

The early implementation of primary care networks in the NHS in England: a rapid evaluation study

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Citation for published version (Harvard):

Smith, J, Parkinson, S, Harshfield, A & Sidhu, M 2020, *The early implementation of primary care networks in the NHS in England: a rapid evaluation study*. National Institute for Health Research.

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HS&DR Rapid Evaluation Centre Topic Report

Early evidence of the development of primary care networks in England: a rapid evaluation study

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Declared competing interests of authors: Professor Judith Smith was a member and Vice-Chair of the NIHR Health Services and Delivery Research (HS&DR) Programme Commissioned Prioritisation Committee (2015-2019), and a member of the UKRI/NIHR Covid-19 Rolling Call College of Experts (April-July 2020) and DHSC/UKRI Global Effect on Covid College of Experts (August-October 2020). She is also a Trustee and Deputy Chair of Health Services Research UK.

Published October 2020

DOI: <https://doi.org/10.3310/hsdr-tr-129678>

This report should be referenced as follows:

Smith JA, Parkinson S, Harshfield A, Sidhu M. *Early evidence of the development of primary care networks in England: a rapid evaluation study*. Southampton: NIHR Health Services and Delivery Research Topic Report; 2020. DOI: <https://doi.org/10.3310/hsdr-tr-129678>

HS&DR Rapid Evaluation Centre Topic Report

This report

The research reported in this topic report was commissioned and funded by the Health Services and Delivery Research (HS&DR) programme as part of a series of rapid service evaluations under project number 16/138/31. For more information visit <https://www.fundingawards.nihr.ac.uk/award/16/138/31>

This topic report has been peer-reviewed and reviewed by the NIHR Journals Library Editors. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR Editors have tried to ensure the accuracy of the authors' work and would like to thank the reviewers for their constructive comments however; they do not accept liability for damages or losses arising from material published in this topic report.

This topic report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health and Social Care.

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Abstract

Background: Primary care networks are groups of general practices brought together in July 2019 to develop new services in response to NHS England/Improvement policy using a shared budget. This study examined the early implementation of primary care networks, especially what has helped or hindered progress, how they operate in relation to pre-existing collaborations, and issues for rural networks.

Objective: To produce early evidence about the development of primary care networks to inform policy for their future development. Our research questions were to investigate 1) the contextual background of primary care networks; 2) the rationale for general practices to enter into collaborations; 3) the early learning from establishing primary care networks; 4) barriers to and facilitators of effective collaboration across GP practices; and, 5) the likely future progress of primary care networks in the English NHS, including in light of Covid-19.

Design: A qualitative cross-comparative case study evaluation comprised of four work packages:

- 1) A rapid evidence assessment;
- 2) A workshop with academics, policy experts, and patient/public representatives;
- 3) Interviews with stakeholders, observations of meetings, a survey, and documentary analysis across four case study sites; and
- 4) Analysis and synthesis of findings to develop recommendations for the next stage of development of primary care networks.

Results: Primary care networks have been implemented in a timely manner and have established a range of new local health services. Previous GP collaborations provide much-needed support in terms of management, leadership and infrastructure, although they can be a source of tension within networks where interests, goals and ways of working do not align.

Reasons for collaborative working typically focus on the sustainability of primary care and a desire for better integrated services, although those cited as the basis for joining primary care networks were mostly related to policy and financial incentives. Early evidence reveals operational success in establishing organisational structures, recruiting to new roles, and providing services as required by the national specification.

Effective management and leadership, particularly with respect to having a committed clinical director, and constructive relationships between primary care networks and clinical commissioning groups, are important in ensuring success. In rural areas there was some perceived lack of fit with aspects of the primary care network specification, alongside existing challenges of providing primary care to rural populations.

Limitations: Arranging and completing interviews proved difficult given the workload associated with implementing networks and wider time pressures. Following the onset of the Covid-19 pandemic, the team was unable to undertake planned face-to-face workshops to explore findings. Given that primary care networks were in their first year of operation at the time of this evaluation, we were cautious in drawing definitive conclusions.

Conclusions: Key lessons focus on:

- Increasing the engagement of GP practices and wider primary care teams with networks.
- Building leadership and management capacity to support networks in fulfilling their contractual obligations and meeting local health needs.
- Clarifying how primary care networks will operate in the post-Covid-19 health and social care system.

Future work: Evaluating the impact and effectiveness of primary care networks using quantitative and qualitative measures; undertaking research in both rural and urban areas, exploring the extent to which this context is significant; the cost and effectiveness of sustaining and extending leadership and management support within primary care networks; and understanding the relationships between primary care networks and the wider health and care system.

Study registration: Ethical approval from the University of Birmingham Research Ethics Committee (ERN_13-1085AP34). Rapid Evidence Assessment protocol registered with PROSPERO (CRD42018110790)

Funding: This project was funded by the National Institute of Health Research (NIHR) Health Services and Delivery Research programme (16/138/31 – Birmingham, RAND and Cambridge Evaluation Centre).

Table of contents

| | |
|---|----|
| Abstract..... | 3 |
| Table of contents | 5 |
| Tables..... | 7 |
| Figures..... | 8 |
| Boxes..... | 9 |
| Supplementary Material Files..... | 10 |
| Abbreviations..... | 11 |
| Plain English summary | 12 |
| Scientific summary..... | 13 |
| Chapter 1: Context..... | 21 |
| Introduction | 21 |
| Policy context..... | 22 |
| General practice collaborations in the NHS in England..... | 23 |
| Primary care networks..... | 27 |
| Chapter 2: Methods | 30 |
| Aims and research questions..... | 30 |
| General approach | 32 |
| Protocol sign off..... | 32 |
| Ethical approval..... | 33 |
| WP1: Rapid evidence assessment..... | 35 |
| WP2: Project design stakeholder workshop..... | 39 |
| WP3: Comparative case studies of four primary care collaborations | 40 |
| Follow up interviews on Covid-19 response | 54 |
| Chapter 3: Lessons from the evidence..... | 55 |
| Rapid evidence assessment | 55 |
| Forms of organisational collaboration in general practice | 56 |
| Reasons for general practice collaboration | 57 |
| Enablers of and barriers to general practice collaboration | 59 |
| The reported impact of GP collaborations..... | 62 |
| Lessons from two particular prior forms of GP collaboration | 63 |
| Gaps in existing evidence on GP collaborations | 66 |

| | |
|--|-----|
| Summary of the rapid evidence assessment | 67 |
| Chapter 4: Description of case study sites | 68 |
| Site A | 69 |
| Site B | 71 |
| Site C | 72 |
| Site D | 74 |
| Chapter 5: Findings from case study research | 76 |
| Reasons to collaborate in primary care | 78 |
| Impact of primary care networks..... | 82 |
| Facilitators of and barriers to the early implementation of primary care networks..... | 97 |
| Primary care network-level responses to Covid-19 | 112 |
| Summary | 117 |
| Chapter 6: Discussion..... | 118 |
| Overview of case study findings | 119 |
| Reflection on robustness of results | 131 |
| Limitations of our findings | 132 |
| Lessons about the conduct of rapid evaluations | 134 |
| Chapter 7: Conclusion and implications | 136 |
| Evaluation findings..... | 136 |
| Implications for decision makers | 138 |
| Conclusions and suggestions for further research and evaluation..... | 143 |
| Acknowledgements..... | 146 |
| Data sharing statement | 148 |
| References | 149 |
| Appendix 1: Primary care collaborations survey as part of sampling strategy..... | 158 |
| Appendix 2: Topic guide for interviews | 165 |
| Appendix 3: Survey | 168 |
| Appendix 4: Code book for interview analysis..... | 173 |
| Appendix 5: Additional survey tables | 181 |

Tables

| | |
|--|-----|
| Table 1: Overview of general practice collaboration models in England (adapted from Rosen et al, 2016) ¹⁴ | 25 |
| Table 2: Summary of work packages and how research questions were addressed | 33 |
| Table 3: Case selection inclusion/exclusion criteria | 42 |
| Table 4: Characteristics of participants interviewed from four case study sites..... | 46 |
| Table 5: Survey responses from each site..... | 49 |
| Table 6: Survey respondent roles | 50 |
| Table 7: Codebook for interview analysis..... | 173 |
| Table 8: Reasons to form or join a primary care network from survey..... | 181 |
| Table 9: Primary care network challenges from survey | 183 |

Figures

| | |
|--|----|
| Figure 1: Flow diagram of screening decisions – 1998 to 2012 inclusive (reviews only) | 37 |
| Figure 2: Flow diagram of screening decisions – 2013 to 2018 inclusive (all methodologies) | 38 |
| Figure 3: Summary of case study site sampling | 44 |
| Figure 4: Site A organogram | 70 |
| Figure 5: Site B organogram..... | 72 |
| Figure 6: Site C organogram..... | 74 |
| Figure 7: Site D organogram | 75 |
| Figure 8: Reasons to form or join a primary care network from survey (N=28)..... | 81 |
| Figure 9: Primary care network advantages from survey (N=28)..... | 83 |
| Figure 10: Primary care network disadvantages from survey (N=28) | 84 |
| Figure 11: Primary care network challenges from survey (N=28) | 98 |

Topic Report

Boxes

| | |
|---|-----|
| Box 1: Key points from Chapter 1 | 21 |
| Box 2: Primary care networks – key features (adapted from Baird et al., 2018 ²¹) | 27 |
| Box 3: Key points from Chapter 2 | 30 |
| Box 4: Search strategy for rapid evidence assessment..... | 35 |
| Box 5: Key points from Chapter 3 | 55 |
| Box 6: Reasons for forming a GP collaboration | 59 |
| Box 7: Summary of learning from Total Purchasing Pilots (TPP), adapted from Mays et al, 2001 ⁶¹ | 63 |
| Box 8: Summary of learning from Personal Medical Services (PMS) Schemes | 64 |
| Box 9: Key points from Chapter 4 | 68 |
| Box 10: Key points from Chapter 5 | 76 |
| Box 11: Key points from Chapter 6 | 118 |
| Box 12: Evaluation research questions | 136 |
| Box 13: Implications of evaluation findings for primary care network decision makers | 139 |

Supplementary Material Files

Supplementary Material File 1: Workshop material

Supplementary Material File 2: Recording instrument for non-participant observations

Supplementary Material File 3: Documentary review extraction sheet

Supplementary material can be found on the NIHR Funding and Awards report topic page
<https://doi.org/10.3310/hsdr-tr-129678>

Supplementary material has been provided by the authors to support the report and any files provided at submission will have been seen by peer reviewers, but not extensively reviewed. Any supplementary material provided at a later stage in the process may not have been peer reviewed.

Abbreviations

| | |
|------------|--|
| BRACE | Birmingham, RAND and Cambridge Evaluation Centre |
| CCG | Clinical commissioning group |
| CD | Clinical director |
| DES | Directed Enhanced Service |
| DHSC | Department of Health and Social Care |
| GDPR | General Data Protection Regulation |
| GMS | General Medical Services |
| GP | General Practice |
| HR | Human resource(s) |
| HSJ | Health Service Journal |
| IT | Information technology |
| KES | Knowledge and Evidence Service |
| NHS | National Health Service |
| NHSE&I | NHS England and Improvement |
| NIHR | National Institute for Health Research |
| NIHR HS&DR | NIHR Health Services and Delivery Research programme |
| PCH | Primary care home |
| PCN | Primary care network |
| PM | Practice manager |
| PMS | Personal Medical Services |
| PPE | Personal protective equipment |
| PPI | Patient and public involvement |
| RCGP | Royal College of General Practitioners |
| R&D | Research and development |
| REA | Rapid evidence assessment |
| RQ | Research question |
| RUC | Rural-urban classification |
| TPP | Total Purchasing Project |
| UK | United Kingdom |
| UKRI | UK Research and Innovation |
| USA | United States of America |
| WP | Work package |

Plain English summary

Over the past 20 years, many general practitioners (GPs) have been working more closely with other local practices to offer a wider range of services for patients. In July 2019, NHS England asked GP practices to join together into primary care networks and use new funding to offer extra services to improve the health and wellbeing of local communities.

This research looked at how these networks were established, what they have achieved so far and what has helped or hindered progress. We were particularly interested in the experience of primary care networks in rural areas, and how networks fit in with other types of collaboration, including GP federations and super-partnerships.

To do this, we first examined previous research that had sought to understand GP groups. We then chose four primary care networks where we carried out interviews and a survey with staff; observed meetings; and reviewed reports and papers. The Covid-19 pandemic emerged during our study, which meant that we had to stop collecting information from sites earlier than expected.

This research revealed that the networks made good progress in their first nine months, forming their new organisation, recruiting staff, and preparing plans to start more services in future years. Although they made considerable progress, primary care networks also faced challenges in their first months, including how to ensure sufficient management support, some tension in trying to agree on the goals and direction of the networks, and concerns about excessive workload.

We concluded that primary care networks can help GP practices run a wider range of services for their patients, and make changes that are needed in response to the Covid-19 pandemic. It will be important for government to give primary care networks the freedom to plan for what local people need, monitor carefully the progress made, and ensure that the particular priorities of primary care networks in rural areas are taken into account.

Scientific summary

Background: In its Five Year Forward View strategic plan published in 2014, NHS England (now NHS England and Improvement) identified the need for new models of care that increasingly require collaboration across a range of health and social care services and providers. This strategic plan suggested that GP practices needed to work together (and with other primary care practitioners and services) in a more systematic, sustained and organised manner.

Primary care networks (PCNs) were built on the many pilots of new 'vanguard' models of integrated health care that had been developed as a result of the Five Year Forward View, and were advocated by NHS England to be "an essential building block of every Integrated Care System". As a result, primary care networks were introduced in 2019 with the aim of forming groups of general practices, with a shared network budget to develop new services in response to national policy intended to bring about better integration of health care within local communities. These networks offer the possibility of significant levels of additional funding by taking on a contract for enhanced services on behalf of groups of practices. Hence, primary care networks have a formal, incentivised and almost compulsory feel compared to many predecessor schemes of collective primary care. Unsurprisingly, almost all general practices have joined a primary care network.

There were (as at May 2020) 1259 primary care networks, serving populations that range from 20,000 to well above the 50,000 suggested in NHS England and Improvement primary care network-related guidance. These primary care networks sometimes build on prior GP collaborations, which can provide organisational infrastructure and support to newly formed networks. Although some primary care networks also bring together practices that had not worked collaboratively in the past.

Objectives: The overarching purpose for this evaluation was to produce early evidence of the development and implementation of primary care networks introduced into the NHS in England in July 2019. The evaluation had a particular focus on seeking to understand how practices entered into collaborations, why some collaborations stall or fail, and whether and how the experience of rural collaborations may differ from that of urban examples.

In order to address our aims, we sought to answer the following evaluation questions:

- **RQ1:** What was the contextual and policy background within which primary care networks were introduced?

RQ1.1: What were the pre-existing forms of GP collaborative working across primary care in England?

RQ 1.2: How have new primary care networks been implemented in a sample of urban and rural settings?

RQ 1.3: How do new primary care networks relate to pre-existing GP collaborations?

- **RQ2:** What are the rationales and motives for general practices to enter into GP collaborations, including new primary care networks? In particular, what role do financial incentives play in facilitating or inhibiting collaboration? What are the expected outcomes for primary care networks?
- **RQ3:** What evidence exists about the positive or negative impacts associated with different experiences of establishing GP collaborations and how do these relate to newly formed primary care networks?
- **RQ4:** What appear to be the barriers to and facilitators of effective collaboration across GP practices, both with respect to successful and unsuccessful collaboration, and achieving impact or not?
- **RQ5:** What does the analysis of prior experience of GP collaborations, and the early implementation of primary care networks, suggest in terms of the likely progress of primary care networks in the NHS in England, including in light of the Covid-19 pandemic and associated challenges?

Methods: We completed a mixed methods cross-comparative case study evaluation with four case study sites. The evaluation comprised of four work packages:

WP1: A rapid evidence assessment: we present an overview of published evidence that distilled prior learning and informed the development of propositions to be tested through comparative case studies of new primary care collaborations/networks. The study team completed a search of evidence summaries (published from 1998-2012) and primary care research studies and reviews (published from 2013-2018) using key search terms in titles and abstracts, in PubMed, Ovid MEDLINE, Web of Science, and Scopus for literature published in English only.

WP2: Stakeholder workshop: we delivered a workshop for relevant stakeholders (e.g. academic and policy experts in the field, patient and public involvement representatives), where initial findings from the rapid evidence assessment were shared and discussed. The aim of this workshop was to clarify evidence gaps and evaluation questions of particular relevance to emerging policy on primary care networks and thus inform next steps for WP3.

WP3: Comparative case studies of four primary care networks (minimum of two in rural settings):

We undertook a multi-faceted sampling process to select a total of four rural and urban case study sites, based on identifying appropriate primary care collaborations through clinical commissioning groups that had not been previously evaluated. Individuals were purposively sampled for maximum variation with the aid of gatekeepers at each site (our lead contact within the primary care network – usually a senior manager or administrator). Interviews (N=25) with those involved in the conceptual design, implementation of the primary care network in their respective sites, and exploration of the relationship of the network with any prior GP collaboration in the case study site; analysis of key documentation (both internal and publicly shared); non-participant observation (N=10) of strategic meetings; and an online survey (N=28) to collate information on challenges associated with collaborative working and measuring early impact. We took a content analysis approach to documentary reviews and observations. Data analysis for interviews was informed by the Gale et al. (2013) framework method for the analysis of qualitative data in multi-disciplinary health research¹. The Covid-19 pandemic emerged during the evaluation and meant that the study team suspended data collection earlier than planned and were unable to complete as many observations as intended (due to local cancellations).

WP4: analysis of findings from work packages 1-3 to develop a set of recommendations for the next stage of development of primary care networks in the NHS in England: We will share and discuss findings generated from data collection develop recommendations for commissioners, providers and policy makers through academic outputs.

Results:

Findings from the rapid evidence assessment identified some important lessons for primary care networks to consider, such as: the time it will likely take for primary care networks to become established as well-functioning organisations in the wider health and social care system; and, the level of high quality management and leadership capacity required to ensure their success. Primary care networks also require sufficient time and capacity to develop trusting and supportive

relationships within the GP collaboration and with other partner organisations, especially early in their implementation. Our rapid review enabled us to identify important gaps in the research evidence and use such insights to frame questions for our case study research.

Purpose of primary care networks

This evaluation has revealed that those working to implement and run primary care networks largely support the overarching policy aims set for them, and general practices across England have seized the opportunity to access new funding to form networks. However, many GPs and their teams place a higher priority on matters of particular concern to those working in general practice and primary care, namely those related to enhancing the sustainability of primary care itself, workload issues and improving the availability and coordination of local primary care services.

There is a paradox for primary care networks in that they are expected on the one hand to meet local population health needs, yet on the other face nationally-specified requirements to employ certain professionals (e.g. pharmacists, social prescribers) and introduce defined services (e.g. enhanced health care in care homes) irrespective of whether these are considered by primary care network leadership teams to be the most pressing in terms of local need. This paradox was a significant source of tension within our evaluation findings, with a rich and varied mix of views about the purpose of primary care networks, sometimes positive and supportive of the national approach, and at others frustrated at having to toe a government line in order to receive new funding, feeling that the 'PCN policy' had been imposed upon general practice in a rather rushed manner.

Prior GP collaborations

In all four case study sites, the new primary care network was established in the context of a prior GP collaboration. For example, where respondents described a particular service innovation or other success, it was often attributed to previous forms of local GP collaboration, with the primary care network seen as a way of sustaining or extending such development.

Previous collaborations helped the primary care network to build on prior successes such as the strong existing relationships between practices and integrated service delivery. Pragmatically, prior collaborations provided the primary care network with operational support for hiring staff in new roles alongside greater management infrastructure. However, it was often a source of tension where the new network was perceived as un-doing the work of the previous collaboration, where the aims of the primary care network and previous collaboration did not align, and where some practices who

were part of two different previous collaborations were coming together to comprise a single new network.

Ownership of and engagement with primary care networks

This evaluation has revealed a tension between the desire for local autonomy and influence over primary care networks, and the top-down nature of national PCN policy. Hence, there were differences between local priorities for primary care networks (compared to national policy objectives) and the extent of control networks had over commissioning with respect to the local clinical commissioning group.

Taking time to clarify the role of primary care networks within the health and social care system may help clarify how they work in relation to their local clinical commissioning groups, and their role in delivering on both local and national priorities. Developing shared goals and objectives also emerged from this evaluation as an enabler of progress, and of positive working relationships within and beyond the primary care network. For some respondents in our evaluation, time and resource for organisational development were important, including through staff away days, joint training events, and forums for practice managers and/or nurses from across the primary care network.

Leadership and management

The need for effective leadership of the primary care network, together with sufficient high-quality management support, was a strong theme in the evaluation fieldwork. It was clear that although small organisations, primary care networks need a significant range of administrative and management capacity and skills, including finance and accounting, human resources, information technology, staff engagement, and governance support.

In terms of management challenges for primary care networks, the time required for meetings, recruitment of staff, implementing new roles and services alongside core services, and administration and management of the network were of particular note. The time pressure for those involved in primary care network development was reported as an acute concern, especially for clinical directors and practice managers having to do this on top of their usual 'day job'. The varied quality of leadership and management from primary care network clinical directors raises a concern about the sustainability of these roles longer term, and the time commitment required of them presents a risk of burn-out and instability in network leadership.

The role of funding and incentives

A strong and consistent message across our evaluation fieldwork was that primary care networks had been established in a near universal manner as a result of NHS England and Improvement using them as the mechanism through which to offer new funding to general practice. The allocation of a new source of funding channelled directly into general practice, rather than through an intermediary organisation such as the clinical commissioning group or sustainability and transformation partnership, was clearly welcomed in principle by most practices.

For others however, the experience of setting up the primary care network, establishing cross-practice working, and having to use the new resources largely to deliver services required by NHS England and Improvement, had led to frustration, disappointment, and even talk of leaving the network. This view was typically based on an assessment of the amount of work (and hence resource) entailed in setting up and running a primary care network and its shared services, and the burden experienced by practices 'losing' GP and management time to support the new organisation. For GPs, this deviated from their initial expectations of primary care networks which they felt would alleviate GP workload and improve the financial stability of practices.

Relationship with the wider NHS system

Our evaluation revealed variation in the relationship between clinical commissioning groups and primary care networks. In some instances, clinical commissioning groups have enabled and supported primary care networks, providing resource and expertise to help establish inter-practice working, hire new staff, and operate contracts. In others areas, however, there was evidence of the clinical commissioning group attempting to hold onto control that had been delegated to primary care networks, exerting close monitoring of budgets and spending decisions, and not operating within the spirit and expectation of national PCN policy. It is important to note that this evaluation took place during the first nine months of operation of primary care networks. Therefore, networks were still very much in their formative phase and were learning not only how to work as a collective of practices, but also with their clinical commissioning group(s), local NHS trusts, and other partners such as community pharmacies, third sector organisations, and social services providers.

The experience of rural primary care networks

Our evaluation set out to look at differences between rural and urban primary care networks. Two of our case study primary care networks were in rural areas while another was semi-rural. Some of

those in more rural areas reflected that they felt that national PCN policy had been developed more with urban practices and collaborations in mind, and did not account adequately for the experience of primary care in rural areas. For example, policy about recruiting new professional staff for primary care networks was developed on the basis that they would deliver services for patients across the network, but challenges around geography, travel time (for staff, patients and carers) and public transport made this much more difficult in rural areas. A key aspect of rural primary care and general practice was that practices had well-established ways of working together to meet local needs and service demands, albeit in a context of restricted choice about who to collaborate with.

Conclusion: Based on the findings of our evaluation, we propose the following implications for local and national decision makers:

Increasing the engagement of GP practices and wider primary care teams with primary care networks

- There is a need for consistent long-term national policy about primary care networks and other forms of GP collaboration that allows for local diversity of size and form of network, also avoiding the temptation to merge or reorganise primary care networks.
- It is important that realistic and clear goals are set for primary care networks, both by NHS England and Improvement, and local clinical commissioning groups.
- Efforts should be made to ensure that national primary care network policy is compatible with both rural and urban area primary care delivery.

Building leadership and management capacity

- It is important for primary care networks to build on the experience and expertise of pre-existing GP collaborations.
- There is a need to ensure sufficient and distributed management and organisational support for the primary care network clinical director role.
- It is important to ensure that the wider primary care team is able to be part of primary care network leadership, and that good practice is shared locally and nationally.

Clarifying how primary care networks fit into the wider health and social care system

- NHS England and Improvement may wish to revisit the role of the primary care network in the context of the health and care system as it emerges from the Covid-19 pandemic.

- It is important to ensure that primary care networks are monitored and performance-managed by NHS England and Improvement in a way that enables them space and permission to develop and pursue local priorities within the context of a national framework.
- There is a need for national decision makers to clarify the role of clinical commissioning groups in relation to primary care networks.

In further research, it will be important to use a mix of quantitative and qualitative measures to evaluate and understand how primary care networks move from an initial stage characterised by relatively high up-front costs, to a more established phase where the resources put into networks might contribute more meaningfully to sustainability and efficiency in primary care. In addition, the ongoing relationship between primary care networks and prior GP collaborations will be important to track, for this evaluation has revealed just how established the concept of collegial or collective working now is across English general practice. Overall, it will be vital that research into primary care network progress, outcomes and ways of working is able to answer the question: do general practices need to collaborate to achieve key outcomes (e.g. improving access, achieving sustainability) and if so, what support and investment is required?

Study registration: Ethical approval from the University of Birmingham Research Ethics Committee (ERN_13-1085AP34). Rapid Evidence Assessment protocol registered with PROSPERO (CRD42018110790).

Funding: The National Institute for Health Research Health Services and Delivery Research programme (16/138/31 – Birmingham, RAND and Cambridge Evaluation Centre).

Chapter 1: Context

Box 1: Key points from Chapter 1

Introduction

Primary care networks are groups of general practices brought together across England in 2019 to develop new services in response to national policy intended to bring about better integration of health care within local communities.

Primary care networks were to build on the many pilots of new 'vanguard' models of integrated health care that had been developed as a result of the NHS Five Year Forward View.

Primary care networks offer the possibility of significant levels of additional funding (allocated through primary care network budgets) for general practice through a compulsory, formal, and incentivised model which differs from many predecessor schemes of collective primary care.

There were (as at May 2020) 1259 primary care networks in England, serving populations ranging from 20,000 to well above the 50,000 suggested in policy.

Primary care networks sometimes build on prior GP collaborations and are often supported by the organisational infrastructure of the extant collaborations. Other networks are brand new entities in the process of becoming established and working out how best to source their management support.

The research took place in a rapidly changing policy and service context – initially as a result of the implementation of the NHS Long-Term Plan and subsequent professional challenge to the primary care network policy and contractual proposals, and thereafter as the global Covid-19 pandemic emerged in early 2020.

The aim of this rapid evaluation study was to provide early evidence about the implementation of primary care networks (PCNs) in the NHS across England, with a particular focus on understanding what has helped or hindered their progress, how they operate in relation to pre-existing collaborations in general practice, and exploring issues for rural as compared with urban primary care networks. The detailed research questions for the study are set out on in Chapter 2 (Methods).

Primary care networks are groups of general practices brought together in 2019 to develop new services in response to national policy intended to bring about better integration of health care within local communities, with each network holding a shared budget for primary care network activities. The study entailed a review of existing international research evidence about collaborations within general practice and then, based on identified knowledge gaps, case study research to examine the nature, functioning, potential and shortcomings of primary care networks.

The research took place in a rapidly changing policy and service context – initially as a result of the implementation of the NHS Long Term Plan and subsequent professional challenge to the primary care network policy and contractual proposals, and thereafter as the global Covid-19 pandemic emerged.

The findings from this rapid evaluation study are intended to inform NHS England and Improvement's and the primary care community's future planning and guidance for primary care networks. Our analysis of these findings forms the basis of recommendations for how the sustainability of primary care networks can be assured and how they might develop in future, including in the context of significant changes taking place in primary health care and general practice as a result of the 2020 Covid-19 global pandemic.

Policy context

The General Practitioner (GP) practice is one of the main first points of contact that patients have with the National Health Service (NHS) and acts as a gateway connecting people to specialist care at treatment centres, hospitals, mental health services and community health care. NHS general practice has until recently had high approval ratings among patients and the public², and is considered important and cost-effective in that it enables health outcomes to be improved and health inequalities to be addressed, whilst helping to contain costs in the wider health system^{3,4}.

In its Five Year Forward View strategic plan published in 2014, NHS England (now NHS England and Improvement) identified the need for new models of care that increasingly require collaboration across a range of health and social care services and providers. Related to this, it was asserted that GP practices needed to work together (and with other primary care practitioners and services) in a more systematic, sustained and organised manner⁵. The 2016 General Practice Forward View built on the NHS Five Year Forward View, describing how the NHS needed to change to make sure that sufficient and sustainable primary health care could be provided⁶. The NHS Five Year Forward view also noted that GP practices needed to be flexible and ready to change, including by adapting to evolving health needs – in particular those of an ageing population living with multiple complex conditions - and the opportunities presented by new technology. The context for these plans was one of general practice in the UK being under considerable strain, as evidenced by the Commonwealth Fund 2019 survey of primary care physicians where just 6% of UK GPs reported feeling 'extremely' or 'very satisfied' with their workload (the lowest of all countries surveyed), and 49% reported wanting to reduce their clinical hours in the next 3 years⁷.

The NHS Long Term Plan (for England) published in January 2019⁸ confirmed that spending on primary and community health services was to be at least £4.5 billion higher in five years' time to "fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices" (NHS England 2019a, para 1.9). Subsequent guidance published by NHS England and the British Medical Association (BMA) later in January 2019 (NHS England 2019b) confirmed the requirement for all GP practices in England to form local 'primary care networks' (PCNs) covering patient populations of 30,000-50,000 by July 2019, "so that no patients or practices are disadvantaged"⁹.

Primary care networks were to build on the many pilots of new 'vanguard' models of integrated health care that had been developed as a result of the Five Year Forward View, and these new networks were advocated by NHS England to be "an essential building block of every Integrated Care System". Those vanguard models of care entailed pilots of significant integration of: general practice and community health services; hospital, mental health, community and primary care; general practice and social care (particularly in providing support to residential care homes); and services focused on particular clinical conditions such as cancer. The funding for these vanguard schemes ended in March 2018, and early and interim assessment of their progress concluded that their long-term impact and sustainability was unproven^{10,11}. Our evaluation of the early implementation and progress of primary care networks took place in the context of these prior vanguard schemes, and in some sites the work of the networks was building on aspects of those schemes, and the joint working in health and social care that had underpinned the vanguard projects.

General practice collaborations in the NHS in England

Collaborations in general practice, also sometimes known in international health policy as 'organised general practice' or 'managed primary care', have emerged in many health systems over the past three decades¹². Primary care networks represent the latest incarnation of such collaborations in the NHS in England.

In 2017, the Nuffield Trust and the Royal College of General Practitioners (RCGP) undertook a survey of all GP practices across England, to establish the pattern and frequency of collaborative working across practices¹³. Eighty-one per cent of respondents reported that their practice was already working in collaboration with other local GP practices, this having been at 73% in the prior iteration of the survey in 2015. The primary reasons given for working collaboratively were: to improve access for patients to general practice; to transfer more health services into the community; to strengthen

financial and organisational sustainability of general practice; and to improve staff experience, training and education. The survey results also emphasised that:

- working at scale in collaborative arrangements was broadly accepted as the future for general practice in England;
- there were many forms of GP collaboration across the NHS, with GP federations being the most commonly reported (see Table 1 below for an explanation of GP federations);
- in almost all cases these collaborations had emerged from within general practice rather than being mandated in national policy;
- GP practices were often part of more than one collaboration;
- these collaborations varied in size, with over 50% having more than 100,000 registered patients;
- networks varied in focus and motivation for collective working, with smaller groups tending to prioritise practice sustainability, staff experience, and patient access. Larger groups tended to prioritise patient access and transferring services to the community; and
- time and work pressures were considered the main barrier to collaborations achieving their aims.¹³

Table 1, drawing on the work of Rosen et al. sets out the main GP collaboration models in England in place in 2019, and thus provides important context about the pre-existing GP collaborations from - or alongside which - new primary care networks have formed. The inter-play of pre-existing GP collaborations and primary care networks formed a core aspect of this evaluation study (see Chapter 2, Methods). The collaboration models in Table 1 vary considerably. For example, super-partnerships represent a formal merger of practices and have a board of directors to oversee the collaboration, together with a shared contract which binds all practices together. GP federations can either be informal or formal in the way they are set up and work together, and take a variety of legal and contractual forms. Networks are typically informal in nature, coming together around a set of specific issues such as enabling extended hours opening of general practice or a 24/7 out-of-hours service, or to inform the planning of local services¹⁴.

Along with different models of collaborative working, GP collaborations also vary in terms of how they are set up geographically. While GP practices can group together based on geographical proximity (as is the case for primary care networks), some collaborations are not geographically contiguous; rather, they are regional or national multi-practice organisations that are geographically

dispersed¹⁵. Notably, some types of collaborations may go by more than one name (federation, super-partnership, primary care group, etc.) but may share common characteristics in terms of functions performed¹⁶.

The nature and extent of these prior GP collaborations is important context to the implementation and development of primary care networks, as many have continued to operate alongside new networks, often providing management and infrastructure support. It has been noted in prior analysis that GP collaborations can bring opportunities for smaller practices who have struggled to tailor services for patients living with complex needs in both rural and urban areas¹⁷. It is of note that the prior collaborations in place as primary care networks were established are largely ones that evolved from within general practice and primary care (as opposed to being mandated in national policy), and are typically considered to be ‘owned’ by local practices and practitioners (or may indeed formally be owned by them). By contrast, primary care networks have been mandated in national policy, and the issue of general practitioners’ sense of ownership of and belonging to the new networks is explored in the research reported here.

Table 1: Overview of general practice collaboration models in England (adapted from Rosen et al, 2016)¹⁴

| Collaboration model | Key characteristics |
|----------------------------------|---|
| Informal network | Networks (described as ‘informal networks’ here in order to distinguish between them and ‘primary care networks’ as set out in the NHS Long Term Plan) are one way in which GP practices can collaborate. There are no formal ties between the practices, instead relying on informal discussions, meetings and cooperation. All practices in such a network keep their own contracts and funding sources, and no particularly tangible objectives are typically set. |
| Multi-site practice organisation | These organisations are very formal in nature, where there is one core company or group of directors that holds one GP contract for all practices within that management framework. The goals of each practice, therefore, should be in alignment with those of the organisation as a whole. Funds are held in the central hub of the organisation and disseminated to practices for specific purposes. |

| | |
|-------------------------|--|
| Super-partnership | <p>Similar to multi-site practice organisations, super-partnerships represent mergers of previously independent GP practices into a single new organisation. The governance for super-partnerships is complex. Practices may either choose to manage each of their contracts separately, although activities and goals are shared and aligned across all participating practices, or they may choose to redraw a new General Medical Services (GMS) contract with an executive board to oversee the work of all participating practices. In the latter case, funds will be redistributed according to any new processes in place.</p> |
| Federation | <p>Federations are more formal than networks, but less formal than multi-site practice organisations and super-partnerships. In federations, participating GP practices maintain responsibility for their own contracts. However, some additional legal agreements might be pursued and put into place in order to carry out joint activities. An executive board function typically exists to oversee the federation, however, each practice may set its own goals and objectives that do not necessarily align with those of the organisation as a whole.</p> |
| Primary care home (PCH) | <p>The primary care home model was created by the National Association of Primary Care (NAPC) building on the Health Care Home from the USA¹⁸. An integrated care model, it has four key characteristics that need to be met in order for a collaboration to be categorised as a primary care home: 1) the partnership must span across primary, secondary, and social care; 2) there is a strong element of personalised care with the aim of improving the health of the population as a whole; 3) all funding is channelled through one central budgetary system between all stakeholders in the collaboration; and 4) it covers a population of 30,000-50,000 registered patients across collaborators.</p> |
| Hubs | <p>Hubs often emerge as part of existing collaborative relationships amongst different GP practices that are already in place, and are</p> |

usually focused on delivering extended access to general practice care. Their aims and objectives can differ depending on local population needs; however, a core feature is that they provide same-day urgent appointments to registered patients. For example, this can be done by having a shared triage system to point patients to the most appropriate route of care. Additionally, they may offer out-of-hours care. More recently Covid-19 primary care hubs have been formed¹⁹.

Primary care networks

Primary care networks are the latest attempt on the part of the NHS in England to engage general practice (and other primary care practitioners and teams) in bringing about a range of service changes intended to support local populations living with ever more complex long-term conditions, and reduce the reliance of such people on in-patient hospital care. Previous similar policy initiatives have included GP fundholding, total purchasing projects, personal medical services schemes, and primary care groups²⁰. Furthermore, with primary care networks there is a desire to use this more collaborative approach as a means to strengthen the sustainability of general practice, including in respect of its workforce and financial health. The key features of primary care networks are set out in Box 2 below.

Box 2: Primary care networks – key features (adapted from Baird et al., 2018²¹)

Commenced on 1 July 2019, as required by NHS England and Improvement.

There are 1259 networks across England – the intention was that they cover a population of 30,000 to 50,000, in line with the primary care home model (National Association of Primary Care).

Around 50 networks, usually in rural areas, cover a population of less than 30,000, and 35% of registered primary care networks cover a population greater than 50,000.

Each primary care network holds a Directed Enhanced Service (DES) contract as a formal agreement across the constituent practices, with one practice holding this on behalf of those within the network.

