NHS Doncaster Clinical Commissioning Group

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Primary Care Strategy 2019-21

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Introduction

Doncaster's Primary Care Strategy for the next two years is written within the context of the overarching Health and Social Care Commissioning Strategy 2019-2021, which focuses around three broad life stages – starting well, living well and ageing well to ensure services are available for everyone based on their health and care needs at different stages in their lives and that these services are accessed at the right place, in the right way at the right time.

Primary care is the cornerstone of the NHS and naturally sits under all three life stages and whilst it is broadly considered under living well, primary care services will still be universally available to people that need them at whatever stage of their life they may be. Effective primary care is characterised by the strength of team working and ongoing relationships between patients, GPs and other professionals.

This strategy sets out the vision for primary care over the next two years and beyond and sets out the priorities to be taken forward to ensure high quality primary care (in its widest sense) continues to be available for the Doncaster population.

A Vision for Primary Care

This has been developed in partnership with Primary Care Doncaster and the Local Medical Committee and tested with local stakeholders (see engagement section). This vision states that:

We will ensure the resilience and long term sustainability of primary care through the development of primary care at scale. This will:-

- *facilitate integrated working between partnership organisations at neighbourhood level, encouraging integration and collaboration;*
- *improve access to consistent high quality and holistic care that promotes health and wellbeing*
- *increase the cost effective use of resources*
- *provide a focus for the prevention and management of long term conditions, including mental health, leading to improved health outcomes.*

We will work with our communication and engagement team and Healthwatch Doncaster to ensure that the vision resonates with the general public and is patient focused.

Why we need to update the strategy

The Primary Care Strategic Model developed in 2015/16 was built around the four pillars of:

1. Extended Primary Care – Local enhanced services commissioning
2. Proactive Co-ordinated Care – Holistic care for more frail/complex patients
3. Responsive Primary Care – Improved access and responsiveness
4. Keeping People Well – to be refocused on population health management

These pillars remain relevant, to a certain extent; (see http://primarycare.doncasterccg.nhs.uk/primary-care-strategic-model) however significant developments have taken place since this strategy was written including:

- GP Forward View publication and funding streams
- Doncaster place plan refresh including joint commissioning within 3 life stages of –Starting Well, Living Well and Ageing Well and integrated neighbourhood working including the development of primary care networks
- Establishment of Primary Care Doncaster the GP Federation
- Extended access and hubs model went live on 1 October 2018
- The development of the Integrated Care System in South Yorkshire & Bassetlaw and the production of the primary care charter
- A new focus on population health management
- The Long Term plan for the NHS published on 7 January 2019
- The Five Year Framework for GP Contract Reform published on 31 January 2019
- Development of a new Children & Young People's Plan (2017-2020)

Engagement

Primary Care Doncaster and the Local Medical Committee are key partners in the development of this strategy. Discussions have also taken place with the Local Pharmaceutical Committee, Healthwatch, the medical director of Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust and the Deputy Chief Operating Officer of RDaSH. A stakeholder engagement plan has been developed as a framework and has been included on the CCG's primary care website http://primarycare.doncasterccg.nhs.uk/.

Early themes emerging for providers:

- Uncertainty about the medium and long term future of key sources of income for general practice and community pharmacy due to the impact on business planning and recruitment
- DBTH is keen to work closer with primary and community care but need this to be supported with a robust system of clinical governance

More detailed engagement was undertaken with practices/stakeholders on the back of discussions at the workforce and primary care strategy event on 26 October 2018. An initial survey completed by a lead GP and practice manager from each of the 32 practices signed up to a Quality Contract showed that:

> 59% of those present agreed with the vision for the strategy but 13% felt it needed to be simpler.
>
> 24.5% felt unsure about primary care at scale and when asked to put themselves on a scale of 0-100 in terms of understanding primary care networks practices were just over 50.

Practices were also asked what they felt they needed to help deliver the vision. Workforce support, stability of commissioned services and better engagement on long term plans were the priority.

Staff from practices and community pharmacies (through the LPC) will have further opportunity to comment on the final draft of the Strategy in order that the perspective of the wider primary care workforce on the direction of travel is taken into account.

Public engagement

Public engagement will build on work that has already taken place primarily through the System Perfect survey to understand why people choose to go to A&E and the 569 million reasons campaign on over the counter medication.

The System Perfect survey was undertaken to understand why people choose to go to A&E especially younger people aged 20-35 whose use of the service is more prevalent. Reasons given included lack of GP capacity, difficulty in making an appointment or an individual not being registered with a GP as well as people needing reassurance that nothing was seriously wrong with them.

The primary care strategy engagement will therefore seek to understand the barriers people have found in accessing GP appointments and to understand better patients' perceptions in this regard. 4 practices undertook an audit during the same week which showed that appointments were available in practices and that DNAs represented a significant issue in lost appointment time. This suggests that there may be issues with patient perceptions about access and also about the responsibility of the patient in keeping appointments.

