West of England
Academic Health
Science Network

Evaluation of the General Practitioner Clinical Evidence Fellowship Programme

Understanding the benefits and challenges of the GP Clinical Evidence Fellow role for all stakeholders

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Summary

This report summarises findings from the evaluation of the West of England Academic Health Science Network (AHSN) and Health Education England (HEE) GP Clinical Evidence Fellows programme. The objective of the evaluation is to define the value of the GP clinical evidence fellow role, and areas for improvement, for all stakeholders.

Now in its second year, the programme represents an ambitious and innovative attempt to highlight the importance of evidence and evaluation in clinical commissioning and support its integration into routine activity.

The findings of the evaluation should acknowledge that fellows work one or two sessions (half day) a week with their respective CCG while having substantial roles as general practitioners, some with partner responsibilities.

This limited time presents challenges in terms of continuity and having a sense of belonging in the CCGs and highlights the need particular efforts to ensure the fellows to be fully embedded within aspects of CCG activity that they can make an impact.

Despite these challenges, all fellows report a high degree of personal and professional satisfaction.

Notwithstanding the challenges, for CCG chairs and accountable officers who were interviewed and their commissioning colleagues, the fellows have undoubtedly added value by highlighting the importance of research and the use of evidence as core business.

They have achieved this by performing evidence appraisals that summarise the current knowledge base and identifying gaps in this knowledge that are needed for informed commissioning decision making, and in some cases by strengthening the relationship between CCGs and the public health teams within local authorities.

In terms of current management and investment in the programme, the West of England AHSN and HEE have successfully established an entirely new job description through the West of England region and recruited 14 highly motivated GPs to work in the seven CCGs over two years. Due to the initial challenges faced by the fellows in learning to work in a very different environment and by the CCGs in having a new post within their organisation, the effectiveness of the fellows has increased over time.

This report asserts that whilst the sustainability of these roles should be discussed by all parties, ultimately the benefactors of these roles are the CCGs through the impact the fellows are having on practical decision-making, the culture of using evidence and in finding a new source of potential GP leaders of the future, it is they who must take a lead in determining current and future value.

Lastly, this report contains a set of recommendations which focus on optimising the productivity of the existing fellows and a number of suggestions to influence any future cohorts.

> *"…There was a sense from the managerial team that research and evidence was something that other people did. So the fellow helped us to recognise that this is the way we do business rather than an additional extra…"*

Background

The West of England Academic Health Science Network (AHSN) aims to deliver positive healthcare outcomes in the region and nationally by driving the development and adoption of new innovations and enabling patients to play an increasing role in their own care and of others.

A key focus of its work is to create a culture of evidence-led best practice across its healthcare community. The NHS has not always been consistent in applying and spreading evidence based practice, resulting in care variations.

The GP Clinical Evidence Fellows programme aims to counter some of this variation by placing fellows directly in clinical commissioning groups (CCGs) to work with healthcare clinicians and managers to implement evidenced informed commissioning which results in services that represent the best available evidence and value at the same time.

Designed by two General Practitioners, Dr Peter Brindle from the West of England AHSN and Dr Martyn Hewett from Health Education England (HEE), the GP Clinical Evidence Fellows programme is based on an ambitious and innovative learning and development model which combines clinical leadership, professional development and the practical application of evidence within CCGs.

Launched in October 2014, the programme aims to place evidence informed decision making at the heart of clinical commissioning through a 12 month placement of a General Practitioner within each CCG for one or two half day sessions per week.

Aims and objectives of the evaluation

The overarching aim of this evaluation is to understand the value and benefits of the GP Clinical Evidence Fellow programme for all stakeholders, and identify areas for improvement.

Taking what we have learnt from the evaluation, the objective is to put in place an action plan which will focus on the following:

- How to continue to influence the work of cohort 2 and any future cohorts
- How to maximise return on investment for the current programme
- Consider the benefits of funding this post recurringly.

Methods

Fellows from cohort 1 and cohort 2 each took part by way of a questionnaire and phone interview.

In addition, a number of stakeholders took part in telephone interviews including CCG Clinical Chairs and Accountable officers, Commissioning managers and programme leads from West of England AHSN and HEE.

Fellows from cohort 1 took part in a mid-point evaluation in June 2015, which consisted of a questionnaire and individual phone interview. Some of their feedback has been used to inform this evaluation.

