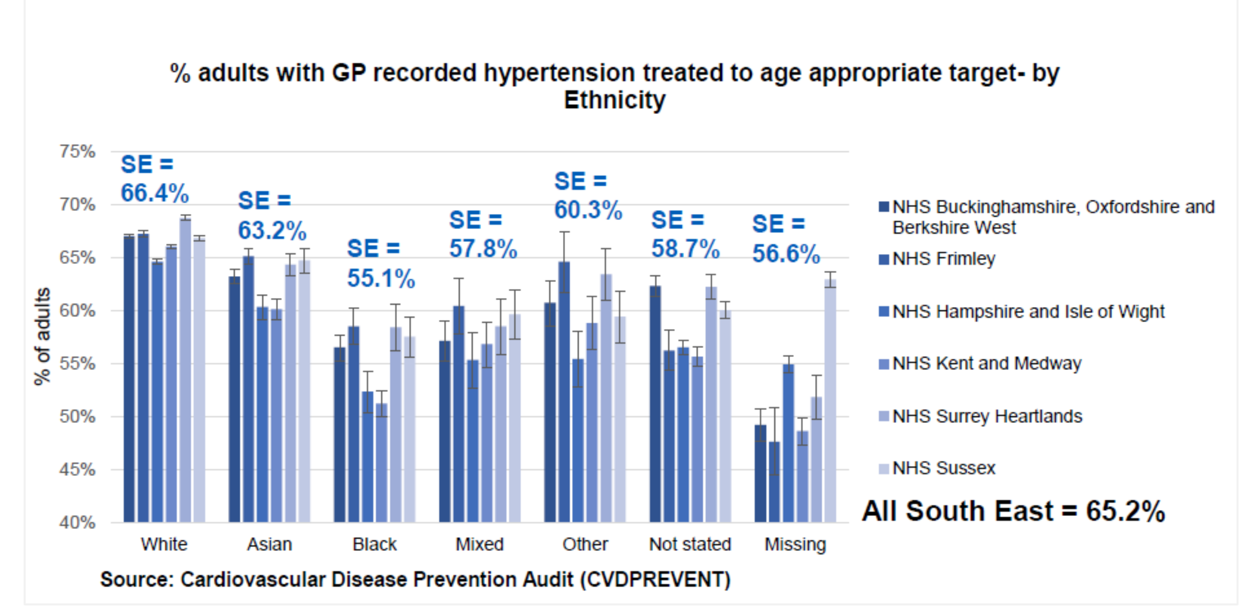
- Cardiovascular Disease (CVD) – Heike Veldtman
- The Community Wellness Outreach Service – Kate Toone and Wendy Tafi

CVD Prevention: why focus on Cardiovascular Disease?

- **1 in 4 deaths** in England caused by CVD, with a person dying from CVD every 25 minutes.
- **6.4 million** living with debilitating CVD symptoms in the UK.
- Nearly **100,000 strokes** annually in the UK, 1 million survivors.
- CVD is the **biggest driver of health inequalities** in the South-East.
- CVD widens gap in **life expectancy :** one-fifth of life expectancy gap exists between most and least deprived communities in England. In South-East, CVD is the leading cause of the life expectancy gap of 7.2 years between most and least deprived quintiles in males (5.4 years for females).
- **South Asian and Black communities** face the highest risk of CVD in England.
- Significant **cost** on NHS and economy (£21 billion annually).

CVD Prevention: Health Inequalities





West Berkshire COUNCIL

CVD Prevention: Impact

Size of the Prize – Buckinghamshire, Oxfordshire and Berkshire West BP Optimisation to Prevent Heart Attacks and Strokes at Scale

UCLPartners

% patients with blood pressure treated to target

QOF 19/20
70.2%

COVID-19 Disruption
49,208 Thousands fewer patients with BP treated to target or BP not recorded

Risk: up to 736 extra heart attacks and strokes in 3 years

50.6%
QOF 20/21

QOF Recovery
70.2%

74%
9,383 additional patients

77%
16,881 additional patients

80%
24,378 additional patients

Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
56 heart attacks	101 heart attacks	146 heart attacks
Up to £0.4 million[2] saved	Up to £0.8 million[2] saved	Up to £1.1 million[2] saved
84 strokes	151 strokes	218 strokes
Up to £1.2 million[2] saved	Up to £2.1 million[2] saved	Up to £3.0 million[2] saved

What is the CWO Service?