The 569 million reasons survey intended to gather public attitudes in South Yorkshire & Bassetlaw to the withdrawal from prescription of common medications that are available over the counter. Interestingly some of the patient questions were mirrored in the prescriber's survey and were quite stark when compared. For example 82% of patients surveyed indicated that they would be willing to purchase medication over the counter if told to do so whereas prescribers felt that this would be much lower at 36%. 4% of patients (5% in Doncaster) felt that they had a right to free medication whereas prescribers assumed a much higher level at 64%.

Usefully the survey also asked about self treatment and patient confidence, there were high levels of confidence in self treating a range of ailments although a concern about skin conditions and vitamin/mineral deficiencies. Therefore there may be more appetite for self care and opportunities to promote the role of community pharmacies.

Initial feedback on the extended access service will also be used to focus future engagement activity, particularly in regard to reasons why people are/are not accessing the service.

Public engagement activities are supported by Healthwatch Doncaster who have scoped a 3 month engagement programme seeking views on:

- The reality of accessing GP appointments in Doncaster
- Barriers patients perceive or experience in accessing an appointment
- Why patients do not keep their appointments (GP and patient perspective)
- What improvements can be made to assist making access better and utilising appointment time as best as possible.

A survey has been drafted and it is planned to undertake some initial pre-engagement work with the PPG network to test out the survey and receive feedback to improve it. A short video explaining the purpose of the survey and why it is important will be produced and a series of events will be run inviting people to share their views and comments on primary care appointments. An on-line survey will be launched which will be promoted via social media and face to face and a series of interviews with key stakeholders will be undertaken along with a survey for primary health care professionals to gain their perspective on the initial outcomes of the patient survey and whether this resonates with them.

It is planned that this Strategy will be refreshed annually and that engagement will be a significant and ongoing part of the development process.

Delivering the Vision

Development of Primary Care Networks

The NHS Planning guidance “Refreshing NHS Plans” set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network. They are groups of practices that collaborate in partnership with community services, social care, educational establishments and other providers. They build on the core of primary care and enable greater provision of proactive personalised co-ordinated and more integrated health and social care.

This ambition resonates strongly with the description of integrated neighbourhoods in the Doncaster Place Plan which sets out the vision for future health and social care provision in the borough and therefore the two workstreams have been brought together under the single umbrella of integrated neighbourhood working.

The diagram below demonstrates the vision for whole system transformation to achieve the outcomes creating a better balance between statutory NHS and social care services and the assets of the neighbourhood and universal services.

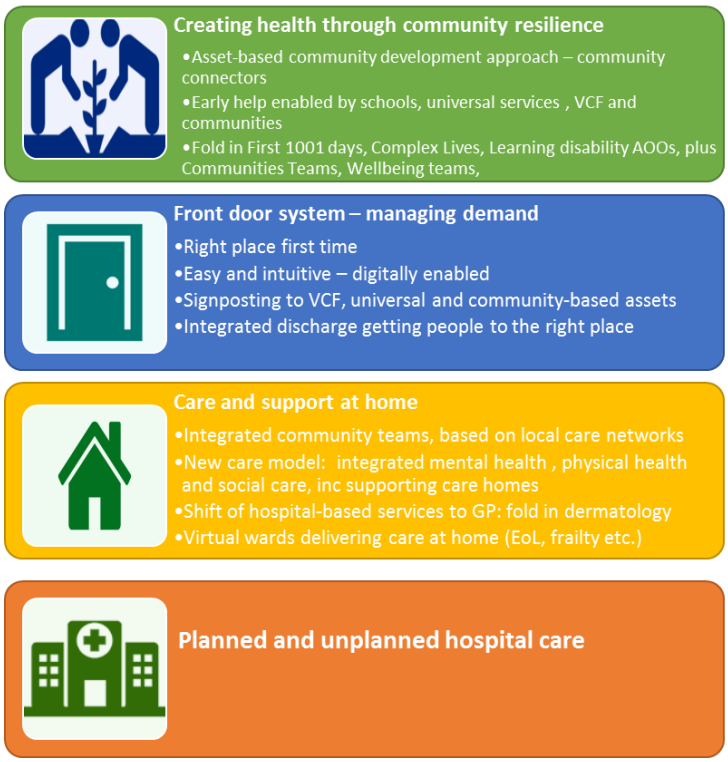


Fig. 1 Refresh of the Place Plan to achieve the outcomes

Primary care networks are key to delivering the neighbourhood based approach provided that they embrace full integration with non GP practice stakeholders.

Fortnightly system wide planning meetings have been put in place to agree an approach to implementation of this model and a series of neighbourhood specific workshops were held in the autumn to begin to define a vision for each neighbourhood and agree priorities to be taken forward.

