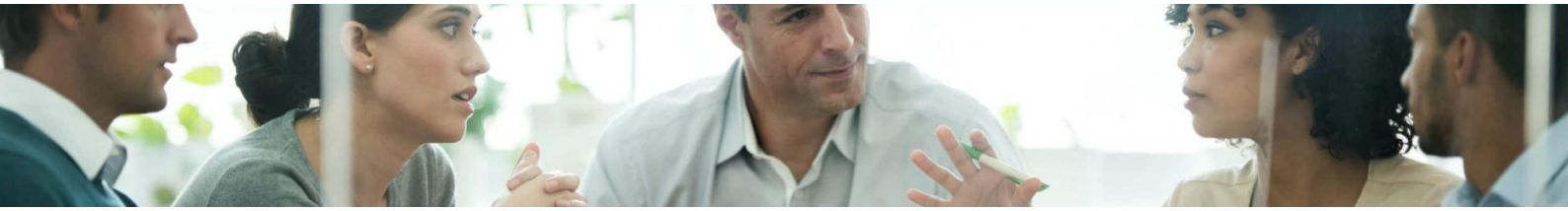
PCC Insight

April 2022



The future

The elephant in the room at the moment seems to be the question “what will general practice look like in the future – is it sustainable in its current form?” More and more practices are starting to work in different ways “at scale”. Whether that is through effective working within their primary care network, within a federation, super-practice models, or working closely with, or as part of, a trust – the vertical integration model. The drivers towards “at scale” seem to be intensifying. Drivers include the use of a range of different health care professionals, employment options for these professionals, sharing staff across practices, and simply maintaining sufficient workforce numbers. Attracting GPs to partnerships seems to be increasingly difficult, and estates issues, often the need to “buy in” are not helping.

The landscape is starting to change as integrated care systems, place level working and provider collaboratives are developing. How primary care networks and all primary care contractor professions work in, and with, the new landscape remains to be seen.

In this edition of PCC Insight we are sharing articles that look into the challenges for general medical practice, consider the model of vertical integration, and explore the

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possible benefits. We also offer tips on what primary care estate strategies need to consider.

There is the bigger picture to consider, and it has been stated in many documents recently that the health service needs to shift from treating illness to supporting wellness. Crucial to this is how health care works with communities, and the potential to overlook some of the smaller but highly valued community organisations is ever present. Mike Etkind looks at where is the C in VCSE and makes a strong case to engage with the community organisations that can help to make this aspiration a reality.

Author
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Chief Executive, PCC

Challenges for general practice

General medical practice needs to continually meet the warranted rising expectations of their registered patients. Inadequate access is perennially an issue and of parallel concern are lapses in quality of care and unwarranted variations in care provision. All these issues are equally of concern in all healthcare services worldwide. Recently there has been specific criticism of lack of face-to-face patient contact since the COVID-19 pandemic hit the UK. All NHS services are equally struggling to return to pre pandemic lockdown levels.

The vexed question of face-to-face care should not be subject to instant comments. This is a complex issue and many of us patients when appropriate welcome virtual consultations. Offering different clinical consultation modes is also the only way general practice can offer a reasonable speedy access response. GP cannot follow the hospital response of ever lengthening waiting lists.

During the COVID-19 outbreak, practices have had to strike a delicate balance between providing face-to-face patient care where clinically necessary and minimising the number of face-to-face patient contacts in line with national infection control protocols. In England, prior to the national lockdown in March 2020, just over 70% of GP appointments and almost 80% of appointments in general practice overall were delivered face-to-face. During the first national lockdown, these proportions changed dramatically, with data from the RCGP Research and Surveillance Centre showing that approximately 70% of GP appointments and over 65% of general practice appointments were being undertaken remotely by telephone or video. As practices have reconfigured their systems and processes to minimise risks of infection from face-to-face attendance, the mix of appointments has shifted to a more even split. By mid-March 2021 in England, telephone and video appointments accounted for 54% of total appointments, while face-to-face appointments made up 46%.

