

Connected by purpose driven by passion. This is Children's Healthcare Canada’s SPARK Conversations podcast series.

**Katharine**: Welcome to SPARK Conversations, Children's Healthcare Canada’s monthly podcast series. At the crossroads of Children's Healthcare System Improvement and leadership, SPARK Conversations is a solution focused podcast that connects the child and youth health community with systems leaders who tackle wicked problems and discuss ideas to inform the development of innovative and integrated systems serving children and youth. SPARK conversations is one component of our spark knowledge mobilization program. SPARK is the Shared Platform for Advocacy Research and Knowledge.

I'm Dr. Katherine Smart, and today I'm absolutely delighted to be speaking with Dr. Helen Bevan. Helen is a strategic advisor with NHS Horizons. She's acknowledged globally for her expertise and energy for large scale change and health and care. During her 25 years as a change leader in the English National Health Service, Helen has been at the forefront of many NHS improvement initiatives that have made a difference for 1000s of patients and for the staff who care for them.

She is one of the top social influencers in health care globally, reaching more than a million people each month through her social media connections, virtual presentations, commentaries, and blogs. Helen has acknowledged globally for her expertise in large scale change and ability to translate it into practical action and deliver outcomes. She provides advanced guidance and training on transformational change to leaders of health and care systems across the world. Helen currently leads the Horizons team, which is a source of ideas and knowledge to enable the spread of improvements at scale. The team uses a variety of different tools and approaches including social movement thinking, community organizing, improvement science, accelerated design and digital connectivity. It champions the rules of emerging leaders, students and trainees at the forefront of radical change.

Today, we are chatting about a very important topic one near and dear to my heart, Health System Transformation. So hello, Helen, and welcome to SPARK Conversations.

**Helen:** Thank you, Catherine. And it's fantastic to be here with you.

**Katharine**: I have to admit, Helen, I have absolutely been a fan of yours for some time now. And even more so after hearing you speak this morning at the conference. You're an action orientated thought leader with considerable experience and influence in the system. Your social media game is next level and you use it effectively for knowledge mobilization, and to inform systems changes. You've been changing the world in which you work and receive care with great success and wisdom to share with all of us today. So let's get going. So as I told you at the beginning, Helen, our podcast listenership is for the most part child and youth health care providers and that community here in Canada, you of course, are joining us from the UK. Can you tell us a little bit about your role and the NHS, so we can set some context for health system transformation work that you've done so far?

**Helen**: Thanks, Catherine. So a little bit to start with about the English National Health System is a very large system, we look after 54 million people from cradle, you know, small children, right the way through to death, and we employ 1.5 million people. I'm a change agent in the system. I you know, I work internally in the NHS to enabled change to happen. And trying to change such a such a big system, I think is Yeah, it's a tricky undertaking. It's, it's fascinating to me, you know, being here with you in Canada, that, you know, our contexts are so different. Our health and care systems work in different ways. And yet, so many of the challenges, I think, and the opportunities are so, so similar. So, yeah, I work at a national level. So most of my work is about how practically, do we enable and policy to be enacted? So, you know, when we think about the topics, or the groups of service users, that are the biggest priorities, and what I do is, is work with other people to help enable, you know, make happen, large scale change, and, you know, I would describe myself as a practitioner, you know, and practice what does that mean?

You know, practice is about how we, how we deliver day to day, it's the sets of routines, it's the habits and that we work with, and in order to change and improve the system and get better outcomes for our users. You know, we have to change the practice. So while I'm really work hard to kind of stay up with, with thinking of large scale change, I think what my absolute passion is that is the practice, it's the practical things that make a difference. So yeah, what I spend my time doing, I mean, things I've been working on recently have been, you know, as the NHS, as in Canada, we have we have very long backlogs of people waiting for procedures waiting for surgeries. So, you know, what can we do to quicken, you know, the process of, of reducing waiting times. So, one of the things I've been working on recently is a very large crowdsourcing activity, where we ask, you know, people who work in the NHS system, people with lived experience, who use services, for their ideas on how we can improve the system. Another thing that I've been working on recently is about retaining our NHS people, and particularly people who have been educated overseas. And you know, we're recruiting huge numbers of people who are overseas educated. And it's one thing putting a lot of effort and energy into the recruitment process. And these colleagues are absolutely vital for our system. But we also need to think about retention, you know, so I've been working with 43 teams, from across England, to think about how do we support our internationally recruited colleagues? How do we, how do we build a real sense of belonging? And how do we help overseas educated colleagues to actually want to stay working in the NHS, and the kinds of ways that I work are a kind of cross between systemic quality improvement methods, and also social movement thinking? And, you know, we need to we have to get the formal and informal system working together? Well, if we want big change to happen.

