Evaluation of the Clinical Evidence Fellowship Programme - Year 3

Professor Pam Moule, Dr Sally Dowling, Dr Julie Taylor
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Contents

Executive summary

- This report presents the findings from the evaluation of the third year of the GP Clinical Evidence Fellows (CEF) programme. Now funded by the West of England Academic Health Science Network (WEAHSN), with initial funding of years 1 and 2 also supported by Health Education England (HEE).
- The evaluation aimed to consider the operation of the initiative and to review the challenges, value and impact of the programme for the CEFs and stakeholders.
- The CEFs work within the Clinical Commissioning Group for one or two sessions a week whilst maintaining General Practitioner roles. This raises a number of challenges around time management and many fellows reported difficulties in accommodating the role requirements within the allocated time.
- The CEFs also reported a range of supportive mechanisms such as: having an induction, the existence of key enablers when starting (such as IT access), having access to a line manager and mentor. It should be noted, however, that reports of these were varied.
- Despite the challenges there were a number of reported benefits from both CEFs and stakeholders.
- Stakeholders reported that the fellows' added value to the work of the CCG by bringing in a clinical perspective that was otherwise not available.
- The CEFs reported they were able to use learning in their own practices, often transferring their new knowledge of the CCG and of evidence understanding to the local work environment.
- CEFs were able to offer examples of impact, such as influencing a policy development. Though limited at this stage, it was anticipated that there might be potential to evidence greater impact in the future.
- The findings have led to a set of recommendations for the funders to consider.

1. Background

Launched in October 2014, the General Practitioner (GP) Clinical Evidence Fellows (CEF) programme is now in its third year and has been subjected to previous evaluation (Howell, 2016). This initial report suggested that the CEFs have experienced a high degree of satisfaction and development in the role; however there have been some challenges in terms of competing workload pressures. The report also suggested a need to explore the sustainability of the roles and provided a range of recommendations for implementation.

The initiative, designed by two GPs, Dr Peter Brindle from the West of England Academic Health Science Network (WEAHSN) and Dr Martyn Hewett from Health Education England (HEE), was part of a wider programme of work to support a culture of evidence-led best practice development to support healthcare delivery in the south-west.

The programme was initially conceived to support the development of a culture of evidence-led best practice across the healthcare community, through placing GP CEFs at the heart of clinical commissioning, to work with healthcare clinicians and managers. In this role, the emphasis was to implement evidence informed commissioning to the benefit of services and the public. The recruited GPs (n= 10) are placed in Clinical Commissioning Groups for 12-month periods, for one to two sessions per week.

Aims of the evaluation

The evaluation addressed a number of aims:

1. To understand the benefits and challenges of the GP CEF role for the main stakeholders in order to maximise impact of the Fellowship Programme, and therefore the return on investment, for the remainder of Year 3 and beyond.
2. To summarise the outputs of the CEFs to demonstrate value and impact of the role.
3. To evaluate the value of the CEFs to the CCGs to enable consideration the benefits of funding this post recurring.
4. To evaluate the impact of the role on personal development of the individual CEFs.
5. To create a short Evaluation Report that can be widely shared across the WEAHSN, and beyond, to promote the Fellowship Programme.

2. Methods

A qualitative approach was taken which used an interview schedule developed by the funder. Following ethical approval from the University of the West of England, Faculty of Health and Applied Sciences, the WEAHSN administrator arranged telephone interviews with key stakeholders, including current CEFs. These were conducted between April and May 2017, each lasting a maximum of 30 minutes.

These included:

1. GP CEFs (n=10)
2. The Programme Director
3. The Programme Sponsor
4. The CCG leads and link staff (n=6)

We explored the following questions from their perspectives as listed below:

a. What went well?
b. What could be improved?
c. What are the tangible benefits?
d. Views on sustainability of the post

The interviews were digitally recorded and notes were made into a summary table. The data were subjected to thematic analysis (Miles, Huberman and Saldana, 2013). Initially the analysis was conducted by Sally Dowling and Julie Taylor, with Pam Moule providing a second independent review.

3. Findings

The findings are presented separately for the GP CEFs and the stakeholders. The GP CEF data is reported using codes CEF 1- 10. Data from the stakeholders including the programme director, programme sponsor and CCG staff who had worked with the GP CEFs is presented as SH.

3.1 GP Evidence Fellows

Following coding, three main themes were identified from the GP CEF data: Organisation and role delivery; Role benefits and impact and Learning and development.