- Community Wellness Outreach Service (CWO)
- 18 months programme to June 2025
- Community Engagement
- Pathway Outreach
- Social Prescribing and Digital Management Solution
- Quality Assurance
- Eligibility

Commissioning intention and impact

- Outcomes focused approach.
- Contribute to place-based efforts.
- It is all about improving access, experience and the health outcomes.

Berkshire West Health and Wellbeing Strategy

"Reduce the differences in health between different groups of people"

"Support individuals at high risk of bad health outcomes to live healthy lives"

Key outcomes

- To increase uptake of the NHS Health Checks Pathway by eligible residents and local workforce disproportionately impacted by cardiovascular disease (CVD) but under-served by the Programme in West Berkshire.
- To prevent and reduce avoidable premature mortality through the early identification and management of CVD risk factors among Service-Users.
- To change beliefs and attitudes towards CVD prevention and lifestyle risk factors, and to increase motivation towards CVD prevention activities through a “Health and Wellbeing/CVD Champion” programme.

Targeted outreach and engagement

- Priority populations and target groups:
  - Residents of Newbury Greenham, Newbury Central, Newbury Clay Hill, Lambourn, Aldermaston, Downlands Wards.
  - Asian, black, mixed minoritised ethnic groups.
  - Gypsy, Roma, Traveller communities.
  - Migrants, Asylum Seekers and Refugees.
  - People with dependencies on drugs or alcohol in contact with services
  - People with disabilities (who are eligible for the national Health Check programme).
  - Survivors of domestic abuse.
  - Sex workers.
  - Offenders / former offenders.
  - Men of working age, manual occupations.

Service update

- Clinics established, can be found here:
  - West Berkshire Community Wellness Outreach Service - Solutions 4 Health
- WBC website in place:
  - Community Wellness Outreach Project - West Berkshire Council
- 128 Health Checks completed to date (as at 10/04/2024).
- Communication from GPs to eligible residents being sent out.
- Community engagement lead in place.

Community Engagement Update

Food Bank

Lambourn Library

Case Study

- **Location and date:** Northcroft Leisure Centre, Thursday 4th April 2024
- **Name:** Rob
- **Age:** 65
- **Gender:** Male
- **Occupation:** Retired Plumber
- **Postcode:** Newbury
- **Type of engagement:** Received a full Health Check

- Rob does not have a smart phone and does not have access to email (not tech savvy).
- Rob received a letter from his GP (Strawberry Hill) informing him that he was eligible for a Health Check
- Rob has been waiting three years for a knee replacement. Walking / mobility has become very difficult, and he now feels isolated. He lives on his own.
- He used to go into town at least once a week.
- He made his way to his Health Check by bicycle (slowly) as that was easier than walking.
- Both of his parents died from heart attacks and his mother was a diabetic.

Case Study

- **Location and date:** Northcroft Leisure Centre, Thursday 4th April 2024
- **Name:** Irenie (speaks Russian)
- **Age:** 68
- **Postcode:** Newbury
- **Type of engagement:** Received a full Health Check

- Irenie’s booking was made by phone.
- She was informed about the Health Check via the NHS App.
- Solutions4Health used Google Translate as Irenie did not speak any English.
- GP (Strawberry Hill).

Case Study

- **Location and date:** Lambourn Library, Wednesday 10th April 2024
- **Name:** Sue
- **Age:** 82
- **Postcode:** Lambourn

- GP (Lambourn).
- Sue had a heart attack two years ago and has COPD. She smoked but gave up when she was 30.
- She had a test over a year ago for diabetes and she was told that she was borderline diabetic.
- Sue was advised by her doctor to go to Newbury Hockey Club for an outreach healthy eating meeting. Unfortunately, Sue does not drive. She is not tech savvy so she cannot access online healthy eating meetings.
- Sue lives with her daughter who also has an ongoing health condition. Sue would love to have a glucose test and a mini health check along with some healthy eating tips.