The Directed Enhanced Service contract provides funds for the network to operate seven new services specified by NHS England and Improvement (five starting from July 2019, and a further two

from April 2020), including social prescribing, practice-based pharmacy (structure medication reviews), enhanced health services for care homes, digital forms of access to general practice, community paramedic and physiotherapist support, more effective early cancer diagnosis, cardiovascular disease diagnosis and prevention, and local action to address health inequalities.

The services provided by the primary care network are being phased in over a period of three years (this has been extended from the initial two-year plan), with social prescribing and practice-based pharmacy being the first to be implemented, followed by enhanced health services for care homes.

Primary care networks will form the geographical basis for the development of integrated community health teams, including for mental health services, with a focus on providing proactive and anticipatory care.

£1.8 billion in funding will be provided via primary care networks by 2023-24, including money to operate the networks and help pay for additional primary care staff.

Primary care networks are distinct from previous collaborations in terms of the context in which they are being implemented. Almost half of GPs in the NHS in England are employed on a salaried or sessional basis (as opposed to having equity ownership of the practice), and a majority are women (many of whom work part-time and/or wish to have portfolio careers, as do some of their male colleagues)²². Even before the Covid-19 pandemic, a significant shortfall has been seen in availability of GPs and other health professionals (including community and practice nurses) at a time of rising demand for services. Furthermore, the sustainability of general practice is a key current concern, both in respect of securing sufficient workforce, and matching supply of services to growing patient demand⁷.

Primary care networks are particularly noteworthy in that they offer general practices the possibility of significant levels of additional funding, and in that there is a contractual basis to this. Hence, PCN working has a formal, incentivised and compulsory feel to it compared to many predecessor schemes of collective primary care. Unsurprisingly given the primary care network approach outlined above, with additional funding on offer from NHS England and Improvement to develop new services for local patients, almost all general practices have joined a primary care network²³, although the extent to which this is an enthusiastic and committed move is explored within this evaluation. In late 2019, NHS England and Improvement ran a consultation about the service specifications to underpin the primary care network contract, which resulted in major concerns on

the part of general practice about the pace, scope and scale of what was expected.²⁴ Subsequent revisions to the primary care network service specifications in early 2020 extended the timescale for networks to take on responsibility for some services, such as early cancer diagnosis. Once the Covid-19 pandemic emerged in the UK in March 2020, a decision was taken to defer implementation of some primary care network services set out in national specifications, although the Enhanced Healthcare in Care Homes scheme was brought forward to start in May 2020, causing further consternation in the primary care community²⁵.

There were (as at May 2020) 1259 primary care networks, serving populations that ranged from 20,000 to well above the 50,000 suggested in policy. These primary care networks sometimes build on prior GP collaborations and are often supported by the organisational infrastructure of the extant collaborations. Other networks are brand new entities in the process of becoming established and working out how best to source their management support. For this latest iteration of GP collaborations in the English NHS, there is much to be learned from examining research evidence on the nature and speed of implementation, development and impact of previous primary care organisations dating back to the early 1990s, and in particular those that were brought together to hold shared contracts to deliver health services for a local population. In the next section, a synthesis is presented of the evidence on GP collaborations deemed most relevant to this evaluation of the implementation and development of primary care networks.

In the next chapter, we describe the methods used for this rapid evaluation of the implementation and early development of primary care networks, what helped and hindered their progress, how they worked with the GP collaborations that were already in place as the new networks were formed, and what this means for future development of primary care networks. Following this, we set out the findings of our rapid evidence assessment of GP collaborations, using this to frame questions for exploration in the case study research which is presented and discussed in subsequent chapters.

Chapter 2: Methods

Box 3: Key points from Chapter 2

The overarching purpose for this evaluation was to produce early evidence of the development and implementation of primary care networks introduced into the NHS in England in July 2019. The evaluation had a particular focus on seeking to understand how practices entered into collaborations, why some collaborations stall or fail, and whether and how the experience of rural collaborations may differ from that of urban examples.

We completed a qualitative cross-comparative case study evaluation comprised of four work packages:

- 1) A rapid evidence assessment;
- 2) A stakeholder workshop with leading academics, policy experts, and patient/public representatives to share findings from the rapid evidence assessment and shape research questions for case study work;
- 3) Interviews with key stakeholders across case study sites alongside observations of strategic meetings, online survey and analysis of key documents; and
- 4) Analysis of findings from work packages 1-3 to develop a set of lessons for the next stage of development of primary care networks in the NHS in England, for dissemination to policy makers, practitioners and representatives of patients, carers and the public.

We undertook a multi-faceted sampling process to select four case study sites, based on identifying appropriate primary care collaborations through clinical commissioning groups that had not been previously evaluated.

A content analysis approach to documentary reviews and observations was undertaken. Data analysis for interviews was informed by a framework method for the analysis of qualitative data in multi-disciplinary health research. Our analysis was guided by theoretical and policy literature on collaborations of general practices.

Aims and research questions

The overarching purpose for this evaluation was to produce early evidence of the development and implementation of primary care networks introduced into the NHS in England in July 2019, to inform subsequent policy and support to be provided to these new collaborations. The evaluation therefore sought to identify the forms of general practice (GP) collaboration previously used in primary care in England, the reasons for general practice to enter (or not) into collaborations, evidence about the

impact of primary care networks and prior GP collaborations, along with any barriers or facilitators to progress.

The evaluation had a particular focus on seeking to understand the rationale behind and how practices entered into collaborations, the potential influence of prior collaborative working on primary care networks, and whether and how the experience of rural collaborations may differ from that of urban examples. The findings from the evaluation are intended to feed into NHS England and Improvement's planning and implementation guidance for primary care networks and inform proposals for longer-term study of primary care networks.

In order to address our aims, we sought to answer the following evaluation questions:

- **RQ1:** What was the contextual and policy background within which primary care networks were introduced?

RQ1.1: What were the pre-existing forms of GP collaborative working across primary care in England?

RQ 1.2: How have new primary care networks been implemented in a sample of urban and rural settings?

RQ 1.3: How do new primary care networks relate to pre-existing GP collaborations?
- **RQ2:** What are the rationales and motives for general practices to enter into GP collaborations, including new primary care networks? In particular, what role do financial incentives play in facilitating or inhibiting collaboration? What are the expected outcomes for primary care networks?
- **RQ3:** What evidence exists about the positive or negative impacts associated with different experiences of establishing GP collaborations and how do these relate to newly formed primary care networks?
- **RQ4:** What appear to be the barriers to and facilitators of effective collaboration across GP practices, both with respect to successful and unsuccessful collaboration, and achieving impact or not?
- **RQ5:** What does the analysis of prior experience of GP collaborations, and the early implementation of primary care networks, suggest in terms of the likely progress of primary

care networks in the NHS in England, including in light of the Covid-19 pandemic and associated challenges?

General approach

We completed a mixed methods cross-comparative case study evaluation²⁶⁻²⁸ comprised of four work packages (Table 2).

1. A rapid evidence assessment;
2. A stakeholder workshop with leading academics, policy experts, and patient/public representatives to share findings from the rapid evidence assessment and shape research questions for case study work;
3. Interviews with key stakeholders across case study sites alongside observations of strategic meetings, online survey and analysis of key documents; and
4. Analysis of findings from work packages 1-3 to develop a set of recommendations for the next stage of development of primary care networks in the NHS in England, for dissemination to policy makers, practitioners and representatives of patients, carers and the public.

NB: Work package 4 was originally designed to be a number of face-to-face case study-specific workshops as well as round table discussion with key experts. As a result of the Covid-19 pandemic (March 2020 onwards) the study team, under the guidance of NIHR Health Services Delivery and Research Programme, suspended data collection and focused on analysis and writing up of findings. NHS colleagues in case study sites were made aware that they were no longer expected to comment on or respond to our communication (May 2020). There is however an intention to share findings via a digital slide deck with policy experts, academics and our case study sites in Autumn 2020 (depending on progress of the pandemic and extent of NHS recovery and restoration work) to share and discuss emerging findings (academic outputs available online and possibly in the form of blogs as well as executive summaries), and ensure their applicability to the next stage of development of primary care networks.

Protocol sign off

The study topic was identified and prioritised for rapid evaluation by NIHR HS&DR after receiving a request from NHS England (in 2018) in respect of primary care network planning and

implementation. This varies from the BRACE Centre’s usual approach to identifying innovation through horizon scanning.

An initial topic specification (first stage protocol) was prepared (September 2018) and once approved, was used as the basis for writing the full research protocol (March 2019), which drew on the findings of the initial rapid evidence assessment (WP1) and workshop (WP2). The full research protocol was revised further (October 2019) as primary care network implementation shifted with regard to policy changes.

Ethical approval

An application for ethical review to the University of Birmingham’s Research Ethics Committee was made by the project team and approval was gained in May 2019 (ERN_13-1085AP34). The project team received confirmation from the Health Research Authority (HRA) that this study was to be categorised as a service evaluation and therefore approval by the HRA or an NHS Research Ethics Committee was not required. At each case study site, we approached relevant local research and development (R&D) offices to register our service evaluation, and received confirmation that all were content for the evaluation to proceed in their local area.

Table 2: Summary of work packages and how research questions were addressed

| Work package (WP) | Description | Research questions |
|----------------------------------|---|---------------------------|
| WP1: A rapid evidence assessment | An overview of published evidence to distil prior learning and inform the development of propositions to be tested through comparative case studies of new primary care collaborations/networks. | RQ1.1, RQ3 |
| WP2: Stakeholder workshop | A workshop led by members of the study team for relevant stakeholders (e.g. academic and policy experts in the field, patient and public involvement representatives), where initial findings from the rapid evidence | RQ1.1, RQ2, RQ3 |

| | | |
|--|---|------------------------------|
| | <p>assessment were shared and discussed.</p> <p>The aim of this workshop was to clarify evidence gaps and evaluation questions of particular relevance to emerging policy on primary care networks and thus inform next steps for WP3.</p> | |
| <p>WP3: Comparative case studies of four primary care networks (minimum of two in rural settings)</p> | <p>Interviews with those involved in the conceptual design, implementation of primary care networks in their respective sites, and exploration of relationship with any prior GP collaboration in the case study site; analysis of key documentation (both internal and publicly shared); non-participant observation of strategic meetings; and an online survey to collate information on challenges associated with collaborative working and measuring early impacts.</p> | <p>RQ1.2, RQ1.3 RQ3, RQ4</p> |
| <p>WP4: analysis of findings from work packages 1-3 to develop a set of recommendations for the next stage of development of primary care networks in the NHS in England</p> | <p>Share and discuss findings generated from data collection from WP3</p> | <p>RQ1, RQ3, RQ4, RQ5</p> |
| <p>WP4: Dissemination to policy makers, practitioners</p> | <p>Develop recommendations for commissioners, providers and</p> | <p>RQ1, RQ3, RQ4, RQ5</p> |

| | | |
|---|--|--|
| and representatives of patients, carers and the public. | policy makers through academic outputs, virtual meetings with policy makers, blogs, podcasts, and online mediums | |
|---|--|--|

WP1: Rapid evidence assessment

A rapid evidence assessment follows a systematic approach, in line with guidance on literature reviews in health care²⁹, but the scope of the search is restricted to key search terms and review criteria to allow for a focused review of the literature within a limited timeframe³⁰. The rapid evidence assessment aims to synthesise the body of evidence on general practice collaborations across primary care drawing on UK and international literature.

Searches were undertaken in two stages on 21 September 2018. First, the study team completed a search for reviews and evidence summaries published during the period 1998 to 2012 inclusive due to the breadth of published literature. Second, a search was then undertaken of all published literature (including primary research studies and reviews) from the year 2013 until September 2018 using key search terms in titles and abstracts. Searches were undertaken of PubMed, Ovid MEDLINE, Web of Science (Social Science Citation Index only), and Scopus (restricted to the following subject areas: Medicine, Social Sciences, Nursing, Multidisciplinary and Health Professions) for literature published in the English language using selected search terms (see Box 4 for the search strategy used), which was then adapted to other publication database. Forward and backward citation searching of relevant articles was undertaken to ensure that key articles had been identified through our search strategy. Search terms were developed in collaboration with an experienced health services research librarian (Rachel Posaner of the University of Birmingham).

Box 4: Search strategy for rapid evidence assessment

((("Primary care*" OR "primary health care*" OR "general practice" OR "GP*" OR "family physician*" OR "family doctor*" OR "primary care*" OR "family health team*") AND ("collaborat*" OR alliance OR "primary care network*" OR network* OR "super-partnership*" OR "super partnership*" OR superpartnership* OR federation* OR "multi-site practice organi*" OR "multi site practice organi*" OR "multisite practice organi*" OR cooperat* OR "co-operat*" OR cluster*) AND ("effective*" OR "efficien*" OR "success*" OR "valu*" OR "impact*" OR "cost*" OR "econom*") AND ("review*"))

OR

((“collaborat*” OR “alliance” OR “primary care network*” OR “network” OR “super-partnership*” OR “super partnership*” OR “superpartnership*” OR “federation*” OR “multi-site practice organi*” OR “multi site practice organi*” OR “multisite practice organi*” OR “cooperat*” OR “co-operat*” OR “cluster*”) AND (“primary care*” OR “primary health care*” OR “general practice” OR “GP*” OR family physician*” OR “family doctor*” OR “primary care*” OR “family health team*”) AND (“economies of scope” OR “at scale” OR “scope” OR “cost*” OR “economies at scale*”) AND (“review*”))

OR

((“primary commissioning” OR “independent practice assessment” OR “community health organi*” OR “independent practice organi*” OR “independent practitioner organi*” OR “health care home” OR “community-oriented primary care” OR “community-owned primary care” OR “community health trust”) AND (“review*”))

Note: These are the search terms for 1998-2012 inclusive for the BRACE primary care collaborations rapid evidence assessment (restricted to review only). 2013+ includes all the same terms but drops the terms “review*”.

The year 2013 was considered of particular importance to GP collaborations in the NHS in England given the introduction of clinical commissioning groups (CCGs) in April of that year, replacing primary care trusts (PCTs) as the bodies responsible for commissioning most NHS services for their local populations. Clinical commissioning groups have all the GP practices in a geographic area as members, and are governed by boards each comprising GPs, other clinicians (including a nurse and a secondary care consultant), and lay members. Thus since April 2013, GP practices in England have been required to collaborate for purposes of *commissioning* secondary and tertiary care services for their registered populations, but have not been required to collaborate in order to *provide* health care services. Our rapid evidence assessment and evaluation were therefore restricted to collaborations for service provision rather than collaborations for commissioning. The evidence review was registered with PROSPERO before screening began. PROSPERO Protocol registration number: CRD42018110790.

Five review articles and 34 peer-reviewed primary research studies were eligible for inclusion. In addition, we identified 16 grey literature publications, bringing the total number of included publications in this rapid evidence assessment to 55. We present these numbers using an adapted version of the PRISMA diagram³¹ in Figure 1 and Figure 2 below.

Figure 1: Flow diagram of screening decisions – 1998 to 2012 inclusive (reviews only)

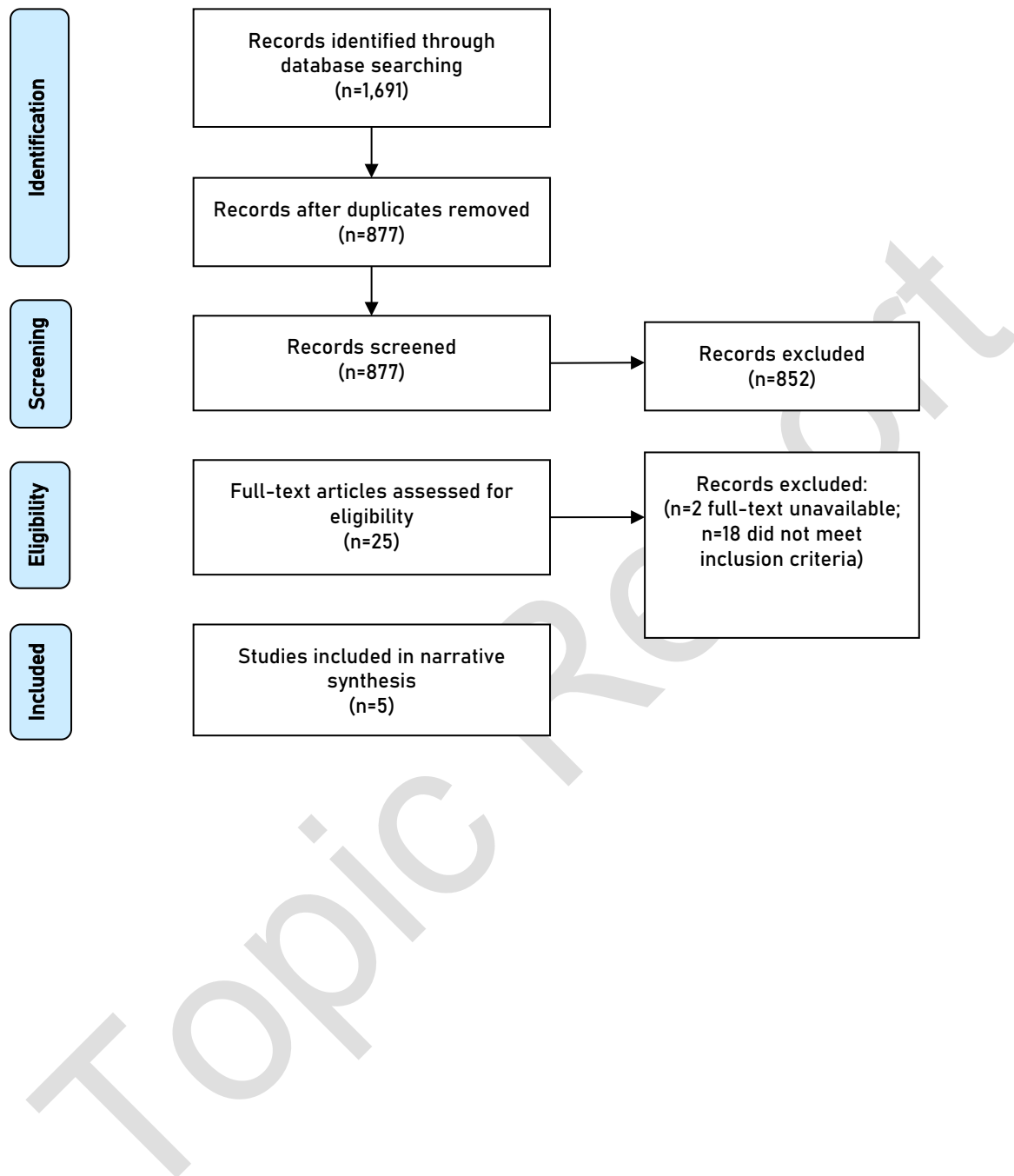
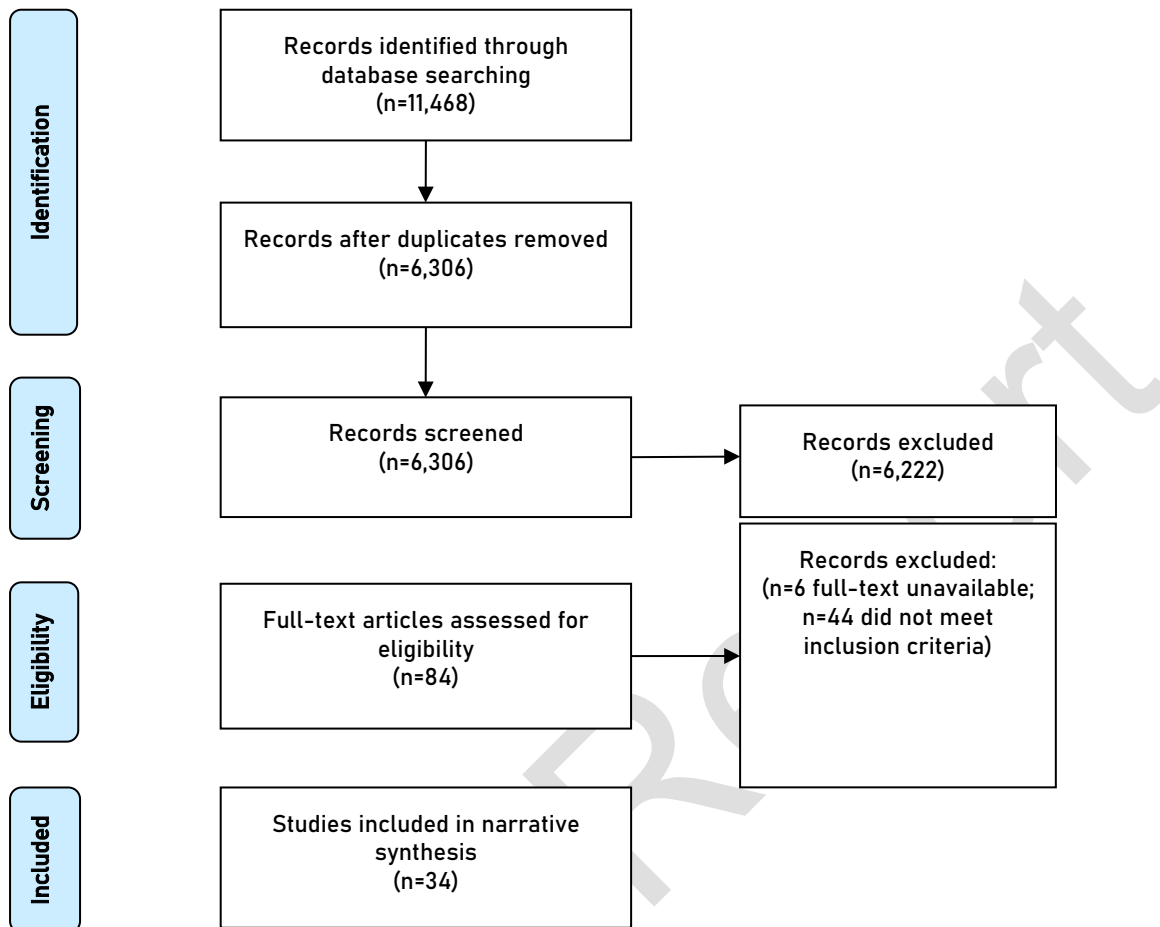


Figure 2: Flow diagram of screening decisions – 2013 to 2018 inclusive (all methodologies)



In summary, the rapid evidence assessment included both scholarly (academic) literature and grey literature (i.e. reports and articles not submitted to a peer-reviewed journal) that described and evaluated models of GP collaboration in the UK and internationally, including demographics of GP collaborations, impacts of primary care collaborative working, and any reported barriers and facilitators to implementing these arrangements.

While we aimed to be inclusive in our approach to the rapid evidence assessment and capture an accurate representation of the body of literature published on collaborations, there were some limitations of the review:

- Defining ‘collaboration’ was challenging given the numerous ways that it was described in the literature and the associated terms attached to it. Despite this, we believe that we captured relevant publications to provide a sufficient overview of evidence relevant to the

objectives of this study, as the reviewers erred on the side of inclusion when screening the titles, abstracts, and full texts where there was doubt about the relevance of a publication after discussion.

- We found that in several cases a particular collaborative model, in particular the GP federation in the London Borough of Tower Hamlets, was discussed in more than one paper^{32, 33}. Consequently, there is a risk of over-emphasising that model.
- We found little evidence of measured outcomes and costs to back up the expected impacts of collaborations. Examples of such outcomes that may be desirable to measure include the incremental costs/savings associated with collaboration, measures of staff satisfaction, and changes in patient health outcomes.

WP2: Project design stakeholder workshop

A half-day project design workshop³⁴ was undertaken in November 2018 and involved, in addition to the research team, primary care policy officials from NHS England and Improvement, a patient representative (from the BRACE Health and Care panel, a source of advice from the health and care sector that acts as a sounding board in relation to the choice, design, delivery and dissemination of rapid evaluations conducted at the BRACE Centre), academics with experience of researching primary care organisations, and policy experts in the field (N=12). The aim of the workshop was to discuss the findings of the rapid evidence assessment (WP1), to help identify gaps in the literature, and thereby identify and agree the appropriate focus of evaluation questions for the case studies in WP3. Furthermore, the results of the rapid evidence assessment were consolidated into a slide set and working paper at this stage, providing a vital resource for the evaluation team to shape the data collection strategy for case study sites.

A structured agenda was prepared in advance of the workshop and included time for plenary discussions, presentations of findings from the rapid evidence assessment (also shared with participants in advance), and smaller group discussions. Members of the study team took detailed notes during the workshop, which were used to further develop and refine the case study design (WP3). Notes from the workshop, including proposed detailed evaluation questions, and confirmed evidence gaps, were shared with all participants following the workshop. For more information on this, please see Report Supplementary Material File 1.

Results from the workshop highlighted a number of evidence gaps that could be addressed throughout the evaluation. Participants felt it was important to understand how 'participation' in a collaboration is understood and how 'success' within a primary care collaboration would be defined.

Participants at the workshop also felt a key unexplored area was to explore experiences of primary care collaborations in rural, as opposed to urban areas, to better understand regionally-specific challenges in primary care. First, questions were raised with regard to how primary care networks can cater for different types of rural and coastal populations; where the population is older than the national average which has implications for demand on health and care services as well as the workforce. Second, good innovation and practice were felt to be too often based on urban examples of primary care delivery with relatively little being known about whether or how easily such learning is transferable to rural settings.

Notably, the study team was encouraged to steer away from case study sites that had already been well evaluated. Finally, attendees were keen for the evaluation to include exploration of what management and organisational development skills/capacity are needed to make a collaboration work and from where collaborations are drawing these skills and capacity.

Following the project design workshop, the study team continued to communicate and share preliminary learning from the evaluation with key stakeholders and policy experts in attendance to: acknowledge and incorporate learning from other national evaluations/research happening in parallel; and, ensure data collection remained responsive to emerging insights captured by policy experts. Thus the study team, throughout the duration of the rapid evaluation, held regular teleconference meetings with policy experts from NHS England and Improvement, the Department of Health and Social Care, the Health Foundation, and senior academics in primary care policy research at the University of Manchester.

WP3: Comparative case studies of four primary care collaborations

We conducted comparative case studies of four primary care collaborations in England (three primary care networks and one GP super-partnership comprised of several primary care networks).

This work package involved three phases:

- 1) case study selection and site recruitment;
- 2) data collection at four case study sites; and
- 3) analysis and reporting.

These phases were undertaken between April 2019 and April 2020. Given that our evaluation began in September 2018, our initial search for case study sites was focused on primary care collaborations (e.g. GP federation, primary care home, 24-hour access hub or GP super-partnership) rather than having a sole focus on primary care networks. However, after the implementation of NHS England and Improvement's primary care networks model in July 2019, and discussion with the NIHR HS&DR secretariat, the research team's focus turned to recruiting primary care networks as case study sites (unless the team was already in the process of recruiting another form of primary care collaboration).

Phase 1: Case study selection and site recruitment

Sampling strategy

We undertook a multi-faceted sampling process to select four case study sites, based on identifying appropriate primary care collaborations through clinical commissioning groups that had not been previously evaluated and varied with respect to:

- Rural or urban setting (based on the 2011 rural-urban classification (RUC) of clinical commissioning groups in England)
- Collaborations facing significant challenges compared to those who are operating without significant operational complications

With the support of the University of Birmingham, Health Services Management Centre's Knowledge and Evidence Service (KES) team, two members of the research team (AH and MS) carried out a search of three online non-academic databases: GPOnline, Pulse and the Health Service Journal (HSJ) (January 2018 to April 2019) to identify well- and poor-performing primary care collaborations using the following terms:

"collaboration" OR alliance OR "primary care network*" OR network* OR "super-partnership*" OR "super partnership*" OR superpartnership* OR federation* OR "multi-site practice organisation*"

However, from the search results, it remained difficult to identify primary care collaborations but easier to ascertain clinical commissioning groups encountering challenges with the delivery of primary care. In addition, at the time of identifying potential case study sites (May 2019), there was no definitive database/source detailing the existence of primary care collaborations in England.

Therefore, the research team obtained an anonymised list of all responses from the Nuffield Trust

and Royal College of General Practitioners (RCGP) “Collaboration in general practice: Surveys of GP practice and clinical commissioning groups” survey¹³ (October 2017) to identify clinical commissioning groups to approach, and contacted a number of experts in the field to support the identification of collaborations who may be interested in taking part in our evaluation (May 2019). From July 2019, the study team primarily focused on recruiting primary care networks for their case study sites. Our inclusion/exclusion is detailed in Table 3.

Table 3: Case selection inclusion/exclusion criteria

| Inclusion criteria | Exclusion criteria |
|---|---|
| <p>Rural or urban setting (based on the 2011 rural-urban classification (RUC) of clinical commissioning groups in England)</p> <p>Collaborations facing significant challenges compared to those who are operating without significant operational complications</p> <p>Informal networks, multi-site practice organisations, super-partnerships, federations, primary care home (pre July 2019) or a primary care network (post July 2020).</p> <p>Collaborations either active or those that have ceased to be operational in the past 12 months.</p> <p>Collaborations consisting of any number of collaborators/GP practices (pre July 2019)/ meet primary care network model specifications (post July 2019)</p> | <p>Collaborations that have already been the focus of research or evaluation within the previous two years.</p> |

Case selection and site recruitment

AH and MS identified eight potential clinical commissioning groups (seven of which were urban and one rural) from online searches. Of the clinical commissioning groups that responded to the 2017 RCGP survey, the total number classified as rural was 28, while the total number of classified as urban was 133 (based on the 2011 rural-urban classification (RUC) of clinical commissioning groups in England). The study team took an executive decision to approach 28 rural and urban clinical

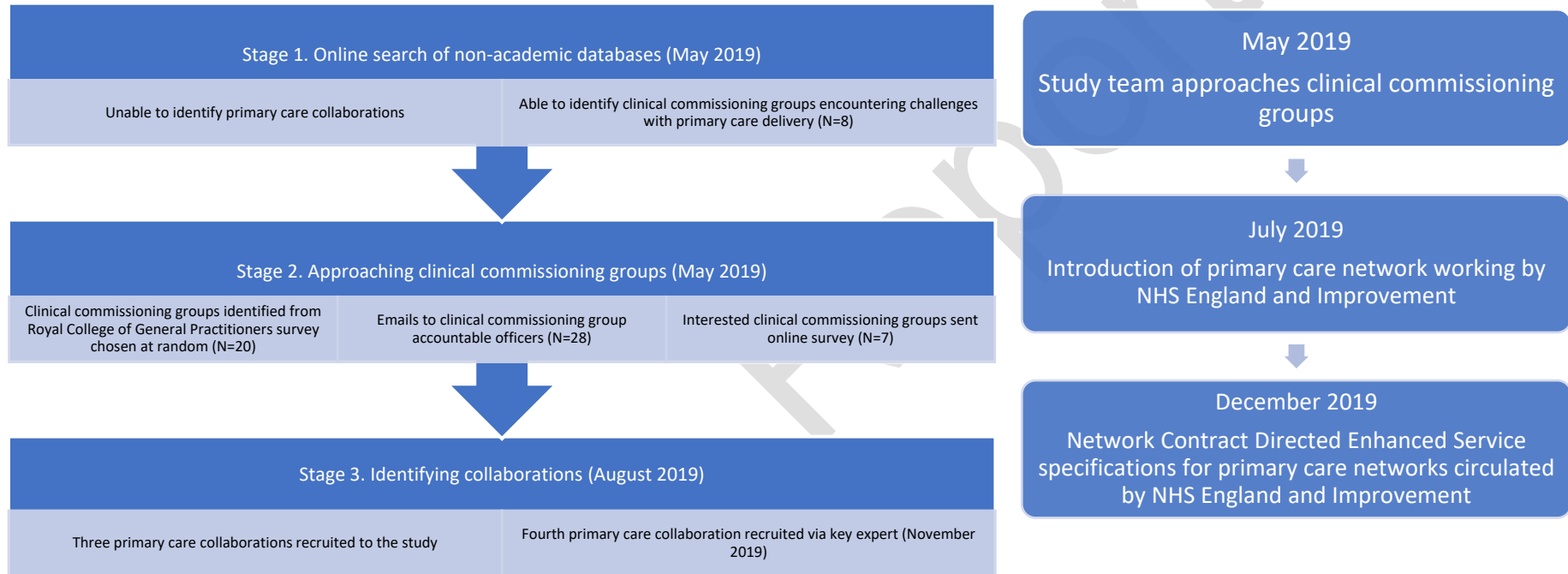
commissioning groups in England in May 2019 (comprised of eight collaborations identified from online searches (1 rural, 7 urban), 20 clinical commissioning groups identified from the 2017 RCGP survey chosen at random (10 rural, 10 urban) respectively based on resources and to begin data collection in a timely fashion).

The study team sent email correspondence directed to clinical commissioning group accountable officers (or their equivalent) on behalf of the principal investigator (JS) (with a follow up email sent four weeks after the initial invitation). The email was accompanied by an information sheet, a reply form asking the clinical commissioning group to name all operational/non-operational primary care collaborations (previous 12 months) in their area, and followed up with a telephone conversation between AH or MS with the primary care lead at the clinical commissioning group. From the 28 invitations sent to clinical commissioning groups, seven responded with a willingness to know more about the evaluation with the possibility of taking part.

To support the identification of primary care collaborations via clinical commissioning groups, the study team disseminated a short online survey (Appendix 1: Primary care collaborations survey as part of sampling strategy) to those groups who had responded to our initial approach asking them to provide details about their primary care collaborations and whether pre-existing collaborations were now primary care networks or how they were part of the local emerging network configuration. The survey was pilot tested with two policy experts prior to circulation.

By August 2019, only three primary care collaborations that met our inclusion criteria, from three different clinical commissioning groups, were committed to taking part in our evaluation (two primary care networks and one GP super-partnership). All three primary care collaborations were recruited as our case study sites. Our fourth case study site (a primary care network), which met our inclusion criteria, was recruited directly via a key expert employed by a GP super-partnership in England (November 2019). Figure 3 summarises our sampling process.

Figure 3: Summary of case study site sampling



Phase 2: Data collection at four case study sites

The study team followed Johl and Renganathan's (2010) phased framework for responsible engagement with organisations and gatekeepers, which includes 'pre-entry', 'during fieldwork', 'after fieldwork' and 'getting back' phases³⁵. The use of this framework helped the study team establish a communication plan to build gatekeeper trust and support for the project. A gatekeeper was defined as a person based at our case study sites who could act as an intermediary between a researcher and potential participants with the authority to deny or grant permission for access to potential research participants³⁶.

Potential participants for interviews were identified, where possible, via a stakeholder mapping exercise with a gatekeeper at each site. Individuals were purposively sampled for maximum variation³⁷ with regard to knowledge of impacts of, and barriers and enablers to GP collaboration in their area. Where stakeholder mapping was not possible, the team incorporated both a snowballing and convenience sampling methods to identify interviewees³⁸.

The gatekeeper helped the team by forwarding documents for analysis and arranging interviews with participants. Communication with gatekeepers across case study sites was often challenging given the changing policy landscape of primary care during late 2019 (such as Brexit planning, NHS financial and workforce challenges, and the scope and pace of primary care network policy implementation as discussed in Chapter 1). Although the research team established significant rapport with gatekeepers, it was difficult to engage clinical and non-clinical staff responsible for delivering front line primary care health services during a period of policy turbulence, which was made more difficult with the rise of the Covid-19 pandemic.

Our data collection involved four components: stakeholder interviews; non-participant observation of meetings at primary care network or GP collaboration executive board level; document review; and an online survey.

Stakeholder interviews

Interviewees included: clinical commissioning group staff (related to the set up and implementation of primary care networks), GPs in collaboration lead roles, practice managers, pharmacists, and those in roles focused on the financial and operational management of collaborations/primary care networks. Depending upon the size of the primary care collaboration/primary care network, the

evaluation team planned to complete 10-15 interviews across each case study site or until data saturation³⁹.

All interviewees received an information sheet (by email or in person) and were given time to make a decision with regard to participation and ask questions about the process. Participants signed a consent form prior to participating in the interview, including whether they consented to the recording of the interview. Participants were allowed to withdraw from the study at any time (without giving a reason), and were given information about how to find out more about the study or raise any concerns about its conduct.

Individuals participated in a semi-structured interview with either one or two members of the study team, either in-person or via telephone, and interviews lasted between 30-60 minutes. A topic guide was developed and used during interviews (Appendix 2: Topic guide for interviews), although the semi-structured nature of the interviews allowed interviewers to deviate from the topic guide based on the interviewee’s knowledge, experience and previous responses. The topic guide contained questions relevant to understanding barriers and facilitators to primary care networks (and/or larger collaborative working within which primary care networks exist), operational challenges associated with establishing and running the primary care network/collaboration, and the early successes/impacts achieved at each case study site.

Interviews were audio-recorded (all participants gave consent) and transcribed verbatim by a professional transcription service. These transcriptions were anonymised and kept in compliance with the General Data Protection Regulation (GDPR) 2018 and Data Protection Act 2018.

In total, we interviewed 25 participants across four case study sites. Table 4 provides a description of those we interviewed.

