Primary Care Network
NHS Confederation

Primary care networks

Three years on

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About

This report considers the progress of primary care networks (PCNs) since their establishment in July 2019, taking stock of the challenges they have faced as well as their successes.

It outlines factors that contribute to a 'strong PCN,' setting out recommendations for integrated care systems (ICSs) and policy makers to realise this, with a focus on specific asks for the PCN contract 2023/24. The report is informed by ongoing engagement with approximately 200 PCN clinical directors and managers, as well as leaders in wider primary care organisations such as GP federations.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

The Primary Care Network, which is part of the NHS Confederation, support, connects and empowers primary care members to maximise the impact they have on patient care and drive change.

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July of this year marked the third anniversary of primary care networks (PCNs), which are the flagship policy – and vehicle – for increasing primary care capacity through multi-disciplinary team (MDT) and at-scale working, as well as addressing health inequalities.

These three years, however, have been marred by extraordinary events. Within a year, the COVID-19 pandemic had taken hold; within two years, PCNs and their primary care partners were delivering the lion's share of the vaccination programme; and within three years, the Health and Care Act 2022 had passed through parliament, marking a wholesale reorganisation of the NHS.

The effects of these events have also been extraordinary, with high demand for all NHS services and high rates of public dissatisfaction, down from 83 per cent in 2021 to 72 per cent in 2022, prompting the Health and Social Care Select Committee to urge government to acknowledge that general practice is in crisis. In primary care, demand for GP appointments remains high despite record activity, while there is a similar picture for dental services and community pharmacy, all of which look set to increase as the cost-of-living crisis likely pushes more people into ill health.

Against this backdrop however, PCNs have performed remarkably well. From responding to COVID-19 and leading vaccination efforts to increasing the number of available appointments through the Enhanced Access service, PCNs have shown themselves to be agile and efficient delivery vehicles.

The tumultuous policy environment has not done justice to these successes, further destabilising PCNs. Think tank policy papers touting reform of the general practice model led to rumours that a government review was on the horizon, fuelling the British Medical Association's ballot to withdraw from the Network Contract Directed Enhanced Service (DES) that governs PCNs. The Fuller Stocktake report, Next Steps for Integrating Primary Care, set out a vision for primary care building on the integration with health and care partners that PCNs spearheaded. Although the report received mixed reviews from across primary care, there is appetite for the direction of travel. With all integrated care system leaders backing the report, it is now within their gift to take the proposals forward, comprehensively setting out how it will be implemented to regain much-needed momentum.

Where there has been reform, primary care has felt unequally treated. For instance, when NHS England reprioritised its funding to cover the Agenda for Change uplift for NHS trusts, primary care had to cover its own costs. Although the general practice and PCN funding has risen faster than elsewhere in the NHS, this resulted in many primary care leaders feeling mistreated.

All of which leaves PCNs in a state of uncertainty, especially when there are no guarantees for their future beyond 2024. With the cost-of-living crisis only looking set to worsen, affecting the social determinants of health as well as increasing primary care operating costs, PCNs' story continues to be tumultuous.

As we look ahead and consider what the future holds for PCNs, it is important to remember that they are the building blocks of ICSs and that general practice has been the test bed for both provider

integration and person-centred care. Ultimately, PCNs have delivered all that has been asked of them, and indeed more.

PCNs are already playing a strategic role within their systems. As ICSs develop, primary care must be a leading voice and the default vehicle for clinical delivery in their neighbourhoods and places, spearheading the prevention agenda and helping to keep patients out of hospital.

As the Health and Social Care Select Committee notes: PCNs have potential. Over the past three years this potential, and their development, has been overshadowed by extraordinary events, pushing general practice into crisis and in turn destabilising the foundations of PCNs and ICSs.

Our role at the NHS Confederation is to promote primary care at scale, ensuring the wider health and care system recognises its value and that, crucially, primary care itself does, enabling it to take full advantage of the opportunities the new NHS architecture presents. It is vital that PCNs' potential is realised.

Key points

- The three years since PCNs were introduced have been tumultuous, including a global pandemic, a wholesale reorganisation of the NHS, rumours of reform to the GP operating model, dwindling numbers of GPs and extremely high demand for NHS services. All this has caused a crisis in general practice, affecting the development of PCNs and rendering them unable to deliver on their stated aims of stabilising general practice, dissolving the historic divide between primary and community services and reducing health inequalities.

