Enabling collaborative health research

A qualitative longitudinal study of a large-scale co-production programme

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Not basic science or early stage innovation

University, NHS, third sector, industry, patients and the public

NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester

~3m population, lots of health challenges, health budget to be devolved from 2016

Initial theoretical framework

- Co-operative inquiry
- Internal evaluation

PARIHS Framework

Model for Improvement

Multiprofessional implementation teams

Evaluation & Learning

- Evidence
- Facilitation
- Context

with Plan-Do-Study-Act cycles

with designated roles

(Harvey et al. 2011)

Designing a CLAHRC

Large-scale knowledge mobilisation programme

Research

Implementation

- *How to design a CLAHRC?*
- *How to ensure that the whole is more than the sum of its parts?*
- *How to fill the 'designated' roles in multiprofessional teams?*

Evolution of CLAHRC Greater Manchester

1. From the separation of 'research' and 'implementation' towards their integration and co-production
2. From a number of bounded silos towards enabling the 'cross-cutting' way of working
3. From a relatively rigid structure towards a flexible framework that can be modified depending on the needs of specific projects
4. From individual knowledge brokering roles towards collective brokering performed by multi-professional teams

What enabled these changes?

- ***Actionable knowledge***—implementable by the users whom it is intended to engage

Reflexivity—a dynamic interaction between reflection and action with an intention to learn and to change

Concrete Experience → Reflective Observation → Abstract Conceptualization → Active Experimentation → Concrete Experience

CLAHRC structure (2008-2011)

Four research themes

People with long-term conditions

Heart disease

Diabetes

Kidney disease

Stroke

Practitioners

Systems

Services

Four implementation teams, each including...

...knowledge brokers

...clinical lead

...academic lead

...data analyst

...manager

Reflections on initial structure

- Strong boundaries between and within the themes (Kislov, 2014)
- More clinical input needed into knowledge brokering

...knowledge brokers

...clinical lead

...academic lead

...data analyst

...manager

CLAHRC structure (2011-2013)

Partial loss of funding

Implementation team

- Trying to bridge the boundaries between research and implementation
- Integration of the implementation theme
- Seconding clinicians to the implementation projects to support knowledge brokering

Clinical knowledge brokers

CLAHRC structure (2014-2015)

- Most projects combine research AND implementation
- Multi-professional project teams including:

...researchers

...managers

...facilitators

- Knowledge brokering shared by the team members
- Most staff works across several projects and networks
- Hybrid roles *('research-savvy implementers and implementation-savvy researchers')*

Stakeholder engagement

Capacity development

Learning and evaluation

Primary Care

Community Services

Patient-Centred Care

CLAHRC structure (2016-2017)

Enabling network

Cross programme research

Kidney health

Organising healthcare

Wound care

End of Life

Exploiting technologies

Stroke

Stakeholders, people, learning

- Strengthening cross-project research
- Flexible approach to team staffing depending on project needs
- Recognition that there are different TYPES of knowledge mobilisation projects

External review!

Sources of actionable knowledge

- Strategic meetings at different organisational levels
- Feedback from staff (away days, workshops, informal discussions)
- Systematic evaluation of CLAHRC projects
- Advisory Panel Review
- External CLAHRC evaluations (somewhat limited value in terms of 'actionable knowledge')
- Internal cross-project research into knowledge mobilisation

Context!!!

External facilitation!

Concrete Experience → Reflective Observation → Abstract Conceptualization → Active Experimentation → Concrete Experience

Organisational reflexivity

Enablers

Leadership and management

- openness to critique
- investing time and resources into reflection
- creating effective feedback mechanisms
- giving staff an opportunity to shape things

Culture

- 'critique culture'—rather than 'blame culture'
- shared sense of belonging to the organisation

External stimuli

often help to trigger reflection and action

Lessons learnt

- Reflexivity can be painful:
  - Realising some of the previous decisions were wrong
  - Critique can be taken by some individuals too personally
  - Individual reflexive abilities differ!

- Taking into account multiple (and often competing) points of view
  - Professional and epistemic differences
  - Internal evaluation too 'rosy' while research too 'critical'
  - Finding the balance and making decisions!

- Context can significantly constrain action
  - ...and it often changes quickly and unpredictably

- Cross-cutting structures do not always function as intended
- Structure should FOLLOW function

- Knowledge mobilisation approaches evolve in the process of their implementation:
  - Adaptation
  - Distortion

Eight years later...

- Limited relevance for research co-production...
- ...But the PDSA logic is embedded in reflexivity

PARIHS Framework

Model for Improvement

Multiprofessional teams

Evaluation & Learning

- Explanatory framework
- Its main premises inform our thinking
- Fundamental to our design
- Became more inclusive
- Grown in importance

The 'practical reality' of co-production in collaborative health research

We all want to **make a difference!**

There are multiple competing views about how to make a difference

Co-production approaches evolve over time

Both structure and function are important

Reflect and act!

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