



From creating to ‘curating’ knowledge – what is the role of research?

Workshop hosted by PHCRIS and APHCRI – Sydney, 27 October 2015

Evaluation Report

KERTI at NHMRC:

Thank you to all who participated in this KERTI workshop and provided valuable feedback.

Summary:

Key points about the experience

The overall feedback was very positive. Participants engaged with the scenario, commenting that it was *‘a good exercise to start a discussion’*; *‘useful to stimulating thought’* and, *‘clear, practical, hands on stimulating scenario’*. Their evaluation comments indicated they found the workshop a valuable opportunity to discuss *‘the challenge and solutions’* with colleagues. They enjoyed the time to collaborate and network with *‘other experts in the field’*. They appreciated the opportunity to talk with other researchers, to *‘bridge gaps in knowledge and practice’* and meet *‘people from different areas & discussing problem and solution focused topics’*. As one respondent commented, the most useful aspect of the workshop was *‘finding out about KERTI!’*.

Key learnings from the event

Major barriers identified by participants included the lack of university performance measurement/funding for knowledge exchange, research translation and implementation activities. The lack of buy-in or shared understanding is not helped by different organisational incentives. Examples include research questions that don’t match clinical priorities as well as a lack of opportunities to interact/understand perspectives of funders. The need for a culture change was identified.

Strategies to overcome barriers included developing a new way of thinking to overcome ‘academic’ motives. Ideas included revising definitions of research/research design to include funding for engaging with research users as part of the research process. Other change management suggestions included building research into clinicians’ awards as well as making knowledge exchange/research translation/implementation part of career paths with short term exchanges. The value of harnessing the power of consumers was identified.

The discussion on resources indicated the need to support knowledge exchange, research translation and implementation activities financially. One suggestion included ‘changing the carrot’, i.e. changing funding guidelines so that successful grant applications would need to demonstrate a solid history of engagement with their research users. Another suggestion noted the value of widening grant processes to recognise the value of non-RCT methodologies as well as the use of grey literature.

Capacity building generated a great deal of discussion. The need to build capacity in knowledge exchange and research translation across the board was identified, i.e. researchers, policy makers, practitioners, consumers and managers. The value of role models or KERTI style champions was identified.

The importance of relationships was clearly identified to facilitate integration within universities as well as across the wider health system –e.g. policy, practice, consumers, managers and research. The value of exchange opportunities across sectors was suggested.

Where to now...

One participant suggested that KERTI evolve as an identifiable subfield in Australian research. The idea is attractive however there are a number of steps to traverse on the way...

Possibilities include the following:

- Continuing to expand the KERTI Community of Solutions
- Keep talking/writing about KERTI to engage other people/organisations and widen the circle of influence; raising the profile of KERTI at organisational level; opportunities for KERTI lobbying
- Meeting by webinar to discuss opportunities/issues
- Arranging face-to-face meetings/workshops at relevant conferences to explore future areas of common interest/leverage
- Working with primary health networks (PHNs)
- Develop a KERTI website (potentially as a subsite of the PHCRIS website)

Suggestions for future KERTI workshops:

Participants contributed some excellent topics for future KERTI workshops and activities.

- Evolving KERTI as identifiable subfield in Australian research
- What can KERTI do to assist researchers in KT?
- How to identify and overcome barriers
- Research impact | measuring impact
- How to break down silos
- Measuring research translation output, e.g. google cites
- Assessing and utilising less traditional evidence source for policy development
- How to address 'wicked problems' in health that may have a difficult or 'thin' base of research evidence in terms of answers/positive strategies with demonstrated benefit

Workshop Task:

The workshop task was to discuss issues and challenges in the translation and implementation of research. (Copies of the Workshop Scenario and Tip Sheet are attached as Appendix One).

Participants were able to address the issues at 2 levels:

Option A: Working within the **current operating environment; say 2 – 5 years.**

Working within the current system, what could be done differently that would have an impact?

How can KERTI influence and help build capacity?

Option B: Working towards **more extensive system changes; say over 5 – 10 years +**

What could be done to effect major change in the system?

How can KERTI help change the landscape?

