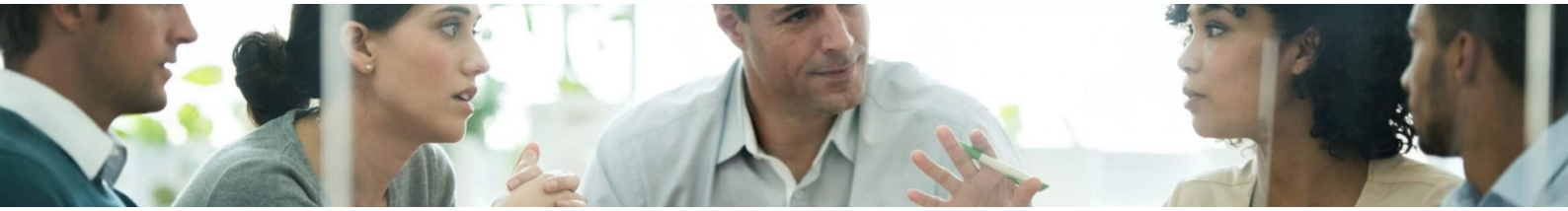
Insight

February 2022



Looking forward to 2022

As we are now into 2022, and the health service has already been challenged and has responded well once again. Booster vaccinations have been delivered, another wave of COVID is being managed, and business as usual has been continued. So, what next in 2022? In a year where we are expecting to see integrated care boards (ICBs) become statutory bodies, clinical commissioning groups (CCGs) being subsumed and integrated care systems (ICSs), finding their feet and starting to deliver joined up services at place and system level what are the hurdles that will need to be overcome?

Pressure on staff is one of the biggest challenges – with high sickness rates seen over winter, requirements to self-isolate and the toll of working under pressure for such an extended period it's crucial to ensure that all members of the team work supportively together and new roles, responsibilities, and a multi-organisational, multi-disciplinary team work effectively together. There is also a need for those needing care to have tolerance and understanding that they may be seeing different professionals and be accessing care in different ways so the whole team can continue to work safely and effectively.

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The planning guidance signs the extended role of community care, virtual wards and this will have an impact on how teams need to work to manage increased numbers of patients in out of hospital settings. The multi-disciplinary team will be crucial to ensure success of virtual wards, which, if waiting times are to be managed will be essential. How this will all be co-ordinated and the role of primary care networks (PCNs) and place as system players will be key. Enabling capacity to allow this to happen is vitally important with PCN clinical directors playing a vital role. They have already delivered hot and cold hubs, vaccination programmes and vastly expanded multi-disciplinary team working in primary care. To now support increased numbers of people needing care in the community who would previously have been in hospital will be a challenge. Headspace and time for the clinical directors will be vital, as will increased working at place level. Many PCNs have already come together to work at place level, to enable the additional roles funded via the additional role reimbursement scheme (ARRS) to be most effectively employed, managed and deployed. It's now time to work at this level to enable care to be managed. It's crucial to allow these clinical leaders the headspace and time to manage these roles successfully, they have already proven themselves and need every support to do it again. Failure to allow this could jeopardise the success of PCNs and the support they will vitally give to practices.

The clinical directors will also play a crucial role in the expansion of population health management and addressing health inequalities, supporting work to prevent ill health in the first place. Again, work at place level will help, but each network may have different patient needs, and population health needs considering at a local level. Finding the time to work upstream and prevent future illness is vitally important and will be where all in the ICS need to work together, as many of the answers are not within health care, but across local authorities, the voluntary sector, and local community. To realise the vision of PCNs engagement across the system and with local communities is important. Finding time and headspace will be the biggest challenge.

> "Finding time and headspace will be the biggest challenge"

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It would be easy to overlook the technicalities of the wider organisational changes but with CCGs due to be no more by July and ICBs starting on their journey; they need the governance and oversight to work effectively. ICBs will in time take on additional commissioning roles, dental, eyecare and pharmaceutical services, as well as current CCG responsibilities, and the challenge is how can all work most effectively together to deliver the best care possible for the population.

It will not be an easy year, and the most important areas to address, will be headspace for clinical leaders to plan how care can best be delivered with effective multi-disciplinary teams and all parts of the system working together. Good community engagement so that both the strengths in the community are used, and so that understanding of the new ways services are delivered are communicated at community level to enable understanding of the different ways health care will operate in the future.

