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French Institute for Public Health Research (IReSP) and ITMO Public Health International Session

**Mobilising evidence in the workplace: professional
expertise and sensegiving strategies in adopting
innovations in English hospitals**

HSR Seminar, 9 January 2018 Paris

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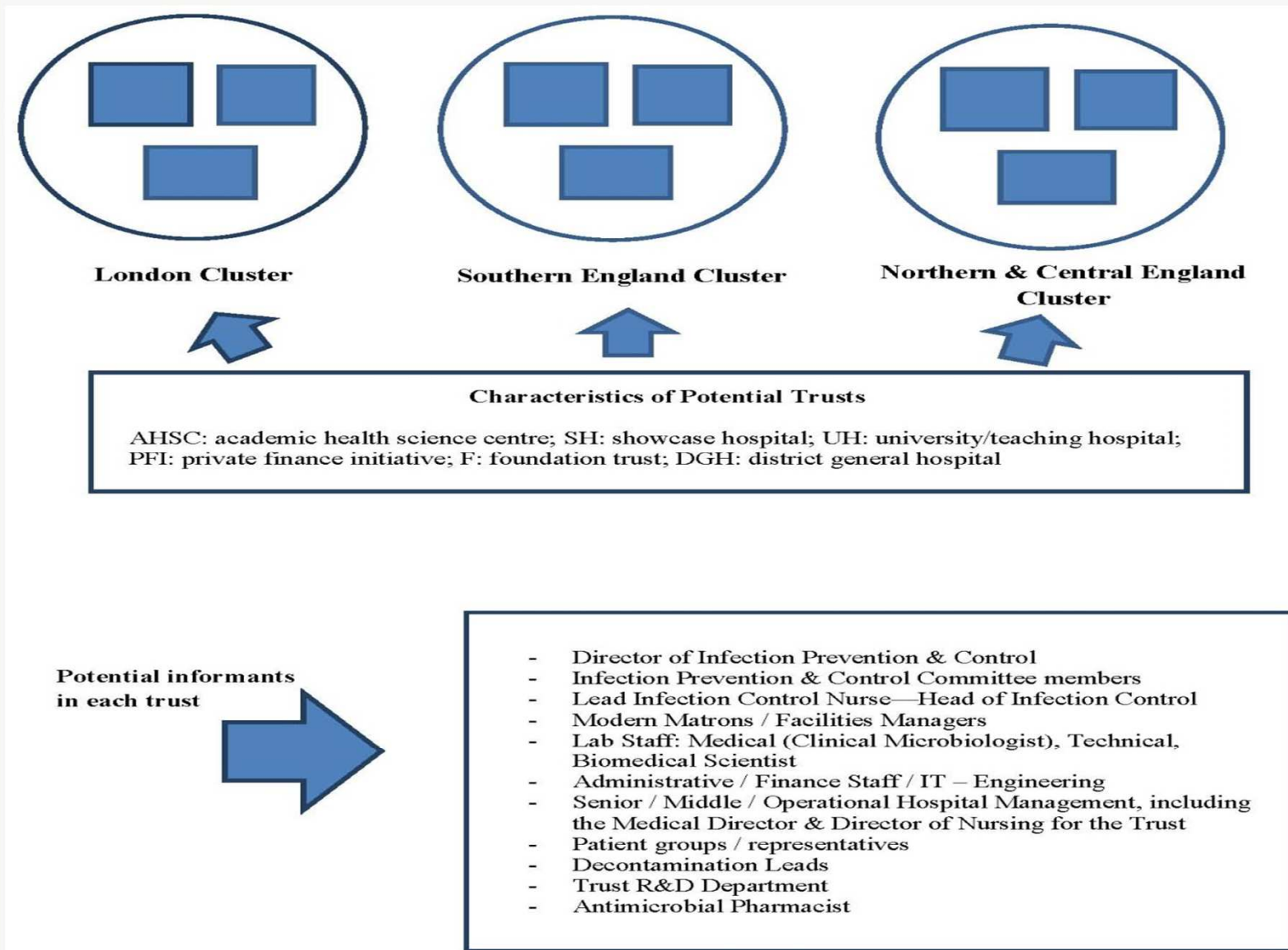
Study Aims – Research Questions

- How do diverse professionals in healthcare with different work identities (e.g. clinical vs. non-clinical) use various forms of evidence in making organisational (non-clinical) decisions?
- How does this process unfold in the adoption of health innovations?

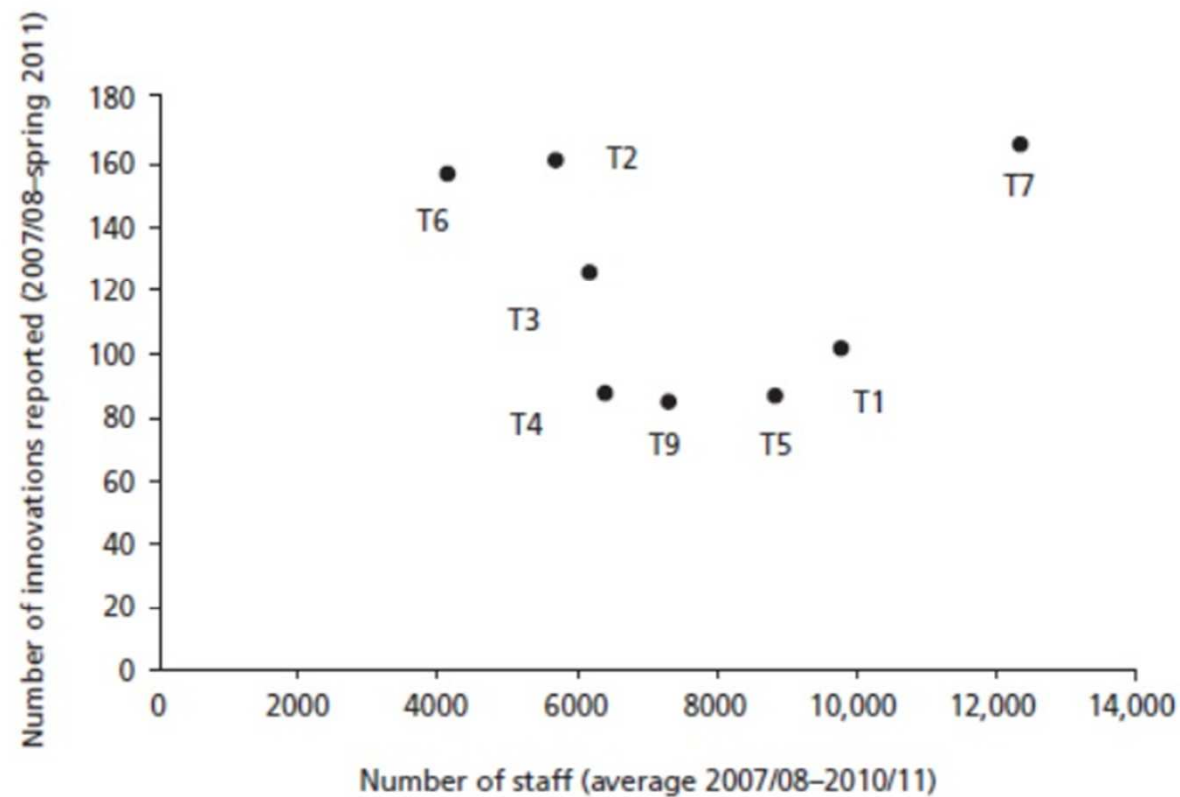
Methods

- Multiple case study design, mixed methods qualitative study
 - 191 interviews & structured surveys from different professional groups
 - 9 English hospital organisations (NHS trusts), 30 individual hospitals
- We followed organisational sensemaking and sensegiving processes in real time
 - over eighteen months
 - across the 'decision domains' for 27 innovation technologies