Feedback

Very convenient that this service is available in the community, it's been hard to access the GP for appointments so it's a great help that I can have a health check in a drop-in setting.

Simon Amor

Many thanks to the health check team, I am 66 and have never got my cholesterol checked. So I am quite happy I can have this done with results on the day. Will get my daughter to attend too!

Bridgette

I've never been called by the GP to have a health check done so I am glad I was able to drop in today at Northcroft Leisure Centre and get a full MOT straight after my class.

Gill

Never knew I could get so many things checked in one go, so fast as well! Many thanks to the service for also letting me know about the stop smoking service as I wasn't aware of this either!

Maxine

Q&A – Session 1

Break

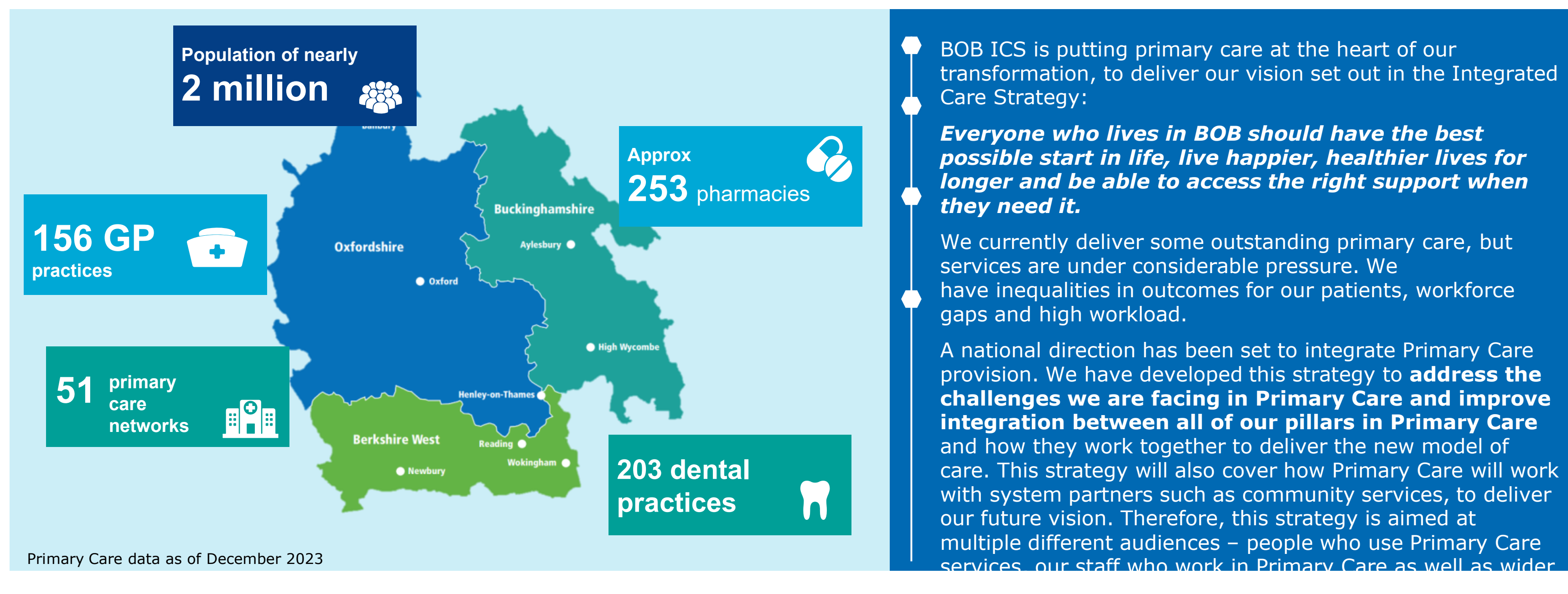
Transforming Primary Care – Executive Summary

General Practice, Community Pharmacy, Optometry and Dentistry

Sanjay Desai
Head of Primary Care Operations

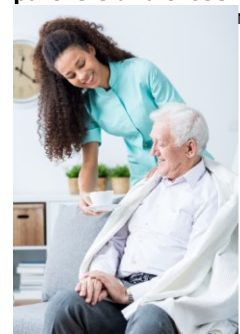
Why we need a primary care strategy

Primary Care includes General Practice, Community Pharmacy, Optometry and Dentistry services. These services provide the first point of contact, have an ongoing connection with local communities, and lead on improving the 'whole person' health of our population.



