

North Durham Primary Care Strategy

Vision

General Practice as partners leading healthcare for the people of North Durham

1.0 Context

There are many factors affecting the direction of travel for primary care services over the next five years, not least the growing financial pressure being placed on the NHS. There is a greater demand on services due to an ageing population with more complex health needs as well as increasing patient expectation and fewer resources available to deliver services. Indeed within the North Durham area there has been an increase in population size of 7.2% between 2001 and 2013.

It is estimated that general practice delivers around 90 per cent of NHS contacts meaning even a slight patient shift from primary to secondary care would put unmanageable pressure on the system (*NHS Employers, 2014*). Nationally there is a drive to move services into the community and closer to home where appropriate. The Five Year Forward View outlines new models of care which are centred on the ability of primary care to have the capacity and capability to deliver services at scale.

North Durham CCG has always had a role to play in driving up quality within primary care and now the CCG has responsibility for commissioning general practice. This strategy will begin to identify the challenges now and in the future and outline the vision for ensuring successful and sustainable primary care is commissioned and delivered within North Durham. The primary care strategy will also need to be viewed in the context of other work programmes i.e. urgent care and frail elderly.

1.1 Case for Change

Workforce

As at September 2014 there were 176 whole time equivalent (wte) GPs within North Durham. Evidence is also emerging from the NHS Information Centre that the GP workforce is now shrinking rather than growing. Whilst the number of GPs per

100,000 head of population across England increased from 54 in 1995 to 62 in 2009, it has now declined to 59.5.

It is most concerning to note that nationally 54% of GPs over the age of 50 are intending to quit direct patient care within five years. A recent study within North Durham (2013) found that 40% of the primary care nursing workforce is due to retire in the next ten years.

Quality

There are a range of measures used to measure quality within primary care including; the Quality Outcomes Framework (QoF), patient surveys, practice profiles (PHO), and the Friends and Family Test.

We can also measure the quality within general practice across North Durham by looking at the primary care outcomes tool. As an overview of the overall picture in terms of quality it outlines 18 achieving and 9 higher achieving practices. As a CCG we can identify (using this tool) areas which require further quality improvement. Some examples include the need to further increase the levels of identification for conditions such as Atrial Fibrillation (AF), Chronic Obstructive Pulmonary Disorder (COPD) and Coronary Heart Disease (CHD). Also the rate of emergency admissions for those with a long term condition is slightly above the NHS England average (57.39% and 58.88% respectively).

In the 2013/14 financial year North Durham practices achieved 96.31% attainment of the Quality and Outcomes Framework (QoF) compared to the Durham, Darlington and Tees sub-region of 95.81%

The friends and Family test was introduced into general practice in 2014 and as at December 2014 85% of respondents extremely likely and likely to recommend their GP practice to a friend or family member.

1.1.2 Our People and Place

Within North Durham there are 31 practices and the total registered list size for North Durham is 252,565 (HSCIC, April 2015). By using national figures, we can estimate that approximately 2400 people are seen every day in general practice within North Durham. The average payment made to general practice per patient across North Durham is £137.12 compared to a national average of £136.

Derwentside comprises a mixture of urban, semi-urban and rural areas with the population concentrated in Stanley and Consett. Durham and Chester-le-Street cover a mixture of rural and urban areas with two main population centres, Durham City and Chester-le-Street. The University in Durham is home to a large and internationally diverse student population. There are significant variations in health across these three areas.

People who live in the North Durham area have significant health challenges and problems. They are also more likely to die sooner than those living in other parts of the country. The main causes of early death include high levels of cancer, cardiovascular and cerebrovascular diseases.

With an ageing population, we will also experience greater demand for hospital services and an increase in illnesses related to older people such as stroke, long-term conditions and dementia. The large student population in Durham City results in a demand for sexual health, alcohol and harm reduction services.

Other key challenges facing North Durham include:

- Reducing lifestyle risk factors such as smoking, alcohol, obesity
- Economic inequality related to unemployment and low incomes
- People with disabilities have worse health than those without
- Children's health and lifestyles are poorer than elsewhere in the country

Population

Overall, the population of North Durham CCG (6.8%) has grown at a much quicker rate than County Durham (4.0%) or NE region (3.2%) over the last ten years. Specifically this can be seen in Durham (7.6%) and Derwentside (7.8%).

