NHS England

Primary Care Networks: sharing learning from local areas

Tuesday 5 February 2019, 10-11.30am

NHS England

Aims of the webinar

This engagement webinar aims to:

- Provide an update on the primary care networks programme.
- Provide examples of the some of the positive impacts for patients and staff.
- Consider what support may be needed in the journey to PCNs and how this could be delivered at a national, regional and local level.

Things are changing…

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The changing health needs of the population are putting pressure on the health and social care system in England.

Ageing population

Between 2017 and 2027, there will be 2 million more people aged over 75.

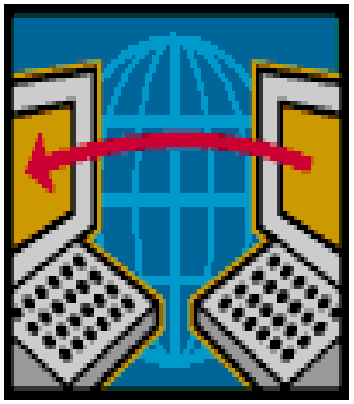
Chronic conditions

The main task has changed from treating individual episodes of illness, to helping people manage long-term conditions.

New Treatments

The steady expansion of new treatments gives rise to demand for an increasing range of services.

And our expectations are changing too.



… and the system has not changed enough to meet our needs

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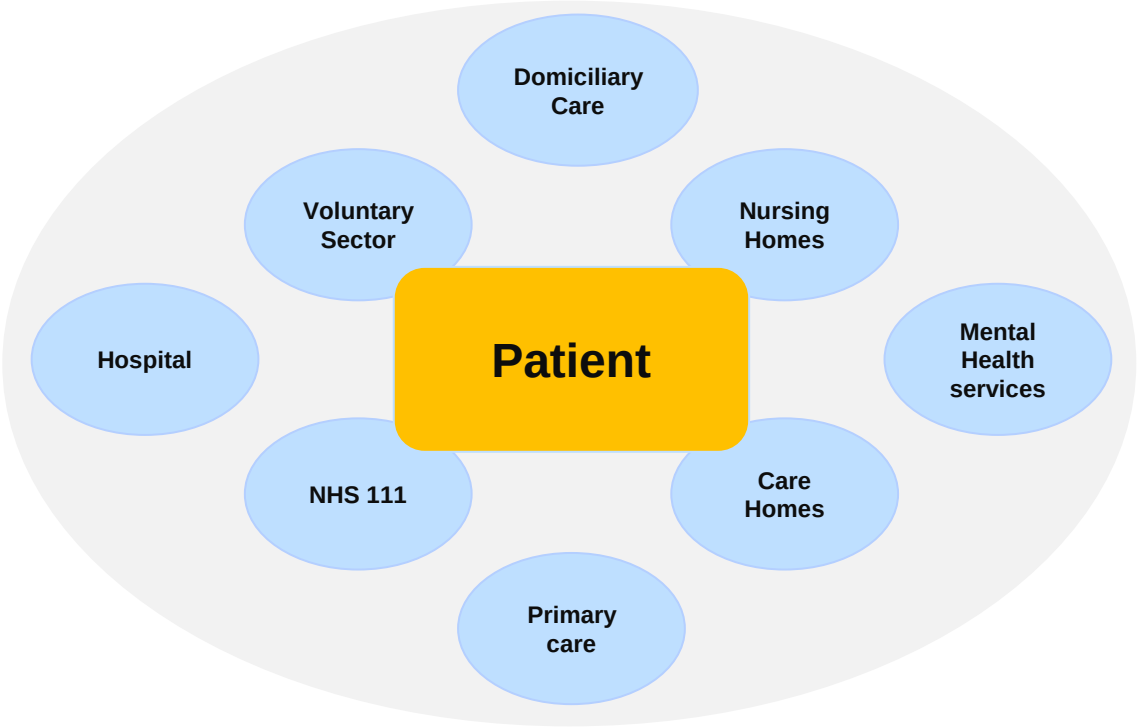

- Service provision is fragmented in multiple different types of organisations
- Too often, these services don't communicate effectively with each other
- The totality of patients' needs are not always understood by those serving them
- Care is not always delivered in a person-centred way

Despite growing pressures, the NHS is efficient, equitable, and improving

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The system operates under considerable pressure

- Helps over 20 million mental health service users a year[1]
- Conducts 5 million GP consultations per week[2]
- Serves over 1 million patients[3], delivers 1,900 babies[4], admits 64,000 people to A&E[1], completes 28,000 operations a day[1]

