Primary Care Networks (PCNs) Maturity Impact Evaluation

Report for Lancashire and South Cumbria ICS

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Edge Hill University

EPA
Unit for
Evaluation &
Policy Analysis

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Executive Summary

Lancashire and South Cumbria (LSC) Integrated Care System (ICS) have commissioned an evaluation project from the Evaluation and Policy Analysis Unit (EPA) at Edge Hill University in collaboration with the University of Cumbria to help inform development of a robust development support offer for Primary Care Networks (PCNs) going forward.

The evaluation gathered views and opinion of key stakeholders about the usefulness, strengths and potential areas for improvement of the LSC PCN Development Support tool. Our analysis revealed enthusiasm and widespread support for the application of this tool and identified some areas to further strengthen the utility of the tool for PCNs.

- For our respondents, maturity was associated with added value delivering high quality health care services to local populations and reflective of good partnership work with other organisations addressing health inequalities
- Respondents welcomed the developmental support derived from the tool and it was perceived as helpful during the initial developmental phase of PCNs
- Improving the tool should be guided by current and future needs, taking into account learning from the COVID-19 period
- A balance should be struck between granular detail capturing specifics of PCNs and the generic side of the tool
- To maximise its potential role in addressing health inequalities, linking the tool domains with dashboard data was seen as important
- The tool should capture risks to PCN maturity such as the high workload demands on clinical directors of PCNs
- It was felt that new skills and competencies were required not just at PCN level but also at neighbourhood team level
- The PCN Development Support tool was seen as a key tool to facilitate shared learning across PCNs
- Information from self-assessment returns should be synthesised to formulate key lessons across PCN footprint including other partner organisations

On the basis of our findings we make the following recommendations:

1. Continue to use the PCN Development Support tool as a quality improvement and shared learning mechanism for PCNs across the LSC Integrated Care System (ICS) footprint
2. Embed the PCN Development Support tool within a narrative of quality improvement taking into consideration factors including workload wellbeing, fatigue and burnout of staff
3. Co-produce the next iteration of the PCN Development Support tool with all stakeholders, including neighbourhood team leads
4. Link dashboard data to matrix domains where possible
5. Develop a theory of change on maturity and its impact on health equalities
6. Identify future development support offers specific to PCNs

1. Introduction

Transforming primary care services through maximising the benefits of Primary Care Networks (PCNs) supporting neighbourhoods is a key priority for the Lancashire and South Cumbria (LSC) Integrated Care System (ICS). Additional investment of £1.34 million per year has been allocated across LSC in 2019/20 and in 2020/21 to support PCN development. There has been significant progress with the development of PCNs since they were formally established in 2019, with many areas already having operated as neighbourhoods prior to this. LSC have commissioned an evaluation project from the Evaluation and Policy Analysis Unit (EPA) at Edge Hill University in collaboration with the University of Cumbria to help inform development of a robust development support offer for PCNs going forward.

1.1. Background to the LSC PCN Development Support Tool

Maturity matrix tools are commonly used in healthcare organisations as a means to assess and improve the maturity of new practices (Carvalho et al., 2016). They can be a useful method for organisations to assess their progress of development over time, and to identify development needs and encourage quality improvement attempts (Elwyn et al., 2010; Tonkin et al., 2020).

Although maturity matrix tools are widely used within healthcare, the literature suggests that there is no shared definition of what 'maturity' in fact means. Most studies instead define maturity in terms of 'stages of maturity'. Tonkin et al. (2020) refer to five stages of maturity which include pre-contemplation, awareness and planning, active commitment, embedded and leading. Whilst Kirk et al. (2014) refer to three stages: emerging, maturing and established.

The LSC PCN Development Support tool was 'developed by partners across Lancashire and South Cumbria to support the development of Primary Care Networks and Neighbourhoods' (Healthier Lancashire and South Cumbria, 2019, p. 3). The tool was updated in September 2019 in light of the NHS England Primary Care Maturity Matrix (NHS England and NHS Improvement, 2019), 'the NHS Long Term Plan and the five year framework for GP contract reform' (Healthier Lancashire and South Cumbria, 2019, p. 3). The PCN Development Support tool focuses on aspects of maturity across six developmental themes:

1. Leadership and Corporate Governance
2. Population Health Management and Care Models
3. Empowering People and Communities
4. Care Teams and Clinical Governance
5. Resource Management
6. Provider Collaboration

LSC conducted an initial self-assessment exercise in 2019 which utilised an earlier version of the Development Support tool as a tool for reporting and developing an action plan.

