Evaluation of the NIHR CLAHRCs and publication of results: A brief reflection

Roman Kislov and Ruth Boaden, Manchester Business School

5th January 2015

This document presents a brief summary of the themes emerging from the growing body of research into the activities of the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care (NIHR CLAHRCs). To date, this research has focused on the pilot CLAHRCs (2008-2013) and it is anticipated that more work is still to be published from these, as well as evaluation of the new CLAHRCs funded from 2014-2018.

Background

The 'pilot' CLAHRCs (2008-2013) were evaluated in a range of ways. There were four independent research projects commissioned and funded by the NIHR (then) Service Delivery and Organisation (SDO) programme – which is now the NIHR Health Services and Delivery Research (HS&DR) programme. These are detailed in Appendix 1, and two of the four final reports from these studies are now published. In addition, journal papers have also been published as a result of these evaluations.

Most CLAHRCs also carried out their own evaluations on a range of aspects of CLAHRC operation, which again led to publication in many cases. It therefore seemed appropriate to identify and analyse academic publications resulting from the evaluation of CLAHRC activity, along with any relevant publicly available reports.

Methods

Using 'CLAHRC(s)' and 'Collaboration(s) for Leadership in Applied Health Research and Care' as search terms on Google Scholar, we identified 34 papers that fulfilled at least one of the following inclusion criteria:

(a) empirical and conceptual papers discussing the activities of the CLAHRC(s) as a novel organisational form;
(b) empirical and conceptual papers drawing on external and internal evaluations of CLAHRC(s);
(c) theory-focused empirical papers using the CLAHRC(s) as a research setting.

Six papers were excluded from the analysis because they represented either *programme protocols* describing the approaches to knowledge mobilisation taken by individual CLAHRCs as envisaged at the beginning of the first five-year funding cycle (2008-2013) (Baker *et al.*, 2009, Harvey *et al.*, 2011, Mawson and Scholefield, 2009, Rowley *et al.*, 2012) or *study protocols* of external (Rycroft-Malone et al., 2011) and internal (Rowley, 2012) CLAHRC evaluations.

The remaining 28 papers (listed in alphabetical order in Appendix 2, with links and abstracts/excerpts provided, including any reference to practical implications from the studies) were analysed to identify main themes.

We also attempted to identify any other 'grey' literature through CLAHRC websites (where they still existed) in case internal evaluations had been made available in this format. Only one was identified: the Executive summary of an internal evaluation report from the CLAHRC for South Yorkshire (CLAHRC SY) (Ariss *et al.*, 2012). We also draw on a Briefing Paper developed by the CLAHRC Directors partway through the pilot period (NHS Confederation, 2012).

Results

The publications can be classified into the following seven groups:

1. *Papers reporting on the four external HS&DR-commissioned evaluations of the CLAHRCs* (Ling *et al.*, 2011, Lockett *et al.*, 2014, Rycroft-Malone *et al.*, 2011, Scarbrough *et al.*, 2014)—see also Appendix 1—*or on several internal CLAHRC evaluations;* all of these papers draw their conclusions from the analysis of more than one CLAHRC.

   Martin et al. (2011) identify *challenges of evaluating the CLAHRCs* (evaluating disparate, developing activities; evaluating the right things at the right time; evaluating neutrally and contributing formatively; evaluating sustainability of change; dealing with the NHS governance issues; balancing the evaluation work with other responsibilities within the CLAHRC; overburdening and over-studying the CLAHRC staff).

   Drawing on the comparison of all nine CLAHRCs, Oborn et al. (2013) identify five different *knowledge translation 'archetypes'* representing different ways of achieving the balance between research production and research implementation. According to Soper et al. (2013), *key features* of the CLAHRCs include a range of knowledge mobilisation approaches, efforts to promote cultural change and freedom to experiment, learn and adapt whereas Rycroft-Malone et al. (2013) identify collaborative action, relationship building, engagement, motivation, knowledge exchange and learning as *key mechanisms* important to the processes and outcomes of CLAHRC activity.

   Interestingly, a number of papers from this group highlight the influence of CLAHRC *senior leaders* and their networks on the CLAHRC strategy. Senior leaders and managers play an important formative role in selecting, enacting and interpreting different knowledge mobilisation practices (D'Andreta et al., 2013). Involving well-known clinical academics and relying on existing relationships may help early mobilisation but may restrict the development of novel, integrated approaches to the production and implementation of applied health research (Currie et al., 2013). In the light of these findings, CLAHRC leaders need to be aware of system-level issues, to be able to work across professional and organisational boundaries, to be embedded in existing power structures and to be willing to change such structures (Lockett et al., 2014).

2. *Papers exploring 'boundaries' within the CLAHRCs.* Kislov et al. (2012) describe inter-organisational boundaries between general practices and their implications for knowledge mobilisation in primary care; Kislov (2014) analyses the boundary between the research and implementation activities within one of the CLAHRCs; Currie et al. (2014) describe epistemic differences and power struggles unfolding between health services researchers and organisation scientists in relation to the CLAHRC activities; Evans and Scarbrough (2014) focus on the differences between 'bridging' and 'blurring' approaches to boundary-spanning.

   Whilst the main purpose of these papers is to develop the theory around the concepts of boundaries and boundary spanning, some useful practical implications can also be drawn. CLAHRCs should 'diagnose' the existing professional and organisational context when implementing knowledge mobilisation projects (Kislov et al., 2012), actively facilitate the negotiation of concepts, approaches, and objectives that are interpreted in conflicting ways by different groups, create incentives to support productive joint working, and articulate the overarching goals and philosophy of a collaborative enterprise at early stages (Kislov, 2014). Drawing on the internal evaluation of CLAHRC for Leicestershire, Northamptonshire and Rutland (CLAHRC LNR), Martin et al. (2013) demonstrate that deep-seated institutional divisions between CLAHRC members were overcome by concerted action resulting from the *External Advisory Review* (Øvretveit et al., 2010). This challenge was also highlighted in the NHS Confederation (2012) briefing, described there as 'overcoming institutional inertia … having to reconcile multiple languages, multiple viewpoints and disparate priorities in a quest for mutual understanding.'

3. *Papers exploring knowledge brokering and 'hybrid' roles within the CLAHRCs.* Although these roles are seen as a promising solution to the problem of bridging the second translational gap (Currie et al., 2010, Harvey et al., 2011, Kislov et al., 2011, Rowley, 2012, Rowley et al., 2012), CLAHRC-based research has highlighted the that there is often lack of support and recognition for these roles at an organisational level (Chew et al., 2013, Wright, 2013), that formidable professional boundaries, existing organisational norms and lack of institutionalised career pathways for knowledge brokers may make such roles difficult to sustain in the longer term (Chew et al., 2013), and that the potential of formalised knowledge brokering roles can be decreased by over-formalisation, infrequency of interaction, competition for recognition and resources, low trust and lack of rewards (Kislov, 2014). In their evaluation report, Scarbrough et al. (2014) also show that in more decentralised structures, confusion of role specifications may limit the effectiveness of knowledge brokering roles. Finally, at an individual level of analysis, Spyridonidis et al. (2014) describe differing responses to taking on a hybrid physician-manager roles in the CLAHRC and identify the groups of 'innovators', 'sceptics' and the 'late majority'.

