PenCLAHRC: the pilot years

A summary of the work of the internal evaluation team

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From the beginning, the CLAHRCs were conceived as local experiments in knowledge translation. Seven of the nine original CLAHRCs each carried out internal evaluations to learn from their respective experiences during the 5-year pilot phase.[1] NIHR also commissioned not one but four national external evaluations to help inform decisions about the future of the CLAHRC programme; one of these included PenCLAHRC.[2] These evaluations were as diverse as the CLAHRCs themselves.

Our design of the internal evaluation of PenCLAHRC was influenced by ideas from exponents of realist evaluation and complexity theory; we also drew on theories of coproduction and risk as our analysis developed. In keeping with its formative nature, we endeavoured to carry out the evaluation in participatory style, involving academic and NHS members of PenCLAHRC in its emergent design - while also being mindful of not over-burdening colleagues in the process.

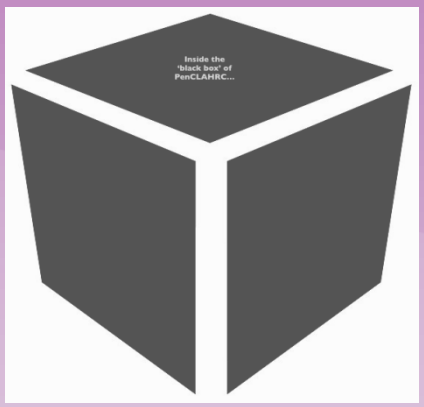
Over the course of the pilot we interviewed stakeholders about their initial expectations for PenCLAHRC, and then again about how they saw it unfolding. We observed and participated in 'learning together' events and other activities. We examined records of the question-generation and prioritisation process and of the managers' regular risk assessments. And around the end of the third year we selected four PenCLAHRC projects as case studies of 'closer collaboration', interviewing those involved to obtain their insights on whether and why they were making good progress or not towards their goals.

Through our work, we were able to contribute to PenCLAHRCs formative years by alerting managers to possible systemic issues and sticking points with the programme's development. We also made a wider contribution by publishing our findings in three articles and contributing to a fourth with co-authors from the internal evaluation teams in the other CLAHRCs.[1, 3, 4, 5]

Key messages

What have we learned? As we all know, achieving knowledge translation is not easy. There is no one pathway to success. But we think that there are some so-called 'simple rules' that, as complexity theorists have described more generally, can help guide us in our collaborative research and so actively shape the outcomes of projects and the environments in which they are situated.

Our five simple rules are listed in Figure 1. They are based on a series of mechanisms that we identified inside the 'black box' of PenCLAHRC as being associated with the more successful projects – depending on the contexts in which participants were working and striving to achieve their project's goals, some of which were more conducive and receptive to their efforts than others.[3]



One PenCLAHRC project that readily achieved its goals was the stroke thrombolysis project. We used this project, which was one of those we examined in depth, as an illustrative case study of the mechanisms of closer collaboration we identified in the wider evaluation. The case study also allowed us to elaborate our idea that the style of collaborative working that was successful in PenCLAHRC was consistent with the principles of coproduction. These principles could, if made explicit, form a strong foundation for future knowledge-based collaborations.[4]

We also learned that the success of the stroke thrombolysis project and other projects in PenCLAHRC was not achieved without taking some risks. Indeed, the strategy taken by the architects of PenCLAHRC – to try and develop a system or model for translating knowledge into practice based on 'Engagement by Design' – was very different from the other CLAHRCs and recognised to be a risky approach from the outset, both in terms of winning the award and then delivering it. In the evaluation, we examined how operational risks were routinely conceptualised and managed using a risk tool as part of our work.[5]

As a small team, we were only able to examine selected aspects of the workings of PenCLAHRC in the pilot phase, and in a limited number of projects. There is obviously a lot more to be learned and we would encourage members to continue to reflect on, learn from and share their experiences of the challenges of tackling knowledge translation in PenCLAHRC.

Figure 1:
Five simple rules based on nine mechanisms (Ms) of closer collaboration

Rule 1: Base applied health research (AHR) on coproduction through closer collaboration	
M1: ***Local end-user driven***	Local end-users are placed at the heart of AHR. They are involved in driving research, so that it focuses on real-life issues that are relevant and important to them, and throughout the research life-cycle
M2: ***Meeting of minds***	End-users and researchers find a common and coherent objective around which they coalesce. Their commitment and enthusiasm is matched with strategic support from their respective organizations
M3: ***Knowledge appetite***	End-users and researchers are open and receptive to melding different forms of knowledge. This includes clinicians' knowledge of routine clinical practice, patients' experiential knowledge, and researchers' methodological expertise. Each recognizes and values what the other partners can contribute
M4: ***Game changers***	End-users and researchers find new and more productive ways of doing and implementing research through working in collaboration. They see wider potential for the new way of working
Rule 2: Establish small strategic teams led by strong facilitative leaders	
M5: ***Facilitative leadership***	Project teams are led by one or more leaders, who are regarded within and outside the team as credible and having real clout, connections, drive, enthusiasm and tenacity. A facilitative style of leadership works well to involve partners, and to co-produce and mobilize knowledge for implementation
M6: ***Small strategic core***	Project teams are formed around a small strategic core of end-users and researchers from the partner organizations involved in the project
Rule 3: Harness and develop respective assets	
M7: ***Creative assets***	Partners harness existing and build up new assets to facilitate the conduct and implementation of AHR. "Assets" include: people with particular knowledge and skills; continuing professional development opportunities; routine data; Web sites for sharing learning; publications
Rule 4: Promote relational adaptive capacity	
M8: ***Relational adaptive capacity***	Learning from local AHR is actively shared with and adapted to kindred settings or populations in other areas (locally, nationally, internationally)
Rule 5: Remember – the end-user is King!	
M9: ***End-user is king!***	Partners recognize that the key change agents are not the program "makers and shakers" and the strategies they introduce but rather the agents on the ground and how they respond to the opportunities afforded by the program to change how AHR is routinely carried out and implemented

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