Developing a shared approach to evaluation in the West

Report of the workshop on the Principles of Pragmatic Evaluation, 16th December 2015

Summary

The West of England Evaluation Strategy Group (WEESG) hosted a workshop on 16th December 2015, to bring together local key leaders in the field of health and social care policy, practice, research and evaluation. Thirty-five attended from 22 organisations.

The purpose of the workshop was to create a space for collaboration and to start to develop a local community of action. The intention was to use the outputs of the workshop to inform and shape the development of a shared common vision, strategy and action plan for evaluation across the West. This would then enable the West of England to meet the challenge set by the NHS Five Year Forward View.

The session was organised with preliminary information provision and scene setting, prior to engagement with 5 tables each exploring different key questions:

1. **How do we best involve patients, carers and the public in evaluation?**
2. **How do we ensure that evaluation is of value to health and social care?**
3. **How do we build a culture of evaluation?**
4. **How do we create an ethical approach to evaluation?**
5. **How do we make the trade-off between rigor and relevance?**

Supported by a facilitator and scribe, the table sessions inspired a broad range of discussions and reflections as well as a chance to share good practice, challenges and innovative ideas and solutions. These sessions were fed back to the room for further discussion.

The main findings were structured around the table questions and included:

- Genuine co-production in evaluation is needed through the active involvement of public members supported by project leads. Recruitment to projects should aim to be inclusive and address issues of access to hard to reach populations
- Conducting valuable evaluations that are supported by evaluators with an appropriate skill base is desirable. Efforts to make evaluation accessible to others requires a common and accessible language and is supported by collaborative working and sharing of good practice.
- Developing a culture that assimilates evaluation into the development of new services or practices would ensure that this activity becomes ‘normal’ practice. This can be supported through sharing learning from a wide range of case studies, as well as impact where possible. Additionally, evaluations should be patient centred, and focussed on a

quality improvement approach rather than a tick box exercise.

- Evaluations should be conducted ethically and subjected to a review process. Whilst some good practice is in place, this is inconsistent and further efforts are required to develop consistency.

- Evaluation needs to be both rigorous and relevant. This can be supported through early planning for evaluation and the use of published frameworks.

Participants also identified individual and organisational actions that they would take following the event. These were summarised under seven headings:

1. Lead or instigate process change within their organisation (or across organisations) to raise the profile of evaluation

2. Link with other organisations specifically to promote evaluation or quality improvement

3. Take action to investigate the funding of evaluation resource(s) within or outside their organisation

4. Personal reflections - the commitment to reflect on their own role within the organisation in the context of evaluation.

5. PPI in evaluation – to work collaboratively with public members to ensure they have an opportunity to contribute to evaluation.

6. Evaluation- a national view – linking with national organisations to promote the place of evaluation.

7. Write formally about evaluation to share learning in the form of case study examples and more formal publications.

This report details actions arising from key recommendations to address these issues going forward to achieve a local shared approach and promote best practice in evaluation. These can be found on page 10. It concludes with a statement of intent to work collaboratively to implement key recommendations from the event, led by WEESG.

Setting the scene

Following the publication of the NHS Five Year Forward in October 2014 by NHS England, the Health Services and Delivery Research Programme held a workshop to consider the implications for research and evaluation (Ref: HS&DR Report). The workshop report provided a very useful insight into the participant's views of the challenges and opportunities this set for research and evaluation as well as informing possible future research topics.

The West of England Evaluation Strategy Group (WEESG) identified an opportunity to build on this work by bringing together local key leaders in the field of health and social care policy, practice, research and evaluation into a workshop. The purpose of the workshop was to

create a space for collaboration and to start to develop a local community of action. The intention was to use the outputs of the workshop to inform and shape the development of a shared common vision, strategy and action plan for evaluation across the West. This would then enable the West of England to meet the challenge set by the NHS Five Year Forward View.

The workshop was led by Dr Peter Brindle, Leader for Commissioning Evidence Informed Care at the West of England Academic Health Science Network (WEAHSN) and Evaluation Lead at the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West) and supported by members of the WEESG.

The workshop

Thirty-five participants from 22 organisations across the West of England took part in this interactive workshop to explore the principles of pragmatic evaluation. They came from a variety of backgrounds in the fields of health and social care policy, practice, research and evaluation. A list of all the participants is available in Appendix 1.

The workshop started with scene setting and short talks from Dr Peter Brindle and Prof Jo Rycroft-Malone (Bangor University). Their presentations were titled:

- Why we are here and what we want to achieve; and
- The implications of pragmatic evaluation for the NIHR HS&DR Programme.

Peter Brindle reminded the delegates why evaluation is crucial to ensuring that patients get the best care and the tax-payer gets the best value, explored some of the barriers to an effective culture of evaluation, and the importance of considering a range of methodologies so the right tool is used for the job.

Jo Rycroft-Malone described the key challenges, opportunities and implications of pragmatic evaluation for the National Institute of Health Research HS&DR Programme. These included the need to agree what is considered to be 'good enough' evaluation, how do we bridge the gap between those knowing (research) and those doing (practice), and what are the rules of engagement?

These were followed by round table discussions on culture, ethics, involvement, rigor and relevance in evaluation. Delegates were invited to make notes on the table cloths during the discussions, which were subsequently incorporated into the meeting outcomes. The meeting closed with a chance for participants to identify individual and organisational actions they wanted to take forward to support the agenda.

Prior to the workshop, the attendees were sent a short digest of key documents that had been identified by the group to inform discussions, this included the original HS&DR workshop report. This digest is included in Appendix 2.

Summary of table and group discussions

Detailed summaries of each of the five table discussions can be found in Appendix 3. A briefer

summary for each is included below.

Table 1: How do we best involve patients, carers and the public in evaluation?