Approach to developing this draft strategy

This strategy builds from national guidance and our own local plans. We have carried out extensive engagement and analysis to inform the development of this draft primary care strategy, which we now want to refine through further engagement with system partners and those n



2022

National guidance such as The Fuller Stocktake

Spring 2023

BOB Integrated Care Strategy and Joint Forward Plan

Summer 2023

Focus Groups and Surveys

We carried out focus groups with key stakeholders - General Practice, Community Pharmacy, Optometry, and Dentistry and surveyed all pillars of Primary Care for their views.

Research on good practice

We researched global, national and local examples of good practice delivery of Primary Care services within other systems and within BOB.

Autumn 2023

System-wide workshop

Bringing together over 130 stakeholders from across the system to discuss the future vision and opportunities for Primary Care.

Data Analysis

We have analysed available data to understand how people in BOB are using services today as well as what our workforce looks like.

Winter 2023

Current State Report

Compiles documents, good practice, data analysis and views from engagement order to describe BOB's Primary Care Landscape.

Ongoing engagement

Feeding in all our research and engagement so far, we started to draft the strategy and continued to meet with key stakeholder groups to get their input and feedback.

January 2024

First draft of the Primary Care Strategy

This document summarises the key challenges facing Primary Care and how we plan to address these through a change in our model of care. We will continue engaging with system partners' and the public to hear their views.

Our primary care system has many strengths

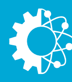
There is much outstanding practice across primary care in BOB, and unique capabilities across its Places. Below are five highlights where the system has particular strengths that can be built upon.

01

General Practice access and quality metrics in line with or above the national average

The proportion of GP appointments seen within 14 days is **higher** than the national and regional average. Most GP practices have either good or outstanding CQC ratings. Quality and Outcomes Framework scores are just above average.

02



High uptake of the Community Pharmacy Consultation Service

BOB has the **third highest** number of referrals (per population) to the Community Pharmacy Consultation Service across the Southeast region. 122 of the 156 GP practices are 'live' and referring their patients to community pharmacists, with a further 27 preparing to start using this service (as of December 2023).

03

Strong focus on inequalities, prevention, and wider determinants of health

All three Place-based Partnerships have focused on this. For example, 'Opportunity Bucks' targets the 10 most deprived areas in Buckinghamshire. Oxfordshire work focuses on specific communities such as people who are homeless. In Berkshire West community outreach is focused on reducing premature mortality.

04

Population Health Management Infrastructure

In parts of BOB, the Connected Care model has been developed with the addition of Population Health Management tools and is enabling people to be directed to the most appropriate health and care service, based on their needs. This supports better triage and navigation, identification of people who would benefit from intensive case management, and ability to design prevention interventions.

05

Flexible dentistry commissioning for our most vulnerable populations and extended commissioning for Minor Eye Conditions

BOB has started a pilot for flexible commissioning, where 10% of the contract can vary depending on local needs. This has enabled practitioners to service patients from under served communities who require dental care. Additionally, there has been great uptake of the referrals to the Minor Eye Conditions service and patient feedback has been positive.

06

Strength of existing at-scale delivery structures

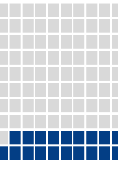
Each Place has a Placed-Based-Partnership (including local authorities, VCSE and others) which can drive and deliver transformation and integration at a local level. There are evolving Federations of General Practices established in each Place – FedBucks, PML in parts of Oxfordshire and the Primary Care Alliance in parts of Berkshire West that can lead change and deliver services for a large part of the population.

1: NHS Digital (2023); 2: Primary Care Access and Recovery Plan (2023); 3: Brookside Case study – Segmentation in Primary Care (2023)

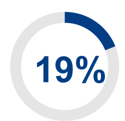
There are challenges within primary care and within the wider system that require new ways of working

Demand for primary care outstrips current capacity and inefficiencies are created (for patients and staff) where the parts of the system do not work well together. The challenges require a system response, they cannot be solved by primary care alone.