4. *Papers concerned with particular knowledge mobilisation activities undertaken by individual CLAHRCs.* Those papers taking a more descriptive approach covered activities including: interprofessional learning in CLAHRC LNR (Sinfield et al., 2012), co-production of research in CLAHRC for Birmingham and Black Country (CLAHRC BBC) (Hewison et al., 2012), priority-setting in CLAHRC for South West Peninsula (PenCLAHRC) (Whear et al., 2012) and developing 'communities of practice' in CLAHRC for Nottinghamshire, Derbyshire and Lincolnshire (CLAHRC NDL) (Thomson et al., 2013). In a more critical paper underpinned by the PARIHS framework

(Kitson *et al.*, 1998), Tierney et al. (2014) explore the dynamic relationship between facilitation and context in one of the CLAHRC for Greater Manchester (CLAHRC GM) implementation projects. Ariss et al. (2012) report data from an internal evaluation conducted in CLAHRC SY which considered a range of issues including context, priority setting, and outcomes and impact. They identify implications and recommendations for each of these areas, planning, for instance, to explore in future why participation and collaboration is more or less successful and determine what sustains engagement but, as this is an internal paper, the generalisability of the detail is somewhat limited.

5. *Papers exploring capacity building* describe the potential of the CLAHRCs to develop research capacity for nursing (Gerrish, 2010), identify the criteria for judging the success of secondment arrangements within the CLAHRC SY (Gerrish and Piercy, 2014) and offer a novel conceptual framework for building knowledge mobilisation capabilities in healthcare organisations (Kislov et al., 2014).

6. *Papers exploring patient and public involvement (PPI)* describe how patients used elements of organisational culture to collaborate healthcare professionals (Renedo et al., 2014), how patients' views on PPI differ from those of healthcare professionals (Marston and Renedo, 2013) and how the analysis of roles, relations and responsibilities between researchers and service users may help ensure that patients' expectations in relation to PPI match their actual experiences (Jordan et al., 2014). None of the external evaluations published to date has a focus on PPI.

7. *Papers exploring the CLAHRCs as a whole from a particular theoretical standpoint.* Kislov et al. (2011) theorise the CLAHRCs from the 'communities of practice' perspective while Caldwell et al. (2012) use a macro, meso and micro frame analysis to empirically explore the translation of the national-level understanding of the aims and objectives in the CLAHRCs is translated into local implementation in the CLAHRC for North West London (CLAHRC NWL). Currie et al. (2010) conceptualise the CLAHRCs from an organisational behaviour viewpoint and highlight potential challenges to enacting knowledge brokering roles; the inconsistency of policy in its support for CLAHRCs and the need to move from relying on the single 'clinical champion' to engaging a wide range of stakeholders at different levels.

Conclusions

Much of the published material based on the evaluation of the CLAHRC to date has been focused on the advancement of theory - boundaries, hybrid roles, knowledge brokering, and institutional entrepreneurship. Given the interests of the teams involved in the external evaluations, we anticipate that future papers based on this data are likely to be focused in similar areas. It may become more difficult to identify whether a theory-based paper has used data from CLAHRCs if the sources are anonymised; our search may have missed some of the relevant papers if authors have replaced the term 'CLAHRC(s)' by generic terms (such as 'collaboration' or 'partnership').

The relative lack of data about practical implications for those who are actually 'doing' CLAHRC business is notable, not least because the developing academic literature (where this might not be

expected to constitute a key element) does not appear to be supplemented by publicly accessible grey literature with a more pragmatic focus. The benefit to practice of the large funding invested in evaluation of the pilot CLAHRCs by HS&DR is not evident from this analysis in terms of outputs or timing, given that the second round of CLAHRC funding was awarded in 2013, before any of the reports were published.

Some topics received relatively little attention: PPI, sustainability of change, collaboration between the CLAHRCs, managing the boundaries between the CLAHRCs and its various partner organisations. The Directors of the pilot CLAHRCs (NHS Confederation, 2012) identified challenges from their perspective which have not been given attention to date in evaluation as far as this analysis can identify, including maintaining matched funding resources, ensuring that the full range of NHS staff are engaged and the need to demonstrate academic outputs as well as improvements in care.

If evaluation is to be helpful to those involved in CLAHRCs, as well as developing new knowledge and research outputs, the implications of this analysis should be taken into account. Given that the next round of CLAHRC funding is already underway (2014-2018) and that there are no large national evaluations currently planned, to our knowledge, this puts the onus on the CLAHRCs themselves to design and conduct rigorous and 'useful' local evaluations on issues of common interest, if learning is to be shared and benefit all.

References

Ariss, S., Cooke, J., Smith, C., Reed, J. & Nancarrow, S. 2012. *NIHR CLAHRC for South Yorkshire Internal Evaluation Report November 2011: Executive Summary* [Online]. Sheffield: NIHR CLAHRC SY. Available: http://clahrc-sy.nihr.ac.uk/resources/toolkits/NIHR%20CLAHRC%20SY%20Internal%20Evaluation_Exec%20summary_10062013.pdf [Accessed 05/01/2015].

Baker, R., Robertson, N., Rogers, S., Davies, M., Brunskill, N., Khunti, K., Steiner, M., Williams, M. & Sinfield, P. 2009. The National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Leicestershire, Northamptonshire and Rutland (LNR): A programme protocol. *Implementation Science,* 4**,** 72.

Caldwell, S.E. & Mays, N. 2012. Studying policy implementation using a macro, meso and micro frame analysis: the case of the Collaboration for Leadership in Applied Health Research & Care (CLAHRC) programme nationally and in North West London. *Health Research Policy and Systems,* 10**,** 32.

Chew, S., Armstrong, N. & Martin, G. 2013. Institutionalising knowledge brokering as a sustainable knowledge translation solution in healthcare: How can it work in practice? *Evidence & Policy,* 9(3)**,** 335-351.

Currie, G., El Enany, N. & Lockett, A. 2014. Intra-professional dynamics in translational health research: The perspective of social scientists. *Social Science & Medicine,* 114**,** 81-88.

Currie, G., Fitzgerald, L., Keen, J., McBride, A., Martin, G., Rowley, E. & Waterman, H. 2010. An organizational behaviour perspective upon CLAHRCs (Collaboratives for Leadership in Health Research and Care): Mediating institutional challenges through change agency. Available: http://www.download.bham.ac.uk/hsmc/graeme-currie.pdf [Accessed 05/01/2015].

Currie, G., Lockett, A. & El Enany, N. 2013. From what we know to what we do: lessons learned from the translational CLAHRC initiative in England. *Journal of Health Services Research & Policy,* 18(3 suppl)**,** 27-39.

D'Andreta, D., Scarbrough, H. & Evans, S. 2013. The enactment of knowledge translation: A study of the Collaborations for Leadership in Applied Health Research and Care initiative within the English National Health Service. *Journal of Health Services Research & Policy,* 18(3 suppl)**,** 40-52.

