NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Health Innovation Oxford & Thames Valley

Understanding the benefit of small health inequality grants to Primary Care Networks (PCNs) with the greatest levels of socio-economic deprivation.

A rapid insight evaluation

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Introduction

NHS England (NHSE) describe health inequalities as unfair and avoidable differences in health across the population and between different groups within society. NHSE (2019) highlighted the need to respond to a widening gap around health inequalities in their Long Term Plan. They describe the role that Integrated Care Systems (ICS) may have to address this gap in collaboration with local government and voluntary sectors. In 2021 they established the National Healthcare Inequalities Improvement Programme (HiQiP). HiQiP are responsible for setting the direction for tackling healthcare inequalities ensuring equitable access, excellent experience, and optimal outcomes. Within HiQiP an approach to reducing healthcare inequalities Core20PLUS5 was launched, with a focus on working with the most 20% deprived in the population and a priority in five key clinical areas of health inequalities.

Background

Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care Board (ICB) offered a small amount of funding for Primary Care Networks (PCNs). The funding was to deliver a one-year project which specifically sought to address health inequalities, ideally in the CORE20PLUS5 category. Twelve PCNs who had the highest levels of deprivation in BOB ICS were invited to complete a non-competitive expression of interest form. Ten PCNs took up the offer, and were awarded the funding to support their work within Population Health Management (PHM).

Methodology

This rapid insight evaluation involved interviews with managers, clinicians and project leads within ten Primary Care Networks across Buckinghamshire, Oxfordshire, and Berkshire West. The PCNs were chosen by BOB Integrated Care Board as they were noted to have the greatest levels of socio-economic deprivation. Interviews took place between July 2023 and February 2024. The aim was to understand how the provision of small grants to PCNs in BOB Integrated Care System supported the reduction of health inequalities in the region.

The methodology including interview questions was co-designed and agreed by Health Innovation Oxford and Thames Valley and BOB Integrated Care Board.

Population: Ten PCNs in the BOB ICS region were awarded funding. The funding agreement included taking part in the rapid evaluation. Contacts at each PCN were shared by BOB ICB and followed up by Health Innovation Oxford and Thames Valley (formerly Oxford Academic Health Science Network) via electronic mailing. Initial conversations were held with each PCN, and two project leads per PCN identified for interview. All identified were invited to participate in interviews.

Interviews: Data was collected through semi-structured interviews. We aimed to undertake one interview with each person prior to the project commencing (Appendix One) and one follow up interview four months post the project initiation (Appendix Two). Interviews took place virtually and were conducted by three individual interviewers.

Twenty project leads were contacted via electronic mailing. When a response was not received, further attempts to engage were undertaken. In total thirty-three interviews were

undertaken across ten Primary Care Networks (33/40, 83% response rate). Fifteen interviews took place at the start and eighteen during the implementation phase of the project (Table One). One PCN who was invited to apply for funding and chose not to, kindly agreed to be interviewed. The roles of those interviewed varied widely including Clinical Director, PCN Manager, Social Prescriber, Pharmacist, General Practitioner, and Community Members.

Table One: Breakdown of interviews by Primary Care Networks

Primary Care Network	No interviewed at start of project	No interviewed during project
Aylesbury Central	0	1
Banbury cross	2	2
Cygnet	2	2
City East Oxford	2	2
Dashwood	1	1
Hedena Health	2	2
Holybrook	2	1
Maple	2	2
Reading West	0	2
South East Oxford Health Alliance (SEOxHA)	2	2
Total number of project interviews	15	18
Interviews undertaken to understand why a PCN did not apply for funding		
Reading Central	1	NA
Total number of overall interviews	34	
Total % of interviews offered vs actual	83% response rate (34/41)	

Workshops: Three workshops were held to bring PCNs together. The primary focus was to share learning from individual projects, and overall findings from this evaluation.