We continue to improve in specific areas

- Waiting times are lower than a decade ago (although slowly rising)[7]
- Annual cancer survival rates are improving[8]
- Heart attack and stroke deaths have tumbled (total CVD mortality is down 68% since 1980)[7]

The NHS is more efficient that the rest of the economy

- In 2016-17 healthcare productivity grew by 3.0%, more than treble the rate achieved across the wider UK economy

However, we still lag behind our international counterparts in some areas

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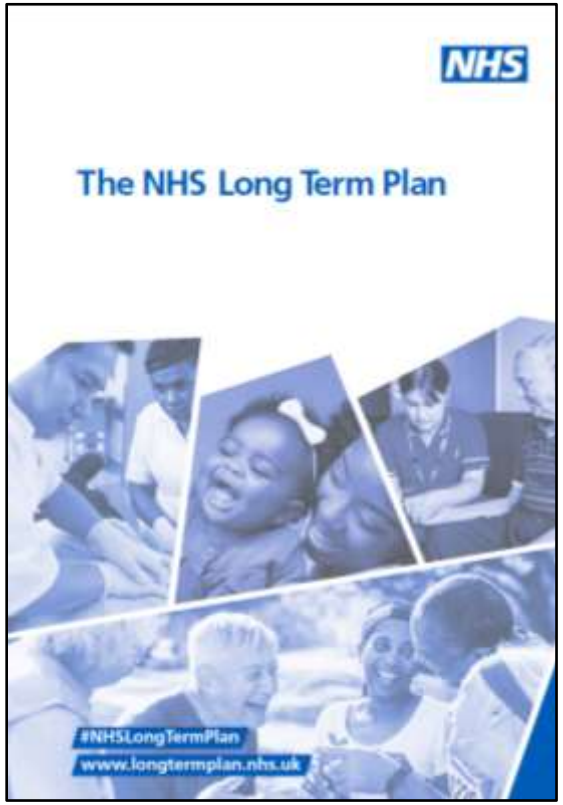
Above average performance	Below average performance, but improving	Below average performance
Diabetes	Breast cancer	COPD
Kidney disease	Colorectal cancer	Heart attack
Suicide	Lung cancer	Amenable mortality
Patient experience	Pancreatic cancer	Birth
	Stroke	
	Lower respiratory tract infection	

Source: Nuffield Trust Report – How Good is the NHS? (2018)

The NHS Long Term Plan

NHS England



Aims:

- Everyone gets the best start in life
- World class care for major health problems
- Supporting people to age well

How:

- Developing integrated care systems with primary care networks as the foundation
- Preventing ill health and tackling health inequalities
- Supporting the workforce
- Maximising opportunities presented by data and technology
- Continued focus on efficiency

The NHS Long Term Plan – Funding and Support

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- **£4.5bn of new investment.**

- This new investment will enable PCNs to attract and fund additional staff to form an integral part of an expanded multidisciplinary team.

- Initially this will focus on clinical pharmacists, link workers, physiotherapists and physician associates. Over time, it will be expanded to include additional groups such as community paramedics.

- The Government has also committed to a new state-backed GP indemnity scheme from April 2019.

The NHS Long Term Plan - Workforce

NHS England

- Building on the General Practice Forward View (GPFV) commitment to increase the number of doctors working in general practice - continued commitment to the increase of 5,000 doctors.

- In addition, there will be a continued focus for a range of other roles – pharmacists, counsellors, physiotherapists, nurse practitioners.

- Expanded neighbourhood teams including GPs, nurses, pharmacists, community geriatricians, dementia workers and AHPs plus social care and the voluntary sector.

- Newly qualified doctors and nurses entering general practice will be offered a two-year fellowship.

- Training and development of multi-disciplinary teams in primary and community hubs.

- Through social prescribing the range of support available to people will widen, diversify and become accessible across the country. Link workers with PCNs will work with people to develop tailored plans and connect them to local groups and support services.

The NHS Long Term Plan - Digital

NHS England

- A digital NHS ‘front door’ through the NHS App will provide advice, check symptoms and connect people with healthcare professionals.

- Digital first primary care will become a new option for every patient improving fast access to convenient primary care. Over the next five years every patient in England will have a new right to choose this option – usually from their practice, or if they prefer, from one of the new digital GP providers.

- We will do this by:
  - Creating a new framework for digital suppliers to offer their platforms to PCNs on standard NHS terms.