01 People report a worsening experience of accessing primary care



Since 2021, there has been a 19% decrease in positive responses with regards to the overall experience of booking an appointment.[1]



19% said there were no dental appointments available or said that the dentist was not taking on any new patients.[2]

02 Many primary care staff feel they are under extreme pressure

BOB LMC data shows that GPs are responsible for more patients, and are spending a large proportion of time on administrative tasks relating to how patients move between parts of the system. [3]

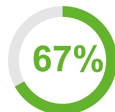
Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.

03 This is driven by a mismatch between demand and capacity across the system

BOB's growing population and changing demographic profile is increasing demand for primary care services - more than one in four of the adult population live with more than two long term conditions.[5]

14 community pharmacies closed in 2023 and 16 out of 20 100hr pharmacies reduced their opening hours (mainly the 9pm-12am slot).[6]

04 Capacity is difficult to grow due to funding, recruitment, retention and estates challenges



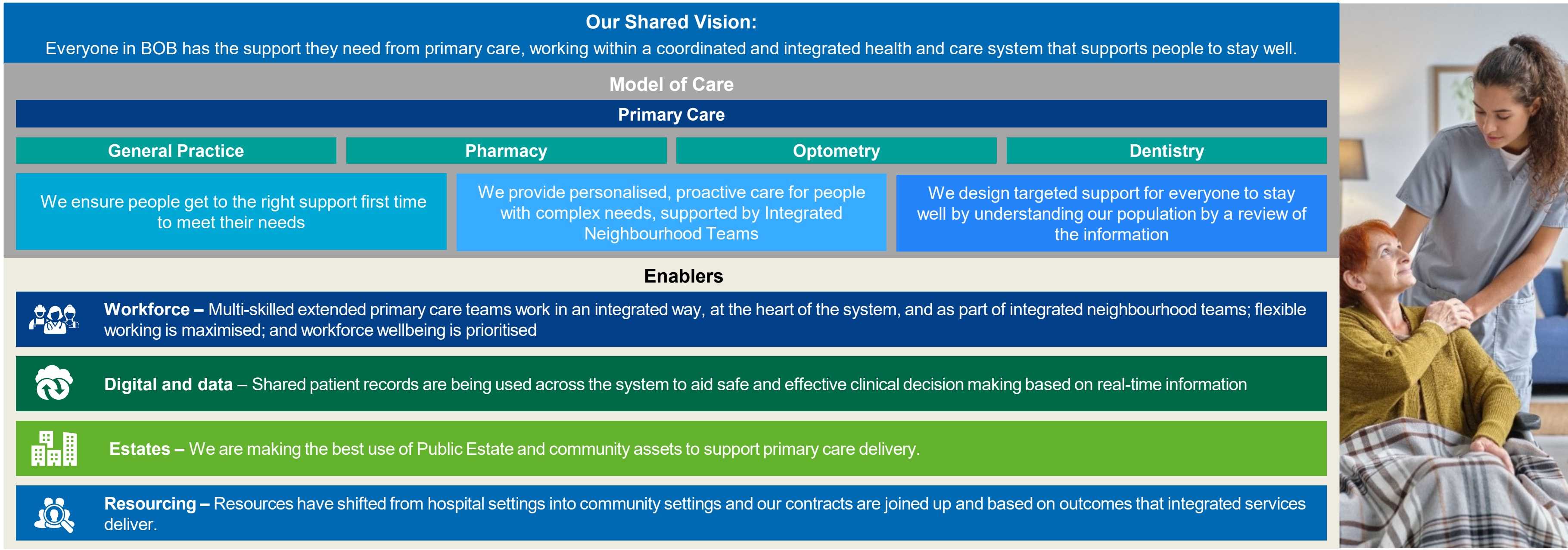
In the Community Pharmacy workforce survey, 67% of respondents said it is very difficult to fill vacant roles for pharmacists.[7]

There are estates pressures across the system for example, in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121 m^2.