Table 4: Characteristics of participants interviewed from four case study sites

| Site | Description | Number (N) |
|-------------|---------------------------------|-------------------|
| Site A | Primary care clinical staff | 4 (Int1-4) |
| | Primary care non-clinical staff | 5 |

| | | |
|--------------|------------------------------------|---------------------|
| | | (Int5-9) |
| Site B | Primary care clinical staff | 3 (Int10-12) |
| | Primary care non-clinical staff | 3 (Int13-15) |
| | Clinical commissioning group staff | 2 (Int16-17) |
| Site C | Primary care clinical staff | 4 (Int18, 20-22) |
| | Primary care non-clinical staff | 2 (Int23-24) |
| | Clinical commissioning group staff | 1 (Int19) |
| Site D | Primary care non-clinical staff | 1 (Int25) |
| Total | | 25 |

Primary care clinical staff: general practitioners, primary care network clinical directors, nurses

Primary care non-clinical staff: practice managers, primary care network managers, collaboration leads, back office network/collaboration management leads (e.g. finance, IT, procurement)

Clinical commissioning group staff: senior strategic leads responsible for primary care delivery

Non-participant observation of meetings

We observed meetings (at an executive and managerial level where operational and clinical delivery was discussed) between key stakeholders at case study sites to gain a deeper understanding of how the collaboration was operating and what priorities and challenges it was addressing. These interactions were recorded on an observation template based on the agenda for the meeting, as well as using sociograms (visual representations of relationships between individuals in a given setting) where possible (meetings with fewer attendees) to map the nature of interactions within the meeting⁴⁰. This observation template can be found in Report Supplementary Material File 2.

A participant information sheet and written consent form were circulated in advance or on the day of the meeting to all attendees. Prior to each observation, a member of the study team provided a verbal explanation of the project and its aims and gave attendees an opportunity to ask questions. Individuals who did not consent were omitted from recorded observation notes. Two participants from different case study sites requested their comments be omitted from observation notes. During meetings, team members were seated appropriately to record observations but remain unobtrusive to discussion.

Throughout the evaluation, being able to attend meetings proved challenging in three of the four case study sites; for example, meetings were regularly re-scheduled at short notice and the study team often had limited access to high-level strategic meetings. Thus, collaborations were selective with regard to the nature of meetings they allowed the evaluation team to attend. In addition, it was sometimes difficult to gain access to meetings where individual practices expected that they might divulge information which may represent their primary care collaboration in a negative manner. Therefore, such concerns had a significant impact on the number of observations that were completed (N=9), despite extensive efforts on the part of the evaluation team working with case study gatekeepers.

Document review

Members of the study team gathered documents describing and containing data on the nature of primary care collaborations, priorities and aims, challenges and objectives, activities, set-up, operation, staff involvement, and the costs and outcomes of collaboration. These were used to contextualise the development and functioning of the collaboration/primary care network and to provide a historical perspective. Documents were sourced through case study gatekeepers and included:

- material related to the structure of the collaboration/primary care network;
- infrastructure and governance arrangements and charts;
- agendas and minutes of collaboration/primary care network board and other meetings; and
- local communications materials.

Data were extracted from source documents using a structured Excel template, which is available in Report Supplementary Material File 3. The research team summarised information from documents which have informed the writing of our context (Chapter 1) and case study summaries (Chapter 4).

Online Smart Survey

Throughout data collection, members of the evaluation team struggled across all four case study sites to arrange and complete interviews with clinical staff working in primary care (who were time-limited), although other non-clinical staff were more available for interviewing. Therefore, in January 2020, the research team designed a short online survey (no more than 10 minutes to complete) (Appendix 3: Survey) to supplement data collected from interviews and observations, as well as to gather further data from GPs, nurses, practice managers, and newly-introduced staff members recruited via implementation of NHS England and Improvement's primary care network model (i.e. social prescribers, pharmacists). Prior to circulation, a draft version of the survey was piloted with two senior and experienced GPs - external to the case study sites to ensure questions were appropriate to our evaluation questions, and to check for ease of comprehension and completion. Once re-drafted following comments, the survey was distributed across case study sites via gatekeepers (Feb-Mar 2020). A breakdown of survey responses from each site and characteristics of participants is detailed below in Table 5 and Table 6. Results are discussed in Chapter 5, and additional information on survey responses are available in Appendix 5, Tables 8 and 9.

Table 5: Survey responses from each site

| Site | N |
|--------------|-----------|
| Site A | 2 |
| Site B | 14 |
| Site C | 4 |
| Site D | 8 |
| Total | 28 |

Table 6: Survey respondent roles

| Role | N |
|---|-----------|
| Primary care clinical staff | 17 |
| Primary care non-clinical staff | 4 |
| Primary care organisational management-related staff | 3 |
| Other (community based health-care providers/leaders) | 4 |
| Total | 28 |

Phase 3: Analysis and write-up

Between January and April 2020, the insights gained through interviews, documents, non-participant observations, and the online survey were analysed for each case study site.

We took a content analysis approach to documentary reviews and observations; hence, an iterative process of reading appropriate primary care literature and engaging in interpretation. To aid in the process of analysing and interpreting the data, the core evaluation team (MS, SP and JS) undertook an online data analysis half day workshop in March 2020 followed by regular weekly online video calls (March-April 2020). These meetings had to take place on-line, as the Covid-19 pandemic was under way during the majority of Phase 3, and the evaluation team was working from home as per government guidance.

Our analysis was guided by theoretical and policy literature on collaborations of general practices, and in particular the framework developed by Smith and Mays (2007), seeking to identify and understand the:

- objectives underpinning a collaboration;
- measures (or proxy measures) of the impact of a collaboration;

- degree of success in ‘tipping the balance’ i.e. shifting policy attention away from more traditionally powerful elements of health systems, such as acute hospitals, towards primary healthcare (in this case the local primary care network area, and overarching clinical commissioning group); and
- the role played by primary care collaborations in strengthening primary care services and influence.¹²

Data analysis for interviews was informed by Gale et al. (2013) framework method for the analysis of qualitative data in multi-disciplinary health research¹. This method of analysis is a highly systematic method of categorising and organising data whilst continuing to make analytical and interpretive choices transparent and auditable. Hence, the aim for the project team was to facilitate comparison across the case studies.

There are seven stages to analysis within the framework approach:

- 1) Transcription
- 2) Familiarisation with the interview
- 3) Coding
- 4) Developing a working analytical framework
- 5) Applying the analytical framework
- 6) Charting data in a framework matrix
- 7) Interpreting the data¹

Data analysis and early interpretation of emerging findings was led by AH (November 2019 to February 2020). However, AH was on maternity leave from March 2020 onwards and SP led data analysis and writing up of the findings with input from JS and MS throughout.

Stage 1. Transcription

All interviews across the four case study sites were transcribed verbatim (word for word) through a professional outsourced transcribing company - a single organisation, specialising in transcribing health-related qualitative interviews, was used for all interviews.

Stage 2. Familiarisation with the interview

Members of the project team (AH and MS) established familiarity with the data by reading two transcripts (or one page summaries of transcripts) from each case study site and discussing emerging findings and areas of interest (which may warrant further probing in subsequent interviews) via telephone weekly meetings (November 2019 to February 2020). During meetings, team members were able to reflect on, discuss and share preliminary thoughts and impressions of early findings. This in return led the evaluation team to construct detailed case descriptions for each of the four sites (Chapter 4).

Stage 3. Coding

Stage 3 and Stage 4 (coding and developing a working analytical framework) of analysis occurred in tandem. The study team applied a deductive approach, having developed first an initial coding framework focusing on specific areas of interest identified from our rapid evidence assessment and primary care policy literature, as well as interview guides and an initial reading of interview transcripts and field notes. Second, two researchers (SP and MS) independently coded the one interview transcript to ensure no important aspects of the data were missed. The qualitative data analysis software package NVivo 12 was used to undertake coding⁴¹.

Stage 4. Developing a working analytical framework

After piloting the initial coding framework and revising it based on the coding of an initial transcript, an analytical coding framework was agreed by all project team members (Appendix 4: Code book for interview analysis). The analytical coding framework differed from the initial framework in that it had fewer and more grounded codes in relation to the study research questions. Once agreed, all remaining interview transcripts were coded (N=24). The codes in the final analytical framework were categorised under the following broad themes: general information (including the nature of primary care collaboration, governance, and pragmatic information with regard to implementation e.g. stakeholder involvement); description of and reasons for developing a collaboration/primary care network; understanding and measuring impact (service delivery, financial, and organisational); goals/metrics; what had gone well and poorly since the introduction of primary care networks; and future steps.

Stage 5. Applying the analytical framework

The working analytical framework was then applied by indexing (the systematic application of codes from the agreed analytical framework to the whole interview dataset) by two project team members (SP and MS). MS coded data from two sites where he had collected data to build upon existing levels of immersion. However, SP coded data across all four sites to build a wider encompassing understanding of the data. Each code (N=140) was shortened in name (if possible) for easier application. Data from observations and document analysis was discussed in data analysis meetings (March and April 2020) with regard to supporting emerging findings from interview data.

Stage 6. Charting codes

As opposed to traditional methods to charting data (summarising data from each transcript by category of code), the project team took a novel rapid approach of a single researcher reading all content (from interviews across each site) under each code. The summary of codes was discussed at a second data analysis online video half day workshop amongst team members (April 2020). Divergent interpretations and theoretical engagement with the coded data were completed through discussions during the workshop amongst study team members. As a result, the evaluation principal investigator (JS) wrote a critical summative narrative paper of our findings and their relevance to policy literature which was member checked by SP and MS. This overarching narrative paper helped team members to understand the scope and relevance of their findings, and supported the team in working out how best to write up themes in a coherent and integrated manner. No data were re-coded following the second data analysis workshop.

Stage 7. Interpreting the data

The critical summative narrative paper was circulated with wider team members (SP and MS) for comments (April 2020). The narrative was further refined with some outstanding queries remaining which would be answered as part of the writing of Chapter 6 (Discussion). In addition, refinements to the narrative summary paper supported the interpretation of data across the four case study sites, interrogating theoretical concepts relational to our evaluation questions, and mapping connections across our themes. Once all members of the project team agreed on the summative narrative, writing up of findings commenced. The project team circulated a summary of findings (digital slide deck) to each case study site providing an opportunity to give comments i.e. member validation⁴² (June 2020). These comments were acknowledged and incorporated into findings.

Summary of analysis

We provide a transparent account of our adapted framework analysis model suitable for rapid evaluation where we detail significant discussion and contribution of project team members. Our approach supported engagement with the data in a timely fashion while iteratively returning to the literature to create a summative narrative paper. In the following chapter, we present a summary of our findings from the rapid evidence assessment. A summary of Chapter 2 is given in Box 4.

Follow up interviews on Covid-19 response

Due to the Covid-19 pandemic, data collection for this evaluation concluded in March 2020, at which point only limited information about the response of each case study site to the pandemic was available. To help fill some of these gaps, the research team contacted the gatekeepers at each site in June 2020 for a short 30 minute semi-structured phone interview on collaborative responses to Covid-19 through primary care networks. Gatekeepers were contacted by email, at which point the study team also sent preliminary findings and the case study site description (Chapter 4) to check the text for accuracy. This member validation process allowed the study team to check the factual accuracy of information about each case study site.

Three follow-up interviews were conducted with representatives from Sites B, C and D. The interviews addressed the following questions:

1. What changes to service delivery have been made across your primary care network since the beginning of the pandemic? Any support or guidance from NHS England and Improvement, clinical commissioning group, local foundation/acute trusts? Success stories?
2. How has primary care network policy helped/hindered primary care delivery during this period? Organisational/managerial/leadership/governance issues.
3. What has been the impact upon staff? (Clinical and non-clinical).
4. What changes do you think will continue beyond the pandemic? And, why?

The information from these interviews is summarised at the end of Chapter 5.

Chapter 3: Lessons from the evidence

Box 5: Key points from Chapter 3

The rapid evidence assessment sought to answer the following questions: i) What are the forms of organisational collaboration used in general practice?; ii) What are the reasons for general practices to enter into collaboration, or not?; iii) What are the perceived facilitators of, or barriers to, effective general practice collaborations?; and iv) What evidence is there of positive or negative impact (both intended and unintended) brought about by collaborations in general practice?

There are many diverse models that GP practices adopt to collaborate with one another and the different approaches taken to developing services. Forty-seven different ways of describing a GP collaboration were identified and the population covered by a GP collaboration ranges from less than a thousand to over 500,000.

In an English context, reasons to collaborate in various types of arrangements have included: to hold budgets and bid together for contracts; to commission services for a local population as part of national policy on primary care-led commissioning; to deliver a wider range of services for patients; to strengthen practices' resilience by providing better primary care management and better staffing resources; and to enable better access to care for patients through longer opening hours in general practice.

The main factors reported in the literature to impact on the progress of general practice collaborations, and of particular relevance to the development of primary care networks can be summarised within four themes: management and leadership, engagement of GPs and the wider primary care team, strategic direction and objectives, and relationship of the GP collaboration with the wider health and care system.

Impacts claimed for GP collaborations included: enabling the delivery of high-quality health care; introducing new specialist services in primary care settings; providing direct access for GPs to diagnostic facilities and hence avoiding unnecessary outpatient referral; pooling resources to avoid duplication of efforts; and a sense of overwhelming workload in respect of understanding what is required to participate in the collaboration.

Rapid evidence assessment

Given the more than thirty-year history of development of GP collaborations in the UK and internationally and the existence of a significant body of research and evaluation, it was considered important to undertake a rapid assessment of this evidence to inform this evaluation of the early

55

implementation of primary care networks. A major review of the evidence relating to large-scale general practice was undertaken by Luisa Pettigrew, Nicholas Mays and colleagues at the London School of Hygiene and Tropical Medicine in 2016¹⁷. Therefore the evidence assessment for this evaluation of PCNs focused primarily on more recent literature (2013-2018), using 55 publications from the UK context and from all high-income countries (as defined by the Organisation for Economic Co-operation and Development), as well as examining reviews and syntheses of prior research (1998-2018). Full details of the methods for the rapid evidence assessment are given in Chapter 2 (Methods).

The rapid evidence assessment sought to answer the following questions:

- i) What are the forms of organisational collaboration used in general practice?
- ii) What are the reasons for general practices to enter into collaboration, or not?
- iii) What are the perceived facilitators of, or barriers to, effective general practice collaborations?
- iv) What evidence is there of positive or negative impact (both intended and unintended) brought about by collaborations in general practice?

Forms of organisational collaboration in general practice

The traditional model of general practice in the UK, in common with many other developed countries, is of small, privately-owned partnerships, operating under a contract with the publicly funded national health system. Over the past three decades, there has been an international move towards more organised and collective general practice, largely based on horizontal integration across practices, and typically involving practices working in networks, federations, or more formal mergers in super-partnerships^{16, 43, 44}. In some of these arrangements, dedicated management and organisational support is put in place centrally, and formal entities that are owned and operated by groups of practices are established.

The rapid evidence assessment offered insights into the diverse models that GP practices adopt to collaborate with one another and the different approaches taken by GP collaborations when developing services. Forty-seven different ways of describing a GP collaboration were identified in this evidence assessment, including those summarised in Table 1 in Chapter 1 which reflect the policy context of GP collaborations in the UK.

The evidence review revealed that in the international context, the population covered by a GP collaboration ranges from less than a thousand through to over 500,000. In 2017 28% GP collaborations in England covered a population of less than 50,000 and 31% a population of over 200,000⁴⁵. In the research literature, there is frequent analysis of the size of GP collaborations and discussion about the advantages and disadvantages of different scales. Many of these discussions conclude that rather than be overly prescriptive about a particular size or structure for GP collaborations, policy makers should seek where possible to allow organisational form to follow function^{17, 46, 47} and that there are perils in a national policy or funding body mandating a specific size or form^{12, 48}. In the case of primary care networks, size and form have been mandated (albeit implementation has in practice allowed more flexibility), with the justification being that this builds on the National Association of Primary Care's suggestion of 30,000 to 50,000 population being appropriate for the primary care home model of care¹⁸.

Reasons for general practice collaboration

Collaborative general practice is most frequently associated with a desire to strengthen and extend the provision of primary care and community-based health and care services, along with enabling financial, workforce and organisational efficiencies^{16, 23, 44}. In some countries, and particularly in England, networked and collaborative primary care has tended to be focused on engaging general practice in the purchasing or commissioning of wider health services (as in GP fundholding, total purchasing pilots, primary care trusts, and more recently clinical commissioning groups). Research into different iterations of primary care commissioning has however shown that they tend to focus mainly on developing local primary care service provision and networking, rather than planning and purchasing a wider range of community and secondary care services²⁰. Primary care networks have been established primarily to focus on extending the provision of local health and care services, and are commissioned and funded to do this by NHS England and Improvement. There is an aspect to the work of primary care networks that is arguably about commissioning – the assessment of local health needs, and then developing services to meet those needs, but this is within a context of service specifications set out by NHS England and Improvement.

In the international context, primary care physician-led and –owned groups have typically emerged as a means to hold contracts with funders or insurers, or to deliver a range of health care services that seek to keep quality high whilst containing costs^{12, 48, 49}. Whilst examples of GP collaborations in

countries such as New Zealand, Canada and the USA have often been able to demonstrate some success in meeting these goals, evaluation studies have found that primary care organisations often under-estimate the complexity and scale of the management capacity required, and pay insufficient attention to the time and support needed to engage local health care professionals in the new service delivery arrangements⁴⁹⁻⁵¹. The vital importance of infrastructure and management support to primary care-led organisations is also reported in studies of community-owned and –led services, including in New Zealand⁵² and the UK⁵³.

GP collaborations have often focused on working together to provide a range of new health services. Some GP practices may start collaborating in order to bid for contracts to offer these services, or assume budgets to provide them, while others may start collaborating for different reasons (for example, to have greater influence in the local or regional health system, to fend off a perceived threat to general practice independence, or provide training and development support for primary care teams) and find that as part of their collaborative process, they then start introducing new services. The latter happened with primary care groups in the English NHS⁴⁴, physician groups in California^{49, 50} and independent practitioner associations in New Zealand^{12, 48}.

In the English context, GP practices have entered into various collaborative arrangements over the past 30 years, citing different reasons for doing so. These reasons include: to hold budgets and bid together for contracts^{43, 54}, to commission services for a local population as part of national policy on primary care led commissioning^{16, 46, 55}; to deliver a wider range of services for patients^{32, 56}; to strengthen practices' resilience by providing better primary care management and better staffing resources⁵⁷; and to enable better access to care for patients through longer opening hours^{58, 59}; amongst others⁶⁰. Unsurprisingly, these collaborations vary in form, functions, staffing arrangements, and culture. It is often difficult to divorce the commissioning aspect of a GP collaboration from its role in developing service provision (and as noted above, there are elements of this overlap within primary care network policy), given that many commissioning collaborations moved to focus on the provision of care within primary and community services^{16, 46, 61}. A summary of reasons for forming a GP collaboration is set out in Box 6.

Box 6: Reasons for forming a GP collaboration

To improve and extend service provision for patients in primary care including for example: practice-based physiotherapy, specialist asthma and diabetic care; pharmacy-led medication reviews in general practice or care homes; dementia cafés and carer support; and intensive home support for people living with multiple complex conditions^{13, 15, 32, 57, 60, 62-72}

To engage GPs and their teams in local care planning and purchasing^{17, 44, 46, 55}

To encourage greater integration of local health services, including through the development of effective multidisciplinary team-working^{15, 16, 21, 57}

A response to governmental mandate or recommendation, including to take on responsibility for commissioning or purchasing certain local health services^{12, 21, 32, 45, 57, 59, 64, 68, 73-76}

To enable general practice to gain greater influence in the local or regional health system^{17, 44, 46, 48, 55}

To improve the sustainability and resilience of general practice^{15, 57, 77-80}

To reduce costs and become more cost-effective^{63, 66, 81-84}; and

To increase, recruitment, retention, job satisfaction or staff experience within primary care^{13, 66}.

Nevertheless, it is clear from literature from different countries that even where GP collaboration is considered a key feature of the policy and organisational landscape, some GP practices have historically chosen not to enter into any collaborative model, presumably for various reasons including fear of loss of professional status or autonomy^{17, 85}. Little research appears to have been undertaken to understand the nature of and reasons for non-collaborative working across GP practices in the NHS or internationally.

Enablers of and barriers to general practice collaboration

The rapid evidence assessment explored those factors perceived to enable or hinder GP collaborations. These factors varied in focus, ranging from leadership and organisational skills, through governance arrangements, to having appropriate technology. Often, an absence of the perceived facilitators was the main barrier to collaboration. The main factors reported in the

literature to impact on the progress of general practice collaborations, and of particular relevance to the development of primary care networks can be summarised within four themes:

- Management and leadership
- Engagement of GPs and the wider primary care team
- Strategic direction and objectives
- Relationship with the wider health and care system

Management and leadership

A theme that recurs across forms of GP collaborations in the UK and overseas, and across three decades is the need for sufficient management and leadership capacity^{21, 44, 55, 81, 86, 87}. This expresses itself in relation to the need for clear roles for those leading the collaboration to enable primary care colleagues within and across practices to work together effectively^{68, 77, 78, 83, 88, 89}. This can include very practical matters such as obtaining physical premises for the GP collaboration core team and shared service delivery^{68, 76, 90}. Undertaking the necessary organisational development work early in the development of a GP collaboration is critical to ensuring that roles are clearly defined, understood and enacted. Likewise, there is a need for time and resource^{32, 45, 54, 59, 77, 87, 91, 92}, ensuring that those running a GP collaboration have the necessary clinical and non-clinical skills^{54, 62, 70, 77, 86, 92} and development support to ensure the aims and objectives of the collaboration can be achieved^{54, 59}.

Organisational and management support is not just about the capacity that is available within the GP collaboration itself; it is also vital that there is adequate health system and management support available from the wider local and national health system, for example in relation to training resources, IT systems, policy advice, governance and regulatory matters^{59, 64, 82, 84, 91, 93}. Clear and agreed governance and regulations for the establishment and maintenance of the GP collaboration are important, and often under-estimated by GP groups at the outset^{45, 54, 73, 86, 92}.

Funding for management support and leadership capacity is reported as critical^{44, 61, 71, 82} (yet often insufficient) for the development and operation of GP collaborations, and is typically under-estimated at the outset^{57, 65, 82}. Related to this issue of resources, access to integrated patient records and other IT systems across practices in the collaboration is considered vital to the

functioning of GP collaborations, but is often difficult to put in place and hence becomes a barrier to progress^{21, 54, 60, 64, 68, 82, 86, 88, 91, 92}.

Engagement of GPs and the wider primary care team

Studies of GP collaborations in the UK and overseas repeatedly emphasise the vital importance of ensuring that there is sufficient trust between members of the GP collaboration^{17, 32, 44, 54} and also that there are effective working relationships within and across the practices that comprise the organisation^{33, 54, 60, 66, 77, 78, 86, 94}. Without these, the collaboration will struggle to secure support for its objectives or to enact its plans. This can be summed up as the need for a strong sense of active participation in the GP collaboration, rather than GPs and their teams being passive members^{54, 60, 67, 77, 86, 89, 91, 95}. It can however be harder for some (often smaller, or single-handed) practices to feel that their voice is heard within a GP collaboration, particularly in its early stages of development. Some studies have shown that practices which have traditionally been vocal about local service delivery often take on the leading role in new collaborations^{17, 55}.

There is also evidence emphasising the importance of close geographic proximity of practices within a collaboration, together with the possibility of using shared infrastructure such as back office administrative support, out-of-hours shared cover arrangements, or joint appointments of specialist nursing, pharmacy and other staff^{15, 21, 66, 70, 81}.

Strategic direction and objectives

Many evaluation studies – including Total Purchasing Projects and Personal Medical Services pilots (see Box 6 and Box 7) have highlighted the need for a GP collaboration to have clear aims and objectives, and to ensure that these have been developed with the active engagement of constituent GP practices and their teams. This is linked to the need for clarity about the outcomes a GP collaboration wants to achieve^{44, 61, 73, 74} and its ability to achieve these outcomes. A regional or national top-down approach to developing a particular form of GP collaboration may introduce priorities and policies that are not fully aligned with local needs^{17, 44, 90, 96}, as collaborations initiated and driven by GP practices and primary care teams themselves may be able to respond better to assessments of local needs. There will however be trade-offs in respect of achieving national and local priorities, and a key task for a GP collaboration is to undertake this planning and priority-setting work⁸⁷.

Relationships with the wider health and care system

A frequently reported tension or barrier to the development and longer-term success of GP collaborations has been for policy makers and funders to adopt what is perceived by general practice to be a top-down approach, whether expressed through excessive governmental legislation or regulations, too much prescription of governance arrangements and service priorities, and overbearing performance management approach^{48, 49, 66}. This can lead to GPs feeling that their autonomy and core purpose are being challenged or that they are under threat^{56, 73, 74, 77, 87}.

Short-term political cycles have been reported in some studies to introduce uncertainty about what GP collaborations are required to do, leading to cynicism and lack of engagement on the part of GPs and their teams^{12, 44, 60, 77, 86}. Furthermore, for some collaborations, their leadership can find it time-consuming and distracting to navigate a complex wider health system infrastructure^{17, 44, 57, 77, 81} which points to the importance of policy makers and funders being thoughtful and proportionate in how far they expect GP collaborations to be integrated with overall health system management infrastructure. Finally, a frequent barrier to the sustained progress of GP collaborations is the disillusionment they and their teams encounter following initial over-optimism (often on the part of policy makers and funders who are impatient for 'results') about what is achievable in a limited timeframe^{44, 45, 54, 97}; or feeling that the contributions of the collaboration are not being acknowledged⁶⁸. This in many ways reflects a cultural clash between large-scale health policy organisations, and that of newer, smaller and more fragile GP collaborations.

The reported impact of GP collaborations

The evidence review identified a number of areas of impact associated with GP collaboration. There was, however, a relative lack of quantitative evidence to support these claims, and many evaluation studies had focused more on the initial implementation of GP collaborations, rather than sustained tracking of progress in achieving service or health outcomes. Nevertheless, impacts claimed for GP collaborations included: enabling the delivery of high-quality health care (e.g. practice-based physiotherapy, specialist asthma and diabetic care; pharmacy-led medication reviews in general practice or care homes; dementia cafes and carer support; and intensive home support for people living with multiple complex conditions^{15, 32, 44, 57, 61, 66, 67, 69, 70, 75, 82, 88}); introducing new specialist services in primary care settings^{44, 61, 64}; providing direct access for GPs to diagnostic facilities and hence avoiding unnecessary outpatient referrals^{21, 98}; and pooling resources together (e.g. electronic

health records) to avoid duplication of efforts^{54, 64, 77, 81, 83}. Other areas of impact associated with GP collaborations were focused on organisational or infrastructure matters, including improved employee satisfaction^{59, 66, 67, 83, 88} and strengthened working relationships between staff^{66, 77, 81}. There have also been negative unintended impact from GP collaborations that was identified in the literature, including challenging the role and sense of autonomy of GPs^{66, 73} and a sense of overwhelming workload in respect of understanding what is required to participate in the collaboration, set it up and make it succeed^{44, 73}.

Lessons from two particular prior forms of GP collaboration

There is particular learning to be gained for primary care networks from an examination of the experience of two particular UK experiments with GP collaborative working, both of which were subject to three-year national evaluation studies. These are the Total Purchasing Pilot (TPP) schemes that were established in 1995 as extensions to the Conservative Government policy of GP fundholding, and the Personal Medical Services (PMS) scheme of local contracts for primary care, brought in as part of the implementation of the NHS (Primary Care) Act 1997. Our rapid evidence assessment and the key policy components of the primary care network approach in 2019 has led us to consider that these two prior forms of GP collaboration have particularly relevant insights for current developments, given that they also took up the opportunity to have additional funding, through a contract held collectively across practitioners or practices, to purchase or deliver a wider range of local health services. The summary of learning from Total Purchasing Pilots and Personal Medical Services Schemes is set out in Box 7 and Box 8 below.

Box 7: Summary of learning from Total Purchasing Pilots (TPP), adapted from Mays et al, 2001⁶¹

Background

There were 53 Total Purchasing Pilots in the first wave of these schemes introduced in 1995, and they remained in place until 1999. The Total Purchasing Projects comprised general practices in a local area that came together to hold a budget with which to purchase the majority of hospital and community health services, building on the GP fundholding scheme that had commenced in 1991. They varied in size from 7,000 to 80,000 population and adopted a range of organisational forms. TPPs were evaluated by a national team of researchers led by Nicholas Mays of the King's Fund. Some of the key lessons from the evaluation were:

Enablers of and barriers to progress

Clarity of objectives and planning for the Total Purchasing Project was seen to be a key enabler of progress

Progress was enabled significantly where there were higher levels of management capacity and expertise

Smaller Total Purchasing Projects appeared to have more success in engaging their clinical community in their work

Effective GP leadership of a Total Purchasing Project was considered critical, however some struggled to engage the wider GP and practice membership of the Total Purchasing Project, citing a lack of direct incentives for GPs

Data and IT were barriers to progress, including problems in securing utilisation and financial data

They struggled to engage social care and local authorities in their work, and likewise local communities and service users

Impact

Their achievements were typically modest in scale, local and incremental, and tended to focus on improving and extending primary and community health service provision

They were able to make some changes to patients' use of emergency secondary care services by providing alternative forms of community health care

TPPs were found to have increased the cost of running the local health system, given the additional transaction costs of smaller health purchasers

Box 8: Summary of learning from Personal Medical Services (PMS) Schemes

Background

Personal Medical Services (PMS) Pilots were established in 'waves' following implementation of the NHS (Primary Care) Act (1997) which was passed with cross-party support just prior to the Labour

General Election victory of 1997. Personal Medical Services was a voluntary scheme that allowed a GP practice (or group of practices) to take on a local contract to deliver an extended range of primary care services to meet local population needs in a flexible and multi-disciplinary manner, working to quality and service standards negotiated with the local health authority and subsequently the primary care trust. Personal Medical Services contracts proved popular (22% GPs were working to them in 2002) and continued beyond the initial pilot phase. In 2002, a national contractual framework was introduced for Personal Medical Services schemes, alongside wider reform of primary care contracts. It is notable that Personal Medical Services has remained an attractive approach for GPs across the years. Personal Medical Services contract pilots were evaluated by a number of academic teams funded through a national Department of Health programme of research. Key findings included:

Enablers of and barriers to progress

Enablers of progress were cited by evaluators as: clear objectives for the local scheme; effective management support and expertise; commitment and support from clinicians in the scheme; and strong teamwork and shared culture within practices/practice groups^{99, 100}

The contractual freedoms on offer were considered to enable practices/practice groups to develop innovative services

A small number of Personal Medical Services schemes were led by nurses who held the contract for the organisation, and provided overall leadership to the practice team

Impact

Personal Medical Services schemes led to modest and steady improvements in the quality of primary care¹⁰⁰

Personal Medical Services schemes led to innovation in the use of a wider range of skill-mix in primary care, including employment of salaried GPs, practice-based pharmacists, and nurse practitioners

Personal Medical Services schemes were able to develop services that went some way to addressing long-standing inequities in primary care, for example in establishing services for homeless people, refugees and those with severe mental ill health¹⁰¹

Patients' experience of primary care did not change as much as had been hoped for Personal Medical Services schemes, and innovations in care provision were not as significant as vaunted in the initial policy

Gaps in existing evidence on GP collaborations

In preparation for our stakeholder workshop at which we shared the findings of our rapid evidence assessment, we distilled what we considered to be the main gaps in the evidence on GP collaborations, framing these as questions that needed to be answered by future research, and where possible, our own rapid evaluation of the implementation and early development of primary care networks. These questions were as follows:

- What are the benefits of collaboration – i) for patients, ii) for staff, iii) for the local health system?
- What are the costs of collaboration (financial costs, opportunity costs and other kinds of cost)?
- To what extent are the enablers/facilitators for successful collaboration in place within local systems of care?
- What further kinds of support and/or investment are most needed to create an environment for effective collaboration?
- Why do some practices choose not to collaborate? What happens in areas where practices choose not to collaborate? Does this affect care outcomes in any way, and if so how?
- Do general practices need to collaborate to achieve key outcomes (e.g. improving access, achieving sustainability)?

These questions informed our methods and approach for the case study element of our evaluation, and are examined as part of the discussion chapter (Chapter 6) when reflecting on what this study

has revealed in respect of collaboration within general practice, and in particular for the future monitoring and development of primary care networks in the NHS in England.

Summary of the rapid evidence assessment

The rapid evidence assessment underlined many of the factors considered essential to the operation of effective GP collaborations that have been identified in prior reviews, which provide important lessons for new primary care networks to consider as we have reported elsewhere⁹⁷. Some important lessons for primary care networks to consider include the time it will likely take for them to become established as well-functioning organisations in a wider health system, and the level of high quality management and leadership capacity required to ensure their success.

Lessons from previous GP collaborations suggest that primary care networks will need an appropriate balance of autonomy and control in relation to health funders and planners, along with clarity of remit and objectives that enables them to develop plans and work programmes aligned with the expectations of both policy makers and local primary care stakeholders. Primary care networks will also require sufficient time and capacity to develop trusting and supportive relationships within the GP collaboration and with other partner organisations, especially early in their implementation. Finally, from the literature on previous forms of GP collaboration it is clear that primary care networks have the potential to use the funding allocated to them to enable new and extended forms of primary care service provision, but expectations should be managed to ensure that they can make progress in a measured manner that is proportionate to the challenges that evidence suggests they will face.

Our rapid review enabled us to identify important gaps in the research evidence which we explored in a workshop of key stakeholders (see Chapter 2 - Methods), then using these insights to frame questions for the case study research set out in the Chapters 4 and 5 of this report. In the next chapter, we describe the four case study primary care networks and their extant GP collaborations, and then set out the findings of our research in these sites.

Chapter 4: Description of case study sites

Box 9: Key points from Chapter 4

This chapter provides a brief overview and context to each of the four case study sites, along with their core characteristics.

Site A is a primary care network of eight GP practices serving a population of 75,000 patients in a rural setting in England dispersed over a large geographical area. The stated overall aim of the primary care network is to improve access for local people to the resources they need to lead healthier lives.

Site B is a super-partnership containing 13 practices serving over 130,000 patients, which was formed in 2017 in response to a workforce crisis. Site B is located in a largely rural area of England characterised by a largely ageing White British population. The super-partnership aims to create efficiencies from working at scale, including by providing some centralised back office functions for constituent practices.

Site C is a primary care network of eight practices serving a population of 60-70,000 patients in a largely urban setting in England dispersed over a town-based geographical area. The area is socio-economically disadvantaged with a large elderly population many of whom live with long term health conditions. The current primary care network mirrors the previous collaborative model, the Site C neighbourhood with the aim of providing better integrated care for the local community.

Site D is a primary care network of four practices, serving a population of more than 30,000. It is located in a rural area in England, characterised by an ageing, and dispersed population with complex health and social care needs. Prior to becoming a primary care network, there was a strong sense of collaborative working between all the practices currently in the primary care network.

In this chapter, a brief overview is given of the background and context to each of the four case study sites, along with their core characteristics. Particular attention has been paid to previous and existing forms of GP collaboration within each case study site, illustrating the complex and varying context within which primary care networks have been introduced. The way in which these sites were selected for study is set out in Chapter 2 (Methods).

Site A

Site A is a primary care network of eight GP practices serving a population of 75,000 patients in a rural setting in England dispersed over a large geographical area.

The area is characterised by an ageing, White British population, with many living with a range of long-term health conditions. The patient population has good access to primary care services (the majority will be seen by their GP within 48 hours) compared to the general English population. The stated aim of the primary care network is to improve access for local people to the resources they need to lead healthier lives.

There is an established history of these eight practices working collaboratively prior to the creation of the primary care network, in an informal model of locality working, as well as engaging in partnership working with practices who are part of neighbouring primary care networks. The locality model focused on developing an integrated multi-professional workforce to enable primary care, community health and social care professionals to work in partnership with acute and community care providers. Hence, locality working was based on:

- delivering a more community-focused service,
- multi-disciplinary clinical and social care team service delivery,
- making the most of existing relationships between practices and those delivering community services, and
- reducing organisational boundaries and increased collective working through networked arrangements

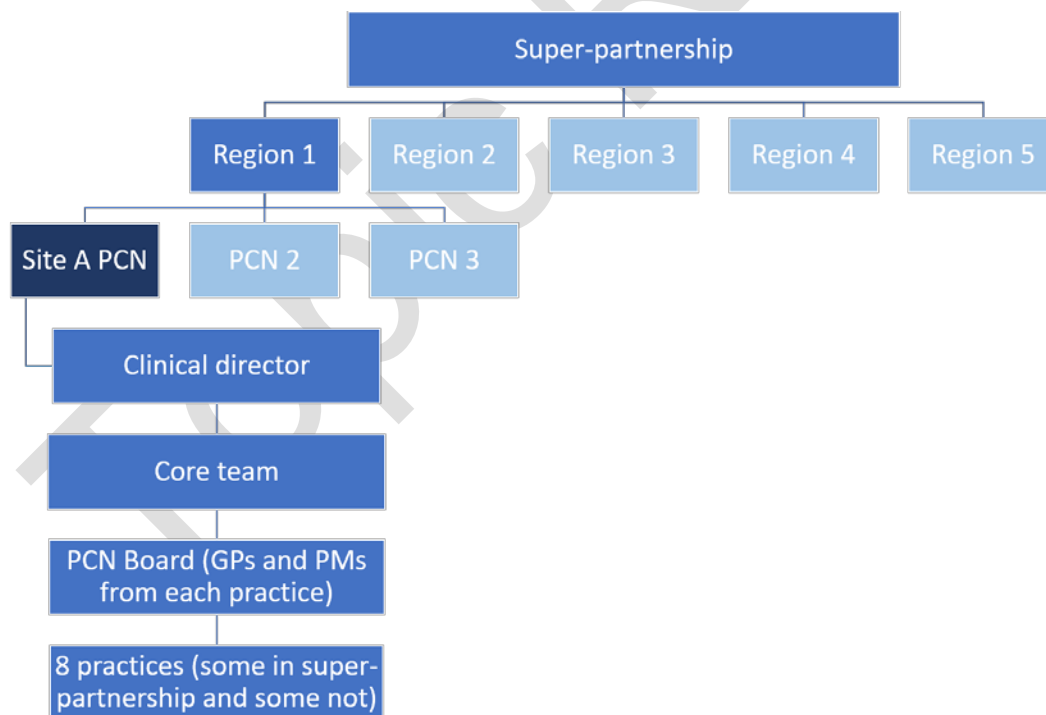
The primary care network is supported by a large GP super-partnership established across two counties in England serving over 350,000 patients, of which some of the practices within the primary care network are members, but not all. The GP super-partnership offers practices administrative and management support which frees up time for clinical work, enables economies of scale, and builds upon established relationships with acute and community providers of care. As a result, the eight practices decided collectively to use primary care network funding to pay the GP super-partnership to provide certain services for the PCN, including for legal advice, setting up contracts, financial management, monitoring support and procurement. As part of this GP super-partnership structure,

the primary care network continued to have strong relationships with a neighbouring network which also has constituent practices from within the GP super-partnership.