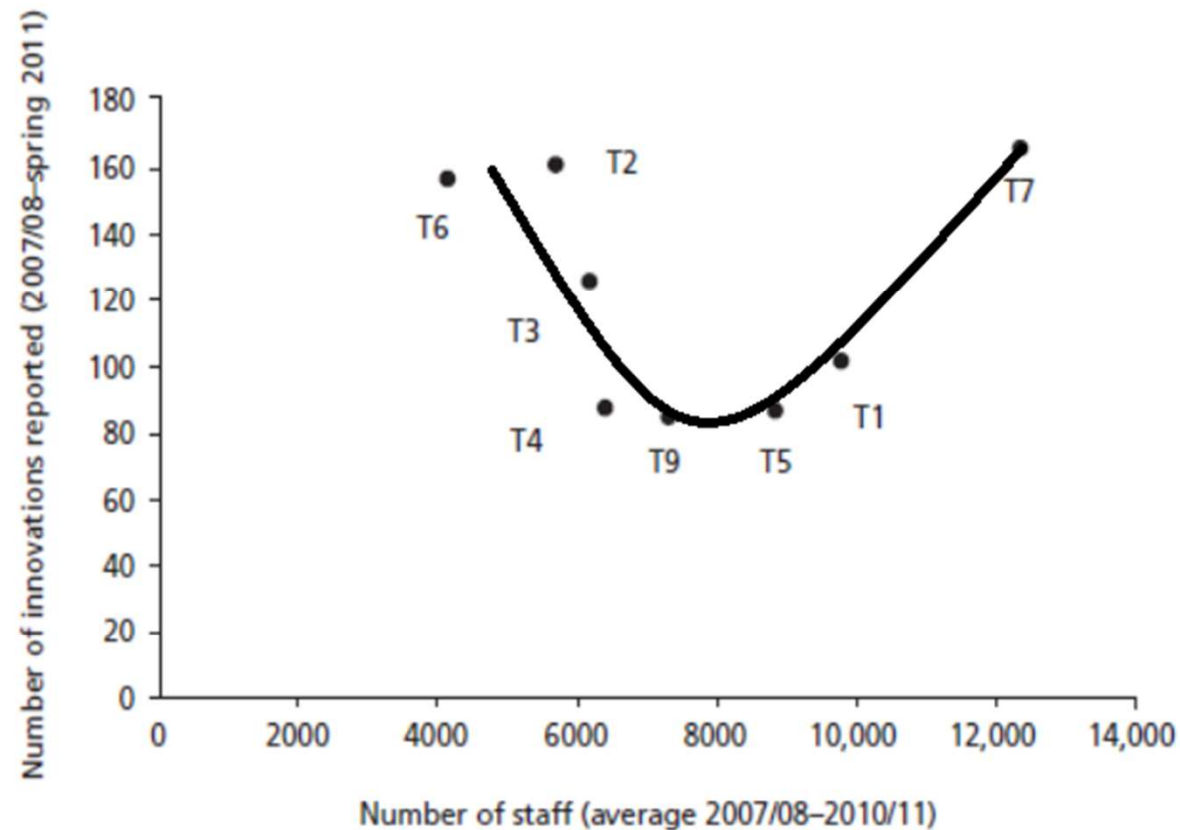
Sampling: cases & participants



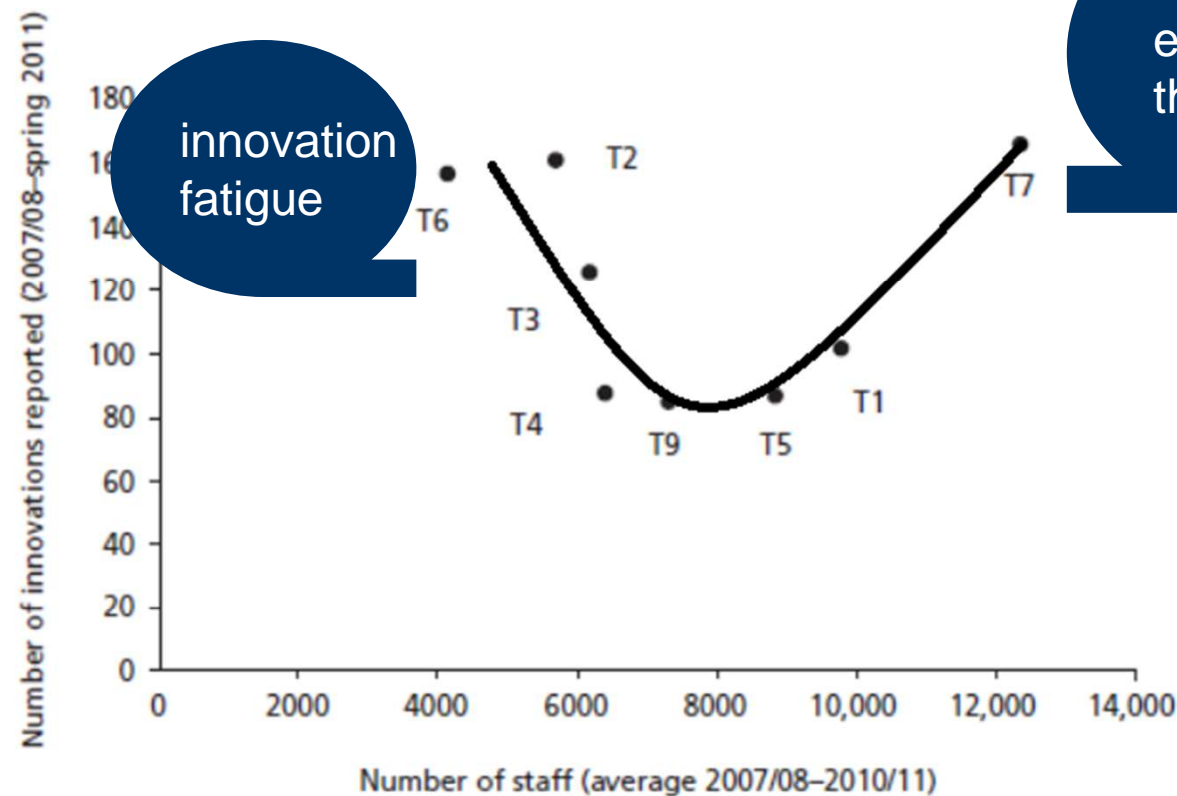
Context - a range of hospitals and innovation activity



Staffing and innovations in infection prevention & control



Staffing and innovations in infection prevention & control



Evidence – paralysing or motivator?