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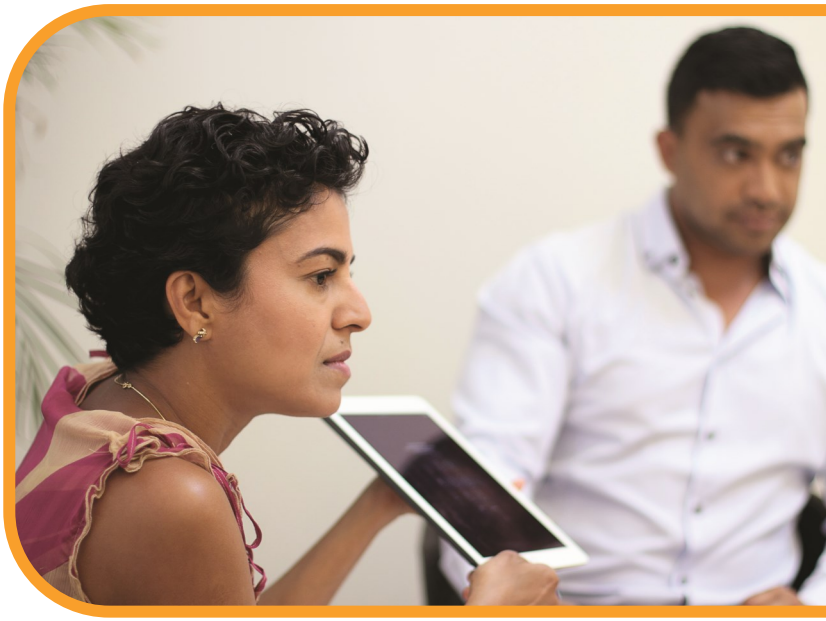
General practice is a multifaceted service encompassing care, cure and health and wellbeing. The essential attributes of a GP service are:

- First point of contact care for many
- Continuous person and family focussed care
- Care for all common health needs
- Management of long-term conditions
- Referral and coordination of specialist care
- Care of the health of the population as well as the individual

Any lack of access to that range of services is potential deleterious to patients. Alternatives are inevitably of lesser value although certainly still of use. GP out of hours services and various hospital urgent care services all offer very limited access to the huge amounts of people who attend general practice. Pressure induced by GP patients are claimed to overwhelm these services who inadequately cope with quite small shifts in numbers of attendees.



General practices though not solely responsible, are key to early diagnosis so important in better patient outcomes for instance in malignant conditions but also in long term conditions. Their care of vulnerable and frail patients is of manifold importance to patients and NHS alike. Recent Red Cross research figures suggest less than 1% of the population account for 16% of emergency department visits in England. There are similar figures for emergency ambulance use. This cohort of patients often respond positively to proactive case management techniques usual within or in association with their GPs. The necessary pandemic lockdown has negatively impacted on many such services where GP involvement is essential. Most of long-term conditions care is delivered in general practice, augmented by the quality and outcomes framework. The NHS high ranking by the Commonwealth Fund is largely due to general

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practice success in long term conditions care.

The present model of general practice has for the vast majority served the patients of its registered population well, and in turn the NHS well. General practice is the only NHS organisation that cares for the individual and registered population. And its strength is its localness. At a time when especially for socio-economic deprived populations services are becoming larger and more distant and inaccessible, general practice is an important part of local social capital. Do not remove or change it but support and enhance it. That was the purpose of the hugely successful and previously noted Primary Care Home model. The national policy successor the primary care network, should take on the mantle of the of its antecedent to support, nourish and enhance general practice so enhancing local community provision.

By Professor David Colin-Thomé, OBE, chair of PCC and formerly a GP for 36 years, the National Clinical Director of Primary, Dept of Health England 2001-10 and visiting Professor Manchester and Durham Universities.

Author
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Chair of PCC

New e-learning courses for spring

Following requests from our clients, we have added some new course topics to our e-learning portal.

The new course topics include planning, hybrid working, effective recruitment training, appraisal and interview training and mental health.