- Despite these peculiar circumstances, PCNs have delivered all – and more - of what was asked of them, including the lion's share of the COVID-19 vaccination programme, the recruitment of nearly 20,000 additional roles reimbursement scheme (ARRS) staff and the introduction of seven new services, in turn aiding prevention and providing much-needed additional capacity within a stretched health system.

- In addition to this unstable operating environment, workload pressures and inadequate infrastructure have proven to be challenges for PCNs. However, the workload and urgency of COVID-19 saw rapid adoption of new technologies and ways of working, as well as purpose-driven collaboration within the NHS and communities. Workforce has also evolved, with new ARRS staff bringing both an expanded workforce and new skills while clinical directors have matured into their roles and many PCNs have taken the initiative to recruit other, non-ARRS staff.

- Despite PCNs now delivering new services their development has not been uniform, with success often being dependent on local factors. This means that systems have a role to play in promoting integration at place through primary care leadership, providing supporting infrastructure and committing to transformation both in empowering PCNs themselves and in recognising that PCNs – as the 'building blocks' of ICSs – are the transformation that underpins all others.

- To remedy the rollercoaster of the past three years, PCNs require certainty and capacity. This includes guarantees for their existence beyond 2024, no further service specifications, increased flexibility within ARRS alongside introduction of an access lead reform of the mental health practitioner role and further support for transformation.

- Wider policy must also focus on capacity creation through workforce measures, including a fully funded whole workforce plan, pension reform to encourage more clinical sessions and equitable access, as well as capital investment and a focus on research and innovation, particularly in primary care as it will return the highest yield.

PCNs: expectation vs reality

In 2019 when PCNs were created, their stated aims were to stabilise general practice, dissolve the historic divide between primary care and community services, and to reduce health inequalities, all of which were to be achieved through the phased introduction of additional services and an expanded multi-disciplinary workforce.

Despite the tribulations of the past few years, PCNs have set up and are delivering these additional services, they have also recruited and expanded the primary care workforce through ARRS, with the latest figures standing at 19,229 positions filled, all while rolling out 71 per cent of all COVID-19 vaccinations. But it is a rare instance when PCNs have achieved this without support, whether that is with back office functions or existing relationships, or even via clinical commissioning group (CCG) discretion, pointing to the need to better understand the levers of success for PCNs and the full primary care ecosystem.

Unfortunately, however, this success has not translated into achievement of their stated aims or a realisation of their full potential. General practice continues to haemorrhage its workforce, general practitioners are leaving the profession to the tune of 1,622 since 2015, while we have also heard that turnover of administrative staff is high. Similarly, a divide between primary care and community services persists despite the two working in partnership to deliver the Enhanced Health in Care Homes service. This also rings true for reducing health inequalities, with PCNs making remarkable progress under the tackling neighbourhood

health inequalities service, ensuring annual physical health checks for 75 per cent of patients on the learning disability register and, latterly, making good use of Core20Plus5 to identify those experiencing health inequalities, in turn expanding the service.

This indicates that PCNs are an extremely successful and responsive delivery model. They have made impressive headway against a backdrop of disruption and huge workforce constraints, as well as the sheer volume and sickness of patients. Ultimately, they have added significant value to the health system.

The disconnect with their aims therefore lies with what they have been contracted to deliver, factors outside of their control, or simply that they are an unfinished project whose tenure has been marked by extraordinary events.

What has gone well for PCNs?

COVID-19

PCNs rose – and continue to rise – to the challenges COVID-19 presents. With primary care administering 71 per cent of all vaccinations as of October 2021, the vaccination programme is proof that PCNs and primary care at scale are effective delivery models, especially for reaching underserved communities

The pandemic crystallised relationships between PCN practices, uniting them behind a shared purpose and leading to innovations such as hot and cold hubs for patient treatment at the height of the pandemic. It also had the same effect on local stakeholder relationships, with PCNs working together as 'networks of networks' and with federations, local authorities and the voluntary sector.

The pandemic also brought technological transformation, enabling communication and relationship building between member practices as well as accelerating progress against digital access targets. Although remote access has come under significant criticism, it is an integral part of accessing the NHS and helping to meet capacity challenges.

