BRACE General Practice Quality Improvement Rapid Evaluation Protocol

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Protocol summary

Title

A rapid evaluation of the commissioning and delivery of quality improvement programmes in general practice in England

Introduction

Demand and patient complexity in general practice are increasing, and practices are facing a widening gap between this demand for consultations and the capacity available to meet it. Changes in the 2023/24 GP contract and publication of the NHS England 'Delivery plan for recovering access to primary care' have created a national policy push for quality improvement in general practice focussed on access.

Various quality improvement programmes and offerings have, in the last few years, been made available to support GP practices to make changes and improvements to how they organise access and manage demand. This includes the NHS England General Practice Improvement Programme (GPIP) and the Quality and Outcomes Framework (QOF) Quality Improvement (QI) project. From our scoping and engagement work, we understand GPIP remains one of several quality improvement programmes to recover access in GP practices, with many other programmes focusing more broadly on interdependent challenges, including patient safety, continuity of care, or personalised support.

However, little is known about the implementation of policies through quality improvement programmes designed to improve access in general practice, their alignment with local priorities and improvement programmes, and the role of regional stakeholders in supporting both national policy implementation and local improvements in GP practices. Integrated Care Boards (ICBs) are organised to meet the health needs of people in a specified geographical area. They are involved in commissioning, delivering, monitoring, and supporting improvement programmes in general practice. Yet their role and responsibilities in respect of commissioning and supporting general practice provider service improvement remain relatively under-specified.

The overall focus of this rapid evaluation will be on establishing a fuller understanding of quality improvement programmes that focus on improving access to general practice and achieving equity. We seek to identify the breadth of national, regional and local improvement programmes, and explore the role of ICBs in commissioning, supporting and delivering these programmes aiming to improve access to general practice. Accordingly, we will explore the preparedness of ICBs, their current activity, investment and approach to supporting quality improvement in general practice. Further, we will explore the extent to which ICBs align their efforts with national policies and programmes, and how they work with local primary care networks, and GP practices to support and build capacity for quality improvement. Through this investigation, we aim to generate timely lessons for the design and delivery of programmes aiming to improve access to general practice and access equity. Lessons

drawn from this study will inform a possible follow-on impact evaluation of quality improvement programmes addressing access to general practice.

Research design and methodology

To inform our study design and the development of this protocol, the research team engaged in scoping work to establish a contextual understanding of quality improvement in general practice across various organisational levels: GP practices, primary care networks, ICBs, and NHS England. We drew on perspectives from colleagues currently working across these levels as well as stakeholders within local medical committees and academics with expertise in primary care and general practice. We engaged with relevant peer-reviewed and grey literature, including one ongoing and one recently completed systematic review of quality improvement and organisational development in primary care. We consulted the BRACE Methodological (n=6), Patient and Public Involvement and Engagement (n=5) and BRACE Service Leaders panels (n=2), who provided feedback which helped to shape research questions and overall evaluation design.

Aims

The overall aim of this evaluation is to develop insights about the organisation, commissioning and delivery of quality improvement programmes targeted at improving access to general practice in a way that meets diverse local priorities and population needs. In doing so, we will explore the breadth of general practice improvement programmes that currently exist in general practice and explore their associated delivery models. We will examine the role of ICBs in commissioning, development and delivery of such quality improvement programmes, focusing on ICBs' engagement with evidence, and their collaboration with national stakeholders, and local primary care networks and GP practices. We will investigate how the role and activities of ICBs in quality improvement programmes are shaped both by national priorities and influences, and local issues and population needs.

Evaluation questions

1. What are the drivers, rationale and key characteristics of current general practice quality improvement programmes aiming to improve access and access equity?
2. How do ICBs support the commissioning, development and delivery of quality improvement programmes in general practice?
3. How (and to what extent) do ICBs work with primary care networks and GP practices, as well as national stakeholders, to support quality improvement and build the capacity necessary to improve access to general practice according to local population needs?
4. What lessons can be synthesised to support the commissioning, development and delivery of programmes for improving access to general practice?
5. How can findings inform future decision-making and research on general practice quality improvement programmes for commissioners and providers of general practice?

Method

The evaluation will consist of 4 work packages:

WP1. Mapping relevant literature

We identified two systematic literature reviews of quality improvement in general practice. We will draw on these two reviews as well as a prospective engagement with relevant policy and empirical literature to contextualise, categorise and describe interventions in our evaluation. We will also work with the BRACE Service Leaders' panel (comprised of members with extensive experience within the NHS including positions such as: NHS Foundation Trust Chief Executive, Community NHS Trust Chief Executive, ICB Chief Executive, ICB member, GP) to identify stakeholders at the ICB level, including policy and practice experts to establish an ICB Advisory Group. The ICB Advisory group will comprise of 4-6 members, including individuals with policy and practical experience of primary care integration and development within the ICB/ICSs. The group will support the evaluation team with insights into the ongoing organisation of ICBs and national developments impacting their role in the implementation, delivery and oversight of general practice quality improvement programmes.

WP2. Experiences of national stakeholders

Building on earlier scoping interviews, we will gather data from the perspectives and experiences of national stakeholders in commissioning, development and delivery of quality improvement programmes in general practice. We will interview 10-15 individual stakeholders to understand what is currently working well and what is needed for ICBs, in partnership with GP practices and primary care networks, to build capacity for, develop and support quality improvement activities. These interviews will focus on exploring policies and contextual factors that may enable or inhibit quality improvement initiatives at the GP practice level.

WP3. Qualitative case study work

We will select four ICB region case studies to explore in-depth how general practice quality improvement programmes are understood and experienced locally by stakeholders at ICB, primary care network and GP practice levels. A subset of case studies will include ICBs whose primary care networks or GP practices have undergone the GPIP programme, as well as those that have completed (or are completing) other (or a range of) quality improvement programmes. We will interview stakeholders, including primary care and quality improvement leads and Patient and Public Involvement and Engagement (PPIE) contributors at ICBs and primary care networks, GP partners, practice managers, salaried GPs, practice nurses and other clinical and administrative staff involved in or impacted by quality improvement (N=10-12 interviews per case study site). We will also conduct focus groups with GP practice patient participation groups (N=1-2 focus groups per case study site) and review local policy documents and reports about the quality improvement programmes. To a gain a more representative understanding of stakeholder experiences we will supplement the interviews with an online survey with bespoke questions for each stakeholder group.