The primary care network holds six-weekly governance meetings with one lead GP and one practice manager from each practice in attendance. The primary care network also has a core management structure made up of the clinical director, two GPs, and a practice manager informally acting as a primary care network manager who provide oversight to the network's operational and service development decision making and day-to-day management. At the time of data collection, there was a newly appointed clinical director.

A diagram of Site A's organisational structure is in Figure 4 below. The dark blue represents the unit of analysis for this evaluation (i.e. case study site collaboration), and the light blue represents parts of the organisational structure within each site that were outside the focus of this evaluation.

Figure 4: Site A organogram



Site B

Site B is a super-partnership containing 13 practices serving over 130,000 patients, which was formed in 2017. The practices within the super-partnership are part of four primary care networks. Some of these networks have a majority of practices from the super-partnership, although in some primary care networks, super-partnership practices are in the minority. Site B practices had previously collaborated through an integrated neighbourhood team, a GP Hub and through a GP federation which is still in place and whose membership overlaps with that of the super-partnership. Although primary care networks and the GP federation continue to exist in parallel, the collaboration that seemed to hold the most influence over collaborative working within Site B was the super-partnership.

Site B is located in a largely rural area of England characterised by an ageing White British population.

The super-partnership was created in part to respond to a workforce crisis, to help address GP recruitment issues, to meet service pressures caused by changes in patient demand, and to attract more investment into primary care. The super-partnership aims to create efficiencies from working at scale, including by providing some centralised back office functions for constituent practices.

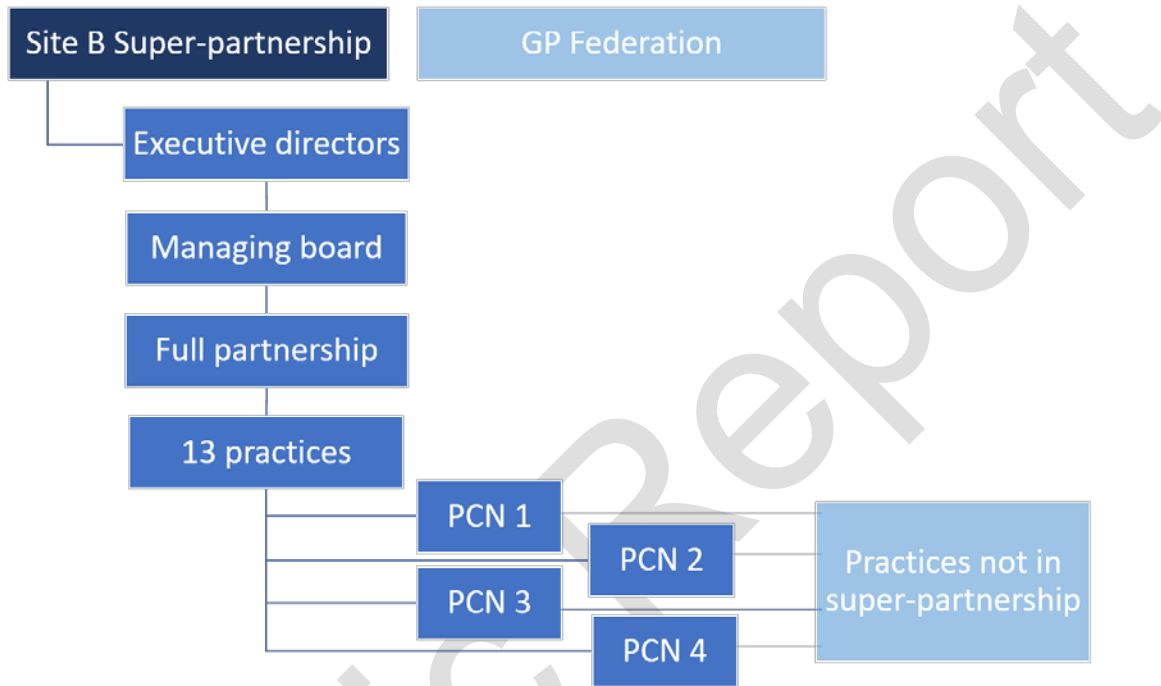
A central tenet of the super-partnership is to create parity between partners and safety in numbers, seeking to reduce the risk borne by any one partner. One way that the super-partnership accomplishes this is through a 'property solution' in which property in the super-partnership is held jointly by all partners, which has been highlighted as a key success. Within the super-partnership, each practice retains clinical autonomy and is its own profit/loss centre, although the super-partnership carried the overall risk for any financial losses. The super-partnership has a set of clear due diligence procedures for new practices wishing to become part of the organisation, and they pay a joining fee based on their number of registered patients.

The super-partnership has a two-tier system of governance in which some decisions are made by the full partnership and some decisions are made by a managing board with GP partners who represent different localities from across the super-partnership along with a team of executive directors. The

full super-partnership meets on a quarterly basis, with the management board meetings held monthly, while the executive team meets weekly.

A diagram of Site B's organisational structure is provided in Figure 5 below.

Figure 5: Site B organogram



Site C

Site C is a primary care network of eight practices serving a population of 60-70,000 patients in a largely urban setting in England dispersed over a town-based geographical area.

The area is socio-economically disadvantaged with a large elderly population many of whom live with long-term health conditions. There is also a significant minority-ethnic South Asian community representing a mainly younger cohort.

The current primary care network mirrors the previous collaborative model, the Site C Neighbourhood, which comprised the same eight practices. The purpose of the neighbourhood, integrated with the local NHS foundation trust, was to promote greater patient self-management by

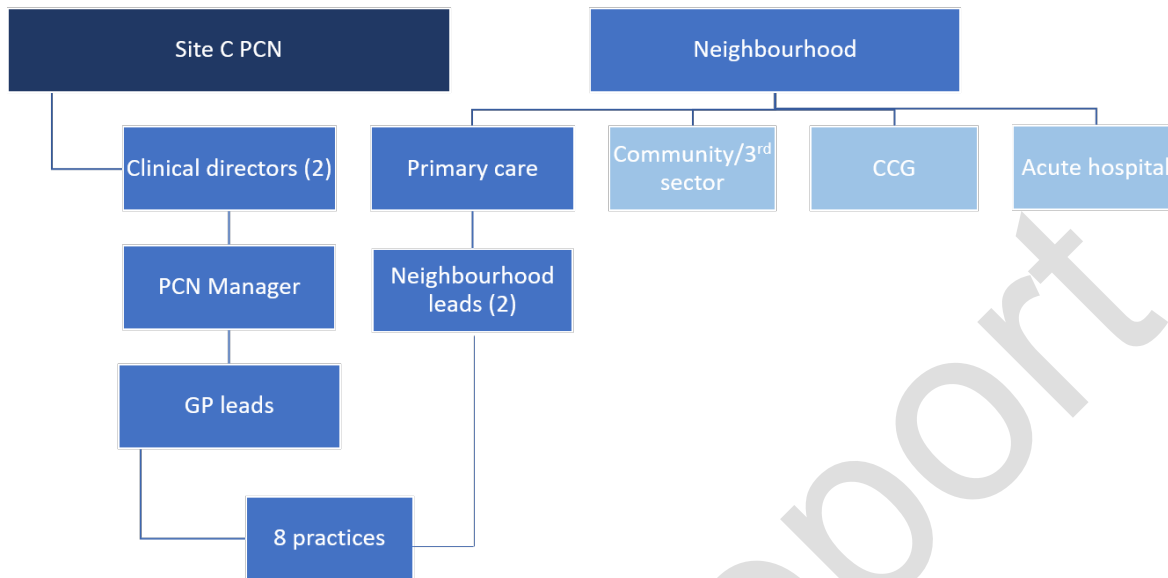
enabling care nearer to home through closer working across primary care, health and social care services in addition to voluntary, community and faith sector service provision. Hence, the neighbourhood promoted multi-disciplinary working across a range of services including general practice teams. The neighbourhood model was implemented in 2017 and was expected to end in 2020 (based on pre Covid-19 pandemic information). At the time of data collection, both the primary care network and neighbourhood were working in parallel. The governance and management structure of the neighbourhood and the primary care network had both similarities and differences; both models are led by two clinical directors (one neighbourhood lead is also joint primary care network lead). Neighbourhood working was led via monthly meetings attended by both clinical and managerial staff, as well as patient participation group leads, with collective input with regard to decision making and strategic direction. In comparison, monthly primary care network meetings were attended by lead GPs from each of the eight practices, with discussions fed back once meetings had concluded. Nevertheless, the primary care network was established to build upon the aims and objectives of the neighbourhood, as detailed below:

- to address health inequalities in the area and improving access for patients at a reduced cost.
- to support patients living with long-term conditions to support self-management.
- to have better integrated care in the community with the development of mental health teams, increased social prescribing, and training receptionists as care navigators.
- to develop and support the workforce to deliver a range of extended health services.

To help achieve these aims, the primary care network has appointed a manager to oversee governance and manage a shared budget across the eight practices designated for network activities, while the clinical director's focus is on improving service level provision aligned with quality improvement monitoring.

A diagram of Site C's organisational structure is provided in Figure 6 below.

Figure 6: Site C organogram



Site D

Site D is a primary care network of four practices, serving a population of around 30,000. It is located in a rural area in England, characterised by an ageing, dispersed population with complex health and social care needs. The population is mostly White British, and faces issues such as frailty, isolation and those living with long term health conditions.

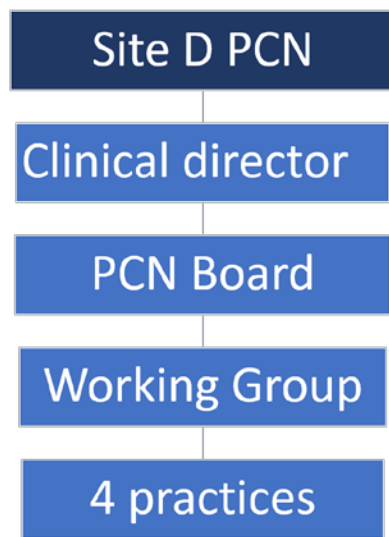
Prior to becoming a primary care network, there was a strong sense of collaborative working between all the practices currently in the network. This informal collaboration had grown to meet the needs of practices working to support the local rural population, and to encourage effective links with community providers, the voluntary sector, social care and others in the health and social care system.

The primary care network board is made up of one GP and one practice manager from each practice, with an overall primary care network manager on the board working alongside the clinical director.

There is also a working group with representatives from across the primary care network which implements network level decisions, comprised of GPs, practice managers, IT staff and others. The primary care network board meets monthly, while the working group meets fortnightly.

A diagram of Site D's organisational structure is provided in Figure 7 below.

Figure 7: Site D organogram



In the next chapter, we set out the findings of the research undertaken in these four case study sites, using the themes from the rapid review of evidence about GP collaborations to organise and contextualise the results, exploring the early experience of primary care networks, including their implementation and what enabled or hindered progress.

Chapter 5: Findings from case study research

Box 10: Key points from Chapter 5

General practices across England have seized the opportunity to access new funding to form primary care networks. GPs and their teams place particular priority on enhancing the sustainability of primary care. However, there are mixed views about the purpose of primary care networks, sometimes supportive of the national policy and approach, and others frustrated at having to adhere to a government line in order to receive new funding.

In all four case study sites, the new primary care network was established in the context of a prior GP collaboration. Previous collaborations helped the primary care network to build on previous successes such as the strong existing relationships between practices and integrated service delivery. Yet, it was often a source of tension where the primary care network was perceived to be un-doing aspects of the work of the previous collaboration.

This evaluation has revealed a tension between the desire by GPs and their teams for local autonomy and influence over primary care networks, and the perceived top-down nature of PCN policy. Developing shared goals and objectives emerged as an enabler of progress, and of positive working relationships within and beyond the primary care network.

The need for effective leadership of the primary care network, together with sufficient high-quality management support, was a strong theme in the evaluation fieldwork.

It was clear that although small organisations, primary care networks need a significant range of administrative and management capacity and skills, including finance and accounting, human resources, information technology, staff engagement, and governance support, which were not present in all case study sites in this evaluation. Additionally, the evaluation revealed significant challenges faced by clinical directors in terms of workload, and pointed to the need to improve non-clinical management skills in this role.

The allocation of a new source of funding that is channelled directly into general practice, rather than through an intermediary organisation such as the clinical commissioning group or sustainability and transformation partnership, is clearly welcomed in principle by most practices.

In some instances, clinical commissioning groups have enabled and supported primary care networks, providing resource and expertise to help establish inter-practice working, hire new staff, and operate contracts. In others areas, however, there is evidence of the clinical commissioning group attempting to hold onto resource or control that has been delegated to primary care networks and not perceived to be operating within the spirit and expectation of PCN policy.

For rural collaborations, they feel that primary care network policy has been developed with urban practices and collaborations in mind, and are concerned the policy does not adequately account for the distinctive experience of delivering primary care in rural areas.

With regard to Covid-19, primary care networks were part of an integrated response alongside the clinical commissioning groups, the extended hours access providers, and local community, foundation and acute trusts. In response to patient demand and access to primary care, primary care networks experienced a significant drop in patients requesting appointments with GPs, with the majority of consultations completed by video or telephone consultations; a transition which the majority of patients were pleased with as they received a quicker than usual response from their practice. However, requests for GP appointments is gradually increasing. Throughout the pandemic, all four primary care networks continued to deliver the Network Contract Direct Enhanced Service specification.

The findings from the case study research are presented below, examining reasons to work as part of primary care networks and other forms of GP collaboration, the early impact of network implementation and other forms of collaborative working, and facilitators and barriers that primary care networks have faced within their first nine months of operation. Barriers faced by rural primary care networks and small practices are also highlighted. Where possible, this chapter includes consideration of how primary care networks and other collaborative working arrangements have responded to the Covid-19 pandemic, which first started to impact UK health services in the final stages of this evaluation (March 2020).

These findings draw together the primary data collected for this evaluation through interviews and non-participant observations, as well as evidence from documentary analysis (see Chapter 2-

Methods). Where relevant, evidence is contextualised through learning from the background review of research literature (Chapter 3 Evidence Review).

Reasons to collaborate in primary care

In Chapter 3 (Evidence Review) we examined the rationale and incentives for general practice to enter into different forms of collaboration, as noted over several decades in the UK and overseas, including the role of financial incentives, the desire by GPs to have greater influence in the local health system, a concern to improve and extend primary care service delivery, and a need to secure the sustainability of general practice for the longer term. Throughout this evaluation, it has become clear that the rationale and incentives associated with primary care networks are in some ways distinct from those associated with GP collaborations more broadly, and as such these have been treated separately in the sections below.

Reasons to enter into a collaboration within primary care

Over the past decade, primary care in the UK has faced challenges in terms of workforce, efficiency and resilience, which cause serious issues in terms of the sustainability of primary care⁷. These issues of sustainability, both in terms of finances and the primary care workforce, emerged as significant across the case study sites in this evaluation, and were identified as key reasons to enter into collaborations in primary care (Int1, Int3, Int10, Int13, Int14, Int15, Int20).

Collaborations can help address issues of general practice sustainability in a number of ways. First, practices collaborating with one another can help distribute workload and pressures between them, and can allow for some tasks and procedures to be shared between practices in order to reduce the burden on any one practice team (Int6, Int7, Int10, Int15, Int20). Collaboration between practices can also help recruit and retain staff within primary care, including by enabling the organisation to offer better training resources, flexible work arrangements and better benefits to staff (Int15, Int14, Int10).

'It's very difficult for small, singlehanded GP practices to survive with the workloads that are on them in terms of the pressures. And only by working together and collaborating can we sort of be strong enough to face the issues that we face on a daily basis in general practice. So those were the sort of ideas around making it sustainable and future proof' (Int15)

'There was a recognition some time ago...that nine practices are essentially from an administration point in very many cases doing the same thing nine times over, which is a fundamental waste of time and money. There was an argument that things such as practice policies, methods of using clinical systems, scanning and coding could all be, if not the same, similar, so that when we did make changes we could try and use one person to make the bulk of the changes, and then the other nine well the other eight would just be tinkering around the edges.' (Int7)

Collaborations can also help address issues with the financial sustainability of primary care. For example, before primary care networks, some discretionary funding was available through the clinical commissioning group to improve collaboration between GP practices at many of the case study sites, increasing the budget for primary care (Int17, Int21, Int22, Int25). Economies of scope and scale, creating financial efficiencies and implementing better financial and organisational management were also mentioned as reasons to form collaborative organisations in general practice (Int13, Int16, Int17).

'If you look at [redacted]... there was a lot more clarity about what they wanted to do, so they wanted to actually see primary care at scale in a structured way where they could get the economies of scale from a bigger organisation, get rid of that kind of corner shop mentality that a lot of practices have got, inject some professional management into general practice.' (Int17)

Improvements to patient care and service provision were also mentioned as reasons to form collaborations in primary care. Collaborating between practices can help fill gaps in service provision where single practices are not able to provide all services (Int3, Int15, Int17, Int20), and help provide patients with better coordinated care, particularly for patients with complex health and social care needs (Int3, Int24). Collective working in primary care also helps with planning and providing services at a population-level, and the evaluation heard about some pre-primary care network collaborations having started as a result of undertaking population-level service planning for a locality (Int6) and devising ways to improve care for older people (Int24, Int22, Int25). However, there were also interviewees who expressed that providing care at a larger scale would result in

poorer patient experience and outcomes, which is explored in the section below on the impact of primary care networks.

'We're only a small network, 35,000 patients in the network... I sort of see the 35,000 rather than the 3,000 we've got on our list. So I'm really enthusiastic, and I want to make sure that the 35,000 are looked after, as much as my 3,000' (Int6)

Reasons to enter into a primary care network

Although the reasons for entering into GP collaborations are diverse, as noted in Chapter 3 (Evidence Review) the reasons for entering into primary care networks appear to be more tightly focused on policy and financial incentives, which is unsurprising given the nature of the policy with its national approach to contracts and service specifications. Many interviewees reflected that practices were effectively obligated to form primary care networks, and that practices had no choice but to accept the financial incentives associated with networks for fear that they would be "left behind" (Int1, Int2, Int4, Int5, Int8, Int12, Int17, Int23). Some of these interviewees framed primary care network policy as negative, and that practices were coerced into entering into collaborative arrangements of which they were unsure. However, others expressed ambivalence about primary care network requirements, describing them as an external policy development to which practices needed to adapt (Int1, Int17).

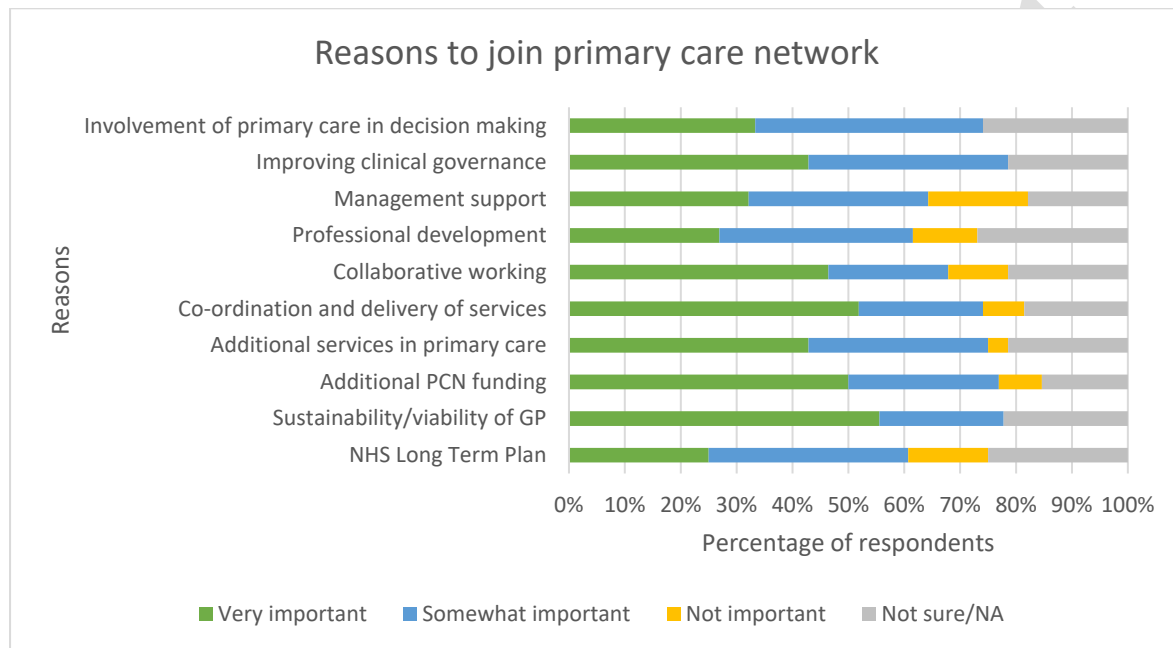
'With the PCNs we've been told we have to, and if we don't we're being told that our patients will go into a PCN... and it will be out of our hands. So we're being bullied into something that the doctors don't have time for' (Int8)

'If we're going to talk about the PCNs, the rationale for getting involved is it's a national policy and there's a lot of cash on the back of it, and their motivation has been OK, because general practice is very good at adapting to contractual context and particularly when there's a set of incentives which is what primary care networks are partially about' (Int17)

Although the majority of reasons that were identified by interviewees for joining or forming a primary care network focused on policy and funding, survey responses revealed more varied reasons, albeit the survey was only completed by 28 respondents across the four case study sites at a time when data collection was stalling due to the Covid-19 pandemic. When asked to rate reasons

why they had formed a primary care network, over half of respondents reported “To help sustain the viability/sustainability of general practice”, and “Improving co-ordination and delivery of primary care services for patients” as very important. Figure 8 below demonstrates the mixed response to this survey item.

Figure 8: Reasons to form or join a primary care network from survey (N=28)



Fundamental question around the purpose of primary care networks

A central tension about the purpose of primary care networks arose again and again throughout this evaluation. Some respondents had a view that primary care network funding should be spent to help improve the financial sustainability of primary care and reduce GP workload, while others thought that the new resource should be allocated to developing new primary care services (Int3, Int18, Int21, Int22 Int24). This tension about the purpose of primary care networks has revealed itself in disagreements between those active in management of the networks, and also plays into questions about whether the new organisations have effectively accomplished their goals.

Some mentioned that they felt primary care networks were being ‘sold’ as a cure-all within primary care, and that there should be a more realistic assessment of what they could reasonably expect to achieve (Int17, Int19, Int24), something that will likely be all the more acute in the context of the

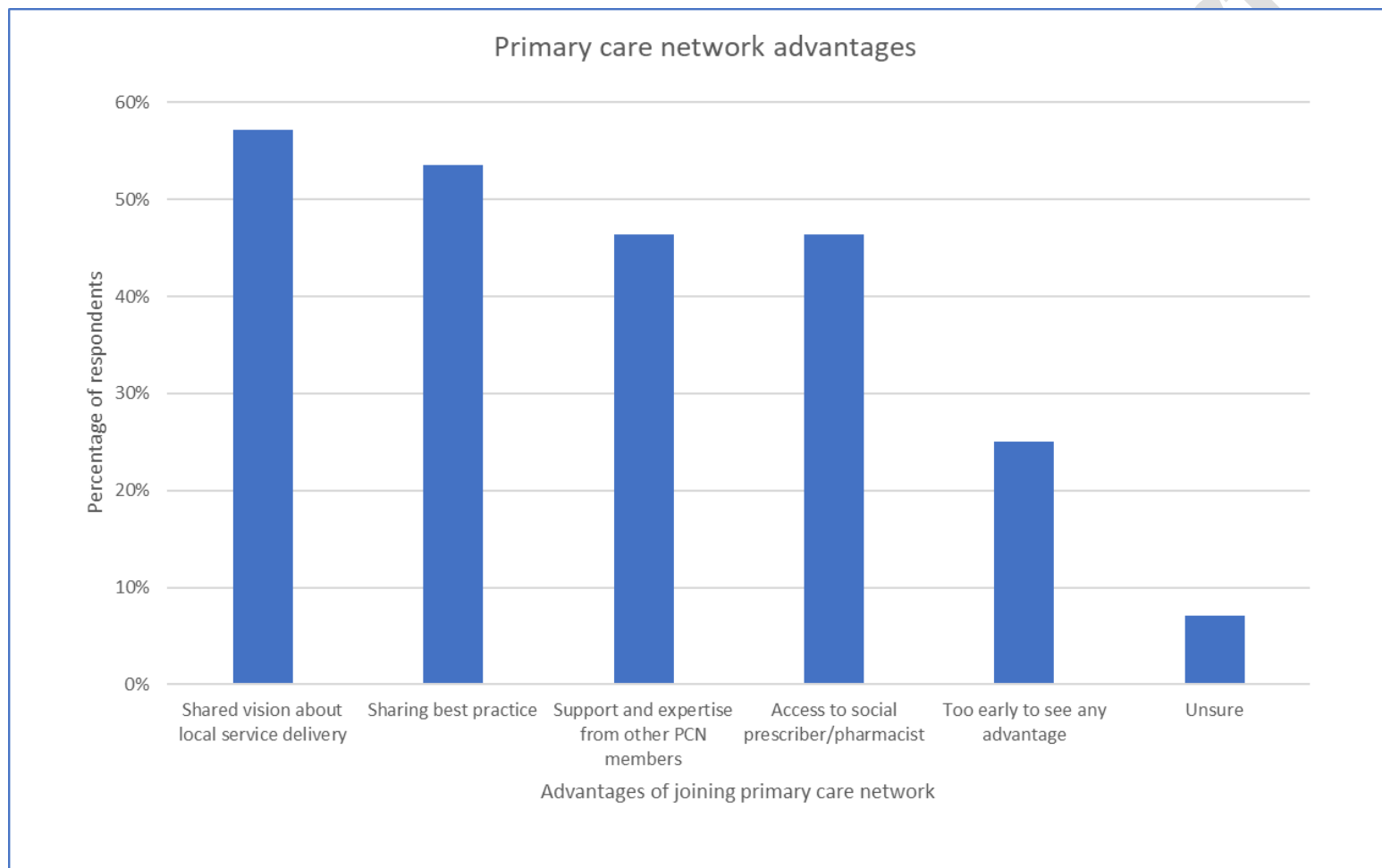
Covid-19 pandemic and its aftermath. This underlined the need to identify clear goals for primary care networks to help solve some of these tensions about their direction.

'There's other areas and snippets of conversation where you can imagine that PCNs are seen to be the cure of the world's woes really, or diabetes care or care home care or keeping people out of hospital. And I think, again that is another tension because really they're trying to make up for there being six thousand GPs short. They're not saying we can do any more of these, we're just saying we need this to do what we can do... the enthusiasm is great but undoubtedly some of the clinical leads... see the potential as being wider than it actually is. I mean I have said myself, I think actually being called a primary care network is a bit egging the pudding that isn't it? We're not really are we? We're a GP network. We're not going to devolve control of optometry or pharmacy or anything else, but hey, wasn't me that picked the name.' (Int19).

Impact of primary care networks

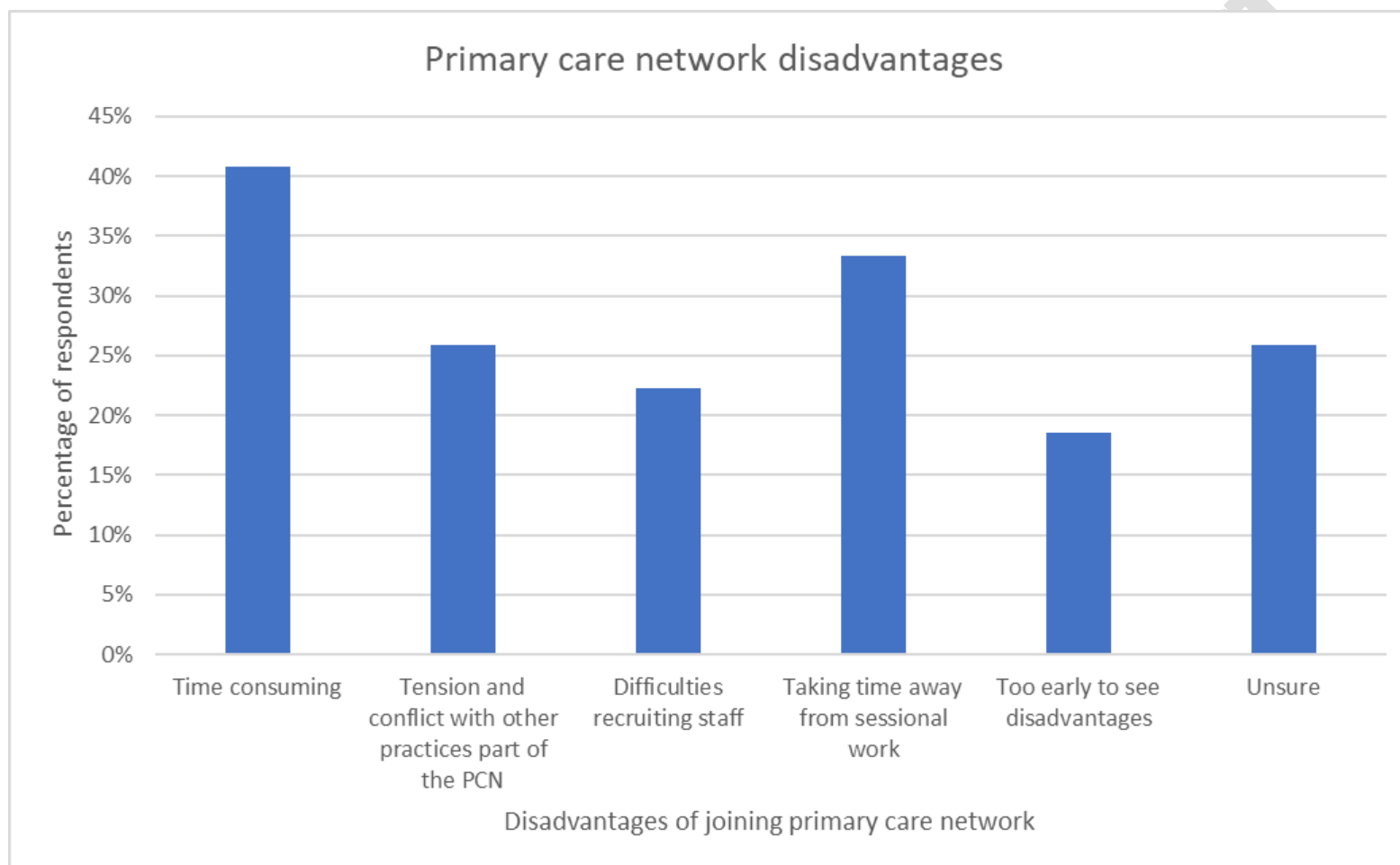
This evaluation sought to examine the early impact of primary care networks, and identified positive and negative consequences that have stemmed from these networks in their first nine months of operation. The evidence for this impact is largely qualitative, drawn from interviews and non-participant observations. Unsurprisingly, at this early stage of network development, very little quantitative evidence was found in respect of their impact. Survey respondents were asked about the advantages and disadvantages of primary care networks, and these are set out in Figure 9 and Figure 10 below.

Figure 9: Primary care network advantages from survey (N=28)



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Figure 10: Primary care network disadvantages from survey (N=28)



It is important to note that some respondents in this evaluation study reported that it was too early to see the impact of primary care networks, particularly as many areas were still working to address operational, back office and regulatory issues, before shifting their attention to health service redesign (Int14, Int15, Int17, Int21, Int23). This also aligned with survey evidence, as 26% of survey respondents reported that it was too early to see any advantages of working as part of a primary care network.

A large proportion of interviewees emphasised that although primary care networks had changed the policy landscape in terms of some requirements made of primary care, they have not yet led to any substantial changes to modes of working within practices, services offered to most patients, or ways of collaborating between practices (Int2, Int4, Int7, Int6, Int8, Int9, Int12, Int19, Int23, Int25, Site A Observation). When exploring the impacts described below, it is important to note that many of those interviewed reported that primary care networks had had no or very little impact thus far.

'As far as I'm aware we haven't made any changes to service delivery... I think we've all carried on doing what we've always done, the same way we've always done it.' (Int7)

'From somebody who comes into the PCN meetings and just responds to the information and isn't involved in attending meetings for the leads or the finance and things – there doesn't seem to be an awful lot done... Occasionally I sit there and am thinking why on earth are we here? Because we're not actually achieving anything.' (Int9)

Some respondents reported that the implementation of primary care networks had been a negative change when compared with how things had been before. For example, during an observation of a network meeting at Site A, those present were asked by a facilitator (funded through NHS England and Improvement's Time for Change programme) to report how they viewed changes resulting from the primary care network. Ten network members rated the primary care network as "Negative" or "Very Negative", while only three rated it as "Positive" or "Very Positive". Reasons cited for negative views of the primary care network included a lack of long-term vision, an excessive burden for practices (and lead GPs in particular) in terms of workload, failure to move quickly to implement the primary care network, perceived irrelevance of national PCN policy in rural contexts, and a perceived lack of leadership from NHS England and Improvement. Some of the reasons for positive views of the primary care network included the additional funding coming into general practice and support

given by the super-partnership (Site A_Observation). These themes were common across the sites, and are explored below in more detail.

Service delivery and patient-level impact

Extended hours general practice services had been put into place by primary care networks as per the NHS England and Improvement specification (Int2, Int5, Int7, Int9, Int5, Int20, Int21), along with some primary care network-determined services such as group counselling services (Int6), older people's community care (Int3), integrated care for those with hypertension (Int24) and diabetes (Site D_Observation), a rapid diagnostic pathway for patients with a suspected cancer diagnosis (Site D_Observation), video consultation services (Site C_Observation) and multi-disciplinary teams to discuss and plan care for patients with complex needs (Int18). Site D was also in the process of planning the building of a central hub for integrated working with other areas of the health and social care system, to be led by primary care and have its own dedicated facilities (Site D_Observation). Several interviewees also commented that primary care networks had the potential to increase the influence of primary care in the local health system (Int17), and act as a mechanism to build relationships with community providers and the voluntary sector (Int16), which was supported by the number of integrated services described above.

Some interviewees reported that practices in their area were already meeting primary care network service specifications prior to their introduction in January 2020 (Int21, Int24). For example, practices at Site A, Site B and Site C were already collaborating to work to provide primary care support to local care homes (Int8, Int13, Int14, Int15, Int17, Int21, Int22, Int24). Site B and Site C had also already been working on drug monitoring with high-risk medications, resulting in safer prescribing of opiates and other medications (Int11, Int20, Int22, Int23, Site C_Observation).

'When the PCN was first published, and we first heard about this, I looked at it and thought well this is everything that I'm doing with the network, surely it's the same thing' (Int21)

Prior to primary care networks, many practices already worked collaboratively to improve care for their patients. For example, the Site B super-partnership had already hired mental health nurses, developed services to improve mental health in primary care, and created new standardised protocols for managing long-term conditions (Int13, Int14, Int15,). Likewise, the neighbourhood at Site C had already been working with district nurses, the voluntary sector, mental health sector and

with local schools on asthma care (Int21, Int22, Int23, Int24); and practices in Site D had worked collaboratively to audit those in the local population who used services the most, as a basis to plan the optimum provision of social care for this population, as well as putting in place a paramedic visiting service and introducing enhanced dementia care services for older people (Int25). Site A and Site B had also worked jointly across constituent practices to improve safety measures through training, developing and implementing standard operating procedures, together with internal audit controls and peer-based benchmarking across practices (Int2, Int13, Int11). In providing these services, many collaborations and practices had also previously engaged with community health care teams, mental health services, local councils, care homes and social services through relationships that had grown organically through years of joint working (Int8, Int16, Int17, Int18, Int21, Int24).

'We also developed a healthy memory café which has been much more of a success than we expected it to be, and that's held once a month ... We have a GP there... nurses... Alzheimer's nurse... a dementia practitioner...the fire service... occupational health, social worker and it is just an opportunity for anybody that's got a diagnosis of dementia or may just be worried about their memory to pop in and have some advice and help and guidance should they need it. So, I think we've been running four months and we've had about 95 patients attend so far all of which have gone away really grateful for the input. Quite a few are returning on a monthly basis because actually it's a really nice place to just sit and socialise and specifically for carers.' (Int24)

As many primary care networks had already been working collaboratively to deliver services and improve patient care prior to becoming a network, some felt that the primary care network was a step backwards and that these new networks had started to undo the work of previous GP collaborations. Some reported that the primary care networks were smaller in scope in terms of what services would be delivered through the network (Int18, Int24) and the parties involved in the collaboration (Int2, Int6) were more limited in number and type of profession, particularly as the early focus of primary care networks has been on sorting out the managerial and administrative aspects of setting them up (Int2, Int24). A few interviewees reflected that since primary care networks were more focused on general practice than some other prior forms of collaboration that include different parts of the health and social care system - such as multispecialty community provider vanguard schemes⁵ or integrated care and support pioneers¹⁰², - primary care networks

offered fewer options in terms of referring patients to alternative services (Int9). Several respondents also reported that they felt that the NHS direction of travel in terms of consolidation of independent practices into larger entities would negatively impact the continuity of care that patients experienced in smaller practices (Int19), and the ability for services to be planned on a smaller scale in a way that aligns with local population needs (Int4).

