Cathy Howe: The first 6 months

NIHR Knowledge Mobilisation Fellowship
January - June 2013

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When I accepted an NIHR Knowledge Mobilisation Fellowship I wasn't quite sure what I was getting into. 3 years (0.7WTE) to undertake a knowledge mobilisation research and implementation project seemed daunting. I felt I'd been given permission to sail to America based on my picture of a boat – and I wasn't sure I had any boat building skills!

But these first 6 months have been fascinating...

I have found a level of **freedom to explore and learn** that has been refreshing and rewarding. I have a natural thirst for knowledge and I'm indulging this through the literature, shadowing people and attending conferences. These have led to new ideas, conversations and connections including one with a software developer. We hope to create an interactive game format to make learning about evidence-based healthcare improvement altogether more fun.

My **organisational research project** has begun studying organisational systems and networks for knowledge mobilisation. Extensive reading about social network analysis, knowledge mobilisation (transfer/exchange/translation/management etc) and soft systems methodology has enabled me to develop a new knowledge base. I can't wait for the results of my first social network analysis survey as I start to build a picture of how my partner organisations fit together and interact with each other and the evidence base. The time it's taking helps to reinforce the reasons healthcare managers don't routinely engage with the evidence base for their work!

I've had one **first author paper published** (Is Quality Improvement in Healthcare Mustard or Ketchup? *JHSRP*) and a second (Using Assessment to Support Generative Learning in a QI Collaborative *BJHCM*) is in peer review. Another multi-author paper has been published and 3 others have been submitted. 7 out of 10 abstracts have been accepted at conferences, and I've given oral presentations at the Canadian Knowledge Mobilisation Forum and the Health Services Research Network Symposium.

Four papers nearing final draft distil key CLAHRC NWL learning about implementing evidence into practice. The oral presentations on the 'Conceptual Framework for improving healthcare' and 'QI tools contribution to healthcare improvement' and the poster on 'Assessing engagement with quality improvement methods' reflect part of this work. All of these have drawn considerable interest. The QI tools slideshare has been tweeted 7 times and viewed over 320 times. Two of these will be first author publications. I'm currently using this learning to develop a practical training course to support the development of capacity and capability for evidence-based healthcare improvement in middle managers.

I've entered the world of **mobilising knowledge through social networks**. My blog (www.cathyhowe.net (http://www.cathyhowe.net)) and twitter account (@cathgreenhalgh) have both proved new but rewarding challenges; working out what to say, how to say it, how often to say it, and when to still those twitching fingers. I have over 543 website hits and 123 twitter followers including Trish Greenhalgh, Jo Rycroft-Malone, Ruth Boaden, Helen Bevan, Sarah Fraser and Derek Bell in the UK, and Knowledge Mobilization Works in Canada, Ko Awatea in New Zealand and Healthcare Improvement Scotland. I've extended my national and international networks, building relationships with people in health and other industries who

share my passion for making evidence-based change efficient, effective and sustainable.

And then there's Norman. He's my **new cartoon character 'Norman the Novice'**. He's just a got his first job as a knowledge broker. He's hugely enthusiastic, but he's not really very good at it… Cartoons are a fun way to mobilise knowledge.

This book contains snapshots of all this and more. I'm learning new skills, discovering new interests, revealing new strengths and generally having a blast. There have been highs and lows of course. Balancing the duties and responsibilities of two jobs is never straightforward, and the necessary overlap of my CLAHRC NWL work and my fellowship complicates this further. Having the CLAHRC NWL team around me for support, knowledge and advice has been invaluable.

Bring on the next 6 months I say; I'm not rushing back into full time NHS management just yet!

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June 2013

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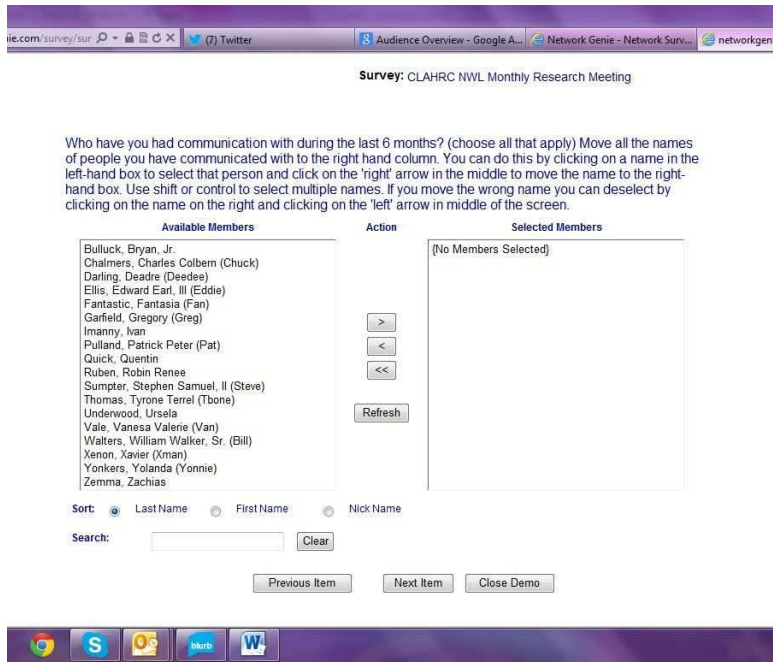
Organisational Research:

Creating an organisational knowledge mobilisation system: using established organisational networks to effect system-level change in the use of quality improvement tools and techniques to implement evidence into practice

My fellowship research seeks to understand the current system in an organisational (Chelsea & Westminster NHS Foundation Trust) using a soft systems methodology action research approach (Checkland, 2000) to study established organisational networks relating to knowledge mobilisation. This baseline will then provide the basis for the design and delivery of a system-level intervention to build awareness, capacity and capability for continuous improvement through embedding knowledge generated by the NIHR CLAHRC for Northwest London (CLAHRC NWL) and their academic and research partners, and on the use of QI tools and techniques to collaboratively implement evidence into practice.

I've done alot of reading around knowledge mobilisation, social networks and network analysis and systems. Two social network analysis surveys are underway, one looking at internal organisational connections between people involved in improvement projects, and one looking at connections between those in the CLAHRC NWL research network.



Papers Published:

Quality improvement in health care: Is it mustard or ketchup?
by Cathy Howe
J Health Serv Res Policy, 1355819613480764,
first published online ahead of print May 2, 2013

This paper deliberately uses Malcolm Gladwell, an unlikely suspect in the health services research world, to attempt to prompt people's thinking about whether we need - or can we create - a simple basic system for quality improvement.

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Worth a Second Look

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Quality improvement in health care: Is it mustard or ketchup?

Cathy Howe[1]

Gladwell M. The ketchup conundrum. *The New Yorker*, 6 September, 2004. Reprinted in *What the Dog Saw: And Other Adventures*. London: Penguin, 2010.

Introduction

In this article, Malcolm Gladwell explains how there came to be many kinds of mustard in supermarkets but only one ketchup. He tells how an almost unheard of Dijon mustard called Grey Poupon stole market share from the dominant mild yellow variety. Importantly, its flavour meant an incredible proportion of people (in food marketing terms) would change brands after a single taste. Combined with a sophisticated ad campaign its success showed that tastes could change. Mustard didn't have to be yellow. Now supermarket shelves are filled with different mustards.

Henry J Heinz entered the ketchup market in 1906. In the process of developing a ketchup without benzoate preservative, he made a condiment that was bitter and salty, sweet (lots of extra sugar) and sour (lots more vinegar), and by using ripe tomatoes increased the 'umami' or 'body' (the same effect mono-sodium glutamate provides). By 1907, Heinz was producing 12m bottles of ketchup a year and exporting them around the world[1]

But, not everyone likes it. And there are other ketchups. Jim Wigon, inspired by Grey Poupon's success, put great effort into creating the 'World's Best' ketchup. It has more tomato, hand-chopped basil leaves and maple syrup instead of corn syrup. But he sold only 90 jars a day and didn't draw a salary in five years. In the consumer mind ketchup isn't 'ketchup' unless it's Heinz.

What can this have to do with health services research and policy?

So, is health care quality improvement like mustard or ketchup?

In health care there are numerous quality improvement tools and techniques that can be used to support service improvements – stakeholder mapping, plan-do-study-act cycles, measurement for improvement, system/process ownership, project initiation documents, knowledge brokers, statistics, etc. My question is: are these different mustards where you choose the right one (or quality improvement tool) for the task, effectively a pick-n-mix? Or are they separate ingredients that need to be put together to make a quality improvement ketchup recipe, where you use the whole thing?

The case for mustard

If quality improvement tools are mustard, I would look at my situation, think about the tools and simply pick out the one I want. If I want to improve a process I use process mapping. If I want to increase stakeholder engagement I use stakeholder analysis. If I want to increase referrals I use measurement for improvement and chart the referral count.

I can mix my mustards if I want. There's nothing to stop me using process mapping, stakeholder analysis and measurement for improvement in the same improvement project. I can spread them thick or thin. I can spend weeks or months on one technique. If it's mustard, then the selection, approach and combinations are entirely my choice. It seems easy enough. Except that generally it doesn't happen.

People don't mix mustards. Frequently they don't use mustard at all. Stereotypically, clinicians and managers have an idea to implement and they tell their teams 'Let it be so. Add this to your busy day please. It's good for patients and/or the organization'. An audit may be completed and reported at a Grand Round. Rarely will they map processes or stakeholders. Even good audits may not be prospective or use

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continuous measurement. They're busy getting on with it. They may or may not be engaging with the right people or putting in efficient effort for a sustainable reward.

The case for ketchup

Now let's say quality improvement tools are ingredients. To make 'QI ketchup' someone chooses which ingredients to put together in combination to make a single quality improvement toolkit. If it's 'ketchup' then this toolkit has to be used in its entirety. The justification would be that this is the 'right' approach to maximize the chances of long-term success. There are already several different QI 'ketchups', including PRINCE2, Six Sigma, Lean Thinking, Lean Sigma, the Action Research Cycle. Each preaches (in its pure form) that all elements should be completed as prescribed by that school of improvement. All of them have been used to improve health care and reported in peer-reviewed publications.

However, are any of these 'QI ketchups' the 'Heinz' – the ketchup to beat all other ketchups? According to Gladwell, Heinz ketchup not only hits all five primal tastes (sweet, sour, salt, bitter and umami) but the blend and balance is good too. It has 'high amplitude'. Heinz sells 650 million bottles of ketchup in over 140 countries each year.[2]

I couldn't tell you which QI ketchup is being used most in health care. None predominates to my knowledge. The lasting impact and spread of these approaches in their pure form in health care is hard to see. PRINCE2 is considered too cumbersome (except perhaps for IT innovations); better for construction. Lean works well in manufacturing but has a sustainability issue in health care organizations which are, anecdotally, not very lean.[3] Even conceptually Six Sigma seems an unlikely fit for the human complexities of health care. The development of Lean Six Sigma hardly seems a glowing endorsement for either system. As for the evidence, a recent systematic review of several QI ketchups (Six Sigma, Lean/Toyota Production System and Studer's Hardwiring Excellence) found only nine studies could be included and the majority had methodological limitations.[4]

Lots of people in health care have heard of them and even been trained. They might have been involved in Kaizen events or in value stream mapping. But staff don't routinely build these approaches into their daily work. They're complicated and difficult. Integrating these approaches is just not the obvious thing to do. Health care staff are busy. They care but they're really busy with lots of important and urgent priorities to deliver before something else can be added. And making change is difficult. Attempting change using an approach that is complicated and difficult is, in short, just never going to happen.

In Gladwell's terms, the current QI ketchups seem to be like 'World's Best' ketchup. The aficionados identified all the things that made 'World's Best' different from Heinz: the extra tomato, the different sweetness, the lower salt and little vinegar. But they also identified that 'World's Best' had really low amplitude. That cooked-tomatoey flavour formed an aftertaste. The blend and balance were not right. It was judged to be more of a sauce. I imagine that's a pretty harsh criticism of a ketchup.

This seems to relate to what was suggested by Justin Keen: that high modernist ideologies such as evidence-based medicine and implementation science are attempting to impose scientific standardization onto automaton clinicians.[5] He proposes that the reason these things work at all is not their scientific evidence base but the common sense of clinicians who understand their complex, human working lives. My suggestion is that the improvement 'ketchup' approaches listed above could be perceived as being high modernist ideologies. If these well-known toolkits are not 'Heinz', there's perhaps a gap in the market for the ultimate commonsensical health care quality improvement ketchup.

Could there be a QI Heinz?

To be a QI Heinz ketchup the approach has to be so intuitive and straightforward, that once you've tried it you never want your health care improvement fridge to be without it. That way, every time you reach for an improvement, your QI ketchup is right there waiting for you. It's an approach where you have just the perfect minimum amount of aim agreement and goal setting, an intuitive process mapping approach, the optimal amount of stakeholder analysis and engagement, in collaboration with patients and the public.

As with any condiment, there's nothing to stop extras being added in your local context. If you need more salty process mapping, add some. If you need to spend more time on measurement or re-defining your aim you have a whole spice rack at your disposal; optional extras, to locally enhance your initial basic mix.

What you don't need is a cheap imitation in a Heinz bottle. It'll be likely to leave a slightly bitter aftertaste and taste tests would show it has low amplitude. It just won't grab you. It won't achieve sustainability in your QI fridge. Equally, anything too expensive might be perfect for the occasional treat but again, won't suit the mass market. And health care improvement needs to be a mass market.

Policymakers don't currently seem to be considering systematic and sustainable approaches to improvement. Policy seems to be focussing on solutions – improvements that must be made quickly – and they'd better save money.

Some people might say there are different correct approaches for different settings. Gladwell talks about Moskowitz identifying the 'plural nature of perfection' and how there are now 36 varieties of Ragu spaghetti sauce. But really, who wants to have to work out which subtly different version of spaghetti sauce you should use when you want to improve your health service. I prefer ketchup: Gladwell's universal option (citing Elizabeth Rozin) – part of the collective unconscious – with an "unprecedented ability to provide something for everyone." But then again, maybe it's all just mustard.