Life Expectancy

The healthy life expectancy for County Durham is significantly worse for both males (58.7) and females (59.4) than for England (63.4 and 64.1 respectively).

Health Inequalities

Health inequalities exist between County Durham and England. For example: Life expectancy for men living in County Durham is 1.3 years less than the England average. For women it is 1.5 years less than the England average (at birth 2010-12).

Premature Mortality

Premature mortality rates from all cardiovascular diseases (2010-12) in County Durham (92.4 per 100,000) are significantly higher than England (81.1 per 100,000).

Disease Prevalence

- CHD prevalence in County Durham (4.9%) is higher than England (3.3%)
- Diabetes prevalence in County Durham (6.8%) is higher than England (6%)
- COPD prevalence in County Durham (2.7%) is higher than England (1.7%)

2.0 Strategic Objectives

Our overall vision within the CCG is to **'Improve the health of North Durham'** we need to understand how general practice contributes to this vision.

North Durham CCG has four strategic objectives; our primary care strategy is aligned to these in terms of how primary care will contribute to the delivery of the CCG's vision.

1. Improving the health status of the population.
2. Addressing the needs of the changing age profile of the population.
3. Commissioning clinically effective, better quality services closer to home.
4. To make best use of public funds to ensure healthcare meets the needs of patients and is safe and effective.

Aligned to these are North Durham CCG's primary care objectives which will be used to develop primary care to ensure its fit for purpose now and in the future;

- To develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home.
- Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care.
- Commission clinically effective planned and unplanned out of hospital care.

To develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home

Workforce and Training

Invest the PMS premium over the next five years into workforce within general practice such as GP posts e.g. joint posts within urgent care and diabetes, primary care nursing, career start for GPs as well as nursing, extending the role of nurses and training.

We will actively plan our workforce to look at future demand including population growth and other factor such as working patterns and retirement and plan for this demand.

We will promote North Durham CCG practices as a great place to work and we will link into universities to attract the newly qualified workforce.

We will work with GP and nurse tutors to develop a rolling programme to ensure that staff training needs are met and to enhance workforce skills particularly in relation to long term conditions. We will align this programme to CCG commissioning priorities.

We will develop primary care teams as CCG leaders

We will work with Health Education North East to maximise the impact of any workforce related programmes.

We will develop and support our existing primary care teams, e.g. via Protected Learning Time

We will address the need to use a multidisciplinary model to support and develop the use of non-medical prescribers as part of the primary care team (nurses and pharmacists). In particular we will identify the associated challenges such as training and work with HENE to mitigate against these.

Premises
Develop a primary care estates plan which takes into account changes in population and changes in ways of working
We will develop an investment plan in line with the national capital programme for primary care premises to ensure need is met.
We will identify practice premises that are in greatest need and prioritise support to those.
Informatics
We will develop functionality to deliver mobile working.
We will support the delivery of interoperability between systems across health and social care.
We will further develop the utilisation and effectiveness of a central communication system.

Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care

Federated working
By the end of 2015-16 all practices within North Durham will be working as part of a federated model
The CCG will support federations to set up and develop into successful primary care provider organisations.
The CCG will work with federations on an ongoing basis to share ideas and ensure two way communication is in place
In line with the Five Year Forward View, the preferred model for primary care to be part of is Multi-Speciality Community Providers (MCP). North Durham CCG will facilitate and commission from trusts, other partners and primary care organisations that develop these new models of care by the end of 2016-17.
Engagement
We will effectively engage and consult with general practice via a variety of means including the constituency lead model, the Director of Primary Care role and through the central communication system as well as formal Council of Members meetings.
We will play an active role in supporting the Protected Learning Time (PLT) work programme which will include time dedicated to them as commissioners.
We will ensure that our member practices are involved in the priority setting process.
We will strive to ensure that member practices think of the commissioning organisation as “our CCG”.
We will engage with our local community about primary care services through our engagement model including Patient Reference Groups and the Patient, Public and Carer Engagement Committee.
Patient safety, experience and quality
We will continue to support general practice in terms of the implementation of the Friends and Family Test, and specifically in relation to the patient experience kiosks.
We will ensure that quality is monitored and actively managed within primary care using national tools and supporting practices to develop. The aim is to reduce variation, NICE guidance implementation and to ensure patient safety, experience and effectiveness of care is delivered.
We will support GP practices through the CQC process.

