NHS
Northamptonshire
Integrated Care Board

Archus
The healthcare infrastructure specialist

# Northamptonshire Rural PCN Clinical Strategy

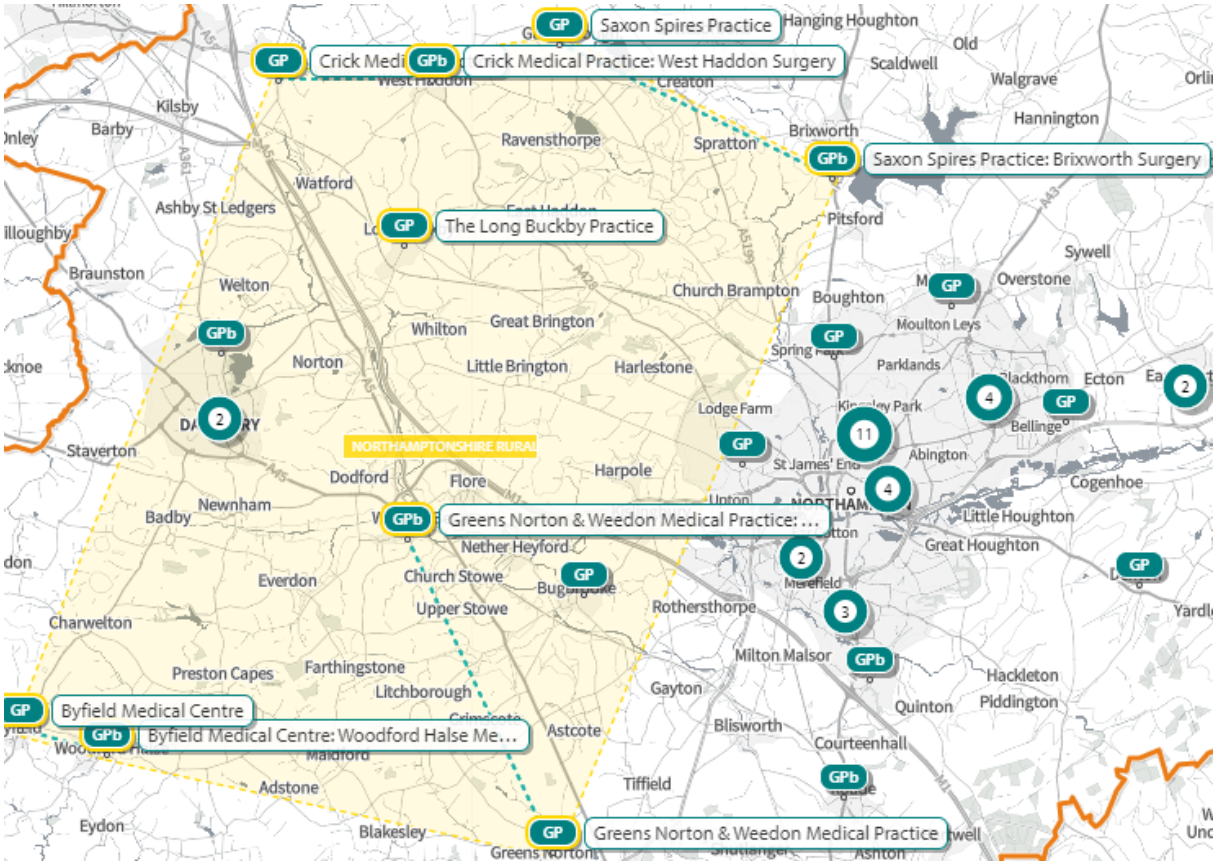
Contents

# Glossary of Terms

*Table 1: Glossary of Acronyms within the Clinical Strategy*

| Acronym | Description |
|---|---|
| A&E | Accident and Emergency |
| ARRS | Additional Role Reimbursement Scheme |
| CHD | Coronary Heart Disease |
| COPD | Chronic Obstructive Pulmonary Disease |
| CQC | Care Quality Commission |
| DES | Direct Enhanced Services |
| FTE | Full Time Equivalent |
| GP | General Practice |
| ICB | Integrated Care Board |
| ICP | Integrated Care Partnership |
| ICS | Integrated Care System |
| IMD | Index of Multiple Deprivation |
| LAP | Local Area Partnerships |
| LD | Learning Disability |
| LTC | Long Term Condition |
| LTP | Long Term Plan |
| MH | Mental Health |
| MSK | Musculoskeletal |
| NAPC | National Association of Primary Care |
| PCDG | Primary Care Data Gathering |
| PCN | Primary Care Network |
| QOF | Quality Outcomes Framework |
| SMI | Severe Mental Illness |
| TIA | Transient Ischaemic Attack |

# About Northamptonshire Rural PCN




Integrated Care Northamptonshire

Our services and estates strategy are endorsed by all the Primary Care Network General Practices:

- Byfield Medical Centre in Byfield including a branch at Woodford Halse
- Crick Medical Practice in Crick including a branch at West Haddon
- Greens Norton and Weedon Medical Practice in Weedon including a branch at Greens Norton
- The Long Buckby Practice
- The Saxon Spires Practice in Guilsborough including a branch at Brixworth

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Dr Julia Railson

Approved by CD Julia Railson via e-mail on 5/5

# PCN Clinical Service Strategy: Plan on a page

## Primary Care Network Profile

- There are five main practices and four additional branches in Northamptonshire Rural PCN
- The PCN has a total population of 51,510 (as of January 2023)
- Those 65 and over constitute 22.8% of the population
- 0 to 19-year-olds make up 19% of the population
- A 15.7% increase in the PCN population is anticipated between 2023 and 2036
- However, the PCN anticipates a further increase in its population due to a significant level of housing development underway and a higher than average growth across the ICB. Projections show an expected increase of 22.3% from 2023 to 2036, when including residential growth

## Population Health Need

- Higher prevalence of several Long-Term Conditions compared to England including Asthma (7.3% vs 6.5%), Cancer (4.2% vs 3.3%), Depression (12.75% vs 12.7%) and Hypertension (16.7% vs 14%)
- 3% of the PCN population has a diagnosis of Coronary Heart Disease (CHD), which is equal to the national average.
- The Index of Multiple Deprivation (IMD) of the GP practices are: Crick Medical Practice West Haddon (4.92), Greens Norton and Weedon (5.93), Crick Medical Practice (6.21), Byfield Medical Centre (11.25), Weedon Surgery (15.31), Byfield Medical Centre Woodford (17.45), Long Bucky (20.25) and Saxon Spires (4.92).

## Clinical Strategy

- Provide high quality, locally delivered services to meet the needs of our patient population
- Maintain a motivated and highly skilled multidisciplinary workforce
- Maintain pride and identity of individual practices while working together at PCN level to improve services and learn from each other
- Ensure all practices deliver high quality care to their patients and are supported by the PCN to share expertise, staff and services where appropriate
- Maintain continuity of care with services delivered in practices local to the patient. This will be supported by additional online or telephone resources to boost capacity but maintain accessibility without the need for patients to travel long distances

## Workforce

- **GP:** Total headcount: 46, Full time equivalent (FTE): 38.6
- **Nurse:** Total headcount: 20, FTE: 14.5
- **Admin:** Total headcount: 84, FTE: 56.2
- **ARRS:** Total headcount FTE:24, FTE: 17.38

## Next Steps

- Finalisation of Northamptonshire Rural PCN Clinical Strategy
- This work will inform the subsequent estates strategy which will set out a series of options for Northamptonshire Rural PCN

# Introduction

## Scope

PCNs are groups of GP practices that are based around a GP registered list of between 30,000 and 50,000 patients. As PCNs bring practices together, they enable GPs to offer care on a scale which is sufficient for patients to get the continuous and personalised care they value, but large enough to be resilient through the sharing of workforce, administration and other operational and clinical functions of general practice. Primary care development continues to centre on the growing maturity and capacity of PCNs, establishment of at-scale service delivery, appointment of ARRS staff, integrated services, and improving clinical outcomes and access for patients.