Organisation and role delivery

The CEFs commented on a number of mechanisms that they found supportive on initially commencing the role and as part of on going working, such as the induction, local meetings and Avon Primary Research Collaborative (APCRC) support. Additionally, CEFs felt having the initial ID and other necessary logins ready when they started was helpful. However there was some variation in the comments received. Some seemed to have had a formal induction that received positive comment, whereas others didn't report such an experience.

> " *No real formal introduction. Met one of the Doctors, was introduced to a couple of people.*" (CEF7).

There was one suggestion regarding how an induction could be improved through a meeting with finance, and a second CEF suggested it would be helpful to have information on the CCG processes (CEF8).

Support of managers and mentors at the early stages was also important, though not always reported. One highlighted that the initial line manager had left and so he doesn't feel he has support now (CEF7).

Ongoing network meetings between CEFs were highly valued and in addition to this two who were geographically closely located met and emailed independently for support. CEF1 and CEF4 also mentioned the help offered by the APCRC.

A number of CEFs did report some challenges when starting in the role. These were related to a lack of clarity about role expectations from themselves and others, they didn't always feel connected into the organisation and were unsure who key people were.

> " *I wasn't really sure what I should be doing*." (CEF6)

CEF6 also suggested that there was limited feedback that would be helpful to gauge performance in the role:

> "*The CCG have never really given me any feedback*".

The CEFs also reported differences in experiences of the role. One found it difficult to get on to projects initially. CEF4 reported,

> "*My role and experience may be very different to other people…other people may still be doing little bits of work, evaluating the evidence. Other people have been involved in an area, which I seem to have done*."

All had organised the way they worked at the CCG, either having a regular half or full day commitment. This seemed to be necessary to accommodate the wider demands on them as GPs, but this way of working often led to clashes with key meetings or events at the CCG which led to tension. A number had changed their CCG day to try and accommodate meetings, but not all could do this. Some also felt they were less integrated into the CCG as a result of the ways of working.

> " *I don't feel massively integrated, part of that is I don't work on a day when a lot of the clinical leaders are in*." (CEF1)

Another factor that a number of the CEFs had found difficult was the open plan-working environment, though this was helpful for networking.

> "*Slightly odd environment .. Hard to concentrate*" (CEF5)

Workload pressures were mentioned by a number of the CEFs. There was variation in the amount of time worked, some completing whole days and some half days. Those on the lesser hours felt these were not adequate.

> " *A day a week might be better, a morning is a very short amount of time*." CEF1

Other issues related to the role were identified by individuals such as, issues of getting paid (CEF1), and adjusting to cultural differences as in practice change is quick but in the CCG not so (CEF1). One also seemed to be working differently to others, using the library staff to undertake the searches**,** as they were better at it (CEF1).

Role benefits and impact

Here we are presenting impact defined as a change in policy or practice resultant from the activity undertaken and clearly linked to the GP CEF. The GP CEFs offered some examples of work they were doing, but in light of our impact definition there was limited evidence presented at this stage. Examples included;

> "*Evidence on exercise for knee arthritis ..is being used by S.Glos*." (CEF7)

"*Helped to set up spirometry audit…hoping that it will have an impact on care*." (CEF10)

It was also felt that any impact would depend on who you worked with and that you needed a network and to meet with clinicians to achieve this (CEF7). There was also a view that the role was more about presenting evidence to decision makers.

It should be noted that the work undertaken by the GP CEFs was beneficial in a number of ways. CEF1 made reference to the importance of understanding how the CCG worked. CEF5 reported using evidence with more confidence '*in the day job*' and also trying to persuade GP colleagues to use evidence. CEF10 felt that the clinical view had value and is important as the GP is on the shop floor. One candidate had made a successful application for funding to the Elizabeth Blackwell Institute. It was also suggested that the CEFs provided a much needed clinical input to projects and that had they not been available this may not have been sought.

"*There wouldn't have been any General Practice input into the development of the COPD pathway if I wasn't there- which I was amazed by, when we see 95% of these patients*." (CEF6)

One CEF is also having input to GP training on evidence use now and has a role on a NICE panel. Furthermore, one had provided evidence to support a policy outcome change (CEF5).

It is worth noting that one CEF felt he had done lots of things but there was not much with his "*name on it*", although he has contributed a lot (CEF8).

