Independent review of Lesley Wye’s work on the NIHR Knowledge Mobilisation Fellowship

Preliminary report
July 2015

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This independent evaluation is funded by the NIHR Knowledge Mobilisation Fellowship that Lesley Wye holds at the Centre for Academic Primary Care, School for Social and Community Medicine, University of Bristol.
# Contents

Executive summary .................................................................................................................. 3  
Introduction ............................................................................................................................... 3  
Key findings ................................................................................................................................ 3  
1. How, where and why are commissioner-researcher collaborations developing .................. 3  
2. The mechanisms of collaboration: What are people doing or not doing that helps collaborations to flourish or flounder? .............................................................................. 5  
3. Identifying the contextual drivers and inhibitors that affect collaborations ......................... 6  
4. Developing recommendations for what could be done differently .................................... 8  
Main report ................................................................................................................................ 9  
1. Introduction ........................................................................................................................... 9  
2. Defining a community of practice ......................................................................................... 10  
3. Evaluation methods ............................................................................................................. 10  
4. Findings ................................................................................................................................. 11  
   Aim 1: How, where and why are commissioner-researcher collaborations developing .......... 12  
   Aim 2: The mechanisms of collaboration: What are people doing or not doing that helps those collaborations to flourish or flounder ........................................................................... 14  
   Aim 3: Identifying the contextual drivers and inhibitors that affect collaborations .......... 20  
   Revisiting aim 1: Emerging learning and knowledge mobilisation outcomes .................... 23  
   Aim 4: Developing recommendations for what could be done differently ......................... 26  
5. Discussion and conclusion .................................................................................................. 27  
References .................................................................................................................................. 28  
Appendix 1 Defining a community of practice ......................................................................... 30  
Appendix 2 A realist evaluation methodological approach ......................................................... 31  
Appendix 3 Information sheet and consent form for interviews ................................................ 33  
Appendix 4 Interview topic guide ........................................................................................... 36  
Appendix 5 Observation template for meetings ........................................................................ 38  
Appendix 6 Data coding framework .......................................................................................... 38
Executive summary

Introduction
This is a preliminary report of the independent evaluation of Lesley Wye’s National Institute for Health Research (NIHR) Knowledge Mobilisation (KM) fellowship, which runs from June 2014 to June 2017. It reports on the embryonic stages of the KM fellowship in the first year of its development. As such this report develops some initial and tentative findings about the activities associated and funded by the NIHR KM fellowship. This report has four aims and objectives:

1. To learn more about how, where and why commissioner-researcher collaborations are developing.
2. To find out what people are/are not doing that helps those collaborations to flourish or flounder.
3. To identify the contextual drivers and inhibitors that affect the development of commissioner-researcher collaborations.
4. To develop recommendations for what could be done differently.

This preliminary report focuses on four groups that Lesley is supporting under the auspices of this KM fellowship. These are:

- The development of two co-produced evaluations with commissioners and researchers; one evaluating the telehealth service and a second, evaluating the end of life care co-ordination centre.
- The facilitation of a knowledge mobilisation team: comprising of Lesley Wye; two Researchers in Residence (Centre for Academic Primary Care University of Bristol researchers who as part of their role are seconded to Bristol CCG); two NHS Fellows (commissioners who are seconded part time into the Centre for Academic Primary Care at the University of Bristol); and a communications manager. The activities of the NHS Fellows and Researchers in Residence are funded by Avon Primary Care Research Collaborative (APCRC), and as such are not fully covered in this report.
- The development of a qualitative research skills group, members of which are NHS Fellows and researchers within the Centre for Academic Primary Care at the University of Bristol.

For the purposes of this report 13 people were interviewed to find out about their experiences and perceptions of their involvement in the above groups. Some people had multiple memberships of various groups and were interviewed about their role in several groups. Between 5-6 participants of each group were interviewed, comprising of at least 2 commissioners/providers and 2 researchers from each group to understand different people’s perspectives. In addition to this, 6 observations were carried out of different meetings of the groups listed above.

Key findings

1. How, where and why are commissioner-researcher collaborations developing

The knowledge mobilisation team share learning and support each other to understand how collaborations between commissioners and researchers can be developed. Lesley provides a key role in developing a supportive and coaching environment, sharing knowledge and understanding about knowledge mobilisation theory and practice.

The qualitative skills group is a peer support group based at the Centre for Academic Primary Care within the University of Bristol. It was originally set up to support NHS Fellows to gain qualitative
research skills to support their work in their secondments at the University of Bristol. The group members share experiences of qualitative research practices including focus groups, interviewing, framework analysis, coding and analysis of transcripts. Whilst the group was initially set up to support the two NHS fellows in developing their qualitative research skills, the group has developed to include issues that University researchers are also working on in association with knowledge mobilisation.

The co-produced evaluations consist of groups of researchers, commissioners and providers who are developing and undertaking specific service evaluations in telehealth and the end of life care co-ordination centre. In both cases Lesley knew the commissioner who needed the evaluation and had worked with them previously. The telehealth co-produced evaluation began in May 2014. Whilst a decision has been made to decommission the current telehealth service, the evaluation will inform future health technology commissioning decisions. This group is currently undertaking data collection and analysis with a view to completing the evaluation by the end of 2015. The end of life care co-ordination centre (EoLCCC) co-produced evaluation group has formed more recently and has had just a few meetings so far. The group is currently completing the evaluation protocol. Commissioners and providers saw that these co-produced research based evaluations had substantial additional rigour in comparison with evaluations that had previously been carried out in the commissioning world.

The emerging learning and knowledge outcomes that have been generated from these different work streams include:

**Research skills:** Commissioners (including NHS Fellows) and providers spoke about how they had gained increased knowledge and understanding of:
- control groups - random selection and matching patients for control groups
- the value of qualitative research and qualitative research skills
- developing patient information leaflets for research
- topic guides for interviews
- interview skills with both staff and patients
- the benefits of using recording and transcriptions for interviews
- the diversity and variation of research skills
- information governance
- the different ways in which research evidence is developed and interpreted.

In addition to these specific skills, one commissioner spoke about how they were also considering other possible NIHR collaborations in the future. Researchers also spoke of how their own research skills had developed, understanding the implementation and application of different evaluation methodologies.

**Commissioning skills:** As a result of this work researchers have:
- increased understandings of the commissioning world
- learnt specific facilitation and workshop techniques
- developed project management skills
- developed new co-produced evaluations beyond the two evaluations considered here
- developed new grant applications and collaborations with commissioners
- learnt and developed different knowledge mobilisation techniques.
The **co-produced evaluations** have begun to embed evaluations skills into the commissioning environment. Commissioners and providers who have taken part in these evaluations said that they had learnt to:

- consider different evidence bases before embarking on a project
- develop evaluation plans for the projects that they are involved in or may embark on
- appreciate the benefits of qualitative research to better understand patient experiences and narratives
- reconsider how to measure service quality and use particular CQUINs
- consider the importance of evaluation
- how to set up an evaluation and to plan it in a more robust fashion.

**Improving networks and relationships**

- Within the co-produced evaluations, networks between researchers, the CCG, CSU and providers were seen to have been improved.
- Commissioners valued the additional networks and knowledge that contact with researchers and the NHS fellows brought with them.
- Both researchers and commissioners felt more likely to contact each other through the new links and connections that have been developed.

2. The mechanisms of collaboration: What are people doing or not doing that helps collaborations to flourish or flounder?

**The knowledge mobilisation team**

Actions that supported and developed the knowledge mobilisation team include:

- The creation of a mentoring and supportive environment
- The appreciating and valuing of the diversity of people’s skills and how these support different aspects of knowledge mobilisation
- An enabling leadership role. Lesley’s leadership of the KM team was enhanced by her strong interpersonal skills, managing in a consensual and mutually inclusive way, getting everybody’s opinions and perspectives. Members spoke of being mentored within their roles and supported in their personal development.
- A wider advocacy and PR role was also needed to highlight the work of the KM team.

Areas where the knowledge mobilisation team could develop further included:

- The setting of boundaries with clear goals to achieve, developing action logs with a greater task and activity focus
- Having clear priorities when managing the different demands of the organisations that they work within and between
- Developing different ways of evidencing the impacts of the knowledge mobilisation work, which can sometimes be relational, tacit and intangible.

**The co-produced evaluations**

In relation to developing the two co-produced evaluations, actions that supported these collaborations included:

- Understanding different people’s agendas and interests to generate common concerns
- Generating enthusiasm, interest and commitment from a range of different people
- Interest in and valuing different people’s perspectives
- Creating a safe environment where people could ask ‘silly’ questions
• Developing an involving and participative style
• Co-ordinating and valuing different people’s expertise and creating specific group roles
• Tapping into people’s own motivations.

There were also several difficulties that were cited in developing co-produced evaluations, including:
• Explaining things at an appropriate level so that different people could understand particular issues. Communication could take more time, thought and detail to explain issues to people from different organisations and backgrounds.
• If there are sensitivities between providers and commissioners with respect to commissioning agreements, this may influence how and when providers get involved. This may interfere with a collaborative approach.
• Different commissioners, providers and researchers may all have quite different understandings of the definitions and boundaries between performance management, service evaluation and research-informed evaluations.
• Negotiating common interests may be difficult where there is a diversity of thinking.
• Patients have not been involved within the co-produced evaluation groups. This was seen as adding additional complexity to the collaboration. However patients have been involved as evaluation research participants.
• ‘Changing goalposts’: several people spoke of the difficulties in how whilst the evaluations have had to adapt to changing circumstances, constantly being in a process of evolution can make the process even more difficult.
• Time and capacity are both in short supply, and whilst the collaborative approach was largely appreciated there was also a sense that this took substantial additional time.
• Data sharing and information governance were particularly tricky issues and participants spoke about the need to understand the extent to which information could be shared at an early stage in the process.

The key research question that Lesley asks in her knowledge mobilisation fellowship application concerns: ‘When fostering commissioner researcher collaborations through communities of practice, what works, with whom, when and why?’ (Wye 2013). This research has illustrated that all four groups that Lesley is facilitating through her fellowship can be considered a community of practice, defined as: ‘a group of people who may not normally work together, but who are acting and learning together in order collectively to achieve a common task while acquiring and negotiating appropriate knowledge’ (Gabbay et al. 2003: 285). Key characteristics are that people are sharing particular concerns, and that they use and share information, insights and advice to extend their knowledge and understanding of that concern (following Gabbay et al. 2003: 287). Within the four groups learning and practices are shared amongst all the different members of the groups. However the cross disciplinary nature of these communities of practice presents distinct challenges. Whilst there are elements of social learning within the two co-produced evaluations they are also complex project management groups with diverse members that collaborate across organisational boundaries.