WP4. Analysis, synthesis and sharing of learning

We will draw on relevant theories and frameworks, such as assemblage thinking and concepts such as power, resistance and opinion leaders, in our analysis to develop insights within and across case studies. The experiences of national stakeholders will be analysed thematically to identify enablers and barriers to commission, develop and implement quality improvement programmes in general practice. These themes will be elaborated in the case study analysis with the perspectives from stakeholders at ICBs, primary care networks and GP practices. Each case study will be written-up as a descriptive account of how general practice quality improvement programmes developed locally, how they have been commissioned, how they are implemented, and what impact they have or are expected to

have. The case study narratives will inform further within and cross case analysis that draws on existing theoretical lenses as mentioned above to describe the role and activities of ICBs as they relate to quality improvement programmes for general practice. Alongside the case study narratives, we will develop a 'theory of change' for each case study, describing the drivers, rationale and key characteristics of the quality improvement programmes. We will hold research team workshops to build and reflect on emergent themes to draw together findings across case studies and across work packages. Two online workshops will be held to rapidly test and refine findings, one workshop with NHS England, ICB leads, GPs and selected members from the BRACE advisory panels and another workshop with stakeholders from each case study site.

Outputs and dissemination

Results from this evaluation project will be written up in a report and published in the NIHR Journals Library (HSDR programme), and we will also share the findings from this project in a number of ways, both written and oral, as described below:

1. A summary slide deck highlighting key findings and their implications, which may be of particular interest to NHS England and the NHS more widely.
2. Work with National Voices to understand how best to communicate findings with relevant patient groups.
3. Web-based resources such as blogs/short-read pieces to highlight key findings to non-expert as well as more expert audiences.
4. Papers published in high quality, peer-reviewed, academic journals.
5. Workshops highlighting the key findings and methodology, intended for NHS primary and secondary care organisations such as the NHS Confederation and ICBs.
6. Oral and/or poster conference presentations.
7. Disseminating findings through BRACE networks and drawing on the expertise and assistance of our PPIE collaborators, service leaders and methods advisory group members as well as steering group members.

Timescale

This study take place over a period of 12 months from July 2024 to June 2025.

Funding roles and responsibilities

BRACE is funded by the NIHR Health and Social Care Delivery Research (HSDR) Programme (HSDR Project: NIHR156533 - The Birmingham, RAND and Cambridge Evaluation (BRACE) Rapid Evaluation Centre).

Background design and rationale

Background and rationale

Demand and patient complexity in general practice are increasing, and practices are facing a widening gap between this demand for consultations and the capacity available to meet it (1–3). Practices experience pressures and workforce challenges, with these often felt most acutely in practices working in areas of high need and deprivation, and in isolated rural locations (4–7).

Various national quality improvement programmes and offerings have in the last few years been made available to support GP practices to make changes and improvements to how they work. This includes the NHS England General Practice Improvement Programme (GPIP) (8), the Quality and Outcomes Framework (QOF) Quality Improvement (QI) project (first developed in 2019 by the Royal College of General Practitioners in collaboration with NICE and the Health Foundation) (9–11), and other technology- and workforce-based improvement innovations (12,13).

Improving access to general practice has always been national priority but even more so since NHS England published the 'Delivery plan for recovering access to primary care' in May 2023 (14). This was accompanied with changes in the GP contract, setting out the requirement for practices to offer patients an assessment of need and next steps at first contact (15). Guidance to improve access specifies a 'modern general practice model' (16), which builds on prior digital and workforce innovations such as remote consultation, digital triage, and the Additional Roles Reimbursement Scheme (ARRS). It aims to help GP practices improve access by:

- understanding practice demand and capacity
- improving online and telephone access routes
- using care navigation and triage systems
- signposting patients to the most appropriate service
- allocating clinical capacity according to need

Defining access

Access to general practice is often defined in terms of supply and/or utilisation of care based on need (17). The strategies proposed in the NHS England access recovery plan aim to improve access according to this definition. The five domains of the 'modern general practice model' aim to address the appropriate utilisation of care by implementing processes and technologies that support the appropriate allocation of appointments based on patient needs. Other strategies aim to increase the supply of appointments, for example, through extended access services outside of core working hours and diversification of the clinical workforce offering appointments through the ARRS and community pharmacies.

An interpretive literature review of healthcare access highlighted that the utilisation of care is not simply the appropriate allocation of care based on need, but a dynamic and contingent process of negotiation between patients, healthcare professionals and health services to establish which patients are eligible candidates for care (17). Under this broader definition, access is also affected, for example, by the capabilities of patients to navigate health services as well as seamless health service integration, or the capabilities of patients to express and assert their needs and preferences across different consultation modalities. Improving access, as such, involves a wider set of interventions and approaches, including continuity of care, personalised care, telehealth or patient education programmes.

Yet the effectiveness of national policy efforts to implement and deliver quality improvement programmes to improve access in general practice remains unclear. General practice staff express concerns about the implementation and impact of the improvement strategies outlined in the general practice recovery plan. The ARRS, for example, has been cited as lacking flexibility, while making the organisation of general practice and its workforce more complex, increasing administrative and supervisory work, without reducing GP workloads (18,19). Moreover, technological innovations run the risk of requiring staff to do more, more quickly, and in more complicated ways (16,20,21).

The role of integrated card boards in general practice improvement

Alignment between national general practice access improvement programmes and the improvement efforts and priorities in GP practices needs to be better understood (22). Integrated Care Boards (ICBs) are expected to play an increasingly important role in mediating between the national change agenda and local improvement programmes. ICBs were established following the 2022 Health and Care Act to encourage better integration of services to meet local population needs. ICBs are one part of an Integrated Care System (ICS) alongside Integrated Care Partnerships (ICPs). An ICS is a partnership of NHS organisations, local authorities and other organisations responsible for planning services, improving health and reducing inequalities in a geographical area of 500 000 to 3 million people. Within an ICS, the ICP is responsible for developing a health and care strategy for the ICS area, and the ICB is responsible for the planning and commissioning of most NHS services, including primary care services and general practice.

ICBs have specific responsibilities for supporting GP practices moving to a ‘modern general practice model’ and to monitor and report on local progress against elements of the national delivery plan (22). Yet it is unclear how ICBs are expected to fulfil this responsibility, and how they are working with primary care networks and GP practices to support and build capacity for quality improvement activities aimed at delivering equitable access to general practice. Besides potential challenges for ICBs to manage national priorities alongside local priorities based on population needs, their dual role in supporting and monitoring quality improvement could be problematic. When not managed carefully, an unbalanced split between monitoring and improvement activities across organisations can create tensions as experienced prior in the relationships between GP practices and commissioners in primary care trusts (23). Nevertheless, ICBs are expected to play an increasingly prominent role in commissioning, delivering and supporting quality improvement programmes in general practice. To support and prepare ICBs accordingly, their current role, challenges, preparedness and support needs should be understood.