Supporting PPI membership in evaluation activity requires policy guidance and a commitment from organisations to enable participation. Measures taken should include the provision of clear information on the requirements and expectations of PPI members involved in projects and the provision of leadership that enables active engagement. Currently, there is a predominance of "passive" involvement in evaluation, with PPI members providing limited influence through for example, focus groups (UK Evaluation Society). Addressing this will require a culture change that embraces active engagement with PPI members, who are enabled to provide meaningful contributions to evaluation projects. The approaches taken to support recruitment to projects is also critical and organisations need to be reminded to consider adopting innovative approaches to engage with hard to reach populations who are underrepresented in evaluation and to consider using practical enablers such as meeting locations and times. All of this activity requires resource support.

Table 2: How do we ensure that evaluation is of value to health and social care?

Ensuring valuable evaluation of new service and practice can be supported through various means. The development of an accessible and common language for evaluation activity, in what is a complex health and social care context, should aid engagement with evaluation activity. In addition, the current dearth of evaluation expertise needs to be addressed in a number of ways, such as through up skilling the health and social care workforce in addition to enhancing the skills amongst commissioners and academics. Fostering collaborative working in evaluation across these groups would also support effective evaluation, something that is starting to happen through innovative local practices which themselves require evaluation. Further learning to support skill development would be enhanced through sharing experiences and methodologies.

Table 3: How do we build a culture of evaluation?

Developing a culture that integrates the evaluation of new services or practice as routine will be supported in a number of ways, some of which were also considered important in ensuring valuable evaluations are conducted (see notes above from Table 2). The need to address skills training to meet unmet demand in this area is proposed. Sharing learning through various forums, including the provision of "What good looks like" guidance and sharing of case studies are suggested. The evaluation culture should permeate organisations at all levels, being valued by managers and practitioners. Their focus should be to understand the patient experience, putting patient care at the centre of quality improvement. Additionally, involving practitioners in evaluation activity is important in building skills and understanding of evaluation, so that it is viewed by practitioners as providing positive learning that supports enhanced practice and patient experience.

Table 4: How do we create an ethical approach to evaluation?

The appraisal of evaluation activity is currently ad hoc and could be enhanced through adopting a risk appraisal approach which then seeks to plan to avoid harm and supports adherence to ethical principles in evaluations. Including the project team and PPI members in this approach would be helpful to ensuring all possible risks are identified. To fully support working ethically, a systematic review process would be required; an activity that is also remains informal. Whilst some good practice is in place and local organisations are considering the development of good practice guidance, moving to a local practice consensus would be required to ensure standard ethical practice.

Table 5: How do we make the trade-off between rigor and relevance?

Through discussion it was agreed that evaluation would and could be both rigorous and relevant, with a published innovation tool seen as helpful to supporting this. To achieve synergy between timely, relevant and rigorous evaluation activity, it is important to ensure initial planning includes all relevant stakeholders and the lead evaluator understand the evaluation questions. These processes are critical to selecting the right approach, method and tools needed to address the question.

Individual and organisational actions

Following the table discussions, attendees were invited to give commitment to one or more actions they could to take to support and promote the use of evaluation, either personally or organisationally. These were written on postcards, and displayed on the day for others to read. In total, 44 intentions of follow on actions were made by the attendees. Of these, 19 (43%) showed there was an appetite to take a specific action within their own organisation to raise the profile of evaluation. Harnessing and supporting these individuals through the WEESG to implement their intended changes will have a positive impact on raising the profile and value of evaluation amongst their varied organisations, and thus the West of England. This, as well as other noted actions, forms an exciting virtual strategic network of evaluation advocates across the region that can be nurtured through the West of England Evaluation Strategy Group. All the actions noted on the day are detailed in full in Appendix 4. They have been grouped into seven themes as follows:

1. Lead or instigate process change within your organisation (or across organisations) to raise the profile of evaluation
2. Link with other organisations specifically to promote evaluation or quality improvement
3. Take action to investigate funding evaluation resource(s) within or outside your organisation
4. Personal reflections
5. PPI in evaluation
6. Evaluation- a national view
7. Write formally about evaluation.

Discussion

The findings suggest a number of challenges exist in moving to agree a shared approach to evaluation, though there are clear facilitators that can be harnessed to support onward working.

Involving member of the public in research activity has seen much development locally and nationally and is generally recognised by researchers and funders as good practice, as well as being supported by a series of frameworks and guides. However, public involvement in evaluation activity is often viewed as passive and lacks the support infrastructure, policy and tools that exist in research. In particular, there are concerns relating to the engagement of hard to reach populations and a reliance on public members from known networks, rather than exploring wider engagement opportunities. The challenge for evaluators is to develop policy guidance and frameworks that can be applied as part of normal evaluation practice and seek to engage with wider populations as a matter of course.

Evaluation activity isn't yet embedded as part of healthcare culture. The challenge is to support the development of a culture that automatically seeks to evaluate new services and practices and supports evaluations that are both rigorous and relevant. Such a development would require changes in a number of areas. For example, the development of a common language for evaluation, which is understood by different stakeholders, the implementation of appropriate methodological approaches and tools to answer evaluation questions. Timely evaluation is also required. This would support rigorous evaluation that ensures appropriate approaches, methodologies, and tools are used to support engagement with meaningful and valuable evaluations which are then used to inform and develop practice.

It is clear that there is a dearth of expertise in evaluation knowledge and skills identified and that what does exist is patchy. There is unmet need for skills training in a number of areas, particularly amongst commissioners and practitioners. However the knowledge and skill base amongst local academic institutions also requires enhancement. Some activity is developing here with training being provided locally through CLAHRC West, West of England AHSN with contributions from the Avon Primary Care Research Collaborative (APCRC), and through the provision of the online Evidence & Evaluation Toolkits along with other online resources. Additionally, there is concern that learning opportunities from evaluation may be lost and that much could be gained from sharing evaluation methods, practice and impact amongst the evaluation community. Locally case study development is being encouraged, however there are challenges to developing a broader sharing of practice and learning, in particular some of the challenges of evaluation and how these have been overcome.