Planning

In these courses you will learn what planning is, how it can be used in a project, and the important steps that must be carried out whilst using an action plan. Learn how to contribute to your organisation's strategic planning process and how to support strategic initiatives by developing and executing action plans.

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Hybrid working

Hybrid working has become increasingly common as organisations recognise the advantages of operating outside of the traditional office-based roles in favour of more flexible options. Let's discover how a hybrid method of office work and working from home can be beneficial for productivity, innovation and your mental health. We look at the benefits it can bring to both the organisation and the individual.

Effective recruitment/hiring

Hiring is a crucial part of management. In these courses, we explain how to avoid the pitfalls of hiring and make sure you recruit the best person for the job. The courses include how to prepare for an interview, including the consideration of essential and desired criteria, how to start an interview, the types of questions to ask, and what to do once the process is concluded.

Mental health

We all have mental health but do you know how to take care of it? In these courses we'll explore what mental health is, ways to check in with your own mental health and when to seek support. We also look at mental health at work and what you can do to support your team and colleagues.

We have also added some new courses to our resilience and health and wellbeing playlists. These include courses on sleep, reflecting on work and life and building resilience at work.

E-learning is automatically included in our subscription contract offers to clients and can be purchased under a credit contract agreement at a discounted rate when you purchase other support from PCC.

To see our full list of courses at https://www.pcc-cic.org.uk/e-learning/. For information about e-learning, please contact enquiries@pcc-cic.org.uk

Vertical Integration

The secretary of state for health has recently announced the new priorities for the upcoming ICSs to deliver health and social care. These include prevention (public health and primary care), personalisation (patient centered) and performance priorities (measurement and accountability). While the new health and social care bill is being drawn into an act and law, primary care contracts themselves are nearing their review period at the end of 2023/24 and gives an opportunity for both commissioning teams and GPs/front line staff to test new models that can cater to the ever-changing health care needs of the new post-pandemic patient population groups.

Vertical Integration Model:

As part of this review of primary care, one such model that is being discussed and tested successfully is vertical integration (related distantly to the former PACS based model). In health and social care, vertical integration (VI) refers to the coordination of primary, secondary, and tertiary health care services within a tiered service delivery system. Having corporate and experienced teams managing NHS hospitals take over the operation of GP practices means that patients can continue to consult a range of health care professionals at the local practice rather than seeking healthcare elsewhere. In several places in the UK, GP practices are now being run by NHS hospitals, enabling some GP practices to continue that would otherwise have closed, says a new study by the National Institute for Health Research (NIHR) undertaken by researchers at the University of Birmingham and RAND Europe. Part of the on-going review is looking at how to better integrate GPs with hospitals and incentivise to link up with trusts. This would include ‘academy-style’ hospitals that are similar to the Wolverhampton model.

Benefits/opportunities of Vertical Integration:

- Successful vertical integration can lead to improvement in the continuity of care for each patient across the various tiers of health care delivery. For example, care necessary after a hospital stay should be provided by a primary care facility; in a successfully vertically integrated system, a patient’s primary care provider would be in communication with the hospital team caring for their patient and receive all the

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necessary documentation of the hospital or post-acute facility stay and discharge plans.

- VI could offer solutions for some primary care challenges such as rising demand and a high number of workforces nearing retirement
- Work activities can become equitable for all, and hours invested are paid appropriately
- Historically, GP practice staff have restricted career development opportunities and this model of working at scale with larger workforce and patient numbers can offer broader career opportunities
- VI can bring GP practice staff under the scope of NHS pensions, improved salary and redundancy packages, sickness benefits, cover arrangements, and other corporate perks available to Trust based staff
- In today's workforce, having the opportunity for a more flexible, work/life balance is becoming an increasing priority. This new VI model can help reduce some of the current burden in primary care, through streamlining some non-value-based functions.
- Front line clinical and patient focussed time can increase if the VI model can subsume back-office administration, HR, finance, estates and other non-clinical maintenance and support function roles
- Anecdotal information has suggested that GP's working lives have been broadly positive under VI model
- GPs also have access to professionalised governance, which supports things such as CQC processes, complaints, and incidents, while patients have access to more services from their practices.
- Practice staff can have access to high quality training and personal development package which is more often lacking in a traditional small practice
- Practices can improve their outcomes by piggybacking on the Trusts intelligence and data driven teams for population health management focus style patient prioritisation
- There is protection of employment for staff and access to unions and basic employment rights
- There is a good relationship between GPs and the trust where it is working