Commission clinically effective planned and unplanned out of hospital care

We will review the out of hours specification and recommission a service to meet the demand and needs of unplanned care provision. The service will also support patients to be cared for in their own home.

We will commission seven day primary care services tailored to those with the greatest health need

We will support primary care services to manage long term conditions such as diabetes, mental health, palliative care and cancer, with the aim of moving more care closer to home.

We will engage with public health to support the delivery of the prevention agenda through primary care.

We will evaluate the primary care outcomes scheme and commission those schemes as part of the mainstream commissioning agenda which have made an impact. Such services will be commissioned across the CCG area.

We will wrap community, social care and mental services around primary care services to deliver an integrated service for patients.

3.0 How will we know we have made a difference?

- There will be an increase in the primary care workforce and there will be fewer under-doctored areas within North Durham.
- There will be an increased proportion of commissioned services within the community compared to secondary care.
- Patient satisfaction (measured as part of the Friends and Family Test) has improved within primary care for North Durham
- Tailored seven day services are in place

North Durham Primary Care Strategy Implementation Plan

Background and scope

The North Durham Primary Care Strategy was shared with Practice members in July 2015. The following is a draft implementation plan identifying the programme of key work streams in which to take it forward.

In drawing up this implementation plan it is important to acknowledge that the Primary Care Strategy forms the basis of an overall integrated strategy for 'Out of Hospital Care'.

The Vision

- To develop a fit for purpose workforce and infrastructure to deliver Care closer to home
- To support General Practice to work with each other and with local people to deliver high quality, cost effective Primary Care
- To commission clinically effective planned and unplanned out of hospital care

To deliver that vision the CCG has **5 key strategic objectives for Primary Care**

1. To have high quality care services supporting 7 day working with additional capacity to support an out of hospital strategy
2. To have a service that strengthens the prevention and management of long term conditions
3. To have a service that co-ordinates the care for our most vulnerable patients eg The frail elderly and the dying
4. To secure quality of Primary Care Services and reduce variation
5. To involve Primary Care in a systematic approach to health improvement

To deliver these objectives, we believe that a stronger GP sector must have the following **key features**:

- Maintains the strengths of General Practice in terms of personalised, continuity of care to a registered population, when necessary
- Builds organisational capacity within General Practice at Locality level and an infrastructure to enable Cross Practice working
- Is bigger, wider and integrates seamlessly with social and community services
- Is aligned and works in partnership with Public Health
- Enables patients to feel engaged in their care
- Provides a rewarding and enjoyable place to work, enabling adequate recruitment and retention for sustainable services

To bring about these changes, the CCG will focus on the following initiatives to provide integrated services based on new operating models at Locality level. This will be supported by 'enabling' workstreams that help to build the infrastructure of Primary Care in those Localities.

Service Developments

1. Moving towards 7 day working and extending access to Primary Care
2. Developing a new model of care for Diabetes
3. Developing integrated services for the Frail elderly and dying
4. Driving up quality across Practices through a Quality Improvement strategy
5. Identifying and implementing a key role for Primary Care aligned to the Public Health agenda (Health and Wellbeing strategy)