Acknowledgements

The views expressed in this publication are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

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Acceptability and necessity of HIV and other blood-borne virus testing in a psychiatric setting

by Camilla Sanger, Janine Hayward, Gira Patel, Karen Phekoo, Alan J. Poots, Cathy Howe, Owen Bowden-Jones and John Green

British Journal of Psychiatry Short Report
BJP 2013, 202:307-308. DOI: 10.1192/bjp.bp.112.119529

This paper reports the results of a CLAHRC NWL project I supported, demonstrating testing is acceptable and that 18% had a BBV infection.

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Short report

Acceptability and necessity of HIV and other blood-borne virus testing in a psychiatric setting

Camilla Sanger, Janine Hayward, Gira Patel, Karen Phekoo, Alan J. Poots, Cathy Howe, Owen Bowden-Jones and John Green

Summary

Studies in North America and Europe indicate that the prevalence of blood-borne viruses (BBVs) is elevated in individuals with severe mental illness; there are no comparable data for the UK. We offered routine testing for HIV, and hepatitis B and C in an inner-London in-patient psychiatric unit as a service improvement. Of the patients approached 83% had mental capacity to provide informed consent for testing and 66% of patients offered testing accepted. Although it was not our objective to establish the prevalence of BBVs, 18% of patients had serological evidence of a current or previous BBV infection. We found that offering routine testing in an in-patient psychiatric setting is both practical and acceptable to patients.

Declaration of interest

None.

In the UK, the majority of HIV testing occurs in sexual health and antenatal services.[1] Studies outside of the UK have found patients with severe and enduring mental illness to be a high-risk group for blood-borne viruses (BBVs; HIV, hepatitis B and hepatitis C), with reports of HIV seroprevalence of up to 23%,[2] hepatitis B up to 25%[3] and hepatitis C up to 20%.[3,4] Individuals with severe mental illness who are sexually active have been found to engage in elevated rates of sexual risk behaviours.[2,5,6] Routine BBV testing in psychiatric populations is not widespread in the UK, although findings from other countries suggest such a practice would be 'sensible', with mental health services being in a very important position for HIV prevention.[7] This service improvement project allowed us to assess the acceptability and practicality of routinely offering BBV tests to patients with severe mental illness in a UK acute psychiatric in-patient setting.

Method

A total of 105 patients of whom 64% were male aged between 21 and 71 years old from a central London psychiatric hospital (three open admission wards and one intensive care unit) were approached (up to a maximum of three times) and offered BBV tests over a 12-month period. Where patients were identified by staff as very disturbed on a particular day, the offer of a test was delayed and the patient approached later. All participants were provided with an information leaflet and a written account of BBV testing; interpreters were utilised for non-English speakers. Testing was offered by a trained clinical member of the service improvement team who also notified the patient of their results and arranged specialist support for any patient with a positive result. Where possible, tests were undertaken on blood already collected for other tests. Demographic data, psychiatric diagnosis, mental capacity to test, test uptake, test result and transfer to care were collected.

Results

Table 1 shows that 83% (87/105) of the participants had mental capacity to make an informed decision regarding testing. Of those with mental capacity 66% (57/87) gave informed consent. During result notification and follow-up there were no reports by patients or staff of patients being distressed by the offer of a test.

Although this was a service improvement project and not an epidemiological study, prevalence of BBVs in this cohort was high. In total 18% (10/57) of the consenting patients and 13 individuals (12%) in the entire cohort showed serological evidence of past or current infection with a BBV or had a known history of BBVs. Four individuals with current or past infections were identified for the first time including one person dually infected with HIV and hepatitis B. A further nine patients were already known to services.

Among the three individuals with HIV one was a new discovery and was referred to specialist support services. Of the participants with hepatitis B serological results showed one had spontaneously cleared the virus and the other three were referred for follow-up (two surface antigen positive and one core antigen positive). All seven individuals with hepatitis C were already known to services.

Discussion

Testing for BBVs in a psychiatric setting was acceptable to the majority of patients with severe and enduring mental illness and feasible to deliver. The strategy was successful in identifying and engaging in appropriate care for previously undiagnosed BBV-infected individuals. However, testing was delivered by staff within the service improvement team and further work needs to be conducted to find ways to integrate BBV testing sustainably into standard clinical procedures.

At the outset there were concerns among some staff about patients' capacity to provide informed consent[8] and about the possibility that offering tests might be disturbing to patients. In practice it was straightforward to obtain consent. Previous research indicates that the vast majority of individuals with schizophrenia are able to provide informed consent.[8] An educational intervention across more than one session can allow many of those with a reduced capacity to provide informed approval.[9] Capacity in mental health patients varies over time and some in this cohort who lacked capacity initially were able to consent to BBV testing when re-approached at a later date. Similarly, patients welcomed the offer of a test even when deciding to refuse and reacted with appreciation for the service's interest in their entire well-being rather than appearing distressed.

In conclusion, the routine offering of BBV testing was both acceptable to patients and feasible in this in-patient mental health setting. The project was small and not intended to establish the epidemiology of BBVs among our in-patients and it was carried out in an area where the background population rate of BBVs is high.[1] However, the prevalence in our cohort was strikingly high,

Table 1 Acceptability of testing for blood-borne viruses (BBVs; HIV, hepatitis B and hepatitis C) in psychiatric in-patients

	n (%)			*n*								
				Consenting individuals with newly identified BBV			Consenting individuals with known BBV			Non-consenting individuals with known BBV		
	Approached (*n* = 105)	Capacity (*n* = 87)	Consent gained (*n* = 57)	HIV	Hepatitis B	Hepatitis C	HIV	Hepatitis B	Hepatitis C	HIV	Hepatitis B	Hepatitis C
Male	67 (64)	56 (64)	41 (72)	1[a]	3[a]		1		4			2
Female	38 (36)	31 (36)	16 (28)		1				1	1		

a. One person with dual (HIV-hepatitis B) diagnosis.

results which are consistent with studies elsewhere suggesting that people with severe mental illness are at increased risk of BBVs. Hepatitis B and C and HIV are treatable conditions; but it is vitally important to diagnose them early. For instance most deaths from HIV occur in those who are detected late, whereas treatment markedly reduces infectiousness and hence, potentially, population spread. There is a strong case for a study to establish the prevalence of BBVs in patients with severe mental illness nationally and for the routine offer of testing to this group nationally, particularly in areas of high-population prevalence. If BBV interventions are to be included as a routine part of patients' care, additional resources and staff training will be required.

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Papers submitted:

‘Making change last: applying the NHSIII Sustainability Model to healthcare improvement’

by
Cathal Doyle, Thomas Woodcock, Cathy Howe, Rowan Myron, Karen Phekoo, Chris McNicholas, Jessica Saffer and Derek Bell

Abstract

Background: The implementation of evidence-based treatments to deliver high quality care is essential to meet the healthcare demands of ageing populations. However, the sustainable application of recommended practice is difficult to achieve and variable outcomes well recognised. The NHS Institute for Innovation and Improvement Sustainability Model (SM) was designed to help healthcare teams recognise determinants of sustainability and take action to promote the embedding of new practice in routine care. This article describes application of the SM by the NIHR Collaboration for Leadership in Applied Health Research and Care for Northwest London (CLAHRC NWL).

Methods: Data from project teams’ responses to the SM and formal reviews was used to assess acceptability of the SM and the extent to which it prompted teams to take action. Projects were classified as ‘engaged’, ‘partially engaged’ and ‘non-engaged’. Quarterly survey feedback data was used to explore reasons for variation in engagement. Score patterns were compared against formal review data and a ‘diversity of opinion’ measure was derived to assess response variance over time.

Results: Of the 19 teams, six were categorized as ‘engaged’, six ‘partially engaged’ and seven as ‘non-engaged’. 12 teams found the model acceptable to some extent. Diversity of opinion reduced over time. A minority of teams used the SM consistently to take action to promote sustainability but for the majority SM use was sporadic. Feedback from some team members indicates difficulty in understanding and applying the model and negative views regarding its usefulness as projects progress.

Conclusions: The SM is an important attempt to enable teams to systematically consider determinants of sustainability, provide timely data to assess progress and prompt action to create conditions for sustained practice. Tools such as these need to be tested in healthcare settings to assess strengths and weaknesses and findings disseminated to aid development. This study indicates the SM provides a potentially useful approach to measuring teams’ views on the likelihood of sustainability and prompting action. Securing engagement of teams with the SM was challenging and redesign of elements may need to be considered. Capacity building and facilitation appears necessary for teams to effectively deploy the SM.

Keywords: Sustainability, implementation

“Adopting an assessment framework to support generative learning in a quality improvement collaborative”

by
Cathy Howe, Katie Randall, Sylvia Chalkley, Derek Bell

Abstract:

Quality improvement collaboratives seek to address the mandate to improve healthcare quality and reduce inappropriate variations in care through the use of defined methods and change concepts. There are indications of positive effects, but less evidence of the effectiveness of the methods – the ‘black box’ of the intervention – and how to effectively implement a collaborative. This study uses an assessment framework to quantify engagement with and uptake of collaborative methodology in 17 projects in a quality improvement collaborative in Northwest London. The framework developed by the NIHR CLAHRC for Northwest London showed variation in uptake and use of methods within and across projects. For example, most projects involved patients and the public and disseminated learning. There was more limited engagement with the NHS III Sustainability Model. The framework provides detailed methods-related information that collaborative leaders could use for generative learning to meet participants’ needs, and identify peer exemplars. This study raises important questions about implementation fidelity and highlights the need to open the ‘black box’ both while the work is in progress to allow generative learning, and for the purposes of evaluation.

Keywords: Quality improvement, collaborative, assessment, generative learning, implementation fidelity

“Identifying the Challenges and Facilitators of Implementing a COPD Care Bundle”

by
Laura Lennox, Stuart Green, Cathy Howe, Hannah Musgrave, Derek Bell, Sarah Elkin

Abstract

Background: The implementation of a Chronic Obstructive Pulmonary Disease (COPD) Care Bundle across northwest London was undertaken to reduce variation in the delivery of care. This paper describes the challenges faced by clinical teams implementing a COPD Care Bundle, how these challenges were overcome, and how this knowledge may be transferred to support the future implementation of COPD or other condition specific care bundles.

Methods: An initial retrospective documentary analysis of data from six clinical implementation teams was undertaken to review challenges faced by the clinical teams. Three focus groups with healthcare professionals and managers explored solutions to these challenges developed during the project.

Results: The documentary analysis revealed challenges within 5 high level themes; staffing, infrastructure, process, use of improvement methodology and patient and public involvement. There were 28 recognized associated challenges. The focus groups identified solutions the teams had developed to address specific challenges such as the use of project champions, early and continued education and multidisciplinary team involvement.

Conclusions: Teams implementing the COPD care bundle faced a number of challenges that were common to all sites. Understanding and learning from the challenges faced by previous endeavours and identifying the facilitators to overcoming these barriers provides an opportunity to mitigate issues that waste time and resources, and ensures that training can be tailored to the anticipated challenges.

Keywords: Quality Improvement, Chronic Obstructive Pulmonary Disease, Clinical Practice Variation, Qualitative Research, Care Bundle

"Pulmonary rehabilitation following hospitalisation for acute exacerbation of COPD: fact or fiction?"

by
Sarah E. Jones, Stuart A. Green, Amy L. Clark, Mandy J. Dickson, Ann-Marie Nolan, Clare Moloney, Samantha S.C. Kon, Fasial Kamal, Joy Godden, Cathy Howe, Derek Bell, Sharon Fleming, B. Mimi Haselden, William D-C Man

Abstract:

Several randomised controlled trials support the provision of early pulmonary rehabilitation (PR) following hospitalisation for acute exacerbation of chronic obstructive pulmonary disease (AECOPD). However there is indirect evidence from published trials to suggest poor uptake and completion rates. An audit was conducted to prospectively document referral, uptake, and completion rates for early post-hospitalisation PR in Northwest London over a 12-month period. Despite 448 hospital discharges for AECOPD, only 43 patients (9.6%) received and completed early PR despite a fully commissioned PR service. There is a major translational gap that exists between evidence and practice in post-hospitalisation PR.

Keywords: Chronic Obstructive Pulmonary Disease, Rehabilitation, Disease Exacerbation, Hospitalization

Conference presentations:

Canadian Knowledge Mobilization Forum 2013

Oral Presentation:

From Theory to Improvement: A conceptual framework for delivering improvements in healthcare

From Theory to Improvement: A conceptual framework for delivering improvements in healthcare

Authors:
Julie E. Reed, Cathal Doyle, Cathy Howe, Derek Bell

Abstract

Background:
There is an urgent need to understand how to mobilise knowledge into practice efficiently and effectively within all 'real world' healthcare settings. The NIHR CLAHRCs were established to find ways to help close this 'translational gap'.