Document review: All project plans were reviewed to understand aims, measurement, and desired outcome. These were compared alongside interview data.

Analysis: Interviews were transcribed and reviewed using thematic analysis.

Data sharing: All interviews were confidential. All transcripts were anonymous, stored on a secure data drive and deleted after the report agreed.

Funding: This work was commissioned by NHSE BOB Integrated Care Board. Each individual PCN was offered funding of £10,000 to undertake a project that addressed health inequalities in their regional population. This funding was one-off.

Findings

There was a wide variety of project topics and designs within each PCN (Table Two). All of them focused their work within the NHS England CORE20PLUS5 approach. Eight out of ten projects (80%) focused on the most deprived 20% as identified by the national Index of Multiple Deprivation (IMD) and two (20%) focused on the clinical areas of mental health.

Seven out of the ten projects (70%) chose to build on work already being undertaken in their area and three chose to commence work in a new area (30% of projects). At the beginning of the funding BOB ICB offered each PCN time with a data analyst, Health Inequalities subject matter expert and where appropriate time with a place-based partner. None of the PCNs took up these offers.

Table Two: Descriptions of projects undertaken in each PCN

PCN	Project Description
Aylesbury Central	To Increase the uptake of health checks in the cohort of patients who are at risk of complications from lifestyle related diseases in the most deprived population. Dedicated sessions with health coach/social prescriber.
Banbury cross	To offer support of housebound patient living in the most deprived quintile through the introduction of a social prescriber home visit. All patients to be discussed at a bi-monthly MDT meeting to ensure they received appropriate support.
Cygnet	To increase the uptake of cancer screening (breast, bowel, cervical) in patients with serious mental illness.
East Oxford	To understand the need of the reproductive health of East Timorese women. Engaging an East Timor community support officer to co-design support for these women and their families.
Dashwood	To improve the uptake of childhood immunisations with patients who are in the highest risk of deprivation.
Hedena Health	To undertake a bespoke clinic for those who have serious mental health illness. Ensuring that physical, social, and psychological needs are supported where necessary
Holybrook	To engage the Nepalese Diabetic cohort post Covid-19 and co-design relevant diabetic patient information.
Maple	To increase vaccinations (Covid-19, Flu, Pneumonia) in the Chronic Obstructive Airways Disease cohort of patients. Focus on patients who are vaccine hesitant.
Reading West	To improve diabetes understanding and care within the Nepalese community.
SEOxHA	To identify children and young people in the top 20% deprivation and who have been admitted to hospital with an exacerbation of asthma or wheeze. To follow up with a home visit to review housing situation.

The following information has been gleaned from the ten PCNs who engaged in the evaluation. The projects took a variety of approaches from co-production, involvement in community organisations and governance arrangements (Table Three).

Table Three: Breakdown of key components to projects

Key Component	Number of PCNs	% of PCNs
Reached a minimum of 30 members of the public (as per funding agreement)	4 (numerator 10)	40%
Governance (a group accountable for the project design and progress)	2 (numerator 10)	20%
Co-production with other organisations, communities, or individuals	4 (numerator 10)	40%
Inclusion of voluntary organisations	5 (numerator 10)	50%
Engaged a community where English is not the first language	3 (numerator 10)	30%

Project design and delivery

Project design and methodology including scope, baseline data, measurement plans and communications are key to the capture of learning and findings (Provost and Murray, 2022). Most of the projects had good ideas but limited design and methodology applied. This made it difficult for some to demonstrate impact.

A consensus was held that there was not enough time to explore in detail the project focus and design due to the suggested timelines of the project delivery. Eighty percent (8 out of 10 PCNs) of projects chose to work at PCN level and the other 20% at General Practice (GP) surgery level. Those who chose to work at PCN level encountered issues with accessing patient data at surgery level.