Evans, S. & Scarbrough, H. 2014. Supporting knowledge translation through collaborative translational research initiatives: 'Bridging' versus 'blurring' boundary-spanning approaches in the UK CLAHRC initiative. *Social Science & Medicine,* 106**,** 119-127.

Gerrish, K. 2010. Tapping the potential of the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care (CLAHRC) to develop research capacity and capability in nursing. *Journal of Research in Nursing,* 15(3)**,** 215-225.

Gerrish, K. & Piercy, H. 2014. Capacity Development for Knowledge Translation: Evaluation of an Experiential Approach through Secondment Opportunities. *Worldviews on Evidence-Based Nursing,* 11(3)**,** 209-216.

Harvey, G., Fitzgerald, L., Fielden, S., McBride, A., Waterman, H., Bamford, D., Kislov, R. & Boaden, R. 2011. The NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester: Combining empirical, theoretical and experiential evidence to design and evaluate a large-scale implementation strategy. *Implementation Science,* 6**,** 96.

Hewison, A., Gale, N. & Shapiro, J. 2012. Co-production in research: some reflections on the experience of engaging practitioners in health research. *Public Money & Management,* 32(4)**,** 297-302.

Jordan, M., Rowley, E., Morriss, R. & Manning, N. 2014. An analysis of the Research Team–Service User relationship from the Service User perspective: a consideration of 'The Three Rs' (Roles, Relations, and Responsibilities) for healthcare research organisations. *Health Expectations,* published online before print.

Kislov, R. 2014. Boundary discontinuity in a constellation of interconnected practices. *Public Administration,* 92(2)**,** 307-323.

Kislov, R., Harvey, G. & Walshe, K. 2011. Collaborations for Leadership in Applied Health Research and Care: Lessons from the theory of communities of practice. *Implementation Science,* 6**,** 64.

Kislov, R., Walshe, K. & Harvey, G. 2012. Managing boundaries in primary care service improvement: A developmental approach to communities of practice. *Implementation Science,* 7**,** 97.

Kislov, R., Waterman, H., Harvey, G. & Boaden, R. 2014. Rethinking capacity building for knowledge mobilisation: Developing multilevel capabilities in healthcare organisations. *Implementation Science,* 9**,** 166.

Kitson, A., Harvey, G. & McCormack, B. 1998. Enabling the implementation of evidence based practice: a conceptual framework. *Qual Health Care,* 7(3)**,** 149-158.

Ling, T., Soper, B., Marjanovic, S., Celia, C., Yaqub, O., Reding, A., Milewa, T. & Hanney, S. 2011. *Delivering the aims of the CLAHRCs: evaluating CLAHRCs' strategies and contributions* [Online]. Available: http://www.rand.org/pubs/working_papers/WR820.html [Accessed 05/01/2015].

Lockett, A., El Enany, N., Currie, G., Oborn, E., Barrett, M., Racko, G., Bishop, S. & Waring, J. 2014. A formative evaluation of Collaboration for Leadership in Applied Health Research and Care (CLAHRC): institutional entrepreneurship for service innovation. *Health Services and Delivery Research,* 2(31).

Marston, C. & Renedo, A. 2013. Understanding and measuring the effects of patient and public involvement: an ethnographic study. *The Lancet,* 382**,** S69.

Martin, G.P., McNicol, S. & Chew, S. 2013. Towards a new paradigm in health research and practice?: Collaborations for Leadership in Applied Health Research and Care. *Journal of Health Organization and Management,* 27(2)**,** 193-208.

Martin, G.P., Ward, V., Hendy, J., Rowley, E., Nancarrow, S., Heaton, J., Britten, N., Fielden, S. & Ariss, S. 2011. The challenges of evaluating large-scale, multi-partner programmes: the case of NIHR CLAHRCs. *Evidence & Policy: A Journal of Research, Debate and Practice,* 7(4)**,** 489-509.

Mawson, S. & Scholefield, H. 2009. The national institute for health research; collaboration for leadership in applied health research and care for South Yorkshire. *Journal of Research in Nursing,* 14(2)**,** 169-174.

NHS Confederation. 2012. Integrating research into practice: The CLAHRC experience. *Health Services Research Network Briefing*, June 2012, Issue 245.

Oborn, E., Barrett, M., Prince, K. & Racko, G. 2013. Balancing exploration and exploitation in transferring research into practice: a comparison of five knowledge translation entity archetypes. *Implementation Science,* 8**,** 104.

Øvretveit, J., Lomas, J., Davies, H. & Powell, A. 2010. External Advisory Review of the LNR CLAHRC: Report to the Management Board.

Renedo, A., Marston, C.A., Spyridonidis, D. & Barlow, J. 2014. Patient and Public Involvement in Healthcare Quality Improvement: How organizations can help patients and professionals to collaborate. *Public Management Review***,** published online before print.

Rowley, E. 2012. Protocol for a qualitative study exploring the roles of 'Diffusion Fellows' in bridging the research to practice gap in the Nottinghamshire, Derbyshire and Lincolnshire Collaboration for Leadership in Applied Health Research and Care (CLAHRC-NDL). *BMJ Open,* 2**,** e000604.

Rowley, E., Morriss, R., Currie, G. & Schneider, J. 2012. Research into practice: Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Nottinghamshire, Derbyshire, Lincolnshire (NDL). *Implementation Science,* 7**,** 40.

Rycroft-Malone, J., Wilkinson, J., Burton, C.R., Harvey, G., McCormack, B., Graham, I. & Staniszewska, S. 2013. Collaborative action around implementation in Collaborations for Leadership in Applied Health Research and Care: towards a programme theory. *Journal of Health Services Research & Policy,* 18(3 suppl)**,** 13-26.

Rycroft-Malone, J., Wilkinson, J.E., Burton, C.R., Andrews, G., Ariss, S., Baker, R., Dopson, S., Graham, I., Harvey, G., Martin, G. & others 2011. Implementing health research through academic and clinical partnerships: a realistic evaluation of the Collaborations for Leadership in Applied Health Research and Care (CLAHRC). *Implementation Science,* 6**,** 74.

Scarbrough, H., D'Andreta, D., Evans, S., Marabelli, M., Newell, S., Powell, J. & Swan, J. 2014. Networked innovation in the health sector: comparative qualitative study of the role of Collaborations for Leadership in Applied Health Research and Care in translating research into practice. *Health Services and Delivery Research,* 2(13).

Sinfield, P., Donoghue, K., Horobin, A. & Anderson, E.S. 2012. Placing interprofessional learning at the heart of improving practice: the activities and achievements of CLAHRC in Leicestershire, Northamptonshire and Rutland. *Quality in primary care,* 20(3)**,** 191-198.

Soper, B., Yaqub, O., Hinrichs, S., Marjanovich, S., Drabble, S., Hanney, S. & Nolte, E. 2013. CLAHRCs in practice: combined knowledge transfer and exchange strategies, cultural change, and experimentation. *Journal of Health Services Research & Policy,* 18(3 suppl)**,** 53-64.

Spyridonidis, D., Hendy, J. & Barlow, J. 2014. Understanding hybrid roles: The role of identity processes amongst physicians. *Public Administration,* published online before print.

