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An analysis of policy to practice initiatives in Scotland: what are the key lessons learned?

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An analysis of policy to practice initiatives in Scotland: what are the key lessons learned?

Aim The study sought to identify and explain common issues and lessons arising from four national health policy initiatives related to nursing, midwifery and allied health professions (NMAHPs) in Scotland between 2005 and 2010.
Background The Scottish government has been seeking effective practice developments in NMAHPs through enacting policy initiatives to improve patient care. Despite many of these initiatives being individually evaluated, no integrative systematic study has been undertaken to synthesise better understandings.
Design Multiple case study design involving qualitative research was the main methodology.
Methods The study used purposive and snowball sampling and in-depth interviews to elicit the views of 24 stakeholders.
Findings This study enabled identification and explanation of key generic lessons such as internal policy alignment, good leadership and governance at all levels, effective communication, and sustainability linked to policy external alignment.
Conclusion and implications for nursing management Findings highlight the importance of strategy for internal policy alignment involving top-down and cross-sectional cooperation and appraising external policy alignment when progressing a sustainable policy initiative. At all levels, leadership is important to provide clear guidance, manage different expectations and enable understanding of initiatives for enactment. Analysis of such initiatives would be useful in preparing nurse managers.

Keywords: case study, framework analysis, lessons, nursing and allied health professions, policy to practice initiatives

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Introduction

Many countries are experiencing increasing demands on their health services, which have to adapt to the changing needs and expectations of patients, clients and carers, especially as a result of aging populations and the growing burden of chronic disease. Within this context, changes in health policy are inevitable and essential (Scottish Executive 2005). A major challenge is how best to ensure that the intentions of a policy lead to effective practice development in the health care service. Thus, it is important to consider not only whether policies have been seen to work in practice, but also to learn cumulative lessons about processes, such as how and why they develop as they do. This paper seeks to address this challenge by

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synthesizing key lessons from four selected policy to practice developments that originated in Scotland between 2005 and 2010.

Background literature and rationale

The international literature on policy to practice initiatives is substantial and diverse, spanning analyses and models of policy formulation (e.g. Kingdon 2002), top-down implementation (e.g. Sabatier 1999), bottom-up approaches (e.g. Hupe & Hill 2007) and practice development (e.g. McCormack *et al.* 2013). Empirical studies of individual developments using mixed methods or qualitative evaluation methods predominate in nursing, midwifery and allied health professions, but there is a dearth of integrative, cross-case analyses that synthesise key lessons across several studies and cover the full gamut from policy formulation through to enactments and outcomes in practice (Ross *et al.* 2011).

Indeed the latter authors' retrospective study of four major nursing developments in England is one of the few substantive studies of this type to date, emphasizing the importance of governance, incentives and outcomes. Leadership at all levels was found to be particularly important, and a range of constraining and supportive mechanisms were highlighted, including contextual, professional and personal factors. However, their work is based solely on documentary analysis of cases that they personally evaluated, and is somewhat limited in its consideration of implementation processes.

As such there is a need for external studies that address this gap. The authors identified a particular need and opportunity in Scotland where, during the last 10 years, the Scottish Government has been developing practice in nursing, midwifery and allied health professions (NMAHPs) through initiatives designed to directly, or indirectly, improve patient care. These initiatives are typically top-down (Sabatier 1999) in character in that they involve centrally initiated national policy developments whose enactment into NHS organisations is actively managed and monitored through central project staff, national steering committees, commissioned education programmes and commissioned external evaluations. While such evaluation studies have been undertaken for individual initiatives, a literature review suggests that no integrative systematic study has been carried out in Scotland. Accordingly, this paper presents key findings from a recent study which addressed this knowledge gap and considers the implications for nursing management.

Research design and methods

A multiple case study design (Yin 2003) offered a suitable underpinning methodology for studying the complexities of a number of initiatives involving a range of stakeholder perspectives. Figure 1 provides an overview of the main phases of this retrospective enquiry in terms of design and enactment.