1.2. Evaluation aim

The aim of the evaluation was to evaluate the impact of PCNs, identifying the characteristics of an effective PCN and informing the future LSC PCN development support offer.

The evaluation had the following objectives:

1. To obtain the views and opinions of key stakeholders on the PCN Development Support tool
2. To gather evidence about the strengths and areas for improvement of the PCN Development Support tool

2. Methods

To achieve the aims of this evaluation, a mixed-methods approach was undertaken. In summary, the following data collection activities were conducted:

1. A documentary analysis of programme policies and documents guided by an evaluability assessment framework
2. Semi-structured interviews with key stakeholders

Further details of the data collected are outlined below.

2.1. Data collection

The project team undertook a series of individual and group interviews (*N*=10) to assess the PCN Development Support tool. In total 11 participants were interviewed including PCN programme staff, ICP Leads, and Mature PCNs (a breakdown of participant demographic information is provided in table 1 below).

Table 1. **Number of participants by type of participant**

Participant group	Number of participants
PCN Programme Staff	5
ICP Leads	4
Mature PCNs	2

All interviews were conducted remotely either online using Microsoft Teams or Zoom or by phone, at a time convenient to the participants between August of 2021 and April of 2022. A semi-structured approach was followed, with the evaluators utilising an interview schedule and exploring concepts and responses in more depth through follow-up question. The interviews lasted between 21 and 54 minutes and were on

average approximately 37 minutes long. All of the interviews were recorded with the consent of the interviewee, transcribed and anonymised.

2.2. Data analysis

The anonymised interview transcripts were analysed using Thematic Analysis (Braun and Clarke, 2006). For the analysis, two researchers read through the transcripts independently and identified initial codes. These codes were then compared and refined into a number of key themes. Disagreements were resolved through discussion and consensus. The themes were then integrated and examined against the aims and objectives of the PCN maturity impact evaluation.

3. Findings

We report our findings below in three sections. The first section presents the evidence with regard to the PCN Development Support tool itself, how to define it, as well as perceptions of it by our respondents and their views on how to develop it further.

The second section summarises our respondents' views on which support is needed to develop mature integrated care systems with PCNs as their core component.

In the last, third, section we synthesise comments from our interviewees in relation to shared learning and how the PCN Development Support tool can support this process. We illustrate the findings with selective verbatim quotes without attribution to maintain confidentiality.

3.1. Defining Maturity

There was a broad range of views amongst our respondents about what constitutes maturity of Primary Care Networks in the present context. Some attempted to define maturity through a series of skills and competencies, whereas others framed it through the ability of strategic staff to provide leadership capacity and capability.

Respondents also articulated that these different approaches to understanding maturity may be reflective of its ambiguous nature, speak to its flexibility and adaptability, yet also makes it difficult to define precisely. To some extent respondents thought that the way in which the PCN Development Support tool has been utilised in Lancashire and South Cumbria has helped to address this latent ambiguity of the concept.

The most detailed attempt to define maturity in primary care networks was formulated by one respondent who identified different layers of maturity, closely aligning with what we found in the literature on the topic.

The respondent defined maturity as:

1. A quality of the relationship between GP practices

2. The existence of appropriate contract and infrastructure
3. A focus on patient outcomes and the ability to maximise PCNs' impact on health inequalities

The third aspect of maturity was reiterated by almost all respondents. Addressing health inequalities was seen as a key component and main impetus for maturing PCNs.

> "I would be saying, we're improving outcomes, reducing inequalities by working in that effective team, everyone knows each other and are we an amazing team? That would be the gold standard."

Maturity was perceived as something that added value to existing services and was essential to bringing about system integration. It was clear from our interviews that respondents interpreted this broadly, including an engagement with local communities and alignment to other care services for communities.

> "The ultimate goal of primary care networks, and the ultimate goal of integrated care communities, are exactly the same, in that they ultimately look to ensure that populations within local communities are thriving in every sense, not just from a physical health perspective, or a mental health perspective, but in a general wellbeing setting as well."

There were, however, some reservations about the future direction of travel. Much of this remaining scepticism was rooted in the perception that integration policy had to be translated into strong actions on the ground improving health inequality of local populations.