Introducing the Clinical Evidence Fellows

At the time of writing, there were 11 fellows in post across the West of England AHSN area. There have been two cohorts to date. Cohort 1 was recruited in July 2014 and took up post in October 2014. Cohort 2 was recruited in July 2015 and took up post in October 2015. Each cohort consists of a number of fellows who are each assigned to a CCG. Fellows are predominately mid-career GPs recruited for their special interest in using and applying evidence in their clinical practice.

Cohort 1 (recruited in October 2014)

L-R: Dr Francis Campbell* - Swindon CCG, Dr Julian Treadwell - Wilts CCG, Dr Ed Mann* - North Somerset CCG, Dr Phil Simmons - South Glos CCG, Dr Peter Brindle West of England AHSN, Dr Katharine Shorrocks - BANES CCG, Dr Nick Snelling - Bristol CCG.

*Successfully reapplied to continue for a second year

Of the 7 fellows recruited to cohort 1, five chose to extend their fellowship for an additional 12 months and two completed the full programme and left to pursue other development opportunities.

Cohort 2 (recruited in October 2015)

L-R: Dr Farida Ahmad – Bristol CCG, Dr Jo Tricker – BANES CCG, Dr Caroline Ward – Swindon CCG, Dr Peter Brindle, Dr Simon Cleave – Wilts CCG, Dr Emily Lake – North Somerset CCG, Dr Alan Gwynn – Glos CCG, Dr Will Wallage – Wilts CCG, Dr Martyn Hewett.

Clinical Evidence Fellows by CCG area:

L-R: Simon Cleave (Wilts CCG), Emily Lake (North Somerset CCG), Ed Mann (North Somerset CCG), Caroline Ward (Swindon CCG), Will Wallage (Wilts CCG), Phil Simons (South Glos CCG), Alan Gwynn (Glos CCG), Nick Snelling (Bristol CCG), Farida Ahmad (Bristol CCG). Not in photo: Jonathan Tricker (BANES CCG), Francis Campbell (Swindon CCG).

Clinical Evidence Fellows perspectives': cohort 1 (October 2014 – present)

In this section we explore feedback from the fellows themselves on the positives and challenges of the role.

Interview, induction and introduction to the CCG

On the whole fellows gave positive feedback on the interview process and cited the 2 day induction provided by the West of England AHSN and HEE as being an excellent introduction to the role, the contributions they would make to their CCGs and the key skills they would be expected to develop.

Many experienced challenges when first being introduced to their CCG, and found they spent a great deal of time understanding the organisational culture of the CCG, identifying who they needed to meet with and the networks already in place.

"...At first, the CCG appeared to have quite a complex organisational structure with fragmented pockets of thinking. I spent quite a lot of time thinking about how the CCG worked…"

Some reported a number of practical issues which seemed slow to resolve, such as obtaining security passes and access to desk space and the internet. A small number of fellows reported that the mentor they had been assigned was either not a clinician themselves or was restricted in the time they could spend with them.

In addition, a small number experienced a lack of receptivity and understanding of their roles in their CCG, either because it was unclear how they could be utilised or because evidence was thought to be the domain of academic researchers rather than commissioners.

Defining projects

Fellows were asked by the West of England AHSN to define one or more projects they would focus on during their placement. Scoping their projects was challenging given the range of priorities under discussion.

Many felt that they wanted clearer direction from their mentors. Having taken the initiative to identify a project to work on, sometimes the priorities would change and they were left unsure about next steps. However, most fellows had a powerful drive to add instant value and realised that they could do this, either through carrying out an evidence search or literature review, and that this created impetus for further conversations about their work.

Learning and development

All fellows reported a steep learning curve which lasted approximately three months from the beginning of their placement. Central to this learning curve was the experience of feeling challenged personally. Some questioned their own abilities and realised they had to manage their own expectations about what they could realistically deliver in 1 session a week. Many felt that they had to manage their time and wanted focus on pieces of work that would add most value. In particular, creating a balance between attending meetings to meet key people, and to get a better understanding of the issues, was offset by not wanting to spend their entire weekly session in meetings.

However, some of these meetings proved an invaluable opportunity to describe their work, its relevance to the CCG and how they could contribute. All fellows reported the good level of respect afforded to them as a GP and it was their clinical knowledge and expertise that they relied on initially. Despite the steep learning curve, by months 5 and 6 fellows were ‘settled in’ and had demonstrated a high level of impact considering the limited amount of time they spent at the CCG each week.