Other ways of supporting culture changes and the development of skills are modelled through new roles being supported locally and funded currently through APCRC. These include the 'researcher in residence' model and 'NHS Knowledge Management Fellows' who work bridging the gap between academia and practice. These roles are trail blazers in the movement of knowledge and understanding between organisations and cultures. Further ways of enhancing collaborative working might be developed to support evaluation practice and also skill development, seeking to support a community of practice that supports evaluation activity that is relevant and robust. For example, the importance of leadership in modelling evaluation

practice is important amongst commissioners, practitioners and academics. This can be through developing the local culture as well as supporting evaluation practice and skill development, prioritising this as part of local key performance indicators (KPIs) and other performance measures. Additionally, embedding evidence into practice can be seen as part of a key leadership role in an evaluation culture. This will require some development and support of healthcare leaders. Good practice in evaluation and evidence utilisation in decision-making was discussed in the workshop, evidence being embedded into organisational internal business case templates as part of standard practice being presented as examples. In addition, service conditions within the NHS contracts acknowledge the importance of evaluation and evidence based care delivery. These practices are working well to support evaluation activity and might be used to inform future development.

Research activity is highly governed and has been for some time, with risk assessment being in place and developed in response to reports of poor practice. Governance in evaluation is in its infancy, drawing on some research frameworks and practice being ad hoc across evaluators, with some seeking approvals and others not. Development of a shared framework to support ethical evaluation activity is desirable, and whilst locally some work is starting on this, there is a need to develop, share and disseminate good practice in this area. Organisations might routinely think about reviewing evaluation projects and maintaining a record of those being undertaken, for example.

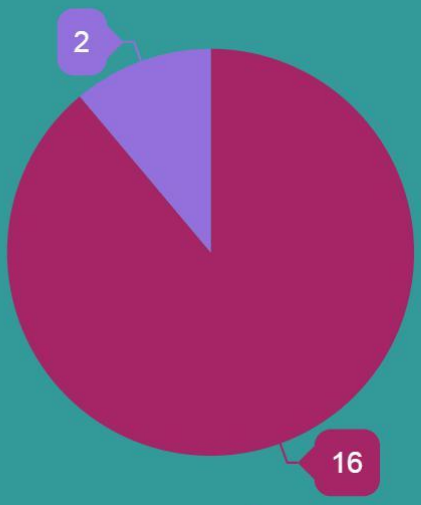
How participants evaluated the event

The evaluation results were compiled into an infographic summary, shown over the next 2 pages.

Principles of Pragmatic Evaluation workshop

16 December 2015, Bristol

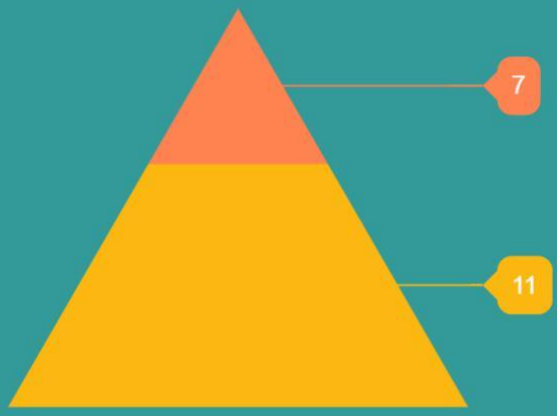
Did the event meet your expectations?



Yes, fully - 89%

Yes, partially - 11%

Did the event support networking opportunities?