> "They are … genuinely going to start looking at variation across their area, [but] are they really empowered to do that, what does that really mean, what would the expectation be, because unless we can be very clear about what PCNs will do in the future and what are we developing them towards, you know what is the end goal, and that's where I think it gets blurry."

There was also a recognition that PCNs are at different levels of maturity. Respondents expressed the desire to see the wider strategic direction supported by processes that measured the impact of PCNs on patient care and improving patient care quality and patient satisfaction.

3.1.1. Summary

- There is a strong consensus that maturity is associated with added value delivering high quality health care services to local populations
- There is also clear agreement that maturity is reflective of good partnership work with other organisations addressing health inequalities
- There remains some ambiguity about what constitutes maturity in the current PCN context

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3.2. Maturity matrix as tool

Most of our respondents had been part of the initial self-assessment exercise in 2019 which utilised an earlier version of the PCN Development Support tool as a tool for reporting and developing an action plan. They commonly acknowledged that the PCN Development Support tool is just one tool amongst others in the planning and quality improvement arsenal and there was agreement on its importance and usefulness for PCNs strategic planning and assessment.

> "I see it as being a really important tool for PCNs to reflect on where they are and start planning on where they want to be."

There were some voices which also pointed to some limitations of the current tool. In particular, respondents thought it may fall short to capture the individual character, specific needs, and unique conditions of some PCNs. For those interviewees, the tool however still functioned as an important mechanism to initiate conversations amongst PCN colleagues.

> "The Maturity Matrix gave us a number of different headings and that generated a number of conversations."

> "It's a place to start conversations from, I think, as a summative tool. I think it kind of misses points somewhere along the line… given the individual how we're all very, very different to each other... it's going to be very difficult to kind of come up with a single, a single summative tool as it were."

> "We were doing something slightly different to everywhere else in that [location] and [location]; they're technically two separate PCNs but they were going to work very, very closely together and I don't think the maturity matrix was really that flexible to reflect that."

It was noteworthy that those in strategic positions outside PCNs would generally perceive of the PCN Development Support tool as a useful tool to be applied across PCNs whereas those working within, or leading PCNs were more sceptical about its generic applicability.

For example, one of our respondents was confident that the PCN Development Support tool 'was a consistent model that we could apply across all the primary care networks'; a view that was not shared by others.

The *practical* applicability was also an important aspect of the tool for some respondents. They reflected positively on how the tool guided the developmental process of PCNs but also commented on its limitations.

> "It was a little bit like a roadmap for the PCNs, of how d'you get from kind of like square one to kind of like where you need to be."

In contrast there were some voices which pointed out the limits of what a single tool could accomplish in developing PCNs.

> "I realised that the maturity matrix only took you so far. You then had to develop a whole series of documents like workforce sharing agreements, all the

> governance, setting up a payment system, governance charts, building relationships with the people who are going to pay money to you like the CCG and NHS England and making sure that's all streamlined. So, we almost had to put the maturity matrix to one side."

It therefore appears that the PCN Development Support tool plays a heuristic and normative function in the development of PCNs. It sets out basic parameters of development and maturity thereby defining standards and benchmarks, whilst also being a useful aid to initiating critical conversations.

Respondents were agreed however that the PCN Development Support tool should not be understood as a tool to define next steps for operational activities of PCNs.

> "But I do think that at times it was misconstrued as something that could be used to—giving people a list of things to do, and that will develop you. Not sure that always works in the real world."

An important insight was provided by one of our respondents who speculated that PCNs may in fact overestimate their maturity when self-assessing their services. There were also some who thought that the exercise itself in 2019 had been insufficiently based on SMART (Specific, Measurable, Achievable, Relevant and Time-bound) benchmarks and standards.

This was related to the wider theme encapsulating the dual nature of the LSC PCN Development Support tool as a self-assessment tool and a mechanism to begin conversations about PCN development with colleagues. The tension between the 'quality improvement' impetus of the tool and its compliance or assessment aspect was commented on repeatedly by our interviewees.

> "It was helpful to have that as a guide. My sort of main motivation, though, is just having that as one of many supportive tools rather than as an assessment."

The way in which PCNs used the PCN Development Support tool may itself, in fact, be associated with maturity levels. There were some indications from our respondents that where the networks had been working well and, incidentally, had a history of collaborative working, the tool was welcomed and utilised quickly, whereas PCNs which had just established themselves often struggled to use it to maximum effect when it was first rolled out in 2019.