Learning and development

The CEFs identified a number of areas of learning including developing understanding of the CCG functioning (CEF5, CEF6, and CEF7), decision-making (CEF3, CEF4), and appreciating the work pressures of the CCG (CEF2). One commented on the lack of evidence for the majority of practice (CEF4) and a second with a business background suggested that the NHS would not survive as a corporate business (CEF6).

Learning how to use evidence within clinical expertise (CEF5) was mentioned and developing presentation and literature searching skills (CEF4). Two felt their Masters level education had helped in the role and that they already had the skills of undertaking a literature search and review (CEF7 and CEF8), however the Masters and CEF role fitted together well and enhanced their knowledge and practical application.

In addition, one CEF particularly understood more about public health following the experience.

"*Good to meet with the public health consultant and learn how public health gets applied.*" (CEF5)

One had been affected "*massively*" (CEF8) by the experience and wanted to keep doing something in the wider health care agenda. Another remarked that their interest in medicine had been refreshed and he now understood more about the overall system.
A number had enjoyed the experience.

"*I've enjoyed that I've got the time to research and to look at evidence…..and I've become much more… I just think, right, where's the evidence for that.*" (CEF6)

This was seen as important because "*General Practice is under such pressure it's easy to just carry on and not question.*" (CEF6)

Some expressed continuing development needs such as the need for statistical knowledge which was referred to by a couple of CEFs, CCG processes were still viewed as "*baffling*" (CEF6) and CEF3 suggested it would have been useful to have seen completed reviews and understand what was required in the role. Another had been inspired to undertake MSc in Public Health (CEF2).

3.2 Stakeholders

Following coding, three main themes were also identified from the stakeholder data. These were: Role of the CEF within the CCG, Time constraints and Value of the role.

Role of the CEF within the CCG

Overall the role was perceived positively from all stakeholders. They all highlighted the importance of having an independent practitioner within the CCG *"…an extra resource… this is different from having someone who is embedded in the service"* (SH) who was given specific time to focus on evidence gathering.

The main positive aspect that reoccurred was the importance of having someone with the necessary skills to evaluate but who also had a clinical background (SH) as this was perceived as being "*Really useful being a GP, it carries weight with the other clinicians"* and thus adding a perspective on the practicalities and "*extra level of understanding of what really goes on in primary care*" (SH).

> *"I don't think we would have had the richness of that dedicated time for people to look at depth and offer an opinion, they are able to be non-biased and neutral."* (SH)

However there was also a consensus of opinion suggesting that it is down to the role being *"very individually dependent"* (SH) and often relied on the CEFs experience and commitment rather than the role itself, with the individual needing to be proactive for the role to be successful.

> *"They are very different from each other but hugely up for a challenge, success has been very much down to them and their ability to hit the ground running."* (SH)

From those that have worked with several CEFs it seems that the role has improved over the past three years, this appears to be partly down to "*understanding expectations*" (SH) on both sides and partly due to recruiting the correct person, this in turn has improved outputs and achievements.

> *"It gets better each year. The CCGs have a better idea of it. At first neither the CCGs nor the CEFs knew what they should be doing. Now it works better – the leaders of the programme prepare the CEFs and CCGs better. They achieve things quicker. There have been frustrations sometimes in previous years."* (SH)

Time Constraints

More time was requested from all stakeholders as the challenge of one session a week sometimes limited productivity. For example, trying to attend meetings or make contacts can be difficult often leading to inappropriate loss of time and delays. It was also deemed a problem if the CEF could not be flexible due to their other demands, and visibility seemed key to their success.

> *"They have to be committed and visible and understand their role……The last CEF has been independent and has had an impact and been very productive, … however always thought one day a week would be better"* (SH)

All stakeholders acknowledge that the learning has been on both sides to enable the role to become more productive with learning around "*how we can induct them quickly so that time isn't taken up with that"* (SH) and also to increase productivity with the limited of amount of time.

> *"First on – it was a new experience for him and for me and for the CCG so it took longer to get things off the ground, whereas I was a bit more savvy with the second one and he was up and running very quickly as I knew what I had to set up for him"* (SH)

The stakeholders have been much quicker at identifying the needs of the CEFs and also what they want to gain from the role to ensure that it is mutually beneficial.

With regards to time management the general suggestion is that more *"protected time*" (SH) is needed to ensure that the impact of this role can be maintained and also to lead to the role being embedded in the CCG.

