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# Evaluation Report

## HEE North Central and East London & NIHR CLAHRC North Thames Clinical Nurse/Midwife/AHP (NMAHP) Academic Fellowship Scheme

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# HEE North Central and East London & NIHR CLAHRC North Thames Clinical Nurse/Midwife/AHP (NMAHP) Academic Fellowship Scheme

## Evaluation Report

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## Introduction

One aim of the NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) is to increase the capacity and capability of the nation's health professionals to undertake high quality applied health research. The *Shape of Caring* review highlighted a need to generate a greater research culture in nursing, with all nurses being involved in supporting or leading research in the future (Willis 2015). In response to this report, the CLAHRCs have been working to create new pathways to support nurses, midwives and allied health professionals and to build the capacity of this workforce to undertake applied health research (NIHR 2016).

There is an increasing evidence base regarding the positive impacts that research-active Trusts have on patient outcomes through the embedding of evidence-based practice (Willis 2015; Ozdemir et al 2015; Boaz et al; 2015). As highlighted in *Modernising Nursing Careers: Setting the Direction* (Department of Health 2016), developing a highly skilled workforce of nurses, also in research work, is an important aspect of preparing the profession for the challenges of the current and future healthcare service. UKCRC's *Developing the Best Research Professionals* report (2007) made recommendations including the development of a clinical academic pathway for nurses, involving training award schemes, flexible working arrangements for combining clinical and academic work, and mentorship. While these reports focused on the nursing profession, parallels were made across the healthcare professions, resulting in these recommendations leading to the establishment of a clinical academic pathway and training across the healthcare professions.

The NIHR/CNO/HEFCE Clinical Academic Training Programme ran from 2009 to 2015, awarding 77 doctoral fellowships, 36 clinical lectureships, and 13 senior clinical lectureships to healthcare professionals over this six-year period (NIHR Trainees Coordinating Centre). Following a review in 2014 by Health Education England (HEE), this was replaced in 2015 by the NIHR/HEE Integrated Clinical Academic Programme for non-medical healthcare professionals. A key feature of the integrated programmes is that emphasis is placed on both academic and clinical progression. When the evaluation was undertaken, the pathway was formed of four stages of awards ranging from Masters studentships in clinical research, to clinical doctoral research fellowships, clinical lectureships, and senior clinical lectureships (HEE 2015). Other sources of funding, training, and fellowship awards come from a variety of sources, such as CLAHRCs, regional partnerships between trusts and HEIs, charities, and other such organisations (NIHR 2016; AUKUH 2013; AUKUH 2016).

Since 2015, NIHR CLAHRC North Thames and Health Education England's (HEE) north central and east London team (now part of the north London local team), have been working together to develop a novel one-year fellowship scheme for nurses, midwives and allied health professionals (NMAHPs), which aims to promote clinical academic pathways and develop the research leaders of the future. The scheme involves the secondment of NMAHP fellows for four days a week to a research department in CLAHRC North Thames, allowing the fellows to work on a project of their own choosing, or on a current CLAHRC project. The

scheme facilitates this secondment by backfilling the fellows' salary for three days a week, while the fellows' employing organisation is required to fund the fourth day of the secondment. The fellows spend the fifth day as normal, remaining in clinical practice at their organisation.

HEE/CLAHRC fellows are recruited from across the North Thames partnership via a competitive selection process. In spring 2015, the first cohort, comprising three fellows, began secondments to the CLAHRC. In 2016, a further two fellows were recruited. A third cohort of four fellows was recruited in March 2017, and a fourth cohort of four fellows was recruited in August 2017. This present report focuses on evaluating the first two cohorts of the scheme (2015 and 2016).

During the secondment, fellows are provided with support and mentorship by a senior CLAHRC academic in order to develop an application for doctoral or post-doctoral research funding (for example, by applying to the HEE/NIHR Clinical Doctoral Research Fellowships). They also have access to peer-to-peer mentoring and networking during the fellowship, as well as to the full range of Academy training opportunities. In line with the goal of building research capacity across the CLAHRC, fellows are required to undertake activities to raise levels of research awareness at their base NHS organisation.

## Evaluation Aim & Objectives

The aim was to evaluate the 2015 and 2016 HEE/CLAHRC Research Fellowship Scheme for nurses, midwives and allied health professionals, in terms of its impact on the fellows, the local health care system and on CLAHRC North Thames.

There were five main objectives:

1. To assess the success of the scheme with regard to supporting NMAHP fellows to complete applications for external doctoral research funding, and the outcome of those applications
2. To describe the wider impacts of the scheme on the fellows' research careers, their base NHS Trusts and their host research organisations
3. To explore the experiences of those involved in both participating in and running the scheme, including their recommendations for the future
4. To examine the effectiveness of the advertising and recruitment process, including perceived barriers to participation
5. To contextualise the scheme with other national initiatives aimed at supporting NMAPH research careers and to identify key areas for learning

## Methods

We carried out 22<sup>1</sup> semi-structured interviews with a number of different stakeholder groups and analysed questionnaires on the fellows' progress from Cohort 1 and 2.

