ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Thomas P, Graffy J, Wallace P, Kirby M. How primary care networks can help integrate academic and service initiatives in primary care. *Ann Fam Med.* 2006;4:0-0.

http://www.annfammed.org/cgi/content/full/4/3/ppp/DC1

Supplemental Appendix. Context and Comparative Data for Networks A, B, C, and D

Origins of the Networks

In 1998, 4 groups of primary care researchers secured funding from the UK Department of Health to establish primary care research networks (PCRNs) in adjacent areas of North London. The 4 authors of this article were the inaugural directors of these networks. Two of us (PT and PW) were nominated by our university departments to apply for funds and lead the network from a university base, primarily because of our previous experience with outreach to general practice. Two of us (JG and MK) were invited by our peers to apply for funds and lead the network from a practice base, primarily because we were practitioners active in research. Funding conditions required a lead primary care organization and a host academic unit. These conditions posed quite different challenges to each of us and resulted in different types of academic-practitioner partnerships in each network.

Our networks were expected to undertake and disseminate research relevant to primary care, increase primary care research capacity, and "facilitate the development of a research culture." We came to reframe the third aim as "developing multidisciplinary coalitions," because we saw this objective as more verifiable (and realistic) and an important stimulus to cultural change. Because we each inherited a very different pattern of previous primary care research participation, organizational support, and local expectation, we devised strategies that appeared most suited to our contexts.

An evaluation of our networks was completed in 2000 by a team of researchers from Warwick University. This evaluation helped us to stand back and consider the strengths and weaknesses of our approaches. It also began our shared interest in the phenomenon of a network as a form of organization that later translated into this article.

Post-2002 Network Developments

To address weaknesses in our networks and to take advantage of new opportunities, after 2002 we started to adopt features of each others' networks. In 2006 these networks are about to undergo fundamental change and coalesce to serve larger areas and connect better with primary care organizations and clinical networks. We are therefore mindful not only of how to make sense of our experience, but also how our understanding of networks might help to conceptualize "networks of networks" that are able to make academic and service contributions more relevant to each other. We anticipate that partners in an enhanced network role could include those who lead research, audit, learning, and organizational development.

Limitations of Our Study

We were able to assess the outcomes for our 4 networks in their first 3-1/2 years; however, our study does have some limitations. We were not able to validate our proxy measures of outcome, which therefore need to be treated with some caution. In addition, we did not consider other measures of outcome, such as practitioners' views about the value of the networks, or sustainability. The preexisting relationships between academics and service practitioners in each area also differed greatly and are likely to have had a substantial impact on outcome, independent of the strategies adopted. No account is taken of the impact of leadership styles of the authors, which must inevitably have played a part in shaping the networks. Our findings should therefore be interpreted in the light of the different contexts in which the networks operated. To be confident that our findings apply more widely, it would be important to validate them by comparison with the structure and output of other networks.

The following table shows progress in achieving the 3 network aims.

Supplemental Appendix Table 1. Comparing Indicators of Success

Characteristic	A	B	C	D
Context				
General population served, No. (in millions)	1.1	1	3	2
General practices in area served, No.	139	221	617	529
Network 3-year budget, £ (in thousands)	660	879	897	816
Network aim: increasing primary care research capacity				
Success indicator: primary care practitioners in research project teams*				
Total individuals†	42	80	140	137
With academic post‡	6	50	31	35
Without academic post	36	30	109	102
General practitioners	21	19	43	35
Other primary care clinicians	13	20	40	37
Nonclinicians in primary care	1	6	16	15
People from outside primary care	7	35	41	50
Network aim: developing a research culture/ multidisciplinary coalitions				
Success indicator: interorganizational collaboration, No. (%) of viable projects§				
Projects without a lead general practice	0	5 (14)	4 (7)	0
Only general practices leading	6 (67)	17 (47)	37 (65)	2 (6)
General practices and other organizations leading in partnership	3 (33)	14 (39)	16 (28)	29 (94)
Network aim: research productivity				
Success indicator: projects, grants and dissemination				
Viable projects,¶ No.	9	36	57	31
Projects started before 1998, No.	0	0	8	1
External grant income 1998-2001, £ (in thousands)	611	2,833	403	490
Dissemination,‖ No. of items				
Peer-reviewed publications	8	20	18	15
Other publications and posters	67	10	46	29
Presentations	42	67	117	82

* The core group of researchers who planned and carried out the project. This group does not include the large number of individuals and organisations who recruited to the studies.
† Many were involved in more than 1 project.
‡ Refers to people with university contracts, regardless of whether they also worked in the National Health Service (NHS).
§ Members of the host academic unit were excluded from this analysis. "Other organizations" included universities, NHS Trusts, and independent research organizations, but not other general practices.
¶ A viable project was defined as a project listed by the network at April 2001 as ongoing.
‖ Includes all papers, presentations, and posters identified by the principal investigator.