Through a search of Scottish government websites and university libraries, 31 NMAHPs policy to practice initiatives were initially identified as having being completed between 2005 and 2010. From this pool, 16 initiatives were then excluded owing to them not being of a national scope or not having included education and evaluation programmes. The evaluation reports relating to the remaining 15 initiatives were then reviewed, and their main characteristics were mapped using a matrix technique (Miles *et al.* 2013). In this way it was possible to identify four cases to study that appeared to offer the best coverage of each of the following four main types of initiative: (1) new role, (2) extended/expanded role, (3) enhanced role and (4) general education framework.

Case 1 was an initiative concerned with the development of an extended practice role for the nursing

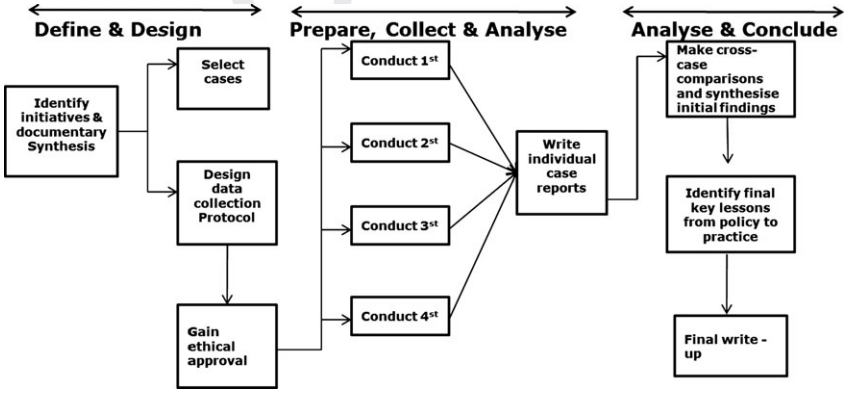

Figure 1
Overview of study design.

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Table 1
Details of participants interviewed

Roles in initiative	*Case 1 (extended role)*	*Case 2 (New role)*	*Case 3 (General educational framework)*	*Case 4 (Enhanced role)*	*Numbers of participants*
Central initiative staff	1	2	3*	1	7
Educator	1	1	1	1	4
Evaluator	1		1	1	3
Manager	2	1	1	1	5
Practitioner	1	1		1	3
Service user representative				2	2
Total numbers of participants	6	5	6	7	24

workforce in Scotland. Case 2 concerned the development of a new practice education role for the workforce across Scotland. Case 3 was a pilot initiative focused on an on-line development programme for learning through a range of learning activities with additional support from work-based mentors, to support newly qualified practitioners of all Allied Health Professionals (AHPs) in Scotland. Case 4 was a national policy initiative which aimed at enhancing practitioners' knowledge, skills and behaviour to achieve best practice, through a specific training programme across mental health services in Scotland.

Study sample and data collection

The following participants were sought to cover a range of stakeholder perspectives across policy to practice development:

- a member of the central initiative staff (e.g. project officer/programme director/project facilitator/steering group member);
- a member of the team involved in the educational programme/framework;
- a member of the evaluation team;
- a manager involved in translating the initiative into practice;
- a practitioner involved in translating the initiative into practice; and
- where relevant, a representative of a service user/public stakeholder group.

Drawing on publically available sources and network contacts, it was possible to use a mixture of purposive (Patton 2002) and snowball sampling approaches (Berg & Lune 2012) to recruit 24 participants for an in-depth interview as detailed in Table 1. As Table 1 shows, it was not always possible to achieve even coverage across all cases. Case 3 had several relevant central staff and not all initiatives involved service users.

All the interviews were in-depth, face-to-face, individual and semi-structured in nature, except for Case 3, where two participants requested to be interviewed together. The lead author conducted all interviews. The core interview schedule explored:

- Why and how did the particular initiative emerge?
- How did it progress and impact?
- What has been learned about the particular initiative (e.g. why did it develop as it did)?

The length of the interviews varied from 45 to 120 minutes. They were audio recorded then transcribed verbatim and imported to NVivo for data analysis.

Statistical analysis

Statistical analysis for each case was driven by the above questions. Additionally, the cross-case analysis (Miles *et al.* 2013) sought to establish:

- What has been learned from these initiatives?
- What are the key transferable lessons from initiatives of this type?