Thomson, L., Schneider, J. & Wright, N. 2013. Developing communities of practice to support the implementation of research into clinical practice. *Leadership in Health Services,* 26(1)**,** 20-33.

Tierney, S., Kislov, R. & Deaton, C. 2014. A qualitative study of a primary-care based intervention to improve the management of patients with heart failure: The dynamic relationship between facilitation and context. *BMC Family Practice,* 15**,** 153.

Whear, R., Thompson-Coon, J., Boddy, K., Papworth, H., Frier, J. & Stein, K. 2012. Establishing local priorities for a health research agenda. *Health Expectations,* published online before print.

Wright, N. 2013. First-time knowledge brokers in health care: the experiences of nurses and allied health professionals of bridging the research-practice gap. *Evidence & Policy,* 9(4)**,** 557-570.

Appendix 1. NIHR-funded evaluations of CLAHRCs

Principal Investigator	Title	Years and funding	NIHR HS&DR programme page	Final report	Outputs (see reference list)
Prof Andy Lockett	HS&DR - 09/1809/1073: A formative evaluation of Collaboration for Leadership in Applied Health Research and Care (CLAHRC): institutional entrepreneurship for service innovation	2009-2012 £550,000	http://www.nets.nihr.ac.uk/projects/hsdr/0918091073	http://www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-31	Currie et al (2013) Currie et al (2014) Oborn et al (2013)
Prof Harry Scarborough	HS&DR - 09/1809/1075: Networked innovation in the health sector: comparative qualitative study of the role of Collaborations for Leadership in Applied Health Research and Care in translating research into practice	2010-2013 £575,000	http://www.nets.nihr.ac.uk/projects/hsdr/0918091075	http://www.journalslibrary.nihr.ac.uk/hsdr/volume-2/issue-13	D'Andreta et al (2013) Evans and Scarbrough (2014)
Prof Jo Rycroft-Malone	HS&DR - 09/1809/1072: Collective action for knowledge mobilisation: a realist evaluation of the Collaborations for Leadership in Applied Health Research and Care	2010-2014 £600,000	http://www.nets.nihr.ac.uk/projects/hsdr/0918091072	Protocol was published: Rycroft-Malone et al (2011) Final report waiting to publish – due May 2015	Rycroft-Malone et al (2013)
Dr Ellen Nolte	HS&DR - 09/1809/1074: Narrowing the second translation gap: evaluating CLAHRCs' potential, strategies and contributions	2009-2012 £465,000	http://www.nets.nihr.ac.uk/projects/hsdr/0918091074	Interim report on RAND website: http://www.rand.org/pubs/working_papers/WR820.html Final report (NIHR format) waiting to publish – due March 2015	Soper et al (2013)

Appendix 2. Academic outputs

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Caldwell, S. E. and N. Mays (2012). "Studying policy implementation using a macro, meso and micro frame analysis: the case of the Collaboration for Leadership in Applied Health Research & Care (CLAHRC) programme nationally and in North West London." *Health Research Policy and Systems 10*: 32.	Qualitative research in CLAHRC NWL	The goal of this paper is to assess how national-level understanding of the aims and objectives of the CLAHRCs translated into local implementation and practice in North West London. This study uses a variation of Goffman's frame analysis to trace the development of the initial national CLAHRC policy to its implementation at three levels. Data collection and analysis were qualitative through interviews, document analysis and embedded research. Analysis at the macro (national policy), meso (national programme) and micro (North West London) levels shows a significant common understanding of the aims and objectives of the policy and programme. Local level implementation in North West London was also consistent with these. The macro-meso-micro frame analysis is a useful way of studying the transition of a policy from high-level idea to programme in action. It could be used to identify differences at a local (micro) level in the implementation of multi-site programmes that would help understand differences in programme effectiveness.	http://www.health-policy-systems.com/content/10/1/32
Chew, S., N. Armstrong and G. Martin (2013). "Institutionalising knowledge brokering as a sustainable knowledge translation solution in healthcare: How can it work in practice?" *Evidence & Policy 9*(3): 335-351.	A qualitative case study in an anonymised CLAHRC	In healthcare, translating evidence into changed practice remains challenging. Novel interventions are being used to address these challenges, including the use of 'knowledge brokers'. But how sustainable these roles might be, and the consequences for the individual of enacting such roles, are unknown. We explore these questions by drawing on qualitative data from case studies of full-time roles in research-practice collaboration. We suggest that structural issues around professional boundaries, organisational norms and career pathways may make such roles difficult to sustain in the long term, but highlight interventions that might improve their feasibility.	http://www.ingentaconnect.com/content/tpp/ep/2013/00000009/00000003/art00003
Currie, G., A. Lockett and N. El Enany (2013). "From what we know to what we do: lessons learned from the translational CLAHRC initiative in England." *Journal of Health Services Research & Policy 18*(3 suppl): 27-39.	Qualitative semi-structured interviews with 174 participants across nine CLAHRCs plus in-depth case studies across four CLAHRCs.	Social positions of the CLAHRC leaders, conceived as institutional entrepreneurs, together with the antecedent conditions for CLAHRC bids, had an impact on the vision for a CLAHRC. The process of envisioning encompassed diagnostic and prognostic framing. Within the envisioning process, the utilization of existing activities and established relationships in the CLAHRC bid influenced early mobilization. However, in some cases, it led to a translational 'lock in' towards established models regarding applied research. The CLAHRC experiment in England holds important lessons for policy-makers regarding how to address the translation gap. First, policy makers need to consider whether they set out a defined template for translational initiatives or whether variation is encouraged. We might expect a degree of learning from pilot activities within a CLAHRC that allows for greater clarity in the design of subsequent translational initiatives. Second, policy makers and practitioners need to understand the importance of both antecedent conditions and the social position of senior members of a CLAHRC (institutional entrepreneurs) leading the development of a bid. Whilst established and well-known clinical academics are likely to be trusted to lead CLAHRCs, and the presence of pre-existing organizational relationships are important for mobilization, privileging these aspects may constrain more radical change.	http://hsr.sagepub.com/content/18/3_suppl/27.short