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Challenges to consider:

- There has been no extensive independent evaluation of outcomes for such an approach in UK, but models do exist and work well where they have been implemented elsewhere (such as in USA, Canada, Australia) – but this can be developed prospectively, and one can learn from local UK models where these have been implemented in the past few years.
- There is limited evidence, to date as to improvements in patient satisfaction, GP workload reduction or better health outcomes – this must be built in and captured at every stage in the first few years of implementation.
- There is also a question of choice being limited for patients if most practices are run as such, and more so, if the same Trust also offers acute or community care as well in the locality.
- Some patients prefer smaller boutique style local practices closer to their homes and workplaces and shy away from large healthcare providers (although this can be mitigated by having local branch practices in the traditional sense).
- Loss of autonomy by some GPs has been noted and have described feeling more like locums or salaried GPs, although this can be averted by including willing or experienced GP reps on Trust boards which will only improve their influence on combined pathways.
- For commissioners, there is a concern that a two-tier service could develop in local places, where patients at trust practices get priority access.
- It has also been pointed out that once a practice joins, it is difficult to leave – partly because staff move to different terms and conditions.

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Implementation support we can offer

PCC is experienced in implementing models such as these through our experience working at scale, including development of GP Federations, and working across community and acute trusts. Through our experienced team of experts and associates well versed in years of such experience, they are aware of what works and what does not, and where trusts can face challenges or have historically suffered failures. Primary and secondary care work very differently and it is not a case of 'one type fits all', rather working with organisations to help identify which model and approach would be most appropriate for them. Primary care is a very sensitive area and localities have their own unique issues and challenges. The single most important consideration is for both parties/sets of organisations to understand each other's cultures and to agree a vision and journey to become one over a period of time.

PCC can help develop and implement vertical integration through a system of modelling and GP engagement with trust partners and leads. Successful vertical integration relies upon active collaboration and cooperation from stakeholders at all levels of the health care system. To that end, PCC can help each member understand its clearly defined role and range of services that can be offered and proactively participate in the communication system.

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While higher-tier trust teams can be guided to offer support in the form of technical assistance, mentorship, partnership, workforce development, and/or supervision to lower-tier facilities, they should not be the sole (or even primary) drivers of the integration. The GP practice teams equally must contribute bottom up and be viewed as gatekeepers of health care. PCC thrives in its experience and engagement skills and having relationships with PCNs and practices. When one considers VI, there are various models that can be tested as per the local requirements, and often having an external partner such as PCC present, to act as a coordinating and facilitating stakeholder in the building phase, can prove beneficial. Where such VI models have been implemented, often they have been treated with suspicion at the time but have been viewed as a 'lifeline' for the practices involved.

PCC can help remove the various challenges highlighted above and help to build the trust between partners from day one, allowing the creation of successful and long-lasting models. Such approaches should not look like a top-down done deal, but rather an engaged, informed, and equitable partnership. We can help you realise your aspirations and develop a VI model to establish an integrated primary healthcare-based health system.

