Developing community education provider networks in South London

Lessons learnt in the first four months

October 2013
Key messages

What are CEPNs?

Community education provider networks are a federated model of partnerships developed to improve the quality and localisation of education for health professionals. The aim is to empower community organisations to work with higher educational institutions to assess workforce training needs, expand capacity for training in the community, innovate in the field of training and deliver multi-professional training.

In South London, four CEPN pilots are being funded from May 2013 – March 2014 to test the feasibility and potential benefits of this model. Each CEPN took a slightly different approach.

After four months of operation, a rapid external review was conducted to examine progress to date and what stakeholders believed to be the benefits and challenges with this approach. The aim was not to evaluate the CEPNs, because it is not possible to assess outcomes after only four months. Instead the focus was on collecting preliminary information to help Health Education South London consider whether the pilots could be continued and expanded in 2014.

The external review comprised examination of 30+ programme documents and discussions with 29 stakeholders, 18 of whom were involved in CEPN implementation and 11 of whom were representatives of broader stakeholders such as higher educational institutions or local GPs.

Perceived benefits

Stakeholders were positive about the potential for CEPN models. Although the four CEPN pilots each have a different focus and structure, the perceived benefits of community based networks were common and included a more localised approach to training needs assessment and education provision and shifting the focus from acute to community-based education and care.

Some CEPNs reported early successes, including:

- undertaking educational needs assessments using surveys or discussions with local health professionals;
- running engagement events attending by many different professions to consider local priorities or engaging with GP practices at primary care fora or practice meetings;
- setting up training courses for specific cohorts, identified as being in high need locally (such as healthcare assistants or practice nurses);
- encouraging a small number of nurses working in secondary care to transfer to primary care;
- making links with other organisations to fund training or to deliver training.
Perceived challenges

As with all initiatives, there have been some challenges setting up CEPNs. The three most commonly mentioned included:

- not being clear what constitutes a CEPN;
- difficulties setting up promptly or engaging people (especially over the summer period);
- concerns about sustainability and where CEPNs fit in with other educational models.

Those leading the CEPNs generally did not feel able to comment about further development needs at this stage and felt this would become clearer as implementation progressed. However if further pilots are set up, Health Education South London might usefully consider providing:

- more support to promote the concept of CEPNs locally;
- more visibility of a senior champion from Health Education South London to give status to the initiative locally;
- basic training or templates about project management, timetabling and planning how to ensure that activities will achieve objectives;
- basic training or templates to support evaluation design, including how to ensure a wide range of outcomes are measured;
- more opportunities for support / communities of practice.

Key design principles

The differing nature and focus of each CEPN, variation in progress and the short timescale in which they have been operating mean it is not possible to identify key success factors. To do so would require information about the relative success of each initiative. However, it is possible to suggest design factors that may speed the process of set up and implementation. Three important top level factors are:

- Vision and management: such as clarity about function; visible leaders; and project management capacity;
- Infrastructure: such as established relationships and close links with the CCG, but not necessarily (co)dependent on the CCG;
- Processes: such as including secondary care and higher educational institutions as partners; taking time to engage; and undertaking needs assessments.

The lack of some of these characteristics should not be used as a reason against funding future potential CEPNs. They merely reflect factors that have been found beneficial for prompt set up.

Overall, the external review suggests that CEPNs are beginning to gather momentum and that there is positivity about the potential of this concept. Health Education South London’s planned evaluation of outcomes in 2014 will help to understand whether these benefits are realised and whether CEPNs could be a feasible model for the future.
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1. Background

1.1 Context

NHS workforce planning and development must be more local and responsive to account for increasing pressures on clinical and educational workloads, a challenging fiscal landscape, changes to how education is commissioned and the desire to improve population health outcomes through integrated working.\textsuperscript{1,2} There are many potential models for training health professionals. In 2013, Health Education South London began testing an innovative approach to managing training for primary and community care professionals, known as community-based educational provider networks (CEPNs).

CEPNs are collectives or networks of primary care and community organisations working collaboratively to enhance educational delivery in local geographic areas. Such networks may take a multitude of different forms. Figure 1 illustrates one model, to emphasise the wide variety of organisations that may be involved.

In South London, four CEPNs were funded from May 2013 to test the feasibility of this concept. Each of the CEPNs is taking a slightly different approach, but the guiding remit was to act as the orchestrating unit for community-based education and encourage local organisations to work collectively and develop ownership of educational provision.

“In short, the CEPNs were set up to support innovation in educational delivery and the diffusion of best practice and to provide training to professional groups that are a priority for local workforce development.” (stakeholder)

This model is also an attempt to broaden the types and range of organisations involved in the delivery of community-based education with the hope that organisations unused to working together will collaborate around the provision of training.

Figure 1: Potential components of a CEPN\textsuperscript{3}
1.2 Review scope

Health Education South London is planning an evaluation of the outcomes from CEPNs, beginning in the first quarter of 2014. This will draw on material collected by each CEPN as well as independently compiled material. The evaluation may examine the benefits and challenges of this model for trainees, trainers, patients, practices, community organisations and other stakeholders. In advance of this detailed evaluation it was important to gain some feedback about how CEPNs are developing in order to feed into decisions about next steps. Health Education South London therefore commissioned a rapid external review to draw together feedback from stakeholders about the first few months of operation.

The external review was conducted over a three week period in September and October 2013.

Within just four months of the CEPNs being awarded funding, it was not appropriate to objectively assess outcomes. Instead the review aimed to:

- describe the progress CEPNs have made during the first four months based on feedback from those involved in setting up and running the networks and associated stakeholders. This involved comparing what has actually happened during initial implementation against what was anticipated in the original invitation to bid;

- identify perceptions of the benefits of this approach and potential challenges moving forward according to the key stakeholders most closely involved in implementation;

- draw out important building blocks of CEPNs to assist in planning the potential rollout of this approach. The focus was on identifying what has worked well and not so well to date in order to propose key success factors that could be considered when implementing CEPNs in future;

- begin to consider key components that may be needed in a detailed evaluation of CEPNs.
1.3 Review approach

To achieve these aims, Health Education South London commissioned an independent organisation, The Evidence Centre, to review CEPN progress using the following activities:

- reviewing documents about aims and progress provided by each of the CEPNs and other background materials;

- speaking with clinical and operational leads from each of the CEPNs to gain information about progress, perceived benefits and challenges with the CEPN model and potential key success factors;

- speaking with key team members from Health Education South London, the London School of General Practice and other organisations to gain feedback about perceived benefits and challenges;

- informal discussions with a convenience sample of broader stakeholders from the CEPN regions, such as frontline staff who may benefit from the training and higher educational institutions and secondary care organisations that may be called upon to partner or support training;

- group meetings to discuss findings and next steps.