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Currie, G., L. Fitzgerald, J. Keen, A. McBride, G. Martin, E. Rowley and H. Waterman (2010). 'An organizational behaviour perspective upon CLAHRCs (Collaboratives for Leadership in Health Research and Care): Mediating institutional challenges through change agency'. An unpublished symposium paper.	This paper draws upon illustrations from four CLAHRCs over the first 18 months of their operations to provide some early analysis of the practical challenges CLAHRCs face in enacting their conceptual models.	Our paper conceptualizes CLAHRCs from an OB perspective. We represent the case of CLAHRCs as one where change agency and knowledge brokering at the local level need to mediate powerful macro-level institutional forces that potentially drive research and practice apart. Our early analysis of CLAHRCs is revealing. CLAHRCs vary in the specific ways they organize for change agency and knowledge brokering. However, they face a similar institutional landscape. The institutional challenge is both professional and policy orientated. Professional hierarchy means that some change agents or knowledge brokers are accorded greater legitimacy than others, but we note that change agent or knowledge broker roles may be so novel that their enactment is slow to realize. If embedded in pre-existing professional, supported by managerial, hierarchy, then change agency and knowledge brokering may prove more successful. Meanwhile the policy institution itself may be inconsistent in its support for CLAHRCs, more so when focused upon productivity gains. The health and social care system is complex, with considerable variation across organizations regarding the extent to which R&D is institutionalized. To make the necessary impact, CLAHRCs are moving beyond the single clinical champion to drive change. More or less in the various CLAHRCs, the need to engage a wide range of stakeholders to engender a critical mass for change efforts is explicit. In summary, structural arrangements for change agency and knowledge brokering within the various CLAHRCs offer considerable promise. The challenge remains one to operationalize the CLAHRC model in a way that mediates institutional boundaries to 'move from what we know to what we do' in accelerating the translation of evidence-based innovation into healthcare practice.	http://www.download.bham.ac.uk/hsmc/graeme-currie.pdf
Currie, G., N. El Enany and A. Lockett (2014). "Intra-professional dynamics in translational health research: The perspective of social scientists." *Social Science & Medicine 114:* 81-88.	A longitudinal case study design across several CLAHRCs	In contrast to previous studies, which focus upon the professional dynamics of translational health research between clinician scientists and social scientists (inter-professional contestation), we focus upon contestation within social science (intra-professional contestation). Drawing on the empirical context of Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) in England, we highlight that although social scientists accept subordination to clinician scientists, health services researchers attempt to enhance their position in translational health research vis-à-vis organisation scientists, whom they perceive as relative newcomers to the research domain. Health services researchers do so through privileging the practical impact of their research, compared to organisation scientists' orientation towards development of theory, which health services researchers argue is decoupled from any concern with healthcare improvement. The concern of health services researchers lies with maintaining existing patterns of resource allocation to support their research endeavours, working alongside clinician scientists, in translational health research. The response of organisation scientists is one that might be considered ambivalent, since, unlike health services researchers, they do not rely upon a close relationship with clinician scientists to carry out research, or more generally, garner resource.	http://www.sciencedirect.com/science/article/pii/S0277953614003396#

Output	Design	Excerpts from the abstract and other sections where relevant	Link
D'Andreta, D., H. Scarbrough, S. Evans (2013). "The enactment of knowledge translation: A study of the Collaborations for Leadership in Applied Health Research and Care initiative within the English National Health Service." *Journal of Health Services Research & Policy 18*(3 suppl): 40-52.	A mixed method external evaluation of three CLAHRCs	A comparative, mixed method study created a typology of enactments (Classical, Home-grown and Imported) using qualitative analysis and social network analysis. We identify systematic differences in the enactment of the CLAHRC model. The sources of these different enactments are subsequently related to variation in formative interpretations and leadership styles, the implementation of different governance structures, and the relative epistemic differences between the professional groups involved. Enactment concerns the creative agency of individuals and groups in constituting a particular context for their work through their local interpretation of a particular knowledge translation (KT) model. Our theory of enactment goes beyond highlighting variation between CLAHRCs, to explore the mechanisms that influence the way a particular model is interpreted and acted upon. We thus encourage less focus on conceptual models and more on the formative role played by leaders of KT initiatives.	http://hsr.sagepub.com/content/18/3_suppl/40
Evans, S. and H. Scarbrough (2014). "Supporting knowledge translation through collaborative translational research initiatives: 'Bridging' versus 'blurring' boundary-spanning approaches in the UK CLAHRC initiative." *Social Science & Medicine 106:* 119-127.	Comparative qualitative case study of two anonymised CLAHRCs	Recent policy initiatives in the UK and internationally have sought to promote knowledge translation between the 'producers' and 'users' of research. Within this paper we explore how boundary-spanning interventions used within such initiatives can support knowledge translation between diverse groups. Using qualitative data from a 3-year research study conducted from January 2010 to December 2012 of two case-sites drawn from the CLAHRC initiative in the UK, we distinguish two different approaches to supporting knowledge translation; a 'bridging' approach that involves designated roles, discrete events and activities to span the boundaries between communities, and a 'blurring' approach that de-emphasises the boundaries between groups, enabling a more continuous process of knowledge translation as part of day-to-day work-practices. In this paper, we identify and differentiate these boundary-spanning approaches and describe how they emerged from the context defined by the wider CLAHRC networks. This highlights the need to develop a more contextualised analysis of the boundary-spanning that underpins knowledge translation processes, relating this to the distinctive features of a particular case.	http://www.sciencedirect.com/science/article/pii/S0277953614000525
Gerrish, K. (2010). "Tapping the potential of the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care (CLAHRC) to develop research capacity and capability in nursing." *Journal of Research in Nursing 15*(3): 215-225.	Conceptual paper	Each CLAHRC represents a collaborative partnership between one or more universities and their neighbouring NHS organisations. This investment in research infrastructure presents considerable opportunities for nursing to develop capacity and capability to undertake research and knowledge translation activity and support clinical academic careers. However, in order for the potential of CLAHRCs to be realised investment in nursing leadership is required.	http://jrn.sagepub.com/content/15/3/215
Gerrish, K. and H. Piercy (2014). "Capacity Development for Knowledge Translation: Evaluation of an Experiential Approach through Secondment Opportunities." *Worldviews on Evidence-Based Nursing 11*(3): 209-216.	Internal evaluation of CLAHRC SY	Six criteria for judging the success of the secondments at individual, team, and organization level were identified: KT skills development, effective workload management, team working, achieving KT objectives, enhanced care delivery, and enhanced education delivery. Benefits to the individual, KT team, seconding, and host organizations were identified. Hosting teams should provide mentorship support to secondees, and be flexible to accommodate secondees' needs as team members. Ongoing support of managers from seconding organizations is needed to maximize the benefits to individual secondees and the organization.	http://onlinelibrary.wiley.com/doi/10.1111/wvn.12038/abstract