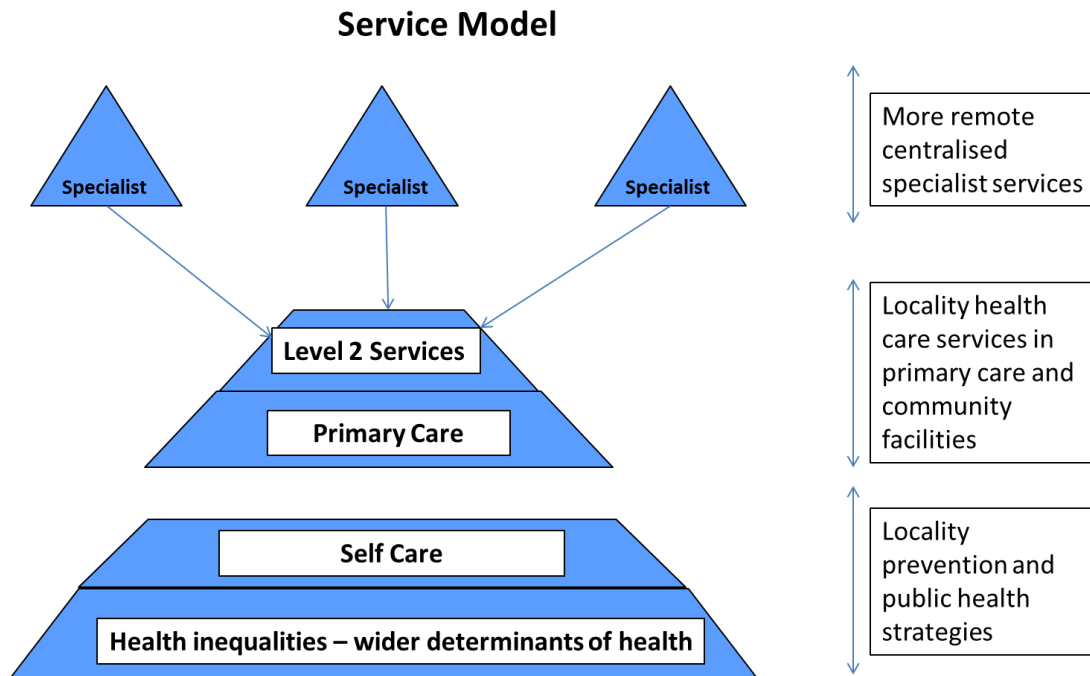
Infrastructure Developments

1. Building organisational capacity through the support and development of **Federations and scaled up General Practice**
2. Creating opportunities for increased capacity and development of the **Primary Care workforce**, including better integration with Community staff
3. Supporting **IT development** to find solutions that make services more accessible and joined up
4. Develops an **Estates strategy** that makes the most of current estate and looks for opportunities to develop the Estate to deliver the new service models

The remainder of this document looks firstly at the operating model of Locality working which forms the basis of our 'Out of Hospital Care' strategy in all our workstreams. It then takes each individual area and identifies the progress made so far and the work that needs to be done to take it forward.

Key to taking it forward is the continued engagement with patients, practices and other providers in building on the model and finding new solutions to old problems.

Key features of a new operating model for 'Out of Hospital Care'



Out of hospital care will be delivered and co-ordinated at locality level.

Local Practice Teams to provide continuity to their registered population supported by aligned community services consisting of designated District Nurses and Community Matrons to each locality.

Hubs within each locality to provide supporting services across Practices in each Locality.

This may consist of specialist clinical, specialist nursing, diagnostic, outreach, rehabilitation, out of hours services or even shared 'core' GP services .

Key elements at this level are :

- Cross practice working eg Out of hours services
- Integration between social and community services, eg Intermediate Care + (IC+) services
- Vertical integration between Acute, Community and General Practice services. Eg Diabetic clinics

These hubs may be based at specified practices or community locations depending on the PC and community estate or historical agreements at locality level, hence the importance of an estates strategy to follow the service strategy.

Continuity of information through effective IT solutions is imperative to enable access to a single patient record where possible and effective working across practices and community services.

A co-ordinated approach to improving health and wellbeing can be planned, contracted and integrated at practice or community level wherever is best accessible for patients.

Federations (or other models of scaled up General Practice at Locality level) will be perfectly placed to take the lead for some, or all, of these services, either providing them as a Provider organisation themselves, or working with other Organisations within a Multi-speciality Care provider model.

Service Developments

Moving towards 7 day working and extended access to Primary Care

Update

- A review of Urgent Care services and out of hours services is underway with notice given to the existing Provider (CDDFT) of the CCG's plan to re-procure the Out of hours element with an updated service specification. This will require a disaggregation of the contract between North and South Durham to identify the financial envelope to re-invest in a model going forward.
- In line with Government policy, there is a drive to move towards 7 day working and extended weekday working as part of the core GP contract. The Prime Minister has recently announced a new 'voluntary' GP contract that will be in place by April 2017 that requires GP opening from 8am to 8pm during both weekdays and weekends. The detail of this is not yet available but it will be delivered and contracted for through Federations enabling new models of working across practices in geographical localities.