Contact enquiries@pcc-cic.org.uk

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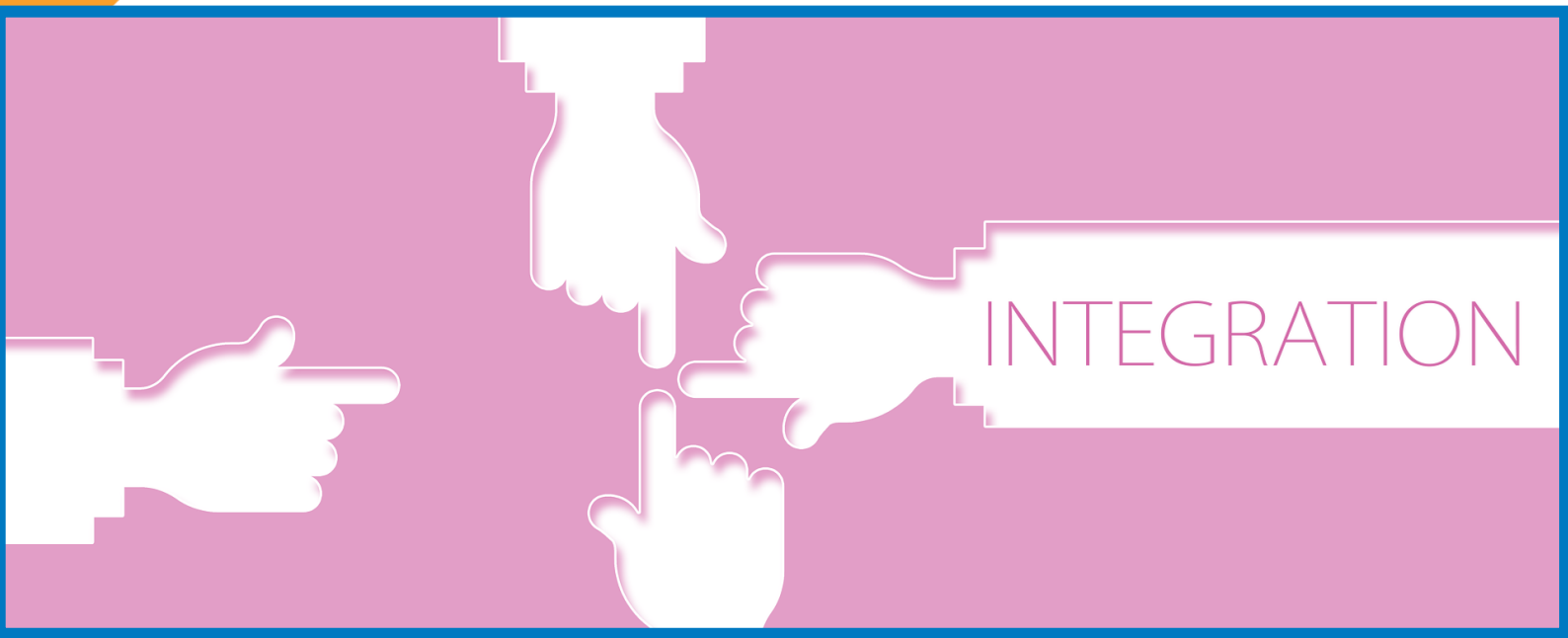

What makes a PCN leader?

PCN leaders, whether they are PCN managers, clinical directors, pharmacy leads, practice managers or others will be beginning to position themselves to take a metaphorical and literal seat at the new ICS table. They are going to need a strong, clear voice, the confidence to represent their PCNs, persuasion skills and a fair amount of political acumen.

In the last two years, PCC has worked with over 200 leaders from PCNs across the country who have either attended one of our leadership development programmes or had individual executive coaching. It's clear from this experience, that there are high levels of both trepidation and excitement in terms of applying leadership skills to the new challenge.

Feedback has been that the biggest issues facing PCN leaders include the need to influence and engage with sometimes reluctant groups of peers and with new potential partners and the need to develop the confidence to represent the PCN in a new political and organisational environment.

We have worked on identifying the voice and the message, who to communicate to, who to communicate with, and how. We've encouraged network groups to work together – to build trust and work in an open and transparent way promoting a joint approach. The aim is to be the unified and perhaps formidable voice of primary care.