3. Identifying the contextual drivers and inhibitors that affect collaborations

<table>
<thead>
<tr>
<th>Contextual drivers</th>
<th>Contextual inhibitors</th>
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<tbody>
<tr>
<td><strong>Funding:</strong> APCR funded support for the NHS Fellows and Researchers in Residence</td>
<td><strong>Language:</strong> Both commissioners and researchers spoke of the difficulties of specific technical</td>
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<tr>
<td><strong>Spaces where researchers and commissioners may meet</strong> such as APCRC seminar activities</td>
<td><strong>Timing:</strong> It was seen that the process of research and evaluation was elongated whilst commissioners needed answers now.</td>
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<td><strong>Senior management support</strong> that enables the collaborations through advocacy, and giving permissions for people to spend time on this work, releasing staff to work on particular projects.</td>
<td><strong>The changing nature of service interventions</strong> within co-produced evaluations meant that the evaluations had to manage evolving interventions. Both researchers and commissioners highlighted the difficulties of this changing context, wanting to ensure that the evaluations were still valuable and important pieces of work.</td>
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<td><strong>Having both NHS Fellows and Researchers in Residence</strong> who supported each other in navigating around their seconded organisations</td>
<td><strong>Capacity:</strong> Researchers, providers and commissioners all highlighted problems of capacity</td>
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<td>Other organisational initiatives that promote collaborations between researchers and healthcare commissioners and providers e.g. <strong>Health Integration Teams</strong> (cross-organisational and interdisciplinary groups that have been developed to tackle health priorities across Bristol).</td>
<td><strong>Relevance of research findings:</strong> Commissioners did not necessarily always see or understand the value of research findings. In addition the context within which commissioning decisions are made are much more complex, where issues of increasing demands and lack of resources may be important elements within decision making, making the application of research findings more complex.</td>
</tr>
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<td><strong>Organisational structures:</strong> Collaboration with universities has been nationally supported through the development of Academic Health Science Networks. The Avon Primary Care Research Collaborative (APCRC) was also seen as an important resource for information and advice on service evaluations. Within the CCG the work and emphasis made on the development of evidence based commissioning was also perceived as an important driver.</td>
<td><strong>Methodologies and implications for research careers:</strong> The methodologies most valued within academia may not be easily applied within changing commissioning contexts. This may have implications for academic publication records which are a key promotion criteria.</td>
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<td><strong>Focussing on evaluation</strong> was understood as a common concern that people could collaborate on across commissioner and researcher communities.</td>
<td><strong>Bridging different worlds</strong> that have distinct values, ways of understanding the world, beliefs, and cultures can be a complex challenge.</td>
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<td><strong>National agendas</strong> such as the importance of showing evidence of service effectiveness, the quality agenda, and the focus on patient experiences. Patient narratives were highly valued by both providers and commissioners, who both identified a gap in being able to produce this data by other means.</td>
<td>Organisational levers and incentives to promote collaboration across organisations may not always be present.</td>
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4. Developing recommendations for what could be done differently

As detailed in section 1 above there is clear evidence of how the different knowledge mobilisation activities are already having a range of outcomes and impacts, both within commissioning and researcher contexts. This report has started to track both the activities and outcomes of this KM work, drawing on a limited number of interviews with a range of different participants. Initial and tentative recommendations drawn from the interviews conducted as part of this evaluation include:

**Within the co-produced evaluations:**

1. Further clarity on people’s roles within the evaluation may be of benefit, especially when new people join the group so that they understand different people’s roles and responsibilities.
2. Consider whether a terms of reference agreement may be helpful to guide publication issues where there may be potentially attributable material to specific organisations.
3. These evaluations need to navigate different organisations’ data governance policies and procedures. Potential data governance issues need be investigated at an early stage in evaluations to support an initial assessment of the feasibility of different work streams. However it also may be that only when data collection begins that problems can be unearthed.
4. Having a good understanding of the service from the start before an evaluation is designed, may support the evaluation and research design. Although observations have been completed at an early stage of evaluation design, the in-depth learning about services was facilitated through staff interviews. Therefore would informal conversations with front line staff at an early stage help to inform the evaluation design?
5. Facilitators need to be mindful of keeping boundaries and aims clear. This means being clear on the content of meetings, having action logs where appropriate, and avoiding changing remits and goal posts where decisions have been made. ‘I think that the research element can mushroom things … you feel like you have drilled down and then suddenly it is boom, you are up into a mushroom again with loads of ideas with how you might do it’.
6. There was a sense of needing to be mindful and to consider broader partners in the work that were not present at evaluation meetings.

**Within the knowledge mobilisation team** there was a sense that the development of the group may need to shift to one that became more focussed on tasks and activities, whilst still maintaining its mentoring and supportive elements. Suggestions to improve the KM team meetings included having an action log of who is doing what by when, and ensuring that the meetings had clearer boundaries. Because of the diverse organisations that the team were funded by and worked with, there was sometimes a sense of how this could make priorities and objectives more complex, responding to a range of demands from different places and changing goalposts. More generally there was a feeling that evidencing the tacit, relational and informal aspects of knowledge mobilisation work was a challenge and needed further work on. Some members felt that the work that they were doing was often in an experimental stage. For researchers in residence this could centre on working out when, how and where to best include research evidence within commissioning meetings and discussions so that decisions may become more evidence informed. Both researchers and commissioners considered that the usual way that academics present findings was not conducive to knowledge being applied in practice. Here the work of the communications manager was seen as particularly important. Further reflection may also need to be given to consider whom within the commissioning world is learning research and evaluation skills, how they will be able to use these in their future work and how these skills may be valued and embedded within a commissioning context.
Main report

1. Introduction

This is the first preliminary report of the independent evaluation of Lesley Wye’s NIHR Knowledge Mobilisation (KM) fellowship, which runs from June 2014 to June 2017. It focuses on those KM activities funded through the NIHR. The KM fellowship aims to learn ‘if and how collaborative projects carried out by commissioners and researchers lead to useful relationships between the two resulting in more use of research’ (Wye 2013). Through the KM fellowship Lesley intends to ‘deliberately engineer’ (Wye 2013) communities of practice (Wenger et al. 2002) to develop collaborations between commissioners and researchers. Communities of practice are groups of people who share a skill, common concern or a particular passion (see section 2 for further definition).

This preliminary report focuses on four groups that Lesley is supporting under the auspices of this fellowship. These are:

- The development of two co-produced evaluations with commissioners and researchers; one within telehealth and one within end of life care co-ordination.
- The facilitation of a knowledge mobilisation team: comprising of Lesley Wye; two Researchers in Residence (University of Bristol researchers who as part of their role are seconded to Bristol CCG); two NHS Fellows (commissioners who are seconded part time into the Centre for Academic Primary Care at the University of Bristol); and a communications manager. The NHS Fellows and Researchers in Residence are funded by Avon Primary Care Research Collaborative (APCRC), and as such are not fully covered in this report.
- The development of a qualitative research skills group, members of which are NHS Fellows and researchers within the Centre for Academic Primary Care at the University of Bristol.

This first evaluation report has four aims and objectives:

1. To learn more about how, where and why commissioner-researcher collaborations are developing.
2. To find out what people are/ are not doing that helps those collaborations to flourish or flounder
3. To identify the contextual drivers and inhibitors that affect the development of commissioner-researcher collaborations.
4. To develop recommendations for what could be done differently.

In addition to these aims and objectives, one of the briefs for this preliminary report was to explore the extent to which the four groups listed above resemble communities of practice, to provide some insight into the overall research question of Lesley’s NIHR KM fellowship:

- When fostering commissioner researcher collaborations through communities of practice, what works, with whom, when and why?

Thus the next section provides a brief overview of the concept of a community of practice, before going onto summarise the evaluation methods and data analysis.
2. Defining a community of practice

Communities of practice can be defined as groups of people ‘who share a concern, a set of problems, or a passion’ (Wenger et al. 2002). In their work on health and social service multi-agency groups, Gabbay et al. (2003: 285) defined a community of practice as:

‘a group of people who may not normally work together, but who are acting and learning together in order collectively to achieve a common task while acquiring and negotiating appropriate knowledge’.

The key characteristics of a community of practice is that people within them share particular concerns, and that they use and share information, insights and advice to extend their knowledge and understanding of that concern (Gabbay et al. 2003: 287). These groups may occur naturally or be purposively constructed. Appendix 1 provides further details on communities of practice literature.

This evaluation report explores the activities of the four different multi-professional groups detailed in section 1 that Lesley is facilitating through her fellowship to understand the extent to which they align with a communities of practice model, providing insights into the question that Lesley asks in her knowledge mobilisation fellowship application:

‘When fostering commissioner researcher collaborations through communities of practice, what works, with whom, when and why?’

3. Evaluation methods

The evaluation used a realist evaluation approach as outlined in detail in Appendix 2. All activities under the NIHR KM Fellowship to develop commissioner-researcher collaborations, including this evaluation, have been reviewed by the Ethics Committee for the Faculty of Medicine and Dentistry at the University of Bristol. The independent evaluator, Michelle Farr, met with Lesley Wye on several occasions to develop the focus and aims of the independent evaluation. Michelle liaised with one of Lesley Wye’s mentors, André le May, through the process of the evaluation. Michelle Farr, as the independent evaluator was the only person who conducted the observations and interviews, and was the only person who had access to interview recordings and transcripts.

The inclusion criteria for interviews were people involved in the researcher-commissioner collaborations within four different groups:

1. The telehealth evaluation (6 participants interviewed)
2. The end of life care coordination centre evaluation (5 participants interviewed)
3. The knowledge mobilisation team (5 participants interviewed)
4. The qualitative research skills group (5 participants interviewed).

Lesley initially contacted the people she was working with to inform them about the evaluation, and Michelle then followed these communications up with an introductory email, explaining the purpose of the evaluation and enclosing an information sheet, inviting people to be interviewed. 13 interviews were conducted with members of the knowledge mobilisation team (KMT), the qualitative research skills group, the telehealth evaluation (TH) and the end of life care co-ordination centre (EoLCCC) evaluation. Several people had multiple memberships of various groups and were interviewed about their role in several groups. At least 5 participants of each group were interviewed, comprising of at least 2 commissioners/providers and 2 researchers from each group to understand people’s different perspectives. 8 commissioners/practitioners were interviewed and 5 University researchers/staff were interviewed. Within these figures Researchers in Residence are considered as researchers and NHS Fellows are considered as commissioners, following their ‘home’ institutions. Interview quotes
are labelled either as either ‘manager’ (commissioners and practitioners/providers) or ‘researchers’ (University staff). When quoting participants of the knowledge mobilisation team if they are specifically referencing aspects of the knowledge mobilisation team, they are just labelled KM team member to protect anonymity. A similar strategy has been used for members of the qualitative skills group, when they specifically discuss this group.