Running video group clinics for long COVID

Wokingham North Primary Care Network has been running video group clinics since the COVID-19 pandemic and has successfully engaged with over 700 patients across a range of conditions. The long COVID group clinics have been health-coach led but had the input of the wider health and wellbeing team including care coordinators, GPs and mental health practitioners, as well staff from Royal Berkshire Hospital's long COVID team. Patients have reported positive experiences with the sessions, particularly the peer support elements and the support provided by a dedicated MDT.

Read the full case study in the primary care hub app

Workforce evolution

As of June 2022, the number of ARRS roles recruited against the target of 26,000 was 19,229. Despite issues with some specific roles, some roles are having a positive impact on patient care, reducing clinical workload and aiding integration. The NHS Confederation has researched and documented numerous case studies of social prescribing link workers, care coordinators and health coaches being used in innovative and impactful ways. It is also often the case that this wider workforce has been taking the lead on population health management projects, making the connections across systems partners that are vital for integrated patient care. Given the depleting ranks of GPs, with Health Foundation research forecasting one in four posts will be vacant by 2030/31, and the government's admittance that its own target of 6,000 new recruits by 2024 will not be met, ARRS roles are a significant plus to this gap, and a delivery mechanism for the government's commitment of 20,000 more non-GP roles by 2024.

Despite workload pressures impacting clinical directors, they have matured into their roles. They have taken on the strategic and clinical leadership of their PCNs and many have taken on the primary care partner role on ICBs. This is shown through the number of PCNs that have incorporated as limited companies and demonstrates a desire to formalise working arrangements and manage risk, as well as the desire to bring in management and transformation expertise, using the PCN Management and Leadership Payment to contract third parties such as federations, or to directly employ additional managerial staff.

Workforce evolution at place level

In Peterborough, PCNs working together through their local federation have introduced integrated neighbourhood managers to bridge the potential gap between primary and community care, as well as to aid further place-level integration with hospitals and the voluntary sector. This demonstrates that PCNs are growing the workforce through prescription and, moreover, innovation.

Read the full case study in the primary care hub app

Service delivery

Despite the interruptions to the introduction of PCN services, PCNs are now delivering seven additional services to patients, standardising these services across England with an expectation that they will contribute to a system-led anticipatory care service in the next financial year.

Across the board, clinical directors have lauded the Enhanced Health in Care Homes specification as an example of person-centred care and integration, while some PCNs are going further

than the contractual baseline, for example by tailoring services around their population needs by taking a CORE20Plus6 approach, instead of CORE20Plus5. This has also been the case with the enhanced access service, with many PCNs using their patient engagement exercises to inform the mix of services that best suit their populations' needs.

What have been the challenges for PCNs?

Unstable operating environment

Since 2019, the environment PCNs operate within has drastically changed, leaving PCNs to grapple with destabilising events as well as uncertainty surrounding their future beyond 2024.

Firstly, within 12 months of PCNs being established they, like the rest of the NHS, were contending with COVID-19. For PCNs, this resulted in their planned DES services online being suspended and temporarily replaced with the vaccination programme, losing months of planned service delivery. Furthermore, with the instruction that appointments could not take place in person, PCNs had to alter how they delivered their services overnight, moving to online and telephone consultations.

Secondly, system working and the transition to integrated care boards (ICBs) has presented challenges for PCNs. The relationship between PCNs, general practice and federations, as well as the functions of PCNs, and their relationships with system partners remains woefully misunderstood by the wider NHS. The dissolution of CCGs and their functions moving upwards to ICBs has also impacted PCNs, removing much-needed back office support while eroding relationships. Without full coverage of federations and with them often not being recognised by system partners, this has led, in many places, to a vacuum of planning and support at place level

between PCNs and the ICB. Some tensions with system working have been illustrated by the ARRS mental health practitioner role, which uses a mixed funding model between the PCN and the local mental health provider. However, as of autumn 2022/23, 57 per cent of PCNs had recruited at least one mental health practitioner.

Finally, and underpinning these issues, is the uncertainty surrounding the future of wider primary care policy and that of PCNs. Among think tank policy papers touting reform of the GP operating model, a stocktake and ballots concerning withdrawal from the PCN contract, there remains no guarantees for PCNs' future beyond 2024. In turn, this is affecting longer-term planning with many PCNs being hesitant to recruit permanently into ARRS positions. Although there are reassurances that ARRS roles will form part of the core general practice cost base from 2023/24, for many, the future of PCNs remains uncertain.

