



Primary care networks

A pre-mortem to identify
potential risks

Working paper

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Primary care networks: A pre-mortem to identify potential risks

At the start of 2019, the NHS Long Term Plan introduced primary care networks (PCNs) as the building block of integrated care systems (ICSs).¹ PCNs are intended to cover 30-50,000 registered patients, and NHS England has produced a set of ambitions for these new bodies. However, while these ambitions provide a sense of direction for PCNs, further clarity at local levels about what the ambitions mean and how they can be realised is important for PCNs to avoid failure. Yet at this stage there is no indication that formal national guidance will be issued to direct local activity.

To help the system anticipate the risks and challenges PCNs are likely to face in the next five years, the Nuffield Trust and event partners drew together 45 GPs, local commissioners and representatives from NHS England/Improvement and the British Medical Association to undertake a 'pre-mortem' exercise to consider the threats and weaknesses of the introduction of PCNs by imagining their hypothetical failure. This working paper presents six risks that could lead to the failure of PCNs:

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- **Failure could be inherent in the policy design**
 - **PCNs may not be able to create effective organisations**
 - **PCNs could have a lack of focus**
 - **PCNs could experience failures of leadership and followership**
 - **PCNs could become overwhelmed by external pressure**
 - **Failure could be unfairly identified too early**
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We suggest a set of recommendations and possible solutions for avoiding each of these pitfalls.

¹ <https://www.longtermplan.nhs.uk>

Introduction

At the start of 2019, the NHS Long Term Plan introduced primary care networks (PCNs) as the building block of integrated care systems (ICSs).² PCNs are intended to cover 30-50,000 registered patients (with some flexibility). Around 1,300 PCNs came into existence on 1 July 2019.³

NHS England's PCN Development Support Guidance and Prospectus⁴ outlines five ambitions for PCNs by 2023/24. These include both the 'core clinical tasks' that define PCNs operationally, as well as their 'system functions' within the wider health and care structure.

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- Stabilise general practice, including the GP partnership model
 - Help solve the capacity gap and improve skill-mix through national funding for new roles
 - Become a proven platform for further local NHS investment
 - Dissolve the divide between primary and community care, with PCNs working with community partners not just in to other practices (as has happened in most large-scale GP collaboration initiatives to date)
 - Deliver new services to implement the Long Term Plan, including the seven new service specifications⁵ (outlined in the GP contract framework⁶ and PCN direct enhanced service guidance⁷), and achieve clear, positive and quantified impacts for people, patients and the wider NHS.
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While these ambitions provide a sense of direction for PCNs, further clarity at local levels about what these ambitions mean and how they can be realised is important for PCNs to avoid failure. Yet at this stage there is no indication that formal national guidance will be issued on national development or to direct local activity.⁸

² <https://www.longtermplan.nhs.uk>

³ <https://www.health.org.uk/publications/reports/understanding-primary-care-networks>

⁴ <https://at-scale.co.uk/wp-content/uploads/2019/08/PCN-Development-Support-Prospectus-FINAL.pdf>

⁵ Service specifications for 2020/21 include: structured medicines review and optimisation, enhanced health in care homes, anticipatory care, personalised care, supporting early cancer diagnosis. In 2021/22, these will include cardiovascular disease prevention and diagnosis and tackling neighbourhood inequalities.

⁶ <https://www.england.nhs.uk/publication/gp-contract-five-year-framework/>

⁷ <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-des-guidance-2019-20/>

⁸ <https://www.england.nhs.uk/wp-content/uploads/2019/03/pcn-faqs-july-2019.pdf>

Since their introduction, some GPs and researchers have raised doubts about whether PCNs will deliver more than previous models in which GPs have gone into collaboration as providers (e.g. GP fundholding 1991-7) and out-of-hours cooperatives (1990s–2004). They have also questioned whether the way the contract is structured might actually increase the divisions between primary and community care by directing money towards primary care staff (or, more specifically, general practice staff). More positive policy supporters have said the injection of funding and national focus on a collaborative form of primary care provide a real opportunity to improve the integration between primary care and the health and care system.⁹

Pre-mortem approach

To help the system anticipate the risks and challenges PCNs are likely to face in the next five years, and to identify actions that could be taken now to avoid future failure, the Nuffield Trust and event partners drew together 45 GPs, local commissioners and representatives from NHS England/Improvement and the British Medical Association to undertake a 'pre-mortem' exercise.¹⁰

What is a pre-mortem?

