Narrowing the second translation gap: evaluating CLAHRCs’ potential, strategies and contributions

Core Team

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Background

Nine Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) were established in October 2008 by the National Institute for Health Research. Their aim is to encourage and strengthen collaborations between Universities and local NHS organisations. These collaborations are focused on improving patient outcomes through changing the way applied health research is conducted, and strengthening the use of research results in health care practice. Each of these collaborations share some overarching purposes, but there are also many differences reflecting local circumstances, including local research and health care priorities and historic strengths. RAND Europe and the Health Economics Research Group at Brunel University have been commissioned by the NIHR Service Delivery Office as one of four teams evaluating CLAHRCs.

The Cooksey Report on UK health research funding (HM Treasury, 2006)¹ identified two gaps in the translation of health research into practice. The first gap is in translating ideas from basic and clinical research into the development of new products, technologies and approaches to the treatment of disease and illness. The second gap is in implementing these products, technologies and service approaches in clinical practice.

Our evaluation of CLAHRCs focuses on the second translation gap. In an approach that will evolve as the CLAHRCs establish their ways of working, we will explore the various interventions and strategies being adopted by CLAHRCs to address the second gap. We will identify common features between

CLAHRCs, explore promising ideas, and examine the strengths and weaknesses of distinct interventions. Our style of working will be collaborative, and we hope to contribute to shared learning and improvement during the lives of the CLAHRCs. Through doing so, we hope to provide pragmatic support to future decisions in this important area.

Aims

Our project aims to:

Improve understandings of attempts to bridge the second translation gap in ways that make sense to policy makers, practitioners, and academic researchers

Contribute to recommendations that are evidence based, acceptable and feasible given health research and practice architectures and policy drivers

Contribute to the methodologies used in studying the translation gap, and multi-agency and evolving interventions/programmes

Key research questions

This project will seek to answer one overarching and three subsidiary questions:

How, and how effectively, do CLAHRCs address the second translation gap?

How, and how effectively, do CLAHRCs support local health research?

How, and how effectively, do CLAHRCs build local infrastructures to utilise globally and locally generated health research for local patient benefit?

Does bringing together activities for health research and activities for delivering health research benefit both sets of activities equally (e.g. by stimulating local research that is more relevant to the needs of patients or by encouraging a ‘research-literate’ local community)?

Study design and methods - summary

This is a three year project with three phases. Our approach will be to better understand the sequence of activities supported by CLAHRCs and to assess how far they contribute to bridging the second translation gap. We will draw upon some of the concepts and analytical approaches developed in literature on how to manage innovation, and on how knowledge is produced and used in organisations.

In phase one we will identify types of interventions (and combinations of interventions) used by the CLAHRCs to address the second translation gap, and examine the logic behind their approach. We will do this through drawing upon existing research, analysing documentation from the CLAHRCs, and learning from workshops with multiple stakeholders in each CLAHRC. We would like to develop a typology of interventions the CLAHRCs are using to encourage and increase the adoption or
research and innovations in health care practice. We are assuming that some approaches will be used in many CLAHRCs and some might be used only in isolated cases. In Phase II, we will explore in more detail some of the issues and factors identified in Phase I as likely to influence the CLAHRCs’ evolution and performance in relation to bridging the second translation. This Phase of the work will include an online survey of all CLAHRCs, a case study phase focusing on 2 to 3 CLAHRCs, a validation phase and a broader phase looking to situate the CLAHRCs within the broader NHS landscape. In phase III we will draw together the data and analyses and identify lessons learnt, before developing conclusions and recommendations. We will assess our recommendations for feasibility, suitability and acceptability through a series of workshops with academics, policy makers and practitioners.

**Outputs**

NIHR has made a significant investment in CLAHRCs on the understanding that these sorts of interactive collaborations can make an important contribution to the use of research. The outputs of this study should be relevant to the NIHR and other health research funders, healthcare practitioners, academics and policy makers. Through a combination of reports, briefs and workshops, we will regularly feedback of our emerging findings to the SDO, other evaluation teams and to CLAHRCs. We will also actively participate in conferences, as well as forums with policy makers and healthcare practitioners, and intend to publish our findings in peer-reviewed journals. Our final outputs form this project will also include documents tailored to the unique discourse and priorities of academic, practitioner and policy communities.