It appears that using the PCN Development Support tool itself required skills and respondents noted that there was a significant amount of support and learning events organised by the emerging ICS to help them complete the initial self-assessment.

> "The extent to which PCNs recognise the value of doing that process is variable. I think some of them are really... and they embraced it the first year that we did it and found it helpful."

> "If they see it as a supportive tool and a tool to help develop themselves, I think they …want to fill it in because they know it supports them. I think those PCNs who are … not as mature as others, those who view it as a tick box exercise are not using it to its full potential."

There was a strong consensus that completing the PCN Development Support tool itself required significant administrative capacity and, where PCN managers had been appointed, the process appeared to be smooth and without any glitches. Some other PCNs thought they lacked the capacity and capability to complete the tool yet.

3.2.1. Summary

- Respondents perceived some tension between the generic nature of the PCN Development Support tool and the specific circumstances of PCNs
- They welcomed the developmental support derived from the tool
- The tool was perceived as helpful during the initial developmental phase of PCNs
- Respondents were more sceptical as to the tool's operational utility to define next steps in their journey

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3.3. Improving the tool

Improving the current version of the tool was an important topic for our respondents. Addressing the issue of its generic nature, one interviewee thought that an additional narrative would be able to capture the specific aspects of each PCN, increasing its applicability in the long term.

> "We can try and find a way of having some sort of narrative that goes alongside it, to really capture the granularity of what is happening in each place."

But others thought there were risks in using the tool as a regular assessment mechanism. The main reservation would be potential duplication with other ongoing assessments.

> "Some people were actually developing the maturity matrix into a full-blown development plan that again, you come along and that's where it started to wear people down because they were constantly being asked similar but not exactly the same questions and where they were up to with different documents."

In addition, there were some omissions in the tool that respondents would like to see added to future versions. Reporting on GP burnout and staff wellbeing was one issue repeatedly mentioned. This was seen as particularly important in the wake of the COVID-19 pandemic and the enormous increase in workloads for practices.

Some felt that there may also be some sections that appeared quite extensive and of more limited value to some respondents.

> "I found it, as I remember, just a bit, a little bit too detailed or too much. There was a lot of stuff to fill in and I didn't really know how to fill it in if I'm totally honest, coming from a very naive standpoint really."

However, interviewees were agreed that, if the tool could be adapted to the current challenges facing GPs and PCNs it would maximise its utility and effectiveness for future PCN development.

> "I do think that it'd be beneficial to review it, just to make sure that it's not particularly outdated in any way."

Better alignment of the tool with the key component of PCN work, co-producing and maintaining a neighbourhood approach, was stressed as a potential area for improvement. It was felt that as a key strategic aim of PCNs, the neighbourhood model and the place-based approach should constitute an important part of the tool.

> "It probably needs to be a bit more place-based so that it stretches beyond the GP practices necessarily and into the relationships that they have with borough councils and any sort of things that they've set up throughout the pandemic."

Others expanded on this thought and linked it with the strategic direction and central policy goal of PCNs to improve health inequalities in local populations. To achieve this aim, respondents thought that the PCN Development Support tool could be helpful to assist in widening the organisational boundaries of collaborative working and conversations to be had.

> "Other clinicians that will have a positive influence on the function of the Primary Care Network and those are the clinical providers, namely community nursing and community pharmacy, and then [the question is] which are all of the other partners that we should be working with, so included in that are people like the local authority, housing, the voluntary sector."

There was a sense amongst our respondents that much of the partnership and relationship building was still ahead of them, highlighting a potential key purpose and utility of the tool.

> "Multi-agency working is the next big developmental step for PCNs, and that's difficult, you know building those relationships, the local authority and housing for example, you don't even know who to talk to."

Last but not least, some respondents expressed a desire to see the PCN Development Support tool connected with a data dashboard which would capture PCN performance. Again, this aligned with the tension that respondents noted about whether the LSC PCN Development Support tool was to be a compliance and monitoring tool or, alternatively, a quality improvement tool in a broader sense.

> "It would be really good to be able to have some sort of dashboard that gives us an idea of performance now."