This is the clinical strategy for Northamptonshire Rural PCN; however we consider primary care as a wider consideration which includes community pharmacy, primary care dentistry and optometry, in line with new requirements for ICBs from April 2023. Ensuring there is appropriate estate and capacity is integral to the planning and delivery of transformational changes. Adequate primary care capacity both enables and supports the development and improvement of integrated services in community and primary care settings.

Benefits of services working together include:

- Sharing skills, specialist sessions and staff across the PCN
- Better access to specialist health professionals locally
- A wider range of services are available closer to patients' homes
- Sharing of information, resources and technology
- Enhanced access

This work aims to ensure that there is a clear link between Northamptonshire Rural PCN's clinical strategy and the needs of their primary care estate so that any investment requirements demonstrate how the primary care future planning will meet the specific local population need and will optimise GP and partnership working through better estate optimisation. The information provided aligns with the Primary Care Data Gathering (PCDG) datasets, NHS Digital analytics and SHAPE PCDG Atlas reporting tools to establish an initial baseline in order to demonstrate future need utilising a 'One Public Estate' approach

## Methodology and Stakeholder Engagement

Focusing on fit for purpose community-based estate is a catalyst for transformational service change. Providing well-organised services in high quality, accessible facilities which suit patient needs better enables the NHS to achieve improved health outcomes. When staff are given the chance to work in good quality, well-designed buildings which allow them to collaborate, evidence shows that recruitment and retention of staff improves. By making better use of poorly used primary care premises, funding can be reinvested to develop new and better ways of working.

The methodology for the clinical strategy starts with a focus on key stakeholder engagement and consideration of priorities in line with a population health-led approach to care design. Articulation of the clinical service strategy sets out how the PCN expects their primary care-led integrated service delivery to change over the coming years and what changes are required for service led sustainability. The National Association of Primary Care (NAPC) commenced engagement with Wave 3 PCNs, including Northamptonshire Rural PCN, in January 2023.

Subsequent meetings were held in February and March to further establish a strategic clinical vision. In December 2022, Archus was appointed to author the clinical strategies for all Northamptonshire PCNs.

This clinical strategy for Northamptonshire Rural PCN has been developed based on a full review of the range of requirements of services delivered locally, and where future changes may need to be. For example, the needs of local populations and how to make the best use of investment for extra ARRS staff based on local need and the space required.

# National Context

The NHS is facing a series of challenges due to growing demand driven by an ageing and increasing population, workforce shortages and a rise in the proportion of people living with long term illnesses. These issues were compounded by the Covid-19 pandemic which placed further pressures on the healthcare system nationally, regionally across Northamptonshire Integrated Care System (ICS) and locally within Northamptonshire Rural PCN. Six key issues which have led to the current context of a need for change are noted below:


*Figure 1: NHS Key Issues*

## *NHS Long Term Plan*

The NHS Long Term Plan (LTP) builds on the Five Year Forward View which provided a detailed national plan to revive general practice. The Five Year Forward View highlighted the challenges currently facing GPs, particularly around workforce, noting the need to "expand and support GPs and wider primary care staffing" and address investment, workforce, workload, practice infrastructure and care redesign.

The NHS LTP published in 2019 sets out how the NHS can improve the quality of patient care and health outcomes to make it fit for future purpose. The LTP provides a framework for local systems to develop plans, based on the principles of collaboration and co-design, as demonstrated in this clinical strategy for Northamptonshire Rural PCN in Northamptonshire.

One key message of the Plan is that clinical pathways should be shared across primary and secondary care, with resources fairly directed to where the care would be best delivered. This is supported by the British Medical Association[1] which finds that 94% of GPs support more collaborative and coordinated working, as evidenced in the establishment of PCNs nationwide. The Plan considers looking beyond healthcare provision, noting that the NHS has a wider role in influencing the shape of local communities to increase the capacity and responsiveness of the primary, community and intermediate care services to those who are clinically judged to benefit the most.

The LTP aims to continue to improve patient access through the introduction of digital appointments, supported by a new patient right to web and video consultations since 2021. This builds on the progress during the Covid-19 pandemic which saw greater availability of evening and weekend appointments nationwide. Primary Care will lead on

[1] 1 British Medical Association. Caring, supportive, collaborative? Doctors' views on working in the NHS. November 2018.

improving the ‘whole person’ health of a local population, with a greater understanding of mental health, the benefits of social prescribing, personalised care, medicines management and how to age well. People will experience more timely access to a wider range of services closer to where they live by funding bigger, more widely skilled teams so people can easily connect with the right person for their needs. This is demonstrated by the NHS Network Contract Direct Enhanced Services (DES) for 2022/23.

Through the NHS Long Term Plan there will be:


*Figure 2: NHS Long Term Plan*

## Direct Enhanced Service Plans

The new NHS Network Contract DES for 2022/23 was introduced in October 2022. This saw an additional £280m allocated to PCNs to appoint more Additional Role Reimbursement Scheme (ARRS) roles under the new contract. Over £1bn in funding is currently available for recruitment of these roles. These measures provide PCNs with greater flexibility to ensure enhanced access capacity is dedicated where it is most needed. Key ambitions of the model are shown right:

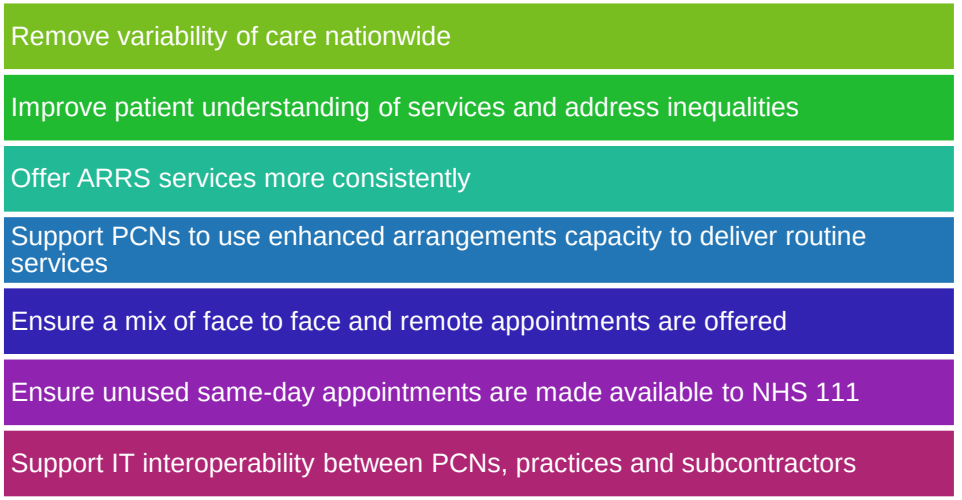



*Figure 3: Components of Direct Enhanced Service Plans*

## Next Steps for Integrating Primary Care: Fuller Stocktake Report

Published in May 2022, the Fuller Stocktake Report considers how the implementation of integrated primary care can be accelerated by incorporating the current four pillars of general practice, community pharmacy, dentistry, and optometry across systems. Key challenges identified in the report include access and continuity of care, with frustrations shared by both patients and staff alike.

The Report finds that integrated neighbourhood ‘teams of teams’ need to evolve from PCNs and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. PCNs should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

A consensus on what can be done differently emerged from the report, as noted below:

- Streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.
- Ensuring those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals.
- Taking a more active role in creating healthy communities and reducing incidence of ill health by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.
- Alongside a commitment to local action, the report sets out a requirement for additional support from Government and NHS England, targeted most of all at fixing workforce supply, estates and digital infrastructure.