Thematic analysis based on the Framework approach of Spencer *et al.* (2003) was the main method used to identify the key issues and core themes. The lead author undertook primary analysis and the second author checked, critiqued and verified coding and resultant themes.

Results: key themes

Five main themes predominated across the four cases. These were evident from almost every interview in each case, as illustrated in Table 2.

Gaps and challenges

Gaps and challenges were a perceived feature of each initiative. These could relate to the identification of a need for the initiative in the first place.

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Table 2
Common themes relating to lessons learned

Common themes	*Case 1 (sources)*	*Case 2 (sources)*	*Case 3 (sources)*	*Case 4 (sources)*
Gaps and challenges	6	4	5	7
Internal alignment	6	5	5	5
Communication	6	5	4	4
Leadership and governance	6	3	3	6
Sustainability	6	3	3	6

> The Minister for Health at that time had been visiting these different clinical areas, and people were telling him that there wasn't enough support for learning and practice.
>
> (Central Initiative staff, Case 2)

> I think there was also the service user movement was beginning to create, or beginning to develop an influence at the Scottish Government level.
>
> (Educator, Case 4)

There could also be gaps in the means for national enactment.

> Scottish Government had some additional money available which was just there for the AHPs, it was never there for the nurses or midwives, so that was quite controversial.
>
> (Central Initiative staff, Case 3)

Most often the challenges involved the diverse contexts for policy enactment.

> Some Boards had clear strategic professional leadership structures, which were absolutely absent in others. Boards also had different infrastructures, or lack of, for practice development and education.
>
> (Central Initiative staff, Case 4)

> The main issues in terms of the translation process, once again it's about organisation priorities, what is a priority to an organisation?
>
> (Evaluator, Case 4)

At the level of practice, there was often a challenge of gaining initial traction, and a tension between need for prescriptive clarity from the top and centre, and a need for local interpretation and innovation.

> There was a lack of direction there in the early days. The directions there now and that's great but when it first started it was a wee bit up in the air.
>
> (Practitioner, Case 1)

Internal alignment

Good establishment of internal alignment at the vertical and horizontal level was regarded as fundamental if policy to practice initiatives were to have cohesion and lasting impacts.

> … We allocated a number of posts to each board depending on the size and the population of staff that they had there. But we kept the network nationally. We had a national study base for them, we had induction nationally. So we then worked out a model that was national as well as regional as well as local. So, … the core job description and the core function was the same function that we were trying to achieve across the country. Which allowed us a degree of consistency, transferability, sharing the good practice and understanding, and it allowed us to have much more sustainable impact.
>
> (Central Initiative staff, Case 2)

The above quote from the centre highlights top-down (vertical) control but recognises some differences in local settings. Such (horizontal) differences could be a significant issue for both policy enactment and service recipients.

> Every NHS Board wanted them to do something different … every Board; everybody had different expectations of them.
>
> (Central Initiative staff, Case 1)

> I mean its 14 Health Boards and they all took different approaches.
>
> (Service user representative, Case 4)

Leadership and governance

Leadership and governance were intertwined aspects that were seen as key to dealing with the sort of vertical–horizontal tensions alluded to above. Participants viewed clear governance and good leadership at different levels as critical to steer policy into practice. Leadership was about providing support, legitimising professional actions across the wider organisation, access to resources and providing expertise to enable policy change.

> Where you've got a funding model you've got to have robust governance.
>
> (Central Initiative staff, Case 2)

> Leadership at all levels, so from executive to general management to nurses management to ward management.
>
> (Manager, Case 4)

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> Good leaders who understand how to take things forwards and understand the benefit of things can influence their co-workers and they can become the mechanism for communication and I think that's really important.
>
> (Evaluator Case 3)

Communication

Indeed, effective communication was vitally important throughout the process of the policy initiatives. In particular, some participants highlighted what constituted effective/ineffective communication, for example:

> You can't operationalise something in a vacuum and it is working and knowing that those influences like finance, like resource, change, they're all going to bring pressures to bear, so we've got to be mindful of those you know, in terms of how we communicate, when we communicate, who with, but I think communication is the influencing thing really.
>
> (Manager Case 2)

> There is no point in the strategic leader coming to the organisation just saying "this is what we're going to do, this is how we're going to do it" and pass it on to middle management and leave them to get on with it.
>
> (Evaluator Case 4)

Sustainability

Generally, interviewees in Cases 1 and 2 viewed their particular initiatives as overcoming initial challenges to become sustainable, which manifest as recognisable roles within Scottish nursing practice.

