Hybrid professionals as institutionalised knowledge brokers: Limited managerial authority in a constraining context

or *'You can't do it on your own!'*

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Overview

- *Background:* Clinicians employed within a large-scale collaboration (CLAHRC GM): *"quasi-managerial practitioners"* (designated knowledge brokers)

- *Empirical study:* Strategies used by knowledge brokers working in a primary care context

- *Methods:* interviews, observation and documentary analysis

Practical and theoretical basis

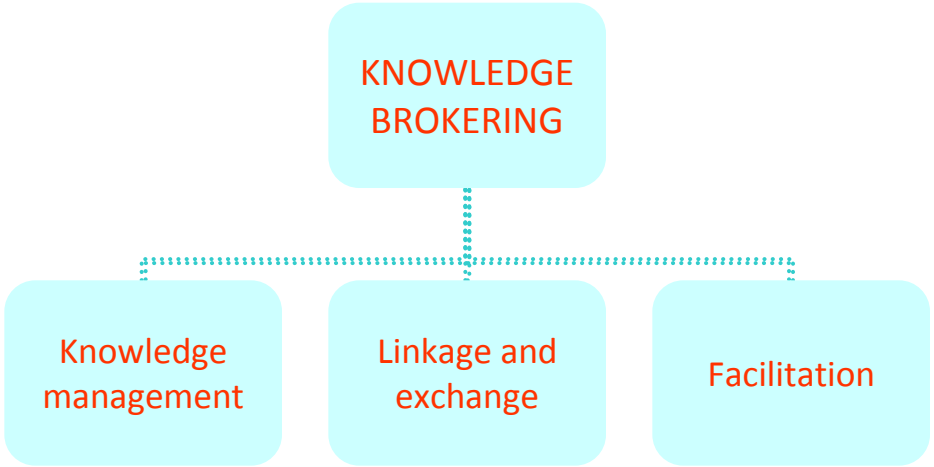
- Supporting general practice to make evidence-based improvement: the primary care context
- Intended to provide facilitation
- "*Seemed like an advantage*" to use people:
  - With a clinical background, who could draw on their clinical knowledge
  - Who would be accepted by other clinicians (legitimacy)

... but

… there are challenges

- Tensions between:
  - professional autonomy and managerial control
  - performance-orientated and collaboration-orientated policies
- Limited managerial influence
- Lack of support from host organisations
- Difficult to broker knowledge to higher-status professionals
- Fragmented nature of healthcare context, especially in primary care

What strategies do knowledge brokers use to moderate these tensions in the fragmented context of primary care?



Relying on additional boundary bridges

…I would confess to… probably taking a back seat a little bit and observing and letting [the managers]… do all the talking [in the meetings with senior people]…

CLAHRC managers as 'external bridges'

…Having a clinical link and a sort of admin link and probably a link with one of the practice nurses… within the surgery seems to be the best model to have… communication with [one of the surgeries]… is difficult because it all goes through one person… and it's hard to know how much information that's sent to her is disseminated.

Primary care clinicians and administrators as 'internal bridges'

Conforming to existing ways of doing things

You have to be ***flexible***, you have to go with their way of working; otherwise they just won't want the meetings to take place… You can't just go in with a blueprint of how it's going to work...

…We have tried to show the GPs who've shown initial reluctance what we've managed to achieve by coding all their patients correctly which will ultimately not only make much better for patient care but will also improve their practice figures. ***…GPs and practice managers are very keen on their QOF figures***

…One GP said to me last week, *'There's no incentive for me to do heart failure reviews'.* People will get better care but he was talking in terms of ***remuneration*** because of the QOF points and things that they get…

Shifting from 'facilitating' to 'doing'

…Our secondees have been encouraged and pushed towards *doing* rather than *facilitating* to achieve [project] outcomes.