- In parallel we will ensure that new ‘digital first’ practices are safe and create benefit to the whole NHS. This means reviewing current arrangements including out-of-area arrangements.

- Reviewing GP regulation and terms and conditions to better support the return to practice and increased participation rates by GPs wanting to work in this way.

The NHS Long Term Plan in summary

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1. Do things **differently, through a new service model**
2. Take more action on **prevention** and **health inequalities**
3. Improve **care quality and outcomes** for major conditions
4. Ensure that **NHS staff** get the backing that they need
5. Make better use of **data** and **digital technology**
6. Ensure we get the most out of **taxpayers' investment** in the NHS

How will the LTP support delivery of networks?

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Service Integration

- Community service redesign into clinical networks 30-50K with an accountable clinical director for each PCN
- Community multi-professional teams, responsive and proactive
- Expansion of community MDTs to operate in networks of practices, funding through a network contract
- Fully integrated community based health care , training locally, community hospital hubs
- Enhanced health in care homes
- Direct booking to 111

Financial

- 4.5billion over five years
- Contracting may be at PCN level for some services
- Need to develop the provider landscape
- Should develop local clinical leadership- Network clinical directors
- Accountability
- Shared saving scheme, links to emergency avoidance
- Review of QOF
- £1.50 per head recurrent funding

Prioritisation

- Focus on outcomes, less on targets
- Use Population Health Management – tools, data, intelligent decision making, create the right architecture to support this
- Prevention – stronger immunisation
- Personalised care plans
- Increase social prescribing
- Focus on children and young people, safer maternity services, and mental health – addressing unmet need
- Early detection cancers

Governance & Leadership

- Clear line of sight from primary care to ICS exec team
- Accountability
- Local ownership
- Focus on outcomes
- Dedicated time for clinical leaders
- Clear career progression

Digital front end and technology

- Sharing records
- Population Health focus
- Home based and wearable monitoring (tech)
- Improved urgent care as a system, clinical assessment service
- Digital first access to primary care

Addressing the workforce shortfall – additional roles reimbursement

- In 2023/24, NHS England will make £891 million available which equates to £726,000 new annual funding for a network with an average weighted 50,000 population.

- NHS England and GPC England are committed to making funding available for up to estimated 20,000+ additional staff in five groups by 2024.
  - social prescribing link workers (reimbursement from 2019/20)
  - clinical pharmacists (reimbursement from 2019/20)
  - first contact physiotherapist (reimbursement from 2020/21)
  - physician associates (reimbursement from 2020/21)
  - first contact community paramedics (reimbursement from 2021/22).

- The scheme covers 70% of the actual ongoing salary costs of additional clinical pharmacists, physician associates, first contact physiotherapist and first contact community paramedics. There is 100% reimbursement of the cost for social prescribing link workers.

- Reimbursement for roles will be dependent on network size and skill-mix preference.

- In 19/20, every network of at least 30,000 population will be able to claim 70% funding as above for one WTE clinical pharmacist and 100% funding for one WTE social prescribing link worker. Beyond 100,000 network size, this doubles to two WTE clinical pharmacists and two social prescribers; with a further WTE of each, for every additional 50,000 population.

Introducing the Network Contract DES (1)

- The Network Contract will be a large Directed Enhanced Service (DES). By 2023/24, it is expected to create national entitlements worth £1.799 billion, or £1.47 million for a typical PCN covering 50,000 people, in return for phased and full implementation of all relevant NHS Long Term Plan commitments. Of this, £1.235 billion is new investment.

- The Network Contract has three main parts:
  - the national Network Service Specifications - these set out what all networks have to deliver;
  - the national schedule of Network Financial Entitlements, akin to the existing Statement of Financial Entitlements for the practice contract; and
  - the Supplementary Network Services. CCGs and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.

- GPC England and NHS England are committed to 100% geographical coverage of the Network Contract by the Monday 1 July 2019 ‘go live’ date.

Introducing the Network Contract DES (2)

- Every practice will have the right to join a Primary Care Network (PCN) in its CCG and have a right to participate in the Network Contract DES.
- To be eligible for the Network Contract DES, a PCN needs to submit a completed registration form to its CCG no later than 15 May 2019, and have all member practices signed-up to the DES.
- CCGs are responsible for confirming that the registration requirements have been met by no later than Friday 31 May 2019.
- Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the PCN can start receiving national investment from 1 July 2019.
- A typical practice can also receive over £14,000 each year from April 2019 as a new SFE payment, in return for their active participation in a PCN as demonstrated by signing up to the Network Contract DES.
- In the highly unlikely event that a practice doesn't want to sign-up to the Network Contract, its patient list will nonetheless need to be added into one of its local Primary Care Networks.
- A PCN will typically serve a population of at least 30,000 people and must have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community. Normally a practice will only join one network.

