Working in a System-Level knowledge Mobilisation Initiative:

Experience and reflections on the first 5 years in the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester

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Outline of presentation

- Some background on CLAHRCs
- The Greater Manchester CLAHRC
- Experiences
  - Project level
  - Overall CLAHRC level
- Reflections
  - Realising the benefits of the collaboration
  - Boundaries
  - Organisational design features
  - Internal and external knowledge mobilisation

CLAHRCs

- First established in 2008 as partnerships between universities and local health service providers
- Competitive bidding process
- 9 CLAHRCs funded 2008 to 2013
- Second round funded from January 2014; 13 in total

CLAHRC objectives

- Conduct high quality applied health research
- Implement the findings from research in clinical practice
- Increase the capacity of NHS organisations to engage with and apply research

Greater Manchester CLAHRC (2008-2013)

- A collaboration between the University of Manchester and 19 NHS organisations
  - 10 primary care, 5 acute, 3 mental health, 1 ambulance
- Focus on cardiovascular health
- Total of £20 million funding over 5 years
  - £10 million from the National Institute for Health Research; £10 million matched funding from local primary care organisations

CLAHRC structure

Hosted by an NHS organisation
University Director and Deputy Director
Stakeholder board
Mix of university and NHS employees (new and seconded)

Research Theme

- People with long-term conditions
- Practitioners
- Services
- Systems

Implementation theme

- Stroke
- Heart failure
- Chronic kidney disease
- Diabetes

Examples of research studies

- PLANS study: Development of a Patent-Led Assessment for Network Support
- BRIGHT study: Bringing Information and Guided Help Together (for self-management of people with CKD)
- COINCIDE trial: evaluating the effectiveness and cost-effectiveness of collaborative care in treating symptoms of depression in patients with coronary heart disease and/or diabetes

Implementation Programme

- Initial plan: years 1-2 focus on implementing existing evidence; years 3-5 implementing evidence produced by research themes
- Designing an implementation framework
- Applying the framework across a number of projects
- An example from the Chronic Kidney Disease (CKD) project

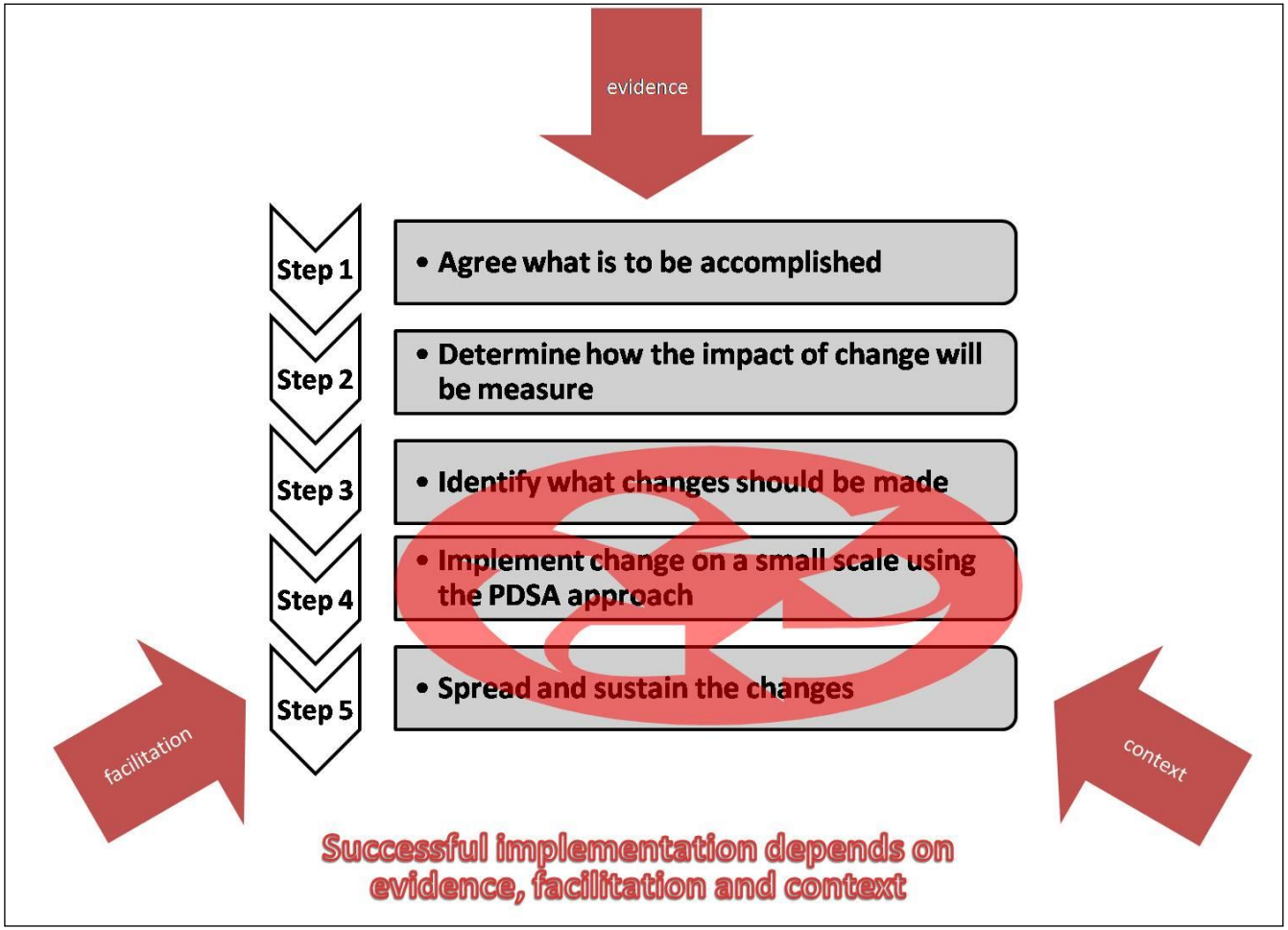
Evidence-informed approach to implementation