“…The fellowship has helped me develop as a clinician, and given me a greater awareness of evidence-based practice, clinical research evaluation, and the structures of the CCG/CSU and the intricacies of the commissioning process. I have passed some of this knowledge to my GP practice colleagues…”

In addition, some were able to attend the CCG on the same day clinical executive groups met and reported this was particularly beneficial. For those fellows unable to attend these days, there was a sense that they were ‘missing out’ on key conversations and decisions and the opportunity to influence these.

All fellows reported learning a lot from each other during quarterly meetings facilitated by the West of England AHSN and through exchange of emails in-between meetings. In particular, as cohort 1 settled into their roles, there was an increase of knowledge and information between the fellows and each was able to use information and evidence collected from their own ccg and take key messages back. This spread of learning they felt was valuable for the CCG.

“…A week is a long time in a CCG – many decisions are made and progress is fast – you feel like you’re catching up all over again the next time you’re in the office…”

The second year / aspirations

Four of the original seven fellows from cohort 1 continued into a second year with the agreement of their CCG. Now familiar with the workings of the CCG, some of the fellows reported doing “some of their best work” in months six to twelve, due to an increase in confidence, a solid grasp of evidence appraisal and review techniques and a greater sense of independence.

By their second year, all fellows had built a good network of colleagues with whom they worked on specific projects and went to for advice and direction. In a number of cases, these supportive colleagues were from a public health background and were particularly enthusiastic about utilising the fellows to bridge the gap between the local authority and the CCG.

On the following page are some of the key outputs from Cohort 1 in their first year. For a full list of outputs in the period October 2014 – October 2015, please see appendix 1.

Key outputs by CCG
Cohort 1: key outputs at Februry 2016

In South Gloucestershire

- Evidence appraisal and research on minor injury units and their provision from primary care premises to inform the CCG's commissioning plans in this area.
- Evidence appraisal and research on LGBT suicide prevention as requested by South Gloucestershire Public Health and the CCG Lead Mental Health.
- Presented findings and recommendations at South Gloucestershire Suicide Prevention Group to health and council leads in children's and schools' services.
- Led the application for the Elizabeth Blackwell funding for assessment of performing Brief Comprehensive Geriatric Assessments (CGAs) in primary care. Funding received.

In Bristol

- Evidence review of pyscho-social factors in low back pain.
- A review of the economic costs of backpain.
- Evidence of effectiveness of the STarT Back Screening Tool.
- Analysis of current practice in the use of nerve root blocks.

In Swindon

- Design and delivery of audit on paediatric length of stay to help inform commissioning decisions, focusing on local evidence of admissions and evidence from what works at surrounding hospitals.
- Presented work on paediatric admissions to the CCG Clinical Leadership Group to inform measures on reducing admissions.

In Bath and North East Somerset

- Analysis of the Cochraine review on cellulitis.
- A map of all provision in the locality.
- Research, consultation and design of a local cellulitis pathway.
- Analysis of a co-amoxiclav use audit.
- Evidence-based evaluation map of medicine.
- Represented BANES at the National MSK Knowledge Network launch meeting in London.

In Wiltshire

- Evidence review for back pain, including work with universities on recent trials into early intervention.
- Contribution towards the development of an evidence-based resource to help GPs 'unprescribe' and explore the risks and benefits of specific medicines.
- Exploration of a questionnaire for GPs to detect early signs.
- Identifying pyscho-social factors and a summary of the economic costs of back pain.
- Facilitation of an education day for GPs on back pain and MSK diagnosis.

In North Somerset

- An evidence review on interventions to reduce unplanned admissions from nursing homes to complete the CCG's aim to reduce unplanned admissions by 20%.
- Contribution to the CCG's new proposals sheet for using evidence and evaluation in the prioritisation process for new projects.

Clinical Evidence Fellows perspectives': cohort 2 (October 2015 – February 2016)

Cohort 2 took up post in October 2015. Like the cohort before them, the majority of fellows reported a steep learning curve in the first three months of their placements. These included being in the office on the same day as clinical leads, attending clinical leadership groups and being introduced to the right people at an early stage. Some reported being in contact with fellows from cohort 1 and thought that this had been helpful.