Task Outcomes:

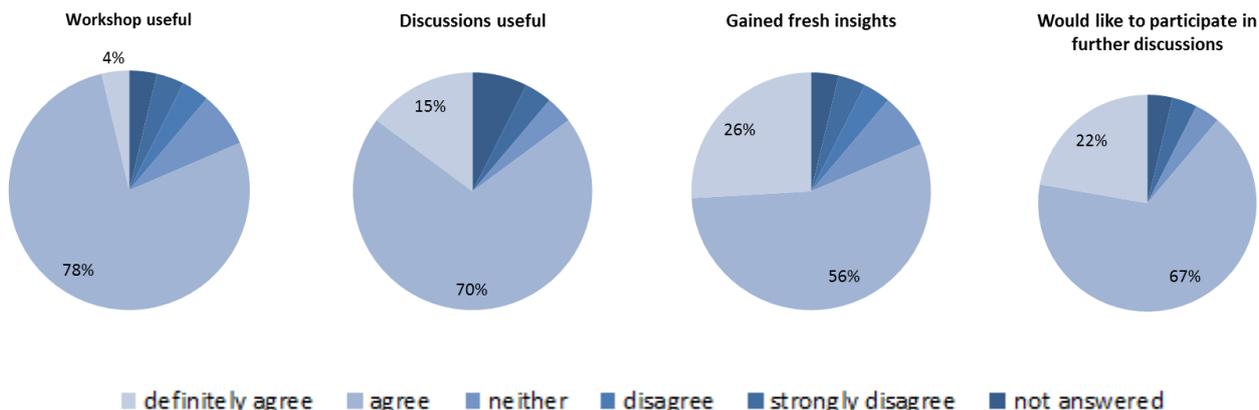
	Operational 2-5 years	Systematic change 5-10 years +
Systems barriers	<ul style="list-style-type: none"> ◦ Time constraints. ◦ Knowing audience - insight, engaging. Dissemination (value) - peer review vs professional. Recognition (funding) - informal ways to measure i.e. social media. Having PhD. ◦ Area of focus not always agreed upon. Different incentives, values e.g. about costs, what is appropriate outcome? Lack of buy-in and shared understanding. ◦ ARC NHMRC assessment. University promotional measurement. Performance measurement doesn't support. Ethics & Governance. ◦ Need for "innovation" rather than synthesis. ◦ Research considered an "add-on". Proactive vs reactive. Data-mining, use & access e.g. activity coding & reporting. ◦ Research Questions do not address/match clinical priorities. Policy makers may not proactively source research to answer legislative questions. 	<ul style="list-style-type: none"> ◦ Workshops to engage planners or funders. Communications. Career paths. Not co-located. 16 week exchanges. Time constraints ◦ Risk management. Culture change. Resources/risk. Push->innovation (solution looking for a problem). Pull->incentives (solves problems). ◦ Integrated knowledge translation model. Time. Capacity. Communication barrier. What's important? ◦ Gender balance. Disconnect between researcher & power. ◦ Knowledge translation is operationalised funded. ◦ Lack of siloing. Human resources e.g. graphic design ◦ "Academic" success. - How to measure impact -> multiple stakeholders. Culture ◦ Time-line longer-term. Planning research agenda -> political system wants immediate answers. ◦ Not many opportunities to interact with funders. - no framework to engage/understand perspectives of funders.
Strategies to overcome barriers	<ul style="list-style-type: none"> ◦ Co-production = Integrated knowledge translation ◦ Change management - build research into clinicians' awards. ◦ Stakeholder engagement - forward thinking / networking - broad representation. 	<ul style="list-style-type: none"> ◦ Competing priorities of funders. ◦ Framework crystallisation. Harness power of consumers. ◦ Performance assessment. Slow research must remove quantitative pressures. Encourage funding of "risky" research. Encourage users of research design – more focus on funding early stages of research. Problem funding only end stages of research. ◦ Knowledge translation is operationalised and funded. ◦ New people or new way of thinking to overcome 'academic' motive -> Leadership -> Strategy -> Business Plan-Key Performance Indicators. ◦ Win-win make engagement value for better policies. Research priorities framework. Work exchange.