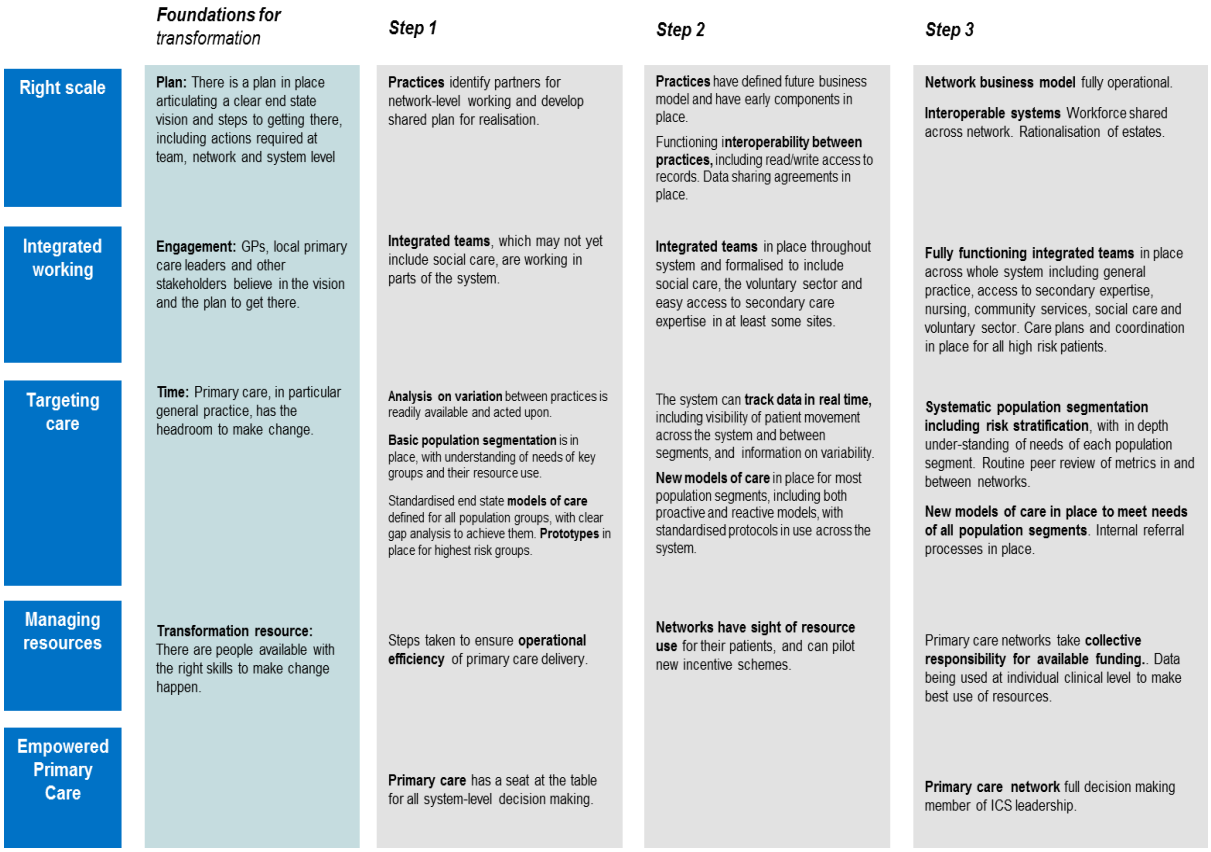
A number of themes emerged from the workshops, particularly connecting practices with the stronger communities work in the Council and the use of Your Life Doncaster as a resource for implementing community led approaches.

These priorities were revisited at follow up workshops held for each neighbourhood in January 2019. Primary Care Doncaster is commissioned to develop primary care networks and has now recruited a project manager to work with each neighbourhood to commence more detailed action planning.

The initial focus has centred around living well and ageing well but there is now a desire to include the starting well agenda; and in particular develop links and connectivity to other players within the system such as schools and academies.

The Long Term Plan and subsequent GP Contract Framework provide further strategic direction and investment to support the ongoing development and maintenance of primary care networks. In 19/20 £2.50 per head of population will be made available to take this forward (£1 non recurrent from ICS and £1.50 recurrently from CCG allocations) with the aim of:

- Progressing all neighbourhoods to level 3 on the maturity matrix
- Piloting new ways of working through a neighbourhood approach
- Development of neighbourhood leaders and infrastructure
- Supporting further development of risk stratification and population segmentation at neighbourhood level
- Ensuring the Network Agreement is used to strengthen collaboration between practices and used as the formal basis for working with other community based organisations including community pharmacies and the voluntary, community and faith sector.