**Katharine**: Wow, that sounds like absolutely fascinating work. And I think we all know that changes is probably one of the hardest things that we do day to day, and getting people on board for it can be very challenging. So tell us what are a few of your secrets? How have you been successful in getting people, especially people in healthcare, to embrace change, and to march forward and implementing it successfully?

**Helen**: You know, the number one thing I'd say about enabling change is, it isn't about communication isn't about persuasion, it's about power. And, you know, we have to work with the power to enable change. And now the thing is that all of us at work in the system have all got power to make change happen. Most of the time, you know, we don't use it. And there's also a myth that the people with power in the in the system to make change happen are, are the most, you know, the most senior people have got the most power. And, yeah, that's true to a certain extent, you know, having the former authority to push power down in the system. But, you know, that's not the reality of how it how it works. Because if it was, I think we'd be a lot more successful than we are.

So, you know, really, when you look, I think it's the same in your system is it isn't ours? Who are the people that actually got the most influence to make change happen? Okay, and who are the people that make or break change? Actually, it's the people that are the informal influencers. You know, it's the people that that like everybody else goes to, you know, for, for opinions, it's the people that are trusted. And, you know, we can look at this scientifically, I mean, if you look at organizational network analysis, in healthcare organizations, what it shows us is that, there’s about 3% of people in organizations and systems that drive 85% of the conversations. So those are the powerful people. But the reality is that most people in formal authority in health and care organizations don't even know who those people are.

And very often the change goes wrong, because you know, senior leaders are not engaging enough in informal dialogue with those with those very powerful people. So, yeah, most of the work I do in terms of supporting change agents is, is working with people and supporting them to build their own power. So you know, if I think about the example of the 43 teams that I've been working with, recently, on, on the retention of international educated colleagues, we are we've got this fantastic social movement it's called stay in thrive. You know, because we want our internationally educated colleagues to stay in the NHS system and to really thrive in the system.

So we've supported them to stay in their own community. And, you know, they have a lot to say, and they feel safe. You know, people feel safe in that community. And, and it works, it works very effectively. So yeah, I mean, the things I'd say about, you know, some of my secrets are about you know, how to rock the boat stay in it, you know, how to be, you know, somebody who is able to work effectively with other people, and to build their own power for change. But do it in a way that takes people with you, you know, that doesn't go round, you know, creating havoc in organizations, you know, the most disruptive people in effectively disruptive people in health and care are, you know, aren't the people that are charging round, you know, like, like, you know, unguarded Exocet missiles, the people that are, that are most disruptive, effectively, are the people that have got strong relationships with others. And it's through relationships that we build power.

**Katharine**: That's so fascinating. And I think it really links to what I heard you talk about this morning, too, when you were talking about not really empowering people, but helping people sort of self actualize and see themselves as powerful. So what are the traits that you look for in these change agents that you're developing, like, who what kinds of people are the ones where you go, yes, that's someone who's really going to be able to take these learnings and use them in a way to have influence in their organization in a positive way.

**Helen:** So, you know, I would talk about strong ties and weak ties, and people that can work with work with both. And these are principles from network thinking. So mean, I would look for people that are, that are really good at building strong type relationships. And what we mean by that is, you know, if we want, if we want change to happen in a health and care system, the easiest way for change to happen is peer to peer. So, you know, emergency physician to emergency physician, you know, children's nurse to children's nurse, because, because the reality is that we are far more likely to be influenced to change by someone like us. So, you know, having change agents that are, you know, that live at the heart of the clinical community, who, who work effectively with their peers who can make meaning of change, I think you know, can make a massive difference.

And I'd also say that, you know, when it comes to the people that oppose change, actually, people with strong tight relationships are the people that can do that really effectively. Because if you've got organizational leaders with one message, and then you've got clinical peers with a different message, people are going to believe their clinical peers far more than they believe, believe, organizational leaders, and that's why, you know, having, like really strong, effective clinical leadership is at the heart of change in healthcare. So that's kind of one side of things, which is was a strong ties. And then the other side of things are weak ties. And what we mean by weak ties is, is when I connect with people who, who aren't like me, but in a sense, people that are really good at weak ties are the people that can build that can build bridges between different groups.

