A knowledge translation project on community-centred approaches in public health

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ABSTRACT

This article examines the development and impact of a national knowledge translation project aimed at improving access to evidence and learning on community-centred approaches for health and wellbeing. Structural changes in the English health system meant that knowledge on community engagement was becoming lost and a fragmented evidence base was seen to impact negatively on policy and practice. A partnership started between Public Health England, NHS England and Leeds Beckett University in 2014 to address these issues. Following a literature review and stakeholder consultation, evidence was published in a national guide to community-centred approaches. This was followed by a programme of work to translate the evidence into national strategy and local practice.

The article outlines the key features of the knowledge translation framework developed. Results include positive impacts on local practice and national policy, for example adoption within National Institute for Health and Care Evidence (NICE) guidance and Local Authority public health plans and utilization as a tool for local audit of practice and commissioning. The framework was successful in its non-linear approach to knowledge translation across a range of inter-connected activity, built on national leadership, knowledge brokerage, coalition building and a strong collaboration between research institute and government agency.

Keywords community, knowledge exchange, knowledge translation

Introduction

Community-centred practice in public health is well established but often seen as having little evidence, and there are many potential barriers to uptake of evidence within the public health system that need addressing.[1] Structural changes in the English health system in 2013/14 meant that knowledge on community engagement was at risk of becoming lost as new priorities and organizational structures emerged and old dissemination routes were no longer active. Additionally, a fragmented knowledge base, where existing evidence on community engagement had been generated through multiple national and local initiatives crossing different sectors, was seen to impact negatively on policy and practice. A partnership started between Public Health England (PHE) and Leeds Beckett University in 2014 to address these issues. A national knowledge translation project on community-centred approaches for health and wellbeing was developed. The aim of this paper is to examine the development and impact of the project and to outline the key features of the knowledge translation framework built through the project.

Public Health England, as a recently formed national public health agency, had a role in providing knowledge, evidence and delivery support, especially to a new local public health system increasingly centred on people and place. The transition of local public health teams from the NHS to local government in 2013 provided greater opportunities to tackle the social determinants of health and improve the health of communities.[2] Leeds Beckett University had been involved in a national multi-sectoral network seeking to maintain knowledge translation from previous national community engagement in health initiatives. There was no central place to access this knowledge and the network recognized that further resources were needed to progress dissemination of community engagement evidence.

The project started when the academic and the policy lead identified mutual goals in relation to implementing evidence-based practice in community approaches. There

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was increasing recognition of community capacity building and empowerment as central to reducing health inequalities, especially since the Strategic Review of Health Inequalities in England[3]—Priority 5: creating and developing healthy and sustainable communities. However, because practice is very localized and shaped by community action, approaches look and feel different. Furthermore, the changing context, new stakeholders, combined with a range of terminology and overlapping concepts,[4,5] added to the complexity that can cloud recognition of this approach as evidence-based public health.

The rationale for the knowledge translation project was that building an evidence resource on working with communities would be a cornerstone for supporting local action and system level change. PHE in collaboration with NHS England could provide the necessary strategic leadership to ensure the long-term sustainability of the work, supported by academic expertise.[6]

Synthesizing the knowledge

Phase 1 of the project (March 2014–March 2015) involved synthesizing existing evidence and developing a conceptual framework to bring the evidence together. A systematic scoping review of reviews was undertaken to map sources of evidence and existing models for community engagement and empowerment approaches.[7] Evidence from systematic reviews, e.g. O'Mara-Eves *et al.*,[5] was supplemented with theoretical papers and practice-based knowledge from grey literature to develop a conceptual framework for working with communities. Some stakeholder consultation was also undertaken to help ensure a good fit with UK practice. The evidence was published in a national guide to community-centred approaches for health and wellbeing.[8] A key component of the conceptual framework within the guide was the organization of the evidence into a family of community-centred approaches, with four branches and sub-branches grouped into: (i) strengthening communities; (ii) volunteer and peer roles; (iii) collaborations and partnerships; and (iv) access to community resources. A full description of the family and types of approaches included can be found in the Guide.[8]

The processes and mechanisms of knowledge translation

It was recognized that producing the evidence guide would not be enough in itself to increase implementation of evidence at scale.[9] The second phase of the project (April 2015–March 2016) focused on supporting implementation

of the evidence into practice and policy—the 'knowledge into action' process characterized by the Canadian Institute for Health Research.[10] This involved considering the levers of change for practitioners and decision-makers within the public health system, e.g. strategic fit, organizational priority, personal knowledge, skills and motivation. This phase was considered critical for effective knowledge translation, as evidence alone is rarely sufficient. These levers shaped the knowledge translation approach outlined below.