Helen Northall is the chief executive of PCC, a not for profit organisation providing expert support, leadership programmes, personal and team development to practices, PCNs and all across health and care services. www.pcc-cic.org.uk

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Improving population care

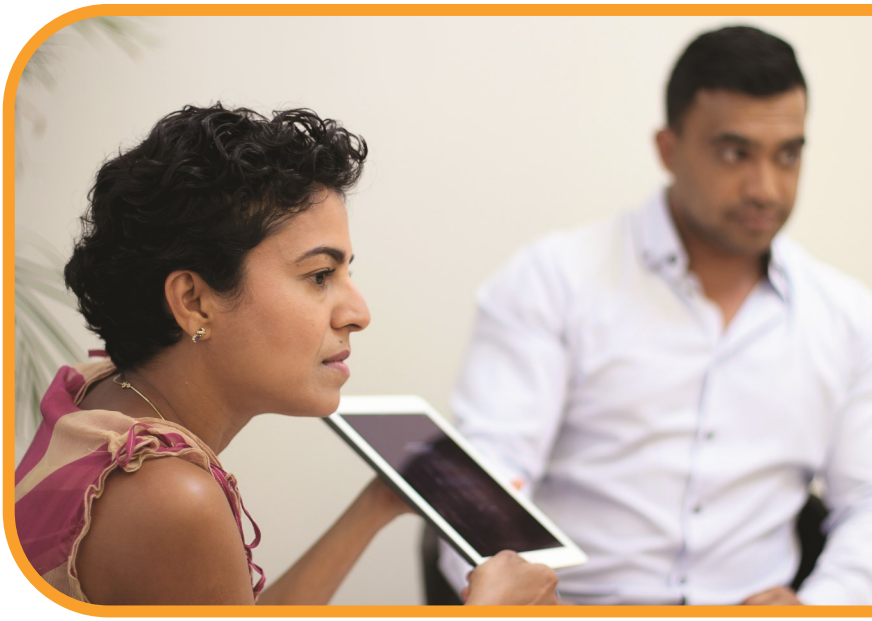
Improving population health outcomes and tackling health inequity is an understandable focus as we all reflect on the impact of the COVID-19 pandemic and the inequalities which have affected the most vulnerable people in our communities.

The policy framework underpinning Integrating Care (NHS England and Improvement 2020) makes clear the core purpose of integrated care systems, which amongst others is to improve population health outcomes and tackle inequalities in 'outcomes, experience and access.'

Population health has long been a goal of policy makers and commissioners but has proved difficult to demonstrate in the way we think about designing care models. Partly this is due to the unerring focus tends to be on the performance of health care providers driven by targets such as improving access and disease or service related outcome measures.

My own experience of recently completing 30 years as a GP Principal in East Merton has demonstrated that inequalities in terms of outcome for those living in the most deprived parts of the borough compared with those in the most affluent have for some indicators widened over my time. This is a picture that I'm sure is very familiar to colleagues living and working in different parts of the country.

The concepts underpinning population health may seem difficult to embrace especially to colleagues on the front line, all of whom are coping with the overwhelming pressures of delivering care 'in the moment'. Yet if we can inspire a wider group of colleagues across the health and care sector with some of the core principles, we may yet have an opportunity to embed population health approaches into design and delivery.



I have found it helpful to think of 'population health' as a broader ambition which embraces building a rich picture of the population in question with a view to improving its health and wellbeing irrespective of its size.

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The notion of 'population health management' then becomes an action orientated and solution focused set of activities that involve (data driven) planning, population segmentation and proactive prevention and management. There is a risk, however, by introducing the notion of 'management' that we could end up 'medicalising' care design and delivery rather than following the principles of co-production to improve health and wellbeing.

Delgado and colleagues (2021) have introduced the term 'population health improvement' as a means of working towards measurable improvement of health and wellbeing outcomes through approaches which are concerted and systematic, collaborating and co-produced with and for the population in their locality.

The notion of co-production is arguably the dimension of population health improvement that is most difficult to demonstrate. Based on the 'Ladder of co-production' (National Co-production Advisory Group 2021), co-production is a higher order function in which there is an 'equal relationship between people who use services and the people responsible for services.' This requires a fundamental rethink away from the lower order functions we may use when we think about designing services such as informing, consulting or engaging. If we wish to genuinely think about population health improvement we must move away from 'doing to' and embrace the principles of co-production.

