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

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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) 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 two we will select four or five types of interventions, based on the degree to which the intervention is innovative, develops new understanding, and is capable of being generalised; and on the extent to which the intervention, if generalised, is likely to have a significant impact. We will then collect detailed evidence to assess the extent to which the intervention is achieving its intended outcomes, the extent to which there are unintended outcomes, and the extent to which we can be certain that the outcomes are causally a result of the intervention. We will build on a case-study approach and primarily use evidence from workshops, key informant interviews and effort-consequence analysis.

In phase three 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 1:
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 1 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 1 include literature review, document review and primary data collection through workshops/interviews with CLAHRCs. More details on different components and timelines for phase 1 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. (May 2010-September 2010).
  - In terms of interviews with each CLAHRC, we will interview approximately 3-4 people per CLAHRC. This is likely to include clinicians, academics, managers, commissioners. The interviews will provide background information on the details of CLAHRC implementation strategies, approaches and activities; why
these were selected to achieve the CLAHRC goals; who will be managing and delivering them, and anticipated milestones and targets for outputs. These insights will guide subsequent workshops.

- 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

- 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 2:**

At the start of Phase 2 we will draw on the analysis from Phase 1, and on CLAHRCs' self-evaluations, to identify the strengths and weaknesses of key strategic approaches to the second translation gap, and any complementarities or conflicts that emerge when different approaches (interventions and combinations of interventions) are implemented together or in parallel. We will then select a limited number (4-5) of case studies of approaches (interventions and/or combinations of interventions) to study in more detail, and develop an evaluation protocol for each. These protocols will include developing a 'thick' description of the approaches and contexts in which they are being used; an analysis of what is required to deliver them (including to the extent possible costs and time commitments); an analysis of processes of implementation; and, where available outcome/consequence data. The selection of cases to study in more detail will depend on findings from phase 1 research. This might include particularly common, innovative and/or promising interventions and combinations of interventions.

For each case study we will also capture more detail about key organisations, the frequency and depth of relationships and interactions, the flow of information and resources, and how continued relationships are sustained and incentivised. We will revisit the logic models behind the approaches, and we will feedback our developing understanding of each approach to the teams concerned. This will be through a formal meeting with key team members, and through informal contacts, in order to validate findings and share learning.

We will also examine 4-5 alternative approaches to CLAHRCs. The selection of alternative approaches will be informed by the emergent findings, implications and lessons learnt from previous phases, from the cross-case study analyses, and discussion with our Advisory Group and the SDO. We are interested in investigating how similar or distinct the alternative interventions and strategies and their effects are, in comparison to those deployed by
CLAHRCs. We would examine the alternative approaches based on the same criteria of efficiency and effectiveness that will be used when evaluating CLAHRCs' strategies and interventions.

The core methods to be used in phase 2 include case studies operationalised via workshops and interviews with stakeholders, qualitative "effort-consequence analysis" (with effort proxied by time and cost commitments when possible), and triangulation of phase 2 findings against information from phase 1 research and the literature. More details of different components and timelines for phase 2 are provided below.

- Select approaches (up to 5) for in-depth evaluation in agreement with Advisory group and SDO. This will involve examining in more detail certain ways of working which will cast light on each of our subsidiary research questions. – (December 2010-March 2011).
- Stakeholder workshops for each case-study engaging key representatives from different stakeholder groups (e.g., academics, clinicians/practitioners, representatives of patients and the public in their professional capacity, commissioners etc; approximately 10 -15 participants). The workshops will allow us to gain more in-depth understanding of logic(s) of intervention and develop a map of processes involved. We will also identify and agree the categories of costs involved in the CLAHRC (e.g., time commitments, financial) - (March-August 2011).
- Selection of alternative approaches (up to 5) in order to examine how the aims of each of the CLAHRC approaches have, or have not, been successfully pursued in alternative approaches - (August 2011).
- Stakeholder workshops examining alternative approaches - (September 2011-November 2011).
- "Effort" estimation activities for models on in-depth sites and comparator sites building on stakeholder workshop and with follow-up interviews (x 8-10). This will include estimations of time commitments, financial inputs and other categories of effort - (September 2011 – November 2011).
- Validation interviews for in-depth case-study and for alternative approach examinations (3 telephone interviews per site, involving a cross section of stakeholders but including researchers, clinicians and service user representatives - (December 2011-February 2012).
- Produce Second Interim Report on emerging findings and discuss with Advisory Group - (March-April 2012).
- Quality Assurance on Second Interim Report by two peer reviewers (April 2012).
- Present emerging findings to SDO and other evaluation teams funded by SDO - (May 2012).

PHASE 3
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 3 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 3 are provided below:

- Preparing and writing Final Report and Briefing Document - (June-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).

Disclaimer

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