The COM-B model for behaviour change[11] was useful in considering the conditions needed to enable the adoption of evidence-based practice, in this case community-centred approaches. For practice to change, practitioners need capability (C), opportunity (O) and motivation (M). Building capability within the system to adopt community-centred practice included building the knowledge and skills of commissioners and practitioners. This was supported by creating opportunities within the practice, organizational and policy environments that enabled and accelerated implementation and removed barriers. Building motivation amongst system leaders and practitioners alike to value that this change was worthwhile and beneficial was important. How the project increased capability, opportunity and motivation was through a knowledge translation framework with six interconnected knowledge translation mechanisms (Fig. 1):

(1) Interpretation of the evidence to different audiences.
(2) Alignment of the evidence to organizational goals and key programmes of work within different sectors.
(3) Implementation through a practical framework and supporting early adopters.
(4) Application to learning opportunities and workforce development.
(5) Coalition building with partners, advocates and champions.
(6) Amplification of knowledge through increasing access via a knowledge management platform and generation of case studies.

Six mechanisms were needed to affect the multiple factors of knowledge translation and activity relating to these occurred simultaneously throughout the Phase 2 period. Examples of activity are summarized in Table 1. Interpreting the evidence for public health leaders and practitioners was done throughout the 12-month period to gain maximum coverage, and this continues to be a key activity. This includes reframing the evidence to different public health functions, roles and priorities. Aligning the message to organizational priorities was important to gain ownership and sustainability of the agenda both internally and externally. The project
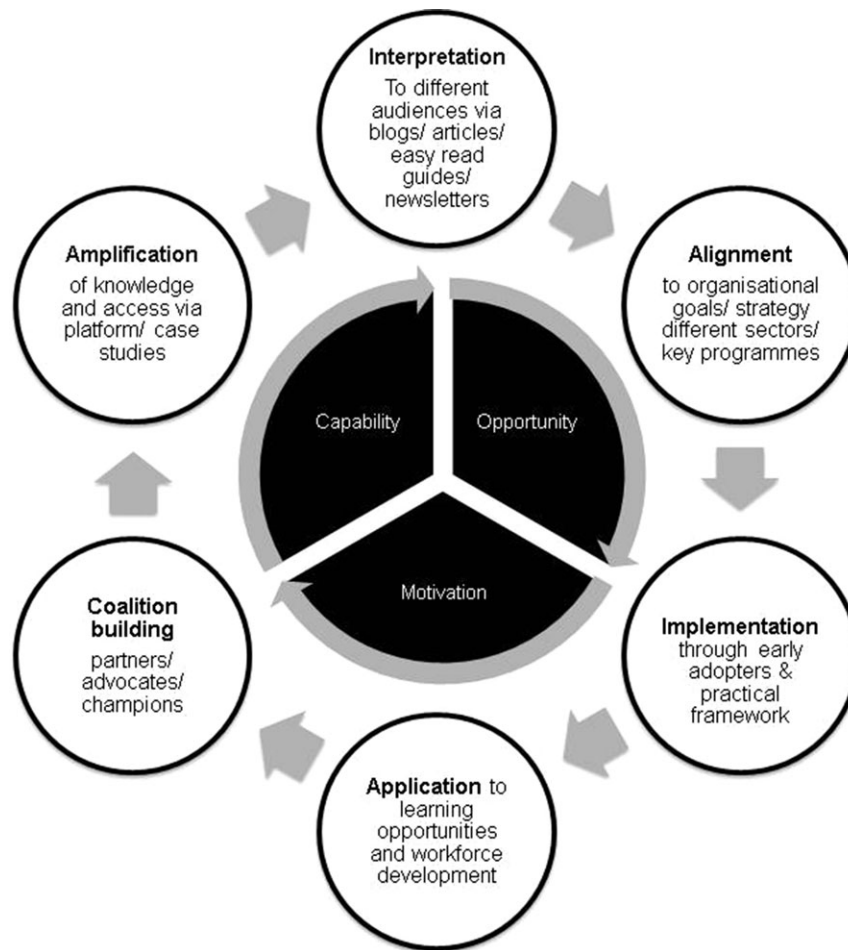
Fig. 1 Framework for knowledge translation.

fulfilled a role within PHE as a new organization with a remit for providing evidence, supporting delivery and being a credible and legitimate voice in the public health system. Those who were already innovating and the early adopters and advocates reinforced this. They were critical to making the change happen across the system and PHE invested in building and maintaining partnerships throughout all phases of the work. There was high interest in community-centred approaches amongst local practitioners which meant a thirst for knowledge and a willingness to adopt new practice. Tapping into knowledge, expertise and networks where they existed further supported implementation within localities and sectors.