As first steps on delivering population health improvement, it may be helpful to follow the suggestions of Delgado and colleagues (2021) by firstly identifying who is not thriving in our communities and explore this through various data lenses, both quantitative and qualitative. Then to truly understand the assets that sit in our communities and work with and alongside them, and to follow: co-produce a bold purpose with citizens and partners.

In time, I hope this approach at least sets the foundation steps on the way to genuine health improvement.

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Emerging integrated care boards – the GP federation perspective

In the third of our interviews about the emergence of integrated care boards, we talk to Dr Rishi Chopra about his experiences of working as part of a federation across a number of PCNs. Rishi is a General Practitioner in Central London based at Paddington Green Health Centre for the past 15 years. He has a number of current leadership roles, including being the Clinical Director for Regent Health Primary Care Network – a network of eight practices, providing care for a population of around 60,000 patients, as well as being a board director for Healthcare Central London, Westminster's GP federation, managing care for 250,000 Westminster residents. He is an experienced educator, teaching medical students from Imperial College, Junior Doctors, GP trainees, appraising GP colleagues, and teaching A-Level students who are interested in becoming Doctors. Additionally, he is the Westminster Primary Care Training hub clinical lead. He is also the borough COVID vaccination lead for care home residents, housebound patients, and pop-up sites.

Can you give us a little background to Healthcare Central London (HCL) and its primary care networks (PCNs)?

Westminster is a fairly unique place. We're very small geographically, with approximately a quarter of a million patients including two very large universities with around 30-40,000 students registered with two student practices. We look after some of the wealthiest people in Britain and some of the most deprived immigrant communities who often find their way into Westminster.

I hid behind the uniqueness of Westminster for a long time because our data on outcomes is quite often skewed for several reasons. We have a transient population. We have a commuter population. We have lots going on in Westminster and that's why our urgent care rates are so high.

Four years ago, our Commissioners piloted a new contract, which was basically an out of hospital contract called Partnership in Practice, or PIP, which covered additional

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things that General practice wasn't funded for that could be offered at scale. Our then federation became the contract holder and that was the precursor to primary care home delivery of care. In terms of performance management, it fell into units of about 50,000 patients and Westminster divided into four neighbourhoods which ultimately became the four PCNs. Because of this, delivery for us had happened at “place” level, and so we proposed that we should have a clinical director of each PCN on the board of the federation, because that's where delivery happened as opposed to at network level.

About two and a half years ago, our federation transformed into Healthcare Central London, a limited company with every single Central London or Westminster practice, of which there are 34, becoming shareholders based on their list size. This meant that everyone has got buy in, pride and a financial incentive to make sure the vehicle works.

Why don't you have your delivery model at PCN level?

The key point is for us is that a patient in my network may live next door to somebody who's registered at a different practice in a different network who may live next door to third practice who's in a different network because our footprint is so small. We felt it unfair and not at all equitable if the offer to that patient is different to their next-door neighbour.

Obviously, relationships are really key, so the four primary care network clinical directors (CDs) of Westminster are so in tune, and the vision is so similar that work becomes easier. We think about everything together but still allow for some autonomy to reflect specific needs when needed more locally.

What support has HCL been able to provide across PCNs in delivering the network directed enhanced service (DES)?

There are lots of opportunities for federations to provide support, an important one is around workforce both for the additional roles reimbursement scheme (ARRS) and wider staff groups. Our ARRS will be delivered pretty much at federation level because on the whole most things can be delivered equitably across the entire patch. An example would our clinical pharmacists of whom we employ 14 with a plan to have about 30. We've modelled our numbers to say we think every 10,000 patients needs a full-time clinical pharmacist to do a defined list of work whilst allowing some practice autonomy. Again, every patient gets the same offer from a clinical pharmacist across the four PCNs.

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This kind of strategic planning is much more manageable for us because of the scale working across four PCNs provides.

How have you avoided conflict across the PCNs?

We've tried to make the Federation and the PCNs feel like the same organisation with Federation issues being a rolling agenda item at PCN meetings. Things that come up in each PCN are then fed straight to the Federation board. This allows a PCN to identify their specific needs, mainly around the use of the ARRS, which can be discussed and then added to the workforce plan.

How can primary care get its voice heard and influence the ICB?