In total, more than 30 documents were reviewed and 29 people provided feedback, 18 of whom were directly involved in CEPN implementation from a provider or a commissioner perspective.

To safeguard anonymity, throughout this compilation of key themes, any quotes are identified only as being sourced from a ‘CEPN’ or from a stakeholder (meaning those from Health Education South London or stakeholders in local areas such as higher educational institutions or frontline staff).

There was no attempt made to compare between individual CEPNs or to judge progress in any way. Instead, the focus was on compiling perceived learning points at an early stage.

It is important to emphasise that the focus was on helping Health Education South London think about what could be done in future, rather than considering what might have been done in setting up these four pilots. The review is not suggesting that Health Education South London should have done anything differently – but rather focuses on considering what might be useful when considering the next phase.
2. Current happenings

2.1 Models being tested

Four CEPNs are being funded between May 2013 and March 2014. Each is testing a different model, which is described in simplistic terms below.

**Bromley CEPN**

The Bromley model is built on a strong relationship with the CCG (in fact the CCG is the host organisation).

This CEPN is focusing on developing nurse capacity in the community, as this has been identified as a particular shortage in this area.

The work programme covers two broad components:

- retraining fully qualified nurses who may have been working in secondary care and who are now considering working within general practice or community care;

- training for healthcare assistants (originally this was to facilitate entry to nurse training, but is now focusing on a broader programme).

These activities are closely tied to the CCG’s existing work plans.

**SLOVTS CEPN**

SLOVTS is the South London Organisation of Vocational Training Schemes, which is a combination of several of GP postgraduate training schemes. The SLOVTS CEPN model is focused around an established GP training provider network.

This CEPN is targeting improved GP training, including exploring the possibility of joint training with other primary and community care teams and secondary care specialists to increase both the quality and quantity of training programmes and thus attract high quality candidates.

The topic focus is paediatrics, which has been identified as a priority by local stakeholders.

**St Georges CEPN**

The St Georges model involves situating the management of the CEPN within a higher educational institution. This approach is a partnership between St George’s University of London and the GP training network around the St Helier area (VTS scheme).

This CEPN is using a disease pathway approach. Dementia is being used as a case study topic around which a multidisciplinary educational programme will be developed for trainee doctors and nurses.
Wandsworth CEPN

The Wandsworth model involves a network of primary care providers coming together to form a community interest company (CIC). Most general practices in the area are now engaged with the CIC, which was set up well before the CEPN pilot and took significant time and effort to develop.

Wandsworth Healthcare CIC’s shareholders are local GP practices throughout the Wandsworth Borough (excluding Putney and Roehampton). Thirty-one of Wandsworth’s 42 practices are shareholders in the CIC. For the CEPN, to date 39 of the 42 practices have engaged by completing the practice questionnaire. Thus this model focuses both on a local area and on a federated model of GP practices working together.

Over the period between May 2013 and March 2014, the Wandsworth CEPN is focusing on:

- mapping all training provided or supported in local GP practices and collecting basic staff demographic information from practices to help identify training needs
- engaging non-training practices to offer continuing professional development and other training
- expanding the training offered in current training practices

The overall aim is to learn more about training needs and to use GP practices as the base for providing more training.

Model characteristics

There are differences in the extent to which these four approaches include the characteristics inherent in Health Education South London’s vision of CEPNs (see Table 1).

Comparing current progress against Health Education South London’s original specification, it could be argued that some models appear to fit most closely with the initial vision of CEPNs – but every one of the models being tested has positive points. It is important to emphasise that there may be changes in functions over time as the CEPNs are at an early stage of development, but initially it appears that some approaches are not so much operating as a ‘network as much as setting up ‘projects’ where different organisations can take part in training. In these cases, the ‘network’ and multiprofessional aspect thus comes in at the point of receiving training (or via trainers), but not through the planning and organisation of the training itself.

Exploring the extent of alignment with the original specification is not a criticism of individual CEPNs. Instead it merely highlights that a variety of strategies are being trialled and some of them more closely fit Health Education South London’s original vision of what a CEPN might comprise. Testing a range of model variations arguably strengthens the process, because with careful evaluation it will be possible to draw out the components of the models that have worked well and less well. It is also true that Health Education South London’s original conceptualisation is not necessarily ‘correct’ and may be further developed to include, exclude or differently prioritise some of these components in future.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Bromley</th>
<th>SLOVTS</th>
<th>St Georges</th>
<th>Wandsworth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting as the orchestrating unit for all community-based education</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Encouraging local organisations to work collectively, including primary and secondary care and HEIs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Encouraging local organisations to develop ownership of educational provision</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Broadening the range of organisations involved in education (including non-training practices)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisations unused to working together are collaborating to deliver training</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Broadening CEPN membership to providers such as optometry, dentistry, and pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting innovation in educational delivery</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Supporting diffusion of best practice</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Undertaking training needs assessment and workforce planning</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Engage patients to ensure patients are driving the new ways of working</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing training to professional groups that are high priority locally</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary teams are running training</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary learners are involved in training</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including undergraduate and postgraduate needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Providing educational placements</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support transformation of the workforce from secondary to primary care</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helping design a local workforce to support sustainable improvements in population health</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitating integrated working with the aim of improving productivity and value for money</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Complying with regulatory and governance requirements</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Note: The CEPN characteristics are drawn from documents outlining Health Education South London’s vision for CEPNs. This is not the only characterisation of CEPNs possible. CEPNs have been assessed as fulfilling each criteria based on programme documents and feedback from implementation teams and stakeholders. This reflects achievements at an early stage, not potential.
2.2 Progress to date

Just as each CEPN is taking a different broad approach, so too the degree of progress is varied. Table 2 provides a brief summary of progress as of September 2013.

All of the CEPNs have varied from the timeframes or focus areas specified in their original bids, and Health Education South London has accommodated this flexibility.

It is important to re-emphasise that the purpose of tabulating progress is not to judge or criticise individual CEPNs, but rather to learn about what has been working well to date. It is also important to highlight that CEPNs have several more months left in the initial pilot period and all believe they will have made significant progress in that period.

2.3 Perceived benefits

There was solid support for the CEPN concept. Current models for educating health professionals were perceived to be unsustainable both financially and politically. It was felt that the trend towards relocating service provision from acute care into the community needed to be mirrored by similar changes to the provision of education for health professionals in the community.