> The courses are fairly well subscribed so there must be a need there and we must obviously be able to sustain it.
>
> (Manager, Case 1)

Both initiatives had been running for over 6 years, and their sustainability seemed associated with the development of strong vertical alignment from national, regional to local levels. In contrast, the Case 3 educational framework initiative was more fragmented and was seen by interviewees as being unsustainable for AHPs once funding ceased.

In attempting a values-based enhancement of existing practitioners' knowledge, skills and behaviour, perhaps the Case 4 initiative had the biggest challenge and this was evident in interviewees reflections on its sustainability. Despite strong vertical alignment in this case, the horizontal dimension proved challenging.

> Each of the Health Board areas went off and did their thing … I think very few places would be able to say "Yeah, definitely, it's being maintained".
>
> (Educator, Case 4)

Given the variability in pre-existing clinical cultures, the initiative developed a further national strategy of embedding the education into programmes for new practitioners.

> I think it is sustained through the preregistration programmes, so now all of the mental health nurses, the future generation, should be exiting their programmes having undertaken that sort of the learning.
>
> (Central Initiative staff, Case 4)

Arguably this strategic shift of focus addressed sustainability while providing an exit strategy for the initial centrally funded initiative. Moreover, local managers were able to link and integrate parts of the initial initiative with newer strategies or trends.

> It's now moved in to the sort of quality strategy and we're using those bits of work from that. You know, the patient experience and the work behind that, the person centredness. I like that because it keeps it fresh.
>
> (Senior Manager Case 4)

However, this brought a related danger that practice staff may view them simply as recycled ideas.

> It was interesting people saying "Oh this is just the same stuff as we got years ago, the same stuff, different day".
>
> (Senior Manager Case 4)

Indeed, many interviewees situated initiatives in relation to other preceding, concurrent or successive policy initiatives. This could pertain to related policy drivers or infrastructures for supporting enactment.

> I mentioned that mutuality is a bit of a driver, because it is part of Caring for Scotland, which was our national policy document at the time and it still very much ties into the equality strategy.
>
> (Senior Manager Case 1)

> There's got to be a good support system in place so that in itself, the initiatives got to be linked into other on- going initiatives.
>
> (Manager Case 2)

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Overall, managers seemed well aware of the need to understand particular initiatives as part of a bigger picture.

> ... It's important to see it as part of a big jigsaw where, if you take one piece out, it's going to be missed, but really, so it's important to have all the pieces in place and to think about how they work with each other and how you demonstrate that they work with each other.
>
> (Manager Case 2)

Discussion

Looking at the five main themes to emerge, it can be argued that three are well recognised in the literature, whereas two (internal alignment and sustainability) have received less scrutiny. Accordingly, the former three will be discussed first, more briefly, whereas the latter will be the focus of more developed interpretation.

Gaps and challenges are often the starting point for policy formulation and initial advancement at the top/central level. Kingdon (2002) explains how a gap or'window'may open to enable a policy to be adopted if an arising problem may be brought into alignment with wider policy and politics. Interestingly in several of the initiatives practitioners and service users were seen to provide leverage for leaders to open such windows.

However, the focus for interviewees was more often on gaps and challenges in the process of policy enactment, such as differences in infrastructure and Health Board priorities. The importance of this sort of contextual influence is highlighted by Pettigrew (1988), and contextual integration is the main component of May's Normalisation Process Model (2006) which posits key factors which influence the embedding of new interventions into routine healthcare.