More effort expended in seeking evidence to resist change

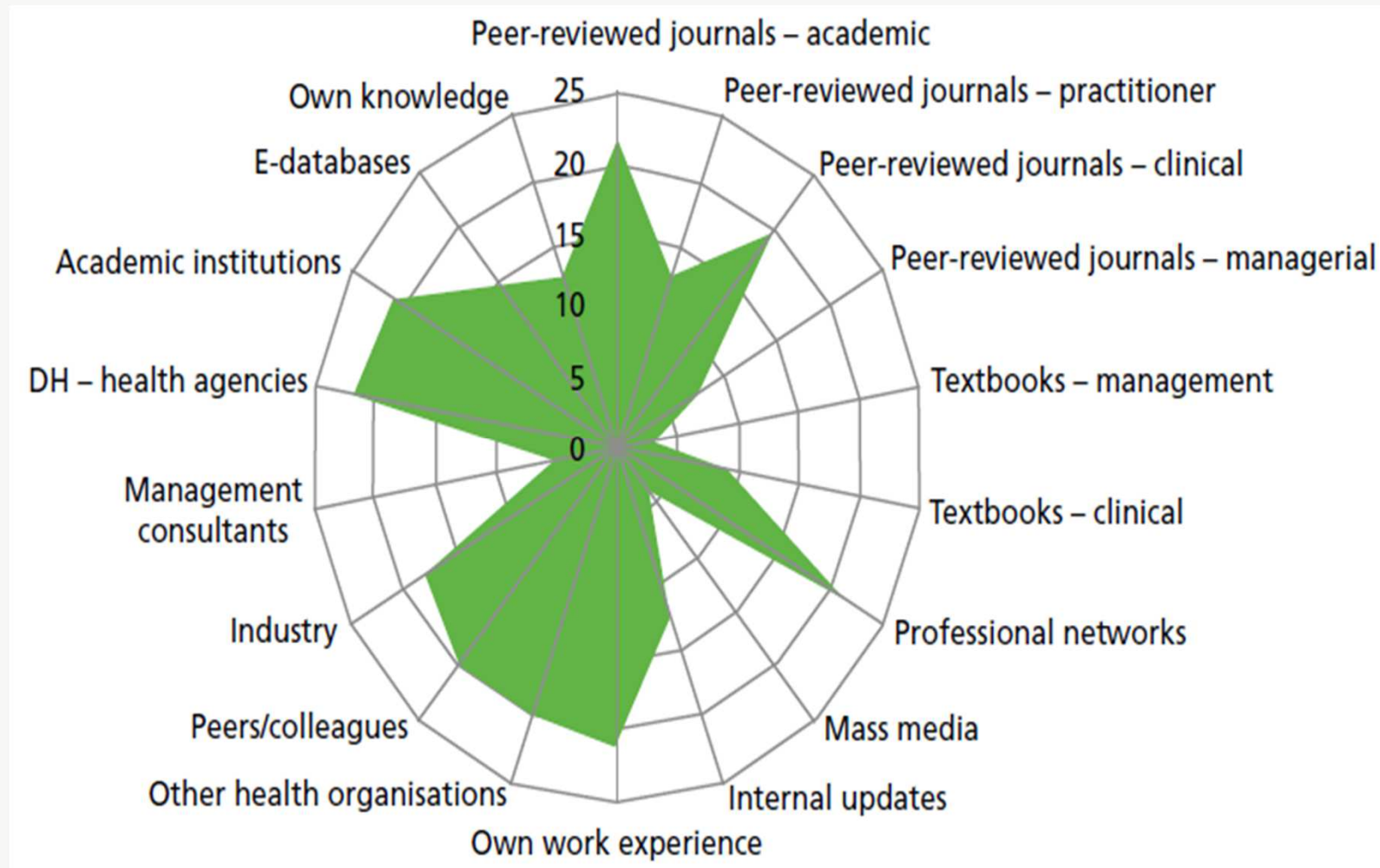
Greater emphasis on 'principles' than 'how-to' knowledge

Different professional groups viewed evidence differently

Kyratsis, Ahmad, Hatzaras, Iwami & Holmes *Health Serv. Deliv. Res* 2014;2(6)
Kyratsis et al, *Implementation Science* 2012; 7(22)

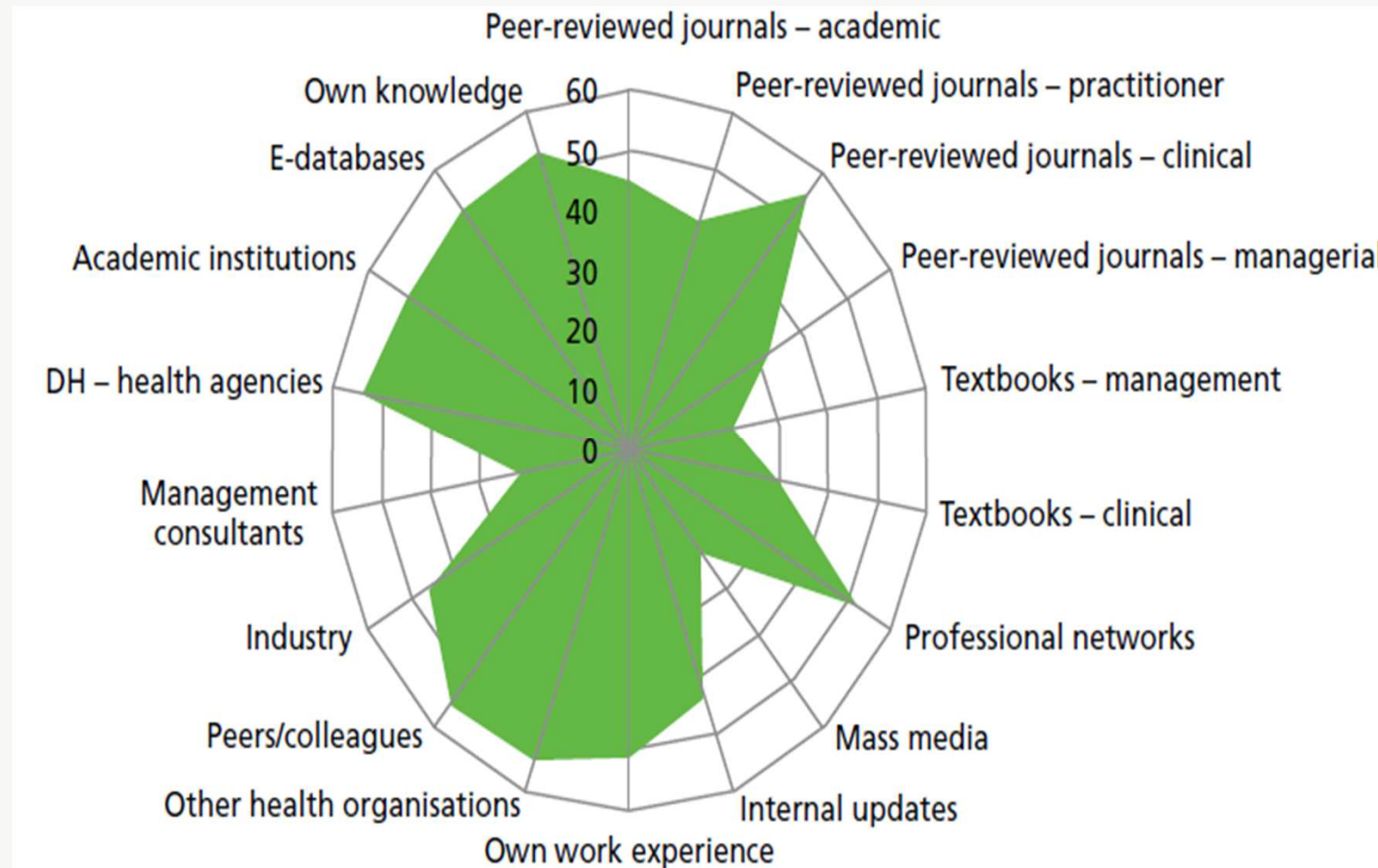
Reported use of general Sources of evidence