*Table 1: Stakeholder Participants*

<i>Stakeholder</i>	<i>Data collection method</i>
<i>Fellows</i>	progress questionnaires; 4 interviews
<i>Scheme Steering Group Members</i>	4 interviews
<i>Fellows' Supervisors</i>	4 interviews
<i>Fellows' Line Managers at Host Trust</i>	3 interviews
<i>Local Clinical Academics</i>	4 interviews
<i>Senior Representative from a Trust who did not participate in the scheme</i>	1 interview
<i>Senior Representative from participating Trust</i>	1 interview
<i>Representatives from other CLAHRCs running similar schemes</i>	2 interviews

### **Component 1 – Questionnaire**

In order to assess the success of the scheme with regard to the opportunities for applying for external doctoral research funding (obj. 1), we used quarterly progress questionnaires submitted by all the fellows from cohort 1 and 2 (n=5) to examine the following points:

- The success of personal research fellowship applications
- Research outputs during the fellowship
- Training courses completed
- Activities to raise levels of research awareness within their Trust
- Other engagement activities

<sup>1</sup> One interviewee was a member of the steering group, and a supervisor. This interviewee has been counted twice in the table below.

## ***Component 2 – Semi-structured interviews***

In order to explore the wider impacts of the scheme and the experiences of those involved in the scheme, including their recommendations for the future (obj. 2 and 3), we conducted 15 semi-structured interviews (one interviewee straddled two groups), comprising:

- Four<sup>2</sup> NMAHP Fellows
- Four<sup>3</sup> Fellow Supervisors
- Three Line Managers in base Trusts
- One Director of Nursing at a Trust engaged in the scheme
- Four<sup>4</sup> members of the scheme's steering committee

These interviews explored reflections on participation in the scheme, including the impact of the scheme on host NHS organisations, from the perspective both of the fellows and their wider professional support network. Topics for discussion included arranging a secondment, the impact of the scheme on the fellow and his/her career, and any challenges or barriers to participation.

To examine the effectiveness of our advertising and recruitment process, including perceived barriers to participation (obj. 4), we conducted 5 semi-structured interviews with groups who did *not* directly participate in the fellowship. These were:

- One Director of Nursing (or equivalent senior representative) in a local Trust who did not engage with the scheme
- Four Senior Clinical NMAHP Academics in local universities

Interviews explored awareness of the scheme, NMAHP career progression pathways and barriers to participation in the scheme.

To contextualise the scheme with other national initiatives aimed at supporting NMAPH research careers and to identify key areas for learning (obj. 5), we undertook 2 semi-structured interviews with senior staff involved with other national NMAHP initiatives. The emerging findings from the evaluation were shared with participants in advance of these interviews. The document acted as a starting point for discussions around how the CLAHRC North Thames Fellowship Scheme compares to schemes they offer, to any similar examples of best practice or mutual barriers, and then lead into a broader discussion about supporting NMAHP barriers more generally.

These interviews focused on identifying areas for mutual learning with a view to running future iterations of the scheme.

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<sup>2</sup> Out of a possible five fellows (one chose not to participate)

<sup>3</sup> Out of a possible five interviewees (one per fellow)

<sup>4</sup> Comprising Senior Clinical Academics, funding partners, training leads.

## Ethics

As a form of evaluation, the project was deemed to be exempt from NHS and UCL institutional ethical approval. All participants provided written consent to participate.

The report was shared among research participants and the HEE north central and east London Steering Group committee for comment.

The codes given to each interviewee indicate the order in which the interview took place, and do not relate to the fellow, their supervisor, line-manager on a location or case-based labelling system.

## Analysis

Framework analysis was used. Transcripts were analysed for themes by stakeholder group, and then key themes were compared across datasets in order to provide a rounded view of any points or issues raised, in view of the objectives of the evaluation.

Questionnaires were read and the number and type of publication, training attended, and capacity-building activities undertaken by the fellows were recorded as simple metrics.

## Key Findings

### Fellows – experience of participating in the scheme and impact of scheme on their research career

Of our first two cohorts of fellows, four out of five were shortlisted for either a DRF or C-DRF NIHR fellowship.

*Table 2: Fellows*

	<i>Fellow</i>	<i>Journey</i>
<i>Fellow01</i>	AHP	Shortlisted, awarded CDRF
<i>Fellow02</i>	Nurse	Not-shortlisted
<i>Fellow03</i>	Nurse	Shortlisted CDRF
<i>Fellow04</i>	AHP	Shortlisted, awarded DRF
<i>Fellow05</i>	Nurse	Shortlisted DRF, Shortlisted CDRF (withdrew)

**Fellows who engaged in the scheme were ambitious to develop a clinical academic career and had developed a keen interest in research throughout their careers**, often starting out with audits which had led them to identifying areas in their clinical roles where they wished to make a difference to patient care:

*So I'd done research throughout my career, I'd done posters and taking part in audit and those things, but after doing that piece of [Masters] research and it being successful I decided I wanted to take that further (Fellow02);*

*audit's always included in every part of your education pathway, and I think sometimes these audits naturally turn into bigger questions ... and I think that's where you know, that's where I first started thinking about research...and in my clinics I kind of started asking myself questions about you know how we can improve patient care (Fellow04).*

The scheme was viewed as positive because it was funded and enabled participants to engage in training without taking a cut in income:

*I already had a Masters, I was not going to take any more, I could not take any more unpaid time for education [...] So I was only really able to take on opportunities that allowed me to keep on working at the same rate instead of sort of set me back you know, so the fellowship really stood out as different (Fellow01).*

