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Using Knowledge Mobilisation theory to inform the design of a co-design workshop for healthcare research and innovation

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Introduction

The intersection of design and health allows the flourishing of practice driven by and drawn from other disciplines. In this paper, we explore the contribution of understanding drawn from the theory of Knowledge Mobilisation within health on and through the practice of design; specifically, the practice of co-design workshops as a means to develop and deliver new insights and knowledge.

Background

Knowledge Mobilisation in health care initially attended to the challenge identified that the time between the findings of research being available to the time the findings were implemented into routine clinical practice was too long. In the apocryphal tale, there was some 15 years between the benefits of subcutaneous Clexane, a preventative measure to reduce the chance of deep vein thrombosis, being identified and it becoming common practice in hospitals. Knowledge Mobilisation and the study of knowledge Mobilisation (sometimes called Implementation Science) sought to explore and test the different approaches to this process and generate theoretical understanding of what worked and what didn't work (Nilsen et al. 2015). As the science advanced, so did the understanding of the thing that was being studied. What was originally perceived rather crudely as academics in ivory towers throwing their knowledge into the swampy lowlands (Schön 1983) of front line professional practice, prompted the realisation that there was a need to better understand contextually specific processes, that were difficult to describe without understanding the who, where, what and why.

This has been more elegantly described by Gibbons as a shift from mode 1 to mode 2 research (1994). Mode 1 being the creation of research by academics which is then 'translated' to end users. In contrast, Mode 2 research is generated where it will be applied and by those who will apply it, and therefore by dint of its generation must recognise and accommodate the views of a range of stakeholders. The emergence of mode 2 knowledge creation also coincided with the recognition of complexity and uncertainty in science and society with some arguing that this approach of bringing

multiple perspectives together to approach these 'wicked problems' to which there might not be a right answer may be a successful strategy (Buchanan 1992).

This co-creation process is also described in practice as well as in the literature as coproduction, of which there are well-documented levels of participation. (Arnstein 1969; Wilcox 1994)

Design Practice

It is against this background that we position the relatively young discipline of design research. Design and specifically in this instance co-design methods, have sought to use a range of practices to allow stakeholders to come together to design the best product, service, system, communications etc. to meet their needs and desires (Manzini 2017).

Through the practice of Lab4living (www.lab4living.org.uk), at Sheffield Hallam University in the United Kingdom and User-centred Healthcare Design (www.uchd.org.uk) we have built up 10 years' worth of experience of doing design in health care using co-design approaches to participatory research, service improvement and service re-design within healthcare contexts. It is through this practical experience that we feel that design is able to respond to the challenges and opportunities of co-creation as defined in the literature. Whilst we cannot address all the literature in this abstract we will focus on 3 key areas identified as being particularly problematic in the practice of coproduction where creative and participatory practice has a role to play:

Power relationships

Whenever we bring people from different backgrounds together in a group setting there are issues of power. These issues are magnified in health and social care where patients are invited to work alongside professional staff of different types. Patients tend to presume expertise on behalf of professional staff rather than recognising their own expertise gained through their own experience. In workshops, we try to prioritise methods that do not preference 'professional' ways of working. Through creative practices and visual methods, that don't use spoken and written language as the dominant approach, we are able to facilitate the sharing and better understanding of all the views of the members of a broad and diverse group.

The bringing together of different world views

It is recognised that reconciling different perspectives is challenging to do, often the issue of sector specific methods and processes, professional language and use of acronyms can limit meaningful engagement. By using methods that make visible or tangible the subject being explored we have found that participants can better see and understand what is being proposed or discussed. This is further supported through iterative, participatory, prototyping processes ensuring that the activities and outputs of the workshop embody the knowledge of all participants. Our argument is that through a process of participatory making, we allow different forms of knowledge to emerge.

A systems approach, reframing

The literature suggests that in order for co-production to be successful for Knowledge Mobilisation a systems approach needs to be taken. Creative practice and specifically design encourages this approach with a set of methods that encourage a broader challenging of the 'problem' from different and often competing perspectives. Often activities will allow participants to step back from what they feel the problem is and together explore broader determinants and therefore to imagine different solutions. This reframing of the problem speaks directly to the co-creation, mode 2, Knowledge Mobilisation approach that recognises the context and social interactions that make up most health and social care interactions.

Conclusion

Knowledge Mobilisation, design and creative practices are not usual bedfellows, but from the practice of applying methods from design in health to health and social care projects over the last 10 years we have seen the benefits of this conflation. From the academic discourse around Knowledge Mobilisation and its study we feel that the practice and theory reinforce each other and that designers can be confident that their methods can address challenges to more traditional approaches of delivering meaningful engagement and therefore better services and care for society. This paper will unpack details of Knowledge Mobilisation, design and creative practices relationships through case-study exemplars.

Acknowledgements

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