## *Core20PLUS5 – Reducing Health Inequalities Strategy*

Published in 2021, Core20PLUS5 is an NHS England and Improvement approach to help ICSs reduce health inequalities. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' clinical areas in which rapid improvements should be made for the target population to improve health inequalities.

- **Core20** – The most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD).
- **PLUS** – ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes but not captured in the 'Core20' alone.
- There are **five** Clinical focus areas, as shown below, including:

1. **Maternity**: ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups
2. **Severe Mental Illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
3. **Chronic Respiratory Disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4. **Early Cancer Diagnosis**: 75% of cases diagnosed at stage 1 or 2 by 2028
5. **Hypertension Case-Finding**: to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke

These focus areas are considered in subsequent sections of this strategy (including the **Error! Reference source not found.** section). ICSs are expected to understand what their 'Core20PLUS' population is and identify their specific healthcare needs, in order to make informed decisions about how to ensure equitable access, excellent experience and optimal outcomes for these populations. Nationally, the five clinical focus areas are a priority for the 'Core20PLUS' population. This approach enables the biggest impact on avoidable mortality in these populations and contributes to an overall narrowing of the health inequalities gap.

Northamptonshire Rural PCN is keen to collaborate with local authorities in the vicinity to identify opportunities to tackle health inequalities. The PCN is equally eager to ensure alignment to other PCNs and Federations on the overall primary care strategy development across Northamptonshire.

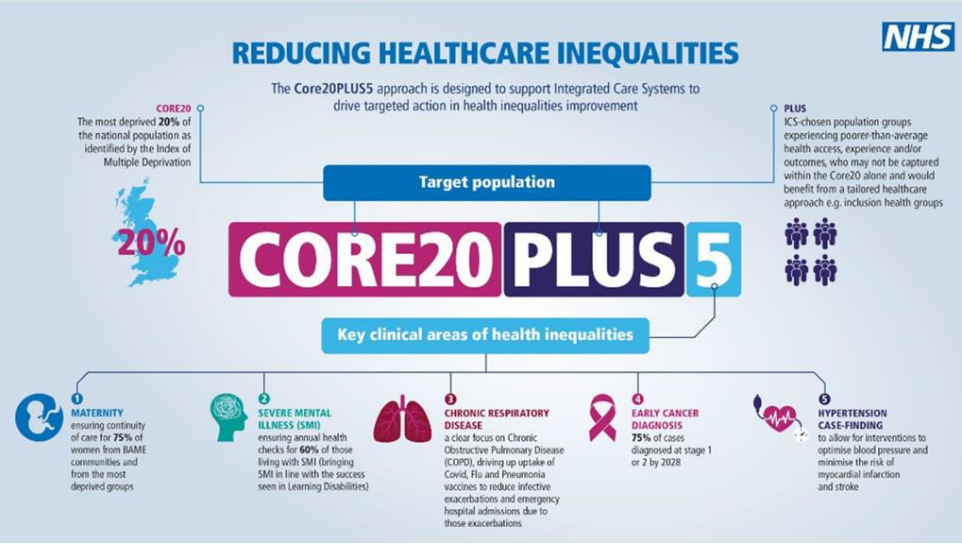



*Figure 4: Core20Plus5 Approach*

# Regional Context

800,000 people live in Northamptonshire and each have different and distinct health and care needs. Northamptonshire Integrated Care Partnership (ICP) is committed to supporting local people to *"live your best life,"* as supported by the following objectives. The objectives highlighted in bold are those which are agreed as being ICB "owned":

- **Best start in life**
- Access to the best available education and learning
- **Opportunity to be fit, well and independent**
- Employment that keeps them and their families out of poverty
- Housing that is affordable, safe, and sustainable in places which are clean and green
- Feel safe in their homes and when out and about
- Connected to their families and friends
- The chance for a fresh start when things go wrong
- **Access to health and social care when they need it**
- To be accepted and valued simply for who they are

The strategy focuses on improving on a set of outcomes for the health, care and wellbeing of local people which will meet these ambitions. These are highlighted because these outcomes matter to people, they are the outcomes the ICB is responsible for, and these outcomes can only be changed by aligning overall system ambitions and resources. Personal characteristics occupy the core of the model and include sex, age, ethnicity and hereditary factors. Individual 'lifestyle' factors include behaviours such as smoking, alcohol intake, and physical activity. Social community networks include family and wider social circles.

Bridging with personal characteristics, Northamptonshire ICB also recognises that health, care and wellbeing of its population is proportionally impacted by health and social care received, life style choice and population genetics and wider economic, physical and social environments. Although the effects of these factors vary, it is the wider determinants of health that have the largest impact. To enable our communities and residents to truly flourish, we need to understand what drives our health and wellbeing. The circumstances in which people are born, grow, live, work and age provided the foundations for people to live healthy.

In September 2022, a set of priority outcomes were agreed by the ICB to tackle key Core20Plus5 indicators as well as locally informed priorities:

- **Childhood Development:** Increasing good level of development at age 2-3
- **Obesity:** Reducing prevalence of adult overweight and obesity

- **Smoking:** Reducing prevalence of adult smoking
- **Adolescent Mental Health:** Improving self-reported wellbeing score
- **Cancer survival:** Increasing proportion cancer diagnosed stage1/2
- **Respiratory Health:** Reducing rate of emergency COPD admissions
- **Gap in healthy life expectancy for vulnerable:** groups Increasing Health Checks for LAC and adults with LD/SMI
- **Falls and Musculoskeletal Health:** Reducing rate of ED attendance for falls in those aged 65+
- **Independence:** Increasing proportion of people discharged from hospital to their homes

Northamptonshire ICB is dedicated to the prevention and management of conditions, providing accessible care that empowers local people in an integrated, inclusive and sustainable manner.

The Northamptonshire ICS Digital Transformation Strategy sets out four digital transformation drivers:

1. **Joining Up Health and Care Data**: Ensuring health and care information is **joined up across care systems and pathways**; enabling the ability to easily gather and understand holistic health and care needs
2. **Addressing Impacts of Covid-19**: Leveraging the accelerated use of digital across health and care **to address built up demand**; preventing unsatisfactory care experiences, and addressing workforce capacity constraints
3. **Connecting Health and Care Pathways**: **Integrating health and care pathways** that are presently fragmented; facilitating smooth transitions across health and care providers that are personalised and intuitive
4. **Developing Insights to Transform Care**: Creating **an ability to effectively combine health and care data**; advancing analysis of historic trends and forward-looking outcomes through data modelling

The Digital Transformation strategy aligns to the ICS's wider objectives, also aiming to provide inclusive, integrated and high quality services to all people in the locality.

## *Northamptonshire Health and Care Partnership*

Northamptonshire ICB and Local Authorities are part of the Northamptonshire Health and Care Partnership. One of the key ambitions within the partnership is to look at supporting the community's health and wellbeing needs through changes to primary, community and social care services to help shift pressure from hospital services. Northamptonshire Rural PCN is also aware that as strategic commissioning develops, the greater focus on outcomes will mean that ensuring their approach to providing continuity and care closer to home for patients aligns with the desired outcomes as guided by public health and other data.

## *Demographics*

While the county as a whole is less diverse than the England population, there is huge variation in the shapes of the communities in Northamptonshire. This can very broadly be divided into much less diverse rural communities and much more diverse towns and urban areas. Understanding the communities better and how they differ will be key to delivering better outcomes for all. A breakdown in the ethnicity of Northamptonshire ICB includes; 3.67% are Asian/Asian British, 2.45% Black/African/Caribbean/Black British, 2.05% Mixed/multiple ethnic groups, 91.45% White and 0.38% classify their ethnicity as 'Other.'