**The fellowship buys the fellows out of their clinical practice to allow them time to develop an application in a way which would have been difficult had they being trying to accomplish it whilst employed full-time in a clinical role:**

*I wanted to apply for the NIHR PhD fellowship, but it's just so difficult to get the time to think when you work in a very busy clinical environment. So that was the ideal opportunity really and when I saw the advert ... and then the other positive aspect of that was that it was in the CLAHRC, so it's very supportive environment (Fellow03).*

**A further benefit of the scheme was that it allowed fellows time to experience and consider whether they wished to continue in a clinical academic role:**

*it was a really, really positive experience, I really enjoyed it, it was really stimulating...I learnt loads, I think it really helped with my confidence and helped, I do want to follow a clinical academic career, I do know that (Fellow02);*

*I loved it, I would jump at the chance to do more, to take three more years and I would continue to try and manage that clinical research life because I still want to be a clinician. So yes I would definitely, I have loved it, I have loved the opportunities to keep going with the ideas, I have loved the learning curve (Fellow01).*

**Fellows also spoke about it aiding their development as a clinician.** Firstly, that patient care could improve as a result, and secondly that as a clinician their skills were enhanced by it:

*I couldn't help but identify and like play emphasis on the areas where there was a lot of research where I needed to do something about it... the heat spots, you know, like the areas where the research was really good actually were kind of driving me to make changes in the service (Fellow04);*

*I am much more immersed in the evidence, I think I was already reasonably good at evidence around my particular area, I tried to stay on top of it, I follow on twitter, all the relevant kind of links and stuff like that but I am much better now and I also had some really amazing collaborators and supporters (Fellow01).*

In line with our goal to build research capacity across the CLAHRC, fellows have been involved in a range of work to raise levels of research awareness in their base NHS Trusts. During the fellowship year, they **undertook a wide range of capacity-building activities** in their host organisations, totalling over 40 different activities. These included making presentations to colleagues about their projects, mentoring colleagues to propose and conduct evaluations, facilitating 'writing for publication' workshops and journal clubs and increasing awareness of good research practice. Three fellows were involved in planning and implementing aspects of their host trust's research strategy, with two incorporating a greater focus on research into their role upon return to working full-time within the clinical team.

All five fellows **participated in activities promoting clinical academic careers and research**, outside of their host organisation. Examples include writing for the national CLAHRC newsletter, as well as presenting to post-graduate nursing students and potential fellowship scheme applicants, securing a bid for £10,000 to support research in their area of specialty, and being involved in the organisation of a new Research Centre partnership. Other activities in research included being part of national audits, contributing to NICE evaluations, piloting the CLAHRC Academy's online evaluation course, and becoming editor of a specialist nursing textbook.

The scheme has helped to **improve communication and partnership working between clinical and academic staff**. Fellows have taken part in conferences and symposiums linked to their area of research. They were also involved in many other engagement activities such as presenting their work at HEE/CLAHRC Stakeholder meetings, and at meetings with potential research collaborators. Collaborations for current and future research projects were formed with one charity, three UK universities, and one European university, as well as CLAHRCs, CLAHRC North Thames partners, and NHS Trusts. **The fellowship enabled fellows to produce a substantial number of research outputs**. Between the two cohorts, fellows worked on 10 publications aimed at a variety of journals, including open access multidisciplinary journals, specialist journals, nursing journals and protocol journals. One fellow was also invited to write an editorial for a specialist journal. Four fellows presented at conferences, with 7 posters and two talks in the UK and two presentations at conferences in Europe.

Finally, fellows have **used their research directly to improve care for patients**, for example, by undertaking improvement evaluations. Fellows have actively engaged with the CLAHRC PPI group to obtain feedback on the development of their research proposals to ensure that the research outcomes benefit patients, service users and those close to them. **Fellows embraced the training opportunities available to them**. They completed 14 courses and workshops, 9 training conferences and attended multiple seminars, these included training on mix-methodologies, systematic reviewing, writing for publication, critical appraisal, patient and public involvement in research, and statistics.

**Participation in the scheme opened up new opportunities**, in addition to PhD. Some fellows moved jobs into new (more senior) roles, and this should be recognised as an

additional outcome of the fellowship. The scheme offers a taster of a clinical academic career, but is also a stepping stone and opens up new pathways, both clinical and in research, by equipping fellows with new skills:

*I have got this post which is a promotion and I think that it has impacted quite a lot on a lot of my skills I would say, so stuff around critical thinking skills most definitely, presentations, confidence, talking in meetings and confidence generally (Fellow02);*

*I've got a very exciting new job so I had my appraisal with my boss because I've achieved so much in this year while I've been on the scheme in terms of building up this collaboration and research and doing so many things like helping mentor so many valuable audits and the evaluation project ... I'm being given a new role so I'm going to be upgraded and put in a kind of research co-ordinator [role] (Fellow04).*

Despite the very positive experiences of participating in the scheme, **the fellowship year was not without its challenges**. For the fellows, these related in the main to **the difficulties working across a clinical and academic role** and maintaining a presence in both positions.