Information sheets were given out to invite people to be interviewed (Appendix 3), consent forms were signed prior to interviews (Appendix 3). Interviews covered people’s roles within the group, group dynamics and processes, the knowledge and learning that is being generated through involvement in the groups and the outputs and outcomes of involvement within the groups. The interview topic guide used is available in Appendix 4. Interviews lasted between 30 to 70 minutes and all were conducted face to face in private rooms to ensure confidentiality within interviewee’s work spaces.

In addition to the interviews 6 observations were conducted of:
- 3 knowledge mobilisation team meetings, 2 at Canynge Hall, University of Bristol and 1 at Bristol CCG, South Plaza
- 1 telehealth evaluation meeting of the qualitative sub-group at Bristol CCG, South Plaza
- 1 qualitative skills group meeting at Canynge Hall, University of Bristol.
- 1 ‘wine and reading’ evening where the knowledge mobilisation team meet to discuss academic literature on knowledge mobilisation.

The observation template used (Appendix 5) covered the purpose and aims of the meeting; key contextual issues mentioned; the content and facilitation of the meeting and the dynamics between participants. Agreement from meeting participants was obtained before the observations began. Interviews and observations took place in June and July 2015. Interviews were transcribed and analysed by the independent evaluator. Data was analysed using both context-mechanism-outcome configurations (Pawson 2013), alongside codes and categories derived from the communities of practice literature. The data analysis framework is available in Appendix 6. A draft report and initial findings were discussed with one of the fellowship mentors, Andrée le May.

4. Findings

This report focuses on four areas where commissioner-researcher collaborations are being developed and are funded through the NIHR KM Fellowship that Lesley Wye is working on:

1. the co-produced evaluation in telehealth;
2. the co-produced evaluation on the end of life care co-ordination centre (EoLCCC);
3. the facilitation of the knowledge mobilisation team. The focus here is on the work that Lesley is doing to facilitate this, rather than the work of the two NHS fellows and two researchers in residence who are funded through the APCRC.
4. the qualitative research skills group that meets at the University of Bristol and consists of researchers and NHS fellows seconded to the university.

The first section of the data analysis provides a brief outline of the four areas and the key activities that are involved in developing commissioner-researcher collaborations. The second section outlines what people are doing to support those collaborations and where further development may support the collaborations further. The third section explores the contextual issues that support and hinder these collaborations. The fourth section outlines some of the emerging outcomes of this work that were discussed in the interviews, before a final section outlines some of the recommendations that were suggested by interviewees as ways to help develop and support the work further. These
recommendations are thus some emerging reflections from those interviewed, and do not include all stakeholders' perspectives as not all people were able to be interviewed as part of this evaluation.

**Aim 1: How, where and why are commissioner-researcher collaborations developing**

**Knowledge mobilisation (KM) team**

In 2013 two NHS fellows employed within commissioning organisations were seconded into the University of Bristol, within the Centre for Academic Primary Care. Funded by the Avon Primary Care Research Collaborative (APCRC) the aim of these fellows was to encourage ‘research-informed commissioning’ and ‘commissioning-informed research’. The knowledge mobilisation team, managed by Lesley, developed with these first two NHS fellows and aimed to provide a space for shared learning in relation to knowledge mobilisation activities. After these first two NHS fellows finished their secondment, two new NHS fellows from commissioning organisations have been seconded part time into the Centre for Academic Primary Care (CAPC). In addition to this two Researchers in Residence, employed by CAPC, seconded part time into Bristol CCG have joined the KM team. All positions are again funded through APCRC. Lesley’s role in the KM team is as a leader and manager of these posts, funded through her NIHR KM fellowship.

**Practices within the KM team**

The KM team tend to meet on a fortnightly basis, both at the CCG and CAPC within the University of Bristol. These meetings act as a structure to bring the knowledge mobilisation team together, as they may be working on separate but related activities in day to day work. The purpose of the KM team meetings, as seen by its members, is to share the different perspectives of commissioners entering the world of the University, and researchers going into the CCG. This facilitates learning and support of each other in their respective knowledge mobilisation activities.

‘The KM we are learning from each other lots about how to make collaborations happen, or not happen. What works and what doesn’t work and how can you pull together researchers and commissioners and clinicians’ (KM Team 1).

Within the team people share networks and contacts ‘who to talk to for x y and z’ (KM Team 2), helping each other to make sense of the new worlds that they are navigating through their secondments.

‘We use each other to debrief, test things out, test our understanding and clarify where we have not really understood what’s happening in our respective roles. So that has felt very good’ (KM Team 3).

One member spoke of how knowledge mobilisation involved ‘working in the gaps and so you don’t really belong anywhere’. Because of the sometimes ‘unsettling’ nature of this work, the KM team was highly valued as a place for ‘support and reassurance’ (KM Team 4). It was seen by some members of the KM team that the purpose of the group was beginning to change and that whilst initially it had been largely a mentoring, supportive and sharing group and was quite ‘vaguely defined’ (KM Team 5); it was moving to one where strategy, direction and delivery were becoming increasingly important concerns. Whilst being a place for support, reflection and mentoring the knowledge mobilisation team was also seen as an important forum for sharing discussions on knowledge mobilisation theoretical frameworks and historical trends. One example of this sharing of theoretical perspectives was a ‘wine and reading’ evening where members would read particular academic articles on knowledge mobilisation and share thoughts and perspectives on these, discussing how the academic papers may relate to people’s own knowledge mobilisation practices. The linking of this research to specific KM activities can be seen as another example of an informal learning process.
The qualitative skills group

The qualitative skills (QS) group is a peer support group based at CAPC that aims to discuss and share practices concerning qualitative research. Its members are NHS Fellows, funded by APCRC, and researchers based at CAPC who work with the current NHS Fellows on particular research projects. It was set up to provide support for the NHS fellows to develop their qualitative research skills, particularly qualitative interviewing that they were both going to be doing. Initially it had been thought that the NHS fellows would be able to attend qualitative skills courses, but ‘the timing of the courses wasn’t ideal’ (QS Group 1). After an initial meeting it was agreed that the discussions were of value and so further meetings were arranged to cover a variety of qualitative research skills. Initially there were three researchers and two NHS fellows as members but other people have also attended the qualitative skills group who have been involved in aspects of the co-produced evaluations. The group is informal and aims to provide a space to share the learning of qualitative skills, ‘sharing ideas and practices and tips, being able to vent’ (QS Group 2). The qualitative research practices within the group that have been shared include focus groups, interviewing, framework analysis, coding and analysis of transcripts: ‘it is very much grounded in people’s experience’ (QS Group 3). It was considered by research members that whilst the group was initially set up to support the two NHS fellows in developing their qualitative research skills, the group had developed to include issues that University researchers were also working on: ‘it has become more of an equal status where ideas are bounced around and talked through... all under the umbrella of knowledge mobilisation’ (QS Group 1).

The co-produced evaluations

Telehealth evaluation: This was initiated in April-May 2014 through conversations between Lesley Wye and a commissioner at South Plaza. Lesley and this commissioner had already worked with each other as the commissioner had been a NHS Fellow at UWE. The commissioner needed to undertake an evaluation of telehealth and Lesley’s KM fellowship had just been awarded, where she was seeking to develop co-produced evaluations with commissioners. Both saw a good opportunity to work with each other to develop the evaluation. Whilst a decision has been made to decommission the current telehealth service, the aim of this evaluation is ‘to inform where we go next with health technology as a health community’. This group is currently undertaking data collection and analysis with a view to completing the evaluation by the end of 2015.

EoLCCC: This group has formed more recently and has had just a few meetings so far. Here Lesley Wye and a commissioner had already developed working relationships, where the commissioner was a co-applicant on another research project. There was a discussion between the two about the commissioner’s need to evaluate the service, and Lesley explained about her fellowship. Both saw an opportunity to work together on a ‘much more robust, an independent evaluation’. Lesley had previously done research in the area of end of life care, she presented her previous work to the group, and this went on to help shape the project. The evaluation group is currently completing the evaluation protocol.

Practices within the co-produced evaluations

There was agreement that the practices that these two groups focus on are the evaluations of the specific services. However there are different understandings of evaluation practices within the groups:

‘The knowledge that is being shared, it’s how research does it, versus how commissioners’ (Manager 7).

A continuum of different forms of evaluation practice can be drawn from performance management at one end, through to commissioners’ understandings of evaluation to a research-led evaluation. It
was considered by researchers that elements of a research led evaluation consisted of a control group for quantitative data, and recordings, transcriptions and dual analysis for qualitative data, using larger samples. Commissioners and providers saw that these co-produced research based evaluations had substantial additional rigour in comparison with evaluations that had previously been carried out in the commissioning world:

‘Working with the research team has meant that there is much more robustness around what we are doing, so instead of it just being what I fancy doing, what I think is interesting and my bias on it; there is a lot more challenge around why are we doing that, what does that mean, how big does that need to be. All of those kind of things, which I think will make it more robust’ (Manager 13).

‘CSU analysts have been involved in the quantitative bit, looking at control groups and that sort of thing which is not something that normally happens in NHS evaluation, when we actually bother to evaluate things at all’ (Manager 7).

Within both co-produced evaluations commissioners saw that the evaluation protocols were written from a research perspective, which could be a ‘very different’ (Manager 9) type of document to that which a commissioner may write. There were differences between participants in the extent to which they saw the group as a process by which they could learn particular evaluation skills. Some participants explicitly mentioned that involvement in the group was a way to learn about both quantitative and qualitative methods, focus group facilitation, conducting interviews and how control groups can be used. Others saw this learning as a by-product of their involvement: ‘I think it is always better to not be told that you are learning something, and then just to learn it by osmosis’ (Manager 13). Detailed analysis of interviewee’s transcripts suggests a link between people’s motivations to get involved in the evaluations and the extent to which they learn particular skills.

‘People’s different levels of interest I think within the CCG shape what we get from it’ (Manager 9).