Introducing the Network Contract DES (3)

- All PCNs will have a Network Agreement, even those with one large practice. The Network Agreement is also the formal basis for working with other community-based organisations and must be signed by all constituent GP practices.

- A PCN must appoint a Clinical Director as its named, accountable leader, responsible for delivery.

- PCNs will also benefit from:

  - 0.25 WTE Clinical Director support funding (per 50,000 population);
  - a guaranteed £1.50 per registered patient from CCG allocations;
  - many CCGs also provide support in kind for their PCNs e.g. through seconding and paying for staff to help with particular functions; and
  - during 2019, NHS England will establish a significant new national development programme for PCNs.

Background

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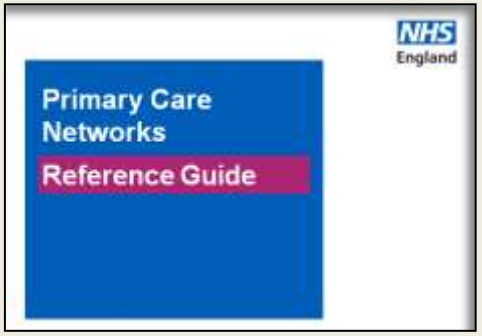
A working definition

Primary care networks enable the provision of **proactive, accessible, coordinated and more integrated primary and community care** improving outcomes for patients. They are likely to be formed around natural communities based on GP registered lists, often serving **populations of around 30,000 to 50,000**. Networks will be small enough to still provide the personal care valued by both patients and GPs, but large enough to have impact through deeper **collaboration between practices and others in the local health (community and primary care) and social care system**. They will provide a platform for providers of care being sustainable into the longer term.



- Provides support for local communities, building on learning from the existing models;
- Provides advice on the key areas commissioners and practices might consider in establishing primary care networks locally;
- Sets out the vision for networks, core characteristics, care models at the heart of primary care at scale;
- Identifies key enablers that underpin effective development of networks;
- Shared widely for comments and we'd like your views – released in autumn.