The overall focus of this rapid evaluation will be on establishing a fuller understanding of quality improvement programmes that focus on improving access to general practice and access equity. On the one hand, we seek to explore the breadth of national, regional and local improvement programmes, and explore how these programmes are intended to achieve improvements in access to general practice and access equity. From our scoping and engagement work, we understand that GPIP remains one of several quality improvement programmes being delivered in support of the general practice recovery plan, with many programmes taking a broader approach to address interdependent challenges, such as patient safety, continuity of care, and personalised support. For example, Birmingham and Solihull ICB are involved in the Primary Care Transformation programme, and Birmingham and Solihull ICB are delivering the Right Access First Time (RAFT) programme (24) and have established a General Practice Support Unit to work with their 182 practices on the full range of practice development and support. Similarities and differences across these programmes and how they are experienced by different stakeholder groups

can provide lessons for the development of future improvement programmes in general practice.

Additionally, we will investigate and explore the potential roles of ICBs in commissioning, supporting and delivering quality improvement programmes aiming to improve access to general practice and access equity. Very little is known about the preparedness of ICBs, and their current activity around, investment in and approach to supporting quality improvement in general practice, nor the degree to which they work with primary care networks and GP practices to support and build capacity for quality improvement in general practice. As discussed, some interventions in quality improvement programmes on access might not be well received by GP practice staff, and the distribution of roles across ICBs, primary care networks, and GP practices might cause tensions when not managed carefully. As such, findings from this evaluation can provide lessons to support the implementation of quality improvement programmes in general practice and further clarify possible roles of ICBs, primary care networks and GP practices in relation to commissioning and supporting general practice service improvement. Moreover, it would provide the foundation for a possible follow-on study to assesses the effectiveness of quality improvement programmes delivered in general practice nationally against a range of primary care outcomes including (but not limited to) access, continuity of care, and patient and staff satisfaction.

Preliminary scoping work

We have undertaken scoping activities to better understand the landscape of quality improvement interventions in general practice and perspectives at ICB levels to help shape the design of the rapid evaluation with service leaders. These scoping activities comprised:

- **Scoping conversations with key stakeholders** (total n=12, with 15 participants):
    - Leaders within primary care teams based in ICBs (n=2).
    - General practitioners either working as GP partners or locums, as part of primary care networks (PCNs) as well as large scale super partnerships (n=4)
    - Regional NHS England stakeholders with responsibility for oversight quality improvement programmes for general practice (n=1)
    - Leading academic experts (n=3)
    - Clinical lead at Local Medical Committee (n=1)
    - Clinical lead working in NHS community healthcare trust (n=1)

- **Workshops with the BRACE Patient and Public Involvement and Engagement (PPIE) (n=5) and BRACE methodological groups (n=6)** who provided feedback on the initial topic specification and drafts of the protocol.

- **Between December and June 2024, the BRACE team (FW, JS, MS) held five meetings with the NHS England Primary Care Transformation team**, who oversee the delivery of the GPIP. NHS England have shared various programme documents related to GPIP (e.g. recruitment of primary care networks and GP practices, content covered as part of the programme and theoretical underpinning using the Support Level Framework), and documents related to Accelerate, the predecessor quality improvement programme delivered to general practice in England. A review of these documents, a wider rapid evidence review, and attendance at two GPIP webinars for programme applicants helped us to understand the programme context and content.

- **A tightly focused academic literature search**. In our literature search, we identified two systematic literature reviews of quality improvement in general practice. One review, completed by the Health Foundation in March 2023, catalogued and categorised interventions to improve access to general practice up until 2023, which we will use to contextualise, categorise and describe any interventions in our evaluation (25). Early findings from another ongoing review of quality improvement and organisational development in primary care and general practice will be used to inform interview questions about quality improvement programme impact and measures.

What have we learnt after undertaking scoping interviews with key stakeholders?

Synthesis from our scoping interviews has identified the following key learning:

Bottom-up vs top-down approach to GP quality improvement. Quality improvement has always been a key focus in general practice; however, much of the focus has gone into small scale projects led by junior colleagues and/or trainees at a practice level. For many of the stakeholders we spoke to, quality improvement in general practice should be locally driven and locally led as opposed to being initiated from the ICB level. Indeed, many felt ICBs were too remote for primary care networks and practices to engage with. In addition, clinical stakeholders felt there was a lack of clarity in the ICB's role in leading quality improvement work regionally and how they plan to operationalise learning captured. For example, how would data collected at regional ICB-level be used to support GP practice-level activity to address local population health needs, and would ICB involvement lead to increased collaborative working across primary, secondary and tertiary care?

The GPs interviewed stated that previous interaction with ICBs regarding quality improvement has been top down (driven by the ICS), poorly organised and not undertaken robustly enough, as well as lacking support and process to share learning. When asked what quality improvement work should entail, many felt it should go beyond improving access (although this remains important) but should include addressing:

1) local population needs in a wider context of addressing health inequalities;

2) improving the quality of care for the patient and ensuring they get treated by the 'right' health professional in a timely fashion and

3) having nationally prescribed and locally determined metrics in place to measure improvement as part of incentivised payment mechanism.

Integrated care board capacity for GP improvement. Stakeholders currently working with general practice felt that ICBs were still evolving but remained critical of their capacity to lead and coordinate quality improvement work regionally and their role in trying to dictate the work general practice has traditionally completed collaboratively from a grass roots level. Individuals we spoke to generally agreed that ICBs fail to understand how general practice operates. However, those we spoke to from ICBs described the greater leadership roles given to GPs recruited from local practices and PCNs to support quality improvement work alongside the development of local primary care collaboratives to acquire buy-in from primary care networks and GP practices. Yet, there are still challenges to achieving buy-in from GP practices due to a history of tensions between commissioner and provider.

Stakeholder interviewees felt any rapid evaluation should focus on how quality improvement is understood from the perspective of primary care networks and GP practices with consideration of priority of access for patients within the wider context of quality of care. There is a political and policy agenda to take in account too, where there is a national push

to ensure patients are seen as quickly as possible with a potentially lesser focus on care quality and continuity. In addition, there is a need to consider leadership and organisational maturity of primary care networks and practices alongside the strength of these relationships to work collaboratively to engage with national and local quality improvement programmes.

Why is this research important?

From our scoping and engagement work, we understand that a national intervention such as GPIP remains one of several quality improvement programmes being delivered in GP practices to improve access. Other programmes are being developed at the ICS level, in primary care networks and in GP practices to address both national priorities, like the GP Recovery programme, and local priorities based on population needs. Such quality improvement programmes often address challenges of access as part of broader goals to improve patient safety, patient experience, and continuity of care.

An understanding of quality improvement programmes that address general practice access, and the extent to which they are funded, supported and delivered at the ICB, primary care network and GP practice levels is important because it provides time-critical learning about the future commissioning, organisation and delivery of quality improvement programmes in general practice in a way that can meet diverse local priorities and population needs.