The 'pre-mortem' is a strategic exercise that aims to consider why a project might fail, thinking prospectively rather than retrospectively. The main principle of the pre-mortem is to imagine that a project has failed (when it is still 'alive' or 'yet to be born') and then to consider what factors have resulted in the failure of the project or initiative.

Source: Mills, J.K. and McKimm, J., 2017. Pre-empting project failure by using a pre-mortem. *British Journal of Hospital Medicine*, 78(10), pp.584-585. <https://www.magonlinelibrary.com/doi/abs/10.12968/hmed.2017.78.10.584>

A pre-mortem can help to consider the threats to, and weaknesses of, a project by presuming hypothetical failure. A project is more likely to succeed if these can be addressed, so we asked event participants to focus on both the potential risks *and* solutions.

The pre-mortem exercise is also meant to break groupthink, improve collective intelligence in a group and improve active engagement. Trying to decide what could go wrong provides a safe forum in which those dissenting about how to proceed with a project have the opportunity to voice their concerns.¹¹ Imagining an event has already occurred

⁹ <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey/quarterly-survey-results/quarterly-survey-q2-2019>

¹⁰ The event was held on 4 June 2019, hosted by the Nuffield Trust (Nigel Edwards, Stephanie Kumpunen, Richard Lewis, Rebecca Rosen), in partnership with the Dartmouth Institute (Al and Margaret Mulley), the King's Fund (Beccy Baird), and the National Association of Primary Care (Nav Chana) at the Mills and Reeve London office. Thank you to the event attendees for their participation, and to our event partners for their contributions to editing of this briefing.

¹¹ Klein G (2007) Performing a project pre-mortem. *Harv Bus Rev* 85(9): 18–19.

(prospective hindsight) increases the ability to identify reasons for future outcomes by 30%.¹² However, there are also disadvantages in that focusing on the causes of failure may waste time and money if they never happen.¹³

What might failure look like in 2025?

Putting national expectations aside, we asked event participants to describe their worst-case scenario. They suggested PCNs will have failed if in five years:

- The health and social care system remains as fragmented and siloed as it is today with a significant and unhelpful divide between general practice, community care, social care and secondary care.
- In many PCNs, access to general practice worsens and there is a continuing decline in their abilities to offer continuity of care and access close to home to patients who need it.
- PCNs in deprived areas are not able to progress in the same way as PCNs in affluent areas. Deprived areas develop vicious cycles where practice closures increase the pressure on other parts of the network.
- PCNs fail to increase capabilities or capacity within general practice, or fail to deliver on the goal of providing 'proactive, personalised, coordinated and more integrated health and social care' as set out in the Long Term Plan.

What risks could cause failure? What can be done to avoid failure?

Below we summarise risks identified by participants, and consolidate them into six key themes describing why the failures identified above might occur.¹⁴ The risks are related to the underlying design of the policy, internal to PCNs, and the wider environment. Drawing on comments from the pre-mortem workshop and on the expertise of the authors and expert reviewers, we then pair risks with potential solutions.

¹² Mitchell DJ, Edward Russo J, Pennington N (1989) Back to the future: temporal perspective in the explanation of events. *J Behav Decis Making* 2(1): 25–38.
<https://doi.org/https://doi.org/10.1002/bdm.3960020103>

¹³ Mills, J.K. and McKimm, J., 2017. Pre-empting project failure by using a pre-mortem. *British Journal of Hospital Medicine*, 78(10), pp.584-585.

¹⁴ The most recent results of the BMA PCN survey echo the pre-mortem findings and suggest that the top five challenges facing PCNs in their first year are: insufficient funding to deliver new services; time and resources to set up the network; difficulty recruiting; working with neighbouring practices. See more here: <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey/quarterly-survey-results/quarterly-survey-q2-2019>

1. Failure could be inherent in the policy design

There are several potential risks in the design of the policy, which can be partly mitigated through action now.

- **The timetable to set out and deliver plans could be overly ambitious.** There may be unreasonable expectations about the ease with which new relationships and ways of working can be developed and the speed with which this will translate into outcomes.

To avoid failure: Policy makers and evaluators should explicitly acknowledge that agreeing an organisational plan can take up to two years, and outcomes will take 5-10 years to realise. Some prioritisation of objectives will need to be agreed within PCNs and then with their commissioners – whether it is rescuing and transforming the operations of general practice; providing a digital offer to all patients; or extending the service offer and acting as a system steward.