**Details of each phase**

Each phase of the study is detailed below:

**PHASE I:**

During the first phase, we will work collaboratively with all CLAHRCs to build a taxonomy of their approaches to the second translation gap (i.e., the gap in health research translation that refers to implementing research-informed product and service innovations into clinical practice). Each CLAHRC is likely to have more than one approach to the second translation gap, and each approach may be present in more than one CLAHRC. We will look at the approaches being adopted by CLAHRCs, identifying and exploring: (a) the types of interventions being used by CLAHRCs to promote practice change and the mechanisms through which they operate (e.g., interactions, social influence, facilitation, etc.) and (b) the various levels at which these interventions will be used to promote change in practice (e.g., individual, organisational, and system-wide), and c) the logic behind the intervention (i.e., why the CLAHRC believes that implementing certain interventions, in certain contexts and with specific inputs, should result in specific outcomes).

Our concern will be to capture initiatives to support improvements in clinical practice at:
a micro-level, i.e. interventions that promote translation among individual practitioners within a
single organisation (e.g., targeting research findings on doctors and nurses in a primary care practice
setting, coupled with feedback opportunities),

a meso-level, i.e. interventions that promote translation among researchers, managers and
practitioners working in different organisations. Among these we include interventions that aim to
enhance the roles service managers can play in supporting improvements in clinical care; and a
macro-level, i.e. interventions that promote translation designed to facilitate organisation to
organisation partnership, e.g., across research and health care sectors (such as the CLAHRCs
themselves).

At the end of Phase I we will draft a First Interim Report, and feedback our early findings to all
CLAHRCs, to the SDO, and the wider community of policy makers and practitioners in and around the
SDO.

The core methods to be used in phase I include literature review, document review and primary data
collection through workshops/interviews with CLAHRCs. More details on different components and
timelines for phase I are provided below:

Refining the evaluation design: it is important that the initial design and approach has been
scrutinized by academics and practitioners within CLAHRCs.(November - December 2009).
Completed.

Reviewing key literature and assessing its significance for the evaluation project. (November 2009-
March 2010).

Kick off meetings with SDO and CLAHRCs: The SDO organised kick off meetings with all the funded
evaluation teams and with the CLAHRC Directors in October 2009 and February 2010 respectively. At
these meetings, discussion and consensus building took place on issues of coordinating evaluation
activities, minimising burden on CLAHRC time, and maximising learning.

Reviewing background information/CLAHRC documentation to assist in the scoping of CLAHRC ways
of working and as inputs for data gathering at workshops/interviews. (November 2009- end
February 2010). Completed.

Scoping the ways of working/logic models with each CLAHRC through meetings with each CLAHRC
team and key informant interviews. These will be coordinated with other SDO-funded evaluation
activities to minimize unnecessary burden. In terms of workshops, there will be 1 workshop at each
CLAHRC to take place at the lead institution, and to involve approximately 5-6 representatives of
different stakeholder groups and organisations within a CLAHRC (May 2010-September 2010).

Using meetings with CLAHRCs, their application forms, and CLAHRCs’ own developing
documentation, we will model the logic(s) of intervention/ways of working for each CLAHRC. This
will include describing the existing inputs, the processes (implementation plans) through which the
second translation gap is to be addressed by the CLAHRC, and the expected outputs/outcomes from
CLAHRC activity. (September- November 2010).
We will then hold a national ‘learning’ event for CLAHRCs, SDO, other SDO-funded evaluation teams (involving also our Advisory group). We will disseminate and discuss our emerging findings, and identify questions which would benefit from further investigation. November 2010).

We will then meet with our Advisory group consider the significance of different intervention approaches and hold an initial discussion about which approaches to investigate further in phase two (November 2010).

Produce First Interim Report: identifying key models/ways of working, their significance, and the agenda for further evaluation in Phase Two. (December 2010)

Quality Assurance on First Interim Report by two peer reviewers (December 2010).

PHASE II:

In phase I, the RAND/HERG team examined the CLAHRC landscape, and identified the various logics of intervention that different CLAHRCs are pursuing. CLAHRCs are each seeking to change the way research is done and the way the NHS uses research in commissioning, managing and delivering services. Our phase I work identified some similarities between the approaches of different CLAHRCs but also significant differences in areas such as operational approaches, disease focus, structures/governance approaches and stakeholder dynamics (as some examples). A range of interesting questions/themes around factors which are likely to influence CLAHRC evolution and performance emerged from our ‘landscape mapping’ in phase I.