## *Population Growth*

Northamptonshire's location and setting makes it an attractive county to settle in. Over the last decade the population has grown faster than most local authorities, not just in the region but in England. While the population that has grown the most over that time is those aged over 70,

we have also locally seen a big increase in the numbers of children aged 5 to 15. Conversely, the numbers of babies born in the county has been slowly decreasing over the last ten years. This change in population presents real challenges for the healthcare system, as there will be an increase in demand for public services. If we are to meet these needs, we need to change how we work as a system.

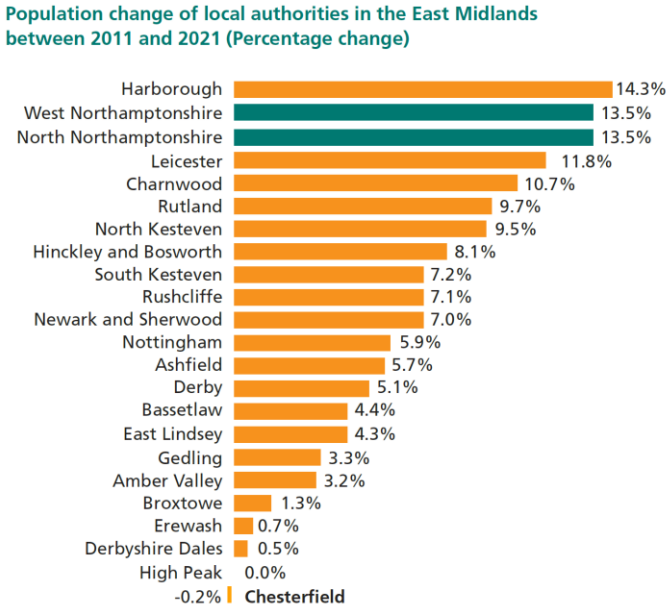



*Figure 5: Population change of local authorities in East Midlands between 2011 and 2021 (% change)*

## *Economic Environment*

To create a Northamptonshire where everybody's health and wellbeing can thrive, the right building blocks need to be in place including stable jobs, good pay, and quality housing. Right now, in too many of the communities, the national economic downturn means that these building blocks are not in place. There is strong evidence that economic crises have a significant impact on population mental health. As was the case during the COVID pandemic, those most vulnerable residents in the county are likely to be hit hardest by this – thereby widening the health gap. In response to this situation, we are likely to see continued real-terms reduction in public sector funding meaning that more will need to be done with less.

# Local Context

The PCN consists of five main practices and four branches, located across seven sites. All practices provide the following Care Quality Commission (CQC) regulated activities -maternity and midwifery services; family planning services; treatment of disease, disorder or injury; surgical procedures and diagnostic and screening procedures. In addition, all practices provide dispensing services. All practices are based in local villages throughout Northamptonshire.

**Byfield Medical Centre including one branch at Woodford Halse**

Byfield Medical Centre is open from 08:00 to 18:30 Monday to Friday. Enhanced access is provided fortnightly alternating on Tuesdays and Thursdays from 18:30 to 20:00. Woodford Halse is currently out of use as it is under refurbishment. The latest CQC inspection of the medical centre took place in 2019 and rated it as "good" across all review domains (safe, well-led, caring, responsive, effective).

**Crick Medical Practice with one branch at West Haddon**

Crick Medical Practice is located in Crick and Crick Medical Practice West Haddon is in West Haddon. The practice is open from Mondays to Fridays from 08:00 to 18:30, with enhanced access provided on Mondays and Wednesdays when it is open until 20:00. The latest CQC inspection was undertaken in 2016 which rated it as good across all domains.

**Greens Norton and Weedon Medical Practice with one branch at Greens Norton**

Greens Norton and Weedon Medical Practice has the second highest list size of all PCN practices. A branch site is based at Weedon in Northamptonshire. Both practices are open from 08:00 to 18:30 Monday to Friday with enhanced access provided from 18:30 to 20:00 on Tuesdays and fortnightly on Saturdays from 08:30 to 13:00. A 2022 CQC inspection of the site rated it as “good” across all review areas.

**The Long Buckby Practice**

The Long Bucky Practice is open from 08:00 to 18:30 Monday to Friday and offers enhanced access every three in four Thursdays from 18:30 to 20:00. A 2020 CQC inspection rated the premises as ”good” across all review categories.

**Saxon Spires Practice with one branch at Brixworth**

Saxon Spires Practice has the largest patient list size of all practices within Northampton Rural PCN. The main practice is open from 08:00 to 18:30 Monday to Friday. Enhanced access is available from 08:00 to 10:30 on Saturdays. The Brixworth Surgery site is open from 08:00 to 18:30 Monday to Friday. Enhanced access is provided every Tuesday 18:30 to 20:00 and fortnightly on Saturdays from 09:00 to 13:00. In 2017, the CQC rated the site as “good” across all review domains.

# Primary Care Network Overview

## Demographics

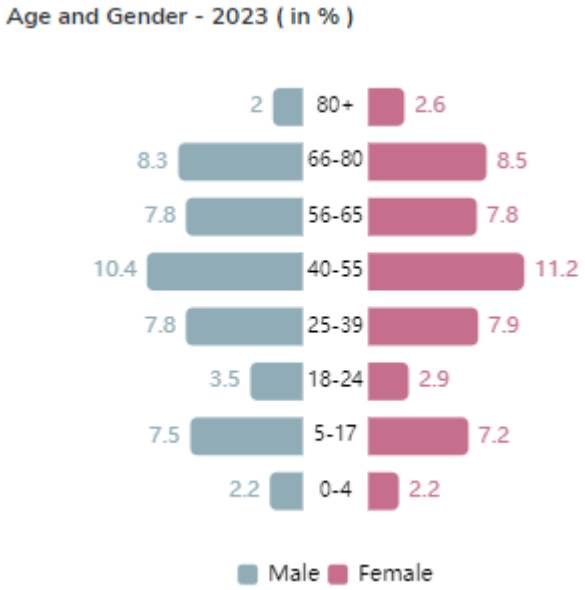



*Figure 6: Age Structure within Northamptonshire Rural PCN (January 2023)*[2]

Northamptonshire Rural PCN is based in West Northamptonshire Northampton. As of January 2023, the PCN has a population of 51,510 patients. Those 65 and over constitute 22.8% of the population, above the England and Wales average of 18.6% (ONS 2021). The higher proportion of older people within the PCN will likely exert greater pressure on its practices, particularly in the provision of frailty, dementia and Musculoskeletal (MSK) care. 0-to 17-year-olds make up a smaller proportion at 19% of the population, as one would likely expect given the rurality of the PCN.

There are five main GP practices and four branches within the PCN; Byfield Medical Centre in Byfield including a branch at Woodford Halse; Crick Medical Practice in Crick including a branch at West Haddon; Greens Norton and Weedon Medical Practice in Weedon including a branch at Greens Norton; The Long Buckby Practice and The Saxon Spires Practice in Guilsborough including a branch at Brixworth

*Table 2: Registered Patients at Northamptonshire Rural Primary Care Network (NHS Digital, January 23)*

| ***GP Practices*** | ***Number of Registered Patients*** |
|---|---|
| *Byfield Medical Centre with branch at Woodford Halse* | 8,240 |
| *Crick Medical Practice with branch at West Haddon* | 6,112 |
| *Greens Norton and Weedon Medical Practice with branch at Greens Norton* | 14,380 |
| *The Long Buckby Practice* | 6,392 |
| *Saxon Spires Practice with branch at Brixworth* | 16,386 |

[2] SIDM Health, Quality Outcomes Framework 2021 - 2022

| GP Practices | Number of Registered Patients |
|---|---|
| **Total** | **51,510** |

### *Patient numbers*

An increase of 15.7% in the PCN population is anticipated between 2023 and 2036. This will bring the total PCN patient list size to 59,606. However, Northamptonshire Rural PCN anticipates a further increase in its population due to a significant number of housing developments underway in the region and a higher than average growth across the ICB. Population projections show an expected increase of 22.3% from 2023 to 2036, when including residential growth [3].This would increase the population by over 10,000 patients from the existing list size to 62,986 patients.