And again, you know, we can learn greatly from, you know, from social movement leaders, who were able to build really strong shared purpose and, and mobilize lots of lots of different people. And, you know, the thing about strong tie change and we see this again and again, in the health and care system is, it's great for if you've got like a community of people with a with a similar clinical background or similar specialism you know, our ability, through our strong tight relationships to make change happen in a in a kind of contained community is really good. But if we actually want to change the world, and we want to, you know, create real breakthroughs, the biggest breakthroughs come from when we when we create the bridges, you know, through weak ties, and the people that are really good at that are the people who can, can tell stories, you know, can build shared purpose can, you know, work with other people's points of views can build, you know, distributed leadership can bring on people with lived experience. And, you know, support those people to build their power to sit alongside to sit alongside clinical leaders. So, you know, for me, it's that it's that kind of combination of, you know, strong anti credible clinical leaders, and, and the kind of leaders who, who can create weak ties. And, you know, when I was when I was like earlier in my career, and I went to like improvement school, you know, what I got, what I was taught was, I could never influence medical doctors to change because I wasn't a medical doctor, that change only happened peer to peer. And, you know, I mean, I think I think there's something in that, but it's just, but it's not true. Because, if you're the kind of leader that can mobilize other people, and, and make connections, then you know, you can influence of lots of different people.

**Katharine**: That's sofascinating. And I love what you're talking about, just because I'm also really passionate about change. And I love how you're breaking it down just those relational elements. And, and also, the other themes I'm hearing, you know, it's a certain tolerance of uncertainty. Because when you're letting you know, sharing your power, you have to tolerate uncertainty. And you also have to be willing to not necessarily always be in control of what's coming next, either. So those are other things I'm sort of thinking about, as I'm hearing you talk. You know, as you've heard, and you were hearing here at the Children's Healthcare Canada conference today, we are absolutely experiencing a crisis in children's health care across Canada. And I think there's really no part of the country that's untouched by that right now. And I think you know, where we're a bit stuck is we know what the issues are, we even actually have a lot of really well thought out solutions. And there's a lot of consensus that we need transformation, but we're struggling a bit to move that forward. So what advice would you give to health systems leaders about how to transform the system while operating within it, you know, basically, rebuilding the plane while flying it?

**Helen**: So maybe what I'd like to talk about Katherine is some research that was published about five weeks ago, in England, and I think this this research is globally significant. So if you just bear with me, while I tell the story of it, because I will add to it, I will get around to answering your question. And through it. So what happened in England in 2015? Okay, the National Health Service in England, brought over the Virginia Mason Institute from the USA to work with five English hospital systems. And, you know, for those of you that don't know, Virginia Mason, it is an amazing health system in the in the USA, that uses like Japanese quality systems, and has got absolutely spectacular improvements. And as an Virginia Mason has been able to build a system of confute continuous improvement that is like the envy of the world of healthcare. So Virginia Mason set up the Virginia Mason Institute, a not for profit institute that like works with health systems around the world to help them improve. So, you know, our senior leaders at that time brought the Virginia Mason Institute to England to work with five hospital systems.

And what happened, which is almost unheard of in our world was that there was a long term evaluation. And what the evaluation looked at was what happened to these five hospital systems over time. And there is so much learning in this. And I would, I would encourage anybody, okay, in our world to read this evaluation report, and it's from work University. So what they found was that of these five and hospital systems, okay, three of them, made big improvements in overall performance moving forward. And two of them went backwards in performance. So what was the difference between the three that move forward in overall performance and the two that went backwards in overall performance? And this is what the evaluators wanted to find out, because all of these hospital systems got the same inputs, you know, they all got the expert help from Virginia Mason Institute, they all got resources to support them, they were all in the learning set together.

And yet there was such a difference and overall outcome. So so, you know, why was that? So this is how I'm going to add to your question and Katherine, because what is it that leaders need to do, okay, based on this learning, okay, to build, you know, the possibility of a system that improves and moving forward. So the, the number one issue that the researchers found was that difference between the organization's was the extent to which they had what I would call social capital. So the extent to which there were really strong relationships and connections in the organization that people learned and shared and shared together and in the three that you know, were the perfect performance was moving forward.