Within this ambit, the importance of leadership to mediate or overcome such challenges is a theme frequently highlighted in the literature (Hunter 2010, Green *et al.* 2011, Ross *et al.* 2011). They suggest that leadership has a great influence on policy to practice change by shaping the system, altering the climate, balancing resources and leading the policy initiatives. Interviewees cited examples from all levels, spanning the sort of top-down nursing leadership that influences and shapes both policy and practice (Antrobus & Kitson 1999), mid-level leadership that bridges the gap between policy and practice change (Birken *et al.* 2013), and the leadership of individual practitioners and service users.

Moreover, at all these levels, interviewees cited communication as a key factor that could enable or inhibit such leadership and the initiative itself. Effective communication was seen as highly necessary to give people a good understanding and awareness of the policy, and to engage people fully within and across vertical and horizontal communication networks when implementing policy to practice changes. This is well documented in existing literature as a necessary (but not in itself sufficient) factor for successful translation of policy (Babcock *et al.* 2010, Scott *et al.* 2012).

All the above three themes emerged as very important in influencing the degree of vertical and horizontal alignment initiated and developed within the four enacted policies. Figure 2 sets this out this skeleton for policy to practice change as a simple schema.

Policy vertical alignment refers to the extent to which a particular governmental sector has sought to implement the policy objectives as central in the portfolio and the hierarchies of management powers within organisations. For example, national steering groups led the implementation of the policy initiatives, along with the hierarchal management, such as the chief nurse, line manager and ward manager within health boards. Policy horizontal alignment is the extent to which a comprehensive cross-sectorial structure for the policy initiatives is developed within and across organisations (Lafferty & Hovden 2003), such as HEIs, Health Boards and their constituent departments.

Mitchell and Shortell (2000) argue that where vertical and horizontal alignments are high, the result is 'high policy alignment—high influence of policy over practice change'. Where the two are low, there is a 'low policy alignment—low influence of policy over practice change'. Even when one of the two is low, there is to some extent the low influence of policy over practice.

Based on the perceptions of the interviewees about these processes and related outcomes, and understandings from the relevant evaluation reports, it was possible to categorise the four cases and map them using a similar typology (see Table 3).

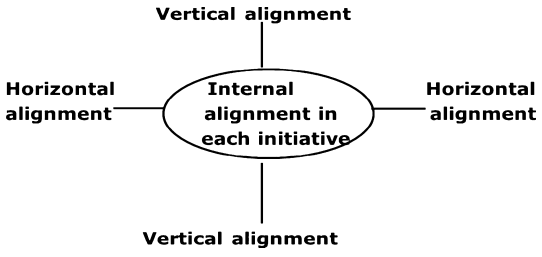

Figure 2
Policy internal alignment.

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internal policy

As suggested by Table 3 and previous findings, the Scottish Government steering groups led and controlled the four national programmes from a top-down governance structure (vertical), whereas collaboration between universities and health boards, coordination between different disciplines within organisations, and support from peers and colleagues (horizontal) influenced implementation. Clearly optimal horizontal alignment was more difficult to achieve even across devolved governmental structures. As can be seen from the findings, Health Boards will not necessarily do what the government wishes.

The cross-case study indicated different levels of sustainability in the four cases. Case 1 and 2 showed high sustainability associated with internal alignment. Focusing on internal alignment, Case 3 and 4 tended to show the opposite. The literature illustrates many factors that can affect the sustainability of policy initiatives, such as financial security, clear strategic planning, education, effective leadership and support from different levels (Israel *et al.* 2006, Parrish *et al.* 2009). These themes also emerged consistently across the four cases.

Sustainability, however, should not necessarily be seen as an absolute goal. Indeed, the challenge is how and when to sustain policy initiatives in NMAHPs practice (Achterberg 2013). In other words, when should an initiative end: when it has served its policy purpose or when it has been thoroughly embedded in existing practice? For example, if the central government stops actively engineering internal alignments, is an initiative sufficiently embedded within individual Health Boards that it will sustain itself?