## Existing Services and Challenges

As noted above, a high proportion of the Northamptonshire Rural PCN is elderly. Therefore, a frailty lead and Age Well team are in place across the PCN and a large local initiative is underway to support this cohort of patients. Due to the rurality of the PCN, practices and patients are quite spread out from one another, impacting patient access to primary care services. There are limited public transport links across the region, further impacting patient access.

Patients based in the south of the PCN often access services based in Oxfordshire which goes beyond Northamptonshire county boundaries.

Some communications issues exist with acute teams and practices often do not receive discharge letters electronically from Northampton hospitals. This issue predominantly impacts Byfield. Despite this, overall, the PCN does not have high levels of acute admissions.

Byfield Medical Centre faces the most pressure in terms of space and due to this, patients often travel to nearby practices to access ARRS staff led services, e.g. Byfield patients attend physiotherapy appointments at Weedon Surgery. Whilst this highlights an area of good collaboration of PCN practices, it further exacerbates access issues and travel times for patients.

The PCN is embedded across many local community services. A district nursing team was previously based within the PCN, at Saxon Spires. However, the team was later moved due to space constraints. In addition, health visitors are based in one room, however this service may need to move due to insufficient space. Space limitations also prevent wider usage of MDTs across PCN practices. In addition, there is a special interest in Dermatology across practices and a commissioned community carcinoma service is provided at Saxon Spires.

Northamptonshire Rural PCN is keen to host a diagnostic hub in its locality. Ultrasound equipment was set up in Saxon Spires, funded by the local Patient Participation Group . However, as it was not commissioned, the service is not provided at present. The PCN  is keen to maintain links with specialist output clinics. The podiatrist for Byfield also works out of Greens Norton.

[3] SHAPE (ONS population projections and Savills Housing projections)

# Population Health Needs

## Case for Change: Our local population Health Priorities

### *Population Health profile*

Northamptonshire Rural PCN has a higher prevalence of several Long-Term Conditions (LTCs) compared to England including Asthma (7.3% vs 6.5%), Cancer (4.2% vs 3.3%), Depression (12.75% vs 12.7%) and Hypertension (16.7% vs 14%). In addition, 3% of the PCN population has a diagnosis of Coronary Heart Disease (CHD), equal to the national average.

*Table 3: Summary of LTC prevalence using QOF indicators 21/22. Highlighted are LTCs where the PCN has an equal or higher prevalence than England*

| Long Term Condition | PCN (%) | ICS (%) | England (%) |
|---|---|---|---|
| Asthma | 7.3 | 6.5 | 6.5 |
| Cancer | 4.2 | 3.3 | 3.3 |
| CHD | 3.0 | 2.9 | 3.0 |
| COPD | 1.5 | 1.9 | 1.9 |
| Dementia | 0.6 | 0.7 | 0.7 |
| Depression | 12.75 | 14.5 | 12.7 |
| Diabetes | 6.6 | 7.4 | 7.3 |
| Hypertension | 16.7 | 14.9 | 14.0 |
| LD | 0.4 | 0.5 | 0.6 |
| MH | 0.6 | 0.8 | 1.0 |
| Obesity | 9.5 | 9.6 | 9.7 |
| Stroke/TIA | 1.9 | 1.7 | 1.8 |

**Benchmarks across all graphs: PCN ICB ENGLAND**

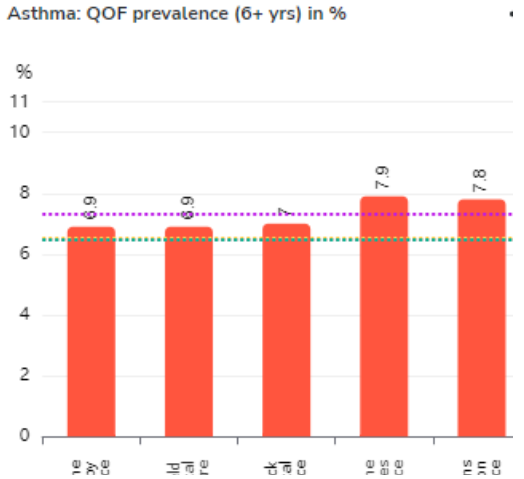



*Figure 7 Prevalence of Asthma at Northamptonshire Rural PCN*

The graph above highlights the high prevalence of Asthma in the PCN. All practices are the national and ICB averages (both 6.5%) for this condition, with a particularly high prevalence at the Saxon Spires Practice (7.9%) and Greens Norton Practice (7.8%).

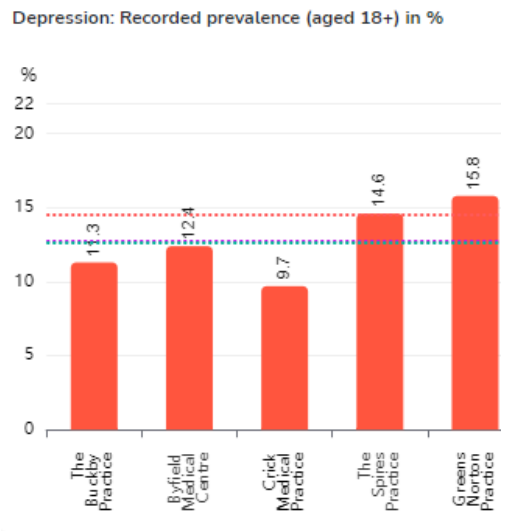



*Figure 8: Depression Prevalence at Northamptonshire Rural PCN*

The graph above demonstrates the high prevalence of Depression at the Spires and Greens Norton practices. This indicates that Mental Health service provision should be focused on these practices in particular as they are experiencing higher than the national average incidences.

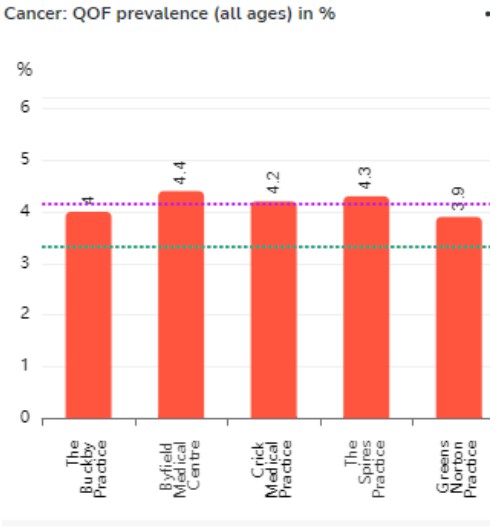



*Figure 10: Cancer Prevalence at Northamptonshire Rural PCN*

Cancer rates across all PCN practices are above the national average. This demonstrates that additional screening services such as bowel, breast, cervical, prostate may be required at Northamptonshire Rural PCN.