Operational 2-5 years		Systematic change 5-10 years +	
Resources	<ul style="list-style-type: none"> ◦ \$ ◦ re-distribute funds ◦ Funding -> changing grant process ◦ Knowledge & use of Guidelines for use of non-RCT methodologies. "grey literature" - robust - systematic framework for how to use this evidence. 	Resources	<ul style="list-style-type: none"> ◦ Changing the Carrot. ◦ Encourage more focus on funding early stages of research - problem funding only at end stages i.e. transmission of solutions.
Capacity building	<ul style="list-style-type: none"> ◦ Training. Already running training. KT Australia. NHMRC - need KT component - \$ incentives. ◦ Research education - development of journal. ◦ Building KT capacity. ◦ Capacity building policy maker in terms of using research. Capacity building - mobilising for clinicians & nurses. \$\$, time & experience/ knowledge/ mentoring in navigating research world. Practitioners to produce research evidence, & translate their 'operational' knowledge. Aggregating skill bases & practices to transfer knowledge across disciplines & sectors. 	Capacity building	<ul style="list-style-type: none"> ◦ Role models. Champions. Policy entrepreneurs. ◦ Re-establishment of permanent positions. Longer term funding. Encourage even effort across: <ol style="list-style-type: none"> 1. Formulation 2. Results 3 Communication/dissemination
Relationships	<ul style="list-style-type: none"> ◦ Breaking down silos within university & externally. Issue of high turnover in government. ◦ Industry \$\$ 	Relationships	<ul style="list-style-type: none"> ◦ Increase exchange opportunity across sectors. ◦ Research training. ◦ Embedded. Seconded. Public policy prevention.

Who was in the room + what they said about the workshop

- Estimated no. of participants at the workshop: N ≈ 40
- 27 respondents to the evaluation (approx. 67% response rate)

8	Researchers	10	Researcher & Practitioner
2	Policy analysts	1	Health Services Manager
1	Researcher/Policy analyst	1	Researcher/Consumer representative
		4	<i>Not answered</i>
		27	Total respondents



Suggestions to improve this style of event:

- Group discussion - maybe having a facilitator at each table | More facilitators | Have an "expert" at each table to guide the discussion and is there for questions
- Allow us to workshop more | Coming back together at the end of the event to hear other tables thoughts | More sharing across groups | Share everyone's ideas from workshop after workshop
- The instructions were too long - hard to follow exactly what was required
- Why separate out 'consumer' [from the categories of participants] – symptomatic of the thinking!
- Obtain list of challenges then address by running this by those who can speak to the challenges
- It was a bit hard to do this task in the time
- Keep informal as much as possible
- I would love to hear about practical ways to become more involved & support the work of KERTI/ PHCRIS/ APHCRI :)
- The task initially was a little unclear so perhaps a clearer purpose statement / lots to read to be able undertake the exercise
- Excellent
- Give handout before workshop

Comments welcome – please direct to:

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November, 2015

KERTI at NHMRC: Scenario

“The University Vice Chancellor has noted the increasing interest in Knowledge Exchange, Research Translation and Research Implementation. Your Faculty Executive Dean has been directed to hold a ‘research user engagement forum’ to discuss issues and challenges in the translation and implementation of research undertaken.

As a researcher you have been provided with the attached Tip Sheet that outlines feedback raised by consumers, policy makers and industry (health service planners, funders and practitioners) about using and accessing research.

In your group consider the perspectives of one or more of these user groups.
How might you lead your research team to better address the challenges raised?

Note: any research users on your table can add value by contributing from their experience.

Timeframe

Option A: Working within the **current operating environment; say 2 – 5 years.**

Working within the current system, what could be done differently that would have an Impact?

How can KERTI influence and help build capacity?

Option B: The extended version for tables that wish to consider **more extensive system changes; say over 5 – 10 years +**

What could be done to effect major change in the system?

How can KERTI help change the landscape?

Points to tease out

- What in your experience have been systems barriers to engaging with research users?
- What strategies (short and long term) can you suggest to overcome these barriers?
- What training and educational resources do you think are required by the research workforce to develop a KERTI mindset?
- Where do you see opportunities to build capacity (of researchers and research users)?
- How can we establish and nurture trans-disciplinary relationships?