Value of the role and future thoughts

The overall consensus was that the role of the CEF was pivotal in the evidence gathering within the CCG. However, this varied depending on the experience of the CEF and the projects that they were allotted to as some projects are presently ongoing and long term. Despite recognising their value and the fact that impact was difficult to measure stakeholders were still able to acknowledge the fact that the CEF had *"fulfilled expectations and more."* (SH)

> *"I'm not sure some of those pathways would have been implemented, the project manager would have been a bit stuck without (CEF) at that stage*". (SH)

The future of the role was summarized as being important if it could someway be embedded within the CCG and all stakeholders accepted the need for a continuation of a mutual benefit.

> *"They are now an established part of the team, building on networks and relationships. We need to start looking at where would their role would fit in accountable care…. How do they come embedded in service redesign, how do you work with the provider? In the long term we would have a plan as a commissioner and a provider where would they sit?"* (SH)

Overall the value of the CEF and the support for its continuing role could be summarized by the following quote:

> *"Our successful experience of the scheme…we would certainly support it perpetuating, it's something we value and the more we can get evidence based analysis into our bloodstream and the more we can get clinical colleagues involved in that analysis, the better".* (SH)

5. Discussion

The study has been focussed in one AHSN area implementing the innovative programme, drawing on those stakeholders and CEFs able to contribute to the evaluation. It should also be acknowledged that the programme was in its third year and therefore there was a limited by the evidence of its effect at this stage. Despite this, a number of important findings have emerged that can be used to inform the ongoing development of the initiative.

The overall consensus was that the CEFs added value to the work of the CCG by bringing in a clinical perspective that was otherwise not available. This was reiterated by all stake holders who felt that these clinical skills were potentially beneficial and time saving when producing health care packages and advisory policies. It was however recognised that this value was dependent on the individuals' perspective and commitment to their role, and more should be done within the recruitment and induction process to ensure that both the applicant and the members of the CCGs understood the role of the CEF. This would be in line with previous research which has suggested that poorly defined roles can be a source of conflict and lead to reduced effectiveness in the workplace (Bault *et al.*, 2014). Indeed, Bault *et al.* (2014) recommend that there is a need to clarify the role when introduced to a new work environment to maximise effectiveness and assimilation.

It was evident that the role was of value to the individual CEFs and had the potential to influence change in their clinical workplaces. Many GPs reported that they promoted evidence based practice in the workplace and practised in this way themselves. This was seen as critical for effective GP functioning in today's healthcare context. Delivering effective evidence based care in a cost saving culture was important. Indeed this resonates with the Royal College of General Practitioners (2013) vision for the GP of 2022. It should also be noted that a number of the CEFs had used this opportunity as a platform to further their own development and maximise local and national opportunities. Whilst some reported ongoing development needs in areas such as statistics and literature review, there were examples of others commencing further Master's level study and securing funding to undertake evidence related work.

Impact, such as the clinical influence exerted on policy development and the adoption of recommendation from their evidence reviews, was reported by some, though at this stage tangible evidence is limited. There is however a potential to see this realised over time and many were anticipating this. Currently it was felt that policy change and individual learning and practice changes had the greatest scope to achieve further impact and wider benefit to the NHS community.

It was also clear that a number of areas might need further consideration as the role continues to evolve and develop. For example, the induction process and support

mechanisms may warrant review. The conclusion by all parties was that one session a week restricted flexibility, and therefore limited input/output. The work was often carried through outside of this allocated session over the hours determined by the job description. It was suggested that two sessions a week completed by one individual would be more practical, providing there could be some flexibility from both parties on how this worked. For example, a CEF could work two sessions a week to allow attendance at meetings, as well as undertaking specific project work. It should be noted that time related issues have been raised in previous evaluations (Howell, 2016) and remain an area for ongoing consideration and review.