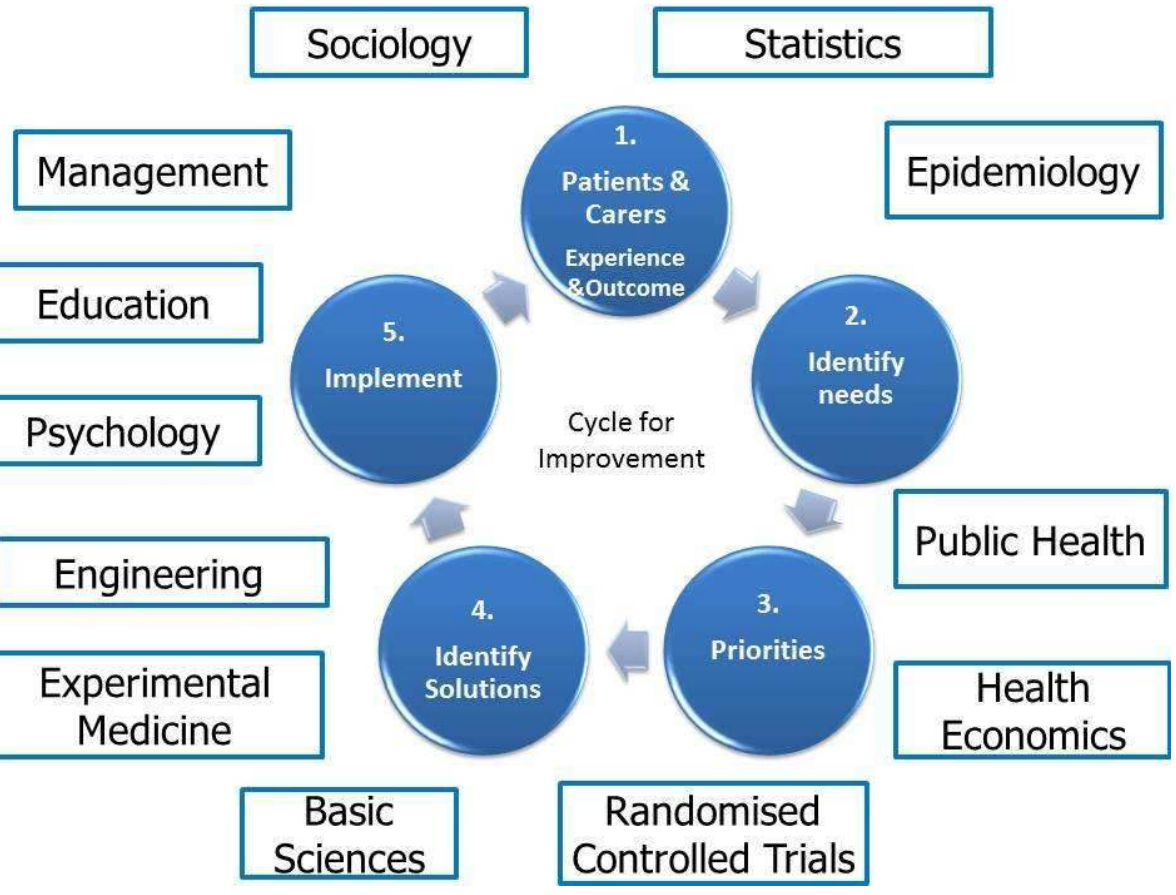
Methods:
This presentation combines knowledge gained from extensive direct experience of working with healthcare practitioners and patients (sharing responsibility for the design, conduct and evaluation of improvements) and a wide and diverse transdisciplinary literature that we found useful in developing our approach both initially, and in response to practical, technical or social challenges.

Results:

1. Knowledge of '**what**' to do does not simply transfer into practice. Healthcare staff utilise multiple evidence sources, influenced by experience and professional cultures.
2. Knowledge of '**where**' care is delivered and by '**who**' reveals an evolving complex environment which cannot be explicitly known. Changes in practice are integral to everyday care delivery.
3. Knowledge of '**how**' to deliver improvements requires engaged staff with local knowledge. Improvement must be a continuous iterative process.

When the literature was combined with direct experience it allowed the development of a conceptual framework of 4 values and 12 interdependent principles (see diagrams).

Implications:
There are practical implications from the fact that knowledge mobilisation is a complex non-linear process. The conceptual framework is novel and practical, and provides a basis for further research in practice: it is designed to enhance delivery of improvements not just explain the complexities.



What improvements should be made to improve care?

- Translating Medical Research into Practice
  - Multiple evidences need to be considered at once – continual growth of EBM
  - Evidence needs to be relevant to local context considerations
  - Staff and patients are not passive recipients, individual, group perceptions affect uptake, acceptance & behaviour
  - Translation is not a linear process

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Where does improvement take place and who is involved?

- Healthcare systems and context
  - Healthcare complex multi-level system
  - Healthcare is an organic/social system – relationships, identity, power, emotion (inc stress)
  - Quality of care is dependent on collaboration between multiple individuals as well as individual behaviour
  - Care is delivered by many individuals and organisations
  - Perpetually evolving and adapting, unpredictable

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How should improvement take place?

- Change management and high performing organisations
  - Knowledge management and valuing knowledge – external and internal
  - Value staff and patients – necessary engagement
  - Political alignment (shifting political landscape)
  - Continued learning and feedback loops – responsive and dynamic

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3 separate perspectives on improvement

What?

Where and who?

How?

Considering 3 perspectives together….

What should be done to improve care/improvements should be made?

Where does improvement take place and **who** is involved

How change and improvement should take place

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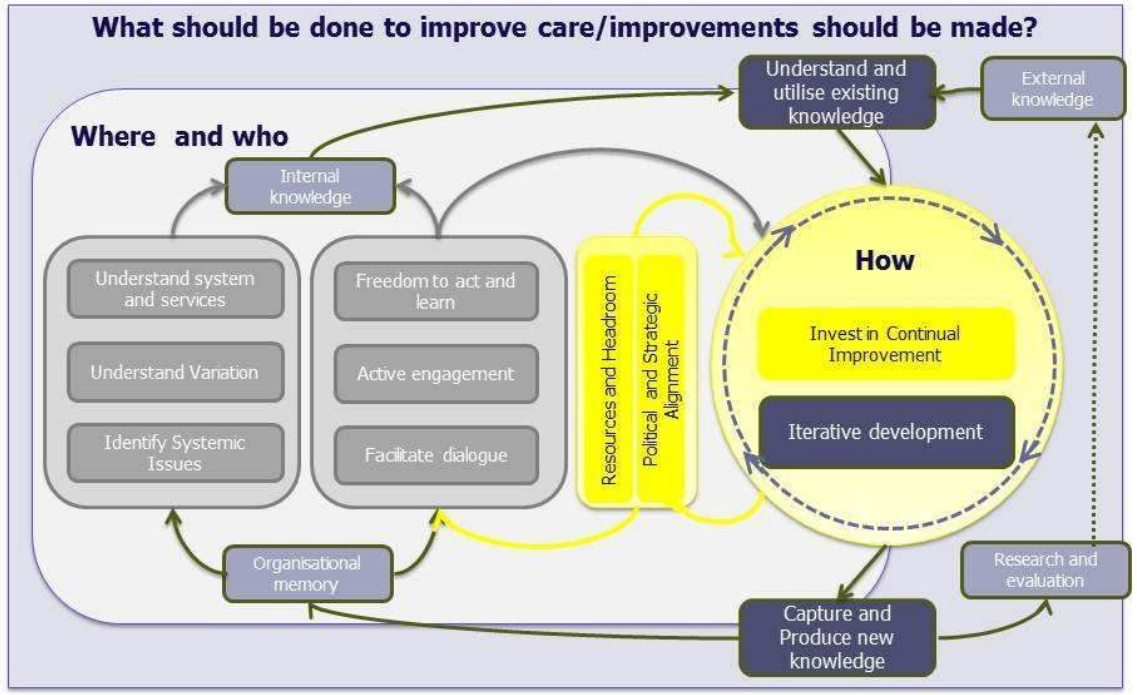
Reveals the complexity and overlap/interdependency of these 3 different perspectives
(shows the 12 objectives plus 4 extra concepts (internal knowledge, org memory, external knowledge, research and evaluation) which help expand the knowledge/acting scientifically theme)



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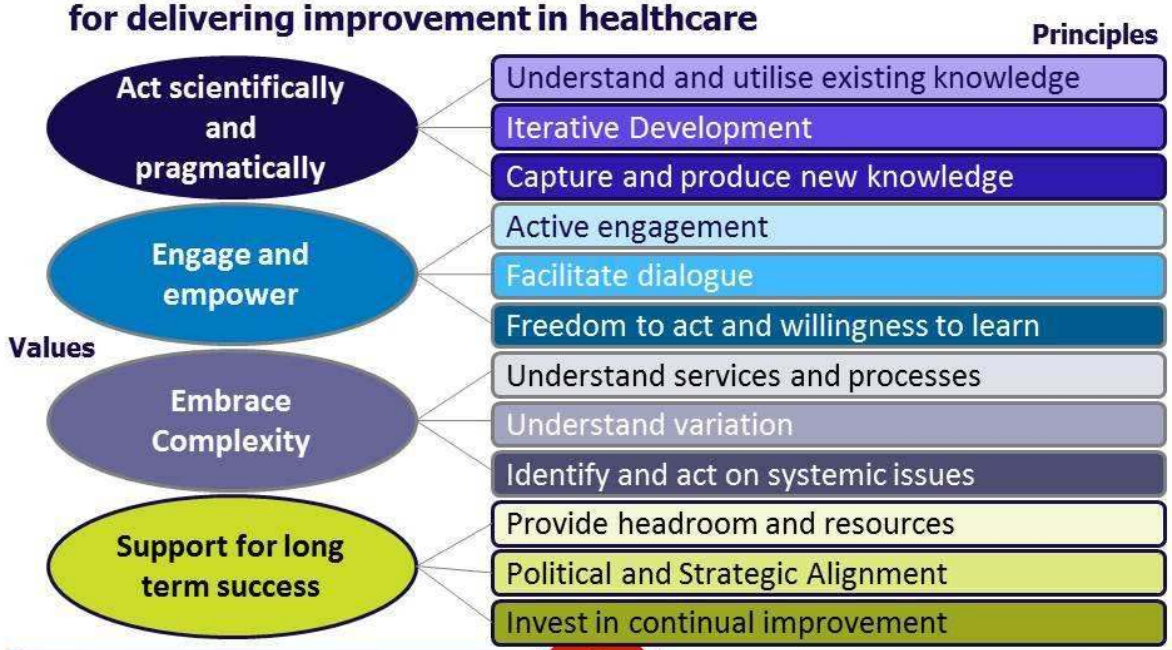
Conceptual Framework
for delivering improvement in healthcare



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Implications

- Recognition of the complexity of the problem
- Need to move the research agenda to the 'black box' of improvement
- Value (necessity?) of transdisciplinary working and multiple perspectives
- A framework that is applicable in all situations but it's counter-cultural!

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Oral Presentations:

How do quality improvement tools & methods contribute to healthcare improvement?

How do quality improvement (QI) tools and methods contribute to healthcare improvement?

Authors:
Cathy Howe, Julie E. Reed, Cathal Doyle, Derek Bell

Abstract

Background:
Many improvement programmes in healthcare use quality improvement (QI) tools and methods. The evidence for their effectiveness in healthcare settings is not well described and this area is currently under-theorised.

Methods:
Through extensive literature review and direct experience/participant observation the NIHR CLAHRC for Northwest London identified 4 values and the 12 associated principles that we propose are key to improvement in healthcare. 11 selected QI tools were used in forty-three diverse 18 month projects over three years. From this basis we theorise the social and technical functions of QI tools and how their utilisation can achieve the 12 improvement principles and thereby support delivery of improvements in healthcare.

Results:
We now have theoretical descriptions of how each QI tool contributes in complex healthcare settings including important technical and social functions they serve. For example, one of the technical functions the Model for Improvement serves is to provide structure and critical reflection for experimental study of changes in practice. One social function is its role as a communication tool to explore diverse perspectives about the predicted effect of an intervention.

Not all tools contribute in the same way or to the same extent to all principles. The findings are briefly summarised by mapping each tool as contributing significantly, partially or only indirectly (S, P or I) to the 12 principles.

Implications:
Further work is now required to consider how the theory of QI tools compares to their utilisation in practice and how this learning can be translated into supporting the development and use of QI tools.

CLAHRC NWL Approach

Primary aim:

Improve health outcomes and patient experience through delivery of clinically effective care.

A collision of different worlds…

Research
Rigorous Design and Use of Data

Education
Training, Support and Collaboration

NIHR CLAHRC
For Northwest London
systematic approach

Health Outcomes
Patient Experience

4 Rounds: 21 Projects over 55 Sites engaging over 500 NHS staff

Patient and Public Involvement
Engaging Patients and Staff

Quality Improvement
Quality Improvement Methods

Conceptual Framework

for delivering improvement in healthcare

Values

Act scientifically and pragmatically

Engage and empower

Embrace Complexity

Support for long term success

Principles

- Understand and utilise existing knowledge
- Iterative Development
- Capture and produce new knowledge
- Active engagement
- Facilitate dialogue
- Freedom to act and willingness to learn
- Understand services and processes
- Understand variation
- Identify and act on systemic issues
- Provide headroom and resources
- Political and Strategic Alignment
- Invest in continual improvement

Contribution of QI tools and methods : The CLAHRC NWL approach

Representative Team (Centre)
Clinical lead, project manager, information lead and executive sponsor, plus others including patients.

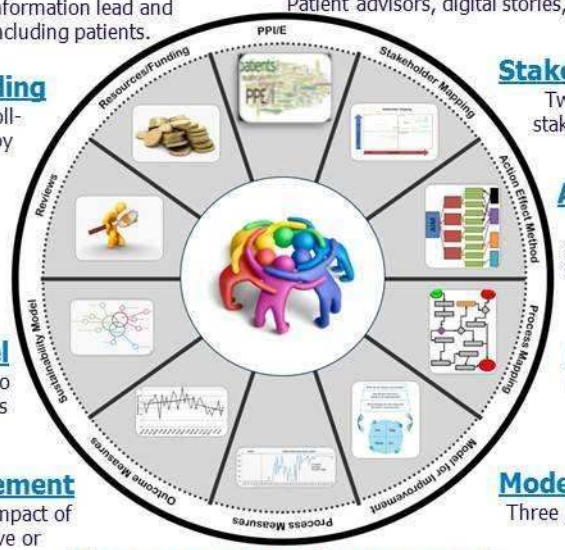
Patient & Public Involvement
Patient advisors, digital stories, focus groups…

Resources/ Funding
£100k or £50k to develop or 'roll-out' projects matched funded by NHS and/or industry partners.

Reviews
Two-way formative 6 month reviews exploring how teams use and engage with QI tools.

Sustainability Model
NHS III Sustainability Model to identify and address factors that affect sustainability.

Outcome Measurement
One or two measures to show impact of the work on outcomes, qualitative or quantitative.



Stakeholder Mapping
Two-by-two matrix to identify key stakeholders interest and influence plus management plan.

Action Effect Method
A facilitated approach to represent the 'theory of change' including a patient-focused aim, contributing factors, and ideas for interventions.

Process Mapping
Representation of activities and branching points in a care or data process.

Model for Improvement
Three questions and rapid-cycle small tests of change.

Measurement for Improvement
A 'few key weekly measures' to show progress using run charts and automated SPC charts.