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Hewison, A., N. Gale and J. Shapiro (2012). "Co-production in research: some reflections on the experience of engaging practitioners in health research." *Public Money & Management 32*(4): 297-302.	A piece describing the activities of CLAHRC BBC.	This article has highlighted the practical elements of co-production. A 'micro' focus on specific projects and teams was found to be a successful way of embedding co-production. Arriving at a position where there is engagement and 'buy in' for the tracer studies took much longer than would have been the case if a 'traditional' approach had been used and the research carried out with minimal input from practitioners. The hope is that this investment of time and money will lead to greater benefits in the longer term as some narrowing of the 'second gap' occurs—at least in this setting and context. In addition, if co-production does become increasingly important,, then more thought about how it is best achieved in a range of settings, involving different teams will be needed.	http://www.tandfonline.com/doi/full/10.1080/09540962.2012.691311#.VG9t__msXzg
Jordan, M., E. Rowley, R. Morriss and N. Manning (2014). 'An analysis of the Research Team–Service User relationship from the Service User perspective: a consideration of 'The Three Rs' (Roles, Relations, and Responsibilities) for healthcare research organisations', *Health Expectations*, published online before print.	Internal evaluation of CLAHRC NDL	This article explores the nature of the Research Team–Service User relationship, plus associated roles, relations and responsibilities of collaborative health research. Qualitative social science research was undertaken in a health-care research organization utilizing interview method and a medical sociology and organizational sociology theoretical framework for analysis. Data utilized originate from a larger evaluation study that focuses on the CLAHRC as an iterative organization and explores members' experiences. There can be a disparity between initial *expectations* and actual *experiences* of involvement for service users. Therefore, as structured via 'The Three Rs' (Roles, Relations and Responsibilities), aspects of the relationship are evaluated (e.g. motivation, altruism, satisfaction, transparency, scope, feedback, communication, time). Regarding the inclusion of service users in health research teams, a careful consideration of 'The Three Rs' is required to ensure *expectations* match *experiences*.	http://onlinelibrary.wiley.com/doi/10.1111/hex.12243/full
Kislov, R. (2014). "Boundary discontinuity in a constellation of interconnected practices." *Public Administration 92*(2): 307-323.	Interviews, documentary analysis and observation in CLAHRC GM	This article uses the theory of 'communities of practice' to explore the discontinuity of knowledge sharing across different groups co-located within a collaborative research partnership. It presents the findings of a qualitative case study conducted within one of the Collaborations for Leadership in Applied Health Research and Care (CLAHRCs)—large-scale UK-based knowledge mobilization initiatives bringing together the producers and users of health research. Focusing on the boundaries emerging between and within the research and implementation strands of the CLAHRC, the article describes how differences between communities of practice give rise to discontinuities in knowledge sharing. Its findings highlight the role of fragmented organizational design, divergent meanings and identities, and dysfunctional boundary bridges in the (re)production, legitimization, and protection of boundaries between groups. Finally, the article questions the role of research implementation as a boundary practice bridging the gap between academic research and clinical practice.	http://onlinelibrary.wiley.com/doi/10.1111/padm.12065/full

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Kislov, R., G. Harvey and K. Walshe (2011). "Collaborations for Leadership in Applied Health Research and Care: Lessons from the theory of communities of practice." *Implementation Science 6:* 64.	Conceptual paper	The multiprofessional and multi-agency nature of the CLAHRCs operating in the traditionally demarcated organisational landscape of the NHS may present formidable obstacles to knowledge sharing between various professional groupings, formation of a shared 'collaborative' identity, and the development of new communities within the CLAHRCs. To cross multiple boundaries between various professional and organisational communities and hence enable the flow of knowledge, the CLAHRCs will have to create an effective system of 'bridges' involving knowledge brokers, boundary objects, and cross-disciplinary interactions as well as address a number of issues related to professional and organisational identification. Achieving the aims of the CLAHRCs and producing a sustainable change in the ways applied health research is conducted and implemented may be influenced by how effectively these organisations can navigate through the multiple communities of practice involved and promote the development of new multiprofessional and multi-organisational communities united by shared practice and a shared sense of belonging—an assumption that needs to be explored by further empirical research.	http://www.implementationscience.com/content/6/1/64
Kislov, R., H. Waterman, G. Harvey and R. Boaden (2014). "Rethinking capacity building for knowledge mobilisation: Developing multilevel capabilities in healthcare organisations." *Implementation Science 9:* 166.	Conceptual paper drawing on some of the CLAHRC GM practical experience	The discussion is structured around the following three themes: (1) defining and classifying capacity building for knowledge mobilisation; (2) mechanisms of capability development in organisational context; and (3) individual, group and organisational levels of capability development. Capacity building is presented as a practice-based process of developing multiple skills, or capabilities, belonging to different knowledge domains and levels of complexity. It requires an integration of acquisitive learning, through which healthcare organisations acquire knowledge and skills from knowledge mobilisation experts, and experience-based learning, through which healthcare organisations adapt, absorb and modify their knowledge and capabilities through repeated practice. Although the starting point for capability development may be individual-, team- or organisation-centred, facilitation of the transitions between individual, group and organisational levels of learning within healthcare organisations will be needed. Any initiative designed to build capacity for knowledge mobilisation should consider the subsequent trajectory of newly developed knowledge and skills within the recipient healthcare organisations. The analysis leads to four principles underpinning a practice-based approach to developing multilevel knowledge mobilisation capabilities: (1) moving from 'building' capacity from scratch towards 'developing' capacity of healthcare organisations; (2) moving from passive involvement in formal education and training towards active, continuous participation in knowledge mobilisation practices; (3) moving from lower-order, project-specific capabilities towards higher-order, generic capabilities allowing healthcare organisations to adapt to change, absorb new knowledge and innovate; and (4) moving from single-level to multilevel capability development involving transitions between individual, group and organisational learning.	http://www.implementationscience.com/content/9/1/166

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Kislov, R., K. Walshe and G. Harvey (2012). "Managing boundaries in primary care service improvement: A developmental approach to communities of practice." *Implementation Science 7:* 97.	Qualitative study of one of the CLAHRC GM knowledge mobilisation projects	The study showed that in spite of epistemic and status differences, professional boundaries between general practitioners, practice nurses and practice managers co-located in the same practice over a relatively long period of time could be successfully bridged, leading to the formation of multiprofessional communities of practice (CoPs). While knowledge circulated relatively easily within these CoPs, barriers to knowledge sharing emerged at the boundary separating them from other groups existing in the same primary care setting. The strongest boundaries, however, lay between individual general practices, with inter-organisational knowledge sharing and collaboration between them remaining unequally developed across different areas due to historical factors, competition and strong organisational identification. Manipulated emergence of multi-organisational CoPs in the context of primary care may thus be problematic. Boundary issues could be addressed by adopting a developmental perspective on CoPs, which provides an alternative to the analytical and instrumental perspectives previously described in the CoP literature. This perspective implies a pragmatic, situational approach to mapping existing CoPs and their characteristics and potentially modifying them in the process of service improvement through the combination of internal and external facilitation.	http://www.implementationscience.com/content/7/1/97
Marston, C. and A. Renedo (2013). "Understanding and measuring the effects of patient and public involvement: an ethnographic study." *The Lancet 382:* S69.	Ethnography in CLAHRC NWL	At first, health professionals demanded evidence of PPI effects of the type typical in clinical practice, such as cost-effectiveness data, treating PPI as a discrete intervention to improve a specific health outcome. They often spoke about effect in linear terms, focusing on individual participants; for example, patient input leads to improved clinical knowledge, which in turn leads to better health outcomes. Even so, they also measured their own PPI success using indicators such as successful participant recruitment and retention or tangible non-health outputs (eg, leaflets codesigned with patients), rather than changes in health outcomes. Patients added complexity by acting outside the official remit of their participant role. For instance, they facilitated collaboration within and between clinical teams and engaged powerful decision makers to ensure interventions were sustained. Patients talked about their own contributions in collective and utilitarian terms: they were reluctant to attribute success to individuals, emphasising the role of the team. For them, effect meant timely (and rapid) implementation of incremental changes in health care, which were then sustained and improved upon through collaborative relationships between patients, clinicians, researchers, and others. Staff gradually focused more on creating environments conducive to patient collaboration, and less on calculating the effect of individual contributions as time went on. They increasingly described PPI success in terms of collaborative relationships between diverse patients and professionals, and acknowledged the importance of unpredictable positive effects of patient innovations. The effect of PPI is not captured in simple quantification of PPI elements (eg, patients reached, outcome measures improved). To define and assess the effects of PPI, we should take patient voices into account, and track the dynamic social processes and networks through which PPI contributes to health-care improvement. We present a framework for future assessment of PPI effect: how, whether, and when patient input is integrated into projects; level of sustained and expanded collaborative relationships created via PPI; changes in working relationships between multidisciplinary professionals; presence of new patient-led projects; institutional investment in PPI; and patient engagement in service improvement and self-care.	http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62494-0/abstract