### **Fellows - Working across a clinical and academic role**

The fellowship requires fellows to be seconded out of their clinical roles for 0.8 FTE, leaving them remaining in practice for one day per week. Fellows enjoyed having protected time for research. However, there were challenges in moving between clinical and academic roles.

Firstly, there were **challenges adjusting to a new role**:

*As a nurse it's like you're on the ward, here are the jobs, go off and do them, something else will come in, this will happen, that will happen...the space that you're given to think in an academic environment is just completely different, completely, that's what people just want you to do is read stuff and think about it and then come up with ideas...I think that transition was really quite difficult. (Fellow02);*

*Well at first I found it really frustrating and I felt like I was going round and round in circles, but I think that's more because I ... I always used to be in quite a senior position and being a PhD student of a fellow is like you know, it's not that at all, it's a training ... you know it's about learning and it took me a long time to get that mind-set (Fellow04).*

**Getting used to receiving critical feedback** was something noted by a number of fellows:

*quite difficult at first, is the criticism which isn't directed at you, it's directed at the applications and stuff like that, but in academia it's like they will just rip it to shreds which is fine and when you look back you think yeah that's a really good way... but that can be quite hard at first, but I guess that's another skill that you learn as well isn't it? (Fellow02).*

In supporting them in their transition, fellows suggested that when they stepped into the role on Day 1, they should be fully prepared and logistics in place; for example, access should already have been set up for them in their Research Department:

*The only thing I would say was getting the paperwork and the ID card and computer access and library access, it took three months to get that. And no one knew who I am, what type of secondment I had, what type of contract I needed and again I think it's worth*

*preparing in advance of these things. Because when ... you have a year, if you waste three months trying to sort out your ID and library access it's not good (Fellow03).*

Along the same lines, a **'welcome pack' of need-to-know information would also be useful:**

*I think there needs to be, I would like to see like a little package of information of what you can expect and key resources that you need to kind of go to because I think you kind of muddle through and find it out, but I was sort of finding out things in June and July that I could have done with knowing in February you know what I mean? (Fellow01).*

**Removing themselves from a busy clinical department to concentrate on their research was also a challenge.** Fellows spoke about feeling guilty that they were leaving an often-strained service behind:

*at the beginning I guess in some ways I felt guilty about not being here and having this amazing experience and then other people struggling, so it can be quite difficult (Fellow02).*

Often they **compensated for being absent from their full-time clinical role by working long hours and extended days.** This could impact on other commitments, such as family life:

*I mean I tried to isolate my clinical day on a Friday which often ended up being a 12 hour day because one clinic is never one clinic, there is always more things to do and when you're around people ask questions, patients ring. So it's not just the nine patients you see in the morning. (Fellow03);*

*Just the volume of emails I get from [the Clinic] is you know really phenomenal I'll probably get a day's worth of emails from the Trust a week you know like to read through and thankfully I've got remote email and so I can use like train journeys and weekends but that's slightly eating up into my own time and my children's time and I'm answering emails when I'm at home and stuff so yeah, it's tricky (Fellow04).*

Linked to this transition, moving between different roles and identities was not easy, particularly with regard to **balancing their presence in clinical practice with their fellowship role:**

*suddenly things go round you that used to go through you, you know what I mean and you kind of find out about things after and that is quite challenging then you just have to accept it, you are doing a different role (Fellow01).*

Other issues included a lack of understanding in their Trust department as to the purpose of the fellowship, which was sometimes seen as short term 'studying', rather than a positive development opportunity for the immediate clinical department:

*I think in some ways there's a definite lack of understanding of what I was actually doing, so people would talk about me being on a course, well I wasn't on a course, at the end of it, and so at the end of it are you going to have a PhD, well no, that would be nice, but it, there's a definite lack of understanding of those sort of things (Fellow02);*

*many people here were telling me that I'm a student. They said you are studying now are you? Not really. So it's that perception (Fellow03).*

### Take-home points

- **Successes:** The scheme has been a success in supporting fellows to submit high quality applications for NIHR fellowships (see table 2). Fellows embraced the training opportunities available to them and attended a wide range of training events and workshops.
- **Capacity building:** Fellows undertook many activities to raise research awareness in their Trust and worked to feed back their learning to colleagues in the department.
- **Scheme opens up new opportunities:** In addition to PhD opportunities, some fellows also moved on into new (more senior) roles.
- **Returning to training:** returning to a learning environment took a period of adjustment. A front loading of information in terms of a 'welcome pack' or similar would be helpful.
- **Movement between roles:** Moving between different roles and identities was a challenge. For example, moving from a senior clinical position to a junior/student research role. Difficulties of keeping one foot in both camps.
- **Fellows sometimes compensated for being absent from their full time clinical role:** they spoke about working long hours and extended days.
- **Not necessarily a research culture in clinical department:** Lack of understanding as to the purpose of the fellowship. Sometimes seen as short term 'studying' rather than a positive development opportunity for the immediate clinical department.