QI tools contribution

- All tools make social and technical contributions
- All tools contribute to two or more values
- Most tools contribute to most values
- Tools contribute differently to all values – but exactly how, is still to be explained
- No 'super-tool' or subset of 'super-tools'

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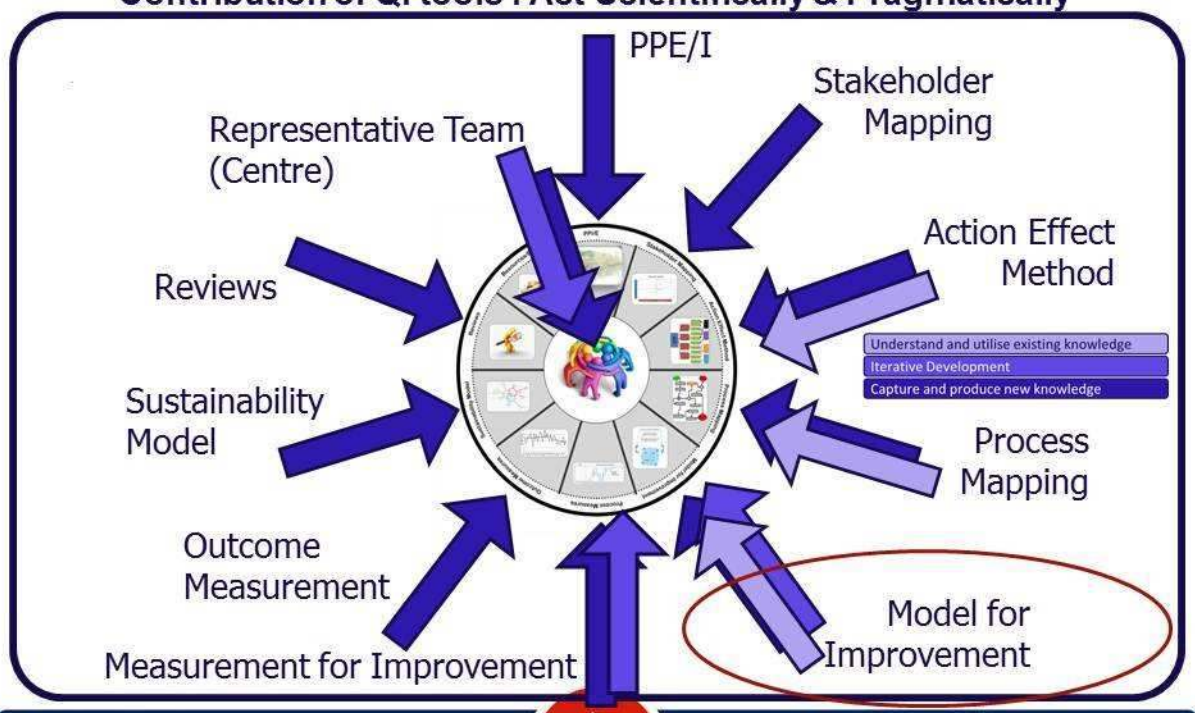
Contribution of QI tools : Act Scientifically & Pragmatically



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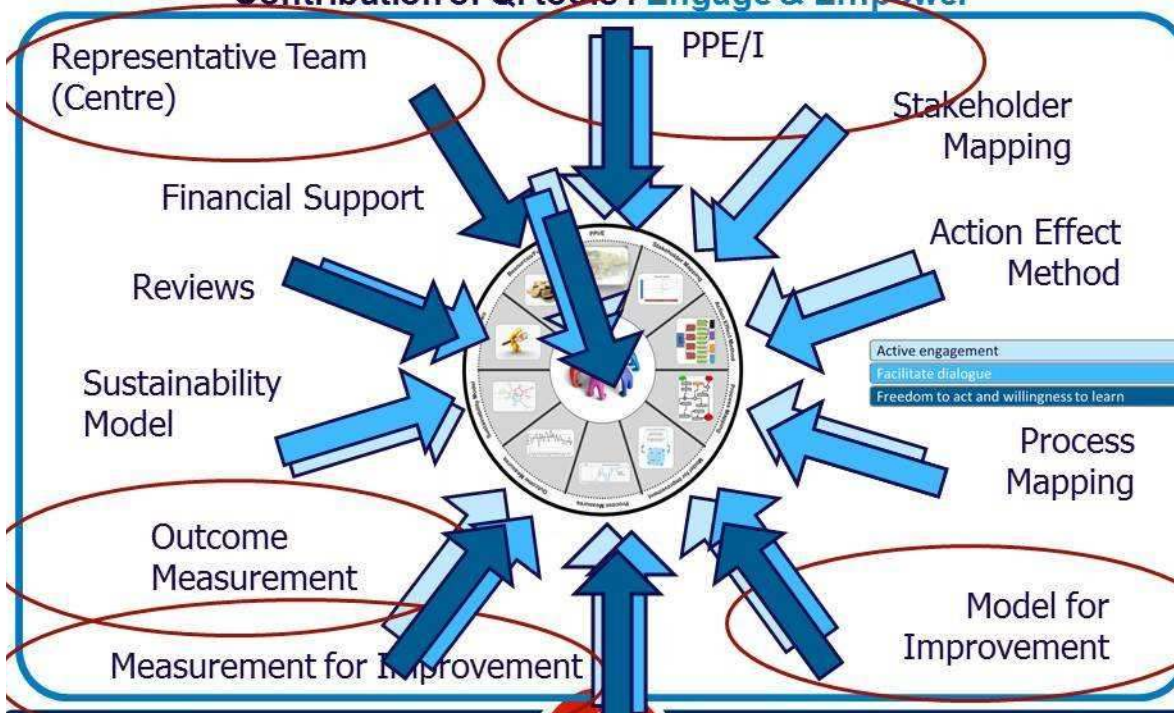
Contribution of QI tools : Engage & Empower



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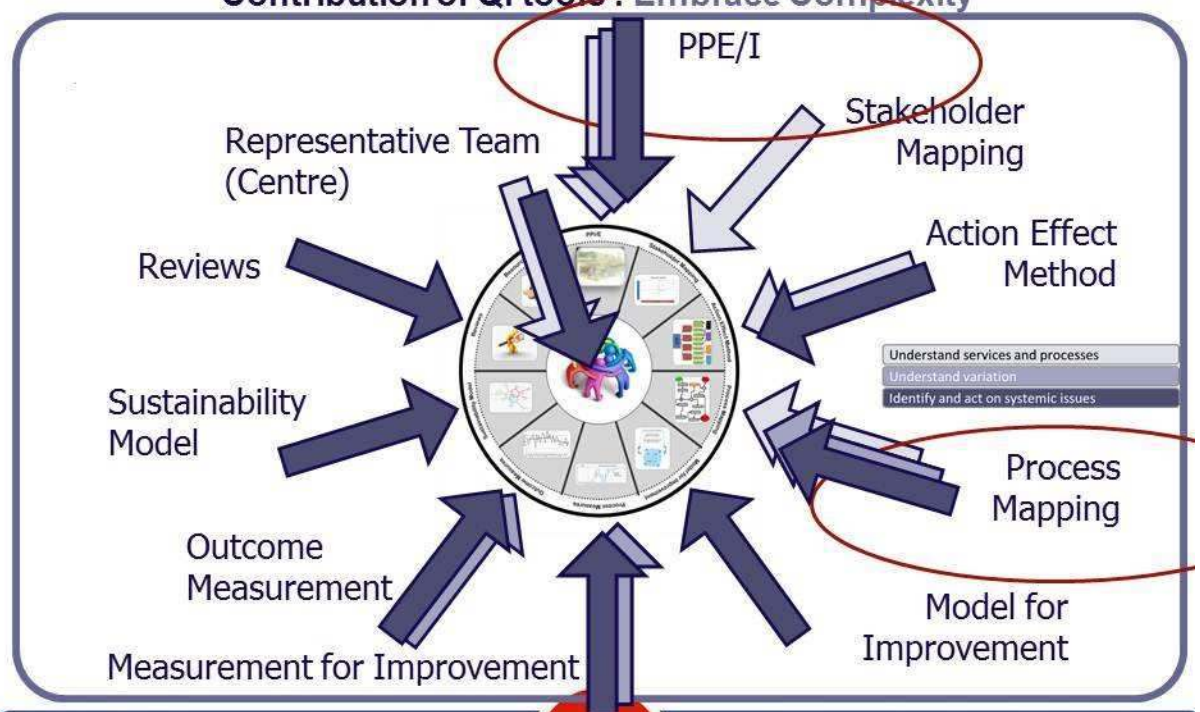
Contribution of QI tools : Embrace Complexity



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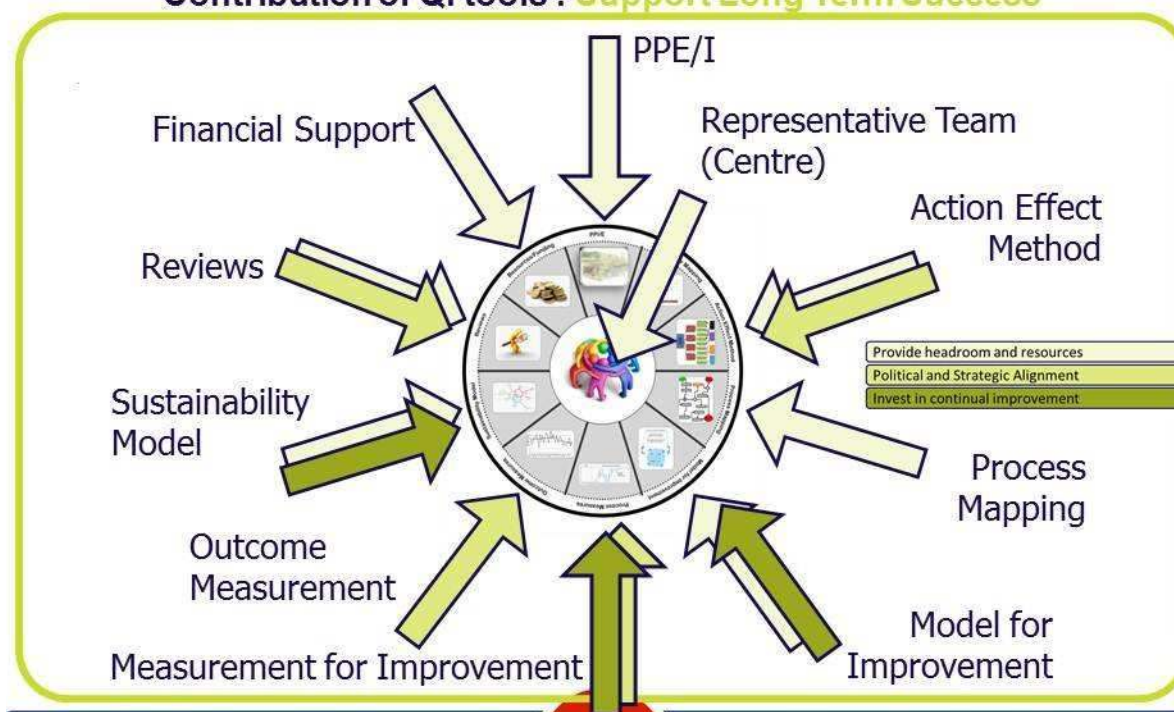
Contribution of QI tools : Support Long Term Success



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Posters presented:

Poster Presentation:
Assessing engagement with quality improvement tools & methods

NIHR CLAHRC for Northwest London

Assessing Engagement with Quality Improvement Tools and Methods

Cathy Howe, Katie Randall & Derek Bell
NIHR CLAHRC for Northwest London

National Institute f Health Researc

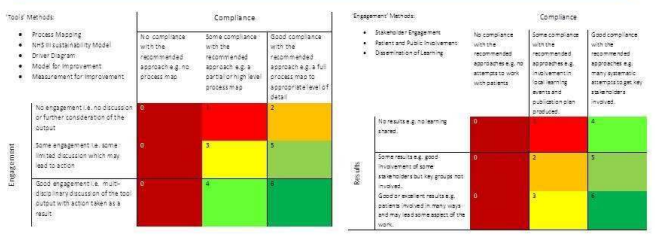
Background:

Many healthcare improvement programmes, including quality improvement (QI) collaboratives, use a range of QI tools and methods. There is some evidence of positive effect of QI collaboratives, but less about the effectiveness of the QI methods – the 'black box' of the intervention. Few studies refer to the degree of utilisation of methods despite the assumption they facilitate delivery.

This study considers an assessment framework to quantify engagement with and use of QI tools in 3 Rounds of improvement projects in a collaborative in Northwest London.

Methods:

A framework to assess engagement with and use of QI tools was applied to 43 projects in the NIHR CLAHRC for Northwest London collaborative covering a range of specialties and settings including respiratory, paediatrics, medicines management and mental health.



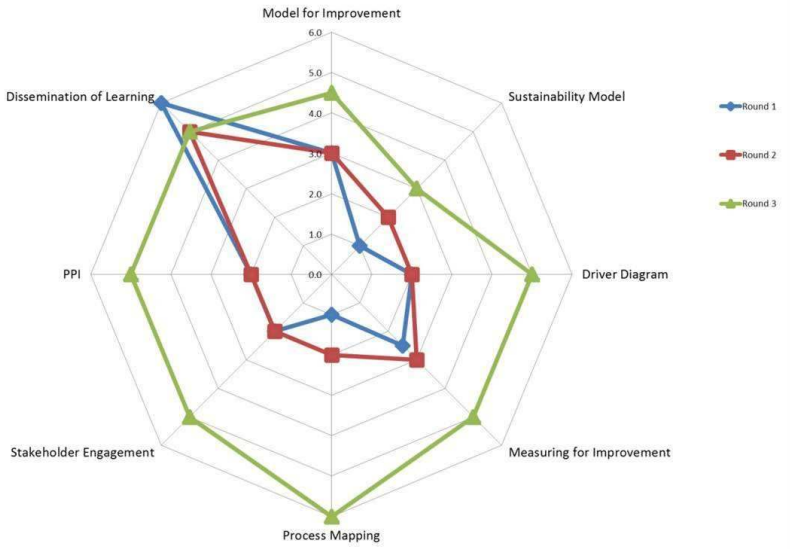
Two non-linear 7 point scales:

- Scale 1 for QI 'tools' considering compliance and engagement (did they do it and did they pay attention to it).
- Scale 2 for QI 'engagement' methods considering compliance and results (did they try and did they achieve anything through their efforts).

At the end of each 18 month round, each project was assessed against each QI method using project documents and the knowledge of the CLAHRC NWL faculty. Discussions revealed the importance of the tacit knowledge held by those working directly with the QI projects, particularly in relation to how the methods are actually used in practice and how 'ideal' this was for an individual project.