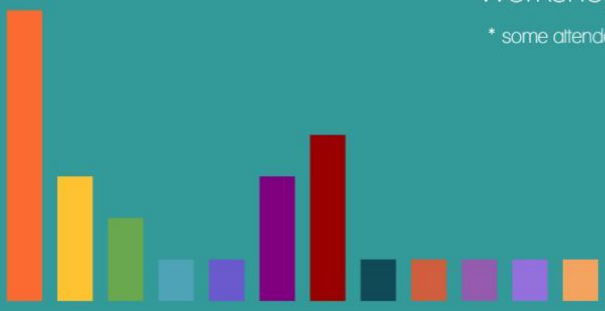


Yes, fully - 61%

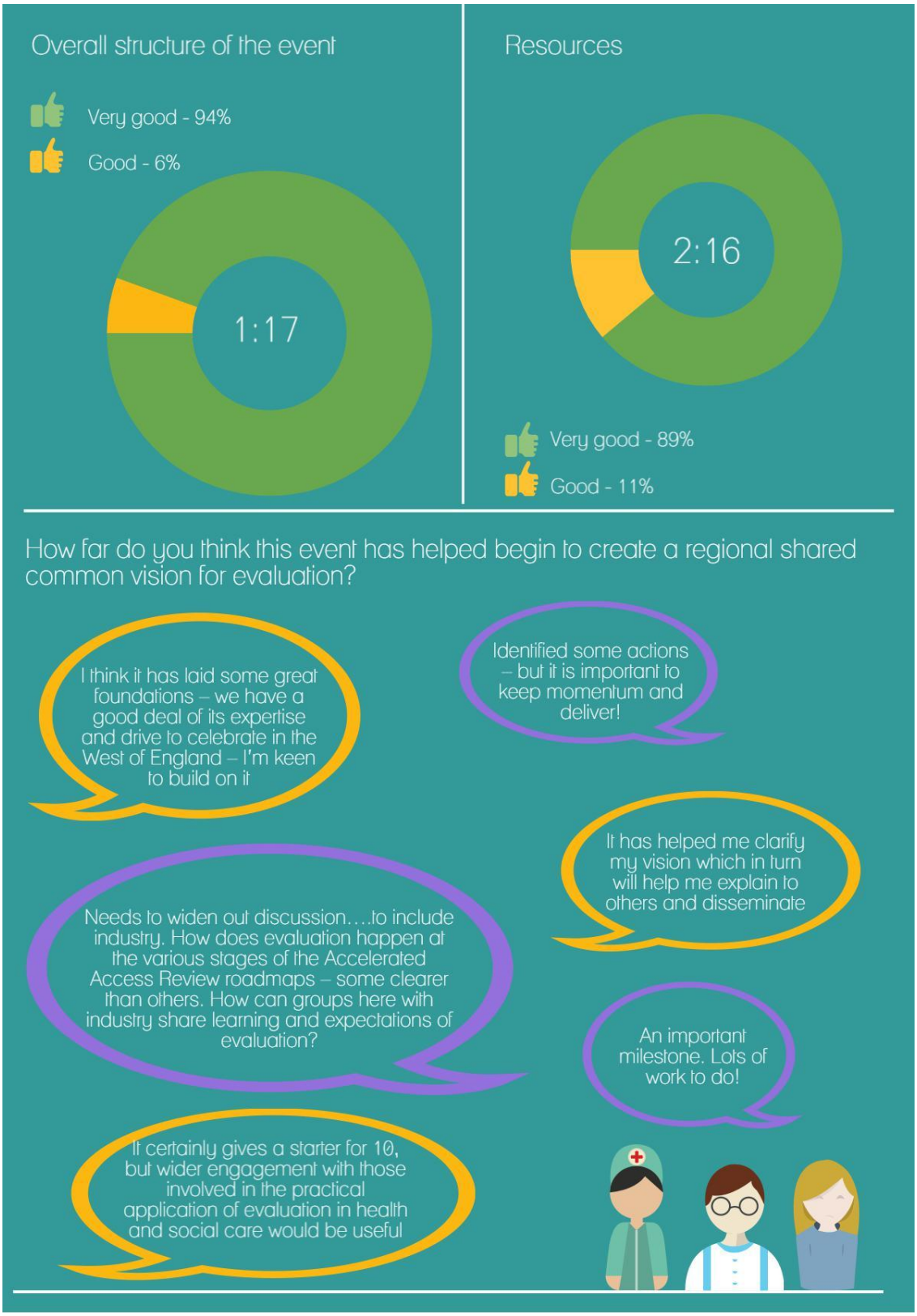
Yes, partially - 39%

Workshop attendees: background*

* some attendees selected more than one background area



Researcher | Commissioner | Manager | GP | NIHR | University | NHS | Local authority | WEAHSN | Ambulance service | NHS Management Fellow | Public Health England



Actions arising from key recommendations for the West of England

Recommendations	Current Initiatives	Implications and Actions going forward
Develop a set of principles or guidelines to support patients and the public involvement in Evaluation	The South West Evaluator Forum, led by the APCRC, focus for 2015 (international year of evaluation) and 2016 is to develop a PPI in Evaluation Charter. They have conducted a mapping exercise and held a workshop to inform the development of this charter. The next step is to conduct a consensus exercise to develop the charter. This work is part funded by the UK Evaluation Society.	Take forward with South West Evaluator Forum, due to next meet on 9th May 16. Recommendation is for a final workshop.
	The group will continue to invite two public contributors as members of the West of England Evaluation Strategy Group on a 2-year contract basis.	The West of England Evaluation Strategy Group to work collaboratively with public members to enable their engagement in delivery of all aspects of its action plan as appropriate.
	West of England PPI Strategy Group and Public in Health West of England.	
Develop principles or guidelines around good practice in ethics and governance of evaluation.	West of England Evaluation Strategy Group ethics working group have been developing these principles with key stakeholders across the region using a consensus exercise (Delphi). The group are about to enter into a second round of the consensus exercise. There is an	A potential opportunity for CLAHRC West to develop a register across West of England, and provide governance and ethical review.

	opportunity to champion this at a national level.	
Develop a one page guide on "what is a good evaluation?"	UWE have developed a one page guide.	
Recommendations	Current Initiatives	Implications and Actions going forward
Develop guidance on planning an evaluation	APCRC, CLAHRC West and WEAHSN have launched their online web-based evaluation toolkit	Evaluation Toolkit launched online on 22nd March 2016, www.nhsevaluationtoolkit.net
	UWE have released three excellent short (lego) videos about evaluation.	
Develop and provide training for health and care professionals, leaders and academics	CLAHRC West, APCRC and University of Bristol have developed a one day introductory short course to service evaluation. This has been very popular.	Develop a short course for academics
	CLAHRC West are running specific methodological training (e.g. realist evaluation, SROI)	
	Realist Evaluation half-day course run at UWE. It was very well received.	
	CLAHRC West, WEAHSN and APCRC have developed 2 hour workshops for commissioning organisations. These support use of the new online Evaluation and Evidence Toolkits.	These are being scheduled in each of the 7 CCGs in the West of England geography with an STP focus in sharing places.
	Development of 'Train the Trainer'	

	material for 2 hour workshops to enable sustainability of the program.	
Identify ways to demonstrate the benefits and learning from evaluations	Individual organisations, such as the APCRC, Gloucester Hospital and AWP, have their own organisational register but it is patchy across the patch.	Explore options for a central register across the West of England.
	Increase the pool of available Case Studies on the online Evaluation Toolkit to share learning and demonstrate benefits.	Record Case Studies and follow-up to record impact.
Recommendations	Current Initiatives	Implications and Actions going forward
Researcher in residence model	Researcher-in-residence model being driven by Martin Marshall at UCL, London & Peter Brindle through his work at the Avon Primary Care Research Collaborative and Lesley Wye at the University of Bristol, as a way of bridging the 'know-do' gap and supporting putting evidence into practice.	This model has been evaluated locally by Kate Beckett, along with role of NHS Management Fellows. Martin Marshall (UCL) is applying for an NIHR grant to evaluation the different researcher-in-residence model in UCL.
Provide support for evaluation virtual network.	West of England Evaluation Strategy Group to actively stay in touch with virtual evaluation network via a 'communities of practice' communication tool. This is to provide support to members, who may be a sole 'evaluation promotor' in their organisation, and to share	

	learning and new initiatives.	
Publish an innovation tool to support rigorous and relevant evaluation.	Review tool developed by Andrew Rix, Independent Research & Evaluation Consultant as a starting point.	
Identify 'good practice' principles for NHS Contracts with regard to evaluation activity and conditions.	Noted that requirement for evaluation was included in the recent re-commissioning of mental health services in Bristol.	Review NHS Contracts for evaluation activity and conditions. APCRC have developed a 'Guide to building evaluation into Service Specifications'. This is available on the Evaluation Toolkit in the 'Plan' step Toolbox: APCRC Guide to building Evaluation into Service Specifications
Recommendations	**Current Initiatives**	**Implications and Actions going forward**
Making evaluation language 'accessible and common'.		Define what this language should be; identify and incorporate into existing material and resources.
Dissemination of POPE Report outcomes		Send a copy of the final report to HS&DR, as this work inspired the event.
		Send report summary to UK Evaluation Society.
		Review actions for postcard outputs.