### The Secondment

Trusts were supportive in principle to the career development of the fellow, and to enabling them to undertake the fellowship scheme. **The main issue fellows faced when negotiating a secondment was financial**, but this appeared to be dependent on the individual Trust and its situation:

*It was a bit of a struggle because of the additional money that the Trust had to give up and I think this Trust is always in special, this Trust has been in special measures, financial issues literally as soon as, since I've ever worked here (Fellow02).*

It was felt that perhaps the requirement for a financial contribution from the Trust could have been made clearer at the outset:

*I applied, we were all surprised when I got it and only then did they realise that they would be paid for three days but I would be gone for four and my boss then got in trouble with her boss for having agreed to that because it was a one day financial hit for a strained NHS department and I think there was a little bit of, it was challenging to get around that (Fellow01).*

**Returning to practice after the secondment could be difficult.** Two fellows discussed how they felt frustrated that they were not able to put their learning into practice, once they had returned to a full-time clinical role:

*the team here expected me to just slot in in the same way as when I left whereas the service hadn't changed, but I had changed, so I had changed immeasurably in terms of all of the new skills and all of the things that I wanted to do and actually it was just that I'd just go back in and do the job that I've always done and so that was really awful and really*

*difficult... I think there's a real lack of understanding of what I can now contribute (Fellow02);*

*coming back, and that's been a little bit difficult because I lost my research aspect. So previously I had health, 50 percent clinical, 30 percent research and 20 percent professional development, and other activities. So I lost that. So I'm now doing five clinics a week so it's more or less about 80 to 90 percent clinical and I have no time for research (Fellow03).*

These two cases illustrate the need to have clear communication from the start as to the role the fellow can expect to return to, and how they can put their learning into practice to benefit the service. Maintaining a closer contact with the service could help with this.

After completion of the secondment, fellows continued to meet with representatives from HEE's north central and east London team and receive mentoring for their career development. Fellows commented that they appreciated this ongoing support during their transition back to practice and beyond, but that they felt that the CLAHRC could have been more involved in post-secondment mentorship.

### **Take-home points**

- **Clarify upfront about fellows' role when they return to practice:** Transition back can be hard. Map out early what is expected of fellows when they go back to practice, and stress importance of Trust commitment to long-term career progression.
- **Returning to Practice:** Some fellows had limited time for research once they returned to practice. This made it difficult to maintain momentum.
- **Stronger CLAHRC/Trust communication:** Fellows would benefit from more formalised communication between CLAHRC and Trust at outset of scheme – e.g., agreeing before the secondment the type of role the fellow can expect to return to, so that they are able to use their knowledge. Negotiate what is expected of the fellow in both clinical and academic roles from the outset (perhaps write this in the contract).
- **Mentoring:** Informal mentoring continues after scheme finishes (currently with HEE's north central and east London team). There is scope to formalise this and involve the CLAHRC.

The next section of this report addresses objectives 2-4, exploring the effectiveness of the advertising and recruitment process, the impact of the fellowship scheme on base NHS Trusts and their host research organisations, and the experiences of those involved in both participating in and running the scheme.

### **Advertising and recruitment**

The CLAHRC and HEE's north central and east London team advertised the fellowship opportunity through their networks and email distribution lists. Therefore, **advertising and recruitment largely relied on the cascading of emails by staff in organisations**, and on

targeting potential individuals who may be interested in the scheme. Relying on an email cascade had shortcomings, and was recognised by every stakeholder group:

*communication is much more challenging than you think it is and you think you send things out to people. So we rely a lot on e-mail and that's not always, it does get information out to people, but it requires someone to act on it. If I am interested in this and I see an e-mail about it, that might alert me, but if I hadn't previously thought about it and just looked at that, I must just press the delete button because I think that's nothing. When you get hundreds of e-mails (Senior Representative in Non-Participate Trust);*

*I think in terms of barriers the obvious one is do people even know it is out there, so there is something about how is the opportunity advertised and disseminated so that as many people as possible are hearing about this...I think in health organisations, depending on the organisation, the structures may be such that information only gets so far and does not necessarily get to the right people (Academic02).*

This approach to advertising depended on many factors, and was hit-or-miss in reaching the right individuals:

*So in any organisation it depends on how seriously the person who receives the email takes it; whether they're around at the time when the email comes in and how they disseminate it through their organisation (Steering Group01).*

The scheme may benefit from receiving wider awareness, and making sure that key contacts in an organisation know what the scheme offers, so that they can target their dissemination accordingly.

The scheme is aimed at Nurses, Midwives and Allied Health Professionals, however, although AHPs are trained in CLAHRC North Thames partner universities, there is no School of Nursing in CLAHRC partner universities. This creates an additional barrier in terms accessing a large cohort of individuals undertaking a Masters in nursing.

Word-of-mouth and identifying of individuals who may be interested in participating in the scheme was a recognised avenue for recruitment:

*The other thing is these sorts of things; it's often word of mouth as well isn't it? So once someone's applied for one of these and been successful they will tell colleagues and friends, do you know I did this fantastic, and that word of mouth is often the thing that tips it from being just an e-mail in a box that people aren't paying attention to someone thinking that's what so and so was talking about, I need to look at that. So I suppose that's about people that have been successful with the fellowship scheme also helping to disseminate (Steering Group01).*

It was felt that the **wording of the advertisement could be improved or clarified to broaden the appeal of the scheme:**

*I have to say, initially when I saw the way it was advertised and the requirements and so forth it very much led you to think that unless you were interested in those particular CLAHRC schemes that you almost were excluded from applications. So if your interests were elsewhere and they did not align with what was listed you could easily think actually I cannot apply because I am not interested in any of those (Academic02).*

### Take-home points

- **Scheme would benefit from wider awareness:** Could link with Colleges and Chartered Societies to get better coverage (e.g., RCN, CSP) when advertising the fellowships. There is no nursing school in CLAHRC partner universities, although other AHP professions are represented (e.g. Pharmacy).
- **Work on networks and forming a closer CLAHRC/Trust communication within the local area:** e.g., CLAHRC giving presentations in Trusts to raise awareness of the scheme.
- **Advertising materials:** Make it clearer at the outset that applicants do not have to be tied to a particular CLAHRC project, since this could be limiting, if potential applicants think it does not fit within their research interests.