"It takes time to build relationships across GP surgeries - PCNs introduced about 2019 but it takes time to build relational trust between surgeries". General Practitioner

Permissions and access to this data caused delays to the projects progressing. One project did not have access to GP based data and could only get the names of children from another source. They required the names of the parents to contact them. This added time and administrative burden to the project (SEOxHA).

Several projects worked iteratively which boosted their engagement with the cohort they were reaching out to.

"PCN had sent out letters to this patient group and got one attendee to a patient group. Our approach got > 200 attending"
PCN Manager

"We started our peer support group. We thought it would work best on a Saturday. The group changed it to what worked for them"
Community Leader

"We held a session for this cohort with limited success. Now seeking input from voluntary sector to change approach"
Practice Manager

Data

All the PCNs involved in the interviews applied population health management principles to some extent, using their data to identify target cohorts of patients. There was a wide variety in data capture whether qualitative or quantitative. The majority of the PCNs would have valued more time at the outset to obtain the relevant baseline data from GP surgeries. The lack of this data made it complex to note impact. One of the two PCNs who did not apply for funding indicated that lack of time to peruse data and think about the most suitable approach to tackling health inequalities was a factor which prevented them from applying.

However, there are examples of PCNs working hard to use their data to make sure they offered the right care, to the right people, at the right time. These PCNs found real value in their data and appreciated the opportunity to explore it in greater depth. One project emphasised the value of having a data expert on their team (SEOxHA). At the outset BOB ICB offered a session with a data analyst, but no organisation took them up on this offer.

In some cases, taking time to explore data which initially looked concerning, yielded surprising results. For example, one PCN discovered that "non-attenders" were in fact engaging with health, but not in the way they would usually expect. This PCN learnt to become more flexible about delivering care when the patient engages in another service, rather than providing a specific clinic for them (Hedena).

"Data is important to understand what works and what doesn't, it increased our physical checks quite dramatically" Contract Manager

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Another PCN discovered that people coded as having needs no longer had these requirements. This exercise has enabled them to reduce the number of at-risk people coded on their system (Banbury Cross).

Co-production

Health inequalities are often present in seldom heard groups which may make it more complex to introduce change. Understanding asset-based strengths for individuals and communities are central to working in health and social care (NICE, 2019). We explored with PCNs the co-production of their projects with patients, voluntary and community sector (VCS) organisations, and other relevant groups. Five (5/10, 50%) PCNs connected with VCS during the project, including faith and charity groups. Three PCNs co-produced their projects, two with voluntary organisations, and one with the local authority.

Most of the PCNs involved in the interviews recognised the value of the voluntary and community sector.

> "We might collaborate more (with the VCS) once we have the results of our work and can see the common themes about support which people need." PCN Manager

Most interviewees felt that at the outset of a new project, initial engagement with the patient should be led by the GP surgery. Some suggested that patients would be reassured through hearing directly from the surgery or doctor. A smaller number of PCNs recognised the VCS's ability to engage patients at the outset.

Those PCNs who have worked more collaboratively with the voluntary sector at the outset have tended to have more success in engaging the patient cohort that they are keen to access. For example, one PCN collaborated with a local community group to hold health information sessions in a community location. This has helped to broker trust as many community members are concerned about immigration status, and accessing official buildings is a concern for them. This same PCN used part of the funding to pay a project worker who is fluent in the relevant community language (East Oxford).

Two PCNs have long-term collaborations with voluntary sector agencies who manage social prescribers on their behalf. The current projects therefore provide an opportunity to build on these strong links. This has meant that the voluntary sector has been involved in the initial outreach activities. (SEOxHA and Holybrook).

One of the PCNs passed £5,000 to the local voluntary sector infrastructure agency (who in turn passed funding to five local community groups). They then worked collaboratively to engage a particular community in a series of preventative activities concerning diabetes. More than 200 people attended a health screening event. They have also co-designed three health leaflets for this community (Holybrook).