They all had, you know, very strong social connections and strong relationships across the organization, significantly less. So in the to the to that hadn't done that. And why, I mean, I think you have to be very careful about, you know, correlation and causality and these kinds of situations. But what the three that have moved forward or done is they're all invested in building the relational kind of culture, they, you know, they'd all done it all and culture work, before they embarked on the Virginia Mason work. And what that meant was that when the improvement approach came along with Virginia, Mason, those three hospital systems all had strong, or had really strong foundations, that in a sense, the Virginia Mason approach could just plug into what they were doing already. And the other two organizations hadn't invested previously in, in building a strong culture. So it was much harder, you know, for them to make the change happen. And the second thing was about having leaders who, you know, who really like led the way and role modeled, and, and so much of this was, was not just about being strong leader, it was about the actions and the deeds and the words of these leaders every day in terms of living improvement.

And the third thing that they did was they made the time for improvement. So even though they're phenomenally busy, things are, you know, things are really tricky, tricky, and everyone's under massive pressure to deliver that, actually, you know, they're working with, they're having huddles, and peer assists, and after action reviews and networks and communities, and, you know, improvement and change won't just kind of happen by magic, in a sense, you have to institutionalize it, you have to build it in, and the managers, and the leaders need to be sending messages to say, actually, this this time for improvement, okay, is, is just as important as your clinical work. Because, you know, we have to do, we have to, of course, we've got to deliver clinically for our, you know, for our users, and we've got to build the timing and the spacing, you know, to improve. And we have to do it together. So, you know, those are some of the things I'd say it's about. Yeah, it's about institutionalizing change and improvement it yes, it's about you know, building capability. But if you train a whole load of people and improvement transformation techniques, and then you don't, and you don't change the systems, it's a waste.

**Katharine**: Yeah, absolutely. It is really about that relentless focus on people and culture first, and then the process, right. And I think that's so interesting, because I thought that so much about our health care system in Canada as well is that we have neglected the culture of care, we've neglected really being people centric, both for providers and with patients. And I think a lot of that leads to the systems that that just don't work well. So it's really interesting to hear you hear you talk about that so eloquently, it makes a lot of sense to me.

**Helen:** And, you know, Nicole Burgess, who was the lead investigator. And, you know, she, when she summarized the outcomes of the Virginia Mason evaluation, in the NHS, what she said was, you know, relationships aren't just a priority, they're a prerequisite, you know, if we haven't put the time and effort and energy into building the relationships into creating the psychological safety, where people can work and do things in different ways, we haven't got a strong foundation for building transformation and continuous improvement.

**Katharine**: Makes sense. It sounds like a beautiful roadmap of sort of where to start and how to move forward. That's also very practical it really breaks down like, these are the steps you have to go through and that experience to really show just like you said, why would the exact same intervention? In one case, it worked, and in one case, it didn't. And that was the underlying factor. So I think that's a great lesson for all of us. And I think we're fortunate in child health in that we I think, do value culture and people and, you know, for me, it was certainly one of the things that drew me to pediatrics was that culture around the care of children. So I think we're a step ahead there, perhaps, than other areas of the system, but that's a really great reminder of the importance of building from there.

**Helen**: But you know, what I'd say, Katherine is that's a fantastic start. And, you know, we have to we have to build systematic approaches on those foundations. And, you know, we need we need both and need, you know, leaders who, who will have the courage to make the time and space and give the priority to creating the improvement system. And then, you know, the other thing I'd say about it is one of the things that I see, in terms of, you know, the strong leadership that enables this and doesn't is having is having leaders who don't tinker. Because, you know, when I look at our system, like, you know, why does a lot of large scale change, not work out, it kind of fizzles out. And the reason why is either leaders, you know, lose their energy, or, you know, when we move on to the next priority, okay, so the energy and the focus goes away.

And another thing that happens is that if we don't get results immediately, like, we stopped doing it, and again, because these things, this, you know, these improvements can take years, and we as leaders have to have the faith that, you know, we've got the right people in place, that they've got the right skills they've got, they've got strong leadership, and we've got to, we've got to give it time to work through I mean, if you look globally, at the systems that have created outstanding results, in terms of quality improvement, you know, you look at places like young shipping in Sweden, that gets that gets, you know, amazing results, you look at Intermountain Healthcare in Utah, you know, that, that took 10 to 15 years, you know, to, to enable on even though we've got a crisis, you know, now and things are, are really bad, we've, we've, we've got to give it time, and we as leaders have got to make the time and the space to, to enable it and take a we have to take a long term view of it. There's things that we can do quickly and short term, but most of it, I'd say is longer term. And we've got to, we've got to make the investment and we got to be prepared to work through for the long term and stay the course.