	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level	**Practices** identify partners for network-level working and develop shared plan for realisation.	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place.	**Network business model** fully operational. **Interoperable systems** Workforce shared across network. Rationalisation of estates.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** in place throughout system and formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites.	**Fully functioning integrated teams** in place across whole system including general practice, access to secondary expertise, nursing, community services, social care and voluntary sector. Care plans and coordination in place for all high risk patients.
Targeting care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups.	The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system.	**Systematic population segmentation including risk stratification**, with in depth under-standing of needs of each population segment. Routine peer review of metrics in and between networks. **New models of care in place to meet needs of all population segments**. Internal referral processes in place.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen.	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding.**. Data being used at individual clinical level to make best use of resources.
Empowered Primary Care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

Fig 2. NHS England Primary Care Network Maturity Matrix

A Network Contract DES will be in place from 1 July 2019 which will provide further significant investment to enable expansion of the workforce in return for service delivery against national specifications. This will provide a mechanism in future for the commissioning of enhanced services and for funding to flow through into primary care. The approach to commissioning in this way will be tested for wound care delivery from April 2019 and the proactive care service specification over the next 12 months will move towards a network approach.

Longer term networks will be offered a “shared savings” scheme so that they can benefit from actions to reduce avoidable A&E attendances, admissions and delayed discharges, streamlining patient pathways to reduce avoidable outpatient visits and over medication through pharmacist review. We will work with Primary Care

Doncaster and the LMC to make the Long Term Plan a reality and implement the five year framework for the GP contract. This will include ensuring that all 40 practices in Doncaster register to participate in the Network Contract DES by 15 May 2019 which will include the signing of a Network Agreement and identification of a clinical director responsible for delivery. We will also support constituent practices and their Networks to access national development programmes provided by NHS England.

Case study: South West Proactive Care Nursing Team

The new proactive care specification builds on the learning from an innovative group of practices in the South and Central neighbourhoods that have built a joint service from scratch over the last couple of years that jointly employs a team of 4 proactive care nurses and a health care assistant to provide a high quality service across 8 practices. This service has demonstrated early improvements in health confidence scores, patient contacts with the practice and even unplanned care activity for the frail and vulnerable patients that it covers. Through pooling their resource, those practices have been able to deliver a service that is different to what they could have done on an individual basis, in what is effectively a primary care network and wholly in keeping with the principles of the Long Term Plan. The new specification has specific outcomes that will drive this kind of relationship building and collaborative working between practices and other health and social care partners in other parts of Doncaster.

Population Health Management

Commissioning in Doncaster is focused around a population health approach which aims to improve the health of the entire population. It is about improving the physical and mental health outcomes and well being of people whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill health including the wider determinants of health and requires working with communities and partner organisations.

Population health management improves population health by data driven planning and delivery of care to achieve maximum impact. It includes segmentation of the population, risk stratification and impactability modelling to identify at risk cohorts and in turn design and target interventions to prevent ill health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

The approach is developing with the aspiration that it can be used at a number of levels to improve the delivery of health and care services. Population health management can be used to help personalise individual care according to need and at a neighbourhood level support targeted delivery at a Doncaster wide level population health management techniques should inform integrated care design and integrated care through multidisciplinary team/network approaches.

Multiple sources of data are being pulled together to develop a picture of the population and their needs. Community profiles for each neighbourhood are included in Appendix (1)

Data relating to primary care provision is contained within the primary care matrix.

The Primary Care Matrix was built to enable NHS Doncaster Clinical Commissioning Group to understand the variation in behaviour between GP Practices in Doncaster. The intention was to provide the organisation with insight into struggling organisations at an early stage, allowing the CCG to support the GP Practice before significant risk occurred.

The process combines a number of data elements ranging from patient experience to hospital admissions which are then grouped into 'domains' and 'demographic tiers'. Once this is complete, the data is analysed using statistical process control (SPC).

Statistical process control is a method that allows the Clinical Commissioning Group to see how activity spreads between all the various organisations. By seeing the data in this way, we are able to see if an agenda requires a system wide change to drive improvement or simply a more targeted approach at specific organisations that operate out of the common range. We are also able to see which GP Practice outlie more than others, providing NHS Doncaster CCG an indication of potential risks at organisational level or convert the data into vital heat maps to understand the information at a geographical level.

Internal process such as evaluation groups, committees or project boards at NHS Doncaster Clinical Commissioning Group can utilise this information along with support from GP Practices (where appropriate) to gain a better understanding of the barriers within General Practice. Also, Primary Care organisations such as GP Practice can use this information when comparing themselves to peers as all the information is published via web based system available on the N3 network.

From 2019 we intend to continue to develop the Primary Care Matrix and all of its data aspects. Over the next two years, we intend to rebuild and package the process and architecture to enable NHS Doncaster CCG to offer the system to other Clinical Commissioning Groups. Also, a redesign on the customer (or user end) of the website will provide insight into statistical process control as currently this method is only used internally.