Even though learning may happen by an informal ‘osmosis’ process, the motivation to get involved and learn new skills was an important aspect in this social learning process:

‘I think sometimes it can be difficult to convince other people to make that time, because what they are thinking is, well ideally what I want is for someone else to do it for me, and give me the outcome. And they are missing the bit where if you don’t shape and get involved in the conversations, the outcome isn’t going to be what you want it to be and you won’t be embedding that learning in the future’ (Manager 9).

Aim 2: The mechanisms of collaboration: What are people doing or not doing that helps those collaborations to flourish or flounder

The flourishing of the knowledge mobilisation team
Actions that supported and developed the knowledge mobilisation team include:

The creation of a mentoring and supportive environment: KM team members spoke of how they supported and coached each other, both within and outside of team meetings. This included helping each other to navigate through their new organisations, ‘translating, debriefing, supervising, mentoring, coaching’ (KM Team 3) one another. This sharing of perspectives and experiences was valued by different members:
‘It is really good to have that, other people who understand the challenges and the difficulties that you are facing’ (KM Team 4).

There was a strong sense of a ‘nice team spirit and camaraderie’ (KM Team 5) and people valued each other’s reflections and honesty:

‘It’s kind of very, very accepting and everything is valuable and nobody is criticised.... There’s a recognition that everybody is working very, very hard and it’s all about the learning, it’s all very experimental’ (KM Team 4).

**Appreciating and valuing diversity:** It was considered that the KM team was a diverse group but that people were all focussed on and motivated toward the common objective of knowledge mobilisation. There was a strong degree of respect for each other’s knowledge and skills, acknowledging and appreciating the diversity of experiences that different people have. This supported the process of secondment into each other’s organisational environment, as people were ‘very committed to supporting each other and supporting the work’ (KM Team 4), supporting each other in the navigation and understanding of a new working environment.

**An enabling leadership role:** Lesley’s role within this group was one that helped support to create this environment:

‘She’s very charismatic ... she has just got a particular approach that is very empowering, it makes you feel that you can do anything. Makes you feel like you are very supported and valued’ (KM Team 4).

The leadership skills needed included a strong degree of interpersonal skills, managing in a consensual and mutually inclusive way, getting everybody’s opinions and perspectives. Some members spoke of the sense of being supported in their own personal development, and this mentoring and development role was seen as an important aspect of the leadership from some perspectives. In addition to this, the input of specialist knowledge was also appreciated as a part of the leadership role:

‘She comes with fresh ideas and her expertise just brings something else which is really valuable’ (KM Team 3).

‘You talk about something and she will relate it back to the literature and so I feel that I am learning a lot from her, almost without realising it because it is all so, as we are going along’ (KM team 4).

**A wider advocacy and PR role:** was also needed to highlight the work of the team, promoting the work through the wider organisational systems.

**Roles and identities within the team:** People felt that their roles within the KM team were to be generally supportive and enabling of each other, appreciating each other’s respective skills and knowledge, as opposed to having a specific role in the KM team. More generally some researchers began to identify themselves as knowledge mobilisers, whereas commissioners tended to maintain their identities:

‘People say what do you do, and I say I’m a knowledge mobiliser’.

‘Knowledge mobilisation.... that is my brand now’.

‘I think in terms of my identity I think I still identify myself as a commissioner, I think I would see myself as a commissioner with some research skills’.
Areas of development for the KM team

Sometimes it’s just not bounded enough … There was a general sense that whilst team members appreciated the informal, mentoring and supportive environment, there was also an increasing need to be more task and activity focussed within the KM meetings.

‘We need to be clear about what needs to be done by when and who is actually going to do it’ (KM Team 3).

Suggestions to improve the KMT meetings included having an action log of who is doing what by when, and ensuring that the meetings had clearer boundaries.

Sometimes the fact that it is Friday afternoon I struggle with. So often I feel impatient on a Friday that I have got so much to do and did I achieve it in the week. And then I have got a less defined, slightly vaguer meeting to go to when I have got so many things that I have to deliver in the week (KM Team 5).

In an environment where people feel pressured for time, the unbounded and ‘vaguely defined’ nature of it where there were ‘changing goalposts’ did cause some irritations and impatience. This may be symptomatic of the time at which interviews were conducted with a wider feeling that the nature of the group was shifting and needed to become more focussed, now that people had been in their roles for some time.

Having clear priorities: With having fellowship and researcher in residence funding from APCRC, Lesley’s work being funded through the NIHR KMF, and the KM team working across both the CCG and the University of Bristol, it was commented upon how this could make priorities and objectives more complex, responding to a range of demands from different places.

‘There are so many different things that we could do and what are we being measured against’ (KM Team 5).

Understanding, evidencing and rewarding work that creates impact: More generally there was a feeling that evidencing the tacit, relational and informal aspects of knowledge mobilisation work could be a challenge:

‘It can be quite difficult working in this way, where you can’t really see a product very often. You’re chipping away, you don’t know if it is making any difference’ (KM Team 4).

There was a broader discussion with some members that the work that they were doing was often in an experimental stage. For researchers in residence this could centre on working out when, how and where to best include research evidence within commissioning meetings and discussions so that decisions may become more evidence informed. Both researchers and commissioners considered that the usual way that academics present findings was not conducive to knowledge being applied in practice. In addition to this the knowledge that is produced within research does not incorporate the social and political elements that commissioners need to manage, where budgets, resources and service delivery were important elements of decisions. One member of the KM team felt that some of the KM work was still quite researcher led:

‘It still very much seems to be well I have got this research project and this is what I’m going to do and so now I’ll go and find a commissioner that I can co-opt to doing this, rather than saying, “well this is an idea, that I’ve got, what’s your idea”. And “ok how do we build something jointly out of that”’ (KM Team 2).

People also discussed how whilst a considerable amount of time was spent upon developing and facilitating relationships between commissioners and researchers to support new collaborations, this
was not easy to evidence as impact. How the relationships that were facilitated then went onto enable knowledge mobilisation is not an easy process to quantify. In addition it was considered that these connection and facilitation skills, whilst supporting those who are connected, did not necessarily bestow rewards on those who were the connectors. What’s in it for the connector? How do their skills get recognised?

Facilitating the qualitative skills group
There was a general sense that this informal group was ‘iterative and fluid’ in its focus and aims. Both researchers and commissioner members of the group commented on how the group felt ‘safe’ where ‘it feels ok to expose the gaps in your knowledge and just discuss things on an equal level’. Here:

‘There is no such thing as a wrong answer…. There is no pulling rank or competitiveness’ (QS Group 3).

Motivations to stay involved in the group included that it provided a good learning space, one participant commenting that they felt ‘valued’ through their participation. Roles in the group were informal participation with Lesley taking on a coordinating, facilitative role. This was done in a way that recognised other people’s contributions and expertise, enabling people to be open and comfortable, providing an overarching perspective that could identify particular issues and ‘sum up a situation very readily’.

Enabling the co-produced evaluations
In relation to developing the two co-produced evaluations, actions that supported these collaborations included:

Understanding common concerns: Getting everybody’s buy in across different organisations and roles was essential, understanding different people’s agendas, interests and concerns.

‘Lesley is very good at is the collaborative, encouraging everyone to be involved. She very much wants everyone’s opinion and wants everyone around a table talking’ (Manager 9).

From this understanding of people’s perspectives, it was important to generate common agendas and concerns that different people could all sign up to, being flexible, open to negotiation and compromise. It was important to ensure that this collaborative style continued in the face of difficulties:

‘We all actually threw something in as to how we could resolve it’ (Manager 5).

Generating enthusiasm: Getting people interested and motivated to contribute in a project was important to ensure continued commitment:

‘Lesley is very influential because she is very charismatic ... the subject could be as dull as ditch water but you would still want to join in’ (Manager 8).

Interest in and valuing other people’s perspectives: People spoke of how there was an inclusive sense within the group, ensuring that different people are integrated. An environment was generated where everybody contributes and is valued, developing a sense of equality:

‘They make me feel like an equal’ (Manager 10).

Within this it was considered important for people not to pursue personal agendas at the cost of collaboration, ensuring that there are wins for everybody through the process.

Creating a safe environment: People spoke of being comfortable within the group and being able to ask ‘silly’ questions:

‘I have never felt like an idiot when I have said stuff that probably is idiotic’ (Manager 13).
An involving and participative style then helps to generate trusting relationships:

‘I think she has got a particular skill at getting all the views from all around the table and I really, really like that. And it makes me trust her and her work’ (Manager 8).

**Co-ordination, valuing different people’s expertise and creating specific group roles:** Members of the co-produced evaluations saw that all members had particular expertise that was important to the functioning of the group. Within the co-produced evaluations representatives from providers, commissioners and researchers are all present and contributing their specific knowledge and skills in relation to the evaluation. Membership from each of these three groups can be seen as essential:

- providers to illustrate the key issues in service provision and whether particular approaches would work on the ground: ‘there are things that we would suggest or wouldn’t suggest dependent upon what is appropriate for the patient’ (Manager 10);
- commissioners to provide the core overview of the commissioning landscape and the focus of the evaluation: ‘we need something that will tell us, this is the correct model to go with ... that learning will also shape, go into the CCG, thinking about other projects’; ‘from the perspective of the CCG we want to know what, how to inform future health technology’.
- researchers as ‘real experts, fiercely passionate people about those [quantitative qualitative] elements, has been really helpful because they are able to create an evaluation that has robustness in both elements’ (Manager 13).

It was important that people understood each other’s roles within the group and their place within the evaluation work. Key people were needed to ‘do the doing’, ‘churning data’ (Manager 13) and doing the ‘nitty-gritty’ (Researcher 12). Co-ordination and allocation of specific work to the specific people within different organisations was needed, according to their roles and skills. Here the project management lead took on one of the key underpinning and overarching roles:

‘You need someone who has got a handle on the project, and who is trying to herd the cats because I think it has been like herding cats at some point because I think we are difficult to pin down, because we have all got other stuff going on’ (Manager 13).

It was seen that the project management lead needed to be able to bridge across organisations and be someone ‘who knows both worlds and can manage them’ (Manager 7). This role consists of having considerable organisational and co-ordination skills ‘managing the whole thing to make sure that it happens, make sure people know what they are doing’ (Manager 5), and communicating that with all group members:

‘It is the organisational skills of getting the group together, maintaining, convening the meetings... keeping on top of the project and what needs to be done next, making sure that the momentum is carried forward, the data collection, taking a lead on this and allocating data to different people, taking a lead on the analysis’ (Researcher 12).