I think the ICB wants innovation at place, or network level, and ultimately improved outcomes. If you can deliver outcomes that are demonstrable across the wider population and are transferable to other areas, you'll get people listening. So I think that demonstrating innovation at the coalface is the best way to show what we can do.

I also think that currently the integrated care place is a maturing at a rate faster than the ICB as they are still in the process of making Board appointments. I would like to think that as a result, local primary care has an opportunity to get recognition at ICB level for work already undertaken.

What positive examples do you have of initiatives to integrate care over the last two years?

The biggest one is the vaccination campaign. We were the borough with the lowest vaccine uptake in the country at one stage, and although the emphasis was on delivery at PCN level, we decided on day one to deliver it at federation level because that made sense given our geography. One of the highest profile examples of this was when we set up a vaccination centre at Lords Cricket ground twice a week and at the peak we were delivering 3,300 vaccines a day. We also identified that there were certain communities who were scared or hesitant about the vaccine and so we did pop up clinics in local community and religious centres and also involved the local authority and public health to support us with other initiatives like a vaccine bus that targeted specific

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neighbourhoods.

Those relationships with public health and the local authority have now enabled us to think about bigger initiatives looking at things like why there are differing life expectancies in different areas and what can we do collaboratively to bridge the gap.

Although this collaborative working would have happened over time, Covid has definitely been a catalyst to get us in the same room at the same time with a common, unified focus and vision. And that's key, because otherwise you get conflict where everyone's agenda is different and transparency, honesty and openness doesn't necessarily come out.

What do you think the most significant achievements of CLH have been?

I think again, it has been the vaccination campaign. We've rolled it out wider than just for our patients and helped colleagues from outside our borough because people come into central London for lots of reasons and as we've been set up to be able to give them a jab while they're here, it's a bonus for everyone.

But equally the way the federation has matured with a clear and shared understanding of our strategic vision has really gone well over the last year or two. We're working really closely together and have formed great relationships with other providers in the patch. We have recently rebranded the Federation with a new name and an entirely new board so that members feel part of a new organisation that they all own and have a say in what is being delivered.

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What do you see as the biggest challenge facing primary care in the ICB?

I think it's important to remember the goodwill that exists in primary care. The minute one starts trying to itemise every line of work that every provider does, you're going to run into problems because you're going to see there's so much that people do without the remuneration and financial reward. So the minute you start trying to itemise every piece of work that goodwill will start to go, and patient relationships become purely focused on ticking boxes which is a real worry. I acknowledge that people should absolutely be remunerated for work that they do, but I flag this as a risk.

How do you plan to develop relationships with the wider primary care team?

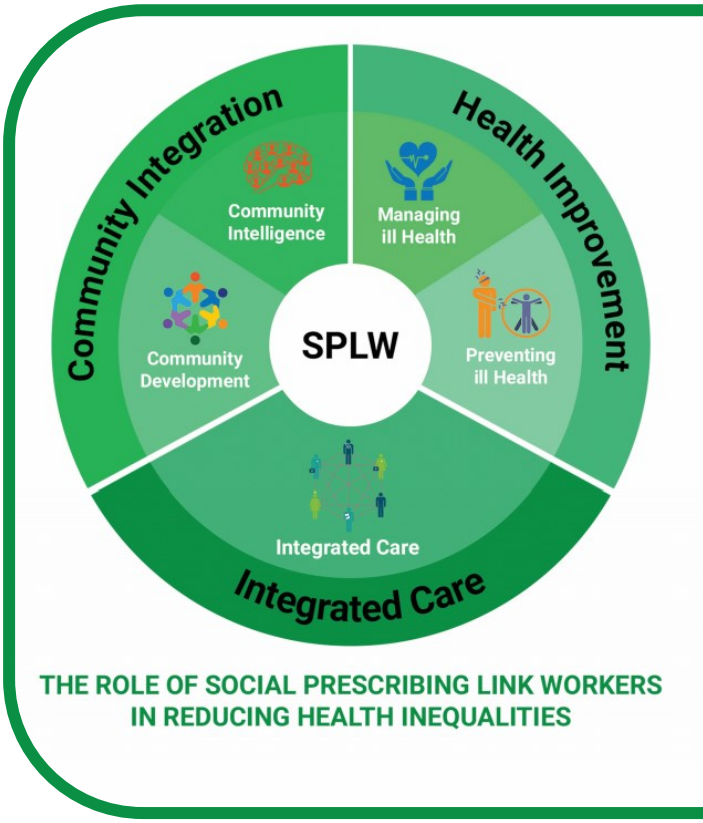
Relationships with the community pharmacists have always been very strong, as we've done lots of collaborative work informally with our local chemists for years and now we have the community pharmacist consultation service (CPCS) which has formalised much of what had been done as informal referrals till now. I think that relationships with optometrists and dentists will take time and we all need to understand the pressures within the system and develop our relationships to address them together.