- Evidence is broader than research
- Good research is not enough to guarantee its uptake in practice
- Rational/linear models are inadequate in planning and undertaking implementation
- Acknowledgement of and responsiveness to the context of implementation
- Need for tailored, multi-faceted approaches to implementation
- Importance of forming networks and building good relationships
- Individuals are needed in designated roles to lead and facilitate the implementation process
- Integrated approach to the production and use of evidence about implementation

Building blocks of the implementation framework

- The PARIHS framework as an underpinning conceptual model representing the complexity of implementation and the interplay of evidence, context and facilitation (Kitson et all 1998 and 2008)
- A modified version of the Model of Improvement, providing an actionable set of steps for implementation, with inherent flexibility (Langley et al, 1996)
- Multi-professional teams with designated roles to lead, influence and guide the process of implementation
- Embedded evaluation and learning, in the form of cooperative inquiry and internal evaluation

The implementation framework



Illustrating implementation in action: the CKD project

- Starting point: 2% difference between predicted and actual prevalence on GP practice registers; 30% of patients on practice registers estimated to have suboptimal management
- 4 building blocks used to design an improvement collaborative
- Implemented with 30 GP practices over 2 time periods
- Key elements of intervention: learning events; agreed improvement targets; local context assessment; PDSA cycles; monthly data submission, feedback and benchmarking; external facilitator support; staff time reimbursement; formative evaluation

Outcome evaluation

- Evaluation against two indicators:
  - Number of CKD patients on practice register
  - %age of patients on register achieving NICE blood pressure targets
- Participating practices recorded an increase of 30% (n=1863) of patients with CKD; management of BP improved (34 to 74% phase1; 58 to 83% phase 2)