One concept that is helpful in explaining how initiatives do adapt and evolve, or wither or die, is the process of external policy alignment. As can be seen, many of those interviewed situated and understood particular initiatives in relation to others. Ketels (2003) stresses the importance of seeing one policy as 'part of a big jigsaw'. Dynamic and integrative relationships were identified across our case analyses, but there can also be challenges in how policy initiatives cluster and inter-relate (OECD 2010). Some initiatives have strong thematic and temporal linkages with each other, but others may be 'locked in' or clash with existing initiatives, making the new initiatives more difficult. Thus, there is a question of how these'cluster initiatives'co-exist and develop. The clear message is that the implementation of these initiatives at the time depends on the strength of interaction between the various organisations involved, which allows knowledge to flow more easily and enables the participants to organise collective actions with a significant impact on how the available assets of the policy initiatives are deployed (Ketels 2003).

Thus, sustainability is bound up with the concept of external policy alignment. Schmiedeberg (2010) argues that the continued success of policy initiatives depends on their capacity to change and adapt. This often involves processes where parts of an existing initiative have synergy with a new, upcoming set of ideas or initiative, and there is some integration and re-branding. This raises the prospect of serial versions of similar initiatives (clustering over time) and the danger of experienced staff feeling that they have seen it all before, as highlighted in our findings.

Perhaps the biggest challenge for local organisations is how to use the impetus of such initiatives and to integrate them flexibly into strategies. While government action was key to funding the initiatives and ensuring some level of organisational support, local organisations and individuals played a critical role in prioritising and integrating the policy initiatives into practice. It is here at the sharp end of policy translation that initiatives flourish or founder (Lipsky 1971).

Table 3
Typology of policy internal alignment applied to the four cases

Policy internal alignment	*Degree of alignment/Cases*			
	Case 1	*Case 2*	*Case 3*	*Case 4*
Vertical	High	High	Medium	High
Horizontal	Medium to high	High	Medium	Low/ Medium
Outcome in terms of influence on practice	Medium/high	High	Medium	Mixed, patchy

Limitations

The main limitation of the study relates to the use of snowball sampling as part of the interviewee selection method. As Berg and Lune (2012) point out, this inevitably tends to introduce colleagues from the interviewee's own networks, with the attendant risk of excessive convergence of perspectives. This risk was offset by the initial use of purposive sampling from a matrix to optimise coverage from stakeholders with different roles in each initiative, but it is not possible to definitively say that saturation was achieved in terms of data from all relevant perspectives, especially as practitioner and evaluator groups were less represented.

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Conclusion

This systematic analysis and synthesis of four Scottish policy-to-practice initiatives in NMAHPS, demonstrates that valuable insights can be generated about how and why initiatives develop as they do. While some of the related lessons such as the value of good leadership and effective communication are well recognised, the importance of policy internal and external alignment in influencing the potency and sustainability of initiatives is less well understood. Collectively these lessons are very valuable, not only for future policy-makers, educators, researchers and practitioners, but also for the general public, with the aim of improving patient care.

Implications for nursing management

While the initiatives analysed were all based in Scotland, a country with some distinctive challenges and strengths (Smith 2014), review of the literature suggests that similar types of NMAHP initiatives are not hard to find elsewhere in the world (e.g. Green *et al.* 2011, Ross *et al.* 2011). Within this ambit, nurse managers emerge as a key group in mediating the translation of policy. Our study has shown that horizontal alignment across the managerial bodies who will handle the important issues is critical. Only when policy internal alignment is solid at hierarchical central control and there is co-operation with horizontal inter-managerial bodies, does the policy initiative seem to run smoothly. At the same time, having appropriate policy external alignment is critical to balance the competitions and priorities of cluster initiatives and to support rather than hinder each other. The study suggests that to make this happen there is a need for strategic leadership at different levels which provides clear guidance, manages different expectations and enables people to clearly understand the initiative and situate it in relation to other agendas. This is skilled work which requires good preparation. Accordingly, educational preparation for managerial roles in nursing would benefit from including study of how and why these initiatives arise and develop, so that key lessons such as those identified here can be understood and used to support improvements for practice and for influencing policy.

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Xxxxxx.

Ethical approval

This study was approved by the School of Nursing and Midwifery Ethics Review Panel in Robert Gordon University. NHS ethical permission was not required.

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