Statement of Intent

To collaborate in taking forward the key recommendations from this event as outlined in the table above, led by the West of England Evaluation Strategy Group, in conjunction with all stakeholders across the region, including those who attended the event.

Appendix 1

Attendees List – Louise Waters has the final list of attendees – may need to seek permission to use name or do we already have agreement

Name	Job role	Organisation
Mrs Amanda du Cros	Head of PMO	Swindon CCG
Mr Andrew Rix	Research and Evaluation Consultant	Independent
Dr Andy Gibson	Associate Professor in Patient & Public Involvement	UWE
Anne-Laure Donskoy	Survivor researcher and consultant	Evaluation Strategy group member
Mrs Becca Robinson	NHS Management Fellow	University of Bristol
Prof. Chris Salisbury	Professor of Primary Health Care	University of Bristol
Dr Christos Vasilakis	Director and Associate Professor	Centre of Healthcare Innovation & Improvement, University of Bath
Mr David Relph	Director	Bristol Health Partners
Donna Buxton	Research Manager	The Health Foundation
Edmund Brooks	Organisational Development	Freelance
Elizabeth Coates	Head of Research Governance	Public Health England
Dr Elizabeth Dymond	Deputy Director Enterprise	West of England AHSN
Dr Emma Gibbard	Head of Evaluation	APCRC
Dr Helen Baxter	Research Associate	University of Bristol
Dr Janet Brandling	Research & Evaluation Specialist	AWO
Miss Jessica Maloney	Economic Assistant	South Gloucester CCG
Dr Jiri Chard	Evaluation and Policy Lead	NHS England
Prof. Jo Rycroft-Malone	Head of the School of Healthcare Sciences	Bangor University
Jo Bangoura	Evaluation & Commissioning Liaison Manager	CLAHRC West / WEAHSN
Mr Joe Poole	Service Improvement Lead	Bristol CCG

Dr Julian Walker	Director of R&D and Consultant Clinical Psychologist	Avon and Wiltshire Mental Health Partnership NHS Trust
Dr Julie Hapeshi	Associate Director of Research & Development	Gloucestershire Hospitals NHS Foundation Trust
Miss Katherine McNee	Quality Improvement Paramedic	SWASFT
Dr Laura Eyre	Research Associate	UCL
Miss Louise Waters	Project Support Officer	NIHR CLAHRC West
Dr Maria Palmer	Principal Pharmacist	University of Bristol Hospitals NHS Trust
Megan Lewis	Evidence Assistant	North Somerset CCG
Name	**Job role**	**Organisation**
Mr Neil Riley	Senior Analytical Lead - Operational Research & Evaluation	NHS England
Prof. Pam Moule	Research Centre Director	UWE
Dr Peter Brindle	Leader - Evaluation and Commissioning Liaison	NIHR CLAHRC West
Rachel Anthwal	Programme Manager	South, Central & West CSU
Tom George	Evaluation Assistant	South Gloucester CCG
Trish Harding	Evaluation Officer	Bristol Health Partners
Valerie Shanks-Pepper	Head of Unit, Research and Innovation	NHS England
Ms Zoe Trinder-Widdess	Communications Manager	Bristol Health Partners and NIHR CLAHRC West

Appendix 2

See separate attachment – The Principles of Evaluation; short digest of key documents sent to delegates prior to the event.

Appendix 3

Table 1: How do we best involve patients, carers and the public in evaluation?

Facilitator: Anne-Laure Donskoy, independent service user researcher and consultant in mental health and social care.

Scribe: Megan Lewis, Graduate Evidence Assistant North Somerset CCG

The main issue raised during the discussion concerned the nature of PPI in evaluation. While PPI in research is a well-established concept and an increasingly common practice, PPI in evaluation is still very underdeveloped and suffers from similar issues as PPI in research in the early stages, namely misunderstanding and confusion about involvement (active involvement in a project as opposed to participation as subjects), a dearth of guidance and policy, as well as PPI budget issues (virtually non-existent due to PPI in evaluation not being established).

Overall, the main issues focused on:

- The nature of PPI in evaluation
    - Active involvement in evaluation is still rare as opposed to passive involvement when individuals are asked to take part as subjects of evaluation. A recent mapping exercise in the West of England funded by the UK Evaluation Society showed that out of 140 responses, only seven had any active involvement (REF). Many submissions described passive roles (e.g. as subjects in focus groups) or extremely light consultation as forms of active involvement.
- PPI recruitment:
    - The same issues which are often mentioned in research were mentioned:
        - How to **avoid the "usual suspects"** and how to ensure good representation: it was agreed that the issue of representativeness was misleading and that PPI members should not necessarily be expected to be "representative" since professionals around the table were not necessarily representative of their own constituency. PPI members could be involved in their own right as people with a specific experience (of a condition, of using certain services etc.)
        - How to **involve seldom heard** populations and communities:
        - Budgets: At present, few projects benefitted from any formal PPI budgets for active involvement.
- How do we make PPI in evaluation happen?
    - Organisations need to be fully committed to active, genuine PPI which also takes into account diversity issues (cultural, ethnic, etc.)