What is your key message for primary care right now?

I think the relationships between PCNs and the ICP that then feed into the ICB are key. Our four PCNs are so aligned that their voice at the ICP is four times stronger and more trusted. If you've got networks who have very differing views, their voice gets diluted, or it doesn't get heard at all. So, the more collaboration at place level that you can do, the more likely it will be that innovations and local plans will get adopted.

Social prescribing link workers can help reduce health inequalities

GPs had always 'operated outside the biomedical model', which is what separated them from specialist colleagues. However general practice had not always had the resources or skills to operate in the 'psycho-social space' until the introduction of social prescribing link workers says Martin Marshall RCGP Chair.



Health care is holistic. It is not about responding to ill health but instead addressing and preventing drivers like social injustice and health inequalities. The personalised care approach empowers and enables people to take control of their health and wellbeing which improves health outcomes. However, despite the increase in the use of personalised care, its growth is uneven across England and population groups.

Social prescribing link workers play a critical role in helping to reduce inequalities.

Any health care system that genuinely wants to reduce inequalities has to work with social prescribing link workers (SPLWs) to proactively work with people. By its very nature, social prescribing is a mechanism meant to empower and enable. The main driver of the SPLW model is the acknowledgment that the health and wellbeing of individuals and communities are often dictated by a range of environmental and socio-economic factors. Social determinants of health account for approximately 80% of all health outcomes. Social prescribing is all about holistic wellbeing and placing control of health with individuals, so they can save themselves.

How social prescribing can help GPs and practice teams

A telephonic intervention made by an SPLW identified barriers to attending smear tests and markedly increased the uptake of cervical smears in a group of women over 40 at a practice in Wirral.

SPLWs enable general practice and teams to offer holistic service to empower individuals and communities to help themselves. It also helps to bring general practice much

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closer to the community, highlighting that the GP is the glue that connects other services, rather than being the focal point where patients are over-reliant on their GP.

Increase recruitment and utilisation of SPLWs

The way that health care systems do this is by increasing resources and expanding the rollout to expand the number of SPLWs. Providing an exponential return, SPLWs are a valuable resource that can help increase an already strained NHS's capacity. Working alongside primary care and community services, SPLWs play a pivotal role.

Ensuring that SPLWs are meaningfully embedded within primary care opens new opportunities for public health and healthcare to become more person and community-centered to meet the needs of local people.

Revolutionizing the future

With an ever-increasing evidence base for the success of social prescribing and its impact on reducing social inequality, more and more primary care networks, GPs and integrated care systems are embracing social prescribing and committing resources to it.

Empowering our SPLWs and leveraging their engagement in and understanding of communities to help identify gaps in services and need, can inform local planning and knowledge of key issues. In many ways, SPLWs are the eyes and ears of their communities, ensuring no one is left behind. By identifying and removing key barriers to health, social prescribing addresses issues of social justice and health inequalities. As flexible, mobile individuals working closely with their respective communities, SPLWs can empower people to tackle social determinants of health that the NHS cannot traditionally reach.

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The National Association of Link Workers (NALW) is the only national professional body for link workers in the UK. As the largest UK professional membership body for Social Prescribing Link Workers, NALW plays a vital role in developing and supporting professional industry standards (including Continuing Professional Development) as well as a clear code of practice that underpins this vital workforce. NALW is a vibrant independent grassroots social innovation that serves to increase resilience, professionalism, and connectedness amongst Social Prescribing Link Workers & organisations.

Ensuring the voice of primary care is heard – facilitation support to help launch a clinical director reference group

In June 2021, the Government published the Integrated Care Systems (ICS) Design Framework, providing a broad overview of the future role, functions, and governance arrangements for the proposed NHS Integrated Care Boards (ICB), their relationships with ICS partners and anticipated timetable for their establishment.