The timescale to define a new model of working and contract for its implementation is by April 2017 when the first examples of new models will go live.

- In addition to this the new Vanguard project across the North East and Yorkshire will drive initiatives as to how locality models of urgent care services integrates with a cross region model of working.

For example:

- Central data collection and monitoring of demand
- Better self care and education of use of services
- Future use of 111 as a point of access for urgent care or advice, including availability of GP appointments
- Integration with ambulance and paramedic services



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- Fewer, but more specialised centres of Accident and Emergency care through new payment models
- More accessible integrated care 'out of hospital service' at a Locality level

Next steps

1. There is a CCG working group set up to take forward the Urgent Care strategy which will co-ordinate its implementation going forward, anticipating the key role 'Urgent Care' will play in a wider 'Out of hospital' strategy in each Locality.
2. The CCG will work with each Federation (as part of their Organisational Development plan) to define a model of 7 day working for General Practice in each Locality which will describe aspects of how that service may be provided.

Where, when, how, who

3. Consult with patients and the public about emerging models of access to 7 day services at locality level.
4. Work with other Providers as to how this integrates with other 7 day working strategies eg Community Matrons, IC+ services, diagnostics, new consultant contracts, A&E services.
5. Understand the financial framework (from disaggregation of the Out of Hours contract) and new Commissioning routes (new GP contract model, or Vanguard sites) that we can use to drive and implement new models of 7 day working.
6. Work with the System Resilience Group to understand the implications of the North East and Yorkshire Regional Vanguard initiatives.
7. Engagement with Practices, Federations and the Constituency leads is now paramount in how General Practice will work within this model to find an effective solution.

Implementing a new model of Care for Diabetes

Update

- A multidisciplinary working group has been working over the last 18 months to define a new locality model of working and the CCG has invested £450,000 in its implementation



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- The model is based around secondary and primary care, with supporting services, working together at a locality level to manage a defined cohort of patients
- Each locality will have a consultant lead, a specialist nurse and work with individual practices and their clinical leads either in practices or at locality hubs which are accessible for the patients
- The model will involve an integrated approach to prevention, diagnosis, surveillance, and intervention
- The model will also introduce new models of commissioning diabetes care and allocation of funds at practice / locality level

Next steps

- A Diabetes Governance Board is being set up to oversee the implementation across 7 Locality Groups in Co Durham (3 for North Durham) by Dec 2015
- Each group will :
 - Map out the baselines of care in each of their Localities, including registers, skills base, outcomes/current performance and patient cohort profile
 - Identify its priorities based on savings targets, practice baselines and investment allocations
 - Submit Practice investment proposals, via the Governance Board, to each CCG for approval
- Investment will be allocated to individual Practices , or Federations, according to agreed criteria

The next 6 months to April 2016 will focus on:

- Creation of a prevention investment plan, with Durham County Council, to align at all levels of the model
- Further education and ownership of the model at locality level.
- Prescribing campaign launched
- Benchmarking of Practice baselines
- Setting up 'Diabetic Groups' at each Locality level with agreed representation from the Practices (or Federation).
- Creating a plan for transition of current services for April 2016 going forward

Implementing integrated services for the Frail Elderly

Update

The model for the frail elderly has been developed at 4 different levels of care that together form an integrated pathway for the frail elderly patient. Its implantation is already well under way the elements of which will all be in place by early 2016.

Four levels of Care

1. Prevention and wellbeing

Public health and the Health and Wellbeing Board working on a strategy to reduce social isolation.

2. Practice level

Primary Care identifying a register of the Frail Elderly in each practice using agreed search criteria as a case finding tool.

Each Practice being contracted to assess all patients on this register in terms of frailty, risk of falls, cognitive assessment and medication review.

Each patient to have an Advanced Care Plan / Emergency Health Care Plan by March 2016.

According to need, to provide targeted proactive and reactive care using a case management approach on a multidisciplinary team basis where required.