We will also continue to evolve the evaluation process, which enables NHS Doncaster to speak to GP Practice directly that deviates from the Doncaster average. A forward operating plan for this group will ensure a consistent approach over the next year and inclusion of Public Health colleagues will ensure a greater joint approach in regards to both health and social care.

Finally, the Primary Care Matrix will offer a more secure and reliable way to receive information from General Practice in regards to (but not limited to) Local Enhanced

Service Claims. This development alongside the growing PowerBi platform will increase the quality and effectiveness of intelligence available to Primary Care.

Improving Access

The extended access service is commissioned from Primary Care Doncaster and delivery is through extended access hubs in each neighbourhood on a Saturday morning, through inclusion health clinics for people who experience difficulty in accessing primary medical services, access to First2Physio services and additional capacity at the Same Day Health Centre.

An evaluation of the first six months of the service will start to inform where improvements to the service can be made in terms of appointment utilisation. There is a requirement to increase utilisation to 75% by March 2020 from the current position of just over 40%. The number of appointments available is also set to increase from November 2019 in line with national requirements to 45 minutes per 1,000 population meaning an increase from 160 to 240 hours commissioned in Doncaster.

> Julia Burne, Health Ambassador for Asylum Seekers and Refugees and a Co-ordinator at the Doncaster Conversation Club is quoted in Healthwatch Q1 report on patient feedback and information regarding the Extended Access Service:
>
> "*....Those attending are pleased with the service as the doctors attending are interested and flexible to the needs of the patients. The initiative has been particularly helpful for new arrivals as they often have a delay in accessing health services through generic services....*"

From 2021 the Primary Care Networks will be responsible for a core access offer to their patients which will include the extended access DES as well as the extended access service.

At the same time Doncaster falls below national averages in the GP Patient Survey in relation to access to primary medical care during core hours. An ongoing review of core hours access in line with NHS England guidance on reasonable access will conclude in 2019/20.

A focus on access in our public engagement work will help us to make improvements where needed, to support public acceptance of accessing services appropriately and understanding patients own obligations with regard to cancelling unwanted appointments.

Starting Well

Starting well is the local term to define all aspects of the children and maternity agendas and sits within the strategic framework of the Doncaster Children and Young People's Plan (2017 -20). This plan marks a significant step forward in our

collective efforts driven by the goal of being the most child friendly Borough in the country.

Responsibility for the lives and well-being of children across Doncaster rests primarily with their families and carers, who are supported by Doncaster Council, Doncaster Schools, Doncaster Children's Trust, St Leger Homes, South Yorkshire Police and the NHS. The efforts of these agencies, together with families and carers are critical to children staying safe, being healthy and achieving.

The Children and Young People Plan is a partnership plan with an agreed set of priorities and collective responsibility for improving outcomes for Children and Young People. These outcomes are measured and grouped as follows:

- Staying Safe
- Being Healthy and Happy
- Achieve and Equality

The partnership has agreed on some key themes, which are captured in the plan. These are as follows:

- Listen to what Children and Young People have told us is important to them, and improve outcomes in these areas.
- Adopt new ways of working that builds resilience in Young People, their families and communities.
- Place a renewed focus on social mobility and how services enable Children and Young People to get on.

The plan sets out how the overall ambition for Children and Young People translates into action, and how we can assess the impact we are having. It sets out the priorities, who will do these and how we will measure these over the life of the plan. It acts as the overarching document that directs strategic commissioning across the partnership.

There is a drive to develop a more area based commissioning focus, which fits with the concept of Primary Care Networks. To this end there are a number of activities in primary care that will contribute to delivering this intention:

- Engaging with partners to think how best the starting well agenda can be included into Primary Care Networks
- Explore if the concept of area based commissioning fits within the networks or if new commissioning hubs could be established
- Agreement to share local knowledge to feed into wider system thinking.
- Agreement to explore data sharing agreements
- Ensuring connectivity to the wider system
- Piloting new paediatric hubs
-

Living Well

The neighbourhood approach described in this strategy resonates with the commissioning intentions outlined in the first Health and Social Care Commissioning strategy for Doncaster whereby people are encouraged to engage with community neighbourhood support to manage aspects of their health and well being.