The issues for this cohort are in many ways similar to the first cohort.

In the summary, feedback from fellows in cohort 2 suggests that:

- All enjoyed the induction event facilitated by the West of England AHSN and HEE and found it to be a very useful opportunity to get to know each other and explore each other's interests.
- Fellows with more experience in the workings of the CCG reported a shorter settling in period and greater levels of satisfaction in the first 5 months.
- Those fellows with greater career experience took less time to understand the organisational culture, although still faced practical challenges such as finding desk space and internet access.
- The less experienced reported a lack of confidence in knowing when to challenge new colleagues and acknowledged that they were learning essential and new skills in addition to contributing their medical and evidence expertise.
- The majority of fellows experienced confusion as to how to determine which projects they were going to work on and felt overwhelmed by the number of priorities facing the CCG.
- They reported the importance of having leadership to promote and embed their roles within the CCG. This was more relevant to some ccgs than others. 4 out of the 7 fellows felt they were under-utilised in the first 5 months. The role of mentor was unclear in some placements.
- All had a positive experience of the learning groups held quarterly and facilitated by the West of England AHSN and felt that they were given ample opportunity to meet and discuss ideas with each other. A number of fellows commented on the restrictions of an email group and hoped for a more interactive portal to share their work, thoughts and ideas.

CCG perspectives

In this section we explore the views of CCG Clinical Chairs in addition to other commissioners and managers who worked alongside the fellows. It should be noted that the majority of Chairs were most familiar with fellows from cohort 1 and their feedback reflects this.

Clinical Chairs: expectations of the Clinical Evidence Fellows role

For many of the Clinical Chairs, the introduction of the Clinical Evidence Fellows had been instrumental in highlighting the importance of using and applying research and evidence in their organisations.

"…I expected the fellow to develop a presence and input of an academically grounded individual who would bring a more evidential based approach to the decision making of the CCG…"

"…There was a sense from the managerial team that research and evidence was something that other people did. So the fellow helped us to recognise that this is the way we do business rather than an additional extra…"

It was also seen as crucial that the fellows were clinicians and that this in itself was seen as valuable as their opinions were respected by other clinicians.

The general opinion on the induction of fellows from cohort 1 was that expectations against what the role would offer were not as clear as they would have liked and in hindsight it would have been beneficial for all parties to agree and set clear expectations from the start. The Chairs did recognise, however, that their organisations were going to need to learn about the role and about evidence more generally and that this was a learning process for all.

"My expectations were…effectively a champion to help the clinical leaders diffuse to the rest of the organisations the message throughout the organisation…"

Several Chairs suggested that whilst the fellows were there to engage and support colleagues to understand evidence, it was clear that they were also still learning key skills and that clear outputs of specific projects would need to be refined.

Adding value

For the majority of Chairs the fellows had added fairly immediate value, both through adopting an informal clinical leadership role and through their work on bringing forth the evidence on various priorities. It was commonly stated that it would be difficult for fellows to add any more value given the time restriction of working one or two sessions a week. For those with fellows who worked one day a week, this was seen as a distinct advantage. In particular, Chairs valued the fellows who actively presented at GP learning events, attended clinical executive meetings and liaised with commissioners to practically help them to define indicators for outcome based commissioning, for example.

"…Our Fellow's work on de-prescribing has been really interesting and he presented to learning groups and message has gone out to GPs very strongly so that's an area that we should be able to see savings in in the future…"

On adding value to the CCG and its relationship with public health in particular, one Chair commented that

"...our interaction with public health has been finessed into a sleeker operation – people engaging earlier so more discussion and refining before doing too much work."

Support, expectation and spreading the message

A small number of CCGs provided their fellows with a formal induction, including inviting them to join regular clinical leadership group meetings. For fellows invited to sit on key clinical leadership groups, the integration of their role in the CCG, and the perception of its value, were intrinsically linked.

Chairs stressed the difference in support needs for newly arriving fellows and the importance of identifying a 'go to' person in their senior management team. For new fellows in particular the first three months were seen as being very much about the fellows own learning needs and the challenge of understanding the culture of the CCG. For fellows who had some previous exposure to CCGs this process was shortened. For example, those fellows with a greater understanding of the politics of the health system appeared to have an ability to challenge clinical leaders whilst developing relationships based on mutual respect.

It was felt that second year fellows were more comfortable in asking 'now what?' and questioning how their input would add value.