Results:

Median scores improved for each round. Process Mapping increased most, Sustainability Model increased least and Dissemination decreased slightly between Rounds 1 & 3.



The degree of engagement with each of the QI tools and methods varied within and across projects. More projects engaged with more methods in each round.

Discussion:

Throughout the programme CLAHRC NWL faculty regularly reflected and reviewed how teams were engaging with and using QI methods. As a result we changed how we operationalised our approach. Examples include:

- **Process Mapping:** was highly beneficial when it was used so it was built into the application process for Round 3.
- **Driver Diagrams:** were "worth it in the end, but they make your brain hurt", so we developed the Action Effect Method where project teams were supported to participate in a facilitated discussion which CLAHRC NWL expert observers captured in diagram format.
- **Patient & Public Involvement:** was considered daunting, so a 14 day challenge to create a digital Patient Story gave teams a specific time-limited mechanism to engage with patients.
- **NHS III Sustainability Model:** was not felt to be useful unless teams discussed the results together. We strongly encouraged teams to hold facilitated discussions, leading to a small improvement in engagement by Round 3.
- **Dissemination of Learning:** was influenced in Round 1 by a high proportion of projects having clinical academic leads. In Rounds 2&3 workshops were held to support NHS practitioners in 'writing for publication'.

Increasing scores suggest changes made to teaching and facilitation successfully increased collaborative teams' engagement and confidence with QI tools.

Implications:

The framework provides detailed methods-related information that can be used to assess progress and make improvements.

Variable engagement with QI tools and methods may contribute to the mixed evaluation of QI collaboratives. This study therefore raises important questions about implementation fidelity and highlights the need to open the 'black box' both while the work is in progress, and for the purposes of evaluation. We believe that degree of use of tools should be quantified in all QI publications. Further research could consider whether engagement with QI tools and methods is associated with sustained success.

International Forum on Quality & Safety in Healthcare, London

NIHR CLAHRC for Northwest London

NHS National Institute for Health Research

Identifying the Impact of the Challenges and Facilitators on the Implementation of a COPD Discharge Care Bundle

L Lennox., S Green., C Howe., H Musgrave., S Elkin.

1. Background

Care bundles have been identified as a way of reducing variation patient care[1]. The National Institute for Health Research (NIHR) Collaboration for Applied Health Research and Care (CLAHRC) for Northwest London worked with clinicians and patients to develop a COPD discharge care bundle[2], which has been implemented across 7 acute hospitals. Each of the sites adapted the bundle according to available resources and local settings.

2. Problem

While care bundles are effective at reducing unwarranted variation [2], they are often subject to significant challenges that impact their successful implementation. The aim of this study was to identify the challenges encountered by local teams assess the solutions and facilitators the developed to mitigate these issues. It is hoped that these findings can be used to inform future implementation across other sites.

3. Assessment of problem and analysis of its causes

Identifying the challenges faced by the clinical teams that implemented the COPD Bundle provides an opportunity to understand the professional, organisational and technical barriers to the successful and timely delivery of this type of intervention. Furthermore, understanding the solutions and facilitators to overcome these challenges provides an additional opportunity to share learning from these initiatives with future clinical teams looking to implement the COPD Care Bundle.

4. Intervention

Documentary analysis, using a thematic framework approach, of implementation data generated by the clinical teams was used to identify challenges and barriers that were encountered. The results of the analysis were used as the basis to construct focus groups and bring together implementation teams to consider some of the greatest challenges and reflect on some of the strategies used to overcome them.

5. Results

Documentary analysis:

The most common challenges revealed in the documentary analysis were related to 5 high-level themes: **staffing, process, infrastructure, patient and public involvement** and, **Quality Improvement methodology.** Within these themes 28 associated challenges were identified.

Focus groups:

A total of 17 healthcare professionals and healthcare managers from five teams agreed to participate. Participants voted that *staffing* posed the greatest high level challenge for the project implementation (Figure 1). The 5 most significant thematic challenges, as voted for by the focus groups were: *staff too busy, staff shortages, lack of staff engagement, added workload of the bundle* and *patient coding issues.* The focus group discussion revealed a number facilitators associated with these specific challenges, some of which are shown in table 1.

Figure 1

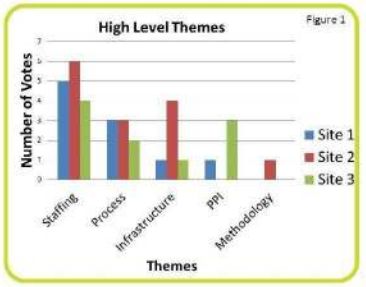


Table 1

Challenge	Facilitator	Focus group demonstration
Staff too busy	Use of a multi-disciplinary team	*"Having multidisciplinary people get involved helps with the initiation of the bundle. Because even if one person misses it a physio or nurse comes and starts it and even a pharmacist can say this patient isn't on a bundle and start one." (Physiotherapist)*
Staff engage-ment	Finding project champions	*"Having a nurse champion or a bundle nurse aided in getting people on board and motivated staff members to complete the bundles."(Clinical lead)*
Added workload of the bundle	Changing the perception of the work involved in delivering the bundle	*"A large part was changing the perception of the bundle, they envisaged it as more time consuming than it actually was, because they are constantly being given more paperwork around various diseases and to them it was just another piece of paper that they thought would be a lot of work." (Nurse)*
Patient coding issues	Engaging coders in the project	*"The team asked the coders to talk us through their process...by understanding their process we were able to help them understand ours" (Bundle Nurse)*

6. Measurement of improvement:

Using statistical process control, coupled with Plan-Do-Study-Act cycles, the implementation teams generated run charts to guide their implementation of the COPD bundle. The run charts themselves exemplify the effects of challenges faced by teams as uptake and compliance to the bundle was variable throughout the project (Figure 2). This pattern continues irrespective of the funding period.

Figure 2

7. Message for others:

Maximising impact of the COPD Bundle relies on the successful and timely implementation in the acute medical setting. A priori understanding of the challenges that the team may encounter provides an opportunity for mitigating challenges that cost time and resource and ensure training tailored to the anticipated challenges. Shared learning of the facilitators to challenges can also equip the team with skills to ensure successful implementation.

1Cooke, F. & Holmes, A. (2007). The missing care bundle: antibiotic prescribing in hospitals. International Journal of Antimicrobial Agents 30,35-38.

2Hopkinson, N. et al. (2011). Designing and implementing a COPD discharge care bundle. Thorax BMJ Quality. bmjqc.bmj.com 1-2.

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Poster: L Lennox, S Green, H Musgrave, C Howe, S Elkin (2013)

"Identifying the Impact of the Challenges and Facilitators on the Implementation of a COPD Discharge Care Bundle"

NIHR CLAHRC for Northwest London

Royal Brompton & Harefield NHS Foundation Trust

NHS National Institute for Health Research

Increasing referral to and completion of early post-hospitalisation pulmonary rehabilitation: A quality improvement collaborative

S Green, S Jones, A Clark, S Fleming, C Howe, M Haselden, S Kon, M Dickson, C Moloney, K Mindel, K Joslin, C Howard, G Hawkes, R Grewal, J Godden, B Dahele, W Man

Aim

To improve access, uptake and completion of post-hospitalisation pulmonary rehabilitation (PR) following admission for an acute exacerbation of COPD

Problem

Over 3000 patients within Hillingdon, Northwest London, have a recorded diagnosis of COPD. In 2011, there were 391 emergency admissions for COPD and the average length of stay for patients is the shortest in London at 4.9 days (versus 6.7 days). However, COPD 90-day hospital readmission rates in Hillingdon are 42.5% in comparison to 30% reported by other trusts in national COPD audits.

Assessment of problem and analysis of its causes

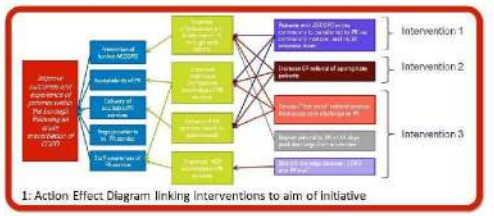
Evidence indicates that early post-hospitalisation PR can reduce the 90-day readmission rate. The majority of referrals for PR are of stable patients rather than post-hospitalisation referrals. Prior to this quality improvement initiative there were no direct referrals from the COPD discharge team to PR. The quality improvement collaborative was formed of members from seven organisations including primary, secondary, community care; commissioners, public health, academia and the voluntary sector. To explore how to link these services an Action Effect Diagram was used to provide a framework for discussion of potential activities/interventions to increase access, uptake and completion of PR (Figure 1).

Interventions

Intervention 1: A Community Matron referral pathway was set up and a teaching session was delivered to these healthcare professionals to raise awareness of PR and provide support for referral of patients that exacerbate and are cared for in the community.

Intervention 2: A GP referral pathway was set up and a teaching session was delivered to these healthcare professionals to raise awareness of PR and provide support for referral of patients admitted to hospital following COPD exacerbation not referred to PR during discharge.

Intervention 3: A COPD discharge team referral pathway was setup from the acute hospital to the PR service. This has been supported through the reciprocal shadowing of healthcare professionals from the PR service and the COPD discharge team at Hillingdon Hospital.

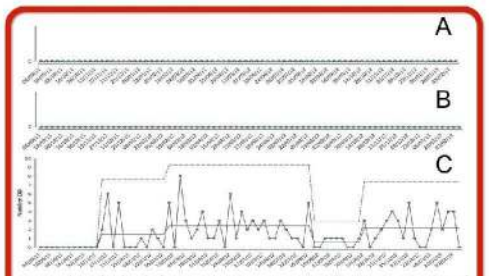


1: Action Effect Diagram linking interventions to aim of initiative

Measuring for improvement

The effect of interventions were monitored through the collection of weekly improvement measures using an online data collection tool:

1. Number of referrals from community matrons in Hillingdon
2. Number of referrals from GPs in Hillingdon
3. Number of referrals from the COPD Discharge team in Hillingdon



A - Number of referrals from community matrons in Hillingdon; **B** - Number of referrals from GPs in Hillingdon; **C** - Number of referrals from the COPD Discharge team in Hillingdon

Effects of change

The run charts generated from the weekly data demonstrated an increase in the number of referrals from the COPD discharge team where a significant amount of resource has been utilised to support clinical staff to understand the benefits of PR and also embedding routine PR referral through the use of a COPD care Bundle (Fig 2C). This success has not been replicated through the educational sessions for community matrons (Fig 2A) and GPs (Fig 2B) although referrals rates of stable patients for PR from these professional groups has increased over the same period. The monthly outcome measures demonstrate successful attendance and completion of PR (table 1).

Quarter	1	2	3	4	5
Number of referrals (Access)	0	17	28	31	14
Percentage referred who attend first session (Uptake)	0	77%	68%	81%	71%
Percentage of patients that attend first session that complete the course (Completion)	0	46%	79%	56%	60%

Monthly outcome measures were also developed to monitor uptake (conversion of referral to attendance at first session) and completion (completion of at least 8 sessions of PR) to ensure benefits of PR are realised. Project began in Quarter 2.

Conclusion

A collaborative approach has yielded results working with the COPD discharge team, although there is still some inconsistency, which may be due to seasonal variation in number of admissions. Whilst there have been no post-hospitalisation referrals from the community matrons and GPs there have been increases in stable patient referrals. The quality improvement collaborative is now exploring opportunities to identify patients that have an exacerbation of COPD but are not admitted to hospital, to further increase referrals from patients that could benefit from early PR. The delivery of evidence based care often requires the linking of services across traditional organisational and professional boundaries and quality improvement collaboratives can provide a vehicle for driving change to improve services and the quality of patient care.

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Poster: S Green, S Jones, A Clark, S Fleming, C Howe, M Haselden, S Kon, M Dickson, K Mindel, K Joslin, C Howard, R Grewal, J Godden, B Dahele, W Man (2013)

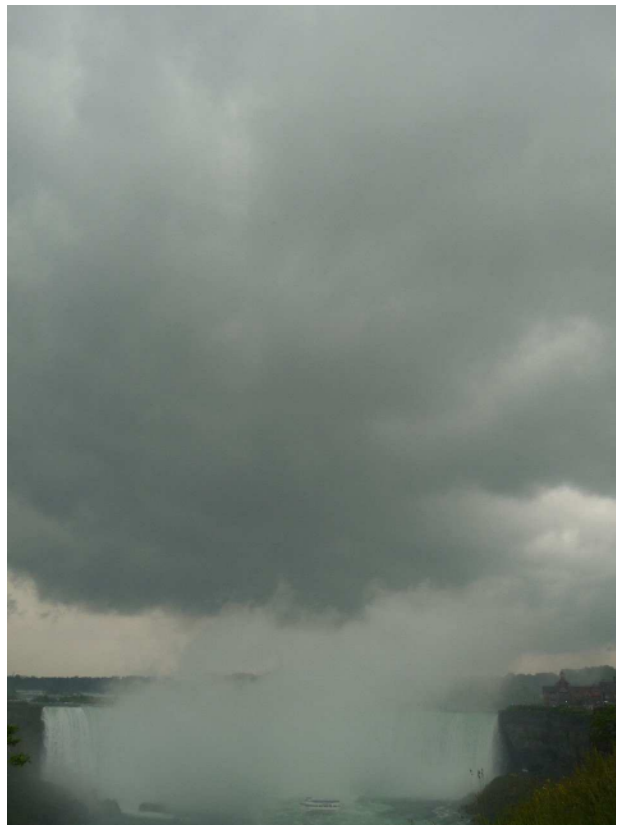
"Increasing referral to and completion of early post-hospitalisation pulmonary rehabilitation: A quality improvement collaborative"

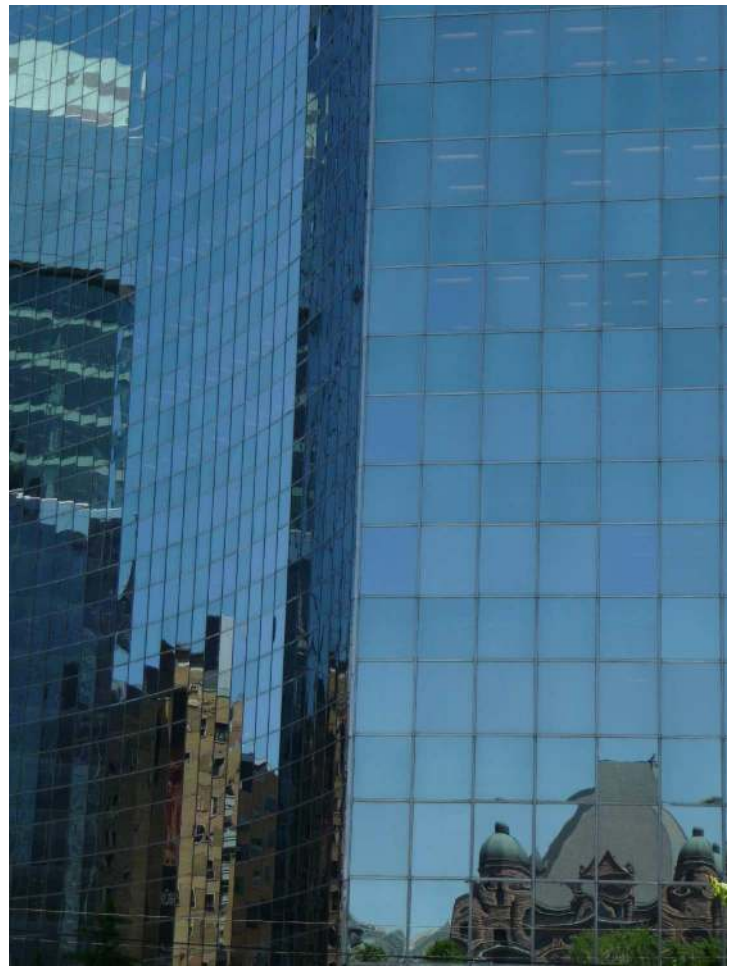
Study Visit to Ontario, Canada:

The Canadian Knowledge Mobilization Forum may be a conference like no other. In all my years I have never been to one that was so friendly, and genuinely seemed to provide attendees with a 'tribe'. It may not have been by design, but this collegiate atmosphere prevailed. They are placing so much value on this they are limiting places next year to ensure the forum doesn't get bigger.