“This is a great model. It is about supporting one another in small peer support groups. It fits into theory of change models and it is so applicable and appropriate to education models. Other models don’t work for community education.” (CEPN)

“Changing people’s behaviour starts at grass roots level.” (CEPN)

Furthermore, people thought there was more scope to share training and resources in small groups (such as across GP practices).

“To run training properly you need to have groups that are smaller than CCGs. Small groups are better for collaborating and peer support and getting things done. Larger groups can be too formal. A tight knit smaller group is needed to make this model work that is a large enough organisation to be viable but that can be more local and responsive than CCGs can be.” (CEPN)
## Table 2: CEPN progress over the first four months

<table>
<thead>
<tr>
<th>Feature</th>
<th>Bromley</th>
<th>SLOVTS</th>
<th>St Georges</th>
<th>Wandsworth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordinating organisation</td>
<td>CCG</td>
<td>GP training scheme network</td>
<td>University</td>
<td>GP provider network</td>
</tr>
<tr>
<td>Broad purpose (during pilot)</td>
<td>Improve community nursing capacity and increase patient satisfaction with nursing care</td>
<td>Improve quality and quantity of GP postgraduate education, focused on paediatrics</td>
<td>Use dementia as a case study to develop a multidisciplinary education programme in the community</td>
<td>Develop into a recognised CEPN organisation in order to assess needs and provide training to fill gaps</td>
</tr>
<tr>
<td>Target group</td>
<td>Nurses</td>
<td>GP trainees</td>
<td>GP and nurse trainees</td>
<td>GPs as a first step</td>
</tr>
<tr>
<td>Activities already completed</td>
<td>Diabetes training for HCAs and nurses running, with all 77 places filled</td>
<td>Two engagement events held to undertake needs assessment</td>
<td>Needs assessment / training scoping / stakeholder map</td>
<td>Promoted CEPN at GP forum, practice manager forum and practice nurse forum</td>
</tr>
<tr>
<td></td>
<td>8 nurse mentors completed update training and 8 new potential mentors identified</td>
<td>Workplan being finalised based on event feedback. Likely to focus on training in paediatrics</td>
<td>Running engagement events on a larger scale</td>
<td></td>
</tr>
<tr>
<td>Activities scheduled / underway</td>
<td>Provide training for secondary care nurses ready to relocate to primary care (4 nurses have relocated)</td>
<td>Engage GP practice(s) as host venue</td>
<td>Develop multidisciplinary educational programme and trial sessions with group of GP undergraduate and postgraduate trainees and nursing students (also others invited)</td>
<td>Define training gaps across multiple professions</td>
</tr>
<tr>
<td></td>
<td>Cardiology training for HCAs / nurses being developed</td>
<td>Develop into a recognised CEPN organisation in order to assess needs and provide training to fill gaps</td>
<td>Co-ordinate with other organisations to run training to fill gaps</td>
<td>Identify funding from other sources for training</td>
</tr>
<tr>
<td></td>
<td>One GP identified for leadership training for sustainability of programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other plans</td>
<td>Analysis of existing capacity for GP trainees in practices</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Development of new trainers and supervisors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proposals for paediatric registrar outpatient training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation planned</td>
<td>Before and after training impacts</td>
<td>Approach not yet finalised</td>
<td>Approach not yet finalised</td>
<td>Before and after training impacts</td>
</tr>
</tbody>
</table>

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*Developing community education provider networks*
“It is very important to deliver training in the community. It allows you to set up a type of bartering system between GP practices. You can share capacity for training across practices so courses are always full and you can exchange services, like venues or admin help, rather than paying for training. This will be more cost-effective in the long-term.” (CEPN)

There was positivity about putting ‘control’ of education into the community.

“We are trying to create a network of all stakeholders in primary care education to allow it to be bottom up so primary care organisations themselves are in charge of what education is needed.” (CEPN)

Thus there was support for the concept of CEPNs in principle, and no sign of ‘burnout’ relating to the initiatives, although questions remained about sustainability, funding and security within a constantly changing NHS landscape.

In addition to thinking about the potential of the CEPN concept as a whole, the implementation teams were asked about the perceived benefits of the individual CEPN initiatives. It is important to note that these benefits are the perceptions of senior stakeholders rather than objectively assessed benefits, or the perceptions of those who may not be so closely involved in implementation.

Bearing this caveat in mind, perceived benefits of local implementation of the CEPN model(s) included:

- increased engagement with local GP practices and social services (for example Bromley sees working with social services in nursing homes as a key success factor, Wandsworth reports regular engagement with the majority of local practices and SLOVTS has held specific engagement events);
- an increase in knowledge about the training needs of professionals (for instance SLOVTs and Wandsworth are compiling needs assessment data, based on surveys and feedback from practices and professionals);
- an increase in the number of professionals who have taken part in or will be given the opportunity to take part in training that would not otherwise have been available to them (for instance Bromley has training for nurses and HCAs underway);
- four nurses moved from working in secondary care to primary care in Bromley

There were plans to forge new links, perhaps set up e-learning resources and undertake many other activities that could have benefits throughout the pilot period.

Everyone spoken to thought that this approach was worth testing further, and it was acknowledged that it may take some time for benefits to accrue.
2.4 Perceived challenges

As with perceived benefits, the teams setting up CEPNs and representatives from Health Education South London were asked about potential challenges with the CEPN model(s) to date. The most commonly mentioned challenges are outlined here.

Unclear scope

The scope of the CEPN model in South London remains unclear, to both providers and commissioners to some extent. It is not clear whether the network model is being organised around specific pathways of care, around geographic areas or around a population focus (or all of the above).

“The team was not clear what CEPNs were so it is hard to create one and assess it. It is hard to promote this idea and conceptualise it. As a result the original specification was not clear.” (stakeholder)

The CEPNs each have a different focus, and whilst this diversity would be useful if detailed comparisons of processes and outcomes were being undertaken, this is not currently the case. Thus much of the learning from the diversity may be lost, leaving only a feeling that the purpose and scope of CEPNs is unclear.

In planning any future rollout of CEPNs in South London, it may be important to clarify exactly what model should be tested. For example, is the main focus on giving GP practices or other community organisations a leading role in co-ordinating a larger group of organisations to provide training or is the focus on bringing together any group of organisations to jointly offer training (about a specific topic area or for certain groups of professionals)? Clarity of scope would help potential provider networks better understand what was required and would also help Health Education South London better assess the extent to which those objectives are being met.