Therefore, in the midst of the COVID-19 pandemic, with intense pressures on the health and care system, we are embarking on significant transformation and change. ICS are fast approaching 1 April 2022 when they will hold significant responsibility in relation to service planning and managing NHS resources. The clock is ticking, nationally we are already starting to see ICSs establish new structures and governance, providing the basis for collaboration across the health and care organisations within their system.

The West Yorkshire Health and Care partnership identified the need for a forum that could capture views, concerns and priorities for primary and community care and its primary care networks (PCNs) across Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

West Yorkshire and Harrogate Health and Care Partnership

A clinical director reference group was established in 2020, initially all 52 clinical directors across the system were invited. Due to the pandemic, it was difficult to reconvene the group for some time but Kathryn Giles, primary care programme director was keen to re-launch the group to make sure the voice of clinical directors was heard.

The ambition for the group was:

- For the workplan and areas of focus to be led by clinical directors
- To offer peer support across West Yorkshire
- To complement not duplicate place activities
- To discuss place priorities and also areas that the group could work on collectively
- To make recommendations to the ICS in relation to future priorities and funding for PCNs
- To provide a forum for sharing innovation and best practice

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Dr Julia Sutton-McGough
PCC Associate

In July and October 2021 Dr Julia Sutton-McGough provided facilitation support to enable the group to discuss and agree their terms of reference including representation for each place, frequency of meetings and the role of the clinical lead for the group. Views on priorities for future funding for PCNs were also discussed.

Keeping the clinical directors engaged and involved in the discussion was key to these sessions. Making sure that they could share place-based discussions and highlight concerns including how best to represent the views of others, identifying areas to work on collectively and recommending priorities for any funding allocated to support PCNs or the group. Action plans were agreed after each session.

It was agreed that the reference group would have representatives from each Place rather than all 52 clinical directors attending each meeting with an expectation that the representatives would gather views and seek input to priority areas and future agenda items. Recommendations around priorities and funding were collated and fed back to the programme board to inform their decision making.

Contact enquiries@pcc-cic.org.uk if you would welcome help to:

- Move a group forward when dealing with difficult issues
- Create the atmosphere for open discussion
- Bring neutrality and fresh perspectives
- Ask difficult questions and confront assumptions if needed

Reducing our carbon footprint

The recent COP26 conference and the various news headlines on the impact of climate change have brought issues on the environment and sustainability to the forefront and leave no doubt that action needs to be taken now. From a business perspective two factors have ensured that this topic has moved up the agenda. The first was the issue of the government's Procurement Policy Note (PPN)06/21 which set out how suppliers will need to demonstrate their Net Zero Carbon Reduction Plans if they wish to respond to tenders for government contracts and the second is the NHS's ambition, set out in October 2020, to be the world's first carbon net zero national health service.

Like many organisations PCC has had environmental and sustainability policies in place and we have all done our bit to support the environment such as using public transport, recycling and using energy efficient technology in our Leeds office. The time has come now though to up our game so that we can demonstrate that PCC is not only aware of its impact on the environment but that, as part of the NHS supply chain, we are taking action to support our clients in the NHS to meet their targets. Taking a pragmatic approach we also need to ensure the sustainability of our own business so we can compete for government contracts and places on frameworks. PPN 06/21 currently only applies to contracts over £5 million however the plan is that by 2024 this will apply to all contracts.

> "home-based working hasn't reduced the carbon emissions, it has just transplanted it and made it harder to assess".

As a small business PCC needs to balance its desire to meet its environmental and sustainability responsibilities with the resources this will require. We have put together a small working group who are reviewing what the organisation already has in place, identify relevant targets, what data we will need to collate and the actions we need to take to meet those targets. There is a lot of information out there and conflicting views on what is needed – for example, one way of carbon off-setting is tree planting, however surprisingly this isn't always the best option. As a predominantly home-based workforce this will make assessing our current carbon

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footprint a bit trickier – home-based working hasn't reduced the carbon emissions, it has just transplanted it and made it harder to assess.