This life stage involves a wide range of services that we commission for people aged 18-65. It also includes an intention to ensure that where services are required they will be readily accessible and responsively matched to people's level of need and access will be co-ordinated to enable people to be proactively signposted and avoid handoffs. There are five strands to the commissioning approach described as:

- Low level interventions based in neighbourhoods
- Co-ordinated access to services when they are needed
- Holistic delivery of care and support
- Responsive and accessible care in a crisis
- Person centred support for people with complex needs

To this end there are a number of activities in primary care that will contribute to delivering this approach:

- Delivery of the universal personalised care model to ensure person centred care including strengthening social prescribing and community based support delivered through Primary Care Networks.
- Roll out of the new social prescribing model from 1 April 2019
- Development of closer links with stronger communities and the third sector to enable people at risk to be identified such as those suffering from social isolation. Loneliness and social isolation are significantly harmful to people's health and research shows that lacking social connections can be as harmful as smoking 15 cigarettes a day, (*Holt-Lundstadt et al (2010) Social Relationships & Mortality Risk: A meta-analytic Review)* therefore this approach is of real importance and is a priority in the Primary Care Delivery Plan for 19/20
- Piloting of community participation groups
- Care navigation at the point of enquiry to a GP practice to a more appropriate service such as a dentist, IAPT, social prescribing or minor ailments.
- Ongoing development of the GP Find Tool to enable GPs and others to quickly and easily identify appropriate services for patients and refer on effectively.
- Access to consultant advice and opinion via Consultant Connect.
- Optimising the use of the extended access services delivering additional GP and nurse appointments in order to further support service integration such as enhanced physical health checks for people with severe mental illness which require general practice and RDaSH to work closely together.

- Direct referral from NHS 111 to community pharmacies to support urgent care and promote patient self-care and self-management.
- Developing the role of community pharmacy so that it becomes the front door to primary care offering health promotion and prevention advice and support, self care advice and support and the treatment of minor ailments.
- A review of enhanced services to ensure services are delivered as close to the patient as possible and are value for money.
- Better management of people in crisis at the point of presentation reducing the reliance on secondary care. GP practices have a pivotal role in supporting someone in difficulty through the NHS 111 pathway.
- Supporting the co-location of IAPT services with primary care and extending service provision to enable an additional 2,000 people to be supported over the next two years
- Participation in the evaluation of IAPT support on patients with physical health conditions with a view to extending the number of conditions supported.
- Provision of additional resources and early intervention in the care of people with psychosis.

Ageing Well

The CCG has formally commissioned a Proactive Co-ordinated care service since 2016 to cover a minimum of 2% of a practice's frail, vulnerable or otherwise complex patients. The specification has been further refined and extended for another two years with clear outcomes to achieve. In the second year it is likely that the service will be commissioned on a network basis. Through this service practices are already routinely identifying people with severe frailty and care planning to meet their needs.

The Long Term Plan requires primary care networks from 2020/21 to assess their local population by risk of unwarranted health outcomes and working with local community services make support available to people where it is most needed. Using a proactive population approach outlined above and focused on moderate frailty will enable earlier detection and intervention to treat undiagnosed disorders such as heart failure. People identified as having the greatest risks and needs will then be offered targeted support with integrated primary and community teams working with people to maintain their independence.

Increased diagnosis and care planning for patients with dementia is part of the proactive care approach. A deep dive of primary and secondary care recording and case finding will be undertaken to ensure improvements are made. This will include an examination of thresholds and pre-referral criteria.

We are also working on a community care model for care homes, it is likely that a national enhanced health in care homes service will be developed and rolled out in 2020/21.

Enablers

GP Contract Reform

2019/20 will be a transitional year to embed new ways of working through the Network Contract DES which will be introduced in July 2019. We will work with practices and our partners as well as NHS England and the ICS to ensure the implications of the framework are understood locally including understanding of the state backed indemnity scheme which is to be introduced in April 2019 and the requirements relating to a phased approach to expansion of the primary care workforce.

Working with the LMC we will examine the new Quality Improvement Modules within the QOF framework to ensure that any duplicative funding is reinvested. In 19/20 the review will cover prescribing safety and end of life care. We will also review the seven national service specifications as they emerge during 2020/21 for the same reason.

Technology

We will continue to support practices to increase the number of patients using online services to reduce the burden on them in relation to appointment booking, issuing prescriptions for repeat medication, using electronic repeat dispensing and providing access to full medical records and online correspondence

The Long Term Plan promises that by April 2021 every patient will have a right to online and video consultations. The procurement process for South Yorkshire and Bassetlaw has commenced with systems to be rolled out during 2019/20.

NHS England North region commissioned the Apex tool providing workforce and workload data for each practice, this is also in the process of being rolled out across South Yorkshire & Bassetlaw. This will provide practices with valuable information about managing their workload and workforce data which can be analysed on a Doncaster wide basis.

There are a number of programmes of work that need to be borne in mind in the development of primary care and the impact on technology must not be ignored. The new GP IT Operating Model requires all practices to sign new CCG/practice agreements by December 2019. All devices will be upgraded to windows 10 by January 2020 and any linked equipment will need to be compliant.

The standards for paper light are being reviewed to reflect the digitising of the NHS record, faxes are to be removed from use for NHS purposes by April 2020 and links are being made with GP systems and care homes. There will be ongoing development and increased access to the integrated Doncaster Care record, the HSCN programme will replace N3 connections across the NHS and the launch of the

NHS App will change the way people find out about services and navigate the system.