Doctors



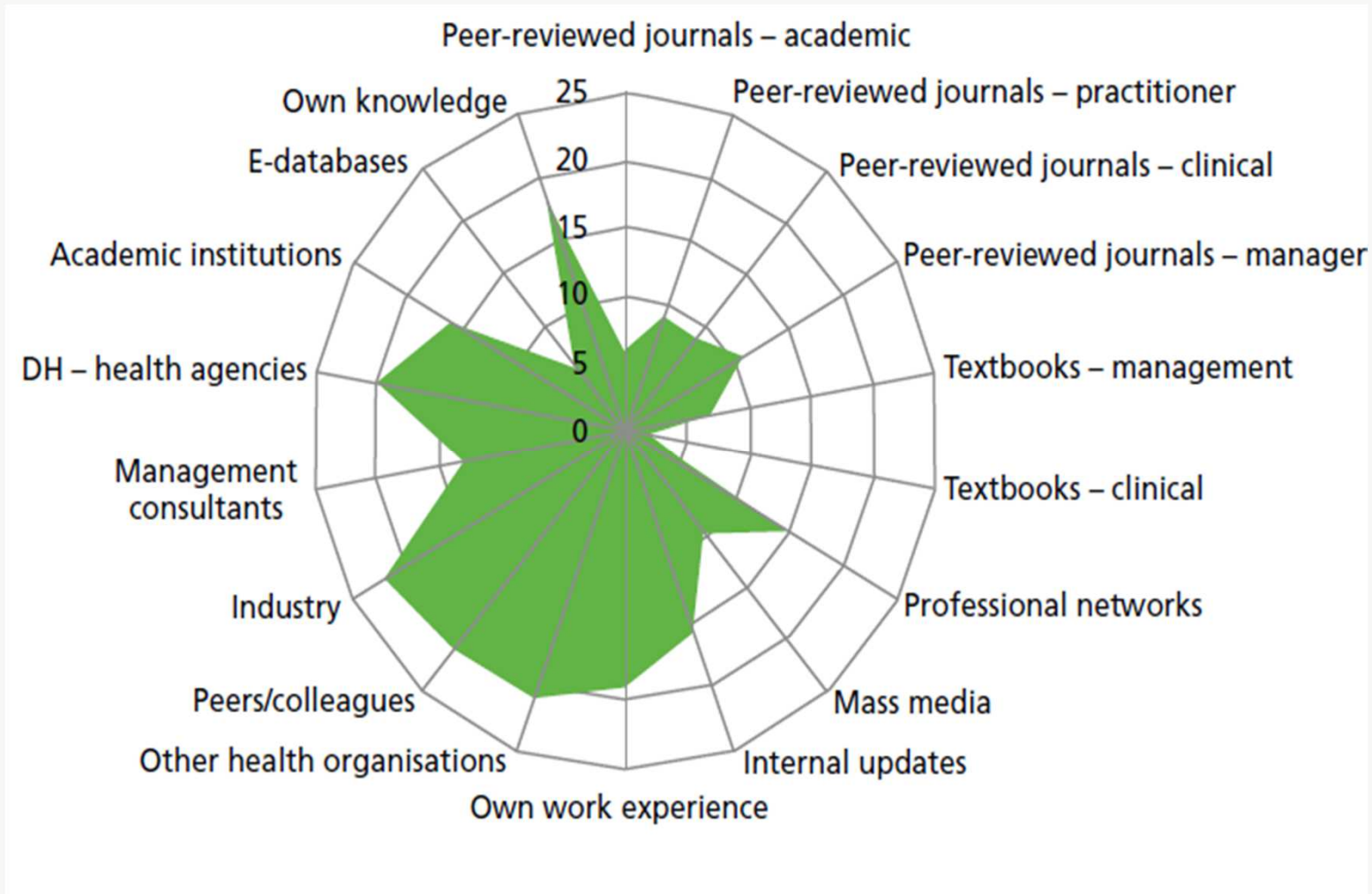
Reported use of general Sources of evidence