Understanding the challenges and successes at primary care network and GP practice level, and the extent to which they have been effectively supported by their ICBs, can add to the existing limited evidence on what works well in terms how ICBs can work with primary care networks and GP practices to address local challenges. Findings would support ICBs to define their roles and goals for commissioning and supporting quality improvement in general practice. Insights can be used by ICBs and primary care networks to appraise the preparedness and capabilities of ICBs to commission, support and guide such improvement activity.

Plan for this evaluation

Aims and objectives

The aim of this evaluation is to improve our understanding of the commissioning, organisation and delivery of quality improvement programmes that aim to improve access to general practice and access equity across areas with diverse local priorities and population needs. Through this understanding, the evaluation aims to provide time-critical learning to stakeholders involved in these quality improvement programmes, including NHS England, ICBs, primary care networks and GP practices.

Our evaluation will address the following objectives:

1. To understand the drivers, rationale and key characteristics of current general practice quality improvement programmes, including associated programme rationales
2. To examine the role of ICBs in the commissioning, development and delivery of such quality improvement programmes in general practice, with a focus on the evidence used for their commissioning and general practice support work.
3. To understand what factors influence how ICBs work with GP practices and primary care networks as well as national stakeholders to build capacity for, develop and support quality improvement activities aimed at addressing local problems with general practice access and quality of care.

4. To draw lessons for implementation and possible future impact evaluation of quality improvement initiatives in general practice, including how ICBs can work with primary care networks and GP practices to build and sustain the capacity necessary to deliver general practice quality improvement, and what elements might need to be included in ICB commissioning guidance for general practice improvement work.

Evaluation questions

To address the aim and objectives, the rapid evaluation seeks to answer the following research questions:

1. What are the drivers, rationale and key characteristics of current general practice quality improvement programmes aiming to improve access and access equity?
2. How do ICBs support the commissioning, development and delivery of quality improvement programmes in general practice?
3. How (and to what extent) do ICBs work with primary care networks and GP practices, as well as national stakeholders, to support quality improvement and build the capacity necessary to improve access to general practice according to local population needs?
4. What lessons can be synthesised to support the commissioning, development and delivery of programmes for improving access to general practice?
5. How can findings inform future decision-making and research on general practice quality improvement programmes for commissioners and providers of general practice?

Evaluation design

The evaluation will take a two-fold approach to 1) gather data on the perspectives of national and ICB stakeholders and 2) a deep-dive case study approach in several ICB areas to explore a range of current models and approaches being used to deliver quality improvement in general practice.

The BRACE team will answer the research questions through: the use of a mixed methods approach; input from the BRACE PPIE, Methodological and Services Leaders' panels; and insights and challenge from an ICB Advisory Group established specifically for this project.

Patient and Public Involvement and Engagement

The rapid evaluation has been designed with input from the BRACE Methodological, Service Leaders' and PPIE groups. During the scoping phase, we have obtained feedback from five independent PPIE reviewers on our topic specification form (a short proposal), which has been incorporated into the rapid evaluation design. Advice from PPIE members, which has been or will be acted upon, included: framing of research questions; how best to engage with stakeholders and PPIE contributors across ICBs, primary care networks and GP practices; and specific questions to include in stakeholder interview topic guides.

Topic guides for interviews and study information sheets will be reviewed by members of the BRACE PPIE group. We will have meetings with our PPIE group to provide input at various points throughout the evaluation, i.e. to advice on our proposed methods and provide input on data collection instruments and documents, to review and inform the interpretation of emerging findings, and to inform our approach to share learning. We will seek the advice of these PPIE members, alongside National Voices, in terms of the best ways to communicate findings to patient and public audiences, helping to ensure that dissemination activities have

a wide reach and impact. Project outputs will be reviewed by PPIE group members and revised accordingly.

Method

Theoretical framework

We will draw on multiple relevant theoretical concepts and literature, as set out in the next paragraph, to explore the breadth of quality improvement programmes to improve access in general practice, and the role of ICBs in commissioning, delivering, and supporting these programmes. We will compare and contrast different quality improvement programmes and varying manifestations of the same quality improvement programme across case study sites, describing each of the programmes in terms of their 'core components', 'causal mechanisms', and 'theory of change' (26–30). This will include the perspectives of commissioners, clinicians, and patients on the programme delivery model and relevant outcomes.

We will draw on 'assemblage thinking' to make sense of their connectedness and the role of ICBs (and other stakeholders) within the improvement programmes (31,32). We will refer to concepts such as power, resistance and opinion leaders to get a deeper understanding of the relational dynamics and any potential tensions between national stakeholders, ICBs, primary care networks and local GPs, who are engaging in and delivering improvement programmes (33–37). Additionally, Weick's concept of sensemaking will be considered to understand the processes by which relatively newly established ICBs navigate their local context to support general practice improvement (38,39).

Drawing on these different theoretical concepts will allow us to understand the role of ICBs:

1) within general practice improvement programmes
2) in relation to national, primary care network, and GP practice-level stakeholders involved in quality improvement
3) as relatively new public authorities in the process of becoming more practically defined

This will take into account the nature of relationships and responsibilities across organisational levels, to support general practice while simultaneously taking actions in pursuit of other ICB objectives.

Work Packages

We propose 4 Work Packages (WPs), as shown in Figure 1:

- WP1: Mapping of relevant literature of general practice improvement programmes and undertaking scoping interviews
- WP2: Understanding perspectives of national stakeholders
- WP3: Qualitative case study work
- WP4: Analysis, synthesis and sharing of learning