Primary care networks – key to the future

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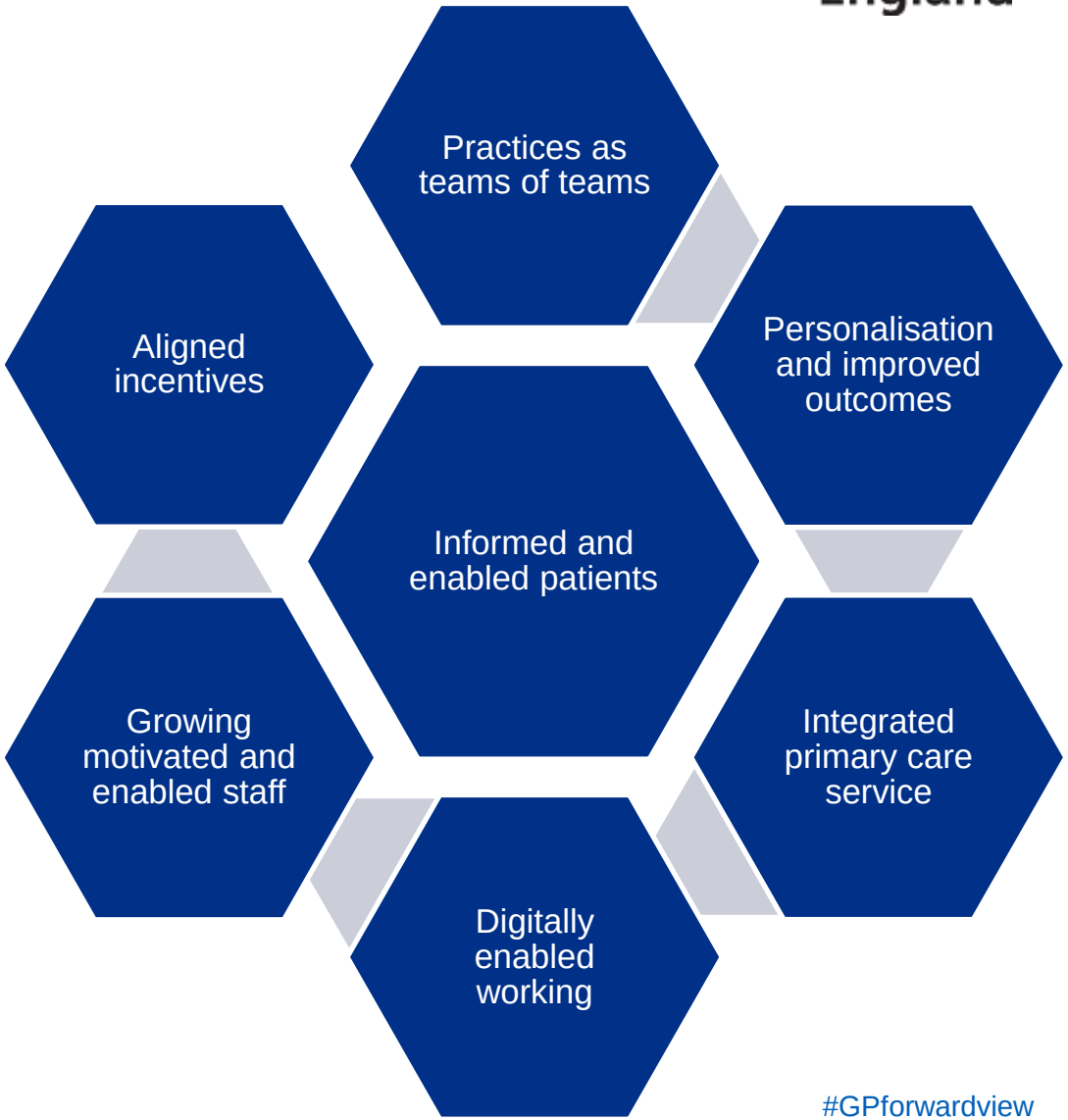
- Primary care networks are small enough to give a sense of local ownership, but big enough to have impact across a 30-50K population.
- They will comprise groupings of clinicians and wider staff sharing a vision for how to improve the care of their population and will serve as service delivery units and a unifying platform across the country.



#GPforwardview

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The role of continuity - small enough to care, big enough to cope:

How can we get better at providing patient centred care: does continuity matter?

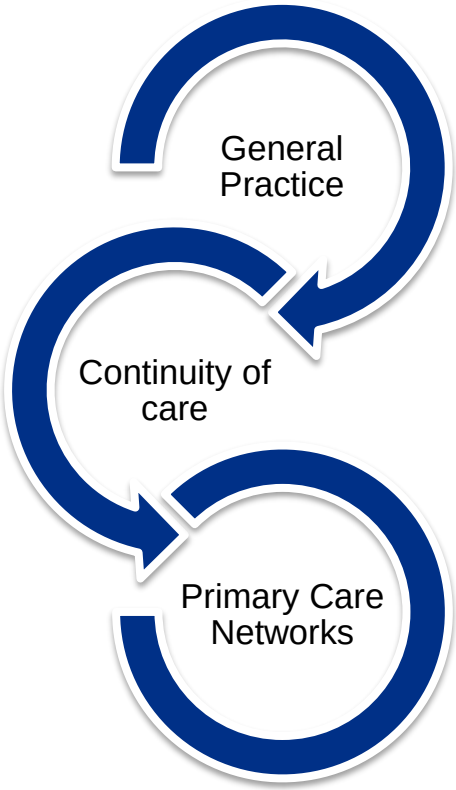
https://www.bmj.com/content/350/bmj.h1127/rr

Divided we fall: getting the best out of general practice

https://www.nuffieldtrust.org.uk/research/divided-we-fall-getting-the-best-out-of-general-practice

Personalising care for patient sub-groups in general practice

https://www.health.org.uk/programmes/innovating-improvement/projects/segmenting-within-general-practice-personalising-care



"With enough funding and staffing it should be possible to offer every patient both timely, convenient access for immediate problems and a continuous relationship with one or more clinicians for those with more complex ongoing needs."