"I thought it would be a breeze, but people wouldn't engage"
PCN Manager

"It has to come from the community. We couldn't make much progress ourselves"
PCN Manager

"Not everyone want texts or screening. It's finding out what will work (for that cohort of patients)"
General Practitioner

Project roles and responsibilities

Due to the funding being a small one-off offer, all PCNs could not employ a specific project lead. The allocated project leads were already in a role, and this was additional to their current workload. There were concerns of the project having an impact on other areas in their role. Several projects were supported through the engagement of variety of roles including care co-ordinators, social prescribers, pharmacy technicians, medical students, and administration.

Some of these support roles are relatively new, and patients unaware of them. To build trust with the patient, one PCN made the initial contact via a GP letter to introduce the role of the social prescriber who would follow them up (SEOxHA). One PCN used the opportunity to demonstrate new ways of working to medical students (SEOxHA)

“Having medical students has been nice, (they are really) enthusiastic and it’s introducing them to this type of thinking” *GP Partner*

The use of social prescribers in one project helped to grow awareness of their role within the multidisciplinary team and improved communications. The did however feel that they were a stepping stone in the process with no ability to “fast track” any patients (Banbury Cross).

Communication around the initiation of the project to support roles was felt to have been lacking in some PCNs and they would have liked to have been involved in the design of the project or at least understand the “why”.

Outcomes

Most interview respondents agreed that within the timeframes and funding available, it was not possible to clearly demonstrate a change in health outcomes which can be attributed to this investment. Most of the outputs focus on initial engagement however, there have been other benefits noted below.

- This work has helped PCNs find out more about specific patients or communities who they work with
- In most cases, engagement with the target community has improved
- Through deeper understanding of a specific community, translators with the right language sourced (translators from a neighbouring country had been used and there is friction between these nations)
- Health leaflets have been co-produced
- There has been some shift in health beliefs and the need to physically go to a community where they frequent, whether at work, home, or a community space.

There is less certainty about the extent to which health outcomes will improve because of this work. It is worth noting that several PCNs highlighted a common anxiety about this work’s potential to create demand for support, which PCNS and their partners may not have ongoing capacity to meet.

Governance and project monitoring

Most PCNs were unclear about the governance and oversight of their projects. Similarly, very few projects appear to have employed project management or service improvements principles. By this we mean a focus on the goal to be achieved and the collection of evidence to demonstrate whether the goal is being achieved. As a result, some projects were unclear about whether they were delivering work which was of value. Three PCNs felt that the reporting expected from BOB ICB was out of proportion with the relatively small amount of funding received.

Funding

Most interviewees indicated that this funding has provided the impetus required to pause, collaborate with partners, think strategically, and implement some population health management approaches. However, the short-term funding has created serious challenges for the projects. There was a generic consensus that it may have artificially limited the scope of projects which has reduced the potential impact, and the ability to plan for the longer term.

Three PCNs have been able to use the funding to create something "additional" in their service. Two recruited project workers on a short-term contract, (SEOxHA and East Oxford) and another has passed a large proportion of the funds to the voluntary sector (Holybrook).

Most of the remaining PCNs have absorbed the funding into their budget which has tended to lead to less capacity to trial something innovative. However, all PCNs have tried something different to a greater or lesser extent.

"Small grant are time consuming. We need funding that is not just one off – 3 years enables good impact, measurement and evaluation"
Community Organiser

"Little pots of money are helpful to move things forward but then it stops and goes nowhere"
PCN Project Lead

"Funding gives us headspace to think. It can give us time to fact find rather than undertake a small project"
Practice Manager

All interviewees shared insights around how the funding has helped them and what might be better in the future.

Clarity and timing of funding offer

There was consensus that last minute requests for funding does not leave time to think about where the money could be best spent. One PCN felt that a clearer remit around the criteria of the funding would have been beneficial. They felt that some PCNs did a large amount of work whilst others not as much.