'The PCN is so far behind, or the new model of the PCN is so far behind where we already are, that I feel we're thwarted. And in fact since it was launched I feel as though lots of things have kind of been in abeyance, lots of kind of projects and things that were moving forward sort of seem to be on hold because we're waiting for the PCNs to evolve.' (Int18)

'I just can't see how on earth the PCN is going to be even remotely in a position to take on that kind of level of work. I just can't. And I think we would be setting ourselves up to fail massively if we even tried... I think because you've already got a neighbourhood set up, and its actually worked very well, to have then a PCN is all... it's duplication' (Int24)

'NHS England has really bought into this... making things bigger, bigger providers, bigger scale. It seems to be ignoring much stronger evidence for the advantages of continuity of care... There is a tension between access and continuity of care, and at the moment we're following the one that isn't evidence-based.' (Int19)

New roles and staff

Primary care networks have provided funding explicitly to hire additional roles in primary care, which have been one of the most substantial changes described by those consulted in this evaluation. The case study sites had all recruited (or were in the process of hiring):

- Pharmacists;
- Social prescribers;
- Complex care nurses, community matrons and dementia nurses;
- Community paramedics;
- Physiotherapists;
- Administrator roles;
- Care coordinators; and

- Dementia specialist practitioners and advanced practitioners to help take some of this workload from GPs.

Since primary care networks are not independent legal entities, hiring arrangements for staff varied between the case study sites, with some sites having a lead practice to recruit staff on behalf of the others, and some sites having the clinical commissioning group, super-partnership or a local NHS trust to hire staff. Sometimes, the recruitment of staff by entities other than primary care groups had been viewed positively, although it had also caused difficulties which are described in the facilitators and barriers section below. Although the primary care networks had progressed in terms of getting people hired for these roles, some respondents reported difficulty in terms of the time it had taken to put together job descriptions (Int8, Int24) and sort out details such as who would induct primary care network staff (Int7). There were also reports of challenges in terms of high staff turn-over, particularly for primary care network nurses which was observed at Site C (Site C_Observation).

Other forms of GP collaboration had enabled the creation of additional roles for primary care prior to primary care networks being introduced in our case study sites. Several sites had introduced shared staff between practices, including mental health professionals (Int13), community matrons (Int22, Int24), community paramedics (Int15, Int25), social prescribers (Int10) and community pharmacists (Int19). Some individual practices had also hired staff for roles that were later funded by primary care networks (Int1, Int5, Int8). For collaborations and practices that had already been working with the network-funded roles, there was a view that hiring roles through the primary care network could cause a disruption where previous ways of working were already functioning well (Int7, Int8, Int24).

Some respondents commented on the positive impact that these new roles were expected to have on primary care networks and on general practice and wider community health provision. For example, it was noted that social prescribers would be able to look at lifestyle factors, and could potentially bring about improvements in patients' health (Int2, Int5, Int6, Int8), and that roles such as social prescribers, pharmacists and physiotherapists would be able to provide more community services to support primary care (Int17, Int21). Others commented that new roles would help reduce

GP workload by creating efficiencies (e.g. by having a single pharmacist to work across all care homes in an area) and by taking away work from GPs (Int6, Int9, Int20, Int22, Int24).

Many were, however, more conservative in their assessment of the difference that these new roles would likely make in primary care. Some commented that although new roles might help a small number of patients, the roles would not make a difference for most patients who may not need or have contact with the new primary care network-funded roles (Int5, Int21), and would not reduce workload for most staff (Int5, Int17). Additionally, even with new network-funded roles, some had reflected that there might not be the workforce available to make primary care sustainable to the extent needed (Int7, Int9), particularly in rural areas (Int9, Int12, Int17, Int24). Although new funding is provided for additional roles through primary care networks, some expressed that the additional requirements and targets set out in the national PCN specification were such that the additional roles might not reduce GP workloads, and that a moratorium on new targets was needed in order to reduce workload (Int1, Int17).

'At the moment, it's an extra person, but here's the work for an extra two people is what it feels like for your average GP. So they don't feel the benefit, that's been the problem.'
(Int17).

'You know, 1 new worker over 8 practices ain't doing much for anybody really. But we're not going to say no, obviously, but they're not going to change the world are they?' (Int21).

Impact on practice staff

In some instances, primary care networks appeared to be starting to have a positive impact on staff in GP practices. One interviewee commented that in practices with a small number of partners, primary care networks were providing security to partners and had given them the confidence that if the other GPs pulled out of the partnership they would not be left isolated (Int9). Also, it was reported that primary care networks had generated enthusiasm in terms of GPs becoming involved in local strategic planning for health services (Int19) and resulted in new training and shared resources (Int5, Int18).

'We've got a couple of practices within our PCN that are only two partner practices – and I think that it's knowing that they have got the support of a larger organisation and that they

can share resources and that it doesn't have to all fall down on them I think would be encouraging for somebody coming in, knowing that they have that wider support and networking' (Int9)

'The main thing that has come in – and this isn't just here – is the enthusiasm with which mostly a new set of GP faces have really taken on a new role and are invigorated and believe they're a bit empowered, and they're doing something at a bigger, more strategic level than out of practice' (Int19)

Much of the positive impact on staff described by interviewees was attributed to other models of collaboration, rather than the primary care network. For example, the super-partnership at one site had been able to offer improved support and resources to staff, including additional training, flexible working arrangements and more generous benefits (Int11, Int14, Int16). Also, through collaboration they were able to offer more opportunities for specialisation within the field of primary care, which was described as having the potential to enhance career options (Int10 Int11, Int14).

'The fact that you've got the support of peers has helped to retain GPs who would have otherwise retired, and has been an attraction for people to move from not wanting to contemplate partnerships to being partners, because actually we're demonstrating that there's so much support around the things that put people off, whether it's the property management, HR or whatever, actually you don't need to worry about that. So I think that's in part one of the attractions'. (Int11)

Although some have reported positive impact on staff from the introduction of primary care networks, the evidence collected through this early evaluation suggests that networks have to date tended to be experienced in a rather negative light by some primary care staff. Workload for existing clinical and non-clinical staff was a significant cause of tension given the time required to set up and establish primary care networks across practices. For example, being part of a primary care network was often entailing multiple weekly and monthly meetings, in which many of the same staff were involved, on top of their clinical duties and other responsibilities (Int4, Int13, Int14). The administrative and managerial aspect of primary care networks was also time-consuming, particularly for practice managers and clinical directors, despite funding being made available for

managerial aspects of networks (Int1, Int3, Int4, Int5, Int7, Int8), and many mentioned that primary care network-related tasks felt too much on top of the regular day job (Int1, Int5, Int7, Int8, Int9, Int12, Int14). This was also supported by survey evidence. When asked about the disadvantages of primary care networks, 41% of survey respondents selected that a disadvantage was that networks were time-consuming, making it the disadvantage most frequently selected by survey respondents.

'It can't be a bolt on to the day job, and that's what it is at the moment. I have been averaging... 55-60 hours over the last couple or three months and that in itself wouldn't be a problem... what is a problem is that for all of that we're no further forward than when I started three months ago. That is fundamentally a problem, and when I listen to all the other PCNs I get the impression that there's a lot that are in the same boat.' (Int7)

Primary care networks not only add to workload in terms of managerial and administrative duties, but also shift a proportion of the responsibility for funding and implementing local primary care service development from the clinical commissioning group and community health trust to primary care networks. Some respondents commented that this shift, while providing more funding to primary care, had caused issues in terms of increased workload, as GPs found it difficult to meet the additional services in the national primary care network specifications even with the additional new staff that had been funded (Int1, Int19, Int6, Int8, Int9, Int19, Int24).

'We want to make our working lives better rather than just having more money, and we couldn't really see the PCNs initially were going to make our working lives better. But we had a hope... that we would have more clinical support and that would make us be able to deliver more sustainable general practice. Of course that's been turned on its head completely by the targets that have been set up and in the specifications, which are completely unachievable.' (Int1)

Organisational impact

Primary care networks had however led to perceptions on the part of some respondents of more efficient working and the introduction of more robust managerial and administrative structures. At Site C, the primary care network had implemented centralised human resource management support, governance structures and training resources (Int20, Int21), along with a shared process and support for Quality and Outcomes Framework (QOF) primary care contract monitoring

requirements (Int21). Practice managers at this site had worked together to align back-office procedures, helping to ensure that administrative tasks could be completed centrally by appropriately skilled staff (Int20, Int23, Int24), and that staff such as nurses and receptionists could move around practices as needed (Int18). Site D had set up a primary care network triaging process using a commercially available online symptom assessment system to help refer patients to allied health professionals in a standardised way across the network. This was reported to create efficiencies in terms of triaging processes, and had helped the primary care network collect data on the use of allied health professionals to aid its resource planning (Int25). Across primary care networks where centralised and standardised processes had been implemented, some respondents commented on what they considered to be the increased stability of their organisations (Int4, Int6).

‘We do know that in each practice you’ll say “oh yeah such a body brilliant at admin” or “great at coding”, “brilliant on ‘scripts”, so why not take them and have them taken out of the practice and just working centrally, because we’re electronic nowadays’ (Int23)

Some of the organisational impact from collaborating across practices was attributed to other forms of collaboration that preceded and were continuing alongside primary care networks. For example, the super-partnerships at Site A and at Site B had both provided practices with centralised support for Care Quality Commission inspections, including a joint Care Quality Commission registration at Site A (Int2, Int6, Int16, Site B_Observation,). The super-partnership at Site B had also set up standardised processes for GP practice reception and patient triaging, and for back-office functions including accounting and financial reporting, and a standardised way to respond to General Data Protection Regulation policy, and the logging and handling of complaints and incidents. These processes had created efficiencies and increased stability across the super-partnership and its practices, and allowed for staff to move across practices as required (Int11, Int15).

‘We now have one way of doing the books across all of the practices, with one accountancy firm that has driven down cost. And there’s been bumps in the road on that one, trying to get everyone aligned to a single year end and trying to align all of the different financial reporting mechanisms that we all have into one way of doing it, which was never going to be simple. We’ve now got to the position – it has taken three years but we have now got to a position where it feels a lot more stable.’ (Int11)

Although primary care networks could be a vehicle to introduce more effective and efficient processes across primary care, this evaluation pointed to potential organisational challenges. By obliging practices to form collaborations, the implementation of PCN policy had in effect forced some practices to work together that had fundamental and sometimes long-standing differences in terms of their operational environment, ways of working and values (Int1, Int2, Int4, Int9, Int17). Although practices within a primary care network were required to be geographically contiguous, there have been instances where the border of a network appears geographically contiguous on a map, but has failed to encapsulate areas with similar demographic factors or what are locally considered to be 'natural communities' for local people or health professionals (Int12, Int19). Bringing together practices in this top-down fashion had caused tensions within some primary care networks, which are explored further in the section below on barriers that have been faced.

'The challenges really were that PCN were something that were... an arbitrary formation... The idea of collaborative working sounds great, but, you know, when you are forced into a relationship rather than a relationship happening organically, it is very challenging... Some of the practices in our PCN area footprint... always had different viewpoints of how a PCN should be run.' (Int1)

'Sometimes the reason you've got two practices in a particular area is a practice split ten years ago and now one or two of the GPs left the other two or three GPs and started another practice inside a town. And you still get some of that hangover even now.' (Int17)

Financial impact

The evidence from this evaluation about the financial impact of primary care networks is mixed. On the one hand, these new networks provide a mechanism through which more funding has come into primary care, which has been seen by some as a very important early impact (Int1, Int4, Int14, Int17, Int20, Int21, Int25), and has encouraged practices to work together that would not otherwise have done so (Int17).

'Obviously in some respects this exercise is just a re-churning of cash inflow into practices and rebranding it under a different name' (Int4)

'So the average PCN in our patch in the year that we're about to go into is going to have just under half a million pound each... if you can access that resource, that is a big incentive to put up with Dr X and Dr Y who you find quite irritating. If there wasn't a lot of resource being invested, I suspect they'd go 'I really can't stand him or her, I'm not getting involved.' (Int17)

The funding coming directly into primary care had given more financial freedom and security to primary care. Some interviewees commented that there were fewer "strings," or caveats associated with funding for primary care networks, since the clinical commissioning group or local trust does not have the power to dictate precisely how it is spent (Int19, Int20), and that there was a more steady flow of funding compared with previous arrangements (Int23). However, there had also been tensions with clinical commissioning groups and trusts attempting to maintain oversight of primary care network budgets, which are discussed in the section on barriers below.

'When this DES PCN came along, it was a voluntary contract but it was quite autonomous independent contract, there were no strings attached to it, so the CCG could not dictate, you know, what we do and how we do it. Our... local trust, could not dictate how we set the whole thing up and what thing we should do or we shouldn't do.... So it's us, we're deciding what is best for general practice and what is best for our patients.' (Int20)

Some evidence pointed to more efficient spending and achieving economies of scale (Int14, Int15), for example through better financial management centrally within primary care networks or the prior collaboration (Int2, Int16), or the ability to purchase medications at wholesale prices (Int11). However, some of these positive impacts in terms of financial efficiency may have been attributable to other forms of GP collaboration rather than the introduction of primary care networks.

'There is a contribution that is made by the practices to run the organisation, but through collaborative working, through better use of staff and resources, effectively that money comes back... the idea obviously if we are delivering high performance and high quality care, that our performance targets will be higher, that will achieve more, which will generate additional income, but income that we can then not just think of it as profit but a way to sort of develop the organisation even further. So there is initially obviously a financial implication in joining [redacted] but we feel that the practices get that back, get that benefit back in higher values than what they contributed.' (Int15)

Despite some examples of success, there was evidence that primary care networks could have a negative financial impact on practices. Some expressed a view that although new funding was coming into primary care, this money had had to be spent on the up-front additional management and administrative costs associated with the new networks, due to an underestimation of the time and resources needed (Int3, Int7). There had also been reports that funding from NHS England and Improvement had not been sufficient to cover expenses, leading to financial dis-benefit for some practices as a result of joining primary care networks (Int5, Int13). Similarly, some commented that the new funding would be spent on the additional services required through the national primary care network specification (Int7) or on topping up where the full cost of these new roles was not covered by new resources for networks (although the funding for these roles has since been increased by NHS England and Improvement to cover 100% of the costs¹⁰³ (Int1, Int13).

'I think one of the dangers is underestimating the amount of time and commitment people would put into it so it then makes it a negative impact on the finances of practices for time put in.' (Int3)

'The £1.50 per patient is fixed as well that's going to be used up very quickly by... employing additional roles. And actually, we were always worried even when we started that... this was going to end up making more work for GPs and it will cost us more in the long run because of all this overlay... And certainly, that's the way it's looking at the moment and I can't really see that there is much in it for us at the moment' (Int1)

Some asserted that although clinical directors were being paid for their role, the remuneration was not enough to cover the number of clinical sessions they needed to drop to attend to primary care network-related tasks (Int2, Int3, Int20). The loss of clinical sessions for clinical directors also had the potential to impact practices, as there was at least one practice that was reported in our fieldwork as not having allowed one of their GPs to stand for election for the clinical director role due to general practice shifts that would be left uncovered (Int2, Int5, Int7 Int8, Site A_Observation).

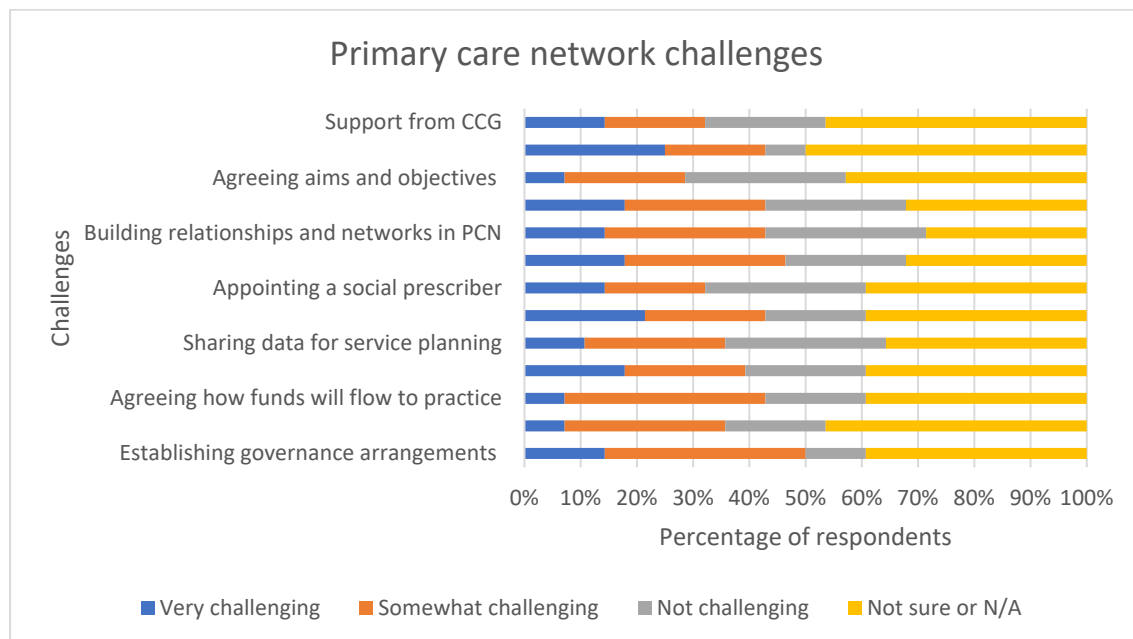
'It's not that any GP didn't want to take the clinical directorship from a prospective of finances. We actually had two GPs that were very interested in doing it. The problem was that practices stopped them because they could not afford the lack of capacity.' (Int7)

It was suggested that the existence of a “dual system” in which practices contribute to the financial costs of the collaboration for centralised functions such as management and administration, while also continuing to operate these same activities on a practice-by-practice basis, had been detrimental to primary care networks trying to realise their full potential in terms of financial savings (Int10, Int12, Int13). The practices risked bearing the up-front costs required to implement collaborations, without realising the potential financial benefits from moving towards shared back-office functions, economies of scale and improved financial management, among other mechanisms for potential cost savings.

Facilitators of and barriers to the early implementation of primary care networks.

This evaluation has explored facilitators that have contributed to the early progress of primary care networks along with their pre-existing GP collaborations, and the barriers that they have faced to date. In many cases, facilitators and barriers are closely linked, and as such they are discussed in parallel below. They are also very resonant with those identified in Chapter 3 (Evidence Review) suggesting that primary care networks are in many ways closely related to their antecedent forms of GP collaboration. While most of the evidence around the facilitators and barriers described below stems from interviews and observations, survey respondents were also asked about the challenges that primary care networks had faced in their early months, which are summarised in Figure 11 below, although responses to the survey were limited.

Figure 11: Primary care network challenges from survey (N=28)



Management and leadership

Many of the facilitators to collaborative working focused on strong leadership and management of the primary care network and other forms of pre-existing collaboration. A few interviewees reported that their network had effective meetings, and that learning was shared at a managerial level across the organisation (Int18, Int20). Characteristics of good leadership encompassed strong consensus around decisions made at a board and managerial level (Int14, Int20), as well as having people in leadership roles who listened to the concerns of staff (Int14).

‘Everyone knows that you’re voting as a partnership. Everyone knows that we go by the majority so... you can’t bring that many partners together and everyone be 100% happy with the outcome. Believe it or not, the majority of stuff that we’ve done and delivered we have had 100% of those there because they’ve bought into the ethos of what we’re trying to do... If someone is unhappy, we always look at what they’re unhappy about and we try and address that, which we have done on many occasion. And nine times out of ten obviously we find a solution.’ (Int14)

Some interviewees commented on the importance of the clinical director role in terms of ensuring the success of primary care networks. They noted that having a single person who was responsible

for resolving issues, facilitating collaboration and building relationships between members was an important aspect of networks (Int10, Int17), which might help facilitate their development and ensure that they succeeded. Some also commented on qualities that a clinical director should have, which went beyond clinical skills to encompass good leadership, communication, being personable and approachable, drive, enthusiasm and being politically 'savvy' (Int1, Int2, Int3, Int5, Int6, Int9, Int23), along with a genuine desire to get involved with management functions (Int1, Int5).

'That higher level management work, with all the management speak and the politics and that kind of thing, is not really my cup of tea at all, and I think to be a good clinical director it has to be your cup of tea. It's got to be the kind of thing you actually enjoy doing and the challenge... that you actually want to take on... I think that's probably one of the most important skills to have is an enthusiasm for that kind of work.' (Int1)

'We've got three groups [of clinical directors]. We've got those who've been around, quite experienced, been involved with local medical committee and the local federation or CCG. They know how the system works, they're quite experienced and so on. There's another group that are younger generally, quite enthusiastic, also quite idealistic sometimes, but they're not sure how to make it work yet, which levers to pull or necessarily how to work things, but they are really relatively quite motivated. And then there's a third group who look a bit bewildered and they've got into it because nobody else wanted to do it and they were probably the least unwilling...and there's a few of those who are doing it but they're not sure why they're doing it or how they got to be doing it. And their motivation and experience is different so a) they're not quite as motivated to develop themselves or their PCN, and also they've probably got fewer tools to enable them to do it as well.... I call the final group the permanently bewildered – they're not quite sure what they're doing or why they're there or how they got there!' (Int17)

Although strong leadership and management can act as a facilitator, this was not yet reported as being present in the primary care networks in our case study sites. Many interviewees commented on the lack of strong leadership within their network, resulting in frustrating meetings and an inability to achieve progress (Int3, Int8, Int9, Int21, Int24). In some cases, this had resulted from the clinical director role being taken on reluctantly after difficulties in filling the role, which was felt to

have inhibited the appointment of a clinical director with the necessary mix of skills, communication abilities, experience and time and energy (Int2, Int3, Int4, Int5, Int6, Int7, Int8). Difficulty in filling the clinical director role was reported by some respondents, and in one case this had resulted in less than ideal arrangements such as the rotation of the clinical director role on a yearly basis (Int2, Int4, Int6, Int7).

'We have tended to just go round in circles on discussions on how we do things... everybody will be in agreement and then somebody else will bring it back round to the start again and say 'but what about this.'' (Int9)

'I don't think we think things are progressing very quickly and not quickly enough. We've had a clinical director who isn't very communicative I'm not saying [redacted] is not doing his job because I understand he has been going to lots of meetings and everything and when he comes to talk to us he's, he does give feedback but in between we've no idea what's going on so I just think he's finding it difficult to do his day job go to all the meetings and make sure we're all kept up to speed with things.' (Int5)

Some interviewees suggested that primary care networks were relying too heavily on the clinical director, who may not have all the managerial and financial skills, or time, to successfully manage the network (Int2, Int4, Int7, Int23). This issue was observed at a primary care network board meeting in one site, where the clinical director and other clinicians discussed the technical details of building maintenance and legal details about holding property as a primary care network, yet the clinical director admitted to having little experience of such matters. To make up for this lack of managerial capacity, several interviewees suggested that a professional, non-clinical management role should be implemented to support the effective management of primary care networks (Int4, Int7), signalling the importance of role allocation within these new organisations. One site was already considering splitting the clinical director post into two roles, one focused on clinical leadership and the other on operational management, and had discussed increasing administrative support as the primary care network grows (Site A_Observation).

'I think [what] NHS England did get completely wrong is that they should have funded immediately a management position for a professional manager to come in and actually get the structure sorted, I think to ask a clinician to also be an expert when we are talking about

management set up, about roles, about job descriptions, [is] fundamentally wrong it should have been somebody brought in to concentrate on those tasks.’ (Int7)

At one site, there were tensions with regard to leadership and the purpose of the primary care network. There was a divide between network staff who wished to continue and build upon the achievements of the neighbourhood collaboration and its integrated working in wider health economy (Int 24, Int20, Int22) while others wanted to use newly acquired primary care network resources specifically to decrease GP workload and improve the financial situation of practices (Int21, Int22, Int23). The division, with regard to the purpose of the primary care network, manifested itself during early board meetings (Int21, Int22, Int23, Int24, Int20) where even democratically decided decisions about care delivery were challenged (Int22).

‘It had quite a negative effect because they’re coming from two completely different ends of the spectrum, so [redacted] was wanting the PCN to actually work for the GPs, clinicians, so he wanted a system that meant the pressure was taken off the clinicians, whereas [redacted]’s always been for what’s best for the patient and patient care. And really there should have been something in the middle but they are at extremes. So initially it’s caused quite a lot of conflict and board meetings have been a bit – I’ve not been, this is hearsay, so I can’t confirm – a bit fraught at times.’ (Int23)

‘The way that they work is they do a vote on a decision and they go with the majority, and that was agreed when the PCN was set up that that would be the way forward... That isn’t happening -- If the CD doesn’t agree with the unanimous decision that was made, he seems to be going off and doing his thing.’ (Int22)

Relationships with clinical commissioning groups

Some interviewees reported that the local clinical commissioning group was supportive of primary care network development (Int1, Int11, Int13, Int16, Int25), and had been helpful in tasks such as the recruitment and hiring of new staff (Int15, Int16), fostering relationships between practices and providing practices with dedicated time for network meetings (Int11). It was noted that it was important for clinical commissioning groups to be supportive of primary care networks and other forms of pre-existing GP collaboration, while also providing them with room to innovate and make autonomous decisions (Int16, Int25). This echoed the messages in Chapter 3 (Evidence Review)

about the importance of effective relationships between a GP collaboration and its funding or authorising body.

Although positive relationships with clinical commissioning groups were viewed as facilitators to collaborative working, this was not present across all the case study sites. Some respondents reported that support for the primary care network from the clinical commissioning group was weak, something that seemed to be a particular issue in one site (Int4, Int5, Int7). This poor relationship with the clinical commissioning group was also observed during a primary care network meeting at this site, where some felt that the commissioning group was meddling with the primary care network's jurisdiction in terms of recruiting staff for new roles (Site A_Observation). Some reported a concern about how their clinical commissioning group was distributing funds to the primary care network, including instances where the CCG had allegedly not distributed funds as was agreed (Int1, Int4, Int7, Int20, Int22, Int24). There were also reported instances where it had been unclear under what conditions funding would be distributed by the clinical commissioning group to the primary care network, and how much scrutiny would be made of network expenditure (Int17, Int23, Int24).

The issues apparently causing poor relationships between some networks and their local clinical commissioning group brought to the surface a more fundamental tension about the role of primary care networks in commissioning care. Primary care networks represent a shift of some commissioning power away from the clinical commissioning group into primary care. Some respondents reported that the local commissioning group had attempted to exert control of budgets allocated directly to primary care networks (Int1, Int4, Int18, Int19, Int21, Int22, Int24). It was also reported that the agenda of primary care networks and that of clinical commissioning groups did not necessarily align, as some GPs were more likely to want to spend network budgets on supporting practices and decreasing GP workload, while the commissioning group would likely want something more to be done with the money (Int2, Int19, Int21), such as a more community-focused approach to population health.

'They've kind of held back on some of the funds that probably should have come directly to us, I don't think they were doing anything with that, I think that they just sort of felt they had some role in kind of redirecting it really, but I think that's probably misguided.' (Int4)

'I have not found it a positive experience there's the PCN view that the clinical commissioning group should not dictate then how the money that has been given to the PCN is spent.'

(Int22)

Ways of working and relationships across practices

Many respondents noted that clear communication across the network and a good relationship between practices, and particularly between practice managers, was important in facilitating effective primary care network development (Int2, Int7, Int9, Int23, Int24). Establishing shared goals and aims (Int7) was also cited as important, particularly in moving towards a more meaningful sharing of resources to cover the whole population of the network, rather than each practice focusing exclusively on their own patients (Int3). Staff away days and other forums for staff from across the collaboration to talk to one another were reported to create a sense that staff are working as part of a unified team rather than a collection of practices (Int14, Int15, Int16).

'I think as a group of people all the doctors in the primary care network group and all the practice managers work very well together we have very open discussions and we have a common wish and a common aim to create a better service' (Int7)

'I think the biggest challenge was getting twelve practices together who have worked differently to suddenly think about working as one organisation, and there's still ongoing work with that around the culture of being part of one organisation, being part of [redacted] rather than just the individual practice that you were part of previously. I think there's always going to be a struggle with that and things we can learn and how we can do that better or improve how we integrate staff and practices. But certainly I think we've come a long way from where we were sort of two years ago and you can already see the difference with people.' (Int15)

Despite strong relationships and shared ways of working acting as a facilitator to collaboration, there had also been challenges associated with joint working in the early development of primary care networks. Interviewees reported that differences in ethos, operational environments, organisational culture and operating procedures had made it difficult at times to get activities or services under way across practices in the primary care network (Int1, Int10, Int11, Int13, Int14, Int15, Int24), and in one site had even led some practices to leave the primary care network, and the super-partnership

at another site (Int13, Int15, Int16, Int25). As one GP commented regarding the differences in priorities and attitudes between different partners:

'When I was in my 30s, I was quite ambitious and I wanted, you know, if you set up some goal I would try and get the right end of it. As I've got older, I've probably done what most people do which is I want to just sit somewhere around the mean so that people just leave me alone. And I don't want to be a trailblazer, I don't want to be a laggard, I just want to sit in the middle. That I think that what we've done with [redacted] is we are right outside of the normal general practice and I think that exposes us to the potentially benefits, I mean, that's why we're doing it, but it exposes to the risk that actually policy just doesn't fit.' (Int10)

'Some people were happy to work in low cost, low value environments and some of us wanted higher value environments that came at a higher cost, and therefore a profit would be lower. And trying to move towards a parity of drawing drove out one partnership... Another partnership left because it felt that it wasn't getting change that was creating value quick enough...they didn't feel they were getting enough really.' (Int11)

'I know what they say about groups that they need to form, storm, and norm, but we're definitely in the storm version at the moment and there's a lot of clashing of heads from my point of view. It seems a bit of a shame really.' (Int24)

Since primary care networks have brought together practices that often did not organically form a partnership, there have been challenges that have arisen due to the sometimes 'imposed' nature of PCN collaborations. Many expressed an anxiety that GPs may have about the loss of independence caused by primary care networks and other forms of collaboration (Int6, Int7, Int9, Int13, Int14, Int18, Int23, Int24), particularly compared to more bottom-up forms of collaboration that were perceived to better retain the autonomy of GP practices (Int2, Int23).

'Joining 6 practices was challenging enough – I hate to think about bigger practices, bigger networks – because I think by the nature of GPs, they can be quite strong willed. They have their ideas. It's their own business. And now we're saying in a way, forget being your own business, we'll join up with another 5, and work together for the greater good.' (Int6)

Technical issues have also stood as a barrier to shared ways of working, such as a lack of shared IT systems and record keeping systems (Int4, Int7, Int9, Int11, Int13, Int14, Int24).

Many sites had struggled so far to promote staff engagement below the primary care network governance level, which threatened to hinder the formation of a shared sense of identity and working across the network (Int6, Int10, Int15, Int24, Site C_Observation). Lack of engagement within constituent practices of a primary care network was also reported to be a challenge, something that is consistent with the historical experience of GP collaborations reported in Chapter 3 (Evidence Review). It was observed that practices with poorer engagement with the primary care network were less likely to utilise network resources such as social prescribers, hence undermining the overall mission of the new organisation (Site C_Observation). However, several interviewees noted that this was not necessarily a bad thing, as it allowed staff who did not wish to be engaged in the primary care network to continue with their regular way of working and get involved at their own pace (Int15, Int20)

'It's not easy, because every staff member is different. We've done staff newsletters and things like that to communicate. Our chief officer does a weekly update that goes to all staff, so update on what we're doing, and some staff will find that really interesting, and some staff will say "Why am I reading this? I don't care. I just want to do my job and go home and get paid". So it's trying to understand what your staff want to hear.' (Int15)

'Some of the staff wouldn't know that we were in a network, even though we've told them about it. If you then said about the PCN, they'd say well what's that? Because there's no – there isn't any sort of joined up working at the moment.' (Int6)

The relationship between a primary care network and previous GP collaborations

Where the establishment and implementation of primary care networks had built on the strengths of previous general practice collaborative working arrangements, this was almost always reported to have been a facilitator of network development. For example, at Site A it was reported that the super-partnership (of which some primary care network members were a part) had been able to help share learning across the network about how to manage collaborations (Int2, Int8), and provided support for legal matters, governance, finances and data management (Int7, Int9). Some also commented that at Site B, the goals of primary care networks were largely aligned with the

goals of the super-partnership (Int15), and that the super-partnership had helped foster a maturity of collaborative working that put them ahead of other networks (Int17) including in terms of what the primary care network had been able to accomplish in just a few months (Int18, Int19, Int23, Int25, Site D_Observation).

All four sites had been able to build on the success of previous GP practice collaborations in some way, although each had faced tensions and challenges associated with the interplay of the former and new organisational arrangements. Many interviewees expressed a concern that primary care networks had affected previous ways of collaborative working in a negative way (Int2, Int6, Int17, Int18, Int21, Int24, Int22), and some respondents continued to view the pre-existing forms of collaboration as more relevant and helpful than the primary care network, albeit the new networks were only a few months 'old' (Int9, Int19, Int23). At one site's super-partnership board meeting, one of the operational priorities for the year ahead was to address the mismatch between the priorities of the super-partnership and the primary care network, pointing to the issues caused when these do not align.

'When PCNs were being set up, there was an awful lot of discussion about what about the existing collaboratives and the relationships that had been developed and formed were really helpful... But in most cases... it's caused the end of the existing collaborative arrangements. They're still there but... they're a shadow of their former selves.' (Int17)

Previous GP practice collaborations were reported by some to be a source of tension in instances where some practices within a primary care network belonged to a pre-existing GP organisation, and others did not. For instance, at two sites, only some of the practices in primary care networks were part of a wider super-partnership, and these differing allegiances had caused tension and distrust among the PCN members about whether the super-partnership was exerting control over the network, or even if the partnership was positioning itself to take over the practices outside the super-partnership. In at least one primary care network, professional mediation had helped them to devise a voting solution to address this, so that the practices that were a part of the super-partnership could not secure a majority just by voting as a block (Int1, Int6, Int15, Int16).

'It was a bit like getting peace in the Middle East you know, we had to reach a compromise where... all the parties felt that it was -- specifically these two non [redacted] practices -- felt

that we had to rig the voting so that we didn't have a simple majority... When decisions are being made that we had to have sort of a fail-safe put in there that they, we as collective four [redacted] practices, we couldn't overrule the two other practices if they dissented with us... so we eventually reached a compromise after much horse trading... quite a lot of emotional sort of anger and people being suspicious and that sort of thing, and we eventually reached a PCN agreement.' (Int1)

There have also been practical issues that have arisen out of pre-existing collaborative arrangements across GP practices, most notably through confusion related to the hiring of new staff. In cases where primary care networks were not established as a legal entity able to hire staff, it was unclear which party should recruit the new roles funded through networks (Int2, Int4, Int23, Site B_Observation), particularly with respect to the overhead costs and the risk to hiring practices if other practices were to leave the primary care network, or if it were to be discontinued (Int2, Int6, Int7). Where shared staff had already been hired by collaborations that existed prior to the implementation of primary care networks, this had often caused confusion about how these human resources (HR) arrangements should adapt, particularly where the interests of the hiring body (e.g. the clinical commissioning group, trust or super-partnership) did not align with those of the primary care network (Int7, Int10, Int16, Int19, Int20, Int23, Int24). However, several interviewees reported that they were happy for the trust or super-partnership to hire staff and deal with the administrative details, overheads and risks (Int2, Int6, Int7, Int20).

Challenges in fulfilling the national primary care network specification and expectations

This evaluation has identified some policy-related challenges faced by primary care networks. Some of these relate to the national primary care network service specifications (as explored in Chapter 1 - Context), which although considered by case study sites to have improved from their first version (Int1, Int2, Int17, Int20), were sometimes still considered too demanding and overly prescriptive considering the (pre-Covid-19 pandemic) financial and workforce challenges in primary care (Int1, Int6, Int8).

Although primary care networks were viewed positively by some respondents in terms of the increased power of primary care to negotiate contracts when they work in collaboration (Int2), there was a countervailing view that the national nature of the specification risked lumping together

requirements that would have traditionally been negotiated separately and/or locally (Int1). This was particularly an issue in cases in which the services described in the primary care network specification were not considered to align with the needs of local populations (Int1, Int5, Int12, Int19, Int21, Int23, Int24).

'Each time, the contract is being renegotiated it's for twelve months, it's got lots of promises about what's going to happen in the future, but the first contract that they brought out was rejected by everybody this time. So, in a way, we might have more strength now we are in networks to actually say no, than we did have as individual GPs so that could be good.' (Int2)

Similarly, some interviewees expressed a view that too much was being expected too soon from primary care networks (Int4, Int5, Int24), particularly as they were still working out how to function operationally before they could accomplish goals such as decreasing workload and improving care to align with NHS Long-Term Plan ambitions (Int1, Int6, Int19). There was a view among some interviewees that primary care networks had been rushed in their implementation, and had not been given sufficient time to find a model that worked across primary care (Int7, Int14, Int24).