- **The relationship and funding arrangements between PCNs and their CCGs and STPs/ICSs relative to STP/ICS objectives may not be sufficiently clear.** The system lacks realism about how likely PCNs will be to engage at this level and to contribute effectively to STP/ICS goals. PCNs may struggle to get their voices heard and have unrealistic expectations placed on them by their STPs/ICSs, which could result in top-down direction around PCN agendas.

To avoid failure: STPs/ICSs and CCGs should work closely with their PCNs to agree roles, responsibilities, development plans, timelines and funding arrangements until 2025. The more detail that can be agreed early on, the better. National policies should provide clarity around the funding commitments CCGs and STPs/ICSs have to PCNs.

- **The new workforce could fail to deliver on expectations.** The lack of operational support to fully realise the potential of the 20,000 new PCN roles, including guidance on terms and conditions, regulation and management and team building, could mean that the new roles do not deliver what is needed from them. There is also a risk that in some local areas, PCNs may not be able to consolidate funds from member practices to appoint the partially reimbursed workforce at all.

To avoid failure:

- *PCN leads and practice liaisons should jointly agree the purpose of new roles and their contractual terms and conditions. They will need to support people in new roles to work effectively in each member practice, and be clear about whose responsibility it will be to offer professional leadership and supervision. Leads should learn from peers with experience of joint appointments wherever this exists.*
- *CCGs should examine where their management support would be best placed – this role has had little attention to date in primary care workforce planning and funding.*
- *CCGs should avoid rigidly specifying service design and allow teams to design services that respond to local needs. Where new appointments are needed, but not being funded, CCGs may want to use commissioning levers to find interim solutions.*

- **The absence of a set of rules and processes governing networks that are failing could mean that there are no mechanisms available to support PCNs that have run into difficulty.**

To avoid failure:

- *PCNs will need to go through their own journey and most will recognise that there are no short cuts. The wider system will also need to recognise that some level of failure is likely, given the scale of the enterprise.*
 - *Without a national failure regime, to support struggling networks, STPs/ICSs, CCGs and federations will need to take the lead locally and work with PCNs to discuss what should happen if a PCN in this patch fails, and who should step in.*
 - *Local commissioners may also want to host learning events on practical barriers raised by local PCNs and practices, encouraging PCNs to work together where possible to fix 'fixable' problems.*
 - *Comparing networks as equals when they are at different points on the national maturity matrix will be unhelpful to all.*
- **The funding allocation formula for general practice does not fully account for deprivation and more complicated case mix, including high numbers of elderly patients.** The 2019/20 and future proposed PCN direct enhanced service specification compound this pressure, as it reduces individual practice incomes.

To avoid failure: National bodies should regularly review the funding formula.

- **In some areas, practices have been forced into groupings that did not fit them** in terms of historical patient flows, cultural differences, and/or business competition or personal rivalries. **This could lead to later disruption**, with time being wasted on mergers and reorganisation in subsequent years.

To avoid failure: Where initial groupings are not sensible or effective, PCNs and practices should be encouraged to shift memberships before 2021. Research demonstrates that there is no ideal size for supra-practice organisations, and early input of practices to their 'new' PCN vision will be needed for sustained engagement through to 2025.

- The focus of the seven service specifications could be good for the system, but could also
 - create an imbalance between the range of demands and the resources made available at PCN level
 - place overwhelming pressure on practices to deliver new services
 - soak up staff and other resources to an extent that undermines the sustainability of participating practices.

To avoid failure: PCNs could undertake a stocktake of the time and resources needed to deliver the new service specifications and consider allocating additional money or other resources - such as service development support.

- Since the introduction of PCNs, there has been little explicit central political will to change health care information governance rules. This perpetuates current fears about sharing information among practices and PCN partners.

To avoid failure: National bodies should examine the impacts of GDPR on PCNs. There are reports that it is currently the biggest barrier to data sharing. In the meantime, and where physically possible, PCNs may want to try to co-locate multi-disciplinary teams and introduce data sharing agreements among themselves and waivers with patients (borrowing from existing templates¹⁵) to enable multidisciplinary team working.

2. PCNs may not be able to create effective organisations

If PCNs are unable to create effective relationships between practices and to deal with difficult practices, a lack of trust and inhibited decision-making could ensue. Energy could be dissipated in internal disputes and in some cases practices could continue to work in isolation and resist collaboration.

There is also a risk that funding and support for organisational development is unavailable or insufficient, even in areas with mature federations that are prepared to help. To cope, some PCNs could develop overly bureaucratic and cumbersome management processes, and interfere in unhelpful ways at practice level. This internal focus could also risk PCNs' abilities to work with other local community providers.