**Katharine:** I so agree with you, because you're right, nothing major is going to happen in a short timeline. And, you know, one of the challenges I think we have, of course, is the political cycle, which is often, you know, three to four, maybe five years, how do we convince our political leaders to let us set this, you know, chart this course, for change to really invest in the relational and the systems work that's needed to chart out this transformation that we've been talking about? But to protect it from that political cycle? You know, do you have any recommendations or insights there, because I think sometimes those frequent changes make the priorities change, and then we don't actually see the follow through that we need to really affect that large scale transformation.

**Helen**: So we have the same problem, you know, in, in the in the UK, in a sense, you know, we have a five year electoral cycle, nationally, and, you know immediate results are, are wanted. So I think, you know, this morning, I talked about polarities and paradoxes. And I think there's a paradox here that we actually have to embrace and work with. So. So I think that there are, there are quick wins and things that we could do, that we could do, very quickly. I also think if we're going to enable that, then we have to work much more in community. And when we think about the spread and scale of change, I think that we're, we're stuck in a kind of mental model of, of pilot and rollout. And then, and the reality is like pilot and rollout is not a very good model. It's good for the pilots because they get a lot of focus and attention. And they do, they do some good things.

But you know, there's what proportion of things that actually get piloted end up being rolled out across making a difference across a whole system, actually, you know, not very many. So I think if there were, if there were things that we could do in terms of building really strong communities of action communities of practice around topics that really matter, if we had senior leaders who acted more like conveners, you know, bringing people together to share their tacit knowledge, you know, so much in our system is we're thinking about explicit knowledge and we have the best practice databases and repositories and toolkits. Now, the reality is, most improvement toolkits hardly get looked at at all. And so, where the real breakthrough thinking is, is in that tacit knowledge, which is what people learn in clinical environments, or care environments, every single day, so actually creating or convening much more of kind of a community feel where we bring together to you know, people can learn from the tacit knowledge rather than piloting stuff and pushing it down. I think, you know, we can make change happen.

We can make change happen very, very quickly. I think there's things that we can do around storytelling, you know, and, and making compelling cases for long term change. And I know like when I look at my system at the moment, I mean, we have got very, very big workforce challenges, you know, we've got, you know, over 100,000 vacancies in our system. And it basically meant the people that were doing the workforce planning 15 years ago didn't get it. Right. So how, you know, what do we need to do now to be the workforce planners that get it?

Right, you know, in another 15 years? So I think, you know, we just have to manage the polarity between short term and long term, really, really well, and, and do you know, things that can make a difference? Short term, build the conditions. And, and, you know, think about where it could go long term. The other thing I'd say about the long term, is we have to differentiate, and again, it's another polarity between forecasting and foresight. And again, you know, when we talk about, oh, what's the what's the future of primary care? You know, all we can do is look at the primary care system at the moment, mostly and say, oh, we need a bit more of that, and a bit less of that, you know, that's as far as our imagination goes a lot of the time. And where we need to be, I think, with our thinking, is, is like foresight, how could it be? What are the multiple possible futures of primary care? You know, where are the weak signals, the things that are already happening in our system, but are mostly happening around the, you know, around the margins? And I think if, if we as leaders are clear, okay, and I said, I don't think we can blame the politicians for this, I think, you know, that so many of us, as leaders are so focused on the kind of immediate day to day that, you know, we're not thinking in that way. So we need to be pushing and suggesting those things as well. But I think, yeah, manage the polarity.

**Katharine**: That makes tons of sense, we always worry about that tyranny of the urgent. And I think, you know, you're also really hearing you think about disruption, right to healthcare is ripe for disruption. And we've got to be sort of looking at what's coming next around the corner, and what are maybe those things we haven't anticipated? And I think we've seen that in a lot of other industries, where they're completely different today than we might have imagined 10 years ago. And I often wonder, you know, what's coming next in healthcare that maybe we haven't even imagined yet? And it sounds like you spend a lot of your time in that space thinking about those things.

**Helen**: Yeah. And we need to have different people in the conversation as well. You know, if the only people that are doing the thinking are the people that are the senior leaders of the of the current system, we won't get very far. But if we're thinking in in, you know, with different people, like people with lived experience, people from other industries, and the actual up and coming generation, who are, who are, you know, the trainees and the young managers in the in the system at the moment who are actually going to be the leaders in 15, 20 years time, you know, let's get their voices in the conversation as well. I think we can get to some pretty, pretty good places.

