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

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Scientific summary

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Background

In its *Five Year Forward View* strategic plan published in 2014 (NHS England. *Five Year Forward View*. London: NHS England; 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 general practices (GPs) 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' (contains public sector information licensed under the Open Government License v3.0). As a result, PCNs were introduced in 2019 with the aim of forming groups of GPs to hold shared budgets and 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, PCNs have a formal, incentivised and almost compulsory feel compared with many predecessor schemes of collective primary care. Unsurprisingly, almost all GPs have joined a PCN.

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

Objectives

The overarching purpose of this evaluation was to produce early evidence of the development and implementation of PCNs 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 if and how the experiences of rural collaborations may differ from those of urban examples.

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

- What was the contextual and policy background within which PCNs were introduced?
    - What were the pre-existing forms of GP collaborative working across primary care in England?
    - How have new PCNs been implemented in a sample of urban and rural settings?
    - How do new PCNs relate to pre-existing GP collaborations?
- What are the rationales and motives for GPs to enter into GP collaborations, including new PCNs? In particular, what role do financial incentives play in facilitating or inhibiting collaboration? What are the expected outcomes for PCNs?
- 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 PCNs?

- What appear to be the barriers to and facilitators of effective collaboration across GPs, both with respect to successful and unsuccessful collaboration, and achieving impact or not?
- What does the analysis of prior experience of GP collaborations, and the early implementation of PCNs, suggest in terms of the likely progress of PCNs in the NHS in England, including in the 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 four work packages.

Work package 1: 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 to 2012) and primary care research studies and reviews (published from 2013 to 2018) using key search terms in titles and abstracts in PubMed® (National Library of Medicine, Bethesda, MD, USA), Ovid® (Wolters Kluwer, Alphen aan den Rijn, the Netherlands) MEDLINE® (National Library of Medicine), Web of Science™ (Clarivate™, Philadelphia, PA, USA) and Scopus® (Elsevier, Amsterdam, the Netherlands) for literature published in English only.

Work package 2: stakeholder workshop

We delivered a workshop for relevant stakeholders (e.g. academic and policy experts in the field, patient and public involvement representatives), at which 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 PCNs and thus inform next steps for work package 3.

Work package 3: comparative case studies of four primary care networks (minimum of two in rural settings)

We undertook a multifaceted 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 (CCGs) 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 PCN – usually a senior manager or administrator). We also undertook interviews ($n = 25$) with those involved in the conceptual design, implementation of the PCN in their respective sites and exploration of the relationship of the network with any prior GP collaboration in the case study site; analysis of the key documentation (both internal and publicly shared); non-participant observations ($n = 10$) 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.* (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 Med Res Methodol* 2013;**13**:117) framework method for the analysis of qualitative data in multidisciplinary health research. 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 (owing to local cancellations).

Work package 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

We will share and discuss findings generated from data collection and develop recommendations for commissioners, providers and policy-makers through academic outputs.

Results

Findings from the rapid evidence assessment identified some important lessons for PCNs to consider, such as the time it is likely to take for PCNs 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. PCNs 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 PCNs largely support the overarching policy aims set for them, and GPs across England have seized the opportunity to access new funding to form networks. However, many general practitioners and their teams place a higher priority on matters of particular concern to those working in GP and primary care, namely those related to enhancing the sustainability of primary care itself, workload issues and improving the availability and co-ordination of local primary care services.

There is a paradox for PCNs in that, on the one hand, they are expected to meet local population health needs, yet, on the other hand, 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 or not these are considered by PCN 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 PCNs: some participants expressed positive views and were supportive of the national approach, whereas others were frustrated at having to toe a government line to receive new funding, feeling that the 'PCN policy' had been imposed on GP in a rather rushed manner.