Whilst all knowledge translation activity potentially impacts on workforce development, it was important to identify formal learning opportunities and consider the implications for skill development. The messages included that a specific, potentially new, way of working was needed and this shaped the formulation of workforce competencies.[16]

Development of a system that could continue to link practice to evidence was critical. We focussed initially on providing current, relevant examples of practice aligned to the evidence but with potential to grow into a single point of access and interaction for knowledge management.

Results and impact

Both phases of the knowledge translation project (the development of the guide in Phase 1 and the six knowledge translation mechanisms of Phase 2) were designed to support evidence into practice. Reach and identified impacts are now considered in turn. The Guide was launched in February 2015 at the Local Government Association (LGA) public health conference with an initial dissemination and communications strategy aimed to raise awareness to a range of audiences through different media. There was immediate social media interest, becoming the fourth most tweeted government item. One year on from publication, the website page had been visited almost 14 000 times.

By the end of 2016, there was evidence that the guide had achieved considerable reach and was regarded as a

Table 1 Knowledge translation mechanisms and example activity

Knowledge translation mechanisms	Example activity
Interpretation of the evidence to different audiences	Using newsletters, briefings, professional journals and leaders' blogs to target specific but consistent messages to key sectors, e.g. article on the role of community public health nurses in building community capacity,[12] National Directors Blog, PHE.[13]
Alignment of the evidence to organizational goals and key programmes of work within different sectors	Pro-active and re-active opportunities to shape strategy and policy and align messages into new system delivery programmes and mechanisms and build leadership. For example, 'Vanguards' programme developing blueprints for new ways of working within the NHS.
Implementation through a practical framework and supporting early adopters	Using the 'family' as a planning framework to support local commissioning. For example, mapping local practice against the evidence.
Application to learning opportunities and workforce development	Several national conferences and regional events were used for dissemination and learning, e.g. PHE conference stream. Key messages were incorporated into workforce development frameworks and specific competencies were identified. Slide-decks and ELearning modules were developed. For example, refreshed Public Health Skills and Knowledge Framework.[14]
Coalition building with partners, advocates and champions	Developing and maintaining informal partnerships and undertaking scoping study into stakeholder views on next steps. For example, Think Local Act Personal Partnership,[15] NHS Alliance.
Amplification of knowledge through continuing to collate evidence and improve access to it	Working with PHE knowledge directorate to develop a topic resource as part of the development of a digital knowledge management platform, generation of local case studies of practice.

significant output, being referenced in a number of other publications. More critically, there is evidence that the guide as a conceptual, evidence-based framework together with knowledge translation activities led by PHE are achieving impact across a number of sectors and spheres of activity (Table 2).

Discussion

'Positive change does not automatically result from sound evidence alone, no matter how well synthesized or how effectively communicated.[…] Due to the many factors influencing the process of translating research findings into practice including the actors involved, the social and political environment and financial constraints, no one strategy alone can possibly be effective in all settings'.
[WHO 2004, World health report on knowledge][9]

Effective implementation of the evidence required concerted efforts across the full range of knowledge translation mechanisms over a 12-month period. An 'insider account'[26] is provided here to reflect on some of the learning to have emerged.

Developing a clear narrative and achieving a shared narrative across sectors increasingly became important as the project developed. The publication and conceptual framework ('the family of approaches') was initially framed as a way of organizing evidence and identifying practical models. However, this quickly became the most significant message being communicated. Firstly because the 'family' provided some definitional clarity of terms and models. Secondly, and most crucially, because it could also be used as a practical framework to support application of evidence to practice. This is evidenced in some of the early impacts summarized in Table 2.

Partnership development and maintenance was resource intensive but made a valuable contribution to knowledge translation. It helped to provide additional feedback loops direct to policy-makers and commissioners through national partners endorsing the work and communicating its impact on their work, further supporting the non-linear approach.[6] The range of partners included government departments, voluntary and community sector organizations and professional bodies across the public health, local government, social care, healthcare and community development sectors. Partners who were early adopters of the evidence into their practice demonstrated a range of practical applications, indicating leadership and innovation. As implementation gains further traction the goal of the next phase is to see a move from early adopters to a minority then majority of localities adopting evidence informed community-centred practice at scale.[27]

Aligning the message to policy and informing the policy context went hand-in-hand by having a partnership between