In turn this role needs additional support so that the person holding the project management role can effectively act as a bridge across organisations, and feed in expertise from different perspectives. Part of Lesley’s KM Fellowship means that she has this overarching role as ‘the evaluator, intellectual lead’ (Researcher 4). This has meant taking on an intensive coaching role, to support the co-ordination of the evaluation project.

**Tapping into people’s own motivations:** Most participants that were spoken to got involved with the co-produced evaluations by virtue of their organisational role, rather than it being a voluntary choice.
However several participants spoke of how their own interests aligned with aspects of the evaluation, which provided additional motivation to get involved.

‘I like research. I like discovering new things. I also want to learn about the process as well. I’ve done lots of project management courses and that sort of thing, but nothing to do with research in the past…. I was intrigued a little bit to see how research worked in this environment, and I just like being involved’ (Manager 10).

‘I thought it was really interesting and for my own personal learning’ (Manager 13).

Working with people who have an interest in the area of research, and the process and outputs of the evaluation supported the process:

‘People who are really enthusiastic about the evaluation happening and wanting to see the outcomes of the evaluation. So really up for providing solutions, really up for doing work to make it happen’ (Manager 5).

Some participants spoke about additional motivational factors to be part of the co-produced evaluations. Motivations to get involved can be divided into motivations about the process of the evaluation and its outcomes. In terms of the process, motivations included being able to influence the group processes, learn about specific areas that were in relation to their jobs and develop their skills in evaluation; ‘understanding how to set up a more robust evaluation’ (Manager 9). One member saw that it was particularly important to be involved to have some influence within the group:

‘To be able to influence what it is that goes forward rather than to have it written down like a prescription to carry out’ (Manager 8).

In relation to evaluation outcomes, in both projects providers and commissioners spoke about the value of having a greater understanding of patients’/carers’ experiences and perspectives that would come out of the evaluations. These patient narratives were highly valued by both providers and commissioners, who both identified a gap in being able to produce this data by other means. In addition to this specific learning about particular services, more general and wider lessons about care co-ordination, the role of assistive technologies and different commissioning models were also hoped for. Both providers and commissioners were interested particularly in the results of the evaluation, to better understand and improve their particular services.

**Difficulties in collaborating on co-produced evaluations**

There were also several difficulties that were cited in developing co-produced evaluations, including:

- Explaining things at an appropriate level so that people understand, not assuming that people have particular knowledge and understanding. Communication across difference can take more time, thought and detail; with misunderstandings potentially more likely to happen: ‘Maybe the way that I have meant something hasn’t necessarily been interpreted in that way’ (Manager 1).

- If there are sensitivities between providers and commissioners with respect to commissioning agreements, this may influence how and when providers get involved. This may interfere with a collaborative approach where everybody is invited, issues are discussed openly and all participants’ contributions are welcomed.

- Different commissioners, providers and researchers may all have quite different understandings of the definitions and boundaries between performance management, service evaluation and research-informed evaluations.
• Negotiating common interests may be difficult where there is a diversity of thinking. If needs and interests are so diverse this may reduce the common ground upon which a collaborative agenda can be developed.

• The involvement of patients within the co-produced evaluation groups was discussed by some participants, but this was seen as adding additional complexity to the collaboration: ‘I thought about patient engagement earlier on, but then I thought that would muddy the water a little bit and would make things harder because you would need to explain everything to them, you’d have to spend a lot of time going through everything’ (Manager 10).

Thus patient and family carer involvement was seen in terms of being evaluation participants rather than having a role in the development of the evaluation. However in the EoLCCC the involvement of patients and carers as participants within the evaluation was also understood as particularly ethnically complex, given the nature of the service.

‘Sometimes I feel it is just so hard getting researchers and commissioners and clinicians to work together, much less getting patients and family carers involved’ (Researcher 12).

• ‘Changing goalposts’: several people spoke of the difficulties in how whilst the evaluations have had to adapt to changing circumstances, constantly being in a process of evolution can make the process even more difficult. There was a sense that sometimes decisions needed to be made and stuck to: ‘we started with this massive idea and then it got honed down into something smaller, and then it got honed down into something smaller, and then honed down into something smaller and you kind of end up going, what’s left of it?’ (Manager 13).

• Time and capacity are both in short supply, and whilst the collaborative approach was largely appreciated there was also a sense that this took substantial additional time.

• Data sharing and information governance are important contextual issues. Participants spoke about the need to understand the extent to which information could be shared at possibly an earlier stage in the process to identify whether particular work streams are a possibility.

In spite of these difficulties however there was also a clear sense of the need to keep going:

‘It would feel sad if, having put in all of this effort, if it wasn’t sustainable so I am really keen to work with the peaks and troughs and use the learning from the evaluation to help inform that’ (Manager 8).

Aim 3: Identifying the contextual drivers and inhibitors that affect collaborations

Contextual drivers

It was seen that through the APCRC funded rounds of the NHS fellowships and researchers in residence, this would support ‘an increasing cohort of people’ that would help to create ‘a critical mass who are interested in this area’ (Manager 5). APCRC seminar activities were also seen as a resource where both researchers and commissioners could meet. The role of senior management within all participating organisations was important in allowing the collaborations and knowledge mobilisation to be funded and/ or prioritised, or in enabling staff to be released to work on particular activities so that they could have dedicated time on particular activities. Other organisational drivers included the Elizabeth Blackwell Institute, that had recently done a call for research ideas and this was promoted by commissioners to GPs, with a number of successful ideas and proposals developing from this. Health Integration Teams (HITs), cross-organisational and interdisciplinary groups that have been developed to tackle health priorities across Bristol, were seen as an important network and resource to tap into with regard to knowledge mobilisation activities. Both CCG and researcher respondents highlighted their importance, one commissioner suggesting that further CCG presence was needed within the HITs. However another suggested that this could sometimes be a ‘tick-box’ approach, ‘rather than what is really in it for the commissioner’ (Manager 11).
In the work with the ITHACA HIT both NHS fellows and Researchers in Residence were active in introducing more commissioners into the group. It was seen that an additional advantage of working through the HITs was that different people are aware of these, in contrast to Researcher in Residence roles which are relatively new. Where researchers in residence were associated with HITs, these were seen as an additional organisational lever.

‘I think that they [HITs] are really useful in terms of making contacts and working within the CCG because … I bring all those contacts with me, and I think that the CCG values that’.

NHS fellows could act as navigators for researchers, highlighting the commissioning meetings and spaces where commissioners concerned about a particular topic would meet. Finding areas of joint interest where researchers are interested in a particular topic, and are open to negotiation and influence, alongside commissioners having similar priorities and concerns were seen as potentially important synergies where further collaboration could occur. Being more of a research generalist than a specialist was helpful here as there is a wider array of knowledge that can be drawn from to support commissioners. More generally the navigational role to identify potential links and collaborations with commissioners was perceived as important by researchers, to draw together people who were not previously aware of each other’s work. However it was understood that this was not an easy task: ‘communication between organisations, within organisations, it is a challenge. If it was easy it would have been done’ (Researcher 3).

It was seen that the co-produced evaluations were a good vehicle to bring together researchers and commissioners:

‘I think evaluation is a good way of bringing the two groups [commissioners and researchers] together because I think it is something in the NHS that we don’t do well. And we know we need to do better at’ (Manager 7).

It was recognised that several national agendas in the area of commissioning supported the development of these co-produced evaluations. Financial pressures upon the CCG were seen to highlight the importance of evidence of service effectiveness, alongside the quality agenda and the increasing importance of patient experiences. It was seen that collaboration with universities has been nationally supported through the development of the Academic Health Science Network. The Avon Primary Care Research Collaborative (APCRC) was also seen as an important resource for information and advice on service evaluations. Within the CCG the work and emphasis made on the development of evidence based commissioning was also perceived as an important driver.

‘One thing that the transformation team are very good at drumming home to us is trying to ensure, have you factored in the evaluation from the outset’ (Manager 1).

Contextual inhibitors

Language: Both commissioners and researchers spoke of the difficulties of specific technical language within their own field which could make collaboration more difficult.

‘When I see blank faces I realise that I have completely lost them’ (Manager 9).

‘We literally could not find a way of talking to each other’ (Researcher 12).

Avoiding acronyms and providing clear explanations was crucial to overcome this barrier.

Timing: More generally it was seen that the process of research and evaluation was elongated whilst commissioners needed answers now.

‘With commissioners it is all about the here and now. We need that by tomorrow’ (Manager 7).
With knowledge mobilisation activities, there was an example where commissioners themselves did not consider that there was sufficient time to include within a meeting an academic presenting relevant and related work to the discussion at hand. With the co-produced evaluations, decisions needed to be made before evaluation results were available. This mismatch of timing is related to the degree to which the research and evaluation is rigorously done according to academic standards, one researcher commenting that:

‘Sometimes you can’t give them the kind of answers that they are looking for in the time and the resource that is available. And there is a danger that we could fall into trying to do that and producing poor quality data. That would be my concern’ (Researcher 2).

With the co-produced evaluations it was seen that the timing of both was complex, with the telehealth evaluation possibly starting later than would have been useful from a commissioning perspective. Conversely, it was suggested that the EoLCCC evaluation may be being implemented too early within the intervention.

**Changing nature of service interventions within co-produced evaluations:** One of the major contextual factors in the co-produced evaluations was the changing nature of the service interventions. Within the end of life care co-ordination centre, the ‘test and learn’ model that was being used was in a state of flux with the model in the process of change. Within the telehealth evaluation, this service was being decommissioned, with staff beginning to leave jobs and equipment being brought back in. Both researchers and commissioners highlighted the difficulties of this changing context, wanting to ensure that the evaluations were still valuable and important pieces of work.

**Capacity:** Researchers, providers and commissioners all highlighted problems of capacity. In some knowledge mobilisation activities where specifically applied research was taking place it was sometimes seen that commissioners were less interested in the process, but only the results. This issue could relate both to the capacity to get involved in the process, as in the co-produced evaluations, but also the extent to which there was a general awareness of and interest in research.

**Relevance of research findings:** Commissioners did not necessarily always see or understand the value of research findings. In addition the context within which commissioning decisions are made are much more complex, where issues of increasing demands and lack of resources may be important elements within decision making, making the application of research findings more complex.