### Timing of scheme

**For the first two cohorts, the timing of the scheme meant that if they were to submit two applications for NIHR funding during the year (DRF and C-DRF), then the first application would need to be submitted not long into their secondment:**

*the fellowship starts in January, the C-DRF application is due in April. So basically, you do not have enough time to learn before you get that application (Fellow01).*

This timing also had drawbacks with regard to fellows having access to the same training opportunities at their CLAHRC partner university as doctoral students.

*PhD students normally start in October so she started in January so some of the courses that she might have wanted to go on had already happened (Supervisor01).*

The application the fellow submits is not guaranteed to translate into funding for a PhD. There is a long waiting period between submitting an application for funding and hearing whether or not the application has been successful. In the meantime, fellows returned to their clinical role, and this could be a driver for change and new opportunities:

*I've applied for a new job partly because I think it will serve better my ends as a clinical academic, but also I can't sit around waiting for the Fellowship to come because it might not even happen (Fellow02).*

### Take-home point

- **Timing of fellowships:** There were some drawbacks to the timing of the fellowship. In relation to NIHR applications, there was not a lot of notice for fellows to put in a project for NIHR CDRF scheme that year. The fellowship does not align with academic year, so fellows potentially miss some early doctoral training opportunities. There is a long limbo period between submitting a PhD application and finding out if it has been shortlisted/successful – difficult for fellows returning to practice/moving on (to new jobs).

## Base NHS Trust experience of scheme

Although there was **recognition that the HEE/CLAHRC Fellowship scheme was a good opportunity in the long-term, for the fellow's career development**, for the department, and ultimately for patients, **releasing a senior member of staff for 4 days a week for a year was a challenge for the frontline service:**

*for an individual to get any kind of Research Fellowship or sabbatical for teaching or anything else, it's obviously great for the individual from their own professional development. And I think also, in the overall picture, it's better for the Trust because we have people doing this and then hopefully they bring back an increased awareness of research, an increased ability to do research into the Trust. So I think everyone benefits and then ultimately, of course, the patients benefit in the long-term. But the difficulty is there is very little, there's no slack whatsoever in the system (Line Manager01).*

There are **conflicting demands** where there is a pressure to deliver the service and to meet patient demand, when losing one senior member of staff for a year and also desiring to support individual staff development. Although the HEE/CLAHRC Fellowship backfills the salary for 3 days a week, their host trust is required to contribute one day's salary to the scheme:

*you're offering three days paid, and one day there has to be the contribution of the service. Contribution of the service is a problem and I know the thinking behind that was to ensure that the service had some buy-in, but I think that's extremely naïve given the current climate within the NHS particularly for small Trusts (Academic04).*

Some of these issues could potentially be addressed by reducing the academic days to 3 and increasing clinical days to 2, and removing the requirement for the Trust to contribute 1 day's salary to the scheme. Part of building a clinical academic is nurturing the ability to work across roles. This might be easier facilitated if the fellow maintained a closer contact with the clinical department:

*four days is really taking them out of their service commitment and I can understand why their colleagues feel that this is a bit of a jolly they've been on for a year and they've really lost touch with their service colleagues and find it very difficult to get back in. Have you thought about maybe reducing it to two days a week and then maybe you can get more, you could afford to have more people on that course so your hit rate of success will probably increase (Senior Representative Other Schemes02)*

Having one fixed day per week was also limiting for the fellows, who could miss training opportunities which fell on their clinical day. Having a more flexible approach to the clinical time e.g. running 2 or more of their clinical days together to cover busy periods in the clinic or to free up research time to attend specific training events, may be helpful.

**Trusts benefited from fellows implementing their learning in their clinical practice throughout the year:**

*it was so good and you could just see the changes, the ideas of what she had learnt over the period, whenever she came back to work we were able to use some of the*

*functionalities of things and tools to implement some stuff in A&E and on the wards as well* (Line Manager03).

However, there was also some recognition that success in the scheme would mean that fellows move on from their role:

*the main thing is if people take this as a career move, which it is, hopefully that they do come back to the Trust and then we can implement what they've learnt rather than they come back and get a little bit bored or whatever because things have moved on and they're back to where they are* (Line Manager01).