This is not to suggest that multiple models are not possible or desirable, but the learning from the first four months suggests that a lack of clarity about scope and purpose has been inhibiting for some groups and may have hindered prompt rollout and broader buy-in. In the short-term it may be useful for Health Education South London to concentrate on more clearly specifying the functions that CEPNs should fulfil, and then test in detail whether this model is feasible and sustainable compared to more traditional approaches.

Another suggestion is to spend more time engaging with groups that may consider putting in a bid for CEPN funding, so that the intricacies of the concept can be explained and people have an opportunity to test their ideas, perhaps by writing a short one or two page expression of interest and getting feedback on that before progressing further. This may help to promote a shared vision of the concept.
Wider promotion and support

Whilst members of Health Education South London and those implementing CEPNs were supportive of the broader ideas behind CEPNs, the extent to which this is true of other stakeholders remains unclear. Only 11 stakeholders not heavily involved in CEPN implementation were spoken to during the review so conclusions cannot be drawn from this small sample, however there was a trend towards some frontline professionals and higher educational institution representatives being unclear about the role of CEPNs and where they fit in with other structures. This may be due to a lack of clarity about purpose due to the developmental nature of CEPNs or signal the need for greater promotion and engagement of a wider range of stakeholders than has currently been the case.

CEPN representatives suggested that a key challenge had been gaining buy-in to the concept of CEPNs because this is such a new idea. Other organisations may feel anxious about their own future or unclear of the CEPN remit, and this can lead to ‘push back.’ Health Education South London may like to consider ways to address this, perhaps through wider promotion and support of the concept if CEPNs are going to be tested further.

“...This is a huge opportunity. Getting people around the table in the community is the way forward. There is support for this concept but it needs more advertising through GP magazines and so on to get the terminology out there. CCGs need to know more about it and do more to promote it.” (CEPN)

CEPNs also need to be mindful that their initiatives may appear threatening to other stakeholders, particularly as much training has traditionally been centred in secondary care.

“A challenge is that people have their own empires to defend. Maybe hospitals wants to bring things into the hospital rather than in GP practices and this could be worse if the hospital is under threat of closure.” (CEPN)

Some suggested that there may even be attitudinal barriers to multiprofessional learning, for instance if doctors do not think it is relevant to learn with and from social workers or vice versa.

Once CEPNs have their infrastructure set up, they may need support to build partnerships and generate projects to work on. In the short-term most of the CEPNs have a defined topic area or project plan, but in the longer term promotion of the existence and capabilities of these networks will be key to facilitating their integration as a ‘mainstream’ part of educational provision. Health Education South London and the primary care forum may have a role to play here in making links between networks and projects that they could conceivably partner with others to complete. For example, even within the current set of four pilots, it might be possible for two to partner up – with one having the infrastructure and networks to roll out training and another having an innovative model of multidisciplinary training to test (as in the Wandsworth and St Georges models, for example).
Funding

Interestingly, a lack of funding was not described as a major barrier to progress. Nor did CEPNs talk about wanting more upfront funding to pump prime their activities. Of course, further resources are always welcomed, but this was not seen a key limiting factor, except in one case.

Some CEPNs did say that the funding provided was not enough to run training itself, just to build a structure and start engaging people in a network to take the next steps. Thus some CEPNs were applying for other funding streams or seeking partnerships with the CCG to provide training. However this is not a limit in itself, and in fact could be argued to be a good way forward: using funds to set up a structure that is ready to take on training work. The lack of funding available to provide funding though was a frustration, once the groundwork had been put in to developing the network and partnership ready to do this.

Another funding issue is that there were some technical or process bottlenecks, such as Health Education South London’s finance department reportedly being slow to process payments, which means that funding was not available when needed to finance activities.

Personnel

The main practical barrier was having enough time and capacity from senior and visionary personnel to devote to developing and maintaining the CEPN.

Having a programme manager in place on at least a part-time basis was essential to ensure the smooth running of activities and CEPNs that had existing programme management personnel or could readily appoint someone seem to have moved forward more quickly because they did not have the delay of recruitment.

“You can’t underestimate the time it takes to do all the liaison and admin work and also the thinking through and planning. Having good management and day to day admin support is crucial. If these things get bigger and roll out, adequate admin time will be much more needed.” (CEPN)

Some of the CEPNs said they were not well placed to collect workforce and training needs data because they did not have capacity to do the work needed and they did not have the links with necessary organisations throughout the community.
**Timing**

The CEPNs began their work over the summer period when there is traditionally a loss of momentum as many people away on leave and it can be difficult to set up meetings or events or encourage people to send back needs assessment surveys. This even further reinforces the caution expressed earlier about progress. Progress to date should not be used as an early indicator of success throughout the entire pilot period.

CEPNs who were undertaking **training needs assessments** said that it took a great deal of time to get feedback from organisations and teams, perhaps more time that they had built into their project plans. This is a lesson for the future: when Health Education South London reviews any future funding applications for CEPNs, it may be important to **help applicants revise their schedules** to do needs assessments over the first quarter rather expecting these to be completed within the first month.

It also takes **significant time to meet with stakeholders** and explain the role of the CEPN. This reportedly has been most effective when done face to face in small groups, so time and capacity needs to be allocated to this, done by a person who is passionate and knowledgeable about the CEPN rather than seeing it as ‘just another project.’

“The pace of change is a challenge. It is difficult to keep the momentum going due to having to hurry to fit everything into the pilot period. It takes time to develop relationships across organisations.” (CEPN)

**Terminology**

Early on, Health Education South London used the term ‘community hubs’ to describe the CEPN model but this was altered to ‘networks’ as it was felt that people perceived that a hub would be associated with a building. This illustrates the importance of terminology in shaping the way that CEPNs are viewed. It could be argued that using the term ‘education networks’ would be even more appropriate so as to simplify the terminology and to not implicitly exclude providers that may be based outside community organisations from the partnerships. Indeed if partnerships with secondary care organisations are thought to be key, then the term ‘education networks’ or ‘multiprofessional education networks’ may more readily incorporate this concept, as well as allow for a broad range of functions and foci, depending on local needs.

**Other practicalities**

Another challenge for some CEPNs has been locating **community venues** in which to run training that are of sufficient size to account for multidisciplinary learners. When a wider range of professionals are involved in training the number of people taking part may be larger than can be accommodated in a GP practice, for instance.

“The minute you go multidisciplinary, the number of participants for training skyrockets. The practicalities of finding rooms to fit people are difficult.” (CEPN)
Positioning of CEPNs

Most people involved with implementing CEPNs as well as external stakeholders saw CEPNs as an addition to current structures of education for health and care professionals, rather than as entities that may one day take on a ‘lead provider’ role. Again, this may be due to the phase of development, whereby CEPNs are just being set up. However, it may be a cause for concern if Health Education South London’s vision is for these networks to take on a central role in local education planning and provision in future.