In phase II we will explore some of these questions in more detail. The core questions to focus on were selected from the long list of questions, in consultation with our Advisory Board and some CLAHRCs (those who responded to our survey consultation). They were selected with the following criteria in mind:

- be relatively under-researched (as identified through our literature review)
- have a potentially high impact with transferable lessons
- be relevant to the success of the CLAHRCs
- not be covered by one of the three other evaluations (at least not as a central question)
- be capable of being researched across more than one CLAHRC to support comparisons and contrasts.

In light of the above, we will be examining three interrelated aspects of CLAHRCs processes in more detail.

1) Core Question: How does the NHS influence CLAHRCs evolution, outcomes and impact, (and indeed how does having a CLAHRC influence NHS behaviour)? This requires examining and specifying the nature and extent of NHS involvement, including to what extent rhetoric matches reality.

2) Complementary Question A: How are effective multi-stakeholder and multidisciplinary research and implementation teams for service improvement built: what can we learn from the CLAHRCs model, and what mechanisms are being used to enable it?
3) Complementary Question B: What can we learn from the CLAHRCs that can cast new understanding on how to use research knowledge and evidence to change commissioning and clinical behaviour for patient benefit?

A number of assumptions related to our phase I findings are driving the questions above. These assumptions include:

- High levels of NHS involvement underpin the CLAHRC ethos and theory of change.
- Collaboration between multiple stakeholders in academic research and service provision can lead to service improvements and a better healthcare system. Important stakeholders in this respect include: academics; NHS executives; clinicians; senior, middle and front-line managers; patient and public representation groups; commissioners etc.
- It is not enough to generate ‘good evidence’ for it to be adopted and lead to improved service. In addition to producing relevant and implementable research, a range of approaches and conducive infrastructures need to be in place for it to lead to service improvement.
Study design:

We propose a 4-step approach in phase II as illustrated in the figure below.

Phase II study design

The section below provides more detail about each of the tasks to be undertaken in Phase II. We have also included indicative timescales for when we expect these tasks to be undertaken. Given the range of methodologies being used in this phase of the work, some of the components of these tasks will be carried out in parallel as reflected in the overlapping timelines given for some of these tasks. Should these timescales be required to be readjusted significantly due to delays associated with undertaking the online survey, we would seek approval from our funder (the SDO) and would duly notify the research ethics committee of these delays in our next progress report.

**TASK 1: Stakeholder survey across CLAHRCs (from April 2011 to November 2011)**

In this phase we would design and conduct an online survey across all CLAHRCs who agree to participate and with different stakeholders in each. This survey would help generate insights
about core issues related to our three questions (NHS involvement, multi-stakeholder research and implementation teams, and evidence adoption) across the CLAHRC landscape. We will investigate the interventions CLAHRCs are implementing as associated with all three questions; the contexts and variables that influence their actions; and the effects of the various interventions. We will do so in a way that can capture the multiple perspectives of different actors that constitute CLAHRCs: researchers, clinicians, NHS managers, commissioners, academic leadership, Trust executive leadership and patient/public representatives. Based on the insights that emerge from this survey, we would select specific ‘sites’ to dig deeper into through a case-study approach.

The key steps in task 1 include:

- Survey design
- Survey pilot
- Survey administration
- Survey results analysis
- Brief executive summary of findings or Powerpoint presentation to use as dissemination material, e.g. for SDO learning events
- Internal team analysis workshop
- Advisory Board meeting

In order to increase buy-in for the online survey, we envisage asking CLAHRC managers to send the link to the survey to relevant respondents. We would also seek to obtain an email/letter endorsed by the National Institute for Health Research to inform potential respondents about the importance of the survey for this research.

**TASK 2: Deep dives: interviews and workshop (from November 2011 to April 2012)**

We will select 2 to 3 case-studies/sites exemplifying distinct types of interventions/combinations of interventions related to our research questions (likely to be two or maybe three sites). Site selection will be driven by the results of the stakeholder survey and pragmatic concerns. Issues to consider include: focusing on sites which are addressing the questions we are researching in relatively novel, unexplored and/or promising ways; not overlapping with sites that other teams are researching (i.e. coordination).