6. Recommendations

A number of recommendations are made to the funders for consideration based on the reported findings:

- Review the recruitment process and provide clear role expectations that are communicated within the wider stakeholder group and CCG workplace.
- Provide a job description with role expectations and ensure this is shared and understood by the CEF, AHSN and CCG manager, CCG mentor and wider teams.
- Review the induction process within the AHSN and CCG to ensure that this is fit for purpose and is applied consistently.
- Induction to include examples of literature reviews and instruction on statistics and finance.
- Review the time allocation to the role and whether it is feasible to increase the time allocated or to change the way the role operates.
- There is scope to consider different models of working that might reduce the workload burden. For example, reducing the number of CEFs within each CCG but supporting more sessions being delivered by each. A second option may be to allocate CEFs to work within a clearly defined team delivering an allocated project(s).
- Ensure all the CEFs are introduced to key staff on commencing the role.
- Consider how the role should operate to provide maximum learning for the CEFs and benefit to the CCG. As other recommendations listed suggest, this could include; identifying learning needs and providing learning materials ahead of appointmen, the provision of a list of key resources and staff contacts, provision of a mentor and line manager.
- Consider how to ensure structured feedback is provided from the CCG to those who are new to post.
- Develop and maintain a systematic approach to capturing evidence of impact.
- Consider capturing evidence on the impact of the opportunity of the individual CEFs, collecting case studies of ongoing development and effectiveness.
- Consider whether there is potential to identify and meet ongoing development needs of the CEFs.

- Consider the longer term future of the role and how it might be embedded in CCG practice.

7. References

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Appendix

An Evaluation of the GP Clinical Evidence Fellowship programme- Year 3

Background and evaluation context

The GP Clinical Evidence Fellow (CEF) programme was initially conceived to support the development of a culture of evidence-led best practice across the healthcare community, through placing GP CEFs at the heart of clinical commissioning, to work with healthcare clinicians and managers. In this role, the emphasis was to implement evidence informed commissioning to the benefit of services and the public.

The role has been implemented with some differences. Most, but not all, CEFs have worked for one session a week. An induction programme has been delivered to some and line manager/ mentor arrangements have varied.

Methods

A qualitative evaluation in the third year of the programme drew on interview data secured from the GP CEFs (n=10) and other stakeholders (n=8), including the programme director, sponsor and CCG staff who had had some involvement with the programme.

Though limited in its scope, the evaluation identified some key findings from both the CEFs and stakeholders and was able to make recommendations for practice.

Findings

GP CEFs

A number of support mechanisms were valued by the CEFs, in particular the availability of a mentor and line manager support and the provision of an induction programme. The network meetings taking place between the CEFs was also welcomed.

There were challenges when starting as a CEF, with a number reporting a lack of clear agreement on the role description and expectations.

> " *I wasn't really sure what I should be doing*." CEF6

Differing experiences were also reported, perhaps reflecting this initial lack of common agreement. Whereas some were working as part of a team on specific projects, others had less structure and were working on a range of different areas.

Commonly, there was a recognition that time was limited and a preference was expressed for a contract that provided two sessions a week to the CCG.

Importantly a number of benefits were reported, in particular gaining knowledge of the working of the CCG and developing or enhancing critical review skills. Additionally, despite the short length of time in the role, there were examples of impact on policy and practice change reported and over time it is anticipated that further might be evidenced.

> " *Evidence on exercise for knee arthritis ..is being used by S.Glos*." CEF7

CEFs also reported that they were adopting a more evidence-aware approach in clinical practice settings, often questioning practice delivery. Some also shared learning from the role with practice colleagues. This was seen as important because "*General Practice is under such pressure it's easy to just carry on and not question.*" CEF6

Some were inspired to continue studies and the work, with one example of a CEF securing new research income.

Stakeholders (SH)

Overall the role was perceived positively from all stakeholders. In particular the additional resource and clinical practice expertise was welcomed.

> "*Really useful being a GP, it carries weight with the other clinicians"* (SH)

There was also acknowledgement that effectiveness in the role often related in the CEFs experience and to their commitment.

Stakeholders also commented on the lack of initial clarity of expectation of the role and felt that this had developed over time. Time was also raised as a challenge within the role, with a suggestion that one session was not enough for the role.

> "*…however always thought one day a week would be better"* (SH)

Despite the time constraints the stakeholders recognised the value that the role brought to the CCG and one respondent suggested,

> "*I'm not sure some of those pathways would have been implemented, the project manager would have been a bit stuck without (CEF) at that stage*". (SH)

There was a desire to see the scheme continue, and to explore how to embed the role in the CCG and ensure sustainability.

Next steps

A number of recommendations were made to the sponsor for consideration. In particular these related to a review of the processes of induction, support and model of operation. Other models of time allocation might be considered and ways of working in CCGs might be standardised. In addition, collecting evidence of ongoing impact on practice and policy might be collected systematically to support sustainability arguments.