Mental health practitioners role

Some areas have struggled to fill their mental health practitioner roles, citing difficulties with PCNs and local mental health trusts working together to establish and embed the role.

The mental health practitioner role is different to other ARRS roles in that funding is split 50/50 between the PCN (via their ARRS entitlement) and the mental health provider (via ICB Long Term Plan funding for transformation of community mental health services). This is intended to ensure PCNs and mental health providers work together to design integrated mental health pathways for their population.

In some areas PCNs have experienced pushback from mental health providers to fund these roles, particularly on a recurrent basis, with providers citing lack of ringfenced funding as a particular challenge. While funding has been made available for the roles in ICB and trust budgets for mental health, this does not

always translate to staff on the ground as ICS' have flexibility on how to use that funding and can invest it in other initiatives.

It should be noted that mental health providers are contractually required to offer at least one mental health practitioner per PCN (two for larger PCNs), but provision of mental health practitioners over that amount is subject to agreement between the mental health provider and PCN, with discussions supported by local commissioners.

Workload

Echoing issues expressed at both 12 and 24 months, high workload remains a challenge for PCNs.

Alongside the additional work resulting from the operating environment, running a PCN itself comes with a heavy workload, which falls on clinical directors and PCN managers (where the latter exist) as the only specified strategic and clinical leadership of the PCN. Clinical directors and PCN managers have expressed concern over the volume of bureaucracy, with reporting such as for the Investment and Impact Fund (IIF), taking up considerable amounts of time.

However, as noted in Primary Care Networks: Two Years On, the interdependencies between general practice and PCNs means it is difficult to separate the two workloads, thus capacity issues in general practice affect PCNs. With GP numbers declining and patient demand increasing, this has often meant that clinical directors, the majority of whom are GPs, often experience competing demands between day-to-day general practice work and PCN priorities. Commendable headway has been made with recruiting ARRS professionals, increasing capacity and meeting patient needs but, as The King's Fund notes, their potential is not being fully realised and they are not leading to an overall reduction in workload in the first instance. Furthermore, the training and

supervision of ARRS staff also falls on the clinical director, once more increasing workload.

The clinical workload is also increased by the situation elsewhere in the NHS. The backlogs in secondary care result in primary care managing patients' worsening conditions while they wait for referral or a procedure. Examples also abound of transfers of work from secondary care and unsafe discharges from hospitals as they strive to free up beds. This includes unsafe discharge plans as well as advice from consultants for patients to raise waiting list queries with their GP.

> "We are seeing a massive increase in rapid discharges from hospital so our pharmacist and medicine management team are completely overwhelmed with discharge letters and medication issues as the letters are often complex and poor."
>
> PCN Clinical Director

Inadequate infrastructure

Infrastructure continues to be a limiting factor for PCNs. This includes both hard infrastructure, such as estates and technology, and soft infrastructure, such as training and development and management support.

Although the Network Contract DES was intended to expand services and workforce, there has been no specific provision for estates or IT to ensure ARRS staff are able to undertake their work. This has resulted in primary estates operating at full capacity while staff that are able to undertake appointments do not have a room to consult from, or lack computers to undertake remote consultations. This limits the expansion of the workforce itself, as

as PCNs are reluctant to recruit for roles they cannot fully deploy, in turn decreasing primary care capacity and delivery of the NHS Long Term Plan aim of moving services out of hospital. Similarly, PCN services have been rolled out without the necessary technology being in place to fulfil contractual requirements, such as the ongoing IT interoperability issues with the enhanced access service.

This is also the case for soft infrastructure, with no standardised provision being in place for the majority of ARRS staff or even for clinical director training. Furthermore, many PCNs lack the necessary internal systems and legal mechanisms, such as HR functions and company structures, to employ an expanded workforce and manage associated risks. Here, federations play a key role in the HR function although there is no uniform coverage.

> "I have stopped recruiting because I have nowhere to put any more staff. There is NHS estate available but I have been told I cannot use it."
>
> PCN Clinical Director

What makes a strong PCN? Considerations for systems and policy makers

Through our engagement, it has become clear that PCNs' development has not been uniform and that, despite success in implementing services, some PCNs are stronger than others. This points to local factors determining success, namely how well integrated the PCN is at place level, the supporting infrastructure that PCNs have access to, and how committed the PCN and wider system are to primary care transformation.