One way to combat this and support fellows in implementing their learning into practice is to have a contractual agreement with the Trust from the outset regarding how the fellow's role may develop to reflect their new learning:

*be something that may actually go into a contract for the organisation that as it's coming from to say, how would you intend to use this person, give an example of how you intend to use this person when they come back* (Line Manager03)

### **Take-home points**

- **Conflicting demands:** Pressure to deliver service when losing one member of staff vs. wanting to support individual staff development.
- **Planning:** Stressed the need for the fellowship to be planned well in advance – timing can be difficult with relation to working planning and arranging staff cover. Early conversations and planning would help.
- **Maintaining communication:** fellows can be isolated/lose touch, when they are in clinic only for one day a week – discuss possible flexibility in the scheme, e.g., a flexible 1 day per week.
- **Clinical/Academic days:** In order to maintain a closer relationship with the clinical department and ease the pressure on staff providing cover, consider revising the weighting of the fellowship to 0.4FTE clinical 0.6FTE academic. More clinical time may help the service and the fellows to feel less removed from the department, so that they can maintain clinical relationships and integrate their learning into their everyday practice.
- **Financial pressures:** Consider whether to reduce the need for the Trust to contribute 1 day's salary to the fellowship scheme.
- **Supporting career development:** Have early discussions with the Trust about how the fellows will be expected to implement their new learning, and how their clinical role can develop to reflect this.

### **Supervising a clinical academic fellow**

Supervisors spoke about how motivated and enthusiastic their fellows were, and this led to them **having a positive experience of involvement in the scheme:**

*She's so enthusiastic and she's buzzing with ideas (Supervisor01);  
She threw herself into the department and I think we missed her afterwards  
(Supervisor02).*

However, they also identified **training-needs** for their fellows, particularly around writing skills:

*Things like writing skills, I guess we assume ... well, certainly I had assumed a certain base-line of writing skills (Supervisor02);*

*teaching writing and actually how do you get someone who has probably had a scientific background that has not involved very much writing at all, how do you get them, unless they're naturally gifted, into a position where they can write a coherent Fellowship application or a coherent paper (Supervisor04).*

There was also a recognition that the **pre-doctoral fellows were not quite at the level of a PhD student, but are more advanced than a Masters student, and having a clinical background also provided a different type of student/supervisor relationship:**

*I think in terms of understanding how to supervise, it's good for that. Because it's a different relationship to a young, junior PhD student or an MSc student and it's a different relationship to some of the medics that I've supervised (Supervisor 02).*

There was also a sense of **learning from the fellows**, who brought with them a knowledge base associated with working in a clinical environment:

*it was just great to see her be able to get on and recruit, it seems that everybody's quite happy to use the intervention used to follow up and agree to doing qualitative research so it has been fantastic from that point of view to have, to not have those hurdles that I've been having in my own research so it's been quite refreshing from that point of view (Supervisor01);*

*it was such a pleasure to work with her and I learned loads and it gave me new reflections on my own ... I did learn loads about [the fellow's clinical area] which I never knew before (Supervisor02);*

*I think it's been an interesting experience, I think it's made me reflect quite a lot on my own experiences as a clinical academic (Supervisor04).*

### **Take-home points**

- **Training:** Recognise that not all fellows are starting from the same skills set. They may need additional support in skills such as academic writing.
- **Mutual learning:** The relationship between supervisor and fellow has different characteristics from that between student and teacher – there is capacity for mutual learning, especially around working day-to-day in a clinical environment. This insight is valuable for academics working in Applied Health Research.

## Steering Group – developing clinical academic fellows

The purpose of the Fellowship Steering Group is twofold. Firstly, it aims to oversee the running of the fellowship as a whole, review fellows' quarterly reports and progress, and discuss how to address any issues and support fellows' professional development. Secondly, its purpose is to discuss more generally how to support Clinical Academic Career Pathways for NMAHPs in the local area.

There was an overall recognition that the **scheme is quite small and limited in resource**:

*Well, it's tiny, it's tiny, it's costly and it's going to be a real challenge to sustain it in the future (Steering Group01).*

However, there is a **strong commitment to the scheme** and there continues to be a need for the scheme, recognising the contribution it makes to the overall clinical academic career pathway of NMAHPs. It is important and has the potential to grow, once an alumni cohort of fellows has been established:

*It is only a small drop in the ocean and I guess that's where my kind of circular model comes in; it is a drop, but it ripples. That's the story of our lives professionally I think and actually when you're talking, we forget. We're talking about nursing, midwifery, all of the AHPs, we talk about them as if they're a group. They are nine professions, Healthcare Scientists and all of the different groups within Healthcare Science; actually, that's huge (Steering Group02).*

There is a **need to build a greater awareness amongst local Trusts regarding the real-term benefit of having a staff member undertake the scheme**, thus potentially breaking down some of the barriers to engagement as discussed above:

*So at the application phase I think there's a challenge encouraging or supporting line managers to understand what the benefits are by having essentially one day a week being paid into a scheme that they don't necessarily see an immediate return on investment (Steering Group03);*

*Their leaderships skills, they look at their services in a different way and that should be amazing, and they should be able to harness that if they want to. You grow research awareness in their practice areas they want to mentor and support people. We should be attaching that to our QI and service improvement folk. That's the way we do it, I think. We're a bit sniffy about quality improvement and research, they're two different camps. So, some of the shouting about it I think is shouting about it in a much broader sense. What do you get when you get a Fellow back? What does that look like, what does that mean, how could we translate that (Steering Group02).*

One way to address this could be through a closer working relationship between the Trust, HEE's north central and east London team and the CLAHRC, mapping out before the start of the fellowship what the Trust can expect from the fellow during the secondment year, and also, what kind of role the fellow can expect to return to, and how they can put their skills into action.