3. Locality based services

- At Federation level, working across Practices to provide a weekend GP service to support those on the Frail Elderly register, and those in care Homes, providing reactive and proactive care alongside Community Matrons, to keep this vulnerable cohort of patients out of hospital or facilitate discharge where necessary.
- Community Services and Care Home provision
 - District Nurses are now aligned to specific Practices and specific Care homes
 - Investment in Community Matron capacity with CDDFT to align with existing District Nursing teams in Care Homes
 - Re-align named Practices to specific Care Homes to complete a clinical support team of GP, District nurse and Community Matron to each Care Home in a Locality
 - All Care homes to have completed Emergency health Care Plans for each resident by March 2016
- After April 2016 onwards

Full alignment of District Nurses to Practices and Care Homes, providing a range of proactive and reactive care on a case management basis, with integration of Community Matrons working at Practice level to a register of frail elderly patients both in Care homes and at their own homes.
- Locality based Multidisciplinary Intermediate Care Services

The IC+ 'Intermediate Care Plus'

 - Integrated support from specialist nurses, rehab teams and access to carer support, provided from a Single Point of Access (SPA)



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- This is now in place, allowing urgent intervention in a co-ordinated approach. This can arise from either a step up referral from the community, or a step down referral from hospital
- The service provides rapid access to an appropriate level of support to keep people out of hospital or facilitate discharge
- It is available 7 days a week, 24 hours per day

4. Linking with Specialised Elderly care Services

- Rapid Assessment Clinics
 - Daily Clinics Monday to Friday to provide same day / next day appointments for urgent medical assessments
 - Access via Single Point of Access service
 - Locations at Shotley Bridge and Chester le Street Community Hospitals
 - Providing full elderly assessment, access to diagnostics, therapy, medical opinion and onward referral if necessary
- Consultant Advice lines – Daily 12-2 pm
- Proposed Front of House Service – working alongside A+E at UHND to provide a consultant led service, providing urgent assessment to the frail elderly attending A&E, including diagnostics, access to therapy and IC+ services
This will be integrated with other Community support services described above through shared access to Community service and Social Service IT systems

Driving up Quality of Primary Care Services and reducing variation

Working with NHS England Area Team to:

1. Report Primary Quality using The Primary Care Web Tool
2. Improve reporting of serious incidents in Primary Care
3. Reduce variation of quality across Primary care
4. Ensure dissemination and uptake of NICE guidelines
5. Implement a Programme of audit work for quality improvement in specific areas
6. Review processes for improving quality in referral pathways



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7. Improve use of GP Teamnet across North Durham as an information management tool to enable dissemination of :
 - a. Updates , information and diary events
 - b. NICE guidelines
 - c. Clinical support information (CSI) guidelines
 - d. Medicines optimisation guidelines and newsletters
 - e. GP appraisal documentation.
8. Improve quality of prescribing through the prescribing incentive scheme and the Medicines Optimisation programme.
9. Explore potential for re-instigating the Quality Improvement Scheme at Practice level to re-engage Practices in areas of Quality Improvement.

(See Quality Improvement strategy update)

Introducing a systematic approach to Health Improvement

1. To work with Public Health and Federations to explore how Primary Care can work contribute to the Health improvement programme to provide solutions to reduce social isolation.
2. Work on Lifestyle schemes to reduce:
 - a. Smoking
 - b. Obesity
 - c. Cardiovascular risk through patient health checks
 - d. Low exercise rates
 - e. Mental illness
3. Improve self-management schemes for people with Long term conditions
4. Increasing screening and vaccination rates
5. Reducing Health inequalities and causes of ill health.

Developing the Primary Care infrastructure

Building organisational capacity through Federations

1. In North Durham we have 3 Federations based around 3 distinct geographical Localities:

Chester le Street	6 Practices	approx. 60,000 patients
Durham	8 Practices	approx. 100,000 patients
Derwentside	15 Practices	approx. 95,000 patients

Each area historically are used to working well with each other.