Nurses



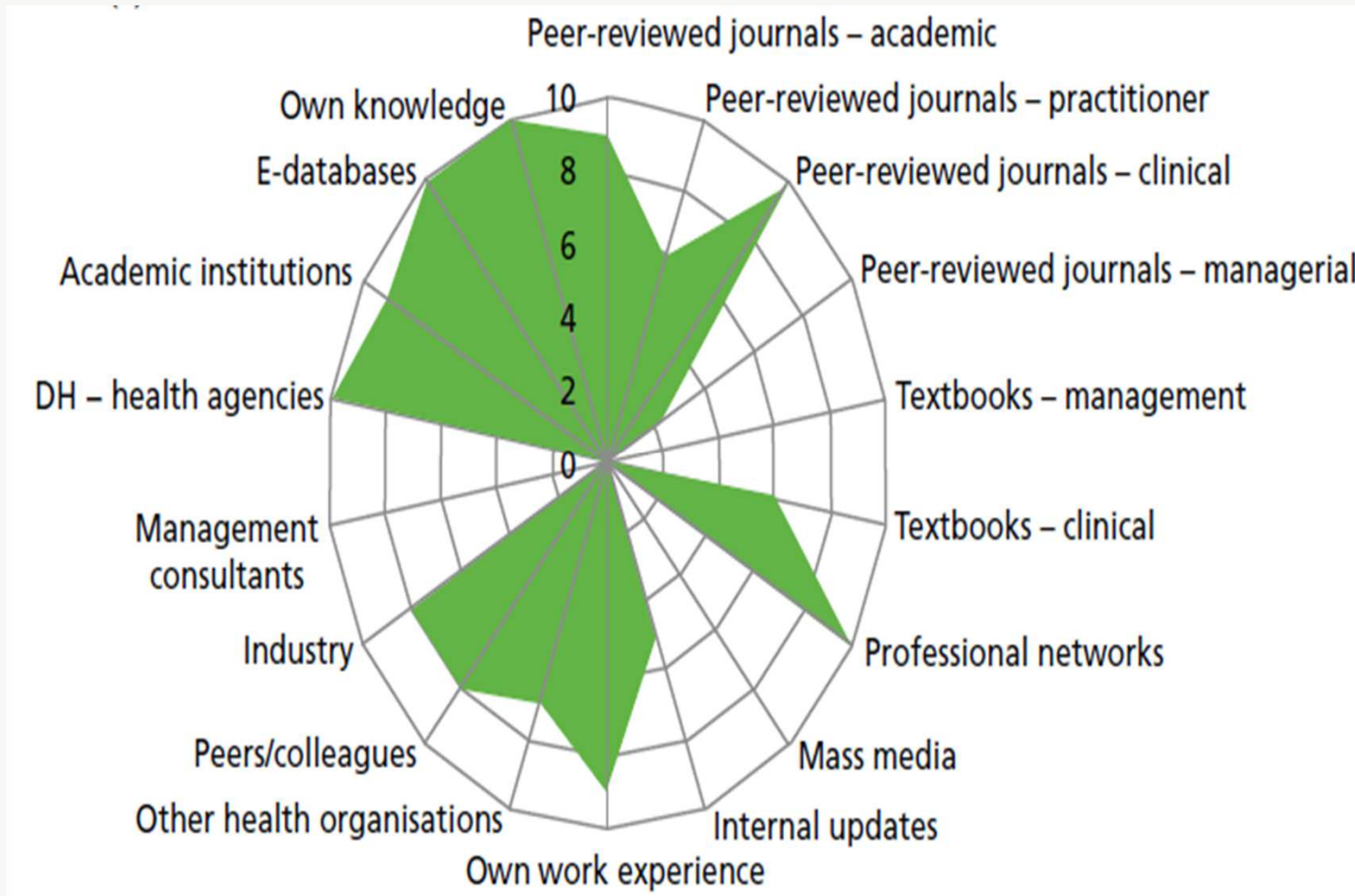
Reported use of general Sources of evidence

Non-clinical Managers



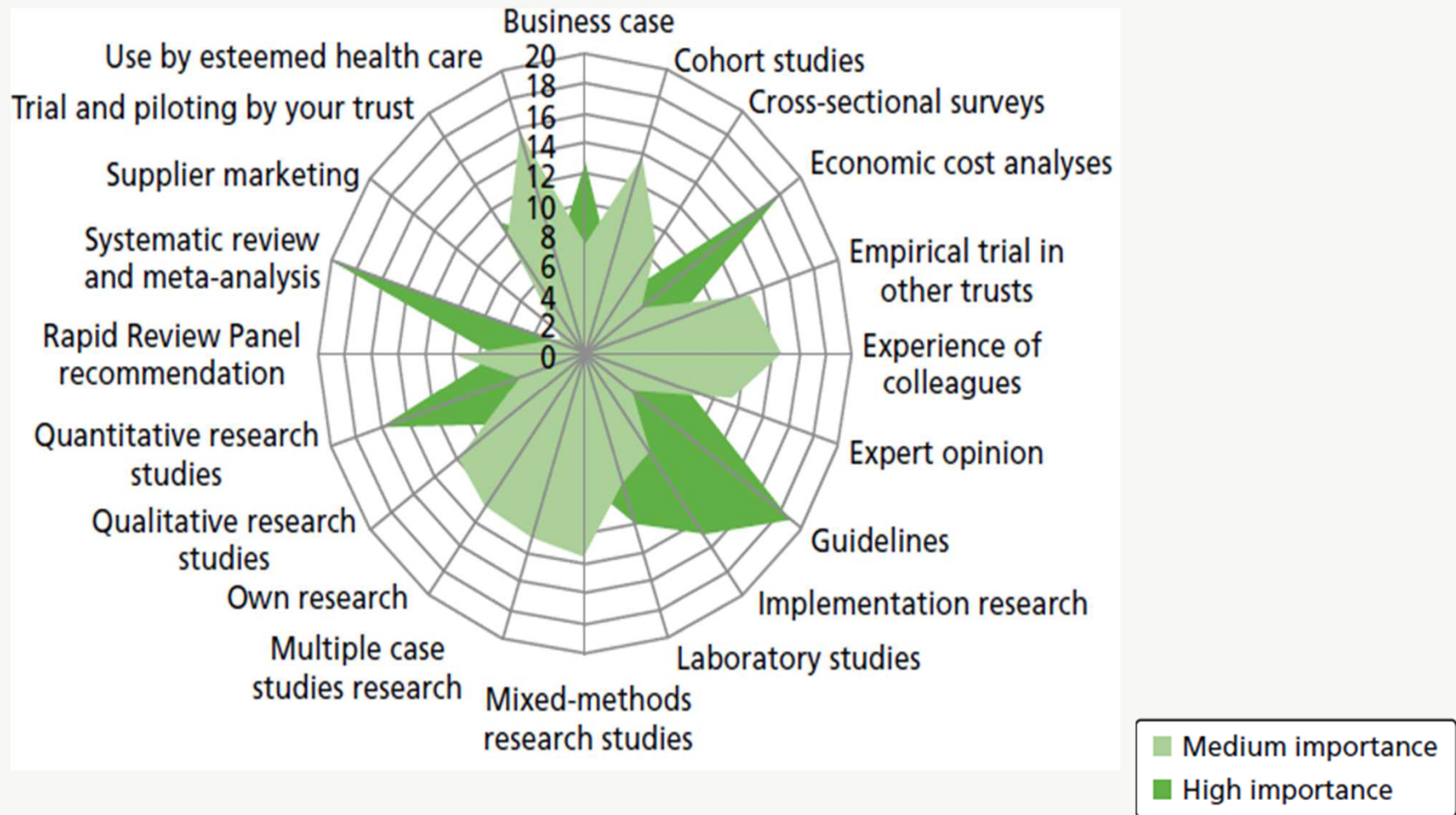
Reported use of general Sources of evidence