To avoid failure, PCNs and local commissioners and partners will need to:

- *Carve out time (using paid backfill, ideally from CCGs/STPs) to build a shared organisational vision*
- *Develop a new vision for primary care, defining what good looks like, and encouraging a bottom-up culture – moving away from historic top-down imposition of policy*
- *Draft visions statements as practical documents that help member practices understand and engage with the decisions to be made. Communicate and consult on the vision*
- *Create clear roles for each of the different levels of the local system (e.g. practices, PCNs, federations/super PCN, locality/borough, CCG, STP/ICS) to ensure that they can work together for the system rather than carve out roles for themselves.*

¹⁵ <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-data-templates/>

3. PCNs could have a lack of focus

Having a large number of objectives could represent a further pitfall for PCNs. Five of the seven service specifications are expected to be delivered in 2020/21, potentially putting intolerable pressure on practices and leaving little time to embed one initiative into routine practice before another is meant to start. Current expectations about pace of implementation could either lead to efforts at 'heroic' leadership (and burnout) or could spread resources too thinly across multiple projects without time to develop a sense of joint ownership. Alternatively, some practices could 'freeload' – leaving their peers to deliver necessary changes without taking on significant responsibilities themselves. Other 'internal facing' objectives, such as practice sustainability, are unclear and have no protected funds in the contract framework, which risks making them difficult to prioritise and action.

In some cases, taking a narrow approach to delivering population health – and the accompanying lack of an operational understanding of 'population health' – could mean that some PCNs are overly medical in their focus and fail to address the wider social determinants of health. Some PCNs may find it difficult to engage with local authorities, which have limited resources for collaborating with PCNs.

It is possible that some PCNs may view their role as being a narrow one, focused on offering back-office support and coordination for member practices. They may not adopt proactive population health management approaches regardless of the 'threat' of national monitoring via the 'network dashboard' or the 'incentive' of the Impact and Investment Fund¹⁶ because these require major changes to ways of working. Conversely, some PCNs may expend energy on the new policy imperatives before sorting the basics. This could mean access and other measures of patient opinion fail to shift, or even worsen.

To avoid failure, PCNs will need to:

- *Work with CCGs and commissioning support units to undertake multi-level approaches to tackling population health and general operations. Some initiatives will need to operate at the PCN level (e.g. service specifications, improvements in line with the Quality and Outcomes Framework (QOF)), some at the practice level (e.g. QOF management, CQC inspections), others at the federation or borough level (e.g. musculoskeletal services, extended specialist clinics, or intermediate care beds). Discuss what makes most sense for varied levels of organisation to take on.*
- *Share learning across practices and governance levels in a neighbourhood to create a sense of shared ownership and problem solving.*

¹⁶ NHS England has suggested that there will be a 'Network Dashboard' from April 2020, which will include key metrics on population health and prevention, urgent and anticipatory care, prescribing and hospital use. Information will also cover metrics for the seven-new national network service specifications. The dashboard will be accompanied by an Impact and Investment Fund (IIF) that will provide additional funding to PCNs that go 'further and faster' to deliver the national service specifications and provide an incentive for PCNs to reduce unwarranted demand on NHS services. See here: <https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-guidance-2019-20-v2.pdf>

4. PCNs could experience failures of leadership and followership

A lack of focus or a failure to create an effective organisation could arise as the result of leaders failing to engage all practices, and failing to develop productive relationships within the PCN and with other parts of the health system including neighbouring PCNs. Some PCNs will have appointed the 'usual suspects' as leaders, while other clinical directors will be new in post without the relationships and experience needed to drive changes in GP behaviour. The challenges of creating PCNs and building links with other local teams and organisations requires different skills and experience from those needed in predecessor CCGs or PCTs, and not every clinical director will have the necessary skills and experience.

PCNs may not develop distributed models of leadership with a wider group of people than is the case with current GP partners in local practices. Salaried GPs and the whole range of other practice staff could feel disenfranchised too if they are not included in planning and management. A lack of development, support and, in particular, a failure to organise succession planning could be a problem, especially in PCNs that are already struggling with vacancies and other workforce challenges. The role of young GPs in making the PCN a success risks not being given sufficient attention. These factors could mean that in places where there is good leadership there may not be enough people to support them.