> "the training encouraged everyone to think about how they communicate with each other and make positive steps to improve communication and team working moving forward"

Essentially, we've been focussing on the importance of leaders getting the communication right, on the importance of creating a safe space where everyone can engage and contribute, feeling valued and represented. We provided a leadership development programme for a group of PCN leads who said that "the training encouraged everyone to think about how they communicate with each other and make positive

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steps to improve communication and team working moving forward”

Recent evaluation feedback included learning outcomes as follows:

“Being more able to work as a compassionate leader to lead, create and maintain change, and to apply the power of persistence”

“I’m going to look at different approaches to apply to changing our organisational culture so that we all have a clear picture of why we do what we do as this is increasingly lost to us”

“Our one-to-one coaching has demonstrably supported individuals through turbulent times as they’ve juggled leading and developing the PCN as well as co-ordinating the response to Covid-19.”

One testimonial states that the coaching “Helped me prioritise and together we tackled a few key problems. Helped me view these using different lenses and analyse the issues before helping me create a list of actions"

In one leadership development programme that finished in early March, the group spent time on organising themselves to work together going forward and were already coming up with new creative ideas to take to the ICB, ideas that they believed would strengthen primary care in their community.

Our programmes are delivered by coaches who quickly assess and respond to different learning styles. We’ve got experience of working with so many different people with different priorities, challenges and learning styles. We adapt our approach and the delivery of sessions according to the needs of the groups and ensure that everyone has an opportunity to learn and contribute in ways that suit them. We encourage groups to build trust and work together, offering opportunity for pairs and small break-out groups to work together as well as in the larger discussion. We utilise the online chat function and offer other methods such as Slido.

Through listening to feedback we’ve learnt that the most valuable learning happens through the experiential and we’ve designed our programmes so that they run along the lines of an action learning set. Each participant agrees to an action or takeaway at the end of every session. At the start of the following session, we revisit these pledges and

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can all benefit from the learning of each other's experience. It makes the learning very real and applicable and imperceptibly reinforces the group trust

We also understand the pressure of work and life. We don't ask for quantities of homework, but we do offer theories and models as well as suggested further reading on our topics and the leadership skills focussed on, for instance understanding others, influencing and the ability to act on behalf of and represent others.

Author
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Head of development, PCC

Where is the C in VCSE?

There are many, many local groups of volunteers who do stuff for their local community. And then there is the VCSE.

This, of course, is a misrepresentation. But from where I sit, involved as chair of my surgery's patients group, previously running a small social badminton group, and linked in to several local volunteer efforts, I wonder whether there is enough recognition of the micro/nano-scale activities when the acronym VCSE (Voluntary, Community and Social Enterprise) is deployed. And I am raising this because ICSs are meant to be operating at place and neighbourhood/PCN scale and involving the VCSE.

We all know of the 'wartime' response from communities as the pandemic hit. A good deal of this was not organised by, or set within, established volunteer groups, but simply neighbours and local groups of people providing support for residents of their street, block of flats, etc.

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But, both before and after that, there have always been people volunteering in their local community to run things which are helpful to the health and wellbeing of their fellow citizens. And there are also social enterprises or micro-businesses that do the same.

Things like:

- Street associations
- Volunteer hospital transport groups
- One-off local charity shops
- Community hall committees
- Patient groups
- Zumba, pilates, yoga, bridge classes
- Social groups
- Cubs, Scouts, Guides etc
- Faith groups (I believe some use the acronym VCSEF to include this 'sector')
- Parent teacher associations
- Local clubs and societies: historical, choral, dramatics, photography, walking
- WI/Rotary/Lions/Oddfellows
- Book groups
- Community shops and cafés
- Gardening and allotment societies
- Community associations and campaign groups
- Informal sports clubs/fitness activities
- Acts of kindness Facebook groups

Here's a posting on a local community email group:

"Afternoon tea groups: One Sunday a month, a group of elderly people who live alone gather for an afternoon tea. Volunteer drivers pick them up and take them to a host's house. The host prepares the tea, the drivers help to serve it, and all enjoy socialising for 2 hours…We are looking for new hosts. There are usually about 7 elderly people and 3 drivers and you would be asked to host once a year. If you think you might be able to help and would like to find out more, please call XXX."