KERTI

KERTI is an informal national network of people with a shared vision of improving health care policy and practice through routine application of relevant research. The network name acknowledges the fundamental elements of research application: knowledge exchange (KE), research translation (RT), and implementation (I) –KERTI.

The purpose of KERTI is to share learnings, identify mutual priorities, test innovation in the field and build the capacity of researchers as well as research users. Importantly, it seeks to cultivate a systems wide culture that values multi-level engagement between policy, management, practice, research and consumer perspectives. Central to this culture is an attitude or mindset that views research as a resource to be utilised.

The KERTI Secretariat is based at the Primary Health Care Research and Information Service (PHCRIS)

KERTI at NHMRC: Tip Sheet

A knowledge exchange/research translation mindset appreciates that research is only one part of the answer to complex health issues. Research is most useful, not as an isolated product, but when it is informed, produced and contextualised from multiple sources – known in the UK National Health Service as ‘curating’ rather than creating knowledge.

Such a systems view seeks multi-level engagement between policy, management, practice, research and consumer perspectives. This tip sheet offers a few general pointers...

Policy makers

Public servants serve the government of the day, recognising its policy parameters and philosophical leanings. We are expected to be impartial, apolitical, professional, objective and efficient in all that we do and to maintain appropriate levels of confidentiality.

We often work to tight deadlines with only limited time available to read relevant research and research findings.

In providing advice to government, the key issues we generally need to address are:

- what is the problem;
- what is the background;
- what are the possible solutions including implementation details;
- what are the risks and sensitivities;
- what are the costs; and,
- what is the preferred way forward and why?

We appreciate succinct summaries of your research and findings (e.g. 1-2 pages) that seek to address the issues outlined above.

Health service planners, funders and practitioners

As health professionals, we seek robust research evidence to underpin operational policy, program development and interventions. Increasingly we recognise the value of working with research users to inform research directions and improve the quality of our work. Some key issues reported by users of primary health care research include:

- the need to be involved in devising research priorities. Much research isn’t focused on our key challenges; e.g. research on ‘chronic disease’ or ‘integration’ is a priority, but what about studies orientated to address issues we face day-in/day-out?
- not involving us means research may not be designed with reality at the core
- funding is always an issue, but if we work together with researchers to build a good evidence base we have better chances of securing it
- we often don’t have a strong knowledge base in research – even things like reviewing literature
- we reinvent the wheel as we don’t know what we don’t know. As an example, if we have evidence of unmet need, we might start a project only to find out there is already lots of information and there were mistakes we could have avoided.

We appreciate robust relevant research and evidence that is easily accessible and provided in a useful format that addresses our needs.

Consumers

Engaging consumers or consumer representatives in health research can be a new challenge for many researchers. Consumer involvement allows researchers to inform and strengthen their research. This creates more transparency, openness and accountability, and research which is more relevant to the community.

It is useful for researchers to consider the following:

- Working with us helps determine the value your research can bring to a community. It develops a focus on the real issues and how they can be addressed.
- Using co-design principles brings our values into the research design process.
- Involving us in the research process can enable researchers to access services/ information/ networks they may not have known existed, and can also help to problem solve when the planned research process doesn't go as expected.
- Be sure to factor in adequate time/ funding to foster relationships. This can be as simple, and important, as covering costs of invited consumer representatives to attend your meetings.
- Engage in different ways: on-line forums; face-to-face; formal/ informal meetings.
- Working with consumer/ consumer representatives can build research literacy in consumers and consumer literacy in the research team.

We appreciate being involved as partners from the beginning of and throughout the research process.

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PHCRIS Getting Started Guide, Introduction to Knowledge Exchange

http://www.phcris.org.au/guides/knowledge_exchange.php

<http://www.involvingpeopleinresearch.org.au/>

<http://www.nihr.ac.uk/documents/about-NIHR/NIHR-Publications/Extra%20Mile2.pdf>

Resource prepared by Hagger C (PHCRIS) and E Whitehead (APHCRI), 2015