With hindsight, a number of the Chairs recognised the challenges the fellows faced in understanding new cultures and the importance of ensuring the fellows were introduced to the right people and the right groups at the start of the process.

There was also a recognition that some of the fellows could have been utilised more in their first year and that the approach had been to call on them if a relevant project came up rather than working proactively with them to identify projects to work on. However, as was the case with one fellow who completed a 1 year placement, the relationship continued to flourish after the fellow had left and he continues to support the CCG on a number of projects.

In terms of embedding these new roles, the overriding message was that the Chairs themselves were spreading new messages and trying to change practice within their organisations and that these messages needed constant reinforcement. The more proactive the fellow in putting forward ideas and engagement, the easier it was for the Chairs to champion the role.

"…The fellows need to keep badgering us…It's easy for us to get lost in day to day business, so them being proactive is really important…"

Sustainability and funding

In terms of the longer term view of the role, the majority of Chairs viewed the fellows as a free and highly qualified resource which they valued and would like to sustain on a more permanent basis.

"…Would we like to continue to have a fellow in post? The answer is a resounding yes…" CCG Clinical Chair

However, all cited the need to demonstrate value, and possibly savings, in order to fund the role themselves in future and this presented a commonly referred to challenge for CCGs – essentially that they were required to track benefits and pinpoint the source of those benefits.

"…It's mirrored across the board – we know that projects (and people) will deliver savings but it's difficult to demonstrate that reduction in admissions is down to one organisation - every organisation will claim success. Individual savings or improvements are difficult to fathom because they are so multi factorial…"

In addition, constraints on financial resources meant that Chairs would need to prioritise the role against other staff costs and that 'very tight running costs means justifying every role' and this would be challenging given that some of them had had to cut clinical replacement costs.

"…You know instinctively that they're doing good work and adding value but our finance people would want to see more than that. It's not easy to prove…"

CCG Commissioner / Management perspectives

Feedback from colleagues working directly with the fellows was overwhelmingly positive. In particular, the role of bridge builder between public health and the CCG was seen as 'added value', and that some of the fellows had worked to support more junior colleagues to widen their knowledge and improve their skill sets. In addition, having a clinical resource to bring authority and gravitas to a particular area, in addition to highlighting the CCGs lack of evidence in particular areas, was seen as very helpful and that recommendations made by the fellows had, in some cases, directly influenced local plans and strategic priorities.

There was a general consensus that CCGs operate under a certain level of ambiguity and this resulted in it being hard to give fellows a clear steer at times. This was compounded by the time 'lag' between their sessions and that often discussions and decisions had moved on.

Feedback suggests that whilst there is significant opportunity for fellows to help influence priorities (and how these are presented in strategic plans) the fellows must be involved and utilised to the full for these to be realised. Co-designing the fellows work programme for the year, in addition to agreeing on expectations at the beginning of the placements were seen as very important.

"…Our fellows added value is being linked into the system as a whole not just the CCG, Avon Primary Care Research Collaborative etc having that system wide view is more helpful. It doesn't matter who employs them. Senior GP as part of the evidence and research contingent is really useful…"

Conclusion

As the first programme of its kind in the country, there is no evidence, anecdotal or otherwise, to compare it to. However, the programme draws on best practice in applying evidence in commissioning organisations coupled with best practice in professional development for GPs. There is no doubt it makes a bold attempt to champion clinical leadership and the role of the clinician in using and applying evidence in the commissioning process.

Notwithstanding the challenges highlighted in this report, it is clear that all stakeholders have invested a significant amount of time and effort to ensure these roles are as successful as possible.

For the Fellows themselves these are challenging and rewarding roles which require tenacity, flexibility, high levels of motivation and the ability to push themselves outside of their comfort zones, often working in uncertain and new environments.

These skills, once mastered, are invaluable and will only enhance their ability to influence and add value to the organisations they work with. The fellows recognise that their role is to contribute by practically assessing and presenting evidence and that in order to do so successfully, they need to build networks and trusted relationships.

Perhaps one of the biggest challenges is the part time nature of the role. Despite this, all fellows reported enjoying their placements enormously and praise should be given to the fellows for delivering a vast number of outputs in a very limited amount of time.