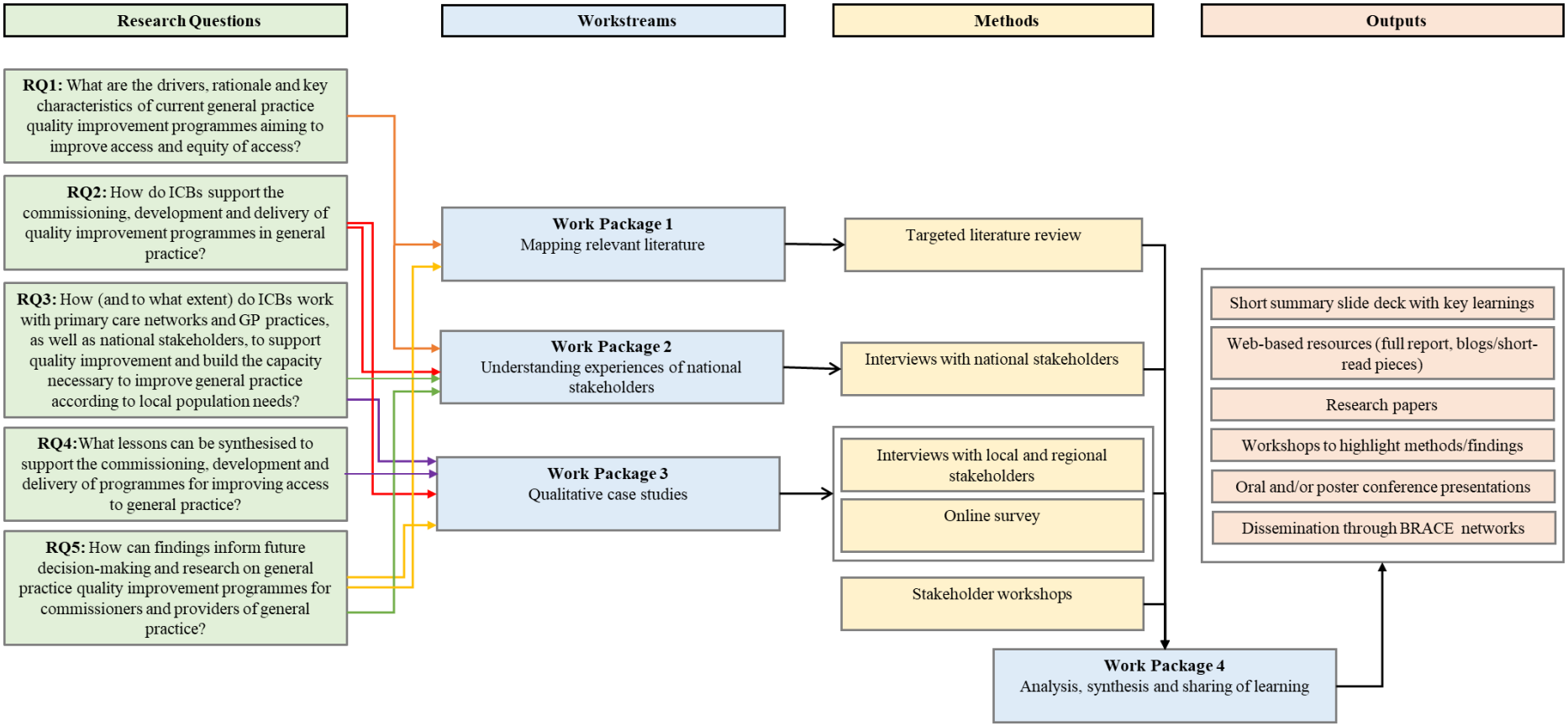


Figure 1. Summary of evaluation activities and links to research questions

The rapid evaluation has been designed with consultation with BRACE PPIE, Methodological and Service Leaders' advisory panels. Details of the study's Work Packages (WPs) are set out here.

Work package 1. Mapping relevant literature of large-scale national and other bespoke general practice improvement programmes as well as undertaking scoping interviews with key experts and stakeholders to inform qualitative case study work.

WP 1.1. We identified two systematic literature reviews of quality improvement in general practice in a rapid literature scan. One review, completed by the Health Foundation in March 2023, catalogued and categorised interventions to improve access to general practice up until 2023 (23). A NIHR HSDR-funded review by the University of Sheffield identifies studies of UK-based quality improvement and organisational development interventions in primary care and general practice and aligns them with the domains of the GPIP programme (defined as access to primary care systems/clinical services; structured information gathering, care navigation and triage; managing demand and capacity; managing the whole practice workload, and standard actions and outcomes, e.g. perceived time/cost savings, improvements to staff and/or patient experience, etc.). We will conduct a further rapid literature scan using HMIC, Medline, and Social Science Citation Index databases, as well as grey literature to identify quality improvement programmes with a focus on improving access delivered in general practice in the UK prospectively from 2023. Both reviews and the ongoing literature scan will be used to contextualise, categorise and describe interventions in our evaluation. We will be assisted in this by the Health Services Management Centre Knowledge and Evidence Service at the University of Birmingham.

The ongoing review of quality improvement and organisational development interventions by the University of Sheffield focuses on the metrics and indicators used in primary care and general practice. We will draw on these findings to inform our work on how current programmes of general practice quality improvement could be evaluated (RQ5).

WP1.2. We will work with our Service Leaders' panel to identify a convenience sample of key stakeholders involved in the design, implementation and oversight of general practice quality improvement programmes at the ICB level, along with other national primary care policy and practice experts from our BRACE networks and invite them to take part in scoping interviews (approximately N=10-15). Findings from the interviews will be integrated with learning from the mapping of literature and relevant ongoing review of quality improvement programmes (see WP1.1) to help shape and prioritise evaluation questions.

WP 1.3. Following this work package, we will submit a full study protocol to the NIHR HSDR programme and, in parallel, seek clarification from University of Birmingham Research Governance and Integrity about the types and levels of approvals needed for the study. We will also establish an ICB Advisory Group to provide ongoing input into the rapid evaluation.

Work package 2. Experiences of national stakeholders

WP2.1**.** Our iterative approach to undertaking scoping interviews (WP1.2) seeks to deepen our understanding of the broader context within which GP practices are undergoing quality improvement activity, and to help refine the focus of our evaluation with the role of ICBs in mind. Building on these scoping interviews, we will gather data from the perspectives and experiences of national stakeholders in commissioning, development and delivery of quality improvement programmes in general practice. We will interview 10-15 individual stakeholders to understand what is currently working well and what is needed for ICBs to build capacity for, develop and support quality improvement activities in partnership with GP practices and primary care networks (see Figure 2). These interviews will focus on exploring

policies and contextual factors that may enable or inhibit the implementation of quality improvement programmes in general practice. Interview participants will be sampled through snowballing, by asking people involved in our scoping work to identify organisations and individuals with a national perspective on quality improvement in general practice, access recovery in general practice, and the role of ICBs in general practice improvement. Interview participants will be asked to suggest further relevant organisations and individuals to interview. Our scoping highlighted several relevant national organisations in addition to NHS England, including

- the Royal College of General Practitioners, a new GPIP delivery partner;
- the Health Foundation and The Healthcare Improvement Studies (THIS) Institute at the University of Cambridge, finalising the Improving access to primary care (IMPRESS) project;
- the Q community of the Health Foundation, which develops and supports quality improvement communities of practice, including a Primary Care Special Interest group with 238 members;
- the NHS Confederation Primary Care Network;
- the King's Fund primary care lead and her team;
- Local Healthwatch and the National Association for Patient Participation;
- Care Quality Commission
- Colleagues across academic institutions, studying the development of ICSs and ICBs

Within these organisations, individuals have been identified who are either directly involved in work relating to quality improvement in primary care or who can refer us to the relevant individuals to interview.