People I met in Canada were almost without exception welcoming, open and curious about me, what I was working on and wanted to know how we could work together.

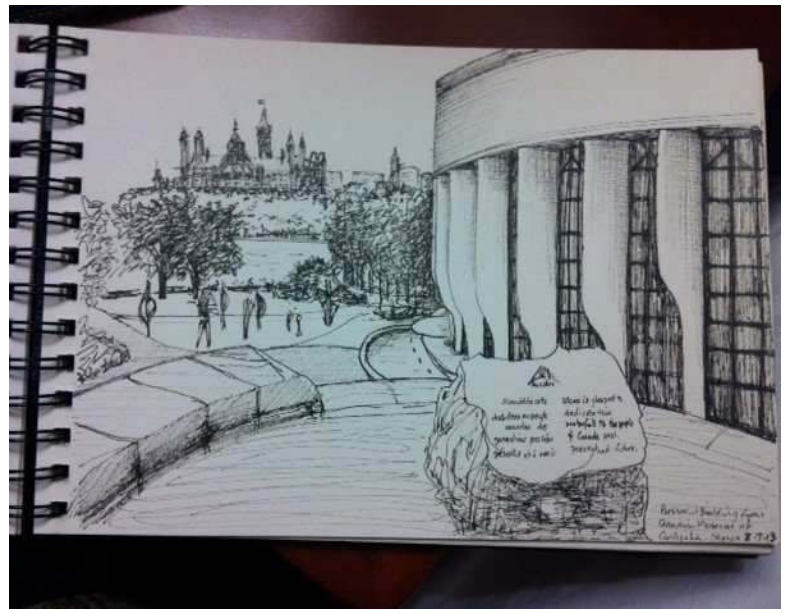
Two potential collaborations are already being explored only one week after I returned.





RocketOwl: is a game developer who wants to use games to solve global problems. We're discussing how we might collaborate on a game to support healthcare improvement, bringing consequences closer to actions, allowing iterative testing in a safe environment and supporting people to see the whole system.

Peter Levesque: President & CEO of the Institute for Knowledge Mobilization has a remarkable skills and knowledge base and is keen to find ways to work together - perhaps on an UK KMb Forum.



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Canadian Knowledge Mobilisation (KMb) Forum & Study Visit (June 2013)

Cathy Howe, NIHR Knowledge Mobilisation Fellow & NIHR CLAHRC for Northwest London
(e: c.howe@imperial.ac.uk t: @cathgreenhalgh w: www.cathyhowe.net)

Want more? : see my blog at www.cathyhowe.net

Canadian KMb Forum:

A multi-sector forum for researchers and practitioners working in any aspect of knowledge mobilisation, run by the Institute for Knowledge Mobilization (IKMb). The 142 attendees represented 12 countries.

CKF13 IKMb

I presented CLAHRC NWL Values, QI tools contribution and Laura Lennox presented the COPD story all attracting significant interest (321 views of QI tools ckf13 slideshare).

Other highlights:

•York U & United Way
This partnership brings together academics and community workers to collaboratively solve community problems.

•Soufflearning
A collaborative providing bespoke training to SMEs e.g. dealing with drunk customers in a florist.

•Traffic Injury Research Foundation (TIRF)
By focusing on doing what they do best, TIRF has stopped chasing funding as collaborators now seek them out.

Rachel Hirsch: undertakes networks-based research combining with soft system methodology.

Ideas immediately transferable:
•Multi author blog:
Share the burden maximise output
•Kwicky Konnections (right)
•KMb Jeopardy:
Quiz show game
(below left & centre)

Networking: speed (above), slow (below right)

Event photos taken by Cait Levesque & used with kind permission of IKMb

Mississauga:

Peter Levesque: President & CEO IKMb (usually Ottawa based): Wide & varied knowledge, experience & interests including contribution to numerous examples on here including the Forum. Introductions to RocketOwl and to Ken Robinson's work.

WSPS: Using 'Positive Social Norms' to address issues of personal safety during driving activities undertaken for work.

Ottawa:

Burning tiny tourists

RocketOwl: a game development company with the aspiration to solve global problems through gaming. Introduction by Peter Levesque to explore opportunities to develop games to support healthcare improvement e.g. in unscheduled care, QI project development or for e-learning.

Canadian Foundation for Healthcare Improvement:
Building capacity & capability for improvement and evidence utilisation through programme such as 'Extra' for trios of fellows from a single organisation and provincial collaboratives improving care.

University of Ottawa Centre for Continuing Education: self-funded department running numerous courses internally & externally to the university including a Certificate in Knowledge Management.

Niagara:

Ontario has lots we can learn from. Most people I met are really interested in what we are doing and in collaborating. Are their curiosity in others and self-reflection key success factors…?

Collaboration Key:
- Actively exploring options
- Interest expressed

Toronto:

Centre for Addiction & Mental Health: Knowledge Exchange Team using an Implementation Science approach to support system level collaboratives to improve services for children & adolescents. EENet forum enables interactions across time and distance.

CAMH EENet

Ross Baker, Professor UoT: Keen to establish post-doc Improvement Science Fellowships in Canada.

Sarah Caldwell, Department of Social Care: Breathing a sigh of relief after submitting her PhD; insight into aspects of Canadian healthcare.

KT Canada, based at St Michael's: focus on evidence synthesis and how to improve guidelines. Interested in implementation and working internationally including sub-Saharan Africa re maternal and neo-natal mortality.

York U, Knowledge Mobilization Unit: David Phipps: developing excellence in brokering knowledge and collaborations between researchers and community/business organisations.

SickKids Hospital: Melanie Barwick has developed and runs training courses for Scientists (2 days) and KT practitioners (5 days). Currently may be the only courses in the world!

Institute for Work & Health: KT team translating research into formats more easily digested by others, including 1 page summaries and newsletters.

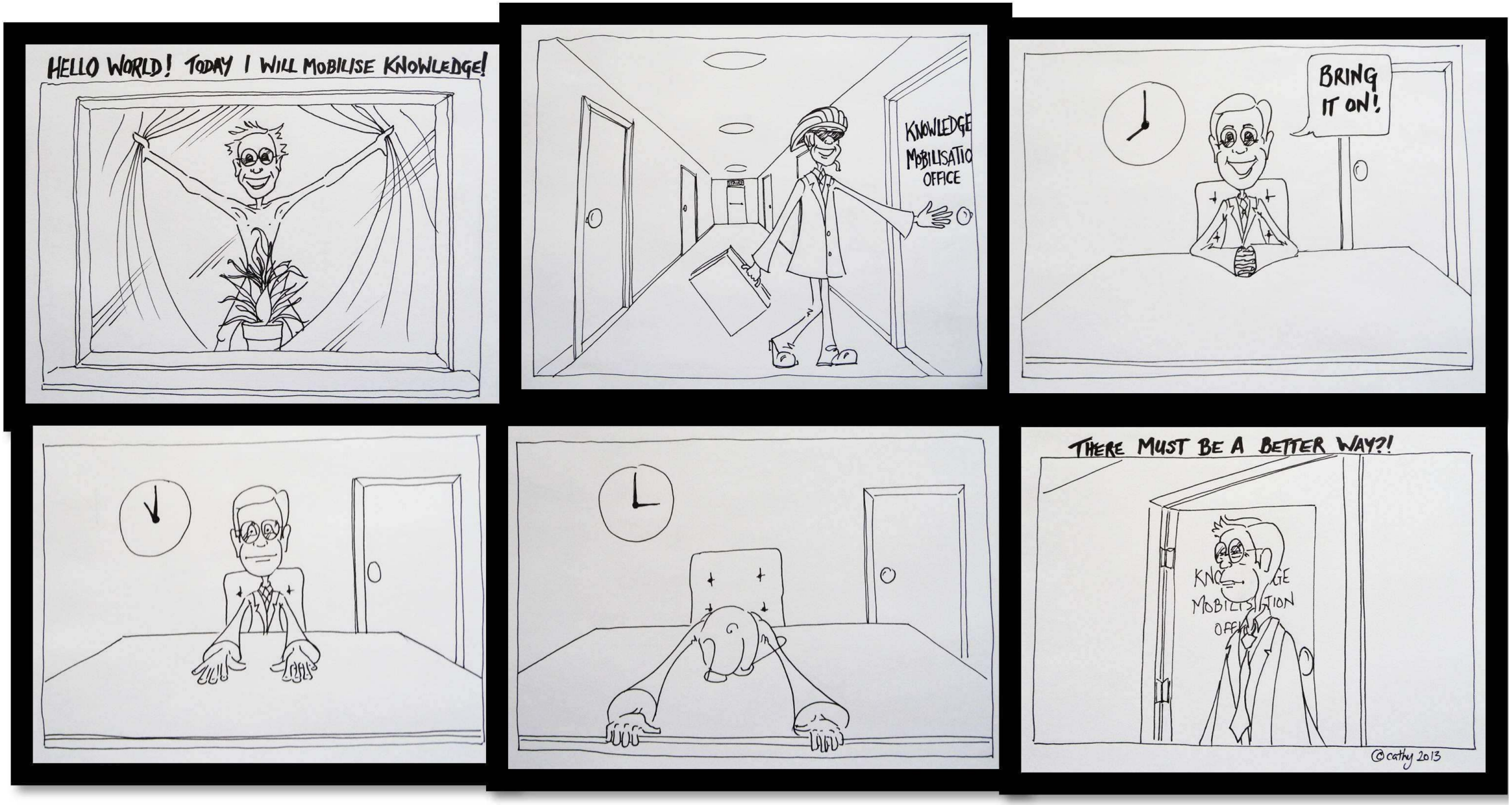
Norman the Novice
Knowledge Broker: appeared under my pencil on the paper tablecloth on night while I was waiting for my steak. He's very enthusiastic, but I have a feeling he's not going to be very good at KMb….

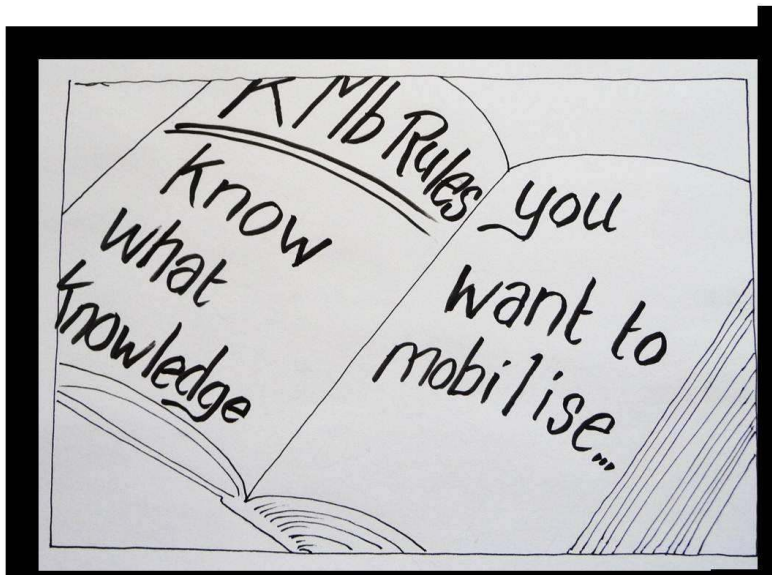
Norman the Novice Knowledge Broker

By Cathy Howe

NIHR Knowledge Mobilisation Fellow

On a recent visit to Canada I had time to spend thinking about all sorts of things, including the knowledge and skills needed to mobilise knowledge. 'Knowledge Brokers' are an increasingly popular idea, but that doesn't mean it's an easy job. Norman emerged one evening in Toronto while I was waiting for my steak in a restaurant with paper table cloths. Join me as he very enthusiastically starts his new job as a knowledge broker…


HELLO WORLD! TODAY I WILL MOBILISE KNOWLEDGE!
KNOWLEDGE
MOBILISATIO
OFFICE
BRING
IT ON!
THERE MUST BE A BETTER WAY?!
©cathy 2013


KMb Rules
Know what knowledge
you want to mobilise...


Hmmm...