We have outlined the key enablers of PCN success and some recommendations for systems to take forward, which build on our previous reports: Primary Care Networks: One Year On, The Role of Primary Care in Integrated Care Systems, Primary Care Networks: Two Years On, and our response to the Health and Social Care Select Committee's inquiry into the future of general practice, as well as the recommendations set out in Next Steps for Integrating Primary Care. Many of these recommendations have already been voiced, but with 2024 drawing closer and the slower than expected progress in implementing the recommendations of the stocktake, systems must ensure they are prioritised. There is a real opportunity to reform services to improve patient outcomes and, with PCNs already embedding population health management approaches, to ensure they are scaled across places and systems.

Notably, yet expectedly as PCNs are the building blocks of ICSs, many of these enablers are within the gift of the wider system, therefore falling outside of the remit of the nationally commissioned PCN contract, and we have suggested the following recommendations for ICSs to take forward. Furthermore, many of these enablers are already being provided by federations and we strongly recommend that their role is recognised in future policy.

Recommendations

Integration at place

Why?

Both relationships and inclusion within decision-making at place level affect the success of PCNs. To date, the high point for PCNs has been the vaccination programme where local stakeholders worked together to achieve an objective. They were free and empowered to make decisions in the best interests of their population's health, engaging the entirety of the primary care ecosystem as well as the communities they serve.

How can systems enable this?

The principle of subsidiarity must be applied within systems themselves, enabling local leaders to lead and for decisions to be made as close to the population served as possible. With primary care having consistently expressed a desire for increased influence and autonomy, systems have a role to play in facilitating partnership working, both with secondary care and other system partners, as well as enabling community outreach.

Building primary care leadership capability and capacity will be vital in achieving this. A clinical director is a strategic leader of a transformation project across separate GP surgeries; a leader

within communities at the neighbourhood level; a leader within the new system architecture, as well as being a clinical leader, all of which is often undertaken in addition to clinical sessions. Systems must therefore recognise the breadth of the role and equip clinical directors with the capacity and capability to fulfil its duties.

Recommendations

- Ensure there is strong representation within place-based partnerships.
- Ensure clinical directors are included in wider system development opportunities.
- Work with primary care to evolve integrated neighbourhood teams from PCNs, in line with recommendations from Next Steps for Integrating Primary Care.
- Provide expertise and resources to support engagement, facilitating collaborative relationships with community organisations such as schools and the voluntary sector.

Same-day access in Gateshead

In 2013, access to general practice's same-day and urgent services varied widely across the Gateshead system. As a result, acute providers were seeing high numbers of patients presenting with conditions which would be best treated in primary care. A key driver in this spill over from primary care to acute was the need for timely access to services. The Gateshead system partnered with primary care and community services to build triage hubs and co-locate primary and secondary services. Access has improved dramatically, and Gateshead is now a leading example of integrated services.

Read the full case study in the primary care hub app

Supporting infrastructure

Why?

The availability of infrastructure, from back office support to estates provision, impacts the success of a PCN. This is due to the PCN DES increasing both the scope and scale of service provision, as well as the number of professionals working within primary care.

However, there is no specific, corresponding provision – neither funding nor expertise – for PCN estates, technology, or access to business intelligence to support these services or new staff. Instead, PCNs must make use of schemes for general practice or be reliant on ICS-managed funds. This can be overly bureaucratic and can lead to delays, such as the 2021 Winter Access Fund, which was administered by systems and in some cases saw funds being released to primary care as late as the spring, after it was made available in the autumn. Furthermore, many place-level supporting functions undertaken by CCGs may have been lost with the transition to ICBs.

How can systems enable this?

Systems must invest in both hard and soft infrastructure for primary care, helping them to both accommodate and support their workforce, gain an in-depth understanding of their population's health needs, and aid integration. Additionally, they must engage primary care in system plans and release funds to primary care within reasonable timeframes.

Recommendations

- Recognise the contribution of federations in the primary care ecosystem and system architecture.

- Develop a system-wide, strategic plan for infrastructure provision and usage, including IT.
- Develop a system-wide, strategic plan for data, analytics and business intelligence provision and usage.
- Develop mechanisms to ensure primary care can drawdown expertise and skills to analyse and interpret data.
- Ensure appropriate training and support is in place for ARRS staff.

