IMPLEMENTATION IN THE ARC: ORGANIZATIONAL CHALLENGES & SOLUTIONS

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IMPLEMENTATION SCIENCE NEEDS TO DANCE WITH ORGANIZATION SCIENCE

- Existing implementation science frameworks not provide in-depth analysis of organizational issues: Damschroder et al's CfiR Incorporates 39 constructs, including organizational context but 'ploughs the whole field' superficially & only useful as a first cut of data analysis?
- More sociologically informed theories such as Normalization Process Theory (NPT) examine how evidence-based intervention is embedded in clinical practice, but narrow view of organizational issues
- Organization science brings additionality to the 'party' regarding detailed insight into organizational issues (the managerial agenda across & within organizations)

KEY ISSUE 1: KNOWLEDGE MOBILIZATION

- Develop knowledge brokering roles, but insufficient on their own
- 'Cultivate' communities of practice as a vehicle to engage internal & external stakeholders
- Build 'authentic' knowledge contribution of patients & public: Starts at start & should not be exploitative
- Build 'absorptive capacity (ACAP)' to draw down & utilize evidence at organizational level
- Translation: Allow contextual knowledge of frontline professionals to adapt innovation as it spreads to other settings, but maintain fidelity of core elements

KEY ISSUE 2: DISTRIBUTE LEADERSHIP

- Implementation science alerts us to importance of leadership, but doesn't tell us much about it & assumes senior leadership is key
- 'Innovation' is a four-phase journey (ideation, implementation, sustaining, scaling up), which demands changing leadership configuration
- Need for individualistic leadership (clinical champions acting as 'souls of fire')
- High status doctors well-positioned as clinical champions because they enjoy legitimacy to influence others
- Distribute leadership to others in the innovation journey for knowledge of context (other clinicians), cultivating receptive context (managers) & experiential knowledge (patients/public)

KEY ISSUE 3: HUMAN RESOURCE MANAGEMENT (HRM)

- Much of evidence-based innovation in health care is process or service innovation that involves workforce re-configuration (e.g. new roles & new ways of working)
- Michie's COM-B framework pre-dated by the longstanding Ability-Motivation-Opportunity (A-M-O) framework in HRM
- A: Training & development need, but the implementation of new roles involves more than merely enhancing ability of role holder
- M: Job design & performance management to motivate clinicians to take on new roles?
- O: Talent management & organization development to create the opportunity to enact the new role; e.g. in the face of powerful professionals 'blocking it"

CALL TO ARMS: CHALLENGE OF BRINGING IN YOUR BUSINESS SCHOOLS

- B-schools are ‘cash cows’ for university & set up as factories to teach profitable students (health & care less profitable)
- Research income not important to majority of b-school faculty
- B-school faculty privilege theory development not practice
- Procedural assessment criteria for good research varies across b-schools & medical schools
- Perspective & language vary across b-schools & medical schools
- Solution? You need to identify or recruit key senior knowledge brokers in your b-schools that focus upon health & care

ORGANIZATION SCIENCE & IMPLEMENTATION SCIENCE: LET'S DANCE