Sunderland Food with Friends, with 413 members, says: "We are group of people who come together for friendship and support".

The Greater Manchester State of the Voluntary Sector 2013 report estimated that there were 9,624 'below the radar' organisations compared to 4,968 registered voluntary groups in Greater Manchester.

To make clear, I am not detracting from the excellent work the 'mainstream' VCSE sector does. I just want to query two things:

A. whether the voice of micro community activities is sufficiently well represented

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at the policy table;

B. whether those seeking to integrate health and social care sufficiently recognise the resource that exists in local communities.

Taking these in turn, I do not know what goes on in policy circles, but what I have seen does make me think that VCSE often tends to be seen in terms of larger bodies or, as my local VCSE alliance recently described to me, "constituted" organisations. Thus, do the 19 members of the Voluntary, Community and Social Enterprise (VCSE) Health and Well-being Alliance, all seemingly national bodies, give enough voice to micro community activities? Is the NHS Confederation's 2020 briefing How health and care systems can work better with VCSE partners talking about micro community activities when it says:

> "Local VCSE organisations need to be included in health and care pathways and service redesign planning across systems, including population health management and social prescribing in primary care networks".

I entirely understand that it is hard enough for large, constituted bodies to find the time for all the meetings necessary to have a policy presence. So for those involved with micro community activities, the time and skills to get involved will in most cases be too demanding or daunting. So my call is for the larger VCSE bodies and everyone involved in an ICS to keep in the front of their mind that bigger VCSE is not everything.

As an aside, one issue does worry me about the scope for larger VCSE bodies to speak their minds. It seems to me that they are often also within the system as service deliverers commissioned by ICS members and therefore may feel constrained in what they say.

As to recognising the micro community resource, I hope that social prescribing link workers will be able to play a big part. It seems to me an essential role for these relatively new players on the primary care scene to build up and maintain a comprehensive database of who in their patch is offering what – down to the micro scale. Indeed, I see benefits from them sharing their database as a public resource.

But, at ICS policy levels, there is again an opportunity to factor in where services are already being provided at the micro scale. This might be with a view to providing support (financial or other). Or it might be generating ideas on whether similar volunteer effort might be encouraged elsewhere; building a picture of what is available 'out there' for strategic planning purposes; or engaging with the micro activities to get their

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perspective on delivering integrated health and social care at neighbourhood scale. The 2016 Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector said:

"Targeted support for the very smallest social enterprises and community groups can play a large part in creating health and wellbeing, as fewer people will be left unsupported where there is a wide range of community-based and innovative interventions from which to choose."

And how do these micro activities help with health and wellbeing. I'll let the Tea Break Gardener have the final word (about her joining two local gardening societies):

"I instantly met a group of people from diverse social backgrounds with a common love for plants and gardening. For an annual subscription costing no more than a cup of tea and a bun in my local cafe, I've attended half a dozen widely different but stimulating presentations from external speakers, taken part in my first shows and begun to make friends in my community that I'd never otherwise have met."

Mike Etkind is among other things chair of a PPG, founding member of his PCN's patient group, a member of the advisory panel of his local Healthwatch, a Mind befriender, and lay advisor on the Wellbeing Impact Study of HS2.

Author
Mike Etkind

Estate strategies – why now?

"Bursting at the seams" is a phrase that we regularly hear when talking about our primary care premises. With the delivery of primary medical contracts, the increasing number of roles through the additional roles reimbursement scheme (ARRS) and plans to deliver care closer to home the pressure on our primary care estate is ever increasing.

All too often the conversations about the premises to deliver care come way after the planning and redesign of services, which quickly lead to the realisation that our buildings are not suitable or fit for purpose.

The reality is we need a modern fit for purpose primary care estate to enable the delivery of primary care medical services in a clean, secure, compliant environment for both patients and the primary care team. However, there isn't a pot of gold at the end of the rainbow for primary care premises, so why even bother setting out your estates needs for the future?