NHS England... they have ideas, they seem to have ideas and then these ideas get filtered through with not a lot of meat on the bones. And I find – and this is nationally – everyone then has their own interpretation of what they're trying to achieve and what they're trying to deliver... if you're all going off on a tangent what you're going to end up with isn't going to work.' (Int14).

'The PCN is in its infancy, and they seem to be desperately trying to run before they can walk which I can't quite understand' (Int24)

In one site, which had a more formalised and permanent structure in place for its pre-existing collaboration, the primary care network policy was seen as a “curve ball” (Int10, Int13, Int15).

'Everything takes a lot longer than everyone envisages. And the NHS has a habit of changing just at the point when you're mastering something...consistency should not be underestimated' (Int13)

'Most of us I think felt quite annoyed when PCNs came along because actually we were trying to do something similar but then all of a sudden the ground changed underneath us.'

(Int10)

Some primary care networks seemed to have responded to the new policy context by taking (at least for the initial few months) a 'box ticking' approach to fulfilling the national specification (Int1, Int24, Site B_Observation, Site D_Observation). While not uncommon, this approach had the potential to undermine some of the broader goals and priorities of primary care networks.

'We just thought, well we've been there before. We deal with the box ticking. Get the box ticking done and then deliver what... might improve care for our patients, but this is on a completely different level to anything we've found we've done before.' (Int1)

Some interviewees also commented on what they considered to be a lack of clarity about how primary care networks should be set up and what their longer-term vision was to be (Int8, Int20, Int23). This was supported by our survey evidence, for when asked what challenges primary care networks have faced, "Support and guidance provided by NHS England" was ranked as "Very challenging" by 25% of survey respondents, the highest proportion among the challenges listed in the survey, although only 28 respondents completed the survey.

Barriers for rural areas and small practices

Barriers for rural primary care networks

Rural areas face particular challenges in establishing and operating primary care networks. Some interviewees in this evaluation felt that the overall primary care network policy had been designed more for urban areas, and had not been sufficiently well thought out in terms of implications for rural practices (Int2, Int4, Int7).

'I think they are the right way forward I don't have any problem with the concept of a primary care network as such. Where I think there are issues is that at very short notice we were asked to create a primary care network based on a model that had been tested in an urban environment... While I agree there are a lot of things that we could do to generate additional time and capacity in the practices, what I don't think works is the urban model in

the rural location. So we are at short notice being pushed into accepting a method of working that in our, certainly my, heart of hearts, I don't think is fit for this county.' (Int7)

Some of these challenges were related to distance and the time taken to drive across the geographical boundary of a rural primary care network, which could make it difficult for shared staff such as district nurses, as well as unpaid volunteers, to be able to attend to many patients within a single working day. Distance and a lack of reliable public transport could also make it undesirable or challenging for both patients and staff to travel to health centres other than their home practice, making some of the primary care network specification and sharing of primary care roles seem less relevant than in a setting where practices and their patients were in a small geographical area (Int2, Int3, Int4, Int5, Int7, Int8, Int9, Int12, Int20, Site C_Observation).

Some interviewees mentioned extended hours general practice as a service that was rarely accessed in rural areas, as patients were considered less likely to be willing to travel long distances between practices to be seen more quickly (Int2, Int4, Int5, Int8, Int9). Digital or phone solutions were mentioned as a potential way to address issues in terms of distance and travel (before the Covid-19 pandemic suddenly increased the use of such approaches across UK primary care), although it was noted that rural areas face unique challenges in terms of digital access and broadband speeds (Int2, Int3).

'The first one that is critical across everything we do is drive time... the reality is patients can get everywhere, albeit in a rural location that is much more difficult because of course there are very often no buses and no transport methods. But it's not can a patient get there, it's how long will it take them. For us in a rural location very often if a patient can't come to the local surgery... they have to be taken by volunteers so drive time becomes key because you're actually asking people to give up their own time to take somebody to somewhere else and bring them back that cannot take hours because you're not going to get volunteers to do that' (Int7)

Rural areas face particular workforce challenges that impact on their ability to hire shared staff across a primary care network and deliver on requirements within the national service specification. For example, rural areas may be less attractive to work for locums who get paid on a fee-for-service

basis, as they will necessarily cover fewer patients in a less populated area than in a busy urban setting (Int4, Int7, Int9, Site C_Observation).

'There are locums in the area. There aren't many -- they're not easy to get hold of... the difficulties with locum over here is that if you're working one practice in the morning, you could actually find yourself too far away from any other practice for the afternoon. So of course they by nature tend to congregate around the urban areas where they know they can earn a greater income.' (Int7)

Lastly, primary care networks were said to present an issue in rural areas in that country localities typically had fewer options in terms of practices that were geographically contiguous to form a PCN. It was likewise potentially more challenging in rural areas to find geographically contiguous practices that shared common outlooks and ways of working, compared with urban areas (Int1, Int2, Int9).

'Some of the practices in our PCN area footprint... had different viewpoints of how a PCN should be run, and then because we are a very rural PCN... we had to form a PCN with the practices that were geographically continuous, whereas for example in a big city or a big town in theory you would be those things would be diluted or you could pick and choose.' (Int1)

Barriers for smaller practices

Primary care networks also pose a particular challenge for smaller practices, some of which may be situated in rural areas. Smaller practices may be less able to adapt to meet primary care network specifications (e.g. extended hours access to general practice), based on limitations of staff and resources. As such, some interviewees commented that networks risked pushing out smaller practices, rather than supporting them to meet PCN requirements (Int2, Int19). Smaller practices were also reported by some to be potentially less able to allocate staff time to set up, operate or engage with the primary care network, and that there would be a disproportionate effect on a small practice if a partner wished to be the clinical director of the network (Int2, Int6).

'There's as much chance that a primary care network is hostile and says to a smaller practice, 'cause it is usually the smaller ones that can't stretch to meet those hours "You're not part of the team" as opposed to, "Well we'll help you and support you"' (Int19)

There was likewise a view among respondents that primary care networks might prove less beneficial to smaller practices, for where practices are paid through PCN funding on a per-patient basis, the remuneration may not prove to be enough to cover the costs associated with being part of the network (Int2, Int24).

'The PCN funding I think it depends who you asked isn't it? ... Your £1.76 that the individual practices have got it's great if you're a large practice. You are absolutely stuffed if you're a small practice because actually your level of commitment and work is exactly the same, but the funding is considerably less.' (Int24)

Along with these challenges, it was asserted by some respondents that there might also be increased sensitivity among smaller practices in terms of being susceptible to a take-over, as several interviewees recounted a history of smaller practices being taken over by larger practices in terms of the context surrounding primary care networks (Int1, Int3, Int19), together with a perceived government agenda of wanting more consolidation of practices into larger groups (Int9). This issue also came up in the context of voting arrangements within primary care networks, as one site struggled about whether votes should be distributed evenly across practices or by patient population (Int19, Int20).

'I'm a smaller practice and the two practice one is a huge practice. Their history is that they've taken over five smaller practices. If history were to repeat itself they would take over another... A bigger practice will see it as an opportunity to just firm up and make life really quite hard until a smaller practice gives up and goes away... I think for me the biggie is whether PCNs are going to be supportive of all practices or are they not.' (Int19)

Primary care network-level responses to Covid-19

The timescale of this study was such that fieldwork concluded just as the Covid-19 pandemic was gaining hold across the UK. Although the evaluation did not set out to examine collaborative responses to public health emergencies, the study team attempted to conduct short interviews with the gatekeepers at each case study site in order to gather information about each collaboration's response to Covid-19. In the discussion (Chapter 6) and conclusion (Chapter 7), we propose suggestions about longer term tracking of the role of primary care networks in relation to Covid-19, its further progression, and the changes to primary care service provision made rapidly in early 2020.

Site A

A follow up interview with the Site A gatekeeper informed the study team that the Covid-19 response had been “pretty good” with an integrated response alongside the clinical commissioning group, the extended hours access provider, and the local community trust. GPs were heavily involved in strategically planning a countywide response and the majority of practices were on board; however, some practices from neighbouring primary care networks developed their own localised approach. GPs from the primary care network and the clinical commissioning group were part of a virtual group to co-ordinate the response to the pandemic. These meetings were initially held thrice weekly (now once a week). The virtual group is now forward planning for a potential second wave. The appointment of their recent clinical director has significantly improved leadership and decision making within the primary care network, which was pivotal in order to move at speed and with decisiveness during the pandemic response.

Throughout the pandemic, the primary care network continued to deliver the Network Contract Direct Enhanced Service specification. Due to their county-wide approach, two ‘hot’ sites were set up across the local area to treat suspected Covid-19 patients, which saved primary care networks from setting up individual ‘hot’ and ‘cold’ sites. In addition, more clinical and non-clinical staff are volunteering to give their time to support primary care network initiatives such as supporting patients with suspected Covid-19 in nursing homes, people with learning difficulties, and cancer care.

The study team collected a number of documents generated by the primary care network to communicate operational and service-level changes related to the pandemic. These documents were a mixture of standard operating procedures, guidance and information, and updates covering the following: changes to outpatient services at the local acute trust, impact on patients receiving palliative care treatment, how to address safeguarding issues and how best to support people experiencing domestic abuse, and continued treatment for long-term health conditions (particularly those being ‘shielded’) as well as those living with mental illnesses. Finally, specific guidance was developed to help GPs acquire personal protective equipment (PPE).

In response to patient demand and access to primary care, the primary care network experienced a significant drop in patients requesting appointments with GPs, while those that did were happy with

video or telephone consultations and pleased with quicker than usual responses from their practice. Some GPs were reluctant to familiarise themselves with video consultations largely because they were inexperienced in holding these, required further skills training, and/or felt potentially out of their “technological comfort zone”. Unsurprisingly, as the pandemic lockdown restrictions eased, patients were starting to return and ask for face-to-face appointments, these patients being those considered to be “frequent users of primary care”. Lastly, communication between the primary care network and the wider local health economy had improved, along with a sense of togetherness. This had compelled the clinical commissioning group to complete its own evaluation of the primary care pandemic response, in order to explore what changes to primary care should remain beyond the Covid-19 pandemic.

Site B

The follow-up interview with the Site B gatekeeper revealed that since the evaluation study team had ceased data collection in March 2020, the super-partnership had expanded considerably, assuming a greater degree of control of the primary care networks within the super-partnership. This had led them to create one large primary care network covering a population of over 150,000 patients. Several practices that were not part of the Site B super-partnership were now members of the expanded primary care network, although these practices had not been part of the collaborative responses to Covid-19 that are described below. Since the super-partnership was now running a single large primary care network, primary care pandemic responses had been coordinated by the super-partnership.

In response to Covid-19, several Site B practices had been designated as “hot” and “cold” practices (with respect to suspected Covid-19 patients), and staff re-distributed between practices as appropriate. The super-partnership had also conducted a personal protective equipment audit of all practices and had conducted weekly staff absence and sickness audits to respond rapidly to early warnings signs of practice closure. A shared phone messaging system, virtual teleconference system and e-consultation service had been implemented across all practices, along with a shared communications system and a Covid-19 planning communications channel to share learning across practices (although it was noted that fewer than half of partners and fewer than 10% of staff had to date used the Covid-19 planning channel). The super-partnership had also provided guidance for general practices on routine services that could safely be suspended or altered during the pandemic,

as well as those that could be provided appropriately in the patient's home (either by a practitioner or by the patient themselves). It had however been at the clinicians' and practices' discretion to implement these changes to clinical practice.

It was reported that some of the positive changes that had been implemented at Site B would be continued after the pandemic, such as offering phone and video consultations for patients.

Site C

At Site C, the primary care network had continued to deliver as much of the national PCN service specification as possible, including: social prescribing, medicines optimisation, extended hours access, newly appointed musculoskeletal practitioners, and practice receptionists trained as care coordinators. In response to tackling the spread of Covid-19, a newly established pandemic response team with representatives from the primary care network (eight lead GPs), the clinical commissioning group, and the local trust, had been set up with the aim of delivering a co-ordinated response with regard to diagnosis/treatment of suspected Covid-19 patients.

More specifically, all eight practices within the primary care network had agreed to share staff to address the geographical challenges of treating patients during the pandemic and established two 'hot hubs'. At these two locations, patients with suspected Covid-19 were able to undergo tests for temperature, blood pressure and oxygen saturation through their car window before completing a face-to-face consultation. It was reported that the primary care network had helped with the co-ordination of the local response to the pandemic but that the most significant facilitator of collaborative working had been the pre-existing collaborative working in the area (familiarity with other staff across the network, understanding general practice working in the area, and having knowledge of local population health needs and challenges).

Lastly, despite the primary care network having introduced telephone consultation in the past six years, the pandemic had created a shift in patient opinions who were now more inclined to request digital consultations due to an unwillingness to come into practice. Increased availability of telephone (and video) consultations, coupled with a decrease in a patient demand for GP appointments had improved access to primary care services. Hence, almost three quarters of patients were now able to have some form of initial primary care contact within 24-48 hours (compared with 1-2 weeks prior to the pandemic).

Site D

At Site D, a slightly slower response to Covid-19 was observed in a non-participant observation in early March 2020 in which a primary care network board member commented that there had been no discussion at a board level regarding Covid-19 and that there seemed to be undue hesitancy in talking about it. Despite this initially hesitant response, the later follow-up interview with the Site D gatekeeper revealed that the primary care network had enacted a number of network-wide changes due to Covid-19, after a meeting with all GPs within the network later in March 2020 to re-model service delivery.

The primary care network had established one practice within the network as their 'hot hub' to lead Covid-19 related work and see patients who had potentially contracted the virus, while the other three practices remained open for routine general practice. The primary care network had purchased additional personal protective equipment, respiratory kit and individual cleanable consultation cabins to be used outdoors at the 'hot' practice. The network had also conducted a risk assessment exercise within the overall primary care clinical team to identify staff at an increased risk of Covid-19 related harms, and these staff had been prioritised to work in the 'cold' practices where possible.

The primary care network had increased their capacity to conduct video and telephone consultations for both routine and Covid-19 patients, and had implemented a network-wide communications strategy, informing patients of services within each practice. A GP coordinator had been appointed to help share learning and knowledge across the primary care network, and to help form links with acute care teams for patients requiring hospital admission or respiratory support. The Site D primary care network was asked by their local clinical commissioning group to provide 'hot hub' services for a number of surrounding practices outside the network, and saw Covid-19 patients from external practices during the pandemic.

Although the practices would in any case have likely implemented some forms of collaborative working during the pandemic, it was reported that without the formal primary care network they would not have been able to accomplish the same level of impact.

It was reported that the pandemic had meant that fewer patients had contacted their GP, giving clinical staff time for critical reflection and an opportunity to provide better personalised care to

complex patients by reducing the number of patients presenting with less acute issues. Clinical staff were also reported to have benefited from the technological resources and telephone triaging systems that were now available as a result of the pandemic, as well as rapid support from NHS Digital. It was noted however that non-clinical staff in the primary care network might have faced more significant challenges with changed ways of working and rotation between practices. The gatekeeper from Site D reported that the primary care network was likely to retain some of the positive Covid-19 related changes, such as the telephone triaging system and video consultations.

Summary

In the next chapter, we reflect on the findings of this evaluation of the implementation and early development of primary care networks, doing so in the context of our review of research evidence from over 30 years of GP collaborations, and examining the extent to which primary care networks are similar to, or distinctive from, their predecessor primary care organisations. This analysis is then used as the basis for drawing conclusions and making recommendations about the future direction of primary care networks (in Chapter 7).

Chapter 6: Discussion

Box 11: Key points from Chapter 6

Primary care networks are exhorted in policy to be central to NHS England and Improvement plans to enable: better integrated health and care services; more community-based provision of care; less reliance on hospital services; and a more population-focused approach to determining local health needs.

There is a paradox for primary care networks in that they are expected on the one hand to meet local population health needs, yet on the other face nationally-specified requirements to employ certain professionals and introduce defined services irrespective of whether these are considered most pressing in terms of local need.

Prior collaborations in some instances provided significant management and infrastructure support to the new primary care network, and organisational capacity to implement and run new networks required by NHS England and Improvement. How far prior collaborations prove able to provide ongoing support to primary care networks, and together become a force for change and influence in primary care remains to be seen.

This evaluation has revealed this tension between the desire for local professional autonomy and influence over the primary care network and the top-down nature of PCN policy. However, the variation in experiences reported across just four primary care networks indicates that there is in practice flexibility in how the new organisations have been implemented and the degree of freedom they have been afforded by their clinical commissioning group, and also by their constituent practices.

The clinical director role is emphasised strongly in PCN policy, and this was similarly evident in our evaluation case study work. The varying nature of leadership and management able to be provided by primary care network clinical directors raises a concern about the sustainability of these roles longer term, and the time commitment required of them presents a risk of burn-out and deciding to step down.

The allocation of a new source of funding that is channelled directly to general practice is viewed as offering greater security to local practices previously very worried about long-term sustainability, and in some cases as liberating, giving an opportunity to plan new services without some of the perceived constraints of waiting for the local clinical commissioning group to offer (or withhold) support.

A key aspect of rural primary care and general practice is that primary care networks in these areas may comprise a greater number of smaller practices, and arguably be accustomed to being more independent in how they work. Our rural case studies wished to pursue the PCN policy, but appeared to be finding it more challenging to coalesce as primary care networks, and develop a clear rationale and plan for new services.

The aim of this rapid evaluation study was to provide early evidence about the implementation of primary care networks in the NHS across England, with a particular focus on understanding what has helped or hindered their progress, how they operate in relation to pre-existing collaborations in general practice, and exploring issues for rural as compared with urban primary care networks. In this chapter we set out an overview of our evaluation findings, reflect on the robustness of our results, and distil lessons for the conduct of rapid evaluation studies.

Overview of case study findings

Purpose of primary care networks

Primary care networks are exhorted in policy to be central to NHS England and Improvement plans to enable: better integrated health and care services; more community-based provision of care; less reliance on hospital services; and a more population-focused approach to determining local health needs. In this, primary care networks are very similar to many prior iterations of GP collaborations in the UK and overseas.

This evaluation has revealed that those working to implement and run primary care networks largely support the overarching policy aims set for them, and general practices across England have seized the opportunity to access new funding to form networks. However, many GPs and their teams may place a higher priority on matters of particular pressing concern to those working in general practice and primary care, namely those related to enhancing the sustainability of primary care itself and improving the availability and coordination of local primary care services. The challenges facing general practice in terms of workforce scarcity, rising demand for services, and falling job satisfaction on the part of GPs and their teams were acknowledged in the NHS Long-Term Plan⁸, and seem to underpin the formation of primary care networks alongside other motivations such as increasing integration of health and social care. At times, these potentially conflicting aims of primary care networks were a source of frustration among those charged with their implementation, as it was not always possible to work towards increased integration of the health and social care system while also working towards addressing sustainability and workload-related concerns for GPs.

There is a paradox for primary care networks in that they are expected on the one hand to meet local population health needs, yet on the other, face nationally-specified requirements to employ certain professionals (e.g. pharmacists, social prescribers) and introduce defined services (e.g.

enhanced health care in care homes) irrespective of whether these are considered by primary care network leadership teams to be the most pressing in terms of local need. This paradox was a significant source of tension within our evaluation findings, with a rich and varied mix of views about the purpose of primary care networks, sometimes positive and supportive of the national approach, and at others frustrated at having to toe a government line in order to receive new funding, reportedly feeling that the 'PCN policy' had been imposed upon general practice in a rather rushed manner.

There was, however, evidence of primary care networks enabling general practices to come together to share services and create collective solutions to long-standing problems related to the sustainability of primary care. This included new practice-based pharmacy support and reviews for people using multiple medications, the opportunity to work together to provide extended hours access to general practice, and sharing 'back office' administrative and management support, including for human resources and training purposes. However, as with the paradox referred to above, networks often reported that they felt that new services were only likely to benefit a relatively small number of patients, and as nationally-specified, were sometimes considered 'must do's' from on high, rather than a reflection of the main priorities for the local population and primary care teams, something that was a particular concern for rural primary care networks.

In addition, there were 'soft' benefits of getting to know other practices, finding support at a time of policy turbulence (Brexit, the NHS Long-Term Plan and then the Covid-19 pandemic), new GP leaders emerging from within the clinical community, and feeling the value of long-awaited investment in primary care and its services. These positive aspects very much echo the wider international experience of GP collaborations, where 'strength in numbers' becomes a key feature of primary care organisations, along with mutual support, shared expertise and opportunities for new clinical leaders and practice managers taking on wider responsibilities.

Prior GP collaborations

In all four case study sites, the new primary care network was established in the context of a prior GP collaboration. This is unsurprising, given that the Nuffield Trust and RCGP established in 2017 that over 80% GP practices in England were part of one or more collaborations, including GP federations, super-partnerships, locality groups, or community health organisations. This complex

organisational landscape was reflected in our evaluation fieldwork. For example, where respondents described a particular service innovation or other success, it was often attributed to previous forms of local GP collaboration, with the primary care network seen as a way of sustaining or extending such development, especially where practices were collaborating for the first time (in the primary care network).

Prior collaborations in some instances provided significant management and infrastructure support to the new primary care network, as well as organisational capacity to implement and run new networks as required by NHS England and Improvement. This echoes the experience of independent practice associations (IPAs) in New Zealand providing management support for nationally-mandated primary health organisations in the early 2000s, which was both pragmatic on the part of the primary care community, but also an attempt by IPAs to 'survive and thrive', which they did, and have been able to provide important capacity, leadership and support for New Zealand primary care more generally⁵¹.

Although in the English NHS some primary care networks have been able to utilise the management support and organisational capacity from prior collaborations, the mapping of prior collaborations to new primary care networks has not been straightforward. For example, primary care networks are expected to be geographically contiguous, whereas federations, super-partnerships and other such organisations are typically 'coalitions of the willing' based on a shared vision or set of goals, and draw from an often wide and dispersed area. Indeed, in our case study sites, the primary care network was sometimes regarded as an additional bureaucratic burden, including in respect of meetings, hiring staff and handling budgets and contracts. Where the boundaries of prior collaborations and primary care networks did not align, the support provided by prior collaborations was at times contentious, particularly for PCN members who were not part of prior collaborative working arrangements. How far prior collaborations prove able to provide ongoing support to primary care networks, and together become a force for change and influence in primary care (as in New Zealand) remains to be seen.

What is clear is that three decades of increasingly frequent and intense collective working in general practice have made collaboration – for a majority of practices – the usual way of operating. Our evaluation revealed hardly any fundamental protest or disagreement about the value of and need to

work in collaboration with other practices, whether for service planning and development, or to share administrative and management support. What was notable, however, was the extent and depth of involvement of prior collaborations in primary care networks. In two case study sites (Site A and Site B), the prior collaboration (a super-partnership) was in effect running the primary care network with some resistance from practices not in the super-partnership. In another case (Site C), the prior collaboration (a neighbourhood focused on integrated care) clashed with the new primary care network (focused more on the sustainability of general practice), and in the fourth case (Site D) the prior ways of collaborative working simply morphed into a more formal collaboration through the establishment of the network.

In similar vein, the capacity, expertise and experience of prior collaborations was often highly valued by those in new primary care networks, saving time and offering useful learning for the new organisation. There were, however, some reservations – particularly in practices that had not been part of the prior collaboration – of being ‘taken over’ or subsumed into something they had not previously wished to join, thus reflecting the well-documented culture of autonomous general practice. Furthermore, the existence of parallel primary care collaborations does entail some overlap of functions and management support, and this evaluation revealed some early concerns about the transaction costs of this ‘dual operation’.

In most cases however, it was clear that primary care networks were working out with prior collaborations how best to clarify respective roles, responsibilities, and source of organisational support. This is something that has been experienced by many collaborations cited in the research literature, for GP-developed and –owned collaborations often sustain and thrive alongside new government-instigated primary care organisations, which our evaluation suggests is likely to be the case with primary care networks. Evidence from prior GP collaborations, including total purchasing projects⁶¹ and primary care groups and trusts⁴⁴ underlines the importance of having such clarity of roles and functions, and the challenge of attempting to determine the precise nature of transaction costs and hence any duplication. Primary care networks, as with their antecedents, build on and learn from previous primary care collaborations, and need to be attentive to roles, functions, and governance (and the cost of these) as they work alongside one another. In particular, they have to determine their own distinctive role in funding, planning and running primary care services, and how

this fits with the functions and remit of the clinical commissioning group, and (where relevant) the activity of the pre-existing GP collaboration(s) in their area.

Ownership of and engagement with primary care networks

Primary care networks are fundamentally about the bringing together of GP practices into wider networks, albeit they are quite small in scale compared with many prior GP collaborations. The smaller scale of the primary care network, comprising sometimes just a few practices, means that the potential for close engagement of GPs and their teams with the network is significant. Evidence on GP collaborations points to the importance of the scale of the collaboration for the 'ownership' and engagement of professionals with the network, federation or super-partnership¹⁶. The other key factor in the research literature in respect of practice and GP engagement with collaborations is the need for GPs to consider the cross-practice organisation as 'theirs' and ideally to have an active role in creating these organisations, as opposed to being required to form them by a funder or planning body^{12, 16}.

This evaluation has revealed this tension between the desire for local professional autonomy and influence over the primary care network and the top-down nature of national PCN policy. This is clearly something that is built into the policy design, given it is a nationally mandated scheme intended to accomplish national health priorities as part of a significant investment in primary care and general practice. However, the variation in experiences reported across just four primary care networks indicates that there is in practice flexibility in how the new organisations have been implemented and the degree of freedom they have been afforded by their clinical commissioning group, and also by their constituent practices. In this way, despite some frustration about having to focus on national priorities, primary care networks are proving fleet of foot in developing something of a mosaic of organisational forms – echoing the metaphor used in work on primary care-led commissioning nearly 25 years ago¹⁰⁴.

Taking time to clarify roles within the primary care network, and to develop shared goals and objectives for the work of the collaboration, emerged from this evaluation as an enabler of progress, and of positive working relationships within and beyond the network. For some respondents to our evaluation, time and resource for organisational development across practices and with other primary care services was important, including through staff awaydays, joint training events, and

forums for practice managers and/or nurses from across the primary care network. This comment echoes the sentiment expressed in this study, yet could come from any one of countless prior evaluations of collaborations in general practice and primary care: “I think the biggest challenge was getting twelve practices together who have worked differently to suddenly think about working as one organisation, and there’s still ongoing work with that around the culture of being part of one organisation” (Int15). The fact that this remains an issue after 30 years bears witness to its profoundly important nature – cultural change within primary care is complex and often fragile, reflective of the typically small and independent nature of the constituent practices.

Leadership and management

The need for effective leadership of the primary care network, together with sufficient high-quality management support, was a strong theme in the evaluation fieldwork, and one prefigured in the prior research evidence about enablers of successful GP collaborations. In the case study primary care networks, it was clear that although small organisations, they need a significant range of administrative and management capacity and skills, including finance and accounting, human resources, information technology, staff engagement, and governance support. Resourcing such capacity and skills for a collective of a few practices is a considerable challenge, and hence it is not surprising to find a diversity of approaches, sometimes involving prior collaborations as described above, and in other cases entailing shared roles for administration and management or accessing additional expertise from the local clinical commissioning group or NHS trust.

In terms of management challenges for primary care networks, the time required for meetings, recruitment of staff, implementing new roles and services alongside core services, and administration and management of the network were of particular note. The time pressure for those involved in primary care network development was reported as an acute concern, especially for clinical directors and practice managers having to do this on top of their usual ‘day jobs’. The clinical director role is emphasised strongly in primary care network policy, and this was similarly evident in our evaluation case study work. The varied quality of leadership and management from primary care network clinical directors that was reported by respondents to our evaluation raises a concern about the sustainability of these roles longer term, and the time commitment required of them presents a risk of burn-out and deciding to step down, something that had already happened in one of our case studies, and was reported as a worry in another. As primary care networks move forward and take

responsibility for running a wider range of integrated health and care services, they will likely need to have a more distributed approach to leadership and management, perhaps sharing the clinical director role (or elements of it) with other clinicians in the network, and/or also employing a non-clinical general manager to provide professional management support. This general management may come from one or more local practice managers, or from a clinical commissioning group or trust.

The management challenge for primary care networks is complex and sophisticated, especially for new and small network-based organisations, and research evidence consistently points to the difficulty of bringing about new forms of integrated care¹⁰⁵, something that is a key ambition within national PCN policy. It was striking in this evaluation to find that just a few months into their operation, primary care networks had undertaken collective management work including: implementing innovative ways of increasing extended access to primary care; hiring a range of new professionals to deliver services such as pharmacy and social prescribing; sharing back office functions such as accounting, Quality and Outcomes Framework data reporting, and Care Quality Commission registration; setting up shared triage for access to allied health professional services; and organising awaydays, training, and other engagement activity. There were a range of concerns and frustrations about management and leadership, and it seemed that the quality of management available to primary care networks was varied, albeit they were often able to draw on the capacity and expertise of prior collaborations. They were however largely accustomed to some form of cross-practice working, and had clear ideas about what was needed for the next phase of development.

The role of funding and incentives

A strong and consistent message across our evaluation fieldwork was that primary care networks have been established in a near universal manner as a result of NHS England and Improvement using them as the mechanism through which to offer new funding to general practice. Whilst NHS general practice has had prior experience of new forms of contract being offered for collective service commissioning and provision – most notably Total Purchasing Projects in the 1990s and Personal Medical Services schemes in the 2000s (see Chapter 3 - Evidence Review) – this is the first time that there has been what is effectively a national mandate for practices to hold a joint cross-practice contract to receive new funding. This use of funding to incentivise different forms of organisation, planning and service delivery is, in cultural and organisational development terms, radical for

general practice, and has the potential to revolutionise or destabilise the way in which practices operate.

The allocation of a new source of funding that is channelled directly to general practice, rather than through an intermediary organisation such as the clinical commissioning group or sustainability and transformation partnership, is clearly welcomed in principle by most practices, fulfilling the promise in the NHS Long-Term Plan to invest in primary care. Our evaluation revealed that for some, this investment is viewed as offering greater security to local practices previously very worried about long-term sustainability, and in some cases as liberating, giving an opportunity to plan new services without some of the perceived constraints of waiting for the local clinical commissioning group to offer (or withhold) support. This was encapsulated in the reflection 'so it's us, we're deciding what is best for general practice and what is best for our patients' (Int20).

Others, however, reported that the experience of setting up the primary care network, establishing cross-practice working, and having largely to use the new resource to deliver services required by NHS England and Improvement, has led to frustration, disappointment, and even talk of leaving the network. This view was typically based on an assessment of the amount of work (and hence resource) entailed in setting up and running a primary care network and its shared services, and the burden experienced by practices 'losing' GP and management time to support the network. This was reflected in the comment 'I can't really see that there is much in it for us at the moment' (Int1). In this way, the allocation of new resource reflects the paradox and tension evident in the purpose of primary care networks, one that can be conceptualised as liberating or constraining, bottom-up or top-down, an issue to which we return in the discussion below about primary care networks' relationship with the wider health system.

Money as a metaphor for wider dynamics within general practice organisation is something that has been explored in the international research literature, including in relation to the charging and subsidising of user fees for general practice consultations in New Zealand¹⁰⁶ and the allocation of budgets to physician groups in the USA and UK⁴⁹. Our early evaluation of primary care networks indicates the need to explore further the tension between budget-holding as freedom or constraint as these new organisations take on a wider range of responsibilities over the coming years, together with larger budgets.

Relationship with the wider NHS system

The development of primary care networks represents a shift of responsibility for the allocation of part of the funding for primary care service development away from the clinical commissioning group to a collective of practices, something that will be important to track as time goes on and primary care networks assume increasing levels of funding to provide a wider range of additional services. Whilst this accords with the policy narrative of empowering and strengthening primary care to deliver a wider range of integrated health and care services, it will change and challenge elements of how clinical commissioning groups work with their local general practices. Our evaluation reveals how much the relationship between a clinical commissioning group and a primary care network can vary. In some instances, respondents reported that clinical commissioning groups have clearly enabled and supported primary care networks, providing resource and expertise to help the establishment of inter-practice working, the hiring of new staff, and the operation of contracts. In others areas, however, it was reported that the clinical commissioning group was attempting to hold onto control, exerting close monitoring of budgets and spending decisions, and not operating within the spirit and expectation of the overall primary care network policy.

This tension between a budget-holding primary care organisation and its funding or authorising body is widely reported in the research literature from the UK and internationally, as noted in Chapter 3 (Evidence Review). This issue appears as a particular fault-line in those countries with a nationally-funded health system, yet with more independent general practice in the business or partnership model, namely New Zealand, Australia, Canada, Netherlands and the UK. This is likely a result of an inherent clash of organisational cultures within the health system, the one national, collective and tending to bureaucratic roles and control, and the other more small-scale, responsive, and prone to locally-determined decisions among a small group of business partners¹². This appears to play out again with primary care networks, with comments in our evaluation such as ‘they [GPs] appear to be distrustful of everybody and they want to be independent,’ (Int18) and others alleging that the local clinical commissioning group had withheld development funding for primary care networks which had been allocated by NHS England and Improvement. The perhaps inevitably awkward position of a regional or district funding body in a health system with regard to how to relate to GP collaborations, was evident from the comment in this study ‘Everybody has frustrations, don’t they, with the CCGs on the whole’ (Int24).

It is important to note that this evaluation took place during the first nine months of operation of primary care networks, and hence they were still very much in their formative phase and were learning not only how to work as a collective of practices, but also with their clinical commissioning group(s), local NHS trusts, and other partners such as community pharmacies, third sector organisations, social services providers and others. The varying nature of the relationship between a primary care network and the local clinical commissioning group(s) was not therefore surprising, and has been reported in other studies such as those of GP-fundholding¹⁰⁷, Total Purchasing Pilots⁶¹ or primary care groups and trusts^{44, 108}. This may reflect the increasingly common presence of collaborative working in English general practice^{16, 67} and an associated increase in trust between general practice and local commissioning or funding bodies.

The experience of rural primary care networks

Two of our case study primary care networks were in rural areas, one was semi-rural, and the fourth was on the edge of a conurbation and abutting rural communities. The study set out to examine the experience of rural primary care networks to fill this gap in the literature, given that prior evidence suggested that case studies of GP collaboration are more frequently drawn from urban settings.

There was a theme in our fieldwork of primary care network policy being considered by those in more rural areas to be one developed with urban practices and collaborations in mind. For example, national policy dictated the expectation of recruiting new professional staff for a primary care network on the basis that they would deliver services for patients across the network, but the challenges of geography, travel time (for staff, patients and carers) and public transport made this much more difficult in rural areas. Also, whilst people in rural areas are used to having to travel a distance to access health and other public services, they are typically less keen to travel to primary care hubs or specialist services to be seen by providers other than their own GP. Our study took place prior to the emergence of the Covid-19 pandemic, but it will be interesting for further evaluations of PCNs to explore how far innovations with phone, digital and video consultation – as described in Chapter 5 (Findings) - will have taken root in rural areas, what appetite there is among rural and/or elderly populations for these approaches, and what role primary care networks will play longer term in sustaining and developing such services.

A key aspect of rural primary care and general practice is that primary care networks in these areas may comprise a greater number of smaller practices, and arguably be accustomed to being more independent in how they work, as a result of being 'on their own' and having to serve a wider range of health and care needs, with less easy access to specialist and other support Palmer et al (2019) Rural health care: A rapid review of the impact of rurality on the costs of delivering health care¹⁰⁹. Furthermore, some aspects of the primary care network national specification may already be taking place in rural areas, causing confusion about how services may need to adapt to fit with primary care network policy. For example, practices in rural areas often have dispensing rights, and in effect work as integrated general practice and pharmacy services, and may be more likely to already have been providing support to care homes. Our rural case studies wished to pursue the primary care network policy, but appeared to be finding it harder to coalesce as networks, and develop a clear rationale and plan for new services. Rurality is an aspect of primary care network development that we suggest should be examined in more depth in future evaluations of these networks and other primary care innovations, as with the BRACE Centre study of hospitals managing general practice¹¹⁰ where a follow-up phase of research is planned.

Maturity of development of primary care networks

Primary care networks had been established for just a few months when fieldwork for this rapid evaluation study was undertaken. Despite this, it was of note that all the case study sites had established governance arrangements, developed plans for local service development, and recruited (or taken steps about how to recruit) new professional staff to deliver primary care network services as required by NHS England and Improvement service specifications. There were inevitable frustrations as practices within primary care networks 'formed, stormed and normed'¹¹¹ but there were clear signs of them starting to achieve operational success as new organisations.

The reasons for this relatively swift organisational progress appears to be in part the existence of prior GP collaborations which have been able to support the establishment of primary care networks. Furthermore, for some, the local clinical commissioning group or an NHS trust has been able to offer management advice and support. More generally, it would seem that general practice in the NHS in England is demonstrating the way in which it has moved, over the past 30 years, to a much more collective and collegial way of working, whereby the forming of new networks is not as

troublesome and challenging as with say GP-fundholding in the 1990s, or primary care groups and trusts in the early 2000s.

Perhaps the main challenge facing primary care networks in terms of their ability to deliver on the many policy expectations placed on them will be the way in which they are able to respond to the complex and uncertain context of the Covid-19 pandemic in 2020 and after. We know from follow-up fieldwork with case study gatekeepers that primary care networks have provided vital support for practices, and a basis for planning rapid service innovations such as on-line and phone access to primary care, enhanced health service support to care homes, and 'hot hub' centres for patients suspected of having Covid-19 symptoms. How far these developments are sustained longer term, and the role of primary care networks in enabling or inhibiting this, remains to be seen, and will be an important matter for further studies in this area.