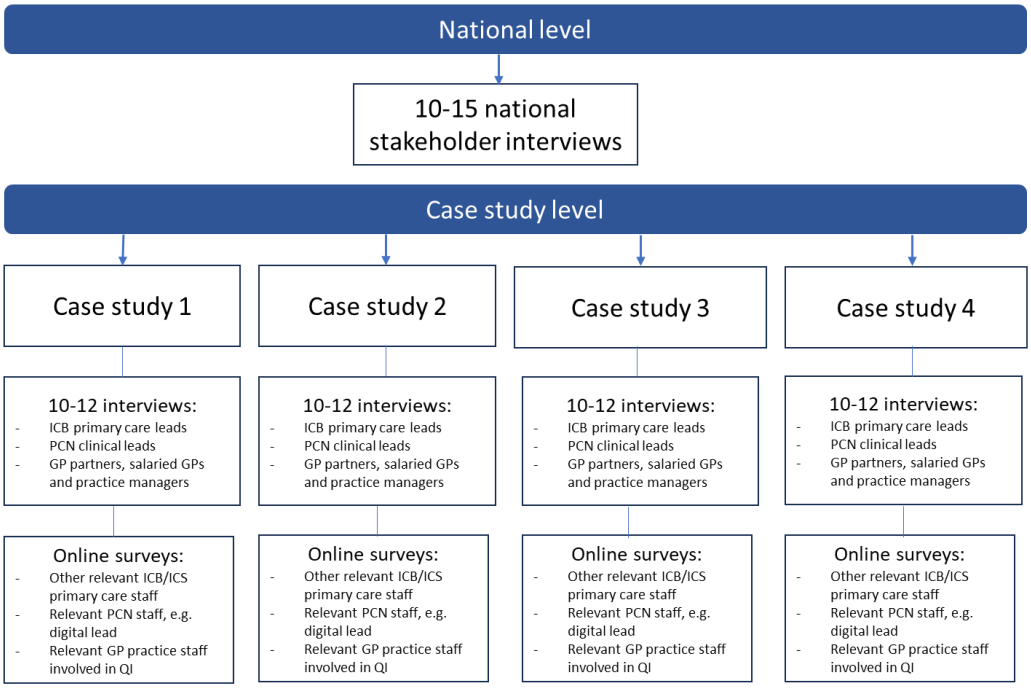
Work package 3. Qualitative case study work

WP3.1. A case study approach will be taken to explore in-depth the experiences of general practice quality improvement programmes across ICB, primary care network and GP practice levels (see Figure 2). We will recruit four case study sites. Each case study site represents the geographical area associated to an ICB (including the primary care networks and GP practices within this area). Case study sites are sampled by seeking variation in terms of prior history (if any) of developing regional quality improvement programmes, size and socioeconomic deprivation of population served, geography (rural, urban, coastal), and types of general practice models within the locality (e.g. Primary Care Networks (PCNs), GP federations, and GP super partnerships). A subset of case study sites will include ICBs whose primary care networks or GP practices have undergone the GPIP programme, as well as those that have used other (or a range) of quality improvement interventions. We will seek input from The Health Foundation-sponsored Q's Learning and Improving Across Systems participants. The initiative is through Q in partnership with NHS Confederation and engages those leading improvement in a range of roles within ICBs and local providers. We will seek to use this existing network to identify potential case study sites that range across the characteristics as described above. Site recruitment and selection will serve as an important engagement opportunity for supporting subsequent activities.

WP3.2. Interviews with local (GP practice and primary care network) and regional (ICB) stakeholders at case study sites. Such stakeholders will include general practice and quality improvement leads in ICBs and primary care networks, PPIE contributors, GPs (both GP partners and salaried GPs), practice managers, practice nurses and other clinical and administrative staff involved in or impacted by quality improvement (N=10-12 online interviews per case study site across possible GP practice and primary care networks).

Where appropriate we will undertake interviews with delivery partners at each case study site to understand more about training and support needs. We will also conduct focus groups with GP practice patient participation groups (N=1-2 focus groups per case study site) and review local policy documents and reports about the quality improvement programmes. Interviews and focus groups will explore the rationale and objectives of the general practice quality improvement programme as understood by different types of stakeholders. They will also address the challenges and opportunities experienced in undertaking the programme, the resources and incentives provided, and the overall sense of whether the programme has worked. We will ask how changes and impact are measured by ICBs, primary care networks and GP practices and how patients and the public have influenced the design, delivery and governance of programmes. Interviews will be scheduled in collaboration with local service leaders to prevent increased burden on staff. Flexible interview options (e.g. online or telephone) will be offered to accommodate interviewees where appropriate (see Table 2. Potential risks and mitigation strategies).

WP3.3. Online surveys using the Thiscovery platform to gain a wider breadth of understanding of stakeholder experiences within each case study site. We will supplement the interviews with an online survey with bespoke questions for different stakeholder group (including ICB primary care leads; relevant clinical leads at the primary care network or GP partnership level; individuals at the GP practice level, including GP partners and salaried staff as well as practice managers and patient representatives). The survey will include a combination of closed ended questions using ranking, Yes/No, and Likert scale response options as well as open ended questions. This will allow us to include a wider range of perspectives on general practice improvement programmes, including more diverse experiences on participation in improvement programmes (or reasons for not participating), on implementing change in general practice (either through formal improvement programmes or otherwise), and the perceived impact following improvement programmes (or lack thereof).



GP = general practitioners; ICB = integrated care board; ICS = integrated care system; PCN = primary care network; QI = quality improvement

Figure 2. Summary of national and case study level data collection approaches.

Case study data analysis is discussed in the following work package, WP4.

WP4. Analysis, synthesis and sharing of learning

Analysis of national stakeholder experiences

We will use multiple analytical approaches to analyse and synthesise findings across work packages and answer the evaluation questions. The experiences of national stakeholders (WP2) will be analysed thematically to identify enablers and barriers for the development and implementation of quality improvement programmes in general practice. Analysis follows the framework method for qualitative data in multi-disciplinary health research (40). This method of analysis is a systematic method of categorising and organising data while continuing to make analytical and interpretive choices transparent and auditable. The framework method allows us to combine deductive analysis, based on existing implementation frameworks such as the Consolidated Framework for Implementation Research (CFIR) (41,42), and inductive analysis to capture other barriers and facilitators related to the commissioning, development, and delivery of general practice quality improvement programmes. These themes will be elaborated in the case study analysis (WP3) with the perspectives from stakeholders at ICB, primary care network and GP practice level captured in interviews and the online survey.

Analysis of case studies

The qualitative case studies (WP3) are analysed with multiple analytical approaches, as set out below. We continue our use of the framework method to develop a descriptive account for each case study site, describing how general practice improvement support is designed, implemented and delivered across an ICS region. The framework approach allows us to develop descriptive accounts that are structurally similar, which facilitates constant comparison across the case study sites (40). We draw on relevant theories and frameworks to support the analysis and identify and develop relevant themes within and across cases. These will focus in part on the role and activities of ICBs as they relate to different quality improvement programmes for general practice.