KNOWLEDGE
MOBILISATION
OFFICE


THERE MUST BE A BETTER WAY?!
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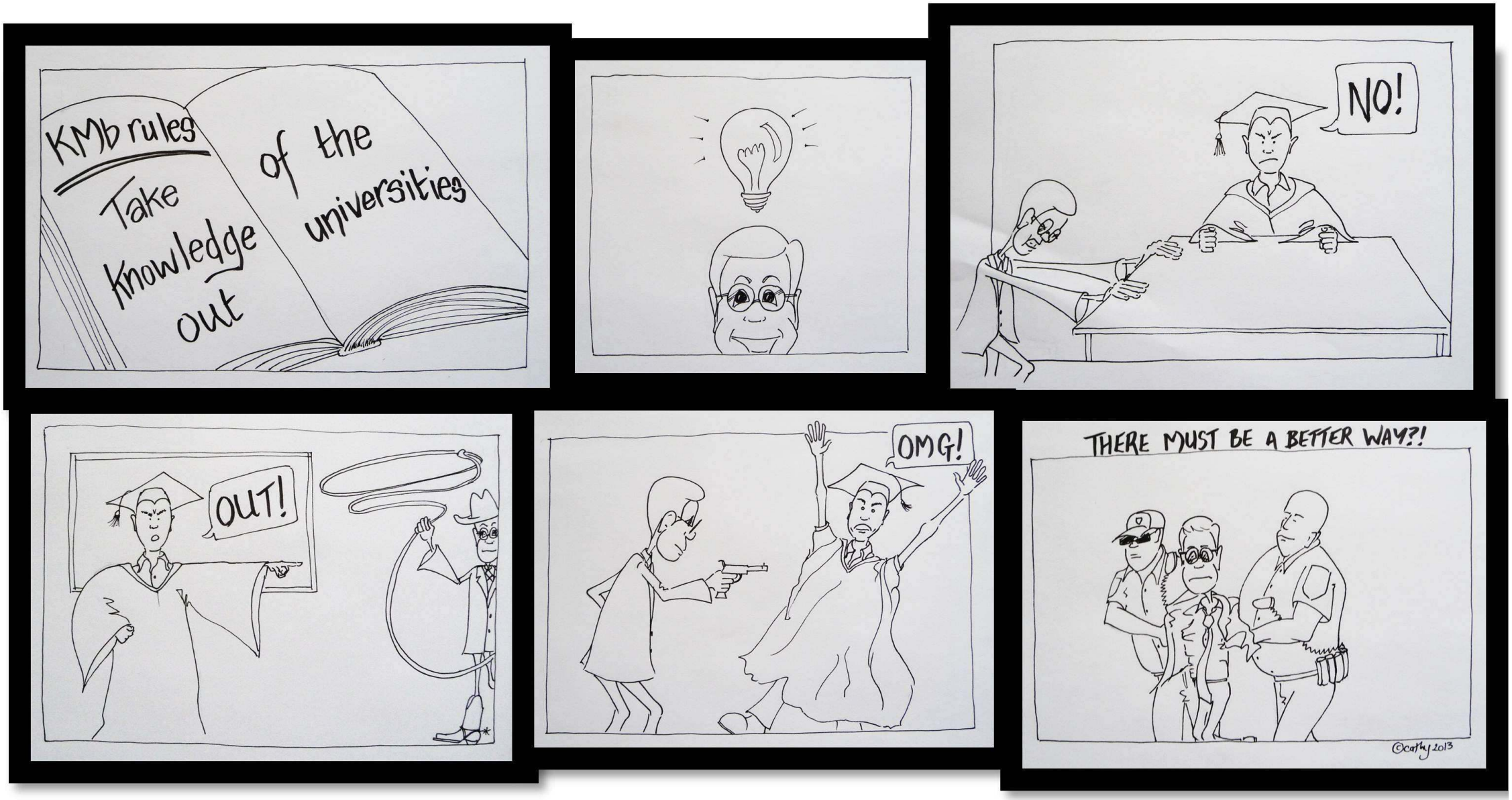
KMb rules
Take Knowledge out of the universities
NO!
OUT!
OMG!
THERE MUST BE A BETTER WAY?!
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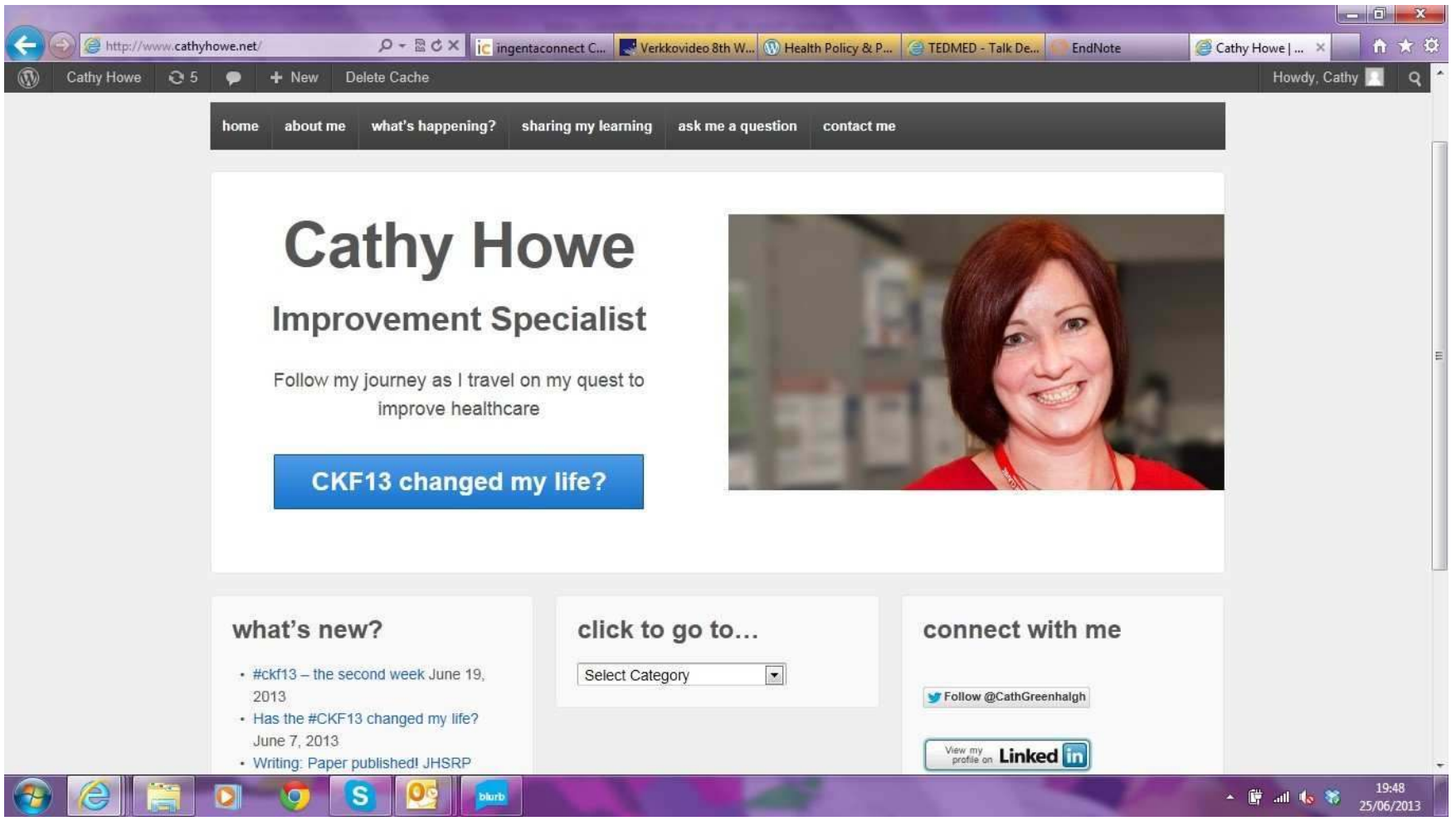
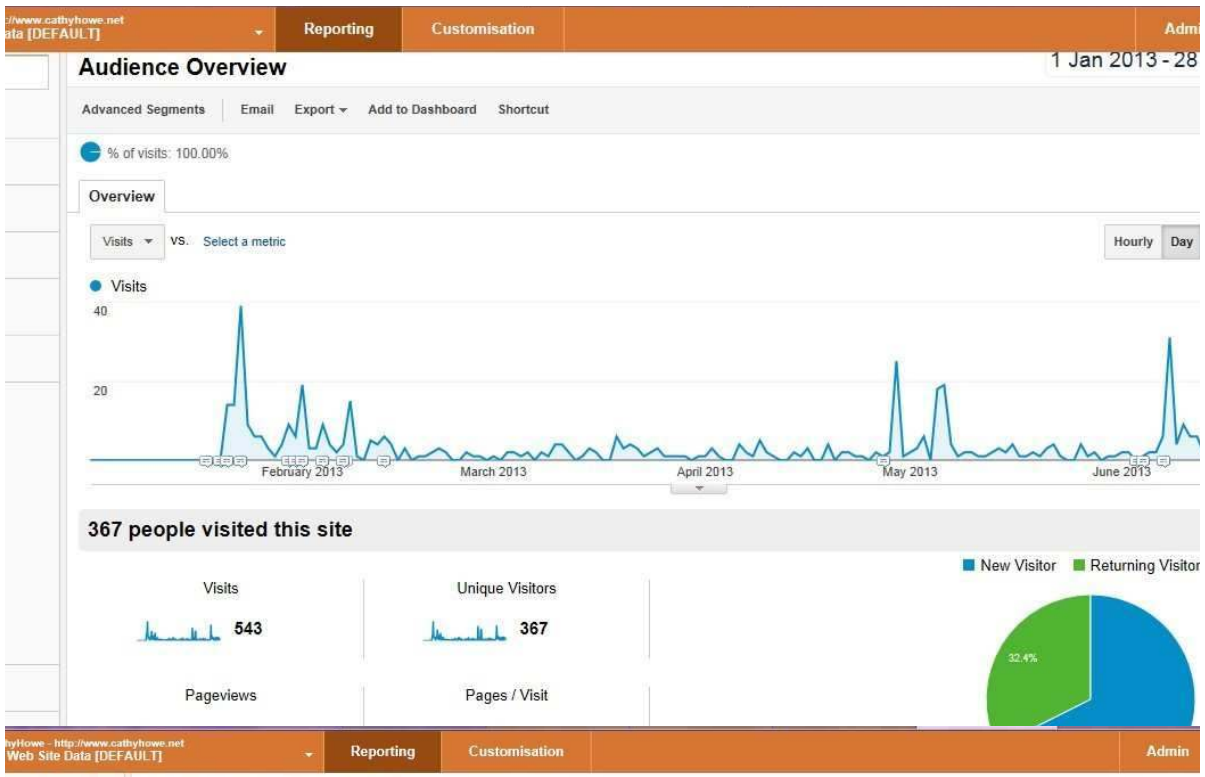
Social networking:

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Audience Overview
1 Jan 2013 - 28
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Overview
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vs.
Select a metric
Hourly
Day
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40
20
February 2013
March 2013
April 2013
May 2013
June 2013
367 people visited this site
New Visitor
Returning Visitor
Visits
543
Unique Visitors
367
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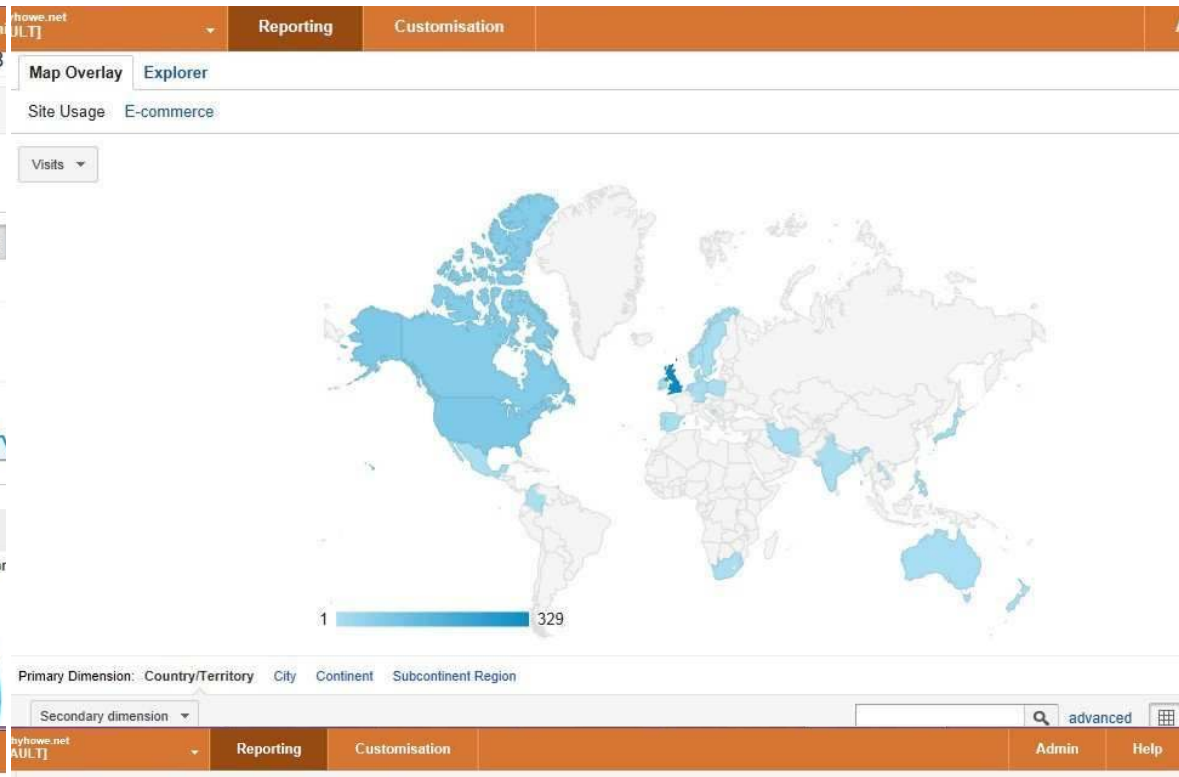
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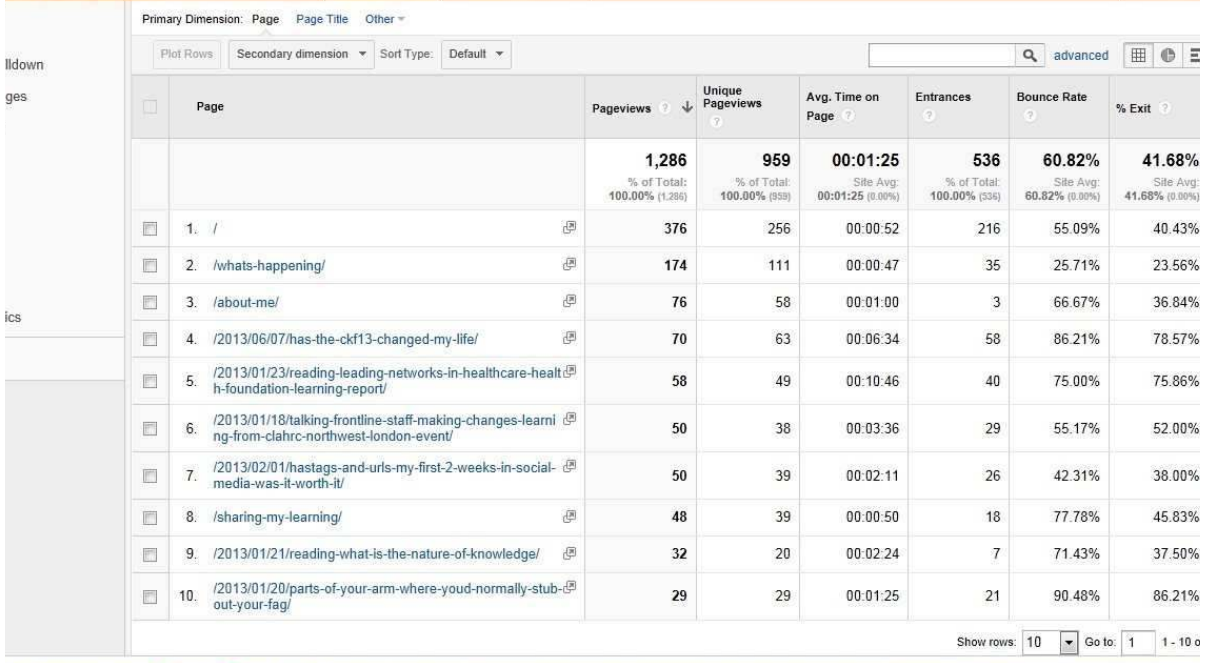
Help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Site Avg: 41.68% (0.00%)
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3. /about-me/ 76 58 00:01:00 3 66.67% 36.84%
4. /2013/06/07/has-the-ckf13-changed-my-life/ 70 63 00:06:34 58 86.21% 78.57%
5. /2013/01/23/reading-leading-networks-in-healthcare-health-foundation-learning-report/ 58 49 00:10:46 40 75.00% 75.86%
6. /2013/01/18/talking-frontline-staff-making-changes-learning-from-clahrc-northwest-london-event/ 50 38 00:03:36 29 55.17% 52.00%
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8. /sharing-my-learning/ 48 39 00:00:50 18 77.78% 45.83%
9. /2013/01/21/reading-what-is-the-nature-of-knowledge/ 32 20 00:02:24 7 71.43% 37.50%
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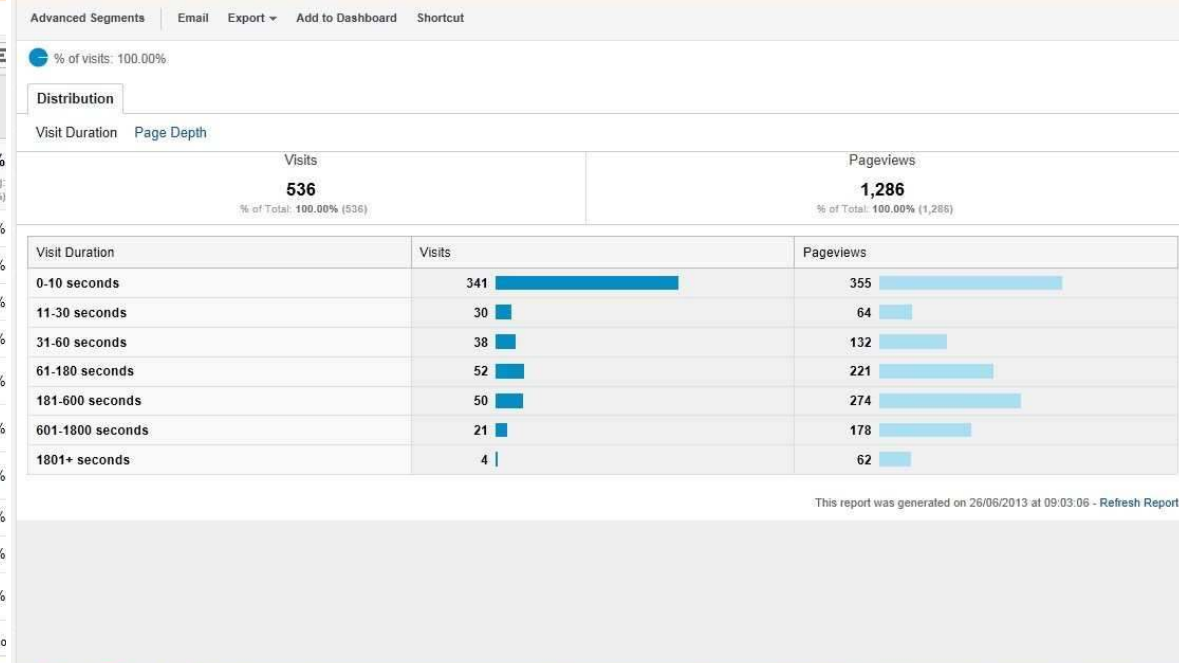
Advanced Segments
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11-30 seconds 30 64
31-60 seconds 38 132
61-180 seconds 52 221
181-600 seconds 50 274
601-1800 seconds 21 178
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@CathGreenhalgh
Improvement obsessive. UK healthcare NIHR Knowledge Mobilisation Fellow and Programme Lead at the NIHR CLAHRC for Northwest London. All views my own.
London and North Wales · cathyhowe.net
655 TWEETS
80 FOLLOWING
123 FOLLOWERS
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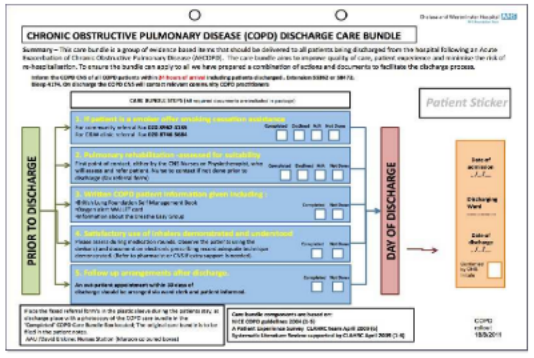
Cathy Howe @CathGreenhalgh 22s
18,000+ community health champions, improving health outcomes @Altogtherbeter vimeo.com/deckchair/revi... impressive stuff
Expand
Becky Malby @CIHM_Becky 29m
Real need to put in evidence on health to EU as its pretty new in terms of EU expertise #ehma13
Retweeted by Cathy Howe
Expand
Becky Malby @CIHM_Becky 31m
EU interest in health because cost of health key solvency
09:23
28/06/2013

Knowledge Mobilisation Activities & Teaching:

Workshop: **Why Quality Improvement in Healthcare: from Theory to Practice (Jan 2013)**
NHS Education Scotland Leadership Group
with D Bell, JE Reed, C Howe, T Woodcock, R Myron and C McNicholas

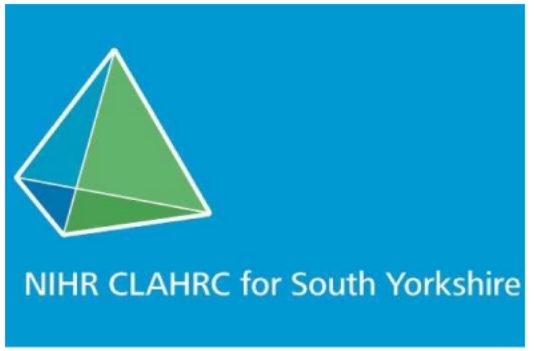

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) DISCHARGE CARE BUNDLE

Summary – This care bundle is a group of evidence based items that should be delivered to all patients being discharged from the hospital following an Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD). The care bundle aims to improve quality of care, patient experience and minimise the risk of re-hospitalisation. To ensure the bundle can apply to all we have prepared a combination of actions and documents to facilitate the discharge process.

Patient Sticker

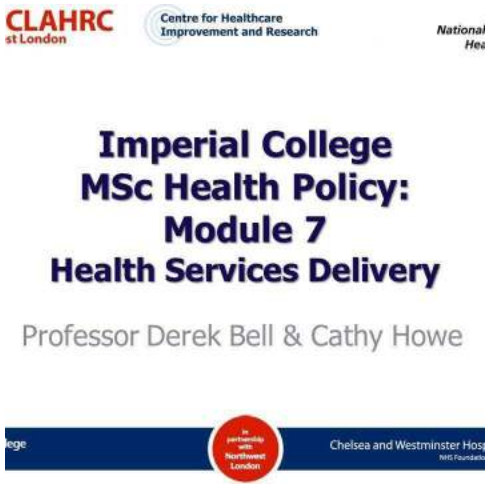
PRIOR TO DISCHARGE

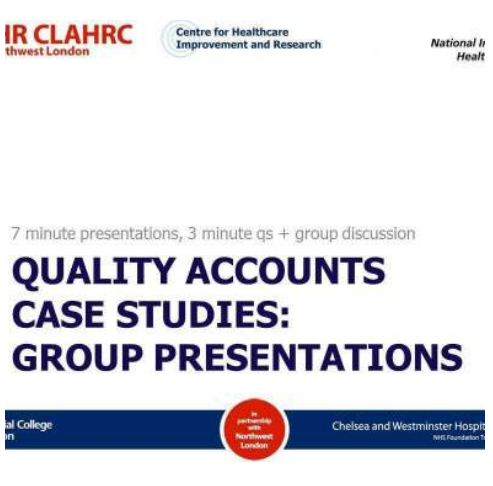
DAY OF DISCHARGE

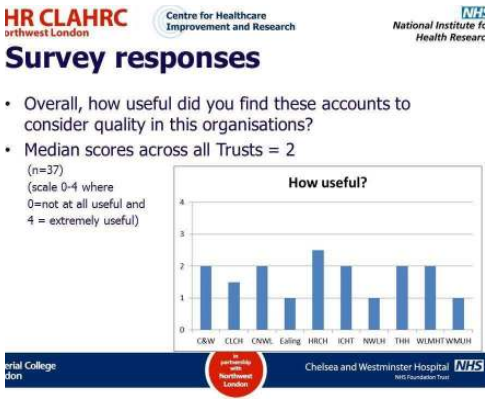


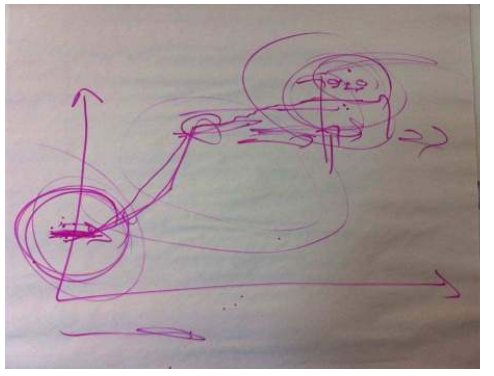
Knowledge Exchange:

Supporting implementation of the CLAHRC NWL COPD Discharge Bundle in Rotherham and Doncaster health economies in South Yorkshire, in association with the SYorks CLAHRC. Combination of face to face and web-based support provided.
With Tom Woodcock and Alan Poots.







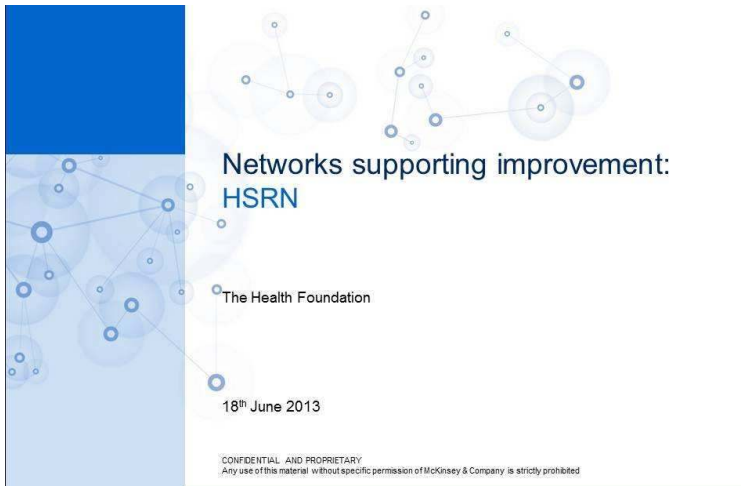


Imperial College MSc Health Policy: Module 7 Health Services Delivery (April 2013)
Coordinated by Cathy Howe and co-delivered by Cathy Howe Professor Derek Bell

At the Health Services Research Network Symposium The Health Foundation was presentating the findings of two reports they'd commissioned relating to networks.

I was invited by The Health Foundation to join a panel with Graeme Currie (WBS) to reflect on the presentations.

The Health Foundation
Inspiring Improvement



Supporting bid development:

NIHR CLAHRC for Northwest London

NHS National Institute for Health Research

I've supported several bid submissions through the CLAHRC NWL and the Centre for Healthcare Improvement and Research, including leading the development of the Collaborative Learning & Partnerships Theme for the second wave CLAHRC NWL application, provided support to other themes (Improvement Science and Breathlessness) and assisted with the main application abstract and strategy.

When I accepted an NIHR Knowledge Mobilisation Fellowship I wasn't quite sure what I was getting into. 3 years (0.7WTE) to undertake a knowledge mobilisation research and implementation project seemed daunting. I felt I'd been given permission to sail to America based on my picture of a boat – and I wasn't sure I had any boat building skills!

But these first 6 months have been fascinating...

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t: @cathgreenhalgh
w: www.cathyhowe.net