1: National GP survey results, 2023; 2: BOB GP Patient Survey Dental Statistics 2023; 3: BBOB LMC The Health of General Practice in BOB; 4: BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023); 5: BOB Joint Forward Plan (2023); 6: Buckinghamshire Executive Partnership Report on Primary Care July 2023; 7: Community Pharmacy Workforce Survey 2022; 8: OCCG Primary Care Estates Strategy (2020)

Our shared system vision for primary care

The challenges – and opportunities – facing primary care result from complex system-wide factors and a whole system response is required. BOB's Joint Forward Plan commits the system to developing new models of care and primary care is at the heart of that. This is our future vision for primary care, but it requires other system partners to also work differently to deliver it.



Our priorities for delivery

We have identified three areas where we can make a real impact on improving people's health and wellbeing and reducing pressure on staff. Where possible, we will focus on working with communities that experience the most inequalities. In line with BOB's overall system strategy, we have focused on aligning the priorities with two of our system goals and introducing more joined-up ways of working between services – rather than discrete priorities with one area like dentistry or general practice. The priorities are described in more detail on later pages.

1 Non-complex same-day care

General Practice, Community Pharmacy, Optometry and Dentistry will work together, with 111 and Urgent Care, to **better manage those who require support that day, but whose need is not complex.**

Around 70% of population health need is low complexity, and this makes up approx. 50% of GP activity.

Impact:

- Improved patient experience as they get the urgent support they need.
- Release capacity in General Practice to focus those with more complex needs.

John Hopkins ACG System

2 Integrated Neighbourhood Teams

General Practice, Community Pharmacy, Optometry and Dentistry will work together with community, mental health, acute and VCSE services to provide **proactive, personalised care to a defined population group with more complex needs**, for example, frail older people.

Around 70% of health and social care spending is on long term conditions.

Impact:

- People's health conditions are better managed reducing their need for unplanned hospital care.
- System capacity better coordinated and directed at need leading to greater staff satisfaction

Long-term conditions and multi-morbidity | The King's Fund (kingsfund.org.uk)

3 Cardiovascular Disease (CVD) prevention

General Practice, Community Pharmacy, Optometry and Dentistry will work together with Local Authorities, VCSE and the wider health system to **reduce the risk factors for Cardiovascular Disease (CVD)** including smoking, obesity and high blood pressure.

CVD is one of the most common causes of ongoing ill-health and deaths in BOB.

Impact:

- Reduce 797 heart attacks and 290 strokes (CVD events) in the next 4 years.
- Reduce demand on General Practice and Secondary Care and reduce the overall societal cost.

BOB Size of Prize 2023

Thank you

We are grateful to all those in the BOB Integrated Care System who have helped to shape this draft strategy.

General Practice

Dr Heike Veldtman
GP Partner, Thatcham Medical Practice
BOB ICB CVD Prevention Lead

Apr 2024

Challenges & Opportunities

1. Access

- Telephone v NHS App & Online consultations

2. Appointments

- Urgent On the Day
- Routine Care
    - Managing Long Term Conditions
    - Empowering the patient
    - Care Planning – e.g. personalised care planning
    - Self-Management

Challenges & Opportunities

3. Workforce

- Reception v Care Navigators
- GP v Primary Care Team
  - E.g. Physio; Pharmacist; Physicians Associate; Advanced Nurse Practitioner; Mental Health Worker; Paramedics; Social Prescriber
  - How we can meet your needs

4. Community Pharmacy

- 7 Minor Ailments

5. Growing Population

We cannot do this on our own…We need your help

- Be involved – Join your Patient Participation Group
- Self Help – Control your Blood Pressure; Understand and manage your Long Term Condition (s)
- Attend your NHS Health Check
- Stop smoking
- Be active
- **Let us work together and help everyone in West Berkshire LIVE WELL**

Community Pharmacy across West Berkshire

Julie Dandridge Head of Pharmacy, Optometry and Dentistry
19 April 2024

Community Pharmacy services

16 Community Pharmacies across West Berkshire

Delivered per month in West Berkshire:

56,700 Prescriptions dispensed

323 New Medicine Service reviews

129 Blood Pressure Checks each month

203 GP/111 referrals
(Community Pharmacy Consultation service)

Other services offered by community pharmacy

- flu vaccination
- smoking cessation referrals from secondary care
- Discharge medication service
- Lateral flow device service
- Pharmacy consultation service
- Bank Holiday provision
- Pharmacy First