2. They are currently supported and resourced by the CCG through contracts to:
 - a. Develop an Organisational Development Plan to set up themselves as legal entities, Governance arrangements, capacity and a Business plan
 - b. To set up a weekend on call service for the Frail elderly
 - c. To identify other 'examples' of Cross Practice working
 - d. To deliver an example of Multi-speciality Care provision
3. Progress update.
 - All 3 Organisations are now set up as legal entities
 - Each will have completed an Organisational Development plan template to show progress after 6 months in existence (by end of October)
 - To date, the Weekend on call service of the elderly has only been set up in one locality. (Chester-le-Street)
 - Both others are keen to proceed but have been delayed due to CQC registration delays
4. Comments
 - Federation development is still in its infancy although each shows potential
 - Whilst gaining the support and credibility of their member Practices it is also important for the CCG that they become engaged with the objectives of the Primary Care strategy and we have an early success in what they can deliver

Creating opportunities for the Primary Care Workforce

1. PC Strategy group to oversee initiatives.
2. Work with HENE and the Federations to develop workforce plans for Practice Nurses and GP in each Locality, including a survey to understand the current situation and the position 5yrs from now to identify risks and potential gaps.
3. Work is in progress to set up a CCG funded Career Start scheme for GP's recruiting 5 new GP's to the area to work in designated Practices with GP mentor support. This is in addition to the continuing Career Start scheme for Practice Nurses which is an ongoing success at attracting more Practice Nurses onto a training and recruitment programme across Co Durham.
4. Explore other potential initiatives with HENE and other CCG's for recruitment, retention and use of other primary care professionals for alternative access to care. Eg Community Matrons and clinical pharmacists
5. An Education and Training steering group with an approved budget has been set up, bringing together GP tutors, Practice Nurse tutors and Locality representatives to develop a menu of education and training events that supports Primary Care professionals and their teams. This will include mandatory training such as Safeguarding adults and children training events, and GP and Practice Nurse 'Update' courses
6. Continuing Protected Learning times for practices, but aligning them to the same 3rd Thursday afternoon each month across all Localities. This provides protected time for Practices and individuals to focus on key areas of education. By aligning the timing of the PLTs, the CCG will facilitate 4 PLT's a year as a whole North Durham event to engage with Practices to take forward the Primary Care strategy.

Driving IT development

1. Set up an IT steering group including a NECS lead on IT development and identify SystemOne lead, EMIS lead and Community services representation.
2. To ensure 100% sign up to new GPSOC agreement by December 2015
3. The current 4 priorities within the National System implementation plan have now been technically implemented across 100% of Practices. These are:
 - a. Patient Online
 - b. GP2GP
 - c. Summary Care Record
 - d. Electronic transfer of Prescriptions (EPS2)

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4. Next steps are to map utilization of these functions and to encourage greater use and reduce variation across Practices..
5. Strong IT GP leadership has already seen the development of shared templates and recall systems across SystmOne Practices and community staff. Similar leadership needs to be identified for EMIS Practices so both can work together on sharing best Practice of the two systems
6. To identify priorities going forward including:
 - a. Work on specific IT solutions to enable 7 day working, joined up working in delivering the Frail elderly strategy , and the new Diabetic model.
 - b. Enabling Cross System accessibility to allow for Cross practice working and single input data entry for Community staff.
 - c. Improve mobile capability
 - d. Enable remote consultation and conferencing
7. Drive increasing use of GP teamnet as an information management tool for Practices. (See Quality Improvement Scheme)

Develop an Estates strategy that aligns with existing and developing services

1. Review existing work with NHS Property Services. – including the 6 facet survey of Practices and Community Estate in each Locality.
2. Work with Federations on a potential operating model/ service strategy in each Locality.
3. Define Estates requirements in each Locality, including best use of existing space
4. Explore opportunities for accessing funding for Estates development through centrally funded Primary Care Infrastructure Fund (£250 million)
5. Deal with new applications for funding as they arise, and identify criteria for making Premises investment decisions.

Next steps

Implementation of this strategy represents a challenging project agenda of transformational change that will require:

1. Engagement , communication and ownership with Practices and patients
2. Agreement of the new models of delivery of care in each Locality.
3. Support towards the organisational development of Federations , including ownership and engagement of the Primary Care Strategy as part of their Business Plans.
4. Creating effective commissioning models, new contracts and incentives to make it happen.

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