Alongside the descriptive accounts, we develop a ‘theory of change’ for the general practice improvement programmes identified in each case study site (26–30). These will integrate diverse stakeholder perspectives on (expected and perceived) outcomes, rationale, and key characteristics of the general practice improvement programmes. The analysis will be informed by relevant documents in addition to stakeholder interviews and survey data. We draw on ‘assemblage thinking’ to make sense of the connectedness of diverse general practice improvement programmes, and the understand the role of ICBs (and other stakeholders) within these improvement programmes (31,32). We will also draw on our literature scan of general practice quality improvement programmes to support the development of assemblages and ‘theories of change’ by comparing and contrasting the programmes delivered in our case study sites across a broader range of general practice quality improvement interventions focus on improving access. This analysis will help us identify how to evaluate the effectiveness of diverse general practice improvement programmes implemented nationally.

The descriptive case study accounts and assemblages inform further interpretive analysis to explore the relational dynamics between ICBs, primary care networks, and GP practice-level stakeholders and how they either foster or hinder the delivery of quality improvement programmes. We will draw on theoretical concepts like power, resistance, opinion leaders and sensemaking to highlight the relational dynamics and tensions between national

stakeholders, ICBs, primary care networks and local GPs, and to understand how ICBs evolve across case study sites to better support general practice improvement (33–39)(38,39). This analysis combined with the contextual understanding of barriers and enablers (WP2, WP3) will help us to develop relevant guidance for ICBs to commission and support quality improvement in general practice based on a realistic understanding relational dynamics and needs across national stakeholders, ICBs, primary care networks, and GP practice staff.

Online workshops to analyse, test and refine findings

The research team will analyse and synthesise the findings from all the WPs iteratively and cumulatively by means of a series of online team workshop meetings. The team will iteratively engage with theoretical, empirical and policy relevant literature throughout the design, data collection, and analysis/interpretation stages of the evaluation to support synthesis of learning.

To further clarify, rapidly test and share interim/emerging findings from our data analysis, one 90-minute online workshop will be facilitated with representatives from NHS England Primary Care Transformation team, ICB primary care leads, GPs (with primary care network or other GP partnership leadership roles, GP partners, and salaried GPs), BRACE and selected members from BRACE Advisory Panels (i.e. Methodological, Service Leaders, Patient and Public Involvement, and ICB Advisory Group). This workshop will include presentation of early findings via a slide deck as a series of structured themes that will be deliberated and prioritised to draw lessons for the commissioning, development and delivery of quality improvement programmes in primary care and general practice.

A 60-minute online workshop will be facilitated with stakeholders from each case study site to test out emerging findings (N=4). We will synthesise learning from workshops along with overall data analysis and suggest recommendations for a) developing the evidence base for general practice quality improvement programmes including a framework for a possible longer-term evaluation; and b) how the initial rapid evaluation offers learning for how ICBs can build capacity to support quality improvement programmes in primary care.

Research outputs and dissemination

Results from this evaluation project will be written up in a threaded series of research outputs and published, along with an overarching narrative summary paper in the NIHR Journals Library (HSDR programme) and shared widely in a number of forms, both written and verbal as described below:

1. Protocol paper in an academic journal which sets out the team's plan of action, detailing in advance the rationale, methodology and analyses.
2. A slide deck including interim findings from each work package used as part of workshops with stakeholders and case study sites
3. A case study summary synthesising learning from workshops with sites
4. Web-based resources such as blogs/short-read pieces to highlight key findings to non-expert as well as more expert audiences
5. Papers published in high quality, peer-reviewed, academic journals for work package 2 and 3
6. An overall narrative summary which includes a framework for a possible longer-term evaluation of GPIP
7. Workshops highlighting the key findings and methodology, intended for NHS primary and secondary care organisations such as the NHS Confederation, the British Medical Association and Integrated Care Boards (ICBs)
8. Oral and/or poster conference presentations

9. Disseminating findings through BRACE networks and will draw on the expertise and assistance of our PPIE collaborators, service leaders and methods advisory group members as well as steering group members who are involved with the project and the BRACE Centre.
10. Work with National Voices to understand how best to communicate findings with relevant patient groups.

Throughout this process of sharing learning, particular attention will be paid to creating accessible forms of communication to lay audiences to ensure the benefit of this research can also be communicated to the public. We will work with National Voices to understand how to best communicate our findings in a positive way.

Project timetable

The project is anticipated to last a total of 12 months, including the 4-month scoping stage.

Table 1: Study timeline and key milestones

	2024									2025					
	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6
WP1. Scoping															
Scoping interviews															
Panel workshops															
(Grey) literature review															
Submit NIHR protocol															
WP2. National experiences															
Stakeholder interviews															
WP3. Case studies															
Site recruitment															
Case study interviews															
Online surveys															
WP4. Analysis, sharing learning															
Early finding workshops															
Analysis															
Drafting outputs															
Final NIHR report															

Project management, governance, and delivery

The co-principal investigators, Dr Manbinder Sidhu and Professor Judith Smith (University of Birmingham), will be responsible for the overall delivery and quality assurance of this project. The project manager and lead researcher, Dr Frances Wu (RAND Europe), will be responsible for the day-to-day management of inputs by the evaluation team members, which also includes Dr Sophie Spitters (University of Birmingham). All evaluation team members will conduct data collection, analysis and dissemination of the research.

We will apply the following project management principles and processes: ensuring clarity of team members' roles, and the delegation of tasks and reporting duties; internal team meetings and catch-ups; and use of project planning tools (such as Gantt chart, timesheets, internal monitoring reports). We will hold fortnightly team meetings to review progress and promptly address any issues arising. The project team will report to the BRACE Executive

team, the BRACE Steering Group, and NIHR HSDR as required. We describe potential risks and mitigation strategies in Table 2.

Research team

Team member	Role and contribution in research team	Relevant expertise
Professor Judith Smith, University of Birmingham	Principal investigator from the University of Birmingham, project conception and scoping, data collection, analysis, writing of reports/dissemination, overall editing and quality assurance.	Professor of Health Policy and Management. Methodology and Quality Assurance Lead for BRACE. Almost 30 years' experience in health services research, following an earlier career as a senior manager in the NHS. Specialising in healthcare organisation and management of primary care.
Dr Manbinder Sidhu, Associate Professor, University of Birmingham	Principal investigator from the University of Birmingham, project conception and scoping, data collection, analysis, writing of reports/dissemination	Associate Professor at the Health Services Management Centre. Deputy Director of BRACE. Expertise in rapid evaluations, including in primary care, evaluating primary care networks, and exploring impact on health inequalities.
Dr Frances Wu, Senior Analyst, RAND Europe	Project conception and scoping, project management, data collection, analysis, writing of reports/dissemination	Applied mixed methods researcher with experience in healthcare improvement and embedded research within healthcare delivery organisations, with a background in the sociology of organisations.
Dr Sophie Spitters, BRACE Fellow, University of Birmingham	Data collection and analysis. Writing of reports/dissemination, project management.	Research experience in primary care and studying quality improvement in healthcare. Specialised in qualitative research methods.