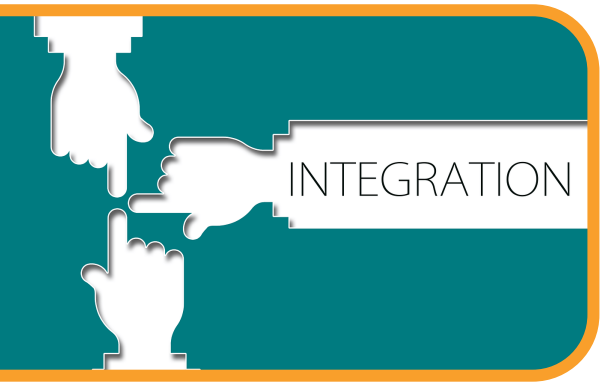
In April 2020 PCC switched to a mainly virtual delivery platform for our events and workshops. If we can take any small silver lining from the pandemic this switch to virtual delivery has helped PCC to reduce its carbon footprint with the additional benefit of proving popular with our clients. We plan to continue with this delivery model but are also looking forward to when we can meet you all face to face, albeit in an environmental conscious way.

When you are thinking of working with PCC, be assured we are actively working to reduce our carbon footprint and responsibly addressing environmental and sustainability factors across all our work areas.

Author
Wendie Groves, Assoc CIPD
Head of business support, PCC

Can the voluntary sector be successfully embedded in integrated care systems?

Integrated care systems (ICS) will become formalised in July, with the statutory incorporation of integrated boards and integrated care partnerships in the 42 system areas across England. This reform aims to create a better system of health and care where the patient or service user receives more timely and efficient care, delivered seamlessly across organisations and sectors. This builds on aspirations in the NHS Long-Term Plan, which has a focus on reducing health inequality, putting citizens, patients and carers at the centre, and moving services 'upstream' to focus more on prevention. This policy shift speaks very strongly to the voluntary, community and social enterprise (VCSE) sector.



Furthermore, the ICS Design Framework, published by NHS England in June 2021, includes an enhanced role for the VCSE sector, not just as service providers but in system leadership and governance. The guidance gives local systems flexibility in how they interpret guidance on the role of the sector, but it does also make some key recommendations:

- It sets out benefits of working with the sector, encouraging ICS leaders to value its knowledge and expertise and invest in grassroots groups.
- It points to the value of local VCSEs, rather than focusing solely on the work of larger providers and refers to some of the challenges the sector faces, including the substantial resource required to engage strategically with the new structures.
- It requires integrated care boards (ICBs) to have a formal agreement in place for engaging and embedding the VCSE sector in system-level governance by April 2022.
- It focuses on VCSE alliances as the mechanism to develop this, and to build on what already exists, including local VCSE infrastructure (explained below).
- It notes the importance of the role of the VCSE sector at place and neighbourhood, and the need to join these together across an ICS area, and to work with what already exists.

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- It notes the need for a coordinated system approach to social prescribing and engaging the VCSE in multi-disciplinary working via primary care networks.

- There is brief reference to the expectation that provider collaboratives operating at ICS or supra-ICS level should continue to involve the VCSE sector, noting the innovation the sector brings to the design and delivery of services.

Sceptics among us might feel that this is yet another public service restructure that is being hailed as a 'gamechanger' for the VCSE sector. But I am heartened by the level of attention the guidance has given to the VCSE sector, and this has been backed up by funded programmes to build the capacity of the VCSE to engage in the transformation. I have been involved as a consultant delivering some of this work for the last five years, currently with NAVCA, the national body that represents what our sector calls 'local infrastructure' – organisations that support and represent charities at a local level.

With this opportunity comes immense challenge. A key challenge in terms of the 'VCSE as equal partner' is the very nature of the sector. Unlike the NHS provider sector, which is usually a handful of large NHS foundation trusts, the VCSE is thousands, or tens of thousands, of organisations, ranging from tiny community groups with no staff to multi-million pound 'household name' charities. This is what enables the sector to be agile, responsive to the needs of its constituents, and able to reach the most vulnerable in society. Yet from the outside it can appear unwieldy, difficult to navigate and uncoordinated.

The VCSE sector in all 42 ICS areas is currently being supported to develop a VCSE Alliance. This can:

- provide a unified 'voice' for the sector
- manage competing interests
- provide a 'front door' to the sector for external stakeholders
- amplify the voices of the most vulnerable and unheard
- provide a platform for the sector to work towards being a proactive, independent and well organised sector, with its own agenda and strategies
- enable the sector to have a stronger voice and more coherent relationship with other stakeholders, such as local and devolved regional government, the corporate sector and the bigger and more strategic grant funders.