### Take-home points

- **Cost:** The scheme is quite small and resource intensive.
- **Size:** In terms of the bigger picture, the scheme is just a 'drop in the ocean'. Think about how it can link in with other work going on.
- **Build a closer working relationship between HEE's north central and east London team, CLAHRC and the fellows' NHS Trust:** Early conversations around what the Trust can expect from the fellow in terms of immediate and mid-term benefits may challenge some of the issues above regarding a lack of understanding about what the fellowship entails and how the fellows' service can benefit in the short term. In addition, early mapping out of the role the fellows can expect to return to would also allow them to maintain momentum with the research- and capacity-building activities, and address some issues regarding the frustrations of having limited time for research on returning to their previous role.

### Location of the scheme in supporting NMAHP academic career pathways

**The scheme bridges a gap between Masters and PhD, or PhD and Post-doc. It allows Fellows time to think about research and learn research skills.** It offers a 'taster' of a Clinical Academic career:

*it's a fantastic opportunity for the right individual, at that point where the scheme would be helpful to them, you know for their pathway and their career aspirations really ... you know it has got to be someone who is at that point in their clinical career, who could drop to... one day a week clinical, who has got that sort of vision (Academic01).*

**The findings of this evaluation were not unique and chimed with the experiences of others in their work to support Clinical Academic development.** Developing good communication and a close working relationship between the CLAHRC and the NHS organisations was identified as an important task, which works very well, but it is time-consuming and hard to develop those relationships:

*I don't know what the answer to that is other than I've tried all sorts. I think I get quite ... when I do get involved in nearly all of the interviews so I meet the clinical staff where they're be working clinically and prior to that all of our PhDs from our NHS organisations, all the Directors of Nursing I know and I've obviously met and we talk about the next research priority. So it kind of feels a bit more as if they're involved in the decision about what the research is (Senior Representative Other Schemes01).*

**Involving the NHS organisations in agreeing the research priorities of the fellowships was identified as a key way to increase Trust buy-in** of schemes, especially if the research would help to tackle problems that are immediate to them in the service.

**Academic-training for non-medical trainees was agreed to be a continuing challenge, and was far less developed in terms of opportunities when compared to schemes available to medics:**

*if you're looking at physios or nurses they're just torn between service and academia and the problem is there's no clear pathway or academic posts for these people. So, it is the*

*perennial problem so, you know what you're saying is it's a problem everywhere and I don't know how one gets around that especially with the problems in the NHS at the moment and the underfunding. (Senior Representative Other Schemes02);*

*in medicine we've got a reasonably long history of clinical academic development and lots of different opportunities for doctors who want to take a clinical academic career pathway to get into that. In nursing, midwifery and the allied health professions, opportunities are extremely limited and there are very few nurses, midwives and allied health professionals who are successful, particularly in being awarded fully-funded or part-funded opportunities to pursue that kind of career (Steering Group01).*

**In terms of carving out a clear academic career pathway for NMAHPs, there was a recognition that there needed to be strong leadership:**

*one of the things that I've looked at in the past is how we would create senior people, in other words professorial appointments that were clinical academic joined and once you had the people that were those role models then we would try to fill in all the way down the chain if you like with more people in those positions that could work their way up, but putting somebody in at a junior level and asking them to create the expectations and the model is actually difficult (Academic03).*

Carving a pathway as a solitary individual in a department was something which was difficult for fellows to achieve:

*I think the biggest difficulty throughout the whole process is that mismatch and misunderstanding between the academic and the NHS Trust for me. I don't know, I think other people have far more of a, far more accommodating Trusts or far more understanding, but for me here I feel often like I'm the only person who has done anything like this and the only person thinking in this way and that can be really difficult and I think that is the hard thing (Fellow02).*

Developing a larger body of alumni fellows would enhance awareness of the scheme and increase the pool of developing academics. Especially if this involved **developing a wider network of early career clinical academics across the UK:**

*we really want to promote the scheme to our colleagues, yeah, and make things better for everybody else who goes through that. Because it's a lifetime opportunity, just to take a year out to do research on something you would do in the evenings, it's great (Fellow03).*

### **Take-home points**

- **Need to link in with, and start to carve out, a clearer academic pathway for NMAHPs:** Suggestions include creating a stronger Alumni network that champions the scheme. Many participants suggested the need for role models and a clearer career pathway.
- **Networks:** Creating a Clinical Academic Network for NMAHPs would help to mobilise and motivate others. Alumni network to champion clinical academic careers. Link with other schemes and pathways for medics/scientists to add up to the bigger picture of making a difference to patients and public.

## Actions

In response to some issues raised in the evaluation we have made the following adaptations to the scheme:

- Formalised a **'roles and responsibilities' document**, which fellows and their supervisors must agree to and sign.
- Encouraged **'start-up' meetings with fellows' base Trusts** in order to have early discussions about how fellows can put their learning into practice throughout the fellowship year.
- Maintained informal **mentoring with past fellows to cultivate an Alumni cohort**.
- Encouraged fellows to **participate in wider CLAHRC capacity-building activities** e.g. contributing to the development and delivery of CLAHRC Academy short courses.
- Fellows are leading the **development of a general 'resource pack' for clinical academic careers** to be distributed at host Trusts.

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