



An Untapped Resource: Patient and Public Involvement in Implementation

Comment on “Knowledge Mobilization in Healthcare Organizations: A View From the Resource-Based View of the Firm”

Christopher Burton*, Jo Rycroft-Malone



Abstract

This commentary considers the potential role of patient and public involvement in implementation. Developing an analytical thread from the resource-based view of the Firm, we argue that this involvement may create unique resources that have the capacity to enhance the impact of implementation activity for healthcare organisations.

Keywords: Resource-Based View, Implementation, Patient Involvement

Copyright: © 2015 by Kerman University of Medical Sciences

Citation: Burton C, Rycroft-Malone J. An untapped resource: patient and public involvement in implementation: Comment on “Knowledge mobilization in healthcare organizations: a view from the resource-based view of the firm.” *Int J Health Policy Manag.* 2015;4(12):845–847. doi:10.15171/ijhpm.2015.150

Article History:

Received: 30 May 2015

Accepted: 6 August 2015

ePublished: 7 August 2015

*Correspondence to:

Christopher Burton

Email: c.burton@bangor.ac.uk

The recent interest in the potential of the resource-based view of the Firm as an explanatory framework for knowledge mobilisation in healthcare^{1,2} provides an opportunity to consider the roles that different stakeholders, and specifically patients and the public, might play in creating unique and important knowledge resources for organisations. Protecting personal health, including the lay management of health problems, is largely influenced by the media, and social and cultural norms. However, the increasing complexity of healthcare, together with the growing prevalence of long-term health conditions has required a re-evaluation of the ways in which services are delivered.³ In this sense, healthcare can be seen as a collaborative endeavour between patients and professionals, which focuses on the exchange of different forms of knowledge, addressing uncertainty and ongoing evaluation.

Broadly, implementation focuses on closing the gap between evidence and practice. Current debates within the field of implementation research have principally focused on 4 key areas: broadening conceptualisations of knowledge⁴; the contingent nature of clinical, organisational and political contexts in shaping and mediating implementation⁵; strategies and interventions that facilitate implementation action,⁶ and the interface between knowledge production and its use in healthcare policy and practice.⁷ Patient and public involvement in implementation has significant potential to change the debate and practice within each of these 4 key areas, but as yet, this resource remains largely untapped. Growing patient and public involvement in healthcare is evident within a number of different, but related fields. These include shared decision-making at the level of clinical practice, through to strategic engagement of service users resulting from a growing consumerist discourse within

public services, and challenges to professional dominance in health service provision.⁸ In addition, patient and public involvement in research has been institutionalised in the United Kingdom through organisations such as INVOLVE, which seek to raise awareness and spread good practice (<http://www.invo.org.uk/>). This is mirrored in the research funding application itself, where applicants are required to specify the degree of involvement, ranging from consultation to partnership that patients have had, and will have in the proposed research (eg, <http://www.invo.org.uk/makeitclear/>). The impacts of these shifts have recently been summarised in a systematic review,⁹ which appear limited to shaping research questions, and influencing the quality and appropriateness of research design. The degree to which more patient and public involvement has generated a more radical partnership across stakeholders in health research is uncertain.

Findings from our evaluation of a national implementation programme (Collaborations for Leadership in Applied Health Research & Care ‘CLAHRC’) within the United Kingdom has indicated that patient and public involvement in implementation has not matured to the same degree as patient and public involvement in research.¹⁰ In the sites that we studied, involvement was largely aspirational, and mainly focused on consultation in the design of implementation artefacts such as clinical guidelines and information booklets. Participants were attempting to ‘figure out’ the potential for involvement and there was a keenness to develop this aspect of implementation further. Here we set out 4 areas which might be helpful to consider in tapping into the potential of the expertise of patients and the public.

Firstly, and from the perspectives of those living with long-term conditions, an evidence-base that focuses on discrete interventions, or which focuses on specific problems and

needs may have limited relevance. Patients will draw on different forms of both professional and lay knowledge, often with limited contextual specificity, to construct personal strategies that help them manage their health. Although current conceptualisations of evidence pay attention to patient feedback, the personal and collective wisdom that emerges as a result of this knowledge construction over time provides a knowledge resource that is generally not collated, and therefore untapped.

Paying attention to context is now a core feature of implementation. It is generally considered as an integrated, multilevel matrix of enabling and constraining forces within which implementation activity operates. It has both the capacity to transform, and to be transformed by, implementation. Complementing research to understand professional behaviour change, considerable attention has been paid to organisational level attributes of context such as leadership; evaluation and learning culture; and resource availability. The missing component, which has not received the same level of attention, is the micro-level context within which patients construct their own healthcare. Models of shared decision-making generally focus on integrating 'professional evidence' into patients' personal reference frames of value and social support.¹¹ As healthcare becomes more complex, then the decisions that patients are making are more complex and uncertain, with the need for regular renegotiation as interventions are experimented with, and personal circumstances change over time. Understanding these issues at an individual level is an important attribute of personalised healthcare. However, investigating how this personal layer of context can be melded with other aspects of existing models and frameworks may prove helpful in re-focusing attention to the individual within implementation research.