Short vs long-term investment

The short-term funding prompted the PCNs to pause and think about health inequalities within their region. Whilst two PCNs did recruit members of staff to support, most felt that they needed the security of further funding to recruit on a permanent basis. This is not just for the applicant, but also for the time it takes to recruit, undertake an induction process and support within the work environment.

There was a general feeling that small pots of money can enable change in a small cohort, however it can also lead to fragmented work. All PCNs were united in acknowledging that to introduce and embed change in any underserved community takes planning and time. A longer-term funding would support a more sustainable model.

Key learning

All the interviewees revealed that the funding had created a variety of opportunities and learning over the past year. These fall into three categories:

Change in attitudes and beliefs
Through work supported by this funding, interviewees noted a variety of change in attitudes towards health inequalities. These ranged from increasing empathy towards those in need, to ensuring that any change is patient centred including what they need rather than what "we" feel they would benefit. There was a noted shift in health beliefs in one PCN understanding that what was important to the clinician may not be to the patient (Maple).

"Be flexible – what you have in your head doesn't always translate when you are working with people" *PCN Manager*

Deeper understanding of addressing health inequalities in a meaningful way
The need to understand health inequalities in a meaningful way was centred around relationships and data. It was noted that it takes time and consistency to build trustworthy relationships. Through these relationships it becomes easier to understand what motivates the patient, and what is important to them. One PCN noted that a reduction in hospital visits was a key motivator for their group of patients (SEoxHA). It was highlighted that there was a need to move past pre-conceived boundaries and move in relationships and flexibility.

Access and understanding of patient data was vital to the way some PCNs chose their approach. The data helped one PCN to focus on the individual rather than providing a "special clinic on a special day, based on clinician availability" (Hedena). Reviewing data is time consuming and setting aside time to do this is challenging, but most agreed it is integral to meaningful and sustainable improvement.

Change working arrangements to support sustainable improvements in health inequalities
To support this work going forward it was felt that PCNs needed to work together to address regional need. For social prescribers and care co-ordinators to fully support, their role needed to be understood and further training undertaken e.g. care planning.

"PCNs don't understand the role. Sometimes they think we are just poking our noses in or just sign posters" *Social Prescriber*

There was some thought that GPs needed time in the community to lead relationship building. This could be in the youth centre, place of worship or community hub. This may be the start of work that needs to happen "deep in the communities". One community space felt that the ICB could help to connect organisations together, for example to locate underused physical workspaces that other organisations may have.

Discussion

Health inequalities in the NHS is not a new concept. Since the Marmot Review was commissioned in 2008, the health inequality gap appears to be widening with shifting trends in life expectancy (Adebowale, 2018). NHSE have approached this with a variety of frameworks, and several public health campaigns, and still the gap widens. Adebowale (2018) suggests that the "NHS cannot be imposed on people but must be developed with them – and

change with them too". He goes on to suggest that devolved health and social care budgets, overseen by democratically elected representatives, may provide the greatest potential to make this a reality. The evolvement of Integrated Care Boards may be able to facilitate this type of oversight for health inequalities funding.

Undertaking change deep in communities where health inequality is prevalent is challenging. This evaluation has highlighted that the requirements to reduce the inequality gap within the BOB ICS region are multifaceted. These include, building relationships, and trust, a change in mindset, new job roles and responsibilities, as well as sustainable funding. There are three key ingredients highlighted which may enable the region to journey towards reducing health inequalities in the BOB ICS region.

Funding is essential for this work to progress, and can be offered in different categories. Small funding opportunities may enable PCNs to explore where their efforts may be best served. This enables them to link with communities, review data and understand need. Larger funding grants bring the opportunity to invest deeply in communities, offer sustainable and co-designed solutions.

Co-design is paramount to exploring solutions that will not only meet the need of the population group but supports the design of a realistic offering between community, and health provider. There is a need to recognise that what suits one group will not suit another. Co-design supports understanding this from the outset and reduces waste. Trust takes time to build, and it can take at least five years for good relationships to flourish in communities. Realistic expectations and consistency are key.