Community Pharmacy closures

- In January 2023, LloydsPharmacy announced it would withdraw pharmacy services from all Sainsbury's supermarkets with many of its other community pharmacies sold to new owners. This has contributed to approximately 20% of BOB pharmacies having new owners.
- Across BOB we have seen the closure of 6 pharmacies since April 23 with two pharmacies opening during this time.10 of these closures were as a result of Lloyds withdrawing from Sainsburys supermarket
- Following notification of closure of a pharmacy, Health and Wellbeing Boards will consider if they need to review their Pharmaceutical Needs Assessment and identify if there is any gap identified
- The ICB working alongside the Local Pharmaceutical Committee also assesses the local impact of closing a pharmacy linking with other local community pharmacies to ensure that they can absorb dispensing numbers as well as provide other services. This can often strengthen remaining community pharmacies making them more financially viable.
- Application to join the pharmaceutical list is controlled through the NHS Pharmaceutical Regulations.

Health and Wellbeing Board Area	No of pharmacy closures
Buckinghamshire	3
Oxfordshire	8
Reading	2
West Berkshire	3
Wokingham	0

Community Pharmacy next steps

- Primary Care Strategy
  - linking General Practice , Community Pharmacy, Optometry and Dentistry

- NHS App – for repeat prescriptions and to track dispensing

- Workforce support

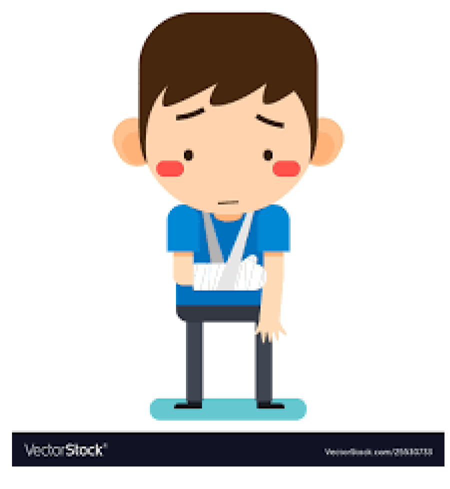
- Pharmacy First

West Berkshire Pharmacy First Update

Play Video

Releases Capacity
Longer Appointments
Complex Patients

Uses Skill Set
Improves Business Model



Quicker Appts
Better Access to Treatment

What have we learned in first 2 months?

- Sore Throat & UTI are the top 2 conditions
- Many consultations are completed outside of 9-5
- Referrals from GP have doubled compared to old service without treatment
- Patients need better messaging (e.g., Prescription exemption)
- Less than 10% of patients are referred back to GP for further diagnosis
- AntiBiotic use hasn’t gone up
- Patients like the ability to self-refer
- Pharmacy Teams relish clinical development
- Better promotion of the service in surgery and pharmacy

Dental Services

West Berkshire Health and Well Being Board Conference
19th April 2024

Hugh O'Keeffe

NHS
Buckinghamshire, Oxfordshire
and Berkshire West
Integrated Care Board

NHS Dental services

- Primary Care NHS Dental services provided under NHS (GDS/PDS) Regulations 2006
- Patients are not registered with dental practices
- Patient recall intervals based on https://www.nice.org.uk/guidance/cg19 (October 2004)
- NHS treatment based on 3 treatment bands
- Patient Charges apply https://www.nhs.uk/nhs-services/dentists/understanding-nhs-dental-charges/
- Information about whether practices accepting new patients https://www.nhs.uk/service-search/find-a-dentist
- Dental contract currency – Units of Dental Activity (UDAs) – based on treatment bands
- Practices required to deliver an agreed number of UDAs each year within cash limited contracts
- UDA ‘prices’ vary; based on casemix in reference year 2004-05
- Out of hours cover evenings and weekends
- Specialist referral services (Oral and Maxillofacial Surgery; Oral Surgery; Orthodontics; Restorative; Special Care and Paediatric Dentistry; Sedation)
- Pathways based on NHS England Commissioning guides (level 1, 2, 3)