3.3.1. Summary

- Improving the tool should be guided by current and future needs, taking into account learning from the COVID-19 period

- There needs to be a balance struck between granular detail capturing specifics of PCNs and generic tool as developmental mechanism
- To maximise its potential role in addressing health inequalities, linking the tool domains with dashboard data was seen as essential

3.4. Support needs

Our interviews produced a considerable amount of views and opinions about the type of support that should underpin the maturity development of PCNs. We report our findings in the section below. Generally, respondents identified needs at system, organisational and team level. There was a sense shared by interviewees that developing maturity in PCNs was a journey from being a loose network to a corporate entity. It was felt that this journey had to be underpinned by different types of development support offers.

Starting with individual support first, interviewees commented on the novel nature of their work when incorporating and organising PCNs. The position of clinical director was repeatedly mentioned as particularly vulnerable given the high workload and competing demands on this dual clinical and strategic role.

> "You get a real sense of PCN clinical directors as islands and what you don't hear them certainly in that report is their wider leadership teams and their wider support mechanisms... one of the things that I think we need to do is work with them and support them to think about it's not just me on my own. I might be the clinical director but I need to think organisationally."

For the wider team, respondents thought that specific skills were required which could be developed through continuing professional development. The need for leadership training and coaching was mentioned frequently in this category.

> "PCNs [need to] understand how they anchor with some of those new organisational forms… and how they can continue to have a strong voice in terms of the leadership within those new places."

Respondents also highlighted that PCNs created new roles and responsibilities for other clinical and administrative staff. The ability to undertake commissioning tasks was perceived as particularly challenging as it went hand in hand with responsibilities of addressing health inequalities.

> "We will need both business intelligence, but also clinical informatics' in the commissioning role."

Again, specific skill sets were seen to correlate with these new tasks and roles, as well as capabilities that had previously been provided by Clinical Commissioning Groups (CCGs).

> "We will become micro commissioners, as it were, we will take ownership of the extended access piece of work that was previously held at the CCG level, that's going to transfer over to primary care networks. So, we need that

> commissioning arm of what we do. And that support and that knowledge in that skill set."

With regard to the wider organisational context, respondents noted that the exact position of PCNs within the Integrated Care System landscape was still to be determined which required ongoing work to understand where PCNs fit into the integrated care partnerships.

They emphasised that the exact relationships between multiple agencies operating in the place based and neighbourhood context still had to be clarified. To some it seemed not sufficiently clear how PCNs would link in with the various care organisations they were supposed to work with. In particular, there appeared to be some concern about how to structure the work with those partner organisations that were outside the NHS.

Respondents articulated that they were conscious of the magnitude of change. Developing mature PCNs was seen as nothing less than a wholesale transformation of the delivery and commissioning structure.

> "How do you develop PCNs into a structure, an organisation that has that maturity and sophistication around delivering services at scale because historically GPs have done a great job at working independently as GPs but maybe there's different dynamics, different tensions in different areas around working together and what we need to be doing is … effectively forming them organisational units for delivery of care and everything that underpins an organisation."

It was felt that much of the arrangements were still emerging and still needed to be clarified.

> "[New partnerships] will need to go through our governance and processes, some of it will go to the place-based partnership board and some of it will go up to the integrated care board and that's where they will have to agree the different governance measures, things like the quality agenda I think will sit more locally and each place-based partnership will have their own quality team."

> "For me, it's the clarification around budgets and finance but I still think that will sit in one place and we'll all link into it."

Echoing this, some interviewees pointed out that control appeared to be gravitating away from CCGs and the centre to neighbourhood teams who would need to be upskilled and competent in exercising control and oversight.

> "Historically … GPs [through CCGs had a direct] influence over policy or decisions being made whereas that's going to become more distant and I guess the challenge is making sure that still informs anything that gets shaped because we [GPs] are the people that have the greatest contacts with the public, that level of activity."

There was a recognition that the new arrangements also required other organisations to adjust, to increase their competencies and skills which raised the question who would drive those changes.

> "You can't do it unless you've got a really strong team behind you and that team is your Integrated Neighbourhood Team, so it all comes down to sort of, it's almost like locus of control issues really."

A considerable challenge would also be the need to deal with uncertainties, risks and complexities on a daily basis where previously, routine clinical practices had dominated the work of primary care practices. Our respondents were keen to stress that managing these complexities required additional skills. Some felt that GP work had previously occurred largely within the primary care field but this area was now redefined through partnership work at neighbourhood level with significant analytical and strategic planning tasks.

Interviewees also pointed out that partnership work takes time to mature which meant that PCNs and their leads needed some time and space for informal networking and relationship building with partners.