Furthermore there was some concern that CEPNs could become a branch of CCGs or that there would be an inappropriate amount of crossover in funding and roles, thus negating the potential benefits of separating training from service provision and commissioning.

Others were concerned about negotiating the relationship between CEPNs and CCGs, so that CCGs ‘relinquished the reins’ but did not feel unduly challenged.

“The CCG is an important stakeholder because they have held the budget for training. But we need to work together now and they need to realise that practices will only buy-in if they see a benefit for themselves. Over time we hope to change what training money is spent on.” (CEPN)

“At first there might have been a little bit of push back from the CCG, because they didn’t really understand what was happening and maybe they felt threatened for their own security. It take a lot of time to have meetings and to build collaborative relationships so people can see we are developing a network, rather than trying to take over.” (CEPN)

Health Education South London may consider ways to smooth this process in future, perhaps by inviting CCGs to introductory meetings, providing letters to explain the purpose of CEPNs and providing reassurance that CEPNs are not an attempt to destabilise CCGs.
Linked to this, an important issue is how CEPNs can be set up in a sustainable manner that does not rely on ‘project’-type funding from Health Education South London. Whilst CEPNs may be funded from core costs in the short-term, in the longer term there is a desire to ensure that they become self-sustaining entities, perhaps linked to CCGs or higher educational institutions. Learning during the first four months of the pilot period does not allow conclusions to be drawn about sustainability because set up and implementation has just got underway.

The legal form of organisations is important from a procurement point of view because networks need to be able to hold funds and operate as a ‘business.’

CEPNs that begin from an established structure (such as a community interest company) or with strong links to CCGs may have more longevity than those where a team has been set up to fulfil a specific ‘project brief’ such as delivering training about a certain topic. The process of setting up a community interest company is long and potentially arduous, and has not been done within the pilot timeframe. It may be that CEPNs are encouraged to consider this route in future, as they begin to demonstrate success, but it would be unreasonable to rule out potential networks from receiving pilot funding because they do not already hold this status.

There is a perception that CEPNs have not been good at reporting back their progress to Health Education South London. Whilst the CEPNs have had a few short months to set up and there may not be a great deal to report, some CEPNs have not kept in contact to notify Health Education South London of this.

This may be a function of how the relationships between the organisations were set up from the outset. As this is a developmental pilot, Health Education South London has taken a supportive role rather than a ‘top down’ or authoritarian role, but is heavily reliant on CEPNs to report back progress, identify any support needs and evaluate their processes and successes robustly in order to help with decisions about further rollout of the CEPN concept. In contrast, it appears that some of the CEPNs have treated the funding a little like a ‘development grant’ where they are given funds to go away and try new things, perhaps reporting back on activities at the end of the grant period, and feeling free to change the scope of what they’re doing as they go along rather than seeking permission from the funder.

The lack of clarity about the importance of regular contact is something that could be remedied by including a reporting schedule in the invitation to bid, ensuring the funding award letter requires attendance at meetings or telephone progress updates, making payment instalments dependent upon the receipt of a satisfactorily detailed progress report and using a reporting template more tailored to generate the information Health Education South London needs.
3. Thinking about the future

3.1 Developmental needs

In addition to asking CEPNs about current progress, the review also considered issues for future development – both the development of the four individual CEPNs and the model more generally. Once again it is important to note that this is not suggesting that these things should have been done in the initial pilot period – but rather considers what the next steps might usefully be.

Support during set up

If Health Education South London is considering piloting further CEPNs, there have been some lessons learnt about the clarity and support needed from the outset.

Stakeholders from both Health Education South London and the CEPNs suggested that it may have been useful to have more guidance about what constituted a CEPN and what was expected. The initial commissioning brief was purposefully broad to allow innovation and so that various different types of models could be tested. It also reflected Health Education South London’s own developmental phase in terms of understanding what a CEPN may look like. However for future pilots, learning from these pilots can be applied about what helps speed development and these broad principles could be built into commissioning specifications (see the section on ‘key design principles’ and Box 1 overleaf).

Another opportunity for supporting future CEPNs may be to provide learning sets, written templates or podcasts to help strengthen project planning, management and evaluation skills. Those running CEPNs are doing so in addition to many other activities and for some, planning and managing large scale initiatives such as this may be new. Even experienced project managers could benefit from sharing ideas with others and learning how concepts may need to be adapted locally.

Ideally a one or two day workshop could be offered early on in CEPN development, to cover topics such as:

- expectations for CEPNs
- how to come together as a network
- how to work as a ‘business’
- how to clarify objectives and activities
- how to plan project timelines
- how to build in evaluation from the outset
- how to engage with local stakeholders and practitioners
- how to undertake a training needs assessment

It is important to note that each CEPN is unique and thus not all would want or need support in all of these areas. However, workshop(s) like this would help to ensure that all CEPNs are starting from a common framework as well as building camaraderie.
This initial workshop or series of learning sets in quick succession could then be followed up in about one month with another session to:

- encourage CEPNs to report back on progress and receive support with any challenges encountered
- go into more detail about how to make links with local organisations
- describe how to work with established lead providers and higher educational institutions
- cover how to develop appropriate communication tools such as email newsletters and leaflets to promote the CEPN and the training offered
- begin planning for sustainability

Health Education South London was seen to be a useful resource for providing contacts and making introductions, so any learning sets could include this activity.

Following initial learning sets, progress update sessions could be held quarterly, with selected CEPNs perhaps taking the lead in presenting a ‘how to guide’ on an aspect of their work – such as how to analyse training needs or how to encourage practices to allow staff time away from clinical work for training, for example. In this way, a community of practice would begin to be built, with CEPNs taking the lead on sharing learning about how to progress this model rather than merely reporting on their activities.

“There needs to be more peer support and more clarity about what is needed. CEPNs need to be able to articulate what is the benefit for practices and get the good news stories out.” (stakeholder)

Some suggested that group teleconferences between CEPNs and Health Education South London every six weeks or so during the first few months may help people keep engaged and keep prioritising the process.

Templates could also be provided from the outset to help CEPNs with various activities. This would provide a structure for the work in the initial stages. Providing completed templates could be built in as milestones as part of the requirements of receiving funding. Templates may include, amongst others:

- project plan
- training needs assessment
- evaluation plan
- interim and final reports

The Health Education South London team acknowledged that during this initial development phase they focused their energy on getting funds out into the community, but in future could perhaps hold some of the funding in-house to provide ongoing development support.
Support during implementation

In terms of ongoing development for existing CEPNs, most stakeholders did not identify significant support needs at this stage although they noted that these may become apparent as implementation progressed.