NHS Dental services in West Berkshire – Primary Care

18 practices (9 full NHS; 9 Child or Child/Exempt only)

UDAs commissioned = 171,711

Practice locations

Ward	Number of practices	Ward	Number of practices
Burghfield and Mortimer	2	Pangbourne	2
Hungerford and Kintbury	2	Thatcham Central; North-West and West	3
Lambourn	1	Theale	1
Newbury Central and Newbury Speen	6	Tilehurst Birch Copse	1

NHS Dental services in West Berkshire – other services

- 1 Out of Hours (Thatcham, Saturdays; Reading other days)
- 1 Orthodontic practice (Newbury)
- 1 Special Care and Paediatric Dental Service ('Community Dental Service'); Berkshire Healthcare NHSFT (Berkshire service)
- 1 Tier 2 Oral Surgery provider (Berkshire West)
- 1 Tier 2 Restorative provider (Berkshire West)
- 1 Sedation provider (Reading)
- Hospital provision (Royal Berkshire Hospital, spoke; Oxford University Hospitals, hub)

Challenges for NHS Dental Services (1)

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

% population accessing NHS dental services in previous 2 years - BOB ICB

55.00%
50.00%
45.00%
40.00%
35.00%
30.00%

Apr-18 Jun-18 Aug-18 Oct-18 Dec-18 Feb-19 Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24

Challenges for NHS Dental Services (2)

- Reduced capacity March 2020 – July 2022
- Backlog of patients
- Increased treatment need; treatments taking longer to complete
- Practices struggling to meet activity targets (28% in 20-21; 66% in 21-22; 80% in 22-23)
- Difficult for new patients to get into the system
- Business risk to practices of new patients with high needs
- Many practices closed to new patients
- Some Dentists not willing to work under NHS contracts
- Contract handbacks/reductions – 18 handbacks in BOB and 8 reductions (110,472 UDAs c.5% of capacity)
- West Berkshire handbacks/reductions = 0

Actions to address challenges – local (1)

- Additional Access sessions – low take-up in BOB
- Temporary UDAs to replace lost activity – to 31st March 2024
- Allow practices to be paid to deliver up to 110% of contracted activity (increase from 102% under national changes 2022)
- Flexible Commissioning: convert % of contract value from UDA target to access sessions for patients facing challenges:
  - Not attended practice for 2 years
  - Relocated to the area
  - Looked After Children
  - Families of Armed Forces personnel
  - Asylum Seekers
  - Others where dental attendance medically indicated

Actions to address challenges – local (2)

- Flexible Commissioning pilot 23-24:
  - 33 practices (20 Oxon; 8 Bucks; 5 Berks West, 1 West Berks)
  - 3,081 sessions to Mar '24
  - 10,491 new patients seen/14,521 attendances
- ICB approval to continue in 2024-25 – 35 practices to take part
- Re-commissioning of lost UDAs
  - Phase 1 local practices and additional activity (68,798 UDAs from 1April24; includes 4,800 for West Berkshire)
  - Phase 2 open market procurement – focus on Oxfordshire
- Continue to monitor impact on access
- Restoration and Re-set investment into SCPD and tier 2 services to help address waiting list backlogs

Contract changes 2022:

- Minimum UDA value of £23
- 110% overperformance
- Increased payment for more complex cases
- More powers for commissioners to recover monies for persistent contract underperformance
- Re-iteration of NICE guidance re recall intervals
- Improving information for patients (requirement to update nhs.uk)

Actions to address challenges – national (2)

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Contract changes 2024:

- Minimum UDA value of £28
- New patient premium - £15 - £50
- Ringfence dental budgets
- Public Health campaign to raise awareness about how to access
- ‘Golden Hello’ for Dentists to work in areas of high need
- Dental Vans for areas with significant access challenges
- Legislation to support more use of skill mix
- Make it easier for overseas Dentists to work in NHS
- Further dental contract reform 2025
- Support oral health improve with ‘Smile for Life’ programmes in early year settings

Q&A – Session 2

Closing Remarks

Councillor Alan Macro

West Berkshire Health & Wellbeing Board Chairman