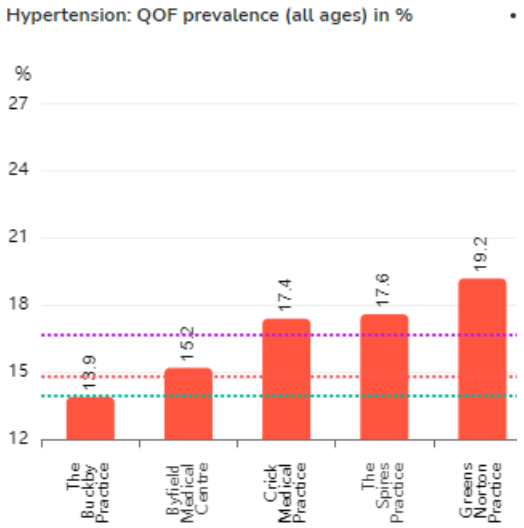



*Figure 9: Hypertension Prevalence at Northamptonshire Rural PCN*

Hypertension rates are above the national average in all practices except the Long Buckby Practice, indicating that a PCN wide programme could be considered to reduce this across the region.

Priorities noted during clinical engagement with Northamptonshire Rural PCN included improved management with and at risk of developing LTCs such as obesity and diabetes. Due to the PCN's ageing population, delivering high quality care for this cohort of patients is a key ambition, in particular focused on frailty services.

Therefore, combining the data with feedback from stakeholder engagement, the key healthcare priorities of Northamptonshire Rural PCN are:

## *Deprivation*

2019 Indices of Multiple Deprivation (IMD) provide a measure of relative deprivation for small areas. It ranks each small area in England from most to least deprived based on a combination of seven factors including income, employment, education, health, crime, barriers to housing and living environment [4]. There is evidence that shows that those living in the most deprived areas of England face the worst healthcare inequalities in terms of healthcare access, experience, and outcomes. Health inequalities are ultimately about the differences in the status of people's health; however the term is also often used to describe the differences in the care that people receive and the opportunities that they have to lead healthy lives, these are both factors that have an impact on health status [5]. Health inequalities therefore involves differences in:

- Health Status
- Access to care
- Quality and experience of care
- Behavioural risks to health
- Wider determinants of health

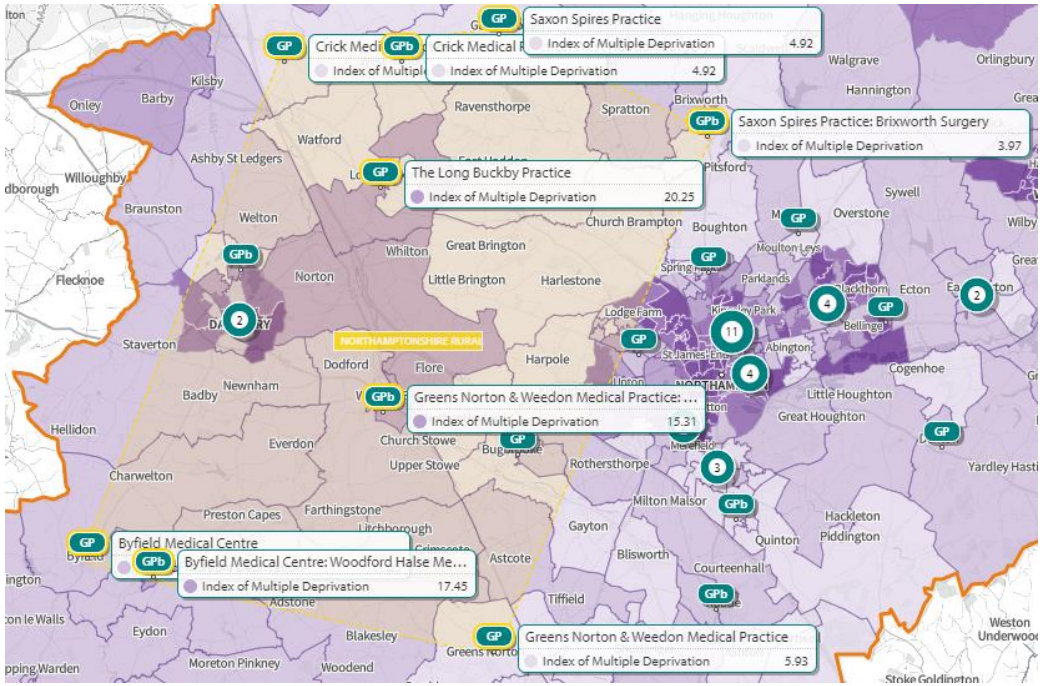



*Figure 11: Deprivation map of Northamptonshire Rural PCN. Darker purple areas are LSOAs with higher levels of deprivation*

Areas of higher deprivation are shaded a deeper shade of purple in the map of PCN shown right

A comparison of all nine indicators of deprivation across the practices in Northamptonshire Rural PCN with the ICB and national averages is shown in the table overleaf. Higher numbers indicate areas of higher deprivation, and lower numbers indicate areas of lower deprivation. The findings of this IMD analysis indicate that there are varying levels of deprivation across the PCN, as seen in the differences between The Long Buckby Practice (20.05) and Brixworth Surgery (3.97). Despite this, remarkably all practices are located in areas below the national IMD mean of 21.67, indicating that overall deprivation is not a key concern for Northamptonshire Rural PCN[6].

[4] NHS England Equality Hub
[5] King's Fund
[6] SHAPE

While overall deprivation is not a key concern, deprivation in terms of Health and Disability is evidently a key concern, with all practices except The Long Buckby Practice ranking poorer than the England average. This should undoubtedly be considered by the PCN in the planning of current and future clinical services. The score for this domain is found by considering the years of potential life lost, comparative illness and disability ratio, acute morbidity and the proportion of mood and anxiety disorders in a region so by taking a focused approach on these areas, the PCN could see an improvement in this rating.

| Deprivation Type | Byfield Medical Centre | Byfield Medical Centre Woodford | Crick Medical Practice | Crick Medical Practice West Haddon | Greens Norton and Weedon | Weedon Surgery | Saxon Spires Practice | Brixworth Surgery | The Long Buckby Practice | ICB | England |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Health and Disability | -0.74 | -0.30 | -0.94 | -1.05 | -0.89 | -0.20 | -1.05 | -1.32 | 0.01 | -0.07 | 0 |
| Income | 0.06 | 0.11 | 0.06 | 0.04 | 0.05 | 0.10 | 0.04 | 0.02 | 0.11 | 0.1 | 0.13 |
| Employment | 0.06 | 0.08 | 0.05 | 0.04 | 0.05 | 0.08 | 0.04 | 0.02 | 0.10 | 0.08 | 0.1 |
| Education, Skills and Training | 8.81 | 35.92 | 5.73 | 3.93 | 4.58 | 29.12 | 3.93 | 3.05 | 31.03 | 24.21 | 21.69 |
| Crime | -0.89 | -1.11 | -0.57 | -0.50 | -2.03 | 0.04 | -0.50 | -0.20 | 0.06 | 0.01 | 0 |
| Barriers to Housing and Services | 27.80 | 30.21 | 3.41 | 2.55 | 15.02 | 9.53 | 2.55 | 24.04 | 24.24 | 22.35 | 21.69 |
| Living Environment | 32.22 | 5.77 | 23.27 | 22.37 | 20.40 | 12.71 | 22.37 | 0.84 | 17.07 | 15.25 | 21.69 |
| Income Deprivation affecting Children | 0.09 | 0.15 | 0.07 | 0.03 | 0.05 | 0.09 | 0.03 | 0.03 | 0.11 | 0.13 | 0.16 |
| Income Deprivation affecting Older People | 0.05 | 0.15 | 0.07 | 0.06 | 0.17 | 0.07 | 0.06 | 0.05 | 0.15 | 0.13 | 0.17 |
| **Overall IMD** | 11.25 | 17.45 | 6.21 | 4.92 | 5.93 | 15.31 | 4.92 | 3.97 | 20.25 | **18.6** | **21.67** |

*Table 4: IMD by GP Practice in Northamptonshire Rural PCN*

# Clinical Strategy

## *Introduction*

Northamptonshire ICB and its PCNs are eager to work in collaboration with neighbouring NHS organisations, local authorities and the voluntary sector. All partners have a clear shared ambition to work with local people, communities and staff to improve the health and wellbeing of individuals and to ensure collective resources are used effectively. The

# Scope

PCNs are groups of GP practices that are based around a GP registered list of between 30,000 and 50,000 patients. As PCNs bring practices together, they enable GPs to offer care on a scale which is sufficient for patients to get the continuous and personalised care they value, but large enough to be resilient through the sharing of workforce, administration and other operational and clinical functions of general practice. Primary care development continues to centre on the growing maturity and capacity of PCNs, establishment of at-scale service delivery, appointment of ARRS staff, integrated services, and improving clinical outcomes and access for patients.