- Address issues of representation especially of hard to reach populations, making a demonstrable effort of going out to populations which are concerned by the evaluation and have the right experience (e.g. prisoners)
- Address accessibility issues: time and location (for instance offer evening and weekend meetings to encourage diversity and new people); reaching out (use of social media)
- PPI methodology:
    - Need to be clear why, how and when people will be involved in evaluation: for instance a lot of collaboration is often rebranded co-production whereas decision making clearly remains in the hands of professionals.
    - Using measures which are more relevant to patient experience: for instance patient designed measures versus patient outcome measures.
- PPI in evaluation needs to be properly framed through policy and guidance and properly funded

Table 2: How do we ensure that evaluation is of value to health and social care?

Facilitator: Helen Baxter, Researcher in Residence (UoB), Bristol CCG

Scribe: Jo Bangoura, Evaluation and Commissioning Liaison Manager, WEAHSN & CLAHRC West

The many challenges of carrying out a valuable evaluation of a new or developed service have been well documented: the pace within commissioning in which decisions often need to be made does not always allow time for an in-depth evaluation to be carried out; there are often limited or no resources allocated to carry out the evaluation and the terminology of 'evaluation' can mean different things to different stakeholders, which can cause misunderstandings. These issues were discussed and acknowledged by the group and a further set of challenges and ideas were explored further.

Language & Terminology: as well as evaluation terminology having different meanings in the academic and health arenas, it was also highlighted that the language of health is somewhat different to that of social care. Indeed, there are already complex relationships and multiple organisations at the health and social care interface, regardless of academia. A practical suggestion for facilitating a common understanding and demystifying terminology that can be associated with academia, is to use lay terms and plain English. For example, we can ask our health colleagues: "Is your service having the desired effect or outcomes and how do you know?" Or a more relevant question might be: "How can this service be improved and what aspects are working well?" These questions are less open to misunderstandings, although they may elicit different responses from different stakeholders. These questions also cut to the chase of what evaluation is about, without using jargon specific to any organisation or sector. Focusing on 'the patient' or 'service user' can also be helpful common currency.

Skills: in the discussions about enabling 'evaluation' capacity, the group swayed between supporting skilling up health care professionals (including commissioners), and expanding the academic resources available to them. The group felt that there was merit in both approaches, as long as the gap was bridged. Skilling up health care professionals through training course(s) could improve their knowledge sufficiently to talk confidently about evaluation in their everyday language without shying away from what feels an unknown art. It may also encourage them to seek out academic colleagues for specialist support as collaborators, recognising the limitations of their own abilities in designing a 'good enough' evaluation. It may even facilitate open and healthy challenge and debate between specialist evaluator and commissioner, or extend a consultation to include modelling. Having evaluation expertise on a Clinical Commissioning Board would provide rigour, challenge and capability to demand evaluation input into commissioning decisions. The need to plan evaluation at the beginning of any service development was felt to be more likely where confidence was improved through training for health professionals (and commissioners). There was discussion about the extent of 'skilling-up' health professions – as specialists, or as generalists, with support through provision of toolkits and local or regional experts to consult?

In terms of the skilling up of academics to have a better understanding of the worlds of the commissioner and service provider the 'researcher in residence' model was highly regarded by

the group as a very good solution to bridge the knowledge gap. Here, an academic with a health research background is placed in a Clinical Commissioning Group. However, it was noted that this model does not offer academic career development or progression in its current form. The Management Fellowship Programme was mentioned, where commissioners are placed in the academic setting to learn more about research and to be trained in research methodologies Further reflections on this by the group facilitator after the event suggested that the evaluation of the Knowledge Mobilisation Team at the University of Bristol may be a suitable mechanism to evaluate the success of these models, and how links and skills are maintained to benefit individuals and organisations after each placement has completed.

Training: There was much discussion about an 'Evaluation' training course. Who would be the target audience? Could commissioners and academics be trained together, giving the added side-effect of cross-organisational networking and culture sharing? It was felt that health professionals (including commissioners) needed, and indeed wanted, training in evaluation but would not realistically release more than a day of their time for this. However, academics, who may have more time, may need only a refresher on evaluation, but may be interested in or benefit from learning about the commissioning cycle, for example.

Keep banging the drum: The achievement of adding 'Evaluation' as a mandatory field on the 'Business Case' template in Bristol's Clinical Commissioning Group is very worthy of note in reflecting the organisational value of carrying out evaluation. However, the group acknowledged that there was a long way to go before evaluation would be every-day language across all organisations in the west. This culture is likened to where Public and Patient involvement (PPI) was 10 years ago; some groups embraced it but mostly it was not robust, tokenistic, not valued or completely absent. The group felt PPI is now largely understood and very commonly considered to a high standard, and this is down to long term investment in PPI lead posts to continue to make a noise about its value, promoting its purpose and providing guidance to those who need it.

Recording & Sharing: The group discussed that typically evaluations are not well documented. One participant from Gloucester advised that her group kept a registry of all known research and evaluation in the area through providing an 'ethics and grants advisory service'. There seemed to be little sharing of evaluation learning across the region, with individuals reinventing the wheel and often working with best intentions but in isolation. Providing a support network and making case studies available for learning felt a valuable step.

Table 3: How do we build a culture of evaluation?

Facilitator: Ed Brooks, Patient and Public Contributor

Scribe: Jessica Maloney, Graduate Economic Assistant, South Gloucestershire Council

The purpose of this inquiry was to come up with a deeper understanding of how to create a supportive and enabling environment in which evaluation helps solve problems, inform decision making and helps build evidence and disseminate knowledge about best practice.

Although evaluation is embedded in NHS standard contracts it was recognised that relationships needed to be developed that allowed challenge and debate and that individuals had the tools to challenge and debate service development and what constituted an improvement in patient care in terms of the evidence.

It was said that there was a shortage of skills needed to do a rigorous evaluation or there were problems of access to those with knowledge and skills. It was thought that a culture of evaluation needed to be built from the grass roots up by making education and training more readily available. Most of the courses are oversubscribed and clearly there is a demand that is not being met.

Questions were asked about how to incentivise a culture of evaluation. In most NHS organisations a specific healthcare service is scored and judged against others in the form of a "league table" based on performance indicators. The challenge in meeting performance targets is to ensure that patient care is the driver for change rather than the performance target. In that sense a patient centred culture needs to be preserved and maintained in any evaluation process and patient representation built into the design and delivery of evaluation.