Prior general practitioner collaborations

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

Previous collaborations helped the PCN to build on prior successes such as the strong existing relationships between practices and integrated service delivery. Pragmatically, prior collaborations provided the PCN with operational support for hiring staff in new roles alongside greater management infrastructure. However, it was often a source of tension when the new network was perceived as undoing the work of the previous collaboration, when the aims of the PCN and the previous collaboration did not align, and when some practices that were part of two different previous collaborations were coming to 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 PCNs, and the top-down nature of national PCN policy. Hence, there were differences between local priorities for PCNs (compared with national policy objectives) and the extent of control that networks had over commissioning with respect to the local CCGs.

Taking time to clarify the role of PCNs within the health and social care system may help clarify how they work in relation to their local CCGs, 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 PCN. For some respondents in our evaluation, time and resources for organisational development were important, including through staff away days, joint training events and forums for practice managers and/or nurses from across the PCN.

Leadership and management

The need for effective leadership of the PCN, together with sufficient high-quality management support, was a strong theme in the evaluation fieldwork. It was clear that, although they are small organisations, PCNs 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 PCNs, the time required for meetings, recruitment of staff, implementing new roles and services alongside core services, and for administration and management of the network, was of particular note. The time pressure for those involved in PCN development was reported as an acute concern, especially for clinical directors and practice managers who have to do this on top of their usual 'day job'. The varied quality of leadership and management from PCN clinical directors raises a concern about the sustainability of these roles in the longer term, and the time commitment required of them presents a risk of burnout and instability in network leadership.

The role of funding and incentives

A strong and consistent message across our evaluation fieldwork was that PCNs 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 GP. The allocation of a new source of funding channelled directly into GP, rather than through an intermediary organisation such as the CCG or Sustainability and Transformation Partnership, was clearly welcomed in principle by most practices.

For others, however, the experience of setting up the PCN, 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 resources) entailed in setting up and running a PCN and its shared services, and the burden experienced by practices 'losing' general practitioners and management time to support the new organisation. For general practitioners, this deviated from their initial expectations of PCNs, which they felt would alleviate their workload and improve the financial stability of practices.

Relationship with the wider NHS system

Our evaluation revealed variation in the relationship between CCGs and PCNs. In some instances, CCGs have enabled and supported PCNs, providing resources and expertise to help establish interpractice working, hire new staff and operate contracts. In other areas, however, there was evidence of the CCG attempting to hold onto control that had been delegated to PCNs, 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 9 months of operation of PCNs. 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 how to work with their CCG(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 PCNs. Two of our case study PCNs were in rural areas whereas another was semirural. 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 adequately account for the experience of primary care in rural areas. For example, policy about recruiting new professional staff for PCNs 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 GP 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 suggest that local and national decision-makers consider the following:

- Increasing the engagement of GPs and wider primary care teams with PCNs –
  - There is a need for consistent long-term national policy about PCNs and other forms of GP collaboration that allows for local diversity of size and form of network, and also avoids the temptation to merge or reorganise PCNs.
  - It is important that realistic and clear goals are set for PCNs, both by NHS England and Improvement and by local CCGs.
  - Efforts should be made to ensure that national PCN policy is compatible with both rural and urban area primary care delivery.
- Building leadership and management capacity –
  - It is important for PCNs to build on the experience and expertise of pre-existing GP collaborations.
  - There is a need to ensure that there is sufficient and distributed management and organisational support for the PCN clinical director role.
  - It is important to ensure that the wider primary care team is able to be part of PCN leadership, and that good practice is shared locally and nationally.
- Clarifying how PCNs fit into the wider health and social care system –
  - NHS England and Improvement may wish to revisit the role of the PCN in the context of the health and care system as it emerges from the COVID-19 pandemic.
  - It is important to ensure that PCNs 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 CCGs in relation to PCNs.

In further research, it will be important to use a mix of quantitative and qualitative measures to evaluate and understand how PCNs move from an initial stage characterised by relatively high up-front costs to a more established phase in which the resources put into networks might contribute more meaningfully to sustainability and efficiency in primary care. In addition, the ongoing relationship between PCNs 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 GP. Overall, it will be vital that research into PCN progress, outcomes and ways of working is able to answer the question: do GPs need to collaborate to achieve key outcomes (e.g. improving access, achieving sustainability) and, if so, what support and investment is required?

Study registration

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