Key skills and job roles must evolve to meet the need. Whilst faith organisations, charities, and voluntary organisations are pivotal, health care providers must bridge the gap consistently. There are evolving roles that can support e.g. Social Prescribers, Care Co-ordinators. However, for their role to embed in the community they will require consistent training to meet their changing needs. There may be benefit in changing current job roles to facilitate the health care professional more time in the community setting. This in turn may dilute mistrust in health services by certain communities. Community influencers employed by PCNs to work within their own communities may help to grow connections across the region. Organisations benefit from employing people with different expertise including Health Promotion, Public Health, Project Management and Data Analysis.

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Appendix One – Interviews to evaluate PCN Health Inequality Grants

Introduction

Thank you for taking part in this conversation today. As you know, Oxford AHSN's Community Involvement and Workforce Innovation team has been asked to do a small evaluation of the Health Inequality grant you have received. There are nine other PCNs involved in the evaluation.

Our plan is to talk to two people from each PCN, at two points in time: firstly, whilst the project is underway, and secondly once the project has finished.

The evaluation will describe the impact of the provision of small grants to BOB ICS Primary Care Networks on individual and system learning about health inequalities.

Below are the evaluation questions – we're hoping that our conversation today will help us to understand your view on these issues.

Evaluation questions

- To what extent did each project deliver its intended aim/s?
- How did each project intend to monitor and evidence change?
- What did each project team learn about how to address health inequalities?
- What are the benefits and drawbacks of offering £10,000 grants to PCNs to address health inequalities?

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Consent

The information shared will be analysed in combination with data from other PCNs to draw out key themes for the report. This discussion in confidential. We will not attribute any views to you, or to your PCN in the report. Given the different activities which each PCN is carrying out, there is a chance that some readers will be able to guess which comments come from which project. However, we will always try to phrase the report in a way which reduces this risk.

- Do you have any questions about this evaluation?
- Are you happy to consent to be involved in this evaluation, both now and during a follow-up conversation once the project has finished?
- Do you have my contact details in case you have questions later, or would like to withdraw from the evaluation?

Interview questions FIRST TIME INTERVIEWS

1.1 Tell me a bit about your job.

(i) What's your job role?
(ii) What's your role in this project and how long have you been involved?

1.2 Can you describe the project to me? I know you have put this information in the application form, so I don't need lots of detail. But it's always interesting to hear what people have to say when describing what's important about the project.

(iii) What difference are you hoping to make, and who for?
(iv) We understand your approach is to [insert information from application form]. Is that still the approach you are using?
(v) Why this approach and why now? Are there reasons why this work is not happening anyway?
(vi) Do you feel there is value in working in this way? If yes, what prevents it from happening as part of your usual ways of working?
(vii) To what extent has this grant made a difference to the way you approach the problem? Have you had any other funding to support this same work?

1.3 Tell me a bit about who is involved and how

(viii) Are you working with any partner agencies (e.g. voluntary sector, other statutory professionals)?
(ix) Have you passed any funds directly to a partner agency? If yes, tell me more about that.
(x) Is the project accountable to a group or individual?
(xi) To what extent are these partnership and governance arrangements supporting or enabling the project?
(xii) Is the project being coproduced with the community – by that I mean are members of the community involved in governance, design, delivery or evaluation of the project? Please can you describe how this is happening?

3.4 Tell me about the progress of the project.

(xiii) What is going well? What specifically is making it work well?
(xiv) What are the areas which could be better?
(xv) To what extent do you feel you are delivering the project in the way you had anticipated?
(xvi) What factors do you think will enable you to make progress?
(xvii) What factors do you think might reduce your ability to make progress?

3.5 Tell me about any project achievements

(xviii) To what extent are you achieving the overall goals of the project? Do you have data or other evidence which helps you to demonstrate these achievements to others? In your application form, you said you intended to monitor progress as follows: [share details]. Is that still your intended approach? Do you foresee any challenges?