The evidence base for the PCN population size:

National Association of Primary Care (2015). Primary Care Home: An Overview
Dunbar R (2010). How many friends does one person need? London: Faber and Faber
Ham C (2010). GP budget holding: Lessons from across the pond and from the NHS University of Birmingham HSM
Martin S, Rice N, Smith P (1997) Risk and the GP Budget Holder York: Centre for Health Economics
Bachmann M, Bevan G (1996) Determining the size of a total purchasing site to manage financial risks of rare costly referrals: computer simulation model British Medical Journal

Networks in action

ZIO network, Maastricht, the Netherlands

'15% decrease in proportion of patients with poor glycaemic control'

Lakes district health board, Midlands Health Network, NZ

'…a history based around quality improvement and the sustainability of the GP-patient relationship'

Primary Care Networks, Alberta, Canada

'The Quality Council of Alberta research confirms that patients attached to a Primary Care Network (PCN) showed decreased use of acute care services'

THE MODEL OF CARE

NHS England

Integrated care system	•Alliance of commissioners and providers across health and social care •Population based and outcomes focused within a shared budget
The at-scale primary care provider	•Delivering efficiencies of scale and leadership support •Providing a voice for integration across boundaries of care
The primary care network	•Geographically contiguous teams of practices caring for 30-50,000 people •Delivery of data driven integrated multidisciplinary team based services
The practice	•Provision of resilient and sustainable core general practice •Coordination and planning of holistic, personalised accessible care
The person	•Supported by families and local communities •Enabled and empowered to access care in a way which works for them

Primary care networks: where are we?

NHS England

Many practices are already part of a network:

As at 30 November 2018 (**) Note: 15 CCGs are missing from this report	Registered Population	Registered Population (excluding CCGs that did not submit a return)	Number of practices	Number of practices (excluding CCGs that did not submit a return)	Number of practices which are part of a network	% of practices which are part of a network	Number of Primary Care Networks currently existing
EN	59,483,315	55,749,714	7,039	6,424	5,998	93.4%	953
North	16,448,930	13,399,622	2,143	1,661	1,461	88.0%	260
Midlands and East	17,955,024	17,955,024	2,080	2,080	1,960	94.2%	300
London	9,975,083	9,290,790	1,286	1,153	1,117	96.9%	105
South West	5,805,507	5,805,507	604	604	554	91.7%	99
South East	9,298,771	9,298,771	926	926	906	97.8%	189

Source: GPFV monitoring survey

So we are building from a good position, but we need to support this important development in the NHS…

What great PCNs look like and how they will develop

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level	**Practices** identify partners for network-level working and develop shared plan for realisation.	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place.	**Network business model** fully operational. **Interoperable systems** Workforce shared across network. Rationalisation of estates.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** in place throughout system and formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites.	**Fully functioning integrated teams** in place across whole system including general practice, access to secondary expertise, nursing, community services, social care and voluntary sector. Care plans and coordination in place for all high risk patients.
Targeting care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups.	The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system.	**Systematic population segmentation including risk stratification**, with in depth under-standing of needs of each population segment. Routine peer review of metrics in and between networks. **New models of care in place to meet needs of all population segments**. Internal referral processes in place.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen.	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding.** Data being used at individual clinical level to make best use of resources.
Empowered Primary Care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

How will the new GP contract support primary care networks?

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- PCN contract introduced from 1 July 2019 as a Directed Enhanced Service (DES).
- Will **ensure general practice plays a leading role in every PCN** and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.
- By **2023/24, PCN contract is expected to invest £1.799 billion**, or £1.47 million per typical network covering 50,000 people.
- includes **funding for around 20,000 more health professionals** including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.
- **New shared savings scheme for PCNs so GPs benefit from their work** to reduce avoidable A&E attendances, admissions and delayed discharge, and from reducing avoidable outpatient visits and over-medication through a pharmacy review.
- **Extra access funding of £30 million a year** will expand extended hours provision across PCNs and from 2019 see GP practices taking same-day bookings direct from NHS 111 when clinically appropriate.

What are the other key elements of the contract?

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- **Core general practice funding will increase by £978 million per year** by 2023/24.
- New **state backed indemnity scheme will start from April 2019** for all general practice staff including out-of-hours.
- Additional **funding for IT** which will allow both people and practices to benefit from the latest digital technologies.
- All **patients will have the right to digital-first primary care**, including web and video consultations by 2021. All practices will be offering repeat prescriptions electronically from April 2019 and patients will have digital access to their full records from 2020.
- A new **primary care Fellowship Scheme** will be introduced for newly qualifying nurses and GPs, as well as Training Hubs.
- **Improvements to the Quality and Outcomes Framework (QOF)** to bring in more clinically appropriate indicators such as diabetes, blood pressure control and cervical screening.
- Reviews of **heart failure, asthma and mental health**. In addition, introduction of quality improvement modules for prescribing safety and end of life care.