**Methodologies and implications for research careers:**Whilst randomised controlled trials may sit at the top of the academic knowledge hierarchy, their application within commissioning is much more contested. One commissioner with research experience highlighted how different methodological approaches were needed for the complexity of commissioning and service evaluations. Whilst such applied research may be ‘looked down on’ in academic circles, it was seen as ‘really valuable’ within a commissioning context. In addition methodological academic rigour in both qualitative and quantitative methods took substantial time which did not fit with commissioning deadlines. This could have substantial implications for researchers’ motivations to get involved, where they are performance measured on the strength of their publications. The quality and research rigour that was needed for academic publication could be particularly difficult to achieve in a service context where interventions and contexts were constantly changing, data was difficult to share between organisations and the pragmatic methods needed to operationalise the evaluation fell below particular academic standards. There was a particular issue concerning publication in the co-produced
evaluations where organisations may be identifiable within publications, which created ‘reputational risks’.

‘We are scared of discussing our failures, we really want to discuss our successes, and we’re not happy if we’re told that they are not that successful’ (Manager 9).

**Bridging different worlds:** It was seen by commissioners that researchers worked:

‘Very differently and come with very different thoughts, beliefs, ways of working, what’s important, time frames’ (Manager 11).

‘Day to day patient care is quite different to the research, everything in a box kind of perfection’ (Manager 13)

In addition to these differences between researchers and commissioners, it was also seen that there were substantial complexities in relationships and interests between the CSU, the CCG and providers, that add to the difficulties in developing collaborative relationships, between these diverse organisations.

**Organisational levers and motivations:** Perhaps because of the complex context within which these collaborative relationships are developing, organisational levers to promote collaboration are highly important, some examples having already been given in the previous section such as the support of APCRC and development of Health Integration Teams. However it was seen by some interviewees that further organisational levers could be developed. Firstly in relation to the university, it was seen that whilst they had been successful with regard to research impact within the Research Excellence Framework 2014 (the system that assesses quality of research in UK higher education institutions), further work could be done to promote the importance of research impact. It was considered that getting a commissioner involved within a grant ‘might be whistles and knobs on, but it is not essential’ (Researcher 4). Another researcher explained that whilst patient and public involvement had become much more emphasised within health research there was still yet to be an emphasis upon involving other stakeholders such as commissioners. It was seen that promotion criteria for researchers was not sufficiently focused upon impact to make a significant difference to researchers’ incentives and actions in this area, whereas in other universities the promotions criteria sometimes put a much stronger focus upon impact. Further institutional investment in and the valuing of impact was seen as particularly important.

Conversely, the rewards for commissioners to learn research skills and engage in evidence-informed practice was also seen as a lever that could be developed much further, developing positive incentives to engage with researchers and evidence within commissioning. It was unclear whether there were specific organisational rewards or incentives for commissioners to both learn and engage with research beyond the APCRC funded positions.

‘They [commissioners] are very pragmatic, often researchers don’t come up with anything particularly useful so why should they do it. And it’s not going to add to their careers’ (Researcher 12)

**Revisiting aim 1: Emerging learning and knowledge mobilisation outcomes**

**Knowledge and learning**

Having explored the mechanisms that support collaboration between researchers and commissioners, the difficulties encountered and the contextual drivers and inhibitors of these collaborations, an overview of the emerging outcomes is now presented. This analysis provides further insight into aim 1 of this report; learning about how, where and why commissioner-researcher collaborations are developing. The outcomes detailed here cover only those that were discussed in interviews. Data from
quarterly knowledge management team progress reports is not included within this section to avoid repetition. Where it is clear that a specific intervention has led to an outcome this is specified. However in some cases participants were involved in several of the groups discussed here, alongside some being in the roles of NHS Fellow or Researcher in Residence. Here it was sometimes difficult to pinpoint exactly which knowledge mobilisation intervention (e.g. being part of the knowledge mobilisation team meetings or being a NHS fellow) lead to a particular learning outcome. Emerging learning and knowledge outcomes include:

**Better understanding of commissioners and researchers:** Both researchers and commissioners felt that they understood each other’s domains to a greater extent:

> ‘I think there is very much a process of osmosis, a diffusion of the different worlds’ (Manager 7).

**Research skills:** Commissioners (including NHS Fellows) and providers spoke about how they had gained increased knowledge and understanding of:

- control groups - random selection and matching patients for control groups
- the value of qualitative research and qualitative research skills
- developing patient information leaflets
- topic guides for interviews
- interview skills with both staff and patients
- the benefits of using recording and transcriptions for interviews
- the diversity and variation of research skills
- information governance
- the different ways in which research evidence is developed and interpreted.

In addition to these specific skills, one commissioner spoke about how they were also considering other possible NIHR collaborations in the future. Researchers also spoke of how their own research skills had developed. In the qualitative skills group, researchers spoke of how the reflective space also allowed them to participate in ‘shared learning’ (Researcher 3).

**Workshop and commissioning skills:** In addition to learning about the commissioning world itself, one researcher also spoke about how they had learnt specific facilitation and workshop techniques from a commissioner that had gone on to support their own work with commissioners. Project management skills and setting the boundaries of these were also skills cited by researchers that they had learnt through their work with commissioners.

**Embedding evaluation:** Commissioners and providers spoke of the co-produced evaluations taking place on a much larger scale than they had experience of previously. Most commissioning and provider participants felt that not only had they learnt a substantial amount about evaluation, but they could also identify how they have, or may in the future, embed that learning into their work. This included:

- considering the evidence base before embarking on a project
- developing evaluation plans for the projects that they are involved in or may embark on
- having an increased appreciation of the benefits of qualitative research
- developing methods to better understand patient experiences and narratives
  > ‘It has started to make me question how we truly measure performance and quality in services and patients journeys’ (Manager 9)
- reconsidering how to measure quality and the use of CQUINs

24
the importance of evaluation: ‘From a commissioning point of view, they key learning for me is that if you are going to set up a massive project and you are going to invest in it, you should evaluate it properly. And you should invest in evaluating’ (Manager 13)

- acknowledging and accounting for the amount of work that is involved in developing a robust evaluation ‘which says an awful lot about our current evaluations’ (Manager 9)
- knowledge of how to set up an evaluation and to plan it in a more robust fashion.

Researchers saw that involvement in co-produced evaluations helped them to compare and contrast the implementation of evaluation methodologies in different projects that they are involved with. It also increased their understandings of the meanings of evaluation and how they are used and represented within commissioning. They also spoke about the increased understanding in pulling out statistical data and information governance issues around this. People were asked as to whether they felt they had the confidence to lead an evaluation themselves. Responses were dependent upon the size and required robustness of that evaluation, but people generally considered that they had much more detailed knowledge and understanding of the different evaluation processes and skills and knowledge that was needed.

Better understanding of the services being evaluated: Different participants identified how involvement in the co-produced evaluations had helped them to understand the specific service provisions better; including an increased understanding of the complexities of end of life care provision and the usage of telehealth devices and healthcare technologies. Some commissioners and providers spoke of how they had got to know aspects of their own organisations and those that they worked with better.

Mobilising knowledge into commission decisions: More generally knowledge mobilisation team work and outcomes are covered in the KM team quarterly progress reports that are circulated. Key issues reiterated in the interviews included the continuing learning of how and when to feed in research findings into commissioning discussions. When and where is it appropriate? Associated with this one commissioner discussed how generally academic papers were not written in a way that was easy to apply in the commissioning world. Here the recommendation was for researchers to do ‘an executive summary translation into 3-5 recommendation in plain English’ (Manager 11).

Relationships and networks
Within the co-produced evaluations, networks between the CCG, CSU and providers were seen to have been improved by some respondents.

‘It just makes it easier in this job when you get to meet people from various sectors’ (Manager 10).

Commissioners who have been through the NHS Fellow positions were seen as an important resource and people whom could be gone to for advice.

‘I wouldn’t like to pick up the phone to the university, I would ask someone like [NHS Fellow] for advice’ (Manager 1).

Commissioners and providers generally felt comfortable to approach those researchers they felt that they knew through the co-produced evaluations, with a view to that person potentially identifying further links. Some commissioners did feel that they might approach a researcher directly:

‘I’m more likely to now, whereas before I would have probably just read their paper and then been terrified to talk to them. Whereas now I have started to realise that actually all of us want to talk to each other, we just have to do it’ (Manager 9)
Similarly researchers felt more able to contact commissioners, although also considered that tapping into existing relationships and networks smoothed this process.

‘I would feel happy to contact a commissioner directly if I knew who the person to contact was. But it is how to get into the organisation, that’s the barrier’ (3)

Researchers tended to value these links with the commissioning world to enable collaborative work and develop research impact.

Aim 4: Developing recommendations for what could be done differently

Recommendations and hopes for the future

There is clear evidence of how the different knowledge mobilisation activities are already having a range of outcomes and impacts, both within commissioning and researcher contexts. This report has started to track both the activities and outcomes of this KM work, drawing on a limited number of interviews with a range of different participants. Initial and tentative recommendations drawn from the interviews conducted as part of this evaluation include:

- Further clarity on people’s roles within the evaluation may be of benefit, especially when new people join the group so that they understand people’s roles and responsibilities.
- Considering whether a terms of reference and agreement may be helpful to guide publication issues where there may be potentially attributable material to specific organisations: ‘we want to be transparent, but this is also incredibly personal, reputationally risky’ (Manager 9).
- It was important to be ‘mindful of the broader partners... the stakeholders who aren’t around the table’ (Manager 8)
- Data governance should be investigated at an early stage in the project to understand potential issues with an initial assessment of the feasibility of different work streams. ‘I think that that is where we came unstuck and we have had to drop some of the work streams so I think more of an analysis of the feasibility of what we are trying to do ... right from the start’ (Manager 5).
- Having a clear understanding of the service from the start before an evaluation is designed: ‘Having a more thorough understanding of what it was that I was evaluating I think would have been really useful.... Getting a real understanding of what the service is, because some people in that group know it in-depth and others don’t’ (Manager 5). It was also commented that it was when qualitative interviews and focus groups with telehealth nurses from different backgrounds were done, that in-depth learning of the service was really enabled. Therefore would informal conversations with front line staff at an early stage help to inform the evaluation design?
- Facilitation that keeps boundaries and aims clear: ‘Sometimes, there needs to be a control button in the room ... I think that the research element can mushroom things ... you feel like you have drilled down and then suddenly it is boom, you are up into a mushroom again with loads of ideas with how you might do it. So it needs really strong leadership, the group, to go, no we’re not going there any more, we have decided about this’. (Manager 13).

Within the co-produced evaluations commissioners and providers hoped for an evaluation that ‘everyone is happy with’ and ‘to be able to make recommendations about the service future’ (Manager 1). More generally people saw that:

‘Whatever individual’s motivations are, we have to collectively create something that is workable to take forward’ (Manager 8)
Within the knowledge mobilisation team there was a hope that:

‘this group of people, will become bigger, so that then maybe it almost becomes the norm ... you have those connections, that those are people that are in your sphere of knowledge, people that you might call on’ (Manager 5).

Others also hoped for a stronger and broader base for the knowledge mobilisation work that was taking place, understanding and evaluating the work of NHS Fellows and Researchers in Residence, embedding learning from this and developing the work further, enhancing institutional levers and enablers to support this work. Some researchers spoke about their interest in developing co-produced evaluations with commissioners. Because of the vast scope of potential activities of the KM team and a need for navigation of where the team may have most impact, one finding from this evaluation would be to identify those commissioners who are most research aware and interested in researcher collaborations. And similarly to identify researchers who are most interested in working collaboratively and value the importance of research impact. In this way the KM team can draw together ‘coalitions of the interested, the willing, and the able’ (Sannier 2014). Further reflection may need to be given to consider whom within the commissioning world is learning research and evaluation skills, how they will be able to use these in their future work and how these skills may be valued and embedded within a commissioning context.

5. Discussion and conclusion

The key research question that Lesley asks in her knowledge mobilisation fellowship application concerns:

‘When fostering commissioner researcher collaborations through communities of practice, what works, with whom, when and why?’ (Wye 2013).

The above sections suggest that all four groups that Lesley is facilitating through her fellowship can be considered a community of practice, defined as:

‘a group of people who may not normally work together, but who are acting and learning together in order collectively to achieve a common task while acquiring and negotiating appropriate knowledge’ (Gabbay et al. 2003: 285).

Key characteristics are that people are sharing particular concerns, and that they use and share information, insights and advice to extend their knowledge and understanding of that concern (following Gabbay et al. 2003: 287). Within the four groups learning and practices are shared amongst all the different members of the groups. However the cross disciplinary nature of these communities of practice presents distinct challenges. Whilst there are elements of social learning within the two co-produced evaluations they are also complex project management groups with diverse members that collaborate across organisational boundaries. Other academic literature has explored the co-production of research within public services, highlighting some of the issues that are faced within this fellowship. ‘Walking the tightrope of co-produced research’ (O’Hare et al. 2010: 245) has been explored in public management literature on co-production and research impact (see the special issue in which O’Hare et al. is based). Other public management literature on inter-agency collaborative working may provide different theoretical insights into the enablers and constraints of this type of working. For example Rigg and O’Mahony (2013) provide a list of key factors such as ‘trust, power, language, governance, leadership and clarity of shared outcomes’ that help to explain whether collaborative working may be ‘facilitated or frustrated’ (Rigg and O’Mahony 2013: 84). They highlight that institutional contexts can have a significant effect on collaboration, drawing on institutional theory that illuminates the issues of differing rules, logics, beliefs and conventions (Rigg and O’Mahony 2013: 103).
People within this evaluation research spoke about the importance of developing relationships to facilitate knowledge mobilisation. However a further strategic approach may also be needed that explores how to institutionally encourage and reward this work, working with more senior figures to enable this to happen. How can the current KM team further embed itself within existing structures and support work to change these? What cultural levers can be developed to support and encourage the development of research informed commissioning and commissioning informed research? Practically this may mean that the KM team could also work at a more strategic level, reaching higher managerial levels where the performance criteria of commissioners and researchers are developed.

Within the University where Lesley is becoming Deputy Director of Impact there is an important opportunity to begin to shape this strategy around impact, exploring how impact can be more defined and developed within institutional culture, building on the driver of the Research Excellence Framework 2020 research quality criteria where research impact will be taking on yet stronger significance. Elements of cultural change may also be explored within a commissioning context. What national agendas can be harnessed to support the normalisation of using research within commissioning? More specifically how can commissioners be recognised and rewarded for the work they do where it becomes increasingly evidence based. Levers to support this work may be able to be explored further, building on national and local trajectories outlined in the executive summary.

This preliminary report shows that a broad range of social learning opportunities are being developed to enhance collaborations between researchers and commissioners, using communities of practice. Thus the NIHR KM fellowship is well on-track to answer the research question of: ‘When fostering commissioner researcher collaborations through communities of practice, what works, with whom, when and why?’ (Wye 2013). However there is also the question of whether there is a broader ambition to institute more research-informed commissioning and commissioning-informed research within the CCG and University. This is a much more challenging aim that goes beyond social learning through communities of practice, with the ambition to affect more structural and cultural changes within two large institutional bureaucracies. Here public management literature on inter-agency collaborative working may provide different theoretical insights into the enablers and constraints of this much wider intention.

References


Appendix 1 Defining a community of practice

The concept of a community of practice is derived from Lave and Wenger’s (1991) work that studied how apprentices and newcomers learnt a particular profession or craft. Their focus was on naturally occurring communities of newcomers and experts, illustrating that learning is essentially a social process that occurs through situated activity. Wenger et al. (2002) has since developed the concept to explore how groups participate and learn through communal activity. Communities of practice can be defined as groups of people ‘who share a concern, a set of problems, or a passion’ (Wenger et al. 2002) and:

- deepen their understanding and knowledge through interaction
- share information, insight and advice
- solve problems and help each other out
- ‘think about common issues’
- may create tools and standards or just have tacit understandings of shared issues
- develop personal relationships, and possibly ‘a common sense of identity’ (Wenger et al. 2002: 4-5)

Wenger et al. (2002) considers that a community of practice consists of three core structural elements, without which it is not possible to operate. These are:

- The domain of knowledge which is the topic that the community focuses on; ‘working with the domain enables the community to determine and progress its common goals’ (le May 2008: 8)
- A community of people whereby their interactions generate social learning
- Practices which can be understood as ‘frameworks, ideas, tools, language, stories and documents’ that are shared to further understanding and knowledge of the domain (le May 2008: 8)

Following le May (2008: 4) to ensure that a community of practice (CoP) is effective the following need to be considered:

- Membership – who is involved, their knowledge and expertise. Wenger et al. (2002) suggest that members should self-select although Kislov et al. (2011) suggest that project teams may become CoPs.
- Enthusiasm of its members to the particular domain and practices
- Commitment within the community to its aims and outside of the community to support its activities.
- Relevance of the CoP to the communities within which it is situated
- Infrastructure to support the work of the CoP
- Skills in relation to the particular practices of the community
- Resources to support the community.

Whilst the original CoP concept focussed on the organic development of groups who share practices; this concept has since been used to investigate how CoP may be deliberately and intentionally developed to support knowledge exchange, learning and practice development (Kislov et al. 2011). With one of the aims of the KM fellowship being to ‘deliberately engineer’ (Wye 2013) communities of practice it is useful to outline seven principles that have been suggested by Wenger et al. (2002) to support the cultivation of communities of practice:

1. Design for evolution, grow in an organic way, building on pre-existing personal networks
2. Open a dialogue between inside and outside perspectives
3. Invite different levels of participation
4. Develop both public and private community spaces
5. Focus on value
6. Combine familiarity and excitement
7. Create a rhythm for the community.

The communities of practice that are being cultivated in this KM fellowship are cross-organisational and multi-professional which may produce some distinct challenges. For example in their work on Collaborations for Leadership in Applied Health Research and Care (CLAHRCS) (partnerships between universities and NHS Trusts), Kislov et al. (2011: 2) suggest that the multi-professional and multi-agency nature of CLARHCs may present particular obstacles to knowledge sharing and mobilisation between professional groups. They identify that further work needs to explore: contextual factors that facilitate their development; the dynamics of actors interactions; and how members reconcile ‘existing professional identities with a new collaborative identity’ (Kislov et al. 2011: 9). These gaps in the literature directly relate to the main research question that Wye (2013) asks within her KM fellowship (section 1).

Appendix 2 A realist evaluation methodological approach

This evaluation has been informed by and developed using realist evaluation methods (Pawson and Tilley 1997; Pawson 2013). Realist evaluation is a form of theory-based evaluation approaches, which are often used within the analysis of complex social interventions. Two theory-based evaluation approaches include a theories of change (ToC) approach (Connell and Kubisch, 1998) and a realist evaluation model (Pawson and Tilley, 1997). These are now overviewed, to illustrate the rationale for using a realist evaluation approach.

A ToC approach involves a ‘systematic and cumulative study of the links between activities, outcomes and contexts of the initiative’ (Connell and Kubisch, 1998: 18), involving stakeholders in a process of explicating their theories of how and why a programme will work. This process of surfacing and explicitly detailing underlying theories of change ideally takes place within the planning stage of an initiative, with stakeholders specifying ‘what (outcome) they hope to achieve (in the long, medium and short term), how (action) they expect to achieve them and why the proposed actions should deliver the intended outcomes (rationale)’ (Mason and Barnes 2007: 156). A ToC approach assumes a rational process whereby intended outcomes, methods to achieve these and rationale behind these can be explicated. This model has been criticised for an overly linear approach (Barnes et al. 2003), Mason and Barnes (2007: 158) illustrating how the theories of change that were developed within their evaluation were more ‘discursive and narrative in form’ rather than ‘logic models or other diagrammatic forms’ which tended to be found in the evaluation methodology literature. A ToC approach assumes a linear model of change where implementers pre-specify how actions will lead to outcomes, Barnes et al. (2003) illustrate how this model omits feedback loops, does not anticipate change in context or chance and ‘cannot embrace the way complex systems actually work’ (p. 277).

Realist evaluation approaches, in contrast, can account for the way in which complex systems actually work, and realist approaches have been developed that incorporate insights from complexity theory (Byrne 2013; Pawson 2013; Room 2013). Realist evaluation aims to understand why a programme works, for whom it works and the sets of circumstances within which it works. A detailed, theoretically-led analysis of both the contexts and mechanisms of an intervention is first necessary to develop potential context mechanism outcome (CMO) configurations (Pawson and Tilley, 1997) which can then be used within the realistic evaluation. A realist evaluator articulates the underlying theory through conversations and interviews with a set of stakeholders to understand their rationale for
programme interventions (Pawson and Tilley 1997). Once these CMO configurations have been developed they can then be refined following the realistic evaluation cycle.

The first stage in the realist evaluation model is to surface underlying theories of projects. These can then be mapped and diagrammatically represented and may be simple logic models, or more complex systems mapping (Rogers, 2008). Whereas in a theories of change approach (Connell and Kubisch, 1998) this map would perhaps be used to facilitate a discussion with programme stakeholders to agree on one overarching theory of change, Pawson (2006) and Barnes et al. (2003) have found that this in practice is sometimes a struggle as these theories ‘never keep still’ (Pawson 2006: 231). The next stage is prioritisation, to decide where to focus the evaluation. This is achieved through a process of:

- Establishing the components of the programme theory that seem to have most influence on overall outcomes.
- Clarifying which elements of the programme theory are least researched and known about.
- Understanding which linkages are vital to the effectiveness of a programme.
- Recognising which theories have been well tested and can be assumed to be relatively safe to leave from extensive testing (Pawson 2006).

Realist evaluation uses retroduction (also referred to as abduction) to understand and explain what actually causes particular events and outcomes. Whilst induction refers to developing generalisations from numerous observations, and deduction moves from a generalisation or theory to infer particular future events, retroduction explores what actually causes particular events, moving from empirical observations to analysing deeper causal mechanisms (Lawson 1997: 24).

Using realist evaluation (Pawson and Tilley 1997; Pawson 2013) the independent evaluation will use context-mechanism-outcome configurations (Pawson 2013) to understand how particular actions affect collaborations between researchers and commissioners, and what contextual drivers and constraining factors affect this. In addition, through the analysis it may be useful to draw upon complexity theory to enable the analysis of the NIHR fellowship as a complex social intervention (Byrne 2013). This approach allows for the fact that there may be several different interventions within the NIHR Fellowship which co-evolve within the specific contexts where the fellowship is occurring. These different interventions may create ‘transformative synergies’ (Room 2013) within a complex system which enable or constrain these commissioner-researcher collaborations.
Appendix 3 Information sheet and consent form for interviews

Independent Evaluation of Lesley Wye’s Fellowship
Participant Information Sheet

I would like to invite you to take part in the independent evaluation of the work that Lesley Wye is doing at the University of Bristol. This information sheet explains why the evaluation of her work is being done and what it would involve for you, to enable you to decide if you would like to take part or not. The independent evaluator (Michelle Farr) is available to answer any questions you have.

What is the purpose of the study?
The aim of this evaluation is to understand what helps to foster commissioner-researcher collaborations. The evaluation intends to support the ongoing development of Lesley’s knowledge mobilisation work to improve the usefulness of her activities.

Why have I been invited?
Potential participants will be asked to take part if they have been involved in the different activities that Lesley supports to develop researcher-commissioner collaborations. This includes: the evaluations in telehealth and the Bristol end of life care coordination centre; the knowledge mobilisation team and the qualitative research/evaluation skills group.

What will happen to me if I take part and what will I have to do?
Interviews will be conducted with people involved in the above evaluations and groups. If you decide to participate, Michelle Farr, the independent evaluator, will arrange a time that is convenient with you to conduct an interview. These should last between 30-60 minutes. Interviews can either be conducted over the phone or within your own workspace, whichever is most convenient for you. You will be asked if you consent to the interview being voice recorded. After having gone through this information sheet and consent form, the evaluator will ask you about your perspectives on commissioner-researcher activities that you have been involved with such as the telehealth evaluation, Bristol end of life care coordination centre evaluation; the knowledge mobilisation team and the research/evaluation skills group.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason, and ask for any information you give to the evaluation to be withdrawn.

What are the possible disadvantages and risks of taking part?
The main burden for participants will be the time taken to participate in an interview, which should take about 30-60 minutes.

What are the possible benefits of taking part?
The evaluation has been designed to support the ongoing development of knowledge mobilisation work in Bristol, S Glos and N Somerset and researcher-commissioner collaborations. Findings from this study will be fed back to improve the usefulness of the work.

Will my taking part in this study be kept confidential and what will happen with the data I give?
Information that you give to the independent evaluator will not be accessible to any other people working on the knowledge mobilisation activities (including Lesley Wye). Ethical and legal practices will be followed and all information about you will be handled in confidence. All information that you provide the independent evaluator will be anonymised using a code number to label the data. If you consent, interviews will be recorded on a digital recorder.
These interviews will then be transcribed. Following anonymised transcription, the voice recording files will be deleted. Whilst Lesley Wye has provided details of the key people involved in the knowledge mobilisation work, and who may be potential participants of the evaluation, she will not have access to recordings or anonymised transcripts. All data and quotes you provide the evaluator will be anonymised in any write-ups. Participants have the right to check the accuracy of data held about them and correct any errors. Participants can also ask for any material that they have given to the research to be withdrawn before the report is completed.

What will happen to the results of the research study?
Anonymised quotes from interviews and the results of this study will be written up into a report. This will be given to Lesley Wye to enable the improvement of her work to support researcher-commissioner collaborations. Interview participants will be able to access a copy of this report. The report will also be given to Lesley Wye’s mentors: Gene Feder; Cathy Pope; and Andree le May. The anonymised material may also be used in conferences, websites and practitioner and academic publications.

Who has reviewed the study?
All activities that Lesley Wye is doing to develop commissioner-researcher collaborations, including this evaluation, have been reviewed by the Ethics Committee for the Faculty of Medicine and Dentistry at the University of Bristol. The independent evaluator, Michelle Farr, will be liaising with one of Lesley Wye’s mentors, Andree le May, through the process of the evaluation.

Who is funding the independent evaluation?
This independent evaluation has been funded through the NIHR Knowledge Mobilisation Fellowship that Lesley Wye holds to develop researcher-commissioner collaborations.

Expenses and Payments
No expenses or payments are available for participating in this independent evaluation.

Further information and contact details
Dr Michelle Farr, Independent Evaluator. Tel: 07900 585270. Email: michelle.c.farr@gmail.com

Complaints
If you have any questions or concerns about any aspect of this study, please speak to the independent evaluator (Michelle Farr, contact details above).

If you would like to contact Lesley Wye about this work, her contact details are:
Lesley Wye. Email: Lesley.Wye@bristol.ac.uk
NIHR Knowledge Mobilisation Fellow, Centre for Academic Primary Care, School for Social and Community Medicine, Canynge Hall, 39 Whatley Road, Bristol BS8 2PS. Phone no: 0117 331 4538.

If you wish to complain formally about an aspect of this study, you can do this via Lesley Wye’s mentor, Andree le May. Email: A.C.le-May@soton.ac.uk
EVALUATION OF NIHR KNOWLEDGE MOBILISATION FELLOWSHIP

INTERVIEW CONSENT FORM

Participant Identification Number:

Name of independent evaluator: Michelle Farr

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I can also ask for information that I give to be withdrawn.

3. I agree for my interview to be digitally voice recorded and transcribed with the possible use of verbatim anonymous quotes.

4. I understand that my comments may be edited and anonymously quoted in peer review journals, internal reports, conferences and publications on websites.

5. I agree to take part in the above study.

_________________________  ________________________  ________________________
Name of Participant          Date                        Signature

Name of Person taking consent
_________________________  ________________________  ________________________
Date                        Signature
Appendix 4 Interview topic guide

NIHR Knowledge Mobilisation Fellowship

Interview topic guide

1. Can you tell me briefly about your role working with Lesley on [Eol CCC/ telehealth/ KM team/ qualitative skills group etc.]

2. Who would you consider part of the (telehealth/ EOL CCC evaluation/KM) team?

3. About the group processes:
   a. What do you think the purpose of this group is?
   b. What is your role within this particular group?
   c. How did you get involved in this particular group? Why?
   d. What is it like working in this particular group? Does it differ from other groups you work with? (How?)
   e. What motivates you to keep being involved in this group?
   f. What knowledge and learning is being shared in the group?
   g. What works well in this group? What could be done differently? Explore:
      i. Can you give me an example of when the group worked well together? What happened? What helped to make it work well?
      ii. Can you give me an example of when the group didn’t work so well together? What happened? How were things resolved (if they were)?
   h. What roles are important to the success of the group? What do people do (don’t need to name names) that helps the group work together and achieve their goals?
   i. How are people influential in the group?

4. For those with roles in more than one group, are there particular differences in the way these groups work together?

5. What have you got out of participating in the group?
   a. What have you learnt about commissioners/ researchers (delete as appropriate) from being in this group?
   b. Have you developed any more collaborative relationships with commissioners/ researchers (delete as appropriate) through being part of this group? Have there been any outcomes from these collaborative relationships?
   c. What skills and knowledge have you gained from being part of this project?
   d. What have you learnt about evaluation? Have you applied that learning elsewhere?
   e. Are you doing anything differently in your other work, as a part of what you’ve learnt from working with this group?
   f. Have you made any changes to the types of knowledge that you are using in your work?

6. What outputs is the group producing?

7. Do you think that the networks between people have changed as a result of this group? If so, how?

8. What makes it easier to form collaborations between researchers and commissioners? (Commissioning context/ University context)

9. What makes it harder to form collaborations between researchers and commissioners? (Commissioning context/ University context)
10. What understanding do you have of the pressures/levers/constraints/norms that commissioners/researchers work under (for clinicians ask about researchers)?

11. Do you feel you have the confidence to undertake/lead an evaluation yourself?

12. Would you contact a researcher/commissioner directly, if you wanted information or help on a project? If so, would it be someone you've been working with in this group or someone else?

13. What are your hopes for the future of the group? Might it be developed and sustained?

14. Is there anything else that you would like to add?

15. Is there anyone else in particular that you think that it would be good to talk to as part of this evaluation?
Many thanks for your time!
Appendix 5 Observation template for meetings
What is the purpose and aims of the meeting?

Major issues arising in the development of collaborations between researchers and commissioners.

Contextual issues mentioned. Enablers/ constrainers.

Content of the meeting

Who is doing the talking/ contributing?

Who is leading/ facilitating?

What are the outcomes of the meeting?

Appendix 6 Data coding framework

Community of practice structural elements
Domain (topic the community focuses on) (‘working with the domain enables the community to determine and progress its common goals’ (le May 2008: 8)
Practices (frameworks, ideas, tools, language, stories and documents that are shared (le May 2008: 8)
Mechanisms
Membership – who is involved, how got involved?
Commitment/ enthusiasm/ motivation of members, why got involved?
Roles of members
Identity of members
Facilitation (of the community)

Context
Relevance of C of P
Resources
Infrastructure
Commitment to C of P outside the C of P
Other commissioning/ university context

Outcomes
Learning (skills – research, evaluation, management, communication)
Networks
Relationships
Knowledge and its application
Individual outcomes
Organisational outcomes
Hopes for future
Leading an evaluation yourself
Contacting researcher/ commissioner directly