Pressure from the CLAHRC

…The restriction of having a [secondee] that, yes, *links* into the rest of the mental health teams, but isn't specifically there to *do* that job… is slightly frustrating…

Pressure from primary care practices

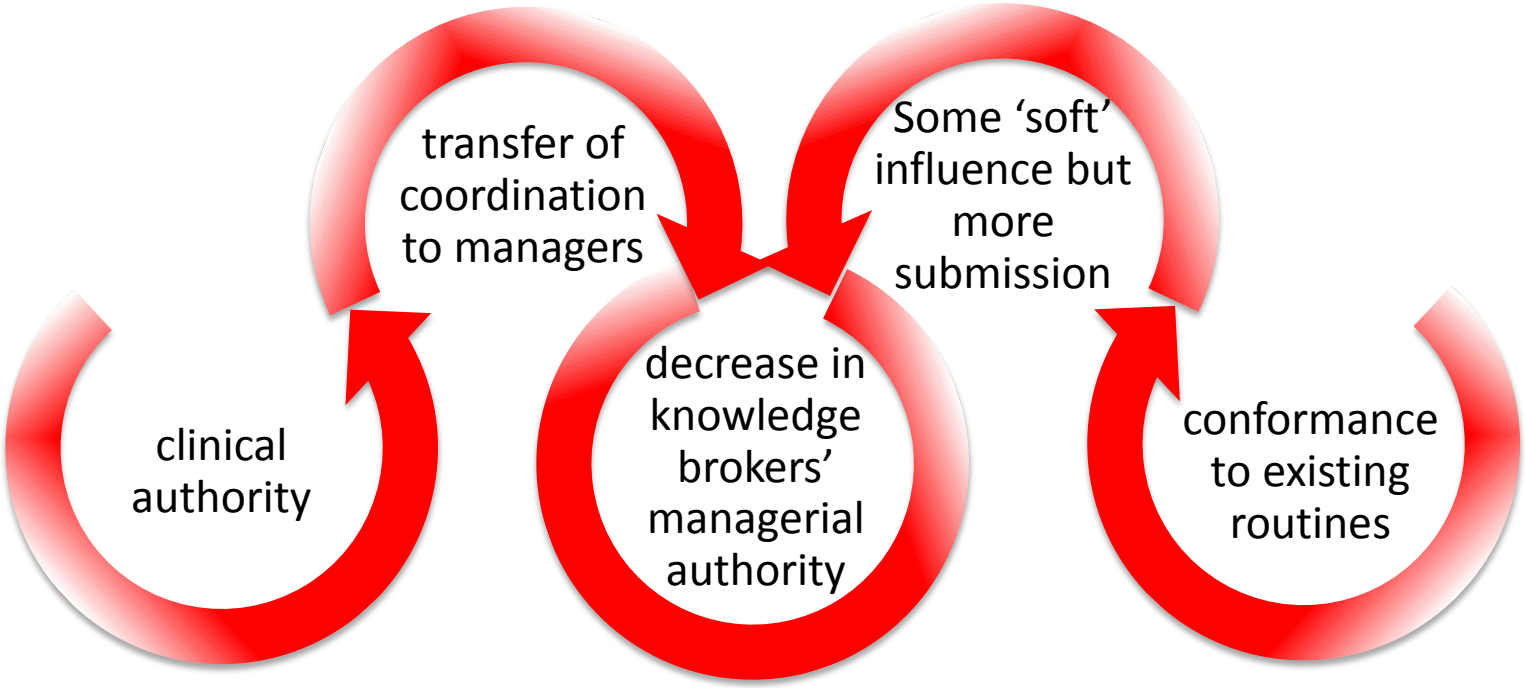
Sometimes, especially with workloads, it's been very, very difficult for [the practices]; I've actually gone in and done some work with them… working through the registers to try and help them tidy up their lists and to generate patients that need reviews...

Theoretical implications

- ***Knowledge brokering as a collective process***
  - Internal and external 'boundary bridges'… but limited choice in selecting the 'bridges'!
  - are 'internal' and 'external' useful terms?

- ***Marginalisation of actual 'knowledge brokering' (tacit, situated, facilitative)***
  - in favour of knowledge codification and meeting performance targets

Power of knowledge brokering clinicians



Practical implications

- Knowledge brokering **teams** including managers
- Multiple **links with actual healthcare practices** at different levels
- **Targets and incentives** are more powerful than the idea of 'helping' the practices improve patient care by brokering knowledge – so use this to advantage
- Need to **support and encourage facilitation** and brokering of tacit knowledge in order to achieve sustainable change in clinical practice…

…but to what extent can 'facilitative' knowledge brokering be deliberately engineered?..