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The main challenge is that, in many of the ICS areas, the VCSE sector has not needed to organise at this geographic level before, and so new relationships and working arrangements are needing to be formed. And we know from much of our previous work in this sphere that the 'pick a model' approach to collaboration simply does not work. It is vital that time is spent doing the hard work of building the foundations of collaboration.

In a nutshell, these are:

- Building sustainable relationships
- Creating a truly shared vision and values
- Working out principles of joint working, and getting these recorded in policy documentation
- Investment and resources
- Strong leadership.

Of course, another big challenge is how the sector it is resourced to create and maintain leadership and representative structures. These roles, to be done properly, require significant time commitment.

My team has been commissioned to do a 'deep dive' into the VCSE structures and networks, and their influence, in one system area. The aim of this is to map their existing structures and capability, to inform their new system-wide alliance structure. This highlighted some great examples of leadership and representation, linked into to statutory sector structures, for example, a pilot project to mentor leaders of small BAME-led organisations in new rep roles, which included funding to backfill their time, to enable their participation in strategic networking. Yet it also exposed significant structural weaknesses, such as big disparities of investment in the VCSE sector, and particularly the local infrastructure function, and the lack of voice that many charity leaders experience, particularly those from very small organisations. We hope that our recommendations will help them to resolve some of these challenges as they build their VCSE alliance.

LEV PEDRO & ASSOCIATES

Lev Pedro is a freelance consultant, specialising in the role of charities in public service transformation and delivery, currently working as an associate to NAVCA on the programme 'Embedding the VCSE in ICS', funded by NHS England.

PCC support to commissioners

Our annual contracts continue to be popular with our NHS commissioners. We take time to talk to our clients to understand their support needs so that we can tailor our delivery.

We are known to our clients for our team's expert knowledge in primary care commissioning, through our training, surgery sessions and quality assured helpdesk. However, more recently clients are using their contracts to support team development. We have delivered MBTI (Myers Briggs) and Belbin sessions which help teams to find out how they can best work with their colleagues.

Feedback from sessions includes:

'A very engaging event. Presented in an excellent manner and obtained feedback from all individuals within the group. It was great to be placed in different groups to discuss preferred ways of working and finding out that some colleagues work the same as yourself.'

'Thought provoking, we are already using what we have learnt during the course to communicate and understand the team.'

We know we can support your team through the organisational changes that will take place in coming months and we would welcome the opportunity to talk to you about our annual contracts. For more information contact enquiries@pcc-cic.org.uk or go to our website to find out more www.pcc-cic.org.uk/annual-contracts/ All our contracts can be novated to successor organisations.

Upcoming PCC Events

Introduction to primary care estates management

Tuesday 22, Wednesday 23 (10.00-12.00) and Thursday 24 March 2022 (10.00-11.30)

Online training session

https://www.pccevents.co.uk/2609

Primary care medical contracts: key considerations and variations - an introduction

Tuesday 22, Wednesday 23 and Thursday 24 March 2022 (14.00-16.00)

Online training session

https://www.pccevents.co.uk/2685

Conflict in partnerships and PCNs: getting positive outcomes

Wednesday 23 March 2022 (14.00-16.00)

Online training session

https://www.pccevents.co.uk/2657

New to people management programme

Thursday 28 April 2022 to Thursday 28 July 2022

Online training programme

https://www.pccevents.co.uk/2669

Full events calendar https://www.pccevents.co.uk/calendar

Thriving at work in 2022 – developing personal resilience

How many of us may have set (and already feel thwarted by) new years resolutions, thinking about what we want to change about ourselves – be more this, do less that. Sometimes these plans can serve only to further dent our resilience at a time of year when it may already be low . During a global pandemic what we really need is a full tank.

'One day at a time' springs to mind as we think about how to cope entering the second full year of working through COVID times. PCC runs resilience workshops that focus on finding optimism at work and identifying what we can control, with tips on how to keep on keeping on. Our sessions are delivered for small groups of people, offering a chance to have some headspace, find practical ways to boost your resilience and also offer the opportunity to talk and listen to one another, enabling teams and groups valuable time to become more resilient together.

Our workshops can be delivered virtually or face to face, if its COVID safe, and personal resilience is just one of the personal and team development workshops we offer.

Visit www.pcc-cic.org.uk/people-and-teams for more information or contact events@pcc-cic.org.uk

PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk