

Evaluating impact and planning knowledge mobilisation activities



A Template for Reflection and Taking Notes

CORE EVALUATION QUESTIONS for CLAHRC NWC Partners Priority Programme (PPP)

Lay summary of the project or activity

The CLAHRC NWC Partners Priority Programme (PPP) ran from 2017 to 2019 as three consecutive workshop series aimed at helping partners develop evaluation capacity within their practices. It focused on finding the most cost-effective out-of-hospital treatments to reduce health inequalities, improve population health and wellbeing, and decrease emergency admissions.

The programme included two 12-month workshops (PPP1 in 2017/2018 and PPP2 in 2018/2019) that brought together various stakeholders to collaborate and learn using Collaborative Implementation Groups (CIGs) based on participatory, action-based inquiry methods. These mixed teams of practitioners, commissioners, patients, the public, and researchers worked through cycles of reflection and action to enhance their skills and knowledge.

Twenty-three projects participated, each evaluating their local initiatives against the overarching PPP question. Teams completed extensive documentation, including intervention descriptions, evaluation plans, logic models, health inequalities assessments, outcome syntheses, stakeholder analyses, SWOT analyses, and progress and final reports. Some projects also produced academic publications and summaries called CLAHRC Bites.

The purpose is to sketch out how we will show or evidence:

A. Impacts: Who or what changed, in what ways, and how do we know?

B. Causes of impact: Why/how did changes occur? Which factors or processes caused impact?

C. Lessons and actions: What lessons can be learned? Which actions should follow to generate impact?

SAMPLE

A. IMPACTS

What changed? (Progress towards goals)	
<p>1) Instrumental: changes to plans, decisions, behaviours, practices, actions, policies</p>	<p>The PPP demonstrated effective integration of full public engagement in evaluations through structured workshops and meetings with clear expectations and deadlines. As a result, some researchers and clinicians now routinely involve public groups in developing their research protocols and have improved methods for recruiting public advisors.</p> <p>Participants recognised that the process of commissioning services also needs improvement and that implementing top-down changes without a solid evidence base or evaluation plan incurs opportunity costs. The support provided to embed a focus on health inequalities in evaluations helped participants pilot and deliver services that meet the needs of patients, communities, and healthcare organisations. This support also re-energised some participants' commitments to reducing health inequalities.</p>
<p>2) Conceptual: changes to knowledge, awareness, attitudes, emotions</p>	<p>Being part of the programme encouraged deeper thinking about action on health inequalities and also raised the potential to incorporate people's experiences of their health conditions into improving practice and services. Participating in the programme gave evaluation teams the tools and the confidence to clarify how they would identify and evaluate health inequalities. Each of the project teams produced final evaluation reports. Some produced CLAHRC Bites, some teams have published academic papers.</p> <p><u>Example findings:</u></p> <p>The evaluation of the Later Life and Memory Service was able to identify barriers to young people with dementia engaging with local groups and activities that provided important information for future development of resources to support young onset dementia.</p>

	<p>Evidence, both quantitative and qualitative, indicated mental health improvements for young people using the Youth Information Advice and Counselling (YIAC) service, as well as for their parents and wider family members. The service was equally accessible across socio-economic groups, helping to reduce health inequalities. The evaluation also showed that the service effectively reduced health inequalities for young people from the LGBTQ+ community.</p> <p>The clear referral pathway from Adult Social Care and GP services to the Community-based early intervention and prevention programme made the service more accessible to residents. This change resulted in a significant reduction in the waiting list for Adult Social Care cases, from 920 in 2017 to 576 in 2018. The programme successfully increased social support, helping 48 people join 24 local groups and services, and improved mental wellbeing, reducing loneliness and social isolation. It was particularly effective in reaching disadvantaged populations.</p> <p>Community-based mental health hubs provide support for recovery through various opportunities, including social, housing, educational, and emotional assistance. The evaluation aimed to assess the hubs' impact on recovery by examining clinical service use and user feedback. Key outcomes included self-development and self-awareness, such as building skills, confidence, and relaxation techniques. Qualitative findings concluded that the hubs were central to the users' recovery journeys, contributing significantly to improved health and wellbeing, despite the lack of quantitative measurement of mental health changes.</p> <p>The Community Chronic Obstructive Pulmonary Disease (COPD) Service offers a borough-wide, consultant-led approach for diagnosing, treating, and managing COPD. Its primary goals are to enhance local access to services, improve quality of life, expedite care, reduce COPD-related deaths, and lower costs. The evaluation showed that the service improved patients' recovery and respiratory health, decreasing emergency hospital</p>
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	<p>admissions. Physiotherapy-led clinics aided rehabilitation, and nurse-led rapid response clinics reduced hospital re-admissions. Specialists providing community care improved access for hard-to-reach patients, thus reducing health inequalities.</p> <p>The Community Cardiovascular Service is a comprehensive, consultant-led initiative covering an entire borough, aimed at providing diagnostics, treatment, and management for cardiovascular diseases (CVD). It encompasses rehabilitation for heart failure, cardiac conditions, cancer-related cardiovascular issues, and stroke, with a primary goal of standardising care across the borough. The service was evaluated using both quantitative and qualitative methods to determine its impact. Key evaluation objectives included assessing improvements in access to specialist CVD care, ensuring equitable access to recommended treatments across the borough, and evaluating the service's effect on CVD mortality rates. The evaluation revealed significant positive outcomes: Increased Referrals - referrals to the Community CVD diagnostics service nearly doubled from 2010/11 to 2015/16. Similarly, referrals to cardiac rehabilitation almost tripled by 2018; Reduction in Emergency Admissions - the service was associated with a reduction of 66 emergency CVD admissions per 100,000 population per year in the post-intervention period compared to a control group (Downing, Rose, Saini et al, 2020). This indicates a significant decrease in acute CVD incidents due to improved management and preventive measures. Overall, the evaluation demonstrates that the Community Cardiovascular Service effectively increased access to specialised CVD care, promoted equitable treatment across the borough, and contributed to lowering CVD mortality rates through proactive management and rehabilitation efforts.</p> <p>The Local Quality Improvement Scheme aimed to enhance investment and access to primary care, ensuring equitable funding based on population needs for each GP practice. It also aimed to incentivise improvements in healthcare quality. The evaluation over a 5-year period assessed the scheme's impact on healthcare activity,</p>
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	<p>general practice quality, and patient experience. The scheme was associated with a decrease in emergency admission rates. Notably, deprived areas experienced a greater reduction in emergency admissions compared to areas not covered by the scheme. Overall, the evaluation indicates that the Local Quality Improvement Scheme successfully reduced emergency admissions and potentially improved healthcare quality and patient experiences, particularly in socioeconomically disadvantaged areas.</p>
<p>3) Capacity-building: changes to skills and expertise</p>	<p>The PPP workshops aimed to build capacity among partners to embed service transformation evaluations and new care models, focusing on tackling health inequalities in NWC. The programme supported 23 interns with part salary-backfill and training in research methods to conduct small research projects aligned with the evaluation.</p> <p>Project teams enhanced their ability to support public advisors in research/evaluation roles, recognising and valuing their contributions. Specific PPI training, knowledge sharing, and facilitation of public advisor recruitment and involvement were key elements.</p> <p>Public advisors' continued engagement in workshops, CIGs, and project activities increased their confidence and research capacity, allowing some to take on core roles such as data collection and analysis. Two public advisors progressed to become interns and led projects in subsequent PPP rounds, integrating into the wider CLAHRC NWC infrastructure.</p> <p>The workshops also raised participants' awareness of different knowledge types and how to access them, helping to combine scientific/factual knowledge with their technical knowledge to produce evidence recognised by all stakeholders.</p>
<p>4) Enduring connectivity: changes to the number and quality of relationships and trust</p>	<p>This study illustrates the effective partnership formation between public advisors and professionals/academics within project teams. Public advisors became integral to the evaluation, rather than a token presence. Their participation led to further involvement in other CLAHRC NWC projects and future</p>

	<p>PPP cohorts, with many developing the capacity to lead future research projects. The PPP model was effective in enhancing understanding of the value of public and patient involvement (PPI) in applied research and supported innovative methods for involving the public. Participants noted the benefits of reciprocal relationships between practice and academia, emphasising the value of combining research and technical knowledge to influence practice and sustain problem-solving connections. The Collaborative Implementation Groups (CIG) approach prioritised public recruitment for evaluations, often resulting in significant project contributions from public members, whose involvement was generally seen as positive.</p>
5) Culture/attitudes towards knowledge exchange, and research impact itself	<p>The PPP structure was crucial in building public and patient involvement (PPI) capacity among its members, addressing the complexity and theoretical challenges of PPI. Participants benefited from learning alongside public members and trialling effective PPI methods, aiding the transition from theory to practice. Insights from the first cohort, such as earlier recruitment and co-design of public advisors' roles, enhanced PPI practices in the second cohort. This collaborative 'thinking together' approach cultivated PPI as a community of practice, facilitating the sharing of tacit knowledge through individual reflection. Participation in the PPP empowered members with the skills to incorporate diverse evidence types into their evaluations, including resource-intensive methods.</p>

Who was involved in the change? (Influencers and influenced) Stakeholder groups might typically include:	
1) Policy-makers: including NIHR, regulatory bodies; local, national and international	A variety of organisations providing or commissioning healthcare nominated the projects that they wished to evaluate; these were assigned to a thematic CIG and support and learning were facilitated by a dedicated member of the academic team
2) Practitioners: local authorities, NHS, third sector	NHS/LA project evaluation leads and interns Local partners involved in project-level evaluation teams
3) Communities: of place or interest	
4) Researchers: within and beyond the project and institution	University workshop facilitators and methodological experts
5) The public: users of services, their carers	Public advisors – users of the services and/or their carers

How do we know? What evidence do you have? What evidence might you easily get? (Evidence and feedback)	
Which indicators and methods should be used, and questions asked, to demonstrate impacts, and progress towards generation of impacts?	We evaluated the initiative (interviews, focus groups and a survey) culminating in three peer-reviewed publications: DOI: 10.1111/hex.13774 SSM - Qualitative Research in Health 3 (2023) 100235 https://doi.org/10.1186/s40900-021-00289-8

B CAUSES OF IMPACT

Why or how did changes occur? Why do you think changes occurred?	
<p>1) Problem-framing: Level of importance; active negotiation of research questions; appropriateness of research design.</p>	<p>The PPP was co-produced with NHS and Local Authority partners to address the strategic priority of identifying the most cost-effective out-of-hospital treatments to reduce health inequalities, enhance population health and wellbeing, and decrease emergency admissions. The initiative aimed to build evaluation capacity and provide timely, practical evidence for local decision-making. The workshops were motivated by the need to develop local solutions to reduce emergency admissions and to change practices and behaviours by employing robust evaluations to support equity-sensitive service transformations.</p>
<p>2) Research management: research culture; integration between disciplines and teams; planning; strategy.</p>	<p>The initiative aimed to integrate three key dimensions: Engagement brought together practitioners, providers, commissioners, academics, and the public into a collaborative community focused on applied health research and service evaluation. Domain Creation allowed participants to explore shared interests and develop understanding, fostering collaborative learning. Sharing Practice promoted collaborative working by sharing good practices and lessons learned from individual projects, facilitating collective thinking and mutual guidance among participants rather than mere knowledge transfer.</p> <p>Additionally, 23 interns received support with part salary-backfill and additional research methods training to conduct small projects aligned with the evaluation. The training was made meaningful by focusing on participants' own projects, with teams tackling similar issues placed together in Collaborative Implementation Groups (CIGs) for enhanced information sharing and mutual learning.</p>

Why or how did changes occur? Why do you think changes occurred?	
<p>3) Inputs: Funding; staff capacity and turnover; legacy of previous work; access to equipment and resources.</p>	<p>NIHR infrastructure funding through CLAHRC was used flexibly, including for patient and public involvement (PPI) payments. Workshop sessions supported teams with structured and adaptable academic assistance funded by CLAHRC to collaboratively develop equity-sensitive evaluations. An evaluation workbook, integrating the Health Inequalities Assessment Toolkit (www.HIAT.org.uk), was created and distributed to all workshop participants as a resource. Initially released incrementally based on feedback from the first cohort, the workbook was provided at the outset of the workshop series for the second cohort.</p>
<p>4) Outputs: Quality and usefulness of content; appropriate format.</p>	<p>Coproduced outputs include 14 internal evaluation reports and 10 peer-reviewed articles, each responding to health inequalities.</p> <p>Participants indicated that taking part gave them the opportunity to widen the scope and rigour of their evaluation, increasing the relevance and value to local stakeholders and also confidence in the decisions to change or maintain, aspects of their service</p>
<p>5) Dissemination: Targeted and efficient delivery of outputs to users and other audiences.</p>	<p>Each project team produced a final report, shared with their line managers and CLAHRC Steering Board</p> <p>Most project team prepared and presented a poster at a celebration event at conclusion of the workshops</p> <p>Some projects produced a BITE, which was shared with other CLAHRCs and ARCs</p> <p>Some project teams produced a peer-reviewed journal article.</p> <p>A dedicated webpage has links to all outputs.</p> <p>https://arc-nwc.nihr.ac.uk/resources-old/clahrcnwlegacy/partner-priority-programme/</p>
<p>6) Engagement: Level and quality of interaction with users and other stakeholders; co-production of</p>	<p>Project teams were actively encouraged and supported to integrate public advisors as equal partners within their research teams. This involvement encompassed engaging public advisors across various project stages,</p>

Why or how did changes occur? Why do you think changes occurred?	
knowledge; collaboration during design, dissemination and uptake of outputs.	such as design, data collection, podcast recordings, conference presentations, co-authored journal articles, and creating public-facing research summaries.
7) Users: Influence of knowledge intermediaries, e.g. 'champions' and user groups; incentives and reinforcement to encourage uptake.	The findings or new knowledge originated from service delivery providers, members of the public receiving services, commissioners overseeing services, and academics
8) Context: Societal, political, economic and geographical factors.	Being involved in the PPP provided participating teams with dedicated time and a conducive environment, away from their typical workplace or home settings. This opportunity allowed for deeper reflection on patient and public involvement, fostering the development of more meaningful approaches and moving away from superficial or tokenistic forms of engagement.

C LESSONS AND ACTIONS

What lessons can we learn for impact identification and generation?	
1) What worked? What could (or should) have been done differently?	
2) What could (or should) be done in the future?	

D RESOURCES

<https://doi.org/10.1016/j.forpol.2019.101975>: A forestry pilot study, by David M. Edwards and Laura R. Meagher

[A framework to evaluate the impacts of research on policy and practice – Integration and Implementation Insights \(i2insights.org\)](#)

[How to tell an impact story? The building blocks you need | Impact of Social Sciences \(lse.ac.uk\).](#)

SAMPLE