This is the clinical strategy for Northamptonshire Rural PCN; however we consider primary care as a wider consideration which includes community pharmacy, primary care dentistry and optometry, in line with new requirements for ICBs from April 2023. Ensuring there is appropriate estate and capacity is integral to the planning and delivery of transformational changes. Adequate primary care capacity both enables and supports the development and improvement of integrated services in community and primary care settings.

Benefits of services working together include:

- Sharing skills, specialist sessions and staff across the PCN
- Better access to specialist health professionals locally
- A wider range of services are available closer to patients' homes
- Sharing of information, resources and technology
- Enhanced access

This work aims to ensure that there is a clear link between Northamptonshire Rural PCN's clinical strategy and the needs of their primary care estate so that any investment requirements demonstrate how the primary care future planning will meet the specific local population need and will optimise GP and partnership working through better estate optimisation. The information provided aligns with the Primary Care Data Gathering (PCDG) datasets, NHS Digital analytics and SHAPE PCDG Atlas reporting tools to establish an initial baseline in order to demonstrate future need utilising a 'One Public Estate' approach

# Methodology and Stakeholder Engagement

Focusing on fit for purpose community-based estate is a catalyst for transformational service change. Providing well-organised services in high quality, accessible facilities which suit patient needs better enables the NHS to achieve improved health outcomes. When staff are given the chance to work in good quality, well-designed buildings which allow them to collaborate, evidence shows that recruitment and retention of staff improves. By making better use of poorly used primary care premises, funding can be reinvested to develop new and better ways of working.

The methodology for the clinical strategy starts with a focus on key stakeholder engagement and consideration of priorities in line with a population health-led approach to care design. Articulation of the clinical service strategy sets out how the PCN expects their primary care-led integrated service delivery to change over the coming years and what

changes are required for service led sustainability. The National Association of Primary Care (NAPC) commenced engagement with Wave 3 PCNs, including Northamptonshire Rural PCN, in January 2023. Subsequent meetings were held in February and March to further establish a strategic clinical vision. In December 2022, Archus was appointed to author the clinical strategies for all Northamptonshire PCNs.

This clinical strategy for Northamptonshire Rural PCN has been developed based on a full review of the range of requirements of services delivered locally, and where future changes may need to be. For example, the needs of local populations and how to make the best use of investment for extra ARRS staff based on local need and the space required.

National Context and Regional Context sections of this strategy outline a number of key ambitions of the NHS and the ICB, as set out in the Fuller Report, LTP and 2022/23 DES.

## *Clinical Vision*

Northamptonshire ICS set out their clinical priorities to;

1. Give local people the best start in life
2. Give local people the opportunity to be fit, well and independent
3. Ensure people have access to health and social care when they need it

The Health inequalities plan envisions Northamptonshire working with communities to ensure that people living in the area have the opportunity to thrive, to access quality services and provide excellent experiences and optimal outcomes. The long-term ambition is to see;

- An increase in healthy life expectancy
- A reduction in health inequalities
- A reduction in premature mortality
- Improved community cohesion

Our clinical vision for Northamptonshire Rural PCN is to:

- Provide high quality, locally delivered services to meet the needs of our patient population
- Maintain a motivated and highly skilled multidisciplinary workforce
- Maintain pride and identity of individual practices while working together at PCN level to improve services and learn from each other
- Ensure all practices deliver high quality care to their patients and are supported by the PCN to share expertise, staff and services where appropriate
- Maintain continuity of care with services delivered in practices local to the patient. This will be supported by additional online or telephone resources to boost capacity but maintain accessibility without the need for patients to travel long distances

## *Clinical Services Strategic Objectives*

Key drivers of any clinical services strategy include

1. **Prevention and Management**: Accelerating prevention programmes and ensuring there is access to health and wellbeing services to prevent ill health. One means of preventing ill-health is by providing vaccination and screening programmes that are accessible to all
2. **Accessible:** This can be achieved by **i**mproving access to health care services and better integrating health and social services so they are accessible to those most in need or at risk of poor.

3. **Empowering:** Providing personalised and anticipatory care that enables people to be involved in their treatment. Enabling people to access information that promotes health and independence
4. **Integrated:** Ensure technology is used to support access to health services and information. Include plans to reduce digital exclusion and ensure data analytics and intelligence guide actions
5. **Inclusive:** Promote community cohesion, address health inequalities and develop plans that accommodate individuals of all ages and background
6. **Sustainable**: Ensure services are fit for purpose and planned to accommodate future demand. Embed a focus on sustainability to help achieve the ‘triple aim’ of better health and wellbeing, improved quality of services and the sustainable use of resources

# Clinical Strategy and Care Model

The table below demonstrates a series of potential plans for Northamptonshire Rural PCN to improve the health and care of its population

*Table 5: Clinical Strategy and Care Model for Northamptonshire Rural PCN*

| Population health issue - What will change? | How will we make it happen? | Enablers |
|---|---|---|
| **We will improve care for our frail and elderly population based in rural geography with poor transport links. This can limit access to services and means these patients depend on their local surgery and often rely on home visits.** | ◆ Age Well team in the PCN to take referrals from practices and proactively identify patients who may need more support. | ◆ Age well team members needed to have adequate resources to visit patients and provide support. Better links with social care and community teams are being built.<br>◆ Age Well funding provides for lead GP and project lead. Age well team members being provided by NHFT but currently under staffed. |
| **Improved social support for patients presenting with complex needs** | ◆ Expanding the social prescribing team to allow increased provision for the PCN<br>◆ Focus on patients with Asthma, Cancer, CHD and Hypertension in particular<br>◆ Expand use of MDTs and pharmacists to support chronic disease management across the PCN, relieving some pressure on nurses | ◆ Hybrid home/ onsite working to allow for problems with travel and room availability in practices.<br>◆ Two excellent existing social prescribers who are developing links in the community such as local libraries and carers groups. |
| **New multidisciplinary staff becoming embedded in primary care and creating additional capacity.** | ◆ We have already recruited pharmacists, physiotherapists, a Podiatrist, paramedics and care coordinators who are working in the network. | ◆ There is a high training and supervision requirement for new additional roles staff but this should improve as they become more embedded in the team.<br>◆ Enthusiastic trainers in the practice to supervise new starters. Good team developing<br>◆ Capital grant funded MDT hub being created at Long Buckby Practice to enable team meetings and provide onsite space for remote working staff. |