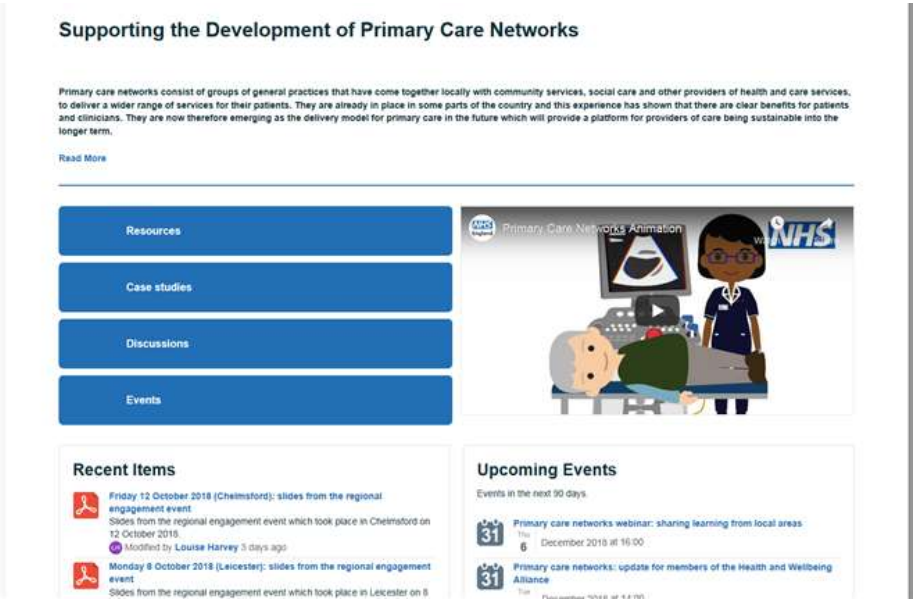
How to keep in touch

NHS England

- NHS England has developed an animation to help explain what a PCN is. You can watch the animation and view dates and details of upcoming webinars and events at the following webpage: www.england.nhs.uk/pcn

- We have also set up a Future NHS platform to share slides and documents which you can request access to via our generic email address: england.PCN@nhs.net

- For any other queries, please email the team at england.PCN@nhs.net



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Thank you

For a copy of the slides, please email: england.pcn@nhs.net
Visit www.england.nhs.uk/pcn for more information

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Andrea Melluish
and Pam Smith,
NHS England South West

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MODELS OF CARE PORTAL

*View and share examples of innovation and good practice from providers across the health and care system. Review **resources** and **case studies** which aid learning by showcasin achievements and experiences. Home to the **Collaboration Spaces** secure, safe online area vate discussion, document sharing and editing. Go to place for **Digital Platforms** – a of resilience tools, including the Workforce Analysis Tool and the Health Education Engla ool.*

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Featured Links

NHS CHOICES LINK

BMA PLUS DIRECT LINK TO LMCS ACROSS ENGLAND

Tweets

NHS England SW Retweeted

NHS Bristol, N Somerset & S Gloucestershin

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Case Studies

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View Resource

Lyn Health Medical and Minor Injury Services - Integrated Nursing

By **Paula Ing** | Posted For Lynton Health Centre | Posted on 09/01/2019 at 08:33

Description

LYN Health Medical and Minor Injury Services

lyntonhealthcentre.co.uk

Lynton is a small rural practice based on the coast of North Devon close to the Somerset border. Four years ago we moved into our new purpose built surgery which had been designed to incorporate a minor injury service and accommodation for our community nursing team who were to run it. Due to our small numbers at the time, we had initial concerns about how we were going to manage the practice nursing side of the GP Practice.

What Has Been Done?

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Current – Case Studies

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- South of England Collaborative – Building QI Capability in Mental Health Organisations through a Patient Safety Collaborative
- St Austell Healthcare – Social Prescribing – Working with Healthy Cornwall
- Beacon Medical Group – The Role of an Advanced Paramedic Practitioner in Primary Care
- East Devon Health – Integrated Telephone Systems
- St Thomas Medical Group – Preparing for a CQC
- Beacon Medical Group – Patient Engagement
- St Austell Healthcare – Practice Pharmacist

