Knowledge Transfer and Mobilisation

Results of the Wales Scoping Study

Executive Summary

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Purpose

The primary aim of this scoping study was to learn more about how research findings are currently used to inform and advance healthcare practice in Wales so that we can better develop initiatives to improve the transfer and mobilisation of knowledge.

Method

Semi-structured telephone and face-to-face interviews were carried out with senior representatives from Health Boards in Wales and Board members from South East Wales Academic Health Science Partnership (SEWAHSP) (n=28). The interviews were audio-recorded, transcribed verbatim and analysed according a framework informed by the literature, particularly Walker et al's[1] organisation of factors that influence knowledge transfer and mobilisation (KT&M). Their four broad factors are:

- *Context*: factors in the external and internal environment
- *Content*: the changes being implemented
- *Process*: actions taken by the change agents
- *Individual dispositions*: attitudes, behaviours, reactions to change

Selected staff members within Health Boards and SEWAHSP were invited to complete a short, anonymous online questionnaire (n=27 responses). These individuals were identified by interviewees as having influence or involvement in KT&M.

Main findings

The full report presents findings from both components of the data gathering. This summary draws across the data and provides an overview of activity, identifying barriers and enablers of KT&M.

The current status of KT&M in Wales

Interest in KT&M was said to be increasing locally, nationally and within Government policy. However, KT&M was an integral part of personal or organisations' professional practice for only a minority of respondents; around half of all questionnaire respondents spent less than 20% of their work time on KT&M. In most organisations KT&M was thought to be fairly unsystematic, with some exceptions (certain topic areas, professional groups). Some organisations had structures and processes in place (e.g. organisational development programmes, regular information dissemination). Others suggested that the use of guidelines (e.g. NICE), improvement programmes such as 1,000 Lives Plus, and the transmission of evidence via teaching activities and CPD provided some help with KT&M processes.

[1] Walker, HJ, Armenakis, AA and JB Bernerth. 2007. 'Factors influencing organisational change efforts.' *J Organ Change Manage* 20:761-773.

Summary of Factors Influencing KT&M according to respondents

	Barriers	Enablers
Context	Competing priorities/agendas; meeting different demands on a finite budget	Targeted Government policy to create a "push" for change; policy based on meeting areas of patient need; REF encouraging awareness of need to address impact
	Organisational culture which does not recognise the value of new evidence/change	Bottom-up changes in organisational culture to reframe professional role, valuing evidence and innovation; good leadership and management support at all levels – empowering staff and encouraging change
	Unsupportive organisational infrastructure; no clear path of accessing/implementing evidence; reliance on personal interest or motivation	Clearer signposting of opportunities /resources; support from an identified KT&M broker within the organisation
	Lack of cross-professional working (professions, organisations, NHS and HEIs)	Multi-professional networks and face-to-face meetings; communication and discussion to share knowledge and encourage opportunities for innovation; engagement with organisations to make links (e.g. SEWAHSP); communication
Content	Difficult to see relevance to practice in academic papers	KT&M broker with good knowledge of target audiences to synthesise information & recommendations for practice and disseminate to appropriate professionals; involving NHS in research process; involving researchers in dissemination
	Valuing scientific research over organisational services research; "soft" intelligence and experiential knowledge not valued as evidence	Recognising the importance of tacit knowledge/ experience.
Process	Lack of time to reflect on practice/do KT&M activities	Embedding KT&M activities as part of every professional's role; protected time within workload
	Overload of evidence; too much to appraise; generalised dissemination of information; over-reliance on electronic dissemination (emails)	More effective dissemination of information (timely, condensed, clinically relevant, meeting patient needs); central repository of relevant information
	Overload of improvement initiatives	Focussed, targeted interventions/initiatives aligned with local need; outcome measures in implementation programmes to provide guidance and reward achievement, aiding staff motivation and belief in the process of change; management support

	Lack of communication; difficulty getting people together	Collaborations/partnerships and effective research/practice links; greater cooperation between NHS and universities
Individual factors	"Inward-looking" staff members	The presence of "can doers"; outward looking, motivated and open to change; leaders modelling good practice
	Lack of skills to appraise evidence	Embed skills in clinician education; KT broker with knowledge of research skills

The KT&M role

It was believed that, as a matter of patient safety, KT&M should be the responsibility of every practitioner as part of their professional role. Such activities are implicit within many job descriptions but the need for KT&M activities should be made explicit and embedded within day-to-day practice.

However, there was also support for the creation of specific knowledge broker roles within organisations. It was noted that many teams already have people who take on these tasks but the role could be optimised and recognised. Providing support to other team members, the role could include collaborating with relevant departments, identifying new research, disseminating and implementing it and observing outcomes. However, their role should be to support the process, rather than risk being seen as solely responsible for KT&M within the organisation.

Conclusions and recommendations

While it was acknowledged that many professionals recognise the need for keeping up to date with new evidence, KT&M as a process was still finding its place within organisations.

Workload pressures, competing organisational priorities and a target-driven rather than innovative culture were said to leave little time for reflection on practice or to seek out new evidence. This coupled with a lack of clearly signposted pathways meant that KT&M activities tended to be individually-driven, rather than embedded within organisations.

KT&M is not just about the transfer of knowledge between professionals but involves the implementation of that knowledge and innovation in practice. Knowledge and evidence should have clear implications for application to practice, with the aim of improving patient healthcare.

Recommended ways of improving KT&M in Wales include:

I. Clear Government policy and coordination linking KT, innovation, R&D and QI.

II. Local, patient-centred, policy should encourage and expect KT&M and address identified areas of local concern with manageable, measurable outcomes.

III. Development of better communication and collaboration within and across organisations and sustained interaction between researchers and practitioners.

IV. The reporting of evidence via accessible, user-friendly communication with clear and relevant recommendations for practice. Linked to this, the creation of an easily accessible repository of such information.

V. Increased visibility and signposting of the KT&M processes within organisational infrastructure.

VI. KT&M activities should be understood as a valued part of every clinician's professional role with time and suitable processes in place to support it. Alongside this, there is value in the broker role, individuals skilled in appraising, synthesising and communicating knowledge and linking professionals and organisations.