Table 2 Evidence of impact from knowledge translation activities

Impact on	Examples	Type of impact
National guidance	Updated NICE guidance on community engagement NG44 recommends using the guide as complementary to the guidance.[17]	Guidance
National strategy	Six principles for engaging people and communities developed by NHS England's People and Communities Board.[18] Guide listed as key document for building community resources. Community-centred approaches adopted as an underpinning theme within PHE's strategy.[19]	Agenda setting and influence
System leadership	Health inequalities and public health included in cross-sector leadership summit, regional workshops and shared narrative document.[15]	Integrated working and sector commitment
Public health knowledge management	Family of community-centred approaches adopted as taxonomy for PHE to organize evidence and resources on Healthy Communities for new PHE Knowledge platform.	Knowledge mobilization
NHS delivery	NHS England New Models of Care programme using guide as a resource to help localities develop new services and implement community-centred approaches.[20]	Evidence into practice
Local government delivery	DPH Annual reports using family to map community health activity in districts. Key messages from guide used to influence commissioning and local health strategies.[21] PHE North East Centre using guide to support North East local authorities develop Integrated Wellness services and asset-based approaches.	Evidence into practice Agenda setting and influence
Voluntary and community sector	Local community anchor organizations using guide to demonstrate range of health and wellbeing activities across the family.[22]	Evidence into practice
Workforce	Development of Masterclass for public health registrars and specialists. Development of E-Learning module for national E-Learning for Health platform.[23]	Workforce development
Knowledge sources and libraries	Guide placed in online libraries and collections of resources e.g. Housing Learning and Improvement Network (LIN)—a professional housing network supporting over 46 000 people working in housing, health and social care.[24]	Knowledge mobilization
Innovation and ideas	Evidence of major think tanks and research organizations recognizing the significance of the Guide and key messages on community-centred approaches in public health.[25]	Agenda setting and influence

PHE, NHS England and the University.[28] By seconding an academic into the public sector there was immediate opportunities to inform policy with evidence and advocate for evidence-based practice.

The academic role was highly valued by practitioners and decision/policy-makers, reflecting the importance of researcher–user relationship.[27,29] The secondment to PHE has been maintained through an honorary academic contract and an ongoing relationship between the university and the organization.

The knowledge translation model therefore evolved throughout the project. In considering Lavis *et al.*'s four models of linking research into action[28,30] the project started through 'push and pull efforts'. Firstly the researcher identified that existing research was not being put into practice and practitioners were not being made aware of it ('push efforts' model 1); alongside the policy-maker reaching into the research world to get help in providing up to date evidence in a relevant and appropriate format to inform policy and practice ('pull efforts' model 2). The relationship quickly moved into a partnership project to take this forward (model 3).

As the initial project (Phase 1) ended this led into a broader partnership for knowledge translation efforts (model 4).

The wider context influencing implementation throughout the project was the ongoing cuts to local services and the recognition of the impact of this on communities. There was stakeholder interest in building sustainable community solutions because public sector interventions were diminishing; and this rationale remains controversial. The implementation of evidence-based outcomes and approaches alongside evidence on the principles and enabling conditions, as outlined in NICE guidance,[17] was therefore important; e.g. sufficient resources, long-term planning, training and support.

Limitations

Evaluation has been iterative, capturing learning and feedback throughout delivery stages. A full evaluation to identify uptake and implementation across England would help to measure the impact of knowledge translation.[31]

Building acceptance of different sources of knowledge remains a challenge within the public health system.[32] Using

knowledge from research, practice and from citizen insights was recognized within the project but further work is needed to capture and triangulate this evidence. Involving communities and the wider public in translating evidence into practice is also a challenge not fully explored in the work. It is recognized that making knowledge available to the public is a first step[27] and activity did include production of a lay easy-read guide of the evidence to support this.

Conclusion

The project has produced a framework for knowledge translation based on principles of good practice that may be useful in other areas seeking to link research, practice and policy. The six interconnected knowledge translation mechanisms were all of value in achieving reach and early impact. It has potential for transferability to other areas of practice that are characterized by diversity of approaches and local variation (rather than a single standard intervention) and a wide range of stakeholders with different roles. Further evaluation would be needed to test this.

The paper concludes that concerted and sustained activity across a range of factors was important for successful adoption and implementation. The collaboration between research institute and government agency was valuable as a platform for good knowledge translation, as the literature suggests. The paper provides an example of what enabled this partnership and what resulted from it. It reinforces the value of a non-linear approach to knowledge translation, built on national leadership, knowledge brokerage and coalition building.

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