Primary care networks in a time of Covid-19

Fieldwork for this evaluation concluded just as the Covid-19 pandemic was emerging in the UK. As such, we have limited evidence (gathered via follow-up interviews in July 2020 with our gatekeeper contact in each case study primary care network) about how the four case study sites reacted to the pandemic and the extent which the primary care network proved helpful or otherwise as changes to general practice service provision were made in response to Covid-19. Given the reported rapid and extensive changes to the mode of delivery of many general practice services – typically moving from face-to-face to phone or on-line¹¹² – it will be interesting longer term for researchers to examine the role of primary care networks in supporting and enabling such change, and reviewing whether it should be sustained following the pandemic. Likewise, it will be useful to explore how far practices might have retreated into their own teams in a time of emergency and needing to make rapid changes to workforce and other service delivery issues. Another area of interest might be the ways in which primary care networks and practices have worked with other NHS organisations, social care, and the voluntary sector as part of wider community support efforts intended to support people during pandemic lockdown. Finally, in relation to the focus on this evaluation on GP collaborations, the extent to which a pre-existing GP collaboration was instrumental in providing support to primary care as it faced the need for urgent change, or if this was more focused on the new primary care network collective.

Reflection on robustness of results

The study team completed this mixed methods comparative evaluation following established methodology and guided by previous evidence of implementation studies, while engaging iteratively with published literature. The robustness of our findings has been shown in a number of ways throughout our evaluation. We used a rapid assessment of the evidence on GP collaborations to establish the key elements of such organisational arrangements, and specifically to identify where there remain gaps in the research evidence. These evidence gaps (see Chapter 3) informed our scoping of case study research and in particular the precise nature of questions posed. The use of triangulation¹¹³ (collecting data through interviews, non-participant observation, online surveys and documentary analysis) enabled the team to develop a comprehensive understanding of the barriers and facilitators associated with the implementation and early development of primary care networks.

First, we interviewed a range of stakeholders across primary care, but more specifically those involved with establishing a strategic direction and providing leadership with regard to primary care networks, seeking to fill gaps identified from our rapid evidence review. Second, we were able to capture rich detailed accounts, being privy to a number of discussions and decision-making processes in our non-participant observations. These varied data sources permitted the evaluation team to reach what we considered to be adequate saturation¹¹⁴.

Throughout the evaluation, the team made use of member validation¹¹⁵ with regard to data collection, analysis, write up and checking of research questions, and emerging findings. The team held a number of meetings with NHS England and Improvement, and Department of Health and Social Care primary care policy leads, to share early learning and seek insights into evolving policy about the implementation of primary care networks. A summary of project findings was circulated to case study sites during the drafting of this report, allowing sites an opportunity to reflect and comment on the findings, and add insights about the work of primary care networks in a time of pandemic.

The evaluators sought to establish good rapport with gatekeeper managers in the case study sites which assisted with data collection. However, data collection proved challenging at times given the pressures faced by primary care in a changing policy context, and there was a need for adaptability

within the evaluation team and approach as described in Chapter 2 (Methods), including greater use of observation of meetings, to compensate for some interviews that could not be secured. During analysis, we adopted novel approaches to expedite interpretation and synthesis of findings, for example by discussing case study summaries during online digital team workshops, allowing for open discussion and cross analysis.

Overall, there was a need for the evaluation team to be responsive to the changing policy context, most specifically in shifting the focus of the research away from all GP collaborations towards the implementation of primary care networks in particular, albeit the relationship of prior collaborations with new networks formed an important theme in the evaluation.

Limitations of our findings

There were a number of limitations to this rapid evaluation. As noted above, gaining access, arranging and completing interviews proved difficult in all four case study sites. This delayed data collection considerably, and more interviews and observations were completed in some sites than others. In particular, the team were restricted to completing only one interview at Site D. Yet, a number of meeting observations were completed while a high number of participants from Site D responded to the online survey that strengthened our findings. On reflection, rather than pursuing data collection using interviews, it would have been preferable to distribute the online survey earlier, despite a low response rate.

There are a number of reasons which might explain why we encountered such difficulties with data collection and access. First, the study team intentionally approached cases study sites without a prior history of taking part in research/evaluation and those with well documented challenges in delivering primary care services. Therefore, our sites may have underestimated the time involved in taking part in a formal research study. Second, data collection commenced when primary care networks were first registered, which was a difficult time for the set-up and implementation of network-based collaborative working and therefore many case study sites deprioritised the need to complete interviews in the short term. Third, towards the conclusion of fieldwork in early 2020, a number of scheduled observations were cancelled at short notice while a number were postponed due to the onset of the Covid-19 pandemic. Nevertheless, one case study site continued to give

study team access to documentation relevant to service level changes arisen due to the pandemic (which has been presented in Chapter 5 - Findings).

The evaluation took nine months longer than originally anticipated in the original study protocol. The delay was, in part, due the study team shifting focus. The initial premise for the evaluation was to explore primary care collaborations, and the study team (with input from the BRACE Centre steering group) shifted focus to evaluate primary care networks, in order to be responsive to emerging NHS policy. This shift had a considerable impact on sampling and recruitment of case study sites whereby the initial aim had been to ascertain a maximum variation sample of case study sites by type of GP collaboration. Ultimately, this resulted in super-partnerships and primary care networks with a prior history of collaborative working forming our final sample, which might not be as representative of current general practice where some primary care networks are formed of practices with no experience of collaboration.

Despite these challenges, there is strong substantive learning from our evaluation in relation to the early implementation of primary care networks, particularly given the research team's responsiveness to changing primary care policy and ability to complete data collection during the Covid-19 pandemic.

This evaluation project had relatively limited patient and public involvement, notwithstanding input from BRACE Health and Care Panel patient/public members to our project design workshop in November 2018, and one of these colleagues undertaking peer review of the full study proposal. The study team kept BRACE Health and Care Panel members updated about project progress through quarterly e-bulletins, and we presented a full update of the study and its emerging themes at a Health and Care Panel workshop in Birmingham in September 2019, seeking advice and challenge about the focus of the project, and its likely dissemination.

In addition, project updates were shared on a four-monthly basis with members of the BRACE Steering Group, which includes Charlotte Augst (Chief Executive of National Voices, the network that represents health and social care user organisations in the UK) who, in May 2020, advised the study team to undertake further interviews about the impact of Covid-19 on primary care networks. The study team recognises the drawback of not involving GP practice patient participation groups in our case study data collection. However, understanding the patient experience of general practice since

the introduction of primary care networks and the subsequent changes introduced because of Covid-19 may be explored in forthcoming BRACE Centre evaluations.

In conclusion, despite using multiple methods for data collection, additional interviews and observations would have strengthened the robustness of our findings. Lastly, due to the onset of the Covid-19 pandemic occurring during project write-up, the team were unable to undertake planned site-specific and overall face- to-face workshops with policy experts. The team did however share a concise slide deck of the project findings with each site in June 2020 without the obligation of providing comments, and offered to give a seminar (in virtual form) to each site later in 2020 or early 2021.

Lessons about the conduct of rapid evaluations

We have summarised some of the main lessons learned from our experiences of conducting a National Institute of Health Research-funded rapid evaluation below:

- 1) Responsiveness:** at the request of our funders (NIHR HS&DR) the team was responsive to immediate national policy changes to support learning in relation to the implementation of primary care networks in England. The team completed a rapid evidence assessment as opposed to a formal systematic literature review which saved time and resources, but the quality and breadth of relevant evidence was limited. The evaluation has taken longer to complete (nine months longer than stated in the original protocol) because of challenges with recruiting suitable case study sites (at a time of national policy changes) and arranging data collection. The onset of the Covid-19 pandemic has been detrimental to sharing real-time feedback to case study sites especially with those sites seeking to learn from our findings to inform their primary care network implementation strategy. There was also difficulty in determining whether our study should be categorised as research or a service evaluation using the Health Research Authority (HRA) online algorithm.
- 2) Relevance:** there has been continued and close collaboration with the BRACE Health and Care panel (which includes members of the BRACE patient and public involvement group) to discuss the priority of our evaluation, comment on our participant facing material (e.g. information sheets), and listen to our emerging findings. The involvement of key stakeholders and policy experts in the project design ensured the team answered the most

appropriate research questions with regard to current health policy changes. However, collaboration from stakeholders has been largely consultation rather than co-production.

- 3) **Rigour:** throughout the evaluation the study team have shared early insights with regard to the conduct and learning of their rapid evaluation with colleagues from NHS England and Improvement, Department of Health and Social Care, researchers at the University of Manchester, and policy experts. The team engaged iteratively with theoretical and policy-relevant literature throughout the design, data collection, and analysis/interpretation stages of the evaluation. Online surveys, designed for primary care colleagues, were member checked by two GPs before dissemination. During data analysis, there was appropriate use of online workshops to add rigour to analysis and interpretation.

Chapter 7: Conclusion and implications

This evaluation of the early implementation of primary care networks provides a rich source of learning about the implementation and early development of primary care networks in four case study sites in England. The data collected through this evaluation provide policy-relevant insights for each of the research questions that formed the basis of the evaluation. The evaluation research questions are set out in Box 12 below, followed by a short explanation of how each question has been addressed.

Box 12: Evaluation research questions

- RQ1: What was the contextual and policy background within which primary care networks were introduced?
- RQ1.1: What were the pre-existing forms of GP collaborative working across primary care in England?
- RQ 1.2: How have new primary care networks been implemented in a sample of urban and rural settings?
- RQ 1.3: How do new primary care networks relate to pre-existing GP collaborations?
- RQ2: What are the rationales and motives for general practices to enter into GP collaborations, including new primary care networks? In particular, what role do financial incentives play in facilitating or inhibiting collaboration? What are the expected outcomes for primary care networks?
- RQ3: What evidence exists about the positive or negative impacts associated with different experiences of establishing GP collaborations and how do these relate to newly formed primary care networks?
- RQ4: What appear to be the barriers to and facilitators of effective collaboration across GP practices, both with respect to successful and unsuccessful collaboration, and achieving impact or not?
- RQ5: What does the analysis of prior experience of GP collaborations, and the early implementation of primary care networks, suggest in terms of the likely progress of these networks in the NHS in England, including in light of the Covid-19 pandemic and associated challenges?

Evaluation findings

We found that primary care networks have been implemented in the context of many well-established ways of formal and informal collaborative working in general practice across rural and urban settings. In some cases, these previous collaborations provide much-needed support in terms of management, leadership and infrastructure, although they can also be a source of tension within

primary care networks where interests, goals and ways of working of the prior collaboration and new network do not necessarily align (RQ1.1-1.3). Reasons for collaborative working in general practice typically focus on wishing to enhance the sustainability of primary care and offer better integrated care for patients, although the reasons cited for joining or forming a primary care network were often more narrowly focused on policy and financial incentives, indicating the top-down nature of network formation (RQ2).

At the time of writing this report (June 2020), it was too early to determine the impact of primary care networks, but early evidence points to operational success in networks in terms of setting up managerial structures, hiring for new roles, and providing integrated services as set out in the national primary care network specification. There was also evidence that primary care networks can address sustainability issues in primary care by bringing in new funds, creating efficiencies such as shared back-office support functions and increasing managerial and leadership capacity. Furthermore, it was striking that all of this had been achieved in just nine months, with almost all practices remaining in their primary care network, suggesting that networks have been able to form, plan and mobilise more swiftly than most of their predecessor primary care organisations, and we posit that this is due in part to the experience and support of prior GP collaborations.

Primary care networks have however caused some negative impacts such as increased workload and organisational tensions, particularly in the initial set-up phase as they worked out managerial and decision-making processes, and practices negotiated the role of networks in a landscape of previous collaborative working arrangements (RQ3). In terms of facilitators of and barriers to the operation of primary care networks, we found that effective management and leadership, particularly with respect to having a committed clinical director who is able to take on the role for the medium to longer term, and constructive relationships with CCGs and trusts are important in ensuring the success of primary care networks.

It is essential for primary care networks to build on the success of previous collaborations in general practice rather than un-doing their work, and to explore and build a new shared understanding of the goals of networks in the context of prior collaborations. For example, there seemed to be some tension among respondents to this evaluation as to whether the central purpose of primary care networks is to reduce GP workload and improve sustainability of primary care or to improve

integrated care for patients. In rural areas, there was evidence of particular barriers to the establishment and operation of primary care networks such as a perceived lack of fit with aspects of the national primary care network specification and local capabilities and needs, alongside existing challenges of providing primary care to rural populations (RQ4). What is clear is that primary care networks will need to be able to handle multiple and at times competing priorities set by NHS England & Improvement, together with seeking to meet the needs of local practices and patient populations. Critical to this will be having sufficient policy and organisational headroom to make choices about service priorities, and adequate management support to get the work done.

Weighing the evidence from this evaluation and from previous experiences of GP collaboration within the English NHS, it seems that primary care networks have significant potential in terms of increasing sustainability in primary care and delivering integrated health and care services to local populations. The case study sites examined in this evaluation have mobilised quickly, focused on seeking to achieve the expectations set out in national primary care network policy, and all at a time of a complex and shifting political and societal backdrop (Brexit, NHS Long Term Plan, Covid-19). To realise the full potential of primary care networks, it will be important to increase commitment on the part of local GP practices and wider community health and care teams to their local network, build managerial and leadership capacity, and clarify the role of previous GP collaborations within the primary care network landscape, which is explored in more detail in the recommendations below. Primary care networks provide a potentially powerful and effective mechanism to coordinate primary care responses to the Covid-19 pandemic in England, including new forms of service delivery that are resilient to health emergencies, playing a role in public health testing and tracking, and supporting vulnerable patients and families needing to be 'shielded'. Follow-up research is needed to understand better how primary care networks have responded to the pandemic so far, and their role in enabling new forms of primary care service provision in a post-Covid-19 England (RQ5).

Implications for decision makers

The implications of our evaluation for those at a national and local level making decisions about primary care network policy and development are summarised in Box 13, organised into three categories, and are explained in more detail below. These implications are directed mainly at national decision makers, and in particular those related to the engagement, and the role of primary care networks in the wider health and social care system. Those relating to leadership and

management capacity are directed primarily at local decision makers, albeit they will likely require resources and expertise from a national level to support primary care network development activity.

Box 13: Implications of evaluation findings for primary care network decision makers

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| <p>Increasing the engagement of GP practices and wider primary care teams with primary care networks</p> <ul style="list-style-type: none">• There is a need for consistent long-term national policy about primary care networks and other forms of GP collaboration that allows for local diversity of size and form of network, also avoiding the temptation to merge or reorganise primary care networks• It is important that realistic and clear goals are set for primary care networks against which the performance and progress of the networks can be measured• Efforts should be made to ensure that primary care network policy is compatible with both rural and urban area primary care delivery <p>Building leadership and management capacity</p> <ul style="list-style-type: none">• It is important to build on the experience and expertise of pre-existing GP collaborations• There is a need to ensure sufficient and distributed management and organisational support for the primary care network clinical director role• Ensure that the wider primary care team is able to be part of primary care network leadership. <p>Clarifying how primary care networks fit into the wider health and social care system</p> <ul style="list-style-type: none">• It would be helpful to revisit the role of the primary care network in the context of the health and care system as it emerges from the Covid-19 pandemic• Ensure that primary care networks are monitored and performance-managed in a way that enables them space and permission to develop and pursue local priorities within the context of a national framework• There is a need to clarify the role of clinical commissioning groups in relation to primary care networks |
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Increasing the engagement of GP practices and wider primary care teams with primary care networks

Increasing the commitment by general practices and others in primary care to primary care networks will be important in ensuring that the full benefits of networks can be realised. Some

practices are inevitably (at this set-up stage) still running a dual-system in which resources are spent up-front on the implementation and management of primary care networks without realising the full benefits of communal working. Increased engagement in primary care networks will also help address tensions around the autonomy of general practice alongside a desire to collaborate with other practices, which were found in this evaluation, and which have been a historical tension within the experience of GP collaborations in the UK and internationally. Based on our evaluation findings, we propose the following that may help increase engagement in primary care networks among practices and others involved in the delivery of primary care services:

- **There is a need for national decision makers to ensure consistent long-term policy about PCNs and other forms of GP collaboration, allowing for local diversity of size and form of network, and avoiding the temptation to merge or reorganise primary care networks:** The NHS has historically made frequent changes to policy about primary care planning and commissioning, which has caused some lack of trust among primary care practitioners consulted in this evaluation about whether primary care networks will be an enduring policy and one in which it is worth investing significant time, commitment and engagement.
- **It is important that national decision makers and local clinical commissioning groups set realistic and clear goals for primary care networks:** There is currently some tension within the primary care networks included in this study as to whether they should be mostly focused on addressing GP workload and the sustainability of primary care, or on providing a wider range of integrated services to local populations. Helping primary care networks to develop an appropriate balance in terms of how they focus on multiple (and at times competing) local and national goals is an important challenge for NHS England and Improvement, and for primary care networks as they gain organisational confidence and maturity. Setting clear and realistic goals will also help monitor the performance and progress of primary care networks, providing a framework against which to measure the networks.
- **Efforts should be made to ensure that primary care network policy is compatible with both rural and urban area primary care delivery:** Primary care networks are a central government initiative based on the major NHS Long-Term Plan and an investment in primary care, with nationally-defined service specifications. This appears from our evaluation to

present a particular potential challenge in rural areas where it is sometimes perceived that primary care network policy does not align easily with local capabilities and needs. By working closely with rural as well as urban primary care networks (and some who are struggling, as well as those making quick progress) in creating future iterations of the primary care network specification, and avoiding the understandable temptation to work with the 'leading light' networks which are often in urban settings, national policy makers can ensure that the evolution of NHS guidance and service specifications for primary care networks achieves an appropriate balance of national direction and space for local delivery.

Building leadership and management capacity

We suggest the following implications from our evaluation for local decision makers (e.g. in clinical commissioning groups and primary care networks) to build further capacity within primary care networks to help address the varied quality of leadership and management within networks as revealed in this evaluation:

- **It is important to build on the experience and expertise of pre-existing GP collaborations:** In some of our case study sites, the primary care network was able to draw on important managerial capacities and infrastructure from previous (and current) GP collaborations, which helped the network achieve operational success. Where managerial and leadership capacities have been enhanced by previous collaborations, primary care networks should be encouraged by NHS England and Improvement, and local clinical commissioning groups to draw on this resource. Local ways of working will determine the exact nature of how primary care networks can best work with pre-existing GP collaborations, and may range from informal advice and support to using paid logistical support from previous collaborations.
- **There is a need for clinical commissioning groups and primary care network governing bodies to ensure sufficient and distributed management and organisational support for the primary care network clinical director role:** From this evaluation, it has become clear that primary care network clinical directors, at least in our case study sites, are often over-extended and do not always have the appropriate mix of non-clinical skills and capacity needed to successfully lead a network. A greater degree of professional managerial roles and support within primary care networks may help address this shortcoming, and sharing of good practice at a local and national level will also likely be helpful.

- **Local primary care network governing bodies should ensure that the wider primary care team is able to be part of primary care network leadership:** There may be local staff within practices and the broader primary care and community health sector (e.g. practice managers, nurses, pharmacists, voluntary sector managers) who would welcome the career development opportunity to become more involved in managing primary care network activity.

Clarifying how primary care networks fit into the wider health and social care system

Nationally, there may be a need for further guidance on the scope and boundaries of primary care networks, as they evolve and take on more significant leadership roles within their sustainability and transformation partnership and/or local authority area. As the NHS and local government adapt to a post-Covid-19 way of organising public health and primary care work (including testing, tracing and isolating people found to have or be at risk of Covid-19) and ensuring the sustainability of all other local health services which may have been paused during the pandemic, the role of the primary care network will likely be important, and needs to be clarified, supported and resourced by both national and local decision makers. Specific implications from our evaluation about clarification of the primary care network role include:

- **It would be helpful for NHS England and Improvement to revisit the role of the primary care network in the context of the health and care system as it emerges from the Covid-19 pandemic:** There will likely be a need for further flexing of the primary care network service specifications as the NHS, social care, and the voluntary sector grapple with the consequences of the pandemic, and work out (and continually adapt) local service development priorities. NHS England and Improvement have already shown their readiness to do this (e.g. in raising the priority of care home support) and it will be important that this flexibility continues, and also that it is developed and agreed in collaboration with networks, and those from a range of urban and rural settings.
- **National decision makers need to ensure that primary care networks are monitored and performance-managed in a way that enables them space and permission to develop and pursue local priorities within the context of a national framework:** Achieving a balance of local goals within a national framework will require sophisticated and flexible performance

management and guidance, but will increase the likelihood of sustainable success for primary care networks.

- **There is a need to clarify the role of clinical commissioning groups in relation to primary care networks:** Where clinical commissioning groups have been perceived as exerting undue influence over primary care networks and associated funding, tensions have arisen between networks and commissioning bodies. As primary care networks are a departure from previous commissioning arrangements, and put more planning and purchasing power in the hands of general practice, further guidance by NHS England and Improvement will likely be needed, not least in the context of Covid-19 and the associated temporary suspension of some commissioning activity (and reverting to national block allocations of resource to NHS trusts and foundation trusts, and temporary suspension of some targets). As the NHS emerges from the pandemic, takes stock of service changes including the significant innovations in the ways in which general practice and primary care services are delivered, there will be a need to clarify the role of primary care networks (alongside clinical commissioning groups) in funding and supporting such developments for the longer term.

Conclusions and suggestions for further research and evaluation

This evaluation has demonstrated the considerable potential for primary care networks to improve sustainability within primary care and provide integrated services to patients, and the early operational success that primary care networks in four case study sites across England have been able to achieve. As primary care networks move forward, it will be important to ensure they reach their full potential, particularly in light of the resources, time and energy that have been put into this new form of collaboration in the English NHS. We have identified several priority areas above with respect to implications from our evaluation for the future direction and support of primary care networks, which will require engagement and close working between NHS England and Improvement, clinical commissioning groups, and local primary care networks across a variety of rural and urban settings.

As primary care networks become more deeply embedded in local care landscapes, it will be important to monitor their development, including measurement of their impact, and understand better the facilitators and barriers to them achieving their goals. In monitoring their progress and impact, a blend of qualitative and quantitative measures will be needed, for it was clear from our

rapid evidence assessment that GP collaborations have typically been subject to extensive qualitative evaluation, and had much less sustained quantitative analysis of their progress.

Areas where evidence could helpfully be gathered about primary care network progress therefore include:

- achievement of targets set out in the national primary care network specification;
- based on this monitoring, a clear articulation of the benefits of primary care network activity for patients, staff and the local health and care system;
- careful monitoring of the management and transaction costs of primary care networks, to enable cost-benefit analysis of their operation; and
- comparative analysis of such measures across primary care networks in a region and nationally, to provide the basis for in-depth exploration of what enables or inhibits progress.

This quantitative tracking of primary care networks can then form the basis for qualitative study of what has enabled or hindered progress; and an exploration of what additional support and investment may be needed to enable effective collaboration and achievement of goals. It will be important to study not only those primary care networks that appear to be making effective progress, but also to explore and understand why some networks struggle and find it hard to collaborate, and in turn whether this affects health and care goals set for networks. Ultimately, research into the longer term operation of primary care networks needs to be able to answer this question raised by our rapid evidence assessment for this study: do general practices need to collaborate to achieve key outcomes (e.g. improving access, achieving sustainability)?

Limited information about primary care networks' response to the Covid-19 pandemic was collected through this evaluation, although additional data-gathering on how networks formed part of the primary care response to Covid-19 would be useful in understanding this more fully. Along with providing information on the Covid-19 primary care response itself and the role of primary care networks within this, additional information gathering would contribute to an understanding of whether practices revert to prior and individual ways of working, or whether they draw more on shared resources within collaborations during moments of stress.

In further research, it will also be important to evaluate how primary care networks move from an initial stage characterised by relatively high up-front costs, to a more established stage where the resources put into networks might contribute more meaningfully to sustainability and efficiency in primary care. In addition, the ongoing relationship between primary care networks and prior GP collaborations will be important to track, for this evaluation has revealed just how established the concept of collegial or collective working now is across English general practice.

Topic Report

Acknowledgements

We are extremely grateful to all the participants who took part in this study and to our contacts at each case study site who helped to coordinate our interactions with interviewees and provided documents to and answered queries from the research team.

We would also like to thank members of the BRACE Centre Executive, Health and Care Panel, Patient and Public Involvement Group, and Core Team for their input and constructive comments throughout the duration of the study, and colleagues from NHS England and Improvement, Department of Health and Social Care, the King's Fund, the Nuffield Trust, and the University of Manchester for their contributions at our half-day project design workshop.

Specifically, we would like to thank Natasha Elmore, Dr Sarah Ball, and Jon Sussex (all from RAND Europe) for their contribution to data collection, gaining ethical approval, and providing project advice; Dr Rebecca Fisher (Senior Policy Fellow, Health Foundation) and Dr Mina Gupta (GP, Modality) for peer review of our online surveys; Samantha Hinks (NHS England and Improvement) and Professor Katherine Checkland (University of Manchester) for their on-going advice and sharing learning from their own evaluations and research throughout; Professor Russell Mannion (University of Birmingham), Dr Katie Colman and Mark Platt (BRACE Health and Care Panel) who reviewed our study protocol from a theoretical, policy, and patient and public involvement (PPI) perspective; Cathy Dakin (BRACE Administrator, University of Birmingham) who reviewed our Plain English Summary and provided excellent support throughout, and Professor Justin Waring (University of Birmingham) and Dr Anna Dixon (Chief Executive, Centre for Ageing Better) for undertaking critical review of the draft report.

Contributions of authors

Professor Judith Smith (Professor of Health Policy and Management, and Director of the BRACE Centre) was the principal investigator and led the study. She contributed to the conception and design of the study, the theoretical framework, data collection at one study site, overall data analysis and interpretation, and is corresponding author of the final report. She led the writing on Chapters 1, 3 (co-led) and 6 while contributing to Chapters 2, 5 and 7. Professor Smith took responsibility for overall editing of the final report, and is the guarantor.

Sarah Parkinson (Analyst, RAND Europe) was the project manager for the study (January to June 2020). She contributed to data collection at two study sites, led overall data analysis and interpretation, and is a co-author of the final report. She led the writing on Chapters 4 (co-led), 5, and 7 while contributing to Chapter 6.

Amelia Harshfield (Analyst, RAND Europe) was the project manager for the study (July 2018 to December 2019). She contributed to the conception and design of the study, the theoretical framework, data collection at two study sites, and is a co-author of the final report. She co-led the writing on Chapter 3.

Dr Manbinder Sidhu (Research Fellow, University of Birmingham) was a researcher for the study. He contributed to the design of the study, the theoretical framework, data collection at two study sites, overall data analysis and interpretation, and is a co-author of the final report. He led the writing on Chapter 2 and 4 (co-led) while contributing to Chapters 5, 6 and 7.

All authors contributed to integrating the findings of the study. JS, SP, and MS made critical revisions to the report for important intellectual content and approved the final manuscript. All authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the article are appropriately investigated and resolved.

Patient and public involvement

A member of the BRACE Health and Care Panel attended the project design workshop while a patient and public involvement member of the panel reviewed and helped shape the proposal for the evaluation. The 'plain English' summary of the report has been reviewed by another patient and public involvement adviser. Project updates were shared on a four-monthly basis with members of the BRACE Steering Group for the duration of the project, which includes our BRACE Centre co-investigator Charlotte Augst (Chief Executive of National Voices) who advised the study team in May 2020 to complete further interviews with regard to the impact of Covid-19 on primary care networks. Updates on the project were given to our BRACE Health and Care Panel in regular e-bulletins, and a presentation of emerging themes from the study was given at a Panel workshop in Birmingham in September 2019, when challenge and advice were given to the evaluation team. Project findings will be shared and discussed at a further meeting of the full BRACE Health and Care Panel in early 2021 – the panel includes eight patient and public members. We will seek further

advice from these members concerning how best to communicate the evaluation's findings to patient and public audiences, building on the steer they gave to us in discussion at the September 2019 workshop.

Publications

Smith J and Harshfield A. Primary care networks: a marathon not a sprint, Health Services Journal, September 2019. <https://www.hsj.co.uk/primary-care/primary-care-networks-a-marathon-not-a-sprint/7025889.article>

Smith J, Parkinson S, Harshfield A, Sidhu MS. Primary care networks in the English NHS: (another) triumph of hope over experience? Health Services Research UK Annual Conference, July 2020, Oral Presentation. <https://hsruk.org/conference-2020/presentations/big-questions-hsr>

Data sharing statement

Due to the consent process for data collection at case study sites within this evaluation, there are no data that can be shared.

References

1. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology* 2013;**13**:117.
2. Robertson R. *Public satisfaction with GP services drops to lowest level in 35 years*. London: The King's Fund; 2018.
3. Kringos D, Boerma W, Bourgueil Y, Cartier T, Dedeu T, Hasvold T, *et al*. The strength of primary care in Europe: an international comparative study. *Br J Gen Pract* 2013;**63**:e742-50.
<https://doi.org/10.3399/bjgp13X674422>
4. Starfield B. *Primary care: balancing health needs, services, and technology*. New York: Oxford University Press; 1998.
5. National Health Service (NHS). *Five Year Forward View*; 2014.
6. NHS England. *General Practice Forward View*; 2016.
7. Fisher R, Turton C, Gershlick B, Alderwick H, Thorlby R. *Feeling the strain: What The Commonwealth Fund's 2019 international survey of general practitioners means for the UK*. London: The Health Foundation; 2020.
8. NHS England. *The NHS Long Term Plan*; 2019.
9. Association NEaBM. *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan* 2019.
10. Office NA. *Developing new care models through NHS vanguards*; 2018.
11. Tallack C, Hinks S. Lessons from the English National Health Service new care models programme. *International Journal of Integrated Care* 2019;**19**.
12. Smith J, Mays N. Primary care organizations in New Zealand and England: tipping the balance of the health system in favour of primary care? *The International journal of health planning and management* 2007;**22**:3-19.
13. Kumpunen S, Natasha Curry, Maddy Farnworth, Rebecca Rosen. *Collaboration in general practice: Surveys of GP practice and clinical commissioning groups*. Nuffield Trust, Royal College of General Practitioners; 2017.
14. Rosen R, Stephanie Kumpunen, Natasha Curry, Alisha Davies, Luisa Pettigrew, Lucia Kossarva. *Is bigger better? Lessons for large-scale general practice*. Nuffield Trust: ISBN: 978-1-910953-12-9; 2016.

15. Smith J, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen, Nicola Walsh. *Securing the future of general practice: new models of primary care*. Nuffield Trust and King's Fund; 2013.
16. Pettigrew LM, Kumpunen S, Rosen R, Posaner R, Mays N. Lessons for 'large-scale' general practice provider organisations in England from other inter-organisational healthcare collaborations. *Health Policy* 2019;**123**:51-61. <https://doi.org/10.1016/j.healthpol.2018.10.017>
17. Pettigrew L, Nicholas Mays, Stephanie Kumpunen, Rebecca Rosen. *Large-scale general practice in England: what can we learn from the literature?* Nuffield Trust; 2016.
18. National Association of Primary Care. URL: <https://napc.co.uk/primary-care-home/> (accessed 29 May 2020).
19. Fisher R. General practice in the time of covid-19. In: *BMJ Opinion*; 2020.
20. Smith JA, Mays N. GP led commissioning: time for a cool appraisal. *BMJ* 2012;**344**:e980.
21. Baird B, Shilpa Ross, Matthew Honeyman, Bilal Sahib, Hugh Reeve, Mike Nosa-Ehima, David Omojomolo. *Innovative models of general practice*. The King's Fund: ISBN: 978 1 909029 81 1; 2018.
22. Salisbury H. Oh, those lazy, part time GPs! *BMJ* 2019;**367**.
23. Baird B. *Primary care networks explained*. London: The King's Fund; 2019.
24. NHS England. *Network Contract DES – Engagement on Draft Outline Service Specifications Summary Report 2020*.
25. Serle J. Contentious NHS scheme to bolster care homes brought forward. In: *HSJ*; 2020.
26. Stake RE. *Multiple case study analysis*: Guilford press; 2013.
27. Yin RK. *Case Study Research: Design and Methods*. Thousand Oaks, CA: Sage; 2009.
28. De Silva MJ, Breuer E, Lee L, Asher L, Chowdhary N, Lund C, *et al*. Theory of change: a theory-driven approach to enhance the Medical Research Council's framework for complex interventions. *Trials* 2014;**15**:267.
29. Higgins JP, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, *et al*. *Cochrane handbook for systematic reviews of interventions*: John Wiley & Sons; 2019.
30. Barends E, Denise M. Rousseau, & Rob B. Briner (Eds.). *CEBMA Guideline for Rapid Evidence Assessments in Management and Organizations, Version 1.0*. Amsterdam: Center for Evidence Based Management. Amsterdam: Center for Evidence Based Management; 2017.

31. Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med* 2009;**6**:e1000097.
<https://doi.org/10.1371/journal.pmed.1000097>
32. Pawa J, Robson J, Hull S. Building managed primary care practice networks to deliver better clinical care: a qualitative semi-structured interview study. *Br J Gen Pract* 2017;**67**:e764-e74.
<https://doi.org/https://dx.doi.org/10.3399/bjgp17X692597>
33. Robson J, Hull S, Mathur R, Boomla K. Improving cardiovascular disease using managed networks in general practice: an observational study in inner London. *Br J Gen Pract* 2014;**64**:e268-74. <https://doi.org/https://dx.doi.org/10.3399/bjgp14X679697>
34. Ørngreen R, Levinsen K. Workshops as a Research Methodology. *Electronic Journal of e-Learning* 2017;**15**:70-81.
35. Johl SK, Renganathan S. Strategies for gaining access in doing fieldwork: Reflection of two researchers. *Electronic Journal of Business Research Methods* 2010;**8**:42.
36. Andoh-Arthur J. Gatekeepers in Qualitative Research.
37. Ritchie J, Lewis J, Nicholls CM, Ormston R. *Qualitative research practice: A guide for social science students and researchers*: sage; 2013.
38. Patton MQ. *Qualitative research & evaluation methods: Integrating theory and practice*: Sage publications; 2014.
39. Bryman A. How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research. *National Centre for Research Methods Review Paper Swindon: Economic and Social Research Council* 2012.
40. Tubaro P, Ryan L, D'angelo A. The visual sociogram in qualitative and mixed-methods research. *Sociological Research Online* 2016;**21**:1-18.
41. QSR International Pty Ltd. NVivo qualitative data analysis software. In.
42. Miles MB, Huberman AM. *Qualitative data analysis: An expanded sourcebook*: sage; 1994.
43. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, et al. *Securing the future of general practice: new models of primary care*. Nuffield Trust and King's Fund; 2013.
44. Smith J, Goodwin N. *Towards managed primary care: the role and experience of primary care organizations*: Ashgate Publishing, Ltd.; 2006.