If operational staff are to be encouraged in engaging with evaluation they need support from leadership at the top. Managers who use evidence-based evaluation in their decision making are more likely to reinforce and support the value and purpose of evaluation. Involving people in data collection would help them understand the value of evaluation in testing organisational policies, procedures and practices against the evidence of what works. Beside encouraging debate and discussion as to whether an intervention has been a success or not, many other things can be learnt. Did the intervention work in the way we thought it would? If not, why not? What made it work? What were the unforeseen consequences that need to be considered when we plan for an evaluation in future.

It was agreed that more discussion and debate about the lessons learnt from evaluation would help in understanding why some interventions were more successful than others. There needed to be much more sharing of information about failures as well as successes. What use was evaluation being put to? The limitations of evaluation needed to be recognised where there was a lack of data (hard evidence).

The competing tensions between service evaluators and providers needed to be acknowledged in any debate or discussion of Evaluation because developing and sustaining relationships was

critical to the process and its outcome.

How can we make a culture of evaluation happen?

A summary that explains what “good” evaluation is in one page that can be used as an assessment measure. The Royal college of Psychiatry has 20 criteria for success that explains in one page how to create an enabling environment.

An expectation is needed from the leadership at the top that a culture of evaluation has real importance and evaluation is a continual process of “action research” rather than something that is tagged on at the end of a project.

The dissemination of information and evaluation processes needs to come from the top.

There needs to be a change in behaviour and relationships between service evaluators and providers in order to effect real change. Relationships need to be built on trust.

It is important to show the economic benefits of evaluation; the costs and benefits to all stakeholders and to explain the consequences of change to the way in which health care is delivered.

More needs to be done to develop case histories and to share the learning that comes from engaging with evaluation as to whether an intervention was successful or not and why. These are not always published. Barriers to sharing such information need to be addressed.

Commissioners who set out contracts and service specifications have a vital role in laying out the ground work for evaluation and in managing the competing tensions between service evaluators and providers.

Table 4: How do we create an ethical approach to evaluation?

Facilitator: Janet Brandling, Research, Evaluation and Quality Improvement Expert, AWP

Scribe: Trish Harding, Evaluation Officer, Bristol Health Partners

One of the key challenges for evaluation is how to ensure good quality, proportionate and appropriate ethics and governance frameworks are in place. By including a table discussion on the conduct of evaluation, the event generated an interest in this particular challenge that might otherwise have not received the attention it deserves. There was a lively debate on how to create an ethical approach and it was clear that this was an issue of great interest to participants.

The discussion started by considering the **level of ethical governance required** for service evaluation compared with that for research. Discussion was invigorated when participants considered quality and risk. It was felt that shifting the focus from 'whether it is research or evaluation' towards 'what are the risks associated with the work?' or 'what would unethical evaluation look like?' would be helpful. Judging the level of risk associated with the work should be central, rather than merely defining it as research or evaluation. There might be risks to patients, carers, staff and organisations. These could be breaches of confidentiality, interminable data collection, waste, inadequate evidence review, poor design and lack of skills/expertise, and dissemination of findings.

Participants agreed that **principles to guide the conduct of evaluation studies** are required as there is a lack of clear and accessible ethics guidelines for evaluation studies. These principles might be derived from existing disciplinary or research guidance. They need to be proportionate and have utility. These should be related to the scale of the service, the experience of the evaluator and level of risk to those involved in the evaluation. In the spirit of 'nothing about us without us', also highlighted was the need to ensure there is service user or public and patient involvement (PPI) at the design and planning stage of any evaluation, when ethical issues are being considered. Without adequate involvement there is a risk that service user or patient concerns will be overlooked during the governance process and ethical issues may be raised later that will have a detrimental effect on the evaluation.

Guidance would need to take account of existing policy and procedure, particularly around **who should be responsible** for ensuring ethics scrutiny and carrying out governance. Some NHS Trusts in the West of England have established mechanisms for governing evaluation and often University ethics committees provide some oversight but it was acknowledged that this is ad hoc. The general feeling of the event was that work is needed around clarifying and sharing evaluation governance. It was noted that the West of England Strategy Group is undertaking a consensus exercise to understand what local partners think an ethical approach to evaluation might be. The findings will inform common guidance in the region and help to build an ethical approach to evaluation that is clear and consistent.

Table 5: How do we make the trade-off between rigour and relevance?

Facilitator: Emma Gibbard, Head of Evaluation, Avon Primary Care Research Collaborative

Scribe: Thomas George, Graduate Evaluation Assistant, South Gloucestershire Council

The NHS 5 Year forward view has set the challenge of promoting "**more rigorous ways of answering high impact questions**" with an emphasis on the role evaluation can play in transformation, innovation and quality improvement. This is accompanied with the view that a gap exists between research (rigour) and practice (relevance) with a need to find new ways to bridge this gap. This helped set the question for the group - **how do we make a trade-off between rigour and relevance?**

There were interesting discussions as to whether it was necessary to make a trade-off between rigour and relevance and that rigour, time, risk and impact might be the greater trade-offs. It was felt by some that **you can be both rigorous and relevant** and in fact that being relevant was a key part of being rigorous i.e. the **"right tool for the right question."** In other words, by ensuring that your evaluation was pragmatic, proportionate and appropriate to the question at hand your approach will be both rigorous and relevant. This highlighted the need for evaluators and researchers to **consider** a wide **range of different approaches, tools and methods**.

These discussions also raised question as to **what do we mean by rigour and relevance? What do we mean by good enough?** Does rigour always mean the gold standard a Randomised Controlled Trail (RCT)? Or is it "the right tool for the right question" and simply a well-designed and planned evaluation that is appropriate to the purpose? Is relevance about what is useful to practice? Or about using the most appropriate approach for the purpose of the study?