Thank you very much for you time. Is there anything else which you think is important to tell me, or which you expected me to ask you about?

Finally, we are making plans for the next two workshops.

- What would be of value to you?
- And looking to the future, would you see value in a network of people interested in tackling health inequalities via PCNs?

2. Interview questions SECOND TIME INTERVIEWS (re-interviewing a previous participant)

2.1 Tell me about the progress of the project

(ii) What went well? What specifically is made it work well?
(iii) What are the areas which could have been better?
(iv) To what extent did you deliver the project in the way you had anticipated?
(v) To what extent are the partnership and governance arrangements supporting or enabling the project?
(vi) What factors do you think enabled you to make progress?
(vii) What factors do you think reduced your ability to make progress?

2.2 Tell me about any project achievements

(viii) To what extent did you achieve the overall goals of the project? Do you have data or other evidence which helps you to demonstrate these achievements to others?
(ix) In your application form, you said you intended to monitor progress as follows: [share details]. Has that been the approach? What did you learn along the way?

2.3 Tell me your overall thoughts….

(x) What are the most important learnings from this piece of work?
(xi) On this occasion, BOB has given out a relatively small amount of money, on a one-off basis to 10 PCNs. There are a number of different funding models which could be considered in future. I'll be interested in your views on the benefits and drawbacks on some of them. For example:
   (I) Do you think this funding has been useful?
   (II) Another approach would be to offer a larger amount of money to a smaller number of PCNs, with or without making it a competitive process. What do you think about this approach? Please describe the benefits and drawbacks of this approach? What difference might this have made to your project (if you had been successful AND if you had not been successful).
   (III) Another option may be to offer recurrent funding. What do you think about this approach? What difference might this have made to your project had it been available.
(xii) In your view, what is needed to enable Practices / PCNs to work sustainably with communities to address inequalities in a way which is co-produced?

Thank you very much for you time. Is there anything else which you think is important to tell me, or which you expected me to ask you about?

3. Interview questions SECOND TIME INTERVIEWS (interviewing a new participant)

3.1 Tell me a bit about your job.

(i) What's your job role?
(ii) What's your role in this project and how long have you been involved?

3.2 Tell me about the progress of the project

(iii) What went well? What specifically is made it work well?
(iv) What are the areas which could have been better?
(v) To what extent did you deliver the project in the way you had anticipated?
(vi) To what extent are the partnership and governance arrangements supporting or enabling the project?
(vii) What factors do you think enabled you to make progress?
(viii) What factors do you think reduced your ability to make progress?

3.3 Tell me about any project achievements

(ix) To what extent did you achieve the overall goals of the project? Do you have data or other evidence which helps you to demonstrate these achievements to others?
(x) In your application form, you said you intended to monitor progress as follows: [share details]. Has that been the approach? What did you learn along the way?

3.4 Tell me your overall thoughts....

(xi) What are the most important learnings from this piece of work?
(xii) On this occasion, BOB has offered a relatively small amount of money, on a one-off basis to 10 PCNs. There are a number of different funding models which could be considered in future. I'll be interested in your views on the benefits and drawbacks on some of them. For example:
    (I) Do you think this funding has been used well?
    (II) Another approach would be to offer a larger amount of money to a smaller number of PCNs, and make it a competitive process. Please describe the benefits and drawbacks of this approach? Please describe the differences this would this have made to your project (if you had been successful AND if you had not been successful).
    (III) Another option may be to offer recurrent funding. Please describe the benefits and drawbacks. Please describe the differences this would have made to your project had it been available.
(xiii) In your view, what is needed to enable Practices / PCNs to work more sustainably with communities to address inequalities in a way which is co-produced?

Thank you very much for you time. Is there anything else which you think is important to tell me, or which you expected me to ask you about?

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