45. Kumpunen S, Natasha Curry, Tim Ballard, Hannah Price, Mike Holmes, Nigel Edwards. *Collaboration in general practice: surveys of GPs and CCGs*. Nuffield Trust and Royal College of General Practitioners; 2015.
46. Smith J, Mays N, Dixon J, Goodwin N, Lewis R, McClelland S, *et al*. *A review of the effectiveness of primary care-led commissioning and its place in the NHS*; 2004.
47. Bojke C, Gravelle H, Wilkin D. Is bigger better for primary care groups and trusts? *Bmj* 2001;**322**:599-602.
48. Thorlby R, Smith J, Barnett P, Mays N. Primary care for the 21st century: learning from New Zealand's independent practitioner associations. Research report. 2012.
49. Casalino L. *GP commissioning in the NHS in England: ten suggestions from the United States*. London; 2011.
50. Ham CJ. *GP budget holding: lessons from across the pond and from the NHS*. Birmingham: Health Services Management Centre 2010.
51. Thorlby R, Rosen R, Smith J. GP commissioning: insights from medical groups in the United States. *Nuffield Trust: London* 2011.
52. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. *International Journal of Health Services* 2004;**34**:709-27.
53. Imison C, Williams S, Smith J, Dingwall C. Toolkit to support the development of primary care federations. *RCGP, The King's Fund, Nuffield Trust and Hempsons* 2010.
54. Elvey R, Bailey S, Checkland K, McBride A, Parkin S, Rothwell K, *et al*. Implementing new care models: learning from the Greater Manchester demonstrator pilot experience. *BMC Fam Pract* 2018;**19**:89. <https://doi.org/10.1186/s12875-018-0773-y>
55. Checkland K, Coleman A, McDermott I, Segar J, Miller R, Petsoulas C, *et al*. Primary care-led commissioning: applying lessons from the past to the early development of clinical commissioning groups in England. *Br J Gen Pract* 2013;**63**:e611-9. <https://doi.org/10.3399/bjgp13X671597>
56. Rosen R, Kumpunen S, Curry N, Davies A, Pettigrew L, Kossarva L. *Is bigger better? Lessons for large-scale general practice*. Nuffield Trust: ISBN: 978-1-910953-12-9; 2016.
57. Erler A, Bodenheimer T, Baker R, Goodwin N, Spreeuwenberg C, Vrijhoef HJM, *et al*. Preparing primary care for the future - Perspectives from the Netherlands, England, and USA. *Zeitschrift fur Evidenz, Fortbildung und Qualitat im Gesundheitswesen* 2011;**105**:571-80. <https://doi.org/10.1016/j.zefq.2011.09.029>

58. Baird B, Ross S, Honeyman M, Sahib B, Reeve H, Nosa-Ehima M, *et al.* *Innovative models of general practice*. The King's Fund: ISBN: 978 1 909029 81 1; 2018.
59. Rosen R, Stephanie Kumpunen, Judith Smith. *Developing care for a changing population: Learning from GP-led organisations*. Nuffield Trust; 2016.
60. Pettigrew L, N. Mays, S. Kumpunen, R. Rosen, and R. Posaner. *Large-scale general practice in England: what can we learn from the literature? Literature review*: Nuffield Trust; 2016.
61. Mays N, Wyke S, Evans D. The purchasing of health care by primary care organisations: an evaluation and guide to future policy. In: Buckingham: Open University Press; 2001.
62. Angstman KB, Horn JL, Bernard ME, Kresin MM, Klavetter EW, Maxson J, *et al.* Family medicine panel size with care teams: Impact on quality. *Journal of the American Board of Family Medicine* 2016;**29**:444-51. <https://doi.org/10.3122/jabfm.2016.04.150364>
63. Beehler GP, Funderburk JS, King PR, Wade M, Possemato K. Using the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ) to identify practice patterns. *Translational behavioral medicine* 2015;**5**:384-92. <https://doi.org/10.1007/s13142-015-0325-0>
64. Breton M, Maillet L, Haggerty J, Vedel I. Mandated local health networks across the province of Québec: A better collaboration with primary care working in the communities? *London Journal of Primary Care* 2014;**6**:71-8. <https://doi.org/10.1080/17571472.2014.11493420>
65. Ham C. GPs must adapt to a new model of care. *Pulse* 2012.
66. Harris MF, Advocat J, Crabtree BF, Levesque JF, Miller WL, Gunn JM, *et al.* Interprofessional teamwork innovations for primary health care practices and practitioners: Evidence from a comparison of reform in three countries. *Journal of Multidisciplinary Healthcare* 2016;**9**:35-46. <https://doi.org/10.2147/JMDH.S97371>
67. Kumpunen S, Rebecca Rosen, Lucia Kossarova, Chris Sherlaw-Johnson. *Primary Care Home: Evaluating a new model of primary care*. Nuffield Trust; 2017.
68. Lane R, Russell G, Bardoel EA, Advocat J, Zwar N, Davies PGP, *et al.* When colocation is not enough: a case study of General Practitioner Super Clinics in Australia. *Australian Journal of Primary Health* 2017;**23**:107-13. <https://doi.org/https://dx.doi.org/10.1071/PY16039>
69. Oelke ND, Milkovich L, Whitmore B. Using the Awareness, Motivation, Skills, and Opportunity Framework for Health Promotion in a Primary Care Network. *Health promotion practice* 2018; 10.1177/1524839918801912:1524839918801912. <https://doi.org/10.1177/1524839918801912>

70. Richters A, Nieuwboer MS, Olde Rikkert MGM, Melis RJF, Perry M, van der Marck MA. Longitudinal multiple case study on effectiveness of network-based dementia care towards more integration, quality of care, and collaboration in primary care. *PLoS one* 2018;**13**:e0198811. <https://doi.org/10.1371/journal.pone.0198811>
71. Valentijn PP, Vrijhoef HJ, Ruwaard D, de Bont A, Arends RY, Bruijnzeels MA. Exploring the success of an integrated primary care partnership: a longitudinal study of collaboration processes. *BMC Health Services Research* 2015;**15**:32. <https://doi.org/https://dx.doi.org/10.1186/s12913-014-0634-x>
72. Henderson J, Javanparast S, MacKean T, Freeman T, Baum F, Ziersch A. Commissioning and equity in primary care in Australia: Views from Primary Health Networks. *Health & social care in the community* 2018;**26**:80-9. <https://doi.org/10.1111/hsc.12464>
73. Dowswell G, Harrison S, Wright J. The early days of primary care groups: General practitioners' perceptions. *Health and Social Care in the Community* 2002;**10**:46-54. <https://doi.org/10.1046/j.0966-0410.2001.00332.x>
74. Rodriguez C, Belanger E. Stories and metaphors in the sensemaking of multiple primary health care organizational identities. *BMC Family Practice* 2014;**15**:41. <https://doi.org/https://dx.doi.org/10.1186/1471-2296-15-41>
75. Rousseau C, Pontbriand A, Nadeau L, Johnson-Lafleur J. Perception of interprofessional collaboration and co-location of specialists and primary care teams in youth mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry* 2017;**26**:198-204.
76. Thomas P. Achieving community oriented integrated care through the 2014 England GP contract. *London Journal of Primary Care* 2014;**6**:55-64. <https://doi.org/10.1080/17571472.2014.11493416>
77. Anaf J, Baum F, Freeman T, Labonte R, Javanparast S, Jolley G, *et al.* Factors shaping intersectoral action in primary health care services. *Australian and New Zealand Journal of Public Health* 2014;**38**:553-9. <https://doi.org/10.1111/1753-6405.12284>
78. Bailie R, Matthews V, Brands J, Schierhout G. A systems-based partnership learning model for strengthening primary healthcare. *Implementation science : IS* 2013;**8**:143. <https://doi.org/10.1186/1748-5908-8-143>
79. Rosen R. *Transforming general practice: what are the levels for change?* Nuffield Trust; 2015.

80. Toop L. Steps towards more integrated care in New Zealand: a general practice perspective. *BJGP Open* 2017;**1**. <https://doi.org/10.3399/bjgpopen17X100845>
81. Addicott R, Chris Ham. *Commissioning and funding general practice: Making the case for family care networks*. The King's Fund: ISBN: 978 1 909029 25 5; 2014.
82. Bienkowska-Gibbs T, Sarah King, Catherine L. Saunders, and Marie-Louise Henham. *New organisational models of primary care to meet the future needs of the NHS: A brief overview of recent reports*. Santa Monica, CA: RAND Corporation; 2015.
83. Jaruseviciene L, Liseckiene I, Valius L, Kontrimiene A, Jarusevicius G, Lapao LV. Teamwork in primary care: perspectives of general practitioners and community nurses in Lithuania. *BMC Family Practice* 2013;**14**:118. <https://doi.org/https://dx.doi.org/10.1186/1471-2296-14-118>
84. Miller R, Weir C, Gulati S. Transforming primary care: scoping review of research and practice. *Journal of integrated care (Brighton, England)* 2018;**26**:176-88. <https://doi.org/10.1108/jica-03-2018-0023>
85. Baird B, Charles A, Honeyman M, Maguire D, Das P. *Understanding pressures in general practice*: The King's Fund; 2016.
86. Brown LJ, Oliver-Baxter J. Six elements of integrated primary healthcare. *Australian Family Physician* 2016;**45**:149-52.
87. Sangaleti C, Schweitzer MC, Peduzzi M, Zoboli E, Soares CB. Experiences and shared meaning of teamwork and interprofessional collaboration among health care professionals in primary health care settings: a systematic review. *JBI Database System Rev Implement Rep* 2017;**15**:2723-88. <https://doi.org/https://dx.doi.org/10.11124/JBISRIR-2016-003016>
88. Barnett S, Jones SC, Bennett S, Iverson D, Bonney A. General practice training and virtual communities of practice - A review of the literature. *BMC Family Practice* 2012;**13**. <https://doi.org/10.1186/1471-2296-13-87>
89. Yates R, Wells L, Carnell K. General practice based multidisciplinary care teams in Australia: Still some unanswered questions. A discussion paper from the Australian General Practice Network. *Australian Journal of Primary Health* 2007;**13**:10-7. <https://doi.org/10.1071/PY07018>
90. Suter E, Mallinson S, Misfeldt R, Boakye O, Nasmith L, Wong ST. Advancing team-based primary health care: a comparative analysis of policies in western Canada. *BMC Health Services Research* 2017;**17**:493. <https://doi.org/https://dx.doi.org/10.1186/s12913-017-2439-1>

91. Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: An integrative literature review. *Int J Nurs Stud* 2015;**52**:1217-30.
<https://doi.org/https://dx.doi.org/10.1016/j.ijnurstu.2015.03.008>
92. Rosen R, Helen Parker. *New models of primary care: practical lessons*. Nuffield Trust; 2013.
93. Hespe C, Rychetnik L, Peiris D, Harris M. Informing implementation of quality improvement in Australian primary care. *BMC Health Services Research* 2018;**18**. <https://doi.org/10.1186/s12913-018-3099-5>
94. Mannion R. General practitioner-led commissioning in the NHS: Progress, prospects and pitfalls. *British Medical Bulletin* 2011;**97**:7-15. <https://doi.org/10.1093/bmb/ldq042>
95. Jolanki O, Tynkkynen LK, Sinervo T. Professionals' views on integrated care. *Journal of Integrated Care* 2017;**25**:247-55. <https://doi.org/10.1108/JICA-06-2017-0018>
96. Stukel TA, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, *et al*. Multispecialty physician networks in Ontario. *Open Med* 2013;**7**:e40-55.
97. Smith J, Harshfield A. Primary care networks: a marathon not a sprint. *Health Services Journal* 2019.
98. Smits M, Rutten M, Keizer E, Wensing M, Westert G, Giesen P. The Development and Performance of After-Hours Primary Care in the Netherlands: A Narrative Review. *Ann Intern Med* 2017;**166**:737-42. <https://doi.org/https://dx.doi.org/10.7326/M16-2776>
99. Leese B, Petchey R. Achievements of the first wave personal medical services (PMS) pilots in England. A health authority perspective. *J Health Organ Manag* 2003;**17**:181-93.
<https://doi.org/10.1108/14777260310480730>
100. Campbell S, Steiner A, Robison J, Webb D, Raven A, Richards S, *et al*. Do Personal Medical Services contracts improve quality of care? A multi-method evaluation. *Journal of Health Services Research & Policy* 2005;**10**:31-9. <https://doi.org/10.1177/135581960501000108>
101. Lewis R, Gillam S. Personal medical services. *Bmj* 2002;**325**:1126-7.
<https://doi.org/10.1136/bmj.325.7373.1126>
102. NHS England. *Integrated Care Pioneers*.
103. NHS and BMA. *Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance*: NHS England and NHS Improvement; 2019.

104. Smith J, Bamford M, Ham C, Scrivens E, Shapiro J. Beyond fundholding: a mosaic of primary care led commissioning and provision in the West Midlands. *Birmingham: University of Birmingham* 1997.
105. Curry N, Ham C. *Clinical and service integration: the route to improved outcomes*: King's Fund London; 2010.
106. Croxson B, Smith J, Cumming J. Patient fees as a metaphor for so much more in New Zealand's primary health care system. *Wellington: Health Services Research Centre* 2009.
107. Glennerster H, Cohen A, Bovell V. Alternatives to fundholding. *International Journal of Health Services* 1998;**28**:47-66.
108. Dowling B, Glendinning C. *The new primary care: modern, dependable, successful?*: McGraw-Hill Education (UK); 2003.
109. Palmer B, Appleby J, Spencer J. Rural health care: A rapid review of the impact of rurality on the costs of delivering health care. *Nuffield Trust Report London: Nuffield Trust* 2019.
110. Sidhu M, Pollard J, Sussex J. *Vertical integration of GP practices with acute hospitals: a qualitative rapid evaluation study*: NIHR Health Services and Delivery Research In submission.
111. Tuckman BW. Developmental sequence in small groups. *Psychological bulletin* 1965;**63**:384.
112. Baird B. How has general practice responded to the Covid-19 (coronavirus) outbreak? In. London: The King's Fund; 2020.
113. Flick U. Triangulation in qualitative research. *A companion to qualitative research* 2004;**3**:178-83.
114. Fusch PI, Ness LR. Are we there yet? Data saturation in qualitative research. *The qualitative report* 2015;**20**:1408.
115. Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. *BMJ: British Medical Journal* 2000;**320**:114.

Appendix 1: Primary care collaborations survey as part of sampling strategy



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National
Voices

Online Survey for Primary Care Collaboration leads

Evaluation of large scale collaborations between GP practices

You are invited to complete a short survey, which is being carried out by researchers from the Birmingham, RAND and Cambridge Evaluation (BRACE) Centre funded by the National Institute for Health Research (NIHR). This survey forms part of the process of selecting case study sites for a research study that will examine large-scale collaborations across GP practices, in order to inform the development of new Primary Care Networks (PCNs) in England.

We provide background context to the evaluation project, and more specific information on this survey. Please take the time to read this before deciding whether or not to take part in the survey.

What is the purpose of this evaluation?

This project has been designed by the BRACE Rapid Evaluation Team to provide evidence that can inform the implementation and operation of PCNs in the NHS in England. The study will evaluate the nature, functioning, potential and pitfalls of large scale collaborations between GP practices (e.g. federations, networks, super-partnerships). The study has a particular focus on understanding issues for rural as compared with urban collaborations, and on the challenges in creating and sustaining successful collaborations. We are in the process of identifying and recruiting four case study sites.

How would you like me to contribute?

We would like you to take part in a 10-minute survey to help us ascertain whether to select one or more of the GP practice collaboration(s) in your CCG area as a case study. Relevant collaborations include any that have ceased to operate in the last 24 months, as well as those currently active.

Who else is involved?

If your site is selected to be a case study site, we would like to:

- Involve you and other key individuals working within your collaboration to take part in interviews with a member of the research team;
- invite all GPs working within the collaboration to undertake a short online survey; and
- undertake non-participant observation of a small number of meetings of the executive or board of your collaboration.

Do I have to take part?

It is entirely your decision whether to take part in this survey. If you decide to take part, you will be asked to provide consent prior to taking the survey. You can withdraw your participation at any time while answering the survey questions without any penalty to you. You do not have to give a reason for not taking part.

What are the possible disadvantages and risks of taking part?

The survey will take approximately 10 minutes to complete. There are no known risks in completing this survey.

What are the possible benefits of taking part?

The information gained from the evaluation of case studies will improve policy makers' and decision makers' understanding of the operation (including challenges faced) and the impacts of large scale GP collaborations. The evidence-base will help shape the understanding of the practicalities of implementing and supporting new PCNs, as detailed by NHS England.

Who should I contact if I have a question?

If you have any questions or queries pertaining to any aspect of this evaluation, please contact either the Project Lead, Professor Judith Smith, at the University of Birmingham on j.a.smith.20@bham.ac.uk or the Project Manager, Amelia Harshfield, at RAND Europe on aharshfi@rand.org. Any complaints raised during this time will be dealt with in accordance with the University of Birmingham Research Practice Guidelines.

Will my taking part in this project be kept confidential?

All information provided in response to this survey will be kept strictly confidential in compliance with the General Data Protection Regulation (GDPR) 2018 and Data Protection Act (2018). The data will be recorded and stored in accordance with the University of Birmingham and RAND Europe's procedures. Any potential outputs will be aggregated and data anonymised prior to publication. All data from this survey will be destroyed after five years.

Who is organising and funding the research?

BRACE is funded by the National Institute for Health Research's Health Services and Delivery Research (HS&DR) programme (HSDR16/138/31). For more information, please see:

<https://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/research/brace/index.aspx>

By ticking the box below "I agree to participate in this survey" and by continuing with the survey you are indicating your agreement with the following:

1. I have read and understand the information about this project.
2. I understand that my participation in this survey is voluntary and that I am free to withdraw my participation at any time without giving a reason.
3. I give permission for my responses to be accessed by researchers in this project.
 - I agree to participate in this survey
 - I do not agree to participate in this survey

Your experiences with large scale GP practice collaborations

The following questions ask about the collaboration you are or have been a member of.

ASK ALL

1. Is your primary care collaboration currently operational?

Please tick the category that applies to you.

- a. Yes
- b. No

If participant has answered Yes, then open up questions 9-15

If participant has answered No, then open up questions 2-8

For those who ticked 'no' in Q1

2. Was your primary care collaboration in operation during the past 24 months?

Please tick the category that applies to you.

- a. Yes
- b. No

If participant has answered No, then go to survey finish

If participant has answered Yes, then they go to Question 3

3. What was the name of your primary care collaboration?

[OPEN TEXT]

4. When was your primary care collaboration established?

[DATE]

5. What term best describes the type of collaboration you were a member of?

Please tick the category that applies to you.

- a. Informal network
- b. Multi-site practice organisation
- c. Super-partnership
- d. Federation
- e. Primary Care Home
- f. Extended access hub
- g. Other, please describe below [OPEN TEXT]

6. How many GP practices were members of your primary care collaboration?

- a. Fewer than 5 practices
- b. 5-10 practices
- c. More than 10 practices
- d. Don't know

7. What was the main purpose behind your collaboration being set up?

[OPEN TEXT]

8. What was the main reason behind your collaboration ceasing to operate?

[OPEN TEXT]

For those who ticked 'yes' in Q1

9. What is the name of your primary care collaboration?

[OPEN TEXT]

10. When was your primary care collaboration established?

[DATE]

11. What term best describes the type of collaboration you are a member of?

Please tick the category that applies to you.

- a. Informal network
- b. Multi-site practice organisation
- c. Super-partnership
- d. Federation
- e. Primary care home
- f. Extended access hub
- g. Other, please describe below [OPEN TEXT]

12. How many GP practices are members of your primary care collaboration?

- e. Fewer than 5 practices
- f. 5-10 practices
- g. More than 10 practices
- h. Don't know

13. What was the main purpose behind your collaboration being set up?

[OPEN TEXT]

14. Is your primary care collaboration transitioning to become a Primary Care Network as defined in the NHS Long Term Plan?

- a. Yes
- b. No

If yes, please tell us what actions you are currently taking to become a primary care network?

163

[OPEN TEXT]

15. Please use the text box below to share any other relevant information about your collaboration and its current working practices.

[OPEN TEXT]

Thank you for completing the survey.

Topic Report

Appendix 2: Topic guide for interviews

Evaluation questions:

1. What are the different forms of GP collaboration in primary care in England and how have they been implemented in a sample of urban and rural settings?
2. What are the rationales and incentives for general practices to enter into different forms of collaboration, and what are the reasons for and consequences of not doing so? In particular, what role do financial incentives play in facilitating or inhibiting collaboration? What are the expected outcomes of GP collaborations?
3. What evidence exists about the positive or negative impacts associated with different experiences of establishing (or not) GP collaborations?
4. What are the barriers to and facilitators of effective collaboration across GP practices, both with respect to successful and unsuccessful collaboration, and achieving impact or not?

Before the interview begins

- Ensure the participant has read the information leaflet
- Ensure the participant feels able to ask any questions about the evaluation including issues about confidentiality, the findings and/or dissemination before being asked to sign a consent form.
- Explain that they do not have to answer all the questions just because they have consented to the interview, and that they can take a break or stop the interview at any time.
- Check that they are happy to be audio-recorded and have signed for this on the consent form.
- Start audio-recording and begin the interview.

Themes to be covered in the interview

1. Describe your current model of collaboration in your area at present?
 - Current stakeholders
 - Number of practices
 - Length of time since collaboration commenced
 - The population being covered by the network (has there been any learning from the 'primary care home model'?)
2. Describe any specific challenges the network has faced for being located in an urban/rural setting?
3. Describe how current collaborative working model has evolved since commencement/past 12 months?
 - have the numbers of collaborators increased/decreased? Why?
 - What have been the issues of tension? How have they been resolved?
 - Describe improvements (if any) to GP practice working in your area since the formation of the network? i.e. increasing access and extending services?
 - Integration across secondary, community and third sector organisations?
4. Discussion on the nature of relationships that exist within the network (perhaps use the stakeholder mapping document):
 - across the different layers of stakeholders
 - amongst GP practices
 - how is the collaboration being led and by whom?
 - Is there greater/lesser inter-dependency
5. What have been some of the reasons for choosing this particular model of collaboration over others?
 - Describe the financial incentives involved as part of this model of collaboration?
 - Describe the financial drawbacks involved as part of this model of collaboration?

- What are the risks associated with maintaining and supporting this collaboration?
6. What are some of the key goals/outcomes you would like to achieve, both in the immediate and the medium-long term?
- What processes/changes in practice have taken place in order to achieve said goals/outcomes?
 - How is 'success' being determined and/or measured?
7. What benefits have you seen since the development/commence of this collaboration?
- Indemnity
 - Governance
 - Data sharing
 - Improved organisational development
 - Workforce satisfaction

Have there ever been occasions where practices have expressed a desire to leave the collaboration and/or left? If yes, could you please describe what happened?

Appendix 3: Survey

Survey landing page:

Do I have to take part?

It is entirely your decision whether to take part in this survey. If you decide to take part, you will be asked to provide consent prior to taking the survey. You can withdraw your participation at any time while answering the survey questions without any penalty to you. You do not have to give a reason for not taking part.

What are the possible disadvantages and risks of taking part?

The survey is estimated to take no more than 10 minutes to complete. There are no known risks in completing this survey.

What are the possible benefits of taking part?

The information gained from the evaluation will inform policy and decision-makers' understanding of the implementation (including challenges faced) of Primary Care Networks (PCNs). The insights from this evaluation will help shape understanding of working within PCNs and enable wider lessons about the risks and opportunities of general practice working in a collaborative manner to try and fulfil objectives set for it by NHS England/Improvement.

Will my taking part in this project be kept confidential?

All information provided in response to this survey will be kept strictly confidential in compliance with the General Data Protection Regulation (GDPR) 2018 and Data Protection Act (2018). The data will be recorded and stored in accordance with the University of Birmingham and RAND Europe's procedures. Any potential outputs will be aggregated and data anonymised prior to publication. All data from this survey will be destroyed after five years.

By ticking the box below "I agree to participate in this survey" and by continuing with the survey you are indicating your agreement with the following:

- I have read and understand the information about this project (both as set out above and as is detailed in the invitation email).

- I understand that my participation in this survey is voluntary and that I am free to withdraw my participation at any time without giving a reason.
- I give permission for my responses to be accessed by researchers in this project.
 - I agree to participate in this survey
 - I do not agree to participate in this survey

Survey content

Your experiences with a Primary Care Network

1. Are you PCN clinical director?
 - a. Yes
 - b. No

2. Which of the following options best describes your main role within the Primary Care Network?
 - a. GP partner
 - b. Salaried GP
 - c. Practice manager
 - d. PCN manager
 - e. Other GP collaboration manager (including CEO)
 - f. Nurse
 - g. Pharmacist
 - h. Social prescriber
 - i. Other role

[Open text box for "other" boxes above]

3. Do you have any other role(s) within your Primary Care Network? If so please note this/these below.

[open text]

Information about practice's reason to form or join the Primary Care Network

4. To what extent were the following factors important when your practice decided to form or join the Primary Care Network? [Matrix with options: Very important, Somewhat important, Not important, Not sure, not applicable]
 - a. To help us meet the objectives of the NHS Long Term Plan
 - b. To help sustain the viability/sustainability of general practice
 - c. Access additional funding available to our practice via the PCN contract
 - d. Secure additional primary care services (for example practice-based pharmacy, social prescribing, etc.)
 - e. Improving co-ordination and delivery of primary care services for patients
 - f. Increasing collaborative working with other practices and primary care providers
 - g. Increasing opportunities for professional development for GPs and other members of staff
 - h. Enabling us to strengthen the management support available to our practice and local primary care services
 - i. Improving clinical governance arrangements across local practices and services (i.e. having a systematic approach to maintaining and improving the quality of patient care and service delivery)
 - j. Increasing involvement of primary care and general practice in decision making about the commissioning of local health services
5. Are there any other reasons that influenced the decision of your practice to join the PCN?
[Open text]

Challenges, opportunities and impacts associated with forming Primary Care Network

6. To what extent would you say the following challenges have ever been an issue for the Primary Care Network to which you belong? [Matrix with options: Very challenging, Somewhat challenging, Not challenging, Not sure, not applicable]
 - a. Establishing governance arrangements for the PCN

- b. Accessing funds specific to supporting collaborative/PCN working
- c. Agreeing how funds will flow from the PCN to practice
- d. Sharing data across practices with regard to clinical governance
- e. Sharing data across practices with regard to service planning
- f. Appointing a pharmacist
- g. Appointing a social prescriber
- h. Securing enough management and administration support
- i. Building relationships and networks between those involved in PCN
- j. Securing sufficient leadership by senior members of collaboration
- k. Agreeing aims and objectives for the PCN
- l. Support and guidance provided by NHS England
- m. Support provided by the clinical commissioning group (CCG)

Please elaborate on any of the points above where you feel additional information is helpful.

[Open text]

- 7. If there are any other challenges that your Primary Care Network has faced, please note these here. [Open text]
- 8. If there are opportunities that have helped with or enabled the establishment of your PCN, please note these here. [Open text]
- 9. Have there been any advantages to you and/or your practice from joining the PCN?
 - a. Shared vision about primary care delivery for the local population
 - b. Sharing best practice
 - c. Access to support and expertise from other members of the PCN
 - d. Access to social prescriber/pharmacist
 - e. Too early to see any advantage
 - f. Unsure
 - g. Other [Open text]

10. Have there been any disadvantages to you and/or your practice from joining the PCN?
- Time consuming
 - Tension and conflict with other practices part of the PCN
 - Difficulties recruiting staff
 - Taking time away from sessional work
 - Too early to see disadvantages
 - Unsure
 - Other [Open text]
11. Was your practice part of a pre-existing primary care collaboration prior to establishing your PCN?
- Yes
 - No
12. If you have answered Yes to Q11, does your pre-existing collaboration continue alongside your PCN?
- Yes (please provide further information in open text box)
 - No
13. If you had a pre-existing GP collaboration, how is this working with/supporting the PCN?
[Open text]
14. Is there anything else you would like to comment on that has not been covered in the survey (either about your PCN or PCNs in general? Please share them here. [Open text])

Thank you for taking the time to complete this survey. Your responses will inform the final NIHR report for this evaluation, which will be made available to your practice and PCN.

Appendix 4: Code book for interview analysis

The following code book, presented in Table 7, was exported from NVivo12⁴¹. The number of files represents the number of unique interviews within that code, and the number of references refers to the number of text sections within that code.

Table 7: Codebook for interview analysis

| Name | Files | References |
|---|-------|------------|
| 01 General information | 0 | 0 |
| 01.01 Models | 0 | 0 |
| 01.01.01 Primary care networks | 22 | 109 |
| 01.01.02 Super partnerships | 8 | 25 |
| 01.01.03 Other collaboration models | 13 | 46 |
| 01.02 Governance | 0 | 0 |
| 01.02.01 Management, leadership and decision making | 20 | 132 |
| 01.02.02 Regulation | 3 | 6 |
| 01.02.03 Meetings | 21 | 53 |
| 01.02.04 Commissioning | 14 | 34 |
| 01.02.05 Important documents or policies | 2 | 2 |
| 01.02.06 Other governance topics | 3 | 3 |
| 01.03 Stakeholder involvement | 0 | 0 |
| 01.03.01 Internal stakeholders | 0 | 0 |

| Name | Files | References |
|---|-------|------------|
| 01.03.01.01 Management staff | 9 | 29 |
| 01.03.01.02 GPs | 8 | 12 |
| 01.03.01.03 Nurses | 5 | 13 |
| 01.03.01.04 Mental health | 2 | 3 |
| 01.03.01.05 Social care | 2 | 2 |
| 01.03.01.06 Social prescribers | 13 | 30 |
| 01.03.01.07 Pharmacists | 14 | 36 |
| 01.03.01.08 Practice managers | 10 | 18 |
| 01.03.01.09 Other clinical staff | 3 | 5 |
| 01.03.01.10 Other non-clinical staff | 4 | 6 |
| 01.03.01.11 Other community-based staff | 6 | 9 |
| 01.03.01.12 Other staffing comments | 13 | 28 |
| 01.03.02 External stakeholders | 20 | 49 |
| 01.03.03 Relationships between stakeholders | 7 | 11 |
| 01.03.04 Other stakeholder information | 0 | 0 |
| 01.04 Demographic information | 0 | 0 |
| 01.04.01 Patient population | 4 | 16 |
| 01.04.01.01 Patient demographics | 4 | 4 |

| Name | Files | References |
|--|-------|------------|
| 01.04.01.02 Health issues | 0 | 0 |
| 01.04.01.03 Number of patients | 9 | 10 |
| 01.04.02 Geography | 0 | 0 |
| 01.04.02.01 Rural | 12 | 39 |
| 01.04.02.02 Urban | 0 | 0 |
| 01.04.02.03 Other | 2 | 4 |
| 01.04.03 Other demographic information | 2 | 2 |
| 01.05 GP practices in collaboration | 0 | 0 |
| 01.05.01 Number of practices | 17 | 40 |
| 01.05.02 Information on specific practice in collaboration | 9 | 10 |
| 01.05.03 Other information on GP practices | 5 | 5 |
| 01.06 Implementation of collaboration | 0 | 0 |
| 01.06.01 Timeline | 4 | 5 |
| 01.06.02 Prior to becoming collaboration | 14 | 49 |
| 01.06.03 Process of implementation and rationale | 13 | 43 |
| 01.06.04 Other information on implementation | 0 | 0 |
| 01.07 Other general information | 0 | 0 |
| 02 Reason for becoming GP collaboration | 1 | 1 |

| Name | Files | References |
|--|-------|------------|
| 02.01 Policy and regulation-related reasons | 0 | 0 |
| 02.01.01 NHS Long Term Plan | 1 | 1 |
| 02.01.02 GP contract | 0 | 0 |
| 02.01.03 Other policy and regulation reason | 3 | 3 |
| 02.02 Care-related reasons | 0 | 0 |
| 02.02.01 More or improved services | 8 | 16 |
| 02.02.02 Patient outcomes | 2 | 3 |
| 02.02.03 Other care-related reasons | 3 | 4 |
| 02.03 Organisational reasons | 0 | 0 |
| 02.03.01 Financial reasons | 1 | 1 |
| 02.03.01.01 Money received by collaboration | 8 | 28 |
| 02.03.01.02 Money spent or used by collaboration | 4 | 4 |
| 02.03.01.03 Other financial reasons | 7 | 9 |
| 02.03.02 Non-financial organisational efficiency | 8 | 10 |
| 02.03.03 Other organisational reasons | 4 | 4 |
| 02.04 Other reasons to become collaboration | 4 | 4 |
| 03 Collaboration services | 0 | 0 |
| 03.01 Patient services | 0 | 0 |

| Name | Files | References |
|--|-------|------------|
| 03.01.01 Community-based services | 13 | 27 |
| 03.01.02 Digital services | 2 | 2 |
| 03.01.03 Extended hours | 9 | 14 |
| 03.01.04 Personalised or specialised services | 2 | 2 |
| 03.01.05 Population-level services | 6 | 9 |
| 03.01.06 Other additional services | 7 | 12 |
| 03.02 Organisational resources | 0 | 0 |
| 03.02.01 Shared administration and back office support | 10 | 21 |
| 03.02.02 Pooled resources | 8 | 13 |
| 03.02.03 Data sharing | 8 | 13 |
| 03.02.04 Other organisational resources | 8 | 10 |
| 03.03 Other collaboration services | 0 | 0 |
| 04 Impacts | 0 | 0 |
| 04.01 Services delivery impacts | 0 | 0 |
| 04.01.01 Positive | 12 | 34 |
| 04.01.02 Negative | 7 | 19 |
| 04.01.03 No or neutral impact | 13 | 14 |
| 04.02 Patient outcome impacts | 0 | 0 |

| Name | Files | References |
|-------------------------------|-------|------------|
| 04.02.01 Positive | 9 | 14 |
| 04.02.02 Negative | 2 | 2 |
| 04.02.03 No or neutral impact | 4 | 5 |
| 04.03 Staff impacts | 0 | 0 |
| 04.03.01 Positive | 14 | 32 |
| 04.03.02 Negative | 10 | 25 |
| 04.03.03 No or neutral impact | 5 | 5 |
| 04.04 Organisational impacts | 0 | 0 |
| 04.04.01 Positive | 13 | 25 |
| 04.04.02 Negative | 8 | 20 |
| 04.04.03 No or neutral impact | 9 | 10 |
| 04.05 Financial impacts | 0 | 0 |
| 04.05.01 Positive | 12 | 20 |
| 04.05.02 Negative | 6 | 14 |
| 04.05.03 No or neutral impact | 11 | 19 |
| 04.06 Other impacts | 0 | 0 |
| 04.06.01 Positive | 2 | 3 |
| 04.06.02 Negative | 3 | 4 |

| Name | Files | References |
|--|-------|------------|
| 04.06.03 No or neutral impact | 3 | 3 |
| 05 Goals and metrics | 0 | 0 |
| 05.01 Stated goals of collaboration | 14 | 41 |
| 05.02 Metrics used to measure success | 10 | 15 |
| 05.03 Other information on goals and metrics | 4 | 5 |
| 06 What is going well | 0 | 0 |
| 06.01 Types of successes | 0 | 0 |
| 06.01.01 Ways of working and collaborating between staff | 15 | 39 |
| 06.01.02 Management and governance | 12 | 22 |
| 06.01.03 Services provision improvements | 13 | 37 |
| 06.01.04 Policy and regulation successes | 2 | 2 |
| 06.01.05 Resources | 7 | 9 |
| 06.01.06 Other types of successes | 6 | 7 |
| 06.02 Facilitators of success | 2 | 2 |
| 06.03 Other information on successes | 2 | 2 |
| 07 What is not going well | 0 | 0 |
| 07.01 Types of challenges or failures | 0 | 0 |
| 07.01.01 Ways of working and collaborating with staff | 20 | 39 |

| Name | Files | References |
|--|-------|------------|
| 07.01.02 Management and governance | 18 | 87 |
| 07.01.03 Services provision challenges | 11 | 27 |
| 07.01.04 Patient-level challenges | 3 | 5 |
| 07.01.05 Policy and regulation challenges | 17 | 63 |
| 07.01.06 Resources | 15 | 49 |
| 07.01.07 Other types of challenges or failures | 14 | 36 |
| 07.02 Tensions | 17 | 58 |
| 07.03 Overcoming challenges or failures | 12 | 21 |
| 07.04 Other information on challenges or failures | 2 | 3 |
| 08 Future of collaboration | 0 | 0 |
| 08.01 Future priorities | 22 | 74 |
| 08.02 Future challenges | 17 | 34 |
| 08.03 Other information on future of collaboration | 1 | 1 |
| 09 Other topics | 1 | 1 |
| 10 Interviewee information | 0 | 0 |
| 10.01 Role | 24 | 35 |
| 10.02 Other information about interviewee | 5 | 6 |
| 11 Quotes | 24 | 122 |

Appendix 5: Additional survey tables

Table 8 and Table 9 provide additional information on survey responses for this evaluation.

Table 8: Reasons to form or join a primary care network from survey

| | Very important | Somewhat important | Not important | Not sure or N/A |
|---|-----------------------|---------------------------|----------------------|------------------------|
| To help us meet the objectives of the NHS Long Term Plan | 7 (25%) | 10 (36%) | 4 (14%) | 7 (25%) |
| To help sustain the viability/sustainability of general practice | 15 (56%) | 6 (22%) | 0 (0%) | 6 (22%) |
| Access additional funding available to our practice via the PCN contract | 13 (46%) | 7 (25%) | 2 (7%) | 4 (14%) |
| Secure additional primary care services (for example practice-based pharmacy, social prescribing, etc.) | 12 (43%) | 9 (32%) | 1 (4%) | 6 (21%) |
| Improving co-ordination and delivery of primary care services for patients | 14 (52%) | 6 (22%) | 2 (7%) | 5 (19%) |
| Increasing collaborative working with other practices and primary care providers | 13 (46%) | 6 (21%) | 3 (11%) | 6 (21%) |
| Increasing opportunities for professional development for GPs and other members of staff | 7 (27%) | 9 (35%) | 3 (12%) | 7 (27%) |
| Enabling us to strengthen the management support available to our practice and local primary care services | 9 (32%) | 9 (32%) | 5 (18%) | 5 (18%) |
| Improving clinical governance arrangements across local practices and services (i.e. having a systematic | 12 (43%) | 10 (36%) | 0 (0%) | 6 (21%) |

| | | | | |
|--|------------|-------------|-----------|------------|
| approach to maintaining and improving the quality of patient care and service delivery) | | | | |
| Increasing involvement of primary care and general practice in decision making about the commissioning of local health services | 9 (33%) | 11 (41%) | 0 (0%) | 7 (26%) |

Table 9: Primary care network challenges from survey

| | Very challenging | Somewhat challenging | Not challenging | Not sure or N/A | Response Total |
|--|-----------------------------|---------------------------------|----------------------------|----------------------------|---------------------------|
| Establishing governance arrangements for the PCN | 4 14% | 10 36% | 3 11% | 11 39% | 28 |
| Accessing funds specific to supporting collaborative/PCN working | 3 7% | 8 29% | 5 18% | 13 46% | 28 |
| Agreeing how funds will flow from the PCN to practice | 2 7% | 10 36% | 5 18% | 11 39% | 28 |
| Sharing data across practices with regard to clinical governance | 5 18% | 6 21% | 6 21% | 11 39% | 28 |
| Sharing data across practices with regard to service planning | 3 11% | 7 25% | 8 29% | 10 36% | 28 |
| Appointing a pharmacist | 6 21% | 6 21% | 5 18% | 11 39% | 28 |
| Appointing a social prescriber | 4 14% | 5 18% | 8 29% | 11 39% | 28 |
| Securing enough management and administration support | 5 18% | 8 29% | 6 21% | 9 32% | 28 |
| Building relationships and networks between those involved in PCN | 4 14% | 8 29% | 8 29% | 8 29% | 28 |
| Securing sufficient leadership by senior members of collaboration | 5 18% | 7 25% | 7 25% | 9 32% | 28 |

| | | | | | |
|---|----------|----------|----------|-----------|----|
| Agreeing aims and objectives for the PCN | 2 7% | 6 21% | 8 29% | 12 43% | 28 |
| Support and guidance provided by NHS England | 7 25% | 5 18% | 2 7% | 14 50% | 28 |
| Support provided by CCG | 4 14% | 5 18% | 6 21% | 13 46% | 28 |

Topic Report