Our interviews also revealed strong views on the wider system support needs if PCNs were to mature over time. Respondents acknowledged that PCNs had already attracted significant investment and appreciated where central financial support made it possible to create the post of manager.

> "[There] was a real clear commitment that 80% of the resource and the activity around transformation will be at place level, with 20% at system level."

They reflected on the fact that expectations were high for PCNs to deliver better care across their local populations in a cost-effective way. In this context, there was a concern that PCNs were perhaps at times seen as a panacea for challenges that had developed over a long time. In particular, respondents were clear about the governance challenge as responsibilities were moving to the PCNs previously held elsewhere. Governance arrangements were not always seen as sufficiently robust yet for this shift to be effective.

> "I think a lot of our PCN issues at the minute are where PCNs don't have a strong governance. They're not clear about how the PCN is supposed to work, what they do when issues arise: all of the kind of the small bits but become a big bit if something goes wrong. So I think, for me, [there needs to be] a really strong clinical director leader underpinned by a really good manager and a very strong governance arrangement."

Yet there was also an enormous amount of positivity about how much this transformation had opened up opportunities to change and improve services to patients. New collaborative agreements amongst PCNs were now seen as possible which could be underpinned by innovative ways of working.

> "I think one thing we've tried to do is spread the workload amongst the practices. So, recognising certain expertise in some areas. So, for instance, one of our practices had already previously employed a physio. So, what we were able to

do was to ask that practice was to take care of any new physios that came along and in fact, they've done a great job. We've gone from no physios to this time last year to five and when you get five working across nine practices, it's really very, very good coverage."

In particular, new innovative solutions were found with regard to workforce development and recruitment practices for nurses.

> "What we've done is we've gone back a step almost and recruited trainee nurse associates with the idea of growing our own, maybe in a year, two years' time we'll have a group of nursing associates coming through that way."

3.4.1. Summary

- The position of clinical director in PCNs was perceived as vulnerable due to new demands requiring excellent team management skills to prevent isolation from other colleagues
- There was widespread acknowledgement of the significant financial investment and support for PCNs
- Respondents recognised any change will take time to bed in
- It was felt that new skills and competencies were required not just at PCN level but also at neighbourhood team level

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3.5. Shared learning

In this last section we outline the perceptions of respondents on how to stimulate and maximise shared learning across PCNs and the wider care landscape as part of developing mature networks in primary care. Interviewees identified three different levels at which learning occurred: at the level of strategic partnership, between PCNs and learning with regard to the PCN Development Support tool and in its application in the future.

There was unequivocal praise that the PCN Development Support tool had made possible the development of the leadership programme delivered by the North West Leadership Academy. This was seen as a positive example for the kind of support emerging from the self-assessment returns during the first round of the PCN Development Support tool in 2019.

Respondents were keen to emphasise that support measures should be accessible across the ICS footprint with some bespoke elements for those PCNs with specific needs. The PCN Development Support tool was perceived as an ideal mechanism to identify, monitor and address these generic and specific support needs which could then be synthesised into wider system learning.

There was some concern to understand better how the learning in each individual PCN could be distilled and utilised for the wider ICS organisational landscape. It was noted

that this would require a distinct piece of work extracting key lessons from self-assessment returns on a regular basis.

Some respondents also articulated innovative ideas that may stimulate system learning. The notion of a collective PCN assembly was mooted which could promote shared learning across PCNs and allow clinical directors and the leadership to share their experiences.

In addition, a buddy scheme was mentioned which could see mature PCNs being paired with still developing PCNs to support them through the journey by sharing their expertise and knowledge.

> "I think there's a lot there that we could facilitate shared learning and maybe buddied up and PCNs helping one another to develop and grow and get the best out of it."

3.5.1. Summary

- The PCN Development Support tool is seen as a key tool to facilitate shared learning across PCNs
- Information from self-assessment returns should be synthesised to formulate key lessons across PCN footprint including other partner organisations
- PCN Assembly and Buddy Scheme were suggested as support mechanisms for continuing learning and improvement

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4. Discussion

Our respondents were positive about the initial round of self-assessment with the PCN Development Support tool in 2019. They appreciated its potential to support developmental processes, identifying strengths and room for improvements as PCNs designed and implemented new ways of working with a range of organisations at ICS as well as neighbourhood level. There was good evidence that applying the tool opened up possibilities of new conversations as well as novel ways of working and innovative solutions in workforce development as well as partnership working. The tool's ability to facilitate critical self-assessment of PCNs emerging as new centres of planning, commissioning and delivering care for local populations was also highly appreciated by our respondents. They felt that using the tool provided insights into which areas required additional support and which were reaching maturity.