**Katharine**: Yeah, absolutely. And that's a nice lead into my next question, because I know you're really active on social media, a bit of a rockstar in that space, and you use a lot of different channels to share your ideas and best practice practices. I'm also really interested in social media, and I think we've seen the power of it in the last few years, especially during the pandemic, how do you see social media being used as a lever for systems change?

**Helen**: I think that in general, the health and care system, and the people that lead it, totally underestimate the power of informal influence. And social media is, is no different. It's massively underrated. And then, you know, I'm not gonna tell you so many stories, where, you know, we've been able to use social media effectively, to make stuff happen and to mobilize, you know, 1000s of people really quickly, but, you know, you have to understand social media. And I think you have to understand the nature of influence, because social media is the same as, you know, when it comes to influence in terms of who the powerful people are. So, I've got data that shows that again, when you look at the, in our world of health care, okay. 85% of the content that gets retweeted comes from just 3.3% of people who tweet. So, again, with social media, there's a very small number of, of people who were very influential. So I think sometimes, you know, we think, oh, let's just put stuff out there. But, you know, I think we need to be much more sophisticated.

In our approaches, the first thing is to do the analytics and find out who the influential people are. So whenever I'm working on a new piece of work with a new topic, whether it's whether it's primary care reform, you know, whether it's emergency care, whether it's the NHS people plan, you know, the first thing I will do is, is run the analytics to find out who the influences are. And then, and then reach out to those people and get them on board. So, so for instance, you know, recently, my team did some crowdsourcing on primary care reform, you know, we're looking at new reform process happening. And the person that was that was leading it wanted to get more voices. So what we did, we ran the analytics around who were the most influential people in primary care. And some of them were people in the formal roles, you know, people with positions in the colleges and so on, but an off, but at least 70% of them were like, jabbing family physicians, you know, and who were just really active and very, very influential. But people didn't know about them. So what we did is we just reached out direct message these people and got them on board. And, and we ended up with a completely different conversation, and many more voices in that primary in that primary care, and crowdsourcing. Because, you know, because we did that. So let's understand that, that, that social media is a very, very powerful voice. And to understand it, we have to understand the data and the analytics and work through the influencers, like we would in any other field of change.

**Katharine:** That's fantastic. I love that. And I think it's just an amazing way to sort of bring more people into the conversation, like, like you spoke about, and just gain those perspectives that we may not have otherwise had access to. So it's a great example, I think of the power of social media and connection.

So Helen, I want to thank you so much for sharing all these incredible insights with us today. I've really enjoyed chatting with you. And I've learned a ton. Before we say goodbye, I have a few final rapid fire questions. No right or wrong answers. I just want to hear your thoughts on that. All right. Okay, go for it. Okay, so who has had the biggest influence on your career? And why?

**Helen**: My mom, so my mom was a made a domestic assistant in, in the NHS for 37 years. And oh my goodness, she taught me so much about values and how to behave and also like, how to love and be proud of being part of the NHS. And when I joined the NHS, she was so happy.

**Katharine**: Oh, that's wonderful. I love that story. What is one thing you feel deeply grateful? For right now?

**Helen**: Yeah, I feel grateful for the people that I have around me, the amazing team of, of people that I work with, and the support I get.

**Katharine**: Fantastic! What is the number one thing you think we need to consider right now to move children's healthcare forward in the right direction?

**Helen**: I'd say take your power. And because, you know, change is always about power. And to think about, you know, where your power is. And, you know, you know, when I look at Children's Healthcare Canada, and, you know, the amazing way in which you're, you know, you're bringing together and well, that's clinical community, the right word to use. And you know, when you think about all the other people, and organizations and systems that have got the same interests, and purpose, it's a heck of a lot of people. And you know, if we kind of stand on the sidelines and, and shout with the formal system, like, we'll never get anywhere, because, because some things will change, but most things won't change. So I think, you know, to take your power, and because it's kind of there everywhere, you know, now's the time. Now, you know, now's the time, like, like no other to mobilize and organize for change.

**Katharine**: Well, that'sdefinitely gonna be my takeaway from this conversation, claim and own your own power. I love that. Thank you so much, Helen. It's been an absolute pleasure speaking with you today and I so appreciate your time.

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