Practices will need to ensure that at least 25% of appointments are available for online booking by July 2019 and that NHS 111 will have access to 1 appointment per day per 3,000 population for direct booking in 19/20.

Primary care will also play a part in the digitising of maternity records and the National Diabetes Prevention programme will have a digital option when it is relaunched in the summer.

The evolving new ways of working in primary care need to be supported by technology and we will seek ways of supporting primary care staff to work agilely where they need to.

The CCG will also offer a Data Protection Officer function which aligns to the LMC DPO role.

Estates

The first primary care estates strategy for Doncaster was published in November 2018 and work is progressing to ensure that this strategy is effectively implemented. (http://primarycare.doncasterccg.nhs.uk/dccg-pc-estates-strategy/) to:

- Ensure best use of LIFT buildings and the primary care estate
- Ensure statutory compliance
- Take forward priorities identified for development
- Links are made with wider estates priorities within the borough and that community assets in neighbourhoods are utilised effectively

Workforce

Primary Care Doncaster were commissioned by the CCG in the summer of 2018 to gather workforce data and to develop a workforce strategy. This strategy is now finalised and available on the PCD website: https://www.primarycaredoncaster.co.uk/about-us/organisational-aims/

Key actions identified for the CCG include providing a coherent framework for service redesign and providing support to access national workforce schemes.

We will also support practices and networks to secure training places in order that there is a growth of new doctors, nurses and other professions training and remaining in Doncaster.

We will encourage and support Primary Care Networks to expand and develop the workforce in line with the GP Contract framework. This will include helping to promote primary care as an attractive career choice and working with Primary Care

Doncaster and the South Yorkshire & Bassetlaw Training and Workforce Hub, maximising opportunities to recruit and retain staff within primary care.

By 2019/20 we will have developed and published a Doncaster protocol for a retained doctor scheme to ensure that support is provided where it is needed both for the individual doctor and practices requiring additional clinical capacity.

Finance

Significant additional investment is promised through the NHS Long Term Plan to:

- Support practice sustainability through increases to the global sum
- Continue programmes funded through the GP Forward View such as particular workforce and resilience programmes
- Direct funding through a Network Contract DES to increase workforce capacity, deliver new national service specifications and support infrastructure development as well as supporting the planning and achievement of better performance against identified metrics.

However this is within the context of increasing financial pressure across the health care system and it should be recognised that primary care has an important role to play in ensuring efficiency and increasing productivity as well as reducing pressure on the secondary care system and improving the overall cost effective use of NHS resources.

Wider primary care

Eye Care

NHS England commissions NHS sight tests from any suitable provider under the national general ophthalmic services (GOS) contractual arrangements. NHS England is also responsible for ensuring domiciliary sight testing is provided.

It is the role of the CCG to commission services from community optometrists for the provision of community ophthalmic services under local commissioning arrangements.

To this end, a range of community eye care services are in the process of being commissioned these are:

- Minor eye care service – to support the navigation of eye problems to optometrists instead of GPs. Patients to be triaged and either treated or referred appropriately to Hospital Eye Services
- Stable glaucoma monitoring service – to reduce the pressure on secondary care
- Intraocular pressure referral refinement – to reduce false positive referrals being made to secondary care

- Children's post vision screening service – to ensure an integrated service is delivered between all local providers of the pathway. Local optometrists will screen out referrals not requiring secondary care input.
- Direct cataract referral service, will reduce GP involvement in cataract referrals. Mandated use of the South Yorkshire & Bassetlaw Commissioning for Outcomes checklist increases patient awareness of the options available to them before they opt for cataract surgery. Furthermore a new post operative follow up service will be introduced within community optometrists to save follow ups in secondary care.

It is recognised that eye health services have a relatively low profile but involve a high volume of patient episodes. Commissioning effective and efficient services is a way of reducing avoidable sight loss. Eye health problems and sight loss increase with age and it is estimated that 50% of sight loss is preventable.

There is ongoing significant pressure on the hospital ophthalmology department therefore the commissioning of local services should help to reduce pressure on secondary care, reduce waiting times and make patient care more accessible in neighbourhoods as well as supporting the ageing well life stage and saving the NHS money. It will also ensure that secondary care expertise is spent on care that cannot be treated elsewhere and that the primary care workforce is upskilled and services are better utilised in a local setting.

It is important that the role that optometrists can provide in integrated community health services is recognised. It is crucial therefore that there are ongoing opportunities to engage with the profession through the Local Optical Committee, local professional networks and the South Yorkshire & Bassetlaw ICS to maximise the opportunities in this area.