Figure 1: Change in recorded prevalence by month

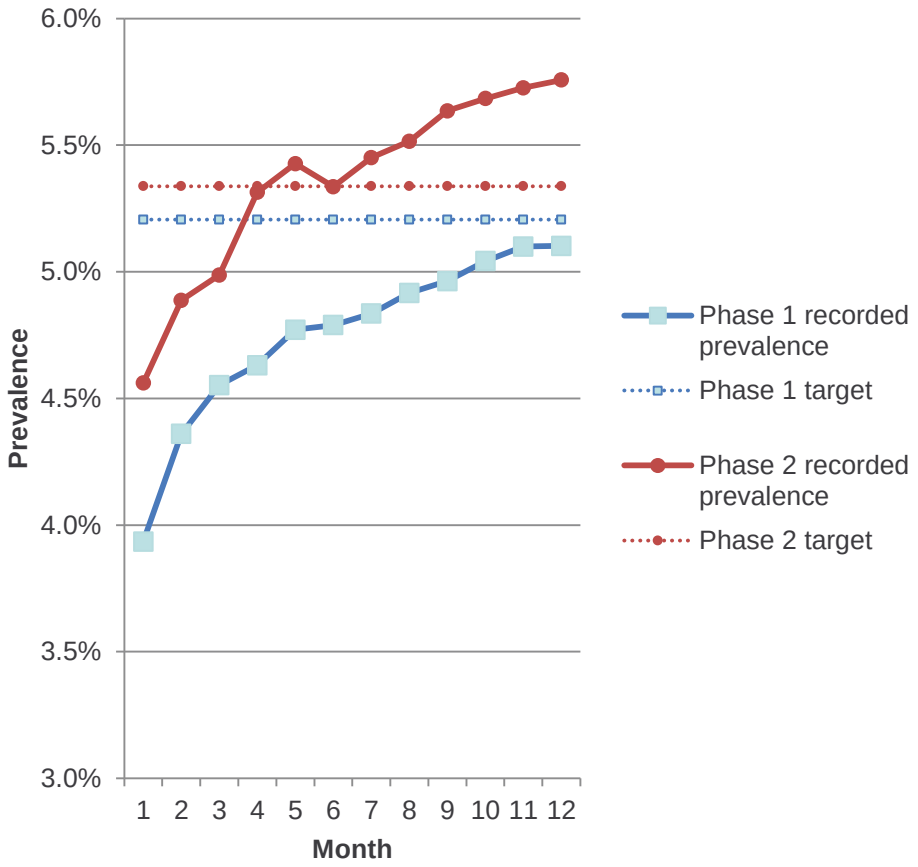
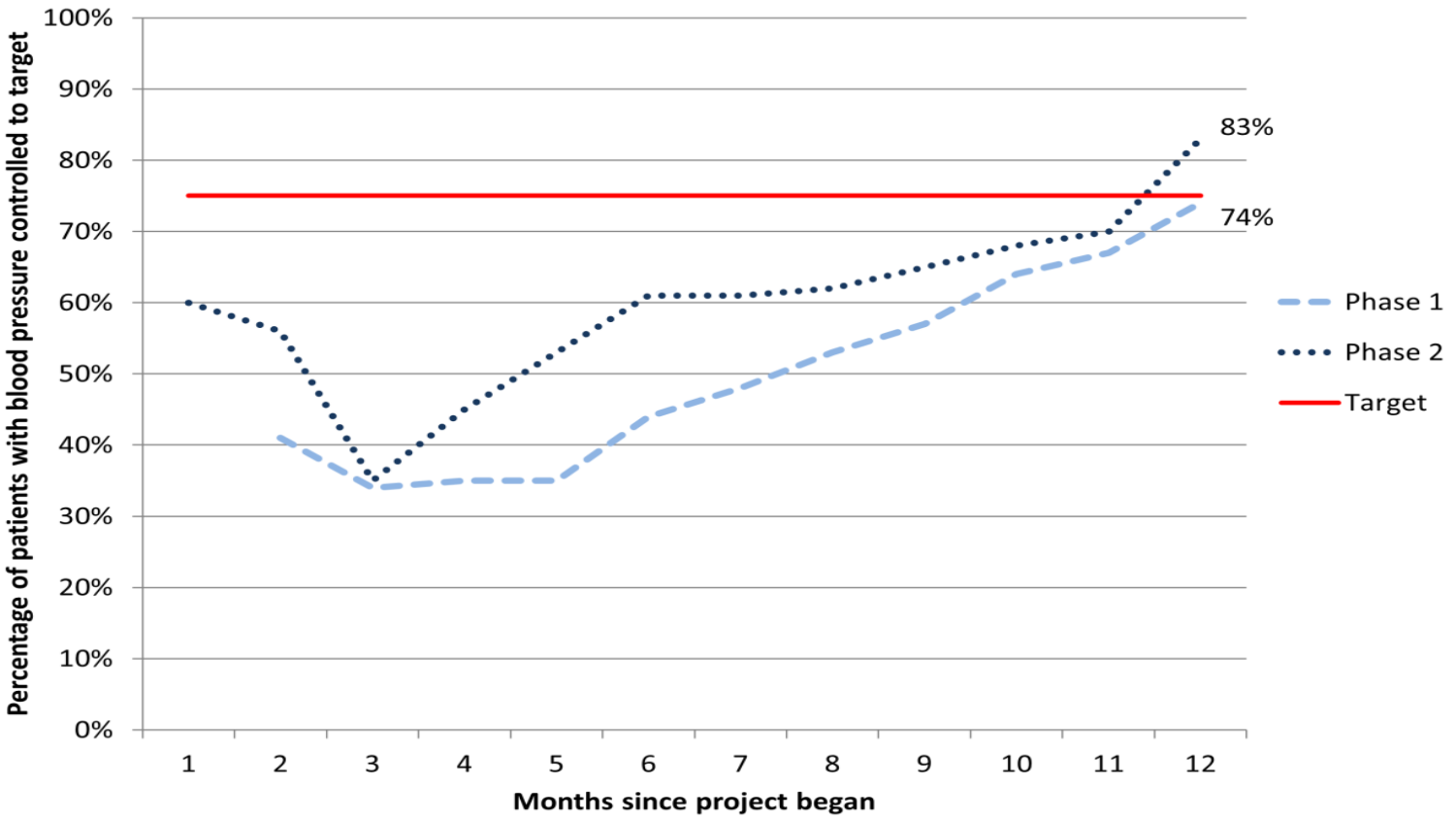