Suggestions for support over the next few months were largely related to promotion, communication and evaluation.

In terms of promotion, CEPNs suggested that they would like more visibility to help increase understanding among local health professionals and others about what a CEPN is and how it can benefit professionals and patients. To support this, suggestions included:

- a champion from Health Education South London writing a letter or memorandum that could be circulated to all local professionals and other stakeholders outlining what a CEPN is, why it is an important opportunity for primary and community care, and why it is important for people to come together to engage and support the concept rapidly whilst funds are available;

- members of the Health Education South London team attending CEPN meetings or stakeholder events to show there is support at senior level for this concept and to address any queries;

- help to find specific training projects (with associated funding) to work on, now that network infrastructures had been set up.

With regard to ongoing communication, CEPNs valued the opportunity to get together with others piloting the concept to learn different approaches and spark new ideas. Some thought it would be useful to have more regular contact with Health Education South London, including visits to the locality rather than only centralised meetings at Health Education South London’s offices.

Stakeholders from Health Education South London raised questions about whether there was a good balance in their commissioning relationship with the CEPNs. As previously noted, in the development phase, Health Education South London has taken a somewhat informal and supportive role in recognition of the developmental nature of these providers. However some wondered about whether a more authoritative role would be useful to prompt progress and to ensure regular reporting and appropriate evaluation.
**Support measuring success**

All of the CEPNs are required to evaluate their progress and successes during the pilot period. Plans for this have been developed to a varying extent and this is an area where further support may be warranted.

Half of the CEPNs have yet to think through fully how they will evaluate what they are doing, but recognise that this needs to be done. The other half have thought through their evaluation strategies, but these tend to focus on descriptive mechanisms and outputs, rather than an evaluation of the CEPN model itself.

All CEPNs are keeping records of their tangible outputs, such as the number of training programmes run.

CEPNs are also planning to measure any gains in knowledge and skills resulting from training, using before and after surveys with participants. In one case there are plans to follow up after training is complete to see whether new skills are embedded in the workplace.

There was a call for support with **planning what to measure and how to measure it**, recognising the short timeframe of the pilot period. For any future pilots, this may be something that Health Education South London wishes to build in from the outset, such that CEPNs are encouraged to think through simple templates with logic models and structured questions itemising their objectives, how they will achieve them and how success will be measured (see Figures 2 and 3 for basic examples).

For the existing pilot sites, Health Education South London may wish to consider providing a template so that CEPNs have a clear idea of the information that is expected in a **final evaluation report**. The template could include a table detailing outputs such as the number of engagement events run, the number of training activities run and the number of professionals of different types trained. It could also include space to report on the extent to which new types of training are being commissioned, whether professionals that would not usually have attended training are doing so, and the extent of multidisciplinary learning. Added to this, there would be space to provide information about outcomes for learners, practices / organisations and patients, if applicable. Finally, Health Education South London may expect a detailed summary of lessons learnt. Providing such a reporting template as early as possible would make it clear that details about processes, outputs, outcomes and learning is required and would give the CEPN sites time to collect this information if they are not already doing so.

Whilst measuring knowledge gains or other immediate impacts from training is useful, it will perhaps not inform Health Education South London about whether the CEPN model itself is beneficial. To do this would require further documentation of what CEPNs do and how they do it and comparisons between areas using this approach and others that are not.
Thus there are two issues regarding evaluation of CEPNs:

1. Some CEPNs may have ongoing development needs in terms of learning simple and effective ways to evaluate the impact of the activities they are undertaking. These could be addressed via providing templates and perhaps a short workshop or evaluation expertise.

2. However, even if each CEPN evaluates their activities well this will not provide evidence that the CEPN model itself is more beneficial than alternatives. To do this would require comparisons between areas and a more detailed focus on processes and success factors, as well as merely impacts from activities. This may be addressed in Health Education South London’s planned evaluation of this approach.
3.2 Key design principles

From the information available to date, it is not appropriate to suggest a ‘best model’ of CEPNs going forward. Not only is no comparative information available, but it would be unfair and unwise to compare progress given the disparate populations and topics of focus. In other words, there are too many confounding factors to be able to say that prompt progress is a function of the model itself versus other issues.

However, it is possible to elucidate factors that have helped or hindered each CEPN to progress which may be considered key design principles for moving forward.

The top three helpful factors for implementing CEPNs rapidly can be divided into the areas of leadership and management, infrastructure and processes. Each of these areas has multiple subcomponents, and all interact with each other like the cogs of a wheel (see Figure 4).

Figure 4: Potential key design principles in prompt set up of CEPNs
**Leadership and management**

Wider research suggests that having strong leadership, good change management and clear shared goals is important when organisations are working together to innovate and support change.\(^4,5,6,7,8\) This seems to apply to the development of CEPNs too.

The CEPNs that have progressed most promptly have a **defined leadership and management structure, with administrative resources**. It is difficult to say whether progress to date can be attributed to various models as opposed to the individuals involved in championing them, but in assessing the potential of additional CEPNs, Health Education South London might usefully examine whether both appropriate structures and leadership and management capacity are in place. This ensures that success isn’t ‘project orientated’ and does not rely heavily on one or two particular individuals.

Having a clear vision of what they want to achieve, why and how has helped some CEPNs progress promptly because they have been able to articulate this vision and share it widely with others. This requires both good leadership, but also communication and networking skills. It is an example of how the key design principles interact – combining elements of leadership and processes.

**Agreeing on common goals** and having strong visionary leadership are essential, but research suggests that this is not enough. Instead it is important to have structured management processes, with due regard to communication strategies, project management and meetings and communication.\(^9,10,11\)

Some CEPNs suggested that these may not be skills that frontline practitioners held, so using specialist management expertise was recommended.

> “You need management support, rather than just being practitioner-led. This gives different expertise. To do this properly you need business skills, experience in governance for holding money and how to run things day to day. GPs might not have those skills or want to develop them so getting in a proper project manager helps.” (CEPN)

As well as leadership and management within the CEPNs, during the pilot period this vision and management may also be crucial at the level of the Local Education and Training Board (LETB). Having **champions** to promote the concept and ‘sell’ it to the wider community may be useful, particularly given the wide range of initiatives ongoing in primary care. To get the buy-in needed by a wide range of stakeholders, Health Education South London champions could usefully articulate that buy-in to the model could lead to a beneficial change in how training is funded, arranged and managed.