Current - Resources

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Digital Platforms

Tool	Description	
WORKFORCE ANALYSIS TOOL	The Workforce Analysis Tool (WAT) is based on the information submitted to the Workforce Minimum Data Set via the Primary Care Web Tool which GP practices complete on a quarterly basis.	VIEW
Practice Resilience Assessment Questionnaire (PRAQ)	The Practice Resilience Assessment Questionnaire (PRAQ) was developed by NHS England Change Managers; for practices to take a temperature check on where they are against a certain number of benchmarks which will inform of their strengths or potential weaknesses.	VIEW
Merger Toolkit	A suite of useful documents to aid practices considering merging, aligning or working more collaboratively.	VIEW
HEE Star Tool	The HEE Star is a tool to support workforce transformation, helping providers understand their workforce requirements and also providing a range of potential solutions.	VIEW
Eastwood Tool	Eastwood allows you to reassign roles within a Practice and view the financial implications.	VIEW
Wilmot Tool	Wilmot allows you to compare Practice Workforce against practices that have a similar Patient population.	VIEW

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Collaboration Space

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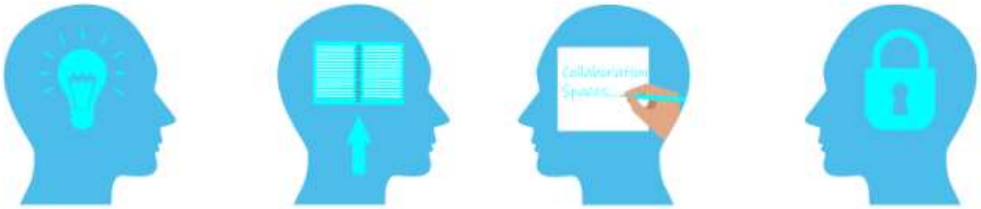
South West Academic Health Science Network

Home | Case Studies | Resources | Collaboration Spaces | Workforce Analysis Tool | Map

What is a Collaboration Space?



A secure online area for private discussion between users, which also permits document sharing and editing

REGISTER TO ACCESS A COLLABORATION SPACE

LOGIN TO ACCESS YOUR COLLABORATION SPACE

Collaboration Space

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South West Academic Health Science Network

Collaboration Space: Developing Primary Care Networks in the South West Live Event 17/10/18 - Documents

OVERVIEW | SHARED DOCUMENTS | PRIVATE FORUM | MEMBERS

Sub-Folders

Title	Documents	Options
Agenda	1	VIEW DOCUMENTS
Becky Malby presentation	4	VIEW DOCUMENTS
Directories	5	VIEW DOCUMENTS
Event Photos	0	VIEW DOCUMENTS
Flyers	7	VIEW DOCUMENTS

Advantages of using the Models of Care Portal

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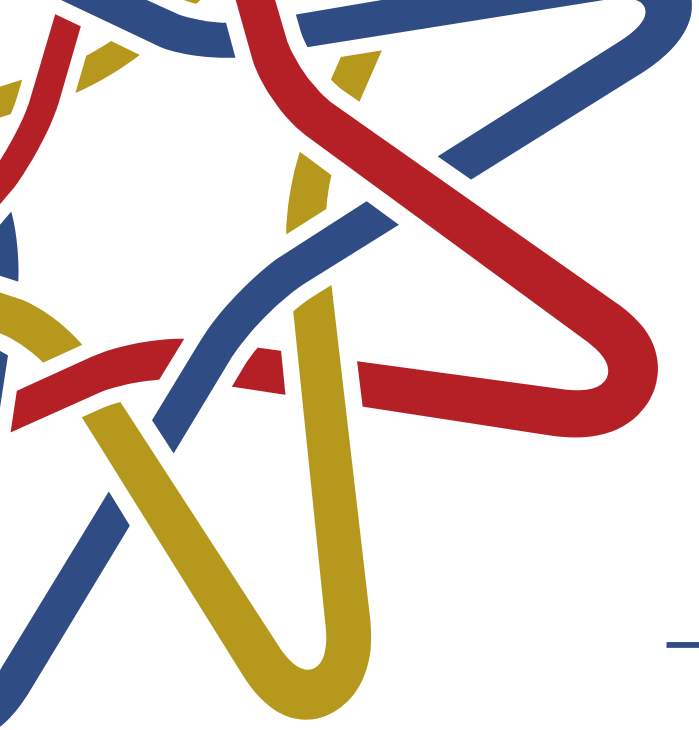
- Inclusive
- Adaptable
- Ownership
- Get sharing
- Start a debate
- Flexible, easy to change, update and evolve
- SW AHSN home-grown concept



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Thank you

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Visit www.england.nhs.uk/pcn for more information