A commitment to transformation

Why?

At their core, and as recognised with the introduction of the new digital and transformation ARRS role, PCNs are a transformation project that require a different approach to working and headspace to transform. Where PCNs have embraced this, such a through employing additional staff, investing in shared systems or leadership capability and capacity, they have fared better. Furthermore, as the first tranche of provider integration, the wider system has much to learn from PCNs and it is vital that the primary care partner of the ICB is equipped to relay insights and advocate for primary care.

How can systems enable this?

Systems should plug any funding gaps for transformation or PCN development that have been lost with the transition to ICBs while ensuring that finance, contracting, regulation and reporting processes are streamlined. Furthermore, primary care member(s)

of the unitary board of the ICB should be equipped with the necessary training and remuneration to ensure parity with other members.

Recommendations

- Ensure primary care partners of the ICB members have sufficient time and training to provide input into discussions.
- Develop a system-wide approach to population health management with a clear, PCN-informed approach to commissioning and focused funding.

The role of leadership in ARRS recruitment

West Leeds PCN has had great success in ARRS recruitment, reaching 42 ARRS staff in spring 2022. The team uses population health management data to scope unmet need and prioritise the roles that will be most beneficial to their community. The non-clinical leadership team is enthusiastic about bringing in new roles and ensure that a thorough process is in place for scoping a role, educating existing staff and inducting new staff. Patients now have access to a wider array of practitioners and the PCN is benefitting from a more resilient workforce and improved management infrastructure.

Read the full case study in the primary care hub app

How can national policy enable strong PCNs?

National primary care policy must focus on measures that create capacity within primary care, affording it the space to transform and integrate.

PCN policy:

- Guarantees for PCNs beyond 2024 to enable long-term planning.
- Not introducing further service specifications in the 23/24 Network Contract DES.
- Increased flexibility around the ARRS, allowing PCNs to tailor their team to population health need.
- Providing adequate funding.
- ARRS to cover training and supervision.
- Reform of the mental health practitioner role funding, so all funding is allocated to PCNs while PCNs and the mental health provider recruit into and design the role requirements in partnership.
- Introducing an access lead to PCNs who could also provide strategic co-ordination at place level within systems.

- Revision of the IIF to improve patient outcomes through primary care at scale and reducing the administrative burden.

- Increased support for management, leadership and transformation, either through the PCN leadership and management fund or specific role(s) via ARRS. Although this has been acknowledged in part through the new ARRS digital and transformation position, the funding for management and leadership remains inadequate for the size of the roles now being undertaken.

With primary care being the foundation – and PCNs being the building blocks - of ICSs, it is vital that all future policies are designed with primary care as the starting point. Not only will this have the greatest impact, as primary care accounts for 90 per cent of all NHS activity thus creating a higher yield, it will also aid integration and delivery of NHS Long Term Plan objectives.

Wider policy:

- A fully funded, long-term plan for the whole health and care workforce, including primary care.

- Pension reform to remedy the disincentivising effects of inflation on pension accumulation for additional hours worked.

- Reform of the eligibility requirements for NHS pensions to ensure sub-contractors' workforce can access the scheme when providing medical services.

- Recognition of federations within the wider primary care ecosystem.

- Capital investment in technology to increase efficiency, including data analysis for population health management, as well as both patient-facing and back office solutions to help manage patient flow, record-keeping and sharing, and clinical care.

- Measures to incentivise collaboration and ensure parity of esteem for all providers within the system, such as gain sharing.

- Proposals to increase research opportunities within primary care, embedding the NHS as an innovation partner.

Next steps

Primary care is the keystone of the NHS, providing high-quality responsive integrated care for patients in health and care systems. Integral to the transformation and future of the NHS, our vision is for primary care to be valued, supported, well-resourced and empowered to drive innovation, improve population health and reduce health inequalities.

To support this vision we are bringing together communities of practice and design groups of entrepreneurial leaders, who will address some of the wicked problems being faced with the aim of contributing to a long-term strategy that meets, not simply manages, need.

We look forward to continuing to work closely with NHS England to help inform the development of PCNs, unlock the power of primary care at scale and ensure that the role of primary care in systems is well understood.

For further information on the projects highlighted in this report, please contact **julia.swift@nhsconfed.org**

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