Gaining the balance between a supportive and a managerial commissioning relationship may also be worthwhile. The existing pilot has perhaps erred on the side of friendly support, whereas stricter adherence to reporting deadlines and provision of templates and learning sets may all have a place in future iterations.
Infrastructure

Published research suggests that organisational and educational change requires shared processes, solid infrastructure and clear resource allocations.\textsuperscript{12,13,14,15,16,17,18}

In the case of CEPNs in South London, the components of infrastructure that have been found to speed implementation progress include:

- an existing structure or network of organisations working together
- close links with the CCG or other local commissioning stakeholders
- close links between primary and secondary care

CEPNs may be based around CCG areas, but this is not necessarily a pre-requisite. It does seem important however for close links to be made with CCGs, so that educational planning and delivery goes hand in hand with service commissioning and provision. In the Wandsworth CEPN pilot, there were established links with the CCG and this has been further strengthened by regular meetings and communication and by branding forthcoming training as being jointly hosted by the CCG and CEPN. This gives the CCG a sense of input and a degree of ownership around the training of health professionals and also benefits the CEPN by linking to an established organisation with funds, infrastructure and status.

However CEPN implementers and other stakeholders also warned against linking future CEPNs too closely CCGs, as these organisations may not themselves have a sustainable future.

“It doesn’t have to be so closely linked with CCGs because we don’t know if CCGs will last and we don’t know what their role or pressures might be. Education might not always be a priority for CCGs. Having a separate organisation is therefore important.” (CEPN)

The CEPN model requires partnerships between primary and secondary care. Whilst the focus is on training in the community, good training of primary and community care professionals cannot be divorced from the role of secondary care. It is also important that training providers based in secondary care do not see CEPNs as ‘competition’, so building close links from the outset and drawing on the skills of secondary care providers appears beneficial.

It is not possible to say whether a particular legal entity or structural form is a key design element at this stage, though networks with an established structure have applied the model more quickly than networks being set up from scratch.
The population size being targeted, both in terms of professionals and patients, may ultimately have a bearing on success but no comparative information is available about this at this stage. This may be something that Health Education South London wishes to collect information about in future.

Interestingly, having a central support organisation, such as Health Education South London, was seen as an important part of the infrastructure when setting up CEPNs to help develop communities of practice and provide practical advice.

“Having a supportive central organisation is good to help share ideas with other pilots, facilitate networking with others in our area and help with setting up legal structures.” (CEPN)

Processes

The things that CEPNs do and the relative priority awarded to different processes may have a bearing on progress. The broader research literature emphasises that gaining buy-in, using change champions appropriately and taking time to build relationships can be significant predictors of success in change initiatives.19,20,21,22,23

In the case of these CEPN pilots, a key design element appears to be the amount of time and planning (and the speed at which) organisations and professionals have been engaged in the process. It can be time-consuming to promote a new concept, but in future it may need to be acknowledged that a core facet of the CEPN role involves promotion and engagement. There is no ‘best’ mechanism to achieve this. Some of the CEPNs have used existing primary care fora or practice meetings, some have set up specific engagement events and others have used face to face meetings with individual practices or small groups of practices. Regular telephone and email communication has also been found to be worthwhile.

“Networking is important. Get people around the table. Don’t procrastinate. Keep the momentum going. Set regular meetings.” (CEPN)

Health Education South London helped prepare short promotional leaflets, but these did not seem to have been an immediate support, so it appears that more interactive promotional methods may be an important first step.
In terms of who to target, CEPNs were generally focusing on those that may be most motivated and easily accessible first, with a view to demonstrating success and then expanding to a greater range of professionals.

“The workforce have esteem and burnout issues so we need to make things better for them. We are starting with those who have capacity now first. So for example, we might target receptionists, then HCAs then nurses then eventually that will release capacity for GPs to attend training. You have to start with the groups that are most enthusiastic first.” (CEPN)

Another important design element involves assessing the training needs of the workforce. Some CEPNs have begun this, and found that more time needs to be devoted to it. In future it may also be important to support CEPNs to draw on health needs assessment data for the population, because a key aim is for CEPNs to improve the quality and capacity of the workforce in order to impact population health and wellbeing. This perhaps requires a better understanding of the needs of the population itself.

It takes time for new things to embed so a key design principle is to allow enough time for initiatives to take shape and for relationships to be built, rather than expecting immediate successes. Health Education South London has been keen to understand early lessons learnt, but it is also important to be realistic and not pressure networks for outcomes at an early stage.

3.3 Evaluation principles

The section about developmental needs highlighted that CEPNs may benefit from some support to plan their own evaluations and self-assessments. Health Education South London is also considering a broader evaluation of the CEPN concept, either drawing on these four pilots, or based on future CEPNs that may be funded.

In thinking about the principles to include in such an evaluation, to really understand the benefits of the CEPN model(s) it will be important to compare with another approach to planning and providing community education. This could involve a combined quasi experimental and before and after design. Outcomes from CEPN pilots could be compared to areas not using the CEPN model, as well as examining outcomes before and after setting up CEPNs – but on area-wide basis, rather than solely for learners in individual training programmes.

The ‘outcomes’ to be measured, and thus the exact methods to be used, would depend on Health Education South London’s and the CEPNs’ objectives, but in broad terms could cover the extent to which CEPNs achieve the ‘vision’ (such as bringing organisations together and multiprofessional education); learner outcomes, including perceptions of multidisciplinary learning / working; increased knowledge; increased confidence in multidisciplinary working; and perceptions of stakeholders about benefits and challenges of this model.

It would be spurious to provide further overarching evaluation ideas at this stage without an idea of the likely timeframe and budget available.
4. Summary

The key points from the review can be summarised as follows:

**Progress to date**

After just four months it is important to be realistic about the progress that CEPNs could make. At this stage:

- all four CEPNs have **planned** what they want to do and why;
- two CEPNs have undertaken a **needs assessment** regarding education in their coverage area and are compiling the findings for use when planning training delivery;
- one CEPN has run **engagement** events for local stakeholder organisations and another CEPN already met regularly with general practices and has used this meeting as a forum for discussion. Another CEPN has engaged via various primary care fora;
- one CEPN has begun running **training courses**. Quantitative information about outcomes for learners is not yet available. Others are in the process of scheduling training or attempting to find funding to offer training.

**Benefits and challenges**

The main perceived benefits of the CEPN model include giving more control and autonomy to community professionals, greater ability to respond to local needs and capacity issues and fostering communities of practice that have the potential to improve multidisciplinary learning and working.