Figure 2: Percentage of CKD patients with blood pressure managed to NICE targets by month



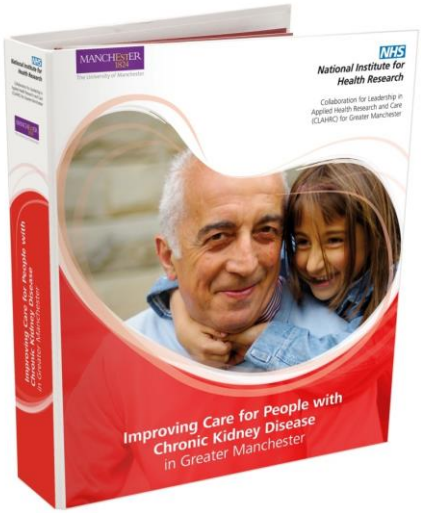
Process evaluation

- Considerable variation between practices
- Key process factors:
  - Support of CLAHRC facilitators +
  - Clearly defined targets +
  - Regular data feedback +
  - Financial reimbursement +
  - CKD data extraction from practice register -
  - Priority attached to topic of CKD +/-
  - Senior leadership support +/-
  - Practice receptiveness to innovation +/-
  - Engagement of whole practice team +/-

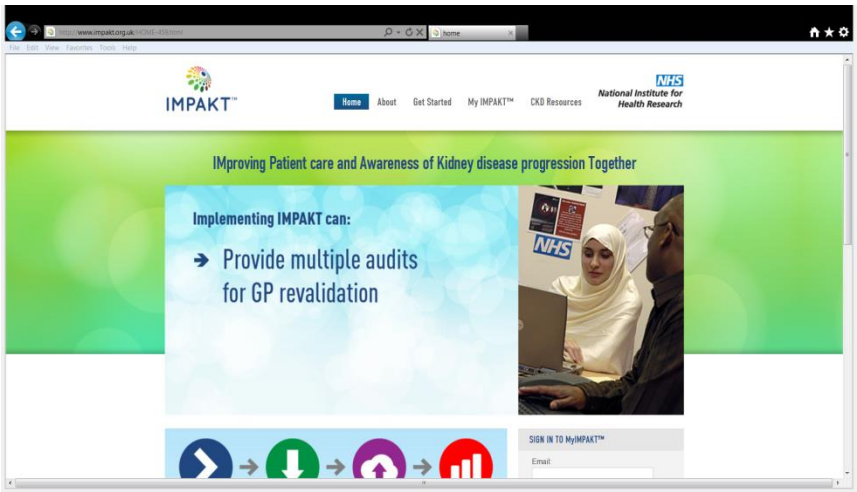
Financial cost	Approx. average cost per practice (£)	
	Phase1	Phase 2
Practice payments: Buy out of staff time for project work and attendance at learning sessions Staged payment for achieving key project milestones and targets (Phase 1)	8525	1251
Collaborative learning events: three learning sessions (full day phase 1; half-day phase 2), plus final summit meeting	797	197
External support team: Phase 1 – 2 CLAHRC improvement facilitators; half-time programme manager; half-time information analyst; clinical and academic lead support time; administrative support Phase 2 – 2 CLAHRC improvement facilitators (1 CLAHRC and 1 part-time practice nurse secondee; part-time project manager; (reduced) clinical and academic lead support time; administrative support	11310	8603
TOTAL	**20632**	**10051**

Building on evaluation findings

- Design of a CKD improvement guide



- Collaboration with a second CLAHRC to develop IMPAKT™



Generating research questions

- How to disclose information to patients with CKD who are unaware of their condition?
- BRIGHT trial (Bringing Information and Guided Help Together for self-management of people with CKD) information leaflet

From project level to overall CLAHRC level evaluation

- Multiple examples of project level success
- **BUT** ….. Is there evidence of network effectiveness? Has the CLAHRC been able to leverage the benefits of collaboration?

Is the whole greater than the sum of the parts?

Areas of analysis

- Accountability, decision making and inclusivity
- Communication and internal knowledge sharing
- Processes and outcomes in knowledge mobilisation

The first 5 years: some concluding thoughts

- Need for negotiation and clarity about network membership, purpose and goals
- Attention to issues of structure and governance
- Better understanding, assessment and management of boundaries
- Aligning the organisational design to the overall goals of the CLAHRC
- Attention to both internal and external knowledge mobilisation

Acknowledgements

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