The “deep dives” would be implemented through a combination of document reviews (CLAHRCs own documents/grey literature); interviews (semi-structured, either face-to-face or telephone), and on-site workshops. The interviews will help refine the task 1 survey results by enriching earlier findings with more contextual data, and test the views/approaches of the selected CLAHRC against the perspectives of other CLAHRCs (based on survey results). The CLAHRCs documentation and interviews will set the scene for the workshops. The workshops would need to bring together representatives of multiple partners in a CLAHRC and attendants should come from different levels of the CLAHRC’s hierarchy. The workshops would focus on understanding the implicit assumptions and causal mechanisms at play in the CLAHRCs, as they relate to our research questions. They will focus not only on ‘the what’, but in depth on the how, why and ‘so what’/effects.

The key steps in task 2 include:
Deep dive site document reviews
Interview template development
Interview conduct
Interview transcription
Workshop preparation
Workshop delivery
Administration related to workshop organisation
Analysis and synthesis of interview and workshop data
Internal reflection and learning workshop
A brief executive summary to use in soliciting validation interviews in task 3
Advisory Board meeting

**Task 3: Validation stage (from November 2011 to June 2012)**

The findings from our deep dives would be further enriched by a validation interview round with all (willing participant) CLAHRCs to test what emerged for transferability and generalisability, and to refine our insights further. We may also interview external stakeholders to get their views on our findings. In addition to interviews, this stage of the work will also include a review of all CLAHRCs’ relevant documentation to supplement our interview findings.

The key steps in task 3 include:

- A review of relevant documents produced by all CLAHRCs
- Interview administration (soliciting participants)
- Telephone validation interviews - template development
- Interview conduct
- Interview transcription
- Analysis of interviews
- Internal team workshop

**Task 4 (led by HERG): The wider translational research and implementation landscape in the UK (and interpretation of phase II findings in this context) (from August 2011 to June 2012)**

In this task, we would produce a review of how CLAHRCs fit into the broader translational research and implementation landscape of the NIHR (and other funders) at present and how they relate to other initiatives. This is a complementary task and will actually be used in the final outputs of phase III. But if possible, we could explore whether and how phase II findings relate to the wider translational research landscape context, and what they imply for it. It may be possible to include some comparative analysis between CLAHRC and non-CLAHRC sites into this.

**Outputs of phase II**

The results of phase two would be communicated through:

- Participation at SDO learning events
- Exec summary of findings for distribution
- Phase II interim report (to be submitted in June 2012)
PHASE III

The third phase will explore the implications of our findings for improving current policy and practice in the establishment of ‘beneficial forward-looking partnerships between universities and their surrounding NHS organisations’, including contributions to increase the capacity of NHS organisations to engage with and apply research (‘absorptive capacity’) and to encourage the effective involvement of patients and the public. We will demonstrate how this adds to, challenges, or reinforces existing international research. Throughout we will seek to work interactively with CLAHRCs to support learning. We will write a Final Report and a short Briefing Document, and will conduct a series of meetings to discuss our findings with policy makers, relevant academics, NHS practitioners and managers, and representatives from patient and public associations. These interactions will be conducted in liaison with SDO. We will hold a final workshop with all CLAHRCs and the SDO to discuss our findings. We will also prepare papers and presentations for peer reviewed journals and conferences, and prepare and present policy-oriented briefings for the Department of Health and organisations such as the Nuffield Trust, funder-oriented material for the funders of medical research (such as NIHR, Wellcome, MRC, The Health Foundation, medical research charities), and management-oriented material for forums such as The NHS Confederation.

The core methods to be used in phase III include workshops and interviews with stakeholders, and triangulation of evidence from previous work packages and the literature. More details on different components and timelines for phase III are provided below:

Preparing and writing Final Report and Briefing Document - (June-November 2012).
Quality Assurance on Final Report and Briefing Document by two peer reviewers - (November 2012).
Final meeting with Advisory Group to discuss findings and dissemination strategy - (October 2012).
Preparing and presenting articles for peer reviewed journals/conferences. (June-December 2012).
Presenting findings to policy makers and policy researchers (DH, NHS Confederation, Nuffield Trust, Health research charities etc) - (June-December 2012).
Workshop with CLAHRCs and SDO to discuss findings - (August-November 2012).
Presentation of final portfolio of work and budget to SDO - (December 2012).
Collaborating with SDO in overall presentation of findings from across the evaluation (August-December 2012).

2 These timelines are currently based on our original timelines for Phase II and could be subject to changes should the tasks in Phase II be delayed by the process of gaining further ethical approval for this study.