There is a growing body of evidence that shows the potential of knowledge brokers and intermediaries in implementation,^{12,13} who play an active role in the flow of evidence across organisational and other boundaries, and so supporting professional behaviour change. Whether patients can themselves take on such a role is of interest. There is an indication that patients can play an important role in changing professional behaviour by prompting staff around safety issues such as hand hygiene.¹⁴ Reflecting an ambition of patient and professional partnership in care, a forthcoming clinical trial in Australia is focusing on the contribution of both patients and nurses working together to implement a care bundle to reduce the incidence of pressure damage in hospital settings.¹⁵

Finally, and most fundamentally, the growing rejection of implementation as a linear model of knowledge transfer from one community to another, in favour of complex model of knowledge mobilisation has brought knowledge production and its use much closer together.¹⁶ Often referred to as co-production, there is an emphasis on recognising the value of knowledge in all its forms that exist across all stakeholder groups, and the importance of collaboration in surfacing this knowledge through research and other strategies, and then transforming and mobilising it to where it has the potential for greatest impact. Our evaluation of the CLAHRC programme uncovered a handful of co-production activities, and

highlighted the need to share learning about the barriers and incentives, and impacts of this approach to implementation. The role that patients and the public play in co-productive activities could and should be central, however to date there are limited examples to draw upon.

As with research, integrating knowledge resources from patient and public involvement in implementation will generate questions about which patient and public representatives get involved and how; whether what is being represented are personal, collective or advocacy perspectives; and the consequences for implementation of differences in language and power across different stakeholder groups. However, we believe that co-production has the greatest potential to provide a new ontological platform with which to progress an ambition of patient and public involvement in implementation. It provides an appropriate framework for the emergence of different forms of knowledge that in combination has the greatest capability to improve health and healthcare. Attention is paid to the role that patients have in constructing their own therapeutic context for implementation, and so emphasises the important role that they can have in mediating the successful use of evidence in practice, care and service delivery.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

Both authors contributed equally to the development and revision of this paper.

References

- Burton CR, Rycroft-Malone J. Resource based view of the firm as a theoretical lens on the organisational consequences of quality improvement. *Int J Health Policy Manag.* 2014;3(3):113-115. doi:10.15171/ijhpm.2014.74
- Ferlie E, Crilly T, Jashapara A, Trenholm S, Peckham A, Currie G. Knowledge mobilization in healthcare organizations: a view from the resource-based view of the firm. *Int J Health Policy Manag.* 2015;4(3):127-130. doi:10.15171/ijhpm.2015.35
- Bate P, Robert G. *Bringing User Experience to Healthcare Improvement: The Concepts, Methods and Practices of Experience-Based Design.* Oxford: Radcliffe Publishing; 2007.
- Rycroft-Malone J, Seers K, Titchen A, Harvey G, Kitson A, McCormack B. What counts as evidence in evidence-based practice? *J Adv Nurs* 2004;47(1):81-90.
- Bate P, Robert G, Fulop N, Øvretveit J, Dixon-Woods M. *Perspectives on Context.* London: Health Foundation; 2014.
- Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. *Lancet* 2003;362(9391):1225-1230. doi:10.1016/s0140-6736(03)14546-1
- Ferlie E, Crilly T, Jashapara A, Peckham A. Knowledge mobilisation in healthcare: a critical review of health sector and generic management literature. *Soc Sci Med.* 2012;74(8):1297-1304. doi:10.1016/j.socscimed.2011.11.042
- Martin G. Representativeness, legitimacy and power in public involvement in health-service management. *Soc Sci Med.* 2008;67(11):1757-1765. doi:10.1016/j.socscimed.2008.09.024
- Brett J, Staniszewska S, Mockford C, et al. A systematic review of the impact of patient and public involvement on service users,

- researchers and communities. *Patient*. 2014;7(4):387-395. doi:[10.1007/s40271-014-0065-0](https://doi.org/10.1007/s40271-014-0065-0)
10. Rycroft-Malone J, Wilkinson J, Burton C, et al. Collaborative action around implementation in Collaborations for Leadership in Applied Health Research and Care: towards a programme theory. *J Health Serv Res Policy* 2013;18(3):13-26. doi:[10.1177/1355819613498859](https://doi.org/10.1177/1355819613498859)
11. Stacey D, Légaré F, Col NF, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Syst Rev* 2014;(1):CD001431. doi:[10.1002/14651858.CD001431.pub4](https://doi.org/10.1002/14651858.CD001431.pub4)
12. Dobbins M, Robeson P, Ciliska D, et al. A description of a knowledge broker role implemented as part of a randomized controlled trial evaluating three knowledge translation strategies. *Imp Sci*. 2009;4:23. doi:[10.1186/1748-5908-4-23](https://doi.org/10.1186/1748-5908-4-23)
13. Gagliardi AR, Legare F, Brouwers MC, et al. Protocol: developing a conceptual framework of patient mediated knowledge translation, systematic review using a realist approach. *Imp Sci*. 2011;6:25. doi:[10.1186/1748-5908-6-25](https://doi.org/10.1186/1748-5908-6-25)
14. Davis RE, Pinto A, Sevdalis N, Vincent C, Massey R, Darzi A. Patients' and health care professionals' attitudes towards the PINK patient safety video. *J Eval Clin Pract*. 2012;18(4):848-853. doi:[10.1111/j.1365-2753.2011.01688.x](https://doi.org/10.1111/j.1365-2753.2011.01688.x)
15. Chaboyer W, Bucknall T, Webster J, et al. INTRoducing A Care bundle To prevent pressure injury (INTACT) in at-risk patients: A protocol for a cluster randomised trial. *Int J Nurs Stud*. 2015; doi:[10.1016/j.ijnustu.2015.04.018](https://doi.org/10.1016/j.ijnustu.2015.04.018)
16. Rycroft-Malone J. From knowing to doing – from the academic to practice: Comment on “The many meanings of evidence: implications for the translational science agenda in healthcare”. *Int J Health Serv Manag* 2014;2(1):45-46. doi:[10.15171/ijhpm.2014.08](https://doi.org/10.15171/ijhpm.2014.08)