Pharmacists



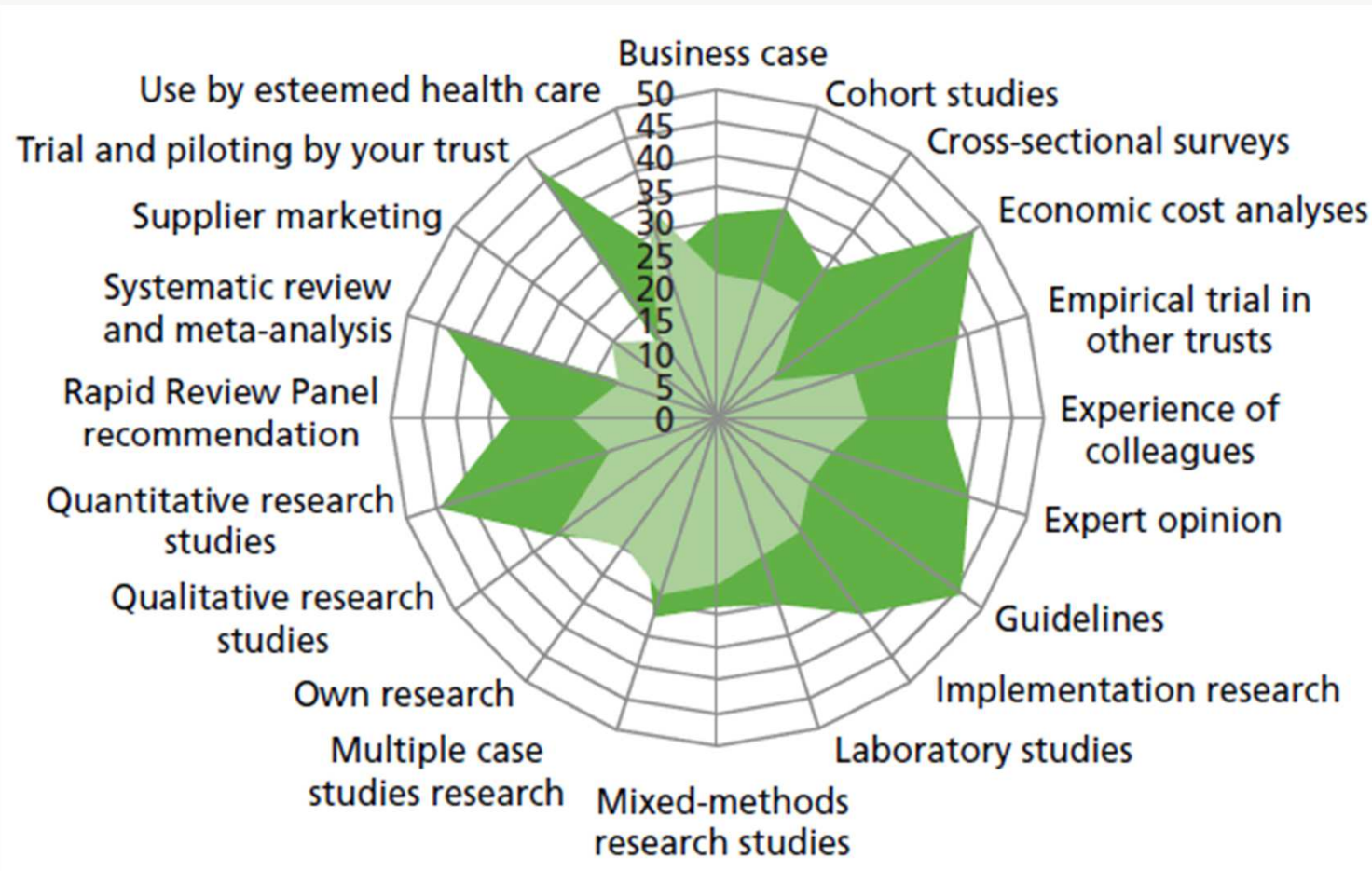
Perceived importance of different *Types* of evidence