Feedback suggests that for many CCGs the role of the clinical evidence fellow has helped to create a shift in thinking within their organisations and to help reinforce and facilitate a culture of using evidence and appropriate evaluation. CCGs recognise that such culture change does happen overnight and acknowledge that developing a currency of evidence is part of their own organisational growth. Furthermore, fellows are being used to strengthen relationships with Public health and greater engagement with GPs outside of the CCG and are a potential resource for future clinical leadership roles.

However, it is clear that there are opportunities for CCGs to further benefit from the fellowship placements to challenge and inform their clinical priorities and support the design of new models of care.

Sustainability

The programme was initially funded by West of England AHSN and HEE for a two-year period from October 2014 to October 2016. In March 2016, the West of England AHSN confirmed further funding for a third cohort to run from October 2016 for one session per week per CCG until September 2017. In order to consider the benefits of funding these posts on a longer terms basis there are some key questions for all stakeholders to address. Such discussions should bear in mind that the current programme is a pilot, designed to be tested and proven.

For the West of England AHSN and HEE the key questions to consider are:

- Does the programme continue to meet each organisations strategic objectives? Is each organisation able to commit to the increase in resource needed to support a third cohort?

- Will the programme continue to provide an exciting and high quality learning and development opportunity for mid-career GPs?
- Are the roles sustainable in their current form, ie one morning / day a week?
- Does the programme add value to the health economy as a whole and is there an indication that organisational behaviour has changed as a result?
- Does the programme dovetail with and complement other evidence and research resources available to CCGs?

In addition to exploring alternative funding routes, all parties should discuss potential refinements to the current model in light of the recommendations made in this report.

Given that all CCGs face significant financial pressures, the question of whether these roles could be recruited to on a longer term basis is one for each CCG to consider based on the perceived value of the current role and its potential to be utilised and adapted to suit local need.

For CCGs, Fellows are a highly valuable resource currently available at no additional cost. If these posts were to be embedded within CCGs on a more permanent basis, all Clinical Chairs stated the need for the CEF to contribute towards financial savings in order to prove a reasonable return on investment.

For CCGs the key points to consider are:

- If these posts were funded on a long term basis, either by the CCG or alternative sources, would the same person hold the fellowship for a set period of time, or would the fellowships continue to be 12 months long?
- Would the fellowship be of sufficient value if funded for one session per week per CCG, or would two sessions per week have a greater return on investment?
- Extending existing fellowships beyond October 2016 would require significant input from each CCG on the scope and outputs of that particular fellow, including management time and costs.
- CCGs would need to consider the central role of the West of England AHSN and HEE to date and whether programme leadership would continue through the current arrangements or be devolved to each CCG or STP.

In summary, it is important for the West of England AHSN, HEE and CCGs to continue to work together to identify the benefit of these roles and how they would need to be adapted if recruited to or extended for a longer period of time.

Recommendations

Recommendations fall under three main themes and have been presented as an action plan.

Theme 1: induction and expectations

- Program lead to meet with each CCG before recruitment to ensure the CCG is able to fully utilise the fellow and has ample notice to prepare for the fellows arrival.
- Fellow to set a time to meet with mentors before the West of England AHSN induction event.
- Request fellows agree and produce a specific plan with their mentor based on priorities for the next year.
- CCG to set up formal induction for new fellows and provide the fellow with a list of relevant contacts and key meetings.
- Review the mentor roles, ensuring that each fellow has access to a clinical mentor (preferably a member of the clinical executive), in addition to access to a manager to ensure they have security passes, internet access etc.

Theme 2: demonstrating impact and return on investment

- Ensure bi-monthly reports are linked directly to defined project plans and outputs agreed with the CCG at induction.
- Submit bi-monthly reports to the CGG for comment to aid the feedback loop.
- Consider a mapping exercise with each CCG to determine what research and evidence services they currently use and which can work more closely with the fellows to ensure a more seamless approach.
- CCG to review bi monthly forms to ensure progress again last form is being completed and assess how progress is being measured and recorded.

Theme 3. Learning, spread and sustainability

- Mentor and West of England ASHN lead to discuss how to promote the role within and outside of their organisations to raise the profile amongst the GP community.
- Develop a systematic approach to sharing evidence across the CCGs to avoid duplication and improve spread.
- Consider how to use the role to deliver regular training sessions to staff within the CCGs.
- Develop an alumni and track the numbers of fellows staying in contact with each other and those going onto new roles within the CCG.

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