Table 2: Potential risks and mitigation strategies

Risk	Impact	Likelihood	Mitigation
Challenges to recruit and engage with NHS staff & stakeholders due to current pressures in general practice, especially areas of high need, social deprivation, and rural areas where they are felt more acutely	High	High	We are building on the established relationships within the BRACE network of researchers, health service leaders, and other stakeholders to advertise our study and make introductions with diverse ICBs and primary care networks, for example, the NENC Deep End GP Network. We are starting recruitment early in the financial year, planning to finish stakeholder interviews before the winter pressures start. Recruitment will be ongoing allowing relationships with some ICBs and practices, where capacity and/or a lack of trust are a barrier to participation, to establish and develop over a longer time. We will provide short summary documents to clarify the needs and benefits of participation. We will engage with non-clinical staff involved in managing access and improvement, like practice and rota managers, in addition to clinical staff. We will seek to have backup participants for interviews and maintain open communication and flexible scheduling for study participants. We will also implement flexible data collection methods, allowing participants to answer question in writing or audio-messages if preferred. In case of delays, we will communicate with the NIHR HSDR team to plan for contingencies.
Challenges to recruit and engage with NHS staff & stakeholders who have negative attitudes towards quality improvement and/or national policies on access	High	High	In our project information and communications, it will be important to highlight the independence of the BRACE evaluation and the objectivity we will bring in our approach. We will need to articulate succinctly why participation in the evaluation is important, so that we can capture the range of views. To capture a wider range of stakeholder views, including views of stakeholders with less favourable experiences and opinions of quality improvement programmes, we supplement qualitative interviews with an anonymous and convenient online survey. We will assure that survey responses will be kept anonymous to the extent possible, and that survey-based data will be reported in the aggregate. Any use of quotes from interviews will be presented in such a way as to keep the participant's identity anonymous.
Findings will lack relevance to the public	High	Medium	This evaluation aims to understand the role of ICBs in general practice improvement initiatives and is not directly focused on the impact of such initiatives on patient care and outcomes. To ensure this question is answered in light of the bigger purpose of improving patient care and access, we engage with our project PPIE panel throughout the different study stages. Our PPIE panel has contributed questions to consider during the study. They will support the interpretation of early findings, and contribute to the development of dissemination materials for the public. Following input from our PPIE panel, we also included focus groups with PPGs in the evaluation design to understand their involvement in the commissioning, development and delivery of quality

			improvement initiatives in their area. And we will interview PPIE contributors who have been involved in general practice quality improvement programmes through ICBs or primary care networks.
Roles and responsibilities in the commissioning, development and delivery of quality improvement initiatives will change during the evaluation	Low	High	Responsibilities for the delivery of the GPIP improvement initiative has shifted twice during scoping. More changes could follow the general elections. Following our scoping, we designed the evaluation to embrace a dynamic policy and improvement landscape. We will explore the role of ICBs across multiple general practice improvement initiatives. We will also contextualise interviews and stakeholder experience through our case study approach.
Stakeholders in our case study sites have limited experience with general practice quality improvement programmes focused on access	Low	Medium	Case study sites are selected based on variable experience with general practice access improvement programmes. Furthermore, within case study sites there are likely to be stakeholder groups and research participants with more or less involvement in general practice access improvement programmes. While our evaluation focuses primarily on the improvement of access in general practice, relevant lessons can also be drawn from other types of quality improvement work. In the first instance, we will ask participants about their experiences of quality improvement programmes with a main focus on improving access in general practice, or where improving access is relevant to achieve a broader or interdependent goal (such as continuity of care or personalised support). If participants have no prior experience of such programmes, we will ask them about their experiences of quality improvement generally. This is facilitated by functionality in the Thiscovery survey platform to ask nested questions.
Loss of key staff	Medium	Medium	RAND Europe has a flexible staffing model that enables access to a broader range of expertise within the team at RAND in the event of project staff turnover. Senior staff at the University of Birmingham and RAND Europe have extensive experience to carry out evaluations.
Loss of data	High	Low	Although data loss is unlikely, the University of Birmingham and RAND Europe have resilient, well-tested IT systems all computer data is backed up in multiple locations, ensuring the recovery of any lost data on local servers. The study team will create a data management plan to comply with the General Data Protection Regulation (GDPR) guidelines for the appropriate storage of consent forms and audio and video files.

Ethical issues and approvals required

We will seek appropriate governance and research ethical approval from the University of Birmingham Arts and Humanities Research Ethics Committee and NHS Health Research Authority (HRA) and local NHS Research and Development approval to recruit participants and collect data, as required.

The project team will contact the University of Birmingham Research Governance and Integrity Service to ascertain whether our study will be categorised as service evaluation or research. This will determine whether NHS Research Ethics Committee (Health Research Authority) approval is required. If the project is categorised as service evaluation an application for ethical review by the University of Birmingham's Research Ethics Committee will be made at the earliest possible opportunity, using our BRACE Centre/University of Birmingham Research Governance rapid ethical application framework agreement.

Participant consent

Interviewees will be asked to provide either oral or electronic consent (whereby electronic signatures include: stylus or finger drawn signature, a typed name, a tick box and declaration and a unique representation of characters). For oral consent the study team will take a three-step approach: 1) at the start of the proposed interview the researcher will explain the study to the participant, providing all pertinent information as covered in the information sheet and allow the potential participant opportunity to ask questions; 2) following this explanation, the participant will be given a few minutes to decide (if needed) whether they are happy to continue with the interview; 3) the researcher will then read all statements as detailed on the consent form verbatim and ask whether the participant agrees to all before commencing the interview.

We will provide information sheets in advance of interviews to all participants taking part in our evaluation which will detail its aim, study design, risks, benefits, who they may contact if they have further questions and their right to withdraw from the study at any point. Participants taking part in interviews will receive a letter from the study team along with an information sheet.

Indemnity and insurance

The University of Birmingham holds the relevant insurance cover for this study, as confirmed via our BRACE contract with NIHR.

Sponsor

The University of Birmingham will act as the main sponsor and guarantor for this study.

Data storage

Data will be stored securely and managed in accordance with the UK Data Protection Act (2018) and General Data Protection Regulation (GDPR) 2018 and in accordance with the University of Birmingham's policies for data storage and management. Identifiable data (names and contact details) may be stored at either the University of Birmingham or RAND Europe. All data will be stored on encrypted recorders, password-protected computers and servers, and will only be accessible to members of the research team. Data will be stored for a period of 10 years (or for no longer than in necessary) in line with the University of Birmingham's Research Data Management Policy, after which it will be destroyed. All data

will be reported anonymously and consent for this data plan will be obtained from all respondents prior to their participation in the study.

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