The main perceived challenges in the development and implementation process have been: gaining clarity about what a CEPN is and where it fits within broader NHS structures; considering the sustainability of CEPNs in terms of how they will continue to operate and what legal entities may best be suited to take up this role; promoting the concept and engaging frontline staff and stakeholder organisations; developing links across organisations to plan and deliver training; and having enough time and capacity for managing the CEPN.

**Key design elements**

Based on information available to date, Box 1 provides a ‘checklist’ of factors that may be considered when assessing the potential of organisations wishing to build a community education provider network. It is important to note that without information about the success of the CEPNs, it is not possible to say that these factors are important for success, only for helping CEPNs set up and get underway promptly.
Box 1: Checklist of building blocks that may help CEPNs to develop promptly

**Leadership and management**
- Is there a clear understanding of the remit of CEPNs?
- Do senior leaders and champions locally have a shared vision?
- Is there a clear plan with objectives and milestones?
- Is capacity available for broad leadership, day to day management, regular liaison and administration?

**Infrastructure**
- Is there an established structure or entity to receive funds and support implementation?
- Does the network align with CCG boundaries (but not necessarily depend on them for sustainability)?
- Are there close links with the CCG or plans in place to build a strong relationship rapidly through face to face contact and ongoing dialogue?
- Does the network include primary and secondary care organisations? Are there plans to involve higher educational institutions?
- Is there capacity to deliver training, rather than just be an organising network?

**Processes**
- Is the network truly multiprofessional in nature or is there a narrower focus? (for example are or could disciplines such as pharmacy, optometry and dentistry be included in educational plans?)
- Is training needs assessment built into the plan? Is there capacity to think about workforce needs and skill mix over the longer-term?
- Is health needs assessment built into the plan (to account for training to improve population health outcomes)?
- Are plans in place to promptly and regularly engage with stakeholders from many organisations and disciplines or is the focus mainly on GPs?
- Are there plans in place to approach CCGs and other organisations to share training funds? (CCGs received funding for CPD in primary care)
- Has evaluation been planned from the outset?
- Does evaluation focus on more than learning outcomes for training participants?
It is important to stress that other design elements may be useful and that models that do not contain the elements above could still be feasible and worthwhile. It is too early to say that the above factors support the success of CEPNs, but they do appear to support prompter implementation.

Health Education South London was interested to know what factors may support CEPNs to link with established lead providers such as higher educational institutions and where CEPNs may best fit within the broader educational landscape. At this stage in development it is not possible to draw conclusions about this.

Nor is it feasible to specify timeframes for achieving key milestones, such as building collaborative relationships or offering specific training. This is because milestones will depend on the starting point from which networks begin, their focus and the things that they are setting out to achieve. However, in broad terms, Box 2 lists potential milestones if a new CEPN was trialled for a two year period.

**Evaluation components**

In order to fully understand the potential of the CEPN model, an evaluation will be required. Important components of an evaluation of current and future CEPNs may include:

- a clear specification of objectives of the CEPN model so that evaluation can assess the extent to which these objectives are achieved. Having a smaller number of well defined objectives may be preferable to a large number of lofty aims in the first instance;

- a comparison between areas implementing and not implementing a CEPN model;

- a comparison of relevant outcomes before and after implementation of the CEPN. The exact outcomes to be measured and the methods used to do so are dependent on the final objectives, but might usefully include descriptive information about the number and type of training programmes, learners and relationships / organisations involved; before and after assessments of improvements in learner outcomes such as perceived knowledge and confidence; system-level outcomes such as increased interprofessional working and documentation about CEPN processes, success factors and challenges. Over a short period, it would not appear appropriate to expect changes in patient outcomes.
Box 2: Milestones that may be expected if a new CEPN was set up over two years

**By end of first six months**

- Legal entity / structure in place to administer funds
- Hire or allocate project management capacity
- Clear objectives, activities and programme timeline in place
- Evaluation strategy and tools finalised
- Meetings with key stakeholders to introduce and promote concept
- Data for health needs assessment compiled (so aware of population health needs)
- Local training needs assessment completed
- CCG and HEIs contacted about training budgets available

**By end of year one**

- Working collaboratively across organisations
- Training programmes scheduled and being run collaboratively
- Evaluation of outcomes data being compiled regularly and monitored to promote change
- Six weekly or quarterly email newsletters being sent out to stakeholders or other proactive communication underway

**By end of 18 months**

- Ongoing promotion of the value of multiprofessional education to local organisations and health professionals
- Sustainability plans considered and discussed widely
- Taking part in learning sets or workshops to support other CEPNs

**By end of year two**

- Implementation of sustainability plans
- Evaluation analysis of outcomes and learning points completed
- Reporting back on outcomes to stakeholders
- Promotion of successes via local newsletters and trade press
Potential LETB actions

This rapid external review suggests that Health Education South London’s pilot of the CEPN concept is progressing well. There are varying models being tested and each CEPN is at different stages of implementation, which has the potential to provide a rich source of learning for Health Education South London and others wishing to implement networks to support community education provision.

The review does not answer the question of whether the CEPN model(s) are worthwhile as it is too early to draw conclusions, but it does suggest that among some stakeholders the concept has been welcomed and that people feel there is potential.

Health Education South London is considering whether to fund further CEPN pilots in future. Box 3 summarises some of the potential action points that could be taken to further strengthen future rollout.

Box 3: Summary of potential supportive actions for Health Education South London

- Allocate time to **clarify the remit** and scope of CEPNs so that a more specific and clear invitation to bid document can be developed.

- Spend time **speaking with potential CEPNs** and helping them write bids to ensure that the group is clear about the scope and so that the bids are tailored both to meet localised needs but also LETB priorities.

- Consider using a simple **checklist** to assess the extent to which potential networks meet the criteria and may be able to flourish during the pilot period.

- Consider providing templates and/or **learning sets** to offer developmental support for CEPNs, including support with project management / planning, training needs assessment and evaluation.

- Think about what support can be provided to foster **communities of practice** and peer support, whereby CEPN pilots take the lead on sharing ideas and teaching each other about strategies that are working well.

- Think about how the concept of CEPNs can be promoted locally and nationally, so that pilot sites feel they are operating in a more supportive environment. This may include visibility at meetings by **LETB change champions**, letters of support / introduction from the LETB that can be widely circulated, direct contact with CCGs and articles in the trade press and journals.

- Consider taking a slightly ‘harder line’ with networks to ensure clear **accountability** and so regular meetings and timely reporting are a requirement of further funding instalments.

- Develop a detailed **template for final reports** so CEPNs are clear early on.

- Build in **evaluation** from the outset, including comparative evaluation methods.
References