In addition, our respondents indicated that the tool had the potential to become a key mechanism to facilitate learning between PCNs and across the wider ICS footprint if data returns were synthesised and distilled into lessons learned. We sensed that there was a difference in opinion about the nature of the tool, perceiving it as a performance compliance and standards assessment mechanism on one hand, and seeing it as a quality improvement tool on the other. Either way, our respondents thought that the tool's potential would be maximised if it struck the right balance between detail and granularity capturing the individual specifics of each PCN and generic items which would permit generalisable evidence about support needs of all PCNs.

Improving the tool to take account of developments during the pandemic as well as more recent clarifications about the role of PCNs within the wider ICS landscape was seen as important to ensure its relevance and utility. There were suggestions about including particular systemic vulnerabilities or risks as PCNs matured, such as the position of clinical director, ensuring that the role was sufficiently supported within the team and received dedicated training and coaching requisite to its new tasks around commissioning, service planning and partnership building. A Collective PCN Assembly was proposed as an innovative and effective way to share learning across the ICS footprint.

4.1. Areas for improvement

Duplication of reporting was frequently mentioned as a possible risk that needed to be reduced in future. Respondents felt that there was a chance that some of the information requested through the PCN Development Support tool may be requested elsewhere as well through other reporting mechanisms.

Whilst the tool was perceived as useful for defining developmental needs of PCNs, in particular for clearly identifying the strengths and areas for improvement, it was stressed by our respondents that it was less practical to use it as a guide for 'next steps'. It was thus seen to have mainly a developmental rather than operational purpose.

We also received comments about the difficulty to assess the impact of maturity on patient care outcomes. The tool was thought to be potentially beneficial to the process of clarifying how using the PCN Development Support tool could leverage better understanding of how health inequalities for citizens have been improved through PCN development. The tool was seen as potentially useful to understand how future demand for health service across primary, urgent and acute care may potentially be influenced by PCN maturity.

In this sense, linking performance data of PCNs to maturity development was understood by our respondents to be a potential benefit of the tool. Interviewees thought that this would produce a strong evidence base of how maturity can underpin improving patient care outcomes. As PCNs strategically develop and embed, it would be important to assess the correlation between PCN maturity and population health outcomes. Identifying relevant metrics and aligning them with maturity domains would be an important next step when utilising the PCN Development Support tool in the future.

4.2. Limitations

Our evaluation has several limitations. The project took place when GPs and clinical directors of PCNs had extraordinarily high workloads during and following the pandemic and we managed to speak only to a small number of stakeholders. Most of them had been involved with the earliest application of the PCN Development Support tool in 2019. At that point some of them were participating in the assessment exercise in the capacity holding leadership positions within Clinical Commissioning Groups or the initial configurations of still emerging PCNs. Widening the range of people to be interviewed, including strategic staff at organisations represented on integrated partnership boards, would have increased the depth of feedback and improved our understanding of how the tool can function as an improvement mechanism supporting PCNs in their developmental journey.

Analysing patient outcomes for maturing and yet developing PCNs was not within the scope of this evaluation. Conducting this analysis however would allow the identification of those PCNs which have the greatest positive impact on patient outcomes and help develop a theory of change model that would support positive impact development in the future. Development support offers could then be formulated on a robust evidence base to ensure PCNs receive the necessary assistance in their journey to maturity.

5. Conclusion

The evaluation gathered views and opinion of key stakeholders about the usefulness, strengths and potential areas for improvement of the PCN Development Support tool. Our analysis revealed enthusiasm and widespread support for the application of this tool and identified some areas to further strengthen the utility of the PCN Development Support tool for PCNs.

6. Recommendations

1. Continue to use the PCN Development Support tool as a quality improvement and shared learning mechanism for PCNs across the LSC Integrated Care System (ICS) footprint
2. Embed the PCN Development Support tool within a narrative of quality improvement taking into consideration factors including workload wellbeing, fatigue and burnout of staff
3. Co-produce the next iteration of the PCN Development Support tool with all stakeholders, including neighbourhood team leads
4. Link dashboard data to matrix domains where possible
5. Develop a theory of change on maturity and its impact on health equalities
6. Identify future development support offers specific to PCNs

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