To avoid failure, PCNs will need to:

- *Appoint leaders who have the skills to make sense of the environment and set the direction, as well as managing the many different aspects of the organisation's functions. A big challenge for leaders will be to get their member GPs to think differently and to learn to think as a group.*
- *Use a balance of data and stories to demonstrate the PCN's vision, building on local enthusiasm and existing (successful/promising) initiatives.*
- *Engage and provide training to emerging leaders and quieter GPs with a fresh perspective, giving them support and authority.*
- *Create a shared physical space for the PCN, and bring people together during their working day to talk about what they want to achieve. This will not happen in the evening. Although it will require that the PCN has already succeeded in getting general practice to a place where the GPs can take time out to meet.*
- *Help clinical directors to improve the capacity and capability of their network by focusing initially on small, achievable initiatives that help or reduce workload in individual practices and build trust in the potential benefits of collaborative working.*
- *Allow practices that are ready to take action to 'get on with it' – and manage some inequity in order to make early gains and generate enthusiasm.*

5. PCNs could become overwhelmed by external pressure

Workforce challenges, the long to-do list that PCNs have, and the pressures within primary care could prove too much for some PCNs. Vacancies could remain and the staff needed for alternative models could find well-functioning networks more attractive. Firefighting – particularly dealing with vacancies, retirements and practice collapse – could divert attention and make leadership roles unattractive and mean that it is not possible to restore job satisfaction and stability for many staff. Staff in these PCNs could withdraw goodwill and disengage because the changes create dissatisfaction.

To avoid failure:

- *PCN leaders will need to build positive relationships between a community of GPs and other practice and PCN-based roles with a shared vision and mechanisms to manage workload. This could encourage recruitment or at least stop people from leaving their posts.*
- *PCN leaders may want to develop relationships with local, regional and national bodies to ensure the external pressure to deliver on service specifications and progress along the maturity matrix are not unnecessarily passed on to member practices. Likewise, these local, regional and national bodies will need to be more understanding and supportive of local issues.*
- *PCNs should try to design, test and embed each new initiative (e.g. service specification) before starting the next one. The contract framework timetable will make this difficult, but if PCNs try to get too many projects going at once, it is likely many will fail.*
- *PCNs will want to redesign care models that make managing different populations as efficient as possible. This may be achievable by centralising the digital offering and same-day access, and wrapping care around people with complex needs via a single anticipatory care plan. This may look different across each PCN.*

6. Failure could be unfairly identified too early

There is a risk that PCNs' effectiveness gets examined too soon, and the varying starting points of development of PCNs are not fully accounted for. This could lead to failure being diagnosed in some PCNs prematurely. The employment of narrow evaluation criteria related to hospital activity (as in the national evaluation of Vanguard sites) or methods could fail to take into account the complexity of the system, and the resulting need for mutual accountability could exacerbate this problem.

However, the large number of PCNs and the level of variety could provide some insulation from universal failure. Many will likely prosper and, where the model has worked, PCNs could create a platform for the development of high-quality multidisciplinary working, including extensive involvement from social care, hospital specialists and community staff.

The best networks could also develop models that incorporate voluntary sector provision. In these organisations, peer review and mutual support and redesigned work processes will likely work well. As a result, vacancies could be filled and staff morale could be high. Networks could also offer a range of ways of working to meet the varying needs of younger GPs and a range of technology-driven ways to offer improved access.

In spite of this success, patients could report feeling as though their preferences are not being accounted for, and that their access and continuity of care and the overall quality of core general practice services became compromised during transformation. Furthermore, impatient policy makers could make the mistake of focusing on finding routes to financial efficiency, and decide that greater and more directive change is required.

To avoid failure, evaluators of PCNs will need to:

- *Take into consideration the complexity of PCN development*
- *Consult widely around suitable metrics – this may help to avoid metrics surrounding financial efficiency, A&E and hospital use dominating over other metrics, such as the impact on patients*
- *Extend evaluation timelines as needed to demonstrate impact*
- *Capture unintended consequences.*

Looking to the future

The pre-mortem's prospective hindsight allows for early identification of potential problems. The good news is that many of the risks and potential routes to failure for PCNs may be avoidable if CCGs and other local organisations provide necessary support. This means that PCNs themselves have some control over failure – but they will also need support from partners.

The enthusiasm for delivering effective PCNs that support practices to stay afloat is evident in the messages between PCN leaders' communication channels, such as Whatsapp groups. However, this is not the first time such enthusiasm has existed. If we are to avoid a familiar conversation in 10 years' time, the NHS hierarchy needs to allow PCNs the space to develop and grow from the bottom up. As highlighted throughout this paper, significant financial and organisational development support from national and local bodies – tailored to the very different starting points of PCNs – will be essential.

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