It was recognised that there would be differing views of methodological **rigour** for different stakeholders, i.e. a researcher's level or understanding of rigour could be very different to that of a clinician or manager. This can also be applied to **relevance** in the consideration of whether we are talking about relevance to the context; or relevance to the needs of the local population; or methodological relevance to the **purpose of the evaluation**? This in turn links to whether it is "good enough" i.e. relevant (appropriate) for to the context and purpose and thus rigorous (proportionate) enough. It also raised the question around the need to consider the risks involved – "can you afford to do an evaluation, can you afford not to do an evaluation?"

To enable evaluations to be more **rigorous and relevant** there were a number of **practical steps**, as well as **specific interventions**, identified that could support this. The practical aspects to evaluation included the benefits of **good early evaluation planning**. Good evaluation planning would include the involvement of the right stakeholders, a clear purpose for the evaluation and consideration of a range of approaches utilising mixed methods (qualitative and quantitative approaches) to enable triangulation.

There were also specific initiatives identified, such as the **researchers in residence** model which

embeds researchers from academic institutions into practice to undertake specific evaluation or research project that could support more rigorous but relevant evaluations. Another initiative, the **NHS Management Fellows** where those working in commissioning organisations are embedded in research projects to exchange skills and knowledge of research and commissioning and improve communication. Both roles have a similar focus of acting as "knowledge Brokers" to support and facilitate knowledge into action i.e. Knowledge mobilisation.

The barriers identified during these discussions reflected those identified during discussions around embedding a culture of evaluation. These included aspects around culture, status of evaluation, skills, knowledge, capacity, time, and data quality. It is recognised that there are **differences in cultures** within academia and practice particularly time and timeliness and impact being key differences. The **status of evaluation** is also often held in a lower regard than research in health and social care and been neglected from a national point of view. In academia, this creates a barrier with researchers not considering it a valuable activity and they are also seen as having a limited impact as they are more difficult to publish and share, and so they focus on conducting research. In practice, there is also the fact that there does not appear to be a culture of evaluation with it quite often seen as an "add on" and more work rather than an integral part of the job.

During one of the workshop discussions a tool developed by Andrew Rix was presented to help to assess the trade-off between rigour and relevance **"not rigour and relevance but rigour and relevance (and timeliness)"** to ensure that you have the most appropriate approach for an evaluation. There was a lot of interest in the tool and that there was a lot of potential for this tool to guide commissioners and providers of evaluation to ensure their evaluation is both rigorous and relevant.

There was a clear message that you can have an evaluation that is both rigorous and relevant by ensuring that you have the right approach for the purpose of the evaluation.

Appendix 4: Individual and organisational actions

1.	Lead or Instigate process change within your organisation (or across organisations) to raise the profile of evaluation	
		Help develop a code of conduct re: evaluation ethics and governance (e.g. 2nd stage of current Delphi exercise) Continue to encourage and 'insist' that the process of evaluation is discussed as part of the 'scoping' phase of the project within the CCGs work programme. Altering the template will be a start! Think about the long term goals, challenge and give a critical appraisal of existing services and tools Work with AWPs evaluation specialists to implement Pam Moule's 1 page evaluation guidelines in all Trust Improvement Projects. Start evaluation of small service developments more formally and disseminate through organisation Feedback the issues raised today at tomorrow's Gloucestershire R&D Consortium meeting Talk more broadly about better decision making, learning and understanding risk Encourage self-awareness in others with regard to decision making Write some guidelines Find out what 'evaluation' training is in the WEAHSN academy quality improvement coach program Do good evaluation and make sure it is used and acknowledged so that evaluation becomes more valued Encourage people to share results of their service evaluations with each other and the general public Help to implement systems that make evaluation more accessible, to share between departments and people involved. Talk to as many people as possible and share the great resources that are available Think about developing a one page guideline on evaluation – what does good look like? Brief my executive team & PMO team of the key points discussed today and ensure that learning from any service change or improvement includes evaluation. Support from WEAHSN on different methodology approaches would help (short term/intermediate outcomes). Feedback what has been learned today to my manager and incorporate

		some of the learning into my QI practice Disseminate lessons learned from this workshop to encourage more evaluation and dissemination of results Get Exec/'Board to implement Pam Moule's 1 page evaluation guideline
2.	Link with another organisation(s) specifically to promote evaluation or QI	
		Engage with West of England AHSN to improve networking opportunities for my QI role. Talk to CLAHRC West to increase frequency of evaluation training Share my learning today with Chew (Charity evaluation working group) which is 3rd sector community or practice for evaluation managers Support from WEAHSN on different methodology approaches would help (short term/intermediate outcomes). Focus on service directors in council and help them access evaluation expertise Support more formal joint working – analogous to PHWE? Widen conversation about evaluation – how is evaluation expertise here today contributing to Accelerated Access Review? – How is industry involved? How is it made clear to innovators what evidence and evaluation is appropriate
3.	Take action to investigate funding evaluation resource(s) within or outside your organisation	
		Look into funding researcher in residence – model research i.e. benefits/challenges. Improve learning opportunities for QI paramedics. Support researcher in residence programme Explore again the idea of a short course on evaluation or knowledge mobilisation Ask Deborah (MD WEAHSN) and Anna (QI Director) QI coaches within SWAFT. QI work done by 2 bank posts on top of WTE jobs

4.	Personal reflections	
		Try to understand and challenge the way I make decisions Find out more about how evaluation effects different stakeholders and how we can be less fragmented Be honest with practitioners (evaluation stakeholders) about the necessary academic activities – balance time between academia and practice Take the learning from my KM role to ensure more robust evaluation in the future
5.	PPI in Evaluation	
		Give greater emphasis to patient and user involvement Investigate how patient and users are involved in research
6.	Evaluation – a national view	
		Engage with NICE to discuss knowledge mobilisation and knowledge management at a national level Lobby for equal status of evaluation and research
7.	Write formally about evaluation	
		Work with APCRC to identify 'peachy' examples of evaluation and examples where not evaluated and risky consequences, and write up in HSJ Publish my rigour and relevance 'positivity/positioning(??)tool