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Martin, G. P., S. McNicol and S. Chew (2013). "Towards a new paradigm in health research and practice? Collaborations for Leadership in Applied Health Research and Care." *Journal of Health Organization and Management 27*(2): 193-208.	Internal evaluation of CLAHRC LNR	The paper draws on in-depth qualitative interview data from the first round of an ongoing evaluation of one CLAHRC to understand the views of different stakeholders on its progress so far, challenges faced, and emergent solutions. The breadth of CLAHRCs' missions seems crucial to mobilise the diverse stakeholders needed to succeed, but also produces disagreement about what the prime goal of the Collaborations should be. A process of consensus building is necessary to instil a common vision among CLAHRC members, but deep-seated institutional divisions continue to orient them in divergent directions, which may need to be overcome through other means. A particularly important catalyst in this case was the External Advisory Review, and the concerted action which followed from this, commissioned and endorsed by the CLAHRC's Board. Alongside consensual vision, then, the authority provided by the backing of the Board was also crucial. Collaborative networks such as CLAHRCs rely on 'harder edges' such as directive mandates just as much as they require the internal volition of their members. As such, a greater ongoing steer from the Boards to which CLAHRCs are accountable is likely to be essential in ensuring that the consensual vision holds sway in the face of institutional forces pulling in opposing directions. A more proactive role in the management of CLAHRCs by their NHS partners also seems important – and is itself likely to be a function, in part, of CLAHRCs' success in developing projects that have immediate relevance to an NHS faced with considerable financial and organisational challenges, while also selling the long-term potential benefits of existing programmes of research.	http://www.emeraldinsight.com/doi/full/10.1108/14777261311321770
Martin, G. P., V. Ward, J. Hendy, E. Rowley, S. Nancarrow, J. Heaton, N. Britten, S. Fielden and S. Ariss (2011). 'The challenges of evaluating large-scale, multi-partner programmes: the case of NIHR CLAHRCs', *Evidence & Policy 7*(4): 489-509.	Conceptual paper	This paper discusses challenges in relation to seven CLAHRC evaluations, eliciting implications and suggestions for others evaluating similarly complex interventions with diverse objectives. 1. Evaluating disparate, developing activities 2. Evaluating the right things at the right time 3. Evaluating neutrally and contributing formatively 4. Evaluating sustainability of change 5. NHS governance issues 6. Balancing the evaluation work with other responsibilities within the CLAHRC 7. Overburdening and over-studying the CLAHRC staff	http://www.ingentaconnect.com/content/tpp/ep/2011/00000007/00000004/art00006
Oborn, E., M. Barrett, K. Prince and G. Racko (2013). 'Balancing exploration and exploitation in transferring research into practice: a comparison of five knowledge translation entity archetypes', *Implementation Science 8:* 104.	Interviews and focus groups across nine CLAHRCs	In this article we develop five archetypes for organizing KT: 1. Archetype A: involving a broad array of stakeholders in a multidisciplinary research process 2. Archetype B: loosely autonomous research streams with designated knowledge brokers 3. Archetype C: independent research and implementation activities 4. Archetype D: collaborating through loose networks 5. Archetype E: centrally controlled service improvement projects The results show how the various CLAHRC entities work through partnerships to create explorative research and deliver exploitative implementation. The different archetypes highlight a range of structures that can achieve ambidextrous balance as they organize activity and coordinate practice on a continuum of exploration and exploitation. This work suggests that KT entities aim to reach their goals through a balance between exploration and exploitation in the support of generating new research and ensuring knowledge implementation. We highlight different organizational archetypes that support various ways to maintain ambidexterity, where both exploration and exploitation are supported in an attempt to narrow the knowledge gaps. The KT entity archetypes offer insights on strategies in structuring collaboration to facilitate an effective balance of exploration and exploitation learning in the KT process.	http://www.implementationscience.com/content/8/1/104/abstract

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Renedo, A., C. A. Marston, D. Spyridonidis and J. Barlow (2014). "Patient and Public Involvement in Healthcare Quality Improvement: How organizations can help patients and professionals to collaborate." *Public Management Review,* published online before print.	Ethnography in CLAHRC NWL	Citizens across the world are increasingly called upon to participate in healthcare improvement. It is often unclear how this can be made to work in practice. This 4-year ethnography of a UK healthcare improvement initiative showed that patients used elements of organizational culture as resources to help them collaborate with healthcare professionals. The four elements were: (1) organizational emphasis on non-hierarchical, multidisciplinary collaboration; (2) organizational staff ability to model desired behaviours of recognition and respect; (3) commitment to rapid action, including quick translation of research into practice; and (4) the constant data collection and reflection process facilitated by improvement methods.	http://www.tandfonline.com/doi/full/10.1080/14719037.2014.881535#tabModule
Rycroft-Malone, J., J. Wilkinson, C. R. Burton, G. Harvey, B. McCormack, I. Graham and S. Staniszewska (2013). 'Collaborative action around implementation in Collaborations for Leadership in Applied Health Research and Care: towards a programme theory', *Journal of Health Services Research & Policy 18*(3 suppl): 13-26.	Longitudinal external realist evaluation of three CLAHRCs	The first round of data collection shows that the mechanisms of collaborative action, relationship building, engagement, motivation, knowledge exchange and learning are important to the processes and outcomes of CLAHRCs' activity, including their capacity for implementation. These mechanisms operated in different contexts such as competing agendas, availability of resources and the CLAHRCs' brand. Contexts and mechanisms result in different impact, including the CLAHRCs' approach to implementation, quality of collaboration, commitment and ownership, and degree of sharing and managing knowledge. Emerging features of a middle range theory of implementation within collaboration include alignment in organizational structures and cognitive processes, history of partnerships, responsiveness and resilience in rapidly changing contexts. CLARHCs' potential to mobilize knowledge may be further realized by how they develop insights into their function as collaborative entities.	http://hsr.sagepub.com/content/18/3_suppl/13.short
Sinfield, P., K. Donoghue, E. Horobin and E. S. Anderson (2012). "Placing interprofessional learning at the heart of improving practice: the activities and achievements of CLAHRC in Leicestershire, Northamptonshire and Rutland." *Quality in primary care 20*(3): 191-198.	Descriptive paper based on the activities of CLAHRC LNR	CLAHRC-LNR's close collaboration with partner NHS trusts has aided the development of a programme of applied research that aims to develop interprofessional teamworking to improve healthcare systems and patient outcomes. Co-ordinators (boundary spanners) have been appointed in trusts and have been crucial in facilitating interprofessional working. Activities include a successful programme of training and education courses within the NHS partner trusts using the principles of interprofessional education. CLAHRC-LNR is developing the use of knowledge exchange events and workshops as well as establishing communities of practice to bring together professionals from across LNR NHS trusts and the University of Leicester to share their expertise and build interprofessional relationships. CLAHRC fellows (knowledge brokers) are being appointed to work with co-ordinators to facilitate the use of research evidence in decision making in the trusts and clinical commissioning groups (CCGs).	http://www.ingentaconnect.com/search/article?option1=tka&value1=clahrcs&pageSize=10&index=2