| Population health issue - What will change? | How will we make it happen? | Enablers |
|---|---|---|
| **More community services available to our patients, particularly for exercise on referral classes which are currently not available in our PCN.** | ◆ Work with Northamptonshire sport to bring Otago or strength and balance classes into the PCN foot print<br>◆ Arranging specific, LTC focused workshops and services based on local need. In particular, focusing on requirements of patients with Asthma, Cancer, CHD and Hypertension such as regular checks and better empowering them to self-monitor their conditions | ◆ Initial discussions revealed issues with instructor availability and need to identify venues.<br>◆ We have offered to support Northamptonshire sport and work with them to set up new classes involving our age well and SPLW team. |
| **Improve digital offering from practices** | ◆ Unify the online presence with development of a PCN website and integrated practice websites which link to the PCN website.<br>◆ Move all practice websites to the same provider and set up a new PCN website. We would also need dedicated PCN resource to maintain the website content.<br>◆ Improve online access and use new technologies to improve efficiency<br>◆ Review new online consulting tools and compare usage between practices to share good practice and look for solutions that could work in the PCN | ◆ Some practices are under contract with current providers and there are different clinical systems in use.<br>◆ We have a lot of expertise in the team and experience of a number of website providers and can take recommendations from other practices<br>◆ Different ways of working between practices, different clinical systems. Need to ensure patients who do not use digital services are not disadvantaged.<br>◆ New and improving online providers will hopefully provide useful online tools. |
| **Focus on mental health to support patients with longer consultations and free up GP time.** | ◆ Recruit mental health workers into the PCN team. We are working towards having adult and younger peoples mental health workers in the PCN | ◆ The recruitment of mental health workers has to be done through the mental health trust. There have been delays and we still do not have workers in post but are working hard to meet this objective<br>◆ Clinical director working on a pilot with NHFT to bring ARRS funded young people's mental health workers to the PCN, funding in place and recruitment ongoing.<br>◆ We are also working on plans to trial band 4 adult mental health support workers due to inability to recruit band 6 workers. |

# Workforce

## *Workforce – (NHS Digital, (SHAPE), January 2023)*

- **GP:** Total headcount: 46, Full time equivalent (FTE)**:** 38.6
  - Proportion of those aged 60 plus is 6.5%
- **Nurse:** Total headcount: 20, FTE: 14.5
  - Proportion of those aged 60 plus is 15%
- **Admin:** Total headcount: 84, FTE: 56.2,
  - Proportion of those aged 60 plus is 22.6%
- As of December 2022, the dispensing activity for the PCNs was 98.460 prescriptions at 255 pharmacies

Northamptonshire Rural PCN has appointed a range of ARRS staff to support with the care of patients. Northamptonshire ICB data from December 2022 forecasts an increase of almost 10 FTE ARRS staff between January to March 2023 and January to March 2024. The PCN aims to fully use the ARRS budget for 2023/24 by expanding the existing care coordinator and paramedic teams as well as appointing mental health practitioners to better meet the needs of the local population.

As mental health is a key priority in the region, the PCN has been involved in setting up a pilot CAMHS project in collaboration with the local mental health trust, NHFT. A child mental health worker is in place in the PCN, jointly funded by ARRS and NHFT. However, overall, the PCN is struggling to appoint mental health practitioners, a common issue across primary care at present. Therefore increased support for Children and Young People (CYP) is a key ambition of the PCN's.

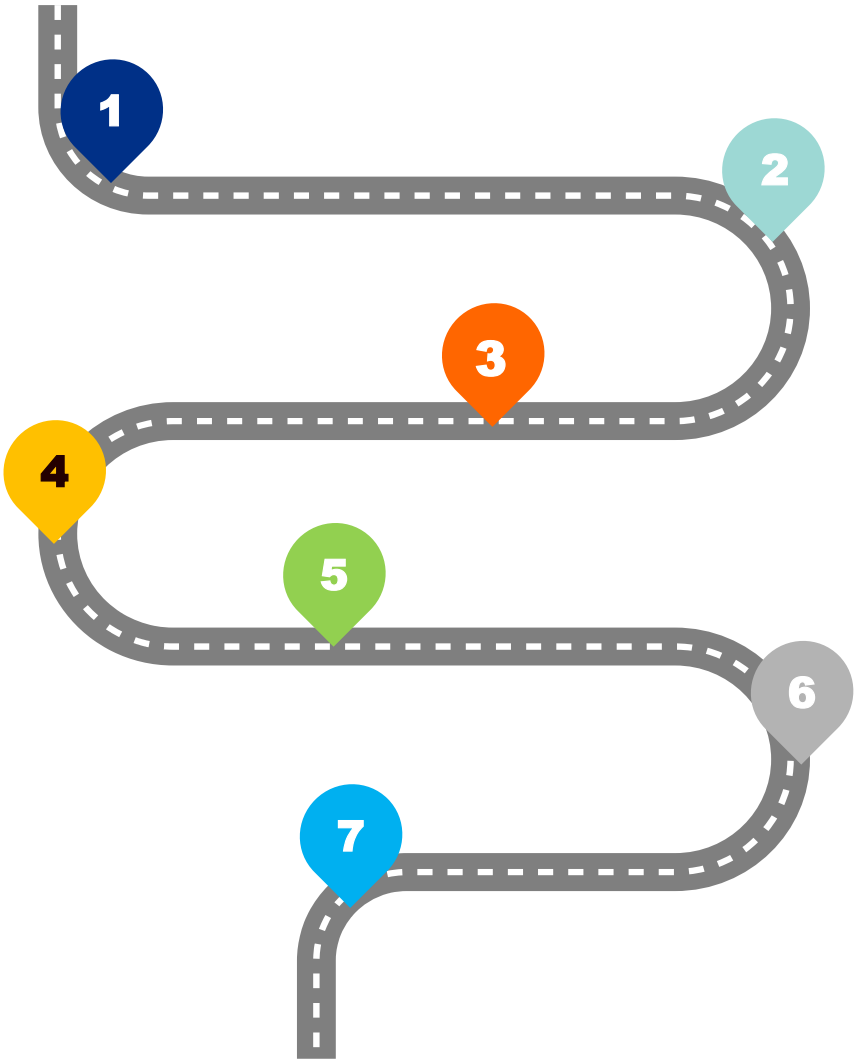
The PCN social prescribing team supports the local elderly population in particular through library based outreach groups, improving digital access for patients as well as focusing on health inequalities. In Q1 2023, a care coordinator team joined the PCN.

| *ARRS in Northamptonshire Rural PCN* | *January to March 2023* | *Year end 2023/2024* |
|---|---|---|
| **Adult Mental Health Practitioners** | - | 1 |
| **Advance Practitioners** | - | 1 |
| **Care Co-ordinators** | 3.5 | 5 |
| **CYP Mental Health Practitioners** | - | 1 |
| **Clinical Pharmacists** | 5 | 6 |
| **First Contact Physiotherapists** | 3 | 3 |
| **GP Assistants** | - | 1 |
| **Paramedics** | 3.5 | 4.5 |
| **Pharmacy Technicians** | 2 | 2 |
| **Podiatrists** | 1 | 1 |
| **Social Prescribing Link Workers** | 2.8 | 3 |
| **Trainee Nursing Associates** | - | 2 |
| **Total** | **20.8** | **30.5** |

While Northamptonshire Rural PCN is keen to use the ARRS budget efficiently, sharing of staff across the PCN is difficult due to the vast region it covers. Therefore, the PCN is very much practice led, with no centralised resource beyond a Clinical Director and PCN Manager. A flat

structure is in place whereby each practice employs their own ARRS staff due to the unique needs of all practices.

# Next Steps




Road Map to implementation to be determined following review of service and estate optimisation opportunities with ICS stakeholders.

1) Engagement with Northamptonshire Rural and follow-up questions (March 2023)

2) Completion of Northamptonshire Rural PCN Clinical Strategy (March to April 2023)

3) Formal approval of Northamptonshire Rural PCN Clinical Strategy by Northamptonshire Rural PCN (March to April 2023)

4) Formal approval of Northamptonshire Rural PCN Clinical Strategy by Northamptonshire ICB (March to April 2023)

5) Handover of materials to Estates Strategy team (March to April 2023)

6) Estates to determine key opportunities and priorities for Northamptonshire Rural PCN (April 2023)

7) Completion of Estates Strategy (April to May 2023)