Doctors



Perceived importance of different *Types* of evidence

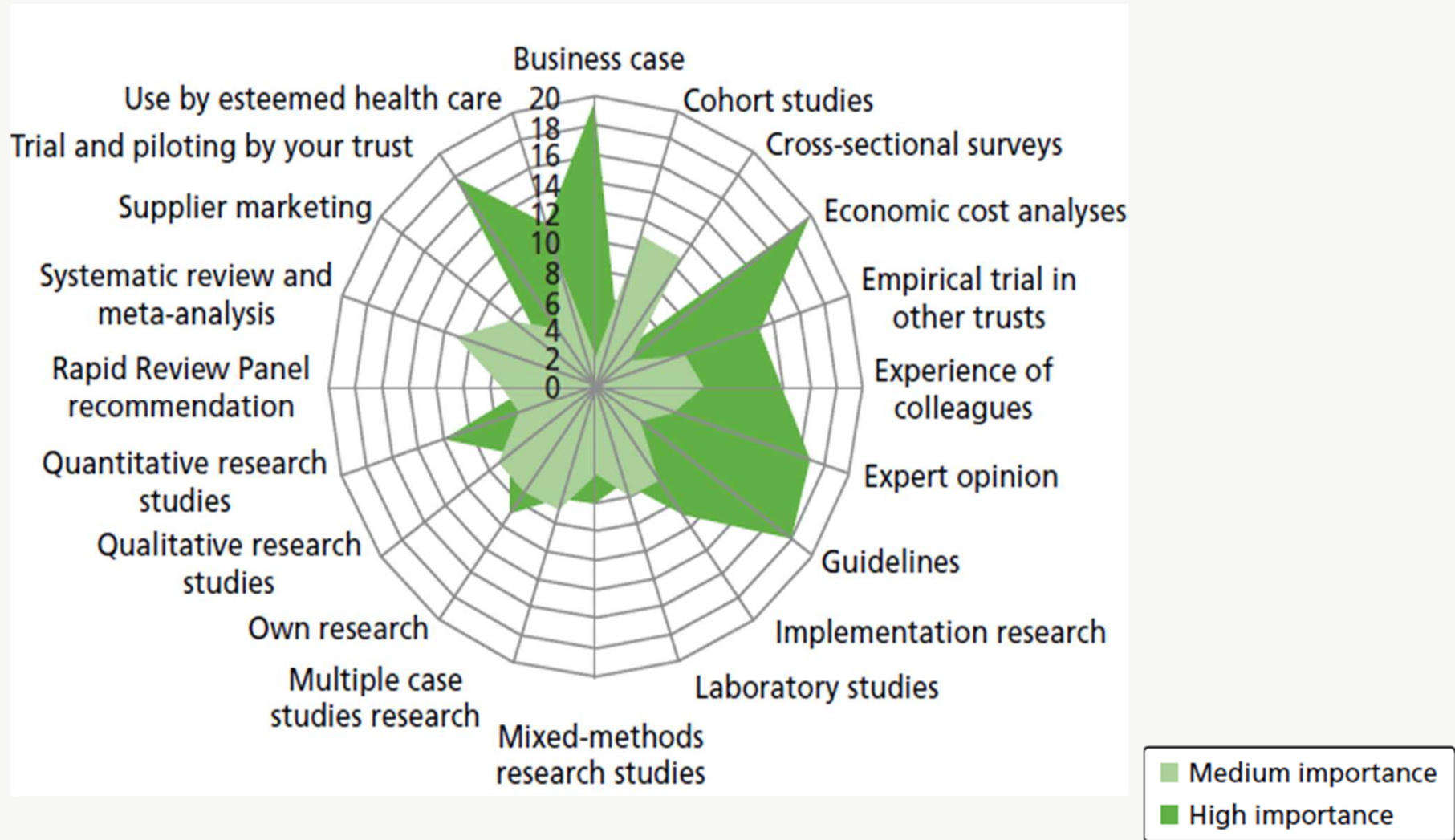
Nurses



■ Medium importance
■ High importance

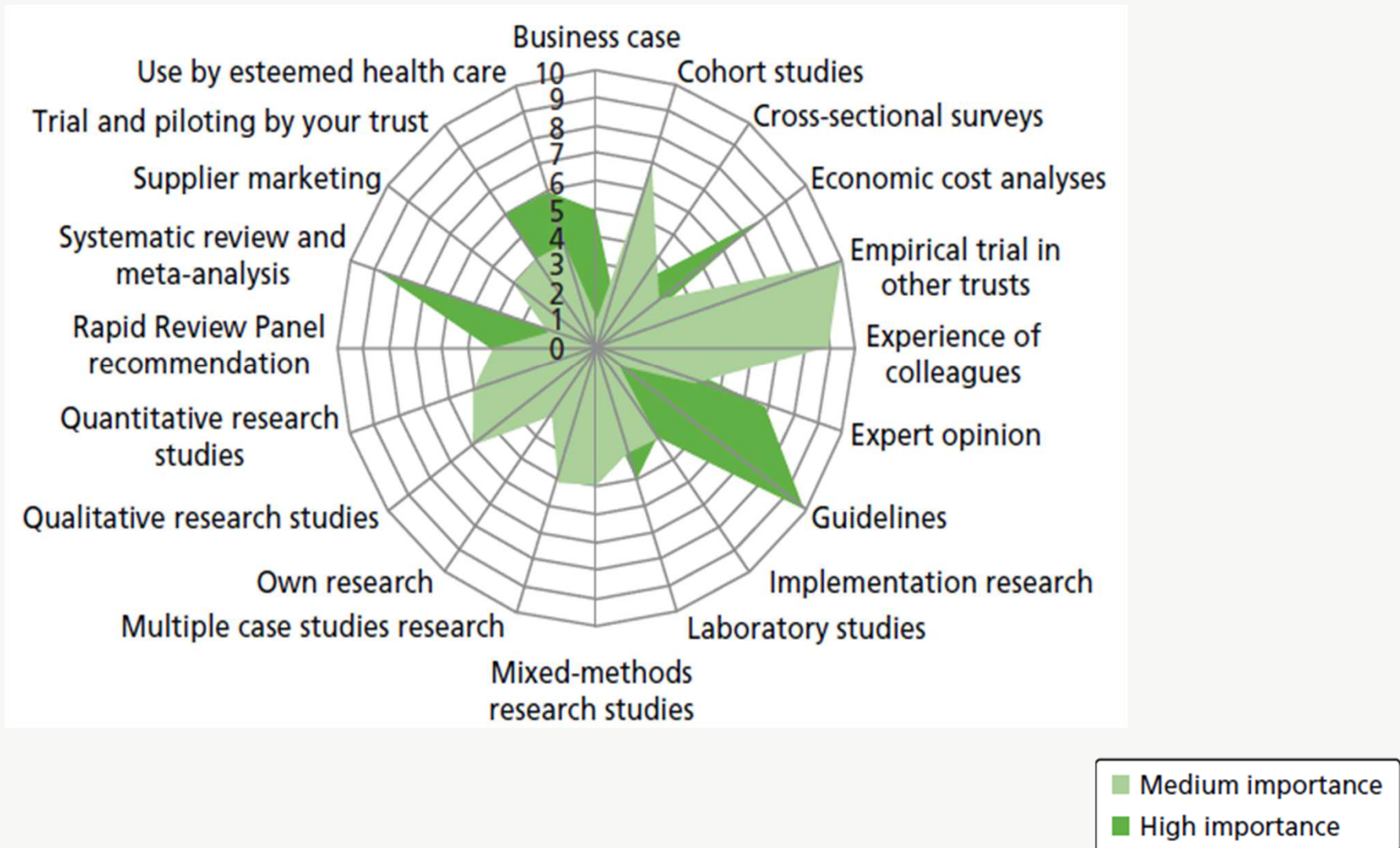
Perceived importance of different *Types* of evidence

Non-clinical Managers



Perceived importance of different *Types* of evidence

Pharmacists



Evidence for clinical vs. managerial decisions

	Clinical Professional	Management Organisational
Entry:	Formal knowledge & training – common frame of reference	Varied backgrounds – no pre-requisite for formal training
Paradigms:	Scientific knowledge	Individualised, experiential
Decision type:	Essentially individual making decision	Making decision on behalf of an organisation
Impact:	Result of decision usually clear	Causation unclear/longer term

Conditions of evidence use

- Organisational problem or **critical event** such as an infection outbreak, or in response to an, '**enthusiast**' or '**champion**'

*Change is forced upon you...a few years ago we had a huge C. Diff outbreak, so we had to do something immediately, or people's lives were at risk. **You can't sort of gather evidence and then go through all the processes; you have to make an instant decision.** I had to make a decision overnight to prevent this outbreak escalating. Obviously I was aware of the Department of Health Guidance, other people's experience. **I had to make reasonable rapid decision.** T4 – doctor*

Hierarchy of evidence

- Processual rather than as an objective vertical hierarchy, or means to exclude certain forms of evidence
- Although the first port of call may be scientific randomised controlled trials (when available), or systematic reviews these types of evidence were assessed in tandem with experiential evidence (own & peers)

The temporal nature of evidence

- The ever-evolving evidence base needs to be considered by managers and decision makers.

- The 'gold standard' of yesterday may even be harmful today

*"I am old enough to see that some of the things that we took as facts, 10 years ago, have already proved incorrect" **T5-doctor***

- The time lag for appropriate evidence to inform decisions

- Temporal constraints

- short time frame to make decisions
- little time to devote to researching for evidence

Internal capacity to process presented evidence

‘content of presented evidence difficult to understand’:

- 75% of medical hybrid managers
- 77% of nursing hybrid managers
- 60% of non-clinical managers

‘difficult to relate evidence to practice’:

- 63% of doctors
 - 72% of nurses
 - 40% of non-clinical managers
-
- Non-clinical managers: placed emphasis on ability to ‘seek out’ relevance to practice in all study types.