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Soper, B., O. Yaqub, S. Hinrichs, S. Marjanovich, S. Drabble, S. Hanney and E. Nolte (2013). "CLAHRCs in practice: combined knowledge transfer and exchange strategies, cultural change, and experimentation." *Journal of Health Services Research & Policy 18*(3 suppl): 53-64.	An external evaluation of two CLAHRCs (CLAHRC for Cambridgeshire andPeterborough and PenCLAHRC)	Both CLAHRCs: strengthened local networks and relationships; built capacity in their local academic and NHS communities to undertake and use research that meets the needs of the service; developed research and implementation methodologies; and added to understanding of the complex relation between research and implementation. There was evidence of impact of CLAHRC projects on health and social care services. The CLAHRCs pursued a strategy that can be categorized as one of flexible comprehensiveness; i.e. their programmes have been flexible and responsive and they have used a range of approaches that seek to match the diverse aspects of the complex issues they face. Key features include their work on combining a range of knowledge transfer and exchange strategies, their efforts to promote cultural change, and the freedom to experiment, learn and adapt. Although the CLAHRCs do not, by themselves, have the remit or resources to bring about wholesale service improvement in health care, they do have features that would allow them to play a key role in some of the wider initiatives that encourage innovation.	http://hsr.sagepub.com/content/18/3_suppl/53.short
Spyridonidis, D., J. Hendy and J. Barlow (2014). 'Understanding hybrid roles: The role of identity processes amongst physicians', Public Administration, published online before print.	Longitudinal qualitative (interview-based) study in CLAHRC NWL with two points of data collection	Increasing attention has been paid in both public administration and organizational theory to understanding how physicians assume a 'hybrid' role as they take on managerial responsibilities. Limited theoretical attention has been devoted to the processes involved in negotiating, developing, and maintaining such a role. We draw on identity theory, using a qualitative, five-year longitudinal case study, to explore how hybrid physician–managers in the English National Health Service and the organizations they are situated in achieve this. We highlight the importance of saliency – how central an identity is to an individual's values and beliefs – in managing new identities. We found three differing responses to taking on a hybrid physician–manager role (the sceptics, the innovators and the late majority), with identity emerging as a mitigating factor for negotiating potentially conflicting roles. We discuss the implications for existing theory and practice in the management of public organizations and identify an agenda for further research.	http://onlinelibrary.wiley.com/doi/10.1111/padm.12114/full
Thomson, L., J. Schneider and N. Wright (2013). 'Developing communities of practice to support the implementation of research into clinical practice', *Leadership in Health Services, 26*(1): 20-33.	A conceptual piece justifying the model adopted by CLAHRC NDL	The development of CoPs across the professional and organisational boundaries of researchers, practitioners, and service users has the potential to enhance the translation of evidence into practice. It requires bringing together the right people and providing a supportive infrastructure to facilitate exchanges. Methods of engaging and involving the different stakeholder groups vary according to the specific context and pre-existing networks, but developing closer working relationships and sharing common values is an important step in this process. Within the applied health research partnership of the Collaboration for Leadership in Applied Health Research and Care for Nottinghamshire, Derbyshire and Lincolnshire (CLAHRC-NDL), the role of Diffusion Fellows, Engagement Fellows and CLAHRC Associates provides a way of engaging with its diverse stakeholders.	http://www.emeraldinsight.com/doi/full/10.1108/17511871311291705
Tierney, S., R. Kislov and C. Deaton (2014). "A qualitative study of a primary-care based intervention to improve the management of patients with heart failure: The dynamic relationship between facilitation and context." *BMC Family Practice 15:* 153.	Internal evaluation of one of the CLAHRC GM projects	We describe a complex and dynamic interplay between facilitation and context, focusing on three major themes: (1) Addressing macro and micro agendas; (2) Forming a facilitative unit; (3) Maintaining momentum. We show that HF specialist nurses (HFSNs) have a high level of professional credibility, which allows them to play a key role in making recommendations to practices for improving patient care. At the same time, we argue that contextual factors, such as top-level endorsement, the necessity to comply with a performance measurement system, and the varying involvement of practice nurses produce tensions that can have both an enabling and constraining effect on the process of facilitation. When facilitating the transfer of evidence, context is an important aspect to consider at a macro and micro level; a complex interplay can exist between these levels, which may constrain or enable efforts to amend practice. Those involved in facilitating change within primary care have to manage tensions arising from the interplay of these different contextual forces to minimise their impact on efforts to alter practice based on best evidence.	http://www.biomedcentral.com/1471-2296/15/153

Output	Design	Excerpts from the abstract and other sections where relevant	Link
Whear, R., J. Thompson-Coon, K. Boddy, H. Papworth, J. Frier and K. Stein (2012). 'Establishing local priorities for a health research agenda', *Health Expectations*, published online before print.	A descriptive piece about the priority-setting activities of PenCLAHRC.	PenCLAHRC's process establishes the priorities of Stakeholders including service users across a regional health system for locally relevant health services research and implementation. Health research questions are collected from clinicians, academics and service users in Devon and Cornwall (UK) using a web-based question formulation tool. There is a two-stage prioritization process which uses explicit criteria and a wide Stakeholder group, including service users to identify important research questions relevant to the south-west peninsula locality. To date, a wide variety of health research topics have been prioritized by the PenCLAHRC Stakeholders. The research agenda reflects the interests of academics, clinicians and service users in the local area. Potential challenges to implementation of the process include time constraints, variable quality of questions (including the language of research) and initiating and maintaining engagement in the process. Shared prioritization of local health research needs can be achieved between Stakeholders from a wide range of perspectives. The processes developed have been successful and, with minor changes, will continue to be used during subsequent rounds of prioritization. Engagement of Stakeholders in establishing a research agenda encourages the most relevant health questions to be asked and may improve implementation of research findings and take up by service users.	http://onlinelibrary.wiley.com/doi/10.1111/hex.12029/full
Wright, N. (2013). "First-time knowledge brokers in health care: the experiences of nurses and allied health professionals of bridging the research-practice gap." *Evidence & Policy 9*(4): 557-570.	Qualitative study in CLAHRC NDL	This study describes the experiences of nurses and allied health professionals as first-time knowledge brokers, attempting to bridge the research-practice gap within health care. A qualitative study using in-depth interviews and documentary analysis was conducted. The data was analysed using a thematic analysis strategy. Participants were 17 knowledge brokers and five individuals mentoring and supporting them. Four themes described their experiences: expectations, pragmatics, emotional reactions and outcomes. In summary, knowledge brokering roles had multi-level benefits. However, there is a lack of support and recognition for these roles at an organisational level, making these activities difficult to sustain in the long term.	http://www.ingentaconnect.com/content/tpp/ep/2013/00000009/00000004/art00008