Because ……

To deliver the primary care network (PCN) clinical vision and operating model there needs to be a fundamental understanding of the existing estate portfolio; its condition, utilisation, future flexibility and ability to support the delivery of patient care. Our estate is an essential component to patient care. We need to understand what we have now and what we are likely to need in the future.

So how do we do this?

There are several helpful guides and support tools to help you through the process. The National Association for Primary Care (NAPC) in conjunction with Community Health Partnership (CHP) produced a guide in 2020 which sets out the considerations as part of your estate plan. What you need to think about can be broadly covered by five key questions:

1. What is the current estate position?
2. How will services be provided in the future?
3. What are the estates implications of the clinical strategy and PCN vision?

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4. What options would meet service requirements and estates gaps?
5. What is the implementation plan?

As well as the guide there is also a toolkit available. Again, developed by NAPC and CHP the toolkit has been designed to utilise data and analysis already gathered via the primary care data gathering programme (PCDG) and live local datasets held on the SHAPE PCDG Atlas. Each PCN can be able to request a pre-populated version of the templates with their local SHAPE data embedded, to provide a good starting point. Further information on the toolkit can be found here. Access to the toolkit is freely available via a simple registration process which enables the download of the generic templates and guidance notes from https://shapeatlas.net/pcntoolkit/

If you are interested in discussing how PCC can support you with developing your estates strategy please contact enquiries@pcc-cic.org.uk.

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Upcoming PCC Events

Getting to grips with the PCN dashboard

Thursday 12 May 2022 (10.00-12.00)

Online training session

https://www.pccevents.co.uk/2708

What is compassion at work and why does it matter?

Tuesday 17 May 2022 (09.30-12.30)

Online training session

https://www.pccevents.co.uk/2695

The leader as a coach - building stronger teams

Thursday 19 (10.00-12.00) and Wednesday 25 May 2022 (14.00-16.00)

Online training session

https://www.pccevents.co.uk/2666

Leading without authority

Wednesday 8 June 2022 (09.30-12.30)

Online training programme

https://www.pccevents.co.uk/2659

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

Community pharmacist consultation service

PCC is delighted to have been commissioned to support practices to implement the community pharmacist consultation service (CPCS) referral pathway. The contract is to help practices review processes to increase the use of the service, essentially to increase referral numbers.

We are mobilising a national support programme which aims to provide practices and PCNs with:

- Support developing and implementing an action plan
- Access to resources
- Training in persuasion and change management skills

Our team of facilitators has a wealth of experience in working with practice teams and we understand and are sensitive to the challenges they face. We can adapt and nuance the support according to where the practice is in the process and their levels of confidence about referring.

We're working with regions and ICS leads to establish the support required in practices and PCNs – it could be conversations with the practice manager about the barriers they're experiencing and how to support the staff to overcome them, or it could be group coaching workshops at PCN level – looking at how to increase referral numbers and keep the momentum going. In addition, we'll be delivering introductory webinars and online training sessions covering softer skills such as influencing skills which can help to build confidence in those making the referrals and having the conversations with patients. These can be accessed by all practices.

There's a network on NHS Networks for participating practices to build a community where they can share experiences and access resources. All the support is free for practices to access.

It's an exciting programme and we're looking forward to sharing the journey over the next few months. For more information https://www.pcc-cic.org.uk/cpcs/

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Head of development, PCC

Event management services

PCC has a dedicated events team in order to organise and deliver its extensive training, workshops and events programmes.

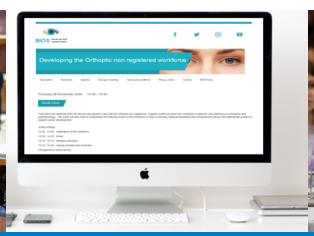
As a not-for profit, community interest company we have been offering event management services to wider clients and have run major events for police forces, local government, the fire and rescue service to name a few.

We can help with any aspect of event planning right through to the full end-to-end event management. We offer but not limited to:

If you require any assistance with planning your next event, whether that being face to face, hybrid or online we'd love to hear from you.

www.pccevents.co.uk

events@pcc.cic.org.uk



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