Perceived confidence of the presenter of evidence

*Although it galls me to say it but I think the medics within the team are better at accessing [evidence] and they may come to a meeting and say I have had a look at the evidence. I don't think it could necessarily have been a systematic review of the evidence. **Stating quite confidently a particular position and that could be quite influential** so that is something they are more likely to do than nursing Members of the team.*

T7 – non-clinical manager

Motivation and span of evidence sourcing

		Behaviour: span of evidence sourcing	
		Narrow	Wide
Motivation	Plausibility to Self dominates	<i>Medical</i> hybrid manager	<i>Non-clinical</i> manager
	Plausibility to Others dominates		<i>Nurse</i> hybrid manager

Sensegiving strategies by professional experts

- perspective taking
- evidence flexing

Perspective taking

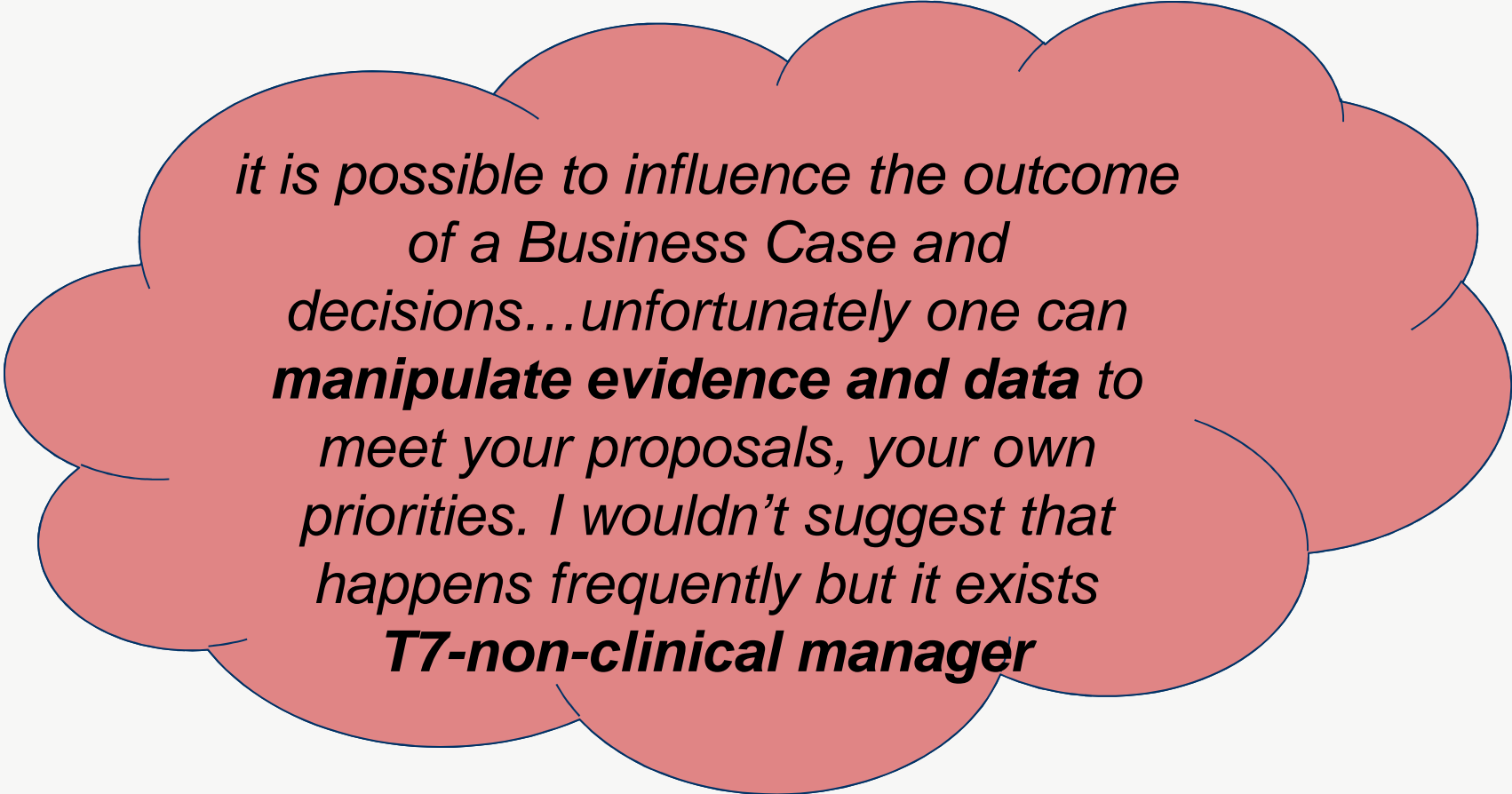
You will see it in very specialist nurses that they will do scoping exercises around what the evidence is, systematic review around evidence of implementing a certain thing and clinical evidence to support it.

*I think **the reason why nurses do that** is because they know that **the doctors**, that are going to try and influence [the decision], **will ask them for that evidence, so they already do it.***

T1 – nurse

Evidence flexing

- Enthusiasts or employed evidence as a '*negotiating tool*' to legitimise positions



*it is possible to influence the outcome of a Business Case and decisions...unfortunately one can **manipulate evidence and data** to meet your proposals, your own priorities. I wouldn't suggest that happens frequently but it exists*
T7-non-clinical manager

Professional experts making sense & using evidence

- Individual and collective 'cognition in context'
 - nature of evidence (type, source)
 - attributes of professionals as presenters or audience (professional identity, managerial role, confidence)
 - sensemaking conditions (timing, contextual pressures, champions, critical events)

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Reference Publications

HEALTH SERVICES AND DELIVERY RESEARCH

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Making sense of evidence in management decisions:
the role of research-based knowledge on innovation
adoption and implementation in health care

Yiannis Kyratsis, Raheelah Ahmad, Kyriakos Hatzaras,
Michiyo Iwami and Alison Holmes

<http://openaccess.city.ac.uk/4712/>

Kyratsis et al. *Implementation Science* 2012, 7:22
<http://www.implementationscience.com/content/7/1/22>



STUDY PROTOCOL

Open Access

Making sense of evidence in management
decisions: the role of research-based knowledge
on innovation adoption and implementation in
healthcare. study protocol

Yiannis Kyratsis*, Raheelah Ahmad and Alison Holmes

Abstract

Background: We know that patient care can be improved by implementing evidence-based innovations and applying research findings linked to good practice. Successfully implementing innovations in complex organisations, such as the UK's National Health Service (NHS), is often challenging as multiple contextual dynamics mediate the process. Research studies have explored the challenges of introducing innovations into healthcare settings and have contributed to a better understanding of why potentially useful innovations are not always

<https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-7-22>

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