Dental Care

NHS England has a statutory responsibility to commission all primary, secondary, tertiary and community NHS dental services. Local Authorities are responsible for: the provision of oral health improvement programmes to improve the oral health of the population; the provision of oral health surveys; and the power to make proposals regarding water fluoridation schemes and a duty to conduct public consultations in relation to these where required. The most common diseases of tooth decay and gum disease are entirely preventable. Although there has been a reduction in tooth decay over the last 30 years, there are still areas of Doncaster which experience very poor oral health. According to the oral health needs assessment for Doncaster, 31% of 5 year old children experienced tooth decay in 2015 which is higher than the national average of 25%. Children in the most deprived areas had tooth decay levels around 3 times higher than in the least deprived areas.

The extraction of teeth under general anaesthetic due to tooth decay is the most frequent reason for hospital admission in children aged 5-9 years in England. In 2016/17 Doncaster had the highest level of extractions for tooth decay in the country for 5-9 year olds.

There are 38 NHS general dental practices distributed across the borough, of which: 1 also provides domiciliary care for the whole of the borough; 1 also provides minor oral surgery; and 7 of which also provide some orthodontic care. 1 practice provides purely NHS orthodontic care and 1 provides both NHS orthodontic care and oral surgery. There is no database of practices offering private dental care, however many NHS dental practices also offer an element of private care. In addition, there are also around 6 fully private general dental practices. The community dental service runs from a base and 3 satellite clinics at Mexborough, Thorne and Balby; and secondary care dentistry is provided at Doncaster Royal Infirmary.

Despite the relatively poor oral health in Doncaster, access to NHS dental services is good and rates for both children and adults accessing dental care are consistently higher than the national average. Urgent dental care is accessed through telephoning NHS111. Patients are triaged and booked into urgent dental care with various providers commissioned across South Yorkshire, including The Flying Scotsman in Doncaster town centre.

An Oral Health Improvement Advisory Group has been established in Doncaster to develop and review the oral health action plan, to keep it updated and monitor delivery. It considers the part that each partner organisation can play in preventing oral health problems and therefore unnecessary hospital admission particularly for extractions of decayed teeth in children. Current oral health improvement programmes commissioned by Doncaster Council include: a supervised tooth brushing scheme; universal provision of oral health packs through health visitors, oral health and nutrition training, Healthy Living Healthy Lives oral health accreditation, and distribution of oral health packs to families attending Doncaster Royal Infirmary for dental extractions.

It is important that oral health needs are included in care plans for the most vulnerable patients including those in residential care homes, and that there is collaboration through integrated neighbourhood working to facilitate oral health improvement. We will continue to ensure that GP practices and pharmacies: know how to recognise common oral problems; sign post to NHS Dental care through care navigation and the NHS.uk website; and promote consistent oral health messages in line with national PHE guidance (e.g. Delivering Better Oral Health, PHE 2017) . We will also work with NHS England's South Yorkshire and Bassetlaw Local Dental Network, and Oral Health and Access to Dental Services Improvement Group to identify opportunities for person centred care particularly for the most vulnerable patient groups for example through the extended access inclusion health service.

Pharmacy

An increasing role for community pharmacists and clinical pharmacists in general medical practice is recognised throughout this strategy. Community pharmacy as the front door for primary care minor ailments is the vision for the future so that general medical practice capacity can be freed up to care for more complex patients. Pharmacists can also provide patients with support to self care and provide prevention support and advice.

Currently the CCG commissions four enhanced services from community pharmacies:

- Minor ailments service – this will require review due to the over the counter consultation referred to earlier in this strategy
- Palliative care drugs
- Inhaler technique
- Pharmacy Urgent Repeat Medicines (PURM)

We will continue to work with the LPC to review and strengthen our investment in community pharmacy including a review of these enhanced services to ensure that the vision articulated in this strategy can be realised.

Included in the NHS Long Term Plan is a case study of an NHS 111 Pharmacy Scheme reducing pressure on the wider health community which has been running in the North East and is due to be extended:

A NHS pharmacy scheme is speeding up access to clinical advice for patients, as well as reducing pressure on the wider health system. The Digital Minor Illness Referral Service enables trained NHS111 health advisors to refer people with minor health concerns to their chosen pharmacy for a clinical assessment and same-day booked consultation with a pharmacist, during the day, at the weekend and out of hours.

Evaluation of the scheme found that minor illness cases referred from NHS 111 to in hours GPs fell from 70% to 40%.

Conclusion

This strategy identifies a number of actions that need to be taken forward over the next two years as well as providing insight in to a longer term plan. A Primary Care Delivery Plan will sit within the overarching Living Well plan. The Delivery Plan underpins this strategy and provides details of the programmes of work to be undertaken, the key milestones and outcomes each action aims to deliver. The primary care delivery plan is available on the CCG's primary care website http://primarycare.doncasterccg.nhs.uk/.